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Coverage When You Need It: Lessons from Insurance Coverage Transitions in California's Individual Marketplace Pre and Post the COVID-19 Pandemic

Introduction

The Marketplaces created under the Affordable Care Act – always intended to provide a backstop when individuals are not eligible for other coverage through their jobs, Medicare, or Medicaid – are facing an unprecedented test as millions of Americans are experiencing job losses and health coverage disruptions due to the COVID-19 pandemic and recession.

Over the past six years, Covered California has taken active steps to maximize enrollment of subsidy-eligible consumers and keep health insurance premiums as low as possible, which lowers subsidy costs to the federal government but, most importantly, makes premiums less costly for consumers not eligible to receive subsidies. Covered California has continued to use all tools possible since the start of the pandemic to help consumers avail themselves of coverage options through the individual market by creating a COVID-19 special enrollment period, paired with ongoing and increasing investments in outreach and marketing.

The pandemic and recession are the first major test to see how the individual marketplaces and the Medicaid expansions launched by the Affordable Care Act can meet consumers needs in a down-economy. Administrative and survey data from Covered California indicate that coordinated state and marketplace policies and implementation decisions can be

Summary of Findings

- Using the tools of the Affordable Care Act, Covered California's experience demonstrates the positive role a marketplace can play to meet health coverage and economic needs of Americans, especially in the time of the COVID-19 recession, as **the California marketplace has reached its the highest number of covered members since its launch in 2014** (over 1.53 million).
- Building on its outreach and promotion with a COVID-19 SEP, **Covered California has enrolled over twice as many people as in the year prior**, with almost 290,000 Californians gaining coverage since March 20, 2020.
- While enrollment in states served by the federally-facilitated exchange (FFE) grew in the months since the beginning of the COVID-19 pandemic, if the FFE states experienced California's trend for new sign-ups in 2020 – driven by outreach and the COVID-19 SEP– **nearly 500,000 more Americans would have signed up for insurance coverage** during the special enrollment period through May 2020.
- There have been dramatic changes in the mix of consumers signing up for coverage since the COVID-19 pandemic began, **with far more signing up after losing job-based coverage**, and one-fifth of new sign-ups from those who likely would be been ineligible to enroll without California's COVID-19 SEP.
- The insurance-related impacts of the recession are evident in changes in where consumers are going when they leave Covered California. **A much smaller share of consumers are leaving for job-based coverage** (only 15 percent compared to the pre-COVID rate of 55 percent), more are enrolling in Medi-Cal as they lose income, and a greater share of consumers are leaving to become uninsured – a troubling indicator of unaffordability of even subsidized coverage in tough economic times.

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

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important factors in how effectively coverage disruptions are addressed. Covered California’s data confirms that, as in all states confronting the pandemic, there have been profound changes in consumers joining or leaving its marketplace. Our data also suggests, however, that by leveraging all the eligibility and marketing tools of marketplace, California reduced the number of those who would have otherwise been uninsured to a far greater degree than states that did not or could not employ such actions.

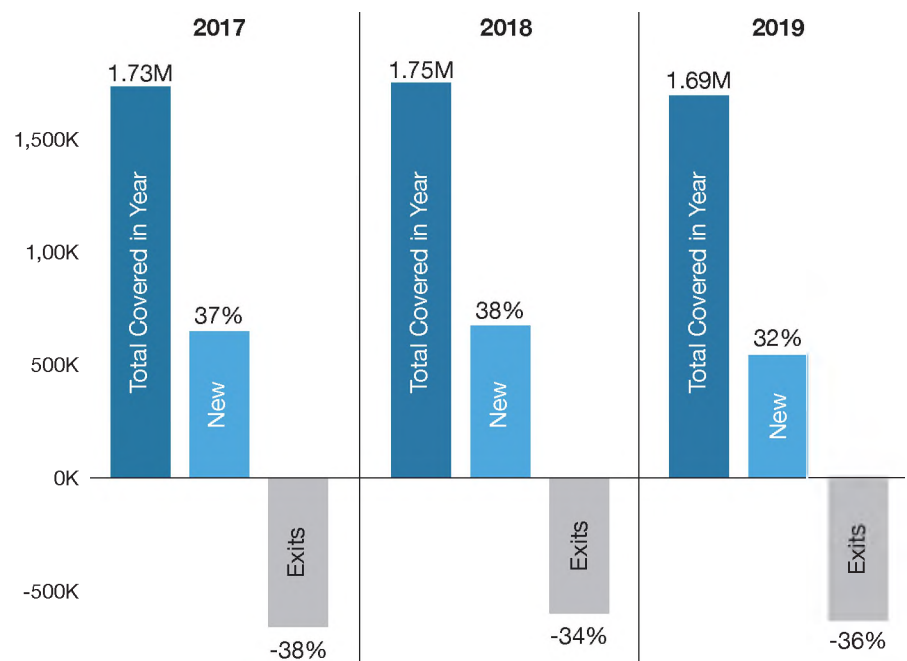
Churn and Individual Marketplace Coverage: Meeting the Changing Needs of Consumers

The individual market has always served as an option for those without other coverage options and for those who experience changes in life circumstances. Transitions between coverage sources are natural aspects of America’s health care landscape, as individuals experience changes in eligibility for employer coverage, Medicaid, or Medicare (due to shifts in factors such as employment, income, and age).¹ Each year, about one-third of Covered California’s membership consists of new enrollees, and one-third of its annual membership leaves the marketplace within the plan year (see Figure 1: Changes in Covered California’s Effectuated Membership: 2017-2019). Historically, enrollment in

Covered California has peaked each year at the end of Open Enrollment, the total enrollment declining slightly each month thereafter, as the number of those enrolling who qualify for a special enrollment period does not fully offset the number who leave the Marketplace to get other coverage.

In years prior to the pandemic, Covered California survey data documents that employer-sponsored insurance (ESI) is consistently the most common source of prior coverage among new entrants, with about one-third of new consumers having had ESI prior to joining the exchange – while others report Medi-Cal, off-exchange individual market coverage, and being uninsured in relatively equal shares.² For those leaving Covered California, by far the largest portion have historically transitioned into ESI, with only very few going to be uninsured. As discussed on the next page, the COVID-19 pandemic has disrupted many of these normal marketplace transitions, leaving far more consumers churning through coverage sources than at any other point since the exchange began in 2014.

Figure 1: Changes in Covered California’s Effectuated Membership: 2017 to 2019



Label percentages shown are the share of total covered members in the year for new entrants and exits, respectively. Source: Covered California administrative data.

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California's Individual Marketplace Going Into the COVID-19 Pandemic

State and national policies, as well as actions taken by Marketplaces themselves, influence how effectively the exchanges met the needs of consumers through 2019 – a time with a strong job economy and job market – and now, in 2020, with the nation facing one of the biggest economic downturns in history.

Since its launch in 2014, the state of California and Covered California have implemented an array of policies to support and even build on the Affordable Care Act (ACA) to promote broad coverage take-up. These policies include expanding Medi-Cal (the state's Medicaid program), limiting the availability of short-term insurance products, and Covered California (the state-based Marketplace) undertaking a range of actions to protect consumers and promote enrollment. These actions include:

- Promoting a marketplace with robust competition among health plans, with over 75 percent of enrollees having a choice of four or more carriers;
- Offering stable plan options, with essentially the same eleven health plans offering coverage since 2014;
- Requiring all plans to offer standardized consumer-centered benefit designs;
- Providing an Open Enrollment period that spans from November through the end of January, with even late January enrollments benefiting from a February 1 effective date; and
- Conducting broad outreach, marketing, and promotion activities, including support for a robust Navigator program.

The combined results of these policies have demonstrated the positive potential impact of effective implementation of the ACA. Through 2019, California showed the largest decline in the rate of uninsured in any state – dropping from 17 percent in 2013 to 7.7 percent.³ In 2019, Covered California saw the effects of national policy that repealed the individual mandate penalty, with the health plans pricing for an average premium increase of nearly 9 percent in anticipation of an enrollment drop, especially among healthier consumers. Unfortunately, the health plans' concerns were indeed borne out, with new enrollment declining significantly in the 2019 Open Enrollment (dropping by 24 percent) and a premium increase averaging 8.7 percent.

The Open Enrollment period for 2020 reflected the impact of California, under the leadership of Governor Gavin Newsom and the State Legislature, enacting policies to protect and build on the ACA. The State of California provided new state subsidies to supplement the federal Advanced Premium Tax Credits (APTCs) for about 600,000 consumers as well as provide new state subsidies for tens of thousands of Californians whose incomes exceed 400 percent of the federal poverty level, making them ineligible for federal financial assistance due to the ACA's "subsidy cliff."⁴ In addition, California implemented a state tax penalty for going uninsured in response to federal action that eliminated the federal individual mandate penalty. Covered California used these new tools as it continued its practice of making large marketing and outreach investments, which were budgeted at \$121 million for the 2020 open enrollment year.⁵

In 2020 Open Enrollment results showed the impact of these policies and actions. Health plans priced their premium increases at an average level of 0.8 percent, in anticipation of an increased and healthier enrollment. The new sign-ups during Open Enrollment in Covered California did increase by 41 percent, driven by the state policies and more than offsetting the 24 percent decline in new enrollments seen in 2019, the first year that the federal penalty was zeroed out. The collective effect on Covered California is that it ended the 2020 Open Enrollment period with slightly over 1.5 million plan selections, the largest number since 2016.⁶

Coverage When You Need It: Lessons from Insurance Coverage Transitions in California’s Individual Marketplace Pre and Post the COVID-19 Pandemic

The COVID-19 Pandemic and Recession – New Need for Marketplace Coverage

The COVID-19 pandemic has introduced the first significant coverage shock for the marketplaces since they began in 2014, and is testing marketplaces in their capacity to serve as a safety net for individuals experiencing coverage disruptions.⁷ Prior to the pandemic, roughly half of adults in California relied on their employers for health coverage.⁸ But California recorded 3.1 million unemployment claims in July 2020, translating to an estimated 1.4 million workers and their dependents who may lose their ESI coverage.^{9,10,11} Similarly across the nation, estimates for loss of job-based coverage range from 17.7 to 33.0 million individuals over the course of the recession.¹²

Under the ACA, the loss of job-based coverage is a qualifying life event for a consumer to obtain coverage outside of the annual Open Enrollment period during the standard special enrollment period (SEP) that runs between the Open Enrollment periods each year. Additionally, both the Centers for Medicare and Medicaid Services (CMS) – which operates the federally-facilitated exchange (FFE) serving 38 states – and state-based exchanges that operate their own marketplaces have the authority to implement separate qualifying life events for SEP under exceptional circumstances. At the onset of the COVID-19 pandemic, California created a COVID-19 qualifying life event (as did 11 other state-based marketplaces), ensuring that all would have access to coverage options during the pandemic, including those who may have been uninsured at the onset of the pandemic. CMS has extended some SEP deadlines for those who lost job-based coverage, but has not created a new qualifying life event in response to the pandemic.¹³ Covered California created the COVID-19 qualifying life event to promote coverage as broadly as possible, complementing efforts to assure broad testing and treatment for people concerned about getting infected. Covered California also launched a major marketing campaign, which included newly developed material specific to the COVID-19 pandemic. It is important to note, that the COVID-19 qualifying life event was put in place for the Covered California marketplace, but was mirrored by regulatory action for the off-exchange individual market in California.¹⁴ In California, the non-subsidized off-exchange individual market has approximately 800,000 consumers enrolled, with the vast majority enrolling in “mirrored products” of those offered through Covered California – reflecting identical pre-subsidy prices negotiated and the same consumer-centered benefit designs.¹⁵ This report reflects only enrollment in the individual market directly through Covered California.

Dramatic Increase in New Covered California Sign-ups during 2020 Special Enrollment Period

Covered California’s total SEP plan selections in 2020 have increased dramatically compared to the same period in 2019, with over 357,000 consumers enrolling, which is more than 167,000 over the 2019 levels. Since the announcement of the COVID-19 SEP on March 20, 2020 until it concluded on August 31st, almost 290,000 consumers have signed up for coverage, more than twice the rate of new sign-ups for the same period in 2019 (see Table 1. Covered California Special Enrollment Plan Selections: 2019 and 2020).¹⁶

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Table 1. Covered California Special Enrollment Plan Selections: 2019 and 2020

Measures	2020	2019	Difference (2019 to 2020)	Percent Change
Pre-COVID SEP (Feb. 1 to March 19)	67,710	54,780	12,930	24%
Post-COVID SEP (March 20 to Aug. 31)	289,460	134,700	154,760	115%
Total (as of August 31)	357,170	189,470	167,700	89%

Source: Covered California administrative data.

Even as Covered California is experiencing a surge in new sign-ups compared to prior years, the rate of members leaving the marketplace is similar to that seen in 2019, with an average monthly disenrollment to-date of 2.9 percent in 2020 compared to 3.1 percent in 2019. The larger number of enrollments and the same general level of disenrollments has resulted in an estimated net gain of over 100,000 consumers with effectuated coverage as of June 2020 due to the pandemic and recession.

The increase in plan selections has also led to a corresponding increase in “effectuated” membership that has more than offset the level of disenrollments. Effectuated enrollment in Covered California is at its highest level ever in its six year history, with over 1,530,000 effectuated consumers with active coverage as of June 2020, based on available effectuation data. This level of enrollment is about eight percent higher than the previous enrollment high point, which was 1,420,000 as of March 2018, and over 14 percent higher than the level of effectuated enrollment for the same period in 2019 (see Figure 2. Covered California Monthly Effectuated Membership: 2018 to 2020). Additionally, the effectuation rate among new SEP sign-ups is just slightly lower than the rate seen among 2019 SEP plan selections.¹⁷

The Reasons Consumers Are Enrolling in Covered California Have Shifted Dramatically During the COVID-19 SEP Compared to Prior Periods

Results from a survey of Covered California enrollees and of those leaving during the 2020 COVID-19 SEP show that the recession has had dramatic impacts on the flows between coverage sources.¹⁸ Among the COVID-19 SEP sign-ups, far more than half (57 percent), or approximately 165,000 sign-ups, report being previously enrolled in ESI in February (see, Figure 3. Prior Source of Coverage Reported by Newly Enrolling Covered California

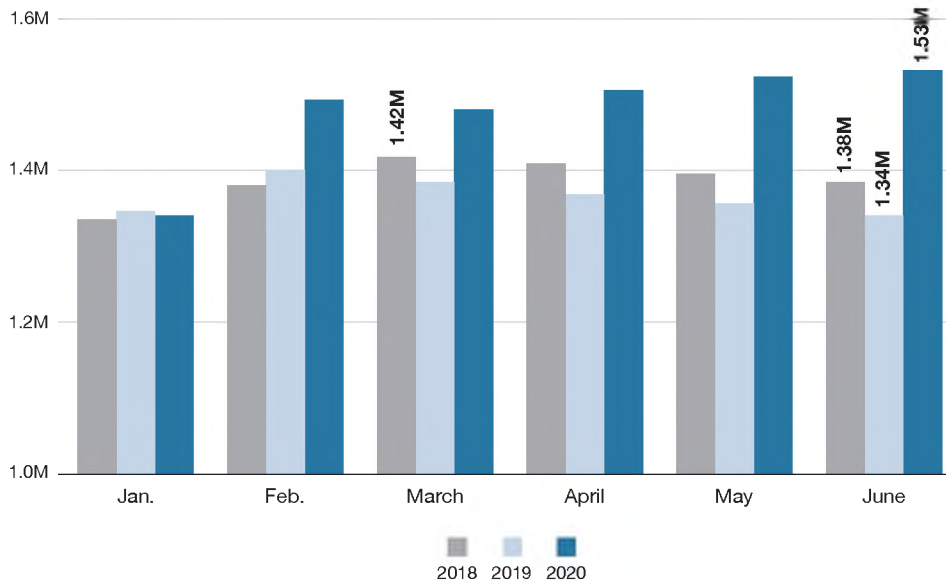
A Note About Measuring Changes in Sources of Coverage:

Measurements of movement between sources of insurance in this analysis coverage rely on self-reported survey data, which Covered California began collecting in 2015 through its member survey (now the California Health Coverage Survey), fielded annually at the end of Open Enrollment. Survey data is used as Covered California is currently unable to collect comprehensive administrative data about sources of coverage before and after enrollment. As indicated in the data from 2018 and 2019 in the Figures below, key metrics related to sources of coverage before and after marketplace coverage have stayed relatively stable since Covered California began measuring, until 2020. To better understand the 2020 pandemic response during SEP, Covered California administered a new survey (the “2020 SEP survey”). This brief presents results from that survey, and makes comparisons with the most relevant metrics from the member survey – despite the inherent limitations for some comparisons related to differences in survey administration, sampling design, and timing – because Covered California does not have equivalent survey data exist for the SEP population for years prior to 2020.

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Consumers: 2020 COVID-19 SEP Compared to 2018 and 2019). This is a far higher share compared to prior surveys of new enrollees, with 39 percent of new entrants during the 2019 Open Enrollment period reporting ESI as their main source of prior coverage.¹⁹

Figure 2. Covered California Monthly Effectuated Membership: 2018 to 2020

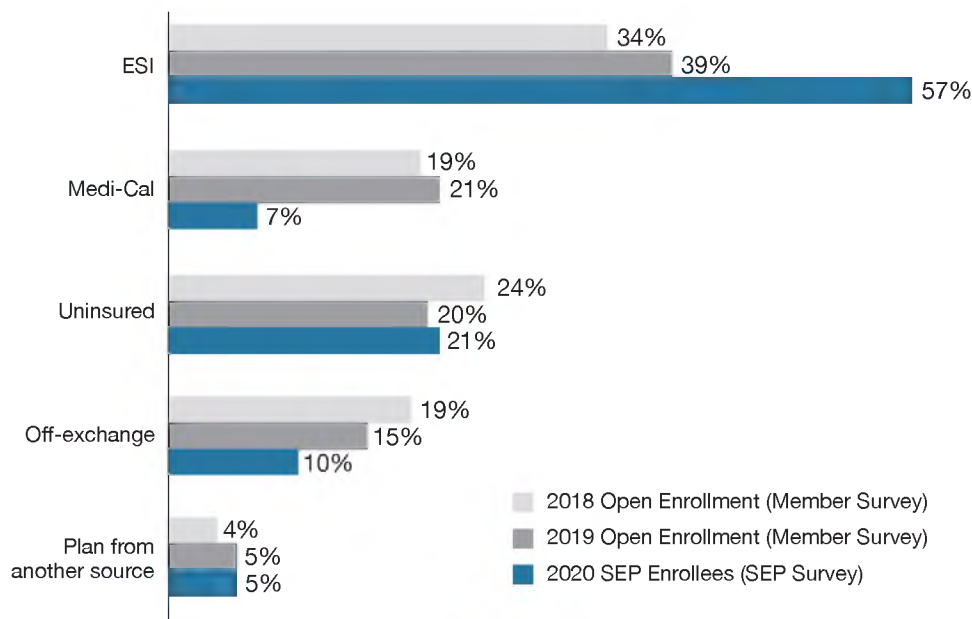


Source: Covered California administrative data.

The shift in coverage sources among new sign-ups also reflects a dramatic drop in consumers reporting Medi-Cal as their prior source of coverage; with only seven percent of new sign-ups coming from Medi-Cal in the COVID-19 SEP, this group dropped to one-third of their relative share in Open Enrollment 2019. One reason for the reduction in new sign-ups reporting Medi-Cal coverage is likely due to the halt on Medi-Cal redeterminations and discontinuances due to the public health emergency.^{20,21}

The share of new enrollees reporting being uninsured is relatively consistent with the shares of uninsured signing up for coverage during Open Enrollment. More specifically, 21 percent of those enrolling in Covered California coverage report that they were previously uninsured prior to the COVID-19 SEP, which is similar to the 20 percent of previously uninsured 2019 Open Enrollment sign-ups, when there are no exceptional circumstance requirements to be eligible to enroll.

Figure 3: Prior Source of Coverage Reported by New Covered California Consumers: 2020 COVID-19 SEP Compared to 2018 and 2019²²



2020 SEP Survey Question: “What was your main source of health coverage or insurance on February 15, 2020?” N=3,210. Member Survey Question is a combination of many questions, primarily: “What was your main source of health coverage in 2018?” Uninsured estimates reflect those who were uninsured for the entire year. N=916 in 2019, n=1298 in 2018. In both surveys, ESI share represents employer-coverage and COBRA coverage. Source: Covered California 2020 SEP Survey and California Health Coverage Survey.

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Covered California has succeeded in connecting hundreds of thousands of Californians to affordable coverage during a dramatic shock to employment-related coverage caused by the recession. This fact supports the contention that the structure of the ACA can work effectively to ensure continuity of coverage for many during times of coverage transitions.

A well-functioning marketplace is always important, but the need will be highlighted as particularly essential as the pandemic and recession continue. National survey data from The Commonwealth Fund indicate that more Americans will continue to lose their employer coverage in the months to come, as survey data indicated that more than half of adults who had ESI but were furloughed due to the recession were still covered through their job as of early June.²³ It remains unclear how long employers will continue to offer coverage to their furloughed employees, but even as the unemployment rate improves, there is likely to be continued instability and uncertainty for many who had ESI at the beginning of 2020. Further analysis of the overall rate of the uninsured will be essential to evaluate how well consumers have been able to access coverage during this pandemic.

While Covered California’s COVID-19 SEP Enrollment Mirrors Previous Diverse Enrollment, Negative Clinical Impacts of COVID-19 on Latinos and African Americans Warrant Further Study

There is compelling and deeply troubling evidence that people of color are disproportionately affected by COVID-19 – with African Americans, Latinos and some Asian-Pacific Islanders having higher infection and mortality rates.²⁴ In addition, there are data that indicate some of these same groups are likely to be overrepresented in industries most impacted by the recession.²⁵ There have not been studies that have specifically assessed the likely changes in insurance coverage by race or ethnicity. Nonetheless, Covered California aggressively invests in and implements ongoing, population-sensitive marketing and outreach programs that target minority communities and evaluate enrollment activities on a range of metrics, including the ethnic and racial mix of consumers enrolling.

Enrollment in Covered California during the COVID-19 SEP shows the distribution among race and ethnicity that is very comparable to the past two years Open Enrollment and 2019’s Special Enrollment Periods (see Table 2. Covered California Enrollment by Race/Ethnicity: Open and Special Enrollment Periods – 2019 and 2020.)²⁶

Covered California and others need to do further research on the actual insurance coverage impacts of the COVID-related economic downturns and the extent to which it and other marketplaces are getting coverage to those who need it most.

Table 2: Covered California Enrollment by Race/Ethnicity: Open and Special Enrollment Periods – 2019 and 2020

Race / Ethnicity - Share of Total Plan Selections				
	Open Enrollment		Special Enrollment (March 20 to August 31)	
	2019	2020	2019	2020
American Indian/Alaska Native	0.2%	0.2%	0.4%	0.3%
Asian	20.2%	22.4%	21.0%	20.7%
Black or African American	3.9%	3.7%	3.8%	3.9%
Latino	30.6%	32.6%	28.3%	29.9%
Multiple Races	2.7%	2.5%	2.6%	2.9%
Native Hawaiian or Pacific Islander	0.2%	0.1%	0.2%	0.2%
Other	7.8%	7.4%	8.7%	7.5%
White	34.4%	31.1%	35.1%	34.6%
Grand Total	100.0%	100.0%	100.0%	100.0%
(nonrespondent)	21.2%	19.8%	20.3%	21.5%

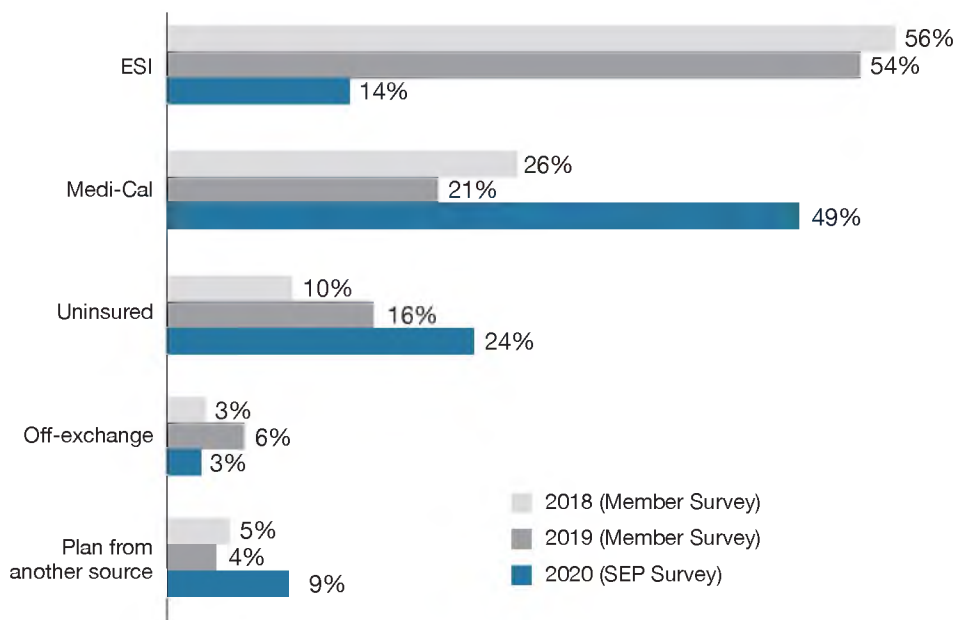
Race/Ethnicity is a roll-up dimension that combines three CalHEERS application questions on race and ethnicity, such that a consumer who reports a Latino, Hispanic, or Spanish origin is counted as "Latino" in Race/Ethnicity. All % calculations except the non-respondents calculated out of respondents only. Non-respondent % is of total population of enrollees.

Coverage When You Need It: Lessons from Insurance Coverage Transitions in California’s Individual Marketplace Pre and Post the COVID-19 Pandemic

During the COVID-Recession, Fewer Leave Covered California for Job-Based Coverage, but Transitions to Medi-Cal Increase

While the percentage of enrollees disenrolling each month has been similar to past years (about 2.9 percent of enrollees in 2020 compared to 3.1 percent in 2019), there have been important changes in where those leaving Covered California are going. Prior to the recession, by far the most common source of coverage reported after leaving the marketplace was to ESI, followed by coverage with Medi-Cal – a finding that has been (roughly) consistent in the Covered California member survey data for many years. But new survey data show that for 2020 the trends between ESI and Medi-Cal have reversed, and far more consumers are going to be uninsured (see Figure 5. Source of Coverage Reported by Consumers Leaving Covered California: 2020 COVID-19 SEP Compared to 2018 and 2019).

Figure 5: Source of Coverage Reported by Consumers Leaving Covered California: 2020 COVID-19 SEP Compared to 2018 and 2019



Member Survey data covers consumer exits from July to December while 2020 SEP survey reports exits from January to June; all exclude exits due to non-renewal. 2020 SEP Survey Question: “What is your main source of current health coverage?” N=1,040. Member Survey Question: “Do you have health coverage right now? What is your main source of health coverage right now?” N=695 in 2019, N=692 in 2018. Sources: Covered California 2020 SEP Survey & 2018 California Health Coverage Survey (“Member Survey”).

When comparing to available data from prior years in Covered California’s Member Survey, some of the major observations regarding these changes in the current recession are:

- **Far Fewer are Leaving for Job-based Coverage** – Exits to job-based coverage have dropped precipitously: only 14 percent of consumers exiting now reports receiving ESI, compared to more than half of disenrolled consumers in 2018 and 2019.
- **Large Growth in Transitions to Medi-Cal** – Exits to Medi-Cal have more than doubled as the reported source of coverage (to 49 percent), compared to the 21 percent in 2019.²⁷
- **More Consumers are Leaving Covered California to Go Uninsured** – The share of consumers reporting no insurance after leaving the marketplace appears to be increasing dramatically, with nearly one in four (24 percent) reporting they are uninsured, compared to 10 percent 2018.²⁸ This data appears to reinforce prior research that affordability of individual market coverage remains a challenge, a concern especially in the context of a global health pandemic.²⁹

Coverage When You Need It: Lessons from Insurance Coverage Transitions in California’s Individual Marketplace Pre and Post the COVID-19 Pandemic

Where consumers report going when they leave Covered California is, unfortunately, consistent with expectations for a recession. First, in a weak economy consumers are not finding jobs or the coverage that accompanies employment. Second, more Covered California consumers are seeing their incomes fall and are becoming newly eligible for Medi-Cal. And finally, even with the state-individual mandate in place in California, more consumers are finding their coverage options unaffordable and are choosing to go without any health insurance. These outcomes reinforce the importance of policies that ensure consumers have real options for affordable coverage when employment and incomes fall.

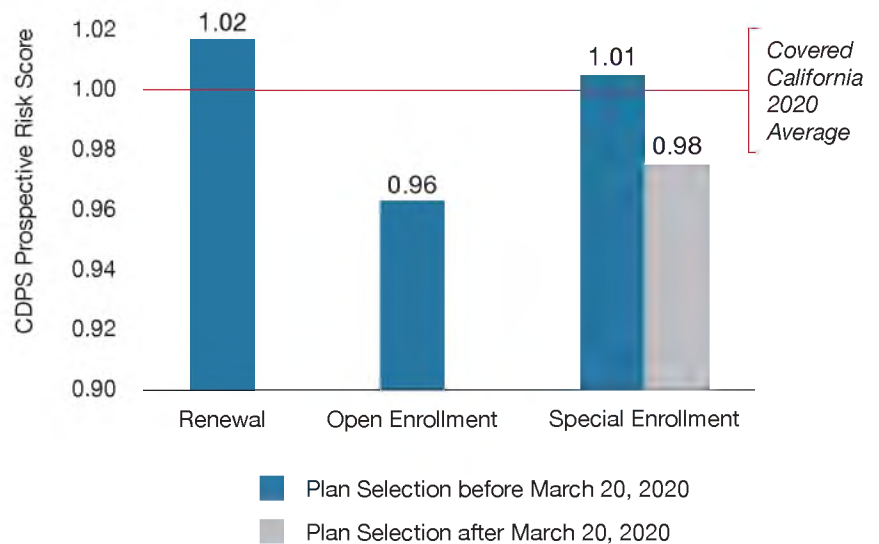
Data on Risk Profile of those Enrolling During the 2020 Open Enrollment Period and the COVID-19 Special Enrollment

One of the rationales behind restricting enrollment outside of the Open Enrollment period is to avoid the possibility of adverse selection and the associated higher costs when consumers choose to enroll only when they are sick. Covered California works closely with the 11 health plans that offer coverage through the exchange and conducts independent reviews of the health status of consumers to understand the risk profile of enrollees so that health plans can price appropriately.

Historically, California’s lower health insurance premium increases have been driven by its ability to promote broad enrollment, resulting in the state having one of the healthiest risk mixes in the nation: the health status of those enrolled in California being about 21 percent healthier than the rest of the nation in 2019.³⁰ Prior analysis has shown that this healthier risk mix has resulted in savings of approximately \$2.5 billion per year for enrollees and the U.S. Treasury, totaling \$12.5 billion from 2014 to 2018.³¹ This healthier risk mix has also helped keep premiums down for consumers; premium rates increased only 0.8 percent for the 2020 plan year.

To inform its negotiations with its contracted health plans, Covered California conducted analysis of both the 2020 Open Enrollment risk profile and the risk profile of those enrolling in SEP, both before and after the announcement of the COVID-19 SEP. While this analysis only looks at prior health experience among the enrolling individuals, it appears that the risk profile of the COVID-19 SEP sign-ups is most similar to the risk mix of the 2020 Open Enrollment cohort.³² The positive risk profile also showing that new enrollment in 2020 was six percent healthier than the overall average contributed to the cycle of maintaining low premiums for consumers – 2021 premiums increased only 0.6 percent.

Figure 6: Relative Risk Scores Among 2020 Plan Selections, by Sign-up Period



Source: Covered California analysis of OSHPD data.

Coverage When You Need It: Lessons from Insurance Coverage Transitions in California’s Individual Marketplace Pre and Post the COVID-19 Pandemic

Comparing California and Federal Marketplace Enrollment During COVID-19 Pandemic and Recession

For the 38 states using the federally-facilitated exchange (FFE), CMS has primarily relied on the existing SEP policies to meet the needs of individuals experiencing coverage transitions during the pandemic. In June, CMS released SEP enrollment data from the end of Open Enrollment through the end of May of 2020, highlighting that total SEP sign-ups are up 27 percent compared to the same period in 2019.³³

California’s 2020 SEP enrollment is double that from the prior year, a markedly larger growth than states on the FFE (see Table 3. New Enrollments During the 2020 Special Enrollment Period – Comparing The Federally-Facilitated Exchange and Covered California). There are several factors that may influence the variation in SEP sign-ups, including differences in unemployment rates and state decisions about Medicaid expansion.³⁴

Table 3: New Enrollments During the 2020 Special Enrollment Period, Comparing the Federally Facilitated Exchange and Covered California³⁵

	Federally-Facilitated Exchange	Covered California
2018	712,507	115,757
2019	704,106	108,647
<i>Percent change from the prior year</i>	-1%	-6%
2020	892,141	215,035
<i>Percent change from the prior year</i>	27%	98%

Source: CMS Special Trends Report 2020 & Covered California administrative data.

Among the factors that may be driven by the actions of the state-based or federal marketplaces and may contribute to the different enrollment experiences seen in California and the FFE are:

- The history of marketing efforts, name recognition, and enrollment infrastructure that supports enrollment and retention, both during Open Enrollment and throughout the year;
- Whether and how to a marketplace implements special and targeted outreach to spread awareness about the availability of marketplace coverage during SEP; and
- Whether a marketplace institutes a new qualifying life event to allow all consumers affected by the pandemic to enroll for coverage, even for those who would not otherwise qualify under standard qualifying life events, such as loss of coverage or moving.

For Covered California, almost four of five (79 percent) consumers who signed up for coverage during the COVID-19 SEP would have been eligible under standard qualifying life events. This means that of the 289,000 who signed up for coverage with Covered California during this period, over 228,000 would have been eligible to enroll without a “special” SEP event that opened the doors, making coverage access more equivalent to Open Enrollment eligibility standards. Given that the largest proportion of the growth in enrollment comes from already eligible individuals, Covered California believes the main driver of increased enrollment was its COVID-19 outreach, which totaled additional spending of about \$9 million during SEP. These investment included launching COVID-specific advertising content on May 04, 2020,³⁶ historic investments in marketing and name recognition,³⁷ and on-the-ground enrollment capacity – consisting of more than 500 Covered California branded storefronts

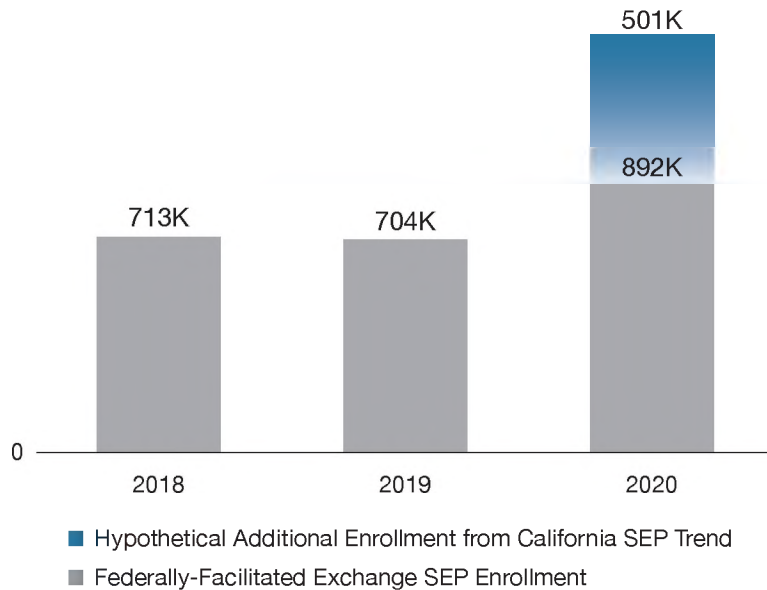
Coverage When You Need It: Lessons from Insurance Coverage Transitions in California’s Individual Marketplace Pre and Post the COVID-19 Pandemic

across that state, a network of 12,000 licensed insurance agents, and a robust paid navigator program with community organizations. This meant that consumers who lost job-based coverage during the recession knew where to go to get coverage.

The creation of a COVID-specific qualifying life event did, however, have a substantial impact in providing coverage to individuals who would likely not have been eligible, with 21 percent of new Covered California COVID-19 SEP sign-ups reported being previously uninsured (see Figure 3). Most, if not all, of these are individuals who would likely have been ineligible to enroll in marketplace coverage under federal policies. Based on the overall volume of new sign-ups with Covered California the decision to open a new qualifying life event allowed an estimated 60,000 more Californians to sign up for coverage than would have otherwise.

If the FFE states had seen the same scale of increased SEP enrollment as seen in California – driven by both historic and ongoing marketing and the COVID-19 SEP – FFE enrollment would total nearly 1.4 million during this time, an increase of 500,000 individuals (see, Figure 7. Federally Facilitated Exchange Enrollment for 2020: Actual Enrollment and Growth if Enrollment Mirrored Covered California).

**Figure 7: FFE SEP Plan Selections:
Hypothetical 2020 Enrollment using California Trends**



Source: CMS Special Trends Report 2020 & Covered California administrative data.

Coverage When You Need It: Lessons from Insurance Coverage Transitions in California’s Individual Marketplace Pre and Post the COVID-19 Pandemic

Endnotes

- ¹ Although most individual market enrollment occurs during Open Enrollment, a special enrollment period (SEP) allows individuals who experience various life events to enroll in marketplace coverage throughout the plan year. One of these life events, “loss of minimum essential coverage,” permits individuals who lose their coverage to enroll in coverage during SEP.
- ² For 2015 Covered California survey data on marketplace exits and churn, see: <https://hbex.coveredca.com/data-research/library/Active-Membership-Slides.pdf>.
- ³ American Community Survey. “Health Insurance Coverage Status and Type of Coverage by State and Age for All Persons” for 2013 and 2019. <https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.2019.html>
- ⁴ Federal premium assistance is available for individual market consumers with incomes above 100 percent and below 400 percent of the federal poverty level (FPL). Because there is no phase-out of subsidies beyond 400 percent, the abrupt cutoff for tax credits is referred to as the “subsidy cliff.” California’s new state subsidy program extends premium assistance to consumers with incomes between 400 and 600 percent of FPL.
- ⁵ Covered California. June 2019. Covered California’s Combined Annual Report to the Governor and Legislature and Annual Fiscal Year 2019-20 Budget. <https://hbex.coveredca.com/financial-reports/PDFs/2019/fv-2019-20-annual-report-final.pdf>.
- ⁶ “Plan selections” reflects both renewing and new consumers’ choice to enroll in coverage, it does not reflect payment of premium and coverage taking effect – which is often called “effectuated coverage” and in Covered California has generally been between 80 percent and 85 percent of those who enroll.
- ⁷ Banthijn J and Holahan J. August 2020. Making Sense of Competing Estimates: The COVID-19 Recession’s Effects on Health Insurance Coverage. Urban Institute. <https://www.urban.org/research/publication/making-sense-competing-estimates-covid-19-recessions-effects-health-insurance-coverage>
- ⁸ KFF. Health Insurance Coverage of Adults 19-64. <https://www.kff.org/other/state-indicator/adults-19-64/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>
- ⁹ State of California Employer Development Department. August 2020. California unemployment lowers to 13.3 percent in July. <https://edd.ca.gov/newsroom/unemployment-august-2020.htm>
- ¹⁰ Estimates are drawn from Lucia, Lee, & Jacobs 2020, adjusted for July 2020 California unemployment data. Estimates exclude partial UI claims for reduced work hours and estimates of coverage loss include adjustments for those who may have retained ESI through furloughs. Lucia L, Lee K, Jacobs K, et al. May 2020. Health coverage of California workers most at risk of job loss due to COVID-19. <https://laborcenter.berkelev.edu/pdf/2020/Health-coverage-of-California-workers-most-at-risk-of-job-loss-due-to-COVID-19.pdf>.
- ¹¹ For reference, in 2020, unemployment rates in California rose from 3.9 percent in February to more than four times that to peak at 16.4 percent in April (compared to 14.0 percent nationally). U.S. Bureau of Labor Statistics. Economic News Release: States and selected areas: Employment status of the civilian non-institutional population, January 1976 to date, seasonally adjusted. <https://www.bls.gov/web/laus.supp.toc.htm>.
- ¹² Garrett B and Gangopadhyaya A. May 2020. How the COVID-19 Recession Could Affect Health Insurance Coverage. Urban Institute. https://www.urban.org/sites/default/files/publication/102157/how-the-covid-19-recession-could-affect-health-insurance-coverage_0.pdf.
- ¹³ Centers for Medicare and Medicaid Services. Marketplace coverage & coronavirus. Healthcare.gov. <https://www.healthcare.gov/coronavirus/>.
- ¹⁴ Department of Managed Health Care. March 2020. APL 20-010 Special Enrollment Period and Coverage Effective Dates. [https://www.dmh.ca.gov/Portals/0/Docs/OPL/APL%2020-010%20Special%20Enrollment%20Period%20and%20Coverage%20Effective%20Dates%20\(3_21_20\).pdf?ver=2020-03-23-081042-343](https://www.dmh.ca.gov/Portals/0/Docs/OPL/APL%2020-010%20Special%20Enrollment%20Period%20and%20Coverage%20Effective%20Dates%20(3_21_20).pdf?ver=2020-03-23-081042-343).
- ¹⁵ Covered California analysis of Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) data on off-exchange enrollment.
- ¹⁶ These counts focus on the SEP timeframe since the announcement of the COVID SEP, but it is important to note that Covered California had launched a separate SEP prior to the COVID-19 pandemic to allow for consumers who had newly become aware of the new state mandate penalty as well as expanded financial assistance through the state subsidy program. Due to the need to adapt the CoveredCA.com application quickly, the application used the same drop-down value for each of: (1) newly becoming aware state subsidies or the penalty; (2) responding to the COVID-19 pandemic; and (3) loss of job-based coverage for several months in 2020, making it difficult to distinguish between the qualifying life events in the administrative data. Plan selection data are as of August 31, 2020.
- ¹⁷ The effectuation rate is the percentage of consumers who pick a plan that make the first month’s premium payment. The effectuation rate for consumers with a plan selection that have coverage beginning April through June is 82.4 percent, compared to 84.3 percent in 2019.

Coverage When You Need It: Lessons from Insurance Coverage Transitions in California's Individual Marketplace Pre and Post the COVID-19 Pandemic

Endnotes (continued)

- ¹⁸ To shed light on how many people benefited from the policy, as well as broader employment and income changes among its membership, Covered California fielded a survey in early July 2020 ("2020 SEP survey") to understand the impacts of COVID-19 on its consumers. The survey was administered online with an email invitation to a representative sample of Covered California consumers, stratified by three distinct consumer groups: (1) individuals who had enrolled or renewed during the 2020 Open Enrollment period; (2) individuals who had signed up for coverage during SEP before Covered California instituted its COVID SEP on March 20th; and (3) individuals who signed up for coverage after Covered California instituted its COVID SEP on March 20th.
- ¹⁹ The California Health Coverage Survey ("Member Survey") is an annual probability-based representative survey conducted by NORC at the University of Chicago for Covered California immediately following Open Enrollment.
- ²⁰ One reason for the reduction in new sign-ups reporting Medi-Cal coverage is likely due to the March 16, 2020 instruction from the Department of Health Care Services for counties to delay the processing of annual redeterminations and delay discontinuances and negative actions for Medi-Cal due to the public health emergency. Department of Health Care Services. March 2020. Medi-Cal Eligibility Division Information Letter No.: I 20-07. Access to Care During Public Health Crisis or Disaster for Medi-Cal. <https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I20-07.pdf>.
- ²¹ Note that the survey question asks consumers to recall their source of coverage in February, and Covered California's prior survey cognitive testing indicates that consumers may not perfectly recall the exact timeframe of recent coverage. As a result, it is possible that some consumers reported Medi-Cal when surveyed about coverage in February, but were actually uninsured prior to enrolling in Covered California.
- ²² Note about Figures in this report using 2019 and 2020 survey data: due to the unique nature of the pandemic and the need to get a survey into the field quickly, the 2020 SEP survey differed from the Member Survey in timing, sample design, and data collection, which should be taken into consideration when comparing the results from each survey.
- ²³ Collins SR, Gunja MZ, Aboulafia GN, et al. June 2020. An Early Look at the Potential Implications of the COVID-19 Pandemic for Health Insurance Coverage. The Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2020/jun/implications-covid-19-pandemic-health-insurance-survey>
- ²⁴ Rubin-Miller L, Alban C, Artiga S, et al. September 2020. COVID-19 Racial Disparities in Testing, Infection, Hospitalization, and Death: Analysis of Epic Patient Data. KFF. <https://www.kff.org/report-section/covid-19-racial-disparities-in-testing-infection-hospitalization-and-death-analysis-of-epic-patient-data-issue-brief/>
- ²⁵ Thomason S, Rhee N, & Bernhardt A. April 2020. Industries at Direct Risk of Job Loss from COVID-19 in California: A Profile of Front-Line Job and Worker Characteristics. UC Berkeley Labor Center. <https://laborcenter.berkeley.edu/industries-at-direct-risk-of-job-loss-from-covid-19-in-california/>
- ²⁶ Covered California. 2020 Special Enrollment Plan Selection Profile. https://hbex.coveredca.com/data-research/librarv/cc_special_enrollment_plan_selection_profile_2020.xlsx.
- ²⁷ Administrative data also support the survey findings showing a roughly two-fold increase in transitions of consumers exiting from Covered California to Medi-Cal.
- ²⁸ We compared to 2018 data on uninsured terminations here because it was the last year of available data when the federal penalty was in effect.
- ²⁹ Gunja MZ and Collins SR. August 2019. Who Are the Remaining Uninsured, and Why Do They Lack Coverage? The Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/who-are-remaining-uninsured-and-why-do-they-lack-coverage>
- ³⁰ Covered California analysis of 2019 risk adjustment data from CCIIO. See "Appendix A to 2019 Benefit Year Risk Adjustment Summary Report – HHS Risk Adjustment Program State-Specific Data." <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs>.
- ³¹ Covered California. December 2019. Covered California's First Five Years: Improving Access, Affordability, and Accountability. https://hbex.coveredca.com/data-research/librarv/CoveredCA_First_Five_Years_Dec2019.pdf.
- ³² Risk scores derived using the Chronic Illness & Disability Payment System. For more on the CDPS see: Kronick R, Gilmer T, Dreyfus T, and Lee L. 2000. "Improving Health-Based Payment for Medicaid Beneficiaries: CDPS." Health Care Financing Review 21(3): 29-64. For more on Covered California's 2021 premium rates, see: <https://www.coveredca.com/newsroom/news-releases/2020/08/04/californias-efforts-to-build-on-the-affordable-care-act-lead-to-a-record-low-rate-change-for-the-second-consecutive-year/>.
- ³³ Centers for Medicare and Medicaid Services. June 2020. Special Trends Report: Enrollment Data and Coverage Options for Consumers During the COVID-19 Public Health Emergency. <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SEP-Report-June-2020.pdf>
- ³⁴ For example, California's unemployment rate has been higher than FFE states, suggesting California might have experienced greater churn during the pandemic due to that factor. Yet many of the largest FFE states did not expand Medicaid under the ACA, which should have led to even more marketplace enrollment among those experiencing loss of employer coverage in those states.

Coverage When You Need It: Lessons from Insurance Coverage Transitions in California's Individual Marketplace Pre and Post the COVID-19 Pandemic

Endnotes (continued)

- ³⁵ Data for 2018 and 2019 include Nevada, which utilized the FFE platform for those years. In 2020, Nevada launched its own state-based exchange and thus are excluded from 2020 SEP FFE reporting. CMS did not release state-level SEP plan selection data, and thus the change from 2019 to 2020 may be slightly understated without the ability to exclude Nevada from this assessment.
- ³⁶ See Covered California May 21, 2020 Board Meeting materials, Slide 8: Lee P. May 2020. Executive Director's Report. Covered California. <https://board.coveredca.com/meetings/2020/May%202020%20Meeting/PPT.ED%20Report.May%202020.5-21.12.30.NEW%20PHONE%20NUMBER.pdf> See <https://www.coveredca.com/newsroom/news-releases/2020/05/04/covered-california-launches-new-ad-campaign-that-focuses-on-the-covid-19-pandemic-and-encourages-the-uninsured-to-sign-up-for-coverage/>.
- ³⁷ During the 2020 Open Enrollment period, Covered California made large marketing investments, as it has done each enrollment period. For 2020 those investments were about \$110 million and included outreach and marketing activities in the first months of the Special Enrollment Period before the COVID SEP, which were designed to raise awareness for a separate special Qualifying Life Event that allowed individuals to enroll in coverage if they recently learned of the reinstatement of the state mandate penalty or new state subsidies that expanded the opportunity of subsidized coverage to many consumers.

About Covered California

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

PUBLICATION </publications>

How Many in Your Area Are Covered by the Affordable Care Act?

2020 Update

SEPTEMBER 24, 2020

Katherine Wilson, Wilson Analytics

SHARE

DOWNLOADS

As Californians continue to live through the COVID-19 pandemic, access to health care is top of mind for many. Below is a reminder of the Affordable Care Act's role in providing health care coverage to Californians, which is especially important during the pandemic. Explore the table below to see how many people in your local area are

covered and protected under the ACA. (A printable PDF of the text and data on this page is available under Document Downloads, along with the raw data in an excel file.)

What Has Been the Impact of the Affordable Care Act in California?

The Affordable Care Act (ACA), which was fully implemented in 2014, increased Californians' access to health coverage. Under the ACA, California established Covered California, a health insurance marketplace where those who don't get coverage through their jobs and don't qualify for public health insurance can purchase coverage. Eighty five percent of Covered California consumers receive a federal subsidy to help them afford coverage.¹ The ACA allowed California to expand its Medicaid program, called Medi-Cal, to more adults with low incomes. The ACA also included vital protections for all consumers, including barring health insurers from denying coverage based on preexisting conditions. As a result:

- California's uninsured rate has fallen from 17% to 7.1%. The number of uninsured Californians has dropped by 3.7 million.²
- 1.5 million Californians get their coverage through Covered California.³
- 12.5 million Californians are covered by Medi-Cal, including 3.7 million adults through the ACA expansion.⁴
- As the uninsured rate has fallen across all groups, racial disparities in coverage have declined.⁵
- 16.8 million nonelderly Californians who have preexisting conditions are protected from being rejected by a health insurer.⁶

California has built on the ACA to further expand access to health coverage, implementing additional subsidies to help more people afford coverage on Covered California. The state has also further expanded Medi-Cal to all children and young adults with low incomes regardless of immigration status.

ACA Coverage During the COVID-19 Pandemic

As the state confronts the COVID-19 pandemic, and the ensuing economic recession, the ACA is providing a vital safety net. Many Californians losing their jobs and job-based health insurance can turn to either Covered California or Medi-Cal to stay covered, options that would not have been there before the ACA.

In addition, it is estimated that Medi-Cal is covering close to a million of the workers Californians are relying on so heavily during the pandemic.⁷ This includes Californians with jobs like home health aides, grocery store workers, farm workers, warehouse workers, and more. Many low-income workers in these jobs are not offered job-based coverage or can't afford the premiums for it.

The ACA Is Still Under Threat

The Trump Administration continues, even during the COVID-19 pandemic, to pursue a federal lawsuit to invalidate the entire ACA. If successful, the lawsuit could end all consumer protections and all forms of health care coverage currently provided under the law. It is estimated that 20 million Americans could lose health coverage, including 3.8 million Californians.⁸

How Many Are Covered by the ACA in Your Area?

Below see how many in your local congressional district get their coverage through Medi-Cal or Covered California, or benefit from the ACA's protections for those with preexisting conditions.

Notes

1. *Active Member Profiles* <<https://hbex.coveredca.com/data-research/>> (March 2020), Covered California, June 8, 2020.
2. SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files, SHADAC, accessed August 27, 2020. This drop in the uninsured rate occurred between 2013 and 2018, the latest data available at the time of publication.

3. *Active Member Profiles* <<https://hbex.coveredca.com/data-research/>> (March 2020), Covered California, June 8, 2020.
4. *Medi-Cal Certified Eligibles Data Table by County and Aid Code Group: June 2020* (Dates Represented: March 2020) (PDF) <<https://www.dhcs.ca.gov/dataandstats/statistics/documents/county-and-4-group-table-mar2020.pdf>>, California Dept. of Health Care Services, July 2020.
5. Tara Becker and Ninez A. Ponce, *Californians Maintain Health Insurance Coverage Despite National Trends*, UCLA Center for Health Policy Research, October 2019. (Report examines 2018 data from the California Health Interview Survey.)
6. Emily Gee, “Number of Americans with Preexisting Conditions by District for the 116th Congress” <<https://www.americanprogress.org/issues/healthcare/news/2019/10/02/475030/number-americans-preexisting-conditions-district-116th-congress/>>,” Center for American Progress, October 2, 2019. (Data derived from 2017 American Community Survey.)
7. Matt Broaddus, “5 Million Essential and Front-Line Workers Get Health Coverage Through Medicaid” <<https://www.cbpp.org/blog/5-million-essential-and-front-line-workers-get-health-coverage-through-medicaid>>,” Center on Budget and Policy Priorities, August 4, 2020.
8. Jessica Banthin et al., *Implications of the Fifth Circuit Court Decision in Texas v. United States: Losses of Coverage, Federal Health Spending, and Provider Revenue* (PDF) <https://www.urban.org/sites/default/files/publication/101361/implications_of_the_fifth_circuit_court_decision_in_texas_v_united_states_final_121919_v2.pdf>, Urban Institute, December 2019.

Document Downloads

How Many in Your Area Are Covered by the Affordable Care Act? (PDF)

<<https://www.chcf.org/wp-content/uploads/2020/09/howmanyyourareaarecoveredaca.pdf>>

How Many in Your Area Are Covered by the Affordable Care Act? (ZIP)

<<https://www.chcf.org/wp-content/uploads/2020/09/howmanyyourareaarecoveredaca.zip>>

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November 2020

PRIVATE HEALTH INSURANCE

Markets Remained Concentrated through 2018, with Increases in the Individual and Small Group Markets

GAO Highlights

Highlights of [GAO-21-34](#), a report to congressional committees

Why GAO Did This Study

GAO previously reported that, from 2011 through 2016, enrollment in the individual, small group, and large group health insurance markets was concentrated among a few issuers in most states (GAO-19-306). GAO considered states' markets or exchanges to be highly concentrated if three or fewer issuers held at least 80 percent of the market share. GAO also found similar concentration on the health insurance exchanges established in 2014 by PPACA. A highly concentrated health insurance market may indicate less issuer competition and could affect consumers' choice of issuers and the premiums they pay for coverage.

PPACA included a provision for GAO to periodically study market concentration. This report describes changes in the concentration of enrollment among issuers in the overall individual, small group, and large group markets; and individual market federally facilitated exchanges.

GAO determined market share in the overall markets using enrollment data from 2017 and 2018 that issuers are required to report annually to the Centers for Medicare & Medicaid Services (CMS). GAO determined market share in the individual market federally facilitated exchanges in 2018 using enrollment data from CMS. For all analyses, GAO used the latest data available.

View [GAO-21-34](#). For more information, contact John Dicken at (202) 512-7114 or dickenj@gao.gov.

NOVEMBER 2020

PRIVATE HEALTH INSURANCE

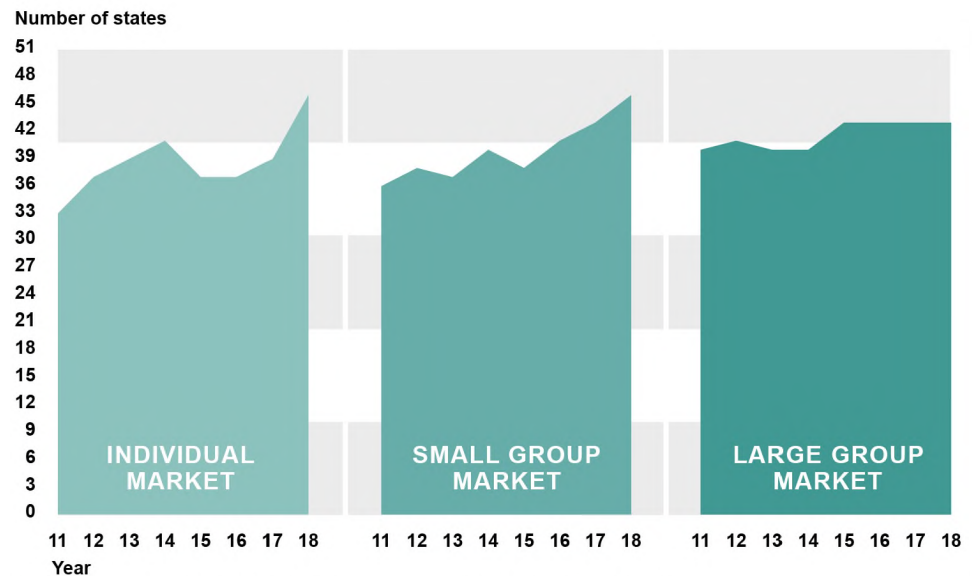
Markets Remained Concentrated through 2018, with Increases in the Individual and Small Group Markets

What GAO Found

Enrollment in private health insurance plans in the individual (coverage sold directly to individuals), small group (coverage offered by small employers), and large group (coverage offered by large employers) markets has historically been highly concentrated among a small number of issuers. GAO found that this pattern continued in 2017 and 2018. For example:

- For each market in 2018, at least 43 states (including the District of Columbia) were highly concentrated.
- Overall individual and small group markets have become more concentrated in recent years. The national median market share of the top three issuers increased by approximately 8 and 5 percentage points, respectively, from 2015 through 2018. With these increases, the median concentration was at least 94 percent in both markets in 2018.

Number of States and District of Columbia Where the Three Largest Issuers Had at Least 80 Percent of Enrollment, by Market, 2011-2018



Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

GAO found similar patterns of high concentration across the 39 states in 2018 that used federal infrastructure to operate individual market exchanges—marketplaces where consumers can compare and select among insurance plans sold by participating issuers—established in 2014 by the Patient Protection and Affordable Care Act (PPACA) and known as federally facilitated exchanges. From 2015 through 2018, states that were already highly concentrated became even more concentrated, often because the number of issuers decreased or the existing issuers accrued the entirety of the market share within a state. In 2017 and 2018 all 39 states were highly concentrated.

GAO received technical comments on a draft of this report from the Department of Health and Human Services and incorporated them as appropriate.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
HHS	Department of Health and Human Services
PPACA	Patient Protection and Affordable Care Act

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November 13, 2020

Congressional Committees

The market for private health insurance in the United States has historically been highly concentrated, meaning that a majority of people with coverage in a given market are enrolled with a small number of issuers.¹ Over a series of reports, we have found that each of the three types of insurance markets—the large group market (coverage offered by large employers), the small group market (coverage offered by small employers), and the individual market (consisting mainly of coverage sold directly to individual consumers who lack access to group coverage)—is highly concentrated.² Specifically, we found that in each of the three types of markets the three largest issuers held at least 80 percent of the market share in most states from 2010 through 2016.³ In addition, we reported similar patterns in concentration in the individual and small group health insurance exchanges—operated by either the state or the federal government (known as a federally facilitated exchange)—that were required to be established in 2014 in each state by the Patient Protection

¹We use the term “issuer” when referring to the entities that are licensed by a state to engage in the business of health insurance in that specific state.

²Federal law defines a small employer as having an average of 1 to 50 employees during the preceding calendar year; however, states may apply this definition based on an average of 1 to 100 employees. See 42 U.S.C. §§ 300gg-91(e)(4), 18024(b)(2).

³See GAO, *Private Health Insurance: Concentration of Enrollees among Individual, Small Group, and Large Group Insurers from 2010 through 2013*, [GAO-15-101R](#) (Washington, D.C.: Dec. 1, 2014); *Private Health Insurance: In Most States and New Exchanges Enrollees Continued to be Concentrated among Few Issuers in 2014*, [GAO-16-724](#) (Washington, D.C.: Sept. 6, 2016); and *Private Health Insurance: Enrollment Remains Concentrated among Few Issuers, including in Exchanges*, [GAO-19-306](#) (Washington, D.C.: Mar. 21, 2019).

and Affordable Care Act (PPACA).⁴ Highly concentrated insurance markets may indicate less competition and could affect consumers' choice of issuers and the premiums they pay.

PPACA included a provision for us to conduct a study on competition and concentration in health insurance markets.⁵ This report describes changes in the concentration of enrollment among issuers in each state's

1. individual health insurance market, as well as in its individual market exchange (for the 39 states with federally facilitated exchanges in 2018);
2. small group health insurance market; and
3. large group health insurance market.

To describe changes in concentration in the individual, small group, and large group markets in each state, we analyzed 2017 and 2018 Medical Loss Ratio data that PPACA requires issuers to report annually to the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS).⁶ Data for 2018 were the most recently available data at the time of our analysis. We previously used this same data source to analyze concentration from 2011 through 2016; where applicable, we present this information alongside our updated analyses in

⁴ Pub. L. No. 111-148, § 1321, 124 Stat. 119, 186 (2010) ("PPACA"). Health insurance exchanges are markets that operate within each state's overall individual and small group market where eligible individuals and small employers can compare and select among qualified insurance plans offered by participating issuers. States may establish separate individual and small group exchanges or a single exchange to serve both individuals and small groups. States may choose to operate their own exchanges, or this responsibility can be carried out by the federal government; who has this responsibility can change over time. States that operate their own exchanges can use a federally facilitated exchange for certain functions, such as enrollment. For this report, states that use federal infrastructure (i.e., Healthcare.gov) to operate their exchanges, even if the states retain plan management functions, are classified as "federally facilitated exchanges."

⁵PPACA, § 1322(i), 124 Stat. at 192. PPACA directs us to report to Congress biennially beginning in 2014. See [GAO-15-101R](#), [GAO-16-724](#), and [GAO-19-306](#) for our prior work in response to this mandate.

⁶PPACA required that all issuers report Medical Loss Ratio data to CMS, which include the percent of premiums the issuers spent on their enrollees' medical claims and quality initiatives, known as their medical loss ratio. These data also include enrollment data that can be used to calculate the market share for fully insured health plans. We did not examine self-funded health plans, where small and large employers set aside funds to pay for employee health care rather than pay premiums to an issuer to do so. The data include state-level enrollment data and are publicly available on the CMS website.

this report.⁷ Within the individual, small group, and large group markets in each of the 51 states, we determined the state-level market share for each issuer by calculating the ratio of the total number of covered life-years for each issuer in a state to the total number of covered life-years in that state.⁸

To analyze changes in concentration in the individual market exchanges, we obtained data from CMS on enrollment in the 39 states that used a federally facilitated exchange in 2018, the most recent data available at the time of our analyses.⁹ For these states, CMS provided us with data from its data warehouse, the Multidimensional Insurance Data Analytics System, for each enrollee who obtained health insurance coverage through federally facilitated exchanges for 2018. (We previously used this same data source to analyze concentration from 2015 through 2017; where applicable, we present this information alongside our updated analyses in this report.)¹⁰ These data included, among other information, the enrollees' coverage start and end dates, the issuers from which the

⁷[GAO-16-724](#); [GAO-19-306](#).

⁸In this report, we use "state" to refer to the 50 states and the District of Columbia. One way to measure beneficiary enrollment is by calculating covered life-years, which measure the average number of lives insured, including dependents, during the reporting year. Rather than a point-in-time measurement, this measure accounts for changes in enrollment that occur throughout the year.

⁹While 2019 MIDAS enrollment data was available prior to issuance of our report, it was not available in time for us to integrate it into our analysis. States can set up exchanges for the small group market, but we chose to not include an analyses of small group exchanges in this report because officials from CMS told us that enrollment data for the small group exchanges was not comprehensive for 2018. Additionally, we have previously reported that enrollment in the small group exchanges was low—typically less than 1 percent of the overall small group market. For more information about concentration in small group exchanges, see [GAO-19-306](#).

¹⁰We previously reported on concentration across both federally facilitated and state-based exchanges, which involved combining this data source with data collected by states. This report focuses exclusively on the states with federally facilitated exchanges; as a result, any analyses of prior years' data with all states will be updated for this report to include only trends among the 39 states with federally facilitated exchanges in 2018. One state, Kentucky, had a state-based exchange in 2015 and 2016, but a federally facilitated exchange in 2017 and 2018. We previously collected data from Kentucky on its state-based exchange enrollment in 2015 and 2016, which we present alongside federal data from 2017 and 2018 in this report. Trends may be different in the remaining 11 states using state-based exchanges, and we have previously reported higher levels of issuer participation in large state-based exchanges such as in California, New York, and Massachusetts. For more information about concentration in state-based exchanges from 2015 through 2017, see [GAO-19-306](#).

enrollees purchased coverage, and the states and rating areas—geographic areas established by states and used, in part, by issuers to set premium rates—in which the enrollees lived. We used these data to calculate the total number of issuers that participated in each state and rating area, as well as each issuer’s market share—measured using covered life-years—within the state and each rating area. To account for the fact that market concentration can vary across rating areas within a state, we weighted each of these estimates by the number of covered life-years held by each issuer in each rating area.¹¹

We analyzed enrollment data from all of our sources as they were reported by issuers to CMS. We did not otherwise independently verify the accuracy or completeness of the information with the issuers. We assessed the reliability of the data in several ways, including reviewing relevant data manuals and other documentation and performing electronic tests of the data to identify any outliers or anomalies. We determined that the data were sufficiently reliable for the purposes of our reporting objectives.

Throughout this report, we counted issuers as participating in a market only if they both offered coverage in a market and had enrollment in that market. We also aggregated all issuers together that shared the same parent company, which we analyzed as a single issuer; if there was no parent company, we analyzed the data by the individual issuers.¹² We calculated the three-firm concentration ratio—the combined shares of covered life-years for the three largest issuers in that market—and the market share of the single largest issuer in that market. We considered states’ markets or exchanges to be highly concentrated if three or fewer issuers held at least 80 percent of the market share. Finally, while states may have multiple local markets with differing concentrations of enrollees among health issuers, the data we used to measure concentration were generally limited to enrollment at the state level, with the exception of our

¹¹For example, to obtain the average market share of the largest issuer in a state’s rating areas, we calculated the market share of the largest issuer in each rating area in the state and then calculated the average of those market shares, weighted by the number of covered life-years in each rating area.

¹²Specifically, we considered issuers to have the same parent company if in their Medical Loss Ratio data they reported having the same National Association of Insurance Commissioners holding group identifier, the same National Association of Insurance Commissioners company identifier, or the same Health Insurance Oversight System company identifier.

individual exchange enrollment data—thus precluding our ability to measure concentration within local markets except for the individual market exchanges.¹³ For all other markets, we present state-wide issuer market share, although issuers may not have all participated across the entire state.

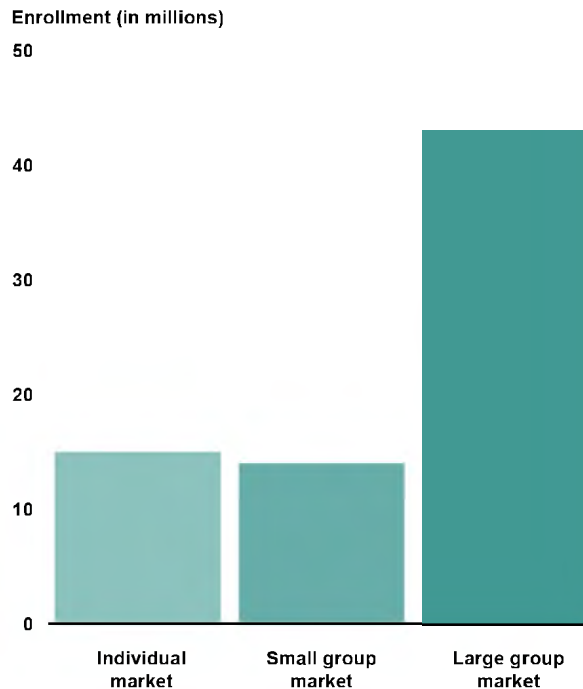
We conducted this performance audit from December 2019 through November 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Private health insurance is the most common form of health insurance coverage in the United States, covering over two-thirds of the insured population in 2018, according to the U.S. Census Bureau. The majority of privately insured individuals are covered through group plans, either small group (for small employers) or large group (for large employers). See figure 1 below for total covered life-years reported by issuers to CMS in the individual and fully insured small and large group markets.

¹³ While the primary data sources we used in our analysis were available at the state level, we reviewed another recent analysis of concentration and found that, in 38 states, the largest issuer in the state overall was also the largest issuer in at least three-quarters of the local markets studied in that state. That analysis used 2018 data on enrollment in fully and self-insured plans by metropolitan statistical areas, which include a county or counties associated with a city or urbanized area that has a population of at least 50,000. See American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2019 Update* (Chicago, IL: 2019).

Figure 1: Covered Life-Years Reported by Issuers to CMS in the Individual, Small Group, and Large Group Health Insurance Markets, 2018



Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

Note: We calculated the size of each market using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year. This is one of several ways to measure health insurance enrollment, so it may differ from other measures of market size. Small and large employers may offer fully insured group plans (by purchasing coverage from an issuer) or self-funded group plans (by setting aside funds to pay for employee health care). Most small employers purchase fully insured plans, while most large employers self-fund at least some of their employee health benefits. For the small group and large group markets, enrollment data is from fully insured plans only.

Small and large employers may offer fully insured group plans (by purchasing coverage from an issuer) or self-funded group plans (by setting aside funds to pay for employee health care). Most small employers purchase fully insured plans, while most large employers self-fund at least some of their employee health benefits.¹⁴ Americans without access to group health coverage, such as those with employers that do

¹⁴Approximately 61 percent of covered workers were in a self-funded plan in 2018, with covered workers in larger firms more likely to be enrolled in a self-funded plan; see Kaiser Family Foundation, *2018 Employer Health Benefits Survey* (San Francisco, CA: October 3, 2018). As previously mentioned, the data sources used in this report do not contain information on self-funded group plans. As a result, they are not included in our analyses.

not offer health coverage, may choose to purchase it directly from an issuer or through an exchange as part of the individual market.

Several factors can affect concentration in health insurance markets.¹⁵ High concentration levels have often been the result of consolidation—mergers and acquisitions—among existing issuers. However, concentration can also increase if existing issuers leave the market, thereby reducing the number of issuers from which enrollees can purchase coverage. In addition, concentration can persist because of the difficulty for new issuers to enter the market. For example, new issuers that do not yet have large numbers of enrollees may have greater challenges negotiating discounts with health care providers, which may encourage issuers to consolidate in order to attain enough enrollees to gain bargaining power.¹⁶

¹⁵In 2009, we conducted a structured literature review that examined the factors that can influence concentration of private health insurance markets. See GAO, *Private Health Insurance: Research on Competition in the Insurance Industry*, [GAO-09-864R](#) (Washington, D.C.: July 31, 2009).

¹⁶PPACA contains provisions that may affect market concentration and competition among health issuers, both in the overall market and in the health insurance exchanges initially established in 2014 within each state's individual and small group markets. For example, PPACA required that issuers offer coverage to all individuals regardless of health status, and it limited the ability of issuers to deny coverage or charge higher premiums to individuals and small groups based on health risks or certain other factors.

For additional discussion about industry consolidation, see Leemore S. Dafny, "Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience," *Commonwealth Fund Issue Brief* (New York, NY: Commonwealth Fund, 2015).

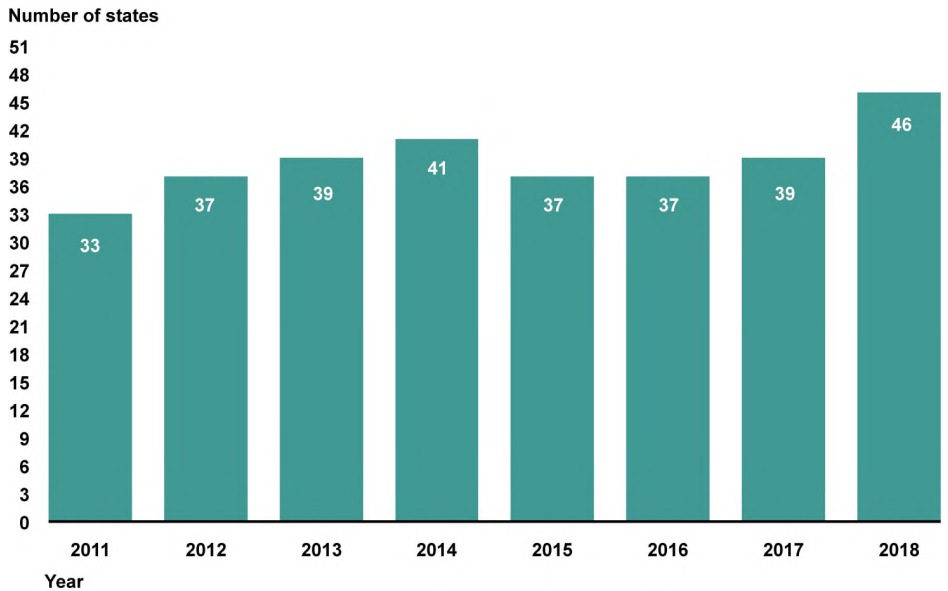
The Individual Health Insurance Market, Including Federally Facilitated Exchanges, Became More Concentrated in Recent Years

The Individual Health Insurance Market Generally Became More Concentrated over Time, with a Larger Increase in 2018

Enrollment in states' individual health insurance markets generally became more concentrated from 2011 through 2018. Despite a temporary decline in the number of states highly concentrated among three or fewer issuers from 2014 through 2016, the number of highly concentrated states increased from 33 states in 2011 to 46 states in 2018. (See fig. 2.) Also, since 2011, the median number of issuers per state decreased from 30 to 12. (See table 1.)¹⁷ We also found that a single issuer held at least 50 percent market share in 31 states in 2018, even in states which still had many issuers participating in the market. For example, although Florida had 17 issuers in 2018, a single issuer, Blue Cross and Blue Shield of Florida, Inc., held around 68 percent of the market share.

¹⁷See appendix I for additional data on the individual market from 2011 through 2018.

Figure 2: Number of States Where the Market Share of the Three Largest Issuers in the Individual Market Was at Least 80 Percent, 2011 through 2018



Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

Note: This figure includes the 50 states and the District of Columbia. All states had more than three issuers in their individual markets during this time period. Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. We calculated market share using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year.

While concentration generally increased from 2011 through 2018, there was a notable decrease in concentration from 2014 through 2016. Specifically, in 2015 and 2016, the total number of states where the market share of the three largest issuers was at least 80 percent—our measure of high concentration—returned to levels previously seen in 2012. However, other measures during this period suggested that aspects of the individual market were continuing to become more concentrated (as shown in table 1). For example, from 2014 through 2016, the median number of issuers decreased and the median market share of the top three issuers increased.

Table 1: Trends in Issuer Participation and Concentration in the Individual Market, 2011 through 2018

Year	Median number of issuers per state	Median market share of three largest issuers (%)	Number of states where single issuer holds at least 50 percent market share
2011	30	85	30
2012	26	87	29
2013	25	88	31
2014	21	88	33
2015	19	90	31
2016	15	90	28
2017	14	96	28
2018	12	98	31

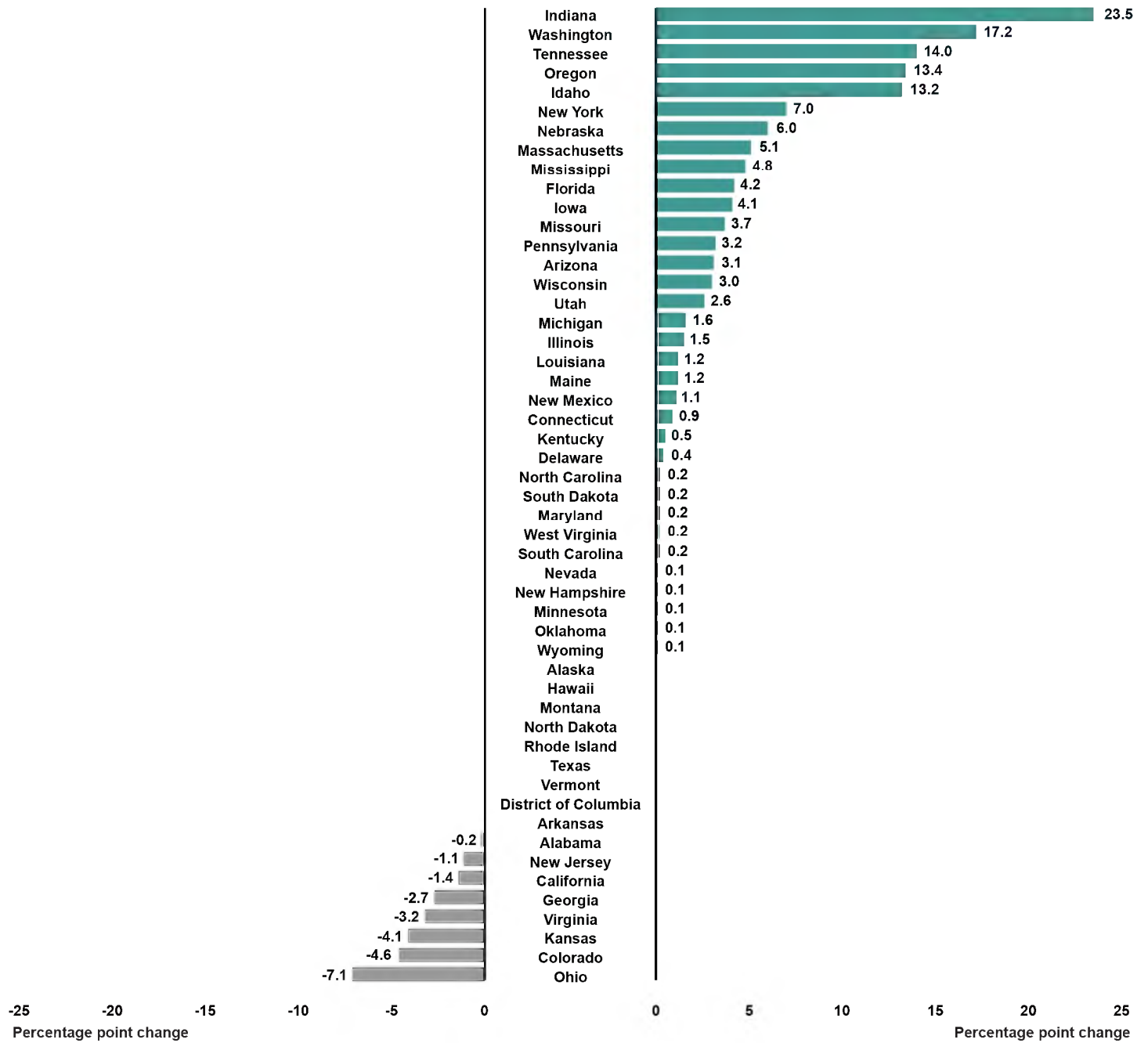
Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

Note: This table includes the 50 states and the District of Columbia. All states had more than three issuers in their individual markets during this time period. Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. We calculated market share using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year.

From 2017 through 2018, 34 states experienced increases in concentration among the three largest issuers; nine states remained consistent during this period; and eight states experienced decreases from the prior year. (See fig. 3.)

- Of the 34 states with increases, eight had increases of 5 or more percentage points, with a median increase of 2 percentage points. For example, in Indiana, the state with the largest percentage point increase from 2017 to 2018, two issuers exited the individual market, contributing to more concentration among remaining issuers.
- Of the eight states with decreases, one had a decrease of 5 or more percentage points, with a median decrease of 3 percentage points.

Figure 3: Percentage Point Change in Market Share Held by the Three Largest Issuers in the Individual Market from 2017 through 2018, by State



Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

Note: This figure includes the 50 states and the District of Columbia. All states had more than three issuers in their individual markets during this time period. Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. We calculated market share using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year.

All Federally Facilitated Individual Market Exchanges Were Highly Concentrated in Both 2017 and 2018, an Increase from Prior Years

The 39 states using the federally facilitated individual market exchanges became more concentrated from 2015 through 2018, with all states being highly concentrated in 2017 and 2018.¹⁸ From 2015 through 2018, states that already had the top three issuers holding at least 80 percent market share became even more concentrated, often either because the number of issuers decreased—such that the state only has three or fewer issuers that hold 100 percent of the market share by default—or the existing issuers accrued the entirety of the market share within a state.¹⁹ For example, the number of states with three or fewer issuers increased from 13 states in 2015 to 32 states in 2018. (See fig. 4.)

Exchange Enrollment Increased as a Proportion of the Overall Individual Market in Federally Facilitated Exchange States from 2015 through 2018

In addition to finding that federally facilitated exchange markets were highly concentrated, we also found that exchange enrollment became a larger proportion of overall individual market enrollment in federally facilitated exchange states from 2015 through 2018. Specifically, we found that exchange enrollment accounted for approximately

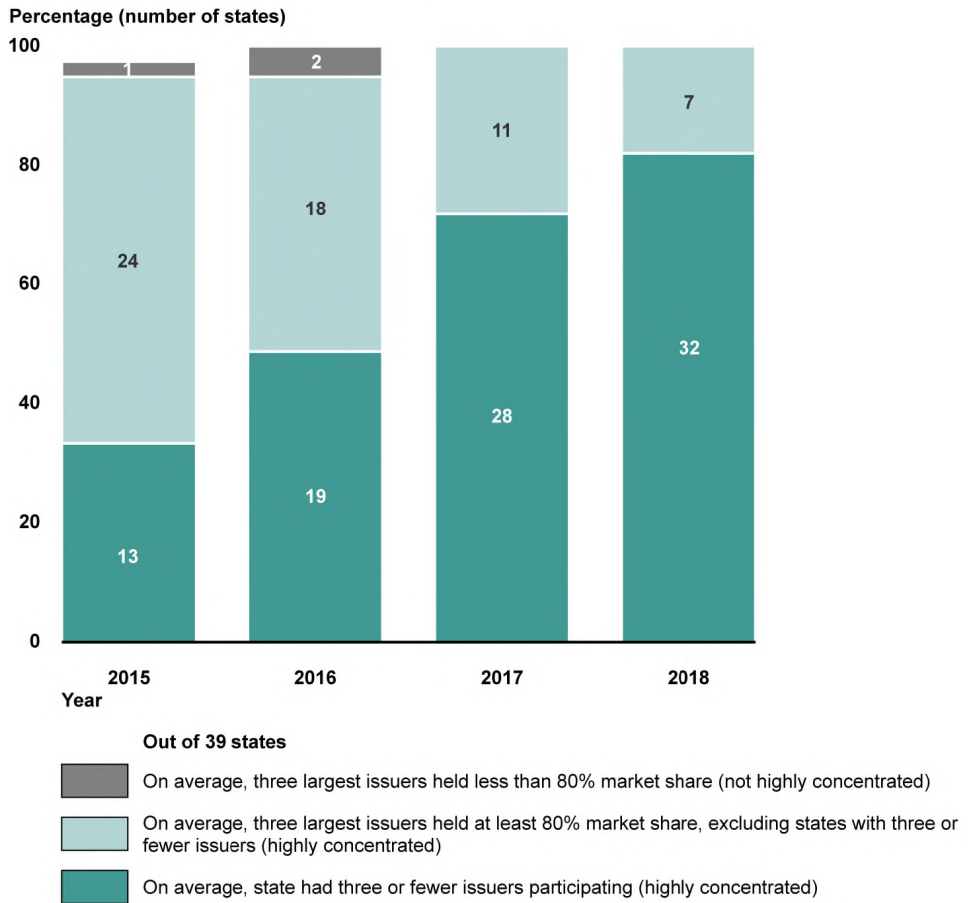
- 54% of the overall individual market in 2015;
- 62% of the overall individual market in 2016;
- 65% of the overall individual market in 2017; and
- 72% of the overall individual market in 2018.

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services | GAO-21-34

¹⁸ We present statistics by state in appendix II.

¹⁹ Twelve states were not included in our review of the individual exchanges because they used state-based exchanges in 2018 (California, Colorado, Connecticut, District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, Washington). Because we are only reporting on federally facilitated exchanges in this report, we excluded these twelve states from our analysis of 2015 through 2018 data presented in appendix III. Data on federally facilitated and state-based exchange concentration from 2015 through 2017 are presented in [GAO-19-306](#).

Figure 4: Extent to Which the Three Largest Individual Market Exchange Issuers Had at Least 80 Percent Market Share, on Average, in 39 States' Rating Areas, 2015 through 2018



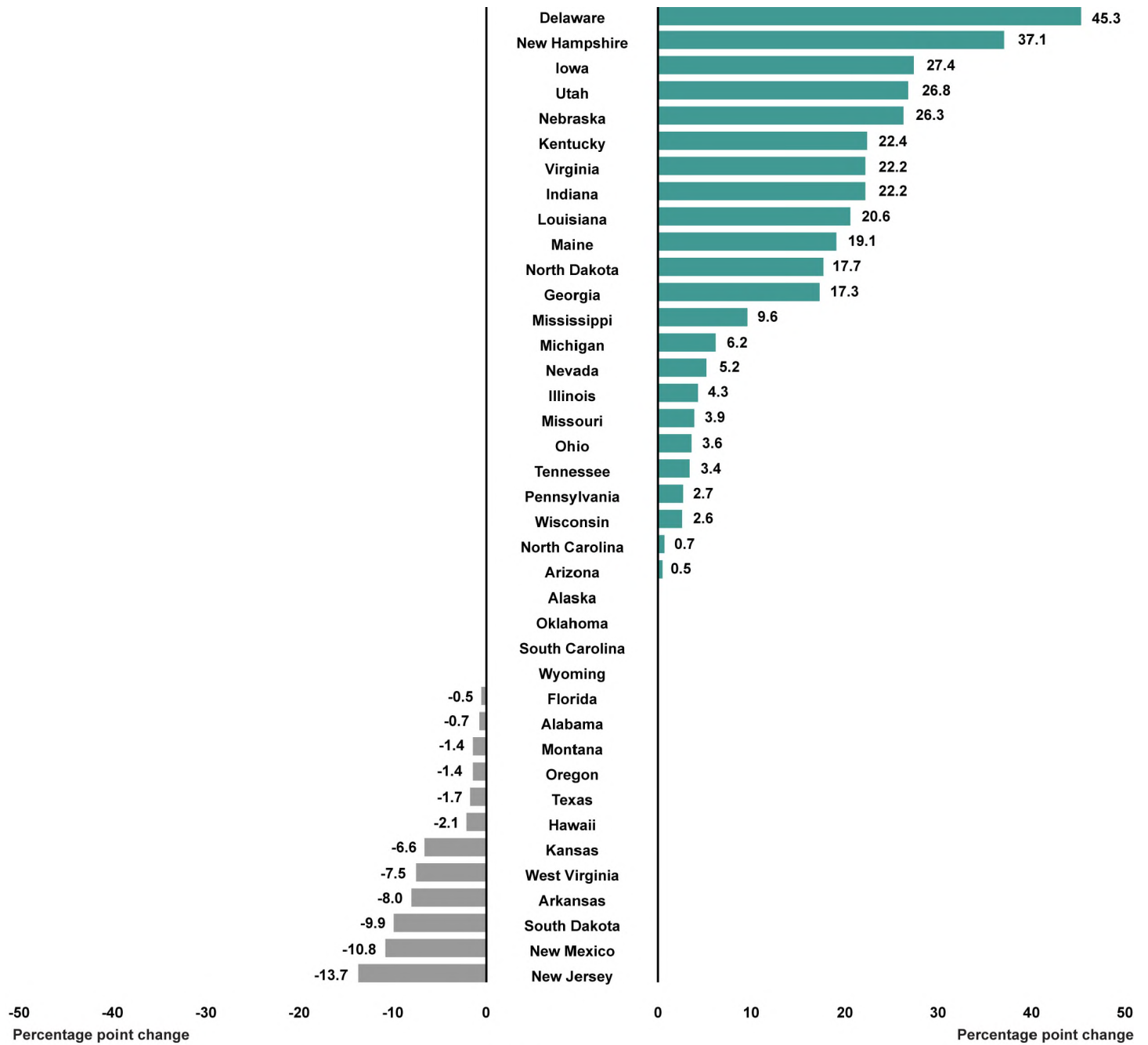
Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

Notes: We defined “highly concentrated” as three or fewer issuers holding at least 80 percent of the market share. Twelve states were not included in this figure because they used state-based exchanges in 2018 (California, Colorado, Connecticut, District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, Washington). Additionally, Hawaii is not included in this figure for 2015 because we were unable to obtain data for that year. The remaining 38 states, including the District of Columbia, are included in 2015, and Hawaii is included for later years. One state, Kentucky, had a state-based exchange in 2015 and 2016 but a federally facilitated exchange in 2017 and 2018. We previously collected data from Kentucky on its state-based exchange enrollment in 2015 and 2016, which we present alongside federal data from 2017 and 2018 in this report. Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. We calculated market share using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year. Market share in this figure refers to the average market share of the three largest issuers across a state’s rating areas—geographic areas established by states and used, in part, by issuers to set premium rates—weighted by the number of covered life-years in each rating area. Issuer counts in this figure reflect the number of issuers, on average, across a state’s rating areas, weighted by the number of covered life-years in each rating area.

We also found that many states' individual market exchanges experienced large increases in the extent of concentration from 2017 through 2018. (See fig. 5.)

- Concentration increased in 23 out of the 39 states, with a median increase of 17 percentage points. In 15 of these 23 states, concentration increased 5 or more percentage points. For example, Delaware, the state with the largest percentage point increase, went from two issuers in 2017 to one issuer participating in 2018.
- The 12 states with decreases had a median decrease of 4 percentage points, and six had decreases of 5 or more percentage points.

Figure 5: Percentage Point Change in Average Market Share of the Largest Individual Market Exchange Issuer across Rating Areas from 2017 through 2018, by State



Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

Notes: Twelve states were not included in this figure because they used state-based exchanges in 2018 (California, Colorado, Connecticut, District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, New York, Rhode Island, Vermont, Washington). Additionally, Hawaii is not included in this figure for 2015 because we were unable to obtain data for that year. The remaining 38 states, including the District of Columbia, are included, and Hawaii is included for later years. Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. We calculated issuers' market share using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year. Market share refers to the average market share of the largest issuer across a state's rating areas—geographic areas established by states and used, in part, by issuers to set premium rates—weighted by the number of covered life-years in each rating area. In some cases, the identity of the largest issuer varied across rating areas in a state, and changed over time.

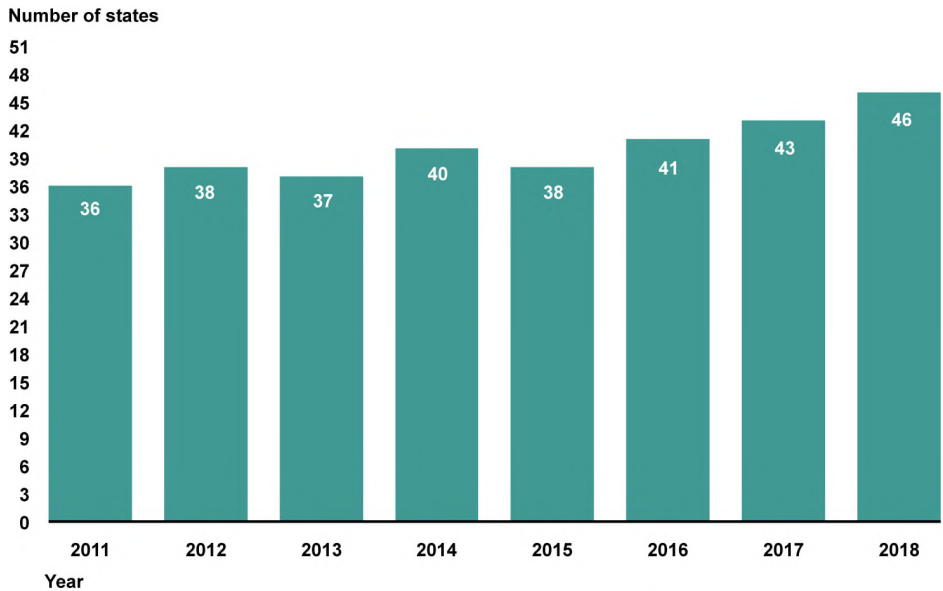
Concentration in Small Group Health Insurance Markets Increased from 2015 through 2018

Enrollment in states' small group health insurance markets generally became more concentrated from 2011 through 2018, but the pattern became more pronounced after 2015.²⁰ From 2011 through 2018, the median number of issuers per state decreased from 13 to 5, and the number of states with high concentration increased from 36 states to 46 states. (See fig. 6.) We also found that a single issuer held at least 50 percent market share in 33 states in 2018, even in states that still had many issuers participating in the market. For example, although Michigan had 13 issuers in 2018, a single issuer, Blue Cross Blue Shield of Michigan, held around 63 percent of the market share.²¹

²⁰See [GAO-19-306](#)

²¹See appendix IV for additional data on the small group market from 2011 through 2018.

Figure 6: Number of States Where the Market Share of the Three Largest Issuers in the Small Group Market Was at Least 80 Percent, 2011 through 2018



Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

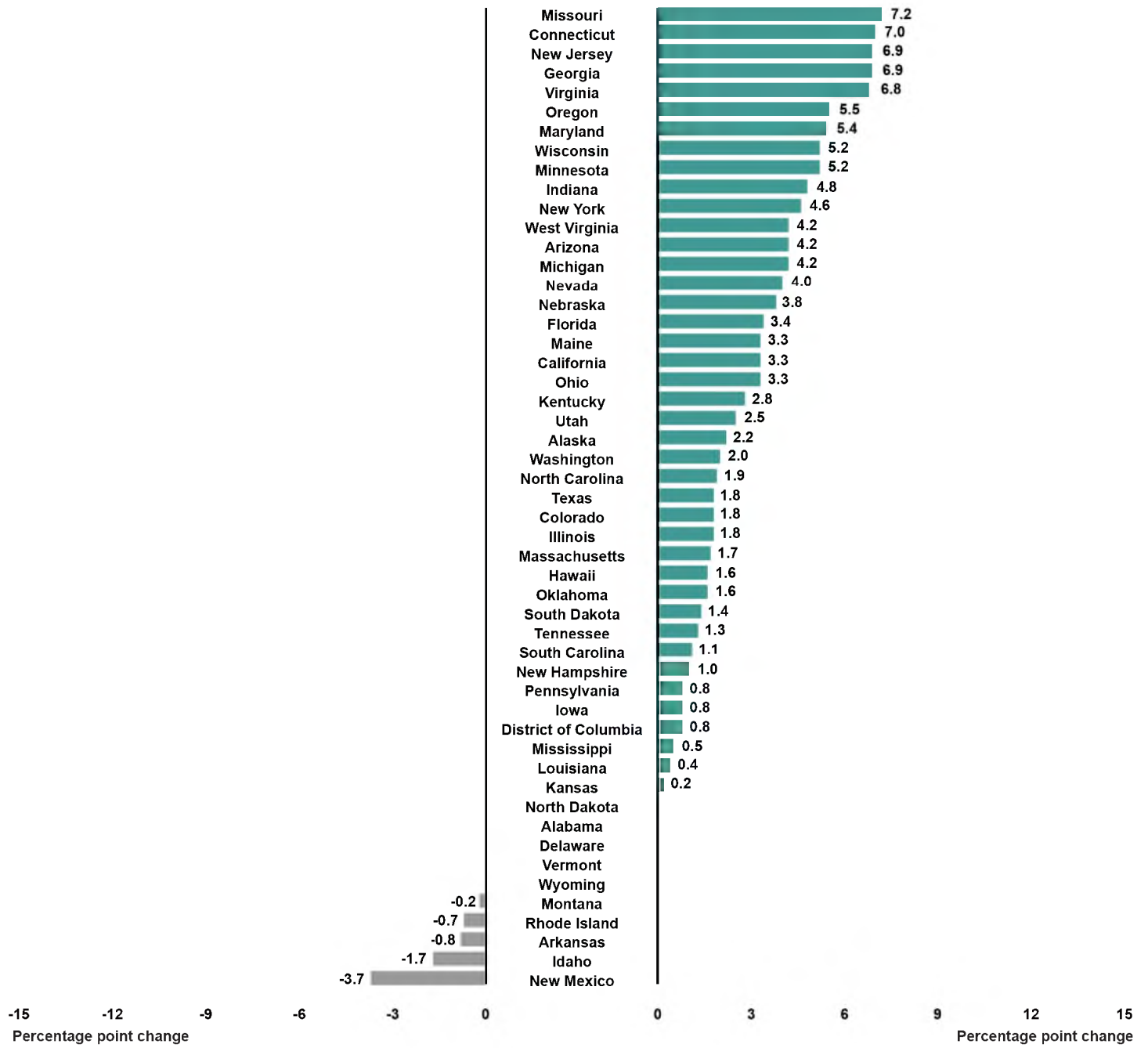
Note: This figure includes the 50 states and the District of Columbia. A number of states had exactly three participating issuers in at least 1 year—Rhode Island in 2013, Delaware from 2016 through 2018, Vermont from 2012 through 2016, Wyoming in 2017, Alabama in 2018, Mississippi in 2018, Nebraska in 2018, and South Carolina in 2018. Therefore, these three issuers held 100 percent of the market share in those years. Two states had less than three participating issuers in at least 1 year – Vermont in 2017 and 2018 and Wyoming in 2018. Small and large employers may offer fully insured group plans (by purchasing coverage from an issuer) or self-funded group plans (by setting aside funds to pay for employee health care). Most small employers purchase fully insured plans, while most large employers self-fund at least some of their employee health benefits. For the small group and large group markets, enrollment data are from fully insured plans only. Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. We calculated market share using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year.

While concentration fluctuated from 2011 through 2014, the market has seen steady increases in concentration each year from 2015 through 2018. From 2015 through 2018, the median number of issuers decreased from nine per state to five per state, and the median market share of the top three issuers has increased by 5 percentage points, from approximately 89 percent to approximately 94 percent. Additionally, a single issuer held at least 80 percent market share in 11 states in 2018, an increase from six in 2015.

From 2017 through 2018, most states also experienced increases in the extent of concentration. (See fig. 7.) Specifically, 41 states experienced increases in concentration among the three largest issuers, five states

remained consistent, and five experienced decreases from the prior year. Of the 41 states with increases from 2017 through 2018, nine had increases of 5 or more percentage points, with a median increase of 3 percentage points. No states had decreases of 5 or more percentage points, with a median decrease of 1 percentage point.

Figure 7: Percentage Point Change in Market Share Held by the Three Largest Issuers in the Small Group Market from 2017 through 2018, by State



Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

Note: Five states had exactly three participating issuers in at least 1 year—Wyoming in 2017, Alabama in 2018, Mississippi in 2018, Nebraska in 2018, and South Carolina in 2018. Therefore, these three issuers held 100 percent of the market share in those years. Two states had less than three participating issuers in at least 1 year—Vermont in 2017 and 2018 and Wyoming in 2018. Therefore, these issuers held 100 percent of the market share in those years. All other states had more than three issuers during this time period. Small and large employers may offer fully insured group plans (by purchasing coverage from an issuer) or self-funded group plans (by setting aside funds to pay for employee health care). Most small employers purchase fully insured plans, while most large employers self-fund at least some of their employee health benefits. For the small group and large group markets, enrollment data are from fully insured plans only. Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. We calculated market share using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year. In some cases, the identity of the largest three issuers changed over time.

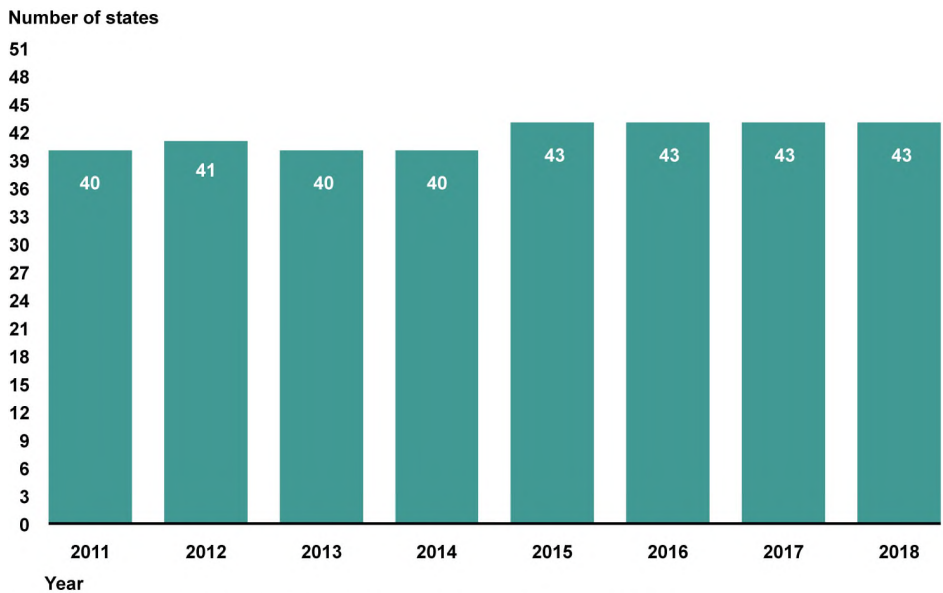
Concentration in Large Group Health Insurance Markets Remained Generally Steady from 2011 through 2018

Concentration in states' large group health insurance markets remained generally steady from 2011 through 2018. The median number of issuers per state decreased from 12 issuers in 2011 to nine issuers in 2018, while the number of states with high concentration increased from 40 states in 2011 to 43 states in 2015 through 2018. (See fig. 8.)²²

- In 2018, a single issuer held at least 80 percent market share in eight states, an increase from seven states in 2015. A single issuer held at least 90 percent of the market share in four states, an increase from two states in 2015.
- We also found that a single issuer held at least 50 percent of the market share in 34 states in 2018, even in states that still had many issuers participating in the market. For example, although Iowa had 13 issuers in 2018, a single issuer, Wellmark Group, held around 79 percent of the market share.

²²See appendix V for additional data on the large group market for 2011 through 2018.

Figure 8: Number of States in Which the Three Largest Issuers in the Large Group Market Held at Least 80 Percent Market Share, 2011 through 2018

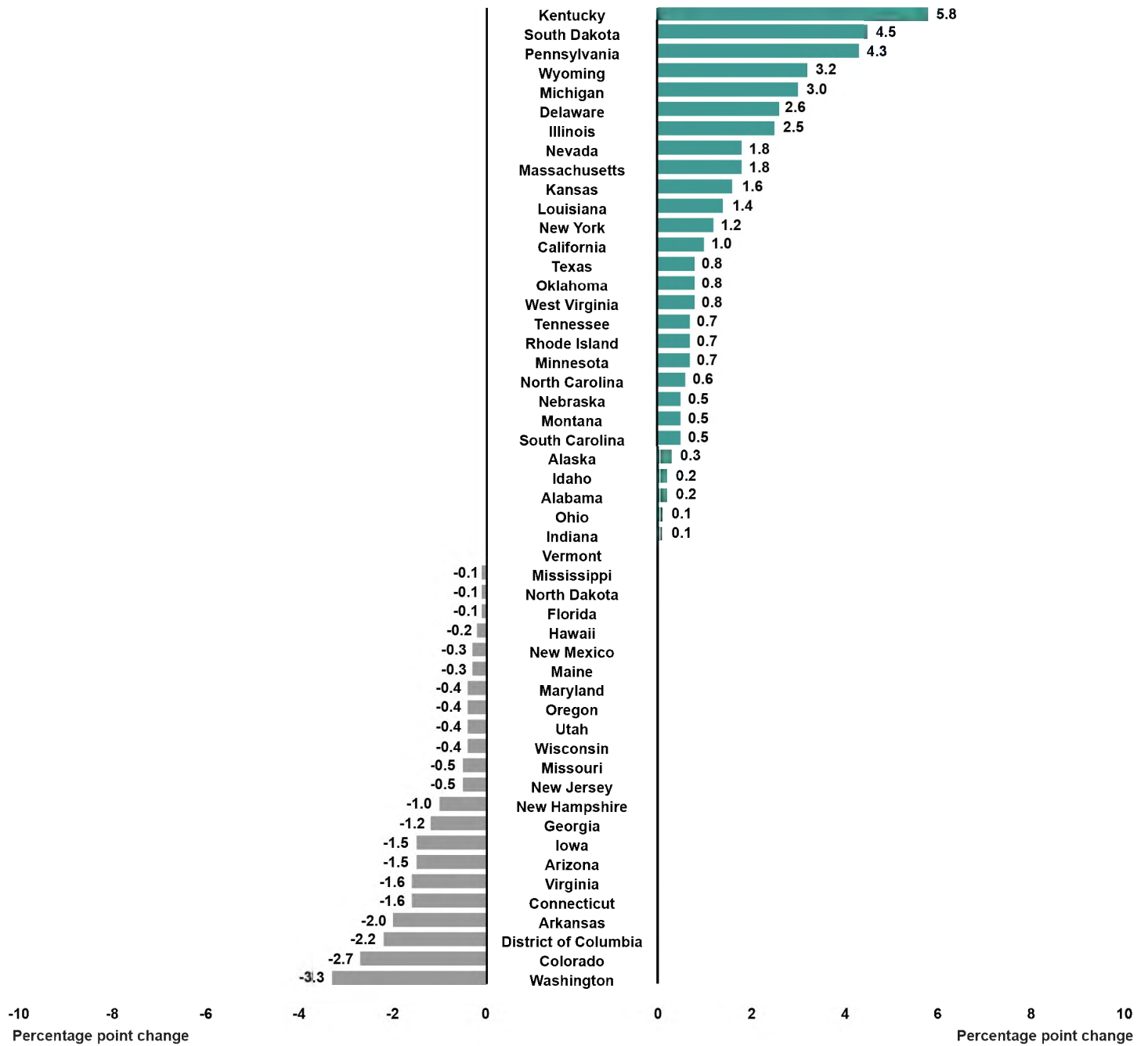


Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

Notes: This figure includes the 50 states and the District of Columbia. Vermont had exactly three participating issuers in 2012, 2015, 2016, 2017, and 2018. Therefore, the three largest issuers were the only three issuers and held 100 percent of the market share in those years. All other states had more than three issuers in each year. Small and large employers may offer fully insured group plans (by purchasing coverage from an issuer) or self-funded group plans (by setting aside funds to pay for employee health care). Most small employers purchase fully insured plans, while most large employers self-fund at least some of their employee health benefits. For the small group and large group markets, enrollment data are from fully insured plans only. Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. We calculated market share using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year.

While the large group market remained generally unchanged in recent years, many states experienced fluctuations in the extent of concentration from 2017 through 2018. Specifically, 28 states experienced increases in concentration among the three largest issuers, one state remained consistent, and 22 experienced decreases from the prior year. (See fig. 9.) Of the 28 states with increases, one had an increase of 5 or more percentage points, with a median increase of 1 percentage point. Of the 22 states with decreases, none had a decrease of 5 or more percentage points, with a median decrease of less than 1 percentage point.

Figure 9: Percentage Point Change in Market Share Held by the Three Largest Issuers in the Large Group Market from 2017 through 2018, by State



Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

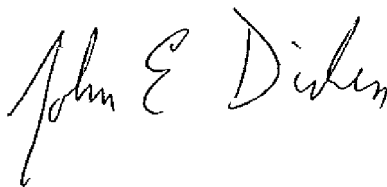
Notes: This figure includes the 50 states and the District of Columbia. Vermont had exactly three participating issuers in 2017 and 2018. Therefore, the three largest issuers were the only three issuers and held 100 percent of the market share in each year. All other states had more than three issuers in each year. Small and large employers may offer fully insured group plans (by purchasing coverage from an issuer) or self-funded group plans (by setting aside funds to pay for employee health care). Most small employers purchase fully insured plans, while most large employers self-fund at least some of their employee health benefits. For the small group and large group markets, enrollment data are from fully insured plans only. Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. We calculated market share using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year. In some cases, the identity of the largest three issuers changed over time.

Agency Comments

We provided a draft of this report to HHS for review and comment. The department provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the appropriate Congressional committees, the Secretary of Health and Human Services, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix VI.



John E. Dicken
Director, Health Care

List of Committees

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House of Representatives

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The Honorable Kevin Brady
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Committee on Ways and Means
House of Representatives

Appendix I: Number and Market Share of Largest Issuers Participating in Each State's Individual Market

The two tables below present information on a) the number of participating issuers in each state's individual health insurance market from 2011 through 2018 and b) the market share of the largest and three largest issuers from 2015 through 2018.

Table 2: Number of Issuers in Each State's Individual Health Insurance Market, 2011 through 2018

State	Number of issuers							
	2011	2012	2013	2014	2015	2016	2017	2018
Alabama	27	22	23	17	16	11	10	10
Alaska	13	13	14	12	10	7	5	5
Arizona	30	26	24	27	23	17	15	11
Arkansas	32	26	24	21	19	16	14	14
California	45	34	30	33	31	27	27	23
Colorado	35	29	25	26	24	19	17	15
Connecticut	26	20	19	17	15	11	9	8
Delaware	20	17	16	14	13	10	8	7
District of Columbia	18	18	18	16	13	10	8	7
Florida	40	33	31	28	30	22	20	17
Georgia	38	32	31	29	25	18	17	15
Hawaii	14	15	12	10	9	7	6	4
Idaho	23	22	19	18	17	14	11	10
Illinois	42	37	34	30	25	21	18	16
Indiana	37	30	28	23	23	19	14	11
Iowa	33	27	25	21	19	14	12	9
Kansas	35	30	28	24	20	15	15	13
Kentucky	27	22	23	21	21	17	15	14
Louisiana	34	26	26	24	22	16	15	14
Maine	20	18	18	15	12	9	8	6
Maryland	27	24	23	19	18	15	13	10
Massachusetts	31	29	28	25	25	20	19	16
Michigan	41	33	33	31	29	22	18	14
Minnesota	36	29	26	25	25	18	15	13
Mississippi	30	25	22	21	18	14	14	12
Missouri	37	31	31	25	23	18	18	15
Montana	25	22	21	20	16	13	11	8
Nebraska	31	28	26	25	19	16	13	11
Nevada	24	20	21	19	19	15	12	10
New Hampshire	20	17	15	13	14	9	7	6

**Appendix I: Number and Market Share of
Largest Issuers Participating in Each State's
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State	Number of issuers							
	2011	2012	2013	2014	2015	2016	2017	2018
New Jersey	24	24	20	19	19	16	14	12
New Mexico	28	24	22	18	18	14	13	11
New York	38	32	28	32	33	27	27	23
North Carolina	31	26	25	22	18	15	14	12
North Dakota	21	20	19	13	12	10	7	8
Ohio	43	36	34	32	29	24	20	19
Oklahoma	30	26	25	23	21	16	15	12
Oregon	31	28	25	29	25	21	17	13
Pennsylvania	38	34	36	33	31	24	22	22
Rhode Island	14	12	13	11	9	7	7	6
South Carolina	31	24	22	20	17	15	13	10
South Dakota	30	26	25	17	14	11	9	9
Tennessee	33	29	26	23	20	15	14	13
Texas	50	40	36	38	37	32	30	25
Utah	24	19	19	19	17	14	13	11
Vermont	16	14	12	10	6	5	5	5
Virginia	32	29	29	29	26	21	21	16
Washington	30	27	25	24	23	19	16	14
West Virginia	27	25	24	19	18	15	12	11
Wisconsin	42	38	35	35	31	24	23	18
Wyoming	25	23	21	16	14	11	9	7

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

Note: Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level.

**Appendix I: Number and Market Share of
Largest Issuers Participating in Each State's
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Table 3: Market Share of the Single Largest and Three Largest Issuers in Each State's Individual Health Insurance Market, 2015 through 2018

State	Largest issuer name	Market share of the largest single issuer (%)				Market share of the largest three issuers (%)			
		2015	2016	2017	2018	2015	2016	2017	2018
Alabama	BCBS OF AL GRP	85.7	76.4	97.6	97.3	99.3	99.6	99.9	99.7
Alaska	OREGON DENTAL GRP	48.5	54.1	—	—	98.0	99.7	99.9	100.0
	PREMERA BLUE CROSS GROUP	—	—	99.3	99.3				
Arizona	BLUE CROSS AND BLUE SHIELD OF ARIZONA, INC.	42.2	42.0	—	—	74.8	80.1	95.8	99.0
	CENTENE CORP GRP	—	—	43.8	49.5				
Arkansas	ARKANSAS BCBS GRP	73.6	68.1	63.6	63.3	93.5	89.9	93.5	93.5
California	BLUE SHIELD OF CALIFORNIA GROUP	—	—	30.0	36.9	82.3	85.3	81.5	80.1
	WELLPOINT INC GRP	30.9	30.3	—	—				
Colorado	COLORADO HEALTH INSURANCE COOPERATIVE, INC.	23.1	—	—	—	63.5	79.9	87.8	83.2
	KAISER FOUNDATION GRP	—	35.6	41.1	41.0				
Connecticut	HIP INS GRP	45.1	53.6	61.4	67.7	86.6	92.1	98.4	99.3
Delaware	HIGHMARK GRP	88.7	89.2	62.2	99.1	98.5	99.5	99.5	99.9
District of Columbia	CAREFIRST INC GRP	80.8	86.3	84.6	81.7	96.5	98.9	99.5	99.4
Florida	BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.	33.6	43.6	60.1	68.5	65.9	69.3	88.8	93.0
Georgia	CENTENE CORP GRP	—	—	—	47.4	83.5	72.3	91.3	88.6
	WELLPOINT INC GRP	—	—	55.5	—				
	HUMANA GRP	46.3	31.5	—	—				
Hawaii	HAWAII MEDICAL SERVICE ASSOCIATION	57.1	60.4	58.7	58.8	99.8	99.9	99.9	99.9
Idaho	BLUE CROSS OF IDAHO HEALTH SERVICE, INC.	60.0	49.4	34.7	50.5	89.1	86.0	78.6	91.8
Illinois	HCSC GRP	80.6	65.6	73.0	76.8	89.5	83.0	89.7	91.1
Indiana	CARESOURCE MANAGEMENT GROUP	—	—	—	46.3	74.9	68.3	72.5	96.1
	WELLPOINT INC GRP	43.9	33.3	28.2	—				
Iowa	WELLMARK GROUP	68.5	66.5	63.5	58.7	97.6	98.8	95.6	99.7
Kansas	BCBS OF KS GRP	41.9	56.0	61.2	67.2	93.7	89.7	97.0	92.9
Kentucky	WELLPOINT INC GRP	52.5	76.3	77.9	55.7	94.3	92.0	99.3	99.8
Louisiana	LOUISIANA HLTH SERV GRP	64.6	60.8	76.1	91.8	86.1	91.0	98.4	99.6
Maine	MAINE COMMUNITY HEALTH OPTIONS	70.8	61.8	40.1	58.6	99.0	99.1	98.6	99.8

**Appendix I: Number and Market Share of
Largest Issuers Participating in Each State's
Individual Market**

Maryland	CAREFIRST INC GRP	86.0	77.2	76.5	66.1	97.3	95.6	99.2	99.4
Massachusetts	TUFTS HEALTH PLAN	29.7	36.2	41.4	44.3	72.3	72.9	78.1	83.2
Michigan	BCBS OF MI GRP	55.8	52.3	49.3	58.5	77.5	81.9	81.4	82.9
Minnesota	BCBS OF MN GRP	68.4	44.7	—	—	89.9	89.5	82.9	82.9
	HEALTHPARTNERS GRP	—	—	38.4	39.2				
Mississippi	MISSISSIPPI INS GRP	44.1	43.5	—	—	85.1	84.8	94.6	99.4
	CENTENE CORP GRP	—	—	45.2	55.7				
Missouri	AETNA GRP	37.8	26.7	—	—	76.8	69.9	82.4	86.2
	WELLPOINT INC GRP	—	—	44.7	—				
	CIGNA HLTH GRP	—	—	—	36.7				
Montana	HCSC GRP	56.8	70.4	50.6	—	92.1	99.6	99.7	99.8
	MONTANA HEALTH COOPERATIVE	—	—	—	42.9				
Nebraska	AETNA GRP	—	—	35.6	—	91.6	95.6	93.7	99.7
	BLUE CROSS AND BLUE SHIELD OF NEBRASKA	49.1	48.5	—	—				
	MEDICA GRP	—	—	—	74.5				
Nevada	UNITEDHEALTH GRP	49.9	58.5	58.4	65.1	82.9	93.3	94.0	94.1
New Hampshire	WELLPOINT INC GRP	64.5	38.7	45.7	61.1	89.9	77.7	99.7	99.8
New Jersey	BCBS OF NJ GRP	56.3	59.9	71.6	61.3	90.7	87.0	98.8	97.8
New Mexico	MOLINA HEALTHCARE INC GRP	—	—	40.4	40.6	93.4	93.9	88.8	89.9
	HCSC GRP	43.5	—	—	—				
	PRESBYTERIAN HLTHCARE SERV GRP	—	35.5	—	—				
New York	AMERICAN INTL GRP	—	14.4	—	—	42.6	41.8	45.5	52.5
	FREELANCERS HEALTH SERVICE CORPORATION	19.1	—	—	—				
	NEW YORK STATE CATHOLIC HEALTH PLAN, INC.	—	—	17.4	25.1				
North Carolina	BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA	75.3	60.3	95.6	96.2	98.0	99.1	99.5	99.7
North Dakota	NORIDIAN MUTUAL INSURANCE COMPANY	77.6	74.5	82.3	85.7	95.1	99.3	99.7	99.6
Ohio	MEDICAL MUTUAL OF OHIO	36.8	35.0	31.4	35.6	66.7	69.2	77.6	70.5
Oklahoma	HCSC GRP	87.8	89.6	93.8	95.5	96.9	99.6	99.7	99.8
Oregon	OREGON DENTAL GRP	40.7	—	—	—	69.7	79.2	76.7	90.1
	PROVIDENCE HEALTH PLAN	—	43.8	46.0	45.3				
Pennsylvania	HIGHMARK GRP	45.2	—	—	—	76.8	68.2	78.1	81.3
	INDEPENDENCE HEALTH GROUP, INC.	—	29.0	37.9	40.0				

**Appendix I: Number and Market Share of
Largest Issuers Participating in Each State's
Individual Market**

Rhode Island	BLUE CROSS & BLUE SHIELD OF RHODE ISLAND	58.5	60.7	61.5	—	99.5	99.6	99.7	99.7
	NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND	—	—	—	52.3				
South Carolina	BCBS OF SC GRP	51.3	90.2	95.7	96.5	90.3	99.3	99.7	99.8
South Dakota	AVERA HEALTH PLANS, INC.	—	—	41.2	—	93.5	96.8	98.2	98.4
	WELLMARK GROUP	61.7	49.2	—	36.4				
Tennessee	BCBS OF TN INC	63.2	58.6	26.8	45.0	86.8	86.3	74.5	88.5
Texas	HCSC GRP	64.6	44.6	39.7	37.1	84.5	63.4	73.4	73.4
Utah	IHC INC GRP	50.6	61.0	60.0	85.2	80.4	91.2	97.2	99.8
Vermont	BCBS OF VT GRP	89.5	87.9	80.1	66.8	100.0	100.0	100.0	100.0
Virginia	WELLPOINT INC GRP	52.7	45.8	49.9	—	73.4	69.8	75.6	72.4
	CIGNA HLTH GRP	—	—	—	24.9				
Washington	PREMERA BLUE CROSS GROUP	48.1	42.4	—	—	78.6	77.0	70.9	88.1
	KAISER FOUNDATION GRP	—	—	29.7	47.6				
West Virginia	HIGHMARK GRP	90.5	90.9	78.2	67.6	98.4	98.8	98.3	98.4
Wisconsin	MOLINA HEALTHCARE INC GRP	—	20.2	23.8	—	42.9	50.0	50.4	53.5
	WISCONSIN PHYSICIANS SERV INS GRP	15.0	—	—	—				
	COMMON GROUND HEALTHCARE COOPERATIVE	—	—	—	23.3				
Wyoming	BLUE CROSS BLUE SHIELD OF WYOMING	58.9	94.7	96.1	96.8	92.8	99.2	99.7	99.7

Legend: — This symbol indicates that this issuer was not the largest in that year.

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

Note: Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. We calculated issuers' market share using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year. We reprinted issuer names as they were reported in the data from the Centers for Medicare & Medicaid Services.

Appendix II: Federally Facilitated Individual Market Exchange Enrollment Compared to the Individual Market, 2018

This table presents a) covered life-years in each state's individual market health insurance exchange, b) covered life-years in each state's overall individual market, and c) covered life-years as a proportion of each state's overall individual market for the 39 states using a federally facilitated exchange in 2018.

Table 4: Covered Life-Years in Each State's Individual Market Federally Facilitated Health Insurance Exchange as a Proportion of Total Covered Life-Years in the Overall Individual Market, 2018

State	Covered life-years, individual market federally facilitated exchange	Covered life-years, overall individual market	Individual exchange covered life-years as a proportion of overall market (%)
U.S. Total	7,149,658	9,897,642	72.2
Alabama	144,889	197,891	73.2
Alaska	15,395	19,146	80.4
Arizona	138,395	208,328	66.4
Arkansas	55,389	347,119	16.0
Delaware	19,263	24,075	80.0
Florida	1,446,987	1,817,108	79.6
Georgia	362,858	400,908	90.5
Hawaii	16,050	35,212	45.6
Illinois	276,051	429,326	64.3
Indiana	133,187	150,576	88.5
Iowa	40,193	108,271	37.1
Kansas	79,794	118,601	67.3
Kentucky	73,133	108,589	67.3
Louisiana	82,978	135,770	61.1
Maine	64,089	72,763	88.1
Michigan	242,314	365,906	66.2
Mississippi	65,221	117,224	55.6
Missouri	196,898	264,509	74.4
Montana	40,784	53,969	75.6
Nebraska	76,023	109,258	69.6
Nevada	69,965	107,005	65.4
New Hampshire	38,896	90,823	42.8
New Jersey	220,602	318,410	69.3
New Mexico	40,637	58,479	69.5
North Carolina	427,785	539,601	79.3
North Dakota	19,406	45,819	42.4

**Appendix II: Federally Facilitated Individual
Market Exchange Enrollment Compared to the
Individual Market, 2018**

State	Covered life-years, individual market federally facilitated exchange	Covered life-years, overall individual market	Individual exchange covered life- years as a proportion of overall market (%)
Ohio	185,151	287,684	64.4
Oklahoma	125,294	153,387	81.7
Oregon	127,401	189,859	67.1
Pennsylvania	332,960	471,142	70.7
South Carolina	173,445	234,830	73.9
South Dakota	26,106	57,046	45.8
Tennessee	192,009	255,781	75.1
Texas	888,153	1,122,989	79.1
Utah	167,768	215,713	77.8
Virginia	315,859	378,060	83.5
West Virginia	21,303	27,087	78.6
Wisconsin	185,361	230,940	80.3
Wyoming	21,666	28,438	76.2

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

Note: We calculated the size of each market using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year. This is one of several ways to measure health insurance enrollment, so it may differ from other measures of market size.

Appendix III: Number and Market Share of Issuers in Federally Facilitated Individual Market Exchanges, 2015-2018

The four tables below present information on the number of participating issuers and the market share of the largest issuers in each state's individual market exchange, from 2015 through 2018, for the 39 states using a federally facilitated exchange in 2018. Specifically: table 5 presents the total number of exchange issuers in each state; table 6 presents the average number of exchange issuers across each state's rating areas; table 7 presents the names and market shares of the single largest exchange issuer and the market share of the largest three issuers, for each state; and table 8 presents the average market share of the largest issuer across each state's rating areas.

Table 5: Number of Issuers in Each State's Federally Facilitated Individual Market Health Insurance Exchange, 2015 through 2018

State	Number of issuers			
	2015	2016	2017	2018
Alabama	3	3	1	2
Alaska	2	2	1	1
Arizona	12	8	2	2
Arkansas	4	5	4	4
Delaware	2	2	2	1
Florida	11	7	5	4
Georgia	9	8	5	4
Hawaii	n/a ^a	2	2	2
Illinois	8	7	5	4
Indiana	9	8	4	2
Iowa	4	4	4	1
Kansas	3	3	3	3
Kentucky	5	7	3	2
Louisiana	5	4	3	2
Maine	3	3	3	2
Michigan	13	11	9	7
Mississippi	3	3	2	1
Missouri	6	6	4	3
Montana	4	3	3	3
Nebraska	4	4	2	1
Nevada	5	3	3	2
New Hampshire	5	5	4	3
New Jersey	5	5	2	3
New Mexico	5	4	4	4

Appendix III: Number and Market Share of Issuers in Federally Facilitated Individual Market Exchanges, 2015-2018

State	Number of issuers			
	2015	2016	2017	2018
North Carolina	3	3	2	2
North Dakota	3	3	3	2
Ohio	16	15	10	8
Oklahoma	4	2	1	1
Oregon	10	10	6	5
Pennsylvania	9	8	5	6
South Carolina	4	3	1	1
South Dakota	3	2	2	2
Tennessee	5	4	3	3
Texas	14	16	10	8
Utah	6	4	3	2
Virginia	7	9	10	6
West Virginia	1	2	2	2
Wisconsin	15	15	14	11
Wyoming	2	1	1	1

Legend: n/a = not applicable.

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

Note: One state, Kentucky, had a state-based exchange in 2015 and 2016 but a federally facilitated exchange in 2017 and 2018. We previously collected data from Kentucky on its state-based exchange enrollment in 2015 and 2016, which we present alongside federal data from 2017 and 2018 in this report. Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level.

^aData were not available from Hawaii for 2015.

**Appendix III: Number and Market Share of
Issuers in Federally Facilitated Individual
Market Exchanges, 2015-2018**

Table 6: Average Number of Federally Facilitated Individual Market Health Insurance Exchange Issuers Participating in a State's Rating Areas, by State, 2015 through 2018

Weighted average number of issuers participating in states' rating areas				
State	2015	2016	2017	2018
Alabama	2.3	2.4	1.0	1.2
Alaska	2.0	2.0	1.0	1.0
Arizona	11.0	6.3	1.2	1.2
Arkansas	3.7	5.0	3.9	3.9
Delaware	2.0	2.0	2.0	1.0
Florida	6.1	4.4	2.9	2.5
Georgia	7.8	6.9	3.9	2.4
Hawaii	n/a ^a	2.0	2.0	2.0
Illinois	5.7	5.2	2.6	2.4
Indiana	6.9	6.7	3.9	1.9
Iowa	2.6	3.4	3.4	1.0
Kansas	2.4	2.4	2.4	2.3
Kentucky	4.8	6.4	2.3	1.6
Louisiana	4.1	3.5	2.5	2.0
Maine	3.0	3.0	3.0	2.0
Michigan	7.6	6.2	6.2	5.1
Mississippi	2.9	2.9	1.9	1.0
Missouri	3.3	3.7	2.0	1.9
Montana	4.0	3.0	3.0	3.0
Nebraska	3.9	4.0	2.0	1.0
Nevada	4.1	2.9	2.9	1.9
New Hampshire	5.0	5.0	4.0	3.0
New Jersey	5.0	5.0	2.0	3.0
New Mexico	5.0	4.0	4.0	4.0
North Carolina	2.7	2.7	1.3	1.2
North Dakota	3.0	3.0	3.0	1.9
Ohio	10.0	9.8	4.9	4.2
Oklahoma	3.6	2.0	1.0	1.0
Oregon	8.2	7.7	4.6	4.0
Pennsylvania	4.9	4.0	2.0	2.2
South Carolina	3.6	1.7	1.0	1.0
South Dakota	3.0	2.0	2.0	2.0
Tennessee	4.1	3.1	1.5	1.3
Texas	7.7	7.3	3.5	3.6

Appendix III: Number and Market Share of Issuers in Federally Facilitated Individual Market Exchanges, 2015-2018

Weighted average number of issuers participating in states' rating areas				
State	2015	2016	2017	2018
Utah	5.3	3.1	2.8	2.0
Virginia	4.4	5.6	5.4	3.3
West Virginia	1.0	1.3	1.8	1.8
Wisconsin	6.3	6.9	5.1	3.7
Wyoming	2.0	1.0	1.0	1.0

Legend: n/a = not applicable.

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

Note: One state, Kentucky, had a state-based exchange in 2015 and 2016 but a federally facilitated exchange in 2017 and 2018. We previously collected data from Kentucky on its state-based exchange enrollment in 2015 and 2016, which we present alongside federal data from 2017 and 2018 in this report. Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. Rating areas are established by states and used, in part, by issuers to set premium rates. Issuer participation and enrollment can vary across rating areas in a state. The issuer counts in this table reflect the average number of participating issuers across a state's rating areas, weighted by the number of covered life-years in each rating area.

^aData were not available from Hawaii for 2015.

Appendix III: Number and Market Share of Issuers in Federally Facilitated Individual Market Exchanges, 2015-2018

Table 7: Market Share of the Single Largest and Three Largest Issuers in Each State's Federally Facilitated Individual Market Health Insurance Exchange, 2015 through 2018

State	Largest issuer name	Market share of single largest issuer (%)				Market share of the largest three issuers (%)			
		2015	2016	2017	2018	2015	2016	2017	2018
Alabama	BCBS OF AL GRP	80.9	67.3	100.0	99.3	100.0	100.0	100.0	100.0
Alaska	OREGON DENTAL GRP	71.3	69.8	—	—	100.0	100.0	100.0	100.0
	PREMERA BLUE CROSS GROUP	—	—	100.0	100.0				
Arizona	CENTENE CORP GRP	32.4	—	72.6	74.1	80.8	76.3	100.0	100.0
	UNITEDHEALTH GRP	—	37.6	—	—				
Arkansas	ARKANSAS BCBS GRP	94.2	91.9	68.7	60.7	100.0	99.2	99.9	99.5
Delaware	HIGHMARK GRP	91.9	90.5	54.7	100.0	100.0	100.0	100.0	100.0
Florida	BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.	26.3	40.1	58.9	68.1	66.1	72.5	97.4	100.0
Georgia	HUMANA GRP	56.7	32.4	—	—	84.9	68.9	93.1	100.0
	WELLPOINT INC GRP	—	—	48.1	—				
	CENTENE CORP GRP	—	—	—	52.3				
Hawaii	n/a ^a	n/a ^a	—	—	—	n/a ^a	100.0	100.0	100.0
	HAWAII MEDICAL SERVICE ASSOCIATION	—	58.6	52.8	50.7				
Illinois	HCSC GRP	77.4	57.1	66.0	72.8	94.4	77.3	90.7	100.0
Indiana	WELLPOINT INC GRP	47.0	30.4	—	—	74.7	66.1	80.3	100.0
	CENTENE CORP GRP	—	—	35.6	—				
	CARESOURCE MANAGEMENT GROUP	—	—	—	52.3				
Iowa	AETNA GRP	97.4	72.8	67.0	—	99.9	99.8	99.2	100.0
	MEDICA GRP	—	—	—	100.0				
Kansas	AETNA GRP	55.6	—	—	—	100.0	100.0	100.0	100.0
	BCBS OF KS GRP	—	62.2	61.3	63.0				
Kentucky	KENTUCKY HEALTH COOPERATIVE	64.3	—	—	—	93.7	87.5	100.0	100.0
	WELLPOINT INC GRP	—	62.7	59.8	—				
	CARESOURCE MANAGEMENT GROUP	—	—	—	65.5				
Louisiana	LOUISIANA HLTH SERV GRP	53.3	47.9	68.2	90.2	89.1	89.3	100.0	100.0
Maine	MAINE COMMUNITY HEALTH OPTIONS	81.0	67.5	42.4	60.3	100.0	100.0	100.0	100.0
Michigan	BCBS OF MI GRP	67.5	55.5	49.5	61.9	88.0	87.8	86.0	94.1
Mississippi	HUMANA GRP	38.2	—	—	—	100.0	100.0	100.0	100.0

Appendix III: Number and Market Share of Issuers in Federally Facilitated Individual Market Exchanges, 2015-2018

State	Largest issuer name	Market share of single largest issuer (%)				Market share of the largest three issuers (%)			
		2015	2016	2017	2018	2015	2016	2017	2018
Missouri	CENTENE CORP GRP	—	50.3	90.4	100.0				
	AETNA GRP	58.3	35.6	—	—	86.2	71.2	91.9	100.0
	WELLPOINT INC GRP	—	—	44.7	—				
	CIGNA HLTH GRP	—	—	—	48.0				
Montana	HCSC GRP	46.1	61.5	43.5	—	98.2	100.0	100.0	100.0
	MONTANA HEALTH COOPERATIVE	—	—	—	50.3				
Nebraska	AETNA GRP	60.4	47.8	56.0	—	96.5	93.9	100.0	100.0
	MEDICA GRP	—	—	—	100.0				
Nevada	UNITEDHEALTH GRP	42.5	56.1	56.6	63.7	86.9	100.0	100.0	100.0
New Hampshire	WELLPOINT INC GRP	60.2	46.0	—	80.6	92.7	96.0	99.8	100.0
	MINUTEMAN HEALTH, INC	—	—	43.5	—				
New Jersey	BCBS OF NJ GRP	54.0	60.1	68.3	54.6	95.5	89.9	100.0	100.0
New Mexico	HCSC GRP	40.3	—	—	—	89.1	93.4	97.0	98.1
	MOLINA HEALTHCARE INC GRP	—	40.0	62.0	58.0				
North Carolina	BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA	67.3	46.5	95.6	96.3	100.0	100.0	100.0	100.0
North Dakota	NORIDIAN MUTUAL INSURANCE COMPANY	69.0	54.0	71.1	80.0	100.0	100.0	100.0	100.0
Ohio	MEDICAL MUTUAL OF OHIO	27.0	—	—	—	61.3	63.2	74.3	89.9
	CARESOURCE MANAGEMENT GROUP	—	28.8	31.7	40.7				
Oklahoma	HCSC GRP	97.5	94.9	100.0	100.0	99.8	100.0	100.0	100.0
Oregon	OREGON DENTAL GRP	41.9	—	—	—	80.3	82.5	82.0	98.3
	PROVIDENCE HEALTH PLAN	—	51.2	50.4	47.8				
Pennsylvania	HIGHMARK GRP	46.1	—	—	—	81.4	67.1	77.3	98.2
	INDEPENDENCE HEALTH GROUP, INC.	—	31.0	39.4	40.6				
South Carolina	CONSUMERS' CHOICE HEALTH INSURANCE COMPANY	42.5	—	—	—	99.7	100.0	100.0	100.0
	BCBS OF SC GRP	—	95.5	100.0	100.0				
South Dakota	AVERA HEALTH PLANS, INC.	52.9	73.2	75.5	50.6	100.0	100.0	100.0	100.0
Tennessee	BCBS OF TN INC	77.6	65.6	35.2	55.0	99.3	92.3	100.0	100.0
Texas	HCSC GRP	64.9	39.6	27.8	27.0	84.7	63.5	73.6	95.4
Utah	IHC INC GRP	49.1	61.9	55.2	88.5	82.7	99.1	100.0	100.0
Virginia	WELLPOINT INC GRP	39.8	38.2	43.6	—	71.9	67.8	74.3	98.9
	CIGNA HLTH GRP	—	—	—	29.3				

Appendix III: Number and Market Share of Issuers in Federally Facilitated Individual Market Exchanges, 2015-2018

State	Largest issuer name	Market share of single largest issuer (%)				Market share of the largest three issuers (%)			
		2015	2016	2017	2018	2015	2016	2017	2018
West Virginia	HIGHMARK GRP	100.0	95.9	79.4	67.5	100.0	100.0	100.0	100.0
Wisconsin	COMMON GROUND HEALTHCARE COOPERATIVE	17.1	—	—	27.7	46.7	57.6	58.7	95.8
	MOLINA HEALTHCARE INC GRP	—	28.4	31.0	—				
Wyoming	BLUE CROSS BLUE SHIELD OF WYOMING	58.3	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Legend: n/a = not applicable.

Legend: — This symbol indicates that this issuer was not the largest in that year.

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

Note: One state, Kentucky, had a state-based exchange in 2015 and 2016 but a federally facilitated exchange in 2017 and 2018. We previously collected data from Kentucky on its state-based exchange enrollment in 2015 and 2016, which we present alongside federal data from 2017 and 2018 in this report. Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. We measured issuers' market share using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year. Market share in this table represents an issuer's total state-level market share, which does not take into account variations in market share across a state's exchange rating areas. We reprinted issuer names as they were reported in the data from the Centers for Medicare & Medicaid Services.

^aData were not available from Hawaii for 2015.

Appendix III: Number and Market Share of Issuers in Federally Facilitated Individual Market Exchanges, 2015-2018

Table 8: Average Market Share of the Largest Issuer across a State's Rating Areas, Federally Facilitated Individual Market Health Insurance Exchanges, 2015 through 2018

Weighted average market share of the largest issuer across states' rating areas				
State	2015	2016	2017	2018
Alabama	80.9	68.0	100.0	99.3
Alaska	71.3	69.8	100.0	100.0
Arizona	38.8	42.3	98.3	98.8
Arkansas	94.2	91.9	68.7	60.7
Delaware	91.9	90.5	54.7	100.0
Florida	58.7	62.0	70.5	69.9
Georgia	60.7	38.1	58.5	75.7
Hawaii	n/a ^a	58.6	52.8	50.7
Illinois	78.4	61.1	70.9	75.2
Indiana	47.8	32.5	46.4	68.5
Iowa	97.4	75.5	72.6	100.0
Kansas	66.1	82.7	90.7	84.1
Kentucky	65.3	63.4	67.4	89.8
Louisiana	53.3	49.9	69.7	90.2
Maine	81.0	67.5	42.4	61.5
Michigan	67.7	57.9	56.0	62.2
Mississippi	56.9	54.3	90.4	100.0
Missouri	66.3	51.9	73.6	77.5
Montana	46.8	61.5	51.7	50.3
Nebraska	60.4	47.8	73.7	100.0
Nevada	47.9	63.4	67.2	72.4
New Hampshire	60.2	46.0	43.5	80.6
New Jersey	54.0	60.1	68.3	54.6
New Mexico	42.6	43.6	68.8	58.0
North Carolina	69.6	60.4	95.6	96.3
North Dakota	72.2	60.3	71.1	88.8
Ohio	41.1	39.2	45.1	48.6
Oklahoma	97.5	94.9	100.0	100.0
Oregon	41.9	55.6	55.0	53.6
Pennsylvania	73.3	64.4	79.6	82.3
South Carolina	59.2	95.5	100.0	100.0
South Dakota	60.7	73.2	75.5	65.6
Tennessee	77.6	65.6	83.7	87.1
Texas	69.4	43.5	53.3	51.6

Appendix III: Number and Market Share of Issuers in Federally Facilitated Individual Market Exchanges, 2015-2018

Weighted average market share of the largest issuer across states' rating areas				
State	2015	2016	2017	2018
Utah	54.5	61.9	61.6	88.5
Virginia	51.2	50.7	56.6	78.8
West Virginia	100.0	95.9	81.1	73.7
Wisconsin	51.8	54.1	57.5	60.1
Wyoming	61.3	100.0	100.0	100.0

Legend: n/a = not applicable.

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

Note: One state, Kentucky, had a state-based exchange in 2015 and 2016 but a federally facilitated exchange in 2017 and 2018. We previously collected data from Kentucky on its state-based exchange enrollment in 2015 and 2016, which we present alongside federal data from 2017 and 2018 in this report. Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. We calculated issuers' market share using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year. Rating areas are established by states and used, in part, by issuers to set premium rates. Issuer participation and enrollment can vary across rating areas in a state. The market shares in this table reflect the average market share of the largest issuer across a state's rating areas, weighted by the number of covered life-years in each rating area. In some cases, the identity of the largest issuer varied across rating areas in a state and changed over time.

^aData were not available from Hawaii for 2015.

Appendix IV: Number of Issuers and Market Share of Largest Issuers Participating in Small Group Health Insurance Market

The two tables below present information on a) the participation of issuers in each state's small group health insurance market from 2011 through 2018 and b) the market share of the largest and three largest issuers from 2015 through 2018.

Table 9: Number of Issuers in Each State's Small Group Health Insurance Market, 2011 through 2018

State	Number of Issuers							
	2011	2012	2013	2014	2015	2016	2017	2018
Alabama	11	9	8	7	6	5	4	3
Alaska	7	6	6	6	5	4	4	4
Arizona	14	12	12	13	12	8	7	7
Arkansas	13	12	11	11	9	6	6	4
California	27	27	22	22	18	15	13	14
Colorado	11	11	9	9	10	8	6	6
Connecticut	11	8	7	9	9	7	6	6
Delaware	9	8	8	6	4	3	3	3
District of Columbia	9	7	6	6	7	5	5	5
Florida	16	13	14	13	12	9	8	9
Georgia	23	22	20	16	14	9	9	7
Hawaii	6	6	6	6	5	5	5	5
Idaho	11	10	11	10	11	10	9	9
Illinois	26	27	21	18	14	13	12	9
Indiana	27	26	24	20	18	16	11	9
Iowa	17	15	15	15	14	11	11	9
Kansas	17	14	13	10	8	6	6	5
Kentucky	10	8	9	8	8	5	5	5
Louisiana	12	10	11	10	8	6	5	5
Maine	8	6	5	5	6	5	5	5
Maryland	8	8	8	7	6	5	5	4
Massachusetts	13	14	13	13	11	12	11	9
Michigan	25	24	24	22	21	16	15	13
Minnesota	10	9	9	9	8	8	7	6
Mississippi	10	9	8	8	7	5	4	3
Missouri	19	19	17	13	11	8	8	7
Montana	10	9	8	9	8	6	5	5
Nebraska	17	15	12	12	8	7	4	3
Nevada	17	16	14	14	12	8	8	8
New Hampshire	9	7	6	7	6	6	5	4

Appendix IV: Number of Issuers and Market Share of Largest Issuers Participating in Small Group Health Insurance Market

State	Number of Issuers							
	2011	2012	2013	2014	2015	2016	2017	2018
New Jersey	7	7	6	7	7	7	6	7
New Mexico	11	8	7	7	4	4	4	5
New York	16	14	14	16	15	16	17	16
North Carolina	16	14	13	10	10	5	5	4
North Dakota	6	6	6	6	5	5	4	4
Ohio	30	29	25	24	22	17	13	10
Oklahoma	18	16	15	11	9	8	6	5
Oregon	9	8	8	13	14	14	13	8
Pennsylvania	21	19	19	16	14	11	10	10
Rhode Island	4	4	3	5	4	4	4	4
South Carolina	15	13	12	10	8	5	4	3
South Dakota	12	11	11	11	8	7	6	5
Tennessee	15	14	14	13	11	6	5	4
Texas	27	25	23	21	18	16	14	11
Utah	12	13	12	11	10	8	8	8
Vermont	4	3	3	3	3	3	2	2
Virginia	20	15	17	15	12	11	11	10
Washington	13	12	13	12	9	8	6	7
West Virginia	14	13	12	9	6	5	5	4
Wisconsin	27	26	24	24	23	21	21	18
Wyoming	9	7	7	7	6	4	3	2

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

Note: Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level.

Appendix IV: Number of Issuers and Market Share of Largest Issuers Participating in Small Group Health Insurance Market

Table 10: Market Share of the Single Largest and Three Largest Issuers in Each State’s Small Group Health Insurance Market, 2015 through 2018

State	Largest issuer name	Market share of the largest single issuer (%)				Market share of the largest three issuers (%)			
		2015	2016	2017	2018	2015	2016	2017	2018
Alabama	BCBS OF AL GRP	97.0	96.8	96.1	96.4	99.9	100.0	100.0	100.0
Alaska	PREMERA BLUE CROSS GROUP	70.6	60.0	70.6	85.3	88.8	93.0	95.4	97.6
Arizona	BLUE CROSS AND BLUE SHIELD OF ARIZONA, INC.	25.0	—	—	—	67.4	76.5	82.7	86.9
	UNITEDHEALTH GRP	—	30.7	42.0	47.6				
Arkansas	ARKANSAS BCBS GRP	66.8	61.0	63.9	62.3	97.9	98.0	98.1	97.3
California	KAISER FOUNDATION GRP	34.4	36.2	37.5	38.9	73.8	74.9	76.0	79.3
Colorado	WELLPOINT INC GRP	28.0	—	—	—	77.3	81.6	92.0	93.8
	UNITEDHEALTH GRP	—	33.4	40.0	46.1				
Connecticut	WELLPOINT INC GRP	—	—	40.3	42.6	80.2	76.5	77.7	84.7
	HIP INS GRP	37.5	33.4	—	—				
Delaware	HIGHMARK GRP	69.6	74.0	74.4	85.5	100.0	100.0	100.0	100.0
District of Columbia	CAREFIRST INC GRP	82.9	82.0	80.4	78.6	96.6	96.6	96.8	97.5
Florida	BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.	35.2	37.0	42.3	39.8	81.7	83.1	81.7	85.1
Georgia	WELLPOINT INC GRP	29.0	—	—	—	78.4	81.0	80.2	87.1
	HUMANA GRP	—	35.2	37.7	39.5				
Hawaii	HAWAII MEDICAL SERVICE ASSOCIATION	47.3	48.2	48.4	49.1	86.3	87.7	88.1	89.7
Idaho	BLUE CROSS OF IDAHO HEALTH SERVICE, INC.	53.7	47.7	42.0	48.9	95.6	97.7	95.9	94.2
Illinois	HCSC GRP	65.0	69.8	72.9	73.4	87.7	90.2	93.6	95.4
Indiana	WELLPOINT INC GRP	51.9	49.2	52.0	53.3	83.5	82.8	87.2	92.0
Iowa	WELLMARK GROUP	77.5	82.6	84.2	81.9	95.2	96.8	97.3	98.1
Kansas	BCBS OF KS GRP	63.8	63.7	61.3	56.8	84.0	85.8	87.5	87.8
Kentucky	WELLPOINT INC GRP	50.8	49.7	50.2	51.0	95.8	96.3	96.8	99.6
Louisiana	LOUISIANA HLTH SERV GRP	76.4	76.3	81.7	81.5	97.1	98.1	98.9	99.3
Maine	HARVARD PILGRIM HTH CARE GRP	43.8	37.3	37.0	53.0	93.4	83.3	86.7	90.0
Maryland	CAREFIRST INC GRP	67.3	67.5	67.4	69.5	90.8	92.4	93.4	98.8
Massachusetts	BCBS OF MA GRP	42.5	44.0	50.8	53.3	79.3	79.5	80.0	81.6
Michigan	BCBS OF MI GRP	52.4	55.2	56.8	63.3	78.9	83.0	84.3	88.5
Minnesota	HEALTHPARTNERS GRP	42.7	44.1	43.5	43.8	92.0	92.0	87.9	93.1

Appendix IV: Number of Issuers and Market Share of Largest Issuers Participating in Small Group Health Insurance Market

State	Largest issuer name	Market share of the largest single issuer (%)				Market share of the largest three issuers (%)			
		2015	2016	2017	2018	2015	2016	2017	2018
Mississippi	MISSISSIPPI INS GRP	79.5	82.3	83.8	85.1	99.3	99.0	99.5	100.0
Missouri	WELLPOINT INC GRP	41.7	39.5	38.6	36.5	76.3	77.1	79.1	86.3
Montana	HCSC GRP	70.8	80.1	68.0	55.1	94.7	98.1	99.5	99.3
Nebraska	BLUE CROSS AND BLUE SHIELD OF NEBRASKA	38.2	50.0	62.7	56.9	89.3	95.0	96.2	100.0
Nevada	UNITEDHEALTH GRP	49.6	53.0	57.6	64.8	76.1	78.0	81.0	85.0
New Hampshire	WELLPOINT INC GRP	56.4	—	—	—	99.2	98.9	97.9	98.9
	HARVARD PILGRIM HTH CARE GRP	—	45.8	49.7	43.0				
New Jersey	BCBS OF NJ GRP	54.4	53.2	56.0	63.7	87.8	87.0	88.9	95.8
New Mexico	HCSC GRP	37.9	—	—	—	87.4	89.9	88.6	85.0
	PRESBYTERIAN HLTHCARE SERV GRP	—	31.8	34.5	38.8				
New York	UNITEDHEALTH GRP	42.4	46.3	46.5	51.1	71.2	71.5	70.9	75.5
North Carolina	BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA	60.0	55.1	46.2	—	96.4	96.3	96.7	98.6
	UNITEDHEALTH GRP	—	—	—	53.5				
North Dakota	NORIDIAN MUTUAL INSURANCE COMPANY	82.6	83.5	85.1	84.5	99.4	99.7	99.8	99.9
Ohio	WELLPOINT INC GRP	37.3	36.2	36.6	35.4	80.1	80.9	80.3	83.6
Oklahoma	HCSC GRP	71.0	72.9	68.1	68.0	92.6	95.2	96.3	97.9
Oregon	PROVIDENCE HEALTH PLAN	16.1	28.2	37.6	37.9	45.4	56.6	72.8	78.2
Pennsylvania	INDEPENDENCE HEALTH GROUP, INC.	26.1	29.5	31.2	31.3	65.3	68.1	73.1	73.9
Rhode Island	BLUE CROSS & BLUE SHIELD OF RHODE ISLAND	78.8	82.4	82.8	81.5	99.6	99.0	98.7	98.0
South Carolina	BCBS OF SC GRP	80.3	85.8	86.0	82.4	97.5	98.4	98.9	100.0
South Dakota	WELLMARK GROUP	60.6	67.1	77.9	75.0	93.1	94.4	94.8	96.2
Tennessee	BCBS OF TN INC	65.4	63.4	63.0	64.6	97.1	98.4	98.5	99.7
Texas	HCSC GRP	60.0	56.9	65.0	69.4	89.7	91.4	92.4	94.2
Utah	IHC INC GRP	54.8	61.2	67.4	71.7	83.7	91.7	91.7	94.2
Vermont	BCBS OF VT GRP	88.7	89.2	86.7	65.7	100.0	100.0	100.0	100.0
Virginia	WELLPOINT INC GRP	44.6	43.9	43.2	40.4	72.8	70.2	72.9	79.6
Washington	PREMERA BLUE CROSS GROUP	56.3	53.2	36.0	36.8	81.7	86.0	89.4	91.4
West Virginia	HIGHMARK GRP	80.8	80.8	83.1	81.1	98.2	97.4	95.1	99.3

Appendix IV: Number of Issuers and Market Share of Largest Issuers Participating in Small Group Health Insurance Market

State	Largest issuer name	Market share of the largest single issuer (%)				Market share of the largest three issuers (%)			
		2015	2016	2017	2018	2015	2016	2017	2018
Wisconsin	UNITEDHEALTH GRP	33.6	39.4	28.9	31.5	56.2	56.6	52.0	57.2
Wyoming	BLUE CROSS BLUE SHIELD OF WYOMING	69.7	85.1	86.0	85.9	92.3	99.1	100.0	100.0

Legend: — This symbol indicates that this issuer was not the largest in that year.

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

Note: Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. We calculated issuers' market share using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year. We reprinted issuer names as they were reported in the data from the Centers for Medicare & Medicaid Services.

Appendix V: Number of Issuers and Market Share of Largest Issuers Participating in Large Group Health Insurance Market

The two tables below present information on a) the participation of issuers in each state's large group health insurance market from 2011 through 2018 and b) the market share of the single largest and three largest issuers from 2015 through 2018.

Table 11: Number of Issuers in Each State's Large Group Health Insurance Market, 2011 through 2018

State	Number of issuers							
	2011	2012	2013	2014	2015	2016	2017	2018
Alabama	7	8	7	7	7	8	6	6
Alaska	6	4	5	5	5	4	4	4
Arizona	13	13	12	12	12	11	9	9
Arkansas	10	10	9	10	10	7	8	8
California	32	28	24	25	24	23	23	25
Colorado	13	10	10	10	10	9	9	9
Connecticut	9	7	5	7	8	8	7	7
Delaware	6	6	6	5	4	5	4	5
District of Columbia	9	7	6	6	7	7	6	7
Florida	14	11	12	11	13	11	10	11
Georgia	16	16	16	14	15	13	11	10
Hawaii	7	7	7	7	6	6	7	6
Idaho	12	9	9	11	12	12	11	11
Illinois	20	21	18	18	19	18	18	17
Indiana	23	24	19	17	16	15	15	14
Iowa	14	14	14	12	13	13	14	13
Kansas	14	13	13	11	10	8	9	8
Kentucky	11	11	8	9	9	8	9	9
Louisiana	9	9	10	10	10	9	8	8
Maine	5	5	5	6	6	6	6	7
Maryland	9	7	6	6	7	6	6	5
Massachusetts	13	12	11	12	13	13	12	11
Michigan	24	25	24	25	25	19	18	17
Minnesota	14	11	11	9	11	11	11	9
Mississippi	9	9	8	9	9	7	7	8
Missouri	18	16	15	14	14	11	10	9
Montana	8	6	7	8	7	8	7	7
Nebraska	10	8	9	10	10	7	8	7
Nevada	14	13	13	13	13	10	12	12
New Hampshire	6	6	6	6	5	8	7	6

Appendix V: Number of Issuers and Market Share of Largest Issuers Participating in Large Group Health Insurance Market

State	Number of issuers							
	2011	2012	2013	2014	2015	2016	2017	2018
New Jersey	9	10	8	9	8	8	8	8
New Mexico	10	8	7	6	6	6	5	6
New York	16	16	15	16	15	16	16	16
North Carolina	13	12	11	10	9	8	7	6
North Dakota	7	8	8	7	7	6	5	7
Ohio	20	21	18	21	21	20	15	14
Oklahoma	12	11	12	11	9	10	8	9
Oregon	12	12	11	11	15	13	13	10
Pennsylvania	17	17	18	17	16	15	17	17
Rhode Island	5	5	4	5	5	4	4	4
South Carolina	12	10	10	8	8	6	7	7
South Dakota	11	11	12	10	7	8	8	8
Tennessee	10	9	9	11	12	9	10	9
Texas	23	22	22	20	21	21	18	16
Utah	12	13	14	13	12	12	12	12
Vermont	4	3	4	4	3	3	3	3
Virginia	14	13	16	16	14	14	13	12
Washington	13	13	12	11	10	10	9	9
West Virginia	11	11	11	8	7	7	5	6
Wisconsin	28	27	27	26	25	23	21	21
Wyoming	6	6	7	7	7	6	4	4

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

Note: Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level.

Appendix V: Number of Issuers and Market Share of Largest Issuers Participating in Large Group Health Insurance Market

Table 12: Market Share of the Single Largest and Three Largest Issuers in Each State’s Large Group Health Insurance Market, 2015 through 2018

State	Largest issuer name	Market share of the largest single issuer (%)				Market share of the largest three issuers (%)			
		2015	2016	2017	2018	2015	2016	2017	2018
Alabama	BCBS OF AL GRP	93.6	92.9	93.2	94.1	99.9	99.8	99.7	99.9
Alaska	PREMERA BLUE CROSS GROUP	84.2	83.9	87.9	92.7	97.8	98.5	98.9	99.2
Arizona	BLUE CROSS AND BLUE SHIELD OF ARIZONA, INC.	38.8	38.4	39.6	49.6	82.4	84.7	86.5	85.1
Arkansas	ARKANSAS BCBS GRP	80.6	78.5	77.5	75.5	99.0	97.2	96.4	94.4
California	KAISER FOUNDATION GRP	45.7	47.9	49.9	51.3	74.3	73.6	74.5	75.6
Colorado	KAISER FOUNDATION GRP	46.1	48.5	48.3	48.2	84.8	85.0	87.1	84.5
Connecticut	UNITEDHEALTH GRP	—	—	—	26.8	69.1	71.0	74.6	72.9
	WELLPOINT INC GRP	31.8	29.8	29.4	—				
Delaware	HIGHMARK GRP	67.0	69.8	62.2	68.6	97.6	97.2	94.7	97.4
District of Columbia	AETNA GRP	39.6	37.4	44.5	42.0	82.6	81.3	82.7	80.5
Florida	BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.	53.2	49.4	46.4	46.6	87.5	87.8	87.8	87.7
Georgia	WELLPOINT INC GRP	46.0	44.1	41.0	36.9	80.8	78.3	76.4	75.1
Hawaii	HAWAII MEDICAL SERVICE ASSOCIATION	69.6	68.9	67.2	66.8	95.8	96.0	95.5	95.4
Idaho	BLUE CROSS OF IDAHO HEALTH SERVICE, INC.	68.1	65.5	66.5	67.4	95.1	93.9	93.0	93.2
Illinois	HCSC GRP	67.0	66.4	65.3	68.9	90.5	88.7	88.5	91.0
Indiana	WELLPOINT INC GRP	60.8	61.5	61.8	65.6	89.8	90.2	92.2	92.3
Iowa	WELLMARK GROUP	77.3	77.7	78.0	79.3	96.1	96.3	96.5	95.0
Kansas	BCBS OF KS GRP	57.1	51.6	45.7	46.5	89.0	91.2	89.0	90.5
Kentucky	WELLPOINT INC GRP	70.5	67.4	65.2	67.0	92.4	91.7	92.5	98.3
Louisiana	LOUISIANA HLTH SERV GRP	63.6	65.0	63.9	66.0	87.8	90.6	90.9	92.3
Maine	WELLPOINT INC GRP	70.0	70.3	68.5	68.9	95.6	96.1	94.8	94.5
Maryland	CAREFIRST INC GRP	66.3	65.5	55.1	55.1	90.3	91.1	91.6	91.3
Massachusetts	BCBS OF MA GRP	57.7	58.1	58.2	60.2	83.9	83.3	82.0	83.8
Michigan	BCBS OF MI GRP	54.3	54.9	55.2	57.6	78.2	80.0	80.3	83.4
Minnesota	HEALTHPARTNERS GRP	49.0	45.8	46.1	48.5	95.0	96.0	96.6	97.3
Mississippi	MISSISSIPPI INS GRP	82.0	82.4	82.7	84.3	98.9	98.5	98.5	98.5

Appendix V: Number of Issuers and Market Share of Largest Issuers Participating in Large Group Health Insurance Market

State	Largest issuer name	Market share of the largest single issuer (%)				Market share of the largest three issuers (%)			
		2015	2016	2017	2018	2015	2016	2017	2018
Missouri	WELLPOINT INC GRP	31.9	—	36.3	35.9	78.4	80.4	84.8	84.3
	BCBS OF KC GRP	—	29.2	—	—				
Montana	HCSC GRP	83.0	83.4	81.1	82.3	98.3	98.0	97.4	97.9
Nebraska	BLUE CROSS AND BLUE SHIELD OF NEBRASKA	79.1	77.1	73.2	73.5	98.9	99.3	98.3	98.8
Nevada	UNITEDHEALTH GRP	66.5	65.4	65.2	66.4	88.0	88.5	87.4	89.2
New Hampshire	WELLPOINT INC GRP	57.5	57.0	56.0	55.6	99.3	98.2	95.0	94.0
New Jersey	BCBS OF NJ GRP	56.8	54.1	54.1	53.6	84.5	85.5	85.9	85.4
New Mexico	HCSC GRP	60.5	61.8	54.6	55.2	98.4	95.1	93.2	93.0
New York	UNITEDHEALTH GRP	—	—	15.7	16.3	47.6	46.5	45.1	46.3
	LIFETIME HLTHCARE GRP	18.2	17.3	—	—				
North Carolina	BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA	72.2	68.7	63.1	66.4	96.1	96.3	94.6	95.1
North Dakota	NORIDIAN MUTUAL INSURANCE COMPANY	73.3	49.7	49.0	51.3	99.7	99.9	99.9	99.9
Ohio	WELLPOINT INC GRP	43.1	44.3	44.0	42.2	77.3	80.3	82.8	82.9
Oklahoma	HCSC GRP	54.0	52.5	50.7	54.2	82.1	80.6	79.9	80.7
Oregon	KAISER FOUNDATION GRP	42.1	41.9	42.4	43.6	79.8	78.6	77.4	77.0
Pennsylvania	HIGHMARK GRP	35.9	35.1	35.1	39.3	72.4	68.0	64.0	68.3
Rhode Island	BLUE CROSS & BLUE SHIELD OF RHODE ISLAND	77.6	78.0	78.3	77.3	98.0	98.3	98.9	99.6
South Carolina	BCBS OF SC GRP	91.1	88.6	87.7	91.1	98.7	99.0	98.1	98.6
South Dakota	WELLMARK GROUP	58.3	55.1	61.7	64.9	89.5	85.7	90.0	94.4
Tennessee	BCBS OF TN INC	78.4	72.5	70.6	71.8	93.9	89.8	92.0	92.8
Texas	HCSC GRP	48.4	45.9	41.4	43.0	84.6	83.7	84.2	85.0
Utah	IHC INC GRP	43.1	42.1	39.9	41.4	84.6	81.9	83.0	82.6
Vermont	BCBS OF VT GRP	84.9	88.7	92.1	90.6	100.0	100.0	100.0	100.0
Virginia	WELLPOINT INC GRP	61.2	48.3	44.3	41.6	81.5	75.5	70.9	69.3
Washington	GROUP HLTH COOP GRP	32.1	32.6	—	—	84.8	85.3	86.0	82.7
	KAISER FOUNDATION GRP	—	—	34.2	34.1				
West Virginia	HIGHMARK GRP	77.7	78.3	78.1	80.2	98.4	96.6	97.6	98.4
Wisconsin	DEAN HEALTH GRP	14.5	—	—	—	39.8	44.4	51.0	50.6
	WELLPOINT INC GRP	—	15.2	—	—				

Appendix V: Number of Issuers and Market Share of Largest Issuers Participating in Large Group Health Insurance Market

State	Largest issuer name	Market share of the largest single issuer (%)				Market share of the largest three issuers (%)			
		2015	2016	2017	2018	2015	2016	2017	2018
	UNITEDHEALTH GRP	—	—	18.6	—				
	UNIVERSITY HEALTH CARE & GUNDERSEN LUTHERAN GROUP	—	—	—	20.6				
Wyoming	BLUE CROSS BLUE SHIELD OF WYOMING	72.5	74.4	71.2	86.0	92.9	95.5	95.8	99.0

Legend: — This symbol indicates that this issuer was not the largest in that year.

Source: GAO analysis of data from the Centers for Medicare & Medicaid Services. | GAO-21-34

Note: Where multiple issuers in a state shared a parent company, we aggregated the individual issuers to the parent company level. We calculated issuers' market share using covered life-years, which measure the average number of lives insured, including dependents, during the reporting year. We reprinted issuer names as they were reported in the data from the Centers for Medicare & Medicaid Services.

Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, William D. Hadley, Assistant Director; Matthew Green, Analyst-in-Charge; Daniel Emirkhanian; and Giselle Hicks made key contributions to this report. Also contributing were Yesook Merrill; Laurie Pachter; Ethiene Salgado-Rodriguez; Emily Wilson Schwark; and Ravi Sharma.

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Trends in Subsidized and Unsubsidized Enrollment October 9, 2020

Key Findings

This report provides data on individual health insurance market enrollment trends for people who purchase health insurance with (subsidized) and without (unsubsidized) advanced premium tax credits (APTC).

- From plan years 2016 to 2019, unsubsidized enrollment declined by 2.8 million people, representing a 45 percent drop nationally. At the state level, the percentage change in unsubsidized enrollment over this period ranged from a 4 percent drop in Rhode Island to a 90 percent drop in Iowa.
- The most recent year of enrollment data shows that average monthly enrollment across the individual market nationally decreased by 3 percent between 2018 and 2019.
- Eighty percent of the decrease in enrollment between 2018 and 2019 occurred among people who did not receive APTC subsidies. Unsubsidized enrollment declined by 9 percent, compared to only a 1 percent decrease in subsidized enrollment, from 2018 to 2019.
- Though unsubsidized enrollment continued to decline in 2019, the rate of decline was substantially lower than the 24 percent drop in 2018 and the 20 percent drop in 2017. This lower rate of decline occurred as premium rates leveled off in 2019, after increasing by double-digits in 2017 and 2018.
- Looking at state-level enrollment trends between 2016 and 2019 also shows the link between enrollment and premium trends. States with larger declines in unsubsidized enrollment tended to experience a larger increase in average premiums.
- Review of state-level data also shows that trends in declining enrollment began from 2015 to 2016 for 10 states. Declining enrollment occurred in 44 states from 2016 to 2017, 43 states from 2017 to 2018, and 39 states from 2018 to 2019.
- Average monthly enrollment in the subsidized portion of the market grew substantially in comparison to the unsubsidized market. The subsidized portion of the market was 140 percent larger than the unsubsidized portion in 2019, up from 122 percent larger in 2018 and 61 percent in 2017.

Introduction

This report provides data on enrollment trends for people who purchased on- and off-Exchange individual market health insurance plans, both with and without federal advanced premium tax credit (APTC) subsidies. These data are based on an analysis of individual market plans that participated in the risk adjustment program established under section 1343 of the Patient Protection and Affordable Care Act (PPACA) and Health Insurance Exchange effectuated enrollment data. The data provided in this report include state-specific, average monthly enrollment covering plan years 2014 to 2019. Over that period, average monthly enrollment in the individual market—including both subsidized and unsubsidized enrollment—peaked in 2016, reaching 14.5 million. Enrollment then declined by 10 percent in 2017, 7 percent in 2018, and 3 percent in 2019. Enrollment among the unsubsidized, who do not receive APTC subsidies, saw a considerable decline of 9 percent from 2018 to 2019, compared to a decrease of 1 percent in APTC subsidized enrollment. From its peak in 2016, unsubsidized enrollment declined by 2.8 million people by 2019, a 45 percent drop nationwide. From 2016 to 2019, unsubsidized enrollment declined by more than 70 percent in Arizona, Georgia, Iowa, Missouri, Nebraska, New Hampshire, Oklahoma, Tennessee, and West Virginia.

Despite the continued erosion of unsubsidized enrollment from 2018 to 2019, the decline is substantially smaller than that in the prior two years, as premiums stabilized from 2018 to 2019. In addition, five states experienced increases in unsubsidized enrollment in 2019, compared to two states in 2018.

Data and Methodology

The enrollment trends in this report cover individual health insurance coverage plans that participated in the HHS-operated risk adjustment program. These include individual and catastrophic health insurance market plans sold on- and off-Exchange but exclude grandfathered plans, transitional plans, excepted benefit plans, short-term, limited duration insurance, and student health insurance plans.¹ The analysis excludes data on plans from Massachusetts and Vermont because both states have merged their individual and small group markets for purposes of the risk adjustment program.²

To derive enrollment trends for people who purchase coverage with and without APTC subsidies, this report uses data from the risk adjustment program and Exchange effectuated enrollment data. The risk adjustment program provides data on the total enrolled member months in all risk adjustment covered plans. Enrolled member months are the total number of months during the plan year for all members enrolled in a health plan.³ Effectuated Exchange enrollment data provide comparable enrollment data for people enrolled in coverage with APTC subsidies. Non-APTC enrollment, referred to as unsubsidized enrollment in this report, is derived by subtracting APTC subsidized enrollment from enrollment in all risk adjustment covered plans. Total enrolled member months is divided by 12 to establish the average monthly enrollment, or the average number of people enrolled during any given month.

¹ See the definition for “risk adjustment covered plan” at 45 C.F.R. § 153.20.

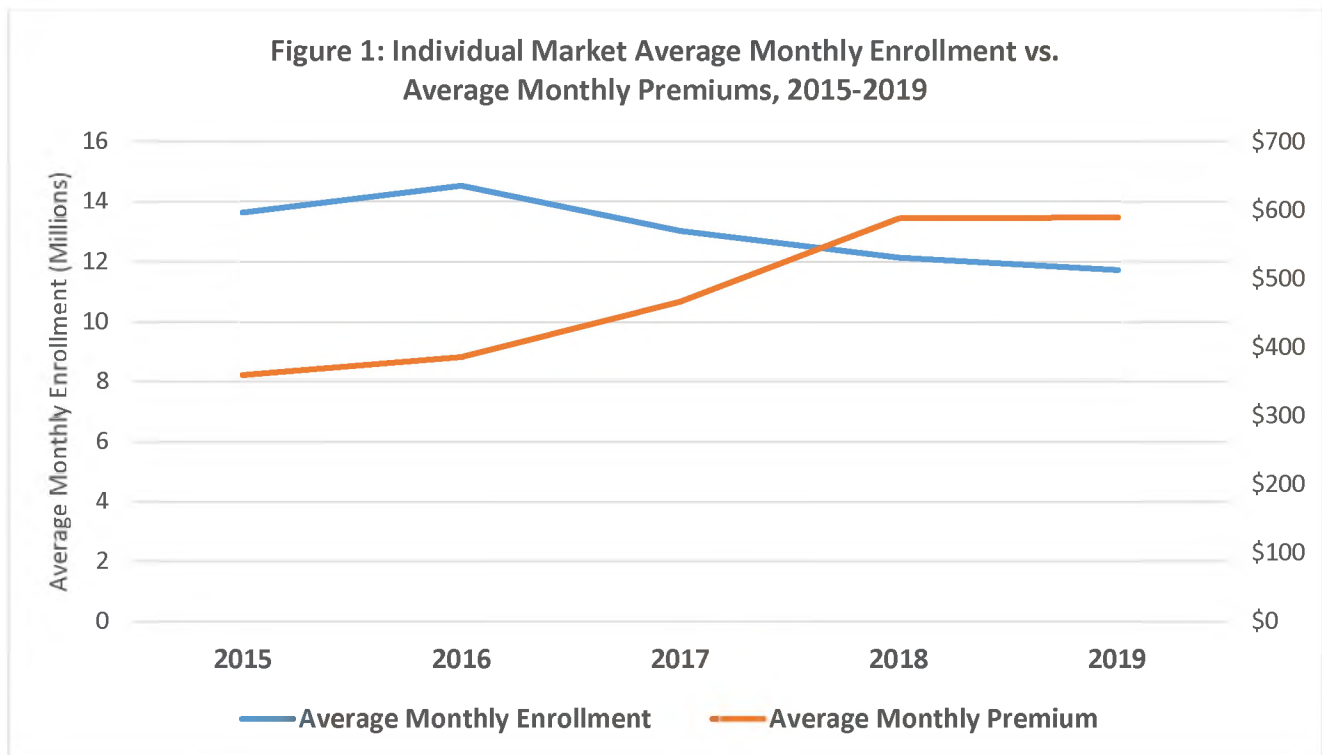
² https://www.regtap.info/uploads/library/RA_GuidanceMergedMarkets2017_030118_5CR_030118.pdf.

³ Note that for purposes of comparison with Exchange data, enrolled member months used for this analysis differ slightly from the billable member months used for risk adjustment and for other reporting on the risk adjustment program.

Note that changes in state Medicaid and Basic Health Programs can significantly affect state-level enrollment. State actions to expand Medicaid eligibility to 138 percent of the federal poverty level (or make a Basic Health Plan available) can substantially reduce the number of people enrolling *with* APTCs from one year to the next. In addition, people who enroll in an Exchange *without* APTCs can include people who enroll through Medicaid premium support programs.⁴ Thus, Medicaid expansion through premium support could increase unsubsidized enrollment for people without APTCs and, likewise, any modification to an existing Medicaid premium support program can affect unsubsidized enrollment.

National Enrollment Trends

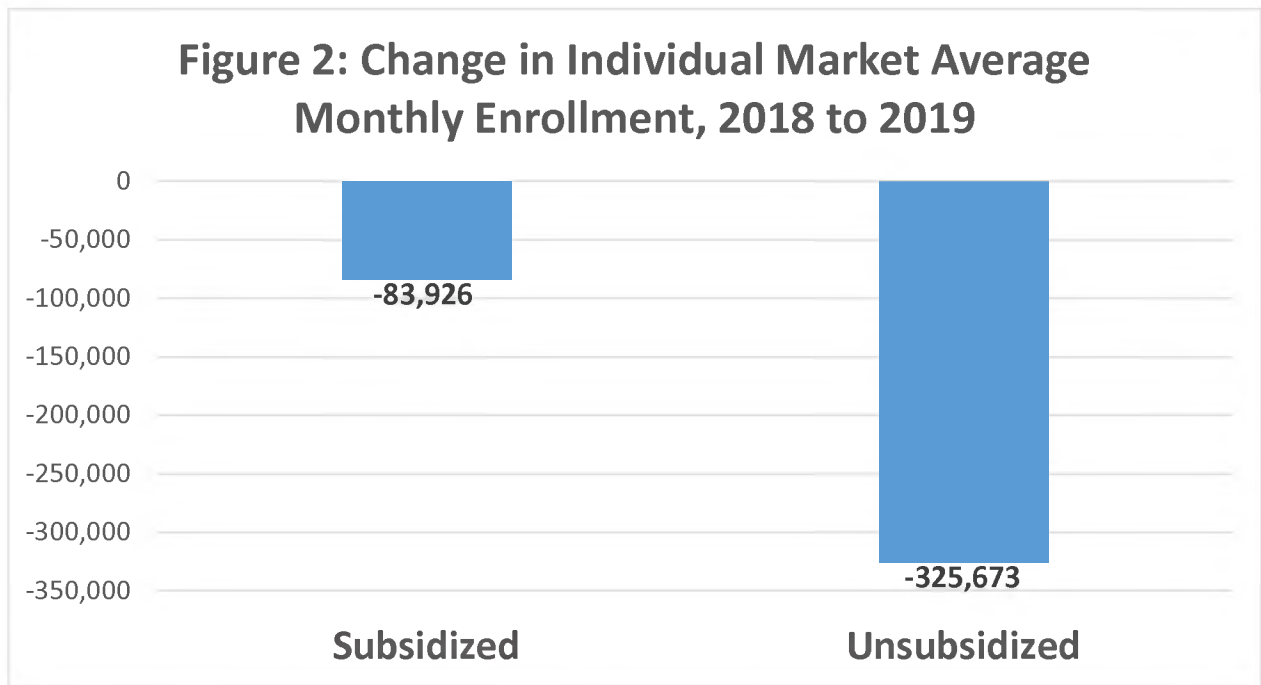
From 2015 to 2016, individual market monthly average enrollment rose by 7 percent to 14.5 million members. However, this trend reversed from 2016 to 2017, when enrollment declined by 10 percent. Enrollment declined another 7 percent from 2017 to 2018. As Figure 1 shows, the declines in enrollment in 2016 through 2018 occurred at the same time premiums were increasing sharply. In 2019, average monthly premiums remained consistent with 2018 average monthly premiums, and enrollment declined more modestly, by 3 percent.



Source: 2015-2019 Risk Adjustment Data

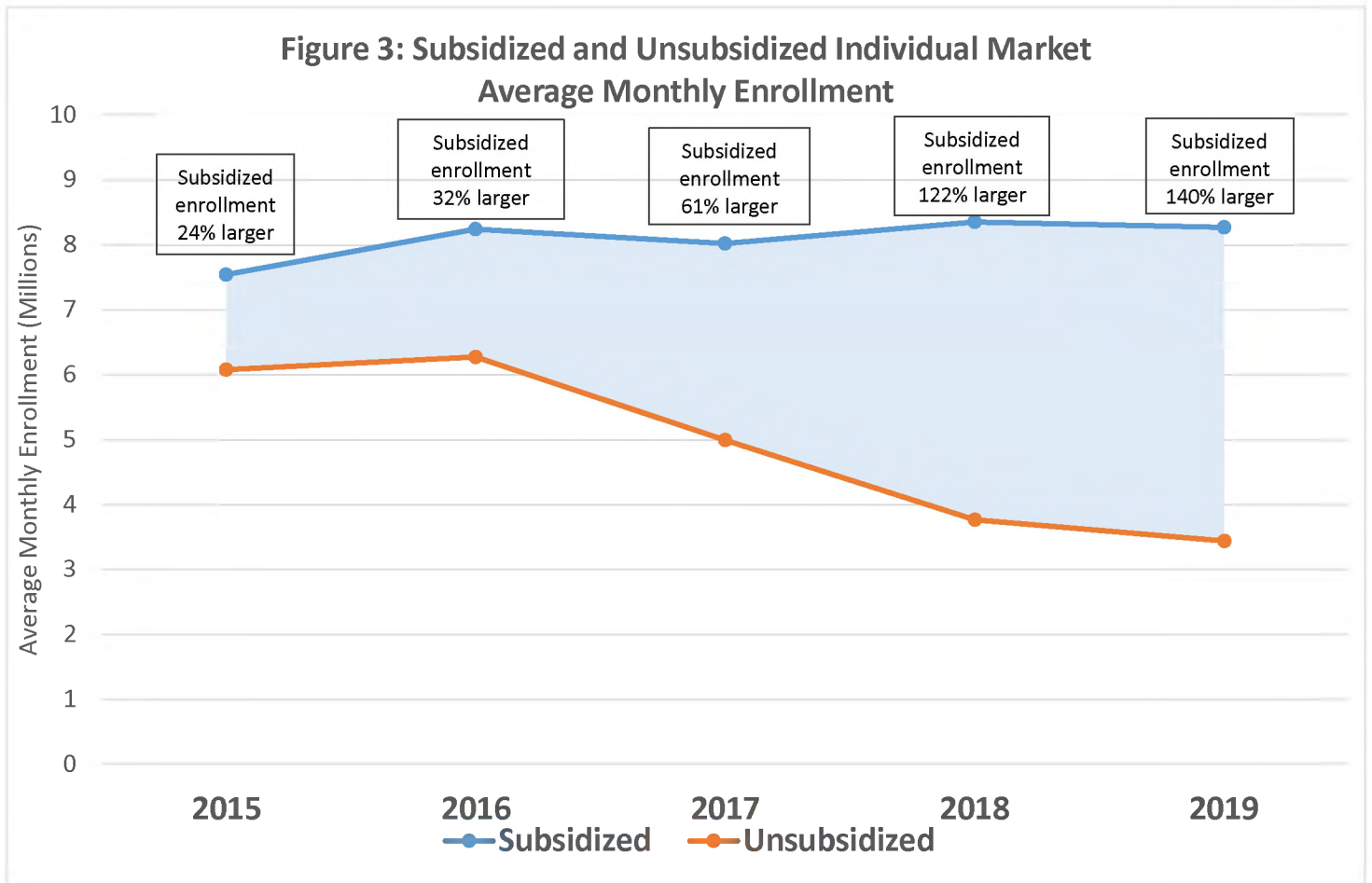
⁴ Arkansas, Iowa, and New Hampshire have all provided Medicaid premium support at some point during the reporting period.

From 2016 to 2017, enrollment declined among both the subsidized and the unsubsidized portions of the market, with the unsubsidized representing 85 percent of the decline in enrollment. From 2017 to 2018, the unsubsidized represented the entire drop in enrollment, which was offset by a small increase in subsidized enrollment. From 2018 to 2019, enrollment again declined among both subsidized and unsubsidized, with the unsubsidized representing 80 percent of the decline. In 2019, as shown in Figure 2, average monthly unsubsidized enrollment declined by 326,000 (9 percent) compared to a decrease in subsidized enrollment of 84,000 (1 percent).



Source: 2018-2019 Risk Adjustment Data and 2018-2019 Exchange Effectuated Enrollment and Payment Data

As unsubsidized enrollment continued to decline at a higher rate, the gap between subsidized and unsubsidized average monthly enrollment in the individual market has grown since 2015. Figure 3 shows the enrollment trend in the subsidized and unsubsidized portion of the markets between 2015 and 2019. The shaded area shows that the APTC subsidized market has been growing larger relative to the unsubsidized market between 2015 and 2019. In 2015, the subsidized portion of the market was 24 percent larger than the unsubsidized portion, a difference that has grown markedly since. In 2018 and 2019, subsidized enrollment was more than double unsubsidized enrollment.



Source: 2015-2019 Risk Adjustment Data and 2015-2019 Exchange Effectuated Enrollment and Payment Data

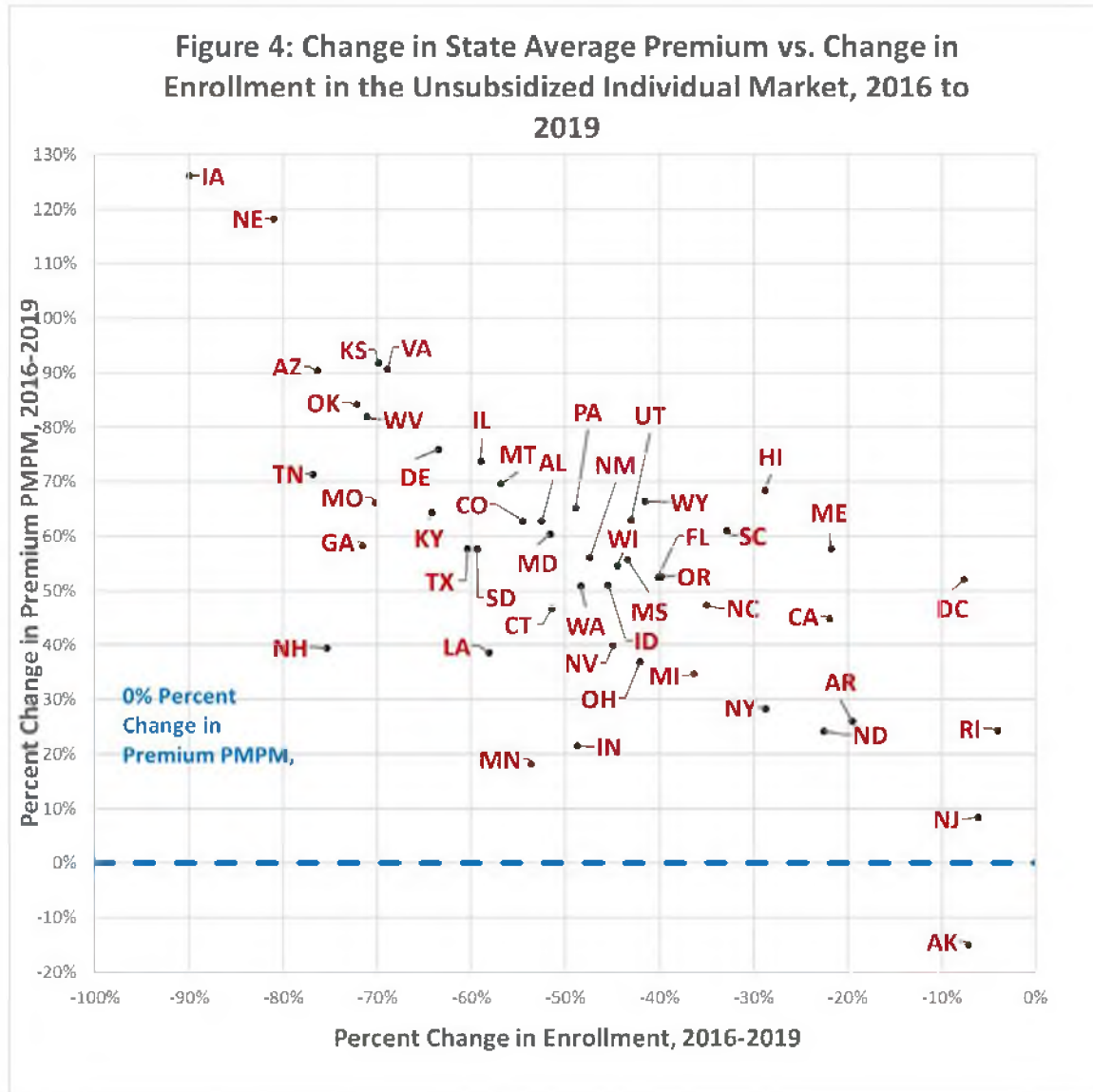
State-Level Enrollment Trends

In the individual market, there is a continuing trend of declining enrollment across most states. However, the rate of decline slowed in most states in 2019 compared to the 2016-2018 period. Ten states began to see declines from 2015 to 2016, including a 17.6 percent decline in Alaska and a 13.5 percent decline in Minnesota. By 2017, the number of states experiencing declining individual market enrollment grew to 44, and 43 states experienced declining enrollment from 2017 to 2018. In 2019, 39 states saw individual market enrollment decline from 2018. These trends were more favorable compared to those from 2017 to 2018, including ten states where the individual market grew from 2018 to 2019.

Declining enrollment has been more dramatic in the unsubsidized portion of state markets, but there were also signs of stabilization in 2019 as premiums leveled off.

Three successive years of declining enrollment from 2016 to 2019 resulted in a 45 percent drop in unsubsidized enrollment nationally. This represents a decline from 6.3 million to 3.4 million average monthly unsubsidized members. During this three-year period, some states experienced declines that were far more substantial than the 45 percent national average decline. At the extreme, unsubsidized enrollment dropped by 90 percent between 2016 and 2019 in Iowa. Over

this period, in addition to Iowa, unsubsidized enrollment declined by more than 70 percent in Arizona (-76 percent), Georgia (-72 percent), Missouri (-70 percent), Nebraska (-81 percent), New Hampshire (-75 percent), Oklahoma (-72 percent), Tennessee (-77 percent), and West Virginia (-71 percent). As shown in Figure 4, these states with larger declines in unsubsidized enrollment tended to experience a larger increase in average premiums.



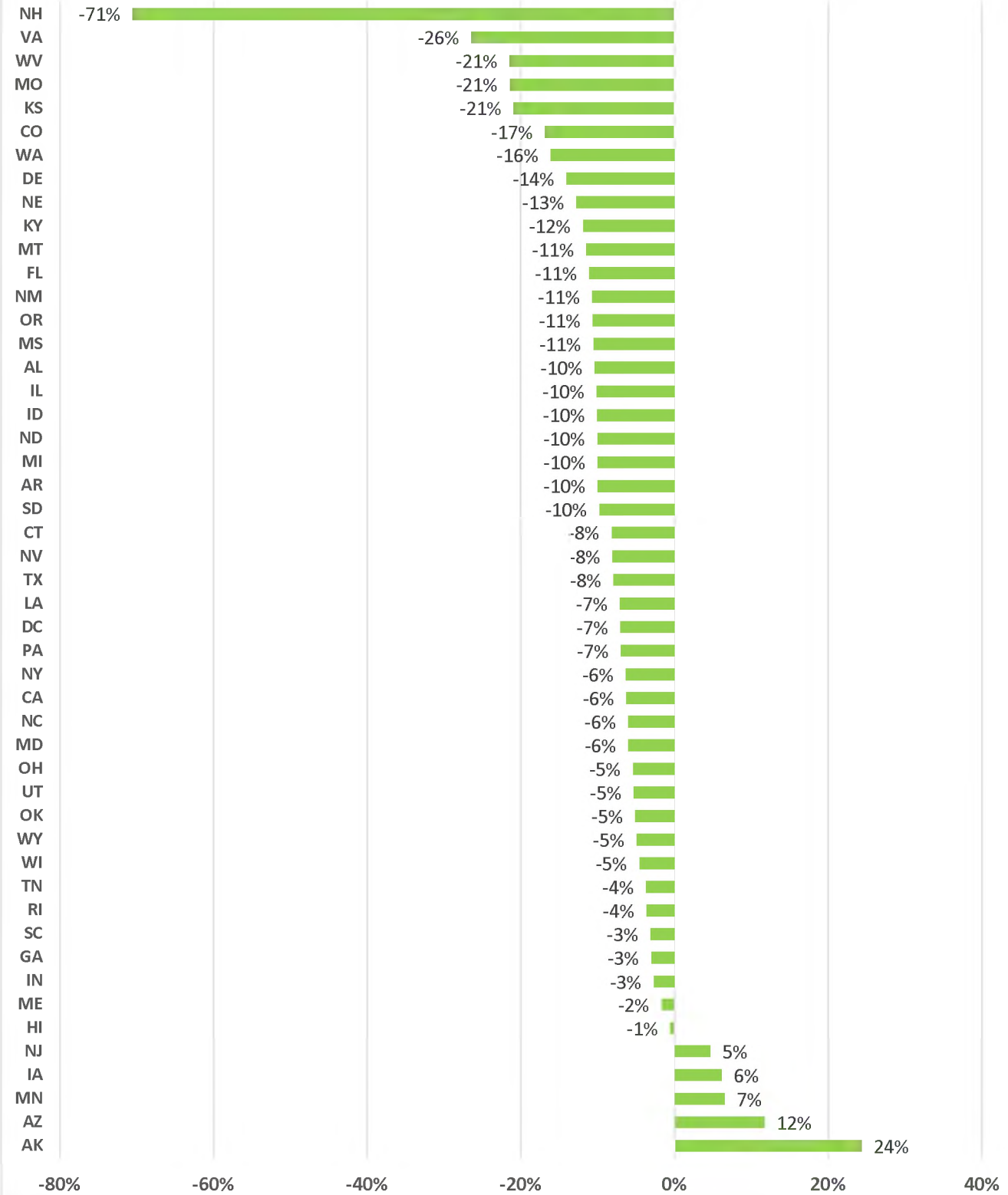
Source: 2016-2019 Risk Adjustment Data and 2016-2019 Enrollment and Payment Data

Figure 5 provides a state-by-state look at unsubsidized average monthly enrollment changes from 2018 to 2019. During this period, 44 states experienced declining enrollment in the unsubsidized

market. The five states experiencing the largest declines were New Hampshire⁵ (-71 percent), Virginia (-26 percent), West Virginia (-21 percent), Missouri (-21 percent), and Kansas (-21 percent). Changes in unsubsidized enrollment ranged from a 24 percent gain in Alaska to a 71 percent decline in New Hampshire. However, every state but three (the District of Columbia, New Hampshire, and North Carolina) experienced either a smaller decline from 2018 to 2019 compared to the 2017 to 2018 period, or growth in enrollment from 2018 to 2019. Unsubsidized enrollment increased in five states from 2018 to 2019: Alaska (24 percent), Arizona (12 percent), Minnesota (7 percent), Iowa (6 percent), and New Jersey (5 percent). Statewide average premiums fell by more than 5 percent in each of these states from 2018 to 2019.

⁵ New Hampshire transitioned Medicaid expansion enrollees from Exchange plans to Medicaid managed care in January 2019. This change applied to approximately 40,000 enrollees, which appears to account for the entire decline in the unsubsidized market from plan year 2018 to plan year 2019.

Figure 5: Percent Change in Unsubsidized Enrollment, 2018 to 2019



Source: 2018-2019 Risk Adjustment Data and 2018-2019 Enrollment and Payment Data

	Individual Health Insurance Market APTC Subsidized and Unsubsidized Average Monthly Enrollment, 2014 to 2019											
	2014		2015		2016		2017		2018		2019	
State	Subsidized	Unsubsidized	Subsidized	Unsubsidized	Subsidized	Unsubsidized	Subsidized	Unsubsidized	Subsidized	Unsubsidized	Subsidized	Unsubsidized
AK	8,283	4,461	14,451	6,906	14,065	3,531	13,442	2,456	14,125	2,636	13,254	3,279
AL	62,238	93,722	115,213	92,683	132,648	77,700	139,996	50,681	138,233	41,202	132,717	36,924
AR	27,869	145,728	44,139	228,450	51,509	282,235	46,711	291,884	49,431	252,345	49,478	227,170
AZ	62,472	60,181	109,874	116,920	119,755	115,523	119,467	31,571	119,495	24,396	111,689	27,253
CA	864,652	768,764	1,104,101	954,032	1,141,457	1,013,307	1,129,187	971,296	1,196,566	844,535	1,174,764	791,597
CO	55,925	83,553	61,935	151,359	85,334	188,231	91,335	152,930	100,869	102,960	111,758	85,627
CT	47,624	48,342	67,844	97,086	73,501	99,867	70,071	75,502	74,045	52,785	66,966	48,472
DC	961	6,871	1,287	13,031	1,128	16,004	886	16,937	966	15,904	969	14,780
DE	8,151	7,173	16,785	16,105	19,330	15,268	18,028	10,789	17,032	6,477	17,276	5,571
FL	603,303	173,265	1,094,336	324,165	1,240,296	361,558	1,229,240	314,501	1,371,754	243,292	1,474,516	216,372
GA	185,250	85,273	340,487	184,319	363,833	213,915	338,217	158,333	330,535	62,773	337,826	60,866
HI	2,481	17,101	11,274	23,777	10,886	22,968	13,583	19,584	13,729	16,433	14,238	16,347
IA	17,221	40,337	31,115	51,501	38,778	43,539	37,011	26,706	37,164	4,129	41,179	4,383
ID	49,484	27,396	71,647	40,525	77,665	41,541	73,142	33,022	76,425	25,203	76,830	22,669
IL	118,752	154,711	211,553	274,792	231,892	271,089	230,265	165,646	240,510	123,730	226,065	111,221
IN	80,848	31,387	134,373	70,485	124,333	80,283	101,588	66,031	92,956	42,294	87,173	41,144
KS	32,811	26,507	61,244	62,093	68,798	62,054	70,441	41,765	71,108	23,632	69,688	18,690
KY	45,374	27,471	59,760	45,503	57,877	48,569	54,449	39,264	58,204	19,714	58,059	17,371
LA	55,125	34,956	112,975	63,476	141,299	67,753	90,846	42,942	76,250	30,563	69,942	28,386
MD	39,900	64,001	77,739	163,908	95,084	160,476	98,261	128,946	110,632	82,595	114,189	77,635
ME	30,920	6,801	56,845	15,817	63,402	18,756	57,984	19,913	57,883	14,918	52,589	14,671
MI	145,220	102,939	239,332	155,916	238,431	172,593	215,804	157,664	210,416	122,135	202,809	109,918
MN	13,811	223,772	25,292	252,637	42,631	197,681	61,932	92,539	62,832	86,111	59,219	91,731
MO	92,598	41,525	172,128	83,155	199,238	89,722	175,662	61,527	174,062	33,921	156,258	26,664
MS	35,858	13,404	62,735	26,765	60,959	30,138	57,172	23,691	64,178	19,070	72,918	17,062
MT	24,500	32,469	38,138	42,323	39,605	35,995	38,625	22,099	35,760	17,542	34,241	15,531
NC	228,142	76,311	386,157	122,230	426,753	115,214	407,524	76,602	406,670	79,664	402,226	74,849
ND	6,976	13,588	10,004	29,494	16,012	26,318	16,399	25,221	16,893	22,660	17,224	20,388

	Individual Health Insurance Market APTC Subsidized and Unsubsidized Average Monthly Enrollment, 2014 to 2019 (Continued)											
	2014		2015		2016		2017		2018		2019	
State	Subsidized	Unsubsidized	Subsidized	Unsubsidized	Subsidized	Unsubsidized	Subsidized	Unsubsidized	Subsidized	Unsubsidized	Subsidized	Unsubsidized
NE	28,029	31,549	53,228	42,080	66,354	41,257	66,602	21,978	73,513	8,956	76,949	7,816
NH	21,958	11,960	27,370	23,089	30,451	65,667	27,844	69,095	30,065	54,735	28,665	16,142
NJ	95,269	82,490	165,220	137,104	186,444	150,161	185,258	157,645	178,312	134,611	162,892	140,916
NM	16,769	18,347	29,181	47,476	29,731	42,209	31,066	34,492	33,803	24,874	30,364	22,215
NV	22,754	26,257	45,984	69,971	63,748	66,549	59,514	56,091	62,054	39,870	58,503	36,662
NY	184,288	155,325	244,393	229,000	112,922	246,104	120,407	216,111	133,154	187,229	140,173	175,385
OH	89,201	60,809	143,087	106,060	157,136	119,429	145,792	104,961	143,676	73,131	132,806	69,176
OK	38,062	29,806	78,783	81,673	103,199	65,769	109,723	26,281	120,156	19,263	131,110	18,278
OR	46,555	98,818	68,098	136,180	87,436	137,234	95,919	114,465	98,489	92,410	95,106	82,609
PA	194,532	144,563	290,771	295,186	286,907	284,844	289,737	204,355	299,649	156,498	266,152	145,577
RI	20,334	14,477	25,783	15,512	27,652	17,970	23,376	19,657	26,394	17,892	27,027	17,237
SC	66,374	23,594	135,801	49,536	160,746	56,115	157,420	44,497	162,859	38,926	167,649	37,708
SD	8,876	12,905	15,728	23,660	20,671	20,876	23,796	12,226	24,684	9,399	24,495	8,481
TN	79,926	55,167	140,103	110,012	178,488	118,944	167,618	60,367	175,560	28,569	155,951	27,501
TX	381,158	213,528	698,768	491,960	804,423	446,661	778,233	276,431	807,405	192,075	822,509	176,854
UT	38,951	48,140	103,938	60,965	135,947	64,127	143,625	54,376	156,607	38,605	165,977	36,547
VA	121,241	61,955	246,856	158,010	286,524	157,547	281,606	136,781	277,453	66,466	218,775	48,928
WA	99,453	193,648	114,164	197,260	113,719	199,058	112,775	181,823	128,435	122,448	126,429	102,795
WI	92,181	39,090	151,723	60,601	174,641	72,071	166,310	62,992	164,999	41,935	157,413	40,008
WV	12,272	8,931	23,113	20,327	26,063	17,143	22,799	10,676	19,390	6,294	16,527	4,946
WY	8,686	5,004	14,901	7,489	19,138	7,137	19,273	7,054	20,869	4,392	20,794	4,174
TOTAL	4,613,617	3,748,369	7,549,756	6,072,605	8,248,839	6,268,703	8,025,959	4,992,392	8,356,247	3,772,200	8,272,321	3,446,527

Source: 2014-2019 Risk Adjustment Data and 2014-2019 Exchange Effectuated Enrollment and Payment Data

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CBO

Policies to Achieve Near-Universal Health Insurance Coverage



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At a Glance

In this report, the Congressional Budget Office examines policy approaches that could achieve near-universal health insurance coverage using some form of automatic coverage through a default plan. As defined by CBO, a proposal would achieve near-universal coverage if close to 99 percent of citizens and noncitizens who are lawfully present in this country were insured either by enrolling in a comprehensive major medical plan or government program or by receiving automatic coverage through a default plan.

Components of Proposals That Would Achieve Near-Universal Coverage

Policy approaches that achieved near-universal coverage would have two primary features:

- At a minimum, if they required premiums, those premiums would be subsidized for low- and moderate-income people, and
- They would include a mandatory component that would not allow people to forgo coverage or that would provide such coverage automatically.

The mandatory component could take the form of a large and strongly enforced individual mandate penalty—which would induce people to enroll in a plan on their own by penalizing them if they did not—or a default plan that would provide automatic coverage for people who did not purchase a health insurance plan on their own during periods in which they did not have an alternative source of insurance. Because lawmakers recently eliminated the individual mandate penalty that was established by the Affordable Care Act, this report focuses on approaches that could achieve near-universal coverage by using premium subsidies and different forms of automatic coverage through a default plan.

Policy Approaches

CBO organized existing proposals into four general approaches, ranging from one that would retain existing sources of coverage to one that would almost entirely replace the current system with a government-run program. All four approaches would provide automatic coverage to people who did not enroll in a plan on their own.

- Two approaches would fully subsidize coverage for lower-income people and partially subsidize coverage for middle-income and some higher-income people while retaining employment-based coverage. Financing would come, in part, from broad-based tax revenues that were not linked to health insurance coverage. Financing also would come from higher taxes on those uninsured people who were covered by the default plan and whose premiums were not fully subsidized; those taxes would be equivalent to their share of the premium. Collecting such taxes from uninsured people would pose challenges.
- Two approaches would fully subsidize coverage for people at all income levels. Financing would come entirely from broad-based tax revenues, and people who did not enroll in a health insurance plan would not owe additional taxes.

Under some approaches, the default plan would be privately managed. Under others, it would be a public plan, operated by the federal government.

The approaches that CBO examined would require varying amounts of government spending to cover the same number of people. They would all require additional federal receipts to achieve deficit neutrality.



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Notes

As referred to in this report, the Affordable Care Act comprises the Patient Protection and Affordable Care Act (Public Law 111-148), the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and the effects of subsequent judicial decisions, statutory changes, and administrative actions.



Policies to Achieve Near-Universal Health Insurance Coverage

Summary

In this report, the Congressional Budget Office examines policy approaches that could achieve near-universal health insurance coverage. Such approaches would provide nearly all people in the United States with financial protection against high-cost medical events, increase overall access to health care, and decrease the costs that providers incur when they provide medical services to uninsured people. The approaches also would increase federal subsidies for health care.

As defined by CBO, a proposal would achieve near-universal coverage if close to 99 percent of citizens and noncitizens who are lawfully present in this country were insured either by enrolling in comprehensive major medical coverage or by receiving automatic coverage through a default plan. Attaining such coverage would be challenging, however. CBO is not aware of any existing proposals—legislative or otherwise—that would achieve complete (that is, 100 percent) universal coverage because they all would require some demonstration of eligibility (such as meeting criteria related to citizenship or residency) that some eligible people would not comply with for various reasons.

Essential Components of Near-Universal Health Insurance Coverage and an Overview of the Approaches That CBO Analyzed

In CBO's view, to attain near-universal coverage, a policy would need to provide premium subsidies for low- and moderate-income people and include a mandatory component that would not allow people to forgo coverage. Subsidizing premiums for low- and moderate-income people would be essential because paying the full cost of comprehensive major medical coverage out of pocket would typically be prohibitive. A mandatory component would be essential because some people would still choose not to purchase insurance even if they had the means to do so. The mandatory component could take

the form of a requirement that people purchase health insurance (sometimes known as an individual mandate), which would be strongly enforced with a large penalty, or it could provide automatic coverage through a default plan for people who did not purchase a health insurance plan of their choice.

Because the Congress recently eliminated the individual mandate penalty that was established by the Affordable Care Act (ACA), CBO did not focus on approaches that would achieve near-universal coverage using such a mandate. Instead, CBO focused on approaches that would attain near-universal coverage by using premium subsidies and different forms of automatic coverage through a default plan. (CBO uses the term “default plan” to describe a plan that would provide automatic coverage to people during periods in which they did not have an alternative source of insurance; eligible people could use it to receive medical care at any time.)

Under an individual mandate, a penalty is levied on people who do not enroll in a plan. Although those people are required to make a payment, they do not have any coverage. If the penalty was large and strongly enforced, then nearly all people would choose to purchase insurance rather than pay the penalty. By contrast, with automatic coverage through a default plan, the government provides or procures insurance for people who do not purchase it on their own and finances the cost of that coverage through the tax system. Financing could come entirely from broad-based revenues if the default plan was fully subsidized, or it could come, in part, from premium-equivalent tax payments levied on people who did not purchase a plan on their own.

In this report, CBO describes the key features—specifically, the enrollment process, premiums, cost sharing and benefits, and the role of private insurance, public programs, and employment-based insurance—of four

general approaches that could achieve near-universal coverage by using premium subsidies and different forms of automatic coverage through a default plan. Those approaches are as follows:

- **Approach 1.** A multipayer system that retains existing sources of coverage while expanding eligibility for premium subsidies and providing partially subsidized default coverage through a private plan or a new public option.¹
- **Approach 2.** A multipayer system that retains employment-based coverage and replaces the current nongroup market and the acute care portions of Medicaid and the Children’s Health Insurance Program (CHIP) with a new public program that allows people to choose between partially subsidized private plans and a publicly administered plan that provides default coverage.
- **Approach 3.** A multipayer system that provides full subsidies for all people to purchase a private plan of their choice, with a default plan that provides automatic coverage to people who do not enroll in a plan on their own.
- **Approach 4.** A single-payer system that acts as a default plan for all people.

Those four general approaches encompass all of the detailed proposals that CBO has identified as potentially achieving near-universal coverage without the use of a large and strongly enforced individual mandate penalty. Although the four approaches described in this report have the potential to achieve near-universal coverage, CBO has not analyzed specific proposals in detail.

This report focuses on people under the age of 65; the Medicare program could continue to provide coverage to people age 65 or older under all of the approaches except for the one that would adopt a single-payer system. The report does not discuss effects on national health expenditures (NHE), which might increase or decrease under different approaches depending on the details of the proposal. Approaches that lowered out-of-pocket costs would increase NHE by encouraging greater use of health care, but that increase could be offset by other features, such as lower provider prices, that would result in lower NHE.

1. A multipayer health care system is one in which more than one insurer provides health insurance coverage.

The approaches CBO examined would require varying amounts of government spending to cover the same number of people, but they would all require at least some additional federal receipts to achieve deficit neutrality. Whether the adopted approach is deficit-neutral is a choice that policymakers would need to make. Much of the new federal costs would stem from the additional tax credits or other subsidies that would be made available to people. Some of those subsidies would reduce or eliminate the out-of-pocket premiums of people who would have been uninsured under the current system, and some would go to people who would have had coverage anyway under the current system. Reallocating existing federal subsidies for health care (such as uncompensated care payments and grants to community health centers) and for other sources of coverage (such as the tax exclusion for employment-based coverage) would not be sufficient to entirely finance the additional federal costs that would be incurred under the four approaches. A complete discussion of how the subsidies for coverage expansions would be financed is outside the scope of the report.

How Subsidies Would Affect Default Coverage Under Different Approaches

All four of the approaches described in this report would provide automatic coverage through a default plan, but the role of default coverage would vary under each of the approaches. Specifically:

- The first two approaches would fully subsidize default coverage for lower-income people and partially subsidize coverage for middle-income and some higher-income people. Under those approaches, the government would collect premium-equivalent tax payments from middle- and higher-income people who did not have an alternative source of insurance. Levying taxes on those people would be the equivalent of charging mandatory premiums for the default plan. To maintain incentives to enroll in other sources of coverage, the amount of the tax associated with default coverage would be made equivalent to the net premium the person would pay to actively enroll in a plan that provided similar benefits.
- The last two approaches would fully subsidize default coverage for people at all income levels, and no premium-equivalent tax payments would be collected. Those approaches could be financed through broad-based tax revenues that are not linked to people’s health insurance coverage.

