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June 9, 2020

The Honorable Mitch McConnell
 Senate Majority Leader
 United States Senate
 Washington, DC 20510

The Honorable Nancy Pelosi
 Speaker of the House
 U.S. House of Representatives
 Washington, DC 20515

The Honorable Charles Schumer
 Senate Democratic Leader
 United States Senate
 Washington, DC 20510

The Honorable Kevin McCarthy
 House Republican Leader
 U.S. House of Representatives
 Washington, DC 20515

Dear Speaker Pelosi and Leaders McConnell, McCarthy, and Schumer:

Thank you for your leadership in responding to the COVID-19 pandemic and your continued work to address both urgent and ongoing needs of your constituents and the economy. State and federal leaders have taken unprecedented actions to protect the health and safety of their residents including steps to ensure access to essential health care services. Access to these services requires the availability of affordable health insurance coverage that can insulate consumers from the high costs of health care while also facilitating access to providers, including telehealth services. Prior to the COVID-19 outbreak, nearly 31 million Americans were uninsured.

Now, millions more are losing coverage as individuals and employers face continued economic uncertainty spurred by this crisis. As State-Based Marketplace (SBM) leaders representing diverse state needs, populations, and political leadership, we are all deeply invested in providing the best and most affordable insurance options for our consumers now and in the future. We write to you to request support and federal policy adaptations to ensure stability and affordability of coverage for the individuals and families we serve during and in the wake of the COVID-19 pandemic's impact on our health care landscape and economy.

How State-Based Marketplaces Are Serving Individuals, Families, and the Newly Unemployed

The health insurance marketplaces provide a critical backstop for individuals and families in need of health insurance coverage. The 19 SBMs (including SBM hybrids using the federal marketplace platform) have enrolled over 4 million individuals in coverage, expanded market competition and have average benchmark premiums approximately 18 percent lower than states that use the federal marketplace.

The National Academy for State Health Policy (NASHP), is a non-profit, non-partisan organization representing an independent academy of state health policymakers. For questions, contact Trish Riley triley@nashp.org

As millions face financial and other life uncertainties, the SBMs are capitalizing on their years of experience successfully enrolling Americans into health insurance coverage to serve as critical touchpoints to provide access to quality, affordable health insurance coverage. In response to COVID-19, the SBMs quickly adapted systems and leveraged local partnerships to ensure that millions of Americans could maintain or acquire coverage. Actions taken by the SBMs include:

- Opening special enrollment periods (SEPs) to allow previously uninsured individuals to enroll in marketplace plans;
- Launching new outreach and marketing campaigns to advertise new and existing SEPs including SEPs triggered by loss of employer coverage, and changes in income;
- Leveraging partnerships with state unemployment offices, community groups, and small businesses to promote access to coverage;
- Adapting eligibility and enrollment systems to ease enrollment processes;
- Coordinating with insurers and state insurance departments to encourage or require grace period extensions, penalty waivers, accelerate coverage start-dates and ensure coverage of critical services including COVID-19 testing and treatment, and telehealth services.

These efforts have helped hundreds of thousands of individuals gain access to critically needed health coverage during these turbulent times.

SBM hybrids using the federal platform, and states that use the federally facilitated marketplace, Healthcare.gov, were not able to offer the opportunity to their citizens as the Centers for Medicare and Medicaid Services (CMS) declined to open a new SEP. In addition, CMS did not invest in supplemental marketing and outreach to increase awareness of existing SEPs that might be available to the millions of Americans who lost their coverage due to job loss or a reduction in hours. As our enrollment indicates, these opportunities are providing needed support for our communities during times of economic upheaval and public health need.

Policy Tools to Enhance Stability and Affordability in the Individual Market

The COVID-19 pandemic has raised national awareness about the importance of health care coverage. However, it has also generated significant uncertainty about the future and stability of the private health insurance market. We recognize that a stable individual market relies on a stable and vibrant group market, but this letter is focused on the needs of the individual market.

Federally-Funded Reinsurance

Many questions remain about how the current pandemic will affect our insurance markets. Recommendations on appropriate courses of treatment, and projections about a possible vaccine are evolving at a rapid pace. Meanwhile, consumers are shifting behaviors related to how they consume health care services, for instance delaying non urgent care, and increasing use of telehealth. Such swift and unanticipated changes make it difficult to predict with certainty what can be expected in the coming months and years, which may lead to significant premium increases for insurers who seek added security against unanticipated costs.

We appreciate attention to policies that may mitigate insurer risk, and specifically note that reinsurance programs have been a proven means to lower premiums and reinforce insurance markets. Immediate establishment of a federal reinsurance program that holds harmless existing state programs, would be

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immensely beneficial by lowering premiums for our consumers at a time when health insurance coverage is especially critical. Currently, 12 states, with federal support, have established reinsurance programs that have been effective in lowering insurance rates. In Colorado, for example, reinsurance has historically lowered insurance premiums by as much as 20 percent. Reinsurance programs were also expected to lower 2021 insurance rates by 7-8 percent in Rhode Island and Oregon, respectively (not accounting for any impact from COVID-19). However, the severe economic impact of COVID-19 on state revenues limits the capacity of states to implement and sustain these programs. A state-run program requires significant state resources at a time when states, who must balance their budgets, face profound decreases in revenues as a result of the pandemic's impact on their economies. Sustained federal funding for reinsurance will provide a consistent, proven solution to improve health insurance affordability.

Enhanced Affordability Supports for Individuals and Families

While federally funded reinsurance is a critical component to protect individuals and families who are suffering the economic impacts of the pandemic, more immediate assistance is needed as well so that people do not lose their existing coverage at this unprecedentedly difficult economic time in our country. The most significant additional step is to enhance federal subsidies available for consumers to purchase health coverage. Increasing subsidies will help ensure that individuals are able to purchase and maintain their health insurance coverage. This will enable access to needed health services such as COVID-19 testing and treatment—essential to help open our economy. Keeping people insured will also protect providers and hospitals from a spike in uncompensated care at a time these practices and institutions are economically vulnerable and will help prevent excess federal spending on care for the uninsured.

Flexibility on tax liability and streamlined eligibility policies

As previously stated, the COVID-19 pandemic is having significant economic impacts on consumers, with a disproportionate effect on low-wage earners who may experience extreme income fluctuations over the coming months and years resulting from changes in employment, wages and eligibility for unemployment insurance benefits.

The Coronavirus Aid, Relief, and Economic Security Act (CARES) included a temporary supplemental unemployment insurance benefit of \$600 per week to bolster individuals experiencing economic hardship. The law also stipulates that this supplemental benefit be disregarded when determining eligibility for Medicaid or the Children's Health Insurance Program but does not explicitly state that the supplemental benefit be waived for determining eligibility for marketplace subsidies including APTCs and cost-sharing reductions (CSRs). Discrepancies in eligibility requirements between programs pose significant operational challenges for integrated eligibility systems that use a single streamlined application and could spur confusion among consumers as they attempt to navigate programs. This confusion may result in consumers either missing out on needed benefits including Medicaid, APTCs or CSRs or may put consumers at risk of tax liability if they inadvertently underreport income and receive excess APTCs or CSRs.

As consumers grapple with significant life changes, including income fluctuations and uncertainty, it would be excessive and destructive to financially penalize individuals and families because of eligibility and income miscalculations. We respectfully request that maximum flexibility be extended

to waive or minimize penalties associated with reconciliation of federal APTCs and CSRs for individuals and families hit by economic hardship for tax years 2020 and 2021. We also encourage that future policies streamline or align eligibility requirements between Medicaid and APTCs/CSRs, including a change in policy so that the \$600 supplemental benefit is waived from eligibility calculations for both Medicaid and marketplace programs. This will mitigate consumer confusion, maximize consumer access to appropriate and needed health benefits, and relieve marketplaces and states agencies from implementing complicated changes to complex eligibility systems.

We thank you for your efforts to date to address this crisis and appreciate your consideration of these additional critical actions. We would be pleased to provide you with any data or information that may be helpful to you. We look forward to working with you to develop solutions that address the urgent health care challenges of COVID-19 and provide stability across all health coverage markets.

Sincerely,



Marlene Caride
Commissioner
New Jersey Department of Banking and
Insurance



Nathan Clark
Chief Executive Officer
MNsure



Michele Eberle
Executive Director
Maryland Health Benefit Exchange



Chiqui Flowers
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Louis Gutierrez
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Lindsay Lang
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Peter V. Lee
Executive Director
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Pam MacEwan
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Washington Health
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James Michel
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Access Health CT



Kevin Patterson
Chief Executive Officer
Connect for Health Colorado



Adaline Strumolo
Director
Department of
Vermont Health Access



Zachary W. Sherman
Executive Director
Pennsylvania Health Insurance Exchange Authority



June 9, 2020

The Honorable Steven Mnuchin
Secretary
Department of the Treasury
1500 Pennsylvania Ave. NW
Washington, DC 20220

The Honorable Charles P. Rettig
Commissioner
Internal Revenue Service
1111 Constitution Ave. NW
Washington, DC 20224

Dear Secretary Mnuchin and Commissioner Rettig:

We write to you as representatives of the State Based Marketplaces (SBMs), whose mission is to offer high-quality, affordable health insurance products to the over 4 million Americans we serve each year. As we all wrestle with the economic and social impacts of the COVID-19 pandemic, the SBMs have been at the vanguard of ensuring that the millions of Americans experiencing disruption of their health insurance benefits have access to a stable and affordable source of insurance coverage. Since the onset of the pandemic, hundreds of thousands of individuals have come to our doors, most struggling with job loss or sudden, significant income changes.

We appreciate the Administration's extraordinary efforts to support health coverage during the crisis, including signing into law legislation to increase federal support for Medicaid and through administrative actions like additional flexibility for tax-preferred health benefits, COBRA continuation coverage, and federal health care programs. These actions to support coverage are crucial to address the pandemic, protect consumers financially, and support front-line health care providers.

We write to ask for action to address a problem that threatens these goals. Specifically, a unique confluence of conditions creates acute risk for individuals seeking to purchase marketplace health insurance with the premium tax credit. Using the credit generally means projecting one's income for the year – and owing money back at tax time if the prediction is off. Current conditions make such prediction infeasible for many taxpayers: employment prospects for the rest of the year are unknowable, and the CARES Act created new income rules that are complex and inconsistent with the long-standing rules reflected in the Marketplace applications. This difficulty predicting income means that taxpayers who receive advance tax credits risk substantial unexpected tax liability. This risk is inimical to our COVID efforts: it discourages taxpayers from enrolling in coverage and imposes potentially onerous tax liability in early 2021, just when the economy should be regaining its stride.

In light of these circumstances, **we respectfully request that the IRS provide the maximum relief possible with respect to repayment of 2020 APTC.** Such relief is clearly permissible under Treasury

and IRS authority granted by the Internal Revenue Code, and it is consistent with previous measures taken by the agencies.

BACKGROUND

The COVID-19 pandemic has resulted in over 40 million unemployment insurance filings across the United States – a number expected to rise. With about 15% of the nation out of work, people in our states are struggling to maintain health coverage. Already we have seen notable upticks in enrollment in coverage offered through our marketplaces as consumers seek out federal subsidies that aid in affording private health insurance coverage.

The main federal subsidy for marketplace coverage is the premium tax credit (PTC) – a refundable tax credit that is generally advanced to taxpayers by the marketplace. Advance PTC (APTC) must then be reconciled against actual PTC on the tax return. Liability for excess APTC is capped for individuals with incomes no more than 400 percent of the federal poverty level (FPL), but the caps run into the thousands of dollars. Because eligibility for the caps and the PTC itself cuts off at a cliff at 400 percent of the federal poverty level, a small difference between projected and actual income for the year can lead to substantial tax liability – in many cases far greater than the income change itself.

Under longstanding rules, eligibility for APTC/PTC, Medicaid, and the Children’s Health Insurance Program (CHIP) are all based on the same income measure, referred to as modified adjusted gross income, or MAGI. Like adjusted gross income, MAGI generally includes unemployment insurance (UI) benefits. However, the CARES Act changed this rule and delinked the income measures used by the programs. Specifically, the additional \$600 per week in UI benefits under the CARES Act (referred to as Federal Pandemic Unemployment Compensation, or FPUC) is specifically excluded from income for purposes of Medicaid and CHIP – presumably with the goal of maximizing eligibility for these programs. But FPUC is included in income for PTC purposes, creating a disconnect. The CARES Act also provides a stimulus payment – generally \$1,200 per adult and \$500 per dependent child – that is excluded from income for all purposes.

UNPRECEDENTED UNCERTAINTY AND CLAWBACK RISK

In normal times, most taxpayers can more easily avoid substantial tax liability by basing their income projections on past experience. But the COVID crisis makes income prediction impossible for many taxpayers, for three key reasons.

First, income for previous years is not currently a good indicator of expected income for the year. This is especially true for those enrolling in or updating marketplace financial assistance mid-year, who are generally doing so because they have lost a job or other income.

Second, predicting income for late 2020 is extremely difficult, since no one knows what the economy will look like in August, let alone November. Taxpayers should not be expected to make predictions about the late-year economy when experts cannot agree.

Finally, the rules under CARES Act rules are novel, complicated, and not reflected in longstanding Marketplace application materials, including those developed by CMS. Taxpayers and enrollment assisters are accustomed to income being the same for Medicaid and APTC, and many do not understand the new rules. This confusion is likely to be exacerbated by the rules for the stimulus

payments, which are excluded for both purposes. Perhaps most concerning, the new rules are not accurately reflected in the architecture of our applications, which were built to reflect the complex set of long-standing rules for income counting. We are sprinting to make changes, but hundreds of thousands have already enrolled used application systems that did not reflect the new rules. Thus, it is likely that mistakes were made, and through no fault of the applicants.

In short, current conditions make it impossible for many taxpayers who receive APTC to avoid the risk of substantial unexpected tax liability.

HARM FROM CURRENT POLICY

In addition to being manifestly unfair, the current dynamic harms the COVID response in several ways.

Discourages health care enrollment. Given the high risk of owing unexpected tax liability, taxpayers facing the current dynamic may simply choose not to enroll in coverage. Without health insurance, individuals face greater risk to both their health and their finances.

Large repayment liability could stall economic recovery. Taxpayers who do accept renewed employment and owe back APTC will face tax bills in early 2021 that could amount to many thousands of dollars, just when they and the economy are getting back on their feet.

These dynamics run counter to federal efforts to expand coverage, contain the spread of the virus, and support economic recovery.

RECOMMENDATION

Fortunately, these harmful dynamics can be averted through straightforward action by the IRS and Treasury Department.

IRS and Treasury Should Immediately Announce Relief from 2020 APTC Clawback for those Affected by the COVID Emergency

In light of the emergent circumstances of the pandemic, we respectfully request that the IRS and Department of the Treasury act to provide temporary relief with respect to APTC repayment. Specifically, given the extraordinary difficulty of projecting 2020 income, taxpayers who receive APTC should be protected from repayment. This relief should be announced as soon as possible to quickly eliminate any disincentive to enroll due to fear of repayment.

We recommend applying this relief broadly given the broadly applicable challenges in predicting income and the importance of administrative simplicity. However, this relief could be limited in a number of ways. For example, relief could be limited to one of the following conditions:

- Individuals who attest at tax filing that they have been adversely affected by the COVID crisis;
- Individuals who received FPUC and therefore were directly affected by the sudden onset of the complex new eligibility rules;
- Individuals who attest at tax filing to having made a good-faith effort to project their income.

LEGAL GROUNDS AND PRECEDENTS FOR RELIEF

The relief described above is within the scope of the Treasury Department's rulemaking authority under the Internal Revenue Code and is consistent with other measures Treasury and IRS have taken over the years and in response to the COVID crisis.

The Code includes both general authority for temporary relief and also specific authority in section 36B. Section 7805(a) of the Code provides broad rulemaking authority to promulgate rules and regulations to support the functioning of the Code. It authorizes the Secretary of the Treasury to "prescribe all needful rules and regulations for the enforcement of [the Tax Code]." It also specifically calls out authority for "rules and regulations as may be necessary by reason of any alteration of law in relation to internal revenue," such as the one created by the CARES Act.

Treasury and IRS have used this authority on numerous occasions to provide temporary relief from the enforcement of tax provisions that were premature or unfair. For example, Treasury relied on this authority in 2013 when it delayed the effective date of three major ACA tax provisions: the employer shared responsibility provision under Code section 4980H, the employer reporting requirement under section 6056, and the coverage reporting requirement under section 6055.

In justifying that action at the time, the Department recounted a long list of similar actions over the years. The list includes actions undertaken by numerous administrations of both parties.¹

In responding to the COVID crisis, Treasury and the IRS have asserted similar broad authority to provide temporary relief. For example, Notice 2020-15 permits HSA-eligible high-deductible health plans (HDHPs) to cover COVID testing and treatment pre-deductible, even though section 223 generally permits HDHPs to cover only preventive care pre-deductible. Notice 2020-15 identifies no specific statutory basis for this change, instead explaining that the relief is necessary "[d]ue to the unprecedented public health emergency, and the need to eliminate potential administrative and financial barriers to testing for and treatment of COVID-19." Notices 2020-29 and 2020-33 similarly provide extraordinary temporary relief given COVID's exigent circumstances. These extraordinary actions show that Treasury appreciates the severity of the crisis and understands its authority to respond with strong temporary action. Similar reasoning is applicable here.

Code Section 36B, which authorizes the premium tax credit, provides additional authority for actions of this sort. Section 36B(g) provides general authority for PTC rulemaking ("The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section..."). And section 36B(g)(1) specifically authorizes regulations to address disconnects between APTC and PTC, calling for "regulations which provide for... the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act."

Flexibility over reconciliation will prevent undue financial hardship and assist Americans in obtaining and retaining health coverage during and after the COVID-19 public health emergency. This aligns with the collective mission of the SBMs and federal actors to increase access to coverage while also

¹ See Testimony of J. Mark Iwry, Senior Advisor to the Secretary and Deputy Assistant Secretary for Retirement and Health Policy, before the House Energy and Commerce Subcommittee on Oversight and Investigations, July 18, 2013, available at <https://www.govinfo.gov/content/pkg/CHRG-113hhrg86396/html/CHRG-113hhrg86396.htm>. A similar explanation and list were included in a [letter](#) dated July 9, 2013 from Assistant Secretary Mark Mazur to House Energy and Commerce Chairman Fred Upton.

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enabling consumers to focus their limited dollars on stimulating our economy rather than risk on unexpected tax liability.

We thank you in advance for considering our recommendation and we would be pleased to provide any assistance or information that could support your decision making on this important topic.

Sincerely,



Marlene Caride
Commissioner
New Jersey Department of Banking and
Insurance



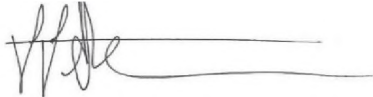
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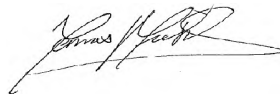
Lindsay Lang
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Access Health CT



Kevin Patterson
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Adaline Strumolo
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United States Secretary of Health and Human Services, Alex Azar

Administrator for the Centers for Medicare and Medicaid Services (CMS), Seema Verma

CMS Deputy Administrator and the Director of the Center for Consumer Information and Insurance Oversight, Randy Pate

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State Insurance Leaders Ask for Federal Action to Make Coverage More Affordable

June 8, 2020 / by NASHFSta

On June 5, 2020, executive directors from 14 state-based insurance companies sent a letter to Congressional leaders voicing support for federal efforts to reinforce insurance markets during the COVID-19 pandemic.

As the coronavirus sweeps across the country, the state-based insurance companies stepped up to provide access to critical health insurance coverage — especially to the millions of uninsured individuals and those newly insured because of job loss. Since opening up special enrollment periods in response to the pandemic, hundreds of thousands of individuals have sought coverage through either the private market or state Medicaid programs.

But challenges remain, particularly how employers and marketplaces can cover their populations given the high costs of insurance that prohibit self-funding coverage. In their letter, SBM directors recommend a federal reinsurance program and enhanced individual insurance subsidies, which have a proven track record of reducing costs and increasing access to coverage.

The mission of the SBMs, which exercise their respective state's more control over their the federal marketplace, is to provide access to affordable, quality insurance plans to individuals. SBMs have a long history of leveraging their flexibility to improve experiences, invest in outreach and working to draw in the uninsured, and to develop policies to lower their health plans costs.



The letter also calls for the waiver of penalties on individuals who inaccurately estimate their future income, increasing their eligibility for tax subsidies with which to purchase coverage through the insurance marketplace. The likely volatility of consumer income during this period may contribute to their under-estimating income and eventually receive excess tax credits.

This issue may be exacerbated by discrepancies in how new unemployment benefits included in the Coronavirus Aid, Relief, and Economic Stimulus Act affect eligibility for Medicaid benefits versus resource subsidies. In a separate letter sent to the US Treasury Department, SBMs elaborate on the need for maximum flexibility on any marketplace-related tax liability.

The letters are signed by SBM directors from California, Colorado, Connecticut, Washington, DC, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, Oregon, Pennsylvania, Rhode Island, Vermont, New York, and Washington.

View the letter to Congressional leaders [here \[https://nashp.org/wp-content/uploads/2020/06/SBM-COVID-Congressional-Letter_FINAL-6-9-2020.pdf\]](https://nashp.org/wp-content/uploads/2020/06/SBM-COVID-Congressional-Letter_FINAL-6-9-2020.pdf).

View the letter to the Treasury [here \[https://nashp.org/wp-content/uploads/2020/06/SBM-Treasury-Response-Letter_FINAL-6-9-2020.pdf\]](https://nashp.org/wp-content/uploads/2020/06/SBM-Treasury-Response-Letter_FINAL-6-9-2020.pdf).

Read the May 11, 2020 NASHP blog: [State-Based Marketplaces Lead in Increasing Access to Coverage during COVID-19 \[https://nashp.org/state-based-marketplaces-lead-in-increasing-access-to-coverage-during-covid-19/\]](https://nashp.org/state-based-marketplaces-lead-in-increasing-access-to-coverage-during-covid-19/)

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COVID-19's Strain On Hospitals May Necessitate More Relief

By **Bruce Deal, Mark Gustafson and Phil Hall-Partyka**

Law360 is providing free access to its coronavirus coverage to make sure all members of the legal community have accurate information in this time of uncertainty and change. Use the form below to sign up for any of our daily newsletters. f Signing up for any of our section newsletters will opt you in to the daily Coronavirus briefing. f

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Law360 (May 26, 2020, 6:02 PM EDT) -- As the U.S. is grappling with the medical and economic repercussions of the COVID-19 pandemic, hospitals are facing an unprecedented financial strain from the costs of mobilizing to treat COVID-19 patients, while practically halting such revenue-generating activities as elective procedures and routine care.

Further pressuring hospital finances, government and commercial reimbursements for COVID-19 cases will likely fall below the average payment that hospitals receive per bed before the pandemic. While the Coronavirus Aid, Relief, and Economic Security Act contains several provisions that direct new funding and resources to hospitals, these amounts are insufficient to cover hospitals' added costs and revenue shortfalls.

Covered California, the Affordable Care Act exchange for California, published initial projections of the financial impact of COVID-19 for hospitals and insurance companies. However, these projections likely overstate the increase in insurance costs during the COVID-19 crisis by overstating the payments that hospitals will receive for treating COVID-19 patients.

Therefore, hospitals may continue to depend on government funding to meet the financial challenges caused by the COVID-19 pandemic.

Hospitals will experience losses from delay of elective procedures.

One large financial blow to hospitals is that many states have ordered or urged hospitals to halt elective procedures, and other hospitals have voluntarily delayed some elective procedures. Hospitals often rely on revenue from elective procedures to fund operating costs; in fact, nearly half of hospital stays that involved an operating room were for elective procedures.[1]

As a result of the near elimination of this revenue source, some hospitals have temporarily closed



Bruce Deal



Mark Gustafson f

outpatient facilities, furloughed nonessential health care workers, and withheld or reduced compensation on staff.[2] Moving work from other cost saving measures may help mitigate these issues, researchers still estimate that 90% of hospitals halting elective procedures will face negative profit margins.[3]



Phil Hall-Partyka

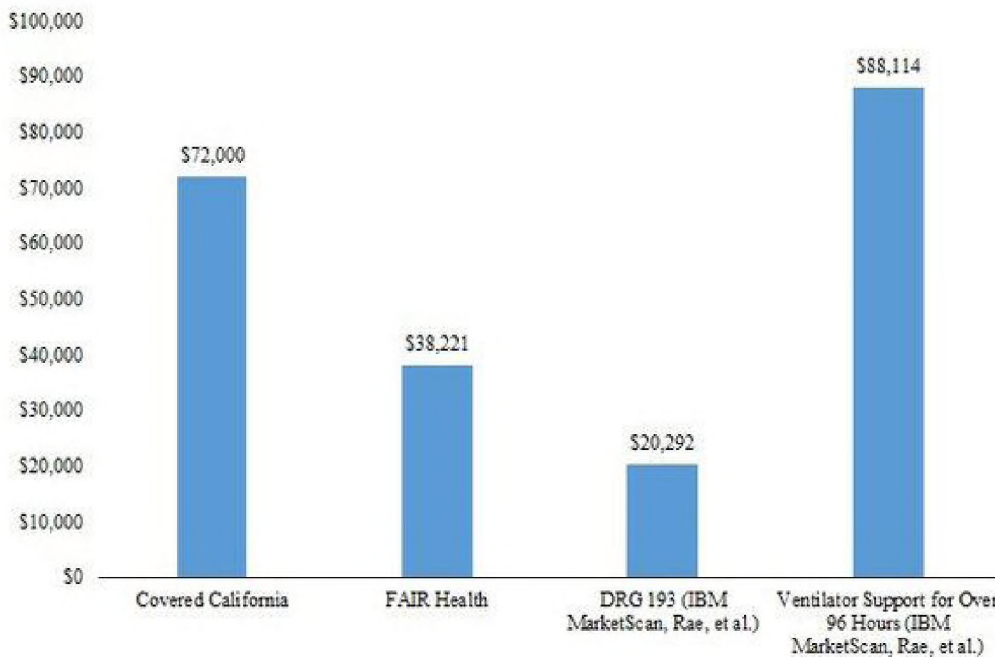
Government policies promoting telemedicine may also assist in the broader economic recovery. Medicare expanded coverage for telemedicine, and on April 2 the [Federal Communications Commission](#) approved a \$200 million program to help providers' cost of connecting with patients.[4] Still, while some patients may receive care with telemedicine or be rescheduled elective procedures after COVID-19 restrictions are lifted, even a temporary delay of appointments will reduce a hospital's profits in the short term.

Hospitals receive smaller payments for COVID-19 cases than for providing other types of care.

As hospitals experience a decline in admissions for elective and even traumatic procedures, in addition to the economic conditions of a patient population that will skew heavily toward COVID-19 patients.

Medicare — and many commercial payers — determine inpatient visits using diagnosis-related groups, or DRGs. As shown in the figure below, COVID-19 inpatient visits will likely fall within one of five DRGs. While Medicare likely would group more moderate inpatient visits as DRGs 193 to 195 — which typically result from diagnoses of influenza/pneumonia and severe cases requiring mechanical ventilation would likely be grouped either as DRG 207 or DRG 208.

DRGs with Highest Medicare Payments for COVID-19 Hospitalizations



It is too early to know the distribution of the severity of COVID-19 cases in the U.S. However, a study by Wei-jie Guan and others found that in China the average length of stay for COVID-19 hospitalizations (regardless of ventilator use) was 12 days for COVID-19 hospitalizations (regardless of ventilator use).[5]

While the differences in medical practices between the two countries and it is unknown to what extent these results will replicate in the U.S., the Guan study suggests that most COVID-19 inpatient visits would not require mechanical ventilation, and thus are likely to result in a DRG of 193 to 195.

Medicare pays between \$5,322 and \$10,009 for inpatient hospitalization for DRG codes 193 through 195, or \$1,378 to \$1,836 per day. In comparison, across all DRGs Medicare pays, on average, \$13,336 per discharge, or \$2,773 per day.

The CARES Act that was signed into law on March 30, contains several provisions that will impact hospitals. For example, Medicare payments for COVID-19 hospitalizations were increased by 20%, and the Medicare sequester that reduces Medicare payment by 2% will be suspended from 1 through Dec. 31.

So, for example, the average payment for DRG 193 will increase from \$1,836 per day to \$2,203 per day. Even with this increase, however, hospitals would still receive \$570 less per day for DRG 193 than the average Medicare payment.

The financial situation is even bleaker for hospitals if the length of stay for COVID-19 cases approaches the 12-day average seen in Wuhan. As shown in the figure above, the average length of stay for DRG 193 is 4.6 days, and even for cases requiring a moderate stay (less than 18 hours), the average length of stay is only 5 days.

While so-called Medicare outlier payments (if the hospital's charges exceed a set fixed-loss cost threshold amount), hospitals will still receive a smaller payment per day if COVID-19 hospitalizations have above-average lengths of stay. Put simply, a hospital full of COVID-19 Medicare patients will likely generate substantially less revenue than a hospital full of the typical Medicare patients.

The financial implications for hospitals with commercially insured patients is less clear. Commercial insurers typically use methodologies and paying a multiple of Medicare rates will be subject to the same kinds of adjustments (at higher per-DRG and per-day equivalents) as Medicare.

Those paying using a per diem method will pay proportional to the length of stay, and those paying as a percentage of charges pay proportional to charges. Either of these methodologies would likely result in higher payment per patient for the hospital than a DRG-based methodology.

Current estimates on financial implications are preliminary

The uncertainty of the severity of COVID-19 impacts on patients is challenging to predict. The Covered California report provided the first national projection of the COVID-19 pandemic for commercial insurers. [7] The authors projected that total costs for COVID-19 treatment for the commercial insurance market would range between \$34 billion for a low scenario (400,000 hospitalizations) and \$251 billion for a high scenario (3 million hospitalizations).

However, the Covered California report likely overstates the increase in projected insurance costs during the COVID-19 crisis and, by extension, overstates the amount of money hospitals will receive from treating COVID-19 patients. First, as acknowledged by Covered California, the report was not intended to offsetting a reduction in claims from delayed or cancelled elective inpatient and outpatient procedures, which could be significant. In addition, we find that the report likely overstates commercial payers' reimbursement for COVID-19 inpatient visits.

The Covered California report assumed that over 90% of the projected costs for COVID-19-related testing and treatment are from inpatient services. The authors assume a large Medicare payment for a COVID-19 inpatient visit was \$30,000, which they then multiplied by the average ratio of commercial payments to Medicare payments (2.4) to calculate an average inpatient payment of \$72,000 per commercial patient.

It is unclear how Covered California determined the average Medicare payment of \$30,000. As shown earlier, this amount is approximately the Medicare standard fee schedule amount for DRG 193 (surgical intensive care unit with major complication or comorbidity) for professional services separately from hospital charges. It would incur additional cost.

However, COVID-19 does not generate significant expense from surgical or other procedures. A very large fraction of patients to be grouped to the most expensive DRGs and a very large number of professional visits per patient to result in an average Medicare payment of \$30,000 per inpatient.

The California Covered study cited a study by Chapin et al. that found a positive relationship between commercial Medicare payments. However, while White and Whaley found a positive relationship across both inpatient and outpatient visits, commercial payments are 241% of Medicare payments for inpatient visits, but only 201% of Medicare payments for outpatient visits.

Using the 201% multiple for inpatient visits reduces Covered California's estimated premium increase by nearly 20%. As a result, hospitals will likely receive something below Covered California's projected \$72,000 amount for commercial COVID-19 hospitalizations, although the amount will depend greatly on the percentage of cases requiring mechanical ventilation.

Other studies also estimate that hospitals will receive far less than \$72,000 for COVID-19 inpatient hospitalizations. A FAIR Health study released on March 25 estimated hospitals and professionals would receive a combined \$38,221 for commercially insured COVID-19 patients.[9] While Covered California estimated an average inpatient stay of 12 days, FAIR Health estimated an average length of stay of only six days and limited the analysis to DRGs 193 to 195, which typically do not involve mechanical ventilation.

A third study by Matthew Rae and others using [IBM MarketScan](#) data estimated average costs per stay of \$20,292 for DRG 193 and \$88,113 for DRG 207 (respiratory system diagnosis with ventilator support for more than 96 hours).[10] If the estimates based on MarketScan data are accurate, the average inpatient commercial reimbursement would approach f \$72,000 only if more than 75% of patients require extended ventilator support.

Estimated Commercial Payment for COVID-19-Related Inpatient Cases

DRG	Description	Medicare Length of Stay	Medicare Standard Payment	Medicare Equivalent Payment per Day
193	Simple Pneumonia & Pleurisy w/ MCC	4.6	\$10,009	\$1,836
194	Simple Pneumonia & Pleurisy w/ CC	3.6	\$7,136	\$1,560
195	Simple Pneumonia & Pleurisy w/o CC/MCC	2.8	\$5,322	\$1,378
207	Respiratory System w/ Ventilator Support >96 Hours	12.1	\$40,218	\$2,961
208	Respiratory System w/ Ventilator Support <=96 Hours	5.0	\$17,437	\$3,067
Average for All Other DRG Codes		4.2	\$13,336	\$2,773

The average Medicare payment is for 2017 and calculated using the Medicare utilization and cost data.

CC = Complication or Comorbidity; MCC = Major Complication or Comorbidity

Summary

The U.S. health care system faces unprecedented physical and financial demands from treating a surge of COVID-19 patients. Hospitals face new costs, such as purchasing additional personal protective equipment and converting hospital wards into ICU levels of care. Payments from treating commercially insured patients are unlikely to cover these costs.

While the CARES Act has directed additional resources to hospitals, these added resources are likely insufficient for hospitals to make up financial shortfalls resulting from practically halting elective procedures and routine care and having f their patient mix shift to a large proportion of COVID-19 patients.

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Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–June 2019

by Robin A. Cohen, Ph.D., Emily P. Terlizzi M.P.H., Michael E. Martinez, M.P.H., M.H.S.A., and Amy E. Cha, Ph.D., M.P.H.
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What's New

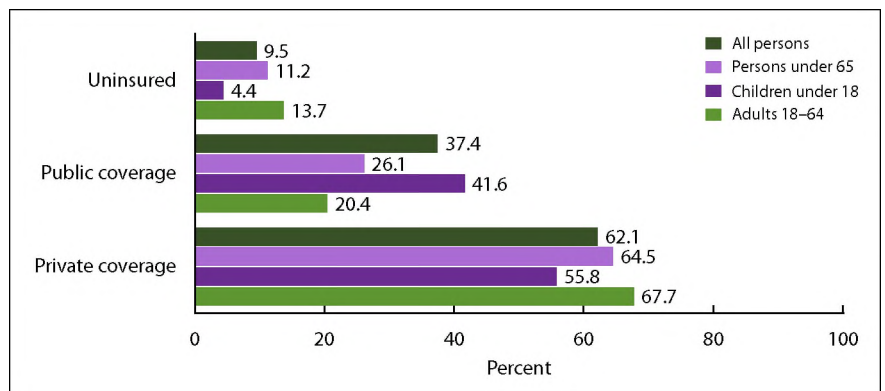
- In January 2019, the National Health Interview Survey launched a redesigned questionnaire. The new design collects health insurance information from one randomly selected adult and child from each household in the survey. Estimates in this report are based on the first two quarters of 2019.

Highlights

- From January through June 2019, 30.7 million persons of all ages (9.5%) were uninsured at the time of interview.
- Among adults aged 18–64, 13.7% were uninsured at the time of interview, 20.4% had public coverage, and 67.7% had private health insurance coverage.
- Among children aged 0–17 years, 4.4% were uninsured, 41.6% had public coverage, and 55.8% had private health insurance coverage.
- Among adults aged 18–64, men (15.4%) were more likely than women (12.1%) to be uninsured.
- Among adults aged 18–64, Hispanic adults (27.2%) were more likely than non-Hispanic black (13.6%), non-Hispanic white (9.8%), and non-Hispanic Asian (7.4%) adults to be uninsured.
- Among adults aged 18–64, 4.6% (9.0 million) were covered by private health insurance plans obtained through the Health Insurance Marketplace or state-based exchanges.

Since 2001, the National Center for Health Statistics (NCHS) National Health Interview Survey (NHIS) Early Release (ER) Program has released selected estimates of health and health care for the civilian noninstitutionalized U.S. population. In 2019, the NHIS questionnaire was redesigned to better meet the needs of data users. The redesign aimed to improve the measurement of covered health topics, reduce respondent burden by shortening the length of the questionnaire, harmonize overlapping content with other federal surveys, establish a long-term structure of ongoing and periodic topics, and incorporate advances in survey methodology and measurement. See [Technical Notes](#) for more information on the potential impact of the questionnaire redesign on insurance estimates. This report presents estimates of health insurance coverage for the civilian noninstitutionalized U.S. population based on data from the January–June 2019 NHIS. These estimates are being published prior to final data editing and final weighting to provide access to the most recent information from NHIS. Detailed appendix tables at the end of this report contain all estimates presented in the figures and additional selected population estimates. Estimates for 2019 by quarter, age group, and poverty status in a separate table, as well as more information about NHIS and the ER Program, are available from the NHIS website at <https://www.cdc.gov/nchs/nhis.htm>.

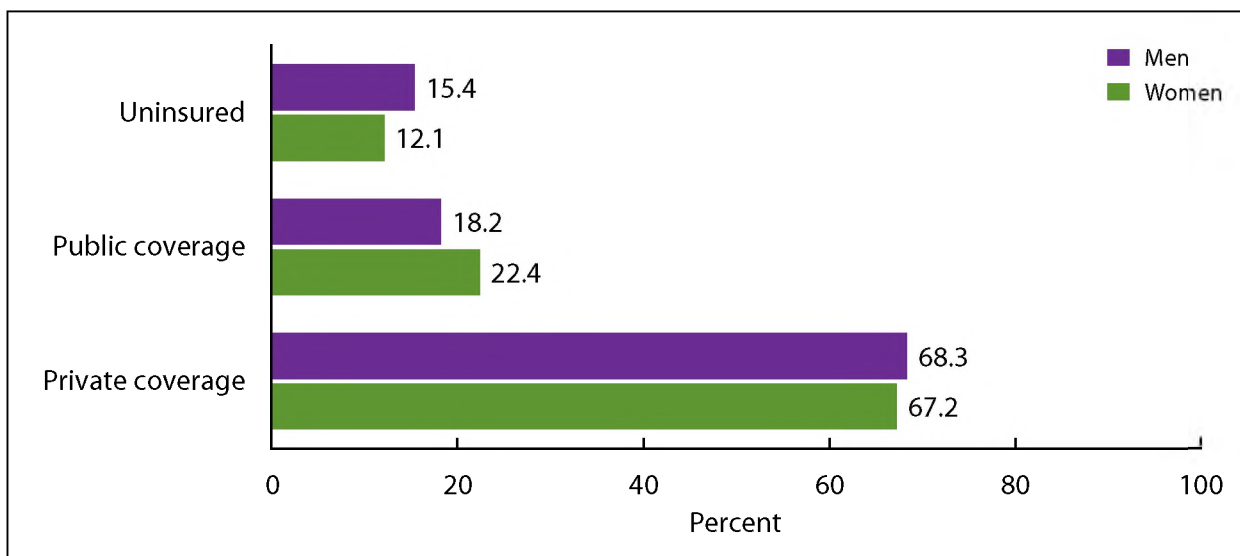
Figure 1. Percentages of persons who were uninsured or had public or private coverage at the time of interview, by age group: United States, January–June 2019



NOTES: Persons were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government plan, or military plan. Persons were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care. Public coverage includes Medicaid, CHIP state-sponsored or other government-sponsored health plan, Medicare, and military plans. Private coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories. Data are based on household interviews of a sample of the civilian noninstitutionalized population. SOURCE: NCHS, National Health Interview Survey, 2019.

- From January through June 2019, among persons of all ages, 9.5% were uninsured, 37.4% had public coverage, and 62.1% had private coverage at the time of interview (Figure 1).
- Among persons under age 65, 11.2% were uninsured, 26.1% had public coverage, and 64.5% had private coverage at the time of interview.
- Among children aged 0–17 years, 4.4% were uninsured, 41.6% had public coverage, and 55.8% had private coverage at the time of interview.
- Among adults aged 18–64, 13.7% were uninsured, 20.4% had public coverage, and 67.7% had private coverage at the time of interview.

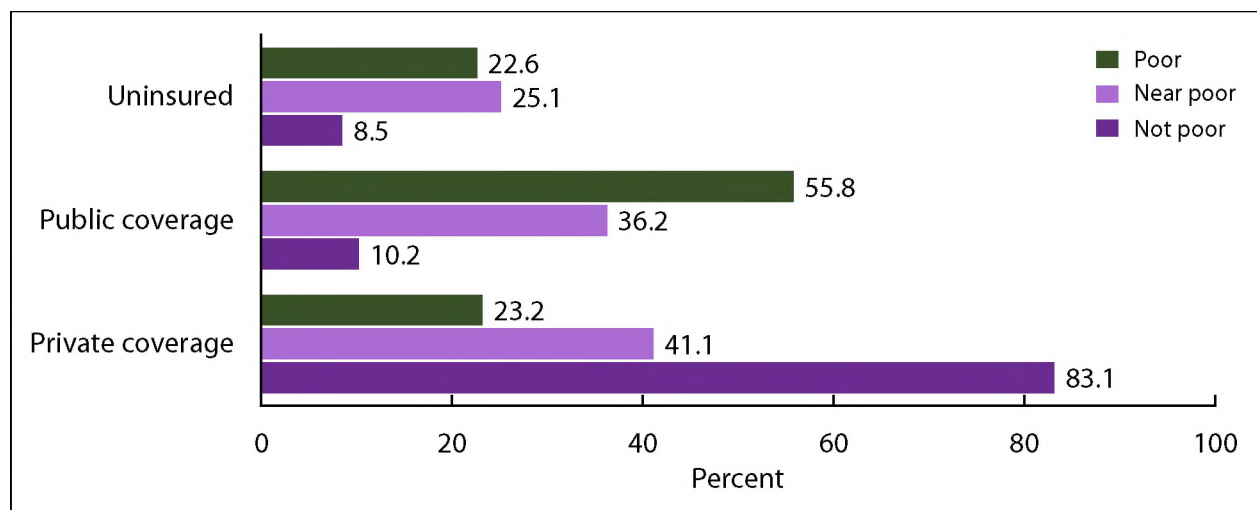
Figure 2. Percentages of adults aged 18–64 who were uninsured or had public or private coverage at the time of interview, by sex: United States, January–June 2019



NOTES: Persons were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children’s Health Insurance Program (CHIP), state-sponsored or other government plan, or military plan. Persons were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care. Public coverage includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. Private coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories. Data are based on household interviews of a sample of the civilian noninstitutionalized population. SOURCE: NCHS, National Health Interview Survey, 2019.

- From January through June 2019, among adults aged 18–64, men (15.4%) were more likely than women (12.1%) to be uninsured at the time of interview (Figure 2).
- Men (18.2%) were less likely than women (22.4%) to have public coverage at the time of interview.
- The observed percentage of men (68.3%) with private coverage at the time of interview was higher than, but not significantly different from, the percentage of women (67.2%) with private coverage at the time of interview.

Figure 3. Percentages of adults aged 18–64 who were uninsured or had public or private coverage at the time of interview, by poverty status: United States, January–June 2019

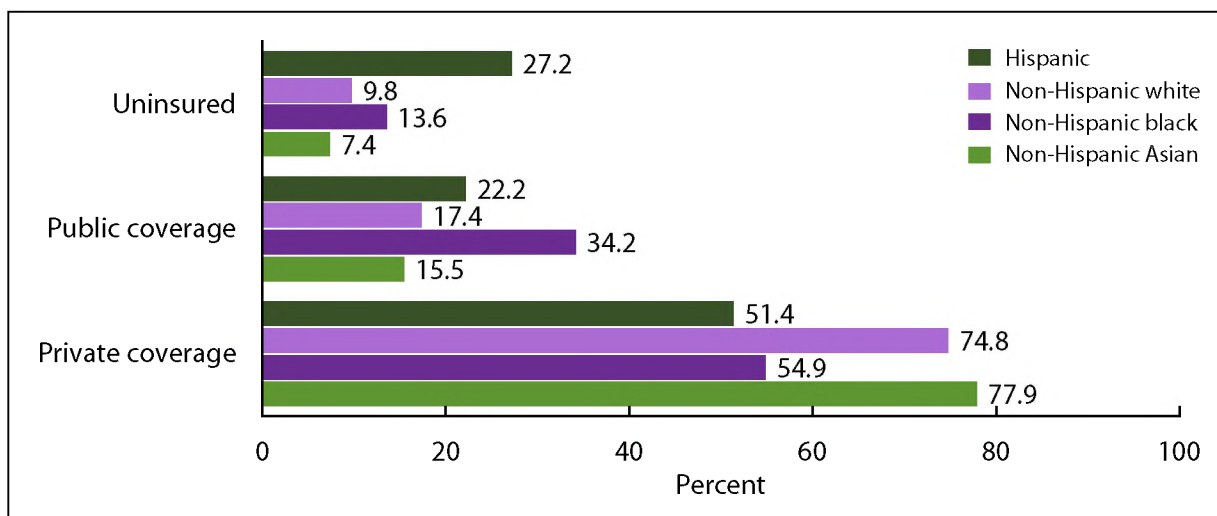


NOTES: Poor persons were defined as those with incomes less than 100% of the federal poverty level (FPL); near-poor persons have incomes 100% to less than 200% of the FPL; not-poor persons have incomes that are 200% of the FPL or greater. Persons were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children’s Health Insurance Program (CHIP), state-sponsored or other government plan, or military plan. Persons were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care. Public coverage includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. Private coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2019.

- From January through June 2019, among adults aged 18–64, the percentage who were uninsured at the time of interview was highest among those who were poor (22.6%) and near poor (25.1%) compared with those who were not poor (8.5%) (Figure 3).
- The percentage who had public coverage was highest among those who were poor (55.8%), followed by those who were near poor (36.2%) and those who were not poor (10.2%).
- The percentage who had private coverage was lowest among those who were poor (23.2%), followed by those who were near poor (41.1%) and those who were not poor (83.1%).

Figure 4. Percentages of adults aged 18–64 who were uninsured or had public or private coverage at the time of interview, by race and ethnicity: United States, January–June 2019

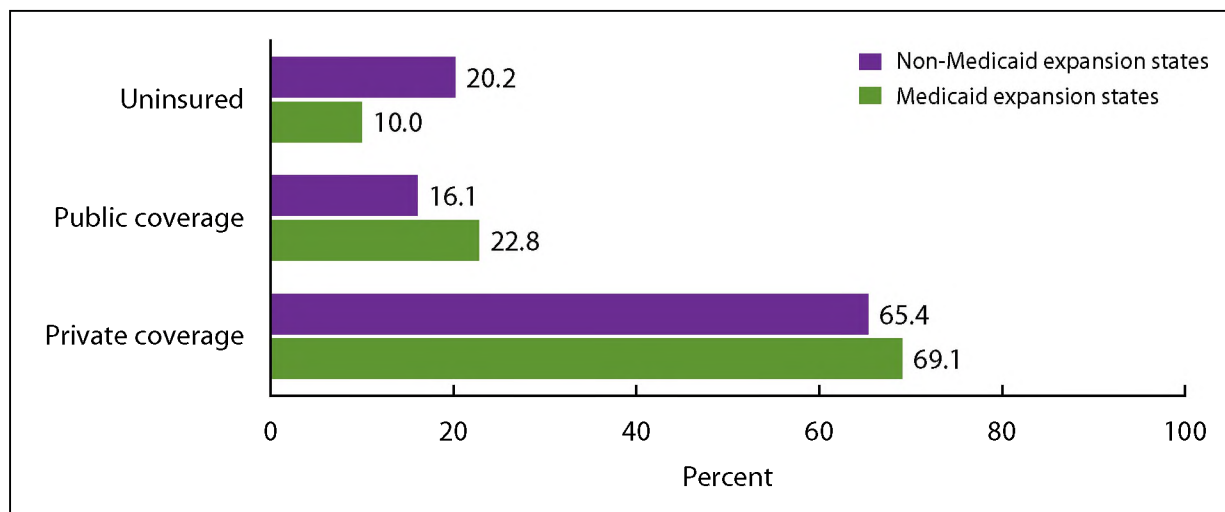


NOTES: Non-Hispanic adults of other or multiple races were not included in the analysis. Persons were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government plan, or military plan. Persons were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care. Public coverage includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. Private coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2019.

- From January through June 2019, 27.2% of Hispanic, 13.6% of non-Hispanic black, 9.8% of non-Hispanic white, and 7.4% of non-Hispanic Asian adults aged 18–64 were uninsured at the time of interview (Figure 4). Hispanic adults were the most likely to lack health insurance coverage, while non-Hispanic white and non-Hispanic Asian adults were the least likely to be uninsured. Non-Hispanic black adults were more likely than non-Hispanic white and non-Hispanic Asian adults to be uninsured.
- Among adults aged 18–64, 34.2% of non-Hispanic black, 22.2% of Hispanic, 17.4% of non-Hispanic white, and 15.5% of non-Hispanic Asian adults had public coverage at the time of interview. Non-Hispanic black adults were the most likely to have public coverage followed by Hispanic adults, and non-Hispanic white and non-Hispanic Asian adults were the least likely to have public coverage.
- Non-Hispanic Asian (77.9%) and non-Hispanic white (74.8%) adults were more likely than non-Hispanic black (54.9%) and Hispanic (51.4%) adults to have private coverage at the time of interview.

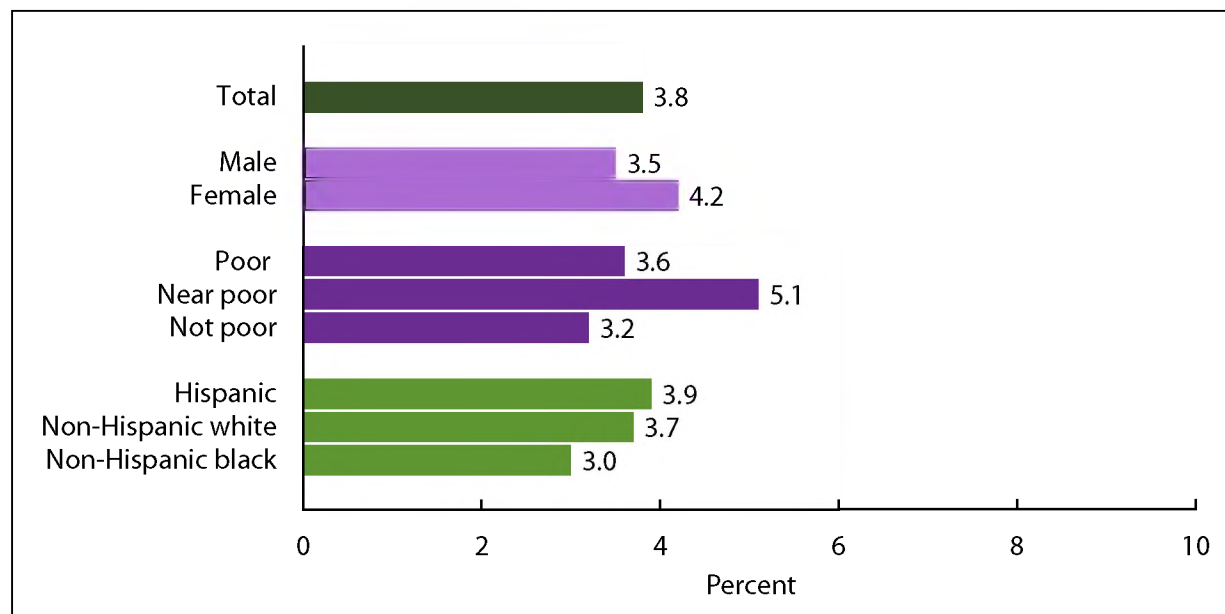
Figure 5. Percentages of adults aged 18–64 who were uninsured or had public or private coverage at the time of interview, by state Medicaid expansion status: United States, January–June 2019



NOTES: Persons were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children’s Health Insurance Program (CHIP), state-sponsored or other government plan, or military plan. Persons were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care. Public coverage includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. Private coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories. Data are based on household interviews of a sample of the civilian noninstitutionalized population. SOURCE: NCHS, National Health Interview Survey, 2019.

- From January through June 2019, among adults aged 18–64, those living in non-Medicaid expansion states (20.2%) were twice as likely as those living in Medicaid expansion states (10.0%) to be uninsured at the time of interview (Figure 5).
- Among adults aged 18–64, those living in non-Medicaid expansion states (16.1%) were less likely than those living in expansion states (22.8%) to have public coverage at the time of interview.
- Among adults aged 18–64, those living in non-Medicaid expansion states (65.4%) were less likely than those living in Medicaid expansion states (69.1%) to have private coverage at the time of interview.

Figure 6. Percentage of persons under age 65 who had exchange-based private health insurance coverage at the time of interview, by selected characteristics: United States, January–June 2019



NOTES: Poor persons were defined as those with incomes less than 100% of the federal poverty level (FPL); near-poor persons have incomes 100% to less than 200% of the FPL; not-poor persons have incomes that are 200% of the FPL or greater. Exchange-based coverage is a private health insurance plan purchased through the Health Insurance Marketplace or state-based exchanges that were established as part of the Affordable Care Act of 2010 (P.L. 111–148, P.L. 111–152). Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2019.

- From January through June 2019, among persons under age 65, 3.8% were covered by exchange-based coverage (Figure 6).
- Males (3.5%) were less likely than females (4.2%) to be covered by exchange-based coverage.
- Exchange-based coverage was higher among those who were near poor (5.1%) compared to those who were not poor (3.2%). However, the observed difference between those who were near poor and those who were poor (3.6%), was not statistically significant.
- Exchange-based coverage did not vary significantly by race and ethnicity.

Technical Notes

All estimates in this report are based on preliminary data. The 2019 estimates are being released prior to final data editing and final weighting to provide access to the most recent information from NHIS. Previously, differences between estimates calculated using preliminary data files and final data files were typically less than 0.1 percentage point. In 2019, the NHIS questionnaire was redesigned to better meet the needs of data users. The redesign aimed to improve the measurement of covered health topics, reduce respondent burden by shortening the length of the questionnaire, harmonize overlapping content with other federal surveys, establish a long-term structure of ongoing and periodic topics, and incorporate advances in survey methodology and measurement. For more information about the redesigned NHIS, visit the website at: https://www.cdc.gov/nchs/nhis/2019_quest_redesign.htm.

Data source

Data used to produce this ER report are derived from the Sample Adult and Sample Child components from the January 2019 through June 2019 NHIS. NHIS is a nationally representative household survey conducted throughout the year to collect information on health status, health-related behaviors, and health care access and utilization. The NHIS interview begins by identifying everyone who usually lives or stays in the household. Then, one “sample adult” aged 18 and over and one “sample child” aged 17 years and under (if any children live in the household) are randomly selected. Information about the sample adults is collected from the sample adults themselves unless they are physically or mentally unable to report, in which case a knowledgeable proxy can answer for them. Information about the sample child is collected from a parent or adult who is knowledgeable about and responsible for the health care of the sample child. This respondent may or may not also be the sample adult. Data analysis was based on information collected on 17,067 sample adults and 4,835 sample children. Visit the NHIS website at: <https://www.cdc.gov/nchs/nhis.htm> for more information about the design, content, and use of NHIS.

Estimation procedures

NCHS creates survey sampling weights to produce representative national estimates. The base weight is equal to the inverse of the probability of selection of the sample address. In 2019, the adjustment method changed to incorporate more robust multilevel models predictive of response propensity. Nonresponse-adjusted weights are further calibrated to U.S. Census Bureau population projections and American Community Survey (ACS) 1-year estimates for age, sex, race and ethnicity, educational attainment, census division, and metropolitan statistical area status. Prior to 2019, calibration was only to age, sex, and race and ethnicity projections. These changes to the nonresponse adjustment approach and the calibration methods have the potential to impact the weighted survey estimates. See the “2019 questionnaire redesign and comparison of estimates to earlier years” section below and <https://www.cdc.gov/nchs/nhis.htm> for more details.

Point estimates and estimates of their variances were calculated using SUDAAN software (RTI International, Research Triangle Park, N.C.) to account for the complex sample design of NHIS, taking into account stratum and primary sampling unit identifiers. The Taylor series linearization method was chosen for variance estimation.

All estimates shown meet the NCHS standards of reliability as specified in “National Center for Health Statistics Data Presentation Standards for Proportions” (1). All differences discussed are statistically significant unless otherwise noted. Differences between percentages were evaluated using two-sided significance tests at the 0.05 level. Lack of comment regarding the difference between any two estimates does not necessarily mean that the difference was tested and found to be not significant.

2019 questionnaire redesign and comparison of estimates to earlier years

In 2019, the NHIS questionnaire was redesigned to better meet the needs of data users. Due to changes in weighting and design methodology, direct comparisons between estimates for 2019 and earlier years should be made with caution, as the impact of these changes has not been fully evaluated at this time. A working paper entitled, “Preliminary Evaluation of the Impact of the 2019 National Health Interview Survey Questionnaire Redesign and Weighting Adjustments on Early Release Program Estimates” available from the [Early Release Program homepage](#), discusses both these issues in greater detail for three indicators of insurance coverage (lack of health insurance [uninsured], public health plan coverage, and private health insurance coverage). However, the discussion of these health insurance indicators is limited to adults aged 18–64. For this age group, this paper suggests that for those who are uninsured, differences observed between estimates for 2018 and 2019 were not affected by either the questionnaire redesign or the updated weighting approach. For the public health plan coverage indicator, differences observed between estimates for 2018 and 2019 may be partially attributable to the updated weighting approach. For the private health insurance coverage indicator, differences observed between estimates for 2018 and 2019 may be partially attributable to both the NHIS questionnaire redesign and the updated weighting approach.

Among persons of all ages, the percentage who were uninsured was 9.4% in 2018 and 9.5% in the first 6 months of 2019, a 0.1 percentage point difference (Table). The percentage who were uninsured was 9.1% in 2017 and 8.8% in the first 6 months of 2018, a 0.3 percentage point difference. Neither of these differences were statistically significant. Differences in private coverage between 2018 (62.3%) and the first 6 months of 2019 (62.1%), and 2017 (62.6%) and the first 6 months of 2018 (62.2%), were of similar magnitude. However, for public coverage, the percentage point differences between 2018 (36.7%) and the first 6 months of 2019

(37.4%), and between 2017 (36.2%) and the first half of 2018 (37.4%), were slightly higher than private coverage at 0.7 and 1.2, respectively. Although the magnitude of the differences ranged between 0.1 and 1.2 percentage points for persons of all ages between 2018 and the first half of 2019, percentage point differences for subgroups may be larger. In addition to variation as a result of weighting and questionnaire design changes, subgroup estimates can also vary due to small sample sizes.

Table. Percentages (and standard errors) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview by time period: United States, 2017–June 2019

Year and time period	Uninsured ¹ at the time of interview	Public health plan coverage ²	Private health insurance coverage ³
2017 (Full year)	9.1 (0.25)	36.2 (0.37)	62.6 (0.45)
2018 (Jan–Jun)	8.8 (0.29)	37.4 (0.50)	62.2 (0.61)
2018 (Full year)	9.4 (0.27)	36.7 (0.38)	62.3 (0.46)
2019 (Jan–Jun)	9.5 (0.30)	37.4 (0.51)	62.1 (0.62)

¹Persons were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children’s Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. Persons were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

²Public health plan coverage includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

³Private health insurance coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2017–2019.

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Suggested citation

Cohen RA, Terlizzi EP, Martinez ME, Cha AE. Health insurance coverage: Early release of estimates from the National Health Interview Survey, January–June 2019. National Center for Health Statistics. May 2020. Available from: <https://www.cdc.gov/nchs/nhis/healthinsurancecoverage.htm>.

Table I. Percentages (and 95% confidence intervals) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group: United States, January–June 2019

Age group (years)	Uninsured ¹ at the time of interview	Public health plan coverage ²	Private health insurance coverage ³
All ages	9.5 (8.9–10.1)	37.4 (36.4–38.4)	62.1 (60.9–63.4)
Under 65	11.2 (10.5–11.9)	26.1 (25.0–27.2)	64.5 (63.2–65.8)
0–17	4.4 (3.7–5.0)	41.6 (39.7–43.5)	55.8 (53.8–57.8)
18–64	13.7 (12.9–14.6)	20.4 (19.4–21.4)	67.7 (66.5–69.0)
65 and over	0.7 (0.4–1.1)	96.0 (95.3–96.6)	49.8 (48.0–51.7)

¹Persons were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. Persons were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

²Public health plan coverage includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

³Private health insurance coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2019.

Table II. Number (millions) of persons who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group: United States, January–June 2019

Age group (years)	Uninsured ¹ at the time of interview	Public health plan coverage ²	Private health insurance coverage ³
All ages	30.7	121.0	201.0
Under 65	30.4	70.8	175.0
0–17	3.2	30.4	40.8
18–64	27.2	40.3	134.1
65 and over	0.4	50.2	26.1

¹Persons were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. Persons were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

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NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2019.

Table III. Percentages (and 95% confidence intervals) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and sex: United States, January–June 2019

Age group (years) and sex	Uninsured ¹ at the time of interview	Public health plan coverage ²	Private health insurance coverage ³
Under 65			
Male	12.4 (11.5–13.5)	25.0 (23.7–26.4)	64.3 (62.7–65.9)
Female	10.0 (9.2–10.7)	27.1 (25.7–28.5)	64.7 (63.1–66.3)
0–17			
Male	4.7 (3.8–5.6)	42.8 (40.4–45.3)	54.1 (51.5–56.6)
Female	4.0 (3.2–5.0)	40.3 (37.6–43.1)	57.6 (55.0–60.2)
18–64			
Male	15.4 (14.2–16.7)	18.2 (16.9–19.6)	68.3 (66.5–70.0)
Female	12.1 (11.1–13.1)	22.4 (21.1–23.8)	67.2 (65.6–68.8)

¹Persons were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. Persons were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

²Public health plan coverage includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

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NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2019.

Table IV. Percentages (and 95% confidence intervals) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and poverty status: United States, January–June 2019

Age group (years) and poverty status ¹	Uninsured ² at the time of interview	Public health plan coverage ³	Private health insurance coverage ⁴
Under 65			
Poor	15.5 (13.2–18.1)	68.5 (65.2–71.7)	17.6 (14.6–20.9)
Near poor	18.7 (16.5–21.0)	47.6 (45.1–50.0)	36.4 (33.8–39.0)
Not poor	7.4 (6.8–8.0)	11.6 (10.8–12.4)	82.7 (81.7–83.6)
0–17			
Poor	3.4 (1.7–6.1)	90.4 (86.8–93.3)	7.9 (5.2–11.2)
Near poor	6.1 (4.5–8.0)	69.8 (65.8–73.6)	27.1 (23.0–31.6)
Not poor	3.7 (3.0–4.5)	16.1 (14.5–17.9)	81.5 (79.7–83.2)
18–64			
Poor	22.6 (19.1–26.3)	55.8 (51.7–59.8)	23.2 (19.0–27.9)
Near poor	25.1 (22.2–28.2)	36.2 (33.6–38.9)	41.1 (38.6–43.6)
Not poor	8.5 (7.9–9.2)	10.2 (9.4–11.0)	83.1 (82.1–84.1)

¹Poverty categories are based on the ratio of the family's income in the previous calendar year to the appropriate poverty threshold (given the family's size and number of children), as defined by the U.S. Census Bureau for that year (Semega JL, Kollar MA, Creamer J, Mohanty A. Income and poverty in the United States; 2018. Current Population Reports, P60–266. 2019). Persons categorized as “poor” have a ratio less than 1.0 (i.e., their family income is below the federal poverty level); “near poor” persons have incomes of 100% to less than 200% of the federal poverty level; and “not poor” persons have incomes that are 200% of the federal poverty level or greater. The percentage of respondents under age 65 with unknown poverty status in the first two quarters of 2019 was 7.7%. Persons with unknown poverty status are not shown in this table. Estimates may differ from estimates that are based on both reported and imputed income.

²Persons were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. Persons were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

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⁴Private health insurance coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as accidents or dental care. A small number of persons were covered by both public and private plans and were included in both categories.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2019.

Table V. Percentages (and 95% confidence intervals) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and race and ethnicity: United States, January–June 2019

Age group (years) and race and ethnicity ¹	Uninsured ² at the time of interview	Public health plan coverage ³	Private health insurance coverage ⁴
Under 65			
Hispanic	20.0 (18.1–22.1)	35.0 (32.7–37.4)	45.8 (43.7–47.9)
Non-Hispanic white	8.4 (7.7–9.1)	20.0 (18.9–21.1)	73.6 (72.4–74.8)
Non-Hispanic black	10.7 (9.1–12.4)	41.9 (38.9–44.9)	50.4 (47.2–53.7)
Non-Hispanic Asian	6.2 (3.7–9.7)	17.1 (14.0–20.7)	77.4 (73.4–81.0)
Non-Hispanic, other races and multiple races	15.6 (11.5–20.4)	33.4 (28.0–39.2)	52.6 (46.2–58.9)
0–17			
Hispanic	6.0 (4.6–7.7)	60.1 (56.8–63.4)	34.9 (32.0–38.0)
Non-Hispanic white	3.8 (3.0–4.7)	28.3 (26.3–30.5)	69.6 (67.5–71.7)
Non-Hispanic black	3.2 (1.7–5.5)	61.0 (55.0–66.7)	39.3 (33.7–45.1)
Non-Hispanic Asian	*	23.1 (18.0–28.9)	75.5 (69.6–80.8)
Non-Hispanic, other races and multiple races	6.6 (3.2–11.8)	45.6 (37.9–53.6)	49.5 (41.1–57.9)
18–64			
Hispanic	27.2 (24.6–29.9)	22.2 (19.5–25.2)	51.4 (49.0–53.8)
Non-Hispanic white	9.8 (9.1–10.7)	17.4 (16.3–18.5)	74.8 (73.6–76.1)
Non-Hispanic black	13.6 (11.7–15.8)	34.2 (31.5–36.9)	54.9 (51.8–57.9)
Non-Hispanic Asian	7.4 (4.4–11.6)	15.5 (12.0–19.7)	77.9 (73.1–82.1)
Non-Hispanic, other races and multiple races	22.9 (17.1–29.5)	23.5 (18.1–29.5)	55.1 (47.5–62.5)

*Estimate is not shown, as it does not meet NCHS standards of reliability.

¹Hispanic origin and race are two separate and distinct categories. Persons of Hispanic or Latino origin may be of any race or combination of races. Hispanic or Latino origin includes persons of Mexican, Puerto Rican, Cuban, Central and South American, or Spanish origin. Race is based on a respondent's description of their own racial background. More than one race may be reported. For conciseness, the text, tables, and figures in this report use shorter versions of the 1997 Office of Management and Budget terms for race and Hispanic or Latino origin. For example, the category "not Hispanic, black or African American, single race" is referred to as "non-Hispanic black" in the text, tables, and figures. Estimates for non-Hispanic persons of races other than white only, black only, and Asian only, or of multiple races, are combined into the "non-Hispanic, other races and multiple races" category.

²Persons were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. Persons were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

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NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2019.

Table VI. Percentages (and 95% confidence intervals) of persons under age 65 who lacked health insurance coverage, had public health plan coverage, and had private health insurance coverage at the time of interview, by age group and state Medicaid expansion status: United States, January–June 2019

Age group (years) and state Medicaid expansion status ¹	Uninsured ² at the time of interview	Public health plan coverage ³	Private health insurance coverage ⁴
Under 65			
Medicaid expansion states ⁵	8.2 (7.5–8.9)	27.4 (25.9–28.9)	66.2 (64.7–67.7)
Non-Medicaid expansion states ⁶	16.2 (14.8–17.7)	23.9 (22.2–25.6)	61.6 (59.0–64.2)
0–17			
Medicaid expansion states ⁵	3.2 (2.6–4.0)	40.2 (37.8–42.5)	58.2 (56.0–60.3)
Non-Medicaid expansion states ⁶	6.1 (4.9–7.5)	43.8 (40.0–47.6)	52.0 (48.0–56.1)
18–64			
Medicaid expansion states ⁵	10.0 (9.1–10.9)	22.8 (21.4–24.4)	69.1 (67.5–70.6)
Non-Medicaid expansion states ⁶	20.2 (18.4–22.1)	16.1 (15.0–17.2)	65.4 (63.1–67.6)

¹Under provisions of the Affordable Care Act of 2010 (P.L. 111–148, P.L. 111–152), states have the option to expand Medicaid eligibility to cover adults who have income up to and including 138% of the federal poverty level. There is no deadline for states to choose to implement the Medicaid expansion, and they may do so at any time. As of January 1, 2019, 33 states and the District of Columbia moved forward with Medicaid expansion.

²Persons were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children’s Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan. Persons were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care.

³Public health plan coverage includes Medicaid, CHIP, state-sponsored or other government-sponsored health plan, Medicare, and military plans. A small number of persons were covered by both public and private plans and were included in both categories.

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⁵For 2019, states moving forward with Medicaid expansion included: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, and West Virginia. The District of Columbia also moved forward with Medicaid expansion.

⁶For 2019, states not moving forward with Medicaid expansion included: Alabama, Florida, Georgia, Idaho, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Wisconsin, and Wyoming.

NOTE: Data are based on household interviews of a sample of the civilian noninstitutionalized population.
SOURCE: NCHS, National Health Interview Survey, 2019.

Table VII. Percentage (and 95% confidence interval) and number in millions of persons under age 65 who had exchange-based private health insurance coverage at the time of interview, by selected characteristics: United States, January–June 2019

Selected characteristics	Percent (95% confidence interval)	Number in millions
Age group (years)		
Under 65	3.8 (3.5–4.2)	10.4
0–17	1.8 (1.5–2.3)	1.3
18–64	4.6 (4.1–5.0)	9.0
Sex		
Male	3.5 (3.0–4.0)	4.7
Female	4.2 (3.7–4.7)	5.7
Poverty status ¹		
Poor	3.6 (2.5–5.1)	1.2
Near poor	5.1 (4.2–6.2)	2.7
Not poor	3.2 (2.9–3.6)	5.9
Race and ethnicity ²		
Hispanic	3.9 (3.1–4.9)	2.2
Non-Hispanic white	3.7 (3.2–4.2)	5.7
Non-Hispanic black	3.0 (2.2–3.9)	1.0
Medicaid expansion status ³		
Medicaid expansion states ⁴	3.4 (3.0–3.9)	5.8
Non-Medicaid expansion states ⁵	4.5 (3.7–5.4)	4.5

¹Poverty categories are based on the ratio of the family's income in the previous calendar year to the appropriate poverty threshold (given the family's size and number of children), as defined by the U.S. Census Bureau for that year (Semega JL, Kollar MA, Creamer J, Mohanty A. Income and poverty in the United States: 2018. Current Population Reports, P60–266. 2019). Persons categorized as “poor” have a ratio less than 1.0 (i.e., their family income is below the federal poverty level); “near poor” persons have incomes of 100% to less than 200% of the federal poverty level; and “not poor” persons have incomes that are 200% of the federal poverty level or greater. The percentage of respondents under age 65 with unknown poverty status in the first two quarters of 2019 was 7.7%. Persons with unknown poverty status are not shown in this table. Estimates may differ from estimates that are based on both reported and imputed income.

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⁴For 2019, states moving forward with Medicaid expansion included: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, and West Virginia. The District of Columbia also moved forward with Medicaid expansion.

⁵For 2019, states not moving forward with Medicaid expansion included: Alabama, Florida, Georgia, Idaho, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Wisconsin, and Wyoming.

NOTES: Exchange-based coverage is a private health insurance plan purchased through the Health Insurance Marketplace or state-based exchanges that were established as part of the Affordable Care Act of 2010 (P.L. 111–148, P.L. 111–152). Data are based on household interviews of a sample of the civilian noninstitutionalized population.

SOURCE: NCHS, National Health Interview Survey, 2019.

Chartbook on Healthcare for Asians and Native Hawaiians/Pacific Islanders



NATIONAL HEALTHCARE
QUALITY AND DISPARITIES
REPORT



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HEALTHCARE FOR ASIANS AND NATIVE HAWAIIANS/PACIFIC ISLANDERS

The *National Healthcare Quality and Disparities Report* (QDR) is supported by a series of related chartbooks that:

- Present information on individual measures.
- Are posted on the web (<https://www.ahrq.gov/research/findings/nhqrd/charbooks/index.html>).

Chartbooks cover different topics, such as:

- Access to care.
- Healthcare priority areas.
- Priority populations.

For a complete list and links to National Healthcare Quality & Disparities Report Chartbooks, go to <https://www.ahrq.gov/research/findings/nhqrd/charbooks/index.html>.

QDR Healthcare Priority Areas

- Patient Safety: Making care safer by reducing harm caused in the delivery of care
- Patient- and Family-Centered Care: Ensuring that each person and family is engaged as partners in their care
- Care Coordination: Promoting effective communication and coordination of care
- Effective Treatment: Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
- Healthy Living: Working with communities to promote wide use of best practices to enable healthy living
- Care Affordability: Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models

Five of these priorities are covered in this chartbook. Care Coordination was addressed separately in the Chartbook on Care Coordination, available at <https://www.ahrq.gov/research/findings/nhqrd/charbooks/carecoordination/index.html>.

Other Chartbooks About AHRQ's Priority Populations

AHRQ's priority populations are specified in the Healthcare Research and Quality Act of 1999 ([Public Law 106-129](#)). Existing chartbooks for priority populations include:

- Rural Healthcare.
- Healthcare for Blacks.
- Women's Healthcare.
- Hispanic Healthcare.

Goals of the Chartbook on Healthcare for Asians and Native Hawaiians/Pacific Islanders

This chartbook presents select demographics for Asians and Native Hawaiians/Pacific Islanders (NHPIs) and summarizes trends in healthcare and disparities by race. It is organized into three parts:

- Overview
- Demographics of the Asian and NHPI populations
- Summary of trends in healthcare for Asian and NHPI populations related to access to healthcare, quality of care, and patient experience of care

In referring to racial groups in this chartbook:

- Asian refers to Asians residing in the United States, whether they were born in the United States or foreign born (OMB, 1997).
- NHPI refers to people residing in the United States with origins in any of the original peoples of Hawaii, Guam, Samoa, or the Pacific Islands (OMB, 1997).

These terms are based on the U.S. Census definitions for defining racial groups. Prior to 1997, the U.S. Census Bureau recognized a single race called Asian or Pacific Islander and abbreviated API. Beginning in 1997, the Office of Management and Budget (OMB) and U.S. Census Bureau separated Asians from Native Hawaiians and Pacific Islanders into two separate racial groups.

In the QDR, a disparity is a statistically significant difference that is also a relative difference of at least 10 percent. Disparities are identified in this chartbook by comparing the Asian or NHPI group with the reference group, which in this chartbook is the White group. When the comparison group is defined as Hispanic or non-Hispanic, the reference group is non-Hispanic White. Otherwise, the reference group is White without respect to Hispanic ethnicity.

AHRQ identifies meaningful differences between groups based on two criteria:

- First, a statistical test of the absolute difference in rates must be significant at the $p < 0.05$ level in a two-tailed test.
- Second, the relative difference between the comparison group and the reference group must be at least 10 percent. For example, if the comparison group had a 22% rate and the reference group had a 20% rate, the relative difference would be $([22\% - 20\%]/20\%) * 100 = 10\%$. For further information on the QDR methodology, see National Healthcare Quality and Disparities Report introduction and methods. Rockville, MD: Agency for Healthcare Research and Quality; September 2019. AHRQ Publication No. 19-0070-EF. <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqdr/2018qdr-intro-methods.pdf>.

KEY FINDINGS OF THE CHARTBOOK ON HEALTHCARE FOR ASIANS AND NHPIs

- Asian and NHPI populations continue to be among the higher performing groups on patient safety measures.
 - As more specific data from subpopulations of both groups become available, important differences in measure performance may emerge.
- Asian and NHPI populations experience disparities in several areas related to person- and family-centered care, access to care, experience with home healthcare, and language assistance.
- Asian and NHPI populations with HIV were less likely than Whites to know their serostatus.

Grouping all Asian adults into a single category ignores important differences that exist among subpopulations. For example, there is wide variation in income/poverty levels, educational attainment, and time since coming to the United States. The Resources slide at the end provides resources for improving culturally appropriate care.

PART 1: OVERVIEWS OF THE REPORT AND THE ASIAN AND NHPI POPULATIONS

Quality and Disparities Report

The QDR is an annual report to Congress mandated in the Healthcare Research and Quality Act of 1999 ([P.L. 106-129](#)). The QDR provides a comprehensive overview of the quality of healthcare received by the general U.S. population and disparities in care experienced by different racial, ethnic, and socioeconomic groups.

The purpose of the reports is to assess the performance of our healthcare system and to identify areas of strength and weaknesses along themes including access to Care, quality of Care, and QDR priorities.

The report is based on more than 260 measures of quality and disparities covering a broad array of healthcare services and settings. Clinical quality measure data are generally available through 2016; more recent data are used as available. The report is produced with the help of an Interagency Work Group led by AHRQ and submitted on behalf of the Secretary of Health and Human Services.

Chartbook Content

This chartbook organizes QDR measures by access to care and quality of care priorities. The QDR Introduction and Methods contains information about methods used in the chartbook and is available at <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqdr/2018qdr-intro-methods.pdf>. A data query tool available at <http://nhqrnet.ahrq.gov/inhqdr/data/query> provides access to all data tables.

Key Metrics Used in the Chartbook

- Trends assess the rate of change over time (typically 2002-2016) for a population.
- Disparities assess whether measure estimates for two populations differ at the most recent time point.
- Change in Disparities assesses whether the rates of change over time for two populations differ.

Trends are based on regression analysis for measures with at least 4 time points. Change in disparities is also based on regression analysis.

Data Collection Standards for Race, 2011

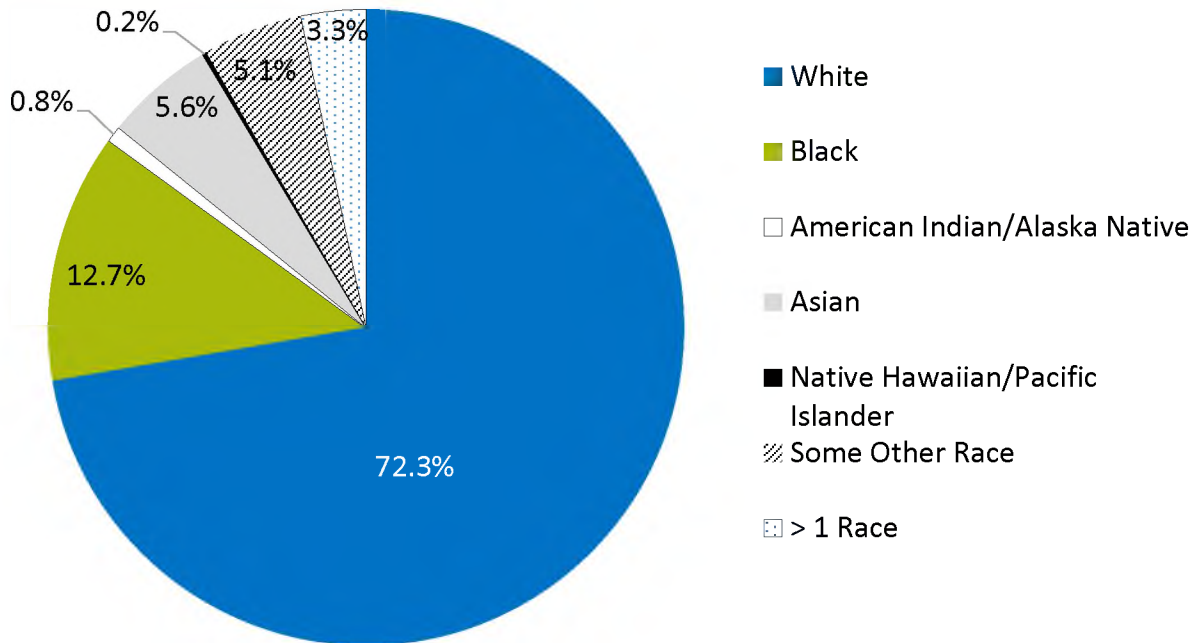
The Office of Management and Budget (OMB) standard permits selection of one or more among 14 racial categories:

- The first three (White, Black or African American, American Indian or Alaska Native) are not subdivided.
- Asian has 7 subcategories:
 - Asian Indian
 - Chinese
 - Filipino
 - Japanese
 - Korean
 - Vietnamese
 - Other Asian
- Native Hawaiian and Pacific Islander has 4 subcategories:
 - Native Hawaiian
 - Guamanian or Chamorro
 - Samoan
 - Other Pacific Islander

In the American Community Survey (ACS), a person is counted as Asian alone if he or she identifies with at least one of the Asian subpopulations listed but does not identify with any other major race category, such as White. People who identify as both Asian and White are counted as Asian in combination with another race. The same is true for people identifying with at least one NHPI subpopulation.

In the 2017 ACS, 15.8% of people identifying as Asian also identified with another race, and 56.8% of people identifying as NHPI also identified with another race. Data are available in the 2017 ACS 1 Year Estimates – U.S. Census Bureau (<https://data.census.gov/cedsci/>).

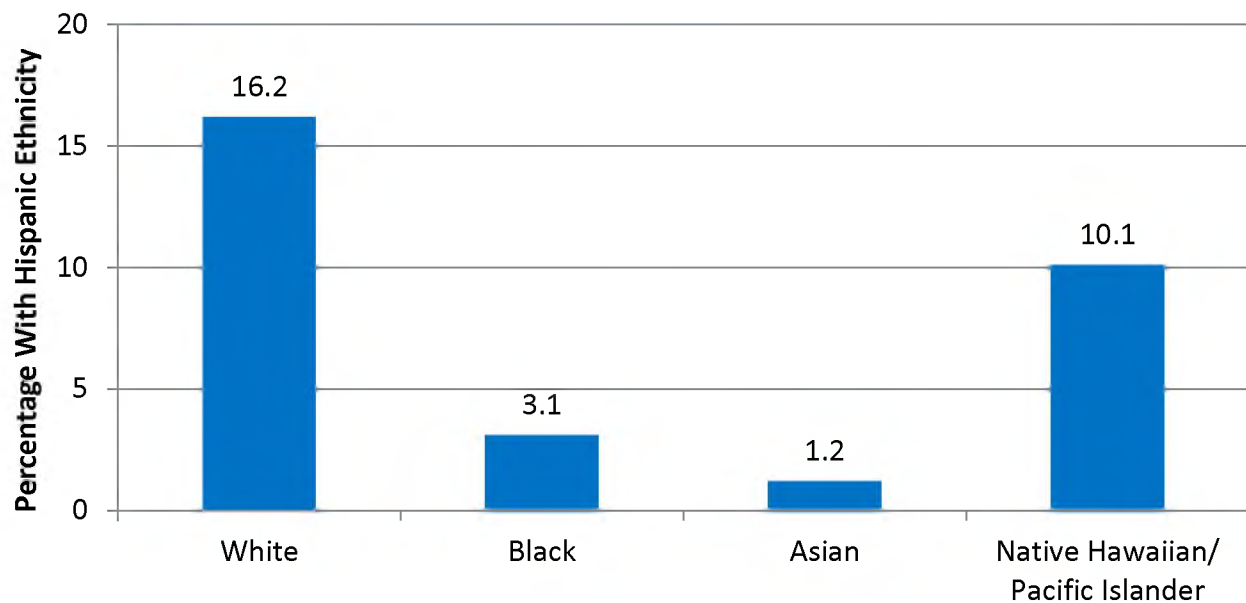
Racial Makeup of the U.S. Population, 2017



Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau ([https://data.census.gov/cedsci/table?q=United States](https://data.census.gov/cedsci/table?q=United+States)). Table DP05.

Note: All race categories exclude people reporting two or more races except the “>1 Race” category.

Ethnic Makeup of the U.S. Population, 2017



Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

- People of any race may also claim Hispanic, Latino, or Spanish origin or ethnicity.

PART 2: DEMOGRAPHICS OF ASIANS AND NHPIS

Health of the Asian and NHPI Populations in the United States

Asians and NHPIS have lower rates of mortality than other racial and ethnic groups for several top causes of death in the United States (Artiga, et al., 2016). The health of Asians and NHPIS is influenced by various social determinants,¹ such as:

- Socioeconomic status,
- Educational attainment,
- Time in the United States,
- English proficiency,
- Household size, and
- Other cultural characteristics.

Asians and NHPIS have lower death rates for diabetes, heart disease, and cancer.

Growth Rate of Asian and NHPI Populations

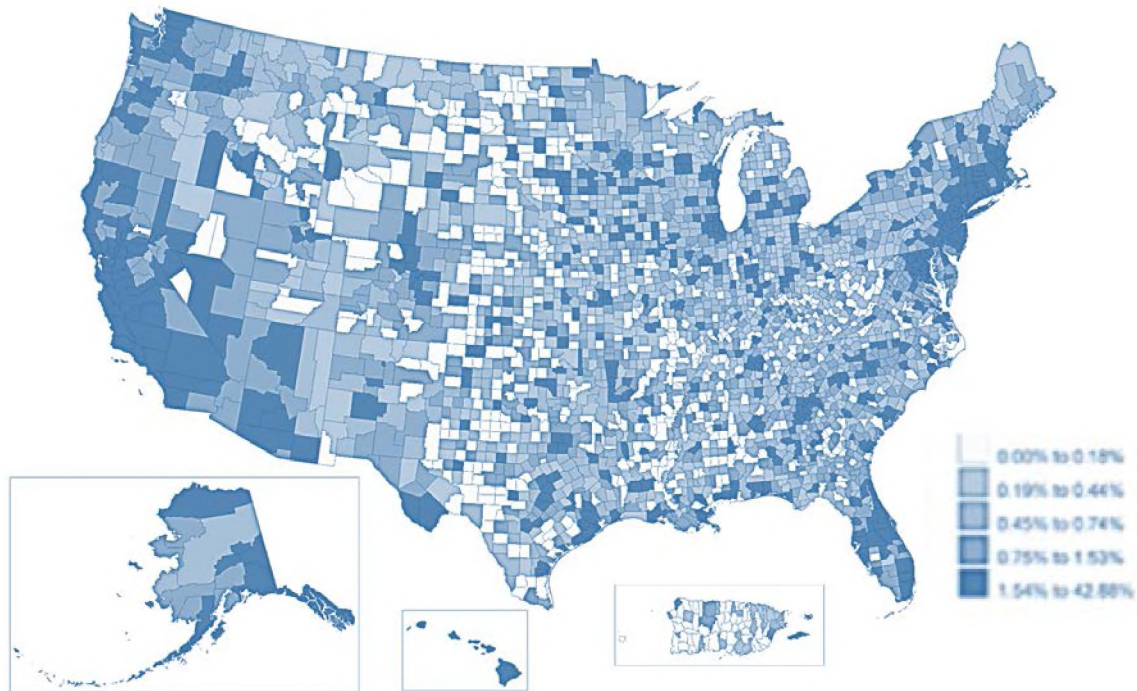
Asians are projected to be the second fastest growing racial/ethnic group in the United States in the next few decades:

- Rapid growth in the Asian population is driven by immigration rather than births.
- NHPIS are also among the fastest growing racial groups (Census Bureau, 2019).