Challenges Associated With Implementing Automatic Coverage Through a Default Plan

Providing automatic coverage through a default plan to achieve near-universal coverage would present several challenges, particularly if the plan was only partially subsidized. Additional challenges would arise if the default plan was part of a risk-adjustment system that shared the cost of insuring a group of enrollees across all plans, as the current nongroup market does. (The nongroup market is a private health insurance market that enables individuals and families who are not eligible for coverage through public programs or who do not have employment-based insurance to purchase a private health insurance policy.) There also would be challenges associated with informing people about their eligibility for default coverage and its associated benefits, particularly the plan's provider network.

Collecting premium-equivalent tax payments when default coverage was partially subsidized would require verifying the coverage status of all tax filers, which would be administratively complex. Although uninsured people would gain coverage through a default plan, many people might be surprised by the new premium-equivalent tax that would be required to finance their coverage if taxes were collected many months after the period during which they were uninsured (unlike a premium, which is collected at the time a person enrolls in health insurance). That tax obligation could total thousands or even tens of thousands of dollars, particularly for the highest-income families who would not qualify for any subsidies.

Additional complexities would arise if the default plan shared the cost of insuring more or less costly people with other plans through the same risk-adjustment system. Determining the appropriate risk-adjustment payments to plans (which adjust their premiums for the cost of their enrollees) would be challenging because it would require the government to determine the number of people covered by the default plan and the cost to insure them relative to the cost of people covered by other plans in the risk-adjustment system.

The government also would need to inform people about their eligibility for default coverage and the benefits associated with that coverage. An outreach campaign could educate people about their eligibility for the default plan and its associated benefits, but it would be difficult to fully inform all people. If some providers did not participate in the default plan's network, informing people

about which providers did participate would present particular challenges. Some people might seek care without knowing whether a provider participated in the default plan's network and might be unexpectedly billed large amounts for their care if they received treatment from a nonparticipating provider.

Policy Approaches That Could Achieve Near-Universal Coverage by Using a Default Plan

CBO analyzed four approaches that have the potential to achieve near-universal coverage by using both premium subsidies and a form of default coverage. Each approach involves a general strategy for covering all people in a defined population, and the approaches have multiple variants and design choices, such as how much to subsidize premiums and the degree of cost sharing. (For a summary of approaches to achieve near-universal health insurance coverage through a default plan, see Table 1. For key features of approaches to achieve near-universal health insurance coverage through a default plan as compared with current law, see Table 2.)

Each successive approach would require more significant changes to the current system and, in general, would be more costly to the federal government. Approaches that involved more incremental changes to the current system—specifically, Approaches 1 and 2—would entail fewer transition costs and changes to existing sources of coverage, but they would impose new tax obligations on some people who did not enroll in a plan, and the resulting system would be more complex than under the other approaches. Approaches that involved more significant changes to the current system—Approaches 3 and 4—would require larger transition costs and changes to sources of coverage, but enrolling people in coverage would be simpler once those initial adjustments took place and transition costs were incurred. Those more significant changes would allow individuals with the same income and similar family characteristics to receive similar subsidies for health insurance. They also would reduce the extent to which subsidies, namely the tax preferences for employment-based health insurance, increased as income increased, or eliminate the subsidies altogether.

The approaches that CBO analyzed are as follows:

Approach 1: Partially Subsidized Default Coverage That Operates in Tandem With Current Sources of Coverage. This approach would use partially subsidized default coverage to cover all people in a defined population who did

Table 1.

Summary of Approaches to Achieve Near-Universal Health Insurance Coverage Through a Default Plan

Approach	Summary	Variants	Examples
Approach 1: Partially Subsidized Default Coverage That Operates in Tandem With Current Sources of Coverage	This approach would provide partially subsidized default coverage through a private or public plan to cover people who did not actively enroll in an alternative source of coverage and were not eligible for Medicaid or CHIP. Most key features of the ACA would remain in place, but premium subsidies would be extended to those whose income was less than 100 percent of the FPL and potentially made more generous for middle- and higher-income households. In addition, the employer firewall would be removed. ^a	Private default plan Public option as default plan	Fiedler and others (2019) ^b Blumberg and others (2019a) ^c
Approach 2: Partially Subsidized Default Coverage Through a Large Public Program That Replaces Medicaid, CHIP, and the Nongroup Market and Retains Employment-based Coverage	A new public program consisting of a publicly administered plan and several private-plan options would replace the existing nongroup market and Medicaid and CHIP acute care coverage. ^d Large employers would be required to offer coverage or make mandatory contributions to the public program, and employees could choose to receive coverage either through their employer or through the public program. Premium and cost-sharing reductions would remain income-based and would become more generous. The public plan would provide partially subsidized default coverage for those without an alternative source of coverage.	n.a.	Medicare for America Act of 2019 (H.R. 2452); Center for American Progress (2019) ^e Blumberg and others (2019b) ^f
Approach 3: Premium Subsidies for All People and Default Coverage Through a Fully Subsidized Plan	All households would receive a subsidy generous enough to cover the entire cost of a specified benchmark plan in a marketplace of private plans, potentially including a public option. Low- and middle-income households would receive cost-sharing reductions, and supplemental coverage that reduced cost sharing or provided additional benefits could be obtained through employers. A benchmark zero-premium plan would provide fully subsidized default coverage for those without an alternative source of coverage.	Subsidy covers catastrophic plan Subsidy covers generous plan	Dolan (2019); Goldman and Hagopian (2012) ^g Halvorson and Oz (2020); Joyce (2019); Janda and Ho (2019); Wynne (2017) ^h
Approach 4: A Single-Payer System	All eligible individuals would be enrolled in a single public plan, typically with no role for private coverage, and no premiums would be collected. Cost sharing could be income-based or, as in existing legislative proposals, zero for all individuals.	n.a.	Medicare for All Act of 2019 (H.R. 1384); Medicare for All Act of 2019 (S. 1129)

Source: Congressional Budget Office.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; FPL = federal poverty level; H.R. = House of Representatives; S. = Senate; n.a. = not applicable.

- a. Under current law, people with an affordable offer of employment-based coverage are ineligible for premium subsidies in the health insurance marketplaces because of a provision of the Affordable Care Act known as the employer firewall. In 2020, an offer of affordable employment-based coverage is defined by the Internal Revenue Service as one in which an employee's out-of-pocket premium is less than 9.78 percent of household income for a single plan. For more details about the employer firewall, see Box 1 on page 22.
- b. Rather than extending eligibility for marketplace subsidies to those whose income is below 100 percent of the FPL, the proposal includes features that would provide incentives for states that have not expanded Medicaid under the terms of the ACA to do so. See Matthew Fiedler and others, "Building on the ACA to Achieve Universal Coverage," *New England Journal of Medicine*, vol. 380, no. 18 (May 2019), pp. 1685–1688, <http://doi.org/10.1056/NEJMp1901532>.
- c. The proposal also would increase the generosity of marketplace subsidies and establish a federal reinsurance program for the nongroup market. See "Simulated Reform Packages: Reform 5," in Linda J. Blumberg and others, *From Incremental to Comprehensive Health Insurance Reform: How Various Reform Options Compare on Coverage and Costs* (Urban Institute, October 2019a), p. 6, <https://tinyurl.com/yy9atuf7> (PDF, 1.05 MB).
- d. The nongroup market is a private health insurance market that enables individuals and families who are not eligible for coverage through public programs or who do not have employment-based insurance to purchase a private health insurance plan.
- e. See Medicare for America Act of 2019, H.R. 2452, 116th Cong. For related information, see Center for American Progress Health Policy Team, *Medicare Extra: Universal Coverage for Less Than \$3 Trillion and Lower Health Care Costs for All* (July 2019), <https://tinyurl.com/yyx9f55d> (PDF, 1.18 MB).
- f. The proposal does not require large employers to offer coverage or make mandatory contributions. See "Description of Policy Options: The Building Blocks of Healthy America," Variant 3: "HA With CARE," in Linda J. Blumberg and others, *The Healthy America Program, An Update and Additional Options* (Urban Institute, September 2019b), p. 3, <https://tinyurl.com/y3x3zys> (PDF, 533 KB).
- g. See Ed Dolan, *Universal Catastrophic Coverage: Principles for Bipartisan Health Care Reform* (Niskanen Center, June 2019), <https://tinyurl.com/y4jkfzco> (PDF, 969 KB). See also Dana Goldman and Kip Hagopian, "The Health-Insurance Solution," *National Affairs* (Fall 2012), <https://tinyurl.com/y3es67tp>.
- h. See George Halvorson and Mehmet Oz, "Medicare Advantage for All Can Save Our Health-Care System," *Forbes* (June 11, 2020), <https://tinyurl.com/yyjvw8j2>; Geoffrey Joyce, "Opinion: The Success of Medicare Advantage Makes It a Better Policy Choice Than 'Medicare for All,'" *MarketWatch* (November 21, 2019), <https://tinyurl.com/y42cj4zl>; Ken Janda and Vivian Ho, "Medicare Advantage for All," *The Hill* (August 27, 2019), <https://tinyurl.com/y6avusv8>; and Billy Wynne, "The Bipartisan 'Single Payer' Solution: Medicare Advantage Premium Support for All," *Health Affairs Blog* (May 11, 2017), <https://tinyurl.com/y6xba4hx>.

Table 2.

Key Features of Approaches to Achieve Near-Universal Health Insurance Coverage Through a Default Plan Compared With the System in Effect Under Current Law

Key Feature	Current Law	Approach 1: Establishes Partially Subsidized Default Coverage ^a	Approach 2: Establishes a Large Public Program ^b	Approach 3: Provides Premium Subsidies for All People ^c	Approach 4: Establishes a Single-Payer System
Premiums					
All eligible individuals have the option of zero-premium primary coverage	No	No	No	Yes	Yes
Premium subsidies are more generous for lower-income people than for higher-income people	Yes	Yes	Yes	n.a.	n.a.
All eligible individuals with income below the federal poverty level have subsidized coverage	No	Yes	Yes	Yes	Yes
Cost Sharing					
Cost-sharing reductions are more generous for lower-income people than for higher-income people	Yes	Yes	Yes	Yes	Maybe
Role of Private Plans					
All eligible individuals have the option of a private plan	Yes	Yes	Yes	Yes	No
Role of Employment-Based Coverage					
Individuals with an offer of affordable employment-based coverage are eligible for premium subsidies and cost-sharing reductions (the “employer firewall” is eliminated) ^d	No	Yes	Yes	Yes	n.a.
Employers are a large source of primary coverage	Yes	Yes	Maybe	No	No
Employment-based coverage is eliminated	No	No	No	No ^e	Yes
Role of Public Coverage					
Medicare is preserved for people over the age of 65	Yes	Yes	Yes	Yes	No
Medicaid and CHIP are preserved for acute care	Yes	Yes	No	No	No
All eligible individuals have the option of enrolling in a public plan	No	Maybe	Yes	Maybe	Yes
All eligible individuals are required to enroll in a public plan	No	No	No	No	Yes

Source: Congressional Budget Office.

CHIP = Children’s Health Insurance Program; n.a. = not applicable.

- a. Approach 1 could be implemented through a variant that introduced a new public option as a source of coverage that also would provide default coverage for otherwise uninsured people who did not actively enroll in another source of coverage. The new public option could be in the form of a public plan offered through existing health insurance marketplaces established by the Affordable Care Act.
- b. The new public program would allow people to choose between a publicly administered plan and multiple private plans meeting the same minimum requirements for cost sharing and covered benefits in a health insurance marketplace. Under some existing proposals, the new program also would replace the current Medicare program.
- c. The new system would allow people to use a premium subsidy to choose among multiple private plans in a marketplace. Variations of this approach also could include a publicly administered plan option alongside the private plans. The new premium support system could exist alongside the current Medicare program, or it could be combined with the current Medicare program.
- d. Under current law, people with an affordable offer of employment-based coverage are ineligible for premium subsidies in the health insurance marketplaces because of a provision of the Affordable Care Act known as the employer firewall. In 2020, an offer of affordable employment-based coverage is defined by the Internal Revenue Service as one in which an employee’s out-of-pocket premium is less than 9.78 percent of household income for a single plan. For more details about the employer firewall, see Box 1 on page 22.
- e. The only type of employment-based coverage that would remain under this approach would be for supplemental coverage that could be used to reduce cost-sharing amounts, or it could be used to offer benefits that are not available through marketplace plans, such as dental and vision services.

not otherwise enroll in a health insurance plan. Default coverage would be provided by a private or public plan for people who are ineligible for Medicaid and CHIP; it would be provided by Medicaid and CHIP to individuals who are currently eligible for but not enrolled in those programs. Existing sources of coverage—including Medicaid, CHIP, employment-based insurance, and nongroup insurance—and subsidies to purchase health insurance would remain in place.

This approach would remove the “employer firewall” provision of the ACA, thus making people with an offer of affordable employment-based coverage eligible for premium subsidies—including partially subsidized default coverage.² Most of the other features of the ACA, such as income-related premium subsidies and insurance market regulations, would remain in place. This approach also would extend full premium subsidies to people whose income was below 100 percent of the federal poverty guidelines (commonly referred to as the federal poverty level, or FPL), as well as to people whose income fell below the tax-filing threshold.³ This approach also could increase the generosity of subsidies for other households.

Under variants of this approach, default coverage could be provided by a private plan or through a new public option offered through the marketplaces. If default coverage was provided through a new public option, that public plan also would be available to all people who chose to actively enroll during an open-enrollment period. People who were otherwise uninsured and not eligible for full subsidies would be assessed a premium-equivalent tax to finance their default coverage. The amount of that tax would be the same as the premium

the uninsured person would pay to enroll in a benchmark plan in the nongroup market that provided equivalent benefits, after applying any premium tax credits for which he or she was eligible. That would preserve incentives for people to actively enroll in other plans, such as subsidized nongroup plans and employment-based plans that they might prefer because of those plans’ more generous benefits or broader provider networks.

Compared with the other approaches CBO analyzed, this approach would represent the most incremental change because most features of the current system, other than the employer firewall, would remain in place. The transition to the system outlined in this approach would lead to some changes in sources of coverage. Removing the employer firewall without imposing additional penalties or requirements on employers to offer generous coverage probably would lead some low-income people who currently receive employment-based coverage to switch to subsidized coverage through the nongroup market if they had the option of paying a lower premium. In addition, some employers might discontinue offering coverage, leaving their employees to enroll in the nongroup market. People who are uninsured under current law would gain coverage, primarily through the partially subsidized nongroup market or the default plan.

Although this approach demonstrates that attaining near-universal coverage while retaining existing sources of coverage is possible, providing default coverage would be significantly more challenging to implement than under other approaches that simplified coverage options and subsidized premiums to a greater degree. Identifying the people who were covered by the new default plan would be particularly complex under this approach because the government would need to verify the coverage status of all eligible people and determine whether they were eligible for Medicaid or CHIP, which would be administratively complex.

Approach 2: Partially Subsidized Default Coverage Through a Large Public Program That Replaces Medicaid, CHIP, and the Nongroup Market and Retains Employment-Based Coverage. This approach would establish a new public program consisting of a publicly administered plan and several privately administered plan options to replace the current nongroup market and the portions of Medicaid and CHIP that cover medical services and prescription drugs. However, many people would continue to enroll in employment-based insurance

2. Under current law, people with an affordable offer of employment-based coverage are ineligible for premium subsidies in the health insurance marketplaces because of a provision of the ACA known as the employer firewall. In 2020, an offer of affordable employment-based health insurance is defined by the Internal Revenue Service as one in which an employee’s out-of-pocket premium is less than 9.78 percent of household income for a single plan.
3. Eligibility for premium tax credits in coverage year 2019 was based on poverty guidelines for 2018. In 2018, the FPL was \$12,140 for a single person, and that amount increased by \$4,320 for each additional person in a household. People with income below a certain level, known as the tax-filing threshold, are not required to file federal income tax returns. In 2019, the tax-filing threshold for single adults under the age of 65 was \$12,200, which was just over the eligibility threshold for premium tax credits.

if those plans had lower out-of-pocket premiums, more-generous benefits, or broader provider networks than the plans offered through the public program.

All low-income people would be eligible for full premium subsidies to enroll in a public or private plan through the large public program, and middle-income people would be eligible for partial premium subsidies that were more generous than the subsidies available through the marketplaces under current law. Large employers would be required to offer private plans or offer coverage through the public program by making mandatory contributions on behalf of their employees. Employees could choose to receive coverage through the public program (in which case, they could choose between the private and public plan options offered through the public program) or through their employer if the employer continued to offer private coverage. The public program also would include income-related cost-sharing reductions for low-income people.

The new public program also would provide partially subsidized default coverage for all people who did not otherwise enroll in health insurance coverage. As with the first approach, a premium-equivalent tax would be imposed on middle- and higher-income uninsured people to finance their default coverage. That tax would equal the premium people would have paid to enroll in the public plan, so that low-income people who were eligible for full premium subsidies (including people whose income is too low to file income tax returns) would not pay such a tax.

The transition to a system following this approach would involve more significant changes than the first approach because all people obtaining coverage in the current nongroup market or through Medicaid or CHIP would transition to a plan offered through the new public program. Some people currently enrolled in employment-based coverage also would transition to the new public program if they opted for coverage through the new program rather than through their employer's plan, if their employer opted to offer coverage through the new program, or if their employer stopped offering coverage altogether. People who were uninsured under current law would gain coverage, primarily through the public program.

Approach 3: Premium Subsidies for All People and Default Coverage Through a Fully Subsidized Plan. Under this approach, all eligible people under age 65

would receive a premium subsidy that would fully cover the cost of a benchmark plan (a plan used to determine subsidies) in a marketplace of private plans. That subsidy could be provided as a refundable tax credit, which would reduce revenues and increase outlays, or through direct payments, which would only increase outlays. Under some variants of this approach, the subsidy could be less generous and cover the cost of a catastrophic plan. (Such health insurance plans, with low premiums and high deductibles, have an actuarial value of less than 60 percent, which means that enrollees are required to pay for more than 40 percent of their health care costs out of pocket, on average.) Alternatively, the subsidy could cover the full cost of a benchmark plan that was relatively generous, similar to a gold plan or the current Medicare program. (A gold plan is a health insurance plan in the marketplaces with an actuarial value of about 80 percent, which means that enrollees are required to pay for 20 percent of their health care costs out of pocket, on average.) Another variation of this approach could include a public plan as an option alongside the private plans.

There would be no requirements for employers to offer coverage. Employers would no longer provide primary health insurance coverage because of the subsidized private coverage available to their employees, but they could offer supplemental coverage to reduce cost sharing or provide additional benefits not covered by the plans their employees chose in the private market. Tax preferences for such supplemental coverage, like those for employment-based insurance under current law, would be eliminated. Low- and middle-income households would receive cost-sharing reductions under all variants of this approach. All people who did not otherwise enroll in a plan would receive fully subsidized default coverage through a benchmark zero-premium plan. The benchmark zero-premium plan could have a narrow network or high cost sharing that would lead some people to choose to pay more to enroll in a plan with a broader network or lower cost sharing. Under this approach, people's choice of health insurance plans would be preserved.

The transition to a system that provided full premium subsidies for all people would involve many more changes to the current system than the approaches discussed above because many people would transition away from employment-based coverage as their primary source of coverage, and private plans would have to adapt to a new market. To achieve deficit neutrality, large new sources of tax revenues would be required to finance universal premium subsidies, in addition to the revenues

raised because tax preferences for employment-based coverage would be eliminated and a greater share of employees' compensation would be taxed.

Once the new system was established, implementation of default coverage generally would be simpler than with the approaches already discussed because there would be no need to collect premium-equivalent tax payments from people who would be covered automatically by a zero-premium default plan. Also, people would not need to change their coverage when they changed jobs or experienced a change in income.

Approach 4: A Single-Payer System. Under this approach, the government would enroll all eligible people in a single-payer system, and in all existing proposals using this approach, there generally would be no role, or there would be a very limited role, for private insurance. If private insurance was allowed, it most likely would be limited to services not covered by the public plan. Private insurance also could be offered as an alternative source of coverage if some enrollees and providers were allowed to opt out of the single-payer system. Cost sharing under this approach typically would be lower than under current law. There would be no premiums, and to achieve deficit neutrality, such a system would need to be financed with broad-based tax revenues.

The transition to a single-payer system would involve greater changes for individuals, insurers, and health care providers than the other approaches, and it would be an enormously complex undertaking. To achieve deficit neutrality, large new sources of tax revenues would be required to finance the single-payer system, and new financing mechanisms would need to be established. However, once it was established and people obtained proof of enrollment, they would be covered under the same system for the rest of their lives.

Background and Scope of the Report

Under the current multipayer health care system, people under the age of 65 receive health insurance from a variety of public and private sources, most of which are partially subsidized by the federal government. That system has not resulted in near-universal health insurance coverage because not everyone is eligible for subsidized coverage—even people with very low income—and not everyone who is eligible for subsidized coverage chooses to purchase it. Lawmakers have considered a variety of proposals to decrease health insurance premiums and increase the number of people with coverage. However,

many of those proposals are not comprehensive enough to achieve near-universal coverage.

Three broad strategies for establishing a health insurance system would achieve near-universal coverage: enacting and enforcing a large individual mandate penalty, instituting automatic coverage through a default plan, or creating a single-payer system that would serve as a default plan for all people. All of those strategies would require generous subsidies for the low- and moderate-income people for whom the cost of health insurance would typically be prohibitive. In this report, CBO does not describe approaches that would achieve near-universal coverage by using an individual mandate penalty because the agency could find no recent proposals that would do so and because the Congress recently eliminated the individual mandate penalty that was established under the ACA.

Definition of Health Insurance Status and Coverage

CBO considers people who enroll in a private health insurance plan or a government program that provides comprehensive major medical coverage to be insured. Such coverage protects people against high-cost medical events, but it still could result in hundreds or thousands of dollars in out-of-pocket costs if it required significant cost sharing, such as a high deductible (an amount a patient is required to pay before a plan begins covering any costs) or large copayments (fixed dollar amounts that a patient is required to pay when using particular services).

CBO considers people who are not enrolled in such a plan or program to be uninsured—even if they are eligible to immediately enroll in a plan or government program that would pay for any previously incurred health care expenses retroactively upon enrollment. For example, people who are eligible for but not enrolled in Medicaid have an implicit protection against high-cost medical events because they can enroll in that program at any time, and they may have retroactive coverage for expenses incurred before enrollment. However, CBO still classifies those people as uninsured. In CBO's view, that definition of uninsured aligns with the concept underlying data from the National Center for Health Statistics, which relies on individuals to report their insurance status in surveys.⁴

4. For previous discussion of related issues, see Congressional Budget Office, *Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018* (April 2019), www.cbo.gov/publication/55094.

Although this report refers to all people who are not enrolled in a comprehensive major medical insurance plan or a government program as *uninsured*—to be consistent with typical definitions—it recognizes that those otherwise uninsured people would have some financial protection against high-cost medical events if they had automatic coverage through a default plan. Consequently, in this report, CBO refers to people who are not enrolled in a plan but have automatic coverage through a default plan as *having coverage* and counts them when assessing the universality of coverage. The tension of describing a group of people as uninsured yet having coverage reflects the complexity that arises when people receive financial protection against high-cost medical events without enrolling in an insurance plan. Such people also could have difficulty accessing care in the absence of a connection to a health insurance plan and provider network and might forgo some care, such as preventive services.

As classified by CBO, a policy would achieve near-universal coverage if close to 99 percent of citizens and noncitizens who are lawfully present in the country were covered either by enrolling in a comprehensive major medical plan or by receiving automatic coverage through a default plan. In addition, a policy could achieve near-universal coverage of all U.S. residents if noncitizens who are not lawfully present also were made eligible for coverage. Policymakers might allow for limited exemptions, such as for people with religious or moral objections.

In CBO's assessment, no existing proposals would achieve complete (that is, 100 percent) universal coverage because they all would require some demonstration of eligibility (such as meeting criteria related to citizenship or residency) that some eligible people would not comply with for various reasons. For example, some people would not comply because of language and literacy barriers or fears of providing information to the federal government. By CBO's classification, a health care system would achieve complete universal coverage only if all people in the country received coverage without any required demonstrations of eligibility criteria.

Sources of Coverage and Uninsured People Under Current Law

In the current multipayer system, people obtain health insurance from a variety of private and public sources. Most uninsured people have at least one subsidized option available to them, but others have no subsidized

option and purchasing health insurance can cost a large share of their income.

Sources of Health Insurance. Under current law, people under the age of 65 receive coverage through three major sources: employment-based health insurance, public programs such as Medicaid and CHIP, and nongroup health insurance for those who do not obtain health insurance through their employer and do not qualify for public programs. Those three sources all provide comprehensive major medical coverage and require no cost sharing for preventive care services, such as vaccinations. (A small number of people in the nongroup market are enrolled in plans that do not provide comprehensive major medical coverage. CBO does not consider those plans to be insurance.)

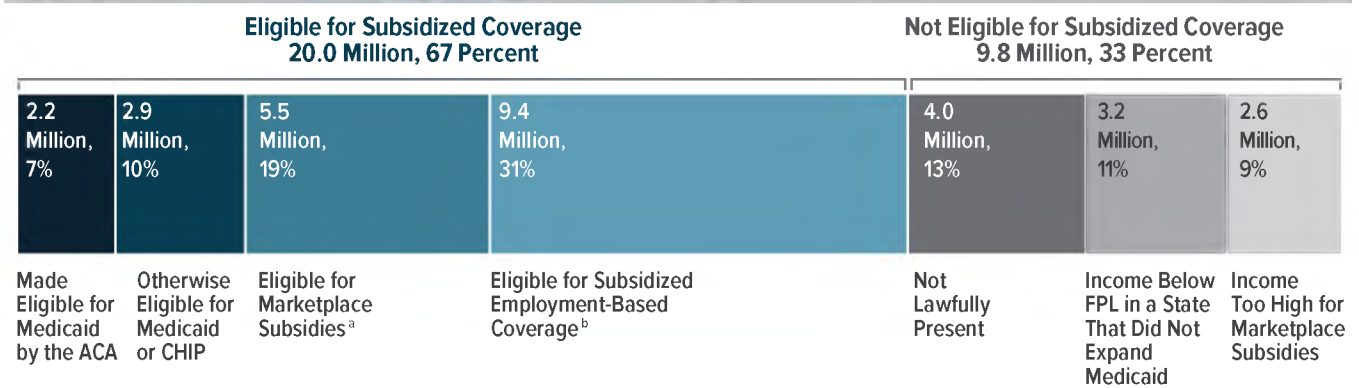
However, the amount of cost sharing required for nonpreventive care and the network of participating providers vary. Employment-based plans tend to have greater cost sharing requirements and a broader network of participating providers than Medicaid. Medicaid and CHIP require no or very limited cost sharing, but many providers do not participate in those programs. Nongroup plans tend to require even higher cost sharing than employment-based plans, and they can have a more limited network of participating providers. However, nongroup plans—including those available both in and outside of the health insurance marketplaces established under the ACA—vary considerably in their levels of cost sharing.

Plans in the nongroup market that provide comprehensive major medical coverage are classified according to their level of cost sharing using “metal tiers,” with more precious metals (for instance, gold) indicating lower levels of cost sharing but higher premiums. For example, a typical silver plan has an actuarial value of 70 percent, which means that enrollees are required to pay for 30 percent of their health care costs out of pocket, on average. By contrast, a typical gold plan has an actuarial value of 80 percent, which means that enrollees are required to pay for only 20 percent of their health care costs out of pocket, on average. Those differences in cost sharing can be seen by comparing average deductibles. In 2019, an average bronze plan had a deductible of about \$6,300, while an average gold plan had a deductible of about \$1,300.⁵ The silver plans with cost-sharing reduc-

5. See Kaiser Family Foundation, “Cost-Sharing for Plans Offered in the Federal Marketplace, 2014–2020” (December 2019), <https://tinyurl.com/y448slxf>.

Figure 1.

Eligibility for Subsidized Coverage Among Uninsured People in 2019



Source: Congressional Budget Office.

Some people may be eligible for multiple sources of coverage. CBO classified uninsured people into mutually exclusive groups on the basis of the most heavily subsidized option available to them or the primary reason they were ineligible for subsidized coverage.

CBO's estimates of the number of uninsured people and their options for coverage were drawn from its health insurance simulation model, HISIM2, and may differ from other sources. For more details about those estimates, see Congressional Budget Office, *Who Went Without Health Insurance in 2019, and Why?* (September 2020), www.cbo.gov/publication/56504.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; FPL = federal poverty level.

- a. A small number of people in this group would technically be eligible for subsidies, but those subsidies would equal zero dollars.
- b. A small number of people in this group were self-employed and could receive a subsidy by deducting their premiums from their income when calculating their federal income taxes.

tion (CSR) subsidies require even less cost sharing. Those subsidies are available through the health insurance marketplaces to people with income between 100 percent and 250 percent of the FPL.

People whose income is between 100 percent and 400 percent of the FPL and who are not eligible for public coverage and do not have access to an offer of affordable employment-based coverage are eligible for premium subsidies to purchase nongroup plans through the health insurance marketplaces. People with an affordable offer of employment-based coverage are ineligible for such subsidies because of the employer firewall. (In 2020, an offer of affordable employment-based coverage is defined by the Internal Revenue Service, or IRS, as one in which an employee's out-of-pocket premium is less than 9.78 percent of household income for a single plan.) The amount of those subsidies is benchmarked to the cost of the second-lowest-cost silver plan, and it is based on affordability thresholds that vary by income. For example, people with the lowest income receive premium subsidies that allow them to purchase that benchmark plan for 2.06 percent of their income. People with higher income receive smaller subsidies that require them to pay 9.78 percent of their income for the same plan.

Options Currently Available to Uninsured People. In 2019, an estimated 30 million people under the age of 65, or 12 percent of that population, were uninsured. One reason for the lack of insurance coverage was a lack of subsidized options. About one-third of uninsured people under the age of 65 did not have access to coverage that was subsidized by the government or an employer: 13 percent were noncitizens who were not lawfully present in this country; 11 percent had income that was less than 100 percent of the FPL and lived in a state that did not expand Medicaid; and 9 percent had income that was too high to qualify for marketplace subsidies (see Figure 1). Many of those people, including nearly all of the people in the first two groups, would have to pay large premiums relative to their income to enroll in a health insurance plan.⁶

Another reason for the lack of health insurance coverage is that not all people who are eligible for subsidized coverage choose to purchase it. About two-thirds of the 30 million uninsured people under the age of 65 had access to some form of subsidized coverage but were not *enrolled*, although those options were subsidized to

6. See Congressional Budget Office, *Who Went Without Health Insurance in 2019, and Why?* (September 2020), www.cbo.gov/publication/56504.

different degrees: 17 percent were eligible for Medicaid or CHIP; 19 percent were eligible for subsidized coverage through the marketplaces established under the ACA; and 31 percent had access to coverage through an employer. Most of those people could have purchased health insurance that cost less than 10 percent of their income, but fewer people had an option that cost less than 5 percent of their income. Those people lacked health insurance coverage because they did not consider it to be worth the cost or because of the complexities of the enrollment process, among other reasons.

Legislative Proposals to Incrementally Expand Access to Coverage and Reduce Out-of-Pocket Premiums

Lawmakers have introduced legislative proposals that would reform health insurance in various ways. Such proposals generally include provisions that would incrementally expand access to coverage by providing people additional plan options, increasing subsidies, or reducing out-of-pocket premiums in other ways. For example, some legislative proposals have been introduced in the current Congress that would expand subsidies to different income groups, introduce a public option in the health insurance marketplaces, or allow people to buy in to public programs.⁷ Although legislation that would reduce out-of-pocket premiums would result in *expanded access* to partially subsidized coverage and encourage more people to enroll in a plan, it would not by itself achieve *near-universal coverage* because some people would choose not to purchase health insurance. Those people would not otherwise have financial protection against high-cost medical events.

Expansion of Subsidies. Some legislative proposals, such as H.R. 1425, the Patient Protection and Affordable Care Enhancement Act, would reduce out-of-pocket premiums by expanding the subsidies available under current law to people whose income is above 400 percent of the FPL and encourage more people to enroll in a plan. That bill also would make the premium subsidies under current law more generous by reducing the amount of income that people must contribute toward their premiums. In addition, the proposal would eliminate the provision of the ACA that prevents low- or moderate-income people from receiving subsidies if a

worker has an offer of affordable employment-based coverage for a single plan.

Public Option. Under legislative proposals that would establish a public option—such as S. 3, the Keeping Health Insurance Affordable Act of 2019, and H.R. 2085, the CHOICE Act—a new public plan would be offered in the health insurance marketplaces alongside private plans, and providers’ payment rates would be set by the government. Some other proposals also would offer a public option in the individual and small-group markets outside of the marketplaces. Such proposals aim to reduce premiums and provide people with additional plan options.

Medicare Buy-In. Under legislative proposals that would establish a Medicare buy-in—such as S. 470, the Medicare at 50 Act, and H.R. 1346, the Medicare Buy-In and Health Care Stabilization Act of 2019—certain older adults under the age of 65 who are not currently eligible for Medicare would be allowed to purchase coverage through that program. Those proposals also would allow marketplace subsidies to be used toward the purchase of that coverage for people who were eligible for subsidies, and they would provide some people with additional plan options that had lower premiums than current nongroup options.

Medicaid Buy-In. Under legislative proposals that would establish a Medicaid buy-in, such as S. 489 and H.R. 1277, the State Public Option Act, people at all income levels would be allowed to purchase coverage through participating state Medicaid programs. Such proposals would not require states to adopt that program—similar to states’ voluntary participation in the Medicaid program more broadly. Under this approach, a Medicaid buy-in program would be offered in the health insurance marketplace alongside private plans, and marketplace subsidies could be used toward the purchase of a Medicaid buy-in for people who were eligible for subsidies. Such proposals would provide some people with additional plan options that would have lower premiums than current nongroup options.

Strategies to Achieve Near-Universal Coverage

Under all three strategies—a large and enforced individual mandate penalty, automatic coverage through a default plan, and a single-payer system—generous subsidies would be required to assist low- and

7. For a comparison of some proposals, see Kaiser Family Foundation, “Compare Medicare-for-All and Public Plan Proposals” (May 15, 2019), www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals.

moderate-income people for whom the cost of health insurance would typically be prohibitive, and a mandatory component would be necessary to ensure that people did not forgo coverage. In contrast with current law, people would not be able to remain uninsured during periods in which they did not anticipate using health care services and enroll in a health plan only after they anticipated or experienced a high-cost medical event.

Large and Enforced Individual Mandate Penalty. One way to provide coverage to nearly all people under a multipayer system would be to combine generous premium subsidies with a requirement that everyone purchase health insurance. To be effective, that requirement would have to be strongly enforced, and people who did not comply would incur large financial penalties. Such a strategy is used by several European countries, including Germany and the Netherlands, that have near-universal coverage through highly regulated multipayer systems.

The ACA combined an individual mandate with an increase in subsidized coverage options. However, the ACA did not result in near-universal coverage because the financial penalties for the individual mandate were modest and only partially enforced and because some low-income people, particularly low-income adults below the FPL in states that did not expand Medicaid, were not made eligible for the new subsidized coverage options. (For example, the ACA prohibited the use of liens or levies by the IRS to collect the financial penalties for not complying with the individual mandate, and people could not be prosecuted for failing to pay the penalty. However, the IRS could offset the financial penalty with any tax refund owed to a person.)⁸ In addition, the Congress later eliminated the financial penalty for not complying with the individual mandate in Public Law 115-97, referred to here as the 2017 tax act.

Automatic Coverage Through a Default Plan. In the absence of a large and strongly enforced individual mandate penalty to induce people to purchase coverage, another strategy to achieve near-universal coverage would be to combine premium subsidies with a mechanism that automatically provided coverage through a default plan. One strategy used by several countries with near-universal coverage is a single-payer system that serves as a

default plan. A single-payer system is an extreme example of a default plan because people would not have a choice of a health insurance plan and everyone who was eligible would be enrolled in the same public plan. Automatic coverage through a default plan also could be used in a multipayer system that fully subsidized the cost of health insurance premiums while still allowing people to choose from among multiple private plans.

Such a default coverage mechanism also could be used to achieve near-universal coverage under a multipayer system that did not fully subsidize the cost of health insurance for all people, as is the case in Switzerland. However, the system would become significantly more complex for the government to administer because it would need a way to identify and collect payments from people who chose not to enroll in a plan and were not eligible for full subsidies.⁹ Those people would be required to make a payment if they did not enroll in any source of coverage, as would be the case under a system that used an individual mandate penalty. However, they would receive health insurance coverage through a default plan for any period in which they did not have another source of coverage—which is different from what would occur under a system that used an individual mandate penalty (in which a person is liable for a tax payment but not covered by insurance). Using the default plan, otherwise uninsured people could receive covered health care services at any time, without waiting for an open enrollment period.

Single-Payer System. A third strategy to achieve near-universal coverage would entail establishing a single-payer system. As discussed above, a single-payer system could serve as a default plan and all people who demonstrated eligibility would enroll in that program and receive care that was covered by the single-payer system. A single-payer system is included here as a separate strategy because, unlike a default plan under a multipayer system, the government would operate the single-payer system, and it would determine payment rates for health care providers. Premiums would be fully subsidized through broad-based tax revenues. Such a

8. See Internal Revenue Service, *Questions and Answers on the Individual Shared Responsibility Provision* (June 2020), <https://go.usa.gov/xGbSD>.

9. See Ewout van Ginneken and Thomas Rice, “Enforcing Enrollment in Health Insurance Exchanges: Evidence From the Netherlands, Switzerland, and Germany,” *Medical Care Research and Review* (April 2015), vol. 72 no. 4, pp. 496–509, <https://doi.org/10.1177/1077558715579867>.

strategy is used by several countries, including Canada, Denmark, and the United Kingdom.¹⁰

Scope of the Report

This report discusses the primary features of four general approaches that could achieve near-universal coverage using a combination of premium subsidies and automatic coverage through a default plan, including a single-payer system. The role of default coverage would vary across each of the four approaches, but in all cases, a default plan would provide coverage to people during periods in which they did not have another source of coverage, whether or not they used any health care services during the year. CBO focused on approaches that would achieve near-universal coverage by using the strategy of automatic coverage through a default plan, rather than by using large and strongly enforced individual mandate penalties, because the Congress recently eliminated the ACA's individual mandate penalty.¹¹ CBO is not aware of any current detailed proposals that would reinstate an individual mandate penalty that would be strongly enforced and large enough to result in near-universal coverage.

Policymakers would need to specify numerous details in drafting legislation that followed any of those approaches, and this report does not address every aspect that would need to be specified. For example, the report does not discuss the extent to which noncitizens who are not lawfully present would be eligible for subsidized coverage. This report focuses on how expansions of health insurance coverage could achieve the goal of near-universal coverage; a discussion of how the subsidies for those coverage expansions would be financed is outside the scope of the report. The report also does not include estimates of the budgetary effects of any of the approaches because those effects would vary considerably under different variants of the approaches and would depend on how numerous other details were specified.

10. For additional discussion of single-payer systems, see Congressional Budget Office, *Key Design Components and Considerations for Establishing a Single-Payer System* (May 2019), www.cbo.gov/publication/55150; and Chris Pope, *Medicare for All? Lessons From Abroad for Comprehensive Health-Care Reform* (Manhattan Institute, November 2019), <https://tinyurl.com/tqq9d52>.

11. For CBO's analysis of the effect of the ACA's individual mandate penalty, see Congressional Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* (November 2017), www.cbo.gov/publication/53300.

Automatic Coverage Through a Default Plan for People Without an Alternative Source of Health Insurance: Design Considerations and Challenges

All four approaches discussed in this report would make use of a default plan to achieve near-universal coverage. The role of the default plan would vary on the basis of the design and other features of the policy approach. The defining feature of each type of default coverage is that everyone without an alternative source of insurance could receive covered care—including comprehensive major medical services and prescription drugs—at any time, without waiting for an open-enrollment period.

Some features of the default coverage would depend on the answers to the following questions: Would default coverage be partially subsidized and require mandatory contributions from uninsured people who are eligible for such coverage, or would it be fully subsidized through broad-based tax revenues? How heavily subsidized would the default coverage be if it was only partially subsidized? And, would default coverage be provided through a private or public plan?

Implementing default coverage would present particular challenges if it was partially subsidized. Additional challenges would arise if the default plan was included in a risk-adjustment system that shared the cost of insuring a group of enrollees with other plans that were available for active enrollment. There also would be challenges associated with informing people about their eligibility for default coverage and the benefits associated with that coverage, particularly the default plan's provider network.

Enrollment in a Default Plan and Use of Health Care Under That Plan

The default plan would provide coverage to everyone during periods in which they did not have an alternative source of insurance, whether or not they used any health care services or actively initiated coverage during the year. The key feature of default coverage is that eligible people could enroll in the default plan and receive covered health care services at any time, without waiting for an open-enrollment period. To use the default plan to receive covered health care services, people could enroll in the plan in one of three ways:

- *Point-of-Service Enrollment.* Certain health care providers would be authorized to enroll their patients at the point of service, which means that

an uninsured person seeking care through those providers would receive health care covered by the default plan without any prior active enrollment. The providers that facilitated such enrollment would be similar to the providers—for instance, most hospitals and certain other safety-net providers such as community health centers—that currently assist with the enrollment of uninsured patients in Medicaid and CHIP (when they are eligible). For example, a person who sought care in a hospital emergency room or medical clinic would be signed up for coverage by the provider at that time. The provider would bill the default plan for payment, minus any required patient cost sharing, for any patient who did not provide proof of enrollment in another source of health insurance. Other providers that agreed to participate in the default plan would accept payment from the default plan, but they would first require patients to enroll in and provide proof of default coverage before seeking care.

- *Self-Enrollment.* Individuals could actively enroll at any time in a default plan through an online portal or an alternative process. Under such a process, they would receive proof of coverage and information on the benefit package, provider network, and other features of the default plan. That would allow the person to make an appointment with any health care provider in the default plan's network and to present proof of enrollment as a source of payment at any participating provider.
- *Automatic Enrollment.* Some people could be enrolled automatically in the default plan and then informed of their enrollment. Automatic enrollment would be more feasible for people who were eligible for full premium subsidies if the government had sufficient information about their income eligibility and coverage status.

Default Coverage Under Medicaid and CHIP. Medicaid and CHIP provide default coverage under current law for some low-income adults and children, with no waiting period to enroll in those programs. For Medicaid and some CHIP programs, certain providers are authorized to enroll people who appear to be eligible for those programs on a presumptive basis at the point of service using a simplified income screen. For example, an uninsured person who visits an emergency room today can be enrolled in Medicaid by the hospital on the basis of a simplified income screen, if he or she appears to be

eligible. In many states, people who enroll in Medicaid also can receive retroactive coverage for up to three months before their application date for any medical expenses incurred during that period. That retroactive coverage removes the financial liability from individuals for the three-month period and allows providers to receive payment for services that are rendered before those individuals can submit a complete application.

However, many people may not be aware that they are eligible for Medicaid or CHIP, or that the presumptive and retroactive eligibility policies exist. As a result, those people may be less likely to seek health care than people who are enrolled and know they have coverage. If a default plan was available to all otherwise uninsured people, those people might be more aware of the option of accessing health care that was paid for by a default plan and more likely to seek care as a result than uninsured people who are eligible for Medicaid and CHIP under current law.

Differences Between Automatic Enrollment in a Default Plan and Automatic Coverage by That Plan.

Under all four approaches discussed in this report, a default plan would provide *automatic coverage* to all eligible but otherwise uninsured people even if they never enrolled in a plan. Each approach also could make use of *automatic enrollment* in other types of health insurance to minimize the number of eligible people who never enroll in a plan. Automatic enrollment identifies eligible people and registers them for coverage, typically when no premiums are required. However, many uninsured people are not eligible for zero-premium options under current law, and identifying eligible uninsured people to auto-enroll would be challenging. Automatic enrollment typically applies on a prospective basis, meaning that people gain coverage only after they are identified as uninsured and their enrollment is processed, which could be many months after they become uninsured. By contrast, automatic coverage does not require identifying uninsured people at the moment they become uninsured.

Under automatic enrollment, more people would be enrolled in coverage than under current law, but eligible people who could not be automatically enrolled would not be covered, and people who were automatically enrolled would generally have coverage only after their enrollment was processed. In CBO's assessment, it would be extremely difficult to identify and automatically enroll otherwise uninsured people when they owed premiums, and millions of people would remain uninsured unless a default plan that provided automatic coverage also

was established. Most Medicaid and some CHIP enrollees would have retroactive coverage for any expenses incurred up to three months before enrollment, but people automatically enrolled in marketplace plans would have no such protections under current law.

Under *automatic coverage*, all people without other sources of health insurance would be covered by a default plan. Expanding the use of automatic enrollment in public and private coverage would increase the number of people who were enrolled in a health insurance plan throughout the year and potentially reduce the number of remaining uninsured people who would be responsible for tax payments to finance default coverage. However, if an automatic coverage mechanism was not in place, the approach would not reach near-universal coverage because some people could not be auto-enrolled. (Other analysts use different terminology to refer to automatic coverage through a default plan, including retroactive coverage by a backstop plan and continuous auto-enrollment with retroactive enforcement.)

Key Design Choices Associated With Default Coverage

Proposals to establish default coverage would require several key design choices, including the extent to which coverage would be subsidized and whether it would be provided by a private or a public plan. Another design choice would center on the degree of cost sharing that would be required under the default plan.

Partially or Fully Subsidized Default Coverage? A key design choice for establishing default coverage would be how heavily to subsidize the cost of that coverage for otherwise uninsured people who would be covered by the default plan. If default coverage was partially subsidized, some people in the eligible population, such as those with low income, would receive a subsidy to cover the entire cost of a benchmark plan while other people in the eligible population, such as middle-income people and some high-income people, would receive a subsidy to partially cover the cost of a benchmark plan; other high-income people would not be eligible to receive any subsidies. Financing would come, in part, from higher taxes on those uninsured individuals who were covered by the default plan and, in part, from broad-based tax revenues that were not linked to health insurance coverage. Default coverage would be partially subsidized under Approaches 1 and 2, both of which would subsidize the entire cost of a benchmark plan for low-income people, but it would provide only partial subsidies for middle-income and some higher-income people.

Levying taxes on uninsured people who were covered by the default plan would be the equivalent of charging mandatory premiums for that coverage. To maintain incentives to enroll in other sources of coverage, the amount of the tax associated with default coverage would be made equal to the net premium the individual would pay to actively enroll in a benchmark plan providing the same benefits. However, some people would choose to continue enrolling in employment-based coverage or other types of plans if those plans included a broader network or more generous benefits.

Some proposals refer to financing for a default plan as retroactive premiums because the funds collected at the end of the year would serve as payment for default coverage provided during the previous year. Legislation specifying such financing as a tax would increase the likelihood that those payments would be upheld as constitutional. Although those people would be required to make a payment if they did not enroll in any source of coverage—as was the case with the ACA's individual mandate penalty—they also would receive health insurance coverage through a default plan for any period in which they did not have another source of coverage.

The amount of the premium-equivalent tax could vary on the basis of income or other criteria. For example, if partially subsidized default coverage was added to existing sources of coverage and subsidies, the benchmark plan could be a silver plan available through the health insurance marketplaces. The amount of the premium-equivalent tax would then be the premium uninsured people would pay to enroll in that silver plan after applying any premium tax credits for which they were eligible.

If default coverage was fully subsidized for all eligible people, everyone in the eligible population would receive a subsidy to cover the entire cost of a benchmark plan. Such coverage would be implemented under Approaches 3 and 4. Financing would come entirely from broad-based tax revenues, and people who did not enroll in a health insurance plan would not owe additional taxes.

A Private or Public Default Plan? Proposals would need to specify whether default coverage would be provided through a private or a public plan. If a private or public plan in the marketplace served as a default plan, all plans in the nongroup market would adjust their premiums to reflect the expected costs of adding enrollees through

the default coverage mechanism to the existing risk-adjustment system. If default coverage was provided by a private plan, a government agency would receive tax revenues to finance default coverage and use those revenues to make periodic premium payments to the private default plan for each person estimated to be covered by that plan. The legislation might specify the characteristics of the private plan that would be designated to serve as the default plan—such as the least expensive silver plan offered in the health insurance marketplace. A private default plan also could be identified through a competitive bidding process, with plans submitting premium bids on the basis of the expected costs of providing coverage to people who would be enrolled through the default coverage mechanism.

If the default plan was a public plan, such as a new public option offered through the marketplaces, the government would set the premium in one of two ways: on the basis of the expected costs of providing coverage to people who would enroll through the marketplaces and the default coverage mechanism, as well as the costs of any risk-adjustment payments; or on the basis of private-market estimates of the cost of insuring a person of average health status, such as the benchmark premium of the second-lowest-cost silver plan in the marketplace. Other plans would adjust their premiums if the public default plan was part of the same risk-adjustment system.

If default coverage was provided by a private plan, provider networks and payment rates could be negotiated by insurers and providers, subject to existing requirements about network adequacy. If default coverage was provided by a public plan, administrators could set payment rates, establish criteria regarding provider participation, and impose other requirements based on those used by the Medicare program or develop new approaches.

Under variants of Approaches 1 and 3, the default plan would be a private plan. Default coverage also could be provided by a public plan, such as a new public option under one variant of Approach 1. A public plan also would serve as the default plan under Approach 2, one variant of Approach 3, and Approach 4.

Default coverage could vary on the basis of the characteristics of the population. For example, Medicaid and CHIP could continue to serve as default coverage for people who were eligible for but not currently enrolled in those programs, and another private or public plan could

serve as default coverage for other uninsured individuals who were not eligible for Medicaid or CHIP (as under Approach 1).

Other Design Choices. Other design choices for default coverage would include the degree of cost sharing that individuals would be responsible for when using care under the default plan. The generosity of the default plan could affect the size of the premium-equivalent tax for people whose coverage was not fully subsidized. For example, if a gold plan was specified as the default plan, all people who were enrolled in the plan would have lower cost sharing than if they were enrolled in a catastrophic plan, but people who were not eligible for subsidies would owe a larger amount in premium-equivalent taxes.

Key Challenges of Implementing Default Coverage

The key challenges of implementing default coverage are as follows: how to ensure that the appropriate premium-equivalent tax payments are collected if default coverage is partially subsidized; how to determine the appropriate premium adjustments for plans when the default plan is part of a risk-adjustment system; and how to inform people about their eligibility for default coverage and the default plan's benefits, particularly the provider network.

Implementing default coverage would be less administratively complex if the requirements for assessing premium-equivalent taxes to finance default coverage were straightforward and fewer alternative sources of coverage were available. For example, implementing default coverage in a single-payer system (as in Approach 4) would present the fewest challenges relative to other approaches because coverage would be fully subsidized through broad-based tax revenues and the government would not need to verify enrollment in other sources of coverage. However, a single-payer system would result in the largest increase in government spending.

Implementing partially subsidized default coverage that operated in tandem with currently available sources of coverage (including Medicaid, CHIP, employment-based insurance, and private nongroup insurance) would present the most challenges relative to other approaches. That is because the government would need to verify enrollment using data from many potential sources of coverage and collect premium-equivalent tax payments from people who were not enrolled in those other plans or programs.

Collecting Premium-Equivalent Taxes When Default Coverage Is Partially Subsidized. Under Approaches 1 and 2, which would provide partially subsidized default coverage, the government would collect premium-equivalent taxes from people who were covered by the default plan because they did not have an alternative source of coverage. Collecting those taxes would be challenging for several reasons. First, in many cases, it would be difficult to determine which people did not have an alternative source of coverage and therefore were responsible for premium-equivalent taxes. Second, the tax payments would be large for higher-income people without other sources of coverage who were eligible for small or no subsidies. Third, both of the two main options for structuring the taxes would add additional complexity to the tax system and would make withholding the appropriate amount of taxes from workers' paychecks throughout the year more difficult.

Identifying People Responsible for Paying Premium-Equivalent Taxes. Under Approaches 1 and 2, the IRS would need to identify the coverage status of all income tax filers and determine their eligibility for premium subsidies in order to collect premium-equivalent taxes. When tax returns were filed, each person's insurance status and eligibility for subsidized coverage would be assessed for each month of the previous calendar year.¹² For each month that an individual did not have an alternative source of coverage, the person would be considered to have been covered by the default plan and, depending on that person's income and eligibility for premium subsidies, he or she would owe additional tax payments. If default coverage was partially subsidized, the premium-equivalent tax would be set equal to the premium of the default plan minus any premium tax credits or subsidies for which the person was eligible.

The IRS would determine coverage status on the basis of self-reported information that would be verified by matching it to information submitted by third parties (such as insurance companies). However, the currently available third-party information is not accurate enough

to adequately enforce such a policy.¹³ Imposing new taxes on the basis of coverage status—and collecting those taxes—would require the IRS to obtain more accurate and comprehensive data on insurance status than are currently available through the information returns filed by third parties. The IRS could use that more accurate data to verify the information that people report on their tax returns. Legislation establishing the default coverage policy could include additional reporting requirements and provide funding for the IRS to improve its ability to accurately measure the monthly coverage status of tax filers, which would enhance the IRS's ability to audit.

The IRS would only be able to verify the coverage status of, and enforce the collection of tax payments from, people who filed income tax returns. Exempting people whose income fell below the tax-filing threshold from the tax obligations associated with default coverage would facilitate enforcement. Exempting those people would have a very small effect on the taxes collected because they tend to have very low income and they would be eligible for large premium subsidies to offset all or nearly all of the tax obligation under all of the proposals that CBO reviewed. (For tax year 2019, a single adult under the age of 65 did not have to file an income tax return if his or her gross income was less than \$12,200, which was just over the eligibility threshold for a premium tax credit. The legislation also could adjust the tax-filing threshold.)

Under proposals in which the Medicaid and CHIP programs continued to exist and provide default coverage for people who were eligible for those programs—similar to Approach 1—the IRS also would have to identify whether people were eligible for those programs to determine whether they would be responsible for taxes to finance the default plan. That would require collecting information from state agencies or making a simplified

12. For a detailed proposal that would require the IRS to collect additional tax payments linked to coverage status, see the description of a retroactive coverage backstop in Christen L. Young, *Three Ways to Make Health Insurance Auto-Enrollment Work* (USC-Brookings Schaeffer Initiative for Health Policy, June 2019), www.brookings.edu/wp-content/uploads/2019/06/Yonu_Autoenrollment_6.19.19.pdf (445 KB).

13. A recent study found that the number of people identified as not having insurance using the currently available third-party reporting (13 percent) was substantially higher than the number of people estimated to not have insurance using nationally representative survey data (9 percent to 10 percent). By contrast, the number of people without coverage who self-reported being uninsured on their tax returns (8 percent) was lower than the nationally representative estimates. Those differences indicate that currently available third-party reporting to the IRS is insufficient to verify the self-reported information. See Ithai Z. Lurie and James Pearce, *Health Insurance Coverage From Administrative Tax Data*, Office of Tax Analysis Working Paper 117 (Department of the Treasury, February 2019), <https://go.usa.gov/xGBZV> (PDF, 18.49 KB).

eligibility determination on the basis of the income and age that tax filers reported on tax returns. It would be challenging for the IRS to make accurate eligibility determinations during the tax-filing process, because eligibility for Medicaid and CHIP is based on monthly income, which may vary throughout the year, whereas the IRS relies on annual income.

Amount of the New Taxes. Partially subsidized default coverage could create a large new tax obligation for people without an alternative source of coverage, particularly people with income that was too high to qualify for premium subsidies. For example, if people with income above 400 percent of the FPL were not eligible for any subsidies other than for employment-based coverage (as is the case under current law), the new tax obligation for someone with an income just above the eligibility threshold (\$48,560 for a single person in 2019) would have been about \$5,700 for a 40-year-old if the cost of the default plan was similar to the cost of the second-lowest-cost silver plan under current law in 2019.¹⁴ That would have amounted to about 12 percent of income for someone with an income just above 400 percent of the FPL and about 8 percent of income for someone with an income equal to 600 percent of the FPL.

Those amounts far exceed the maximum of 2.5 percent of income that was specified under the ACA as the penalty for not having health insurance coverage before that penalty was eliminated under the 2017 tax act. However, those people also would receive health insurance coverage through a default plan for the period in which they did not have another source of coverage; that would not be the case under systems using an individual mandate penalty. As people became more familiar with such a policy over time, more people might elect to actively enroll in a plan and pay premiums earlier in the year, which would reduce the number of people responsible for large tax payments at the time tax returns were filed.

It could be difficult for the IRS to enforce the payment of premium-equivalent taxes, particularly if those taxes were large and exceeded the amount of the tax refund that filers were owed otherwise. The IRS had limited

authority to collect the individual mandate penalties specified under the ACA. Legislation that enacted partially subsidized default coverage could grant the IRS greater authority to collect premium-equivalent taxes by garnishing wages, imposing liens, or other means. However, those strategies might be controversial.

Structuring Premium-Equivalent Taxes. The premium-equivalent tax could be structured and collected in two main ways, both of which would add reporting requirements and additional complexities to the tax system. The simplest option would be to levy a tax directly on those covered by the default plan. That would include people who enrolled in the default plan on their own or through a health care provider or who were enrolled by the government automatically. It also would include people whom the IRS determined did not have another source of coverage for certain periods of the year. That option would be more likely to result in large tax bills at the end of the year for people covered by the default plan, unless withholding was adjusted by those taxpayers during the year to reflect their lack of coverage and anticipated tax obligation. Although income withholding amounts can be changed, most workers do not routinely make adjustments. People who actively enrolled in the default plan during the year could begin making estimated tax payments when they enrolled. Alternatively, the IRS could automatically withhold people's estimated tax obligations if their coverage status could not be verified.

Another option for collecting the new tax would be to levy a premium-equivalent tax on all tax filers, including people who were enrolled in coverage for the entire year. People who demonstrated through third-party reporting that they had qualifying health insurance would then be able to fully offset that tax obligation with a tax credit of equivalent size. Efforts could be made to allow insured filers to adjust their withholding accordingly throughout the year to anticipate the offsetting tax credit. However, because some people who were enrolled in employment-based insurance or other plans might not adjust their withholding, this option probably would cause some of those people to pay too much in taxes during the year and then receive large tax refunds at the end of the year when the IRS determined that they were eligible for a fully offsetting tax credit. This option would reduce the number of people with a large tax obligation due at the time of tax filing, but it also would be more complex to administer.

14. For estimates of average marketplace premiums, see Kaiser Family Foundation, "Average Marketplace Premiums by Metal Tier, 2018–2020," <https://tinyurl.com/y2pzm34>.

Determining Payments to Insurers When the Default Plan Is Part of a Risk-Adjustment System. To ensure that the premium-equivalent taxes for the default plan were similar to equivalent plans that were available for active enrollment, the default plan could be part of a risk-adjustment system that included those plans. In a risk-adjustment system, all plans in the system make or receive payments that adjust their premiums for the costliness of their enrollees relative to that of enrollees in other plans in the system. In anticipation of receiving or making those payments, plans in the risk-adjustment system set their premiums in part to reflect the cost of covering all enrollees in the risk pool. (A risk pool refers to a group of plans that share the cost of covering all enrollees in the pool. Those costs are shared through a risk-adjustment system.) Determining the appropriate payments to compensate plans that are included in the risk-adjustment system would require determining the number of people covered by the default plan and the expected cost to insure them relative to that of enrollees in other plans.

Determining the Number of People Covered by the Default Plan. One challenge would be estimating the number of people who would be covered by the default plan. Two groups would be covered by the default plan: people who were enrolled in the plan and people whom the IRS would need to identify as not having another source of coverage. (People might enroll during the year on their own or through a health care provider, or they might be enrolled by the government automatically.) The people who enrolled in the default plan during the year would all be identified, but the IRS might have difficulty identifying everyone else without another source of coverage because of the gaps in reporting discussed earlier. In addition, it would be even more difficult for the IRS to identify the coverage status of people who did not file tax returns because their income fell below the tax-filing threshold. If the IRS underestimated the number of people who did not have another source of coverage during the year, the people who enrolled in the default plan during the year (many of whom would do so only after experiencing a costly episode of care) would represent a larger share of the people who were identified as covered by the default plan. The risk-adjustment payments to the default plan would then have to be larger to reflect the higher average cost of the people who were identified as being covered by the default plan relative to the entire group of eligible people.

Setting Payments for Insurers Using a Risk-Adjustment System. Once the government identified the group of people who would be covered by the default plan, it would determine the risk-adjustment payments for all plans in the system on the basis of the expected health care spending of people covered by the default plan and other plans in the risk pool. To determine the size of the payments, the government would start with a measure of average spending for all people in the risk pool and then adjust that average up or down to account for plans that tended to have more or less costly enrollees than average.

Those calculations would be done using a new or modified risk-adjustment system, but the ability of the risk-adjustment system to predict the expected cost of people covered by the default plan would be imperfect.¹⁵ Under current law, the health insurance marketplaces use a risk-adjustment system established by the ACA that compensates insurers who attract a more costly group of enrollees by transferring funds from insurers who attract a less costly group of enrollees. That system adjusts payments primarily on the basis of chronic conditions, such as diabetes and hypertension. Such a risk-adjustment system probably would not adequately compensate insurers for the people who would be identified as being covered by the default plan because their spending would disproportionately include acute care events, such as heart attacks and car accidents. Modifications to the risk-adjustment system would be required to adequately capture the differences in costs between people who would be covered by the default plan and people who would actively enroll in other plans. Risk scores for some people who were eligible for default coverage would have to be computed solely on the basis of their demographic characteristics.

15. Existing risk-adjustment systems (such as those used in the Medicare Advantage and Medicare Part D programs and the nongroup market) do not entirely capture the cost of people in the markets in which they are currently used. In particular, some plans are able to receive larger risk-adjustment payments because they record additional health conditions for their enrollees. See Michael Geruso and Timothy Layton, "Upcoding: Evidence From Medicare on Squishy Risk Adjustment," *Journal of Political Economy*, vol. 128, no. 3 (2020), pp. 984–1026, <http://doi.org/10.1086/704756>. Research also shows that insurers change their benefit designs to attract enrollees who result in risk-adjustment payments that are large relative to their cost. See Colleen Carey, "Technological Change and Risk Adjustment: Benefit Design Incentives in Medicare Part D," *American Economic Journal: Economic Policy*, vol. 9, no. 1 (2017), pp. 38–73, <http://doi.org/10.1257/pol.20140171>.

Determining the appropriate risk-adjustment payments also would depend on the overall risk pool that the default plan was a part of—that is, the other plans that participated in the risk-adjustment system. The default plan could be part of the same risk pool as other plans that are available for active enrollment, such as the nongroup market under current law. The default plan probably would draw a less costly group of people than the current nongroup market because, on average, those who do not enroll in coverage tend to spend less on health care. If the IRS was able to accurately identify the less-costly people who would be covered by the default plan, then adding a default plan to the same risk pool as the current nongroup market would probably reduce overall premiums in that market.

Other Risk-Management Tools. The government also might need to use other tools to compensate insurers for the cost and financial risk of administering the default plan or for the cost of being part of the same risk-adjustment system. Particularly in the initial years, private insurers would be uncertain as to the number of people who would be covered by the default plan and their health care spending. As a result of that uncertainty, private insurers might be less willing to participate in a risk-adjustment system that included a default plan or they would require higher premiums to take on the additional risk of offering coverage in the initial years of implementation. To mitigate those concerns, the government could use other tools, such as a reinsurance or risk-corridor program, to reduce uncertainty and stabilize premiums for the default plan and other plans in the risk pool in the initial years after the default plan was introduced.

A reinsurance program would compensate all insurers that participated in the same risk-adjustment system (for example, all insurers in the nongroup market) if the market as a whole experienced unanticipated higher costs in the years following the introduction of the default plan. A risk-corridor program would compensate particular plans (such as the default plan) if their actual costs exceeded anticipated costs by a particular threshold.

Informing People About Their Eligibility for Default Coverage and the Plan’s Benefits. In order for the default plan to provide comprehensive access to care to otherwise uninsured people, those without an alternative source of coverage would need to be made aware that they were automatically covered by the default plan and

be informed of the plan’s benefits. In the initial years following implementation of default coverage, an outreach campaign could educate people about their eligibility for the default plan and its associated benefits. People would need to know who would be covered by the default plan automatically, what cost sharing would be required by that plan, and which providers participated in the default plan. An effective outreach campaign would increase the number of people who would seek health care knowing that the cost of their care would be covered by the default plan, but it would be difficult to fully inform all people.

If only some providers participated in the default plan, informing people about which providers were included in the default plan’s network would be challenging because, in many cases, those people would not have previous experience using the default plan. If people were not adequately informed, some would seek care without knowing whether a provider was in or out of the default plan’s network. If people received treatment from a provider that did not participate in the network of the default plan, they could encounter “surprise billing”—that is, they could be required unexpectedly to pay for the full cost of that care at the out-of-network rate (a price that is typically much higher than the rate negotiated by insurers for providers that participate in the plan’s network).

Policy Approaches

CBO identified four general approaches that have the potential to achieve near-universal coverage using premium subsidies and automatic coverage through a default plan that would be partially or fully subsidized. The introduction of default coverage could be accomplished while otherwise preserving most features of the current system or by completely overhauling the system. The four approaches described here cover that spectrum; each successive approach would require more significant changes.

Approach 1: Partially Subsidized Default Coverage That Operates in Tandem With Current Sources of Coverage

Policies based on this model would retain most key features of the current system. Specifically, employment-based coverage would continue to play a large role, income-based subsidized coverage would still be available through existing health insurance marketplaces, and

current eligibility criteria for Medicaid and CHIP would be preserved.

The most significant new feature of this approach relative to current law would be the introduction of automatic coverage through a partially subsidized default plan for people who do not otherwise enroll in health insurance and are not eligible for Medicaid or CHIP. To provide subsidized default coverage to nearly all people who do not enroll in another source of coverage, the employer firewall also would be eliminated. (See Box 1 for a discussion of the challenges of providing default coverage while retaining the employer firewall.) Full premium subsidies would be extended to people whose income is below 100 percent of the FPL. Policies based on this approach could further reduce out-of-pocket premiums and encourage active enrollment in coverage from other sources by increasing the generosity of premium subsidies for other income groups.

Default Coverage. For people who are ineligible for Medicaid and CHIP and not enrolled in another source of coverage, default coverage would be provided either by a private plan or by a new public health insurance option that would be offered through existing health insurance marketplaces. Premium-equivalent taxes would be collected from those otherwise uninsured people through the tax system to help finance the default coverage and maintain incentives for people to actively enroll in other sources of insurance. Those taxes would be equal to the premium of the default plan less any premium tax credits for which the person was eligible (similar to the amounts those people would pay to enroll in an equivalent plan through the marketplaces) for each month the person did not have another source of coverage. Lower-income people would contribute less to the financing of default coverage, and people whose income fell below the tax-filing threshold would not be required to pay any premium-equivalent taxes. People who are currently eligible for but not enrolled in Medicaid and CHIP would receive default coverage through those programs (and no premium-equivalent taxes would be collected).

Enrollment Process. The enrollment process for Medicaid and CHIP, nongroup coverage, and other sources of coverage would remain unchanged from that in effect under current law. For people who did not actively enroll in a plan during an open-enrollment period, a default private or public plan (or Medicaid and CHIP, for those who were eligible) would provide

coverage without the need for individuals to actively enroll. To use the default plan to receive covered health care, individuals who were uninsured could enroll in the plan at any time themselves or through certain health care providers.

Premiums. Under this approach, premiums for nongroup coverage would continue to be subsidized through premium tax credits for low- and middle-income people who obtained coverage through the health insurance marketplaces.

Premium Subsidies for Nongroup Coverage. Eligibility for premium tax credits to purchase nongroup coverage through the health insurance marketplaces would be extended to those whose income is below 100 percent of the FPL, allowing them to purchase a plan at a zero net premium and filling in the “coverage gap” for people in states that have not expanded Medicaid under the ACA. (Under current law, many adults who reside in states that have not expanded Medicaid and whose income is below 100 percent of the FPL have no options for subsidized coverage because they are ineligible for both Medicaid and premium subsidies for plans obtained through the health insurance marketplaces. Those people are often referred to as falling into a coverage gap.)

Eligibility for health insurance subsidies could be extended to additional households by raising the eligibility threshold for premium subsidies from 400 percent of the FPL to 500 percent of the FPL, or higher. Under current law, people whose income is just under 400 percent of the FPL are eligible for subsidies that limit their cost of purchasing a silver plan to 9.78 percent of their income, whereas people with income just over 400 percent of the FPL receive no subsidies. (In 2019, the eligibility threshold was \$48,560 for a single person and \$100,400 for a family of four.) People who are eligible for subsidies pay premiums that are based primarily on their income. People who are not eligible for subsidies pay premiums that primarily depend on their age, and those premiums are smaller for younger people. The effect on premium payments of having income just below or above the eligibility threshold is correspondingly small for younger people and much larger for older people. For example, 27-year-old single adults paid about 9 percent of their income, on average, for the lowest-cost silver plan in 2019 if their income was \$45,000 (eligible for a subsidy) or \$50,000 (not eligible). Sixty-year-old single adults paid, on average, about 8 percent of their

Box 1.

Introducing Default Coverage While Maintaining an Employer Firewall: Implications and Challenges

Under current law, people with an offer of affordable employment-based coverage are ineligible for premium subsidies in the health insurance marketplaces because of a provision of the Affordable Care Act known as the employer firewall. In 2020, an offer of affordable employment-based coverage is defined by the Internal Revenue Service as one in which an employee's out-of-pocket premium is less than 9.78 percent of household income for a single plan. The employer firewall was enacted as a way to minimize reductions in employment-based insurance by preventing people with an offer of affordable employment-based coverage from switching to subsidized coverage in the marketplaces and to encourage employers to continue offering such coverage.

Although introducing default coverage while maintaining an employer firewall is possible, the Congressional Budget Office did not find any detailed policy proposals that would achieve near-universal coverage while maintaining the firewall. Maintaining an employer firewall would present several challenges. Those challenges would arise only for proposals in which default coverage was partially subsidized. An employer firewall would not be relevant for proposals in which default coverage was fully subsidized through broad-based tax revenues.

The key implications of introducing default coverage while maintaining the employer firewall, compared with approaches that would remove the firewall, are as follows:

- Fewer changes would be made to people's sources of coverage under current law, depending on the relative generosity of the subsidy for default coverage and other sources of coverage.
- Fewer gains in coverage would occur if people with an offer of affordable employment-based insurance were not required to enroll in default coverage. If those people were eligible for default coverage and responsible for the associated tax payment, the firewall would prevent them from being eligible for subsidies to offset the tax obligation, and they would be liable for a large tax payment.
- Administrative complexity would be greater because a government entity would have to verify whether each uninsured person had an offer of affordable employment-based coverage.

Fewer Changes to Sources of Coverage

Under proposals that introduced default coverage and retained the employer firewall, there probably would be fewer changes to current sources of coverage than under the approaches described in this report that would remove the firewall. That is, more people with employment-based insurance probably would retain that coverage if the firewall remained intact.

The extent of changes to sources of coverage would depend on the relative generosity of the subsidy for default coverage and other sources of coverage, the size of the firm, and the income distribution of employees eligible for an offer of employment-based coverage. If the subsidy available for default and other sources of coverage was the same as the premium tax credits under current law, employers' incentives to offer coverage most likely would be similar to the incentives that exist under current law. However, if subsidies became more generous and enough employees found subsidized default and other coverage to be a more attractive alternative to employment-based coverage, some employers might have fewer incentives to offer coverage.

Fewer Gains in Coverage If People With an Offer of Affordable Employment-Based Insurance Were Ineligible for Default Coverage

A policy that introduced partially subsidized default coverage while maintaining the employer firewall would need to specify whether people with an offer of affordable employment-based coverage who chose not to enroll in their employer's plan (or an alternative plan) would be required to enroll in default coverage and responsible for the associated premium-equivalent tax to finance that coverage. If those people were eligible for default coverage and responsible for paying the associated tax, the firewall would prevent them from being eligible for subsidies (such as premium tax credits) to offset the tax obligation. Those people would then be liable for a large tax, which could be surprising and particularly burdensome for people with modest income.

A proposal could include additional requirements to minimize the number of people who would be covered by the default plan and responsible for large tax payments. For example, the policy could require employers to automatically enroll all of their employees in their least expensive plan during the open-enrollment period unless the employee chose an alternative plan offered by the employer, provided proof of

Continued

Box 1.

Continued

Introducing Default Coverage While Maintaining an Employer Firewall: Implications and Challenges

other coverage, or opted out. (A requirement that certain large employers with more than 200 employees auto-enroll those employees in a health insurance plan was attempted in the past, but that requirement was not implemented and was repealed by Bipartisan Budget Act of 2015 before it took effect. Some of the concerns related to employer auto-enrollment include how to determine whether an employee already has coverage through a family member or dependent and how much discretion employers have in choosing a health insurance plan for their employees.)

Alternatively, if a proposal prevented people with an offer of affordable employment-based coverage from receiving default coverage and it did not levy the associated tax to finance default coverage, such a proposal would result in fewer gains in coverage. In that case, many uninsured people who do not currently take up their offer of affordable employment-based

coverage (or another source) would probably continue to decline such coverage, leaving millions of people without health insurance.

Increased Administrative Complexity

Maintaining an employer firewall alongside default coverage would increase the administrative complexity and cost of implementing default coverage. Those administrative complexities and costs would arise because a government entity would have to verify whether each uninsured person had an offer of affordable employment-based coverage, which could require developing new reporting systems. The effectiveness of the employer firewall also would depend on how strongly it was enforced—proposals that increased the relative generosity of the subsidy for default and other coverage would increase the need to enforce compliance with the employer firewall.

income if that income was \$45,000 and 23 percent if their income was \$50,000.¹⁶ Extending eligibility to households whose income is up to 500 percent or more of the FPL would eliminate any sharp increases in premiums for people in that income range, but older people just above the new eligibility threshold might face a similar sharp increase.

Premium subsidies could be made more generous by decreasing the affordability thresholds (the percentage of income that people who qualify for subsidies are expected to pay for a benchmark plan) or by benchmarking the subsidy level to a more generous plan—for example, to the second-lowest-cost gold plan rather than the second-lowest-cost silver plan. More generous subsidies would both reduce the amount that people would pay to enroll in nongroup plans and reduce the size of the premium-equivalent tax that would be levied on people if they did not enroll in a plan. But larger subsidies also would increase the cost to the government.

Gross Premiums in the Nongroup Market. Gross premiums (the total premium charged by insurers before any

premium subsidies are applied) in the nongroup market probably would decrease because previously uninsured and less costly individuals would be brought into the risk pool through default coverage.

If the approach included a new public option, premiums could be even lower. The public option could have lower premiums than comparable private plans available through the health insurance marketplaces if the public option had lower costs—because of lower provider payment rates or administrative costs, for example. Gross premiums in the marketplaces also might decrease if the public option put downward pressure on the premiums of private plans. Alternatively, the public option could have higher premiums if it operated less efficiently, used fewer managed care tools that constrained utilization (such as prior authorization or gatekeeping), or attracted enrollees who were less healthy in ways that were not captured by the risk-adjustment system. A public option with higher premiums also could have a broader network of participating providers or higher payment rates, which would make care more accessible.

In addition, some low- and middle-income people who previously obtained coverage through their employers would be brought into the nongroup market once they were eligible for premium subsidies—because of

16. See Figure 2 in Rachel Fehr and others, *How Affordable Are 2019 ACA Premiums for Middle-Income People?* (Kaiser Family Foundation, March 2019), <https://tinyurl.com/y2lvvmkh>.

the elimination of the firewall—which could increase or decrease gross premiums, depending on the average spending of those enrollees.

Net Premiums in the Nongroup Market. Those lower gross premiums in the nongroup market would primarily decrease net premiums (the premiums paid by individuals after any premium subsidies are applied) for unsubsidized, higher-income households because net premiums for subsidized households are already capped as a percentage of their income. Net premiums for low- and middle-income subsidized households could decrease if the policy increased the generosity of premium subsidies in the ways discussed earlier. Net premiums also would fall to zero for low-income households that became newly eligible for premium subsidies because they were living in a state that had not expanded Medicaid.

Premiums for Other Types of Insurance. Premiums for employment-based insurance would continue to be subsidized through existing tax preferences. Premiums for some employment-based plans might change, depending on whether the people who switched from employment-based coverage to subsidized marketplace coverage were more or less healthy than the people who retained employment-based coverage. Premiums for people obtaining coverage through other sources (such as CHIP) would remain about the same.

Cost Sharing and Benefits. Cost sharing for existing sources of coverage could remain unchanged from current law under some specifications, or it could decrease. For example, cost sharing could decrease for some groups if eligibility for cost-sharing reductions was expanded, or if premium subsidies were benchmarked to a more generous plan, such as a gold plan. Covered benefits for existing sources of coverage would remain unchanged from current law. The default private or public plan could be required to have the same amount of cost sharing as the benchmark plan used to determine premium subsidies (currently a silver plan, with income-based CSRs) or a less generous plan.

Role of Private Plans. Private plans would continue to play a large role under this approach. Most people under the age of 65 would continue to receive private coverage either through employers or through the nongroup market. Enrollment in nongroup private plans would increase if default coverage was provided by a private plan. People who were newly eligible for subsidized

coverage through the marketplaces would enroll in private plans, and some people would gain coverage through a private default plan.

Even if the approach included a public option, private plans would still continue to play a large role. Most people under the age of 65 would continue to receive private coverage through employers or in the nongroup market. Enrollment in nongroup private plans could increase or decrease: On the one hand, some people would switch from private coverage to the new public option; on the other hand, the total size of the nongroup market would increase as more people whose income fell below 100 percent of the FPL became eligible for premium subsidies and as some low- and middle-income workers switched from employment-based coverage to a subsidized marketplace plan.

Role of Employment-Based Coverage. Employment-based coverage would play a smaller role under this approach than under current law, but most people who currently obtain coverage through employers probably would continue to do so, in part because of its tax advantages. Employment-based insurance also would continue because of its effectiveness in pooling risks and because of the lower costs for some administrative activities (for instance, for marketing and collecting premiums) compared with nongroup insurance.

Eliminating the employer firewall would lead some low- and middle-income people who are eligible for employment-based coverage to forgo that coverage in favor of subsidized marketplace or default coverage. Lower-income workers who were eligible for the largest premium subsidies would be the most likely to choose marketplace coverage over employment-based coverage, and some firms would design their insurance offerings to encourage them to do so. For example, some firms might increase employees' premium contributions to a level that would make it more expensive for their lower-income workers to purchase the employment-based plan rather than purchase subsidized marketplace coverage.

Number of Employers Offering Insurance. Employers would respond differently to the elimination of the firewall, depending on the income mix of their workers and the number of workers in their firm. Employers with workers whose income was too high to qualify for marketplace subsidies would have a strong incentive to offer insurance even in the absence of the firewall. Employers

with only some workers who were eligible for such subsidies would weigh the costs and benefits to their employees of offering insurance. Those employers also would consider what fraction of their employees would be likely to take up that offer, because insurers often charge higher premiums to small firms that do not have high participation rates among their workers. Small firms with many workers who qualified for subsidies would be the most likely to stop offering coverage if removing the firewall caused those workers to switch to subsidized marketplace coverage.

Altogether, employers probably would have fewer incentives to offer coverage once the employer firewall was eliminated, but the number of employers that changed their offerings would depend on the generosity of the premium subsidies available to their workers. If the generosity of premium subsidies for marketplace plans remained unchanged from current law, the number of employers who stopped offering insurance would probably be small. Some employers might not offer coverage if enough of their employees found subsidized marketplace and default coverage to be a more attractive alternative than employment-based coverage. In that case, employers generally would offset that reduction in health benefits by offering higher wages to their employees.

However, eliminating the employer firewall might lead a few additional employers to offer coverage. Currently, some firms may choose not to offer coverage because if they did so, the firewall would prevent their low- and middle-income employees from enrolling in more attractive subsidized marketplace coverage. If the firewall was eliminated, those firms could offer coverage primarily for the benefit of higher-income employees, who would not qualify for subsidies, without preventing their low- and middle-income employees from being eligible for subsidized marketplace or default coverage. Because enrollment in that employment-based coverage would largely be limited to higher-income employees, those firms' total costs of offering coverage would be lower in the absence of the firewall.

Although eliminating the firewall might lead slightly more firms to offer employment-based coverage, overall enrollment in that coverage probably would decline because the number of low- and middle-income employees switching to marketplace or default coverage probably would exceed the number of higher-income

employees enrolling in newly offered employment-based coverage.

Role of Public Programs. Under this approach, existing public programs would play a role similar to the role they play under current law. Many low-income people would continue to receive coverage through Medicaid or CHIP, and some would continue to use other public coverage, such as Medicare for the disabled.

Along with extending eligibility for marketplace subsidies to people whose income was below 100 percent of the FPL, the federal government would finance the entire cost of the expansion population in states that expanded Medicaid under the terms of the ACA (rather than 90 percent of the costs as under current law). That would give state policymakers flexibility to choose whether to provide subsidized coverage to people below 100 percent of the FPL through Medicaid or marketplace plans. Because both forms of coverage would be fully subsidized by the federal government, states that have already expanded Medicaid under the terms of the ACA would not have a financial incentive to scale back their expansion of the program. Other states could choose to expand Medicaid (with the federal government financing the entire cost) or they could cover those people through marketplace subsidies, depending on their priorities. Fully financing the cost of Medicaid enrollees made eligible through expansion under the terms of the ACA would increase costs incurred by the federal government for covering those people.

Public plans would play a larger role if the approach included a new public option that was offered through health insurance marketplaces and that provided default coverage. More people would be enrolled in public coverage through the new public option, but enrollment in the public option would be a small share of overall enrollment because most people who currently obtain private insurance through employers would continue to do so, and some people in the nongroup market would continue to choose private plans.

Variants and Examples of This Approach. Covering all people without an alternative source of coverage with a default plan could be accomplished in different ways by defining what type of entity would provide default coverage. Variants of this approach include a default plan that would be provided by private insurers or through a

public option that also would be available to all people through existing health care marketplaces.

Private Default Coverage. Under this variant, a private plan could serve as default coverage for people who did not enroll in another plan or program. A proposal by Fiedler and others incorporates all of the key features of this approach, including a similar default coverage mechanism and the expansion of eligibility for subsidized coverage, but it does so in ways that are somewhat different from those described here.¹⁷ For example, rather than extending eligibility for marketplace subsidies to those whose income was below 100 percent of the FPL, the proposal would provide states that have not expanded Medicaid incentives to do so. That proposal has the potential to achieve near-universal coverage if all states chose to expand Medicaid when faced with those incentives.

Public Option Offered Through the Marketplaces. A public option that was offered through the existing health insurance marketplaces could provide near-universal coverage if the option acted as a default plan and provided coverage to all otherwise uninsured people. The public option could be specified to have the same generosity as the benchmark plan used to determine the amount of premium subsidies (currently, a silver plan), with comparable income-based cost-sharing-reduction subsidies. People who were assigned to the public option through the default mechanism would be responsible for tax payments that were equal to the net premium they would have faced had they enrolled through the health insurance marketplaces.

Another proposal, by Blumberg and others, would incorporate all of the key features of this approach, including introducing a public option with a similar default role and expanding eligibility for subsidized coverage.¹⁸ That proposal also would increase the generosity of

marketplace subsidies and establish a federal reinsurance program for the nongroup market. Many other proposals would introduce a public option in the nongroup market, but they would not achieve near-universal coverage unless paired with a default coverage mechanism.¹⁹

Approach 2: Partially Subsidized Default Coverage Through a Large Public Program That Replaces Medicaid, CHIP, and the Nongroup Market and Retains Employment-Based Coverage

Under this approach, a new public health insurance program would replace the current nongroup market and Medicaid and CHIP acute care coverage, and all coverage would be provided through employers, the new public program, or existing public programs such as TRICARE. The public program would allow people to choose between a publicly administered plan and multiple privately administered plans meeting the same minimum requirements for cost sharing and covered benefits. That structure would be similar to that of the Medicare program, which allows beneficiaries to choose between the publicly administered Medicare fee-for-service program and private Medicare Advantage plans. The publicly administered plan would serve as the default plan, which would provide automatic coverage for people who did not have an alternative source of coverage.

Large employers would be required to offer coverage that qualified for the same tax preferences that are available under current law or to make mandatory contributions to the public program. Employees could choose to receive coverage through their employer or the public program. All low- and middle-income people, including those with an offer of employment-based coverage, would be eligible for premium subsidies to purchase coverage through the public program.

Enrollment Process. Enrollment in the public program could occur through an online portal or an alternative process administered by one or more federal or state agencies, whereas the enrollment process for employment-based coverage and other sources of coverage would remain unchanged from the processes used

17. See Matthew Fiedler and others, "Building on the ACA to Achieve Universal Coverage," *New England Journal of Medicine*, vol. 380, no. 18 (May 2, 2019), pp. 1685–1688, <http://doi.org/10.1056/NEJMp1901532>.

18. See "Simulated Reform Packages: Reform 5," in Linda J. Blumberg and others, *From Incremental to Comprehensive Health Insurance Reform: How Various Options Compare on Coverage and Costs* (Urban Institute, October 2019), p. 6, <https://tinyurl.com/yy9atuf7> (PDF, 1.05 MB).

19. See the Keeping Health Insurance Affordable Act of 2019, S. 3, 116th Cong.; the Choose Medicare Act, H.R. 2463 and S. 1261, 116th Cong.; the Medicare-X Choice Act of 2019, H.R. 2000 and S. 981, 116th Cong.; and the CHOICE Act, H.R. 2085 and S. 1033, 116th Cong.

under current law. For people who did not actively enroll in a plan, the public plan would provide default coverage without the need for active enrollment.

Premiums. Premiums in the new public program could be regulated in a manner similar to that governing the nongroup market under current law (which stipulates that premiums can vary by age, family size, geography, and tobacco use). Alternatively, they might be allowed to vary on the basis of a more limited set of factors (such as requiring that a plan charge the same premium to all people within the same geographic area). Those choices would affect both the gross premiums under the new program and the net premiums that different people would face after applying any relevant premium subsidies. As under current law, premium subsidies would be based on the percentage of income that people would be required to pay to purchase a benchmark plan.

Gross Premiums in the Public Program. Gross premiums in the public program would depend on the average health care spending of people who were enrolled in the program, which might be different from the average spending of people enrolled in nongroup plans under proposals similar to Approach 1 (whether or not a public option was offered). In addition to covering people currently enrolled in marketplace plans and other nongroup insurance plans, the public program would cover people who are currently uninsured (who tend to be younger and healthier), those who are currently enrolled in Medicaid and CHIP (who tend to be less healthy), and some people who are currently enrolled in employment-based plans (who could be more or less healthy, depending on the generosity of the public program and how employers adjusted their coverage offerings in response to the new policy).

Net Premiums in the Public Program. If premiums in the new program were regulated in a manner similar to that governing the nongroup market under current law, net premiums in the proposed public program would be lower than in the nongroup market (as it operates under current law) for the low- and middle-income people who were eligible for subsidies. People with low income would receive a subsidy that would cover the full cost of the benchmark plan used to determine subsidies in the new public program. Middle-income people would be eligible for more generous premium subsidies than the ones that are available through the health insurance marketplaces under current law. As with Approach 1, people

who received coverage through the default mechanism would have a net tax liability equal to the income-based premiums they would have paid if they had actively enrolled in the public plan. Higher-income people who enrolled in the new public program and were not eligible for subsidies would face the entire gross premium of plans in the program.

Premiums for Employment-Based Insurance. Premiums for employment-based coverage also might change if the public program attracted a large number of people who currently are enrolled in employment-based plans, and if the risk profile of those remaining in employment-based coverage differed from that existing under current law. For example, if the public program attracted less healthy individuals (who tend to be more costly to insure), premiums could decrease for those remaining in employment-based coverage.

Cost Sharing and Benefits. Plans in the public program would be required to have a minimum generosity level. For example, they could be required to have the same generosity as a silver or gold plan, with income-based cost-sharing requirements. As is the case with cost-sharing reductions in the marketplaces under current law, lower-income individuals would be responsible for smaller cost-sharing payments. Depending on the specifications of the benefit design, cost sharing could remain unchanged from current law, or it could decrease. For example, cost sharing could decrease for some groups if income-based cost sharing was more generous than under current law or if the minimum plan generosity required by the public program was specified to be greater than under current law.

Covered benefits could be specified to include the essential health benefits required in the marketplaces under current law, or they could be expanded to include additional services, such as dental and vision coverage and long-term services and supports. (Long-term services and supports consist of health care and related services provided to people with functional or cognitive limitations to help them perform routine daily activities over an extended period).

Role of Private Plans. Private plans would continue to play a large role in both the new public program and employment-based insurance. Some people under the age of 65 would continue to receive private coverage through their employers, but enrollment in

employment-based insurance would decrease as some workers and their families enrolled in the new public program. The extent to which people shifted to the public program would depend on the generosity of premium subsidies, the generosity of coverage under the program (that is, the actuarial value and covered benefits) relative to employment-based coverage, and the size of the required employer contributions and any other requirements or penalties to continue offering coverage.

Role of Employment-Based Coverage. Employment-based coverage would continue, but it would play a smaller role under this approach than under current law. Large employers would be required to offer private coverage or to offer coverage through the public program by making mandatory contributions on behalf of their employees (in which case employees could choose between private plans and the public plan offered through the public program). Those mandatory contributions would be larger than the penalties employers face for not offering coverage under current law. The ability of employers to make contributions toward plans offered through the public program would resemble the final rule governing recent health reimbursement arrangements in effect under current law; that rule allows employers to direct a limited amount of pretax premium contributions to subsidize their employees' choice of private plans offered in the nongroup market.²⁰

Many large employers probably would continue offering coverage outside of the public program, particularly if the cost of offering that coverage was less than the contributions they would be required to make to offer coverage through the public program; but the incentives for employers to continue offering coverage would depend on various features of the policy. For example, if the mandatory contributions were structured as a percentage of the employer's payroll, firms employing higher-income workers probably would find it less expensive to continue offering coverage outside of the public program. If the policy did not include sufficiently large employer penalties or requirements to offer coverage, employers would have less incentive to offer coverage outside of the public program.

A more generous level of benefits and premium subsidies for plans offered through the public program also would make covering employees through the public program more attractive than offering coverage outside of the program. Although many employers would continue to offer coverage, others would discontinue coverage and their employees would receive coverage through the public program. Some people, particularly those in lower-income households who would have low or no premiums for the public program, would opt for the public program over employment-based coverage even if their employer offered coverage. As a result, people who retained employment-based coverage would have higher income, on average, than the people enrolled in employment-based coverage under current law and than participants in the public program would have under this approach.

Role of Public Programs. Enrollment in public coverage would increase relative to current law. Although many people would enroll in the public plan through the new public program, many others would select a private plan through the new program or through their employers. The new public program could be based on an existing program, such as Medicare, or it could be an entirely new program. Some individuals would continue to use other public coverage, such as the coverage Medicare provides for the disabled.

Examples of This Approach. The Medicare for America Act of 2019 (H.R. 2452) uses a model that is similar to the one described in this approach. That bill incorporates all of the key features of this approach, including a new large public program called Medicare for America that would entirely replace Medicaid, CHIP, and the nongroup market.²¹ It also includes requirements for large employers and other elements that ensure many people would continue to use private employment-based coverage.

However, H.R. 2452 offers more specific details than the general approach described here, and it includes some elements that are different. For example, H.R. 2452 also would eliminate the existing Medicare program, and it would cover those people in the new Medicare for

20. For further discussion of the final rule for health reimbursement arrangements, see Katie Keith, "Final Rule on Health Reimbursement Arrangements Could Shake Up Markets," *Health Affairs Blog* (June 14, 2019), <https://tinyurl.com/y6rc7gdt>.

21. See the Medicare for America Act of 2019, H.R. 2452, 116th Cong. For a related proposal, see Center for American Progress Health Policy Team, *Medicare Extra: Universal Coverage for Less Than \$3 Trillion and Lower Health Care Costs for All* (July 2019), <https://tinyurl.com/y9f55d> (PDF, 1.18 MB).

America program, which would allow them to choose either a publicly administered plan or one of multiple participating private plans. Large employers would pay an 8 percent payroll tax to help finance the new public program if they did not offer coverage.

If enacted, the legislation would require the government to auto-enroll all uninsured people in Medicare for America. In CBO's assessment, however, prospective auto-enrollment of all uninsured people would not be feasible because it would require the government to identify every person at the moment they lost other coverage and to begin collecting premiums from them. The legislation has the potential to achieve near-universal coverage if the public program also served as a default plan that provided automatic coverage to uninsured people who could not be auto-enrolled.

A different proposal by Blumberg and others also shares the key features of this approach, including a new regulated marketplace of private plans and a public plan that would replace the current nongroup market, Medicaid, and CHIP; generous subsidies to purchase insurance through that marketplace; a continued role for employment-based coverage; and default coverage through a public plan.²² However, that proposal would not require large employers to offer coverage or make mandatory contributions.

Approach 3: Premium Subsidies for All People and Default Coverage Through a Fully Subsidized Plan

The defining feature of this approach (often called a premium support system) is that all people in the eligible population under the age of 65 would receive a premium subsidy from the government that was large enough to cover the entire cost of a benchmark plan. Under this approach, a specified level of benefits would be provided, along with cost-sharing reductions for low-income people. People would use the subsidy to purchase a plan of their choice from a health insurance marketplace that included multiple private plans and, potentially, a public option. Under this approach, preferential tax treatment

for employment-based health insurance would be eliminated. Employers would have little incentive to offer primary health insurance coverage, but they might offer supplemental coverage to reduce cost sharing or provide additional benefits not covered by marketplace plans.

The subsidies could be provided as a refundable tax credit, which would reduce revenues and increase outlays, or as direct payments, which would only increase outlays; the two would be economically equivalent.²³ Different variants could specify a less generous level of benefits (for instance, catastrophic coverage only) that would be similar to those available through a bronze plan under current law. Alternatively, the variants could specify a more generous level of benefits that would be similar to those available through Medicare or a gold plan.

This approach would represent a significant change from the current system: Employment-based insurance would have a much smaller role than under current law, and Medicaid and CHIP would no longer provide primary coverage for acute care services, which include comprehensive major medical services and prescription drugs. The Medicare program would continue to exist for people over the age of 65 and the disabled population.

A fully subsidized benchmark plan would provide default coverage for people who did not actively enroll in a plan and would require no additional tax payments. Because no additional tax payments for default coverage would need to be collected from uninsured people, default coverage would be substantially easier to implement than would be the case with Approaches 1 and 2.

22. That proposal refers to default coverage as continuous autoenrollment with retroactive enforcement. See "Description of Policy Options: The Building Blocks of Healthy America," Variant 3: "HA With CARE," in Linda J. Blumberg and others, *The Healthy America Program, An Update and Additional Options* (Urban Institute, September 2019), p. 3, <https://tinyurl.com/y3x3zyrs> (PDF, 533 KB).

23. For example, under President George H.W. Bush's 1992 proposal, low- and middle-income individuals who were not covered by Medicare, Medicaid, the Veterans Health Administration, or the Civilian Health and Medical Program of the Uniformed Services would have been eligible for a tax credit or tax deduction to purchase health insurance. The tax credit would have extended up to a certain threshold based on modified adjusted gross income and then it would have been phased out. Such a proposal paired with the additional elements of default coverage or a large and enforced individual mandate penalty could achieve near-universal coverage. See R. Glenn Hubbard, "The President's 1992 Health Care White Paper: An Economic Perspective," *National Tax Journal*, vol. 45 no. 3 (1992), pp. 347–356, <https://ntanet.org/NTJ/45/3/ntj-v45n03p347-56-president-1992-health-care.html>.

Enrollment Process. People would use the premium subsidy to purchase a plan from a health insurance marketplace. They would be able to select a new plan each year during an open-enrollment period.²⁴ For people who did not actively enroll in a plan, a default zero-premium plan would provide coverage without the need for them to actively enroll.

Premiums. A premium subsidy that was equal to the full premium of a specified benchmark plan in the marketplace would be more equitable if it varied with both age and income instead of just with income.²⁵ People who chose the benchmark plan (or a plan that cost less than the benchmark plan) could enroll without paying a premium. They could still choose to enroll in a more expensive plan, which would cover additional benefits or have lower cost sharing, but they would be responsible for any additional costs above the benchmark subsidy. The premium subsidy could be made more or less generous by adjusting the plan to which it was benchmarked.

Cost Sharing and Benefits. The premium subsidy would be large enough to cover the entire cost of a benchmark plan with a minimum level of cost-sharing and covered benefits. The minimum amount of cost sharing could be relatively high, as in a plan that provided only basic catastrophic coverage for high-cost medical events in excess of a certain dollar amount, or it could be relatively low, similar to that of a gold plan available through the current health insurance marketplaces. Cost-sharing reductions also would be available for certain populations, such as low-income people. People without cost-sharing reductions could choose to enroll in a plan with lower cost-sharing amounts.

24. Some people also would be eligible to switch plans during a special enrollment period if they experienced a qualifying life event, such as the birth of a child.

25. If the 3:1 age-rating rule in effect under current law remained in place and the refundable tax credit or direct payment did not vary with age, the level of benefits that could be purchased with the refundable tax credit or direct payment amounts would vary by age—for instance, a 64-year-old person would be able to buy a much less generous plan than a 21-year-old. The amount of benefits that could be purchased with a refundable flat tax credit or direct payment also would vary by geographic area because premiums vary by geographic area and state. For further discussion of flat premium tax credits, see American Academy of Actuaries, “Auto-Enrollment Into Individual Market Health Insurance Coverage” (September 2018), <https://tinyurl.com/y5a3v6yo> (PDF, 215 KB).

The required covered benefits under a premium support system could be similar to the essential health benefits specified by the ACA or the benefits provided by Medicare, or they could be based on something else, such as a cost-effectiveness criterion. They could include additional benefits, such as dental and vision services.

Role of Private Plans. Private plans would continue to play a significant role under this approach. People under the age of 65 could use the premium subsidy to purchase a private plan from a marketplace; otherwise, they would be covered under a zero-premium default plan.

Role of Employment-Based Insurance. Employers probably would have little incentive to offer primary health insurance coverage under a premium support system if everyone in the eligible population received a premium subsidy from the government to purchase coverage through a marketplace. However, depending on the premium subsidy amount, cost-sharing requirements, and the type of benefits offered by the marketplace plans, this approach could allow employers to offer supplemental coverage to their employees. Such supplemental coverage could be used to reduce cost-sharing amounts, or it could be used to offer benefits that were not available through marketplace plans, such as dental and vision services. If a marketplace plan provided basic catastrophic coverage, for example, then employers could offer coverage that provided the same benefits they would have provided under current law on top of the catastrophic coverage. In such a case, their employees would experience little change in health insurance benefits under this approach compared with current law.

Because tax preferences for employment-based health insurance would be eliminated under this approach, people with the same income and similar family responsibilities would receive the same benefits for medical costs, and subsidies would not be larger in higher tax brackets. (Current law results in larger subsidies for people in higher tax brackets because of the structure of tax preferences for employment-based coverage).

Role of Public Programs. A premium support system could include a public option that would be available along with private plans in the new marketplace. As in Approach 1, the public option could be modeled on an existing public program, such as Medicare. A premium support system also would need to specify the role of other public programs, such as Medicaid, TRICARE, and the Veterans Health Administration. Some components

of those programs could continue to operate or provide benefits for services not covered by the premium support system. The Medicaid and CHIP programs would be substantially smaller because they would no longer provide primary coverage for acute care services. But those programs could continue to provide long-term services and supports for low-income and disabled populations.

Variants and Examples of This Approach. An approach that offered everyone a subsidy covering the entire cost of a benchmark plan that would be purchased through a marketplace would depend on the way the benchmark plan was defined and how the marketplace was structured.

Fully Subsidized Catastrophic Coverage for All. One variant would be to benchmark premium subsidies to a catastrophic plan with high levels of first-dollar cost sharing, such as a high-deductible plan.²⁶ However, under the catastrophic plan, there would be no cost sharing for the treatment of chronic conditions and preventive services, such as vaccinations and prenatal care. Deductibles would vary on the basis of household income, and individuals whose income was below a certain level would not have a deductible. People could use their subsidy to enroll in a catastrophic plan at no cost or they could use their subsidy toward the cost of a more generous plan offered through a marketplace of private plans if they paid the additional premium. Under this variant, there also could be a public option in the marketplace. Various analysts have proposed an approach similar to the one described here.²⁷

Fully Subsidized Generous Coverage for All. Another variant of this approach would be to benchmark premium subsidies to a plan with generous benefits, similar to the Medicare program or a gold plan under current law. Under this approach, people would use their subsidy to purchase a plan of their choice from a health insurance marketplace that included multiple private

plans.²⁸ A public option also could be offered alongside private plans, similar to the current Medicare program, which gives people the choice of enrolling in traditional Medicare or a Medicare Advantage plan.²⁹ An approach that offered fully subsidized generous coverage would require more federal spending than an approach that offered fully subsidized catastrophic coverage.

Approach 4: A Single-Payer System

Under a single-payer system, everyone in the defined population would receive health insurance coverage from the same public plan, and there generally would be no role for private insurance. There would be no premiums, and to achieve deficit neutrality, such a system would need to be financed through broad-based tax revenues; that is, new mechanisms of financing also would be required.³⁰ This approach would involve the most significant departure from the current health care system, and it would be an enormously complex undertaking. Under current law, people receive coverage through various public and private sources, as described earlier in this report. Under a single-payer system, there generally would be no role for employment-based insurance, and the role of other public programs, such as Medicaid and Medicare, would be greatly reduced or eliminated.

Enrollment Process. Under a single-payer system, the government would strive to enroll all people in the defined population in the public plan. People also could be automatically enrolled at the time they were issued Social Security numbers, newborns could be enrolled in hospitals, and other eligible people could be enrolled at the time they sought medical care. Some people seeking medical care would not be eligible for enrollment—because they were visiting from another country,

26. First-dollar cost sharing is the amount that an enrollee is required to pay out of pocket before the health plan starts to pay for benefits.

27. See Ed Dolan, *Universal Catastrophic Coverage: Principles for Bipartisan Health Care Reform* (Niskanen Center, June 2019), <https://tinyurl.com/y4jkkfzco> (PDF, 969 KB). See also Dana Goldman and Kip Hagopian, “The Health-Insurance Solution,” *National Affairs* (Fall 2012), <https://tinyurl.com/y3es67tp>.

28. See George Halvorson and Mehmet Oz, “Medicare Advantage for All Can Save Our Healthcare System,” *Forbes* (June 11, 2020), <https://tinyurl.com/yjyvw8j2>.

29. See Billy Wynne, “The Bipartisan ‘Single Payer’ Solution: Medicare Advantage Premium Support for All,” *Health Affairs Blog* (May 2017), <https://tinyurl.com/y6xba4hx>; Geoffrey Joyce, “Opinion: The Success of Medicare Advantage Makes It a Better Policy Choice Than ‘Medicare for All,’” *MarketWatch* (November 21, 2019), <https://tinyurl.com/y42cj4z>; and Ken Janda and Vivian Ho, “Medicare Advantage for All,” *The Hill* (August 27, 2019), <https://tinyurl.com/y6avusv8>.

30. For further details, see Congressional Budget Office, *Key Design Components and Considerations for Establishing a Single-Payer Health Care System* (May 2019), www.cbo.gov/publication/55150.

for instance—and the enrollment system would need to confirm that they were not eligible. Because people would need to provide information to the enrollment system and some would not do so, coverage would not be completely universal.

Premiums. There would be no premiums under a single-payer system. To achieve deficit neutrality, such a system would need to be financed through broad-based tax revenues.

Cost Sharing and Benefits. A single-payer system would have lower cost sharing than the average under current law. Such a system could include no cost sharing for most services. If the single-payer system included cost sharing, there could be exceptions for certain populations, such as people with low income, children, and the disabled.

The single-payer system would provide comprehensive major medical coverage, but certain items and services, such as over-the-counter medications and cosmetic procedures, could be excluded from coverage. Existing proposals cover a more comprehensive set of benefits than many current sources of coverage, including dental, vision, hearing, and long-term services and supports, but a single-payer system could be designed without those additional benefits.

Role of Private Plans. There generally would be no role, or a very limited role, for private insurance. If private insurance was allowed, it could be limited to services not covered by the public plan. However, private insurance

also could be offered as an alternative source of coverage if enrollees and providers were allowed to opt out of the single-payer system. Alternatively, private insurance could provide benefit enhancements, such as faster access to care or private rooms instead of semiprivate rooms for inpatient stays, or it could be used to access providers that opt out of the single-payer system or to seek care abroad.

Role of Employment-Based Insurance. Employment-based insurance probably would no longer exist under a single-payer health system, or its role would be greatly reduced. For instance, it might provide supplemental coverage for services not covered by the public plan or reduce cost-sharing amounts, if any.

Role of Public Programs. Most public programs, such as Medicaid, CHIP, and Medicare probably would have a limited role or be eliminated under a single-payer system. Some components of those programs could continue to operate separately and provide benefits for services not covered by the single-payer health plan. For example, Medicaid and CHIP could continue to provide long-term services and support benefits only to low-income populations, but the Medicare program would no longer exist.

Examples of This Approach. The two versions of the Medicare for All Act of 2019 include many of the features described in this approach, including no premiums, comprehensive major medical coverage, limited to no cost sharing, and no private insurance that would duplicate the benefits of the single-payer system.³¹

31. See the Medicare for All Act of 2019, H.R. 1384 and S. 1129, 116th Cong.



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About This Document

This report was prepared at the request of Chairman John Yarmuth of the House Committee on the Budget and Representatives Angie Craig, Lizzie Fletcher, and Susan Wild. In keeping with the Congressional Budget Office's mandate to provide objective, impartial analysis, the report makes no recommendations.

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CBO continually seeks feedback to make its work as useful as possible. Please send any comments to communications@cbo.gov.

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The Benefits and Limitations of State-Run Individual Market Reinsurance

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ABSTRACT

ISSUE: Cost is a major barrier for many individuals seeking to enroll in or use comprehensive health insurance, despite historic gains in coverage since the Affordable Care Act (ACA). Though state policymakers have numerous options for improving the affordability of individual market coverage, they have most often chosen to implement state-run reinsurance programs. Reinsurance has been popular with states because the ACA's temporary federal reinsurance program was successful and because state reinsurance can be funded in significant part with federal dollars available through an ACA Section 1332 waiver.

GOAL: Examine the benefits and limitations of waiver-funded state reinsurance programs.

METHODS: Analysis of state reinsurance programs; applicable federal and state laws, regulations, and guidance; and other state and federal proposals to address coverage affordability.

KEY FINDINGS AND CONCLUSIONS: States have customized waiver-funded reinsurance to meet their specific needs. States with reinsurance have experienced significantly lower individual market premiums and stable insurer participation. However, these premium reductions generally only benefit unsubsidized enrollees and the impact on coverage take-up is unclear. States prioritizing broader improvements should consider other policies in tandem with or in lieu of reinsurance, but need federal leadership and support to succeed.

TOPLINES

- ▶ To make individual market coverage more affordable, states have considered a range of policies but have pursued one approach more than others: reinsurance.
- ▶ The success of reinsurance in reducing unsubsidized premiums has made individual market coverage more affordable, but the broader impact of these programs on the cost of coverage has been more modest.



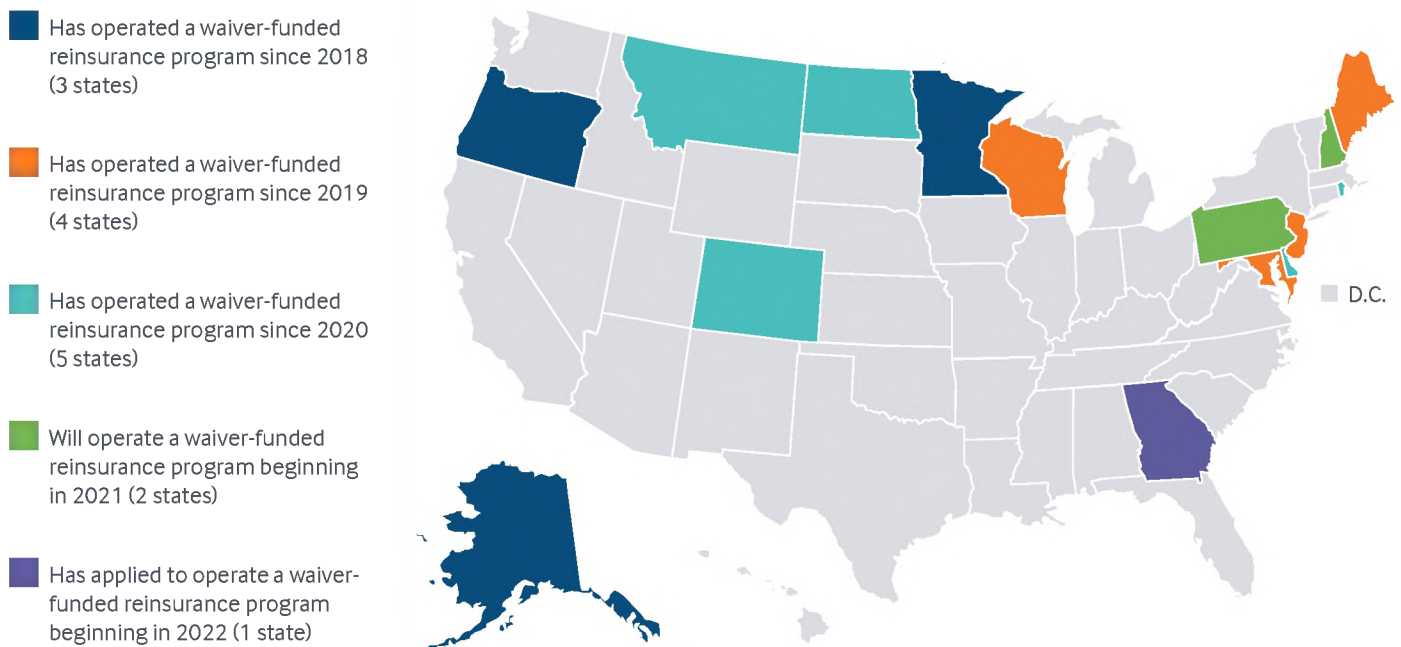
INTRODUCTION

The Affordable Care Act (ACA) produced historic expansions in coverage and has provided millions of Americans — including many who have experienced hardship during the COVID-19 pandemic — with vital access to comprehensive health insurance.¹ Even so, cost continues to present a major barrier to coverage for many.² Though federal subsidies for ACA marketplace coverage can substantially reduce costs for eligible individuals, the uninsured rate remains relatively high among people with moderate and lower incomes.³ Meanwhile, many individuals — including those with incomes above the eligibility threshold, those who fall into the “family glitch,” and undocumented residents — do not qualify for federal financial assistance.⁴ Following large premium increases in 2017 and 2018, individual market enrollment among

those who do not receive a federal subsidy dropped precipitously and has not rebounded.⁵

Though states have considered a range of policies to make individual market coverage more affordable, they have pursued one approach more than others: reinsurance.⁶ By 2021, 14 states will operate individual market reinsurance programs, each designed to moderate premium increases and provide market stability by offsetting some costs borne by insurers of covering enrollees with high medical expenses.⁷ For the first three years of ACA marketplace coverage (2014–2016), a federal reinsurance program lowered premiums and stabilized markets nationwide.⁸ Efforts to make that program permanent foundered, but its success — and, crucially, states’ ability to finance reinsurance with federal dollars available through the ACA’s Section 1332 waiver program — paved the way for states to establish their own programs (Exhibit 1).

Exhibit 1. State Individual Market Reinsurance Programs Supported by Section 1332 Waiver Funding, by Year of Adoption



Notes: Section 1332 of the ACA authorizes states to apply to waive specified provisions of the health law to facilitate state-specific programs for improving coverage. If a state’s “innovation waiver” program is forecast to reduce federal spending, the state is entitled to have these savings passed through to it for purposes of implementing the program. The states identified in this map have secured, or are seeking, approval for innovation waivers that use these federal “pass-through” funds to partially finance the state’s reinsurance program.

Data: Authors’ analysis.

At the federal level, the rationale for deploying reinsurance as part of the emergency response to COVID-19 has weakened considerably. The pandemic has reduced overall demand for health care services, boosting insurer profits, and has had only a modest — and often negligible — effect on 2021 individual market premiums, making an additional influx of funds unnecessary.⁹ Yet for states weighing whether to maintain or pursue waiver-funded reinsurance over a longer time horizon, considerations differ.

This brief examines states' efforts to implement reinsurance programs, and considers flexibilities in funding and program design, the effect of reinsurance on individual market premiums, and trends in enrollment and insurer participation. Finally, it identifies the limitations of state-run reinsurance and key considerations for states.

PROGRAM FUNDING AND DESIGN: A STRAIGHTFORWARD FRAMEWORK WITH OPTIONS TO INNOVATE

Funding

States' reinsurance programs receive substantial funding from the federal government, with “pass-through” dollars available through an ACA Section 1332 waiver. In 10 of the 12 states where programs have commenced operations, waiver funding covers the majority of program costs and in all states, it is this federal support that has made reinsurance viable. Still, states must cover a share of costs and have developed several funding mechanisms to do so.

Eight of the 12 states rely at least in part on insurer assessments to finance their obligations, while five have used general appropriations to cover some or all state costs ([Appendix Exhibit 1](#)). But states have increasingly pursued other funding sources. Two states with individual mandates — New Jersey and Rhode Island — use the penalty dollars they collect to fund reinsurance.¹⁰ Pennsylvania, which recently assumed responsibility for its ACA marketplace from the federal government, will finance its new reinsurance program with savings generated by running its coverage portal more efficiently.¹¹

Other states have acted quickly and creatively to repurpose revenue from an expiring federal tax on health insurers. When Congress temporarily suspended the federal health insurance provider tax for 2019, Maryland required insurers — which benefit from and lobbied for reinsurance — to pay a fee equivalent to their forgone tax obligation to fund the program.¹² Later, after Congress permanently repealed the tax, Colorado and New Jersey followed a course similar to Maryland and established state replacements to help fund both reinsurance and forthcoming coverage subsidy programs.¹³

WHAT ARE SECTION 1332 WAIVERS?

- Section 1332 of the ACA allows states to apply to the federal government to waive certain provisions of the health law to implement their own programs to improve health insurance coverage.
- States can waive rules governing the ACA's marketplaces, premium and cost-sharing subsidies, and essential health benefits, among others.
- States may not waive ACA protections for people with preexisting conditions, prohibitions on health status and gender rating, and nondiscrimination rules.
- States can access federal funding through the waiver. If a state's waiver plan is forecast to reduce federal spending on marketplace subsidies, the federal government will pass through those savings to the state for the purpose of implementing its waiver.
- The program does not give states carte blanche to waive federal law. A waiver cannot be approved unless it complies with statutory “guardrails” that disallow any proposal likely to undermine comprehensive and affordable coverage, cover fewer people, or impose additional costs on the federal government.
- States must have statutory authority to submit the waiver application to the federal government and implement the waiver program.

Program Parameters

Nearly all state reinsurance programs follow a “claims-based” model similar to the ACA’s temporary federal program: they reimburse insurers a percentage (i.e., the coinsurance rate) of all high-cost claims that exceed a specified threshold (i.e., the attachment point), up to a cap. In contrast, Alaska has a “conditions-based” program, under which insurers are reimbursed for the costs of enrollees with specified high-cost health conditions. Maine uses a hybrid of the two models ([Appendix Exhibit 2](#)).

States have used design and program parameters to attain specific policy outcomes. For example, Colorado policymakers structured their program to have the greatest impact in areas that have historically faced the highest health care and premium costs. The state adjusts the coinsurance rate by region: in the most expensive areas, the state picks up a larger share of eligible claims, thereby providing greater premium relief.¹⁴ Georgia plans to establish a program with similar parameters in 2022.¹⁵

In Alaska, insurance regulators modified the list of conditions covered by the reinsurance program to include symptoms of COVID-19.¹⁶

WAIVER-FUNDED REINSURANCE: LOWER UNSUBSIDIZED PREMIUMS AND STABLE INSURER PARTICIPATION, BUT ENROLLMENT EFFECTS UNCLEAR

Premiums

Every state that has implemented a waiver-funded individual market reinsurance program has experienced lower unsubsidized premiums as a result ([Exhibit 2](#)). The magnitude of these savings, largely a function of program funding levels and market size, has varied substantially. Rhode Island’s program, operating with a budget of \$15 million, reduced rates in its inaugural year (2020) by an average of about 4 percentage points. In Maryland, the state’s \$462 million program lowered average premiums by nearly 40 percentage points in its first year (2019). In most states, reinsurance has produced an annual reduction in premiums of more than 10 percentage points.

Exhibit 2. Impact of Waiver-Funded State Reinsurance Programs on Individual Market Unsubsidized Premiums, 2018–2020

Average percentage-point reduction in unsubsidized premium rates because of reinsurance			
State	2018	2019	2020
Alaska	30.2%	34.0%	37.1%
Colorado	—	—	22.4%
Delaware	—	—	13.8%
Maine	—	13.9%	7.2%
Maryland	—	39.6%	35.8%
Minnesota	16.8%	20.2%	21.3%
Montana	—	—	8.9%
New Jersey	—	15.5%	16.9%
North Dakota	—	—	20.0%
Oregon	7.2%	6.7%	8.0%
Rhode Island	—	—	3.8%
Wisconsin	—	9.9%	11.0%

Note: The table displays the difference in the average statewide premium with waiver-funded reinsurance and without it, where each rating area within the state is weighted equally.

Data: Center for Consumer Information and Insurance Oversight, State Relief and Empowerment Waivers: State-Based Reinsurance Programs, June 2020.

These programs have continued to generate premium reductions in the years following initial implementation. The reinsurance programs in Alaska and Minnesota have produced successively greater impact in each year of operation, with Alaska's premium reductions topping 30 percentage points every year. Maryland's program, meanwhile, caused a roughly 36 percentage point drop in premiums in its second year.

Marketplace Enrollment

Though reinsurance has demonstrably reduced unsubsidized individual market premiums, its effect on marketplace enrollment is less clear. During program development, nearly all states projected that reinsurance

would generate only a small (less than 3%) boost in take-up. Raw enrollment trends suggest the positive effects may indeed have been limited (Exhibit 3). Seven of the 12 states with reinsurance programs have seen marketplace plan selections decline by at least 2 percent following program implementation, while two states have experienced corresponding increases. In three states, plan selections were flat.

These data do not rule out the possibility that reinsurance has affected enrollment. When these programs were being implemented, plan selections across the country trended downward. Evidence suggests that broader policy developments in the individual market, including massive cuts to consumer enrollment assistance programs,

Exhibit 3. Total Number of Consumers Who Selected a Marketplace Plan by the End of Open Enrollment, 2017–2020

State	2017	2018	2019	2020	Change in plan selections, pre/post program implementation*
Reinsurance programs implemented in 2018					
Alaska	19,145	18,313	17,805	17,696	-7.6%
Minnesota	109,974	116,358	113,552	110,042	0.1%
Oregon	155,430	156,105	148,180	145,264	-6.5%
Total U.S.	12,216,003	11,750,175	11,444,141	11,409,447	-6.6%
Reinsurance programs implemented in 2019					
Maine	79,407	75,809	70,987	62,031	-18.2%**
Maryland	157,832	153,584	156,963	158,934	3.5%
New Jersey	295,067	274,782	255,246	246,426	-10.3%
Wisconsin	242,863	225,435	205,118	195,498	-13.3%
Total U.S.	12,216,003	11,750,175	11,444,141	11,409,447	-2.9%
Reinsurance programs implemented in 2020					
Colorado	161,568	161,764	170,325	166,852	-2.0%
Delaware	27,584	24,500	22,562	23,962	6.2%
Montana	52,473	47,699	45,374	43,822	-3.4%
North Dakota	21,982	22,486	21,820	21,666	-0.7%
Rhode Island	29,456	33,021	34,533	34,634	0.3%
Total U.S.	12,216,003	11,750,175	11,444,141	11,409,447	-0.3%

Note: The table displays total plan selections at the end of each open enrollment period, not effectuated enrollments.

* The change in enrollment pre/post program implementation shows the percentage change in plan selections from the year prior to implementation of the reinsurance program to 2020. For example, the entry for Maryland shows the percentage change in plan selections from 2018 and 2020. For the U.S. total, the change in enrollment column reflects the percentage change in plan selections nationwide from the corresponding year to 2020.

** Maine expanded Medicaid in early 2019. As a result, marketplace enrollees with incomes between 100% and 138% of the federal poverty level became eligible for Medicaid and likely left the marketplace to enroll in public coverage.

Data: Authors' analysis of the Centers for Medicare and Medicaid Services' annual marketplace open enrollment period public use files.

support by the Trump administration for skimpier coverage products sold outside of the marketplaces, and ongoing legal challenges to the ACA, may have played a role in depressing marketplace enrollment.¹⁷ This negative effect may have swamped any increase in take-up due to reinsurance.¹⁸ Conversely, because reinsurance may reduce the buying power of subsidized enrollees (by decreasing the size of the premium tax credit), it is possible these programs have marginally reduced sign-ups.¹⁹ Additional analysis, controlling for critical factors, is needed to determine the extent to which the programs have influenced enrollment.

Insurer Participation

Along with moderating premiums, a core objective of reinsurance is to offer certainty and stability to the market, to encourage ongoing and increased participation by insurers. In this regard, the programs appear to have been effective. Since implementation, all states have enjoyed stable insurer participation (Exhibit 4). Four states have gained one insurer, while seven have recorded no net

change. Only one state has seen a reduction in their total number of carriers. In Oregon, an insurer with a small share of marketplace enrollment withdrew prior to the 2018 plan year.

THE LIMITS OF REINSURANCE

The success of reinsurance in reducing unsubsidized premiums has made coverage more affordable for the many consumers who, because they are ineligible for federal subsidies, bear the full burden of rate increases. The broader impact of these programs on the cost of coverage, however, has been more modest.

Partly, this is because of the interaction between reinsurance and the ACA's subsidy structure. The size of an eligible enrollee's premium subsidy depends on her household income and the cost of a benchmark plan sold in the marketplace.²⁰ As unsubsidized premiums have risen, so too has the value of the premium tax credit, and this increased buying power has generally insulated subsidized enrollees from rate hikes.²¹ But this effect works both ways.

Exhibit 4. Individual Market Insurer Participation, Marketplace Plans Only, 2017–2020

State	2017	2018	2019	2020	Change in participation, pre/post program implementation*
Reinsurance programs implemented in 2018					
Alaska	1	1	1	2	+1
Minnesota	4	4	4	4	—
Oregon	6	5	5	5	–1
Reinsurance programs implemented in 2019					
Maine	3	2	3	3	+1
Maryland	3	2	2	2	—
New Jersey	2	3	3	3	—
Wisconsin	15	11	12	12	+1
Reinsurance programs implemented in 2020					
Colorado	7	7	7	8	+1
Delaware	2	1	1	1	—
Montana	3	3	3	3	—
North Dakota	3	2	3	3	—
Rhode Island	2	2	2	2	—

Note: The table displays the total number of insurers that offered qualified health plans through the state's ACA marketplace in the given year.

* The change in participation pre/post program implementation shows the difference between the number of insurers participating in the state's marketplace in 2020, compared to the number of insurers that participated in the marketplace in the year prior to implementation of the reinsurance program.

Data: Authors' analysis of state rate filings and data from HealthCare.gov.

In states where reinsurance has reduced unsubsidized premiums, it also has decreased the size of the premium tax credit.²² Subsidized enrollees can generally compensate for this reduction in their buying power by shopping around during open enrollment.²³ But for these consumers, reinsurance does little to improve affordability (though greater market stability and insurer participation may produce benefits over time). Indeed, there is some reason to believe that even modest decreases in buying power may push some to disenroll.²⁴

Reinsurance also has not addressed the underlying drivers of health care costs. While current programs offset expensive claims, they are not designed to encourage more efficient care management or lower provider prices. A reinsurance program could be developed with such objectives: Colorado initially sought to fund its program by requiring hospitals to bring their reimbursement rates into line with a pricing benchmark linked to Medicare rates. However, the Trump administration signaled it would not approve a waiver program that regulates provider payments, forcing the state to abandon this approach.²⁵

Finally, though most reinsurance programs are set to last for at least five years (i.e., the initial term of a Section 1332 waiver), states may find it difficult to sustain their share of funding. In particular, economic damage wrought by the pandemic could complicate near-term financing plans and act as a barrier to program adoption.²⁶ If and when a state program is scheduled to expire, policymakers will face the task of winding it down without spiking rates, a challenge for which there is no clear solution.

DISCUSSION

Whether via tax deduction, tax credit, or direct funding, the federal government subsidizes the health insurance costs of the vast majority of Americans.²⁷ Individual market consumers ineligible for ACA subsidies are the major exception.

By lowering individual market premiums, state-operated reinsurance effectively subsidizes coverage for this population, providing help unavailable elsewhere. Premium reductions, market stability, and access to federal financing to establish the programs have engendered

rare bipartisan support for reinsurance. Consequently, reinsurance has frequently gained traction among state policymakers, even as other affordability reforms have not.

Yet, these substantive and practical advantages do not make reinsurance, on its own, a sufficient solution to the problem of affordability. Nor do they suggest reinsurance is a necessary approach for all states; alternatives may prove superior. Policymakers must carefully consider their objectives as they weigh potential reforms.

For example, if a state aims to make comprehensive coverage more affordable for a broad swath of residents, the effect of reinsurance will be limited. In contrast, state-run coverage subsidy programs, which can be tailored to help both consumers ineligible for ACA subsidies and those for whom such assistance may be insufficient, are likely to have a more substantial impact.²⁸

States that run their own marketplaces, and therefore have administrative and operational control over enrollment, may find that subsidies offer a better return than reinsurance or that these initiatives should proceed in tandem. States that lack such flexibility and find it harder to develop a coordinated subsidy program have other options. Large benefits can be expected from expanding Medicaid, if the state has not already done so.²⁹ On a smaller scale, states could set standard cost-sharing parameters for marketplace health plans that promote high-value care — for example, requiring that such services be covered before a deductible is met.³⁰

For states seeking to address underlying health care costs, waiver-funded reinsurance has little to offer at the moment.³¹ Yet, if states were freed to pursue waivers that include provider price regulations (the Trump administration's prohibition on such waivers is simply a policy preference and not grounded in federal law), they could employ cost containment measures within their programs.

Many state reforms, including both reinsurance and subsidies, require a sustained financial commitment. Yet in many states, funding such initiatives is a continuing challenge made even harder by the pandemic. To make comprehensive coverage affordable, consumers need federal leadership and support.

Appendix Exhibit 1. First-Year Program Costs and State Funding Sources for Waiver-Funded State Reinsurance Programs

State (year)	Total planned program cost	State share of costs*	STATE FUNDING SOURCES			
			Assessment on:		General funds	Other
Health insurers	Providers					
Alaska (2018)	\$60m	3%	X	—	—	X Assessment applies to all lines of insurance
Colorado (2020)	\$250m	32%	X**	X**	X**	—
Delaware (2020)	\$27m	19%	X	—	—	—
Maine (2019)	\$93m	33%	X	—	—	X Premiums for policies ceded to program
Maryland (2019)	\$462m	19%	X	—	—	—
Minnesota (2018)	\$136m	4%	—	X	X	—
Montana (2020)	\$35m	35%	X	—	—	—
New Jersey (2019)	\$295m	39%	—***	—	X	X Revenue from individual mandate
North Dakota (2020)	\$47m	55%	X	—	—	—
Oregon (2018)	\$90m	39%	X	—	—	X Excess funds held by two other state programs†
Rhode Island (2020)	\$15m	65%	—	—	X	X Revenue from individual mandate
Wisconsin (2019)	\$200m	36%	—	—	X	—

Note: Except where otherwise indicated in the notes, the table provides data for the first year in which the state's reinsurance program operated with funding secured by an ACA Section 1332 waiver.

* The state's share of program funding equals the difference of the total planned program cost and the amount of federal pass-through funding allocated for the year identified (as determined by the federal government), expressed as a percentage.

** Legislation enacted in 2020 significantly changed the state funding mechanisms for Colorado's reinsurance program. The new law eliminates general fund support for the program; eliminates the assessment on hospitals for two years but establishes a new hospital assessment beginning in 2022; and imposes a fee on insurers starting in 2021.

*** Beginning in 2021, New Jersey will impose an assessment on health insurers that will be used, in part, to fund the state's reinsurance program.

† Oregon used excess funds from other state programs in 2018, only. Starting in 2020, the state's insurer assessment was expanded to apply to stop loss insurance.

Data: Authors' analysis of state Section 1332 reinsurance waiver applications, related federal correspondence, and state implementing legislation, regulations, and guidance; Center for Consumer Information and Insurance Oversight, State Relief and Empowerment Waivers: State-Based Reinsurance Programs, June 2020.

Appendix Exhibit 2. Key Characteristics of Waiver-Funded State Reinsurance Programs During the First Year of Implementation

State (year)	Program design	Total planned program cost	Attachment point	Coinsurance rate	Cap	Other features
Alaska (2018)	Condition-based	\$60m	—	—	—	Program covers all claims costs for 33 specified conditions*
Colorado (2020)	Claims-based	\$250m	\$30,000	Tier 1: 45% Tier 2: 50% Tier 3: 85%**	\$400,000	—
Delaware (2020)	Claims-based	\$27m	\$65,000	75%	\$215,000	—
Maine (2019)	Hybrid	\$93m	\$47,000	\$47,000– \$77,000: 90% >\$77,000: 100%***	None***	Payment parameters apply to: 1) all policies covering an individual with one of eight specified conditions; and 2) other policies ceded to the program by the insurer
Maryland (2019)	Claims-based	\$462m	\$20,000	80%	\$250,000	—
Minnesota (2018)	Claims-based	\$136m	\$50,000	80%	\$250,000	—
Montana (2020)	Claims-based	\$35m	\$40,000	60%	\$101,750	—
New Jersey (2019)	Claims-based	\$295m	\$40,000	60%	\$215,000	—
North Dakota (2020)	Claims-based	\$47m	\$100,000	75%	\$1m	—
Oregon (2018)	Claims-based	\$90m	\$95,000	59%	\$1m	—
Rhode Island (2020)	Claims-based	\$15m	\$40,000	50%	\$97,000	—
Wisconsin (2019)	Claims-based	\$200m	\$50,000	50%	\$250,000	—

Note: Except where otherwise indicated in the notes, the table provides data for the first year in which the state's reinsurance program operated with funding secured by an ACA Section 1332 waiver.

* In 2020, Alaska regulators modified the list of reimbursable conditions to include symptoms of COVID-19.

** Colorado's program is designed to be more generous (i.e., pay a higher coinsurance rate) in geographic areas that historically have the highest health care costs and the highest health insurance premiums. As specified in its implementing legislation, the program should produce reductions in claims costs of between 15%–20% for geographic areas in Tier 1; 20%–25% for areas in Tier 2; and 30%–35% for areas in Tier 3. The state set coinsurance rates at levels designed to achieve these targets.

*** For claims above \$1 million, Maine's program pays net of amounts covered by the federal risk adjustment program high-cost risk pool.

Data: Authors' analysis of state Section 1332 reinsurance waiver applications, related federal correspondence, and state implementing legislation, regulations, and guidance; and Center for Consumer Information and Insurance Oversight, State Relief and Empowerment Waivers: State-Based Reinsurance Programs, June 2020.

NOTES

1. For information about how the Affordable Care Act (ACA) has produced historic coverage gains, see, e.g., David Blumenthal, Sara R. Collins, and Elizabeth J. Fowler, “The Affordable Care Act at 10 Years — Its Coverage and Access Provisions,” *New England Journal of Medicine* 382, no. 10 (Mar. 5, 2020): 963–69; Sherry A. Glied, Sara R. Collins, and Saunders Lin, “Did the ACA Lower Americans’ Financial Barriers to Health Care?,” *Health Affairs* 39, no. 3 (Mar. 2020): 379–86; and Jennifer Tolbert et al., *Key Facts About the Uninsured Population* (Henry J. Kaiser Family Foundation, Dec. 2019). For information about access to coverage under the ACA during the COVID-19 pandemic, see, e.g., Rachel Schwab, Justin Giovannelli, and Kevin Lucia, “During the COVID-19 Crisis, State Health Insurance Marketplaces Are Working to Enroll the Uninsured,” *To the Point* (blog), Commonwealth Fund, May 19, 2020; and Bowen Garrett and Anuj Gangopadhyaya, *How the COVID-19 Recession Could Affect Health Insurance Coverage* (Urban Institute, May 2020).
2. See, e.g., Munira Z. Gunja and Sara R. Collins, *Who Are the Remaining Uninsured, and Why Do They Lack Coverage?* (Commonwealth Fund, Aug. 2019); and Ashley Kirzinger et al., *Data Note: Americans’ Challenges with Health Care Costs* (Henry J. Kaiser Family Foundation, June 2019).
3. Tolbert et al., *Key Facts*, 2019.
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6. Justin Giovannelli, JoAnn Volk, and Kevin Lucia, *States Work to Make Individual Health Coverage More Affordable, But Long-Term Solutions Call for Federal Leadership* (Commonwealth Fund, Jan. 2020).
7. Justin Giovannelli, Kevin Lucia, and Sabrina Corlette, “What Is Your State Doing to Affect Access to Adequate Health Insurance?,” map, Commonwealth Fund, last updated Oct. 1, 2020.
8. American Academy of Actuaries, *Drivers of 2017 Health Insurance Premium Changes* (AAA, May 2016); and American Academy of Actuaries, *Drivers of 2016 Health Insurance Premium Changes* (AAA, Aug. 2015).
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11. “[Pennsylvania’s 1332 Waiver Application](#),” Commonwealth of Pennsylvania, Feb. 11, 2020.
12. Md. Code, Ins. § 6-102.1.
13. Colorado General Assembly, “[Health Insurance Affordability Enterprise, SB20-215](#),” State of Colorado, June 30, 2020; and New Jersey State Legislature, “[Assembly Bill 20-4389](#),” State of New Jersey, July 31, 2020. In light of the current increase in profitability experienced by many insurers because of the pandemic, additional states may see value in establishing an insurer assessment to safeguard the financial viability of reinsurance and/or other coverage affordability programs.
14. “[Colorado 1332 State Innovation Waiver Request Application to Develop a State Reinsurance Program](#),” State of Colorado, May 20, 2019.
15. “[Georgia Section 1332 State Empowerment and Relief Waiver Application](#),” State of Georgia, July 31, 2020.
16. Alaska Admin. Code tit. 3 § 31.540.
17. See, e.g., Selena Simmons-Duffin, “[Trump Is Trying Hard to Thwart Obamacare. How’s that Going?](#),” *National Public Radio*, Oct. 14, 2019; and Dylan Scott, “[Obamacare Enrollment Is Shrinking After Trump’s Sabotage](#),” *Vox*, updated Dec. 15, 2017. For an examination of the possible effects of the Trump administration’s management of 2018 open enrollment on enrollment outcomes, see Government Accountability Office, *Health Insurance Exchanges: HHS Should Enhance Its Management of Open Enrollment Performance* (GAO, July 2018). For a discussion of the Trump administration’s reduction of funding for consumer enrollment assistance, see, e.g., Karen Pollitz, Jennifer Tolbert, and Maria Diaz, *Data Note: Limited Navigator Funding for Federal Marketplace States* (Henry J. Kaiser Family Foundation, Nov. 2019).
For a discussion of the impact of federal actions on the state-run marketplaces, see Justin Giovannelli and Emily Curran, *How Did State-Run Health Insurance Marketplaces Fare in 2017?* (Commonwealth Fund, Mar. 2018). For an exhaustive accounting of efforts by the Trump administration to undermine the ACA, see Center on Budget and Policy Priorities, “[Sabotage Watch: Tracking Efforts to Undermine the ACA](#),” CBPP, last updated June 22, 2020.
18. Other factors not captured here surely also affected sign-ups. For example, the state with the biggest enrollment decline since reinsurance implementation, Maine, expanded Medicaid during the same period. This decision shifted many marketplace enrollees to public coverage and likely accounts for a significant portion of the observed reduction.
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20. For an explanation of the mechanics of the ACA’s premium tax credit, see “[Key Facts: Premium Tax Credit](#),” *Health Reform: Beyond the Basics* (blog), Center on Budget and Policy Priorities, last updated Aug. 2020.
21. See, e.g., Erik Huth and Peter Fielek, *Has the ACA “Death Spiral” Kicked the Bucket?* (Milliman, July 2019).
22. See Aree Bly and Freddy Quiram, “[Colorado Individual Exchange Renewals: Consumer Impact Analysis](#)” presentation by Wakely Consulting Group, Oct. 14, 2019.
23. See Bly and Quiram, “[Colorado Individual Exchange](#),” 2019; and John Ingold, “[Colorado’s Reinsurance Program Has Been Lauded as a Way to Reduce Health Care Costs. Here’s the Fine Print.](#),” *Colorado Sun*, Nov. 1, 2019.

24. See Drake and Abraham, “Individual Market,” 2019.
25. In 2020, Maine enacted legislation that, among other things, allows for modification of the state’s reinsurance program beginning in 2022. See Maine Legislature, “[An Act to Enact the Made for Maine Health Coverage Act and Improve Health Choices in Maine: LD 2007](#),” State of Maine, Mar. 18, 2020. The new law gives the state authority to exclude from reinsurance certain claims for “high-priced items or services.” If a high-priced item or service — defined as one that is covered under Medicare and identified by the state in advance of the plan year — results in a claim amount that is greater than 200% of Medicare rates, that claim is not eligible for reimbursement under the program.
26. Marlene Caride et al., “[Letter from Fifteen State-Based Marketplaces to U.S. Senate and House Leadership](#),” National Academy for State Health Policy, June 5, 2020.
27. For example, federal law 1) provides a tax deduction for employees’ share of job-based health insurance premiums and creates certain arrangements and accounts, such as health savings accounts and health reimbursement arrangements, that receive preferential tax treatment; 2) provides premium tax credits and cost-sharing reduction subsidies for eligible enrollees in the ACA marketplaces; and 3) funds public coverage programs, including Medicare, Medicaid, the Children’s Health Insurance Program, and TRICARE.
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29. Rachel Garfield, Kendal Orgera, and Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid* (Henry J. Kaiser Family Foundation, Jan. 2020); and Commonwealth Fund, “[Status of Medicaid Expansion and Work Requirement Waivers](#),” map, Commonwealth Fund, last updated Oct. 1, 2020.
30. Giovannelli, Volk, and Lucia, *States Work*, 2020.
31. But see Maine’s efforts, described in note 25, above.

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NASHP

You Can't Unring a Bell – Implications for States if the Supreme Court Upends the Affordable Care Act

November 3, 2020 / by Trish Riley

For more than a decade, states have been at work implementing the Affordable Care Act (ACA). Today, to varying degrees, its provisions are hardwired into all states. If the ACA fails to survive the objections raised in the US Supreme Court case *California vs. Texas*, states will face significant challenges and new costs.

Next week's oral arguments before the nation's highest court could lead to a decision to end the ACA, depending on how broadly the court rules, and create significant disruptions in states.

View/download the slide deck, [A Review of the Affordable Care Act's Key Provisions and the Potential Implications of the Supreme Court's Overturning the Law](https://www.nashp.org/wp-content/uploads/2020/11/ACA-SCOTUS-11_2_20.pdf) [https://www.nashp.org/wp-content/uploads/2020/11/ACA-SCOTUS-11_2_20.pdf].

The court may reaffirm its 2012 ruling that upheld the constitutionality of the mandate that individuals must have insurance coverage or pay a penalty. It could also conclude that the individual mandate is in fact unconstitutional and strike down some but not all the law, or it could end the law altogether. Of course, the most profound impact such a decision would have is on the more than 20 million Americans now covered through ACA's coverage expansions. Most states, now confronting severe budget constraints due to COVID-19, would be unable to replace the federal dollars that now support that coverage through Medicaid expansion and tax subsidies.

But there are more implications – some mundane but substantial – at stake here for states should the court significantly alter or eliminate the ACA. This blog and the accompanying slide deck outlines the far-reaching effect of states' health insurance programs stripped of the ACA.

For starters, the ACA required states to significantly alter how Medicaid eligibility and enrollment is conducted and changed how financial eligibility is determined for many Medicaid enrollees. It required a single application to be used for multiple health coverage programs and streamlined how eligibility is conducted. Federal dollars supported the buildout of new technologies and other administrative apparatus to support the new, consolidated eligibility and enrollment systems and to link Medicaid to health insurance exchanges. This work was transformative and is now well established in all states, but without the ACA:

- Would states be required to again retool all their systems and do it without the federal money that helped build them?
- Would states face federal penalties for noncompliant eligibility determinations as they transitioned Medicaid expansion enrollees off coverage and revamped their systems to once again administer traditional Medicaid programs?
- What about the cost and ensuing confusion as children of state employees, now eligible for the Children's Health Insurance Program (CHIP) and ACA funding, lose that coverage and revert back to their parents' health coverage?

If the ACA's expanded coverage to fill the Medicare Part D's "donut hole" is eliminated, how will states protect low-income Medicare beneficiaries who are dually eligible for Medicare and Medicaid, and at what cost?

Importantly, the ACA set national standards for insurance regulation, particularly for small group and individual markets. Before the ACA, insurers used crude tools to lower costs and maximize revenue, imposing annual and lifetime limits on claims, refusing to cover pre-existing conditions, using discriminatory rating practices, denying renewals, and rescinding coverage while shifting more and more costs to out-of-pocket expenses for consumers. The ACA prohibited such practices and imposed medical loss ratios on all markets to limit what insurers could charge in overhead and administration.

In providing advanced premium tax credits (APTC) and health insurance exchanges to help consumers find and secure affordable, comprehensive coverage, the ACA stabilized and grew the individual markets in states. The loss of these consumer protections and subsidies will alter the dynamic of these markets and challenge states to maintain coverage. While 40 states have enacted laws to allow children to stay on a parent's plan until age 26, some make that coverage optional for insurers, not a requirement. As the chart in this slide deck demonstrates, some states have concretized parts of the ACA in their state laws, protecting those with pre-existing conditions, limiting out of pocket exposure, and banning annual and lifetime benefits. But the majority of states have not followed suit and the loss of APTCs that make that coverage affordable will complicate state policymaking decisions.

These few examples of the data included in NASHP's slide deck make clear that the ACA is deeply embedded in state program operations, policy and law. The elimination of the ACA would indeed create profound loss for the millions of people covered by the program, but the disruption it would cause states' insurance markets and administrative and IT infrastructure cannot be ignored. As the court hears oral arguments and ultimately makes its decision, states must be prepared for potential upheaval as 11 years of work implementing and refining the ACA could be upended.

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Explaining Health Care Reform: Questions About Health Insurance Subsidies

Published: Oct 30, 2020



Health insurance can be expensive, and is therefore often out of reach for lower and moderate income families. To make coverage obtainable for families that otherwise could not afford it and to encourage broad participation in health insurance, the Affordable Care Act (ACA) includes provisions to lower premiums and out-of-pocket costs for people with low and modest incomes.

This brief provides an overview of the financial assistance provided under the ACA for people purchasing coverage on their own through health insurance Marketplaces (also called Exchanges).

Health Insurance Marketplace Subsidies

The ACA offers financial assistance to reduce monthly premiums and out-of-pocket costs in an effort to expand access to affordable health insurance for individuals with moderate and low-income – particularly those without access to affordable coverage through their employer, Medicaid, or Medicare. There are two types of subsidies available to Marketplace enrollees. The first, called the premium tax credit (PTC, or APTC when paid in advance), works to reduce enrollees' monthly premium payments for insurance coverage. The second type of financial assistance, the cost-sharing reduction (CSR), reduces enrollees' out-of-pocket costs when they go to the doctor or have a hospital stay. In order to receive either type of financial assistance, qualifying individuals and families must enroll in a plan offered through a health insurance [Marketplace \(https://www.healthcare.gov/health-plan-information/\)](https://www.healthcare.gov/health-plan-information/).

PREMIUM TAX CREDIT

The premium tax credit reduces Marketplace enrollees' monthly premium payments for insurance plans purchased through a Marketplace. Health insurance plans offered through a Marketplace are standardized into four "metal" levels of coverage: bronze, silver, gold, and platinum. Bronze plans tend to have the lowest premiums but leave the enrollee subject to higher out-of-pocket costs when they receive health care services, while platinum plans tend to have the highest premiums but have very low out-of-pocket costs. The premium tax credit can be applied to any of these metal

levels, but cannot be applied toward the purchase of catastrophic coverage. Catastrophic health plans (<https://www.healthcare.gov/choose-a-plan/plans-categories/#catastrophic>) typically have a lower monthly premium than other Qualified Health Plans in the Marketplace, but generally require beneficiaries to pay all of their medical costs until the deductible is met. To qualify for a catastrophic plan, an individual must either be under 30 years of age or eligible for a “hardship exemption.”

Who is eligible for the premium tax credit?

In order to receive the premium tax credit for coverage starting in 2021, a Marketplace enrollee must meet the following criteria:

- Have a household income from one to four times (100%-400% of) the Federal Poverty Level (FPL), which for the 2021 benefit year will be determined based on 2020 poverty guidelines. In 2021, the subsidy range in the continental U.S. is from \$12,760 to \$51,040 for an individual and from \$26,200 to \$104,800 for a family of four.
- Not have access to affordable coverage through an employer (including a family member’s employer)
- Not eligible for coverage through Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), or other forms of public assistance
- Have U.S. citizenship or proof of legal residency (Lawfully present immigrants whose household income is below 100% FPL and are not otherwise eligible for Medicaid are eligible for tax subsidies through the Marketplace if they meet all other eligibility requirements.)
- If married, must file taxes jointly in order to qualify

For the purposes of the premium tax credit, household income is defined as the Modified Adjusted Gross Income (MAGI) of the taxpayer, spouse, and dependents. The MAGI calculation (<http://laborcenter.berkeley.edu/modified-adjusted-gross-income-under-the-affordable-care-act/>) includes income sources such as wages, salary, foreign income, interest, dividends, and Social Security.

Table 1: Premium Subsidy Ranges, by Income in 2020 and 2021

Income % Poverty	Income Range in Dollars for the 2020 benefit year		Income Range in Dollars for the 2021 benefit year	
	Single Individual	Family of Four	Single Individual	Family of Four
Under 100%	Less than \$12,490	Less than \$25,750	Less than \$12,760	Less than \$26,200
100% – 133%	\$12,490 – \$16,612	\$25,750 – \$34,248	\$12,760 – \$16,971	\$26,200 – \$34,846
133% – 150%	\$16,612 – \$18,735	\$34,248 – \$38,625	\$16,971 – \$19,140	\$34,846 – \$39,300
150% – 200%	\$18,735 – \$24,980	\$38,625 – \$51,500	\$19,140 – \$25,520	\$39,300 – \$52,400
200% – 250%	\$24,980 – \$31,225	\$51,500 – \$64,375	\$25,520 – \$31,900	\$52,400 – \$65,500
250% – 300%	\$31,225 – \$37,470	\$64,375 – \$77,250	\$31,900 – \$38,280	\$65,500 – \$78,600
300% – 400%	\$37,470 – \$49,960	\$77,250 – \$103,000	\$38,280 – \$51,040	\$78,600 – \$104,800
Over 400%	More than \$49,960	More than \$103,000	More than \$51,040	More than \$104,800

NOTES: Alaska and Hawaii have different poverty guidelines. Note that tax credits for the 2021 benefit year are calculated using 2020 federal poverty guidelines, while tax credits for the 2020 benefit year are calculated using 2019 federal poverty guidelines.

SOURCE: KFF

Employer coverage is considered affordable if the employee's contribution is less than **9.83 percent** (<https://www.irs.gov/pub/irs-drop/rp-20-36.pdf>) of his or her household income (for the employee's coverage only, not including the cost of adding family members). The employer's coverage must also meet the "minimum value" standard, meaning that the plan has an actuarial value of at least 60 percent (equivalent to a bronze plan). In situations in which the employer's plan fails to meet one or both of these requirements, the employee and their family may be eligible for subsidized health insurance coverage through the Marketplaces if they meet the other criteria listed above.

In states that **expanded Medicaid** (<http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>), tax credit eligibility effectively ranges from 138% to 400% of the poverty level (because almost all people with incomes below 138% of poverty are eligible for Medicaid and therefore are not eligible for subsidized Marketplace coverage). In states that **did not expand Medicaid** (<http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>), tax credit eligibility ranges from 100% to 400% of poverty. Residents of these states who have incomes below 100% of poverty and who do not qualify for Medicaid under their state's **eligibility criteria** (<https://www.kff.org/state-category/medicaid-chip/medicaidchip-eligibility-limits/>) are also not eligible for any premium tax credits. KFF estimates that **2.3 million Americans** (<https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>) living in states that did not expand Medicaid fall into this coverage gap.

The ACA includes stipulations to offer premium tax credits and Medicaid coverage to eligible lawfully present immigrants. Like U.S. citizens, lawfully present immigrants are eligible for subsidized coverage in the Marketplaces if they meet their state's income eligibility rules. Lawfully present immigrants who meet the income eligibility rules for Medicaid in their state may be eligible for Medicaid, but, with the exception of pregnant women in certain states, are generally subject to a five-year waiting period before they can apply. Immigrants, who would otherwise be eligible for Medicaid but have not yet completed their five-year waiting period, may instead qualify for premium tax credits through the Marketplace. If an individual in this circumstance has an income below 100 percent of poverty, for the purposes of tax credit eligibility, his or her income will be treated as though it is equal to poverty (meaning that the enrollee would pay no more than 2.07% of income for a benchmark silver plan in 2021). Immigrants who are not lawfully present are ineligible to enroll in health insurance through the Marketplaces, receive premium tax credits through the Marketplaces, or enroll in non-emergency Medicaid and CHIP.

What amount of premium tax credit is available to people?

The premium tax credit is determined based on a capped amount an individual or family must spend on their monthly payments for health insurance if they enroll in a "benchmark" plan. The cap depends on the family's income, with lower-income families having a lower cap and higher income families having a higher cap (Table 2).

Table 2: Premium Cap, by Income in 2020 and 2021

Income % Poverty	Premium Cap Max % of income for 2nd lowest silver plan	
	2020	2021
Under 100%	No Cap	No Cap
100% – 133%	2.06%	2.07%
133% – 150%	3.09% – 4.12%	3.10% – 4.14%
150% – 200%	4.11% – 6.49%	4.14% – 6.52%
200% – 250%	6.49% – 8.29%	6.52% – 8.33%
250% – 300%	8.29% – 9.78%	8.33% – 9.83%
300% – 400%	9.78%	9.83%
Over 400%	No Cap	No Cap

NOTES: Alaska and Hawaii have different poverty level guidelines. Note that the premium tax credits for the 2021 benefit year are calculated using 2020 federal poverty guidelines, while tax credits for the 2020 benefit year are calculated using 2019 federal poverty level guidelines. SOURCE: KFF

The “benchmark” for determining the amount of the subsidy is the second-lowest cost silver plan available to the individual or family through their state’s Marketplace. If the cost of the enrollee’s benchmark silver plan exceeds their premium cap, then the federal government will pay any amount over the cap. The amount of the tax credit, therefore, is equal to the difference between the individual or family’s premium cap and the cost of the benchmark silver plan.

As noted above, the premium tax credit can then be applied toward any other plan sold through the Marketplace (with the exception of catastrophic coverage). The amount of the tax credit remains the same, so a person who chooses to purchase a plan that is more expensive than the benchmark plan will have to pay the difference in cost. Conversely, a person who chooses a less expensive plan, such as a bronze plan, may end up paying as little as zero dollars per month for the premium. An example below shows how the premium tax credits would work for an individual during the 2021 benefit year.

Premium tax credits at 250% FPL in 2021

- Pat is 30 years old and estimates her 2021 income will be 250% of poverty (about \$31,900 per year)
- Suppose the second-lowest cost silver plan available to Pat in the Marketplace is \$500 per month
- Under the ACA, with an income of \$31,900 per year, Pat would have a cap of 8.33% of income for the second-lowest cost silver plan
- This means that Pat would have to pay no more than \$221 per month (8.33% of \$31,900, divided by 12 months) to enroll in the second-lowest cost silver plan
- The tax credit available to Pat would therefore be \$279 per month (\$500 premium minus \$221 cap)
- Pat can then apply this \$279 per month discount toward the purchase of any bronze, silver, gold, or platinum Marketplace plan available

The premium tax credit cannot be applied to the portion of a person’s premium that is for non-essential health benefits. For example, a plan may offer a dental or vision benefit that is not considered to be “essential” by the state or federal definition. In that case, the person would have to pay for the corresponding portion of the premium without financial assistance. Similarly, if the person smokes cigarettes and is charged a higher premium for smoking, the premium tax credit is not applied to the portion of the premium that is the tobacco surcharge.

How will premium tax credit be provided?

To receive the premium tax credit, an individual or family must purchase insurance coverage through the Marketplaces. When they apply for Marketplace coverage, enrollees will receive a subsidy determination, letting them know whether they are eligible for a premium tax credit and the amount they may receive. The person or family then has the option to receive the tax credit in advance, claim it later when they file their tax return, or some combination of the two options.

The advanced premium tax credit option allows consumers to receive their tax credit at the time of purchase, and choose how much of the advance premium tax credit to apply toward their premiums each month. If the enrollee chooses the advanced option, then the IRS will pay insurers directly such that the cost of the premium is reduced upfront for the consumer. With this option, the enrollee would need to reconcile their premium tax credit at tax time the following year. (For people receiving an advanced payment of the premium tax credit in 2021, the reconciliation would occur when they file their 2021 tax return in 2022). If the individual or family had a significant change in their income from the time they first applied for Marketplace coverage, they may be asked to repay some or all of the tax credit; or conversely, they may be owed an additional tax credit when filing their taxes. The table below indicates the maximum repayment limits for an individual and family, which varies depending on income level (Table 3).

Table 3: Repayment Amounts under Current Law by Income Level for 2020

Income (% Federal Poverty Level)	Maximum repayment amount for a single individual	Maximum repayment amount for couples and families
Less than 200% FPL	\$300	\$600
200% – less than 300% FPL	\$775	\$1,550
300% – less than 400% FPL	\$1,300	\$2,600
400% FPL or greater	Full Amount	Full Amount

SOURCE: Internal Revenue Service

Alternatively, an individual or family can opt to pay their entire premium costs each month and wait to receive their tax credit at the time they file their annual income tax return the following year. The premium tax credit is available to qualifying enrollees regardless of whether they have federal income tax liability, although an individual is required to file a tax return for a given benefit year in order to receive financial assistance.

Cost-Sharing Subsidies

In addition to the premium tax credits, consumers may also be eligible for a second form of financial assistance — cost-sharing reductions. Cost-sharing subsidies reduce a person or family's out-of-pocket costs, such as deductibles, copayments, and

coinsurance, when they use health care services.

Unlike the premium tax credits (which can be applied toward any metal level of coverage), cost-sharing reductions are only available through a silver metal level plan. In essence, the cost-sharing reductions increase the actuarial value (amount covered by the health insurance plan) of a silver metal level plan, in some cases making the plan similar to a gold or platinum plan.

Are cost-sharing subsidies still available for 2021?

Yes. Cost-sharing subsidies are still available for eligible Marketplace enrollees. Although the federal government will no longer be reimbursing insurers for these subsidies, insurers are required by law to reduce cost sharing for lower-income enrollees.

Who is eligible for the cost-sharing subsidy?

People who are eligible to receive a premium tax credit and have household incomes from 100% to 250% of poverty are eligible for cost-sharing subsidies. (The cost-sharing subsidies are available only to the lowest-income Marketplace enrollees who meet all of the other criteria for receiving the premium tax credit). Again, the eligible individual or family must purchase a silver level plan in order to receive the cost-sharing subsidy. However, American Indian/Native Alaskan enrollees can receive cost-sharing reductions through for any metal level plan purchased through the Marketplaces.

What amount of cost-sharing reductions are available to enrollees?

The ACA sets the maximum out-of-pocket (OOP) spending limits, but otherwise does not specify the combination of deductibles, copayments, and coinsurance that plans must use to meet the actuarial value requirements. For example, one insurer may choose to have a relatively high deductible but low copayments for office visits and other services, while another may choose a lower deductible but higher copayments or coinsurance for each service.

Without the cost-sharing reductions, the out-of-pocket maximum may be no more than \$8,550 for an individual and \$17,100 for two or more people in 2021. (This is the highest a plan may set the OOP max, but plans frequently come with a lower OOP max). With the cost-sharing reduction, the out-of-pocket maximum can be no higher than \$2,850 to \$6,800 for an individual, or \$5,700 to \$13,600 for a family in 2021, depending on income. The table below presents the reduced out-of-pocket maximums and increased actuarial values after cost-sharing subsidies are applied, within each income range.

Table 4: Maximum Annual Limitation on Cost-Sharing

Income (% Federal Poverty Level)	Actuarial Value of a silver plan	OOP Max for Individual/Family	
		2020	20
Under 100%	70%	\$8,150 / \$16,300	\$8,550 /
100% – 150%	94%	\$2,700 / \$5,400	\$2,850
150% – 200%	87%	\$2,700 / \$5,400	\$2,850
200% – 250%	73%	\$6,500 / \$13,000	\$6,800 /
Over 250%	70%	\$8,150 / \$16,300	\$8,550 /

SOURCE: "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021," *Federal Regi*

Typically, silver plans have an actuarial value of 70%, meaning that on average the plan pays 70% of the cost of covered benefits for a standard population of enrollees, with the remaining 30% of total costs being covered by the enrollees in the form of deductibles, copayments, and coinsurance. By lowering an individual or family's out-of-pocket costs, the cost-sharing reductions increase the actuarial value of the silver plan to 73, 87, or 94 percent depending on the enrollee's income.

How will cost-sharing reductions be provided?

When enrolling in a silver plan, an eligible enrollee is placed into a plan that has the cost-sharing reduction automatically applied. This means that the silver plan they choose will already have a lowered out-of-pocket maximum than the same plan would in the absence of a cost-sharing reduction. Unlike the premium tax credit, there is no option for cost-sharing reductions to be paid to the enrollee.

Conclusion

In combination, the premium tax credits and cost-sharing reductions require health plans offering coverage to lower-income enrollees through the Marketplaces to increase the actuarial value of the plans, and in a way that caps enrollees' out-of-pocket liability within the specified levels.

Financial assistance to make insurance more affordable and increase insurance coverage is a key element of the ACA. Premium tax credits and cost-sharing reductions of varying levels are available to individuals and families with low to moderate incomes, making coverage and care more affordable. These financial assistance mechanisms, which represent a substantial share of the federal cost of the ACA, make health insurance more affordable for low to moderate income families, enabling them to purchase coverage and gain better access to care.

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Loss of the ACA Could Greatly Erode Health Coverage and Benefits for Women

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Introduction

As the Supreme Court prepares to hear the most recent [challenge](https://www.kff.org/health-reform/issue-brief/explaining-california-v-texas-a-guide-to-the-case-challenging-the-aca/) (<https://www.kff.org/health-reform/issue-brief/explaining-california-v-texas-a-guide-to-the-case-challenging-the-aca/>) to the Affordable Care Act (ACA), we consider what loss of the ACA would mean for women. The broad reach of the ACA and its impact on women's coverage is [considerable](https://www.kff.org/health-reform/issue-brief/potential-impact-of-california-v-texas-decision-on-key-provisions-of-the-affordable-care-act/) (<https://www.kff.org/health-reform/issue-brief/potential-impact-of-california-v-texas-decision-on-key-provisions-of-the-affordable-care-act/>), as millions have gained private or public coverage, no-cost coverage for recommended preventive services including many pregnancy-related services, caps on out-of-pocket spending, and protections against discrimination based on sex in the insurance market. The expansion of coverage under the ACA was financed in part by increases in a variety of taxes, which directly or indirectly affect women as well. All of these changes – some affecting both men and women and some affecting women specifically — are at risk in the upcoming case.

Affordable coverage options for many uninsured women will shrink as federal funding for Medicaid expansion and subsidized care are eliminated, if the ACA is overturned.

Since the ACA went into effect, the uninsured rate among adult women under 65 has declined among all demographic groups (**Figure 1**). This is a direct result of the ACA's major coverage provisions: expansion of Medicaid, the subsidized plans available through the Marketplaces, and the provision that allows workers to enroll adult children up to age 26 as dependents in their parents' employer-sponsored plans. There has also been a sharp drop in the uninsured rate among men over the past decade,

but compared to women, men (<https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>) remain more likely to be uninsured and comprise more than half (55%) of the remaining uninsured population.

Figure 1

Uninsured Rates Have Dropped Among Most Groups of Women Since the ACA

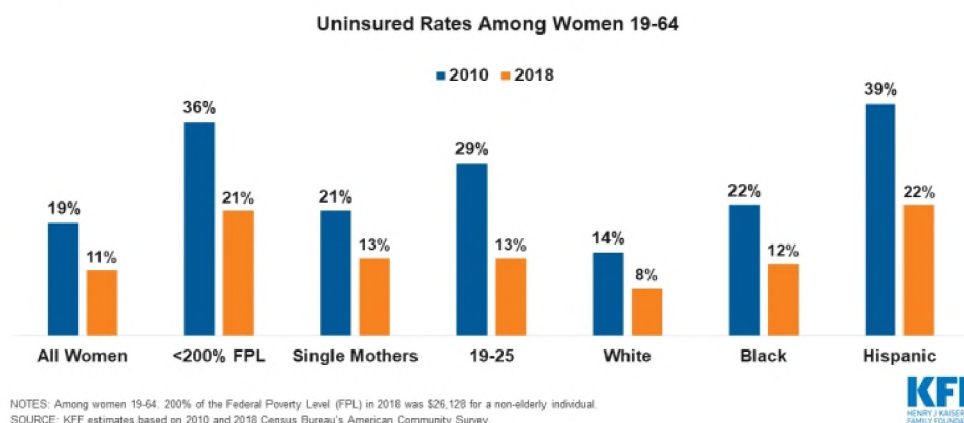


Figure 1: Uninsured Rates Have Dropped Among Most Groups of Women Since the ACA

States would not be able to sustain the costs of coverage for the expanded Medicaid population, especially in the face of budgetary shortfalls arising from the pandemic. Coverage in the individual insurance market would be unaffordable to many people without federal subsidies, reversing coverage gains of the past decade and leading to a rise in uninsured women.

Gains in coverage and affordability of services for pregnancy-related care, pre- and post- partum, would be lost.

The ACA made many improvements to support care for pregnant people. In the private insurance market, the ACA established a floor for "essential health benefits (https://www.kff.org/health-reform/perspective/questions-about-essential-health-benefits/#:~:text=The%20law%20specifies%20that%20the,including%20behavioral%20health%20treatment%3B%20prescription))" (EHB) that individual market plans must cover, including maternity care, (<https://www.kff.org/wp-content/uploads/2013/01/how-accessible-is-individual-health-insurance-for-consumer-in-less-than-perfect-health-report.pdf>) which most non-group plans did not include prior to the ACA. Furthermore, all private plans (group and non-group) as well as Medicaid expansion programs are now required to cover routine pregnancy screenings and vitamins, at no cost under the ACA's preventive services policy. This extends to the postpartum period as well, with all plans now required to cover lactation counseling and breast pumps without charge. The law also requires employers with at least 50 employees to provide break time and a private space for

hourly workers to express milk. One [study](https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2017.304108?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed) (https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2017.304108?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed) found a 10% increase in breastfeeding duration associated with coverage for breastfeeding supports and another study reported that while some women were not [provided](https://www.whijournal.com/article/S1049-3867(15)00117-6/fulltext) ([https://www.whijournal.com/article/S1049-3867\(15\)00117-6/fulltext](https://www.whijournal.com/article/S1049-3867(15)00117-6/fulltext)) with adequate break times and private spaces to pump, those who did were twice as likely to be exclusively breastfeeding at six months.

Coverage for maternity services has been required for decades in most employer-sponsored plans due to the [Pregnancy Discrimination Act](https://www.eeoc.gov/statutes/pregnancy-discrimination-act-1978) (<https://www.eeoc.gov/statutes/pregnancy-discrimination-act-1978>) and under Medicaid as a mandatory benefit in all states. Nationally, the Medicaid program covers more than four in ten [births](https://www.cdc.gov/nchs/products/databriefs/db318.htm#:~:text=Key%20findings&text=Medicaid%20was%20the%20source%20of,to%20women%20aged%2025%E2%80%9334) (<https://www.cdc.gov/nchs/products/databriefs/db318.htm#:~:text=Key%20findings&text=Medicaid%20was%20the%20source%20of,to%20women%20aged%2025%E2%80%9334>) and over half in several states. For low-income mothers in expansion states, Medicaid expansion has afforded greater continuity in coverage, as many can now retain Medicaid coverage because they qualify under the ACA's higher eligibility level, whereas in non-expansion states, many women lose coverage just two months after giving birth (**Figure 2**). Recently, long overdue attention on maternal mortality has highlighted the importance of coverage before, during, and after pregnancy. One [study](https://www.sciencedirect.com/science/article/abs/pii/S1049386720300050) (<https://www.sciencedirect.com/science/article/abs/pii/S1049386720300050>) found that Medicaid expansion was associated with lower maternal mortality rates compared to non-expansion states.

Figure 2

In Expansion States, Higher Rates of Medicaid Coverage and Fewer Uninsured Before and After Pregnancy

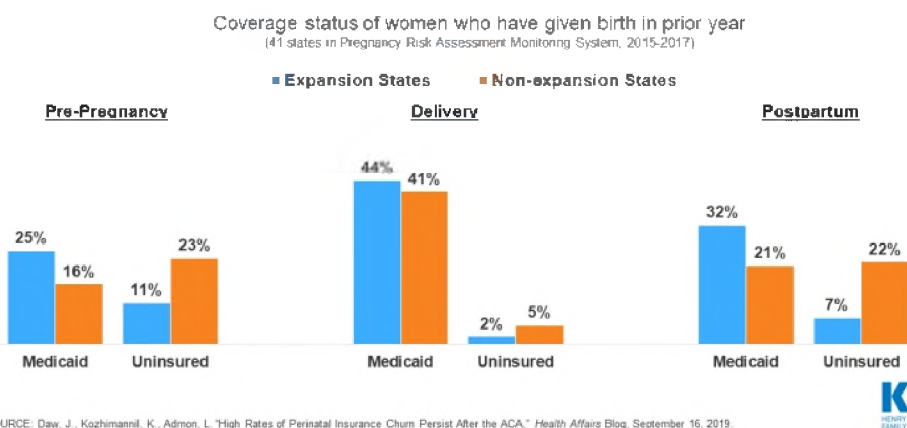


Figure 2: In Expansion States, Higher Rates of Medicaid Coverage and Fewer Uninsured Before and After Pregnancy

Health insurance plans could reinstate discriminatory policies like gender rating (charging women more than men for the same benefits), excluding maternity benefits, and denying coverage or charging more for those with pre-existing conditions.

The ACA banned a number of practices that were common among non-group insurers prior to the law. In addition to excluding benefits important for women such as pregnancy-related care, many individual market insurers charged women more than men for the same coverage, a practice called gender rating (<https://www.ncsl.org/portals/1/documents/health/COGeninsur809.pdf>). Although gender rating affected both women and men, younger women were routinely charged more (<https://www.gao.gov/assets/660/656121.pdf>) than men for plans that typically did not include maternity care. One 2012 study (https://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf) that reviewed gender-based differentials in individual market premiums found that reproductive age women were consistently charged higher rates than men the same age, up to 85% higher depending on the state. Conversely, the study found that among 55-year olds, some plans charged slightly higher rates to men, but the magnitude in difference was much lower compared to younger people.

Pre-ACA, it was also routine for non-group plans to deny coverage or charge higher premiums based on an individual's health status. We estimate that 30% of non-elderly adult women have pre-existing conditions (<https://www.kff.org/health-reform/issue-brief/pre-existing-condition-prevalence-for-individuals-and-families/>), such as breast cancer, heart disease, or pregnancy that would have made them ineligible for purchasing an individual insurance policy before the ACA. Women have higher rates of pre-existing conditions than men, particularly during the reproductive years (**Figure 3**).

Figure 3: Women, Particularly Younger Women, Are More Likely than Men to Have Pre-Existing Conditions

Affordability challenges could worsen without the ACA. The limit on annual out-of-pocket charges under private insurance might be revoked and plans could also resume charging women out-of-pocket for contraception, cancer screenings such as mammograms and colonoscopies, well woman checkups, and other preventive services.

The ACA addressed several affordability challenges experienced by women, who on average use (<https://jamanetwork.com/journals/jama/fullarticle/2340987>) the health system more often and have higher health expenses (<https://www.healthsystemtracker.org/indicator/spending/per-capita-spending/>) compared to men.

Among adults and children in large employer plans, KFF [analysis](https://www.healthsystemtracker.org/chart-collection/know-people-high-pocket-spending/#item-high-oop_percent-of-nonelderly-people-with-large-employer-coverage-who-have-out-of-pocket-spending-2000-by-gender-2017) (https://www.healthsystemtracker.org/chart-collection/know-people-high-pocket-spending/#item-high-oop_percent-of-nonelderly-people-with-large-employer-coverage-who-have-out-of-pocket-spending-2000-by-gender-2017) finds that average out-of-pocket spending is 35% higher among females compared to males. The ACA requires plans to cap annual out of pocket charges for enrollees (\$8,150 for individuals and \$16,300 for families in 2020). This was not required prior to the ACA, and [17%](https://www.kff.org/wp-content/uploads/2013/04/8085.pdf) (<https://www.kff.org/wp-content/uploads/2013/04/8085.pdf>) of workers covered by employer-sponsored insurance were in plans without any limit on out-of-pocket spending.

Cost protections are also integrated in the ACA requirement that all private plans and Medicaid expansion programs cover [preventive services](https://www.kff.org/health-reform/report/preventive-services-tracker/) (<https://www.kff.org/health-reform/report/preventive-services-tracker/>) recommended by the [U.S. Preventive Services Task Force](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations) (<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations>) (USPSTF), the [Health Resources and Services Administration](https://www.hrsa.gov/womens-guidelines/index.html) (<https://www.hrsa.gov/womens-guidelines/index.html>), and the CDC's [Advisory Committee on Immunization Practices](https://www.cdc.gov/vaccines/hcp/acip-recs/index.html) (<https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>), without charging cost-sharing. The slate of covered services includes many that are exclusively or disproportionately used by women, such as prenatal tests, breastfeeding services, mammograms, bone density screenings for older women, and all FDA approved prescribed contraceptives for women, including more expensive methods such as long acting reversible contraceptives (IUDs and implants). Our [analysis](https://www.sciencedirect.com/science/article/pii/S2590151620300198?via%3Dihub) (<https://www.sciencedirect.com/science/article/pii/S2590151620300198?via%3Dihub>) has documented the sharp impact of the contraceptive coverage requirement, with most women now having no out-of-pocket spending for contraception (**Figure 4**).

Figure 4: Out-of-Pocket Spending for Contraceptives Plummeted After the ACA Went into Effect

Should the ACA be overturned, plans could raise the amount of out-of-pocket charges they allow, and full coverage for preventive services would no longer be required by federal law, allowing private plans to return to pre-ACA cost sharing practices. Although [some states](https://www.kff.org/womens-health-policy/issue-brief/state-and-federal-contraceptive-coverage-requirements-implications-for-women-and-employers/) (<https://www.kff.org/womens-health-policy/issue-brief/state-and-federal-contraceptive-coverage-requirements-implications-for-women-and-employers/>) have their own requirements for contraceptive coverage and other services, state laws do not have the same reach as the ACA because they do not apply to self-funded employer plans (which cover [67%](https://www.kff.org/report-section/ehbs-2020-summary-of-findings/) (<https://www.kff.org/report-section/ehbs-2020-summary-of-findings/>) of workers with employer coverage), and many individuals would not be assisted. The loss of the ACA could make many services unaffordable and out of reach for women, who on average have higher health care expenses, lower incomes, fewer financial assets, and higher poverty rates than men.

Older women and women with long-term disabilities who are covered by Medicare may lose full coverage for preventive services and face higher out-of-pocket spending.

For Medicare (<https://www.kff.org/health-reform/issue-brief/potential-impact-of-california-v-texas-decision-on-key-provisions-of-the-affordable-care-act/#medicare>) beneficiaries, the ACA eliminated out-of-pocket charges for preventive services recommended by the USPSTF, such as screenings for breast cancer, osteoporosis, and depression. The ACA also added a new annual wellness visit to Medicare, which is covered at no cost to beneficiaries. Without the ACA, Medicare may return to charging 20% co-insurance for preventive services, as was the case before its enactment, meaning millions of women with Medicare would face higher out-of-pocket costs for needed preventive services.

Nearly all (94%) women covered by Medicare use a prescription medication. The ACA helped reduce beneficiaries' out-of-pocket drug spending if they reached the Medicare Part D coverage gap, or "donut hole (<https://www.kff.org/medicare/issue-brief/closing-the-medicare-part-d-coverage-gap-trends-recent-changes-and-whats-ahead/>)", where beneficiaries were responsible for the full costs of their prescription medications prior to the ACA. The ACA gradually closed the donut hole by phasing down coinsurance charges and adding a manufacturer price discount on brand-name drugs in the donut hole. There is uncertainty around what might happen to the ACA's coverage gap provision as a result of the Supreme Court case, since the provision was modified by subsequent legislation (<https://www.kff.org/medicare/issue-brief/summary-of-recent-and-proposed-changes-to-medicare-prescription-drug-coverage-and-reimbursement/>). However, if the ACA is struck down in its entirety, including the coverage gap provision and subsequent changes to it, that could mean an increase in out-of-pocket drug spending for women enrolled in Part D without low-income subsidies who have drug spending in the donut hole, which was the case for 15% of women enrolled in Part D in 2018.

Conclusion

This is not the first time that the Supreme Court will be deciding an ACA case with great consequences for women's health. In the last six years, the Court has ruled on three CASES (<https://www.kff.org/womens-health-policy/issue-brief/round-3-legal-challenges-to-contraceptive-coverage-at-scotus/>) about the ACA's contraceptive coverage requirement, permitting more employer exemptions and resulting in more women losing guaranteed contraceptive coverage without cost sharing. Fully overturning the ACA would have even broader ramifications, reversing many of the important gains in coverage and the insurance reforms that have benefited women across the country.

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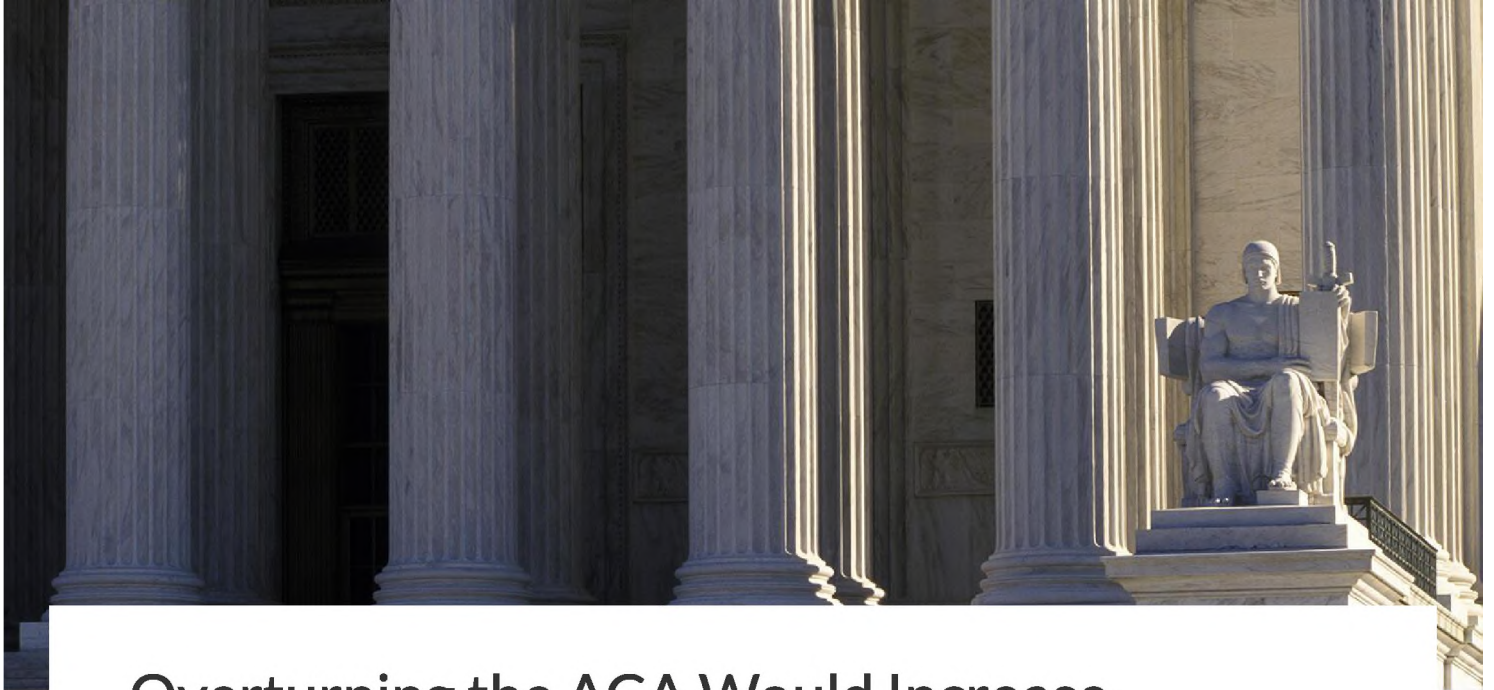
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Overturning the ACA Would Increase Uninsurance among People of All Ages, Races, and Ethnicities

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On November 10, the US Supreme Court [will hear oral arguments in the *California v. Texas* case](#). In this case, a group of state attorneys general, led by the Texas attorney general, argues that the entire Affordable Care Act (ACA) is now unconstitutional because of a 2017 tax law that eliminated the ACA's individual mandate penalties

Overturning the ACA Would Increase Uninsurance among People of All Ages, Races, and Ethnicities

In our [recent analysis](#), we found if the Supreme Court overturns the ACA, an additional **21.1 million people nationwide would be uninsured in 2022**. We also found the following consequences of eliminating the ACA:

- 9.3 million people would lose income-related subsidies for marketplace insurance in 2022;
- Medicaid and Children's Health Insurance Program coverage would decline by 15.5 million people in 2022; and
- federal government spending on health care would fall by \$152 billion per year in 2022.

Based on this study, we produced additional, state-level estimates of the effects on coverage by age group (table 1) and race and ethnicity (table 2) if the ACA is overturned. Full data tables with additional elements not shown in these tables are [downloadable separately](#). Some of our key findings for 2022 include the following:

1. **Invalidating the ACA will increase uninsurance among the nonelderly in every age group.** Children ages 18 and younger will feel the smallest effect because their pre-ACA eligibility for public insurance coverage (through Medicaid and the Children's Health Insurance Program) is greatest. Still, 1.7 million more children will be uninsured, an increase of 48 percent. Adults ages 50 to 64 will experience a 95 percent increase in uninsurance, an additional 5.6 million people. And 4.9 million young adults ages 19 to 26 will be uninsured, a 76 percent increase compared with current law. Adults ages 27 to 49 will experience a 60 percent increase in uninsurance, 8.8 million more uninsured.
2. **States experiencing the largest coverage gains under the ACA will experience the largest increases in the uninsured.** These states include those that expanded Medicaid eligibility under the law, those with high enrollment rates in the ACA-subsidized Marketplaces, and those that had high uninsurance rates before implementation of the law.

For example, Pennsylvania and Michigan are among the most populous states that will have the largest percent increases in the uninsured if the ACA is overturned. In Pennsylvania, the uninsurance rate among young adults will climb by more than 170 percent (to 27 percent uninsured). For adults ages 27 to 49, the uninsurance rate will increase by 152 percent (to 20 percent uninsured), and for adults ages 50 to 64, by 154 percent (to 16 percent uninsured). In Michigan, the uninsurance rate

148 percent for adults ages 50 to 64 (to 18 percent uninsured).

Among states that have not expanded Medicaid eligibility, Florida will experience the largest increases in the uninsured in both absolute numbers and percentage terms because the state has high enrollment in the ACA Marketplace. In Florida, the insurance rate among young adults will increase 35 percent (to 36 percent uninsured). For 27-to-49-year-olds, it will increase 52 percent (to 30 percent uninsured), and for 50-to-64-year-olds, it will increase 89 percent (to 25 percent uninsured).

3. People of all races and ethnicities will experience large increases in uninsurance.

Again, the largest increases across races and ethnicities will occur in states that expanded Medicaid eligibility under the law. In 10 states with sufficient sample sizes to measure the effects (Michigan, California, Idaho, Montana, New Mexico, Utah, Washington, New Jersey, Virginia, and Ohio), uninsurance rates will more than double among American Indians and Alaska Natives. In Louisiana, Kentucky, Michigan, Indiana, and Pennsylvania, uninsurance rates for non-Hispanic Black people will nearly triple or more. Uninsured non-Hispanic white people will more than double in number in 29 states. Uninsurance among the Hispanic population will more than double in Pennsylvania and New Mexico.

4. States that did not expand Medicaid eligibility under the ACA stand to lose somewhat less coverage, but uninsurance will still increase substantially among people of all races and ethnicities. Across all nonexpansion states combined, uninsurance among American Indians and Alaska Natives will increase 26 percent (to 23 percent uninsured). Among Asian and Pacific Islander populations, uninsurance will increase by 25 percent (to 21 percent uninsured). Among non-Hispanic Black people, uninsurance will increase by 34 percent (to 19 percent uninsured). The number of uninsured Hispanic people will increase 15 percent in these states (to 33 percent uninsured). Uninsurance among non-Hispanic white people will increase 36 percent (to 15 percent uninsured), and uninsurance among other races and ethnicities will increase by 28 percent (to 14 percent uninsured).

If the Supreme Court overturns the ACA in *California v. Texas*, coverage will fall considerably in every state and within every age group and across people of all races and ethnicities. And as we have estimated previously, federal spending on health care will fall in every state, and health care providers—hospitals, physicians, prescription drug manufacturers—will experience sizable decreases in revenue. The gains in access and

However, the implications of the law being invalidated have far greater reach than we can estimate, because virtually all insurers, providers, and households across the country have been affected by the law's many provisions. Policymakers have [straightforward legislative options that could protect the ACA as it is operating under current law](#) if they are passed before the court issues its decision; thus far, Congress has not passed bills to do so.

Full data tables with additional elements not shown in these tables are [downloadable separately](#).

Increase in Uninsurance by Age Group and State if the ACA Is Overturned, 2022

	Ages 18 and Younger		Ages 19 to 26		Ages 27 to 49		Ages 50 to 64	
	Additional uninsured (thousands)	Percent increase in uninsurance	Additional uninsured (thousands)	Percent increase in uninsurance	Additional uninsured (thousands)	Percent increase in uninsurance	Additional uninsured (thousands)	Percent increase in uninsurance
Total (US)	1,747	48%	4,946	76%	8,838	60%	5,619	95%
Expansion states								
Total	1,397	73%	4,457	139%	7,060	90%	4,225	129%
Alaska	3	19%	10	57%	23	57%	12	57%
Arizona	38	32%	42	30%	92	27%	50	33%
Arkansas	32	113%	86	193%	153	139%	77	167%
California	352	105%	1,240	161%	1,613	86%	1,118	161%
Colorado	46	95%	146	147%	185	76%	105	113%
Connecticut	8	38%	68	168%	90	92%	73	164%
Delaware	2	22%	4	29%	11	36%	8	69%
District of Columbia	NS	NS	NS	NS	17	78%	12	151%
Hawaii	3	25%	5	17%	13	24%	8	41%
Idaho	25	91%	42	126%	88	131%	40	122%
Illinois	19	11%	227	121%	283	56%	207	98%
Indiana	64	79%	150	163%	254	115%	117	112%
Iowa	22	165%	66	226%	87	125%	46	144%
Kentucky	52	162%	154	270%	214	156%	122	180%
Louisiana	48	142%	149	193%	236	128%	121	140%
Maine	5	76%	19	171%	45	216%	36	240%
Maryland	25	64%	98	124%	161	75%	111	127%
Massachusetts	24	83%	46	70%	109	106%	63	123%
Michigan	69	97%	202	198%	374	152%	197	148%
Minnesota	9	22%	99	197%	121	89%	87	141%
Montana	12	135%	33	224%	50	149%	28	126%
Nebraska	10	42%	29	104%	58	95%	29	125%
Nevada	52	102%	69	101%	125	64%	67	82%
New Hampshire	4	48%	23	175%	38	115%	27	138%
New Jersey	61	76%	135	109%	298	80%	168	111%
New Mexico	23	64%	78	189%	135	133%	82	220%
New York	28	37%	214	101%	459	74%	267	136%
North Dakota	3	18%	13	70%	15	54%	8	74%
Ohio	61	66%	201	162%	318	98%	193	106%
Oregon	37	118%	101	151%	175	101%	95	127%
Pennsylvania	77	70%	233	171%	444	152%	240	154%
Rhode Island	4	54%	35	299%	32	111%	26	216%
Utah	43	59%	57	96%	113	90%	47	113%
Vermont	NS	NS	NS	NS	6	40%	6	67%
Virginia	64	80%	164	95%	292	80%	157	117%
Washington	51	112%	152	111%	250	84%	128	109%
West Virginia	17	215%	50	245%	84	159%	47	168%

Ages 18 and Younger

Ages 19 to 26

Ages 27 to 49

Ages 50 to 64

Overturning the ACA Would Increase Uninsurance among People of All Ages, Races, and Ethnicities

Nonexpansion states

Total	350	20%	488	15%	1,778	26%	1,393	53%
Alabama	9	47%	13	10%	54	22%	46	52%
Florida	149	59%	204	35%	649	52%	498	89%
Georgia	36	36%	38	11%	154	22%	115	43%
Kansas	3	6%	8	10%	28	18%	19	36%
Mississippi	3	5%	8	9%	36	24%	31	39%
Missouri	6	7%	14	9%	59	20%	48	38%
North Carolina	37	44%	45	16%	176	29%	129	61%
Oklahoma	7	5%	16	12%	61	25%	45	51%
South Carolina	15	28%	19	14%	69	25%	58	52%
South Dakota	1	9%	3	11%	8	21%	5	27%
Tennessee	21	44%	15	9%	77	21%	58	37%
Texas	58	8%	86	8%	348	15%	296	38%
Wisconsin	4	7%	19	25%	50	32%	40	46%
Wyoming	1	5%	3	18%	9	31%	6	36%

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Source: Urban Institute Health Insurance Policy Simulation Model, 2020.

Notes: ACA = Affordable Care Act; NS = not shown. Some estimates have been suppressed here because sample sizes in some states for particular ages are too small to confidently produce reliable estimates. Estimates assume Medicaid coverage expansion waivers in place in seven states before the ACA are reinstated. It is likely that some of these waivers will not be reinstated, however, making our estimated increases in uninsurance conservative.

	American Indian/ Alaska Native		Asian/Pacific Islander		Non-Hispanic Black		Hispanic		Non-Hispanic White	
	Additional uninsured (thousands)	Percent increase in uninsurance	Additional uninsured (thousands)	Percent increase in uninsurance	Additional uninsured (thousands)	Percent increase in uninsurance	Additional uninsured (thousands)	Percent increase in uninsurance	Additional uninsured (thousands)	Percent increase in uninsurance
Total (US)	488	75%	1,261	76%	3,103	84%	4,298	41%	11,674	85%
Expansion states										
Total	412	117%	1,141	98%	2,350	160%	3,514	65%	9,439	125%
Alaska	19	68%	NS	NS	NS	NS	NS	NS	23	45%
Arizona	NS	NS	NS	NS	12	46%	79	21%	106	37%
Arkansas	NS	NS	NS	NS	75	234%	21	46%	241	170%
California	99	166%	554	130%	289	189%	1,817	90%	1,479	154%
Colorado	NS	NS	NS	NS	25	153%	116	62%	309	124%
Connecticut	NS	NS	7	65%	35	175%	46	67%	144	149%
Delaware	NS	NS	NS	NS	6	50%	2	11%	17	47%
District of Columbia	NS	NS	NS	NS	30	153%	NS	NS	4	27%
Hawaii	NS	NS	12	34%	NS	NS	3	25%	6	14%
Idaho	7	161%	NS	NS	NS	NS	24	60%	160	144%
Illinois	7	81%	32	56%	183	122%	133	35%	374	81%
Indiana	NS	NS	10	55%	81	192%	39	46%	443	129%
Iowa	NS	NS	NS	NS	NS	NS	14	69%	182	164%
Kentucky	NS	NS	NS	NS	56	211%	16	48%	454	205%
Louisiana	NS	NS	10	98%	268	255%	19	33%	245	125%
Maine	NS	NS	NS	NS	NS	NS	NS	NS	98	203%
Maryland	NS	NS	21	62%	159	164%	30	23%	175	119%
Massachusetts	NS	NS	15	87%	26	99%	41	85%	151	103%
Michigan	16	167%	16	72%	172	198%	39	73%	585	157%
Minnesota	NS	NS	NS	NS	28	129%	16	32%	237	122%
Montana	15	145%	NS	NS	NS	NS	NS	NS	101	160%
Nebraska	NS	NS	NS	NS	NS	NS	13	40%	93	107%
Nevada	NS	NS	NS	NS	37	139%	88	48%	148	104%
New Hampshire	NS	NS	NS	NS	NS	NS	NS	NS	83	129%
New Jersey	6	116%	47	68%	132	170%	177	57%	288	112%
New Mexico	51	131%	NS	NS	NS	NS	165	138%	88	176%
New York	10	73%	174	131%	148	105%	249	57%	369	104%
North Dakota	6	56%	NS	NS	NS	NS	NS	NS	28	51%
Ohio	7	104%	10	49%	140	144%	26	49%	577	108%
Oregon	NS	NS	NS	NS	10	176%	45	55%	314	137%
Pennsylvania	NS	NS	NS	NS	166	191%	90	103%	685	148%
Rhode Island	NS	NS	NS	NS	NS	NS	15	76%	67	206%
Utah	8	127%	8	66%	NS	NS	41	39%	194	116%
Vermont	NS	NS	NS	NS	NS	NS	NS	NS	14	34%
Virginia	9	108%	37	61%	190	146%	51	27%	380	107%
Washington	25	125%	41	78%	26	109%	79	48%	394	123%
West Virginia	NS	NS	NS	NS	NS	NS	NS	NS	182	183%

	American Indian/ Alaska Native		Asian/Pacific Islander		Non-Hispanic Black		Hispanic		Non-Hispanic White	
	Additional uninsured (thousands)	Percent increase in uninsurance	Additional uninsured (thousands)	Percent increase in uninsurance	Additional uninsured (thousands)	Percent increase in uninsurance	Additional uninsured (thousands)	Percent increase in uninsurance	Additional uninsured (thousands)	Percent increase in uninsurance
Nonexpansion states										
Total	76	26%	120	25%	753	34%	784	15%	2,235	36%
Alabama	NS	NS	NS	NS	36	25%	5	8%	79	29%
Florida	11	55%	41	50%	243	58%	372	35%	812	79%
Georgia	2	15%	18	26%	120	31%	24	7%	176	30%
Kansas	1	15%	NS	NS	6	25%	7	9%	42	19%
Mississippi	NS	NS	NS	NS	32	22%	1	4%	41	22%
Missouri	NS	NS	NS	NS	17	18%	4	6%	101	21%
North Carolina	9	41%	10	27%	96	40%	25	9%	242	42%
Oklahoma	23	21%	NS	NS	11	24%	10	9%	81	26%
South Carolina	NS	NS	3	26%	47	31%	8	9%	99	32%
South Dakota	4	21%	NS	NS	NS	NS	NS	NS	13	20%
Tennessee	NS	NS	4	21%	31	27%	5	5%	127	27%
Texas	12	22%	32	16%	105	23%	318	11%	314	22%
Wisconsin	3	39%	NS	NS	8	40%	5	7%	92	36%
Wyoming	NS	NS	NS	NS	NS	NS	NS	NS	16	27%

Source: Urban Institute Health Insurance Policy Simulation Model, 2020.

Notes: ACA = Affordable Care Act; NS = not shown. Some estimates have been suppressed here because sample sizes in some states for particular races and ethnicities are too small to confidently produce reliable estimates. Estimates assume Medicaid coverage expansion waivers in place in seven states before the ACA are reinstated. It is likely that some of these waivers will not be reinstated, however, making our estimated increases in uninsurance conservative.

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2021 Premium Changes on ACA Exchanges and the Impact of COVID-19 on Rates

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Insurers planning to offer health plans on the Affordable Care Act (ACA) marketplaces must submit filings to state or federal regulators detailing their plan offerings and justifying their premiums for the upcoming year. Rates are finalized in early fall (October 15, 2020) ahead of the annual open enrollment period, set to begin on November 1, 2020.

This year, insurers set premiums for 2021 amid the coronavirus pandemic, which has created considerable uncertainty as to what health costs, utilization and enrollment will look like next year. In 2020, many insurers have provided premium relief and/or voluntarily waived cost-sharing (<https://www.healthsystemtracker.org/brief/cost-sharing-waivers-and-premium-relief-by-private-plans-in-response-to-covid-19/>) for COVID-19 treatment for their members due to excessive profits and low medical loss ratios (<https://www.kff.org/private-insurance/issue-brief/health-insurer-financial-performance-amid-the-coronavirus-pandemic/>) during the pandemic. In our earlier look at preliminary rate filings in 10 states, we found that while overall proposed rate increases for 2021 appeared modest, most insurers were taking a “wait-and-see” approach, electing to hold off on factoring the pandemic into their premiums for next year until they had more predictability and claims experience.

Now that 2021 rates are being finalized, this brief summarizes the most current premium rate filings in all 50 states and the District of Columbia. We reviewed rate filings for an overall average premium increase across all plans on the individual market, with a focus on the effect of the pandemic on rate changes. We find that the majority of rate changes for 2021 are still moderate, with increases or decrease of a few percentage points. Proposed rate changes range from a -42.0% decrease to a 25.6% increase, though half fall between a 3.5% decrease and 4.6% increase (Table 1). Insurer and state level rates are shown in Table 2.

Table 1: Overall Rate Change and COVID-19 Load Among ACA Marketplace Plans

Overall	Rate Change	Impact of COVID-19 on Rates*
25th Percentile	-3.5%	0.0%
Median	1.1%	0.0%
75th Percentile	4.6%	2.0%

*Among plans that specified an impact of COVID-19. Many filings included COVID-loads that were redacted.

SOURCE: KFF analysis of insurer rate filings to state regulators.

118 of the 273 (43%) filings specified the effect of COVID-19 on their rates for next year. Among these insurers, the impact of COVID-19 on 2021 premiums ranges from a 3.4% decrease to an 8.4% increase, with half of insurers falling between no impact (0.0%) and 2.0% increases (Table 1). Many insurers used similar language to describe their approach to the pandemic, noting that it would put both upward and downward pressure on health costs in 2021 (see examples below).

The most common factors that insurers cited as driving up health costs in 2021 were the continued cost of COVID-19 testing, the potential for widespread vaccination, the rebounding of medical services delayed from 2020, and morbidity from deferred or foregone care. At the same time, many insurers expect health care utilization to remain lower than usual next year as people continue to observe social distancing measures and avoid routine care, especially in absence of a vaccine or in the event of future waves of the virus. At least 53 insurers included a COVID-19 impact of 0% on their premiums because they did not have enough information to confidently alter their premiums or estimated that these factors would offset one another. 29 of the 273 filings (11%) did not mention COVID-19 at all in their rate filings.

The range of COVID-19 loads included in 2021 rate filings partly reflects differences in issuers' assumptions about the course of the pandemic and individual behavior next year. Below are a handful of representative explanations that insurers provided to justify any impact that COVID-19 had on their overall 2021 rate filings. These examples provide a glimpse of the different expectations that insurers have regarding the availability and distribution of a vaccine, the extent to which pent-up demand for health care services will rebound in 2021, and various other factors.

Pent-up demand and morbidity adjustments. Many insurers expect that health costs will increase in 2021 due to pent-up demand following deferred care, direct costs related to COVID-19 testing and treatment, and vaccination costs, assuming a vaccine will be ready and available to the general public next year. Some insurers also anticipate increased morbidity resulting from deferred care and the impact of that deferred care on chronic conditions, as well as from the impact of the economic downturn on individuals' health and insurance status.

Fidelis (New York) – 8.4% COVID-load

“Premium rates have been adjusted 8.4% to reflect the estimated impact of the COVID-19 pandemic and secondary effects on the cost to provide healthcare coverage in 2021. The morbidity adjustment reflects the anticipated combined impact of COVID-19-related cost drivers on healthcare utilization and intensity in 2021, including:

1. Direct cost of acute COVID-19 treatment, testing, and vaccination.
2. Pent-up demand following social distancing “lockdown” measures
3. Morbidity impact of economic disruption in the form of job terminations, leading to enrollment shifts from employer sponsored coverage to individual ACA and from individual ACA to Medicaid or uninsured
4. Morbidity impact of lasting population health changes precipitated by the pandemic, including healthcare complications following recovery from severe cases of COVID-19, and worsened health outcomes due to deferred or avoided preventive care and maintenance care for chronic conditions during social distancing lockdown periods”

Vaccination costs. Some insurers specify loads for a likely vaccine. For instance, MVP Health Care in Vermont loaded an additional 1.0% to premiums in preparation for covering one dose of a COVID-19 vaccination (priced at \$75) for 80% of their enrollees. (MVP also loaded another 0.3% for deferred services.) Other insurers refrained from factoring in COVID-19 vaccine costs, citing a lack of credible information.

MVP (Vermont) – 1.3% COVID-load

“MVP is assuming that a vaccine to prevent the novel coronavirus (COVID-19) will be tested and widely available in 2021. To account for the costs an immunization would add to claim cost, MVP is assuming that an immunization would be covered in full at the cost of \$75 per dose. MVP is also assuming that 80% of the population would obtain the vaccine (based on an analysis by Wakely Consulting), which corresponds to a PMPM claim cost of \$5.00 PMPM. This factor is increasing the experience period allowed claim cost by 1.0%.”

No adjustments to premiums from COVID-19. Many insurers refrained from specifying any COVID-19 rate impact. Of those that did, several insurers said they would not adjust their rates, citing uncertainty about how the pandemic will affect costs next year. Others expect the upward and downward effects on costs resulting from the pandemic will have a net impact of zero. In some states such as Connecticut, insurers did not apply adjustments due to COVID-19 under the direction of state regulators.

CareSource Indiana, Inc (Indiana) – 0% COVID-load

“At the time of this rate filing submission, we acknowledge there is substantial uncertainty regarding the impact of the COVID-19 pandemic on setting premium rates, including whether the pandemic will increase or decrease costs in 2021. Due to this uncertainty, we have chosen not to make adjustment to the 2021 premium rates.”

Expected decreases in premium costs due to COVID-19. Though less common, a few insurers expect that circumstances surrounding COVID-19 will have a net negative effect on their costs.

Maine Community Health Options (Maine) – -1.2% COVID-load

“An adjustment of -1.2% was applied to the 2019 experience to reflect the estimated impact of the COVID-19 pandemic. The adjustment was developed with consideration to the following key drivers of cost impacts:

1. We have assumed a reduction in total claims experience in 2021 of 1.5% due to deferred and avoided care that will result from a second wave of infections, likely to coincide with the winter flu season.
2. We have assumed an increase in claim costs of 0.34% to cover the costs of continuing testing for COVID-19.
3. No adjustment has been made to account for additional costs related to a potential vaccine. Not enough credible information exists to allow the development of estimates related to the cost and availability of a vaccine.”

DISCUSSION

Most premium changes on the ACA marketplaces will be modest heading into 2021, even with the uncertainty surrounding the pandemic. Most individual market insurers that specify the impact of the pandemic on their 2021 premiums are loading an extra couple percentage points onto the premium (with the median COVID-19 factor being 1.9%). Thus far during the pandemic, individual market insurers have remained profitable and loss ratios have been low (<https://www.kff.org/private-insurance/issue-brief/health-insurer-financial-performance-amid-the-coronavirus-pandemic/>), on average, so large premium increases would have been hard to justify. That said, the range of assumptions that insurers have made about vaccine costs and availability, enrollee utilization, and general morbidity demonstrate just how much uncertainty remains about the state of the pandemic heading into next year.

Methods

Data were collected from health insurer rate filings submitted to state regulators. Most rate information is available in the form of a SERFF filings (System for Election rate and Form Filing) that includes a base rate and other factors that build up to an individual rate. This analysis only includes rate filings that were made public on or before October 15, 2020.

Table 2: Rate Change and COVID-19 Load Among ACA Marketplace Plans, By State and Insurer

State/Insurer	Rate Change	Impact of COVID-19 on Rates
Alabama*		
Blue Cross Blue Shield of Alabama	4.90%	Unknown
Bright Health Insurance Company	25.60%	Unknown
Alaska*		
Moda Assurance Company	0.11%	No mention
Premera Blue Cross Blue Shield of Alaska	-4.15%	No mention
Arizona*		
Blue Cross and Blue Shield of Arizona	1.82%	Unknown
Bright Health Company of Arizona	9.33%	Unknown
Cigna HealthCare of Arizona	1.87%	No mention
Health Net of Arizona	-0.80%	Unknown
Oscar Health Plan	-6.75%	Unknown
Arkansas		
Celtic Insurance Company	4.91%	Unknown
QCA Health Plan	3.05%	Unknown
QualChoice Health and Life Insurance	3.00%	Unknown
USABLE Mutual Insurance	2.90%	0.00%
Oscar Insurance Company	New entrant	Unknown
HMO Partners Health Advantage	New entrant	0.00%
California		
Blue Cross of California (Anthem)	6.00%	No mention
Blue Shield of California	-2.40%	Unknown
Chinese Community Health Plan	-1.30%	Unknown
Health Net	3.40%	1.20%
Kaiser Permanente	1.00%	Unknown
LA Care Health Plan	-4.60%	No mention
Molina Healthcare	-3.80%	0.90%
Oscar Health Plan of California	7.60%	Unknown
Sharp Health Plan	-0.50%	0.00%
Valley Health Plan	9.00%	Unknown
Western Health Advantage	-2.60%	Unknown

Colorado

Anthem (HMO Colorado Inc.)	0.30%	Unknown
Bright Health Insurance Company	-5.50%	Unknown
Cigna Health and Life Insurance Company	3.00%	1.00%
Denver Health Medical Plans	-4.60%	6.40%
Friday Health Plan	-5.10%	No mention
Kaiser Foundation Health Plan of Colorado	-1.50%	0.00%
Oscar Health Plan	-4.20%	Unknown
Rocky Mountain HMO	-10.00%	0.00%

Connecticut

Anthem Health Plans	1.90%	0.00%**
Connecticare	-0.10%	0.00%**

Delaware

Highmark Blue Cross Blue Shield	-1.00%	Unknown
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District of Columbia

CareFirst HMO (Blue Choice)	0.10%	Unknown
CareFirst PPO	1.00%	Unknown
Kaiser Foundation Health Plan	-1.97%	Unknown

Florida

AvMed	-3.30%	2.00%
Blue Cross and Blue Shield of Florida	3.70%	2.00%
Bright Health Insurance Company of Florida	3.70%	2.00%
Celtic Insurance Company	3.90%	2.00%
Cigna Health And Life Insurance Company	-1.40%	2.00%
Florida Health Care Plan, Inc.	-0.10%	2.00%
Health First Commercial Plans	4.80%	2.00%
Health Options, Inc	2.50%	2.00%
Molina Healthcare of Florida	-1.80%	2.00%
Oscar Insurance Company of Florida	2.90%	2.00%

Georgia*

Alliant Health Plans	18.34%	Unknown
Ambetter of Peach State	7.43%	0.00%
Anthem Blue Cross and Blue Shield	10.10%	3.00%
CareSource Georgia	-10.29%	Unknown

Kaiser Foundation Health Plan of Georgia	-19.02%	2.50%
Oscar Health Plan of Georgia	2.11%	Unknown
Hawaii		
Kaiser Foundation Health Plan	-1.06%	No mention
Hawaii Medical Service Association	-3.10%	No mention
Idaho		
Blue Cross of Idaho Health Service	-3.50%	No mention
Mountain Health Cooperative	2.00%	0.00%
Pacific Source Health Plans	-7.10%	0.00%
Regence Blue Shield of Idaho	-1.30%	No mention
SelectHealth	5.90%	No mention
Illinois*		
Blue Cross Blue Shield of Illinois	-0.12%	Unknown
Celtic Insurance Company	0.26%	0.00%
Cigna HealthCare of Illinois, Inc.	0.89%	1.00%
Health Alliance Medical Plans, Inc.	0.00%	Unknown
Quartz Health Benefit Plans Corporation	-10.05%	Unknown
Indiana		
Anthem Insurance Companies, Inc.	-0.30%	No mention
CareSource Indiana, Inc.	4.30%	0.00%
Celtic Insurance Company	-0.55%	1.90%
Iowa*		
Medica Insurance Company	2.45%	Unknown
Wellmark Health Plan of Iowa, Inc.	-42.04%	Unknown
Oscar Health Plan of Iowa	New entrant	Unknown
Kansas*		
Blue Cross and Blue Shield of Kansas	0.70%	Unknown
Cigna Health and Life Insurance	9.96%	1.00%
Medica Insurance Company	7.78%	5.00%
Oscar Insurance Company	-7.86%	Unknown
Sunflower State Health Plan	4.00%	Unknown
Kentucky		
Anthem Health Plans of Kentucky	5.69%	2.60%

Care Source Kentucky	4.00%	Redacted
Louisiana*		
CHRISTUS Health Plan Louisiana	7.44%	Unknown
HMO Louisiana	9.50%	Unknown
Louisiana Health Service & Indemnity	7.95%	Unknown
Vantage Health Plan	2.64%	Unknown
Maine		
Anthem Health Plans of Maine	-12.50%	2.50%
Harvard Pilgrim Health Plan	-13.00%	0.00%
Maine Community Health Options	-13.70%	-1.20%
Maryland		
CareFirst Blue Choice	-11.90%	0.00%
CareFirst CFMI	-17.10%	0.00%
CareFirst GHMS	-17.10%	0.00%
Kaiser Foundation Health Plan	-11.00%	0.00%
Optimum Choice (UnitedHealthcare)	New Entrant	Unknown
Massachusetts*		
Blue Cross and Blue Shield of Massachusetts HMO Blue	6.17%	0.00%
Fallon Community Health Plan	3.52%	0.00%
Harvard Pilgrim Health Care	7.25%	No mention
Health New England	2.23%	Unknown
Tufts Associated HMO	9.03%	Unknown
Tufts Health Public Plans	12.27%	0.00%
UnitedHealthcare Insurance Company	15.10%	Unknown
BMC HealthNet	Unknown	Unknown
AllWays Health Partners	Unknown	Unknown
Michigan*		
Blue Care Network of Michigan	2.50%	No mention
Blue Cross Blue Shield of Michigan	1.70%	No mention
Oscar Insurance Company	6.00%	4.00%
McLaren Health Plan Community	-2.00%	0.00%
Meridian Health Plan of Michigan	-5.60%	2.00%
Molina Healthcare of Michigan	0.40%	Unknown

Physicians Health Plan	3.10%	3.00%
Priority Health Insurance	-0.13%	0.00%
Total Health Care USA	-0.39%	0.00%
Minnesota		
Blue Plus HMO	4.21%	Unknown
Group Health Plan Inc	0.67%	Unknown
Medica Insurance Company	2.42%	Unknown
Preferred One Insurance Company	1.05%	Unknown
Quartz Health Plan	New entrant	Unknown
UCare MN	1.60%	0.00%
Mississippi*		
Ambetter of Magnolia Inc.	11.19%	Unknown
Molina Healthcare of Mississippi, Inc	-2.67%	Unknown
Missouri*		
Blue Cross and Blue Shield Kansas City	New entrant	No mention
Celtic Insurance Company	9.10%	Unknown
Cigna Health & Life Insurance Company	1.40%	Unknown
Cox Health Systems Insurance Company	13.60%	No mention
Healthy Alliance Life Insurance Company	-1.44%	Unknown
Medica Insurance Company	-7.50%	Unknown
Oscar Insurance Company	6.40%	Unknown
SSM Health Insurance Company	-0.49%	Unknown
Montana		
HCSC (Blue Cross Blue Shield of Montana)	0.00%	No mention
Montana Health Co-Op	0.68%	No mention
Pacific Source Health Plans	5.00%	No mention
Nebraska*		
Medica Insurance Company	5.36%	Unknown
Bright Health	Unknown	Unknown
Nevada		
Friday Health Plans of Nevada	New entrant	Unknown
Health Plan of Nevada Incorporated	5.00%	Unknown
HMO Colorado INC D/BA HMO Nevada	3.90%	Unknown
Hometown Health Plan	-5.00%	Unknown

Hometown Health Providers Insurance	-1.60%	Unknown
Rocky Mountain Hospital and Medical Service	11.00%	Unknown
SelectHealth	New entrant	Unknown
Sierra Health and Life Insurance Company	9.80%	Unknown
SilverSummit Health Plan	2.30%	Unknown
New Hampshire*		
Celtic Insurance Company	-4.50%	0.00%
Harvard Pilgrim Health Care	-13.54%	0.00%
Matthew Thornton Health Plan (Anthem BCBS)	-15.12%	Unknown
New Jersey*		
AmeriHealth HMO	11.22%	1.00%
AmeriHealth Insurance Company of New Jersey	3.82%	1.00%
Horizon Healthcare Services	-1.43%	Unknown
Oscar Garden State Insurance	10.59%	Unknown
New Mexico		
Molina Healthcare of New Mexico	-0.40%	Unknown
Blue Cross Blue Shield of New Mexico (HCSC)	-7.61%	Unknown
True Health	-1.40%	No mention
Friday Health Plans	New Entrant	Unknown
Western Sky Ambetter	New Entrant	Unknown
New York		
Capital District Physicians Health Plan	4.30%	0.00%
Health Insurance Plan of Greater New York (Emblem)	3.80%	2.00%
Excellus	-0.20%	0.50%
Fidelis (NY Quality Healthcare Corp)	1.60%	8.40%
Healthfirst PHSP, Inc.	-2.50%	0.00%
Healthnow New York	-2.80%	2.00%
HealthPlus HP	1.00%	5.15%
IHBC	-5.30%	0.00%
MetroPlus	5.00%	2.10%
MVP Health Plan	3.80%	1.60%
Oscar	4.90%	7.40%
UnitedHealthcare of New York	4.80%	1.00%

North Carolina*

Ambetter of North Carolina	3.90%	0.00%
BCBS of NC	4.10%	Unknown
Bright Health Company of North Carolina	1.98%	Unknown
CIGNA HealthCare of North Carolina	-10.50%	No mention
Oscar Health Plan of NC	New entrant	Unknown
UnitedHealthCare of Wisconsin, Inc.	New entrant	Unknown

North Dakota*

Blue Cross Blue Shield of North Dakota	4.42%	No mention
Medica Health Plans	13.16%	Unknown
Sanford Health Plan	20.33%	Unknown

Ohio*

AultCare Insurance Company	-4.99%	2.00%
Buckeye Community Health Plan	1.35%	0.00%
CareSource	9.30%	0.00%
Community Insurance Company	-3.22%	Unknown
Medical Health Insuring Corp. of Ohio	2.30%	0.00%
Molina Healthcare of Ohio	-0.80%	0.00%
Oscar Buckeye State Insurance Corporation	-0.90%	0.30%
Oscar Insurance Corporation of Ohio	6.70%	-0.10%
Paramount Insurance Company	8.94%	0.00%
SummaCare	2.50%	0.00%

Oklahoma*

Blue Cross Blue Shield of Oklahoma	-0.05%	Unknown
Bright Health Insurance Company	1.84%	Unknown
CommunityCare HMO Inc.	-24.40%	Unknown
Medica Insurance Company	-5.27%	Unknown
Oscar Insurance Company	New entrant	Unknown
UnitedHealthcare	New entrant	Unknown

Oregon

Bridgespan Health Company	11.10%	0.00%
Kaiser Foundation Health Plan of the Northwest	-3.51%	0.00%
Moda	4.70%	0.90%
PacificSource Health Plans	4.20%	0.00%

Providence Health Plan	1.40%	1.00%
Regence Blue Cross Blue Shield	2.50%	0.00%
Pennsylvania		
Capital Advantage Assurance Company	-14.43%	0.00%
Highmark Inc.	-0.67%	2.50%
Highmark Benefits Group	-3.96%	2.50%
Highmark Coverage Advantage	3.12%	2.50%
Geisinger Health Plan	-11.28%	0.00%
Geisinger Quality Options	-13.57%	0.00%
Keystone Health Plan East	-3.91%	1.00%
QCC Insurance Company	-3.88%	1.00%
UPMC Health Options	1.28%	0.00%
PA Health and Wellness	-6.60%	1.40%
Oscar Health Plan of PA	6.68%	2.10%
Rhode Island*		
Blue Cross Blue Shield of Rhode Island	4.96%	Unknown
Neighborhood Health Plan of Rhode Island	5.60%	2.50%
South Carolina		
Absolute Total Care, Inc	8.50%	0.00%
Blue Cross and Blue Shield of South Carolina	-1.85%	Unknown
Bright Health Company of South Carolina	-0.05%	Unknown
Molina Healthcare of South Carolina	-3.60%	Unknown
South Dakota*		
Avera Health Plans, Inc.	4.29%	Unknown
Sanford Health Plan	0.24%	1.02%
Tennessee		
Celtic Insurance Company	-2.50%	2.00%
Cigna Health and Life Insurance Company	-6.01%	1.00%
Blue Cross Blue Shield of Tennessee	9.82%	1.80%
Bright Health Insurance Company of Tennessee	3.01%	-2.00%
Oscar Healthcare	9.90%	-0.50%
United healthcare Insurance Company	New entrant	0.00%
Texas*		

Blue Cross Blue Shield of Texas	2.97%	Unknown
Celtic Insurance Company	11.69%	0.00%
CHRISTUS Health Plan	3.16%	Unknown
Community Health Choice, Inc.	8.65%	Unknown
Molina Healthcare of Texas, Inc.	5.30%	Unknown
Oscar Insurance Company	9.91%	Unknown
Sendero Health Plans, Inc.	8.81%	0.00%
SHA FirstCare Health Plans	2.81%	-3.40%
Utah		
Cigna Health and Life Insurance Company	2.20%	1.00%
Molina Healthcare of Utah	-1.63%	0.00%
Regence BlueCross BlueShield of Utah	-7.31%	0.00%
SelectHealth	-1.60%	No mention
University of Utah Health Insurance Plans	3.00%	Unknown
Vermont		
Blue Cross Blue Shield of Vermont	4.20%	0.00%
MVP Health Care	2.70%	1.30%
Virginia*		
CareFirst BlueChoice,	-9.70%	0.00%
Cigna Health and Life Insurance Company	-11.70%	1.00%
Group Hospitalization and Medical Services	5.20%	0.00%
HealthKeepers	-7.70%	Unknown
Kaiser Foundation Health Plan of the Mid-Atlantic States	-13.00%	0.00%
Optima Health Insurance Company	-2.00%	Unknown
Optima Health Plan – HMO	7.74%	0.90%
Optimum Choice, Inc.	New entrant	Unknown
Oscar Insurance Company	2.20%	0.20%
Piedmont Community Healthcare HMO, Inc.	-3.40%	Unknown
Washington		
Bridgespan Health Comapny	-0.17%	Unknown
Community Health Network of Washington	New entrant	No mention
Coordinated Care Corporation	0.93%	Unknown
Kaiser Foundation Health Plan of the Northwest	-1.87%	No mention

Kaiser Foundation Health Plan of Washington	-4.86%	Unknown
Lifewise Health Plan of Washington	-2.06%	Unknown
Molina Healthcare of Washington Inc.	-3.19%	3.20%
Pacific Source Health Plans	7.63%	Unknown
Premera Blue Cross	-8.67%	Unknown
Providence Health Plan	3.18%	No mention
Regence Blue Cross Blue Shield of Oregon	-4.08%	Unknown
Regence BlueShield	-5.35%	Unknown
UnitedHealthcare of Oregon	New entrant	2.50%

West Virginia*

CareSource West Virginia Co.	6.26%	Unknown
Highmark Blue Cross Blue Shield West Virginia	4.34%	Unknown
The Health Plan of West Virginia, Inc.	3.67%	No mention

Wisconsin*

Aspirus Arise Health Plan of Wisconsin, Inc	-12.89%	-2.20%
Children's Community Health Plan	-7.47%	Unknown
Common Ground Healthcare Cooperative	-6.25%	Unknown
Dean Health Plan	-2.27%	Unknown
Group Health Cooperative of South Central Wisconsin	-6.81%	Unknown
HealthPartners Insurance Company	-3.40%	Unknown
Medica Community Health Plan	5.87%	Unknown
MercyCare HMO, Inc.	-1.39%	Unknown
Molina Healthcare of Wisconsin, Inc.	-3.50%	Unknown
Network Health Plan	3.34%	Unknown

Wyoming

Blue Cross Blue Shield of Wyoming	-10.2%	Unknown
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*Indicates that the rates shown for the state have not been finalized.

**Connecticut Insurance Department instructed insurers to include a COVID-impact of 0%

NOTE: 'Unknown' includes plans where the rate change or impact of COVID-19 on rates was redacted or otherwise unavailable for some reason.

SOURCE: KFF analysis of insurer rate filings to state regulators.

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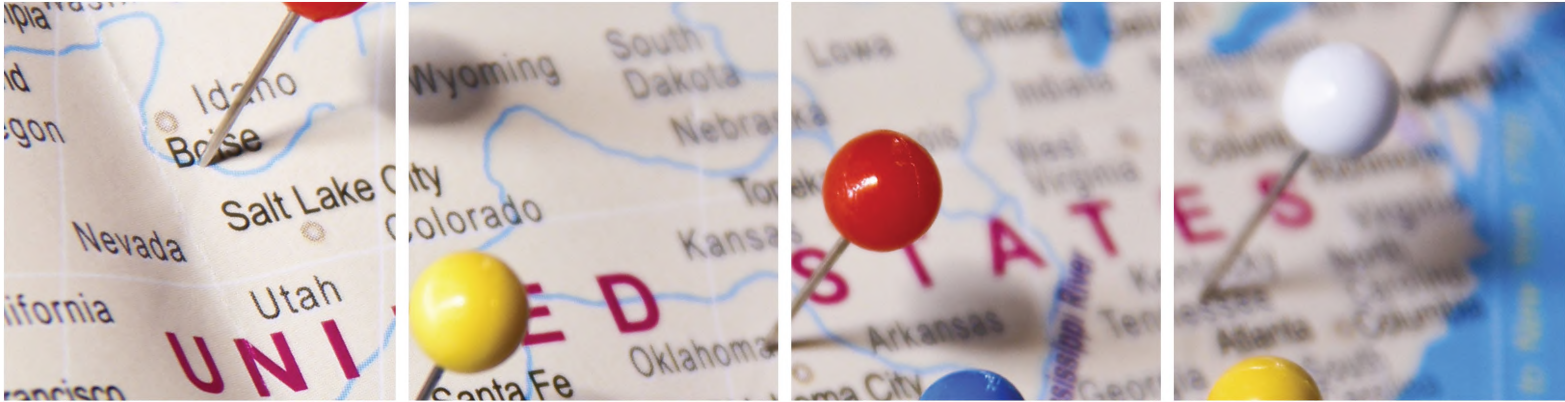
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2020 UPDATE



COMPETITION in HEALTH INSURANCE

A comprehensive study of U.S. markets

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I. Introduction and background

This is the 19th edition of the American Medical Association's "Competition in health insurance: A comprehensive study of U.S. markets." This study presents new data on the degree of competition in health insurance markets across the country. It is intended to help researchers, policymakers, and federal and state regulators identify markets where consolidation among health insurers may cause competitive harm to consumers and providers of care.

This study addresses the following questions: Are health insurance markets competitive, or do health insurers exercise market power? Are proposed mergers between insurers likely to maintain, enhance or create such power? These are important questions of public policy because the use of market power harms society in both output and input markets. When an insurer exercises market power in its *output* market (the sale of insurance coverage), premiums are higher than in a competitive market. When an insurer exercises market power in its *input* market (e.g., physician services), payments to health care providers are below competitive levels. In both settings, the quantity of insurance coverage provided is lower than in a competitive market. In short, the exercise of market power adversely affects health insurance coverage and health care.

A first step in assessing the existence of or the potential for market power is to examine market concentration, as high concentration tends to lower competition and facilitate the exercise of market power. The U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC) examine market concentration in their evaluation of proposed mergers between firms.¹ Thus, it is critical to have this type of information readily available. In this study, we present new information on market concentration in the health insurance industry. Using 2019 data from Decision Resources Group (DRG),² the most comprehensive and consistent source of data on enrollment in health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS), public health exchange and consumer-driven health plans (CDHP),³ we report the two largest

insurers' commercial market shares and Herfindahl-Hirschman Indices (HHIs) for 384 metropolitan statistical areas (MSAs), the 50 states and the District of Columbia.⁴

Among the key findings in this year's update is that, based on the DOJ/FTC Horizontal Merger Guidelines, 74% of MSA-level markets were highly concentrated (HHI > 2500). The average market was also highly concentrated, with an HHI of 3473. Other findings are that in 92% of MSA-level markets, at least one insurer had a commercial market share of 30% or greater, and in 48% of markets, a single insurer's share was at least 50%.

We also calculated changes in market concentration between 2014 and 2019.⁵ Despite a small decrease in 2019, we found an upward trend in concentration over this period. On net, markets are more concentrated than they were five years ago. The share of markets that are highly concentrated increased from 71% to 74%. The level of market concentration also increased, with the average HHI rising by 151 points.⁶ Fifty-six percent of markets experienced an increase in the HHI, and in 17% of markets the increase was at least 500 points. In markets with a rise in the HHI, the average increase was 481 points.

We found evidence of increases in concentration in markets that were already highly concentrated in 2014 as well as in those that were not. More than half (52%) of the markets that were highly concentrated in 2014 became even more concentrated by 2019. Twenty-five percent of the markets that were *not* highly concentrated in 2014 experienced an increase in the HHI large enough to place them in the highly concentrated category by 2019. Another 40% also had an increase, though not large enough to make them highly concentrated.

High concentration levels in health insurance markets are largely the result of consolidation (i.e., mergers and acquisitions), which can lead to the exercise of market power and, in turn, harm to consumers and providers of care. Both consummated and proposed consolidation

1. U.S. Department of Justice and Federal Trade Commission, Horizontal Merger Guidelines. Issued Aug. 19, 2010.

2. Decision Resources Group was formerly known as HealthLeaders-InterStudy—a Decision Resources Group company.

3. We do not report CDHP enrollments as a separate plan type. CDHP lives are *bolted on* to the other plan types, most frequently to PPO plans.

4. For convenience, the District of Columbia is classified as a "state" in this study.

5. There was a change in MSA definitions between the 2016 and 2017 data. For a detailed description of this change, see footnote 5 in the AMA's 2018 "Competition in health insurance" study at https://www.ama-assn.org/system/files/2018-11/competition-health-insurance-us-markets_1.pdf.

6. The change in MSA definitions noted in footnote 5 above factors into the long-term measurement of changes in HHI. However, we believe the impact to be minor. For further details, see footnote 33, below.

of health insurers should raise serious antitrust concerns. Conceptually, mergers and acquisitions can have beneficial and harmful effects on consumers. However, only the latter has been observed. It appears that consolidation has resulted in the possession and exercise of health insurer *monopoly power*—the ability to raise and maintain premiums above competitive levels—instead of the passing of any benefits obtained through to consumers.

Research suggests that health insurers exercise market power and that competition among them lowers health plan premiums. One study assessed whether health insurers charge higher premiums to employers that earn higher profits—i.e., whether they engage in *direct* price discrimination. This would imply that insurers exercise market power. The study found evidence of this behavior and concluded that health insurers possess and exercise market power in an increasing number of geographic markets.⁷ Another study examined the effect of changes in market concentration (HHI) on premiums across the United States. Using the 1999 merger between Aetna and Prudential as an instrumental variable for the HHI, it found that changes in market concentration were positively associated with premiums.⁸ A 2013 case study examined the 2008 merger between UnitedHealth and Sierra Health Services, which led to a large increase in concentration in Nevada health insurance markets. The study concluded that premiums in Nevada markets increased in the wake of the merger.⁹ Other research found evidence that competition in the public health exchanges—in the form of more insurers—also lowered premiums.¹⁰ Finally, eliminating an insurer for an employer to choose from can lead to large (16.6%) increases in premiums.¹¹

High barriers to entry into health insurance markets also enable insurers to exercise market power.¹² Examples of

barriers include state regulatory requirements, the cost of developing a provider network and the development of sufficient business to permit the spreading of risk. Evaluating entry barriers is critical to antitrust analysis. If entry were easy, neither high market shares nor high concentration levels would necessarily translate into higher premiums because potential entry would force insurers to keep premiums in check. However, barriers to entry allow insurers with market power to charge premiums above competitive levels for an extended period of time.

Health insurer consolidation can lead to the exercise of another type of market power. Where health insurers have market power in their output market (i.e., monopoly power), it is very likely they also have market power in their input market (e.g., in the purchasing of physician services). This is because, geographically, these markets roughly coincide.¹³ Market power in input markets is known as *monopsony power*—the ability to reduce and maintain input prices (e.g., prices paid to physicians) below competitive levels. The exercise of monopsony power would also reduce the quantity (or quality) of health care below competitive levels and in turn harm consumers. Research finds evidence that insurer consolidation leads to the exercise of monopsony power vis-à-vis physicians in the form of lower physician earnings and employment.¹⁴ For these reasons, proposed mergers that create or increase insurers' monopsony power should also raise antitrust concerns.¹⁵

In fact, the DOJ has challenged three health insurer mergers based in part on the merged entity's potential to exercise monopsony power over physicians.^{16, 17} In the Aetna-Prudential and the United-Pacificare cases, the DOJ focused on the increased difficulty a physician practice could face in replacing business should the merged insurer terminate its contract.

7. Dafny L. Are Health Insurance Markets Competitive? *Am Econ Rev.* 2010;100(4):1399–1431.

8. Dafny L, Duggan, M., Ramanarayanan, S. Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry. *Am Econ Rev.* 2012;102(2):1161–1185.

9. Guardado, J, Emmons, D., Kane, C. The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra. *HMPI.* 2013;1(3):16-35. Available at <http://hmpi.org/wp-content/uploads/2017/02/HMPI-Guardado-Emmons-Kane-Price-Effects-of-a-Larger-Merger-of-Health-Insurers.pdf>. Accessed July 20, 2020.

10. Dafny, L., Gruber, J., Ody, C. More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces. *Am J Health Econ.* 2015;1(1):53–81, and Abraham, J., Drake, C., McCullough J., Simon, K. What Drives Insurer Participation and Premiums in the Federally-Facilitated Marketplace? *Int J Health Econ Manag.* 2017; Apr 2017:1–18.

11. Ho, K., Lee R.S. Insurer Competition in Health Care Markets. *Econometrica.* 2017;85(2): 379–417.

12. Robinson J. Consolidation and the transformation of competition in health insurance. *Health Aff.* 2004;31(6):12–24.

13. See e.g., Capps, C. Buyer Power in Health Plan Mergers. *J Comp Law and Econ.* 2009; 6:375–391.

14. Dafny L, Duggan, M., Ramanarayanan, S. Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry. *Am Econ Rev.* 2012;102(2):1161–1185.

15. Schwartz, M. Buyer Power Concerns and the Aetna-Prudential Merger. Fifth Annual Health Care Antitrust Forum, Northwestern University School of Law, Chicago, Ill., October 1999. www.justice.gov/atr/public/speeches/3924.pdf. Accessed July 20, 2020.

16. See Complaints, *U.S. v. Aetna Inc.* (June 21, 1999), *U.S. v. UnitedHealth Group Inc.* (Dec. 20, 2005) and *U.S. and multiple states v. Anthem, Inc. and Cigna Corp.* (July 21, 2016).

17. In another proposed merger in 2010, the DOJ announced that it would file an antitrust lawsuit to block Blue Cross Blue Shield of Michigan from acquiring Physicians Health Plan of Mid-Michigan. As a result, the companies abandoned the acquisition. The DOJ argued that the merger would allow the merged entity to control physician payment and thereby lower the quality of care. See DOJ. Press release. March 8, 2010. www.justice.gov/atr/public/press_releases/2010/256259.htm. Accessed July 20, 2020.

The DOJ considered two *buy-side* shares—the share of individual practice revenue accounted for by the merging insurers, and insurers’ locality-wide post-merger share of patients.¹⁸ A high post-merger share of physician practice revenue increases monopsony power by making it more costly for the practice to replace lost patients. This effect is reinforced in markets with a high post-merger share of patients as it would shrink the pool of potential replacement patients in the event of a contract termination. As we have found in the past, this edition of “Competition in health insurance” strongly suggests that most markets are characterized by insurers with high market shares of patients, which increases the risk of the exercise of monopsony power.

Another factor that increases this risk is that most physicians work in small practices. Fifty-seven percent of those providing patient care are in practices with 10 or fewer physicians.¹⁹ Under antitrust law, independent physicians cannot negotiate collectively with health insurers. This imbalance in relative size leaves most physicians with a weak bargaining position relative to commercial payers. To the extent there is anticompetitive behavior by insurers, this would compromise the quantity and quality of care.

In the third, and perhaps most important of those merger cases, the DOJ and state attorneys general

from multiple states filed suit in July 2016 to block Anthem’s acquisition of Cigna.²⁰ Among other things, the plaintiffs alleged that “Anthem’s high market shares already give it significant bargaining leverage with doctors and hospitals,” and that “...this merger would substantially increase Anthem’s ability to dictate the reimbursement it pays providers, threatening the availability and quality of medical care.” Notably, Anthem did not dispute that it would lower provider reimbursement, but instead claimed that those savings would result from efficiencies, which it could then pass through to consumers as lower premiums. However, the courts found that those purported efficiencies were not cognizable.²¹ In February 2017, the U.S. District Court sided with the plaintiffs, and this decision was affirmed by the Second Circuit Court of Appeals. Although Anthem continued its attempt to acquire Cigna, the merger was ultimately abandoned in May 2017.

In sum, we find that the majority of health insurance markets in the United States are highly concentrated and that, on average, markets are more concentrated in 2019 than they were in 2014. Coupled with evidence on their anticompetitive behavior, this strongly suggests that health insurers are exercising market power in many parts of the country and, in turn, causing competitive harm to consumers and providers of care.

18. Capps, C. Buyer Power in Health Plan Mergers. *J Comp Law and Econ.* 2009;6:375–391.

19. Kane C. Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians are Owners than Employees. *Policy Research Perspectives*, 2019–3. <https://www.ama-assn.org/system/files/2019-05/prp-fewer-owners-benchmark-survey-2018.pdf>. Published May 2019. Accessed July 20, 2020.

20. See Complaint at <https://www.justice.gov/opa/file/877886/download>. Accessed July 20, 2020.

21. See the blog *Code Red: Two Economists Examine the U.S. Healthcare System, The Anthem-Cigna Merger*. Available at <https://codereblog.com/2017/07/18/the-anthem-cigna-merger/> Accessed Oct. 1, 2018.

II. Data and methodology

A. Product and geographic market definition

In order to calculate firms’ market shares, we first define the market in which competition takes place. Markets are characterized by two aspects: a product market and a geographic market. A *product market* is a product or group of products for which there are no adequate substitutes. In the health insurance industry, the main product types are PPO, HMO, POS and the exchanges (EXCH). Because it is not clear whether they are substitutes, we examine those products separately in addition to a combined HMO+PPO+POS+EXCH product market.

The other dimension that needs to be defined is the relevant *geographic market*. The geographic market is the area within which consumers can turn to alternative producers in response to an increase in price. In determining the extent of the market for health insurance, distance is a critical consideration. The local nature of health care delivery and the marketing and other business practices of health insurers strongly suggest that health insurance markets are local. Consumers buy coverage that serves them close to where they work and live. Thus, “Competition in health insurance” reports data at the MSA level as well as the state level.

B. Data

The data used for this study were obtained from the Decision Resources Group (DRG) Managed Market Surveyor. The data for the HMO, PPO and POS products are as of Jan. 1, 2019, and for the exchanges as of July 1, 2019. DRG collects commercial medical enrollment data from managed care organizations (MCO) through the DRG National Medical and Pharmacy Census. MCOs are asked for their national, state and county level enrollment for each product type (e.g., PPO) and funding type (e.g., fully insured). In cases where MCOs do not provide county level enrollment, DRG may use previously reported enrollment data to calculate county level shares of state enrollment. The county level enrollment is then aggregated to the state level. Commercial enrollment is based on the membership's residence and includes Individual, Group, Federal Employee Health Benefit Plan, Consumer Driven Health Plan (CDHP),²² State/Local Employee Plan, Blue Card HOME, Student Health, EPO and public health exchange lives.

DRG started collecting public exchange data as of its January 2014 Census.²³ Those data are based on enrollees who paid premiums for coverage. We include data on individuals and families but *exclude* Small Business Health Insurance Option Program (SHOP) lives.

Our objective is to present data on competition in commercial health insurance markets. Accordingly, we report market shares and HHIs for a combined HMO+PPO+POS+EXCH commercial product market as well as for HMO, PPO, POS and exchange markets separately. The key variables we use from the DRG Managed Market Surveyor to obtain this information are:

- Commercial HMO enrollment
- Commercial PPO enrollment
- Commercial POS enrollment
- Public exchange enrollment

For each MSA and state, we use enrollment in those products to calculate:

- Health insurer market shares
- Market-level Herfindahl-Hirschman Indices (HHIs)

22. CDHP-covered lives are not reported as a separate category, but are instead *boltd* on to the other product types, most frequently to PPO plans.

23. When exchange lives were not available from the health insurers or secondary research, DRG estimated enrollment using a regression model.

We seek to calculate market shares and HHIs based on enrollment in fully and self-insured plans. To do so, however, we do not use the entire database as provided by DRG; we exclude certain MCOs and geographic areas. First, with two exceptions, we exclude insurers' enrollment from states where they are not licensed to sell insurance. Blue Cross Blue Shield Association (BCBS) companies that use the Blue brand typically do not compete with one another. Yet some BCBS insurers report enrollment in other Blue insurers' states where they are not licensed.²⁴ We exclude that enrollment because there is no competition among branded companies and to avoid double-counting lives.

In other cases, a Blue company (e.g., Independence) may own a subsidiary that does not use the Blue brand (e.g. AmeriHealth). Because branded and non-branded insurers can compete with each other, we do not exclude the non-branded companies. For example, AmeriHealth is owned by Independence Health Group and sells insurance in New Jersey, where Horizon BCBSNJ also operates. Because AmeriHealth is unbranded, we do not exclude it from New Jersey.

The second exception is that we do not exclude enrollment of non-BCBS insurers in states adjacent to their license-state. This is because the data are based on the membership's residence.^{25,26}

Second, we only present market shares and HHIs for areas where the enrollment data plausibly capture a reasonable fraction of the insured population. Specifically, we calculate the ratio of total commercial enrollment reported by all health insurers in an area to an estimate of the commercially insured population, and only present areas where this ratio is between

24. This is due to the BlueCard® program, which enables members of one BCBS company to get health care while traveling or living in another BCBS company's service area. It is designed for members who have a child attending an out-of-state school, have family members living in different service areas, have a long-term work assignment in another state, or are retirees with dual residence. Claims payment, adjustments, and issue resolutions are done by the local Blue. See: https://www.bcbsil.com/pdf/standards/manual/bluecard_program_manual.pdf. Accessed July 20, 2020.

25. For example, an insurer may be licensed in New York, but could also report enrollees in New Jersey. We keep the New Jersey enrollees in the data because they may work in New York but live in New Jersey. However, we do not include BCBS enrollments reported in neighboring states because that enrollment is often too large to plausibly represent neighboring states' residents. It most likely is due to the BlueCard® program.

26. We make one other minor exclusion. Self-insured employers typically use third-party administrators (TPA) to administer benefits. If TPAs are also risk-bearing insurers, they are included in this study. We exclude other non-risk-bearing MCOs—typically known as *PPO rental networks*—since they are not insurers—i.e. never bear risk—and to avoid double counting enrollees. There were only three of them in the 2019 DRG data so the implications of their exclusions are negligible.

30% and 150%.²⁷ In this edition, however, no areas are excluded because of this criterion. The data perform well in capturing insured lives. On average, the state- and MSA-level data respectively capture 82% and 79% of the commercially insured populations.²⁸

Finally, for HMO, PPO, POS and the combined product markets, we only present data for areas where there are at least 5,000 reported enrollees in that product across all insurers. Accordingly, we do not present HMO data for Alaska, Mississippi, Montana, Nebraska, Wyoming and 156 MSAs, and we do not report POS data for Hawaii and 80 MSAs because each of those areas had fewer than 5,000 reported enrollees in those products. Finally, for the exchanges, we only present data in areas where there are at least 1,000 reported enrollees across all insurers. We do not report exchange data for six MSAs due to that restriction.^{29, 30}

C. Market share and HHI calculations

This study reports competition data for five product markets (HMO+PPO+POS+EXCH, HMO, PPO, POS and EXCH). For each product market, we calculate the market share in a geographic area by dividing an insurer's enrollment by the sum of all insurers' enrollment and multiplying the result by 100.

We also present the market-level HHI for each product market. The HHI is a measure of market concentration, which is a useful indicator of market power and serves as a signal of the likely impact of a merger on competition. The DOJ and FTC use the HHI as an aid in assessing the potential for anticompetitive effects of proposed horizontal mergers. Higher HHIs indicate greater concentration.

The HHI is the sum of the squared market shares of all firms in a market. To illustrate, suppose a market consisted of four firms and that each one held a 25%

share. The HHI for that market would be 2500:

$$25^2 + 25^2 + 25^2 + 25^2 = 2,500$$

If the number of firms in a market increased, the HHI would generally decrease, and vice versa. The largest value the HHI can reach is 10,000, which is obtained when there is a single firm in the market—i.e., a monopoly.

D. DOJ/FTC merger guidelines

In evaluating horizontal mergers, the DOJ and FTC consider both the post-merger market concentration level and the increase in concentration resulting from a merger. Markets are classified into three types:

- Unconcentrated markets: HHI below 1,500
- Moderately concentrated markets: HHI between 1,500 and 2,500
- Highly concentrated markets: HHI above 2,500³¹

Additionally, the DOJ and FTC employ the following general standards to evaluate the competitive effects of a merger:

- Small change in concentration: Mergers involving an increase in the HHI of less than 100 points are unlikely to have adverse competitive effects and ordinarily require no further analysis.
- Unconcentrated markets: Mergers resulting in unconcentrated markets are unlikely to have adverse competitive effects and ordinarily require no further analysis.
- Moderately concentrated markets: Mergers resulting in moderately concentrated markets that involve an increase in the HHI of more than 100 points potentially raise significant competitive concerns and often warrant scrutiny.
- Highly concentrated markets: Mergers resulting in highly concentrated markets that involve an increase in the HHI of between 100 points and 200 points potentially raise significant competitive concerns and often warrant scrutiny. Mergers resulting in highly concentrated markets that involve an increase in the HHI of more than 200 points will be presumed to be likely to enhance market power. The presumption may be rebutted by persuasive evidence showing that the merger is unlikely to enhance market power.

27. The commercially insured population (INS) was calculated as: $INS = POP - UNINS - (MEDICARE + MEDICAID - DUAL)$, where POP is population, UNINS is number of uninsured persons, MEDICARE is number of Medicare beneficiaries, MEDICAID is the number of Medicaid beneficiaries, and DUAL represents persons eligible for both Medicare and Medicaid benefits.

28. The distributions of these ratios are as follows. States: Four percent of states, ≥ 0.30 and < 0.50 ; 20% of states, ≥ 0.50 and < 0.70 ; 47% of states ≥ 0.70 and < 0.90 , and 29% of states ≥ 0.90 . MSAs: Three percent of MSAs, ≥ 0.30 and < 0.50 ; 31% of MSAs, ≥ 0.50 and < 0.70 ; 37% of MSAs ≥ 0.70 and < 0.90 , and 29% of MSAs ≥ 0.90 .

29. Although we do not present data for areas where there are fewer than 5000 reported enrollees in products other than the exchanges and fewer than 1000 enrollees in the exchanges, we still include those enrollments in the calculation of the combined product market (HMO+PPO+POS+EXCH).

30. In addition, we exclude state- and MSA-level exchange data for North Dakota because they appeared to be incomplete. As a result, the combined product market for these geographic areas only consists of HMO+PPO+POS lives.

31. See Section 5.3 of the Department of Justice and Federal Trade Commission Horizontal Merger Guidelines. Issued Aug. 19, 2010.

III. Summary of findings and conclusion

The results are presented in Section IV. Tables 1–5 report the HHI and market shares of the two largest insurers in each state and MSA. Table 1 presents this information for the combined HMO+PPO+POS+EXCH product market while Tables 2, 3, 4 and 5 pertain to the HMO, PPO, POS, and exchange markets, respectively.³² Finally, Table 6 reports the HHIs by product type for all states and MSAs, as well as the mean and median HHI for each product across MSAs. The HMO, PPO and POS data are from Jan. 1, 2019, and the exchange data are from July 1, 2019.

After implementing the restrictions discussed in Section II.B, the numbers of states and MSAs for which we report data differ by product market. Data for the combined HMO+PPO+POS+EXCH market and the PPO market are reported for 384 MSAs and 51 states, HMO data are reported for 228 MSAs and 46 states, POS data are presented for 304 MSAs and 50 states, and exchange data are reported for 375 MSAs and 50 states. A summary of the MSA-level findings is presented below.

A. Market concentration (HHI)

In terms of market concentration (HHI), we found the following:

- Seventy-four percent (284) of the combined **HMO+PPO+POS+EXCH** markets are highly concentrated (HHI>2,500).
- Ninety-six percent (220) of the **HMO** markets are highly concentrated (HHI>2,500).
- Eighty-six percent (330) of the **PPO** markets are highly concentrated (HHI>2,500).
- One hundred percent (303) of the **POS** markets are highly concentrated (HHI>2,500).
- Ninety-nine percent (371) of the **exchanges** are highly concentrated (HHI>2,500).
- The average HHI in the combined **HMO+PPO+POS+EXCH** markets was 3473, and the median HHI was 3176.

32. The HHIs and market shares are rounded. As a result, in a few HMO, POS and exchange markets where the second largest insurer has very few covered lives (Tables 2, 4 and 5), the market share appears as zero. However, the actual, unrounded shares are just above 0%.

- The average HHI in the **HMO** markets was 5404, and the median HHI was 4917.
- The average HHI in the **PPO** markets was 4182, and the median HHI was 3843.
- The average HHI in the **POS** markets was 7076, and the median HHI was 6771.
- The average HHI in the **exchanges** was 6623, and the median HHI was 6157.

B. Market concentration (HHI) changes in combined HMO+PPO+POS+EXCH markets, 2014–2019

In terms of changes in market concentration (HHI), we found the following:

- The average HHI increased by 151 points between 2014 and 2019.³³
- The share of markets that are highly concentrated increased from 71% to 74% between 2014 and 2019.³⁴
- Fifty-six percent of markets experienced an increase in the HHI between 2014 and 2019. Among those markets, the average increase was 481 points.³⁵
- Forty-eight percent of markets experienced an increase in the HHI of at least 100 points between 2014 and 2019.

33. The change in MSA definitions between the 2016 data and that which followed factors into the long-term measurement of changes in HHI. However, we believe the impact to be minor. First, the areas around some of the largest U.S. cities were, through 2016, represented in the data as metropolitan divisions—components of MSAs. After 2016 they were instead included as a smaller number of MSAs “proper.” This change from a greater number of less populous areas (which tend to have higher HHIs) to a smaller number of more populous areas (which tend to have lower HHIs) likely leads to an *understatement* in the average HHI increase over time. Second, about 7% of MSAs are “new” in the data for 2017–2019. Previously they were micropolitan statistical areas. They did not have population counts large enough to be considered metropolitan. These relatively lower-population areas tend to be more concentrated and their movement into the MSA category likely leads to an *overstatement* in the average HHI increase over time. Because they account for a small share of MSAs, we expect that their upward influence is small. Indeed, when we compared only the 318 areas that were considered MSAs and had identical codes in 2014 and 2019 the increase in the average HHI was slightly lower (103 points). The comparison of the 318 areas, however, has the drawback of also excluding some areas whose codes changed for the reason of “name alone” or who had only minor changes in their geographic boundaries. Thus, making comparisons on the full set of data in both years is our preferred approach.

34. The increase in the share of markets that are highly concentrated, 71% to 74%, is the same whether it is based on all MSAs or only the 318 MSAs with identical codes in both years of data.

35. This increase and the statistics in the following four bullets are based on the 318 MSAs with identical codes in 2014 and 2019.

- Seventeen percent of markets experienced an increase in the HHI of at least 500 points between 2014 and 2019.
- Fifty-two percent of markets that were already highly concentrated in 2014 experienced an increase in the HHI between 2014 and 2019.
- Of the markets that were not highly concentrated in 2014, 25% experienced an increase in the HHI large enough to place them in the highly concentrated category by 2019. Another 40% also had an increase, though not large enough to make them highly concentrated.

C. Market shares

In terms of market shares, we found the following:

HMO+PPO+POS+EXCH product market

- In 92% (353) of the MSAs, at least one insurer had a combined HMO+PPO+POS+EXCH market share of 30% or greater.
- In 48% (183) of the MSAs, one insurer had a combined HMO+PPO+POS+EXCH market share of 50% or greater.
- In 10% (38) of the MSAs, one insurer had a combined HMO+PPO+POS+EXCH market share of 70% or greater.

HMO product market

- In 98% (224) of the MSAs, at least one insurer had an HMO market share of 30% or greater.
- In 73% (166) of the MSAs, one insurer had an HMO market share of 50% or greater.
- In 41% (94) of the MSAs, one insurer had an HMO market share of 70% or greater.

PPO product market

- In 96% (370) of the MSAs, at least one insurer had a PPO market share of 30% or greater.
- In 61% (235) of the MSAs, one insurer had a PPO market share of 50% or greater.
- In 24% (91) of the MSAs, one insurer had a PPO market share of 70% or greater.

POS product market

- In 100% (304) of the MSAs, at least one insurer had a POS market share of 30% or greater.

- In 92% (279) of the MSAs, one insurer had a POS market share of 50% or greater.
- In 66% (202) of the MSAs, one insurer had a POS market share of 70% or greater.

Exchanges

- In 98% (369) of the MSAs, at least one insurer had an exchange market share of 30% or greater.
- In 84% (314) of the MSAs, one insurer had an exchange market share of 50% or greater.
- In 56% (210) of the MSAs, one insurer had an exchange market share of 70% or greater.

D. Conclusion

In this study, we present data on competition in health insurance markets across the United States. Specifically, we report market share and concentration (HHI) data for 51 states (including the District of Columbia) and 384 MSAs. This is the most complete picture available of competition in health insurance markets. Our data are based on commercial enrollment in HMO, PPO, POS, and public exchange plans, and include participation in consumer-driven health plans.

We find that the majority of U.S. commercial health insurance markets are highly concentrated, as well as an upward trend in average market concentration between 2014 and 2019. These markets are ripe for the exercise of health insurer market power, which harms consumers and providers of care. Our findings should prompt federal and state antitrust authorities to vigorously examine the competitive effects of proposed mergers between health insurers.

Given the uncertainty in predicting the competitive effects of consolidation, some mergers that are allowed cause competitive harm. For example, in 2008 a merger between UnitedHealth and Sierra was allowed under the condition that UnitedHealth divest most of its Medicare Advantage business in the Las Vegas area.³⁶ Nevertheless, we found in other work that premiums in the commercial health insurance markets in Nevada increased in the wake of that merger.³⁷ Retrospective studies on health insurer consolidation

36. See Final Judgement at: <http://www.justice.gov/atr/cases/f237600/237613.htm>. Accessed July 20, 2020.

37. Guardado, J., Emmons, D., Kane, C. The Price Effects of a Large Merger of Health Insurers: A Case Study of UnitedHealth-Sierra. *HMPI*. 2013;1(3):16-35. Available at <http://hmpi.org/wp-content/uploads/2017/02/HMPI-Guardado-Emmons-Kane-Price-Effects-of-a-Larger-Merger-of-Health-Insurers.pdf>. Accessed July 20, 2020.

add to our understanding of its competitive effects.³⁸ Such retrospective studies complement the present methodology of predicting the competitive effects of mergers at the time of announcement and, in turn, help guide merger enforcement policy.

After years of largely unchallenged consolidation in the health insurance industry, a few subsequent attempts to consolidate have received closer scrutiny. In 2007, a merger proposed by Independence Blue Cross and Highmark was called off because the Pennsylvania Insurance Department insisted that one of them drop its Blues brand. The companies refused and instead called off the merger. In 2010, Blue Cross Blue Shield of Michigan called off its acquisition of Physicians Health Plan of Mid-Michigan because the DOJ announced it would file a lawsuit to block the acquisition.

Most notably, in 2015, two mergers involving four of the largest health insurers in the country were announced. Anthem attempted to acquire Cigna, and Aetna sought to acquire Humana. Proposed mergers of this magnitude are precisely the motivation for this study—to help identify markets where mergers would cause competitive harm. Upon announcement of these mergers, the AMA used data from previous editions of “Competition in health insurance” to assess their competitive effects. Specifically, we calculated the changes in market concentration (HHI) that would result from the mergers and, according to the DOJ/FTC Horizontal Merger Guidelines, classified markets based on how anticompetitive the mergers would be. We found that the mergers would be deemed anticompetitive in numerous markets across the United States.³⁹ Consistent with our findings and after close to a year of antitrust scrutiny, the DOJ and attorneys general from multiple states sued to block both acquisitions.⁴⁰ After intense battle in the courts, the DOJ and state attorneys general ultimately prevailed, and both mergers were abandoned by the merging parties. Our studies will continue to monitor competition in health insurance markets and be used to assess the competitive effects of proposed mergers among health insurers.

38. Ashenfelter, O.C., Hosken D., Weinberg M. Generating Evidence to Guide Merger Enforcement. National Bureau of Economic Research Working Paper 14798; March 2009.

39. See <https://www.ama-assn.org/about/competition-health-insurance-research>. Accessed July 20, 2020.

40. See lawsuits announcement at <https://www.justice.gov/opa/pr/justice-department-and-state-attorneys-general-sue-block-anthem-s-acquisition-cigna-aetna-s>. Accessed July 20, 2020.

IV. State and MSA tables

**Table 1. Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019
Combined HMO+PPO+POS+EXCH (total) product markets**

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Alabama	7461	BCBS AL	86	UnitedHealth Group	6
Anniston-Oxford, AL	8313	BCBS AL	91	Cigna	2
Auburn-Opelika, AL	6980	BCBS AL	83	Cigna	6
Birmingham-Hoover, AL	7148	BCBS AL	84	UnitedHealth Group	8
Daphne-Fairhope-Foley, AL	6725	BCBS AL	81	UnitedHealth Group	9
Decatur, AL	7683	BCBS AL	87	Cigna	5
Dothan, AL	7960	BCBS AL	89	UnitedHealth Group	5
Florence-Muscle Shoals, AL	7636	BCBS AL	87	Cigna	5
Gadsden, AL	8261	BCBS AL	91	UnitedHealth Group	4
Huntsville, AL	7523	BCBS AL	86	Cigna	4
Mobile, AL	7240	BCBS AL	85	UnitedHealth Group	7
Montgomery, AL	7717	BCBS AL	88	UnitedHealth Group	5
Tuscaloosa, AL	8290	BCBS AL	91	UnitedHealth Group	3
Alaska	4333	Aetna	51	Premera	42
Anchorage, AK	4036	Premera	47	Aetna	42
Fairbanks, AK	4400	Aetna	47	Premera	47
Arizona	2273	UnitedHealth Group	31	Aetna	23
Flagstaff, AZ	4618	BCBS AZ	66	UnitedHealth Group	12
Lake Havasu City-Kingman, AZ	3377	BCBS AZ	50	UnitedHealth Group	26
Phoenix-Mesa-Chandler, AZ	2302	UnitedHealth Group	32	Cigna	22
Prescott Valley-Prescott, AZ	3728	BCBS AZ	56	UnitedHealth Group	20
Sierra Vista-Douglas, AZ	2819	BCBS AZ	44	UnitedHealth Group	22
Tucson, AZ	2622	UnitedHealth Group	40	BCBS AZ	24
Yuma, AZ	3476	BCBS AZ	55	UnitedHealth Group	13
Arkansas	3054	BCBS AR	49	UnitedHealth Group	19
Fayetteville-Springdale-Rogers, AR	3069	BCBS AR	50	UnitedHealth Group	16
Fort Smith, AR-OK	1982	BCBS AR	29	UnitedHealth Group	26
Hot Springs, AR	3221	BCBS AR	52	UnitedHealth Group	19
Jonesboro, AR	3427	BCBS AR	54	UnitedHealth Group	15
Little Rock-North Little Rock-Conway, AR	3157	BCBS AR	48	UnitedHealth Group	25
Pine Bluff, AR	4424	BCBS AR	64	UnitedHealth Group	13
California	2161	Kaiser	36	Anthem	23
Bakersfield, CA	2714	Anthem	39	Kaiser	26
Chico, CA	4339	Anthem	58	BS of CA	31
El Centro, CA	2541	BS of CA	42	Anthem	20
Fresno, CA	2544	Anthem	36	BS of CA	25
Hanford-Corcoran, CA	2745	Anthem	40	BS of CA	30
Los Angeles-Long Beach-Anaheim, CA	2031	Kaiser	32	Anthem	25
Madera, CA	2533	Anthem	35	Kaiser	26
Merced, CA	3835	Anthem	57	BS of CA	22
Modesto, CA	3030	Kaiser	46	Anthem	26
Napa, CA	3519	Kaiser	49	Anthem	32

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Oxnard-Thousand Oaks-Ventura, CA	2335	Anthem	36	Kaiser	23
Redding, CA	4798	Anthem	64	BS of CA	25
Riverside-San Bernardino-Ontario, CA	2640	Kaiser	44	Anthem	19
Sacramento-Roseville-Folsom, CA	2932	Kaiser	50	Anthem	14
Salinas, CA	3571	Anthem	52	BS of CA	28
San Diego-Chula Vista-Carlsbad, CA	1559	Kaiser	29	Anthem	16
San Francisco-Oakland-Berkeley, CA	2811	Kaiser	48	Anthem	15
San Jose-Sunnyvale-Santa Clara, CA	2245	Kaiser	39	Anthem	18
San Luis Obispo-Paso Robles, CA	3765	Anthem	52	BS of CA	30
Santa Cruz-Watsonville, CA	2184	Anthem	35	BS of CA	20
Santa Maria-Santa Barbara, CA	3134	Anthem	45	BS of CA	32
Santa Rosa-Petaluma, CA	4195	Kaiser	62	Anthem	13
Stockton, CA	3589	Kaiser	55	Anthem	22
Vallejo, CA	5059	Kaiser	70	Anthem	10
Visalia, CA	3994	Anthem	58	BS of CA	23
Yuba City, CA	3817	Anthem	57	BS of CA	18
Colorado	1975	UnitedHealth Group	25	Anthem	22
Boulder, CO	2016	Cigna	25	UnitedHealth Group	22
Colorado Springs, CO	1940	UnitedHealth Group	25	Anthem	25
Denver-Aurora-Lakewood, CO	2065	UnitedHealth Group	26	Kaiser	24
Fort Collins, CO	2359	Anthem	37	UnitedHealth Group	20
Grand Junction, CO	3152	UnitedHealth Group	45	Anthem	24
Greeley, CO	1988	Cigna	24	UnitedHealth Group	23
Pueblo, CO	2413	Anthem	34	UnitedHealth Group	27
Connecticut	2193	Anthem	33	UnitedHealth Group	19
Bridgeport-Stamford-Norwalk, CT	2193	UnitedHealth Group	29	Anthem	24
Hartford-East Hartford-Middletown, CT	2160	Anthem	32	Cigna	23
New Haven-Milford, CT	2413	Anthem	38	Aetna	21
Norwich-New London, CT	3062	Anthem	47	UnitedHealth Group	25
Delaware	4719	Highmark	64	Aetna	24
Dover, DE	5405	Highmark	71	Aetna	20
District of Columbia	1926	CareFirst	30	UnitedHealth Group	21
Washington-Arlington-Alexandria, DC-VA-MD-WV	1686	CareFirst	25	UnitedHealth Group	16
Florida	2358	BCBS FL	38	UnitedHealth Group	21
Cape Coral-Fort Myers, FL	3175	BCBS FL	49	UnitedHealth Group	19
Crestview-Fort Walton Beach-Destin, FL	4563	BCBS FL	65	UnitedHealth Group	15
Deltona-Daytona Beach-Ormond Beach, FL	2603	BCBS FL	39	UnitedHealth Group	27
Gainesville, FL	5429	BCBS FL	72	Aetna	11
Homosassa Springs, FL	4067	BCBS FL	59	UnitedHealth Group	23
Jacksonville, FL	3272	BCBS FL	51	Aetna	18
Lakeland-Winter Haven, FL	2252	BCBS FL	31	UnitedHealth Group	25
Miami-Fort Lauderdale-Pompano Beach, FL	1828	BCBS FL	27	UnitedHealth Group	23
Naples-Marco Island, FL	3644	BCBS FL	54	Cigna	20
North Port-Sarasota-Bradenton, FL	2996	BCBS FL	46	UnitedHealth Group	20
Ocala, FL	4670	BCBS FL	65	UnitedHealth Group	17
Orlando-Kissimmee-Sanford, FL	2429	BCBS FL	32	Cigna	28

Table 1. (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019. Combined HMO+PPO+POS+EXCH (total) product markets

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Palm Bay-Melbourne-Titusville, FL	2249	BCBS FL	32	Cigna	26
Panama City, FL	5381	BCBS FL	72	UnitedHealth Group	13
Pensacola-Ferry Pass-Brent, FL	4154	BCBS FL	60	UnitedHealth Group	20
Port St. Lucie, FL	3706	BCBS FL	57	UnitedHealth Group	15
Punta Gorda, FL	3188	BCBS FL	50	UnitedHealth Group	19
Sebastian-Vero Beach, FL	4007	BCBS FL	60	UnitedHealth Group	16
Sebring-Avon Park, FL	3284	BCBS FL	50	UnitedHealth Group	21
Tallahassee, FL	7757	BCBS FL	88	UnitedHealth Group	7
Tampa-St. Petersburg-Clearwater, FL	2276	BCBS FL	32	UnitedHealth Group	27
The Villages, FL	4823	BCBS FL	66	UnitedHealth Group	18
Georgia	2356	Anthem	41	UnitedHealth Group	15
Albany, GA	4136	Anthem	62	UnitedHealth Group	13
Athens-Clarke County, GA	2925	Anthem	49	UnitedHealth Group	14
Atlanta-Sandy Springs-Alpharetta, GA	2114	Anthem	36	UnitedHealth Group	17
Augusta-Richmond County, GA-SC	2517	Anthem	41	BCBS SC	20
Brunswick, GA	3129	Anthem	52	UnitedHealth Group	13
Columbus, GA-AL	3104	Anthem	52	Cigna	12
Dalton, GA	2968	Anthem	39	Cigna	35
Gainesville, GA	2429	Anthem	41	Cigna	19
Hinesville, GA	4182	Anthem	63	Humana	9
Macon-Bibb County, GA	3542	Anthem	55	UnitedHealth Group	17
Rome, GA	2887	Anthem	46	Cigna	22
Savannah, GA	2120	Anthem	36	UnitedHealth Group	17
Valdosta, GA	5014	Anthem	69	UnitedHealth Group	13
Warner Robins, GA	5456	Anthem	73	UnitedHealth Group	8
Hawaii	4901	HMSA (BCBS HI)	66	Kaiser	21
Kahului-Wailuku-Lahaina, HI	3919	Kaiser	46	HMSA (BCBS HI)	42
Urban Honolulu, HI	5097	HMSA (BCBS HI)	68	Kaiser	18
Idaho	2468	BC of ID	45	Cambia	13
Boise City, ID	2305	BC of ID	42	Cambia	13
Coeur d'Alene, ID	1927	BC of ID	35	Kaiser	18
Idaho Falls, ID	2896	BC of ID	50	Intermountain	13
Lewiston, ID-WA	2230	Premera	31	BC of ID	25
Pocatello, ID	3542	BC of ID	56	Cambia	13
Twin Falls, ID	2413	BC of ID	43	Cambia	14
Illinois	3913	HCSC (BCBS)	59	UnitedHealth Group	15
Bloomington, IL	4670	HCSC (BCBS)	66	Hlth Alliance	13
Carbondale-Marion, IL	2644	HCSC (BCBS)	44	Cigna	17
Champaign-Urbana, IL	4260	Hlth Alliance	62	HCSC (BCBS)	15
Chicago-Naperville-Elgin, IL-IN-WI	3911	HCSC (BCBS)	59	UnitedHealth Group	14
Danville, IL	3176	HCSC (BCBS)	45	Hlth Alliance	32
Davenport-Moline-Rock Island, IA-IL	2643	UnitedHealth Group	40	HCSC (BCBS)	28
Decatur, IL	4865	HCSC (BCBS)	68	UnitedHealth Group	11
Kankakee, IL	4244	HCSC (BCBS)	62	UnitedHealth Group	13
Peoria, IL	3121	HCSC (BCBS)	47	UnitedHealth Group	27

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Rockford, IL	4820	HCSC (BCBS)	67	UnitedHealth Group	12
Springfield, IL	2965	HCSC (BCBS)	46	Hlth Alliance	22
Indiana	3553	Anthem	56	UnitedHealth Group	16
Bloomington, IN	3930	Anthem	60	IU Health	12
Columbus, IN	3246	Anthem	51	S.E. Indiana Hlth	23
Elkhart-Goshen, IN	4000	Anthem	60	UnitedHealth Group	16
Evansville, IN-KY	3907	Anthem	60	UnitedHealth Group	15
Fort Wayne, IN	3194	Anthem	52	UnitedHealth Group	17
Indianapolis-Carmel-Anderson, IN	3804	Anthem	58	UnitedHealth Group	20
Kokomo, IN	5640	Anthem	74	UnitedHealth Group	11
Lafayette-West Lafayette, IN	2844	Anthem	46	IU Health	19
Michigan City-La Porte, IN	4705	Anthem	67	UnitedHealth Group	14
Muncie, IN	4212	Anthem	62	IU Health	14
South Bend-Mishawaka, IN-MI	2898	Anthem	49	BCBS MI	14
Terre Haute, IN	5291	Anthem	72	UnitedHealth Group	9
Iowa	3177	Wellmark (BCBS)	47	UnitedHealth Group	29
Ames, IA	4672	Wellmark (BCBS)	64	UnitedHealth Group	22
Cedar Rapids, IA	3563	Wellmark (BCBS)	54	UnitedHealth Group	20
Davenport-Moline-Rock Island, IA-IL	2643	UnitedHealth Group	40	HCSC (BCBS)	28
Des Moines-West Des Moines, IA	3192	UnitedHealth Group	40	Wellmark (BCBS)	38
Dubuque, IA	3030	Wellmark (BCBS)	44	UnitedHealth Group	30
Iowa City, IA	4611	Wellmark (BCBS)	66	UnitedHealth Group	12
Sioux City, IA-NE-SD	2070	Wellmark (BCBS)	32	UnitedHealth Group	28
Waterloo-Cedar Falls, IA	3139	UnitedHealth Group	44	Wellmark (BCBS)	32
Kansas	2471	BCBS KS	42	Aetna	16
Lawrence, KS	3181	BCBS KS	50	Aetna	15
Manhattan, KS	5950	BCBS KS	76	UnitedHealth Group	7
Topeka, KS	5642	BCBS KS	74	UnitedHealth Group	11
Wichita, KS	3270	BCBS KS	44	Aetna	33
Kentucky	4409	Anthem	64	Humana	14
Bowling Green, KY	4290	Anthem	62	Humana	17
Elizabethtown-Fort Knox, KY	5159	Anthem	70	Humana	15
Lexington-Fayette, KY	4667	Anthem	65	Humana	17
Louisville/Jefferson County, KY-IN	3948	Anthem	60	UnitedHealth Group	13
Owensboro, KY	5715	Anthem	74	UnitedHealth Group	11
Louisiana	4269	LA Hlth Serv & Ind (BCBS)	62	UnitedHealth Group	17
Alexandria, LA	4792	LA Hlth Serv & Ind (BCBS)	67	UnitedHealth Group	18
Baton Rouge, LA	4449	LA Hlth Serv & Ind (BCBS)	64	UnitedHealth Group	13
Hammond, LA	4575	LA Hlth Serv & Ind (BCBS)	65	UnitedHealth Group	15
Houma-Thibodaux, LA	4539	LA Hlth Serv & Ind (BCBS)	64	UnitedHealth Group	20
Lafayette, LA	4700	LA Hlth Serv & Ind (BCBS)	66	UnitedHealth Group	16
Lake Charles, LA	4259	LA Hlth Serv & Ind (BCBS)	62	UnitedHealth Group	15
Monroe, LA	4376	LA Hlth Serv & Ind (BCBS)	62	UnitedHealth Group	22
New Orleans-Metairie, LA	3918	LA Hlth Serv & Ind (BCBS)	58	UnitedHealth Group	20
Shreveport-Bossier City, LA	4627	LA Hlth Serv & Ind (BCBS)	66	UnitedHealth Group	16

Table 1. (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019. *Combined HMO+PPO+POS+EXCH (total) product markets*

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Maine	2818	Anthem	47	Harvard Pilgrim	13
Bangor, ME	2570	Anthem	43	Cigna	20
Lewiston-Auburn, ME	2530	Anthem	41	Cigna	20
Portland-South Portland, ME	2765	Anthem	46	Harvard Pilgrim	16
Maryland	2813	CareFirst	46	Aetna	15
Baltimore-Columbia-Towson, MD	3146	CareFirst	50	Cigna	15
California-Lexington Park, MD	3986	CareFirst	59	Aetna	13
Cumberland, MD-WV	2587	CareFirst	37	UnitedHealth Group	26
Hagerstown-Martinsburg, MD-WV	1880	CareFirst	23	Cigna	21
Salisbury, MD-DE	2846	Highmark	43	CareFirst	27
Massachusetts	2004	BCBS MA	36	Tufts	18
Barnstable Town, MA	2661	BCBS MA	36	Harvard Pilgrim	34
Boston-Cambridge-Newton, MA-NH	1731	BCBS MA	31	Harvard Pilgrim	16
Pittsfield, MA	2936	BCBS MA	49	Baystate	17
Springfield, MA	1802	BCBS MA	27	Baystate	21
Worcester, MA-CT	1676	BCBS MA	32	Tufts	14
Michigan	4724	BCBS MI	67	Spectrum Hlth	10
Ann Arbor, MI	6142	BCBS MI	78	Aetna	7
Battle Creek, MI	5796	BCBS MI	75	UnitedHealth Group	9
Bay City, MI	5725	BCBS MI	74	Henry Ford HS	12
Detroit-Warren-Dearborn, MI	4815	BCBS MI	68	Henry Ford HS	9
Flint, MI	4910	BCBS MI	68	Henry Ford HS	13
Grand Rapids-Kentwood, MI	4060	BCBS MI	57	Spectrum Hlth	27
Jackson, MI	5925	BCBS MI	76	Henry Ford HS	9
Kalamazoo-Portage, MI	5282	BCBS MI	70	UnitedHealth Group	16
Lansing-East Lansing, MI	5634	BCBS MI	72	Sparrow (Physicians HP)	19
Midland, MI	5544	BCBS MI	71	Aetna	21
Monroe, MI	5205	BCBS MI	71	Henry Ford HS	7
Muskegon, MI	4720	BCBS MI	65	Spectrum Hlth	21
Niles, MI	5376	BCBS MI	72	UnitedHealth Group	7
Saginaw, MI	4919	BCBS MI	67	Henry Ford HS	18
Minnesota	2771	BCBS MN	45	HealthPartners	19
Duluth, MN-WI	2723	BCBS MN	46	HealthPartners	16
Mankato, MN	4580	BCBS MN	63	Medica	22
Minneapolis-St. Paul-Bloomington, MN-WI	2252	BCBS MN	38	HealthPartners	23
Rochester, MN	4754	BCBS MN	65	Medica	22
St. Cloud, MN	3345	BCBS MN	51	HealthPartners	20
Mississippi	3584	BCBS MS	55	UnitedHealth Group	17
Gulfport-Biloxi, MS	3949	BCBS MS	60	UnitedHealth Group	16
Hattiesburg, MS	3589	BCBS MS	52	UnitedHealth Group	27
Jackson, MS	4137	BCBS MS	62	UnitedHealth Group	13
Missouri	1907	Anthem	26	UnitedHealth Group	26
Cape Girardeau, MO-IL	3236	Anthem	41	UnitedHealth Group	38
Columbia, MO	3691	UnitedHealth Group	55	Anthem	21
Jefferson City, MO	3058	Anthem	39	UnitedHealth Group	36

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Joplin, MO	2082	Anthem	35	UnitedHealth Group	20
Kansas City, MO-KS	2740	BCBS KS City	45	UnitedHealth Group	18
Springfield, MO	1661	UnitedHealth Group	25	Anthem	18
St. Joseph, MO-KS	3799	BCBS KS City	59	UnitedHealth Group	12
St. Louis, MO-IL	2270	UnitedHealth Group	33	Anthem	26
Montana	2901	HCSC (BCBS)	41	Cigna	32
Billings, MT	3060	HCSC (BCBS)	45	Cigna	30
Great Falls, MT	3545	HCSC (BCBS)	51	Cigna	29
Missoula, MT	3086	HCSC (BCBS)	43	Cigna	34
Nebraska	3076	BCBS NE	46	UnitedHealth Group	28
Grand Island, NE	3638	BCBS NE	55	UnitedHealth Group	20
Lincoln, NE	3470	BCBS NE	50	UnitedHealth Group	30
Omaha-Council Bluffs, NE-IA	2727	UnitedHealth Group	35	BCBS NE	35
Nevada	2318	UnitedHealth Group	38	Anthem	22
Carson City, NV	2123	Anthem	37	UHS (Prominence HP)	18
Las Vegas-Henderson-Paradise, NV	2776	UnitedHealth Group	46	Anthem	18
Reno, NV	1944	UnitedHealth Group	28	Anthem	26
New Hampshire	2894	Anthem	47	Cigna	20
Manchester-Nashua, NH	2874	Anthem	46	Cigna	18
New Jersey	2659	Horizon BCBS	40	Aetna	24
Atlantic City-Hammonton, NJ	6537	Horizon BCBS	80	Aetna	8
Ocean City, NJ	6034	Horizon BCBS	77	Aetna	9
Trenton-Princeton, NJ	2991	Horizon BCBS	39	Aetna	34
Vineland-Bridgeton, NJ	4246	Horizon BCBS	58	Aetna	28
New Mexico	2729	HCSC (BCBS)	44	Presbyterian	25
Albuquerque, NM	2467	Presbyterian	34	HCSC (BCBS)	32
Farmington, NM	2707	HCSC (BCBS)	42	UnitedHealth Group	22
Las Cruces, NM	3984	HCSC (BCBS)	61	Presbyterian	12
Santa Fe, NM	2385	HCSC (BCBS)	36	Presbyterian	28
New York	1542	UnitedHealth Group	27	Anthem	16
Albany-Schenectady-Troy, NY	2463	CDPHP	39	UnitedHealth Group	25
Binghamton, NY	3729	Lifetime Hlthcare	55	UnitedHealth Group	23
Buffalo-Cheektowaga, NY	2839	Independent Hlth	48	Lifetime Hlthcare	14
Elmira, NY	4453	Lifetime Hlthcare	62	UnitedHealth Group	23
Glens Falls, NY	1973	UnitedHealth Group	28	CDPHP	28
Ithaca, NY	3201	Lifetime Hlthcare	40	Aetna	37
Kingston, NY	2178	UnitedHealth Group	36	MVP Hlth Care	24
New York-Newark-Jersey City, NY-NJ-PA	1676	UnitedHealth Group	26	Anthem	18
Poughkeepsie-Newburgh-Middletown, NY	1903	UnitedHealth Group	30	Anthem	24
Rochester, NY	6073	Lifetime Hlthcare	77	MVP Hlth Care	9
Syracuse, NY	4847	Lifetime Hlthcare	67	UnitedHealth Group	16
Utica-Rome, NY	3663	Lifetime Hlthcare	54	UnitedHealth Group	24
Watertown-Fort Drum, NY	3706	Lifetime Hlthcare	55	UnitedHealth Group	21
North Carolina	3720	BCBS NC	55	UnitedHealth Group	19
Asheville, NC	4446	BCBS NC	63	UnitedHealth Group	18

Table 1. (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019. Combined HMO+PPO+POS+EXCH (total) product markets

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Burlington, NC	3599	BCBS NC	53	UnitedHealth Group	19
Charlotte-Concord-Gastonia, NC-SC	2536	BCBS NC	39	UnitedHealth Group	21
Durham-Chapel Hill, NC	3490	BCBS NC	52	Aetna	20
Fayetteville, NC	4441	BCBS NC	63	UnitedHealth Group	20
Goldensboro, NC	5825	BCBS NC	75	Cigna	13
Greensboro-High Point, NC	3801	BCBS NC	54	UnitedHealth Group	26
Greenville, NC	6501	BCBS NC	80	Cigna	12
Hickory-Lenoir-Morganton, NC	4874	BCBS NC	66	UnitedHealth Group	21
Jacksonville, NC	5710	BCBS NC	74	UnitedHealth Group	10
New Bern, NC	6279	BCBS NC	78	Cigna	10
Raleigh-Cary, NC	3179	BCBS NC	48	UnitedHealth Group	21
Rocky Mount, NC	5086	BCBS NC	69	UnitedHealth Group	13
Wilmington, NC	3881	BCBS NC	52	UnitedHealth Group	32
Winston-Salem, NC	3644	BCBS NC	52	Cigna	22
North Dakota	3710	BCBS ND	54	Sanford	26
Bismarck, ND	3703	BCBS ND	54	Sanford	27
Fargo, ND-MN	2199	BCBS ND	34	BCBS MN	24
Grand Forks, ND-MN	2340	BCBS ND	34	BCBS MN	27
Ohio	2170	Anthem	33	Medical Mutual	25
Akron, OH	2412	Medical Mutual	39	Anthem	25
Canton-Massillon, OH	2055	Medical Mutual	36	Anthem	22
Cincinnati, OH-KY-IN	3133	Anthem	50	UnitedHealth Group	23
Cleveland-Elyria, OH	2845	Medical Mutual	46	Anthem	21
Columbus, OH	2151	UnitedHealth Group	29	Anthem	27
Dayton-Kettering, OH	3153	Anthem	50	UnitedHealth Group	23
Lima, OH	2517	Medical Mutual	41	Anthem	24
Mansfield, OH	2985	Medical Mutual	48	Anthem	19
Springfield, OH	2285	Anthem	37	UnitedHealth Group	22
Toledo, OH	1993	Medical Mutual	31	Anthem	22
Weirton-Steubenville, WV-OH	2035	Anthem	36	Medical Mutual	18
Youngstown-Warren-Boardman, OH-PA	1907	Anthem	29	Medical Mutual	27
Oklahoma	3531	HCSC (BCBS)	55	UnitedHealth Group	17
Enid, OK	3820	HCSC (BCBS)	58	UnitedHealth Group	15
Lawton, OK	4896	HCSC (BCBS)	69	UnitedHealth Group	9
Oklahoma City, OK	3424	HCSC (BCBS)	54	UnitedHealth Group	16
Tulsa, OK	2910	HCSC (BCBS)	45	UnitedHealth Group	25
Oregon	1477	Cambia	21	Kaiser	20
Albany-Lebanon, OR	1517	Cambia	27	UnitedHealth Group	14
Bend, OR	1847	Cambia	29	PacificSource	25
Corvallis, OR	2008	Cambia	37	Moda Health	14
Eugene-Springfield, OR	1926	PacificSource	30	Cambia	25
Grants Pass, OR	1922	Cambia	27	PacificSource	23
Medford, OR	1899	Cambia	32	Moda Health	19
Portland-Vancouver-Hillsboro, OR-WA	1744	Kaiser	29	Providence Hlth	20
Salem, OR	1995	Kaiser	33	Cambia	23

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Pennsylvania	1723	Highmark	28	Aetna	20
Allentown-Bethlehem-Easton, PA-NJ	1928	Highmark	33	Capital BC	18
Altoona, PA	2771	Highmark	35	UPMC	35
Bloomsburg-Berwick, PA	3722	Geisinger	55	Highmark	21
Chambersburg-Waynesboro, PA	3263	Highmark	50	Capital BC	22
East Stroudsburg, PA	3492	Highmark	55	Aetna	13
Erie, PA	3073	Highmark	43	UPMC	30
Gettysburg, PA	2791	Highmark	45	Capital BC	23
Harrisburg-Carlisle, PA	2838	Highmark	45	Capital BC	21
Johnstown, PA	3001	Highmark	39	UPMC	34
Lancaster, PA	3124	Highmark	47	Capital BC	27
Lebanon, PA	3459	Highmark	53	Capital BC	21
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	2365	Independence Hlth Grp	35	Aetna	29
Pittsburgh, PA	2833	UPMC	36	Highmark	35
Reading, PA	2655	Highmark	42	Capital BC	24
Scranton--Wilkes-Barre, PA	3408	Highmark	49	Geisinger	30
State College, PA	2902	Highmark	43	Aetna	24
Williamsport, PA	2612	Highmark	42	Geisinger	22
York-Hanover, PA	2680	Highmark	43	Capital BC	23
Rhode Island	2937	BCBS RI	39	UnitedHealth Group	35
Providence-Warwick, RI-MA	1741	UnitedHealth Group	24	BCBS RI	22
South Carolina	4573	BCBS SC	64	Cigna	15
Charleston-North Charleston, SC	4926	BCBS SC	68	Cigna	12
Columbia, SC	5003	BCBS SC	68	Cigna	14
Florence, SC	4770	BCBS SC	66	UnitedHealth Group	16
Greenville-Anderson, SC	4028	BCBS SC	58	Cigna	20
Hilton Head Island-Bluffton, SC	5051	BCBS SC	69	UnitedHealth Group	13
Myrtle Beach-Conway-North Myrtle Beach, SC-NC	2955	BCBS SC	47	UnitedHealth Group	18
Spartanburg, SC	4313	BCBS SC	61	Cigna	19
Sumter, SC	4940	BCBS SC	67	Cigna	17
South Dakota	2696	Avera Hlth	34	Wellmark (BCBS)	32
Rapid City, SD	2640	Wellmark (BCBS)	38	Avera Hlth	25
Sioux Falls, SD	2496	Wellmark (BCBS)	32	Avera Hlth	30
Tennessee	2957	BCBS TN	44	Cigna	26
Chattanooga, TN-GA	2457	BCBS TN	40	Cigna	19
Clarksville, TN-KY	2266	Anthem	32	BCBS TN	30
Cleveland, TN	3463	BCBS TN	51	Cigna	25
Jackson, TN	3111	BCBS TN	45	Cigna	28
Johnson City, TN	4578	BCBS TN	64	Cigna	14
Kingsport-Bristol, TN-VA	2657	BCBS TN	38	Anthem	26
Knoxville, TN	3267	BCBS TN	47	Cigna	23
Memphis, TN-MS-AR	2632	Cigna	42	BCBS TN	25
Morristown, TN	4029	BCBS TN	58	Cigna	21
Nashville-Davidson--Murfreesboro--Franklin, TN	2609	BCBS TN	37	Cigna	25

Table 1. (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019. Combined HMO+PPO+POS+EXCH (total) product markets

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Texas	2332	HCSC (BCBS)	36	UnitedHealth Group	21
Abilene, TX	3413	HCSC (BCBS)	54	UnitedHealth Group	16
Amarillo, TX	2437	HCSC (BCBS)	40	UnitedHealth Group	20
Austin-Round Rock-Georgetown, TX	2222	HCSC (BCBS)	31	UnitedHealth Group	25
Beaumont-Port Arthur, TX	2556	HCSC (BCBS)	40	UnitedHealth Group	20
Brownsville-Harlingen, TX	3977	HCSC (BCBS)	60	UnitedHealth Group	14
College Station-Bryan, TX	2875	HCSC (BCBS)	45	Baylor Scott & White	22
Corpus Christi, TX	2986	HCSC (BCBS)	45	UnitedHealth Group	24
Dallas-Fort Worth-Arlington, TX	2408	HCSC (BCBS)	35	UnitedHealth Group	23
El Paso, TX	2270	HCSC (BCBS)	36	Aetna	27
Houston-The Woodlands-Sugar Land, TX	2079	HCSC (BCBS)	29	UnitedHealth Group	21
Killeen-Temple, TX	2311	Baylor Scott & White	33	HCSC (BCBS)	28
Laredo, TX	4780	HCSC (BCBS)	67	UnitedHealth Group	12
Longview, TX	3161	HCSC (BCBS)	49	UnitedHealth Group	21
Lubbock, TX	3292	HCSC (BCBS)	52	UnitedHealth Group	19
McAllen-Edinburg-Mission, TX	3651	HCSC (BCBS)	57	UnitedHealth Group	14
Midland, TX	3697	HCSC (BCBS)	56	UnitedHealth Group	16
Odessa, TX	4207	HCSC (BCBS)	62	UnitedHealth Group	14
San Angelo, TX	3618	HCSC (BCBS)	54	Aetna	20
San Antonio-New Braunfels, TX	2418	HCSC (BCBS)	35	Aetna	24
Sherman-Denison, TX	2847	HCSC (BCBS)	43	UnitedHealth Group	22
Texarkana, TX-AR	2865	HCSC (BCBS)	49	BCBS AR	13
Tyler, TX	3403	HCSC (BCBS)	53	UnitedHealth Group	20
Victoria, TX	2996	HCSC (BCBS)	46	UnitedHealth Group	19
Waco, TX	2313	HCSC (BCBS)	34	Baylor Scott & White	27
Wichita Falls, TX	3831	HCSC (BCBS)	57	UnitedHealth Group	16
Utah	2457	Intermountain	42	Cambia	14
Logan, UT-ID	2706	Intermountain	46	UnitedHealth Group	16
Ogden-Clearfield, UT	2331	Intermountain	39	Aetna	17
Provo-Orem, UT	3152	Intermountain	51	Cigna	18
Salt Lake City, UT	2443	Intermountain	42	Cigna	15
St. George, UT	2869	Intermountain	48	UnitedHealth Group	15
Vermont	3624	BCBS VT	53	Cigna	25
Burlington-South Burlington, VT	4057	BCBS VT	58	Cigna	25
Virginia	2317	Anthem	41	Cigna	15
Blacksburg-Christiansburg, VA	4207	Anthem	61	Aetna	19
Charlottesville, VA	2927	Aetna	38	Anthem	36
Harrisonburg, VA	4819	Anthem	67	Sentara (Optima Hlth)	12
Lynchburg, VA	3904	Anthem	60	Centra (Piedmont)	12
Richmond, VA	3158	Anthem	47	Cigna	25
Roanoke, VA	3663	Anthem	54	Aetna	25
Staunton, VA	4126	Anthem	59	Aetna	25
Virginia Beach-Norfolk-Newport News, VA-NC	3384	Anthem	52	Sentara (Optima Hlth)	22
Winchester, VA-WV	3536	Anthem	55	Aetna	13

State and MSAs	TOTAL HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Washington	1699	Kaiser	23	Premera	21
Bellingham, WA	2066	Kaiser	33	Cambia	21
Bremerton-Silverdale-Port Orchard, WA	2038	Kaiser	30	Cambia	27
Kennewick-Richland, WA	2124	Premera	31	Kaiser	27
Longview, WA	3289	Kaiser	53	Premera	18
Mount Vernon-Anacortes, WA	1936	Kaiser	28	Cambia	23
Olympia-Lacey-Tumwater, WA	1749	Kaiser	29	Premera	20
Seattle-Tacoma-Bellevue, WA	1721	Kaiser	22	Premera	22
Spokane-Spokane Valley, WA	2157	Premera	36	Kaiser	22
Walla Walla, WA	2034	Premera	33	Kaiser	21
Wenatchee, WA	2483	Premera	43	Hlth Alliance	16
Yakima, WA	1909	Premera	26	Kaiser	26
West Virginia	2560	Highmark	42	Aetna	20
Beckley, WV	3464	Highmark	55	UnitedHealth Group	13
Charleston, WV	2553	Highmark	42	Aetna	18
Huntington-Ashland, WV-KY-OH	2792	Anthem	48	Highmark	15
Morgantown, WV	3226	Highmark	52	Aetna	14
Parkersburg-Vienna, WV	3204	Highmark	52	Cigna	15
Wheeling, WV-OH	1947	Anthem	36	Highmark	15
Wisconsin	1501	UnitedHealth Group	28	Anthem	20
Appleton, WI	2197	UnitedHealth Group	42	Anthem	13
Eau Claire, WI	1503	Anthem	23	Marshfield (Security HP)	21
Fond du Lac, WI	2499	Quartz	35	UnitedHealth Group	33
Green Bay, WI	1739	UnitedHealth Group	35	Anthem	12
Janesville-Beloit, WI	2146	Quartz	35	SSM Health (Dean HP)	23
La Crosse-Onalaska, WI-MN	1582	Quartz	30	Anthem	15
Madison, WI	2231	Quartz	30	SSM Health (Dean HP)	30
Milwaukee-Waukesha, WI	3248	UnitedHealth Group	50	Anthem	26
Oshkosh-Neenah, WI	2430	UnitedHealth Group	44	Anthem	16
Racine, WI	3260	UnitedHealth Group	53	Anthem	18
Sheboygan, WI	3021	UnitedHealth Group	50	Anthem	18
Wausau-Weston, WI	1948	UnitedHealth Group	29	Anthem	23
Wyoming	3086	Cigna	44	BCBS WY	28
Casper, WY	4326	Cigna	61	BCBS WY	17
Cheyenne, WY	3494	Cigna	48	BCBS WY	31

Notes:

1. Source: Managed Market Surveyor Suite | MSA Medical Program | January 1, 2019 | Managed Market Surveyor | Selected Geographies | January 1, 2019, and Managed Market Surveyor | Data Extraction | Enterprise License © 2019 DR/Decision Resources, LLC. All rights reserved.
2. Data point for the exchanges is July 1, 2019.
3. State and MSA-level Herfindahl-Hirschman Indices (HHIs) and the market shares of the two largest insurers in the combined HMO+PPO+POS+EXCH (TOTAL) product market are reported. However, all state and MSA-level data for North Dakota exclude exchange enrollment because those data appeared to be incomplete.
4. Data are based on enrollments in both fully and self-insured health plans.

**Table 2. Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019
HMO product markets**

State and MSAs	HMO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Alabama	8790	Triton (Viva Hlth)	94	UnitedHealth Group	6
Birmingham-Hoover, AL	7899	Triton (Viva Hlth)	88	UnitedHealth Group	12
Arizona	2677	BCBS AZ	33	Aetna	29
Phoenix-Mesa-Chandler, AZ	2936	BCBS AZ	37	Aetna	33
Tucson, AZ	2825	UnitedHealth Group	42	Humana	19
Arkansas	6641	Catholic Hlth Initiatives	80	UnitedHealth Group	12
Fayetteville-Springdale-Rogers, AR	6978	Catholic Hlth Initiatives	83	UnitedHealth Group	9
Little Rock-North Little Rock-Conway, AR	5504	Catholic Hlth Initiatives	70	UnitedHealth Group	23
California	4798	Kaiser	68	BS of CA	8
Bakersfield, CA	4239	Kaiser	60	BS of CA	19
Chico, CA	4535	Anthem	56	BS of CA	37
El Centro, CA	3187	BS of CA	48	SIMNSA HP	25
Fresno, CA	4392	Kaiser	63	Anthem	17
Hanford-Corcoran, CA	1950	Anthem	23	UnitedHealth Group	21
Los Angeles-Long Beach-Anaheim, CA	4384	Kaiser	64	BS of CA	10
Madera, CA	4281	Kaiser	62	Anthem	16
Merced, CA	3426	Kaiser	44	Anthem	37
Modesto, CA	6294	Kaiser	79	Anthem	8
Napa, CA	7184	Kaiser	84	Anthem	10
Oxnard-Thousand Oaks-Ventura, CA	3790	Kaiser	57	Anthem	16
Redding, CA	9010	Anthem	95	Kaiser	4
Riverside-San Bernardino-Ontario, CA	5235	Kaiser	71	BS of CA	11
Sacramento-Roseville-Folsom, CA	5095	Kaiser	70	Western Hlth Advantage	12
Salinas, CA	5922	Anthem	73	Kaiser	23
San Diego-Chula Vista-Carlsbad, CA	2843	Kaiser	50	Sharp HealthCare	12
San Francisco-Oakland-Berkeley, CA	6692	Kaiser	81	Anthem	5
San Jose-Sunnyvale-Santa Clara, CA	6623	Kaiser	81	Anthem	6
San Luis Obispo-Paso Robles, CA	3181	Anthem	38	UnitedHealth Group	31
Santa Cruz-Watsonville, CA	2726	Kaiser	45	BS of CA	18
Santa Maria-Santa Barbara, CA	2557	Anthem	39	BS of CA	27
Santa Rosa-Petaluma, CA	7713	Kaiser	88	Western Hlth Advantage	4
Stockton, CA	7020	Kaiser	83	Anthem	6
Vallejo, CA	7752	Kaiser	88	Western Hlth Advantage	4
Visalia, CA	2707	Anthem	40	BS of CA	30
Yuba City, CA	3877	Kaiser	49	Anthem	38
Colorado	5292	Kaiser	71	Anthem	13
Boulder, CO	6227	Kaiser	77	Anthem	14
Colorado Springs, CO	4864	Kaiser	67	Anthem	16
Denver-Aurora-Lakewood, CO	6482	Kaiser	80	Anthem	8
Fort Collins, CO	4186	Kaiser	56	Anthem	31
Grand Junction, CO	8092	UnitedHealth Group	89	Anthem	9
Greeley, CO	4649	Kaiser	65	Anthem	16
Pueblo, CO	4475	Kaiser	63	Anthem	20
Connecticut	5684	Anthem	74	EmblemHealth	14
Bridgeport-Stamford-Norwalk, CT	5950	Anthem	75	UnitedHealth Group	15

State and MSAs	HMO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Hartford-East Hartford-Middletown, CT	5317	Anthem	71	EmblemHealth	16
New Haven-Milford, CT	5773	Anthem	74	EmblemHealth	16
Norwich-New London, CT	8021	Anthem	89	EmblemHealth	5
Delaware	4833	Highmark	49	Aetna	49
Dover, DE	4931	Aetna	54	Highmark	45
District of Columbia	2948	Kaiser	40	CareFirst	29
Washington-Arlington-Alexandria, DC-VA-MD-WV	2971	Kaiser	37	CareFirst	35
Florida	2479	BCBS FL	39	UnitedHealth Group	21
Cape Coral-Fort Myers, FL	4202	BCBS FL	61	UnitedHealth Group	16
Deltona-Daytona Beach-Ormond Beach, FL	6265	BCBS FL	78	UnitedHealth Group	15
Gainesville, FL	3189	BCBS FL	48	SantaFe (AvMed)	21
Jacksonville, FL	3629	BCBS FL	55	UnitedHealth Group	18
Lakeland-Winter Haven, FL	2389	BCBS FL	36	UnitedHealth Group	21
Miami-Fort Lauderdale-Pompano Beach, FL	2495	SantaFe (AvMed)	34	UnitedHealth Group	27
Naples-Marco Island, FL	3761	BCBS FL	55	UnitedHealth Group	20
North Port-Sarasota-Bradenton, FL	4128	BCBS FL	58	Aetna	26
Ocala, FL	5164	BCBS FL	66	UnitedHealth Group	27
Orlando-Kissimmee-Sanford, FL	2876	BCBS FL	38	UnitedHealth Group	33
Palm Bay-Melbourne-Titusville, FL	4916	Health First Hlth	67	BCBS FL	19
Pensacola-Ferry Pass-Brent, FL	5394	BCBS FL	70	UnitedHealth Group	16
Port St. Lucie, FL	4239	BCBS FL	61	UnitedHealth Group	15
Punta Gorda, FL	4945	BCBS FL	68	Aetna	14
Sebastian-Vero Beach, FL	5612	Health First Hlth	72	UnitedHealth Group	21
Tallahassee, FL	9836	BCBS FL	99	UnitedHealth Group	0
Tampa-St. Petersburg-Clearwater, FL	2541	BCBS FL	40	UnitedHealth Group	20
Georgia	3164	Anthem	42	Kaiser	34
Albany, GA	9330	Anthem	97	UnitedHealth Group	3
Athens-Clarke County, GA	3626	Anthem	53	Humana	23
Atlanta-Sandy Springs-Alpharetta, GA	3228	Kaiser	44	Anthem	33
Augusta-Richmond County, GA-SC	4181	Anthem	59	Humana	26
Columbus, GA-AL	4971	Anthem	65	Humana	26
Gainesville, GA	3410	Anthem	52	Kaiser	20
Macon-Bibb County, GA	5576	Anthem	72	Humana	18
Savannah, GA	4057	Anthem	52	Humana	36
Warner Robins, GA	7433	Anthem	86	Humana	8
Hawaii	5095	HMSA (BCBS HI)	57	Kaiser	43
Kahului-Wailuku-Lahaina, HI	6404	Kaiser	76	HMSA (BCBS HI)	24
Urban Honolulu, HI	5244	HMSA (BCBS HI)	61	Kaiser	39
Idaho	4174	Intermountain	48	Kaiser	42
Boise City, ID	6426	Intermountain	78	Aetna	19
Coeur d'Alene, ID	7951	Kaiser	88	Intermountain	11
Illinois	6415	HCSC (BCBS)	79	Hlth Alliance	9
Bloomington, IL	7055	Hlth Alliance	83	Humana	10
Champaign-Urbana, IL	9618	Hlth Alliance	98	Aetna	1
Chicago-Naperville-Elgin, IL-IN-WI	7906	HCSC (BCBS)	89	UnitedHealth Group	4

Table 2. (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019. HMO product markets

State and MSAs	HMO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Davenport-Moline-Rock Island, IA-IL	2781	UnitedHealth Group	41	Wellmark (BCBS)	22
Peoria, IL	3282	Hlth Alliance	42	HCSC (BCBS)	35
Rockford, IL	5782	HCSC (BCBS)	75	Humana	10
Springfield, IL	4258	Hlth Alliance	55	HCSC (BCBS)	34
Indiana	4181	IU Health	51	Physicians Hlth Plan	40
Bloomington, IN	8091	IU Health	89	Physicians Hlth Plan	9
Indianapolis-Carmel-Anderson, IN	4615	Physicians Hlth Plan	63	IU Health	23
Lafayette-West Lafayette, IN	8076	IU Health	89	Physicians Hlth Plan	10
Muncie, IN	8098	IU Health	89	Physicians Hlth Plan	9
Iowa	3915	Wellmark (BCBS)	57	Medical Associates	18
Ames, IA	4320	Wellmark (BCBS)	56	UnitedHealth Group	33
Cedar Rapids, IA	7300	Wellmark (BCBS)	84	Medical Associates	13
Davenport-Moline-Rock Island, IA-IL	2781	UnitedHealth Group	41	Wellmark (BCBS)	22
Des Moines-West Des Moines, IA	4032	Wellmark (BCBS)	45	UnitedHealth Group	43
Iowa City, IA	4840	Wellmark (BCBS)	52	Medical Associates	46
Waterloo-Cedar Falls, IA	4450	Wellmark (BCBS)	50	Medical Associates	44
Kansas	4813	Aetna	65	BCBS KS	23
Wichita, KS	8327	Aetna	91	BCBS KS	8
Kentucky	3278	Humana	36	UnitedHealth Group	33
Lexington-Fayette, KY	3395	UnitedHealth Group	37	Humana	37
Louisville/Jefferson County, KY-IN	3039	Humana	36	UnitedHealth Group	33
Louisiana	4165	LA Hlth Serv & Ind (BCBS)	60	Vantage Hlth	17
Baton Rouge, LA	4176	LA Hlth Serv & Ind (BCBS)	59	Vantage Hlth	20
Lafayette, LA	6732	LA Hlth Serv & Ind (BCBS)	81	Humana	7
New Orleans-Metairie, LA	3378	LA Hlth Serv & Ind (BCBS)	49	Aetna	26
Shreveport-Bossier City, LA	3570	LA Hlth Serv & Ind (BCBS)	49	Aetna	29
Maine	4780	Anthem	60	Harvard Pilgrim	34
Bangor, ME	4694	Anthem	58	Harvard Pilgrim	36
Lewiston-Auburn, ME	5052	Anthem	64	Harvard Pilgrim	30
Portland-South Portland, ME	4745	Anthem	58	Harvard Pilgrim	38
Maryland	3985	CareFirst	57	Kaiser	23
Baltimore-Columbia-Towson, MD	4881	CareFirst	67	Kaiser	15
California-Lexington Park, MD	5044	CareFirst	66	Aetna	25
Hagerstown-Martinsburg, MD-WV	3702	CareFirst	56	UnitedHealth Group	15
Salisbury, MD-DE	2823	Aetna	34	CareFirst	31
Massachusetts	3081	BCBS MA	47	Harvard Pilgrim	24
Barnstable Town, MA	4102	BCBS MA	56	Harvard Pilgrim	30
Boston-Cambridge-Newton, MA-NH	2965	BCBS MA	43	Harvard Pilgrim	29
Pittsfield, MA	4859	BCBS MA	63	Baystate	29
Springfield, MA	2871	BCBS MA	36	Baystate	36
Worcester, MA-CT	2983	BCBS MA	49	Harvard Pilgrim	15
Michigan	3765	BCBS MI	55	Spectrum Hlth	23
Ann Arbor, MI	6068	BCBS MI	76	Spectrum Hlth	14
Battle Creek, MI	6655	BCBS MI	79	Spectrum Hlth	20
Bay City, MI	5480	BCBS MI	69	Henry Ford HS	27

State and MSAs	HMO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Detroit-Warren-Dearborn, MI	4379	BCBS MI	61	Henry Ford HS	24
Flint, MI	3864	BCBS MI	51	Henry Ford HS	34
Grand Rapids-Kentwood, MI	5421	Spectrum Hlth	65	BCBS MI	35
Jackson, MI	4718	BCBS MI	63	Spectrum Hlth	24
Kalamazoo-Portage, MI	6463	BCBS MI	77	Spectrum Hlth	23
Lansing-East Lansing, MI	4724	Sparrow (Physicians HP)	52	BCBS MI	45
Midland, MI	9018	BCBS MI	95	Henry Ford HS	5
Monroe, MI	3729	BCBS MI	55	Henry Ford HS	22
Muskegon, MI	5003	Spectrum Hlth	53	BCBS MI	47
Niles, MI	7217	BCBS MI	83	Spectrum Hlth	16
Saginaw, MI	4221	BCBS MI	53	Henry Ford HS	37
Minnesota	4950	HealthPartners	64	BCBS MN	28
Minneapolis-St. Paul-Bloomington, MN-WI	4471	HealthPartners	63	BCBS MN	17
Missouri	4100	BCBS KS City	56	Anthem	30
Kansas City, MO-KS	6054	BCBS KS City	76	Aetna	15
St. Louis, MO-IL	4028	Anthem	60	HCSC (BCBS)	12
Nevada	7271	UnitedHealth Group	85	Renown Hlth	5
Las Vegas-Henderson-Paradise, NV	9078	UnitedHealth Group	95	Aetna	3
Reno, NV	3397	Renown Hlth	43	UHS (Prominence HP)	36
New Hampshire	5446	Anthem	65	Harvard Pilgrim	34
Manchester-Nashua, NH	5680	Anthem	69	Harvard Pilgrim	31
New Jersey	4631	Aetna	65	UnitedHealth Group	17
Trenton-Princeton, NJ	7674	Aetna	87	UnitedHealth Group	6
Vineland-Bridgeton, NJ	9358	Aetna	97	Horizon BCBS	2
New Mexico	5640	Presbyterian	73	Evolent (True Hlth)	11
Albuquerque, NM	5133	Presbyterian	69	Evolent (True Hlth)	14
Las Cruces, NM	7607	Presbyterian	87	HCSC (BCBS)	6
Santa Fe, NM	6966	Presbyterian	83	Evolent (True Hlth)	7
New York	2485	Anthem	34	EmblemHealth	33
Albany-Schenectady-Troy, NY	4917	CDPHP	67	MVP Hlth Care	18
Buffalo-Cheektowaga, NY	5559	Independent Hlth	71	HealthNow NY (BCBS)	23
Kingston, NY	3603	MVP Hlth Care	48	CDPHP	34
New York-Newark-Jersey City, NY-NJ-PA	3156	EmblemHealth	40	Anthem	38
Poughkeepsie-Newburgh-Middletown, NY	3028	Anthem	43	MVP Hlth Care	29
Rochester, NY	5013	MVP Hlth Care	57	Lifetime Hlthcare	42
Syracuse, NY	6964	MVP Hlth Care	82	Lifetime Hlthcare	16
Utica-Rome, NY	9415	MVP Hlth Care	97	CDPHP	3
North Carolina	5517	UnitedHealth Group	73	FirstHealth	8
Asheville, NC	6869	UnitedHealth Group	81	BCBS NC	19
Charlotte-Concord-Gastonia, NC-SC	5672	UnitedHealth Group	73	BCBS SC	12
Durham-Chapel Hill, NC	5699	UnitedHealth Group	74	BCBS NC	10
Greensboro-High Point, NC	8381	UnitedHealth Group	91	BCBS NC	4
Raleigh-Cary, NC	5374	UnitedHealth Group	71	Cigna	16
Winston-Salem, NC	7728	UnitedHealth Group	87	BCBS NC	9

Table 2. (continued)Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019. *HMO product markets*

State and MSAs	HMO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
North Dakota	9698	Sanford	98	Avera Hlth	1
Bismarck, ND	9978	Sanford	100	HealthPartners	0
Fargo, ND-MN	9700	Sanford	98	BCBS MN	1
Grand Forks, ND-MN	9718	Sanford	99	BCBS MN	1
Ohio	1976	ProMedica	31	Humana	21
Akron, OH	2040	Aetna	30	Humana	25
Cincinnati, OH-KY-IN	3006	Humana	46	UnitedHealth Group	24
Cleveland-Elyria, OH	2780	Aetna	35	Medical Mutual	34
Columbus, OH	3659	Humana	49	Aetna	30
Toledo, OH	8424	ProMedica	92	Humana	4
Youngstown-Warren-Boardman, OH-PA	2082	Highmark	32	Aetna	21
Oklahoma	3325	CommunityCare	49	GlobalHealth	25
Oklahoma City, OK	2906	CommunityCare	43	UnitedHealth Group	24
Tulsa, OK	4031	CommunityCare	58	GlobalHealth	23
Oregon	9411	Kaiser	97	PacificSource	3
Eugene-Springfield, OR	5731	PacificSource	69	Kaiser	31
Portland-Vancouver-Hillsboro, OR-WA	9883	Kaiser	99	PacificSource	0
Salem, OR	9818	Kaiser	99	PacificSource	1
Pennsylvania	2334	Independence Hlth Grp	36	Aetna	22
Allentown-Bethlehem-Easton, PA-NJ	3297	Aetna	51	Capital BC	23
Bloomsburg-Berwick, PA	9752	Geisinger	99	Capital BC	1
East Stroudsburg, PA	3789	Highmark	47	Geisinger	38
Erie, PA	5874	Highmark	74	Aetna	20
Harrisburg-Carlisle, PA	4161	Aetna	57	Geisinger	22
Lancaster, PA	4405	Capital BC	50	Aetna	43
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	4343	Independence Hlth Grp	52	Aetna	39
Pittsburgh, PA	4068	Highmark	47	UPMC	42
Reading, PA	4671	Aetna	53	Capital BC	43
Scranton--Wilkes-Barre, PA	6855	Geisinger	81	Highmark	18
State College, PA	4125	Highmark	52	Geisinger	37
Williamsport, PA	5909	Geisinger	72	Highmark	26
York-Hanover, PA	3549	Aetna	49	Capital BC	30
Rhode Island	4548	Tufts	58	Harvard Pilgrim	34
Providence-Warwick, RI-MA	4183	BCBS MA	60	Harvard Pilgrim	18
South Carolina	7713	BCBS SC	87	UnitedHealth Group	6
Charleston-North Charleston, SC	7761	BCBS SC	88	Aetna	9
Columbia, SC	8314	BCBS SC	91	Aetna	6
Greenville-Anderson, SC	8855	BCBS SC	94	UnitedHealth Group	3
South Dakota	4988	Avera Hlth	51	Sanford	49
Rapid City, SD	4998	Sanford	51	Avera Hlth	48
Sioux Falls, SD	5493	Sanford	66	Avera Hlth	34
Tennessee	4233	Humana	61	Aetna	15
Chattanooga, TN-GA	6094	Anthem	76	Humana	16
Kingsport-Bristol, TN-VA	4609	Anthem	62	UnitedHealth Group	26
Memphis, TN-MS-AR	2885	Humana	36	Cigna	29

State and MSAs	HMO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Texas	2475	Baylor Scott & White	45	Aetna	12
Amarillo, TX	9117	Baylor Scott & White	95	UnitedHealth Group	3
Austin-Round Rock-Georgetown, TX	2742	Baylor Scott & White	36	Sendero Hlth Plans	34
College Station-Bryan, TX	9725	Baylor Scott & White	99	UnitedHealth Group	1
Dallas-Fort Worth-Arlington, TX	3081	Aetna	42	HCSC (BCBS)	31
Houston-The Woodlands-Sugar Land, TX	1646	Aetna	25	Memorial Hermann	17
Killeen-Temple, TX	9723	Baylor Scott & White	99	Humana	1
Lubbock, TX	9415	Baylor Scott & White	97	HCSC (BCBS)	1
San Antonio-New Braunfels, TX	2997	University HS (CFHP)	43	UnitedHealth Group	29
Waco, TX	9667	Baylor Scott & White	98	Humana	1
Utah	6133	Intermountain	75	Aetna	24
Logan, UT-ID	8171	Intermountain	90	Aetna	9
Ogden-Clearfield, UT	5076	Intermountain	58	Aetna	41
Provo-Orem, UT	7859	Intermountain	88	Aetna	10
Salt Lake City, UT	6639	Intermountain	79	Aetna	18
St. George, UT	7657	Intermountain	87	Aetna	11
Vermont	8806	BCBS VT	94	Harvard Pilgrim	3
Burlington-South Burlington, VT	9479	BCBS VT	97	MVP Hlth Care	2
Virginia	1894	Kaiser	26	Anthem	23
Blacksburg-Christiansburg, VA	5585	Anthem	73	Sentara (Optima Hlth)	15
Charlottesville, VA	2557	Anthem	35	Centra (Piedmont)	26
Harrisonburg, VA	4352	Anthem	60	Sentara (Optima Hlth)	24
Lynchburg, VA	3276	Anthem	44	Centra (Piedmont)	28
Richmond, VA	2942	Anthem	43	Aetna	23
Roanoke, VA	3615	Anthem	49	Aetna	28
Staunton, VA	4520	Anthem	62	Aetna	22
Virginia Beach-Norfolk-Newport News, VA-NC	5486	Sentara (Optima Hlth)	68	Anthem	28
Winchester, VA-WV	3086	Anthem	49	Sentara (Optima Hlth)	21
Washington	9939	Kaiser	100	UnitedHealth Group	0
Bellingham, WA	9990	Kaiser	100	UnitedHealth Group	0
Bremerton-Silverdale-Port Orchard, WA	9983	Kaiser	100	UnitedHealth Group	0
Kennewick-Richland, WA	9954	Kaiser	100	UnitedHealth Group	0
Longview, WA	9994	Kaiser	100	UnitedHealth Group	0
Olympia-Lacey-Tumwater, WA	9980	Kaiser	100	UnitedHealth Group	0
Seattle-Tacoma-Bellevue, WA	9946	Kaiser	100	UnitedHealth Group	0
Spokane-Spokane Valley, WA	9987	Kaiser	100	UnitedHealth Group	0
Yakima, WA	8637	Kaiser	93	Hlth Alliance	7
West Virginia	5328	Hlth Plan Upper Ohio	71	UnitedHealth Group	11
Wisconsin	1840	Quartz	32	SSM Health (Dean HP)	21
Appleton, WI	2525	Marshfield (Security HP)	40	Ascension	24
Eau Claire, WI	3890	Marshfield (Security HP)	57	Anthem	20
Fond du Lac, WI	5747	Quartz	75	SSM Health (Dean HP)	8
Green Bay, WI	2323	Marshfield (Security HP)	36	SSM Health (Dean HP)	23
Janesville-Beloit, WI	3966	Quartz	55	SSM Health (Dean HP)	29
La Crosse-Onalaska, WI-MN	2802	Marshfield (Security HP)	38	Quartz	32

Table 2. (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019. HMO product markets

State and MSAs	HMO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Madison, WI	3232	Quartz	40	SSM Health (Dean HP)	33
Milwaukee-Waukesha, WI	2818	Anthem	44	Ascension	22
Oshkosh-Neenah, WI	2709	Marshfield (Security HP)	43	Ascension	20
Racine, WI	2719	Anthem	37	Ascension	31
Sheboygan, WI	2195	Anthem	28	Ascension	26
Wausau-Weston, WI	2902	Marshfield (Security HP)	46	Anthem	18

Notes:

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2. State and MSA-level Herfindahl-Hirschman Indices (HHIs) and the market shares of the two largest insurers in the HMO product market are reported.
3. Data are based on enrollments in both fully and self-insured health plans.
4. We do not present data for geographic areas with fewer than 5,000 reported HMO enrollees.
5. The HHIs and market shares are rounded. As a result, in a few markets where the second largest insurer has very few covered lives, the market share appears as zero. The actual, unrounded shares are just above 0 percent.

**Table 3. Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019
PPO product markets**

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Alabama	8442	BCBS AL	92	Cigna	4
Anniston-Oxford, AL	8795	BCBS AL	94	Cigna	3
Auburn-Opelika, AL	7831	BCBS AL	88	Cigna	8
Birmingham-Hoover, AL	8391	BCBS AL	91	Cigna	4
Daphne-Fairhope-Foley, AL	7765	BCBS AL	88	Cigna	5
Decatur, AL	8464	BCBS AL	92	Cigna	6
Dothan, AL	8935	BCBS AL	94	Cigna	3
Florence-Muscle Shoals, AL	8301	BCBS AL	91	Cigna	5
Gadsden, AL	9072	BCBS AL	95	Cigna	2
Huntsville, AL	8211	BCBS AL	90	Cigna	5
Mobile, AL	8365	BCBS AL	91	Cigna	4
Montgomery, AL	8661	BCBS AL	93	Cigna	3
Tuscaloosa, AL	9133	BCBS AL	96	Cigna	2
Alaska	4524	Aetna	54	Premera	39
Anchorage, AK	4192	Aetna	46	Premera	45
Fairbanks, AK	4537	Aetna	50	Premera	45
Arizona	2907	Aetna	35	BCBS AZ	29
Flagstaff, AZ	5262	BCBS AZ	71	Aetna	12
Lake Havasu City-Kingman, AZ	3731	BCBS AZ	56	Cigna	18
Phoenix-Mesa-Chandler, AZ	2974	Aetna	34	Cigna	34
Prescott Valley-Prescott, AZ	4235	BCBS AZ	61	Aetna	16
Sierra Vista-Douglas, AZ	3437	BCBS AZ	52	Cigna	21
Tucson, AZ	2973	BCBS AZ	38	Aetna	33
Yuma, AZ	3908	BCBS AZ	58	Cigna	16
Arkansas	4503	BCBS AR	64	Cigna	15
Fayetteville-Springdale-Rogers, AR	4371	BCBS AR	62	Cigna	18
Fort Smith, AR-OK	2548	BCBS AR	36	HCSC (BCBS)	24
Hot Springs, AR	4556	BCBS AR	65	Cigna	12
Jonesboro, AR	5268	BCBS AR	69	Cigna	21
Little Rock-North Little Rock-Conway, AR	4992	BCBS AR	68	Cigna	16
Pine Bluff, AR	6349	BCBS AR	79	Cigna	9
California	3092	Anthem	47	BS of CA	23
Bakersfield, CA	4355	Anthem	61	BS of CA	24
Chico, CA	4613	Anthem	60	BS of CA	32
El Centro, CA	3842	BS of CA	55	Anthem	26
Fresno, CA	3994	Anthem	51	BS of CA	36
Hanford-Corcoran, CA	4107	Anthem	52	BS of CA	37
Los Angeles-Long Beach-Anaheim, CA	3235	Anthem	49	BS of CA	23
Madera, CA	4039	Anthem	54	BS of CA	33
Merced, CA	4372	Anthem	58	BS of CA	32
Modesto, CA	3637	Anthem	51	BS of CA	29
Napa, CA	4994	Anthem	67	BS of CA	20
Oxnard-Thousand Oaks-Ventura, CA	3711	Anthem	55	BS of CA	22
Redding, CA	4559	Anthem	60	BS of CA	30
Riverside-San Bernardino-Ontario, CA	3473	Anthem	53	BS of CA	19

Table 3. (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019. PPO product markets

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Sacramento-Roseville-Folsom, CA	2945	Anthem	45	BS of CA	23
Salinas, CA	4088	Anthem	55	BS of CA	32
San Diego-Chula Vista-Carlsbad, CA	2527	Anthem	39	BS of CA	20
San Francisco-Oakland-Berkeley, CA	2550	Anthem	37	BS of CA	22
San Jose-Sunnyvale-Santa Clara, CA	2582	Anthem	36	Aetna	24
San Luis Obispo-Paso Robles, CA	4801	Anthem	64	BS of CA	25
Santa Cruz-Watsonville, CA	3760	Anthem	55	BS of CA	24
Santa Maria-Santa Barbara, CA	3841	Anthem	53	BS of CA	31
Santa Rosa-Petaluma, CA	3077	Anthem	43	BS of CA	32
Stockton, CA	3616	Anthem	54	BS of CA	21
Vallejo, CA	2887	Anthem	44	BS of CA	21
Visalia, CA	4688	Anthem	63	BS of CA	25
Yuba City, CA	5219	Anthem	68	BS of CA	24
Colorado	3186	Cigna	45	Anthem	27
Boulder, CO	3373	Cigna	49	Anthem	23
Colorado Springs, CO	2949	Cigna	39	Anthem	31
Denver-Aurora-Lakewood, CO	3565	Cigna	52	Anthem	22
Fort Collins, CO	3310	Anthem	42	Cigna	36
Grand Junction, CO	3742	Cigna	53	Anthem	29
Greeley, CO	3636	Cigna	52	Aetna	23
Pueblo, CO	3667	Anthem	47	Cigna	37
Connecticut	2780	Cigna	31	Aetna	31
Bridgeport-Stamford-Norwalk, CT	2764	Aetna	34	Cigna	33
Hartford-East Hartford-Middletown, CT	3014	Cigna	38	Aetna	29
New Haven-Milford, CT	2869	Aetna	34	Anthem	32
Norwich-New London, CT	3392	Anthem	49	Aetna	22
Delaware	5235	Highmark	69	Aetna	22
Dover, DE	6322	Highmark	78	Aetna	13
District of Columbia	2098	CareFirst	32	Aetna	21
Washington-Arlington-Alexandria, DC-VA-MD-WV	2182	CareFirst	28	Cigna	26
Florida	3097	BCBS FL	42	Cigna	29
Cape Coral-Fort Myers, FL	2852	BCBS FL	38	Aetna	28
Crestview-Fort Walton Beach-Destin, FL	5013	BCBS FL	69	Aetna	12
Deltona-Daytona Beach-Ormond Beach, FL	2887	BCBS FL	41	Cigna	28
Gainesville, FL	6306	BCBS FL	78	Aetna	14
Homosassa Springs, FL	5023	BCBS FL	69	Cigna	10
Jacksonville, FL	3979	BCBS FL	56	Aetna	26
Lakeland-Winter Haven, FL	2939	Cigna	36	BCBS FL	33
Miami-Fort Lauderdale-Pompano Beach, FL	3047	BCBS FL	36	Cigna	34
Naples-Marco Island, FL	3521	BCBS FL	48	Cigna	33
North Port-Sarasota-Bradenton, FL	2947	BCBS FL	43	Aetna	24
Ocala, FL	5087	BCBS FL	69	Aetna	13
Orlando-Kissimmee-Sanford, FL	3513	Cigna	50	BCBS FL	26
Palm Bay-Melbourne-Titusville, FL	3479	Cigna	50	BCBS FL	29
Panama City, FL	6339	BCBS FL	79	Cigna	9

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Pensacola-Ferry Pass-Brent, FL	4985	BCBS FL	68	Aetna	14
Port St. Lucie, FL	4223	BCBS FL	60	Cigna	23
Punta Gorda, FL	3122	BCBS FL	46	Cigna	24
Sebastian-Vero Beach, FL	5185	BCBS FL	70	Cigna	16
Sebring-Avon Park, FL	3561	BCBS FL	52	Cigna	27
Tallahassee, FL	5882	BCBS FL	75	Cigna	10
Tampa-St. Petersburg-Clearwater, FL	2882	BCBS FL	33	Cigna	33
The Villages, FL	4832	BCBS FL	67	Aetna	10
Georgia	2930	Anthem	34	Aetna	30
Albany, GA	4357	Anthem	62	Aetna	16
Athens-Clarke County, GA	2883	Anthem	40	Cigna	30
Atlanta-Sandy Springs-Alpharetta, GA	3004	Cigna	33	Aetna	32
Augusta-Richmond County, GA-SC	2493	BCBS SC	32	Anthem	32
Brunswick, GA	3714	Anthem	55	Cigna	21
Columbus, GA-AL	2939	Anthem	44	Cigna	26
Dalton, GA	3843	Cigna	56	Anthem	19
Gainesville, GA	3149	Cigna	42	Anthem	30
Hinesville, GA	4411	Anthem	63	Cigna	15
Macon-Bibb County, GA	3851	Anthem	56	Aetna	22
Rome, GA	3268	Cigna	45	Anthem	30
Savannah, GA	2651	Cigna	34	Anthem	30
Valdosta, GA	3875	Anthem	58	Cigna	18
Warner Robins, GA	5984	Anthem	76	Aetna	8
Hawaii	5919	HMSA (BCBS HI)	75	Univ Hlth Alliance	13
Kahului-Wailuku-Lahaina, HI	5188	HMSA (BCBS HI)	69	Univ Hlth Alliance	19
Urban Honolulu, HI	5925	HMSA (BCBS HI)	75	Univ Hlth Alliance	13
Idaho	3014	BC of ID	50	Cambia	17
Boise City, ID	2865	BC of ID	47	Cambia	17
Coeur d'Alene, ID	1864	BC of ID	30	Cambia	23
Idaho Falls, ID	3751	BC of ID	58	Cigna	12
Lewiston, ID-WA	2376	Premera	33	Cambia	26
Pocatello, ID	3654	BC of ID	57	Cambia	16
Twin Falls, ID	3218	BC of ID	52	Cambia	19
Illinois	4621	HCSC (BCBS)	65	Aetna	17
Bloomington, IL	6211	HCSC (BCBS)	78	Aetna	9
Carbondale-Marion, IL	3383	HCSC (BCBS)	52	Cigna	22
Champaign-Urbana, IL	2562	Hlth Alliance	36	HCSC (BCBS)	29
Chicago-Naperville-Elgin, IL-IN-WI	4557	HCSC (BCBS)	65	Aetna	13
Danville, IL	4312	HCSC (BCBS)	63	Hlth Alliance	15
Davenport-Moline-Rock Island, IA-IL	2727	HCSC (BCBS)	45	Wellmark (BCBS)	19
Decatur, IL	6190	HCSC (BCBS)	78	Aetna	8
Kankakee, IL	5815	HCSC (BCBS)	75	Aetna	11
Peoria, IL	3506	HCSC (BCBS)	52	UnitedHealth Group	26
Rockford, IL	5726	HCSC (BCBS)	74	Cigna	12
Springfield, IL	3663	HCSC (BCBS)	56	Aetna	19

Table 3. (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019. PPO product markets

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Indiana	4621	Anthem	65	Cigna	16
Bloomington, IN	5992	Anthem	76	Aetna	12
Columbus, IN	5318	Anthem	71	Aetna	16
Elkhart-Goshen, IN	4866	Anthem	67	Cigna	18
Evansville, IN-KY	5029	Anthem	69	Cigna	16
Fort Wayne, IN	4082	Anthem	59	Cigna	22
Indianapolis-Carmel-Anderson, IN	5077	Anthem	69	Cigna	15
Kokomo, IN	6793	Anthem	82	Cigna	9
Lafayette-West Lafayette, IN	5206	Anthem	71	Cigna	10
Michigan City-La Porte, IN	5926	Anthem	75	Cigna	14
Muncie, IN	6575	Anthem	80	Cigna	11
South Bend-Mishawaka, IN-MI	3336	Anthem	52	BCBS MI	18
Terre Haute, IN	6002	Anthem	76	Cigna	12
Iowa	4916	Wellmark (BCBS)	67	Cigna	17
Ames, IA	7219	Wellmark (BCBS)	85	Aetna	6
Cedar Rapids, IA	4964	Wellmark (BCBS)	67	Cigna	20
Davenport-Moline-Rock Island, IA-IL	2727	HCSC (BCBS)	45	Wellmark (BCBS)	19
Des Moines-West Des Moines, IA	4445	Wellmark (BCBS)	62	Cigna	21
Dubuque, IA	5115	Wellmark (BCBS)	68	Cigna	22
Iowa City, IA	7166	Wellmark (BCBS)	84	Cigna	9
Sioux City, IA-NE-SD	2834	Wellmark (BCBS)	47	Cigna	16
Waterloo-Cedar Falls, IA	4516	Wellmark (BCBS)	59	Cigna	32
Kansas	3074	BCBS KS	48	BCBS KS City	18
Lawrence, KS	3464	BCBS KS	51	Cigna	20
Manhattan, KS	6105	BCBS KS	77	Aetna	6
Topeka, KS	6631	BCBS KS	81	Cigna	8
Wichita, KS	4438	BCBS KS	60	Aetna	28
Kentucky	5462	Anthem	72	Humana	14
Bowling Green, KY	4759	Anthem	66	Humana	17
Elizabethtown-Fort Knox, KY	5783	Anthem	74	Humana	14
Lexington-Fayette, KY	5796	Anthem	74	Humana	16
Louisville/Jefferson County, KY-IN	5056	Anthem	69	Humana	13
Owensboro, KY	6843	Anthem	82	Humana	9
Louisiana	5751	LA Hlth Serv & Ind (BCBS)	75	Cigna	10
Alexandria, LA	6583	LA Hlth Serv & Ind (BCBS)	81	Cigna	7
Baton Rouge, LA	5800	LA Hlth Serv & Ind (BCBS)	75	Cigna	11
Hammond, LA	5918	LA Hlth Serv & Ind (BCBS)	76	Cigna	10
Houma-Thibodaux, LA	6306	LA Hlth Serv & Ind (BCBS)	79	Cigna	9
Lafayette, LA	6148	LA Hlth Serv & Ind (BCBS)	77	Cigna	11
Lake Charles, LA	5541	LA Hlth Serv & Ind (BCBS)	73	Cigna	14
Monroe, LA	6385	LA Hlth Serv & Ind (BCBS)	79	Cigna	8
New Orleans-Metairie, LA	5649	LA Hlth Serv & Ind (BCBS)	74	Cigna	10
Shreveport-Bossier City, LA	6138	LA Hlth Serv & Ind (BCBS)	78	Cigna	8
Maine	2866	Anthem	42	Cigna	25
Bangor, ME	2751	Cigna	35	Anthem	34

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Lewiston-Auburn, ME	2826	Cigna	35	Anthem	30
Portland-South Portland, ME	2853	Anthem	42	Cigna	23
Maryland	3458	CareFirst	48	Cigna	27
Baltimore-Columbia-Towson, MD	3655	CareFirst	50	Cigna	30
California-Lexington Park, MD	4477	CareFirst	62	Cigna	23
Cumberland, MD-WV	3116	CareFirst	41	Cigna	35
Hagerstown-Martinsburg, MD-WV	2430	Cigna	33	Aetna	24
Salisbury, MD-DE	3429	Highmark	50	CareFirst	26
Massachusetts	2212	BCBS MA	37	Tufts	19
Barnstable Town, MA	3006	Harvard Pilgrim	44	BCBS MA	30
Boston-Cambridge-Newton, MA-NH	1881	BCBS MA	33	Tufts	16
Pittsfield, MA	2850	BCBS MA	46	Cigna	21
Springfield, MA	2265	Cigna	31	BCBS MA	26
Worcester, MA-CT	1825	BCBS MA	28	Tufts	18
Michigan	6074	BCBS MI	77	Aetna	8
Ann Arbor, MI	7075	BCBS MI	84	Aetna	9
Battle Creek, MI	7154	BCBS MI	84	Spectrum Hlth	4
Bay City, MI	6387	BCBS MI	79	Henry Ford HS	10
Detroit-Warren-Dearborn, MI	6185	BCBS MI	78	Aetna	8
Flint, MI	6502	BCBS MI	80	Aetna	7
Grand Rapids-Kentwood, MI	5449	BCBS MI	73	Spectrum Hlth	10
Jackson, MI	7182	BCBS MI	84	Henry Ford HS	9
Kalamazoo-Portage, MI	7662	BCBS MI	87	Henry Ford HS	3
Lansing-East Lansing, MI	7992	BCBS MI	89	Aetna	3
Midland, MI	5359	BCBS MI	68	Aetna	26
Monroe, MI	6789	BCBS MI	82	Aetna	9
Muskegon, MI	5798	BCBS MI	75	Spectrum Hlth	9
Niles, MI	6068	BCBS MI	77	Henry Ford HS	8
Saginaw, MI	5802	BCBS MI	75	Henry Ford HS	14
Minnesota	3318	BCBS MN	51	HealthPartners	18
Duluth, MN-WI	3499	BCBS MN	53	HealthPartners	18
Mankato, MN	4963	BCBS MN	66	Medica	22
Minneapolis-St. Paul-Bloomington, MN-WI	2744	BCBS MN	44	HealthPartners	22
Rochester, MN	5139	BCBS MN	68	Medica	23
St. Cloud, MN	3936	BCBS MN	57	Medica	18
Mississippi	5623	BCBS MS	73	Cigna	14
Gulfport-Biloxi, MS	6001	BCBS MS	76	Cigna	10
Hattiesburg, MS	6410	BCBS MS	79	Cigna	9
Jackson, MS	6002	BCBS MS	76	Aetna	11
Missouri	2154	Anthem	32	BCBS KS City	22
Cape Girardeau, MO-IL	3118	Anthem	51	Cigna	12
Columbia, MO	2742	Anthem	42	Aetna	22
Jefferson City, MO	3240	Anthem	48	Aetna	26
Joplin, MO	2610	Anthem	41	CoxHealth	22
Kansas City, MO-KS	3795	BCBS KS City	56	Cigna	19

Table 3. (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019. PPO product markets

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Springfield, MO	2054	CoxHealth	28	Anthem	23
St. Joseph, MO-KS	4876	BCBS KS City	68	Aetna	13
St. Louis, MO-IL	2468	Anthem	35	Cigna	28
Montana	3510	HCSC (BCBS)	44	Cigna	39
Billings, MT	3553	HCSC (BCBS)	47	Cigna	36
Great Falls, MT	4234	HCSC (BCBS)	55	Cigna	34
Missoula, MT	3638	HCSC (BCBS)	44	Cigna	40
Nebraska	5161	BCBS NE	69	Aetna	17
Grand Island, NE	6223	BCBS NE	78	Aetna	9
Lincoln, NE	6063	BCBS NE	76	Aetna	14
Omaha-Council Bluffs, NE-IA	3968	BCBS NE	57	Aetna	24
Nevada	2009	Anthem	30	Aetna	20
Carson City, NV	2766	Anthem	46	UHS (Prominence HP)	17
Las Vegas-Henderson-Paradise, NV	1955	Anthem	26	Cigna	20
Reno, NV	2190	Anthem	36	Renown Hlth	20
New Hampshire	3055	Cigna	42	Anthem	34
Manchester-Nashua, NH	2911	Cigna	43	Anthem	28
New Jersey	2872	Aetna	37	Horizon BCBS	31
Atlantic City-Hammonton, NJ	6083	Horizon BCBS	77	Aetna	11
Ocean City, NJ	4335	Horizon BCBS	62	Aetna	19
Trenton-Princeton, NJ	3618	Aetna	52	Horizon BCBS	24
Vineland-Bridgeton, NJ	3770	Horizon BCBS	54	Aetna	24
New Mexico	4733	HCSC (BCBS)	66	Presbyterian	13
Albuquerque, NM	3745	HCSC (BCBS)	55	Presbyterian	23
Farmington, NM	4191	HCSC (BCBS)	60	Cigna	20
Las Cruces, NM	6382	HCSC (BCBS)	79	Cigna	8
Santa Fe, NM	4333	HCSC (BCBS)	62	Presbyterian	16
New York	1468	Aetna	18	UnitedHealth Group	18
Albany-Schenectady-Troy, NY	2191	UnitedHealth Group	31	CDPHP	30
Binghamton, NY	4068	Lifetime Hlthcare	59	UnitedHealth Group	22
Buffalo-Cheektowaga, NY	1783	Independent Hlth	25	Lifetime Hlthcare	23
Elmira, NY	5186	Lifetime Hlthcare	70	UnitedHealth Group	15
Glens Falls, NY	1951	UnitedHealth Group	29	CDPHP	26
Ithaca, NY	3314	Lifetime Hlthcare	40	Aetna	38
Kingston, NY	2190	UnitedHealth Group	36	MVP Hlth Care	23
New York-Newark-Jersey City, NY-NJ-PA	1676	Aetna	23	Anthem	20
Poughkeepsie-Newburgh-Middletown, NY	1798	UnitedHealth Group	26	Anthem	23
Rochester, NY	6728	Lifetime Hlthcare	81	MVP Hlth Care	6
Syracuse, NY	5458	Lifetime Hlthcare	72	UnitedHealth Group	12
Utica-Rome, NY	4430	Lifetime Hlthcare	62	UnitedHealth Group	22
Watertown-Fort Drum, NY	4137	Lifetime Hlthcare	60	UnitedHealth Group	19
North Carolina	4455	BCBS NC	62	Cigna	22
Asheville, NC	4743	BCBS NC	65	Cigna	20
Burlington, NC	4393	BCBS NC	61	Cigna	22
Charlotte-Concord-Gastonia, NC-SC	2913	BCBS NC	41	Cigna	30

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Durham-Chapel Hill, NC	4116	BCBS NC	57	Aetna	26
Fayetteville, NC	5605	BCBS NC	73	Cigna	12
Goldensboro, NC	6579	BCBS NC	80	Cigna	15
Greensboro-High Point, NC	4841	BCBS NC	65	Cigna	22
Greenville, NC	6651	BCBS NC	80	Cigna	15
Hickory-Lenoir-Morganton, NC	6424	BCBS NC	79	Cigna	13
Jacksonville, NC	6135	BCBS NC	77	Aetna	12
New Bern, NC	6284	BCBS NC	78	Cigna	12
Raleigh-Cary, NC	4038	BCBS NC	56	Cigna	24
Rocky Mount, NC	6402	BCBS NC	79	Cigna	12
Wilmington, NC	4970	BCBS NC	67	Cigna	18
Winston-Salem, NC	4335	BCBS NC	57	Cigna	33
North Dakota	6548	BCBS ND	80	Cigna	6
Bismarck, ND	6517	BCBS ND	80	Aetna	6
Fargo, ND-MN	3130	BCBS ND	44	BCBS MN	31
Grand Forks, ND-MN	3308	BCBS ND	44	BCBS MN	34
Ohio	2677	Anthem	36	Medical Mutual	33
Akron, OH	3031	Medical Mutual	47	Anthem	25
Canton-Massillon, OH	2975	Medical Mutual	47	Anthem	22
Cincinnati, OH-KY-IN	4292	Anthem	63	Aetna	12
Cleveland-Elyria, OH	3605	Medical Mutual	55	Anthem	21
Columbus, OH	2464	Anthem	33	Aetna	30
Dayton-Kettering, OH	4118	Anthem	62	Aetna	10
Lima, OH	2912	Medical Mutual	45	Anthem	25
Mansfield, OH	3715	Medical Mutual	56	Anthem	19
Springfield, OH	2919	Anthem	47	Aetna	18
Toledo, OH	2685	Medical Mutual	39	Anthem	26
Weirton-Steubenville, WV-OH	2296	Anthem	37	Aetna	21
Youngstown-Warren-Boardman, OH-PA	2177	Medical Mutual	31	Anthem	30
Oklahoma	4895	HCSC (BCBS)	67	Aetna	15
Enid, OK	5425	HCSC (BCBS)	71	Cigna	17
Lawton, OK	5848	HCSC (BCBS)	75	Cigna	10
Oklahoma City, OK	4756	HCSC (BCBS)	66	Aetna	14
Tulsa, OK	4214	HCSC (BCBS)	60	Aetna	20
Oregon	2016	Cambia	32	Providence Hlth	24
Albany-Lebanon, OR	2186	Cambia	38	PacificSource	15
Bend, OR	2114	Cambia	37	PacificSource	16
Corvallis, OR	2853	Cambia	47	Moda Health	18
Eugene-Springfield, OR	2174	Cambia	31	PacificSource	27
Grants Pass, OR	2383	Cambia	36	PacificSource	29
Medford, OR	2166	Cambia	37	PacificSource	18
Portland-Vancouver-Hillsboro, OR-WA	2169	Providence Hlth	32	Cambia	28
Salem, OR	2432	Cambia	40	Providence Hlth	20
Pennsylvania	2077	Highmark	34	Aetna	23
Allentown-Bethlehem-Easton, PA-NJ	2432	Highmark	41	Capital BC	19

Table 3. (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019. PPO product markets

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Altoona, PA	3117	Highmark	39	UPMC	36
Bloomsburg-Berwick, PA	2922	Highmark	46	Capital BC	22
Chambersburg-Waynesboro, PA	3854	Highmark	57	Capital BC	21
East Stroudsburg, PA	4287	Highmark	62	Aetna	16
Erie, PA	3488	Highmark	46	UPMC	32
Gettysburg, PA	3597	Highmark	54	Capital BC	23
Harrisburg-Carlisle, PA	3356	Highmark	51	Capital BC	21
Johnstown, PA	3290	Highmark	43	UPMC	34
Lancaster, PA	3517	Highmark	51	Capital BC	26
Lebanon, PA	3972	Highmark	58	Capital BC	20
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	2490	Aetna	35	Independence Hlth Grp	31
Pittsburgh, PA	3081	Highmark	39	UPMC	35
Reading, PA	3087	Highmark	47	Capital BC	24
Scranton--Wilkes-Barre, PA	4446	Highmark	64	Aetna	14
State College, PA	3146	Highmark	43	Aetna	27
Williamsport, PA	3120	Highmark	50	UPMC	16
York-Hanover, PA	3292	Highmark	51	Capital BC	23
Rhode Island	4697	BCBS RI	67	Cigna	11
Providence-Warwick, RI-MA	2512	BCBS RI	43	BCBS MA	18
South Carolina	5198	BCBS SC	69	Cigna	20
Charleston-North Charleston, SC	5531	BCBS SC	72	Cigna	16
Columbia, SC	5611	BCBS SC	72	Cigna	18
Florence, SC	5642	BCBS SC	72	Cigna	20
Greenville-Anderson, SC	4656	BCBS SC	62	Cigna	27
Hilton Head Island-Bluffton, SC	5188	BCBS SC	70	Cigna	14
Myrtle Beach-Conway-North Myrtle Beach, SC-NC	3094	BCBS SC	49	Cigna	18
Spartanburg, SC	5034	BCBS SC	66	Cigna	26
Sumter, SC	5582	BCBS SC	71	Cigna	23
South Dakota	4234	Wellmark (BCBS)	60	Avera Hlth	24
Rapid City, SD	6102	Wellmark (BCBS)	77	Cigna	7
Sioux Falls, SD	3703	Wellmark (BCBS)	52	Avera Hlth	29
Tennessee	3819	BCBS TN	52	Cigna	30
Chattanooga, TN-GA	3540	BCBS TN	53	Cigna	24
Clarksville, TN-KY	2711	BCBS TN	37	Anthem	32
Cleveland, TN	4251	BCBS TN	56	Cigna	31
Jackson, TN	3498	BCBS TN	45	Cigna	34
Johnson City, TN	6088	BCBS TN	76	Cigna	15
Kingsport-Bristol, TN-VA	3282	BCBS TN	46	Cigna	26
Knoxville, TN	4340	BCBS TN	58	Cigna	31
Memphis, TN-MS-AR	3399	Cigna	48	BCBS TN	31
Morristown, TN	5227	BCBS TN	67	Cigna	26
Nashville-Davidson--Murfreesboro--Franklin, TN	3509	BCBS TN	48	Cigna	29
Texas	3265	HCSC (BCBS)	45	Aetna	29
Abilene, TX	4878	HCSC (BCBS)	67	Aetna	17
Amarillo, TX	3438	HCSC (BCBS)	51	Cigna	22

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Austin-Round Rock-Georgetown, TX	3215	HCSC (BCBS)	39	Aetna	37
Beaumont-Port Arthur, TX	3405	HCSC (BCBS)	49	Aetna	27
Brownsville-Harlingen, TX	5849	HCSC (BCBS)	75	Aetna	12
College Station-Bryan, TX	4377	HCSC (BCBS)	61	Cigna	23
Corpus Christi, TX	4115	HCSC (BCBS)	58	Aetna	26
Dallas-Fort Worth-Arlington, TX	3150	HCSC (BCBS)	40	Aetna	28
El Paso, TX	3265	HCSC (BCBS)	41	Aetna	37
Houston-The Woodlands-Sugar Land, TX	3102	HCSC (BCBS)	38	Aetna	30
Killeen-Temple, TX	2459	HCSC (BCBS)	37	Cigna	21
Laredo, TX	6148	HCSC (BCBS)	77	Aetna	10
Longview, TX	4254	HCSC (BCBS)	60	Cigna	19
Lubbock, TX	4992	HCSC (BCBS)	68	Aetna	17
McAllen-Edinburg-Mission, TX	5452	HCSC (BCBS)	72	Aetna	15
Midland, TX	5257	HCSC (BCBS)	70	Cigna	18
Odessa, TX	6320	HCSC (BCBS)	78	Cigna	11
San Angelo, TX	4400	HCSC (BCBS)	60	Aetna	28
San Antonio-New Braunfels, TX	3503	HCSC (BCBS)	44	Aetna	38
Sherman-Denison, TX	3142	HCSC (BCBS)	45	Aetna	25
Texarkana, TX-AR	3858	HCSC (BCBS)	59	Aetna	13
Tyler, TX	4765	HCSC (BCBS)	66	Aetna	17
Victoria, TX	3325	HCSC (BCBS)	48	Aetna	24
Waco, TX	3193	HCSC (BCBS)	50	Aetna	18
Wichita Falls, TX	4526	HCSC (BCBS)	63	Aetna	21
Utah	2324	Intermountain	35	Cambia	22
Logan, UT-ID	2491	Intermountain	39	Cigna	24
Ogden-Clearfield, UT	2269	Intermountain	32	Cambia	25
Provo-Orem, UT	3019	Intermountain	45	Cigna	29
Salt Lake City, UT	2338	Intermountain	35	Cigna	22
St. George, UT	2244	Intermountain	37	Cambia	17
Vermont	3486	Cigna	51	BCBS VT	26
Burlington-South Burlington, VT	3858	Cigna	55	BCBS VT	27
Virginia	3055	Anthem	46	Cigna	23
Blacksburg-Christiansburg, VA	3805	Anthem	53	Aetna	28
Charlottesville, VA	3765	Aetna	52	Anthem	30
Harrisonburg, VA	5473	Anthem	72	Aetna	13
Lynchburg, VA	3921	Anthem	58	Cigna	16
Richmond, VA	3745	Anthem	50	Cigna	31
Roanoke, VA	3807	Anthem	49	Aetna	35
Staunton, VA	4211	Anthem	53	Aetna	36
Virginia Beach-Norfolk-Newport News, VA-NC	4495	Anthem	64	Cigna	16
Winchester, VA-WV	3806	Anthem	56	Aetna	19
Washington	2101	Cambia	28	Premera	27
Bellingham, WA	2058	Cambia	31	Premera	18
Bremerton-Silverdale-Port Orchard, WA	2105	Cambia	36	Kaiser	15
Kennewick-Richland, WA	2491	Premera	40	Aetna	22

Table 3. (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019. PPO product markets

State and MSAs	PPO HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Longview, WA	2845	Premera	47	Aetna	15
Mount Vernon-Anacortes, WA	2199	Cambia	32	Premera	24
Olympia-Lacey-Tumwater, WA	1810	Premera	26	Aetna	20
Seattle-Tacoma-Bellevue, WA	2167	Premera	28	Cambia	26
Spokane-Spokane Valley, WA	3021	Premera	50	Aetna	15
Walla Walla, WA	2671	Premera	43	Cambia	24
Wenatchee, WA	3255	Premera	51	Hlth Alliance	19
Yakima, WA	2311	Premera	35	Cambia	22
West Virginia	3481	Highmark	50	Aetna	25
Beckley, WV	4858	Highmark	68	Aetna	13
Charleston, WV	3633	Highmark	53	Aetna	23
Huntington-Ashland, WV-KY-OH	3121	Anthem	50	Highmark	20
Morgantown, WV	4330	Highmark	62	Aetna	17
Parkersburg-Vienna, WV	4429	Highmark	63	Cigna	18
Wheeling, WV-OH	2201	Anthem	36	Highmark	19
Wisconsin	1959	Anthem	37	Cigna	14
Appleton, WI	1963	Cigna	31	Anthem	25
Eau Claire, WI	1795	Anthem	29	Cigna	22
Fond du Lac, WI	1735	Anthem	31	Cigna	17
Green Bay, WI	1710	Cigna	27	Anthem	22
Janesville-Beloit, WI	1587	Anthem	28	UnitedHealth Group	15
La Crosse-Onalaska, WI-MN	1994	Quartz	35	BCBS MN	20
Madison, WI	1565	Anthem	31	Aetna	12
Milwaukee-Waukesha, WI	2929	Anthem	49	Cigna	14
Oshkosh-Neenah, WI	2040	Anthem	32	Cigna	25
Racine, WI	2071	Anthem	34	Cigna	21
Sheboygan, WI	1915	Anthem	36	Cigna	13
Wausau-Weston, WI	2476	Anthem	44	Humana	15
Wyoming	4089	Cigna	60	BCBS WY	17
Casper, WY	6074	Cigna	77	BCBS WY	10
Cheyenne, WY	4443	Cigna	61	BCBS WY	26

Notes:

1. Source: Managed Market Surveyor Suite | MSA Medical Program | January 1, 2019 | Managed Market Surveyor | Selected Geographies | January 1, 2019 | Enterprise License © 2019 DR/ Decision Resources, LLC. All rights reserved.
2. State and MSA-level Herfindahl-Hirschman Indices (HHIs) and the market shares of the two largest insurers in the PPO product market are reported.
3. Data are based on enrollments in both fully and self-insured health plans.

**Table 4. Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019
POS product markets**

State and MSAs	POS HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Alabama	8393	UnitedHealth Group	91	BCBS AL	9
Auburn-Opelika, AL	5475	BCBS AL	65	UnitedHealth Group	35
Birmingham-Hoover, AL	9003	UnitedHealth Group	95	BCBS AL	5
Daphne-Fairhope-Foley, AL	9723	UnitedHealth Group	99	BCBS AL	1
Huntsville, AL	7378	UnitedHealth Group	84	BCBS AL	16
Mobile, AL	9126	UnitedHealth Group	95	BCBS AL	5
Montgomery, AL	9861	UnitedHealth Group	99	BCBS AL	1
Alaska	10000	UnitedHealth Group	100	-	-
Arizona	8959	UnitedHealth Group	95	Cigna	4
Lake Havasu City-Kingman, AZ	9408	UnitedHealth Group	97	Humana	3
Phoenix-Mesa-Chandler, AZ	9030	UnitedHealth Group	95	Cigna	4
Prescott Valley-Prescott, AZ	9503	UnitedHealth Group	97	Humana	2
Sierra Vista-Douglas, AZ	9526	UnitedHealth Group	98	Humana	2
Tucson, AZ	8507	UnitedHealth Group	92	Cigna	7
Arkansas	4029	UnitedHealth Group	55	BCBS AR	25
Fayetteville-Springdale-Rogers, AR	3484	UnitedHealth Group	43	BCBS AR	31
Fort Smith, AR-OK	5279	UnitedHealth Group	69	BCBS AR	17
Hot Springs, AR	4211	UnitedHealth Group	57	BCBS AR	23
Jonesboro, AR	3533	UnitedHealth Group	44	BCBS AR	30
Little Rock-North Little Rock-Conway, AR	4747	UnitedHealth Group	64	BCBS AR	20
Pine Bluff, AR	3850	UnitedHealth Group	52	BCBS AR	26
California	4944	UnitedHealth Group	64	Anthem	27
Bakersfield, CA	4847	Anthem	55	UnitedHealth Group	43
Chico, CA	5030	Anthem	55	UnitedHealth Group	45
Fresno, CA	4935	UnitedHealth Group	53	Anthem	46
Hanford-Corcoran, CA	5300	UnitedHealth Group	63	Anthem	37
Los Angeles-Long Beach-Anaheim, CA	4013	UnitedHealth Group	54	Anthem	30
Merced, CA	5100	Anthem	59	UnitedHealth Group	40
Modesto, CA	4882	UnitedHealth Group	53	Anthem	45
Napa, CA	4928	Anthem	51	UnitedHealth Group	49
Oxnard-Thousand Oaks-Ventura, CA	4587	UnitedHealth Group	52	Anthem	43
Redding, CA	5595	Anthem	67	UnitedHealth Group	33
Riverside-San Bernardino-Ontario, CA	4127	UnitedHealth Group	57	Anthem	27
Sacramento-Roseville-Folsom, CA	6093	UnitedHealth Group	75	Anthem	23
Salinas, CA	5194	UnitedHealth Group	60	Anthem	40
San Diego-Chula Vista-Carlsbad, CA	5708	UnitedHealth Group	73	Anthem	20
San Francisco-Oakland-Berkeley, CA	6773	UnitedHealth Group	81	Anthem	16
San Jose-Sunnyvale-Santa Clara, CA	7328	UnitedHealth Group	85	Anthem	13
San Luis Obispo-Paso Robles, CA	5104	Anthem	59	UnitedHealth Group	40
Santa Cruz-Watsonville, CA	5252	UnitedHealth Group	64	Anthem	33
Santa Maria-Santa Barbara, CA	3669	UnitedHealth Group	44	Anthem	39
Santa Rosa-Petaluma, CA	5982	UnitedHealth Group	73	Anthem	25
Stockton, CA	5264	UnitedHealth Group	64	Anthem	34
Vallejo, CA	6215	UnitedHealth Group	76	Anthem	22
Visalia, CA	4917	Anthem	53	UnitedHealth Group	46
Yuba City, CA	5036	Anthem	55	UnitedHealth Group	45

Table 4. (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019. POS product markets

State and MSAs	POS HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Colorado	6686	UnitedHealth Group	79	Anthem	19
Boulder, CO	6559	UnitedHealth Group	78	Anthem	21
Colorado Springs, CO	6351	UnitedHealth Group	77	Anthem	22
Denver-Aurora-Lakewood, CO	7428	UnitedHealth Group	85	Anthem	14
Fort Collins, CO	5351	UnitedHealth Group	65	Anthem	34
Grand Junction, CO	6236	UnitedHealth Group	75	Anthem	24
Greeley, CO	6577	UnitedHealth Group	79	Anthem	20
Pueblo, CO	6079	UnitedHealth Group	73	Anthem	26
Connecticut	4010	UnitedHealth Group	54	Anthem	29
Bridgeport-Stamford-Norwalk, CT	5358	UnitedHealth Group	70	Anthem	19
Hartford-East Hartford-Middletown, CT	3586	UnitedHealth Group	48	Anthem	30
New Haven-Milford, CT	3586	UnitedHealth Group	41	Anthem	39
Norwich-New London, CT	5148	UnitedHealth Group	65	Anthem	29
Delaware	7021	UnitedHealth Group	82	Highmark	18
District of Columbia	9821	UnitedHealth Group	99	Cigna	1
Washington-Arlington-Alexandria, DC-VA-MD-WV	6691	UnitedHealth Group	80	Anthem	18
Florida	9125	UnitedHealth Group	95	Cigna	3
Cape Coral-Fort Myers, FL	9685	UnitedHealth Group	98	Humana	1
Crestview-Fort Walton Beach-Destin, FL	9447	UnitedHealth Group	97	Humana	3
Deltona-Daytona Beach-Ormond Beach, FL	7987	UnitedHealth Group	89	BCBS FL	10
Gainesville, FL	9234	UnitedHealth Group	96	Humana	4
Homosassa Springs, FL	9788	UnitedHealth Group	99	Humana	1
Jacksonville, FL	9646	UnitedHealth Group	98	Humana	1
Lakeland-Winter Haven, FL	8096	UnitedHealth Group	89	Cigna	10
Miami-Fort Lauderdale-Pompano Beach, FL	8761	UnitedHealth Group	93	Cigna	6
Naples-Marco Island, FL	9645	UnitedHealth Group	98	Humana	1
North Port-Sarasota-Bradenton, FL	9705	UnitedHealth Group	99	Humana	1
Ocala, FL	8477	UnitedHealth Group	92	Cigna	7
Orlando-Kissimmee-Sanford, FL	9355	UnitedHealth Group	97	Cigna	2
Palm Bay-Melbourne-Titusville, FL	9244	UnitedHealth Group	96	Humana	2
Panama City, FL	9555	UnitedHealth Group	98	Humana	2
Pensacola-Ferry Pass-Brent, FL	9655	UnitedHealth Group	98	Humana	2
Port St. Lucie, FL	8152	UnitedHealth Group	90	Cigna	9
Punta Gorda, FL	9662	UnitedHealth Group	98	Humana	1
Sebastian-Vero Beach, FL	9468	UnitedHealth Group	97	Cigna	2
Tallahassee, FL	9575	UnitedHealth Group	98	Humana	2
Tampa-St. Petersburg-Clearwater, FL	9660	UnitedHealth Group	98	Humana	1
Georgia	4560	Anthem	54	UnitedHealth Group	40
Albany, GA	5128	Anthem	65	UnitedHealth Group	31
Athens-Clarke County, GA	5308	Anthem	69	UnitedHealth Group	22
Atlanta-Sandy Springs-Alpharetta, GA	4509	Anthem	49	UnitedHealth Group	46
Augusta-Richmond County, GA-SC	4431	Anthem	49	UnitedHealth Group	45
Brunswick, GA	4736	Anthem	59	UnitedHealth Group	34
Columbus, GA-AL	5619	Anthem	72	UnitedHealth Group	19
Dalton, GA	6652	Anthem	80	UnitedHealth Group	13

State and MSAs	POS HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Gainesville, GA	4893	Anthem	61	UnitedHealth Group	33
Hinesville, GA	5415	Anthem	70	UnitedHealth Group	20
Macon-Bibb County, GA	4799	Anthem	58	UnitedHealth Group	38
Rome, GA	5812	Anthem	73	UnitedHealth Group	19
Savannah, GA	4138	Anthem	49	UnitedHealth Group	40
Valdosta, GA	5305	Anthem	69	UnitedHealth Group	22
Warner Robins, GA	5952	Anthem	73	UnitedHealth Group	25
Idaho	6488	UnitedHealth Group	77	BC of ID	23
Boise City, ID	7652	UnitedHealth Group	86	BC of ID	14
Coeur d'Alene, ID	5051	BC of ID	55	UnitedHealth Group	45
Illinois	9417	UnitedHealth Group	97	Hlth Alliance	3
Bloomington, IL	5604	UnitedHealth Group	67	Hlth Alliance	33
Champaign-Urbana, IL	5911	Hlth Alliance	71	UnitedHealth Group	29
Chicago-Naperville-Elgin, IL-IN-WI	7624	UnitedHealth Group	86	Anthem	13
Davenport-Moline-Rock Island, IA-IL	9414	UnitedHealth Group	97	Wellmark (BCBS)	2
Kankakee, IL	9624	UnitedHealth Group	98	Hlth Alliance	2
Peoria, IL	7749	UnitedHealth Group	87	Hlth Alliance	13
Rockford, IL	9978	UnitedHealth Group	100	Hlth Alliance	0
Springfield, IL	7982	UnitedHealth Group	89	Hlth Alliance	11
Indiana	4713	Anthem	55	UnitedHealth Group	41
Bloomington, IN	5334	Anthem	68	UnitedHealth Group	25
Columbus, IN	3738	S.E. Indiana Hlth	45	Anthem	37
Elkhart-Goshen, IN	5019	Anthem	60	UnitedHealth Group	37
Evansville, IN-KY	4670	Anthem	54	UnitedHealth Group	41
Fort Wayne, IN	4888	Anthem	52	UnitedHealth Group	47
Indianapolis-Carmel-Anderson, IN	4810	Anthem	51	UnitedHealth Group	47
Kokomo, IN	6107	Anthem	74	UnitedHealth Group	26
Lafayette-West Lafayette, IN	4933	Anthem	52	UnitedHealth Group	48
Michigan City-La Porte, IN	5459	Anthem	66	UnitedHealth Group	34
Muncie, IN	6190	Anthem	75	UnitedHealth Group	25
South Bend-Mishawaka, IN-MI	4696	Anthem	56	UnitedHealth Group	39
Terre Haute, IN	6123	Anthem	74	UnitedHealth Group	25
Iowa	8367	UnitedHealth Group	91	Wellmark (BCBS)	9
Ames, IA	7138	UnitedHealth Group	83	Wellmark (BCBS)	17
Cedar Rapids, IA	7697	UnitedHealth Group	87	Wellmark (BCBS)	13
Davenport-Moline-Rock Island, IA-IL	9414	UnitedHealth Group	97	Wellmark (BCBS)	2
Des Moines-West Des Moines, IA	9009	UnitedHealth Group	95	Wellmark (BCBS)	5
Dubuque, IA	8608	UnitedHealth Group	92	Wellmark (BCBS)	8
Iowa City, IA	6453	UnitedHealth Group	77	Wellmark (BCBS)	23
Sioux City, IA-NE-SD	9118	UnitedHealth Group	95	Wellmark (BCBS)	5
Waterloo-Cedar Falls, IA	9264	UnitedHealth Group	96	Wellmark (BCBS)	4
Kansas	9808	UnitedHealth Group	99	Humana	1
Lawrence, KS	9650	UnitedHealth Group	98	Humana	2
Topeka, KS	9826	UnitedHealth Group	99	Humana	1
Wichita, KS	9880	UnitedHealth Group	99	Humana	1

Table 4. (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019. POS product markets

State and MSAs	POS HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Kentucky	3974	UnitedHealth Group	46	Anthem	42
Bowling Green, KY	3833	Anthem	43	UnitedHealth Group	42
Elizabethtown-Fort Knox, KY	4032	Anthem	53	UnitedHealth Group	32
Lexington-Fayette, KY	3865	Anthem	48	UnitedHealth Group	36
Louisville/Jefferson County, KY-IN	4193	UnitedHealth Group	48	Anthem	42
Owensboro, KY	4362	Anthem	46	UnitedHealth Group	46
Louisiana	8949	UnitedHealth Group	94	Humana	5
Alexandria, LA	9157	UnitedHealth Group	96	Humana	4
Baton Rouge, LA	8694	UnitedHealth Group	93	Humana	7
Hammond, LA	8750	UnitedHealth Group	93	Humana	6
Houma-Thibodaux, LA	9085	UnitedHealth Group	95	Humana	5
Lafayette, LA	8855	UnitedHealth Group	94	Humana	6
Lake Charles, LA	8782	UnitedHealth Group	93	Humana	6
Monroe, LA	9216	UnitedHealth Group	96	Humana	4
New Orleans-Metairie, LA	9186	UnitedHealth Group	96	Humana	4
Shreveport-Bossier City, LA	8711	UnitedHealth Group	93	Humana	7
Maine	5105	Anthem	57	UnitedHealth Group	42
Bangor, ME	5153	Anthem	59	UnitedHealth Group	41
Lewiston-Auburn, ME	5058	Anthem	56	UnitedHealth Group	44
Portland-South Portland, ME	5009	Anthem	53	UnitedHealth Group	47
Maryland	9748	UnitedHealth Group	99	Cigna	1
Baltimore-Columbia-Towson, MD	9904	UnitedHealth Group	100	Cigna	0
Cumberland, MD-WV	9802	UnitedHealth Group	99	Hlth Plan Upper Ohio	1
Hagerstown-Martinsburg, MD-WV	8904	UnitedHealth Group	94	Cigna	4
Salisbury, MD-DE	8494	UnitedHealth Group	92	Highmark	8
Massachusetts	9807	UnitedHealth Group	99	Cigna	0
Boston-Cambridge-Newton, MA-NH	6363	UnitedHealth Group	76	Anthem	23
Springfield, MA	8436	UnitedHealth Group	92	EmblemHealth	6
Worcester, MA-CT	5475	UnitedHealth Group	69	Anthem	26
Michigan	6770	UnitedHealth Group	80	Spectrum Hlth	18
Ann Arbor, MI	5470	UnitedHealth Group	66	Spectrum Hlth	34
Battle Creek, MI	7771	UnitedHealth Group	87	Spectrum Hlth	13
Detroit-Warren-Dearborn, MI	6629	UnitedHealth Group	79	Spectrum Hlth	19
Flint, MI	5454	UnitedHealth Group	67	Spectrum Hlth	30
Grand Rapids-Kentwood, MI	6725	UnitedHealth Group	79	Spectrum Hlth	20
Kalamazoo-Portage, MI	8439	UnitedHealth Group	91	Spectrum Hlth	9
Niles, MI	6841	UnitedHealth Group	80	Spectrum Hlth	20
Minnesota	6953	UnitedHealth Group	81	HealthPartners	19
Duluth, MN-WI	6343	UnitedHealth Group	78	Anthem	15
Minneapolis-St. Paul-Bloomington, MN-WI	5851	UnitedHealth Group	74	HealthPartners	19
Rochester, MN	8940	UnitedHealth Group	94	HealthPartners	6
St. Cloud, MN	5446	UnitedHealth Group	65	HealthPartners	35
Mississippi	9980	UnitedHealth Group	100	Cigna	0
Gulfport-Biloxi, MS	9959	UnitedHealth Group	100	Cigna	0
Hattiesburg, MS	10000	UnitedHealth Group	100	-	-
Jackson, MS	9998	UnitedHealth Group	100	Cigna	0

State and MSAs	POS HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Missouri	7255	UnitedHealth Group	84	Anthem	16
Cape Girardeau, MO-IL	7175	UnitedHealth Group	83	Anthem	17
Columbia, MO	8909	UnitedHealth Group	94	Anthem	6
Jefferson City, MO	7384	UnitedHealth Group	85	Anthem	15
Joplin, MO	6016	UnitedHealth Group	73	Anthem	27
Kansas City, MO-KS	9862	UnitedHealth Group	99	Humana	0
Springfield, MO	7868	UnitedHealth Group	88	Anthem	12
St. Joseph, MO-KS	9980	UnitedHealth Group	100	Humana	0
St. Louis, MO-IL	7602	UnitedHealth Group	86	Anthem	14
Montana	9458	UnitedHealth Group	97	HCSC (BCBS)	3
Nebraska	9999	UnitedHealth Group	100	Cigna	0
Lincoln, NE	10000	UnitedHealth Group	100	-	-
Omaha-Council Bluffs, NE-IA	9898	UnitedHealth Group	99	Wellmark (BCBS)	1
Nevada	6032	UnitedHealth Group	73	Anthem	27
Las Vegas-Henderson-Paradise, NV	6231	UnitedHealth Group	75	Anthem	24
Reno, NV	7107	UnitedHealth Group	82	Anthem	17
New Hampshire	4885	UnitedHealth Group	55	Anthem	43
Manchester-Nashua, NH	5098	UnitedHealth Group	60	Anthem	39
New Jersey	5059	Horizon BCBS	60	UnitedHealth Group	39
Atlantic City-Hammonton, NJ	8572	Horizon BCBS	92	UnitedHealth Group	7
Ocean City, NJ	8935	Horizon BCBS	94	UnitedHealth Group	5
Trenton-Princeton, NJ	5726	Horizon BCBS	70	UnitedHealth Group	29
Vineland-Bridgeton, NJ	8410	Horizon BCBS	91	UnitedHealth Group	8
New Mexico	6949	UnitedHealth Group	81	Presbyterian	19
Albuquerque, NM	6135	UnitedHealth Group	74	Presbyterian	26
Farmington, NM	9649	UnitedHealth Group	98	Presbyterian	2
Santa Fe, NM	8403	UnitedHealth Group	91	Presbyterian	9
New York	6614	UnitedHealth Group	80	Anthem	10
Albany-Schenectady-Troy, NY	4688	UnitedHealth Group	58	CDPHP	36
Buffalo-Cheektowaga, NY	6857	Independent Hlth	82	UnitedHealth Group	12
Kingston, NY	8439	UnitedHealth Group	92	Anthem	7
New York-Newark-Jersey City, NY-NJ-PA	4871	UnitedHealth Group	64	Horizon BCBS	26
Poughkeepsie-Newburgh-Middletown, NY	6760	UnitedHealth Group	80	Anthem	19
Rochester, NY	4845	UnitedHealth Group	54	Lifetime Hlthcare	44
Syracuse, NY	8968	UnitedHealth Group	95	Lifetime Hlthcare	5
Utica-Rome, NY	9808	UnitedHealth Group	99	CDPHP	1
North Carolina	8527	UnitedHealth Group	92	BCBS NC	7
Asheville, NC	8425	UnitedHealth Group	91	BCBS NC	9
Burlington, NC	8630	UnitedHealth Group	93	BCBS NC	7
Charlotte-Concord-Gastonia, NC-SC	8878	UnitedHealth Group	94	BCBS NC	6
Durham-Chapel Hill, NC	8270	UnitedHealth Group	91	BCBS NC	9
Fayetteville, NC	8160	UnitedHealth Group	90	BCBS NC	10
Greensboro-High Point, NC	9175	UnitedHealth Group	96	BCBS NC	4
Hickory-Lenoir-Morganton, NC	9040	UnitedHealth Group	95	BCBS NC	5
Raleigh-Cary, NC	8888	UnitedHealth Group	94	BCBS NC	5

Table 4. (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019. POS product markets

State and MSAs	POS HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Rocky Mount, NC	8396	UnitedHealth Group	91	BCBS NC	9
Wilmington, NC	9270	UnitedHealth Group	96	BCBS NC	4
Winston-Salem, NC	8586	UnitedHealth Group	92	BCBS NC	8
North Dakota	9890	UnitedHealth Group	99	HealthPartners	1
Fargo, ND-MN	9629	UnitedHealth Group	98	HealthPartners	2
Ohio	4508	UnitedHealth Group	58	Anthem	32
Akron, OH	3918	UnitedHealth Group	50	Anthem	37
Canton-Massillon, OH	3985	UnitedHealth Group	54	Anthem	32
Cincinnati, OH-KY-IN	4757	UnitedHealth Group	60	Anthem	33
Cleveland-Elyria, OH	4112	UnitedHealth Group	56	Anthem	29
Columbus, OH	6347	UnitedHealth Group	77	Anthem	21
Dayton-Kettering, OH	5181	UnitedHealth Group	63	Anthem	34
Lima, OH	3294	UnitedHealth Group	43	Medical Mutual	28
Mansfield, OH	4690	UnitedHealth Group	62	Anthem	28
Springfield, OH	4392	UnitedHealth Group	60	Anthem	25
Toledo, OH	3168	UnitedHealth Group	39	Anthem	30
Weirton-Steubenville, WV-OH	3225	Anthem	37	UnitedHealth Group	35
Youngstown-Warren-Boardman, OH-PA	3468	UnitedHealth Group	44	Anthem	34
Oklahoma	9994	UnitedHealth Group	100	Cigna	0
Oklahoma City, OK	9989	UnitedHealth Group	100	Cigna	0
Tulsa, OK	9996	UnitedHealth Group	100	Cigna	0
Oregon	9253	UnitedHealth Group	96	Centene	4
Albany-Lebanon, OR	10000	UnitedHealth Group	100	-	-
Eugene-Springfield, OR	10000	UnitedHealth Group	100	-	-
Portland-Vancouver-Hillsboro, OR-WA	9204	UnitedHealth Group	96	Centene	4
Salem, OR	10000	UnitedHealth Group	100	-	-
Pennsylvania	8006	UnitedHealth Group	89	Independence Hlth Grp	10
Allentown-Bethlehem-Easton, PA-NJ	5047	UnitedHealth Group	57	Horizon BCBS	42
Chambersburg-Waynesboro, PA	9893	UnitedHealth Group	99	Cigna	1
East Stroudsburg, PA	9892	UnitedHealth Group	99	Cigna	1
Erie, PA	10000	UnitedHealth Group	100	-	-
Harrisburg-Carlisle, PA	9959	UnitedHealth Group	100	Cigna	0
Lancaster, PA	9898	UnitedHealth Group	99	Cigna	0
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	4108	UnitedHealth Group	54	Horizon BCBS	33
Pittsburgh, PA	9838	UnitedHealth Group	99	UPMC	1
Reading, PA	9953	UnitedHealth Group	100	Independence Hlth Grp	0
Scranton--Wilkes-Barre, PA	9621	UnitedHealth Group	98	Geisinger	2
York-Hanover, PA	9965	UnitedHealth Group	100	Cigna	0
Rhode Island	9962	UnitedHealth Group	100	EmblemHealth	0
Providence-Warwick, RI-MA	9958	UnitedHealth Group	100	Cigna	0
South Carolina	9957	UnitedHealth Group	100	Cigna	0
Charleston-North Charleston, SC	9969	UnitedHealth Group	100	Cigna	0
Columbia, SC	9997	UnitedHealth Group	100	Cigna	0
Florence, SC	9991	UnitedHealth Group	100	Cigna	0
Greenville-Anderson, SC	9976	UnitedHealth Group	100	Cigna	0

State and MSAs	POS HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Hilton Head Island-Bluffton, SC	9619	UnitedHealth Group	98	Cigna	2
Myrtle Beach-Conway-North Myrtle Beach, SC-NC	9602	UnitedHealth Group	98	BCBS NC	2
Spartanburg, SC	9968	UnitedHealth Group	100	Cigna	0
South Dakota	9950	UnitedHealth Group	100	HealthPartners	0
Sioux Falls, SD	9940	UnitedHealth Group	100	HealthPartners	0
Tennessee	9126	UnitedHealth Group	95	Humana	3
Chattanooga, TN-GA	4234	UnitedHealth Group	57	Anthem	29
Clarksville, TN-KY	4455	UnitedHealth Group	58	Anthem	31
Cleveland, TN	8518	UnitedHealth Group	92	Humana	4
Jackson, TN	8915	UnitedHealth Group	94	Humana	5
Johnson City, TN	9394	UnitedHealth Group	97	Humana	3
Kingsport-Bristol, TN-VA	4945	UnitedHealth Group	57	Anthem	41
Knoxville, TN	9560	UnitedHealth Group	98	Humana	2
Memphis, TN-MS-AR	9140	UnitedHealth Group	96	Humana	2
Morristown, TN	9457	UnitedHealth Group	97	Humana	3
Nashville-Davidson--Murfreesboro--Franklin, TN	9499	UnitedHealth Group	97	Humana	2
Texas	6326	UnitedHealth Group	78	HCSC (BCBS)	16
Abilene, TX	5915	UnitedHealth Group	74	HCSC (BCBS)	21
Amarillo, TX	6341	UnitedHealth Group	77	HCSC (BCBS)	19
Austin-Round Rock-Georgetown, TX	6496	UnitedHealth Group	78	HCSC (BCBS)	18
Beaumont-Port Arthur, TX	5953	UnitedHealth Group	75	HCSC (BCBS)	17
Brownsville-Harlingen, TX	6341	UnitedHealth Group	78	HCSC (BCBS)	17
College Station-Bryan, TX	5109	UnitedHealth Group	69	HCSC (BCBS)	15
Corpus Christi, TX	6960	UnitedHealth Group	82	HCSC (BCBS)	15
Dallas-Fort Worth-Arlington, TX	6873	UnitedHealth Group	81	HCSC (BCBS)	16
El Paso, TX	5696	UnitedHealth Group	72	HCSC (BCBS)	20
Houston-The Woodlands-Sugar Land, TX	5793	UnitedHealth Group	74	HCSC (BCBS)	14
Killeen-Temple, TX	4575	UnitedHealth Group	64	HCSC (BCBS)	16
Laredo, TX	6176	UnitedHealth Group	76	HCSC (BCBS)	18
Longview, TX	7102	UnitedHealth Group	83	HCSC (BCBS)	14
Lubbock, TX	5830	UnitedHealth Group	73	HCSC (BCBS)	23
McAllen-Edinburg-Mission, TX	6465	UnitedHealth Group	79	HCSC (BCBS)	15
Midland, TX	6752	UnitedHealth Group	81	HCSC (BCBS)	15
Odessa, TX	6382	UnitedHealth Group	78	HCSC (BCBS)	17
San Angelo, TX	5863	UnitedHealth Group	73	HCSC (BCBS)	21
San Antonio-New Braunfels, TX	6680	UnitedHealth Group	80	HCSC (BCBS)	16
Sherman-Denison, TX	6330	UnitedHealth Group	77	HCSC (BCBS)	19
Texarkana, TX-AR	4154	UnitedHealth Group	61	BCBS AR	14
Tyler, TX	6769	UnitedHealth Group	81	HCSC (BCBS)	15
Victoria, TX	6357	UnitedHealth Group	78	HCSC (BCBS)	18
Waco, TX	4349	UnitedHealth Group	59	Baylor Scott & White	27
Wichita Falls, TX	5843	UnitedHealth Group	73	HCSC (BCBS)	22
Utah	9973	UnitedHealth Group	100	Cigna	0
Logan, UT-ID	10000	UnitedHealth Group	100	-	-
Ogden-Clearfield, UT	9977	UnitedHealth Group	100	Cigna	0

Table 4. (continued)

Market concentration (HHI) and largest insurers' market shares, as of Jan. 1, 2019. POS product markets

State and MSAs	POS HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Provo-Orem, UT	9968	UnitedHealth Group	100	Cigna	0
Salt Lake City, UT	9971	UnitedHealth Group	100	Cigna	0
St. George, UT	9974	UnitedHealth Group	100	Cigna	0
Vermont	7035	BCBS VT	82	UnitedHealth Group	16
Burlington-South Burlington, VT	6693	BCBS VT	79	UnitedHealth Group	21
Virginia	4098	UnitedHealth Group	48	Anthem	42
Blacksburg-Christiansburg, VA	5530	Anthem	66	UnitedHealth Group	34
Charlottesville, VA	3865	Anthem	48	UnitedHealth Group	36
Harrisonburg, VA	4534	Anthem	61	Sentara (Optima Hlth)	24
Lynchburg, VA	5654	Anthem	69	UnitedHealth Group	30
Richmond, VA	4936	Anthem	53	UnitedHealth Group	46
Roanoke, VA	4992	Anthem	53	UnitedHealth Group	47
Staunton, VA	4804	Anthem	63	UnitedHealth Group	28
Virginia Beach-Norfolk-Newport News, VA-NC	3475	Sentara (Optima Hlth)	39	Anthem	38
Winchester, VA-WV	4459	Anthem	50	UnitedHealth Group	44
Washington	9921	UnitedHealth Group	100	Cigna	0
Kennewick-Richland, WA	9990	UnitedHealth Group	100	Cigna	0
Olympia-Lacey-Tumwater, WA	9982	UnitedHealth Group	100	Cigna	0
Seattle-Tacoma-Bellevue, WA	9891	UnitedHealth Group	99	Cigna	1
Spokane-Spokane Valley, WA	9991	UnitedHealth Group	100	Cigna	0
West Virginia	8060	UnitedHealth Group	89	Hlth Plan Upper Ohio	6
Charleston, WV	8663	UnitedHealth Group	93	Hlth Plan Upper Ohio	7
Huntington-Ashland, WV-KY-OH	4349	Anthem	49	UnitedHealth Group	43
Wheeling, WV-OH	4268	UnitedHealth Group	48	Anthem	44
Wisconsin	5989	UnitedHealth Group	75	Anthem	17
Appleton, WI	7593	UnitedHealth Group	87	Anthem	8
Eau Claire, WI	5053	UnitedHealth Group	66	Anthem	27
Fond du Lac, WI	6921	UnitedHealth Group	83	Anthem	7
Green Bay, WI	7252	UnitedHealth Group	85	Anthem	8
Janesville-Beloit, WI	2548	UnitedHealth Group	38	Anthem	26
La Crosse-Onalaska, WI-MN	5325	UnitedHealth Group	69	Anthem	23
Madison, WI	2365	UnitedHealth Group	31	Anthem	25
Milwaukee-Waukesha, WI	7383	UnitedHealth Group	85	Anthem	13
Oshkosh-Neenah, WI	7520	UnitedHealth Group	86	Anthem	10
Racine, WI	7814	UnitedHealth Group	88	Anthem	10
Sheboygan, WI	7536	UnitedHealth Group	86	Anthem	10
Wausau-Weston, WI	5846	UnitedHealth Group	74	Anthem	18
Wyoming	10000	UnitedHealth Group	100	-	-

Notes:

1. Source: Managed Market Surveyor Suite | MSA Medical Program | January 1, 2019 | Managed Market Surveyor | Selected Geographies | January 1, 2019 | Enterprise License © 2019 DR/ Decision Resources, LLC. All rights reserved.
2. State and MSA-level Herfindahl-Hirschman Indices (HHIs) and the market shares of the two largest insurers in the POS product market are reported.
3. Data are based on enrollments in both fully and self-insured health plans.
4. We do not present data for geographic areas with fewer than 5,000 reported POS enrollees.
5. The HHIs and market shares are rounded. As a result, in a few markets where the second largest insurer has very few covered lives, the market share appears as zero. The actual, unrounded shares are just above 0 percent.

Table 5. Market concentration (HHI) and largest insurers' market shares, as of July 1, 2019 Exchanges

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Alabama	9854	BCBS AL	99	Bright Health	1
Anniston-Oxford, AL	10000	BCBS AL	100	-	-
Auburn-Opelika, AL	10000	BCBS AL	100	-	-
Birmingham-Hoover, AL	9363	BCBS AL	97	Bright Health	3
Daphne-Fairhope-Foley, AL	10000	BCBS AL	100	-	-
Decatur, AL	10000	BCBS AL	100	-	-
Dothan, AL	10000	BCBS AL	100	-	-
Florence-Muscle Shoals, AL	10000	BCBS AL	100	-	-
Gadsden, AL	10000	BCBS AL	100	-	-
Huntsville, AL	10000	BCBS AL	100	-	-
Mobile, AL	10000	BCBS AL	100	-	-
Montgomery, AL	10000	BCBS AL	100	-	-
Tuscaloosa, AL	10000	BCBS AL	100	-	-
Alaska	10000	Premera	100	-	-
Anchorage, AK	10000	Premera	100	-	-
Fairbanks, AK	10000	Premera	100	-	-
Arizona	4253	Centene	55	BCBS AZ	34
Flagstaff, AZ	10000	BCBS AZ	100	-	-
Lake Havasu City-Kingman, AZ	10000	BCBS AZ	100	-	-
Phoenix-Mesa-Chandler, AZ	6134	Centene	77	Bright Health	8
Prescott Valley-Prescott, AZ	10000	BCBS AZ	100	-	-
Sierra Vista-Douglas, AZ	10000	BCBS AZ	100	-	-
Tucson, AZ	4687	BCBS AZ	60	Centene	33
Yuma, AZ	10000	BCBS AZ	100	-	-
Arkansas	5370	BCBS AR	64	Centene	36
Fayetteville-Springdale-Rogers, AR	5370	BCBS AR	64	Centene	36
Fort Smith, AR-OK	3473	BCBS AR	44	HCSC (BCBS)	31
Hot Springs, AR	5369	BCBS AR	64	Centene	36
Jonesboro, AR	5371	BCBS AR	64	Centene	36
Little Rock-North Little Rock-Conway, AR	5370	BCBS AR	64	Centene	36
Pine Bluff, AR	5368	BCBS AR	64	Centene	36
California	2411	Kaiser	35	BS of CA	31
Bakersfield, CA	4821	BS of CA	63	Kaiser	27
Chico, CA	5004	BS of CA	52	Anthem	48
El Centro, CA	8342	Molina Hlthcare	91	BS of CA	9
Fresno, CA	5595	BS of CA	67	Kaiser	33
Hanford-Corcoran, CA	8457	BS of CA	92	Kaiser	8
Los Angeles-Long Beach-Anaheim, CA	2174	BS of CA	29	Centene	24
Madera, CA	5609	BS of CA	67	Kaiser	33
Merced, CA	8088	Anthem	89	BS of CA	10
Modesto, CA	5266	Kaiser	68	Anthem	25
Napa, CA	5794	Kaiser	74	Western Hlth Advantage	14
Oxnard-Thousand Oaks-Ventura, CA	6116	BS of CA	74	Kaiser	26
Redding, CA	5143	Anthem	59	BS of CA	41
Riverside-San Bernardino-Ontario, CA	2854	BS of CA	36	Centene	28

Table 5. (continued)**Market concentration (HHI) and largest insurers' market shares, as of July 1, 2019. Exchanges**

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Sacramento-Roseville-Folsom, CA	5259	Kaiser	66	BS of CA	29
Salinas, CA	9699	BS of CA	98	Kaiser	2
San Diego-Chula Vista-Carlsbad, CA	2102	Kaiser	28	Centene	21
San Francisco-Oakland-Berkeley, CA	5621	Kaiser	72	BS of CA	21
San Jose-Sunnyvale-Santa Clara, CA	3306	Kaiser	47	Valley Hlth	28
San Luis Obispo-Paso Robles, CA	9997	BS of CA	100	Kaiser	0
Santa Cruz-Watsonville, CA	4775	Kaiser	58	BS of CA	37
Santa Maria-Santa Barbara, CA	9992	BS of CA	100	Kaiser	0
Santa Rosa-Petaluma, CA	5584	Kaiser	72	Western Hlth Advantage	16
Stockton, CA	6202	Kaiser	76	Anthem	18
Vallejo, CA	7601	Kaiser	87	Western Hlth Advantage	8
Visalia, CA	6881	Anthem	82	BS of CA	15
Yuba City, CA	4069	BS of CA	47	Anthem	42
Colorado	2702	Kaiser	38	Anthem	28
Boulder, CO	3337	Kaiser	47	Anthem	24
Colorado Springs, CO	3843	Kaiser	56	Bright Health	20
Denver-Aurora-Lakewood, CO	2897	Kaiser	41	Cigna	27
Fort Collins, CO	5012	Kaiser	61	Anthem	36
Grand Junction, CO	5618	Anthem	68	UnitedHealth Group	32
Greeley, CO	4771	Kaiser	55	Anthem	42
Pueblo, CO	5513	Anthem	66	Kaiser	33
Connecticut	6727	EmblemHealth	79	Anthem	21
Bridgeport-Stamford-Norwalk, CT	6792	EmblemHealth	80	Anthem	20
Hartford-East Hartford-Middletown, CT	6911	EmblemHealth	81	Anthem	19
New Haven-Milford, CT	6829	EmblemHealth	80	Anthem	20
Norwich-New London, CT	5454	EmblemHealth	65	Anthem	35
Delaware	10000	Highmark	100	-	-
Dover, DE	10000	Highmark	100	-	-
District of Columbia	7095	CareFirst	82	Kaiser	18
Washington-Arlington-Alexandria, DC-VA-MD-WV	3180	Kaiser	37	Cigna	35
Florida	5029	BCBS FL	63	Centene	32
Cape Coral-Fort Myers, FL	10000	BCBS FL	100	-	-
Crestview-Fort Walton Beach-Destin, FL	10000	BCBS FL	100	-	-
Deltona-Daytona Beach-Ormond Beach, FL	6428	Centene	77	BCBS FL	22
Gainesville, FL	9874	BCBS FL	99	Centene	1
Homosassa Springs, FL	7122	BCBS FL	83	Centene	17
Jacksonville, FL	7274	BCBS FL	84	Centene	15
Lakeland-Winter Haven, FL	6080	BCBS FL	74	Centene	23
Miami-Fort Lauderdale-Pompano Beach, FL	4599	Centene	55	BCBS FL	40
Naples-Marco Island, FL	10000	BCBS FL	100	-	-
North Port-Sarasota-Bradenton, FL	7863	BCBS FL	88	Centene	12
Ocala, FL	9815	BCBS FL	99	Centene	1
Orlando-Kissimmee-Sanford, FL	6489	BCBS FL	79	Oscar	14
Palm Bay-Melbourne-Titusville, FL	9174	BCBS FL	96	Health First Hlth	4
Panama City, FL	10000	BCBS FL	100	-	-

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Pensacola-Ferry Pass-Brent, FL	10000	BCBS FL	100	-	-
Port St. Lucie, FL	6871	BCBS FL	81	Centene	19
Punta Gorda, FL	8301	BCBS FL	91	Centene	9
Sebastian-Vero Beach, FL	10000	BCBS FL	100	-	-
Sebring-Avon Park, FL	10000	BCBS FL	100	-	-
Tallahassee, FL	10000	BCBS FL	100	-	-
Tampa-St. Petersburg-Clearwater, FL	5752	BCBS FL	71	Centene	27
The Villages, FL	10000	BCBS FL	100	-	-
Georgia	4352	Centene	60	Anthem	26
Albany, GA	10000	Centene	100	-	-
Athens-Clarke County, GA	9431	Centene	97	Anthem	3
Atlanta-Sandy Springs-Alpharetta, GA	4328	Centene	56	Anthem	32
Augusta-Richmond County, GA-SC	5041	BCBS SC	55	Anthem	45
Brunswick, GA	10000	Centene	100	-	-
Columbus, GA-AL	7127	Centene	83	BCBS AL	17
Dalton, GA	5123	Alliant Hlth Plans	58	Centene	42
Gainesville, GA	8702	Alliant Hlth Plans	93	Anthem	6
Hinesville, GA	10000	Centene	100	-	-
Macon-Bibb County, GA	9503	Centene	97	Anthem	2
Rome, GA	8353	Alliant Hlth Plans	91	Anthem	8
Savannah, GA	10000	Centene	100	-	-
Valdosta, GA	10000	Anthem	100	-	-
Warner Robins, GA	10000	Centene	100	-	-
Hawaii	5338	HMSA (BCBS HI)	63	Kaiser	37
Kahului-Wailuku-Lahaina, HI	5017	Kaiser	53	HMSA (BCBS HI)	47
Urban Honolulu, HI	5705	HMSA (BCBS HI)	69	Kaiser	31
Idaho	3879	Intermountain	47	BC of ID	38
Boise City, ID	4095	Intermountain	54	BC of ID	31
Coeur d'Alene, ID	5003	BC of ID	61	Montana Health CO-OP	35
Idaho Falls, ID	5556	Intermountain	70	BC of ID	25
Lewiston, ID-WA	6837	BC of ID	81	Premera	18
Pocatello, ID	9039	BC of ID	95	Montana Health CO-OP	5
Twin Falls, ID	4450	Intermountain	61	Montana Health CO-OP	22
Illinois	6360	HCSC (BCBS)	79	Hlth Alliance	9
Bloomington, IL	6277	HCSC (BCBS)	75	Hlth Alliance	25
Carbondale-Marion, IL	5308	HCSC (BCBS)	62	Hlth Alliance	38
Champaign-Urbana, IL	9472	Hlth Alliance	97	HCSC (BCBS)	3
Chicago-Naperville-Elgin, IL-IN-WI	6116	HCSC (BCBS)	77	Centene	13
Danville, IL	7692	Hlth Alliance	87	HCSC (BCBS)	13
Davenport-Moline-Rock Island, IA-IL	3962	HCSC (BCBS)	52	Medica	33
Decatur, IL	5113	HCSC (BCBS)	58	Hlth Alliance	42
Kankakee, IL	3648	HCSC (BCBS)	48	Hlth Alliance	28
Peoria, IL	5004	HCSC (BCBS)	51	Hlth Alliance	49
Rockford, IL	8642	HCSC (BCBS)	93	Quartz	7
Springfield, IL	5048	HCSC (BCBS)	55	Hlth Alliance	45

Table 5. (continued)Market concentration (HHI) and largest insurers' market shares, as of July 1, 2019. *Exchanges*

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Indiana	5220	Centene	60	CareSource	40
Bloomington, IN	7008	CareSource	82	Centene	18
Columbus, IN	7231	CareSource	83	Centene	17
Elkhart-Goshen, IN	6026	Centene	73	CareSource	27
Evansville, IN-KY	7421	Centene	85	Anthem	15
Fort Wayne, IN	6794	Centene	80	CareSource	20
Indianapolis-Carmel-Anderson, IN	5051	Centene	55	CareSource	45
Kokomo, IN	5305	Centene	62	CareSource	38
Lafayette-West Lafayette, IN	6397	CareSource	76	Centene	24
Michigan City-La Porte, IN	5121	Centene	58	CareSource	42
Muncie, IN	6685	CareSource	79	Centene	21
South Bend-Mishawaka, IN-MI	3508	CareSource	43	Centene	38
Terre Haute, IN	5249	Centene	61	CareSource	39
Iowa	8866	Medica	94	Wellmark (BCBS)	6
Ames, IA	8852	Medica	94	Wellmark (BCBS)	6
Cedar Rapids, IA	8863	Medica	94	Wellmark (BCBS)	6
Davenport-Moline-Rock Island, IA-IL	3962	HCSC (BCBS)	52	Medica	33
Des Moines-West Des Moines, IA	8867	Medica	94	Wellmark (BCBS)	6
Dubuque, IA	8860	Medica	94	Wellmark (BCBS)	6
Iowa City, IA	8860	Medica	94	Wellmark (BCBS)	6
Sioux City, IA-NE-SD	6517	Medica	80	Sanford	9
Waterloo-Cedar Falls, IA	8852	Medica	94	Wellmark (BCBS)	6
Kansas	4879	BCBS KS	65	Centene	24
Lawrence, KS	9293	BCBS KS	96	Medica	4
Manhattan, KS	9287	BCBS KS	96	Medica	4
Topeka, KS	9296	BCBS KS	96	Medica	4
Wichita, KS	9295	BCBS KS	96	Medica	4
Kentucky	5120	Anthem	58	CareSource	42
Bowling Green, KY	10000	Anthem	100	-	-
Elizabethtown-Fort Knox, KY	9465	Anthem	97	CareSource	3
Lexington-Fayette, KY	5136	CareSource	58	Anthem	42
Louisville/Jefferson County, KY-IN	3877	CareSource	46	Anthem	40
Owensboro, KY	10000	Anthem	100	-	-
Louisiana	8142	LA Hlth Serv & Ind (BCBS)	90	Vantage Hlth	10
Alexandria, LA	8135	LA Hlth Serv & Ind (BCBS)	90	Vantage Hlth	10
Baton Rouge, LA	8144	LA Hlth Serv & Ind (BCBS)	90	Vantage Hlth	10
Hammond, LA	8140	LA Hlth Serv & Ind (BCBS)	90	Vantage Hlth	10
Houma-Thibodaux, LA	8138	LA Hlth Serv & Ind (BCBS)	90	Vantage Hlth	10
Lafayette, LA	8137	LA Hlth Serv & Ind (BCBS)	90	Vantage Hlth	10
Lake Charles, LA	8143	LA Hlth Serv & Ind (BCBS)	90	Vantage Hlth	10
Monroe, LA	8148	LA Hlth Serv & Ind (BCBS)	90	Vantage Hlth	10
New Orleans-Metairie, LA	8142	LA Hlth Serv & Ind (BCBS)	90	Vantage Hlth	10
Shreveport-Bossier City, LA	8140	LA Hlth Serv & Ind (BCBS)	90	Vantage Hlth	10
Maine	3499	Community Hlth Options	42	Anthem	34
Bangor, ME	3984	Community Hlth Options	48	Anthem	38

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Lewiston-Auburn, ME	3492	Community Hlth Options	42	Anthem	33
Portland-South Portland, ME	3382	Community Hlth Options	39	Anthem	31
Maryland	5060	CareFirst	55	Kaiser	45
Baltimore-Columbia-Towson, MD	5095	CareFirst	57	Kaiser	43
California-Lexington Park, MD	10000	CareFirst	100	-	-
Cumberland, MD-WV	7184	CareFirst	83	Highmark	17
Hagerstown-Martinsburg, MD-WV	5596	CareFirst	67	Highmark	32
Salisbury, MD-DE	4999	CareFirst	51	Highmark	49
Massachusetts	4112	Tufts	55	BMC HealthNet	32
Barnstable Town, MA	4168	Tufts	55	BMC HealthNet	33
Boston-Cambridge-Newton, MA-NH	3797	Tufts	53	BMC HealthNet	31
Pittsfield, MA	3531	Tufts	50	BMC HealthNet	30
Springfield, MA	3249	Tufts	47	BMC HealthNet	27
Worcester, MA-CT	3410	Tufts	50	BMC HealthNet	29
Michigan	4939	BCBS MI	68	Spectrum Hlth	17
Ann Arbor, MI	5278	BCBS MI	70	Spectrum Hlth	18
Battle Creek, MI	6163	BCBS MI	76	Spectrum Hlth	20
Bay City, MI	6537	BCBS MI	78	Spectrum Hlth	20
Detroit-Warren-Dearborn, MI	4345	BCBS MI	62	Spectrum Hlth	16
Flint, MI	4683	BCBS MI	65	Spectrum Hlth	17
Grand Rapids-Kentwood, MI	5101	BCBS MI	69	Spectrum Hlth	18
Jackson, MI	6157	BCBS MI	76	Spectrum Hlth	20
Kalamazoo-Portage, MI	6001	BCBS MI	75	Spectrum Hlth	20
Lansing-East Lansing, MI	4011	Sparrow (Physicians HP)	48	BCBS MI	39
Midland, MI	6536	BCBS MI	78	Spectrum Hlth	20
Monroe, MI	6004	BCBS MI	75	Spectrum Hlth	20
Muskegon, MI	6158	BCBS MI	76	Spectrum Hlth	20
Niles, MI	6157	BCBS MI	76	Spectrum Hlth	20
Saginaw, MI	6538	BCBS MI	78	Spectrum Hlth	20
Minnesota	2588	UCare	32	Medica	24
Duluth, MN-WI	3182	UCare	48	Medica	23
Mankato, MN	5068	Medica	56	BCBS MN	44
Minneapolis-St. Paul-Bloomington, MN-WI	3287	HealthPartners	40	UCare	38
Rochester, MN	5068	Medica	56	BCBS MN	44
St. Cloud, MN	3508	HealthPartners	52	UCare	21
Mississippi	10000	Centene	100	-	-
Gulfport-Biloxi, MS	10000	Centene	100	-	-
Hattiesburg, MS	10000	Centene	100	-	-
Jackson, MS	10000	Centene	100	-	-
Missouri	3706	Centene	47	Cigna	35
Cape Girardeau, MO-IL	9470	Anthem	97	HCSC (BCBS)	2
Columbia, MO	6809	Cigna	80	Anthem	20
Jefferson City, MO	10000	Anthem	100	-	-
Joplin, MO	10000	Centene	100	-	-
Kansas City, MO-KS	3864	Centene	53	Cigna	27

Table 5. (continued)Market concentration (HHI) and largest insurers' market shares, as of July 1, 2019. *Exchanges*

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Springfield, MO	10000	Centene	100	-	-
St. Joseph, MO-KS	8867	Centene	94	BCBS KS	6
St. Louis, MO-IL	3900	Cigna	48	Centene	37
Montana	3435	HCSC (BCBS)	38	Montana Health CO-OP	37
Billings, MT	4711	HCSC (BCBS)	58	Montana Health CO-OP	37
Great Falls, MT	3490	HCSC (BCBS)	40	Montana Health CO-OP	37
Missoula, MT	3746	HCSC (BCBS)	46	Montana Health CO-OP	37
Nebraska	10000	Medica	100	-	-
Grand Island, NE	10000	Medica	100	-	-
Lincoln, NE	10000	Medica	100	-	-
Omaha-Council Bluffs, NE-IA	9925	Medica	100	Wellmark (BCBS)	0
Nevada	5048	UnitedHealth Group	55	Centene	45
Carson City, NV	10000	Centene	100	-	-
Las Vegas-Henderson-Paradise, NV	5197	UnitedHealth Group	60	Centene	40
Reno, NV	5175	UnitedHealth Group	59	Centene	41
New Hampshire	4915	Anthem	64	Centene	28
Manchester-Nashua, NH	4786	Anthem	63	Centene	28
New Jersey	4601	Independence Hlth Grp	50	Horizon BCBS	45
Atlantic City-Hammonton, NJ	5014	Independence Hlth Grp	53	Horizon BCBS	47
Ocean City, NJ	5014	Independence Hlth Grp	53	Horizon BCBS	47
Trenton-Princeton, NJ	4520	Independence Hlth Grp	50	Horizon BCBS	45
Vineland-Bridgeton, NJ	5014	Independence Hlth Grp	53	Horizon BCBS	47
New Mexico	4971	Molina Hlthcare	61	New Mexico Hlth Conn.	35
Albuquerque, NM	4708	Molina Hlthcare	52	New Mexico Hlth Conn.	44
Las Cruces, NM	6217	Molina Hlthcare	77	New Mexico Hlth Conn.	19
Santa Fe, NM	4997	Molina Hlthcare	62	New Mexico Hlth Conn.	34
New York	1981	Centene	39	Healthfirst	15
Albany-Schenectady-Troy, NY	2637	Centene	34	CDPHP	26
Binghamton, NY	4544	Centene	58	Lifetime Hlthcare	34
Buffalo-Cheektowaga, NY	3143	Centene	40	HealthNow NY (BCBS)	29
Glens Falls, NY	3284	Centene	49	HealthNow NY (BCBS)	22
Ithaca, NY	6673	Lifetime Hlthcare	79	MVP Hlth Care	21
Kingston, NY	3918	Centene	51	MVP Hlth Care	36
New York-Newark-Jersey City, NY-NJ-PA	1643	Independence Hlth Grp	24	Horizon BCBS	22
Poughkeepsie-Newburgh-Middletown, NY	5441	Centene	71	MVP Hlth Care	20
Rochester, NY	4161	MVP Hlth Care	50	Lifetime Hlthcare	39
Syracuse, NY	4429	Centene	52	Lifetime Hlthcare	41
Utica-Rome, NY	3721	Centene	49	Lifetime Hlthcare	30
North Carolina	9554	BCBS NC	98	Centene	1
Asheville, NC	10000	BCBS NC	100	-	-
Burlington, NC	10000	BCBS NC	100	-	-
Charlotte-Concord-Gastonia, NC-SC	8005	BCBS NC	89	BCBS SC	11
Durham-Chapel Hill, NC	8566	BCBS NC	92	Centene	5
Fayetteville, NC	10000	BCBS NC	100	-	-
Goldensboro, NC	10000	BCBS NC	100	-	-

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Greensboro-High Point, NC	10000	BCBS NC	100	-	-
Greenville, NC	10000	BCBS NC	100	-	-
Hickory-Lenoir-Morganton, NC	10000	BCBS NC	100	-	-
Jacksonville, NC	10000	BCBS NC	100	-	-
New Bern, NC	10000	BCBS NC	100	-	-
Raleigh-Cary, NC	7555	BCBS NC	86	Centene	10
Rocky Mount, NC	6013	BCBS NC	73	Cigna	27
Wilmington, NC	10000	BCBS NC	100	-	-
Winston-Salem, NC	10000	BCBS NC	100	-	-
Ohio	2439	Medical Mutual	38	CareSource	26
Akron, OH	3535	Medical Mutual	42	CareSource	40
Canton-Massillon, OH	4474	Centene	62	Aultman Hlth	23
Cincinnati, OH-KY-IN	2735	CareSource	34	Centene	33
Cleveland-Elyria, OH	4258	Medical Mutual	59	CareSource	21
Columbus, OH	3778	Medical Mutual	51	CareSource	28
Dayton-Kettering, OH	3529	Centene	41	CareSource	37
Mansfield, OH	9969	Medical Mutual	100	CareSource	0
Springfield, OH	3538	Centene	42	Medical Mutual	36
Toledo, OH	3090	Medical Mutual	45	CareSource	27
Weirton-Steubenville, WV-OH	5659	CareSource	73	Anthem	16
Youngstown-Warren-Boardman, OH-PA	2501	Medical Mutual	26	CareSource	25
Oklahoma	9579	HCSC (BCBS)	98	Medica	2
Enid, OK	9581	HCSC (BCBS)	98	Medica	2
Lawton, OK	9581	HCSC (BCBS)	98	Medica	2
Oklahoma City, OK	9579	HCSC (BCBS)	98	Medica	2
Tulsa, OK	9579	HCSC (BCBS)	98	Medica	2
Oregon	2765	Providence Hlth	38	Kaiser	25
Albany-Lebanon, OR	5863	Providence Hlth	71	Kaiser	29
Bend, OR	6946	PacificSource	82	Providence Hlth	13
Corvallis, OR	6276	Providence Hlth	75	Kaiser	25
Eugene-Springfield, OR	3300	PacificSource	47	Providence Hlth	25
Grants Pass, OR	8459	Moda Health	92	Providence Hlth	8
Medford, OR	7435	Moda Health	85	Providence Hlth	15
Portland-Vancouver-Hillsboro, OR-WA	3355	Kaiser	43	Providence Hlth	38
Salem, OR	3691	Kaiser	49	Providence Hlth	28
Pennsylvania	2711	Independence Hlth Grp	40	UPMC	28
Allentown-Bethlehem-Easton, PA-NJ	3139	Capital BC	49	Geisinger	20
Altoona, PA	9643	UPMC	98	Geisinger	1
Bloomsburg-Berwick, PA	5017	Capital BC	58	Geisinger	40
Chambersburg-Waynesboro, PA	6604	Capital BC	78	Highmark	22
East Stroudsburg, PA	5016	Geisinger	53	Highmark	47
Erie, PA	8320	UPMC	91	Highmark	9
Gettysburg, PA	4584	Capital BC	55	Geisinger	38
Harrisburg-Carlisle, PA	3189	Capital BC	45	UPMC	29
Johnstown, PA	9574	UPMC	98	Geisinger	1

Table 5. (continued)Market concentration (HHI) and largest insurers' market shares, as of July 1, 2019. *Exchanges*

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Lancaster, PA	3982	Capital BC	58	Geisinger	18
Lebanon, PA	3742	Capital BC	48	Geisinger	33
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	7164	Independence Hlth Grp	84	Horizon BCBS	7
Pittsburgh, PA	9175	UPMC	96	Highmark	4
Reading, PA	3399	UPMC	44	Capital BC	35
Scranton--Wilkes-Barre, PA	4950	Geisinger	52	Highmark	47
State College, PA	3903	UPMC	52	Capital BC	28
Williamsport, PA	5197	UPMC	60	Geisinger	40
York-Hanover, PA	4469	Capital BC	55	Geisinger	38
Rhode Island	6644	Neighborhood HP	79	BCBS RI	21
Providence-Warwick, RI-MA	2874	Neighborhood HP	43	Tufts	26
South Carolina	9905	BCBS SC	100	Centene	0
Charleston-North Charleston, SC	9454	BCBS SC	97	Centene	3
Columbia, SC	10000	BCBS SC	100	-	-
Florence, SC	10000	BCBS SC	100	-	-
Greenville-Anderson, SC	10000	BCBS SC	100	-	-
Hilton Head Island-Bluffton, SC	10000	BCBS SC	100	-	-
Myrtle Beach-Conway-North Myrtle Beach, SC-NC	6063	BCBS SC	73	BCBS NC	27
Spartanburg, SC	10000	BCBS SC	100	-	-
Sumter, SC	10000	BCBS SC	100	-	-
South Dakota	5003	Sanford	51	Avera Hlth	49
Rapid City, SD	5003	Sanford	51	Avera Hlth	49
Sioux Falls, SD	5003	Sanford	51	Avera Hlth	49
Tennessee	3701	BCBS TN	52	Cigna	30
Chattanooga, TN-GA	5167	BCBS TN	59	Centene	41
Clarksville, TN-KY	2338	Cigna	31	Anthem	27
Cleveland, TN	7558	BCBS TN	86	Centene	14
Jackson, TN	10000	BCBS TN	100	-	-
Johnson City, TN	5451	BCBS TN	65	Cigna	35
Kingsport-Bristol, TN-VA	3736	BCBS TN	48	Anthem	32
Knoxville, TN	6804	BCBS TN	81	Cigna	11
Memphis, TN-MS-AR	3562	Cigna	50	Centene	30
Morristown, TN	7510	BCBS TN	86	Cigna	10
Nashville-Davidson--Murfreesboro--Franklin, TN	3778	Cigna	56	Bright Health	19
Texas	2578	HCSC (BCBS)	42	Centene	20
Abilene, TX	6049	HCSC (BCBS)	73	Baylor Scott & White	27
Amarillo, TX	5062	Baylor Scott & White	56	HCSC (BCBS)	44
Austin-Round Rock-Georgetown, TX	2624	Oscar	34	Centene	24
Beaumont-Port Arthur, TX	2587	Community Hlth Choice	31	Molina Hlthcare	26
Brownsville-Harlingen, TX	3503	HCSC (BCBS)	39	Molina Hlthcare	38
College Station-Bryan, TX	5593	HCSC (BCBS)	67	Centene	33
Corpus Christi, TX	5045	HCSC (BCBS)	55	CHRISTUS	45
Dallas-Fort Worth-Arlington, TX	4003	HCSC (BCBS)	54	Centene	26
El Paso, TX	2729	Oscar	36	HCSC (BCBS)	26
Houston-The Woodlands-Sugar Land, TX	2591	Community Hlth Choice	31	Molina Hlthcare	27

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
Killeen-Temple, TX	6027	HCSC (BCBS)	73	Centene	27
Laredo, TX	5288	HCSC (BCBS)	62	Molina Hlthcare	38
Longview, TX	5302	HCSC (BCBS)	62	CHRISTUS	38
Lubbock, TX	5977	HCSC (BCBS)	72	Baylor Scott & White	28
McAllen-Edinburg-Mission, TX	3503	HCSC (BCBS)	39	Molina Hlthcare	38
Midland, TX	6318	HCSC (BCBS)	76	Baylor Scott & White	24
Odessa, TX	5036	Baylor Scott & White	54	HCSC (BCBS)	46
San Angelo, TX	10000	HCSC (BCBS)	100	-	-
San Antonio-New Braunfels, TX	3680	HCSC (BCBS)	48	Oscar	31
Sherman-Denison, TX	10000	HCSC (BCBS)	100	-	-
Texarkana, TX-AR	3242	HCSC (BCBS)	42	CHRISTUS	35
Tyler, TX	5045	HCSC (BCBS)	55	CHRISTUS	45
Victoria, TX	10000	HCSC (BCBS)	100	-	-
Waco, TX	3334	HCSC (BCBS)	34	Centene	33
Wichita Falls, TX	10000	HCSC (BCBS)	100	-	-
Utah	8211	Intermountain	90	Univ of Utah Health	10
Logan, UT-ID	8108	Intermountain	90	Univ of Utah Health	9
Ogden-Clearfield, UT	8212	Intermountain	90	Univ of Utah Health	10
Provo-Orem, UT	8207	Intermountain	90	Univ of Utah Health	10
Salt Lake City, UT	8206	Intermountain	90	Univ of Utah Health	10
St. George, UT	8207	Intermountain	90	Univ of Utah Health	10
Vermont	5004	MVP Hlth Care	51	BCBS VT	49
Burlington-South Burlington, VT	5004	MVP Hlth Care	51	BCBS VT	49
Virginia	3146	Anthem	40	Cigna	37
Blacksburg-Christiansburg, VA	10000	Anthem	100	-	-
Charlottesville, VA	7173	Anthem	83	Sentara (Optima Hlth)	15
Harrisonburg, VA	5670	Anthem	68	Sentara (Optima Hlth)	32
Lynchburg, VA	6517	Anthem	78	Centra (Piedmont)	22
Richmond, VA	6789	Cigna	81	Virginia Premier	11
Roanoke, VA	10000	Anthem	100	-	-
Staunton, VA	8528	Anthem	92	Centra (Piedmont)	8
Virginia Beach-Norfolk-Newport News, VA-NC	4846	Anthem	59	Sentara (Optima Hlth)	36
Winchester, VA-WV	8259	Anthem	90	Highmark	10
Washington	2870	Kaiser	39	Centene	26
Bellingham, WA	5354	Kaiser	63	Premera	37
Bremerton-Silverdale-Port Orchard, WA	5354	Kaiser	63	Premera	37
Kennewick-Richland, WA	3488	Kaiser	42	Centene	34
Longview, WA	8153	Kaiser	90	Premera	10
Mount Vernon-Anacortes, WA	10000	Kaiser	100	-	-
Olympia-Lacey-Tumwater, WA	2550	Premera	28	Kaiser	27
Seattle-Tacoma-Bellevue, WA	2771	Kaiser	36	Centene	29
Spokane-Spokane Valley, WA	2546	Premera	28	Centene	28
Walla Walla, WA	3335	Premera	34	Kaiser	33
Wenatchee, WA	10000	Centene	100	-	-
Yakima, WA	5075	Kaiser	56	Centene	44

Table 5. (continued)

Market concentration (HHI) and largest insurers' market shares, as of July 1, 2019. Exchanges

State and MSAs	EXCH HHI	Insurer 1	Share (%)	Insurer 2	Share (%)
West Virginia	5621	Highmark	68	CareSource	32
Charleston, WV	5066	Highmark	56	CareSource	44
Huntington-Ashland, WV-KY-OH	4601	CareSource	62	Anthem	21
Morgantown, WV	5105	Highmark	57	CareSource	43
Wheeling, WV-OH	5437	CareSource	71	Anthem	15
Wisconsin	1794	Common Ground	34	SSM Health (Dean HP)	16
Appleton, WI	6763	Common Ground	80	Ascension	20
Eau Claire, WI	6579	Marshfield (Security HP)	78	Medica	22
Fond du Lac, WI	5806	SSM Health (Dean HP)	71	Common Ground	26
Green Bay, WI	7840	Common Ground	88	Molina Hlthcare	12
Janesville-Beloit, WI	3490	MercyCare	42	SSM Health (Dean HP)	35
La Crosse-Onalaska, WI-MN	5776	Quartz	72	Medica	25
Madison, WI	4571	SSM Health (Dean HP)	61	Quartz	27
Milwaukee-Waukesha, WI	3596	Common Ground	54	Children's Hosp of WI-CCHP	21
Oshkosh-Neenah, WI	7243	Common Ground	84	Ascension	16
Racine, WI	3852	Common Ground	56	Children's Hosp of WI-CCHP	22
Sheboygan, WI	9950	Common Ground	100	Ascension	0
Wausau-Weston, WI	5360	Marshfield (Security HP)	63	WPS Health	37
Wyoming	10000	BCBS WY	100	-	-
Casper, WY	10000	BCBS WY	100	-	-
Cheyenne, WY	10000	BCBS WY	100	-	-

Notes:

1. Source: Managed Market Surveyor | Data Extraction | Enterprise License © 2019 DR/Decision Resources, LLC. All rights reserved.
2. State and MSA-level Herfindahl-Hirschman Indices (HHIs) and the market shares of the two largest insurers in the exchange are reported.
3. We do not present data for geographic areas with fewer than 1,000 reported exchange enrollees.
4. We exclude all data for North Dakota because those data appeared to be incomplete.
5. The HHIs and market shares are rounded. As a result, in a few markets where the second largest insurer has very few covered lives, the market share appears as zero. The actual, unrounded shares are just above 0 percent.