The fastest growing racial or ethnic group is “Two or More Races,” driven by natural increase (the excess of births over deaths); next is “Asian Alone,” with international migration the primary driver. Third is “Hispanic,” with natural increase the primary driver.

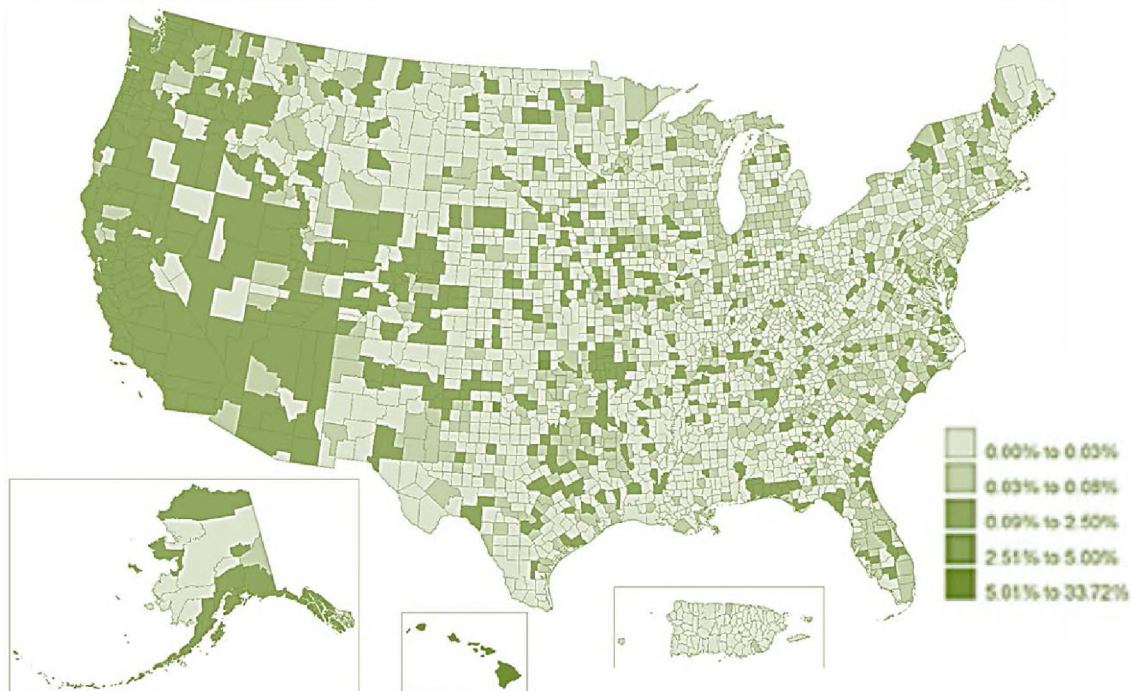
¹ Social determinants of health are economic and physical conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Kelly, 2015).

Geographic Distribution of the U.S. Asian Population, 2017



Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Table B02001.
Note: Data include individuals reporting one race alone, not in combination with any other race.

Geographic Distribution of the U.S. NHPI Population, 2017



Source: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Table B02001.
Note: Data include individuals reporting one race alone, not in combination with any other race.

Geographic Distribution of Asian and NHPI Populations

Ten States are home to 72.3% of Asian and NHPI populations:

- California (31.4%)
- New York (9.3%)
- Texas (7.4%)
- New Jersey (4.7%)
- Illinois (3.7%)
- Hawaii (3.7%)
- Washington (3.6%)
- Florida (3.2%)
- Virginia (2.9%)
- Massachusetts (2.4%)

Data are from the 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau. Data include individuals reporting one race alone. Individuals reporting two or more races make up 3.3% of the total population.

Asian and NHPI Populations Compared, 2017

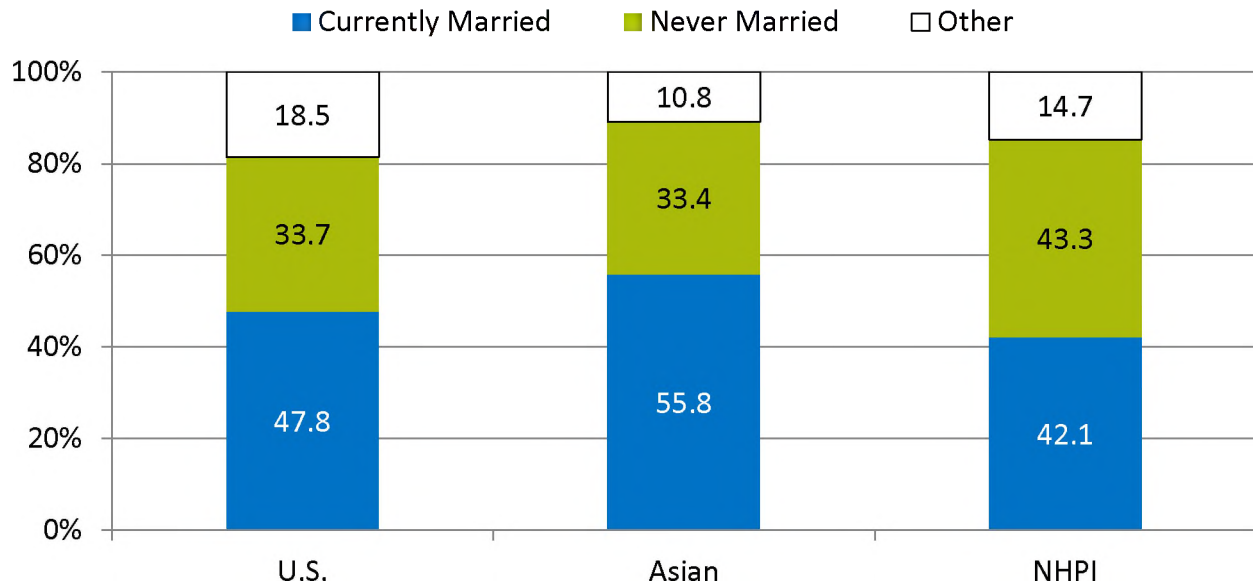
	Asian	NHPI
Population	21.6 million	1.4 million
Male	47.8%	50.2%
Female	52.2%	49.8%
Percentage of Total U.S. Population	6.6%	0.4%
U.S. born	9.1 million (41.9%)	1.2 million (84.3%)
Foreign born	12.6 million (58.1%)	0.2 million (15.7%)
U.S.-Born Group as a Percentage of Total U.S. Population*	2.8%	0.4%
Foreign-Born Group as a Percentage of Total U.S. Population*	3.9%	0.1%

* U.S.-Born Group and Foreign-Born Group percentages may not add to Percentage of Total U.S. Population U.S. born or foreign born due to rounding.

Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

Note: Data include individuals reporting one race alone or in combination with one or more races. Total U.S. population in 2017: 325.7 million.

Marital Status of the Population Age 15 Years and Over, 2017



Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

Note: Data include individuals reporting one race alone or in combination with one or more races. Other includes Widowed, Divorced, and Separated.

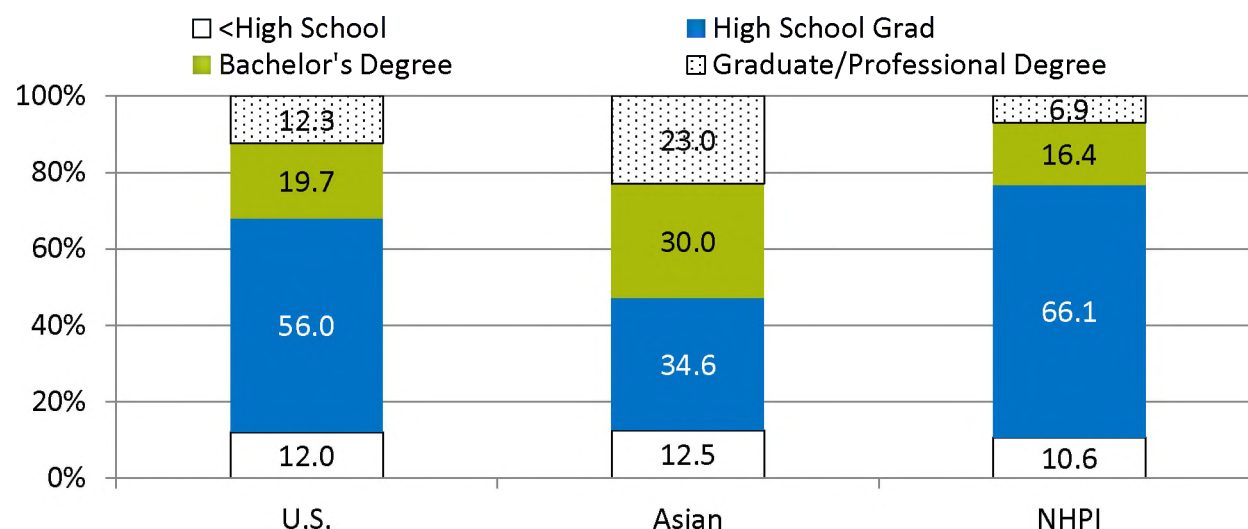
- As of 2017, 55.8% of Asians and 42.1% of NHPIs reported being married, while 33.4% and 43.3%, respectively, reported never being married.

Households by Type, 2017

- Among both the Asian and NHPI populations in 2017, approximately three-quarters (72.7% and 71.2%, respectively) lived in a family household.
- In 2017, approximately one-quarter of Asians and NHPIs (27.3% and 28.8%, respectively) lived in a non-family household.
- The average household size in 2017 was 3.04 for Asians and 3.23 for NHPIs, compared with 2.65 for the U.S. population as a whole.
- For the U.S. population as a whole, 65.5% lived in family households and 34.5% in non-family households in 2017.

Data are from the 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau. Data include individuals reporting one race alone or in combination with one or more races.

Educational Attainment of the Population Age 25 Years and Over, 2017



Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

Note: High school graduate includes equivalency and some college or associate's degree. Data include individuals reporting one race alone or in combination with one or more races.

- In 2017, 53% of Asians had a bachelor's degree or higher (30.0% with bachelor's degrees and 23.0% with graduate/professional degrees), 34.6% were high school graduates, and 12.5% had less than a high school diploma.
- By contrast, among the NHPI population in the same year, 23.3% had a bachelor's degree or higher (16.4% with bachelor's degrees and 6.9% with graduate/professional degrees), 66.1% were high school graduates, and 10.6% had less than a high school diploma.

Disaggregation of Subpopulation Data

This chartbook does not include health and disparity data broken down by subpopulations because quality data are not yet available. This chartbook does include select demographic data for subpopulations to illustrate:

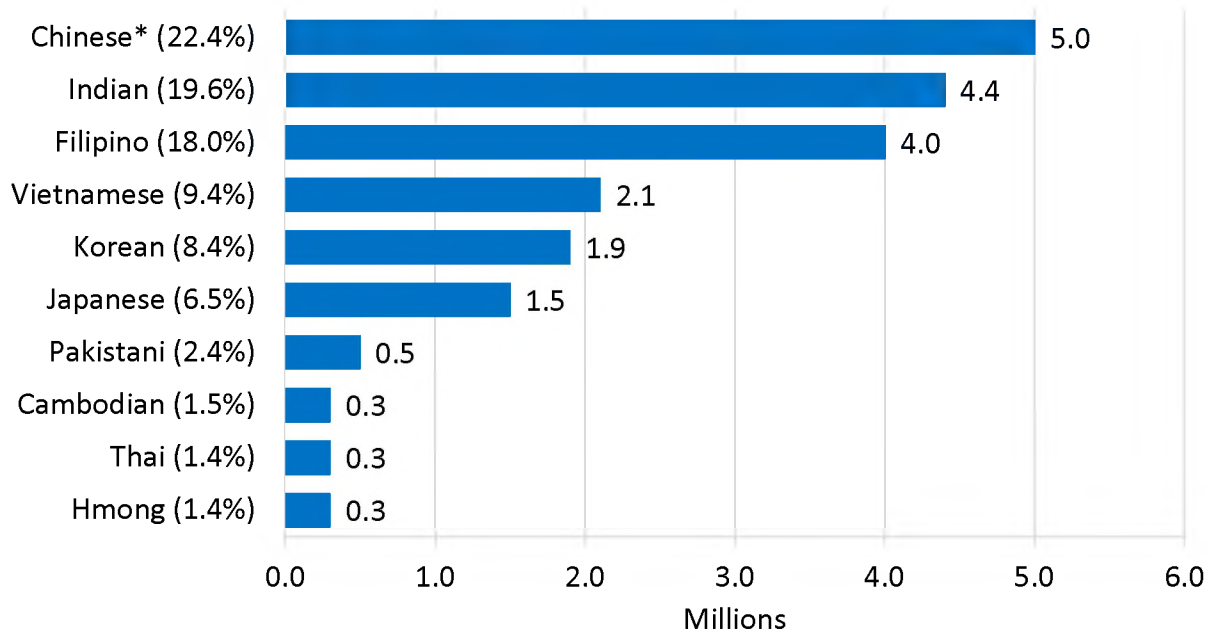
- The wide range of variability among subpopulations.
- The importance of collecting data at a more granular level.

A more granular view may become possible given the evolution of data collection instruments to allow disaggregation into smaller subpopulations of Asians and NHPIs:

- 2011: The U.S. Department of Health and Human Services (HHS) adopted data collection standards that included additional specificity for Asian and NHPI racial groups on population surveys.
- 2012: The Centers for Disease Control and Prevention and the Centers for Medicare & Medicaid Services (CMS) began oversampling Asian subpopulations in some health surveys to provide additional granularity.

The two represent distinct racial groups with very different disease profiles, such as for cancer, although demographic and health data are often available only in aggregate.

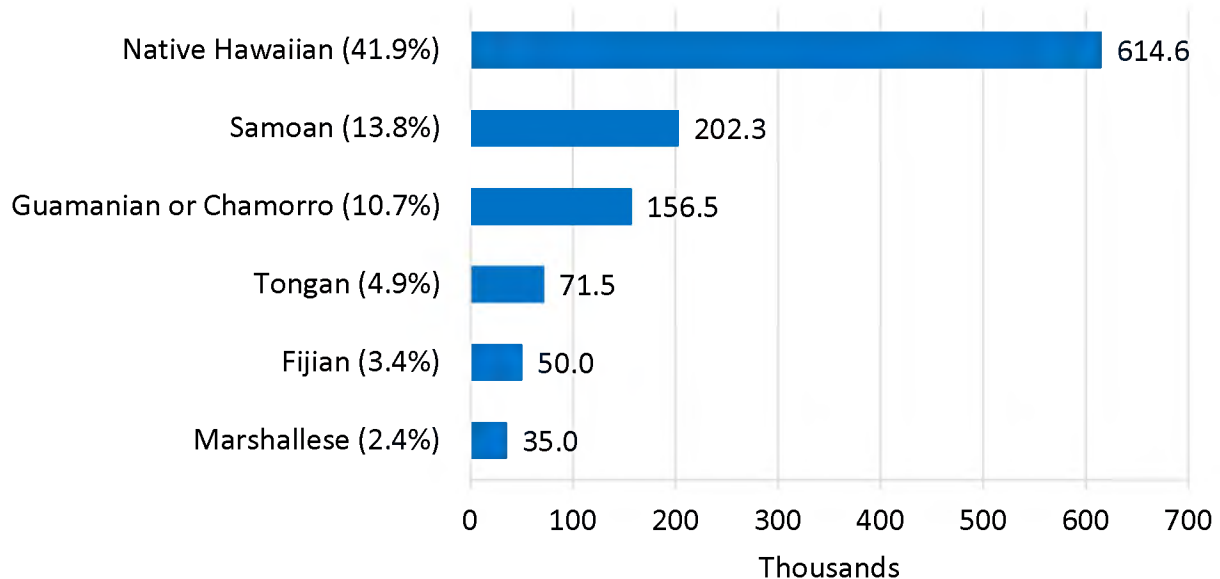
Ten Largest Asian Subpopulations, United States, 2017



* Excluding Taiwanese.

Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau. Data include individuals reporting one race alone or in combination with another race. Individuals reporting two or more races comprise 3.3 percent of the total population. Percentages represent each subpopulation as a percentage of the sum of all subpopulations. Because people may have identified with two or more subpopulations, the sum of subpopulations may exceed the total Asian population.

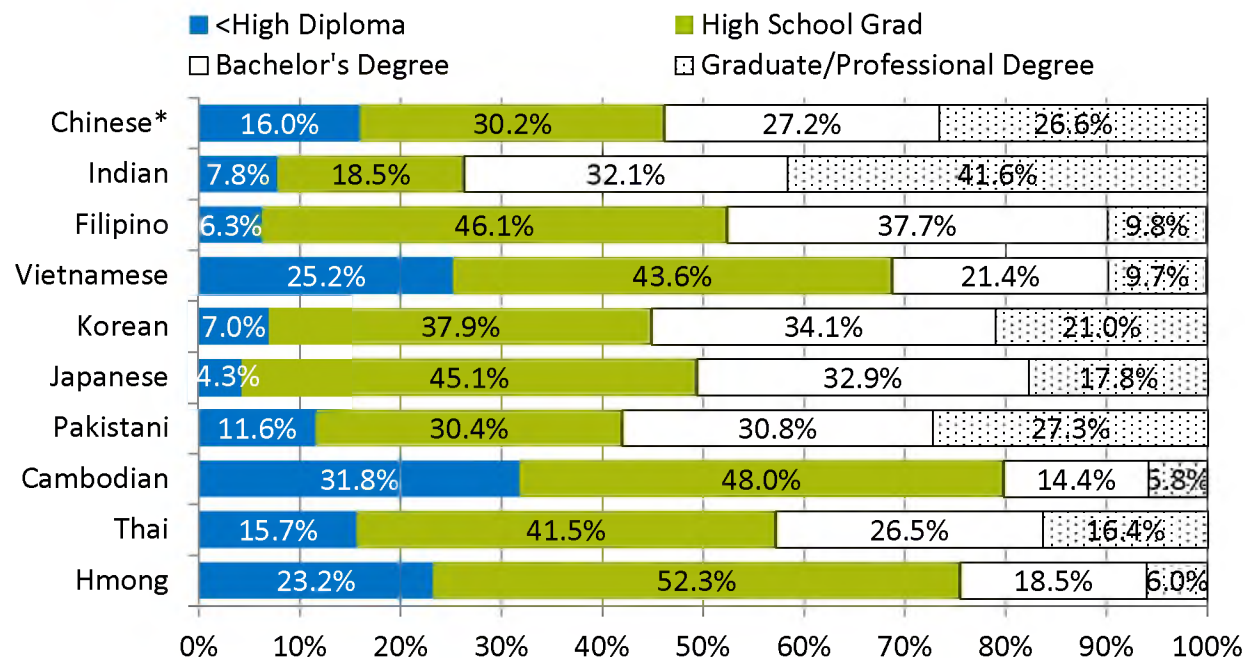
Six Largest NHPI Subpopulations, United States, 2017



Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

Note: Data include individuals reporting one race alone or in combination with another race. Individuals reporting two or more races make up 3.3 percent of the total population. Percentages represent each subpopulation as a percentage of the sum of all subpopulations. Because people may have identified with two or more subpopulations, the sum of subpopulations may exceed the total NHPI population.

Educational Attainment of Asian Subpopulations Age 25 Years and Over, 2017

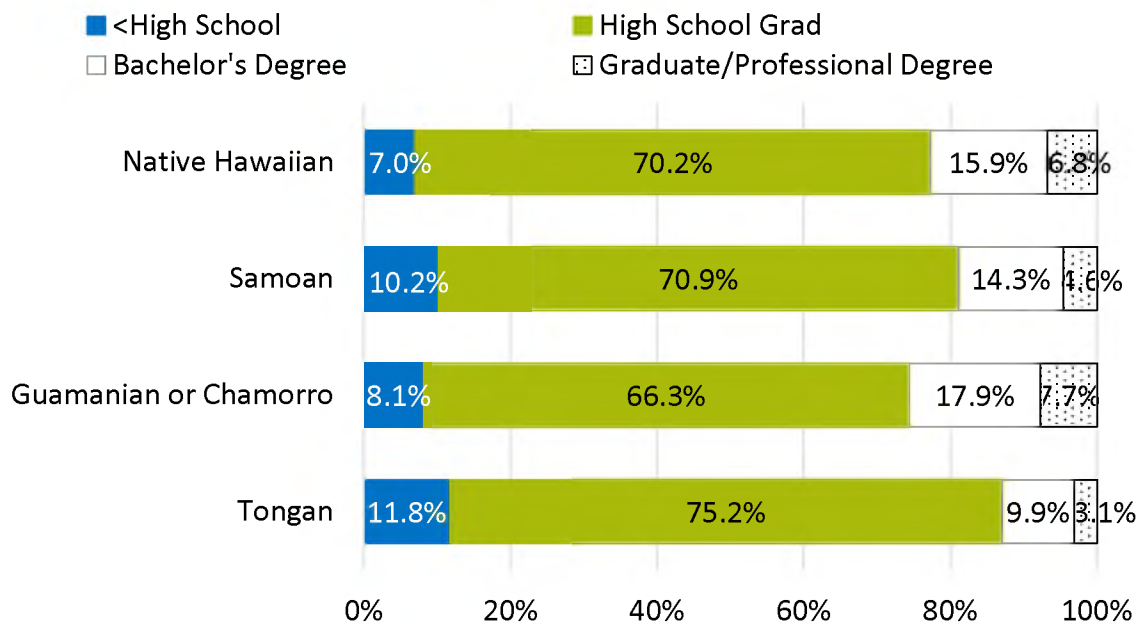


* Excluding Taiwanese.

Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

Note: Data include individuals reporting one race alone or in combination with one or more races.

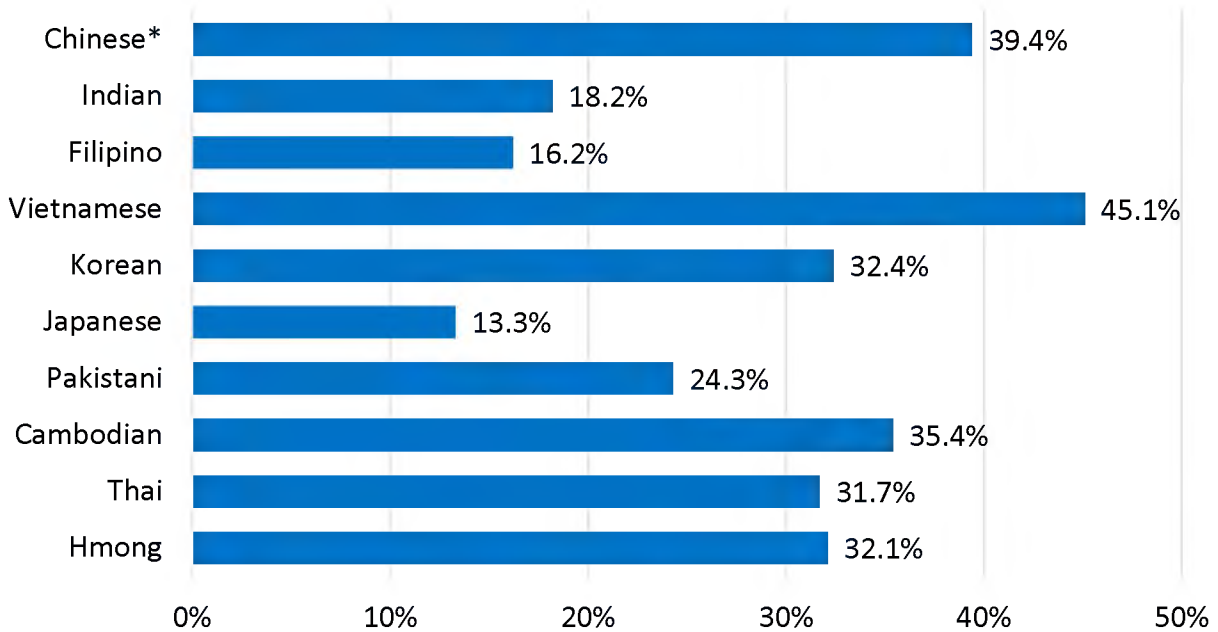
Educational Attainment of NHPI Subpopulations Age 25 Years and Over, 2017



Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

Note: Data include individuals reporting one race alone or in combination with one or more races. Data are not available for Fijian and Marshallese subpopulations due to low data reliability.

Asian Subpopulations Age 5 Years and Over With Limited English Proficiency, 2017

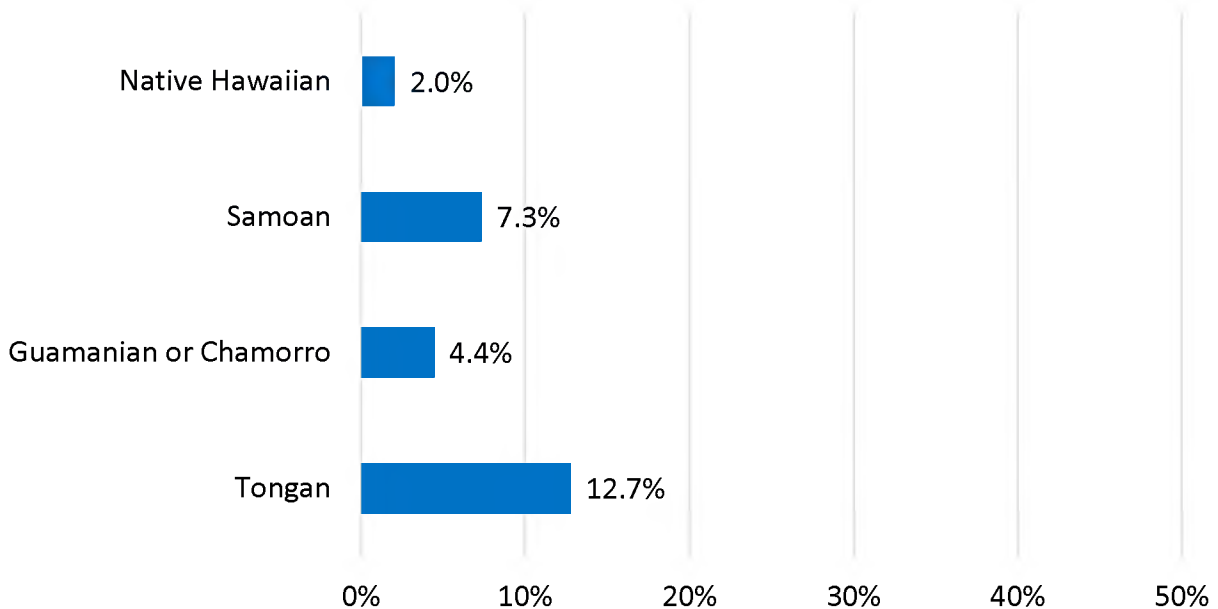


* Excluding Taiwanese.

Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

Note: Data include individuals reporting one race alone or in combination with one or more races. Limited English proficiency is defined as people who speak English less than “Very well.” Those who speak only English at home are not asked to rate their English proficiency.

NHPI Subpopulations Age 5 Years and Over With Limited English Proficiency, 2017



Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

Note: Data include individuals reporting one race alone or in combination with one or more races. Limited English proficiency is defined as people who speak English less than “Very well.” Those who speak only English at home are not asked to rate their English proficiency. Data are not available for Fijian and Marshallese populations due to low data reliability.

Growth of the Asian and NHPI Populations

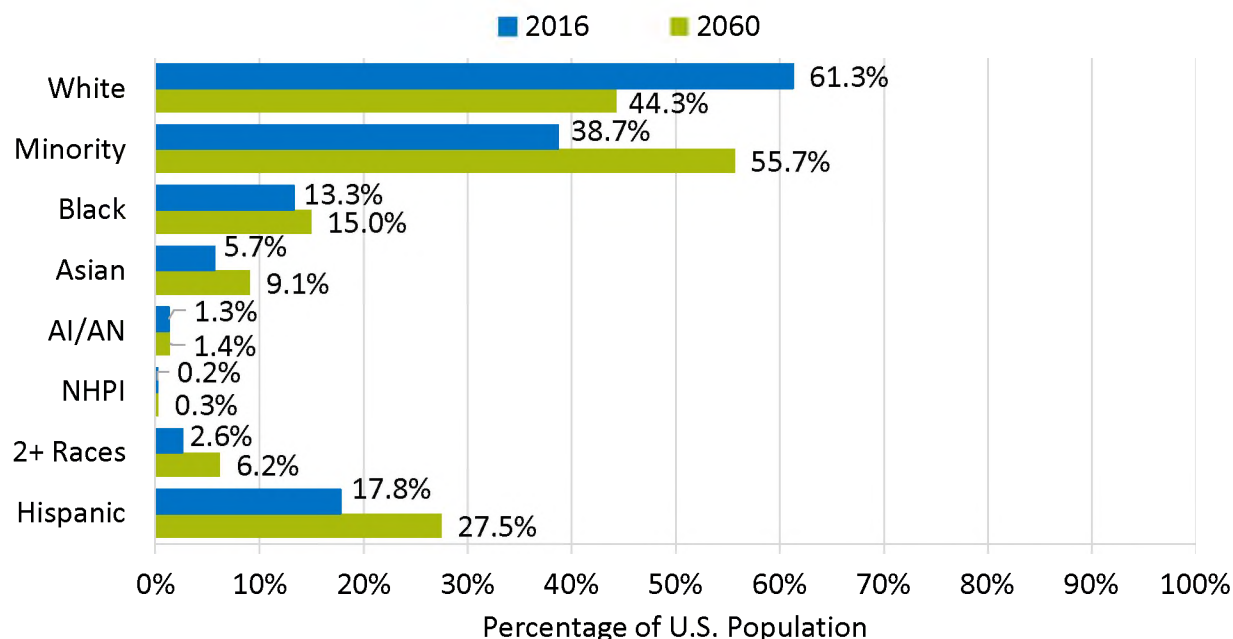
Year of Entry of the Foreign-Born Asian and NHPI Population, 2017

As of 2017, 58.1% of Asians and 15.7% of NHPIs were foreign born.

- Almost half of the foreign-born Asian population (48.9%) had arrived in the United States before 2000 while more than one quarter (27.1%) had arrived in 2010 or later.
- Similarly, among foreign-born NHPIs as of the same year, 49.3% had arrived in the United States before 2000 and 23.8% had arrived in 2010 or later.

In 2017, nearly 9 million Asians and over 1.1 million Native Hawaiians and Pacific Islanders had been born in the U.S. Over 12 million Asians and over 200,000 Native Hawaiians and Pacific Islanders were foreign-born. Data are from 2017 American Community Survey 1 Year Estimates—U.S. Census Bureau. Data include individuals reporting one race alone or in combination with one or more races.

Projected Growth of the U.S. Resident Population Between 2016 and 2060, by Race



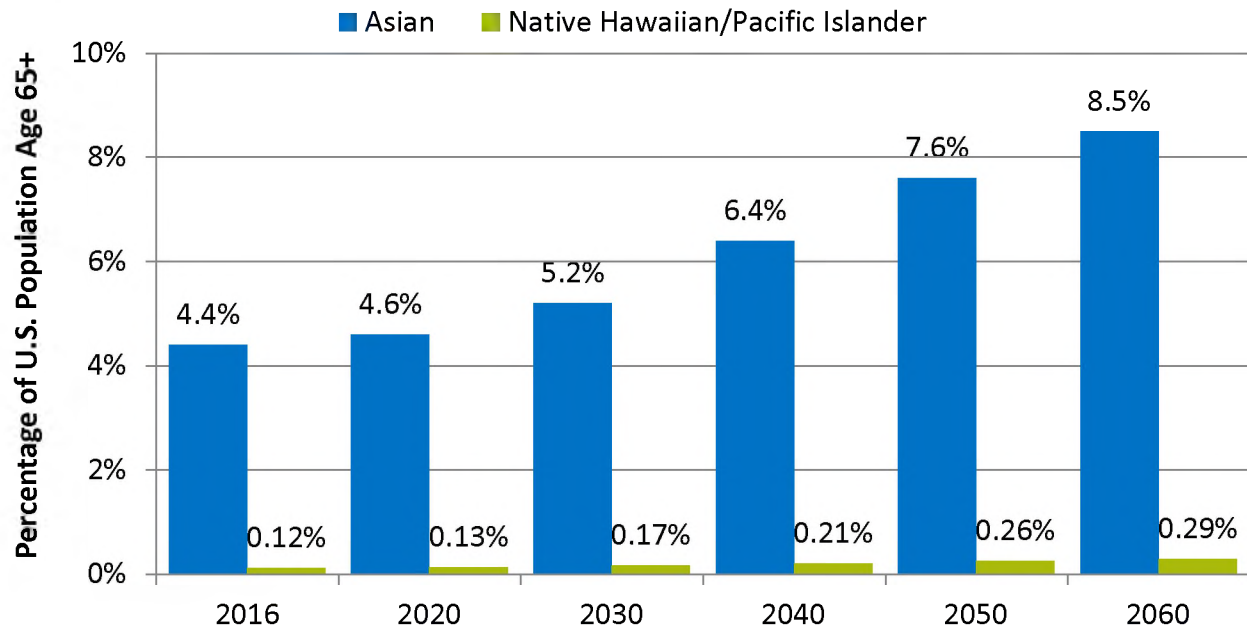
Key: AI/AN = American Indian or Alaska Native; NHPI = Native Hawaiian/Pacific Islander.

Source: U.S. Census Bureau., Population Division. Projected Race and Hispanic Origin: Main Projections Series for the United States, 2017 to 2060. <https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html>.

Note: Categories are not mutually exclusive; therefore, percentages may add to more than 100 percent. Racial categories other than 2+ Races exclude people reporting two or more races. Whites are non-Hispanic only; all other categories may include Hispanics. Minority includes all groups other than the non-Hispanic White population.

- Population estimates for July 1, 2016, are based on the 2010 U.S. Census. Population projections for 2017-2060 were developed using evidence-based assumptions regarding demographic trends. The 2016 population estimates are the baseline for the 2017-2060 population projections. (See <https://www.census.gov/programs-surveys/popproj/about.html>.)

Projected Growth of Asians and NHPIs as Share of U.S. Population Age 65+ Between 2016 and 2060



Source: U.S. Census Bureau, Population Division. Race and Hispanic Origin by Selected Age Groups: Main Projections Series for the United States, 2017 to 2060. <https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html>.

Note: Excludes people reporting two or more races; does not include Hispanics.

- Population estimates for July 1, 2016, are based on the 2010 U.S. Census. Population projections for 2017-2060 were developed using evidence-based assumptions regarding demographic trends. The 2016 population estimates are the baseline for the 2017-2060 population projections. (See <https://www.census.gov/programs-surveys/popproj/about.html>.)

Labor Force Participation

Labor Force and Employment Status of Civilian Population 16 Years and Over, 2017

In 2017, over 65% of both the Asian and NHPi populations were in the civilian labor force; only 1.1% or less of either population was in the military. Males made up a slight majority over females in the civilian labor force among both populations (5.8 million vs. 5.3 million for Asians; 356,000 vs. 321,000 for NHPis).

For more information, refer to 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau. Data include individuals reporting Asian or NHPi race alone or in combination with one or more races.

Occupation of the Asian Civilian Employed Population 16 Years and Over, 2017

Sector	Percentage
Management, business, sciences, and arts	51.0%
Service occupations	17.0%
Sales and office occupations	19.7%
Natural resources, construction, and maintenance	3.2%
Production, transportation, and material moving	9.2%

Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

Note: Data include individuals reporting one race alone or in combination with one or more races.

Occupation of the NHPI Civilian Employed Population 16 Years and Over, 2017

Sector	Percentage
Management, business, sciences, and arts	29.6%
Service occupations	23.1%
Sales and office occupations	25.5%
Natural resources, construction, and maintenance	8.7%
Production, transportation, and material moving	13.1%

Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

Note: Data include individuals reporting one race alone or in combination with one or more races.

Income

Income and Poverty Status, Asian Households, Families, and Individuals, 2017

Income and Poverty Status	Number
Median household income	\$82,180
Median family income	\$95,689
Median earnings	
Male	\$64,883
Female	\$51,428
Families living in poverty	7.9%
Individuals living in poverty	11.0%

Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau. Data include individuals reporting one race alone or in combination with one or more races. Median earnings are reported for full-time year-round workers only.

Note: Median household income is defined by the Census Bureau at <https://www.census.gov/quickfacts/fact/note/US/INC110218>.

Income and Poverty Status, NHPI Households, Families, and Individuals, 2017

Income and Poverty Status	Number
Median household income	\$64,308
Median family income	\$71,783
Median earnings	
Male	\$46,511
Female	\$39,085
Families living in poverty	13.0%
Individuals living in poverty	15.4%

Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau. Data include individuals reporting one race alone or in combination with one or more races. Median earnings are reported for full-time year-round workers only.

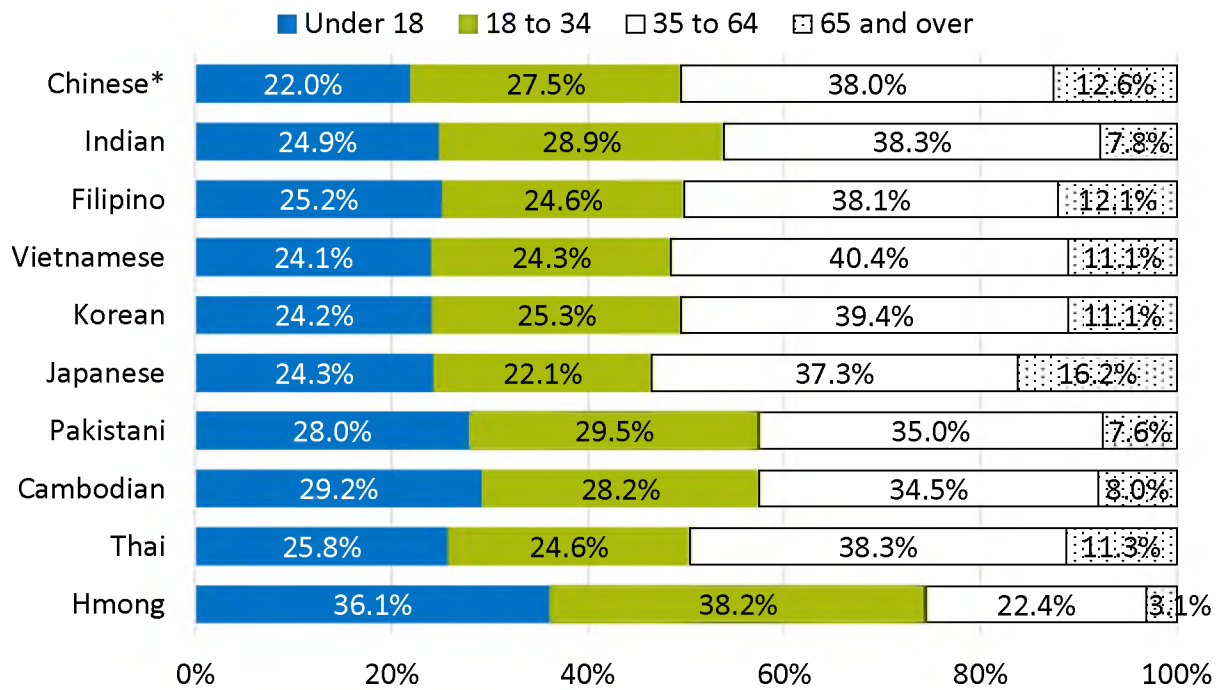
Note: Median household income is defined by the Census Bureau at <https://www.census.gov/quickfacts/fact/note/US/INC110218>.

Age

Largest Age Groups in the Asian and NHPI Population, 2017

The largest age group among Asians and NHPIs in 2017 was individuals ages 35-64. The next largest age group for both populations was individuals ages 18-34. The median age was 34.6 years old for Asians and 28.7 years old for NHPIs. For more information, refer to 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau. Data include individuals reporting one race alone or in combination with one or more races.

Age Distribution Among Asian Subpopulations, 2017

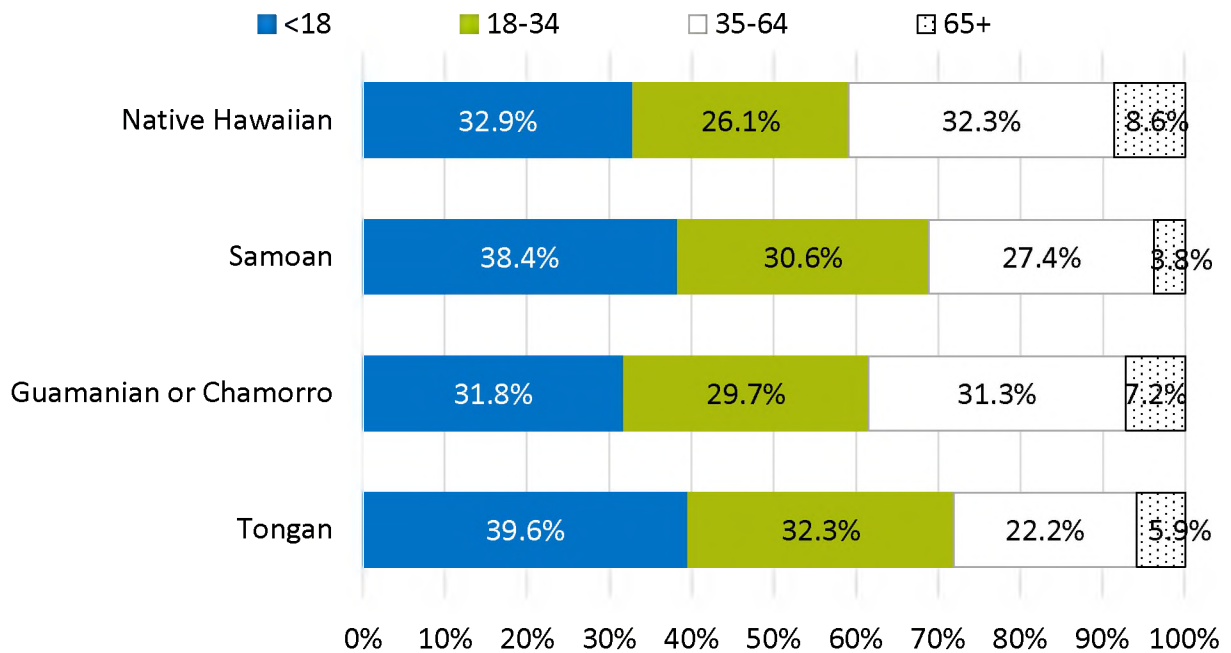


* Excluding Taiwanese.

Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau. Data include individuals reporting one race alone or in combination with one or more races.

- Among these Asian subpopulations, the Japanese population is the oldest, with 53.5% age 35 and over, and 16.2% age 65 and over.
- The Hmong population is the youngest, with 74.3% under 35 and 36.1% under 18.

Age Distribution Among NHPI Subpopulations, 2017



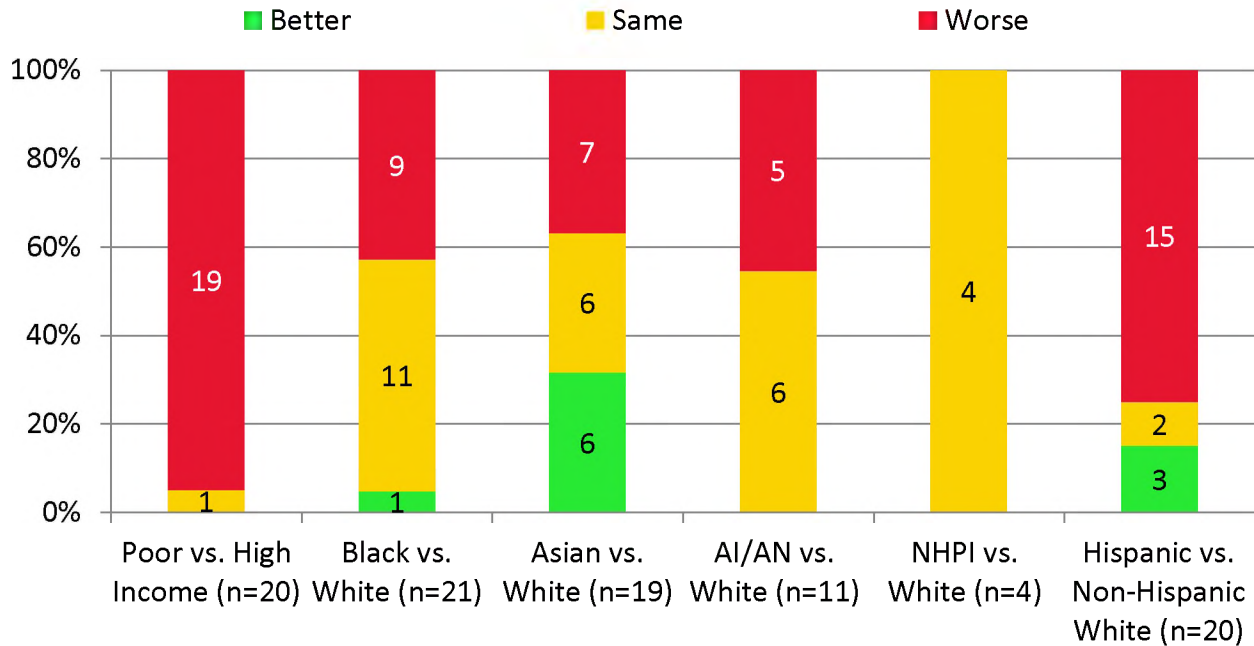
Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

Note: Data include individuals reporting one race alone or in combination with one or more races. Data are not available for Fijian and Marshallese populations due to low data reliability.

PART 3: HEALTHCARE ACCESS AND PRIORITY AREAS

Access to Care

Disparities in Access: Number and Percentage of Access Measures for Which Selected Groups Experienced Disparities in Access, 2016, 2017



Key: n = number of measures; AI/AN = American Indian or Alaska Native; NHPI = Native Hawaiian/Pacific Islander.
Note: The measures represented in this chart are available in Appendix A. The number of measures is based on the measures that have data for each population group.

- For the most recent data year (2016 or 2017), findings show that many disparities persist in access to care.

Health Insurance

Health Insurance Status, 2017

Health Insurance Status	United States	Asian	NHPI
Private	67.6%	74.3%	66.9%
Public	35.5%	25.7%	33.5%
Uninsured	8.7%	6.4%	8.3%

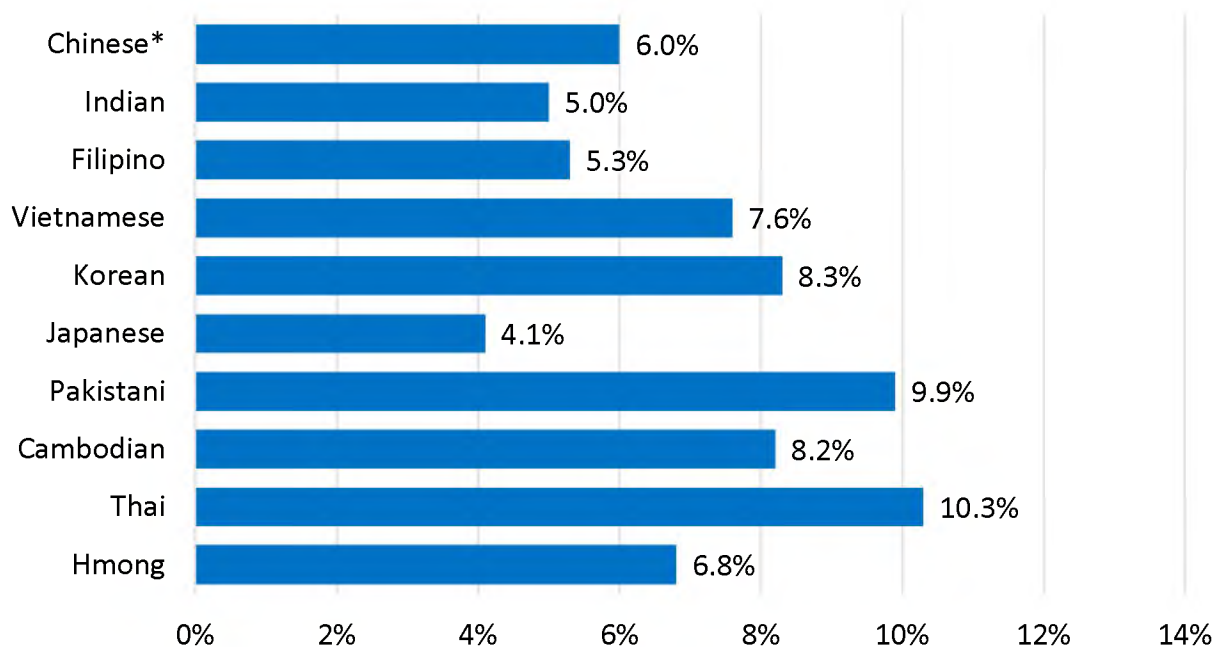
Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

Note: Includes all individuals in the civilian noninstitutionalized population. All race categories include individuals reporting one race alone or in combination with one or more races. Hispanics/Latinos may include individuals of any race. Totals exceed 100 percent because individuals may have both private and public coverage.

- Compared with the total U.S. population in 2017, Asian and NHPI individuals were:
 - More likely or as likely to have private health insurance.
 - Less likely to have public coverage.
 - Less likely to be uninsured.

- Compared with other racial and ethnic groups, Asians were the most likely to have private health insurance, while Hispanics/Latinos (of any race) were least likely (49.0%).
- Conversely, Asians were the least likely to have public coverage, while Blacks or African Americans were the most likely (43.8%), followed closely by American Indians and Alaska Natives (43.2%).
- Hispanics were the most likely to be uninsured (17.8%), while Asians were the least likely.

Individuals with no health insurance coverage, Asian subpopulations, 2017



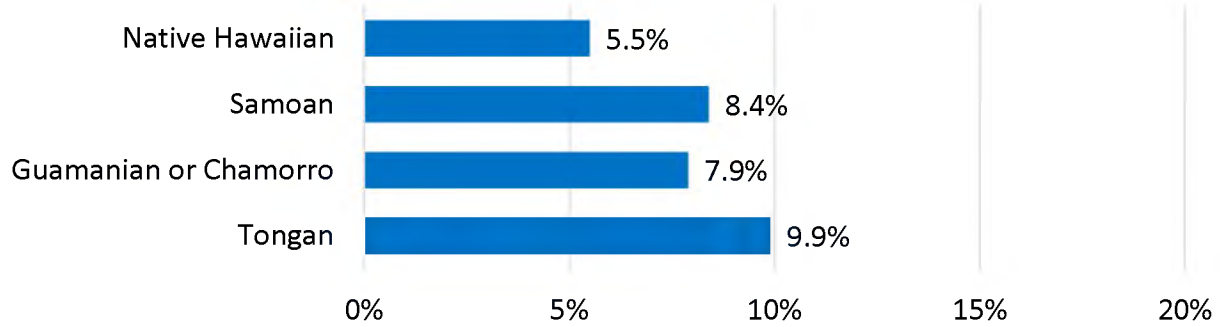
* Excluding Taiwanese.

Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

Note: Data include civilian noninstitutionalized population, all ages. Data also include individuals reporting one race alone or in combination with one or more races.

- In 2017, over 8.0% of Thais, Pakistanis, Koreans, and Cambodians were uninsured, the highest among Asian subpopulations.
- For individuals with health insurance coverage, the source varied considerably across groups. Among these Asian subpopulations, Japanese people had the highest level of private health insurance (84%) and Hmong people had the lowest level (58.1%).
- Conversely, Hmong people had the highest level of public health coverage (41.3%) and Indians had the lowest level (16.3%).
- Variations among groups likely reflect historical differences across the groups in how long they have been settling in the United States, the conditions under which they migrated, and their relationship to the labor market.

Individuals with no health insurance coverage, NHPI subpopulations, 2017



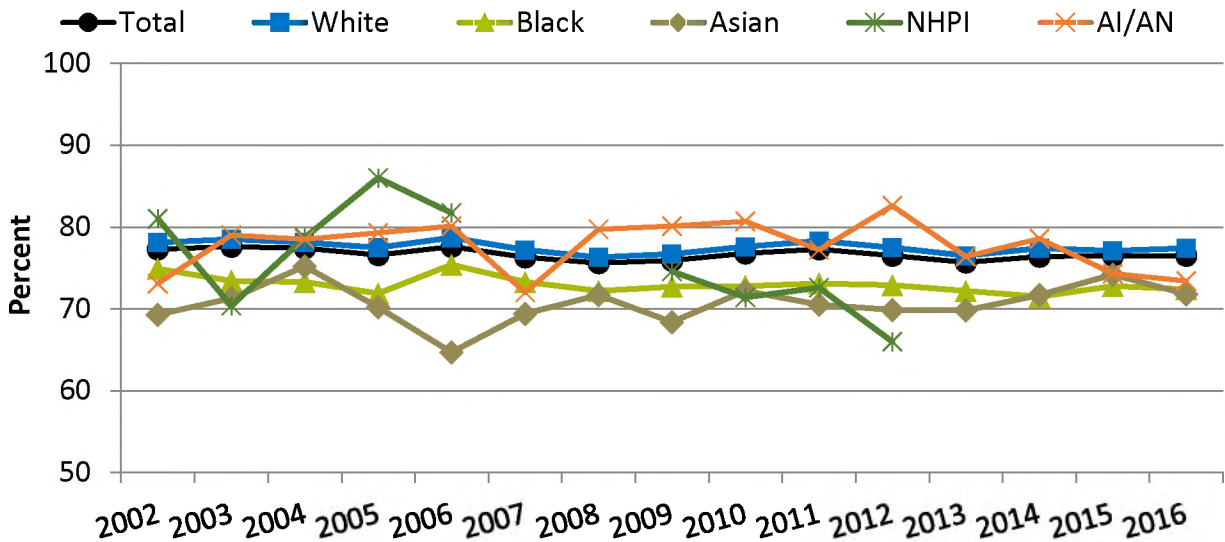
Source: 2017 American Community Survey 1 Year Estimates – U.S. Census Bureau.

Note: Data include civilian noninstitutionalized population, all ages. Data also include individuals reporting one race alone or in combination with one or more races.

- In 2017, among the NHPI subpopulations, Tongans were most likely to be uninsured (9.9%) and Native Hawaiians were the least likely (5.5%).
- For individuals with health insurance coverage, the source varied less among these NHPI subpopulations than among the Asian subpopulations shown previously.
- Guamanians/Chamorros were most likely to have private health insurance (71.1%) and Samoans were least likely (61.5%).
- Samoans were most likely to have public coverage (36.8%) and Guamanians/Chamorros were least likely to have public coverage (30.4%).

Access to Providers

People with a usual primary care provider, by race, 2002-2016



Key: AI/AN = American Indian or Alaska Native.

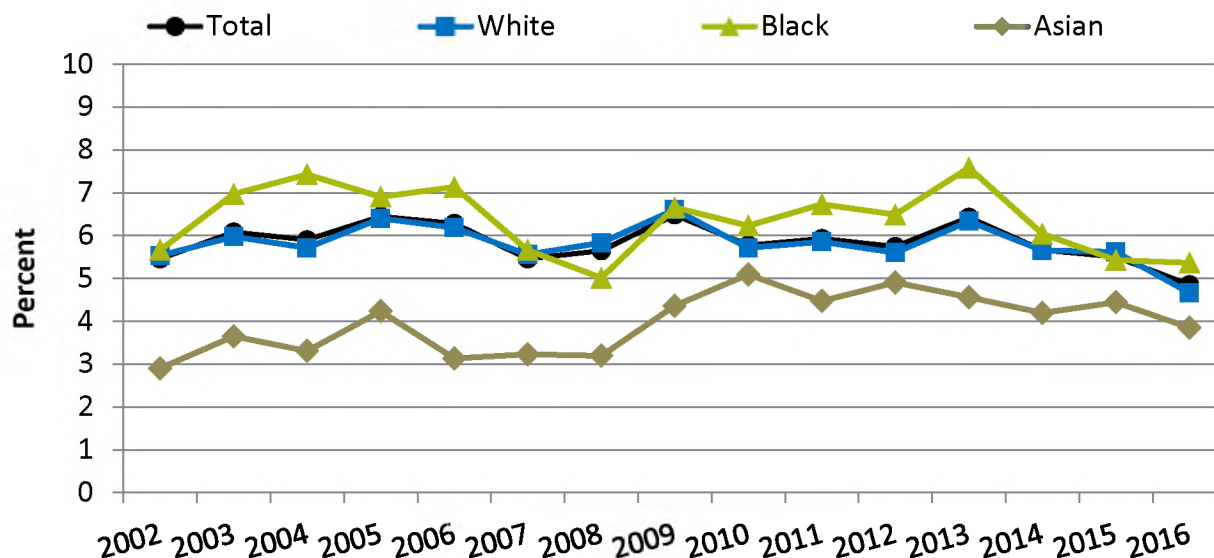
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2016.

Denominator: U.S. civilian noninstitutionalized population.

Note: Hispanics may be included in any racial group. A person is determined to have had a primary care provider if his or her usual source of care setting was either a physician's office or a hospital setting (other than an emergency room), and he or she reported going to this usual source of care for new health problems, preventive health services, and referrals. Trends could not be calculated for NHPI adults because data for 2007, 2008, and 2013-2016 did not meet the criteria for statistical reliability, data quality, and confidentiality.

- **Importance:** Having adequate access to a primary care provider can significantly influence appropriate healthcare use and health outcomes. Lacking a usual source of care may have important implications for the appropriateness, quality, and continuity of care received and patient outcomes (Roberts, 2002). The likelihood of having a usual source of healthcare may differ among Asian and NHPI subpopulations (Barnes, et al., 2008).
- **Overall Rate:** In 2016, 76.5% of people had a usual primary care provider.
- **Groups With Disparities:** In 2002, the baseline year for this analysis:
 - Asians were less likely to have a usual primary care provider compared with Whites (69.3% vs. 78.1%). This gap did not narrow over time (71.8% for Asians in 2016 vs. 77.4% for Whites).
 - Blacks were less likely to have a usual primary care provider compared with Whites (74.9% vs. 78.1%). This gap did not narrow over time (72.4% for Blacks in 2016 vs. 77.4% for Whites).

People who were unable to get or delayed in getting needed dental care in the last 12 months, by race, 2002-2016



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2016.

Denominator: U.S. civilian noninstitutionalized population.

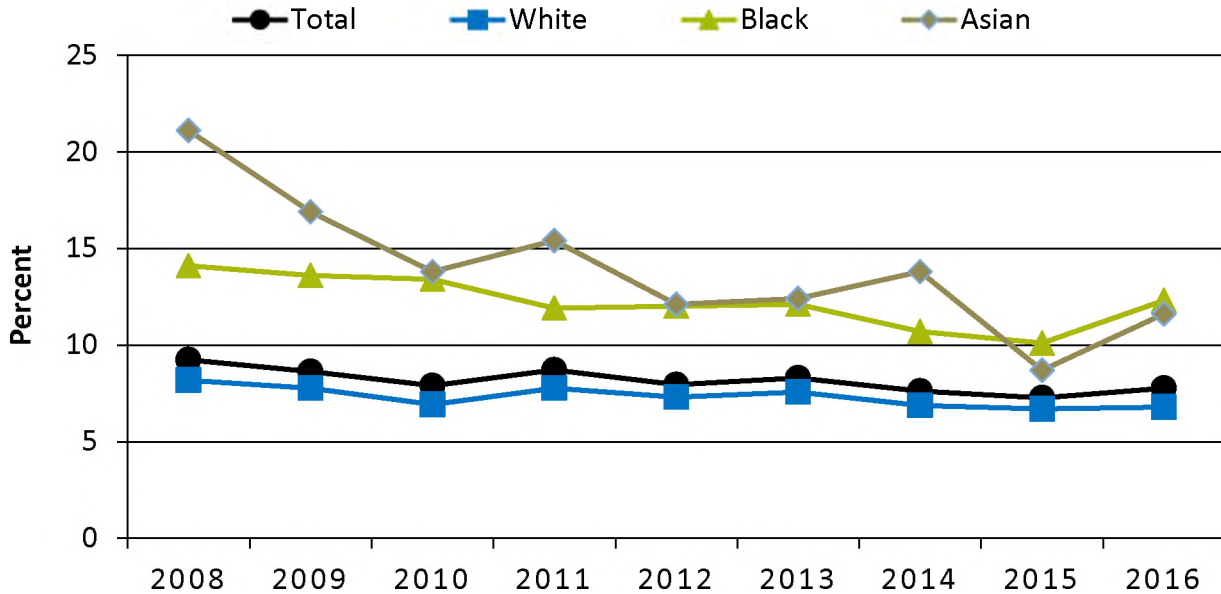
Note: For this measure, lower percentages are better. Data for NHPI adults did not meet the criteria for statistical reliability, data quality, and confidentiality.

- **Importance:** Oral health is important to an individual’s overall health and well-being. While advances in oral health have benefited most Americans, some cannot afford all the care they need, resulting in needless pain and suffering, complications that may devastate overall health and well-being, and social costs that diminish quality of life (National Institute of Dental and Craniofacial Research, 2000).
- **Overall Rate:** In 2016, 4.9% were unable to get or delayed in getting needed dental care in the last 12 months.

• **Trends:**

- The percentage of Asians unable to get or delayed in getting needed dental care in the last 12 months worsened between 2002 and 2016, increasing from 2.9% to 3.9%.

Adults who had a doctor's office or clinic visit in the last 12 months and needed care, tests, or treatment who sometimes or never found it easy to get the care, tests, or treatment, by race, 2008-2016



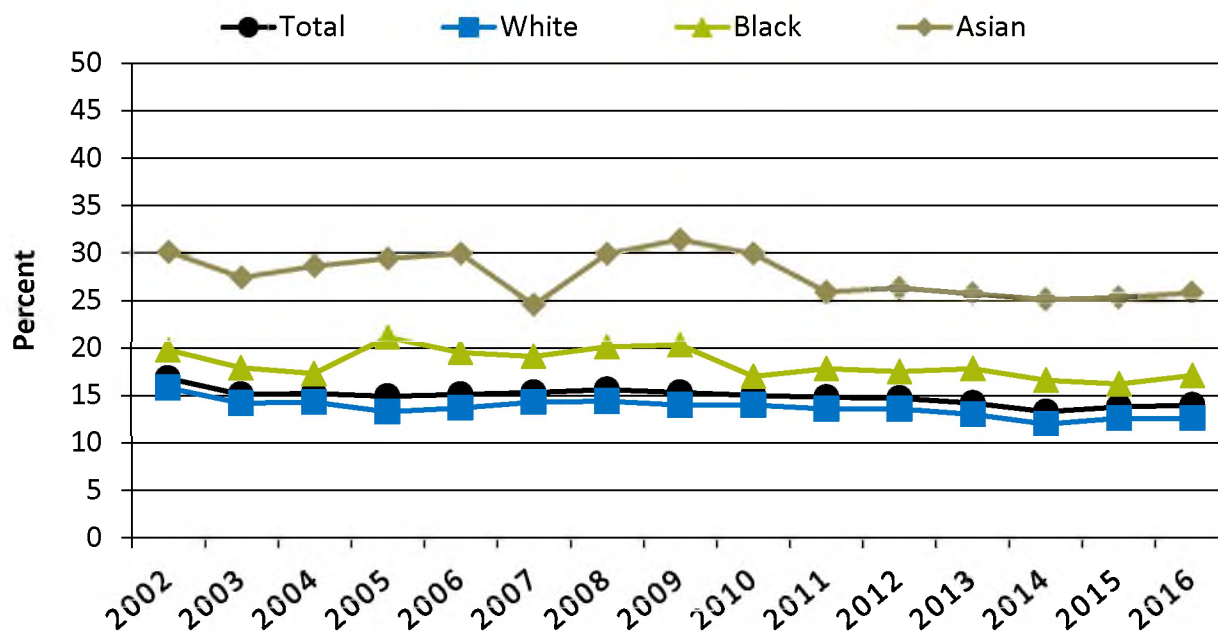
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Self-Administered Questionnaire, 2008-2016.

Denominator: U.S. civilian noninstitutionalized adults age 18 and over who needed care, tests, or treatment in the last 12 months.

Note: For this measure, lower percentages are better. Disparities could not be calculated for NHPI adults because data did not meet the criteria for statistical reliability, data quality and confidentiality.

- **Importance:** Timely delivery of appropriate care can help reduce mortality and morbidity for chronic conditions (Smart and Titus, 2011) and is a measure of the healthcare system’s capacity to provide care quickly after a need is recognized (Healthy People 2020).
- **Overall Rate:** In 2016, 7.8% of adults sometimes or never found it easy to get the care, tests, or treatment in the last 12 months.
- **Trend:** All groups improved between 2008 and 2016.
- **Groups With Disparities:** In 2008, the baseline year for this analysis:
 - The percentage of adults who had a doctor’s office or clinic visit in the last 12 months and needed care, tests, or treatment and sometimes or never found it easy to get the care, tests, or treatment was higher for Asians (21.1%) than for Whites (8.2%). This gap did not narrow over time (11.6% for Asians vs. 6.8% for Whites).
 - The percentage of adults who had a doctor’s office or clinic visit in the last 12 months and needed care, tests, or treatment and sometimes or never found it easy to get the care, tests, or treatment was higher for Blacks (14.1%) than for Whites (8.2%). This gap did not narrow over time (12.3% for Blacks vs. 6.8% for Whites).

Adults who had any appointments for routine healthcare in the last 12 months who sometimes or never got an appointment for routine care as soon as needed, by race, 2002-2016



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Self-Administered Questionnaire, 2002-2016.

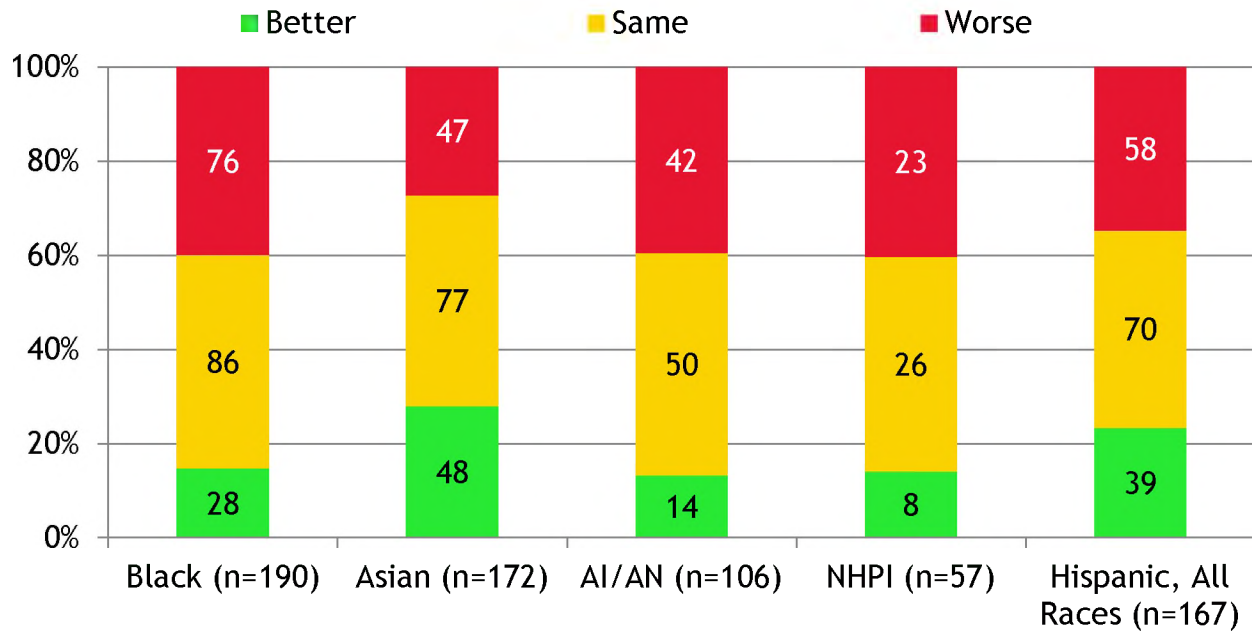
Denominator: U.S. civilian noninstitutionalized population age 18 and over who made an appointment for regular or routine healthcare in the past 12 months and had a valid response to the question, "In the last 12 months, how often did you get an appointment for regular or routine healthcare as soon as you wanted?"

Note: For this measure, lower percentages are better. Disparities could not be calculated for NHPPI adults because data did not meet the criteria for statistical reliability, data quality and confidentiality.

- **Importance:** Timely delivery of appropriate care can help reduce mortality and morbidity for chronic conditions (Smart and Titus, 2011) and is a measure of the healthcare system’s capacity to provide care quickly after a need is recognized (Healthy People 2020).
- **Overall Rate:** In 2016, 14% of adults sometimes or never got an appointment for routine healthcare as soon as they needed.
- **Trend:** All groups improved between 2002 and 2016.
- **Groups With Disparities:** In 2002, the baseline year for this analysis, among adults who had any appointments for routine healthcare in the last 12 months:
 - Asians were more likely to answer that they sometimes or never got an appointment for routine care as soon as needed compared with Whites (30.1% vs. 15.8%). This gap did not narrow over time (25.8% for Asians in 2016 compared with 12.6% for Whites).
 - Blacks were more likely to answer that they sometimes or never got an appointment for routine care as soon as needed compared to Whites (19.8% vs. 15.8%). This gap did not narrow over time (17.1% for Blacks in 2016 compared with 12.6% for Whites).

Quality of Care

DISPARITIES IN QUALITY: Number and Percentage of Quality Measures for Which Selected Groups Experienced Disparities in Quality of Care



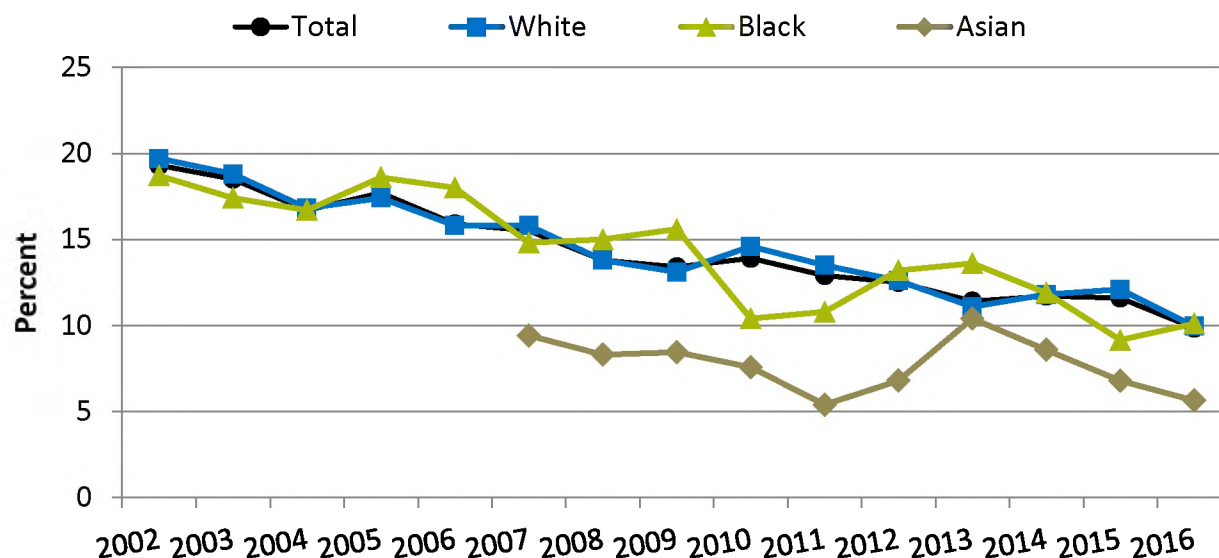
Key: n = number of measures; NHPI = Native Hawaiian/Pacific Islander; AI/AN = American Indian or Alaska Native.
Note: The most recent data years are used for this analysis. Different data sources have different data years for most recent data year. For example, the most recent data year from NIDDK USRDS is 2013 and from AHRQ HCUP is 2016.

- For the most recent data year (2016 or 2017), findings show that many disparities persist.
- Asians performed better than Whites on 28% of quality measures and NHPIs Asians performed better than Whites on 14% of quality measures.

Priority Area: Patient Safety

Patient Safety is the first of five healthcare priorities covered by this chartbook. The other four priorities are Person- and Family-Centered Care, Effective Treatment, Healthy Living, and Care Affordability. A sixth priority, Care Coordination, was addressed separately in the Chartbook on Care Coordination, available at <https://www.ahrq.gov/research/findings/nhqrdp/chartbooks/carecoordination/index.html>.

Adults age 65 and over who received in the calendar year at least 1 of 33 potentially inappropriate prescription medications for older adults, by race, 2002-2016



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2016.

Denominator: U.S. civilian noninstitutionalized population age 65 and over.

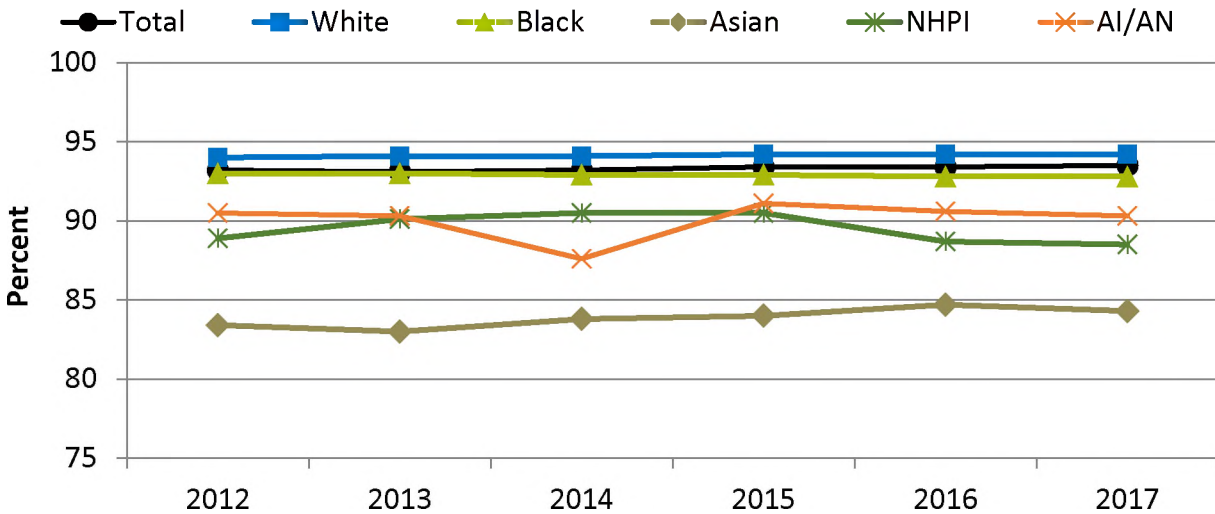
Note: For this measure, lower percentages are better. Data for Asians prior to 2007 and data for NHPs do not meet criteria for statistical reliability, data quality, and confidentiality. Prescription medications received include all prescribed medications initially purchased or otherwise obtained during the calendar year, as well as any refills. For more information on inappropriate medications, refer to the American Geriatrics Society 2012 BEERS Criteria Update Expert Panel: American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. J Am Geriatr Soc 2012 Apr;60(4):616-31. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3571677/>.

- **Importance:** Some drugs prescribed for older adults are known to be potentially harmful for this age group and can lead to adverse drug events that are both expensive and associated with poor health outcomes (American Geriatrics Society, 2015).
- **Overall Rate:** In 2016, 9.9% of adults age 65 and over had received at least one of 33 potentially inappropriate medications during the calendar year.
- **Trends:**
 - From 2007 to 2016, there was no statistically significant change in the percentage of older Asian adults who were prescribed potentially inappropriate medications.
 - For all other groups, the percentage decreased between 2002 and 2016.
- **Groups With Disparities:**
 - In 2016, Asians were less likely than Whites to have received any of the 33 potentially inappropriate medications (5.6% vs. 10.0%).

Priority Area: Person- and Family-Centered Care

Person- and Family-Centered Care is one of five healthcare priorities covered by this chartbook. The other four priorities are Patient Safety, Effective Treatment, Healthy Living, and Care Affordability. A sixth priority, Care Coordination, was addressed separately in the Chartbook on Care Coordination, available at <https://www.ahrq.gov/research/findings/nhqdr/chartbooks/carecoordination/index.html>.

Adults who reported that home health providers always treated them with courtesy and respect in the last 2 months of care, by race, 2012-2017



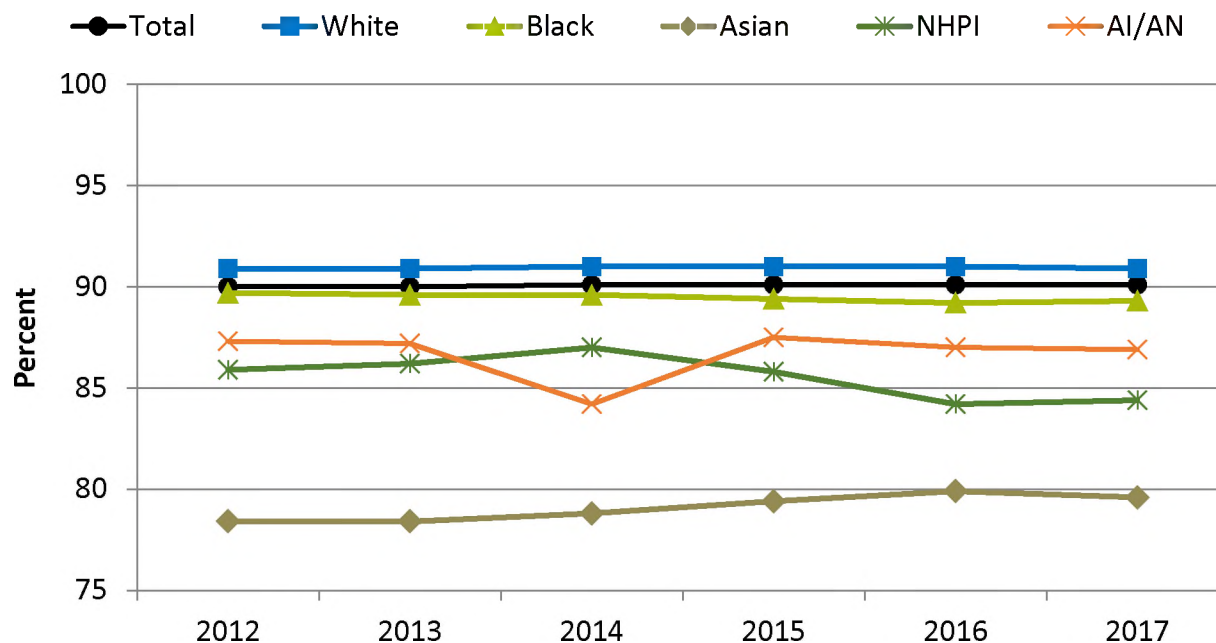
Key: AI/AN = American Indian or Alaska Native; NHPI = Native Hawaiian and Pacific Islander

Source: Centers for Medicare & Medicaid Services, Home Health Consumer Assessment of Healthcare Providers and Systems, 2012-2017.

Denominator: Adult home health patients age 18 and over who provided a valid response to the question, "In the last 2 months of care, how often did home health providers from this agency treat you with courtesy and respect?" excluding nonrespondents.

- **Importance:** A person- and family-centered approach to healthcare is defined by the inclusion and participation of patients and their families in decision making and treatment. A fundamental basis for inclusivity is treating patients with courtesy and respect. There is a positive association between being treated with courtesy, dignity, and respect and improved patient experiences with care and health outcomes (Beach, 2005; Van de Ven, 2014).
- **Overall Rate:** In 2017, 93.5% of adults reported that home health providers always treated them with courtesy and respect in the last 2 months of care.
- **Trends:** From 2012 to 2017, adults who reported that home health providers always treated them with courtesy and respect in the last 2 months of care improved for Asians (83.4% to 84.3%) and overall (93.2% to 93.5%).
- **Groups With Disparities:** In 2012, the baseline year for this analysis:
 - Asian adults were less likely to report that home health providers always treated them with courtesy and respect in the last 2 months of care compared with White adults (83.4% vs. 94.0%). This gap did not narrow over time (84.3% for Asians in 2017 vs. 94.2% for Whites).
 - NHPI adults were less likely to report that home health providers always treated them with courtesy and respect in the last 2 months of care compared with White adults (88.9% vs. 94.0%). This gap did not narrow over time (88.5% for NHPIs in 2017 vs. 94.2% for Whites).
 - American Indian or Alaska Native (AI/AN) adults were less likely to report that home health providers always treated them with courtesy and respect in the last 2 months of care compared with White adults (90.5% vs. 94.0%). This gap did not narrow over time (90.3% for AI/ANs in 2017 vs. 94.2% for Whites).
 - Black adults were less likely to report that home health providers always treated them with courtesy and respect in the last 2 months of care compared with White adults (93.0% vs. 94.0%). This gap did not narrow over time (92.8% for Blacks in 2017 vs. 94.2% for Whites).

Adults who reported that home health providers always treated them as gently as possible in the last 2 months of care, by race, 2012-2017

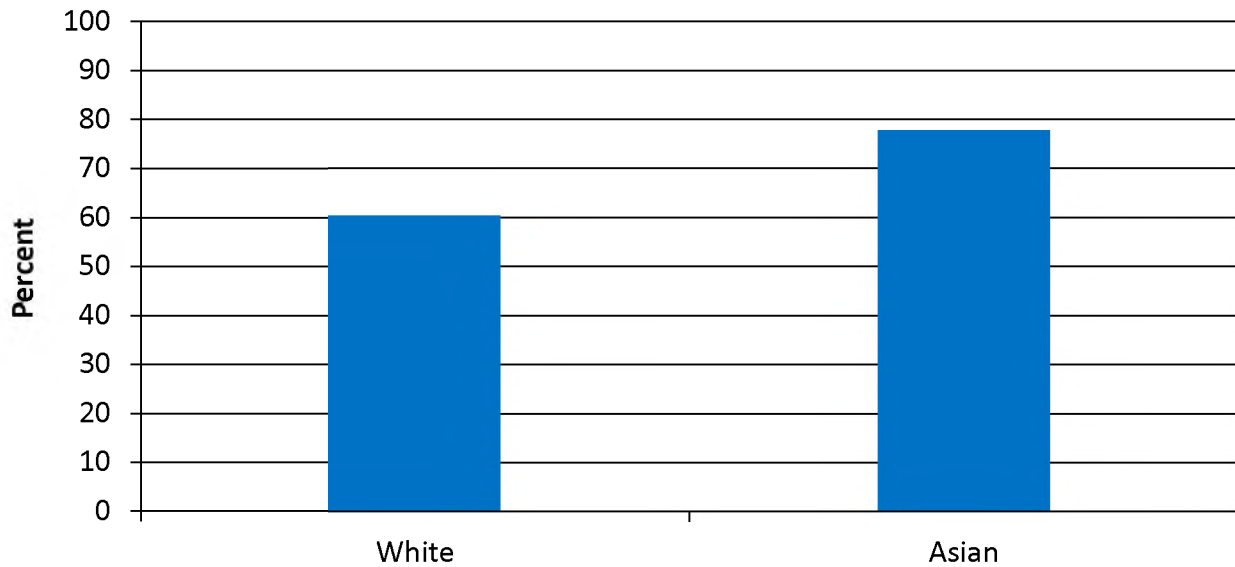


Key: AI/AN = American Indian or Alaska Native; NHPI = Native Hawaiian/Pacific Islander.
Denominator: Adult home health patients age 18 and over who provided a valid response to the question, "In the last 2 months of care, how often did home health providers from this agency treat you as gently as possible?" excluding nonrespondents.
Source: Centers for Medicare & Medicaid Services, Home Health Consumer Assessment of Healthcare Providers and Systems, 2012-2017.

- **Importance:** A person- and family-centered approach to healthcare is defined by the inclusion and participation of patients and their families in decision making and treatment. A fundamental basis for inclusivity is treating patients with courtesy and respect. There is a positive association between being treated with courtesy, dignity, and respect and improved patient experiences with care and health outcomes (Beach, 2005; Van de Ven, 2014).
- **Overall Rate:** In 2017, 90.1% of adults reported that that home health providers always treated them as gently as possible in the last 2 months of care.
- **Trends:** Between 2012 and 2017, the percentage of Asian adults who reported that home health providers always treated them as gently as possible in the last 2 months of care improved from 78.4% to 79.6%.
- **Groups With Disparities:** In 2012, the baseline year for this analysis:
 - Asians were less likely to report that home health providers always treated them as gently as possible in the last 2 months of care compared with Whites (78.4% vs. 90.9%). This gap did not narrow over time (79.6% for Asians in 2017 vs. 90.9% for Whites).
 - NHPIs were less likely to report that home health providers always treated them as gently as possible in the last 2 months of care compared with Whites (85.9% vs. 90.9%). This gap did not narrow over time (84.4% For NHPIs in 2017 vs. 90.9% for Whites).

- AI/ANs were less likely to report that home health providers always treated them as gently as possible in the last 2 months of care compared with Whites (87.3% vs. 90.9%). This gap did not narrow over time (86.9% for AI/ANs in 2017 vs. 90.9% for Whites).
- Blacks were less likely to report that home health providers always treated them as gently as possible in the last 2 months of care compared with Whites (89.7% vs. 90.9%). This gap did not narrow over time (89.3% for Blacks in 2017 vs. 90.9% for Whites).