Table 6. State and MSA HHI by product type, as of Jan. 1, 2019

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI	EXCH HHI
Alabama	7461	8790	8442	8393	9854
Awnniston-Oxford, AL	8313	-	8795	-	10000
Auburn-Opelika, AL	6980	-	7831	5475	10000
Birmingham-Hoover, AL	7148	7899	8391	9003	9363
Daphne-Fairhope-Foley, AL	6725	-	7765	9723	10000
Decatur, AL	7683	-	8464	-	10000
Dothan, AL	7960	-	8935	-	10000
Florence-Muscle Shoals, AL	7636	-	8301	-	10000
Gadsden, AL	8261	-	9072	-	10000
Huntsville, AL	7523	-	8211	7378	10000
Mobile, AL	7240	-	8365	9126	10000
Montgomery, AL	7717	-	8661	9861	10000
Tuscaloosa, AL	8290	-	9133	-	10000
Alaska	4333	-	4524	10000	10000
Anchorage, AK	4036	-	4192	-	10000
Fairbanks, AK	4400	-	4537	-	10000
Arizona	2273	2677	2907	8959	4253
Flagstaff, AZ	4618	-	5262	-	10000
Lake Havasu City-Kingman, AZ	3377	-	3731	9408	10000
Phoenix-Mesa-Chandler, AZ	2302	2936	2974	9030	6134
Prescott Valley-Prescott, AZ	3728	-	4235	9503	10000
Sierra Vista-Douglas, AZ	2819	-	3437	9526	10000
Tucson, AZ	2622	2825	2973	8507	4687
Yuma, AZ	3476	-	3908	-	10000
Arkansas	3054	6641	4503	4029	5370
Fayetteville-Springdale-Rogers, AR	3069	6978	4371	3484	5370
Fort Smith, AR-OK	1982	-	2548	5279	3473
Hot Springs, AR	3221	-	4556	4211	5369
Jonesboro, AR	3427	-	5268	3533	5371
Little Rock-North Little Rock-Conway, AR	3157	5504	4992	4747	5370
Pine Bluff, AR	4424	-	6349	3850	5368
California	2161	4798	3092	4944	2411
Bakersfield, CA	2714	4239	4355	4847	4821
Chico, CA	4339	4535	4613	5030	5004
El Centro, CA	2541	3187	3842	-	8342
Fresno, CA	2544	4392	3994	4935	5595
Hanford-Corcoran, CA	2745	1950	4107	5300	8457
Los Angeles-Long Beach-Anaheim, CA	2031	4384	3235	4013	2174
Madera, CA	2533	4281	4039	-	5609
Merced, CA	3835	3426	4372	5100	8088
Modesto, CA	3030	6294	3637	4882	5266
Napa, CA	3519	7184	4994	4928	5794
Oxnard-Thousand Oaks-Ventura, CA	2335	3790	3711	4587	6116
Redding, CA	4798	9010	4559	5595	5143
Riverside-San Bernardino-Ontario, CA	2640	5235	3473	4127	2854

Table 6. (continued)

State and MSA HHI by product type, as of Jan. 1, 2019

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI	EXCH HHI
Sacramento-Roseville-Folsom, CA	2932	5095	2945	6093	5259
Salinas, CA	3571	5922	4088	5194	9699
San Diego-Chula Vista-Carlsbad, CA	1559	2843	2527	5708	2102
San Francisco-Oakland-Berkeley, CA	2811	6692	2550	6773	5621
San Jose-Sunnyvale-Santa Clara, CA	2245	6623	2582	7328	3306
San Luis Obispo-Paso Robles, CA	3765	3181	4801	5104	9997
Santa Cruz-Watsonville, CA	2184	2726	3760	5252	4775
Santa Maria-Santa Barbara, CA	3134	2557	3841	3669	9992
Santa Rosa-Petaluma, CA	4195	7713	3077	5982	5584
Stockton, CA	3589	7020	3616	5264	6202
Vallejo, CA	5059	7752	2887	6215	7601
Visalia, CA	3994	2707	4688	4917	6881
Yuba City, CA	3817	3877	5219	5036	4069
Colorado	1975	5292	3186	6686	2702
Boulder, CO	2016	6227	3373	6559	3337
Colorado Springs, CO	1940	4864	2949	6351	3843
Denver-Aurora-Lakewood, CO	2065	6482	3565	7428	2897
Fort Collins, CO	2359	4186	3310	5351	5012
Grand Junction, CO	3152	8092	3742	6236	5618
Greeley, CO	1988	4649	3636	6577	4771
Pueblo, CO	2413	4475	3667	6079	5513
Connecticut	2193	5684	2780	4010	6727
Bridgeport-Stamford-Norwalk, CT	2193	5950	2764	5358	6792
Hartford-East Hartford-Middletown, CT	2160	5317	3014	3586	6911
New Haven-Milford, CT	2413	5773	2869	3586	6829
Norwich-New London, CT	3062	8021	3392	5148	5454
Delaware	4719	4833	5235	7021	10000
Dover, DE	5405	4931	6322	-	10000
District of Columbia	1926	2948	2098	9821	7095
Washington-Arlington-Alexandria, DC-VA-MD-WV	1686	2971	2182	6691	3180
Florida	2358	2479	3097	9125	5029
Cape Coral-Fort Myers, FL	3175	4202	2852	9685	10000
Crestview-Fort Walton Beach-Destin, FL	4563	-	5013	9447	10000
Deltona-Daytona Beach-Ormond Beach, FL	2603	6265	2887	7987	6428
Gainesville, FL	5429	3189	6306	9234	9874
Homosassa Springs, FL	4067	-	5023	9788	7122
Jacksonville, FL	3272	3629	3979	9646	7274
Lakeland-Winter Haven, FL	2252	2389	2939	8096	6080
Miami-Fort Lauderdale-Pompano Beach, FL	1828	2495	3047	8761	4599
Naples-Marco Island, FL	3644	3761	3521	9645	10000
North Port-Sarasota-Bradenton, FL	2996	4128	2947	9705	7863
Ocala, FL	4670	5164	5087	8477	9815
Orlando-Kissimmee-Sanford, FL	2429	2876	3513	9355	6489
Palm Bay-Melbourne-Titusville, FL	2249	4916	3479	9244	9174
Panama City, FL	5381	-	6339	9555	10000

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI	EXCH HHI
Pensacola-Ferry Pass-Brent, FL	4154	5394	4985	9655	10000
Port St. Lucie, FL	3706	4239	4223	8152	6871
Punta Gorda, FL	3188	4945	3122	9662	8301
Sebastian-Vero Beach, FL	4007	5612	5185	9468	10000
Sebring-Avon Park, FL	3284	-	3561	-	10000
Tallahassee, FL	7757	9836	5882	9575	10000
Tampa-St. Petersburg-Clearwater, FL	2276	2541	2882	9660	5752
The Villages, FL	4823	-	4832	-	10000
Georgia	2356	3164	2930	4560	4352
Albany, GA	4136	9330	4357	5128	10000
Athens-Clarke County, GA	2925	3626	2883	5308	9431
Atlanta-Sandy Springs-Alpharetta, GA	2114	3228	3004	4509	4328
Augusta-Richmond County, GA-SC	2517	4181	2493	4431	5041
Brunswick, GA	3129	-	3714	4736	10000
Columbus, GA-AL	3104	4971	2939	5619	7127
Dalton, GA	2968	-	3843	6652	5123
Gainesville, GA	2429	3410	3149	4893	8702
Hinesville, GA	4182	-	4411	5415	10000
Macon-Bibb County, GA	3542	5576	3851	4799	9503
Rome, GA	2887	-	3268	5812	8353
Savannah, GA	2120	4057	2651	4138	10000
Valdosta, GA	5014	-	3875	5305	10000
Warner Robins, GA	5456	7433	5984	5952	10000
Hawaii	4901	5095	5919	-	5338
Kahului-Wailuku-Lahaina, HI	3919	6404	5188	-	5017
Urban Honolulu, HI	5097	5244	5925	-	5705
Idaho	2468	4174	3014	6488	3879
Boise City, ID	2305	6426	2865	7652	4095
Coeur d'Alene, ID	1927	7951	1864	5051	5003
Idaho Falls, ID	2896	-	3751	-	5556
Lewiston, ID-WA	2230	-	2376	-	6837
Pocatello, ID	3542	-	3654	-	9039
Twin Falls, ID	2413	-	3218	-	4450
Illinois	3913	6415	4621	9417	6360
Bloomington, IL	4670	7055	6211	5604	6277
Carbondale-Marion, IL	2644	-	3383	-	5308
Champaign-Urbana, IL	4260	9618	2562	5911	9472
Chicago-Naperville-Elgin, IL-IN-WI	3911	7906	4557	7624	6116
Danville, IL	3176	-	4312	-	7692
Davenport-Moline-Rock Island, IA-IL	2643	2781	2727	9414	3962
Decatur, IL	4865	-	6190	-	5113
Kankakee, IL	4244	-	5815	9624	3648
Peoria, IL	3121	3282	3506	7749	5004
Rockford, IL	4820	5782	5726	9978	8642
Springfield, IL	2965	4258	3663	7982	5048

Table 6. (continued)

State and MSA HHI by product type, as of Jan. 1, 2019

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI	EXCH HHI
Indiana	3553	4181	4621	4713	5220
Bloomington, IN	3930	8091	5992	5334	7008
Columbus, IN	3246	-	5318	3738	7231
Elkhart-Goshen, IN	4000	-	4866	5019	6026
Evansville, IN-KY	3907	-	5029	4670	7421
Fort Wayne, IN	3194	-	4082	4888	6794
Indianapolis-Carmel-Anderson, IN	3804	4615	5077	4810	5051
Kokomo, IN	5640	-	6793	6107	5305
Lafayette-West Lafayette, IN	2844	8076	5206	4933	6397
Michigan City-La Porte, IN	4705	-	5926	5459	5121
Muncie, IN	4212	8098	6575	6190	6685
South Bend-Mishawaka, IN-MI	2898	-	3336	4696	3508
Terre Haute, IN	5291	-	6002	6123	5249
Iowa	3177	3915	4916	8367	8866
Ames, IA	4672	4320	7219	7138	8852
Cedar Rapids, IA	3563	7300	4964	7697	8863
Davenport-Moline-Rock Island, IA-IL	2643	2781	2727	9414	3962
Des Moines-West Des Moines, IA	3192	4032	4445	9009	8867
Dubuque, IA	3030	-	5115	8608	8860
Iowa City, IA	4611	4840	7166	6453	8860
Sioux City, IA-NE-SD	2070	-	2834	9118	6517
Waterloo-Cedar Falls, IA	3139	4450	4516	9264	8852
Kansas	2471	4813	3074	9808	4879
Lawrence, KS	3181	-	3464	9650	9293
Manhattan, KS	5950	-	6105	-	9287
Topeka, KS	5642	-	6631	9826	9296
Wichita, KS	3270	8327	4438	9880	9295
Kentucky	4409	3278	5462	3974	5120
Bowling Green, KY	4290	-	4759	3833	10000
Elizabethtown-Fort Knox, KY	5159	-	5783	4032	9465
Lexington-Fayette, KY	4667	3395	5796	3865	5136
Louisville/Jefferson County, KY-IN	3948	3039	5056	4193	3877
Owensboro, KY	5715	-	6843	4362	10000
Louisiana	4269	4165	5751	8949	8142
Alexandria, LA	4792	-	6583	9157	8135
Baton Rouge, LA	4449	4176	5800	8694	8144
Hammond, LA	4575	-	5918	8750	8140
Houma-Thibodaux, LA	4539	-	6306	9085	8138
Lafayette, LA	4700	6732	6148	8855	8137
Lake Charles, LA	4259	-	5541	8782	8143
Monroe, LA	4376	-	6385	9216	8148
New Orleans-Metairie, LA	3918	3378	5649	9186	8142
Shreveport-Bossier City, LA	4627	3570	6138	8711	8140
Maine	2818	4780	2866	5105	3499
Bangor, ME	2570	4694	2751	5153	3984

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI	EXCH HHI
Lewiston-Auburn, ME	2530	5052	2826	5058	3492
Portland-South Portland, ME	2765	4745	2853	5009	3382
Maryland	2813	3985	3458	9748	5060
Baltimore-Columbia-Towson, MD	3146	4881	3655	9904	5095
California-Lexington Park, MD	3986	5044	4477	-	10000
Cumberland, MD-WV	2587	-	3116	9802	7184
Hagerstown-Martinsburg, MD-WV	1880	3702	2430	8904	5596
Salisbury, MD-DE	2846	2823	3429	8494	4999
Massachusetts	2004	3081	2212	9807	4112
Barnstable Town, MA	2661	4102	3006	-	4168
Boston-Cambridge-Newton, MA-NH	1731	2965	1881	6363	3797
Pittsfield, MA	2936	4859	2850	-	3531
Springfield, MA	1802	2871	2265	8436	3249
Worcester, MA-CT	1676	2983	1825	5475	3410
Michigan	4724	3765	6074	6770	4939
Ann Arbor, MI	6142	6068	7075	5470	5278
Battle Creek, MI	5796	6655	7154	7771	6163
Bay City, MI	5725	5480	6387	-	6537
Detroit-Warren-Dearborn, MI	4815	4379	6185	6629	4345
Flint, MI	4910	3864	6502	5454	4683
Grand Rapids-Kentwood, MI	4060	5421	5449	6725	5101
Jackson, MI	5925	4718	7182	-	6157
Kalamazoo-Portage, MI	5282	6463	7662	8439	6001
Lansing-East Lansing, MI	5634	4724	7992	-	4011
Midland, MI	5544	9018	5359	-	6536
Monroe, MI	5205	3729	6789	-	6004
Muskegon, MI	4720	5003	5798	-	6158
Niles, MI	5376	7217	6068	6841	6157
Saginaw, MI	4919	4221	5802	-	6538
Minnesota	2771	4950	3318	6953	2588
Duluth, MN-WI	2723	-	3499	6343	3182
Mankato, MN	4580	-	4963	-	5068
Minneapolis-St. Paul-Bloomington, MN-WI	2252	4471	2744	5851	3287
Rochester, MN	4754	-	5139	8940	5068
St. Cloud, MN	3345	-	3936	5446	3508
Mississippi	3584	-	5623	9980	10000
Gulfport-Biloxi, MS	3949	-	6001	9959	10000
Hattiesburg, MS	3589	-	6410	10000	10000
Jackson, MS	4137	-	6002	9998	10000
Missouri	1907	4100	2154	7255	3706
Cape Girardeau, MO-IL	3236	-	3118	7175	9470
Columbia, MO	3691	-	2742	8909	6809
Jefferson City, MO	3058	-	3240	7384	10000
Joplin, MO	2082	-	2610	6016	10000
Kansas City, MO-KS	2740	6054	3795	9862	3864

Table 6. (continued)**State and MSA HHI by product type, as of Jan. 1, 2019**

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI	EXCH HHI
Springfield, MO	1661	-	2054	7868	10000
St. Joseph, MO-KS	3799	-	4876	9980	8867
St. Louis, MO-IL	2270	4028	2468	7602	3900
Montana	2901	-	3510	9458	3435
Billings, MT	3060	-	3553	-	4711
Great Falls, MT	3545	-	4234	-	3490
Missoula, MT	3086	-	3638	-	3746
Nebraska	3076	-	5161	9999	10000
Grand Island, NE	3638	-	6223	-	10000
Lincoln, NE	3470	-	6063	10000	10000
Omaha-Council Bluffs, NE-IA	2727	-	3968	9898	9925
Nevada	2318	7271	2009	6032	5048
Carson City, NV	2123	-	2766	-	10000
Las Vegas-Henderson-Paradise, NV	2776	9078	1955	6231	5197
Reno, NV	1944	3397	2190	7107	5175
New Hampshire	2894	5446	3055	4885	4915
Manchester-Nashua, NH	2874	5680	2911	5098	4786
New Jersey	2659	4631	2872	5059	4601
Atlantic City-Hammonton, NJ	6537	-	6083	8572	5014
Ocean City, NJ	6034	-	4335	8935	5014
Trenton-Princeton, NJ	2991	7674	3618	5726	4520
Vineland-Bridgeton, NJ	4246	9358	3770	8410	5014
New Mexico	2729	5640	4733	6949	4971
Albuquerque, NM	2467	5133	3745	6135	4708
Farmington, NM	2707	-	4191	9649	-
Las Cruces, NM	3984	7607	6382	-	6217
Santa Fe, NM	2385	6966	4333	8403	4997
New York	1542	2485	1468	6614	1981
Albany-Schenectady-Troy, NY	2463	4917	2191	4688	2637
Binghamton, NY	3729	-	4068	-	4544
Buffalo-Cheektowaga, NY	2839	5559	1783	6857	3143
Elmira, NY	4453	-	5186	-	-
Glens Falls, NY	1973	-	1951	-	3284
Ithaca, NY	3201	-	3314	-	6673
Kingston, NY	2178	3603	2190	8439	3918
New York-Newark-Jersey City, NY-NJ-PA	1676	3156	1676	4871	1643
Poughkeepsie-Newburgh-Middletown, NY	1903	3028	1798	6760	5441
Rochester, NY	6073	5013	6728	4845	4161
Syracuse, NY	4847	6964	5458	8968	4429
Utica-Rome, NY	3663	9415	4430	9808	3721
Watertown-Fort Drum, NY	3706	-	4137	-	-
North Carolina	3720	5517	4455	8527	9554
Asheville, NC	4446	6869	4743	8425	10000
Burlington, NC	3599	-	4393	8630	10000
Charlotte-Concord-Gastonia, NC-SC	2536	5672	2913	8878	8005

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI	EXCH HHI
Durham-Chapel Hill, NC	3490	5699	4116	8270	8566
Fayetteville, NC	4441	-	5605	8160	10000
Goldensboro, NC	5825	-	6579	-	10000
Greensboro-High Point, NC	3801	8381	4841	9175	10000
Greenville, NC	6501	-	6651	-	10000
Hickory-Lenoir-Morganton, NC	4874	-	6424	9040	10000
Jacksonville, NC	5710	-	6135	-	10000
New Bern, NC	6279	-	6284	-	10000
Raleigh-Cary, NC	3179	5374	4038	8888	7555
Rocky Mount, NC	5086	-	6402	8396	6013
Wilmington, NC	3881	-	4970	9270	10000
Winston-Salem, NC	3644	7728	4335	8586	10000
North Dakota	3710	9698	6548	9890	-
Bismarck, ND	3703	9978	6517	-	-
Fargo, ND-MN	2199	9700	3130	9629	-
Grand Forks, ND-MN	2340	9718	3308	-	-
Ohio	2170	1976	2677	4508	2439
Akron, OH	2412	2040	3031	3918	3535
Canton-Massillon, OH	2055	-	2975	3985	4474
Cincinnati, OH-KY-IN	3133	3006	4292	4757	2735
Cleveland-Elyria, OH	2845	2780	3605	4112	4258
Columbus, OH	2151	3659	2464	6347	3778
Dayton-Kettering, OH	3153	-	4118	5181	3529
Lima, OH	2517	-	2912	3294	-
Mansfield, OH	2985	-	3715	4690	9969
Springfield, OH	2285	-	2919	4392	3538
Toledo, OH	1993	8424	2685	3168	3090
Weirton-Steubenville, WV-OH	2035	-	2296	3225	5659
Youngstown-Warren-Boardman, OH-PA	1907	2082	2177	3468	2501
Oklahoma	3531	3325	4895	9994	9579
Enid, OK	3820	-	5425	-	9581
Lawton, OK	4896	-	5848	-	9581
Oklahoma City, OK	3424	2906	4756	9989	9579
Tulsa, OK	2910	4031	4214	9996	9579
Oregon	1477	9411	2016	9253	2765
Albany-Lebanon, OR	1517	-	2186	10000	5863
Bend, OR	1847	-	2114	-	6946
Corvallis, OR	2008	-	2853	-	6276
Eugene-Springfield, OR	1926	5731	2174	10000	3300
Grants Pass, OR	1922	-	2383	-	8459
Medford, OR	1899	-	2166	-	7435
Portland-Vancouver-Hillsboro, OR-WA	1744	9883	2169	9204	3355
Salem, OR	1995	9818	2432	10000	3691
Pennsylvania	1723	2334	2077	8006	2711
Allentown-Bethlehem-Easton, PA-NJ	1928	3297	2432	5047	3139

Table 6. (continued)

State and MSA HHI by product type, as of Jan. 1, 2019

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI	EXCH HHI
Altoona, PA	2771	-	3117	-	9643
Bloomsburg-Berwick, PA	3722	9752	2922	-	5017
Chambersburg-Waynesboro, PA	3263	-	3854	9893	6604
East Stroudsburg, PA	3492	3789	4287	9892	5016
Erie, PA	3073	5874	3488	10000	8320
Gettysburg, PA	2791	-	3597	-	4584
Harrisburg-Carlisle, PA	2838	4161	3356	9959	3189
Johnstown, PA	3001	-	3290	-	9574
Lancaster, PA	3124	4405	3517	9898	3982
Lebanon, PA	3459	-	3972	-	3742
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	2365	4343	2490	4108	7164
Pittsburgh, PA	2833	4068	3081	9838	9175
Reading, PA	2655	4671	3087	9953	3399
Scranton--Wilkes-Barre, PA	3408	6855	4446	9621	4950
State College, PA	2902	4125	3146	-	3903
Williamsport, PA	2612	5909	3120	-	5197
York-Hanover, PA	2680	3549	3292	9965	4469
Rhode Island	2937	4548	4697	9962	6644
Providence-Warwick, RI-MA	1741	4183	2512	9958	2874
South Carolina	4573	7713	5198	9957	9905
Charleston-North Charleston, SC	4926	7761	5531	9969	9454
Columbia, SC	5003	8314	5611	9997	10000
Florence, SC	4770	-	5642	9991	10000
Greenville-Anderson, SC	4028	8855	4656	9976	10000
Hilton Head Island-Bluffton, SC	5051	-	5188	9619	10000
Myrtle Beach-Conway-North Myrtle Beach, SC-NC	2955	-	3094	9602	6063
Spartanburg, SC	4313	-	5034	9968	10000
Sumter, SC	4940	-	5582	-	10000
South Dakota	2696	4988	4234	9950	5003
Rapid City, SD	2640	4998	6102	-	5003
Sioux Falls, SD	2496	5493	3703	9940	5003
Tennessee	2957	4233	3819	9126	3701
Chattanooga, TN-GA	2457	6094	3540	4234	5167
Clarksville, TN-KY	2266	-	2711	4455	2338
Cleveland, TN	3463	-	4251	8518	7558
Jackson, TN	3111	-	3498	8915	10000
Johnson City, TN	4578	-	6088	9394	5451
Kingsport-Bristol, TN-VA	2657	4609	3282	4945	3736
Knoxville, TN	3267	-	4340	9560	6804
Memphis, TN-MS-AR	2632	2885	3399	9140	3562
Morristown, TN	4029	-	5227	9457	7510
Nashville-Davidson--Murfreesboro--Franklin, TN	2609	-	3509	9499	3778
Texas	2332	2475	3265	6326	2578
Abilene, TX	3413	-	4878	5915	6049
Amarillo, TX	2437	9117	3438	6341	5062

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI	EXCH HHI
Austin-Round Rock-Georgetown, TX	2222	2742	3215	6496	2624
Beaumont-Port Arthur, TX	2556	-	3405	5953	2587
Brownsville-Harlingen, TX	3977	-	5849	6341	3503
College Station-Bryan, TX	2875	9725	4377	5109	5593
Corpus Christi, TX	2986	-	4115	6960	5045
Dallas-Fort Worth-Arlington, TX	2408	3081	3150	6873	4003
El Paso, TX	2270	-	3265	5696	2729
Houston-The Woodlands-Sugar Land, TX	2079	1646	3102	5793	2591
Killeen-Temple, TX	2311	9723	2459	4575	6027
Laredo, TX	4780	-	6148	6176	5288
Longview, TX	3161	-	4254	7102	5302
Lubbock, TX	3292	9415	4992	5830	5977
McAllen-Edinburg-Mission, TX	3651	-	5452	6465	3503
Midland, TX	3697	-	5257	6752	6318
Odessa, TX	4207	-	6320	6382	5036
San Angelo, TX	3618	-	4400	5863	10000
San Antonio-New Braunfels, TX	2418	2997	3503	6680	3680
Sherman-Denison, TX	2847	-	3142	6330	10000
Texarkana, TX-AR	2865	-	3858	4154	3242
Tyler, TX	3403	-	4765	6769	5045
Victoria, TX	2996	-	3325	6357	10000
Waco, TX	2313	9667	3193	4349	3334
Wichita Falls, TX	3831	-	4526	5843	10000
Utah	2457	6133	2324	9973	8211
Logan, UT-ID	2706	8171	2491	10000	8108
Ogden-Clearfield, UT	2331	5076	2269	9977	8212
Provo-Orem, UT	3152	7859	3019	9968	8207
Salt Lake City, UT	2443	6639	2338	9971	8206
St. George, UT	2869	7657	2244	9974	8207
Vermont	3624	8806	3486	7035	5004
Burlington-South Burlington, VT	4057	9479	3858	6693	5004
Virginia	2317	1894	3055	4098	3146
Blacksburg-Christiansburg, VA	4207	5585	3805	5530	10000
Charlottesville, VA	2927	2557	3765	3865	7173
Harrisonburg, VA	4819	4352	5473	4534	5670
Lynchburg, VA	3904	3276	3921	5654	6517
Richmond, VA	3158	2942	3745	4936	6789
Roanoke, VA	3663	3615	3807	4992	10000
Staunton, VA	4126	4520	4211	4804	8528
Virginia Beach-Norfolk-Newport News, VA-NC	3384	5486	4495	3475	4846
Winchester, VA-WV	3536	3086	3806	4459	8259
Washington	1699	9939	2101	9921	2870
Bellingham, WA	2066	9990	2058	-	5354
Bremerton-Silverdale-Port Orchard, WA	2038	9983	2105	-	5354
Kennewick-Richland, WA	2124	9954	2491	9990	3488

Table 6. (continued)

State and MSA HHI by product type, as of Jan. 1, 2019

State and MSAs	TOTAL HHI	HMO HHI	PPO HHI	POS HHI	EXCH HHI
Longview, WA	3289	9994	2845	-	8153
Mount Vernon-Anacortes, WA	1936	-	2199	-	10000
Olympia-Lacey-Tumwater, WA	1749	9980	1810	9982	2550
Seattle-Tacoma-Bellevue, WA	1721	9946	2167	9891	2771
Spokane-Spokane Valley, WA	2157	9987	3021	9991	2546
Walla Walla, WA	2034	-	2671	-	3335
Wenatchee, WA	2483	-	3255	-	10000
Yakima, WA	1909	8637	2311	-	5075
West Virginia	2560	5328	3481	8060	5621
Beckley, WV	3464	-	4858	-	-
Charleston, WV	2553	-	3633	8663	5066
Huntington-Ashland, WV-KY-OH	2792	-	3121	4349	4601
Morgantown, WV	3226	-	4330	-	5105
Parkersburg-Vienna, WV	3204	-	4429	-	-
Wheeling, WV-OH	1947	-	2201	4268	5437
Wisconsin	1501	1840	1959	5989	1794
Appleton, WI	2197	2525	1963	7593	6763
Eau Claire, WI	1503	3890	1795	5053	6579
Fond du Lac, WI	2499	5747	1735	6921	5806
Green Bay, WI	1739	2323	1710	7252	7840
Janesville-Beloit, WI	2146	3966	1587	2548	3490
La Crosse-Onalaska, WI-MN	1582	2802	1994	5325	5776
Madison, WI	2231	3232	1565	2365	4571
Milwaukee-Waukesha, WI	3248	2818	2929	7383	3596
Oshkosh-Neenah, WI	2430	2709	2040	7520	7243
Racine, WI	3260	2719	2071	7814	3852
Sheboygan, WI	3021	2195	1915	7536	9950
Wausau-Weston, WI	1948	2902	2476	5846	5360
Wyoming	3086	-	4089	10000	10000
Casper, WY	4326	-	6074	-	10000
Cheyenne, WY	3494	-	4443	-	10000
Mean MSA-Level HHI	3473	5404	4182	7076	6623
Median MSA-Level HHI	3176	4917	3843	6771	6157

Notes:

1. Source: Managed Market Surveyor Suite | MSA Medical Program | January 1, 2019 | Managed Market Surveyor | Selected Geographies | January 1, 2019, and Managed Market Surveyor | Data Extraction | Enterprise License © 2019 DR/Decision Resources, LLC. All rights reserved.
2. Data point for the exchanges is July 1, 2019.
3. State and MSA-level Herfindahl-Hirschman Indices (HHIs) are reported. The "Total HHI" pertains to the combined HMO+PPO+POS+EXCH product market. However, all state and MSA-level data for North Dakota exclude exchange enrollment because those data appeared to be incomplete.
4. We do not present product-specific data for geographic areas with i) fewer than 5,000 reported enrollees in the TOTAL, HMO, PPO and POS product markets or ii) fewer than 1,000 reported enrollees in the exchanges. In the 2020 Update, these restrictions only affected HMO, POS and exchange markets.

5 Charts About Public Opinion on the Affordable Care Act and the Supreme Court

Liz Hamel (<https://www.kff.org/person/liz-hamel/>) (<https://twitter.com/lizhamel>),

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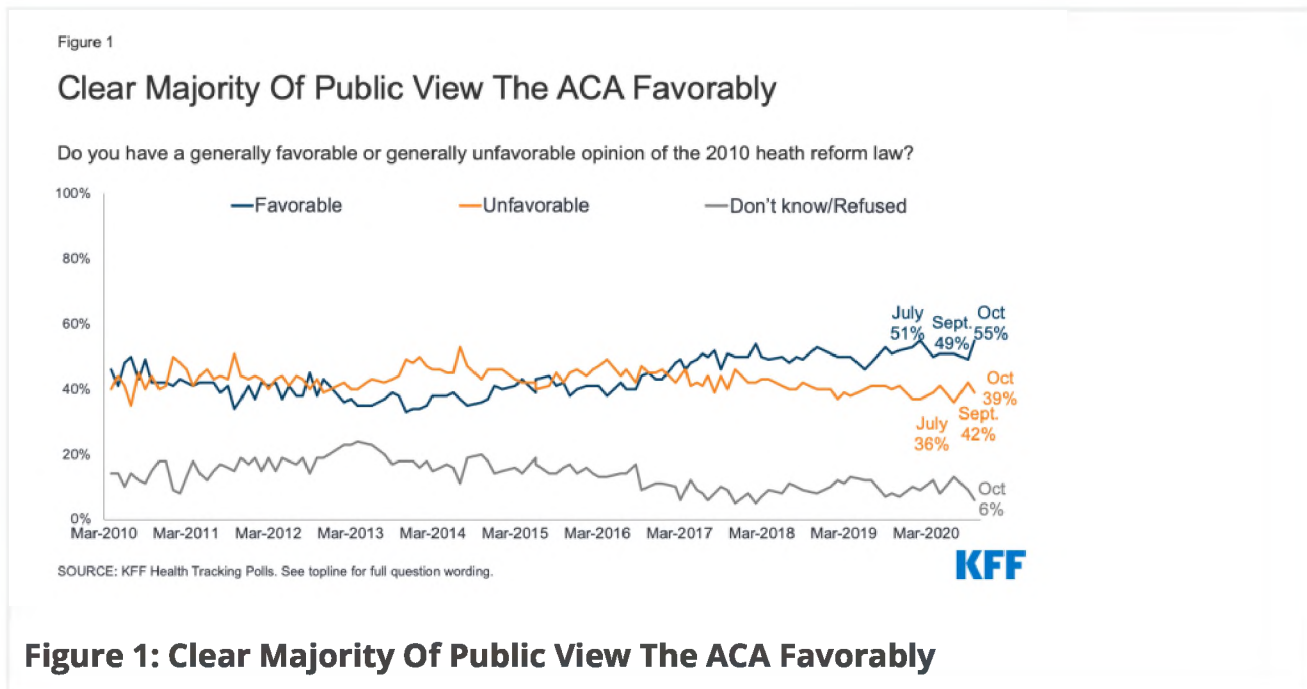
and **Mollyann Brodie** (<https://www.kff.org/person/mollyann-brodie/>) (<https://twitter.com/Mollybrodie>)

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#1: Attitudes Toward the ACA Are Divided; Somewhat More Favorable Than Unfavorable Since 2017

Public opinion of the Affordable Care Act (ACA) has been largely divided along partisan lines since the law was passed in 2010. Following Republican efforts to repeal the ACA in the summer of 2017, KFF Health Tracking Polls found a slight uptick in overall favorability towards the law, and since then a somewhat larger share has held a favorable than an unfavorable view. The most recent [KFF Tracking Poll](https://www.kff.org/health-reform/report/kff-health-tracking-poll-october-2020) (<https://www.kff.org/health-reform/report/kff-health-tracking-poll-october-2020>) conducted in October 2020 found over half of the public (55%) now hold a favorable opinion of the ACA while about four in ten (39%) hold a negative opinion of the law. Across partisans, over eight in ten Democrats (85%) have a favorable view of the ACA compared to about six in ten independents (59%) and a much smaller share of Republicans (18%). Explore more demographic breakdowns using our [ACA interactive](https://www.kff.org/interactive/kaiser-health-tracking-poll-the-publics-views-on-the-aca/#?response=Favorable--Unfavorable&aRange=twoYear) (<https://www.kff.org/interactive/kaiser-health-tracking-poll-the-publics-views-on-the-aca/#?response=Favorable--Unfavorable&aRange=twoYear>).



#2: Partisans Are Split On The Supreme Court Overturning The ACA

In June 2020, the Trump administration issued a brief asking the U.S. Supreme Court to overturn the ACA. The brief was filed in support of an ongoing challenge to the ACA by a group of Republican attorneys general in California v. Texas (<https://www.kff.org/health-reform/issue-brief/explaining-texas-v-u-s-a-guide-to-the-case-challenging-the-aca/>), a case that challenges the legality of the ACA in light of the zeroing out of the individual mandate penalty in the 2017 Tax Cuts and Job Acts. The death of Supreme Court Justice Ruth Bader Ginsburg on September 18 and the possibility of the Senate confirming a new Justice appointed by President Trump before the presidential election has brought heightened attention to the potential outcome of this case and the future of the ACA. In October 2020, a majority (58%) of the public said they do not want to see the Supreme Court overturn the 2010 health care law, and eight in ten (79%) said they do not want to see the ACA's protections for people with pre-existing conditions overturned. There are partisan differences on both questions, with the majority of Democrats and independents saying they don't want the Court to overturn the ACA or pre-existing condition protections. However, among Republicans, three-fourths (76%) say they want to see the ACA overturned, but two-thirds say they **do not** want to see pre-existing condition protections overturned.

Figure 2

Majorities Do Not Want Court To Overturn ACA's Pre-Existing Condition Protections, Republicans Want Entire Law Overturned

Would you like to see the Supreme Court overturn...?

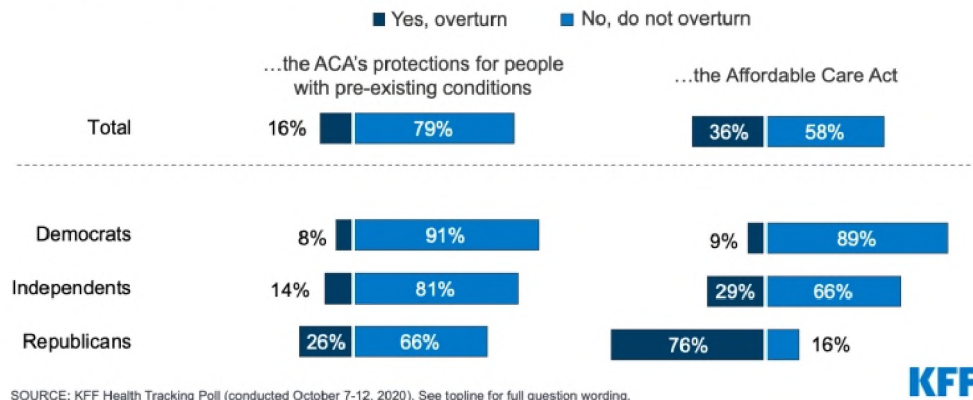


Figure 2: Majorities Do Not Want Court To Overturn ACA's Pre-Existing Condition Protections, Republicans Want Entire Law Overturned

#3: Most Say It Is Important That Pre-Existing Condition Protections Remain In Place if ACA Is Overturned

If the Supreme Court overturns the ACA, a host of provisions could be eliminated, including the law's protections for people with pre-existing medical conditions. These provisions prohibit insurance companies from denying coverage based on a person's medical history (known as guaranteed issue) and prohibit insurance companies from charging those with pre-existing conditions more for coverage (known as community rating). The [July 2019](https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-july-2019/) (<https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-july-2019/>) KFF Health Tracking Poll found that a majority of the public says it is very important for many of the ACA provisions to be kept in place, including the guaranteed issue provision (72%) and community rating (64%). While partisans divide over the importance of keeping many provisions of the ACA in place, majorities of Democrats, Republicans, and independence say it is very important to continue each of these protections for people with pre-existing conditions.

Figure 3

Most Say It Is Important That ACA Provisions Remain In Place

Percent who say it is "very important" that each of these parts of the ACA are kept in place:	Total	Democrats	Independents	Republicans
Prohibits health insurance companies from denying coverage for people with pre-existing conditions	72%	88%	73%	62%
Prohibits health insurance companies from denying coverage to pregnant women	71	89	73	49
Prohibits health insurance companies from charging sick people more	64	76	64	55
Requires health insurance companies to cover the cost for most preventive services	62	80	58	49
Prohibits health insurance companies from setting a lifetime limit	62	72	65	48
Gives states the option of expanding their Medicaid programs	57	84	55	36
Provides financial help to low- and moderate-income Americans to help them purchase coverage	57	82	54	31
Prohibits private health insurance companies from setting an annual limit	51	67	46	38
Allows young adults to stay on their parents' insurance plans until age 26	51	68	50	36

SOURCE: KFF Health Tracking Poll (conducted July 18-23, 2019). See [topline](#) for full question wording and response options.

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Figure 3: Most Say It Is Important That ACA Provisions Remain In Place

#4: Pre-Existing Condition Protections Affect Large Shares Of The Public

A KFF analysis (<https://www.kff.org/health-reform/issue-brief/pre-existing-condition-prevalence-for-individuals-and-families/>) estimates that 27% of adults ages 18-64 have a pre-existing condition that would have led to a denial of insurance in the individual market prior to the implementation of the ACA. An even larger share of the public believes they or someone in their family may belong in this category. According to the most recent survey data, about six in ten of the public say they or someone in their household suffers from a pre-existing or chronic medical condition, such as asthma, diabetes, or high blood pressure.¹

Figure 4: Nearly Six In Ten Americans Say They Or Someone In Their Household Has A Pre-Existing Or Chronic Health Condition

#5: Voters Prefer Joe Biden's Approach To The ACA And Pre-Existing Condition Protections Over President Trump's

A majority of registered voters say Democratic presidential nominee Joe Biden has the better approach to determining the future of the ACA (57%) and to maintaining protections for people with pre-existing conditions (56%), while roughly four in ten prefer President Trump's approach on each of these issues (37% and 36%, respectively). Partisan voters break along expected lines, with large shares of Republican voters preferring the president's approach, and large shares of voters who

identify as Democrats preferring former Vice President Biden’s approach. Among the crucial group of swing voters – those who say they are undecided or say they are “probably” going to vote for either Trump or Biden but haven’t made up their minds yet – the former Vice President has a large edge over President Trump on this question, with about six in ten (58%) preferring Biden’s approach on the ACA, about three in ten (28%) preferring Trump’s approach, and one in ten (11%) saying they aren’t sure.

Figure 5: Partisans Split On Whether They Think Trump Or Biden Has The Better Approach To ACA, Protections For Pre-Existing Conditions

Endnotes

1. This estimate is a household measure of all groups and does not classify pre-existing conditions by whether they are or not a “deniable” condition.

[← Return to text \(https://www.kff.org/health-reform/poll-finding/5-charts-about-public-opinion-on-the-affordable-care-act-and-the-supreme-court/#endnote-link-490724-1\)](https://www.kff.org/health-reform/poll-finding/5-charts-about-public-opinion-on-the-affordable-care-act-and-the-supreme-court/#endnote-link-490724-1)

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Marketplace Pulse: Broad Range of Insurers Enter an Increasingly Competitive ACA Marketplace

Author: Hempstead, K

The Marketplace Pulse series provides expert insights on timely policy topics related to the health insurance marketplaces. The series, authored by [RWJF Senior Policy Adviser Katherine Hempstead](#), analyzes changes in the individual market; shifting carrier trends; nationwide insurance data; and more to help states, researchers, and policymakers better understand the pulse of the marketplace.

Though the Affordable Care Act (ACA) faces another existential threat with the controversial *Texas vs. California* case scheduled for a November hearing before the Supreme Court, insurer interest in the marketplaces continues to rise. Available information for 2021 reveals increased participation from a widening group of carriers. This will mark the third straight year of increased offerings, and the reasons are not hard to decipher.

First is the premium stability and profitability in the marketplace in recent years. And though enrollment has been flat, the marketplace is an increasingly important bridge to growing opportunities in Medicaid and Medicare Advantage. The current economic dislocation has caused a drop in employer enrollment that increases the importance of developing other markets. And in the event of a new administration, increased subsidies and a potential public option could boost marketplace growth considerably.

A good example of the widening range of participation is the United Health Group's (UHG) return to the marketplace. At its peak, in 2016, United was in more than 30 states, selling marketplace plans in nearly one-third of all counties. In 2017, they executed a nearly complete withdrawal, remaining only in a handful of counties in a few states. This situation remained largely unchanged until recently, when United has announced re-entry in six states so far: Virginia, Maryland, Oklahoma, North Carolina, Washington and Tennessee. These are all states where UHG currently sells Medicaid, or where the opportunity to participate in Medicaid may present itself in the future.

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While United is returning to some states, it is not necessarily re-occupying all of the same territory, a decision that reflects the increased competitiveness of the marketplace. In Tennessee, for example, UHG participated statewide in 2016, before withdrawing entirely. In 2021, they are choosing their spots, and will be in roughly half of the state's counties. Most of the time they will compete with Blue Cross Blue Shield and/or Cigna, and will stay out of counties occupied by Oscar, Bright Health, and/or Centene, but there are some exceptions. In the lively Nashville area, for example, all six carriers will offer plans in a metro area with a population one quarter the size of New York City.

In addition to UHG, a number of other insurers that substantially withdrew from the marketplace are increasing their participation. Both Anthem and Cigna have announced some expansion to additional counties in their existing states. They are joined by newer companies that have been steadily building their marketplace presence. Oscar, Bright House, and Friday Health Plan have announced expansion or entry in at least sixteen states. Centene and Molina have additionally announced expansions, but the growth in participation that has in recent years been dominated by Medicaid managed care organizations (MCOs) this year reflects a broader array of insurers.

The strong connections between Medicaid and the marketplace are more evident than ever. The percent of counties with at least one "overlap plan," a carrier participating in both Medicaid and the marketplace, will rise, as UHG and others enter the marketplace in places where they already participate in Medicaid. The interest in states that are expanding Medicaid and/or transitioning to managed care is clear, with considerable new participation in Oklahoma, Missouri, and North Carolina. Given the economic uncertainty, there may be more churn than usual between these two segments, and consistency in coverage and provider networks may help enrollees stay connected to care. Overlap appears to be beneficial from both a cost containment (<https://www.healthaffairs.org/doi/10.1377/hblog20200511.314433/full/>) and patient standpoint, although we should remain vigilant about the potential for excessive consolidation in these markets.

The connections between the marketplace and Medicare Advantage are increasingly recognized as important, given the older age distribution of marketplace enrollees. Among the many insurers who have recently announced new Medicare Advantage plans include marketplace insurers like Oscar and Bright Health. The prospect of lowering the eligibility age for Medicare under a Biden Administration only enhances the importance of the marketplace to Medicare Advantage plans, and could eventually tempt the return of the largest Medicare Advantage carrier, Humana, and/or Aetna/CVS, which increased its Medicare Advantage offerings considerably this year.



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As seen by the upcoming court case, the politicization of the ACA is ongoing. Yet the contours of growing marketplace participation reveal insurers' perceptions of the business opportunities, wherever they may be. Over the past few years, choice has increased in areas which had previously been less well served, including in states which had not been particularly supportive of the ACA. This has led, for example, to entry in metro areas in Tennessee and Texas, and statewide entry in Iowa and Nebraska. This year Molina will expand in Mississippi, and Oscar will enter Arkansas, Iowa, North Carolina, and Oklahoma. And despite the intense lobbying by providers and insurers against the specter of a public option, through groups like the [Partnership for America's Healthcare Future \(https://americashealthcarefuture.org/about-us/\)](https://americashealthcarefuture.org/about-us/), state reform efforts do not seem to have raised the threat level excessively. Washington State's public option, Cascade Care, will be offered by five carriers. In Colorado, another state with an ambitious policy agenda, including ongoing efforts to create a public option, five carriers have announced expansions for 2021.

While the federal government seeks to use the Supreme Court to repeal the law, insurer investment in the marketplace will grow for the third straight year. There is a political narrative about the ACA, but there is also a business narrative. Increasingly they diverge.

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The Potential Effects of a Supreme Court Decision to Overturn the Affordable Care Act: Updated Estimates

Linda J. Blumberg, Michael Simpson, Matthew Buettgens, Jessica Banthin, John Holahan

OCTOBER 2020

Introduction

The Supreme Court is set to hear oral arguments in *California v. Texas* (called *Texas v. U.S.* when heard by the lower courts) on November 10, 2020. In the case, a group of state attorneys general, led by the Texas attorney general, argue the entire Affordable Care Act (ACA) should be found unconstitutional and overturned, given that a 2017 tax law set the ACA's individual mandate penalties to \$0 but did not eliminate the now-unenforced individual mandate language along with them. Another group of attorneys general, led by the California attorney general, argue that the law has operated effectively since the penalties were eliminated, the mandate is severable from the rest of the law, and there are no constitutional grounds for overturning it. Here, we update previous analyses of the implications for insurance coverage, federal spending, and health care providers if the ACA is overturned.^{1,2} These estimates, computed using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), are based on a newly developed projection of coverage and spending in 2022 that accounts for an anticipated partial economic recovery from the COVID-19 recession. Our estimates of that economic recovery align with employment levels projected by the Congressional Budget Office for 2022.³

Using these projections, we estimate that overturning the ACA would have the following effects in 2022:

- An additional 21.1 million people will be uninsured, a 69 percent increase nationally.
- As the marketplace, premium tax credits, and cost-sharing reductions are eliminated, 9.3 million people will lose income-related subsidies for marketplace insurance.
- Medicaid/CHIP coverage (acute care for the nonelderly) will decline by 22 percent nationally, or 15.5 million people.
- The number of people with individually purchased (nongroup) insurance will fall by 7.6 million. In almost all states, the remaining nongroup coverage will have lower value (e.g., lower benefits, higher cost-sharing requirements, higher administrative costs as a percentage of the premium) than the nongroup coverage provided under the ACA's framework.
- Low-income states that expanded Medicaid eligibility under the ACA will see the largest percent increases in uninsurance, such as Maine (197 percent increase, from 5 percent to 15 percent), Kentucky (184 percent increase, from 8 percent to 22 percent), and West Virginia (181 percent increase, from 8 percent to 21 percent). Iowa's uninsurance rate will climb more than 150 percent (from 6 percent to 14 percent), as will Michigan's (from 7 percent to 18 percent). The uninsured population will increase by at least 90 percent in 25 states and the District of Columbia.
- Increases in uninsurance will be spread across all racial and ethnic groups. Uninsurance will increase by about 85 percent for both Black people (from 11 percent to 20 percent) and white people (from 8 percent to 15 percent); by about 75 percent for both American Indians/Alaska Natives (from 13 percent to 24 percent) and people who are Asian/Pacific Islander (from 11 percent to 19 percent); and by about 40 percent for Hispanic people (from 21 percent to 30 percent). In addition, the coverage gaps between white people and every other specified racial/ethnic group will increase.
- Uninsurance among the lowest-income population (with incomes below 138 percent of the federal poverty level, or FPL) will more than double, though uninsurance will also increase significantly among the middle class.
- Federal government spending on health care will fall by \$152 billion per year, a 35 percent drop relative to current spending on marketplace subsidies and Medicaid acute care for the nonelderly population.
- States that will experience the largest percent decreases in federal funding include Nebraska (56 percent, from \$2.1 billion to \$0.9 billion), Virginia (56 percent, from \$9.5 billion to \$4.2 billion), Montana (51 percent, from \$2.3 billion to \$1.1 billion), and Colorado (47 percent, from \$6.3 billion to \$3.3 billion).
- Nationally, health care spending by and for nonelderly Americans will fall by \$135 billion. This spending decline will be spread across hospitals (\$56 billion), pharmaceutical manufacturers (\$30 billion), physicians (\$17 billion), and other services (\$33 billion).

- Relative to current levels, hospital revenues will be hardest hit in California (\$10.4 billion decrease), Florida (\$3.8 billion decrease), Louisiana (\$1.7 billion decrease), Kentucky (\$1.7 billion decrease), New Mexico (\$1.1 billion decrease), Arkansas (\$836 million decrease), Idaho (\$600 million decrease), and Montana (\$503 million decrease).
- Because of the 69 percent increase in uninsurance, the demand for uncompensated care will rise by 74 percent, or \$58 billion. The demand for uncompensated care from hospitals alone will increase by \$17.4 billion in 2022.

Data and Methods Overview

We use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) for our analysis. HIPSM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed policy options. The model has been used extensively to estimate the cost and coverage implications of health reforms at the national and state levels and has been widely cited, including in the Supreme Court's majority opinion in *King v. Burwell*.⁴ HIPSM is based on two years of the American Community Survey, and the population is aged to future years using projections from the Urban Institute's Mapping America's Futures program.⁵ HIPSM is designed to incorporate timely, real-world data when

they are available. We regularly update the model to reflect published Medicaid and marketplace enrollment and costs in each state. The enrollment experience in each state under current law affects how the model simulates policy alternatives. The Appendix contains more information about the model and our methods for this paper.

Results

Changes in Coverage. Table 1 compares the expected current-law distribution of health insurance coverage for the nonelderly population in 2022 with the coverage distribution that same year should the ACA be overturned. We estimate that the number of uninsured people will increase by 21.1 million. The substantially lower insurance rate is attributable to 15.5 million people having lost Medicaid and Children's Health Insurance Program (CHIP) coverage (a 22 percent decrease) and 7.6 million people having lost private nongroup insurance coverage (a 43 percent decrease). The losses of public insurance coverage and nongroup coverage will be offset modestly by 1.9 million more people having employer-based insurance. More than 9 million people will lose marketplace income-related subsidies that help them pay for private nongroup insurance under current law.

Federal regulations of nongroup insurance markets under the ACA will be eliminated if the law is overturned, meaning insurers in

almost all states will be expected to revert to pre-2014 practices of denying coverage to people with health problems, offering much more limited benefits, increasing cost-sharing requirements, and setting premiums based on a range of factors often without effective limits (e.g., health status, gender, occupation, health history, age, neighborhood of residence, past health care use). In addition, federal rules requiring that a minimum percentage of premium dollars go toward paying claims (as opposed to insurer administrative cost, including profit) will be eliminated. Combined, this means the coverage sold will be harder for many people to access, particularly those with significant health care needs, and the coverage purchased will be less valuable to the consumer.

Figure 1 shows that the lowest-income groups will experience the biggest increases in uninsurance if the ACA is overturned. People in families with income below 138 percent of FPL will see their uninsurance rate more than double, from 16 percent under current law to 35 percent. People with incomes between 138 percent and 200 percent of FPL will see their uninsurance rates increase by 71 percent, from 16 percent to 28 percent. Uninsurance rates for people with incomes between 200 and 400 percent of FPL will climb 30 percent, from 11 percent under current law to 14 percent absent the ACA. Those with higher incomes will experience more modest increases in uninsurance.

Table 1. Health Insurance Coverage Distribution of the Nonelderly Population under Current Law and If the ACA Is Overturned, 2022

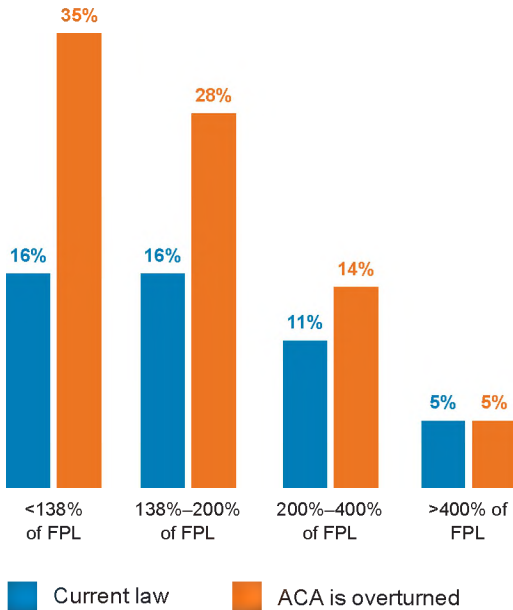
	Current Law ACA		ACA Is Overturned		Difference	
	1,000s of people	%	1,000s of people	%	1,000s of people	%
Total	277,446	100%	277,446	100%	0	0%
Insured	246,680	89%	225,531	81%	-21,149	-9%
Employer	149,325	54%	151,245	55%	1,920	1%
Nongroup, ACA-compliant	17,528	6%	9,953	4%	-7,575	-43%
ACA nongroup (with tax credits)	9,322	3%	0	0%	-9,322	-100%
ACA nongroup (without tax credits)	5,638	2%	0	0%	-5,638	-100%
Noncompliant nongroup	2,567	1%	9,953	4%	7,385	288%
Medicaid/CHIP	71,162	26%	55,668	20%	-15,494	-22%
Other (including Medicare)	8,665	3%	8,665	3%	0	0%
Uninsured	30,766	11%	51,916	19%	21,149	69%

Source: Urban Institute Health Insurance Policy Simulation Model, 2020.

Notes: ACA = Affordable Care Act. CHIP = Children's Health Insurance Program.

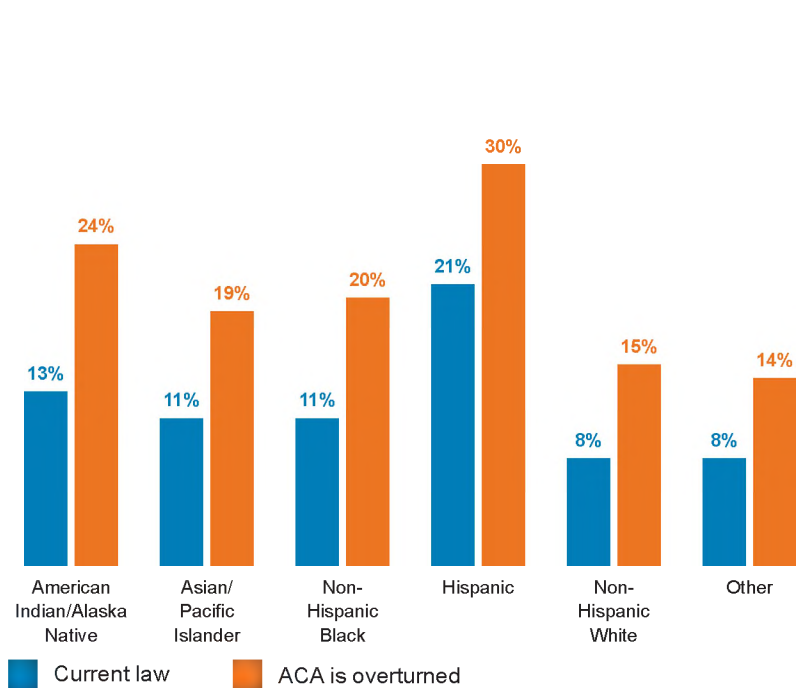
Estimates assume Medicaid coverage expansion waivers in place in seven states before the ACA are reinstated. It is likely that at least some of these waivers will not be reinstated, however, making our estimated increases in uninsurance conservative.

Figure 1. Uninsurance Rates among the Nonelderly Population under Current Law and If the ACA Is Overturned, by Family Income Relative to the Federal Poverty Level, 2022



Source: Urban Institute Health Insurance Policy Simulation Model, 2020.
Notes: ACA = Affordable Care Act. FPL = federal poverty level.
Estimates assume Medicaid coverage expansion waivers in place in seven states before the ACA are reinstated. It is likely that at least some of these waivers will not be reinstated, however, making our estimated increases in uninsurance conservative.

Figure 2. Uninsurance Rates among the Nonelderly Population under Current Law and if the ACA is Overturned, by Race and Ethnicity, 2022



Source: Urban Institute Health Insurance Policy Simulation Model, 2020.
Notes: ACA = Affordable Care Act.
Estimates assume Medicaid coverage expansion waivers in place in seven states before the ACA are reinstated. It is likely that at least some of these waivers will not be reinstated, however, making our estimated increases in uninsurance conservative.

Figure 2 shows that overturning the ACA will have substantial implications for all racial/ethnic groups. Because the ACA narrowed gaps in coverage between Black people and non-Hispanic white people, overturning the ACA reverses those improvements; uninsurance will increase by roughly 85 percent for Black people and white people, leaving 20 percent of Black people and 15 percent of white people uninsured. Uninsurance will increase by about 75 percent among American Indians/Alaska Natives (from 13 percent to 24 percent) and people who are Asian/Pacific Islander (from 11 percent to 19 percent). Uninsurance among the Hispanic population will rise by more than 40 percent, from 21 percent to 30 percent—the highest uninsurance rate of any racial/ethnic group. Together, people of other races/ethnicities will experience an 80 percent increase in uninsurance (from 8 percent to 14 percent).

If the ACA is invalidated, the largest percent increases in uninsurance will occur in states that experienced the

largest coverage gains under the ACA: states that expanded Medicaid eligibility under the law and states that had high pre-ACA uninsurance rates (Table 2). These include Maine (197 percent increase, from 5 percent to 15 percent), Kentucky (184 percent increase, from 8 percent to 22 percent), West Virginia (181 percent increase, from 8 percent to 21 percent), Montana (155 percent increase, from 9 percent to 24 percent), Michigan (152 percent increase, from 7 percent to 18 percent), and Pennsylvania (143 percent increase, from 7 percent to 20 percent). Overall, uninsurance in the 37 states that expanded Medicaid eligibility under the ACA (including the District of Columbia) will more than double. However, even states that did not expand Medicaid will experience large increases in uninsurance as marketplace subsidies are eliminated along with other ACA reforms. On average, uninsurance in those 14 states will increase by 28 percent. Some of the largest increases among these states will be felt in Florida (57 percent increase, or 1.5 million more

uninsured people), North Carolina (33 percent increase, or 387,000 people), Wisconsin (30 percent increase, 112,000 people), and Georgia (24 percent increase, or 343,000 people).

Changes in Federal Spending. Table 3 shows ramifications for states' federal health care funding if the ACA is overturned. Nationally, federal investment in health care will decrease by \$152 billion in 2022 if the ACA is invalidated. Again, states that gained the most assistance under the ACA will lose the most federal spending. In 21 states, federal funding for marketplace subsidies and Medicaid acute care for the nonelderly will fall by 40 percent or more. Under ACA repeal, Florida's federal funding will drop by \$10.7 billion in 2022 (41 percent), and Wyoming's will drop by \$311 million (49 percent). These large percent decreases in two states that did not expand Medicaid eligibility reflect their limited traditional Medicaid programs and, in Florida, high marketplace enrollment. Federal spending on health care in California will fall by \$25.4 billion, or 47

Table 2. The Uninsured Nonelderly Population under Current Law and If the ACA Is Overturned, by State and Medicaid Expansion Status, 2022

	Current Law		ACA Is Overturned		Difference	
	1,000s of people	%	1,000s of people	%	1,000s of people	%
Total	30,766	11%	51,916	19%	21,149	69%
Expansion States	16,229	9%	33,368	18%	17,139	106%
Alaska	95	13%	143	20%	48	51%
Arizona	755	12%	978	16%	223	30%
Arkansas	230	9%	579	23%	349	152%
California	3,682	11%	8,004	23%	4,323	117%
Colorado	484	10%	966	20%	482	100%
Connecticut	203	7%	442	15%	239	118%
Delaware	67	8%	92	11%	26	38%
District of Columbia	43	7%	84	14%	40	94%
Hawaii	114	9%	143	12%	29	25%
Idaho	161	11%	356	23%	195	121%
Illinois	1,073	10%	1,810	17%	737	69%
Indiana	499	9%	1,085	19%	586	118%
Iowa	144	6%	365	14%	221	153%
Kentucky	294	8%	836	22%	542	184%
Louisiana	381	10%	935	24%	554	145%
Maine	54	5%	159	15%	105	197%
Maryland	420	8%	816	16%	395	94%
Massachusetts	248	4%	488	9%	241	97%
Michigan	552	7%	1,395	18%	842	152%
Minnesota	291	6%	608	13%	317	109%
Montana	79	9%	202	24%	123	155%
Nebraska	135	8%	260	16%	125	93%
Nevada	397	14%	710	25%	313	79%
New Hampshire	74	7%	166	15%	91	123%
New Jersey	731	10%	1,392	19%	662	91%
New Mexico	216	12%	534	29%	318	147%
New York	1,106	7%	2,075	13%	969	88%
North Dakota	75	12%	115	18%	39	52%
Ohio	724	8%	1,496	16%	772	107%
Oregon	346	10%	753	22%	407	118%
Pennsylvania	693	7%	1,687	16%	994	143%
Rhode Island	60	7%	156	18%	97	162%
Utah	299	10%	559	19%	260	87%
Vermont	44	9%	59	12%	16	36%
Virginia	755	10%	1,433	19%	678	90%
Washington	597	9%	1,180	18%	583	98%
West Virginia	109	8%	307	21%	198	181%
Nonexpansion States	14,537	15%	18,547	20%	4,010	28%
Alabama	486	12%	608	15%	122	25%
Florida	2,641	15%	4,140	24%	1,499	57%
Georgia	1,401	15%	1,745	19%	343	24%
Kansas	341	14%	399	16%	58	17%
Mississippi	371	15%	448	18%	77	21%
Missouri	676	13%	804	16%	128	19%
North Carolina	1,179	13%	1,565	17%	387	33%
Oklahoma	597	18%	726	21%	129	22%
South Carolina	572	14%	733	17%	161	28%
South Dakota	95	13%	112	15%	17	18%
Tennessee	731	13%	901	16%	171	23%
Texas	4,996	19%	5,784	23%	788	16%
Wisconsin	366	8%	478	10%	112	30%
Wyoming	85	16%	104	20%	19	22%

Source: Urban Institute Health Insurance Policy Simulation Model, 2020.

Notes: ACA = Affordable Care Act. Estimates assume Medicaid coverage expansion waivers in place in seven states before the ACA are reinstated. It is likely that at least some of these waivers will not be reinstated, however, making our estimated increases in uninsurance conservative.

Table 3. Federal Spending on Marketplace Subsidies and Medicaid/CHIP Acute Care for the Nonelderly Population under Current Law and If the ACA Is Overturned, by State and Medicaid Expansion Status, 2022

	Current Law	ACA Is Overturned	Difference	
	Millions of \$	Millions of \$	Millions of \$	%
Total	435,704	283,743	-151,962	-35%
Expansion States	299,012	179,548	-119,464	-40%
Alaska	1,462	950	-512	-35%
Arizona	12,639	10,102	-2,537	-20%
Arkansas	5,652	3,563	-2,090	-37%
California	53,748	28,338	-25,410	-47%
Colorado	6,309	3,347	-2,962	-47%
Connecticut	5,268	3,228	-2,040	-39%
Delaware	1,551	1,211	-340	-22%
District of Columbia	1,559	1,303	-257	-16%
Hawaii	1,236	892	-345	-28%
Idaho	2,763	1,268	-1,495	-54%
Illinois	9,697	6,175	-3,522	-36%
Indiana	9,111	5,355	-3,757	-41%
Iowa	4,059	2,637	-1,423	-35%
Kentucky	9,356	4,996	-4,360	-47%
Louisiana	8,669	4,570	-4,099	-47%
Maine	2,173	1,427	-746	-34%
Maryland	8,142	4,736	-3,406	-42%
Massachusetts	9,124	7,363	-1,761	-19%
Michigan	14,774	8,754	-6,020	-41%
Minnesota	7,309	4,962	-2,347	-32%
Montana	2,266	1,119	-1,148	-51%
Nebraska	2,079	912	-1,167	-56%
Nevada	3,471	2,047	-1,424	-41%
New Hampshire	1,068	629	-439	-41%
New Jersey	7,564	4,131	-3,433	-45%
New Mexico	5,844	3,072	-2,772	-47%
New York	34,812	22,447	-12,365	-36%
North Dakota	560	310	-250	-45%
Ohio	15,202	10,376	-4,826	-32%
Oregon	6,599	3,654	-2,944	-45%
Pennsylvania	16,853	11,086	-5,767	-34%
Rhode Island	1,368	880	-488	-36%
Utah	4,121	2,114	-2,006	-49%
Vermont	1,297	1,071	-226	-17%
Virginia	9,455	4,177	-5,278	-56%
Washington	8,597	4,237	-4,360	-51%
West Virginia	3,254	2,112	-1,142	-35%
Nonexpansion States	136,693	104,195	-32,498	-24%
Alabama	5,837	4,538	-1,298	-22%
Florida	25,939	15,257	-10,683	-41%
Georgia	11,562	8,992	-2,569	-22%
Kansas	2,211	1,671	-540	-24%
Mississippi	5,016	4,303	-712	-14%
Missouri	8,289	7,064	-1,225	-15%
North Carolina	16,518	12,622	-3,896	-24%
Oklahoma	5,166	3,920	-1,246	-24%
South Carolina	5,967	4,521	-1,446	-24%
South Dakota	887	650	-237	-27%
Tennessee	9,102	7,509	-1,593	-18%
Texas	34,205	28,572	-5,633	-16%
Wisconsin	5,358	4,250	-1,108	-21%
Wyoming	637	326	-311	-49%

Source: Urban Institute Health Insurance Policy Simulation Model, 2020.

Notes: ACA = Affordable Care Act. Estimates assume Medicaid coverage expansion waivers in place in seven states before the ACA are reinstated. It is likely that at least some of these waivers will not be reinstated, however, making our estimated decreases in federal health care spending conservative.

percent, reflecting the size of the state and the importance of the Medicaid expansion there. Virginia will lose \$5.3 billion in federal funding (a 56 percent decrease) with the law overturned, Michigan will lose \$6.0 billion (41 percent), and Pennsylvania will lose \$5.8 billion (34 percent).

Implications for Providers. Table 4 highlights the financial implications of decreased spending on health care (both public and private) to different types of health care providers. As the number of insured people falls under ACA repeal, so will spending on various types of medical care. We estimate that health care spending will fall by \$135 billion nationally. Of that, \$56 billion is attributable to lower spending on hospitals, \$17 billion owes to lower spending on physician care, \$30 billion owes to lower spending on pharmaceuticals, and \$33 billion owes to lower spending on other medical services. These decreases will be spread across the country, but some of the largest percent decreases will be seen in New Mexico, a very low-income state that has benefited considerably from the ACA's Medicaid expansion, as well as Montana, Louisiana, Kentucky, and Idaho. These states all expanded Medicaid under the ACA and had high pre-ACA uninsurance rates.

Given a 69 percent increase in the number of uninsured people in the United States, overturning the ACA will greatly increase the demand for uncompensated medical care, or care provided without payment from the patient or an insurer. How much of this increased need for uncompensated care would be met is unclear, particularly given increasing financial pressures on state governments due to the pandemic that will likely last years. Health care providers cannot feasibly meet all or even most of this increased need. We estimate that the demand for uncompensated care will increase by \$58 billion in 2022, or 74 percent, should the ACA be overturned (Table 5). This increased demand would be distributed across different health care providers: \$17 billion for hospitals, \$7 billion for physicians, \$12 billion for pharmaceutical manufacturers, and \$22 billion for other provider types.

Conclusion

The Supreme Court can invalidate the entire ACA via *California v. Texas*. If the court sides with Texas and eliminates

the ACA, the consequences will be felt throughout the U.S. health care system. Many of these implications are beyond our ability to measure. Here, we estimate the impact of overturning the law on health insurance coverage and federal spending on health care. We also show how a 69 percent increase in the number of uninsured Americans would affect spending on health care providers of different types, as well as the demand for uncompensated care. The implications of reduced federal spending and an additional 21 million uninsured people would be particularly pronounced as the recession abates. In addition, higher levels of demand for an array of public services and lower state and local tax revenues will continue for some time, making it difficult for state and local governments to increase funding enough to meet these demands, let alone support replacing lost coverage.

Thus, invalidating the ACA will have massive financial consequences for health care providers and households, and millions of people will experience reduced access to necessary medical care. However, some legislative mechanisms could help eliminate these eventualities before a Supreme Court decision is issued: Congress can pass and the president can sign legislation eliminating the now-toothless individual mandate while explicitly retaining the remainder of the law. Alternatively, a law could reinstate a more modest individual mandate penalty, a step that could also make the case moot.

Methodology Appendix

Given uncertain economic conditions in 2020, owing to the COVID-19 pandemic and consequent recession and its rapid evolution, we opted to simulate the consequences of overturning the ACA using a 2022 current-law baseline, a year when conditions should be more stable. In doing so, we assume, consistent with Congressional Budget Office projections,³ that the economy will have partly recovered from the pandemic recession by that time. We assume the characteristics of people who remain unemployed at that time are largely consistent with the distribution identified in U.S. Department of Labor data from August 2020, which showed clearly that higher-wage jobs had recovered to a

much greater extent than had lower-wage jobs.

The simulations account for relevant state regulations, such as banning short-term, limited-duration plans.⁶ Our current-law estimates account for the federal individual mandate penalties being set to \$0 beginning in plan year 2019, as well as the fact that California, the District of Columbia, Massachusetts, and New Jersey have their own individual mandate penalties. We treat Missouri and Oklahoma, where the ACA Medicaid expansion has been approved by ballot initiative but not yet implemented, as nonexpansion states. We do this because the political environments surrounding expansion, even once ballot initiatives are passed, remain uncertain, and the timing and implementation of these expansions are therefore still unknown.

The current version of HIPSM is calibrated to state-specific targets for marketplace enrollment following the 2020 open enrollment period, 2020 marketplace premiums, and late 2019 Medicaid enrollment from the Centers for Medicare & Medicaid Services monthly enrollment snapshots. Aging our projections to 2022 involved several steps. First, we aged the 2020 population to 2022 using projections from the Urban Institute's Mapping America's Futures program. We then inflated incomes and health costs to 2022. Because the pandemic has reduced use of expensive care, we assume costs for private nongroup health insurance and Medicaid are flat in 2021 but return to default inflation assumptions in 2022.^{7,8} Under our default assumptions, we estimate Medicaid will grow at 5 percent annually, private premiums will grow at 6 percent, and out-of-pocket spending and uncompensated care will grow at 3 percent.

Other ACA provisions that affect Medicare, payment and delivery system reform, support for community health centers, and preventive care initiatives will be eliminated if the ACA is fully invalidated. As with our prior analyses, we do not analyze elimination of those provisions here. We estimate the impacts of the ACA coverage provisions being overturned, comparing them with insurance coverage and health care spending under current law at the national and state levels.

Table 4. Health Care Spending by Insurers (Public and Private) and Households on Acute Care for the Nonelderly Population under Current Law and If the ACA Is Overturned, by State and Medicaid Expansion Status, 2022

Current Law					
	Total health care spending (millions of \$)	Hospitals (millions of \$)	Physician services (millions of \$)	Prescription drugs (millions of \$)	Other services (millions of \$)
Total	1,925,293	678,397	308,464	431,903	506,528
Expansion States	1,302,043	457,631	207,581	292,574	344,257
Alaska	4,801	1,694	756	1,052	1,299
Arizona	42,215	14,913	6,662	9,538	11,101
Arkansas	17,819	6,375	2,789	4,041	4,614
California	226,374	78,800	36,020	51,207	60,347
Colorado	33,830	11,657	5,548	7,521	9,105
Connecticut	24,335	8,346	3,843	5,604	6,542
Delaware	6,367	2,256	1,006	1,444	1,661
District of Columbia	4,828	1,763	749	1,064	1,252
Hawaii	7,178	2,563	1,145	1,611	1,859
Idaho	10,361	3,701	1,621	2,331	2,707
Illinois	71,159	24,657	11,652	15,868	18,982
Indiana	41,227	14,644	6,540	9,271	10,772
Iowa	20,115	7,012	3,273	4,462	5,368
Kentucky	28,037	10,039	4,330	6,412	7,256
Louisiana	26,855	9,737	4,098	6,136	6,884
Maine	8,347	2,926	1,306	1,943	2,172
Maryland	36,876	12,841	5,897	8,297	9,840
Massachusetts	43,679	15,432	7,035	9,691	11,521
Michigan	59,331	21,009	9,311	13,505	15,506
Minnesota	39,475	13,777	6,366	8,770	10,563
Montana	6,727	2,410	1,056	1,511	1,749
Nebraska	11,626	4,046	1,894	2,567	3,120
Nevada	17,134	6,072	2,760	3,846	4,455
New Hampshire	8,195	2,783	1,348	1,861	2,203
New Jersey	52,002	17,642	8,627	11,668	14,064
New Mexico	13,205	4,811	1,985	3,013	3,396
New York	121,564	44,183	18,962	26,991	31,428
North Dakota	4,352	1,518	722	937	1,175
Ohio	70,564	24,928	11,168	15,966	18,501
Oregon	25,876	9,049	4,097	5,871	6,859
Pennsylvania	82,747	29,049	13,323	18,515	21,860
Rhode Island	6,141	2,141	990	1,382	1,628
Utah	20,024	6,997	3,258	4,278	5,492
Vermont	4,756	1,706	732	1,085	1,232
Virginia	48,923	17,021	7,913	10,968	13,022
Washington	44,676	15,406	7,221	9,976	12,074
West Virginia	10,324	3,728	1,579	2,369	2,648
Nonexpansion States	623,250	220,766	100,883	139,330	162,271
Alabama	26,271	9,348	4,210	5,898	6,816
Florida	107,615	37,905	17,301	24,620	27,789
Georgia	58,199	20,500	9,510	12,978	15,211
Kansas	16,522	5,743	2,747	3,629	4,403
Mississippi	16,802	6,152	2,639	3,772	4,239
Missouri	38,215	13,743	6,130	8,545	9,797
North Carolina	63,372	22,604	10,182	14,164	16,422
Oklahoma	21,820	7,821	3,478	4,873	5,648
South Carolina	26,559	9,450	4,266	5,997	6,846
South Dakota	5,139	1,812	838	1,130	1,358
Tennessee	39,550	14,042	6,331	8,916	10,261
Texas	163,857	58,005	26,803	36,002	43,047
Wisconsin	35,739	12,380	5,860	8,012	9,487
Wyoming	3,591	1,261	588	794	949

continued

Table 4. Health Care Spending by Insurers (Public and Private) and Households on Acute Care for the Nonelderly Population under Current Law and If the ACA Is Overturned, by State and Medicaid Expansion Status, 2022 (continued)

	Change if ACA is Overturned									
	Total health care spending		Hospitals		Physician services		Physician services		Other services	
	Millions of \$	%	Millions of \$	%	Millions of \$	%	Millions of \$	%	Millions of \$	%
Total	-135,460	-7%	-55,934	-8%	-17,214	-6%	-29,681	-7%	-32,632	-6%
Expansion States	-108,839	-8%	-44,862	-10%	-13,119	-6%	-24,235	-8%	-26,623	-8%
Alaska	-470	-10%	-190	-11%	-59	-8%	-105	-10%	-116	-9%
Arizona	-1,804	-4%	-674	-5%	-252	-4%	-431	-5%	-447	-4%
Arkansas	-1,968	-11%	-836	-13%	-221	-8%	-434	-11%	-477	-10%
California	-25,436	-11%	-10,361	-13%	-3,056	-8%	-5,781	-11%	-6,237	-10%
Colorado	-2,825	-8%	-1,218	-10%	-344	-6%	-612	-8%	-651	-7%
Connecticut	-1,929	-8%	-776	-9%	-219	-6%	-445	-8%	-489	-7%
Delaware	-232	-4%	-90	-4%	-35	-4%	-55	-4%	-52	-3%
District of Columbia	-249	-5%	-100	-6%	-25	-3%	-56	-5%	-68	-5%
Hawaii	-166	-2%	-62	-2%	-22	-2%	-40	-2%	-41	-2%
Idaho	-1,489	-14%	-600	-16%	-180	-11%	-345	-15%	-364	-13%
Illinois	-3,483	-5%	-1,472	-6%	-429	-4%	-739	-5%	-842	-4%
Indiana	-3,734	-9%	-1,574	-11%	-431	-7%	-829	-9%	-899	-8%
Iowa	-1,183	-6%	-504	-7%	-144	-4%	-256	-6%	-279	-5%
Kentucky	-4,167	-15%	-1,714	-17%	-469	-11%	-964	-15%	-1,021	-14%
Louisiana	-4,027	-15%	-1,682	-17%	-453	-11%	-921	-15%	-972	-14%
Maine	-776	-9%	-309	-11%	-101	-8%	-177	-9%	-189	-9%
Maryland	-3,283	-9%	-1,337	-10%	-400	-7%	-750	-9%	-797	-8%
Massachusetts	-901	-2%	-414	-3%	-146	-2%	-133	-1%	-207	-2%
Michigan	-6,109	-10%	-2,480	-12%	-709	-8%	-1,392	-10%	-1,528	-10%
Minnesota	-2,105	-5%	-924	-7%	-248	-4%	-417	-5%	-516	-5%
Montana	-1,225	-18%	-503	-21%	-148	-14%	-280	-19%	-294	-17%
Nebraska	-989	-9%	-390	-10%	-119	-6%	-232	-9%	-248	-8%
Nevada	-1,368	-8%	-566	-9%	-165	-6%	-300	-8%	-338	-8%
New Hampshire	-421	-5%	-172	-6%	-53	-4%	-95	-5%	-102	-5%
New Jersey	-3,748	-7%	-1,514	-9%	-467	-5%	-835	-7%	-933	-7%
New Mexico	-2,792	-21%	-1,107	-23%	-304	-15%	-670	-22%	-711	-21%
New York	-5,174	-4%	-2,279	-5%	-728	-4%	-916	-3%	-1,250	-4%
North Dakota	-237	-5%	-106	-7%	-30	-4%	-48	-5%	-53	-5%
Ohio	-4,682	-7%	-1,945	-8%	-533	-5%	-1,071	-7%	-1,134	-6%
Oregon	-2,921	-11%	-1,214	-13%	-355	-9%	-648	-11%	-704	-10%
Pennsylvania	-5,594	-7%	-2,284	-8%	-686	-5%	-1,222	-7%	-1,403	-6%
Rhode Island	-460	-7%	-195	-9%	-54	-5%	-98	-7%	-114	-7%
Utah	-2,039	-10%	-814	-12%	-259	-8%	-460	-11%	-506	-9%
Vermont	-145	-3%	-58	-3%	-23	-3%	-27	-2%	-36	-3%
Virginia	-5,268	-11%	-2,145	-13%	-626	-8%	-1,223	-11%	-1,274	-10%
Washington	-4,358	-10%	-1,801	-12%	-499	-7%	-994	-10%	-1,064	-9%
West Virginia	-1,081	-10%	-452	-12%	-125	-8%	-237	-10%	-266	-10%
Nonexpansion States	-26,621	-4%	-11,072	-5%	-4,096	-4%	-5,445	-4%	-6,009	-4%
Alabama	-952	-4%	-405	-4%	-144	-3%	-190	-3%	-213	-3%
Florida	-9,364	-9%	-3,771	-10%	-1,446	-8%	-1,959	-8%	-2,186	-8%
Georgia	-2,026	-3%	-863	-4%	-310	-3%	-404	-3%	-449	-3%
Kansas	-421	-3%	-174	-3%	-63	-2%	-93	-3%	-91	-2%
Mississippi	-482	-3%	-207	-3%	-74	-3%	-97	-3%	-104	-2%
Missouri	-962	-3%	-415	-3%	-149	-2%	-187	-2%	-211	-2%
North Carolina	-3,226	-5%	-1,334	-6%	-488	-5%	-680	-5%	-724	-4%
Oklahoma	-921	-4%	-383	-5%	-139	-4%	-194	-4%	-205	-4%
South Carolina	-1,126	-4%	-474	-5%	-172	-4%	-228	-4%	-252	-4%
South Dakota	-128	-2%	-57	-3%	-19	-2%	-22	-2%	-29	-2%
Tennessee	-1,318	-3%	-558	-4%	-196	-3%	-268	-3%	-295	-3%
Texas	-4,523	-3%	-1,935	-3%	-704	-3%	-894	-2%	-990	-2%
Wisconsin	-916	-3%	-388	-3%	-149	-3%	-177	-2%	-202	-2%
Wyoming	-255	-7%	-107	-8%	-40	-7%	-51	-6%	-57	-6%

Source: Urban Institute Health Insurance Policy Simulation Model, 2020.

Notes: ACA = Affordable Care Act. Estimates assume that Medicaid coverage expansion waivers in place in 7 states prior to the ACA are reinstated. It is likely that at least some of these waivers will not be reinstated, however, making our estimated decreases in federal health care spending conservative.

Table 5. Uncompensated Care Sought under Current Law and If the ACA Is Overturned, by Type of Service, 2022

	Total uncompensated care	Hospitals	Physician services	Prescription drug manufacturers	Other services
Current law (millions of \$)	78,501	22,171	10,081	16,033	30,217
ACA is overturned (millions of \$)	136,462	39,558	16,962	28,016	51,927
Difference (millions of \$)	57,961	17,387	6,881	11,983	21,710
Percent difference	74%	78%	68%	75%	72%

Source: Urban Institute Health Insurance Policy Simulation Model, 2020.

Notes: ACA = Affordable Care Act. CHIP = Children's Health Insurance Program.

Estimates assume Medicaid coverage expansion waivers in place in seven states before the ACA are reinstated. It is likely that at least some of these waivers will not be reinstated, however, making our estimated increases in uninsurance conservative.

We present estimated effects of ACA repeal assuming pre-ACA Medicaid Section 1115 coverage expansion waivers will be reinstated. We therefore likely underestimate the number of people who will become uninsured and the amount of federal health care dollars that will be lost if the law is overturned. Before the ACA, seven states received federal Section 1115 waivers to expand eligibility for Medicaid coverage; most often, these states had demonstrated that their expansion would be budget neutral for the federal government because savings would accrue from moving Medicaid enrollees into managed-care organizations. The seven states were Arizona, Delaware, Hawaii, Massachusetts, New York, Vermont, and Wisconsin. Because the ACA made these waivers obsolete in states that expanded Medicaid, not all waivers, or the coverage aspects of the waivers, have been renewed since 2014. If the ACA is overturned and not all state waivers are reinstated, Medicaid eligibility in the nonrenewed states will shift back to its pre-waiver implementation level. These states would be able to apply to renegotiate their waivers with the federal government, but the outcome would be uncertain. First, states would have to be willing and able to invest the time and expenses involved with the waiver. Second, it is unclear what terms the Trump administration would agree to. And third, it is unclear whether states would be able to show that their new waivers would be budget neutral to the federal government, given changes in circumstances since the waivers' original approval and intervening changes in the administration's calculation

of budget neutrality. It is also possible that, if the ACA is overturned and the Trump administration has a second term, invalidation of the law could be used to introduce large-scale changes to Medicaid the current administration now encourages through waivers, such as the imposition of work requirements. We did not simulate any such changes to the program.

Health care spending data used in HIPSM come from the Medical Expenditure Panel Survey Household Component and other sources. We estimate total health care spending for each person represented in HIPSM for each possible health insurance status; these estimates of spending control for a broad array of sociodemographic variables and health statuses. Using the Medical Expenditure Panel Survey Household Component, we then compute the share of individual health expenditures attributable to each type of care (hospital, office-based physician, prescription drugs, other) by individual characteristics (health insurance coverage, age, gender, income, and health status). The percentage of spending assigned to each provider type is then imputed to the individuals represented in HIPSM.

Though the ACA reduced the volume of uncompensated care by reducing the number of uninsured people, uncompensated care is currently funded in several ways:

- Medicare DSH payments
- Veterans Health Administration
- other federal programs
- state and local government programs
- private programs, such as patient assistance programs providing free or reduced-cost prescription drugs to those who qualify
- charity care and bad debt absorbed by health care providers

HIPSM estimates the demand for uncompensated care by people who are uninsured or underinsured based on pre-ACA data. Coughlin and colleagues estimated that, in 2013, the federal government funded about 39 percent of uncompensated care through programs such as Medicaid and Medicare DSH payments, state and local governments funded 24 percent, and health care providers funded 37 percent.⁹ It is unclear how willing or able different levels of government and different providers will be to increase funding for such care if the ACA is overturned. Current patterns of uncompensated care use may not persist if, for example, large increases in the number of uninsured people are not met with commensurate increases in government funding or provider contributions of free or reduced-price care. Consequently, we discuss estimated amounts of care (based on recent patterns of uncompensated care use) as the value of care sought by the newly uninsured, not the value of the uncompensated care they would actually receive.

ENDNOTES

- 1 Banthin J, Blumberg LJ, Buettgens M, Holahan J, Pan CW, Wang R. Implications of the Fifth Court decision in *Texas v. United States*. Urban Institute. 2020. <https://www.urban.org/research/publication/implications-fifth-circuit-court-decision-texas-v-united-states>. Published December 19, 2019. Accessed October 7, 2020.
- 2 Blumberg LJ, Buettgens M, Holahan J, Pan CW. State-by-state estimates of the coverage and funding consequences of full repeal of the ACA. Urban Institute. 2019. <https://www.urban.org/research/publication/state-state-estimates-coverage-and-funding-consequences-full-repeal-aca>. Published March 26, 2019. Accessed October 7, 2020.
- 3 We calculate job losses as the difference in 2022 employment rates between the pre- and postpandemic economic forecasts from the Congressional Budget Office. Prepandemic forecasts are from Congressional Budget Office. *The Budget and Economic Outlook: 2020 to 2030*. Washington: Congressional Budget Office; 2020. <https://www.cbo.gov/publication/56020>. Accessed October 7, 2020. Postpandemic forecasts are from Congressional Budget Office. An Update to the Economic Outlook: 2020 to 2030. <https://www.cbo.gov/publication/56442>. Accessed October 7, 2020.
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ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector. For more information specific to the Urban Institute's Health Policy Center, its staff, and its recent research, visit <http://www.urban.org/policy-centers/health-policy-center>.

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For more than 45 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working alongside others to build a national Culture of Health that provides everyone in America a fair and just opportunity for health and well-being. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.

KFF/The Undeclared Survey on Race and Health

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Overview

The *Survey on Race and Health*, a joint project between KFF and ESPN's The Undeclared, explores the public's views and experiences on the topics of health care, racial discrimination, and the coronavirus pandemic, with a special focus on Black adults, a group that has borne a disproportionate burden of COVID-19 cases and deaths. This survey of 1,769 U.S. adults includes an oversample of 777 Black Americans to allow for in-depth reporting among this group, as well as comparison groups of White and Hispanic adults. This project focuses on African Americans' views and experiences of being Black in America, including views of unconscious bias and structural racism; experiences of discrimination within and outside of health care settings; trust in the health care system; the social and economic impacts of the pandemic; and views of a potential coronavirus vaccine.

Read The Undeclared's [reporting](https://theundefeated.com/tag/race-and-health-care/) (<https://theundefeated.com/tag/race-and-health-care/>):

[New poll shows Black Americans see a racist health care system setting the stage for pandemic's impact](https://theundefeated.com/features/new-poll-shows-black-americans-see-a-racist-health-care-system-setting-the-stage-for-pandemics-impact/) (<https://theundefeated.com/features/new-poll-shows-black-americans-see-a-racist-health-care-system-setting-the-stage-for-pandemics-impact/>)

[Half of Black adults say they won't take a coronavirus vaccine](https://theundefeated.com/features/half-of-black-adults-say-they-wont-take-a-coronavirus-vaccine/) (<https://theundefeated.com/features/half-of-black-adults-say-they-wont-take-a-coronavirus-vaccine/>)

[New poll shows Black Americans put far less trust in doctors and hospitals than white people](https://theundefeated.com/features/new-poll-shows-black-americans-put-far-less-trust-in-doctors-and-hospitals-than-white-people/) (<https://theundefeated.com/features/new-poll-shows-black-americans-put-far-less-trust-in-doctors-and-hospitals-than-white-people/>)

[New poll shows how the pandemic has devastated Black families](https://theundefeated.com/features/new-poll-shows-how-the-pandemic-has-devastated-black-families/)

[\(https://theundefeated.com/features/new-poll-shows-how-the-pandemic-has-devastated-black-families/\)](https://theundefeated.com/features/new-poll-shows-how-the-pandemic-has-devastated-black-families/)

[COVID-19 unveils an America that always sees itself in Black and white](https://theundefeated.com/features/covid-19-unveils-an-america-that-always-sees-itself-in-black-and-white/)

[\(https://theundefeated.com/features/covid-19-unveils-an-america-that-always-sees-itself-in-black-and-white/\)](https://theundefeated.com/features/covid-19-unveils-an-america-that-always-sees-itself-in-black-and-white/)

[Black Americans overwhelmingly say unconscious bias is a major barrier in their lives](https://theundefeated.com/features/black-americans-overwhelmingly-say-unconscious-bias-is-a-major-barrier-in-their-lives/)

[\(https://theundefeated.com/features/black-americans-overwhelmingly-say-unconscious-bias-is-a-major-barrier-in-their-lives/\)](https://theundefeated.com/features/black-americans-overwhelmingly-say-unconscious-bias-is-a-major-barrier-in-their-lives/)

Main Findings

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Introduction

Racial disparities in health and health care have been longstanding and persistent in the United States. Even before the coronavirus pandemic, African Americans were experiencing [lower rates of health insurance coverage](https://www.kff.org/racial-equity-and-health-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/) (<https://www.kff.org/racial-equity-and-health-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/>), increased [barriers to accessing health care](https://www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-coverage-access-to-and-use-of-care/) (<https://www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-coverage-access-to-and-use-of-care/>), and [worse health outcomes](https://www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-health-status/) (<https://www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-health-status/>) compared to their White counterparts. Black adults in the U.S. also face [social and economic inequities](https://www.kff.org/policy-watch/health-disparities-symptom-broader-social-economic-inequities/) (<https://www.kff.org/policy-watch/health-disparities-symptom-broader-social-economic-inequities/>), including higher rates of unemployment, that play a major role in shaping health. Beyond these factors, [research](https://www.nap.edu/catalog/12875/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care) (<https://www.nap.edu/catalog/12875/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care>) shows that historic abuse and mistreatment of communities of color by the medical system and ongoing racism and discrimination drive disparities in health,

contributing to lower quality of care, distrust of the health care system, and stress and trauma (https://facstaff.necc.mass.edu/wp-content/uploads/2012/01/racism_and_psychological_injury_articl.pdf). Reflecting these experiences, KFF surveys dating back to 1999 (<https://www.kff.org/racial-equity-and-health-policy/poll-finding/race-ethnicity-medical-care-a-survey-of/>) have documented a gap in trust of health care providers between Black and White Americans.

The COVID-19 pandemic has drawn new attention to and compounded these existing disparities in health and health care. Since the pandemic hit the U.S. in early 2020, a growing body of research (<https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-covid-19-key-findings-available-data-analysis/>) has consistently shown that people of color have borne a disproportionate burden of COVID-19, including being at increased risk for exposure and experiencing higher rates of infection, hospitalization, and death (<https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-racial-disparities-testing-infection-hospitalization-death-analysis-epic-patient-data/>). Data also show that people of color are taking a harder hit financially from the economic downturn associated with the pandemic (<https://www.axios.com/coronavirus-economy-jobs-unemployment-racial-disparities-29e3c6c4-bb43-4eaf-bf90-04697ca66b2d.html>), experiencing higher rates of increases in unemployment and difficulty paying for basic needs. In addition, the deaths of Black men and women including George Floyd and Breonna Taylor at the hands of police, and ensuing protests around the country and the world, have shined a spotlight on inequities in the criminal justice system, and the threat of violence that feels like an all-too-common occurrence for many Black Americans (<https://www.kff.org/racial-equity-and-health-policy/report/kff-health-tracking-poll-june-2020/>).

In light of these facts, KFF partnered with ESPN's The Undefeated (<https://theundefeated.com/>) to conduct a survey exploring African Americans' views and experiences of being Black in America, focusing on experiences with racism and discrimination, including within the health care system; the impacts of the pandemic; and views of a potential coronavirus vaccine. The survey of over 1,700 U.S. adults includes an oversample of nearly 800 Black Americans to allow for in-depth reporting among this group by age, gender, education, and income, as well as comparison groups of White and Hispanic adults. Other groups, including Asian, American Indian and Alaska Native, and Native Hawaiian and Pacific Islander people are included in the total in proportion to their population, but the sample size is not sufficient to break their responses out separately.

This work builds on KFF's long history of documenting racial and ethnic disparities in health and health care (<https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-covid-19-key-findings-available-data-analysis/>), as well as our history of using surveys to document the views and experiences of African Americans on broader issues of race, culture, and discrimination in partnership with media organizations like CNN (<https://www.kff.org/other/report/survey-of-americans-on-race/>) and The Washington

(<https://www.kff.org/racial-equity-and-health-policy/poll-finding/black-women-in-america/>) [Post \(https://www.kff.org/racial-equity-and-health-policy/poll-finding/washington-postkaiser-family-foundationharvard-survey-of-african/\)](https://www.kff.org/racial-equity-and-health-policy/poll-finding/washington-postkaiser-family-foundationharvard-survey-of-african/).

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Executive Summary

- The share of Black adults who believe it is a good time to be Black in America has plummeted in recent years, but most believe the current protest movement will lead to meaningful change that will improve Black people's lives.** Just a quarter of Black men now say it is a good time to be a Black man in America, down from 60% in 2006, and just a third of Black women (34%) now say it's a good time to be a Black woman, down from 73% in 2011. Yet almost six in ten Black adults (57%) believe the current protest movement and fight for racial equality will lead to meaningful change that will improve the lives of Black people in the United States.
- Black Americans – and Black parents in particular – have been especially hard-hit by the coronavirus pandemic, both financially and emotionally.** Half of Black adults (compared to 42% of White adults) say someone in their household has lost a job or had their income reduced as a result of the pandemic, and one-third (compared to 17% of White adults) say it has had a major negative impact on their ability to afford basic needs like housing, utilities, and food. Among Black parents, the share reporting income loss rises to two-thirds, and almost half (46%) of Black parents report a major problem affording necessities. Black parents are also more likely than White parents to say the pandemic has had a major impact on their relationships with family members and their ability to care for their children. Overall, Black adults are more likely than their White counterparts to say they that know someone who has died from COVID-19, that they are worried about contracting the virus at work, and that the pandemic has caused a major decline in their mental health. Two-thirds of Black adults think that the federal government would be taking stronger action to fight the pandemic if White people were getting sick and dying at higher rates than people of color.
- About half of Black adults say they would not want to get a coronavirus vaccine if it was deemed safe by scientists and freely available, with safety concerns and distrust cited as the top reasons.** By contrast, most White adults say they would get vaccinated, and those who wouldn't get a vaccine are more likely to say they don't think they need it. Majorities of Black adults also lack confidence that the vaccine development process is taking the needs of Black people into account, and that when a vaccine becomes available it will have been properly tested and will be distributed fairly.
- Seven in ten Black adults believe race-based discrimination in health care happens at least somewhat often, and one in five say they have personally experienced it in the past year.** Black adults are also more likely than those who are White to report some specific negative experiences with health care providers, including providers not believing they were telling the truth or refusing to provide pain medication or other treatments they thought they needed. Two-thirds of Black adults – across income and education levels – say it is difficult to find a health care provider who shares their background and experiences, and one-quarter say they

have never received care from a Black doctor. Reflecting these experiences, Black adults are less likely than their White counterparts to say they trust doctors, local hospitals, and the health care system to do what is right for their communities.

- **Black women – particularly mothers – report experiencing even higher rates of discrimination in health care settings.** Among Black women who have a child under the age of 18, 37% say they have been treated unfairly based on their race while getting health care for themselves or a family member in the past year, and 41% say there was a time in the past three years when a health care provider talked down to them or didn't treat them with respect. (Among Black men these shares are 15% and 17%, respectively). Black women overall are also more likely than Black men to report feeling that a health care provider didn't believe they were telling the truth, assumed something without asking, or suggested they were personally to blame for their health problems.

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The Big Picture: Being Black in America Today

Majorities of Black men and women, regardless of age, income, and education, say it is a bad time to be Black in America. The survey finds that Black men and women largely agree that it is a difficult time to be Black in America, a finding that is perhaps not surprising given the disproportionate impact of the coronavirus pandemic on Black families and the national attention drawn to police violence against Black Americans, along with broader issues of systemic racism, over the summer of 2020. Among Black men, just one quarter say now is a good time to be a Black man in America, down 35 percentage points from 60% in a 2006 survey conducted by KFF and *The Washington Post*. Similarly, the share of Black women who say it's a good time to be a Black woman in America dropped by more than half, from 73% in a 2011 KFF/*Washington Post* survey to 34% in 2020. Now, majorities of both groups say it is a bad time to be a Black man (65%) or a Black woman (59%), a finding that holds true across Black men and women regardless of age, income, and education.

Figure 1: Most Black Men And Women Feel It Is A Bad Time To Be Black In America

When asked to say in their own words the biggest concerns facing them and their families right now, 36% of Black adults cite financial issues and a similar share (34%) cite concerns related to the COVID-19 pandemic. These are also the top two concerns mentioned by White and Hispanic adults, though Black adults are 10 percentage points more likely than White adults to name financial challenges among their top concerns (36% vs. 26%). Conversely, White adults are more likely than Black or Hispanic adults to cite concerns about government and politics, such as the upcoming

presidential election (15% of White vs. 7% of Black and 5% of Hispanic). Notably, six percent of Black adults cite issues related to racism as being among their top concerns, and three percent cite worries about police violence.

Figure 2: Financial Stability And COVID-19 Pandemic Are Biggest Concerns Facing Individuals And Families

Most Black adults report experiencing race-based discrimination in the past year.

The survey finds that nearly six in ten (58%) Black adults say they were treated unfairly while shopping, working, getting health care, or interacting with police in the past 12 months because of their race or ethnic background. Four in ten Hispanic adults also report experiencing such unfair treatment, compared with just 16% of White adults.

Figure 3: Most Black Adults Report Experiencing Race-Based Discrimination In Past Year

Black adults identify multiple structural and systemic barriers as major obstacles to achieving equal outcomes with White people, as well as individual acts of racism and unconscious bias.

When asked about obstacles to Black people achieving equal outcomes with White people in the U.S., larger shares of Black adults compared to White adults view various things as “major obstacles.” At least three-quarters of Black adults see structural or systemic racism (79%) and historic wealth gaps (76%) as major barriers, and about seven in ten say the same about individual acts of racism and discrimination (73%), unconscious bias (71%), limited opportunities for career advancement (70%), and limited access to quality housing (69%). Two-thirds of Black adults see limited access to quality education as a “major obstacle.” The share of White adults viewing each of these things as a major obstacle to Black people achieving equal outcomes with White people is at least 20 percentage points lower than the share of Black adults giving the same answer.

Figure 4: Black Adults More Likely Than White Adults To Perceive Many Obstacles To Racial Equality

Most Black adults report that unconscious bias, racism and discrimination, and structural and system barriers have been personal obstacles in their lives. When Black adults were asked whether this same list of items had been an obstacle in their own life, the list was similar, but unconscious bias was at the top (71% say this has been an obstacle), followed by about two-thirds who named individual acts of racism and discrimination (65%), structural or systemic racism (65%), and historic wealth gaps (63%). Nearly as many (57%) say that limited opportunities for career advancement has been a personal barrier. Fewer Black adults – about four in ten – see limited access to quality housing (44%) or quality education (41%) as obstacles in their own lives.

Figure 5: Most Black Adults Say Unconscious Bias, Discrimination, And Systemic Racism Have Been Personal Obstacles

Although unconscious bias ranks at the top of the list of personal obstacles, most Black adults who report experiencing discrimination in the past 12 months (58% of all Black adults) say that when people treat them unfairly based on their race, they are usually discriminating on purpose (70%), rather than being unaware they are being unfair (27%).

Figure 6: Most Black Adults Who Have Faced Discrimination Feel It Was Intentional Rather Than Unconscious

Despite these challenges, Black Americans are not without hope, with most believing the current protest movement will lead to meaningful change that will improve their lives. A majority (57%) of Black adults say they believe that “the current protest movement and fight for racial equality will lead to meaningful change that will improve the lives of Black people,” while a slight majority (53%) of White adults say they do not think the movement will lead to meaningful change. Hispanic adults respond similarly to Black adults, with 56% saying protests will lead to meaningful change. These racial differences at least partially reflect differing partisanship; 72% of Democrats (including 65% of Black Democrats and 75% of white Democrats) expect the protest movement to lead to meaningful change, while eight in ten Republicans (the large majority of whom are White) expect no meaningful change.

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The Disproportionate Impact of the COVID-19 Pandemic

Beyond its stark impacts on health and mortality, the coronavirus pandemic is also

Figure 7: Most Black Americans Say Protest Movement Will Lead To Meaningful Change; Most White Adults Say It Will Not

having significant economic impacts and taking a toll on individuals' mental and emotional health. Similar to the disproportionate rates of infection, serious illness, and death people of color are experiencing from the virus, the survey findings show that they also are bearing a disproportionate burden of negative consequences on their financial and emotional well-being.

Black and Hispanic adults are more likely to report employment disruptions and financial hardships associated with the pandemic compared to their White counterparts. With unemployment rising to record levels, about half of all U.S. adults, including higher shares of those who are Black (51%) or Hispanic (57%) compared to 42% of White adults, say that they or someone in their household has lost a job, been placed on furlough, or had their hours or income reduced as a result of the pandemic. The shares are even higher among Black parents with children under age 18 living at home, two-thirds (66%) of whom report a pandemic-related disruption in employment or income.

For many, these employment disruptions are leading to significant financial struggles. About three in ten of those who are Black (32%) or Hispanic (28%) say the pandemic has had a "major negative impact" on their ability to pay for basic necessities like housing, utilities, and food, compared with 17% of White adults. Again, Black parents have been hit particularly hard, with nearly half (46% of Black parents overall, 48% of Black mothers) saying the pandemic has had a major negative impact on their ability to pay the bills.

Figure 8: Black And Hispanic Adults Hit Harder Financially By Pandemic

Black parents also report disproportionate impacts on their ability to care for their children and their family relationships. Larger shares of Black parents than White parents say the coronavirus pandemic has had a "major negative impact" on their ability to care for their children (32% vs. 13%) and on their relationships with family members (25% vs. 12%). Majorities of both Black parents (60%) and White parents (59%) say the pandemic has had a major negative impact on their children's education.

Black and Hispanic adults are more likely to report the pandemic has had a major negative impact on their mental health and to say they know someone

Figure 9: Black Parents Report Major Impacts Of Pandemic On Education, Relationships, And Ability To Care For Their Children

who has died from coronavirus compared to those who are White. The coronavirus pandemic is taking an emotional toll on many Americans, including people of color. While more than half of adults across racial and ethnic groups say the pandemic has had a negative impact on their mental health, the share saying it has had a “major negative impact” is higher among Black and Hispanic adults (28% each) compared to White adults (19%). In addition, four in ten Black adults (39%) and a third of Hispanic adults say they know someone who has died from coronavirus, compared with 24% of those who are White.

Figure 10: Most Say The Pandemic Is Taking A Toll On Their Mental Health

Black adults who work outside their homes are also disproportionately worried about contracting the virus while at work. Among those who work outside of their home, six in ten Black adults are worried about getting sick from coronavirus while at work (including 34% who are “very worried”), compared with just under half of White adults who are worried (11% “very worried”). Worry rises to seven in ten among Black women who work outside the home (69%) and among working Black adults who live in a household where someone has a serious health condition (71%).

Figure 11: Among Working Adults, Those Who Are Black Are More Worried About Contracting Coronavirus At Work

Two-thirds of Black adults think that the federal government would be taking stronger action to fight the pandemic if White people were getting sick and dying from coronavirus at higher rates than people of color. In contrast, 72% of White people believe the government’s response would not be different. Attitudes among Hispanic adults are more mixed: 42% say the government’s response would be stronger and 47% say it would not be different. These attitudes are also highly partisan, with six in ten Democrats believing the government response would be stronger if more White people were dying and the vast majority (90%) of Republicans saying the response would be no different.

Figure 12: Most Black Adults, Democrats Say Government Pandemic Response Would Be Stronger If More White People Were Affected

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Views Of A Potential COVID-19 Vaccine

With planning beginning for an eventual COVID-19 vaccine, one important consideration is making sure that distribution processes and outreach and communication strategies reach people of color. Vaccination among people of color will be particularly important because they are bearing a heavy, disproportionate burden of the disease, and population immunity is not likely to be reached without high vaccination rates across all communities. However, achieving a high vaccination rate will require public health officials and providers to overcome a range of [barriers to vaccination](https://www.kff.org/policy-watch/racial-disparities-flu-vaccination-implications-covid-19-vaccination-efforts/) among people of color, many of which are rooted in a historic legacy of abuse and mistreatment by the medical system and ongoing racism and discrimination today. The survey findings provide greater insight into these barriers.

The survey finds that Black adults are less likely than other groups to say they would get a coronavirus vaccine if it was free and determined safe by scientists. Half of Black adults say if a coronavirus vaccine was determined to be safe by scientists and available for free to everyone who wanted it, they would “definitely” or “probably” get vaccinated, compared to six in 10 Hispanic adults and 65% of White adults. In fact, just 17% of Black adults say they would “definitely” get the vaccine, 20 percentage points lower than the share of both Hispanic and White adults (37% each).

Figure 13: Black Americans Less Likely To Say They Would Get COVID-19 Vaccine Even If It Was Free And Determined Safe By Scientists

The racial differences in willingness to obtain a vaccine widen when partisan differences are taken into account. About three-quarters of Democrats (77%) say they would “definitely” or “probably” get a coronavirus vaccine if it was free and safe, compared to about two-thirds of independents (67%) and just under half of Republicans (47%). Considering both race and partisanship together, the racial divide in vaccine hesitancy among Democrats and independents is stark. Two-thirds (65%) of White Democrats say they would “definitely” get vaccinated, compared with just 23% of

Black Democrats. Similarly, among independents, those who are White are more than 3 times as likely to say they would definitely get a vaccine as those who are Black (41% vs. 12%).

Table 1: Coronavirus vaccine attitudes by race and political party identification

	Democrats			Independents			Republicans*	
	Total	Black	White	Total	Black	White	Total	White
If a coronavirus vaccine was determined to be safe by scientists and available for free to everyone who wanted it, would you...?								
Definitely/Probably get it (NET)	77%	55%	87%	67%	48%	70%	47%	50%
Definitely get it	51	23	65	35	12	41	20	20
Probably get it	26	33	22	31	36	29	27	30
Definitely/Probably not get it (NET)	21	44	10	31	51	29	51	49
Probably not get it	12	24	8	12	20	9	20	21
Definitely not get it	9	20	2	20	31	20	31	28

* Sample size of Black Republicans insufficient to report separately.

Risk factors appear to play a small role in Black adults' willingness to obtain the vaccine. Six in ten Black adults ages 65 and over – who are at higher risk for serious illness if they contract coronavirus– say they would probably or definitely get vaccinated if a safe vaccine was available for free, slightly higher than among those under age 65. But, Black adults who live in a household where someone has a serious health condition or works in a health care setting – two other groups at disproportionate risk for serious illness or exposure – are not significantly more likely than their counterparts to say they would be willing to take a vaccine.

Figure 14: Among Black Adults For Whom COVID-19 Poses Increased Risks, Many Are Hesitant To Get Vaccinated

The racial difference in willingness to take a coronavirus vaccine may at least partially reflect a difference in attitudes towards vaccines in general. Black adults are less likely than their White counterparts to say they usually get a flu vaccine each year (49% vs. 60%). Still, this doesn't explain the difference entirely, as Black adults who normally get a flu vaccine are 18 percentage points less likely than White adults who normally get a flu vaccine to say they would get a vaccine for coronavirus if it was determined to be safe and freely available (66% vs. 84%).

Figure 15: Racial Differences In COVID-19 Vaccine Hesitancy Persist Among Those Who Normally Get A Flu Vaccine

The primary reasons Black adults cite for saying they definitely or probably would not get a coronavirus vaccine are safety concerns and distrust of the health care system. When asked to say in their own words why they would not get a coronavirus vaccine, four in ten Black adults (39%) cite safety concerns, as do three in ten White adults. Thirty-five percent of Black adults who say they won't get vaccinated cite distrust in either the health care system, the government, or vaccines in general as a reason, higher than the share of White adults who say the same (23%). By contrast, White adults who say they won't get vaccinated are more likely than Black adults to say they don't want or need a vaccine or don't think they're at risk of getting sick from coronavirus (39% vs. 21%). Six percent of both Black and White adults who say they would not get vaccinated cite concerns about the vaccine development process.

Figure 16: Black Adults Who Are Vaccine Hesitant Cite Safety Concerns, Distrust; More White Adults Say They Don't Need/Want It

In Their Own Words

Survey respondents' open-ended answers to the question "What is the main reason why you would not get a vaccine for coronavirus?" reveal the breadth of questions and concerns that people have about a potential vaccine. Some examples are shown below:

Safety concerns/side effects

"Not sure if it would work or could cause some kind of bad reaction or death. I will have to see if it actually works before I take it." (Black woman, age 65+)

"Because I believe they would be putting the virus in me instead of protecting me from it. I would need more proof that it's safe before I would allow myself or my child to take the vaccine." (Black woman, age 18-29)

"It's new. Even if tested, there will be negative impacts." (White woman, age 30-49)

Distrust of health care system/vaccines/government

"Because I am a Black woman as you know and don't trust the people who give the vaccine and want [it] to be tested on another race before it's given to Black people." (Black woman, age 50-64)

"Do not trust the safety of a vaccine given the current President's adversarial relationship with the truth and transparency." (Black man, age 30-49)

"Because it would take a long time for the research to come through, I don't trust the medical community because of mistakes in the past." (Black man, age 65+)

Don't need or want/Not at risk

"I'm healthy. If I get the virus, [I] don't think there is not much risk to my health." (Black man, age 30-49)

"I've never gotten vaccines and I don't ever get sick." (White woman, age 18-29)

"[I] don't think the coronavirus is as deadly as it is said to be." (White man, age 50-64)

"I am a Republican, Republicans do not get coronavirus." (White man, age 65+)

Concerns about development process

“Rush to market. Not taking vaccines through the typical test studies.” (Black woman, age 50-64)

“They’re pushing it too fast because of the president.” (White man, age 65+)

Overall, a majority of Black adults express concerns about whether an eventual vaccine will have been properly tested for safety and effectiveness and whether it will be distributed fairly. Nearly two-thirds (65%) of Black adults are “not at all confident” or “not too confident” that the development of the vaccine is taking the needs of Black people into account. Moreover, six in ten Black adults (61%) say they are “not too confident” or “not at all confident” that an eventual vaccine will have been properly tested for safety and effectiveness, and 66% are not confident that it will be distributed in a way that is fair. By contrast, about half of Hispanic adults and about six in ten White adults say they are at least somewhat confident that a vaccine will be properly tested and that it will be distributed fairly.

Figure 17: Most Black Adults Are Not Confident In COVID-19 Vaccine Development Process, Safety, And Fair Distribution

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Trust And Experiences In The Health Care System

The longstanding and persistent racial disparities in health reflect a variety of factors both within and beyond the health care system, including differences in [health insurance coverage](https://www.kff.org/racial-equity-and-health-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/) (<https://www.kff.org/racial-equity-and-health-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/>), [health care access](https://www.kff.org/racial-equity-and-health-policy/report/key-facts-on-health-and-health-care-by-race-and-ethnicity/) (<https://www.kff.org/racial-equity-and-health-policy/report/key-facts-on-health-and-health-care-by-race-and-ethnicity/>), and [social and economic factors](https://www.kff.org/policy-watch/health-disparities-symptom-broader-social-economic-inequities/) (<https://www.kff.org/policy-watch/health-disparities-symptom-broader-social-economic-inequities/>) that influence health. Moreover, [research](https://www.nap.edu/catalog/12875/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care) (<https://www.nap.edu/catalog/12875/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care>) shows that racial disparities in health persist after controlling for these factors, suggesting that other factors, including historic and ongoing racism and discrimination, play a role in driving these differences. The survey findings provide greater insight into how racism and discrimination shape Black adults’ experiences with the health care system.

Trust of Providers and Hospitals

Reflecting their experiences with discrimination and systemic racism, Black people express lower levels of trust in a variety of organizations and institutions compared to those who are White. The gulf is widest when asked how often they can trust the police to do what is right for them and their community – just 30% of Black adults say they can trust the police “almost all of the time” or “most of the time,” compared with 72% of White adults. A little over half of Hispanic adults (56%) say they can trust the police.

While Black and Hispanic adults are generally more trusting of doctors and hospitals than they are of the police, courts, and schools, there is a racial gap in trust when it comes to health care as well. Compared to White adults, Black adults are 19 percentage points less likely to trust doctors (59% vs. 78%), 14 percentage points less likely to trust local hospitals (56% vs. 70%), and 11 percentage points less likely to trust “the health care system” (44% vs. 55%) to do what is right for them and their communities. On each of these items, the responses for Hispanic adults fall in between those of Black and White adults.

Figure 18: Black Adults Less Likely Than White Adults To Trust A Variety Of Groups And Institutions, Including In Health Care

There is an age gap in trust as well, with younger Black adults less likely than their older counterparts to say they trust doctors and the health care system to do what is right for them and their communities. For example, roughly half of Black adults under age 50 say they can trust doctors almost all or most of the time, compared with about 7 in 10 Black adults ages 50 and over.

Figure 19: Younger Black Adults Less Likely To Trust Doctors And The Health Care System

Perceptions of Unfair Treatment in Health Care

Most Black adults feel the health care system treats people unfairly based on their race or ethnic background, and this share has increased over time. Fully seven in ten Black adults say that “our health care system treats people unfairly based on their race or ethnic background” very often or somewhat often, compared to 41% of White adults and 43% of Hispanic adults.

Figure 20: Black Adults More Likely To Perceive Discrimination In U.S. Health Care System

The share of Black adults who believe race-based discrimination in health care happens very or somewhat often has increased over the past 20 years (from 56% in 1999 to 70% now), while the shares among Hispanic and White adults have remained statistically similar to what they were in 1999.

Figure 21: Share Of Black Adults Perceiving Racial Discrimination In Health Care Has Increased Since 1999

Black adults identify a range of reasons why Black people have worse average health outcomes compared to White people. When asked about potential reasons why Black people in the U.S. have worse outcomes on average compared to White people, Black adults are much more likely than White adults to view various factors as major reasons, including disparities in access to health care and insurance (72% vs. 49%), environmental exposures (70% vs. 40%), and disparities in the level of care provided to Black vs. white patients (54% vs. 26%). Black adults are also somewhat more likely than their White counterparts to blame lack of healthy behaviors (38% vs. 24%) and genetic differences (26% vs. 14%) for racial disparities in health outcomes. The perception of the role of genetic differences stands in contrast to research (<https://www.healthaffairs.org/doi/10.1377/hblog20200630.939347/full/>) disproving biologic differences as a driver of racial disparities in health; moreover, there is growing recognition that individual health behaviors are influenced by policies, systems, and environments (<https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/>).

Figure 22: Black Adults Perceive A Variety Of Reasons For Poorer Average Health Outcomes In U.S.

Experiences With and Access to Health Care Providers

A significant and longstanding body of research (<https://www.nap.edu/catalog/12875/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care>) suggests that provider and institutional bias and discrimination are drivers of racial disparities in health, contributing to racial differences in diagnosis, prognosis, and treatment decisions. Research further points to the role of communication and interactions between

providers and patients and suggests that enhancing providers' ability to provide culturally and linguistically appropriate care (<https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53#:~:text=The%20National%20Standards%20for%20Culturally,the%20nation's%20increasin gly%20diverse%20communities.>) as well as increasing diversity of the health care workforce (https://minorityhealth.hhs.gov/npa/files/plans/hhs/hhs_plan_complete.pdf) may help address disparities in health. Reflecting these factors, studies show, for example, that people of color receive lower quality of care (<https://www.ahrq.gov/research/findings/nhqdr/nhqdr18/index.html>), receive less adequate treatment (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3111792/>) for acute and chronic pain, and report higher rates of mistreatment (<https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-019-0729-2>) during the course of their pregnancy. Pointing to the importance of culturally competent care, one recent study (<https://www.pnas.org/content/117/35/21194>) found that there were significant improvements in mortality for Black newborns who were cared for by Black physicians. Beyond these factors, people of color may face increased difficulty accessing care (<https://www.kff.org/racial-equity-and-health-policy/report/key-facts-on-health-and-health-care-by-race-and-ethnicity/>) due to cost or lack of easily accessible providers, among other factors. The survey findings provide greater insight into individuals experiences with health care providers and their ability to access providers, including those with a shared background and experience.

One in five Black and Hispanic adults report they were personally treated unfairly because of their race and ethnicity while getting health care in the past year, with higher shares among younger Black adults and women, particularly mothers. Twenty percent of Black adults and 19% of Hispanic adults say they were *personally* treated unfairly because of their race or ethnicity when getting health care for themselves or a family member in the past 12 months, while just 5% of White adults say this has happened to them. Younger Black adults (23% of those ages 18-29 and 28% of those ages 30-49) and Black women (25%) are more likely than older Black adults to report being treated unfairly when receiving care. Among Black mothers of children under age 18, nearly four in ten (37%) say they have been treated unfairly in the past 12 months while getting health care for themselves or a family member. Familiarity with the medical community also does not appear to shield Black adults from discrimination in health care settings; 34% of those who work in a health care delivery setting or live with someone who does say they've experienced race-based discrimination while getting health care in the past year.

Figure 23: One In Five Black Adults Report Experiencing Discrimination Getting Health Care, Higher Among Mothers And Younger Adults

In addition to reporting being treated unfairly, an even larger share of Black adults - 36% - say there was a time in the past few years when they think they would have gotten better medical care if they belonged to a different race or ethnic group. Mirroring age patterns of reported discrimination, Black adults under age 50 are more likely than those ages 50 and over to feel they would have gotten better care if they were a different race.

Figure 24: One-Third Of Black Adults Feel They Would Have Gotten Better Medical Care If They Were A Different Race, Higher Among Young

Across racial and ethnic groups, many adults report having some specific negative experiences with health care providers. Overall, about a quarter of adults say that in the past 3 years, a doctor or other health care provider has assumed something about them without asking (24%) or talked down to them or treated them without respect (23%). Just under one in five say there was a time in the past 3 years when a provider didn't believe they were telling the truth (19%) or suggested they were personally to blame for a health problem (17%). About one in seven say a doctor refused to order a test or treatment (14%) or pain medication (13%) they thought they needed.

Figure 25: Nearly Half Of Adults Overall Report One Of Six Negative Experiences With Health Care Providers In Last 3 Years

Black adults are more likely than White adults to report some negative experiences with health care providers. These differences include feeling that a provider didn't believe they were telling the truth (22% of Black adults vs. 17% of White adults say this happened to them in the past 3 years), being refused a test or treatment they thought they needed (19% vs. 12%), and being refused pain medication (18% vs. 13%). Other negative experiences were reported at similar rates among Black and White adults, including health care providers suggesting they were personally to blame for a health problem, assuming things without asking, and treating them with a lack of respect. About half of Black adults (49%), a similar share of White adults (45%), and four in ten Hispanic adults (39%) report experiencing at least one of these things in the past 3 years. Together, these findings suggest that across groups, patients encounter negative experiences obtaining care, but Black people are more likely to report negative experiences in some specific instances.

Interestingly, most Black adults who experienced at least one form of mistreatment do not believe their race was a factor. About four in ten (38%) of those who had at least one negative experience (19% of all Black adults) think it happened specifically because of their race, while the majority (27% of all Black adults) say it was for some other reason.

Figure 26: Black Adults More Likely Than White Adults To Report Providers Not Believing Them, Refusing Tests/Treatment, Or Pain Medication

In addition to differences by race, there are also gender differences in the treatment people report receiving from health care providers. Black women are more likely than Black men to report feeling that a health care provider didn't believe they were telling the truth (27% vs. 16%), assumed something without asking (32% vs. 22%), talked down or treated them without respect (27% vs. 17%), or suggested they were personally to blame for their health problems (24% vs. 15%). Among Black women with children, the share who say a health care provider talked down to them or treated them with disrespect rises to 41%.

In most cases, there are similar gender gaps between the experiences of White women and men as well, though when it comes to being personally blamed for their health problems, the opposite pattern is true, with White men more likely than White women to report this experience.

Table 2: Negative experiences with health care providers by race and gender

In the last 3 years, have you ever felt that a doctor or health care provider...? (percent saying "yes")	Total		Black		White	
	Women	Men	Women	Men	Women	Men
Assumed something about you without asking	29%*	20%	32%*	22%	29%*	21%
Talked down to you or didn't treat you with respect	27*	19	27*	17	27*	19
Didn't believe you were telling the truth	23*	15	27*	16	20*	13
Suggested you were personally to blame for a health problem you were experiencing	16	19	24*	15	13	20*
Refused to order a test or treatment you thought you needed	17*	11	20	17	14	10
Refused to prescribe pain medication you thought you needed	14	13	20	16	12	13
Experienced at least one of the above	49*	42	52	45	47	43

* indicates statistically significant difference between men and women within group.

Black and Hispanic adults are more likely than their White counterparts to say it's difficult to find a doctor who shares their background and experiences and one who treats them with dignity and respect. About two-thirds (65%) of Black adults and over half (54%) of Hispanic adults say it is very or somewhat difficult for them to find a doctor who shares their background and experiences, while most White adults (53%) say this is easy. Similarly, about one in five adults who are Black (21%) or Hispanic (22%) say it is difficult to find a doctor who treats them with dignity and respect, compared to a smaller share of those who are White (14%).

Figure 27: Black And Hispanic Adults Report More Difficulty Finding Doctors Who Share Their Background And Treat Them With Respect

Among White adults, those with college degrees are much more likely than those without a degree to say it's easy to find a doctor who shares their background and experience. However, this education advantage does not exist among Black adults. Nearly two-thirds (64%) of Black adults with a college degree say it's difficult to find a doctor who shares their background and experience, about two and a half times the rate among college-educated White adults (27%). The pattern is similar across income groups – higher-income White adults are more likely than those with lower incomes to say it is easy to find a provider who shares their background and experiences, while about two-thirds of Black adults across income groups say it is difficult.

Table 3: Difficulty finding doctor with shared background by race and education

How easy or difficult is it to find a doctor who shares the same background and experience as you?	Black		White	
	No 4-year degree	College graduate	No 4-year degree	College graduate
Very/somewhat easy	31%	35%	47%	64%
Very/somewhat difficult	66	64	48	27
Don't know/Refused	3	1	5	10

Table 4: Difficulty finding doctor with shared background by race and household income

How easy or difficult is it to find a doctor who shares the same background and experience as you?	Black			White	
	<\$40K	\$40-\$89.9K	\$90K+	<\$40K	\$40-\$89.9K
Very/somewhat easy	33%	31%	33%	44%	53%
Very/somewhat difficult	65	67	67	52	47
Don't know/Refused	2	2	1	4	0

For Black and Hispanic Americans, finding a doctor who shares their background and experience may or may not mean seeing a doctor of the same race or ethnicity. In fact, about one quarter (24%) of Black adults say they would prefer to see a Black doctor, while most say it doesn't make much difference. Still, 24% of Black adults say they've *never* received care from a Black doctor, including 35% of those ages 18-29 and 28% of those who say they would prefer to see a doctor who is Black. A similar 28% of Hispanic adults say they've never received care from a doctor who is Hispanic or Latino.

Figure 28: Most Black, Hispanic Adults Say Race Of Doctor Makes No Difference; One-Quarter Haven't Had A Doctor Of Same Race

Black and Hispanic adults are more likely than White adults to report financial and accessibility barriers to obtaining health care. About half of Black (48%) and Hispanic (49%) adults say it is very or somewhat difficult to find health care they can afford, compared to a somewhat smaller share of White adults (39%). Similarly, about a quarter (24%) of Black adults and three in ten Hispanic adults say it is difficult to find health care at a location that is easy for them to get to, compared to 18% of White adults.

Figure 29: Black And Hispanic Adults Report More Difficulty Finding Affordable Care At Accessible Locations

The differences between Black and White adults on these questions are largely driven by income differences. That is, those with lower incomes generally report more difficulty finding accessible and affordable care than those with higher incomes, and Black and White adults at similar income levels report similar levels of difficulty on both these measures.

Table 5: Difficulty finding affordable and accessible health care by race and household income

How easy or difficult is it to find health care you can afford?	Black			W	
	<\$40K	\$40-\$89.9K	\$90K+	<\$40K	\$40K+
Very/somewhat easy	46%	57%	64%	49%	
Very/somewhat difficult	54	43	34	48	
How easy or difficult is it to find health care at a location that is easy for you to get to?					
Very/somewhat easy	73	77	86	73	
Very/somewhat difficult	27	22	13	26	

Note: There were not enough Hispanic respondents in the survey to provide similar income breaks.

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Conclusion

These survey findings highlight some of the many challenges facing Black individuals and families in 2020. Black people in the U.S. are bearing a heavy burden of the health and economic consequences of the COVID-19 pandemic, and the survey shows the pandemic is taking an unequal toll on their financial stability, their ability to care for their children, and their emotional well-being. The findings further illustrate that, once a COVID-19 vaccine becomes available, accomplishing a high vaccination rate will require addressing multiple barriers to vaccination among the Black community, including building public trust and willingness to obtain the vaccine by addressing distrust and safety concerns.

In addition, despite longstanding research documenting racial health disparities, the survey shows that racism and discrimination still play a major role in shaping people's perceptions and experiences with obtaining health care. Most Black adults believe that race-based discrimination in health care happens at least somewhat often, and they are more likely compared to White adults to report experiencing specific negative experiences with health care providers. Many of these experiences are even more common among Black women, particularly those with children. Black adults also face difficulties finding providers who share their background and experiences and treat them with dignity and respect, as well as challenges finding health care they can afford and easily access – challenges shared by Hispanic adults. These findings point to the importance of continuing to prioritize equity in health care, and, in particular, efforts to address individual and institutional bias and discrimination and social and economic inequities that increase barriers to health.

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The combined landline, cell phone, and web sample was weighted to match the sample demographics to estimates for the national population. A multi-stage weighting process was used to adjust for the fact that not all survey respondents were selected with the same probabilities and to account for systematic non-response. In the first weighting stage, adjustments were made to 1) correct for the oversampling of different groups; 2) account for the fact that respondents with both a landline and cell phone have a higher probability of selection in the RDD sample; 3) adjust for likelihood of non-response for the re-contacted sample; 4) match estimates of the population (Black and non-Black) that do not use the internet based on estimates from the Pew Research Center; and 5) match current patterns of telephone use (Black and non-Black) according to the June-December 2019 National Health Interview Survey. In the second weighting stage, the sample was weighted (separately for Black and non-Black respondents) to match demographics of the adult U.S. population using data from the Census Bureau's 2018 American Community Survey (ACS) on age by gender, education, race and Hispanic origin (for non-the non-Black sample), parent status (by gender), metropolitan status, and Census region. Weights were then trimmed separately for the Black and non-Black samples, and in the final stage, the samples were combined and adjusted to ensure the proportion of Black respondents in the total sample would equal their share of the adult population. All statistical tests of significance account for the effect of weighting.

The margin of sampling error including the design effect for the full sample is plus or minus 3 percentage points. Numbers of respondents and margins of sampling error for key subgroups are shown in the table below. For results based on other subgroups, the margin of sampling error may be higher. Sample sizes and margins of sampling error for other subgroups are available by request. Note that sampling error is only one of many potential sources of error in this or any other public opinion poll. KFF public opinion and survey research is a charter member of the [Transparency Initiative](http://www.aapor.org/Transparency_Initiative.htm) (http://www.aapor.org/Transparency_Initiative.htm) of the American Association for Public Opinion Research.

Group	N (unweighted)	M.O.S.E.
Total	1,769	± 3 percentage points
Black, non-Hispanic	777	± 5 percentage points
Hispanic	201	± 9 percentage points
White, non-Hispanic	687	± 4 percentage points

Endnotes

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State Medicaid Programs Respond to Meet COVID-19 Challenges: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2020 and 2021

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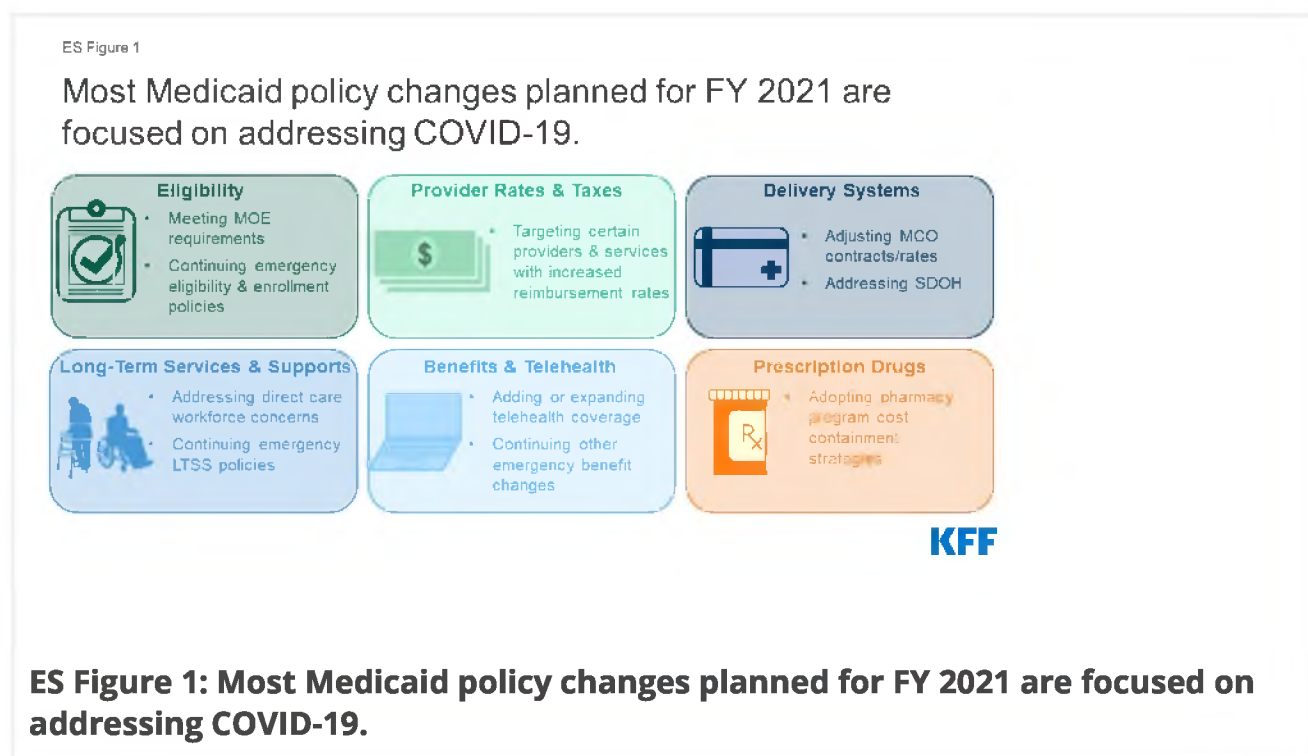
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Executive Summary

The coronavirus pandemic has generated both a public health crisis and an economic crisis, with major implications for Medicaid, a countercyclical program. During economic downturns, more people enroll in Medicaid, increasing program spending at the same time state tax revenues may be falling. As demand increases and state revenues decline, states face difficult budget decisions to meet balanced budget requirements. To help both support Medicaid and provide broad fiscal relief, the **Families First Coronavirus Response Act (FFCRA)** (<https://www.kff.org/global-health-policy/issue-brief/the-families-first-coronavirus-response-act-summary-of-key-provisions/>)¹ authorized a 6.2 percentage point increase in the federal match rate (“FMAP”)² (retroactive to January 1, 2020) available if states meet **certain “maintenance of eligibility” (MOE) requirements** (<https://www.kff.org/coronavirus-covid-19/issue-brief/key-questions-about-the-new-increase-in-federal-medicaid-matching-funds-for-covid-19/>).³ The fiscal relief is in place until the end of the quarter in which the Public Health Emergency (PHE) ends. The **current PHE** (<https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-2Oct2020.aspx>) is in effect through January 21, 2021 which means the enhanced FMAP is slated to expire at the end of March 2021 unless the PHE is renewed.⁴

States ended state fiscal year (FY) 2020 and adopted budgets and policies for FY 2021, which began on July 1 for most states⁵, while faced with uncertainty about the pandemic, the economy, and the duration of the PHE. This report examines Medicaid policy trends with a focus on planned changes for FY 2021 based on data provided by state Medicaid directors as part of the 20th annual survey of Medicaid directors in all 50 states and the District of Columbia. Unlike previous years, the survey instrument was modified to primarily collect information about policy changes planned for FY

2021, especially policies related to responding to the pandemic. Overall, 43 states⁶ responded to the survey by mid-August 2020, although response rates for specific questions varied. Key findings suggest that most policy changes and issues identified for FY 2021 were related to responding to the COVID-19 PHE (Figure 1).



Eligibility and Enrollment

As part of the federal response to the COVID-19 pandemic, states meeting certain “maintenance of eligibility” (MOE) conditions (<https://www.kff.org/coronavirus-covid-19/issue-brief/key-questions-about-the-new-increase-in-federal-medicaid-matching-funds-for-covid-19/>) **can access enhanced federal Medicaid funding.**⁷ In addition to meeting the **MOE requirements** (<https://www.kff.org/medicaid/issue-brief/medicaid-maintenance-of-eligibility-requirements-issues-to-watch-when-they-end/>),⁸ some states are utilizing **Medicaid emergency authorities** (<https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>) to adopt an array of actions to help people obtain and maintain coverage.⁹ While many states remained undecided, five states reported plans to continue COVID-19 related changes to eligibility and enrollment policies after the PHE ends, such as allowing self-attestation of certain eligibility criteria. States reported a variety of outreach efforts to publicize COVID-19 related eligibility and enrollment changes, and 10 states reported expanding enrollment assistance or member call center capacity during the PHE. At the time of survey submission, thirteen states had an approved State Plan Amendment (SPA) in place for the new Uninsured Coronavirus Testing group;¹⁰ however, this option that allows states to access a 100% federal match rate for coronavirus diagnostic testing expires at the end of the PHE.

Non-emergency eligibility changes were limited, except for plans to implement the Medicaid expansion. To date, 39 states (including DC) have adopted the ACA Medicaid expansion (<https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>).¹¹ Of these, 37 states have implemented expansion coverage (including Idaho and Utah, which both implemented the expansion on January 1, 2020, and Nebraska, which implemented the expansion as of October 1, 2020). Two additional states, Missouri and Oklahoma, will implement the expansion in FY 2022 as a result of successful Medicaid expansion ballot initiatives. Six states reported plans to implement more narrow eligibility expansions. Only a few states reported planned eligibility restrictions or plans to simplify enrollment processes in FY 2021.

Provider Rates and Taxes

The COVID-19 pandemic has resulted in financial strain for Medicaid providers, so unlike in prior economic downturns more states are implementing policies to provide targeted support to providers rather than rate cuts. At the time of the survey, more responding states implemented or were planning fee-for-service (FFS) rate increases relative to rate restrictions in both FY 2020 and FY 2021. More than half of responding states indicated that one or more payment changes made in FY 2020 or FY 2021 were related in whole or in part to COVID-19. Many states adopted FFS payment changes in FY 2020 and/or planned to make changes in FY 2021 to provide additional relief to providers in response to the PHE. Still, three states have cut provider rates across all or nearly all provider categories and other states have indicated rate freezes or reductions were likely. Historically, states tend to increase or impose new provider taxes during economic downturns; however, only one state reported the addition of a new provider tax in FY 2021 and few states reported making significant changes to their provider tax structure in FY 2021. Impacts of COVID-19 on provider tax collections and provider rates are still emerging.

Nearly half of states reported that federal provider relief funds were not adequate for Medicaid providers, while other states did not know at the time of the survey. The Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act provide \$175 billion in provider relief funds (<https://www.kff.org/coronavirus-policy-watch/update-on-covid-19-funding-for-hospitals-and-other-providers/>) to reimburse eligible health care providers for health care related expenses or lost revenues that are attributable to the pandemic.¹² Almost half of states responding to the survey reported that relief funds under the CARES Act have not been adequate to address the negative impact of COVID-19 faced by providers serving a high share of Medicaid and low-income patients.

Delivery Systems

Since nearly seven in ten Medicaid enrollees nationwide

([https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?](https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)

[currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D](https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D))

receive comprehensive acute care services (i.e., most hospital and physician services) through capitated managed care organizations (MCOs), these plans have played a critical role in responding to the COVID-19 pandemic.¹³ Twelve MCO states (of 31 responding) indicated plans to make adjustments to FY 2021 MCO contracts or rates in response to *both* COVID-related depressed utilization *and* unanticipated treatment costs. Fourteen MCO states (of 32 responding) reported implementing directed payments to selected provider types in response to the COVID-19 pandemic. MCO states reported a variety of programs, initiatives, or “value-added” services newly offered by MCOs in response to the PHE. Beyond addressing pandemic-related issues, twelve states in FY 2020 and seven in FY 2021 reported notable changes in the benefits and services covered under their MCO contracts.

The pandemic has elevated the importance of addressing social determinants of health (<https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>) **(SDOH)**¹⁴ **to improve health and reduce longstanding disparities in health and health care.** Nearly two-thirds of responding states reported implementation, expansion, or reform of a program or initiative to address Medicaid enrollees’ SDOH in response to COVID-19 (27 states).

Long-Term Services and Supports

The majority of responding states reported concerns about the pandemic’s impact on the long-term services and supports (LTSS) direct care workforce supply as well as concerns about access to personal protective equipment (PPE), access to COVID-19 testing, and risk of COVID-19 infections for LTSS direct care workers. Medicaid is the nation’s primary payer for LTSS (<https://www.kff.org/report-section/medicaid-home-and-community-based-services-enrollment-and-spending-issue-brief/>).¹⁵ As the pandemic continues, states have taken a number of Medicaid policy actions (<https://www.kff.org/medicaid/issue-brief/state-actions-to-sustain-medicaid-long-term-services-and-supports-during-covid-19/>) to address the impact on seniors and people with disabilities who rely on LTSS to meet daily self-care and independent living needs.¹⁶ States noted plans to retain a variety of LTSS policy changes adopted in response to COVID-19 after the PHE period ends, most commonly citing the continuation of HCBS telehealth expansions.

Benefits, Cost-Sharing, and Telehealth

The majority of states added or expanded telehealth access in response to the pandemic, and many states plan to extend these and/or other benefit and cost-sharing changes beyond the PHE period. The majority of responding states report currently covering a range of FFS services delivered via telehealth when the originating site is the beneficiary’s home, most of which newly added or expanded this coverage in response to the COVID-19 pandemic. Most states reported that services delivered via telehealth from the beneficiary’s home have payment parity as compared to services delivered face-to-face, and just over half of states planned to extend newly

added/expanded FFS telehealth coverage beyond the PHE period, at least in part and at least for some services. Approximately one-third of responding states noted plans to extend other benefit and cost-sharing changes adopted during the PHE period (15 states); most of these are pharmacy changes. [Prior to the COVID-19 pandemic \(https://www.kff.org/report-section/a-view-from-the-states-key-medicare-policy-changes-benefits-and-cost-sharing/\)](https://www.kff.org/report-section/a-view-from-the-states-key-medicare-policy-changes-benefits-and-cost-sharing/), state changes to Medicaid benefits most commonly pertained to enhanced mental health and substance use disorder (SUD) services.¹⁷ Less than one-third of responding states reported plans to make benefit or cost-sharing changes that are not related to the PHE in FY 2021 (13 states).

Prescription Drugs

States continued to adopt pharmacy program cost containment strategies despite the COVID-19 emergency and other competing priorities. Managing the Medicaid prescription drug benefit and pharmacy expenditures remains a policy priority for state Medicaid programs, and state policymakers remain concerned about Medicaid prescription drug spending growth. Thirty-three responding states reported plans to newly implement or expand upon at least one initiative to contain prescription drug costs in FY 2021.

Challenges and Priorities

Nearly all states reported significant adverse economic and state budgetary impacts driven by the pandemic, as well as uncertainty about the future. In the face of the COVID-19 pandemic, states continue to encounter challenges to provide Medicaid coverage and access for a growing number of Americans, while also facing plummeting revenues and deepening state budget gaps. State Medicaid officials highlighted swift and effective state responses to the pandemic, such as the rapid expansion of telehealth, as well as ongoing efforts to advance delivery system reforms and to address health disparities and other public health challenges. In these ways, the pandemic has demonstrated how Medicaid can quickly evolve to address the nation's most pressing health care challenges. However, the ability of states to sustain policies adopted in response to the pandemic (including through emergency authorities) may be tied to the duration of the PHE as well as the availability of additional federal fiscal relief and support. Looking ahead, great uncertainty remains regarding the future course of the pandemic, the scope and length of federal fiscal relief efforts, and what the "new normal" will be in terms of service provision and demand. Results of the November 2020 elections could also have significant implications for the direction of federal Medicaid policy in the years ahead.

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Report

Introduction

Like all other aspects of the American health landscape, the COVID-19 pandemic and subsequent public health emergency (PHE) declaration (<https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-20Oct2020.aspx>)¹ have dramatically impacted state Medicaid programs, requiring states to rapidly adapt to meet the changing needs of their Medicaid beneficiaries and providers. Nationwide, Medicaid provides health insurance coverage to about one in five Americans (<https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>)² and accounts for nearly one-sixth of all U.S. health care expenditures.³ Prior to the pandemic, the Medicaid program had a history of constantly evolving to react to changes in federal and state policies, the economy, and other state budget and policy priorities. The current pandemic, however, has generated both a public health crisis and an economic crisis with increased unemployment, which contributes to growth in Medicaid enrollment and spending at the same time state tax revenues may be falling.

In response to the pandemic, Congress has authorized changes to Medicaid through the Families First Coronavirus Response Act (FFCRA) (<https://www.kff.org/global-health-policy/issue-brief/the-families-first-coronavirus-response-act-summary-of-key-provisions/>)⁴ and Coronavirus Aid, Relief, and Economic Security (CARES) Act (<https://www.kff.org/global-health-policy/issue-brief/the-coronavirus-aid-relief-and-economic-security-act-summary-of-key-health-provisions/>)⁵ including a 6.2 percentage point increase in federal Medicaid matching funds (FMAP) (retroactive to January 1, 2020) available to states that meet five

“maintenance of eligibility” (MOE) conditions (<https://www.kff.org/coronavirus-covid-19/issue-brief/key-questions-about-the-new-increase-in-federal-medicaid-matching-funds-for-covid-19/>) that ensure continued coverage for current enrollees as well as coverage of coronavirus testing and treatment.⁶ This fiscal relief is in place until the end of the quarter in which the PHE ends, which means it is currently slated to expire at the end of March 2021. Beginning early in the pandemic, states have adopted Medicaid policies to respond to COVID-19 through a variety of emergency authorities (<https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>) (Disaster-Relief State Plan Amendments (SPAs), traditional SPAs, other administrative authorities, HCBS waiver Appendix K, Section 1115 demonstration waivers, and Section 1135 waivers).⁷ The beginning and end dates (<https://www.kff.org/report-section/state-actions-to-sustain-medicaid-long-term-services-and-supports-during-covid-19-appendix/>) for these actions vary by authority and many are tied to the PHE.⁸

This report draws upon findings from the 20th annual budget survey of Medicaid officials in all 50 states and the District of Columbia conducted by KFF and Health Management Associates (HMA), in collaboration with the National Association of Medicaid Directors (NAMD). (Previous reports are archived [here](https://www.kff.org/medicaid/report/medicaid-budget-survey-archives/) (<https://www.kff.org/medicaid/report/medicaid-budget-survey-archives/>).⁹) This year’s survey instrument was modified to focus on policy changes planned for FY 2021 and policies adopted in response to the pandemic, and was sent to each state Medicaid director in June 2020. Overall, 43 states¹⁰ responded by mid-August 2020, although response rates for specific questions varied. Given differences in the financing structure of their programs, the U.S. territories were not included in this analysis. An acronym glossary and the survey instrument are included as appendices to this report.

This report highlights policy changes in place or planned for FY 2021 (which began for most states on July 1, 2020).¹¹ Key findings, along with state-by-state tables, are included in the following sections:

- Eligibility and Enrollment (<https://www.kff.org/report-section/state-medicaid-programs-respond-to-meet-covid-19-challenges-eligibility-and-enrollment>)
- Provider Rates and Taxes (<https://www.kff.org/report-section/state-medicaid-programs-respond-to-meet-covid-19-challenges-provider-rates-and-taxes>)
- Delivery Systems (<https://www.kff.org/report-section/state-medicaid-programs-respond-to-meet-covid-19-challenges-delivery-systems>)
- Long-Term Services and Supports (<https://www.kff.org/report-section/state-medicaid-programs-respond-to-meet-covid-19-challenges-long-term-services-and-supports>)
- Benefits, Cost-Sharing, and Telehealth (<https://www.kff.org/report-section/state-medicaid-programs-respond-to-meet-covid-19-challenges-benefits-cost-sharing-and-telehealth>)
- Pharmacy Cost Containment Actions (<https://www.kff.org/report-section/state-medicaid-programs-respond-to-meet-covid-19-challenges-pharmacy-cost-containment-actions>)

- [Challenges and Priorities in FY 2021 and Beyond Reported by Medicaid Directors \(https://www.kff.org/report-section/state-medicaid-programs-respond-to-meet-covid-19-challenges-challenges-and-priorities-conclusion\)](https://www.kff.org/report-section/state-medicaid-programs-respond-to-meet-covid-19-challenges-challenges-and-priorities-conclusion)

Eligibility and Enrollment

As part of the federal response to the COVID-19 pandemic, states meeting certain “maintenance of eligibility” (MOE) conditions (<https://www.kff.org/coronavirus-covid-19/issue-brief/key-questions-about-the-new-increase-in-federal-medicaid-matching-funds-for-covid-19/>) **can access enhanced federal Medicaid funding.** The **Families First Coronavirus Response Act** (<https://www.kff.org/global-health-policy/issue-brief/the-families-first-coronavirus-response-act-summary-of-key-provisions/>),¹ amended by the **Coronavirus Aid, Relief, and Economic Security (CARES) Act** (<https://www.kff.org/global-health-policy/issue-brief/the-coronavirus-aid-relief-and-economic-security-act-summary-of-key-health-provisions/>),² authorizes a 6.2 percentage point increase in the federal Medicaid match rate (“FMAP”)³ (retroactive to January 1, 2020) through the end of the quarter in which the public health emergency ends. To qualify for the enhanced funds, states must ensure continued coverage for current enrollees and are prohibited from increasing premiums or making eligibility standards, methodologies, or procedures more restrictive than those in effect on January 1, 2020, among other requirements.⁴

The **MOE requirements** (<https://www.kff.org/medicaid/issue-brief/medicaid-maintenance-of-eligibility-requirements-issues-to-watch-when-they-end/>)⁵ contribute to **enrollment increases** (<https://www.kff.org/coronavirus-covid-19/issue-brief/data-note-analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/>)⁶ by eliminating the usual enrollment churn that occurs when some individuals lose eligibility and are dis-enrolled from Medicaid each month. In the past, some eligibility churn occurred when otherwise eligible individuals **lost coverage** (<https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey/>) because they encountered **barriers** (<https://www.kff.org/medicaid/fact-sheet/implications-of-emerging-waivers-on-streamlined-medicaid-enrollment-and-renewal-processes/>) preventing them from timely documenting continued eligibility during the eligibility renewal process or when states conducted periodic data matches between renewals.⁷ Prior to the pandemic, these types of barriers were potentially depressing overall Medicaid enrollment levels.⁸

In addition to the MOE requirements, some states are utilizing Medicaid emergency authorities (<https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>) **to take other actions to help people obtain and maintain coverage.** These include actions to expand eligibility and make it easier to apply such as allowing for self-attestation of eligibility criteria; eliminating premiums; expanding the use of presumptive eligibility; and otherwise simplifying application processes.⁹ The **beginning and ending dates of these policies**

(<https://www.kff.org/report-section/state-actions-to-sustain-medicaid-long-term-services-and-supports-during-covid-19-appendix/>) vary by authority¹⁰ and many will expire with the end of the public health emergency (PHE) declaration (<https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-2Oct2020.aspx>) (currently set for January 21, 2020).¹¹

Survey Findings

We asked states to report any non-emergency eligibility changes planned for FY 2021, including eligibility expansions, eligibility restrictions, and changes to enrollment processes. We also asked about changes to eligibility policies made in response to the COVID-19 pandemic and, specifically, whether states planned to adopt these changes on a more permanent basis. Finally, we asked states to report on outreach efforts to publicize COVID-19 related eligibility changes and/or the availability of Medicaid coverage following the economic downturn.

NON-EMERGENCY ELIGIBILITY CHANGES

Seven states reported non-emergency plans to expand eligibility in FY 2021. As of October 2020, 39 states (including DC) have adopted the ACA Medicaid expansion (<https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>) (Figure 1).¹² Of these, 37 states to date have implemented expansion coverage to 138% FPL (\$17,609 per year for an individual in 2020),¹³ including Idaho and Utah, which both implemented the expansion on January 1, 2020 (FY 2020), and Nebraska, which implemented on October 1, 2020 (FY 2021). Two additional states, Oklahoma and Missouri, will implement the expansion in FY 2022 as a result of successful Medicaid expansion ballot initiatives.

- **Nebraska** implemented the expansion on October 1, 2020 (FY 2021) pursuant to a ballot measure passed in November 2018. The state is currently seeking a Section 1115 waiver to implement its expansion with program elements that differ from what is allowed under federal law.
- **Oklahoma** voters approved a ballot measure on June 30, 2020 which adds Medicaid expansion to the state's constitution and requires coverage to begin *no later than* July 1, 2021. The ballot measure language also prohibits the imposition of any additional burdens or restrictions on eligibility or enrollment for the expansion population. The Oklahoma Health Care Authority intended to submit the necessary State Plan Amendments (SPAs) for expansion by September 30, 2020 with an effective date of July 1, 2021 (FY 2022).¹⁴
- **Missouri** voters similarly approved a ballot measure on August 4, 2020 which adds the expansion to the state's constitution with coverage to begin July 1, 2021 (FY 2022). Like Oklahoma's, Missouri's approved ballot measure prohibits the imposition of any additional burdens or restrictions on eligibility or enrollment for the expansion population.

Six states reported plans to implement the following more narrow eligibility expansions in FY 2021. These other expansions include the following:

Figure 1: Status of State Medicaid Expansion Decisions

- Expanding coverage for parent/caretaker relatives and other low-income adults.** One non-expansion state (**South Carolina**) has an approved Section 1115 waiver and plans to increase the income limit for parent/caretaker relative enrollees from 67% to 100% FPL and also to provide coverage with an enrollment cap for a new Targeted Adult group. Both expansions of eligibility are contingent on compliance with a work requirement. As a result of both the pandemic and litigation,¹⁶ no states are currently implementing approved work requirements.¹⁶
- Expanding coverage for postpartum women.** Two states are expanding coverage for postpartum women beyond the 60 days provided under federal rules: Pending waiver approval, **Georgia** and **New Jersey** are extending to six months.¹⁷ (Additionally, **Indiana** reported plans to extend postpartum coverage to one year beginning in FY 2022.)
- Expanding coverage for certain older adults and people with disabilities.** **California** is expanding income eligibility for the optional aged, blind, and disabled (ABD) population from 100% to 138% FPL and also creating a new ABD income disregard in the amount of the individual's Medicare Part B premium (which is paid by Medicaid). The new disregard in California is expected to allow individuals to retain eligibility in the ABD pathway and reduce churn between the ABD and medically needy with share of costs pathways and administrative burden. **New Hampshire** reported plans to implement its "Medicaid for Employed Older Adults with Disabilities" program, which will expand Medicaid buy-in coverage for working people with disabilities to include those ages 65 and older with incomes up to 250% FPL. (New Hampshire already covers working people with disabilities ages 18 to 64 up to 250% FPL.) **Louisiana** is expanding HCBS waiver coverage for children with significant disabilities without regard to household income and assets for children who live at home but would otherwise qualify for institutional placement in a hospital, skilled nursing facility, or intermediate care facility for individuals with intellectual disabilities.

Only two states reported a planned eligibility restriction in FY 2021 after the expiration of the PHE. **Missouri** reported that scheduled premium increases would go forward after the PHE ended and **Montana** reported plans to implement a community engagement/work requirement and premium changes for expansion adults pending CMS approval of the state's Section 1115 waiver renewal.

Although not counted as an eligibility expansion or a restriction for purposes of this survey, **Texas** reported that it would implement changes (including applying modified adjusted gross income (MAGI) financial eligibility methodologies to individuals eligible for family planning-only services) to its Healthy Texas Women (HTW) Section 1115 waiver program as required under the waiver's January 2020 approval from CMS.¹⁸ The approved HTW waiver extended eligibility for family planning services to women age 18-44 up to 200% FPL not otherwise eligible for Medicaid and allowed Texas to waive

non-emergency medical transportation (NEMT); retroactive eligibility; early and periodic screening, diagnostic, and treatment (EPSDT) coverage; and freedom of choice of provider for family planning services.

Two states reported non-emergency plans to simplify enrollment processes in FY 2021. **Montana** reported plans to implement an auto-renewal process for non-MAGI eligibility groups and **Virginia** reported plans to expand ex parte auto-renewals when individuals experience changes such as reaching the end of their postpartum coverage period or attaining an age requiring evaluation in other covered groups. While Virginia did not characterize this change as the extension of an emergency authority, the state did note that the proposed changes are intended to reduce caseworker caseloads when the PHE period ends.

ELIGIBILITY CHANGES IN RESPONSE TO COVID-19

Only five states¹⁹ reported plans to continue COVID-19 emergency changes related to eligibility and enrollment policies beyond the PHE period. One state (**Vermont**) noted that a variety of certain emergency flexibilities would likely extend beyond the PHE period due to the time required to re-implement prior policies. A few states reported specific plans for the continuation of policies to simplify/expedite enrollment processes:

- **Massachusetts** intends to continue allowing self-attestation of all eligibility criteria except for citizenship and immigration status.
- **Washington** is working to adopt self-attestation of income and resources for aged, blind, and disabled (ABD) populations. Washington also reported working to adopt hospital presumptive eligibility for ABD populations and post-enrollment verification of assets for ABD populations.
- **Arizona** indicated that it would continue allowing electronic signatures on eligibility documents for its long-term care program (institutional and HCBS).
- **Virginia** intends to continue allowing applicants and enrollees to verbally appoint/authorize assisters, advocates, and other individuals.

Another 12 states reported that the continuation of emergency eligibility and enrollment policies remained undetermined. **Indiana** and **Louisiana** reported that more time could be needed to re-implement their prior policies; **Missouri** indicated that it may continue to allow self-attestation of most eligibility factors for ABD and MAGI populations; and a few states (**West Virginia, Kansas, and Missouri**) reported potential plans to further extend renewal timelines.²⁰

At the time of survey completion, thirteen states had approved State Plan Amendments (SPAs) in place for the new Uninsured Coronavirus Testing group at the time of survey submission. This [new optional eligibility pathway](https://www.kff.org/coronavirus-covid-19/issue-brief/key-questions-about-the-new-medicaid-eligibility-pathway-for-uninsured-coronavirus-testing/) (<https://www.kff.org/coronavirus-covid-19/issue-brief/key-questions-about-the-new-medicaid-eligibility-pathway-for-uninsured-coronavirus-testing/>) provides 100% federal matching funds for states

to cover coronavirus testing and testing-related services for uninsured individuals through the end of the PHE.²¹ In addition to this option, providers can alternatively obtain reimbursement for coronavirus testing and treatment provided to uninsured individuals from additional federal funds through the Health Resources and Services Administration (<https://www.hrsa.gov/CovidUninsuredClaim>).²² One state (**California**) reported covering a significant number of persons under its Uninsured Coronavirus Testing group as of June 30, 2020 (6,390). All other states reported more modest enrollments: **Colorado, Louisiana, and Minnesota** reported covering between 50 and 450 individuals and **Maine** reported covering approximately 850 individuals. Other states that had adopted the option (including **Alabama, Iowa, Montana, Nevada, New Hampshire, South Carolina, and West Virginia**) reported between zero and 50 persons covered and **Washington** has an approved SPA for this group but did not report the number of individuals covered. Since the time of survey submission, two additional responding states (**Connecticut and North Carolina**) have received SPA approvals for this group.²³

States reported a variety of outreach efforts to publicize COVID-19 related eligibility and enrollment changes, and ten states reported expanding enrollment assistance or member call center capacity during the PHE. Most states reported using their websites and social media platforms to provide COVID-19 related enrollment information. Many states also cited working with provider groups and advocacy organizations to disseminate information in addition to direct mailings to members and applicants and provider notices and alerts. A few states also commented on their managed care organizations' (MCO) outreach efforts. Additionally, ten states (California, Florida, Indiana, Kentucky, Maryland, Missouri, Nebraska, South Carolina, Texas, and Virginia) reported expanding enrollment assistance or member call center capacity. Very few states reported experiencing application processing delays due to COVID-19 at the time of survey completion.

Oregon COVID-19 Medicaid Outreach

The Oregon Health Authority (OHA) created targeted messaging for potential applicants who may have recently lost a job, had a change in hours, or had a change in unemployment benefits and also created messaging about changes in eligibility for Medicaid, including changes in income, stimulus payments, and suspending case closure. The state has and continues to disseminate this messaging through customer service talking points, fact sheets and webpages, social media, e-bulletins, and plan and provider talking points, as well as through the statewide network of community assisters. The state also plans to send a direct mailing with this information to all Medicaid households. The OHA is also fostering a partnership with Oregon's employment agency to ensure cross-promotion of vital information about eligibility and unemployment.

Provider Rates and Taxes

The coronavirus pandemic has resulted in financial strain for Medicaid providers.

In prior economic downturns, states have typically resorted to provider rate reductions as well as cuts to optional benefits (<https://www.kff.org/medicaid/issue-brief/trends-in-state-medicaid-programs-looking-back-and-looking-ahead/>), restoring those rates and benefits when economic conditions improved.¹ Provider rate cuts may be harder to implement during the current downturn, however, due to the fiscal strain the pandemic has placed on many providers, particularly those serving Medicaid enrollees. While some providers are dealing with both increased utilization and costs related to COVID-19 testing and treatment, others have experienced substantial revenue losses as utilization has declined for non-urgent care. Providers that predominantly serve Medicaid enrollees and/or deliver services primarily financed by Medicaid, such as behavioral health or long-term care providers, may face disproportionate risks to their continued financial viability as their pre-pandemic operating margins were already modest due to lower Medicaid reimbursement levels relative to costs. To address the current fiscal challenges faced by providers, states have implemented various options to support providers (<https://www.kff.org/coronavirus-covid-19/issue-brief/options-to-support-medicaid-providers-in-response-to-covid-19/>)² directly or by directing plans to do so (<https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-rates-and-flexibilities-state-options-to-respond-to-covid-19-pandemic/>).^{3,4}

The Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act provide \$175 billion in provider relief funds (<https://www.kff.org/coronavirus-policy-watch/update-on-covid-19-funding-for-hospitals-and-other-providers/>)

to reimburse eligible health care providers for health care related expenses or lost revenues attributable to coronavirus.⁵ Specifically, funds are available for building or constructing temporary structures, leasing properties, medical supplies and equipment including personal protective equipment (PPE) and testing supplies, increased workforce and trainings, emergency operation centers, retrofitting facilities, and surge capacity. In June 2020 (<https://www.hhs.gov/about/news/2020/06/09/hhs-announces-enhanced-provider-portal-relief-fund-payments-for-safety-net-hospitals-medicaid-chip-providers.html>), CMS announced the allocation of \$15 billion in provider relief funds specifically for Medicaid/CHIP providers that were not funded in a prior distribution to Medicare fee-for-service providers, addressing concerns that Medicaid providers had been disadvantaged in prior distributions, both in the amount and timing of funding received.⁶

States can use provider taxes and intergovernmental transfers (IGTs)

(<https://www.kff.org/report-section/medicaid-financing-the-basics-issue-brief/>) **to help finance the state share of Medicaid.**⁷ Over time, states have increased their reliance on provider taxes (<https://www.kff.org/medicaid/issue-brief/trends-in-state-medicaid-programs-looking-back-and-looking-ahead/>), especially during economic downturns.⁸ States also have some flexibility to use funding from local governments to help finance the state share of Medicaid. All

states (except Alaska) have at least one provider tax in place (<https://www.kff.org/report-section/a-view-from-the-states-key-medicare-policy-changes-provider-rates-and-taxes/>) and many states have more than three.⁹ On September 14, 2020, CMS withdrew the proposed Medicaid Fiscal Accountability Regulation, providing at least some stability for states with one or more provider taxes at risk under the proposed rule.

Survey Findings

PROVIDER RATES

This survey examines rate changes across major provider categories: inpatient hospitals, outpatient hospitals, nursing facilities, primary care physicians, specialists, obstetricians and gynecologists (OB/GYNs), dentists, and home and community-based services (HCBS) providers. States were asked to report aggregate rate changes for each provider category in their fee-for-service (FFS) programs and whether these or other payment changes (e.g., retainer payments, interim payments) were adopted in response to the COVID-19 emergency. States were also asked to describe whether provider relief funds made available under the CARES Act were adequate.

At the time of the survey, more responding states implemented or were planning FFS rate increases relative to rate restrictions in both FY 2020 and FY 2021 (Tables 1 and 2). Out of the 43 states responding to this year's survey, 41 states reported implementing rate increases for at least one category of provider in FY 2020 and 17 states reported implementing rate restrictions in FY 2020. In FY 2021, fewer states reported at least one planned rate increase (35 states) and the number of states planning to restrict rates increased (21 states). Most of the rate restrictions are freezes in rates for inpatient hospitals and nursing facilities that are counted as restrictions. Three states (**Colorado, Nevada, and Wyoming**) reported rate reductions across all or nearly all provider categories. These reductions were related to the states' budget shortfalls for FY 2021. Six of the responding states did not report payment changes planned for FY 2021 in one or more categories of providers, but two of these states identified that rate freezes or reductions were likely pending final budget negotiations.

More than half of the responding states indicated that one or more payment changes made in FY 2020 or FY 2021 are related in whole or in part to COVID-19.

Twenty-four out of the 43 responding states indicated that one or more provider rate changes implemented in FY 2020 and/or FY 2021 were related to COVID-19 at least in part. COVID-19 related payment changes were most commonly associated with nursing facilities (20 states) and HCBS providers (18 states) followed by inpatient hospital services (11 states).

At the time of the survey, many states adopted FFS payment changes in FY 2020 and/or are planning to make changes in FY 2021 to provide additional relief to providers in response to the COVID-19 emergency. These changes include increasing payment rates (per diem or percentage rate increases) and providing

retainer payments, directed payments, or interim payments to certain provider types. Additional payments in some states are associated with facilities, services, or patients with a COVID-19 diagnosis (California, Florida, Indiana, Louisiana, Kentucky, Massachusetts, and Michigan).

At least 16 states have instituted retainer payments for HCBS providers¹⁰ and 19 states are providing rate increases, interim payments, or add-on payments to nursing facilities and other long-term care facilities.¹¹ A few states did not specifically update long-term care facility rates in response to COVID-19 but describe that their cost-based reimbursement systems improve payment due to inflation or COVID-19 related expenses. Other examples of COVID-19 related payment changes across state Medicaid programs include:

- **Alaska** adjusted its pharmacy reimbursement methodology and professional dispensing fees to address drug shortages, social distancing and increases in prescription drug deliveries.
- **California** and **Louisiana** are reimbursing COVID-19 related lab services at 100% of the Medicare payment rate.
- **Oklahoma** waived hospital penalties related to potential preventable readmissions and is allowing additional therapeutic leave days for certain long-term care facilities.
- **Indiana** and **Washington** increased payment rates for emergency medical service providers (EMS) and ambulance providers for transporting COVID-19 positive patients.
- **Kentucky** and **West Virginia** increased inpatient reimbursement for Diagnosis Related Groups (DRGs) with a COVID-19 diagnosis by 20%.
- **Michigan** increased the FFS rate for personal care services by \$2/hour.

Almost half of states responding to the survey reported that relief funds under the CARES Act have not been adequate to address the negative impact of COVID-19 faced by providers serving a high share of Medicaid and low-income patients while others were uncertain. About half of states reported that the provider relief funds were inadequate, while the other half of states reported they did not know. In the states that did not believe funding was adequate, dental providers, long-term care facilities, HCBS providers, primary care providers, behavioral health providers, and non-emergency transportation were the most often cited provider types needing relief or additional funding. Many of these provider types are dependent on Medicaid reimbursement. States also explained that providers faced challenges in understanding whether they qualified for funding, resulting in missed opportunities for qualified providers. A few states noted that the funding methodology potentially disadvantaged Medicaid providers who did not serve a large Medicare patient population and that limiting relief to the 2% of net patient revenue may not be sufficient for some providers or to offset losses.

PROVIDER TAXES

States were asked to report any provider tax changes in FY 2021. States were also asked to report any impacts related to COVID-19 on tax collections.

Only one state reported the addition of a new provider tax in FY 2021. Arizona added a new hospital tax on outpatient services in FY 2021 to raise additional money for its Medicaid program. However, two states (**Hawaii** and **Wyoming**) reported that they are investigating opportunities to add new provider taxes, or increase existing provider taxes, to address expected shortfalls related to COVID-19's negative impact on the economy and available state general funds.

Few states reported making significant changes to the provider tax structure in FY 2021. Nine states reported planned increases to one or more provider taxes (Alabama, California, Colorado, Georgia, Hawaii, Idaho, Louisiana, Missouri, and New Jersey) in FY 2021, while four states reported provider tax decreases (Maryland, North Carolina, Oklahoma, and Pennsylvania). Montana reports that it is eliminating its provider tax for intermediate care facilities for individuals with intellectual disabilities (ICF-ID) in FY 2021.

Impacts of COVID-19 on provider tax collections are still emerging. States were asked to describe any COVID-19 related impacts on provider tax collections anticipated in FY 2021. Some states anticipated no material impact, while a few states identified that the impact was yet to be determined. For states that reported a change in provider tax collections related to COVID-19, the impact was mixed and varied by the type of provider tax and the state. For example, **Washington** noted that the number of nursing facility bed days was on the decline, resulting in reduced revenue attributed to its Safety Net Assessment fee, while **California** observed an increase in nursing facility and ICF-ID provider tax collections due to corresponding rate increases for these providers. States noted that COVID-19 impacted provider tax collections in other ways, with providers in some states receiving partial refunds (**Oklahoma**) or deferring payments (**Connecticut**). **Vermont** reported a decrease in provider tax revenue collection and delays in payment and is working with providers to develop repayment plans. At least one state increased its hospital provider tax to generate additional revenue and protect providers from further rate cuts (**Colorado**).

TABLE 1: PROVIDER RATE CHANGES IN ALL 50 STATES AND DC*, FY 2020

States	Inpatient Hospital		Outpatient Hospital		Primary Care Physicians		Specialists		OB/GYNs		Dentists		N Fa
	+	-	+	-	+	-	+	-	+	-	+	-	
Alabama	X				X				X		X		X
Alaska		X		X	X			X	X			X	
Arizona	X												X
Arkansas		X											X
California	X		X										X
Colorado	X		X		X		X		X		X		X
Connecticut	X		X										X
DC*													
Delaware*													
Florida	X		X										
Georgia	X		X										X
Hawaii	X		X								X		X
Idaho		X		X									X
Illinois*													
Indiana		X											X
Iowa		X											X
Kansas		X											
Kentucky	X		X		X								X
Louisiana	X		X										X
Maine	X		X		X								X
Maryland	X		X		X		X		X				X
Massachusetts	X		X		X		X		X				X

Michigan		X	X				X						X
Minnesota	X		X										X
Mississippi	X		X										X
Missouri	X			X	X		X		X		X		X
Montana		X			X		X		X		X		X
Nebraska	X		X		X		X		X		X		X
Nevada	X										X		X
New Hampshire	X		X		X		X		X		X		X
New Jersey	X		X		X		X		X		X		X
New Mexico*													
New York*													
North Carolina	X		X		X		X		X		X		X
North Dakota	X		X		X		X		X		X		X
Ohio*													
Oklahoma	X		X		X		X		X		X		X
Oregon		X											X
Pennsylvania		X											
Rhode Island*													
South Carolina		X			X		X		X				X
South Dakota	X		X		X		X		X		X		X
Tennessee		X											
Texas	X				NR		NR		NR		NR		X
Utah*													
Vermont		X	X		X		X		X				X

Virginia	X		X		X		X						X
Washington	X		X		X								
West Virginia	X				X		X		X		X		X
Wisconsin	X		X										X
Wyoming		X											X
Totals	29	14	25	3	21	0	17	1	17	0	14	1	37

NOTES: "+" refers to provider rate increases and "-" refers to provider rate restrictions. OB/GYNs: Obstetricians and gynec based services. For the purposes of this report, provider rate restrictions include cuts to rates for physicians, dentists, outp as well as both cuts or freezes in rates for inpatient hospitals and nursing facilities. NR: State submitted a survey, but did n and/or FY. "*" indicates the state did not submit a survey by mid-August 2020 (DC, DE, IL, NM, NY, OH, RI, UT).

SOURCE: KFF Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2020

TABLE 2: PROVIDER RATE CHANGES IN ALL 50 STATES AND DC*, FY 2021

States	Inpatient Hospital		Outpatient Hospital		Primary Care Physicians		Specialists		OB/GYNs		Dentists		Nursing Facilities
	+	-	+	-	+	-	+	-	+	-	+	-	
Alabama		X											X
Alaska	X		X		X		X		X		X		X
Arizona		X			X		X		X		X		
Arkansas		X					X						X
California	X		X										X
Colorado		X		X		X		X		X		X	X
Connecticut	X		X										X
DC*													
Delaware*													
Florida	X		X										X
Georgia	X		X		X								X
Hawaii	NR		NR		NR		NR		NR		NR		
Idaho		X		X									X
Illinois*													
Indiana	X												X
Iowa		X											X
Kansas		X									X		
Kentucky	X		X		X								X
Louisiana	X												X
Maine		X	X										X
Maryland	X		X		X								X
Massachusetts	X		X		X		X		X		X		X

Michigan		X	X										X
Minnesota		X	X										X
Mississippi	X		X										X
Missouri		X											
Montana		X			X		X		X		X		X
Nebraska	X		X		X		X		X		X		X
Nevada		X		X		X		X		X		X	
New Hampshire	X		X		X		X		X		X		X
New Jersey	X		X		X		X		X		X		X
New Mexico*													
New York*													
North Carolina		X											X
North Dakota	X		X		X		X		X		X		X
Ohio*													
Oklahoma		X											
Oregon		TBD		TBD		TBD		TBD		TBD		X	T
Pennsylvania		X											
Rhode Island*													
South Carolina		X					X						X
South Dakota	X		X		X		X		X		X		X
Tennessee		X											
Texas	X				NR		NR		NR		NR		T
Utah*													
Vermont		NR		NR		NR		NR		NR		NR	T

Virginia	X		X										X
Washington	X		X										
West Virginia		X			X		X		X		X		X
Wisconsin	X		X										X
Wyoming		X		X		X		X		X		X	
Totals	20	20	20	4	13	3	12	3	10	3	12	3	30

NOTES: "+" refers to provider rate increases and "-" refers to provider rate restrictions. OB/GYNs: Obstetricians and gynecology community-based services. For the purposes of this report, provider rate restrictions include cuts to rates for physicians, community-based providers as well as both cuts or freezes in rates for inpatient hospitals and nursing facilities. NR: State submitted a survey for this provider type and/or FY. "*" indicates the state did not submit a survey by mid-August 2020 (DC, DE, IL, NM, NY, OH, RI).
SOURCE: KFF Survey of Medicaid Officials in 50 states and DC conducted by Health Manager 2020.

Delivery Systems

Managed Care

Capitated managed care remains the predominant delivery system for Medicaid in most states. As of July 2019 (<https://www.kff.org/report-section/a-view-from-the-states-key-medicare-policy-changes-delivery-systems/>), 40 states were contracting with comprehensive risk-based managed care organizations (MCOs).¹ MCOs provide comprehensive acute care (i.e., most physician and hospital services) and in some cases long-term services and supports (LTSS) to Medicaid beneficiaries. Among the 40 states with MCOs, 33 states reported that 75% or more of their Medicaid beneficiaries were enrolled in MCOs. As of July 1, 2019, 28 states were contracting with one or more limited benefit prepaid health plans (PHPs) to provide Medicaid benefits including behavioral health care, dental care, vision care, non-emergency medical transportation (NEMT), or LTSS. Twelve states reported operating a primary care case management (PCCM) program. PCCM is a managed fee-for-service (FFS) based system in which beneficiaries are enrolled with a primary care provider who is paid a small monthly fee to provide case management services in addition to primary care.

With 69% of Medicaid beneficiaries enrolled in MCOs nationally

(<https://www.kff.org/other/state-indicator/total-medicare-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>).

MCOs play a critical role in responding to the COVID-19 pandemic and its fiscal implications for states.² Given unanticipated costs related to COVID-19 testing and treatment, as well as depressed utilization affecting the financial stability of many

Medicaid providers, many states are currently evaluating options to adjust current MCO payment rates and/or risk sharing mechanisms (<https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-rates-and-flexibilities-state-options-to-respond-to-covid-19-pandemic/>).³ CMS has outlined state options (<https://www.cms.gov/files/zip/covid19allstatecall04102020.zip>) to modify managed care contracts and rates in response to COVID-19 including risk mitigation strategies, adjusting capitation rates, covering COVID-19 costs on a non-risk basis, and carving out costs related to COVID-19 from MCO contracts.⁴ States can also direct that managed care plans make payments (<https://www.medicare.gov/federal-policy-guidance/downloads/cib051420.pdf>) to their network providers (known as “state directed payments”) using methodologies approved by CMS to further state goals and priorities, including COVID-19 response.⁵ States can therefore impose state directed payment requirements on MCOs to help mitigate the impacts of the PHE on providers that are experiencing decreased utilization and reimbursement while non-urgent services are suspended or patients are hesitant to seek care.

SURVEY FINDINGS

On this year’s survey, states were asked to identify any acute care MCO policy changes in FY 2020 or planned for FY 2021, including changes to increase enrollment in MCOs or changes to the benefits or services carved-in or out of MCO contracts. States were also asked to describe any other managed care changes (e.g., implementing, expanding, reducing, or terminating a PCCM program or limited-benefit prepaid health plan (PHP)) made in FY 2020 or planned for FY 2021.

In response to the COVID-19 pandemic, states were also asked whether adjustments to FY 2021 MCO contracts or rates have been made or are planned in response to unanticipated COVID-19 related testing and treatment costs or depressed utilization and whether they have imposed or plan to impose new provider payment requirements on MCOs. Finally, states were asked to describe any other COVID-19 related MCO policy changes made in response to the pandemic and to identify any COVID-19 related initiatives newly offered by MCOs.

Non-Emergency Acute Care MCO Policy Changes

Reflecting nearly full MCO saturation in most MCO states, only three states reported changes to expand comprehensive managed care as a delivery system in FY 2020 or FY2021. In FY 2020, **Pennsylvania** implemented the third phase of Community HealthChoices (a program covering both acute care and LTSS for full benefit dual eligible beneficiaries and individuals receiving LTSS), to new geographic areas of the state, while **West Virginia** began mandatorily enrolling foster care youth into MCOs. In FY 2021, **Nebraska** reported plans to enroll all expansion adults into MCOs upon the implementation of its ACA Medicaid expansion in October 2020. **North Carolina** reported delays to its MCO implementation plans noting its new managed care contracts will be effective in FY 2022.

Although MCOs provide comprehensive services to beneficiaries, states may carve specific services out of MCO contracts to FFS systems or limited-benefit plans. Services frequently carved out include behavioral health, pharmacy, dental, and LTSS. However, there has been significant movement across states in recent years to carve these services in to MCOs.

Twelve states in FY 2020 and seven in FY 2021 reported notable changes in the benefits and services covered under their MCO contracts (Exhibit 1).

- **Pharmacy drugs.** The most frequently reported changes were to carve in or carve out one or more pharmacy drug products (especially high cost/specialty drugs). Two states reported carve-outs of the entire pharmacy benefit (**North Dakota** in FY 2020 and **California** in FY 2021) and **Missouri** reported plans to carve out outpatient hospital drugs in FY 2021 (in addition to other covered outpatient drugs which were already carved out and covered on a FFS basis). (See Pharmacy Cost Containment Actions section for more information on pharmacy changes.)
- **Behavioral health services.** Four states reported changes related to behavioral health services. In FY 2020, **New Jersey** added autism benefits; **Washington** carved in high intensity behavioral health benefits in three geographic regions, but also carved out out-of-state inpatient psychiatric services for children; **Wisconsin** added sub-acute psychiatric services as an in-lieu of benefit for the BadgerCare Plus population; and **West Virginia** added services authorized under its Substance Use Disorder (SUD) and Children with Serious Emotional Disorder (SED) waivers. In FY 2021, **Oregon** is adding care coordination for persons with severe and persistent mental illness (SPMI), children with SED, and individuals with SUD receiving medication assisted treatment (MAT).

Exhibit 1: MCO-Covered Benefit/Service Changes, FY 2020 and FY 2021 (n = 32 MCO states)

Benefit/Service Carve-ins	FY 2020	FY 2021
Behavioral health	NJ, WA, WI, WV	OR
Pharmacy drugs	MD, SC	—
Non-emergency medical transportation	NE	TX
Community supports	HI, ND	—
Other ⁶	MO, SC	NJ
Benefit/Service Carve-outs	FY 2020	FY 2021
Behavioral health	WA	—
Pharmacy drugs	HI, ND	CA, MD, MO, SC, TX
Transplants	AR, WA	—
Other ⁷	CA	NJ

Other Non-Emergency Managed Care Changes – PCCM & PHP

Four states reported making changes to their PCCM programs or limited benefit PHP programs. In FY 2020, **Alabama** replaced its previous PCCM program (Patient 1st) and Maternity PHP program with a new PCCM entity program (the Alabama Coordinated Health Network) that covers care coordination services for most of the traditional Medicaid population including maternity, family planning, behavioral, and physical health care coordination services. In FY 2020, **Washington** reported eliminating its remaining three regional behavioral health PHP contracts, which had been providing non-integrated behavioral health benefits. As a result, Washington MCOs now provide integrated physical health and behavioral health statewide. In FY 2021, **Texas** will expand from two to three dental MCOs and **Louisiana** will move from one to two. Also, Texas will eliminate its NEMT PHP while adding NEMT services to its MCO contracts.

COVID-19 Related MCO Policy Changes & MCO Initiatives

Twelve MCO states (of 31 responding) indicated plans to make payment adjustments to FY 2021 MCO contracts or rates in response to both COVID-19 related depressed utilization and unanticipated treatment costs (Exhibit 2).

Sixteen states reported plans to make payment adjustments to FY 2021 MCO contracts or rates in response to COVID-19 related depressed utilization while 14 states reported plans to make payment adjustments in response to unanticipated COVID-19 related testing and treatment costs. Many states remained undetermined about adjustments to FY 2021 MCO contracts at the time of survey completion. [COVID-19 related payment adjustments](https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-rates-and-flexibilities-state-options-to-respond-to-covid-19-pandemic/) (https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-rates-and-flexibilities-state-options-to-respond-to-covid-19-pandemic/) could include risk corridors, capitation rate adjustments (upward or downward), carve-outs, or covering costs on a non-risk basis.⁸ States planning to make payment adjustments to FY 2021 MCO contracts were asked to describe the contract and/or rate adjustments planned. A majority of states described plans to implement or tighten risk corridors, often specifying two-sided risk corridors which aim to mitigate risk to both MCOs and states. In addition to adjustments planned for FY 2021 MCO contracts, several states also reported implementing retroactive risk mitigation and/or rate adjustment strategies for FY 2020 MCO contracts.⁹

Exhibit 2: MCO States Reporting Adjustments to FY 2021 MCO Contracts or Rates in Response to COVID-19 (n = 3

States reporting adjustments to reflect:				
	Testing and treatment costs		Depressed utilization	
Yes	14 states	AR, GA, HI, IN, KY, LA, MA, MD, MI, MS, NV, SC, TN, WV	16 states	AR, GA, HI, IN, KS, KY, LA, ME, NJ, NV, SC, T
No	5 states	CA, MN, ND, OR, VA	3 states	ND, OR, VA

Fourteen MCO states (of 32 responding) reported implementing directed payments to selected provider types in response to the COVID-19 pandemic.

Under certain circumstances, federal regulations permit states to direct MCOs to make specific provider payments ("state directed payments (<https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-rates-and-flexibilities-state-options-to-respond-to-covid-19-pandemic/>)").¹⁰ In response to the COVID-19 pandemic, 12 states in FY 2020 and three in FY 2021 reported implementing state directed payments (usually noted as temporary) for selected provided types (Exhibit 3). The most frequently identified provider type was for certain home and community-based services (HCBS) (8 states) followed by nursing facilities (5 states). Six of the eight states noting HCBS-related directed payments (Arizona, Florida, Iowa, Kansas, Massachusetts, and Tennessee) reported requiring MCOs to make retainer payments to allow certain HCBS providers to continue to bill for individuals when circumstances prevent these individuals from receiving these services.

Exhibit 3: MCO Directed Payments Implemented in Response to the COVID-19 Emergency, FY 2020 and FY 2021 (n = 32 MCO states)

	FY 2020	FY 2021
Home and community-based services	AZ, FL, IA KS, MA, MI, NJ, TN	AZ
Nursing facility	IA, MI, TN, VA	AZ
Hospital	MA, WV	LA
Physician, PCP, or providers of evaluation & management services	MA, TN, VA	—
Behavioral health	MA, TN, WV	—
Ambulance	MA, WV	KY
Dental	TN, WV	—
Laboratory	MD	—
Other (unspecified provider types)	NH, WV	—

MCO states reported a variety of other MCO policy changes implemented to respond to the COVID-19 pandemic. In many cases, MCO states reported that emergency authorities obtained by the states were applied to MCOs (see Introduction for more information on Medicaid emergency authorities). These include requirements to lift prior authorization requirements, waive cost sharing requirements, and relax certain provider credentialing requirements. Many MCO states also reported requiring MCOs to expand telehealth access, consistent with changes adopted for the FFS delivery system (see Benefits, Cost-Sharing, and Telehealth section for more information). Additional contract changes reported include:

- restructuring of provider incentive arrangements or suspension of provider performance penalties;
- changes to required MCO quality metric reporting and incentive programs;
- relaxation of certain reporting requirements;
- suspension of capitation withholds; and
- adjustments to the minimum medical loss ratio (MLR) requirement from a three-year standard to a one-year standard.

Massachusetts also directed its MCOs to contract with Community Support Program providers working in emergency overnight shelters that were expanded as a result of the pandemic.¹¹

Tennessee: Response to COVID-19 through Managed Care

Tennessee reported many MCO policy changes in response to COVID-19, including:

Provider Support

- Refraining from denying claims or conducting normal utilization management-level of care reviews
- Eliminating the requirement of authorization reviews before patients would be moved from an acute level setting to the appropriate post-acute care setting
- Suspending requests of medical records to reduce administrative burdens on hospitals
- Suspending site of service reviews and postponing manual collection of medical records for Healthcare Effectiveness Data and Information Set (HEDIS) and in-office reviews
- Postponing audits and recoupments related to medical claims
- Suspending all re-credentialing requirements for providers and refraining from denying services if they were provided in an unlicensed space or non-traditional location
- Expediting the review of requests for use of experimental drugs and devices
- Supporting hospitals in establishing new service locations in non-traditional areas

Payment

- Creating new COVID-19 testing and diagnosis codes
- Accelerating claims processing to decrease interruption to cashflow
- Paying for all COVID-19 related services performed by hospital providers who do not yet have credentialing but do have a Medicaid provider ID

MCO states reported a variety of programs, initiatives, or value-added services newly offered by MCOs in response to the COVID-19 emergency. Although federal reimbursement rules prohibit expenditures for *most* non-medical services, plans may use administrative savings or state funds to provide these services. “Value-added” services are extra services outside of covered contract services and do not qualify as a covered service for the purposes of capitation rate setting. The most frequently mentioned offerings and initiatives were food assistance and home delivered meals (11 states) and enhanced MCO care management and outreach efforts often targeting persons at high risk for COVID-19 infection or complications or persons testing positive for COVID-19 (8 states). Other examples include states reporting MCO provision of personal protective equipment (4 states), expanded MCO telehealth and remote supports (3 states), expanded pharmacy home deliveries (3 states), and MCO-provided gift cards for members to purchase food and other goods (2 states).¹² **Texas**, a state with a uniform preferred drug list (PDL) across FFS and its MCOs, reported coordinating with its MCOs to identify drug shortages to enable the state to adjust its formulary and uniform PDL accordingly.

Social Determinants of Health

Social determinants of health (<https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>) (SDOH) are the conditions in which people are born, grow, live, work, and age that shape health.¹³ Addressing SDOH is important for improving health and reducing longstanding disparities in health and health care. SDOH include but are not limited to housing, food, education, employment, healthy behaviors, transportation, and personal safety. Within the health care system, there are multi-payer federal and state initiatives as well as Medicaid-specific initiatives focused on addressing social needs. Although federal Medicaid reimbursement rules prohibit expenditures for most non-medical services,¹⁴ states have been developing strategies to identify and address enrollee social needs both within and outside of managed care. Medicaid MCOs may use administrative savings or state funds to provide some of these services.¹⁵

The pandemic has exacerbated the challenges for state Medicaid programs related to health care access and other SDOH and has shined a light on persistent health inequities and disparities due to the disparate impact of COVID-19 (<https://www.kff.org/disparities-policy/issue-brief/racial-disparities-covid-19-key-findings-available-data-analysis/>) on people of color.¹⁶ Access to food, for example, is one area of growing need as many people have lost jobs and income and many children have lost access to school-provided meals due to school closures. At the same time, community food resources are facing higher service demands. Among Medicaid adults, 23% reported food insufficiency in the week ending July 21, 2020 (<https://www.kff.org/report-section/food-insecurity-and-health-addressing-food-needs-for-medicaid-enrollees-as-part-of-covid-19-response-efforts-issue-brief/>).¹⁷

SURVEY FINDINGS

Nearly two-thirds of responding states reported implementation, expansion, or reform of a program or initiative to address Medicaid enrollees' SDOH in response to COVID-19 (27 states).¹⁸ States were asked whether the COVID-19 emergency caused their state to implement, expand, or reform a program or initiative to address enrollees' SDOH, particularly related to housing and/or food insecurity. States reported a variety of initiatives, including many initiatives which are broader than Medicaid but may help Medicaid enrollees. Sixteen states reported efforts to address food insecurity and nine states reported efforts to address housing insecurity and homelessness. Four states implemented or enhanced technology platforms and phone call-in lines that support assistance identifying community resources to address SDOH (Exhibit 4).

Exhibit 4: SDOH Programs and Initiatives Implemented in Response to COVID-19 (n = 43 states)

	# of States	States
Food insecurity	16	AK, AZ, HI, IA, IN, KS, MA, MI, MN, MT, NC,
Housing insecurity and homelessness	9	AZ, CA, CT, HI, MA, MI, MN, NI
Technology platforms or phone call-in that support identifying community resources to address SDOH	4	MI, NE, NC, PA
Increased SDOH survey, screenings, and assessments	4	KY, PA, VA, WV
Targeting social needs of people under quarantine	2	ME, NC

Examples of new initiatives or policies states reported related to SDOH implemented during the public health emergency (PHE) include:

- **Food Insecurity. Arizona** expanded home-delivered meals to people with intellectual and developmental disabilities (I/DD). **Minnesota** created the Food Security Work Group, an interagency governmental structure to strategize, share information and leverage funds. This group will work to support food banks; to support and expand access to SNAP and school meals; and to increase access to food for seniors, individuals in homeless shelters, and Native American Indians.¹⁹ **Montana**, through the state's Senior and Long-Term Care Division, sends frozen meals to very isolated individuals on the Northern Cheyenne and Crow reservations.
- **Housing/Homelessness. Michigan** put an eviction and foreclosure ban in place through July 15, 2020 and set up an eviction diversion program for households up to 100 percent of Area Median Income (AMI)²⁰ facing eviction after the ban expired. **California** implemented **Project RoomKey** (<https://www.cdss.ca.gov/Portals/9/FEMA/Project-Roomkey-Fact-Sheet.pdf>) to fund hotel and motel rooms around the state that provide non-congregate shelter options for the sick and medically vulnerable who lack stable housing.²¹
- **Social Services Referrals. North Carolina** fast-tracked²² the rollout of NCCARE360, the country's first statewide technology platform connecting health care and human

services. This platform makes it easier for providers, insurers, and community-based organizations to connect residents with the community resources they need during the COVID-19 pandemic. **Pennsylvania** added requirements to Medicaid MCO agreements that MCOs must work with community-based organizations to address key SDOH, with their reimbursement tied to moderate and high-risk value-based payment arrangements which will increase over time. **Virginia's** Medicaid MCOs have created a grant program for community- and faith-based organizations to support outreach programs related to SDOH.

Managed Long-Term Services and Supports

About half of the states have a capitated managed long-term services and supports (MLTSS) program in place. As of July 1, 2019, 27 states reported having an MLTSS program (<https://www.kff.org/report-section/a-view-from-the-states-key-medicaid-policy-changes-long-term-services-and-supports/>).²³ Two states (Alabama and Washington) reported having a managed fee-for-service MLTSS model while the remaining 25 states covered LTSS through one or more of the following types of capitated managed care arrangements: Medicaid MCO covering Medicaid acute care and LTSS; PHP covering only Medicaid LTSS; MCO arrangement for dual eligible beneficiaries covering Medicaid and Medicare acute care and Medicaid LTSS services in a single, financially aligned contract under the federal Financial Alignment Initiative (FAI).

SURVEY FINDINGS

Non-Emergency MLTSS Policy Changes

States were asked to identify MLTSS policy changes in FY 2020 or planned for FY 2021 including changes to increase enrollment in capitated MLTSS contracts or to carve benefits/services in or out of MLTSS contracts.

Six states reported changes to their MLTSS programs in FY 2020 or FY 2021 (Exhibit 5). No states reported implementation of capitated MLTSS contracts or making enrollment mandatory for an additional population for the first time in FY 2020 or in FY 2021.

- **Geographic expansions.** Two states (**Idaho** and **Pennsylvania**) reported MLTSS expansion into new geographic regions in FY 2020 while one state (**Massachusetts**) reported geographic expansion in FY 2020 and planned geographic expansion in FY 2021. **Idaho** expanded IMPlus to an additional 13 counties in April 2020, while **Pennsylvania** completed the third phase of implementation of its MCO-based MLTSS program, Community HealthChoices, on January 1, 2020. One Care, **Massachusetts'** MCO-based capitated **FAI** (<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsInCareCoordination/>),²⁴ expanded to an additional county in FY 2020 and proposed to fully expand to another two counties in FY 2021.
- **Benefit/service changes.** Three states (**Arizona**, **Massachusetts**, and **New Jersey**) carved in additional benefits/services to MLTSS contracts in FY 2020 while one state

(**Wisconsin**) carved out benefits in FY 2020. **Massachusetts** added services to One Care (transitional living program, high intensity residential services, enhanced residential rehabilitation services to ensure member medical, mental health, and addiction needs are addressed, and recovery coaching). **Arizona** integrated behavioral health services into contracts with the Arizona Department of Economic Security Division of Development Disabilities (DDD). Arizona DDD contracted with MCOs effective October 1, 2019 to offer eligible members physical and behavioral health services, children’s rehabilitative services, and limited LTSS.²⁵ **New Jersey** carved in autism services and some SUD services. In FY 2020, **Wisconsin** carved out most prescription outpatient drugs from Family Care Partnership, its integrated Medicare-Medicaid MLTSS program serving frail elderly and people with disabilities.²⁶

Exhibit 5: MLTSS Policy Changes, FY 2020 and FY 2021 (n = 19 states)*

	FY 2020	FY 2021
Implemented MCO contracts for the first time	-	-
Made enrollment mandatory for additional population(s)	-	-
Expanded MLTSS to new geographic region(s)	ID, MA, PA	MA
Carved in additional benefits/services	AZ, MA, NJ	-
Carved out benefits/services	WI	-

*n=19 states only include states that cover LTSS through MCO and/or PHP

Long-Term Services and Supports

Medicaid is the nation’s primary payer for long-term services and supports

(<https://www.kff.org/report-section/medicaid-home-and-community-based-services-enrollment-and-spending-issue-brief/>) (LTSS).¹ State Medicaid programs must cover LTSS in nursing homes, while most home and community-based services (HCBS) are optional, which

results in considerable differences among states in HCBS

(<https://www.kff.org/medicaid/issue-brief/key-state-policy-choices-about-medicaid-home-and-community-based-services/>) eligibility, scope of benefits, and delivery systems.² The COVID-

19 pandemic has greater implications for people who utilize LTSS, who may be at increased risk (<https://www.kff.org/medicaid/issue-brief/covid-19-issues-and-medicaid-policy-options-for-people-who-need-long-term-services-and-supports/>) for adverse health outcomes if

infected with coronavirus due to their older age, underlying health conditions, and/or residence in congregate settings (<https://www.kff.org/coronavirus-covid-19/issue-brief/key-questions-about-nursing-home-regulation-and-oversight-in-the-wake-of-covid-19/>).

Members of the long-term care (LTC) workforce (<https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-and-workers-at-risk-examining-the-long-term-care-workforce/>)—which is predominantly female and low wage, and disproportionately Black—are also at elevated risk of coronavirus

infection.³ LTC facilities have implemented many protocols to mitigate the spread of

the virus, such as visitor restrictions and universal testing of residents and staff. These new measures have played an important role in reducing the number of new LTC cases and deaths in later months of the pandemic (<https://www.kff.org/coronavirus-covid-19/issue-brief/key-questions-about-the-impact-of-coronavirus-on-long-term-care-facilities-over-time/>).⁴

However, given the close relationship between community transmission and LTC cases and deaths, there is still enormous state-level variation in patterns of new cases and deaths in LTC facilities. Notably, LTC cases and deaths continue to rise faster in “hotspot” states than “non-hotspot” states (<https://www.kff.org/coronavirus-covid-19/issue-brief/rising-cases-in-long-term-care-facilities-are-cause-for-concern/>).⁵ As of October 8, 2020 (<https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address-coronavirus/>), LTC facilities across the country had reported a total of over 500,000 cases of COVID-19 as well as nearly 85,000 deaths related to the virus.⁶

As the pandemic continues, states have taken a number of Medicaid policy actions (<https://www.kff.org/medicaid/issue-brief/state-actions-to-sustain-medicaid-long-term-services-and-supports-during-covid-19/>) **to address the impact on seniors and people with disabilities who rely on LTSS to meet daily self-care and independent living needs.** These actions include expanding eligibility and streamlining enrollment, easing premium and/or cost-sharing requirements, enhancing benefits, increasing provider payment, modifying provider qualifications, and altering reporting requirements. Many of these policy changes have been adopted through temporary authorities that, according to CMS guidance (<https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>),⁷ will expire when the COVID-19 public health emergency (PHE) declaration ends or are otherwise time-limited. Prior to that time, policymakers will need to assess whether any changes can or should be retained and transitioned to other authorities.⁸

Survey Findings

To better understand the impact of COVID-19 on the LTSS direct care workforce, we asked states to indicate whether they had a variety of concerns about the pandemic’s impact on HCBS and institutional direct care workers. We also asked states about whether COVID-19 has impacted institutional/HCBS rebalancing efforts and whether it has impacted access to non-home and residential HCBS settings. Finally, we asked states to identify the top three LTSS policy changes adopted in response to COVID-19 that they plan to retain after the PHE period.

The majority of responding states reported concerns about the pandemic’s impact on the LTSS direct care workforce, with similar issues across HCBS and institutional settings (Figure 2). Specifically, states reported the following concerns:

- **More than three-quarters of states reported concerns about reductions in LTSS direct care workforce supply as a result of the pandemic.** At least five states reported that the LTSS direct care workforce supply was an issue prior to COVID-19 but has become a greater issue during the pandemic; in general, LTSS direct care workforce supply was an issue for many states prior to the pandemic

(<https://www.kff.org/report-section/a-view-from-the-states-key-medicare-policy-changes-long-term-services-and-supports/>).⁹ Using **HCBS Appendix K emergency authority** (<https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>), some states are providing overtime and the use of legally responsible relatives (such as parents or spouses) as **paid caregivers** (<https://www.kff.org/medicaid/issue-brief/state-actions-to-sustain-medicare-long-term-services-and-supports-during-covid-19/>) to address workforce supply issues.¹⁰

- **Nearly all states reported concerns about access to personal protective equipment (PPE) for LTSS direct care workers.** A few states noted that they were prioritizing supply of PPE for workers in institutional or congregate settings.¹¹
- **Nearly three-quarters of states reported concerns about access to COVID-19 tests for LTSS direct care workers.** Several states reported the length of COVID-19 test processing times as a particular challenge.
- **Over two-thirds of states reported concerns about COVID-19 infections among LTSS direct care workers.** Several states noted that better access to PPE and testing would help mitigate concern about infections.

Some states noted some improvements since the beginning of the pandemic in workforce supply, access to PPE and testing, and ability to control infection rates, while a few states identified specific LTSS populations or geographic areas that presented particular issues or concerns. For example, a few states reported issues with workforce, testing, and infection rates specifically for the population with intellectual and developmental disabilities (I/DD). A small number of states noted that workforce issues, distribution of PPE, and testing (due to lack of transportation to testing sites) were of greater concern for rural areas.

Figure 2: State Concerns of COVID-19's Impact on LTSS Direct Care Workforces (including HCBS and Institutional Workforces)

State responses regarding COVID-19 implications on state institutional/HCBS rebalancing efforts were mixed. Most frequently, states did not expect the pandemic to have an impact on rebalancing efforts to support more people in community-based over institutional settings. Several states, however, indicated that the pandemic would halt or delay HCBS expansion and others reported that fewer nursing facility transitions to the community would occur. Fewer states indicated that the pandemic would likely drive further rebalancing. Several states reported that the potential impact was unknown and/or was under review. Finally, a few states specifically indicated that negative fiscal and budget impacts resulting from the pandemic may delay rebalancing. When asked about access to existing HCBS services, nearly all responding states reported reduced access to non-home HCBS settings such as adult day health and day habilitation as a result of the COVID-19 pandemic, while fewer states reported reduced

access to residential HCBS settings. Although residential settings were less likely to be closed or eliminated in response to the pandemic, these settings were still impacted by the pandemic including by its effects on the direct care workforce (as described above).

States noted plans to retain a variety of LTSS policy changes adopted in response to COVID-19 after the PHE period ends, most commonly citing the continuation of telehealth expansions. As many LTSS emergency policy changes

(<https://www.kff.org/medicaid/issue-brief/state-actions-to-sustain-medicaid-long-term-services-and-supports-during-covid-19/>) were adopted through time-limited temporary authorities

(some of which will expire with the end of the PHE), states may need to assess how to retain changes and transition to other authorities.¹² Fourteen states reported they are still evaluating whether LTSS policy changes will be continued and three states reported that there are no plans to retain LTSS policy changes after the PHE declaration or other Medicaid emergency authority (such as HCBS waiver Appendix K) expires. The remaining states indicated plans to continue policy changes including:

- **Telehealth expansions.** The majority of responding states reported plans to retain telehealth or remote provision of HCBS services (21 states), far exceeding all other types of LTSS policy changes reported. For example, a few states mentioned plans to continue allowing personal care monitoring to be delivered via telehealth. (See Benefits, Cost-Sharing, and Telehealth section for more information on state expansions of telehealth for services including HCBS.)
- **Streamlined processes for LTSS eligibility determinations and service authorizations.** Six states cited continued remote delivery of assessments, reassessments, and case management (Connecticut, Minnesota, North Carolina, North Dakota, Oklahoma, and Oregon). A small number of states also mentioned continuing to allow verbal consent and electronic signatures, accepting self-attestation to verify Medicaid applications for aged, blind and disabled populations, and streamlining utilization review. (See Eligibility section for more information on changes to eligibility determination processes.)
- **Changes to provider enrollment processes.** Five states reported an intent to keep changes made to LTSS provider enrollment and training processes including simplification, modified qualifications, and recruitment techniques (Florida, New Hampshire, North Dakota, Oregon, and Washington). A couple of states also mentioned an intent to retain remote provider site inspections.
- **Increased access to paid family caregiver services.** Three states reported plans to continue allowing family members to provide certain services (Connecticut, Maine,¹³ and North Dakota).¹⁴
- **Other LTSS policy changes.** Other types of policies cited for retention by one or two states include modifications to provider payments (such as providing overtime or tying nursing facility reimbursement to quality and infection control), expansions of settings where HCBS may be delivered (such as acute hospital settings), and increased access to certain benefits (such as home delivered meals and assistive technology).

Benefits, Cost-Sharing, and Telehealth

Prior to the COVID-19 pandemic (<https://www.kff.org/report-section/a-view-from-the-states-key-medicaid-policy-changes-benefits-and-cost-sharing/>), **the most common state changes to Medicaid benefits were enhancements of mental health and substance use disorder (SUD) services.** In recent years, the number of states reporting benefit expansions outpaced the number of states reporting benefit restrictions. For FY 2019 and FY 2020, more states reported policies to eliminate or reduce cost-sharing requirements than those that reported new or increased cost-sharing requirements.¹ The COVID-19 pandemic has shifted state priorities for Medicaid benefits and cost-sharing, with states utilizing **Medicaid emergency authorities** (<https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>) to adopt new benefits, adjust existing benefits, and/or waive prior authorization requirements.²

In particular, states have focused on expanding telehealth access for Medicaid beneficiaries (<https://www.kff.org/coronavirus-covid-19/issue-brief/state-efforts-to-expand-medicaid-coverage-access-to-telehealth-in-response-to-covid-19/>) **to increase health care accessibility and limit risk of exposure during the pandemic.**³ Prior to the pandemic, the use of telehealth in Medicaid was becoming more common and all states had some form of Medicaid coverage for services delivered via telehealth; however, the scope of this coverage varied widely across states and many included restrictions on allowable services, providers, and originating sites.⁴ In response to COVID-19, states have utilized **Medicaid emergency authorities** (<https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>) to expand telehealth⁵ as well as taken advantage of broad authority to further expand telehealth without the need for CMS approval. To guide states considering telehealth expansions, CMS released a **State Medicaid & CHIP Telehealth Toolkit** (<https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf>) on April 23, 2020 which identified key areas of telehealth for state consideration, including what services can be delivered via telehealth; what kinds of sites can serve as originating sites (patient location); payment rates for services; technological modalities that can be used to deliver services; and whether Medicaid managed care organizations (MCOs) are required to cover all services that are available in fee-for-service (FFS) Medicaid.⁶

Survey Findings

We asked states about non-emergency benefit and cost-sharing changes unrelated to COVID-19 planned for FY 2021. Further, to better understand the impact of COVID-19 on Medicaid benefit design and coverage policy, we asked about emergency benefit and cost-sharing changes made in response to the pandemic and, specifically, whether states planned to adopt the changes on a more permanent basis. Finally, we asked states about recent changes in FFS telehealth coverage policy and whether these changes were likely to continue past the public health emergency (PHE) period.

NON-EMERGENCY CHANGES TO BENEFITS AND COST-SHARING

Less than one-third of responding states plan to make benefit or cost-sharing changes that are not related to the COVID-19 pandemic in FY 2021 (12 states).

Many states have not determined whether they will adopt any non-emergency benefit or cost-sharing changes (12 states), with at least one state noting that uncertainty regarding the length of the PHE period and its budgetary impact is a barrier to determining FY 2021 benefit and cost-sharing changes. Key reported changes for FY 2021, excluding telehealth coverage changes, include the following:

- Seven states are adding or expanding benefits (**Alaska, California, Hawaii, Idaho, Montana, Texas, and Wisconsin**). Reported benefit changes include expanded home and community-based (HCBS) services as well as behavioral health (BH) and SUD services, consistent with [findings in prior years \(https://www.kff.org/report-section/a-view-from-the-states-key-medicaid-policy-changes-benefits-and-cost-sharing/\)](https://www.kff.org/report-section/a-view-from-the-states-key-medicaid-policy-changes-benefits-and-cost-sharing/).⁷
- Two states are eliminating or restricting benefits (**Alaska** and **Wyoming**). **Alaska** is adding prior authorization requirements for benefits that include non-preventive dental, vision, and therapies. **Wyoming** is removing its chiropractic benefit for all individuals, limiting some HCBS services, and reducing its adult vision and dental benefits.
- Four states (**Colorado, Idaho, Michigan, and South Dakota**) will be implementing new or expanded co-payments for a variety of services, or other cost-sharing. Idaho and Michigan report that these changes will apply to the Medicaid expansion population.
- Two states (**California** and **Massachusetts**) will be eliminating or reducing certain co-payments in FY 2021.

BENEFIT CHANGES IN RESPONSE TO COVID-19

Approximately one-third of responding states intend to extend other benefit and cost-sharing changes adopted during the PHE period (15 states); many of these are pharmacy changes. (See the Pharmacy Cost Containment Actions section of this report for more information on state pharmacy changes.) Similar numbers of states said they would not extend changes adopted in response to the PHE (15 states) or that they had not yet determined whether the changes would be extended (13 states). The benefit changes states were most likely to extend beyond the PHE period include covering a 90-day drug supply (five states), relaxing various documentation and other authorization or referral requirements to qualify for long-term care or HCBS (six states), and relaxing or waiving certain prior authorization requirements for some services (five states). A few states also indicated they would retain other pharmacy changes, including paying for prescription deliveries (two states), allowing pharmacists to administer medications and/or vaccines (two states), and covering additional types of medication (two states).

TELEHEALTH POLICY CHANGES IN RESPONSE TO COVID-19

The majority of responding states report covering a range of FFS services

Figure 3: States Reporting Existing, Expanded, or Newly Added Coverage of FFS Services Delivered via Telehealth from the Home in Response to COVID-19

delivered via telehealth when the originating site is the beneficiary's home; most of these states newly added or expanded this coverage in response to the COVID-19 pandemic (Figure 3). States most commonly reported adding or expanding telehealth delivery from the beneficiary's home for occupational therapy (OT), physical therapy (PT), and speech therapy (35 states), followed by home and community-based services (HCBS) (33 states) and well/sick child visits (30 states). Several states noted they had utilized Section 1915 (c) Appendix K emergency authority to expand telehealth in their HCBS waivers.⁸

Most states reported that FFS services delivered via telehealth from the beneficiary's home have payment parity as compared to services delivered face-to-face. Payment parity for telehealth (<https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/>) increases access for patients by incentivizing providers to offer services delivered via telehealth.⁹ Most states reported that reimbursement was the same for telehealth and in-person delivery of all FFS services asked about (well/sick child visits, mental health services, SUD services, prenatal care, contraceptive visits, HCBS, OT/PT/speech therapies, and dental services).

Just over half of responding states report plans to extend newly added/expanded FFS telehealth coverage when the beneficiary's home is the originating site beyond the PHE period (Figure 4 and Table 3). Twenty-two states report that they will continue newly added/expanded telehealth coverage, at least in part and at least for some services. For most services with newly added/expanded coverage, however, the majority of states have not yet determined whether this coverage will continue beyond the PHE period. (See the Long-Term Services and Supports section for more information on state plans to retain telehealth or remote provision of long-term services and supports including HCBS after the end of the PHE).