Adults with limited English proficiency who had a usual source of care, by race, 2016



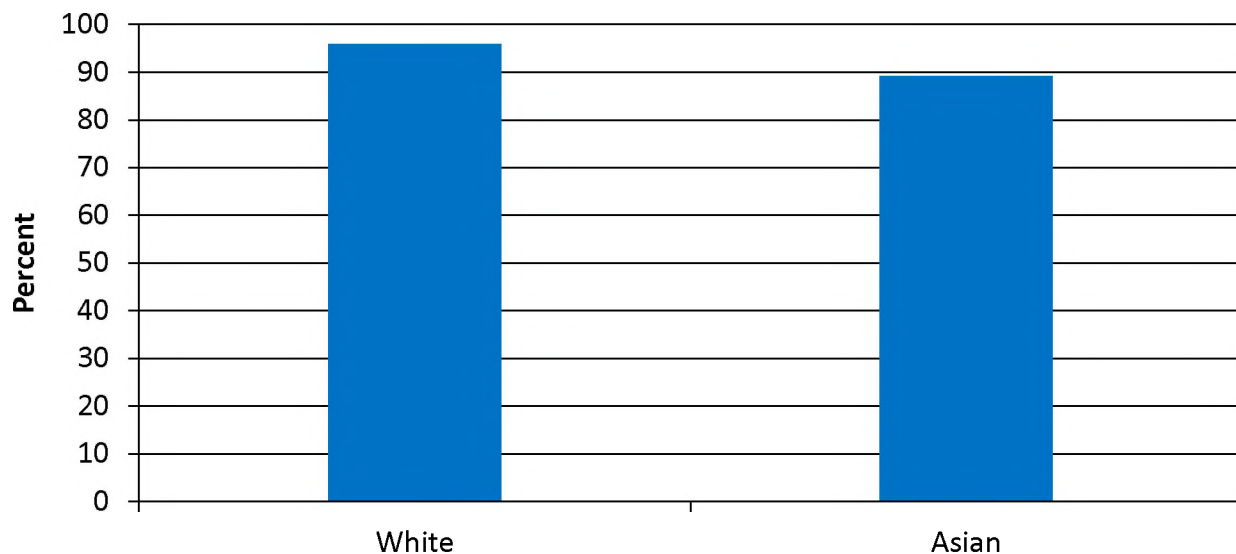
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2016.

Denominator: U.S. civilian noninstitutionalized adults age 18 and over.

Note: Data did not meet the criteria for statistical reliability, data quality, and confidentiality for any groups other than Whites and Asians. The source data could not be disaggregated for Asian and NHPI subpopulations and thus does not reflect the variance among subpopulations that has been observed in rates of LEP.

- **Importance:** Having adequate access to healthcare services and language-appropriate care can significantly influence healthcare utilization and health outcomes. People with limited English proficiency (LEP) face additional communication challenges when interacting with the healthcare system that can contribute to fewer physician visits, less preventive care, reduced patient safety, and healthcare disparities (Association of Asian Pacific Community Health Organizations, 2014; Tsoh, et al., 2016).
- **Overall Rate:** In 2016, 62.9% of adults with LEP had a usual source of care.
- **Groups With Disparities:** In 2016, among adults with LEP, Asians were more likely to have a usual source of care compared with Whites (77.7% vs. 60.3%).

Adults with limited English proficiency and usual source of care (USC) whose USC had language assistance, by race, 2016



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2016.

Denominator: U.S. civilian noninstitutionalized adults age 18 and over with limited English proficiency and a usual source of care.

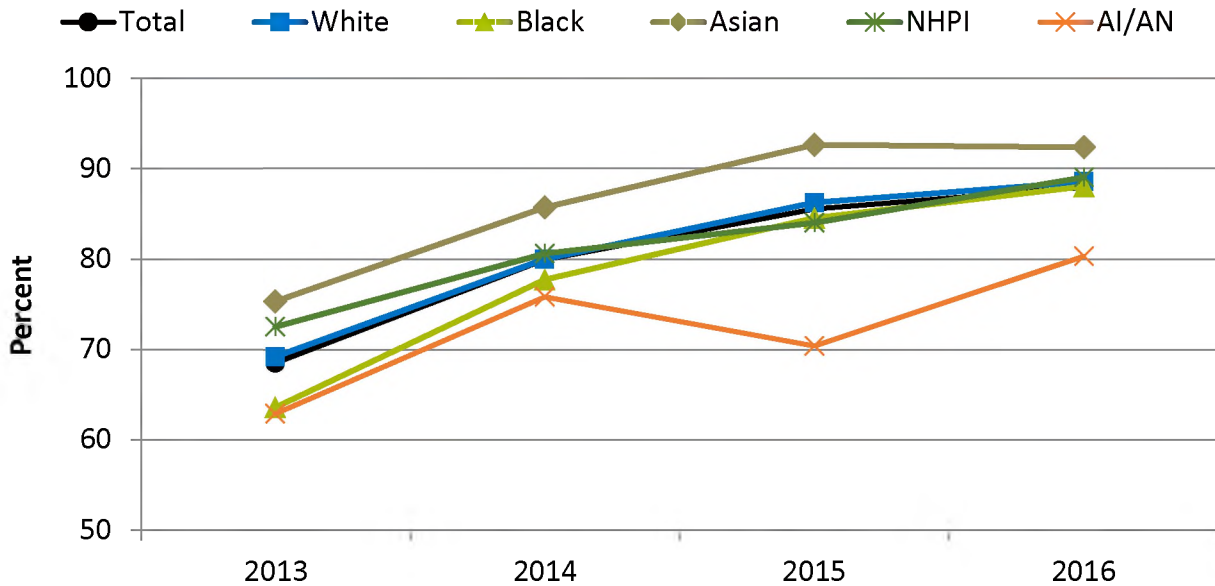
Note: Data did not meet the criteria for statistical reliability, data quality, and confidentiality for any groups other than Whites and Asians. The source data could not be disaggregated for Asian and NHPI subpopulations and thus does not reflect the variance among subpopulations that has been observed in rates of LEP.

- **Importance:** Having adequate access to healthcare services and language-appropriate care can significantly influence healthcare utilization and health outcomes. People with limited English proficiency face additional communication challenges when interacting with the healthcare system that can contribute to fewer physician visits, less preventive care, reduced patient safety, and healthcare disparities (Association of Asian Pacific Community Health Organizations, 2014; Tsoh, et al., 2016).
- **Overall Rate:** In 2016, 94.1% of adults with limited English proficiency and USC had language assistance.
- **Groups With Disparities:** In 2016, among adults with limited English proficiency and USC, Asians were less likely to have language assistance compared with Whites (89.2% vs. 95.9%).

Priority Area: Effective Treatment

Effective Treatment is one of five healthcare priorities covered by this chartbook. The other four priorities are Patient Safety, Person- and Family-Centered Care, Healthy Living, and Care Affordability. A sixth priority, Care Coordination, was addressed separately in the Chartbook on Care Coordination, available at <https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/index.html>.

Acute stroke patients for whom IV thrombolytic therapy was initiated at hospital within 3 hours of time last known well, by race, 2013-2016



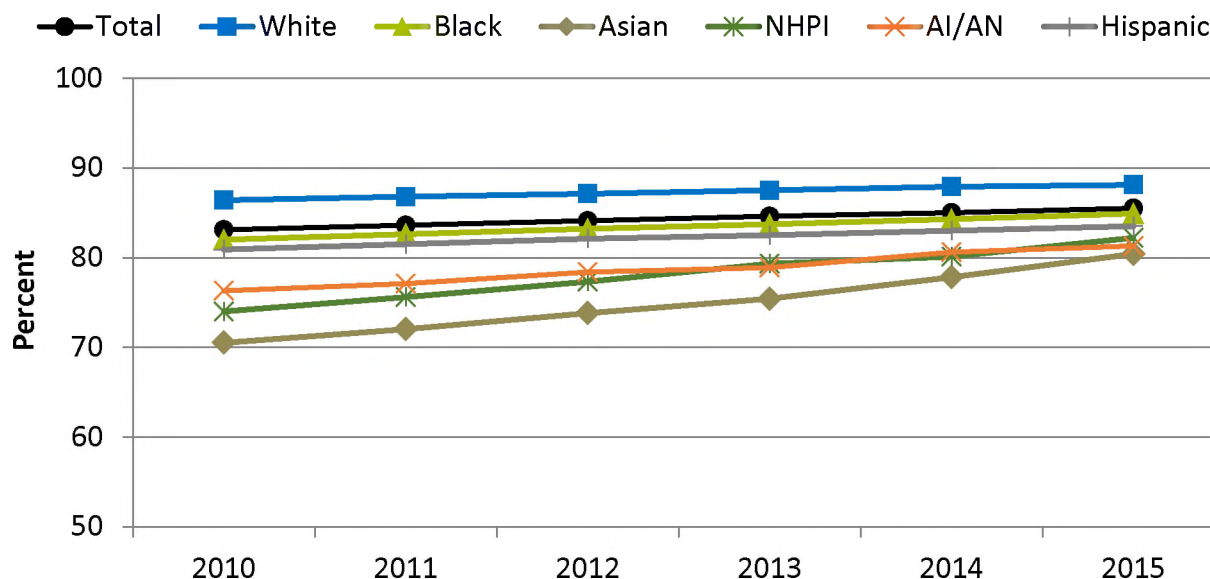
Key: AI/AN = American Indian or Alaska Native; NHPI = Native Hawaiian and Pacific Islander.

Source: Centers for Medicare & Medicaid Services, Quality Improvement Organization Program, Clinical Data Warehouse for Hospital Inpatient Quality Reporting Program, 2013-2016.

Denominator: All Patients age 18 years and over with a diagnosis of acute stroke whose time of arrival is within 3 hours (less than or equal to 180 minutes) of time last known well.

- **Importance:** Cerebrovascular disease (stroke) is one of the leading causes of death and serious long-term disability in the United States (Demaerschalk, et al., 2010). The appropriately timed administration of thrombolytic agents to carefully screened eligible patients with acute ischemic stroke has been shown to save lives, improve outcomes, and lower costs (Fagan, et al., 1998; Johnston, 2010). Obesity-related stroke risk may differ among Asian and NHPI subpopulations (Ritenour, et al., 2017).
- **Overall Rate:** In 2016, 87.9% of adults who were acute stroke patients had IV thrombolytic therapy initiated at the hospital within 3 hours of time last known well.
- **Trends:** All groups improved between 2013 and 2016 except AI/ANs, which did not change significantly during this time.
- **Groups With Disparities:**
 - In 2016, Asians were more likely to have IV thrombolytic therapy initiated at the hospital within 3 hours of time last known well compared with Whites (92.3% vs. 88.5%).
 - AI/ANs were less likely to have IV thrombolytic therapy initiated at the hospital within 3 hours of time last known well compared with Whites (80.3% vs. 88.5%).

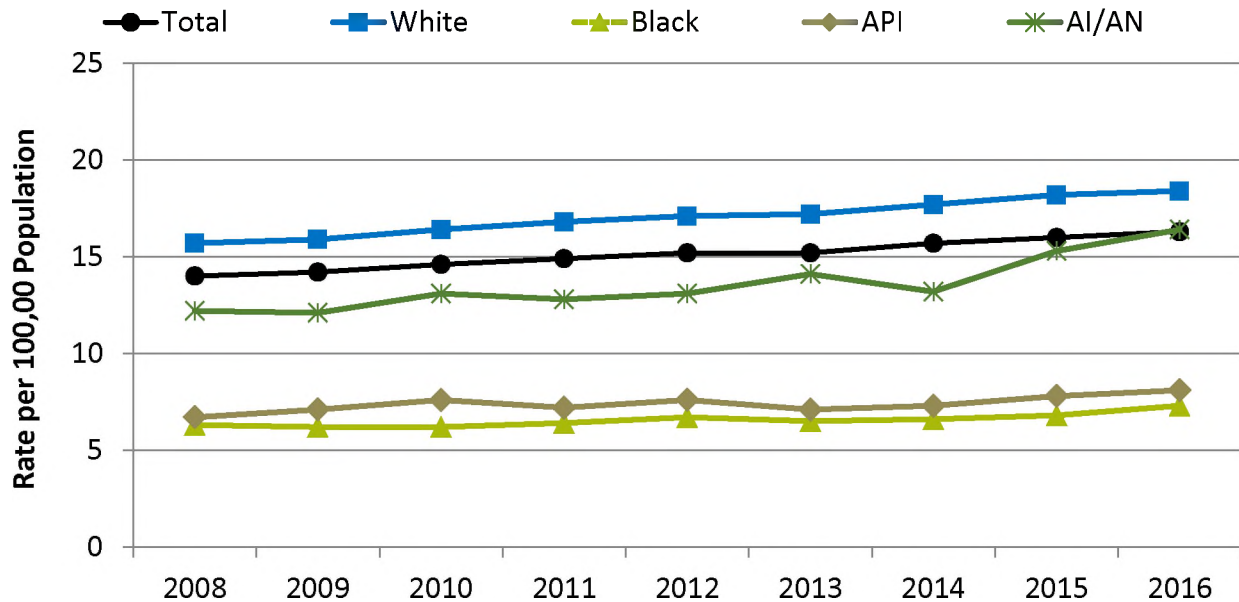
People age 13 and over living with HIV who know their serostatus, by race/ethnicity, 2010-2015



Key: AI/AN = American Indian or Alaska Native; NHPI = Native Hawaiian/Pacific Islander.
Source: Centers for Disease Control and Prevention, National Center for HIV, Viral Hepatitis, STD, and TB Prevention, Division of HIV/AIDS Prevention, National HIV/AIDS Surveillance System, 2010-2015.
Denominator: Adolescents and adults age 13 and over.
Note: White, Black, Asian, NHPI, and AI/AN are non-Hispanic. Hispanic includes all races. For more information on Asians and NHPIs and HIV, see, for example, Substance Abuse and Mental Health Services Administration, A Snapshot of Behavioral Health Issues for Asian American/Native Hawaiian/Pacific Islander Boys and Men: Jumpstarting an Overdue Conversation. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2016. HHS Publication No. (SMA) 16-4959.

- **Importance:** People with HIV need to know they are HIV positive so they can take medicine to treat HIV. Taking HIV medicine as prescribed can make the level of virus in their body very low or even undetectable. A person with HIV who gets and stays virally suppressed or undetectable can stay healthy and has significantly low risk of transmitting HIV to HIV-negative partners through sex (CDC, 2019a, 2019b).
- **Overall Rate:** In 2015, 85.5% of people age 13 years and over living with HIV knew their serostatus.
- **Trend:** All groups improved from 2010 to 2015.
- **Groups With Disparities:** In 2010, the baseline year for this analysis, among people age 13 years and over living with HIV:
 - Asians were less likely to know their serostatus compared with Whites (70.5% vs. 86.4%). This gap narrowed over time (80.4% for Asians in 2015 vs. 88.1% for Whites).
 - NHPIs were less likely to know their serostatus compared with Whites (74.0% vs. 86.4%). This gap narrowed over time (82.2% for NHPIs in 2015 vs. 88.1% for Whites).
 - AI/ANs were less likely to know their serostatus compared with Whites (76.3% vs. 86.4%). This gap did not narrow over time (81.3% for AI/ANs in 2015 vs. 88.1% for Whites).
 - Blacks were less likely to know their serostatus compared with Whites (82.0% vs. 86.4%). This gap did not narrow over time (84.9% for Blacks in 2015 vs. 88.1% for Whites).
 - Hispanics were less likely to know their serostatus compared with Whites (80.9% vs. 86.4%). This gap did not narrow over time (83.5% for Hispanics in 2015 vs. 88.1% for Whites).

Suicide deaths among people age 12 and over per 100,000 population, by race, 2008-2016



Key: API = Asian/Pacific Islander; AI/AN = American Indian or Alaska Native.

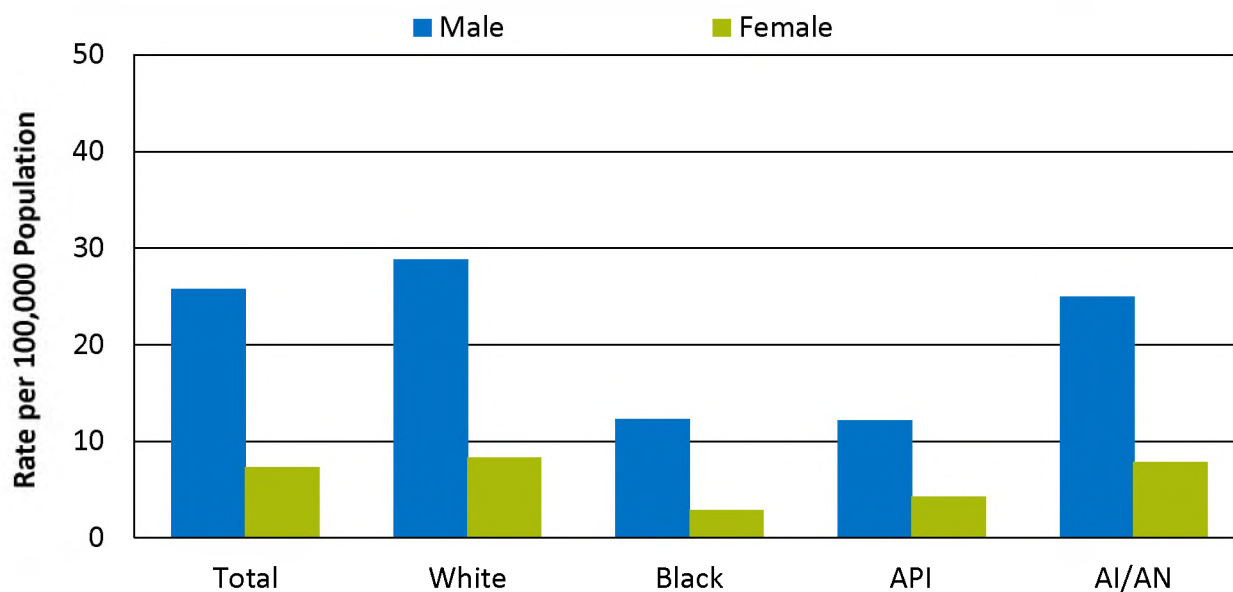
Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System—Mortality, 2008-2016.

Denominator: U.S. resident population age 12 and over.

Note: For this measure, lower rates are better. Suicides may be undercounted because of difficulty in the determination of suicidal intent by the coroner or medical examiner. Estimates are age adjusted to the 2000 U.S. standard population. Individuals for whom age is not reported are not included in the age adjustment calculations and are excluded from numerators. This data source combined data for Asian and NHPI into a single category, API.

- **Importance:** The age-adjusted suicide rate in the United States in 2017 was increasing and was 33% higher than the rate in 1999 (Curtin and Hedegaard, 2019). In 2017, suicide was the leading cause of death for Asian Americans ages 15 to 24 (Office of Minority Health, 2019) and the second leading cause for those ages 25 to 34 (CDC, 2017). Among the Asian and Pacific Islander population, complex interactions between social environments, developmental contexts, and acculturation serve as both risk and protective factors for the manifestation of depression and suicide (SAMHSA, 2016; Wyatt, et al., 2015).
- **Overall Rate:** In 2016, 16.3 per 100,000 people age 12 and over died by suicide.
- **Trends:** Suicide deaths per 100,000 population for people age 12 and over increased for all groups between 2008 and 2016.

Suicide deaths among people age 12 and over per 100,000 population, by race and sex, 2016



Key: API = Asian or Pacific Islander; AI/AN = American Indian or Alaska Native.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System—Mortality, 2016.

Denominator: U.S. resident population age 12 and over.

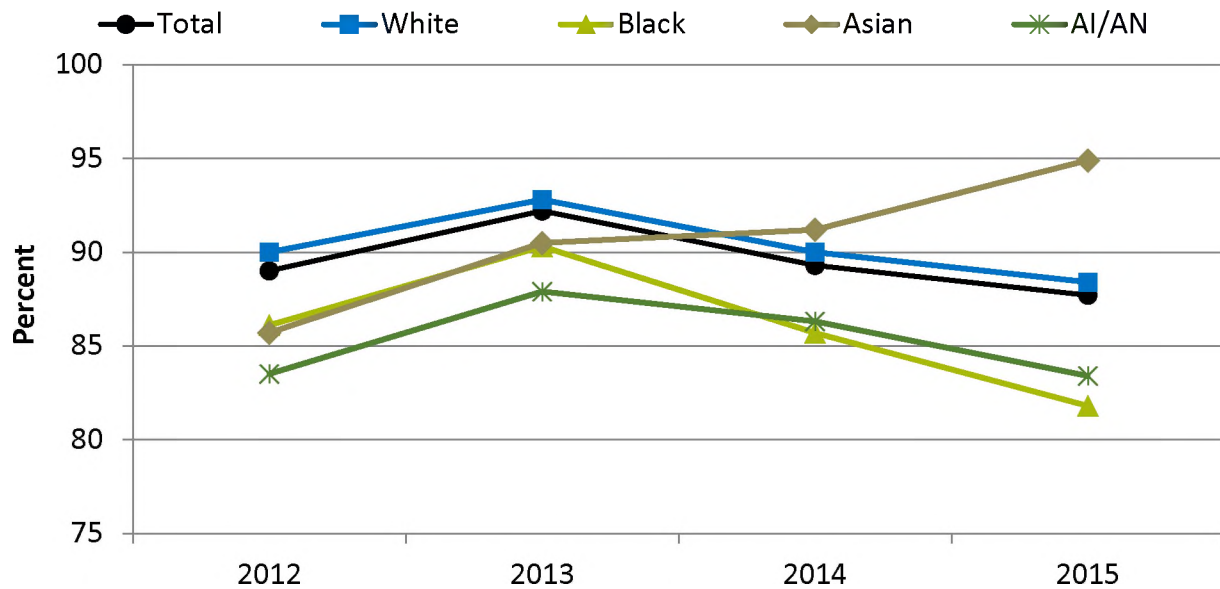
Note: For this measure, lower rates are better. Suicides may be undercounted because of difficulty in the determination of suicidal intent by the coroner or medical examiner. Estimates are age adjusted to the 2000 U.S. standard population. Individuals for whom age is not reported are not included in the age adjustment calculations and are excluded from numerators. This data source combined data for Asian and NHPI into a single category, Asian/Pacific Islander.

- **Importance:** The age-adjusted suicide rate in the United States in 2017 was 33% higher than the rate in 1999. Suicide rates are typically higher among males than females (Curtin and Hedegaard, 2019; SAMHSA, 2016).
- **Overall Rate:** In 2016, 16.3 per 100,000 people age 12 and over died by suicide.
- **Groups With Disparities:** In 2016, among people age 12 and over:
 - Overall and across all racial groups, males were significantly more likely to die by suicide than females. (Other results reported below were not tested for statistical significance.)
 - Overall, the suicide rate was 25.8 per 100,000 for males and 7.3 per 100,000 for females.
 - The ratio of male to female suicides was largest among Blacks (4.2:1) and lowest among Asians/Pacific Islanders (2.8:1)
 - Among males, Whites were the most likely to die by suicide (28.8 per 100,000), while Asians/Pacific Islanders were the least likely (12.2 per 100,000).
 - Among females, Whites were the most likely to die by suicide (8.3 per 100,000) and Blacks were the least likely (2.9 per 100,000).

Priority Area: Healthy Living

Healthy Living is one of five healthcare priorities covered by this chartbook. The other four priorities are Patient Safety, Person- and Family-Centered Care, Effective Treatment, and Care Affordability. A sixth priority, Care Coordination, was addressed separately in the Chartbook on Care Coordination, available at <https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/index.html>.

Hospital patients who received pneumococcal immunization, by race, 2012-2015



Key: AI/AN = American Indian or Alaska Native.

Source: Centers for Medicare & Medicaid Services, Quality Improvement Organization Clinical Data Warehouse for Hospital Inpatient Quality Reporting Program.

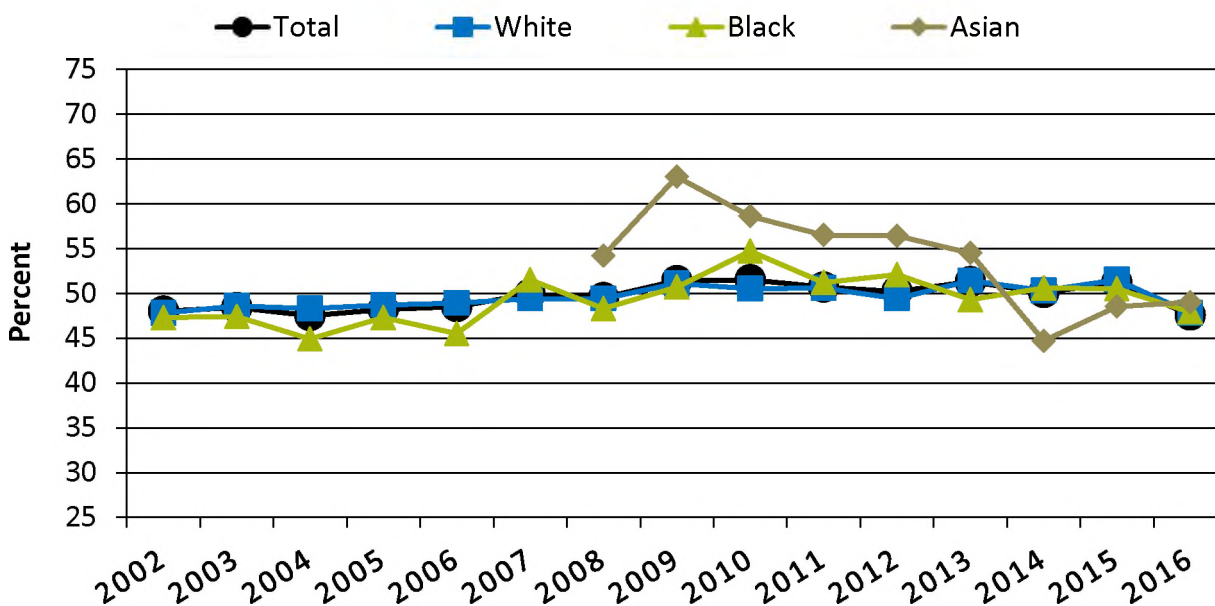
Denominator: Discharged hospital patients age 65 years and over and ages 5-64 years with a high-risk condition.

Note: NHPI is excluded from this analysis because data were only available for 2013-2015; 4 years of data are required for inclusion in trend analyses. Estimates are calculated using hospital-level scores. Further information on this and other immunization measures is available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalProcessOfCareMeasures.html>.

- Importance:** Pneumococcal disease is caused by bacteria and can result in a range of ailments, from mild ear infection to meningitis, sepsis, and fatal pneumonia (NIAID, 2014). Adults over age 65 and individuals of any age with chronic illness are at increased risk for pneumococcal disease and death. The best way to prevent pneumococcal disease is by getting vaccinated (CDC, 2019c). Immunization rates may differ among Asian and NHPI subpopulations (Barnes, et al., 2008).
- Overall Rate:** In 2015, 87.7% of hospital patients age 65 years and over and ages 5-64 years with a high-risk condition received pneumococcal immunization.
- Trend:** The percentage of Asian hospital patients age 65 years and over and ages 5-64 years with a high-risk condition who received a pneumococcal immunization increased from 85.7% in 2012 to 94.9% in 2015. No other group experienced a statistically significant change over this period.

- Groups With Disparities:** In 2012, the baseline year for this analysis, among hospital patients age 65 years and over and ages 5-64 with a high-risk condition:
 - Asians were less likely to receive the pneumococcal immunization compared with Whites (85.7% vs. 90.0%). By 2015, Asians were more likely than Whites to receive pneumococcal immunization (94.9% vs. 88.4%).
 - American Indians/Alaska Natives were less likely to receive the pneumococcal immunization compared with Whites (83.5% vs. 90.0%). This gap did not narrow over time (83.4% for AI/ANs in 2015 vs. 88.4% for Whites).
 - Blacks were less likely to receive the pneumococcal immunization compared with Whites (86.1% vs. 90.0%). This gap did not narrow over time (81.8% for Blacks in 2015 vs. 88.4% for Whites).
 - In 2015, Native Hawaiians/Pacific Islanders were more likely to receive the pneumococcal immunization compared with Whites (95.6% vs. 88.4%).

Adults with obesity who ever received advice from a health professional about eating fewer high-fat or high-cholesterol foods, by race, 2002-2016



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2016.
Denominator: U.S. civilian noninstitutionalized population age 18 and over with a body mass index (BMI) of 30 or greater, excluding pregnant women.
Note: Data for Asians before 2008 do not meet criteria for statistical reliability, data quality, and confidentiality. BMI is based on reported height and weight. Estimates are age adjusted to the 2000 U.S. standard population using three age groups: 18-44, 45-64, and 65 and over. Nonrespondents and "Don't Know" responses were excluded from the analysis. Data were not included for NHPI adults because they did not meet the criteria for statistical reliability, data quality, and confidentiality.

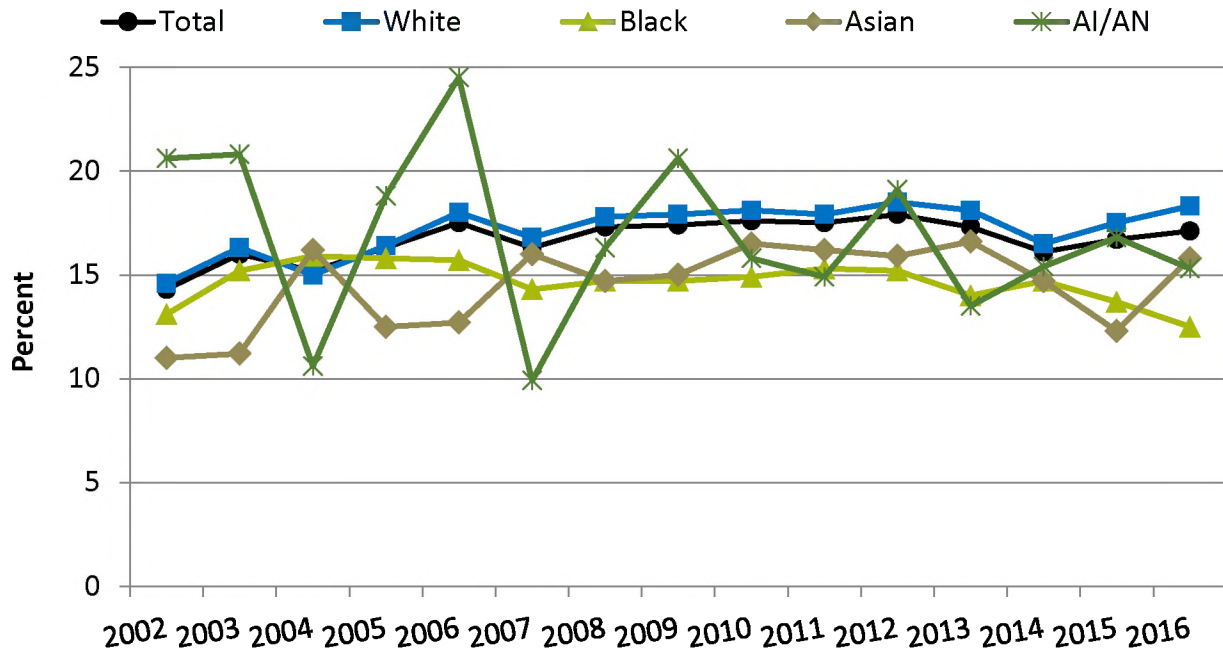
- Importance:** Obesity increases the risks for numerous diseases and detrimental health conditions, such as hypertension, diabetes, coronary heart disease, stroke, sleep apnea, and depression. In addition, obesity increases individual risk for mortality, particularly from cardiovascular disease and cancer (Jensen, et al., 2014).

- **Overall Rate:** In 2016, 47.6% of adults with obesity received advice from a health professional about eating fewer high-fat or high-cholesterol foods.
- **Trends:**
 - The percentage of Asian adults with obesity who ever received advice from a health professional about eating fewer high-fat or high-cholesterol foods decreased from 54.2% to 49.0% between 2008 and 2016.

Priority Area: Affordable Care

Care Affordability is one of five healthcare priorities covered by this chartbook. The other four priorities are Patient Safety, Person- and Family-Centered Care, Effective Treatment, and Healthy Living. A sixth priority, Care Coordination was addressed separately in the Chartbook on Care Coordination, available at <https://www.ahrq.gov/research/findings/nhqrdc/chartbooks/carecoordination/index.html>.

People under age 65 whose family's health insurance premium and out-of-pocket medical expenditures were more than 10% of total family income, by race, 2002-2016



Key: AI/AN = American Indian or Alaska Native.

Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2016.

Denominator: U.S. civilian noninstitutionalized population under age 65.

Note: For this measure, lower percentages are better. Health insurance premium is the sum of insurance premiums (imputed) and Medicare Part B expenditures. Total family income is the sum of person-level pretax total income, refund income, and sales income. "Family" is defined in terms of health insurance eligibility units (HIEUs), which are composed of individuals who could be covered as a family under most private health insurance plans. For income, insurance, expenditures, and premiums, a family is defined in terms of HIEUs. Trends could not be calculated for NHPI adults because data did not meet the criteria for statistical reliability, data quality, and confidentiality.

- **Importance:** Healthcare costs can represent a significant financial burden on patients and their families. Even with commercial insurance, Medicare or Medicaid coverage, patients still face out-of-pocket costs for premiums, deductibles, cost sharing, and costs for noncovered services. These healthcare costs can pose a challenge, particularly for individuals with modest incomes and those with significant medical needs.
- **Overall Rate:** In 2016, 17.1% of the population under age 65 family's health insurance premium and out-of-pocket medical expenditures were more than 10% of total family income.
- **Trends:**
 - Between 2002 and 2016, the percentage of people under age 65 whose family's health insurance premium and out-of-pocket medical expenditures were more than 10% of total family income increased for Asians (from 11.0% to 15.8%) and Whites (from 14.6% to 18.3%).
 - There was no statistically significant change in the overall trend or the trend for other groups included in the analysis.
- **Groups With Disparities:**
 - Blacks under age 65 were less likely to spend more than 10% of total family income on their family's health insurance premiums and out-of-pocket medical expenditures compared with Whites (12.5% vs. 18.3%).

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Marketplace Pools: The Shape of the Marketplace Entry

Marketplace Entry

June 11, 2020 | Publisher: Robert Wood Johnson Foundation
Author(s): Heidi Stender

Millions of people are losing their jobs, and will also lose their employer-sponsored health insurance coverage.

[Download Figure 1 \(JPG\)](#)

A recent study (<https://www.urban.org/research/publication/how-covid-19-recession-could-affect-health-insurance-coverage>) by the Urban Institute projected that 25 to 43 million workers and their families may lose employer-sponsored coverage. They will lose the safety net created by the ACA—(especially in the majority of states that expanded) and the individual market. Enrollment in Medicaid and marketplace plans is projected to grow by as much as 20 and 10 million, respectively, due to fallout from the recession. <https://ccf.georgetown.edu/2020/05/28/medicaid-as-first-responder-enrollment-is-on-the-rise/> suggests that Medicaid enrollment has already increased by nearly three percent. At the same time, there will be some tension between these two segments, as some current individual market enrollees may lose enough income to qualify for Medicaid. The exact outcome depends on both eligibility for coverage as well as take-up, and other factors like the potential subsidization of COBRA. The coverage impact will vary, with those states that did not expand seeing a greater number of uninsured residents.

Given the expected rise in Medicaid and marketplace enrollment as well as increased churn, continuity between Medicaid and the marketplace is more important than ever. In a recent *Health Affairs* blog (<https://www.healthaffairs.org/doi/10.1377/hblog20200511.314433/full/>), we analyzed overlap plans, which we define as plans from a single carrier that may offer both marketplace and Medicaid (or other state) options in the same county. Overlap plans are currently quite common: 60 percent of counties have at least one parent carrier offering plans in both the individual market and Medicaid. This tendency increases in urban areas, with the result that 80 percent of the population under 65 years lives in a county with overlap. In large metropolitan areas, 85 percent of counties have overlap plans, compared with 52 percent of counties classified as non-urban. These statistics, however, do not capture continuity between Medicaid and the marketplace. In counties with overlap, two-thirds of counties in expansion states have at least one overlap offering, as compared with only half of counties in states that did not expand. Our analysis also showed that the gap between the two is significantly lower in counties with overlap plans.

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County	Overlap counties
Arizona	659
Arkansas	327
California	286
Florida	161
HDC	143

Competitive conditions in overlap counties vary considerably. Counties with overlap plans are more likely than others to have more than one carrier (Figure 1), but this is not always the case. In nearly one in five counties with an overlap plan, the overlapping carrier has a monopoly. In another roughly 20 percent of counties with overlap, there are only overlapping carriers in the market. About one-third (35%) of the 1,858 counties with overlap plans have more than one. In some urban counties, there are more than two. Not surprisingly, Manhattan (New York County) has the largest number of overlapping carriers offering both individual and marketplace plans. MetroPlus, and United

Figure 1

Of the 2,740 parent/county instances of overlap on the individual market, more than half are from national carriers. Provider Sponsored Health Plans, such as Kaiser, offer 21 percent, and not-for-profit Blues plans offer 17 percent. But large national carriers lead the list of the parent companies with overlap plans in the counties.

It is easy to see why overlap plans are important to enrollees and policy makers, from a standpoint of continuity of care as well as affordability. Given the near certain presence of employees in certain segments of the labor force and Medicaid, it is likely that insurer interest in these segments will increase as well, and links to Medicaid may shape the pattern of future marketplace participation.

During their First Quarter earnings call (<https://www.fool.com/transcripts/2020/04/15/unitedhealth-group-inc-unh-q1-2020-earnings-call-t.aspx>), United Health Group responded to a question about marketplace entry, by saying that they will choose states based on "the efficiency of their networks, ability to expand, and desire to expand." Shortly thereafter, United filed to enter the individual markets in Michigan and Maryland where they do not currently participate in Medicaid. As can be seen in this interactive map, United has entered a dozen other states where United currently participates in Medicaid, but not the Medicaid marketplace. There are similar possibilities for Anthem and Centene. On the other hand, companies with Medicaid presence may find it hard to be competitive in the new ACA marketplace.

Over time, as both Medicaid and marketplace participation have grown, with increased marketplace participation of Medicaid and a prevalence of high-premium overlap, and an association between overlap and affordability at the county level. These trends suggest that Medicaid participation may facilitate entry and increase the ability to be competitive in the marketplace for both segments. As the market grows, their geographies are increasingly intertwined, and Medicaid marketplace participation may shape the contours of entry in an increasingly competitive individual market.

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Key Points

- For the first half of 2020, increased health spending due to the direct costs of diagnosing and treating COVID-19 appears to be more than offset by a reduction in non-COVID-19 health services. It's unknown how trends will continue through the rest of 2020.
- The COVID-19 pandemic has introduced significant uncertainty with respect to projecting 2021 claims levels.
- How COVID-19 will affect 2021 premiums depends on assumptions related to:
 - The emergence of subsequent COVID-19 waves in 2020 or in 2021,
 - Whether non-COVID-19 utilization continues to be deferred or eliminated in 2021 or whether treatment deferred in 2020 is provided in 2021,
 - The pandemic's economic effects on shifts in insurance coverage and risk pool composition, and
 - COVID-19 testing and treatment costs, the availability of new treatments and vaccines, increases in mental health and substance treatment needs, changes to telehealth utilization and costs, and changes to provider reimbursement rates.



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Drivers of 2021 Health Insurance Premium Changes: The Effects of COVID-19

JUNE 2020

The 2021 individual and small group health insurance premium rate filing process is underway. Actuaries develop proposed premiums based on their projections of medical claims and administrative costs for pools of individuals or groups with insurance. Projected medical claims reflect unit costs and utilization levels, as well as the mix and intensity of services, all of which can vary by geographic area and from one health plan to another. The composition of risk pools is also important, as medical claims will reflect the health status of individuals in the risk pool. Laws and regulations—such as benefit requirements, issue and rating rules, and risk-sharing programs—can affect the composition of risk pools and projected medical spending, as well as the amount of taxes, assessments, and fees that need to be included in premiums.

The COVID-19 pandemic has introduced new uncertainties into the development of premium rates for 2021. Each year, the American Academy of Actuaries Individual and Small Group Markets Committee publishes a public policy issue brief outlining the major factors driving premium changes for the next plan year. Unlike those previous issue briefs, this year's issue brief focuses primarily on the impact of COVID-19 on the 2021 premium rate filings.¹

The typical rating factors still apply, but issues surrounding the COVID-19 pandemic are a major consideration for rate setting and will impact both the individual and small group markets. To date, the effects of the pandemic have varied significantly by region, both in acuity and duration. While this issue brief broadly addresses COVID-19 considerations, we anticipate that the actual impact of these considerations on rate filings will reflect specific regional and market conditions.

¹ We refer readers to our [2020 premium drivers issue brief](#) for a fuller discussion of the premium drivers that are typically considered each year.

COVID-19 Impact on 2020 Claims Experience

The Affordable Care Act (ACA) rate review process typically requires issuers to develop premium rates based on the plan year of experience, which is two years prior to the pricing plan year, adjusted to reflect expected differences between the experience plan year and the pricing plan year. Thus, 2021 rate development will primarily be based on 2019 (pre-U.S. pandemic) experience with adjustments to project the experience forward to 2021. Issuers consider emerging experience from the current plan year while setting rates, so 2021 rate development would normally be informed by year-to-date 2020 plan experience. COVID-19 has introduced considerable uncertainty into that 2020 experience, and this uncertainty is extremely likely to continue into 2021.

COVID-19 is resulting in high-cost hospitalizations, and these costs have the potential to be material. Direct COVID-19-related health spending is highly dependent on the percentage of the population that is infected and the percentage of those individuals who are hospitalized. For instance, the USC-Brookings Schaeffer Initiative for Health Policy estimates that a COVID-19 infection rate of 5% could increase claims in the commercial insurance markets by about 1%; while a COVID-19 infection rate of 60% could increase commercial claims by 4% to 11%.² Cost-sharing for COVID-19 testing and related services is being waived pursuant to federal legislation.³ Some carriers are additionally waiving cost-sharing for COVID-19 treatments and/or certain telehealth services as well.

Direct spending for COVID-19 will be offset, at least in part, by reductions in other services. The pandemic has led to significant social distancing requirements, and utilization of many services such as office visits has declined dramatically. In addition, non-emergency hospital services, which include elective surgeries that typically generate significant revenues for providers, have also declined, due to social distancing, state restrictions on elective procedures, and a desire to free up space for COVID-19 patients. Emergency services have experienced a decline, possibly due to patient concerns around contracting the virus. Some practices have expanded availability of telehealth services in order to fill in some of the gaps in office visits. However, many services cannot be

² Matthew Fiedler and Zirui Song; “[Estimating Potential Spending on COVID-19 Care](#)”; USC-Brookings Schaeffer Initiative for Health Policy; May 7, 2020. The percentage increase in claims due to COVID-19 is relative to 2020 projected spending prior to the emergence of COVID-19.

³ Centers for Medicare and Medicaid Services; [FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42](#); April 11, 2020.

Members of the Individual and Small Group Markets Committee, which authored this issue brief, include Barbara Klever, MAAA, FSA—*Chairperson*; Joyce Bohl, MAAA, ASA—*Vice Chairperson*; Dylan Ascolese, MAAA, FSA; Eric Best, MAAA, FSA; Alfred Bingham, MAAA, FSA; Brent Bish, MAAA, FSA; Frederick Busch, MAAA, FSA; April Choi, MAAA, FSA; Andrea Christopherson, MAAA, FCA, FSA; Richard Diamond, MAAA, FSA; David Dillon, MAAA, FSA; Beth Fritchen, MAAA, FSA; Rebecca Gorodetsky, MAAA, ASA; Audrey Halvorson, MAAA, FSA; Casey Hammer, MAAA, FSA; David Hayes, MAAA, FSA; Kevin Hurley, MAAA, FSA; Shiraz Jetha, MAAA, FCIA, FSA; Jason Karcher, MAAA, FSA; Neil Kelsey, MAAA, FSA; Rachel Killian, MAAA, FSA; Kuanhui Lee, MAAA, ASA; Raymond Len, MAAA, FCA, FSA; Julia Lerche, MAAA, FSA; Timothy Luedtke, MAAA, FSA; Scott Mack, MAAA, ASA; Ryan Mueller, MAAA, FSA; Valerie Nelson, MAAA, FSA; Donna Novak, MAAA, ASA, FCA; Jason Nowakowski, MAAA, FSA; Bernard Rabinowitz, MAAA, FCIA, FIA, FSA; Paul Schultz, MAAA, FSA; David Shea, MAAA, FSA; Martha Stubbs, MAAA, ASA; Ari Szafranski, MAAA, FSA; Tammy Tomczyk, MAAA, FCA, FSA; David Tuomala, MAAA, FCA, FSA; Roderick Turner, MAAA, FSA; Dianna Welch, MAAA, FCA, FSA; and Thomas Wildsmith, MAAA, FSA.

provided through telemedicine, particularly those elective surgeries that help support hospitals' and physicians' financial stability.

Due to the widespread nature of social distancing requirements, there is evidence that the decrease in costs due to deferred and avoided services has occurred across the nation and is not limited to areas hard hit by COVID-19.⁴ However there is significant variation at the state and local level as to when and how medical providers may begin offering these services again and many providers may be subject to capacity restrictions. Additionally, it is unclear how many of the missed services will return and how many will be eliminated outright. While there are still many sources of uncertainty as to the long-term impact of COVID-19 on other medical care, it is clear at this point that these deferred and avoided services have reduced health care utilization in the first half of 2020. To date, it appears likely that the impact of deferred and avoided care has outweighed cost increases in the commercial market related to direct COVID-19 diagnosis and treatment costs, including cost-sharing waivers in most areas.

While medical care has been significantly affected in early 2020, prescription drug spending appears less likely to be significantly impacted, at least for now. Pharmacy spending could decrease if people are unable to afford their prescriptions due to loss of income and if patients continue to avoid going in for office visits. On the other hand, prescription drug spending could increase if there are new COVID-19 drug therapies and/or a vaccine becomes available.

It's unknown how trends will continue through the rest of 2020, but high rates of deferred and canceled care could continue, even as the availability of non-emergent care is increasing in many geographic areas. The arrival of another COVID-19 wave in the second half of the year could further increase care deferrals.⁵ Claims levels are likely to be impacted by the continued duration and severity of the COVID-19 pandemic, the degree of compliance with social distancing guidelines and any resulting deferred and avoided care, utilization levels of COVID-19 testing and related cost-sharing waivers, the duration of the coronavirus public health emergency, and other factors. To date, the prevalence of COVID-19 has varied dramatically by region, indicating that the costs of covering COVID-19 related claims may also vary by region. These same considerations may affect net impacts on 2021 expenditures as well.

⁴ Ateev Mehrotra, Michael Chernew, David Linetsky, Hilary Hatch, and David Cutler; "[The Impact of the COVID-19 Pandemic on Outpatient Visits: A Rebound Emerges](#)"; The Commonwealth Fund; May 19, 2020.

⁵ Hayley M. Rogers, Charlie Mills, and Matthew J. Kramer; "[Estimating the Impact of COVID-19 on Healthcare Costs in 2020: Key Factors of the Cost Trajectory](#)"; Milliman; April 2020.

Drivers of 2021 Rate Changes

When developing 2021 health insurance rates, insurers are likely to run multiple scenarios involving different assumptions on if any new COVID-19 waves will emerge later in 2020 or in 2021, the degree of deferred and avoided services, the amount of testing (including antibody testing), the cost and availability of vaccines, and other factors relevant to their enrolled population to inform their premium development.⁶ Greater degrees of uncertainty could lead to more conservative assumptions and risk margins for some insurers. In many states, health insurers are permitted to file updated rates on a quarterly basis in the small group market, which could reduce the need for conservatism. However, individual market rates are filed annually and cannot be updated during the calendar year.

Changes in Risk Pool Composition Due to Economic Impacts of COVID-19

Individual Market

The composition of the 2021 individual market is likely to be volatile and may see significantly different underlying experience than in 2019; there is likely to be some level of influx of individuals who lost employer-sponsored coverage due to the economic downturn resulting from the COVID-19 pandemic. While many individuals who lose income may qualify for Medicaid, some will not, particularly in states that have not expanded Medicaid. An increase in enrollment may be partially offset by individuals who leave the individual market, particularly non-subsidy-eligible individuals who leave the individual market due to unaffordability or subsidy-eligible individuals who become eligible for Medicaid.⁷

Even if the net enrollment change is small, the underlying morbidity level may change depending on the characteristics of those leaving and those entering the market. Individuals with employer coverage are generally thought to be healthier than people with coverage in the individual market. On the other hand, coverage transitions can result in adverse selection. For instance, when individuals lose coverage, they must decide whether to purchase coverage, and less-healthy people are generally thought to be more likely to purchase coverage than healthy individuals. During the Great Recession of 2008–2009, COBRA⁸ coverage was subsidized by the federal government. Although similar subsidies are being considered as part of current legislative efforts, as of this publication, such a provision has not been part of any of the coronavirus relief legislation passed into law. In the absence of significant COBRA subsidies that facilitate the ability of workers losing jobs to maintain their prior employer coverage, previous COBRA experience may be an appropriate proxy for the morbidity of members moving into the individual market.

⁶ The Health Actuarial Task Force of the National Association of Insurance Commissioners released a [template](#) to help rate reviewers evaluate COVID-19 pricing adjustments (retrieved June 4, 2020).

⁷ Health Management Associates; [COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, by State](#); April 3, 2020.

⁸ Consolidated Omnibus Budget Reconciliation Act.

However, the COVID-19 pandemic may have increased the perceived value of insurance, thereby reducing adverse selection among people moving from employer coverage to the individual market. In addition, healthy uninsured individuals could be more likely to obtain coverage.

Small Group Market

Small employers are less likely to offer coverage than large employers, and the economic downturn has the potential to accelerate this trend. During past recessions, some insurers have seen increased morbidity in insureds among employers that retain coverage, suggesting that employer plans that stayed in force had less-healthy members than those that lapsed. The ACA's single risk pool provisions create additional exposure to insurers beyond what was present during past recessions, particularly if small employers with healthier workers are more likely to drop coverage. Morbidity increases could also occur if less-healthy COBRA-eligible employees⁹ who suffer job losses are more likely to sign up for COBRA. This effect could be magnified with the extension of the COBRA election period as well as the extension of the window for timely premium payments during the national emergency period generated by COVID-19.¹⁰ As with the individual market, adverse selection in the small group market might be reduced due to the health-related nature of this particular crisis, with more value being placed on retaining health coverage, even if the small group market shrinks due to small employers going out of business.

COVID-19 Treatments and Testing Costs

Ongoing experience in 2020 on COVID-19 has provided insurers with some information on the cost of treatment of COVID-19. However, there is still significant uncertainty regarding COVID-19 treatment costs per case for 2021 due to the possibility of new treatment therapies, antibody tests, and/or vaccines, as well as the overall mix of case severity should the virus persist and doctors refine best practices.

The cost of testing is also uncertain and could be significant if insurers are required to cover the cost of testing for public health and occupational safety reasons, which goes beyond the diagnostic testing of an individual for diagnosis and treatment typically covered under health insurance. Reopening the economy requires more and more frequent COVID-19 testing. Employers may have to frequently test employees until a vaccine is available. At this time, it is unclear who will pay for these tests—health plans, employers as a business expense—or whether there will be federal funding. The coverage of testing for public health reasons rather than for the diagnosis and treatment of an individual may require government funding, otherwise it could add to insurance premiums.

⁹ COBRA requirements generally apply to employers with at least 20 employees.

¹⁰ On May 4, 2020, the Department of Labor put forth policies to extend COBRA timelines for the duration of the National Emergency Declaration declared by the president. See "[Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak](#)"; *Federal Register*; May 4, 2020.

Medical services deferred during 2020 could be delayed into 2021. However, the amount of services provided could be limited by capacity restraints, whether due to social distancing guidelines or facility-specific limitations. Many providers could seek to increase capacity by extending hours in order to accommodate more of the deferred services. This could even potentially result in minimal deferred service load in 2021 if providers can clear any service backlog in the second part of 2020. On the other hand, patients may be reluctant to seek care, especially if COVID-19 infections are ongoing and additional significant waves of infections occur, pushing more deferred care into 2021 or increasing outright care forgone.

There is evidence that some essential services are also being deferred.¹¹ This leads to the potential that individuals with chronic conditions could see a degradation of their health status, resulting in higher future costs on a per-member basis. In addition, many preventive services such as vaccinations and cancer screenings are being avoided, which could lead to increased future illness or condition severity.¹²

While telehealth services have been used to help fill in some of the service gaps in 2020, there is still uncertainty as to whether that increase will continue to replace certain office visits or whether treatment patterns will return to pre-COVID-19 levels. Prior to COVID-19, telemedicine services were typically reimbursed at a lower unit cost than similar in-office services. In some cases, providers are currently receiving the standard in-office payment rates, and changes to reimbursements may influence provider incentives relative to telemedicine. Additionally, telemedicine is not likely as comprehensive as an in-person visit for certain services, and as such could lead to increased utilization if it takes longer to identify and treat health conditions in this medium. There could also be increased utilization due to the convenience of telehealth compared to an office visit if providers begin to offer the option more broadly.

Mental health services may be more in demand. Stay-at-home orders have separated individuals from their normal support systems and social interactions. Economic factors, including the loss of some or all of household income, as well as increased child care and home schooling responsibilities, have put significant strain on household mental welfare. There are concerns that alcohol use has risen since the start of the pandemic,¹³ which could increase the need for substance use disorder services. In addition, health-related factors also contribute to patient stress. Beyond the increased general worry about health, patients that spend long periods of time on ventilators are showing signs of post-traumatic stress disorder (PTSD). These and other stressors have resulted in a

11 Liz Hamel, Audrey Kearney, Ashley Kirzinger, et al.; [KFF Health Tracking Poll-May 2020: Impact of Coronavirus on Personal Health, Economic and Food Security, and Medicaid](#); Henry J. Kaiser Family Foundation; May 27, 2020.

12 See for instance Jan Hoffman; "Vaccine Rates Drop Precipitously as Patients Avoid Doctor's Visits"; *New York Times*; April 23, 2020.

13 Caren Chesler; "As Pandemic and Stay-at-Home Orders Spread, So Does Alcohol Consumption"; *Washington Post*; April 2, 2020.

general increase in anxiety and depression,¹⁴ which will likely result in increased short- or long-term mental health service needs, much of which is reasonable to assume will continue into 2021.

Provider Reimbursement Rates

As they face financial difficulties during the COVID-19 outbreak, providers, especially hospitals, may have success negotiating (and renegotiating) higher payments from payers, depending in part on what federal relief they might have received. Some payment increases may be temporary in nature, thereby affecting 2021 costs only minimally. However, to the extent that there are changes in service utilization that impact the mix of services that providers rely on to achieve desired profitability targets, some services could see more permanent payment rate increases as providers seek to offset the lost revenue streams.

Increases in Medicaid enrollment are likely to result in providers who accept Medicaid seeing a greater proportion of Medicaid patients. These providers may attempt to make up for lower Medicaid payment rates by negotiating higher commercial payment rates.

Medical Loss Ratio (MLR) Impacts

To date, claims in 2020 have widely been reported to be significantly below priced levels. If claims over the full year continue to remain below expectations, premium rebates may be required under the MLR. The MLR calculation is done as a three-year average. 2018 and 2019 saw significant MLR rebates in the individual market, which could increase the potential for rebates if 2020 claims levels are lower than expected. Also, the MLR is one-sided: Carriers do not receive payments if claims come in significantly higher than 2020 expectations.

Issuers may consider projected MLR rebates when setting their 2021 rates, especially given the level of MLR rebates expected for 2019.¹⁵ This consideration could be given additional weight if the issuers anticipate owing rebates for 2020 given their expectations regarding the net impact of COVID-19. For instance, issuers could reduce the level of conservatism in rate filings to reduce the possibility of owing rebates for 2021. On the other hand, issuers may be less concerned about having rates that end up being too high, relying on the MLR to return any excess premiums to enrollees, particularly in markets where an issuer is able to maintain a competitive position without significant reduction to rates.

¹⁴ Hamel, *op cit*.

¹⁵ Rachel Fehr and Cynthia Cox; [Data Note: 2020 Medical Loss Ratio Rebates](#); Henry J Kaiser Family Foundation; April 17, 2020.

State Considerations

COVID-19 could additionally impact state ACA Section 1332 waivers. For instance, some states fund their reinsurance programs through insurer assessments, and these assessments fall primarily on group insurance. The economic downturn could result in declines in group market enrollment and an increase in individual market and Medicaid enrollment. This could lead to a decrease in reinsurance funding with the potential of an increase in reinsurance claims. For states that are allowed to retrospectively adjust the coinsurance or other reinsurance program parameters to either achieve a specified cost to the state (e.g., \$50 million) or else align the state's cost with the assessments collected, reinsurance payments would go down on a per-reinsured claims basis and carriers would therefore bear more risk than anticipated in rate filings. In states with reinsurance programs, issuers will need to consider whether and how program funding will affect 2021 reinsurance reimbursements and net 2021 claims.

States have issued varied guidance to meet the challenges of health care coverage brought on by COVID-19 in several areas, including restrictions on prior authorization, extended grace periods or non-cancellation periods, and implementing increased access to telehealth. Many of these public policies are temporary, but if any are anticipated to continue into 2021, issuers may likely consider the impact on rates.

Other Legislative Actions

In response to the COVID-19 pandemic, several federal relief measures were enacted to provide economic assistance to individuals, businesses, health care providers, and state and local governments. The measures contained some requirements for health insurers, such as waivers of cost-sharing for COVID-19 testing. At the time of this publication, additional legislation is being considered. Depending on what, if any, health insurance-related provisions are included, 2021 premiums may be affected.¹⁶

Other Premium Drivers

Changes in Federal Taxes and Fees

The Further Consolidated Appropriations Act, 2020,¹⁷ enacted in December 2019, included changes related to three federal tax provisions that may impact 2021 rates. Most prominently, the act repealed the Health Insurance Provider Fee (HIPF) for plan years beginning in 2021. Eliminating this fee could reduce premiums by 1% to 3%. Additionally, the act restored the Patient Centered Outcomes Research Trust Fund fee, which could increase premiums by a little less than \$3 per member per year, and removed the medical device excise tax, which should produce minimal downward pressure on claims.

¹⁶ See the Academy issue brief, [Health Insurance Risk Mitigation Mechanisms and COVID-19](#), for information on the implications of implementing mechanisms such as risk corridors and reinsurance to address COVID-19 related insurer risks.
¹⁷ <https://www.congress.gov/116/bills/hr/1865/BILLS-116hr1865enr.pdf>.

Risk Adjustment Data Validation (RADV)

In the final 2020 Health and Human Services Department (HHS) Notice of Benefit and Payment Parameters for 2020, the Centers for Medicare & Medicaid Services (CMS) significantly extended the timeline for RADV payment transfers, with the initial round of payments based on the 2017 benefit year RADV to be made in 2021.¹⁸ In the final 2020 Unified Rate Review Template Instructions, CMS indicated that states may elect to allow issuers to reflect RADV transfers in their 2021 premium rates because amounts will be reflected in 2021 calendar year experience for MLR filings. This could result in additional rate volatility for states and issuers with material RADV transfer amounts as a result of 2017 benefit year RADV transfers.

Summary

Rate setting in the ACA-compliant individual and small group markets is complex, and pricing actuaries are considering a wide range of factors when determining rate levels. This year, the COVID-19 pandemic has introduced significant additional uncertainty related to 2020 and 2021 claims levels and needed 2021 premium rates.

For the first half of 2020, increased health spending due to the direct costs of diagnosing and treating COVID-19 appears to have been more than offset by a reduction in non-COVID-19 health services. It's unknown how trends will continue through the rest of 2020. When developing 2021 health insurance rates, insurers are likely to project claims under multiple scenarios involving different assumptions on if any new COVID-19 waves will emerge later in 2020 or in 2021. The economic impacts of COVID-19 could cause shifts in insurance enrollment along with changes in the risk pool composition related to these shifts. COVID-19 testing and treatment costs, the availability of new treatments and vaccines, increases in mental health and substance abuse treatment needs, changes to telehealth utilization and costs, as well as any changes to provider reimbursement rates also will be considered. In addition, the timing of any subsequent COVID-19 waves will affect whether non-COVID-19 utilization continues to be deferred or forgone in 2021 or whether treatment deferred in 2020 is provided in 2021. While new information continues to emerge regarding the epidemiological, economic, and health care impacts of this pandemic, there is still a wide range of potential effects.

¹⁸ See the Academy's [comments on changes to RADV timing in the final 2020 NBPP and related documents](#) for more information about the potential impacts of this change.

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Cutting through the Jargon

Health Care Reform Design Issues and Trade-Offs Facing Us Today

Linda J. Blumberg

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The intersection of the presidential election and the COVID-19 pandemic is likely to make health care reform a frequent subject of conversation in the coming months. Yet for many voters, the proposals and their implications for typical years remain hard to decipher, let alone for years potentially plagued by economic and health crises. Candidates and others describe their plans using such terms as *universal coverage*, *single payer*, *Medicare for All*, *public option*, *market-based reforms*, and *protections for preexisting conditions*. But watching debates, listening to news reports, or attending public forums (virtually or otherwise) can leave people confused about what each plan includes and uncertain about the differences between them. Here, I describe the central issues at the heart of current health care reform proposals, with a focus on understanding that each proposal requires society to make difficult choices and appreciating the trade-offs of each choice. The crux of the debate will always be over defining the goals we want to achieve and deciding who should bear the costs of achieving those goals.

Our current system of paying for health care needs (coverage) is complex, with people holding various forms of insurance coverage: Medicare, Medicaid, the Children's Health Insurance Program (CHIP), employer-sponsored health insurance, insurance purchased by individuals outside of employment (i.e., nongroup, individual, or directly purchased insurance),¹ and other public programs through the US Department of Defense. Other people remain uninsured. Each type of coverage has its own financing system and eligibility rules, all relying on different combinations of public and private funds. Despite expanding coverage for millions of people and improving affordability for many more since 2014, the current system's shortcomings continue to keep health care reform front and center in the political arena. The pandemic only exacerbates those shortcomings. A substantial number of people remain uninsured (with more becoming uninsured during economic crises), health care costs tend to increase faster than incomes, and many people still incur large financial burdens to access coverage.

And the broad patchwork of people's current insurance situations means that any reform will affect different people differently.

Evaluating the trade-offs inherent in the answers to each of the five core questions below is critical to understanding the philosophical underpinnings and general implications of health reform proposals.

1. How broadly should the costs of the sick be shared with the healthy?
2. How important is reaching true universal coverage? How many US residents must be insured?
3. How generous should federally financed subsidies of premiums and cost sharing be?
4. How should reform options be financed?
5. Should there be regulations limiting the prices paid to health care providers of different types (i.e., hospitals, physicians, prescription drug manufacturers, medical device manufacturers), and if so, how broadly should those regulations apply, and how should prices be set?

Below, I address the significance of each of these questions and the trade-offs inherent in different answers.

Exploring the Five Core Questions Necessary to Evaluate the Trade-Offs Inherent in a Health Reform Proposal

Question 1. How Broadly Should the Costs of the Sick Be Shared with the Healthy?

How health care risk is shared speaks to who will pay how much of a population's health care bills. How much should the person receiving the actual care pay, and how much should be shared with others? Should shared costs stay within groups of similarly situated people (e.g., people with high health care needs should share with other people who have serious health problems, and healthy people should share with other healthy people), or should costs be spread more broadly across diverse groups (e.g., currently healthy people sharing in the costs of those who are currently sick)?

Current health insurance arrangements spread health care costs and risk in different ways.² More risk sharing tends to lower the costs associated with obtaining medical care for people with health service needs but tends to increase the costs for people who are healthy. Conversely, separating the risks (e.g., charging the healthy and the sick different premiums, limiting benefits, or blocking some people from getting coverage) tends to increase the costs for people in worse health status and often impedes their access to care while reducing costs for the healthy.

All insurance policies spread risk to some degree but vary in how much is shared. "**Market-based**" approaches generally lie at one end of the spectrum with the least amount of risk sharing. They provide the greatest separation of risk (e.g., healthy young people are grouped with other healthy young people, creating a pool where the risk of insurer payout is low and requires lower premiums). The private

insurance industry extensively used tools to separate risks before 2014, but these tools were limited or prohibited in regulated markets under the Affordable Care Act (ACA). Market-based approaches often advocate reinstating such segmentation policies (as would occur if the ACA was repealed) or otherwise reducing how broadly risk is shared. Proposals include the following:

- **Introducing plans with higher out-of-pocket cost (lower actuarial value³) into the individual and small employer group⁴ markets (i.e., “copper” plans).⁵** These plans place more health care expenses on people using medical services because the insurer pays out a smaller share of expenses.
- **Promoting the use of health savings accounts⁶ by eliminating or lifting limits on them.** These accounts provide financial benefits for high-income enrollees to transfer more resources out of the insurance pool and into tax-preferred individual accounts.
- **Allowing unrestricted sales of insurance across state lines,** which would permit healthy people in states with more regulations to purchase insurance in less regulated states, allowing the healthy to avoid sharing in the costs of the sick in their own state.
- **Eliminating many insurance market regulations** (i.e., guaranteed issue,⁷ modified community rating,⁸ benefit and actuarial value standards,⁹ and preexisting condition exclusion prohibitions) for some or all insurance products, leaving many people with considerable health care needs to rely on high-risk pools, which have historically been underfunded and provided more limited coverage at higher prices than standard coverage.¹⁰
- **Lowering premiums for young adults and raising them for older adults,** by broadening age-rating bands or modifying the premium tax credit schedule. This makes it harder for older adults (who incur a disproportionate share of health problems) to afford coverage.

At the other end of the policy spectrum (i.e., maximization of risk sharing) lies **single-payer or Medicare for All approaches**. Medicare for All is essentially a brand name for particular single-payer proposals.¹¹ These approaches require the full population to have identical coverage through the same government plan and to share in the costs of providing the specified levels of care to that population, regardless of health status or health care risk. The prominent Medicare for All bills include broad benefits, require no (or extremely limited) out-of-pocket costs, and do not charge premiums. Costs of care are fully financed through the tax system. In this way, single payer creates one national risk pool for the entire population, with household costs varying according to the tax rules chosen but not by medical need or actual use of services.

Other policies fall in between these extremes, increasing current risk sharing but not spreading costs as broadly as single-payer approaches. Examples include

- reversing the current administration’s policy changes, which have decreased enrollment in Marketplace and Medicaid coverage (Trump administration executive actions include expanded access to short-term limited-duration plans, elimination of outreach funding, cuts in enrollment assistance, and shortening of the annual enrollment period);

- increasing subsidies to lower cost sharing faced by consumers;
- providing additional federal funding to lower household contributions for insurance premiums as a share of income and enhancing low-income cost-sharing subsidies;
- using additional federal funding to fill in the Medicaid “gap” for poor adults living in states that have refused to expand Medicaid eligibility under the ACA;¹²
- expanding minimum benefit standards (e.g., adult dental, vision, and hearing); and
- requiring people to enroll in a defined minimum level of insurance coverage (actual insurance enrollment could be required, or, alternatively, people could be assessed a penalty for not enrolling).

Increasing the number of people with insurance coverage, a goal that can be accomplished through one of several strategies (some noted above), usually will increase the sharing of health care costs. But, more directly, how much health care costs are shared depends on how much people of different health statuses share in the population’s total health care costs. For example, many people enrolled in an insurance plan that covers few benefits or requires lots of out-of-pocket spending when accessing care does not spread health care risk much. Large numbers of people contributing to a comprehensive insurance plan does. Large numbers of enrollees with low health care risk in their own separate insurance plan do not spread costs broadly, while large numbers of people of diverse health care risk do.

SUMMARY OF THE TRADE-OFFS INHERENT IN MORE SHARING VERSUS LESS SHARING OF HEALTH CARE RISK

Lower premiums for healthy people at a given point can be achieved with more benefit limits or exclusions, higher cost-sharing requirements, and a reversal of various consumer protections, such as guaranteed issue, community rating, and prohibitions on preexisting condition exclusions. All these strategies reduce risk sharing across the population. The resulting trade-off is that people seeking health care services, especially those with significant health care needs, face higher costs and reduced access to care. And although people save money while they are healthy, they could face higher costs and reduced access to care when they need health care services in the future. Conversely, as covered benefits increase, cost-sharing requirements fall, regulatory reforms are strengthened, and risk sharing increases, premiums for the currently healthy and the need for injections of government dollars to keep coverage affordable will increase as well. Affordability for the sick and access to necessary care increase as risk sharing increases.

Question 2. How Important Is Reaching True Universal Coverage?

Strong evidence shows that, regardless of how generously insurance coverage is subsidized, some people will not voluntarily enroll. We see this in the Medicaid program, the state-administered insurance program for low-income people for whom premiums and cost-sharing requirements are zero or near zero. Participation rates among eligible people vary by state and between children, parents, and nonparents, but they average 89 percent for parents and 96 percent for children (Haley et al. 2018) and

tend to be lowest for nonparents. Financial assistance through the ACA Marketplaces has improved insurance affordability markedly for many people, yet enrollment rates among people eligible for premium tax credits range from 74 percent among people with incomes below 200 percent of the federal poverty level (FPL) to 48 percent among people with incomes between 200 and 400 percent of the FPL.¹³ Some people do not believe they need insurance coverage, some object to insurance on religious grounds, some do not use traditional medical care, some feel coverage remains unaffordable or the “hassle factor” of enrolling is too high, some remain unaware that they can access coverage, and others simply prefer not to contribute to the cost of their own care or that of others.

Therefore, **to reach true universal coverage** (i.e., an entire specified population insured with no exceptions), people must be required to participate, and **there must be some enforcement mechanism** for those who would otherwise choose not to. This compelled participation will mean a financial contribution for some, either through premiums or increased taxes.¹⁴ For others who have very low incomes and may not be asked to contribute financially but who still resist participation, this may mean some type of autoenrollment mechanism that evades their objections. This is true for single-payer programs or other approaches designed to achieve universal coverage. Requiring participation among the unwilling creates a political challenge. Yet, an automatic transfer of coverage -- for example, from employer-based insurance to publicly subsidized insurance during the 2020 economic crisis -- can prevent workers who lose their jobs from becoming uninsured.

If we accept that some people will remain uninsured, we must assess the acceptable number of uninsured people. Absent the pandemic, we estimate that repealing the ACA in its entirety would increase the number of uninsured by 19.9 million, leaving 50.3 million people nationwide uninsured (more than 15 percent of the US population) (Banthin et al. 2019). Policymakers advocating repeal implicitly find this level of uninsurance acceptable. For policymakers designing policies to increase coverage, is a 2 to 5 percent uninsurance rate still too high? Should a program cover undocumented immigrants, or is covering all legal residents sufficient? Are acceptable coverage rates during a public health crisis different from those during more typical periods?

SUMMARY OF THE TRADE-OFFS INHERENT IN EXPANDING COVERAGE VERSUS ACHIEVING TRUE UNIVERSAL COVERAGE

Providing additional financial assistance and improving cost-containment can increase voluntary enrollment by making insurance coverage more affordable, but voluntary measures alone will not lead to universal coverage. The trade-offs become political backlash associated with compelling full participation and requiring households to contribute to the costs either through premiums (e.g., some hybrid public-private approaches) or taxes (e.g., single payer) versus leaving some people uninsured, along with the resulting uncompensated care and unmet medical need. Effective auto-enrollment systems, while admittedly challenging to design, would reduce uninsurance resulting from lack of information and administrative barriers, allowing for coverage consistency during crises and typical times.

Question 3. How Generous Should Federally Financed Subsidies of Premiums and Cost Sharing Be?

Not everyone can equally afford premiums. If coverage and affordability are a priority, the federal government, through tax dollars, can subsidize or contribute to premiums for at least some people, with subsidization of coverage for low-income people particularly critical. The government can also subsidize out-of-pocket costs. Doing so requires the government to set some standards as to what type of coverage to subsidize. Four main parameters determine the generosity of health insurance premium and cost-sharing subsidies: the number and characteristics of people eligible for them, the amount people are expected to contribute themselves in the form of premiums, the benefits covered, and the level of cost-sharing requirements.

The larger **the eligible population** and the greater the inclusiveness for people with high health care needs, the larger the government subsidy bill will be because the costs the insurer pays out will be higher. Excluding more people from eligibility for assistance will reduce government costs but can create unfairness. For example, subsidizing people below an arbitrary income cutoff (current law terminates premium tax credits at 400 percent of the FPL) can leave people with slightly higher incomes facing much higher costs, making them less likely to enroll in coverage. Extending tax credits above 400 percent of the FPL could eliminate the inequitable subsidy “cliff” but would require additional government funding.¹⁵ The larger **the share of premiums and out-of-pocket costs a government subsidy covers** and the extent to which the assistance offered is income-related also has substantial implications for costs and household affordability. If subsidy levels are higher, more people will enroll under a voluntary system and there will be less unmet medical need and demand for uncompensated care.¹⁶ At the same time, greater government subsidization increases public costs and the need for revenue sources. Relatedly, a given amount of government funding can either be concentrated on low- or middle-income people or be spread among people of all incomes. The former approach has a larger effect on affordability and likelihood of voluntary enrollment, but political support for reform may broaden among high-income voters if they too can expect to receive assistance.

As with premiums, **out-of-pocket health care costs** (e.g., deductibles, coinsurance, copayments, and out-of-pocket maximums) can be subsidized at different levels. The lower the household contributions required when using services, the more affordable the access to care, with the greatest implications for people with substantial health problems and people with low incomes who may not be able to cover even modest cost-sharing requirements. But the lower the cost-sharing requirements, the higher the government subsidy costs because people will use more care and the government will cover a higher share of the bills.

A broader **set of covered benefits in subsidized plans** increases access to care for people needing the covered services but also increases government costs and premiums for people ineligible for subsidies. Of course, premiums would be less expensive if plans excluded prescription drug coverage, maternity care, and mental health care (like many policies did before 2014), but then affordability, and thus access to those services, would be compromised for the people who need them. Expanding benefits beyond those that are typical today will increase use of those services, increasing costs and premiums.

SUMMARY OF THE TRADE-OFFS INHERENT IN MORE GENEROUS VERSUS LESS GENEROUS SUBSIDIZATION OF HEALTH INSURANCE AND OUT-OF-POCKET COSTS

More generous subsidies, resulting from subsidizing more people, lowering the amount households are expected to contribute to premiums or out-of-pocket costs, increasing the benefits covered in subsidized programs, or some combination of those actions will increase the government's costs of subsidizing insurance while improving affordable access to medical care. Reducing the comprehensiveness of coverage being subsidized or increasing the share of premiums some enrollees pay (e.g., older enrollees) would have the opposite effect. Improved generosity is likely to most favor people with modest incomes and people with substantial health care needs. Reducing generosity is most likely to disadvantage those same groups. Excluding particular benefits from subsidized coverage is likely to deny access to that type of care for people who need it, particularly if those benefits carry a high price.

Question 4. How Should Reform Options Be Financed?

Most policymakers agree that if health insurance and necessary medical care is going to be accessible to everyone, at a minimum, premiums and cost-sharing requirements must be income-related, with after-subsidy premiums and out-of-pocket costs increasing as income rises. In other words, a household's health care costs should reflect the household's ability to pay, given its income. This is part of the design of the ACA and related reforms that would build upon it. It was also part of the design of many of the 2017 market-oriented repeal-and-replace bills Congress considered, albeit with lower subsidy levels. Income-related assistance requires a combination of government and private financing. Single-payer bills do not generally include premiums. All the costs associated with such programs would be raised through the tax system and would provide people of all incomes identical benefits. They require more taxes to fully finance them.

Premium contributions are familiar to many people, particularly those who have or have had private insurance coverage. Premiums support the notion that everyone should contribute to the insurance system, perhaps with the exception of people with the lowest incomes. Premiums lower the amount of program funding that needs to be financed with taxes, but they require households (and sometimes employers) to make tangible payments to be enrolled in and maintain insurance coverage. Premium payments can be fixed, as is the case in some systems in other countries, or they can increase with income as they do in the US Marketplaces. For people who have means but do not pay premiums, the premiums must be collected in a different way (e.g., through the tax system¹⁷), or some people will remain uninsured. It is not credible, however, to rely solely on premiums to finance a reform, if coverage is to be made affordable for people with low and modest incomes.

To provide the necessary financial support to make coverage affordable for financially vulnerable people, taxes will have to be raised. Taxes can be politically unpopular, so using premiums to reduce the amount of additional taxes required to finance a reform may increase support. Premiums also appeal to people who value personal responsibility in health insurance.

Tax financing requires identifying taxation options and determining how the revenue will be raised across the revenue options. Possible revenue sources include income taxes, payroll taxes, sales taxes, value-added taxes, and corporate taxes. Depending on the amount of additional tax revenue needed, one or several new revenue sources might be used. Each revenue source has implications for how people of different incomes and circumstances will be affected.

Theoretically, carefully designed tax financing provides an avenue for explicitly allocating the costs of health reforms across people and entities by income and other characteristics. But challenges remain in ensuring these costs are borne as intended. For example, raising shares of needed revenue from high-income people reduces financial burdens on people with modest incomes. But depending on how the taxes are assessed and how big they are, they could change investment and other behavior if people who are assessed attempt to avoid them and identify mechanisms for doing so. Taxes also may be perceived as unfairly concentrating the financial burdens in a small share of the population, potentially hampering long-term political sustainability of reforms.

In another example, taxing employers who do not provide health insurance to their workers may be considered fair because many employers already contribute to the health insurance costs of their workers while others do not. But workers without offers of employer coverage generally are low-paid and low-income employees, and their employers, if taxed, are likely to reduce their workers' wages to offset the new taxes. Thus, this approach has the potential to place a significant new financing burden on some low- and middle-income workers.

Using a mix of revenue sources may add to the complexity of financing systems but would likely spread the costs of reforms more broadly across a population, lowering the perception that any group is carrying a disproportionate share of the financing weight.

SUMMARY OF THE TRADE-OFFS INHERENT IN FINANCING HEALTH INSURANCE REFORMS

Premium financing spreads the costs of insurance coverage broadly across enrollees, implicitly conveying a message of personal responsibility in financing one's care and reducing the need for politically unpopular tax increases. But premiums alone cannot develop systems that provide adequate and affordable coverage to low- and middle-income people. Using highly progressive taxes to finance reforms reduces health care cost burdens on financially vulnerable people and places the burdens much more heavily on people with the greatest ability to pay. But concentrating the financing burdens for a reform that carries substantial government costs on a small segment of the population may lead to tax avoidance and perceptions of unfairness that could impede the reform's long-term sustainability. Using a mix of financing mechanisms increases complexity but spreads the costs of a program more broadly across the population than would relying solely on taxes directed at the wealthy.

Question 5. Should there be regulations limiting the prices paid to health care providers of different types

Current law regulates the provider (e.g., hospitals, physicians, other medical professionals, prescription drug manufacturers, and device manufacturers) prices paid in certain public programs, including

Medicare and Medicaid. Physicians and hospitals are also paid under government programs for veterans and active-duty military personnel and their family members. **Provider payment rates** (the prices paid to those delivering health care services or products) under these programs tend to be significantly lower than those paid by typical commercial insurers. Supporters of market-based approaches generally do not support expanding the number of people enrolled in markets that regulate provider prices, and they generally do not support lowering prices in current programs by government dictate.

Yet **unregulated health care markets** are seldom competitive in the economic sense. Lack of competition results from barriers to entry in provider and insurance markets,¹⁸ information asymmetries,¹⁹ differences in services provided across providers,²⁰ and positive externalities of medical care.²¹ Because of these combined factors, unregulated health care markets lead to market distortions, not efficiency. In many circumstances, left unregulated, prices are higher than would be the case in competitive conditions.

Those interested in reducing total health care spending increasingly recognize that **provider price regulation** (i.e., setting or capping the prices that public and private insurers pay to hospitals, physicians, and prescription drug manufacturers) is the most promising policy option. Provider groups tend to disagree with this approach, however, arguing that it would decrease the quality of care and supply of providers and that it could decrease investments in research and development for new prescription drugs and treatments.²² Without price regulation, and as the costs of care and insurance premiums have increased, advocates of market-based solutions tend to rely on higher levels of household cost-sharing requirements (e.g., higher deductibles, coinsurance, or copayments and reductions in covered benefits). As household out-of-pocket costs increase, use of care tends to decrease. Lower use of care and reductions in the share of expenses an insurance policy covers yield lower premiums. Although this approach can lower spending by insurers, it places higher costs directly on people needing care and increases unmet medical need among people who cannot afford to pay those higher costs. Consequently, it does not necessarily lower total health spending, or, if it does, it can reduce it in a way that harms health. For people who believe that provider price regulation is warranted, at least in some circumstances, design issues remain.

A public option, capped provider payment rates, and a single-payer program are points on a continuum regarding how many people should have access to price-regulated plans. A **public option** provides a government-designed and government-administered insurance plan as an option in one or more insurance markets (e.g., in the nongroup insurance market alone or perhaps also as an option for employers offering coverage to their workers). Such a plan would pay health care providers according to a specified price schedule set at levels below those commercial insurers typically pay. **Capping provider payment rates** limits the prices providers can charge to *any* insurer in a particular market, so this approach could lower premiums for more people.²³ A **single-payer plan** (also known as Medicare for All) would apply regulated prices to an entire population through a single government insurance plan, with no option for consumers to choose a plan that pays providers at higher rates.

The lower the provider prices are set, the greater the reduction in health care costs, but the lower is the income of health care providers. We do not know what level of pricing would best balance cost

containment, access to care, and quality of care. Ideal prices across providers and geographic areas may differ (e.g., rural versus urban areas). Plus, the more people to whom the regulated prices apply, the higher the prices may need to be to reduce access and quality concerns.

In addition, the greater the desired reduction in prices paid to providers and the more consumers to whom the regulated prices apply, the longer the time likely required to move from current to target prices while avoiding significant disruptions to the delivery of care.

The COVID-19 pandemic has led to substantially reduced revenue and layoffs in many US hospitals. The financial pressures on hospitals and independent physician practices created by the crisis likely make it more difficult to engage policymakers in a near-term discussion of limiting provider prices. However, the public health crisis does not negate the long-term concerns with overall system costs and pricing at inefficient levels. Effective short-term policy strategies to help providers weather unusual circumstances, such as the pandemic, can and should be separated from policy initiatives geared toward efforts to move the broader health care system in the direction of efficient pricing and lower overall costs for the longer term.

SUMMARY OF THE TRADE-OFFS INHERENT IN GREATER VERSUS LESS REGULATION OF PROVIDER PRICES

Public options, capped payment rate reforms, and single-payer approaches can lower the prices paid for the health care delivered to at least some people. As more households enroll in insurance plans using regulated prices, prices are set lower, prices increase more slowly over time, and overall health system spending is likely to be lower. But large price reductions, applied to large swaths of people, particularly if implemented quickly, could significantly disrupt the delivery of medical care. Implementing changes more slowly would allow hospitals and other providers time to lower their underlying costs and for governments to implement systems to measure changes in access and quality as prices decrease. But moving slower means system-wide savings also would be lower, at least over an extended period.

Answers to These Five Central Questions Frame Policy Proposals

Each fully developed health reform proposal explicitly or implicitly responds to the five central questions delineated above, and the choices made relay the philosophical values and objectives of those who designed the proposal. Open and honest discussion of a policy approach's intent and implications should begin by identifying the answers to these questions.

To illustrate how this five-decision framework clarifies the reforms most frequently discussed, I use three policy examples:

- Full repeal of the ACA
- Build upon the ACA with additional financial assistance and a public option

- Replace the current system with an enhanced single-payer program

Full Repeal of the ACA

This policy has been the one most consistently supported by the Trump administration and most Republican members of Congress. The policy began as a legislative effort and is being advocated via the *Texas v. US* litigation, which the Supreme Court will hear in fall 2020.

1. **How broadly should the health care costs of the sick be shared with the healthy?** The ACA significantly increased the sharing of health care risk, particularly through reforms to the nongroup and small-group insurance markets and the expansion of public program eligibility in Medicaid. Repealing or overturning the ACA would reverse these changes, returning the system to a situation of greater separation of health care costs between people who are healthy and those projected to need significant medical care. ACA repeal would increase costs for people with current or past health problems and lower them for people who are very healthy.
2. **How important is reaching true universal coverage?** This approach would reverse the recent gains made toward universal coverage. Prior to the pandemic, we estimated that an additional 19.9 million people would be uninsured, a 65 percent increase compared with current law (Banthin et al. 2019). Given the largest job losses in generations and the consequent loss of employer-based insurance for millions of people due to the pandemic, overturning the ACA now would lead to even larger numbers of uninsured people.
3. **How generous should federally financed subsidies of premiums and cost sharing be?** Full ACA repeal would significantly reduce federal investment in health care, eliminating the subsidization of private nongroup insurance through the Marketplaces, rolling back Medicaid eligibility to pre-2014 levels,²⁴ and reintroducing the Medicare prescription drug “doughnut hole” for seniors.²⁵ Thus, the approach indicates that the current levels of subsidization are too high and should be reduced. Prior to the pandemic, my colleagues and I estimated that full ACA repeal would have reduced federal spending on health care by \$134.7 billion in 2019, a 35 percent decrease compared with current law spending on Medicaid/CHIP acute care for the nonelderly and Marketplace subsidies (Banthin et al. 2019). As job losses ballooned due to the pandemic, reliance on the ACA’s Medicaid expansion and subsidized marketplace coverage has grown. Thus, the drop in federal spending on health care would be even larger than those estimates indicated should the law be overturned.
4. **How should the reform option be financed?** Because this approach would reduce both federal and state government spending on health care, no new financing mechanisms are required.
5. **Should there be regulation of the prices paid to health care providers?** With fewer people enrolled in Medicaid under ACA repeal, a smaller share of people would be enrolled in insurance coverage where government regulates the prices paid to providers. Implicitly, then, this approach would reduce the reach of health care provider price regulation. In addition, if the ACA is overturned, monopoly and duopoly nongroup insurer pricing and market power may

once again become the norm in areas where the law increased market competition and lowered premiums.

Build upon the ACA with Additional Financial Assistance and a Public Option

Joe Biden, the presumptive Democratic presidential nominee as well as other Democratic presidential candidates have presented such policies, and my colleagues and I have included a similar construct in our recent quantitative analysis of a spectrum of health reform proposals (Blumberg, Holahan, Buettgens, Gangopadhyaya, et al. 2019). This type of proposal would increase premium and cost-sharing subsidies for people currently eligible and extend them to additional people currently ineligible. It would fill in the Medicaid eligibility gap, allow workers with employer offers to opt into the Marketplaces and access subsidies if they prefer that to their employer's plan, and provide a public option in the nongroup market that pays providers at prices roughly equivalent to those paid by Medicare. In addition, the approach we modeled as reform 5 in the cited analysis would use an autoenrollment backup to enroll anyone not voluntarily enrolling in coverage into either Medicaid or the public option, collecting any income-related premiums as appropriate through the tax system.²⁶ Notably, such a policy would ensure that those losing their employer-based insurance due to a crisis like the current one would not experience a gap in insurance coverage.