Figure 4: States Reporting Continuation Post-PHE of Newly Added or Expanded Coverage of FFS Services Delivered via Telehealth from the Home

States also reported other policies aimed at making telehealth widely accessible in response to COVID-19. Thirty-nine out of 42 responding states expanded available telehealth modalities in response to the pandemic, with telephone (or voice-only) most

frequently reported. As one state noted, this expansion is important because beneficiaries may lack access to broadband internet. States also reported covering digital platforms, such as FaceTime, Zoom, and Skype. At least two states, **Florida** and **Virginia**, began allowing remote patient monitoring as a type of newly expanded telehealth service delivery. All responding states that contract with managed care organizations (MCOs) required MCOs to implement newly adopted FFS telehealth changes; three of these states required MCOs only to implement FFS telehealth changes in part. **Tennessee**, a state with 100% of its beneficiaries enrolled in managed care, indicated it worked closely with its MCOs to coordinate and increase use of telehealth.¹⁰ In Minnesota, some contracted MCOs cover virtual e-visits as an “in lieu of” services.¹¹

TABLE 3: STATES PLANNING TO CONTINUE NEWLY ADDED OR EXPANDED COVERAGE OF FFS SERVICES DELIVERED VIA TELEHEALTH FROM THE BENEFICIARY’S HOME

Does State Plan to Continue Newly Added/Expanded Telehealth Coverage From the Home

States	Well/Sick Child Visits	Mental Health Services	SUD Services	Prenatal Care Visits	Contraceptive Visits	HCBS
Alabama	?	?	?	?	?	?
Alaska	NA	?	?	?	?	Yes, in p
Arizona	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	NA	NA	Covered Pre-PHE
Arkansas	?	?	?	?	?	NA
California	?	Covered Pre-PHE	?	Covered Pre-PHE	Covered Pre-PHE	?
Colorado	NA	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Yes
Connecticut	?	Covered Pre-PHE	Covered Pre-PHE	?	?	Yes, in p
Delaware*						
DC*						
Florida	?	?	?	NA	?	?
Georgia	?	?	?	?	?	Covered Pre-PHE
Hawaii	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	NA
Idaho	Covered Pre-PHE	Covered Pre-PHE	Yes, in part	Yes, in part	Yes, in part	Yes, in p
Illinois*						
Indiana	?	Yes, in part	Yes, in part	?	?	?
Iowa	?	?	?	?	?	?
Kansas	NA	?	?	NA	NA	?
Kentucky	?	?	?	?	Covered Pre-	?

					PHE	
Louisiana	?	NA	NA	?	?	?
Maine	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Yes
Maryland						
Massachusetts	Yes	Yes	Yes	Yes	Yes	?
Michigan	Yes	Yes	Yes	Yes	Yes	?
Minnesota	?	?	?	?	?	?
Mississippi	?	?	?	?	?	?
Missouri	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE
Montana	Covered Pre-PHE	?	?	Covered Pre-PHE	Covered Pre-PHE	?
Nebraska	?	Yes, in part	Yes, in part	?	?	NA
Nevada	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	?
New Hampshire	Yes, in part	Yes, in part	Yes, in part	Yes, in part	Yes, in part	Yes, in part
New Jersey	?	?	?	?	?	?
New Mexico*						
New York*						
North Carolina	No	Yes, in part	Yes, in part	No	Yes, in part	Yes, in part
North Dakota	?	?	?	?	?	No
Ohio*						
Oklahoma	No	Yes, in part	Yes, in part	Yes	Yes	Yes
Oregon	Yes, in part	Yes, in part	Yes, in part	Yes, in part	Yes, in part	Yes

Pennsylvania	Yes	Yes, in part	Yes, in part	Yes	Yes	?
Rhode Island*						
South Carolina	?	?	?	?	?	No
South Dakota	?	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	NA
Tennessee						
Texas	?	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	No
Utah*						
Vermont	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE
Virginia	?	?	?	?	?	?
Washington	Yes, in part	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Yes, in part	Covered Pre-PHE
West Virginia	?	?	?	?	?	?
Wisconsin	Yes	Yes	Yes, in part	Yes	Yes	Yes, in part
Wyoming	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Covered Pre-PHE	Yes, in part
Yes, in all or part	7	10	11	8	10	11
No	2	0	0	1	0	3
Undetermined (?)	20	16	17	17	17	18
Covered Pre-PHE	9	14	12	12	12	5
NA, not covered	3	1	1	3	2	4

NOTES: States were asked whether newly added/expanded FFS telehealth coverage of each service from the beneficiary's home. SUD: Substance-use disorder. HCBS: Home and community-based services. OT: Occupational therapy. PT: Physical therapy delivered via telehealth from the beneficiary's home. Covered Pre-PHE (pre-public health emergency): the state covers this service from the beneficiary's home, but this coverage was not newly added/expanded in response to the PHE. "?" indicates that the state has not yet determined coverage of this service delivered via telehealth from the beneficiary's home in response to the PHE, but has not yet determined coverage. "*" indicates the state did not submit a survey by mid-August 2020 (DC, DE, IL, NM, NY, OH, RI, UT). Additionally,

not report data for this question.

SOURCE: KFF Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2020

Pharmacy Cost Containment Actions

Managing the Medicaid prescription drug benefit and pharmacy expenditures remains a policy priority for state Medicaid programs, and state policymakers remain concerned about Medicaid prescription drug spending growth. Because state Medicaid programs are required to cover all drugs from manufacturers that have entered into a federal rebate agreement (in both managed care and FFS settings), states cannot limit the scope of covered drugs to control drug costs. Instead, states use an array of payment strategies and utilization controls (<https://www.kff.org/report-section/how-state-medicaid-programs-are-managing-prescription-drug-costs-introduction/>) to manage pharmacy expenditures, including preferred drug lists (PDLs), multi-state purchasing pools, and managed care pharmacy carve-outs.¹ States continue to update and refine their drug utilization controls to respond to changes, especially new product offerings, in the pharmaceutical marketplace.

Survey Findings

In this year's survey, states were asked to describe any new or expanded pharmacy program cost containment strategies planned for FY 2021. States were asked to exclude routine updates to PDLs or state maximum allowable cost programs as these utilization management strategies are employed by states regularly and are not typically considered major new policy initiatives.

Thirty-three out of 43 responding states reported newly implementing or expanding upon at least one initiative to contain costs in the area of prescription drugs in FY 2021. Pharmacy cost containment actions included implementation of new policies (23 states) as well as expansion of policies adopted in prior years (19 states). Frequently reported pharmacy cost containment strategies include expanded PDLs (11 states), new or expanded value-based purchasing arrangements that link pharmacy reimbursement to patient outcomes (11 states), and targeted reforms to address transparency or other pharmacy benefit manager (PBM) concerns (7 states).²

Three states report adopting a uniform PDL in FY 2021 (**Kentucky, Massachusetts, and Michigan**) and **North Carolina** plans to use a uniform PDL for FFS and managed care when it implements managed care in FY 2022. In FY 2021, one state is carving the prescription drug benefit out of managed care organization (MCO) contracts (**California**) and three states report newly carving out certain high cost drugs (**Iowa, Maryland, and South Carolina**). **North Dakota** implemented a pharmacy carve out in FY 2020 and **Nevada** plans to carve out the prescription drug benefit effective in FY 2023, when MCO contracts are renewed. Both **Michigan** and **Missouri** will be

partnering with other state agencies or initiatives to purchase drugs at lower costs, including Michigan's Hepatitis C initiative aimed at reducing pharmacy and medical costs associated with the disease and working to eliminate Hepatitis C altogether.

Challenges and Priorities in FY 2021 and Beyond Reported by Medicaid Directors and Conclusion

Most state Medicaid officials remained heavily focused on their response to the COVID-19 public health emergency (PHE), taking action to assure health care access for a growing number of Medicaid beneficiaries while working to maintain the fiscal integrity of their programs. At the same time, many states also reported plans to move forward on other high priority initiatives.

Nearly all states reported significant adverse economic and state budgetary impacts driven by the pandemic, as well as uncertainty about the future. Many states commented on dramatic declines in state revenue collections leading to significant state budget shortfalls. While the full scope and extent of the economic downturn remains unknown, nine states indicated that its negative impacts were likely to exceed those of the Great Recession and nine states reported planning for or expecting future Medicaid budget reductions. At the same time, many states commented on the increased Medicaid enrollment expected to occur as a result of the economic downturn and high unemployment rates, placing added fiscal pressure on state Medicaid programs. Most responding states reported that dealing with state Medicaid budget and fiscal concerns was one of the biggest challenges facing the states in the coming year. Many states also commented on the great fiscal uncertainties that states currently face including how long the current enhanced FMAP will remain in place and how the course of the pandemic will continue to impact state economies and unemployment rates.

Many states reported the need for ongoing or greater fiscal relief as well as the need to strengthen the provider relief program for Medicaid-dependent providers to be able to continue to address the pandemic. Most states noted that state and federal responses to the pandemic were effective, but some states also identified needs related to improving or expanding federal communication efforts and guidance, further streamlining the emergency authority process, and receiving advance notice regarding when the PHE period will end. A few states were critical of the federal response regarding public health guidance (including mask wearing), the availability of personal protective equipment, and testing (e.g., supplies, distribution, inconsistent advice, and effectiveness of the tests).

At the time states responded to this survey in late July and early August, most indicated that the worst effects of the pandemic were likely still ahead or were unknown. Several states also commented on future challenges to treat the lingering impacts of COVID-19 infections as well as the population health impacts resulting from delayed health care utilization. A few states also expressed concern regarding the longer-term impact of the COVID-19 pandemic on the Medicaid provider network and access due, for example, to business closures. States also mentioned key priorities such as restoring utilization of preventive and routine care and transitioning from emergency authorities after the PHE ends.

Nearly half of responding states indicated that delivery system and payment reforms are a key priority. Efforts to better align payment with quality and improved health outcomes remain an important focus area for many states. States are pursuing these goals in part through managed care contract changes focused on value-based payment initiatives and the social determinants of health. States also mentioned efforts to integrate physical health and behavioral health, expand Health Homes¹, reform provider reimbursement methodologies, implement substance use disorder initiatives, and develop maternal health initiatives. Ten states also reported that assessing and/or expanding telehealth was a priority. Other priorities mentioned by multiple states include: implementation or pursuit of Section 1115 demonstration waivers, waiver amendments, or waiver renewals; technology projects (e.g., Medicaid Management Information System replacements and integrated eligibility and enrollment systems); improving quality metrics and eliminating health disparities and inequities; long-term services and supports reforms; and implementing or advocating for the ACA Medicaid expansion in states that have not adopted the expansion.

Conclusion

In the face of the COVID-19 pandemic, states continue to encounter challenges to provide Medicaid coverage and access for a growing number of Americans, while also facing plummeting revenues and deepening state budget gaps. State Medicaid officials highlighted swift and effective state responses to the pandemic, such as the rapid expansion of telehealth, as well as ongoing efforts to advance delivery system reforms and to address health disparities and other public health challenges. In these ways, the pandemic has demonstrated how Medicaid can quickly evolve to address the nation's most pressing health care challenges. However, the ability of states to sustain policies adopted in response to the pandemic (including through emergency authorities) may be tied to the length of the public health emergency (PHE) as well as the availability of additional federal fiscal relief and support. Looking ahead, great uncertainty remains regarding the future course of the pandemic, the scope and length of federal fiscal relief efforts, and what the "new normal" will be in terms of service provision and demand. Results of the November 2020 elections could also have significant implications for the direction of federal Medicaid policy in the years ahead.

Methods

KFF commissioned Health Management Associates (HMA) to survey Medicaid directors in all 50 states and the District of Columbia to identify and track trends in Medicaid spending, enrollment, and policy making. This is the 20th annual survey, each conducted at the beginning of the state fiscal year from FY 2002 through FY 2021. Additionally, eight mid-fiscal year surveys were conducted during state fiscal years 2002-2004 and 2009-2013, when a large share of states were considering mid-year Medicaid policy changes due to state budget and revenue shortfalls. Findings from previous surveys are referenced in this report when they help to highlight current trends. Archived copies of past reports are available on the following [page](http://www.kff.org/medicaid/report/medicaid-budget-survey-archives/) (<http://www.kff.org/medicaid/report/medicaid-budget-survey-archives/>).¹

The KFF/HMA Medicaid survey on which this report is based was conducted from June through August 2020. The survey instrument (in Appendix B) was designed to primarily document policy actions implemented or adopted for FY 2021 (which began for most states on July 1, 2020).² The survey captures information consistent with previous surveys, particularly for eligibility, provider payment rates, benefits, long-term care, and managed care, to provide some trend information. Each year, questions are added or revised to address current issues. This year, in light of the ongoing COVID-19 pandemic, the survey was scaled back in length and scope and a number of questions were added or reframed to capture information regarding state actions taken or planned in response to the pandemic.

Medicaid directors and staff provided data for this report in response to a written survey and, in some cases, follow-up emails seeking additional information or clarifications. Unlike the surveys conducted in prior years, the project team did not conduct follow-up telephone interviews. The survey was sent to each Medicaid director in June 2020 and 43 states³ provided responses by mid-August 2020.

The survey does not attempt to catalog all Medicaid policies in place for each state. This report highlights certain policies in place in state Medicaid programs in FY 2020 and policy changes implemented or planned for FY 2021. Experience has shown that adopted policies are sometimes delayed or not implemented for reasons related to legal, fiscal, administrative, systems, or political considerations, or due to delays in approval from CMS. Policy changes under consideration without a definite decision to implement are not included in the survey. Given differences in the financing structure of their programs, the U.S. territories were not included in this analysis.

Appendices

Appendix A: Acronym Glossary

ABD – aged, blind, and disabled

ACA – Affordable Care Act

AMI – Area Median Income

BH – behavioral health

CARES – Coronavirus Aid, Relief, and Economic Security Act

CDC – The Centers for Disease Control and Prevention

CHIP – Children’s Health Insurance Program

CMS – The Centers for Medicare and Medicaid Services

DRG – Diagnosis Related Group

EMS – emergency medical services

EPSDT – Early and Periodic Screening, Diagnostic, and Treatment

FAI – Financial Alignment Initiative

FFCRA – Families First Coronavirus Response Act

FFS – fee-for-service

FMAP – Federal Medicaid Assistance Percentage

FPL – federal poverty level

FY – state fiscal year

HCBS – home and community-based services

HEDIS – Healthcare Effectiveness Data and Information Set

ICF-ID – intermediate care facility for individuals with intellectual disabilities

I/DD – intellectual and developmental disabilities

IGT – intergovernmental transfer

LTC – long-term care

LTSS – long-term services and supports

MAGI – modified adjusted gross income

MAT – medication assisted treatment

MCO – managed care organization

MLTSS – managed long-term services and supports

MLR – medical loss ratio

MOE – maintenance of eligibility

NEMT – non-emergency medical transportation

OB/GYN – obstetrician and gynecologist OT – occupational therapy

PBM – pharmacy benefit manager

PCCM – primary care case management

PCP – primary care physician

PDL – preferred drug list

PHE – public health emergency

PHP – prepaid health plan

PPE – personal protective equipment PT – physical therapy

SDOH – social determinants of health

SED – serious emotional disturbance

SNAP – Supplemental Nutrition Assistance Program

SPA – State Plan Amendment

SPMI – severe and persistent mental illness

SUD – substance use disorder

Appendix B: Survey Instrument

[Download the Survey \(http://files.kff.org/attachment/Appendix-B-Survey-Instrument.pdf\)](http://files.kff.org/attachment/Appendix-B-Survey-Instrument.pdf) (.pdf)

Endnotes

Executive Summary

1. Pub. L. 116-127 (March 18, 2020), <https://www.congress.gov/116/plaws/publ127/PLAW-116publ127.pdf> (<https://www.congress.gov/116/plaws/publ127/PLAW-116publ127.pdf>).
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2. FMAP = Federal Medicaid Assistance Percentage
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5. State fiscal years begin on July 1 except for these states: New York on April 1; Texas on September 1; Alabama, Michigan, and DC on October 1.
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10. Since the time of survey submission, two additional responding states (Connecticut and North Carolina) have received SPA approvals for this group. For an updated count of states with SPA approval to cover the new Uninsured Coronavirus Testing group, see: KFF, "Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19," last updated October 7, 2020, <https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/> (<https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>)

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19. New Hampshire also reported plans to continue coverage of COVID-19 diagnostic testing, testing-related services, and treatment services for the uninsured but is not counted here as authority for this coverage, created by the Families First Coronavirus Response Act, continues only through the end of the PHE period.

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20. Additionally, Nevada noted that eligibility for the new uninsured COVID-19 group may continue for up to 90 days after the end of the PHE period to allow for prior medical requests to cover testing and diagnostic services. Per the Families First Coronavirus Response Act, authority to cover the uninsured COVID-19 testing group will not extend past the end of the PHE.

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10. These 16 states are: Arizona, California, Colorado, Florida, Georgia, Hawaii, Iowa, Kansas, Massachusetts, Montana, New Jersey, Pennsylvania, South Carolina, South Dakota, West Virginia, and Virginia.

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11. These 19 states are: California, Colorado, Connecticut, Florida, Georgia, Indiana, Iowa, Kentucky, Louisiana, Maine, Michigan, Montana, North Carolina, Oregon, South Carolina, Texas, Virginia, West Virginia, and Wyoming.

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Delivery Systems

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6. "Other" carve-ins reported include chiropractic, "treat-no transport" ambulance services, and diabetes prevention services (Missouri), doula services (New Jersey), and adult podiatry services (South Carolina).

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7. "Other" carve-outs reported were lens fabrications from selected plans (California) and elective C-sections (New Jersey).

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8. Elizabeth Hinton and MaryBeth Musumeci, *Medicaid Managed Care Rates and Flexibilities: State Options to Respond to COVID-19 Pandemic* (Washington, DC: KFF, September 9, 2020), <https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-rates-and-flexibilities-state-options-to-respond-to-covid-19-pandemic/> (<https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-rates-and-flexibilities-state-options-to-respond-to-covid-19-pandemic/>)

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9. The survey did not ask states to specify whether MCO contract or rate adjustments were made to FY 2020 MCO contracts so we are unable to report this information comprehensively.

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10. Elizabeth Hinton and MaryBeth Musumeci, *Medicaid Managed Care Rates and Flexibilities: State Options to Respond to COVID-19 Pandemic* (Washington, DC: KFF, September 9, 2020), <https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-rates-and-flexibilities-state-options-to-respond-to-covid-19-pandemic/> (<https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-rates-and-flexibilities-state-options-to-respond-to-covid-19-pandemic/>)

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11. MassHealth Managed Care Entity Bulletin 36, "Community Support Program for Homeless Individuals Residing in Department of Housing and Community Development-Funded New Temporary Shelters," July 2020, <https://www.mass.gov/doc/managed-care-entity-bulletin-36-community-support-program-for-homeless-individuals-residing-0/download> (<https://www.mass.gov/doc/managed-care-entity-bulletin-36-community-support-program-for-homeless-individuals-residing-0/download>)

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12. The 11 MCO states that reported food assistance or home delivered meal initiatives are: Hawaii, Indiana, Kansas, Massachusetts, Michigan, Missouri, Nebraska, New Jersey, South Carolina, Virginia, and Wisconsin.
The eight MCO states that reported enhanced MCO care management and outreach efforts often targeting persons at high risk for COVID-19 are: California, Colorado, Indiana, Kentucky, Missouri, Nebraska, Pennsylvania, and West Virginia.
The four MCO states that reported provisions of PPE are: Arizona, Kansas, Kentucky, and Pennsylvania.
The three MCO states that expanded telehealth and remote support are: Nebraska, Wisconsin, and West Virginia.
The three MCO states that reported expanded pharmacy home deliveries are: Kansas, Nebraska, and West Virginia.
The two MCO states that reported MCO-provided gift cards are: Kentucky and Virginia.

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13. Samantha Artiga and Elizabeth Hinton, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity* (Washington, DC: KFF, May 10, 2018), <https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/> (<https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>)

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14. In June 2015, CMS issued an [Informational Bulletin](https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf) (<https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf>) to clarify when and how Medicaid reimburses for certain housing-related activities, including individual housing transition services, individual housing and tenancy sustaining services, and state-

level housing related collaborative activities. In January 2018, CMS issued a [State Medicaid Director Letter \(https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf\)](https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf) providing guidance on state Section 1115 waiver proposals to condition Medicaid on meeting a work requirement. CMS explicitly stated the demonstration opportunity does not provide states with the authority to use Medicaid funding to finance employment support services. Predating this guidance, a few states implemented voluntary work referral programs. Federal Medicaid funds also cannot be used to finance work referral programs. Centers for Medicare and Medicaid (CMS), "Coverage of Housing-Related Activities and Services for Individuals with Disabilities," June 26, 2015, <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf> (<https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf>) Centers for Medicare and Medicaid (CMS), "RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries," January 11, 2018,, <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf> (<https://www.medicaid.gov/federal-policy-guidance/downloads/cib-06-26-2015.pdf>)

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15. Under federal Medicaid managed care rules, Medicaid MCOs may have flexibility to pay for non-medical services through "in-lieu-of" authority and/or "value-added" services. "In-lieu-of" services are a substitute for covered services and may qualify as a covered service for the purposes of capitation rate setting. "Value-added" services are extra services outside of covered contract services and do not qualify as a covered service for the purposes of capitation rate setting.

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17. Cornelia Hall, Samantha Artiga, Kendal Orgera, and Rachel Garfield, *Food Insecurity and Health: Addressing Food Needs for Medicaid Enrollees as Part of COVID-19 Response Efforts* (Washington, DC: KFF, August 14, 2020), <https://www.kff.org/report-section/food-insecurity-and-health-addressing-food-needs-for-medicaid-enrollees-as-part-of-covid-19-response-efforts-issue-brief/> (<https://www.kff.org/report-section/food-insecurity-and-health-addressing-food-needs-for-medicaid-enrollees-as-part-of-covid-19-response-efforts-issue-brief/>)

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18. Oklahoma and Missouri responded that "yes" the COVID-19 emergency caused the state to implement, expand, or reform a program or initiative to address enrollees' social determinants of health but did not describe specific related actions and are

therefore not included in Exhibit 4, but are included in count of 27 states.

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19. Minnesota Governor Walz directed more the 75 billion dollars in Coronavirus Relief funding toward food security.

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20. The area median income (AMI) is the household income for the median, or middle, household in a region and is calculated annually by the Department of Housing and Urban Development for every metropolitan region in the country. See: Brian McCabe, "The Area Medium Income (AMI), Explained," (Washington, DC: Greater Greater Washington: September 1, 2016), <https://ggwash.org/view/42671/the-area-median-income-ami-explained> (<https://ggwash.org/view/42671/the-area-median-income-ami-explained>)

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21. California Department of Social Services, "Project Roomkey: Emergency Housing for Immediate Protection Fact Sheet," <https://www.cdss.ca.gov/Portals/9/FEMA/Project-Roomkey-Fact-Sheet.pdf> (<https://www.cdss.ca.gov/Portals/9/FEMA/Project-Roomkey-Fact-Sheet.pdf>)

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22. North Carolina implemented NCCARE360 six months ahead of schedule.

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24. Centers for Medicare and Medicaid (CMS), "Financial Alignment Initiative (FAI)," last updated September 28, 2020, <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination> (<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination>)

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2. MaryBeth Musumeci, Molly O'Malley Watts, and Priya Chidambaram, *Key State Policy Choices About Medicaid Home and Community-Based Services* (Washington, DC: KFF, February 4, 2020), <https://www.kff.org/medicaid/issue-brief/key-state-policy-choices-about-medicaid-home-and-community-based-services/> (<https://www.kff.org/medicaid/issue-brief/key-state-policy-choices-about-medicaid-home-and-community-based-services/>)

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3. Sarah True et al., *COVID-19 and Workers at Risk: Examining the Long-Term Care Workforce* (Washington, DC: KFF, April 23, 2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-and-workers-at-risk-examining-the-long-term-care-workforce/> (<https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-and-workers-at-risk-examining-the-long-term-care-workforce/>)

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5. Priya Chidambaram, *Rising Cases in Long-term Care Facilities Are Cause for Concern* (Washington, DC: KFF, July 21, 2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/rising-cases-in-long-term-care-facilities-are-cause-for-concern/> (<https://www.kff.org/coronavirus-covid-19/issue-brief/rising-cases-in-long-term-care-facilities-are-cause-for-concern/>)

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10. For updated counts of states taking this action using Medicaid emergency authorities, see: KFF, “Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19,” last updated October 7, 2020, <https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/> (<https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>)

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11. Examples of congregate settings include assisted living facilities for seniors and group homes for individuals with disabilities.

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12. MaryBeth Musumeci, Rachel Dolan, and Madeline Guth, *State Actions to Sustain Medicaid Long-Term Services and Supports During COVID-19* (Washington, DC: KFF, August 26, 2020), <https://www.kff.org/medicaid/issue-brief/state-actions-to-sustain-medicare-long-term-services-and-supports-during-covid-19/> (<https://www.kff.org/medicaid/issue-brief/state-actions-to-sustain-medicare-long-term-services-and-supports-during-covid-19/>)

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13. Maine reported plans to increase access to its shared living model, in which a family member can serve as a live-in paid caretaker.

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14. A number of states allowed legally responsible relatives to be paid providers prior to the COVID-19 pandemic. For more on this and other pre-pandemic HCBS policies, see: MaryBeth Musumeci, Molly O'Malley Watts, and Priya Chidambaram, *Key State Policy Choices About Medicaid Home and Community-Based Services* (Washington, DC: KFF, February 4, 2020), <https://www.kff.org/medicaid/issue-brief/key-state-policy-choices-about-medicare-home-and-community-based-services/> (<https://www.kff.org/medicaid/issue-brief/key-state-policy-choices-about-medicare-home-and-community-based-services/>)

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Benefits, Cost-Sharing, and Telehealth

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2. KFF, "Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19," last updated October 7, 2020, <https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/> (<https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>)

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3. Madeline Guth and Elizabeth Hinton, *State Efforts to Expand Medicaid Coverage & Access to Telehealth in Response to COVID-19* (Washington, DC: KFF, June 22, 2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/state-efforts-to-expand-medicare-coverage-access-to-telehealth-in-response-to-covid-19/> (<https://www.kff.org/coronavirus-covid-19/issue-brief/state-efforts-to-expand-medicare-coverage-access-to-telehealth-in-response-to-covid-19/>)

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4. *State Telehealth Laws & Reimbursement Policies* (Center for Connected Health Policy, Spring 2020), [https://www.cchpca.org/sites/default/files/2020-05/CCHP %2050 STATE REPORT SPRING 2020 FINAL.pdf](https://www.cchpca.org/sites/default/files/2020-05/CCHP%2050%20STATE%20REPORT%20SPRING%20FINAL.pdf) ([https://www.cchpca.org/sites/default/files/2020-05/CCHP %2050 STATE REPORT SPRING 2020 FINAL.pdf](https://www.cchpca.org/sites/default/files/2020-05/CCHP%2050%20STATE%20REPORT%20SPRING%20FINAL.pdf))

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5. KFF, "Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19," last updated October 7, 2020, <https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/> (<https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>)

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6. Centers for Medicare and Medicaid (CMS), "State Medicaid & CHIP Telehealth Toolkit," last updated April 23, 2020, <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf> (<https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>)

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8. For more information on this emergency authority, see KFF, Table: Approved Section 1915 (c) Waiver Appendix K Strategies to Address COVID-19 *from* "Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19," last updated October 7, 2020, <https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/> (<https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>)

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9. Gabriela Weigel et al., *Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond* (Washington, DC: KFF, May 11, 2020), <https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/> (<https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/>)

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10. Because 100% of Tennessee's Medicaid beneficiaries are enrolled in managed care, the state has no fee-for-service telehealth policies and thus is not included elsewhere in this write-up of emergency telehealth policies.

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11. For more information on how states can implement or update Medicaid managed care telehealth policies, see: Centers for Medicare and Medicaid (CMS), "COVID-19 Frequently Asked Questions (FAQs)", question V.A.1, last updated June 30, 2020,

<https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>

(<https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf>)

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Pharmacy Cost Containment Actions

1. Kathleen Gifford et al., *How State Medicaid Programs are Managing Prescription Drug Costs* (Washington, DC: KFF, April 29, 2020), <https://www.kff.org/report-section/how-state-medicaid-programs-are-managing-prescription-drug-costs-introduction/> (<https://www.kff.org/report-section/how-state-medicaid-programs-are-managing-prescription-drug-costs-introduction/>)

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2. The 11 states that expanded PDLs are: Alaska, California, Colorado, Connecticut, Louisiana, Massachusetts, Missouri, Mississippi, Nebraska, New Hampshire, and Washington.

The 11 states that had new or expanded value-based purchasing arrangements are: Alaska, Arizona, Colorado, Indiana, Massachusetts, Michigan, Nevada, North Carolina, Texas, Virginia, and Vermont.

The seven states that had targeted reforms to address transparency and other PBM concerns are: Arizona, Kentucky, Maryland, Massachusetts, Mississippi, South Carolina, and Virginia.

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Challenges and Priorities in FY 2021 and Beyond Reported by Medicaid Directors and Conclusion

1. Health Homes (created under Section 2703 of the ACA) target beneficiaries who have at least two chronic conditions (or one and risk of a second, or a serious and persistent mental health condition), and provide a person-centered system of care that facilitates access to and coordination of the full array of primary and acute physical health services, behavioral health care, and social and long-term services and supports.

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Methods

1. KFF, *50-State Medicaid Budget Survey Archives*, (Washington, DC: KFF, October 2020), <https://www.kff.org/medicaid/report/medicaid-budget-survey-archives/> (<https://www.kff.org/medicaid/report/medicaid-budget-survey-archives/>).

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2. State fiscal years begin on July 1 except for these states: New York on April 1; Texas on September 1; Alabama, Michigan, and DC on October 1.

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3. The eight states that did not respond by mid-August 2020 are: Delaware, District of Columbia, Illinois, Ohio, New Mexico, New York, Rhode Island, and Utah.

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Health Insurer Financial Performance Amid the Coronavirus Pandemic

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Published: Oct 12, 2020

Issue Brief

The coronavirus pandemic, social distancing, and resulting economic downturn have had considerable implications for the U.S. health system, including health insurers. The pandemic caused a sizable decrease (<https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-start>) in the use of health care services during the first half of 2020, job losses appear to have led to coverage loss (<https://www.kff.org/policy-watch/what-have-pandemic-related-job-losses-meant-for-health-coverage/>) in the employer market and increases (<https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/>) in Medicaid enrollment, and insurers projecting costs (<https://www.kff.org/private-insurance/issue-brief/an-early-look-at-2021-premium-changes-on-aca-exchanges-and-the-impact-of-covid-19-on-rates/>) for next year must assess the relative effects of pent-up demand for delayed care, the continuing pandemic, and a potential vaccine.

In this brief, we analyze data from 2013 to 2020 to examine how insurance markets performed through the first half of this year as the pandemic developed and worsened in the U.S. We use financial data reported by insurance companies to the National Association of Insurance Commissioners and compiled by Mark Farrah Associates to look at average medical loss ratios and gross margins in the individual (also known as non-group), fully-insured group (employer), and Medicare Advantage health insurance markets. A more detailed description of each market is included in the Appendix.

We find that, as of the end of June 2020, average margins have increased and loss ratios have dropped across the fully-insured group and Medicare Advantage markets, relative to the same time period in 2019. If administrative costs were roughly the same

in 2020 as in 2019, these findings suggest higher profits for many insurers during the pandemic. Individual market loss ratios were already quite low and remained flat into 2020, suggesting continued profitability. The results for the individual and group markets indicate that commercial insurers are on track to owe substantial rebates to consumers again next year under the Affordable Care Act (ACA) Medical Loss Ratio provision.

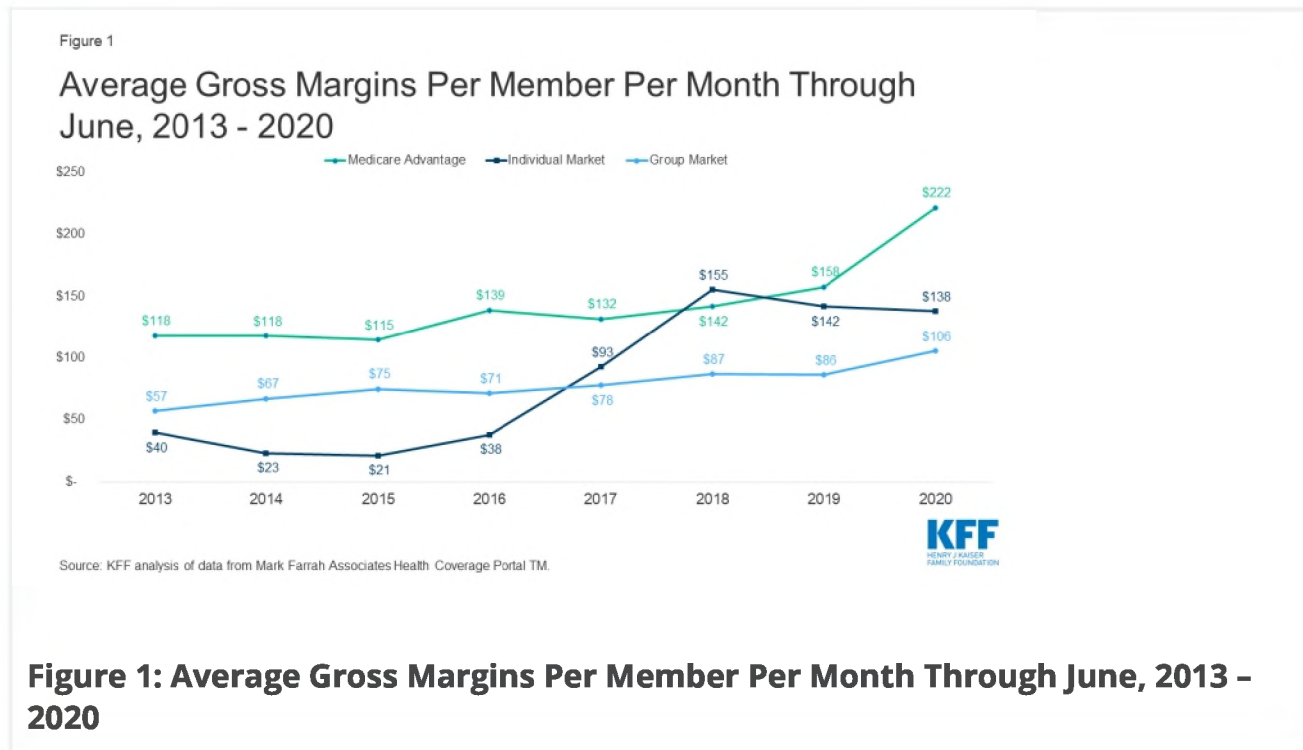
Gross Margins

One way to assess insurer financial performance is to examine average gross margins per member per month, or the average amount by which premium income exceeds claims costs per enrollee in a given month. Gross margins are an indicator of performance, but positive margins do not necessarily translate into profitability since they do not account for administrative expenses. However, a sharp increase in margins from one year to the next, without a commensurate increase in administrative costs, would indicate that these health insurance markets have become more profitable during the pandemic.

Despite many insurers (<https://www.healthsystemtracker.org/brief/cost-sharing-waivers-and-premium-relief-by-private-plans-in-response-to-covid-19/>) covering the full cost of coronavirus testing and treatment for their enrollees, insurers across most markets have seen their claims costs fall, and margins increase since the start of the pandemic, and relative to 2019. This is consistent with the sharp drop in utilization documented in other analyses (<https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/>).

Gross margins among group market plans increased 22% (or \$20 pmpm) through the second quarter of 2020 relative to the same period in 2019. Gross margins among Medicare Advantage plans also increased, rising 41% (or \$64 pmpm) through the first six months of 2020 compared to gross margins at the same point last year. (Gross margins per member per month tend to be higher for Medicare Advantage than for the other health insurance markets mainly because Medicare covers an older, sicker population with higher average costs). Prior to the pandemic, margins in the group and Medicare Advantage markets had grown gradually over recent years.

Individual market margins have been more volatile than the other private markets since the early years of the Affordable Care Act (ACA), as described in more depth in our earlier analyses (<https://www.kff.org/private-insurance/issue-brief/individual-insurance-market-performance-in-2019/>) of individual market financial performance. Individual market margins remained relatively stable through the first six months of 2020, decreasing just \$4 per member per month, and remaining much higher than in the earlier years of the ACA. These data suggest that insurers in the individual market remain financially healthy after a year and a half with no individual mandate penalty, even while the coronavirus outbreak worsened.



Medical Loss Ratios

Another way to assess insurer financial performance is to look at medical loss ratios, which are the percent of premium income that insurers pay out in the form of medical claims. Generally, lower medical loss ratios mean that insurers have more income remaining, after paying medical costs, to use for administrative costs or keep as profits. Each health insurance market has different administrative needs and costs, so low loss ratios in one market do not necessarily mean that market is more profitable than another market. However, in a given market, if administrative costs hold mostly constant from one year to the next, a drop in loss ratios would imply that plans are becoming more profitable.

Medical loss ratios are used in state and federal insurance regulation in a variety of ways. In the commercial insurance (individual and group) markets, insurers must issue rebates to individuals and businesses if their loss ratios fail to reach minimum standards set by the ACA. Medicare Advantage insurers are required (<https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/MedicalLossRatio>) to report loss ratios at the contract level; they are also required to issue rebates to the federal government if they fall short of 85%, and are subject to additional penalties if they fail to meet loss ratio requirements for multiple consecutive years in a row.

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. The chart below shows simple medical loss ratios, or the share of premium income that insurers pay out in claims, without any modifications (Figure 2). Loss ratios in the Medicare

Advantage market decreased 5 percentage points through the first six months of 2020 relative to the same period in 2019, and group market loss ratios decreased by an average of 3 percentage points relative to last year.

Figure 2: Average Medical Loss Ratios Through June, 2013 – 2020

The individual market was the only market in which average loss ratios held steady from last year. Even so, loss ratios in the individual market were already quite low and insurers in that market are issuing record-large (<https://www.kff.org/private-insurance/issue-brief/data-note-2020-medical-loss-ratio-rebates/>) rebates to consumers based in part on their 2019 experience.

Discussion

Although we cannot measure profits directly, all signs suggest that health insurers in most markets have become more profitable so far during the pandemic. Medicare Advantage and group health plans saw rising margins and falling loss ratios through June 2020, relative to the same time last year. In contrast, margins and loss ratios among individual market insurers have generally remained flat through the second quarter compared to the same time last year, though insurers in this market already had high margins and low loss ratios last year.

That insurers appear to be becoming more profitable during a pandemic may be counter-intuitive. Insurers were generally required to cover COVID-19 testing costs, and many also voluntarily covered (<https://www.healthsystemtracker.org/brief/cost-sharing-waivers-and-premium-relief-by-private-plans-in-response-to-covid-19/>) the full cost of COVID-19 treatment for a period of time (see for example, announcements from UnitedHealthcare (<https://www.uhc.com/health-and-wellness/health-topics/covid-19/coverage-and-resources>), CVSHealth (Aetna) (<https://cvshealth.com/covid-19/aetna-faq>), and Cigna (<https://www.cigna.com/newsroom/news-releases/2020/cigna-waives-customer-cost-sharing-for-covid-19-treatment-and-deploys-clinical-teams-to-increase-virtual-care-capacity>)). Even with these increased pandemic-related expenses, though, many insurers saw claims costs fall as enrollees delayed or went without other types of health care due to social distancing restrictions, cancellation of elective procedures, or out of fear of contracting the virus. Job losses and economic instability may also affect health care utilization.

The drop in utilization that has contributed to higher gross margins and lower medical loss ratios presents uncertainty and challenges for insurers, particularly given the unknown trajectory of the pandemic. For Medicare Advantage insurers, these trends may result in plans offering more benefits than they currently do (<https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/>), which are popular and attract enrollees. But if insurers fall short in meeting required loss

ratio requirements for multiple years, they face additional penalties, including the possibility of being terminated. In the individual and group markets, insurers are reporting pandemic-related uncertainty as they set premiums (<https://www.kff.org/private-insurance/issue-brief/an-early-look-at-2021-premium-changes-on-aca-exchanges-and-the-impact-of-covid-19-on-rates/>) for next year, and insurers are making different assumptions about the extent to which utilization will rebound or health costs will change due to factors like the potential for widespread vaccination.

Unless these patterns change substantially in late 2020, ACA medical loss ratio rebates in 2021 likely will be exceptionally large across commercial markets. Rebates to consumers are calculated using a three-year average of medical loss ratios, meaning that 2021 rebates will be based on insurer performance in 2018, 2019, and 2020. In the individual market in particular, insurers were quite profitable in 2018 and 2019, so even if 2020 turns out to be a more average year, these insurers will likely owe large rebates to consumers. Group market insurers may also owe larger rebates to employers and employees than plans have in typical years, as loss ratios have dropped substantially. This may, in part, explain why many commercial insurers have volunteered to cover (<https://www.healthsystemtracker.org/brief/cost-sharing-waivers-and-premium-relief-by-private-plans-in-response-to-covid-19/>) COVID-19 treatment costs, waived (<https://www.healthsystemtracker.org/brief/how-private-insurers-are-using-telehealth-to-respond-to-the-pandemic/>) telemedicine cost-sharing, or expanded mental health services during the pandemic. By increasing their claims costs, insurers can proactively increase loss ratios and owe smaller rebates next year.

Methods

We analyzed insurer-reported financial data from Health Coverage Portal TM, a market database maintained by Mark Farrah Associates, which includes information from the National Association of Insurance Commissioners (NAIC). The dataset analyzed in this report does not include NAIC plans licensed as life insurance or California HMOs regulated by California's Department of Managed Health Care. We excluded plans that filed negative enrollment, premiums, or claims and corrected for plans that did not file "member months" in the annual statement but did file current year membership. The group market in this analysis only includes fully insured plans¹. Premiums to Medicare Advantage plans do not include payments for Medicare Part D benefits.

Gross margins were calculated by subtracting the sum of total incurred claims from the sum of unadjusted health premiums earned and dividing by the total number of members in each market. Premiums for Medicare Advantage plans primarily consist of federal payments made to plans for Medicare-covered benefits, and also include any additional amounts plans may choose to charge their enrollees. Premiums for the individual market were not adjusted to account for rebates required to be remitted

(<https://www.kff.org/health-reform/state-indicator/mlr-rebates-total/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>) to enrollees. To calculate simple medical loss ratios, we divided the market-wide sum of total incurred claims by the sum of all unadjusted health premiums earned. Medical loss ratios in this analysis are simple loss ratios and do not adjust for quality improvement expenses, taxes, or risk program payments.

Appendix

Individual Market. The individual market, which accounted for more than 13 million people (<https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/>) in 2019, includes coverage purchased by individuals and families through the Affordable Care Act's exchanges (Marketplaces) as well as coverage purchased directly off-exchange, which includes both plans complying with the ACA's rules and non-compliant coverage. (e.g., grandfathered policies purchased before the ACA went into effect and some short-term plans). The federal government provides subsidies for low-income people in the Marketplace and includes measures, such as risk adjustment, to help limit the financial liability of insurers. Insurers in the individual market receive premium payments from enrollees, plus any federal subsidies for people in the Marketplaces.

Group Market. The fully-insured group market serves employers and their employees that are enrolled in fully-insured health plans. This market includes both small and large group plans, but excludes employer-sponsored insurance plans that are completely or partially self-funded, which account for 61% of all workers (<https://www.kff.org/report-section/ehbs-2019-section-10-plan-funding/>) with employer-sponsored insurance. Roughly 30 million people were enrolled in fully-insured group market plans in 2019. Plans typically receive premium payments from both employers and their employees. While both average claims and average premiums for enrollees in the group market have increased, the market has been relatively stable for insurers over the past decade.

Medicare Advantage. The Medicare Advantage market provides Medicare-covered benefits through private plans to 24 million (<https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/>) Medicare beneficiaries in 2020, with enrollment projected to increase steadily over the next decade. The federal government makes risk-adjusted payments (higher payments for sicker enrollees and lower payments for healthier enrollees) to plans (averaging \$11,545 per enrollee (<https://www.cbo.gov/system/files?file=2019-05/51302-2019-05-medicare.pdf>) in 2019) to cover the cost of benefits covered under Medicare Parts A and B, with additional payments for costs associated for prescription drug coverage. Some plans charge enrollees an additional premium. The majority of Medicare Advantage plans provide supplemental benefits, such as dental, vision and hearing.

Endnotes

Methods

1. **61% of workers** (<https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-10-plan-funding/>) with employer-sponsored insurance are enrolled in a plan that is completely or partially self-funded. This analysis only includes fully-insured group plans.

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A Reconfigured U.S. Supreme Court: Implications for Health Policy

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Published: Oct 09, 2020

Issue Brief

U.S. Supreme Court decisions shape health policy in important ways. The nomination of Judge Amy Coney Barrett, if confirmed, is expected to establish a solid 6:3 conservative majority that could affect case outcomes in several areas. This issue brief considers the potential implications of a reconfigured Court for health policy issues, including those already on the Court's docket for the coming term and those that the Court may choose to consider in this term or in the future:

- **The future of the ACA:** The Court will decide *California v. Texas*, a case that could determine whether the entire Affordable Care Act can continue, with significant implications for the U.S. health care system and virtually every American. Oral argument is scheduled for November 10, 2020.
- **Cases requesting Supreme Court review:**
 - **Abortion:** The Court may decide to consider one or more cases that could overturn the precedent of *Roe v. Wade*, alter the standard to evaluate whether abortion regulations are constitutional, or decide that abortion providers cannot sue to challenge abortion regulations.
 - **Title X:** The Court is likely to want to resolve conflicting appeals court decisions about whether the Trump Administration Title X Federal Family Planning regulations that prohibit federal funding to clinics that offer or refer for abortion are permissible under federal law.
 - **Medicaid enrollees' free choice of provider:** The Court will decide whether to hear a case about whether Medicaid enrollees can sue to challenge a state's refusal to allow Planned Parenthood to offer Medicaid services if that provider also separately offers abortion services (which are not covered by Medicaid). Federal appeals courts are split on this issue. The case has implications for enrollees' ability to bring lawsuits challenging state violations of federal Medicaid law as well as enrollees' free access to providers.
 - **Medicaid work requirements:** The Court will decide whether to hear cases about whether the HHS Secretary can approve Section 1115 waivers that condition Medicaid eligibility on meeting work and reporting requirements, which have led to over 18,000 people losing coverage in Arkansas.

• Cases that could reach the Supreme Court:

- **Payment of ACA cost-sharing reductions to insurers:** The Court could be asked to hear cases brought by Marketplace insurers seeking unpaid cost-sharing reductions (CSRs) from the Trump Administration. Restoring CSR payments could lower Marketplace premiums and federal costs and improve affordability for individuals who do not qualify for Marketplace premium tax credits.
- **Nondiscrimination in health coverage and care:** The Court could be asked to review cases challenging the Trump Administration's rollback of regulations implementing ACA Section 1557, which bans discrimination in health programs and activities that receive federal funding. Issues include whether discrimination based on gender identity is prohibited and the extent to which individuals and entities are exempt from discrimination claims based on religious freedom.
- **Public charge rule:** The Court could be asked to review cases challenging the Trump Administration's regulations that prevent individuals from obtaining a green card or entering the U.S. if they are determined likely to use certain public programs, including Medicaid. The regulations are likely to lead to decreased participation in Medicaid by immigrant families and their primarily U.S. born children.
- **Hospital price transparency rule:** The Court could be asked to hear a challenge to the Trump Administration's regulations requiring hospitals to disclose their negotiated rates with insurers. The Administration argues that the regulations could lead to lower costs for consumers. However, if the Supreme Court accepts the argument, supported by the Trump Administration, that the entire ACA is invalid, Congress would need to pass new legislation before any price transparency regulations could be adopted.

Introduction

Along with legislation and administrative agency actions, U.S. Supreme Court decisions shape health policy issues in important ways. In the upcoming October 2020 term, the Court will hear a case involving the Affordable Care Act's (ACA) survival. It also will decide whether to review cases involving abortion, Title X, Medicaid enrollees' free choice of provider, and Medicaid work requirements. Other cases affecting health policy may reach the Court, such as payment of ACA cost-sharing reductions to Marketplace insurers, whether gender identity and sexual orientation are prohibited bases of discrimination in health care, issues affecting immigrants' access to health coverage under the public charge rule, and regulations requiring hospital price transparency. With the exception of the abortion cases, all of these cases involve federal regulations and laws and could become moot if the administration and congressional majorities change. For example, if Congress raises the tax above zero dollars for failure to comply with the individual mandate, the question raised in the ACA case could become moot before the Supreme Court issues a decision.

Members of the Court, including Chief Justice John Roberts (<https://www.nytimes.com/2018/12/23/us/politics/chief-justice-john-roberts-supreme-court.html>), reject the assertion that judicial decisions may be motivated by particular political party's ideology. Still, analysis of the justices' voting patterns (<https://www.axios.com/supreme-court-justices-ideology-52ed3cad-fcff-4467-a336-8bec2e6e36d4.html>) reveals a spectrum with those appointed by Democratic Presidents typically supporting positions characterized as liberal and those appointed by Republican Presidents typically supporting positions characterized as conservative. As with any generalization, there can be exceptions, as the issues before the Court and its composition evolve over time. Even so, the recent death of Justice Ruth Bader Ginsburg and the nomination of Judge Amy Coney Barrett, if confirmed, to fill the empty seat is expected to establish a solid 6:3 conservative majority that could affect case outcomes in a number of areas.¹ This issue brief considers the potential implications of a reconfigured Court for key health policy issues, including the ACA case, scheduled to be heard November 10, 2020, and cases the Court may choose to consider this term or in the future.

The Supreme Court Will Decide the Future of the ACA

The Court will once again consider the survival of the Affordable Care Act (ACA) in *California v. Texas* (<https://www.kff.org/health-reform/issue-brief/explaining-california-v-texas-a-guide-to-the-case-challenging-the-aca/>), **a case with far-reaching consequences**

(<https://www.kff.org/health-reform/issue-brief/potential-impact-of-california-v-texas-decision-on-key-provisions-of-the-affordable-care-act/>), **affecting nearly every American in some way.**²

Currently scheduled for oral argument on November 10, 2020, the case challenges the constitutionality of the ACA's individual mandate and asks the Court to decide whether the entire law can continue. A group of Republican-led states and two individuals who have purchased Marketplace coverage argue that, because Congress reduced the payment for failure to comply with the individual mandate to zero dollars, the mandate is no longer a constitutional tax. They further argue that the rest of the law is not severable from the mandate, so the entire ACA must be invalidated as a result. Notably, the Trump Administration is not defending the ACA. Instead, the Administration is arguing that the entire ACA is invalid, though it is asking the Court to prohibit it from enforcing only the provisions that ultimately are found to harm the individual plaintiffs.

A decision by the Court invalidating all or even some of the ACA would have significant implications for the U.S. health care system and virtually every American. At stake are the ACA's changes to the individual insurance market, including protections for people with pre-existing conditions, restrictions on premium surcharges based on health or gender, coverage of essential benefits, insurance marketplaces, and premium subsidies for people with low and modest incomes. Overturning the ACA could also roll back other changes throughout the health care system including expanding Medicaid eligibility for low-income adults; requiring private insurance, Medicare, and Medicaid expansion to cover preventive services with no patient cost sharing; phasing out the Medicare prescription drug doughnut hole

coverage gap; reducing the growth of Medicare payments to health care providers and insurers; establishing new national initiatives to promote public health, care quality, and delivery system reforms; and authorizing a variety of tax increases to finance these changes.

Cases Requesting Supreme Court Review

There currently are cases in three key health policy cases requesting *certiorari*, for the Supreme Court to accept the case to review this term. Four justices must vote to accept a case.

Abortion

If the Court accepts a case involving abortion, the precedent of *Roe v. Wade* could be overturned or states could be granted more authority to restrict abortion access or doctors could lose the ability to sue to challenge abortion regulations.

Among the most contentious issues in the country right now is abortion. There are two abortion cases the Supreme Court is currently considering whether to hear.

The first case is [Thomas E. Dobbs, State Health Officer of the Mississippi Department of Health v. Jackson Women's Health Organization](https://www.supremecourt.gov/search.aspx?filename=/docket/docketfiles/html/public/19-1392.html) (<https://www.supremecourt.gov/search.aspx?filename=/docket/docketfiles/html/public/19-1392.html>). This case involves a Mississippi law, House Bill 1510, Gestational Age Act, banning all abortions over 15 weeks' gestational age except in medical emergencies and in the case of severe fetal abnormality. The Court's ruling could allow states to restrict abortions by directly overturning *Roe v. Wade*, establishing a new standard to evaluate state restrictions with more deference to state legislatures, or overturning the long held precedent that abortion doctors and clinics have the right to bring lawsuits to challenge abortion regulations on behalf of their patients (third-party standing). If the Court overturns *Roe v. Wade*, [15 states have laws in place that would immediately ban abortion](https://www.kff.org/womens-health-policy/state-indicator/state-policies-protecting-or-restricting-legal-status-of-abortion/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) (<https://www.kff.org/womens-health-policy/state-indicator/state-policies-protecting-or-restricting-legal-status-of-abortion/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>). If the Court allows more deference to states on restricting abortions, patients may not be able to access abortion [in many states](https://www.kff.org/womens-health-policy/state-indicator/regulations-on-facilities-and-clinicians-providing-abortions/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) (<https://www.kff.org/womens-health-policy/state-indicator/regulations-on-facilities-and-clinicians-providing-abortions/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>). If the Court decides that doctors and clinics no longer have the right to challenge abortion regulations on behalf of their patients (third-party standing), abortion would remain a constitutional right, but many unconstitutional abortion regulations may go unchallenged. Women seeking abortions often must overcome numerous obstacles, including financial limitations, and concerns for privacy and personal safety, that would [make it difficult](https://scholarship.law.wm.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1753&context=wmborj) (<https://scholarship.law.wm.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1753&context=wmborj>) for them to assert their constitutional rights and challenge an abortion restriction. This could have far-reaching implications for other cases where third-party standing has been recognized including physicians'

ability to challenge laws on behalf of their patients' rights to privacy for contraception (<https://supreme.justia.com/cases/federal/us/381/479/>), and to obtain mental health services (<https://casetext.com/case/pennsylvania-psychiatric-v-green-spring-hlt>).

The second case at the Supreme Court is Food and Drug Administration v. American College of Obstetricians and Gynecologists. (<https://www.supremecourt.gov/search.aspx?filename=/docket/docketfiles/html/public/20a34.html>) In this case, the FDA is requesting (https://www.supremecourt.gov/DocketPDF/20/20A34/151289/20200826115042080_20A-%20FDA%20v.%20ACOG%20Stay%20Application%20FINAL%20a.pdf) that the Court lift the national injunction issued by the United States District Court of Maryland preventing the FDA from enforcing the Risk Evaluation and Mitigation Strategies (REMS) requirements for mifepristone. (<https://www.kff.org/womens-health-policy/fact-sheet/the-availability-and-use-of-medication-abortion/>) the abortion medication, during the COVID-19 pandemic. The REMS (https://www.accessdata.fda.gov/drugsatfda_docs/remss/Mifepristone_2019_04_11_REMS_Full.pdf) only permit medical providers who have received special certification from the manufacturer to prescribe and dispense the drug which limits access to abortion during the emergency. On October 8, 2020, the Supreme Court directed the FDA to request that the district court to lift or modify the preliminary injunction before the Supreme Court rules on the issue. It is possible that this unusual order to not rule on the stay until the FDA requests the district court to reconsider the scope of the injunction may reflect a compromise when there are only eight justices. When the case comes back to the Supreme Court, there will likely be nine justices. While this case could be limited to the availability of mifepristone during the pandemic, the case could have broader implications because the Solicitor General is requesting that the Court accept this case in order to clarify the legal standard that should be applied to determine if abortion regulations are constitutional.

Title X Family Planning Regulations

To resolve a split between the 9th Circuit Court of Appeals and the 4th Circuit Court of Appeals, the Court will likely consider a case challenging the Trump Administration's Title X regulations (<https://www.kff.org/womens-health-policy/issue-brief/new-title-x-regulations-implications-for-women-and-family-planning-providers/>). These regulations effectively block the availability of Title X grants to family planning clinics that offer abortion services with other non-federal funds, curtail counseling, ban Title X projects from making referrals to abortion services, and require all pregnant patients served by Title X clinics to be referred for prenatal services, regardless of their pregnancy intention.

The Court's decision could uphold the regulations, which have resulted in 29% of the Title X family planning sites to leave the Title X Program and six states to completely withdraw from the program. This would likely affect the availability of affordable family planning services to low-income people in many parts of the country. Eight lawsuits challenging the regulations (<https://www.kff.org/womens-health-policy/issue-brief/litigation-challenging-title-x-regulations/>) were filed in federal court. There is a

split in decisions between the 4th Circuit Court of Appeals (<https://www.courthousenews.com/wp-content/uploads/2020/09/abortion-md.pdf>), which held that the regulations are arbitrary and capricious and contrary to law, and the 9th Circuit Court of Appeals (http://cdn.ca9.uscourts.gov/datastore/general/2020/02/24/19-15974_opinion.pdf), which allowed the regulations to go into effect. The regulations are currently blocked in Maryland, but in effect in the rest of the country. The American Medical Association, Oregon Medical Association, Planned Parenthood Federation of America, National Family Planning and Reproductive Health Association, and Essential Access Health, Inc. have petitioned (<https://searchlf.ama-assn.org/case/documentDownload?uri=%2Funstructured%2Fbinary%2Fcasebriefs%2Fama-v-azar-us-sup-ct-certiorari.pdf>) the Court to review the case from the 9th Circuit to resolve the circuit split. The Oregon Attorney General with 21 other Attorneys General separately petitioned (https://ag.ny.gov/sites/default/files/oregon_v_azar_petition_for_writ.pdf) the Court to review the case from the 9th Circuit. HHS has also petitioned (https://www.supremecourt.gov/DocketPDF/20/20-454/157141/20201008110146702_Azar%20v.%20Baltimore%20Pet%20updated.pdf) the Court to review the case from the 4th Circuit. Many provisions in the Trump Administration's regulation mirror those issued in 1988 by the Reagan Administration. In 1991, the Supreme Court upheld the Reagan regulations in the case, *Rust v. Sullivan* (<https://supreme.justia.com/cases/federal/us/500/173/>).

The petitioners asking for review from the 9th Circuit argue that the applicable law has changed, and that *Rust v. Sullivan* is not controlling. The Court's ruling about the future of the ACA may ultimately impact the decision for the Title X case. One of the key arguments for those challenging the regulations is based on the violation of Section 1554 of the ACA, which states that HHS shall not promulgate any regulations that create any unreasonable barriers to the ability of individuals to obtain appropriate medical care or restricts communications between a doctor and a patient. They contend that these Title X regulations create barriers to and restrict patient-doctor communication. However, HHS contends that *Rust v. Sullivan* is controlling and that the agency has the statutory authority to promulgate these regulations.

Medicaid Enrollees' Free Choice of Provider

The Court will decide whether to hear *Baker v. Edwards*

(https://www.supremecourt.gov/DocketPDF/19/19-1186/139309/20200327125507902_USSC%20Petition%20for%20Writ%20of%20Certiorari.pdf), **a case about whether Medicaid enrollees can sue to challenge a state's refusal to allow a provider to participate in Medicaid if that provider also separately offers abortion services (not covered by Medicaid).** Federal law (<https://www.law.cornell.edu/uscode/text/42/1396a>) requires states to allow Medicaid enrollees to obtain covered services from any qualified willing provider. South Carolina's Medicaid agency terminated Planned Parenthood as a Medicaid provider after the governor issued an executive order declaring that providers are "unqualified" to participate in Medicaid if they also offer abortion. Planned Parenthood and one of its

Medicaid patients sued to challenge this state action, and the lower court issued a preliminary injunction allowing Planned Parenthood to continue as a South Carolina Medicaid provider while the case is pending. The [Fourth Circuit Court of Appeals found](https://www.ca4.uscourts.gov/opinions/182133.P.pdf) (<https://www.ca4.uscourts.gov/opinions/182133.P.pdf>) that a Medicaid enrollee has the right to sue in federal court to enforce Medicaid's free choice of provider requirement. The Medicaid Act itself does not explicitly authorize third parties, like Medicaid enrollees, to sue to enforce its provisions. However, the Fourth Circuit Court of Appeals found that the enrollee can sue under federal civil rights law, [Section 1983](https://www.law.cornell.edu/uscode/text/42/1983) (<https://www.law.cornell.edu/uscode/text/42/1983>), which allows individuals to bring federal lawsuits to challenge state actions that deprive them of rights provided under federal law. The Fourth Circuit joins the Fifth, Sixth, Seventh, Ninth, and Tenth Circuit Courts of Appeals in upholding a Medicaid enrollee's right to sue to enforce the free choice of provider provision, while the Eighth Circuit Court of Appeals has ruled that Medicaid enrollees cannot bring these lawsuits.

If the Court rules that the enrollees cannot sue to enforce the free choice of provider provision, state rules restricting provider participation in Medicaid may go unchallenged. Medicaid enrollees have often sued as third parties to enforce the free choice of provider provision. Removing the ability of enrollees to sue also eliminates the availability of an injunction to allow providers to continue to participate in Medicaid while the merits of a case are decided. In an [earlier case](https://www.kff.org/medicaid/issue-brief/explaining-armstrong-v-exceptional-child-center-the-supreme-court-considers-private-enforcement-of-the-medicaid-act/) (<https://www.kff.org/medicaid/issue-brief/explaining-armstrong-v-exceptional-child-center-the-supreme-court-considers-private-enforcement-of-the-medicaid-act/>), former CMS administrators explained that the agency does not have the resources to investigate all potential violations of federal Medicaid law and relies on third parties like Medicaid enrollees to bring lawsuits to challenge state actions. If unchallenged, state actions restricting enrollees' free choice of provider can limit enrollees' access to covered services. Planned Parenthood in South Carolina [provides](https://www.supremecourt.gov/DocketPDF/19/19-1186/149004/20200729181358162_Baker%20v%20PP%20Brief%20in%20Opp%20FINAL.pdf) (https://www.supremecourt.gov/DocketPDF/19/19-1186/149004/20200729181358162_Baker%20v%20PP%20Brief%20in%20Opp%20FINAL.pdf) Medicaid enrollees services including physical exams, cancer screening, contraception, pregnancy testing, and screening for chronic conditions such as diabetes, depression, anemia, cholesterol, thyroid disorder, and high blood pressure.

Medicaid Work Requirements

The Court will decide whether to hear *Azar v. Gresham* and *Azar v. Philbrick* (<https://www.supremecourt.gov/search.aspx?filename=/docket/docketfiles/html/public/20-37.html>), **cases about whether the Health and Human Services Secretary can approve Section 1115 demonstration waivers** (<https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/>) **authorizing Medicaid work requirements and other restrictive provisions.**³ The Trump Administration is seeking review of a unanimous DC Circuit Court of Appeals [decision](https://affordablecareactlitigation.files.wordpress.com/2020/02/dcc-gresham-opinion-2-14.pdf) (<https://affordablecareactlitigation.files.wordpress.com/2020/02/dcc-gresham-opinion-2-14.pdf>) which

found that the Secretary's waiver approval in [Arkansas \(https://www.kff.org/medicaid/issue-brief/3-key-questions-about-the-arkansas-medicaid-work-and-reporting-requirements-case/\)](https://www.kff.org/medicaid/issue-brief/3-key-questions-about-the-arkansas-medicaid-work-and-reporting-requirements-case/) was unlawful because he failed to consider the impact on coverage as required by the statute.⁴ The Administration also is seeking review of a second appeals court [decision \(https://affordablecareactlitigation.files.wordpress.com/2020/05/dcc-philbrick-summary-affirmance.pdf\)](https://affordablecareactlitigation.files.wordpress.com/2020/05/dcc-philbrick-summary-affirmance.pdf) in which the court concluded that the reasoning of its Arkansas decision required a similar outcome in a case challenging a New Hampshire waiver approval.

Court decisions about the bounds of the Secretary's Section 1115 authority not only determine the legality of Medicaid work requirements in Arkansas and New Hampshire, but also could have implications for similar waivers in other states [\(https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/\)](https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/) **and the Secretary's discretion in approving waivers more broadly.**

To date, Arkansas is the only state to have implemented a waiver that conditioned Medicaid eligibility on meeting a work and reporting requirement, with significant effects on [enrollees \(https://www.kff.org/medicaid/issue-brief/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees/\)](https://www.kff.org/medicaid/issue-brief/medicaid-work-requirements-in-arkansas-experience-and-perspectives-of-enrollees/). Before Arkansas' waiver was set aside by a lower court, [over 18,000 Medicaid enrollees lost coverage \(https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/\)](https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/) in that state. The Trump Administration has continued to expand the bounds of the Secretary's Section 1115 authority, issuing [guidance \(https://www.kff.org/medicaid/issue-brief/implications-of-cms-new-healthy-adult-opportunity-demonstrations-for-medicaid/\)](https://www.kff.org/medicaid/issue-brief/implications-of-cms-new-healthy-adult-opportunity-demonstrations-for-medicaid/) inviting states to apply for new waivers that would impose work requirements and other eligibility and benefit restrictions in exchange for a federal financing cap, and currently is considering a "modified block grant" proposal from [Tennessee \(https://www.kff.org/medicaid/issue-brief/why-it-matters-tennessees-medicaid-block-grant-waiver-proposal/\)](https://www.kff.org/medicaid/issue-brief/why-it-matters-tennessees-medicaid-block-grant-waiver-proposal/).

Cases That Could Reach the Court

Payment of ACA Cost-sharing Reductions to Insurers

The Court could be asked to hear appeals in the lawsuits brought by Marketplace insurers seeking unpaid cost-sharing reductions (CSRs), *Community Health Choice v. U.S.* [\(https://affordablecareactlitigation.files.wordpress.com/2020/08/fc-chc-maine-cho-opinion.pdf\)](https://affordablecareactlitigation.files.wordpress.com/2020/08/fc-chc-maine-cho-opinion.pdf)

The ACA requires CSR payments to compensate insurers for reducing out-of-pocket costs such as deductibles and copayments to Marketplace enrollees with income from 100-250% of the federal poverty level. In October 2017, the Trump Administration stopped making CSR payments, on the basis that Congress had not appropriated funds. The ACA still required insurers to offer plans with CSRs to enrollees, so insurers sued the federal government to recover their CSR costs. In August 2020, a three-judge panel of the Federal Circuit Court of Appeals ruled that the federal government must reimburse insurers for CSR costs. However, the appeals court limited the amount that insurers can recover, finding that payments must be reduced by the amount insurers

received in higher premium tax credits due to “silver loading (<https://www.kff.org/health-costs/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2020/>).” For example, many insurers increased premiums on silver level plans – which are the benchmarks for ACA premium subsidies — to account for unpaid CSRs. Consequently, the amount of CSR costs that any insurer may recover could vary based on the degree of premium loading each has adopted. **Both** (<https://affordablecareactlitigation.files.wordpress.com/2020/09/fc-maine-cho-pet-for-rehearing.pdf>) **insurers** (<https://affordablecareactlitigation.files.wordpress.com/2020/09/fc-chc-pet-for-rehearing.pdf>) have asked the entire appeals court to rehear the case, and the **federal government may join** (<https://affordablecareactlitigation.files.wordpress.com/2020/09/fc-order-for-conditional-cross-petitions.pdf>) in this request.

The outcome of this case also has implications for the federal deficit and for individuals who do not qualify for premium tax credits and therefore pay full Marketplace plan premiums. Because the second-lowest cost silver level plan is used to determine the premium tax credit amount, higher silver level premiums result in higher premium tax credit costs for the federal government. In 2017, when the Trump Administration ended CSR payments to insurers, the **Congressional Budget Office estimated** (<https://www.cbo.gov/system/files/2018-06/53826-healthinsurancecoverage.pdf>) that premium loading would increase the overall federal cost of Marketplace premium tax credits by about \$10 billion per year. If CSR payments to insurers resume and premium loading stops, the overall cost of Marketplace premium tax credits could be reduced. Premium loading also can result in higher premiums for Marketplace enrollees with incomes above 400% of poverty who are ineligible for premium tax credits and must bear the entire premium cost. Resuming CSR payments to insurers could result in a downward adjustment of silver level Marketplace plan premiums, lowering costs for these enrollees.

Nondiscrimination in Health Coverage and Care

One or more of the pending lawsuits challenging the Trump Administration’s rollback of regulations implementing ACA Section 1557’s prohibition of discrimination in health programs and activities receiving federal financial assistance could reach the Court. The Trump Administration’s June 2020 final regulations (<https://www.kff.org/racial-equity-and-health-policy/issue-brief/the-trump-administrations-final-rule-on-section-1557-non-discrimination-regulations-under-the-aca-and-current-status/>) eliminate the prior regulations’ nondiscrimination protections based on gender identity and specific health insurance coverage protections for transgender individuals issued by the Obama Administration; adopts blanket abortion and religious freedom exemptions for health care providers; reduces protections for those with limited English proficiency; and limits the activities and entities covered, among other provisions. It also eliminates prohibitions on discrimination based on gender identity and sexual orientation in ten other federal regulations outside Section 1557.

The Court could be asked to confirm that its recent decision finding that sex discrimination includes sexual orientation and gender identity in the employment context also applies to the health care context and to determine the parameters of religious freedom objections. Just after the Trump Administration published its final Section 1557 regulations, the Supreme Court decided *Bostock v Clayton County, Georgia* (https://www.supremecourt.gov/opinions/19pdf/17-1618_hfci.pdf), finding that sex discrimination includes sexual orientation and gender identity in the employment context. In *Bostock* (https://www.supremecourt.gov/opinions/19pdf/17-1618_hfci.pdf), the Court said that questions about the intersection of religious freedom and nondiscrimination protections “are questions for future cases.” Based on the *Bostock* decision, two federal courts issued nationwide preliminary injunctions blocking parts of the final Section 1557 rule: **NY and DC courts** (<https://affordablecareactlitigation.files.wordpress.com/2020/08/ajw-pi.pdf>) blocked provisions excluding sex stereotyping from the definition of sex discrimination, and the **DC court** (<https://affordablecareactlitigation.files.wordpress.com/2020/09/6725227-0-26785.pdf>) also blocked the religious freedom exemption. The NY court is now considering whether to block other provisions of the rule, and **other lawsuits** (<https://affordablecareactlitigation.com/aca-enforcement-directly-and-1557/>) are pending.

Public Charge Rule

The Court could be asked to review one or more of the pending lawsuits (https://docs.google.com/spreadsheets/d/1gdbxw6wusU_4ZleAAYG_Qu8qrZs-uHrt_PLBMa4gMT8/edit#gid=1746889895) **challenging the Trump Administration’s final rule changing public charge policy** (<https://www.kff.org/disparities-policy/fact-sheet/public-charge-policies-for-immigrants-implications-for-health-coverage/>) **to prevent individuals from obtaining a green card or entry into the U.S. if they are determined likely to use certain public programs, including Medicaid.** Longstanding policy allows the federal government to deny an individual entry into the U.S. or adjustment to legal permanent resident (LPR) status (i.e., a green card) if he or she is determined likely to become a public charge. Under the Trump Administration rule, officials will newly consider use of certain previously excluded programs, including non-emergency Medicaid for non-pregnant adults, the Supplemental Nutrition Assistance Program (SNAP), and several housing programs, in public charge determinations. As of September 11, 2020, a nationwide preliminary injunction blocking the rule was **lifted** (<https://www.aila.org/advocacy/media/issues/all/public-charge-changes-at-uscis-doj-and-dos>), allowing the Administration to implement the rule while litigation continues.

The public charge changes will create new barriers to getting a green card or immigrating to the U.S. and likely lead to decreases in participation in Medicaid (<https://www.kff.org/racial-equity-and-health-policy/fact-sheet/public-charge-policies-for-immigrants-implications-for-health-coverage/>) **and other programs among immigrant families and their primarily U.S.-born children beyond those directly affected by the new policy.** Nationwide, **over 13.5 million Medicaid and** (<https://www.kff.org/racial-equity-and->

[health-policy/fact-sheet/public-charge-policies-for-immigrants-implications-for-health-coverage/](#)) Children’s Health Insurance Program (CHIP) enrollees, including 7.6 million children, live in a household with at least one noncitizen or are noncitizens themselves and may be at risk for decreased enrollment a result of fear and uncertainty surrounding the rule. Decreased participation in these programs would contribute to more uninsured individuals and negatively affect the health and financial stability of families and the growth and healthy development of their children. Growing [fear and uncertainty](#) (<https://www.kff.org/disparities-policy/issue-brief/living-in-an-immigrant-family-in-america-how-fear-and-toxic-stress-are-affecting-daily-life-well-being-health/>) among individuals in immigrant families may also lead to some individuals avoiding accessing services including [health care](#) (<https://www.kff.org/medicaid/issue-brief/impact-of-shifting-immigration-policy-on-medicare-enrollment-and-utilization-of-care-among-health-center-patients/>) and/or enrolling in public programs, including health coverage through Medicaid and CHIP, even if they are eligible for them.

Hospital Price Transparency

The Court could be asked to review a case challenging the Trump Administration’s regulations implementing the ACA’s hospital price transparency requirement, *American Hospital Association v. Azar*. The [ACA requires](#) (<https://www.law.cornell.edu/uscode/text/42/300gg-18>) each hospital to publicly disclose an annual “list of the hospital’s standard charges for items and services provided by the hospital.” Following President Trump’s [Executive Order](#) (<https://www.whitehouse.gov/presidential-actions/executive-order-i>) on improving price and quality transparency, in November 2019, HHS issued [final regulations](#) (<https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-24931.pdf>) effective January 2021, requiring hospitals to disclose their negotiated rates with insurers and authorizing financial penalties for failure to comply. The new regulations would replace those issued by the [Obama Administration](#) (<https://www.govinfo.gov/content/pkg/FR-2014-08-22/pdf/2014-18545.pdf>), which interpreted the ACA as requiring disclosure only of hospitals’ list prices (or gross charges), absent any discounts. In December 2019, the American Hospital Association with other hospital and health system groups challenged the Trump Administration’s regulations, contending that the statute only allows the Administration to require disclosure of standard list prices, not “custom” negotiated prices. In June 2020, the DC federal district court [ruled](#) (https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2019cv3619-35) in favor of the Administration, finding that the new regulations are a reasonable interpretation of “standard charges,” and the ACA authorizes the imposition of penalties. The district court also [found](#) (https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2019cv3619-35) that the regulations do not violate the hospitals’ First Amendment right to free speech because the requirements are reasonably related to the government’s interests in “providing consumers with factual price information to facilitate more informed health care

decisions” and “lowering healthcare [sic] costs.” The plaintiffs appealed the case the D.C. Circuit Court of Appeals, which will hear oral argument on October 15, 2020 (<https://www.cadc.uscourts.gov/internet/sixtyday.nsf/fullcalendar?OpenView&count=1000>).

If the Supreme Court accepts the argument in *California v. Texas*

(<https://www.kff.org/health-reform/issue-brief/explaining-california-v-texas-a-guide-to-the-case-challenging-the-aca/>), **supported by the Trump Administration, that the entire ACA is invalid, then Congress would need to pass new legislation before any hospital price transparency regulations could be adopted.** The Trump Administration argues that these regulations are necessary to implement the ACA provision that requires hospitals to publicly disclose their standard charges; without the ACA, the Administration would have no legal authority to issue any price transparency regulations. The Trump Administration and organizations supporting the regulations (<https://affordablecareactlitigation.files.wordpress.com/2020/08/5c-patientrightsadvocate-amicus.pdf>) contend that disclosure of negotiated prices is necessary to tackle rising hospital costs by enabling consumers to meaningfully compare prices and improving competition. The hospitals and organizations (<https://affordablecareactlitigation.files.wordpress.com/2020/07/dcc-40-state-hosp-assns-amicus.pdf>) opposing the regulations maintain that disclosure will not lead to lower costs because the regulations are burdensome to implement and could create “confusion” (<https://affordablecareactlitigation.files.wordpress.com/2020/07/dcc-us-chamber-amicus.pdf>) among consumers between insurers’ reimbursement rates and consumers’ out-of-pocket costs.

Looking Ahead

The outcome of the election could impact the underlying laws and regulations related to some of the health policy cases before the Supreme Court, while the Court will remain the final arbiter in others. If former Vice President Biden wins the Presidential election, and the Democrats gain control of the Senate and maintain control of the House, the tax penalty associated with the ACA individual mandate and CSR payments could potentially be reinstated, essentially making these cases moot. Similarly, the regulations changing Title X, Section 1557, public charge policy, and hospital price transparency could be revised or withdrawn. However, the Supreme Court will maintain the final say about the constitutionality of abortions, the rights of states to restrict abortion access, and whether Medicaid enrollees can sue to enforce the free choice of provider provision regardless of the outcome of the 2020 election.

While it is impossible to predict a justice’s decision in a particular case with absolute certainty, the confirmation of Judge Barrett is expected to replace Justice Ginsburg’s vote as the leader of the Court’s liberal wing with votes reflecting a conservative judicial ideology. Judge Barrett is a member of the conservative Federalist Society (<https://fedsoc.org/contributors/amy-barrett-1>) and has said that she follows the same judicial philosophy as Justice Scalia (<https://www.nytimes.com/2020/09/26/us/politics/full-transcript-amy->

[coney-barrett.html](#)), who is well-known for his conservative legal views and for whom Judge Barrett clerked. While not determinative of the current ACA challenge before the Court, Judge Barrett has criticized the Court's *NFIB v. Sebelius* (<https://www.oyez.org/cases/2011/11-393>) decision, [writing](https://scholarship.law.nd.edu/cgi/viewcontent.cgi?article=2330&context=law_faculty_scholarship) (https://scholarship.law.nd.edu/cgi/viewcontent.cgi?article=2330&context=law_faculty_scholarship) that Chief Justice Roberts' opinion upholding the mandate as a constitutional exercise of Congress' taxing power "pushed the Affordable Care Act beyond its plausible meaning to save the statute." While a professor at the University of Notre Dame, Judge Barrett [signed a statement in a 2006](https://thehill.com/homenews/news/519219-amy-coney-barrett-signed-onto-2006-right-to-life-statement-in-newspaper) (<https://thehill.com/homenews/news/519219-amy-coney-barrett-signed-onto-2006-right-to-life-statement-in-newspaper>) advertisement opposing "abortion on demand" published in the South Bend Tribune. On the 7th Circuit, she [dissented](http://media.ca7.uscourts.gov/cgi-bin/rssExec.pl?Submit=Display&Path=Y2018/D06-25/C:17-3163;J:PerCuriam:aut:T:npDp:N:2176287:S:0) (<http://media.ca7.uscourts.gov/cgi-bin/rssExec.pl?Submit=Display&Path=Y2018/D06-25/C:17-3163;J:PerCuriam:aut:T:npDp:N:2176287:S:0>) in two court [decisions](https://www.courthousenews.com/wp-content/uploads/2019/11/Abortion.pdf) (<https://www.courthousenews.com/wp-content/uploads/2019/11/Abortion.pdf>) declining *en banc* hearings after the initial 3 judge panel struck down abortion regulations. She also dissented from a 7th Circuit Court of Appeals [decision](https://casetext.com/case/cook-cnty-v-wolf-1) (<https://casetext.com/case/cook-cnty-v-wolf-1>) in a case challenging the public charge rule, writing that she found the Trump Administration's interpretation to be reasonable. Though her prior opinions cannot definitively predict how she would rule in future individual cases before the Court, it is expected that her confirmation would shift the Court's ideological balance to a solid 6:3 conservative majority, with potential implications for case outcomes affecting a number of health policy issues for years to come.

Endnotes

Issue Brief

1. Judge Barrett is President Trump's third Supreme Court nominee, preceded by Justice Neil Gorsuch (replacing Justice Scalia in 2017) and Justice Brett Kavanaugh (replacing Justice Kennedy in 2018). (After Justice Scalia's death in February 2016, President Obama nominated Judge Merrick Garland to fill the open seat, but Senate Republicans refused to consider the nomination, arguing at that time that the vacancy occurred too close to the November Presidential election.)

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2. In an earlier challenge to the ACA's constitutionality, *National Federation of Independent Business (NFIB) v. Sebelius* (<https://www.kff.org/health-reform/issue-brief/a-guide-to-the-supreme-courts-affordable/>), a divided Court upheld the individual mandate as valid exercise of Congress's taxing power. In reaching this decision, Chief Justice Roberts was joined by Justice Ginsburg, along with Justices Breyer, Kagan, and Sotomayor. The dissent, joined by Justices Alito, Kennedy, Scalia, and Thomas,

concluded that the mandate was unconstitutional and consequently the entire ACA could no longer stand. The Court's *NFIB* decision also found that Congress could not require states to adopt the ACA's Medicaid expansion (<https://www.kff.org/health-reform/issue-brief/a-guide-to-the-supreme-courts-decision/>), effectively making expansion a state option; only Justices Ginsburg and Sotomayor dissented from that part of the opinion. In a subsequent case, *King v. Burwell* (<https://www.kff.org/health-reform/issue-brief/are-premium-subsidies-available-in-states-with-a-federally-run-marketplace-a-guide-to-the-supreme-court-argument-in-king-v-burwell/>), Chief Justice Roberts was joined by Justice Ginsburg, along with Justices Kennedy, Breyer, Sotomayor, and Kagan, in upholding an IRS rule making ACA premium subsidies available to individuals purchasing coverage in states that have not established their own Marketplace but instead participate in a federally-run Marketplace.

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3. Medicaid waivers are popular, with 55 waivers approved across 43 states (<https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/>) as of September 1, 2020. Some of these waivers are comprehensive (<https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-the-current-landscape-of-approved-and-pending-waivers/>), making broad changes in Medicaid eligibility, benefits and cost-sharing, and provider payments across their programs, while other waivers focus more narrowly on specific services or populations.

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4. Section 1115 of the Social Security Act (https://www.ssa.gov/OP_Home/ssact/title11/1115.htm) allows the Secretary to waive state compliance with certain federal Medicaid requirements if the Secretary determines that the initiative is an “experimental, pilot, or demonstration project” that “is likely to assist in promoting the objectives of the program.”

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Filling the need for trusted information on national health issues, the Kaiser Family Foundation is a nonprofit organization based in San Francisco, California.

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2020

ANNUAL SURVEY

KFF

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Filling the need for trusted information on national health issues, KFF (Kaiser Family Foundation) is a nonprofit organization based in San Francisco, California.

NORC at the University of Chicago is an objective, non-partisan research institution that delivers reliable data and rigorous analysis to guide critical programmatic, business, and policy decisions. Since 1941, NORC has conducted groundbreaking studies, created and applied innovative methods and tools, and advanced principles of scientific integrity and collaboration. Today, government, corporate, and nonprofit clients around the world partner with NORC to transform increasingly complex information into useful knowledge.

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Abstract

This annual survey of employers provides a detailed look at trends in employer-sponsored health coverage, including premiums, employee contributions, cost-sharing provisions, offer rates, wellness programs, and employer practices. The 2020 survey included 1,765 interviews with non-federal public and private firms.

Annual premiums for employer-sponsored family health coverage reached \$21,342 this year, up 4% from last year, with workers on average paying \$5,588 toward the cost of their coverage. The average deductible among covered workers in a plan with a general annual deductible is \$1,644 for single coverage. Fifty-five percent of small firms and 99% of large firms offer health benefits to at least some of their workers, with an overall offer rate of 56%.

Survey results are released in several formats, including a full report with downloadable tables on a variety of topics, a summary of findings, and an article published in the journal *Health Affairs*.

Summary of Findings

Employer-sponsored insurance covers approximately 157 million people.¹ To provide current information about employer-sponsored health benefits, the Kaiser Family Foundation (KFF) conducts an annual survey of private and non-federal public employers with three or more workers. This is the twenty-second Employer Health Benefits Survey (EHBS) and reflects employer-sponsored health benefits in 2020.

The social and economic upheavals resulting from the coronavirus pandemic have certainly impacted employers, workers and employee benefits. The EHBS was fielded between January and late July, which means that a portion of the interviews were conducted before the full impact of the pandemic became apparent, and other interviews were conducted as the implications unfolded; including during the period of significant job loss that occurred during and after March. Many of the metrics we look at, such as premiums, contributions, cost sharing and plan offerings, are determined before plan year begins, so it is likely that responses for those items were largely unaffected by the pandemic. Responses for other items, such as incentives for health screenings or inclusion of coverage for telehealth visits, may have changed during the course of the pandemic: employers for example, may have suspended certain incentives to accommodate employee reluctance to visit provider offices. As such we cannot determine how the pandemic has affected employer responses. Because of the timing of the survey, we were unable to include any direct questions about how employers reacted to the pandemic.

HEALTH INSURANCE PREMIUMS AND WORKER CONTRIBUTIONS

In 2020, the average annual premiums for employer-sponsored health insurance are \$7,470 for single coverage and \$21,342 for family coverage [Figure A]. The average single premium increased 4% and the average family premium increased 4% over the past year. Workers' wages increased 3.4% and inflation increased 2.1%.²

The average premium for family coverage has increased 22% over the last five years and 55% over the last ten years [Figure A].

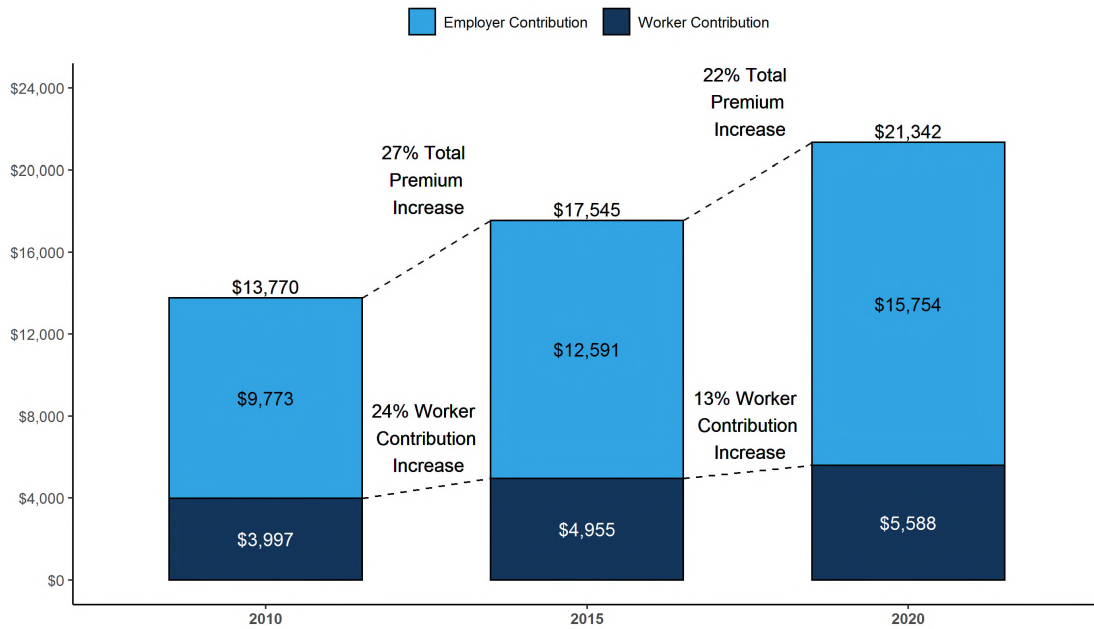
For covered workers in small firms, the average premium is similar to the average premium in large firms for single coverage (\$7,483 vs. \$7,466) but is lower than the average premium in large firms for family coverage (\$20,438 vs. \$21,691). The average premiums for covered workers in HDHP/SOs is lower for single coverage (\$6,890) but similar for family coverage (\$20,359) to the overall average premiums [Figure B]. Covered workers enrolled in PPOs have higher average premiums for single (\$7,880) and family coverage (\$22,248) than the overall average premiums. The average premium for family coverage for covered workers in firms with a relatively large share of lower-wage workers (where at least 35% of the workers earn \$26,000 annually or less) is lower than the average premium for covered workers in firms with a smaller share of lower-wage workers (\$19,332 vs. \$21,486).

¹Kaiser Family Foundation. Health Insurance Coverage of the Total Population [Internet]. KFF (Kaiser Family Foundation). 2019 [cited 2020 Aug 10]. Available from: <https://www.kff.org/other/state-indicator/total-population/> Coverage is based on calculations from the 2018 American Community Survey. During the winter and spring of 2020, there was a steep increase in the unemployment rate, potentially decreasing the number of people covered by employer coverage.

²Bureau of Labor Statistics. Consumer Price Index historical tables for, U.S. City Average of Annual Inflation [Internet]. Washington (DC): BLS; [cited 2020 Aug 10]. Available from: https://www.bls.gov/regions/mid-atlantic/data/consumerpriceindexhistorical1967base_us_table.htm AND Bureau of Labor Statistics. Current Employment Statistics—CES (National) [Internet]. Washington (DC): BLS; [cited 2020 Aug 10]. Available from: <https://www.bls.gov/ces/publications/highlights/highlights-archive.htm>

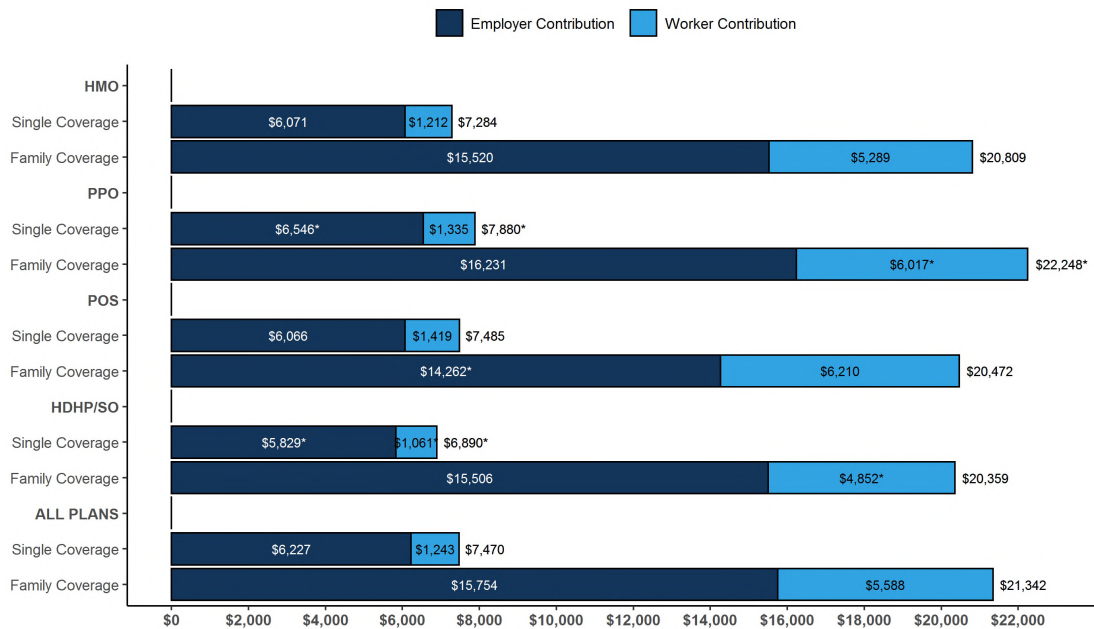
SUMMARY OF FINDINGS

Figure A
Average Annual Worker and Employer Premium Contributions for Family Coverage, 2010, 2015, and 2020



SOURCE: KFF Employer Health Benefits Survey, 2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010 and 2015

Figure B
Average Annual Worker and Employer Premium Contributions for Single and Family Coverage, by Plan Type, 2020



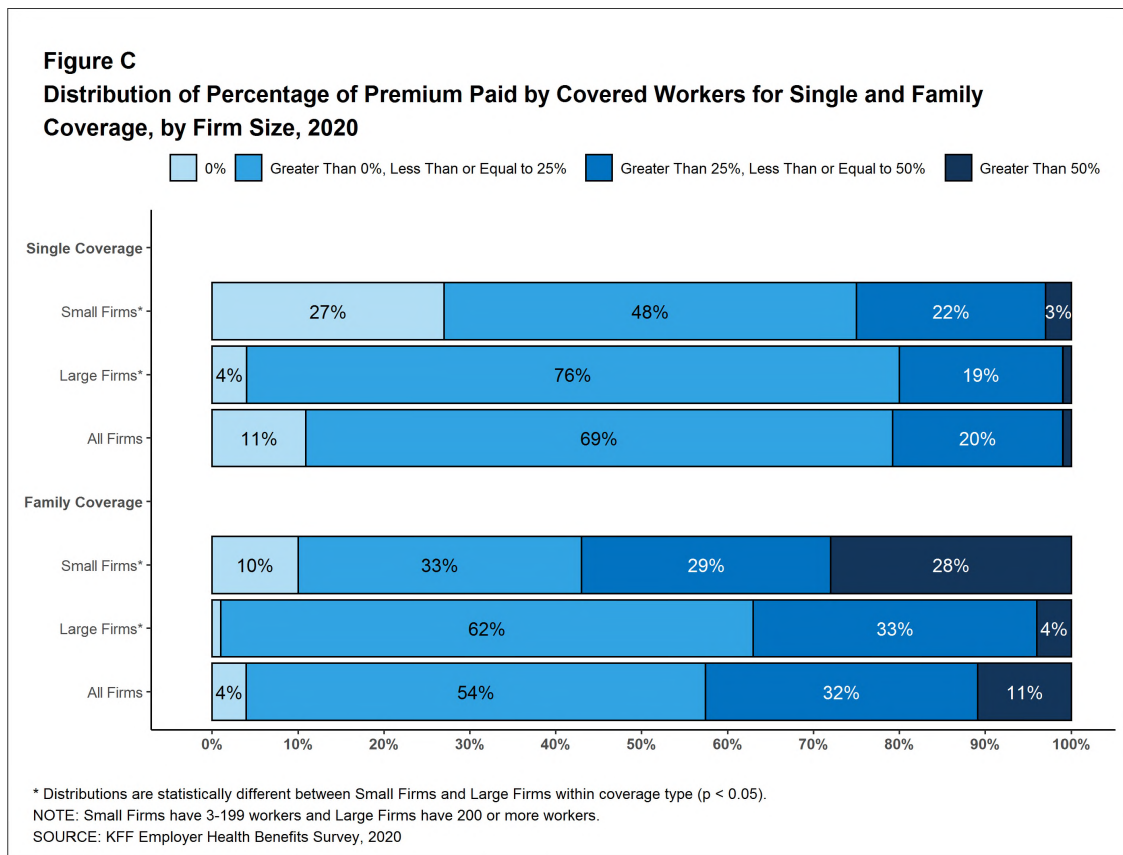
* Estimate is statistically different from All Plans estimate within coverage type (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2020

SUMMARY OF FINDINGS

Most covered workers make a contribution toward the cost of the premium for their coverage. On average, covered workers contribute 17% of the premium for single coverage and 27% of the premium for family coverage. Compared to covered workers in large firms, covered workers in small firms on average contribute a higher percentage of the premium for family coverage (35% vs. 24%). Covered workers in firms with a relatively large share of lower-wage workers have higher average contribution rates for family coverage (38% vs. 26%) than those in firms with a smaller share of lower-wage workers.³ Covered workers at private for-profit firms on average contribute a higher percentage of the premium for both single and family coverage than covered workers at other firms for both single and family coverage.

Twenty-seven percent of covered workers in small firms are in a plan where the employer pays the entire premium for single coverage, compared to only 4% of covered workers in large firms. In contrast, 28% of covered workers in small firms are in a plan where they must contribute more than one-half of the premium for family coverage, compared to 4% of covered workers in large firms [Figure C].

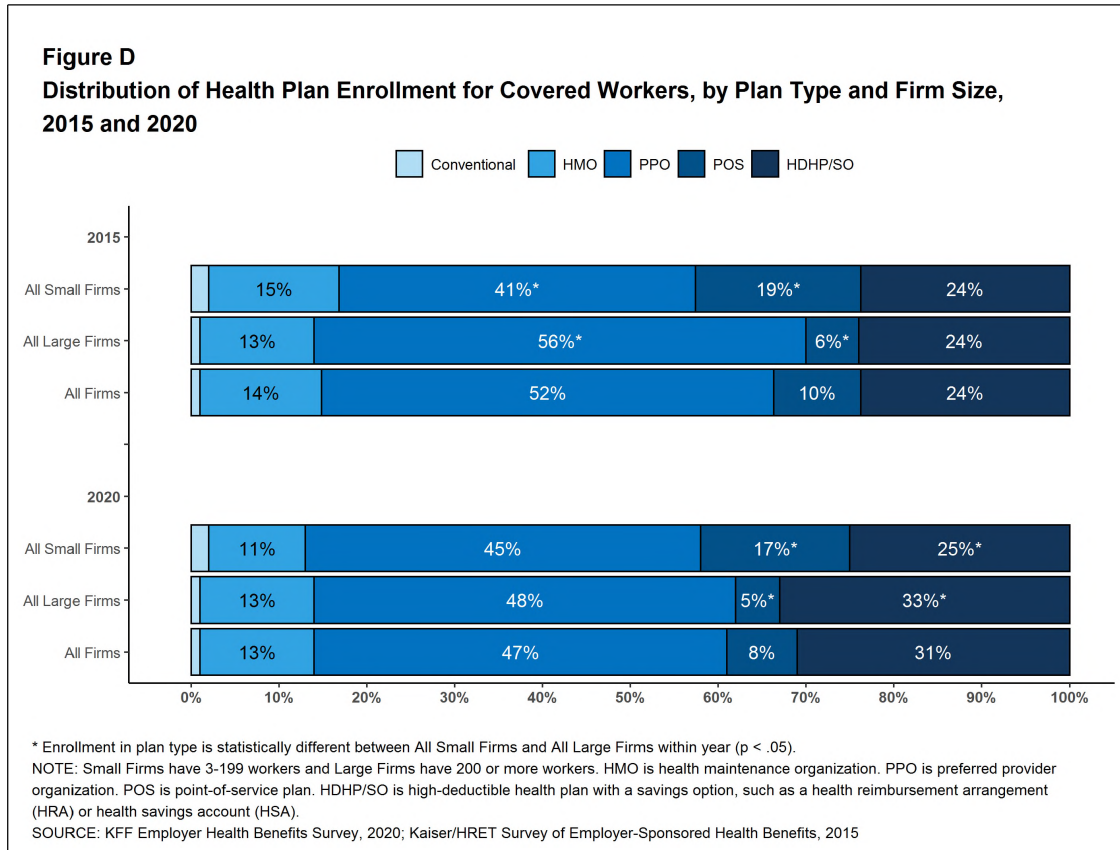
The average annual dollar amounts contributed by covered workers for 2020 are \$1,243 for single coverage and \$5,588 for family coverage, similar to the amounts last year. The average dollar contribution for family coverage has increased 13% since 2015 and 40% since 2010 [Figure A]. Average contribution amounts for covered workers in HDHP/SOs are lower than the average overall worker contribution amounts for both single and family coverage [Figure B]. Six percent of covered workers, including 17% of covered workers in small firms, are in a plan with a worker contribution of \$12,000 or more for family coverage.



³This threshold is based on the twenty-fifth percentile of workers' earnings (\$26,000 in 2020). Bureau of Labor Statistics. May 2018 National Occupational Employment and Wage Estimates: United States. Washington (DC): BLS. Available from: http://www.bls.gov/oes/current/oes_nat.htm

PLAN ENROLLMENT

PPOs are the most common plan type, enrolling 47% of covered workers in 2020. Thirty-one percent of covered workers are enrolled in a high-deductible plan with a savings option (HDHP/SO), 13% in an HMO, 8% in a POS plan, and 1% in a conventional (also known as an indemnity) plan [Figure D]. The percentage of covered workers enrolled in HMOs is significantly lower than the percentage last year (13% vs. 19%). This percentage has risen and fallen over the last four years so it is unclear if this trend will continue.



Self-Funding. Sixty-seven percent of covered workers, including 23% of covered workers in small firms and 84% in large firms, are enrolled in plans that are self-funded. The percentage of firms offering health benefits that are self-funded in 2020 is higher than the percentage (61%) last year.

Thirteen percent of small firms report that they have a level-funded plan, similar to the percentage last year. These arrangements combine a relatively small self-funded component with stoploss insurance with low attachment points that may transfer a substantial share of the risk to insurers. These arrangements are complex and some small employers may not be entirely certain about the funding status of their plans. Among covered workers in small firms, 31% are in a plan that is either self-funded or told us that their plan was level-funded, higher than the percentage (24%) last year.

EMPLOYEE COST SHARING

Most covered workers must pay a share of the cost when they use health care services. Eighty-three percent of covered workers have a general annual deductible for single coverage that must be met before most services are paid for by the plan.

Among covered workers with a general annual deductible, the average deductible amount for single coverage is \$1,644, similar to the average deductible last year. The average deductible for covered workers is higher in small firms than large firms (\$2,295 vs. \$1,418). The average single coverage annual deductible among covered workers with a deductible has increased 25% over the last five years and 79% over the last ten years.

Deductibles have increased in recent years due to higher deductibles within plan types and higher enrollment in HDHP/SOs. While growing deductibles in PPOs and other plan types generally increase enrollee out-of-pocket liability, the shift to enrollment in HDHP/SOs does not necessarily do so if HDHP/SO enrollees receive an offsetting account contribution from their employers. Ten percent of covered workers in an HDHP with a Health Reimbursement Arrangement (HRA), and 3% of covered workers in a Health Savings Account (HSA)-qualified HDHP receive an account contribution for single coverage at least equal to their deductible, while another 41% of covered workers in an HDHP with an HRA and 19% of covered workers in an HSA-qualified HDHP receive account contributions that, if applied to their deductible, would reduce their actual liability to less than \$1,000.

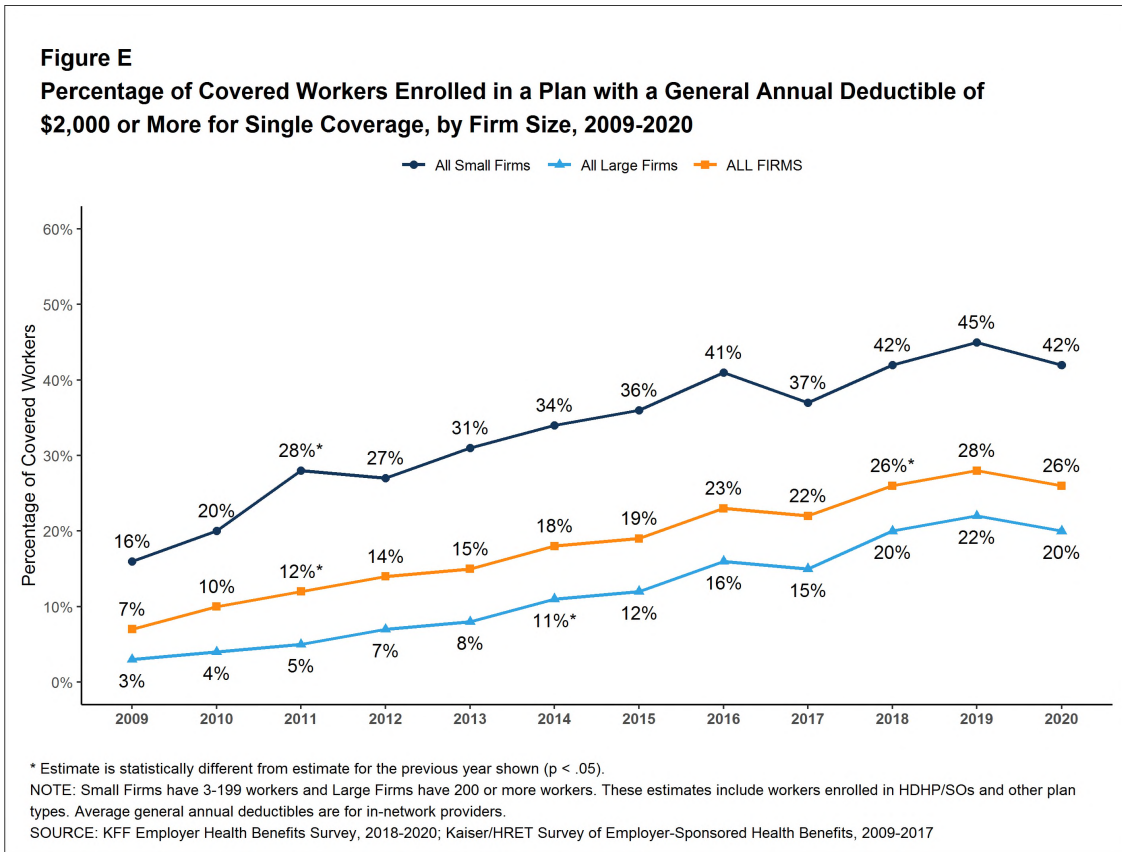
We can look at the increase in the average deductible as well as the growing share of covered workers who have a deductible together by calculating an average deductible among *all* covered workers (assigning a zero to those without a deductible). The 2020 value of \$1,364 is 27% higher than the average general annual deductible for single coverage of \$1,077 in 2015 and 111% higher than the average general annual deductible of \$646 in 2010.

Another way to look at deductibles is the percentage of all covered workers who are in a plan with a deductible that exceeds certain thresholds. Over the past five years, the percentage of covered workers with a general annual deductible of \$2,000 or more for single coverage has grown from 19% to 26% [Figure E].

Whether or not a deductible applies, a large share of covered workers also pay a portion of the cost when they visit an in-network physician. Most covered workers face a copayment (a fixed dollar amount) when they visit a doctor, although some workers face coinsurance requirements (a percentage of the covered amount). The average copayments are \$26 for primary care and \$42 for specialty care. The average coinsurance rates are 18% for primary care and 19% for specialty care. These amounts are similar to those in 2019.

Most workers also face additional cost sharing for a hospital admission or outpatient surgery. Sixty-five percent of covered workers have coinsurance and 13% have a copayment for hospital admissions. The average coinsurance rate for a hospital admission is 20% and the average copayment is \$311 per hospital admission. The cost-sharing provisions for outpatient surgery follow a similar pattern to those for hospital admissions.

Virtually all covered workers are in plans with a limit on in-network cost sharing (called an out-of-pocket maximum) for single coverage, though the limits vary significantly. Among covered workers in plans with an out-of-pocket maximum for single coverage, 11% are in a plan with an out-of-pocket maximum of less than \$2,000, while 18% are in a plan with an out-of-pocket maximum of \$6,000 or more.



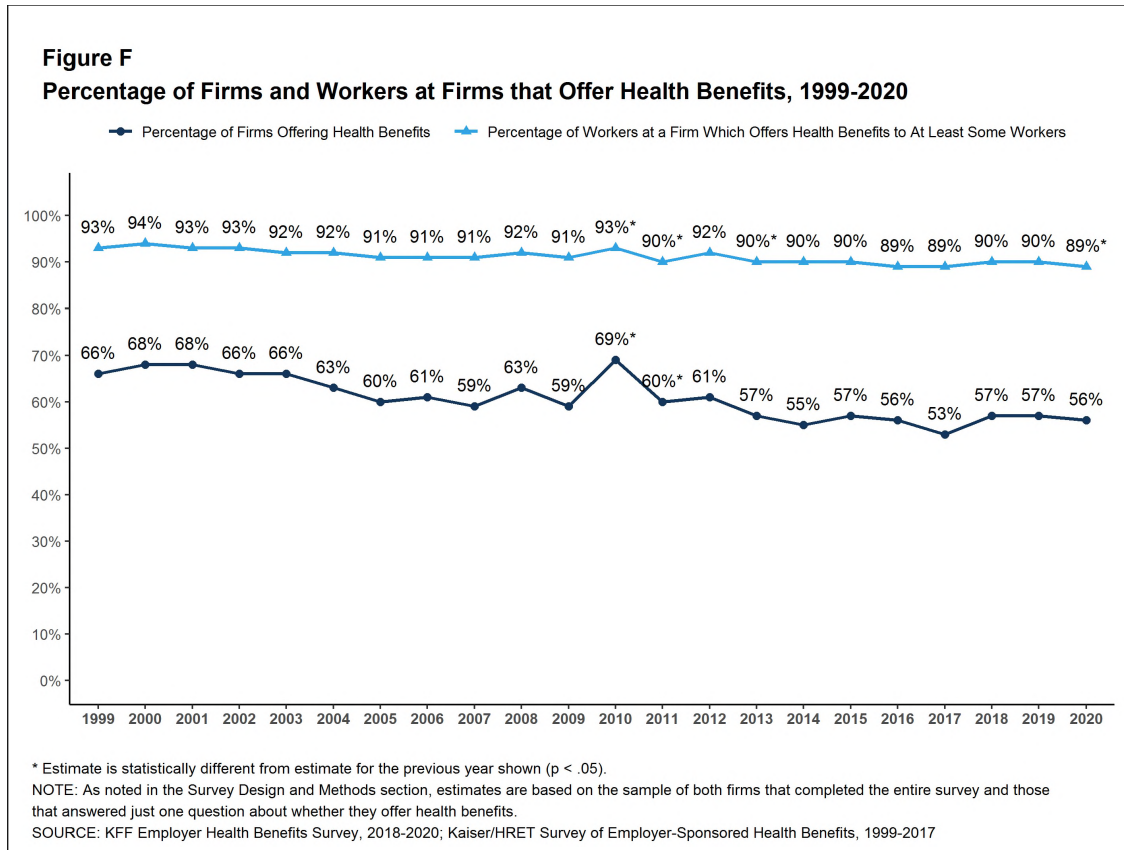
AVAILABILITY OF EMPLOYER-SPONSORED COVERAGE

Fifty-six percent of firms offer health benefits to at least some of their workers, similar to the percentage last year [Figure F]. The likelihood of offering health benefits differs significantly by firm size; only 48% of firms with 3 to 9 workers offer coverage, while virtually all firms with 1,000 or more workers offer coverage.

While the vast majority of firms are small, most workers work for large firms that offer coverage. In 2020, 89% of workers are employed by a firm that offers health benefits to at least some of its workers [Figure F].

Although the vast majority of workers are employed by firms that offer health benefits, many workers are not covered at their job. Some are not eligible to enroll (e.g., waiting periods or part-time or temporary work status) and others who are eligible choose not to enroll (e.g., they feel the coverage is too expensive or they are covered through another source). In firms that offer coverage, 82% of workers are eligible for the health benefits offered, and of those eligible, 78% take up the firm's offer, resulting in 64% of workers in offering firms enrolling in coverage through their employer. All of these percentages are similar to 2019.

Looking at workers in both firms that offer and firms that do not offer health benefits, 57% of workers are covered by health plans offered by their employer, similar to the percentage last year.



HEALTH AND WELLNESS PROGRAMS

Most large firms and many small firms have programs that help workers identify health issues and manage chronic conditions, including health risk assessments, biometric screenings, and health promotion programs.

Health Risk Assessments. Among firms offering health benefits, 42% of small firms and 60% of large firms provide workers the opportunity to complete a health risk assessment [Figure G]. A health risk assessment includes questions about a person’s medical history, health status, and lifestyle. Fifty-two percent of large firms with a health risk assessment program offer an incentive to encourage workers to complete the assessment. Incentives may include: gift cards, merchandise or similar rewards; lower premium contributions or cost sharing; and financial rewards, such as cash, contributions to health-related savings accounts, or avoiding a payroll fee.

Biometric Screenings. Among firms offering health benefits, 33% of small firms and 50% of large firms provide workers the opportunity to complete a biometric screening. A biometric screening is an in-person health examination that measures a person’s risk factors, such as body mass index (BMI), cholesterol, blood pressure, stress, and nutrition. Sixty-five percent of large firms with biometric screening programs offer workers an incentive to complete the screening.

Additionally, among large firms with biometric screening programs, 18% reward or penalize workers based on achieving specified biometric outcomes (such as meeting a target BMI). The size of these incentives varies considerably: among large firms offering a reward or penalty for meeting biometric outcomes, the maximum reward is valued at \$150 or less in 12% of firms and more than \$1,000 in 32% of firms.

Effectiveness of Incentives. This year we asked large firms with an incentive to participate in a health promotion or health screening program, how effective they believed these incentives were at increasing employee participation. 30% believed incentives were ‘very effective’ and 47% believed they were ‘moderately effective’.

Health and Wellness Promotion Programs. Most firms offering health benefits offer programs to help workers identify and address health risks and unhealthy behaviors. Fifty-three percent of small firms and 81% of large firms offer a program in at least one of these areas: smoking cessation, weight management, and behavioral or lifestyle coaching. Among large firms offering at least one of these programs, 44% offer workers an incentive to participate in or complete the program [Figure G].

As health screenings and wellness programs have become more complex, incentives have become more sophisticated and may involve participating in or meeting goals in different programs. We asked firms that had incentives for any of these programs to estimate the maximum incentive for a worker across all of their screening and promotion programs combined. Among large firms with any type of incentive, 20% have a maximum incentive of \$150 or less, while 20% have a maximum incentive of more than \$1,000.

Effectiveness of Programs. Firms may have a variety of objectives for offering health screening and health promotion programs, including improving the health and wellbeing of enrollees, reducing absences from work, and reducing costs. Firms generally responded that their programs were effective to some degree in meeting certain specified objectives, although there were many who responded that they did not know [Figure H].

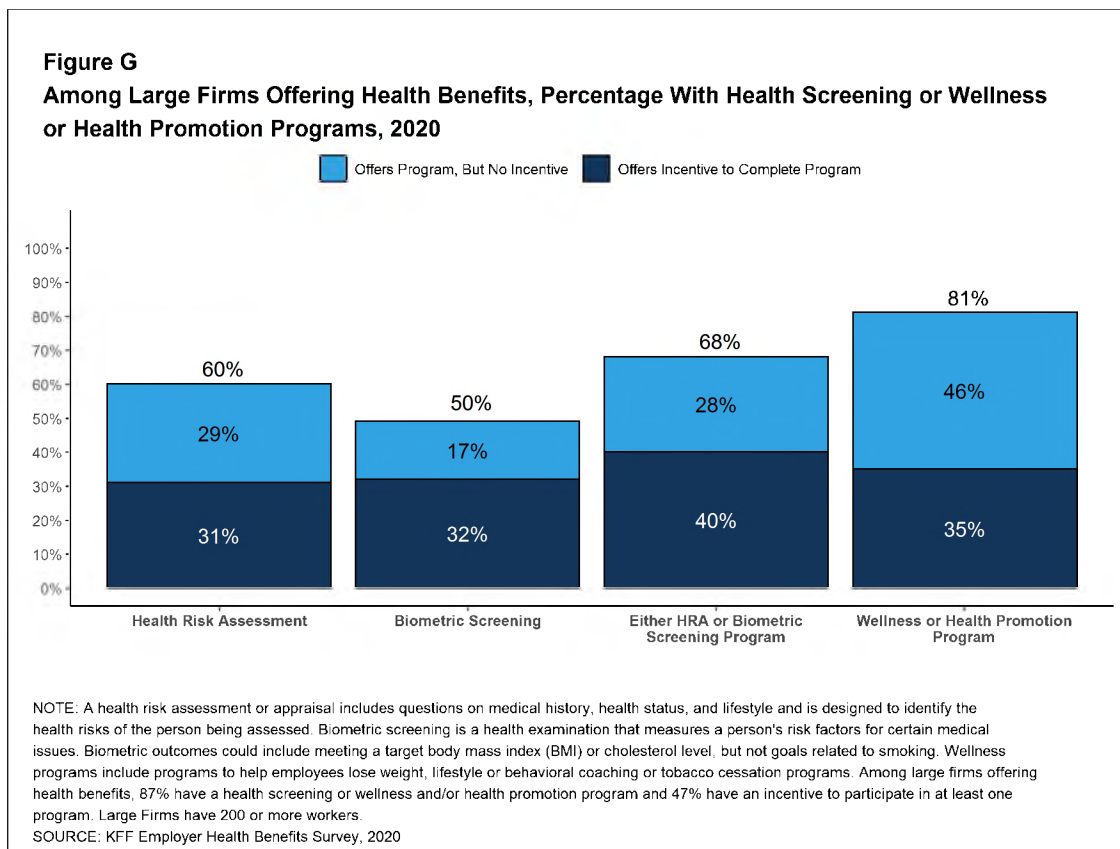
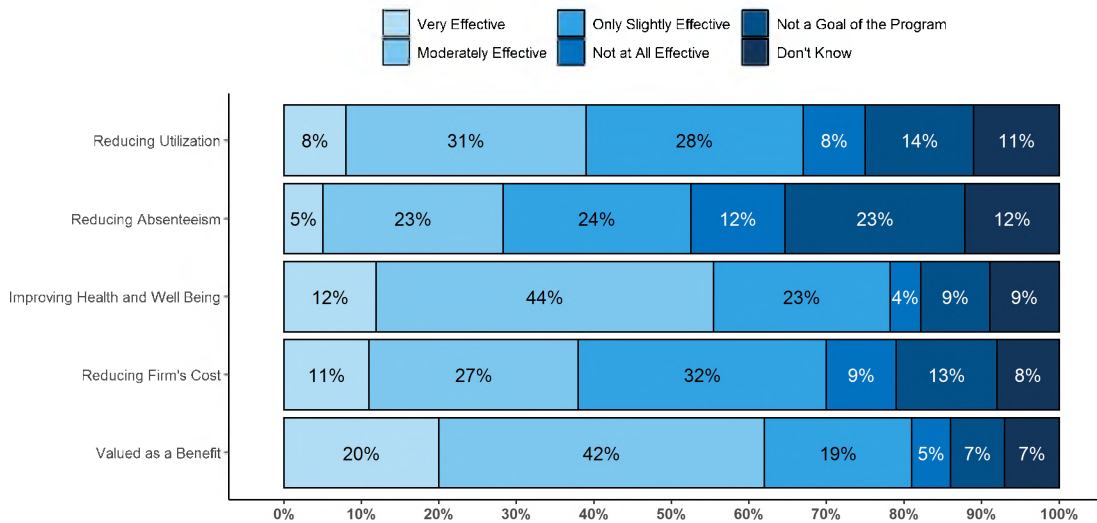


Figure H
Among Large Firms Offering Health Benefits and a Wellness or Health Screening Programs, Firms Opinion of How Effective Programs are at Meeting Various Goals, 2020



NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Wellness programs include programs to help employees lose weight, lifestyle or behavioral coaching or tobacco cessation programs. Among large firms offering health benefits, 87% have a health screening or wellness and/or health promotion program. Large Firms have 200 or more workers. SOURCE: KFF Employer Health Benefits Survey, 2020

SITES OF CARE

Telemedicine. Telemedicine is the delivery of health care services through telecommunications to a patient from a provider who is at a remote location, including video chat and remote monitoring. In 2020, 85% of firms with 50 or more workers offering health benefits cover the provision of health care services through telemedicine in their largest health plan, higher than the percentage last year. Offering firms with 5,000 or more workers are more likely to cover services provided through telemedicine than smaller firms.

Over the past year, there was a significant increase in the percentage of firms, particularly smaller firms (50-199 workers), reporting that they cover some services through telemedicine. While telemedicine has grown in recent years, it is possible that some of the growth this year reflects changes in response to the coronavirus pandemic as well as to an increased awareness. It will be important to watch if this heightened focus on access to care through telemedicine continues or abates as concerns about the coronavirus recede.

Retail Health Clinics. Seventy-six percent of large firms offering health benefits cover health care services received in retail clinics, such as those located in pharmacies, supermarkets and retail stores, in their largest health plan. These clinics are often staffed by nurse practitioners or physician assistants and treat minor illnesses and provide preventive services.

PROVIDER NETWORKS

Firms and health plans can structure their networks of providers and their cost sharing to encourage enrollees to use providers who charge lower costs and/or who provide better care. This involves assuring that there are a

sufficient number of providers to assure reasonable access while also limiting the network to those that deliver good quality and cost-effective care.

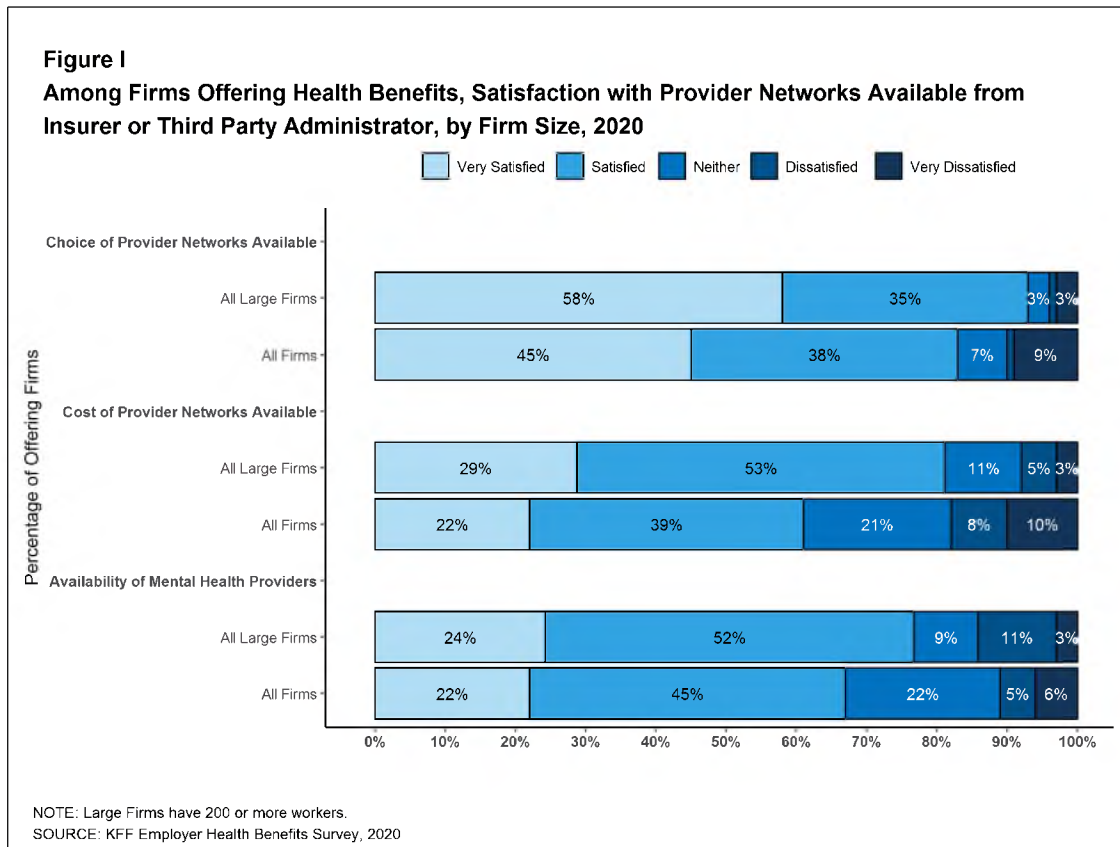
Satisfaction with Network Choices. Among employers offering health benefits, 45% of firms report being ‘very satisfied’ and 38% report being ‘satisfied’ by the choice of provider networks available to them [Figure I]. They are somewhat less satisfied with the cost of the provider networks available to them. Only 22% of these firms report being ‘very satisfied’ while 39% report being ‘satisfied’ with the cost of provider networks available. Small firms are more likely than large firms to be ‘very dissatisfied’ with the cost of the provider networks available.

Breadth of Provider Networks. Employers offering health benefits were asked to characterize the breadth of the provider network in their plan with the largest enrollment. Fifty-one percent of firms say that the network in the plan with the largest enrollment is ‘very broad’, 42% say it is ‘somewhat broad’, and 6% say it is ‘somewhat narrow’.

Seven percent of firms offering health benefits report that they offer at least one plan that they considered to be a narrow network plan, similar to the percentage last year. Firms with 5,000 or more workers were more likely to offer a narrow network plan than smaller firms.

Breadth of Provider Networks for Mental Health. Employers offering health benefits were also asked to characterize the breadth of the network for mental health and substance abuse providers in their plan with the largest enrollment. Thirty-five percent of firms say that the network for mental health and substance abuse in the plan with the largest enrollment is ‘very broad’, 46% say it is ‘somewhat broad’, 15% say it is ‘somewhat narrow’, and 4% say it is ‘very narrow’.

Only about one-in-five (22%) employers offering health benefits report being very satisfied with the availability of mental health providers in their provider networks. Among employers offering health benefits, 15% of employers with 1,000 to 4,999 employees and 23% of employers with 5,000 or more employees asked their insurer or third party administrator to increase access to in-network mental health and substance abuse providers.



COST SHARING FOR PEOPLE WITH CHRONIC CONDITIONS

Among employers with 200 or more employees offering health benefits, 21% say that their health plan with the largest enrollment waives cost-sharing for some medications or supplies to encourage employees with chronic illnesses to follow their treatment. This likelihood increases with firm size.

Recent changes in federal rules expanded the number and types of items and services that may be considered preventive by HSA-qualified health plans, allowing plan sponsors to pay for part or all of these services before enrollees meet the plan deductibles. Among employers with 200 or more employees offering an HSA-qualified health plan, 29% say that they changed the services or products that individuals with chronic conditions could receive without first meeting their deductibles. Firms with 5,000 or more employees (48%) are more likely to say they changed the services or products available before the deductible is met.

DISCUSSION

Looking at the metrics we usually consider, such as premiums, contributions, cost sharing, offer and coverage rates, we would conclude that the marketplace for employer-based health coverage had another stable year in 2020. Premium increases were modest and consistent with recent years, contributions and cost sharing largely did not change, nor did the shares of workers offered coverage or covered at their jobs. There is a meaningful increase in the share of workers in self-funded plans, which will be important to understand if the higher level persists. We will include additional questions in the 2021 survey to explore why employers are taking this option.

Of course the economic and social changes caused by the coronavirus pandemic have dramatically changed the employment landscape across the nation. Unprecedented job loss combined with shelter-at-home requirements and continuing delays in reopening of workplaces and schools are challenging employers and workers in many ways, including health benefits. There are questions, for example, about the continued availability of coverage for furloughed workers, the share of laid-off workers who are electing COBRA continuation coverage, and changes being made to employee assistance programs and health benefit plans to support workers with the emotional, social and financial stresses. As noted above, however, because the survey was fielded as the pandemic unfolded, we are not yet in a position to address how employers responded to the pandemic. Most of the metrics discussed above are fixed at the beginning of the plan year and may not reflect current circumstances. Some other responses may have been affected by the unfolding of the pandemic.

While we observed a relatively modest change in premiums in 2020, this does not capture the pandemic's turbulent impacts on health care costs this year. During the spring, employers and plans saw lower health care utilization and correspondingly lower spending. With enrollees skipping some care, insurers reported lower than predicted cost through the first half of the year. As stay-at-home orders have lifted, health care utilization has again started picking up. Spending in 2021 remains uncertain as employers and insurers continue to adapt to an evolving situation. We do not know how the reduced use of care earlier this year will affect future costs and premiums: in some cases the need for care will have passed but in others the care will just have been deferred. Missed preventive and diagnostic care may also lead to worsening health and higher costs in the future. Beyond any potential pent-up demand, employer-based plans may face higher costs due to new COVID-19 tests, treatments and vaccines. Conversely, we have witnessed a dramatic economic slowdown which may lead to reduced utilization, offsetting some cost on plans.

For a year that started with historically low levels of unemployment, 2020 saw a stark increase in the unemployment rate. A less competitive job market and the economic slowdown may reduce pressure on employers to offer competitive benefit packages in the coming year. We largely reported similar average cost-sharing amounts to 2019 but some employers may be considering reducing plan generosity depending on how the economic crisis unfolds.

The challenge for the 2021 survey will be to understand how employers are responding to the pandemic and accompanying economic fallout while still maintaining the core questions and purpose of the survey. We do not know how long the pandemic will last nor what the longer term economic consequences will be, but we can ask

employers about how this uncertainty affected their benefit plan decisions, what types of benefits they added and/or changed, whether they saw changes in how employees used their benefits, and whether they expect any changes to be more permanent. We also expect to ask how the disruption and uncertainty caused by the pandemic affected employer decisions about changing their plans or shopping for new vendors. The pandemic has already affected many employer benefits, and will continue to shape their decision-making as they anticipate new workplace accommodations, changes in premiums and the direct cost of the pandemic.

METHODOLOGY

The Kaiser Family Foundation 2020 Employer Health Benefits Survey reports findings from a telephone survey of 1,765 randomly selected non-federal public and private employers with three or more workers. Researchers at NORC at the University of Chicago and the Kaiser Family Foundation designed and analyzed the survey. Davis Research, LLC conducted the fieldwork between January and July 2020. In 2020, the overall response rate is 22%, which includes firms that offer and do not offer health benefits. Among firms that offer health benefits, the survey's response rate is 22%. Unless otherwise noted, differences referred to in the text and figures use the 0.05 confidence level as the threshold for significance. Small firms have 3-199 workers. Values below 3% are not shown on graphical figures to improve the readability of those graphs. Some distributions may not sum due to rounding. For the first time since 1999, we contracted with a new data collection firm to conduct the survey. For more information on potential 'house effects' resulting from this change, as well as information on changes to our weighting methodology and measurements of workers' wage and inflation see the Survey Design and Methods section.

For more information on the survey methodology, please visit the Survey Design and Methods section at <http://ehbs.kff.org/>.

Filling the need for trusted information on national health issues, the Kaiser Family Foundation is a nonprofit organization based in San Francisco, California.

EMPLOYER HEALTH BENEFITS

2020 ANNUAL SURVEY

Survey Design
and
Methods

56%
\$21,342
\$7,470
2020

Survey Design and Methods

The Kaiser Family Foundation (KFF) has conducted this annual survey of employer-sponsored health benefits since 1999. KFF works with NORC at the University of Chicago (NORC) and Davis Research LLC (Davis) to field and analyze the survey. From January to July 2020, Davis completed computer-assisted telephone interviews with business owners as well as human resource and benefits managers at 1,765 firms.

SURVEY TOPICS

The survey includes questions on the cost of health insurance, health benefit offer rates, coverage, eligibility, plan type enrollment, premium contributions, employee cost sharing, prescription drug benefits, retiree health benefits, and wellness benefits.

Firms that offer health benefits are asked about the plan attributes of their largest health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) plan, and high-deductible health plan with a savings option (HDHP/SO).⁴ We treat exclusive provider organizations (EPOs) and HMOs as one plan type and conventional (or indemnity) plans as PPOs. The survey defines an HMO as a plan that does not cover nonemergency out-of-network services. POS plans use a primary care gatekeeper to screen for specialist and hospital visits. HDHP/SOs were defined as plans with a deductible of at least \$1,000 for single coverage and \$2,000 for family coverage and that either offer a health reimbursement arrangement (HRA) or are eligible for a health savings account (HSA).

Throughout this report, we use the term “in-network” to refer to services received from a preferred provider. Definitions of the health plan types are available in Section 4, and a detailed explanation of the HDHP/SO plan type is in Section 8.

To reduce survey burden, some questions on worker cost sharing for stoploss coverage, hospitalization, outpatient surgery and prescription drugs were only asked about the firm's largest plan type.

Firms with 50 or more workers were asked: “Does your firm offer health benefits for current employees through a private or corporate exchange?” Employers were still asked for plan information about their HMO, PPO, POS and HDHP/SO plan regardless of whether they purchased health benefits through a private exchange or not.

Firms are asked about the attributes of their current plans during the interview. While the survey's fielding period begins in January, many respondents may have a plan whose 2020 plan year lags behind the calendar year [Figure M.1]. In some cases, plans may report the attributes of their 2019 plans and some plan attributes (such as HSA deductible limits) may not meet the calendar year regulatory requirements.

⁴HDHP/SO includes high-deductible health plans with a deductible of at least \$1,000 for single coverage and \$2,000 for family coverage and that offer either a Health Reimbursement Arrangement (HRA) or a Health Savings Account (HSA). Although HRAs can be offered along with a health plan that is not an HDHP, the survey collected information only on HRAs that are offered along with HDHPs. For specific definitions of HDHPs, HRAs, and HSAs, see the introduction to Section 8.

Figure M.1**Among Firms Offering Health Benefits, Month in Which Plan Year Begins, 2020**

	Percentage of Covered Workers	Percentage of Firms
January	74%	46%
February	<1	2
March	1	6
April	2	3
May	1	3
June	2	5
July	7	4
August	1	3
September	2	3
October	3	7
November	2	5
December	4%	13%

SOURCE: KFF Employer Health Benefits Survey, 2020

The Affordable Care Act (ACA) exempts certain health plans that were in effect when the law was passed, referred to as grandfathered plans, from some standards in the law, including the requirement to cover preventive services without cost sharing, have an external appeals process, or comply with the new benefit and rating provisions in the small group market. In 2020, 16% of firms offering health benefits offer at least one grandfathered health plan, and 14% of covered workers are enrolled in a grandfathered plan.

SAMPLE DESIGN

The sample for the annual Kaiser Employer Health Benefits Survey includes private firms and nonfederal government employers with three or more employees. The universe is defined by the U.S. Census' 2016 Statistics of U.S. Businesses (SUSB) for private firms and the 2017 Census of Governments (COG) for non-federal public employers. At the time of the sample design (December 2019), these data represented the most current information on the number of public and private firms nationwide with three or more workers. As in the past, the post-stratification is based on the most up-to-date Census data available (the 2017 SUSB). We determine the sample size based on the number of firms needed to ensure a target number of completes in six size categories.

We attempted to repeat interviews with prior years' survey respondents (with at least ten employees) who participated in either the 2018 or the 2019 survey, or both. Firms with 3-9 employees are not included in the panel to minimize the potential of panel effects. As a result, 1,235 of the 1,765 firms that completed the full survey also participated in either the 2018 or 2019 surveys, or both. In total, 243 firms participated in 2018, 169 firms participated in 2019, and 823 firms participated in both 2018 and 2019. Non-panel firms are randomly selected within size and industry groups.

Since 2010, the sample has been drawn from a Dynata list (based on a census assembled by Dun and Bradstreet) of the nation's private employers and the COG for public employers. To increase precision, we stratified the sample by ten industry categories and six size categories. The federal government and business with fewer than three employees are not included. Education is a separate category for the purposes of sampling, and included in Service category for weighting. For information on changes to the sampling methods over time, please consult

the Survey Design and Methods Sections of prior Employer Health Benefits Surveys as well as extended methods at <http://ehbs.kff.org/>

Each year, we conduct a series of checks on our instrument to confirm the accuracy of data collection, including test interviews prior to the official launch. Beginning in 2019, we included firms with at least ten employees that had completed a pre-test during the prior year in the current year’s sample. Starting in 2020, we included firms completing a pre-test during either of the two prior surveys. Firms eligible to complete pre-testing had been sampled from the same two universe datasets as the main non-panel sample, differing only by when they made contact with the interview team. We expect to continue including these firms completing an interview during the pre-testing phase of our survey, and believe they will improve our response rate without adding any bias to our data collection effort.

RESPONSE RATE

Response rates are calculated using a CASRO method, which accounts for firms that are determined to be ineligible in its calculation. The overall response rate is 22% [Figure M.2].⁵ The response rate for panel firms is higher than the response rate for non-panel firms. Similar to other employer and household surveys, the Employer Health Benefits Survey has seen a general decrease in response rates over time. Since 2017, we have attempted to increase the number of completes by increasing the number of non-panel firms in the sample. While this generally increases the precision of estimates by ensuring a sufficient number of respondents in various sub-groups, it has the effect of reducing the overall response rate.

The vast majority of questions are asked only of firms that offer health benefits. A total of 1,418 of the 1,765 responding firms indicated they offered health benefits. This year we have a smaller number of completes than in previous years (247 fewer respondents). The decrease may be attributed to a combination of factors including changing data collection firms, disruptions from the COVID-19 pandemic and starting the fielding period later into January.

We asked one question of all firms in the study with which we made phone contact but where the firm declined to participate: “Does your company offer a health insurance program as a benefit to any of your employees?”. A total of 3,582 firms responded to this question (including 1,765 who responded to the full survey and 1,817 who responded to this one question). These responses are included in our estimates of the percentage of firms offering health benefits.⁶ The response rate for this question is 46% [Figure M.2].

Figure M.2		
Response Rates for Various Subsets of the Sample, 2020		
	Response Rate for Full Survey	Response Rate for Firms Answering A6
Small Firms (3-9 Workers)	19%	44%
Small Firms (3-199 Workers)	26%	51%
Large Firms (200 or More Workers)	20%	41%
Panel Firms (Completed Survey in at Least One of the Past Two Years)	51%	74%
Non Panel Firms	11%	36%
ALL FIRMS	22%	46%

SOURCE: KFF Employer Health Benefits Survey, 2020

⁵Response rate estimates are calculated by dividing the number of completes over the number of refusals and the fraction of the firms with unknown eligibility to participate estimated to be eligible. Firms determined to be ineligible to complete the survey are not included in the response rate calculation.

⁶Estimates presented in [Figure 2.1], [Figure 2.2], [Figure 2.3], [Figure 2.4], [Figure 2.5], and [Figure 2.6] are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

While response rates have decreased, elements of the survey design limit the potential impact of a response bias. First, most major statistics are weighted by the percentage of covered workers at a firm. The percentage of the population whose employers completed the full survey has not decreased with response rates. The most important statistic that is weighted by the number of employers is the offer rate; firms that do not complete the full survey are asked whether their firm offers health benefits to any employees. As noted this question relies on a wider set of respondents than just those completing the full survey.

FIRM SIZES AND KEY DEFINITIONS

Throughout the report, we report data by size of firm, region, and industry. Unless otherwise specified, firm size definitions are as follows: small firms: 3-199 workers; and large firms: 200 or more workers. [Figure M.3] shows selected characteristics of the survey sample. A firm's primary industry classification is determined from Dynata's designation on the sampling frame and is based on the U.S. Census Bureau's North American Industry Classification System (NAICS), [Figure M.4]. A firm's ownership category and other firm characteristics such as the firm's wage level and the age of the work force are based on respondents' answers. While there is considerable overlap in firms in the "State/Local Government" industry category and those in the "public" ownership category, they are not identical. For example, public school districts are included in the service industry even though they are publicly owned. Family coverage is defined as health coverage for a family of four.

Figure M.3			
Selected Characteristics of Firms in the Survey Sample, 2020			
	Sample Size	Sample Distribution After Weighting	Percentage of Total for Weighted Sample
FIRM SIZE			
3-9 Workers	161	1,929,879	59.4%
10-24 Workers	243	780,160	24
25-49 Workers	184	284,519	8.8
50-199 Workers	256	195,677	6
200-999 Workers	392	45,945	1.4
1,000-4,999 Workers	321	8,420	0.3
5,000 or More Workers	208	2,295	0.1
REGION			
Northeast	289	563,082	17.3%
Midwest	540	686,171	21.1
South	588	1,251,410	38.5
West	366	746,242	23
INDUSTRY			
Agriculture/Mining/Construction	117	358,475	11%
Manufacturing	176	176,066	5.4
Transportation/Communications/Utilities	94	124,319	3.8
Wholesale	83	162,476	5
Retail	139	375,268	11.6
Finance	101	205,634	6.3
Service	672	1,365,310	42.7
State/Local Government	124	48,567	1.5
Health Care	259	410,760	12.7
ALL FIRMS	1,765	3,246,885	100%

SOURCE: KFF Employer Health Benefits Survey, 2020

**Figure M.4
Industries by NAICS code**

Industry	SIC Code Range	Sector	NAICS Description
Agriculture/Mining/Construction	0100-1799	11	Agriculture Support, Forestry, Fishing, and Hunting
		21	Mining
		23	Construction
Manufacturing	2000-3999	31	Manufacturing
Transportation/Communications /Utilities	4000-4299 & 4400-4999	22	Utilities
		48	Transportation and Warehousing
		51	Information
Wholesale	5000-5199	42	Wholesale Trade
Retail	5200-5999	44	Retail Trade
Finance	6000-6799	52	Finance and Insurance
		53	Real Estate and Rental & Leasing
Service	7000-7999 & 8100-8199 & 8300-8999	54	Professional, Scientific, and Technical Services
		55	Management of Companies and Enterprises
		56	Administrative & Support and Waste Management & Remediation Services
		71	Arts, Entertainment, and Recreation
		72	Accommodation and Food Services
		81	Other Services (except Public Administration)
State/Local Government	9000-9999	NA	
Education	8200-8299	61	Educational Services
Health Care	8000-8099	62	Health Care and Social Assistance

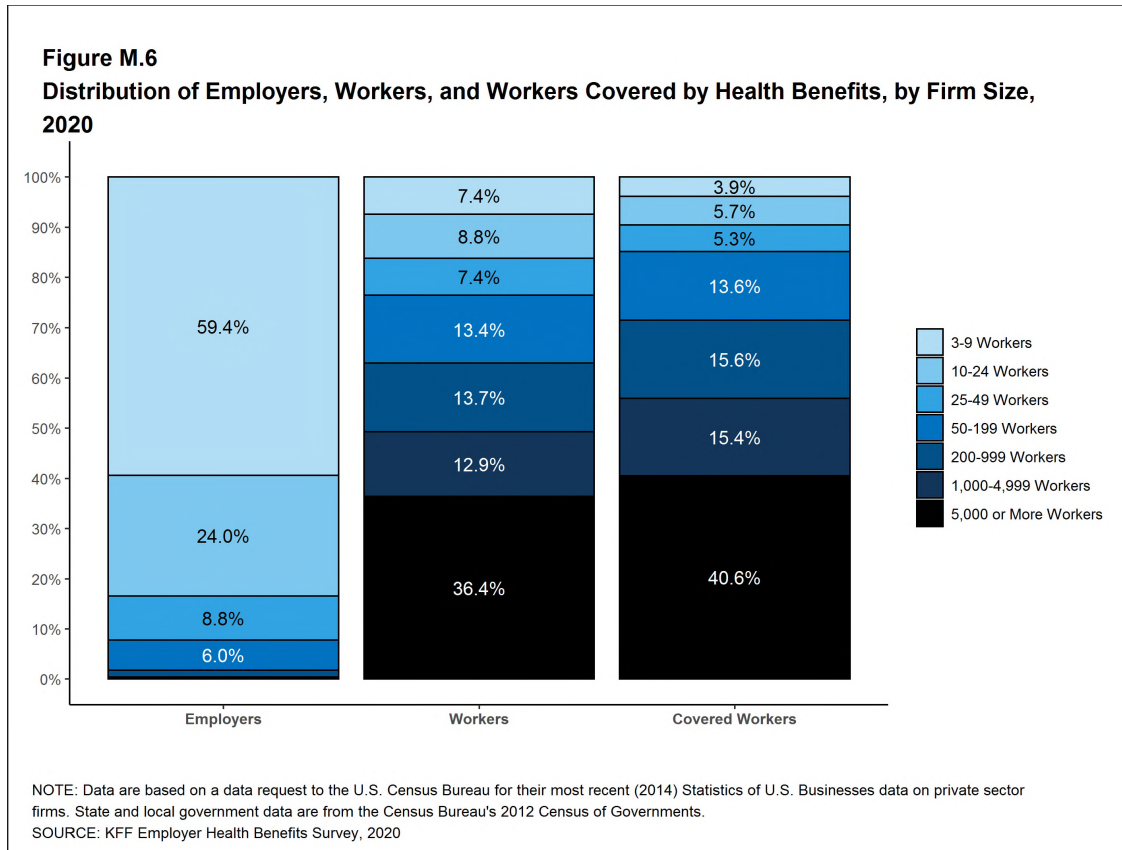
[Figure M.5] presents the breakdown of states into regions and is based on the U.S Census Bureau's categorizations. State-level data are not reported both because the sample size is insufficient in many states and we only collect information on a firm's primary location rather than where all workers may actually be employed. Some mid- and large-size employers have employees in more than one state, so the location of the headquarters may not match the location of the plan for which we collected premium information.

**Figure M.5
States by Region, 2020**

Northeast	Midwest	South	West
Connecticut	Illinois	Alabama	Alaska
Maine	Indiana	Arkansas	Arizona
Massachusetts	Iowa	Delaware	California
New Hampshire	Kansas	District of Columbia	Colorado
New Jersey	Michigan	Florida	Hawaii
New York	Minnesota	Georgia	Idaho
Pennsylvania	Missouri	Kentucky	Montana
Rhode Island	Nebraska	Louisiana	Nevada
Vermont	North Dakota	Maryland	New Mexico
	Ohio	Mississippi	Oregon
	South Dakota	North Carolina	Utah
	Wisconsin	Oklahoma	Washington
		South Carolina	Wyoming
		Tennessee	
		Texas	
		Virginia	
		West Virginia	

Source: KFF Employer Health Benefits Survey, 2020. From U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau, available at http://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf

[Figure M.6] displays the distribution of the nation's firms, workers, and covered workers (employees receiving coverage from their employer). Among the three million firms nationally, approximately 59.4% employ 3 to 9 workers; such firms employ 7.4% of workers, and 3.9% of workers covered by health insurance. In contrast, less than one percent of firms employ 5,000 or more workers; these firms employ 36.4% of workers and 40.6% of covered workers. Therefore, the smallest firms dominate any statistics weighted by the number of employers. For this reason, most statistics about firms are broken out by size categories. In contrast, firms with 1,000 or more workers are the most influential employer group in calculating statistics regarding covered workers, since they employ the largest percentage of the nation's workforce. Statistics among small firms and those weighted by the number of firms tend to have more variability.



Although most firms in the United States are small, most workers covered by health benefits are employed at large firms: 72% of the covered worker weight is controlled by firms with 200 or more employees. Conversely, firms with 3–199 employees represent 98% percent of the employer weight.

The survey asks firms what percentage of their employees earn more or less than a specified amount in order to identify the portion of a firm’s workforce that has relatively lower or higher wages. This year, the income threshold is \$26,000 or less per year for lower-wage workers and \$64,000 or more for higher-wage workers. These thresholds are based on the 25th and 75th percentile of workers’ earnings as reported by the Bureau of Labor Statistics using data from the Occupational Employment Statistics (OES) (2018).⁷ The cutoffs were inflation-adjusted and rounded to the nearest thousand.

Annual inflation estimates are calculated as an average of the first three months of the year. The 12 month percentage change for this period was 2.1%.⁸ Data presented is nominal unless indicated specifically otherwise.

ROUNDING AND IMPUTATION

Some figures in the report do not sum to totals due to rounding. Although overall totals and totals for size and industry are statistically valid, some breakdowns may not be available due to limited sample sizes or high relative standard errors. Where the unweighted sample size is fewer than 30 observations, figures include the notation “NSD” (Not Sufficient Data). Estimates with high relative standard errors are reviewed and in some cases not published. Many breakouts by subsets may have a large standard error, meaning that even large differences between estimates are not statistically different. Values below 3% are not shown on graphical figures to improve

⁷General information on the OES can be found at http://www.bls.gov/oes/oes_emp.htm#scope.

⁸Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 1998-2019; (cited 2019 Sept 6). <https://beta.bls.gov/dataViewer/view/timeseries/CUUR0000SA0>.

the readability of those graphs. The underlying data for all estimates presented in graphs are available in the Excel documents accompanying each section on <http://ehbs.kff.org/>.

To control for item nonresponse bias, we impute values that are missing for most variables in the survey. On average, 9% of observations are imputed. All variables are imputed following a hotdeck approach. The hotdeck approach replaces missing information with observed values from a firm similar in size and industry to the firm for which data are missing. In 2020, there were twenty-seven variables where the imputation rate exceeded 20%; most of these cases were for individual plan level statistics. When aggregate variables were constructed for all of the plans, the imputation rate is usually much lower. There are a few variables that we have decided not to impute; these are typically variables where “don’t know” is considered a valid response option. Some variables are imputed based on their relationship to each other. For example, if a firm provided a worker contribution for family coverage but no premium information, a ratio between the family premium and family contribution was imputed and then the family premium was calculated. We estimate separate single and family coverage premiums for firms that provide premium amounts as the average cost for all covered workers.

To ensure data accuracy we have several processes to review outliers and illogical responses. Every year several hundred firms are called back to confirm or correct responses. In some cases, answers are edited based on responses to open-ended questions or based on established logic rules.

WEIGHTING

Because we select firms randomly, it is possible through the use of weights to extrapolate the results to national (as well as firm size, regional, and industry) averages. These weights allow us to present findings based on the number of workers covered by health plans, the number of total workers, and the number of firms. In general, findings in dollar amounts (such as premiums, worker contributions, and cost sharing) are weighted by covered workers. Other estimates, such as the offer rate, are weighted by firms.

Calculation of the weights follows a common approach. The employer weight was determined by calculating the firm’s probability of selection. This weight was trimmed of overly influential weights and calibrated to U.S. Census Bureau’s 2017 Statistics of U.S. Businesses for firms in the private sector, and the 2017 Census of Governments totals. The worker weight was calculated by multiplying the employer weight by the number of workers at the firm and then following the same weight adjustment process described above. The covered-worker weight and the plan-specific weights were calculated by multiplying the percentage of workers enrolled in each of the plan types by the firm’s worker weight. These weights allow analyses of all workers covered by health benefits and of workers in a particular type of health plan.

The trimming procedure follows the following steps: First, we grouped firms into size and offer categories of observations. Within each strata, we calculated the trimming cut point as the median plus six times the interquartile range ($M + [6 * IQR]$). Weight values larger than this cut point are trimmed. In all instances, very few weight values were trimmed.

The survey collects information on primary and specialty care physician office visits for each plan type. Different plan types at the same firm may have different cost-sharing structures (e.g., copayments or coinsurance). Because the composite variables (using data from across all plan types) are reflective of only those plans with that provision, separate weights for the relevant variables were created in order to account for the fact that not all covered workers have such provisions.

To account for design effects, the statistical computing package R version 4.0.2 (2020-06-22) and the library “survey” version 4.0 were used to calculate standard errors.

STATISTICAL SIGNIFICANCE AND LIMITATIONS

All statistical tests are performed at the .05 confidence level. For figures with multiple years, statistical tests are conducted for each year against the previous year shown, unless otherwise noted. No statistical tests are

conducted for years prior to 1999.

Statistical tests for a given subgroup (firms with 25-49 workers, for instance) are tested against all other firm sizes not included in that subgroup (all firm sizes NOT including firms with 25-49 workers, in this example). Tests are done similarly for region and industry; for example, Northeast is compared to all firms NOT in the Northeast (an aggregate of firms in the Midwest, South, and West). However, statistical tests for estimates compared across plan types (for example, average premiums in PPOs) are tested against the “All Plans” estimate. In some cases, we also test plan-specific estimates against similar estimates for other plan types (for example, single and family premiums for HDHP/SOs against single and family premiums for HMO, PPO, and POS plans); these are noted specifically in the text. The two types of statistical tests performed are the t-test and the Wald test. The small number of observations for some variables resulted in large variability around the point estimates. These observations sometimes carry large weights, primarily for small firms. The reader should be cautioned that these influential weights may result in large movements in point estimates from year to year; however, these movements are often not statistically significant. Standard Errors for most key statistics are available in a technical supplement available at <http://ehbs.kff.org/>.

Due to the complexity of many employer health benefits programs, this survey is not able to capture all the components of any particular plan. For example, many employers have complex and varied prescription drug benefits, premium contributions, and incentives for wellness programs. We attempted to complete interviews with the person who is most knowledgeable about the firm’s health benefits. In some cases, the firm may not know details of some elements of their plan.

While we collect information on the number of workers enrolled in health benefits, the survey is not able to capture the characteristics of the workers offered or enrolled in any particular plan. As discussed above, statistics weighted by the percentage of employers often display a high level of variability.

2020 SURVEY

2020 was a challenging year both in administering the survey, as well as for many of our respondents who were scrambling to respond to the pandemic and the ensuing economic downturn. Our questionnaire was developed before the extent of the pandemic became apparent and the fielding period included response from both before and after. We asked respondents about their plans at the time of the interview, with approximately half of the responses (composing 50% of the covered worker weight) collected between January and March. The remaining interviews were completed before the middle of July. The survey is designed to track changes in benefit and cost between years and is not well suited to answer many of the important questions that emerged this year for a couple of reasons. Firstly, employers make decisions about their plans before the plan year begins. Premiums for self-funded employers are usually reported as the cost for a former worker to enroll in COBRA (deflated by an administrative fee) and do not reflect real-time spending. Many other plan features, including provider networks and cost-sharing, are set before a plan’s open enrollment period. We expect to learn more about how changes in benefits and utilization affected cost in the 2021 survey. Secondly, the month in which a respondent completes the survey is not random, the data collection firm completes interviews with larger panel firms first. We do not believe that these firms are similar to the non-panel firms that complete the survey later in the year. We believe these firms differ in ways which are not corrected for by weighting, which means we cannot look at how responses changed over the period to detect patterns of change. Thirdly, our sample is not sufficient to make many comparisons across fielding period. We plan to ask employers about changes to their plans and the impact of COVID-19 on their decision making in the 2021 survey.

In the summer of 2019, National Research LLC, which had conducted the Employer Health Benefit Survey since its inception, ceased operation. We engaged in a search to identify a new firm to conduct the 2020 survey and selected Davis Research LLC, based on their extensive experience in research on firms and establishments. While we believe that the sampling methodology, questionnaire and survey procedures were consistent between years, readers are strongly encouraged to consider “total survey error” when drawing conclusions about differences between statistics. Survey-adjusted standard errors (and statistical testing) measure uncertainty in estimates based on the sampling strategy, but do not measure biases that may be introduced through the data

collection process such as interviewer or house effects. House effects refer to the impact of a data collection firm's management and workflow processes on final statistics. We do not know how, or if at all, changing the data collection firm from National Research to Davis impacted estimates. Empirical studies of house effects vary greatly, with some reporting almost no impact⁹ and others observing significant differences in point estimates¹⁰. One place where house effects may manifest itself is in the frequency of unit-nonresponse¹¹, or the extent to which different firms code edge cases as "don't know". [Figure M.7] illustrates the difference in missing values for key statistics between 2016 and 2020. On an unweighted basis, there appears to be a marginal increase in unit non-response for some variables; we do not know the extent to which this increase is attributed to changing firms, or other significant disruptions throughout the 2020 fielding period.

Figure M.7
Imputation Rates of Premiums, Worker Contributions, and Deductibles, by Plan Type, 2016-2020

	2016	2017	2018	2019	2020
HMO					
Single Premium	3%	4.3%	1.6% [*]	3.9%	5.1%
Single Contribution	2.7	2.1	2.3	2.5	3.7
Single Deductible	2	3.3	1.6	1.5	2.7
Family Premium	4	6	3.9	5.2	5.7
Family Contribution	4.7	4.8	5.5	5	6.4
Family Deductible	3	5.3	3	2.5	4.7
PPO					
Single Premium	4.2%	4%	3.7%	4.4%	7% [*]
Single Contribution	3	2.3	2.5	2.5	3.6
Single Deductible	1.2	1.5	1	0.8	2.7 [*]
Family Premium	5.4	5.6	4.6	5.3	9.1 [*]
Family Contribution	4.4	4.4	4.3	4.4	6.4 [*]
Family Deductible	3.1	4.5	3.3	2.8	5.4 [*]
POS					
Single Premium	12%	8.4%	3.9%	10% [*]	15.5%
Single Contribution	4.6	4	1.9	7.4 [*]	10
Single Deductible	3.2	3.1	2.9	2.6	8.2 [*]
Family Premium	16.1	12.2	8.3	11.6	21.3 [*]
Family Contribution	12.3	9.5	7.3	11.6	21.3 [*]
Family Deductible	5.7	9	2.9 [*]	5.8	15.7 [*]
HDHP/SO					
Single Premium	4.3%	4.8%	3.9%	4%	4.9%
Single Contribution	3.3	1.8 [*]	2.3	2.4	3.3
Single Deductible	0.6	0.5	0.6	0.8	1.6
Family Premium	5.9	5.6	4.1	4.6	6
Family Contribution	4.5	3.6	3	3.6	4.8
Family Deductible	2.3	2.5	1.6	1.8	3.4

^{*} Estimate is statistically different from estimate for the previous year shown (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2016-2017

In order to minimize house effect impacts, we conducted extensive interview training with managers and interviewers at Davis, including sessions lead by interviewers with prior experience on the project. In addition, KFF pretested and observed interviews to verify that Davis' quality assurance process was consistent with our understanding of how the survey had been conducted historically.

Starting in 2020, we limited the number of margins used to calibrate weights and adjust for non-response. Until 2019, our weighting procedure incorporated offer status, firm size, geographic region, and metropolitan

⁹Russell, J. N., & Bose, J. (2004). House Effects in a Household Transportation Telephone Survey. American Association for Public Opinion Research Annual Meeting, Phoenix, Arizona.

¹⁰Schumann, D., & Shamon, H. (2019). The Importance of House Effects for Repeated Public Opinion Surveys. International Journal of Public Opinion Research. <https://doi.org/10.1093/ijpor/edz039>

¹¹Smith, T. W. (1982). House Effects and the Reproducibility of Survey Measurements: A Comparison of the 1980 GSS and the 1980 American National Election Study. The Public Opinion Quarterly, 46(1), 54-68.

status to adjust for unit nonresponse. Our 2020 weighting algorithm no longer relies on metropolitan vs. non-metropolitan as part of the non-response calculation. Separately, earlier surveys post-stratified each firm's set of weights to industry, firm size, census division, and panel versus non-panel margins. Starting in 2020, we reduced this weight calibration to only industry and firm size controls. Finally, we collapsed industries in our 5,000+ employee firm size category, owing to the fact that many large businesses operate across multiple industries. All three of these changes were prompted by an increase in the number of calibration cells with low sample, which can result in individual firms with highly influential weights if not revised. Without this revision, some 2020 statistics would have been driven by a small number of firms with overly influential weights. Reducing the number of variables in these improves the stability of some published estimates. This issue arose in part due to the smaller number of completed interviews in 2020 relative to 2019.

Historically we measured the annual changes in workers' wages and in inflation by comparing the values for April of the previous year and April of the current year. This year the labor market underwent significant disruptions in March and April as employers laid off and furloughed large numbers of workers in response to the COVID-19 pandemic. A relatively high share of lower-wage workers were furloughed and laid off during these months, resulting in a high change in wages as measured from April to April¹². In response to this unprecedented change in the labor market, we have elected to change how we calculate workers wages and inflation. Beginning with our 2020 publication, we are now calculating the change in workers wages and inflation based on an average of the first quarter of each year. Using this method, workers wages increased 3.4% compared to 7.7% between April and April. And similarly inflation increased 2.1% compared to 0.3%. Prior to 2020, both methods produced very similar estimates.

OTHER RESOURCES

Additional information on the 2020 Employer Health Benefit Survey is available at <http://ehbs.kff.org/>, including an article in the Journal Health Affairs, an interactive graphic and historic reports. Standard errors for some statistics are available in the online technical supplement. Researchers may also request a public use dataset here: <https://www.kff.org/contact-us/>

The survey design and methods section found on our website (<http://ehbs.kff.org/>) contains an extended methods document that was not included in the portable document format (PDF) or the printed versions of this book. Readers interested in the extended methodology should consult the online edition of this publication.

The authors would like to thank Tricia Neuman (KFF), Karen Pollitz (KFF), and Cynthia Cox (KFF), for their contributions to the instrument. Furthermore we would like to thank Ashley Kirzinger (KFF) for her advice on methodological issues; Lawrence Strange and Steve Paradowski (NORC) for assisting in interviewer training and CATI testing; Larry Levitt (KFF), and Drew Altman (KFF), for their review. And lastly, Jackie Cifuentes, Jason Kerns and the staff at Davis Research LLC for their diligence in data collection

Published: October 8, 2020. Last Updated: October 02, 2020.

¹²Crust E, Daly M, Hobbijn B. The Illusion of Wage Growth [Internet]. Federal Reserve Bank of San Francisco; 2020 Aug [cited 2020 Sep 14]. Available from: <https://www.frbsf.org/economic-research/publications/economic-letter/2020/august/illusion-of-wage-growth/>

EMPLOYER HEALTH BENEFITS

2020 ANNUAL SURVEY

Cost of
Health
Insurance

SECTION

1

Section 1

Cost of Health Insurance

In 2020, the average annual premiums are \$7,470 for single coverage and \$21,342 for family coverage. The average premium for single coverage increased by 4% since 2019 and the average premium for family coverage increased by 4%. The average family premium has increased 55% since 2010 and 22% since 2015.

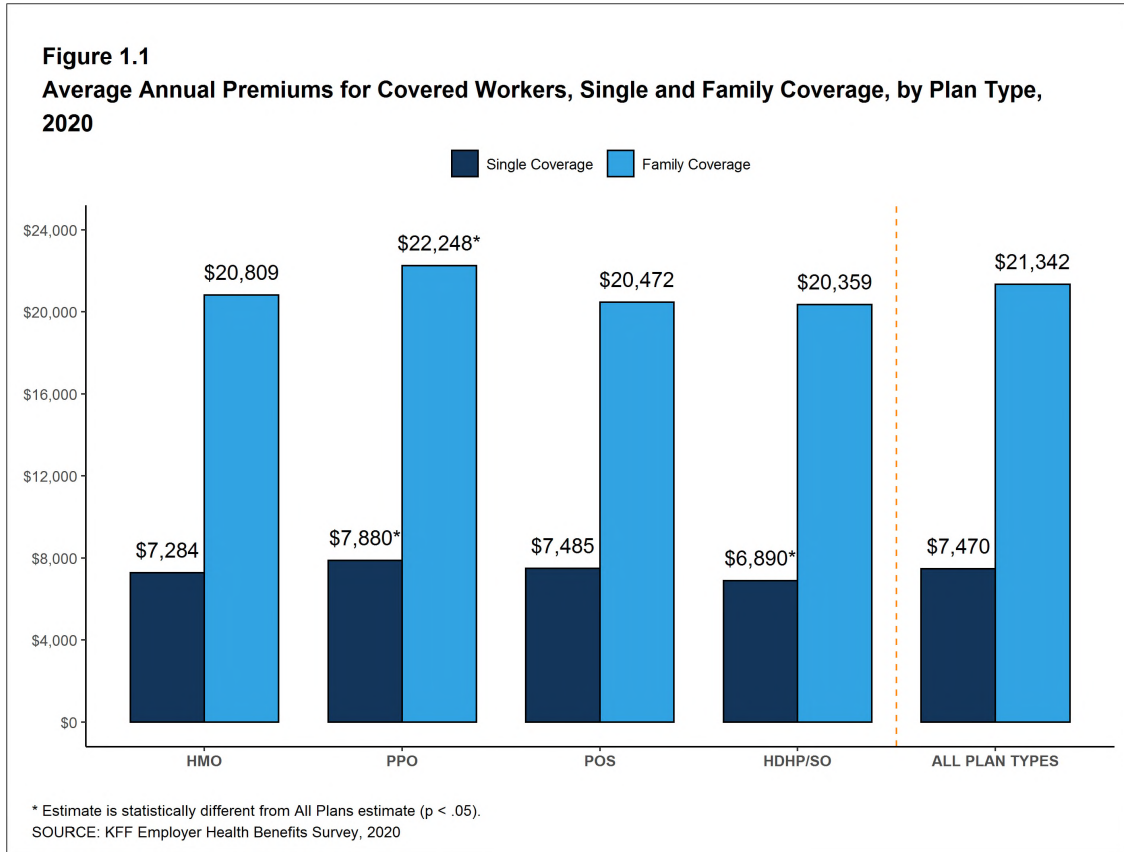
This graphing tool allows users to look at changes in premiums and worker contributions for covered workers at different types of firms over time: <https://www.kff.org/interactive/premiums-and-worker-contributions/>

PREMIUMS FOR SINGLE AND FAMILY COVERAGE

- The average premium for single coverage in 2020 is \$7,470 per year. The average premium for family coverage is \$21,342 per year [Figure 1.1].
- The average annual premium for single coverage for covered workers in small firms (\$7,483) is similar to the average premium for covered workers in large firms (\$7,466). The average annual premium for family coverage for covered workers in small firms (\$20,438) is lower than the average premium for covered workers in large firms (\$21,691). [Figure 1.2].
- The average annual premiums for covered workers in HDHP/SOs is lower for single coverage (\$6,890) but similar for family coverage (\$20,359) to the overall average premiums. The average premiums for covered workers enrolled in PPOs are higher for single (\$7,880) and family coverage (\$22,248) than the overall average premiums [Figure 1.1].
- The average premiums for covered workers with single coverage are relatively high in the Northeast and relatively low in the South. The average premiums for covered workers with family coverage are relatively high in the Northeast and relatively low in the South and West [Figure 1.3].
- The average premium for single coverage varies across industries. Compared to the average single premiums for covered workers in other industries, the average premiums for covered workers in the Manufacturing, Retail, and Agriculture/Mining/Construction categories are relatively low and the average premium for Health Care workers is relatively high [Figure 1.4].
- The average premium for family coverage for covered workers in firms with a relatively large share of lower-wage workers (where at least 35% of the workers earn \$26,000 annually or less) is lower than the average premium for covered workers in firms with a smaller share of lower-wage workers (\$19,332 vs. \$21,486) [Figure 1.6].
- The average premium for single coverage for covered workers in firms with a relatively large share of older workers (where at least 35% of the workers are age 50 or older) is higher than the average premium for covered workers in firms with a smaller share of older workers (\$7,665 vs. \$7,288) [Figure 1.6].
- The average premium for family coverage for covered workers in firms with a relatively large share of younger workers (where at least 35% of the workers are age 26 or younger) is lower than the average premium for covered workers in firms with a smaller share of younger workers (\$19,893 vs. \$21,441) [Figure 1.6].

SECTION 1. COST OF HEALTH INSURANCE

- Covered workers at private for-profit firms have lower average annual premiums than covered workers at public firms or private not-for-profit firms for single coverage [Figure 1.6].



SECTION 1. COST OF HEALTH INSURANCE

Figure 1.2
Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Firm Size, 2020

	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
HMO				
All Small Firms	\$585	\$1,573*	\$7,022	\$18,878*
All Large Firms	614	1,787*	7,369	21,439*
ALL FIRM SIZES	\$607	\$1,734	\$7,284	\$20,809
PPO				
All Small Firms	\$685*	\$1,837	\$8,216*	\$22,044
All Large Firms	646*	1,860	7,752*	22,324
ALL FIRM SIZES	\$657	\$1,854	\$7,880	\$22,248
POS				
All Small Firms	\$587*	\$1,572*	\$6,800*	\$18,860*
All Large Firms	699*	1,885*	8,392*	22,620*
ALL FIRM SIZES	\$624	\$1,706	\$7,485	\$20,472
HDHP/SO				
All Small Firms	\$559	\$1,593	\$6,712	\$19,122
All Large Firms	578	1,725	6,940	20,706
ALL FIRM SIZES	\$574	\$1,697	\$6,890	\$20,359
ALL PLANS				
All Small Firms	\$624	\$1,703*	\$7,483	\$20,438*
All Large Firms	622	1,808*	7,466	21,691*
ALL FIRM SIZES	\$623	\$1,779	\$7,470	\$21,342

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers

* Estimates are statistically different within plan and coverage types between All Small Firms and All Large Firms ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

SECTION 1. COST OF HEALTH INSURANCE

Figure 1.3**Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Region, 2020**

	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
HMO				
Northeast	\$643	\$1,867	\$7,712	\$22,399
Midwest	590	1,662	7,075	19,948
South	604	1,744	7,250	20,934
West	593	1,671	7,115	20,049
ALL REGIONS	\$607	\$1,734	\$7,284	\$20,809
PPO				
Northeast	\$681	\$1,996*	\$8,176	\$23,953*
Midwest	684*	1,935*	8,213*	23,223*
South	624*	1,738*	7,487*	20,853*
West	657	1,830	7,888	21,966
ALL REGIONS	\$657	\$1,854	\$7,880	\$22,248
POS				
Northeast	\$696*	\$1,955*	\$8,350*	\$23,462*
Midwest	622	1,689	7,469	20,265
South	635	1,686	7,616	20,227
West	513*	1,424*	6,152*	17,084*
ALL REGIONS	\$624	\$1,706	\$7,485	\$20,472
HDHP/SO				
Northeast	\$604	\$1,851	\$7,248	\$22,207
Midwest	562	1,686	6,748	20,227
South	571	1,672	6,855	20,066
West	574	1,590	6,890	19,078
ALL REGIONS	\$574	\$1,697	\$6,890	\$20,359
ALL PLANS				
Northeast	\$655*	\$1,929*	\$7,862*	\$23,151*
Midwest	626	1,804	7,515	21,652
South	608*	1,716*	7,296*	20,593*
West	610	1,699*	7,317	20,390*
ALL REGIONS	\$623	\$1,779	\$7,470	\$21,342

* Estimates are statistically different within plan and coverage types from estimate for all firms not in the indicated region ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

SECTION 1. COST OF HEALTH INSURANCE

Figure 1.4
Average Monthly and Annual Premiums for Covered Workers, by Plan Type and Industry, 2020

	Monthly		Annual	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
HMO				
Agriculture/Mining/Construction	NSD	NSD	NSD	NSD
Manufacturing	\$545	\$1,675	\$6,539	\$20,104
Transportation/Communications/Utilities	NSD	NSD	NSD	NSD
Wholesale	NSD	NSD	NSD	NSD
Retail	NSD	NSD	NSD	NSD
Finance	NSD	NSD	NSD	NSD
Service	611	1,699	7,329	20,386
State/Local Government	NSD	NSD	NSD	NSD
Health Care	NSD	NSD	NSD	NSD
ALL INDUSTRIES	\$607	\$1,734	\$7,284	\$20,809
PPO				
Agriculture/Mining/Construction	\$594 ⁺	\$1,729	\$7,124 ⁺	\$20,750
Manufacturing	648	1,888	7,774	22,658
Transportation/Communications/Utilities	639	1,834	7,668	22,004
Wholesale	666	1,839	7,997	22,070
Retail	591 [*]	1,773	7,087 [*]	21,274
Finance	671	1,958	8,050	23,496
Service	673	1,845	8,080	22,135
State/Local Government	668	1,800	8,015	21,802
Health Care	674	1,917	8,092	23,006
ALL INDUSTRIES	\$657	\$1,854	\$7,880	\$22,248
HDHP/SO				
Agriculture/Mining/Construction	\$612 [*]	\$1,432 [*]	\$6,143 [*]	\$17,180 [*]
Manufacturing	527 [*]	1,546 [*]	6,324 [*]	18,550 [*]
Transportation/Communications/Utilities	576	1,815	6,910	21,785
Wholesale	523 [*]	1,568	6,276 [*]	18,818
Retail	533 [*]	1,772	6,394 [*]	21,261
Finance	617	1,930	7,408	23,156
Service	585	1,687	7,022	20,240
State/Local Government	601	1,561	7,214	18,729
Health Care	617 [*]	1,723	7,403 [*]	20,680
ALL INDUSTRIES	\$574	\$1,697	\$6,890	\$20,359
ALL PLANS				
Agriculture/Mining/Construction	\$542 [*]	\$1,574 [*]	\$6,504 [*]	\$18,892 [*]
Manufacturing	579 [*]	1,699	6,948 [*]	20,383
Transportation/Communications/Utilities	632	1,872 [*]	7,583	22,466 [*]
Wholesale	607	1,713	7,280	20,560
Retail	572 [*]	1,772	6,863 [*]	21,266
Finance	644	1,939	7,733	23,266
Service	630	1,758	7,564	21,099
State/Local Government	649	1,749	7,794	20,987
Health Care	657 [*]	1,838	7,883 [*]	22,060
ALL INDUSTRIES	\$623	\$1,779	\$7,470	\$21,342

NOTE: POS premiums are included in the All Plans average. In most cases, there is an insufficient number of firms to report the average POS premium by industry.

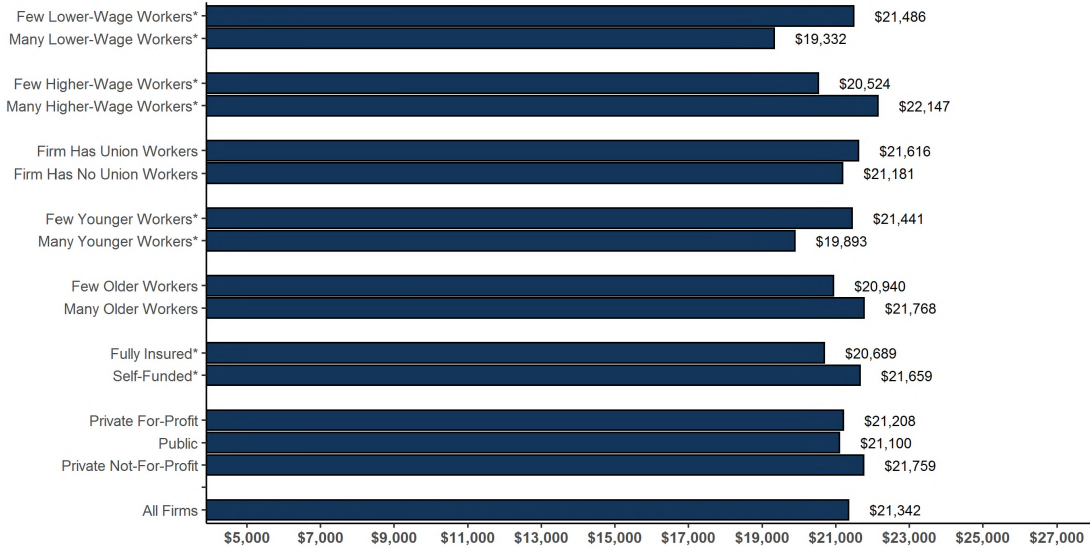
NSD: Not Sufficient Data

^{*} Estimate is statistically different within plan type from estimate for all firms not in the indicated industry (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2020

SECTION 1. COST OF HEALTH INSURANCE

Figure 1.5
Average Annual Premiums for Covered Workers with Family Coverage, by Firm Characteristics, 2020



* Estimates are statistically different from each other within category (p < .05).

NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings (\$26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings (\$64,000 in 2020). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.

SOURCE: KFF Employer Health Benefits Survey, 2020

SECTION 1. COST OF HEALTH INSURANCE

Figure 1.6
Average Annual Premiums for Covered Workers, by Firm Characteristics and Firm Size, 2020

	Single Coverage			Family Coverage		
	All Small Firms	All Large Firms	All Firms	All Small Firms	All Large Firms	All Firms
LOWER WAGE LEVEL						
Few Lower-Wage Workers	\$7,484	\$7,483	\$7,483	\$20,586	\$21,811*	\$21,466*
Many Lower-Wage Workers	\$7,388	\$6,946	\$7,148	\$19,213	\$19,431*	\$19,332*
HIGHER WAGE LEVEL						
Few Higher-Wage Workers	\$7,344	\$7,154*	\$7,218*	\$19,932	\$20,821*	\$20,524*
Many Higher-Wage Workers	\$7,686	\$7,727*	\$7,717*	\$21,183	\$22,424*	\$22,147*
UNIONS						
Firm Has Union Workers	\$7,458	\$7,451	\$7,452	\$20,807	\$21,673	\$21,616
Firm Has No Union Workers	\$7,485	\$7,479	\$7,481	\$20,403	\$21,708	\$21,181
YOUNGER WORKERS						
Few Younger Workers	\$7,516	\$7,499*	\$7,504	\$20,638*	\$21,754	\$21,441*
Many Younger Workers	\$6,942	\$6,996*	\$6,982	\$17,236*	\$20,804	\$19,893*
OLDER WORKERS						
Few Older Workers	\$7,142*	\$7,347	\$7,288*	\$19,358*	\$21,571	\$20,940
Many Older Workers	\$7,670*	\$7,589	\$7,665*	\$21,639*	\$21,816	\$21,766
FUNDING ARRANGEMENT						
Fully Insured	\$7,454	\$7,541	\$7,484	\$20,363	\$21,305	\$20,689*
Self-Funded	\$7,579	\$7,452	\$7,464	\$20,686	\$21,763	\$21,659*
FIRM OWNERSHIP						
Private For-Profit	\$7,145*	\$7,236*	\$7,209*	\$19,906	\$21,794	\$21,206
Public	\$8,154	\$7,726	\$7,792*	\$21,274	\$21,069	\$21,100
Private Not-For-Profit	\$8,038*	\$7,746*	\$7,830*	\$21,377	\$21,911	\$21,759
ALL FIRMS	\$7,483	\$7,466	\$7,470	\$20,438	\$21,691	\$21,342

NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings (\$26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings (\$64,000 in 2020). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger. Small Firms have 3-199 workers and Large Firms have 200 or more workers.

* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size (p < .05).

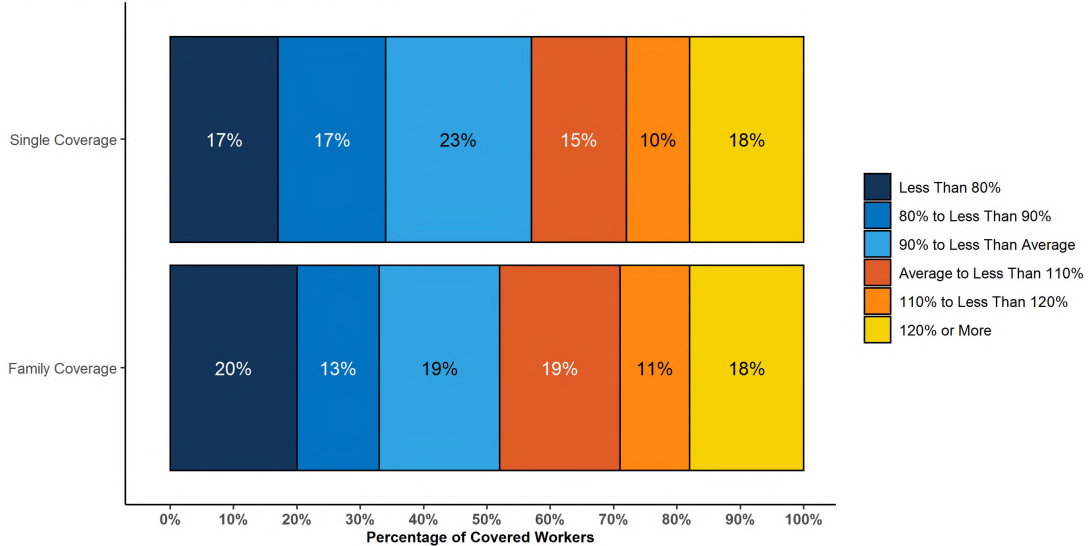
SOURCE: KFF Employer Health Benefits Survey, 2020

PREMIUM DISTRIBUTION

- There remains considerable variation in premiums for both single and family coverage.
 - Eighteen percent of covered workers are employed in a firm with a single premium at least 20% higher than the average single premium, while 17% of covered workers are in firms with a single premium less than 80% of the average single premium [Figure 1.7].
 - For family coverage, 18% of covered workers are employed in a firm with a family premium at least 20% higher than the average family premium, while 20% of covered workers are in firms with a family premium less than 80% of the average family premium [Figure 1.7].
- Nine percent of covered workers are in a firm with an average annual premium of at least \$10,000 for single coverage [Figure 1.8]. Ten percent of covered workers are in a firm with an average annual premium of at least \$28,000 for family coverage [Figure 1.9].

SECTION 1. COST OF HEALTH INSURANCE

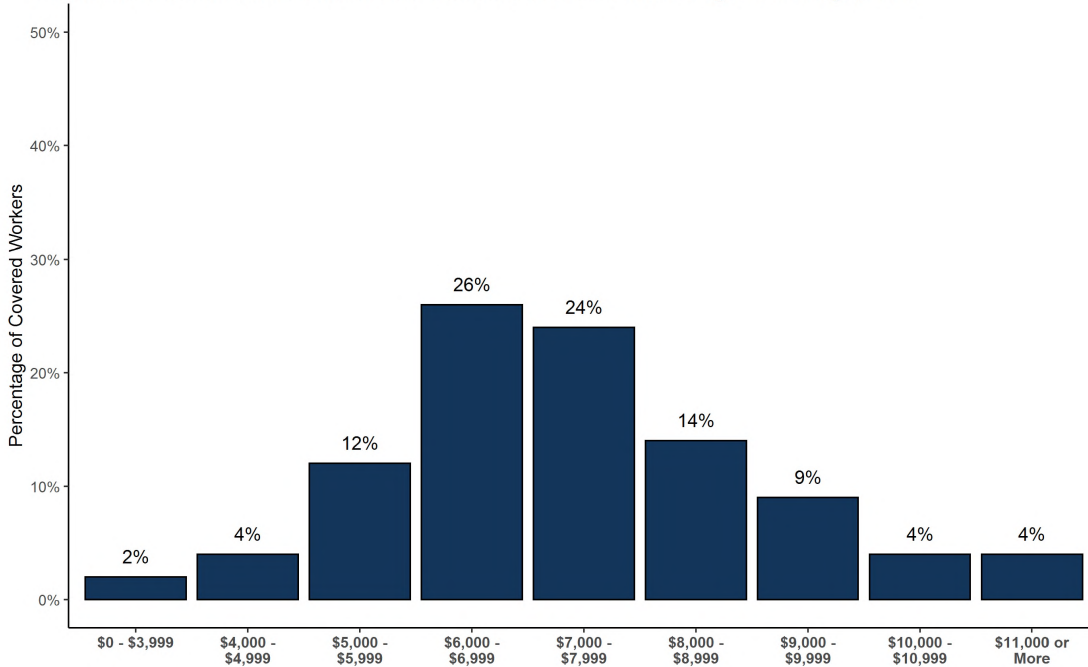
Figure 1.7
Distribution of Annual Premiums for Single and Family Coverage Relative to the Average Annual Single or Family Premium, 2020



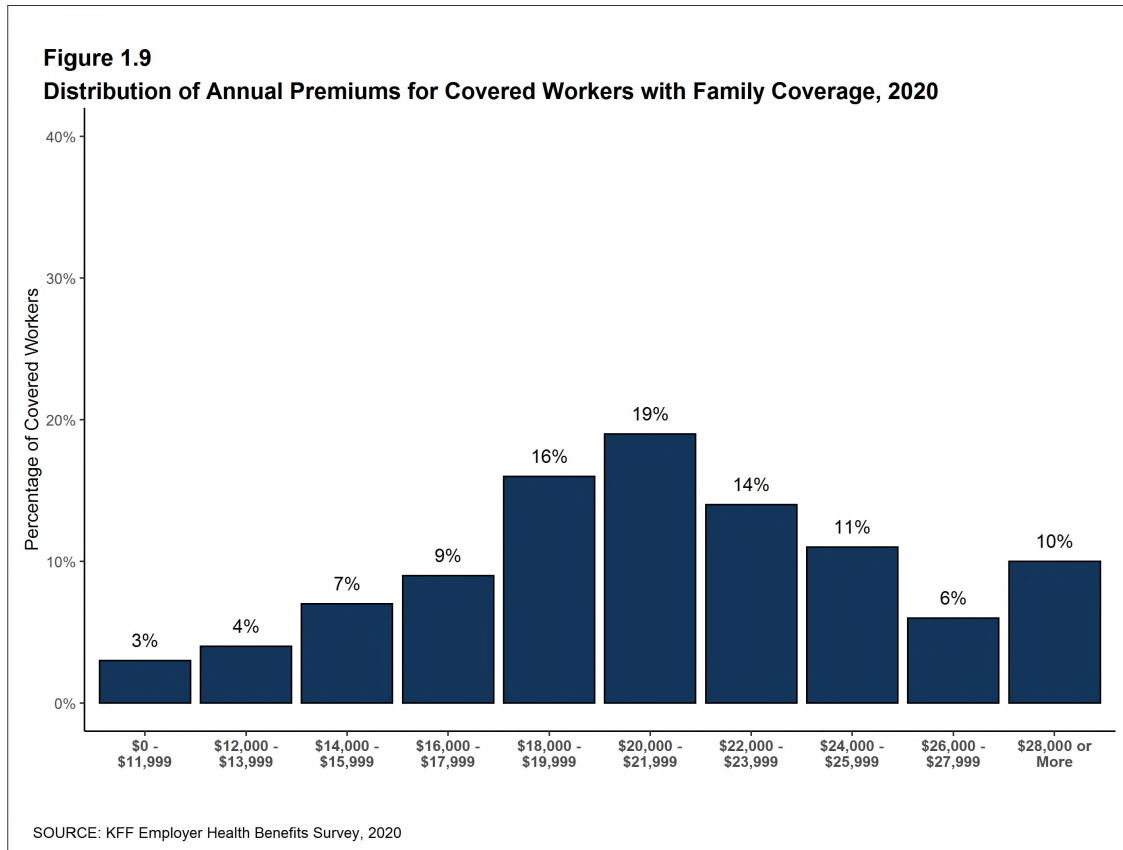
NOTE: The average annual premium is \$7,470 for single coverage and \$21,342 for family coverage. The premium distribution is relative to the average single or family premium. For example, \$5,976 is 80% of the average single premium, \$6,723 is 90% of the average single premium, \$8,217 is 110% of the average single premium, and \$8,964 is 120% of the average single premium. The same break points relative to the average are used for the distribution for family coverage.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 1.8
Distribution of Annual Premiums for Covered Workers with Single Coverage, 2020



SOURCE: KFF Employer Health Benefits Survey, 2020

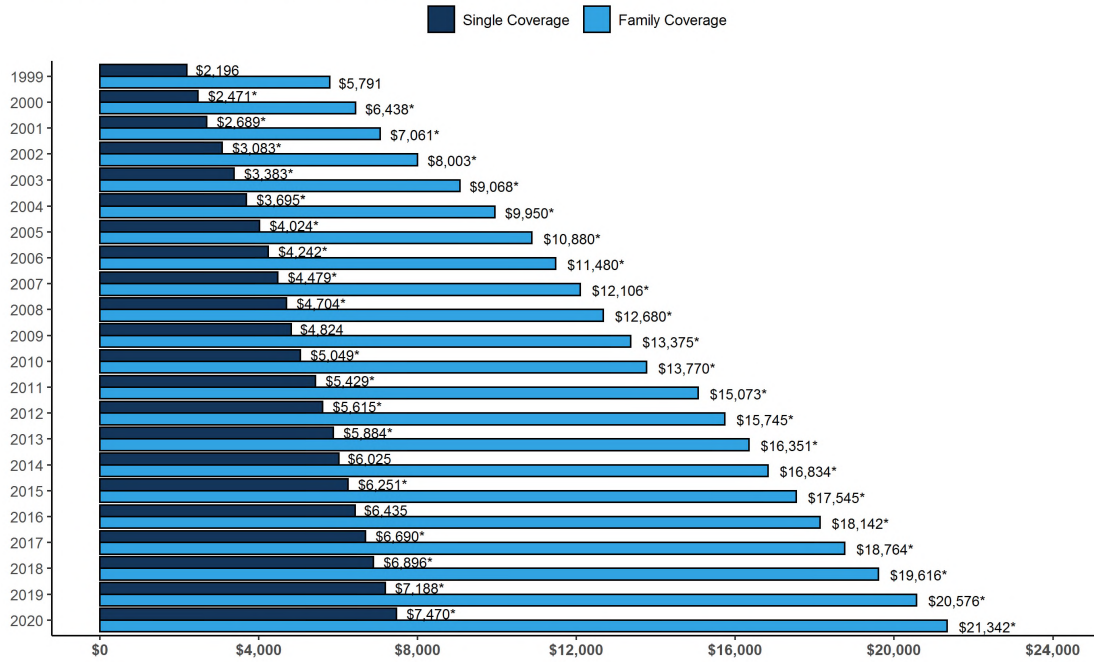


PREMIUM CHANGES OVER TIME

- The average premium for single coverage is 4% higher than the single premium last year, and the average premium for family coverage is 4% higher than the average family premium last year [Figure 1.10].
 - The average premium for single coverage has grown 20% since 2015, similar to the growth in the average premium for family coverage (22%) over the same period [Figure 1.10].
 - The average family premiums for both small and large firms have increased at similar rates since 2015 (23% for small firms and 21% for large firms). For small firms, the average family premium rose from \$16,625 in 2015 to \$20,438 in 2020. For large firms, the average family premium rose from \$17,938 in 2015 to \$21,691 in 2020 [Figures 1.11 and 1.12].
 - The \$21,342 average family premium in 2020 is 22% higher than the average family premium in 2015 and 55% higher than the average family premium in 2010. The 22% family premium growth in the past five years is slower than the 27% growth between 2010 and 2015 [Figure 1.14].
 - The average family premiums for both small and large firms have increased at similar rates since 2010 (54% for small firms and 55% for large firms). For small firms, the average family premium rose from \$13,250 in 2010 to \$20,438 in 2020. For large firms, the average family premium rose from \$14,038 in 2010 to \$21,691 in 2020 [Figures 1.11 and 1.12].
- For covered workers in large firms, over the past five years, the average family premium in firms that are fully insured has grown at a similar rate to the average family premium for covered workers in fully or partially self-funded firms (19% for fully insured plans and 21% for self-funded firms) [Figure 1.13].
- Over the last five years, the average premium for family coverage has risen 22% percent, more than inflation (10%).

SECTION 1. COST OF HEALTH INSURANCE

Figure 1.10
Average Annual Premiums for Single and Family Coverage, 1999-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 1.11**Average Annual Premiums for Covered Workers With Family Coverage, by Firm Size, 1999-2020**

	All Small Firms	All Large Firms
1999	\$5,683	\$5,845
2000	\$6,521	\$6,395
2001	\$6,959	\$7,113
2002*	\$7,781	\$8,109
2003	\$8,946	\$9,127
2004	\$9,737	\$10,046
2005*	\$10,587	\$11,025
2006	\$11,306	\$11,575
2007	\$11,835	\$12,233
2008*	\$12,091	\$12,973
2009*	\$12,696	\$13,704
2010*	\$13,250	\$14,038
2011*	\$14,098	\$15,520
2012*	\$15,253	\$15,980
2013*	\$15,581	\$16,715
2014*	\$15,849	\$17,265
2015*	\$16,625	\$17,938
2016*	\$17,546	\$18,395
2017*	\$17,615	\$19,235
2018*	\$18,739	\$19,972
2019	\$20,236	\$20,717
2020*	\$20,438	\$21,691

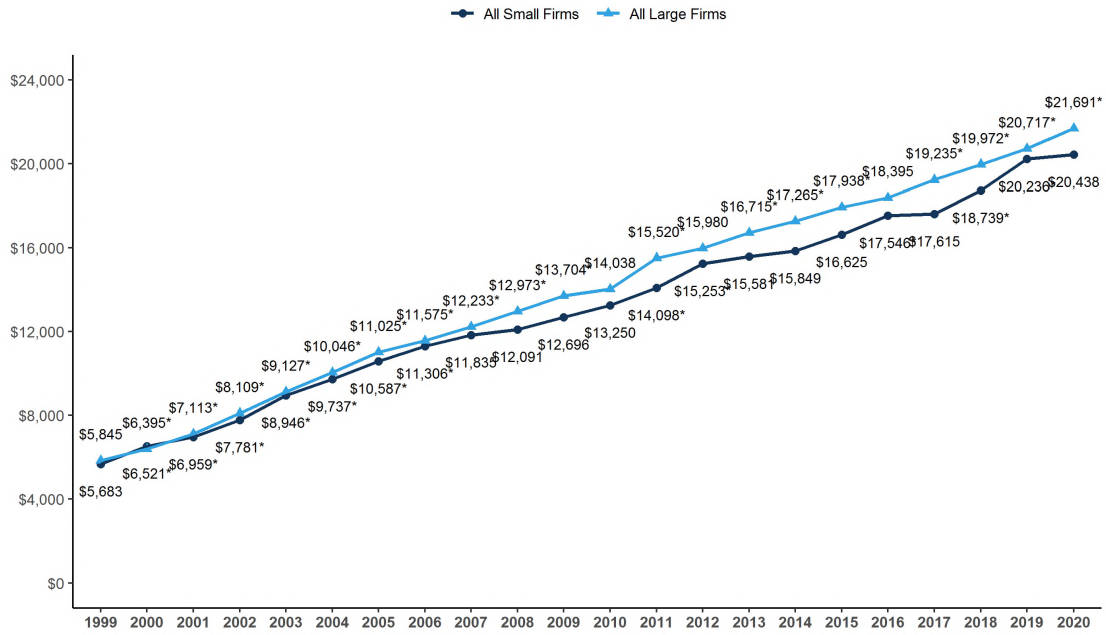
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.

* Estimate is statistically different between All Small Firms and All Large Firms within year ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

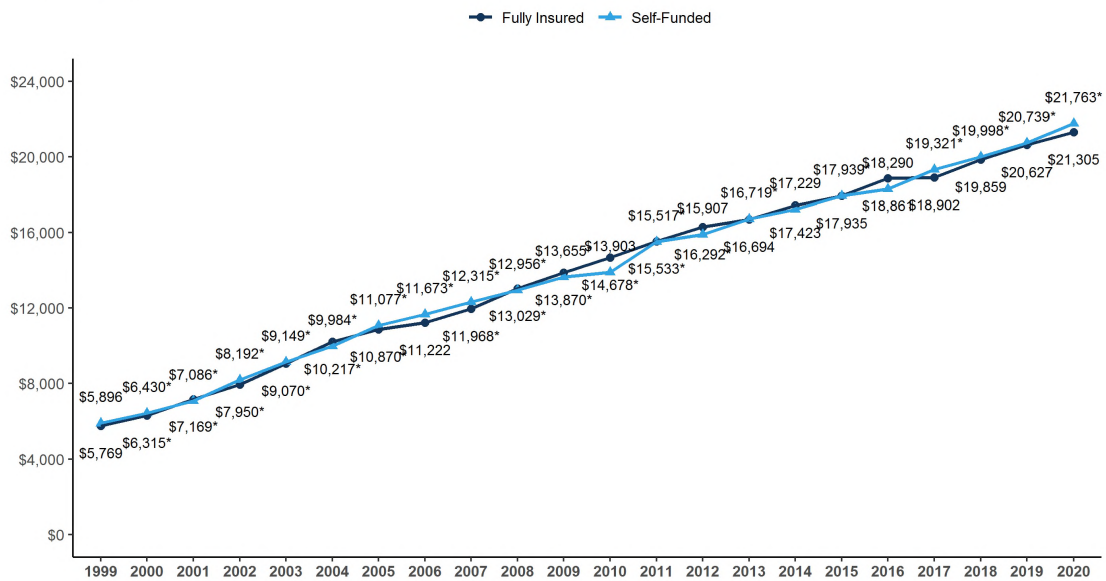
SECTION 1. COST OF HEALTH INSURANCE

Figure 1.12
Average Annual Premiums for Covered Workers with Family Coverage, by Firm Size, 1999-2020



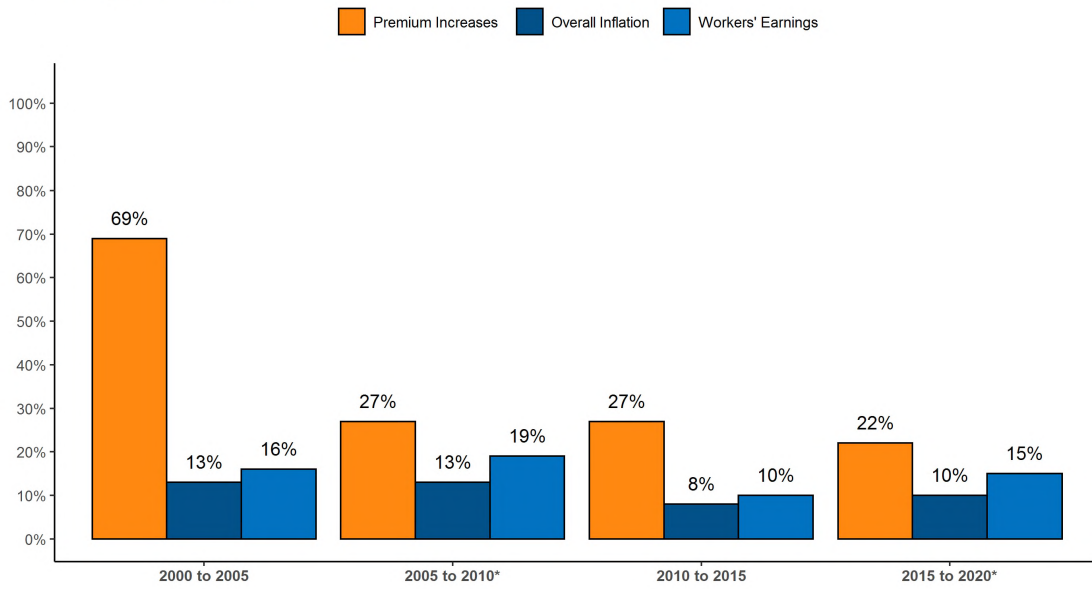
* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 1.13
Among Workers in Large Firms, Average Annual Premiums for Family Coverage, by Funding Arrangement, 1999-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Large Firms have 200 or more workers. For definitions of Self-Funded and Fully Insured Plans, see Section 10. Self-Funded includes plans that purchase stoploss coverage.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 1.14
Cumulative Premium Increases, Inflation, and Earnings for Covered Workers with Family Coverage, 2000-2020



* Percentage change in family premium is statistically different from previous five year period shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 2000-2020; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2000-2020.

EMPLOYER HEALTH BENEFITS

2020 ANNUAL SURVEY

Health
Benefits
Offer Rates

SECTION

2

Section 2

Health Benefits Offer Rates

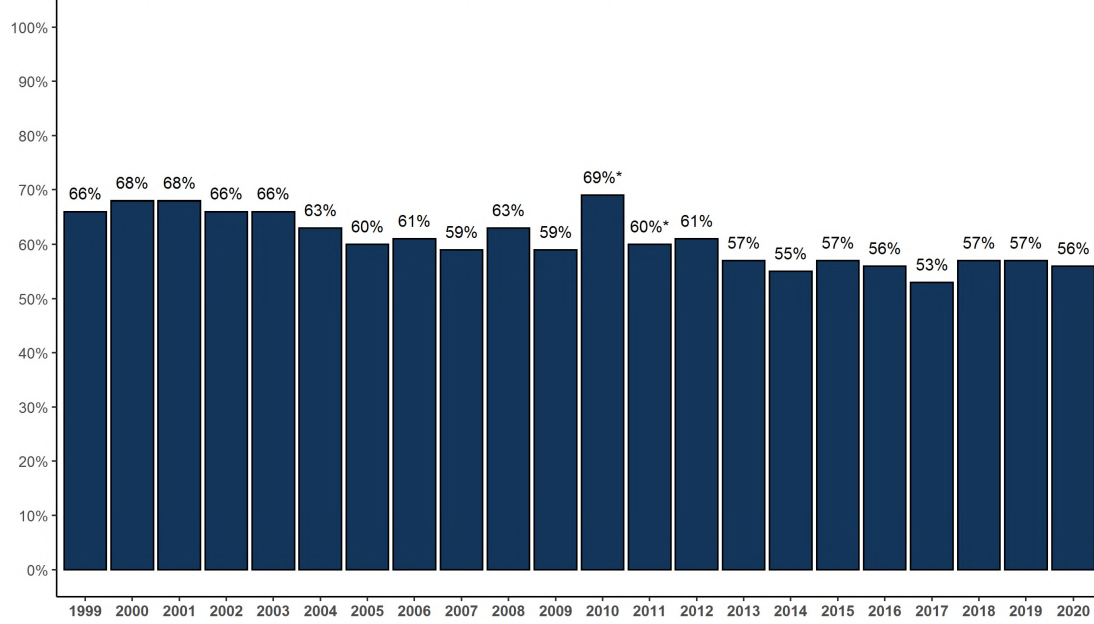
While nearly all large firms (200 or more workers) offer health benefits to at least some workers, small firms (3-199 workers) are significantly less likely to do so. The percentage of all firms offering health benefits in 2020 (56%) is similar to the percentages of firms offering health benefits last year (57%) and five years ago (57%).

Firms not offering health benefits continue to cite cost as the most important reason they do not do so. Almost all firms that offer coverage offer benefits to dependents such as children and the spouses of eligible employees.

FIRM OFFER RATES

- In 2020, 56% of firms offer health benefits, similar to the percentage last year [Figure 2.1].
 - The overall percentage of firms offering health benefits in 2020 is similar to the percentages offering health benefits in 2015 (57%). The percentage of offering firms in 2010 was an aberration so we are not making a 10-year comparison [Figure 2.1].
 - Ninety-nine percent of large firms offer health benefits to at least some of their workers. In contrast, only 55% of small firms offer health benefits [Figure 2.2] and [Figure 2.3]. The percentages of both small and large firms offering health benefits to at least some of their workers in 2020 are similar to those last year [Figure 2.2].
 - * The smallest-sized firms are least likely to offer health insurance: 48% of firms with 3-9 workers offer coverage, compared to 59% of firms with 10-24 workers, 70% of firms with 25-49 workers, and 92% of firms with 50-199 workers [Figure 2.3]. Since most firms in the country are small, variation in the overall offer rate is driven largely by changes in the percentages of the smallest firms (3-9 workers) offering health benefits. For more information on the distribution of firms in the country, see the Survey Design and Methods Section and [Figure M.6].
 - * Only 53% of firms with 3-49 workers offer health benefits to at least some of their workers, compared to 94% of firms with 50 or more workers [Figure 2.4].
- Because most workers are employed by larger firms, most workers work at a firm that offers health benefits to at least some of its employees. Eighty-nine percent of all workers are employed by a firm that offers health benefits to at least some of its workers [Figure 2.6].