1. **How broadly should the health care costs of the sick be shared with the healthy?** By increasing government subsidies for private insurance coverage, lowering cost-sharing requirements for people in the nongroup insurance market, and increasing Medicaid enrollment, this approach would share the health care costs of the sick more broadly than is the case under current law.²⁷ Not all health care risk would be combined into one insurance pool, because some people remain in employer-based coverage and some care is paid for specifically by those who use medical services, but a larger share of care would be collectively financed compared with today. These reforms would lower costs for people when they are having health problems and increase them when they are healthy.
2. **How important is reaching true universal coverage?** The approach we modeled is designed to ensure coverage for all legally present US residents. Approximately 6.6 million undocumented immigrants would remain uninsured (another 4.2 million undocumented residents are estimated to have private coverage), leaving 2 percent of US residents uninsured (all of them undocumented residents).
3. **How generous should federally financed subsidies of premiums and cost sharing be?** This approach increases the generosity of subsidies offered to consumers buying coverage in the nongroup Marketplaces. It would lower out-of-pocket costs and premiums for people already eligible for premium tax credits and would extend them to more people.²⁸ Very low-income people would pay no premium and face very low out-of-pocket costs. Premiums would increase on a sliding scale with income, but no one need pay premiums of more than 8.5 percent of their income.

4. **How should the reform option be financed?** Prior to the pandemic, we estimated that this reform would increase federal government spending by \$122.1 billion in 2020 or \$1.5 trillion between 2020 and 2029, if fully implemented and phased in in 2020. At this time, a particular financing mechanism for the approach has not been proposed. With larger Medicaid and subsidized Marketplace enrollment due to pandemic-related job losses, federal costs prior to economic recovery would be higher than those estimated previously.
5. **Should there be regulation of the prices paid to health care providers?** This reform option's Marketplace includes a public option, a plan with provider payment rates set at approximately the levels used by the current Medicare program. Other private insurers offering nongroup coverage would have the rates they pay providers capped at the same levels. Under this reform, my colleagues and I estimated an additional 30.8 million nongroup insurance enrollees compared with current law, increasing the total to 46.2 million people (Blumberg, Holahan, Buettgens, Gangopadhyaya, et al. 2019). These people, representing 14 percent of the US population, would be enrolled in plans using regulated rates for the first time. These estimates correspond with the pre-pandemic reality; with larger Medicaid and public option enrollment during a crisis, a larger share of the US population would be enrolled in plans using regulated rates than these estimates indicate, at least until the rate of employer-based insurance rebounds.

Replace the Current System with an Enhanced Single-Payer Program

Some legislative proposals would, if enacted, replace the current private-public hybrid insurance system with a purely public system enrolling the entire population in a government-organized and government-administered plan.²⁹ Some Democratic presidential candidates support this type of reform. These approaches, often referred to as Medicare for All, include benefits beyond those in typical private plans, eliminate household out-of-pocket costs and premiums, and would be financed entirely with government revenues. Private insurance plans would be prohibited. In the same work mentioned above, Urban Institute researchers estimated the cost and coverage implications of one such approach: enhanced single payer, which is reform 8 in Blumberg, Holahan, Buettgens, Gangopadhyaya, et al. (2019).

1. **How broadly should the health care costs of the sick be shared with the healthy?** A single-payer program like this one spreads the health care costs for all residents as broadly as possible. Virtually all health care costs are shared across all taxpayers, with the users of medical services contributing no more to financing than those who do not. It would increase the sharing of health care risk substantially beyond current law, essentially eliminating all premiums, out-of-pocket costs, and benefit limits. By removing financial barriers to accessing care, sudden changes in household income, such as job loss due to a pandemic, would not reduce access to care.
2. **How important is reaching true universal coverage?** This approach is designed to eliminate uninsurance in the US. It would include coverage for all US residents, regardless of legal

residency status. Since the coverage is completely unrelated to employment status, no changes or gaps in coverage would result due to crises like the current one.

3. **How generous should federally financed subsidies of premiums and cost sharing be?** With no premiums or cost sharing, this approach is essentially as generous a design as is possible to construct. The intent is that there be no financial barriers to accessing coverage when people need services.
4. **How should the reform option be financed?** We estimate that this reform would increase federal government spending by \$2.8 trillion in 2020 or \$34.0 trillion between 2020 and 2029, if fully implemented and phased in in 2020, a federal budget increase of more than 70 percent.³⁰ Senator Elizabeth Warren has proposed an array of revenue sources to finance this type of reform,³¹ and one of the single-payer bills active in Congress includes a list of potential funding sources, although it has not designated specific ones or a particular structure for covering the full estimated government costs.
5. **Should there be regulation of the prices paid to health care providers?** Every US resident would be in the same insurance plan under this approach, and all providers would be paid according to a regulated schedule of federally determined prices. In our estimates, we assume these would be at approximately Medicare levels.³² As a result, the number of services for which prices would be regulated by the federal government would increase dramatically.

Conclusion

Advocates of various health care reform proposals are quick to extoll the virtues of their preferred reforms. But advocates should acknowledge the trade-offs inherent in their respective approaches. An educated consumer of public policy ideas should be aware that there is no perfect solution. All reforms will yield advantages and disadvantages, gains and losses. The challenge is finding a policy that represents a broadly accepted set of trade-offs. Any one person's preferred trade-offs will hinge on their individual values and preferences. This brief is designed to help people understand the inherent consequences of different options so readers can make more informed choices about the types of reforms they support.

The five questions delineated here, when explored honestly and thoroughly, will expose the central trade-offs inherent in any specified reform proposal. Developing policy approaches that fit the needs of a critical mass of the American people and can engender sufficient support for sustained political viability after implementation necessitates an acknowledgement of, and open dialogue on, the country's priorities and the reform's trade-offs, measured as carefully and transparently as possible.

Notes

- ¹ Marketplaces (also known as exchanges) are organized health insurance markets for consumers to purchase private nongroup insurance policies that meet standards defined under the Affordable Care Act (ACA). The Marketplaces (some run by state governments, others run by the federal government) contract with private insurers to offer coverage, determine applicant eligibility for income-related subsidies, and provide enrollment assistance. Nongroup insurance policies can be purchased through the Marketplaces or outside them, but income-related subsidies to lower premiums and cost-sharing requirements (i.e., deductibles, copayments, and coinsurance) can be provided only for the purchase of coverage through the Marketplaces. Nongroup insurance, sometimes called individual insurance or directly purchased insurance, is private health insurance coverage available for purchase independent of employers. It is the market in which regulatory rules changed the most under the ACA.
- ² Large employer plans share the risk of workers and their dependents among others in the same firm. Small employer plans generally share risk with other small employers buying coverage. Like workers enrolled in employer plans, Medicare enrollees contribute toward their own costs through premiums and out-of-pocket payments, but a large share of Medicare enrollees' health care costs are spread across all federal taxpayers. Virtually all the health care costs of Medicaid enrollees are spread across state and federal government taxpayers, since the beneficiaries are very low income, their coverage is comprehensive, and they are asked to contribute very little to their care out-of-pocket. The private nongroup market is the insurance market for which health care costs were traditionally shared the least, although that has changed significantly under the ACA. Health care costs of nongroup insurance enrollees are largely shared across the population of nongroup enrollees in a state, although federal premium and cost-sharing subsidies pay for some. Depending upon their income and the plan chosen, households may shoulder substantial directly paid premiums, and those who use care may face large out-of-pocket costs. Some additional plans are exempt from the ACA's risk-sharing rules, such as grandmothers plans, health care sharing ministries, and short-term limited duration plans. Consequently, risk sharing has increased significantly because of the ACA, particularly within the individual insurance market, but a significant degree of risk segmentation continues.
- ³ Actuarial value is one measure of a health insurance plan's generosity. It measures the share of insured health care costs the insurance plan pays, as opposed to the share the enrollees pay through deductibles, copayments, and coinsurance. Actuarial value reflects an average over a population of enrollees.
- ⁴ Small-group insurance is sold to employers with fewer than 50 employees (including full-time equivalents).
- ⁵ Higher cost-sharing (lower-actuarial-value) plans have larger deductibles, copayments, coinsurance, or out-of-pocket maximums. Proposed "copper" plans introduce lower-value plans into the nongroup market. These plans would have an actuarial value of 50 percent compared with the standard 70 percent for Marketplace benchmark "silver" plans or 60 percent for "bronze" plans, the current lowest-value plans open to all purchasers. By one estimate, a copper plan in 2019 would have a deductible for a single adult of \$12,000 to \$13,000, with an out-of-pocket maximum of the same amount. See David Anderson, "Why Current Copper Plan Proposals Won't Work," Health Affairs blog, August 9, 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180803.744146/full/>. This compares with the median deductible bronze plan the same year that had a deductible of \$6,650 with an out-of-pocket maximum of the same amount.
- ⁶ Health savings accounts (HSAs) are tax-exempt savings accounts that are used with high-deductible health plans; the funds deposited in the accounts can be used to pay for qualifying medical expenses. Although supporters hope HSAs will make individuals more prudent purchasers of medical care, the tax structure and incentives built into HSAs make them most attractive to the high-income and healthy people who are already advantaged by the current system. Funds deposited into the accounts are deducted from income for tax purposes, and any earnings on the funds accrue tax-free and are not subject to tax or penalty as long as they are withdrawn to cover medical costs.
- ⁷ Guaranteed issue requires insurers to sell a policy to any applicant, regardless of their health status or health risk.
- ⁸ Pure community rating prohibits insurers from selling the same insurance policy to different people at a different price, usually within a defined geographic area. Modified community rating prohibits the use of health status or

past health status or health experience in setting insurance prices but permits limited variation in premiums (e.g., adjustments for age or tobacco use).

- ⁹ Benefit standards define the minimum benefits that must be covered by a policy (e.g., hospital care, physician care, prescription drugs, maternity care, and preventive care). Actuarial value standards define the minimum share of covered expenses for the average enrollee that the policy must reimburse. For example, a policy must reimburse enrollees for at least 70 percent of the cost of covered benefits, on average, across the population of enrollees. The actuarial value standards effectively limit the out-of-pocket costs associated with an insurance policy.
- ¹⁰ High-risk pools are an explicit approach to separate the costs of people with high medical needs from others. Experience with high-risk pools before 2014 demonstrated that providing affordable, adequate coverage to a separated, high-need population required larger investments of public dollars than allocated. The funding required is well beyond levels proponents have suggested, given the large share of total health expenditures attributable to the highest-need population and the income constraints many face. See Blumberg (2011).
- ¹¹ Medicare for All Act of 2019, H.R. 1384, 116th Cong. (2019); Medicare for All Act of 2019, S. 1129, 116th Cong. (2019).
- ¹² Because of a Supreme Court decision in *National Federation of Independent Business v. Sebelius*, the ACA's Medicaid expansion of eligibility to almost all adults and children with incomes up to 138 percent of the federal poverty level was made voluntary to states. As of January 1, 2020, 14 states had not yet adopted the expansion, and another (Nebraska) had adopted it by ballot initiative but had not yet implemented it. Because the ACA stipulated that only people with incomes between 100 and 400 percent of the federal poverty level are eligible for Marketplace subsidies, people with low incomes who are not eligible for their state's traditional Medicaid or CHIP program (adults) are not eligible for any financial assistance to purchase coverage under the ACA. In essence, they are too poor to qualify for help under current law.
- ¹³ Calculation from the Urban Institute's Health Insurance Policy Simulation Model in 2019.
- ¹⁴ See, for example, the description of Continuous Autoenrollment with Retroactive Enforcement (CARE) as described in Blumberg, Holahan, Buettgens, Gangopadhyaya, et al. (2019). CARE would reach universal coverage for the legally present population, deeming those not actively enrolling in insurance coverage insured through either Medicaid or a public option, depending on their income. CARE would create a financial obligation for middle- and high-income people to contribute to their insurance coverage on an income-related basis. Those not enrolling in coverage voluntarily during the year would be required to pay income-related premiums for any months they were uninsured through the tax system at the end of the year. The lowest-income people, eligible for Medicaid or \$0 premium Marketplace coverage, would owe no premium.
- ¹⁵ If Marketplace subsidies had no upper income limit, the value of a person's subsidy would smoothly decrease to zero as the full premium they faced fell below the share-of-income cap as their income increased.
- ¹⁶ Uncompensated care refers to delivered medical services that the patient, insurer, or other third party does not directly pay for. This type of care is financed through a combination of sources, including federal and state government programs and providers' in-kind contributions. As the number of uninsured people increases, the demand for uncompensated care increases. Similarly, some people may have insurance, but because their cost-sharing responsibilities (e.g., deductibles and coinsurance) are large, they may be unable to pay their full portion of their medical bill.
- ¹⁷ For examples of reforms that would work in this way, see Blumberg, Holahan, Buettgens, and Zuckerman (2019) and reforms 5 and 6 in Blumberg, Holahan, Buettgens, Gangopadhyaya, et al. (2019).
- ¹⁸ High levels of concentration in insurer and provider markets are common, as are monopolies and duopolies.
- ¹⁹ Information asymmetries mean that consumers cannot make their own decisions about what services to consume. Providers are generally making the decisions for them.
- ²⁰ Providers deliver services in different ways, so in some respects, they are not selling the same services, another necessary condition of competitive markets.
- ²¹ Good health care provides positive externalities (e.g., workers are more productive, and thus economic conditions improve, and general population health is better when the broad population receives appropriate health care services).

- ²² See Rick Pollack, “Perspective: New Study Shows the Perils of a ‘Medicare for All’ Plan,” American Hospital Association blog, March 15, 2019, <https://www.aha.org/news/perspective/2019-03-15-perspective-new-study-shows-perils-medicare-all-plan>; and Pharmaceutical Research and Manufacturers of America, “Speaker Pelosi’s Drug Pricing Plan Could Result in 56 Fewer New Medicines over 10 Years,” press release, November 21, 2019, <https://phrma.org/Press-Release/Speaker-Pelosis-Drug-Pricing-Plan-Could-Result-in-56-Fewer-New-Medicines-Over-10-Years>.
- ²³ Capped rates can be implemented independently or in conjunction with a public option, the latter similar to the current Medicare market.
- ²⁴ It is possible that Medicaid eligibility levels in at least some of the seven states that had expanded eligibility before 2014 through coverage waivers would be set back even further. This is because not all those waivers are still active and it is unclear whether they would be resubmitted and reapproved.
- ²⁵ Medicare Part D prescription drug coverage plans typically pay for a share of an enrollee’s prescription drug costs up to a threshold. After the enrollee and the insurer spend the threshold amount, the enrollee must pay all additional prescription drug costs out of pocket, up to another threshold. Once that higher threshold is met, the Part D plan kicks in again and begins to help pay for additional prescription drug costs incurred. The range of spending where the insurer stops sharing in costs is referred to as the “doughnut hole.” The ACA includes a provision that eliminates the doughnut hole, requiring insurers to provide coverage all along the range of prescription drug spending.
- ²⁶ For more explanation, see the description of reform 5 in Blumberg, Holahan, Buettgens, Gangopadhyaya, et al. (2019).
- ²⁷ A public option implemented in the nongroup market would not affect risk pooling significantly. The ACA-compliant nongroup market in each state is already treated as a single risk pool under current law. The public option would simply provide another insurance option (at a lower price in many areas) into that single risk pool. But the other policies grouped together with the public option in most proposals would increase the sharing of health care risk.
- ²⁸ The premium tax credits are tied to an 80 percent actuarial value (gold) plan (as opposed to a 70 percent—silver—plan under current law), with people earning below 300 percent of the FPL offered even higher-value plans. Premium tax credits in the nongroup market limit household premium contributions for benchmark coverage to no more than 8.5 percent of income, with share-of-income caps decreasing from there for people with incomes below 400 percent of the FPL. The lowest-income enrollees in the Marketplaces pay no premium and are eligible for 95 percent actuarial value coverage. People choosing a plan more expensive than the second-lowest-cost gold plan would have to pay the full premium difference between the two themselves.
- ²⁹ Medicare for All Act of 2019, H.R. 1384, 116th Cong. (2019); Medicare for All Act of 2019, S. 1129, 116th Cong. (2019).
- ³⁰ Relative increase in the federal budget calculation is based on the Congressional Budget Office’s estimate of the federal budget between 2020 and 2029. See CBO (2020).
- ³¹ “Plans: Ending the Stranglehold of Health Care Costs on American Families,” Warren for President, accessed March 10, 2020, <https://elizabethwarren.com/plans/paying-for-m4a>
- ³² The Urban Institute analysis assumes that professionals would be paid at Medicare rates, hospitals would be paid at 15 percent above Medicare rates, and prescription drug prices would be set halfway between current Medicare and Medicaid prices. But, as explained previously, setting the payment and growth rate levels and delineating a path for moving from current levels to target levels poses significant practical challenges, particularly when the new rates apply to the entire population.

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Linda J. Blumberg is an Institute Fellow in the Health Policy Center at the Urban Institute. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the Affordable Care Act (ACA); in particular, providing technical assistance to states, tracking policy decisionmaking and implementation at the state and federal levels, and interpreting and analyzing the implications of particular policies. Examples of her work include analyses of the implications of congressional proposals to repeal and replace the ACA, delineation of strategies to fix problems associated with the ACA, estimation of the cost and coverage potential of a broad array of health insurance system reforms, including public option and single payer approaches, analysis of the implications of the *Texas v US* and *King v. Burwell* cases, and several studies of competition in ACA Marketplaces. In addition, Blumberg led the quantitative analysis supporting the development of a “Road Map to Universal Coverage” in Massachusetts, a project with her Urban colleagues that informed that state’s comprehensive health reforms in 2006. Blumberg frequently testifies before Congress and is quoted in major media outlets on health reform topics. She serves on the Cancer Policy Institute’s advisory board and has served on the *Health Affairs* editorial board. From 1993 through 1994, she was a health policy adviser to the Clinton administration during its health care reform effort, and she was a 1996 Ian Axford Fellow in Public Policy. Blumberg received her PhD in economics from the University of Michigan.

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U.S. Health Reform—Monitoring and Impact

Which Types of Insurance Are Marketplace Enrollees Choosing?

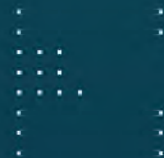
June 2020

By John Holahan, Caroline Elmendorf, and Erik Wengle



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Foundatio

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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.

INTRODUCTION

In recent papers, we have documented that Medicaid-managed care plans—insurers that expanded their business into the private nongroup insurance marketplaces under the *Affordable Care Act* (ACA) (hereinafter referred to as Medicaid insurers)—have increasingly offered plans with the lowest silver-level marketplace premiums. Silver is the level to which premium subsidies are tied and the level with the most marketplace enrollment. For example, in 2020, Medicaid plans offered the lowest silver-plan premium in 59 percent of the regions in which they participated.¹ Since marketplace consumers tend to be lower income than average and thus highly price-sensitive,² recent increases in the number of areas in which Medicaid insurers participate might lead one to expect that these insurers are increasing their market share in the private nongroup marketplaces.³ These insurers tend to have more limited provider networks, reflecting lower than average provider payment rates, so a growing dominance of these insurers could have implications for provider revenues and consumer choice.

However, not all consumers choose their insurance plan based on price.⁴ Having a recognized brand name or broader provider network, for example, can still be important considerations, and, if they are stronger motivators for many consumers' plan choices, they could have important implications for competition in these markets and for federal health spending on marketplace subsidies. Unfortunately, detailed marketplace enrollment data by insurer had not previously been readily available except for a limited number of states.⁵

In this brief, we use data recently made available by Centers for Medicare & Medicaid Services (CMS) to examine marketplace enrollment by state and insurer type to determine whether certain types of insurers are increasing

or decreasing in importance. We are particularly interested in assessing how lower-priced insurers are faring. We categorize each insurer according to the following types: Blue Cross Blue Shield-affiliated (including Anthem), Medicaid (e.g., Centene and Molina); regional (e.g., Moda and Pacific Source), national (e.g., Cigna and Aetna), provider-sponsored by health or hospital system (including Kaiser Permanente), and Co-ops (still participating in a small number of areas). The data do not permit us to identify enrollment by metal tier and insurer simultaneously, and therefore we analyze enrollment by metal tier elsewhere.⁶

DATA

Between the spring of 2018 and fall of 2019, CMS released enrollment data for the plan years 2016 to 2018 for marketplaces that used the federal healthcare.gov platform. This includes 39 states, although not all states were on the federal platform in all years (Kentucky was a state-based marketplace with its own platform in 2016 but transformed into a federally facilitated marketplace in 2017). For each of these states in each year, the data include enrollment statistics by insurer, metal tier, and other characteristics. These data are available for states with Federally Facilitated Marketplaces (FFMs) and those with State-based Marketplaces hosted on the Federal Platform (SBM-FPs). We used the files for calendar years 2016, 2017, and 2018, which were the three most recent years of data available. Insurer names came from healthcare.gov federally facilitated marketplace public use files. We assigned insurer type (Medicaid insurer, Blue Cross-affiliated insurer, national insurer, regional insurer, Co-op, provider-sponsored insurer) based on information available on insurer websites about plans offered and history of the insurance company.

RESULTS

Table 1 shows the national distribution of marketplace enrollment across different types of insurers across the 39 states included in the federal data. Blue Cross Blue Shield-affiliated insurers accounted for about 47 percent of marketplace enrollment in 2018, down slightly from 2017. Medicaid insurer enrollment grew from 15 percent of the marketplace in 2016 to 26 percent in 2017 and 27 percent in 2018. Enrollment in national and regional insurer plans fell from 33 percent in 2016 to 14 percent in 2018. Thus, most of the growth in Medicaid plans essentially replaced enrollment in national and regional insurers. Provider sponsored insurers consistently had 8 to 11 percent of enrollment, while Co-ops had about 2 percent.

In the following sections, we divide states into six categories. The first are states where Blue Cross Blue Shield-affiliated insurers have a dominant presence, with close to 100 percent of enrollment in 2018. In these situations, they are generally the only insurer in the nongroup markets. The second group is made up of states where Blue Cross Blue Shield insurers have a majority of enrollment in 2018, but where there is also a strong competitor—typically a Medicaid insurer. The third group is comprised of states where Medicaid insurers dominate the market. The fourth group consists of states where enrollment is led by national or regional insurers. The fifth group consists of states where provider sponsored plans are dominant, and the last category is made up of states with a strong Co-op insurer presence.

Table 1: Summary of Enrollment by Insurer Type

Insurer Type	2016		2017		2018	
	Enrolled	Share	Enrolled	Share	Enrolled	Share
Blue	4,161,267	42%	4,581,323	50%	4,180,723	47%
Medicaid	1,462,109	15%	2,420,624	26%	2,362,085	27%
National/Regional	3,257,506	33%	1,185,175	13%	1,249,027	14%
Provider	825,135	8%	859,366	9%	950,983	11%
Co-op	168,674	2%	123,250	1%	150,274	2%
U.S. Total	9,874,691	100%	9,169,738	100%	8,893,092	100%

Blue Cross Blue Shield-Dominant States (Table 2)

The first group consists of states where marketplace enrollment is overwhelmingly dominated by Blue Cross Blue Shield-affiliated insurers. In many of these states, a Blue Cross Blue Shield insurer (or insurers) is the only participant in the nongroup marketplace. In others, there may be a small amount of competition from other insurers in at least part of the state.

These states include:

- Alaska – Premera Blue Cross Blue Shield of Alaska had 100 percent of the state’s enrollment in 2018. In 2016, there had been strong competition from Moda, a regional health plan, but that insurer left the state’s small nongroup market in 2017.
- Alabama – Blue Cross Blue Shield of Alabama had 99 percent of the marketplace enrollment in 2018. A small Medicaid insurer entered the market that year with 1 percent of the state’s enrollment. The state lost two large national insurers after 2016.
- Delaware – Highmark Blue Cross Blue Shield had 100 percent of the market as of 2018. Until 2018, Aetna had provided significant competition.
- Illinois – Blue Cross Blue Shield of Illinois had 72 percent of the market in 2018. A mix of other insurers, including a national insurer, a Medicaid insurer, and a provider sponsored insurer had the remainder of enrollees.
- Louisiana – HMO Louisiana Inc., a Blue Cross Blue Shield insurer, had 86 percent of marketplace enrollees in 2018. Their enrollment increased considerably in 2017 and then again in 2018, corresponding with first the market exit of UnitedHealthcare and then Humana the following year. Enrollment in another Blue affiliated insurer, Louisiana Health Service & Indemnity Company, has fallen since 2016.
- North Carolina – Blue Cross Blue Shield of NC had 96 percent of the 2018 market in the state. Aetna and UnitedHealthcare left the state after 2016, but Cigna entered in 2017 and remained with 4 percent of the market in 2018.

- North Dakota – Blue Cross Blue Shield of North Dakota had 79 percent of marketplace enrollees in 2018. A provider sponsored insurer had the remainder of enrollment.
- New Hampshire – Anthem Blue Cross Blue Shield had 79 percent of the market in 2018. A Medicaid insurer and a provider-sponsored insurer share the remainder. A Co-op had the largest marketplace enrollment in 2017 but left the market after that year.
- Oklahoma – Blue Cross Blue Shield of Oklahoma had 100 percent of the market in 2017 and 2018, following the exit of UnitedHealthcare after the 2016 plan year.
- South Carolina – Blue Cross Blue Shield of South Carolina had 100 percent of the state's market in 2017 and 2018.
- Wyoming – Blue Cross Blue Shield had 100 percent of the marketplace enrollment in all three years analyzed.

Blue Cross Blue Shield Affiliates with Majority Market Share (Table 3)

In a number of states, Blue Cross has the greatest market share, but there is a significant and often growing competition from other insurers, typically Medicaid insurers. These include the following states:

- Arkansas – In 2018, USABLE Mutual, the state's Blue affiliated insurer, had 59 percent of marketplace enrollment; Ambetter, a Medicaid insurer and a subsidiary of Centene Corporation, increased its market share each year 2016 to 2018, reaching 39 percent in 2018.
- Florida – Blue affiliated insurers held 69 percent of marketplace enrollment state-wide. The state's two Medicaid insurers had almost all of the remainder of the enrollment, with one, Celtic Insurance, having increased its market share each year to 27 percent of enrollment in 2018.
- Hawaii – Hawaii's Blue affiliated insurer had 51 percent market share in 2018, down from 60 percent in 2016. Kaiser Foundation Health Plan saw increasing market share each year over this period and had 49 percent of enrollment in 2018.
- Kansas – Blue Cross Blue Shield of Kansas had 63 percent of marketplace enrollment in the state in 2018. This was down considerably from the 85 percent and 93 percent market shares for all its affiliates in 2016 and 2017, respectively. A regional (Medica) and a Medicaid (Sunflower State Health Plan) insurer each entered the

marketplace in the years following 2016, both earning significant shares of enrollees quickly.

- Michigan – Combined, two Blue affiliated insurers had 61 percent of the marketplace in 2018. A mix of Medicaid insurers (20%) and provider sponsored insurers (20%) split the remainder. The state lost several insurers between 2016 and 2018, but eight insurers remained. In 2016, 14 insurers shared the state's marketplace enrollment.
- New Jersey – The state's Blue affiliated insurer (Horizon Health Care Services) had 53 percent of the marketplace market share in 2018. AmeriHealth, a regional insurer, saw increasing market shares each year, and across its two subsidiaries had 43 percent of the market in 2018. Oscar, a national start-up insurer returning to the state in 2018, had the remaining 4 percent.
- Pennsylvania – In Pennsylvania there were several different Blue-affiliated insurers that operated in different parts of the state in 2018. Between them, they had 56 percent of the market, down modestly from the 61 percent of the market held by Blue affiliates in 2016. Two large provider sponsored plans, Geisinger and UPMC had 17 percent and 28 percent, respectively, in 2018.
- Tennessee – Blue Cross Blue Shield of Tennessee had 55 percent of marketplace enrollment in 2018. Two national insurers, Cigna and Oscar, held the remaining 45 percent of enrollment that year. The market dominance of Blue Cross fell over this period while it rose for national insurers, although the mix of national insurers changed. UnitedHealthCare left the market in 2017 and Humana left the market in 2018.
- West Virginia – Highmark, the state's Blue affiliated insurer, had a 66 percent market share in 2018, down from 95 percent in 2016. Care Source, a Medicaid insurer operating in the Midwest, grew appreciably to have a 34 percent market share in 2018.

Table 2: Issuer-Level Enrollment in States Where Blue Cross Blue Shield is Dominant Insurer

State	Insurer	Insurer Type	2016		2017		2018	
			Enrolled	Share	Enrolled	Share	Enrolled	Share
AK	Moda Health Plan, Inc.	National/Regional	14,295	70%				
	Premera Blue Cross Blue Shield of Alaska	Blue	6,246	30%	18,577	100%	19,241	100%
	Blue Cross and Blue Shield of Alabama	Blue	121,239	64%	180,467	100%	172,971	99%
AL	Bright Health Insurance Company	National/Regional					1,412	1%
	Humana Insurance Company	National/Regional	18,816	10%				
	UnitedHealthcare of Alabama, Inc.	National/Regional	48,751	26%				
DE	Aetna Health Inc. (a PA corp.)	National/Regional	1,779	6%	7,141	26%		
	Aetna Life Insurance Company	National/Regional	1,457	5%	6,138	22%		
	Highmark BCBSD Inc.	Blue	27,657	90%	14,651	52%	24,192	100%
IL	Aetna Health Inc. (a PA corp.)	National/Regional	14,106	3%				
	Blue Cross Blue Shield of Illinois	Blue	239,223	58%	236,914	65%	249,233	72%
	Ambetter	Medicaid	45,502	11%	48,609	13%	31,480	9%
	Cigna HealthCare of Illinois, Inc.	National/Regional			31,196	9%	30,581	9%
	Coventry Health & Life Co.	National/Regional	11,050	3%				
	Coventry Health Care of Illinois, Inc.	National/Regional	18,450	4%				
	Harken Health Insurance Company	National/Regional	18,551	5%				
	Health Alliance Medical Plans, Inc.	Provider	34,041	8%	41,038	11%	34,440	10%
	Humana Health Plan, Inc.	National/Regional	2,715	1%	5,369	1%		
	Land of Lincoln Mutual Health Insurance Company	Co-op	16,632	4%				
	UnitedHealthcare of the Midwest, Inc.	National/Regional	11,622	3%				
LA	HMO Louisiana, Inc.	Blue	65,858	32%	83,138	59%	90,450	86%
	Humana Health Benefit Plan of Louisiana, Inc.	National/Regional	34,889	17%	29,500	21%		
	Louisiana Health Service & Indemnity Company	Blue	31,501	15%	10,951	8%	4,292	4%
	UnitedHealthcare of Louisiana, Inc.	National/Regional	52,993	25%				
	Vantage Health Plan, Inc.	National/Regional	23,038	11%	16,995	12%	10,420	10%
	Aetna Health Inc. (a PA corp.)	National/Regional	145,751	24%				
NC	Blue Cross and Blue Shield of NC	Blue	273,822	46%	512,274	95%	502,254	96%
	Cigna HealthCare of North Carolina, Inc.	National/Regional			24,784	5%	21,267	4%
	UnitedHealthcare of North Carolina, Inc.	National/Regional	179,996	30%				
ND	Blue Cross Blue Shield of North Dakota	Blue	12,490	52%	16,814	71%	18,808	79%
	Medica Health Plans	National/Regional	6,300	26%	2,727	12%		
	Sanford Health Plan	Provider	5,300	22%	4,090	17%	4,974	21%
NH	Ambetter	Medicaid	33	0%	152	0%	5,862	12%
	Harvard Pilgrim Health Care of NE	Provider	12,243	20%	11,132	20%	4,092	8%
	Maine Community Health Options	Co-op	2,130	4%				
	Matthew Thornton Hlth Plan (Anthem BCBS)	Blue	26,397	44%	20,003	35%	38,288	79%
	Minuteman Health, Inc	Co-op	19,063	32%	25,140	45%		
OK	Blue Cross Blue Shield of Oklahoma	Blue	147,230	95%	148,243	100%	152,192	100%
	UnitedHealthcare of Oklahoma, Inc.	National/Regional	8,046	5%				
SC	Aetna Health Inc. (a PA corp.)	National/Regional	10,230	4%				
	Blue Cross and Blue Shield of South Carolina	Blue	110,987	48%	215,355	100%	213,769	100%
	BlueChoice HealthPlan of South Carolina, Inc.	Blue	111,531	48%				
	UnitedHealthcare Insurance Company	National/Regional	667	0%				
WY	Blue Cross Blue Shield of Wyoming	Blue	26,502	100%	25,797	100%	26,004	100%

Table 3: Issuer-Level Enrollment in States Where BCBS is Largest Insurer

State	Insurer	Insurer Type	2016		2017		2018	
			Enrolled	Share	Enrolled	Share	Enrolled	Share
AR	Ambetter	Medicaid	5,196	7%	23,092	32%	28,168	39%
	QCA Health Plan, Inc.	Medicaid	1,292	2%	707	1%	929	1%
	QualChoice Life & Health Insurance Company, Inc.	Medicaid	119	0%	59	0%	357	0%
	USABLE Mutual Insurance Company	Blue	69,578	91%	48,305	67%	42,413	59%
	UnitedHealthcare of Arkansas, Inc.	National/Regional	646	1%				
FL	Aetna Health Inc. (a FL corp.)	National/Regional	23,465	1%				
	Blue Cross and Blue Shield of Florida	Blue	431,456	24%	454,961	27%	444,546	24%
	Ambetter	Medicaid	144,604	8%	270,663	16%	484,030	27%
	Coventry Health Care of Florida, Inc.	National/Regional	248,886	14%				
	Florida Health Care Plan, Inc.	Blue	22,889	1%	34,348	2%	42,003	2%
	Health First Commercial Plans, Inc.	National/Regional			20,940	1%	21,051	1%
	Health First Health Plans, Inc.	National/Regional	14,659	1%				
	Health Options, Inc.	Blue	265,770	15%	522,659	31%	760,149	42%
	Humana Medical Plan, Inc.	National/Regional	220,420	12%	26,042	2%		
	Molina Healthcare of Florida, Inc.	Medicaid	284,305	16%	374,692	22%	63,705	4%
HI	UnitedHealthcare of Florida, Inc.	National/Regional	113,778	6%				
	Hawaii Medical Service Association	Blue	11,030	60%	11,189	53%	10,935	51%
KS	Kaiser Foundation Health Plan, Inc.	Provider	7,321	40%	9,986	47%	10,322	49%
	Blue Cross and Blue Shield of Kansas City	Blue	24,766	23%	32,330	32%		
	Blue Cross and Blue Shield of Kansas, Inc.	Blue	14,229	13%			61,860	63%
	BlueCross BlueShield Kansas Solutions, Inc.	Blue	51,804	49%	62,946	61%		
	Medica Insurance Company	National/Regional			7,281	7%	14,086	14%
MI	Sunflower State Health Plan, Inc.	Medicaid					22,903	23%
	UnitedHealthcare of the Midwest, Inc.	National/Regional	15,761	15%				
	Alliance Health and Life Insurance Company	National/Regional	6,331	2%				
	Blue Care Network of Michigan	Blue	128,152	35%	114,461	35%	144,959	48%
	Blue Cross Blue Shield of Michigan Mutual Insurance Company	Blue	70,723	19%	46,229	14%	37,284	12%
	Consumers Mutual Insurance of Michigan	Co-op		0%				
	Harbor Health Plan, Inc.	Medicaid	3,707	1%				
	Health Alliance Plan (HAP)	National/Regional	9,402	3%	11,649	4%		
	Humana Medical Plan of Michigan, Inc.	National/Regional	37,678	10%	8,803	3%		
	McLaren Health Plan Community	Medicaid	2,286	1%	3,625	1%	6,842	2%
NJ	Meridian Health Plan of Michigan, Inc.	Medicaid	3,809	1%	8,387	3%	7,628	3%
	Molina Healthcare of Michigan, Inc.	Medicaid	5,443	1%	31,752	10%	22,631	8%
	Physicians Health Plan	Provider	4,275	1%	7,429	2%	8,295	3%
	Priority Health	Provider	78,067	21%	89,757	27%	50,836	17%
	Priority Health Insurance Company (PHIC)	Provider	5,702	2%				
	Total Health Care USA, Inc.	Medicaid	6,897	2%	9,671	3%	21,475	7%
	UnitedHealthcare Community Plan, Inc.	National/Regional	4,778	1%				
	AmeriHealth HMO, Inc.	National/Regional	13,764	5%	12,765	4%	12,236	4%
	AmeriHealth Ins Company of New Jersey	National/Regional	51,116	17%	84,913	28%	108,652	39%
	Freelancers CO-OP of New Jersey, Inc.	Co-op	20,217	7%				
PA	Horizon Healthcare Services, Inc.	Blue	182,981	60%	202,819	67%	149,844	53%
	Oscar Garden State Insurance Corporation	National/Regional					10,155	4%
	Oscar Insurance Corporation of New Jersey	National/Regional	27,205	9%				
	Oxford Health Plans (NJ), Inc.	National/Regional	9,304	3%				
	Aetna Health Inc. (a PA corp.)	National/Regional	39,390	8%				
	Capital Advantage Assurance Company	Blue	19,829	4%	47,098	11%	33,413	8%
	First Priority Health	Blue			20,835	5%	12,546	3%
	First Priority Life Insurance Company, Inc.	Blue	29,623	6%				
	Geisinger Health Plan	Provider	25,593	5%	52,184	12%	68,368	17%
	Geisinger Quality Options	Provider	6,467	1%				
TN	Highmark Choice Company	Blue					3,485	1%
	Highmark Health Insurance Company	Blue	18,594	4%	24,193	6%	16,054	4%
	Highmark Inc.	Blue	23,245	5%	10,219	2%	806	0%
	Highmark Select Resources Inc.	Blue	13,145	3%				
	Independence Blue Cross (QCC Ins. Co.)	Blue	22,565	5%	37,489	9%	29,485	7%
	Keystone Health Plan Central	Blue	41,693	9%				
	Keystone Health Plan East, Inc.	Blue	128,145	26%	131,525	31%	134,311	33%
	UPMC Health Options, Inc.	Provider	87,717	18%	107,224	25%	114,036	28%
	UnitedHealthcare of Pennsylvania, Inc.	National/Regional	29,675	6%				
	BlueCross BlueShield of Tennessee	Blue	174,910	65%	80,505	34%	127,174	55%
WV	Cigna Health and Life Insurance Company	National/Regional	22,206	8%	77,671	33%	81,191	35%
	Humana Insurance Company	National/Regional	26,126	10%	76,789	33%		
	Oscar Insurance Company of Texas	National/Regional					24,718	11%
WV	UnitedHealthcare Insurance Company	National/Regional	47,700	18%				
	CareSource West Virginia Co.	Medicaid	1,825	5%	7,100	21%	9,320	34%
WV	Highmark Blue Cross Blue Shield West Virginia	Blue	37,354	95%	25,974	79%	18,276	66%

Medicaid Insurer Dominant States (Table 4)

Medicaid insurers have grown to be increasingly important in the nongroup marketplaces. In the previous section we highlighted several states with growing Medicaid insurer market share in competition with dominant Blue-affiliated insurers. In this section we highlight states where Medicaid insurer now have the majority of marketplace enrollment.

- Arizona – Health Net of Arizona, a regional Medicaid insurer, had 75 percent of the Arizona marketplace enrollment in 2018. The remainder of the enrollees were enrolled with a Blue-affiliated insurer. Six other insurers left the market after the 2016 plan year.
- Georgia – Ambetter, a Medicaid insurer that is a subsidiary of Centene Corporation, had 52 percent of the market in 2018. Kaiser Foundation Health Plan of Georgia, a provider-sponsored insurer, had another 22 percent, with Blue Cross Blue Shield and a regional insurer having the remainder.
- Indiana – There were eight insurers of a mix of types in the Indiana marketplace in 2016, but by 2018 only two, both Medicaid insurers, remained. CareSource had 53 percent of enrollment and Celtic had 47 percent of enrollment in 2018, up from 17 percent and 10 percent respectively in 2016.
- Kentucky – CareSource, a Medicaid insurer, had 66 percent of the market in 2018, up from 40 percent in 2017. Anthem Blue Cross Blue Shield had the remainder.
- Mississippi – Ambetter, a Medicaid insurer and a subsidiary of Centene Corporation, had 100 percent of the Mississippi marketplace enrollment in 2018. Two national insurers left the market in 2017 and 2018.
- New Mexico – Molina Healthcare, a national Medicaid insurer, had 59 percent of the New Mexico marketplace enrollment in 2018. A local Co-op had 29 percent, and a Blue-affiliated and provider-sponsored insurer had the remainder of market share.
- Ohio – The state had 17 marketplace insurers in 2016, but participants fell to eight by 2018. Three Medicaid insurers, Buckeye, CareSource, and Molina, had a combined 64 percent of the Ohio marketplace enrollment in 2018. The bulk of the remainder enrolled in national/regional insurer plans.
- Texas – Four Medicaid insurers enrolled 60 percent of the Texas marketplace in 2018. Celtic and Molina, both national Medicaid chains, accounted for 46 percent of the

state's enrollment. A local Medicaid insurer, Community HealthChoice, accounted for another 12 percent. Blue Cross Blue Shield of Texas had 27 percent of enrollment in the state. A large number of plans with small market share in 2016 had left the market by 2018.

National and Regional Health Plans Have the Largest Market Share (Table 5)

In six states, national or regional insurers held the most marketplace enrollment. In other states, insurers in this category have typically lost enrollment between 2016 and 2018.

- Iowa – Medica, a regional insurer, had 100 percent of the market in 2018. All other insurers who participated in 2016 and 2017 have left the market; these included other national insurers, a Blue-affiliated insurer, and a provider-sponsored insurer.
- Missouri – Cigna, a national insurer, had the largest market share in 2018 with 48 percent. Ambetter, a Medicaid insurer, and Anthem had the rest, with 30 percent and 21 percent of enrollment, respectively.
- Nebraska – Medica now has 100 percent of the Nebraska marketplace enrollment. Other insurers that participated in 2016-2017, including Aetna, Blue Cross, Coventry, and UnitedHealthcare, have all left the Nebraska marketplace.
- Nevada – A regional insurer, Health Plan of Nevada, had 64 percent of the market in 2018, having held a majority of enrollment in each year of this period. A local Medicaid insurer had the balance in 2018. Two Blue affiliated insurers and a provider-sponsored insurer left the state before the 2018 plan year.
- South Dakota – A national/regional insurer and a provider-sponsored insurer each had 50 percent of the market in 2018, although the national/regional insurer lost significant market share that year compared to the two preceding years.
- Utah – Select Health, a regional insurer, had 88 percent of the Utah marketplace enrollment in 2018. The dominance of this insurer, SelectHealth, is growing due to the exit of the Medicaid insurer, Molina after the 2017 plan year. A provider sponsored insurer had the rest of the state's enrollment in 2018, also gaining enrollment due to Molina's exit.

Table 4: Issuer-Level Enrollment in States Where Medicaid Insurer is Dominant

State	Insurer	Insurer Type	2016		2017		2018	
			Enrolled	Share	Enrolled	Share	Enrolled	Share
AZ	Aetna Health Inc. (a PA corp.)	National/Regional	9,897	5%				
	All Savers Insurance Company	National/Regional	78,729	37%				
	Blue Cross and Blue Shield of Arizona, Inc.	Blue	40,092	19%	46,374	27%	43,282	25%
	Cigna HealthCare of Arizona, Inc.	National/Regional	3,480	2%				
	Health Choice Insurance Co.	National/Regional	15,393	7%				
	Health Net of Arizona, Inc.	Medicaid	16,516	8%	128,151	73%	129,461	75%
	Humana Health Plan, Inc.	National/Regional	6,964	3%				
GA	Phoenix Health Plans, Inc.	Medicaid	40,656	19%				
	Aetna Health Inc. (a GA corp.)	National/Regional	88,491	16%				
	Alliant Health Plans	National/Regional	10,968	2%	28,999	6%	44,332	10%
	Ambetter of Peach State Inc.	Medicaid	106,102	19%	169,089	35%	234,394	52%
	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	Blue	104,241	19%	227,944	47%	75,047	17%
	Cigna Health and Life Insurance Company	National/Regional	4,351	1%				
	Harken Health Insurance Company	National/Regional	11,707	2%				
	Humana Employers Health Plan of Georgia, Inc.	National/Regional	175,092	31%	3,700	1%		
	Kaiser Foundation Health Plan of Georgia	Provider	32,898	6%	50,829	11%	98,240	22%
	UnitedHealthcare of Georgia, Inc.	National/Regional	24,941	4%				
IN	All Savers Insurance Company	National/Regional	19,108	9%				
	Anthem Ins Companies Inc(Anthem BCBS)	Blue	61,805	31%	34,564	19%		
	CareSource Indiana, Inc.	Medicaid	33,432	17%	46,105	26%	88,184	53%
	Ambetter	Medicaid	19,382	10%	63,106	35%	78,784	47%
	Indiana University Health Plans, Inc.	Provider	26,437	13%				
	MDwise Marketplace, Inc.	Medicaid	38,566	19%	34,628	19%		
	Physicians Health Plan of Northern Indiana, Inc.	Provider	3,661	2%				
KY	Southeastern Indiana Health Organization	Provider	224	0%				
	Anthem Health Plans of KY(Anthem BCBS)	Blue			53,049	58%	32,446	34%
	CareSource Kentucky Co.	Medicaid			37,087	40%	63,633	66%
MS	Humana Health Plan, Inc.	National/Regional			2,100	2%		
	Ambetter of Magnolia Inc.	Medicaid	47,208	49%	71,918	90%	81,112	100%
	Humana Insurance Company	National/Regional	27,469	28%	8,194	10%		
NM	UnitedHealthcare of Mississippi, Inc.	National/Regional	21,974	23%				
	Blue Cross Blue Shield of New Mexico	Blue			1,793	3%	3,469	7%
	CHRISTUS Health Plan	Provider	3,863	7%	6,177	11%	2,759	5%
	Molina Health Care of New Mexico, Inc.	Medicaid	23,781	41%				
	Molina Healthcare of New Mexico, Inc.	Medicaid			34,533	63%	30,505	59%
	New Mexico Health Connections	Co-op	17,901	31%	12,498	23%	15,141	29%
OH	Presbyterian Health Plan, Inc.	Provider	12,341	21%				
	Aetna Life Insurance Company	National/Regional	15,916	6%				
	All Savers Insurance Company	National/Regional	1,241	0%				
	AultCare Insurance Company	National/Regional	5,035	2%	4,831	2%	6,169	3%
	Buckeye Community Health Plan	Medicaid	13,271	5%	20,310	8%	27,326	12%
	CareSource	Medicaid	80,808	30%	81,673	33%	98,444	42%
	Community Insurance Company(Anthem BCBS)	Blue	33,376	13%	50,497	20%		
	Consumers Life Insurance Company	National/Regional	995	0%	2,596	1%		
	Coordinated Health Mutual, Inc.	Co-op	3,884	1%				
	HealthSpan	Provider	2,774	1%				
	HealthSpan Integrated Care	Provider	1,903	1%				
	Humana Health Plan of Ohio, Inc.	National/Regional	6,478	2%	1,333	1%		
	MOLINA HEALTHCARE OF OHIO	Medicaid	14,292	5%				
	Medical Health Insuring Corp. of Ohio	National/Regional	53,163	20%	50,309	20%	61,948	26%
	Molina Healthcare of Ohio, Inc.	Medicaid			27,168	11%	24,936	11%
	Oscar Insurance Corporation of Ohio	National/Regional					8,189	3%
	Paramount Insurance Company	Provider	5,150	2%	4,600	2%	6,668	3%
Premier Health Plan, Inc.	National/Regional	6,452	2%	4,381	2%			
Summa Insurance Company, Inc.	National/Regional	3,985	2%	3,467	1%	3,388	1%	
UnitedHealthcare of Ohio, Inc.	National/Regional	16,315	6%					
TX	Aetna Life Insurance Company	National/Regional	47,855	4%				
	All Savers Insurance Company	National/Regional	154,963	12%				
	Allegian Insurance Company	National/Regional	7,403	1%				
	Blue Cross Blue Shield of Texas	Blue	507,570	39%	333,741	28%	298,223	27%
	CHRISTUS Health Plan	Provider	16,058	1%	29,517	3%	25,437	2%
	Ambetter	Medicaid	70,567	5%	242,947	21%	236,003	21%
	Cigna Health and Life Insurance Company	National/Regional	6,023	0%				
	Cigna HealthCare of Texas, Inc.	National/Regional	4,395	0%				
	Community First Health Plans, Inc.	Medicaid	7,081	1%				
	Community Health Choice, Inc.	Medicaid	110,657	9%	162,056	14%	127,130	12%
	Humana Health Plan of Texas, Inc.	National/Regional	55,087	4%	8,903	1%		
	Humana Insurance Company	National/Regional	723	0%				
	Insurance Company of Scott & White	Provider	45,288	4%				
	Molina Healthcare of Texas	Medicaid	157,480	12%				
	Molina Healthcare of Texas, Inc.	Medicaid			288,316	25%	272,378	25%
	Oscar Insurance Company of Texas	National/Regional	39,885	3%	33,395	3%	97,673	9%
	Prominence HealthFirst of Texas, Inc.	Provider	3,935	0%	7,162	1%		
SHA, LLC DBA FirstCare Health Plans	Provider	15,876	1%	13,810	1%	16,906	2%	
Scott and White Health Plan	Provider	6,983	1%					
Sendero Health Plans, Inc.	National/Regional	29,121	2%	54,809	5%	31,596	3%	

Note: Data is not available for Kentucky in 2016.

Table 5: Issuer-Level Enrollment in States Where a National or Regional Insurers have the Largest Marketplace Share

State	Insurer	Insurer Type	2016		2017		2018	
			Enrolled	Share	Enrolled	Share	Enrolled	Share
IA	Aetna Health Inc. (a IA corp.)	National/Regional	42,595	71%				
	Aetna Health of Iowa Inc.	National/Regional			38,245	68%		
	Gundersen Health Plan, Inc.	Provider	103	0%	417	1%		
	Medica Insurance Company	National/Regional	1,716	3%	14,640	26%	52,276	100%
	UnitedHealthcare of the Midlands, Inc.	National/Regional	15,231	26%				
	Wellmark Synergy Health, Inc.	Blue			1,529	3%		
	Wellmark Value Health Plan, Inc.	Blue			1,363	2%		
MO	All Savers Insurance Company	National/Regional	47,782	17%				
	Blue Cross and Blue Shield of Kansas City	Blue	35,080	12%	27,331	11%		
	Ambetter	Medicaid					72,664	30%
	Cigna Health and Life Insurance Company	National/Regional	28,547	10%	91,754	37%	114,837	48%
	Coventry Health & Life Insurance Co.	National/Regional	51,905	18%				
	Coventry Health and Life	National/Regional	49,840	17%				
	Healthy Alliance Life Co(Anthem BCBS)	Blue	55,099	19%	110,612	44%	50,759	21%
	Humana Insurance Company	National/Regional	21,148	7%	20,573	8%		
NE	Aetna Health Inc. (a PA corp.)	National/Regional			49,714	57%		
	Blue Cross and Blue Shield of Nebraska	Blue	24,484	27%				
	Coventry Health Care of Nebraska Inc.	National/Regional	43,929	48%				
	Medica Insurance Company	National/Regional	6,099	7%	37,010	43%	91,054	100%
	UnitedHealthcare of the Midlands, Inc.	National/Regional	17,865	19%				
NV	HMO Colorado, Inc., dba HMO Nevada	Blue	8,155	8%	26,786	28%		
	Health Plan of Nevada, Inc.	National/Regional	55,201	56%	54,253	57%	58,819	64%
	Prominence HealthFirst	Provider	12,989	13%	6,288	7%		
	Rocky Mountain Hospital and Medical Service, Inc., dba Anthem Blue Cross and Blue Shield	Blue	22,451	23%	7,560	8%		
	SilverSummit Healthplan, Inc.	Medicaid					32,679	36%
SD	Avera Health Plans, Inc.	National/Regional	20,929	73%	23,704	75%	16,163	50%
	Sanford Health Plan	Provider	7,804	27%	7,755	25%	15,893	50%
UT	Humana Medical Plan of Utah, Inc.	National/Regional	7,555	4%				
	Molina Healthcare of Utah	Medicaid	71,979	36%	90,838	44%		
	SelectHealth	National/Regional	120,510	60%	111,950	54%	180,579	88%
	University of Utah Health Insurance Plans	Provider	2,126	1%	5,710	3%	24,406	12%

Provider-Sponsored Insurers Have the Largest Market Share (Table 6)

Provider-sponsored insurers are minor players in many states, but they hold substantial market share in these three.

- Oregon – Together, two provider sponsored insurers accounted for almost three-quarters of the state marketplace enrollment in 2018. The Providence Health Plan, an insurer sponsored by the Providence hospital system, accounts for 48 percent of the Oregon market. Kaiser Foundation Health Plan accounts for another 25 percent. Two national/regional insurers account for the vast majority of the rest of enrollment.
- Virginia – In Virginia, provider sponsored insurers have a major marketplace role that has been growing in recent years, reaching half of marketplace enrollment

in 2018, up from 39 percent in 2016. Kaiser Foundation Health Plan accounted for 25 percent of the 2018 market. Optima Health Plan, a hospital-based system insurer, accounted for another 19 percent, and another provider sponsored plan (Piedmont) had 6 percent. In Virginia, Blue affiliated insurers CareFirst and HealthKeepers accounted for 21 percent of the market, and Cigna, a national insurer, accounted for another 29 percent of the market in 2018.

- Wisconsin – Several provider-sponsored insurers accounted for 47 percent of the Wisconsin marketplace enrollment in 2018. The state’s Co-op accounted for another significant share (28 percent). A number of small insurers, a mix of Medicaid and national/regional insurers, account for the balance. Unlike most states, there’s no single insurer with a large share of the market.

Table 6: Issuer-Level Enrollment in States Where a Provider-Sponsored Insurer has the Largest Marketplace Share

State	Insurer	Insurer Type	2016		2017		2018	
			Enrolled	Share	Enrolled	Share	Enrolled	Share
OR	ATRIO Health Plans	National/Regional	2,220	1%	8,405	5%		
	BridgeSpan Health Company	Blue	2,461	1%	10,919	7%	1,428	1%
	Community Care of Oregon, Inc.	Medicaid	3,843	2%				
	Kaiser Foundation Healthplan of the NW	Provider	17,739	11%	37,244	23%	41,167	25%
	LifeWise Health Plan of Oregon	Blue	15,705	10%				
	Moda Health Plan, Inc.	National/Regional	33,175	20%	16,328	10%	33,482	21%
	PacificSource Health Plans	National/Regional	1,551	1%	9,675	6%	9,281	6%
	Providence Health Plan	Provider	86,503	53%	82,790	50%	76,956	47%
	Trillium Community Health Plan	Medicaid	43	0%				
	Zoom Health Plan, Inc.	National/Regional	1,162	1%				
	Aetna Health Inc. (a PA corp.)	National/Regional			37,460	9%		
	Aetna Life Insurance Company	National/Regional	15,459	3%				
	CareFirst BlueChoice, Inc.	Blue	14,863	3%	7,233	2%	5,774	2%
	Cigna Health and Life Insurance Company	National/Regional			22,734	5%	111,507	29%
	VA	Coventry Health Care of Virginia, Inc.	National/Regional	51,750	12%			
Group Hospitalization and Medical Services Inc.		Blue	4,488	1%	3,777	1%	2,319	1%
HealthKeepers, Inc.		Blue	165,581	37%	182,454	43%	72,448	19%
Innovation Health Insurance Company		Provider	62,983	14%	73,432	17%		
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.		Provider	65,710	15%	57,498	13%	94,826	25%
Optima Health Plan		Provider	37,434	8%	19,364	5%	72,650	19%
Piedmont Community HealthCare HMO, Inc.		Provider	2,917	1%	4,407	1%	23,369	6%
Piedmont Community HealthCare, Inc.		Provider	3,253	1%	2,071	0%		
UnitedHealthcare of the Mid-Atlantic Inc.		National/Regional	18,312	4%	16,162	4%		
WI		All Savers Insurance Company	National/Regional	19,652	7%			
	Aspirus Arise Health Plan of Wisconsin, Inc.	Provider			9,696	4%	11,139	5%
	Children's Community Health Plan	Medicaid			3,324	1%		
	Children's Community Health Plan	Medicaid					30,829	13%
	Common Ground Healthcare Cooperative	Co-op	17,373	6%	31,911	12%	63,262	28%
	CompCare Health Serv Ins Co(Anthem BCBS)	Blue	10,014	4%	11,533	4%		
	Dean Health Plan	Provider	47,087	18%	40,049	16%	35,842	16%
	Group Health Cooperative of South Central Wisconsin	National/Regional			2,167	1%	5,165	2%
	Group Health Cooperative- SCW	National/Regional	731	0%				
	Gundersen Health Plan, Inc.	Medicaid	4,043	2%	3,377	1%		
	Health Tradition Health Plan	National/Regional	10,972	4%	10,158	4%		
	HealthPartners Insurance Company	Medicaid			1,852	1%	3,539	2%
	Managed Health Services Insurance Corporation	Medicaid	2,230	1%				
	Medica Health Plans of Wisconsin	National/Regional	8,994	3%	6,987	3%	8,261	4%
	MercyCare HMO, Inc.	Provider	1,517	1%	5,903	2%	7,279	3%
	Molina Healthcare of Wisconsin, Inc.	Medicaid	79,096	29%	80,828	31%		
	Network Health Plan	Provider	3,478	1%	7,523	3%	8,563	4%
	Physicians Plus Insurance Corporation	Provider	384	0%				
Security Health Plan of Wisconsin, Inc.	Provider	30,017	11%	29,646	12%	35,606	16%	
Unity Health Plans Insurance Corporation	Provider	17,254	6%	12,667	5%	20,224	9%	
WPS Health Plan, Inc.	National/Regional	16,157	6%					

Co-ops Have the Largest Market Share (Table 7)

In two states, Co-ops have a major marketplace presence. These include:

- Maine – Maine’s Co-op had 60 percent of the market in 2018, with Harvard Pilgrim, a provider-sponsored insurer, having the remaining 40 percent. In the two preceding years, a Blue-affiliated insurer had between one-fifth and one-third of marketplace enrollment, but it left the state’s marketplace after 2017.

- Montana – Montana’s Co-op accounted for 51 percent of the marketplace’s enrollment in 2018, up from 28 percent in 2016. They seem to be attracting enrollment from the state’s Blue Cross and Blue Shield insurer, with the Blue affiliated insurer’s market share falling from 61 percent in 2016 to 29 percent in 2018. A national/regional insurer’s enrollment has grown as well, from 12 percent of the marketplace in 2016 to 20 percent in 2018.

Table 7: Issuer-Level Enrollment in States Where Co-op Insurer has the Largest Marketplace Share

State	Insurer	Insurer Type	2016		2017		2018	
			Enrolled	Share	Enrolled	Share	Enrolled	Share
ME	Anthem Health Plans of ME (Anthem BCBS)	Blue	18,617	21%	27,050	33%		
	Harvard Pilgrim Health Care Inc.	Provider	15,517	17%	21,971	26%	30,848	40%
	Maine Community Health Options	Co-op	54,958	62%	33,920	41%	46,199	60%
MT	Blue Cross and Blue Shield of Montana	Blue	36,282	61%	23,945	44%	14,291	29%
	Montana Health Cooperative	Co-op	16,516	28%	19,781	37%	25,672	51%
	PacificSource Health Plans	National/Regional	7,128	12%	10,345	19%	10,135	20%

CONCLUSION

Despite low premiums offered by Medicaid insurers, Blue Cross Blue Shield insurers accounted for almost half of marketplace enrollment nationally in 2018. In eleven states, Blue Cross Blue Shield-affiliated insurers have all or close to all of the enrollment in those states’ marketplaces. In another nine states, Blue Cross Blue Shield insurers have the majority of the enrollment, but in some of these states, Medicaid insurers are rapidly increasing their share of the market. In another eight states, Medicaid insurers have the majority of enrollment, albeit usually with some competition from Blue-affiliated insurers or national/regional insurers. Nonetheless, the sustained importance of Blue affiliated plans is noteworthy.

We find that there are six states with national/regional insurers enrolling most of the market’s consumers. Many of the largest national insurers (Aetna, UnitedHealthcare, Humana) have left nongroup marketplaces throughout the country, but this type of insurer, along with regional insurers, remains important in some states.

Provider-sponsored insurers are important in many state marketplaces, but often they have a small share of the market. In three states (Oregon, Virginia, and Wisconsin), however, provider sponsored insurers have the largest market share.

The Kaiser Foundation Health Plan is a key player in four states (Georgia, Hawaii, Virginia, and Oregon). Finally, Co-ops still exist in some markets. In two states, Maine and Montana, they account for a majority of the marketplace enrollment.

Thus, while Medicaid insurers increasingly offer the lowest plans with the lowest premiums in a marketplace rating area, their enrollment is just a little more than half of the enrollment in Blue-affiliated plans. However, this picture is changing over time. At the same time, 2018 enrollment in national and regional insurance plans was less than half what it was in 2016. The widespread exit of these plans has reduced competition in large numbers of marketplaces. The effects of fewer insurers on marketplace premiums has been documented.⁷

There was an increase in the number of insurers participating in 2019 and 2020⁸ and there are now reports of national insurers re-entering marketplaces in 2021.⁹ Whether these insurers will regain previous levels of enrollment, e.g., 2016, will be interesting to observe.

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Tracking Health Reform

Putting The Pieces Together Again: American States and the End of the ACA's Shared Responsibility Payment

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Abstract The Tax Cuts and Jobs Act (TCJA) eliminated the ACA's "shared responsibility payment," which penalized those who failed to comply with the requirement to purchase health insurance. In this article the authors explain efforts in several states to respond to this change by adopting individual health insurance mandates at the state level. Although there are good reasons to think that states may be reluctant to consider establishing their own mandates, New Jersey, the District of Columbia, and Vermont quickly joined Massachusetts in establishing such measures in 2018. In 2019 California and Rhode Island enacted state-level mandates. Four other states—Maryland, Connecticut, Hawaii, and Washington—formally considered mandates but have not enacted them. The authors compare the policy debates among these states and one other state, New York, which has not seen a legislative proposal for a mandate despite its strong support for the ACA. Their analysis explores the dynamics within the US federal system when a key component of a complex and politically salient national initiative is eliminated and states are left with many policy, political, and administrative questions of what to do next.

Keywords health insurance, Affordable Care Act, individual mandate, state policy, federalism

When President Donald Trump signed the Tax Cuts and Jobs Act (TCJA) into law on December 22, 2017 (P.L. 115-97), the federal government effectively eliminated the penalty established by the Patient Protection and Affordable Care Act of 2010 (ACA) on individuals who failed to maintain minimum essential health coverage. The mandate itself was not eliminated—although its constitutional status has been challenged in

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federal court (*Texas v. United States*)—but the “shared responsibility payment,” penalizing those who failed to comply with the requirement, was reduced to zero. Although the mandate may exert a hortatory effect on some individuals to obtain health insurance, the end of the financial penalty will surely weaken its effect.

The individual mandate (also called the “individual responsibility requirement”) was considered a pillar of the ACA, along with guaranteed issue, community rating, and subsidies for those who cannot afford the full price of insurance. Those who drafted the mandate expected it to reduce adverse selection, prevent the least healthy people from dominating the health insurance market, and draw revenues into the insurance market from healthy, typically younger individuals (42 U.S.C. § 18091 (a)(2)(I)). Guaranteed issue and community rating without a mandate may beget an adverse-selection death spiral; a high-risk profile among insured people could lead to increased premiums, which in turn could cause healthy individuals to exit the market and further raise the risk profile (Rosenbaum 2011). Such scenarios did occur, as several states in the 1990s enacted guaranteed-issue and community-rating laws without universal mandates, resulting in “skyrocketing insurance premium costs, reductions in individuals with coverage, and reductions in insurance products and providers” (*National Federation of Independent Business (NFIB) v. Sebelius*, 567 U.S. 519, 2012; shortened hereafter *NFIB v. Sebelius* 2012).

The mandate was also viewed as a way of preventing free riding in society’s provision of health care. As Stuart Butler put it in his 1989 Heritage Foundation lecture, the idea of an individual mandate assumes an “implicit contract between households and society,” where Americans will provide health care, for example, to a person “struck down by a heart attack in the street . . . whether or not he has insurance” (Butler 1989: 6).

The same logic underlay the Massachusetts health care reform of 2006, which was signed into law by then-Governor Mitt Romney. That measure required, with some exceptions, every adult resident of the state to obtain a minimum level of insurance coverage, provided free or subsidized insurance for lower-income individuals, and established a health insurance “connector” that served as a clearinghouse for the purchase of health insurance plans (Woltmann and Gasteier 2017). The 2010 ACA encompassed versions of these basic elements: mandates, exceptions, minimum essential coverage standards, subsidies, and marketplaces. The individual mandate went into effect in 2014; in tax year 2018, payment for not having minimum essential coverage or qualifying for an exemption was \$695 per individual (up to a maximum of \$2,085) or 2.5% of household income.

The brief history of the individual mandate has not been easy. The mandate garnered much less public support than all other ACA provisions. In 2016, only 35% of survey respondents had a favorable opinion of the mandate penalty (Kirzinger, Sugarman, and Brodie 2016). Despite its conservative origins, the mandate was also the target of repeated efforts by conservative organizations and states to undercut the ACA through the federal judiciary. Nonetheless, it was upheld by the US Supreme Court in 2012, in *NFIB v. Sebelius*, as a legitimate exercise of Congress's power to tax, only to have its enforcement stripped away in 2017.

The effects of the mandate have become less clear with experience. When the Congressional Budget Office and the Joint Committee on Taxation (CBO/JCT) estimated the impact of eliminating the shared responsibility payment in December 2016, it concluded that it would increase the number of uninsured by 16 million in 2026. The CBO/JCT's revised its estimates down to 4 million uninsured people in 2019 and 13 million in 2027. Then in May 2018 its estimates were reduced again to 8 million uninsured in 2027 (CBO 2017; JCT 2018).

Analysts outside the federal government have calculated varying predictions regarding the effects of the end of the individual mandate penalty. The Urban Institute, also using a simulation study, concluded that the end of the federal mandate was substantial; that if all states adopted their own individual mandates with penalties, the number of uninsured would be reduced by 7.5 million in 2022, and insurance premiums would decline by 11.8% in 2019 (Blumberg, Buettgens, and Holahan 2018). However, another simulation-based study found that estimates of the effects of individual mandates varied widely depending on hard to measure factors affecting consumer responses, such as a desire to comply with the law, beliefs about enforcement, and inertia in decision making (Eibner and Nowak 2108). One econometric analysis found that the mandate's effects on coverage was negligible, dwarfed by the effects of health insurance premium subsidies and Medicaid expansion (Frean, Gruber, and Sommers 2017).

The hostility of conservatives and the Republican Party toward the mandate, the general unpopularity of the provision, and the uncertainty regarding its impacts on the uninsured and health insurance premiums all suggest that many states may be reluctant to consider establishing their own, state-level mandate to compensate for the loss of the federal requirement. Nonetheless, New Jersey, the District of Columbia, and Vermont quickly joined Massachusetts in establishing such measures in 2018, while California and Rhode Island enacted state-level mandates in their 2019

legislative sessions. Four other states—Maryland, Connecticut, Hawaii, and Washington—formally considered mandates but have not enacted them. By comparing their reactions to one another and one other state, New York, which has not seen a legislative proposal for a mandate despite its strong support for the ACA, we can see some of the dynamics within the US federal system when a key component of a complex and politically salient national initiative is eliminated and states are left with many policy, political, and administrative questions of what to do next.¹

Adopters

Two governments, New Jersey and the District of Columbia, quickly and fully embraced the idea of establishing their own individual mandates, enforced by financial penalties. New Jersey enacted an individual mandate in May 2018, just five months after the passage of TCJA (Keith 2018). The measure, which went into effect in January 2019, required state taxpayers subject to the mandate to have minimum essential coverage each month of the tax year. The New Jersey requirement closely follows the ACA mandate, often by reference to the federal law's penalties, coverage, and exemptions. It departs, however, from the federal provision in one respect. While revenues collected from the federal penalty are not designated for any specific purpose, revenues collected from enforcement of the New Jersey mandate finance a state-based reinsurance program, which was created in 2018 under separate legislation.

The District of Columbia also adopted an individual mandate just months after the enactment of the TCJA. In June 2018, the DC Council passed the Health Insurance Requirement, establishing a health insurance mandate that went into effect in 2019. Like the New Jersey law, the DC law was largely modeled on the federal provision. A tax penalty is assessed if the resident does not carry appropriate health insurance, with exemptions and coverage requirements mostly following federal law. But the DC law also diverged from the federal mandate in some respects. The tax penalty is determined by the DC government each year; and persons who appear to be eligible for Medicaid, based on their tax information, are automatically exempted from the penalty. Also, like New Jersey, revenues collected from

1. In addition to the sources referenced in this article, the authors relied on interviews with a variety of informants in the states discussed here. Interviewees included state agency officials, legislators and staff, advocacy organizations, insurance executives, and academic experts, including individuals in the Rockefeller Institute's ACA Implementation Research Network (rockinst.org/issue-areas/aca/).

the mandate are applied to health-related purposes, namely, support for healthcare affordability and outreach programs.

Vermont also enacted an individual mandate in 2018, scheduled to go into effect in 2020. However, details regarding the penalty, exemptions, coverage requirements, and administration were left to be addressed by the Individual Mandate Working Group, which would make recommendations to the state legislature in 2019. In November 2018, the Individual Mandate Working Group (composed of representatives of government agencies, insurers, and health advocacy groups) reported that it failed to agree on a financial penalty and appropriate affordability exemptions (Individual Mandate Working Group 2018). Some members were concerned that the penalty would fall most heavily on low-income individuals, based on analyses of who paid penalties under the federal mandate; the group only agreed to support public outreach, better monitoring, and timely data for the uninsured. In the 2019 session, legislation was introduced that included a financial penalty, modeled largely on the federal law, but that provision was struck in committee (Vermont Legislative Joint Fiscal Office 2019). Some legislators were concerned about its potential burden on low-income people, and others saw little reason to support a proposal that stood little chance of enactment, given Republican Governor Phil Scott's opposition to the penalty as a new tax.

Two states, Rhode Island and California, enacted state-level mandates and associated tax penalties in their 2019 legislative sessions. In April 2018, the Rhode Island state legislature established a Market Stability Workgroup charged with determining state-level solutions to keep the state's health insurance markets stable (HealthSource RI 2018). In June 2018, the workgroup recommended a state-based shared responsibility requirement as well as a reinsurance program and state regulation of short-term limited duration health plans. In its final January 2019 report, the workgroup confirmed its support for a state-level mandate based on the federal law, though it also recommended modifying the penalty to reduce its impact on low-income persons and dedicating revenues raised from the shared responsibility payment penalty to a state reinsurance program (Market Stability Workgroup 2019). Democratic Governor Gina Raimondo incorporated these recommendations in the 2020 executive budget (State of Rhode Island 2020), and the mandate and other workgroup recommendations were enacted in June 2019.

In California, a state mandate was discussed in 2018 in preparation for the 2019 budget process, yet no bill was introduced. Outgoing Governor Jerry Brown was not supportive; and some Democrats, who controlled

both the legislature and the executive, were concerned that the state's Republican Party might use an enacted mandate as a referendum issue, just as they had placed on the ballot and repealed a gas tax, a previous unpopular measure. California legislators instead responded in 2018 to the Trump Administration's efforts to weaken the ACA by enacting stricter regulations regarding association health plans, a ban on short-term plans, increased advertising budgets, a longer open enrollment period, and state codification of federal ACA and Medicaid laws to insulate against future federal changes.

In January 2019, however, newly elected Governor Gavin Newsom proposed, as his first act as governor, an individual mandate as part of a wide-ranging package of health care reforms (State of California, Office of Governor 2019). The mandate, which was modeled on the federal provision, was passed along with the other reforms and signed into law in June. Under the new legislation, California residents are required to have minimum essential coverage or pay a shared responsibility penalty, starting in 2020 (State of California, Legislative Analyst's Office 2019). The other reforms were intended to make health care premiums affordable for middle-class Californians. Individuals with a household income between 400% and 600% of the federal poverty level (FPL), who are not eligible for federal advanced premium tax credits, will now be eligible for state premium assistance. Undocumented immigrants between the ages of 19 and 25 will qualify for the state's Medi-Cal program. The state will also supplement federal assistance with state aid for persons with a household income between 139% and 400% of the FPL. A combination of an individual mandate and health care subsidies was estimated in a February 2019 report by Covered California, the state's health insurance marketplace, to increase new health insurance enrollment at the lowest amount of new state spending (Covered California 2019). The mandate was expected to add enrollees, while payments by uninsured individuals under the shared responsibility penalty would help finance the subsidies.

Concepts, Proposals, but No Adoptions

In Maryland, Connecticut, Hawaii, and Washington State, legislative proposals establishing state-level mandates were introduced in the legislature yet not enacted.

In 2017, Maryland's legislature established a group, the Maryland Health Insurance Coverage Protection Commission, to develop a "response to and in anticipation of efforts at the federal level to replace the ACA." The

commission's December 2017 report made no recommendations, though it discussed a state individual mandate, including an innovative pilot program to allow persons subject to the tax penalty to apply the payment toward the purchase of health insurance in the following year (Maryland Health Insurance Coverage Protection Commission 2017).

In the 2018 legislative session, that idea was incorporated in a proposal by Democratic legislators for the creation of a Health Insurance Down Payment Escrow Fund (Cousart 2018). Consumers without minimum essential coverage in the prior tax year would be subject to the mandate penalty; the payment, however, could serve as a down payment for health insurance in the current year. Individuals could apply their payment to the purchase of health insurance, or they could indicate on their tax forms that they wanted coverage. If they requested coverage, the state would calculate whether the payment plus available federal subsidies would cover the full costs of insurance; if so, the individual would automatically be enrolled in a plan. If the consumer chose not to purchase insurance, the money would be held in escrow for a year and remain available as a future down payment. If the funds were still not used, the revenues from the penalty would go into a state fund. The legislature, however, did not pass the bill. There were concerns about its administrative feasibility and a possible veto by Republican Governor Larry Hogan.

In late 2018, the Coverage Commission again released a report reviewing options for a state-based individual mandate while making no recommendation (Department of Legislative Services 2018); and though bills with a mandate penalty were again introduced in the 2019 state legislative session, none passed. Instead, the legislature passed the Maryland Easy Enrollment Health Insurance Program. Rather than mandating enrollment, the program would actively seek out and recruit new enrollees, using income tax information (Maryland General Assembly, Department of Legislative Services 2019). The state would identify uninsured individuals through state income tax returns and determine whether they wanted health insurance. If they did, state personnel would work with them to enroll in Medicaid, the state's children's health program, premium tax credits, cost-sharing reductions, or other insurance options and subsidies they might qualify for. The legislation also established an advisory work group charged with reporting back to the legislature on the program's implementation and effectiveness and, by December 2022, on whether it would recommend an individual mandate, enforced by a financial penalty, or automatic enrollment of individuals in a qualified health plan.

Connecticut also considered a state-level mandate that would have permitted consumers to apply their tax penalties toward the purchase of health insurance in a subsequent enrollment period. Two bills were introduced in 2018 that would have established an individual mandate penalty. One closely followed the federal mandate though with smaller fines; another would have deposited the fines into health savings accounts for the individuals penalized. The latter proposal resembled the Maryland plan, though it more directly targeted free riders and uncompensated care in the health care system by imposing penalties equal to what the individual would need to pay for insurance and depositing the fine into an account that the individual could use to pay health care bills or purchase insurance. However, neither bill passed in 2018 due to confusion over the two bills and the overriding focus of the session on the state's financial challenges, according to some observers.

In Connecticut's 2019 legislative session, a statewide individual mandate, like the federal law, was proposed in combination with the Connecticut Option, a subsidized health insurance option offered through insurance companies and available on the Connecticut Health Insurance Exchange (Hughes 2019). The mandate and public option, however, were stripped from the final bill; what remained was authority for state officials to seek permission from the federal government to import less expensive drugs from Canada.

Hawaii established a working group in 2017 to formulate proposals to preserve the ACA's consumer protections in the face of federal efforts to undermine the ACA. In January 2018, the working group produced a report that forecast the problems that could result from the elimination of the federal individual mandate, though the group did not recommend a state mandate. Nonetheless, several bills were introduced in the state legislature in 2018, including provisions for a mandate and reinsurance. The measures failed to pass though some ACA codifications were enacted, including limits on the sale of short-term insurance plans. Some observers suggested that the mandate garnered little support because Hawaii has, since 1974, required employers to provide health insurance to their employees (State of Hawaii 2018), and because the state already has one of the highest rates of insurance coverage in the US (about 96% in 2016).

A state-level mandate was also introduced in the Washington state senate in 2018, one closely aligned with the federal requirement. But the measure was complicated by the fact that Washington has no income tax. To address that obstacle, the bill would have established a task force to develop recommendations on how to implement a mandate. The bill passed in the

senate by a party-line vote but died in the house, in large part because of uncertainty about the mandate's practicality. This was not a new issue for Washington. The state passed an individual mandate to have health insurance coverage back in 1993 and established a task force to develop legislation to enforce it; yet, even after two years, the task force failed to devise a solution.

In lieu of the mandate, the state adopted several other measures in 2018 to counter the effects of the federal actions to undermine the ACA, including strict regulations regarding short-term duration insurance plans and state funding for outreach and enrollment support. Washington also created a form of a public/private option for health insurance purchasing. The state centralized school employee benefits by allowing employees to buy into the state government plan, which was served by private insurers. The new legislation, aimed at eliminating "bare counties," required insurers that provided benefits to school employees in a county to also offer services to other individuals in the county through the exchange (Riley 2018).

The Dog That Didn't Bark

Despite deep political support for comprehensive health care coverage in New York, it has not seen a formal proposal for a state-level individual mandate. There were discussions in the executive branch about including such a measure in the 2019 budget, and the state health department commissioned independent simulations estimating the effects on premiums and enrollment of the TCJA and other federal actions aimed at weakening the ACA. The analyses anticipated significant increases in premiums and decreases in exchange enrollments, with most of the reduction in participation occurring among younger, healthier people.

New York State officials, however, believed these effects could be mitigated by other means. For the 2019 open enrollment period, the Department of Financial Services held premium increases down to 8.5%, rejecting many rates proposed by insurers, who sought widely varying increases, some as high as 24%, half of which insurers justified by the loss of the mandate. New York also considered its Basic Health Plan (also called the Essential Plan), which only requires a \$20 monthly premium for individuals between 138% and 200% of the FPL, to be so affordable that it would keep many lower-income families in health insurance despite the end of the mandate. The state also fully funded consumer outreach and assistance, compensating for the end of federal support for those activities.

In light of these measures and New York's already low level of uninsured (less than 5%), executive officials took a wait-and-see approach

regarding a state mandate in the executive branch, while there was no discussion of the option in the legislature. New York's 2019 open enrollment period confirmed the continued strength of the market. Enrollment in the state's Qualified Health Plans and Essential Plans increased by 7% between 2018 and 2019, with little change in the distribution of enrollees by age (New York State of Health 2019).

Shifting Contexts, State Approaches to Individual Mandates, and Implications for Federalism

Enacting a state-level individual mandate is no easy task. That is not surprising given the national-level unpopularity of the mandate, but the mandate was viewed by many health policy experts to be an essential component of the ACA, and the act enjoyed political support in the states considered here. In Maryland, for example, polls put the ACA's support at 62%, and 52% favored a state-based mandate. However, after Congress zeroed out the penalty, and the question of personal responsibility for health insurance fell to the states, the issues and context changed, and those changes generally worked against widespread and rapid diffusion.

First, when considered on its own by the states, the mandate penalty was more distinctly viewed as a tax. Of course, it was a tax, administered by the Internal Revenue Service. But in its original, national frame, the mandate and the penalty were primarily treated as a pragmatic mechanism to enforce the goals of health insurance coverage, market stability, and personal responsibility, and the decision to implement the mechanism through the tax system was born of convenience. The ACA nowhere refers to the shared responsibility payment as a tax, and in *NFIB v. Sebelius* the IRS was barred from using its typical enforcement powers, such as criminal prosecutions and levies, in ensuring compliance.

When viewed as a tax, the mandate penalty gave rise to a new question: Who pays the tax, and how fair is the distribution of burdens? Vermont found that, as a tax, the penalty was highly regressive. Using 2016 federal income tax returns, the state's working group learned that 92% of the federal penalties fell on persons with adjusted gross incomes between \$10,000 and \$75,000, with about half of the penalized taxpayers in the \$25,000 to \$50,000 range (Individual Mandate Working Group 2018).² That finding contributed to the inability of the working group to reach

2. Levitis (2018) argues that analyses showing a disproportionate impact on low-income taxpayers may be incorrect, because many of the individuals who pay the penalty may be eligible for Medicaid or an exemption. He suggests that improved outreach, consumer assistance, and administration may minimize the problem (Levitis 2018).

consensus on the state-level mandate penalty. Other states also noted the regressive incidence of the penalty. Proposals in Maryland and Connecticut, for example, sought to reduce burdens on lower-income individuals by allowing them to apply the penalty toward the purchase of health insurance or health care.

Second, state implementation of the ACA increased uncertainty about the effects of the mandate, while other measures gained credibility as means of ensuring coverage. The research findings have been mixed: some estimated that the effects of subsidies and the Medicaid expansion have been much greater. Based on a consumer survey, New York State found that the most important factor for consumers in deciding to acquire insurance was cost, a finding consistent with the success of the state's Basic Health Plan in providing affordable insurance to lower-income individuals and households not eligible for Medicaid (Blumberg et al. 2018).³ The states we examined cited several other means of maintaining or extending insurance coverage, including "silver loading," which maximizes federal subsidies to persons buying insurance on the exchanges; state insurance commissioners exercising their authority to reject large annual increases in premiums; and state funding of advertising and other consumer outreach and assistance programs.

In sum, the individual mandate has increasingly appeared as one tool among several to boost enrollment and stabilize markets rather than an indispensable pillar; and in some states, a state-level mandate was outflanked by more politically attractive measures. At the political center, several states found reinsurance proposals to be attractive, especially if federal 1332 waivers permitted estimated federal savings to be invested in the reinsurance programs. On the left, interest in single-payer systems in New York and, at least initially, California may have siphoned away some political support for reinstating the mandate. In Hawaii, the state's long-standing employer mandate and its effectiveness in ensuring widespread health insurance coverage was cited as one reason why an individual mandate was not adopted.

Third, implementation of the mandate appeared to be more difficult for state governments than for the federal government. The case of Washington State was obvious; without a personal income tax, the state

3. Blumberg and colleagues estimated that New York would see little impact from adopting a mandate penalty because of its Basic Health Plan. Minnesota also offers the very affordable Basic Health Plan to persons between 138% and 200% of the FPL. Interviews with Minnesota legislators also brought up the Basic Health Plan as a reason why a mandate may not be needed (Blumberg et al. 2018).

had no clear path to an enforceable requirement. Yet other states also faced challenges. Officials in several states indicated that their health and tax agencies had not shared information in the past, much less worked together, in ways that enforcement of the mandate would require. Vermont's working group concluded that the financial penalty would be costly to administer, and one of the reasons given by Rhode Island officials for doing more analysis before proposing an individual mandate was to find out whether the state tax agency could handle the responsibility for administering the requirement.

Considering these obstacles, it may be surprising that any states adopted an individual mandate. Yet some did, and others may eventually follow. How they did it and how other states are trying to do it reveal some interesting pathways for policy change.

New Jersey and the District of Columbia showed one approach by acting quickly and minimizing policy changes. By enacting measures that closely followed the federal mandate only months after Congress eliminated the tax penalty, these governments appeared to patch up what Congress and the president had taken away. A state-level mandate was thus enacted by retaining its place within the political frame of the locally popular federal ACA. Although both governments added a new dimension by designating revenues from the mandate penalty to a future reinsurance program (New Jersey) or other outreach and affordability measures (DC), these additions were left in general terms, with details to be worked out in future legislation.

Vermont did something similar. It quickly enacted a mandate yet put off decisions about the penalties, exemptions, and implementation by creating a working group to submit recommendations to the state legislature in its 2019 session. That delay, however, had the effect of shifting the political frame away from the quick-patch job and toward seeing the mandate as a distinct policy. Now viewed as a tax policy, and one that disproportionately burdened Vermonters with low to moderate incomes, it was a point of disagreement, along with exemptions for affordability and members of health care sharing ministries, that led to the failure of the state to enact a shared responsibility penalty in 2019.

A second approach was to create a new package around the state mandate, one that linked the mandate to more popular policies. California incorporated its mandate within a system of new premium subsidies. New Jersey and Rhode Island sought to use revenues from the tax penalty to finance reinsurance programs. Other, quite innovative approaches were proposed in Maryland and Connecticut, both of which addressed unfair tax burdens. The proposal in Maryland would have permitted individuals to use penalties levied against them to buy insurance. In Connecticut, one bill would

have channeled the mandate penalties, which were larger than the federal amounts, into a personal health care savings account that the individual could use to pay the cost of health care in current and future years. Of course, neither Maryland nor Connecticut enacted these reforms, so it is still unclear whether such packages would work as alternative approaches. It is also unclear whether such policies are sustainable, as they reflect an inconsistency regarding the purpose of the penalty: Is it expected to shape behavior and eventually wither away, or will it be an enduring source of financial support for health-related programs?

One general finding from these reactions is that states that strongly supported the ACA responded to the end of the shared responsibility payment not simply by reenacting it but by considering how to sustain key outcomes—increasing affordable and comprehensive health care coverage to nearly all state residents—in the absence of an enforceable federal mandate. The TCJA spurred state action, though the actions varied locally and included measures that went beyond efforts to replicate the federal payment at the state level. Of course, Republican Party opposition to the ACA limited the potential spread of state efforts to bolster the program, and the mandate's rationale as a *personal responsibility* to pay for health insurance may not be widely endorsed even in states with Democratic majorities.

This diversity of state responses to national actions to weaken the ACA may stem from these and other challenges in establishing a state-level mandate. Yet it is also true that states are drawing from their particular experiences and political situations to fashion responses aimed at achieving critical health insurance outcomes. This emphasis on results reflects a state-level endorsement of the basic goals of the Affordable Care Act, at least in these states. National policy retrenchment may repercuss through the federal system and generate compensatory action, though not necessarily replacing what the federal government took away.