Figure 2.1
Percentage of Firms Offering Health Benefits, 1999-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: As noted in the Survey Design and Methods section, estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

SECTION 2. HEALTH BENEFITS OFFER RATES

Figure 2.2

Percentage of Firms Offering Health Benefits, by Firm Size, 1999-2020

	3-9 Workers	10-24 Workers	25-49 Workers	50-199 Workers	All Small Firms	All Large Firms	All Firms
1999	55%	74%	88%	97%	65%	99%	66%
2000	57%	80%	91%	97%	68%	99%	68%
2001	58%	77%	90%	96%	67%	99%	68%

Figure 2.3**Percentage of Firms Offering Health Benefits, by Firm Size, Region, and Industry, 2020**

	Percentage of Firms Offering Health Benefits
FIRM SIZE	
3-9 Workers	48%*
10-24 Workers	59
25-49 Workers	70*
50-199 Workers	92*
200-999 Workers	99*
1,000-4,999 Workers	99*
5,000 or More Workers	99*
All Small Firms (3-199 Workers)	55%*
All Large Firms (200 or More Workers)	99%*
REGION	
Northeast	60%
Midwest	59
South	50*
West	59
INDUSTRY	
Agriculture/Mining/Construction	55%
Manufacturing	62
Transportation/Communications/Utilities	64
Wholesale	68
Retail	38*
Finance	62
Service	54
State/Local Government	92*
Health Care	62
ALL FIRMS	56%

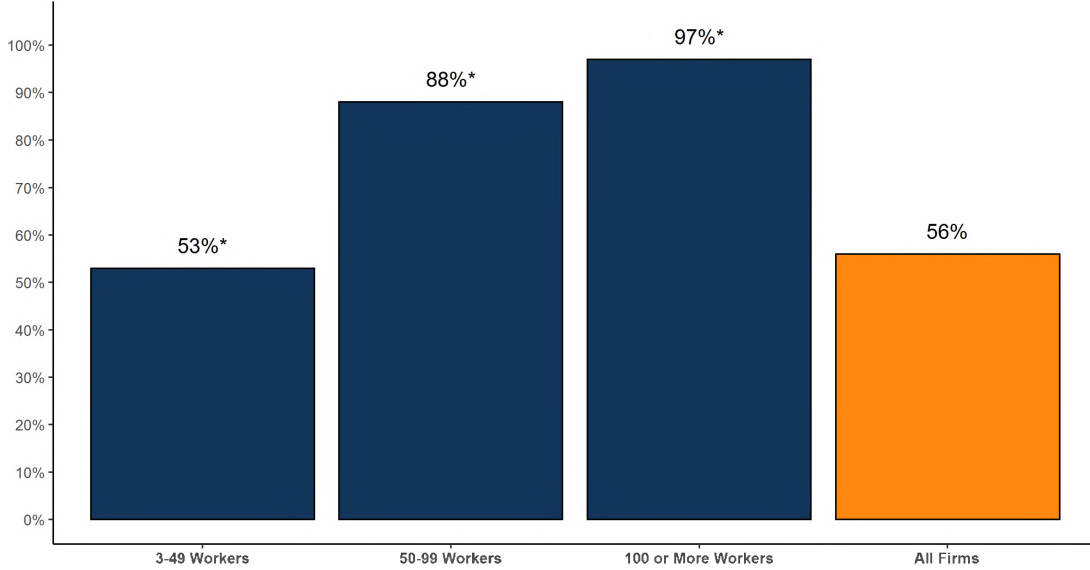
NOTE: As noted in the Survey Design and Methods section, estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

* Estimate is statistically different from estimate for all firms not in the indicated size, region, or industry category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

SECTION 2. HEALTH BENEFITS OFFER RATES

Figure 2.4
Percentage of Firms Offering Health Benefits to At Least Some of Their Workers, by Firm Size, 2020

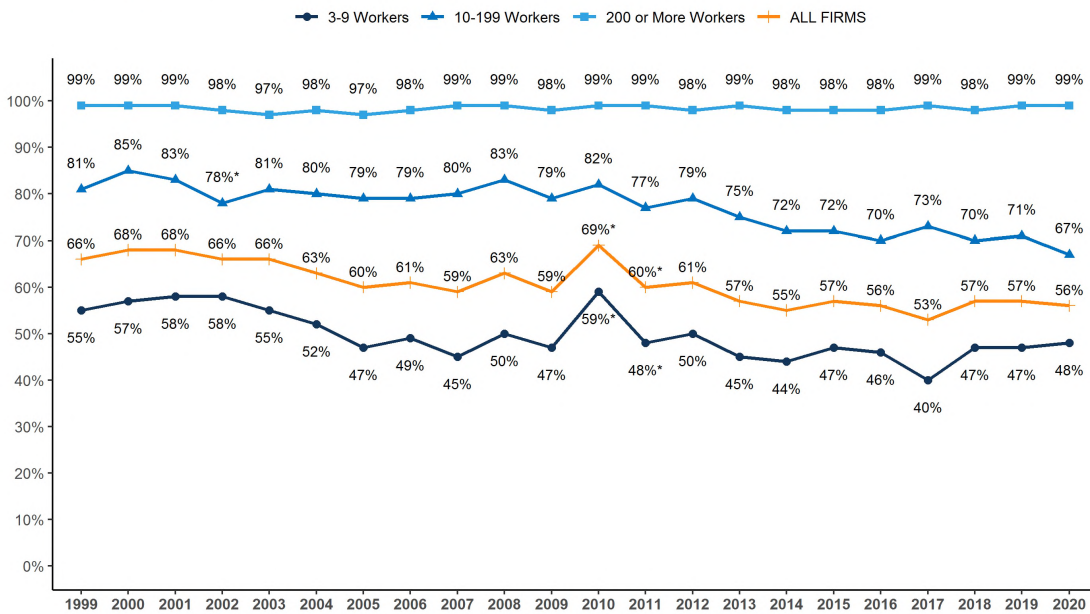


* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

NOTE: As noted in the Survey Design and Methods section, estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits. Firm size categories are determined by the number of workers at a firm, which may include full-time and part-time workers.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 2.5
Percentage of Firms Offering Health Benefits, by Firm Size, 1999-2020

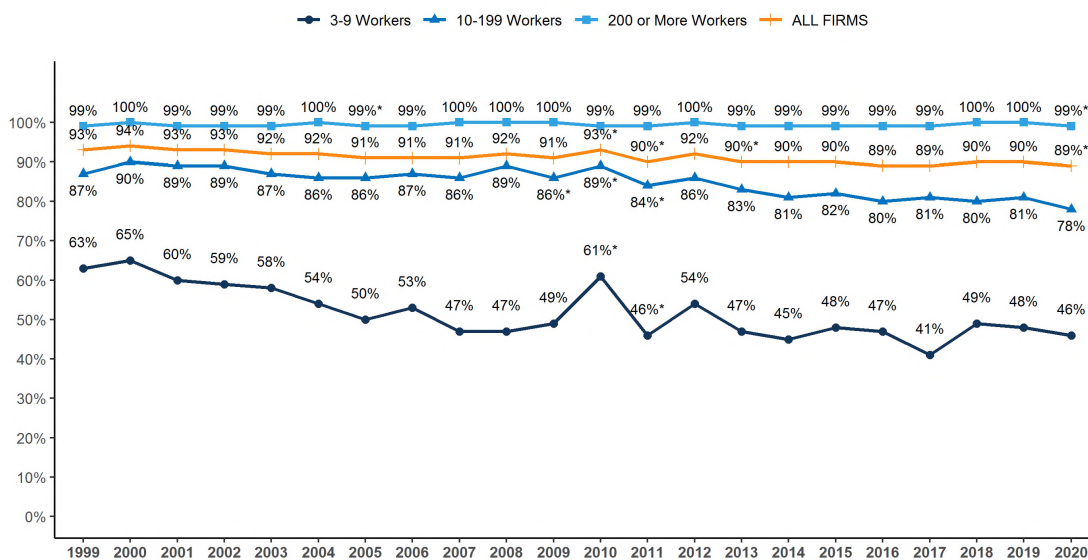


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: As noted in the Survey Design and Methods section, estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 2.6
Percentage of Workers at Firms That Offer Health Benefits to at Least Some Workers, by Firm Size, 1999-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: As noted in the Survey Design and Methods section, estimates are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits. Not all workers at a firm offering benefits are eligible or enrolled in their firm's health benefits.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

PART-TIME WORKERS

- Among firms offering health benefits, relatively few offer benefits to their part-time workers.
 - The Affordable Care Act (ACA) defines full-time workers as those who on average work at least 30 hours per week, and part-time workers as those who on average work fewer than 30 hours per week. The employer shared responsibility provision of the ACA requires that firms with at least 50 full-time equivalent employees offer most full-time employees coverage that meets minimum standards or be assessed a penalty.¹

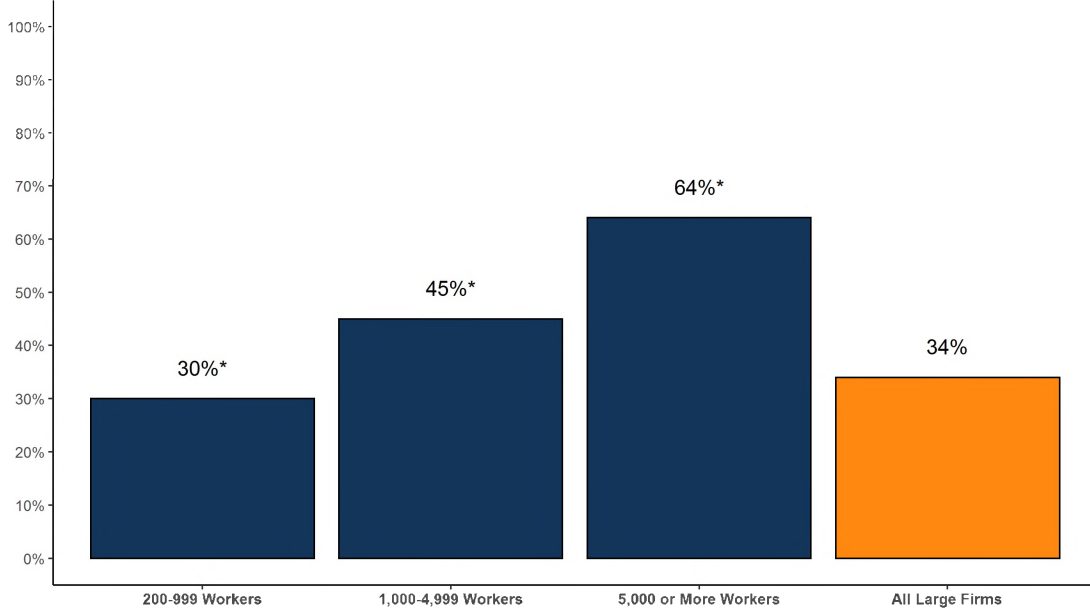
Beginning in 2015, we modified the survey to explicitly ask employers whether they offered benefits to employees working fewer than 30 hours. Our previous question did not include a definition of “part-time”. For this reason, historical data on part-time offer rates are shown, but we did not test whether the differences between 2014 and 2015 were significant. Many employers may work with multiple definitions of part-time; one for their compliance with legal requirements and another for internal policies and programs.

- Thirty-four percent of large firms offer health benefits in 2020 offer health benefits to part-time workers, similar to the percentage in 2019. The share of large firms offering health benefits to part-time workers increases with firm size [Figure 2.7].

¹Internal Revenue Code. 26 U.S. Code § 4980H - Shared responsibility for employers regarding health coverage. 2011. <https://www.gpo.gov/fdsys/pkg/USCODE-2011-title26/pdf/USCODE-2011-title26-subtitleD-chap43-sec4980H.pdf>

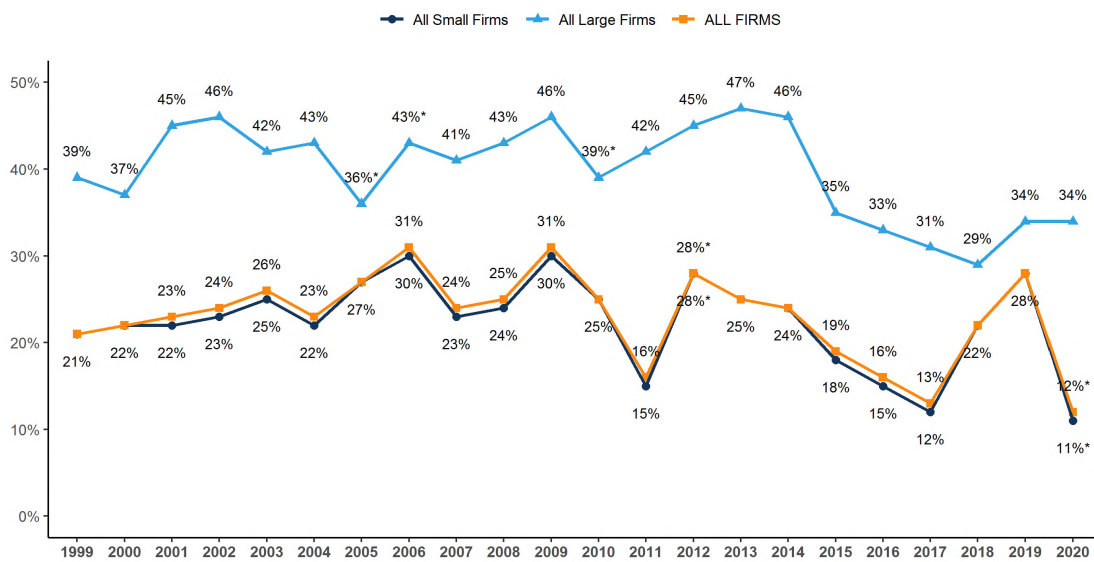
SECTION 2. HEALTH BENEFITS OFFER RATES

Figure 2.7
Among Large Firms Offering Health Benefits, Percentage That Offer to Part-Time Workers, by Firm Size, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
 NOTE: Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

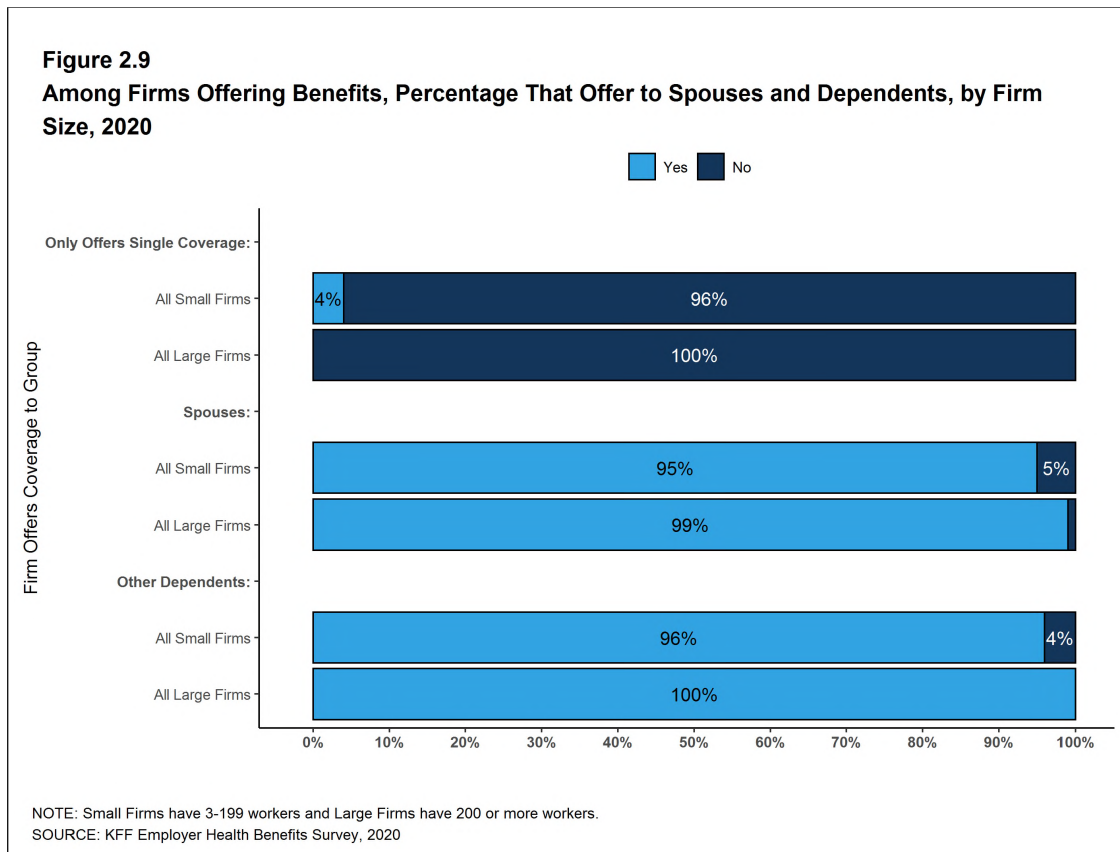
Figure 2.8
Among Firms Offering Health Benefits, Percentage That Offer to Part-Time Workers, by Firm Size, 1999-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
 NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Prior to 2015, each respondent defined part-time according to their firm's policies; starting in 2015, respondents were asked whether employees working fewer than 30 hours per week were eligible for benefits. There was no statistical testing between 2014 and 2015.
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

SPOUSES AND DEPENDENTS

- The vast majority of firms offering health benefits offer to spouses and dependents, such as children.
 - In 2020, 95% of firms offering health benefits offer coverage to spouses, similar to the percentage last year [Figure 2.9].
 - Ninety-six percent of firms offering health benefits cover dependents other than spouses, such as children, similar to the percentages last year [Figure 2.9].
 - Four percent of small firms offering health benefits offer only single coverage to their workers, similar to the percentage last year [Figure 2.9].



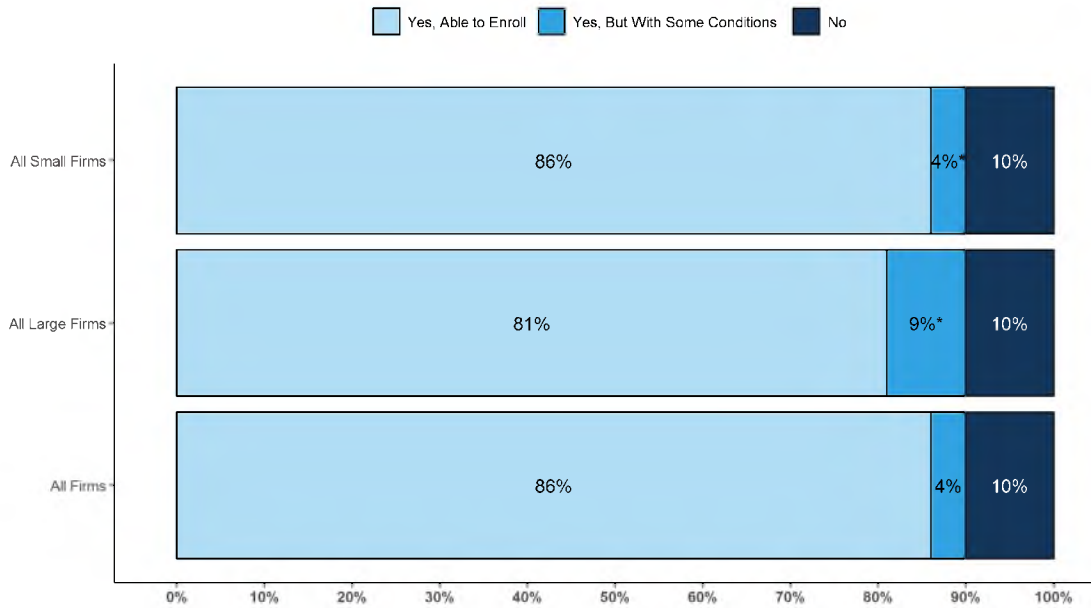
SPOUSAL SURCHARGES

Some employers place conditions on the ability of dependent spouses to enroll in a health plan if the spouse is offered health insurance from another source, such as his or her own place of work.

- Among firms offering health benefits to spouses, 86% say that an employee's spouse is able to enroll in the employee's health plan even if the spouse is offered coverage from another source, 4% say the spouse can enroll subject to some conditions (for example, the type of coverage offered), and 10% say that the spouse is not eligible to enroll [Figure 2.10].
- Among large firms that say that spouses are eligible to enroll in an employee's health plan even if the spouse has access to coverage from another source, 13% require the spouse to pay more to enroll than other spouses, such as a higher premium contribution or cost sharing [Figure 2.12].

SECTION 2. HEALTH BENEFITS OFFER RATES

Figure 2.10
Percent of Firms Offering Spousal Coverage Which Restrict Spouses' Eligibility if They Have an Offer from Another Source, by Firm Size, 2020

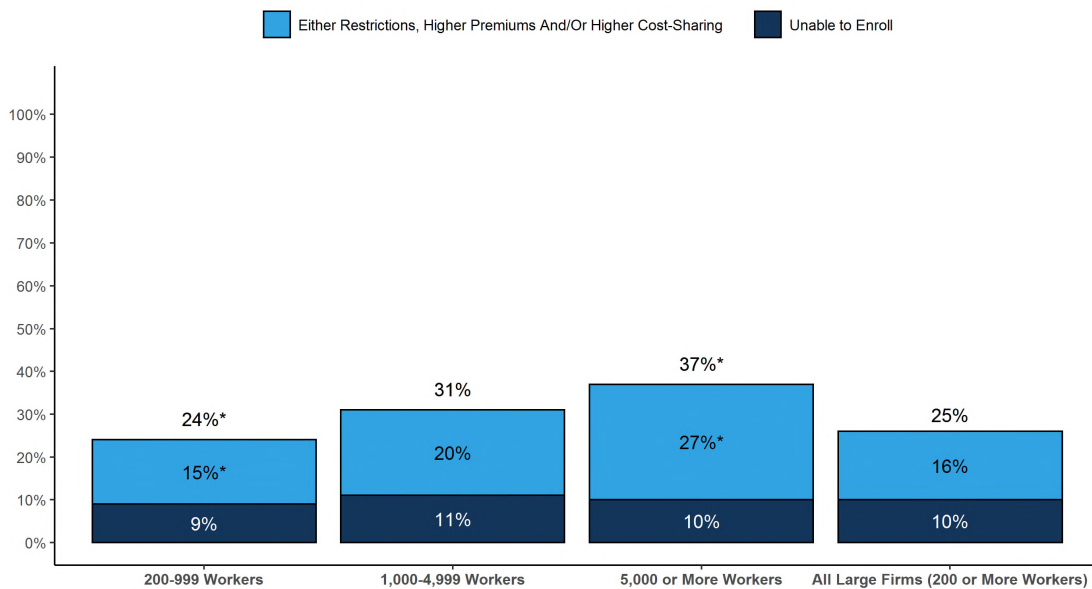


* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).

NOTE: Other restrictions may include requirements on the work status of the spouse, or the type of coverage they have access to.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 2.11
Among Large Firms that Offer Spousal Coverage, Spouses' Eligibility if They Have an Offer from Another Source, by Firm Size, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

NOTE: Large Firms have 200 or more workers. Other restrictions may include requirements on the work status of the spouse, or the type of coverage they have access to.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 2.12**Among Firms Offering Health Benefits to Spouses, Firm's Approach to Spousal Coverage If Employee's Spouse Is Offered Coverage From Another Source, by Firm Size, 2014-2020**

	2014	2016	2019	2020
Spouse Not Eligible to Enroll				
All Small Firms (3-199 Workers)	9%	13%	12%	10%
All Large Firms (200 or More Workers)	8%	5%	11%*	10%
ALL FIRMS	9%	13%	12%	10%
Spouse Required to Contribute More to Coverage				
All Small Firms (3-199 Workers)	5%	12%	3%*	2%
All Large Firms (200 or More Workers)	9%	14%*	10%	13%
ALL FIRMS	5%	12%	3%*	3%

NOTE: A higher contribution includes either a higher premium contribution or higher cost-sharing such as deductibles and copays. Percent required to contribute more is asked of firms who allow spouses to enroll.

* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2019-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014-2016

FIRMS NOT OFFERING HEALTH BENEFITS

- The survey asks firms that do not offer health benefits several questions, including whether they have offered insurance or shopped for insurance in the recent past, their most important reasons for not offering coverage, and their opinion on whether their employees would prefer an increase in wages or health insurance if additional funds were available to increase their compensation. Because such a small percentage of large firms report not offering health benefits, we present responses for small non-offering firms only.
 - The cost of health insurance remains the primary reason cited by firms for not offering health benefits. Among small firms not offering health benefits, 37% cite high cost as “the most important reason” for not doing so. Other factors include “the firm is too small” (20%), employees are covered by another health plan (including a spouse’s plan) (17%) and “most employees are part-time or temporary workers” (11%). Few small firms indicate that they do not offer because they believe employees will get a better deal on the health insurance exchanges (4%) [Figure 2.13].
- Some small non-offering firms have either offered health insurance in the past five years or shopped for health insurance in the past year.
 - Seven percent of small non-offering firms have offered health benefits in the past five years, lower than the percentage reported last year or in recent years [Figure 2.14]. We will monitor this percentage to determine if this is a single-year change or a new and different level.
 - Seventeen percent of small non-offering firms have shopped for coverage in the past year, similar to the percentage last year (14%) [Figure 2.14].
- Among small non-offering firms that report they stopped offering coverage within the past five years, 30% stopped offering coverage within the past year.
- Eight percent of small firms not offering health benefits report that they provide funds for employees to purchase insurance on their own in the individual market or through a health insurance exchange, similar to the percentage in 2019 [Figure 2.15].
- Sixty-nine percent of small firms not offering health benefits believed that their employees would prefer a two dollar per hour increase in wages rather than health insurance. [Figure 2.16].

SECTION 2. HEALTH BENEFITS OFFER RATES

Figure 2.13

Among Small Firms Not Offering Health Benefits, Most Important Reason for Not Offering, 2020

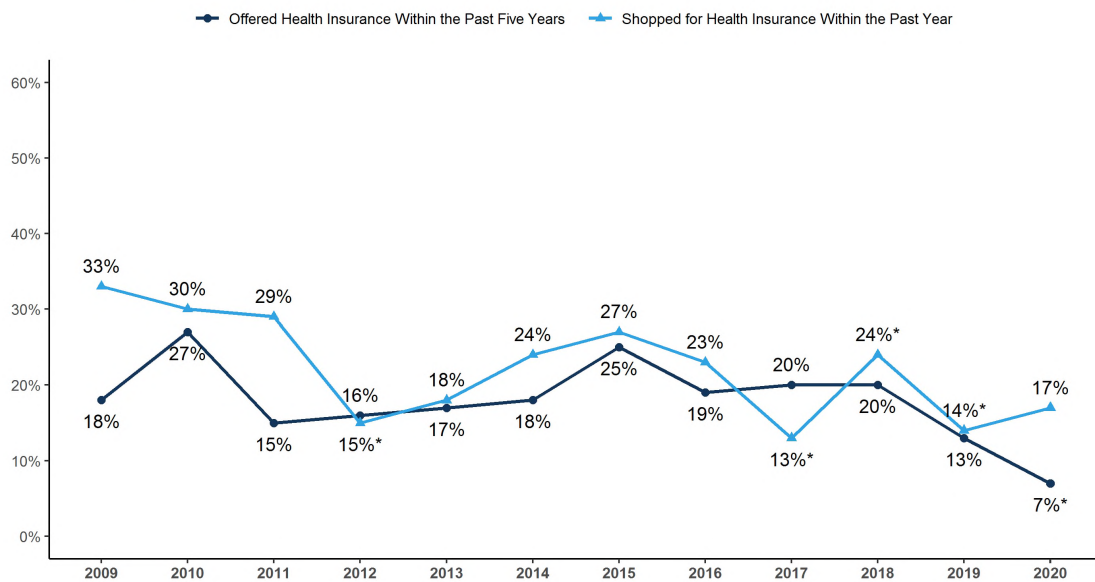
	3-9 Workers	10-199 Workers	All Small Firms
Cost of Health Insurance Too High	28%	56%	37%
Firm Is Too Small	23	14	20
Employees Are Covered Under Another Plan, Including Spouse's	19	11	17
Employees Will Get a Better Deal On Health Insurance Exchanges	5	2	4
Employee Turnover Is Too Great	2	2	2
No Interest/ Employees Do Not Want It	5	3	4
Most Employees Are Part-Time or Temporary Workers	13	6	11
Other	4	4	4
Don't Know	1%	2%	1%

NOTE: Small Firms have 3-199 workers.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 2.14

Among Small Firms Not Offering Health Benefits, Percentage of Firms That Report the Following Actions, 2009-2020



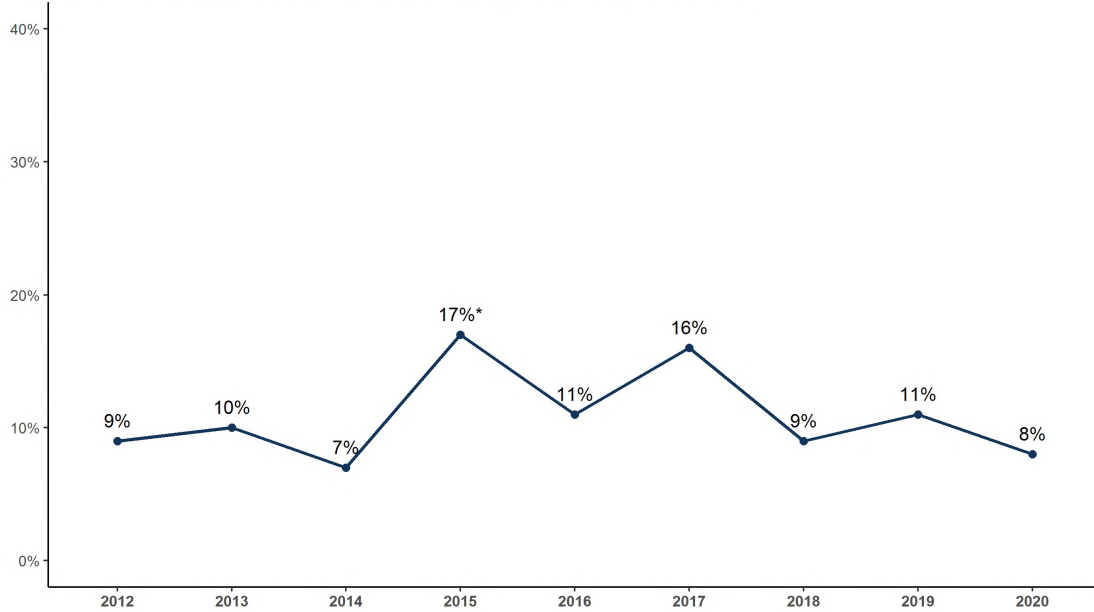
* Estimate is statistically different from estimate for the previous year shown (p < .05).

NOTE: Small Firms have 3-199 workers. 30% of small non-offering firms who indicated they had offered health insurance in the past five years said they stopped offering health benefits in the past 12 months.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

SECTION 2. HEALTH BENEFITS OFFER RATES

Figure 2.15
Among Small Firms Not Offering Health Benefits, Percentage of Firms That Provide Workers Funds to Purchase Non-Group Insurance, by Firm Size, 2012-2020

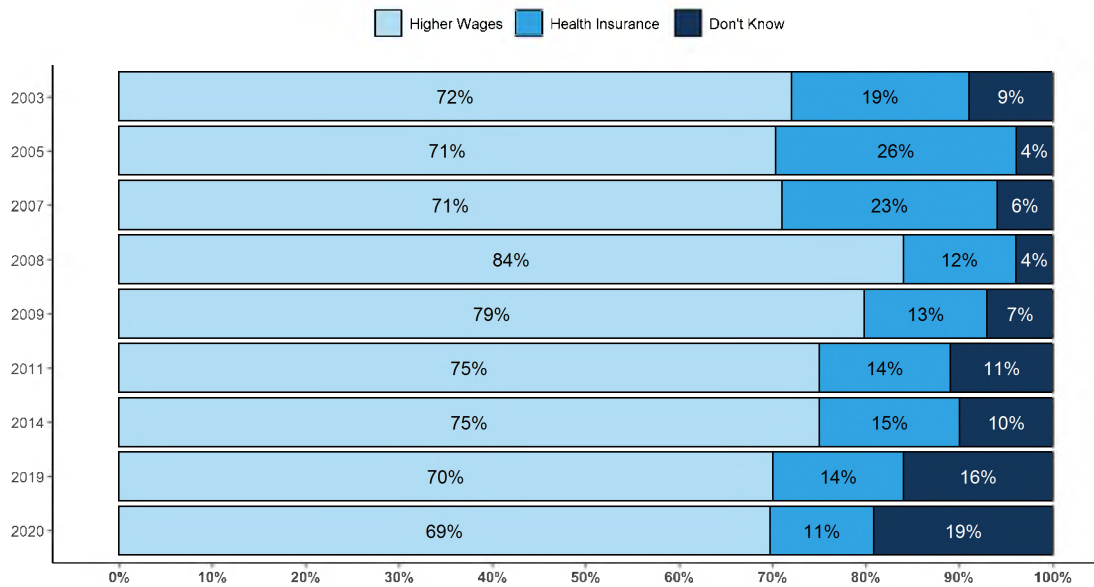


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: Small Firms have 3-199 workers.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012-2017

Figure 2.16
Among Small Firms Not Offering Health Benefits, Firms' View of Employees' Preference for Higher Wages or Health Insurance Benefits, 2003-2020



Tests found no statistical difference from distribution for the previous year shown ($p < .05$).

NOTE: Small Firms have 3-199 workers. The question asks firms whether they believe employees would rather receive an additional \$2 per hour in the form of higher wages or health insurance.

SOURCE: KFF Employer Health Benefits Survey, 2019-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2003-2014

EMPLOYER HEALTH BENEFITS
2020 ANNUAL SURVEY

Employee
Coverage,
Eligibility, and
Participation

SECTION

3

Section 3

Employee Coverage, Eligibility, and Participation

Employers are the principal source of health insurance in the United States, providing health benefits for about 157 million people.¹ Most workers are offered health coverage at work, and most of the workers who are offered coverage take it. Workers may not be covered by their own employer for several reasons: their employer may not offer coverage, they may not be eligible for the benefits offered by their firm, they may elect to receive coverage through their spouse's employer, or they may refuse coverage from their firm. In 2020, 64% of workers in firms offering health benefits are covered by their own firm, similar to the percentages last year, five years ago and ten years ago.

Before eligible workers may enroll in benefits at their firm, 68% of covered workers face a waiting period.

ELIGIBILITY

- Even in firms that offer health benefits, some workers may not be eligible to participate.² Many firms, for example, do not offer coverage to part-time or temporary workers. Among workers in firms offering health benefits in 2020, 82% are eligible to enroll in the benefits offered by their firm, similar to the percentages last year, five years ago, and 10 years ago, for both small and large firms [Figure 3.1].
 - The percentage of workers eligible to enroll in health benefits at their firm is relatively higher in firms with 3-24 workers (86%) [Figure 3.3].
 - Eligibility varies considerably by firm wage level. Workers in firms with a relatively large share of lower-wage workers (where at least 35% of workers earn \$26,000 a year or less) have a lower average eligibility rate than workers in firms with a smaller share of lower-wage workers (72% vs. 82%) [Figure 3.6].
 - Workers in firms with a relatively large share of higher-wage workers (where at least 35% earn \$64,000 or more annually) have a higher average eligibility rate than workers in firms with a smaller share of higher-wage workers (88% vs. 77%) [Figure 3.6].
 - Eligibility also varies by the age of the workforce. Those in firms with a relatively small share of younger workers (where fewer than 35% of the workers are age 26 or younger) have a higher average eligibility rate than those in firms with a larger share of younger workers (84% vs. 62%) [Figure 3.6].
 - Eligibility rates vary considerably for workers in different industries. The average eligibility rate remains particularly low for workers in retail firms (54%) [Figure 3.3].

¹Kaiser Family Foundation. Health Insurance Coverage of the Total Population [Internet]. KFF (Kaiser Family Foundation). 2019 [cited 2020 Aug 10]. Available from: <https://www.kff.org/other/state-indicator/total-population/> Coverage is based on calculations from the 2018 American Community Survey. During the winter and spring of 2020, there was a steep increase in the unemployment rate, potentially decreasing the number of people covered by employer coverage.

²See Section 2 for part-time and temporary worker offer rates.

SECTION 3. EMPLOYEE COVERAGE, ELIGIBILITY, AND PARTICIPATION

Figure 3.1

Eligibility, Take-Up, and Coverage Rates for Workers in Firms Offering Health Benefits, by Firm Size, 1999-2020

	Percentage Eligible			Percentage of Eligible That Take Up			Percentage Covered		
	Small Firms	Large Firms	All Firms	Small Firms	Large Firms	All Firms	Small Firms	Large Firms	All Firms
1999	81%	78%	79%	83%	88%	85%	67%	68%	68%
2000	82%	80%	81%	83%	84%	84%	68%	67%	68%
2001	85%	82%	83%	83%	85%	84%	71%	69%	70%
2002	82%*	80%	81%*	82%	88%	85%	67%*	69%	68%
2003	84%	80%	81%	81%	85%	84%	68%	68%	68%
2004	80%	81%	80%	80%	84%	83%	64%	68%	67%
2005	81%	79%	80%	81%	85%	83%	65%	67%	68%
2006	83%	76%	78%	81%	84%	83%	67%	63%	65%
2007	80%	78%	79%	80%	84%	82%	64%	65%	65%
2008	81%	79%	80%	80%	84%	82%	65%	66%	65%
2009	81%	79%	79%	79%	82%	81%	64%	65%	65%
2010	82%	77%	79%	77%	82%	80%	63%	63%	63%
2011	83%	78%	79%	78%	83%	81%	65%	65%	65%
2012	78%*	78%	77%	78%	82%	81%	61%	62%	62%
2013	80%	76%	77%	77%	81%	80%	62%	62%	62%
2014	79%	76%	77%	77%	81%	80%	61%	62%	62%
2015	81%	79%	79%	76%	81%	79%	61%	63%	63%
2016	82%	78%	79%	77%	79%	79%	63%	62%	62%
2017	82%	78%	79%	75%	79%	78%	62%	62%	62%
2018	82%	77%	79%	73%	78%	76%	60%	60%	60%
2019	82%	79%	80%	74%	78%	76%	60%	61%	61%
2020	84%	81%	82%	74%	80%	78%	61%	65%	64%

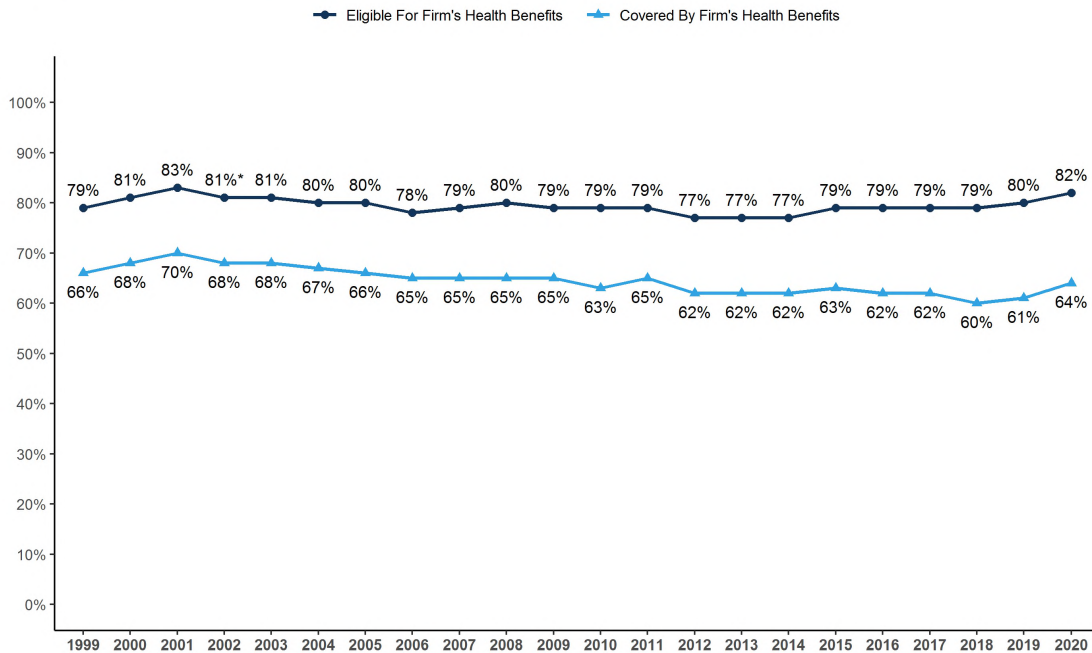
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.

* Estimate is statistically different from estimate for the previous year shown (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 3.2

Eligibility and Coverage Rates for Workers in Firms Offering Health Benefits, 1999-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

SECTION 3. EMPLOYEE COVERAGE, ELIGIBILITY, AND PARTICIPATION

Figure 3.3

Eligibility, Take-Up, and Coverage Rates in Firms Offering Health Benefits, by Firm Size, Region, and Industry, 2020

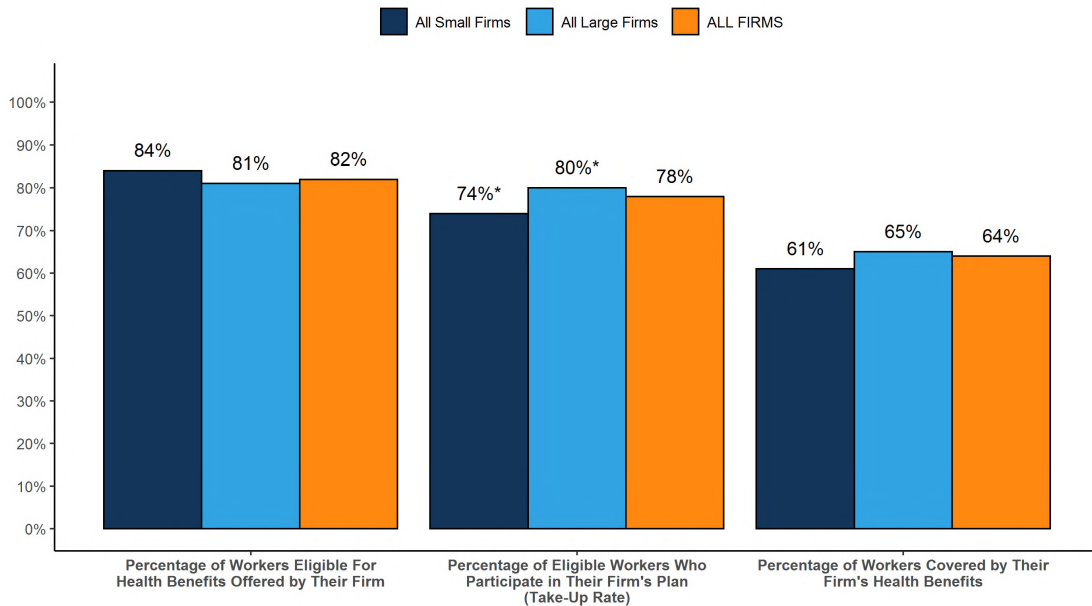
	Percentage of Workers Eligible for Health Benefits Offered by Their Firm	Percentage of Eligible Workers Who Participate in Their Firm's Plan (Take-Up Rate)	Percentage of Workers Covered by Their Firm's Health Benefits
FIRM SIZE			
3-24 Workers	88%*	73%*	63%
25-49 Workers	82	72*	59
50-199 Workers	82	75*	61
200-999 Workers	83	78	65
1,000-4,999 Workers	84	81*	68*
5,000 or More Workers	79	81	63
All Small Firms (3-199 Workers)	84%	74%*	61%
All Large Firms (200 or More Workers)	81%	80%*	65%
REGION			
Northeast	64%	78%	65%
Midwest	82	78	64
South	82	78	64
West	79	80	63
INDUSTRY			
Agriculture/Mining/Construction	79%	72%*	57%*
Manufacturing	92*	81	75*
Transportation/Communications/Utilities	92*	86*	79*
Wholesale	89*	81	72*
Retail	54*	73	40*
Finance	95*	81	77*
Service	81	76*	61
State/Local Government	90*	90*	80*
Health Care	82	75	61
ALL FIRMS	82%	78%	64%

* Estimate for eligibility, take-up, or coverage rate is statistically different from all other firms not in the indicated size, region, or industry category (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2020

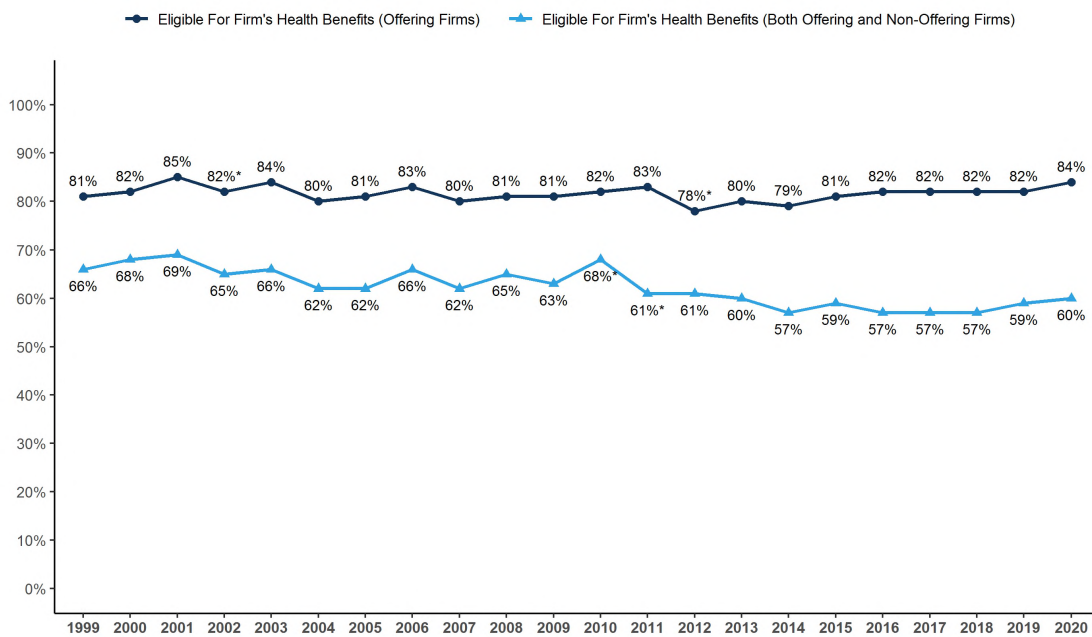
SECTION 3. EMPLOYEE COVERAGE, ELIGIBILITY, AND PARTICIPATION

Figure 3.4
Eligibility, Take-Up, and Coverage Rates in Firms Offering Health Benefits, by Firm Size, 2020



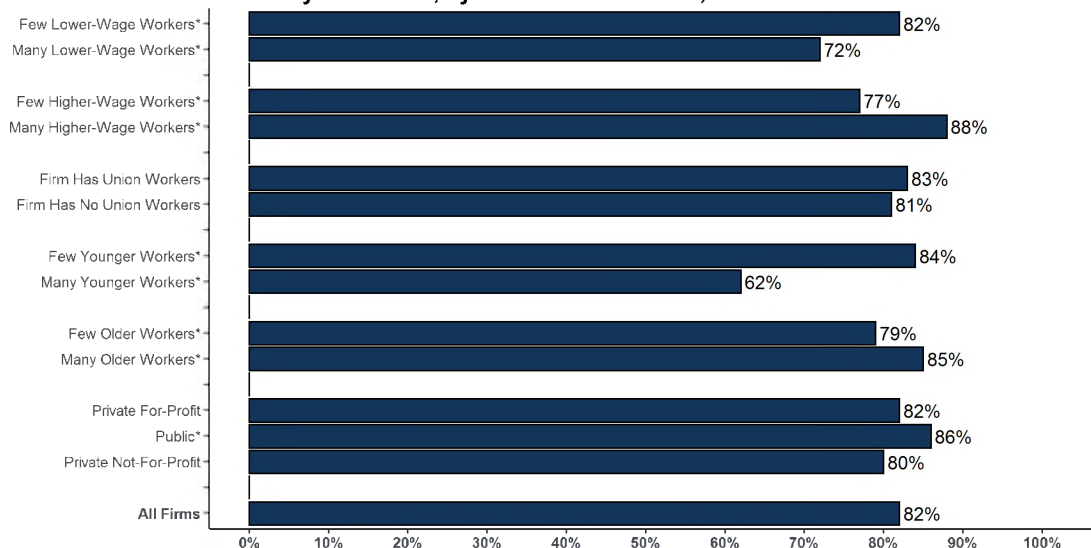
* Estimate for eligibility, take-up, or coverage rate is statistically different between large and small firms ($p < .05$).
 NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 3.5
Among Workers at Small Firms, Eligibility for Workers At Their Own Firms, 1999-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
 NOTE: By definition, no workers at non-offering firms are eligible for health benefits.
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 3.6
Among Workers in Firms Offering Health Benefits, Percentage of Workers Eligible for Health Benefits Offered by Their Firm, by Firm Characteristics, 2020



* Estimates are statistically different from each other within category ($p < .05$).

NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings (\$26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings (\$64,000 in 2020). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.

SOURCE: KFF Employer Health Benefits Survey, 2020

TAKE-UP RATE

- Seventy-eight percent of eligible workers take up coverage when it is offered to them, similar to the percentage last year. The share of eligible workers taking up coverage in large firms is higher than the share in small firms [Figure 3.1].³
 - The likelihood of a worker accepting a firm’s offer of coverage varies by firm wage level. Eligible workers in firms with a relatively large share of lower-wage workers have a lower average take up rate than eligible workers in firms with a smaller share of lower-wage workers (65% vs. 79%) [Figure 3.7].
 - Eligible workers in firms with a relatively large share of higher-wage workers have a higher average take up rate than those in firms with a smaller share of higher-wage workers (82% vs. 75%) [Figure 3.7].
 - The likelihood of a worker accepting a firm’s offer of coverage also varies with the age distribution of the workforce. Eligible workers in firms with a relatively large share of younger workers have a lower average take up rate than those in firms with a smaller share of younger workers (65% vs. 79%) [Figure 3.7].
- Eligible workers in private, for-profit firms have a lower average take up rate (76%) and eligible workers in public firms have a higher average take up rate (89%) than workers in other firm types [Figure 3.7].
- Eligible workers in firms with some union workers have a higher average take up rate than those in firms with no union workers (82% vs. 76%) [Figure 3.7].

³In 2009, we began weighting the percentage of workers that take up coverage by the number of workers eligible for coverage. The historical take-up estimates have also been updated. See the Survey Design and Methods section for more information.

- The average percentages of eligible workers taking up benefits in offering firms also varies across industries [Figure 3.3].
- The share of eligible workers taking up benefits in offering firms (78%) is similar to the shares in 2015 (79%) and in 2010 (80%) [Figure 3.1].

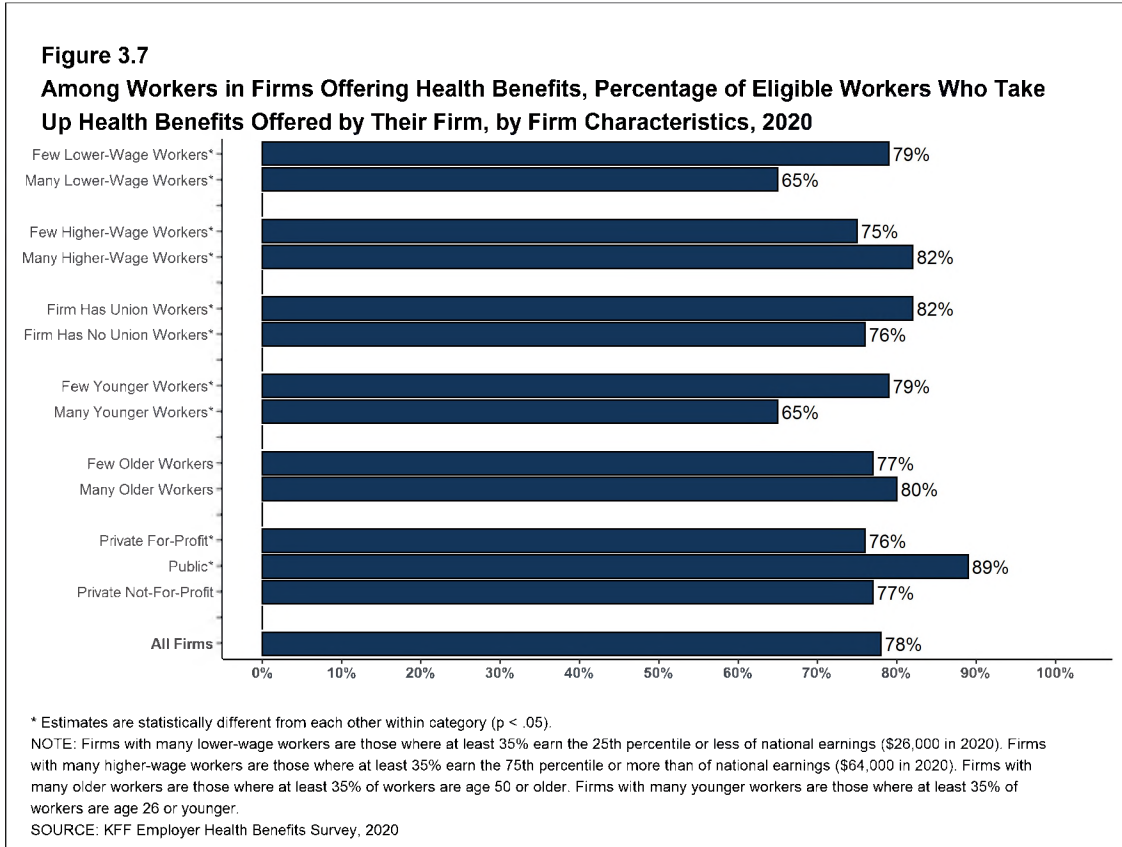
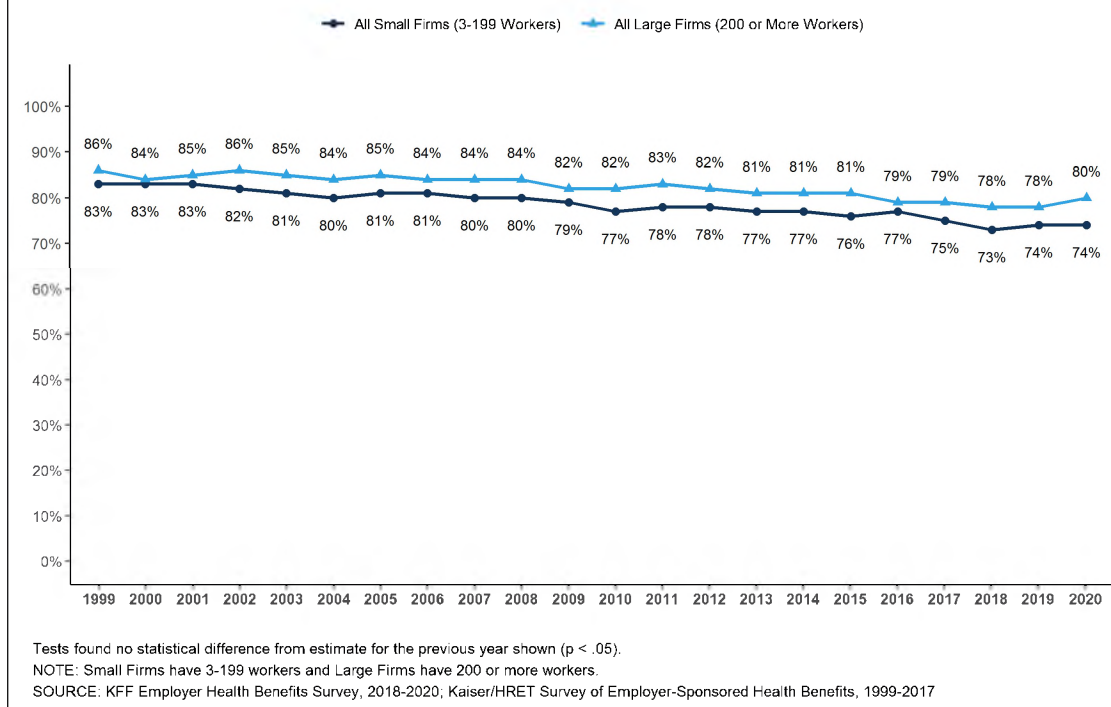


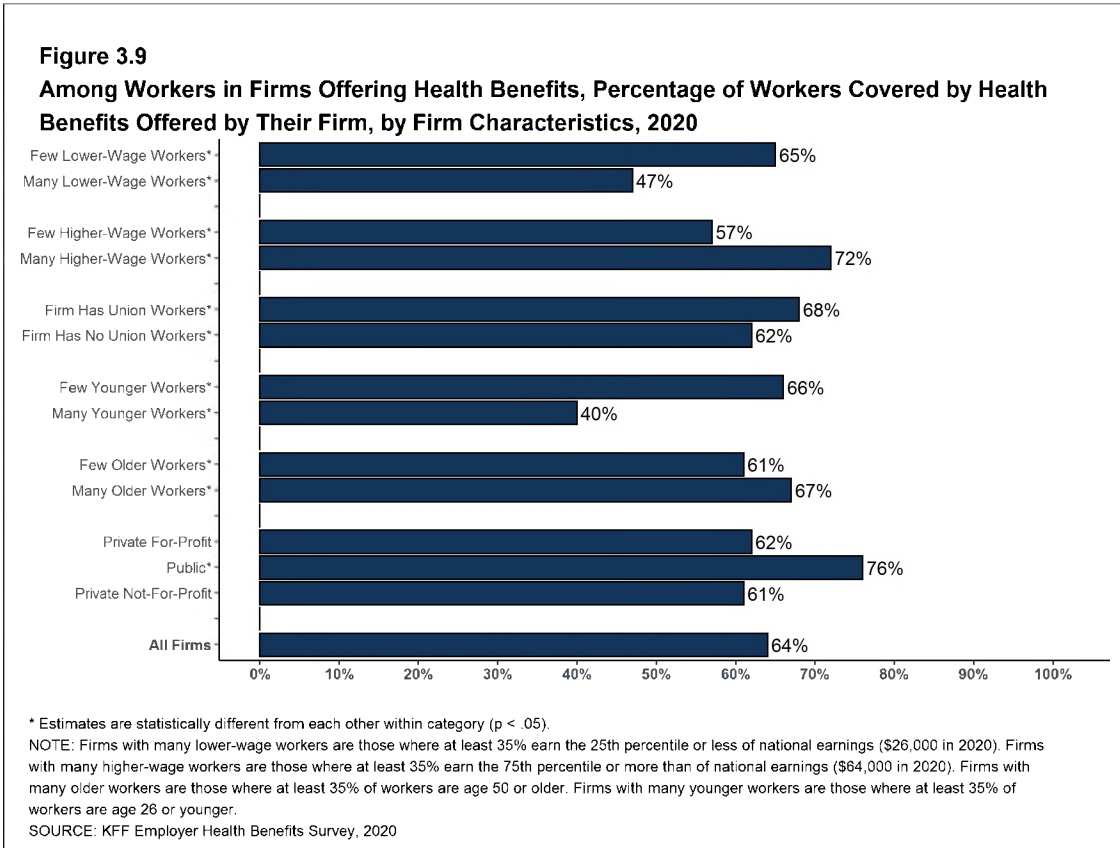
Figure 3.8
Among Workers in Firms Offering Health Benefits, Percentage of Eligible Workers Who Take Up Health Benefits Offered by Their Firm, by Firm Size, 1999-2020



COVERAGE

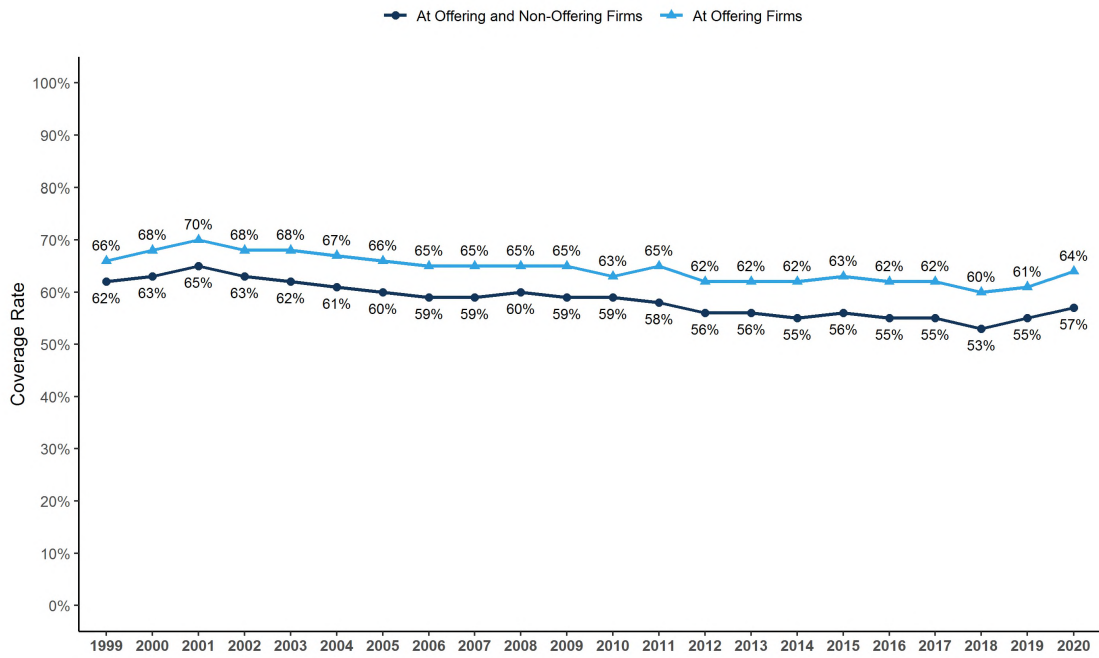
- In 2020, the percentage of workers at firms offering health benefits covered by their firm's health plan is 64%, similar to the percentage last year [Figure 3.1] and [Figure 3.2].
 - The coverage rate at firms offering health benefits is similar for small firms and large firms in 2020. These rates are similar to the rates last year for both small firms and large firms [Figure 3.1] and [Figure 3.3].
- There is significant variation by industry in the coverage rate among workers in firms offering health benefits. The average coverage rate is particularly low in the retail industry (40%) [Figure 3.3].
- There also is variation by firm wage levels. Among workers in firms offering health benefits, those in firms with a relatively large share of lower-wage workers are less likely to be covered by their own firm than workers in firms with a smaller share of lower-wage workers (47% vs. 65%). A similar pattern exists in firms with a relatively large share of higher-wage workers, with workers in these firms being more likely to be covered by their employer's health benefits than those in firms with a smaller share of higher-wage workers (72% vs. 57%) [Figure 3.9].
- The age distribution of workers is also related to variation in coverage rates. Among workers in firms offering health benefits, those in firms with a relatively small share of younger workers are more likely to be covered by their own firm than those in firms with a larger share of younger workers (66% vs. 40%). Similarly, workers in offering firms with a relatively large share of older workers are more likely to be covered by their own firm than those in firms with a smaller share of older workers (67% vs. 61%) [Figure 3.9].

- Among workers in firms offering health benefits, those working in public firms are more likely than workers in other firm types to be covered by their own firm [Figure 3.9].
- Among workers in all firms, including those that offer and those that do not offer health benefits, 57% are covered by health benefits offered by their employer, similar to the percentages last year and five years ago [Figure 3.10]. The offer rate estimate for 2010 was an aberration so we are not making a coverage rate comparison to ten years ago.



SECTION 3. EMPLOYEE COVERAGE, ELIGIBILITY, AND PARTICIPATION

Figure 3.10
Percentage of Workers Covered by Their Firm's Health Benefits, 1999-2020



Tests found no statistical difference from estimate for the previous year shown (p < .05).
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 3.11
Percentage of All Workers Covered by Their Firm's Health Benefits, Both in Firms Offering and Not Offering Health Benefits, by Firm Size, 1999-2020

	3-24 Workers	25-49 Workers	50-199 Workers	200-999 Workers	1,000-4,999 Workers	5,000 or More Workers	All Small Firms	All Large Firms	All Firms
1999	50%	56%	61%	69%	68%	64%	55%	66%	62%
2000	50%	63%	62%	69%	68%	68%	57%	67%	63%
2001	49%	62%	67%	71%	69%	69%	56%	69%	65%
2002	45%	57%	64%	69%	70%	68%	54%	68%	63%
2003	44%	59%	61%	68%	69%	68%	53%	68%	62%
2004	43%	56%	56%	69%	68%	67%	50%	68%	61%
2005	41%	55%	59%	65%	69%	68%	50%	68%	60%
2006	45%	55%	62%	66%	68%	60%	53%	63%	59%
2007	42%	51%	59%	65%	69%	63%	50%	65%	59%
2008	43%	57%	60%	67%	69%	64%	52%	66%	60%
2009	39%	54%	59%	63%	67%	65%	49%	65%	59%
2010	44%	59%	60%	61%	68%	63%	52%	63%	59%
2011	38%	49%	59%	63%	66%	64%	48%*	64%	58%
2012	36%	54%	58%	61%	66%	61%	47%	62%	56%
2013	36%	53%	57%	63%	67%	58%	46%	61%	56%
2014	33%	52%	55%	60%	68%	61%	44%	62%	55%
2015	35%	49%	54%	61%	66%	63%	45%	63%	56%
2016	32%	47%	57%	62%	63%	60%	44%	61%	55%
2017	32%	45%	55%	60%	64%	61%	43%	62%	55%
2018	30%	44%	54%	62%	62%	59%	41%	60%	53%
2019	32%	48%	56%	65%	66%	58%	44%	61%	55%
2020	34%	41%	58%	65%	68%	63%	44%	65%	57%

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
 * Estimate is statistically different from estimates for the previous years shown (p < .05).
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

WAITING PERIODS

- Waiting periods are a specified length of time after beginning employment before a worker is eligible to enroll in health benefits. With some exceptions, the Affordable Care Act (ACA) requires that waiting periods cannot exceed 90 days. For example, employers are permitted to have orientation periods before the waiting period begins which, in effect, means a worker is not eligible for coverage three months after being hired. If a worker is eligible to enroll on the 1st of the month after three months of employment, this survey rounds up and considers the firm's waiting period four months. For these reasons, some employers still have waiting periods exceeding the 90-day maximum.
- Sixty-eight percent of covered workers face a waiting period before coverage is available, similar to two years ago [Figure 3.12]. Covered workers in small firms are more likely than those in large firms to have a waiting period (78% vs. 64%) [Figure 3.12].
- The average waiting period among covered workers who face a waiting period is 1.9 months [Figure 3.12]. A small percentage (5%) of covered workers with a waiting period have a waiting period of more than 3 months.
 - Respondents with waiting periods greater than 4 months generally indicated that employees had training, orientation, or measurement periods in which they were employees but were not eligible for health benefits. Some employers have measurement periods to determine whether variable hour employees will meet the requirements for the firm's health benefits.

Figure 3.12

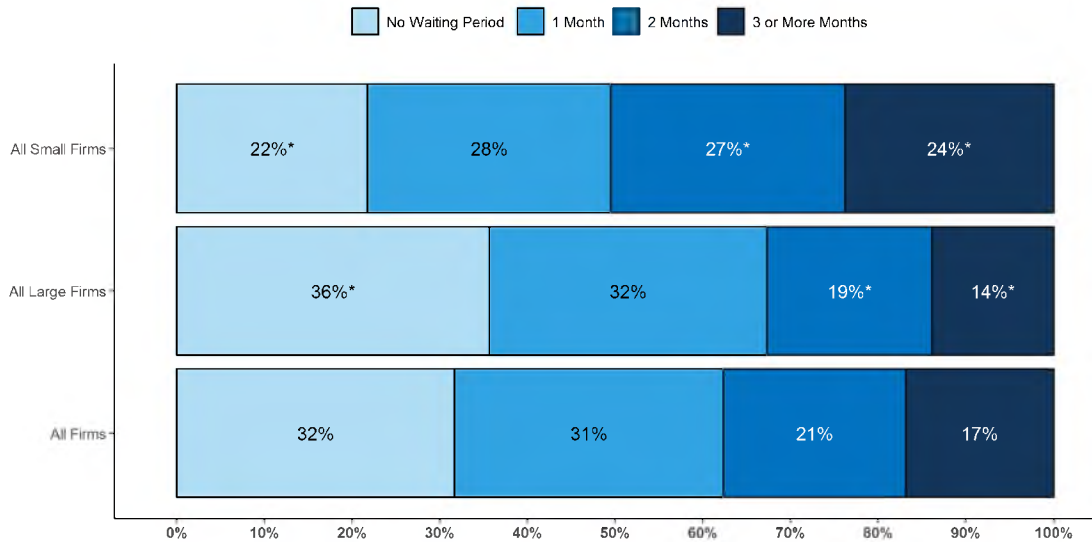
Percentage of Covered Workers in Firms With a Waiting Period for Coverage and Average Waiting Period in Months, by Firm Size, Region, and Industry, 2020

	Percentage of Covered Workers in Firms With a Waiting Period	Among Covered Workers With a Waiting Period, Average Waiting Period (Months)
FIRM SIZE		
All Small Firms (3-199 Workers)	78%*	2.1*
All Large Firms (200 or More Workers)	64%*	1.8*
REGION		
Northeast	63%	2.3*
Midwest	70	1.8
South	68	1.8
West	71	1.9
INDUSTRY		
Agriculture/Mining/Construction	86%*	2.6*
Manufacturing	78	1.9
Transportation/Communications/Utilities	53	1.5*
Wholesale	73	2.2
Retail	78	2.7*
Finance	76	2.1
Service	61*	1.8
State/Local Government	60	1.3*
Health Care	74	1.7*
ALL FIRMS	68%	1.9

* Estimate is statistically different from estimate for all firms not in the indicated size, region, or industry category (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 3.13
Distribution of Covered Workers with the Following Waiting Periods for Coverage, by Firm Size, 2020

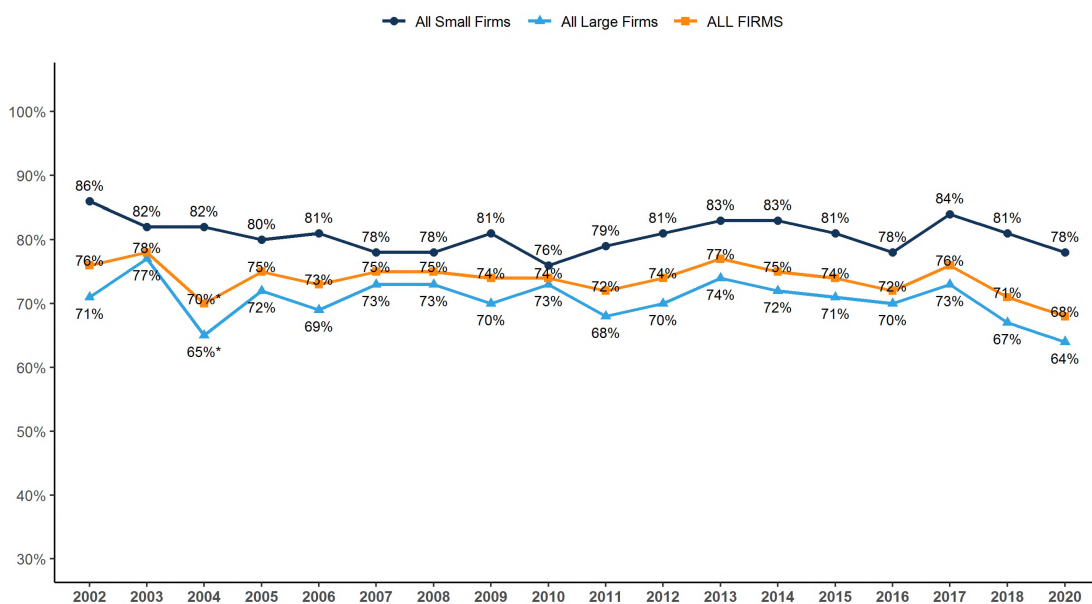


* Estimates are statistically different from each other within category ($p < .05$).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. If a worker is eligible to enroll on the 1st of the month after three months of employment, this survey rounds up and considers the firm's waiting period four months. Some firms indicated that employees had training or measurement periods during which they were not eligible for health benefits. For these reasons, some firms still have waiting periods exceeding the 90-day maximum.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 3.14
Percentage of Covered Workers in Firms with a Waiting Period for Coverage, by Firm Size, 2002-2020



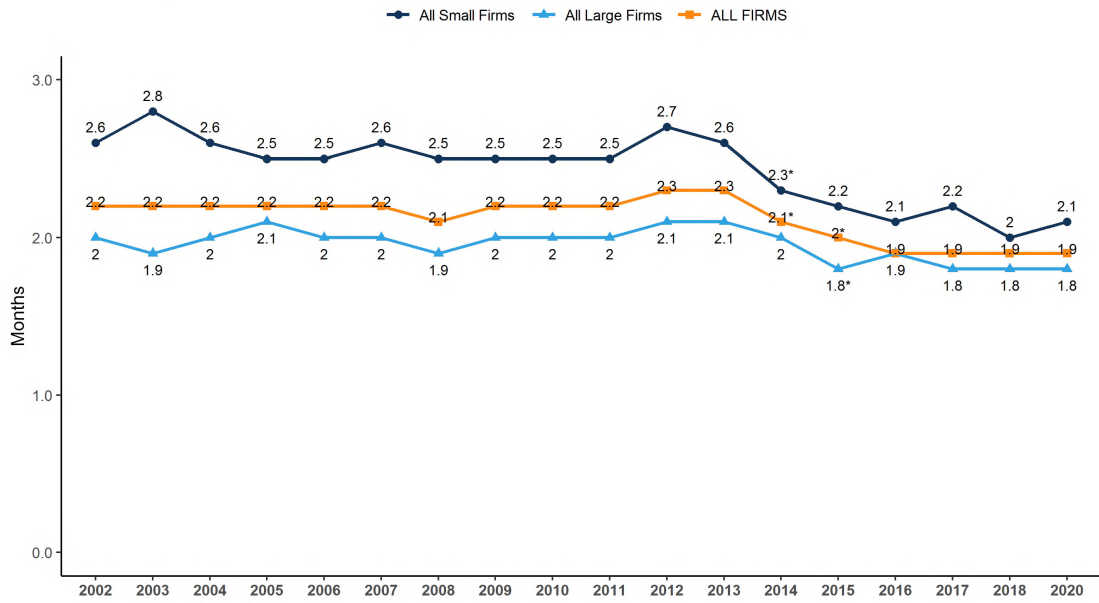
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017

SECTION 3. EMPLOYEE COVERAGE, ELIGIBILITY, AND PARTICIPATION

Figure 3.15
Among Covered Workers With A Waiting Period for Health Benefits, Average Waiting Period in Months, by Firm Size, 2002-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017

EMPLOYER HEALTH BENEFITS

2020 ANNUAL SURVEY

Types of
Plans
Offered

SECTION

4

Section 4

Types of Plans Offered

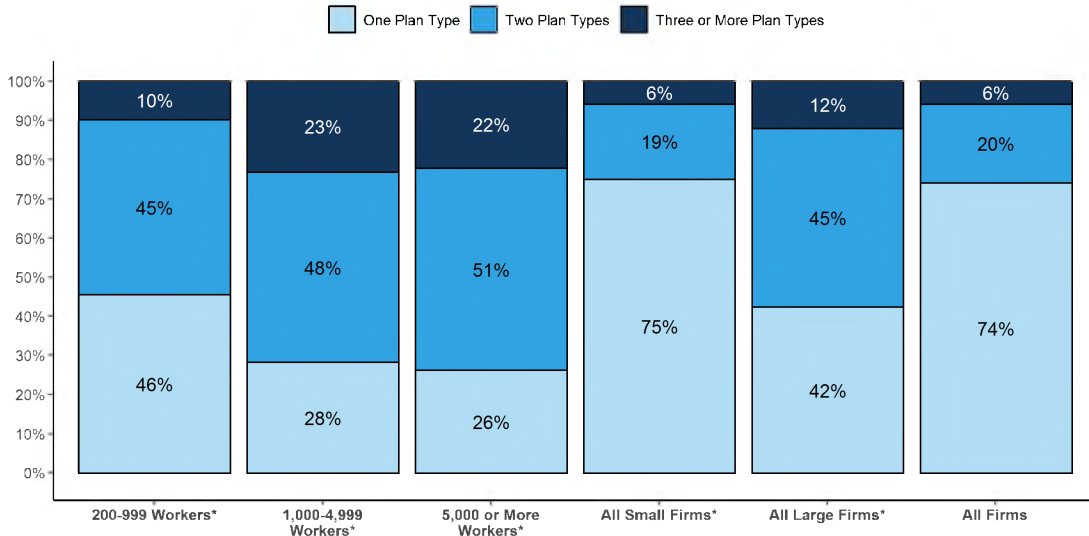
Most firms that offer health benefits offer only one type of health plan (74%). Large firms (200 or more workers) are more likely than small firms (3-199 workers) to offer more than one type of health plan. Firms are most likely to offer their workers a PPO plan and are least likely to offer a conventional plan (sometimes known as indemnity insurance).

NUMBER OF PLAN TYPES OFFERED

- In 2020, 74% of firms offering health benefits offer only one type of health plan. Large firms are more likely than small firms to offer more than one plan type (58% vs. 25%) [Figure 4.1].
- Sixty-four percent of covered workers are employed in a firm that offers more than one type of health plan. Seventy-four percent of covered workers in large firms are employed by a firm that offers more than one plan type, compared to 37% in small firms [Figure 4.2].
- Seventy-eight percent of covered workers in firms offering health benefits work in firms that offer one or more PPOs; 62% work in firms that offer one or more HDHP/SOs; 30% work in firms that offer one or more HMOs; 15% work in firms that offer one or more POS plans; and 3% work in firms that offer one or more conventional plans [Figure 4.4].
- Among covered workers in firms offering only one type of health plan, 56% are in firms that only offer one or more PPOs and 24% are in firms that only offer one or more HDHP/SOs [Figure 4.5].

SECTION 4. TYPES OF PLANS OFFERED

Figure 4.1
Among Firms Offering Health Benefits, Percentage of Firms That Offer One, Two, or Three or More Plan Types, by Firm Size, 2020

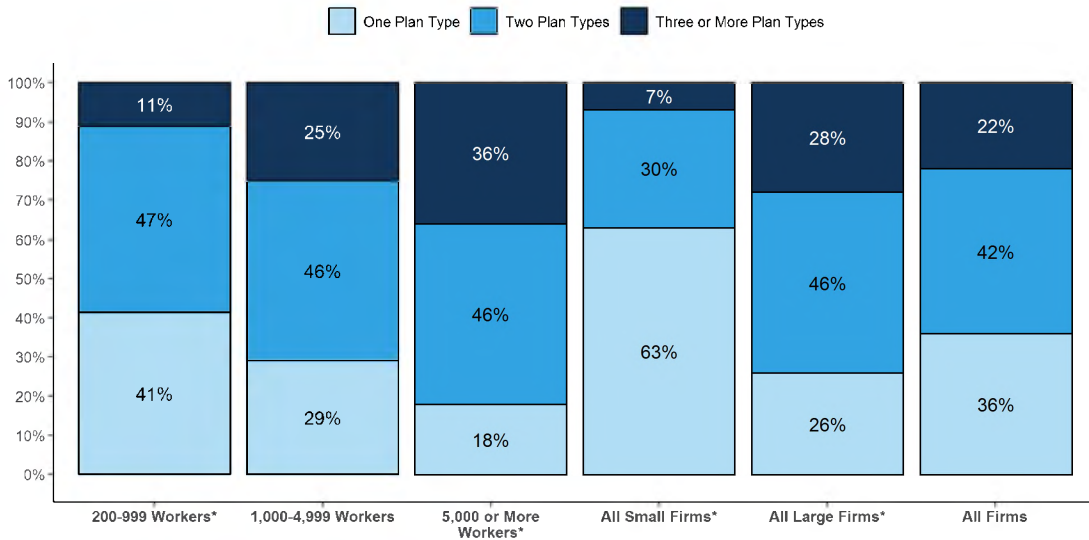


* Distribution is statistically different from distribution for all other firms not in the indicated size category ($p < .05$).

NOTE: The survey collects information on a firm's plan with the largest enrollment in each of the plan types. While we know the number of plan types a firm has, we do not know the total number of plans a firm offers, as firms may offer more than one of each plan type. Additionally, firms may offer different types of plans to different workers. The survey asks how many Conventional, HMO, PPO, POS, and HDHP/SO plans are offered. Small Firms have 3-199 workers and Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 4.2
Among Firms Offering Health Benefits, Percentage of Covered Workers in Firms Offering One, Two, or Three or More Plan Types, by Firm Size, 2020



* Distribution is statistically different from distribution for all other firms not in the indicated size category ($p < .05$).

NOTE: The survey collects information on a firm's plan with the largest enrollment in each of the plan types. While we know the number of plan types a firm has, we do not know the total number of plans a firm offers, as firms may offer more than one of each plan type. Additionally, firms may offer different types of plans to different workers. The survey asks how many Conventional, HMO, PPO, POS, and HDHP/SO plans are offered. Small Firms have 3-199 workers and Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2020

SECTION 4. TYPES OF PLANS OFFERED

Figure 4.3

Among Firms Offering Health Benefits, Percentage of Firms That Offer the Following Plan Types, by Firm Size, 2020

	Conventional	HMO	PPO	POS	HDHP/SO
FIRM SIZE					
3-24 Workers	4%	10%	54%	34%	21%*
25-199 Workers	1	16	59	25	39*
200-999 Workers	2	21*	69*	16*	53*
1,000-4,999 Workers	4	31*	86*	10*	67*
5,000 or More Workers	3	32*	84*	10*	71*
All Small Firms (3-199 Workers)	3%	11%*	55%*	32%*	25%*
All Large Firms (200 or More Workers)	2%	23%*	72%*	15%*	56%*
ALL FIRMS	3%	11%	56%	31%	26%

NOTE: The survey collects information on a firm's plan with the largest enrollment in each of the plan types. While we know the number of plan types a firm has, we do not know the total number of plans a firm offers, as firms may offer more than one of each plan type. Additionally, firms may offer different types of plans to different workers. The survey asks how many Conventional, HMO, PPO, POS, and HDHP/SO plans are offered.

* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 4.4

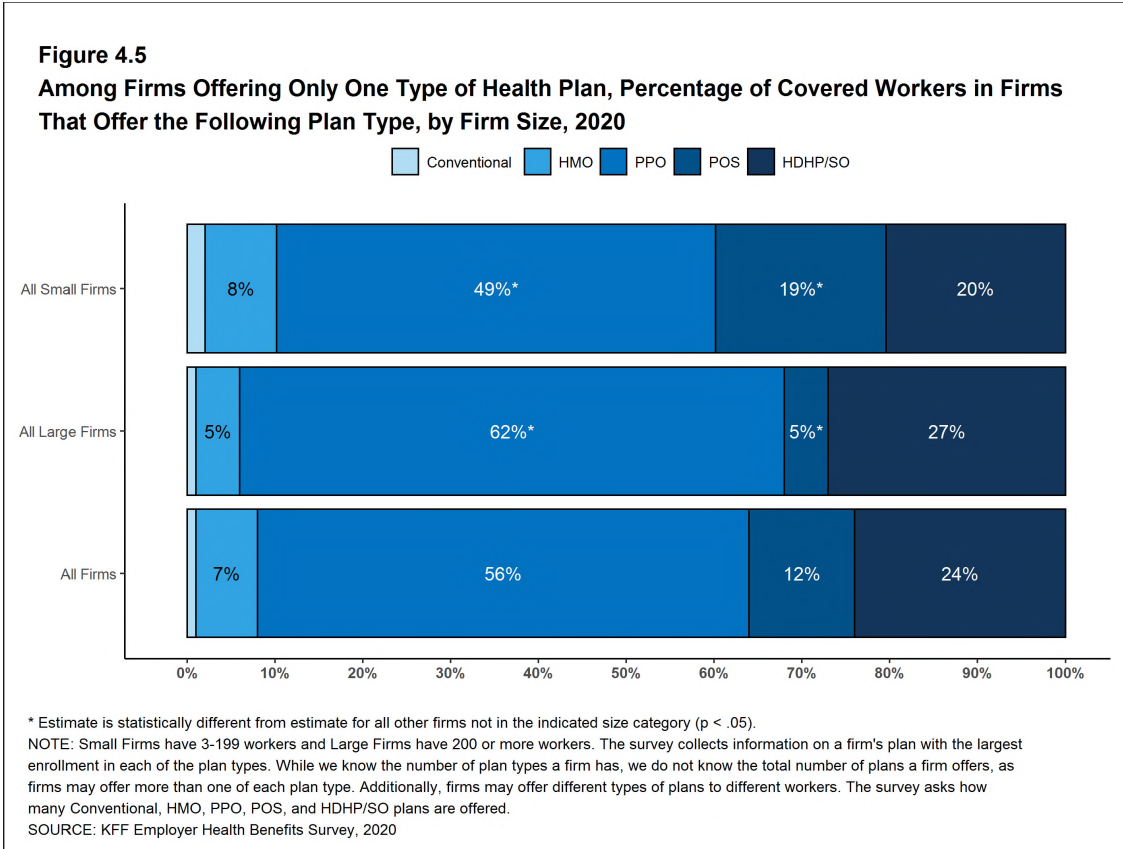
Among Firms Offering Health Benefits, Percentage of Covered Workers in Firms That Offer the Following Plan Types, by Firm Size, 2020

	Conventional	HMO	PPO	POS	HDHP/SO
FIRM SIZE					
200-999 Workers	2%	22%*	75%	13%	57%
1,000-4,999 Workers	4	30	87*	9*	70*
5,000 or More Workers	3	44*	86*	11	77*
All Small Firms (3-199 Workers)	2%	16%*	63%*	23%*	38%*
All Large Firms (200 or More Workers)	3%	36%*	84%*	11%*	71%*
ALL FIRMS	3%	30%	78%	15%	62%

NOTE: The survey collects information on a firm's plan with the largest enrollment in each of the plan types. While we know the number of plan types a firm has, we do not know the total number of plans a firm offers, as firms may offer more than one of each plan type. Additionally, firms may offer different types of plans to different workers. The survey asks how many Conventional, HMO, PPO, POS, and HDHP/SO plans are offered.

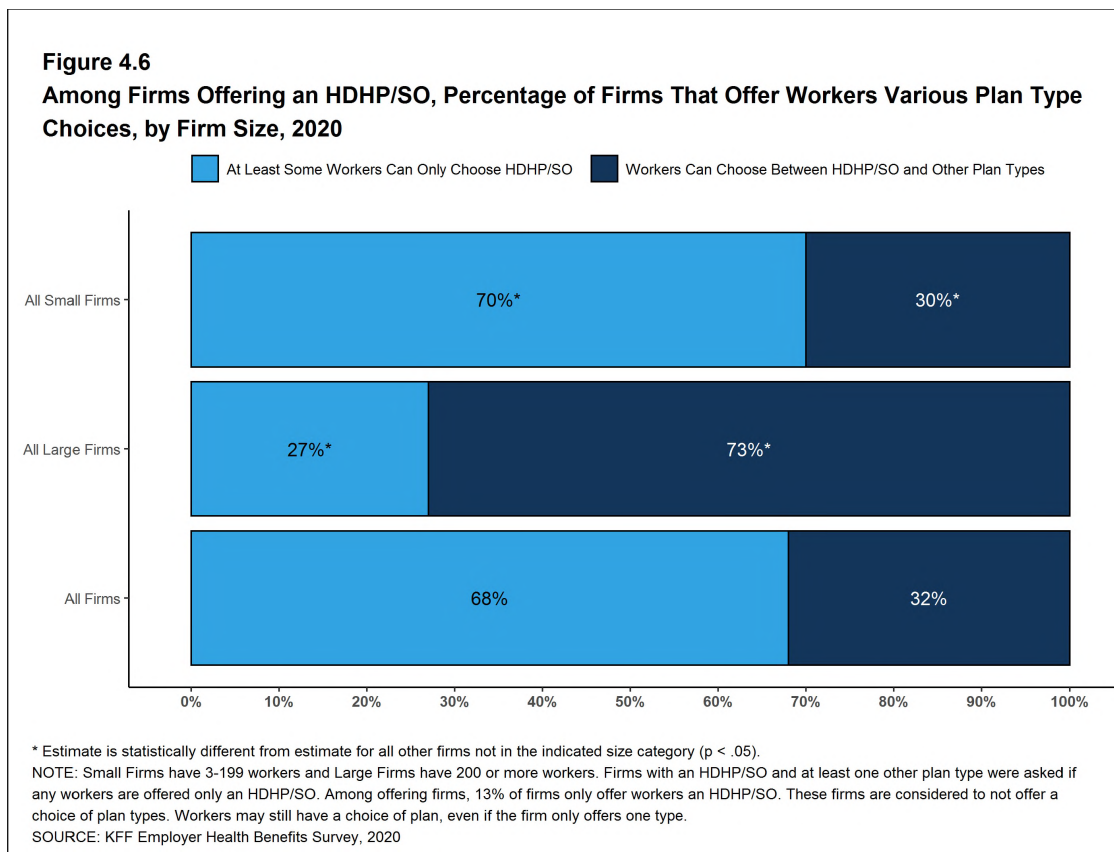
* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2020



CHOICE OF HDHP/SO PLANS

- Some firms only offer workers an HDHP/SO, or do not make other plan choices available to some workers. At 68% of firms that offer an HDHP/SO, at least some workers can only choose an HDHP/SO, while 32% of firms that offer an HDHP/SO allow workers to choose between an HDHP/SO and other plan types [Figure 4.6].



The survey collects information on a firm's plan with the largest enrollment in each of the plan types. While we know the number of plan types a firm has, we do not know the total number of plans a firm offers workers. In addition, firms may offer different types of plans to different workers. For example, some workers might be offered one type of plan at one location, while workers at another location are offered a different type of plan.

HMO is a health maintenance organization. The survey defines an HMO as a plan that does not cover non-emergency out-of-network services.

PPO is a preferred provider organization. The survey defines PPOs as plans that have lower cost sharing for in-network provider services, and do not require a primary care gatekeeper to screen for specialist and hospital visits.

POS is a point-of-service plan. The survey defines POS plans as those that have lower cost sharing for in-network provider services, but do require a primary care gatekeeper to screen for specialist and hospital visits.

HDHP/SO is a high-deductible health plan with a savings option such as an HRA or HSA. HDHP/SOs are treated as a distinct plan type even if the plan would otherwise be considered a PPO, HMO, POS plan, or indemnity plan. These plans have a deductible of at least \$1,000 for single coverage and \$2,000 for family coverage and are offered with an HRA, or are HSA-qualified. See Section 8 for more information on HDHP/SOs.

Conventional/Indemnity The survey defines conventional or indemnity plans as those that have no preferred provider networks and the same cost sharing regardless of physician or hospital.

EMPLOYER HEALTH BENEFITS

2020 ANNUAL SURVEY

Market
Shares of
Health Plans

SECTION

5

Section 5

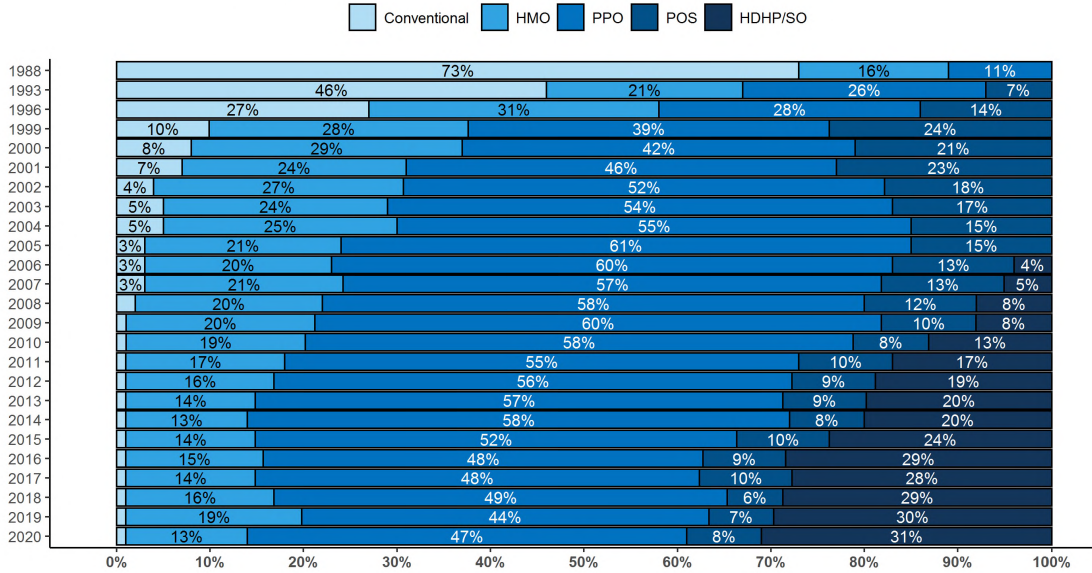
Market Shares of Health Plans

PPOs are the most common plan type, covering 47% of covered workers, followed by HDHP/SOs, HMOs, POS plans, and conventional plans. The drop in the share of covered workers in PPOs in 2019 was not statistically significant.

- Forty-seven percent of covered workers are enrolled in PPOs, followed by HDHP/SOs (31%), HMOs (13%), POS plans (8%), and conventional plans (1%) [Figure 5.1].
- The percentage of covered workers enrolled in HDHP/SOs is similar to last year, but has increased over the past decade. The percentage of covered workers enrolled in PPOs decreased by 11% over the past decade.
- The percentage of covered workers enrolled in HMOs (13%) is significantly lower than the percentage last year (19%) but not different from 2015 (14%). This percentage has moved over the last few years and we are unsure as to why. As noted above, we employed a new survey firm in 2020 and the change could represent a difference in interpretation of plan characteristics by new interviewers. There also may be measurement error in any of the years. We will continue to watch this topic.
- A larger share of covered workers are enrolled in HDHP/SOs than in HMOs in small and large firms.
- Covered workers in large firms are more likely to be enrolled in HDHP/SOs than covered workers in small firms (33% vs. 25%) [Figure 5.2]. Covered workers in small firms are much more likely than covered workers in large firms to be enrolled in POS plans (17% vs. 5%) [Figure 5.2].
- Plan enrollment patterns also differ across regions.
 - HMO enrollment is significantly higher in the West (22%), and significantly lower in the Midwest (7%) [Figure 5.3].
 - Covered workers in the Midwest (39%) are more likely to be enrolled in HDHP/SOs than workers in other regions, while covered workers in the West (24%) are less likely to be enrolled in HDHP/SOs [Figure 5.3].

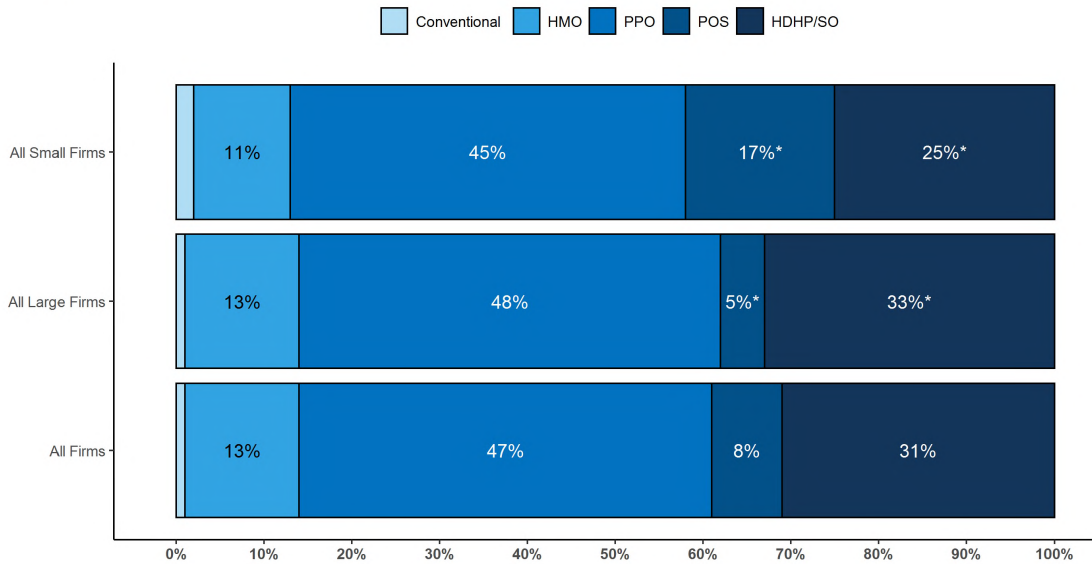
SECTION 5. MARKET SHARES OF HEALTH PLANS

Figure 5.1
Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988-2020



NOTE: Information was not obtained for POS plans in 1988 or for HDHP/SO plans until 2006. A portion of the change in 2005 is likely attributable to incorporating more recent Census Bureau estimates of the number of state and local government workers and removing federal workers from the weights. See the Survey Design and Methods section from the 2005 Kaiser/HRET Survey of Employer-Sponsored Health Benefits.
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017; KPMG Survey of Employer-Sponsored Health Benefits, 1993 and 1996; The Health Insurance Association of America (HIAA), 1988.

Figure 5.2
Distribution of Health Plan Enrollment for Covered Workers, by Plan Type and Firm Size, 2020



* Enrollment in plan type is statistically different between All Small Firms and All Large Firms ($p < .05$).
 NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. HMO is health maintenance organization. PPO is preferred provider organization. POS is point-of-service plan. HDHP/SO is high-deductible health plan with a savings option, such as a health reimbursement arrangement (HRA) or health savings account (HSA).
 SOURCE: KFF Employer Health Benefits Survey, 2020

SECTION 5. MARKET SHARES OF HEALTH PLANS

Figure 5.3

Distribution of Health Plan Enrollment for Covered Workers, by Firm Size, Region, and Industry, 2020

	Conventional	HMO	PPO	POS	HDHP/SO
FIRM SIZE					
3-24 Workers	4%	9%	41%	25%*	21%*
25-49 Workers	0*	9	38	22*	31
50-199 Workers	1	13	50	9	27
200-999 Workers	1	12	51	8	28
1,000-4,999 Workers	<1	11	55*	5*	29
5,000 or More Workers	<1	15	45	4*	36*
All Small Firms (3-199 Workers)	2%*	11%	45%	17%*	25%*
All Large Firms (200 or More Workers)	<1%*	13%	48%	5%*	33%*
REGION					
Northeast	<1%	16%	42%	13%	29%
Midwest	<1	7*	47	6	39*
South	1	10	53	8	29
West	1	22*	43	9	24*
INDUSTRY					
Agriculture/Mining/Construction	2%	7%	57%	14%	21%*
Manufacturing	<1*	7*	48	5	40
Transportation/Communications/Utilities	<1*	15	45	3*	37
Wholesale	1	6*	49	6	38
Retail	1	11	51	6	32
Finance	1	10	43	3*	43
Service	1	16	42*	10	31
State/Local Government	0*	12	53	11	23
Health Care	1	14	55	12	17*
ALL FIRMS	1%	13%	47%	8%	31%
NOTE: HMO is health maintenance organization. PPO is preferred provider organization. POS is point-of-service plan. HDHP/SO is high-deductible health plan with a savings option, such as a health reimbursement arrangement (HRA) or health savings account (HSA).					
* Estimate is statistically different from estimate for all firms not in the indicated size, region, or industry category (p < .05).					
SOURCE: KFF Employer Health Benefits Survey, 2020					

EMPLOYER HEALTH BENEFITS
2020 ANNUAL SURVEY

Worker and
Employer
Contributions
for Premiums

SECTION

6

Section 6

Worker and Employer Contributions for Premiums

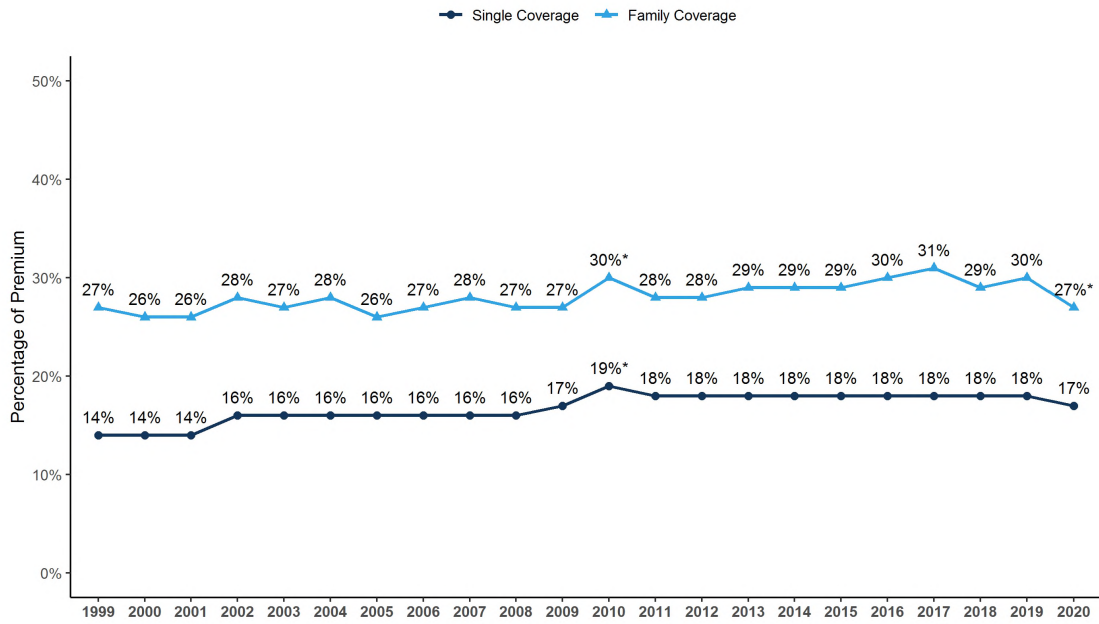
In 2020, covered workers on average contribute 17% of the premium for single coverage and 27% of the premium for family coverage.¹ The average monthly worker contributions are \$104 for single coverage (\$1,243 annually) and \$466 for family coverage (\$5,588 annually). The average contribution amount for family coverage is higher for covered workers in small firms (3-199 workers) than for covered workers in large firms (200 or more workers) (\$6,820 vs. \$5,112).

- In 2020, covered workers on average contribute 17% of the premium for single coverage and 27% of the premium for family coverage. The average percentage contributed for single coverage has remained stable in recent years. The average percentage contributed for family coverage is lower in 2020 than the percentage (30%) last year [Figure 6.1].²
 - Covered workers in small firms on average contribute a much higher percentage of the premium for family coverage (35% vs. 24%) than covered workers in large firms [Figure 6.2].
- Workers with single coverage have an average contribution of \$104 per month (\$1,243 annually), and workers with family coverage have an average contribution of \$466 per month (\$5,588 annually) toward their health insurance premiums [Figure 6.3], [Figure 6.4], and [Figure 6.5].
 - The average worker contributions in HDHP/SOs are lower than the overall average worker contribution for single coverage (\$1,061 vs. \$1,243) and family coverage (\$4,852 vs. \$5,588). The average worker contributions in PPOs are higher than the overall average worker contribution for family coverage (\$6,017 vs. \$5,588) [Figure 6.6].
- Worker contributions also differ by firm size.
 - Covered workers in small firms on average contribute significantly more annually for family coverage than covered workers in large firms (\$6,820 vs. \$5,112). The average contributions amounts for covered workers in small and large firms are similar for single coverage [Figure 6.7].

¹Estimates for premiums, worker contributions to premiums, and employer contributions to premiums presented in Section 6 do not include contributions made by the employer to Health Savings Accounts (HSAs) or Health Reimbursement Arrangements (HRAs). See Section 8 for estimates of employer contributions to HSAs and HRAs.

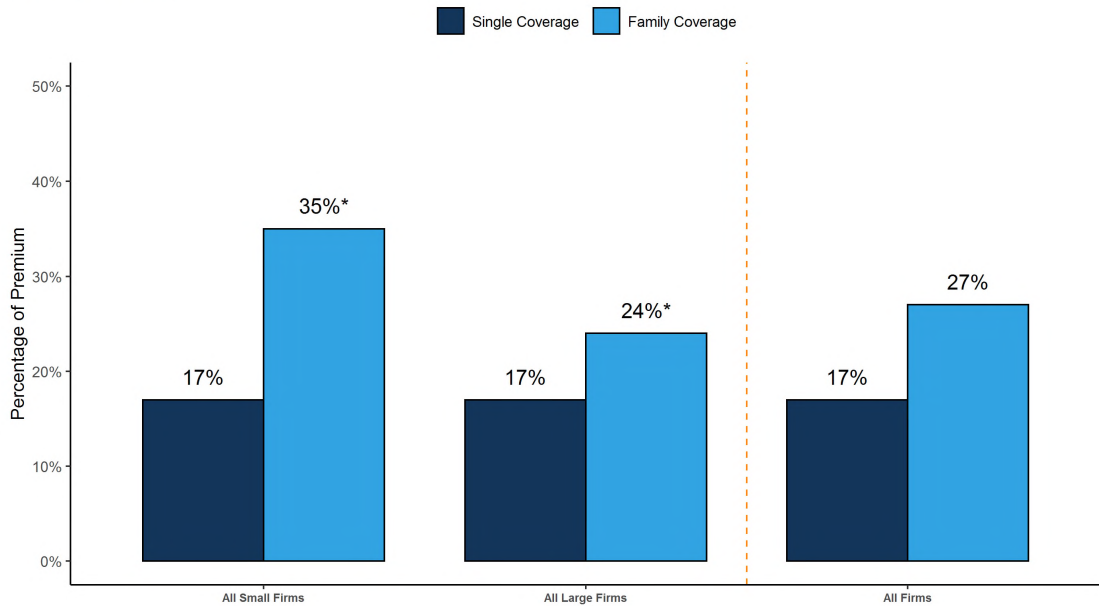
²The average percentage contribution is calculated as a weighted average of all a firm's plan types and may not necessarily equal the average worker contribution divided by the average premium.

Figure 6.1
Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, 1999-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

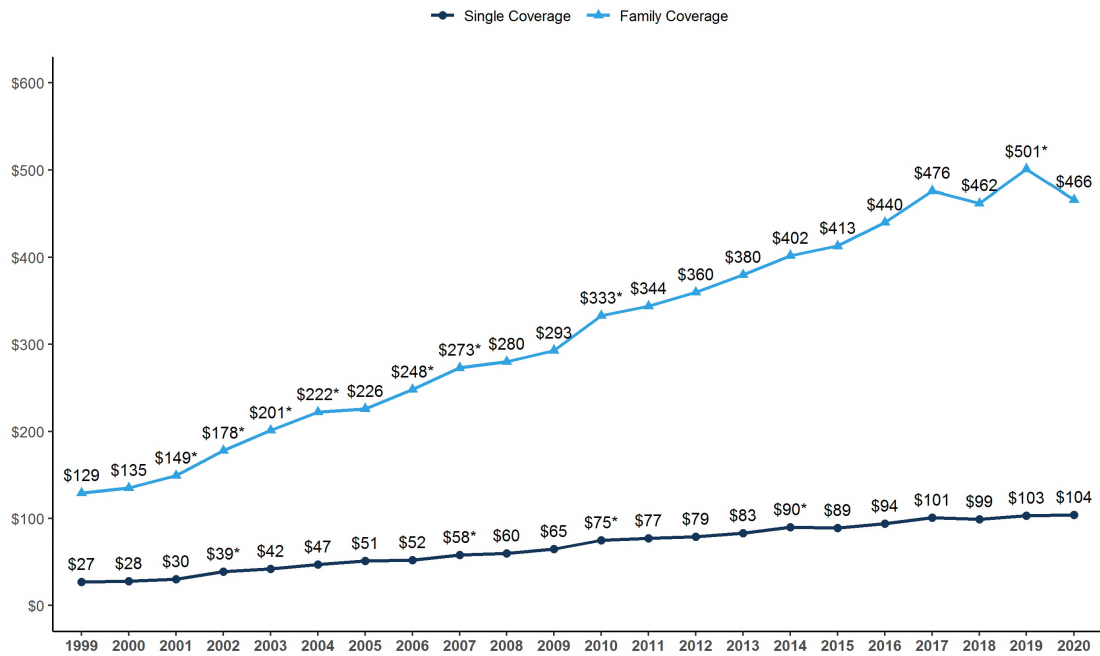
Figure 6.2
Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 2020



* Estimate is statistically different between All Small Firms and All Large Firms within coverage type ($p < .05$).
 NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

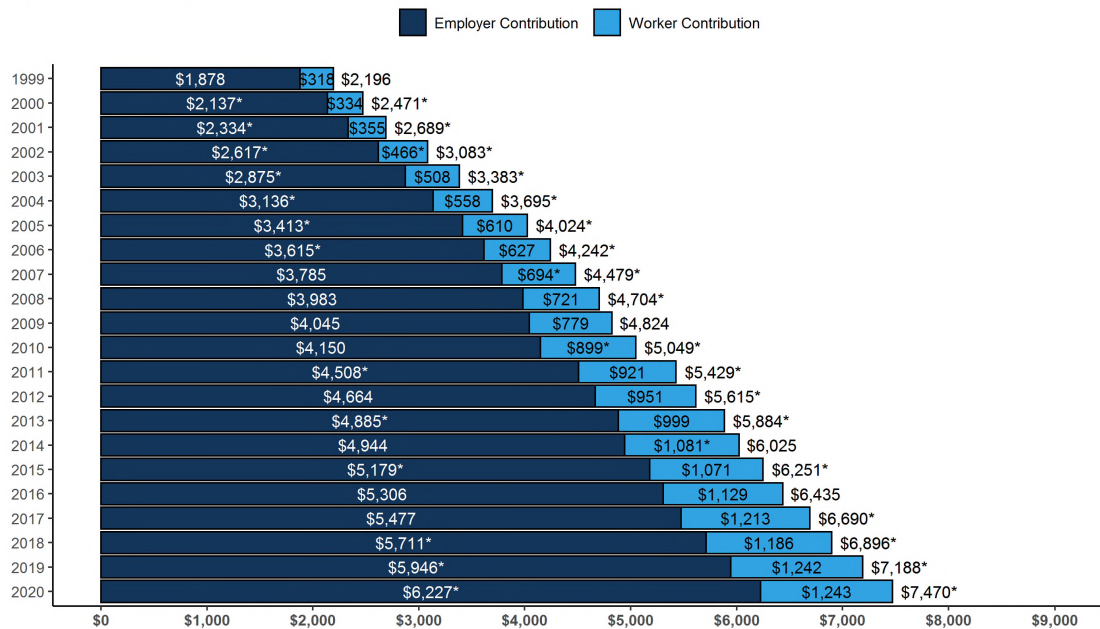
SECTION 6. WORKER AND EMPLOYER CONTRIBUTIONS FOR PREMIUMS

Figure 6.3
Average Monthly Worker Premium Contributions for Single and Family Coverage, 1999-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

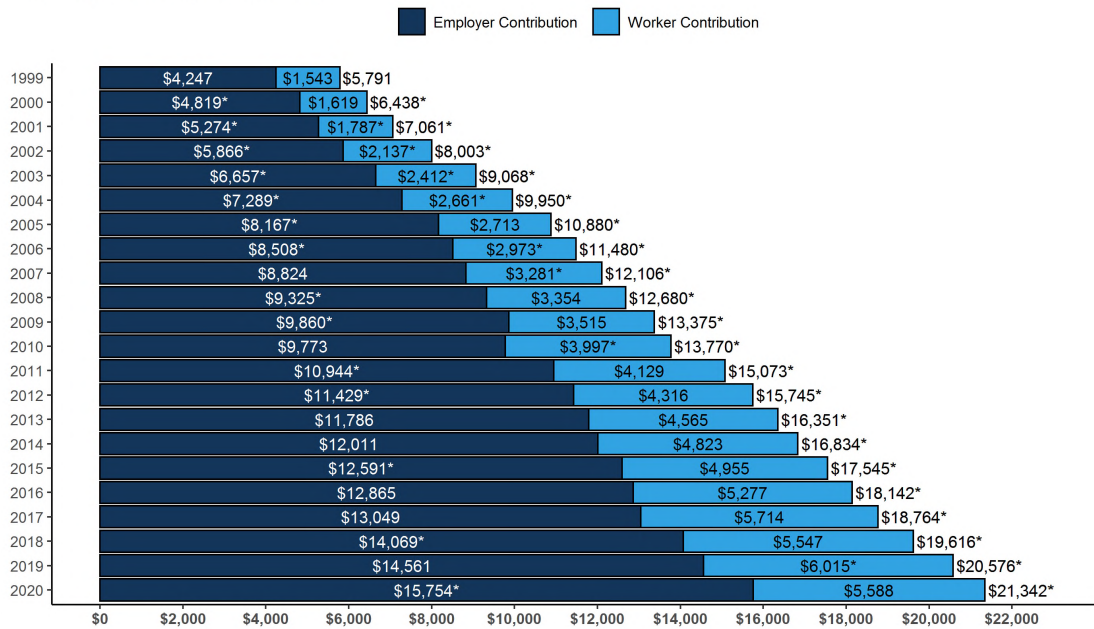
Figure 6.4
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Single Coverage, 1999-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

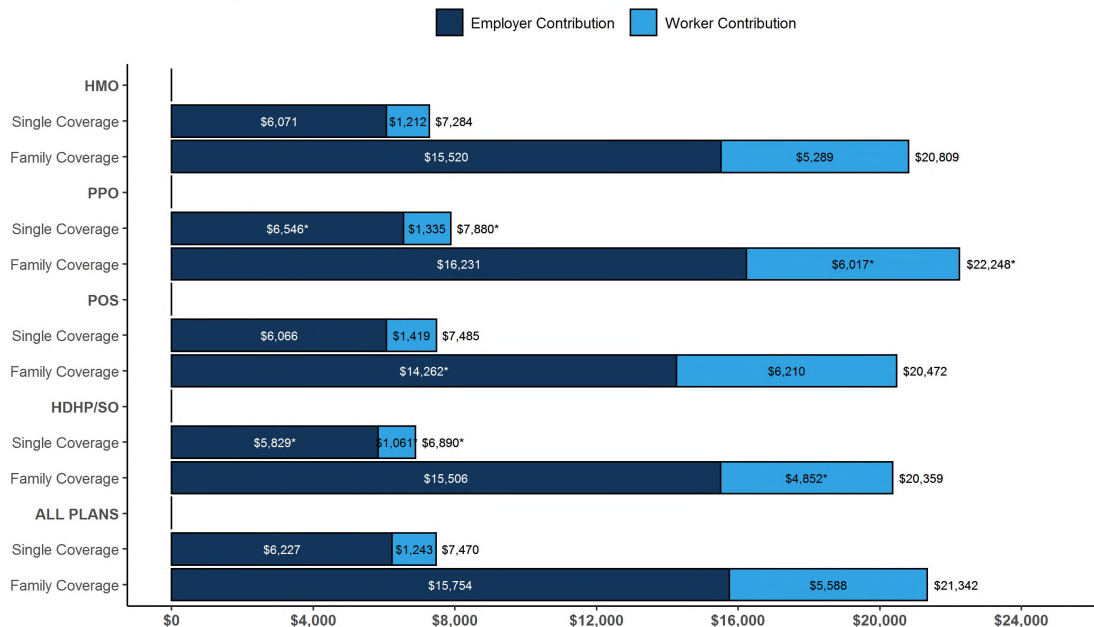
SECTION 6. WORKER AND EMPLOYER CONTRIBUTIONS FOR PREMIUMS

Figure 6.5
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

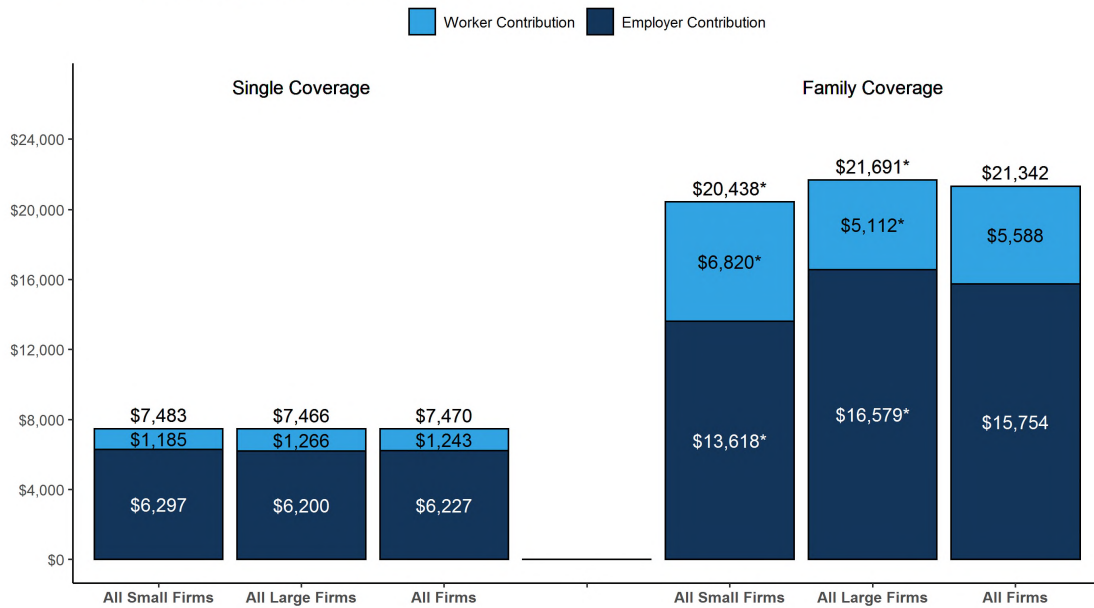
Figure 6.6
Average Annual Worker and Employer Premium Contributions and Total Premiums for Single and Family Coverage, by Plan Type, 2020



* Estimate is statistically different from All Plans estimate within coverage type (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2020

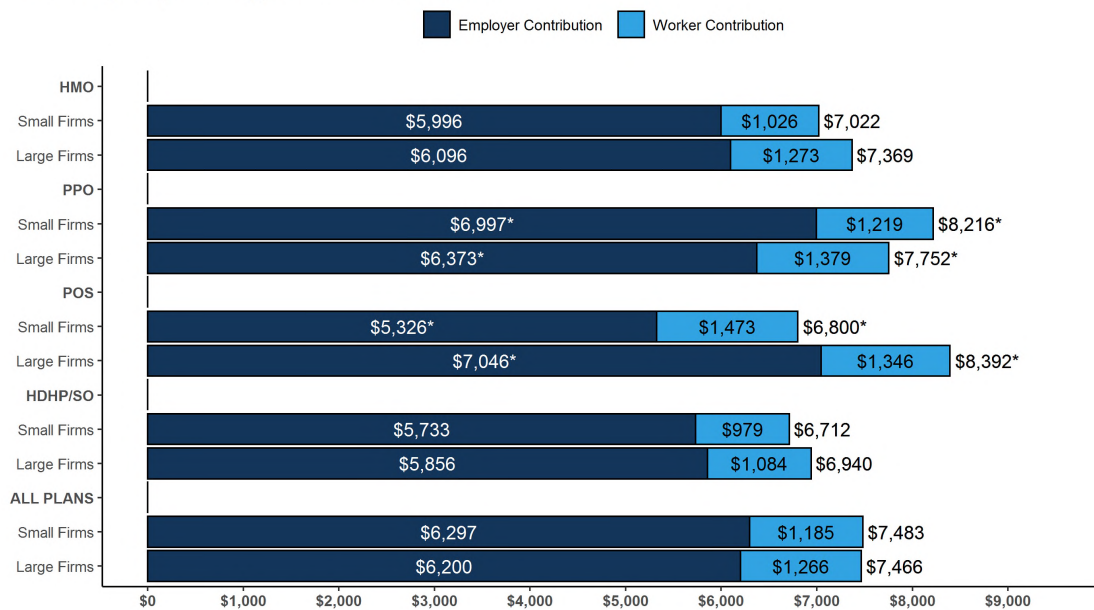
SECTION 6. WORKER AND EMPLOYER CONTRIBUTIONS FOR PREMIUMS

Figure 6.7
Average Annual Worker and Employer Premium Contributions and Total Premiums for Single and Family Coverage, by Firm Size, 2020

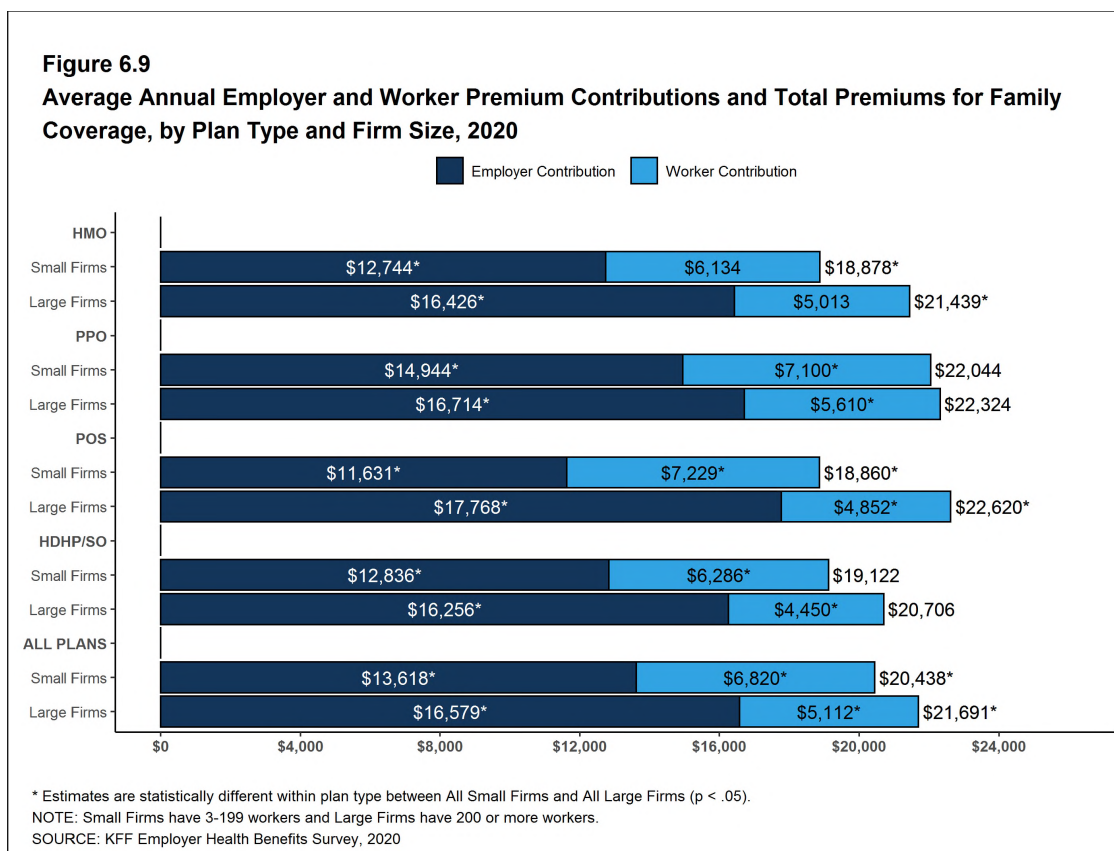


* Estimate is statistically different between All Small Firms and All Large Firms estimate (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 6.8
Average Annual Worker and Employer Premium Contributions and Total Premiums for Single Coverage, by Plan Type and Firm Size, 2020



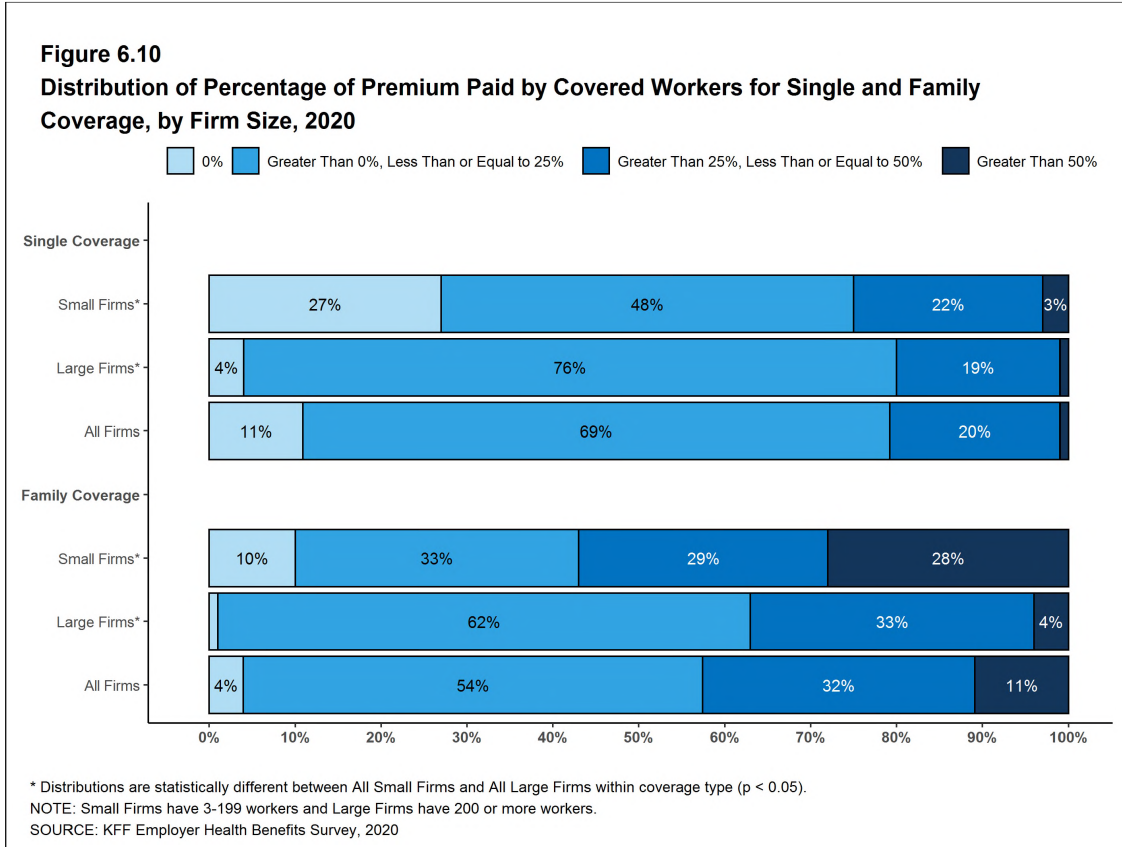
* Estimates are statistically different within plan type between All Small Firms and All Large Firms (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2020



DISTRIBUTIONS OF WORKER CONTRIBUTIONS TO THE PREMIUM

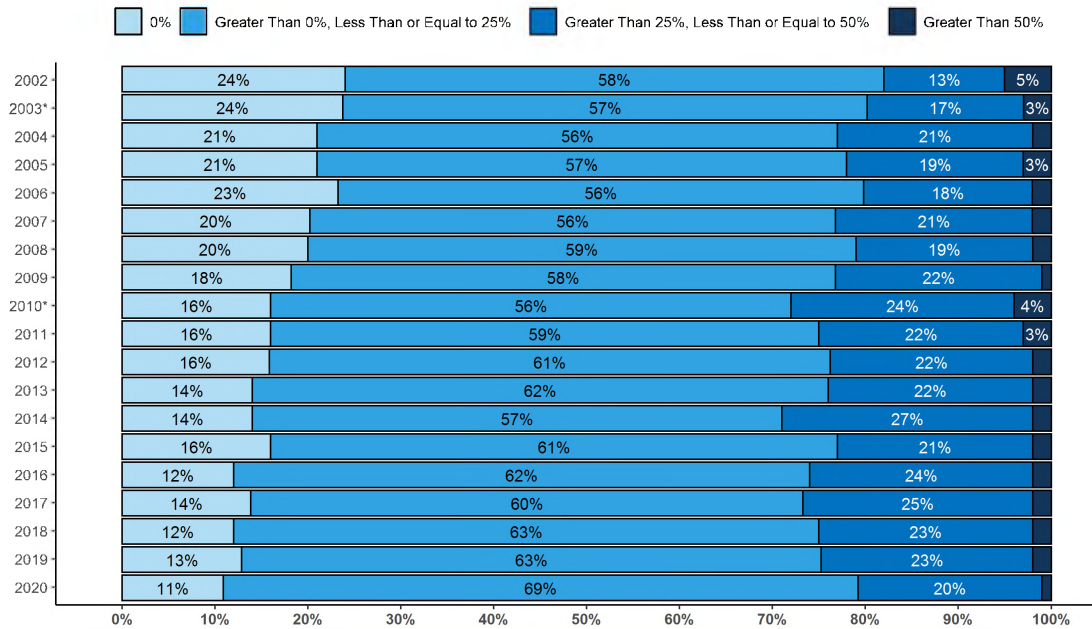
- About nine-tenths of covered workers are in a plan where the employer contributes at least half of the premium for both single and family coverage.
 - Eleven percent of covered workers are in a plan where the employer pays the entire premium for single coverage, while only 4% of covered workers are in a plan where the employer pays the entire premium for family coverage [Figure 6.10].
- Covered workers in small firms are much more likely than covered workers in large firms to be in a plan where the employer pays the entire premium.
 - Twenty-seven percent of covered workers in small firms have an employer that pays the full premium for single coverage, compared to 4% of covered workers in large firms [Figure 6.10].
 - For family coverage, 10% of covered workers in small firms have an employer that pays the full premium, compared to 1% of covered workers in large firms [Figure 6.10].
- Eleven percent of covered workers are in a plan with a worker contribution of more than half of the premium for family coverage [Figure 6.10].
 - Twenty-eight percent of covered workers in small firms work in a firm where the worker contribution for family coverage is more than 50% of the premium, a much higher percentage than the 4% of covered workers in large firms [Figure 6.10].
 - Small shares of covered workers in small firms (3%) and large firms (1%) must pay more than 50% of the premium for single coverage [Figure 6.10].

- There is substantial variation among workers in both small and large firms in the dollar amounts they must contribute.
 - Among covered workers in small firms, 39% have a contribution for single coverage of less than \$500, while 21% have a contribution of \$2,000 or more. For family coverage, 15% have a contribution of less than \$1,500, while 22% have a contribution of \$10,500 or more [Figure 6.13] and [Figure 6.14].
 - Among covered workers in large firms, 13% have a contribution for single coverage of less than \$500, while 12% have a contribution of \$2,000 or more. For family coverage, 6% have a contribution of less than \$1,500, while only 4% have a contribution of \$10,500 or more [Figure 6.13] and [Figure 6.14].



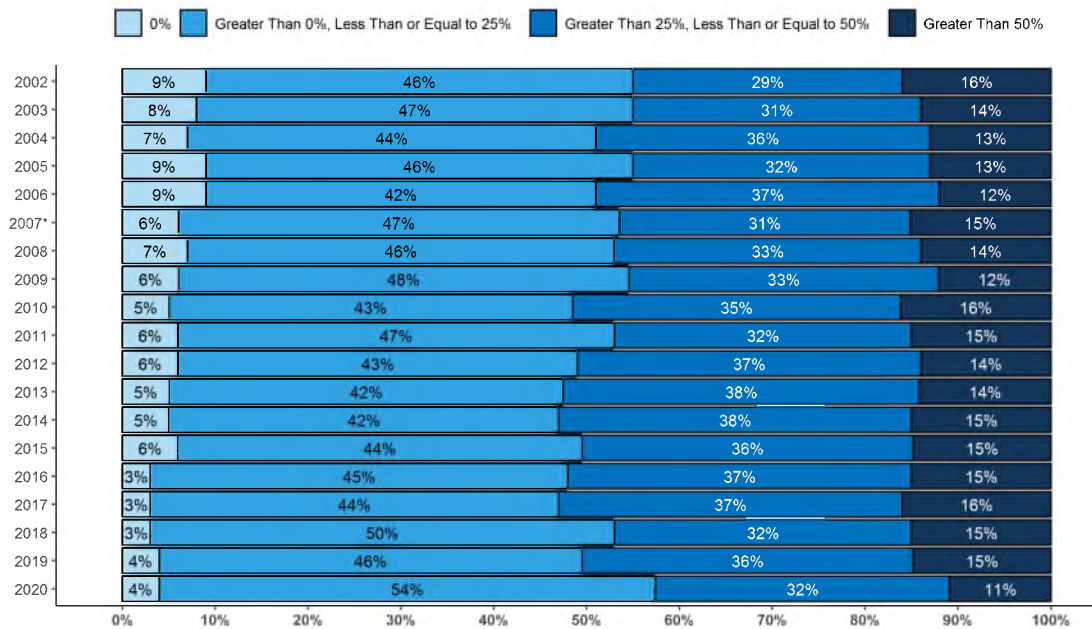
SECTION 6. WORKER AND EMPLOYER CONTRIBUTIONS FOR PREMIUMS

Figure 6.11
Distribution of Percentage of Premium Paid by Covered Workers for Single Coverage, 2002-2020



* Distribution is statistically different from distribution for the previous year shown (p < .05).
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017

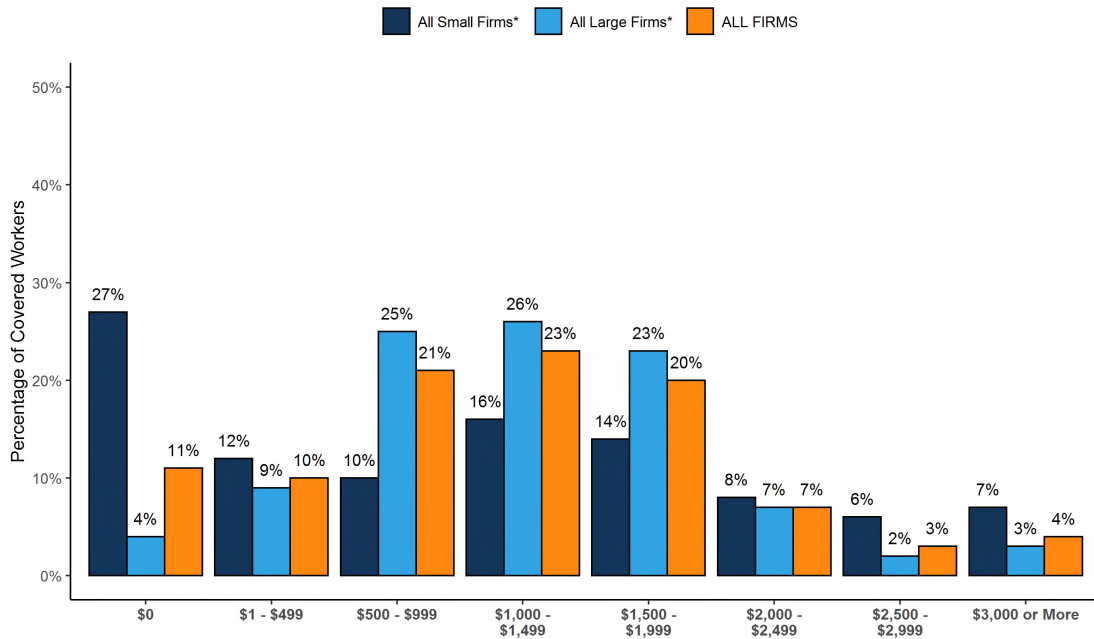
Figure 6.12
Distribution of Percentage of Premium Paid by Covered Workers for Family Coverage, 2002-2020



* Distribution is statistically different from distribution for the previous year shown (p < .05).
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2002-2017

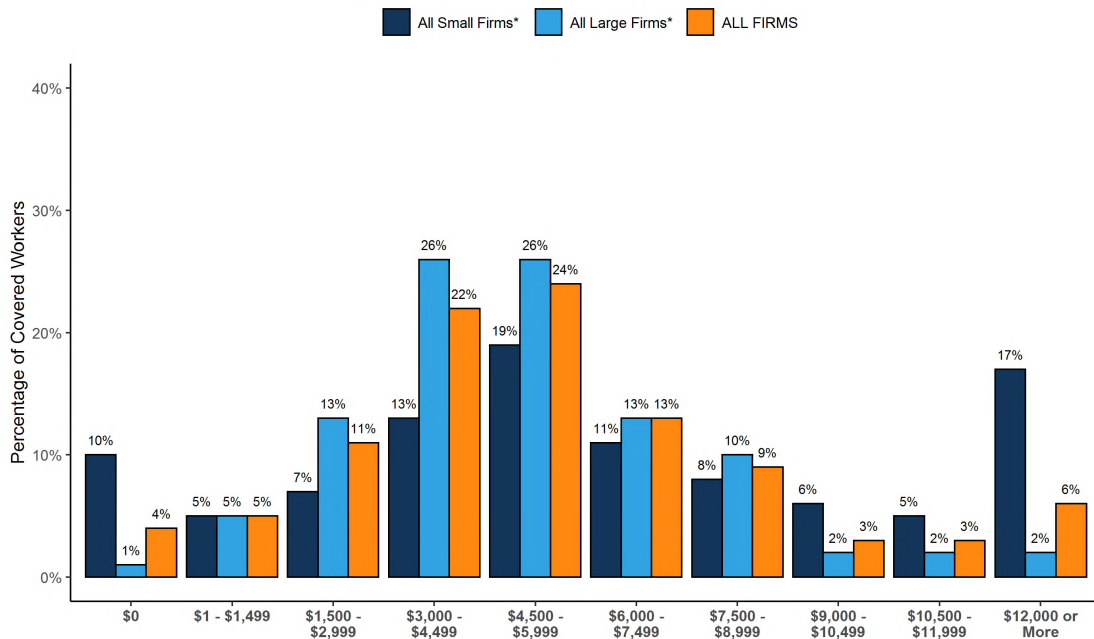
SECTION 6. WORKER AND EMPLOYER CONTRIBUTIONS FOR PREMIUMS

Figure 6.13
Distribution of Worker Contributions for Single Coverage, by Firm Size, 2020



* Distribution is statistically different from distribution for all other firms not in the indicated size category (p < .05).
 NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

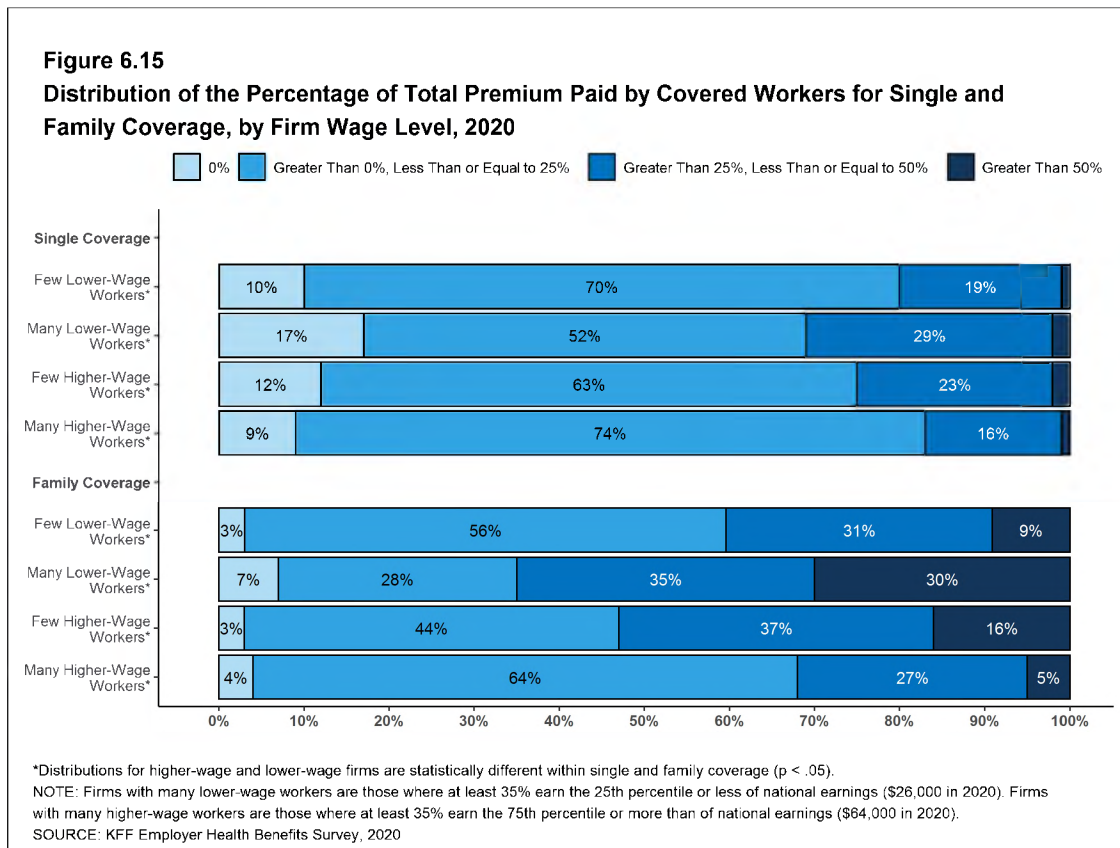
Figure 6.14
Distribution of Worker Contributions for Family Coverage, by Firm Size, 2020



* Distribution is statistically different from distribution for all other firms not in the indicated size category (p < .05).
 NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

DIFFERENCES BY FIRM CHARACTERISTICS

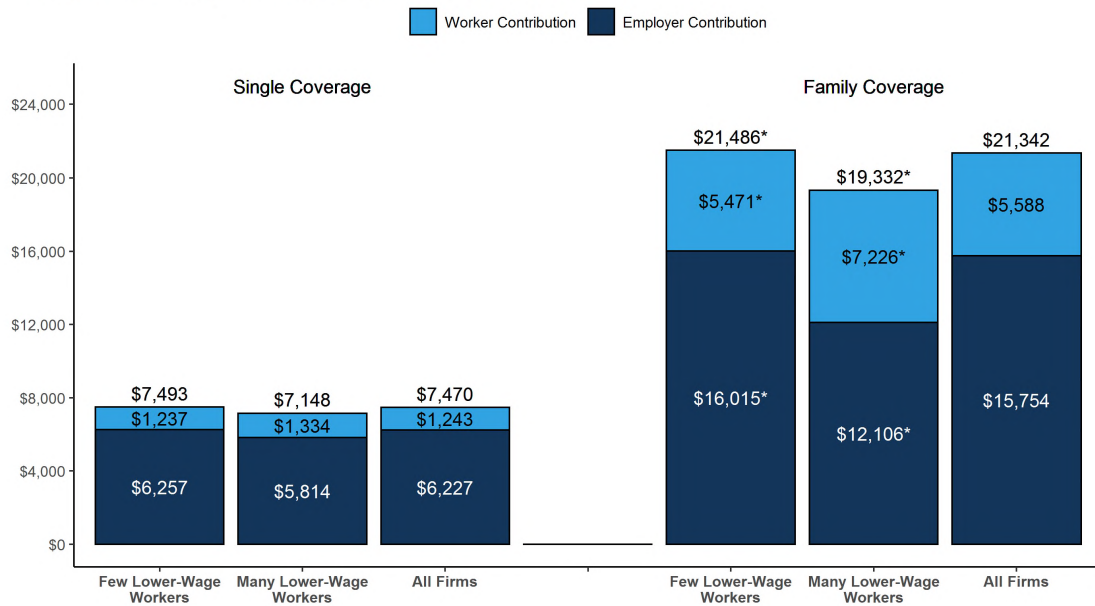
- The percentage of the premium paid by covered workers also varies by firm characteristics.
 - Covered workers in private, for-profit firms have relatively high premium contributions for single (\$1,381) and family (\$5,988) coverage. Covered workers in public firms have relatively low premium contributions for single (\$865) and family (\$4,724) coverage [Figure 6.17].
 - Covered workers in firms with a relatively large share of lower-wage workers (where at least 35% of workers earn \$26,000 a year or less) have a higher average contribution rate for family coverage (38% vs. 26%) than those in firms with a smaller share of lower-wage workers [Figure 6.17].
 - Covered workers in firms with a relatively large share of higher-wage workers (where at least 35% earn \$64,000 or more annually) have lower average contribution rates for single coverage (16% vs. 18%) and for family coverage (23% vs. 31%) than those in firms with a smaller share of higher-wage workers [Figure 6.17].
 - Covered workers in firms that have at least some union workers have lower average contribution rates for single coverage (15% vs. 18%) for family coverage (20% vs. 31%) than those in firms without any union workers [Figure 6.17].
 - Covered workers in firms that are partially or completely self-funded on average have a lower average contribution rate for family coverage than workers in firms that are fully-insured (24% vs. 33%) [Figure 6.17].³



³For definitions of self-funded and fully-insured plans, see the introduction to Section 10.

SECTION 6. WORKER AND EMPLOYER CONTRIBUTIONS FOR PREMIUMS

Figure 6.16
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Single and Family Coverage, By Firm Wage Level, 2020



* Estimate is statistically different between firm wage level categories ($p < .05$).

NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings (\$26,000 in 2020).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 6.17**Average Annual Premium Contributions Paid by Covered Workers for Single and Family Coverage, by Firm Characteristics, 2020**

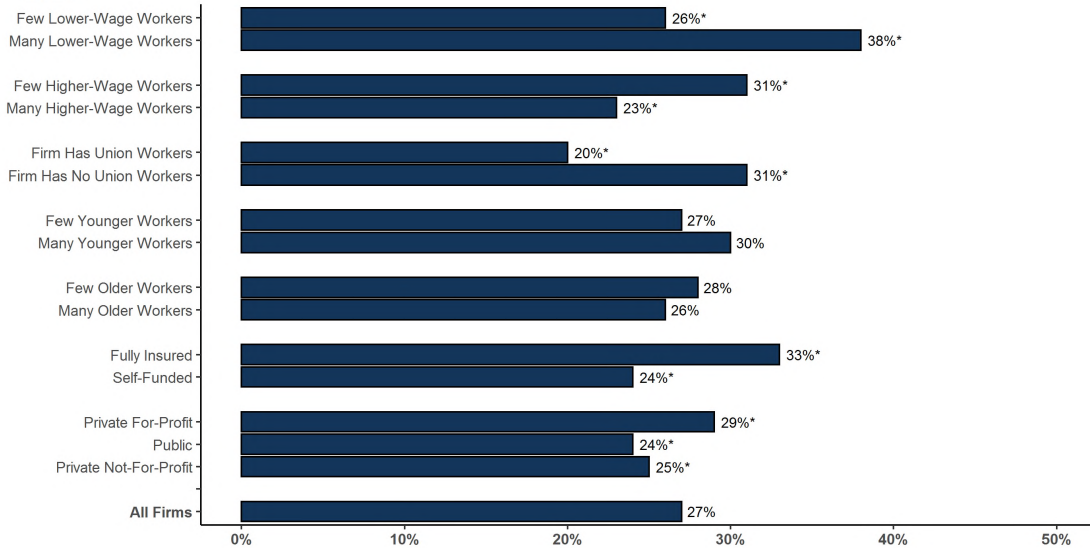
	Single Coverage		Family Coverage	
	Worker Contribution	Percent Contribution	Worker Contribution	Percent Contribution
LOWER WAGE LEVEL				
Few Lower-Wage Workers	\$1,237	17%	\$5,471 [*]	26% [*]
Many Lower-Wage Workers	\$1,334	20%	\$7,226 [*]	38% [*]
HIGHER WAGE LEVEL				
Few Higher-Wage Workers	\$1,278	18% [*]	\$6,149 [*]	31% [*]
Many Higher-Wage Workers	\$1,209	16% [*]	\$5,036 [*]	23% [*]
UNIONS				
Firm Has Union Workers	\$1,130 [*]	15% [*]	\$4,477 [*]	20% [*]
Firm Has No Union Workers	\$1,309 [*]	18% [*]	\$6,240 [*]	31% [*]
YOUNGER WORKERS				
Few Younger Workers	\$1,239	17%	\$5,580	27%
Many Younger Workers	\$1,298	20%	\$5,713	30%
OLDER WORKERS				
Few Older Workers	\$1,217	17%	\$5,679	28%
Many Older Workers	\$1,271	17%	\$5,491	26%
FUNDING ARRANGEMENT				
Fully Insured	\$1,162	16%	\$6,565 [*]	33% [*]
Self-Funded	\$1,283	18%	\$5,105 [*]	24% [*]
FIRM OWNERSHIP				
Private For-Profit	\$1,381 [*]	20% [*]	\$5,988 [*]	29% [*]
Public	\$865 [*]	11% [*]	\$4,724 [*]	24% [*]
Private Not-For-Profit	\$1,173	15% [*]	\$5,260	25% [*]
ALL FIRMS	\$1,243	17%	\$5,588	27%

NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings (\$26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings (\$64,000 in 2020). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.

^{*} Estimates are statistically different from each other within firm characteristic (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 6.18
Average Percentage of Family Premium Paid by Covered Workers, by Firm Characteristics, 2020



* Estimates are statistically different from each other within category ($p < .05$).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings (\$26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings (\$64,000 in 2020). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 6.19

Average Percentage of Premium Paid by Covered Workers, by Firm Characteristics and Size, 2020

	Single Coverage			Family Coverage		
	All Small Firms	All Large Firms	All Firms	All Small Firms	All Large Firms	All Firms
LOWER WAGE LEVEL						
Few Lower-Wage Workers	16%	17%	17%	34%*	23%*	26%*
Many Lower-Wage Workers	19%	21%	20%	45%*	32%*	38%*
HIGHER WAGE LEVEL						
Few Higher-Wage Workers	18%*	18%	18%*	41%*	26%*	31%*
Many Higher-Wage Workers	14%*	16%	16%*	26%*	22%*	23%*
UNIONS						
Firm Has Union Workers	8%*	16%*	15%*	17%*	21%*	20%*
Firm Has No Union Workers	17%*	19%*	18%*	37%*	27%*	31%*
YOUNGER WORKERS						
Few Younger Workers	16%	17%	17%	35%	24%	27%
Many Younger Workers	24%	18%	20%	43%	25%	30%
OLDER WORKERS						
Few Older Workers	17%	18%	17%	37%	24%	28%
Many Older Workers	16%	17%	17%	33%	23%	26%
FUNDING ARRANGEMENT						
Fully Insured	16%	18%	16%	36%	27%*	33%*
Self-Funded	18%	18%	16%	32%	23%*	24%*
FIRM OWNERSHIP						
Private For-Profit	19%*	20%*	20%*	36%	26%*	29%*
Public	7%*	12%*	11%*	34%	22%	24%*
Private Not-For-Profit	15%	15%*	15%*	32%	21%*	25%*
ALL FIRMS	17%	17%	17%	35%	24%	27%

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings (\$26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings (\$64,000 in 2020). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.

* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

DIFFERENCES BY REGION AND INDUSTRY

- The average worker contribution rate for single coverage is lower in the West (14%) than in other regions [Figure 6.20].
- The average worker contribution rate for family coverage is lower in the Northeast (23%) and higher in the South (31%) than in other regions [Figure 6.20].
- There is considerable variation in average worker contribution rates across industries for both single and family coverage [Figure 6.21].

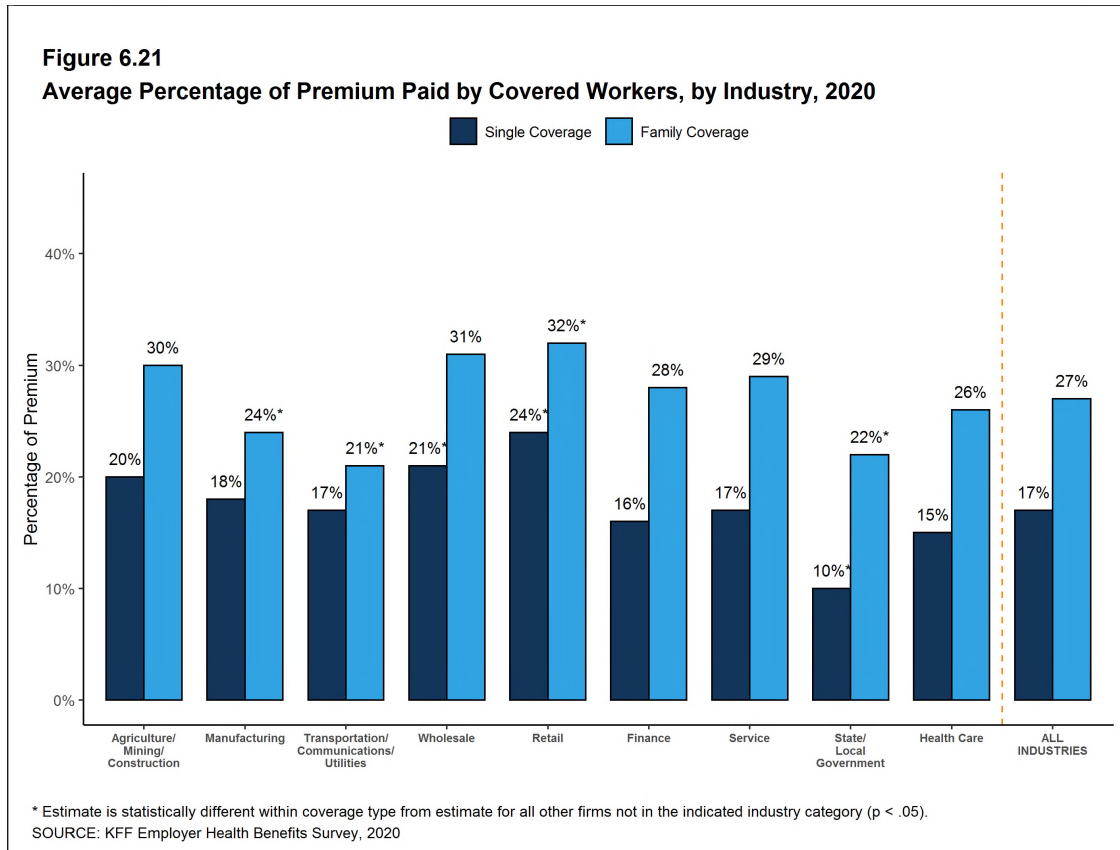
SECTION 6. WORKER AND EMPLOYER CONTRIBUTIONS FOR PREMIUMS

Figure 6.20**Average Premium Paid by Covered Workers for Single and Family Coverage, by Plan Type and Region, 2020**

	Single Coverage		Family Coverage	
	Percent Contribution	Worker Contribution	Percent Contribution	Worker Contribution
HMO				
Northeast	19%	\$1,483	20%*	\$4,551
Midwest	19	1,302	25	4,751
South	19	1,380	30	6,394
West	14*	854*	28	5,186
ALL REGIONS	17%	\$1,212	26%	\$5,289
PPO				
Northeast	19%	\$1,506	23%*	\$5,488
Midwest	18	1,440	28	6,341
South	17	1,263	32*	6,366
West	15*	1,155*	24*	5,269*
ALL REGIONS	18%	\$1,335	28%	\$6,017
POS				
Northeast	21%	\$1,815	24%*	\$5,652
Midwest	22	1,460	28	5,383
South	19	1,367	39*	7,389
West	14	916*	34	6,106
ALL REGIONS	19%	\$1,419	32%	\$6,210
HDHP/SO				
Northeast	15%	\$1,077	23%	\$5,006
Midwest	16	1,044	23	4,632
South	18	1,214	28*	5,364
West	11*	777*	22	4,165
ALL REGIONS	16%	\$1,061	24%	\$4,852
ALL PLANS				
Northeast	18%	\$1,420*	23%*	\$5,226
Midwest	18	1,277	26	5,511
South	18	1,269	31*	6,167*
West	14*	976*	25	5,066
ALL REGIONS	17%	\$1,243	27%	\$5,588

* Estimate is statistically different within plan and coverage type from estimate for all other firms not in the indicated region (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2020

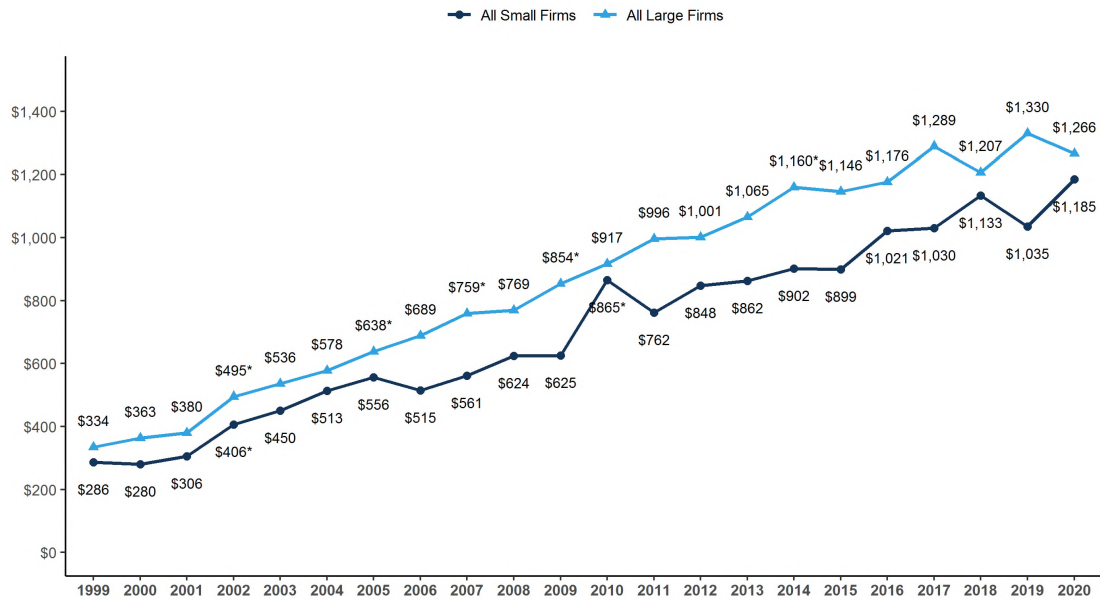


CHANGES OVER TIME

- The average worker contribution for single coverage (\$1,243 in 2020) is similar to the amount last year. The average worker contribution for family coverage (\$5,588 in 2020) appears lower than the average contribution for family coverage last year (\$6,015), but the difference is not statistically significant [Figure 6.4] and [Figure 6.5].
- The average worker contributions for single and family coverage have increased over the last five years (16% and 13%, respectively) and over the last 10 years (38% and 40%, respectively).

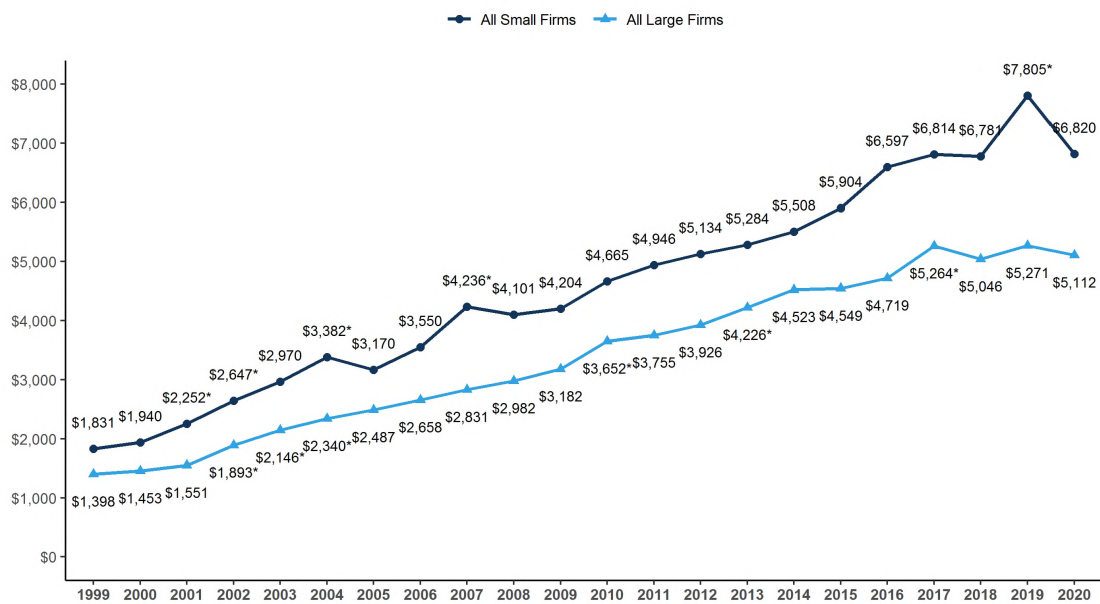
SECTION 6. WORKER AND EMPLOYER CONTRIBUTIONS FOR PREMIUMS

Figure 6.22
Average Annual Worker Contributions for Covered Workers with Single Coverage, by Firm Size, 1999-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

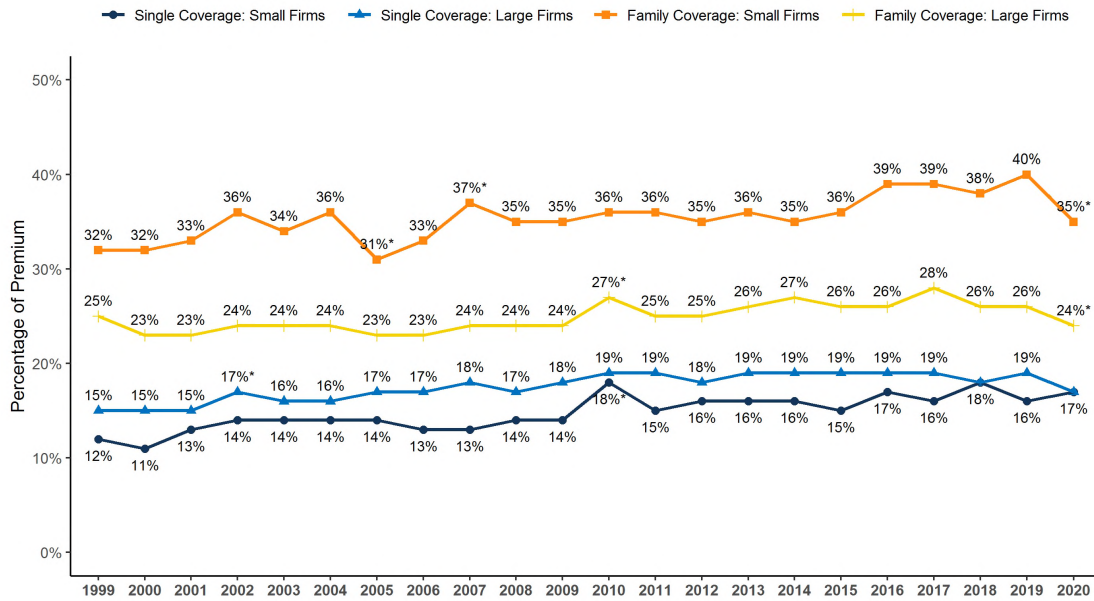
Figure 6.23
Average Annual Worker Contributions for Covered Workers with Family Coverage, by Firm Size, 1999-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

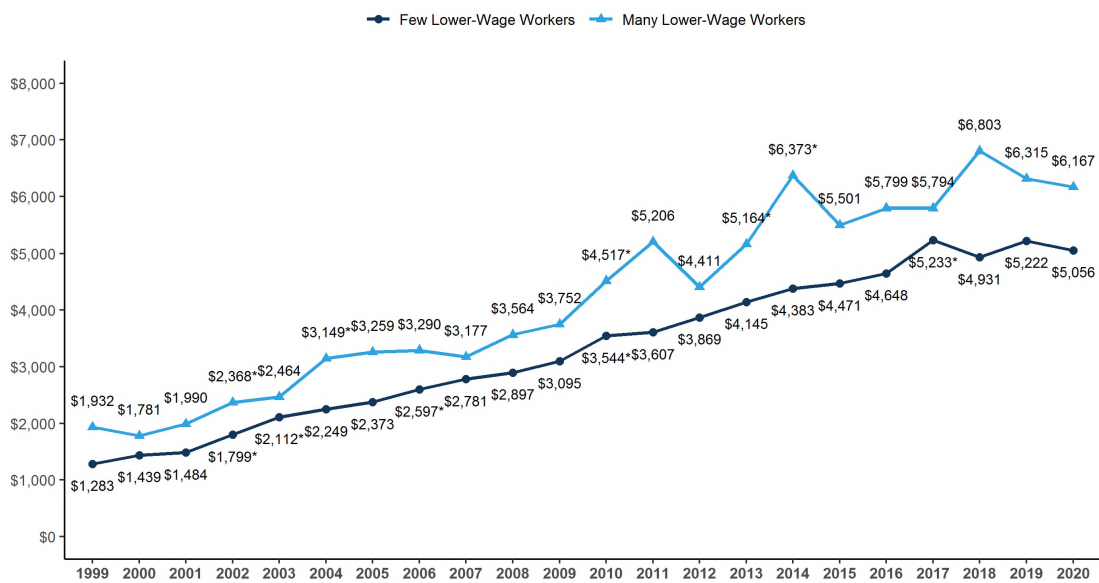
SECTION 6. WORKER AND EMPLOYER CONTRIBUTIONS FOR PREMIUMS

Figure 6.24
Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, by Firm Size, 1999-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
 NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 6.25
Among Large Firms, Average Annual Worker Contributions for Covered Workers with Family Coverage, by Firm Wage Level, 1999-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
 NOTE: Large Firms have 200 or more workers. Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings (\$26,000 in 2020).
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

EMPLOYER HEALTH BENEFITS

2020 ANNUAL SURVEY

Employee
Cost Sharing

SECTION

7

Section 7

Employee Cost Sharing

In addition to any required premium contributions, most covered workers must pay a share of the cost for the medical services they use. The most common forms of cost sharing are: deductibles (an amount that must be paid before most services are covered by the plan), copayments (fixed dollar amounts), and coinsurance (a percentage of the charge for services). Sometimes cost sharing forms are mixed, such as assessing coinsurance for a service up to a maximum amount, or assessing coinsurance or copayment for a service, whichever is higher. The type and level of cost sharing often vary by the type of plan in which the worker is enrolled. Cost sharing may also vary by the type of service, such as office visits, hospitalizations, or prescription drugs.

The cost-sharing amounts reported here are for covered workers using in-network services. Plan enrollees receiving services from providers that do not participate in plan networks often face higher cost sharing and may be responsible for charges that exceed the plan's allowable amounts. The framework of this survey does not allow us to capture all of the complex cost-sharing requirements in modern plans, particularly for ancillary services (such as durable medical equipment or physical therapy) or cost-sharing arrangements that vary across different settings (such as tiered networks). Therefore, we do not collect information on all plan provisions and limits that affect enrollee out-of-pocket liability.

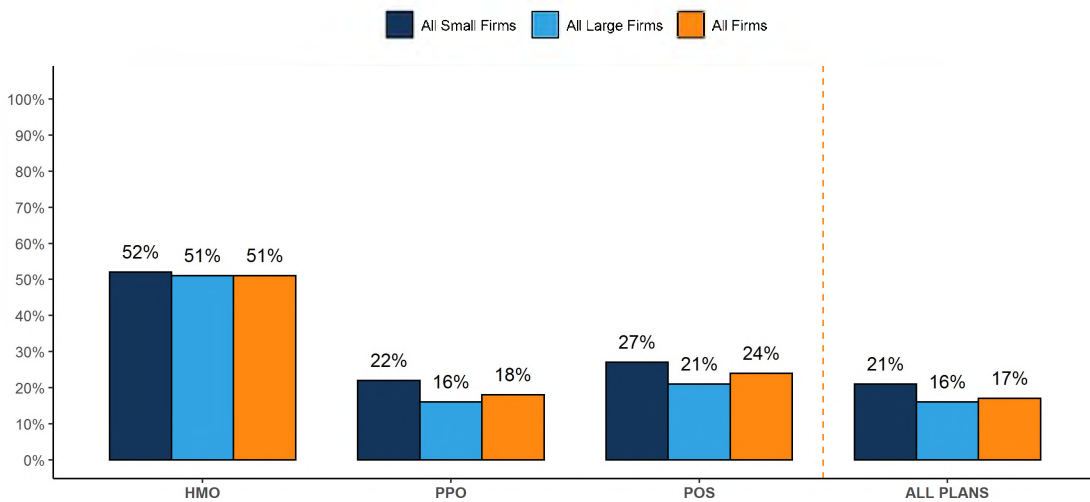
GENERAL ANNUAL DEDUCTIBLES FOR WORKERS IN PLANS WITH DEDUCTIBLES

- We consider a general annual deductible to be an amount that must be paid by enrollees before most services are covered by their health plan. Non-grandfathered health plans are required to cover some services, such as preventive care, without cost sharing. Some plans require enrollees to meet a service-specific deductible, such as for prescription drugs or hospital admissions, in lieu of or in addition to a general annual deductible. As discussed below, some plans with a general annual deductible for most services exclude specified classes of care from the deductible, such as prescriptions or physician office visits.
 - In 2020, 83% of covered workers are enrolled in a plan with a general annual deductible for single coverage, similar to the percentage last year (82%) and much higher than the percentage ten years ago (70%) [Figure 7.2].
 - The percentages of covered workers enrolled in a plan with a general annual deductible for single coverage are similar for small firms (3-199 workers) (79%) and large firms (200 or more workers) (84%) [Figure 7.2].
 - The likelihood of being in a plan with a general annual deductible varies by plan type. Fifty-one percent of covered workers in HMOs do not have a general annual deductible for single coverage, compared to 24% of workers in POS plans and 18% of workers in PPOs [Figure 7.1].
- For covered workers in a plan with a general annual deductible, the average annual deductible for single coverage is \$1,644, similar to the average deductible (\$1,655) last year [Figure 7.3] and [Figure 7.8].
 - For covered workers in plans with a general annual deductible, the average deductibles for single coverage are \$1,201 in HMOs, \$1,204 in PPOs, \$1,714 in POS plans, and \$2,303 in HDHP/SOs [Figure 7.6].

SECTION 7. EMPLOYEE COST SHARING

- The average deductibles for single coverage are higher for most plan types for covered workers in small firms than for covered workers in large firms. For covered workers in PPOs, the most common plan type, the average deductible for single coverage in small firms is considerably higher than the average deductible in large firms (\$1,888 vs. \$960) [Figure 7.6]. Overall, for covered workers in plans with a general annual deductible, the average deductible for single coverage in small firms (\$2,295) is higher than the average deductible in large firms (\$1,418) [Figure 7.3].
- The average general annual deductible for single coverage for covered workers in plans with a general annual deductible has increased 25% over the past five years, from \$1,318 in 2015 to \$1,644 in 2020 [Figure 7.8].

Figure 7.1
Percentage of Covered Workers with No General Annual Deductible for Single Coverage, by Plan Type and Firm Size, 2020



Tests found no statistical difference between All Small Firms and All Large Firms estimate within plan type (p < .05).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers. HDHP/SOs are not shown because all covered workers in these plans face a minimum deductible. HDHP/SOs are included in the All Plans estimate. In HDHP/HRA plans, as defined by the survey, the minimum deductible is \$1,000 for single coverage and \$2,000 for family coverage. For HSA-qualified HDHPs, the legal minimum deductible for 2020 is \$1,350 for single coverage and \$2,700 for family coverage. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services. A similar percentage of covered workers do not face a general annual deductible for single and family coverage within each plan type.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.2
Percentage of Covered Workers in a Plan That Includes a General Annual Deductible for Single Coverage, by Plan Type and Firm Size, 2006-2020

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
HMO															
All Small Firms	17%	14%	25%	27%	34%	36%	33%	44%	59%	46%	44%	41%	56%	58%	48%
All Large Firms	10%	20%*	18%	12%	25%*	27%	28%	40%	28%	40%	47%	37%	53%	43%	48%
ALL FIRMS	12%	18%	20%	18%	28%*	29%	30%	41%	37%	42%	46%	38%	54%*	48%	49%
PPO															
All Small Firms	69%	72%	73%	74%	80%	76%	76%	78%	83%	85%	85%	78%	86%	87%	78%
All Large Firms	69%	71%	66%	74%	78%	83%	77%	82%	85%	84%	84%	88%	89%	84%	84%
ALL FIRMS	69%	71%	68%	74%	77%	81%	77%	81%	85%	85%	84%	86%	88%	85%	82%
POS															
All Small Firms	35%	53%*	59%	83%	84%	86%	56%	78%*	69%	80%	81%	71%	86%	75%	73%
All Large Firms	28%	41%	41%	58%	70%	71%	63%	49%	72%*	61%	56%	58%	63%	76%	79%
ALL FIRMS	32%	48%*	50%	62%	66%	69%	60%	66%	70%	72%	76%	65%	76%	76%	76%
ALL PLANS															
All Small Firms	56%	60%	65%	67%	73%	75%	72%	77%	82%	82%	82%	77%	85%*	83%	79%
All Large Firms	54%	59%	58%	81%	88%*	74%	73%	78%	80%	81%	83%	83%	85%	81%	84%
ALL FIRMS	55%	59%*	59%	63%	70%*	74%	72%	78%*	80%	81%	83%	81%	85%*	82%	83%

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers. By definition, all HD-HP/SOs have a deductible.

* Estimate is statistically different from estimate for the previous year shown (p < .05).

SOURCE: KFF Employer Health Benefits Survey 2018-2020, Kaiser-HRET Survey of Employer-Sponsored Health Benefits 2006-2017

Figure 7.3**Percentage of Covered Workers in a Plan That Includes a General Annual Deductible and Average Deductible for Single Coverage, by Firm Size and Region, 2020**

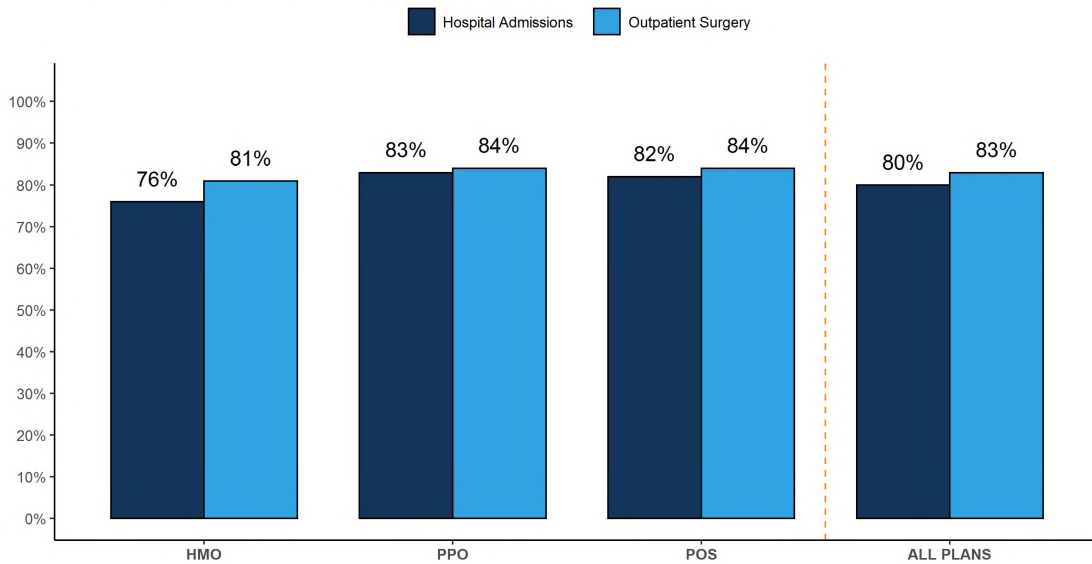
	Percentage of Covered Workers in a Plan With a General Annual Deductible	Among Covered Workers With a General Annual Deductible for Single Coverage, Average Deductible
FIRM SIZE		
3-49 Workers	77%	\$2,413*
50-199 Workers	81	2,179*
200-999 Workers	81	1,668
1,000-4,999 Workers	81	1,404*
5,000 or More Workers	87*	1,331*
All Small Firms (3-199 Workers)	79%	\$2,295*
All Large Firms (200 or More Workers)	84%	\$1,418*
REGION		
Northeast	84%	\$1,605
Midwest	92*	1,669
South	79	1,733
West	75*	1,497
ALL FIRMS	83%	\$1,644
* Estimate is statistically different from estimate for all other firms not in the indicated size or region category (p < .05).		
SOURCE: KFF Employer Health Benefits Survey, 2020		

Figure 7.4**Percentage of Covered Workers in a Plan That Includes a General Annual Deductible and Average Deductibles for Single Coverage, by Firm Characteristics, 2020**

	Percentage of Covered Workers in a Plan With a General Annual Deductible	Among Covered Workers With a General Annual Deductible for Single Coverage, Average Deductible
LOWER WAGE LEVEL		
Few Lower-Wage Workers	84%*	\$1,620*
Many Lower-Wage Workers	71%*	\$2,060*
HIGHER WAGE LEVEL		
Few Higher-Wage Workers	82%	\$1,768*
Many Higher-Wage Workers	83%	\$1,527*
UNIONS		
Firm Has Union Workers	84%	\$1,220*
Firm Has No Union Workers	82%	\$1,902*
YOUNGER WORKERS		
Few Younger Workers	83%	\$1,643
Many Younger Workers	76%	\$1,664
OLDER WORKERS		
Few Older Workers	84%	\$1,740*
Many Older Workers	81%	\$1,541*
FIRM OWNERSHIP		
Private For-Profit	87%*	\$1,755*
Public	75%*	\$1,177*
Private Not-For-Profit	79%	\$1,668
ALL FIRMS	83%	\$1,644
NOTE: Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings (\$26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings (\$64,000 in 2020). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.		
* Estimates are statistically different from each other within firm characteristic (p < .05).		
SOURCE: KFF Employer Health Benefits Survey, 2020		

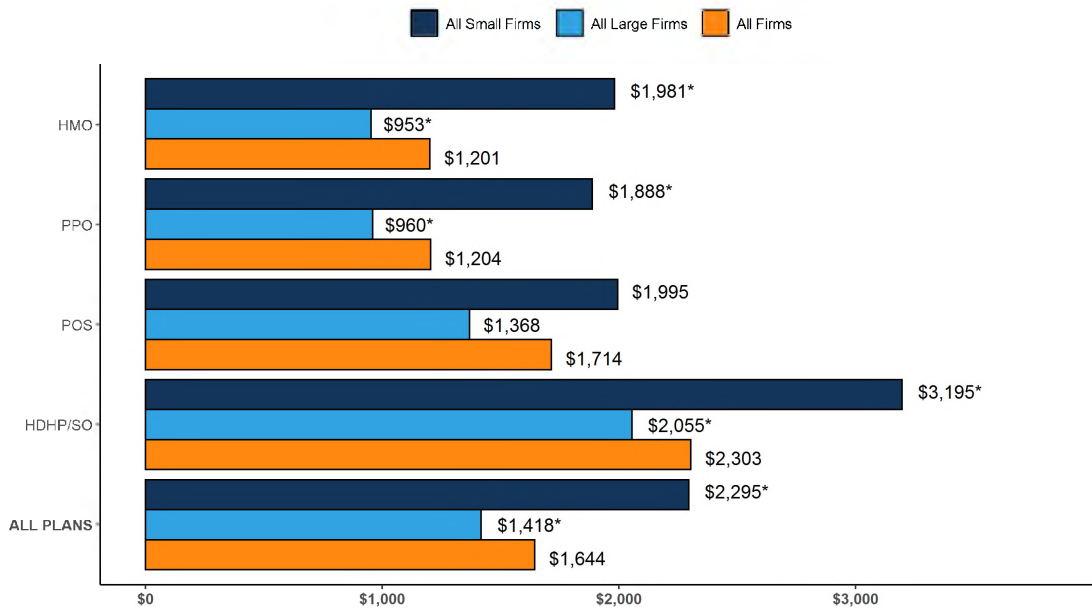
SECTION 7. EMPLOYEE COST SHARING

Figure 7.5
Among Covered Workers with No General Annual Deductible, Percentage with Other Forms of Cost Sharing for Various Services, by Plan Type, 2020



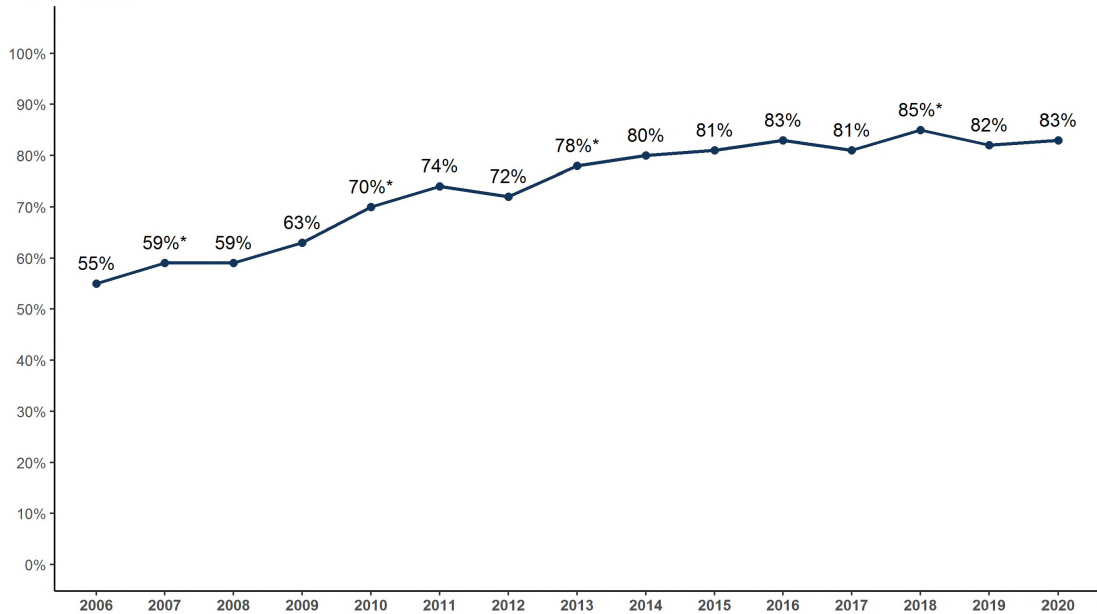
NOTE: Other cost sharing could include a separate annual deductible, copayment, coinsurance or charge per day (for Hospital Admissions). HDHP/SOs are excluded because, by definition, all workers face a deductible. All Plans percentages do not statistically differ between single coverage and family coverage (not shown).
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.6
Among Covered Workers with a General Annual Deductible for Single Coverage, Average Deductible, by Plan Type and Firm Size, 2020



* Estimate is statistically different between All Small Firms and All Large Firms estimate within plan type ($p < .05$).
 NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.7
Percentage of Covered Workers with a General Annual Deductible for Single Coverage, 2006-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).

NOTE: Average general annual deductibles are for in-network providers.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.8
Among Covered Workers With a General Annual Deductible, Average Single and Family Coverage Deductible, by Plan Type, 2006-2020

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Single Coverage															
-MO	\$352	\$401	\$503	\$699*	\$801	\$911	\$691	\$729	\$1,032*	\$1,025	\$917	\$1,175	\$870	\$1,200	\$1,201
>>O	\$473	\$461	\$560*	\$634*	\$675	\$675	\$733	\$799	\$843	\$958	\$1,028	\$1,048	\$1,204*	\$1,208	\$1,204
>>S	\$553	\$621	\$752	\$1,061	\$1,048	\$928	\$1,014	\$1,314	\$1,215	\$1,230	\$1,737*	\$1,301	\$1,688	\$1,657	\$1,714
-DHP>SO	\$1,715	\$1,729	\$1,812	\$1,838	\$1,903	\$1,908	\$2,086	\$2,003	\$2,215*	\$2,099	\$2,199	\$2,304	\$2,349	\$2,486	\$2,303
ALL PLANS	\$584	\$616	\$735*	\$628*	\$917*	\$991	\$1,067*	\$1,135	\$1,217	\$1,318	\$1,478*	\$1,505	\$1,673	\$1,655	\$1,644
Family Coverage Deductible With Aggregate Structure															
-MO	\$751	\$759	\$1,053	\$1,524*	\$1,321	\$1,487	\$1,329	\$1,743	\$2,328	\$2,758	\$2,245	\$2,732	\$2,317	\$2,905	\$3,035
>>O	\$1,034	\$1,040	\$1,344*	\$1,488	\$1,518	\$1,521	\$1,770	\$1,854	\$1,947	\$2,012	\$2,147	\$2,503*	\$3,000*	\$2,883	\$2,716
>>S	\$1,227	\$1,369	\$1,660	\$2,191	\$2,253	\$1,798	\$2,163	\$2,621	\$2,470	\$2,467	\$3,798*	\$2,897	\$3,497	\$4,347	\$3,902
-DHP>SO	\$3,511	\$3,596	\$3,559	\$3,625	\$3,760	\$3,656	\$3,524	\$4,079	\$4,522*	\$4,332	\$4,343	\$4,527	\$4,676	\$4,779	\$4,552
Family Coverage Deductible With Separate Per-Person Structure															
-MO	NSD	NSD	NSD	\$686	\$500	\$685	\$754	\$609	\$870	\$652	\$632	\$1,045	\$681	\$661	NSD
>>O	\$710	\$492*	\$514	\$633	\$593	\$646	\$632	\$782*	\$821	\$944	\$1,052	\$914	\$1,005	\$1,061	\$1,115
>>S	\$992	\$582	\$778	\$1,050	\$1,184	\$912	\$1,092	\$1,080	\$1,153	\$1,153	\$1,180	\$1,128	\$1,864*	\$1,932	NSD
-DHP>SO	NSD	NSD	\$2,334*	\$2,091	\$2,053	\$2,149	\$2,621*	\$2,033*	\$2,126	\$1,965	\$2,411	\$2,645	\$2,560	\$3,078	\$2,523

NOTE: Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate deductible amount in which all family members' out-of-pocket expenses count toward the deductible, and plans that have a separate amount for each family member, typically with a limit on the number of family members required to reach that amount.
 NSD: Not Sufficient Data
 * Estimate is statistically different from estimate for the previous year shown (p < .05).
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

GENERAL ANNUAL DEDUCTIBLES AMONG ALL COVERED WORKERS

- As discussed above, the share of covered workers in plans with a general annual deductible has increased significantly over time, from 70% in 2010 to 83% in 2020 [Figure 7.9]. The average deductible amounts for covered workers in plans with a deductible have also increased, over the period, from \$917 in 2010 to \$1,644 in 2020 [Figure 7.10]. Neither trend by itself, however, captures the full impact of changes in deductibles on covered workers. We can look at the average impact of both trends together on covered workers by assigning a zero deductible value to covered workers in plans with no deductible and looking

SECTION 7. EMPLOYEE COST SHARING

at how the resulting averages change over time. These average deductible amounts are lower in any given year but the changes over time reflect both the higher deductibles in plans with a deductible and the fact that more workers face them.

- Using this approach, the average general annual deductible for single coverage for all covered workers in 2020 is \$1,364, similar to the amount last year (\$1,396) [Figure 7.10].
- The 2020 value is 27% higher than the average general annual deductible of \$1,077 in 2015 and 111% higher than the average general annual deductible of \$646 in 2010 [Figure 7.10].
- Another way to look at deductibles is the percentage of all covered workers who are in a plan with a deductible that exceeds certain thresholds. Fifty-seven percent of covered workers are in plans with a general annual deductible of \$1,000 or more for single coverage, similar to the percentage last year [Figure 7.13].
 - Over the past five years, the percentage of covered workers with a general annual deductible of \$1,000 or more for single coverage has grown 23%, from 46% to 57% [Figure 7.13].
 - Workers in small firms are considerably more likely to have a general annual deductible of \$1,000 or more for single coverage than workers in large firms (64% vs. 54%) [Figure 7.12].
 - In 2020, 26% of covered workers are enrolled in a plan with a deductible of \$2,000 or more, similar to the percentage last year (28%) [Figure 7.15]. This percentage is much higher for covered workers in small firms than large firms (42% vs. 20%) [Figure 7.12].

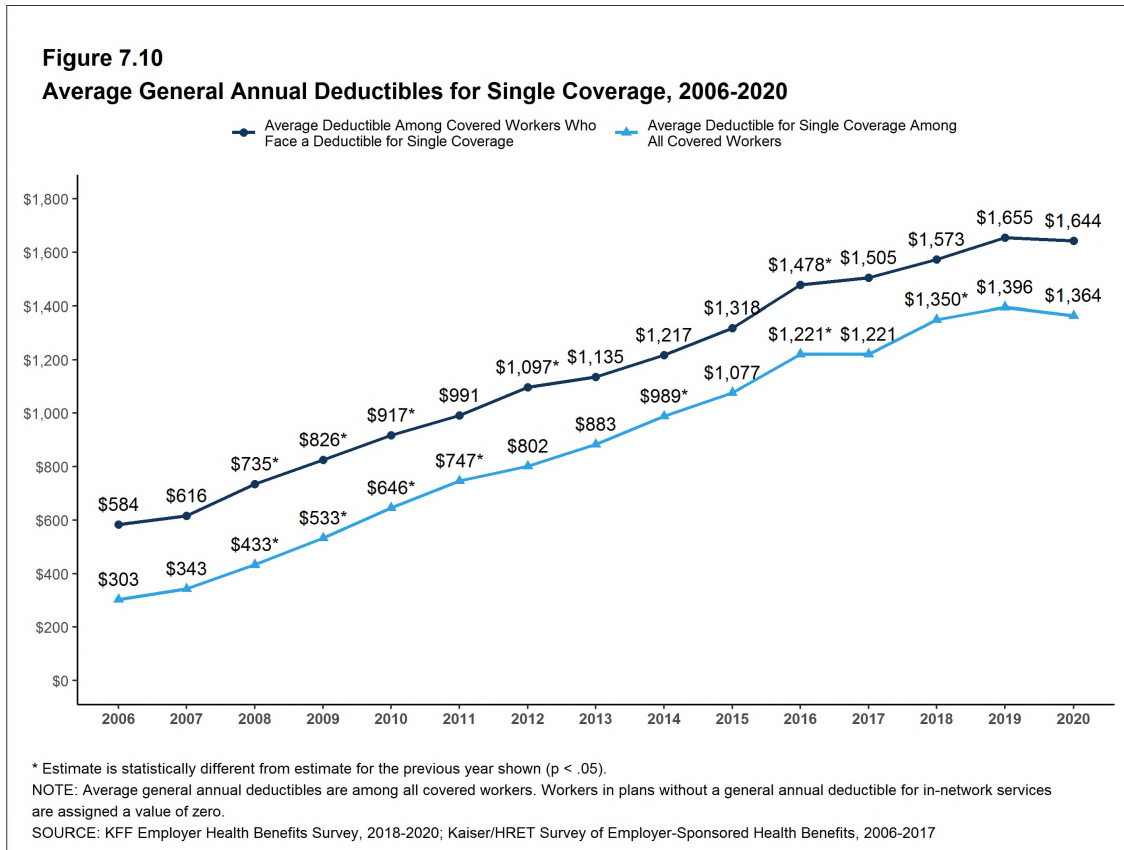
Figure 7.9
Prevalence and Value of General Annual Deductibles for Single Coverage, by Firm Size, 2006-2020

	2006	2007	2008	2009	2010	2011*	2012	2013	2014	2015	2016	2017	2018	2019	2020
Average General Annual Deductible Among Covered Workers Who Face a Deductible for Single Coverage															
All Small Firms	\$775	\$852	\$1,124*	\$1,254	\$1,391*	\$1,537*	\$1,556	\$1,715	\$1,797	\$1,836	\$2,069	\$2,120	\$2,132	\$2,271	\$2,295
All Large Firms	496	519	553	610*	666	757	875*	881	971	1,105*	1,238	1,276	1,365	1,412	1,418
ALL FIRMS	\$584	\$618	\$735*	\$828*	\$917*	\$99*	\$1,097*	\$1,135	\$1,217	\$1,318	\$1,478*	\$1,505	\$1,573	\$1,655	\$1,644
Percentage of Covered Workers With a General Annual Deductible for Single Coverage															
All Small Firms	56%	60%	65%	67%	73%	75%	72%	77%	82%	82%	82%	77%	85%*	83%	79%
All Large Firms	54	58	58	61	68*	74	73	78	80	81	83	83	85	81	84
ALL FIRMS	58%	58%*	59%	63%	70%*	74%	72%	78%*	80%	81%	83%	81%	85%*	82%	83%
Average General Annual Deductible for Single Coverage Among ALL COVERED WORKERS															
All Small Firms	\$43*	\$484	\$727*	\$851	\$1,00*	\$1,177	\$1,163	\$1,330	\$1,493	\$1,507	\$1,869	\$1,831	\$1,818	\$1,856	\$1,819
All Large Firms	234	289	264	376*	456*	548*	629*	670	765*	890*	1,026	1,049	1,168	1,184	1,187
ALL FIRMS	\$303	\$343	\$433*	\$533*	\$646*	\$747*	\$802	\$883	\$989*	\$1,077	\$1,221*	\$1,221	\$1,350*	\$1,366	\$1,364

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers. Average general annual deductibles are among all covered workers. Workers in plans without a general annual deductible for in-network services are assigned a value of zero.

* Estimate is statistically different from estimate for the previous year shown (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2016-2020; KaiserHRET Survey of Employer-Sponsored Health Benefits, 2006-2017

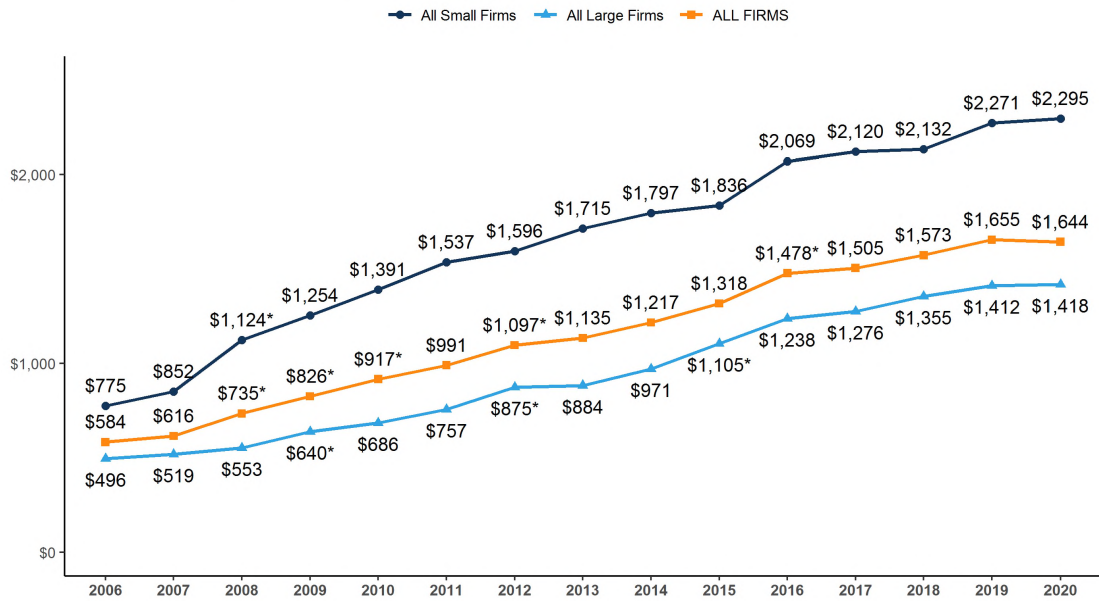


GENERAL ANNUAL DEDUCTIBLES AND ACCOUNT CONTRIBUTIONS

- One of the reasons for the growth in general annual deductibles has been the growth in enrollment in HDHP/SOs, which have higher deductibles than other plans. While growing deductibles in other plan types generally increases enrollee out-of-pocket liability, the shift in enrollment to HDHP/SOs does not necessarily do so because many HDHP/SO enrollees receive an account contribution from their employers, which in essence reduces the high cost sharing in these plans.
 - Ten percent of covered workers in an HDHP with an HRA and 3% of covered workers in an HSA-qualified HDHP receive an account contribution from their employer for single coverage at least equal to their deductible, while another 41% of covered workers in an HDHP with an HRA and 19% of covered workers in an HSA-qualified HDHP receive account contributions that, if applied to their deductible, would reduce the deductible to \$1,000 or less [Figure 7.17].
 - If we reduce the general annual deductibles by employer account contributions, the percentage of covered workers with a deductible of \$1,000 or more would be reduced from 57% to 47% [Figure 7.13] and [Figure 7.14].

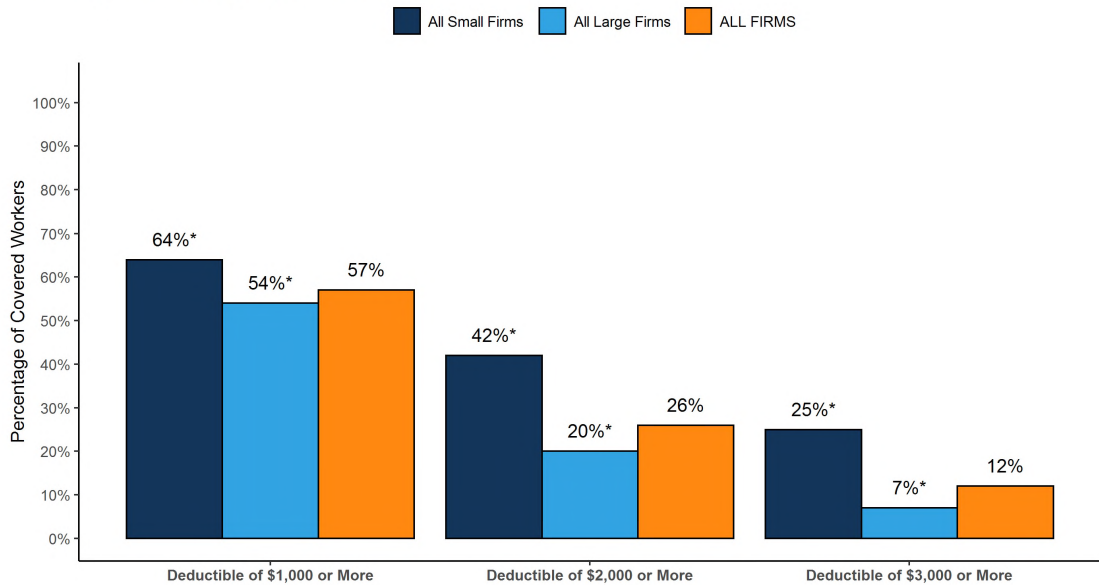
SECTION 7. EMPLOYEE COST SHARING

Figure 7.11
Among Covered Workers Who Face a Deductible for Single Coverage, Average General Annual Deductible for Single Coverage, by Firm Size, 2006-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
 NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers.
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

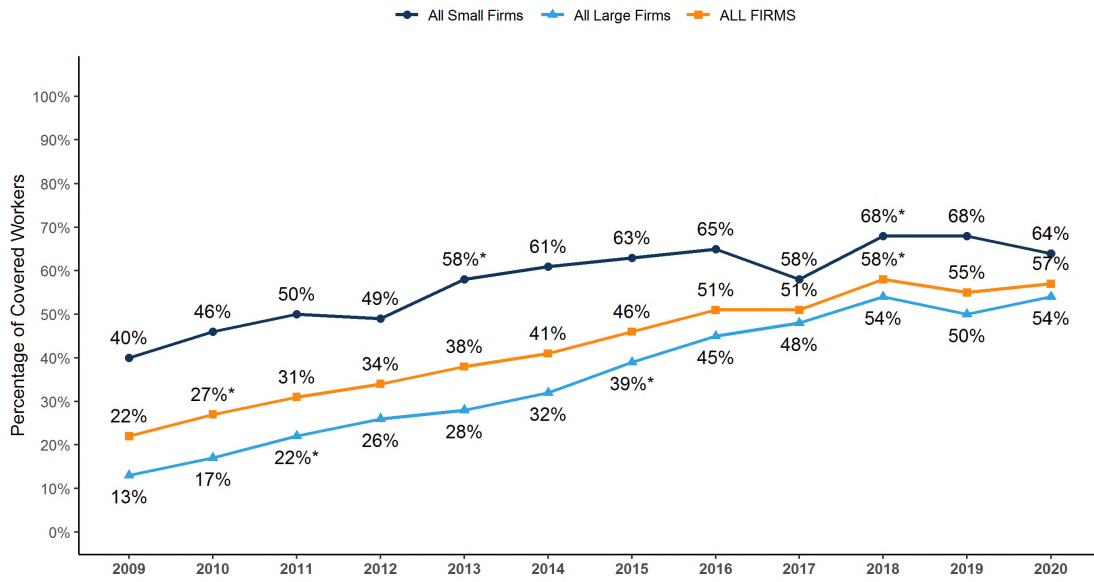
Figure 7.12
Percentage of Covered Workers Enrolled in a Plan with a High General Annual Deductible for Single Coverage, by Firm Size, 2020



* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
 NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.
 SOURCE: KFF Employer Health Benefits Survey, 2020

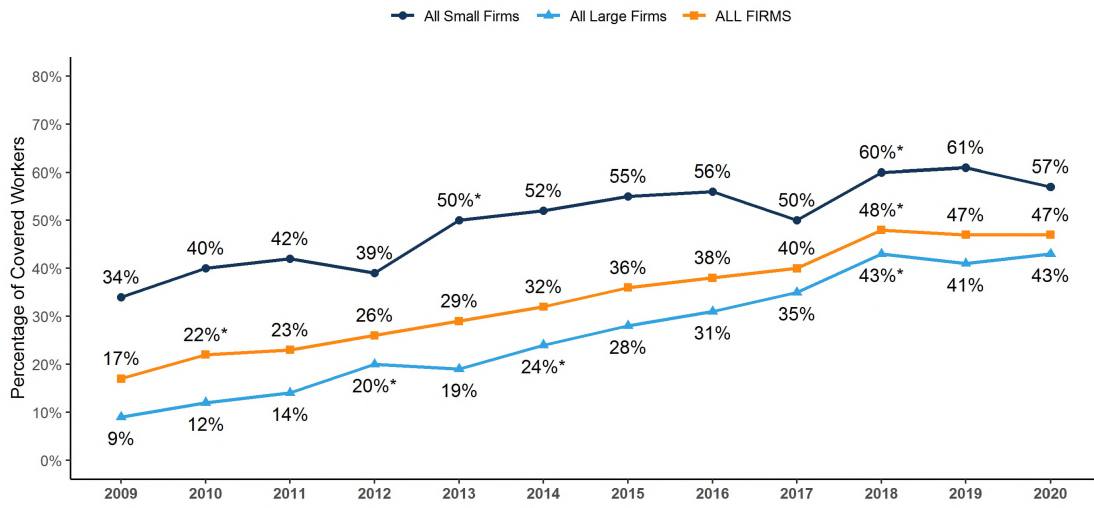
SECTION 7. EMPLOYEE COST SHARING

Figure 7.13
Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of \$1,000 or More for Single Coverage, by Firm Size, 2009-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
 NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

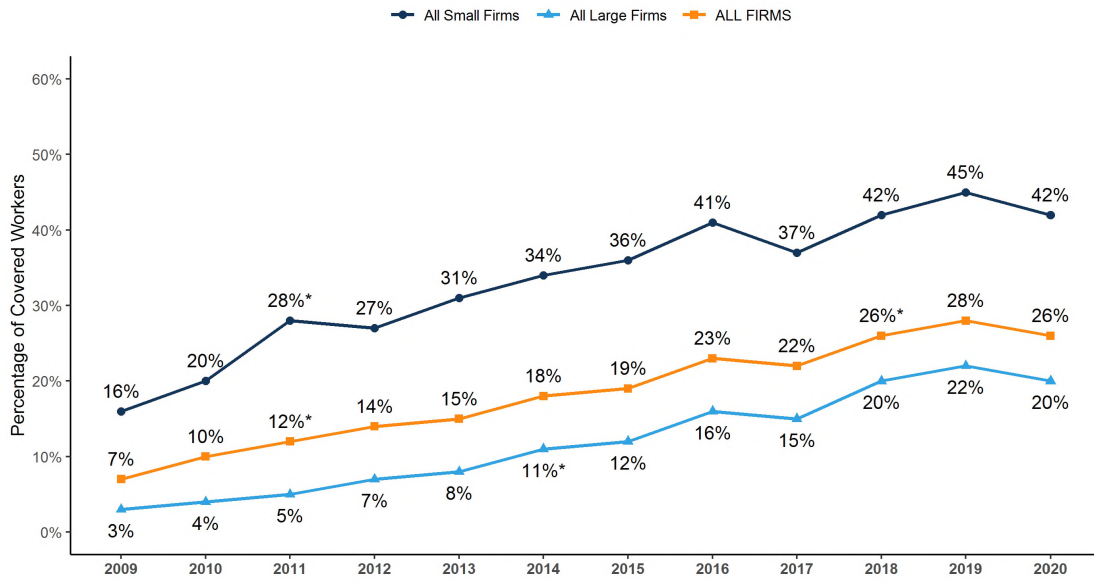
Figure 7.14
Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of \$1,000 or More for Single Coverage, Reduced by Any HRA/HSA Contributions, by Firm Size, 2009-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
 NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SO and other plan types. The net liability for covered workers enrolled in a plan with an HSA or HRA is calculated by subtracting the account contribution from the single coverage deductible. HRAs are notional accounts, and employers are not required to actually transfer funds until an employee incurs expenses. General annual deductibles are for in-network providers.
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

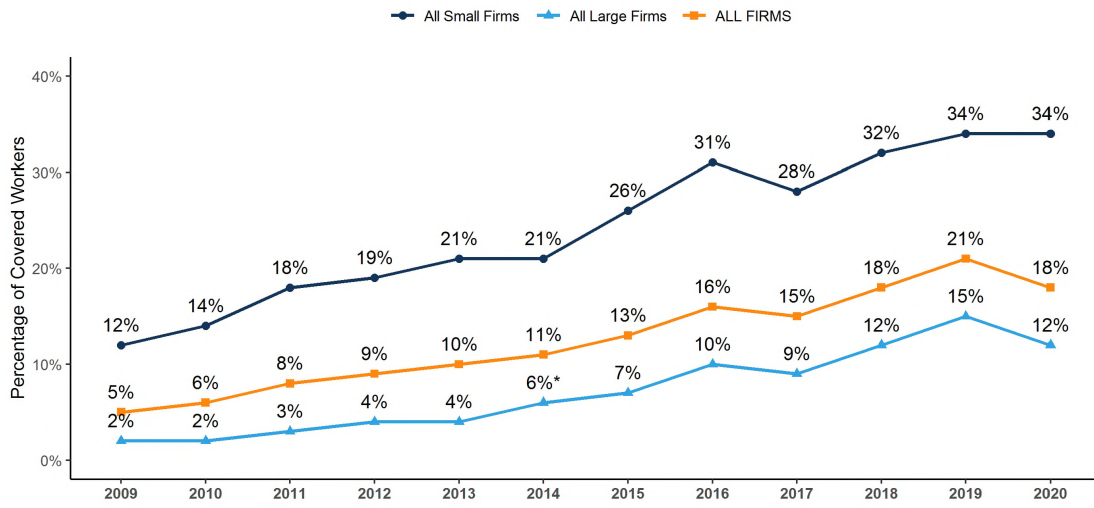
SECTION 7. EMPLOYEE COST SHARING

Figure 7.15
Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of \$2,000 or More for Single Coverage, by Firm Size, 2009-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
 NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

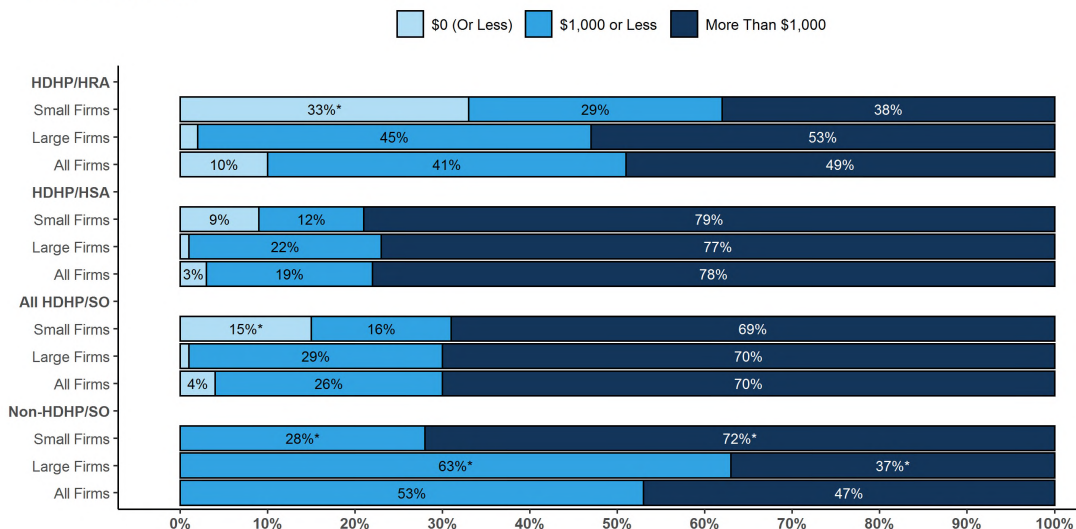
Figure 7.16
Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of \$2,000 or More for Single Coverage, Reduced by Any HRA/HSA Contributions, by Firm Size, 2009-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
 NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. The net liability for covered workers enrolled in a plan with an HSA or HRA is calculated by subtracting the account contribution from the single coverage deductible. HRAs are notional accounts, and employers are not required to actually transfer funds until an employee incurs expenses. General annual deductibles are for in-network providers.
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

SECTION 7. EMPLOYEE COST SHARING

Figure 7.17
Among Covered Workers with a General Annual Deductible, Average General Annual Deductibles for Single Coverage, Reduced by Any HRA/HSA Contributions, by Plan Type and Firm Size, 2020

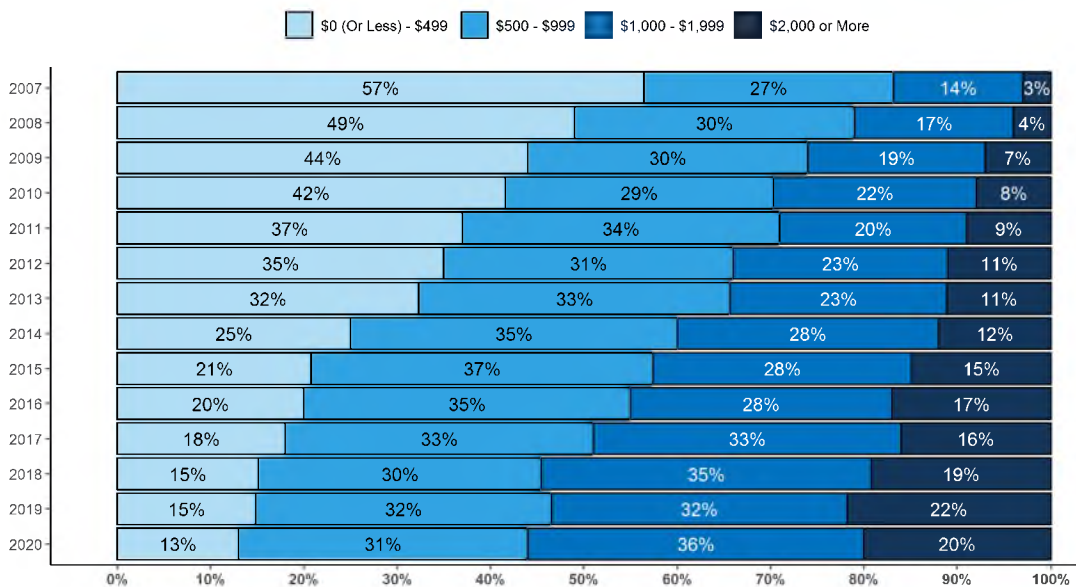


* Estimate is statistically different between All Small Firms and All Large Firms estimate (p < .05).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. The net liability for covered workers enrolled in a plan with an HSA or HRA is calculated by subtracting the account contribution from the single coverage deductible. HRAs are notional accounts, and employers are not required to actually transfer funds until an employee incurs expenses. General annual deductibles are for in-network providers.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.18
Among Covered Workers with a General Annual Deductible, Distribution of General Annual Deductibles for Single Coverage, Reduced by Any HRA/HSA Contributions, 2007-2020



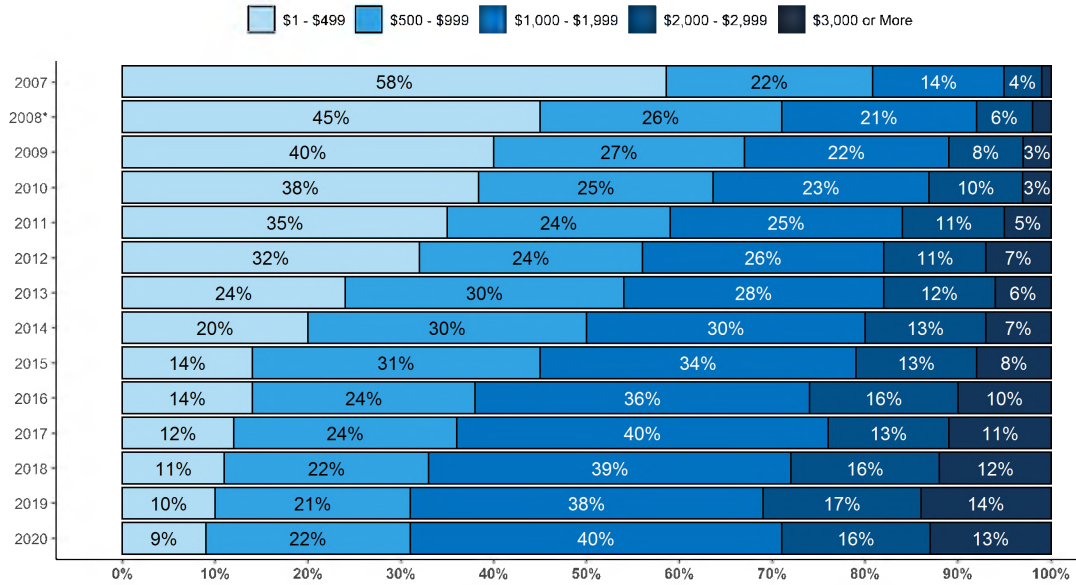
Tests found no statistical difference from distribution for the previous year shown (p < .05).