Such reactions may be part of an important dynamic in US federalism. Some states will embrace the goals promoted by policies enacted by a national administration, and after institutionalizing those goals and policies, their commitments may strengthen. If party control of the national government changes, as it frequently has in recent decades, states with the strongest commitments to the policy goals may, if local politics permit, adopt policies that defend those goals against national-level policy reversals. However, states' defense of prior policy initiatives may be quite varied. A possible consequence of this sequence may be a growing division among states, manifested by an increase in policy innovation and implementation

capacity among a few states sufficiently motivated and politically and administratively able to sustain prior national initiatives in the face of national opposition, while other states continue to be buffeted by policy changes generated by a national government of increasingly uncertain control.

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May 2020

Making ACA Enrollment More Automatic for the Newly Unemployed

This report is available online at: <https://www.brookings.edu/research/making-aca-enrollment-more-automatic-for-the-newly-unemployed/>

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EDITOR'S NOTE

This white paper is part of the USC-Brookings Schaeffer Initiative for Health Policy, which is a partnership between the Economic Studies Program at Brookings and the USC Schaeffer Center for Health Policy & Economics. The Initiative aims to inform the national health care debate with rigorous, evidence-based analysis leading to practical recommendations using the collaborative strengths of USC and Brookings.

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Executive Summary

Tens of millions of Americans are expected to lose their job-based health insurance amid the COVID-19 pandemic and the associated increase in unemployment.¹ Most people in this group are eligible for coverage through Medicaid or through subsidized coverage in the individual market,² but historically take-up of new coverage among those exiting employer-based insurance – particularly those eligible for the individual market – has been quite low.³ This paper uses survey data to examine how many people exiting employer coverage become uninsured in normal times, and how the share that become uninsured has changed since implementation of the Affordable Care Act. We also make a series of policy recommendations to better support enrollment into Medicaid or Marketplace coverage after a loss of job-based insurance.

Specifically, using the Medical Expenditure Panel Survey Household Component, we find that:

- On average, 452,000 people per month left employer coverage for a spell of uninsurance lasting at least 3 months over the period from January 2016 to July 2017, comprising 54% of the total number of people who exited employer coverage during that time period.
- The share of people who exit employer coverage who become uninsured for 3 months or more was 25% higher prior to implementation of the Affordable Care Act.

These data suggest that the Affordable Care Act reduced the risk that losing job-based coverage would result in becoming uninsured, but also demonstrate that important opportunities remain to increase coverage by targeting people who have recently lost job-based insurance. While not everyone who loses employer-based coverage qualifies for or receives unemployment insurance (UI), state UI agencies serve a population that is disproportionately likely to be recently uninsured. To help this group connect to coverage, UI programs can take steps to make coverage enrollment more automatic. States' options, ranging from least to most resource intensive, include:

- Providing general enrollment related information within the UI application and at periodic UI recertification.
- Providing personalized and interactive information regarding likely eligibility at application and recertification.
- Partnering with nonprofit insurance assisters, other state agencies, or web-brokers to refer UI consumers for enrollment support.
- Build an integrated UI and health coverage application in partnership with a state-based Marketplace or web-broker.

States should consider what steps they can take now, and what investments they can make over the medium-term, especially in the context of other improvements to UI technology. In addition, federal policymakers and those administering state-based Health Insurance Marketplaces have options to

¹ Anuj Gangopadhyaya and Bowen Garrett, "How the COVID-19 Recession Could Affect Health Insurance Coverage," *Urban Institute*, May 4, 2020, <https://www.rwif.org/en/library/research/2020/05/how-the-covid-19-recession-could-affect-health-insurance-coverage.html>; U.S. Department of Labor, "Unemployment Insurance Weekly Claims," May, 21, 2020, <https://www.dol.gov/ui/data.pdf>.

² Christen Linke Young, "What Do I Do if I Lose My Job-Based Health Insurance?" *Brookings Institution*, March 17, 2020, <https://www.brookings.edu/blog/use-brookings-schaeffer-on-health-policy/2020/03/17/what-do-i-do-if-i-lose-my-job-based-health-insurance>.

³ Gary Claxton, Anthony Damico, Rachel Garfield, and Larry Levitt, "Eligibility for ACA Health Coverage Following Job Loss." *Kaiser Family Foundation*, May 13, 2020, <https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss>; Matthew Buettgens, Stan Dorn, and Hannah Recht, "More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods," *Urban Institute*, November 2015, <http://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf>.

make enrollment easier for those exiting employer coverage. They can eliminate burdensome and unnecessary verification requirements, broaden eligibility for Special Enrollment Periods (SEPs), and consider making financial assistance more predictable for this group.

Introduction

COVID-19 and accompanying physical distancing measures have caused unprecedented job losses. More than 20 million people have lost their jobs, and the unemployment rate is now approaching 15%, the highest rate since the Great Depression.⁴ Amid this job loss, tens of millions of people are expected to lose their employer-based health insurance. Researchers at the Urban Institute estimate that if unemployment reaches 20%, 25 to 43 million people will lose job-based health coverage and 7 to 12 million will become uninsured, though the actual number of uninsured may be higher.⁵

This increase in uninsurance is harmful to both those who lose coverage and to the health care system, yet is unnecessary. Since enactment of the Affordable Care Act, most people who lose coverage during an employment transition are eligible for subsidized coverage in the individual market or through Medicaid.⁶ Yet this group has historically been unlikely to actually enroll in ACA coverage. Researchers examining coverage transitions in the first year after the ACA's reforms went into effect found no significant impact on the likelihood of an individual becoming uninsured after employer coverage, even as uninsurance across other groups declined precipitously.⁷ Moreover, available data suggest very low initial uptake of coverage among those exiting employer coverage and eligible for an individual market plan. Those losing job-based insurance outside of the 6-week annual open enrollment period each fall must use a Special Enrollment Period (SEP) to enroll in coverage mid-year. Yet based on 2015 data, researchers estimate that only 5% of those eligible for mid-year enrollment were enrolled, though significant uncertainty surrounds their estimates.⁸

⁴ U.S. Department of Labor, "Unemployment Insurance Weekly Claims," May 21, 2020, <https://www.dol.gov/ui/data.pdf>; U.S. Bureau of Labor Statistics, "Employment Situation Summary," May 8, 2020, <https://www.bls.gov/news.release/empsit.nr0.htm>.

⁵ Anuj Gangopadhyaya and Bowen Garrett, "How the COVID-19 Recession Could Affect Health Insurance Coverage," *Urban Institute*, May 4, 2020, <https://www.urban.org/en/library/research/2020/05/how-the-covid-19-recession-could-affect-health-insurance-coverage.html>. As the authors note, these results may significantly understate the amount of uninsurance that results from mid-year coverage loss. The analysis assumes that the group recently losing employer coverage enrolls in ACA coverage at the same rate as other similarly situated people without employer coverage, but that ignores the depressed rate of mid-year enrollment, as discussed below.

⁶ Christen Linke Young, "What Do I Do if I Lose My Job-Based Health Insurance?" *Brookings Institution*, March 17, 2020, <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/03/17/what-do-i-do-if-i-lose-my-job-based-health-insurance>.

⁷ John Graves and Sayeh Nikpay, "The Changing Dynamics of US Health Insurance and Implications for the Future of the Affordable Care Act," 36 *Health Affairs* 297 February 2017, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1165>.

⁸ Matthew Buettgens, Stan Dorn, and Hannah Recht, "More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods," *Urban Institute*, November 2015, <http://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf>. Publicly available administrative data on SEP enrollment is sparse, but similarly suggests very low uptake. During calendar year 2017, the most recent year for which complete data is available, 1.1 million people selected a Marketplace plan through a SEP in the states served by HealthCare.gov that year. This includes 670,000 people (60%) who applied through the SEP associated with losing other coverage. This is somewhat below what would be expected based on prior data showing that between 15,000 and 40,000 people per week used an SEP to enroll on HealthCare.gov in 2016, and that 800,000 people enrolled on HealthCare.gov via an SEP during four-and-half months in 2015, 59% through the loss of coverage SEP (excluding the special SEP associated with the 2015 tax filing season that was only available that year). Finally, in a 2020 rulemaking, the federal government reported that HealthCare.gov had verified SEP eligibility for more than 800,000 people during 2018 and 2019 combined, but not all SEPs require verification. See Centers for Medicare & Medicaid Services, "The Exchanges Trends Report," July 2, 2018, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-3.pdf>; Centers for Medicare & Medicaid Services, "Pre-Enrollment Verification for Special Enrollment Periods," <https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf> (last visited May 28, 2020); Centers for Medicare & Medicaid Services, "2015 Special Enrollment Period Report – February 23–June 30,

This paper lays out strategies to address this gap and help more people who lose employer-based coverage to successfully transition to Medicaid or the individual market. We begin by using survey data to quantify how many people transition from employer coverage into uninsurance. To reach this group, we recommend state unemployment insurance agencies pursue a series of strategies to promote coverage, ranging from providing health insurance information within their workflows to building a fully integrated application. Finally, we consider federal and Marketplace policies that could help improve coverage take-up among those exiting employer insurance.

How Many People Leaving Job-Based Coverage Become Uninsured?

The Medical Expenditure Panel Survey-Household Component (MEPS-HC) is a nationally representative longitudinal survey conducted in two-year waves, with a new wave beginning each calendar year. Each MEPS-HC Longitudinal Data File reports coverage status and coverage type for individuals in 24 consecutive months.

We analyzed MEPS data from July 2010 to June 2017 and tallied the number of people who experienced two types of transitions:

- **Single-month transitions:** We examined people who had employer coverage in one month and were uninsured in the next month. This represents everyone who experienced a transition out of employer coverage and into uninsurance, however briefly. In our results, we express this as a level and as a share of all individuals who had employer coverage in one month and did not have it in the next.
- **Three-month transitions:** We examined people who had employer coverage in one month, followed by three consecutive months of uninsurance. This is intended to capture those who experience a stable spell of uninsurance. As above, we express this as a level and as a share of all individuals who had employer coverage for a month followed by three consecutive months without employer coverage.

We restricted the analysis to individuals under 65 at the end of the first survey year for whom data was collected for all five rounds of interviews covering the two full calendar years. Employer coverage was defined as having health insurance coverage from an employer or union or from TRICARE/CHAMPVA. Uninsurance was defined as having no public or private health insurance. We calculated point estimates and standard errors that account for the survey's complex sample design based on the guidelines in the MEPS-HC documentation.⁹ Results are calculated monthly, drawn from the middle 12 months of each MEPS-HC survey wave (July of year one through June of year two).

Results

In general, this analysis reveals that while there are signs of improvement since 2014 in both the number of and rate at which people who leave employer coverage become uninsured, many people still fail to obtain other coverage after leaving employer-based insurance.

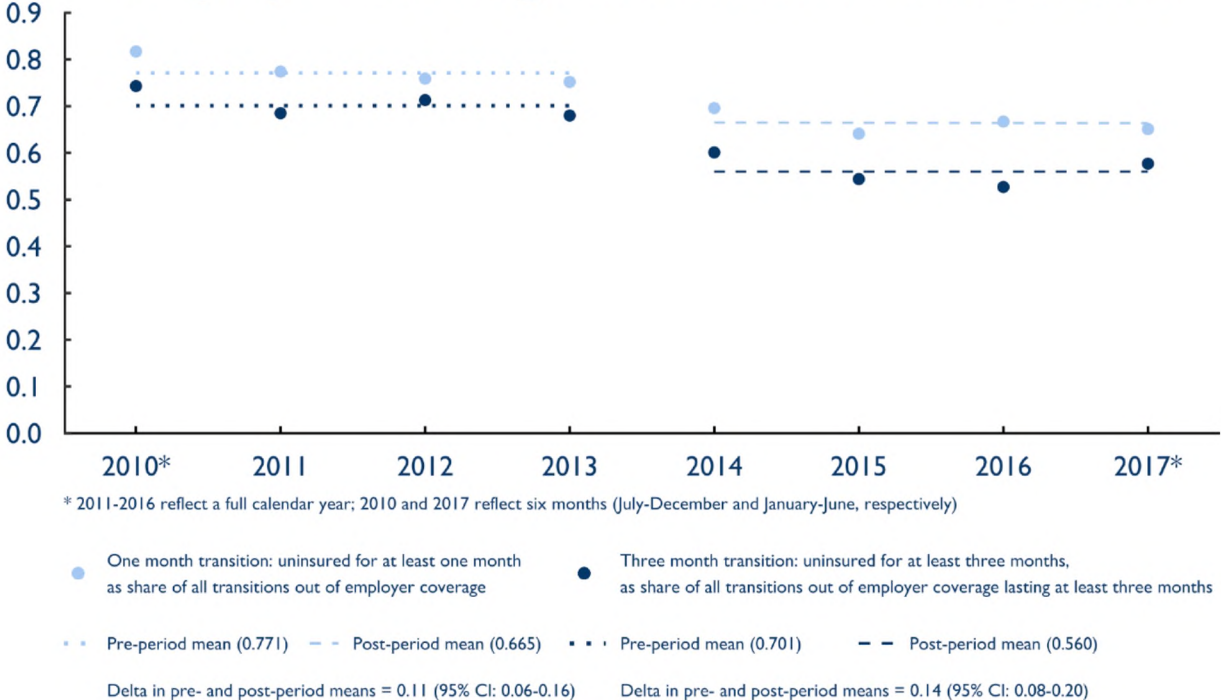
Figure 1 depicts the share of transitions out of employer coverage that result in uninsurance before and after implementation of the ACA's core coverage provisions in January 2014. (Note that this is not intended to represent the share of people *losing* their job who become uninsured; it includes all

2015," August 13, 2015, <https://www.cms.gov/newsroom/fact-sheets/2015-special-enrollment-period-report-february-23-june-30-2015>; "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Government Plans," 85 Fed. Reg. 29164 (May 14, 2020), <https://www.federalregister.gov/documents/2020/05/14/2020-10045/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2021>.

⁹ Steven Machlin, William Yu, and Marc Zodet, "Computing Standard Errors for MEPS Estimates," *Agency for Healthcare Research and Quality (AHRQ)*, https://meps.ahrq.gov/survey_comp/standard_errors.jsp.

coverage transitions without regard to changes in employment status.) The figure displays transitions lasting at least one month and transitions lasting at least three months. As shown, point estimates indicate that implementation of the ACA was associated with an 11 percentage point decrease in the share of people leaving employer coverage who become uninsured for at least one month (to 67%), and a 14 percentage point decrease in the share of people leaving employer coverage who become uninsured for at least three months (to 56%). These estimates are statistically significantly different from zero, albeit subject to some uncertainty.¹⁰

Figure I: Share of Transitions Out of Employer Coverage that Result in Uninsurance



Source: MEPS 2010-2017, authors' calculations.

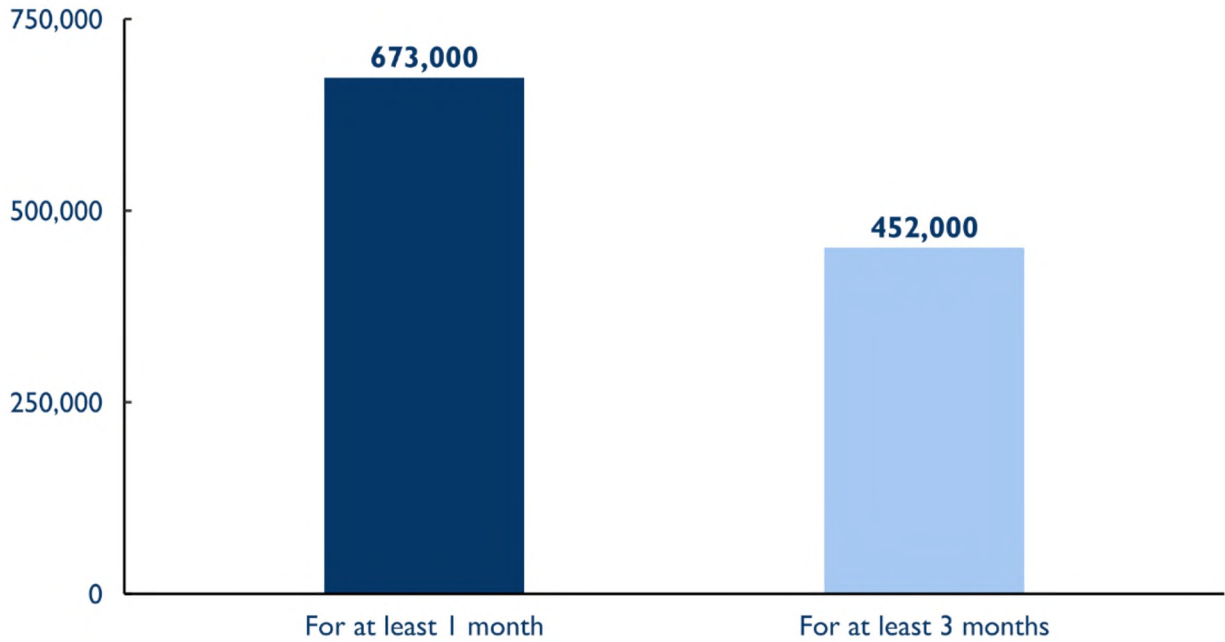


Regardless of improvement we may have seen since 2014, these data reveal that the *number* of people exiting employer coverage into uninsurance remains large. Figure 2 illustrates the number of people per month that leave employer coverage for uninsurance. In the 18 months from January 2016 through June 2017, an average of 452,000 people per month became uninsured for at least three consecutive months after having had employer coverage in the preceding month. An average of 673,000 people

¹⁰ Note that our finding differs from that of Graves and Nikpay (2017). Using MEPS-HC data, they examined the likelihood of a person transitioning from employer coverage to uninsured over 24 months, finding no significant difference between the 24 months ending December 2013 (12.6% of those with employer coverage become uninsured) and the 24 months ending December 2014 (11.9% of those with employer coverage become uninsured). The three additional years of post-period data available to us are likely the most important factor explaining the different result here, though we have not replicated their methodology. See John Graves and Sayeh Nikpay, "The Changing Dynamics of US Health Insurance and Implications for the Future of the Affordable Care Act," 36 *Health Affairs* 297 (February 2017), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1165>.

per month experienced at least one month of uninsurance after having had employer coverage in the preceding month.

Figure 2. Monthly Number of People who Leave Employer Coverage and Become Uninsured



Source: MEPS January 2016-June 2017, authors' calculations

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Limitations

There are several limitations to this analysis. First, there may be inaccuracies with the MEPS reported coverage type. For example, one validation study noted that MEPS respondents underreport insurance coverage; the authors estimated that around 10% of those that indicate they are uninsured actually have private insurance.¹¹ This may lead us to overstate the number of people who leave employer coverage and become uninsured, although if the reporting errors remain constant over time, the impact of errors on our estimates of trends is likely to be small. Second, panel survey like MEPS can suffer from “seam bias” in which people report different coverage status in successive interviews even if their true coverage status did not change. The direction of any bias in our estimates attributable to seam bias is uncertain. Lastly, the denominator of our estimate -- the number of all transitions out of employer coverage -- includes people who voluntarily leave employer coverage for other coverage like Medicare or Medicaid. An increase in these transitions will skew the share of people leaving coverage to uninsurance downward. However, we also see a downward trend in the number of transitions to

¹¹ Steven C. Hill, “The Accuracy of Reported Insurance Status in the MEPS.” 44 *Inquiry* 443 (2007), https://journals.sagepub.com/doi/pdf/10.5034/inquirv1rn1_44.4.443.

uninsurance (the numerator of our result) suggesting this will not cause huge distortions in our estimates.

The Unemployment Insurance System Can Promote More Automatic Enrollment

The data above reveal more can be done to support enrollment into coverage as individuals exit employer-based coverage: nationwide, more than 450,000 people each month transition from employer coverage to being uninsured. Targeted efforts to enroll people exiting employer-based coverage in Medicaid or individual market coverage would expand insurance coverage, benefiting the enrollees themselves and the individual market risk pool, while reducing uncompensated care. Leveraging state unemployment insurance (UI) systems to promote a simpler and more automatic enrollment experience could promote these objectives.

To be certain, not everyone leaving employer coverage will interact with their state UI agency. Unemployment insurance is generally only available to unemployed workers who meet certain thresholds for employment duration and earnings, leave a job involuntarily and not for cause, and meet other criteria. (COVID-19-related policy changes have temporarily broadened the pool of individuals eligible for UI.) But people can exit employer-based coverage into uninsurance after a voluntary separation from an employer, after changing to a new job, or because their current employer's coverage becomes too expensive. Nonetheless, there is significant overlap between ACA coverage eligibility and potential eligibility for unemployment insurance benefits.¹²

The UI System

Unemployment insurance is a state-run program, financed by taxes on employers and operating within federal standards.¹³ Workers who have sufficient prior earnings and who are unemployed through no fault of their own are generally eligible for up to 6 months of cash benefits (more during recessions); payment amounts vary by state but on average replace about half of pre-unemployment income. Congress has added additional more generous federally-funded benefits associated with COVID-19.¹⁴ In 2018, 1.8 million workers received UI benefits, and amid the COVID-19 crisis more than 20 million people are currently receiving UI.¹⁵

Historically, take-up of UI benefits among eligible workers has been higher than take-up of health coverage programs. A variety of estimates suggest that, in recent years, about three quarters of those eligible for UI enroll.¹⁶ Note, though, that those enrolled in UI encompass less than one third of the

¹² Stan Dorn, et al., "Overlapping Eligibility and Enrollment: Human Services and Health Programs Under the Affordable Care Act," *Urban Institute*, December 23, 2013, <https://www.urban.org/sites/default/files/publication/22206/413028-Overlapping-Eligibility-and-Enrollment-Human-Services-and-Health-Programs-Under-the-Affordable-Care-Act.PDF>.

¹³ Chad Stone and William Chen, "Introduction to Unemployment Insurance," *Center on Budget and Policy Priorities*, July 30, 2014, <https://www.cbpp.org/research/introduction-to-unemployment-insurance>.

¹⁴ Manuel Alcaíá Kovalski and Louise Sheiner, "How Does Unemployment Insurance Work? And How Is It Changing During the Coronavirus Pandemic?" *Brookings Institution*, April 7, 2020, <https://www.brookings.edu/blog/up-front/2020/04/07/how-does-unemployment-insurance-work-and-how-is-it-changing-during-the-coronavirus-pandemic/>.

¹⁵ Ryan Nunn and David Ratner, "Rethinking Unemployment Insurance Taxes and Benefits," *Urban-Brookings Tax Policy Center*, October 28, 2019, https://www.taxpolicycenter.org/sites/default/files/publication/157920/rethinking_unemployment_insurance_taxes_and_benefits_research_report.pdf; U.S. Department of Labor, "News Release: Unemployment Insurance Weekly Claims," May 7, 2020, <https://oui.doleta.gov/press/2020/050720.pdf>.

¹⁶ Dahlia K. Remler and Sherry A. Glied, "What Other Programs Can Teach Us: Increasing Participation in Health Insurance Programs," 93 *American Journal of Public Health* 67 (January 2003), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447695/>; Ryan Nunn and David Ratner, "Rethinking Unemployment Insurance Taxes and Benefits," *Urban-Brookings Tax Policy Center*, October 28, 2019, https://www.taxpolicycenter.org/sites/default/files/publication/157920/rethinking_unemployment_insurance_taxes_and_benefits_research_report.pdf; Stéphane Auray, David L. Fuller, and Damba Lkhagvasuren, "Unemployment Insurance

unemployed.¹⁷ This reflects the fact that many unemployed people are ineligible, either because they left employment voluntarily, have exhausted their benefits or, more commonly, because they earned too little in the prior time period to qualify.

UI generally serves households with incomes above the poverty line. For example, at the peak of the Great Recession, only 14% of families receiving UI in 2009 had annual income for 2009 below the poverty level; 19% had annual income between 100% and 200% percent of poverty, and 67% of households had annual income more than double the poverty level.¹⁸ Through 2018, middle and higher income workers are about twice as likely to receive UI benefits as the lowest-wage households.¹⁹

To receive UI benefits, individuals generally apply online through a state website, with telephone and in-person applications also available. State UI agencies take some time to process applications – typically 2-3 weeks prior to the COVID-19 crisis. After eligibility is determined, benefits are paid weekly or biweekly. However, beneficiaries must visit the UI website every week or every two weeks to “recertify” their eligibility for benefits – confirming that they remain willing and able to work and are not yet employed. Those who do not recertify do not continue to receive benefits.

Health Coverage Opportunities

This framework presents an important opportunity to encourage enrollment into health coverage. First, there appears to be significant eligibility overlap between the two programs. As noted above, most UI recipients have incomes that would make them eligible for Marketplace coverage, and some have incomes in the Medicaid range (though it is unclear the extent to which the income distribution of uninsured UI recipients parallels the income distribution of the program as a whole). And, of course, this is a population that is disproportionately likely to have recently become uninsured.

Equally significant, the process of applying for and receiving UI lends itself to efforts to facilitate health coverage enrollment. People generally obtain UI benefits by submitting an online application that is similar to the type of online application used for Marketplace and Medicaid coverage, so consumers are already accustomed to the process and have assembled relevant information. In addition, UI beneficiaries interact with the online UI system several times per month to recertify their eligibility, creating multiple opportunities to encourage health care enrollment. Finally, much of the information needed to apply for health coverage overlaps with information provided on the UI application, creating potential opportunities to streamline enrollment.

Options for State UI Agencies

States have a number of options to support enrollment into health insurance among those applying for and receiving UI benefits. Ranging from least to most resource intensive, states can:

- Provide general enrollment related information within the UI application and at recertification.
- Provide personalized and interactive information regarding likely eligibility in the application and recertification.

Take-Up Rates in an Equilibrium Search Model,” 112 *European Economic Review*1, (February 2019),

<https://www.sciencedirect.com/science/article/pii/S0014292118301855?via%3Dihub>.

¹⁷ Stéphane Auray, David L. Fuller, and Damba Lkhagvasuren, “Unemployment Insurance Take-Up Rates in an Equilibrium Search Model,” 112 *European Economic Review*1, (February 2019),

<https://www.sciencedirect.com/science/article/pii/S0014292118301855?via%3Dihub>.

¹⁸ Congressional Budget Office, “Unemployment Insurance Benefits and Family Income of the Unemployed,” November 17, 2010, <https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/reports/11-17-unemploymentinsurance.pdf>.

¹⁹ Ben Zipper and Elise Gould, “Without Fast Action From Congress, Low-Wage Workers Will Be Ineligible for Unemployment Benefits During the Coronavirus Crisis,” *Economic Policy Institute*, March 26, 2020, <https://www.epi.org/blog/without-fast-action-from-congress-low-wage-workers-will-be-ineligible-for-unemployment-benefits-during-the-coronavirus-crisis/>.

- Partner with nonprofit insurance assisters, web-brokers, or other state agencies and refer consumers for enrollment support.
- Build an integrated UI and health coverage application in partnership with a state-based Marketplace or web-broker.

All of these pathways would create a simpler and more automatic enrollment experience, with individuals able to move more easily from the UI process to a health coverage application. They would not represent truly automatic enrollment – though some variations of the integrated application could approach automaticity. Each of these options is described in more detail below, followed by a brief discussion of the timeline for action.

Provide Basic Information within the Application and Certification Process

With minimal investment of effort, UI agencies can provide information about health coverage enrollment to UI recipients as they are applying and recertifying their eligibility for benefits. Today, 33 state UI agencies have information somewhere on their public-facing websites about enrollment into coverage,²⁰ but individuals may need to seek out that information by searching the website or actively looking for health care information. However, health coverage may not be front of mind for people experiencing a job loss, and many may simply not consider the issue.

A better approach would ensure that UI applicants and beneficiaries encounter information about health coverage *within the consumer's online workflow* as they are applying and recertifying their benefits. The specifics will depend on the structure of the state's application and recertification processes, but in general UI agencies can present a screen that contains health coverage information within the application and recertification submission. For example, after moving through each page of the application, individuals can encounter a screen that provides a few sentences of information on health coverage eligibility, and the customer must click somewhere on the screen to continue. Moreover, in addition to offering this information at the time of an initial applications, UI agencies have a valuable opportunity to present it on an ongoing basis during weekly or biweekly recertifications. The UI recertification process is generally less complex than the initial application, so individuals may be more interested in the material in future weeks, and the ongoing interaction will reinforce the opportunity to obtain coverage. Anecdotally, it appears some UI agencies have taken this approach, but it is not widespread.

The information presented in this context should be simple, and should be focused on driving consumers to apply for coverage through Medicaid or the Marketplace. Marketing experts have emphasized two kinds of messages that can be effective in motivating action to seek coverage – information related to affordability and related to deadlines.²¹ Consumer awareness of affordability is limited. A 2019 survey of uninsured consumers likely to qualify for Marketplace subsidies found only 12% were aware that subsidies existed, and they expected coverage to be more expensive than they were likely to encounter.²² Indeed, 83% thought a plan costing less than \$100 per month would be affordable to them but only 46% expected such a plan to be available, when in fact nearly all in the sample would have that option. Further, given low awareness of other aspects of Marketplace operations like the timing of the open enrollment window each fall,²³ there is no reason to expect UI applicants to have any familiarity with the fact that they may have only a 60 day window to enroll in coverage. Therefore, simple messaging in the UI workflow that conveys low cost options are available

²⁰ Hannah Markus, Stan Dorn, and Cheryl Parcham, "Unemployment Insurance Websites are Not Telling Laid Off Workers About Available Health Programs, Despite Enormous Losses of Employer-Sponsored Insurance," *Families USA*, May, 2020, https://familiesusa.org/wp-content/uploads/2020/05/COV_State-Unemployment-Departments-Websites-and-Health-Insurance_Report_5-8-20.pdf.

²¹ Joshua Peck, "Why Marketing Matters for Healthcare.gov," *Medium*, February 7, 2018, <https://medium.com/get-america-covered/why-marketing-matters-for-healthcare-gov-46d10534a287>.

²² Hart Research Associates, "Memo: New Polling Among ACA Marketplace Insured and Eligible Uninsured," October 23, 2019, <https://drive.google.com/file/d/0BwWzJPOpHwx0VXdIX2hSUIRoVW1UziBmMklqSlZUoFfd2d3/view>.

²³ Joshua Peck, "2019 Open Enrollment Preview," *Medium*, October 30, 2019, <https://medium.com/get-america-covered/get-america-covered-2019-open-enrollment-period-preview-325be4c020c5>.

and that the time to enroll is limited, combined with direct links to the Marketplace website, may be salient in encouraging enrollment, especially if repeated throughout the recertification process.

Note that presenting consumers with this type of information requires limited technical investment from the UI agencies. It does not require the state to add new questions to its application or reconfigure the application; states can add this information within their existing structures. Moreover, state health agencies generally have the necessary expertise to craft messages to consumers. Certainly, some resources are necessary, but it should be possible to provide this kind of information outside of a major technical undertaking.

Provide Personalized and Interactive Information

With a somewhat more significant investment of resources, UI agencies can build on the model described above to offer a more personalized and interactive experience within the consumer's workflow. Indeed, a randomized controlled trial from the Department of the Treasury suggests that a personalized message provided by the Internal Revenue Service based on prior tax data was effective in encouraging enrollment (and reducing mortality), so a more personalized experience may promote coverage uptake.²⁴

For example, at the time of initial application, UI applicants could be asked if they are uninsured or losing health care coverage associated with their job loss, and, if so, as of what date. That information could be used to provide a more targeted message related to the opportunity for coverage and the deadline by which the individual must apply for coverage in the individual market, and this individualized deadline may be more effective in motivating action. Individuals who reported being uninsured or losing coverage could also be asked at recertification if they had obtained or investigated coverage; being asked to interact with the message by answering a question may be more effective in promoting action over time.

In addition, a personalized message related to affordability could also help overcome consumers' skepticism or lack of awareness about the cost of coverage, as described above. The UI agency possesses data regarding the wages an individual earned prior to becoming unemployed and the amount of their weekly UI benefit, and may have access to prior-year tax data about their family size. This is insufficient information to perform a true eligibility determination, but it could be used in combination with some straightforward assumptions to generate an estimate of the cost of coverage for similarly situated individuals. These estimates could be generated at the person-level or across bands of pre-UI income, and presented to the individual within the application and during recertification. Even while being careful to note the limits of the information, estimates like these could help concretize coverage affordability, driving enrollment.

Referral Partnerships with Assisters, Web-Brokers, or State Agencies

Ensuring that consumers are presented with health coverage information within the workflow, and taking steps to make that information as personalized and interactive as feasible, could meaningfully support uptake of coverage. However, it does not directly address another barrier to enrollment: the availability of consumer assistance. Strategic partnerships between UI agencies and other entities can support that need.

Evidence from the implementation of the Health Coverage Tax Credit (HCTC) in the mid-2000s, which subsidized enrollment into available coverage options for workers losing their job-based coverage, suggests that personalized assistance can have a large impact on take-up rates. States and regions with high take-up rates generally relied on union, other non-profit, or state and local government programs to provide intensive outreach and enrollment assistance at the time of job-

²⁴ Jacob Goldin, Ithai Z. Lurie, and Janet McCubbin, "Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach," *NBER Working Paper No. 26533*, December, 2019, <https://www.nber.org/papers/w26533>.

loss.²⁵ Indeed, these experiences reflect that steps that reduce the time and, perhaps more importantly, mental bandwidth necessary to enroll in coverage can be effective – particularly at a time when families are stressed by the disruption associated with having lost a job.

Since implementation of the ACA, coverage assistance has been available to those attempting to enroll, and traditional non-profit and government assisters have been supplemented by an expanding role for insurance agents and brokers, who are paid commissions or otherwise reimbursed by insurance companies for providing enrollment assistance. Publicly available data are limited, but assistance from assisters, agents, and brokers appears to play a numerically significant role in enrollment. For 2018, the federal government reported that 42% of enrollments through HealthCare.gov were connected with one of more than 40,000 agents and brokers, and in 2016 5,000 assister programs estimated they worked with more than 5 million consumers (across both Medicaid and Marketplace coverage).²⁶

In addition, in recent years, HealthCare.gov and some state-based Marketplaces have supported a relatively new type of broker-led enrollment through “direct enrollment.” Under direct enrollment, entities called web-brokers operate their own online portals for applying for coverage in the Marketplace, and generally receive insurance company commissions for those who enroll through their sites.²⁷ Web-brokers may partner with individual insurance agents or brokers who use their technology to work directly with individual consumers. Direct enrollment can also be operated by insurance companies. Available data suggest that for 2020, almost 30% of HealthCare.gov enrollment came through this channel.²⁸ To be sure, significant concerns have emerged about the web-broker and direct enrollment model.²⁹ Web-brokers may promote enrollment in non-ACA-compliant coverage, may steer individuals towards plans that pay higher commissions, and may do a poor job helping Medicaid-eligible consumers understand their eligibility and enroll. However, enhanced oversight and tighter standards may help ameliorate some of these problems.

In this landscape, UI agencies have opportunities to partner with assisters or brokers to refer UI applicants and beneficiaries for assistance in enrolling in coverage, which has the potential to meaningfully increase the rate at which individuals successfully enroll. Building on the type of model used successfully to support HCTC enrollment, UI agencies could contract with a non-profit assister to provide enrollment support. Using the type of interactive workflow described above, UI applicants and beneficiaries who reported being uninsured or losing coverage could be asked to consent to having their information shared with a health insurance assister.³⁰ The assister would be provided contact information for those who agreed, and would work with the individual to help them understand their eligibility and apply for coverage. Assistors could contact consumers directly to help ensure completion; presumably, those consenting to have their information shared are expressing at least some interest in obtaining health coverage, making this is a reasonably well targeted population for

²⁵ Stan Dorn, “Take-Up of Health Coverage Tax Credits: Examples of Success in a Program With Low Enrollment,” *Urban Institute*, December 10, 2006, https://www.urban.org/research/publication/take-health-coverage-tax-credits/view/full_report.

²⁶ Centers for Medicare & Medicaid Services, “The Exchanges Trends Report,” July 2, 2018, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-3.pdf>; Karen Pollitz, Jennifer Tolbert, and Ashley Semanskee, “2016 Survey of Health Insurance Marketplace Assister Programs and Brokers,” *Kaiser Family Foundation*, June 8, 2016, <https://www.kff.org/health-reform/report/2016-survey-of-health-insurance-marketplace-assister-programs-and-brokers/>.

²⁷ Centers for Medicare & Medicaid Services, “Enhanced Direct Enrollment Pathway for Health Insurance Exchange Coverage,” November 28, 2018, <https://www.cms.gov/newsroom/fact-sheets/enhanced-direct-enrollment-pathway-health-insurance-exchange-coverage>.

²⁸ Seema Verma, Twitter, January 29, 2020, <https://twitter.com/SeemaCMS/status/1222628265124339714>.

²⁹ Tara Straw, “Direct Enrollment’ in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm,” *Center on Budget and Policy Priorities*, March 15, 2019, <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>.

³⁰ Federal rules provide a framework to allow UI agencies to share consumer information with other government officials, 20 C.F.R. § 603.5(e), or with other third parties if the individual provides consent, 20 C.F.R. § 603.5(d)(2).

this type of intensive outreach. Assisters could also provide post-enrollment assistance related to eligibility verification or other issues.

Rather than using external assisters, the UI agency may also wish to enter into referral arrangements with the state Medicaid agency or state-based Marketplace for these outreach efforts, in a manner similar to the Maryland “Easy Enrollment” program.³¹ In Maryland, uninsured tax filers are asked to consent to having their tax return information provided to the Medicaid agency and Marketplace and treated as an application for coverage; the UI application could be handled in the same way.

Operating a model like this will require a source of funding, though it may be within reach for states, especially states that operate state-based Marketplaces. State Marketplaces use the revenue collected from user fees levied on insurance companies to support a variety of outreach efforts. Today, resources are generally focused on enrollment during the fall open enrollment period; however, given the opportunity to target support to those who have indicated they are likely to be eligible for a special enrollment period and the very low take-up that exists today, partnerships between UI agencies and assisters could prove to be a cost-effective model. Of course, the federally-facilitated Marketplace may also consider using its own user fee supported outreach resources to support partnerships between UI agencies and assisters in its states.

Alternatively, partnerships between UI agencies and web-brokers have the potential to offer some of these benefits without requiring the same funding commitment, though close supervision will be necessary. As above, for consumers that appear potentially eligible for coverage, the UI agency could ask for consent to share information with a partner web-broker, who would then help support the individual’s enrollment. One could imagine a state UI agency operationalizing this model through a state procurement process. The state would issue a request for proposals (RFP), inviting submissions from web-broker entities that could meet strict standards established by the state. Those standards should include a commitment to accurately assess Medicaid eligibility and support Medicaid enrollment alongside private insurance enrollment, displaying all private insurance options on equal footing without regard to commissions, strict limits on the use of consumer information, and regular oversight. Respondents to the RFP would explain how they would meet the standards and offer specific service-level commitments related to the amount of consumer outreach and post-enrollment assistance they would conduct; the state would select one or multiple web-broker partners based on their responses.

Partnering with a web-broker would require some state resources to conduct the necessary oversight and build the interactive application that would make these referrals possible. But the UI agency would not need to directly support the outreach itself, as the web-broker would be compensated through its commission structure. That said, this blurring between a public benefit application process and a private, revenue-generating activity may generate discomfort and could raise privacy considerations under state law.

Note that states adopting a model like this – whether through assisters, state agencies, or web-brokers – also have a straightforward opportunity to conduct some randomized assessments of the effectiveness of the assistance model. This type of enrollment support does require resources, and whether funded through user fees or through broker commissions, those costs ultimately appear in premiums (where they are largely born by the federal government through increased premium tax credits). To the extent this type of referral partnership led consumers who would otherwise have enrolled without assistance to instead enroll with a paid broker commission or with assister help, that could increase costs. Assessing the effectiveness of the model will enable the state to calibrate appropriately.

Fully Integrated Application

³¹ Maryland Health Connection, “Your Guide to the Maryland Easy Enrollment Health Insurance Program,” <https://www.marylandhealthconnection.gov/guidetoeasvenrollment/> (last visited May 28, 2020).

Finally, states pursuing an overhaul of their underlying UI technology should consider steps to integrate a complete health coverage application into the UI application process. That is, the UI agency could operate as direct enrollment entity itself, offering a portal where individuals could apply for coverage in the Marketplace and in Medicaid. Under this vision, the UI website would operate a two-part application – the first an application for the UI benefit itself, and the second an application for health coverage – and applicant information could be shared across these components. States could determine the extent to which these application processes appeared unified to the consumer, choosing, for example, to integrate them into one application or offer them as separate modules.

Many existing web-broker entities are also technology development companies;³² some have partnered with state-based Marketplaces on various projects.³³ Given their expertise in health coverage applications, the cost of developing an application portal for a state UI agency could be relatively low, especially in a context where the underlying UI system was also being redesigned. (Note that in this model, the state would buy technology from the web-broker vendor; enrollment would not be commission-supported.) The UI agency in a state-based Marketplace state could also work directly with the state Marketplace to develop an application portal. This type of approach offers the opportunity to create a more seamless and integrated enrollment experience.

For example, while some additional information, beyond what is collected in the underlying UI process, must be collected, this model could significantly reduce the application length for health coverage by avoiding duplicate entry of identifying information and some income data. It also allows the state agency to know exactly where consumers are in the health coverage application process and gives them the opportunity to follow-up with consumers throughout the recertification process to encourage submission. It offers the opportunity to generate specialized tools for estimating income that are tailored to the complexity associated with a household receiving UI. Finally, UI agencies may also want to consider allowing consumers to pay their share of the premium through a deduction from their UI benefit.³⁴ This may be especially appealing for consumers with relatively small residual premiums, and the recertification process offers an opportunity to periodically confirm consumers have not obtained other coverage. Further, such a system would represent something close to truly automatic enrollment into coverage for those eligible.

Timeline for Action

Many of the options described above will take some time to implement. Building a fully integrated application, the capacity to seek consent for referrals, or interactive workflow elements will take time and technical resources. However, the recent surge in UI demand associated with COVID-19 has spotlighted the need for improvement in the technical infrastructure that supports UI programs. As the immediate crisis passes and at least some states prepare to make those needed upgrades, there is an opportunity to also take steps to support health coverage enrollment.

And even in the current environment, there may be steps UI agencies can take. States may find it very simple to add some basic and non-interactive information in a relatively-uncomplicated recertification workflow, or to send an email about coverage enrollment to existing customers. States should consider what they may be able to do now to help support coverage enrollment.

³² Centers for Medicare & Medicaid Services, “Enhanced Direct Enrollment Pathway for Health Insurance Exchange Coverage,” November 28, 2018, <https://www.cms.gov/newsroom/fact-sheets/enhanced-direct-enrollment-pathway-health-insurance-exchange-coverage>.

³³ Get Insured, “State-Based Marketplaces,” (n.d.), <https://company.getinsured.com/state-based-marketplaces/>.

³⁴ Christen Linke Young, “Three Ways to Make Health Insurance Auto-Enrollment Work,” *Brookings Institution*, June 13, 2019, <https://www.brookings.edu/research/three-ways-to-make-health-insurance-auto-enrollment-work/>.

Marketplace and Federal Policy Options that Can Facilitate Coverage After Job Loss

The preceding section describes ways that state UI agencies could better support health coverage enrollment for those losing employer-based coverage. But even if a UI agency process successfully connects an eligible consumer to a health coverage enrollment, there are obstacles to enrollment that could deter take-up, particularly for Marketplace coverage with financial assistance. However, there are also steps that Marketplaces and the federal government could take it to remove these barriers and make it easier for this population to enroll.

Special Enrollment Period Verification and Eligibility

As described above, outside of the open enrollment period, a consumer must qualify for a special enrollment period (SEP) to be permitted to enroll. The federal government establishes the terms of SEPs for all states, and Marketplaces, federal or state, may add additional SEPs under existing authority. Loss of other coverage (including loss of job-based coverage) triggers a 60-day opportunity to enroll, so much of the population targeted here is eligible. However, the federal Marketplace and many states require consumers to document this eligibility.

The federal government indicates that 90% of people directed to submit SEP documents after a plan selection do so, implying that 10% do not.³⁵ While some of the people who never submit documentation may find other coverage, it is likely that some of these people become uninsured. This group may also be particularly healthy since those in worse health are likely more motivated to ensure that they retain insurance coverage. Further, this estimate fails to count people who never select a plan because of the application complexity, including documentation. Removing documentation requirements and verifying SEP eligibility by an attestation under the penalty of perjury would make it easier for those losing job-based coverage to enroll.

Further, the existing SEP could be broadened to include not just those who lose job-based health insurance, but rather anyone who loses a job. Job loss results in meaningful changes in household finances, and will therefore change the generosity of coverage available in the Marketplace. Moreover, especially if coupled with the types of outreach efforts described above, a broad job loss SEP could induce higher take-up of the eligible population, and it would ensure that essentially everyone who applies for UI benefits is eligible for an SEP in the weeks surrounding their UI application.

Either of these options would create some adverse selection risk. Relatively unhealthy individuals might intentionally falsify their application and enroll through an SEP for which they are not eligible when they need health care, or only relatively unhealthy people made newly eligible by a job loss SEP might elect coverage. But given the very low take-up we see today and the experience in Massachusetts where continuous enrollment is permitted for most individuals,³⁶ these risks may be overstated.

Income verification

Another obstacle to enrollment is the income verification process. Individuals provide an estimate of yearly income in the Marketplace application process, and Marketplaces attempt to verify that information against payroll records and prior year tax data. (State-based Marketplaces access a wider set of income data sources.) If these data sources show an income different from that reported by the individual, the individual is directed to submit additional documents verifying their income – a time

³⁵ Centers for Medicare & Medicaid Services, “The Exchanges Trends Report,” July 2, 2018, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-3.pdf>.

³⁶ Sarah Lueck, “Proposed Change to ACA Enrollment Policies Would Boost Insured Rate, Improve Continuity of Coverage,” *Center on Budget and Policy Priorities*, June 5, 2019, <https://www.cbpp.org/research/health/proposed-change-to-aca-enrollment-policies-would-boost-insured-rate-improve>.

consuming process that resulted in hundreds of thousands of people losing financial assistance in the early years of Marketplace operations, though affects many fewer people today.³⁷

It is unnecessary to require individuals who have recently lost a job to go through this process. Their households have almost surely experienced a major change in income; they should simply be able to attest to having lost a job. Indeed, any estimate they provide will necessarily be based on information that is not reflected in official data sources and will reflect private household expectations (like the expected timeline for obtaining new employment). There is little that can be authoritatively verified in this circumstance, and recently unemployed households should be exempt from the process. This would avoid needless verification costs and make it easier for this group to connect to coverage, though it might lead to some increased tax obligations when financial assistance is reconciled and lead to some increased federal spending.

Tax credit reconciliation

Finally, note that the underlying fact that Marketplace eligibility rules are based on full year income poses complications for those who have recently lost a job. The newly unemployed are unlikely to have a concrete sense of expected annual income, given uncertainty about when they will find new employment and at what income. The fact that an underestimate could generate significant repayment liability when filing taxes may deter enrollment. Further, even if annual income could be accurately predicted, basing assistance on full year income means the higher-wage period preceding or following unemployment is averaged with the current lower-wage period. This may leave families responsible for paying a larger premium than they can afford during the time they are without a job and job-based coverage. Therefore, federal policy changes that move Marketplace financial assistance away from reliance on full-year annual income could enable the system to better serve those facing a coverage gap after losing their job, though these policies would generally carry federal fiscal cost.

³⁷ Grant Ferowich, "HHS Cuts Down on 'Data Matching' Issues for Exchange Customers," *Fierce Healthcare*, September 9, 2016, <https://www.fiercehealthcare.com/payer/hhs-reduces-health-plan-terminations-for-100-000-consumers-2016>.

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Report #4
**The COVID-19 Case Rate and California’s Diversity:
 Patterns in Coronavirus Exposure**

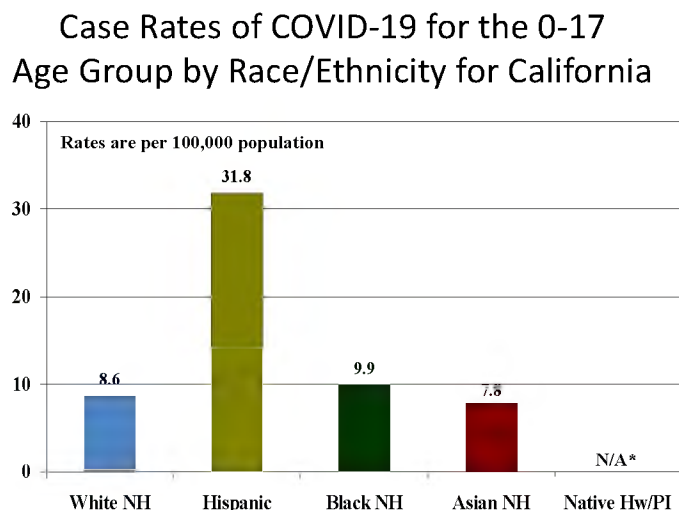
David E. Hayes-Bautista, Ph.D.
 Paul Hsu, M.P.H., Ph.D.

Every case of COVID-19 is the result of someone having been exposed to the coronavirus. Here in California, as elsewhere, different people experience different exposures to the virus. Some individuals and families—those with work that can be done remotely, robust health insurance, and relatively easy access to a physician—have been able to reduce their coronavirus exposure by sheltering at home for the past eight weeks.

In order for them to stay home, however, other individuals have had to expose themselves to the virus, in order to provide the essential goods and services that make sheltering at home possible for others. Farmworkers growing food, truck drivers delivering supplies, grocery store stockers and checkout clerks, bus drivers, auto mechanics, nursing home attendants, and construction workers expose themselves daily so that others can stay home. This, in turn, potentially exposes the essential workers’ families more frequently to the virus. In addition to higher levels of exposure to the virus, many of these essential workers and their families are also less likely to have health insurance or regular access to a doctor.

Different patterns of coronavirus exposure in California’s major racial/ethnic (R/E) groups can be seen in different patterns of actual COVID-19 cases per 100,000 population. State-level data released May 14, 2020, has been compared by R/E for six different age-groups: children (0–17), young adults (18–34) early middle age (35–49), late middle age (50–64), older adults (65–79) and oldest adults (80+). In almost every age group, Latinos, African-Americans, Asian-Americans, and Native Hawai’ian/Pacific Islanders have higher age-specific case rates for COVID-19 than do non-Hispanic (NH) whites. This indicates that these four racial/ethnic populations are experiencing various degrees of greater exposure to the virus than are non-Hispanic whites.

Figure 1. Children: Latino and Black Higher Case Rates.



*the number of cases (n < 30) did not allow for a meaningful calculation.

UCLA CESLAC Tabulations, Deaths: CDPH, 05-14-2020, Population: ACS 2018

Figure 2. Young Adults: Latino, Black, Asian, and Hawai'ian/Pacific Islander Higher Case Rates.

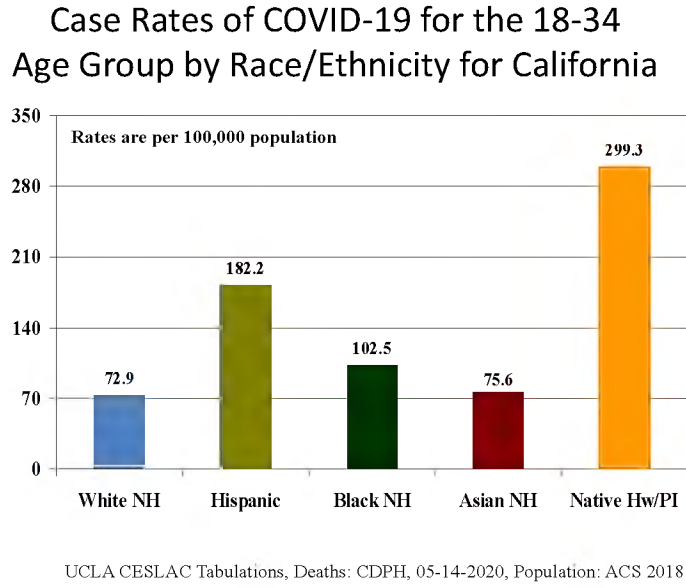


Figure 3. Early Middle Age: Latino, Black, Asian, and Native Hawai'ian/Pacific Islander Higher Case Rates.

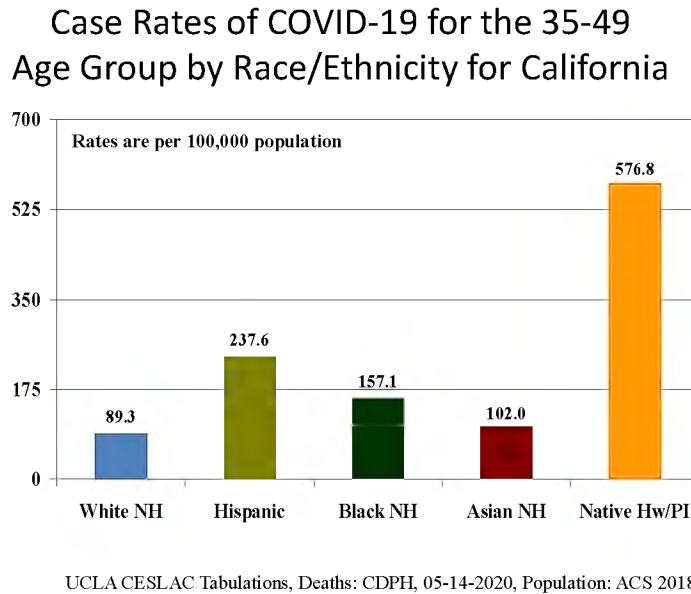
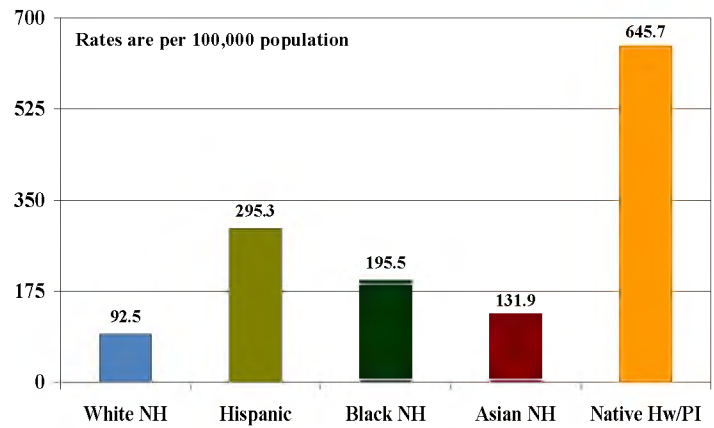


Figure 4. Late Middle Age: Latino, Black, Asian, and Native Hawai'ian/Pacific Islander Higher Case Rates.

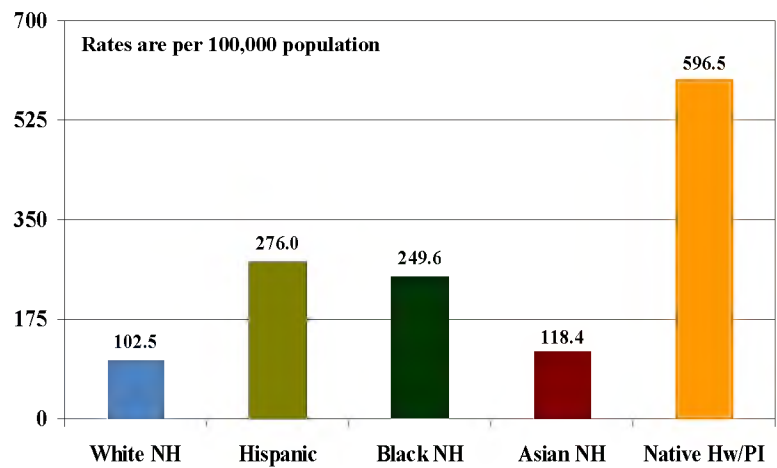
Case Rates of COVID-19 for the 50-64 Age Group by Race/Ethnicity for California



UCLA CESLAC Tabulations, Deaths: CDPH, 05-14-2020, Population: ACS 2018

Figure 5. Older Adults: Latino, Black, Asian, and Native Hawai'ian/Pacific Islander Higher Case Rates.

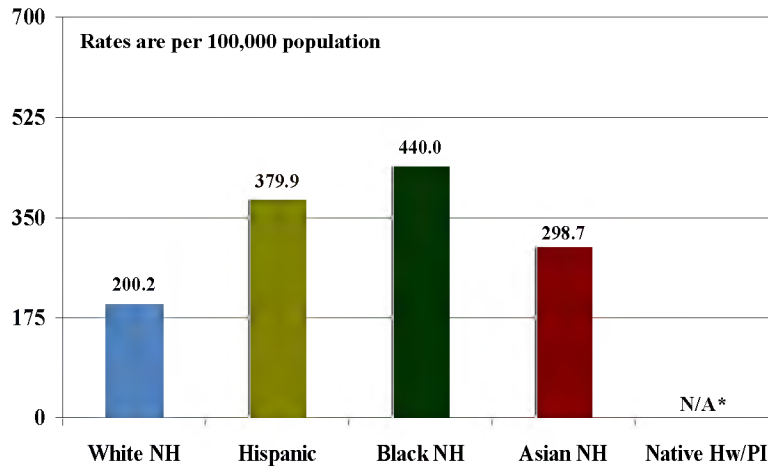
Case Rates of COVID-19 for the 65-79 Age Group by Race/Ethnicity for California



UCLA CESLAC Tabulations, Deaths: CDPH, 05-14-2020, Population: ACS 2018

Figure 6. Oldest Adults: Latino, Black, and Asian Higher Case Rates.

Case Rates of COVID-19 for the 80+ Age Group by Race/Ethnicity for California



*the number of cases (n < 30) did not allow for a meaningful calculation.

UCLA CESLAC Tabulations, Deaths: CDPH, 05-14-2020, Population: ACS 2018

These case rates indicate that exposure to the coronavirus has not been randomly distributed across California's racial/ethnic groups. While the current data do not allow us to draw conclusions as to why the exposure patterns are so different, preliminary data from the American Community Survey suggest that essential occupations and industries may be disproportionately represented by Latino, African-American, Asian-American, and Native Hawai'ian/Pacific Islander workers. While there were fewer than 30 cases for American Indian/Alaska Natives in every age group, the rates for their population also trended higher than NH white.

Methods. Data on COVID-19 cases, stratified by race/ethnicity and age group, were furnished by the California Department of Public Health (CDPH).¹ Of 74,936 cases across all age groups, 23,853 (32%) were missing data on race/ethnicity, and so were not included in these figures. Population denominators were tabulated from the 2018 American Community Survey, the latest available.²

About CESLAC. Since 1992, the Center for the Study of Latino Health and Culture (CESLAC) of the David Geffen School of Medicine at UCLA has provided cutting-edge, fact-based research, education, and public information about Latinos, their health, their history, and their roles in California society and economy.

For more information, or to arrange a telephone interview with the Center's Director, David E. Hayes-Bautista, Ph.D., Distinguished Professor of Medicine, please contact Adriana Valdez, at (310) 794-0663 or cesla@ucla.edu

¹ <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Race-Ethnicity.aspx>

² <https://www.census.gov/programs-surveys/acs>

NASHP—

Delayed Rule Sets 2021 Playbook for Health Insurers and Insurance Marketplaces

May 25, 2020 / by Christina Cousart —

The Department of Health and Human Services (HHS) has issued the final Notice of Benefit and Payment Parameters (NBPP) for 2021 — the annual rule governing health insurance plans and health insurance marketplaces. While the final rule contains several changes, it does not significantly alter automatic re-enrollment for individuals who purchase through the health insurance marketplaces, which the federal government had proposed earlier this year.

The annual NBPP is of particular importance to insurers, insurance regulators, and marketplace officials who rely on the rule and its regulations to set the playbook by which health plans will be required to operate in the following year. The rule also sets requirements for system changes that marketplaces may have to implement as soon as the upcoming enrollment season.

The annual rule was issued May 7, 2020, the latest date that this annual rule has ever been released. As a result, the final regulations come very close to — or for some states after — the filing deadlines by which health insurers must submit their planned offerings for 2021. The delay caused health insurers to develop plans while operating under a level of uncertainty of what might be included in the final rule. Once released, insurers had little, if any, time to adjust their proposed filings in accordance with the changes finalized by the regulation.

Acknowledging the tight timeframe for implementing changes before the 2021 plan year, HHS delayed implementation of several of the requirements imposed under this rule until 2022 — including new requirements for medical loss ratio (MLR) calculations and changes to policies related to special enrollment periods (SEPs).

Delayed implementation of changes and deadlines required of insurers and insurance marketplaces is especially pertinent as markets face ongoing uncertainty resulting from —



the COVID-19 pandemic. As the country works to curb the spread of the virus, questions remain about the pandemic's long-term effects on insurance markets.

- How will consumers who lose employer-sponsored coverage and transition to individual plans affect the competitive insurance market?
- What will be the financial impacts of COVID-19 related treatments, including a possible vaccine?
- What will be the cost of consumers' delaying or foregoing care?
- How will greater utilization of telehealth services impact costs?

Meanwhile, the health insurance marketplaces (<https://nashp.org/state-based-marketplaces-lead-in-increasing-access-to-coverage-during-covid-19/>) are operating in a new environment with increased enrollment of new consumers, while, at the same time, adjusting their operations, which include marketing and outreach strategies that comply with social distancing standards.

Major changes included in the rule are summarized below:

Annual reporting of state-

essential health benefits (EHB) and 10 broad health benefit categories, including hospitalizations, emergency services, and prescription drugs. States' requirements in addition to the federal EHB requirements will increase. Typical, but not universal, costs for health insurance. To insulate the federal government from increased expenditures on health insurance subsidies, which are calculated based on the cost of insurance premiums, states must defray the cost of any state-mandated benefits issued after Dec. 31, 2011, either by issuing payments to the state or insurers to cover the cost of these benefits. State-mandated benefits are also not allowed to be considered as part of federal advance premium tax credit (APTC) calculations or as part of cost-sharing liability for qualified health plans (QHPs).

Citing concerns that states may not be defraying the costs of state-mandated benefits, beginning in July 2021, states will be required to submit an annual report on state-mandated benefits, in addition to EHB. In the first year, states are required to include a comprehensive list of all state benefit requirements for QHPs sold in their individual and small group markets. This will set a baseline – going forward states will only be required to submit an update to the report to include any new or revised state-mandated benefits. If no changes are made in a year, a state may submit the same report during

The report must accurately report information available within 60 days prior to the annual submission deadline. The rule also clarifies that insurers may refer to states to produce any cost analysis associated with additional benefits, rather than perform the calculations themselves.

The new requirement comes despite a majority of comments opposed to increased reporting, noting a lack of evidence that states were not in compliance with defrayal requirements and that such a requirement would be onerous and duplicative of processes already in place to assess the effects of state-mandated benefits. HHS asserts the reporting requirement should be complementary to work already being conducted by states to assess these benefits and will help promote a uniform approach to assuring compliance with federal requirements across all states. The rule also stipulates that HHS will be providing additional technical assistance to states to address concerns over the lack of clarity about defrayal processes and identification of state-benefits that fall outside of EHBs.

Consideration of pharmacy price concessions and wellness incentives in medical loss ratio (MLR) calculations. Beginning in 2022, insurers will be required to deduct prescription drug price concessions from incurred claims considered as part of MLR calculations. Such concessions may include drug rebates or incentive payments given directly to insurers as well as those secured and retained by entities providing pharmacy benefit management (PBM) services or PBM-like entities. This is a change from previous requirements that only mandated inclusion of concessions received directly by an insurer and aligns with MLR policies already in place under Medicare and Medicaid. The change intends to even the playing field between insurers with PBM contracts and promote a uniform standard for what factors are considered when performing MLR calculations. HHS is considering additional rulemaking to provide precise definitions for prescription drug rebates and price concessions in advance of implementation of the new requirement.

HHS has also finalized changes that individual market insurers may include the cost of certain wellness incentives as quality improvement activities (QIA), which are considered medical care for the purposes of MLR calculations. Wellness incentives include rebates, discounts, waivers of cost-sharing, or other incentives provided as part of participation in a wellness program. This change conforms with how MLR calculations are assessed in the group market.

Inclusion of drug rebates into cost-sharing calculations. The rule permits, but does not require, insurers to count direct support offered by drug manufacturers (e.g., drug —

rebates, coupons) toward calculation of an enrollee's cost-sharing responsibility. The rule clarifies that neither HHS nor the departments of Labor or Treasury will take enforcement action against insurers who exclude the value of direct support from cost sharing, even in cases where supports may incentivize take-up of brand-name drugs when generic alternatives are available.

HHS notes advantages to policies that include rebates as part of calculations (e.g., cost protections for consumers who use/need brand-name drugs) as well as policies that mandate exclusion of rebates (e.g., to incentivize use of generics where available). Application of the rule ultimately defers to state law and any restrictions states may impose on how direct supports are included in cost-sharing calculations. Insurers must apply their policies on direct support uniformly across all QHPs. HHS expects that issuers "prominently include" information on websites and other educational collateral explaining how drug manufacturer rebates are included in cost-sharing calculations.

Greater flexibility on plan selection available during a special enrollment period (SEP). Current rules maintain tight restrictions on the types of plans enrollees may select if enrolling during a SEP [<https://nashp.org/how-states-are-increasing-coverage-through-special-enrollment-periods/>]; usually requiring that consumers enroll in a plan at the same metal tier (of the same value) as previously held coverage. This is to ensure that consumers do not take advantage of SEPs to enroll in more generous plans because of an emerging health care need, as well as to provide greater consistency for insurers operating in the market. However, in a case where a SEP is triggered by an increase in income, the income change may render a consumer ineligible for cost-sharing reductions (CSRs), an additional subsidy given to individuals earning between 100 to 250 percent of the federal poverty level to cover out-of-pocket costs of care.

Loss of CSR eligibility may significantly alter affordability of certain health plans for a consumer. To account for this change, beginning with plan year 2022, consumers who lose CSR eligibility may enroll in a plan at a different metal level. The rule also allows consumers who are newly eligible for coverage to enroll in the same QHP as any dependents who are currently enrolled in QHP coverage through a health insurance marketplace.

Expedited effective dates for coverage obtained during a SEP. Current enrollment policies can lead to significant delays in effectuation of health insurance coverage. For instance, enrollees who enroll in coverage from the day 16 through 31 of any given month typically would not start coverage until the first of the month subsequent to the month —

that individuals who have a health plan on June 16, coverage would not begin until Aug. 1).

Recognizing advance in issuers to process the transition, in plan year 2022 insurers participating in the federally-facilitated marketplace (FFM) will be effectuating coverage on the first of the month following enrollment regardless of the date the individual enrolled. State that operate their own marketplaces (SBMs) have flexibility to impose their own effectuation dates – several have already accelerated the timeline for their issuers. In

Limitation on retroactive coverage for individuals

incorrectly determined to be eligible for coverage, in which case they can appeal the decision. In some cases, the person may be eligible for coverage that is retroactive to a certain point before a determination of eligibility was finalized.

Earlier rules had given consumers some flexibility over the start date at which consumers could retroactively elect coverage – which gave consumers some options in case they were in need of retroactive coverage, yet had concerns about paying premiums to cover all the months of retroactive coverage. The new rule eliminates this flexibility and requires consumers to either begin their coverage retroactive to the entire period for which they should have been eligible for coverage or to begin coverage prospectively. The change is expected to have minimal effect as less than .05 percent of consumer verification issues opted for retroactive coverage in 2018 and 2019.

SEP time for Qualified Employee Health Reimbursement Arrangements

(QSEHRAs). Current rules allow that consumers can use the funds in the HRA to purchase health coverage sold through the health insurance marketplaces (for more information on QSEHRAs, read [New Federal Health Reimbursement Proposal Adds New Variables to State Health Insurance Markets](https://nashp.org/new-federal-health-reimbursement-measures-proposed-for-state-health-insurance-markets/) [<https://nashp.org/new-federal-health-reimbursement-measures-proposed-for-state-health-insurance-markets/>]). The rule clarifies that the SEP applies even in cases where the QSEHRA's plan year does follow the calendar year, the typical standard for the coverage year.

Maintains FFA as a national marketplace for individuals to participate on the FFM, also known as healthcare.gov. For states that use a hybrid marketplace as state-based marketplaces on the federal platform (SBM-FPs), HHS will retain 2.5 percent with 0.5 percent available to states to perform functions –



related to outreach, marketing, and plan management. Thirty-two states used the FFM in 2020, while six were SBM-FPs. (For more on health insurance marketplace models read *Where States Stand on Exchanges* [<https://nashp.org/where-states-stand-on-exchanges-3/>].)

Eases process for coverage terminations and verifications. Consumers who are eligible for Minimum Essential Coverage (MEC), including most employer-sponsored coverage, Medicare, and Medicaid – are not eligible to receive federal subsidies to purchase coverage through the health insurance marketplaces. In the case where a marketplace determined that a person was dually enrolled in an exchange plan and MEC, a marketplace was required to redetermine the enrollee’s eligibility for subsidies before terminating that person’s coverage. This rule eliminates the requirement that marketplaces re-determine eligibility before termination, so long as the enrollee has opted in to be automatically terminated from coverage in this circumstance.

The rule clarifies that coverage terminations will be processed retroactive to the date of death in the case of an enrollee who has expired. The rule also clarifies that termination initiated by an enrollee will be effective retroactive to the date that the enrollee first attempted to end coverage, though SBMs are granted flexibility in how to apply this policy.

Finally, currently marketplaces must verify whether consumers are eligible for qualifying employer-coverage as part of determining whether consumers are eligible for marketplace subsidies. In some cases, insufficient data is available to perform this function, in which case marketplaces may use random sampling to verify eligibility. Due to limitations in sampling processes, including availability of adequate data, HHS is continuing its current policy to not enforce action against states that do not conduct random sampling.

Customization of QHP Quality Rating System (QRS) Display. Health insurance marketplaces are required to display quality ratings for insurance plans on their websites. The quality ratings are determined based on the federal QRS, which sets universal standards for the quality of health plans sold across all states. While the rule maintains federal governance over the QRS, it does grant SBM states flexibility in how they choose to display quality data. For example, SBMs may opt to include state-specific information related to quality in addition to QRS data.

Encouraging value-based insurance design. The rule does not explicitly mandate or incentivize adoption of value-based strategies, but does encourage insurer adoption of —

value-based insurance design rinci les consistent with olicies su orted by the University of Michigan Center for Value-Based Insurance Design [<https://ihpi.umich.edu/center-value-based-insurance-design-v-bid>], including benefit models that offer high-value services to consumers with little to no cost-sharing.

Adjusts factors used for risk adjustment calculations. Under the federal risk adjustment program, the federal government redistributes funds between health insurers that take on lower-risk enrollees, to those with a higher risk mix. Calculations are based on a complicated formula that computes risk based on various disease categories known as Hierarchical Condition Categories (HCCs). The rule updates the HCCs to conform with updated codes used to categorize diseases (a shift from ICD-9 to ICD-10 codes for disease classification). Other changes include a recalibration of how hepatitis C treatments factor into risk calculations and inclusion of pre-exposure prophylaxis (PrEP), an HIV-prevention drug, as a preventative service. Collectively, these changes intend to ensure that risk adjustment calculations more accurately reflect current medical diagnoses and practices to ensure better assessment of risk taken on by insurers. The impact of these changes will vary by insurer and enrollee population. —

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Health Insurance Risk Mitigation Mechanisms and COVID-19

MAY 2020

Key Points

- Risk mitigation mechanisms could help address the increased uncertainty health insurers face due to COVID-19.
- One-sided risk corridors can shield insurers from unusually large losses due to COVID-19; two-sided risk corridors would also protect against unusually high insurer gains.
- Reinsurance can offset the costs of high-cost enrollees, regardless of whether the insurer faced unexpected losses.
- Medical loss ratio (MLR) requirements could provide a backstop on unanticipated insurer gains under either one-sided risk corridors or reinsurance.
- Risk mitigation efforts directed at insurers won't address other risks in the health system, including declining enrollment in employer-sponsored insurance, increased pressures on state Medicaid programs, and declines in provider revenues that threaten their financial stability and patient access.



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Executive Summary

The COVID-19 pandemic is affecting the U.S. health system in numerous ways, many of which will have downstream effects on health insurers and group health benefit plans, and ultimately on health insurance premiums.

Although many hospitals are seeing a surge in patients with severe respiratory needs, physical distancing has led to dramatic declines in non-emergency services, including nonessential office visits and high-revenue-producing elective surgeries. Telehealth is filling in some, but not nearly all, of the gaps. As a result, many health care providers are experiencing declines in revenues and the need to lay off staff. At the same time, insurers have been required to cover cost-sharing for COVID-19-related testing and some insurers are waiving cost-sharing for COVID-19 treatments as well. The net effect on 2020 health insurance claims is uncertain—total costs could be higher or lower than expected. The net effect depends in part on whether deferred services are provided later in 2020, are delayed to 2021, or are forgone altogether. This result in turn depends on whether there is another wave of the outbreak this year and whether consumers are comfortable seeking health care.

At the same time, COVID-19's effects on the economy are causing shifts in health insurance enrollment. Nearly all states that operate their own Affordable Care Act (ACA) marketplaces provided a special enrollment period for the uninsured; the federal ACA marketplace did not offer a similar special enrollment period. Workers facing a loss of group insurance coverage due to lower incomes or job losses may have access

to COBRA coverage¹ (which can be expensive), coverage through the individual market (potentially with premium subsidies, which are based on annual income), or Medicaid coverage (eligibility varies by state and is based on monthly income). There could be big shifts in enrollment from the employer group market into Medicaid, the individual market, and the ranks of the uninsured, especially at higher unemployment rates.²

In the midst of so much uncertainty regarding 2020, insurers are developing premiums for 2021. It is unknown whether there will be additional COVID-19 waves in 2021; how many services and treatments deferred in 2020 will take place in 2021; what the risk pools will look like; whether new treatments, vaccines, or antibody tests will be available; and, if so, what their associated costs will be and how they will be paid for. Because not all deferred care is nonessential, greater future health care needs could arise due to worsening of untreated conditions.

Health insurance by its nature deals with risk and uncertainty. But if risks and uncertainty are unusually high, they can also lead to unintended consequences, such as higher premiums or even insurer decisions to leave the market. Various risk mitigation mechanisms can be used to help address risks, thereby leading to more competition and stable premiums. This issue brief provides a primer of the risks that insurers face and the mechanisms that are designed to address those risks. It then assesses the implications of these mechanisms, especially risk corridors and reinsurance, for the heightened risks and uncertainty arising due to the COVID-19.

Historically, insurers have faced several types of risks. These include pricing risk, plan-specific adverse selection risk, and the risk of particularly high-cost enrollees. Mechanisms to mitigate pricing risk have included risk corridors, medical loss ratio (MLR) requirements, aggregate reinsurance, and especially for Medicaid managed care plans, supplemental payments and midyear rate adjustments. Risk adjustment is often used to mitigate plan-specific adverse selection risk, and individual reinsurance is used to mitigate the risk of particularly high-cost enrollees.

¹ As enacted through the Consolidated Omnibus Budget Reconciliation Act (COBRA), it allows eligible employees and their dependents continued benefits of health insurance coverage if an employee loses their job.

² Health Management Associates, [COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, by State](#), April 3, 2020. Bowen Garrett and Anuj Gangopadhyaya, [How the COVID-19 Recession Could Affect Health Insurance Coverage](#). Urban Institute, May 2020.

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COVID-19 has exacerbated some of these risks. One-sided risk corridors could be used to provide insurers relief from unusually large losses due to COVID-19 and would target those insurers rather than providing payments to all insurers. Two-sided risk corridors could also be used to protect against unusually high insurer gains. Reinsurance could be used to provide additional funds to insurers, offsetting the costs of high-cost enrollees generally or only those with COVID-19 diagnoses or treatments. Such reimbursements would be available regardless of whether insurers face total costs (net of reductions for deferred care) that are higher or lower than expected. With either one-sided risk corridors or reinsurance, MLR requirements could provide a backstop on unanticipated insurer gains.

Risk mitigation efforts directed at insurers won't be able to address other risks in the health system, including declining enrollment in employer-sponsored insurance, increased pressures on state Medicaid programs, and declines in provider revenue that threaten their financial stability and patient access.

Risks Insurers Face and Typical Risk Mitigation Mechanisms

Pricing Risk

Pricing risk can result in premiums that are not adequate to cover actual claims. It can also result in unintended windfalls to insurers if premiums are set too high relative to actual claims. Notably, insurers cannot increase future premiums to recover past losses. Health insurers³ set premiums based on their best estimates of who will enroll in their coverage (i.e., the distribution of enrollees by age, gender, health status, etc.), the expected health care utilization of their enrollees (e.g., number and type of office visits and surgeries), and the anticipated costs associated with that utilization (e.g., the prices paid to providers, prescription drug costs). There will always be uncertainty regarding these factors, and insurers typically build some uncertainty into their projections. They also build up surplus specifically to be prepared for unexpected events.

But there are sometimes situations when uncertainty is higher than usual, exposing insurers to more pricing risk. For instance, when a new insurance program begins, it can be especially difficult for insurers to set premiums when their data on health spending for potential enrollees is limited. This was the case during the early years of the Medicare Part D prescription drug program and in the individual market after implementation of the ACA market reforms. Pricing risk also arises because it is not always possible to foresee the availability of new treatment options, as was the case when new and expensive hepatitis C treatments became available.

³ In many Medicaid programs, the state sets the Medicaid managed care rate.

Several mechanisms can be used to mitigate pricing risk, including risk corridors, medical loss ratio rebates, aggregate reinsurance, and midyear rate adjustments.

Risk corridors. Risk corridors can be used to limit insurer losses and/or gains if claims experience is very different from what was expected when developing premiums. Risk corridors can be one-sided—the government pays insurers if their losses exceed a certain threshold, or two-sided—including a provision for insurers to pay the government if their gains exceed a certain threshold. By limiting insurer losses, risk corridors can encourage competition during periods of greater uncertainty and can protect insurer solvency if unforeseen events cause claims to be much higher than expected.

Two-sided symmetric risk corridors are currently used in the Medicare Part D program. Private Part D plans bear the full risk if actual spending is within 5% of expected spending. If actual spending exceeds expected spending by more than 5%, the federal government reimburses the insurer for a share of the losses. If actual claims fall below expected claims by more than 5%, the insurer pays the federal government a share of the gains. Notably, these risk corridors are not constrained to be budget-neutral—there could be a net cost or a net revenue to the federal government.

Two-sided symmetric risk corridors were also included temporarily for ACA-compliant plans in the individual market from 2014 to 2016, the first years of the ACA market reforms. The risk corridors followed the same general structure as the Part D risk corridor program, although with different thresholds.⁴ Some states have also incorporated risk corridors for their Medicaid managed care plans. In contrast to commercial markets in which insurers set the premiums, states typically set the Medicaid managed care rate. Two-sided risk corridors in Medicaid can help mitigate large losses in managed care plans if plan spending exceeds the capitation rate, and can help ensure the state doesn't overspend if plan spending falls below the capitation rate.

Risk corridors can allow insurers to reduce their risk charges, although risk charges are usually a fairly small percentage of the premium (e.g., 2%-4%). Another way risk corridors can result in lower premiums is that having a backstop can allow insurers to price using less conservative assumptions.

⁴ Although not required to be budget-neutral, the Department of Health and Human Services (HHS) issued guidance that it would implement risk corridors in a budget-neutral manner. Because aggregate insurer losses exceeded gains, this decision lowered risk corridor payments relative to what would have been expected through the program parameters. However, a recent Supreme Court decision in *Maine Community Health Options v. United States* ruled that insurers are entitled to full risk corridor payments.

Medical loss ratio (MLR) requirements. Medical loss ratio requirements limit the share of premiums that goes toward administrative expenses and profits, as opposed to being used to pay for health care claims. Under MLR rules, insurers whose claims fall below a certain threshold must refund a portion of the premium. This is somewhat akin to a one-sided risk corridor, in which insurers would bear all of the risk for having claims greater than expected but are required to provide refunds if their claims relative to expenses are lower than expected.

Most insurance markets include MLR requirements. In the individual and small group markets, the minimum MLR is 80%; for fully insured large group plans, the minimum MLR is 85%, recognizing the economies of scale in administrative costs for larger group plans.⁵ To determine any applicable refunds to *policyholders*, claims and expenses are averaged over a three-year period. This can lower the likelihood of refunds and the refunds themselves if within the three-year average period an insurer experiences one year of a low MLR but two other years with a higher MLR. Recall that under risk corridors, insurers would need to make payments to the *government*, as opposed to refunding money to *policyholders*.

Medicare Advantage (MA) and Part D plans must meet an 85% MLR threshold or make payments to the Centers for Medicare and Medicaid Services (CMS) based on that year's difference (as opposed to being averaged over three years). Similarly, Medicaid and Children's Health Insurance Program (CHIP) managed care organizations are also subject to 85% federal MLR standards. However, states have discretion on whether to require rebates below a state-defined threshold (which may be higher than 85%), with any applicable refund payments made to federal and state governments.

Aggregate reinsurance. Aggregate reinsurance is another option to limit insurers' downside risk by paying all or a percentage of claims once a private plan's aggregate claims paid exceed a predetermined threshold. This threshold is typically expressed as a percentage of aggregate expected claims (for example, an aggregate limit might be 102% of projected paid claims). Insurers would keep all gains if actual claims are lower than expected. Government-provided aggregate reinsurance protection would be similar to a one-sided risk corridor that shields insurers from unexpected losses. In other words, the insurer would keep all gains, regardless of the size, if actual spending is less than expected, but would bear the losses only up to a certain point if spending is greater than expected.

⁵ MLR calculations are performed after any other risk mitigation program transfers to or from insurers are made. In other words, claims and premiums used in MLR calculations include any transfers from risk adjustment and risk corridor programs. MLR requirements do not apply to self-funded plans.

Aggregate private reinsurance is available currently to private insurers and self-funded employer plans (i.e., stop-loss coverage) rather than through the government. For instance, a typical aggregate stop-loss attachment point is 125% of total expected claims for the self-funded employer. An insurer's reinsurance expenses are part of the insurer's administrative costs and would be paid through higher insurance premiums. Notably, private reinsurance and stop-loss coverage are not offered on a guaranteed issue basis; groups can be denied coverage or charged higher premiums, and particular individuals can be excluded from coverage (i.e., *lasering*).

Supplemental payments. Supplemental payments (or direct reimbursements) are generally payments made outside of the normal capitation rate once a predefined trigger has occurred. The use of supplemental payments has been limited primarily to the Medicaid program. The payment is a per-occurrence payment as opposed to an amount included in the capitation rate, transferring the risk of the triggering event away from the managed care organization. This approach is used extensively in Medicaid managed care for payments related to maternity delivery and neonatal care. Supplemental payments also have been used when a new treatment has been added to Medicaid managed care but there was not sufficient experience to determine the expected utilization of the treatment.

Prospective or retroactive midyear capitation rate adjustments. Instead of making supplemental payments in the case of new or unexpected treatments, capitation plans potentially could be changed to reflect the change in expected costs. Rate adjustments could be made prospectively or retroactively and could reflect upward or downward rate changes.⁶ CMS is allowing states to make prospective Medicaid capitation rate adjustments to reflect COVID-19-related changes. In addition, CMS may allow states to make retroactive Medicaid capitation rate adjustments based on updated experience.⁷

Plan-Specific Adverse Selection Risk

When insurers are prohibited from denying coverage or charging higher premiums based on health status or expected health care needs, they are exposed to greater adverse selection risk, which occurs when individuals or groups who anticipate higher health care needs are more likely to purchase coverage than those who anticipate lower health care needs. Even if adverse selection is minimized in an insurance market as a whole, a particular plan could end up with a disproportionate share of enrollees with higher health care costs. If payments to the plan do not reflect this, then the plan could be at risk for large losses, which in turn gives them incentives to avoid enrolling people with higher-than average costs. Risk adjustment is the primary mechanism to address plan-specific adverse selection risk.

⁶ Although rate adjustments are not typically seen in commercial insurance, UnitedHealth has announced premium discounts to employers and individuals in its commercial plans. See Reed Abelson, "United Health Customers Will See a Discount on Next Month's Bill," *New York Times*, May 7, 2020.

⁷ CMS, "Medicaid Managed Care Options in Responding to COVID-19," May 14, 2020.

Risk adjustment. Risk adjustment is used to adjust payments to plans based on the risks of the people they enroll. When premiums are not allowed to reflect fully the factors affecting health spending (e.g., health status), risk adjustment helps to make payments to competing plans more equitable and can reduce the incentives for competing plans to avoid enrollees with higher-than-average health care needs. The most simple risk adjustment models have been based on age and gender. More complex risk adjustment models also incorporate health care diagnoses or social determinants of health. Although risk adjustment can help account for the differences in participant health status across plans, no current risk adjustment system is designed to compensate each competitor for the full financial effects of adverse selection.

The ACA individual market and small group market each have a budget-neutral risk adjustment program that operates at the state level. Insurers with higher shares of lower-cost enrollees contribute to a fund that makes payments to insurers with larger shares of higher-cost enrollees, such that the net impact is zero across all insurers. It is a concurrent program—diagnoses coded during the plan year are used to develop the plan year risk scores, on which the risk adjustment payments are based.

The Medicare Advantage and Part D programs also use risk adjustment programs, but their programs are prospective in nature—diagnoses coding during the prior year are used to develop the current plan year risk scores and corresponding payments from CMS. Unlike the ACA program, the MA risk adjustment program does not shift money among participating MA sponsors and is not a zero-sum exercise. Instead, MA plans receive higher payments when they have higher risk scores, regardless of the risk scores of other MA plans. The MA bid process and the CMS budget account for the expected payments.

States have discretion to apply risk adjustment to their Medicaid managed care programs. These programs must be budget-neutral and tend to be prospective.

Risk of Particularly High-Cost Enrollees

Plans also face a risk of having individual enrollees with particularly high health spending. Risk adjustment is not intended to address high-cost outliers. Also, because risk adjustment is meant to address costs that can be predicted in advance in order to lower plan incentives to avoid those with higher expected costs, costs from health needs that arise unexpectedly are not typically included in risk adjustment programs. Individual reinsurance can address this risk.

Individual reinsurance. Individual reinsurance (also known as specific reinsurance or stop-loss) can protect a plan from high claims from individual enrollees. Under a dollar threshold-based government-provided reinsurance program, the government would pay all or a percentage of claims once an enrollee's annual claims exceed a predetermined threshold (e.g., \$200,000). Under a condition-based program, reinsurance is triggered if an enrollee is diagnosed with a particular condition.

Individual reinsurance is used in the Medicare Part D program; the federal government funds 80% (the coinsurance percentage) of spending for Part D enrollees after their out-of-pocket spending exceeds the catastrophic threshold (\$6,350 in 2020). Individual market reinsurance was also used temporarily under the ACA for plans in the individual market during 2014–2016. For instance, in 2014, the ACA reinsurance program was designed to reimburse individual market plans for 80% of an individual's claims between \$60,000 and \$250,000.⁸ Because it was mostly funded through external sources, the ACA reinsurance program reduced premiums by about 10% to 14% in 2014, and less in the subsequent two years as the attachment point increased and the coinsurance rate declined.⁹ After 2016, several states extended the use of reinsurance through section 1332 waivers.¹⁰ Most are dollar-threshold based, but Alaska and Maine use condition-based programs.

As with aggregate reinsurance, private reinsurance can be used to provide individual (i.e., specific) reinsurance or stop-loss coverage. The attachment points for specific stop-loss coverage typically vary by group size, ranging from about \$35,000 for mid-sized groups (51-100 employees) to \$1 million or more for groups exceeding 20,000 employees. But again, insurer reinsurance expenses would be paid through higher insurance premiums and private reinsurers and stop-loss carriers can deny coverage, charge higher premiums, or exclude particular individuals from coverage.

⁸ The ACA reinsurance program was funded through contributions from all health plans and used to offset high claims for individual market health plans. Initial reinsurance parameters were changed retroactively so that reinsurance claims equaled contributions.

For 2014, the attachment point was reduced to \$45,000 and the reinsurance percentage was increased to 100%.

⁹ American Academy of Actuaries, [Drivers of 2016 Premium Changes](#), August 2015.

¹⁰ Kaiser Family Foundation, [Tracking Section 1332 Waivers](#), January 7, 2020.

Implications of Risk Mitigation Mechanisms for COVID-19-Related Risks

Policymakers have enacted and are considering further efforts to provide relief for health care providers, businesses, and individuals affected by the medical and economic effects of the coronavirus. Although not part of legislation enacted to date, risk mitigation provisions have been included in earlier legislative proposals¹¹ and have been put forward by others.¹² These mechanisms have generally focused on using one-sided risk corridors or reinsurance to mitigate risks and stabilize premiums for most types of health insurance. This section examines the implications of those mechanisms for addressing COVID-19-related insurer risks and also highlights how these risks vary by insurance market.

As noted above, insurers face several COVID-19-related risks. Through April 2020, increased claims due to COVID-19 appear to be offset (or even more than offset) by a reduction in non-COVID-19 claims, but it's unclear how that pattern will continue through the rest of the year. Medical care deferred in the first half of the year could be provided later in the year; COVID-19 claims could spike in a second wave. Shifts in insurance enrollment due to the virus's effects on the economy will also change 2020 claims from what was expected. In addition, particular insurers or plans could experience higher costs than expected if they enroll especially vulnerable populations (e.g., enrollees dually eligible for Medicare and Medicaid). The uncertainty will continue in 2021 and perhaps beyond, depending on whether there are future waves of the outbreak and the availability of treatments and vaccines.

Risk Corridors

As noted above, risk corridors can be designed to be either one-sided—shielding insurers from unusually large losses, or two-sided—also mitigating against unusually large insurer gains.

If implemented for 2020, one-sided risk corridors would shield insurers against unusually large losses arising from COVID-19. Government funds could be used to make payments to insurers for a portion of losses exceeding a threshold. Rather than providing payments to the health insurance industry as a whole, risk corridors would target those particular insurers that experienced large losses. If 2020 health spending continues to fall below insurer expectations, it is possible that few insurers would receive risk corridor payments.

¹¹ [Take Responsibility for Workers and Families Act](#) (H.R. 6379).

¹² See for instance Sherry Glied and Katherine Swartz, "[Using Federal Reinsurance to Address the Health Care Financial Consequences of COVID-19](#)," *Health Affairs* blog, April 1, 2020.

One-sided risk corridors could be used to help insurers withstand losses, but wouldn't put them at risk of making payments if they have significant gains. However, the MLR requirements would provide some protections against insurers experiencing large gains due to having lower claims than expected. MLR refunds would be provided to policyholders in the individual and group markets if the three-year average MLR fell below the required threshold. If the risk corridors were extended to Medicare Advantage and Medicaid managed care plans, any MLR refunds would be made by insurers to the federal government (and states for Medicaid programs with refund requirements).

Alternatively, risk corridors could be two-sided, to protect against both unusually high insurer losses and unusually high insurer gains. But as opposed to providing rebates to policyholders in the individual and group markets, any risk corridor payments made by insurers would go to the government.¹³

If implemented for 2021, risk corridors would protect insurers from the pricing risk they face because of the continued uncertainty regarding whether and how COVID-19 will affect 2021 claims. By providing a backstop, risk corridors could result in lower premiums, through reductions in risk charges (usually 2%-4% of premiums)¹⁴ and less conservative pricing assumptions.¹⁵

Setting up a risk corridor program for fully insured commercial plans and Medicare Advantage plans could be relatively straightforward. MLR reporting requirements already include the data elements that would be needed for a risk corridor program. Risk corridors would be calculated after factoring in any transfers from risk adjustment and reinsurance programs.

Risk corridor implementation could be more complicated for self-funded plans. Whereas fully insured plans have premium and other info that can be used to determine an expected claims target, there is not a common standard for determining such a target for self-funded plans. Trending forward prior per capita claims could potentially be used, but adjustments could be needed to reflect any changes in enrollee demographics.

13 In the ACA and Medicare Part D risk corridor programs, any required insurer payments are made to the federal government. Presumably, a two-sided risk corridor program could be structured so that insurer payments to the government are directed to fund payments to health care providers or for other COVID-19-related purposes.

14 In the absence of risk corridors, the increased uncertainty regarding COVID-19 could cause insurers to increase their risk charges above the usual 2%-4%. Such increases could be constrained by MLR requirements, which limit the amount of premiums that can be used for non-claims items, including risk charges.

15 In the face of uncertainty, insurers will consider various scenarios using different assumptions regarding the recurrence of COVID-19 waves, the availability of treatments and vaccines, the degree of pent-up demand that will occur, etc. The availability of risk corridors would allow insurers to use less conservative assumptions regarding 2021 claims expectations.

Risk corridor targets usually reflect expected claims costs and do not include administrative costs. However, administrative costs could also differ due to COVID-19. Although some administrative costs vary with the number and amount of claims, other costs are fixed and are spread across all enrollees. Large enrollment shifts could cause changes in per enrollee administrative costs. For instance, a decline in employer coverage could cause per enrollee administrative costs to be higher than expected; a large increase in Medicaid enrollment could cause per enrollee administrative costs to be lower than expected.

Reinsurance

A federal reinsurance program could be used to reimburse plans for their higher-cost enrollees. Payments could be triggered based on dollar thresholds or it could be condition based. If focused on individuals with a COVID-19 diagnosis, it would need to be determined whether reinsurance payments would be made for all health expenditures or only COVID-19-related treatments and, if the latter, how those would be defined.

If implemented for 2020, reinsurance would provide additional funds to insurers, regardless of whether they face net costs for 2020 that are higher or lower than expected. Plans with unexpected gains due to 2020 costs being lower than expected might have additional gains under a reinsurance program. The MLR requirements could provide a backstop on unanticipated gains and result in refunds to policyholders. However as noted above, MLR refunds for the individual and group markets are based on three-year averages.

If reinsurance is implemented for 2021, it could result in lower 2021 premiums, as some health care claims would now be paid for through the reinsurance program, thereby lowering insurer costs. However, reinsurance wouldn't necessarily address the pricing risk that insurers face because of the continuing uncertainty regarding how COVID-19 will affect 2021 health spending.

Reinsurance could be relatively straightforward to implement and wouldn't be as complicated as risk corridors for self-funded plans. That said, any government reinsurance program may need to be coordinated with private reinsurance and stop-loss coverage, increasing administrative complexity. Implementation for ACA individual market plans could be more complicated in the states that already operate their own reinsurance programs under 1332 waivers. It would need to be determined whether a federal reinsurance program would be the primary or secondary reinsurance payer.

Other Considerations

Although risk corridors and reinsurance could help mitigate some COVID-19-related risks that insurers face, other risks might be better addressed through other mechanisms. For instance, group insurers and self-funded employer plans face declining enrollment due to workers losing their jobs. Lower enrollment reduces the economies of scale for administrative expenses. It also raises selection concerns. For instance, past recessions resulted in morbidity increases among some small group insurers along with enrollment declines. New COBRA guidance¹⁶ that extends the time for eligible workers to choose to enroll in COBRA could exacerbate selection issues. Multiemployer plans have the added concern that because contributions on behalf of active workers typically subsidize coverage for retirees, a reduction in active workers could threaten the financial stability of retiree coverage.

Workers losing coverage may be eligible for COBRA, but that coverage can be expensive. There are some proposals to subsidize COBRA premiums, by as much as 100 percent.¹⁷ During the Great Recession, COBRA premiums were subsidized by 65%. Making coverage more affordable could keep people in employer plans and mitigate adverse selection or other problems that can arise due to declining enrollment. Facilitating COBRA coverage for workers who are laid off can limit health care disruptions arising from shifts to different coverage designs and provider networks, especially if layoffs are shorter term in nature and workers eventually return to their prior jobs.

Risk adjustment is already in place for many insurance markets. But its effectiveness at addressing plan-specific adverse selection could be affected by the COVID-19 outbreak. In particular, the Medicare Advantage risk adjustment program uses diagnoses from the prior year to determine risk scores and risk adjustment payments for the plan year. With many MA enrollees deferring care in 2020, diagnoses may be understated, potentially understating 2021 risk scores. Although CMS has released guidance that diagnoses recorded during 2020 telehealth visits will count toward 2021 risk scores, many conditions will go unrecorded. There may be less of an issue for the individual and small group markets risk adjustment programs, as those are concurrent in nature; diagnoses recorded during 2020 and 2021 will be used to determine 2020 and 2021 risk scores, respectively. That said, the risk adjustment program could advantage insurers with populations that can't defer care compared to plans with some deferred chronic care that results in additional unintended costs.

¹⁶ Internal Revenue Service and Employee Benefits Security Administration, "[Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak](#)" May 4, 2020.

¹⁷ See for instance the [HEROES Act](#) (H.R. 6800).

The Medicaid program will be especially affected by COVID-19. Some Medicaid enrollees are especially vulnerable to COVID-19 due to age, disability, or underlying health conditions. And due to COVID's effects on the economy, Medicaid will likely experience enrollment increases, with new enrollees shifting from group coverage and possibly individual coverage as well. These enrollment increases will occur at the same time state revenues are declining, which will put more pressure on state budgets. The Families First Coronavirus Response Act temporarily increases the federal share of Medicaid spending, or Federal Medical Assistance Percentage, (FMAP), by 6.2 percentage points. This increase will help state budgets in the short term, but some states have already announced Medicaid cuts.¹⁸ In addition, increased Medicaid costs due to higher enrollment and pent-up demand from deferred care could continue even after the FMAP bump is eliminated.

Finally, although COVID-19 is straining some parts of the health system with increased needs for respiratory care, the deferral of non-COVID care has reduced provider revenue across the system. In April, health care employment declined by 1.4 million workers.¹⁹ Such declines lead to concerns regarding access to care, the sustainability of health care providers, possible facility closures, and the potential for increased provider consolidation that can result in higher provider prices. There are particular concerns for safety net providers that already receive lower payment rates. Some insurers are advancing payments to health care providers, typically on a month-to-month basis, with reconciliation. These payments address providers' short-term cash flow concerns but are not meant to act as larger or longer-term loans. Through the various COVID-relief bills that have been enacted, the federal government is paying hospitals and other providers for health care expenses or lost revenues due to COVID-19. More information is needed on how these funds are being distributed, but it is possible that funds appropriated to date will be insufficient to meet provider revenue needs.

¹⁸ Rachel Roubein and Dan Goldberg, "[States Cut Medicaid as Millions of Jobless Workers Look to Safety Net](#)," *Politico*, May 5, 2020.
¹⁹ Bureau of Labor Statistics, "[The Employment Situation—April 2020](#)," USDL-20-0815, May 8, 2020.

Conclusions

The COVID-19 pandemic has had profound effects on the U.S. health system, both directly through its effects on medical needs and indirectly through its related effects on the economy. Health insurers face uncertainty regarding the pandemic's impacts on their 2020 financial experience and 2021 premium setting. This issue brief examines the different types of risks that insurers can face and the various risk mitigation mechanisms that can be used to address them. Some of these mechanisms, particularly risk corridors and reinsurance, have been put forward as ways to address COVID-19-related risks. Risk corridors can target those insurers that experience unexpected losses. Reinsurance would provide financial assistance more generally across insurers, which could benefit both insurers with unexpected losses and those without. Current MLR requirements could limit unexpected insurer gains, however.

When assessing whether to pursue risk mitigation mechanisms, policymakers should consider whether they would address the risk in question; be relatively easy to administer, especially if the mechanism is meant to be temporary; and be fair to different insurers. Because risk mitigation mechanisms are focused on health insurer financial results and are not structured to address all of the issues facing the economy and the health system, other efforts may be needed, such as COBRA subsidies, changes to risk adjustment mechanisms, or increased payments to providers or states.

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MA Y, 19, 2020

Responding to COVID-19: Marketplaces Take Action

OV ID-19

Julie Bataille and Alison Kruzel,

GMMB

As the COVID-19 crisis began to take hold, state-based marketplaces began to take action. In the first nationwide public health emergency since the Affordable Care Act created new coverage options in states. Marketplaces used their decision-making flexibility to trigger new special enrollment periods (SEP), as part of states' responses to the pandemic and to answer an increased demand for health insurance and care. In conversations with seven SBMs that established an SEP—California, Maryland, Massachusetts, Nevada, New York, Rhode Island and Washington—we uncovered strategies that successfully drove enrollment, including: leveraging their SBM status to quickly and efficiently operationalize customer service in a new remote environment, directly engaging with existing customers as well as reaching out broadly to new ones, and adapting outreach tactics based on new insights regarding audience needs and behaviors to reach them most effectively.

Decision to Establish COVID-19 SEP Related in Public Goods

Each year during enrollment, SBMs implement innovative strategies to reduce the number of uninsured rates in their state.

As COVID-19 hit, SBMs and state leaders across the country recognized that if they did not have health coverage, they would be less likely to seek treatment and more prone to the virus, resulting in unnecessary hospitalizations and even deaths. And from a broader public health perspective, marketplaces recognized that having a larger uninsured population would ultimately result in the virus spreading more widely across the population. States quickly reached the decision to implement an SEP that would allow any uninsured residents in their state to enroll in a health plan during the public health emergency. And as the economic impacts of the crisis became clear, this audience grew to those needing marketplace Medicaid coverage—many for the first time—as more residents lost jobs and their employers reduced insurance.

Ability to Quickly Implement the SEP

States worked to quickly operationalize COVID-19 SEP through various mechanisms, including leveraging their SBM status. This entailed not only updating applications and website pages, but also transitioning to virtual in-person enrollment assistance and remote center staffing. Additionally, states extended SEP deadlines and updated materials as the environment changed and redactions of the long-term economic consequences of the pandemic became more severe.

- **Washington:** As the state began rolling out and refining its SEP, the marketplace was intentionally able to rapidly communicate with its assister network as it transitioned from the in-person model to operating virtually. In addition, the SBM worked with community organizations within the assister network who offered to help customers over the phone via their own hotlines and drive all volume away from the call center which had been experiencing extremely high volume.
- **New York:** Following the COVID-19 declaration in New York, NY State of Health, together with the New York State Department of Financial Services, announced a Special Enrollment Period in March for eligible individuals to enroll in health insurance through the marketplace directly through insurers. NY State of Health was able to quickly launch an education and awareness campaign to reach New Yorkers at risk of

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r m te en enr llment: unders ring that market la es are en f r business and here t hel , and
r mding finan ial hel and free enr llment assistan e. There has been an in reasing shift t wards
r mding verage t individuals wh l st their empl yer-s ns red insuran e, as the e n mi
risis has further taken h ld and as s me COVID-s e ffi SEPs have ex ired.

- **Nevada:** While riginally r moting l ss f j b-based verage and COVID-19 SEPs
se arately, the market la e shifted t en urage th se wh missed en enr llment in 2019
t use this rtunity t get verage and the ea e f mind that mes with it. ([Exam ple](#))
- **Ma ssachusetts:** The state is br adly en uraging residents, in luding th se wh have l st
their j b-based verage, t he k ut their verage ti ns thr ugh the Health C nne t r's
u dated web age. Being able t establish a br ad COVID-19 SEP has all wed them t av id
messaging the nuan es f enr lling within 60 days f l sing y ur j b-based verage t
minimize nfusi n f r nsumers. ([Exam ple](#))

Leveraging Direct Consumer Touchpoints with Existing Customers

Bey nd the uninsured, urrent mar t ke la e ust l me s rs are as fa ing impa t f C
Ma rket es are leveraging the trust they've built with existing ust mers t share inf r t n ab ut ma i
h w t u date j b r in hanges, h w t nsider sti lus me ks and unemp y t ayments me n
when a l ying f r a tax redit, and h w th se hanges uld impa t eligibility f r finan ial hel .

- **Massachusetts:** C mmuni ati n with existing members has in luded [r a tive s ial media](#)
[r mdi n](#) and emails f used n h w and why t re rt in me hanges, and larifying that c
sti nus ayments d n't need t be re rted. The market la e als ndu ted r b alls t
existing ust mers t share this inf rmati n.
- **Rhode Island:** The state sent text n eages in English and S anish t existing ust mers
en uraging them t re rt hanges, and sent targeted emails t any ne wh had revi usly
ex l red health insuran e but never enr lled.

Scaling Integrated Marketing and Outreach Campaigns

Ra mp ing Social Efforts Media E

Pr mdi n ften ki ked ff with heavy earned and s ial h t and me c
targeting messaging t wards uninsured individuals and th se wh l st their j b-based verage.
These ta ti s hel ed fill ga s in s reading the w rd that w uld n r nly be ne thr ugh in- ers n
utrea h and enr llment events. They als ta ed int hanging dia e havi rs, as m re
nsumers were turning t l al news f r inf rmati n ab ut COVID-19 and s ending more time nline
while staying h me. States have taken t live streaming, Twitter hats, and strategi email and S MS
marketing t r mte the SEP and engage with nsu al latf r rose nding t their
questi ns in real time. The me dia als res nded with an eagerness t ush ut enr llme t n

inf r t nta i n, wi h r a r e me et la es e rting a l vel f during the annual en enr llment eri d. Websites have als een u dated and re-devel ed t h use inf r ti n f ma nsumers in different languages. c

- **Nevada:** The market la e h sted several Fa eb k live streams and Twitter hats where staff uld res nd t questi ns and engage with key artners and nsumers. The SBM has seen g d res nse and engagement, and has been able t in int where nsu me are nfused and res nd in real time.
- **Colorado:** The state aggressively ushed ut ress releases and r m dted the market la e as a res ur e t media, resulting in 236 media menti ns during the SEP m ared t 184 menti ns during the t tals an f en enr llment—n t nly in the Denver metr area, but als in smaller news a ers that rea h key target audien es.

Increasing Agency Coordination and Organizational Partnerships

As states t k ntr l f the C res rse/ verid, 19 there was an in reased f us n agen ies w rking t gether t best ne residents' needs, in luding r m dding health verage ti ns. Health agen ies are w rking with De artments f Lab r, Insuran e, and Human Servi es, among thers, t utilize nsu me u h ints and hannels t r vide res ur es and inf rmati n ab ut health verage, eligibility and enr llment.

- **Rhode Island:** Publi inf rmati n ffi ers and mmuni ati ns dire t rs a r ss all state agen ies h ld a daily m rning all t share u dates during the state f emergen y and ma ke requests f r ntent t be in luded in the Govern r's daily ress briefings. The et la e is als w rking t in lude a mailer in De art f meand t r i ns with nstituents.
- **Massachusetts:** As the state has seen a deluge f e le filing f r unem l yment, the market la e is rdinating l sely with the state's unem pl yment agen y t in lude inf rmati n ab ut available health insuran e ti ns as e le seek unem pl yment benefits. As a result f these eff rts, a link t the Health C nne t r's website is in luded n the final age f the state's nline unem pl yment a li ati n.
- **New York:** NY State f Health and the New Y rk State Edu ati n De artment are w rking t gether t rea h families wh may have l st health verage during this andemi by , getting inf rmati n ut t s h l leaders t then share with families within their distri ts.

In additi n, many states are ta ing key artners that are ften engaged during the en enr llment eri d, leveraging virtual rtunities t share verage inf rmati n with nsumers and business wners. Market la es are w rking with insuran e arriers, hambers f mmer e, r fessi nal ass iati ns, s h l distri ts, libraries, mmunity rganizati ns, and thers t hel get the w rd ut. c

- **New York:** While the s ring is usually filled with many in- ers n utrea h events, the Market la e f used n existing artners wh uld hel s read the w rd ab ut verage ti ns. This in luded airing PSAs ab ut available verage ti ns in 88 gr ery st res a r ss the state, as well as in m re than 400 CVS Pharma y l ati ns. The market la e is als rdinating l sely with more than 190 lleges t distribute a t lkit t Health Dire t rs t share with students wh are studying rem tely. In additi n, the Market la e nne ted with a l ngstanding artner, Gr w NYC, t get edu ati nal materials ut t d zens c f farmers markets t share with their ust mers. It is als w rking with f d antries t distribute NY State f Health ra k ards thr ough mbile f d antries, i ku s, deliveries, and drive-thru events a r ss the state.

Investing in Digital Advertising

S me states reall ated budget that w uld traditi nally g t wards events and in- ers n utrea h, m ving t m re investme nts t rta l i e di . In s s e the emag , the nus d addi i nal res ur es t amplify aid buys. As residents began t nsume more ntent a r ss digital latt r ms , states have been l sely wat hing and re-all ating their aid media d llars t ma t h shift. All c

states shifted to the heavier on digital and lighter on traditional TV, and in some cases eliminated traditional radio and moved to streaming services due to decreases in “drive time” as most people were not commuting to work.

- **Colorado:** Instead of implementing a statewide digital ad campaign, the market leader continued to have a heavier presence in the Denver metro area as well as in mountain communities where COVID-19 outbreaks and job loss impacts were taking hold.
- **New York:** As part of its advertising awareness campaign, NY State of Health prioritized paid advertising statewide to reach many New Yorker’s who are at risk of losing their health insurance as a result of COVID-19. Advertising was targeted to the following industries most at risk of losing their health coverage due to business closures: the insurers, the nature of the work: accommodation/food services, arts, entertainment and recreation, taxi/Uber, child care, barber shops/hair salons/nail salons, home health care, and some retail). Ads are running statewide on television, digital (through social, search and display) and radio and are in English, Spanish, and Mandarin.

Enrollment Results Demonstrate Urgent Demand for Coverage

SBMs have seen high demand for market leader and Medicaid coverage during this crisis. For example, Maryland Health Connection has enrolled nearly 29,000 individuals to date—a 70% increase from last year’s SEP enrollments. More than 19,000 individuals enrolled through Washington Health Linkfinder and more than 14,000 individuals enrolled through Connecticut Health Connector during each state’s SEP.

States are also taking a closer look at who enrolled during SEPs and, in some cases, are making gains with populations that have been historically underinsured or uninsured. For example, of the 29,000 Maryland enrollees, nearly 35% were young adults.

Looking Ahead: Addressing Inequities and Other Issues

COVID-19 has brought about an increased demand for quality, affordable health insurance. It has also highlighted the existing inequities in our health care system across race, income and other demographics. Moving into the 2021 enrollment period, there will be ongoing issues to address, including improving access to coverage and care for those most impacted by COVID-19; dealing with burn aross public and private programs as eligibility rules and income levels change; and monitoring fluctuating job situations and resulting need for coverage. States will need to consider how the pandemic will impact plan renewals and attitudes towards health insurance, and how shifting marketing and outreach strategies may help address the health inequities they have been confronting for years and have seen elevated as a result of COVID-19. c

May 18, 2020

Congress Should Bolster ACA Marketplace Coverage Amid COVID-19

Marketplaces Can Do Even More to Protect People From Health and Economic Hardship

By Tara Straw, Sarah Lueck, and Aviva Aron-Dine

As the COVID-19 pandemic triggers staggering job losses and slashes families' incomes, the Affordable Care Act's (ACA) health insurance marketplaces are a crucial source of comprehensive health insurance for millions of people. But others who could benefit from marketplace coverage will remain uninsured due to inadequate financial assistance, because enrollment is closed to them, or due to other barriers. Congress should take steps to help as many people as possible access marketplace plans at this critical time.

Comprehensive health coverage is important under any circumstances because it improves access to care, financial security, and people's health outcomes when they get sick. But extending comprehensive health coverage to more people is even more critical during a pandemic and severe recession. Health coverage shields families from financial hardship and also supports public health efforts, allowing people to seek the testing and treatment needed to curb the disease's spread. So far, the federal legislation enacted in response to COVID-19 has not included any provisions to extend health coverage or make it more affordable. Congress can and should address this gap.

Specifically, policymakers should:

- **Make marketplace plans more accessible** with new special enrollment periods (SEPs), both a time-limited emergency SEP for everyone and a new SEP for people who lose their jobs, even if they weren't enrolled in health coverage. Legislation should also fund and require the Administration to conduct outreach about marketplace coverage.
- **Make marketplace plans more affordable** by increasing premium tax credits and protecting people from having to repay large amounts of premium tax credits due to uncertainty and volatility in their incomes during the recession.

Legislation introduced by House Democratic leaders, the Heroes Act (H.R. 6800), would establish an emergency SEP and provide robust funding for outreach. But it falls short on affordability since

it does not include improvements in premium tax credits or protections against premium tax credit repayment.¹

These improvements to marketplace coverage are needed even though the Heroes Act includes subsidies for COBRA, which lets workers losing their jobs continue purchasing coverage through their employers. COBRA coverage is unavailable to many unemployed workers, including many low-income people and people of color, whereas premium tax credit improvements would make coverage more affordable for those who need help the most. Even before the pandemic, low-income people and people of color were more likely to be uninsured and face barriers to accessing health care, and these groups have been especially hard hit by the economic crisis and by the illness itself.²

Likewise, the funding for health providers enacted in previous COVID-19 response bills is no substitute for expanding access to comprehensive coverage. The Trump Administration has claimed there is no need for additional steps to strengthen marketplace coverage because it is planning to use some of this funding to cover COVID-19 costs for the uninsured.³ But reimbursing providers for some COVID-19 treatment costs does not give consumers the financial security and access to health care services that come with comprehensive coverage.⁴

Marketplaces Provide an Alternative to Job-Based Coverage

Millions of people will lose job-based coverage during the economic downturn. About 27 million people (both workers and their family members) had already lost coverage by May 2, as job losses mounted amid the COVID-19 pandemic, the Kaiser Family Foundation estimates.⁵ If the unemployment rate rises from 14.7 percent in April to 20 percent, as some forecasts suggest may occur by June, as many as 43 million people could lose employer-sponsored health coverage, the Urban Institute estimates.⁶

¹ The next COVID-19 response legislation should also include measures to address the looming state budget crisis, protect Medicaid coverage, and improve financial security for struggling families, as the Heroes Act does. See Robert Greenstein, “Pelosi Package Would Provide Needed Support for Economy, Relief to Households,” Center on Budget and Policy Priorities, April 12, 2020, <https://www.cbpp.org/press/statements/greenstein-pelosi-package-would-provide-essential-support-for-economy-relief-to>.

² Samantha Artiga, Rachel Garfield, and Kendal Orgera, “Communities of Color at Higher Risk for Health and Economic Challenges due to COVID-19,” Kaiser Family Foundation, April 7, 2020, <https://www.kff.org/coronavirus-covid-19/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/>; and LaDonna Pavetti and Peggy Bailey, “Boost the Safety Net to Help People With Fewest Resources Pay for Basics During the Crisis,” CBPP, April 29, 2020, <https://www.cbpp.org/research/poverty-and-inequality/boost-the-safety-net-to-help-people-with-fewest-resources-pay-for>.

³ Adam Cancryn, Nancy Cook, and Susannah Luthi, “How Trump surprised his own team by ruling out Obamacare,” Politico, April 3, 2020, <https://www.politico.com/news/2020/04/03/trump-obamacare-coronavirus-164285>.

⁴ Christen Linke Young *et al.*, “Responding To COVID-19: Using The CARES Act’s Hospital Fund To Help The Uninsured, Achieve Other Goals,” *Health Affairs* Blog, April 11, 2020, <https://www.healthaffairs.org/doi/10.1377/hblog20200409.207680/full/>.

⁵ Rachel Garfield *et al.*, “Eligibility for ACA Health Coverage Following Job Loss,” Kaiser Family Foundation, May 13, 2020, <https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/>.

⁶ Bowen Garrett and Anuj Gangopadhyaya, “How the COVID-19 Recession Could Affect Health Insurance Coverage,” Urban Institute, May 2020, https://www.rwjf.org/en/library/research/2020/05/how-the-covid-19-recession-could-affect-health-insurance-coverage.html?cid=xsh_rwjf_tw. ⁷ Anuj Gangopadhyaya and Bowen Garrett, “Unemployment, Health

Since taking effect in 2014, the ACA marketplaces and Medicaid expansion have provided health insurance to many who lack it at their jobs, including gig workers, the self-employed, and people who work for small businesses, as well as those who are unemployed. The uninsured rate among unemployed people fell markedly after the ACA was fully implemented in 2014. While states that expanded Medicaid saw the largest gains, non-expansion states also saw drops in uninsured rates for unemployed people due to the availability of marketplace coverage.⁷

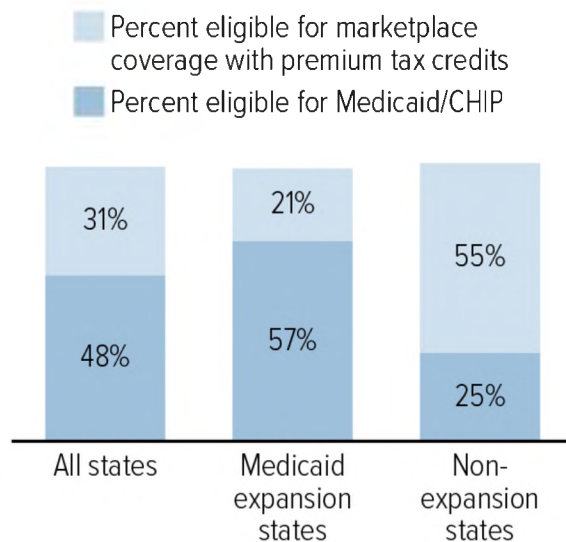
The importance of the marketplaces is likely to grow in this recession. In prior recessions, which occurred before the ACA became law, people who lost job-based coverage often had nowhere to turn. This time, the marketplaces and the ACA’s Medicaid expansion (which 35 states and Washington, D.C. have implemented) are serving as vital sources of affordable coverage. As Senator John Cornyn, a Texas Republican, recently noted, “The good news is that if you lose your employer-provided coverage... [that] makes you then eligible to sign up for the Affordable Care Act... [I]t has a sliding scale of subsidies up to 400 percent of poverty. So that’s an option for people.”⁸

The Kaiser Family Foundation estimates that 31 percent of those who have already lost job-based coverage are eligible for subsidized marketplace coverage. (See Figure 1.) Subsidized marketplace coverage is an important option for workers in all states but will play an especially crucial role for lower-income people in non-expansion states, where an estimated 55 percent of those who have lost

FIGURE 1

Many Losing Job-Based Coverage Can Get Medicaid/CHIP or Premium Tax Credits

Eligibility among people who recently lost job-based coverage



Note: CHIP = Children’s Health Insurance Program. Medicaid expansion states are those that have taken up the Affordable Care Act option to cover low-income adults. Estimates are for May program eligibility for people who lost job-based coverage between March 1 and May 2, 2020 and assume workers receive unemployment benefits.

Source: Kaiser Family Foundation

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Insurance, and the COVID-19 Recession,” Urban Institute, April 2020, https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf.

⁷ Anuj Gangopadhyaya and Bowen Garrett, “Unemployment, Health Insurance, and the COVID-19 Recession,” Urban Institute, April 2020, https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf.

⁸ Jennifer Bendery, “John Cornyn Encourages People to Sign Up for Obamacare After Fighting to Repeal It,” HuffPost, May 13, 2020, https://www.huffpost.com/entry/john-cornyn-affordable-care-act-repeal_n_5eb99535c5b65e6c9a4d98d0.

job-based coverage to date are eligible for premium tax credits.⁹ (These estimates are for May 2020 and assume workers are receiving unemployment insurance, or UI.¹⁰)

But some people who need help won't be eligible to enroll in the marketplace under current rules because they didn't have employer coverage before losing their job. And some people who are eligible for assistance will opt not to enroll because of financial and other barriers. Many millions could become or remain uninsured at the worst possible time. Federal legislation should focus on making it easier and more affordable for these people to enroll in the marketplace.

Make Marketplace Coverage More Accessible

People can enroll in marketplace plans during a yearly open enrollment period each fall. The last open enrollment, for 2020 plans, had already ended when the pandemic and job losses hit the United States. To enroll in the marketplace and access premium tax credits for the rest of the year, people must therefore qualify for a special enrollment period (SEP).

Some people harmed by the COVID-19 crisis will not be eligible for a marketplace SEP under current federal rules. People qualify for an SEP if they have lost other qualifying coverage. Other events that trigger an SEP include the birth of a child and moving to a new geographic area. But people who lose their jobs or experience a sharp drop in income and were already uninsured will not qualify to enroll in the marketplace. Along with the 27 million people who have lost job-based coverage over the past few months, Kaiser estimates that about 7 million people in families where someone has become unemployed were already uninsured prior to job loss and thus wouldn't be eligible to enroll in the marketplace, even if they otherwise qualified for subsidized coverage.

Even for people who do qualify for an SEP, following through to enrollment can be challenging. First, they must know where and how to apply for coverage, but many people are not familiar with the marketplaces or the situations that trigger an SEP. Second, to apply, people must supply all the usual information needed for an eligibility determination as well as details related to SEPs, such as when they lost other coverage, and they usually have to meet a 60-day deadline. Often, people are asked to supply documents (such as a letter from a former employer or health insurer) to verify that they are eligible for an SEP.

This information and related documents may be difficult to obtain due to office closures and other social distancing protocols in place due to the public health emergency. At the moment, many marketplaces, including the federal marketplace, known as HealthCare.gov, are allowing people to attest to their eligibility rather than requiring paper documents, but this may not remain the case for the duration of the public health and economic crises.

⁹ In expansion states, people with incomes between 100 and 138 percent of the poverty line qualify for Medicaid; in non-expansion states, this group qualifies for subsidized marketplace coverage. Many unemployed workers and their families are likely to fall into this income range.

¹⁰ Without UI or after unemployment benefits lapse, more people in expansion states will qualify for Medicaid, but many people in non-expansion states will fall into the coverage gap, being ineligible for both Medicaid and premium tax credits. The Kaiser analysis takes into account the UI enhancements enacted as part of the Coronavirus Aid, Relief, and Economic Security Act.

Require HealthCare.gov to Open a Time-Limited SEP

Eleven states and the District of Columbia that fully run their own health insurance marketplaces (rather than relying on HealthCare.gov) acted quickly to implement time-limited emergency SEPs to allow uninsured people to enroll during the public health emergency. Preliminary data show this helped many people access coverage: thousands enrolled in marketplace plans, while others visited their state marketplaces because of the SEP and learned that they were eligible for Medicaid.

- In California, more than 84,000 people signed up for marketplace plans during roughly the first five weeks of the emergency SEP — 2.5 times more enrollment than during the same calendar period the prior year.¹¹
- In Maryland, more than 4,000 people enrolled in the state’s marketplace plans in just the first two weeks of the state’s emergency SEP, and nearly 6,000 enrolled in Medicaid.¹²
- In Massachusetts, more than 8,000 people enrolled using the COVID-19 SEP within the first 40 days. More than 11,000 additional people have enrolled since early March, using other extended enrollment pathways including the SEP for loss of other coverage or because the state allows many people with lower incomes to enroll throughout the year in private plans.¹³

Many of the states that created emergency SEPs have extended them beyond their initial deadlines, with several allowing people to continue to enroll through June or even, in the case of Washington, D.C., September.

The Administration has the authority to create a similar SEP for the 38 states that rely on HealthCare.gov. This would be a simple way to open the door to people who newly want insurance, for any reason, and to reduce SEP documentation burdens on applicants as well as the agencies and contractors that operate the eligibility and enrollment system. It has broad support from stakeholders, including governors of many states using HealthCare.gov and health insurer associations.¹⁴

Unfortunately, the Trump Administration has so far refused to use this authority. The Centers for Medicare & Medicaid Services (CMS) reportedly was poised to create an SEP, but the White House

¹¹ “Covered California Continues to See Strong Consumer Interest in Quality Health Care Coverage During the COVID-19 Pandemic,” press release, Covered California, April 28, 2020, <https://www.coveredca.com/newsroom/news-releases/2020/04/28/covered-california-continues-to-see-strong-consumer-interest-in-quality-health-care-coverage-during-the-covid-19-pandemic/>.

¹² “Maryland Health Connection Data Report,” March 31, 2020, https://www.marylandhbe.com/wp-content/uploads/2020/04/Executive-Report_3_31_2020.pdf.

¹³ “Massachusetts Health Connector COVID-19 Special Enrollment Period: Results to Date,” Massachusetts Health Connector, May 1, 2020, <https://www.mahealthconnector.org/wp-content/uploads/Health-Connector-COVID-19-SEP-Brief-050120.pdf>.

¹⁴ See Rebecca Klar, “12 Governors Press Trump for Special Obamacare Enrollment Period Amid Coronavirus Pandemic,” *The Hill*, April 13, 2020, <https://thehill.com/homenews/state-watch/492555-12-governors-call-on-trump-to-open-special-obamacare-enrollment-period>; “Governor Ducey Requests Special Health Care Enrollment Period,” March 25, 2020, <https://azgovernor.gov/governor/news/2020/03/governor-ducey-requests-special-health-care-enrollment-period>; and America’s Health Insurance Plans and Blue Cross Blue Shield Association, Letter, March 19, 2020, <https://www.ahip.org/wp-content/uploads/AHIP-and-BCBSA-Legislative-Recommendations-03.19.2020.pdf>.

stepped in to block it from doing so.¹⁵ Given the Administration’s refusal to act, Congress should mandate the creation of an emergency SEP, as the Heroes Act would do. The bill proposes an eight-week SEP for the marketplace, which would take effect in all states that have not already provided an emergency SEP, and it would allow people’s coverage to be effective retroactive to April.

Create an SEP for Loss of Job, Not Just Loss of Job-Based Coverage

It would also be helpful to create an SEP for anyone who loses their job even if they have not lost job-based coverage. Such an SEP could be permanent, or it could be made available for the duration of the current economic crisis.

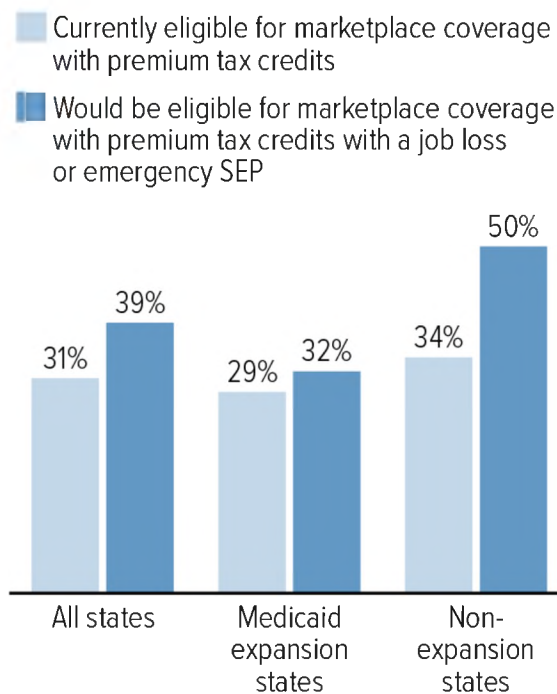
The scale of job losses as a result of the pandemic is staggering. As discussed above, many of these people would qualify for the existing “loss of coverage” SEP because they have also lost their employer-sponsored health coverage. Others will qualify for Medicaid, which allows people to enroll year-round. But a new SEP tied to job loss (irrespective of loss of coverage) would help many more people when they or their family members become unemployed, including cases where the employer didn’t offer coverage or the worker opted not to enroll in their employer plan.

A recent Urban Institute analysis examines workers in industries especially vulnerable to job loss (such as restaurants, certain retail, and child care) and what their coverage options would be if they lost their jobs.¹⁶ Because some such workers are currently uninsured, they would not qualify for marketplace coverage without a special SEP. A job-loss SEP would increase by about a quarter the number of these workers (and their family members) able to access subsidized marketplace coverage if they lost their jobs, the Urban Institute estimates show, with a larger impact in non-expansion states. With a job-loss SEP, 39 percent of

FIGURE 2

Special Enrollment Period (SEP) for Job Loss Would Let More People Access Marketplace Plans

Eligibility for workers in vulnerable industries (and family members) if they lost their jobs



Note: Special enrollment periods allow people to sign up for marketplace coverage outside of the annual open enrollment period. Vulnerable industries are those at risk of job cuts during the pandemic. Marketplace and primary tax credit eligibility assumes that workers lost their jobs and were eligible for unemployment insurance.

Source: Urban Institute, Health Insurance Policy Simulation Model. April 2020

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¹⁵ Susannah Luthi, “Trump rejects Obamacare special enrollment period amid pandemic,” Politico, March 31, 2020, <https://www.politico.com/news/2020/03/31/trump-obamacare-coronavirus-157788>.

¹⁶ Linda J. Blumberg *et al.*, “Potential Eligibility for Medicaid, CHIP, and Marketplace Subsidies Among Workers Losing Jobs in Industries Vulnerable to High Levels of COVID-19-Related Unemployment,” Urban Institute, April 2020, https://www.urban.org/sites/default/files/publication/102115/potential-eligibility-for-medicaid-chip-and-marketplace-subsidies-among-workers-losing-jobs-in-industries-vulnerable-to-high-levels-of-covid-19-related-unemployment_0.pdf.

such workers (and their family members) would qualify for subsidized marketplace coverage, compared to 31 percent in the continued absence of such an SEP. In non-expansion states, the share would increase from 34 to 50 percent.¹⁷ (See Figure 2.)

In addition to expanding eligibility for marketplace coverage, a job-loss SEP would also make it easier for people dealing with job loss to understand and corroborate that they qualify for an SEP; as noted above, currently, even many people who qualify find the requirements confusing. And it would simplify outreach to the newly unemployed since they would all qualify to purchase a marketplace plan regardless of the particulars of their situation. A job-loss SEP would be beneficial even if Congress also establishes a one-time emergency SEP, as the Heroes Act would do, since job losses will continue after that SEP ends. And because job loss usually occurs for reasons unrelated to health care needs, a long-term or permanent job-loss SEP shouldn't create significant concerns about adverse selection.

Expand Consumer Assistance

Since 2017, CMS has slashed the budget for HealthCare.gov outreach and advertising by 90 percent, and funding for navigators, people who provide impartial enrollment assistance to consumers, by 84 percent.¹⁸ Some states supplement this funding, and state-based marketplaces such as Covered California have made a particularly strong outreach push.¹⁹

Requiring and funding HealthCare.gov to mount an aggressive email, digital, and television outreach campaign would let people know that if they've lost insurance or experienced another life change, marketplace coverage may be available. As noted above, creating a new SEP for job loss would simplify this outreach, since the campaign could simply let people know that if they've lost their job, they can enroll through the marketplace. (In addition, outreach can let people know that Medicaid and the Children's Health Insurance Program are available at any time.) Marketplaces can also conduct outreach to current enrollees whose income may have fallen to alert them that they may qualify for a higher premium tax credit or Medicaid.

Additional funding could also be used to facilitate Medicaid and marketplaces' coordination with other state agencies — such as unemployment agencies — to reach people who are newly eligible for help paying for health care. And HealthCare.gov, state-based marketplaces, and Medicaid call centers may need more funding so that additional staff are available to handle a surge in calls, can adapt to remote work and other social distancing requirements, and are sufficiently trained in SEP-, UI-, and Medicaid-related questions. The Heroes Act would require the Department of Health and Human Services (HHS) to conduct education and outreach to inform more people about marketplace plans and financial assistance and would appropriate \$25 million for this purpose.

¹⁷ These estimates assume that workers receive unemployment benefits.

¹⁸ Karen Pollitz, Jennifer Tolbert, and Maria Diaz, "Data Note: Limited Navigator Funding for Federal Marketplace States," Kaiser Family Foundation, November 13, 2019, <https://www.kff.org/private-insurance/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/>; Timothy Jost, "CMS Cuts ACA Advertising By 90 Percent Amid Other Cuts To Enrollment Outreach," *Health Affairs*, August 31, 2017, <https://www.healthaffairs.org/doi/10.1377/hblog20170901.061790/full/>.

¹⁹ Peter Lee *et al.*, "Marketing Matters: Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets," Covered California, September 2017, https://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf.

Make Marketplace Coverage More Affordable

Improve Premium Tax Credits

The ACA provides premium tax credits and cost-sharing assistance for marketplace plans, which has helped millions of people afford health coverage. But many people who are eligible for this assistance remain uninsured, often because the net premium they owe, even with a premium tax credit, is higher than they can afford. Despite ACA subsidies, uninsured rates remain higher among lower-income people, and the share of people without job-based coverage who enroll in individual market plans remains lower.²⁰ State programs that supplement the ACA premium tax credits have been shown to substantially increase enrollment in coverage, confirming that cost is a key barrier.²¹

Affordability problems will become more acute in the current crisis. For people who lose their jobs or experience sharp drops in income this year, their annual incomes, which are used to calculate the amount of premium tax credit they are eligible for, will be high compared to their monthly income after the job loss or income drop. That will make it harder for them to afford the monthly contributions toward premiums they must make to maintain health insurance for themselves and their families. In addition, because premium tax credits are not available to people with incomes greater than 400 percent of the federal poverty line (about \$50,000 for an individual in 2020), some people face high premium costs relative to their incomes but are not eligible for any assistance. This problem is particularly common among older people, who face higher premiums.

The Heroes Act does not include increases in premium tax credits. But a bill that House Democrats proposed in March to respond to COVID-19 (H.R. 6379, the Take Responsibility for Workers and Families Act) rightly prioritized significant improvements, cutting required premium contributions for people at all income levels.²² Under that proposal, people with incomes up to 150 percent of the poverty line would pay nothing toward the premium for a benchmark plan in the marketplace, down from roughly 2 to 4 percent of income that group must pay under current law. And the bill proposed capping how much people with incomes over 400 percent of the poverty line must pay, protecting them from paying more than 8.5 percent of their income on premiums. (See Figure 3.)

²⁰ Aviva Aron-Dine and Matt Broaddus, “Improving ACA Subsidies for Low- and Moderate-Income Consumers Is Key to Increasing Coverage,” CBPP, March 21, 2019, <https://www.cbpp.org/research/health/improving-aca-subsidies-for-low-and-moderate-income-consumers-is-key-to-increasing>.

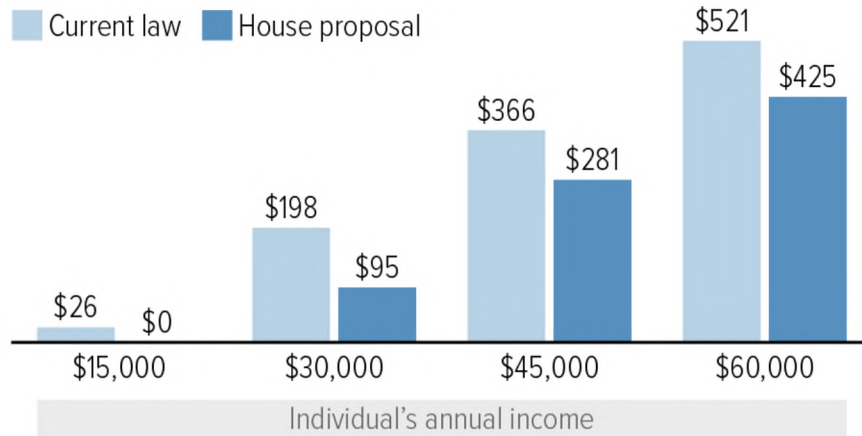
²¹ Amy Finkelstein, Nathaniel Hendren, and Mark Shepard, “Subsidizing Health Insurance for Low-Income Adults: Evidence from Massachusetts,” *American Economic Review*, 2019, <https://pubs.aeaweb.org/doi/pdfplus/10.1257/aer.20171455>; and Jennifer Tolbert *et al.*, “Improving the Affordability of Coverage through the Basic Health Program in Minnesota and New York,” Kaiser Family Foundation, December 2016, <http://files.kff.org/attachment/Issue-Brief-Improving-the-Affordability-of-Coverage-through-the-Basic-Health-Program-in-Minnesota-and-New-York>.

²² Premium tax credit improvements should be set to take effect for 2020, earlier than H.R. 6379’s proposed 2021 effective date; there is no programmatic reason premium tax credit amounts cannot change mid-year.

FIGURE 3

Proposal in Earlier House Bill Would Make Marketplace Coverage More Affordable

Monthly premium for benchmark marketplace coverage for a 45-year-old, based on national average premium



Source: CBPP calculations based on H.R. 6379, the Take Responsibility for Workers and Families Act

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Increasing premium tax credits could expand health coverage while also providing timely and effective economic stimulus. Before the crisis, the Urban Institute estimated that a broadly similar package of premium tax credit improvements would lead almost 5 million people to gain coverage, and that number could grow significantly during the downturn.²³

Helping more people access affordable health care will allow them to visit the doctor and fill prescriptions when they need them, rather than avoiding or delaying those purchases and risking worse health problems down the line. And providing greater assistance with premiums to people who buy their own coverage will help relieve some pressure in families' budgets, so people can spend money on food, housing, and other necessities.

As the Urban Institute estimates above show, improving premium tax credits is especially important for low-income people in states that have not expanded Medicaid; this group is disproportionately people of color, who, as noted, have been especially hard hit by COVID-19 and the resulting economic downturn. In these states, many people losing their jobs or income will end up in the coverage gap, with incomes below the poverty line but ineligible for both Medicaid and subsidized marketplace coverage. But those with incomes a little above the poverty line, who would

²³ See Linda Blumberg *et al.*, "From Incremental to Comprehensive Health Reform: How Various Reform Options Compare on Coverage and Costs," Urban Institute, October 16, 2019, <https://www.urban.org/research/publication/incremental-comprehensive-health-reform-how-various-reform-options-compare-coverage-and-costs>.

qualify for Medicaid if they lived in an expansion state, will qualify for subsidized marketplace coverage.²⁴

But people who have lost their jobs may not be able to afford to pay 2 to 4 percent of their annual income toward premiums, the contribution level required at the most generous levels of premium tax credits. So many will still end up uninsured without premium tax credit improvements.

Protect People With Mid-Year Income Changes Against Large Premium Tax Credit Repayments

Eligibility for the premium tax credit is based on annual income. To get the credit in advance and reduce monthly premium costs, people estimate their income for the year ahead; the health insurance marketplace verifies that projection. When they file their taxes, they can claim an additional premium tax credit or must repay some of what they received, depending on whether their actual income is lower or higher than estimated.

The ACA shielded people from very large repayment obligations by capping repayment amounts for those with lower incomes. But subsequent legislation eroded those protections, and there is no protection at all for people who are determined eligible for tax credits during the year but then turn out to have incomes over the eligibility cutoff of 400 percent of the poverty line. Those who find themselves even a few dollars over that threshold must repay the full credit they received, which can amount to thousands of dollars. The specter of repayment can deter people from enrolling in coverage with the financial help they need.

While accurately predicting income is challenging in normal times, the insufficient repayment caps will be even more of a problem — and for more people — in the current crisis. When someone loses a job, their income plummets. Many unemployed people hope to return to work within the year but are unsure whether or when they will. Adding to the complexity, most of these workers will receive UI to help mitigate the income loss, including a \$600-per-week federal supplemental benefit through July that would be extended by the Heroes Act.

Consider a restaurant manager who lost their job and health benefits in April. They were on track to earn income of about \$50,000 for the year and now expect to earn less — but it's difficult to estimate how much less. When applying at the marketplace, this person would need to consider factors such as how long they expect to have no income, how much UI they might collect, when they might find other work, and what amount of income they will earn at that point. If they estimate they will earn about \$30,000 for the year, but then get a new job in October and end up earning \$45,000, they would owe nearly \$700 in repayment, even if they immediately report their higher income.²⁵ If they end up earning \$50,000 — just over 400 percent of the poverty line — they will have to repay the entire \$1,900 advance premium tax credit they received.

²⁴ The temporary \$600-per-week additional UI payment provided in earlier COVID-19 response legislation will help push more people into this income range.

²⁵ CBPP analysis. The 2020 marketplace premium for a 45-year-old is calculated using the Kaiser Family Foundation's Health Insurance Marketplace Calculator (<https://www.kff.org/interactive/subsidy-calculator/>). People receiving premium tax credits are supposed to report changes in income to the marketplace, which may mitigate large repayment obligations but doesn't prevent them in all cases.

To address these challenges, policymakers should restore more protective repayment caps for people below 400 percent of the poverty line and institute reasonable repayment caps for people with incomes above that threshold.

Proposed Alternatives to Marketplace Affordability Improvements Are Insufficient on Their Own

COBRA Subsidies Alone Leave Out Many of Those Needing Help

The Heroes Act would subsidize the full cost of people’s COBRA premiums from March of this year through January 2021. COBRA (named for the 1985 law that created it, the Consolidated Omnibus Budget Reconciliation Act) allows most people with employer-sponsored coverage to continue their coverage for up to 18 months, though usually people must pay the full cost of their premiums. While subsidizing COBRA would reduce some families’ costs, if enacted in place of (rather than alongside) policies to broaden access to marketplace coverage and make marketplace plans more affordable, it would leave out millions of those who most need assistance, including many low-income people and people of color.

One problem is that COBRA is not available to many workers losing their jobs, such as people who are not offered or are not enrolled in job-based coverage. In 2010, following the Great Recession, just 39 percent of UI claimants overall were eligible for COBRA.²⁶ Among all workers losing their jobs (including those not eligible for UI), the share was probably even lower. Moreover, people who work at businesses with fewer than 20 employees are not eligible for federal COBRA.

Low-income people and people of color are less likely to be eligible for COBRA because of lower enrollment in job-based coverage.²⁷ In 2019, only a quarter of workers in the bottom quartile of the wage distribution and half in the second-lowest quartile were enrolled in a health plan through their employer.²⁸ Only 46 percent of Black and 41 percent of Hispanic workers were enrolled, compared to 60 percent of white workers.²⁹ (See Figure 4.)

A second problem is that COBRA coverage is unavailable, or could become unavailable, to people whose employers go out of business or stop offering a health plan during the economic downturn. If the employer stops offering a plan for any reason, COBRA is no longer an option for its employees. With many businesses struggling as a result of the downturn, even some workers who had employer coverage may be unable to enroll in COBRA. And while a potential advantage of COBRA is that workers could continue their coverage in the same plan, some will face the disruption of losing their COBRA coverage (and any associated subsidy) mid-year if their employer goes out of business.

²⁶ Jillian Berk and Anu Rangarajan, “Evaluation of the ARRA COBRA Subsidy: Final Report,” Mathematica Policy Research, prepared for the U.S. Department of Labor, February 18, 2015, <https://www.dol.gov/sites/dolgov/files/EBSA/researchers/analysis/health-and-welfare/evaluation-of-the-arra-cobra-subsidy.pdf>.

²⁷ *Ibid.*

²⁸ Bureau of Labor Statistics, “Healthcare benefits: Access, participation, and take-up rates, private industry workers,” March 2019, <https://www.bls.gov/ncs/ebs/benefits/2019/ownership/private/table09a.pdf>.

²⁹ CBPP analysis using the Census Bureau’s 2017 Current Population Survey.

Finally, COBRA is unaffordable for many of the workers who are offered it. The Heroes Act addresses this by covering the entire cost of the COBRA premium, but final legislation might provide less generous subsidies, in line with the 65 percent subsidy that was provided during the Great Recession.³⁰ Then, even with some people eligible for a subsidy, only 34 percent of eligible people took the COBRA offer.³¹ This was significantly lower for Black (17 percent) and Hispanic (22 percent) workers than for white workers (41 percent).³² Among subsidy-eligible people, a study concluded the subsidy increased take-up by just 5 percentage points (from 30 to 35 percent).³³

This means that unless final legislation provides extremely deep COBRA subsidies, even many workers eligible for COBRA are still likely to end up uninsured, with lower-income workers and people of color especially likely to be left out.³⁴

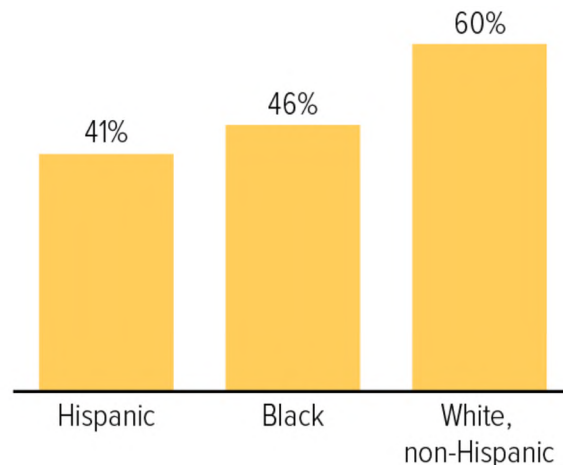
In contrast, the combination of an emergency SEP or SEP for job loss and improved premium tax credits would help most workers with modest incomes, including those who didn't previously have job-based coverage. And while very deep COBRA subsidies would be needed to make COBRA affordable for those who qualify, small increases in premium tax credits could reduce marketplace premiums for these workers to affordable levels.

Take, for example, a family of four whose annual income falls from \$100,000 to \$50,000 due to one parent's job loss. If they lost their health coverage, they would pay just \$259 per month for benchmark marketplace coverage, compared to about \$1,800 for COBRA for a typical plan.³⁵ Even

FIGURE 4

Hispanic and Black People Less Likely to Have Employer Coverage

Percentage enrolled in employer health plans



Source: CBPP analysis of Census Bureau's 2017 Current Population Survey data

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³⁰ The Great Recession subsidy was available to workers and their dependents for up to 15 months. In general, to qualify, a worker needed to have no offer of coverage from another group health plan or Medicare; adjusted gross income under \$125,000 (for a tax-filing status of single) or \$250,000 (for married filing jointly); and an involuntary termination between certain dates.

³¹ Berk and Rangarajan, *op. cit.*

³² *Ibid.*

³³ *Ibid.* In all, only 13 percent of all UI claimants enrolled in COBRA, despite most claimants having access to a 65 percent subsidy.

³⁴ *Ibid.* Among eligible people, the 65 percent COBRA subsidy was used more by people who were white (at twice the rate of Black or Hispanic workers), were college graduates (four times the use as those with a high school diploma), and had higher incomes. It was used less by lower-income workers, those in poor or fair health, and workers with dependent children.

³⁵ CBPP analysis. The 2020 marketplace premium is calculated using the Kaiser Family Foundation's Health Insurance Marketplace Calculator (<https://www.kff.org/interactive/subsidy-calculator/>). The 2020 COBRA premium is based on 2019 average monthly employer coverage premiums for a family of four. Kaiser Family Foundation Employer Health Benefits

with a 65 percent — \$1,200 per month — subsidy, they would still pay a premium of more than \$600. But Congress could eliminate their marketplace premium by increasing their subsidy by \$259 or cut their premium to \$100 per month with a premium tax credit increase of \$159.

Provider Fund Is Not a Substitute for Coverage

In earlier COVID-19 response legislation, Congress provided a total of \$175 billion to support hospitals and other health care providers, and the Heroes Act would add another \$100 billion to the fund. The Administration has announced that it will use a portion of the fund to reimburse providers for COVID-19 treatment for the uninsured. Providers can request reimbursement for COVID-19 testing and for treatment services with COVID-19 as the primary diagnosis for people without another source of coverage.

Reimbursing providers for COVID-19 treatment is no substitute for enrolling people in comprehensive health insurance. As people lose their jobs and health coverage during the economic downturn, this approach does nothing to provide them with access to care and financial protection for health care needs other than COVID-19. It's also inadequate from a public health perspective, since seeking care remains risky for patients who suspect they have COVID-19: they could still incur large bills if they turn out to have some other illness, or if their provider opts to bill them rather than the fund. One in seven U.S. adults say their concerns about not being able to pay for care would lead them to avoid seeking treatment for typical COVID-19 symptoms of a fever and dry cough, according to a recent survey, with higher rates reported for people of color and people with low incomes, groups that are also much more likely to be uninsured.³⁶

Survey, <https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/>), increased by 2 percent to account for permissible administrative fees, and then inflated by projected employer coverage premium growth in 2020 (Centers for Medicare & Medicaid Services' National Health Expenditure Accounts, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected>).

³⁶ Dan Witters, "In U.S., 14% With Likely COVID-19 to Avoid Care Due to Cost," Gallup, April 28, 2020, <https://news.gallup.com/poll/309224/avoid-care-likely-covid-due-cost.aspx>.



One in Six Adults in California Immigrant Families Reported Avoiding Public Benefits in 2019

Hamutal Bernstein, Dulce Gonzalez, Sara McTarnaghan, Michael Karpman, and Stephen Zuckerman

May 2020

California has moved proactively to support immigrant families in response to restrictive federal immigration and safety net policies, but policies like the new “public charge” rule still pose risks, especially in the context of the COVID-19 pandemic. The new rule significantly expands the criteria for determining whether applicants for permanent residency, or green cards, may be denied based on past or potential use of government benefit programs. Even before the rule took effect in February 2020, widespread chilling effects were evident. Nationwide, many immigrant families—including those who would not be subject to the rule—avoided enrolling in public benefit programs for fear of immigration consequences (Bernstein et al. 2019; Bernstein, McTarnaghan, and Gonzalez 2019; Straut-Eppsteiner 2020; Tolbert, Artiga, and Pham 2019).

This phenomenon has become even more alarming during the COVID-19 pandemic, in which many immigrant families are vulnerable to acute medical and economic hardship. Families may avoid medical care and public supports for fear of being deemed a public charge, despite formal clarification by the federal government that COVID-19 testing and treatment will not be considered. This issue is magnified in a state like California, where one in four people were born outside the US (foreign born) and nearly half of nonelderly adults live in families with at least one foreign-born member.¹ Thus, it is critical to understand how the rule is affecting immigrant families, where these families are getting their information about the rule, and which sources they trust to communicate accurate messages about the rule and its impacts.

This brief draws on unique data from California participants in the Well-Being and Basic Needs Survey (WBNS), a nationally representative, internet-based survey conducted in December 2019. This survey round assessed awareness and knowledge of the public charge rule, sources of information on the rule, and chilling effects reported by adults in immigrant families who speak English or Spanish. The California sample included 498 nonelderly adults born outside the US or living with one or more foreign-born family members (hereafter called adults in California immigrant families), who make up about 46 percent of all nonelderly adults in California and about one-quarter of all nonelderly adults in the US, according to the 2018 American Community Survey. We complemented survey findings with follow-up interviews with 17 adults in California immigrant families who reported experiencing chilling effects in the WBNS. We find the following:

- Chilling effects for adults in California immigrant families increased between 2018 and 2019.
 - » Of all adults in California immigrant families, 17.7 percent reported that they or a family member did not participate in a noncash government benefit program, such as Medi-Cal (California's Medicaid program), CalFresh (California's Supplemental Nutrition Assistance Program), or a housing program, in 2019 for fear of risking future green card status, up from 12.2 percent in 2018.
 - » Follow-up interviews described how these decisions to stop or avoid program participation were based on limited information and abundant caution.
- Awareness of and confidence in understanding of the public charge rule were widespread, but many adults in California immigrant families did not understand key aspects of the rule.
 - » Two-thirds of adults in California immigrant families (65.3 percent) were aware of the public charge rule and 69.9 percent were confident in their understanding of the rule. Yet, only 22.5 percent knew it does not apply to citizenship applications, and only 18.2 percent knew children's enrollment in Medi-Cal will not be considered in their parents' public charge determinations.
 - » Follow-up interviews also illustrated confusion and misunderstanding about the rule, including about who it applies to and when it takes effect.
- Adults in California immigrant families were most likely to trust government agencies and legal professionals for information about how using public benefits would affect their or their family member's immigration status, but very small shares reported getting information on the public charge rule from these sources.
 - » Legal professionals were the most trusted source (67.9 percent), followed by US Citizenship and Immigration Services (USCIS; 63.3 percent), state government agencies (55.4 percent), and local government agencies (50.4 percent), but most adults in California immigrant families reported getting information on the rule from the media or personal networks, which they trust less.
 - » Follow-up interviews confirmed a desire for official information from government sources, highlighted barriers to accessing legal assistance, and confirmed a reliance on personal networks and media for information on the rule, as well as mistrust of the media.

Background

As part of a broader policy agenda to limit immigration, the Trump administration has enacted significant changes to implementation of public charge determinations (box 1), part of the admissions process for permanent residency and temporary visas. The administration moved to significantly expand the rule in 2018. After circulating drafts of the new rule and a vigorous public comment period,² litigation efforts temporarily halted implementation of the final rule.³ This included several lawsuits in California, including one led by California Attorney General Xavier Becerra in partnership with several other states.⁴ However, Supreme Court rulings in January and February allowed the administration to begin implementing the rule nationally while legal challenges continued in the lower courts. The rule took effect nationwide on February 24, 2020.⁵

BOX 1

What Is the New Public Charge Rule?

The new public charge rule vastly expands the criteria through which immigrant applicants may be denied admission to and residency in the US for having received public benefits or being deemed likely to receive public benefits in the future. Departing from past practice, where only primary reliance on cash benefits or long-term medical institutionalization were considered, the new rule redefined the “totality of circumstances” test to consider not only previous use of certain cash *and* noncash benefits but a wide range of personal characteristics, including income and assets, age, health, family size, and education and skills, like English proficiency.

The new rule expands the list of benefits to be considered in a public charge determination to include SNAP (formerly known as food stamps), nonemergency Medicaid for nonpregnant adults ages 21 and over, and Section 8 housing assistance or public housing. The revised public charge determination does not consider receipt of federally funded Medicaid for emergency care, pregnancy-related care, or care for children under age 21, nor, in California, state-funded Medi-Cal for undocumented children and young adults ages 19 to 25 (ITUP 2019a).

The rule applies to applications for green cards from within the US and abroad, applications for temporary visas from abroad, and changes or extensions to temporary visas from within the US (e.g., student visas). The rule does not apply to citizenship applications or green card renewals, though a green card holder who leaves the US for more than six months may be subject to a public charge test. Several humanitarian admission groups are exempted, including refugees and asylees; survivors of trafficking, domestic violence, or other serious crimes (T or U visa applicants and holders); Violence Against Women Act self-petitioners; and special immigrant juveniles (Protecting Immigrant Families 2020a).

In addition to expectations that the rule will transform immigrant admissions by excluding many applicants from Asia, Latin America, and Africa,⁶ there is significant concern about the chilling effects produced by the rule, as immigrant families avoid benefit programs and other resources for which they may be eligible for fear of risking a potential public charge determination. More than 200 pages long, the new regulation is confusing to both families and service providers about who is subject to a public

charge test, whose benefit receipt will be considered, and which programs will be considered. This confusion may explain why many families have opted out of programs to avoid potential risks to their immigration status despite suffering negative consequences to their health and well-being (Bernstein, McTarnaghan, and Gonzalez 2019; Greenberg, Feierstein, and Voltolini 2019; Protecting Immigrant Families 2020b; Straut-Eppsteiner 2020). In addition, legal professionals may advise extreme caution and avoidance of benefit programs because of the potential immigration consequences (Bernstein, McTarnaghan, and Gonzalez 2019) and their limited understanding of eligibility for benefits (Straut-Eppsteiner 2020).

Families across the US, including in California, have experienced increasing fear and insecurity around changes in federal immigration policies and heightened immigration enforcement over the last several years, which has led many to avoid engaging with public services and their communities (Ben-Porath et al. 2020; Children's Partnership and California Immigrant Policy Center 2018). Estimates of potential chilling effects in California produced during the public charge rule's formal comment period predicted that up to 2.2 million people could disenroll from Medi-Cal and CalFresh because of the rule, two-thirds of them children (Ponce, Lucia, and Shimada 2018). Half of children in California have at least one immigrant parent, and they make up 60 percent of children in families with incomes below 200 percent of the federal poverty level (Children's Partnership and Kidsdata.org 2018).

Though California is one of the most progressive states when it comes to immigrant eligibility for public benefits, residents are still experiencing chilling effects because of federal immigration policies. California has filled gaps in federal safety net eligibility rules in several ways. It was among the first states to expand Medicaid to a greater number of nonelderly, low-income adults under the Affordable Care Act.⁷ Further, many lawfully present immigrants are barred from enrolling in federally funded Medicaid for five years after obtaining lawfully present status (known as the five-year bar), but California eliminates this five-year bar for lawfully residing pregnant mothers and children (Kaiser Commission on Medicaid and the Uninsured 2015). Unique in the US, California also extends Medi-Cal eligibility to undocumented children and young adults under age 26 (ITUP 2019b). California also uses state funds through its California Food Assistance Program to extend Supplemental Nutrition Assistance Program (SNAP) eligibility to qualified immigrants during the five-year bar.

Our previous analysis of survey data collected in December 2018, during the public comment period on the then-proposed rule, found that one in seven adults in immigrant families—and one in five adults in low-income immigrant families—nationwide reported chilling effects in the previous year (Bernstein et al. 2019). Qualitative follow-up interviews with survey respondents in spring 2019 highlighted their fear and confusion about the rule, a reliance on the media for information and little access to professional advice, and hardship for adults and children after losing supports (Bernstein, McTarnaghan, and Gonzalez 2019). This brief draws on new WBNS data collected from adults in immigrant families in December 2019, after release of the final rule but before implementation, and 17 follow-up telephone interviews with adults in California immigrant families conducted in February and March 2020, around the time of implementation. These data provide unique information on trends in chilling effects in California, as well as information on the level of awareness and knowledge of the

rule, where immigrant families are getting their information on public charge, and which sources they trust to provide helpful information about how using public benefits could affect their immigration status. This information is critical during this unprecedented health and economic crisis, when, like all families, immigrant families in California will need supports.

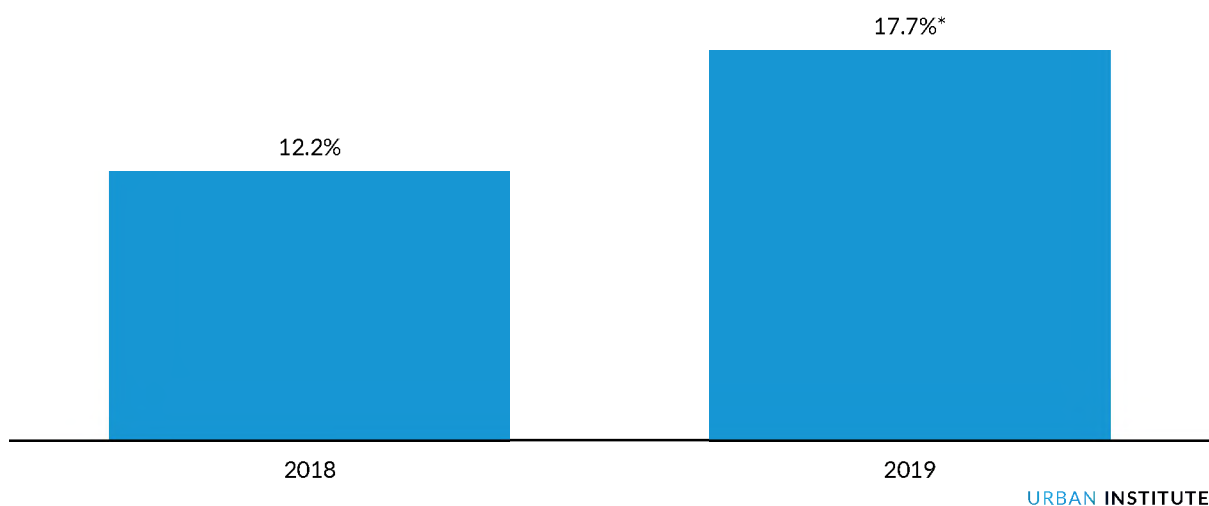
Findings

Chilling effects for adults in California immigrant families increased in 2019.

Controlling for the demographic characteristics of adults in each survey round, we find that chilling effects increased among adults in California immigrant families between 2018 and 2019 (figure 1). In 2019, 17.7 percent of adults reported that they or a family member avoided a noncash government benefit program (e.g., Medi-Cal/CHIP, CalFresh, or housing subsidies) for fear of risking future green card status, up from 12.2 percent in 2018. This change was statistically significant at the 0.10 level. Nationally, 15.6 percent of adults in immigrant families reported chilling effects in 2019, but we did not find a statistically significant increase from 2018 to 2019 (data not shown).⁸

FIGURE 1

Share of Adults in California Immigrant Families Who Avoided Noncash Government Benefits in the Past Year Because of Green Card Concerns, December 2018 and 2019



Source: Well-Being and Basic Needs Survey, December 2018 and December 2019.

Notes: Adults are ages 18 to 64. Estimates are regression adjusted for a respondent's gender, age, race and ethnicity, educational attainment, family size, chronic health conditions, residence in an urban or rural area, internet access, homeownership status, citizenship status, family composition, and family income as a percentage of the federal poverty level; the presence of children under age 19 in the respondent's household; whether the respondent participated in both the 2018 and 2019 survey rounds; and how long the respondent has been a member of the KnowledgePanel.

*/**/*** Estimate differs significantly from 2018 at the 0.10/0.05/0.01 level, using two-tailed tests.

If adults in California immigrant families avoid Medicaid or subsidized Marketplace health insurance coverage because of immigration concerns, they likely have few alternative coverage options. Nearly 4 in 10 adults in California immigrant families (39.6 percent) do not have access to employer-sponsored health insurance (data not shown).

Follow-up interviews suggested uncertainty and confusion about the rule had encouraged many respondents to avoid programs despite need. Interviewees noted that they avoided applying for or dropped out of programs out of an abundance of caution, a lack of understanding of how the public charge rule may affect them in the future, and the desire to avoid jeopardizing any future immigration processes. One interviewee said fear around the public charge rule was the reason she did not pursue CalFresh and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), even though she had experienced an illness and needed support:

El año pasado yo estuve enferma...y estuve a punto de aplicar para CalFresh pero me dio miedo. Me dio miedo porque yo dije, no, no quiero ser una carga pública, no quiero que me afecte. El WIC incluso. Están diciendo...que sería mejor no continuar en el WIC porque [toda] esa comida, leche, y los vales que le dan para jugo, esto y lo otro, pues, el gobierno es el que lo está pagando.

Last year I was sick...and I was about to apply for CalFresh, but I got scared. I got scared because I thought, no, I don't want to be a public charge, I don't want this to affect me. WIC even. They're saying...that it would be best not to continue with WIC because [all the] food, milk, and vouchers that they give you for juice, this and that, well, it's the government that's paying for it.

In many cases, interviewees reported making quick decisions about participating in benefit programs based on limited information. One person recalled withdrawing from programs after hearing a lawyer on television:

Nada más escuché el abogado en la televisión. Pensé que no era conveniente [continuar con los beneficios]. Si el gobierno lo considera como carga pública, no está bien que siga recibiendo ese servicio.

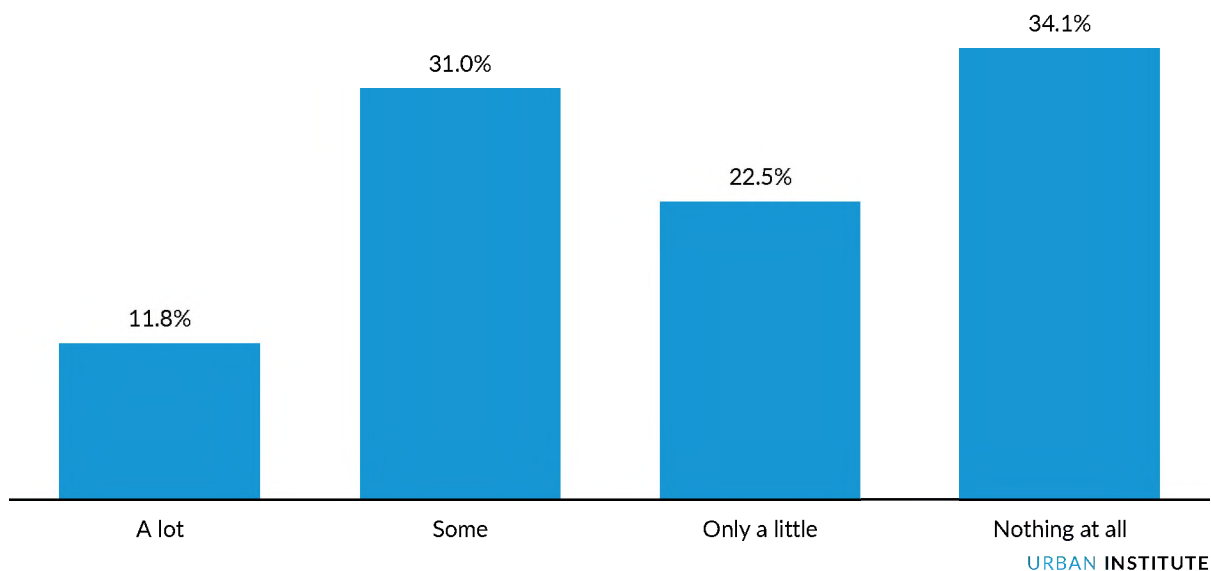
I just heard a lawyer speak on TV. And then I thought it wasn't a good idea [to continue receiving services]. If the government considers it a public charge, then it is not ok to continue receiving the program.

Awareness of and confidence in understanding of the public charge rule were widespread, but adults in California immigrant families did not understand key aspects of the rule.

Overall, nearly two-thirds of adults in California immigrant families reported hearing at least a little about the public charge rule (figure 2). Seven in 10 adults in California immigrant families who were familiar with the public charge rule (i.e., excluding those who have heard nothing about the rule) reported being very or somewhat confident in their understanding (data not shown).

However, most adults in California immigrant families who have heard about the rule either do not know or do not understand what the rule does and who it applies to. Though almost half (47.5 percent) knew the new rule expanded the list of benefits considered in public charge determinations, only 22.5 percent knew it does not apply to citizenship applications, and 18.2 percent knew children's enrollment in Medicaid will not be considered in their parents' public charge determinations (figure 3).

FIGURE 2
How Much Adults in California Immigrant Families Have Heard about the Public Charge Rule, December 2019

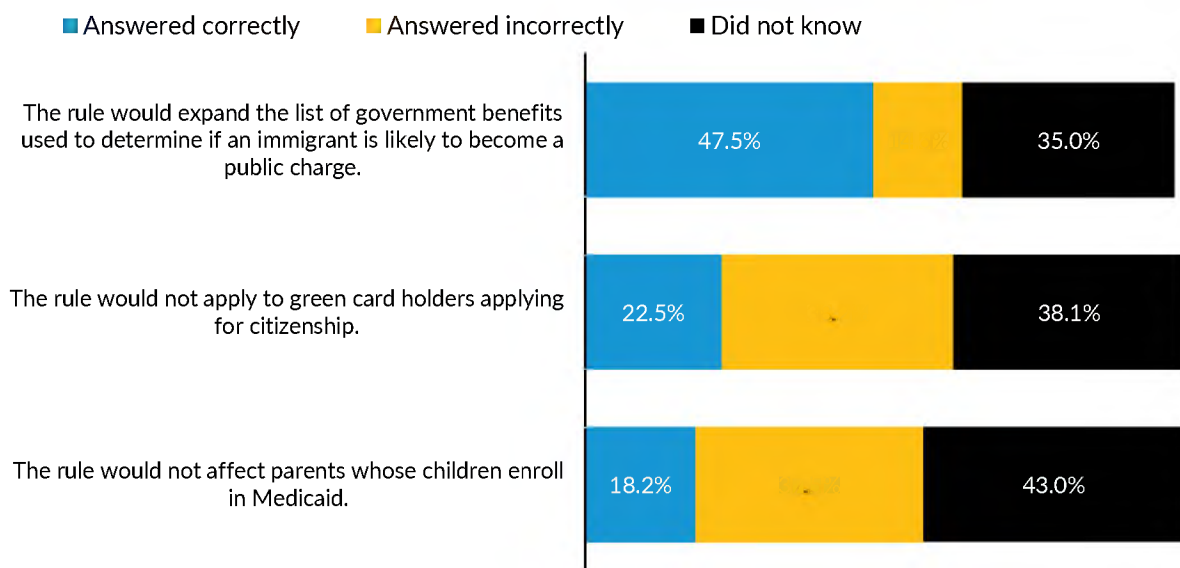


Source: Well-Being and Basic Needs Survey, December 2019.

Notes: Adults are ages 18 to 64. Data for this survey question are missing for 0.6 percent of the sample.

FIGURE 3

Understanding of Key Parts of the Public Charge Rule among Adults in California Immigrant Families Who Have Heard about the Rule, December 2019



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Source: Well-Being and Basic Needs Survey, December 2019.

Notes: Adults are ages 18 to 64. Respondents were asked whether statements about the public charge rule were true or false and were randomly assigned to different wording for the second and third statements (e.g., “would apply” versus “would not apply” for the second statement). We present the true statements here. Missing data are not presented, so totals do not add up to 100.

The follow-up interviews confirmed a lack of understanding of the rule: Most of the 17 interviewees recognized the term public charge and described it as a federal policy change that would make it difficult for immigrants to adjust their immigration status if they used public benefits. But interviewees were confused about which programs would be considered and who would be affected. Reinforcing the survey findings, some interviewees incorrectly believed the rule would apply to naturalized citizens and permanent residents and did not know which programs would be considered:

Si pides cualquier ayuda del gobierno, pueden negarte tu residencia. O incluso ciudadanía.

If you get any aid from the government, they can deny you your residency. Even citizenship.

Several interviewees noted that the rule has many exceptions, making it difficult for them to understand if it would apply in their specific cases and if they should change their benefit usage as a result. One respondent was advised not to cancel government benefits before the rule took effect. But with the rule now in place, she considered whether the rule's exceptions would include her case:

Me dijeron que...no debería de cancelar [el beneficio] por el momento, que...en ese tiempo, según [la norma] todavía no entraba en vigor. Ahora sí ya entró en vigor, pero yo tengo entendido que...aun así, hay excepciones, no es...parejo para todos, no lo es.

They told me that...I shouldn't cancel [benefits] for the moment, that...at that time, supposedly [the rule] was not in effect yet. Now that it is in effect, it is my understanding that...even so, there are exceptions, it isn't...one size fits all for everyone, it isn't.

Interviewees also expressed confusion about whether the rule was already in effect. Though they did not mention dates, some interviewees heard the rule had already taken effect early in 2020. Others believed the rule had been in effect since late 2019, and still others were unsure of the rule's status because they had heard about ongoing legal challenges. According to one interviewee, the confusion over the revised rule's implementation—including the status of various legal challenges—has caused people to stop receiving benefits:

Estaban diciendo, y que le he podido explicar a algunas personas, es que la ley va a entrar en vigencia el 24 de febrero, pero hay unos abogados que están en defensa...están demandando...Por ahorita [la norma] va a entrar en vigor, pero que no va a ser definitivo. Pero ahí donde dice—no va a ser definitivo o va a entrar en vigor—es donde empieza la confusión, porque muchas personas ya están parando de pedir la ayuda.

They were saying, and what I have been able to explain to some people, is that the rule will take effect on February 24, but there are some attorneys on the case...they're suing...For now [the rule] will be implemented, but it won't be definitive. But see, that there—that it's not definitive or that it will be implemented—is where the confusion starts, because already many people are not seeking out aid.

Interviewees seldom had accurate information about the rule, but a few interviewees had sought out information and confirmed whether they would be affected by the rule. One said she avoided SNAP because she heard it could affect her chance of obtaining a green card. But after researching the topic on her own, she realized the rule would not affect her immigration case because children's receipt of benefits is not included in parents' public charge determinations. Because her children—not she—received benefits, she decided to reenroll them.

Some interviewees understood which programs were included in the rule. As an undocumented immigrant, one interviewee knew she would be ineligible for the types of programs included in the rule, though her children were. She also knew which programs would be considered:

Pues, lo que he escuchado es...que inmigrantes que quieren arreglar sus papeles...Se me hace que [si durante] los últimos 12 meses han estado agarrando los beneficios de estampillas, Medi-Cal, Sección 8, les van a afectar. Pero...depende, no es para todos eso...A veces me siento un poco confundida. Si entiendo la información que están diciendo, pero a la vez me siento un poco confundida. Lo que no entiendo es, ¿cómo es carga pública la persona? Por ejemplo, yo, aunque no quiera, yo agarro los beneficios de estampillas, pero son para mis hijos, no son para mí porque, aunque yo quiera...no me las dan a mí, no soy elegible. Igual, la Medi-Cal, tampoco. No la puedo yo tener. Entonces es lo que yo no entiendo. Cuando yo pregunté con un abogado eso me dijo: "No, eso no le afecta porque los beneficios que usted agarra no son para usted, son para sus hijos." Entonces por eso le digo, a veces me siento confundida de eso.

Well, what I've heard is that...for immigrants seeking to fix their papers...I believe that [if] they have been using food stamp benefits, Medi-Cal, Section 8 [during] the last 12 months, it will affect them. But...it depends, because it doesn't apply to everyone...I sometimes feel a bit confused. I do understand the information they're saying, but at the same time I feel a bit confused. What I don't get is, how can a person be a public charge? For example, I, even if I don't want to, I get food stamp benefits, but they're for my children, not for me, because even if I wanted them...I wouldn't get them, I'm not eligible. Same thing with Medi-Cal. I can't get that. So that's what I don't get. When I asked a lawyer, that's what he told me: "No, that won't affect you because the benefits you get are not for you, they're for your children." That's why I'm telling you, sometimes I feel confused about this.