NOTE: Account contributions include an employer's contribution to an HSA or HRA. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

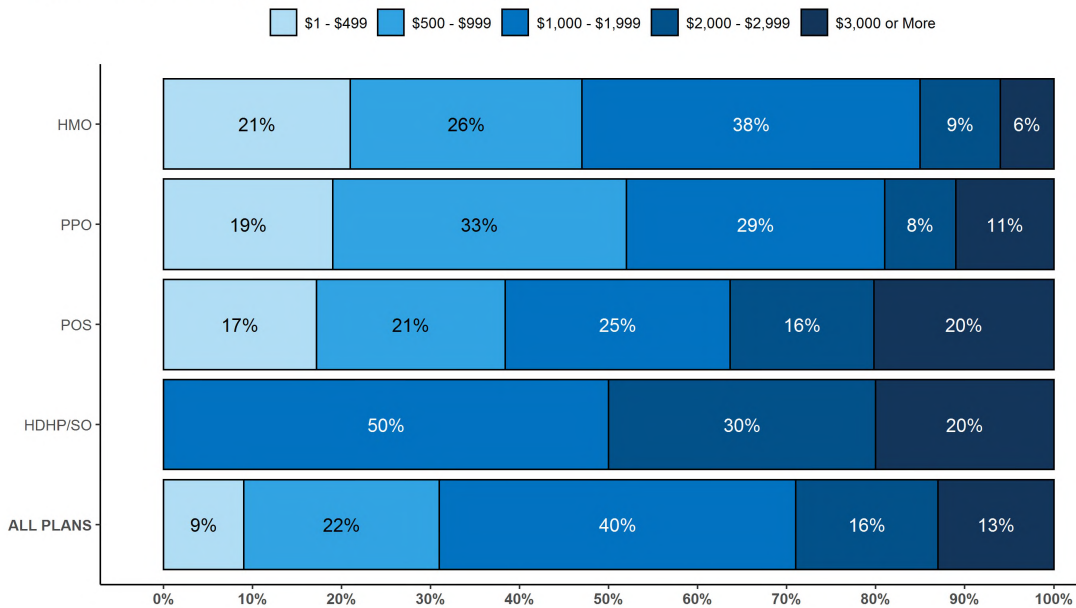
SECTION 7. EMPLOYEE COST SHARING

Figure 7.19
Among Covered Workers with a General Annual Deductible, Distribution of General Annual Deductible for Single Coverage, 2007-2020



* Distribution is statistically different from distribution for the previous year shown (p < .05).
 NOTE: Average general annual deductibles are for in-network providers. In 2020, 83% of covered workers are enrolled in a plan with a general annual deductible.
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

Figure 7.20
Among Covered Workers with a General Annual Deductible, Distribution of General Annual Deductibles for Single Coverage, by Plan Type, 2020



NOTE: Average general annual deductibles are for in-network providers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

GENERAL ANNUAL DEDUCTIBLES FOR WORKERS ENROLLED IN FAMILY COVERAGE

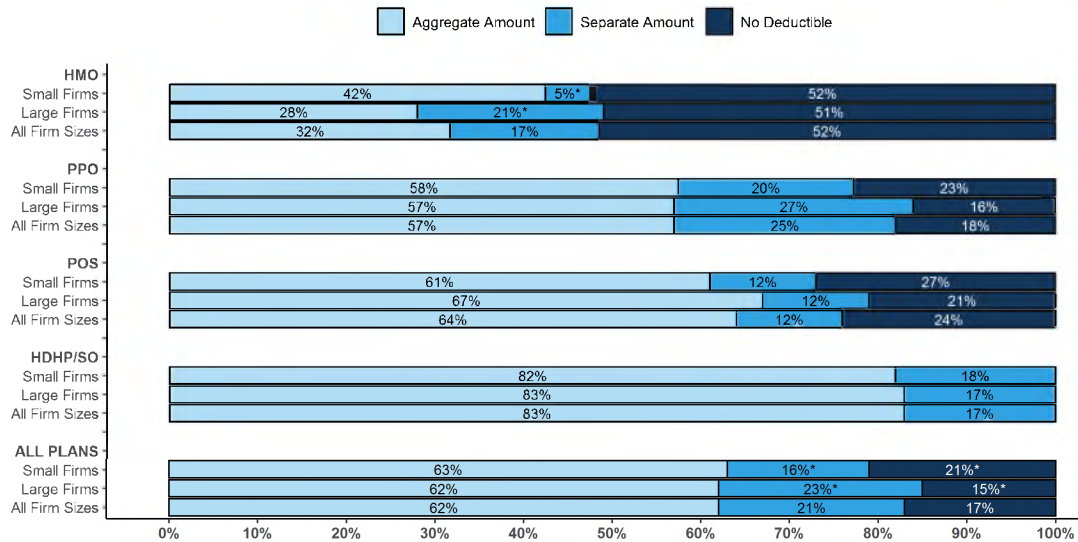
General annual deductibles for family coverage are structured in two primary ways: (1) with an aggregate family deductible, the out-of-pocket expenses of all family members count against a specified family deductible amount, and the deductible is considered met when the combined family expenses exceed the deductible amount; (2) with a separate per-person family deductible, each family member is subject to a specified deductible amount before the plan covers expenses for that member, although many plans consider the deductible for all family members met once a specified number (typically two or three) of family members meet their specified deductible amount.¹

- About one-half (52%) of covered workers in HMOs are in plans without a general annual deductible for family coverage; the percentages in plans without family deductibles are lower for workers in PPOs (18%) and POS plans (24%). As defined, all covered workers in HDHP/SOs have a general annual deductible for family coverage [Figure 7.21].
- Among covered workers enrolled in family coverage, the percentages of covered workers in a plan with an aggregate general annual deductible are 32% for workers in HMOs; 57% for workers in PPOs; 64% for workers in POS plans; and 83% for workers in HDHP/SOs [Figure 7.21].
 - The average deductible amounts for covered workers in plans with an aggregate annual deductible for family coverage are \$3,035 for HMOs; \$2,716 for PPOs; \$3,902 for POS plans; and \$4,552 for HDHP/SOs [Figure 7.22]. Deductible amounts for aggregate family deductibles are similar to last year for each plan type.
- For covered workers in plans with an aggregate deductible for family coverage, the average annual family deductibles in small firms are higher than the average annual family deductibles in large firms for covered workers in HMOs, PPOs and HDHP/SOs [Figure 7.22].
- Among covered workers enrolled in family coverage, the percentages of covered workers in plans with a separate per-person annual deductible for family coverage are 17% for workers in HMOs; 25% for workers in PPOs; 12% for workers in POS plans; and 17% for workers in HDHP/SOs [Figure 7.21].
 - The average deductible amounts for covered workers in plans with separate per-person annual deductibles for family coverage are \$1,115 for PPOs and \$2,523 for HDHP/SOs [Figure 7.22].
 - Forty percent covered workers in plans with a separate per-person annual deductible for family coverage have a limit for the number of family members required to meet the separate deductible amounts [Figure 7.25]. Among those covered workers in plans with a limit on the number of family members, the most frequent number of family members required to meet the separate per-person deductible is two [Figure 7.26].

¹Some workers with separate per-person deductibles or out-of-pocket maximums for family coverage do not have a specific number of family members that are required to meet the deductible amount and instead have another type of limit, such as a per-person amount with a total dollar amount limit. These responses are included in the averages and distributions for separate family deductibles and out-of-pocket maximums.

SECTION 7. EMPLOYEE COST SHARING

Figure 7.21
Distribution of Type of General Annual Deductible for Covered Workers with Family Coverage, by Plan Type and Firm Size, 2020



* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. HDHP/SOs are defined as having a minimum deductible of \$1,000 for single coverage and \$2,000 for family coverage and either an HRA or HSA. Among workers with a general annual family deductible, 65% in HMOs, 69% in PPOs, and 84% in POS plans. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount. N/A: Not Applicable.

SOURCE: KFF Employer Health Benefits Survey, 2020

SECTION 7. EMPLOYEE COST SHARING

Figure 7.22

Among Covered Workers With a General Annual Deductible, Average Deductibles for Family Coverage, by Deductible Type, Plan Type, and Firm Size, 2020

	Aggregate Amount	Separate Per-Person Amount
HMO		
All Small Firms	\$4,181*	NSD
All Large Firms	\$2,467*	NSD
ALL FIRM SIZES	\$3,035	NSD
PPO		
All Small Firms	\$4,231*	\$1,585*
All Large Firms	\$2,137*	\$966*
ALL FIRM SIZES	\$2,716	\$1,115
POS		
All Small Firms	\$4,467	NSD
All Large Firms	\$3,210	NSD
ALL FIRM SIZES	\$3,902	NSD
HDHP/SO		
All Small Firms	\$6,189*	\$3,763*
All Large Firms	\$4,099*	\$2,152*
ALL FIRM SIZES	\$4,552	\$2,523

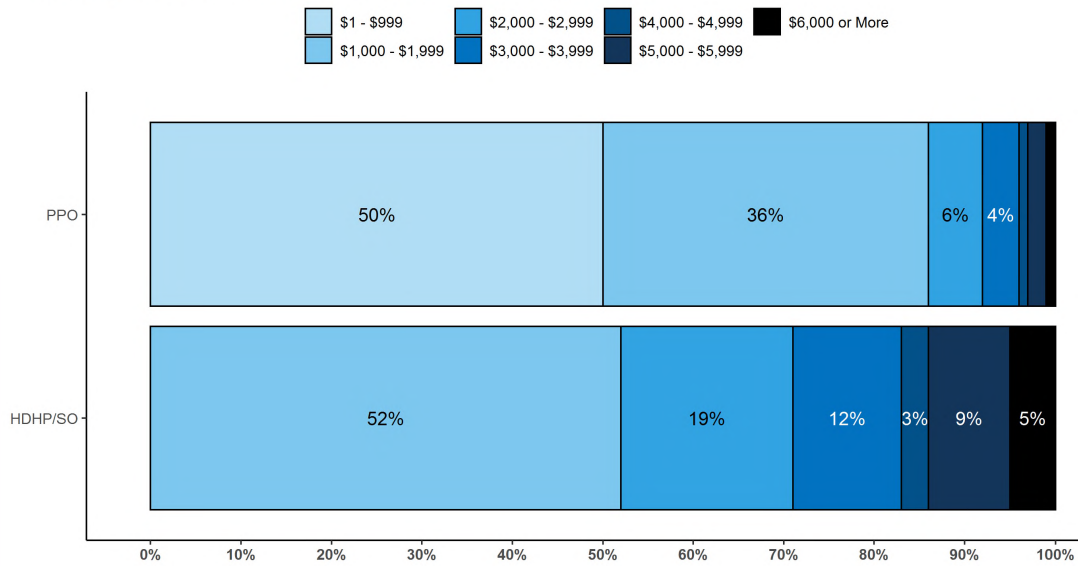
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount.
NSD: Not Sufficient Data

* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

SECTION 7. EMPLOYEE COST SHARING

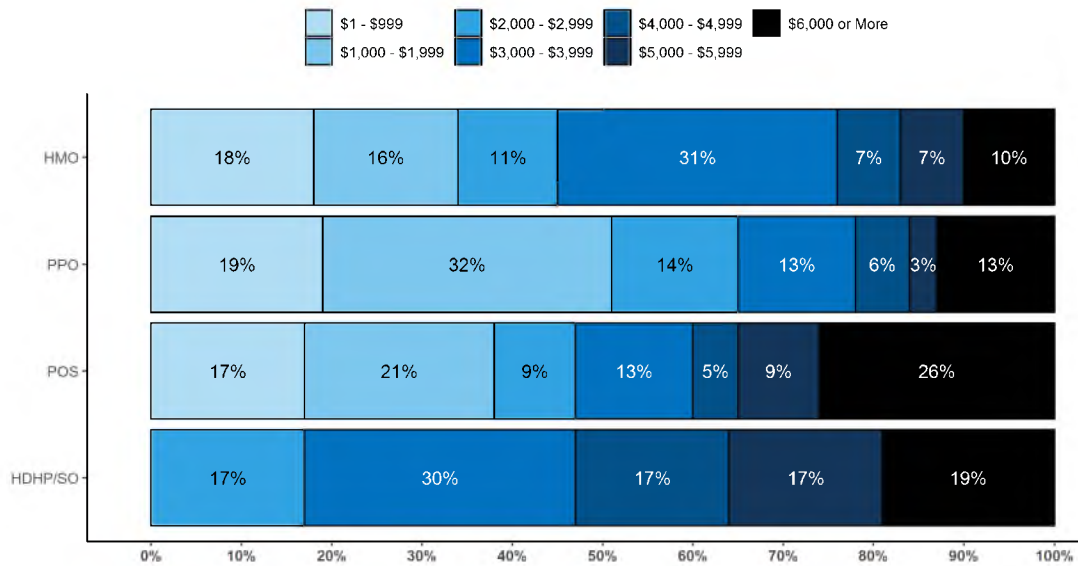
Figure 7.23
Among Covered Workers with a Separate Per-Person General Annual Deductible for Family Coverage, Distribution of Deductibles, by Plan Type, 2020



NOTE: Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount.

SOURCE: KFF Employer Health Benefits Survey, 2020

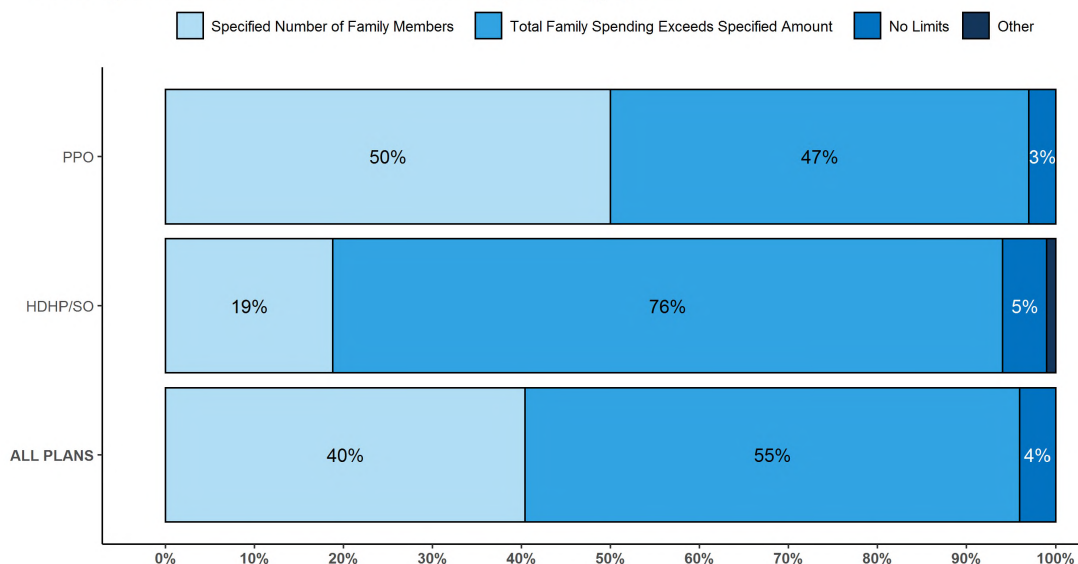
Figure 7.24
Among Covered Workers with an Aggregate General Annual Deductible for Family Coverage, Distribution of Deductibles, by Plan Type, 2020



NOTE: By definition, 100% of covered workers in an HDHP/SO with an aggregate deductible have a family deductible of \$2,000 or more. Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount.

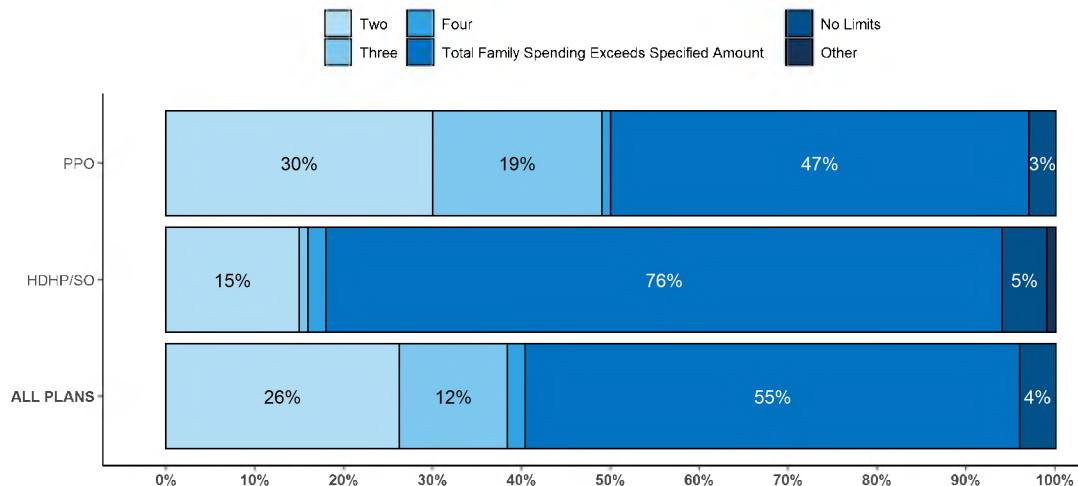
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.25
Among Covered Workers With a Separate Per-Person General Annual Deductible for Family Coverage, Structure of Deductible Limits, by Plan Type, 2020



NOTE: Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount. Plan types with insufficient sample are not shown independently, but included in the all plan estimate.
 SOURCE: KFF Employer Health Benefits Survey, 2020

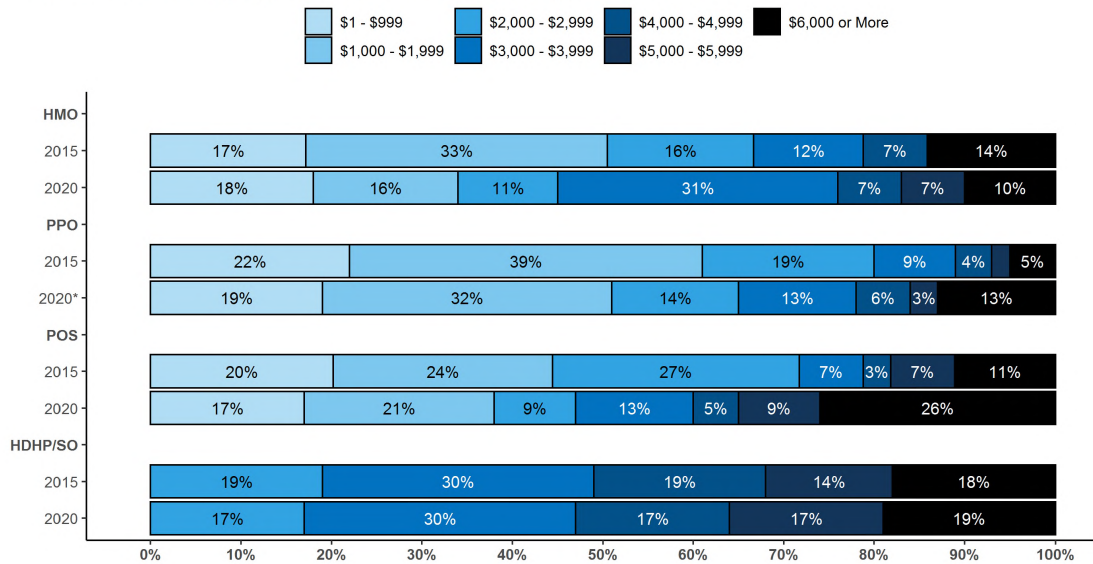
Figure 7.26
Among Covered Workers With a Separate Per-Person General Annual Deductible for Family Coverage and a Per-Person Limit, Distribution of Maximum Number of Family Members Required to Meet the Deductible, by Plan Type, 2020



NOTE: Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount. Firms that reported having a separate family deductible were asked if they had a combined limit or if the limit was considered met when a specified number of family members reached their separate per-person limit. 'Other' category may include per-person limits with a total family dollar limit. Plan types with insufficient sample are not shown independently, but included in the all plan estimate.
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.27

Among Covered Workers With an Aggregate General Annual Deductible for Family Coverage, Distribution of Aggregate Deductibles, by Plan Type, 2015 and 2020



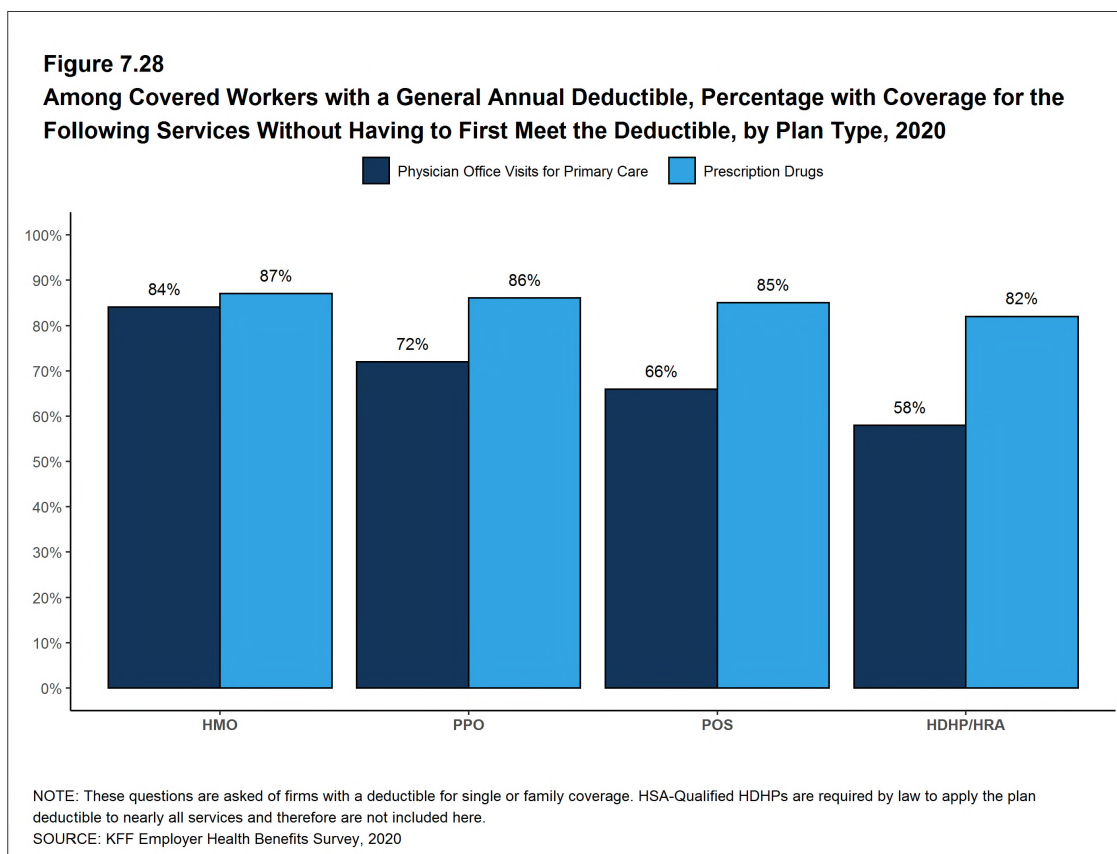
* Distribution is statistically different from distribution for the previous year shown ($p < .05$).

NOTE: By definition, 100% of covered workers in an HDHP/SO with an aggregate deductible have a family deductible of \$2,000 or more. Average general annual deductibles are for in-network providers. The survey distinguishes between plans that have an aggregate family deductible and plans that have a separate per-person deductible, typically with a limit on the number of family members required to reach that amount.

SOURCE: KFF Employer Health Benefits Survey, 2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015

CHARACTERISTICS OF GENERAL ANNUAL DEDUCTIBLES

- The majority of covered workers with a general annual deductible are in plans where the deductible does not have to be met before certain services, such as physician office visits or prescription drugs, are covered.
 - Majorities of covered workers (84% in HMOs, 72% in PPOs, 66% in POS plans, and 58% in HDHP/HRAs) who are enrolled in plans with general annual deductibles are in plans where the deductible does not have to be met before physician office visits for primary care are covered [Figure 7.28].
 - Similarly, among workers with a general annual deductible, large shares of covered workers in HMOs (87%), PPOs (86%), POS plans (85%), and HDHP/HRAs (82%) are enrolled in plans where the general annual deductible does not have to be met before prescription drugs are covered [Figure 7.28].



HOSPITAL ADMISSIONS AND OUTPATIENT SURGERY

- Whether or not a worker has a general annual deductible, most workers face additional types of cost sharing (such as a copayment, coinsurance, or a per diem charge) when admitted to a hospital or having outpatient surgery. The distribution of workers with cost sharing for hospital admissions or outpatient surgery does not equal 100%, as workers may face a complex combination of types of cost sharing. For this reason, the average copayment and coinsurance rates include workers who may have a combination of these types of cost sharing.
- Beginning in 2017, to reduce the burden on respondents, we revised the survey to ask about cost sharing for hospital admissions and outpatient surgery only for their largest health plan type; previously, we asked for this information for each of the plan types that they offered.
- In addition to any general annual deductible that may apply, 65% of covered workers have coinsurance and 13% have a copayment that apply to inpatient hospital admissions. Lower percentages of workers have per day (per diem) payments (7%), a separate hospital deductible (1%), or both a copayment and coinsurance (8%), while 16% have no additional cost sharing for hospital admissions after any general annual deductible has been met [Figure 7.29].
 - For covered workers in HMOs, copayments are more common (33%) and coinsurance (43%) is less common than the average for all covered workers [Figure 7.29].
 - HDHP/SOs, on average, have a different cost-sharing structure than other plan types for hospital admissions. Only 3% of covered workers in HDHP/SOs have a copayment for hospital admissions, lower than the average for all covered workers [Figure 7.29].

SECTION 7. EMPLOYEE COST SHARING

- The average coinsurance rate for a hospital admission is 20%, the average copayment is \$311 per hospital admission, and the average per diem charge is \$313 [Figure 7.32]. Sixty-six percent of workers enrolled in a plan with a per diem for hospital admissions have a limit on the number of days a worker must pay the amount [Figure 7.33].
- The cost-sharing provisions for outpatient surgery are similar to those for hospital admissions, as most workers have coinsurance or copayments. In 2020, 15% of covered workers have a copayment and 68% have coinsurance for outpatient surgery. In addition, 6% have both a copayment and coinsurance, while 16% have no additional cost sharing after any general annual deductible has been met [Figure 7.30] and [Figure 7.31].
 - For covered workers with cost sharing for outpatient surgery, the average coinsurance rate is 20% and the average copayment is \$188 [Figure 7.32].

Figure 7.29

Distribution of Covered Workers With Other Cost Sharing for Hospital Admissions, in Addition to Any General Annual Deductible, by Plan Type, 2020

Plan Type	Separate Annual Deductible for Hospital Admissions	Copayment	Coinsurance	Both Copayment and Coinsurance	Charge Per Day	None
HMO	<1%*	33%*	43%*	8%	9%	19%
PPO	2	11	73*	8	6	11*
POS	4	27*	39*	6	15*	25
HDHP/SO	<1*	3*	69	6	6	21
ALL PLANS	1%	13%	65%	8%	7%	16%

NOTE: We collect information on the cost-sharing provisions in addition to any general annual plan deductible. The distribution of workers with different types of cost sharing does not equal 100% because workers may face a combination of types of cost sharing. Less than one percent of covered workers have an 'Other' type of cost sharing. Information on separate deductibles for hospital admissions was collected only for HDHP/HRAs because federal regulations for HSA-qualified HDHPs make it unlikely these plans would have a separate deductible for specific services. 'Both Copayment and Coinsurance' category includes workers who are required to pay the higher amount of either the copayment or coinsurance under the plan. Zero percent of covered workers are enrolled in a plan that does not cover hospital admissions.

* Estimate is statistically different from All Plans estimate (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.30

Distribution of Covered Workers With Other Cost Sharing for Outpatient Surgery, in Addition to Any General Annual Deductible, by Plan Type, 2020

Plan Type	Separate Annual Deductible for Outpatient Surgery	Copayment	Coinsurance	Both Copayment and Coinsurance	None
HMO	1%	40%*	40%*	11%	16%
PPO	1	11	77*	8	11*
POS	3	37*	46*	7	15
HDHP/SO	<1*	4*	72	2*	23
ALL PLANS	1%	15%	68%	6%	16%

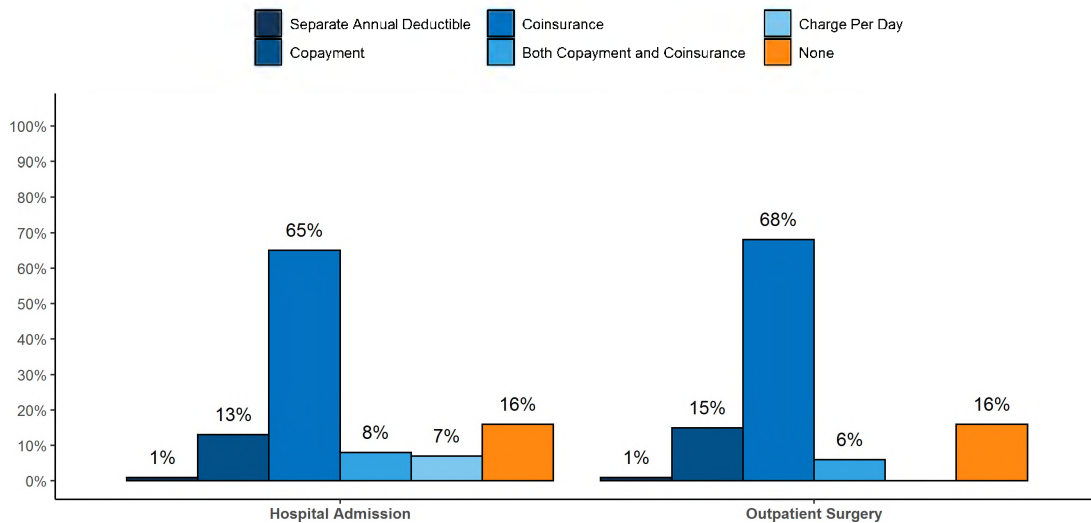
NOTE: We collect information on the cost-sharing provisions in addition to any general annual plan deductible. The distribution of workers with different types of cost sharing does not equal 100% because workers may face a combination of types of cost sharing. Less than one percent of covered workers have an 'Other' type of cost sharing. Information on separate deductibles for hospital admissions was collected only for HDHP/HRAs because federal regulations for HSA-qualified HDHPs make it unlikely these plans would have a separate deductible for specific services. 'Both Copayment and Coinsurance' category includes workers who are required to pay the higher amount of either the copayment or coinsurance under the plan. Zero percent of covered workers are enrolled in a plan that does not cover outpatient surgery.

* Estimate is statistically different from All Plans estimate (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2020

SECTION 7. EMPLOYEE COST SHARING

Figure 7.31
Percentage of Covered Workers with the Following Types of Cost Sharing for Hospital Admissions and Outpatient Surgery, in Addition to Any General Annual Deductible, 2020



NOTE: We collect information on the cost-sharing provisions in addition to any general annual plan deductible. The distribution of workers with different types of cost sharing does not equal 100% because workers may face a combination of types of cost sharing. Less than one percent of covered workers have an 'Other' type of cost sharing. Information on separate deductibles for hospital admissions was collected only for HDHP/HRAs because federal regulations for HSA-qualified HDHPs make it unlikely these plans would have a separate deductible for specific services. 'Both Copayment and Coinsurance' category includes workers who are required to pay the higher amount of either the copayment or coinsurance under the plan.
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.32
Among Covered Workers With Separate Cost Sharing for Hospital Admissions or Outpatient Surgery, Average Cost Sharing, by Type, 2020

	Charge Per Day	Coinsurance	Copayment
Outpatient Surgery	N/A	20%	\$188
Hospital Admission	\$313	20%	\$311

NOTE: Estimates represent cost sharing in addition to any general annual deductible. The average amounts include workers who may have a combination of types of cost sharing. Cost sharing amounts are for in-network providers.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.33

Among Covered Workers With a Charge Per Day for Hospital Admissions, Average Cost Sharing Features, 2020

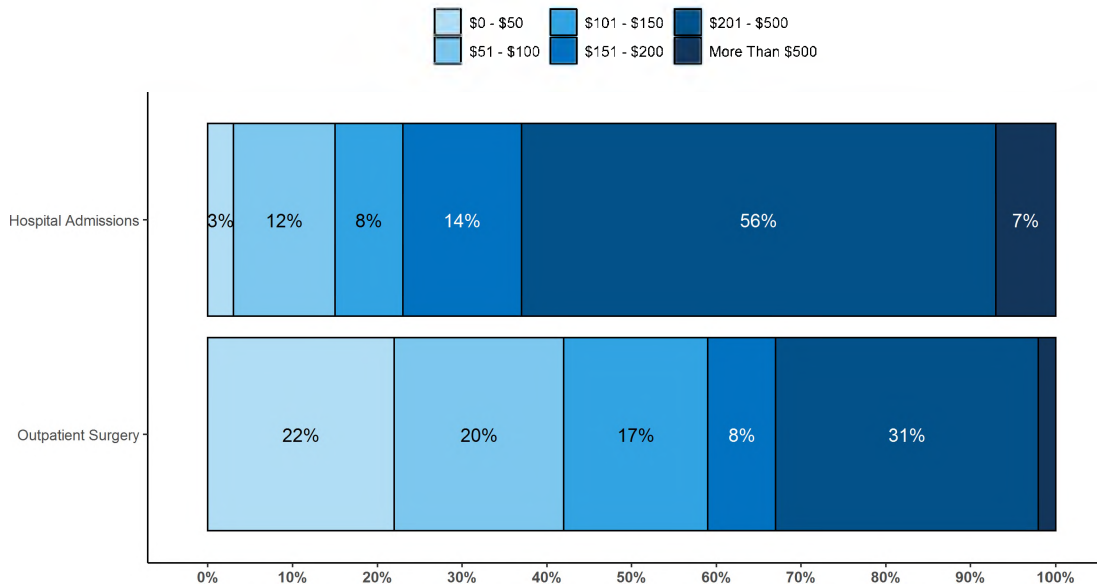
	Among Covered Workers With a Charge Per Day for Hospital Admissions
Average Charge Per Day	\$313
Percentage of Covered Workers With a Limit On the Number of Days a Worker Must Pay Per-Day Amount	66%
Average Number of Days the Per-Day Amount Must Be Paid	5

NOTE: Estimates represent cost sharing in addition to any general annual deductible. Average amounts include workers who may have a combination of types of cost sharing. Amounts are for in-network services.

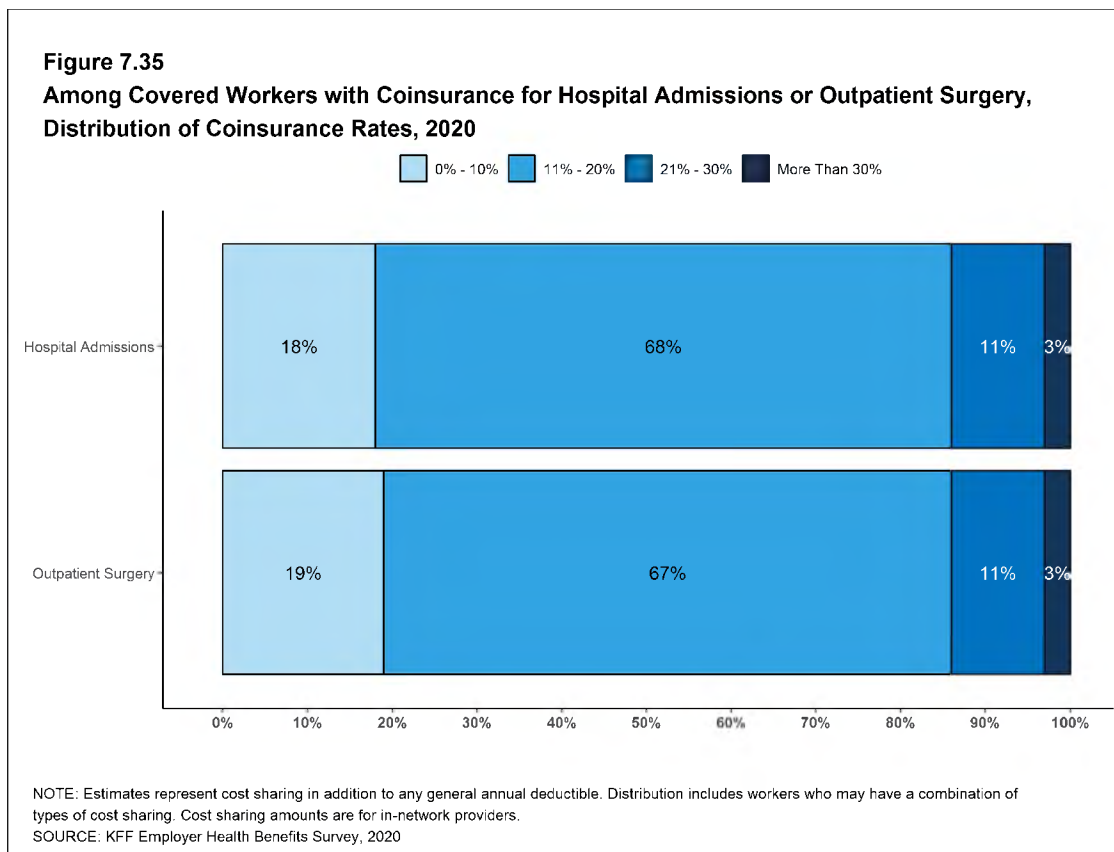
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.34

Among Covered Workers with a Copayment for Hospital Admissions or Outpatient Surgery, Distribution of Copayments, 2020



NOTE: Estimates represent cost sharing in addition to any general annual deductible. Distribution includes workers who may have a combination of types of cost sharing. Cost sharing amounts are for in-network providers.
SOURCE: KFF Employer Health Benefits Survey, 2020



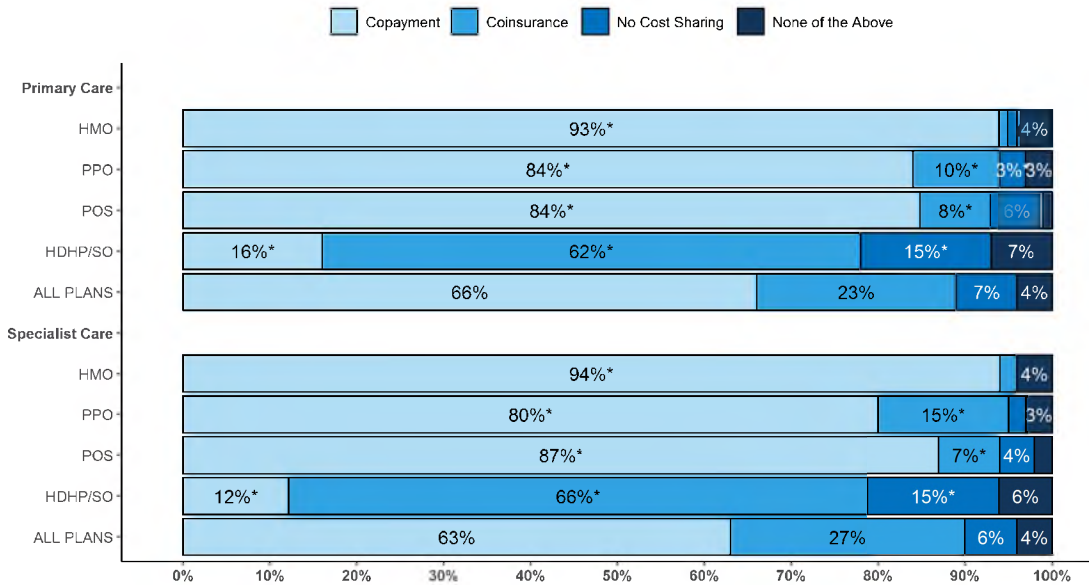
COST SHARING FOR PHYSICIAN OFFICE VISITS

- The majority of covered workers are enrolled in health plans that require cost sharing for an in-network physician office visit, in addition to any general annual deductible.²
 - The most common form of physician office visit cost sharing for in-network services is a copayment. Sixty-six percent of covered workers have a copayment for a primary care physician office visit and 23% have coinsurance. For office visits with a specialty physician, 63% of covered workers have a copayment and 27% have coinsurance [Figure 7.36].
 - Covered workers in HMOs, PPOs, and POS plans are much more likely to have copayments for both primary care and specialty care physician office visits than workers in HDHP/SOs. For primary care physician office visits, 16% of covered workers in HDHP/SOs have a copayment, 62% have coinsurance, and 15% have no cost sharing after the general annual plan deductible is met [Figure 7.36].
 - Among covered workers with a copayment for in-network physician office visits, the average copayment is \$26 for primary care and \$42 for specialty physician office visits [Figure 7.37], similar to the amounts last year.
 - Among covered workers with coinsurance for in-network physician office visits, the average coinsurance rates are 18% for a visit with a primary care physician and 19% for a visit with a specialist [Figure 7.37], similar to the rates last year.

²For those enrolled in an HDHP/HSA, the out-of-pocket maximum may be no more than \$6,900 for an individual plan and \$13,800 for a family plan in 2020. See https://www.irs.gov/irb/2019-22_IRB#REV-PROC-2019-25

SECTION 7. EMPLOYEE COST SHARING

Figure 7.36
Percentage of Covered Workers with the Following Types of Cost Sharing for Physician Office Visits, by Plan Type, 2020



* Estimate is statistically different from All Plans estimate (p < .05).
 NOTE: Figure represents cost sharing in addition to any general annual deductible. The survey includes questions on cost sharing for in-network services only.
 SOURCE: KFF Employer Health Benefits Survey, 2020

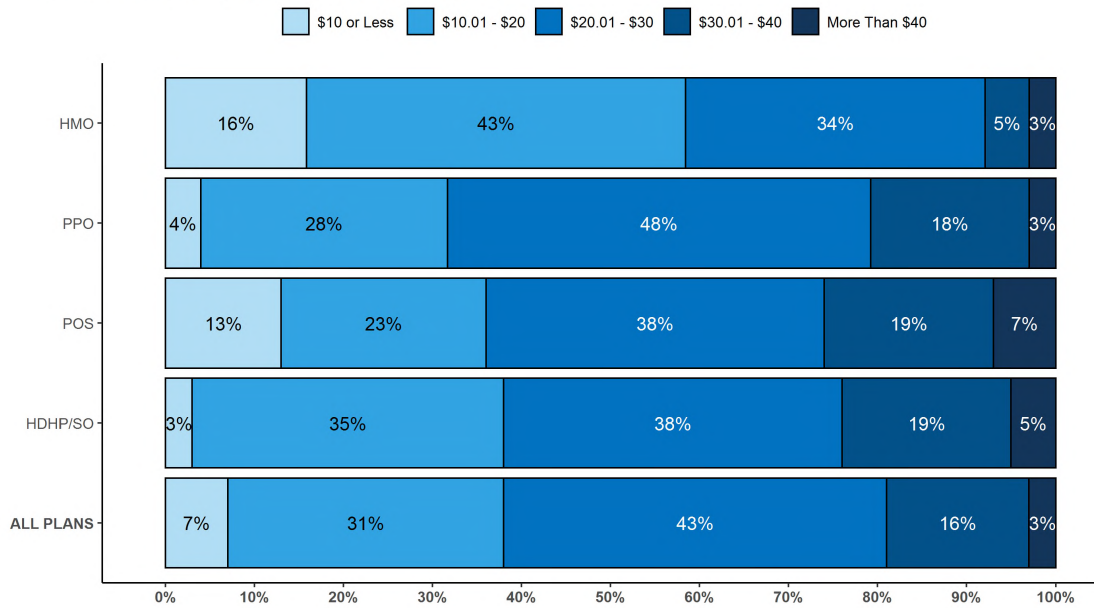
Figure 7.37
Among Covered Workers With Copayments And/Or Coinsurance for Physician Office Visits, Average Copayments and Coinsurance, by Plan Type, 2020

	HMO	PPO	POS	HDHP/SO	All Plans
Primary Care Office Visit					
Average Copayment (\$)	\$22*	\$26	\$26	\$28	\$26
Average Coinsurance (%)	NSD	21%	NSD	18%	18%
Specialty Care Office Visit					
Average Copayment (\$)	\$37*	\$42	\$43	\$53*	\$42
Average Coinsurance (%)	NSD	21%*	NSD	18%	19%

NOTE: Cost-sharing averages are for in-network visits.
 NSD: Not Sufficient Data
 * Estimate is statistically different from All Plans estimate (p < .05).
 SOURCE: KFF Employer Health Benefits Survey, 2020

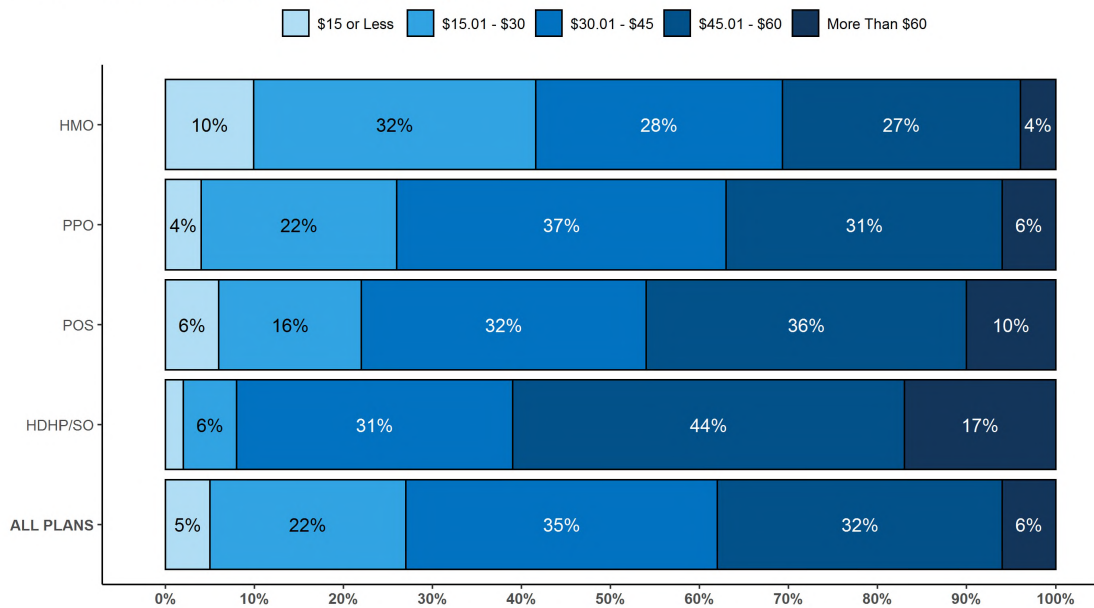
SECTION 7. EMPLOYEE COST SHARING

Figure 7.38
Among Covered Workers with a Copayment for a Primary Care Physician Office Visit,
Distribution of Copayments, by Plan Type, 2020



NOTE: Copayments are for in-network providers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

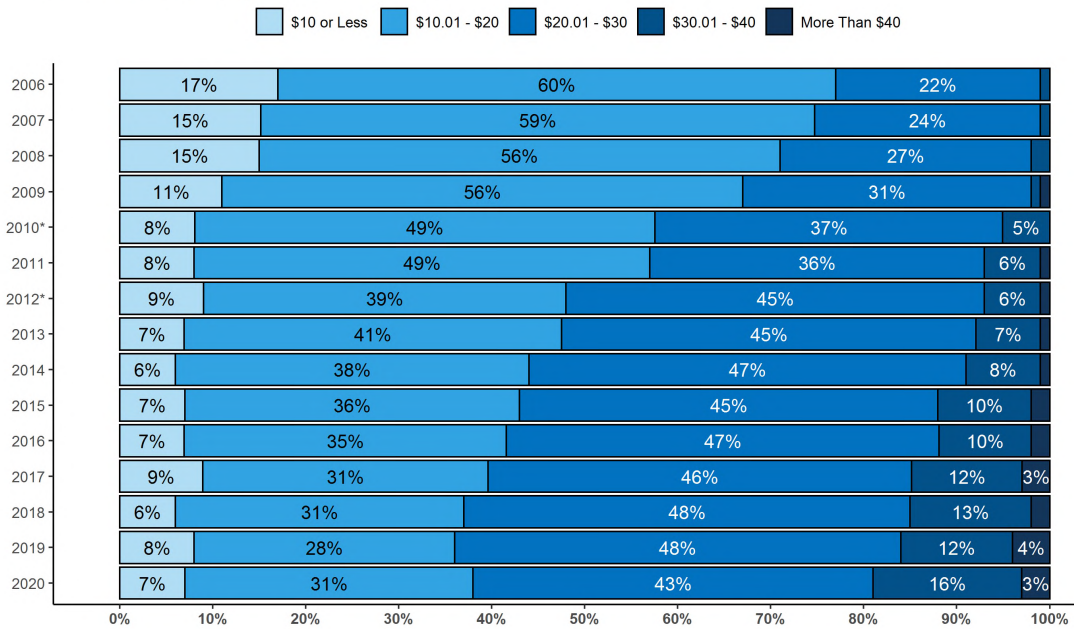
Figure 7.39
Among Covered Workers with a Copayment for a Specialist Physician Office Visit,
Distribution of Copayments, by Plan Type, 2020



NOTE: Copayments are for in-network providers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

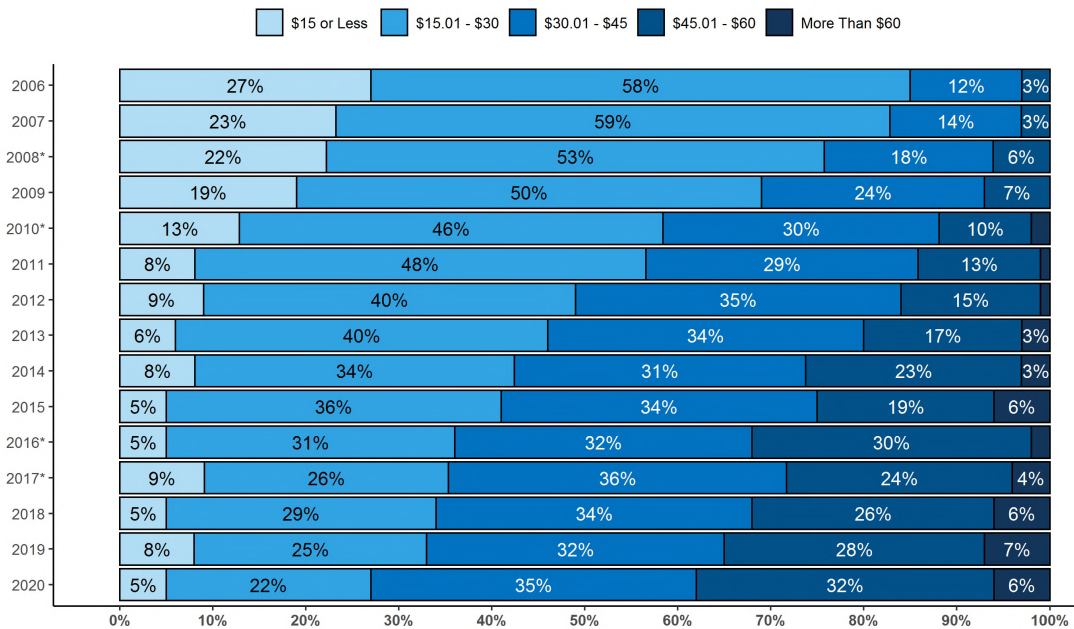
SECTION 7. EMPLOYEE COST SHARING

Figure 7.40
Among Covered Workers with a Copayment for a Primary Care Physician Office Visit,
Distribution of Copayments, 2006-2020



* Distribution is statistically different from distribution for the previous year shown (p < .05).
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.41
Among Covered Workers with a Copayment for a Specialist Physician Office Visit,
Distribution of Copayments, 2006-2020



* Distribution is statistically different from distribution for the previous year shown (p < .05).
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 7.42
Among Covered Workers With a Copayment And/Or Coinsurance
for Physician Office Visits, Average Copayment and Coinsurance,
2006-2020

	Primary Care: Copayment	Primary Care: Coinsurance	Specialist Care: Copayment	Specialist Care: Coinsurance
2006	\$18		\$23	
2007	\$19	17%	\$24	
2008	\$19	17%	\$26*	
2009	\$20*	18%	\$28*	
2010	\$22*	18%	\$31*	18%
2011	\$22	18%	\$32	18%
2012	\$23	18%	\$33	19%
2013	\$23	18%	\$35	19%
2014	\$24	18%	\$36	19%
2015	\$24	18%	\$37	19%
2016	\$24	18%	\$38	19%
2017	\$25	19%	\$38	19%
2018	\$25	18%	\$40	18%
2019	\$25	18%	\$40	19%
2020	\$26	18%	\$42	19%

NOTE: Cost-sharing averages are for in-network visits.

* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

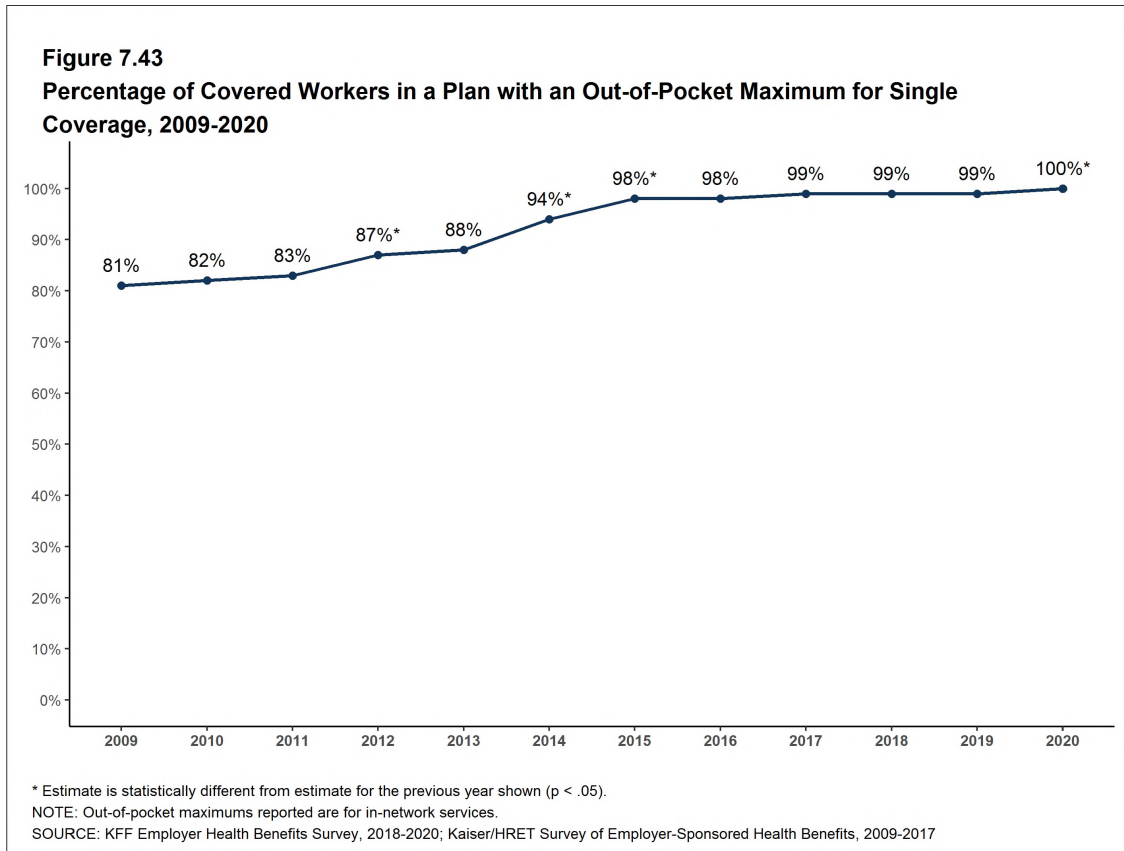
OUT-OF-POCKET MAXIMUMS

- Most covered workers are in a plan that partially or totally limits the cost sharing that an enrollee must pay in a year. This limit is generally referred to as an out-of-pocket maximum. The Affordable Care Act (ACA) requires that non-grandfathered health plans have an out-of-pocket maximum of no more than \$8,150 for single coverage and \$16,300 for family coverage in 2020. Out-of-pocket limits in HSA qualified HDHP/SOs are required to be somewhat lower.³ Many plans have complex out-of-pocket structures, which makes it difficult to accurately collect information on this element of plan design.

³Starting in 2010, the survey asked about the prevalence and cost of physician office visits separately for primary care and specialty care. Prior to the 2010 survey, if the respondent indicated the plan had a copayment for office visits, we assumed the plan had a copayment for both primary and specialty care visits. The survey did not allow for a respondent to report that a plan had a copayment for primary care visits and coinsurance for visits with a specialist physician. The changes made in 2010 allow for variations in the type of cost sharing for primary care and specialty care visits. The survey includes cost sharing for in-network services only.

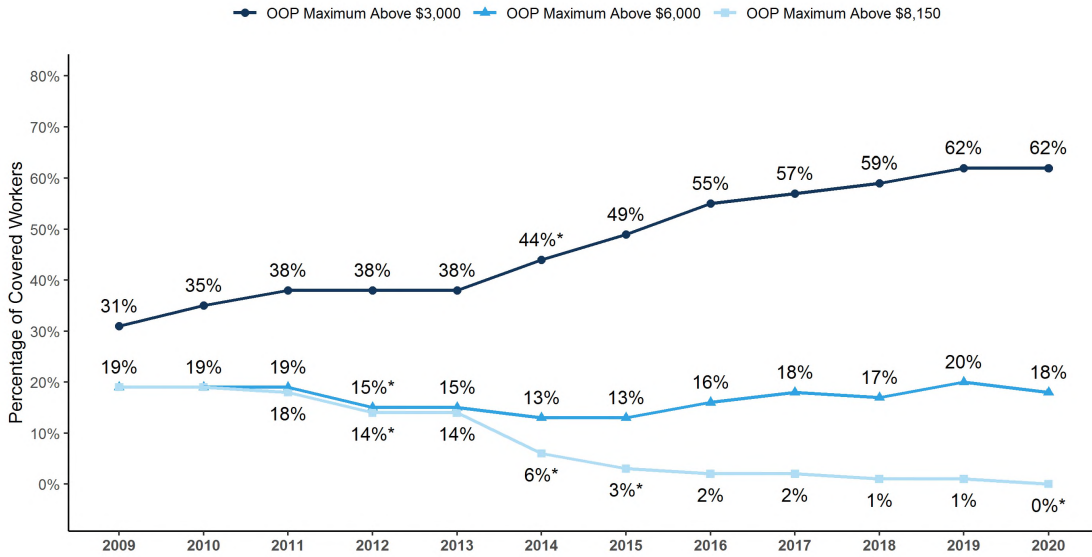
SECTION 7. EMPLOYEE COST SHARING

- In 2020, 100% of covered workers are in a plan with an out-of-pocket maximum for single coverage. This is a significant increase from 98% in 2015 [Figure 7.43].
- For covered workers in plans with an out-of-pocket maximum for single coverage, there is wide variation in spending limits.
 - Eleven percent of covered workers in plans with an out-of-pocket maximum for single coverage have an out-of-pocket maximum of less than \$2,000, while 18% have an out-of-pocket maximum of \$6,000 or more [Figure 7.45].



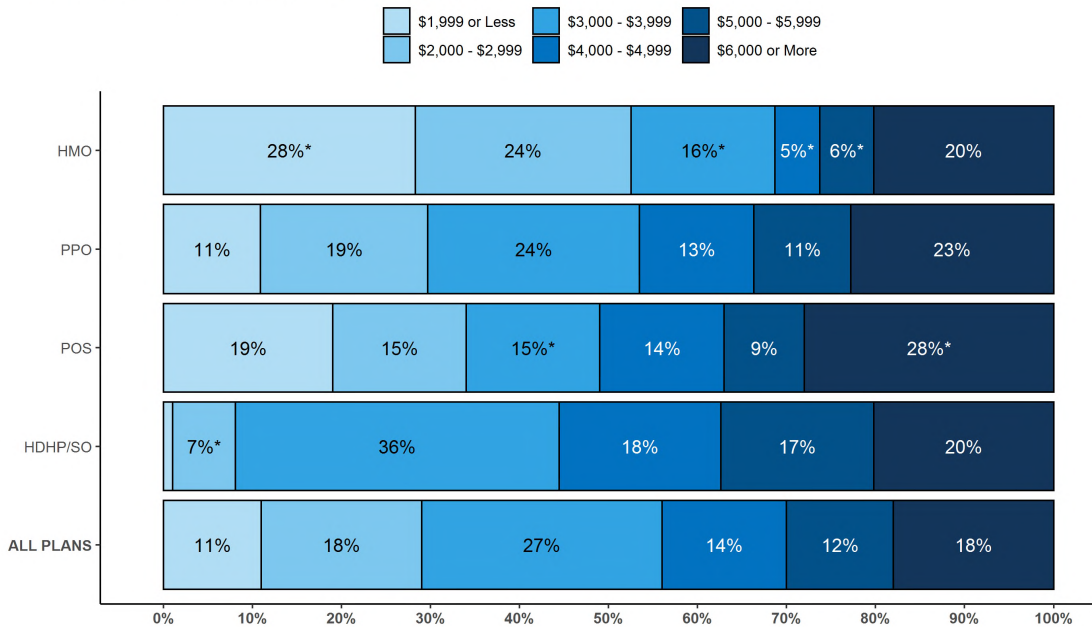
SECTION 7. EMPLOYEE COST SHARING

Figure 7.44
Percentage of Covered Workers in a Plan with an Out-of-Pocket Maximum Above Certain Thresholds for Single Coverage, 2009-2020



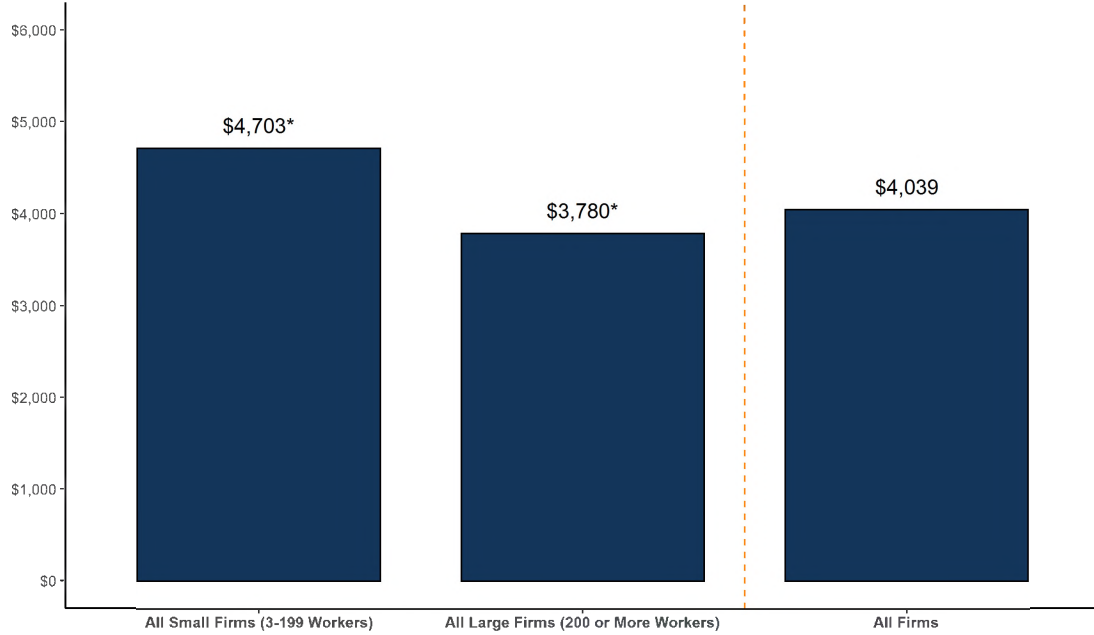
* Estimate is statistically different from estimate for the previous year shown (p < .05).
 NOTE: OOP is 'out-of-pocket'. OOP maximums are for in-network services. Values include covered workers without an OOP max. Covered workers without an OOP maximum are considered to be exposed to at least the specified threshold. Some of these workers may be enrolled in plans whose cost-sharing structure has other limits that make it impossible to reach the specified threshold.
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 7.45
Among Covered Workers with an Out-of-Pocket Maximum for Single Coverage, Distribution of Out-of-Pocket Maximums, by Plan Type, 2020



* Estimate is statistically different from All Plans estimate within plan type (p < .05).
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 7.46
Among Covered Workers with an Out-of-Pocket Maximum for Single Coverage, Average Out-of-Pocket Maximums, by Firm Size, 2020



* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
SOURCE: KFF Employer Health Benefits Survey, 2020

EMPLOYER HEALTH BENEFITS
2020 ANNUAL SURVEY

High-Deductible
Health Plans
with Savings
Option

SECTION

8

Section 8

High-Deductible Health Plans with Savings Option

To help cover out-of-pocket expenses not covered by a health plan, some firms offer high-deductible plans that are paired with an account that allows enrollees to use tax-preferred funds to pay plan cost sharing and other out-of-pocket medical expenses. The two most common types are health reimbursement arrangements (HRAs) and health savings accounts (HSAs). HRAs and HSAs are financial accounts that workers or their family members can use to pay for health care services. These savings arrangements are often (or, in the case of HSAs, always) paired with health plans with high deductibles. The survey treats high-deductible plans paired with a savings option as a distinct plan type - High-Deductible Health Plan with Savings Option (HDHP/SO) - even if the plan would otherwise be considered a PPO, HMO, POS plan, or conventional health plan. Specifically for the survey, HDHP/SOs are defined as (1) health plans with a deductible of at least \$1,000 for single coverage and \$2,000 for family coverage¹ offered with an HRA (referred to as HDHP/HRAs); or (2) high-deductible health plans that meet the federal legal requirements to permit an enrollee to establish and contribute to an HSA (referred to as HSA-qualified HDHPs).²

PERCENTAGE OF FIRMS OFFERING HDHP/HRAS AND HSA-QUALIFIED HDHPS

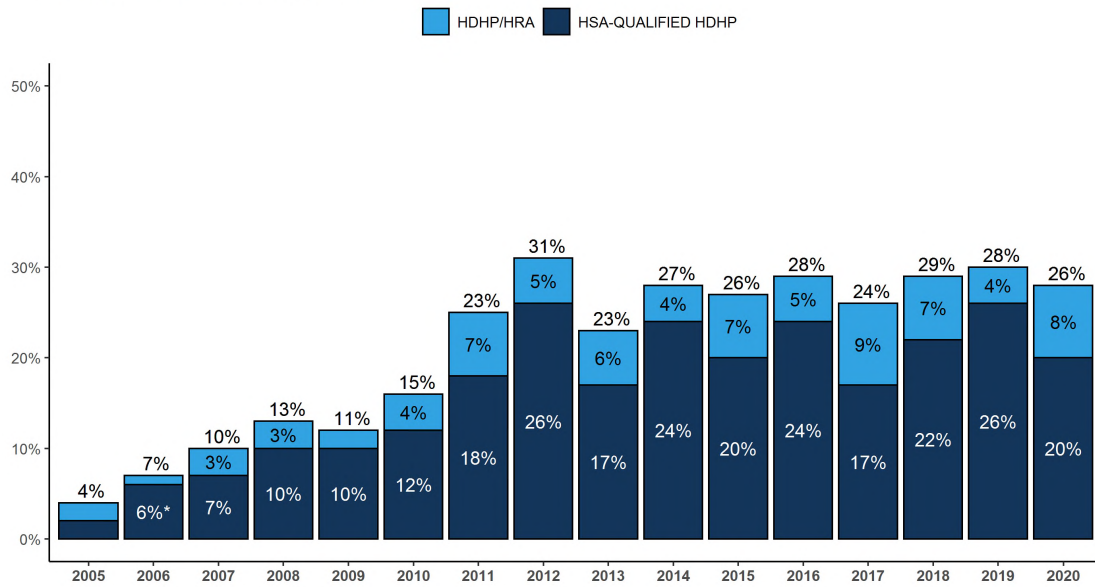
- Twenty-six percent of firms offering health benefits offer an HDHP/HRA, an HSA-qualified HDHP, or both. Among firms offering health benefits, 8% offer an HDHP/HRA and 20% offer an HSA-qualified HDHP [Figure 8.1]. The percentage of firms offering an HDHP/SO is similar to last year.
 - Large firms (200 or more workers) are more much likely than small firms (3-199 workers) to offer an HDHP/SO (56% vs. 25%) [Figure 8.3].

¹There is no legal requirement for the minimum deductible in a plan offered with an HRA. The survey defines a high-deductible HRA plan as a plan with a deductible of at least \$1,000 for single coverage and \$2,000 for family coverage. Federal law requires a deductible of at least \$1,400 for single coverage and \$2,800 for family coverage for HSA-qualified HDHPs in 2020 (or \$1,350 and \$2,700, respectively, for plans in their 2019 plan year). Not all firms' plan years correspond with the calendar year, so some firms may report a plan with limits from the prior year. See definitions at the end of this Section for more information on HDHP/HRAs and HSA-qualified HDHPs.

²The definitions of HDHP/SOs do not include other consumer-driven plan options, such as arrangements that combine an HRA with a lower-deductible health plan or arrangements in which an insurer (rather than the employer as in the case of HRAs or the enrollee as in the case of HSAs) establishes an account for each enrollee. Other arrangements may be included in future surveys as the market evolves.

SECTION 8. HIGH-DEDUCTIBLE HEALTH PLANS WITH SAVINGS OPTION

Figure 8.1
Among Firms Offering Health Benefits, Percentage That Offer an HDHP/HRA and/or an HSA-Qualified HDHP, 2005-2020

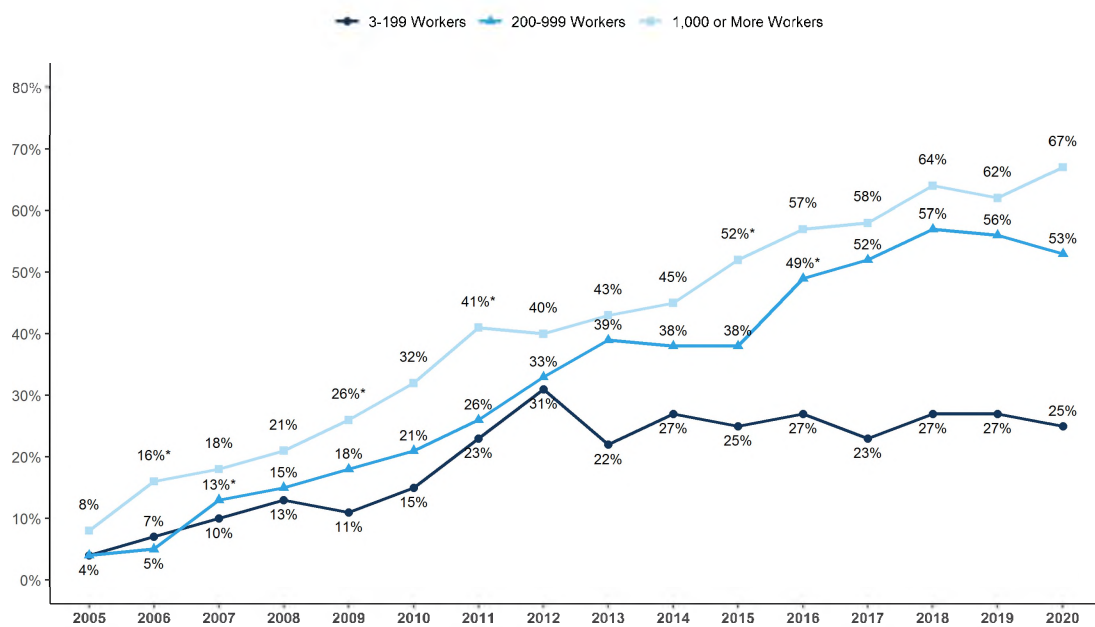


* Estimate is statistically different from estimate for the previous year shown (p < .05).

NOTE: Among all firms that offer health benefits, 2.3% offer both an HDHP/HRA and an HSA-qualified HDHP. Adding the percentage of firms offering HDHP/HRA and HSA-Qualified HDHPs may not sum to the percentage of firms offering HDHP/SOs because some firms offer both.

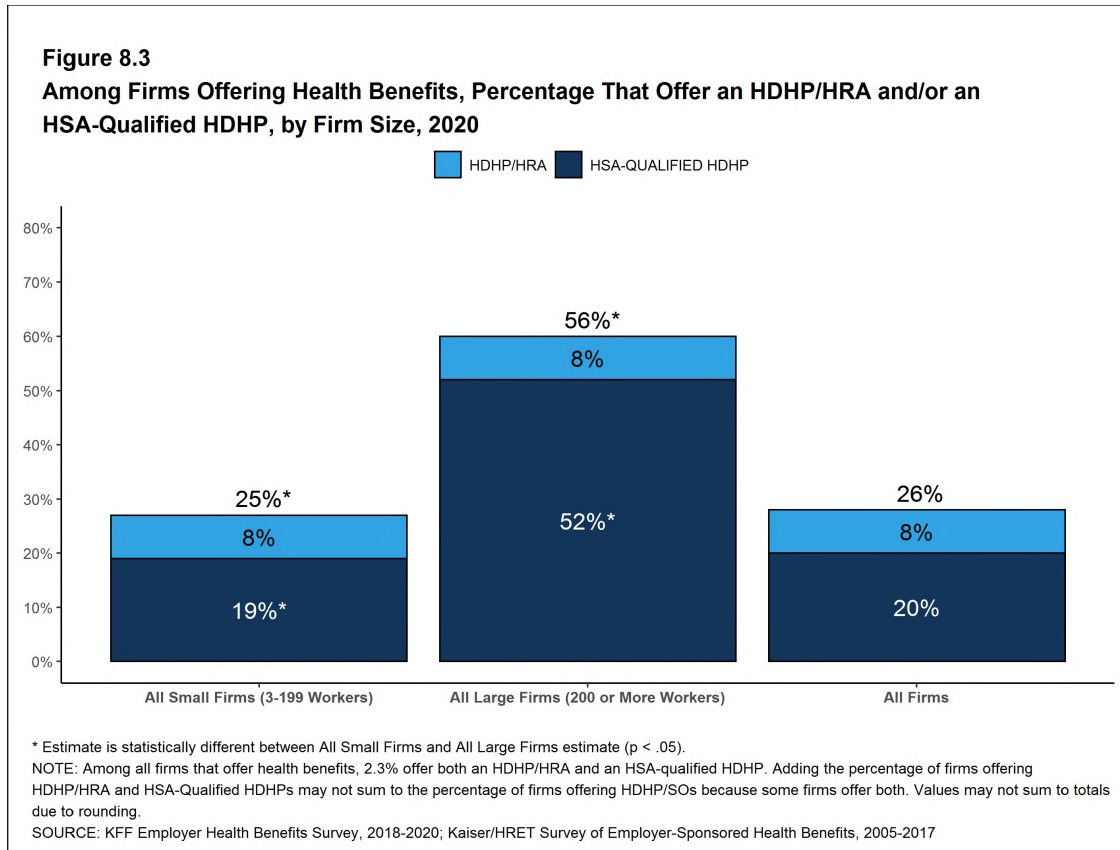
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005-2017

Figure 8.2
Among Firms Offering Health Benefits, Percentage That Offer an HDHP/SO, by Firm Size, 2005-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005-2017

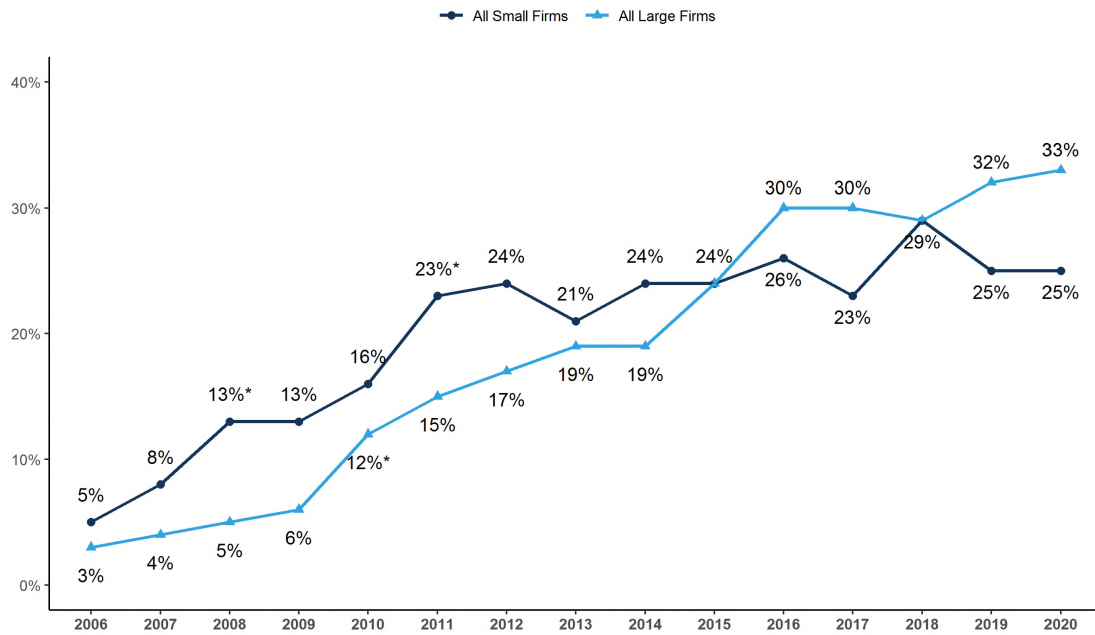


ENROLLMENT IN HDHP/HRAS AND HSA-QUALIFIED HDHPs

- Thirty-one percent of covered workers are enrolled in an HDHP/SO in 2020, similar to the percentage last year (30%) [Figure 8.5].
- Enrollment in HDHP/SOs has increased over the past five years, from 24% of covered workers in 2015 to 31% in 2020 [Figure 8.5].
 - Seven percent of covered workers are enrolled in HDHP/HRAs and 24% of covered workers are enrolled in HSA-qualified HDHPs in 2020. These percentages are similar to the percentages last year [Figure 8.5].
 - * The percentage of covered workers enrolled in HDHP/SOs is higher in large firms (33%) than in small firms (25%) [Figure 8.6].

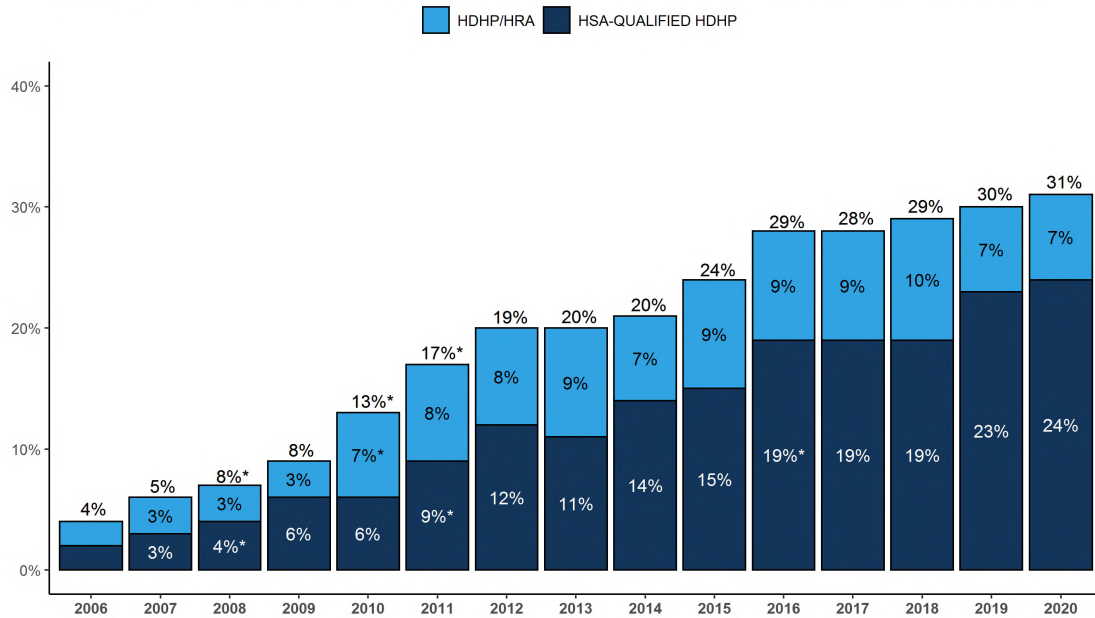
SECTION 8. HIGH-Deductible HEALTH PLANS WITH SAVINGS OPTION

Figure 8.4
Percentage of Covered Workers Enrolled in an HDHP/SO, by Firm Size, 2006-2020

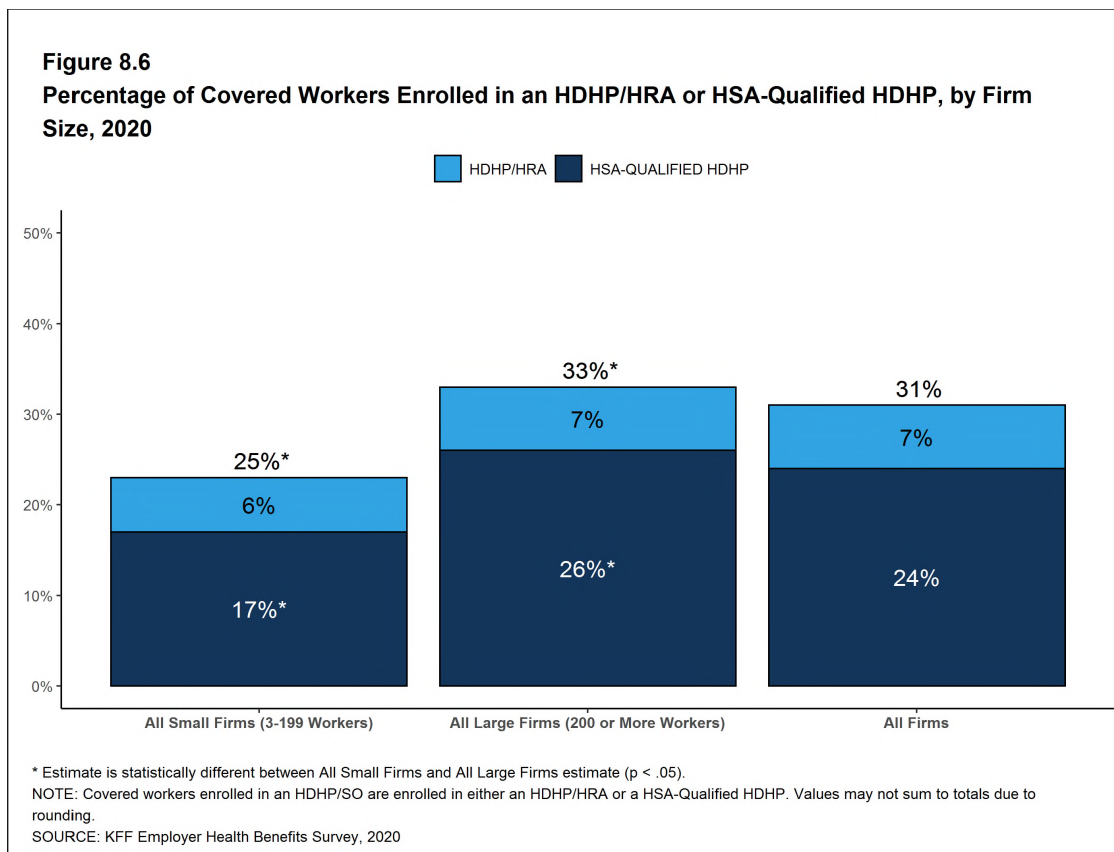


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
 NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017

Figure 8.5
Percentage of Covered Workers Enrolled in an HDHP/HRA or HSA-Qualified HDHP, 2006-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
 NOTE: Covered workers enrolled in an HDHP/SO are enrolled in either an HDHP/HRA or a HSA-Qualified HDHP. Values may not sum to totals due to rounding.
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006-2017



PREMIUMS AND WORKER CONTRIBUTIONS

- In 2020, the average annual premiums for covered workers in HDHP/HRAs are \$7,464 for single coverage and \$22,643 for family coverage [Figure 8.7].
- The average annual premiums for workers in HSA-qualified HDHPs are \$6,737 for single coverage and \$19,819 for family coverage. These amounts are significantly less than the average single and family premium for covered workers in plans that are not HDHP/SOs [Figure 8.8].
- The average premium for single coverage for covered workers enrolled in HSA-qualified HDHPs is lower than the average premium for single coverage for covered workers enrolled in HDHP/HRAs.
- The average annual worker contributions to premiums for workers enrolled in HDHP/HRAs are \$1,221 for single coverage and \$5,480 for family coverage [Figure 8.7]. The average contribution for family coverage for covered workers in HDHP/HRAs are similar to the average premium contribution made by covered workers in plans that are not HDHP/SOs [Figure 8.8].
- The average annual worker contributions to premiums for workers in HSA-qualified HDHPs are \$1,019 for single coverage and \$4,742 for family coverage. The average contributions for single and family coverage for covered workers in HSA-qualified HDHPs are significantly less than the average premium contribution made by covered workers in plans that are not HDHP/SOs [Figure 8.8].

SECTION 8. HIGH-DEDUCTIBLE HEALTH PLANS WITH SAVINGS OPTION

Figure 8.7

HDHP/HRA and HSA-Qualified HDHP Features for Covered Workers, 2020

Annual Plan Averages For:	HDHP/HRA		HSA-QUALIFIED HDHP	
	Single Coverage	Family Coverage	Single Coverage	Family Coverage
Premium	\$7,464	\$22,643	\$6,737	\$19,819
Worker Contribution to Premium	\$1,221	\$5,480	\$1,019	\$4,742
General Annual Deductible	\$2,195	\$4,508	\$2,349	\$4,601
Out-Of-Pocket Maximum	\$4,485	Not Available	\$4,273	Not Available
Firm Contribution to the HRA or HSA	\$1,276	\$2,315	\$550	\$1,018

NOTE: Firms were not asked about out-of-pocket maximums for family coverage in 2020. Deductibles for family coverage are for covered workers with an aggregate amount. 12% of covered workers enrolled in an HDHP/HRA and 19% of covered workers in an HSA-qualified HDHP are in a plan with a separate per-person amount. When those firms that do not contribute to the HSA (51% for single coverage and 53% for family coverage) are excluded, the average firm HSA contribution for covered workers is \$741 for single coverage and \$1,389 for family coverage. Five percent percent of covered workers are enrolled in a plan where the firm matches employee HSA contributions. For HDHP/HRAs, we refer to the amount the employer commits to make available to an HRA as a contribution. HRAs are notional accounts, and employers are not required to transfer funds until an employee incurs expenses. Thus, employers may not expend the entire amount they commit to make available. Covered workers enrolled in a plan where the firm matches any employee HSA contribution are not included in the average contribution (Five percent for single coverage and five percent for family coverage).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 8.8

Average Annual Premiums and Contributions to Savings Accounts for Covered Workers in HDHP/HRAs or HSA-Qualified HDHPs, Compared to Non-HDHP/SOs, 2020

	Single Coverage			Family Coverage		
	HDHP/HRA	HSA-Qualified HDHP	Non-HDHP/SO Plans	HDHP/HRA	HSA-Qualified HDHP	Non-HDHP/SO Plans
Annual Premium	\$7,464	\$6,737*	\$7,724	\$22,643	\$19,819*	\$21,769
Worker Contribution to Premium	\$1,221	\$1,019*	\$1,323	\$5,480	\$4,742*	\$5,908
Firm Contribution to Premium	\$6,243	\$5,719*	\$6,401	\$17,163	\$15,077*	\$15,862
Annual Firm Contribution to HRA or HSA	\$1,276	\$550	Not Applicable	\$2,315	\$1,018	Not Applicable
Total Annual Firm Contribution (Firm Share of Premium Plus Firm Contribution to HRA or HSA)	\$7,519*	\$6,270	\$6,401	\$19,477*	\$16,083	\$15,862
Total Annual Cost (Total Premium Plus Firm Contribution to HRA or HSA)	\$8,739*	\$7,305*	\$7,724	\$24,958	\$20,688*	\$21,769

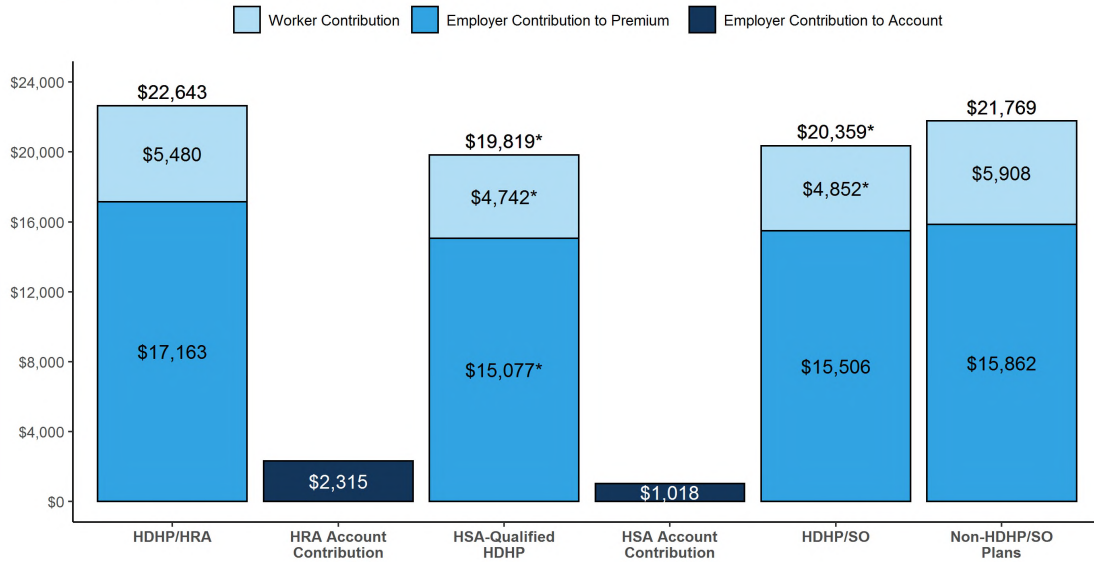
NOTE: Values shown in the table may not equal the sum of their component parts. The averages presented in the table are aggregated at the firm level and then averaged, which is methodologically more appropriate than adding the averages. See the note in Figure 8.7 for additional information on HSA and HRA contributions.

* Estimate is statistically different from estimate from Non-HDHP/SO plans (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2020

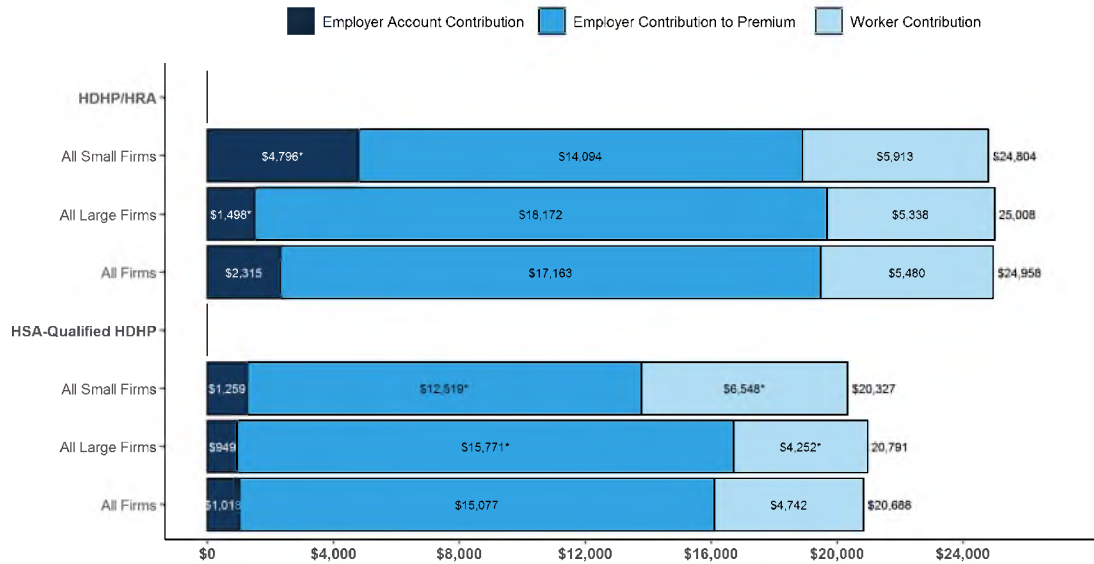
SECTION 8. HIGH-DEDUCTIBLE HEALTH PLANS WITH SAVINGS OPTION

Figure 8.9
Average Annual Premiums and Contributions for Covered Workers in HDHP/SOs and Non-HDHP/SOs, for Family Coverage, 2020



* Estimate is statistically different from estimate from Non-HDHP/SO plans ($p < .05$).
NOTE: Values shown in the table may not equal the sum of their component parts. The averages presented in the table are aggregated at the firm level and then averaged, which is methodologically more appropriate than adding the averages. See the note in Figure 8.7 for additional information on HSA and HRA contributions.
SOURCE: KFF Employer Health Benefits Survey, 2020

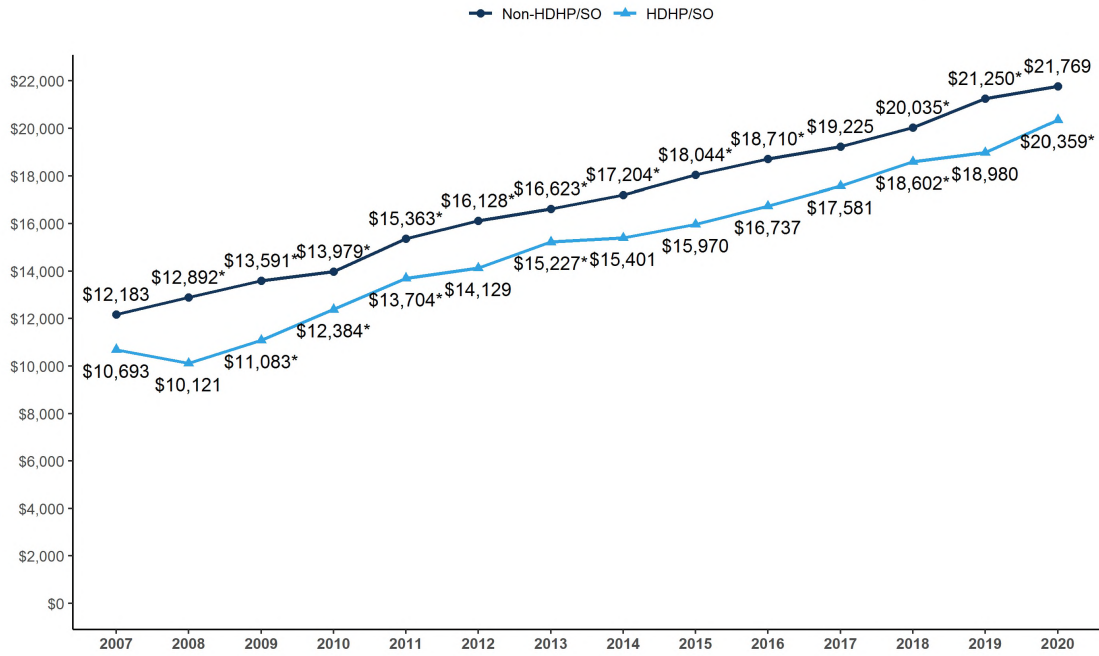
Figure 8.10
Total Annual Costs (Premiums and Account Contributions) for Covered Workers in HDHP/SOs, for Family Coverage, by Firm Size, 2020



* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Values shown in the table may not equal the sum of their component parts. The averages presented in the table are aggregated at the firm level and then averaged, which is methodologically more appropriate than adding the averages. See the note in Figure 8.7 for additional information on HSA and HRA contributions.
SOURCE: KFF Employer Health Benefits Survey, 2020

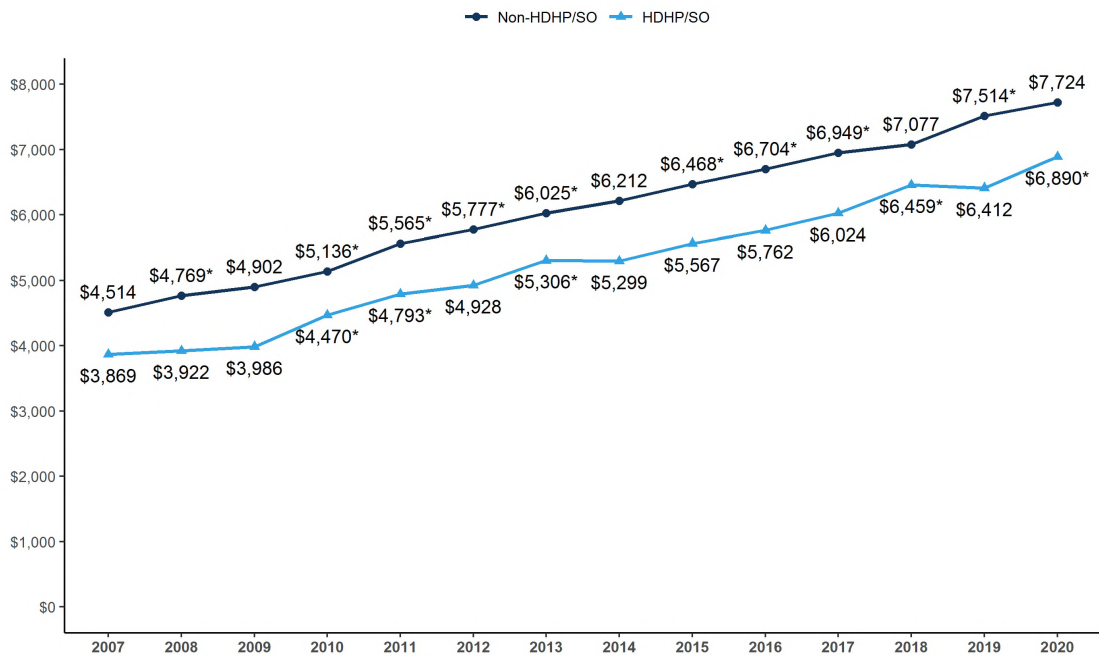
SECTION 8. HIGH-DEDUCTIBLE HEALTH PLANS WITH SAVINGS OPTION

Figure 8.11
Average Annual Premiums for Covered Workers with Family Coverage, by Plan Type, 2007-2020



* Estimate is statistically different from estimate for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

Figure 8.12
Average Annual Premiums for Covered Workers with Single Coverage, by Plan Type, 2007-2020



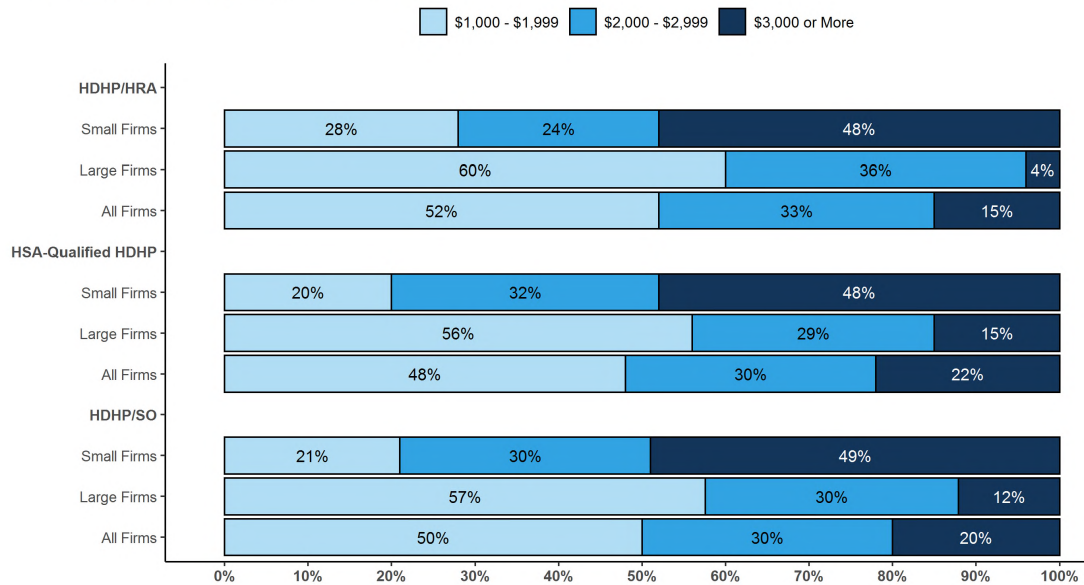
* Estimate is statistically different from estimate for the previous year shown (p < .05).
SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

OUT-OF-POCKET MAXIMUMS AND PLAN DEDUCTIBLES

- HSA-qualified HDHPs are legally required to have an annual out-of-pocket maximum of no more than \$6,900 for single coverage and \$13,800 for family coverage in 2020. Non-grandfathered HDHP/HRA plans are required to have out-of-pocket maximums of no more than \$8,150 for single coverage and \$16,300 for family coverage in 2020.^[^803] Virtually all HDHP/HRA plans have an out-of-pocket maximum for single coverage in 2020.
 - The average annual out-of-pocket maximum for single coverage is \$4,485 for HDHP/HRAs and \$4,273 for HSA-qualified HDHPs [Figure 8.7].
- As expected, workers enrolled in HDHP/SOs have higher deductibles than workers enrolled in HMOs, PPOs, or POS plans.
 - The average general annual deductible for single coverage is \$2,195 for HDHP/HRAs and \$2,349 for HSA-qualified HDHPs [Figure 8.14]. These averages are similar to the amounts reported in recent years. There is wide variation around these averages: 50% of covered workers enrolled in an HDHP/SO are in a plan with a deductible of \$1,000 to \$1,999 for single coverage while 20% are in a plan with a deductible of \$3,000 or more [Figure 8.13].
- The survey asks firms whether the family deductible amount is (1) an aggregate amount (i.e., the out-of-pocket expenses of all family members are counted until the deductible is satisfied), or (2) a per-person amount that applies to each family member (typically with a limit on the number of family members that would be required to meet the deductible amount) (see Section 7 for more information).
 - The average aggregate deductibles for workers with family coverage are \$4,508 for HDHP/HRAs and \$4,601 for HSA-qualified HDHPs [Figure 8.7]. As with single coverage, there is wide variation around these averages for family coverage: 17% of covered workers enrolled in HDHP/SOs with an aggregate family deductible have a deductible of \$2,000 to \$2,999 while 19% have a deductible of \$6,000 dollars or more [Figure 8.16].

SECTION 8. HIGH-DEDUCTIBLE HEALTH PLANS WITH SAVINGS OPTION

Figure 8.13
Distribution of Covered Workers in HDHP/SOs with the Following General Annual Deductibles for Single Coverage, by Firm Size, 2020



NOTE: For HSA-qualified HDHPs, the legal minimum deductible for 2020 is \$1,350 for single coverage and \$2,700 for family coverage. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 8.14
General Annual Deductible for Workers in HDHP/SOs After Any Employer Account Contributions for Single Coverage, by Firm Size, 2020

	HDHP/HRA	HSA-Qualified HDHP	HDHP/SO
General Annual Deductible			
All Small Firms	\$3,026*	\$3,202*	\$3,195*
All Large Firms	1,921*	2,120*	2,055*
All Firms	\$2,195	\$2,349	\$2,303
General Annual Deductible After Any HRA or HSA Contributions			
All Small Firms	\$912	\$2,528*	\$2,136*
All Large Firms	1,123	1,641*	1,495*
All Firms	\$1,071	\$1,837	\$1,638

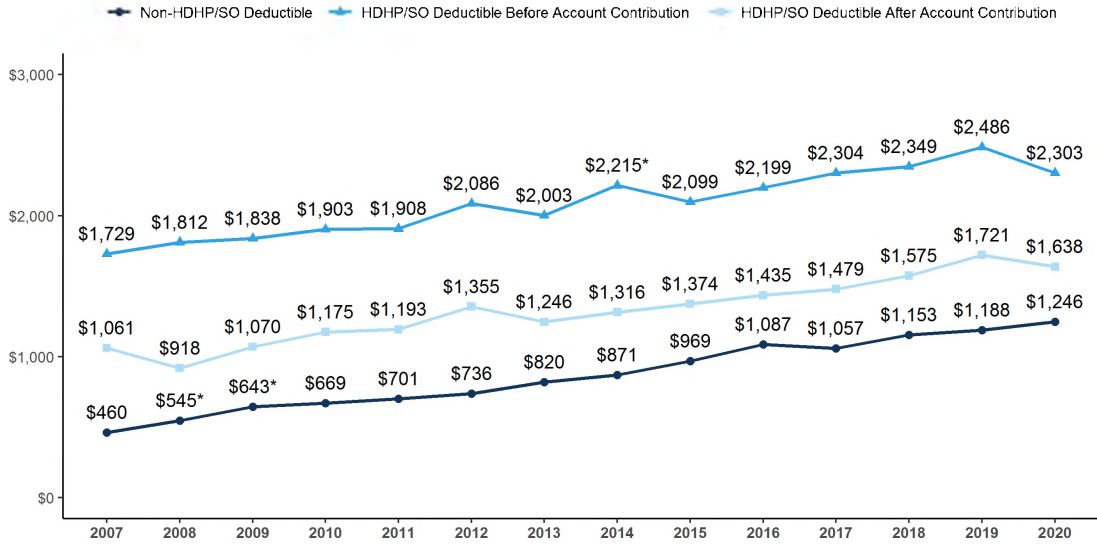
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. The net liability for covered workers enrolled in a plan with an HSA or HRA is calculated by subtracting the account contribution from the single coverage deductible. HRAs are notional accounts, and employers are not required to actually transfer funds until an employee incurs expenses. General annual deductibles are for in-network providers.

* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2020

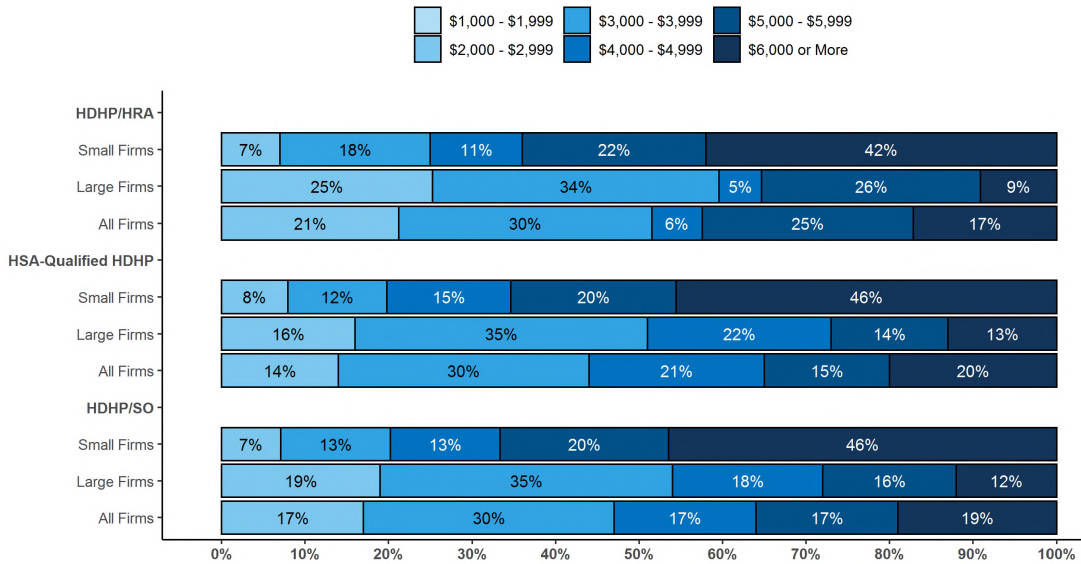
SECTION 8. HIGH-DEDUCTIBLE HEALTH PLANS WITH SAVINGS OPTION

Figure 8.15
Among Covered Workers with a General Annual Deductible, Average Deductibles for Workers in Non-HDHP/SOs Compared to HDHP/SOs Before and After Any Employer Account Contributions, for Single Coverage, 2007-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
 NOTE: The net liability for covered workers enrolled in a plan with an HSA or HRA is calculated by subtracting the account contribution from the single coverage deductible. General annual deductibles are for in-network providers.
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007-2017

Figure 8.16
Distribution of Covered Workers in HDHP/SOs with the Following Aggregate Family Deductibles, 2020



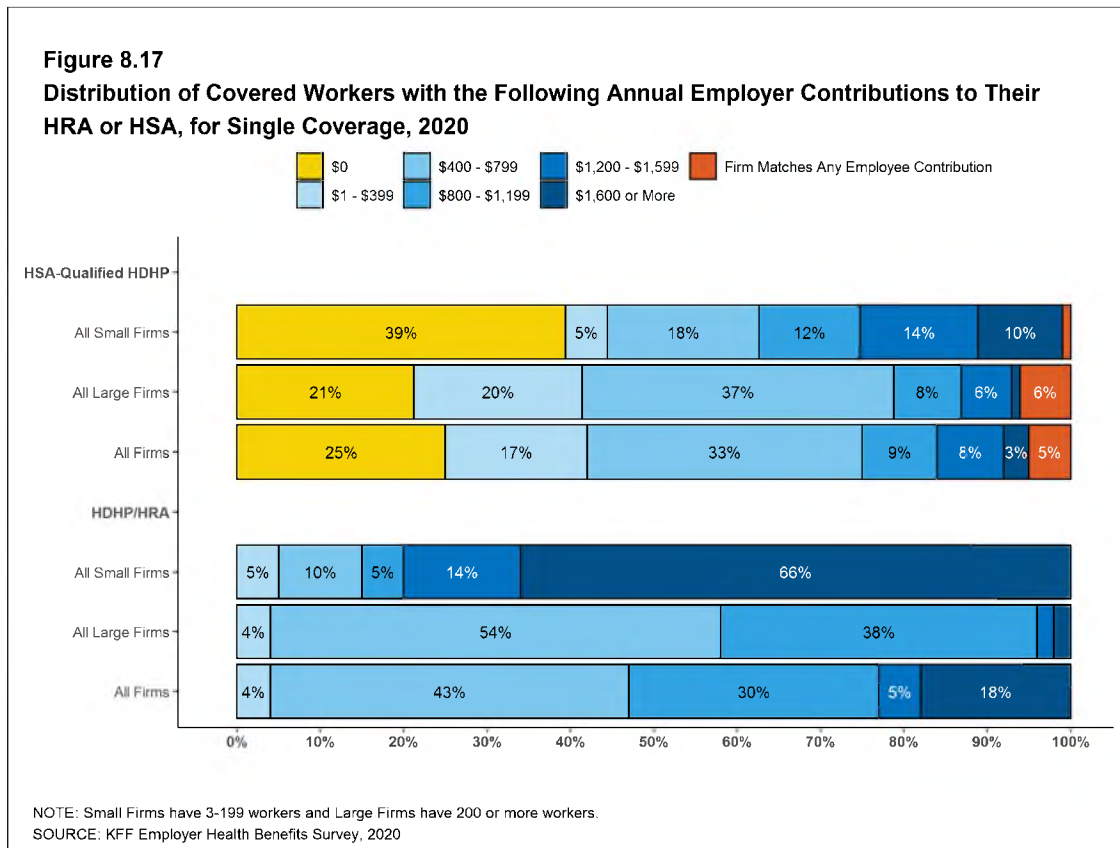
NOTE: Deductibles for family coverage are for covered workers with an aggregate amount. 12% of covered workers enrolled in an HDHP/HRA and 19% of covered workers in an HSA-qualified HDHP are in a plan with a separate per-person amount. For HSA-qualified HDHPs, the legal minimum deductible for 2020 is \$1,350 for single coverage and \$2,700 for family coverage. Small Firms have 3-199 workers and Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

EMPLOYER ACCOUNT CONTRIBUTIONS

- Employers contribute to HDHP/SOs in two ways: through their contributions toward the premium for the health plan and through their contributions (if any, in the case of HSAs) to the savings account option (i.e., the HRAs or HSAs themselves).
 - Looking at only the annual employer contributions to premiums, covered workers in HDHP/HRAs on average receive employer contributions of \$6,243 for single coverage and \$17,163 for family coverage [Figure 8.8]. These amounts are similar to the contribution amounts last year.
 - * The average annual employer contributions to premiums for workers in HSA-qualified HDHPs are \$5,719 for single coverage and \$15,077 for family coverage. Both amounts are significantly higher than the contribution amounts last year. The average employer contributions for covered workers in HSA-qualified HDHPs for single coverage and family coverage are lower than the average contribution for covered workers in plans that are not HDHP/SOs [Figure 8.8].
- Looking at employer contributions to the savings options, covered workers enrolled in HDHP/HRAs on average receive an annual employer contribution to their HRA of \$1,276 for single coverage and \$2,315 for family coverage [Figure 8.8].
 - HRAs are generally structured in such a way that employers may not actually spend the whole amount that they make available to their employees' HRAs.³ Amounts committed to an employee's HRA that are not used by the employee generally roll over and can be used in future years, but any balance may revert back to the employer if the employee leaves his or her job. Thus, the employer contribution amounts to HRAs that we capture in the survey may exceed the amount that employers will actually spend.
- Covered workers enrolled in HSA-qualified HDHPs on average receive an annual employer contribution to their HSA of \$550 for single coverage and \$1,018 for family coverage [Figure 8.8].
 - In many cases, employers that sponsor HSA-qualified HDHP/SOs do not make contributions to HSAs established by their employees. Fifty-one percent of employers offering single coverage and 53% offering family coverage through HSA-qualified HDHPs do not make contributions toward the HSAs that their workers establish. Among covered workers enrolled in an HSA-qualified HDHP, 25% enrolled in single coverage and 25% enrolled in family coverage do not receive an account contribution from their employer [Figure 8.17] and [Figure 8.18].
 - The average HSA contributions reported above include the portion of covered workers whose employer contribution to the HSA is zero. When those firms that do not contribute to the HSA are excluded from the calculation of the average amounts, the average employer contribution for covered workers is \$741 for single coverage and \$1,389 for family coverage.
 - * The percentages of covered workers enrolled in a plan where the employer makes no HSA contribution (25% for single coverage and 25% for family coverage) are similar to the percentages in recent years [Figure 8.17] and [Figure 8.18].
- There is considerable variation in the amount that employers contribute to savings accounts.
 - Forty-seven percent of covered workers in an HDHP/HRA receive an annual HRA contribution of less than \$800 for single coverage, while 18% receive an annual HRA contribution of \$1,600 or more [Figure 8.17].

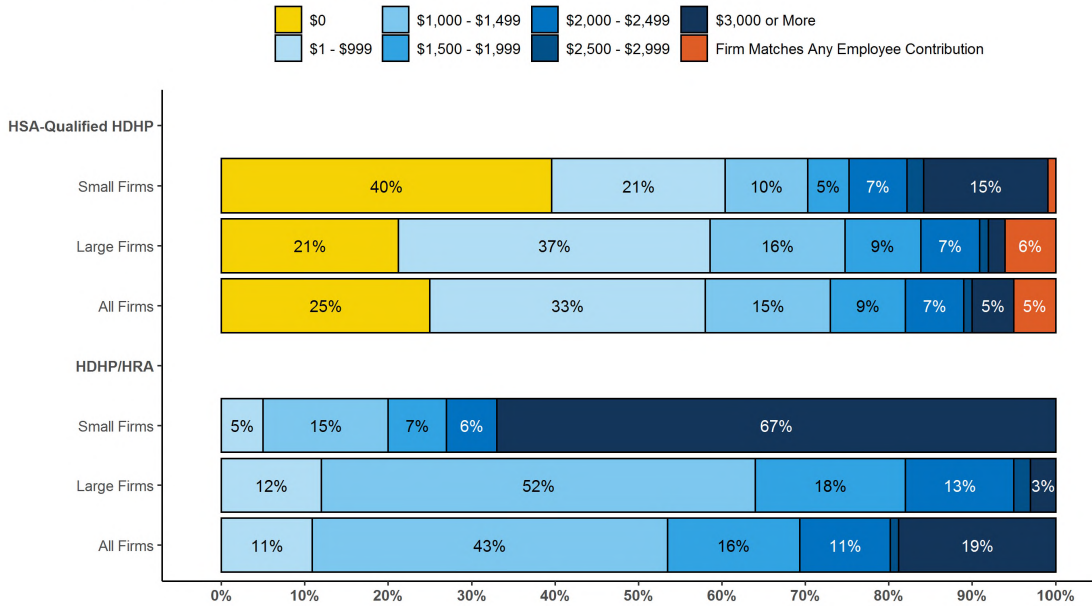
³The survey asks "Up to what dollar amount does your firm promise to contribute each year to an employee's HRA or health reimbursement arrangement for single coverage?" We refer to the amount that the employer commits to make available to an HRA as a contribution for ease of discussion. As discussed, HRAs are notional accounts, and employers are not required to actually transfer funds until an employee incurs expenses. Thus, employers may not expend the entire amount that they commit to make available to their employees through an HRA. Some employers may make their HRA contribution contingent on other factors, such as completing wellness programs.

- Forty-one percent of covered workers in an HSA-qualified HDHP receive an annual HSA contribution of less than \$400 for single coverage, including 25% that receive no HSA contribution from their employer [Figure 8.17]. In contrast, 11% of covered workers in an HSA-qualified HDHP receive an annual HSA contribution of \$1,200 or more. Five percent of covered workers have an employer that matches any HSA contribution for single coverage.
- Employer contributions to savings account options (i.e., the HRAs and HSAs themselves) for their workers can be added to their health plan premium contributions to calculate total employer contributions toward HDHP/SOs. We note that HRAs are a promise by an employer to pay up to a specified amount and that many employees will not receive the full amount of their HRA in a year, so adding the employer premium contribution amount and the HRA contribution represents an upper bound for employer liability that overstates the amount that is actually expended. Since employer contributions to employee HSAs immediately transfer the full amount to the employee, adding employer premium and HSA contributions is an instructive way to look at their total liability under these plans.
 - For HDHP/HRAs, the average annual total employer contribution for covered workers is \$7,519 for single coverage and \$19,477 for family coverage. The average total employer contributions for covered workers for single coverage and family coverage in HDHP/HRAs are higher than the average firm contributions toward single and family coverage in plans that are not HDHP/SOs [Figure 8.8].
 - For HSA-qualified HDHPs, the average total annual firm contribution for covered workers is \$6,270 for single coverage and \$16,083 for workers with family coverage. The average total firm contribution amounts for single coverage and family coverage in HSA-qualified HDHPs are similar to the average firm contributions toward health plans that are not HDHP/SOs [Figure 8.8].



SECTION 8. HIGH-DEDUCTIBLE HEALTH PLANS WITH SAVINGS OPTION

Figure 8.18
Distribution of Covered Workers with the Following Annual Employer Contributions to Their HRA or HSA, for Family Coverage, 2020



NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 8.19
Average Annual Employer Contributions to HSA Accounts for Covered Workers Enrolled in an HSA-Qualified HDHP, 2009-2020

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Among All Workers Enrolled in an HSA-Qualified HDHP: Average Employer HSA Contribution												
Single Coverage												
All Small Firms	\$668	\$549	\$613	\$645	\$642	\$1,142	\$776	\$958	\$670	\$784	\$730	\$739
All Large Firms	450	587	448	402	547	544	481	583	535	531	530	498
All Firms	\$688	\$558	\$611	\$609	\$658	\$769	\$568*	\$686	\$608	\$603	\$572	\$550
Family Coverage												
All Small Firms	\$1,364	\$926	\$1,327	\$1,423	\$1,429	\$1,963	\$1,158*	\$1,487	\$1,396	\$1,302	\$1,182	\$1,259
All Large Firms	815	1,067	864	780	892	878	823	1,084	999	981	1,031	849
All Firms	\$1,126	\$1,006	\$1,069	\$1,070	\$1,154	\$1,346	\$991*	\$1,208	\$1,086	\$1,073	\$1,062	\$1,018
Among Workers Enrolled in an HSA-Qualified HDHP With an Employer HSA Contribution: Average Employer HSA Contribution												
Single Coverage												
All Small Firms	\$1,319	\$999	\$1,189	\$1,246	\$1,384	\$1,510	\$1,224	\$1,486	\$1,337	\$1,277	\$1,427	\$1,226
All Large Firms	619	748	641	818	737	707	657	707	670	645	658	636
All Firms	\$1,000	\$858	\$886	\$919	\$951	\$1,006	\$809	\$916	\$795	\$790	\$768	\$741
Family Coverage												
All Small Firms	\$2,077	\$1,698	\$1,871	\$2,091	\$2,383	\$2,531	\$1,838*	\$2,330	\$2,132	\$2,119	\$2,404	\$2,122
All Large Firms	1,121	1,433	1,241	1,189	1,337	1,267	1,261	1,383	1,253	1,193	1,280	1,227
All Firms	\$1,640	\$1,546	\$1,559	\$1,611	\$1,675	\$1,744	\$1,412*	\$1,617	\$1,417	\$1,406	\$1,433	\$1,389

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. In 2020, 25% of workers in an HSA-qualified single coverage plan and 25% of workers in an HSA-qualified family coverage plan were enrolled in a plan without an employer contribution to the HSA account. Covered workers enrolled in a plan where the firm matches any employee HSA contribution are not included in the average contribution (Five percent for single coverage and five percent for family coverage).

* Estimate is statistically different from estimate for the previous year shown (p < .05).
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser-HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 8.20**Among Covered Workers in HDHP/HRAs and HSA-Qualified HDHPs,
Average Annual Employer HSA and HRA Contributions, 2020**

	Average Employer Account Contribution
HSA: Single Coverage	
All Small Firms	\$739
All Large Firms	496
ALL FIRMS	\$550
HSA: Family Coverage	
All Small Firms	\$1,259
All Large Firms	949
ALL FIRMS	\$1,018
HRA: Single Coverage	
All Small Firms	\$2,649*
All Large Firms	824*
ALL FIRMS	\$1,276
HRA: Family Coverage	
All Small Firms	\$4,796*
All Large Firms	1,498*
ALL FIRMS	\$2,315

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. See the note in Figure 8.7 for additional information on HSA and HRA contributions.

* Estimate is statistically different between All Small Firms and All Large Firms estimate ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

COST SHARING FOR OFFICE VISITS

- The cost-sharing pattern for primary care office visits differs for workers enrolled in HDHP/SOs. Thirty-five percent of covered workers in HDHP/HRAs have a copayment for primary care physician office visits compared to 9% enrolled in HSA-qualified HDHPs [Figure 8.21]. Workers in other plan types are much more likely to face copayments than coinsurance for physician office visits (see Section 7 for more information).

Figure 8.21**Distribution of Covered Workers in HDHP/HRAs and HSA-Qualified HDHPs With the Following Types of Cost Sharing in Addition to the General Annual Deductible, 2020**

	HDHP/HRA	HSA-Qualified HDHP	HDHP/SO	Non-HDHP/SO
Separate Cost Sharing for Primary Care Physician Office Visits				
Copayment	35%	9%*	16%	81%*
Coinsurance	56%	65%	62%	12% [†]
None	5%	18%*	15%	4%*
Other	3%	7%	7%	3%*
Separate Cost Sharing for Specialty Care Physician Office Visits				
Copayment	24%	9%*	12%	78%*
Coinsurance	67%	65%	66%	16% [†]
None	6%	18%*	15%	3%*
Other	3%	7%	6%	3%*

NOTE: The survey asks firms about the characteristics of either their largest HRA or HSA-Qualified HDHP. The HDHP/SO category is the aggregate of both the HRA and HSA plans. For more information, see the Methods Section.

* Estimates are statistically different between HDHP/HRAs and HSA-Qualified HDHPs or HDHP/SO plans and Non-HDHP/SO plans ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

Health Reimbursement Arrangements (HRAs) are medical care reimbursement plans established by employers that can be used by employees to pay for health care. HRAs are funded solely by employers. Employers may commit to make a specified amount of money available in the HRA for premiums and medical expenses incurred by employees or their dependents. HRAs are accounting devices, and employers are not required to expend funds until an employee incurs expenses that would be covered by the HRA. Unspent funds in the HRA usually can be carried over to the next year (sometimes with a limit). Employees cannot take their HRA balances with them if they leave their job, although an employer can choose to make the remaining balance available to former employees to pay for health care. HRAs often are offered along with a high-deductible health plan (HDHP). In such cases, the employee pays for health care first from his or her HRA and then out-of-pocket until the health plan deductible is met. Sometimes certain preventive services or other services such as prescription drugs are paid for by the plan before the employee meets the deductible.

Health Savings Accounts (HSAs) are savings accounts created by individuals to pay for health care. An individual may establish an HSA if he or she is covered by a "qualified health plan" - a plan with a high deductible (at least \$1,400 for single coverage and \$2,800 for family coverage in 2020 or \$1,350 and \$2,700, respectively, in 2019) that also meets other requirements. Employers can encourage their employees to create HSAs by offering an HDHP that meets the federal requirements. Employers in some cases also may assist their employees by identifying HSA options, facilitating applications, or negotiating favorable fees from HSA vendors. Both employers and employees can contribute to an HSA, up to the statutory cap of \$3,550 for single coverage and \$7,100 for family coverage in 2020. Employee contributions to the HSA are made on a pre-income tax basis, and some employers arrange for their employees to fund their HSAs through payroll deductions. Employers are not required to contribute to HSAs established by their employees but if they elect to do so, their contributions are not taxable to the employee. Interest and other earnings on amounts in an HSA are not taxable. Withdrawals from the HSA by the account owner to pay for qualified health care expenses are not taxed. The savings account is owned by the individual who creates the account, so employees retain their HSA balances if they leave their

job. See <https://www.federalregister.gov/d/2019-08017/p-850> For those enrolled in an HDHP/HSA, see <https://www.irs.gov/pub/irs-pdf/p969.pdf>

EMPLOYER HEALTH BENEFITS
2020 ANNUAL SURVEY

Prescription
Drug Benefits

SECTION

9

Section 9

Prescription Drug Benefits

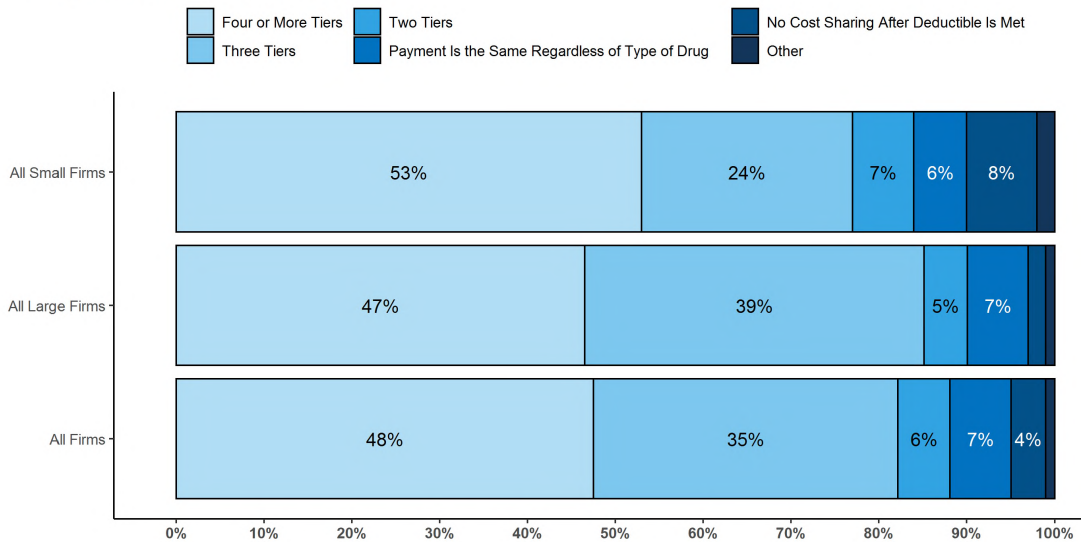
Nearly all (99%) covered workers are at a firm that provides prescription drug coverage in its largest health plan. Many employer plans have increasingly complex benefit designs for prescriptions drugs, as employers and insurers expand the use of formularies with multiple cost-sharing tiers as well as other management approaches. To reduce the burden on respondents, we ask offering firms about the attributes of prescription drug coverage only for their largest health plan. This survey asks employers about the cost-sharing in up to four tiers, and for a tier exclusively for specialty drugs. Some plans may have more than one tier for specialty drugs or other variations. There also may be considerable variation in how plans structure their formularies.

DISTRIBUTION OF COST SHARING

- The large majority of covered workers (89%) are in a plan with tiered cost sharing for prescription drugs [Figure 9.1]. Cost-sharing tiers generally refer to a health plan placing a drug on a formulary or preferred drug list that classifies drugs into categories that are subject to different cost sharing or management. It is common for there to be different tiers for generic, preferred and non-preferred drugs. In recent years, plans have created additional tiers that may, for example, be used for specialty drugs or expensive biologics. Some plans may have multiple tiers for different categories; for example, a plan may have preferred and non-preferred specialty tiers. The survey obtains information about the cost-sharing structure for up to five tiers.
- Eighty-three percent of covered workers are in a plan with three, four, or more tiers of cost sharing for prescription drugs [Figure 9.1]. These totals include tiers that cover only specialty drugs, even though the cost-sharing information for those tiers is reported separately.
 - Although the overall distribution of HDHP/SOs does not statistically differ from non-HDHP/SO plans, certain segments of that distribution have a different cost-sharing pattern for prescription drugs than other plan types. Compared to covered workers in other plan types, those in HDHP/SOs are more likely to be in a plan with the same cost sharing regardless of drug type (17% vs. 2%) or in a plan that has no cost sharing for prescriptions once the plan deductible is met (9% vs. 2%) [Figure 9.2].

SECTION 9. PRESCRIPTION DRUG BENEFITS

Figure 9.1
Distribution of Covered Workers Facing Different Cost-Sharing Formulas for Prescription Drug Benefits, by Firm Size, 2020

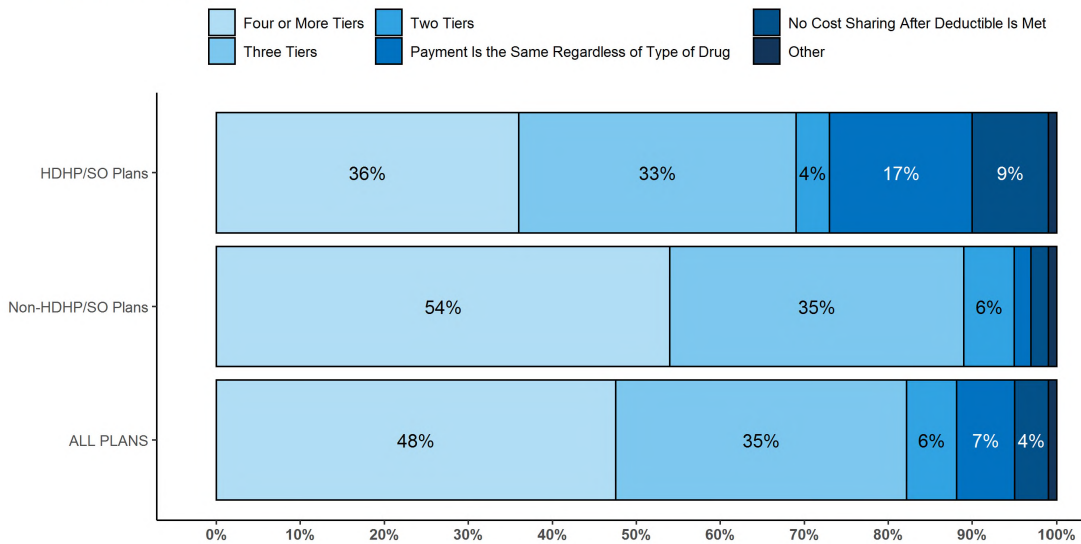


Tests found no statistical difference between Small Firm and Large Firm distributions ($p < .05$).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Number of tiers include any tiers specifically for specialty drugs. Excluding tiers specifically for specialty drugs, 57% of covered workers with prescription drug coverage are enrolled in a plan with four or more tiers, 11% have three tiers, 6% have two tiers, 5% have the same cost sharing regardless of the drug, and 1% have no cost sharing after the deductible is met. For more information on the definition of specialty drugs and how this survey defines drug formulary tiers, see Section 9.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 9.2
Distribution of Covered Workers Facing Different Cost-Sharing Formulas for Prescription Drug Benefits, by Plan Type, 2020



Tests found no statistical difference between HDHP/SO Plan and Non-HDHP/SO distributions ($p < .05$).

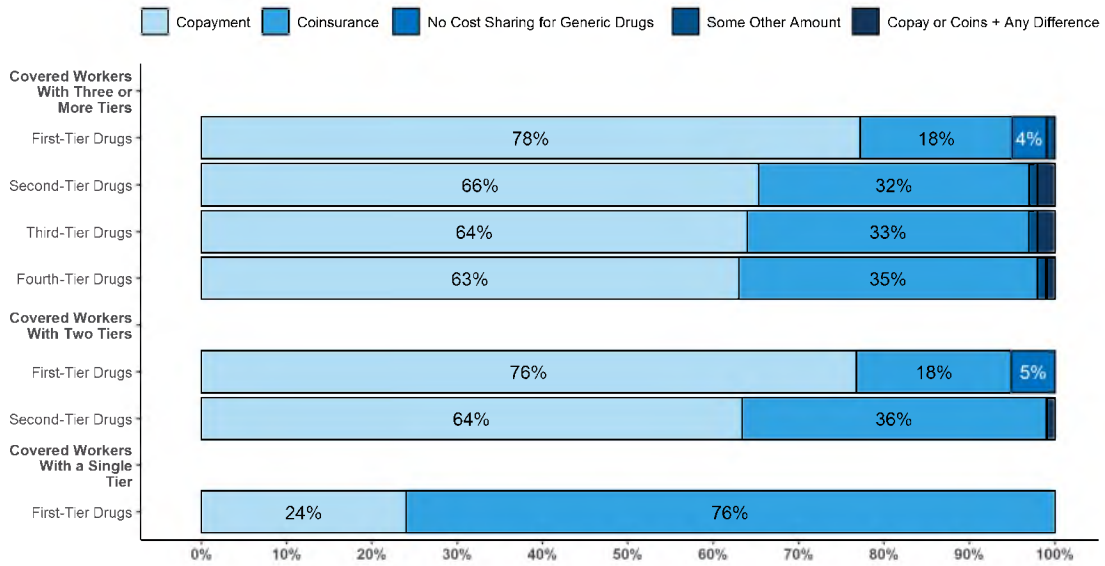
NOTE: Number of tiers include any tiers specifically for specialty drugs. Excluding tiers specifically for specialty drugs, 57% of covered workers with prescription drug coverage are enrolled in a plan with four or more tiers, 11% have three tiers, 6% have two tiers, 5% have the same cost sharing regardless of the drug, and 1% have no cost sharing after the deductible is met. For more information on the definition of specialty drugs and how this survey defines drug formulary tiers, see Section 9.

SOURCE: KFF Employer Health Benefits Survey, 2020

TIERS NOT EXCLUSIVELY FOR SPECIALTY DRUGS

- Even when formulary tiers covering only specialty drugs are not counted, a large share (77%) of covered workers are in a plan with three or more tiers of cost sharing for prescription drugs. The cost-sharing statistics presented in this section do not include information about tiers that cover only specialty drugs. In cases in which a plan covers specialty drugs on a tier with other drugs, they will still be included in these averages. Cost-sharing statistics for tiers covering only specialty drugs are presented further down in this section.
- For covered workers in a plan with three or more tiers of cost sharing for prescription drugs, copayments are the most common form of cost sharing in the first four tiers and coinsurance is the next most common [Figure 9.3].
 - Among covered workers in plans with three or more tiers of cost sharing for prescription drugs, the average copayments are \$11 for first-tier drugs, \$35 second-tier drugs, \$62 for third-tier drugs, and \$116 for fourth-tier drugs [Figure 9.6].
 - Among covered workers in plans with three or more tiers of cost sharing for prescription drugs, the average coinsurance rates are 18% for first-tier drugs, 25% second-tier drugs, 37% third-tier drugs, and 28% for fourth-tier drugs [Figure 9.6].
- Eleven percent of covered workers are in a plan with two tiers for prescription drug cost sharing (excluding tiers covering only specialty drugs).
 - For these workers, copayments are more common than coinsurance for first-tier and second-tier drugs [Figure 9.3]. The average copayment for the first tier is \$12 and the average copayment for the second tier is \$37 [Figure 9.6].
- Six percent of covered workers are in a plan with the same cost sharing for prescriptions regardless of the type of drug (excluding tiers covering only specialty drugs).
 - Among these workers, 24% have copayments and 76% have coinsurance [Figure 9.3]. The average coinsurance rate is 20% [Figure 9.6].

Figure 9.3
Among Covered Workers with Prescription Drug Coverage, Distribution with the Following
Types of Cost Sharing for Prescription Drugs, 2020



NOTE: Number of tiers refers to the number of tiers excluding those specifically for specialty drugs. 'Copayment or Coinsurance Plus Any Difference' category includes workers who pay a copayment or coinsurance plus the difference between the cost of the prescription and the cost of a comparable generic drug. Coins is an abbreviation of Coinsurance.
 SOURCE: KFF Employer Health Benefits Survey, 2020

SECTION 9. PRESCRIPTION DRUG BENEFITS

Figure 9.4

Among Covered Workers With Three or More Tiers of Prescription Drug Cost Sharing, Distribution With the Following Types of Cost Sharing, by Firm Size, 2020

	Copayment	Coinsurance	No Cost Sharing for Generic Drugs	Some Other Amount
First-Tier Drugs, Often Called Generics				
All Small Firms	92%*	3%*	5%	<1%
All Large Firms	73*	23*	3	1
ALL FIRMS	78%	18%	4%	1%
Second-Tier Drugs, Often Called Preferred Drugs			Copayment or Coinsurance Plus Any Difference	
All Small Firms	92%*	5%*	2%	<1%
All Large Firms	57*	41*	2	<1
ALL FIRMS	66%	32%	2%	<1%
Third-Tier Drugs, Often Called Non-Preferred Drugs				
All Small Firms	88%*	9%*	2%	1%
All Large Firms	55*	42*	2	2
ALL FIRMS	64%	33%	2%	1%
Fourth-Tier Drugs				
All Small Firms	66%	31%	1%	2%
All Large Firms	60	37	1	1
ALL FIRMS	63%	35%	1%	1%

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Number of tiers refers to the number of tiers excluding those specifically for specialty drugs. 'Copayment or Coinsurance Plus Any Difference' category includes workers who pay a copayment or coinsurance plus the difference between the cost of the prescription and the cost of a comparable generic drug.

* Estimates are statistically different between Small Firm and Large Firm estimates within category (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2020

SECTION 9. PRESCRIPTION DRUG BENEFITS

Figure 9.5
Among Covered Workers With Three or More Tiers of Prescription Drug Cost Sharing, Distribution With the Following Types of Cost Sharing, by Plan Type, 2020

	Copayment	Coinsurance	No Cost Sharing for Generic Drugs	Some Other Amount
First-Tier Drugs, Often Called Generics				
HDHP/SO Plans	59%*	36%*	5%	0%
Non-HDHP/SO Plans	85*	11*	3	1
ALL PLANS	78%	18%	4%	1%
Second-Tier Drugs, Often Called Preferred Drugs			Copayment or Coinsurance Plus Any Difference	
HDHP/SO Plans	41%*	57%*	2%	<1%
Non-HDHP/SO Plans	75*	23*	2	1
ALL PLANS	66%	32%	2%	<1%
Third-Tier Drugs, Often Called Non-Preferred Drugs				
HDHP/SO Plans	38%*	60%*	2%	<1%
Non-HDHP/SO Plans	72*	24*	2	2
ALL PLANS	64%	33%	2%	1%
Fourth-Tier Drugs				
HDHP/SO Plans	66%	30%	3%	1%
Non-HDHP/SO Plans	62	36	1	1
ALL PLANS	63%	35%	1%	1%

NOTE: Number of tiers refers to the number of tiers excluding those specifically for specialty drugs. 'Copayment or Coinsurance Plus Any Difference' category includes workers who pay a copayment or coinsurance plus the difference between the cost of the prescription and the cost of a comparable generic drug.

* Estimates are statistically different between plan type estimates within category (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 9.6
Among Covered Workers With Prescription Drug Coverage, Average Copayments and Coinsurance, 2020

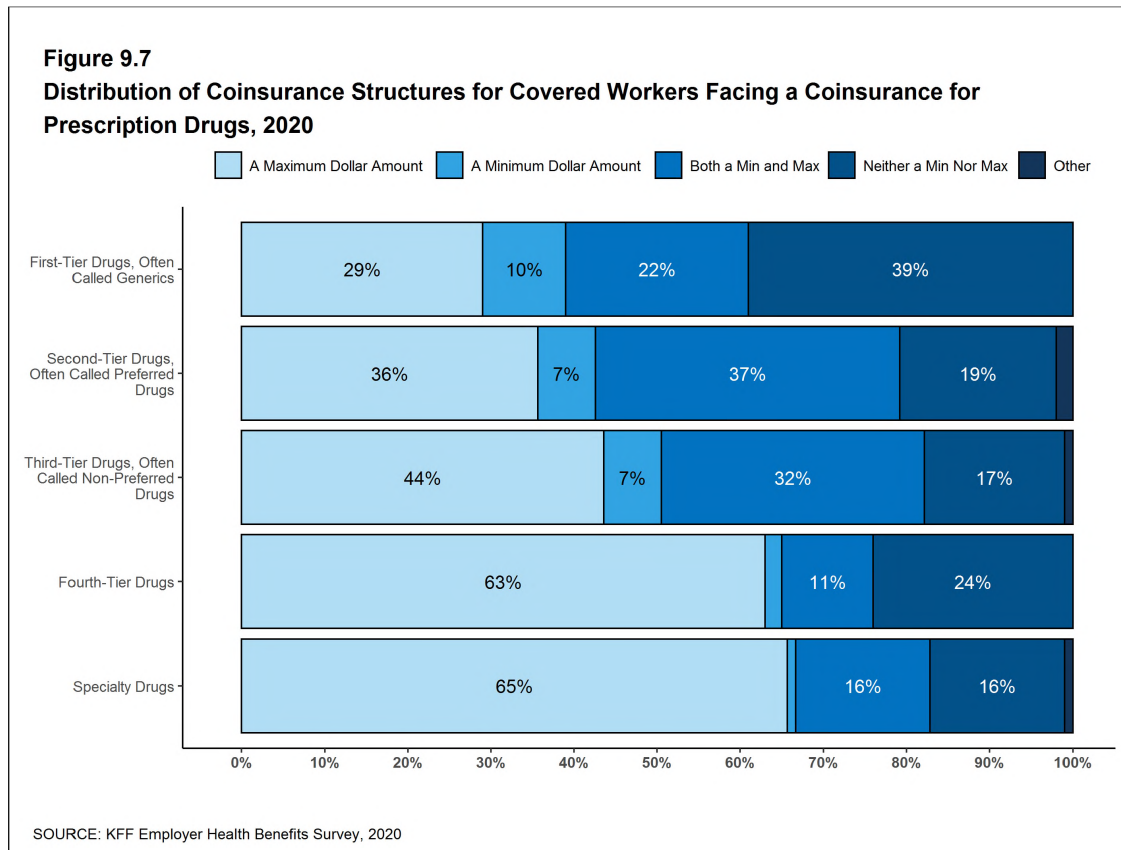
	Average Copayment	Average Coinsurance
Plans With Three or More Tiers		
First Tier	\$11	18%
Second Tier	\$35	25%
Third Tier	\$62	37%
Fourth Tier	\$116	28%
Plans With Two Tiers		
First Tier	\$12	NSD
Second Tier	\$37	29%
Plans With the Same Cost Sharing For All Covered Drugs		
First Tier	NSD	20%

NOTE: Number of tiers refers to the number of tiers excluding those specifically for specialty drugs.
NSD: Not Sufficient Data

SOURCE: KFF Employer Health Benefits Survey, 2020

COINSURANCE MAXIMUMS

- Coinsurance rates for prescription drugs often include maximum and/or minimum dollar amounts. Depending on the plan design, coinsurance maximums may significantly limit the amount an enrollee must spend out-of-pocket for higher-cost drugs. Even in plans without explicit coinsurance maximum amounts, the overall plan out-of-pocket maximum limits enrollee cost sharing on covered services, including prescription drugs.
- These coinsurance minimum and maximum amounts vary across the tiers.
 - For example, among covered workers in a plan with coinsurance for the first cost-sharing tier, 29% have only a maximum dollar amount attached to the coinsurance rate, 10% have only a minimum dollar amount, 22% have both a minimum and maximum dollar amount, and 39% have neither. For those in a plan with coinsurance for the fourth cost-sharing tier, 63% have only a maximum dollar amount attached to the coinsurance rate, 11% have only a minimum dollar amount, 11% have both a minimum and maximum dollar amount, and 24% have neither [Figure 9.7].



SEPARATE TIERS FOR SPECIALTY DRUGS

- Specialty drugs, such as biologics that may be used to treat chronic conditions, or some cancer drugs, can be quite expensive and often require special handling and administration. We revised our questions beginning with the 2016 survey to obtain more information about formulary tiers that are exclusively for specialty drugs. We are reporting results only among large firms because a small firm respondents had large shares of “don’t know” responses to some of these questions.

- Ninety-six percent of covered workers at large firms have coverage for specialty drugs [Figure 9.8]. Among these workers, 45% are in a plan with at least one cost-sharing tier just for specialty drugs [Figure 9.9].
- Among covered workers at large firms in a plan with at least one separate tier for specialty drugs, 45% have a copayment for specialty drugs and 53% have coinsurance [Figure 9.10]. The average copayment is \$109 and the average coinsurance rate is 26% [Figure 9.11]. Eighty-seven percent of those with coinsurance have a maximum dollar limit on the amount of coinsurance they must pay.

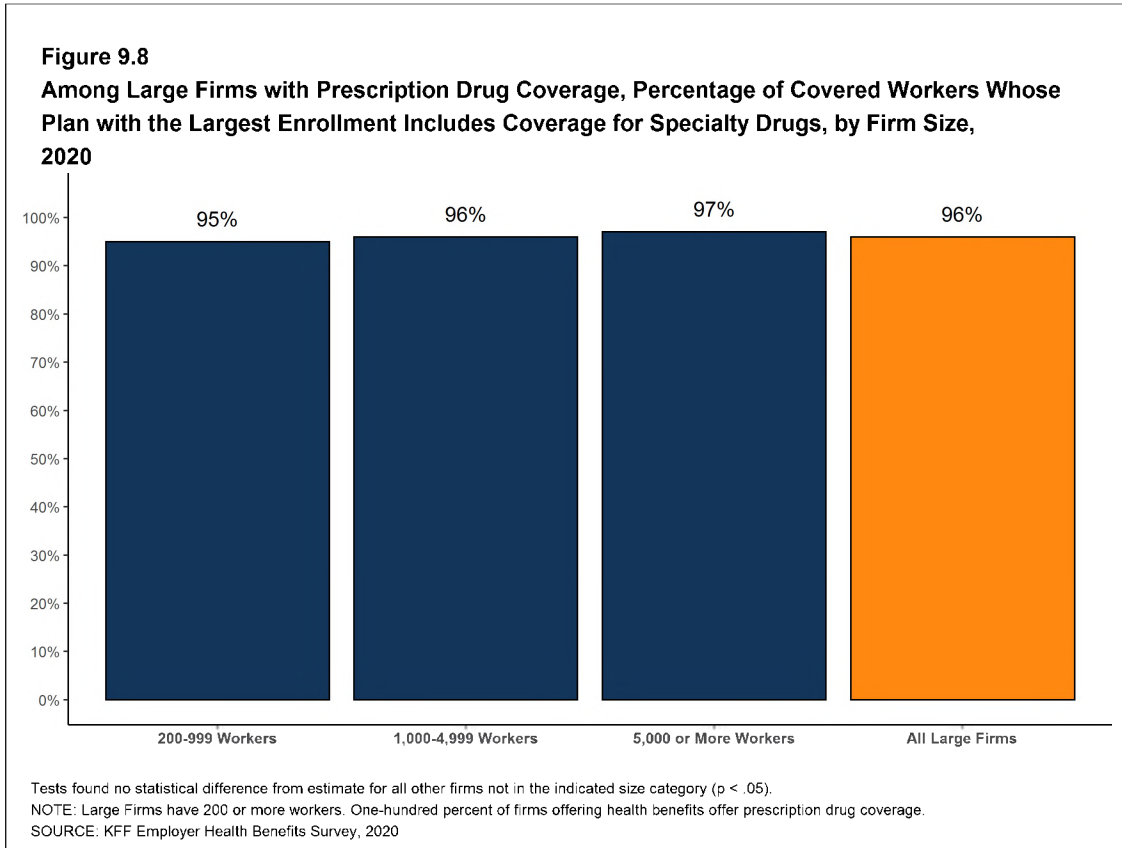
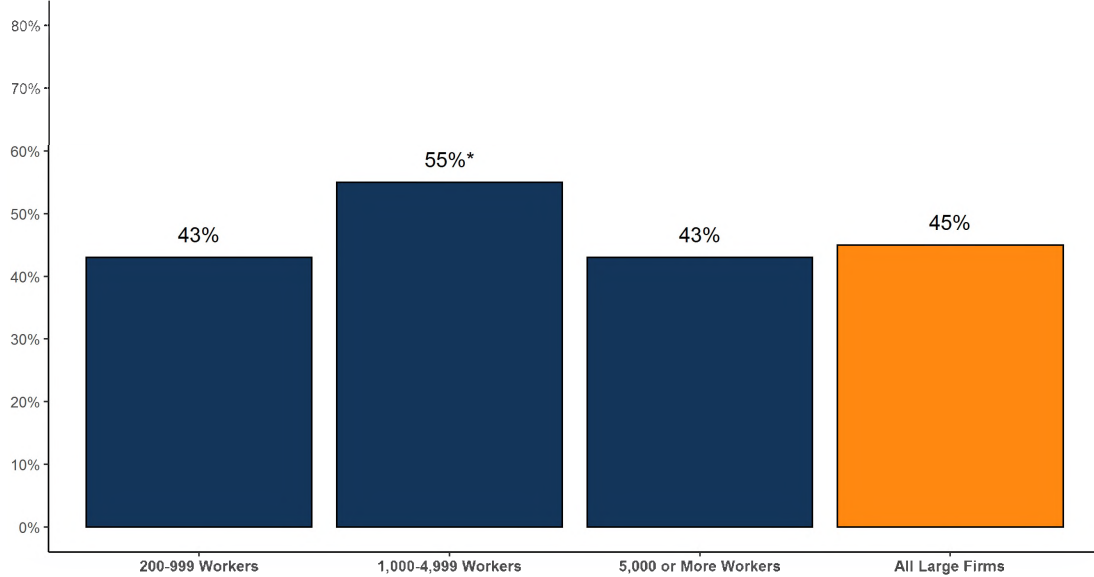
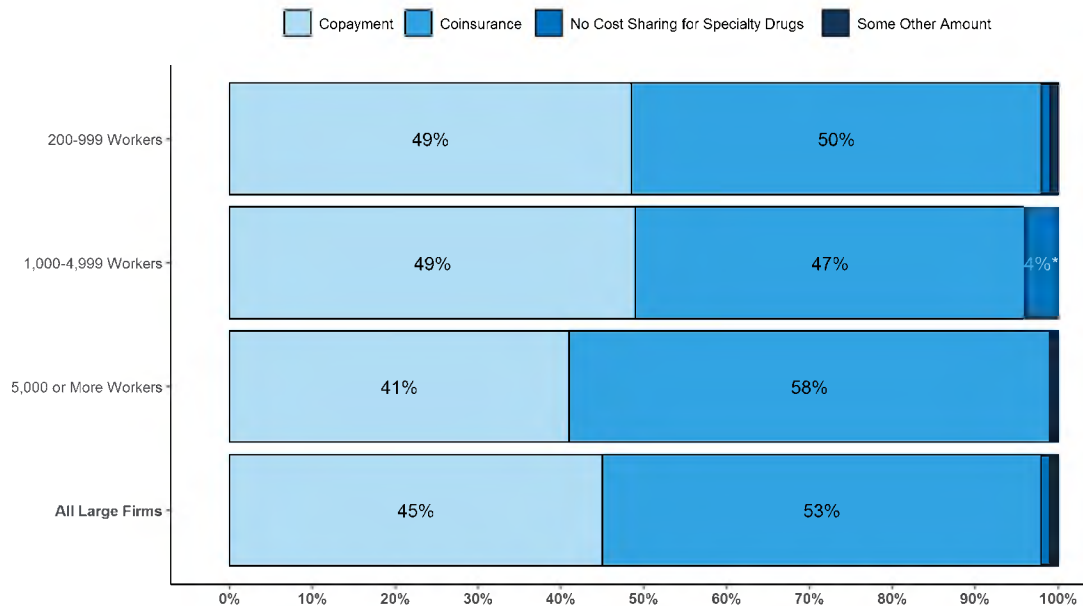


Figure 9.9
Among Large Firms Whose Prescription Drug Coverage Includes Specialty Drugs, Percentage of Covered Workers Enrolled in a Plan That Has a Separate Tier for Specialty Drugs, by Firm Size, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
 NOTE: Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 9.10
Among Covered Workers at Large Firms Enrolled in a Plan with a Separate Tier for Specialty Drugs, Distribution of the Following Types of Cost Sharing, by Firm Size, 2020



* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size ($p < .05$).
 NOTE: Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 9.11

Among Covered Workers at Large Firms Enrolled in a Plan With a Separate Tier for Specialty Drugs, Average Copayments and Coinsurance, by Firm Size, 2020

	Average Copayment (\$)	Average Coinsurance (%)
FIRM SIZE		
200-999 Workers	\$106	27%
1,000-4,999 Workers	97*	25
5,000 or More Workers	118	27
All Large Firms (200 or More Workers)	\$109	26%

* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2020

Generic drugs Drugs that are no longer covered by patent protection and thus may be produced and/or distributed by multiple drug companies.

Preferred drugs Drugs included on a formulary or preferred drug list; for example, a brand-name drug without a generic substitute.

Non-preferred drugs Drugs not included on a formulary or preferred drug list; for example, a brand-name drug with a generic substitute.

Fourth-tier drugs New types of cost-sharing arrangements that typically build additional layers of higher copayments or coinsurance for specifically identified types of drugs, such as lifestyle drugs or biologics.

Specialty drugs Specialty drugs such as biological drugs are high cost drugs that may be used to treat chronic conditions such as blood disorder, arthritis or cancer. Often times they require special handling and may be administered through injection or infusion.

EMPLOYER HEALTH BENEFITS

2020 ANNUAL SURVEY

Plan
Funding

SECTION

10

Section 10

Plan Funding

Many firms, particularly larger firms, choose to pay for some or all of the health services of their workers directly from their own funds rather than by purchasing health insurance for them. This is called self-funding. Both public and private employers use self-funding to provide health benefits. Federal law (the Employee Retirement Income Security Act of 1974, or ERISA) exempts self-funded plans established by private employers (but not public employers) from most state insurance laws, including reserve requirements, mandated benefits, premium taxes, and many consumer protection regulations. Sixty-seven percent of covered workers are in a self-funded health plan in 2020. Self-funding is common among larger firms because they can spread the risk of costly claims over a large number of workers and dependents. Some employers which sponsor self-funded plans purchase stoploss coverage to limit their liabilities.

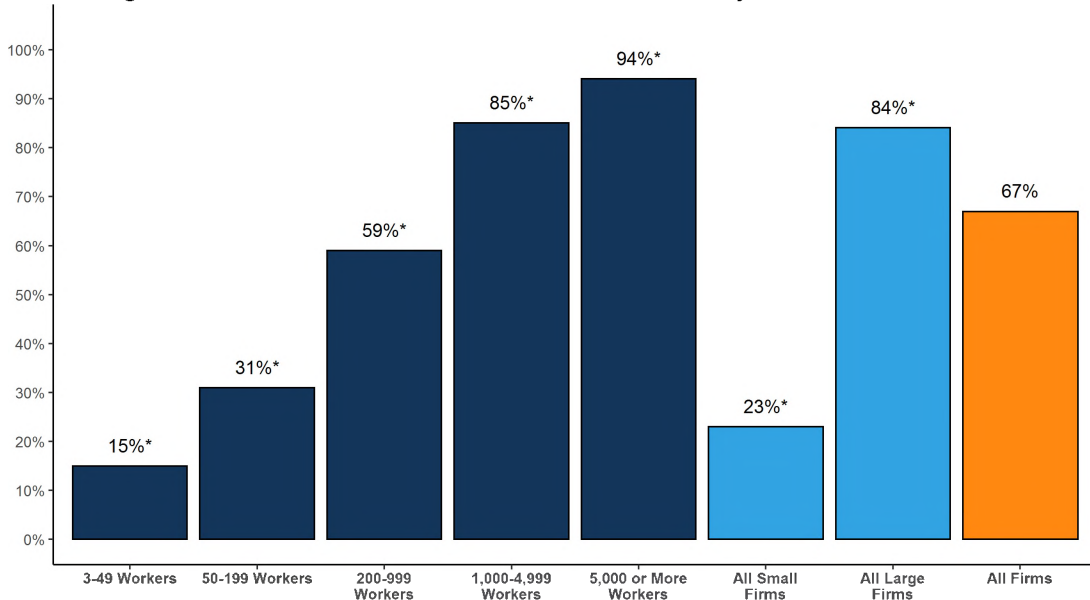
In recent years, a complex funding option, often called level-funding, has become more widely available to small employers. Level-funded arrangements are nominally self-funded options that package together a self-funded plan with extensive stoploss coverage that significantly reduces the risk retained by the employer. Sixteen percent of covered workers in small firms (3-199 workers) are in a level-funded plan.

SELF-FUNDED PLANS

- Sixty-seven percent of covered workers are in a plan that is self-funded, significantly higher than the percentage 61% last year [Figure 10.1] and [Figure 10.2].
 - The percentage of covered workers enrolled in self-funded plans is similar to the percentage in five years ago (63%) but higher than the percentage (59%) ten years ago [Figure 10.2].
 - * As expected, covered workers in large firms are significantly more likely to be in a self-funded plan than covered workers in small firms (84% vs. 23%). The percentage of covered workers in self-funded plans generally increases as the number of workers in a firm increases. [Figure 10.1] and [Figure 10.3].

SECTION 10. PLAN FUNDING

Figure 10.1
Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, 2020

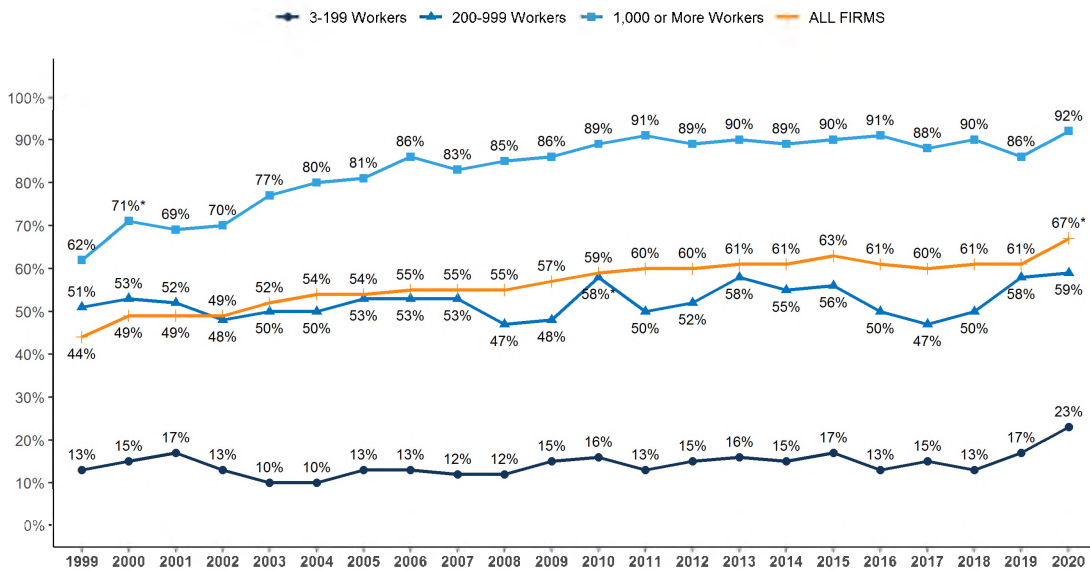


* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. See the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans. Small Firms have 3-199 workers and Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 10.2
Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, 1999-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. Overall, 67% of covered workers are in a self-funded plan in 2020. Due to a change in the survey questionnaire, funding status was not asked of firms with conventional plans in 2006; therefore, conventional plan funding status is not included in the averages in this figure for 2006. See the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

Figure 10.3**Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, Region, and Industry, 2020**

	Covered Workers in a Self-Funded Plan
FIRM SIZE	
200-999 Workers	59%*
1,000-4,999 Workers	85*
5,000 or More Workers	94*
All Small Firms (3-199 Workers)	23%*
All Large Firms (200 or More Workers)	84%*
REGION	
Northeast	68%
Midwest	73*
South	69
West	55*
INDUSTRY	
Agriculture/Mining/Construction	59%
Manufacturing	70
Transportation/Communications/Utilities	88*
Wholesale	67
Retail	80*
Finance	67
Service	54*
State/Local Government	81*
Health Care	73
ALL FIRMS	67%

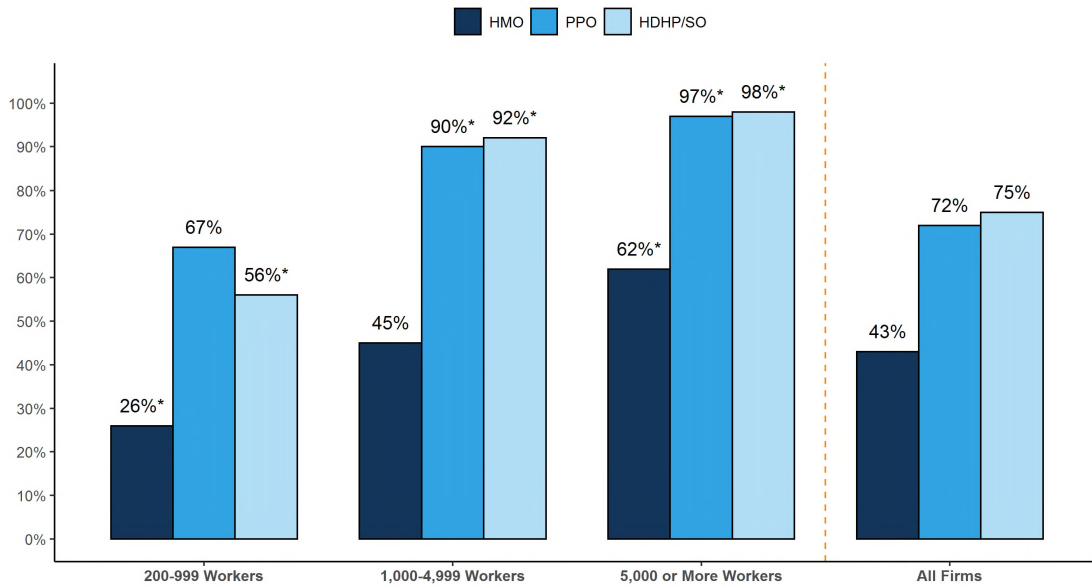
NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. See the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.

* Estimate is statistically different from estimate for all firms not in the indicated size, region, or industry category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

SECTION 10. PLAN FUNDING

Figure 10.4
Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Plan Type and Firm Size, 2020



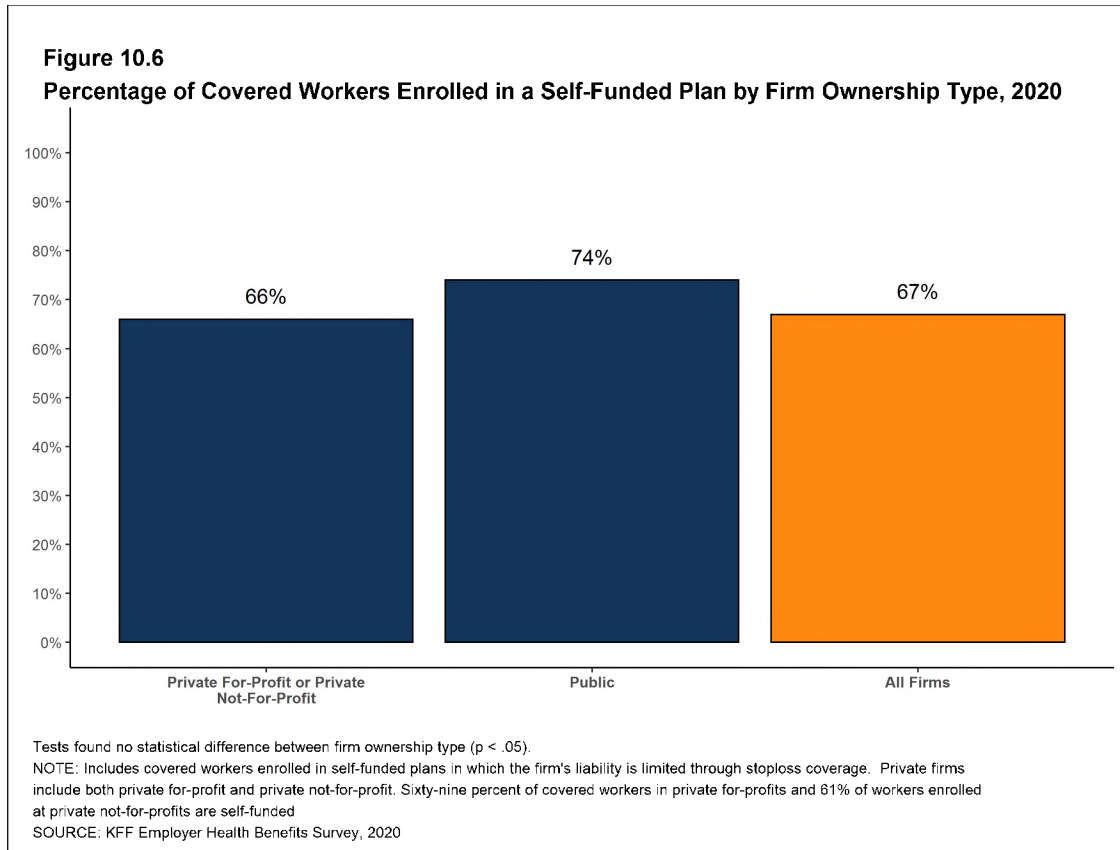
* Estimate is statistically different from estimate for all other firms not in the indicated size category within plan type (p < .05).
 NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. See the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 10.5
Percentage of Covered Workers Enrolled in Self-Funded HMO, PPO, and HDHP/SO Plans, by Firm Size, 1999-2020

Year	HMO					PPO					HDHP/SO				
	3-199 Workers	200-999 Workers	1,000-4,999 Workers	5,000 or More Workers	All HMO Plans	3-199 Workers	200-999 Workers	1,000-4,999 Workers	5,000 or More Workers	All PPO Plans	3-199 Workers	200-999 Workers	1,000-4,999 Workers	5,000 or More Workers	All HDHP/SO Plans
1999	5%	14%	22%	19%	18%	19%	68%	84%	87%	60%					
2000	4%	13%	27%	35%*	23%*	23%	72%	89%	88%	63%					
2001	14%	23%	32%	40%	31%*	23%	66%	87%	87%	61%					
2002	10%	16%	31%	38%	27%	15%	63%	83%	93%	61%					
2003	5%	21%	37%	44%	29%	13%	60%	85%	93%	61%					
2004	4%	18%	49%	40%	29%	13%	63%	88%	93%	64%					
2005	10%	17%	50%	44%	32%	18%	67%	88%	95%	65%					
2006	3%	29%	54%	47%	33%	19%	61%	85%	97%	63%	7%	57%	81%	100%	50%
2007	1%	19%	44%	56%	34%	17%	65%	87%	90%*	65%	4%	27%	66%	97%	41%
2008	10%	22%	48%	66%	40%	15%	55%	85%	94%	64%	7%	48%	72%	91%	35%
2009	6%	26%	50%	61%	40%	21%	55%	87%	93%	67%	18%	36%	81%	96%	46%*
2010	9%	23%	59%	65%	41%	16%	69%*	85%	96%	67%	24%	53%	88%	99%	61%*
2011	5%	16%	54%	67%	41%	19%	65%	84%	96%	70%	11%	45%	89%	98%	54%
2012	13%	14%	45%	60%	37%	20%	63%	84%	97%	70%	14%	39%	85%	98%	54%
2013	10%	12%	50%	52%	31%	16%	66%	87%	98%	70%	17%	57%	83%	97%	62%
2014	1%*	22%	59%	47%	32%	21%	67%	88%	98%	71%	15%	49%	85%	97%	60%
2015	11%	15%	41%	66%	38%	21%	63%	89%	94%	70%	16%	59%	89%	98%	68%*
2016	5%	23%	44%	70%	37%	17%	61%	91%	95%	69%	20%	36%*	87%	98%	67%
2017	5%	20%	39%	35%*	24%	19%	60%	88%	95%	67%	19%	48%	90%	99%	71%
2018	7%	26%	56%	56%	38%*	17%	56%	92%	95%	67%	14%	48%	89%	98%	65%
2019	10%	24%	53%	69%	43%	21%	66%	93%	93%	69%	20%	66%*	90%	84%*	66%
2020	14%	26%	45%	62%	43%	29%	67%	90%	97%	72%	23%	56%	92%	96%*	75%*

NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. Estimates for POS plans are not shown due to high relative standard errors. See the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans. Information on funding status for HDHP/SOs was not collected prior to 2006.

* Estimate is statistically different from estimate for the previous year shown (p < .05).
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017



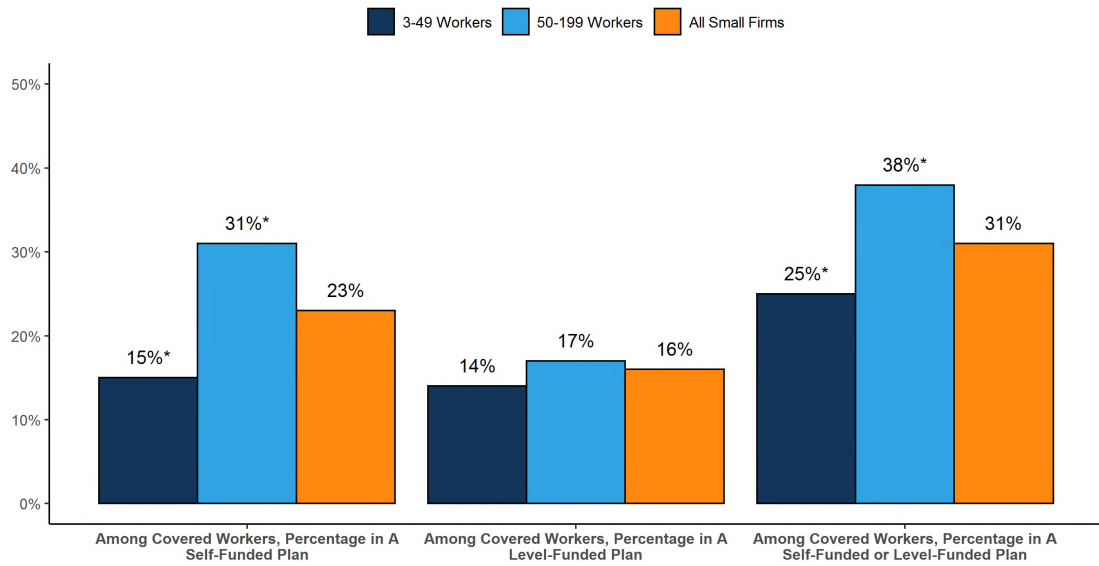
LEVEL-FUNDED PLANS

In the past few years, insurers have begun offering health plans that provide a nominally self-funded option for small or mid-sized employers that incorporates stoploss insurance with relatively low attachment points. Often, the insurer calculates an expected monthly expense for the employer, which includes a share of the estimated annual cost for benefits, premium for the stoploss protection, and an administrative fee. The employer pays this “level premium” amount, with the potential for some reconciliation between the employer and the insurer at the end of the year, if claims differ significantly from the estimated amount. These policies are sold as self-funded plans, so they generally are not subject to state requirements for insured plans and, for those sold to employers with fewer than 50 employees, are not subject to the rating and benefit standards in the ACA for small firms.

Due to the complexity of the funding (and regulatory status) of these plans, and because employers often pay a monthly amount that resembles a premium, respondents may be confused as to whether or not their health plan is self-funded or insured. We asked employers with fewer than 200 workers whether they have a level-funded plan.

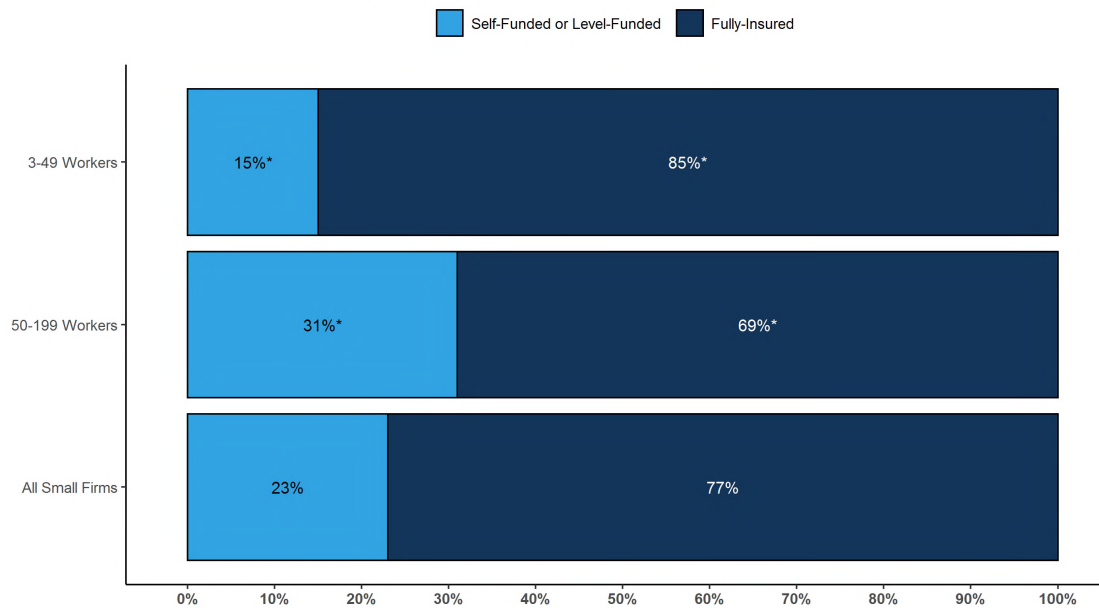
- Thirteen percent of small firms offer a level-funded plan in 2020, similar to the percentage (7%) last year.
- Thirty-one percent of covered workers in small firms are in a plan that is either self-funded or level-funded in 2020, higher than the percentage (24%) last year [Figure 10.7].

Figure 10.7
Among Covered Workers at Small Firms, Percentage Enrolled in a Level-Funded or Self-Funded Plan, by Firm Size, 2020



* Estimates are statistically different from estimate for all other firms not in the indicated category within each firm size (p < .05).
 NOTE: See the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans. Small Firms have 3-199 workers. This figure shows the percentage of covered workers; In 2020, 13% of small firms reported that they had a level-funded plan. This includes respondents who indicated both that their plan was level-funded and fully insured.
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 10.8
Among Covered Workers at Small Firms, Percentage Enrolled in a Level-Funded or Self-Insured Plan, by Firm Size, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).
 NOTE: See the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.
 SOURCE: KFF Employer Health Benefits Survey, 2020

STOPLOSS COVERAGE AND ATTACHMENT POINTS

Stoploss coverage may limit the amount of claims that must be paid by a plan sponsor for each worker or may limit the total amount the plan sponsor must pay for all claims over the plan year. At firms with 50 or more workers, sixty-two percent of covered workers in self-funded health plans are in plans that have stoploss insurance, similar to percentage the last time we asked the question in 2018 [Figure 10.9].

- The percentage of covered workers in self-funded plans with stoploss insurance (62%) is similar to the value when the survey first asked about stoploss insurance in 2011 (58%). [Figure 10.10].
- Among covered workers in self-funded plans with 50 or more workers that have stoploss, 87% are in plans where the stoploss insurance limits the amount the plan must spend on each worker or enrollee, 57% are in plans where the stoploss insurance limits the overall amount the plan must pay, 70% are in plans where the stoploss insurance limits the amounts that the plans must pay for high claims or episodes, and 10% are in plans where the stoploss insurance includes a different type of limit. Respondents were asked to choose all of the options that applied to their stoploss coverage [Figures 10.11]. Some plans have several limits applying to their plan. Starting in 2020, we restructured these questions and, while we believe the answers are similar to 2011 through 2018, changes in question wording may impact responses.
- Firms with 50 or more workers who have a per-enrollee stoploss coverage component were asked for the dollar amount where the stoploss coverage would start to pay for most or all of the claim (called an attachment point). The average attachment points for these firms are \$100,000 for small firms (50-199) and \$380,000 for large firms [Figure 10.13].

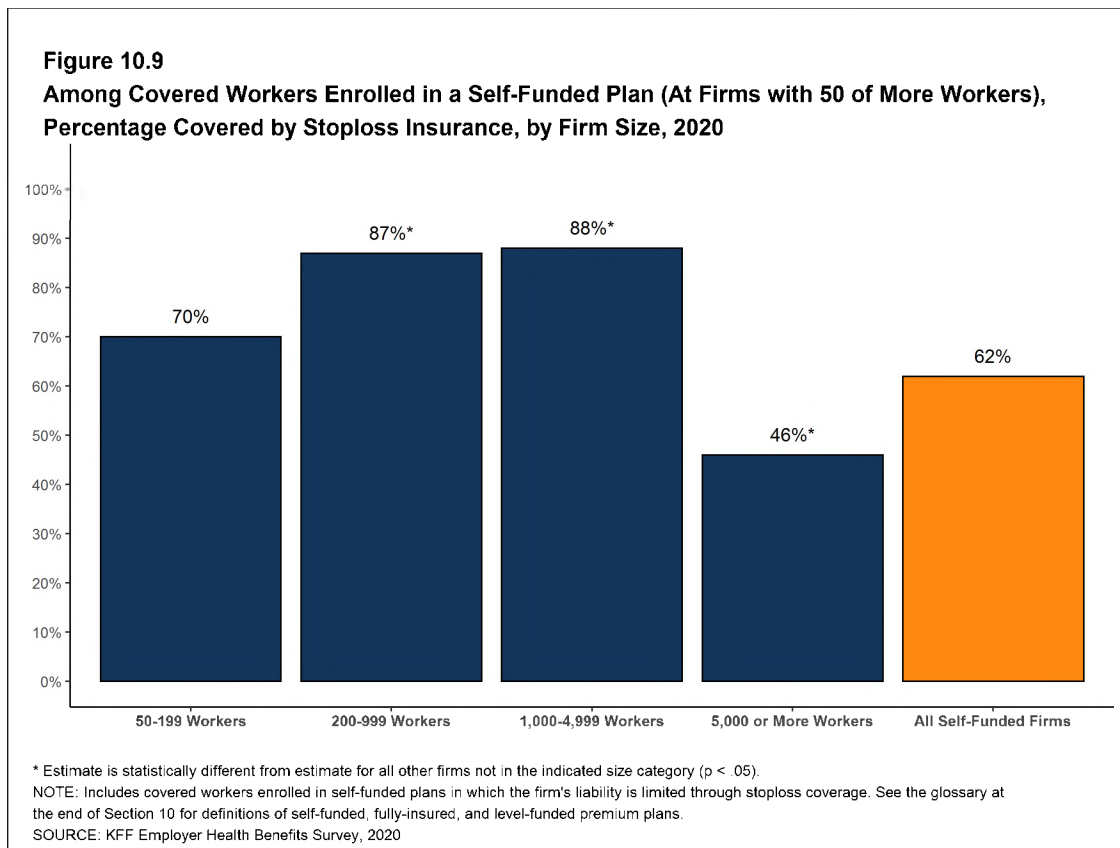
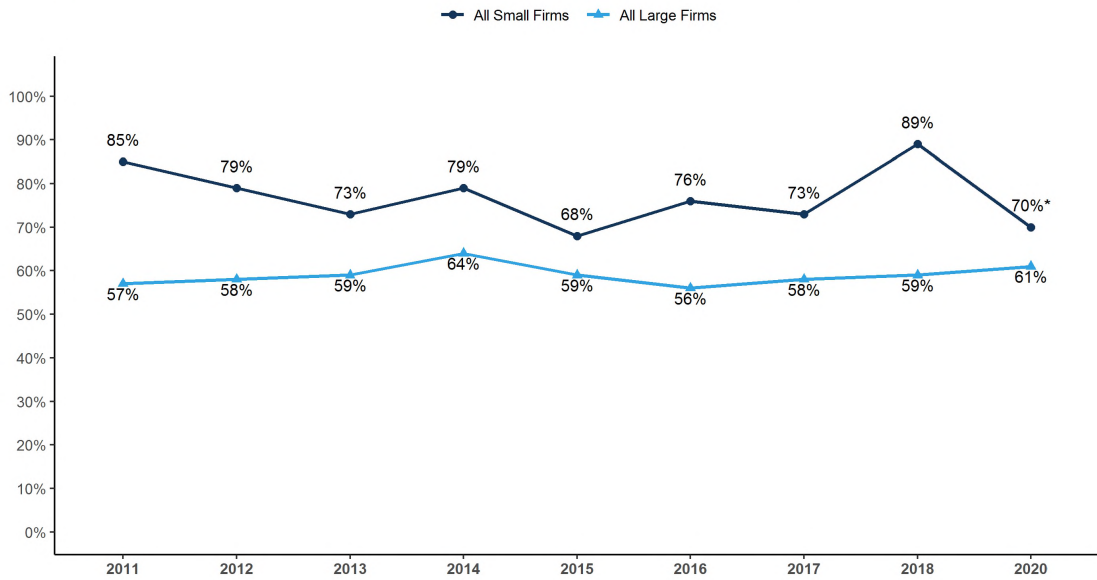
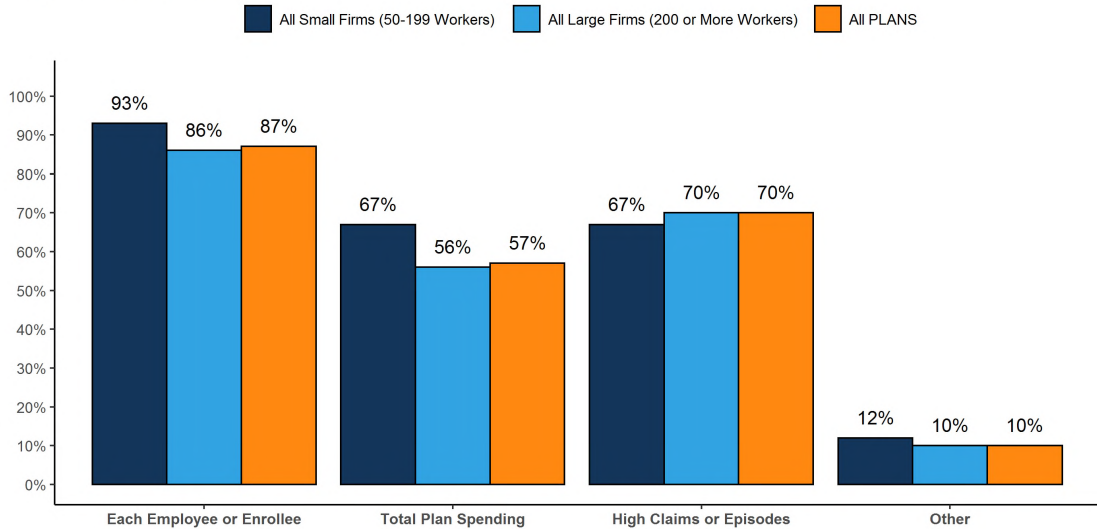


Figure 10.10
Among Covered Workers Enrolled in a Self-Funded Plan, Percentage Covered by Stoploss Insurance (At Firms with 50 or More Workers), by Firm Size, 2011-2020



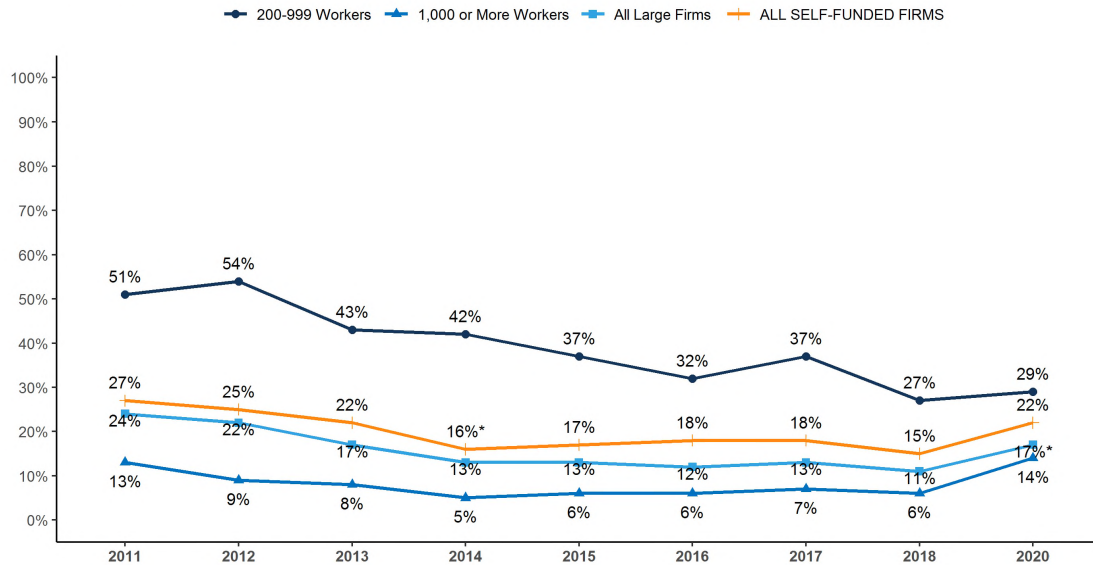
* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
 NOTE: Includes covered workers enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage. Small Firms have 3-199 workers and Large Firms have 200 or more workers. We did not ask about stoploss coverage in 2019.
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011-2017

Figure 10.11
Among Covered Workers at Firms (50 or More Workers) Who Purchase Stoploss Coverage, Percent of Covered Workers Enrolled in Plans With Various Limits on the Plan's Liability, by Firm Size, 2020



Tests found no statistical difference from estimate for all other firms not in the indicated size or region category ($p < .05$).
 NOTE: A per-enrollee spending limit includes stoploss insurance plans that limit a firm's per-enrollee spending. Attachment points refer to the dollar amount at which stoploss coverage begins to pay for most or all of a claim. See the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans.
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 10.12
Among Self-Funded Firms (50 or More Workers) With Stoploss Coverage, Percentage of Covered Workers Enrolled in a Plan With an Attachment Point of \$100,000 or Less, by Firm Size, 2011-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: Among workers covered by a stoploss policy that includes a per-person limit. Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011-2017

Figure 10.13
Prevalence and Average Attachment Points of Stoploss Insurance, by Firm Size and Region, 2020

	Percentage of Covered Workers in a Self-Funded Plan	Percentage Enrolled in a Self-Funded Plan With Stoploss Insurance	Percentage Enrolled in a Self-Funded Plan With Stoploss Insurance With a Per-Enrollee Spending Limit	Average Attachment Point
FIRM SIZE				
200-999 Workers	59*	87*	87	230,000*
1,000-4,999 Workers	85*	88*	86	310,000
5,000 or More Workers	94*	46*	86	510,000*
All Small Firms (3-199 Workers)	31%*	70%	93%	\$100,000*
All Large Firms (200 or More Workers)	84%*	61%	86%	\$380,000*
All Self-Funded Firms	76%	62%	87%	\$350,000

NOTE: A per-enrollee spending limit includes stoploss insurance plans that limit a firm's per-enrollee spending as well as plans that have other limits. Attachment points refer to the dollar amount at which stoploss coverage begins to pay for most or all of a claim, and are rounded to the nearest \$1,000. See the glossary at the end of Section 10 for definitions of self-funded, fully-insured, and level-funded premium plans. There was insufficient data to report estimates for firms with 3 to 49 workers.

* Estimate is statistically different from estimate for all other firms not in the indicated size or region category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

Self-Funded Plan An insurance arrangement in which the employer assumes direct financial responsibility for the costs of enrollees' medical claims. Employers sponsoring self-funded plans typically contract with a third-party administrator or insurer to provide administrative services for the self-funded plan. In some cases, the employer may buy stoploss coverage from an insurer to protect the employer against very large claims.

Fully-Insured Plan An insurance arrangement in which the employer contracts with a health plan that assumes financial responsibility for the costs of enrollees' medical claims.

Level-Funded Plan An insurance arrangement in which the employer makes a set payment each month to an insurer or third party administrator which funds a reserve account for claims, administrative costs, and premiums for stop-loss coverage. When claims are lower than expected, surplus claims payments may be refunded at the end of the contract.

Stoploss Coverage Stoploss coverage limits the amount that a plan sponsor has to pay in claims. Stoploss coverage may limit the amount of claims that must be paid for each employee or may limit the total amount the plan sponsor must pay for all claims over the plan year.

Attachment Point Attachment points refer to the amount at which the insurer begins to pay its obligations for stoploss coverage, either because plan, individual or claim spending exceed a designated value.

EMPLOYER HEALTH BENEFITS

2020 ANNUAL SURVEY

Retiree Health
Benefits

SECTION

11

Section 11

Retiree Health Benefits

Retiree health benefits are an important consideration for older workers making decisions about their retirement. Retiree benefits can be a crucial source of coverage for people retiring before Medicare eligibility. For retirees with Medicare coverage, retiree health benefits can provide an important supplement to Medicare, helping them pay for cost sharing and benefits not otherwise covered by Medicare.

In 2019, we modified the question that we use to ask firms whether or not they provide retiree health benefits; specifically, in contrast to prior years, the 2019 and 2020 surveys explicitly stated that firms that had terminated retiree health benefits but still has some retirees getting coverage, or that had current employees who will get retiree health coverage in the future, should answer 'yes' to the question. For this reason, estimates of retiree health benefits from 2019 onwards are not comparable to prior surveys.

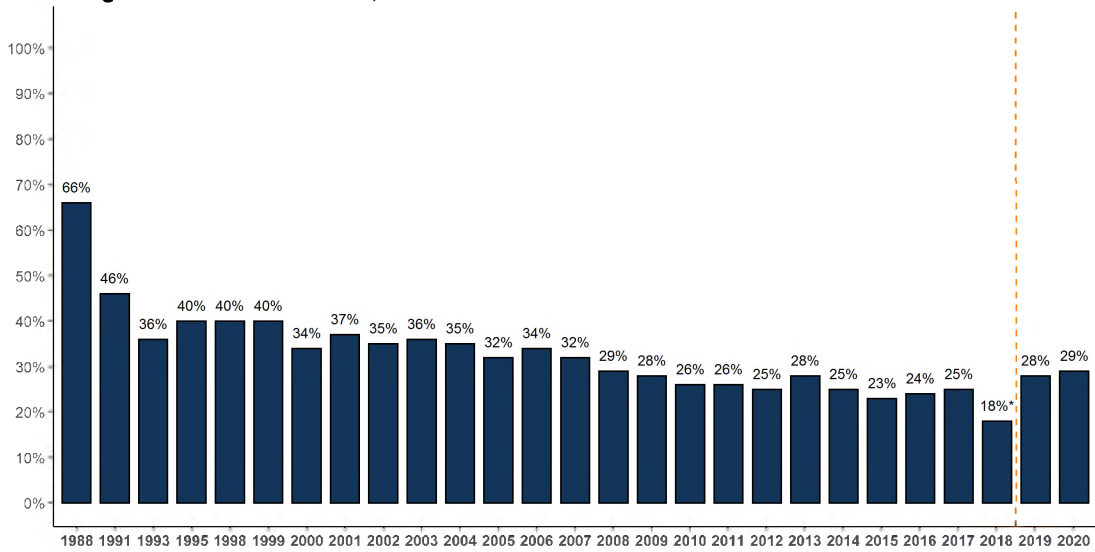
This year's survey finds that 29% of large firms offering health benefits offer retiree health benefits, similar to the percentage (28%) in 2019.

This survey asks retiree health benefits questions only of large firms (200 or more workers).

EMPLOYER RETIREE BENEFITS

- In 2020, 29% of large firms that offer health benefits offer retiree health benefits for at least some current workers or retirees, similar to the percentage last year [Figure 11.1]. See the Methods section for a discussion of changes to survey question on retiree health benefits for 2019 survey. Due to this change, we did not test to see if current percentage is different than those in 2018 or before.
- Retiree health benefits offer rates vary considerably by firm characteristics.
 - Among large firms offering health benefits, the likelihood that a firm will offer retiree health benefits increases with firm size [Figure 11.2].
 - The share of large firms offering retiree health benefits varies considerably by industry [Figure 11.2].
 - Among large firms offering health benefits, public employers are more likely (66%) to offer retiree health benefits than other firm types [Figure 11.3].
 - Large firms offering health benefits with at least some union workers are more likely to offer retiree health benefits than large firms without any union workers (47% vs. 23%) [Figure 11.3].
 - Large firms offering health benefits with a relatively large share of older workers (where at least 35% of the workers are age 50 or older) are more likely to offer retiree health benefits than large firms with a smaller share of older workers (39% vs. 20%) [Figure 11.3].
 - Large firms offering health benefits with a relatively large share of higher-wage workers (where at least 35% of workers earn \$64,000 a year or more) are more likely to offer retiree health benefits than large firms with a smaller share of higher-wage workers (38% vs. 23%) [Figure 11.3].

Figure 11.1
Among Large Firms Offering Health Benefits to Active Workers, Percentage of Firms
Offering Retiree Health Benefits, 1988-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$). No statistical tests are conducted for years prior to 1999.

NOTE: Large Firms have 200 or more workers. In 2019, this question was reworded. Because of this there was no statistical testing between 2018 and 2019. See the Methods section for details.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017; KPMG Survey of Employer-Sponsored Health Benefits, 1991, 1993, 1995, 1998; The Health Insurance Association of America (HIAA), 1988.

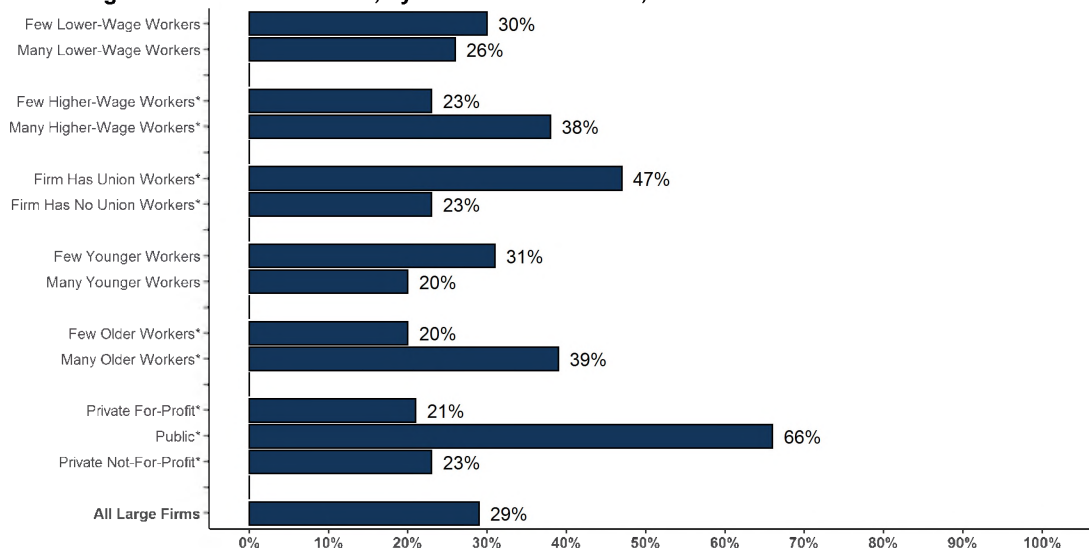
Figure 11.2**Among Large Firms Offering Health Benefits to Active Workers,
Percentage of Firms Offering Retiree Health Benefits, by Firm Size,
Region, and Industry, 2020**

	Large Firms Offering Retiree Health Benefits
FIRM SIZE	
200-999 Workers	27%*
1,000-4,999 Workers	37*
5,000 or More Workers	52*
REGION	
Northeast	28%
Midwest	29
South	33
West	25
INDUSTRY	
Agriculture/Mining/Construction	15%*
Manufacturing	16*
Transportation/Communications/Utilities	58*
Wholesale	13*
Retail	12*
Finance	42
Service	26
State/Local Government	74*
Health Care	16*
All Large Firms (200 or More Workers)	29%

* Estimate is statistically different from estimate for all other Large Firms not in the indicated size, region, or industry category ($p < .05$).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 11.3
Among Large Firms Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, by Firm Characteristics, 2020



* Estimates are statistically different from each other within category ($p < .05$).

NOTE: Large Firms have 200 or more workers. Firms with many lower-wage workers are those where at least 35% earn the 25th percentile or less of national earnings (\$26,000 in 2020). Firms with many higher-wage workers are those where at least 35% earn the 75th percentile or more than of national earnings (\$64,000 in 2020). Firms with many older workers are those where at least 35% of workers are age 50 or older. Firms with many younger workers are those where at least 35% of workers are age 26 or younger.

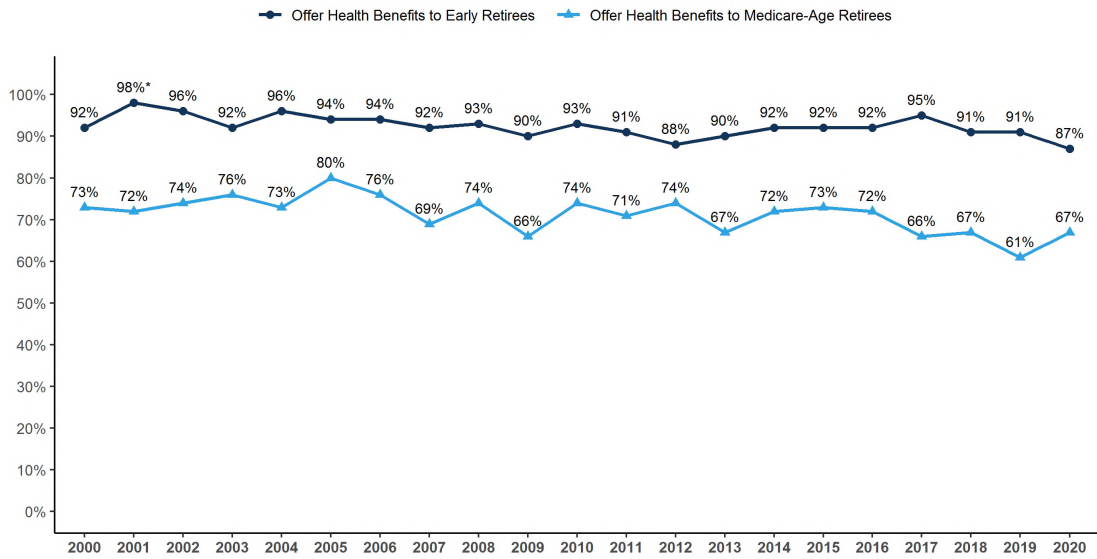
SOURCE: KFF Employer Health Benefits Survey, 2020

EARLY RETIREES, MEDICARE-AGE RETIREES AND SPOUSES

- Among large firms offering retiree health benefits, 87% offer benefits to early retirees under the age of 65 and 67% offer them to Medicare-age retirees [Figure 11.4].
- Among all large firms offering health benefits to current workers, 20% offer retiree health benefits to Medicare-age retirees.
- Among large firms offering retiree health benefits, 56% offer benefits to both early and Medicare-age retirees.
- Among large firms offering retiree benefits, a large share (86%) report offering health benefits to the spouses of retirees [Figure 11.5].