Even interviewees with a more sophisticated understanding of the rule's details expressed general confusion and uncertainty about how to obtain concrete information about the rule.

Adults in California immigrant families were most likely to trust government agencies and legal professionals for information about how using public benefits would affect their or their family member's immigration status.

In addition to trusting lawyers and legal aid organizations, adults in California immigrant families who heard about the public charge rule were most likely to report high levels of trust in government sources, like USCIS and state and local agencies, to provide helpful information if they had a question about how public benefits use would affect their or their family member's immigration status. But among adults in California immigrant families who heard about the rule, the most trusted sources were also least likely to have been a source of information on the public charge rule. For instance, most adults would trust information from USCIS a great deal or a lot (63.3 percent), but only 8.3 percent reported hearing about the public charge rule from this source. This was similar for state agencies, which 55.4 percent of adults reported trusting but only 2.4 percent got information from, and local agencies, which 50.3 percent of adults reported trusting but only 1.2 percent reported getting information from (figure 4).

Consistent with this finding, none of the 17 interviewees reported receiving information about the public charge rule through any government agency. However, several strongly desired information from official government sources, especially their county government. One interviewee described how government would be trustworthy, and they would prefer to hear directly from those entities rather than by word of mouth:

Me gustaría que viniera directamente del estado, del que impone las leyes. Del gobierno, o del county o del estatal. Yo no quiero escuchar de la bodeguita o de fulanita de tal. Yo quiero escucharlo de una institución confiable.

I'd like it to come directly from the state, from those in charge of the law. From the government, whether county or state. I don't want to hear from the *bodeguita* or from so-and-so. I want to hear it from a reputable institution.

A few interviewees specifically noted that social workers in government benefits offices could be well positioned to provide answers and are a trusted source of information. In one respondent's opinion, staff at government benefits offices should be informed about new rules, laws, and policies and could help inform people about how they may affect immigration processes:

Yo pienso que a las diferentes oficinas de esos programas—CalFresh, WIC, Medi-Cal—e ir a cada oficina y tener unas ciertas preguntas específicas de migración...Yo pienso que los trabajadores de estos programas podrían ayudarlos mejor y si están enterados de las noticias, de las nuevas reglas, nuevas políticas, leyes, y cómo podrían estar informados.

I think to the different program offices—CalFresh, WIC, Medi-Cal—and going to each office and having specific questions about immigration...I think that the staff in those programs could help more if they are up to date on the news, new regulations, new political developments, laws, and how they could be more informed.

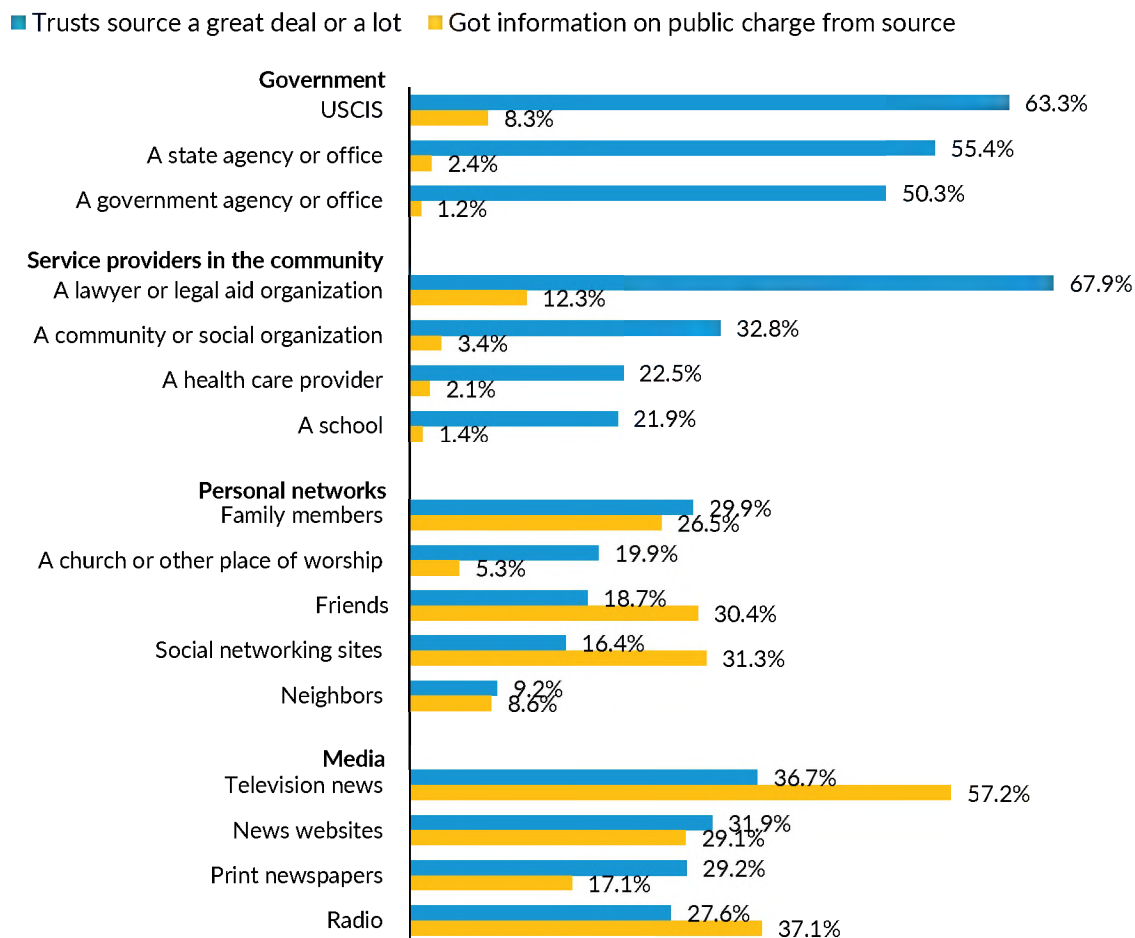
The survey results show adults in California immigrant families also have high levels of trust in lawyers and legal aid organizations, but low shares actually received information on the public charge rule from legal professionals: 67.9 percent of adults in California immigrant families who heard about the rule would trust the advice of a lawyer or legal aid organization, but only 12.3 percent got information about the rule through this source (figure 4).

The follow-up interviews shed some light on this discrepancy. Most interviewees volunteered lawyers as one source they would most trust for information about the rule. However, interviewees cited barriers to getting legal assistance, including not being able to afford private legal services, not knowing how to access *pro bono* legal services, and concerns that long wait times for appointments for *pro bono* legal services would make it impossible to get a timely response.

A relatively low share of adults in California immigrant families reported receiving information on public charge from community or social organizations (3.4 percent). In the follow-up interviews, no interviewees reported receiving information from community-based organizations, even though some interviewees had previously accessed information about government programs through organizations like community health clinics or home visiting programs.

FIGURE 4

Trusted Sources of Information on How Using Public Benefits Affects Immigration Status and Sources of Information on the Public Charge Rule Consulted by Adults in California Immigrant Families Who Have Heard About the Rule, December 2019



URBAN INSTITUTE

Source: Well-Being and Basic Needs Survey, December 2019.

Notes: USCIS = United States Citizenship and Immigration Services. Adults are ages 18 to 64. Health care providers include hospitals, doctor's offices, health clinics, or other health care providers. Social networking sites are platforms such as Facebook, Twitter, WhatsApp, or WeChat.

The sources from which adults in California immigrant families were most likely to have received information on the rule were considered less trustworthy. Television news was the most common source of information about the rule (57.2 percent). However, only 36.7 percent of adults reported a high level of trust in television news as a source of information about public benefits use and immigration status. Similarly, 31.3 percent of adults learned about the rule from social media, but only 16.4 percent placed a high level of trust in social media as a source of helpful information.⁹

The follow-up interviews also confirmed that personal networks and television news are immigrant families' primary sources of information on the public charge rule, despite interviewees having reservations about the quality of information from these sources. Interviewees cited television, friends, and family as key sources of information about the public charge rule, but they also expressed doubt that the information they received from those sources was reliable. With television media specifically, interviewees were concerned that coverage of the rule was producing fear in the audience. One interviewee said she relies on major Spanish-language media networks and trusts they provide full and accurate details, but she also believed they tend to exaggerate:

Sinceramente, hay dos medios latinos... A veces he visto también que exageran, pero dan como una información precisa. Últimamente lo han dicho...por ejemplo...de las personas que pueden aplicar para estos programas, no son todos, pero algunos, con excepción—no van a tener problemas a la hora de arreglar un documento.

Honestly, there are two Latino media outlets... Sometimes I've also seen them exaggerate, but they [can] give precise information. Lately they've said that...for example...of the people who apply for these programs, not all of them, but some of them, with exceptions, are not going to have trouble when it comes time to fix their papers.

Most interviewees reflected that their decisions to stop participating in or avoid applying for a benefit program were solely based on information from television news, social media, or conversations with friends. Additionally, most interviewees did not fully understand whether or how the rule would apply in their particular case. One interviewee said people like herself need more information to make better decisions about whether to avoid or participate in benefit programs:

Sería bueno tener...más información sobre eso de la carga pública, principalmente para todas las personas que necesitan o están en trámite de arreglar su situación migratoria. Porque ya conociendo los pros y los contras de tener esas ayudas o no tenerlas, ya uno buscaría la forma de vivir sin ellas...Y si realmente no afectan [los beneficios]...que la sigan utilizando.

It would be good to have...more information about public charge, especially for those who need to or are in the process of fixing their immigration status. Because knowing the pros and cons of getting that aid or not, one could find a way to live without it...And if the [benefits] really won't affect [one's immigration status]...to continue using them.

Discussion

These findings echo those in our companion brief focused on adults in immigrant families nationally (Bernstein et al. 2020). They show that chilling effects expanded among California immigrant families between 2018 and 2019, as the public charge rule was finalized and entered litigation and as its status remained unclear to the public. These results are alarming in the unprecedented context of the COVID-19 pandemic. Given limited access to and fear of participation in public benefits programs and disproportionate exposure to the virus from working in the most directly affected industries, immigrant communities are particularly vulnerable to threats to health and well-being during the current crisis (Gelatt 2020; Gonzalez et al. 2020). USCIS released guidance on March 13 clarifying that seeking out testing for or treatment of COVID-19-related illness would not be considered in public charge determinations, but the implementation details remain unclear, and the fear and confusion swirling around the rule will be difficult to pierce. The Supreme Court also rejected requests to suspend implementation of the rule during the pandemic.¹⁰ Many worry that immigrant families may be afraid to enroll in public programs that expand access to medical testing and treatment for COVID-19, putting into sharp relief the public health risks of these chilling effects.¹¹

These results show where California immigrant families have been getting information about the public charge rule, which is not consistent with the sources they are most likely to trust on questions related to public benefits and immigration matters. They suggest a desire for more information from government sources and a need to reduce barriers to legal assistance. Our findings also uncover details on the lack of knowledge and the extent of misunderstanding about the public charge rule and who it applies to. They suggest that decisions to drop out of benefit programs are being made amid confusion about the rule.

Though California has moved far beyond other states in expanding eligibility for benefit programs to support multiple-immigration-status families and undocumented residents, federal policies like the public charge rule are still leading immigrant families to fear program participation because of concerns about immigration consequences. California government agencies must continue educating and reassuring families struggling to understand the rule, which has become even more urgent during the COVID-19 crisis. Our results suggest state, county, and city government agencies have significant roles to play in educating the public and disseminating accurate information about the rule, as noted in recent research (Vision Strategy and Insights 2020). Messaging efforts from state officials, who have been outspoken in their defense of immigrant rights and protections against excessive federal immigration enforcement, can be particularly important in localities where immigrants feel less welcome. Communications from government agencies may be more powerful than those from community-based organizations.

Families have questions about the specifics of their own situations, and individual legal assistance is needed to complement broader public education efforts. Free and low-cost legal services, like those funded by the state in California,¹² could also bridge divides between legal assistance providers and social workers, who have different areas of expertise and may offer conflicting advice to families

weighing program participation decisions with potential immigration consequences. Though workers in benefit program offices should not necessarily advise clients on the potential immigration consequences of program participation, they should be equipped to refer clients to accessible legal assistance.

Excluding multiple-immigration-status families and those lacking Social Security numbers from federal relief measures, like the Coronavirus Aid, Relief, and Economic Security, or CARES, Act, risks leaving out many people in need (NILC 2020). Not only does excluding this group endanger many people suffering from economic and medical hardship, it also limits the impact of efforts to protect community well-being and boost the overall economy. In California, state and local efforts to fill the gaps left by the federal government have so far included clarification that emergency Medicaid covers COVID-19 testing and treatment, a \$75 million emergency relief fund for undocumented immigrants, an executive order to protect continuous access to safety net services, creation of multilingual educational materials, supports for immigrant-owned businesses, and protections from evictions and utilities shut-offs for renters.¹³ To both weather and recover from the current crisis, California immigrant families need wider eligibility for federal relief and coordinated efforts among state, county, and city government agencies and their partners to mitigate chilling effects and ensure access to health care and supports.

Data and Methods

Data

SURVEY DATA

We draw on data from the December 2019 round of the Well-Being and Basic Needs Survey, a nationally representative, annual survey of adults ages 18 to 64 launched in December 2017.¹⁴ Our analysis is based on the WBNS core sample and an oversample of noncitizens. To assess chilling effects and related issues specific to California, we constructed a set of weights for analysis of the California population of nonelderly adults who are foreign born or living with a foreign-born relative in their household. The weights are based on the probability of selection from the KnowledgePanel and benchmarks from the American Community Survey for nonelderly adults in immigrant families in California who are proficient in English or primarily speak Spanish.¹⁵ The language criterion is used in the weighting to reflect the survey sample, because the survey is only administered in English or Spanish. Our full analytic sample for this brief consists of 498 adults in California immigrant families.

SEMISTRUCTURED INTERVIEW DATA

To learn more about where families get their information on eligibility for and use of public benefits and related implications for immigration status, our research team conducted follow-up telephone interviews with adults in California immigrant families who (1) reported chilling effects on the survey, meaning they or a family member avoided participating in noncash public programs (e.g., Medicaid/CHIP, SNAP, or housing assistance) in 2019 because of worries about future green card

status and (2) were willing to be contacted about participating in a follow-up interview. The interview recruitment pool consisted of 45 adults in California immigrant families.¹⁶

All but one interview was conducted in Spanish, and interviews generally lasted 20 minutes. The interviews included questions on knowledge about, sources of information on, and access to information on government benefit programs and the public charge rule; decisionmaking related to the rule; and experiences of chilling effects. The 17 interviewees were diverse in regions of residence, ages, citizenship/immigration statuses, and other demographic characteristics (table 1).

TABLE 1
Interviewees' Demographic Characteristics

	Number of interviewees
Interview language	
Spanish	16
English	1
Respondent citizenship and immigration status	
Naturalized citizen	3
Noncitizen	12
Permanent resident	5
Not a permanent resident	7
US-born	2
Age	
25–34	4
35–44	4
45–54	6
55–64	3
Race/ethnicity	
Hispanic	15
Non-Hispanic, other or multiple races	1
Non-Hispanic white	1
Marital status	
Married	13
Living with a partner	2
Not married and not living with a partner	2
Educational attainment	
Less than high school	3
High school graduate	5
Some college	7
Bachelor's degree or higher	2
Number of people in the household	
1	1
2–4	11
5–6	5
Household citizenship and immigration status	
All foreign-born family members are naturalized citizens	4
All noncitizens are permanent residents	5
One or more noncitizens are not permanent residents	8

Sources: Interview language was collected in the December 2019 round of the Well-Being and Basic Needs Survey. All other characteristics come from Ipsos' panel profile questions, which respondents complete when they first join the KnowledgePanel and is updated annually.

Note: Permanent residents are green card holders; we use the latter term in this brief.

Survey Measures

CHILLING EFFECTS WITHIN A FAMILY

For all 498 adults in California immigrant families in our sample, we define chilling effects as either not applying for or stopping participation in a noncash government benefit program, specifically Medicaid or CHIP, SNAP, or housing subsidies, within the previous 12 months because of concerns that the respondent or a family member could be disqualified from obtaining a green card.¹⁷ We also collected information on avoidance of additional programs not listed in the public charge rule, including WIC and Marketplace health insurance coverage.¹⁸ A respondent could have defined family as both their immediate family and other relatives who may live with them or in another household. Respondents may have reported chilling effects for a program for which they may not have been eligible; for instance, some parents likely reported chilling effects on the program participation of a citizen child, or a higher-income respondent may have reported chilling affecting a relative with lower income.

AWARENESS OF THE PUBLIC CHARGE RULE

We asked all adults in immigrant families in our sample to report how much they had heard about the public charge rule:¹⁹ a lot, some, only a little, or nothing at all.

GENERAL UNDERSTANDING AND CONFIDENCE IN UNDERSTANDING OF THE PUBLIC CHARGE RULE

For the following measures, we report estimates for the 367 adults in California immigrant families who reported having heard at least a little about the public charge rule.

Confidence in understanding of the rule. This measure indicates whether respondents reported that they were very, somewhat, not too, or not at all confident in how well they understood the public charge rule.

Understanding of the public charge rule. To gauge understanding of key elements of the rule, we asked respondents to report whether they thought three statements about the rule were true or false (respondents could also answer “don’t know”). These statements included (1) whether the rule would expand the list of government benefits used to determine if an immigrant is likely to become a public charge (true); (2) whether the rule would apply to green card holders applying for citizenship (false); and (3) whether parents could have a harder time getting a green card if their children enroll in Medicaid (false). Respondents were randomly assigned to affirmative or negative versions of the second and third statements. Figure 3 shows the true version of each statement.²⁰

SOURCES OF INFORMATION AND TRUSTED SOURCES

The following two measures are also based on the 367 adults in California immigrant families who reported having heard at least a little about the public charge rule.

Sources of information about the public charge rule. To understand where adults in immigrant families have been getting their information, we asked respondents who heard about the rule to report

all the sources from which they had heard about it, listing options encompassing government sources, service providers, personal networks, and media.

Trusted sources on public benefits use and immigration. We asked respondents to report how much they would trust various sources to provide helpful information if they had a question about how using public benefits affects their immigration status or that of someone in their family, providing the same options listed above. Respondents could report trusting each source a great deal, a lot, somewhat, not much, or not at all.

ACCESS TO EMPLOYER-SPONSORED HEALTH INSURANCE

Finally, we define access to employer-sponsored health insurance as having health insurance coverage through an employer or, for those without such coverage, whether their or a family member's employer *offers* health insurance.

Analysis

We first compare chilling effects between 2018 and 2019 for adults in California immigrant families overall. These estimated changes are regression adjusted to control for any changes in the demographic characteristics of the adults in immigrant families participating in each survey round. We control for a respondent's gender, age, race and ethnicity, educational attainment, family size, chronic health conditions, residence in an urban or rural area, internet access, homeownership status, citizenship status, family composition, and family income as a percentage of the federal poverty level; presence of children under age 19 in the respondent's household; whether the respondent participated in both the 2018 and 2019 rounds of the survey; and how long the respondent has been a member of the KnowledgePanel.

Next, we examine awareness of the public charge rule among adults in California immigrant families.²¹ We assess knowledge of the rule overall and among those who reported being very or somewhat confident in their understanding of the rule. We then compare respondents' sources of information about the rule with the sources they would trust the most if they had a question about how using public benefits affects their immigration status. All estimates are weighted to represent the population of nonelderly adults in California immigrant families (as described above) and account for the complex survey design.

The findings presented in this brief are primarily drawn from the survey data. We also incorporate quotes and themes from the follow-up interviews with adults in California immigrant families who reported chilling effects. The qualitative results do not provide a representative sample, but they complement the quantitative results by shedding light on people's experiences on the ground. We include direct quotations spoken in Spanish and English translations.

Limitations

One limitation of the WBNS is its low response rate, which is comparable with that of other panel surveys accounting for nonresponse at each stage of recruitment.²² WBNS survey weights reduce but do not eliminate the potential for error associated with sample coverage and nonresponse, which are likely larger for the subgroup of adults in immigrant families.²³

In addition, because the WBNS is only administered in English and Spanish, our analytic sample does not describe the experiences of the full spectrum of adults in California immigrant families. Our study excludes adults with limited English proficiency whose primary language is not Spanish. We estimate these excluded adults represent between 5 and 15 percent of all nonelderly adults in California immigrant households as defined for this brief; according to the 2018 American Community Survey, in California, about 5 percent of this group speaks English less than well²⁴ and speaks a primary language other than Spanish.

Some measurement error is likely for questions related to citizenship statuses of respondents and relatives in the household, particularly among adults who are undocumented or have been in the US for a short time (Van Hook and Bachmeier 2013).

During the follow-up interviews, six interviewees indicated they or their family members had *not* decided to avoid participation in noncash public programs because of immigration concerns. There are several possible explanations for a mismatch between what respondents reported on the survey and what they shared during the follow-up interview, including potential misunderstanding of the original survey question, as well as mode effects, whereby respondents may have been less likely to reveal sensitive information in a one-on-one interview than an online survey.

Notes

- ¹ "State Immigration Data Profiles: California," Migration Policy Institute, accessed April 30, 2020, <https://www.migrationpolicy.org/data/state-profiles/state/demographics/CA>.
- ² *Inadmissibility on Public Charge Grounds*, 83 Fed. Reg. 51114 (Oct. 10, 2018).
- ³ *Inadmissibility on Public Charge Grounds*, 84 Fed. Reg. 41292 (Aug. 14, 2019).
- ⁴ State of California Department of Justice, "Attorney General Becerra Leads Coalition of Five Attorneys General, Files Suit Challenging Trump Administration Public Charge Rule," news release, August 16, 2019, <https://oag.ca.gov/news/press-releases/attorney-general-becerra-leads-coalition-five-attorneys-general-files-suit>.
- ⁵ The Supreme Court ruling on the national injunction in January did not apply to Illinois, which had a separate case before the court that was ruled on in February.
- ⁶ Jeanne Batalova, Michael Fix, and Mark Greenberg, "Through the Back Door: Remaking the Immigration System via the Expected 'Public-Charge' Rule," Migration Policy Institute, August 2018, <https://www.migrationpolicy.org/news/through-back-door-remaking-immigration-system-expected-public-charge-rule>.

- ⁷ “Status of State Action on the Medicaid Expansion Decision,” Henry J. Kaiser Family Foundation, last updated April 27, 2020, <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act>.
- ⁸ Though impossible to assess in California given the limited sample size, chilling effects increased nationally among families most likely to be directly affected by the rule, rising from 21.8 percent to 31.0 percent for adults in immigrant families in which at least one member was not a permanent resident. See Bernstein and colleagues (2020).
- ⁹ In this context, social media are platforms such as Facebook, Twitter, WhatsApp, or WeChat.
- ¹⁰ Lawrence Hurley, “US Supreme Court Refuses to Block Trump Immigration Policy during Pandemic,” *Reuters*, April 24, 2020, <https://www.reuters.com/article/us-usa-court-immigration-idUSKCN2263FQ>.
- ¹¹ Catherine Kim, “Low-Income Immigrants Are Afraid to Seek Health Care amid the COVID-19 Pandemic,” *Vox*, March 13, 2020, <https://www.vox.com/identities/2020/3/13/21173897/coronavirus-low-income-immigrants>.
- ¹² “Immigration Services,” California Department of Social Services, accessed May 5, 2020, <https://www.cdss.ca.gov/immigration-services>.
- ¹³ “Resource Guide for State and Local COVID-19 Emergency Responses,” *New American Economy*, last updated April 1, 2020, <https://www.newamericaneconomy.org/uncategorized/15553/?emci=2cfe09ee-7773-ea11-a94c-00155d03b1e8&emdi=2c4823b1-2874-ea11-a94c-00155d03b1e8&ceid=377678>; “Up-to-Date COVID-19 Information,” *Western Center on Law and Poverty*, May 1, 2020, <https://wclp.org/covid-19-coronavirus-information-response-and-considerations/>; “COVID-19 Guidance for Immigrant Californians,” State of California, accessed May 4, 2020, <https://covid19.ca.gov/img/wp/covid-19-immigrant-guidance-final-accessible-1.pdf>
- ¹⁴ For each round of the WBNS, the core sample is a stratified random sample of approximately 7,500 nonelderly adults drawn from Ipsos’ KnowledgePanel, a probability-based online panel recruited primarily from an address-based sampling frame, and includes a large oversample of adults in low-income households. The additional oversample of approximately 300 noncitizens is designed to support analyses of current policy issues affecting immigrant families. The panel includes only respondents who can complete surveys administered in English or Spanish, and adults without internet access are provided free web-enabled devices and internet access to facilitate participation.
- ¹⁵ We define adults with English proficiency as those who speak English at least well, as classified in the American Community Survey. Adults with limited English proficiency are those who speak English less than well. This is a broader measure than is commonly used to define English proficiency; in most analyses, a person must speak English very well to be classified as having English proficiency (Wilson 2014). We use the following measures for weighting: gender, age, race and ethnicity, educational attainment, presence of children under age 18 in the household, census region, homeownership status, family income as a percentage of the federal poverty level, access to the internet, and family composition. We benchmark non-Hispanic respondents who are not white or black by two categories: (1) other race born in Asia and (2) multiple races or other race not born in Asia.
- ¹⁶ Using a recruitment script developed by the Urban team, Ipsos staff called 45 Spanish- and English-speaking respondents to invite them to participate in a qualitative telephone interview. Of the 45 respondents, 3 (7 percent) refused to participate in the study. Twenty-two could not be reached for reasons such as disconnected calls, a wrong or unavailable phone number, or unreturned voice messages. Ipsos successfully scheduled 20 respondents for an interview, and of those, Urban successfully reached and interviewed 17.
- ¹⁷ We drew on measures developed by researchers at the University of California, Los Angeles, for an immigrant follow-up survey to the California Health Interview Survey. For the exact wording of this and other questions on the WBNS, see the survey questionnaire at https://www.urban.org/sites/default/files/wbns_2019_questionnaire.pdf.

We learned in follow-up interviews to the 2018 survey that some respondents did not understand the distinction between the two separate survey items measuring chilling effects: “not applying for a program”

versus “stopping participating in a program.” Consequently, we combined responses to report on the questions together: either not applying for or dropping out of a noncash assistance program.

Because of the insufficient sample size of adults in California immigrant families who reported a chilling effect, we do not report what specific programs were avoided. For national estimates of avoidance of specific programs, see the accompanying brief, Bernstein and colleagues (2020).

- ¹⁸ We asked about additional programs not listed in the public charge rule because of reports that families were avoiding such programs; see, for example, Emily Moon, “Why Is Participation in Food Assistance Programs like WIC Declining?” *Pacific Standard*, May 8, 2019, <https://psmag.com/news/why-is-participation-in-food-assistance-programs-like-wic-declining>.
- ¹⁹ This question was asked later in the survey than the questions on chilling effects. For the exact wording of this and other questions on the WBNS, see the survey questionnaire at https://www.urban.org/sites/default/files/wbns_2019_questionnaire.pdf.
- ²⁰ Respondents were randomly assigned to one of two versions of this question. For the exact wording of this and other questions on the WBNS, see the survey questionnaire at https://www.urban.org/sites/default/files/wbns_2019_questionnaire.pdf.
- ²¹ We allocate missing citizenship status data for respondents using their responses to the Ipsos panel profile question on citizenship; absent that information, we impute respondent citizenship status.
- ²² However, studies assessing recruitment for the KnowledgePanel have found little evidence of nonresponse bias for core demographic and socioeconomic measures (Garrett, Dennis, and DiSogra 2010; Heeren et al. 2008), and WBNS estimates are generally consistent with benchmarks from federal surveys (Karpman, Zuckerman, and Gonzalez 2018).
- ²³ Though the weights are designed to produce nationally representative estimates for adults in immigrant families, the survey’s design implies our analytic sample of 498 adults in California immigrant families has precision comparable to a simple random sample of approximately 196 adults, increasing the sampling error around our estimates.
- ²⁴ See endnote 15 for a definition of English proficiency.

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National Assessment of Surprise Coverage Gaps Provided to Simulated Patients Seeking Emergency Care

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Introduction

Surprise out-of-network bills, which essentially represent surprise coverage gaps, have recently garnered public outrage and the attention of Congress. These coverage gaps occur when patients seek hospital-based services and incur charges from multiple providers participating in different insurance networks or from out-of-network providers practicing at an in-network hospital. Emergency care has been a central focus of policy makers, as patients have no option to select a provider, and the magnitude of charges can be enormous.¹

Increasing transparency, especially price transparency, has been heralded as a consumer-based solution to the high price of health care.² However, price transparency does not necessarily imply coverage transparency. Accordingly, we examined surprise coverage gaps from the patient perspective by conducting a national cross-sectional study of hospitals by using secret shopper phone call methods to assess whether patients could receive timely responses to 3 simple insurance coverage questions.

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

Methods

This study was considered to be non-human subject research and was exempt from review per Yale Human Research Protection Program guidelines. This study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline.

For this cross-sectional study, trained research assistants posing as patients seeking emergency care made calls to every acute care hospital in the United States.^{3,4} Calls were conducted from August 1, 2017, to April 30, 2018. Patients stated they were covered by the most subscribed commercial insurance company within their state.⁵ Patients asked hospital billing staff 3 core and 2 follow-up insurance coverage questions (Table). Additional details on the calling procedure are given in the eMethods in the Supplement. We conducted contingency table analyses with χ^2 testing to compare the probability that patients would receive a separate bill by whether emergency department (ED) physicians were hospital employees. Data were analyzed from July 1, 2018, to March 31, 2020. Statistical tests were 2-tailed, with $P < .05$ representing statistical significance.

Results

Simulated patients connected with hospitals having operational EDs in 4231 (89.0%) of 4752 total calls (Table). In 4059 of 4231 calls (96.0%), the billing staff was able to answer whether the hospital accepted the patient's insurance. In 2623 calls (62.0%), patients received "yes" or "no" responses to all 3 core questions. Responses received by patients showed that separate professional billing for ED physicians varies by state, with North and South Dakota and several northwestern states having a comparatively higher prevalence of separate billing (Figure). Among 2435 hospitals with billing staff responding that they do not employ their emergency physicians or giving an unclear response, 2092 (85.9%) were unable or unwilling to answer the question of who employed their ED physicians. Responses received by patients showed that hospital employment of ED physicians also varied by state (Figure). The proportion of hospitals reporting employment of ED physicians varied by state

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from 0% (Indiana, Kentucky, Missouri, Oklahoma, Tennessee, Utah, and Wisconsin) to 64.2% (North Dakota), with a mean (SD) of 20.0% (18.1%) reporting direct employment of emergency physicians. Our analysis showed that the probability of receiving a single professional and hospital bill for emergency care was associated with hospital employment of ED physicians ($r= 0.49; P< .001$).

Discussion

In this cross-sectional study of more than 4000 hospitals, we were reassured to find that 96.0% of hospitals' billing staff could quickly answer whether they accepted the patient's insurance. However, only 62.0% gave immediate "yes" or "no" responses to all 3 core questions. Furthermore, nearly half of those informing patients they would receive a separate professional bill from the emergency physician could not answer whether the bill would be considered in network. Also concerning, nearly one-third of billing staff were unable or unwilling to answer whether their ED physicians were

Table. Responses From Hospitals' Billing Staff (N = 4231) to Secret Shopper Patient Calls Regarding Surprise Out-of-Network Coverage Gaps^a

Patient call questions	Yes	No	Unclear ^b	Unanswered ^c
1. Do you take my insurance?	4052 (95.8)	7 (0.2)	149 (3.5)	23 (0.5)
2. Will I get a separate bill from my emergency department doctor?	3147 (74.4)	355 (8.4)	147 (3.5)	585 (13.8)
2a. Will the separate bill be considered in network? ^d	1524 (48.4)	76 (2.4)	1523 (48.4)	24 (0.8)
3. Do your emergency department doctors work for the hospital?	637 (15.1)	2195 (51.9)	240 (5.7)	1159 (27.4)
3a. Who do your doctors work for? ^e	254 (10.4) ^f	NA	177 (7.3)	2004 (82.3)

Abbreviation: NA, not applicable.

^a All values are presented as number (percentage).

^b Hospital billing staff responded that they did not know the answer to the question.

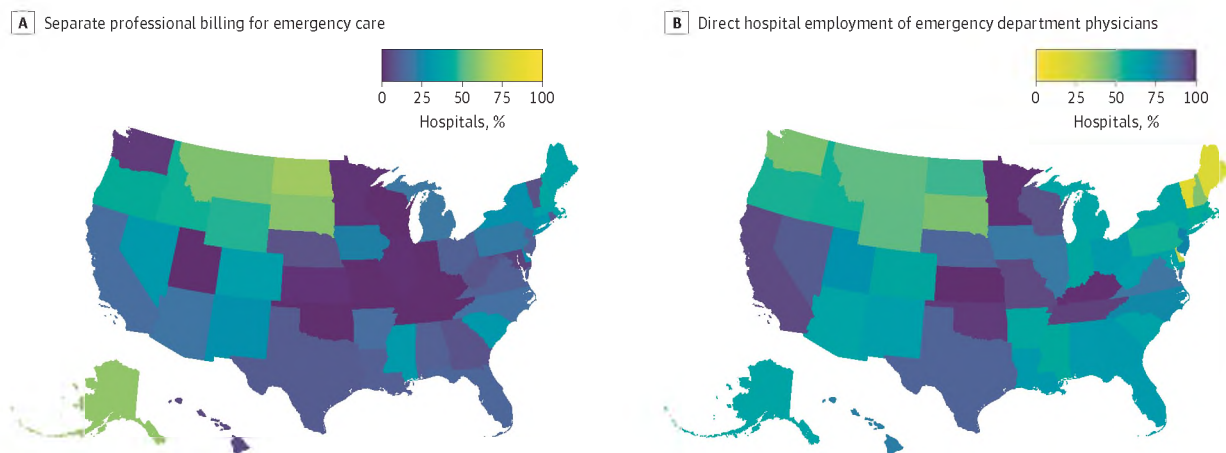
^c In some cases, the initial call taker answered some questions but could not answer all questions. After receiving responses to 1 or 2 questions, simulated patients were placed on hold for extended periods of time, became disconnected, or were transferred and the call went unanswered or to voicemail. Callbacks were not attempted.

^d Question 2a was asked if the answer to question 2 was "yes."

^e Question 3a was asked if the answer to question 3 was "no" or was unclear.

^f Values indicate the number (percentage) of staff who answered the question.

Figure. State-by-State Prevalence of Separate Professional Billing for Emergency Care and Direct Hospital Employment of Emergency Department Physicians



A, Map shows the percentage of acute care hospitals' billing staff responding to secret shoppers that they would receive a separate bill from the emergency department doctor. B, Map shows the percentage of acute care hospitals' billing staff responding to secret shoppers that their emergency department doctors work for the hospital.

hospital employees. These findings suggest that the current system cannot accommodate the coverage information needs of many patients seeking emergency care.

Despite national efforts to increase price transparency and evidence of price transparency successes for nonemergent and scheduled care, our results illustrate the limitations of transparency efforts in solving a surprise coverage gap problem.⁶ Specifically, the percentage of unclear and unanswered responses to questions 2, 2a, and 3 demonstrates the practical obstacles patients face when trying to quickly determine insurance coverage for emergency care. Furthermore, the observed geographic variation suggests that a single transparency solution is unlikely to universally address this issue.

As Congress debates legislation to address surprise billing, we propose that plans (ie, employer based, exchange based, Medicare, and Medicaid) eliminate out-of-network penalties and prior authorization requirements for emergency care and provide standardized, available pricing that applies equivalently to all. This approach does not assume zero out-of-pocket spending for patients, but it would eliminate surprise coverage gaps for emergency care and allow for predictable and reasonable billing. This study's limitations include the following: (1) the unique study questions have not been validated in the research literature, and (2) the accuracy of the responses received were not validated.

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SUPPLEMENT.

eMethods. Secret Shopper Calling Procedure



Original Investigation | Health Policy

Patterns in Geographic Access to Health Care Facilities Across Neighborhoods in the United States Based on Data From the National Establishment Time-Series Between 2000 and 2014

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Abstract

IMPORTANCE The association between proximity to health care facilities and improved disease management and population health has been documented, but little is known about small-area health care environments and how the presence of health care facilities has changed over time during recent health system and policy change.

OBJECTIVE To examine geographic access to health care facilities across neighborhoods in the United States over a 15-year period.

DESIGN, SETTING, AND PARTICIPANTS Using longitudinal business data from the National Establishment Time-Series, this cross-sectional study examined the presence of and change in ambulatory care facilities and pharmacies and drugstores in census tracts (CTs) throughout the continental United States between 2000 and 2014. Between January and April 2019, multinomial logistic regression was used to estimate associations between health care facility presence and neighborhood sociodemographic characteristics over time.

MAIN OUTCOMES AND MEASURES Change in health care facility presence was measured as never present, lost, gained, or always present between 2000 and 2014. Neighborhood sociodemographic characteristics (ie, CTs) and their change over time were measured from US Census reports (2000 and 2010) and the American Community Survey (2008-2012).

RESULTS Among 72 246 included CTs, the percentage of non-US-born residents, residents 75 years or older, poverty status, and population density increased, and 8.1% of CTs showed a change in the racial/ethnic composition of an area from predominantly non-Hispanic (NH) white to other racial/ethnic composition categories between 2000 and 2010. The presence of ambulatory care facilities increased from a mean (SD) of 7.7 (15.9) per CT in 2000 to 13.0 (22.9) per CT in 2014, and the presence of pharmacies and drugstores increased from a mean (SD) of 0.6 (1.0) per CT in 2000 to 0.9 (1.4) per CT in 2014. Census tracts with predominantly NH black individuals (adjusted odds ratio [aOR], 2.37; 95% CI, 2.03-2.77), Hispanic/Latino individuals (aOR 1.30; 95% CI, 1.00-1.69), and racially/ethnically mixed individuals (aOR, 1.53; 95% CI, 1.33-1.77) in 2000 had higher odds of losing health care facilities between 2000 and 2014 compared with CTs with predominantly NH white individuals, after controlling for other neighborhood characteristics. Census tracts of geographic areas with higher levels of poverty in 2000 also had higher odds of losing health care facilities between 2000 and 2014 (aOR, 1.12; 95% CI, 1.05-1.19).

(continued)

Key Points

Question How has change in the presence of health care facilities and pharmacies and drugstores over time across neighborhoods in the United States differed based on the race/ethnicity, age, and socioeconomic characteristics of area residents?

Findings Using business data from the National Establishment Time-Series over a 15-year period, this cross-sectional study of 72 246 census tracts found differential change in the presence of health care facilities across neighborhoods, with more disadvantaged neighborhoods never having or losing health care facilities between 2000 and 2014.

Meaning Differential geographic presence of health care resources over time can further exacerbate disparities in health care access, quality, and outcomes.

+ Supplemental content

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Abstract (continued)

CONCLUSIONS AND RELEVANCE Differential change was found in the presence of health care facilities across neighborhoods over time, indicating the need to monitor and address the spatial distribution of health care resources within the context of population health disparities.

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Introduction

Geographic access to health care is associated with increased use of preventive care and improved health outcomes for certain chronic conditions.¹⁻⁷ Although geographic access is one of several components that can alter an individual's overall access to health care, including insurance status, out-of-pocket costs, facility hours, appointment wait times, and linguistic services, prior research has shown increased geographic access is associated with greater use and improved outcomes. Neighborhoods with more income inequality and residential segregation along sociodemographic lines may not attract or may underinvest in institutions that benefit the general population, resulting in unequal geographic health care access.⁸ Previous analyses of geographic access to health care services, including trauma centers, specialty care for neonatal populations, and mental health care, have indicated that neighborhoods with predominantly minority residents, lower socioeconomic status, and high residential turnover have less geographic access to care.^{9,10} This observation was confirmed by Smiley et al,¹¹ who reported that health-related resources are not equally distributed across space and that disadvantage often clusters with residential racial/ethnic patterning. Although recent data indicate access to health care, as measured by insurance coverage or self-report of having a usual source of care, has improved since implementation of the Patient Protection and Affordable Care Act,¹² few sources are available to understand geographic health care environments, including the presence of ambulatory care facilities, retail clinics, and pharmacies and drugstores, beyond county-level geographies.

Despite increasing demographic change in racial/ethnic composition and household income and aging subgroups over the last few decades, few studies have assessed temporal change in the geographic access to or the presence of health care facilities across neighborhoods in the United States. A study¹³ conducted in Illinois from 1990 to 2000 found an overall improvement in geographic access to health care over time, with worsened geographic accessibility primarily concentrated in rural areas along with a few urban pockets. Areas that experienced decreasing geographic access had higher levels of socioeconomic disadvantage, sociocultural barriers, and health care needs. Similarly, in a 2011 study, Busingye et al¹⁴ found substantial increases in the proportion of the population with geographic access to cardiac facilities from 1999 to 2010, with disparities still existing in rural communities. Hospital closures over the last decade and increased consolidation across hospital systems may also have altered geographic access for certain neighborhoods over time.¹⁵⁻¹⁹ Insights into long-term temporal trends on the availability of health care facilities nationally, particularly with respect to nonhospital facilities and attention to changing neighborhood-level sociodemographic characteristics of residents, are lacking.

This gap in the literature is addressed herein by examining change in the presence of ambulatory care facilities and pharmacies and drugstores across neighborhoods (ie, census tracts [CTs]) as a measure of geographic access in the United States over a 15-year period. Specifically, the objectives of this study were (1) to examine patterns in neighborhood-level presence of health care facilities across the United States by neighborhood-level sociodemographic characteristics and (2) to assess whether neighborhood-level population characteristics (racial/ethnic composition and socioeconomic status) were associated with change in neighborhood-level presence of health care facilities over time. We hypothesized that socioeconomically disadvantaged neighborhoods would continue to experience limited local presence of health care facilities over time compared with more advantaged neighborhoods. We also hypothesized that neighborhoods undergoing demographic

compositional change across time from disadvantaged to advantaged would experience increased presence of health care facilities.

Methods

Study Sample

Using longitudinal business data from the National Establishment Time-Series (NETS), this cross-sectional study compiled health care environment, demographic, and socioeconomic data between 2000 and 2014 for all CTs in the continental United States ($n = 72\,538$). Of these, 292 CTs were excluded because they contained no land area (ie, were water tracts), leaving 72 246 nonwater CTs. For consistency over time despite boundary changes, all health care environment, demographic, and socioeconomic measures were assigned to 2010 US Census geographies.

This study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline.²⁰ The study is part of a larger study (Communities Designed to Support Cardiovascular Health for Older Adults⁵²) that includes human participants not included in this analysis and was approved by the Drexel University Institutional Review Board.

Dependent Variable of Health Care Facilities

To characterize neighborhood-level geographic access, the presence of health care facilities was measured using 2000 to 2014 business data from the NETS database, licensed from Walls & Associates (Denver, Colorado) in January 2017. Detailed methods on the creation and cleaning of the NETS data can be found elsewhere.^{21,22} Briefly, the NETS pulls annual snapshots of Dun & Bradstreet (Short Hills, New Jersey) business data to create time series information on all names of US businesses, years active, and industrial classification using Standard Industrial Classification (SIC) codes. The NETS data represent a census of all businesses across the United States, and the NETS is considered one of the most comprehensive databases of establishments available. Prior studies^{2,23,24} have used the NETS data to examine health care facilities and specific chronic conditions. From the NETS, records were categorized as ambulatory care facilities or as pharmacies and drugstores using SIC codes (eTable 1 in the Supplement). Ambulatory care was a category designed to capture locations able to provide outpatient care, including screenings and other preventive measures. As such, ambulatory care captures offices or clinics of health practitioners, mental health outpatient and continuous care facilities, behavioral health outpatient and continuous care facilities, urgent care locations, retail clinics, physical therapists, kidney centers, and dental care facilities. The pharmacy and drugstore category was designed to capture locations where medications and medical supplies could be purchased. To capture national chain pharmacies and drugstores otherwise missed because of incorrect SIC code, we searched a broader set of SIC codes for any company or trade name that was on the Nielsen (New York, New York) TDLinx list for trade channel "drug" and subchannels "conventional drug store" or "Rx only and small drug store."

Health care facilities were geocoded and aggregated to CT for each year in which a business was open, focused on 2000 and 2014 only. Using this information, counts of health care facilities per CT were calculated. After examining the distribution of counts, CTs were classified as having none vs any for each type of health care facility (ambulatory care facilities or pharmacies and drugstores). Census tracts were divided into the following 4 trajectories of health care facility presence over time between 2000 and 2014: (1) never having any facilities (CTs having none at both time points), (2) losing (CTs going from having at least 1 to having none), (3) gaining (CTs going from having none to having at least 1), and (4) always having a facility (CTs having at least 1 at both time points).

Independent Variables of Demographic and Socioeconomic Characteristics

Neighborhood demographic and socioeconomic characteristics for 2000 and 2010 were accessed using the Longitudinal Tract Database.^{25,26} This database harmonizes data from US Census reports (2000 and 2010) and the American Community Survey (2008-2012), accounting for differences in

geographies and measurements over time. Demographic and socioeconomic characteristics were selected to represent a range of domains while minimizing collinearity. To classify neighborhood demographic characteristics, we used the proportion of residents identifying as non-Hispanic (NH) white individuals, NH black individuals, Hispanic/Latino individuals, NH Asian/Pacific Islander individuals, and non-US born individuals, and those aged 75 years or older. Racial/ethnic composition of neighborhoods was assessed by predominant (>60%) racial/ethnic group into the following racial/ethnic categories: predominantly NH white, predominantly NH black, predominantly Hispanic/Latino, or predominantly NH Asian/Pacific Islander. Places with no predominant group were classified as racially/ethnically mixed areas. These categorizations were based on prior use in the literature.²⁷ To represent socioeconomic conditions, we used the proportion of residents living at 100% of the federal poverty level, the proportion with a high school (HS) diploma or less, and home ownership.

For linear variables, change between 2000 and 2010 was calculated by subtracting 2000 values from 2010 values for each CT. For racial/ethnic composition, places that had the same racial/ethnic composition at both periods were classified as remaining predominantly NH white, NH black, Hispanic/Latino, NH Asian/Pacific Islander, or racially/ethnically mixed areas. Change in the racial/ethnic composition of an area was classified in the following 3 ways: (1) a change from predominantly NH white to predominantly NH black, predominantly Hispanic/Latino, predominantly NH Asian/Pacific Islander, or racially/ethnically mixed; (2) a change to predominantly NH white from predominantly NH black, predominantly Hispanic/Latino, predominantly NH Asian/Pacific Islander, or racially/ethnically mixed; and (3) all other changes.

Statistical Analysis

Between January and April 2019, we calculated descriptive statistics of health care facilities, demographics, and socioeconomic characteristics for 2000, 2010, and 2014 (health care facilities only). Categories of health care facility presence over time were mapped, and frequencies were compared across states. Bivariate analyses were conducted using both baseline (2000) and change (2000-2010) in demographic and socioeconomic characteristics across categories to predict change in health care facilities between 2000 and 2014. Because bivariate analyses include all nonwater CTs in the continental United States (rather than a sample), multinomial logistic regression was used to estimate associations between initial (2000) demographic and socioeconomic characteristics and change in health care facility (2000-2014). Longitudinal multinomial logistic regression models estimated associations between change (2000-2010) in demographic and socioeconomic characteristics and change in health care facility presence (2000-2014). These models were selected instead of a multilevel logistic regression because the intraclass correlation coefficients for outcomes within states were all low (1.4%-6.4%).²⁸ Models were mutually adjusted for all predictors; longitudinal models were also adjusted for living at 100% of the federal poverty level, the proportion of residents with a HS diploma or less, and baseline (2000) population density (population per square kilometer). Select results for specific categories of health care facility change in CTs of areas with predominantly NH Asian/Pacific Islander residents are not given because of small sample sizes of CTs ($n < 10$).

Results

Description of CTs

In 2000, most CTs included individuals who were predominantly NH white, with racially/ethnically mixed individuals being second most common, followed by predominantly NH black individuals (**Table 1**). Between 2000 and 2010, 8.1% of CTs showed a change in the racial/ethnic composition of an area from predominantly NH white to one of the other racial/ethnic composition categories, 0.9% showed a change to predominantly NH white from one of the other categories, and 3.9% showed a change between the other categories (**Table 2**). Census tract proportion of non-US-born residents,

Table 1. Demographic and Socioeconomic Characteristics (2000) Across Categories of Change in Health Care Facilities (2000-2014) for 72 246 Continental Nonwater US Census Tracts

2000 Characteristic ^a	No. (%)									
	All census tracts (N = 72 246)	Ambulatory care facilities				Pharmacies and drugstores				
		None (n = 6035)	Lose (n = 2020)	Gain (n = 10 644)	Always (n = 53 547)	None (n = 32 223)	Lose (n = 5650)	Gain (n = 11 563)	Always (n = 22 810)	
Race/ethnicity ^b										
Predominantly NH white	51 329 (71.1)	3289 (54.5)	1110 (55.0)	7583 (71.2)	39 347 (73.5)	22 275 (69.1)	3902 (69.1)	8500 (73.5)	16 652 (73.0)	
Predominantly NH black	4946 (6.9)	902 (15.0)	373 (18.5)	695 (6.5)	2976 (5.6)	2545 (7.9)	530 (9.4)	602 (5.2)	1269 (5.6)	
Predominantly Hispanic/Latino	3453 (4.8)	470 (7.8)	136 (6.7)	573 (5.4)	2274 (4.3)	1691 (5.3)	235 (4.2)	522 (4.5)	1005 (4.4)	
Predominantly NH Asian/Pacific Islander	120 (0.2)	6 (0.1)	1 (0.1)	17 (0.2)	96 (0.2)	43 (0.1)	8 (0.1)	21 (0.2)	48 (0.2)	
Racially/ethnically mixed	12 398 (17.2)	1368 (22.7)	400 (19.8)	1776 (16.7)	8854 (16.5)	5669 (17.6)	975 (17.3)	1918 (16.6)	3836 (16.8)	
Non-US born, mean (SD), %	10.4 (13.2)	8.9 (13.2)	8.9 (13.1)	9.2 (12.1)	10.9 (13.3)	9.8 (12.7)	9.6 (12.1)	11.3 (13.1)	11.0 (14.1)	
Aged ≥75 y, mean (SD), %	6.0 (4.4)	4.8 (3.8)	5.5 (3.9)	4.7 (4.1)	6.5 (4.5)	5.4 (4.2)	6.5 (4.1)	5.5 (4.6)	7.2 (4.5)	
Living below poverty, mean (SD), %	12.8 (11.1)	17.8 (13.5)	18.5 (13.2)	11.9 (11.0)	12.2 (10.5)	13.1 (11.6)	13.8 (11.2)	10.6 (10.1)	13.4 (10.5)	
HS diploma or less, mean (SD), %	48.6 (19.2)	60.6 (17.7)	60.2 (15.7)	49.8 (18.7)	46.9 (18.7)	50.0 (19.4)	50.1 (18.2)	43.6 (18.8)	49.6 (18.2)	
Home ownership, mean (SD), %	66.1 (23.3)	65.3 (25.6)	63.7 (23.3)	73.2 (22.0)	65.2 (22.5)	68.5 (23.3)	63.6 (21.9)	69.1 (23.1)	62.5 (22.0)	
Population per km ² , mean (SD)	1984.8 (4552.5)	1832.4 (4263.7)	2021.1 (3846.2)	1379.5 (3567.1)	2120.9 (4767.9)	1766.4 (3861.1)	1914.4 (3701.7)	1908.4 (4283.3)	2349.5 (5629.1)	

Abbreviations: HS, high school; NH, non-Hispanic.

^a Data are from the 2000 US Census report unless otherwise indicated.

^b Racial/ethnic composition was assessed by predominant (>60%) racial/ethnic group. Places with no predominant group were classified as racially/ethnically mixed areas.

those 75 years or older, those living below poverty level, and the population density increased between 2000 and 2010. In contrast, the proportion of residents with a HS diploma or less and those who owned a home decreased.

Description of Change in Health Care Facilities

Census tracts had many more ambulatory care facilities than pharmacies and drugstores, and both facility types increased between 2000 and 2014. The mean (SD) count of pharmacies and drugstores was less than 1 per CT (0.6 [1.0] in 2000 and 0.9 [1.4] in 2014, respectively). Conversely, for ambulatory care facilities, CTs had a mean (SD) of 7.7 (15.9) in 2000 and 13.0 (22.9) in 2014.

For most CTs, the presence or absence was stable over time, with 8.4% never having ambulatory care facilities, 74.1% always having at least one ambulatory care facility, 44.6% never having pharmacies and drugstores, and 31.6% always having a pharmacy (Table 1). However, a substantial percentage of CTs went from having no facilities in 2000 to having at least one by 2014 (14.7% for ambulatory care facilities and 16.0% for pharmacies and drugstores). A smaller percentage went from having at least one facility to having no facilities (2.8% for ambulatory care

Table 2. Change in Demographic and Socioeconomic Characteristics (2000-2010) Across Categories of Change in Health Care Facilities (2000-2014) for 72 246 Continental Nonwater US Census Tracts

Change in characteristic (2000-2010)	No. (%)								
	All census tracts (N = 72 246)	Ambulatory care facilities				Pharmacies and drugstores			
		None (n = 6035)	Lose (n = 2020)	Gain (n = 10 644)	Always (n = 53 547)	None (n = 32 223)	Lose (n = 5650)	Gain (n = 11 563)	Always (n = 22 810)
Race/ethnicity ^{a,b}									
Remained predominantly NH white	45 513 (63.0)	2878 (47.7)	972 (48.1)	6636 (62.3)	35 027 (65.4)	19 906 (61.8)	3439 (60.9)	7348 (63.6)	14 820 (65.0)
Remained predominantly NH black	4421 (6.1)	816 (13.5)	341 (16.9)	619 (5.8)	2645 (4.9)	2276 (7.1)	480 (8.5)	534 (4.6)	1131 (5.0)
Remained predominantly Hispanic/Latino	3267 (4.5)	447 (7.4)	126 (6.2)	537 (5.1)	2157 (4.0)	1596 (5.0)	218 (3.9)	496 (4.3)	957 (4.2)
Remained predominantly NH Asian/Pacific Islander	111 (0.2)	4 (0.1)	1 (0.1)	15 (0.1)	91 (0.2)	37 (0.1)	8 (0.1)	20 (0.2)	46 (0.2)
Remained racially/ethnically mixed	9660 (13.4)	1016 (16.8)	298 (14.8)	1336 (12.6)	7010 (13.1)	4358 (13.5)	760 (13.5)	1507 (13.0)	3035 (13.3)
Changed from predominantly NH white	5816 (8.1)	411 (6.8)	138 (6.8)	947 (8.9)	4320 (8.1)	2369 (7.4)	8.2 (463)	1152 (10.0)	1832 (8.0)
Changed to predominantly NH white	645 (0.9)	92 (1.5)	16 (0.8)	128 (1.2)	409 (0.8)	347 (1.1)	31 (0.6)	116 (1.0)	151 (0.7)
All other changes	2813 (3.9)	371 (6.2)	128 (6.3)	426 (4.0)	1888 (3.5)	1334 (4.1)	251 (4.4)	390 (3.4)	838 (3.7)
Non-US born, mean (SD), % ^c	1.7 (5.4)	1.3 (6.7)	1.2 (6.6)	2.1 (5.9)	1.7 (5.1)	1.5 (5.6)	1.6 (5.0)	2.3 (5.7)	1.7 (4.9)
Aged ≥75 y, mean (SD), % ^b	0.3 (2.6)	0.2 (3.5)	0.1 (2.3)	0.5 (2.7)	0.2 (2.5)	0.4 (2.8)	0.0 (2.3)	0.4 (2.7)	0.1 (2.4)
Living below poverty, mean (SD), % ^c	3.1 (7.6)	3.0 (11.4)	3.9 (9.6)	2.5 (7.9)	3.1 (6.9)	2.9 (8.4)	3.7 (7.5)	2.8 (7.0)	3.3 (6.9)
HS diploma or less, mean (SD), % ^c	-5.2 (8.5)	-6.3 (13.0)	-5.7 (9.8)	-5.9 (9.5)	-5.0 (7.5)	-5.5 (9.4)	-5.0 (7.8)	-4.9 (8.4)	-5.2 (7.2)
Home ownership, mean (SD), % ^b	-2.2 (8.5) ^c	-3.4 (14.0)	-2.2 (8.6)	-2.2 (10.3)	-2.1 (7.2)	-2.0 (9.7)	-2.3 (7.0)	-2.6 (9.3)	-2.4 (6.5)
Population per km ² , mean (SD) ^b	33.7 (705.6)	-44.3 (791.9)	-72.7 (666.8)	115.7 (835.0)	28.9 (665.8)	18.7 (647.9)	-27.3 (537.9)	108.8 (807.0)	28.9 (760.4)

Abbreviations: HS, high school; NH, non-Hispanic.

^a Racial/ethnic composition assessed by predominant (>60%) racial/ethnic group. Places with no predominant group were classified as racially/ethnically mixed areas. For 2000 to 2010, census tracts that remained predominantly one race/ethnicity were grouped in their own category. Change in racial/ethnic composition was classified in the following 3 ways: (1) a change from predominantly NH white to predominantly NH black, predominantly Hispanic/Latino, predominantly NH Asian/Pacific Islander, or

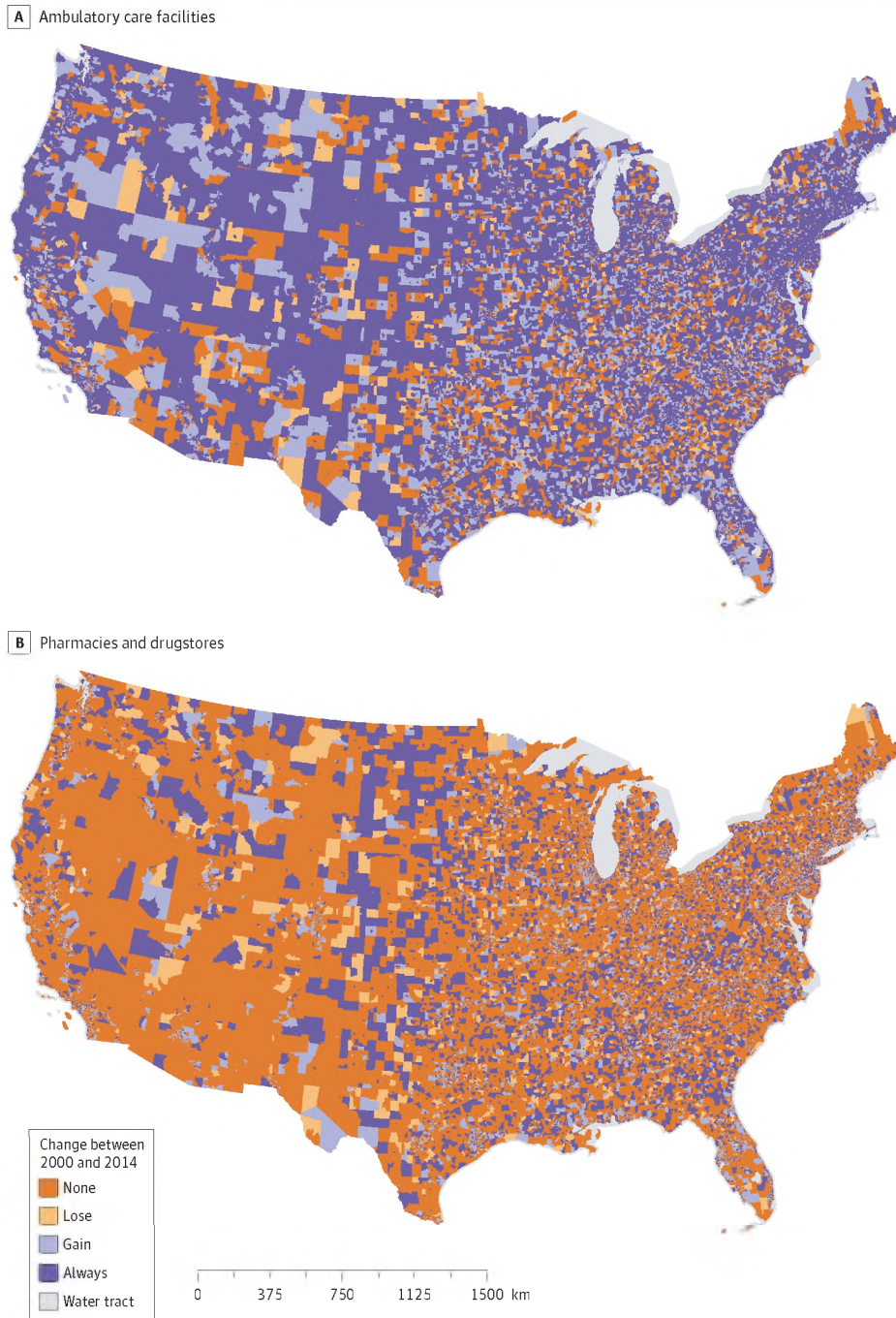
racially/ethnically mixed; (2) a change to predominantly NH white from predominantly NH black, predominantly Hispanic/Latino, predominantly NH Asian/Pacific Islander, or racially/ethnically mixed; and (3) all other changes.

^b Second period data (ie, change from baseline [2000] to 2010) are from the 2010 decennial census.

^c Second period data estimates are from the American Community Survey (2008-2012).

facilities and 7.8% for pharmacies and drugstores). Mapping these categories revealed no clear regional pattern across the United States (Figure), although substantial differences by state existed over time (eFigure 1, eFigure 2, eFigure 3, and eFigure 4 in the Supplement). For example, a higher proportion of CTs within states in the Northeast (ie, Massachusetts, New Jersey, Connecticut, Pennsylvania, and Rhode Island) had consistent availability of health care facilities, and a higher proportion of CTs within states in the South and Southwest (ie, Nevada, New Mexico, and Alabama) had none of these health care facilities in either 2000 or 2014.

Figure. Change in the Presence of Health Care Facilities Between 2000 and 2014



A and B, Census tracts were divided into the following 4 trajectories of health care facility presence over time between 2000 and 2014: never having any facilities, losing, gaining, and always having a facility. Mapping these categories revealed no clear regional pattern across the United States.

Results from the bivariate analyses indicated that CTs for areas that gained or consistently had health care facilities were more likely in 2000 to have a racial/ethnic composition that was predominantly NH white or predominantly NH Asian/Pacific Islander, have a higher proportion of non-US-born residents, have a lower proportion of residents living below poverty level, and have a lower proportion of residents with a HS diploma or less (Table 1). Across categories of health care facility presence over time, similar patterns emerged for change in demographic and socioeconomic characteristics between 2000 and 2010 (Table 2) and for 2010 (eTable 2 in the Supplement).

Characteristics in 2000 Associated With Change in Health Care Facilities Between 2000 and 2014

Consistent with our hypotheses about demographic characteristics, CTs of areas with a racial/ethnic composition classified as predominantly NH black, predominantly Hispanic/Latino, or racially/ethnically mixed in 2000 were more likely to never have any or to lose ambulatory care facilities between 2000 and 2014 than predominantly NH white tracts (Table 3). Census tracts of areas with a racial/ethnic composition classified in 2000 as predominantly NH black (adjusted odds ratio [aOR], 2.00; 95% CI, 1.81-2.22), predominantly Hispanic/Latino (aOR, 1.67; 95% CI, 1.42-1.96), and racially/ethnically mixed (aOR, 1.84; 95% CI, 1.69-2.00) had higher odds of never having any ambulatory care facilities compared with areas classified as predominantly NH white. Similarly, after controlling for other neighborhood characteristics, CTs of areas classified in 2000 as predominantly NH black (aOR, 2.37; 95% CI, 2.03-2.77), predominantly Hispanic/Latino (aOR, 1.30; 95% CI, 1.00-1.69), and racially/ethnically mixed (aOR, 1.53; 95% CI, 1.33-1.77) had higher odds of losing ambulatory care facilities than CTs of areas classified as predominantly NH white. In terms of gaining ambulatory care facilities, CTs of areas with a racial/ethnic composition classified in 2000 as predominantly NH black (aOR, 1.30; 95% CI, 1.18-1.44), predominantly Hispanic/Latino (aOR, 1.26; 95% CI, 1.10-1.45), and racially/ethnically mixed (aOR, 1.26; 95% CI, 1.17-1.36) had substantial odds of gaining ambulatory care facilities compared with CTs of areas classified as predominantly NH white. Conversely, CTs with a higher proportion of non-US-born residents or individuals 75 years or older were less likely to never have any health care facilities, to have lost facilities, or to have gained facilities. Similar patterns, albeit

Table 3. Change in Health Care Facilities (2000-2014) by Demographic and Socioeconomic Characteristics (2000) Using Multinomial Logistic Regression for 72 246 Continental Nonwater US Census Tracts

2000 Characteristic ^a	aOR (95% CI) ^b					
	Ambulatory care facilities change			Pharmacies and drugstores change		
	None vs always	Lose vs always	Gain vs always	None vs always	Lose vs always	Gain vs always
Race/ethnicity^c						
Predominantly NH black vs NH white	2.00 (1.81-2.22)	2.37 (2.03-2.77)	1.30 (1.18-1.44)	1.72 (1.59-1.87)	1.91 (1.68-2.16)	1.62 (1.45-1.82)
Predominantly Hispanic/Latino vs NH white	1.67 (1.42-1.96)	1.30 (1.00-1.69)	1.26 (1.10-1.45)	1.48 (1.32-1.66)	1.40 (1.16-1.70)	1.44 (1.24-1.67)
Predominantly NH Asian/Pacific Islander vs NH white	Not listed ^d	Not listed ^d	1.60 (0.92-2.76)	1.03 (0.66-1.61)	Not listed ^d	0.64 (0.37-1.12)
Racially/ethnically mixed vs NH white	1.84 (1.69-2.00)	1.53 (1.33-1.77)	1.26 (1.17-1.36)	1.33 (1.26-1.41)	1.27 (1.15-1.40)	1.18 (1.09-1.28)
Non-US born, %	0.67 (0.64-0.70)	0.77 (0.71-0.82)	0.90 (0.87-0.93)	0.95 (0.92-0.97)	0.90 (0.86-0.94)	1.14 (1.10-1.18)
Aged ≥75 y, %	0.45 (0.43-0.47)	0.69 (0.65-0.74)	0.48 (0.47-0.50)	0.63 (0.62-0.64)	0.89 (0.87-0.92)	0.69 (0.67-0.71)
Living below poverty, %	1.02 (0.98-1.07)	1.12 (1.05-1.19)	1.08 (1.04-1.12)	1.11 (1.08-1.14)	1.00 (0.96-1.05)	0.99 (0.95-1.03)
HS diploma or less, %	2.35 (2.25-2.45)	2.06 (1.93-2.21)	1.28 (1.25-1.32)	0.98 (0.96-1.00)	0.99 (0.95-1.02)	0.74 (0.71-0.76)
Home ownership, %	1.25 (1.20-1.30)	1.22 (1.13-1.31)	1.69 (1.63-1.75)	1.52 (1.48-1.56)	1.06 (1.02-1.11)	1.46 (1.41-1.51)
Population per km ²	0.99 (0.96-1.03)	1.00 (0.95-1.06)	0.98 (0.94-1.01)	0.99 (0.97-1.01)	0.94 (0.90-0.97)	0.97 (0.95-1.00)

Abbreviations: aOR, adjusted odds ratio; HS, high school; NH, non-Hispanic.

^a All linear variables are standardized such that estimates are equal to a 1-SD increase from the mean.

^b Models mutually adjusted for all other characteristics in 2000.

^c Racial/ethnic composition was assessed by predominant (>60%) racial/ethnic group. Places with no predominant group were classified as racially/ethnically mixed areas.

^d Results for predominantly NH Asian/Pacific Islander census tracts that lost or had no health care facilities are suppressed because of small sample size (n <10).

slightly less pronounced, emerged for change in the presence of pharmacies and drugstores between 2000 and 2014.

Results for socioeconomic variables were more mixed (Table 3). Consistent with our hypotheses, CTs in 2000 that included areas with a high proportion of individuals living below poverty level (aOR, 1.12; 95% CI, 1.05-1.19) and high proportion of individuals with a HS diploma or less (aOR, 2.06; 95% CI, 1.93-2.21) were more likely to have lost ambulatory care facilities. However, areas with a higher proportion of home ownership in 2000 was similarly associated with losing ambulatory care facilities (aOR, 1.22; 95% CI, 1.13-01.31). Only home ownership in 2000 was associated with an increased odds of losing pharmacies and drugstores between 2000 and 2014 (aOR, 1.06; 95% CI, 1.02-1.11).

Change in Characteristics Between 2000 and 2010 Associated With Change in Health Care Facilities Between 2000 and 2014

In general, CTs of areas with a racial/ethnic composition that remained predominantly NH black, predominantly Hispanic/Latino, and racially/ethnically mixed between 2000 and 2010 were more likely to never have any or to lose health care facilities between 2000 and 2014 than CTs of areas with a composition that remained predominantly NH white (Table 4). Census tracts of areas with a racial/ethnic composition that remained predominantly NH black had 251% (aOR, 2.51; 95% CI, 2.25-2.80) higher odds of having no ambulatory care facilities and 202% (aOR, 2.02; 95% CI, 1.86-2.20) higher odds of having no pharmacies or drugstores in both 2000 and 2014 compared with CTs of areas with a composition that remained NH white. Similarly, CTs of areas with a racial/ethnic composition that remained predominantly NH black had 260% (aOR, 2.60; 95% CI, 2.20-3.07) and 199% (aOR, 1.99; 95% CI, 1.75-2.27) higher odds of losing their ambulatory care facility and pharmacy

Table 4. Change in Health Care Facilities (2000-2014) by Change in Demographic and Socioeconomic Characteristics (2000-2010) Using Multinomial Logistic Regression for 72 246 Continental Nonwater US Census Tracts

Change in characteristic (2000-2010) ^a	aOR (95% CI)					
	Ambulatory care facilities change ^b			Pharmacies and drugstores change ^b		
	None vs always	Lose vs always	Gain vs always	None vs always	Lose vs always	Gain vs always
Race/ethnicity^c						
Remained predominantly NH black	2.51 (2.25-2.80)	2.60 (2.20-3.07)	1.92 (1.73-2.14)	2.02 (1.86-2.20)	1.99 (1.75-2.27)	1.97 (1.75-2.22)
Remained predominantly Hispanic/Latino	1.10 (0.96-1.25)	0.80 (0.64-1.00)	1.76 (1.57-1.97)	1.72 (1.57-1.90)	1.19 (1.01-1.41)	2.66 (2.34-3.03)
Remained predominantly NH Asian/Pacific Islander	Not listed ^d	Not listed ^d	1.44 (0.83-2.51)	0.81 (0.52-1.26)	Not listed ^d	1.12 (0.65-1.92)
Remained racially/ethnically mixed	1.64 (1.50-1.78)	1.27 (1.09-1.46)	1.29 (1.20-1.38)	1.33 (1.26-1.41)	1.19 (1.08-1.31)	1.41 (1.31-1.51)
Changed from predominantly NH white	1.35 (1.20-1.51)	1.30 (1.08-1.58)	1.30 (1.20-1.41)	1.13 (1.06-1.21)	1.15 (1.03-1.29)	1.31 (1.21-1.43)
Changed to predominantly NH white	3.45 (2.70-4.41)	1.54 (0.92-2.57)	1.92 (1.56-2.37)	1.84 (1.51-2.24)	0.96 (0.65-1.43)	1.84 (1.43-2.37)
All other changes	1.71 (1.51-1.95)	1.57 (1.28-1.92)	1.49 (1.32-1.67)	1.55 (1.41-1.71)	1.47 (1.26-1.72)	1.57 (1.38-1.79)
Non-US born, %	0.98 (0.95-1.00)	0.95 (0.90-0.99)	1.07 (1.05-1.10)	0.98 (0.97-1.00)	0.98 (0.95-1.01)	1.09 (1.07-1.12)
Aged ≥75 y, %	1.12 (1.08-1.15)	1.05 (1.00-1.11)	1.11 (1.09-1.14)	1.13 (1.10-1.15)	0.98 (0.95-1.01)	1.12 (1.09-1.15)
Living below poverty, %	0.91 (0.88-0.93)	1.02 (0.98-1.06)	0.88 (0.86-0.90)	0.93 (0.92-0.95)	1.03 (1.00-1.06)	0.94 (0.91-0.96)
HS diploma or less, %	1.09 (1.06-1.12)	1.14 (1.09-1.20)	0.95 (0.93-0.97)	0.97 (0.95-0.99)	1.03 (0.99-1.06)	0.91 (0.88-0.93)
Home ownership, %	0.89 (0.86-0.91)	1.08 (1.02-1.13)	1.02 (0.99-1.04)	1.05 (1.03-1.07)	1.04 (1.01-1.08)	0.98 (0.96-1.00)
Population per km ²	0.94 (0.91-0.97)	0.94 (0.89-0.99)	1.18 (1.15-1.21)	0.98 (0.96-1.00)	0.91 (0.88-0.94)	1.07 (1.04-1.09)

Abbreviations: aOR, adjusted odds ratio; HS, high school; NH, non-Hispanic.

^a All linear variables are standardized such that estimates are equal to a 1-SD increase from the mean.

^b Models mutually adjusted for all change characteristics (2000-2010), as well as baseline (2000) living below poverty, HS diploma or less, and population density.

^c Racial/ethnic composition was assessed by predominant (>60%) racial/ethnic group. Places with no predominant group were classified as racially/ethnically mixed areas. For 2000 to 2010, census tracts that remained predominantly one race/ethnicity were grouped in their own category. Change in racial/ethnic composition was classified in the

following 3 ways: (1) a change from predominantly NH white to predominantly NH black, predominantly Hispanic/Latino, predominantly NH Asian/Pacific Islander, or racially/ethnically mixed; (2) a change to predominantly NH white from predominantly NH black, predominantly Hispanic/Latino, predominantly NH Asian/Pacific Islander, or racially/ethnically mixed; and (3) all other changes. The reference group is remaining predominantly NH white.

^d Results for predominantly NH Asian/Pacific Islander census tracts that lost or had no health care facilities are suppressed because of small sample size (n <10).

or drugstore between 2000 and 2014, respectively compared with CTs of areas with a racial/ethnic composition that remained NH white. Notably, CTs of areas in which the racial/ethnic composition changed to predominantly NH white had 345% (aOR, 3.45; 95% CI, 2.70-4.41) higher odds of never having an ambulatory care facility and 184% (aOR, 1.84; 95% CI, 1.51-2.24) higher odds of never having a pharmacy or drugstore between 2000 and 2014. Places that experienced increases in proportion of non-US-born residents or elderly individuals 75 years or older between 2000 and 2010 were more likely to gain (vs always having) health care facilities between 2000 and 2014.

Overall, decreases in neighborhood-level socioeconomic status were associated with never having or losing health care facilities (Table 4). Census tracts that had increases in the percentage of residents living below poverty level and having a HS diploma or less were less likely to gain health care facilities. However, CTs that had increases in the percentage of individuals living below poverty were also less likely to never have a health care facility. Results for change in home ownership were more mixed: an increase in the percentage of individuals who own homes was associated with higher odds of losing or gaining ambulatory care facilities and never having or losing pharmacies and drugstores (vs consistent presence), but an increase in the percentage of individuals who own homes was also associated with lower odds of never having (vs always having) ambulatory care facilities.

Discussion

In this cross-sectional study of neighborhoods across the continental United States over a 15-year period, we found differential change in the presence of health care facilities across neighborhoods, with more socioeconomically disadvantaged neighborhoods never having or losing facilities. Specifically, we observed that CTs of areas with predominantly minority residents (NH black or Hispanic/Latino) or racially/ethnically mixed residents and CTs of areas with a higher percentage of residents living in poverty had a lower number of health care facilities compared with other neighborhoods. There is increasing evidence that racial/ethnic disparities in access to health care have been reduced for some subgroups after implementation of the Patient Protection and Affordable Care Act.²⁹⁻³¹ However, our findings suggest that differential change in geographic presence of health care facilities by neighborhood demographic composition may further widen disparities in population health. Prior studies³²⁻³⁴ indicate that patterns of health care use among racial/ethnic minorities and low-income communities are associated with factors beyond geography, including physician-patient language concordance and health insurance constraints. We also observed increased likelihood of gaining health care facilities over time across all racial/ethnic composition categories, including those with changing racial/ethnic composition, while simultaneously observing decreased likelihood of gaining health care facilities over time among CTs of areas with increasing poverty and lower educational attainment. Complex characteristics and multilayered intricacies of racial/ethnic minority neighborhoods and ethnic enclaves can play beneficial and disadvantageous roles in geographic health care access and health outcomes.³⁵⁻³⁷ Furthermore, emerging data specifically on Asian American residential density suggest bimodal distributions in socioeconomic characteristics and other patterns that are unique from other racial/ethnic communities.³⁸ More nuanced understanding of neighborhood racial/ethnic composition and more complex measurement are warranted, but more complex measurement was beyond the scope of this study. Therefore, increased research is needed on how the geographic presence of health care facilities and use of services are operationalized differently across population subgroups.

In addition, we observed that higher neighborhood socioeconomic status was associated with an increased number of health care facilities across neighborhoods. Medically underserved areas and populations are identified as geographic areas and populations with a lack of geographic access to primary care services.³⁹ These areas are eligible for federal grants and health programs, such as Federally Qualified Health Centers, and are based on ratios of area-level population to health care providers, poverty level, percentage of population older than 65 years, and infant mortality rate.³⁹ However, even after controlling for several of these factors, our findings suggest that areas with

predominantly minority residents continue to disproportionately lack health care facilities. These trends over time may indicate a need for more targeted efforts to address disparities in access to ambulatory care services. Although prior studies⁴⁰⁻⁴⁵ have focused on geographic barriers to hospitals and tertiary care, few studies^{3,46,47} have examined trends in access to ambulatory care within neighborhoods across the nation; therefore, a critical understanding of these patterns is warranted.

Strengths and Limitations

To our knowledge, this cross-sectional study is one of the first studies to examine longitudinal change in the presence of health care facilities across neighborhoods in the United States over a 15-year period. We focused on the presence of nonhospital facilities, thus giving a context for health care services that would provide primary care and care across the life span, and used detailed data on businesses for more accurate geographic location data and dates of operation of each facility.

However, some limitations should be noted. First, we focused on the presence of health care facilities within CTs and did not examine use of services among populations within CTs; therefore, we were unable to directly link availability with use. Second, the context of health care markets and concentrations of health care providers vary across the United States, and state and regional policies, market entry forces, and patterns of health care consolidation may have shaped the patterns observed⁴⁸ but were beyond the scope of this study. Third, we used a broad classification of racial/ethnic composition at CTs, which limited our ability to examine more nuanced associations within and across population groups of high and low density. Fourth, we focused on 2 broad categories of health care facilities, including ambulatory care facilities (which encompass a wide variety of outpatient care services) and pharmacies and drugstores, to limit the consequences of misclassification; however, errors may have remained. Our study specifically spanned a period when urgent care clinics and retail pharmacies and drugstores were increasing, potentially accounting for the longitudinal change in specific areas.^{49,50} Limitations of the NETS data have also been noted in our group's prior work.⁵¹

Conclusions

Given the importance of geographic access to care on health outcomes, it is critical to monitor the spatial distribution of health care resources within the context of population health disparities. The Patient Protection and Affordable Care Act expanded overall health care access to primary care through insurance coverage, including Medicaid expansion in several states. However, even insured populations may face geographic barriers to accessing ambulatory care. Therefore, it remains important to understand neighborhood context and geographic access to health care resources when designing population health programs and policies.

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SUPPLEMENT.

eTable 1. Categorization of National Establishment Time Series (NETS) Data to Identify Health Care Facilities

eTable 2. Description of Demographic and Socioeconomic Characteristics (2010) Across Categories of Change in Health Care Facilities (2000-2014) for Continental Nonwater US Census Tracts (n = 72246)

eFigure 1. Proportion of Census Tracts in Each State Falling Within Each Ambulatory Care Category

eFigure 2. Proportion of Census Tracts in Each State Falling Within Each Pharmacy Category

eFigure 3. Proportion of Census Tracts Falling Within Each Ambulatory Care Category by Racial Composition

eFigure 4. Proportion of Census Tracts Falling Within Each Pharmacy Category by Racial Composition

Eligibility for ACA Health Coverage Following Job Loss

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Data Note

The economic consequences of the coronavirus pandemic have led to historic level of job loss in the United States. Social distancing policies required to address the crisis have led many businesses to cut hours, cease operations, or close altogether. Between March 1st and May 2nd, 2020 (<https://www.dol.gov/ui/data.pdf>), more than 31 million people had filed for unemployment insurance. Actual loss of jobs and income are likely even higher, as some people may be only marginally employed or may not have filed for benefits. Some of these unemployed workers may go back to work as social distancing curbs are relaxed, though further job loss is also possible if the economic downturn continues or deepens.

In addition to loss of income, job loss carries the risk of loss of health insurance for people who were receiving health coverage as a benefit through their employer. People who lose employer-sponsored insurance (ESI) often can elect to continue it for a period by paying the full premium (called COBRA continuation) or may become eligible (<https://www.kff.org/health-reform/issue-brief/changes-in-income-and-health-coverage-eligibility-after-job-loss-due-to-covid-19/>) for Medicaid or subsidized coverage through the Affordable Care Act (ACA) marketplaces. Over time, as unemployment benefits end, some may fall into the “coverage gap” that exists in states that have not expanded Medicaid under the ACA.

In this analysis, we examine the potential loss of ESI among people in families where someone lost employment between March 1st, 2020 and May 2nd, 2020 and estimate their eligibility for ACA coverage, including Medicaid and marketplace subsidies, as well as private coverage as a dependent (see detailed Methods at the end of this brief). To illustrate eligibility as their state and federal unemployment insurance (UI) benefits cease, we show eligibility for this population as of May 2020 and January 2021, when most will have exhausted their UI benefits.

What are coverage options for people losing ESI?

Eligibility for health coverage for people who lose ESI depends on many factors, including income while working and family income while unemployed, state of residence, and family K status. Some people may be ineligible for coverage options, and others may be eligible but

opt not to enroll. Some employers may temporarily continue coverage after job loss (for example, through the end of the month), but such extensions of coverage are typically limited to short periods.

Medicaid: Some people who lose their jobs (<https://www.kff.org/health-reform/issue-brief/changes-in-income-and-health-coverage-eligibility-after-job-loss-due-to-covid-19/>) and health coverage— especially those who live in states that expanded Medicaid (<https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>) under the ACA— may become newly eligible¹ for Medicaid if their income falls below state eligibility limits (138% of poverty in states that expanded under the ACA). For Medicaid eligibility, income is calculated based on other income in the family plus any state unemployment benefit received (though the \$600 per week federal supplemental payment available through the end of July is excluded). Income is determined on a current basis, so prior wages for workers recently unemployed are not relevant. In states that have not expanded Medicaid under the ACA, eligibility is generally limited to parents with very low incomes (typically below 50% of poverty and in some states quite a bit less); thus many adults may fall into the “coverage gap (<https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>)” that exists for those with incomes above Medicaid limits but below poverty (which is the minimum eligibility threshold for marketplace subsidies under the ACA). Undocumented immigrants are ineligible for Medicaid, and recent immigrants (those here for fewer than five years) are ineligible in most cases.

Marketplace: ACA marketplace coverage is available to legal residents who are not eligible for Medicaid and do not have an affordable offer of ESI; subsidies for marketplace coverage are available to people with family income between 100% and 400% of poverty. Some people who lose ESI may be newly-eligible for income-based subsidies, based on other family income plus any state and new federal unemployment benefit received (including the \$600 per week federal supplement, unlike for Medicaid).² While current income is used for Medicaid eligibility, annual income for the calendar year is used for marketplace subsidy eligibility. Advance subsidies are available based on estimated annual income, but the subsidies are reconciled based on actual income on the tax return filed the following year. People who lose ESI due to job loss qualify for a special enrollment period (SEP) for marketplace coverage.³ As with Medicaid, undocumented immigrants are ineligible for marketplace coverage or subsidies. However, recent immigrants, including those whose income makes them otherwise eligible for Medicaid, can receive marketplace subsidies.

ESI Dependent Coverage: People who lose jobs may be eligible for ESI as a dependent under a spouse or parent’s job-based coverage. Some people may have been covered as a dependent prior to job loss, and some may switch from their own coverage to coverage as a dependent.

COBRA: Many people who lose their job-based insurance can continue that coverage through COBRA, although it is typically quite expensive since unemployed workers generally K have to pay the entire premium – employer premiums average \$7,188 for a single person and \$20,576 for a family of four (<https://www.kff.org/report-section/ehbs-2019-summary-of-findings/>) – K

plus an additional 2%. People who are eligible for subsidized coverage through Medicaid or the marketplaces are likely to opt for that coverage over COBRA, though COBRA may be the only option available to some people who are income-ineligible for ACA coverage.

Short-term plans: Short-term plans, which can be offered for up to a year and can sometimes be renewed under revised rules from the Trump administration, are also a potential option for people losing their employer-sponsored insurance. These plans generally carry lower premiums (<https://www.kff.org/health-reform/issue-brief/why-do-short-term-health-insurance-plans-have-lower-premiums-than-plans-that-comply-with-the-aca/>) than COBRA or ACA-compliant coverage, as they often provide more limited benefits and usually deny coverage to people with pre-existing conditions. Even when coverage is issued, insurers generally may challenge benefit claims that they believe resulted from pre-existing medical problems; given the long latency between initial infection and sickness with COVID-19, these plans are riskier than usual during the current pandemic. People cannot use ACA subsidies toward short-term plan premiums.

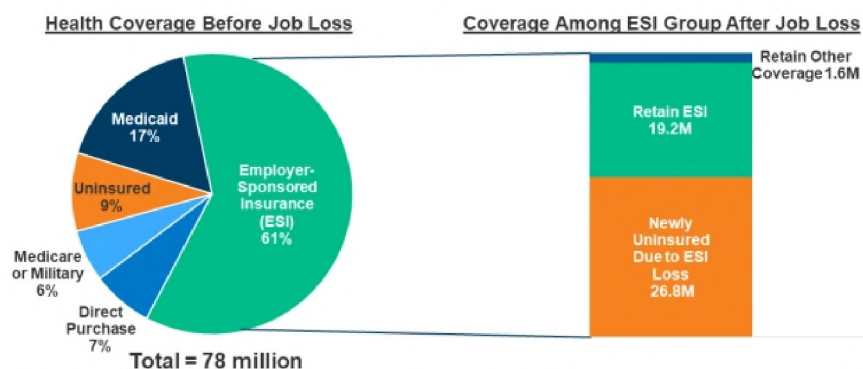
Our analysis examines eligibility for Medicaid, marketplace subsidies, and dependent ESI coverage. We do not estimate enrollment in COBRA, short-term plans, or temporary continuation of ESI. See Methods for more details.

How does coverage and eligibility change following job loss?

Between March 1st, 2020 and May 2nd, 2020, we estimate that nearly 78 million people lived in a family in which someone lost a job. Most people in these families (61%, or 47.5 million) were covered by ESI prior to job loss. Nearly one in five (17%) had Medicaid, and close to one in ten (9%) were uninsured. The remaining share either had direct purchase (marketplace) coverage (7%) or had other coverage such as Medicare or military coverage (6%) (Figure 1). K

Figure 1

Health Insurance Coverage Before and After Job Loss Among People in a Family Experiencing Job Loss as of May 2, 2020



Notes: "Retain Other Coverage" refers to individuals holding multiple sources of coverage prior to family job loss.

"Retain ESI" refers to individuals in families with multiple workers accessing ESI through separate employment-based policies.

Source: KFF. Job Losses occurred March 1st through May 2nd, 2020. See Methods for more details.



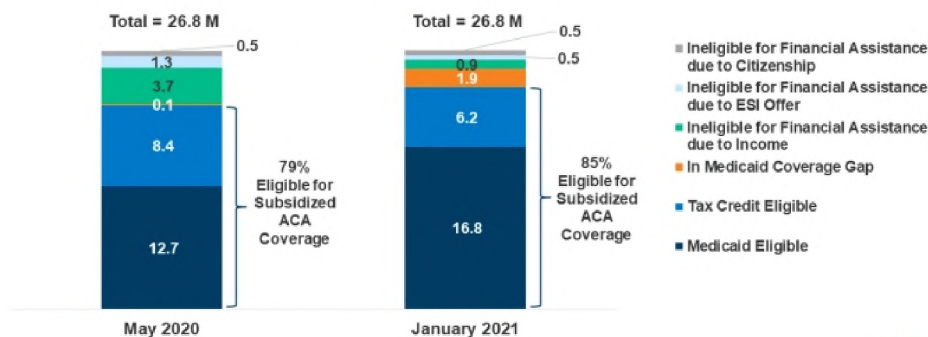
We estimate that, as of May 2nd, 2020, nearly 27 million people could potentially lose ESI and become uninsured following job loss (Figure 1). This total includes people who lost their own ESI and those who lost dependent coverage when a family member lost a job and ESI. Additionally, some people who otherwise would lose ESI are able to retain job-based coverage by switching to a plan offered to a family member: we estimate that 19 million people switch to coverage offered by the employer of a working spouse or parent. A very small number of people who lose ESI (1.6 million) also had another source of coverage at the same time (such as Medicare) and retain that other coverage. These coverage loss estimates are based on our assumptions about who likely filed for UI as of May 2nd, 2020 and the availability of other ESI options in their family (see Methods for more detail).

Among people who become uninsured after job loss, we estimate that nearly half (12.7 million) are eligible for Medicaid, and an additional 8.4 million are eligible for marketplace subsidies, as of May 2020 (Figure 2). In total, 79% of those losing ESI and becoming uninsured are eligible for publicly-subsidized coverage in May. Approximately 5.7 million people who lose ESI due to job loss are not eligible for subsidized coverage, including almost 150,000 people who fall into the coverage gap, 3.7 million people ineligible due to family income being above eligibility limits, 1.3 million people who we estimate have an affordable offer of ESI through another working family member, and about 530,000 people who do not meet citizenship or immigration requirements. We project that very few people fall into the coverage gap immediately after job loss (as of May 2020) because wages before job loss plus unemployment benefits (including the temporary \$600 per week KFF federal supplement added by Congress) push annual income for many unemployed workers in non-expansion states above the poverty level, making them ineligible for ACA KFF marketplace subsidies for the rest of the calendar year.

Figure 2

Eligibility for ACA Coverage Among People Becoming Uninsured Due to Loss of Employer-Sponsored Insurance

Number of People Eligible for Coverage, in Millions:



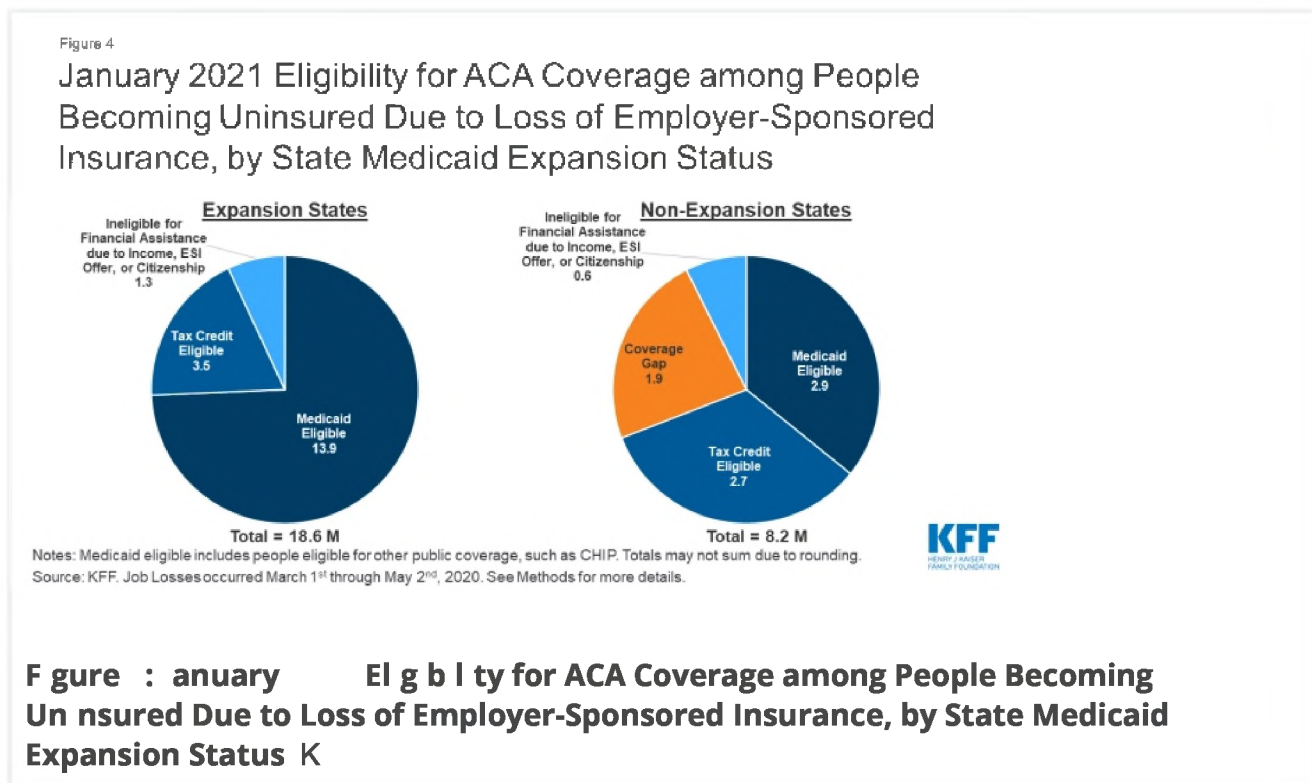
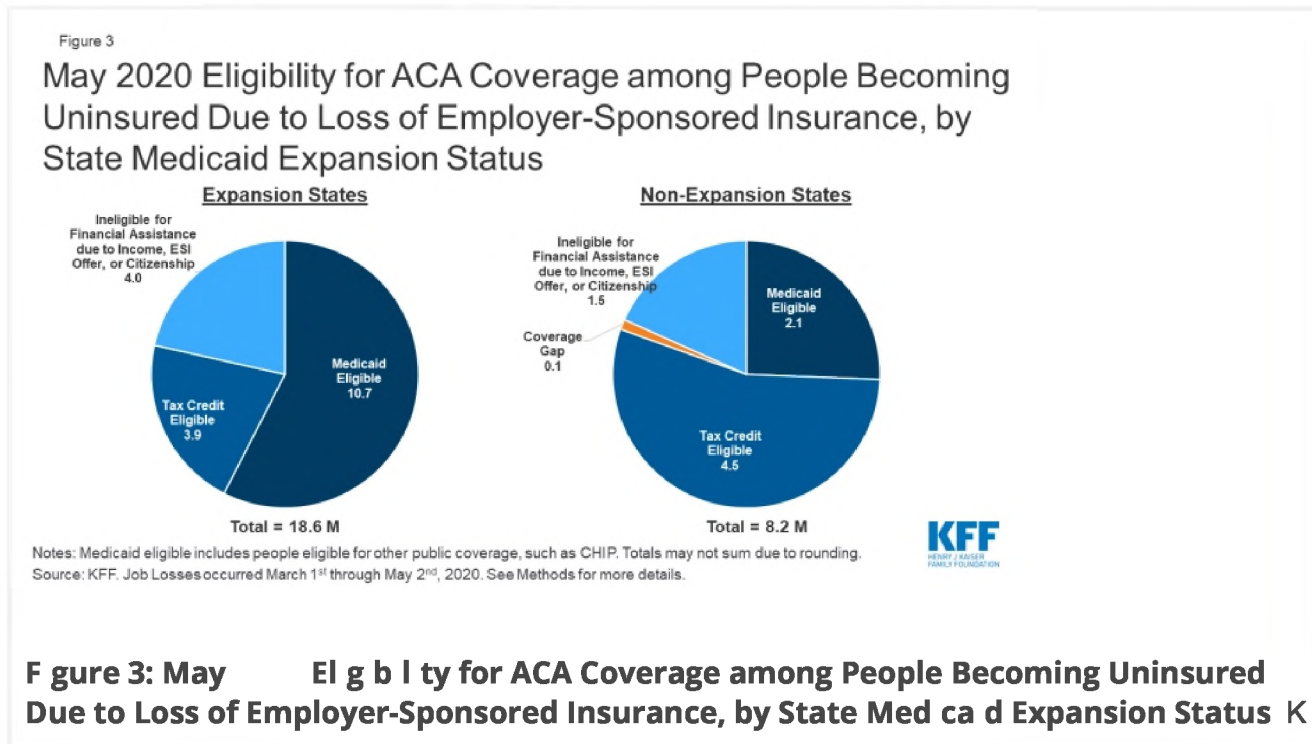
Notes: Medicaid eligible includes people eligible for other public coverage, such as CHIP. Totals may not sum due to rounding.
Source: KFF. Job Losses occurred March 1st through May 2nd, 2020. See Methods for more details.



By January 2021 when UI benefits cease for most people we estimate that eligibility shifts to nearly 17 million being eligible for Medicaid and about 6 million being eligible for marketplace subsidies (Figure 2), assuming those who are recently unemployed have not found work. Many unemployed workers who are eligible for ACA marketplace subsidies during 2020 would instead be eligible for Medicaid or fall into the coverage gap during 2021. The number in the coverage gap grows to 1.9 million ([an increase of more than 80% of its previous size \(https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/\)](https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/)), and the number ineligible for coverage due to income shrinks to 0.9 million.

Estimates of coverage loss and eligibility vary by state, depending largely on underlying state employment by industry and Medicaid expansion status. Not surprisingly, states in which the largest number of people are estimated to lose ESI are large K states with many people working in affected industries ([Appendix Table 1 \(https://www.kff.org/report-section/eligibility-for-aca-health-coverage-following-job-loss-appendix/\)](https://www.kff.org/report-section/eligibility-for-aca-health-coverage-following-job-loss-appendix/)). Eight states (California, Texas, Pennsylvania, New York, Georgia, Florida, Michigan, and Ohio) account for just under half (49%) of all people who lose ESI. Five of the top eight states have expanded Medicaid, and people eligible for Medicaid among the potentially newly uninsured as of May 2020 in these five states account for 40% of all people in that group nationally. Overall, patterns by state Medicaid expansion status show that people in expansion states are much more likely to be eligible for Medicaid, while those in non-expansion states are more likely to qualify for marketplace subsidies (Figure 3). However, K the *number* of people qualifying for marketplace subsidies is similar across the two sets of states, as more people live in expansion states. Three states that have not expanded Medicaid, including Texas, Georgia, and Florida, account for 30% of people who become marketplace tax credit eligible nationally in May 2020. Assuming unemployment extends into 2021 when UI benefits would likely expire for most families, the proportion eligible for K

Medicaid would increase in expansion states while non-expansion states may see more nonelderly adults moving into the Medicaid coverage gap (Figure 4; Appendix Table 2 K (<https://www.kff.org/report-section/eligibility-for-aca-health-coverage-following-job-loss-appendix>)). K



Nearly 11 million people losing ESI and becoming uninsured are children, and the vast majority of them are eligible for coverage through Medicaid or CHIP. Within the 26.8 million people losing ESI and becoming uninsured in May 2020, 6.1 million are children. K

enrollment assistance, which have been reduced dramatically (<https://www.kff.org/private-insurance/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/>) by the Trump Administration, could help people maintain coverage as they lose jobs.

This is the first economic downturn during which the ACA will be in place as a safety net for people losing their jobs and health insurance. The Trump Administration is arguing (<https://www.kff.org/health-reform/issue-brief/explaining-texas-v-u-s-a-guide-to-the-case-challenging-the-aca/>) in case before the Supreme Court that the ACA should be overturned; a decision is expected by next Spring. The ACA has gaps, and for many the coverage may be unaffordable. However, without it, many more people would likely end up uninsured as the U.S. heads into a recession.

Appendix K

Appendix Table 1:

May 2020 Eligibility for Coverage A Job Loss

State	Total Due to ESI Loss	Uninsured Medicaid Eligible	Coverage Gap	Tax Credit Eligible	Ineligible for Financial Assistance due to Income, ESI Offer, or Citizenship
US Total	26,789,000	12,735,000	149,000	8,350,000	5,555,000
Alabama	425,000	107,000	14,000	246,000	57,000
Alaska	58,000	41,000	-	9,000	7,000
Arizona	452,000	314,000	-	73,000	66,000
Arkansas	169,000	95,000	-	47,000	28,000
California	3,427,000	2,068,000	-	701,000	659,000
Colorado	299,000	149,000	-	73,000	77,000
Connecticut	247,000	135,000	-	47,000	65,000
Delaware	76,000	46,000	-	15,000	14,000
DC	55,000	47,000	-	1,000	7,000
Florida	1,418,000	301,000	34,000	835,000	248,000
Georgia	1,444,000	376,000	24,000	775,000	268,000
Hawaii	200,000	104,000	-	63,000	33,000
Idaho	113,000	66,000	-	29,000	18,000
Illinois	846,000	469,000	-	199,000	178,000
Indiana	606,000	386,000	-	126,000	94,000
Iowa	251,000	127,000	-	76,000	49,000
Kansas	230,000	60,000	3,000	121,000	46,000
Kentucky	598,000	330,000	-	166,000	102,000
Louisiana	450,000	335,000	-	63,000	52,000
Maine	99,000	50,000	-	30,000	19,000
Maryland	369,000	220,000	-	72,000	78,000
Massachusetts	621,000	277,000	-	89,000	255,000
Michigan	1,211,000	774,000	-	219,000	218,000
Minnesota	535,000	264,000	-	79,000	192,000
Mississippi	218,000	54,000	6,000	138,000	28,000
Missouri	480,000	125,000	10,000	269,000	76,000
Montana	71,000	41,000	-	18,000	13,000
Nebraska	101,000	56,000	-	28,000	16,000
Nevada	434,000	254,000	-	85,000	95,000

New Hampshire	144,000	84,000	-	31,000	29,000
New Jersey	883,000	456,000	-	152,000	274,000
New Mexico	100,000	59,000	-	23,000	17,000
New York	1,471,000	880,000	-	291,000	300,000
North Carolina	723,000	167,000	13,000	408,000	134,000
North Dakota	53,000	23,000	-	16,000	14,000
Ohio	1,002,000	531,000	-	267,000	204,000
Oklahoma	310,000	75,000	5,000	177,000	53,000
Oregon	276,000	143,000	-	76,000	58,000
Pennsylvania	1,543,000	836,000	-	341,000	366,000
Rhode Island	134,000	75,000	-	21,000	38,000
South Carolina	403,000	111,000	5,000	225,000	62,000
South Dakota	32,000	8,000	-	17,000	7,000
Tennessee	417,000	136,000	4,000	210,000	67,000
Texas	1,608,000	328,000	30,000	881,000	370,000
Utah	162,000	92,000	-	45,000	24,000
Vermont	48,000	26,000	-	12,000	10,000
Virginia	533,000	306,000	-	125,000	102,000
Washington	835,000	426,000	-	150,000	259,000
West Virginia	130,000	82,000	-	29,000	18,000
Wisconsin	446,000	214,000	-	150,000	82,000
Wyoming	31,000	8,000	1,000	16,000	7,000

NOTES: Medicaid eligible includes people eligible for other public coverage. Totals may not sum due to rounding.

SOURCE: KFF. See [Methods \(https://www.kff.org/report-section/eligibility-for-aca-health-coverage-following-job-loss-methods\)](https://www.kff.org/report-section/eligibility-for-aca-health-coverage-following-job-loss-methods) for more details.

Appendix Table 2: January 2021 Eligibility for Coverage A

Job Loss

State K	Total rUn Due to ESI Loss	insu ed Me dicid eligi eCoverage Gap K	Tax Credit K Eligible	Ineligible for Financial Assistance due to Income, ESI Offer, or Citizenship
US Total	26,789,000	16,791,000 K	1,924,000	1,890,000 K
Alabama	425,000	154,000	115,000 K	210,000
Alaska	58,000	45,000	-	3,000
Arizona	452,000	332,000	-	30,000
Arkansas	169,000	118,000	-	10,000
California	3,427,000	2,541,000	-	289,000
Colorado	299,000	217,000 K	-	26,000
Connecticut	247,000	175,000	-	25,000
Delaware	76,000	54,000	-	5,000
DC	55,000	50,000	-	3,000
Florida	1,418,000	418,000	351,000	120,000
Georgia	1,444,000	545,000	398,000	94,000
Hawaii	200,000	145,000	-	16,000
Idaho	113,000	84,000	-	6,000
Illinois	846,000	619,000	-	66,000
Indiana	606,000	455,000	-	31,000
Iowa	251,000	182,000	-	12,000
Kansas	230,000	88,000	52,000	16,000
Kentucky	598,000	454,000	-	26,000
Louisiana	450,000	353,000	-	20,000
Maine	99,000	68,000	-	4,000
Maryland	369,000	268,000	-	33,000
Massachusetts	621,000	456,000	-	63,000
Michigan	1,211,000	933,000	-	61,000
Minnesota	535,000	394,000	- K	34,000
Mississippi	218,000	77,000	58,000	8,000
Missouri	480,000	166,000	119,000	27,000
Montana	71,000	55,000	-	3,000
Nebraska	101,000	72,000	-	6,000
Nevada	434,000 K	331,000 K	-	39,000

New Hampshire K	144,000	109,000	-	27,000	8,000
New Jersey K	883,000	647,000	-	153,000	82,000
New Mexico	100,000	74,000	-	20,000	5,000
New York	1,471,000	1,112,000	- K	258,000	101,000
North Carolina K	723,000 K	233,000 K	178,000 K	261,000 K	52,000
North Dakota K	53,000	37,000	-	13,000	3,000
Ohio K	1,002,000	738,000	- K	211,000	53,000
Oklahoma K	310,000 K	114,000 K	74,000 K	103,000 K	19,000
Oregon K	276,000	203,000	-	53,000	20,000
Pennsylvania K	1,543,000	1,161,000	-	295,000	87,000
Rhode Island	134,000	98,000	- K	26,000	10,000
South Carolina K	403,000 K	139,000 K	99,000 K	141,000 K	24,000
South Dakota K	32,000	11,000	7,000	12,000	2,000
Tennessee	417,000	149,000	86,000 K	157,000	25,000
Texas K	1,608,000	540,000	382,000 K	530,000	157,000
Utah	162,000 K	123,000 K	- K	29,000 K	10,000
Vermont K	48,000	34,000	-	12,000	2,000
Virginia K	533,000	382,000	-	110,000	42,000
Washington K	835,000 K	637,000 K	- K	140,000 K	58,000
West Virginia K	130,000	98,000	-	27,000	5,000
Wisconsin K	446,000	296,000	- K	124,000	26,000
Wyoming	31,000	13,000	6,000	10,000	2,000

NOTES: Medicaid eligible includes people eligible for other public coverage. Totals may not sum due to rounding.

SOURCE: KFF. See [Methods \(https://www.kff.org/report-section/eligibility-for-aca-health-coverage-following-job-loss-methods\)](https://www.kff.org/report-section/eligibility-for-aca-health-coverage-following-job-loss-methods) for more details.

Methods K

Methods and Definitions

This analysis uses our [ACA eligibility model](https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicare/) as applied to the 2018 American Community Survey as a baseline for all calculations. We rely on these calculations to assess the ACA eligibility of a cohort of workers prior to the pandemic (early 2020), during the pandemic (mid-2020), and in the following calendar year (early 2021). Assessing both insurance coverage changes and ACA eligibility at three time points might help policymakers understand both the immediate coverage needs of the population losing jobs due to the pandemic and the longer-term eligibility of the same population assuming they continue without wages into 2021.

In order to estimate the 2020 population within each state, we linearly extrapolated 2020 state population estimates based on [2018 and 2019 population estimates](https://www2.census.gov/programs-surveys/popest/tables/2010-2019/state/totals/nst-est2019-01.xlsx) from the U.S. Census Bureau to determine a population increase factor between 2018 and 2020 within each state. We then applied this multiplier to the weight of each individual in the microdata to approximate state population sizes in mid-2020 rather than mid-2018. With the exception of this population multiplier, our baseline estimates (described in this brief as “May 2020”) align with other Kaiser Family Foundation products such as our [ACA eligibility estimates of the uninsured population](https://www.kff.org/health-reform/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D).

We summed initial unemployment insurance claims filed across the weeks ending March 7th, 2020 thru May 2nd, 2020 using the Department of Labor’s Employment & Training Administration [state-specific statistics](https://oui.doleta.gov/unemploy/claims_arch.asp) to arrive at a nationwide total job loss through early May of approximately 31 million workers. We also assumed [unauthorized immigrants in the labor force](https://www.pewresearch.org/hispanic/interactives/u-s-unauthorized-immigrants-by-state/) lost employment proportionally without filing for unemployment. We did not make assumptions about other people losing jobs but not filing for unemployment insurance.

Within each state, we estimated who lost employment using sampling probabilities based on [recent labor force changes](https://www.bls.gov/web/empsit/cpseea37.htm) by industry recorded by the March 2020 Current Population Survey. For example, leisure and hospitality workers appear more than five times as likely as agricultural workers to have lost a job in March 2020, and these relative probabilities guided sampling of who has become unemployed. We controlled to state unemployment totals (approximately 31 million nationally) for the citizen and legally-present immigrant population, and we separately controlled to state proportional unauthorized labor force unemployment. We estimate for the undocumented working population.

The American Community Survey does not distinguish between ESI policyholders and those covered as dependents. For all full-time workers losing jobs in our sample, we assumed a family-wide loss of ESI for all people who held ESI if there were no other workers present who both worked at least 30 hour weeks and earned at least \$50,000 during the year. If a spouse with wage of at least \$50,000 and weekly average hours over 30 were present within the family, we assumed the spouse held the policy (or another policy) and maintained ESI for the entire family. For part-time workers losing jobs, we assumed a family-wide loss of ESI only when no other workers were present within the family.

We calculated an industry-specific distribution of weekly state unemployment benefit payments from the 2019 Current Population Survey. We then applied a weekly state dollar amount onto most individuals who lost employment according to a random deviate sample using a gamma distribution. After adding unemployment benefit payments onto family income of those imputed to lose jobs, we then scaled each individual weekly payment to account for state-specific generosity using the Department of Labor's 2018Q4 "[Benefits Paid for Total Unemployment divided by Weeks Compensated for Total Unemployment](https://oui.doleta.gov/unemploy/data_summary/DataSum.asp)" (https://oui.doleta.gov/unemploy/data_summary/DataSum.asp)" state-specific estimate divided by the nationwide average of \$361.29. This nationwide weekly average amount matched our CPS-based calculated average. For any individuals imputed to receive a higher weekly state unemployment payment than the state maximum, we capped the imputed amount at the state maximum.

Medicaid eligibility is based on current monthly income. To calculate Medicaid eligibility immediately after job loss, we zeroed out wage and self-employment income for people who lost jobs and calculated monthly family income as a share of poverty based on other family income and the state weekly unemployment benefit. Following Medicaid eligibility policy, we did not include the Federal weekly supplemental unemployment payments of \$600 in the Medicaid eligibility determination.

ACA marketplace subsidy eligibility is based on estimated annual income. To calculate ACA Marketplace subsidy eligibility immediately after job loss, we removed a share of annualized wages and self-employment income in proportion to the calendar week of job loss. For example, calendar year earned income for individuals imputed to lose jobs during the week of March 7th, 2020 were reduced by 75%. We also counted the receipt of Federal supplemental unemployment insurance payments of \$600 for 17 weeks and multiplied the same imputed weekly state unemployment benefit by the [maximum allowable weeks](https://www.cbpp.org/research/economy/policy-basics-how-many-weeks-of-unemployment-compensation-are-available) (<https://www.cbpp.org/research/economy/policy-basics-how-many-weeks-of-unemployment-compensation-are-available>).

To re-calculate both Medicaid and ACA Marketplace subsidy eligibility for 2021, we assumed an exhaustion of both the state and Federal unemployment benefit amounts, K no return to work among job losers, and counted only other income in the family. K

Although our job loss imputation only edited the earned income and public assistance income of the individual worker, that worker's income changes affect the Medicaid and marketplace tax credit eligibility of family members. Therefore, many statistics throughout this brief present the eligibility dynamics of Americans with any job loss in their family rather than solely the worker.

Medicaid/Other Public Eligible: Includes adults and children who were previously eligible for Medicaid and the Children's Health Insurance Program (CHIP) but not enrolled as well as those newly eligible after job loss. Also includes some state-funded programs for immigrants otherwise ineligible for Medicaid.

Tax Credit Eligible: Includes individuals who are not eligible for other coverage, such as Medicaid or Employer-Sponsored Insurance (ESI), and who have incomes between 100% and 400% of the federal poverty level (FPL). This number also includes legally residing immigrants with incomes below the poverty level who do not qualify for Medicaid because they have lived in the U.S. for less than five years. Tax credit-eligible population in Minnesota and New York include uninsured adults who are eligible for coverage through the Basic Health Plan.

Ineligible for Financial Assistance due to Income, ESI Offer, or Citizenship: Includes individuals with incomes above 400% FPL and those with an offer of coverage from an employer (though we cannot determine whether the offer of ESI would be considered affordable under the ACA, which would make the individual ineligible for a premium tax credit). This number also includes undocumented immigrants who are barred from purchasing coverage through the Marketplace even without financial assistance.

In the Coverage Gap: Includes uninsured adults in states that have not expanded Medicaid and have incomes above the state's Medicaid eligibility level (which, in many cases, is 0% FPL for adults without dependent children) but below the poverty, leading them to earn too much to qualify for Medicaid but not enough to qualify for tax credits. Adults in the coverage gap would be eligible for Medicaid if their state expanded under the ACA.

Endnotes K

Data Note

1. Medicaid already covers many workers, and Medicaid beneficiaries who lose their jobs and income will retain their Medicaid coverage, as there is no lower floor on income eligibility for Medicaid.

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2. Notably, eligibility for marketplace subsidies (but not Medicaid) includes the new federal supplemental unemployment insurance benefits recently enacted by Congress for people affected by COVID-19. This supplemental benefit could lead some unemployed

low-wage workers who previously were in the “coverage gap” (income below poverty but above state Medicaid limits) to have income above poverty, making them newly eligible for Marketplace subsidies. [K](#)

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3. People who were uninsured while working may be able to enroll in marketplace coverage if they live in a state with a state-run marketplace, most of which have re-opened enrollment to allow residents to obtain marketplace coverage if eligible. However, people who were uninsured while working and live in one of the [32 states](#) (<https://www.kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>) that use the federal marketplace do not qualify for a “special enrollment period” to enroll in coverage through the federal marketplace.

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Individual Insurance Market Performance in 2019

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Issue Brief

The early years of the Affordable Care Act (ACA) exchanges and broader ACA-compliant individual market were marked by volatility. Markets in some parts of the country have remained fragile, with little competition, an insufficient number of healthy enrollees to balance those who are sick, and high premiums as a result. [By 2017](https://www.kff.org/health-reform/issue-brief/individual-insurance-market-performance-in-2017/) (<https://www.kff.org/health-reform/issue-brief/individual-insurance-market-performance-in-2017/>), however, the individual market generally had begun to stabilize, and [by 2018](https://www.kff.org/private-insurance/issue-brief/individual-insurance-market-performance-in-2018/) (<https://www.kff.org/private-insurance/issue-brief/individual-insurance-market-performance-in-2018/>) insurers in the ACA-compliant market were highly profitable, despite the elimination of cost-sharing subsidy payments and expansion of short-term plans. However, 2019 was the first year that the repeal of the [individual mandate](https://www.kff.org/health-reform/issue-brief/how-many-of-the-uninsured-can-purchase-a-marketplace-plan-for-less-than-their-shared-responsibility-penalty/?utm_campaign=KFF-2017-November-Ind-Mandate-Penalty-Analysis&utm_source=hs_email&utm_medium=email&hsenc=p2ANqtz--GPbhQryF71Zmxxh7bbkIEYsQdn25E_NZijeBfNvZRSOcaCjCCcnFLGR1AGtoKIP5Y0LT) (https://www.kff.org/health-reform/issue-brief/how-many-of-the-uninsured-can-purchase-a-marketplace-plan-for-less-than-their-shared-responsibility-penalty/?utm_campaign=KFF-2017-November-Ind-Mandate-Penalty-Analysis&utm_source=hs_email&utm_medium=email&hsenc=p2ANqtz--GPbhQryF71Zmxxh7bbkIEYsQdn25E_NZijeBfNvZRSOcaCjCCcnFLGR1AGtoKIP5Y0LT) penalty went into effect, raising concerns that healthy enrollees would forgo coverage, leaving sicker and more expensive enrollees behind and requiring insurers to increase premiums. Nonetheless, Marketplace premiums [fell slightly](https://www.kff.org/health-reform/state-indicator/percent-change-in-average-marketplace-premiums-by-metal-tier-2017-2019/?p_currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) (https://www.kff.org/health-reform/state-indicator/percent-change-in-average-marketplace-premiums-by-metal-tier-2017-2019/?p_currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) on average going into 2019, as it became clear that some insurers had raised 2018 rates more than was necessary (and [premiums dropped again](https://www.kff.org/health-costs/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2020/) (<https://www.kff.org/health-costs/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2020/>) heading into 2020).

In this brief, we analyze data from 2011 through 2019 to examine how the individual insurance market performed under the ACA and, most recently, without the individual mandate in place. We use financial data reported by insurance companies to the National Association of Insurance Commissioners and compiled by Mark Farrah Associates to look at the average premiums, claims, medical loss ratios, gross margins, and enrollee utilization in the individual insurance market, as well as the amount of medical loss ratio rebates insurers expect to issue to 2019 enrollees. These figures include coverage purchased p

through the ACA's exchange marketplaces and ACA-compliant plans purchased directly from insurers outside the marketplaces (which are part of the individual market), as well as individual plans originally purchased before the ACA went into effect.

We find that, on average, individual market insurers remained profitable through 2019. Further, despite the absence of the mandate penalty, data indicate that the individual market has not become significantly less healthy. These new data from 2019 offer further evidence that the individual market is stable even without the mandate penalty, though several factors – notably the coronavirus pandemic, ongoing legislative developments, and the Supreme Court's decision in *Sebelius v. Hobby Lobby* – could impact the market in the future.

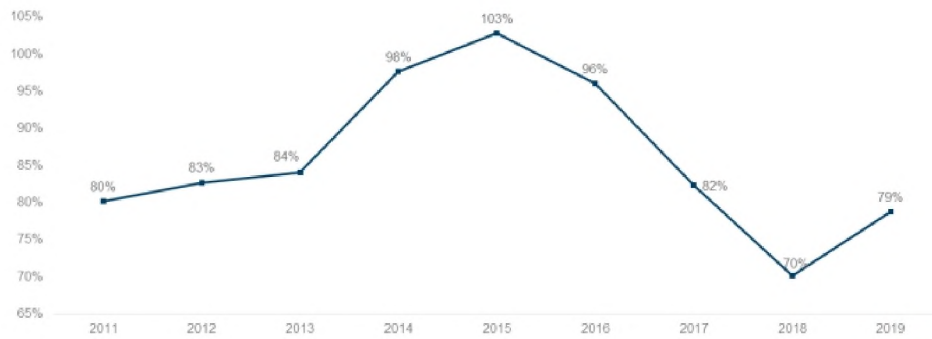
Medical Loss Ratios

As we found in our previous analysis (<http://www.kff.org/health-policy/brief/insurer-financial-performance-in-the-early-years-of-the-affordable-care-act/>), insurer financial performance measures such as medical loss ratios (the share of health care costs paid to providers) improved in the earliest years of the ACA Marketplaces, but began to improve in recent years. This is to be expected, as the market had just undergone significant regulatory changes in 2014 and insurers had very little information about their premium costs.

The chart below shows medical loss ratios, which differ from the ACA's medical loss ratio provision.¹ Loss ratios began to decline in 2016, suggesting improved insurer performance. In 2017, following relatively large premium increases, individual market insurers saw significant increases in loss ratios, suggesting that individual market insurers on average were beginning to better manage their costs. Loss ratios continued to decline in 2018, averaging 70%, suggesting that insurers were able to build in the loss of cost-sharing subsidy payments when setting premiums and some insurers over-corrected. With such losses, insurers could not justify premium increases in 2019, and loss ratios rebounded to average 79% in 2019.

Figure 1

Average Individual Market Medical Loss Ratios, 2011 - 2019

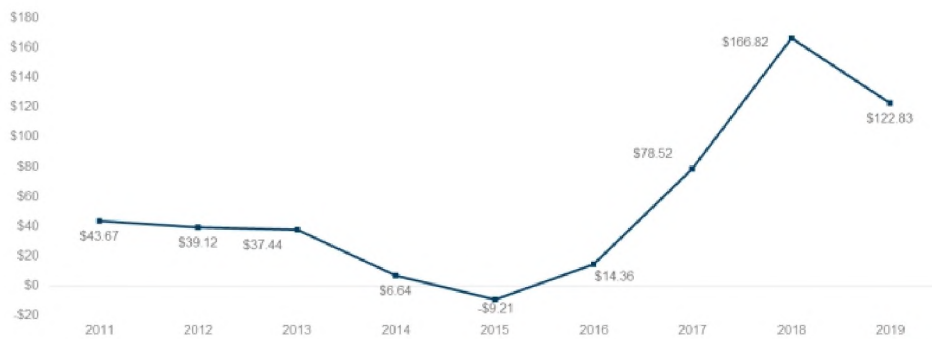


Note: Figures above represent simple loss ratios and differ from the definition of MLR in the Affordable Care Act
Source: KFF analysis of data from Mark Farrah Associates Health Coverage Portal TM.



Figure 2

Average Individual Market Gross Margins Per Member Per Month, 2011 - 2019



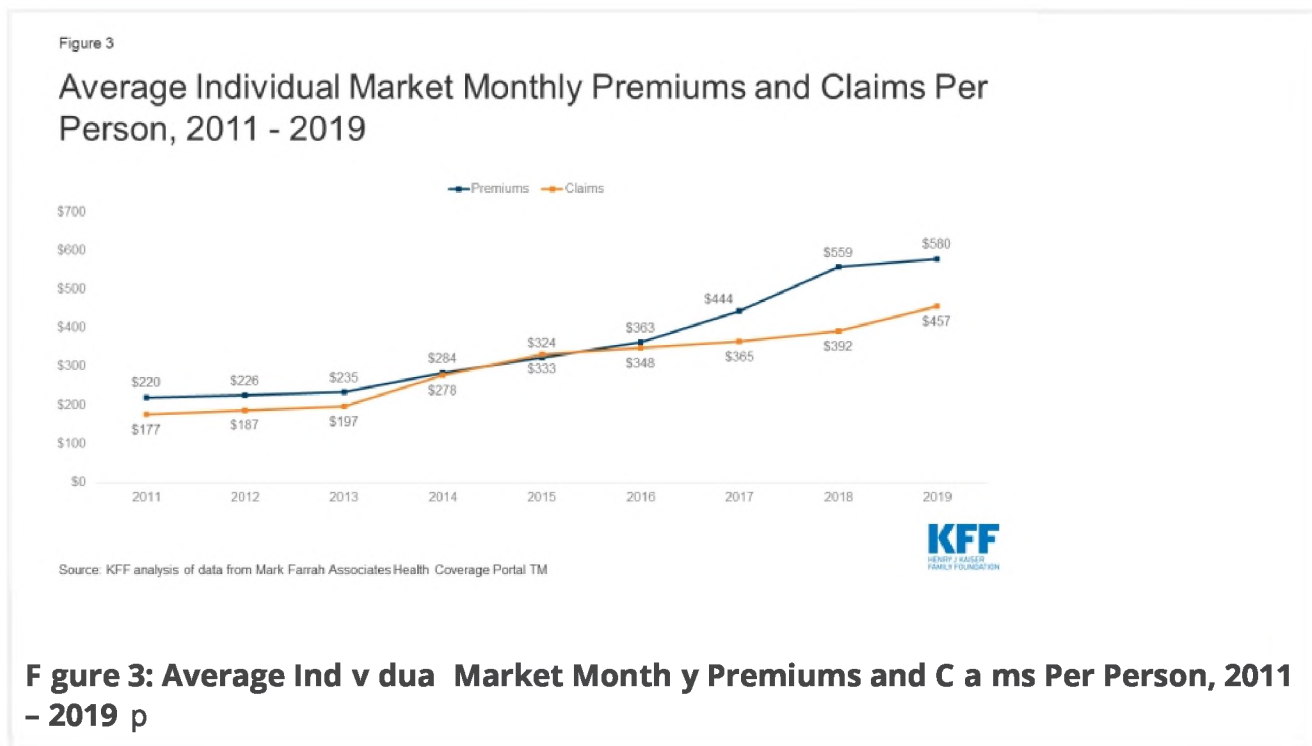
Source: KFF analysis of data from Mark Farrah Associates Health Coverage Portal TM.



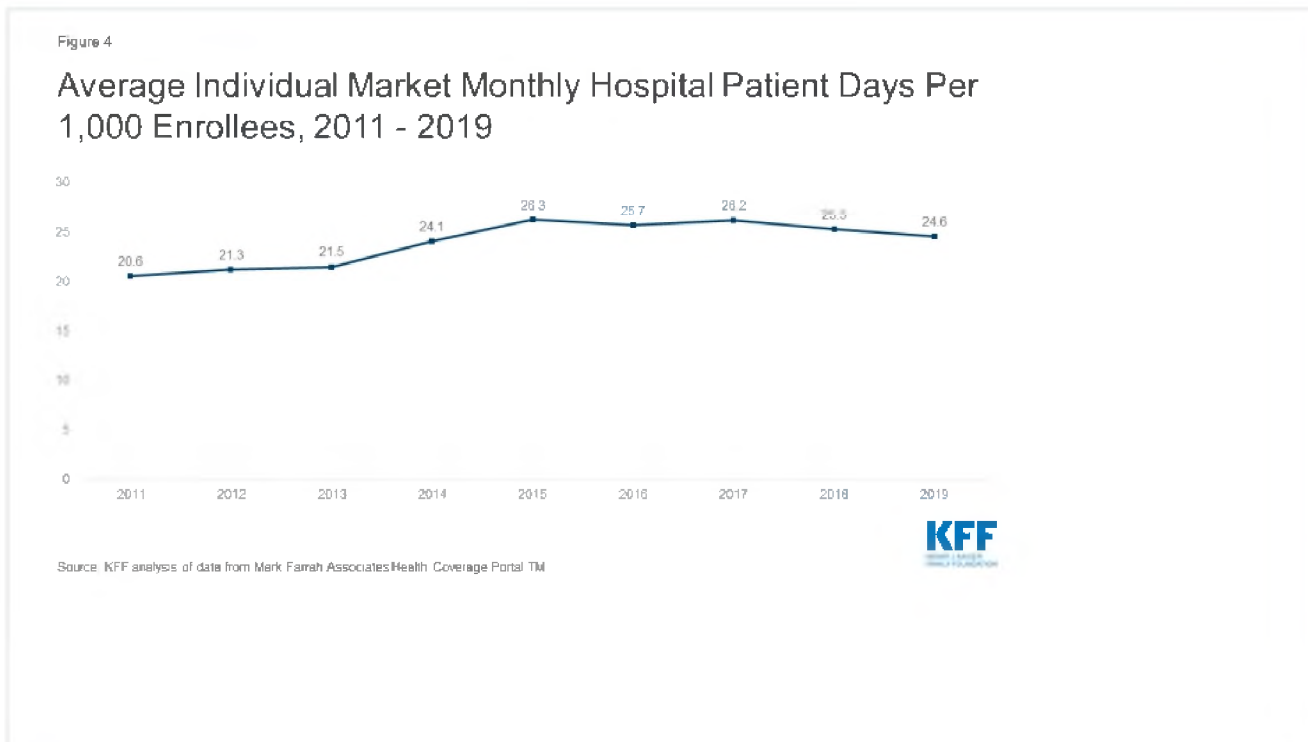
Gross margins show a similar pattern to loss ratios. Insurer financial performance improved dramatically through 2018 (increasing to \$167 per enrollee, from a recent annual low of -\$9 in 2015). Margins fell an average of \$44 per member per month from 2018 to 2019, but they remain higher than all other years before 2018. These data suggest that insurers in this market remain financially healthy, on average.

Underlying Trends

Premiums per enrollee rose slightly in 2019 following steep increases in 2018, while per person claims continued to grow modestly. On average, per member per month premiums grew 4% from 2018 to 2019, and per person claims grew 17%.²



One concern about the elimination of the individual mandate penalty was whether healthy enrollees would drop out of the market in large numbers. However, the average number of days individual market enrollees spent in a hospital in 2019 was slightly lower than inpatient days in the previous four years.³



Taken together, these data on costs and utilization suggest that the individual market risk pool is relatively stable, though sicker on average than the pre-ACA market, which is to be expected since people with pre-existing conditions have guaranteed access to coverage under the ACA. Despite concerns that healthier enrollees may be dropping out of the market in recent years, somewhat lower average inpatient days indicate that the individual market did not get sicker, on average, during 2019.

Discussion

Annual results from 2019 suggest that despite the reduction of the individual mandate penalty to \$0 the individual insurance market has remained stable. Insurer financial results from 2019 – the first year the repeal of the individual mandate penalty went into effect – reveal yet another favorable year for insurers in the ACA-compliant market. The repeal of the individual mandate penalty and expansion of short-term plans does not appear to have led to a significantly sicker group of enrollees, as hospitalization rates remain stable.

Our [recent analysis](https://www.kff.org/private-insurance/issue-brief/data-note-2020-medical-loss-ratio-rebates/) (<https://www.kff.org/private-insurance/issue-brief/data-note-2020-medical-loss-ratio-rebates/>) also finds that individual market insurers expect to pay a record total of nearly **\$2 billion in rebates** (<https://www.kff.org/private-insurance/issue-brief/data-note-2020-medical-loss-ratio-rebates/>) to consumers for falling below the ACA medical loss ratio threshold, which requires insurers to spend at least 80% of premium revenues on health care claims or quality improvement activities. This is more than double the amount insurers paid out in rebates last year. In total, across the individual, small group, and large group markets, insurers expect to issue about \$2.7 billion in rebates this year based on their 2019 performance, nearly double last year's previous record high of \$1.4 billion.

While insurance markets in this country have limited insurer participation and high premiums in the individual market on average remain profitable. In the last two years, so insurers have entered the market and others have **expanded their footprints** (<https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-ac-marketplaces-2014-2020/>), as would be expected in a competitive marketplace. A continuing **legal battle** with (<https://affordablecareactlitigation.files.wordpress.com/2018/12/Texas-v-US-partial-su-wo-rdp-decision.pdf>) threatening the exchange markets and the ACA as a result, significant uncertainties remain. Insurers are now locked in to 2020 premium rates. ACA- for co-located plans, it remains to be seen how continued uncertainty around the coronavirus pandemic, the economic crisis, and the future of the ACA may affect premiums and plan participation in 2021 or beyond.

Methods

We analyze insurer-reported financial data from the [KFF Health Cost Institute](#) database maintained by [Farmers Associates](#), which includes information from the National Association of Insurance Commissioners. The dataset analyzed in this report does not include NAIC plans licensed as life insurance or California Health Reforms regulated by MOs. California's Department of Managed Health Care. In total, the plans in this dataset represent at least 80 million individual lives. All figures in this issue brief are for the individual health insurance market as a whole, which includes employer-sponsored plans and mini-market plans sold both on and off exchange. We excluded plans that filed negative enrollment, premium claims, or were not in force for plans that did not file "member months" in the annual state report did file current year membership.

To calculate the **net** **margin** **per** **member** **per** **month** **across** **the** **individual** **market**, we use the **sum** **of** **all** **unadjusted** **health** **premiums** **minus** **unadjusted** **claims** **paid** **minus** **quality** **improvement** **expenses**, **taxes**, **or** **risk** **program** **payments** **minus** **gross** **margin** **corridors** **we** **calculated** **by** **subtracting** **the** **sum** **of** **total** **claims** **paid** **from** **the** **sum** **of** **unadjusted** **health** **premiums** **and** **dividing** **by** **the** **total** **number** **of** **member** **months** **across** **the** **individual** **insurance** **market**. **Using** **adjusted** **premiums** **for** **taxes** **and** **fees** **to** **calculate** **loss** **ratios** **and** **gross** **margin** **increases** **the** **MLR** **by** **4** **percentage** **points** **and** **decreases** **the** **gross** **margin** **per** **member** **by** **\$31** **in** **2019**. **Average** **across** **all** **years**, **using** **earned** **premiums** **adjusted** **for** **taxes** **and** **fees** **increases** **the** **MLR** **by** **3** **percentage** **points** **and** **decreases** **the** **gross** **margin** **per** **member** **by** **\$16**. **per**

Endnotes

Issue Brief

1. The loss ratios shown in this issue brief differ from the definition of MLR in the ACA, which makes some adjustments for quality improvement and taxes, and do not account for reinsurance, risk corridors, or risk adjustment payments. Reinsurance payments, in

particular, helped offset some losses insurers would have otherwise experienced. However, the ACA's reinsurance program was temporary, ending in 2016, so loss ratio calculations excluding reinsurance payments are a good indicator of financial stability going forward.

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2. Average premiums per member per month increased in 2019, even while **average unsubsidized premiums for the lowest-cost plans in each metal tier** (<https://www.kff.org/health-reform/state-indicator/percent-change-in-average-marketplace-premiums-by-metal-tier-2017-2019/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>) went down, because average premiums per member per month reflect changes in the age and geographic distribution of enrollees, changes in plans selected by enrollees, and changes p in subsidy amounts.

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3. Hospital patient days for 2014 are not necessarily representative of the full year because open enrollment was longer that year and a number of exchange enrollees did not begin their coverage until mid-year 2014.

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Updated June 10, 2020

States Are Leveraging Medicaid to Respond to COVID-19

By Jessica Schubel

Many state Medicaid programs are proposing or implementing new policies to respond to COVID-19 and maintain access to health care during the public health crisis. States are strengthening their home- and community-based services (HCBS) programs, improving access to coverage and care, helping people access care while social distancing, and ensuring financial stability for providers so they can keep their doors open and serve their communities. More states should consider implementing these policies, especially as more people lose their jobs or incomes and need Medicaid coverage. Congress should support states in making these changes by further increasing Medicaid's federal match rate to defray the cost of these policies, as well as to prevent states from reducing access to care.

States Are Implementing New Medicaid Policies to Respond to COVID-19

Every state has made at least one change to its Medicaid program in response to COVID-19, using various available Medicaid authorities (see the textbox below).¹

Expanding or Strengthening HCBS for Seniors and People With Disabilities

HCBS are especially important during the public health crisis because they help seniors and people with disabilities remain in their homes, where they are generally safer from the virus than in nursing homes.

To date, the Centers for Medicare & Medicaid Services (CMS) has approved section 1915(c) waiver Appendix K changes to HCBS in 48 states (see Table 1 for a list of changes by state). These changes are making it easier for seniors and people with disabilities to get HCBS. More than half of states are permitting providers to conduct virtual assessments and person-centered planning meetings, modifying processes for level-of-care evaluations, extending reassessment and re-evaluation dates, and modifying the person-centered planning process.

¹ For a complete list of approved state policies, see Kaiser Family Foundation, "Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19," accessed on May 20, 2020, <https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>.

States are also using these approvals to expand services by allowing beneficiaries to receive services beyond the typical limits, adjusting prior authorizations, adding new services and supplies such as home-delivered meals and adaptive technology, and allowing HCBS to be provided in alternative settings such as hotels, schools, churches, and temporary shelters.

Finally, states are strengthening the HCBS workforce by increasing payment rates, providing retainer payments to help keep HCBS providers stay in business, and paying family caregivers.

State Pathways to Implement New Policies

Medicaid agencies can use four main pathways to implement new policies to respond to COVID-19. Some of these pathways rely on temporary authorities linked to the public health emergency (PHE) declared by Health and Human Services (HHS) Secretary Alex Azar, and the Stafford Act Emergency Declaration issued by President Trump.^a

- **Medicaid state plan amendments** are usually the simplest and quickest way for states to make changes. Each state has a plan describing its rules related to Medicaid eligibility, benefits, cost sharing, and payments, and states have significant latitude to modify these plans.^b
- **Section 1135 waivers** are special waivers available only after both the President and HHS Secretary have declared a national emergency. In addition to certain blanket waiver authorities, section 1135 waiver authority allows the Secretary to waive or modify certain Medicaid requirements to ensure that health care items and services are sufficient to meet the needs of enrollees in areas affected by a PHE.^c
- **Emergency section 1115 waivers** are available after the Secretary has declared a national emergency and relieve states from certain requirements that usually apply to 1115 waivers, like demonstrating budget neutrality and public notice and comment procedures. Emergency section 1115 waivers can be used to implement policies not otherwise allowed under Medicaid law, such as expanding benefits and streamlining enrollment processes.^d
- **Section 1915(c) waiver Appendix K** is an approach states can use during emergencies to amend HCBS programs authorized under approved section 1915(c) waivers, the authority states generally use to implement HCBS. Appendix K changes can be retroactive and the section 1915(c) public notice requirements don't apply to such requests.^e

^a For more information on these pathways, see Jennifer Wagner, "Streamlining Medicaid Enrollment During COVID-19 Public Health Emergency," Center on Budget and Policy Priorities, April 7, 2020,

<https://www.cbpp.org/research/health/streamlining-medicaid-enrollment-during-covid-19-public-health-emergency>.

^b CMS issued a disaster state plan amendment template that lets states change their Medicaid state plans quickly; see <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/state-plan-flexibilities/index.html>.

^c Section 1135 templates are available at <https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/section-1135-waiver-flexibilities/index.html>, and approved waivers can be viewed at

<https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/federal-disaster-resources/index.html>.

^d CMS has issued an emergency section 1115 waiver template, which is available at

<https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-application-process/index.html>.

^e CMS has issued an appendix K template, which is available at <https://www.medicaid.gov/state-resource-center/downloads/sample-appendix-k-template.docx>.

Improving Access to Coverage and Care

States are using disaster-related state plan amendments (SPAs) and administrative actions to make it easier for people to enroll in coverage (see Table 2). For example, some states are electing the new eligibility group authorized under the Families First Act Coronavirus Response Act to cover

COVID-19 testing for uninsured individuals and using less restrictive methodologies to determine eligibility.

Some states are also accepting self-attestation for all eligibility criteria covering non-residents or people living temporarily out of state due to the public health emergency, adopting a simplified/streamlined application, giving non-citizens more time (a longer reasonable opportunity period) to document their eligibility for coverage, and expanding presumptive eligibility (which lets providers and other qualified entities temporarily enroll people who appear eligible for Medicaid) to new populations, including seniors and people with disabilities.

States are also expanding coverage and making it more affordable by adjusting or increasing benefits, covering COVID-19 testing or treatment through emergency Medicaid, and eliminating copayments and other cost-sharing charges as well as premiums.

Helping People Access Care While Maintaining Social Distance

States are using a combination of disaster SPAs, administrative actions, and section 1135 waivers to maintain access to health care while people are social distancing (see Table 3). For example, states are expanding the use of telehealth by waiving or reducing telehealth copayments, paying some telehealth services at the same rate as face-to-face visits, waiving or reducing copayments for telehealth services, and giving providers more flexibility to provide telehealth services.

States are also using these authorities to prevent unnecessary trips to the doctor or pharmacy by suspending or extending prior authorizations for health care services and items, allowing Medicaid beneficiaries to get early prescription drug refills, increasing the maximum supply or quantity limit of certain drugs, making changes to preferred drug lists, and waiving or suspending prescription drug prior authorizations.

Expanding or Strengthening the Health Workforce

CMS has approved disaster SPAs that allow states to increase payment rates and supplemental payments to certain providers (see Table 4). And all states are using section 1135 waivers to make it easier for providers to enroll in their Medicaid programs, allow out-of-state providers to furnish services, and allow providers to offer health care services in alternative settings, including unlicensed facilities.

States Need More Medicaid Funding to Support Their Efforts

While some of the policies above are low cost, others are expensive to implement. Congress should support states in their efforts to respond to COVID-19 by further increasing Medicaid's federal match rate to help them cover these additional costs. Increasing the federal match rate will also help prevent people from losing access to critical services during the public health and economic crises.²

² Aviva Aron-Dine *et al.*, "A Larger, Longer-Lasting Increases in Federal Medicaid Funding Needed to Protect Coverage," Center on Budget and Policy Priorities, May 5, 2020, <https://www.cbpp.org/research/health/larger-longer-lasting-increases-in-federal-medicaid-funding-needed-to-protect>.

TABLE 1

Strengthening Home- and Community-Based Services (HCBS)

State	Making It Easier to Get HCBS				Expanding Services & Settings				Strengthening HCBS Workforce		
	Permitting Virtual Assessments & Person-Centered Planning Meetings	Modifying Processes for Level-of-Care Evaluations	Extending Reassessment & Re-evaluation Dates	Modifying Person-Centered Planning Process	Adjusting Service Limits	Adjusting Prior Authorizations	Adding Services to Address Emergency ¹	Allowing HCBS in Alternative Settings	Expanding Paid Family Caregiver Limits	Increasing Payment Rates	Making Retainer Provider Payments
Alabama	X	X	X	X	X	X	X	X	X	X	X
Alaska		X	X	X	X	X		X	X	X	X
Arizona	X		X	X		X	X	X	X		X
Arkansas										X	
California	X	X	X	X				X	X		X
Colorado	X	X	X		X	X	X	X	X	X	X
Connecticut	X	X	X		X	X	X		X	X	X
DC	X	X	X	X	X	X		X	X	X	X
Delaware	X	X	X				X	X	X	X	X
Florida	X		X		X	X	X	X	X		X
Georgia	X	X	X	X	X	X		X	X	X	X
Hawaii	X	X	X	X	X	X	X	X	X		X
Idaho											
Illinois	X		X	X	X	X	X	X	X	X	X
Iowa	X	X	X		X	X	X	X			X
Indiana	X	X	X	X	X	X	X	X	X	X	
Kansas	X		X		X	X	X	X	X		X
Kentucky	X	X		X	X	X		X		X	X
Louisiana	X	X	X	X	X	X	X	X	X	X	X
Maine	X	X	X	X	X		X	X	X	X	
Maryland	X	X	X	X	X	X		X	X	X	X
Mass.	X	X	X	X	X	X	X	X		X	X
Michigan											
Minnesota	X	X						X		X	
Mississippi	X	X	X	X	X		X	X	X	X	

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Strengthening Home- and Community-Based Services (HCBS)

State	Making It Easier to Get HCBS				Expanding Services & Settings				Strengthening HCBS Workforce		
	Permitting Virtual Assessments & Person-Centered Planning Meetings	Modifying Processes for Level-of-Care Evaluations	Extending Reassessment & Re-evaluation Dates	Modifying Person-Centered Planning Process	Adjusting Service Limits	Adjusting Prior Authorizations	Adding Services to Address Emergency ¹	Allowing HCBS in Alternative Settings	Expanding Paid Family Caregiver Limits	Increasing Payment Rates	Making Retainer Provider Payments
Missouri	X	X	X	X	X	X	X	X	X		
Montana	X	X	X	X	X	X	X	X	X		X
Nebraska	X	X	X	X	X	X		X		X	X
Nevada	X	X	X	X	X	X	X	X	X		X
New Hampshire	X	X	X	X	X	X		X	X		X
New Jersey	X		X		X	X	X	X	X	X	X
New Mexico	X	X	X	X	X	X	X	X	X	X	X
New York	X	X	X	X	X	X		X		X	X
North Carolina	X	X	X	X	X	X	X	X	X		X
North Dakota	X	X	X	X	X	X		X	X	X	X
Ohio	X	X	X	X	X	X		X	X		
Oklahoma	X	X	X	X	X	X	X	X	X		X
Oregon	X	X	X	X				X		X	X
Penn.	X	X	X	X	X	X	X	X	X	X	X
Rhode Island	X	X	X	X	X	X	X	X	X	X	X
South Carolina	X		X	X	X		X	X	X		
South Dakota	X		X	X	X	X		X	X		X
Tenn.	X	X	X	X		X	X	X		X	
Texas											
Utah	X		X	X	X	X		X	X		X
Vermont	X	X	X	X		X		X	X		
Virginia	X		X					X	X		X

TABLE 1

Strengthening Home- and Community-Based Services (HCBS)

State	Making It Easier to Get HCBS				Expanding Services & Settings				Strengthening HCBS Workforce		
	Permitting Virtual Assessments & Person-Centered Planning Meetings	Modifying Processes for Level-of-Care Evaluations	Extending Reassessment & Re-evaluation Dates	Modifying Person-Centered Planning Process	Adjusting Service Limits	Adjusting Prior Authorizations	Adding Services to Address Emergency ¹	Allowing HCBS in Alternative Settings	Expanding Paid Family Caregiver Limits	Increasing Payment Rates	Making Retainer Provider Payments
Washington	X	X	X	X	X	X	X	X		X	X
West Virginia	X	X	X	X	X	X		X	X		X
Wisconsin	X	X	X	X	X	X	X	X	X	X	X
Wyoming	X	X	X		X		X	X		X	
Total	46	38	45	37	39	38	28	46	37	29	37

¹ CO, CT, DE, FL, HI, IA, IN, IL, KS, LA, ME, MO, MS, MT, NC, NV, PA, SC, WA, and WY have temporarily added services to address the emergency. AL, AZ, CT, DE, IA, KS, LA, MA, MO, MS, NC, NJ, OK, SC, and WI have added home-delivered meals. AL, CO, DE, HI, KS, MA, MS, NC, OK, PA, RI, TN, and WY have added medical supplies, equipment and appliances, and KS, LA, MA, NM, and OK have added assistive technology.

TABLE 2

Improving Access to Coverage and Care

State	Making It Easier to Enroll in Coverage							Expanding Coverage & Making It More Affordable			
	Electing New Uninsured Eligibility Group	Accepting Self-Attestation	Permitting PHE-related Out-of-State Temporary Residency & Coverage for Non-Residents	Using Less Restrictive Methodologies to Determine Eligibility	Expanding PE	Using Simplified Application	Extending Reasonable Opportunity Period	Adjusting or Increasing Existing Benefits	Covering COVID Testing or Treatment Through Emergency Medicaid	Eliminating Copays	Eliminating Premiums
Alabama	X							X		X	
Alaska			X				X	X			X
Arizona	X					X		X		X	X
Arkansas								X			
California	X	X		X	X			X	X		X
Colorado	X							X	X		X
Conn.	X								X		
DC		X									
Delaware									X	X	X
Florida								X		X	
Georgia										X	
Hawaii											
Idaho										X	X
Illinois	X	X		X	X					X	X
Iowa	X		X		X			X		X	X
Indiana		X								X	X
Kansas					X		X				
Kentucky						X				X	
Louisiana	X	X	X				X	X		X	
Maine	X	X	X						X	X	X
Maryland								X			X
Mass.	X	X		X	X				X		

TABLE 2

Improving Access to Coverage and Care

State	Making It Easier to Enroll in Coverage							Expanding Coverage & Making It More Affordable			
	Electing New Uninsured Eligibility Group	Accepting Self-Attestation	Permitting PHE-related Out-of-State Temporary Residency & Coverage for Non-Residents	Using Less Restrictive Methodologies to Determine Eligibility	Expanding PE	Using Simplified Application	Extending Reasonable Opportunity Period	Adjusting or Increasing Existing Benefits	Covering COVID Testing or Treatment Through Emergency Medicaid	Eliminating Copays	Eliminating Premiums
Michigan								X	X		
Minnesota	X			X							X
Mississippi											
Missouri		X		X						X	
Montana	X										
Nebraska			X		X		X			X	
Nevada	X								X		
New Hampshire	X				X						
New Jersey											
New Mexico	X	X			X						
New York									X		
North Carolina		X	X	X			X	X			X
North Dakota											X
Ohio		X			X		X	X		X	
Oklahoma								X			
Oregon					X		X	X	X		
Penn.		X	X				X	X	X		
Rhode Island	X		X				X				

TABLE 2

Improving Access to Coverage and Care

State	Making It Easier to Enroll in Coverage							Expanding Coverage & Making It More Affordable			
	Electing New Uninsured Eligibility Group	Accepting Self-Attestation	Permitting PHE-related Out-of-State Temporary Residency & Coverage for Non-Residents	Using Less Restrictive Methodologies to Determine Eligibility	Expanding PE	Using Simplified Application	Extending Reasonable Opportunity Period	Adjusting or Increasing Existing Benefits	Covering COVID Testing or Treatment Through Emergency Medicaid	Eliminating Copays	Eliminating Premiums
South Carolina	X									X	
South Dakota								X			
Tenn.											
Texas	X										
Utah	X				X						
Vermont		X		X				X		X	X
Virginia			X				X			X	
Washington	X	X	X	X	X	X		X	X		X
West Virginia	X										
Wisconsin					X						X
Wyoming		X									X
Total	21	15	10	8	13	3	10	19	12	18	18

Note: PHE = public health emergency; PE = presumptive eligibility

TABLE 3

Helping People Access Care While Social Distancing

State	Expanding Telehealth			Preventing Unnecessary Trips to the Doctor or Pharmacy					
	Waiving or Reducing Copays	Payment Parity w/ Face-to-Face Visits	Greater Provider Flexibility to Furnish Telehealth	Suspending Prior Authorizations for Certain Health Care Services	Extending Prior Authorizations for Certain Health Care Services	Allowing Early Refills	Increasing Quantity Limits of Certain Drugs	Making Changes to Preferred Drug Lists	Waiving or Suspending Drug Prior Authorizations
Alabama		X	X		X				
Alaska		X	X	X	X	X	X	X	X
Arizona	X		X	X	X	X	X	X	X
Arkansas		X	X	X		X	X	X	
California	X	X	X	X	X	X	X		X
Colorado	X	X	X	X	X	X	X	X	X
Conn.	X		X	X	X	X	X		
DC		X	X	X	X	X	X	X	X
Delaware		X	X	X	X	X	X	X	X
Florida		X	X	X	X	X	X		
Georgia			X	X	X	X	X	X	X
Hawaii		X	X	X					
Idaho			X	X	X				
Illinois		X	X	X	X	X	X	X	X
Iowa	X	X	X			X	X		
Indiana		X	X	X	X	X	X	X	X
Kansas			X	X	X		X	X	X
Kentucky	X	X	X	X		X	X		
Louisiana			X		X	X	X	X	X
Maine		X	X	X	X	X	X	X	X
Maryland		X	X	X	X	X	X		
Mass.	X	X	X	X	X	X	X		X
Michigan			X	X	X	X	X		X
Minnesota		X	X	X			X		
Mississippi		X	X	X	X				
Missouri	X	X	X	X	X	X		X	X
Montana		X	X	X	X	X	X	X	X

TABLE 3

Helping People Access Care While Social Distancing

State	Expanding Telehealth			Preventing Unnecessary Trips to the Doctor or Pharmacy					
	Waiving or Reducing Copays	Payment Parity w/ Face-to-Face Visits	Greater Provider Flexibility to Furnish Telehealth	Suspending Prior Authorizations for Certain Health Care Services	Extending Prior Authorizations for Certain Health Care Services	Allowing Early Refills	Increasing Quantity Limits of Certain Drugs	Making Changes to Preferred Drug Lists	Waiving or Suspending Drug Prior Authorizations
Nebraska		X	X	X	X	X			
Nevada		X	X		X	X			
New Hampshire	X	X	X	X	X	X			X
New Jersey	X	X	X	X	X	X	X		
New Mexico	X	X	X	X	X	X	X		
New York	X	X	X	X	X	X	X		X
North Carolina	X	X	X	X			X	X	X
North Dakota	X	X	X	X	X		X	X	X
Ohio			X	X		X	X		X
Oklahoma	X		X	X			X		X
Oregon		X	X	X	X	X			
Penn.	X		X	X	X	X	X		
Rhode Island	X	X	X	X	X	X	X	X	X
South Carolina	X	X	X		X	X			
South Dakota		X	X			X	X		X
Tenn.		X	X			X	X		X
Texas	X	X	X		X	X	X		
Utah		X	X	X		X			
Vermont	X	X	X	X	X	X	X	X	X
Virginia			X	X	X	X	X	X	
Washington		X	X	X	X			X	
West Virginia			X	X	X		X		
Wisconsin		X	X	X	X	X	X		

TABLE 3

Helping People Access Care While Social Distancing

State	Expanding Telehealth			Preventing Unnecessary Trips to the Doctor or Pharmacy					
	Waiving or Reducing Copays	Payment Parity w/ Face-to-Face Visits	Greater Provider Flexibility to Furnish Telehealth	Suspending Prior Authorizations for Certain Health Care Services	Extending Prior Authorizations for Certain Health Care Services	Allowing Early Refills	Increasing Quantity Limits of Certain Drugs	Making Changes to Preferred Drug Lists	Waiving or Suspending Drug Prior Authorizations
Wyoming		X	X	X					
Total	20	39	51	43	39	39	39	20	26

TABLE 4

Strengthening the Health Care Workforce

State	Increasing Provider Payments	Easing Provider Enrollment Requirements	Allowing Out-of-State Providers to Provide Care	Allowing Providers to Offer Services in Alternative Settings
Alabama	X	X	X	
Alaska	X	X	X	X
Arizona	X	X	X	
Arkansas	X	X	X	
California	X	X	X	X
Colorado	X	X	X	X
Conn.		X	X	X
DC		X	X	X
Delaware		X	X	
Florida		X	X	X
Georgia		X	X	X
Hawaii		X	X	X
Idaho		X	X	X
Illinois	X	X	X	X
Iowa		X	X	X
Indiana		X	X	X
Kansas		X	X	
Kentucky	X	X	X	X
Louisiana	X	X	X	X
Maine	X	X	X	X
Maryland	X	X	X	X
Mass.	X	X	X	X
Michigan	X	X	X	X
Minnesota		X	X	X
Mississippi		X	X	X
Missouri		X	X	X
Montana	X	X	X	X
Nebraska		X	X	X
Nevada		X	X	X

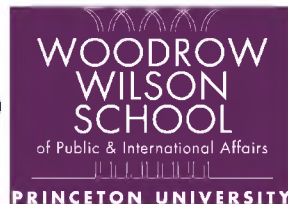
TABLE 4

Strengthening the Health Care Workforce

State	Increasing Provider Payments	Easing Provider Enrollment Requirements	Allowing Out-of-State Providers to Provide Care	Allowing Providers to Offer Services in Alternative Settings
New Hampshire		X	X	X
New Jersey	X	X	X	X
New Mexico	X	X	X	
New York		X	X	X
North Carolina	X	X	X	X
North Dakota		X	X	
Ohio	X	X	X	X
Oklahoma	X	X	X	X
Oregon		X	X	X
Penn.		X	X	X
Rhode Island	X	X	X	X
South Carolina	X	X	X	X
South Dakota		X	X	X
Tenn.	X	X	X	X
Texas		X	X	
Utah		X	X	X
Vermont		X	X	X
Virginia	X	X	X	X
Washington	X	X	X	X
West Virginia	X	X	X	X
Wisconsin		X	X	X
Wyoming		X	X	X
Total	25	51	51	43



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COVID-19 (<https://www.shvs.org/covid19/>)

MAY, 12, 2020

The Final 2021 Notice of Benefit and Payment Parameters: Implications for States

Sabrina Corlette, Georgetown University Center on Health Insurance Reforms

On May 7, 2020, the U.S. Department of Health & Human Services (HHS) published its final annual rule (<https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-10045.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 a 3-part blog series for Health Affairs, here (<https://www.healthaffairs.org/doi/10.1377/hblog20200508.974523/full/>), here (<https://www.healthaffairs.org/doi/10.1377/hblog20200509.663489/full/>), and here (<https://www.healthaffairs.org/doi/10.1377/hblog20200510.375931/full/>). This article focuses on several policies that have implications for state insurance regulation and the operation of the state-based marketplaces (SBMs).

No Change to Automatic Re-enrollment

In its proposed rule (<https://www.govinfo.gov/content/pkg/FR-2020-02-06/pdf/2020-02021.pdf>), HHS sought 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. However, in light of “overwhelming opposition” to such a change, HHS has decided to maintain its current automatic re-enrollment procedures for 2021. .

Privacy - Terms

New Annual Reporting Obligation of Benefit Mandates

HHS proposed requiring states, beginning July 1, 2021, to annually report all state benefit mandates and indicate whether any are in addition to the essential health benefits (EHB). Although a majority of the public comments opposed this new state obligation, HHS is moving forward, arguing that they believe some states have enacted benefit mandates that exceed EHB, but without defraying the costs, as required by federal law. HHS asserts that state reporting will serve a critical program integrity function and help ensure that there are no “improper expenditures” of federal premium tax credits. Furthermore, although states will continue to be responsible for determining whether any benefit mandates are in addition to EHB, if a state chooses not to submit an annual report, HHS will conduct its own analysis of the state’s benefit mandates and identify any that exceed EHB.

HHS also received several comments arguing that HHS has failed, to date, to articulate in rules or guidance any standards for determining what benefit mandates would trigger a defrayal obligation. HHS says that it will continue to “engage with states” on these issues and hopes that “additional technical assistance” will ease states’ concerns about how benefit mandates that require defrayal will be identified.

No Change in User Fees for the FFM

HHS had sought public comment on whether they should lower the rate charged to operate the federally facilitated marketplace (FFM) in 2021 to less than the current 3.0 percent (2.5 percent for SBMs using the federal platform). In its final rule, HHS chose to leave the user fee rate unchanged.

New Flexibility for Insurers on Application of Drug Manufacturers’ Coupons

In its regulations for 2020, HHS allowed insurers to discount the use of drug manufacturers’ coupons to defray cost-sharing associated with brand-name drugs when determining an enrollee’s annual out-of-pocket spending, so long as an equally effective generic is available. For 2021, HHS will expand the flexibility for insurers by allowing them to exclude those coupon amounts from the calculation of enrollees’ annual cost-sharing, even if a generic equivalent is not available. However, this flexibility will only apply to the extent consistent with state law. If a state wants to require insurers to count manufacturers’ coupons towards the annual limit on cost-sharing, they may do so. In its rule, HHS encourages, but does not require, insurers to inform enrollees of their policy with respect to the use of drug coupons and enrollees’ out-of-pocket liability under their plans.

Improving Special Enrollment Period (SEP) Policies

HHS proposed several changes to SEP policy to enhance consumers’ choices and improve efficiency. These included:

- 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. HHS is finalizing this proposal, but delaying the effective date to January 2022 to allow more time for exchanges to implement the change.
- 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. HHS is finalizing this proposal.

- 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 will be allowed to retain their current coverage effective dates. HHS is finalizing this proposal, but delaying implementing until January 2022 to allow time for the exchange to implement.
- 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 1 month of coverage and receive prospective coverage only. HHS is finalizing this proposal.

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 2021 NB proposes that SBMs will have some flexibility to minimize the display of quality information, but the quality ratings that have been developed by HHS.

Program Integrity Changes to Improve

HHS is implementing several changes to periodic data processing 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, or the Basic Health Plan, (2) have not responded to update their information in 30 days, and (3) consent to their termination of 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.

At the same time it released this final rule, HHS also released its final 2021 Letter to Issuers (<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2021-Letter-to-Issuers-in-the-Federally-facilitated-exchange-for-Marketplace.pdf>) rational guidance to insurers offering exchange plans. HHS also revised its timeline for the annual rate review (<https://www.cms.gov/files/document/final-rate-review-revised-2020-notice-bulletin.pdf>) process in order to give insurers more time to assess the impact of the COVID-19 pandemic on health care utilization and costs. In most states, insurers will be required to submit proposed marketplace rates no later than July 22; final 2021 rates will be due no later than August 26 for FFM insurers (an extension of one week) and September 15 for SBM issuers.

VIEWPOINT

COVID-19 and Racial/Ethnic Disparities

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Editorial

The novel SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2) has led to a global pandemic manifested as coronavirus disease 2019 (COVID-19), with its most severe presentation being acute respiratory distress syndrome leading to severe complications and death. Select underlying medical comorbidities, older age, diabetes, obesity, and male sex have been identified as biological vulnerabilities for more severe COVID-19 outcomes.¹ Geographic locations that reported data by race/ethnicity indicate that African American individuals and, to a lesser extent, Latino individuals bear a disproportionate burden of COVID-19-related outcomes. The pandemic has shone a spotlight on health disparities and created an opportunity to address the causes underlying these inequities.²

The most pervasive disparities are observed among African American and Latino individuals, and where data exist, American Indian, Alaska Native, and Pacific Islander populations. Preliminary prevalence

The pandemic presents a window of opportunity for achieving greater equity in the health care of all vulnerable populations.

and mortality estimates in multiple geographic areas, which are being tracked daily, show a consistent pattern of racial/ethnic differences. In Chicago, Illinois, rates of COVID-19 cases per 100 000 (as of May 6, 2020) are greatest among Latino (1000), African American/black (925), "other" racial groups (865), and white (389) residents. Mortality rates are substantially higher among African American/black individuals (73 per 100 000) compared with Latino (36 per 100 000) and white (22 per 100 000) residents.³ New York City (as of May 7, 2020) reported greater age-adjusted COVID-19 mortality among Latino persons (187 per 100 000) and African American individuals (184 per 100 000), compared with white (93 per 100 000) residents.⁴

These reports signal that prevention efforts, such as shelter-in-place, might have less benefit among African American and Latino populations. Why would racial/ethnic minorities or economically disadvantaged people of any background be more susceptible to becoming infected or developing severe disease and dying? What are possible underlying causes of differential outcomes of a highly infectious respiratory illness in disadvantaged populations?

The underlying causes of health disparities are complex and include social and structural determinants of health, racism and discrimination, economic and educational disadvantages, health care access and quality, individual behavior, and biology. Examining possible

precedents, mortality from influenza and pneumonia as causes of death for persons aged 65 years or older are lower among African American and Latino individuals compared with white persons.^{5,6} In contrast, historically, pulmonary tuberculosis disproportionately affects persons of lower socioeconomic status, but there is no convincing evidence that rates of tuberculosis reactivation are influenced by socioeconomic status.

Understanding the reasons for the initial reports of excess mortality and economic disruption related to COVID-19 among health disparity populations may allow the scientific, public health, and clinical community to efficiently implement interventions to mitigate these outcomes, particularly if substantial disease emerges in the fall of 2020 or beyond.

The most common explanations for disproportionate burden involve 2 issues. First, racial/ethnic minority populations have a disproportionate burden of underlying comorbidities. This is true for diabetes, cardiovascular disease, asthma, HIV, morbid obesity, liver disease, and kidney disease, but not for chronic lower respiratory disease or COPD. Second, racial/ethnic minorities and poor people in urban settings live in more crowded conditions both by neighborhood and household assessments and are more likely to be

employed in public-facing occupations (eg, services and transportation) that would prevent physical distancing. As stated by Yancy,² "social distancing is a privilege" and the ability to isolate in a safe home, work remotely with full digital access, and sustain monthly income are components of this privilege. COVID-19-related exposures are also exacerbated by a greater propensity to be homeless and reside in neighborhoods with substandard air quality.⁷

The possibility that genetic or other biological factors may predispose individuals to more severe disease and higher mortality related to COVID-19 is an empirical question that needs to be addressed. These explanations must be considered in the full context of systemic factors such as historical and ongoing discrimination, and chronic stress and its effect on hypothalamic-pituitary-adrenal axis and immunologic functioning. As more data emerge, there will likely be evidence of racial/ethnic health disparities due to differential loss of health insurance, poorer quality of care, inequitable distribution of scarce testing and hospital resources, the digital divide, food insecurity, housing insecurity, and work-related exposures. There is an obligation to address these predictable consequences with evidence-based interventions.

Public policies have the power to enhance health and also exacerbate health disparities. Health interventions that are adapted for local contexts and community

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characteristics are more effective than standard approaches.⁸ For example, culturally adapted mental health services are more effective for people of color compared with standard services.⁸ Thus, uniform public health recommendations related to physical distancing or sheltering-in-place that fail to consider local contexts and population characteristics may be less effective (often for reasons beyond individual control) among African American, Latino, American Indian, and Alaska Native populations, and economically disadvantaged people in general. Strategies that are culturally appropriate and community competent and that consider the nuances of population, community, family, and individual differences have a vital role in reducing health disparities, promoting health equity, and improving population health. Such approaches require a deep understanding of community, consideration of local data-driven approaches, diverse and equitable partnerships across sectors, messaging that resonates with the target audience(s), and the implementation of policies that support the health of all individuals in the US.

Available data on racial disparities in COVID-19 incidence and mortality are currently limited, but expanding. Collecting and reporting accurate data on demographic and social determinants of health depends on clinical systems reporting to local and state public health departments and to the Centers for Disease Control and Prevention. These data may be incomplete, exclude unconfirmed cases, and obscure racial/ethnic disparities. Moreover, current reports exclude patients who sought COVID-19 testing but whose symptoms did not meet the screening threshold or were otherwise deemed ineligible, and those who did not seek help (eg, due to health care system distrust, lack of insurance, fear of medical costs, or lack of paid sick leave). As such, the current reports may not generalize to the population, underestimating or overestimating proportions of confirmed COVID-19 cases by group.

Representative epidemiological data from ongoing or planned studies using weighted random sampling, standardized racial/ethnic categories, and widespread and accessible testing are needed to advance the science. In addition, given initial indications, potential racial/ethnic differences in post-COVID-19 recovery efforts need to be considered. Health care disparities, generally, and those related to COVID-19 require swift attention and amelioration, as the resultant societal burdens are costly to everyone.

Scientific studies that result in improved understanding of COVID-19 may lead to more targeted and effective community-based and health care system-based interventions. The collection and dissemination of COVID-19 data by race/ethnicity remain critically important to guide policy, health care, prevention, and intervention efforts. This novel disease creates an unfortunate opportunity to conduct ecological experiments focused on the etiology and depth of health disparities in a manner unobserved since this area of science emerged, especially as states begin to relax risk-mitigation policies. Rigorous research in representative samples is needed to identify the roots of inequities beyond the individual level, also examining community, policy, health care system, and society-level determinants (and their intersections).

Studies are needed to understand the influence of state and local mitigation policies on differences in health services utilization and health outcomes, the role of community-level protective factors and interventions in mitigating the adverse consequences of the sector disruptions caused by the outbreak, the influence of COVID-19-related racism and other types of discrimination, and the role of social determinants of health in influencing preventive health behaviors.

Studies are also needed to investigate the short-term and long-term effects of COVID-19 on health and how differential outcomes can be reduced in anticipation of subsequent waves of cases. The National Institute on Minority Health and Health Disparities (NIMHD) at the National Institutes of Health (NIH) is soliciting such studies. In addition, NIMHD will focus on community-engaged interventions to implement point-of-care testing for COVID-19 infection in health disparity and other vulnerable populations by leveraging existing NIH-funded networks, community health centers, and local organizations.

These efforts will help pave the way for therapeutic and vaccine trials that must be inclusive of diverse participants at high risk. These studies are also needed to guide the science of community-engaged intervention development, implementation, and evaluation and lay the foundation for a systemwide goal of decreasing health disparities beyond the detrimental effects of COVID-19. The pandemic presents a window of opportunity for achieving greater equity in the health care of all vulnerable populations.

ARTICLE INFORMATION

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ASH

State-Based Marketplaces Lead in Increasing Access to Coverage during COVID-19

May 11, 2020 / by Christina Cousart

As COVID-19 cases continue to climb, access to health insurance remains critical as consumers continue to need access to health care services, including those to prevent and treat COVID-19. However, prior to the outbreak, 28 million Americans were uninsured, which is projected to increase by over 7.3 million as individuals lose jobs and employer-sponsored health insurance coverage. Leading efforts to increase access to insurance are the nation's state-based health insurance marketplaces (SBMs).

The mission of the SBMs, which exercise more control over their marketplaces than states that use the federal marketplace, is to provide access to affordable, quality insurance plans to individuals. SBMs, which currently number at 13 [<https://nashp.org/where-states-stand-on-exchanges-3/>], have a long history of leveraging state flexibility to take proactive steps to improve consumer experiences, invest in outreach and marketing to draw in the uninsured, and to develop policies to lower their health plans costs.

They also offer a no-wrong door eligibility and enrollment portal for all coverage programs, including private coverage, Medicaid, and the Children's Health Insurance Program (CHIP). The SBMs have collectively maintained stable enrollment, while, on average, having lower individual market premiums than states that use the federal marketplace (FFM). (For more about SBM successes, read *State-based Marketplace Leaders Share their Success and Growth with Federal Leaders* [<https://nashp.org/state-based-marketplace-leaders-share-their-success-and-growth-with-federal-leaders/>].)

SBM Efforts during COVID-19

In light of the COVID-19 pandemic, the SBMs have redoubled efforts to ensure that consumers are aware of and able to access health insurance coverage. Responding to one of the nation's first reported COVID-19 outbreaks, on March 9, 2020, Washington State's SBM [<https://www.wahbexchange.org/new-customers/who-can-sign-up/special-enrollment-period/>] was the first to offer a special enrollment period (SEP)

<https://nashp.org/how-states-are-increasing-coverage-through-special-enrollment-periods/>] to enable uninsured individuals to enroll in coverage. Eleven SBMs followed suit <https://nashp.org/how-states-are-increasing-coverage-through-special-enrollment-periods/>], recognizing the public health importance of coverage as a critical step to facilitate access to preventative services such as testing, while also enabling access to treatment without excessive fear of high medical bills.

In addition, all SBMs increased efforts to educate consumers about existing coverage options, including SEPs available to individuals who experience income changes or loss of employer-sponsored job loss. Several developed partnerships with their local departments of unemployment to provide direct outreach to those most effected by economic changes.

Beyond these efforts, SBMs have worked quickly to develop new resources and to enact operational changes. SBMs in California <https://www.coveredca.com/covid19/>], Colorado <https://connectforhealthco.com/support-for-house-bill-1349/>], Washington, DC <https://dchealthlink.com/coronavirus/>], Maryland <https://www.marylandhealthconnection.gov/your-health-plan-and-the-covid-19-what-you-need-to-know/>], Minnesota <https://www.mnsure.org/shop-compare/about-plans/covid-19/index.jsp>], and Nevada <https://www.nevadahealthlink.com/coronavirus/>] launched comprehensive resource pages with links to educational information about COVID-19 and related coverage questions. Washington, DC, for example, included a simple chart to indicate what COVID-19-related services were covered by each of its participating insurance carriers. Meanwhile, SBMs worked with partners and vendors to develop new guidelines and FAQs documents so that outreach and customer service tools such as Navigator programs and call centers could provide robust services even while shifting to socially distanced or modified workplaces.

SBMs are adapting eligibility and enrollment systems to ease enrollment processes and expedite access to coverage. Recognizing the financial and other uncertainties facing millions of Americans who may be experiencing extreme fluctuations in income or circumstance, many SBMs have provided flexibility, where practical, on issues such as providing more time for submission of income verifications normally necessary to determine eligibility. SBMs have also collaborated with insurers to accelerate the start-dates of coverage, eliminating the waiting period usually needed between enrollment through the market and the actual first day of insurance coverage. SBMs have worked closely with their insurers and state insurance departments to encourage or require grace V

period extension and waiver of late-fee or penalty <http://nashp.org/new-state-insurance-requirements-in-response-to-covid-19/> so that consumers can retain their coverage through income disruptions that may cause them to delay premium payments.

Navigating Eligibility Challenges

Meanwhile, SBMs are also working through eligibility challenges presented by discrepancies in how supplemental unemployment benefits provided under the Coronavirus Aid, Relief, and Economic Security (CARES) Act are calculated toward eligibility for coverage benefits. Specifically, the law includes a temporary, supplemental benefit of \$600 per week, per unemployment recipient.

The law specifies that the \$600 not count toward income used to determine eligibility for Medicaid and CHIP, but does not stipulate the same exclusion when determining eligibility for federal marketplace subsidies, including advance premium tax credits (APTCs) and cost-sharing reductions (CSRs). (For more information read: *CARES Act Funds Help Consumers, but Create Coverage Eligibility Challenges for States* [<https://nashp.org/cares-act-funds-help-consumers-but-create-health-coverage-eligibility-challenges-for-states/>]). The discrepancy raises concerns that consumers may either miss out on needed benefits or be held liable for penalties if they inaccurately over- or under-estimate income because of confusion over how to account for the supplemental unemployment income. The discrepancy also poses significant operational challenges for SBMd systems built to be closely coordinate, if not fully integrate, with states' Medicaid systems. The SBMs continue to work toward solutions to ensure that individuals receive appropriate benefits, especially as so many of their consumers grapple with unexpected and ongoing financial hardship.

As the COVID-19 pandemic continues to evolve, so too will the SBMs as they continue to innovate and lead on strategies to bring affordable coverage to individuals in their states. For more information on the work of the marketplaces explore NASHP's Insurance Marketplace Resources page [<https://nashp.org/nashp-insurance-marketplace-resources/>].

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