SECTION 11. RETIREE HEALTH BENEFITS

Figure 11.4
Among Large Firms Offering Health Benefits to Active Workers and Retirees, Percentage of Firms Offering Health Benefits to Early and Medicare-Age Retirees, 2000-2020

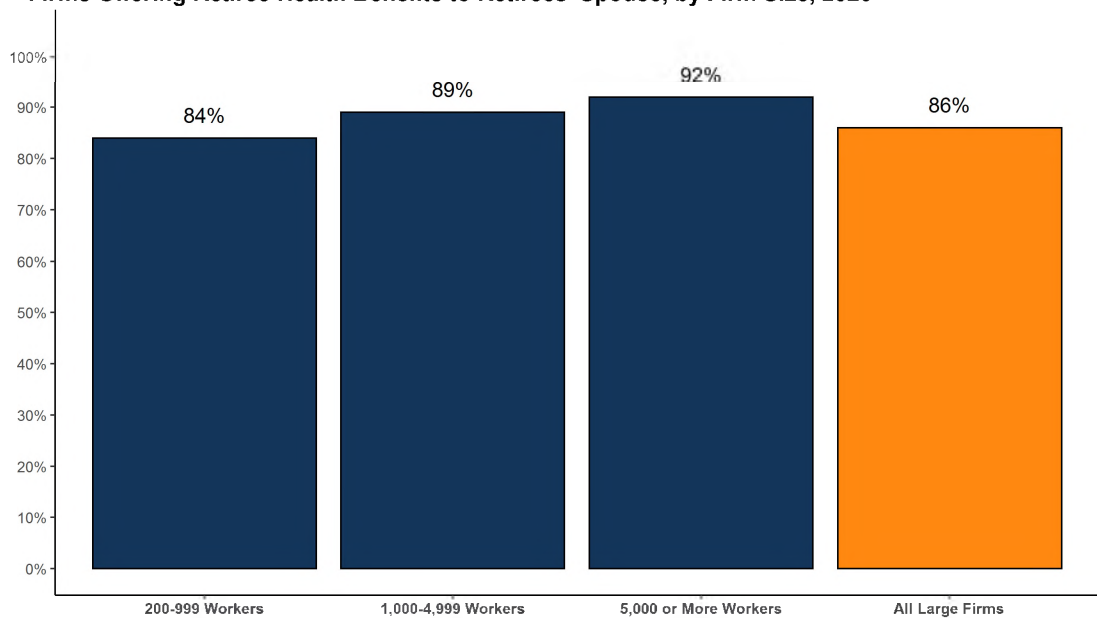


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: Among Large Firms offering health benefits to active workers and offering retiree coverage, 56% offer health benefits to both early and Medicare-age retirees. Large Firms have 200 or more workers. Early retirees are those who retire before the age of 65. In 2019 this question was reworded. Because of this there was no statistical testing between 2018 and 2019. See the Methods section for details.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2017

Figure 11.5
Among Large Firms Offering Health Benefits to Active Workers and Retirees, Percentage of Firms Offering Retiree Health Benefits to Retirees' Spouse, by Firm Size, 2020



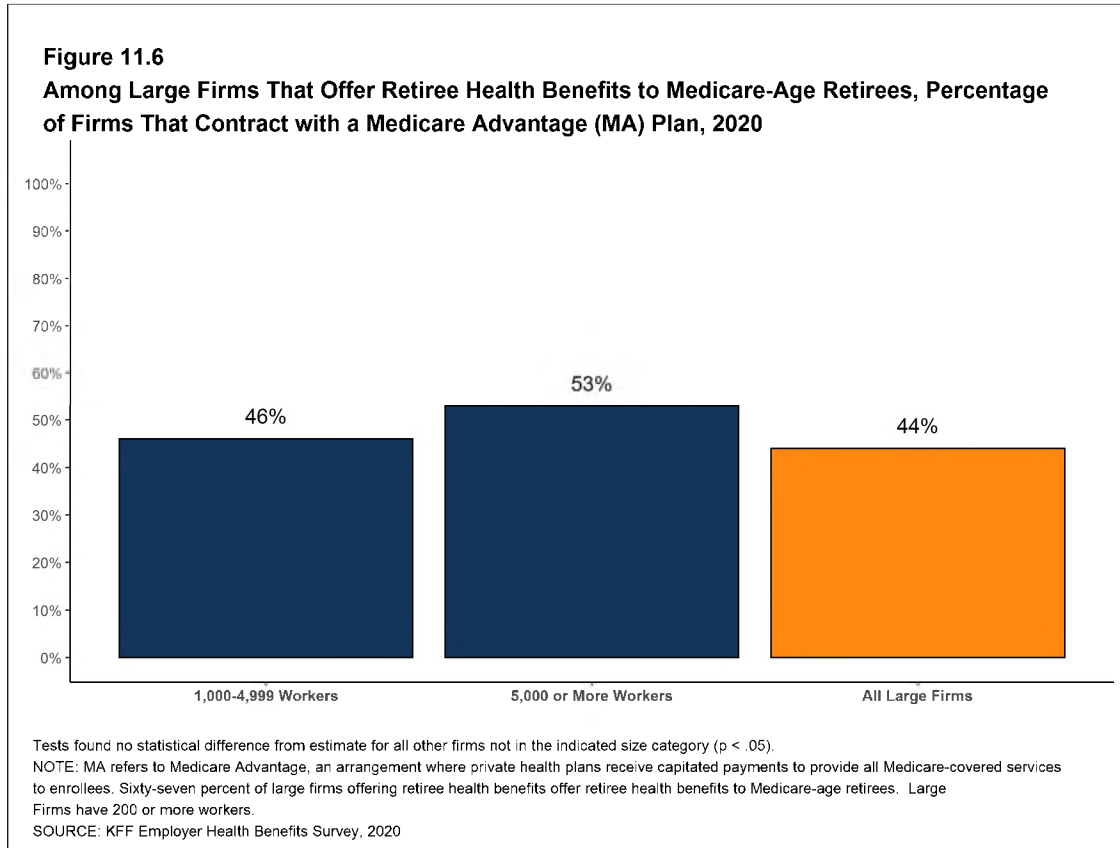
Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).

NOTE: Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2020

MEDICARE ADVANTAGE

- Forty-four percent of large employers offering retiree health benefits to Medicare-age retirees offer coverage to at least some Medicare-age retirees through a contract with a Medicare Advantage plan, similar to the percentage last year (44%) [Figure 11.6].



EMPLOYER HEALTH BENEFITS

2020 ANNUAL SURVEY

Health Screening
and Health
Promotion and
Wellness Programs

SECTION

12

Section 12

Health Screening and Health Promotion and Wellness Programs

Most firms offer some form of wellness program to help workers and family members identify health issues and manage chronic conditions. Many employers believe that improving the health of their workers and their family members can improve morale and productivity, as well as reduce health care costs.

In addition to offering wellness programs, a majority of large firms now offer health screening programs, including health risk assessments, which are questionnaires asking workers about lifestyle, stress, or physical health, and biometric screening, which we define as in-person health examinations conducted by a medical professional. Firms and insurers may use the health information collected during screenings to target wellness offerings or other health services to workers with certain conditions or behaviors. Some firms have incentive programs that reward or penalize workers for different activities, including participating in wellness programs or completing health screenings.

Among large firms offering health benefits in 2020, 60% offer workers the opportunity to complete a health risk assessment, 50% offer workers the opportunity to complete a biometric screening, and 81% offer workers one or more wellness programs, such as programs to help them stop smoking or lose weight, or programs that offer lifestyle and behavioral coaching. Substantial shares of these large firms provide incentives for workers to participate in or complete the programs.

Only firms offering health benefits were asked about their wellness and health promotion programs.

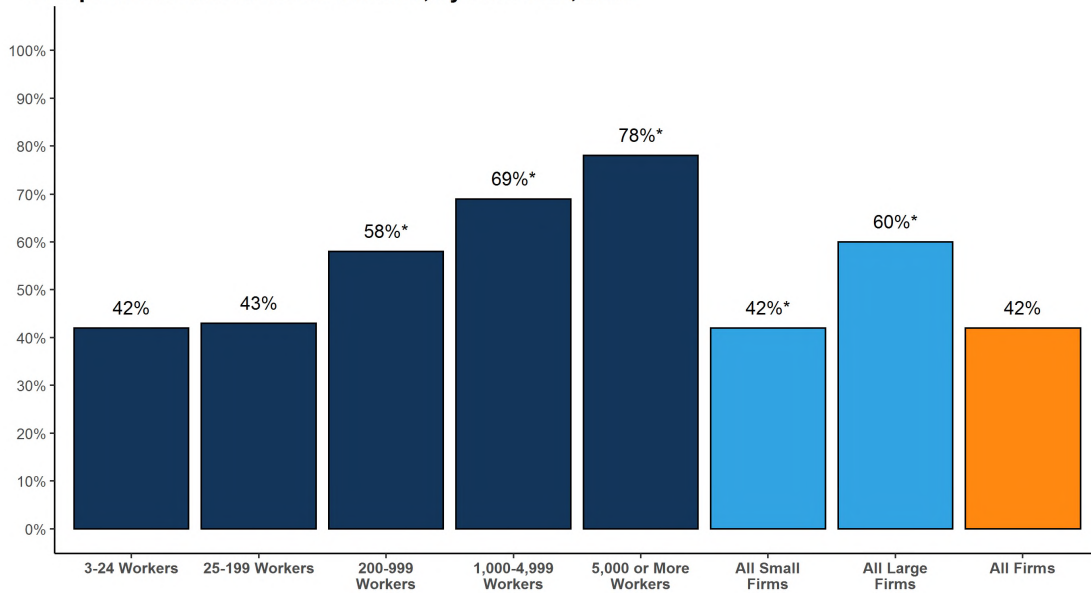
Employers have been and continue to deal with the coronavirus pandemic, including by modifying wellness and screening programs and employee assistance programs. For example, some employees may not be available for health screening or may not be able to participate in wellness-related programs. Some employers may have chosen to modify or suspend financial incentives due to potential difficulties with employees achieving compliance. Due to the timing of the survey, we were not able to include questions about how employers may have adapted their health plans and employee assistance programs to address some of the impacts of the epidemic.

HEALTH RISK ASSESSMENTS

Many firms provide workers the opportunity to complete a health risk assessment to identify potential health issues. Health risk assessments generally include questions about medical history, health status, and lifestyle. At small firms, health risk assessments are often administered by an insurer.

- Among firms offering health benefits, 42% of small firms and 60% of large firms provide workers the opportunity to complete a health risk assessment [Figure 12.1]. These percentages are similar to the corresponding percentages for 2019 (41% for small firms and 65% for large firms) [Figure 12.2].
- Some firms offer incentives to encourage workers to complete a health risk assessment.
 - Among large firms that offer a health risk assessment, 52% offer workers an incentive to complete the assessment [Figure 12.3].

Figure 12.1
Among Firms Offering Health Benefits, Percentage of Firms That Provide an Opportunity to Complete a Health Risk Assessment, by Firm Size, 2020

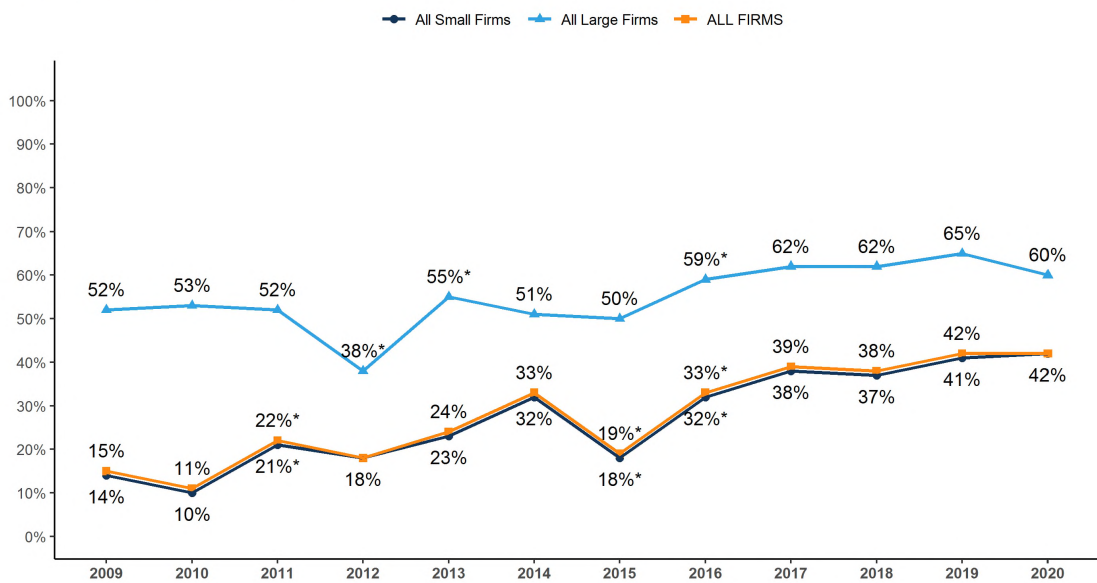


* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Small Firms have 3-199 workers and Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.2
Among Firms Offering Health Benefits, Percentage of Firms That Provide an Opportunity to Complete a Health Risk Assessment, by Firm Size, 2009-2020

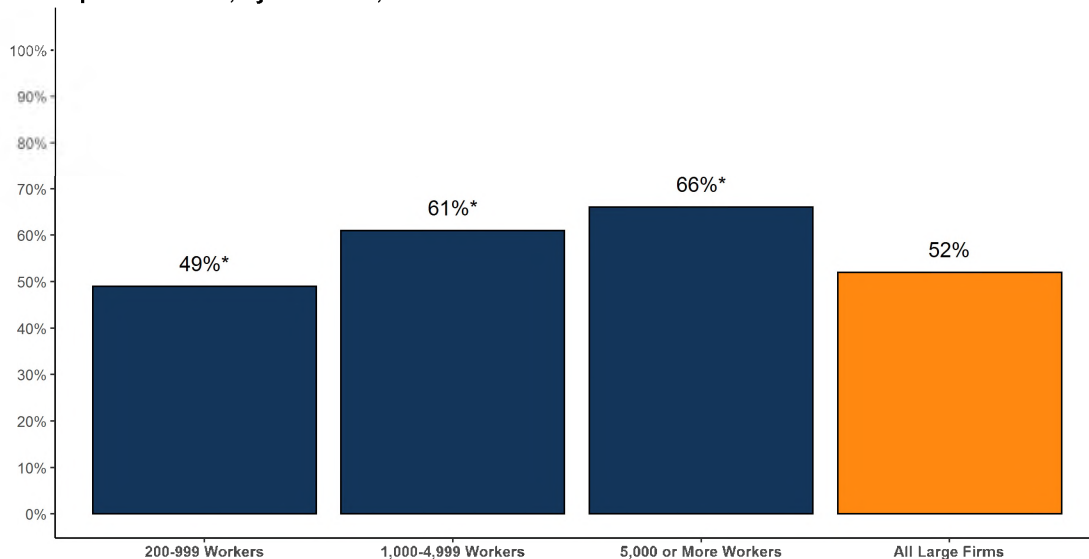


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Small Firms have 3-199 workers and Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

Figure 12.3
Among Large Firms Offering Health Benefits and Providing an Opportunity to Complete a Health Risk Assessment (HRA), Percentage of Firms That Offer Workers Incentives to Complete the HRA, by Firm Size, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2020

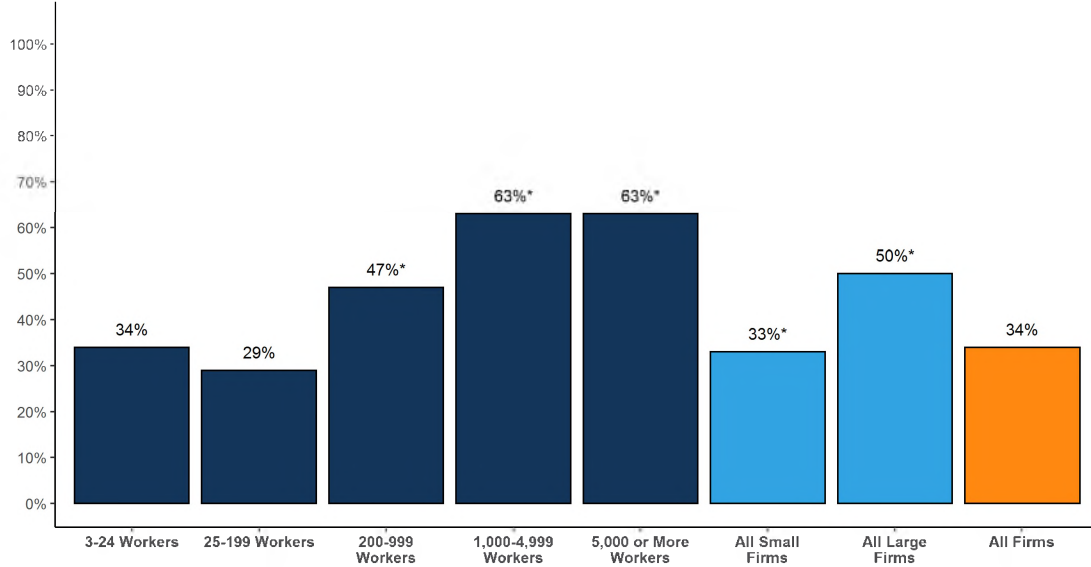
BIOMETRIC SCREENING

Biometric screening is a health examination that measures a person's risk factors (such as cholesterol, blood pressure, and body mass index (BMI)) for certain medical issues. A biometric outcome involves assessing whether the person meets specified health targets related to certain risk factors, such as meeting a target BMI or cholesterol level. As defined by this survey, goals related to smoking are not included in the biometric screening questions.

- Among firms offering health benefits, 33% of small firms and 50% of large firms provide workers the opportunity to complete a biometric screening [Figure 12.4]. These percentages are similar to 2019 (26% and 52%) [Figure 12.5].
- Some firms offer incentives to encourage workers to complete the biometric screening.
 - Among firms with biometric screening programs, 17% of small firms and 65% of large firms offer workers an incentive to complete the screening [Figure 12.6].
- In addition to incentives for completing a biometric screening, some firms offer workers incentives to meet biometric outcomes. Among large firms with biometric screening programs, 18% reward or penalize workers based on achieving specified biometric outcomes (such as meeting a target BMI) [Figure 12.6].
 - The size of the incentives firms offer for meeting biometric outcomes varies considerably. Among large firms offering a reward or penalty for meeting biometric outcomes, the maximum reward is valued at \$150 or less for 12% of firms and more than \$1,000 for 32% of firms [Figure 12.7]. Seven percent of these firms combine the reward with incentives for other activities. This may

include employers who ask employees to complete several health screening, disease management, wellness/health promotion activities in order to qualify for incentives.

Figure 12.4
Among Firms Offering Health Benefits, Percentage of Firms That Provide an Opportunity to Complete a Biometric Screening, by Firm Size, 2020

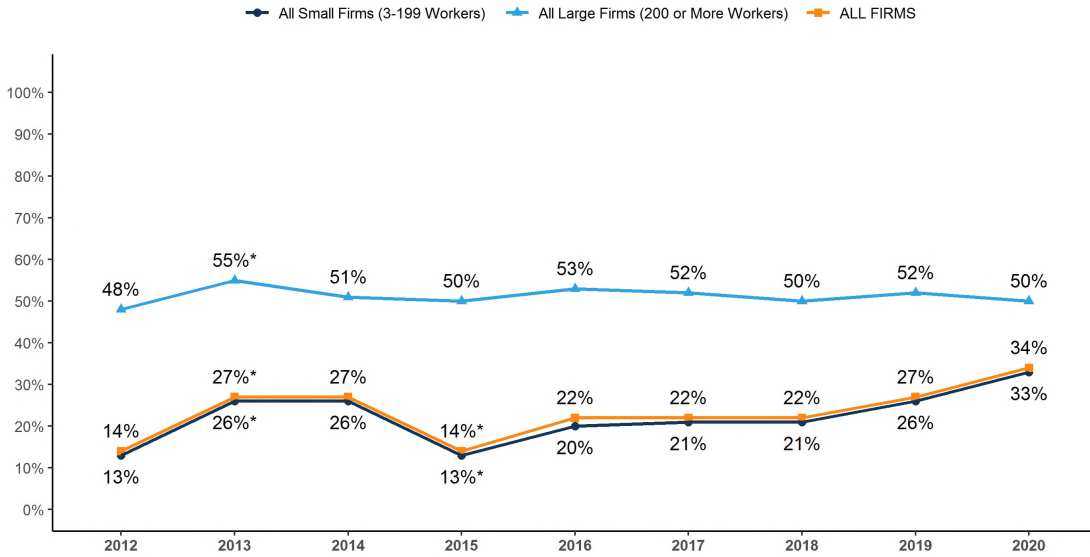


* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

NOTE: Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Small Firms have 3-199 workers and Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.5
Among Firms Offering Health Benefits, Percentage of Firms That Provide an Opportunity to Complete Biometric Screening, by Firm Size, 2012-2020

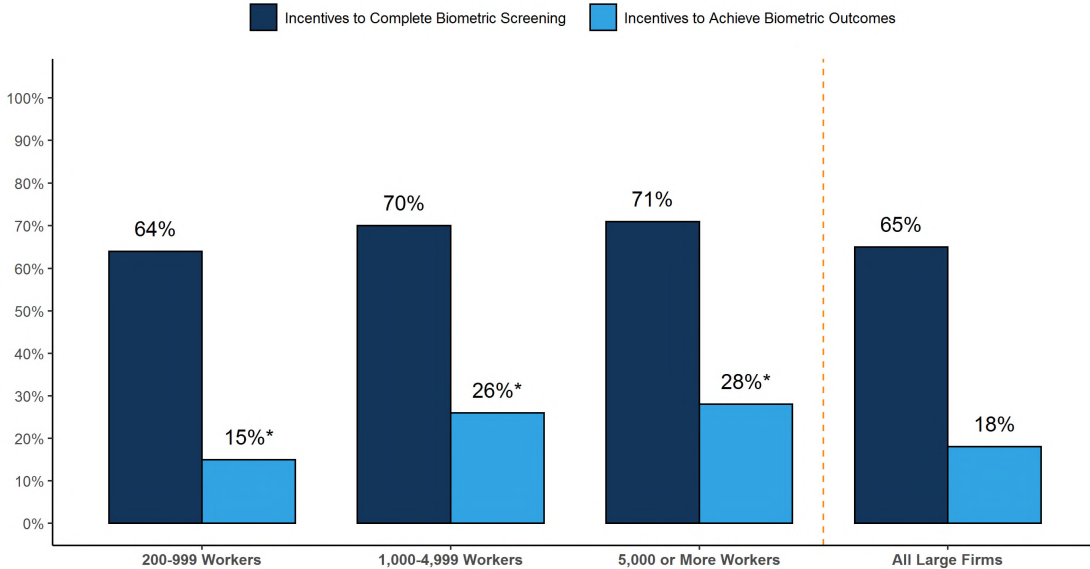


* Estimate is statistically different from estimate for the previous year shown (p < .05).

NOTE: Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Small Firms have 3-199 workers and Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2012-2017

Figure 12.6
Among Large Firms Offering Health Benefits and Providing an Opportunity to Complete a Biometric Screening, Percentage of Firms with Incentives to Complete the Screening or Achieve Biometric Outcomes, by Firm Size, 2020

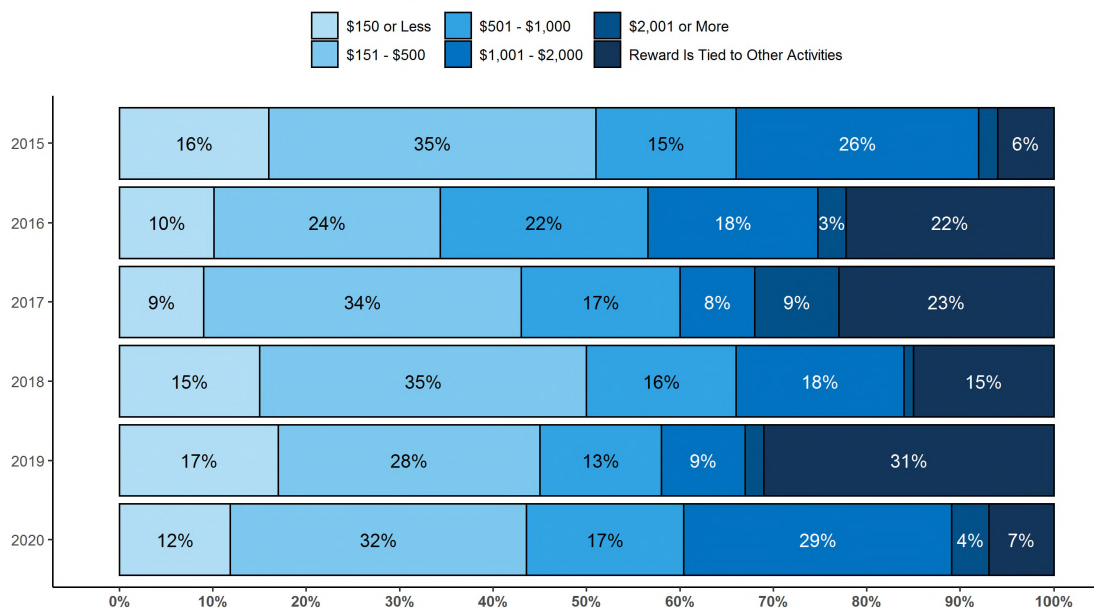


* Estimate is statistically different from estimate for all other firms not in the indicated size category (p < .05).

NOTE: Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.7
Among Large Firms Offering Workers an Incentive to Meet Biometric Outcomes, Maximum Value a Worker Can Receive for Achieving Outcomes, 2015-2020



Tests found no statistical difference from distribution for the previous year shown ($p < .05$).

NOTE: Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017

HEALTH SCREENING PROGRAMS

Among firms offering health benefits, 50% of small firms and 68% of large firms offer workers a health risk assessment, biometric screening or both screening programs.

- Forty percent of large firms offering health benefits have an incentive for workers to complete a biometric screening or health risk assessment [Figure 12.9].
- In large firms providing workers the opportunity to complete a health risk assessment, 44% of covered workers complete an assessment [Figure 12.11].
 - There is considerable variation across firms in the percentage of workers who complete the assessment. Twenty-one percent of large firms providing workers the opportunity to complete a health risk assessment report that more than 75% of their workers complete the assessment, while 37% report no more than 25% of workers complete the assessment.
- In large firms providing workers the opportunity to complete a biometric screening, 45% of covered workers complete a screening [Figure 12.11].
 - There is considerable variation across firms in the percentage of workers who complete a biometric screening. Twenty-one percent of large firms providing workers the opportunity to complete a biometric screening report that more than 75% of their workers complete the screening, while 33% report no more than 25% of workers complete the screening.

Figure 12.8

Among Large Firms Offering Health Benefits, Percentage of Firms That Provide an Opportunity to Complete a Biometric Screening or a Health Risk Assessment, by Region and Industry, 2020

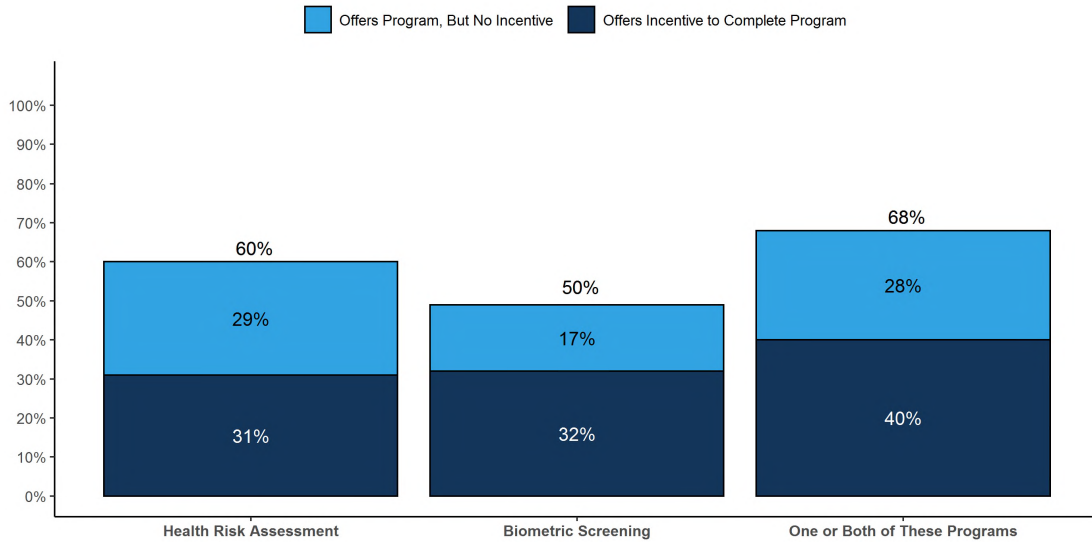
	Health Risk Assessment	Biometric Screening
REGION		
Northeast	55%	48%
Midwest	63	55
South	63	51
West	55	43
INDUSTRY		
Agriculture/Mining/Construction	58%	37%
Manufacturing	57	55
Transportation/Communications/Utilities	67	63
Wholesale	76	52
Retail	37*	29*
Finance	64	60
Service	60	47
State/Local Government	76*	71*
Health Care	51	40*
All Large Firms (200 or More Workers)	60%	50%

NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking.

* Estimate is statistically different from estimate for all firms not in the indicated region or industry category ($p < .05$).

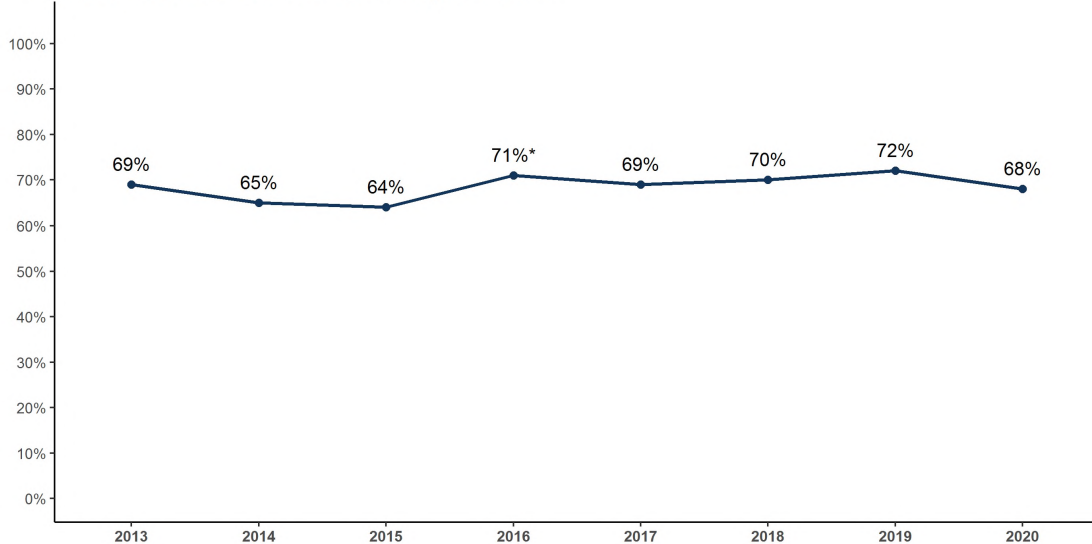
SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.9
Among Large Firms Offering Health Benefits, Percentage With Health Screening Programs, 2020



NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

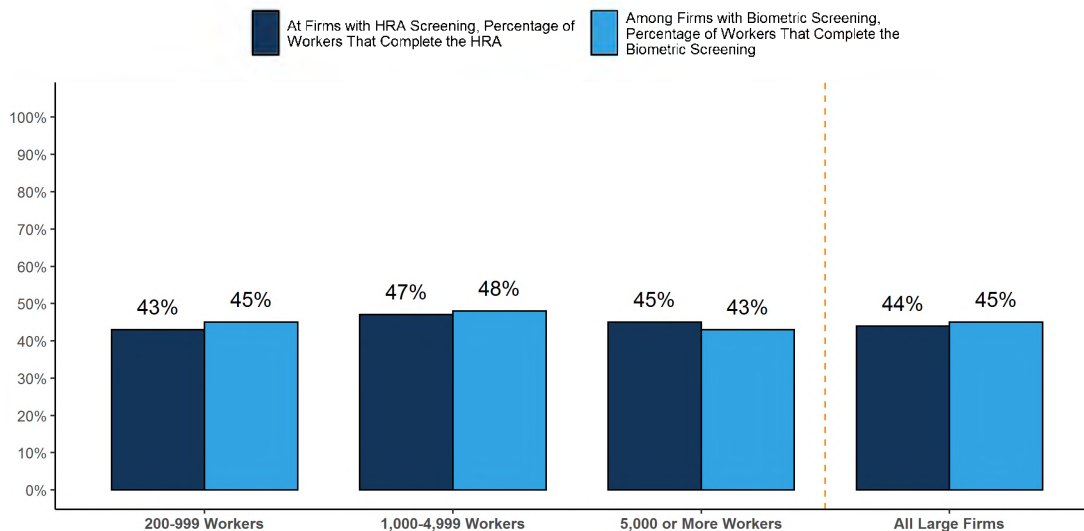
Figure 12.10
Among Large Firms Offering Health Benefits, Percentage With Either a Health Risk Assessment or a Biometric Screening, 2013-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).
 NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.11

Among Large Firms Providing Workers an Opportunity to Complete a Biometric Screening or Health Risk Assessment, Percentage of Workers That Complete the Screening, by Firm Size, 2020



Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).

NOTE: There is considerable variation around these averages. For Health Risk Assessments: At 8% of firms, less than 10% of workers complete the screening, while at 5% of firms more than 90% complete it. For Biometric Screening: At 8% of firms, less than 10% of workers complete the screening, while at 5% of firms more than 90% complete it. Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2020

WELLNESS AND HEALTH PROMOTION PROGRAMS

Large shares of employers continue to offer educational and other programs to help workers engage in healthy lifestyles and reduce health risks. Wellness and health promotion programs may include exercise programs, health education classes, health coaching, and stress-management counseling. These programs may be offered directly by the firm, an insurer, or a third-party contractor.

- Among firms offering health benefits, 41% of small firms and 69% of large firms offer programs to help workers stop smoking or using tobacco, 36% of small firms and 58% of large firms offer programs to help workers lose weight, and 38% of small firms and 67% of large firms offer some other lifestyle or behavioral coaching program. Overall, 53% of small firms and 81% of large firms offering health benefits offer at least one of these three programs [Figure 12.12] and [Figure 12.13].
- Forty-four percent of large firms offering one of these wellness or health promotion programs offer an incentive to encourage workers to participate in or complete the programs [Figure 12.15]

Figure 12.12

Among Firms Offering Health Benefits, Percentage of Firms Offering Specific Wellness Programs to Their Workers, by Firm Size and Region, 2020

	Programs to Help Workers Stop Smoking	Programs to Help Workers Lose Weight	Other Lifestyle or Behavioral Coaching	At Least One of These Programs
FIRM SIZE				
3-49 Workers	38%*	34%*	38%*	51%*
50-199 Workers	60*	47*	51*	72*
200-999 Workers	66*	56*	65*	79*
1,000-4,999 Workers	81*	67*	74*	89*
5,000 or More Workers	87*	78*	84*	95*
All Small Firms (3-199 Workers)	41%*	36%*	38%*	53%*
All Large Firms (200 or More Workers)	69%*	58%*	67%*	81%*
REGION				
Northeast	50%	41%	46%	62%
Midwest	40	29	34	49
South	41	41	42	62
West	37	33	31	40*
ALL FIRMS	41%	36%	38%	54%

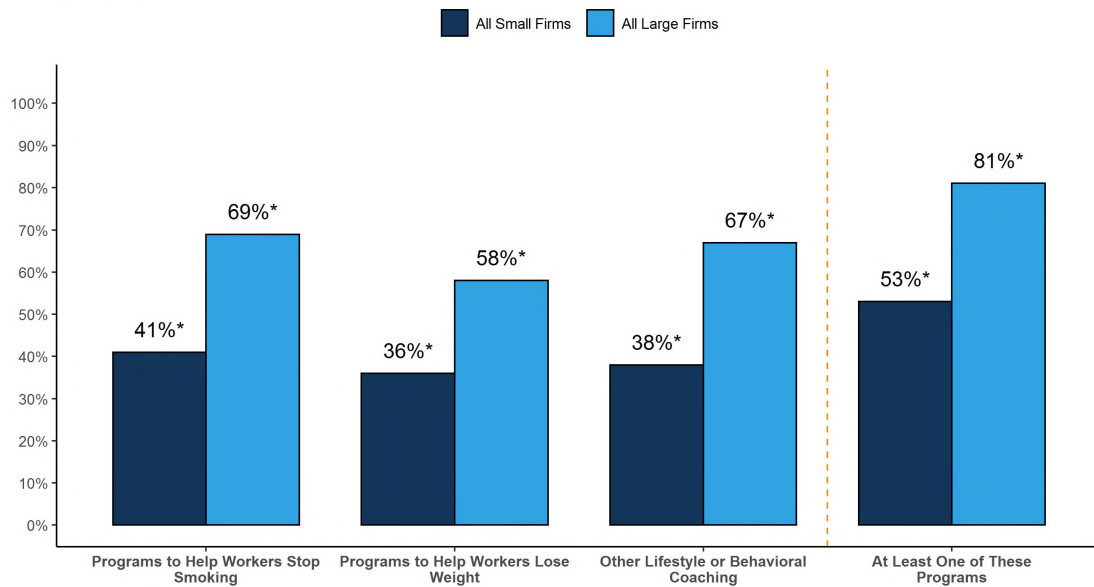
NOTE: 'Other Lifestyle or Behavioral Coaching' can include health education classes, stress management, or substance abuse counseling.

* Estimate is statistically different from estimate for all other firms not in the indicated size or region category (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.13

Among Firms Offering Health Benefits, Percentage of Firms Offering Specific Wellness Programs to Their Workers, by Firm Size, 2020

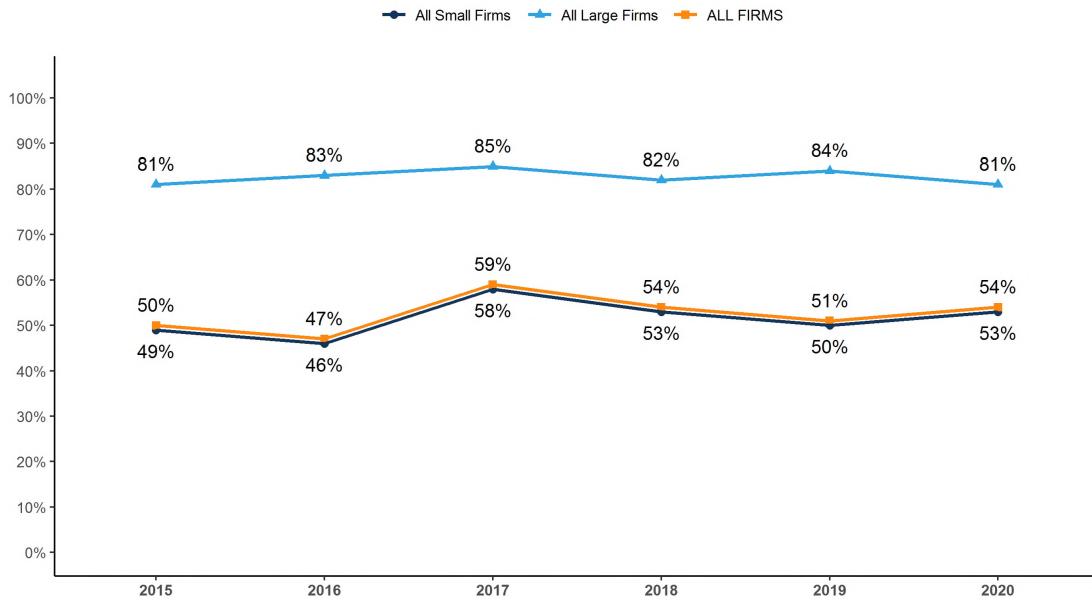


* Estimate is statistically different between All Small Firms and All Large Firms estimate (p < .05).

NOTE: 'Other Lifestyle or Behavioral Coaching' can include health education classes, stress management, or substance abuse counseling. Small Firms have 3-199 workers and Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.14
Among Firms Offering Health Benefits, Percentage of Firms Offering Wellness Programs, by Firm Size, 2015-2020

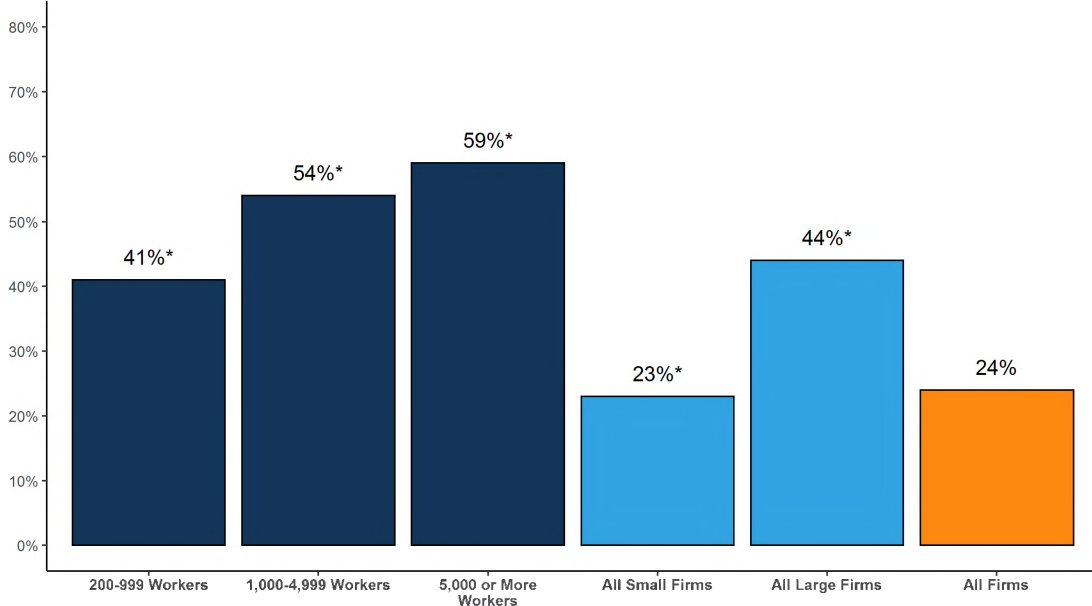


Tests found no statistical difference from estimate for the previous year shown ($p < .05$).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017

Figure 12.15
Among Firms Offering Specific Wellness Programs, Percentage of Firms That Offer Incentives to Participate In or Complete Wellness Programs, by Firm Size, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

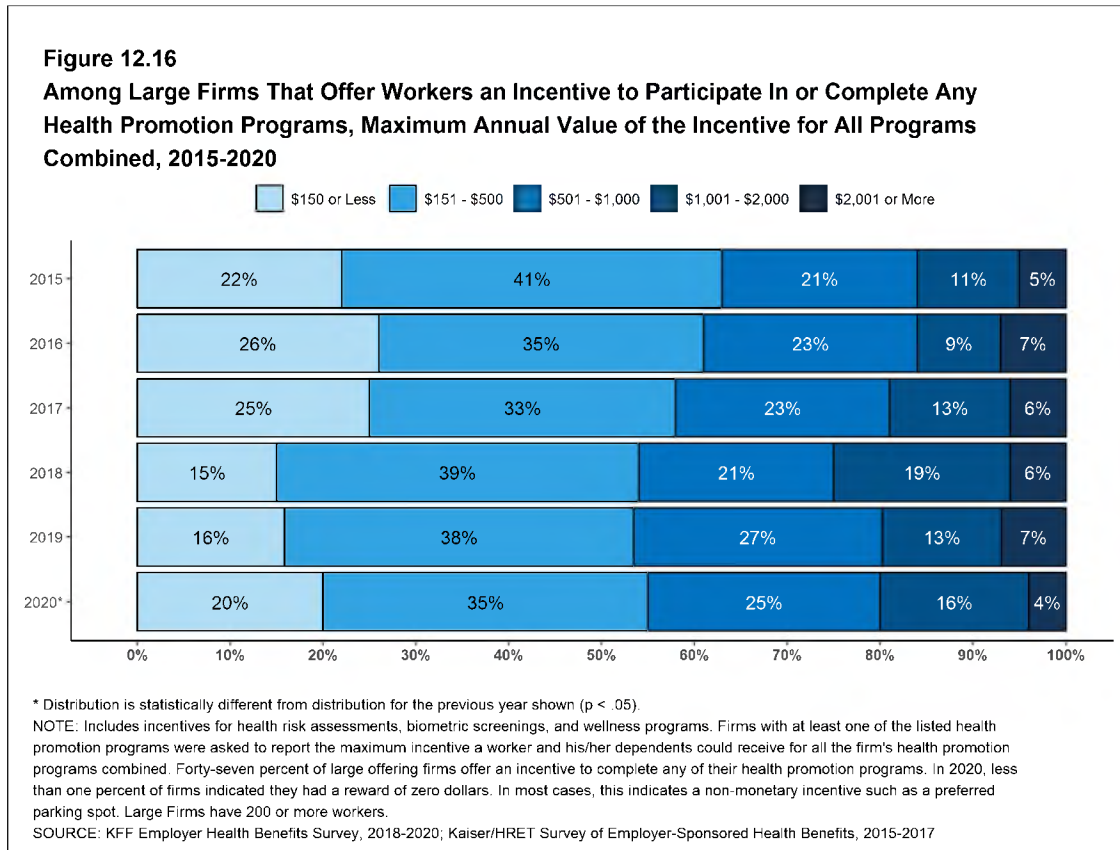
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2020

INCENTIVES FOR WELLNESS AND HEALTH SCREENING PROGRAMS

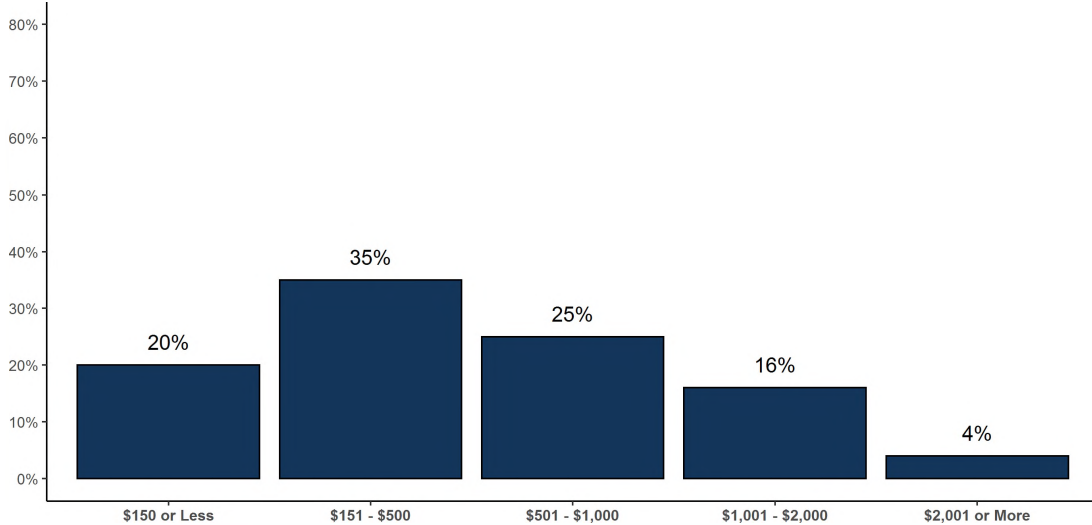
Firms with incentives for health risk assessments, biometric screenings, or wellness or health promotion programs were asked to report the maximum reward or penalty a worker could earn for all of the firm's health promotion activities combined. Some firms do not offer incentives for individual activities, but offer rewards to workers who complete a variety of activities.¹ Among large firms offering incentives for any of these programs, the maximum value for all wellness-related incentives is \$150 or less in 20% of firms and more than \$1,000 in 20% of firms [Figure 12.16].

- This year we asked large firms with an incentive to participate in a health promotion or health screening program, how effective they believed these incentives were at increasing employee participation. 30% believed incentives were 'very effective' and 47% said 'moderately effective'. [Figure 12.18].



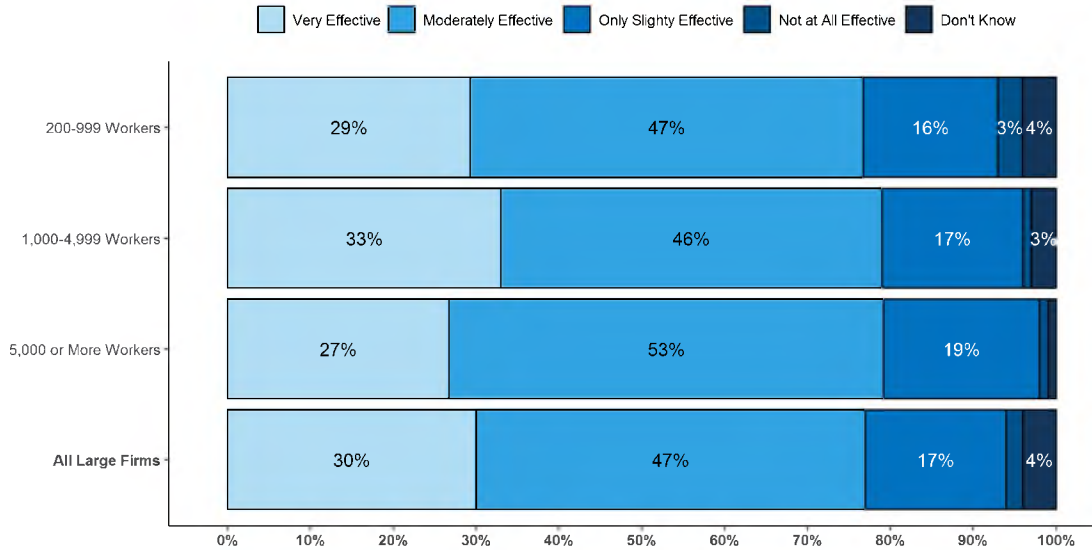
¹In 2020, less than one percent of firms indicated that they had an incentive for completing health risk assessments, biometric screenings, or wellness or health promotion programs, but had a maximum incentive of zero dollars. These firms may have non-monetary incentives such as preferred parking spots or employee recognition programs.

Figure 12.17
Among Large Firms Offering Workers an Incentive for Any Health Promotion Programs, Maximum Annual Value of the Incentive for All Programs Combined, 2020



NOTE: Includes incentives for health risk assessments, biometric screenings, and wellness programs. Firms with at least one of the listed health promotion programs were asked to report the maximum incentive a worker and his/her dependents could receive for all the firm's health promotion programs combined. Forty-seven percent of large offering firms offer an incentive to complete any of their health promotion programs. In 2020, less than one percent of firms indicated they had a reward of zero dollars. In most cases, this indicates a non-monetary incentive such as a preferred parking spot. Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.18
Among Large Firms Offering Health Benefits and an Incentive to Participate In or Complete Wellness or Health Screening Programs, Firms' Opinion on How Effective Incentives are for Employee Participation, by Firm Size, 2020



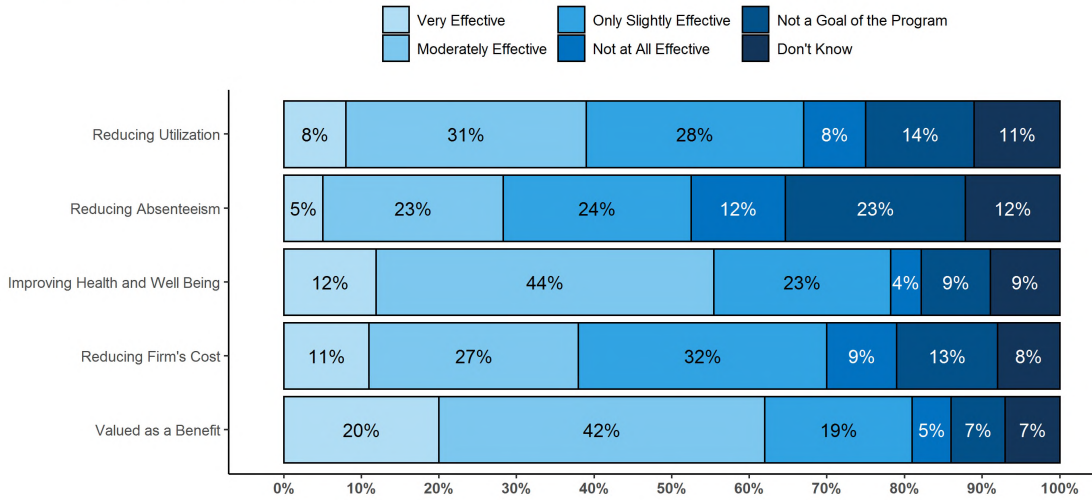
Tests found no statistical difference for response choice from estimate for all other large firms.
 NOTE: Includes incentives for health risk assessments, biometric screenings, and wellness programs. Forty-seven percent of large offering firms offer an incentive to complete any of their health promotion or health screening programs. Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

EFFECTIVENESS OF WELLNESS AND HEALTH SCREENING PROGRAMS

This year we asked firms offering one or more health promotion or health screening programs whether they believed the programs were effective in meeting certain objectives often offered as reasons to have these programs. Firms offering these programs may have different objectives for different programs, so we offered respondents the opportunity to say that a specific objective was not a goal of their programs.

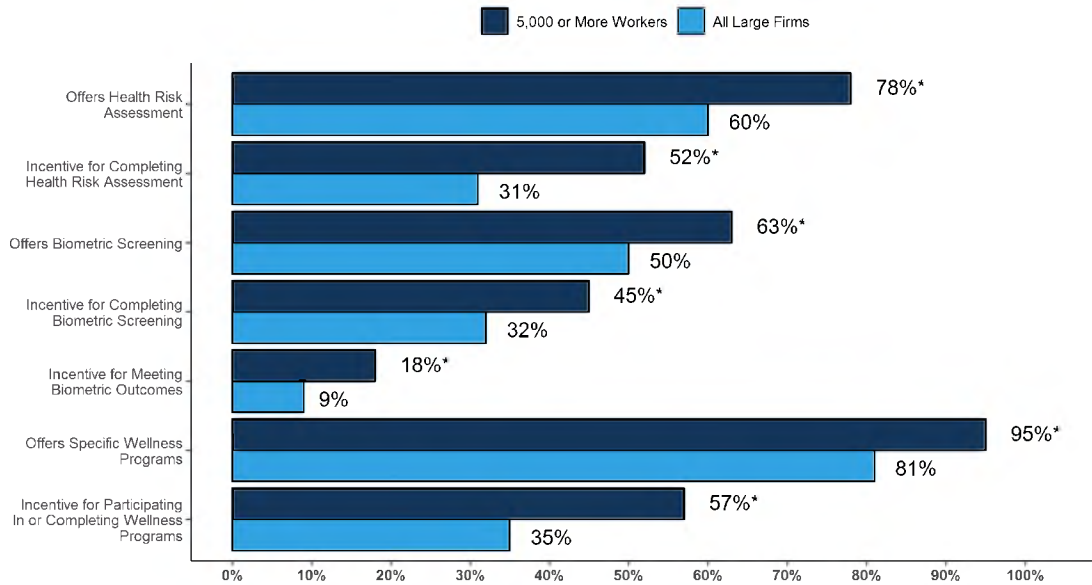
- Reducing utilization. Sixteen percent of small firms and 8% of large firms said that their programs were very effective in reducing utilization, 33% of small firms and 59% of large firms said that their programs were moderately or only slightly effective, while 8% of small firms and 8% of large firms said that their programs were not at all effective. Among large firms offering a health screening or wellness program, 14% said that reducing utilization was not a program goal and 11% said that they did not know.
- Reducing absenteeism. Twelve percent of small firms and 5% of large firms said that their programs were very effective in reducing employee absenteeism, 31% of small firms and 48% of large firms said that their programs were moderately or only slightly effective, while 13% of small firms and 12% of large firms said that their programs were not at all effective. Among large firms offering a health screening or wellness program, 23% said that reducing absenteeism was not a program goal and 12% said that they did not know.
- Improving enrollee health and well being. Fourteen percent of small firms and 12% of large firms said that their programs were very effective in improving enrollee health and well being, 44% of small firms and 66% of large firms said that their programs were moderately or only slightly effective, while 9% of small firms and 4% of large firms said that their programs were not at all effective. Among large firms offering a health screening or wellness program, 9% said that improving enrollee health and well being was not a program goal and 9% said that they did not know.
- Reducing the firm's health costs. Sixteen percent of small firms and 11% of large firms said that their programs were very effective in reducing the firm's health costs, 30% of small firms and 59% of large firms said that their programs were moderately or only slightly effective, while 16% of small firms and 9% of large firms said that their programs were not at all effective. Among large firms offering a health screening or wellness program, 13% said that reducing the firm's health costs was not a program goal and 8% said that they did not know.
- Being valued by employees as a benefit. Thirty-four percent of small firms and 20% of large firms said that their programs were very effective in being valued by employees as a benefit, 26% of small firms and 61% of large firms said that their programs were moderately or only slightly effective, while 6% of small firms and 5% of large firms said that their programs were not at all effective. Among large firms offering a health screening or wellness program, 7% said that being valued by employees as a benefit was not a program goal and 7% said that they did not know.

Figure 12.19
Among Large Firms Offering Health Benefits and a Wellness or Health Screening Programs, Firms Opinion of How Effective Programs are at Meeting Various Goals, 2020



NOTE: A health risk assessment or appraisal includes questions on medical history, health status, and lifestyle and is designed to identify the health risks of the person being assessed. Biometric screening is a health examination that measures a person's risk factors for certain medical issues. Biometric outcomes could include meeting a target body mass index (BMI) or cholesterol level, but not goals related to smoking. Wellness programs include programs to help employees lose weight, lifestyle or behavioral coaching or tobacco cessation programs. Among large firms offering health benefits, 87% have a health screening or wellness and/or health promotion program and 47% have an incentive to participate in at least one program. Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.20
Among Large Firms Offering Health Benefits, Percentage of Firms Offering Various Wellness and Health Promotion Activities and Incentives, by Firm Size, 2020



* Estimates are statistically different between firm size estimates within category (p < .05).
 NOTE: 'Specific Wellness Programs' include 'Programs to Help Workers Stop Smoking', 'Programs to Help Workers Lose Weight', or 'Other Lifestyle or Behavioral Coaching'. Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

SURCHARGES AND INCENTIVES RELATED TO TOBACCO USE

Some firms require employees that use tobacco products to pay higher premium contributions or cost sharing.

- Nine percent of firms offering health benefits have higher premium contributions or cost-sharing for employees who use tobacco products or vape. Five percent of firms offering health benefits provide employees with some form of direct payment (such as a higher account contribution) based on whether or not an employee uses tobacco products or vapes. Some firms noted that not smoking is a condition of employment.
 - Among firms with one of these incentives (higher premium contributions or cost sharing, or direct payments or account contributions), 52% say that the maximum incentive or penalty for an employee based on the employees smoking status was \$150 or less, 32% say the maximum amount was between \$151 and \$500, and 15% say the maximum amount was between \$501 and \$1,000 [Figure 12.22].
 - Among firms with 1,000 or more employees with tobacco cessation programs, 53% say that their program targets people who use electronic cigarettes (known as vaping), 19% say the program does not target vaping, and 28% did not know [Figure 12.23].

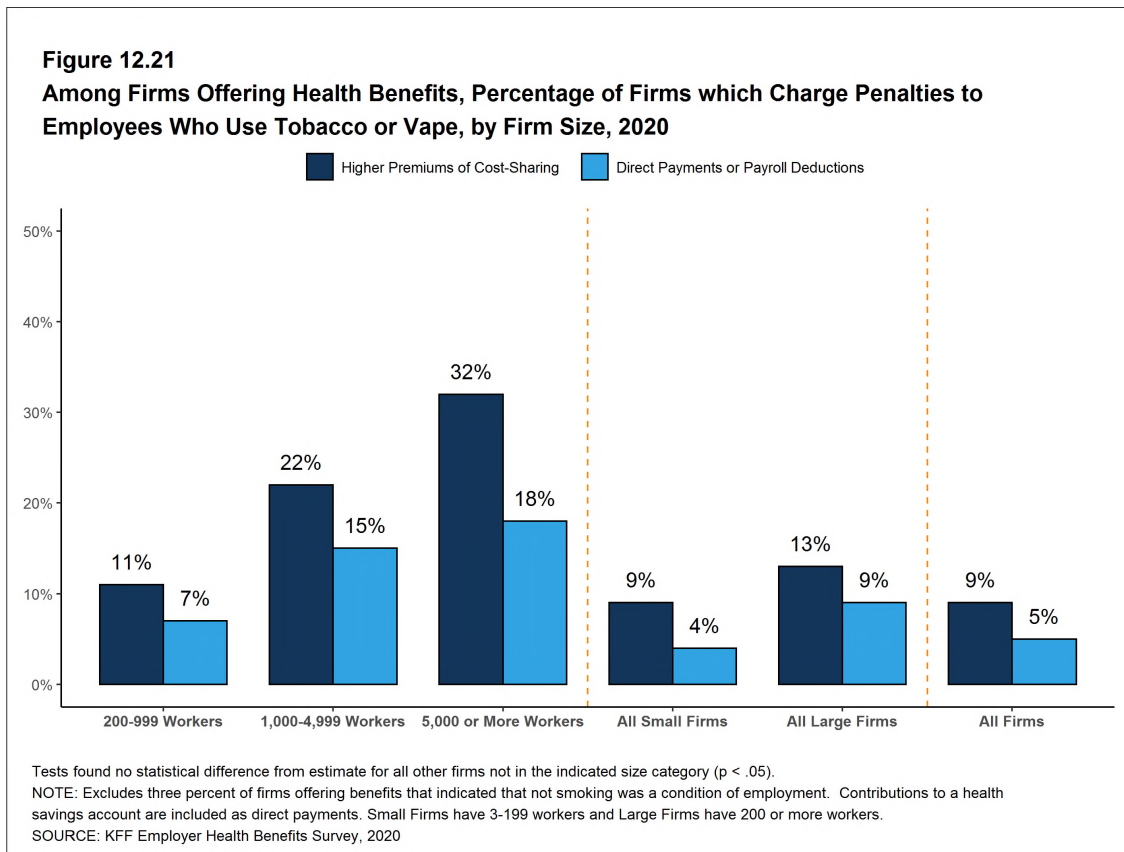
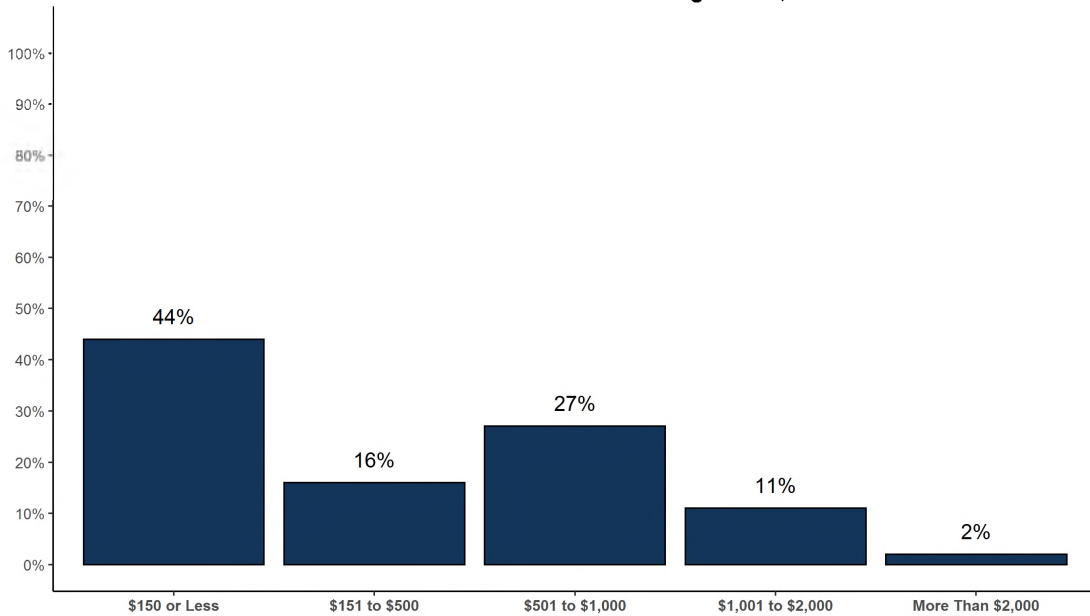
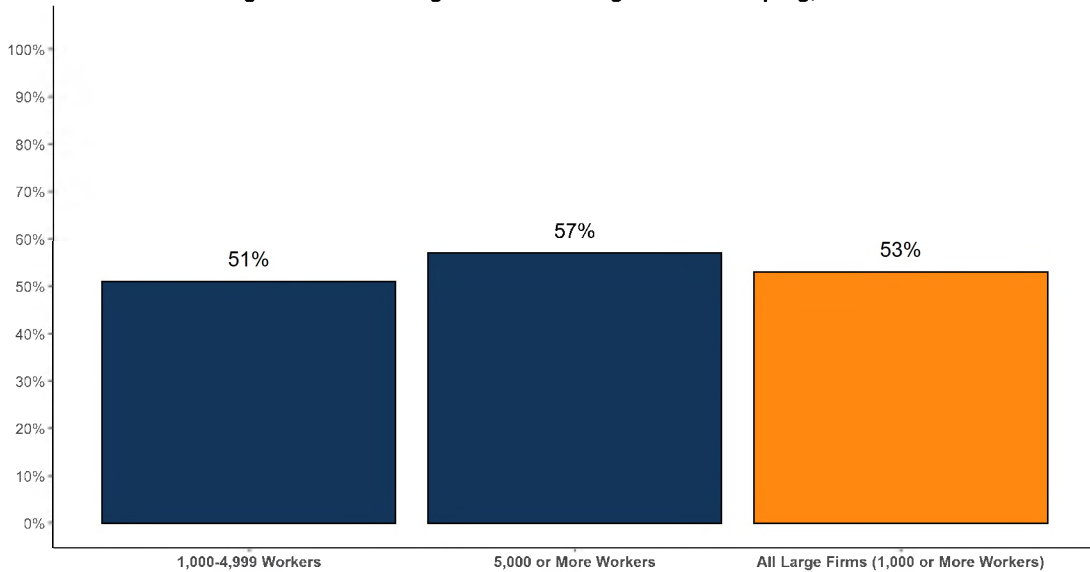


Figure 12.22
Among Large Firms Offering Workers an Incentive or Penalty for Smoking or Vaping, Maximum Annual Value of the Incentive Based on an Enrollee's Smoking Status, 2020



NOTE: Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 12.23
Among Firms with 1,000 or More Workers That Offer Smoking Cessation Programs, Percent of Firms that Offer Programs Which Target Electronic Cigarettes or Vaping, 2020



Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$)

NOTE: Among firms offering health benefits, 82% of firms with 1,000 or more employees offer a smoking cessation program, including 87% of firms with 5,000 or more workers. Among those firms with 1,000 or more employees offering a smoking cessation program, 28% did not know if that program targeted electronic cigarettes.

SOURCE: KFF Employer Health Benefits Survey, 2020

EMPLOYER HEALTH BENEFITS
2020 ANNUAL SURVEY

Employer Practices,
Alternative Sites of
Care and Provider
Networks

SECTION

13

Section 13

Employer Practices, Alternative Sites of Care and Provider Networks

Employers frequently review and modify their health plans to incorporate new options or adapt to new circumstances. We monitor new options, such as telemedicine, and ask about changes in the health or policy environments. This year employers have been dealing with the coronavirus pandemic, which affects health, access to care, workplace health programs and even open enrollments. Because the survey started fielding in January, before the full impacts of the pandemic became apparent, we did not include questions about employers responses to it this year.

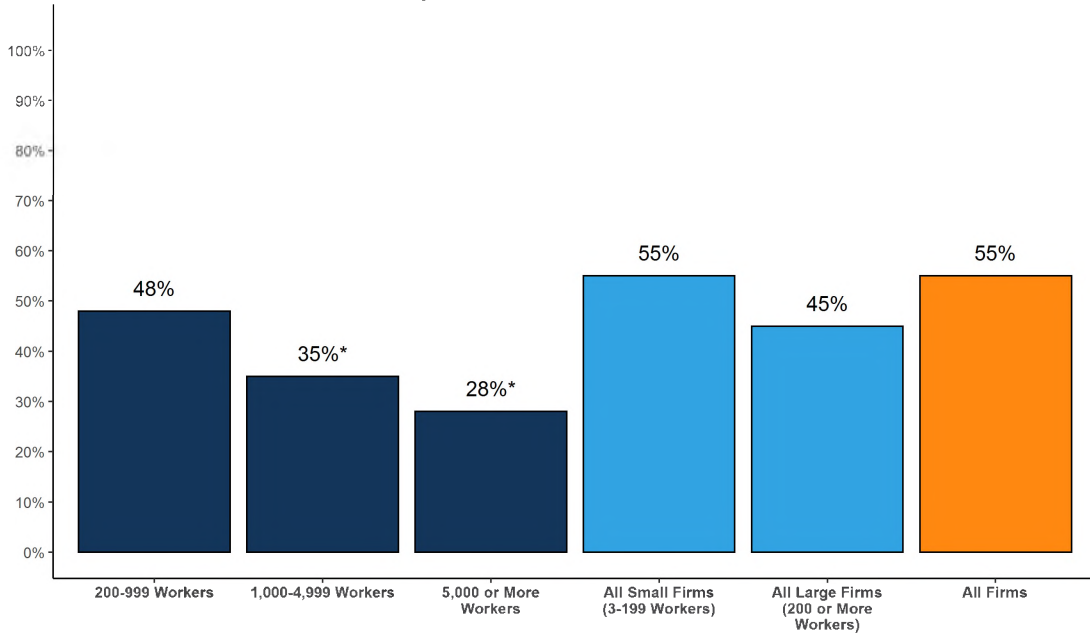
We note that there is a significant increase in the percentage of firms, particularly smaller firms (50-199 workers), reporting that they cover some services through telemedicine. While telemedicine has grown in recent years, it is possible that some of the growth reflects plan changes in response to the coronavirus pandemic as well as to the increased awareness in telemedicine that has occurred over the spring and summer. About one-half of the responses to this year's survey occurred after March, which is when people began to shelter at home and seek alternative ways to get medical care. It will be important to monitor how plans and employers adapt over the longer term when concerns over the coronavirus have ended.

SHOPPING FOR HEALTH COVERAGE

Fifty-five percent of firms offering health benefits reported shopping for a new health plan or a new insurance carrier in the past year, similar to the percentage last year. Firms with 5,000 or more workers were less likely to shop for coverage (28%) than firms in other size categories [Figure 13.1].

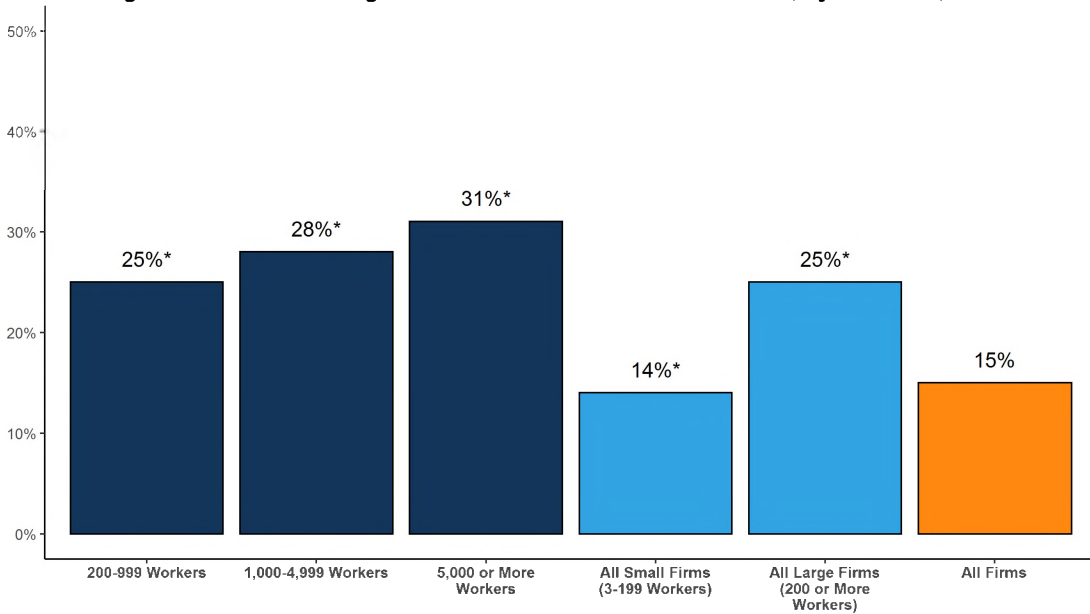
- Among firms that offer health benefits and who shopped for a new plan or carrier in the past year, 15% changed insurance carriers [Figure 13.2].

Figure 13.1
Percentage of Firms Offering Health Benefits That Shopped For a New Plan or Health Insurance Carrier in the Past Year, by Firm Size, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 13.2
Among Firms Offering Health Benefits That Shopped for a New Plan or Insurance Carrier, Percentage of Firms That Changed Insurance Carriers in the Past Year, by Firm Size, 2020



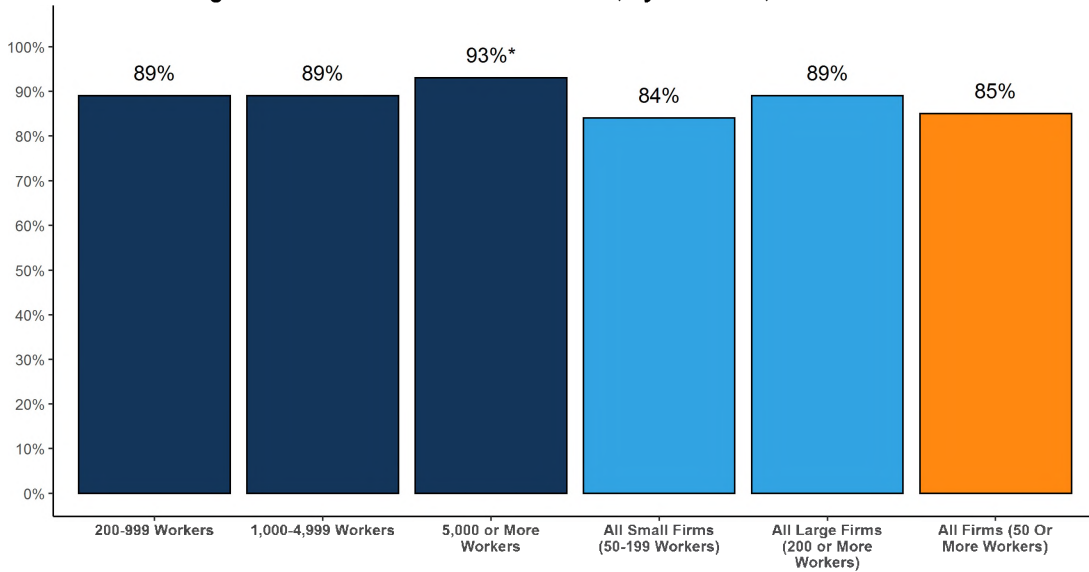
* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
 NOTE: In 2020, 55% of firms offering health benefits shopped for a new plan.
 SOURCE: KFF Employer Health Benefits Survey, 2020

ALTERNATIVE CARE SETTINGS: TELEMEDICINE AND RETAIL CLINICS

Many firms provide coverage for health services delivered outside typical provider settings. Telemedicine is the delivery of health care services through telecommunications to a patient from a provider who is at a remote location, including video chat and remote monitoring. This generally would not include the mere exchange of information via email, exclusively web-based resources, or online information a plan may make available unless a health professional provides information specific to the enrollee's condition. We note that during the coronavirus pandemic, some plans have eased their definitions to allow more types of digital communication to be reimbursed.

- Eighty-five percent of firms with 50 or more workers that offer health benefits cover the provision of some health care services through telemedicine in their largest health plan, a significant increase from the percentage (69%) in 2019. [Figure 13.3].
 - Over the last year, the percentage of small firms (50-199 workers) reporting that they cover services through telemedicine increased from 65% last year to 84% this year and the percentage of large firms increased from 82% to 89% [Figure 13.5].
 - Among firms with 50 or more workers with plans that cover health services through telemedicine, 46% provide a financial incentive for workers to use telemedicine instead of visiting a traditional physician's office in-person, similar to the percentage in 2019 [Figure 13.4].
- Seventy-nine percent of firms with 10 or more employees that offer health benefits cover health care services received in retail clinics, such as those located in pharmacies, supermarkets and retail stores, in their largest health plan [Figure 13.6]. These clinics are often staffed by nurse practitioners or physician assistants and treat minor illnesses and provide preventive services.
 - Among firms with 10 or more employees covering health services received in retail clinics in their largest plan, 17% provide a financial incentive for workers to use a retail health clinic instead of visiting a traditional physician's office [Figure 13.6].

Figure 13.3
Among Firms with 50 or More Workers Offering Health Benefits, Percentage of Firms Whose Plan with the Largest Enrollment Covers Telemedicine, by Firm Size, 2020

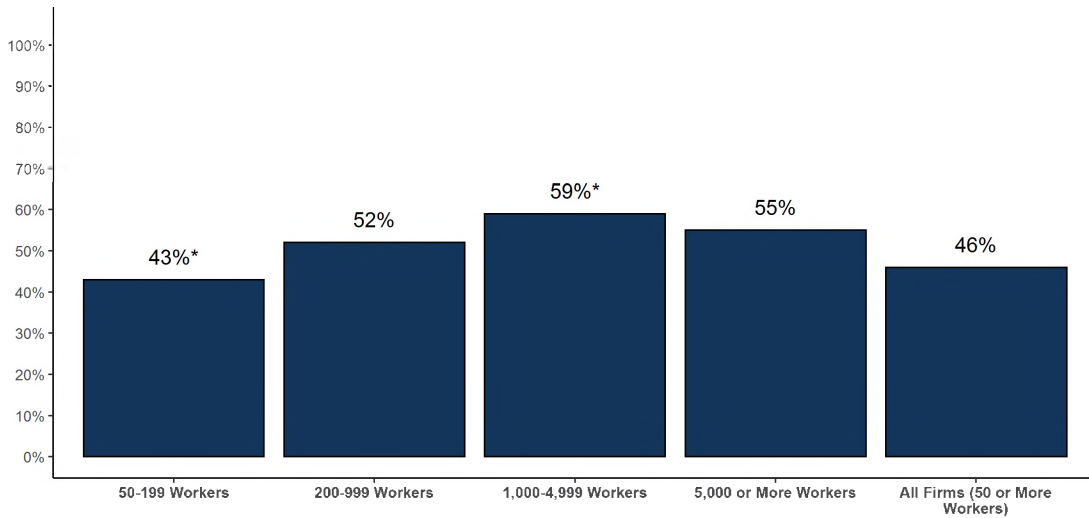


* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

NOTE: Telemedicine is the delivery of health care services through telecommunications to a patient from a provider who is at a remote location, including video chat and remote monitoring. This would not include the mere exchange of information via email, exclusively web-based resources, or online information a plan may make available unless a health professional provides information specific to the enrollee's condition.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 13.4
Among Firms with 50 or More Workers Whose Plan with the Largest Enrollment Covers Telemedicine, Percentage of Firms with Lower Cost-Sharing for Telemedicine, by Firm Size, 2020

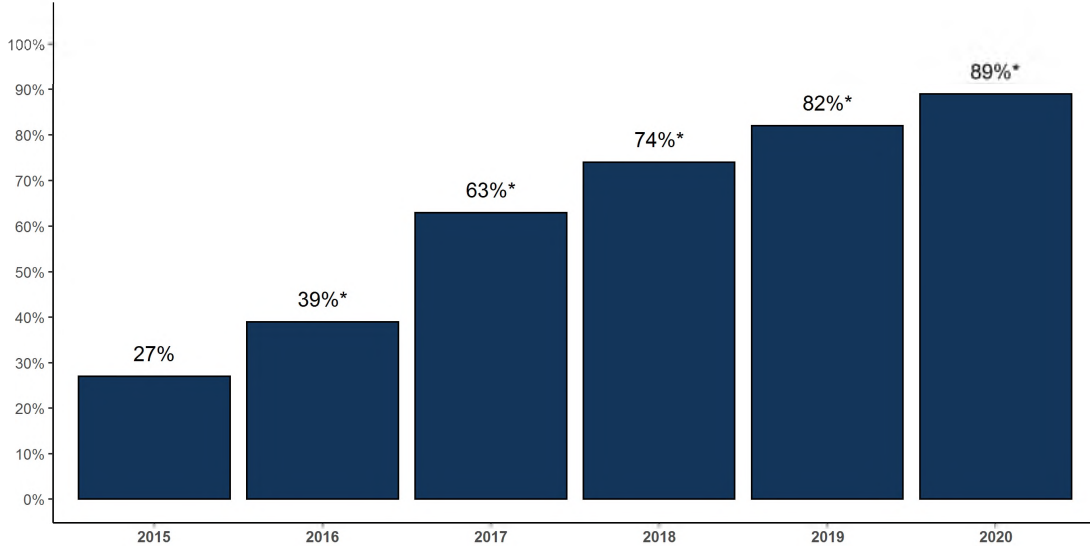


* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

NOTE: Telemedicine is the delivery of health care services through telecommunications to a patient from a provider who is at a remote location, including video chat and remote monitoring. This would not include the mere exchange of information via email, exclusively web-based resources, or online information a plan may make available unless a health professional provides information specific to the enrollee's condition. Lower cost-sharing may include reduced copays or coinsurances.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 13.5
Among Large Firms Offering Health Benefits, Percentage of Firms Whose Plan with the Largest Enrollment Covers Telemedicine, 2015-2020

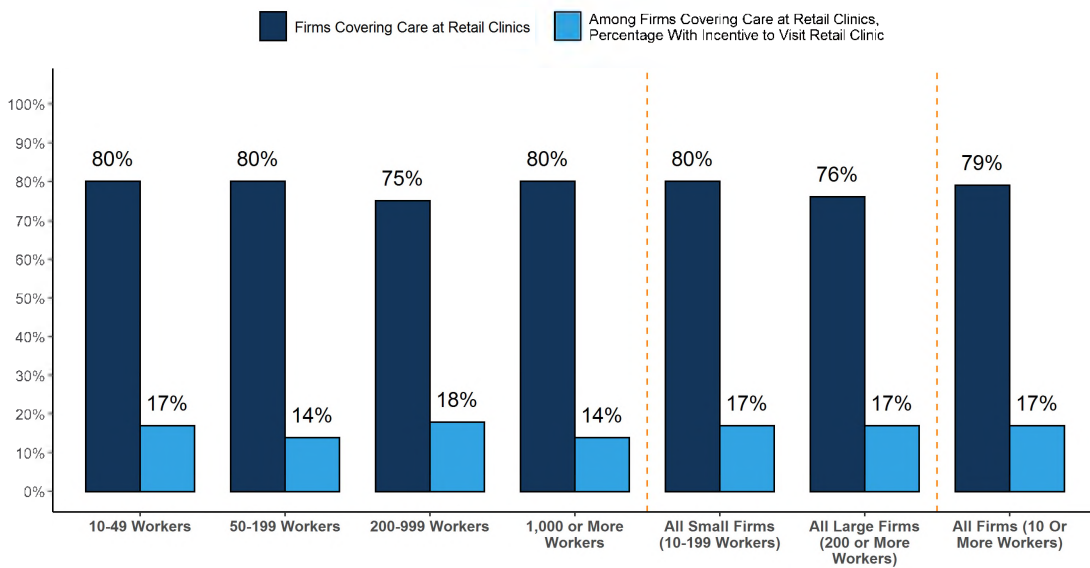


* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: Telemedicine is the delivery of health care services through telecommunications to a patient from a provider who is at a remote location, including video chat and remote monitoring. This would not include the mere exchange of information via email, exclusively web-based resources, or online information a plan may make available unless a health professional provides information specific to the enrollee's condition. Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017

Figure 13.6
Among Firms with 10 or More Workers Offering Health Benefits, Percentage of Firms Whose Plan with the Largest Enrollment Covers Care at Retail Clinics, by Firm Size, 2020



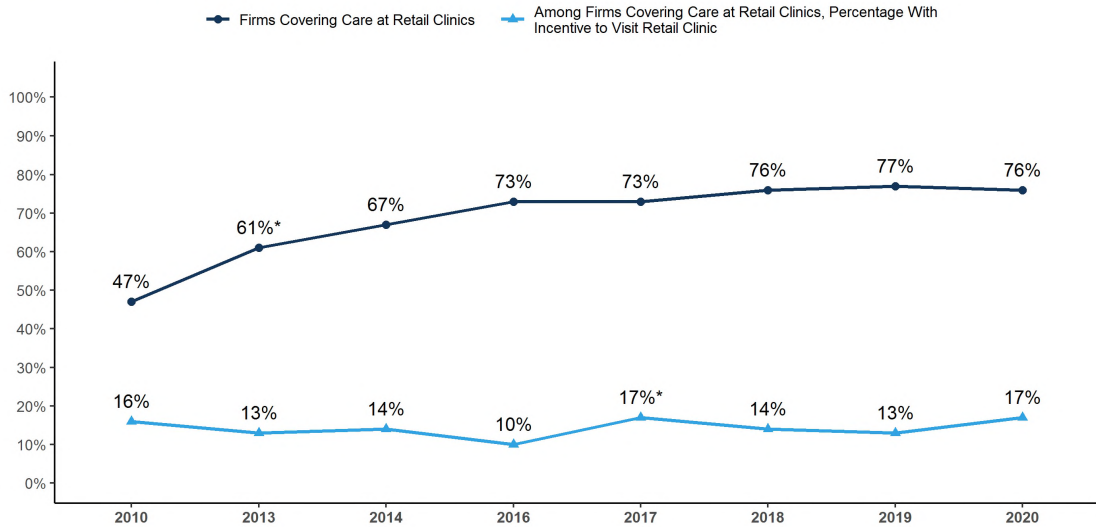
Tests found no statistical difference from estimate for all other firms not in the indicated size category ($p < .05$).

NOTE: A retail clinic is a health care clinic located in a retail store, supermarket, or pharmacy that treats minor illnesses and provides preventive health care services such as flu shots. Financial incentives include lower cost sharing for care received at retail clinics instead of traditional physician offices.

SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 13.7

Among Large Firms Offering Health Benefits, Percentage of Firms Whose Plan with the Largest Enrollment Covers Care at Retail Clinics and That Have a Financial Incentive for Workers to Visit Retail Clinics Instead of a Physician's Office, 2010-2020



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: A retail clinic is a health care clinic located in a retail store, supermarket, or pharmacy that treats minor illnesses and provides preventive health care services such as flu shots. Financial incentives include lower cost sharing for care received at retail clinics instead of traditional physician offices. Large Firms have 200 or more workers.

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2010-2017

FIRM APPROACHES TO PLAN NETWORKS

Firms and health plans can structure their networks of providers and their cost sharing to encourage enrollees to use providers who are lower cost or who provide better care. Periodically we ask employers about network strategies, such as using tiered or narrow networks.

- Employers overall report being quite satisfied with the choice of provider networks made available to them by their insurer or plan administrator.
 - Among employers offering health benefits, 45% of firms report being ‘very satisfied’ and 38% report being ‘satisfied’ by the choice of provider networks available to them. Large firms are more likely to be ‘very satisfied’ with the available network choices than smaller firms. [Figure 13.8].
 - Employers are somewhat less satisfied with the cost of the provider networks available to them from their insurer or administrator. Among employers offering health benefits, only 22% of firms report being ‘very satisfied’ while 39% report being ‘satisfied’ with the cost of provider networks available to them. Small firms are more likely to be ‘very dissatisfied’ with the cost of the provider networks available to them [Figure 13.8].
- One way that employers and health plans can affect the cost and quality of services in their provider networks is to eliminate hospitals or health systems that are not performing well.
 - Only a small share (4%) of firms offering health benefits say that either they or their insurer eliminated a hospital or health system from a provider network during the past year in order to reduce the plan’s cost [Figure 13.9].

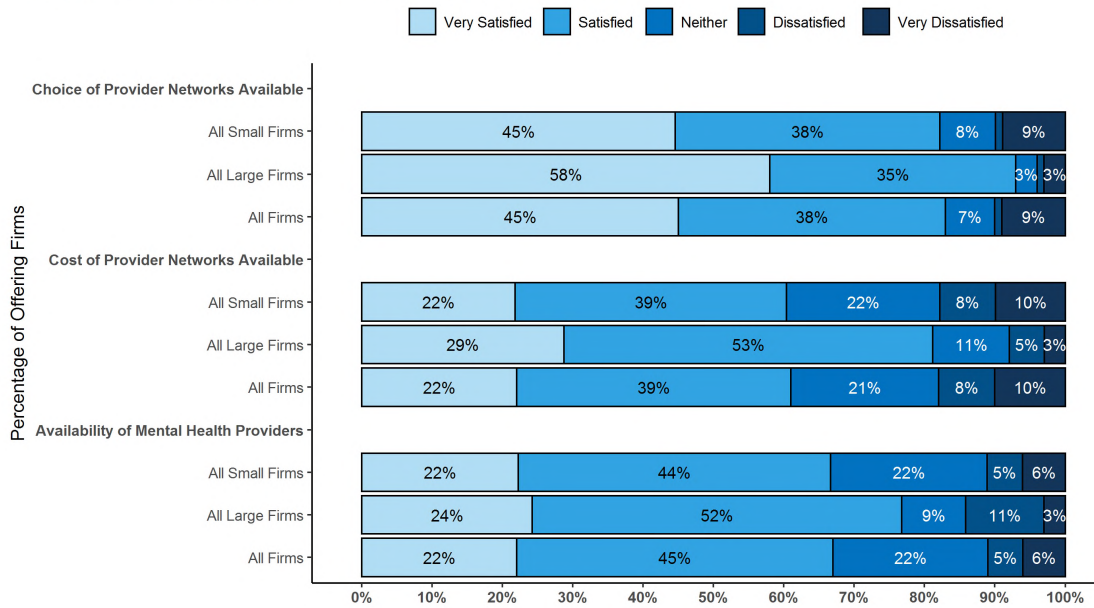
- Another approach that employers can use is to offer a health plan with a relatively small, or narrow network of providers. Narrow network plans limit the number of providers that can participate in order to reduce costs and generally are more restrictive than standard HMO networks.
 - Seven percent of firms offering health benefits report that they offer at least one plan that they considered to be a narrow network plan, similar to the percentage reported last year [Figure 13.9].
 - Firms with 5,000 or more workers offering health benefits are more likely than firms of other sizes to offer at least one plan with a narrow network (26%) [Figure 13.9].
- Employers offering health benefits were asked to characterize the breadth of the provider network in their plan with the largest enrollment. Fifty-one percent of firms say that the network in the plan with the largest enrollment is ‘very broad’, 42% say it is ‘somewhat broad’, and 6% say it is ‘somewhat narrow’ [Figure 13.11].

Employees with mental or behavioral health claims disproportionately receive services from providers outside of plan networks.¹ The coronavirus pandemic has placed a spotlight on the importance of mental and behavioral health care and access to these services, and many plans have been able to enhance access to these services through telemedicine. We asked employers if they were satisfied with the availability of mental health providers in their provider networks. We note that the survey was conducted between January and July this year, so it is possible that employer views changed over the period as the scope of the pandemic became more apparent and as alternative means of providing services became available.

- Only about one-in-five (22%) employers is very satisfied with the availability of mental health providers in their provider networks. The share does not vary with firm size [Figure 13.8].
- Employers offering health benefits also were asked to characterize the breadth of the network for mental health and substance abuse in their plan with the largest enrollment. Thirty-five percent of firms say that the network for mental health and substance abuse in the plan with the largest enrollment is ‘very broad’, 46% say it is ‘somewhat broad’, 15% say it is ‘somewhat narrow’, and 4% say it is ‘very narrow’. The responses do not vary for by firm size. [Figure 13.11]
- Among employers with 50 or more employees offering health benefits, 9% asked their insurer or third party administrator to increase access to in-network mental health and substance abuse providers over the last two years. Firms with 1,000 or more employees were more likely to request more in-network access for these services [Figure 13.12].

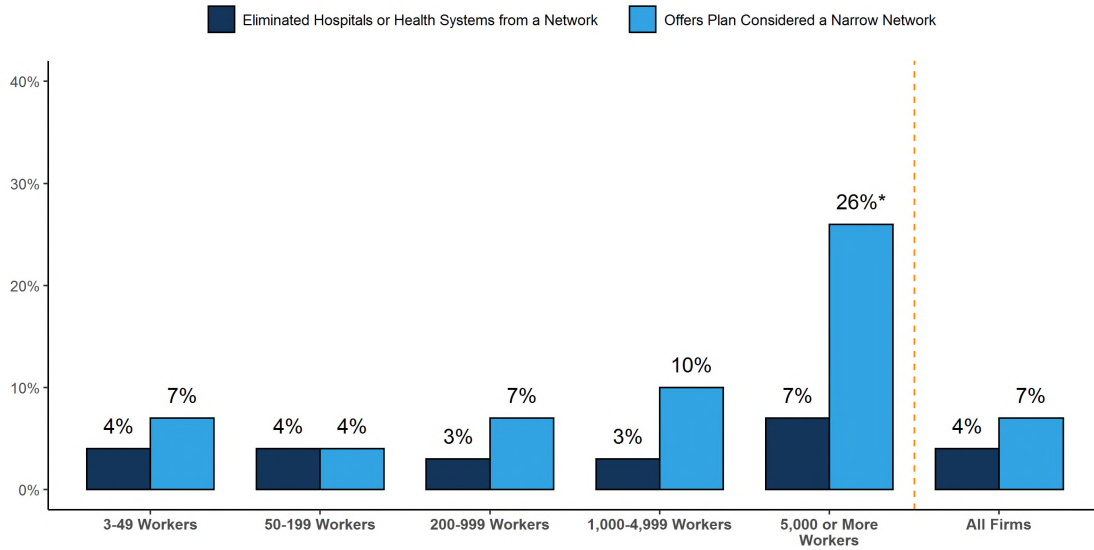
¹Pollitz K, Rae M, Claxton G, Cox C, Levitt L. An examination of surprise medical bills and proposals to protect consumers from them [Internet]. Peterson-KFF Health System Tracker. 2020 [cited 2020 Aug 10]. Available from: <https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them-3/> Rae M, Cox C, Claxton G. Coverage and utilization of telemedicine services by enrollees in large employer plans [Internet]. Peterson-KFF Health System Tracker. 2020 [cited 2020 Aug 31]. Available from: <https://www.healthsystemtracker.org/brief/coverage-and-utilization-of-telemedicine-services-by-enrollees-in-large-employer-plans/>

Figure 13.8
Among Firms Offering Health Benefits, Satisfaction with Provider Networks Available from Insurer or Third Party Administrator, by Firm Size, 2020



NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers.
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 13.9
Among Firms Offering Health Benefits, Percentage of Firms That Eliminated Hospitals From Any of Their Networks in the Past Year to Reduce Cost or Offer a Narrow Network Plan, by Firm Size, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
 NOTE: Narrow network plans limit the number of providers that can participate in order to reduce costs and generally are more restrictive than standard HMO networks.
 SOURCE: KFF Employer Health Benefits Survey, 2020

SECTION 13. EMPLOYER PRACTICES, ALTERNATIVE SITES OF CARE AND PROVIDER NETWORKS

Figure 13.10
Among Firms With 50 or More Workers Offering Health Benefits, Percentage of Firms That Eliminated Hospitals From Any of Their Networks in Past Year to Reduce Cost or Offer a Narrow Network Plan, by Firm Size, 2014-2020

	2014	2015	2016	2017	2018	2019	2020
Eliminated Hospitals or Health Systems From Network							
All Small Firms (50-199 Workers)	8%	6%	6%	8%	9%	7%	4%
All Large Firms (200 or More Workers)	6	5	6	8	5*	6	6
ALL FIRMS (50 or More Workers)	8%	6%	6%	8%	8%	6%	5%
Offers Plan Considered Narrow Network							
All Small Firms (50-199 Workers)	6%	4%	4%	4%	6%	4%	4%
All Large Firms (200 or More Workers)	6	6	5	3	3	3	3
ALL FIRMS (50 or More Workers)	6%	5%	4%	4%	6%	4%	4%

NOTE: This question was asked of offering firms with 50 or more workers in 2014, but has since been asked of all offering firms regardless of firm size. In 2020, 4% of all offering firms eliminated a hospital or health system from their network and 7% of all offering firms offer a plan that could be considered a narrow network plan. Narrow network plans limit the number of providers that can participate in order to reduce costs and generally are more restrictive than standard HMO networks.

* Estimate is statistically different from estimate for the previous year shown (p < .05).

SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2014-2017

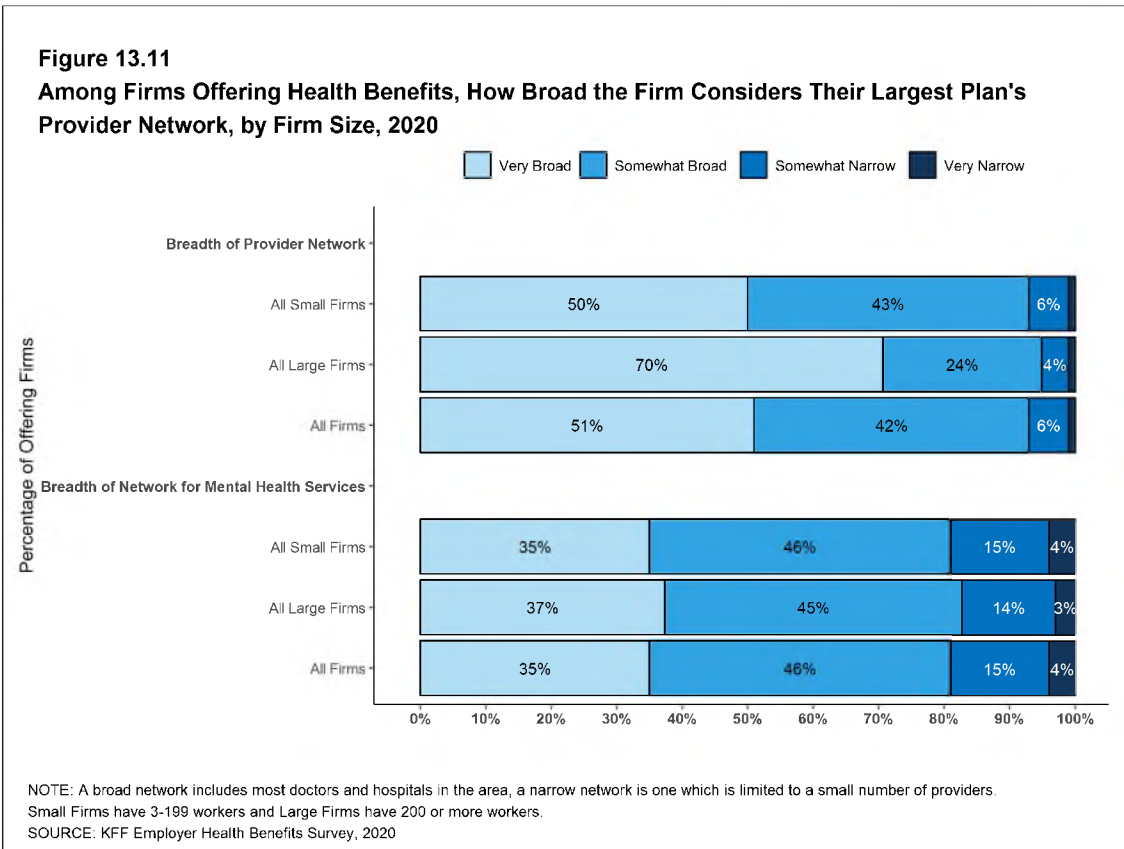
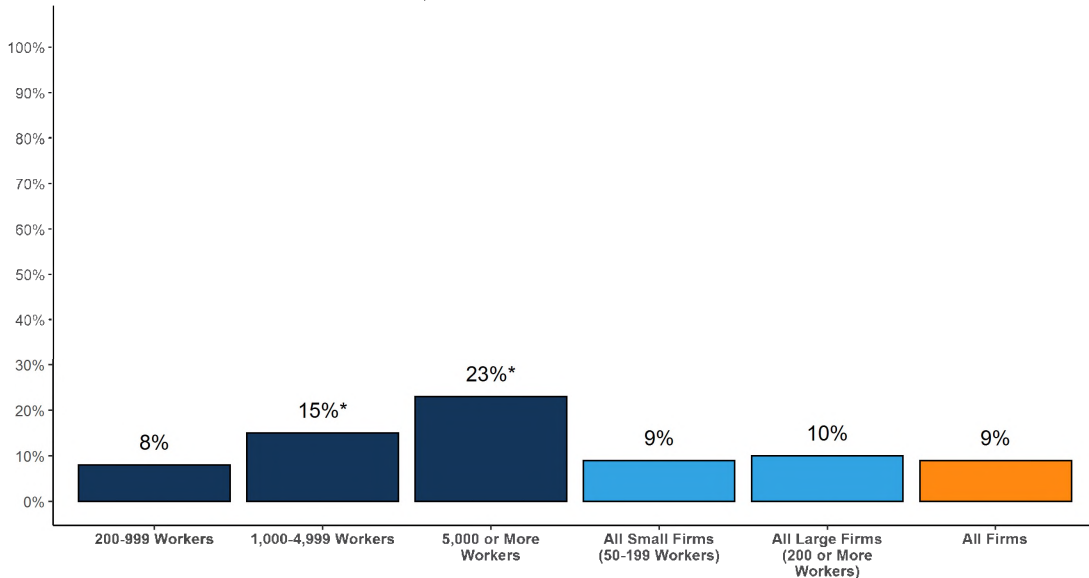


Figure 13.12
Percentage of Firms (50 or More Workers) Offering Health Benefits That Have Asked Insurers or TPAs to Increase Access to In-Network Mental Health or Substance Abuse Providers Within the Last Two Years, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).

NOTE: TPA refers to third party administrator.

SOURCE: KFF Employer Health Benefits Survey, 2020

CHRONIC CONDITIONS

In recent years employers and health plans have taken steps to encourage people with chronic illnesses to obtain the services they may need to maintain their health. Efforts may include communications, case and disease management, or reducing financial barriers, such as cost sharing.

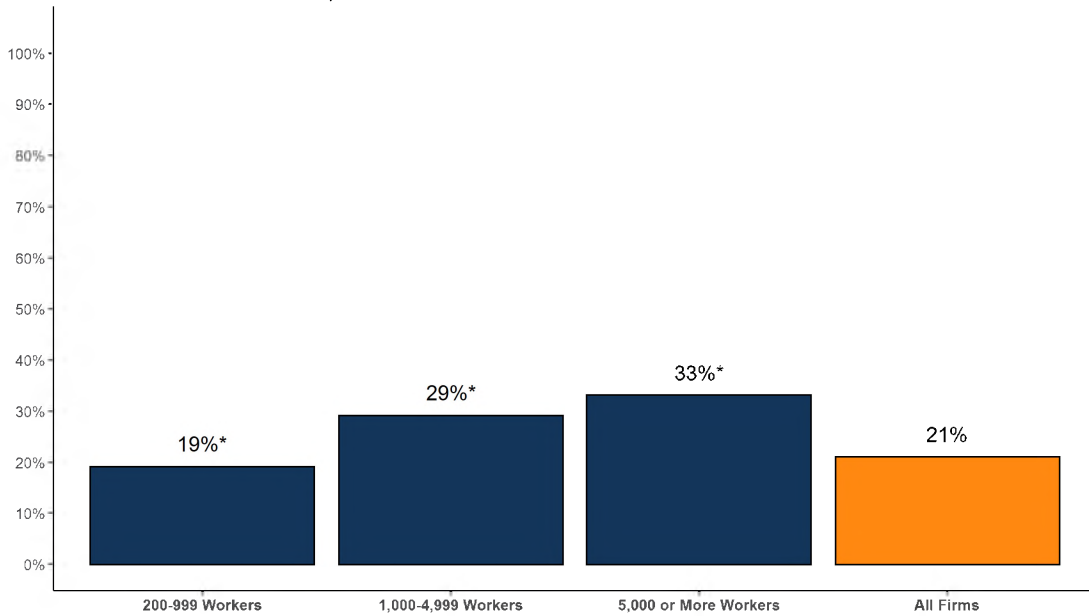
- Among employers with 200 or more employees offering health benefits, 21% say that their health plan with the largest enrollment waives cost sharing for some medications or supplies to encourage employees with chronic illnesses to follow their treatment. This likelihood increases with firm size [Figure 13.13].

In 2019, the federal government issued new rules that expanded the number and types of items and services that may be considered preventive by HSA-qualified health plans, which means that plan sponsors may pay for part or all of these services before enrollees meet the plan deductibles in these plans².

- Among employers with 200 or more employees offering an HSA-qualified health plan, 29% say that they changed the services or products that individuals with chronic conditions could receive without first meeting their deductibles. Firms with 5,000 or more employees (48%) are more likely and firms with 200 to 999 employees are less likely (26%) to say they changed the services or products available before the deductible is met [Figure 13.14].

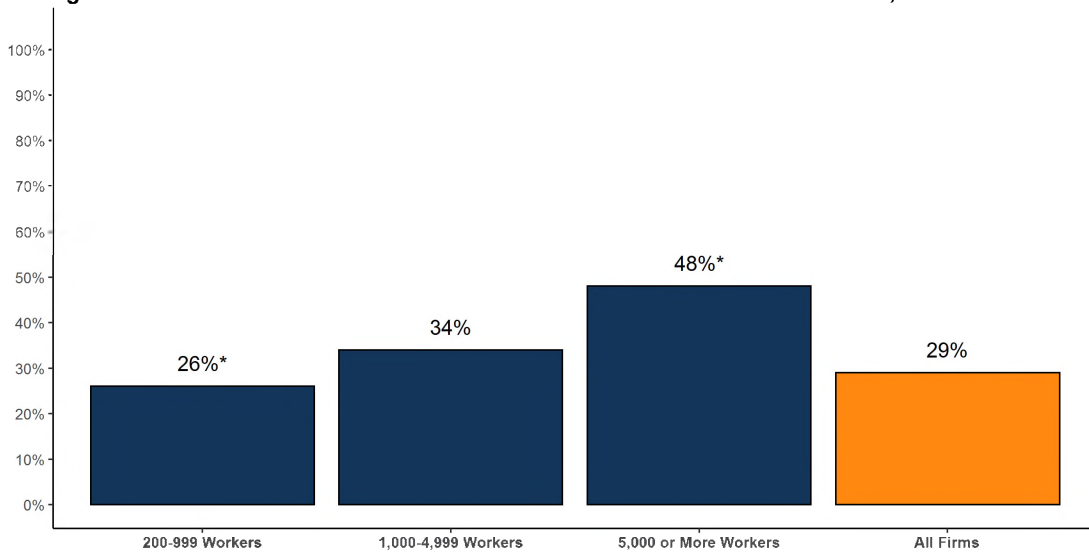
²Internal Revenue Service. Additional Preventive Care Benefits Permitted to be Provided by a High Deductible Health Plan Under § 223 [Internet]. NOTICE 2019-45; 2019. Available from: <https://www.irs.gov/pub/irs-drop/n-19-45.pdf>

Figure 13.13
Percentage of Large Firms Offering Health Benefits That Waive Cost-Sharing for Medication to Treat Chronic Conditions, 2020



* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
 NOTE: Large Firms have 200 or more workers. This may include plans which eliminated cost-sharing for insulin to treat diabetes.
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 13.14
Percentage of Large Firms Offering an HSA-Qualified Plan Which Increased the Number of Drugs and Services to Chronic Conditions which were Considered Preventative, 2020

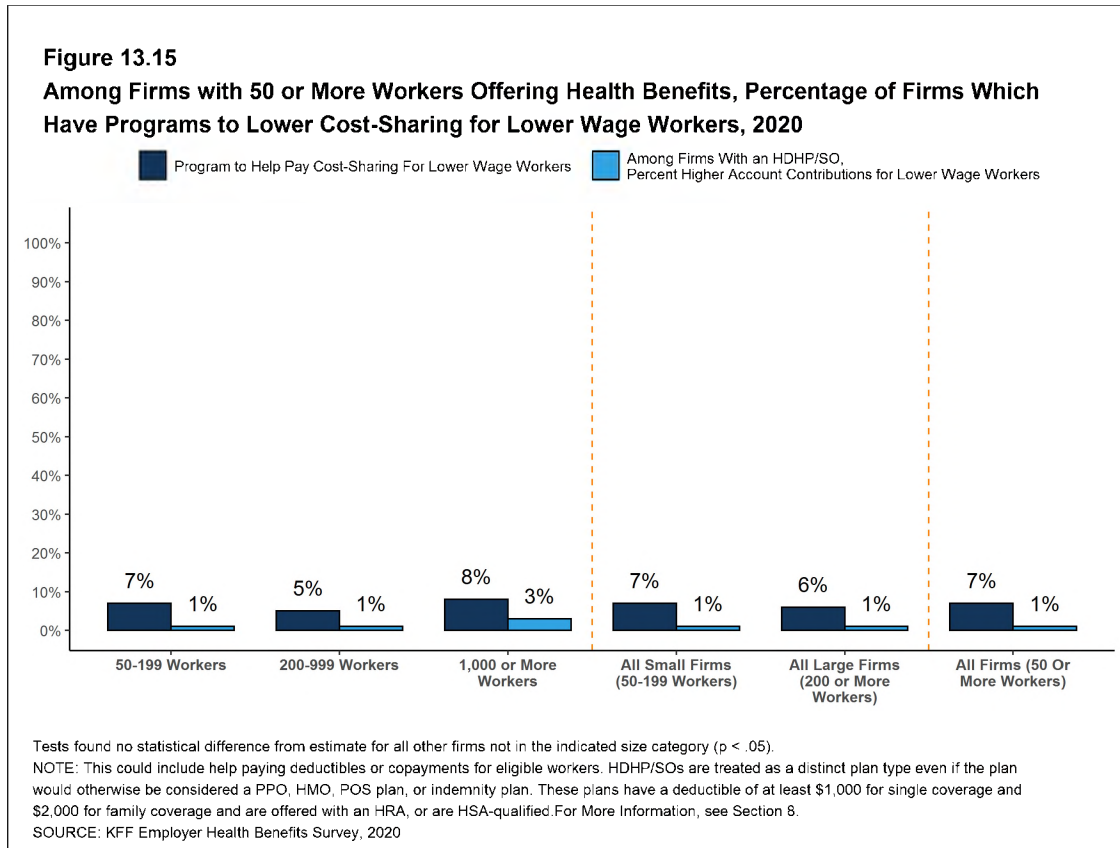


* Estimate is statistically different from estimate for all other firms not in the indicated size category ($p < .05$).
 NOTE: Large Firms have 200 or more workers. Employers were asked if they changed their coverage based on a rule which allowed that certain services and prescription drugs, for certain chronic conditions be classified as preventive care for people with those conditions. Under the rule, enrollees in a HSA qualified plan should face no cost-sharing for these services and products, even though these services would not generally be considered preventive care.)
 SOURCE: KFF Employer Health Benefits Survey, 2020

LOWER WAGE WORKERS

Some firms help lower-wage workers by reducing or subsidizing their cost sharing liability.

- Among employers with 50 or more employees offering health benefits, 7% have a program that reduces cost sharing for lower-wage workers. Among firms with 50 or more employees offering health benefits that make contributions to workers' HSA or HRAs, 1% provide larger account contributions for their lower-wage workers [Figure 13.15].

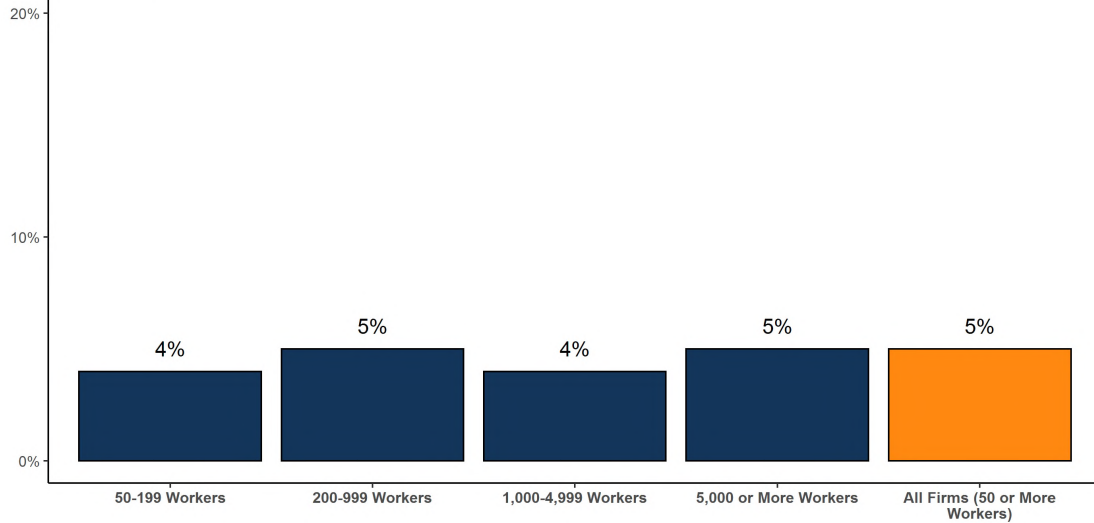


PRIVATE EXCHANGES AND DEFINED CONTRIBUTIONS

A private exchange is a virtual market that allows employers to provide their workers with a choice of several different health benefit options, often including voluntary or ancillary benefits options. Private exchanges generally are created by consulting firms, insurers, or brokers, and are different than the public exchanges run by the states or the federal government. There is considerable variation in the types of exchanges currently offered: some exchanges allow workers to choose between multiple plans offered by the same carrier while in other cases multiple carriers participate. Private exchanges have been operating for several years, but enrollment remains modest.

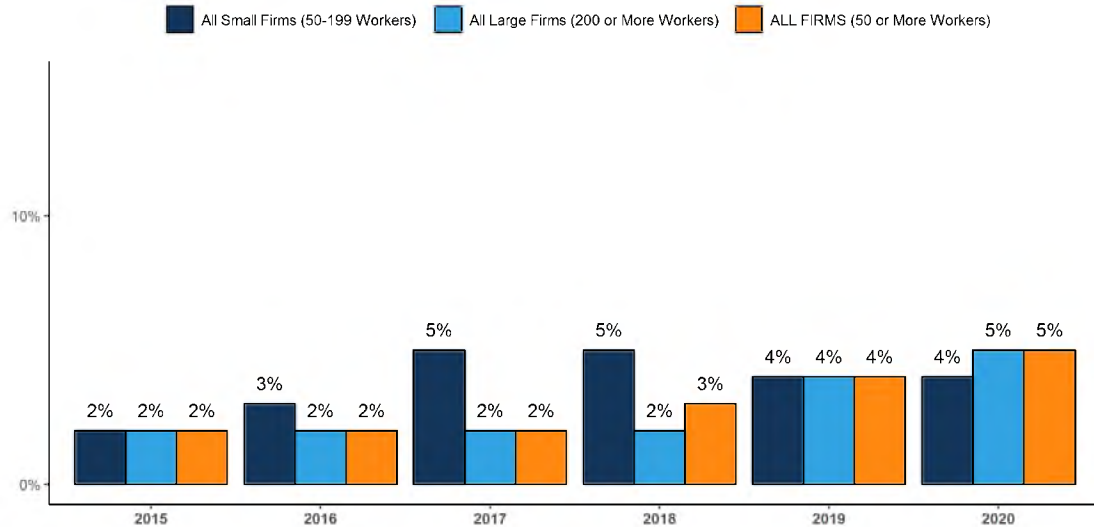
- Five percent of firms offering health benefits with 50 or more workers offer coverage through a private exchange. These firms provide coverage to 5% of covered workers in firms with 50 or more workers. These percentages are similar to those in 2019.

Figure 13.16
Among Firms with 50 or More Workers Offering Health Benefits, Percentage of Covered Workers Enrolled at a Firm That Offers Benefits Through a Private or Corporate Exchange, by Firm Size, 2020



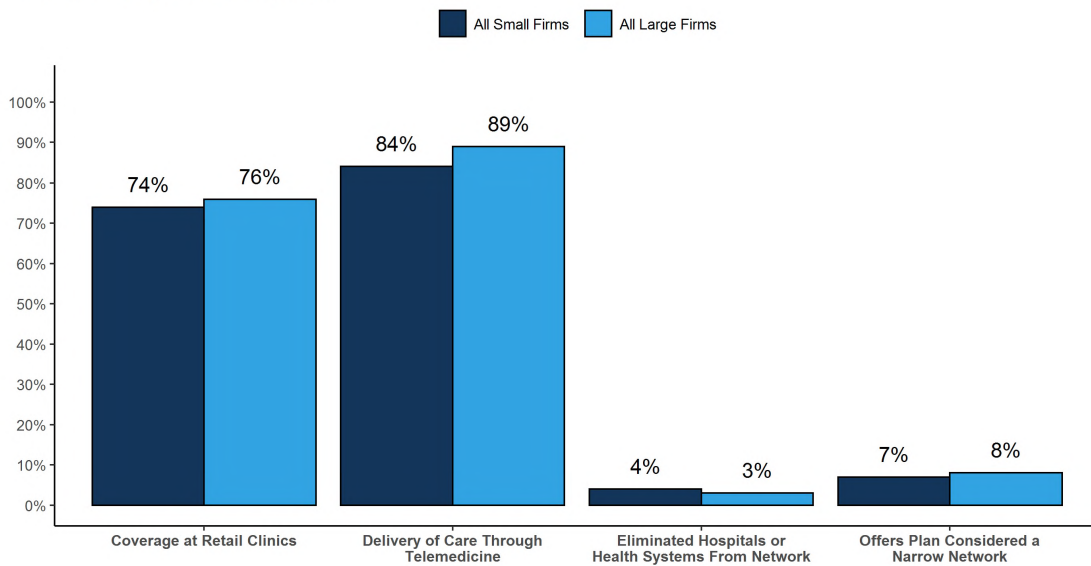
NOTE: A private exchange is one created by a consulting company; not by a federal or state government. Private exchanges allow employees to choose from several health benefit options offered on the exchange. In 2020, 5.0% of offering firms with 50 or more workers offered coverage through a private exchange.
 SOURCE: KFF Employer Health Benefits Survey, 2020

Figure 13.17
Among Firms with 50 or More Workers Offering Health Benefits, Percentage of Covered Workers Enrolled at a Firm That Offers Benefits Through a Private or Corporate Exchange, by Firm Size, 2015-2020



Tests found no statistical difference from estimate for the previous year shown ($p < .05$).
 NOTE: A private exchange is one created by a consulting company; not by a federal or state government. Private exchanges allow employees to choose from several health benefit options offered on the exchange. In 2020, 5.0% of offering firms with 50 or more workers offered coverage through a private exchange.
 SOURCE: KFF Employer Health Benefits Survey, 2018-2020; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2015-2017

Figure 13.18
Among Firms Offering Health Benefits, Percentage of Firms Whose Plan Has Various Features, by Firm Size, 2020



Tests found no statistical difference between All Small Firms and All Large Firms estimate ($p < .05$).

NOTE: See Section 13 text for definitions of these features. For Retail Clinics and Telemedicine, firms were asked if their plan with the largest enrollment had these features. Large Firms have 200 or more workers. Small Firms have 3-199 workers, with the exception of Telemedicine, which were only asked of firms with at least 50 workers.

SOURCE: KFF Employer Health Benefits Survey, 2020



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Protecting People With Pre-Existing Conditions Isn't As Easy As It Seems

Larry Levitt (<https://www.kff.org/person/larry-levitt/>) (https://twitter.com/larry_levitt)
Oct 05, 2020



With the death of Justice Ruth Bader Ginsburg, a lawsuit before the Supreme Court to overturn the Affordable Care Act (ACA) suddenly has a much better chance of succeeding. And, that could make protections for people with pre-existing conditions an even bigger campaign issue.

The Trump administration, which would normally be in court defending a federal law, is instead supporting the [lawsuit](https://www.kff.org/health-reform/issue-brief/explaining-california-v-texas-a-guide-to-the-case-challenging-the-aca/), which was brought by Republican state attorneys general and several individuals.

COVID-19 would likely [become a pre-existing condition](https://www.kff.org/policy-watch/is-covid-19-a-pre-existing-condition-what-could-happen-if-the-aca-is-overturned/) without protections written into law. In fact before the ACA, [having taken hydroxychloroquine](https://twitter.com/larry_levitt/status/1310700971362672640) in the previous year — a marker for malaria, lupus, or rheumatoid arthritis — could get you excluded from coverage.

President Trump has vowed to protect people with pre-existing conditions if the ACA is overturned and recently issued an [executive order](https://www.whitehouse.gov/presidential-actions/executive-order-america-first-healthcare-plan/) saying it is the “policy of the United States” to “ensure that Americans with pre-existing conditions can obtain the insurance of their choice at affordable rates.” However, the president’s order carries no force of law, and he has never released a plan to replace the ACA or protect people with pre-existing conditions. President Trump’s [record](https://www.kff.org/health-reform/issue-brief/president-trumps-record-on-health-care/) includes support for legislation to repeal and replace the ACA that would have weakened pre-existing condition protections, and expansion of short-term insurance plans that are not required to cover pre-existing conditions.

Former Vice President Biden supports the ACA and its protections for people with pre-existing conditions, and has a [proposal](https://www.kff.org/health-reform/issue-brief/affordability-in-the-aca-marketplace-under-a-proposal-like-joe-bidens-health-plan/) to build on the ACA with increased

premium subsidies to make coverage more affordable, as well as a public option health plan available to anyone.

Providing comprehensive protections to people with pre-existing conditions, as the ACA does, requires outlawing a variety of insurance practices that were common before the law took full effect in 2014, including:

- Denying insurance to people with pre-existing conditions or in certain occupations.
- Excluding coverage of any care associated with a pre-existing conditions.
- Charging higher premiums to people based on their health or gender.
- Limiting benefits associated with certain pre-existing conditions, like mental health, substance use treatment, maternity care, and prescription drugs.
- Imposing lifetime or annual caps on benefits.

All of these practices were the norm (<https://www.kff.org/health-costs/report/how-accessible-is-individual-health-insurance-for/>) in the individual insurance market before the ACA. Even in employer-provided health plans, which guaranteed access to coverage for people with pre-existing conditions, lifetime and annual limits were common (<https://www.kff.org/wp-content/uploads/2013/04/7936.pdf>), and coverage for pre-existing conditions could be excluded for up to one year for new enrollees who did not have prior continuous health coverage.

Fifty-four million non-elderly adults (<https://www.kff.org/policy-watch/pre-existing-conditions-what-are-they-and-how-many-people-have-them/>) had a pre-existing condition before the pandemic that would have led to a denial of health insurance in the individual market before the ACA, and more than 100 million had a condition that would have likely led to higher premiums or coverage limitations.

Beyond the insurance regulations required to protect people with pre-existing conditions, a big challenge is preventing a premium “death spiral.” If people are guaranteed access to insurance when they are sick, there is a risk that people will tend to avoid buying coverage when they are healthy and just wait to see if they get sick. That would lead to an insurance pool with disproportionately sick people, and therefore much higher premiums.

The ACA included both a carrot and a stick to encourage currently healthy people to buy insurance. The stick was the individual mandate penalty, which has since been repealed. The carrot is the current subsidy provided to low and middle income people. Providing comprehensive pre-existing condition protections without some similar mechanism to create a balanced insurance pool would cause premiums to increase substantially and result in an unstable market.

While the ACA has provided comprehensive protections for people with pre-existing conditions, it is not the only way to provide those protections. A universal health coverage system like Medicare for all, financed through taxes, could also guarantee affordable health care for people with pre-existing conditions. A high-risk pool available to people who are turned down by private insurers could provide protection as well, if it were adequately financed and had comprehensive coverage at affordable premiums.

All of these approaches, including the ACA, have trade-offs and require significant government regulation and financing. While it seems that every candidate — including President Trump — is vowing these days to protect people with pre-existing conditions, you can't just click your heels together three times and make it come true.

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A Look Under the Hood: Regulatory Policy Making and the Affordable Care Act

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Abstract The Affordable Care Act (ACA) was signed into law a decade ago. Partisanship has limited the number of statutory changes, leaving the law mostly unchanged across the past 10 years. However, the ACA delegated vast powers to the executive branch, which opened the door for significant regulatory policy-making activities (also called “rulemaking”). We collected data on all regulatory actions related to the Affordable Care Act that have been taken since its passage to provide the first exploratory analyses of both the public law itself and the ensuing rulemaking activities. We also provide illustrative examples of two controversial issues: short-term limited-duration insurance plans and contraceptive coverage for women. Despite relative statutory stasis, regulatory actions have continued to shape the implementation of the Affordable Care Act. Both the Obama and Trump administrations have taken advantage of a vast delegation of policy-making power. Importantly, regulatory policy making holds the potential to yield significant changes depending on the policy goals of the presidential administration. Scholars, policy makers, and the public are well-advised to pay attention to ACA-related rulemaking activities. Moreover, “quasi-rulemaking” (i.e., the use of agency guidance as a policy tool) remains largely unexplored but could indicate an even greater regulatory enterprise than illustrated here.

Keywords Affordable Care Act, regulation, rulemaking, administrative presidency

By almost any measure, the US Congress is doing less than it used to (Volden and Wiseman 2014). Yet, even when compared to the overall slow pace of statutory lawmaking in recent years, health policy making in Congress stands out as “far more gridlocked than policy making in most other areas” (Volden and Wiseman 2011: 227). This congressional inaction

has posed particular challenges for the Affordable Care Act (ACA). Due to the unorthodox nature of the ACA's final passage in Congress, after Democrats had lost their filibuster-proof majority in the Senate (Haeder 2012; McDonough 2011), the statute did not benefit from the tidying up of drafting errors and the final reduction of harmful ambiguities, which typically occur when a statute of this magnitude is passed. Moreover, subsequent to its passage, the intense partisanship surrounding the ACA has provided few opportunities to fix the technical and substantive shortcomings via the statutory policy-making process (Oberlander 2016; Rocco and Haeder 2018).

Indeed, over the past decade, the only statutory actions taken have been to scale back certain provisions of the ACA. Yet, while Congress has been able to chip away at the edges of the ACA, its major pillars, such as the expansion of the Medicaid program and insurance market reforms, remain largely intact. In terms of the statutory alterations that have occurred, these changes, which are now part of public law, may be seen as minor in comparison to the wholesale transformations suggested by the numerous bills introduced over the past decade to scuttle the law (Rocco and Haeder 2018). For instance, Congress pushed back numerous times the implementation of the 40% excise tax on high-cost employer-sponsored health plans, the so-called Cadillac tax (Warshawsky and Leahy 2018), until it was finally repealed in 2019. Another example is the Community Living Assistance Services and Supports Act or CLASS Act, a voluntary long-term care insurance program, which died a quick death via a statutory change in 2013, but only after the Obama administration had already abandoned the program (Saldin 2015). And, most significantly, Congress eliminated—that is, set to zero—via statute the individual shared responsibility penalty, which reopened the door to litigating the constitutionality of the individual mandate itself (Keith 2019c).¹

Despite these shifts, the ACA on the books today is largely the same in its statutory content as the bill that was signed into law a decade ago. Yet, this relative stasis masks a great deal of policy change that has occurred since 2010. That change, however, has not been of the statutory variety; instead, it has emerged via the regulatory pathway. Put differently, faced with congressional policy-making inertia, the Obama and Trump administrations have again and again employed the federal bureaucracy, and the delegated discretionary policy-making authority provided by the ACA, to move the policy needle in their direction.

1. In the end, this change could prove to have far-reaching, albeit unanticipated, consequences if the ACA individual mandate is found to be unconstitutional and inseverable (Keith 2019a).

Below, we briefly outline some of these actions over the past decade. We focus, in particular, on the regulatory policy-making activity of public-sector agencies with regard to the ACA. In doing so, we provide the first comprehensive overview of the rulemaking activities by the Obama and Trump administrations based on a new data set containing the universe of regulatory actions triggered by the ACA. These data allow us to illustrate the large amount of policy-making activity going on “under the hood” of the ACA. We also include a brief look at two rulemaking examples that illustrate the significant policy alterations made possible via the regulatory process based on the administration in power. We conclude by summarizing our findings and by highlighting the need for additional scholarship on the ACA and the regulatory process.

The Affordable Care Act and Executive Action

In the years immediately following the ACA’s passage, rampant partisanship and ideological divides dominated its implementation (see Haeder 2020). Faced with these challenges, the Obama administration frequently drafted the bureaucracy to help achieve its ACA-related policy goals. In doing so, it followed well-established theory suggesting that presidents will frequently employ the power of the administrative state to achieve their policy aims (Moe 1985; Nathan 1976; Rudalevige 2009; Haeder and Yackee 2015a). Moreover, the fact that the ACA provided broad implementation discretion to various executive branch agencies assisted in these efforts considerably (Thompson, Gusmano, and Shinohara 2018; Richardson 2019). For example, one of the most crucial applications of this discretion has come in the wake of the US Supreme Court decision to make the Medicaid expansion component optional to states (Haeder and Weimer 2013; Richardson 2019). In reply, the Obama administration’s US Department of Health and Human Services (HHS) negotiated with numerous conservative states and offered broad Section 1115 waivers to entice them to expand their Medicaid programs (Jarlenski et al. 2017; Weissert, Pollack, and Nathan 2017; Wright, Potter, and Nattinger 2016). And while the Obama administration was more than happy to make concessions on issues such as insurance premiums and wellness incentives, it drew a line in the sand with regard to compromises on Medicaid block granting and Medicaid work requirements (Dinan 2014).

The Trump administration has followed a similar path, albeit with rather different policy objectives in mind. That is, the Trump administration has eagerly employed the administrative tools of the presidency to reshape the

ACA in a more conservative fashion. For instance, it has used the HHS to limit open enrollment periods and to sharply scale back outreach and enrollment funding (Thompson, Gusmano, and Shinohara 2018; Richardson 2019; Anderson and Shafer 2019). At the same time, the Trump administration has also sought to transform the Medicaid program by adding new work requirements for Medicaid beneficiaries (Thompson, Gusmano, and Shinohara 2018; Richardson 2019; Haeder 2019).

Lawmaking by Administrative Means: Regulatory Policy Making

While the aforementioned executive actions across two presidential administrations have been empirically recognized by scholars, we argue that much less attention has been paid to a crucial tool at the president's disposal to achieve his ACA policy goals: regulatory policy making (also called *rulemaking*). This is surprising because rulemaking has become increasingly recognized by policy and administration scholars as pivotal to the policy-making process in general. Indeed, the "massive policy output created by public sector administrative agencies" (Haeder and Yackee 2015a, 508) has led some observers of the US policy-making process to conclude that policy making today is primarily administrative rather than legislative. By one estimate, 9 out of 10 US "policies" are the results of the actions of administrative agencies (Warren 2020). Yet, notably, much this activity occurs outside the public's and the media's attention (Haeder and Yackee 2015b).

Rulemaking serves a crucial role in US policy making because Congress routinely delegates the task of filling in the policy details of statutes to public bureaucrats (Golden 1998; West 2004; Coglianese 2006; Wagner 2010; Yackee 2006, 2012, 2019; Kerwin and Furlong 2018). For decades the process of issuing rules has been guided by the Administrative Procedure Act of 1946 (APA) (Rosenbloom 2018). Generally, agencies initiate regulatory actions by formulating a draft regulation, also referred to as a *notice of proposed rulemaking* (NPRM).² This draft is then made available to the public to solicit comments by stakeholders and other interested parties. Agencies must take into account this public feedback before finalizing a regulation in a final rule, which carries the force of law. The president, via the Office of Information and Regulatory Affairs, is heavily

2. At times, agencies take the additional step of issuing an *Advanced Notice of Proposed Rulemaking* (ANPRM), which proceeds an NPRM and gathers public feedback even earlier in the regulatory formation process (Nelson and Yackee 2012, Yackee 2012).

involved in this process for all cabinet-level agencies (Haeder and Yackee 2015a, 2018). There are exceptions, however, to this general process. For instance, under the “good cause” exemption of the APA, which occurs when the standard rulemaking process is “impracticable, unnecessary, or contrary to the public interest,” agencies may skip the initial steps of issuing an NPRM and instead directly issue an *interim final rule*, which then has a retrospective commenting period (Kerwin and Furlong 2018). Furthermore, not all NPRMs are ultimately finalized, as they are sometimes merged with others, withdrawn, or simply left at the draft stage indefinitely.

As mentioned above, Congress regularly delegates considerable authority to make policy decisions by providing new rulemaking authority to administrative agencies. The ACA is no different in this regard. Indeed, it decentralizes clear and critical lawmaking powers to numerous federal agencies. We have documented this pattern by focusing on the statutory text itself.³ For one, the word *secretary* is used more than 3,000 times to refer to 11 different cabinet agency secretaries (see table 1). This suggests that administrative agencies are being employed frequently in the statute. Moreover, commonly used phrases that indicate the delegation of power to government agencies (Haeder and Yackee 2019) are employed more than 1,000 times in the ACA’s public law text (see table 1 for several examples of these). While only indicative of the extent of delegation, even this cursory textual examination of the ACA illustrates that Congress provided a large role for administrative agencies within the implementation of the ACA.

So how extensively have the Obama and Trump administrations resorted to rulemaking to implement the ACA? The two bills that together make up the ACA, as amended, combine for a statutory length of 961 pages, or 474,622 words. In a separate analysis, we identified all of the rules that have been initiated by federal agencies using the ACA for their statutory authority. We identified 265 rulemaking activities indicated by their unique regulation identification number.⁴ Counting only final or interim final rules issued by the end of 2019, these rulemakings combine for a regulatory

3. Here and for the rest of the article we use the Patient Protection and Affordable Care Act (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-154). The document used is posted to the House of Representative’s website and can be found at housedocs.house.gov/energycommerce/ppacacon.pdf.

4. To identify these rules, we conducted a number of searches on Reginfo.gov, the website maintained by Office of Information and Regulatory Affairs to provide an overview of the regulatory actions undertaken by the federal government. We focused on all rule initiatives that listed the ACA for all or part of its statutory authority. Data were accessed on January 2, 2020.

Table 1 Search Results from the Affordable Care Act, as Amended

Wording in the Affordable Care Act	Number of mentions
Secretary shall/must	975
Secretary may	351
Secretary determines	211
As determined by the secretary	84
As defined by the secretary	36
Secretary has the authority	3
Issued by the secretary	3
Secretary	3,135
Secretary of Health and Human Services	143
Secretary of the Treasury	73
Secretary of Labor	22
Secretary of Veterans Affairs	12
Secretary of Defense	11
Secretary of Homeland Security	10
Secretary of Education	2
Secretary of Agriculture	1
Secretary of Transportation	1
Secretary of the Army	1
Secretary of the Air Force	1

Notes: Results represent search results for the exact wording. Word searches were applied to the combined versions of the Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), which can be found at www.healthcare.gov/where-can-i-read-the-affordable-care-act/.

policy length of almost 9,000 pages, or more than 9,000,000 words. That is, each page in the ACA is matched by more than 9 pages of regulations, while each word in the ACA is matched by more than 19 words in regulations. Furthermore, we find these patterns even though about a quarter of the initiated rulemaking activities are not yet finalized by January of 2020 or have been formally abandoned (i.e., withdrawn before finalization). Unquestionably, these are rough indicators that blur the underlying intricacies and nuances. Nonetheless, they highlight the vast regulatory policy-making enterprise triggered by the ACA.

To further explore the 265 rulemakings initiated to implement the ACA to date, we collected additional data from the federal government's regulatory information repository, [Reginfo.gov](http://www.reginfo.gov), which includes information about all regulatory actions planned or conducted by the federal government. In terms of agencies, the largest initiator of ACA-related regulatory activities was the HHS with two-thirds of all rulemakings, followed by the

Departments of Treasury (17%) and Labor (11%), with the remainder distributed among the Departments of Defense, Justice, Veterans Affairs, the Social Security Administration, the Office of Personnel Management, and the Equal Employment Opportunity Commission. In terms of sub-cabinet level agencies, rules were overwhelmingly initiated by the HHS's Centers for Medicare and Medicaid Services (130 rules), followed by Treasury's Internal Revenue Service (43) and Labor's Employee Benefits Security Administration (25).

At the rule level, only 132 of the 265 regulatory actions followed the "standard" APA procedures. Instead, 84 rules were issued directly as interim final rules. Moreover, 35 of the 265 rules were merged with other rules, and 37 rules were ultimately withdrawn. Of the 132 final rules, more than half had a delayed effective date—meaning that the date that they took effect was pushed back for some reason. About a quarter of the 265 regulatory actions included a statutory deadline, 93 were determined as "major" or important. Twenty-two of the 265 regulatory actions triggered a regulatory flexibility analysis, which is required for rules that may have a large burden on smaller entities such as small businesses, 93 were deemed economically significant, and 116 fell into the "other significant" category, as determined by agency rule writers. Pursuant to EO 13132, 28 rules were determined to have substantial effects on the distribution and responsibilities of power between federal and state governments.

The distribution of regulatory actions over time, as identified by their unique regulation identification number, is illustrated in figure 1. Several observations stand out. First, the Obama administration extensively resorted to interim final rules in 2010, the first year of implementation of the ACA. This is likely a direct result of short timetables and resource limitations during the early implementation of the ACA. However, we note that there is also a steady stream of interim final rules that continues into 2019. Second, a large number of regulatory actions were merged in 2011. Again, this is likely the result of the hectic pace and pressure to initiate rulemaking activity quickly in the early years of the ACA. With time, agencies were able to consolidate regulatory actions and bring together similar regulatory initiatives. Third, rulemaking finalization spiked from 2012 through 2014, a time period in which many of the large-scale provisions of the ACA, like the marketplaces and Medicaid expansion, were implemented. Fourth, there were a number of rule withdrawals, but it is worth noting that 15 of the 37 withdrawals occurred during the Trump administration. Finally, ACA-related rulemaking experienced a considerable slowdown under the Trump administration. While we might expect some reduced rulemaking activity a

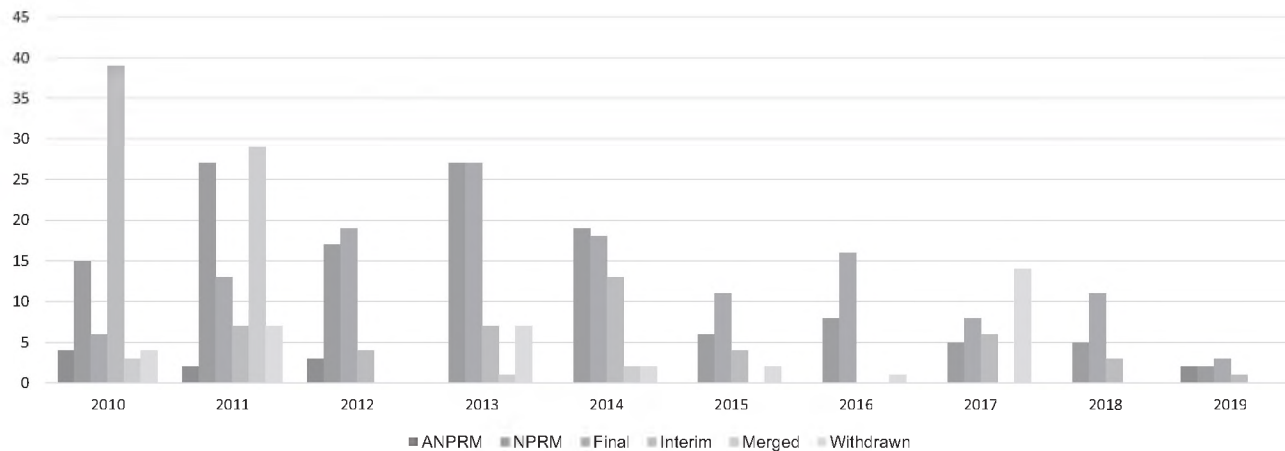


Figure 1 Secular distribution of activity for the Affordable Care Act.

Notes: Based on an analysis by the authors. Regulatory activity may be counted more than once if multiple regulatory actions are taken.

Source: Reginfo.gov. See footnote 4 for further details.

decade after the passage of a major statute, questions emerge as to whether this low level of activity comes as a result of the Trump administration's opposition to the ACA in particular or to rulemaking trends in general.

ACA Rulemaking and the Reversal of Policies

With the aggregate-level picture of ACA rulemaking activity coming into focus above, we next turn to two prominent examples to illustrate how agency rulemaking power may be used differently by presidential administrations to pursue their policy-making goals. Specifically, we highlight the regulations attached to (1) short-term limited-duration insurance plans, and (2) contraceptive coverage for women. In both cases, the content of the policies shifted significantly between rulemaking activities in the Obama administration and those later, during the Trump administration—while the statutory delegation language within the ACA remained the same.

Short-Term Limited-Duration Insurance Plans

One of the crucial goals of the ACA was to expand coverage in an affordable manner to millions of Americans. The ACA envisioned various vehicles to achieve this goal including the expansion of Medicaid, allowing children to stay on their parents' insurance plan until age 26, temporary high-risk pools, and the establishment of marketplaces in conjunction with a number of insurance market reforms (Callaghan and Jacobs 2013; Haeder, Weimer, and Mukamel 2019; Rigby 2012; Haeder 2013; Béland, Rocco, and Waddan 2016). One of the major concerns of the Obama administration, however, was the possibility that short-term limited-duration insurance plans might divert enrollment away from the ACA marketplaces. They might do so because they generally offer coverage at a lower price. However, lower premiums come with the trade-off of skimpier benefits and medical underwriting as compared to ACA-compliant plans that are required to provide a set benefit package (the ACA's Essential Health Benefits) with community-rated premiums. Moreover, short-term plans are also exempt from important consumer protection established by the ACA, such as annual and lifetime coverage limits or medical loss ratios. If enough young and healthy individuals exited the ACA's marketplaces for short-term plans, then it may place the marketplaces in peril—with not enough young and healthy individuals to balance out the costs associated with insuring older and sicker individuals (Keith 2019d). Thus, concerned about adverse selection and the potential ensuing premium increases in the ACA marketplaces, the Obama

administration issued a final rule in 2016 that limited short-term insurance products to 90 days, restricting them to a temporary stopgap for individuals without coverage (Keith 2019d).

After Republican efforts to repeal and replace the ACA failed very publicly in Congress, the Trump administration initiated a number of regulatory actions officially hailed as providing “relief” to Americans from the ACA.⁵ The main goal of this deregulatory package was to establish a secondary insurance market with significantly fewer benefits and protections for consumers that ran parallel to the more regulated, ACA-compliant coverage version. These efforts included a reversal of the Obama administration’s definition of short-term limited-duration insurance products.⁶ Arguing that it wanted to offer Americans a lower-cost alternative to ACA-compliant plans, the Trump administration wrote new interim regulations in 2017, which were finalized in 2018. Both actions increased time limits to 364 days and allowed the policies to be renewed twice, essentially making them effective for three years (Keith 2019d). Practically, this established a notable competitor to ACA-compliant insurance products sold through the marketplaces. While the new rules were challenged in court, they were ultimately upheld in favor of the Trump administration (Keith 2019d). However, a number of states have subsequently moved to limit or even wholly prohibited the sale of short-term insurance products, while others have expanded access to such products (Norris 2020).

Contraception Coverage for Women

Another example of the attempt of presidents to shift policy in their favor via rulemaking comes in the form of the ACA’s contraceptives mandate. Under Section 2713 of the ACA, most insurance plans are required to provide free preventive care and screenings. The details of this policy were delegated by the statute to federal agencies to be established via the regulatory process. In 2012, the Obama administration attempted to comply with this requirement by issuing regulations that offered access to affordable contraception for millions of women, while also not offending the millions of Americans that objected to contraception as a result of their religious beliefs. To achieve these competing goals, the Obama administration’s rules required most insurers to cover all contraception methods approved by the

5. This action also comes on the heels of Executive Order 13765, *Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal*, which President Trump signed on Inauguration Day.

6. It also included the vast expansion of so-called Association Health Plans (Keith 2019b).

US Food and Drug Administration without cost sharing, while exempting places of worship, if they objected to such benefits (Keith 2019e). However, the regulation did not extend this exemption to other religious entities or enterprises, like hospitals and schools. Instead, it provided accommodations to religiously affiliated nonprofits by allowing them to express their opposition to such coverage in the form of “self-certification.” The self-certification process would then assign the responsibility of covering the contraception costs to their insurer, thereby removing the provision of the services from the religious entities while still allowing women to have free access to the services. In the aftermath of the Supreme Court’s *Burwell v. Hobby Lobby* decision in 2014, this arrangement was extended in 2015 to “closely held for-profit entities.” However, a number of religious nonprofit organizations continued to disagree with the accommodation approach and instead sought to be wholly exempted from the coverage requirement resulting in the Supreme Court case *Zubik v. Burwell* in 2016. The Court instructed the federal government and the litigants to find an accommodation, which was still unresolved as President Obama left office.

The Trump administration initiated a reversal of the Obama-era policies on preventive services and contraception for women and issued a set of interim final rules in 2017. These regulations vastly expanded the range of entities eligible for exemptions from the contraception mandate based on their religious beliefs or other moral convictions (Keith 2019e). The interim final rules also opened an opportunity for public feedback as part of a public commenting period. After taking more than 100,000 comments, the Trump administration’s HHS moved to finalize the rules without any substantive adaptations in late 2018 (Keith 2019e). Both the interim and final rules have led to a number of lawsuits that remain unresolved.⁷ In early 2020, the Supreme Court agreed to hear arguments on the Trump administration’s policies, thus setting up yet another highly anticipated Supreme Court confrontation on an ACA-related regulatory policy-making action.

Conclusion

The passage of the ACA was a landmark health and health care policy-making event (Blumenthal and Morone 2010). In the ensuing decade,

7. For instance, the courts found that the Trump administration violated the requirements of the APA by issuing interim final rules without “good cause” and that neither the ACA nor the Religious Freedom Restoration Act delegated the authority to issue the rules (Keith 2019e). The set of final rules also was blocked from enforcement by the courts (Keith 2019e). Notably, another court case has led to a nationwide injunction against the contraceptive mandate in its entirety (Keith 2019d).

despite relative statutory stasis, a great deal of policy-related action regarding the ACA has taken place within the regulatory sphere. Many of these regulations have addressed technical and substantively important policy-making topics. Moreover, in several areas, the change in presidential administration was accompanied by substantive changes in regulations, which suggests the vast policy-making power of federal agencies in the area of health.

Yet, presidents, of course, are not wholly unconstrained in their ability to shape public policy via the regulatory process. Presidents in collaboration with their cabinet agencies have to walk a procedural and substantive tightrope to obtain their preferred policies. For one, they have to follow the process outlined by the APA or open themselves up to legal challenges through the court system that could scale back or even reverse their policies. Similarly, presidents and agencies have to be mindful not to stray too far from the delegated powers assigned to the agencies in statutes, or they, again, open themselves up to legal challenges. As our contextual examples show, the courts often play an important role in policing the regulatory process as well as providing a nonlegislative check on the executive's ability to use administrative policy making to accomplish its goals when it comes to the ACA.

While we see the perspective above as an important corrective on the often legislative- and federalism-centric scholarship on the ACA (see Haeder 2012, 2020), our analysis and perspectives here are necessarily constrained. In particular, our analysis has been confined to federal rule-making. Yet, we readily submit that the ACA relies extensively on a large number of public and private partners to implement many of its policies.

Another limitation of our analysis is its focus on the "typical" ways in which government agencies issue rules. And, while we see our treatment as more expansive than many, especially in its inclusions of a discussion of interim final rules, it is still left wanting. In particular, while we have focused mostly on the notice and comment process, we have not studied its close cousin, *quasi-rulemaking* (Gluck, O'Connell, and Po 2015: 1803), or, as it is more commonly known, agency rulemaking via the *guidance document process* (Haeder and Yackee 2020; Yackee 2020). Guidance documents (also called *guidance statements* or *guidance*) are highly diverse agency policy-making tools and include everything from "policy statements, training manuals for internal agency use, compliance guides, advisory opinions tailored to individual case facts, and memoranda from agency leaders providing direction to agency staff members" (Melnick 2017). Agencies often value the increased flexibility from this unorthodox

approach to rulemaking, which has far fewer procedural requirements, during the implementation of public policy. Not surprisingly, guidance documents are believed to have played a major role in the implementation of the ACA (Haeder 2014; Bagley and Levy 2014).

Going forward, scholars would be well advised to pay close attention to all forms of rulemaking activity in their analyses of the ACA or other health care statutes. That is, it is important for scholars take a closer look “under the hood” to better understand the true extent of health policy creation and implementation.

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Costs versus Coverage, Then and Now

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Abstract To expand coverage to those without it, Democrats in 2010 sacrificed cost control methods that might have helped those already insured. The law therefore did not offer most Americans what they wanted most. President Obama and those who thought like him convinced themselves the legislation would control costs by reforming how health care is organized, but any such effects have been both weak and unpopular. Now many commentators are accusing Democratic candidates of making the same mistake by prioritizing an ideological vision of “Medicare for All” over voters’ worries about out-of-pocket costs. Yet Medicare for All, unlike less “radical” approaches, addresses those concerns directly. Unfortunately, neither elites (outside the industry!) nor voters seem to understand that, and it is politically risky because of the same fears about change, industry opposition, and distrust of government that inhibited more effective action a decade before.

Keywords Medicare for All, costs, lessons, health care industry, public opinion

Politicians in crafting laws and scholars in analyzing them make judgments about both policy and politics. Like many other participants in this issue, I have offered such analyses about the Affordable Care Act (ACA) before,¹ both in a similar effort nine years ago (White 2011) and in other longer works (e.g., White 2013a, 2013b, 2018). So in this piece I must apologize for repeating myself, but I hope to be useful in two ways. I offer a quick version of some of my previous analysis, but further emphasize what that perspective on the ACA might tell us about the situation as Democrats fight

1. I will use this conventional shorthand for the combination of two laws, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act, passed in 2010.

among themselves about what health care policy to promote in the 2020 election and beyond.

Political Premises

Strategies to pass health reform in 2009 were shaped by “lessons” believed at that time.² These included, for example, that the Clinton administration’s drafting of a complex proposal in-house was a mistake, and that the Clinton effort failed in part because even though the “problem” and “politics” streams were flowing in favor of reform, the “policy” stream had not generated an approach ready for action after Clinton’s election (McDonough 2000). The 2009 effort therefore was preceded by years of efforts to build consensus among Democrats on the broad outlines of a policy approach (Kirsch 2011; McDonough 2011), that then could be drafted within Congress rather than the White House (Armstrong and Wayne 2009).

For our purposes, however, three other premises are more important. The first was that Clinton failed partly because people with remotely decent insurance were risk-averse and easily scared. Support for reform to “fix the system” would evaporate if individuals worried about negative effects on them personally (e.g., Nather 2009). Therefore any reform had to be presented as changing as little as possible: a judgment reflected in the many statements from reform advocates, especially President Obama, of versions of, “if you like your health plan, you can keep it” (Gore 2013).

The second was that beneficiaries of health insurance expansion were neither numerous nor mobilized enough to drive reform. Instead, reform had to be sold as protecting those who were already insured, but worried about erosion of either the availability or quality of their insurance. To put this another way, controlling costs was a more politically popular goal than expanding coverage for the uninsured—particularly among Republicans and self-identified independents (KFF 2009; Nather 2009; Saad 2009).

Third, reform could be blocked by powerful special interests working to protect their incomes and, therefore, against cost control. As Larry Brown (2011: 423, 426) wrote, “simultaneously expanding coverage and containing costs is the political equivalent of squaring a circle. . . . Reform passed in part because Obama and the congressional Democrats figured out how to talk about costs without sending affronted special interests and an alarmed general public to the exits.” But this meant, he added, that “nothing

2. A typical list is provided by Oberlander (2010).

in the new law is likely to slow [costs'] near-term growth"—a judgment echoed by other authors in the collection (Oberlander 2011; Gusmano 2011; Rodwin 2011).

Cost Control and Coverage Expansion in the ACA

Legislating the ACA was guided by these premises, but readers may have noted a problem: the last three premises were contradictory. If a popular reform had to control costs for the worried-but-insured, and reform could not be passed if it actually controlled costs, then it should not have been possible to pass a popular reform. The Obama administration, its expert advisers, and its political allies decided there was a way to square the circle: through promoting an approach summarized by Mark V. Pauly (2011: 593) as, “that direct change can be made in the methods, costs, and effectiveness of delivery of medical services by changing its *organizational form*: the medical home model, accountable care organizations, or the ‘high-power’ or ‘evidence-driven’ health care system of the future embody this approach.” This approach was supposed to avoid the twin perils of angering voters by raising cost sharing or the industry by regulating prices.³

President Obama emphasized cost control in making his case for reform. In his first State of the Union address for example, he proclaimed that “we must also address the crushing cost of health care”:

This is a cost that now causes a bankruptcy in America every 30 seconds. By the end of the year it could cause 1.5 million Americans to lose their homes. In the last eight years, premiums have grown four times faster than wages. And in each of these years, 1 million more Americans have lost their health insurance. It is one of the major reasons why small businesses close their doors and corporations ship jobs overseas. And it is one of the largest and fastest-growing parts of our budget. Given these facts, we can no longer afford to put health care reform on hold. We can’t afford to do it. (*New York Times* 2009)

Unfortunately, the organizational reform approach did not win over either most of the public or more hard-nosed analysts.

Republicans and the conservative media machine sold fake news (an accurate term in this case) about “death panels” and the like (Gitterman and

3. Although the two other approaches were included, the first through the “Cadillac tax” and the second to earn creditable budgetary savings within Medicare, far more emphasis was placed on the potential “transformative” effects of the organizational reforms, as explained at more length in White 2018.

Scott, 2011). But the inconvenient truth was that most voters were skeptical of the presumptions behind the reform agenda. As one report concluded, “many consumers’ values, beliefs and behaviors remain rooted in traditional beliefs about the doctor-patient relationship and the medical care system.” They commonly believed, “that medical guidelines represent an inflexible, bargain-basement approach to treating unique individuals,” or might even “discriminate against doctors who give you better care,” and were skeptical of claims that more care meant worse care (Carman et al. 2010: 1401, 1402). In principle, majorities might approve of insurance coverage for treatments depending on those having been shown to be “more effective than existing, less expensive, treatments.” But when told that, “in some cases, treatments for drugs recommended by a person’s own doctor wouldn’t be covered by their health insurance,” responses switched to 63–32 percent opposition (Bernstein 2009: 6–7).

The reform agenda inherently assumed that someone other than a person’s own physician would be shaping care options. This is clear for direct approaches like evidence-based guidelines, but it lurks in more indirect approaches. “Paying for Performance” means someone judges your physician’s performance. “Accountable Care Organizations” presumes someone other than your doctor is accountable—somewhere in that big bureaucracy, somebody, somehow. The problem is that nobody—whether an insurer, government, or employer—could elicit comparable trust. We trust our doctors to touch us in otherwise inappropriate ways, advise us to ingest mysterious chemicals, make us unconscious and do things to us, and stick sharp objects in us. Trusting your doctor is not optional, and what analysts may see as irrational trust in personal physicians is the only way to avoid debilitating cognitive dissonance. Yet the reform agenda begins from the premise that doctors often don’t know best. Under these circumstances, Republican distortions could tap into a powerful vein of preexisting distrust, and President Obama’s defenses of the approach were futile.⁴ It is not an accident that the Democrats did not embark on a big campaign boasting about all the organizational reform cost controls in the ACA—that could have been more risky than not talking about them at all.

Moreover, analysts who were not committed to the dominant worldviews within the health policy community—particularly the Congressional Budget

4. For example, he argued that if evidence showed the red pill cost twice as much as the blue pill and was no more effective, then promoting the blue pill was “not rationing. That’s being sensible” (Nather 2009). But that begged the question of how strongly evidence would be promoted. Note also that if the government required the lower price for both pills, this would not be an issue.

Office staff who tend to look for reliable data—also didn't believe that the ACA would generate meaningful savings within the private insurance system (CBO 2009, 2011). As a result, media coverage of the ACA also expressed skepticism that the law would meaningfully reduce health care costs for the average voter (for one good example, see Roberson 2011). The major measure that CBO would credit as reducing the costs of typical health insurance plans was the “Cadillac Tax,” which was most likely to reduce the cost of plans by reducing their value through increasing cost sharing. Higher costs when they needed care was not the average voter's definition of making care more “affordable” (Altman 2014).

As the editor of this journal and I argued at the time, public opinion suggested then, and had for many years, that price regulation was more popular than other cost-control approaches (Oberlander and White 2009, 2010). Yet the only effort to lower prices for most peoples' care, the “public option,” was abandoned to neutralize interest groups (Oberlander 2010). In Jacob Hacker's (2010: 865) words, “the Obama administration” (which did make many of the key calls in spite of its allegedly “hands-off” approach),

consistently acted as if the crucial swing votes in Congress depended not on wavering citizens, but on organized interests with the greatest ability to shape the positions of congressional moderates within the Democratic Party . . . these up-front concessions . . . limited the law's ability to deliver tangible benefits to the middle class and largely took off the table tools of cost control used in other nations, such as provider rate-setting and government negotiations for lower drug prices.

While this explains how the ACA was crafted, however, it doesn't explain why anyone would have thought the legislation would accomplish its key political goal: support from voters worried about the insurance they had. Apparently the key policy makers in the Obama administration and their allies (mostly in the Senate) believed (in spite of the evidence) that the various organizational reforms would save money in a popular way—thereby satisfying both voters and the interest groups. As time passed, they continually asserted that the delivery system reforms had saved money, in spite of both weak evidence for that proposition and continued or intensifying public concern about costs.⁵

The political failure of the approach is evident enough: Democrats were unable to sell the law in a way that would protect them against electoral

5. A good example is Obama (2016). I do not have space to address the evidence here; please see White (2018) for more.

backlash (especially in 2010), and polling showed more unfavorable than favorable attitudes towards the law for nearly the entire period from 2011 through 2016. It became more popular after the prospect of repeal became more real with the 2016 election,⁶ and that appears to have directed more attention to the real though limited benefits that would be put at risk. The legislation would have been blasted from the Right regardless of what it included. Yet the absence of cost controls that could have been used to win any support has to be part of why support was weak.

The legislation's policy failure—the trend in personal health care costs after it passed—became part of the context for the current reform effort.

Cost Control and Coverage Expansion in the 2020 Election and Beyond

Slow forward (it has been protracted and painful) to December of 2019. As Democratic candidates fought about “Medicare for All” versus a “Medicare option” or “building on the ACA,” numerous experts argued they were fighting about the wrong thing: about coverage expansion across the population rather than how even existing coverage exposes people to unaffordable costs.

In April of 2019, for example, Kaiser Family Foundation president Drew Altman (2019d) argued that both parties' rhetoric about making health care a right (Democrats) or socialism (Republicans) were missing the point: “it's the candidates who can connect their plans and messages to voters' worries about out of pocket costs who will reach beyond the activists in their base. And the candidates aren't speaking to that much.” In June, Robert Blendon, the best-known researcher about public opinion on health care, joined colleagues in emphasizing the breadth and depth of public worries about costs: not total national health spending (about which a miniscule proportion of voters care) but “the belief that health care services are unreasonably priced and that what people pay for care harms their household financial situation” (Blendon, Benson, and McMurtry 2019: 2487).

The *Washington Post* (Goldstein 2019) reported that, “Voters have big health-care worries, but not the ones Democrats are talking about.” While candidates were trumpeting “bold ideas to achieve the party's long-held dream of ushering in health coverage for every American,” the problem was “that many voters are not focused on such lofty goals. They want

6. See the Kaiser data summarized at www.kff.org/interactive/kff-health-tracking-poll-the-publics-views-on-the-aca/#?response=Favorable—Unfavorable&aRange=all.

something simpler—to pay less for their own health care.” In one illustration Celinda Lake, a leading Democratic pollster, said that focusing on Medicare for All might appeal to voters in the nomination contests, but that prescription drug prices were a big issue for both primary and general election voters, adding that, “in my opinion, we’re not talking enough about it.” A review of polling data emphasized that in 2008 worries about cost had been a bit stronger than desires to expand health insurance coverage for the uninsured, but, “since the implementation of the ACA, health care costs now occupy a tier of their own on the public’s list of pressing health care issues” (Kirzinger et al. 2019).⁷

In this case public opinion tracked empirical reality. People should have worried less about coverage, because uninsurance declined (Altman 2019d; Galewitz 2019).⁸ Meanwhile, since 2010 costs had become much more burdensome. By 2018, “health care coverage for a family covered by a large employer cost, on average, \$22,885: equivalent to buying a new car each year” (Altman 2019b). Per capita spending for private insurance and out-of-pocket spending for those with private insurance both rose substantially, relative to personal incomes, over the preceding decade. Employer-based coverage had become even less affordable for low-wage workers who were offered it; “surprise bills” became a publicized problem; and a wide range of data showed substantial portions of voters with employer-sponsored insurance having trouble paying medical bills, foregoing care because of expense, or worried about being unable to pay for an emergency (Altman 2019a, 2019b, 2019c; KFF 2019a; Kirzinger et al. 2019). In short, the problem got worse, which is evidence enough of the ACA’s failings.

But what are the lessons? At one level, 2020 looks like “*déjà vu* all over again.” As in 2009 there is a clear gap between prospective voters’ views of the system as a whole (quite pessimistic) and of their own coverage (better). Advocates for Medicare for All (hereafter M4A), especially, are warned that they may scare risk-averse voters (e.g. Klein 2019, Thomson-Deveaux 2019). As M4A became an object of controversy, like virtually any specific proposal including the 2009 proposals, its popularity declined.⁹ Responses

7. For further information about the priority of costs see figure 1 in Kirzinger, Kearney, and Brodie 2019, which reports 70% calling lowering prescription drug costs a top priority, as opposed to 30% giving implementing a national Medicare-for-All plan the same importance.

8. The main census survey found that “8.5% of the U.S. population went without medical insurance for all of 2018,” compared to 13.3 in 2013). The rate had fallen to 7.9% before rising in 2018, likely due to Trump administration policies in regard to immigration and Medicaid (Galewitz 2019).

9. Trends can be tracked in sources already cited, or by searching the collection of responses at www.pollingreport.com/health.htm.

to opinion surveys have been based more on broad political leanings and loyalties than on knowledge about the questions (Holahan and Karpman 2019; Levitz 2019; KFF 2019b). Public “opposition to allowing experts to make decisions based on cost-effectiveness” was almost identical in 2019 to that in 2012 (Blendon, Benson, and McMurtry 2019: 2490–91).

Yet while all these dynamics persist, the charge that advocates for M4A are prioritizing coverage (which the public doesn’t care about so much) over cost control (which is more popular) is simply false. Yes, coverage expansion is a much more useful platform while chasing the Democratic nomination than for the general election. Yet the candidates pushing M4A have made costs the leading argument for their approach.¹⁰ Their plans would essentially *eliminate* out-of-pocket costs.

Both Sanders and Warren emphasize the statistics about people going without care and financial risks. Warren (2019a) explains her position as grounded in her research into the causes of bankruptcy—including that, “three quarters of those who declared bankruptcy after an illness were people who already had health insurance.” She emphasizes under-insurance, describing it as “like a car with the engine missing. It looks fine sitting in the garage, but is inadequate if they actually need to use it.” She describes her approach as, “the best way to cover every person in America at the lowest possible cost because it eliminates profiteering from our health care and leverages the power of the federal government to rein in spending” (Warren 2019b). Sanders’s (2019) summary of the case for his Medicare for All Act proclaims that the US has the “most expensive, inefficient and bureaucratic health care system in the world,” with much higher per capita costs in the United States than in other countries. He argues that “Medicare for All is the most cost-effective health care plan” because of huge savings in administrative costs from not having to deal with multiple insurers. In contrast, the official description of former Vice President Biden’s plan endorsed price regulation for pharmaceuticals, but declared other prices could be reduced by tackling “market concentration” with antitrust authority. It did not address the potential administrative savings from standardized insurance whether of M4A or some other form.

In short, in the debate as of late 2019, it was precisely the more “radical” candidates who were making the most evidence-based case for policies that would do what most people want: reducing costs. To them, the key lessons of the ACA are that trying to appeal to peoples’ risk-aversion failed both politically (as shown by the law’s weak support and fervent opponents) and

10. I refer below to statements downloaded on December 21, 2019.

as policy (as shown by the cost crisis). They believe, rightly or wrongly, that a better approach is to try to beat the medical industry by demonizing it—especially its least popular parts, pharmaceutical companies and insurers.

They are partially right about the substance. M4A isn't needed to achieve the administrative efficiencies, lower prices, and therefore much lower costs achieved in other countries. That is normally managed, instead, through “all-payer” regulations of plans and payments (White 2013b). But they are far more right than the critics who accuse them of pursuing the wrong goal.

Unfortunately, they appear to be wrong in assuming that ordinary voters know *why* they should support M4A. The problem is not simply that many voters don't know what M4A entails—after all, that's pretty logical given that Medicare for All as proposed is extremely different from *Medicare as It Is*. The real problem is nicely illustrated by an ordinary voter quoted by Goldstein (2019) that, “Medicare-for-all would be great if we could do the other side of the coin—get the cost down.”

Price regulation remains, as it was in 2009, far more popular with the voters than the delivery reform agenda, even if it is not as popular with the health policy community (Oberlander and White 2009; Blendon, Benson, and McMurtry 2019). But we appear to be years away from enough voters believing not only that prices are a big problem but also that Medicare is much better at controlling them. This may be blindingly obvious to the health care industry, but its leaders likely see government as more capable than most voters do. Yes, we can't expect voters to know much about much of anything. We also know that it has to be easier to attack drug companies and insurance companies than hospital and specialty physician group managers.¹¹ But until the cure is linked clearly to the diagnosis—government power and simplification as curing administrative costs and abusive prices—it will be too difficult to pass M4A, or even a less transformative all-payer reform.¹²

It is certainly possible that a frontal attack on the providers would fail. If voters tend to trust their physicians and other providers, then perhaps the latter will always be able to sell arguments that serious price regulation threatens to damage care and create rationing. Yet the evidence is so strong, and the supply of narratives of decline and abuse so large, that there should be a good chance of delegitimizing provider opposition—especially since

11. Even though, as the surprise billing evidence shows, many emergency physician and anesthesiology groups richly deserve to be attacked.

12. All-payer is less transformative because it can leave room for a private insurance industry, on a public utility model.

public opinion has tended to support price regulation in principle. Compared to providing less care, paying lower prices is a much more common sense approach to reducing costs—from patients' perspective, a form of seemingly “painless” cost control. The case has to be made with both evidence about current costs, such as the fact that even Medicare Advantage plans depend largely on government price-setting,¹³ and lots of talk about the scandalous behavior that should reduce faith in hospitals, especially, as authorities on health policy.

In short, no approach to reform is a clear political winner. Yet even M4A advocates might consider the possibility that setting the stage, by highlighting the diagnosis that individuals' cost problems are due to high prices and overhead costs, is a necessary step toward their policy goal. Republicans simply cannot speak as frankly on this topic, and contrasts on issues like drug prices would be easy to draw.

Ironically, then, the critics are right—even though their own refusal to see the cost-control aspects of M4A is part of the problem. It would make more sense, right now, to focus on costs and specific cost controls than on expanding coverage. That could begin with prescription drugs and the services that largely generate “surprise bills.” The first task now is to show ordinary voters that government is better at controlling costs. Democrats could be building toward either M4A or some sort of heavily regulated all-payer system. What they have in common—effective measures to make care more affordable within insurance plans—is far more important than their differences.

■ ■ ■

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13. In essence, plans with few exceptions pay the Medicare rates or something very similar for all services that are covered under prospective payment systems in fee-for-service Medicare. See Berenson et al. 2015 for an overview; the key language is in *Federal Register* 75, no. 73, April 15, 2011, page 21492. www.govinfo.gov/content/pkg/FR-2011-04-15/pdf/2011-8274.pdf.

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Implications for Households If the Supreme Court Overturns the Affordable Care Act

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Introduction

The U.S. Supreme Court is set to hold hearings on *California v. Texas* in November, a case in which the plaintiffs hope the court will invalidate the Affordable Care Act (ACA) in its entirety. The Trump administration has filed briefs in support of the plaintiffs, a group of state attorneys general led by Texas. The plaintiffs contend that the ACA is unconstitutional in light of the elimination of the individual mandate penalties beginning in 2019. Another group of attorneys general, led by California's attorney general, argue that the ACA remains constitutional and should rightfully stay in effect, regardless of the elimination of the individual mandate penalties.

Should the plaintiffs win the case and the ACA be invalidated, the implications would be widespread and affect virtually every corner of the health care system.^{1,2} Just some of the ACA reforms that would be overturned in such a decision and would directly and adversely affect households' health care costs include the following:

- the private insurance marketplaces through which people can purchase individual and family coverage; many of these consumers are eligible for premium tax credits that significantly reduce premiums and out-of-pocket costs falling on households
- expansion of Medicaid eligibility to people with incomes up to 138 percent of the federal poverty level, an option taken up by 36 states and the District of Columbia so far

- substantial changes to the rules of operation for private, individually purchased insurance markets (including insurance sold outside the ACA marketplaces) and small employer markets, such as guaranteed issue of all insurance plans (regardless of an applicant's health status); minimum benefit standards; maximum out-of-pocket limits; prohibitions on exclusions of coverage for preexisting conditions; prohibitions on insurers varying insurance prices based on health status, gender, occupation, or factors other than limited age variation and pricing based on tobacco use; and limits on insurer charges for administrative costs and profits
- prohibitions of coverage rescissions and lifetime and annual dollar benefit limits in all insurance plans in the employer and individually purchased markets
- elimination of the Medicare prescription drug "donut hole," a change that significantly reduced out-of-pocket costs facing elderly adults with significant medication needs

Before the COVID-19 pandemic, Urban Institute researchers estimated that the number of uninsured people in the United States would increase by approximately 20 million should the court find for the plaintiffs in the case (referred to as *Texas v US* when it was before the lower courts), decreasing the federal investment in health care by \$135 billion

per year and increasing the demand for uncompensated care by more than 80 percent.³

Here, we provide an overview of how overturning the ACA would affect average people and illustrative families in different circumstances. Should the law be overturned and its myriad consumer protections eliminated, the associated increases in household costs would fall heavily on families with moderate and low incomes losing federal subsidies to offset their medical costs and people with significant health care needs (a single event or ongoing medical conditions).

Overview of People Most Likely to Experience the Greatest Ramifications if the ACA Is Overturned

As noted, a finding for the plaintiffs in *California v. Texas* would eliminate the ACA's health insurance marketplaces and the federal subsidies that lower premiums and out-of-pocket costs for enrollees with moderate and low incomes. The following statistics provide insight into some financial benefits average marketplace enrollees receive today, benefits they would lose if there is a finding for the plaintiffs in the case:⁴

- Approximately 5.8 million Americans enroll in individual (single adult) marketplace policies and receive federal help paying for their coverage. The average adult in this group receives \$5,550 in assistance each year through premium tax credits.

- Another 2.7 million Americans enroll in marketplace plans with their family members and receive federal subsidies to help pay their premiums. The average family among this group receives \$17,130 in help each year through premium tax credits.
- Marketplace enrollees with the lowest incomes can enroll in insurance plans with lower out-of-pocket costs (e.g., deductibles, co-insurance) when receiving medical care. These cost-sharing reduction plans lower each enrollee's out-of-pocket costs by more than \$1,000 on average.
- 9.1 percent have been diagnosed with diabetes, liver, or kidney conditions
- 5.9 percent have been diagnosed with cancer
- 52.2 percent have been diagnosed with at least one of the above conditions

Certain broader subgroups of nonelderly adults with nongroup insurance would face greater increases in insurance premiums without the ACA in place:

- Over half of nongroup insurance enrollees are ages 45 and older, and their premiums would likely increase substantially because of elimination of the ACA's limits on age rating.
- Of all nongroup enrollees, 23.3 percent are women of child-bearing age (19–44), and their premiums would likely increase substantially when rating insurance premiums by gender is again permitted, despite the fact that maternity benefits were routinely excluded in this market before the ACA required they be included.

Without the ACA's Medicaid eligibility expansion, families with low incomes in 37 states (including DC) will lose the comprehensive coverage they receive through the program:⁶

- People enrolled in Medicaid through the ACA's expansion have an average income of 115 percent of the federal poverty level,⁷ approximately \$30,000 for a family of four.
- The average health expenses incurred by each person enrolled in Medicaid through the expansion is about \$6,450 per year.⁸ Therefore, the typical married couple enrolled in Medicaid through the ACA's expansion would lose almost \$13,000 in health benefits should the ACA be overturned. With an income of 115 percent of the federal poverty level (about \$19,800 for a family of two), replacing such benefits would cost two-thirds of their income.⁹

Illustrative Families in Real-World Circumstances

What follows are examples of what would happen to illustrative families with varying circumstances if the ACA were overturned.

We provide these illustrative scenarios for hypothetical people using realistic information on premiums, subsidies, pre-ACA program eligibility, and the costs of medical conditions to demonstrate how invalidation of the ACA would affect the types of families who rely upon it.

Susan is a 33-year-old divorced mom of two young children. She works as a cashier at the local grocery store in Lansing, Michigan, but she is not offered health insurance. She makes \$9.65 per hour and works full time, so her gross annual income is \$19,300. At this income, her family lives below the federal poverty level. Because of the Affordable Care Act, not only are Susan's children eligible for and enrolled in Medicaid coverage, but Susan is, too. They all receive free, comprehensive insurance coverage with virtually no out-of-pocket costs under the program. If the ACA is invalidated by the Supreme Court, the children can stay enrolled in Medicaid, but Susan will lose her coverage. Before the ACA, even \$19,300 per year for a family of three (89 percent of the federal poverty level) was too much income to make a parent eligible for Medicaid in many states, including Michigan, where the cutoff was 64 percent of the federal poverty level. Susan can barely make ends meet as is, covering rent, food, clothing, and other needs for her and the children. Without the ACA's Medicaid expansion, she will undoubtedly be uninsured. The sole support for her children, Susan is vulnerable to getting seriously ill and losing the family's income if she cannot access necessary medical care.

Berta and John, both 55 years old, are relieved that their jobs in essential industries have kept them employed throughout the pandemic. John works in construction and Berta works as a bookkeeper for a small business in Charlotte, North Carolina. Combined, they make almost \$52,000 per year, or about three times the federal poverty level. They each have mild health conditions (John has some ongoing back issues and Berta has asthma), and they have taken advantage of subsidized ACA marketplace insurance coverage. Today, the ACA provides them with a tax credit of more than \$12,000 that covers 70 percent

However, people obtaining coverage through the individual market using federal subsidies would not be the only privately insured people affected by ACA repeal. Because the ACA reforms that provide access to adequate coverage regardless of health status would be overturned, even enrollees with higher incomes would have difficulty obtaining coverage at all or obtaining sufficient coverage to meet their medical needs when they occur. This is because guaranteed issue and minimum standards for benefits and out-of-pocket cost limits in these markets would be eliminated. In addition, the ACA's safety net that allows people to purchase comprehensive coverage if they lose their employer-based insurance would be eliminated. Today, the population enrolled in insurance coverage through nongroup markets is somewhat more likely to have health problems than the rest of the population below Medicare-eligible age.

National Health Interview Survey data from 2018 indicate the following about adults ages 19 to 64 enrolled in nongroup coverage:⁵

- 25.6 percent have been diagnosed with a cardiovascular condition (coronary heart disease, heart attack, stroke, high cholesterol, angina pectoris, or another heart condition)
- 22.8 percent have been diagnosed with hypertension
- 14.3 percent have been diagnosed with arthritis, rheumatoid arthritis, lupus, fibromyalgia, or gout
- 13.2 percent have been diagnosed with a lung condition (asthma, emphysema, chronic bronchitis)

of the cost of their health insurance. Without the ACA, not only would they lose that large amount of assistance, but they would find health insurance harder to get and higher priced. Without the ACA, North Carolina law (like that of most states) would once again allow insurers to deny coverage to applicants outright, even for mild health conditions. Before the ACA, coverage sold outside of employment often excluded coverage for prescription medications and other services, meaning the coverage sold probably wouldn't meet the couple's needs even if they could get it. In addition, the ACA limits how much older adults can be charged for health care compared with younger adults; without that rule, coverage is much more expensive for John and Berta.

Fred is a 35-year-old living in Milwaukee, Wisconsin. He worked for a big company for eight years but started his own business in 2016, once ACA marketplace insurance coverage made self-employment and guaranteed health insurance possible. He buys health insurance in the nongroup market even though his \$60,000 annual income is high enough that he does not qualify for any tax credits to help him pay for it. Fred has had Crohn's disease, a chronic condition, since he was a teen. He manages the condition well with biologic therapies, but they are pricey. Today, he pays \$451 per month (about \$5,400 per year) for standard marketplace coverage that includes benefits for all his health care needs. Should the ACA be invalidated, the state's rules (again, like those in most other states) mean insurers could reject his applications for coverage or charge him much more for coverage if they were willing to sell it to him. Even then, any coverage he could get would most likely have significant limits, such as excluding the specialty drugs his health depends upon. His financial exposure would be so great, he would be faced with choosing between his health and incurring crushing debt. Recent studies estimate the average annual cost of treating Crohn's disease (for which there is no cure) at about \$25,000 per year.¹⁰

Tim, a 24-year-old recent college graduate works part time at a start-up in Little Rock, Arkansas, that does not offer health insurance to its workers. Under the ACA, he would be covered by his

parents' employer-sponsored policy for two more years. This is a critical provision for him, because he has opioid use disorder (OUD) and anxiety and suffers occasional major depressive episodes. If the ACA is overturned, he would likely be denied insurance in a traditional nongroup insurance market because of his preexisting conditions. Even if he can obtain a policy, coverage in the nongroup market would revert to that available before the ACA, which, as a general rule, excludes benefits for mental health and substance use disorders entirely. Without the ACA's Medicaid expansion, he would be unlikely to be covered by public insurance, because he is not a parent and his part-time job pays him too much to qualify for Medicaid by pre-ACA eligibility rules. He gets treatment for OUD and his mental health conditions today, which is why he can work at all, but his prescription drug treatments and counseling would all cost between \$6,000 and \$14,000 per year if he had to pay out-of-pocket.¹¹ Like other patients with serious behavioral conditions, he also receives more physical medical care than those without behavioral conditions, about 6 times as much in fact.¹² After the ACA is declared null and void, Tim would pay an estimated \$18,000 to \$26,000¹³ to get the kinds of care he does now on his parents' employer-based insurance policy. His parents try to help him out in many ways, but that level of annual financial support is well out of reach given their moderate income.

Lilly, a 78-year-old woman with diabetes and congestive heart failure living in Athens, Georgia, has benefitted quite a bit from the ACA's closure of the Medicare drug benefit's donut hole, the range of out-of-pocket spending wherein the original drug benefit stopped lowering costs for beneficiaries. The donut hole in the benefit passed in 2003 was created to save the federal government money, so the 2010 ACA identified government savings and new revenues to pay for closing it over a 10-year period. Lilly's medications, even with the standalone Part D drug plan she buys to supplement her traditional (fee-for-service) Medicare coverage, cost her \$1,555 annually today.¹⁴ If the ACA is overturned, she will pay about \$2,270 per year out of pocket. This means she would have to come up with an additional \$715 out of pocket

annually, or \$59 per month, roughly the amount she pays now for a discount cell phone plan to stay connected with her great-granddaughters who live in Alabama and Texas.

Angelica and Antonio, a Scottsdale, Arizona, couple both age 36, are parents to two young children. Sara, the baby, now age 4, was born premature and had complications, including surgery, that kept her in the hospital's neonatal intensive care unit for six months after birth. Though Antonio has consistently had employer-sponsored insurance that covers the whole family, without the ACA, the costs associated with Sara's birth alone would have caused the couple to go bankrupt, because the expenses for her care would have easily surpassed the \$1 million lifetime limit on coverage that was very common before the ACA outlawed it in 2010. With the ACA in place, and given Sara's ongoing care needs, Angelica and Antonio still have higher out-of-pocket spending than the average family, but they can afford it with the insurance they have through Antonio's job. Actuaries had concluded that ending lifetime (and annual) limits on insurance coverage would not add much to premiums,¹⁵ but they were commonplace before the ACA prohibited them. The couple recognizes that should the ACA be overturned, any continuing health issues Sara may have throughout her life could easily impede her ability to get adequate, affordable insurance.

Conclusion

The ACA's reach is wide: Beyond providing financial help for people with low and moderate incomes to obtain insurance, the law provides myriad regulations that protect the ability of people with health problems to enroll in adequate and affordable insurance coverage. In addition, it has changed how insurers and health care providers do business and how the latter are reimbursed. And it has changed how state Medicaid programs operate, share costs with the federal government, and measure income. For these reasons, invalidating the ACA would have ramifications for the entirety of the health care system, and it would severely compromise access to necessary medical care for millions of Americans, a vulnerability highlighted by the consequences of a pandemic.

ENDNOTES

- 1 [Brief for Petitioner](#). California v. Texas, No. 19-840 (5th Cir. filed Feb. 14, 2020).
- 2 Stacey McMorrow and John Holahan. A Supreme Court Ruling Finding the Affordable Care Act Unconstitutional Would Have Widespread Negative Implications. The Urban Institute. Forthcoming October 2020.
- 3 Banthin J, Blumberg L.J, Buettgens M, Holahan J, Pan C.W, Wang R. Implications of the Fifth Circuit Court decision in *Texas v. United States*. Urban Institute. 2020. https://www.urban.org/research/publication/implications-fifth-circuit-court-decision-texas-v-united-states/view/full_report. Published December 19, 2019. Accessed September 24, 2020.
- 4 The statistics in the following bullets were estimated using the Urban Institute’s Health Insurance Policy Simulation Model (HIPSM), 2020. HIPSM is a microsimulation model that has been widely used to estimate the cost and coverage implications of health care reforms affecting the U.S. population below age 65.
- 5 The nongroup market refers to directly purchased private health insurance inside and outside the marketplace. Cardiovascular conditions include those ever diagnosed with coronary heart disease, angina pectoris, heart attack, stroke, high cholesterol, or other heart conditions. Lung conditions include those ever diagnosed with emphysema or asthma or diagnosed with chronic bronchitis in past 12 months. Diabetes, renal, and liver conditions include those ever diagnosed with diabetes, hepatitis, or chronic liver conditions and those with weak or failing kidneys or a liver condition in the past 12 months. Hypertension is for those ever diagnosed. Arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia are for those ever diagnosed. Cancer is for those ever diagnosed.
- 6 Two additional states, Missouri and Oklahoma, passed ballot initiatives in 2020 to expand Medicaid under the ACA. However, they have not yet implemented those expansions.
- 7 Estimate from the Urban Institute’s Health Insurance Policy Simulation Model.
- 8 Estimate from the Urban Institute’s Health Insurance Policy Simulation Model.
- 9 Such benefits would actually cost more than that to replace if the couple became uninsured, because health care providers charge Medicaid significantly lower prices than they do people who are uninsured.
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Loss of the Affordable Care Act Would Widen Racial Disparities in Health Coverage

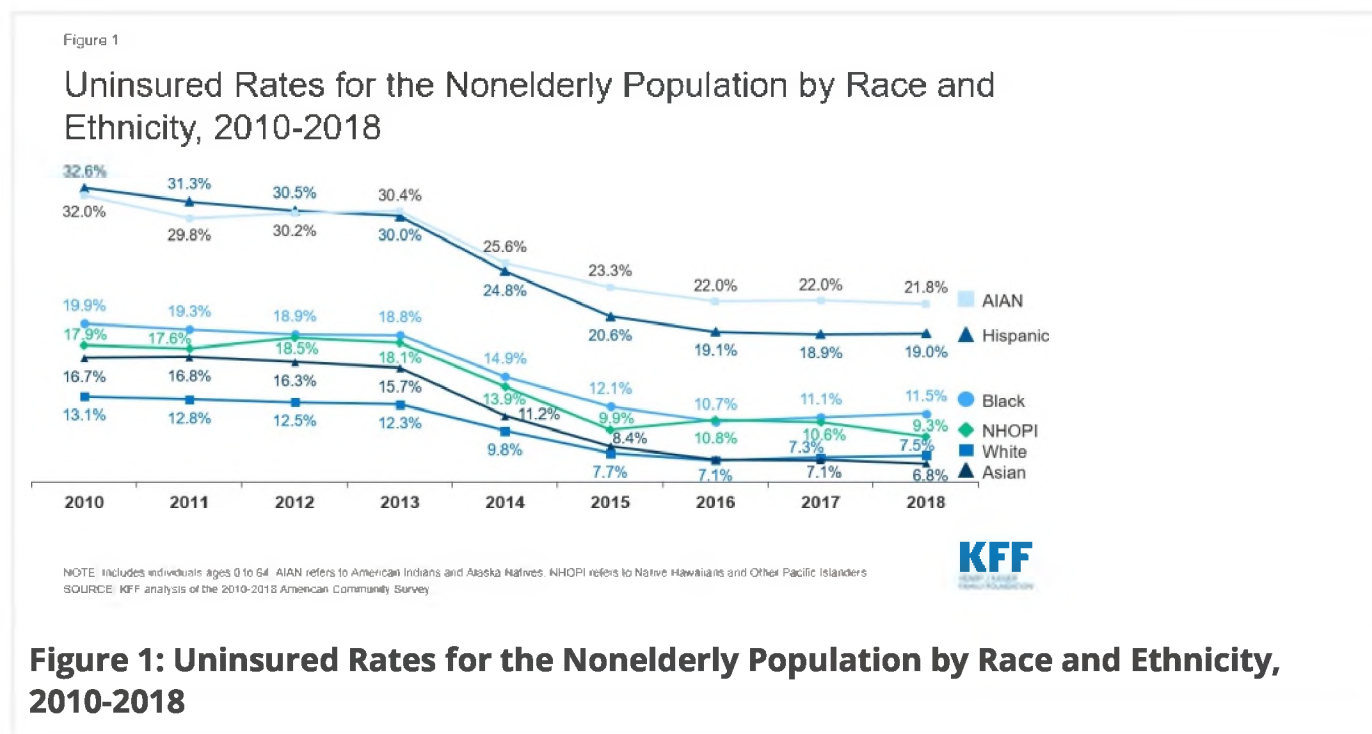
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Oct 01, 2020



In November, the Supreme Court is scheduled to hear arguments on a legal challenge, supported by the Trump administration, that seeks to overturn the Affordable Care Act (ACA). As noted in a previous [KFF analysis \(https://www.kff.org/health-reform/press-release/analysis-examines-the-affordable-care-acts-impact-on-nearly-all-americans/\)](https://www.kff.org/health-reform/press-release/analysis-examines-the-affordable-care-acts-impact-on-nearly-all-americans/), the outcome will have major effects throughout the health care system as the law's provisions have affected nearly all Americans in some way. One of the most significant aspects of the ACA has been its expansion of health coverage options through the Medicaid expansion to low-income adults and the creation of the health insurance marketplaces with subsidies to help people purchase coverage. This analysis shows that these new coverage options have contributed to large gains in coverage, particularly among people of color, helping to narrow longstanding racial disparities in health coverage. The loss of these coverage pathways, particularly the [Medicaid expansion \(https://www.kff.org/policy-watch/eliminating-the-aca-what-could-it-mean-for-medicaid-expansion/\)](https://www.kff.org/policy-watch/eliminating-the-aca-what-could-it-mean-for-medicaid-expansion/), would likely lead to disproportionate coverage losses among people of color, which would widen disparities in coverage, access to care, and health outcomes.

Prior to the ACA, people of color were significantly more likely to be uninsured than White people. The higher uninsured rates among groups of color reflected limited access to affordable health coverage options. Although the majority of individuals have at least one full-time worker in the family across racial and ethnic groups, people of color are more likely to live in low-income families that do not have coverage offered by an employer or to have difficulty affording private coverage when it is available. While Medicaid helped fill some of this gap in private coverage for groups of color, before the ACA, Medicaid eligibility for parents was limited to those with very low incomes (often below 50% of the poverty level), and adults without dependent children—regardless of how poor—were ineligible under federal rules.

People of color experienced large coverage gains under the ACA that helped to narrow but did not eliminate disparities in health coverage. Coverage rates increased for all racial/ethnic groups between 2010 and 2016 (<https://www.kff.org/racial-equity-and-health-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018/>), with the largest increases occurring after implementation of the ACA Medicaid and Marketplace coverage expansions in 2014 (Figure 1). Overall, nearly 20 million nonelderly people gained coverage over this period, including nearly 3 million Black people, over 5 million Hispanic people, and over 1 million Asian people. Among the nonelderly population, Hispanic individuals had the largest percentage point decrease in their uninsured rate, which fell from 32.6% to 19.1% between 2010 and 2016. Black, Asian, American Indian and Alaska Native (AIAN), and Native Hawaiian or Other Pacific Islander (NHOPI) people also had larger percentage point decreases in their uninsured rates compared to their White counterparts over that period. These coverage gains reduced percentage point differences in uninsured rates between some groups of color and White people, but disparities persisted. Most groups of color remained more likely to be uninsured compared to White people. Moreover, the relative risk of being uninsured compared to White people did not improve for some groups. For example, Black people remained 1.5 times more likely to be uninsured than White people, and the uninsured rate among Hispanic people remained over 2.5 times higher than the rate for White people.



Between 2016 and 2017, and continuing in 2018, coverage gains stalled and began reversing for some groups. Over this period there were small but statistically significant increases in the uninsured rates for White and Black people among the nonelderly population, which rose from 7.1% to 7.5% and from 10.7% to 11.5% respectively. Among children (<https://www.census.gov/content/census/en/library/publications/2019/demo/p60-267.html>), there was also a statistically significant increase in the uninsured rate for Hispanic children, which

rose from 7.6% to 8.0% between 2016 and 2018. [Recent data \(https://www.kff.org/policy-watch/what-we-do-and-dont-know-about-recent-trends-in-health-insurance-coverage-in-the-us/\)](https://www.kff.org/policy-watch/what-we-do-and-dont-know-about-recent-trends-in-health-insurance-coverage-in-the-us/) further show that the number of uninsured continued to grow in 2019 despite improvements in household economic measures, and indicate the largest increases between 2018 and 2019 were among [Hispanic people \(https://www.census.gov/library/publications/2020/demo/p60-271.html\)](https://www.census.gov/library/publications/2020/demo/p60-271.html). The growth in the uninsured likely reflects a combination of factors, including rollback of outreach and enrollment efforts for ACA coverage, changes to Medicaid renewal processes, public charge policies, and elimination of the individual mandate penalty for health coverage.

The ACA provides coverage options for people losing jobs amid the economic downturn associated with the pandemic. The economic fallout of the coronavirus pandemic has led to historic levels of job loss. As people lose jobs, many may face disruptions in their health coverage since most people in the U.S. get their insurance through their job. [Early KFF estimates \(https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/\)](https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/) of the implications of job loss found that nearly 27 million people were at risk of losing employer-sponsored health coverage due to job loss. Many of these people may have retained their coverage, at least in the short term, under furlough agreements or employers continuing benefits after layoffs. However, the health coverage options made available through the ACA have provided options for people losing employer-sponsored coverage who might otherwise become uninsured. Following enrollment declines in 2018 and 2019, [recent data \(https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/\)](https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/) indicate Medicaid enrollment increased by 2.3 million or 3.2% from February 2020 to May 2020. Additionally, as of May 2020, [enrollment data \(https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SEP-Report-June-2020.pdf\)](https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SEP-Report-June-2020.pdf) reveal nearly 500,000 people had gained Marketplace coverage through a special enrollment period (SEP), in most cases due to the loss of job-based coverage. The number of people gaining Marketplace coverage through a SEP in April 2020 was up 139% compared to April 2019 and up 43% in May 2020 compared to May 2019.

People of color would likely experience the largest coverage losses if the ACA coverage options were eliminated. In the absence of the ACA, states would lose a pathway to cover adults without dependent children through Medicaid under federal rules. They also would lose access to the enhanced federal funding provided to cover expansion adults. As such, states would face challenges to maintain coverage for adults without dependent children and parents and many would likely roll back this coverage, eliminating a coverage option for millions of low-income parents and childless adults who do not have access to other affordable coverage. Moreover, without the federal subsidies, many people would not be able to afford private coverage. Since people of color experienced larger gains in coverage under the ACA compared to their White counterparts, they would likely also experience larger coverage losses if these coverage options were eliminated.

Loss of the Medicaid expansion, in particular, would likely lead to disproportionate coverage losses among people of color, contributing to widening disparities in coverage, access to and use of care, and health outcomes. Overall, among the nonelderly population, roughly one in three Black, Hispanic, and AIAN people are covered by Medicaid compared to 15% of White people (Figure 2). Further, research shows that the ACA Medicaid expansion to low-income adults has helped to narrow racial disparities in health coverage, contributed to improvements in access to and use of care across groups, and narrowed disparities in health outcomes for Black and Hispanic individuals, particularly for measures of maternal health.

Figure 2: Health Insurance Coverage of the Nonelderly Population by Race/Ethnicity, 2018

In sum, the outcome of the pending legal challenge to overturn the ACA will have effects that extend broadly across the health care system and touch nearly all Americans. These effects could include widening racial disparities in health coverage and health care, at a time when there is a growing focus on prioritizing and advancing health equity and in the middle of a pandemic that has disproportionately affected people of color in the US. Without the ACA coverage expansions, people of color would likely face widening gaps in health insurance coverage, which would contribute to greater barriers to health care and worse health outcomes and leave them at increased risk for medical debt and financial challenges due to health care costs.

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Racial And Ethnic Inequities In Children's Neighborhoods: Evidence From The New Child Opportunity Index 2.0

ABSTRACT Neighborhoods influence children's health, so it is important to have measures of children's neighborhood environments. Using the Child Opportunity Index 2.0, a composite metric of the neighborhood conditions that children experience today across the US, we present new evidence of vast geographic and racial/ethnic inequities in neighborhood conditions in the 100 largest metropolitan areas in the US. Child Opportunity Scores range from 20 in Fresno, California, to 83 in Madison, Wisconsin. However, more than 90 percent of the variation in neighborhood opportunity happens within metropolitan areas. In 35 percent of these areas the Child Opportunity Gap (the difference between Child Opportunity Scores in very low- and very high-opportunity neighborhoods) is higher than across the entire national neighborhood distribution. Nationally, the Child Opportunity Score for White children (73) is much higher than for Black (24) and Hispanic (33) children. To improve children's health and well-being, the health sector must move beyond a focus on treating disease or modifying individual behavior to a broader focus on neighborhood conditions. This will require the health sector to both implement place-based interventions and collaborate with other sectors such as housing to execute mobility-based interventions.

A long tradition of social science research has examined how neighborhoods influence socioeconomic and health outcomes during the life course.¹ In the past decade increasingly strong evidence indicates that there has been a causal relationship between children's neighborhood environment and educational attainment, employment, income, and health outcomes.^{2,3} In addition, a large body of research has documented high levels of racial residential segregation in US metropolitan areas and high levels of geographic concentration of both poverty and affluence.⁴⁻⁷ Starting in the 1990s, groundbreaking work by George Galster and colleagues has connected these two research traditions, ar-

guing that an unequal "geography of opportunity" in metropolitan areas—that is, differential access to neighborhood-based opportunity—leads to inequities in outcomes by race and ethnicity.^{8,9}

Building on the geography of opportunity scholarship,¹⁰⁻¹³ in 2014 we published the Child Opportunity Index to provide the child health field with a measure of children's neighborhood opportunity, which we defined as the context of neighborhood-based conditions and resources (for example, early childhood education, schools, availability of healthy food) that influence children's healthy development and long-term outcomes such as health and socioeconomic mobility.¹⁴ Our goal was to facilitate analysis of the

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relationship between neighborhood opportunity and child outcomes; equity analysis of children's access to neighborhood opportunity, particularly by race and ethnicity; and identification of neighborhoods of low and high opportunity for targeted interventions.

The index was designed as a tool for both research and applied uses in health and other sectors. Since its publication, researchers have found associations between higher child neighborhood opportunity and better child health (reduced cortisol, asthma-related hospitalizations, and pediatric acute care visits).¹⁵⁻¹⁹ Practitioners have used the index to characterize inequities in neighborhood environment in their communities and to develop interventions for specific neighborhoods.²⁰⁻²²

After several years of research and application, we have updated the Child Opportunity Index and improved its methodology, taking advantage of newly released, high-quality data sets on neighborhood features and outcomes of children growing up in different neighborhoods.

Definitions

The Child Opportunity Index builds on a positive definition of children's health: the ability of children to achieve healthy development in all areas (physical, cognitive, emotional, and social) and to reach their full potential.²³

Neighborhood environment is an important influence on children's health because essential proximal inputs for healthy child development (for example, schools and the built environment) are neighborhood based.^{1,10,18,24,25} In addition to a large body of cross-sectional evidence, rigorous research has shown a causal link between neighborhood environment and outcomes. Evidence from a randomized social experiment showed a causal link between growing up in low-poverty neighborhoods and long-term outcomes such as higher college attendance, higher earnings, and lower rates of single parenthood.³ An analysis of data on seven million families further established a causal link between the neighborhoods where children grow up and their earnings, college attendance, and family formation as adults.² A review of the empirical evidence on neighborhood effects is beyond the scope of this article, but several recent systematic reviews have explored the influence of neighborhoods on child health and development.^{1,26-28}

Although neighborhoods influence children's outcomes, evidence on how specific neighborhood traits influence specific outcomes is still emerging. Many studies focused on the neighborhood poverty rate. However, scholars of

neighborhood effects agree that neighborhoods are multidimensional and influence outcomes through a variety of mechanisms; for example, exposure to air pollution may affect childhood asthma, whereas neighborhood walkability may affect physical activity.^{1,24,25,29}

Unique Features Of The Child Opportunity Index 2.0

The Child Opportunity Index is not the only index of neighborhood environment, but it has unique features that make it useful for studying children's neighborhoods. First, the Child Opportunity Index was developed with a conceptual model of child development. Therefore, it includes child-relevant indicators such as the presence of early childhood education centers, availability of healthy food, and walkability. For a complete list of indicators and definitions, see online appendix B.³⁰

Second, the Child Opportunity Index was built to capture neighborhood resources that facilitate healthy child development, not as an index of concentrated disadvantage or vulnerability.

Third, the Child Opportunity Index 2.0 summarizes children's neighborhood conditions around 2015 to capture recent conditions that children experience in their neighborhoods. Other neighborhood measures provide historical prospective information on the extent of socioeconomic mobility that children who grew up in those neighborhoods a few decades ago experienced later as adults.³¹

Finally, the Child Opportunity Index 2.0 includes both 2010 and 2015 data, which are comparable over time, allowing longitudinal analysis.

Differences Between The Child Opportunity Index 1.0 And 2.0

The Child Opportunity Index 2.0 differs from the 2014 version in important ways. The index is now available for virtually all US neighborhoods (that is, census tracts) for both 2010 and 2015, rather than for just the 100 largest metropolitan areas at a single time point. The Child Opportunity Index 2.0 is based on twenty-nine neighborhood indicators, rather than the nineteen indicators used for the Child Opportunity Index 1.0, which capture important mechanisms through which neighborhoods influence children. We improved the quality of measurement for several of the indicators. Furthermore, instead of equally weighting all indicators in the index, the Child Opportunity Index 2.0 makes use of the correlations between its component indicators and health and socioeconomic mobility outcomes

at the neighborhood level to give more weight to indicators more strongly associated with the outcomes of interest. Appendix A provides a more detailed discussion of the differences between Child Opportunity Index 1.0 and Child Opportunity Index 2.0.³⁰

Some of the work presented here has been described previously.³² The current article includes additional analysis, including the distribution of children in poor families across levels of neighborhood opportunity, the correlation between the Child Opportunity Gap and racial/ethnic gaps in child opportunity, and the association between childhood disability and levels of neighborhood opportunity (the latter is in appendix K).³⁰

Study Data And Methods

INDEX DOMAINS AND INDICATORS To select indicators, we adapted Galster's classification of mechanisms through which neighborhoods influence children: social-interactive, environmental, geographic, and institutional.²⁵ However, because our goal is for the index to be applied by diverse stakeholders, not only academic researchers, we grouped the indicators into three domains that correspond to policy and programmatic sectors: education, health and environment, and social and economic opportunity.

We conducted a multidisciplinary literature review of empirical studies documenting the association between the domains of the index and child outcomes. However, data availability was an important constraint. Certain metrics examined in the literature are not available nationally for all census tracts or for our two index time points (2010 and 2015).

Conceptually, the Child Opportunity Index does not assume that there is an underlying construct named "neighborhood opportunity" but instead posits a set of distinct factors that influence multiple outcomes through distinct mechanisms. We tested this assumption by examining the indicators in the Child Opportunity Index using factor analysis. Although we found a socioeconomic conditions factor (neighborhood poverty, public assistance rate, homeownership rate, high-skill employment, median household income, single-headed households, and adult educational attainment), our analysis did not support the existence of an opportunity latent structure (see appendix A).³⁰

INDEX CONSTRUCTION We calculated the Child Opportunity Index 2.0 for 72,000 (nearly all) neighborhoods (that is, census tracts as defined by the Census Bureau) in the US. The present analysis includes all 47,000 neighborhoods in the 100 largest (based on population size) met-

ropolitan areas, which are home to two-thirds of the US child population. Census tracts contain approximately 4,000 people and 1,600 housing units. A metropolitan area contains a core urban population of at least 50,000 people and includes the counties containing the core urban area and adjacent counties that have a high degree of socioeconomic integration with the urban core.³³

Because the Child Opportunity Index indicators are measured on different scales (counts, percentages, currency), the raw values of each indicator are standardized, using z-scores to combine them into the index. Indicators are weighted to reflect the strength of association between selected adult health outcomes (prevalence of poor self-rated mental/physical health) and economic outcomes (mean household income rank and probability of living in a low-poverty census tract at age thirty-five for children with parents at the fiftieth percentile of the parent income distribution) aggregated at the neighborhood level.³⁴ Appendix A contains details on the Child Opportunity Index construction and the measures described below.³⁰

CHILD OPPORTUNITY SCORES To construct Child Opportunity Scores, all neighborhoods are ranked nationally according to their Child Opportunity Index z-scores from lowest to highest and then divided into 100 rank-ordered groups. Each group contains 1 percent of the US child population and is assigned a Child Opportunity Score from 1 (lowest opportunity) to 100 (highest opportunity).

For some analysis, neighborhood-level Child Opportunity Scores are aggregated up to the metropolitan area level and can be interpreted as the neighborhood opportunity score experienced by the typical (that is, median) child in a given metropolitan area, or the overall opportunity score in the metropolitan area. We calculated aggregate opportunity scores for individual metropolitan areas by taking the weighted median value of scores across all census tracts in the metropolitan area of interest, using the number of children in each tract as weights. This method is akin to exposure indices, which are extensively used in the literature on segregation and neighborhood inequality.³⁵⁻³⁷

To break down variation in neighborhood Child Opportunity Scores into between- and within-metropolitan-area variations, we used analysis of variance based on regressing Child Opportunity Scores for all 72,000 tracts on a set of dummy variables for each of the 100 metropolitan areas. The percentage variance explained by this regression measures the amount of variation in the opportunity scores between metropolitan areas, and 100 minus the R^2 yields the

amount of variation within metropolitan areas. A more detailed explanation of the analysis is in appendix A.1.³⁰

CHILD OPPORTUNITY LEVELS Child Opportunity Index z-scores are expressed as Child Opportunity Levels, constructed by dividing all neighborhoods in a metropolitan area into five ordered groups, each containing 20 percent of the child population in that area. We labeled these five groups as very low-opportunity, low-opportunity, moderate-opportunity, high-opportunity, and very high-opportunity neighborhoods.

CHILD OPPORTUNITY GAP To understand variation in opportunity within metro areas, we examined the Child Opportunity Gap: the difference between the conditions in a metropolitan area's very high-opportunity neighborhoods and the conditions in its very low-opportunity neighborhoods (measured by the average Child Opportunity Score for neighborhoods in each of these two levels). Because the gap is measured using nationally normed opportunity scores, we can compare the size of the gap between metropolitan areas.

CHILD OPPORTUNITY HOARDING AND SHARING Metropolitan areas differ in terms of the extent to which communities or neighborhoods hoard or share resources with other communities or neighborhoods in the same area.³⁸ We characterized metropolitan areas with wide Child Opportunity Gaps as areas of child opportunity hoarding. We defined wide gaps as those as wide as or wider than the gap between very high- and very low-opportunity neighborhoods across the entire national neighborhood distribution (80 points). We characterized metropolitan areas with narrower gaps (fewer than 80 points) as areas of opportunity sharing.

RACIAL/ETHNIC SCORES We constructed opportunity scores for the following racial/ethnic groups: non-Hispanic White, Black, or Asian and Pacific Islander and Hispanic (which may be of any race).³⁹ The score for a given racial/ethnic group may be interpreted as the score of the neighborhood experienced by the typical (median) child of that group in a given metropolitan area.

POPULATION DISTRIBUTION ACROSS LEVELS OF NEIGHBORHOOD OPPORTUNITY By construction, each of the five opportunity levels includes 20 percent of the child population. Absent racial/ethnic inequities in neighborhood opportunity, all children, regardless of race/ethnicity, would be distributed evenly across opportunity levels (about 20 percent in each level). We calculated the percentage of children living in each of the five opportunity levels by race/ethnicity and poverty. Poor children are defined as those living

in families with incomes less than 100 percent of the federal poverty level.³⁹

LIMITATIONS Despite its improvements over the first Child Opportunity Index, the new index has limitations. The Child Opportunity Index 2.0 lacks indicators on certain neighborhood features that previous research has identified as relevant for children but for which we were unable to gather comparable data for the entire country. These include measures of neighborhood-level prevalence of violence, crime, aggressive policing, social capital, collective efficacy, and density of primary health care.

Furthermore, the weights used to combine indicators into domains and aggregate scores are constant across all census tracts and over time. We could allow variation by metropolitan areas, but this would impede one of our main goals: producing a metric to compare neighborhoods across the US.

Study Results

Metropolitan area-level Child Opportunity Scores vary considerably across the country, ranging from 20 in Fresno, California, to 83 in Madison, Wisconsin. Regionally, the average score for metros is lowest in the South, with a Child Opportunity Score of 50, compared with 53 in the West, 64 in the Midwest, and 65 in the Northeast. See appendices F–K for data on all measures used in the analysis for each of the 100 metropolitan areas.³⁰

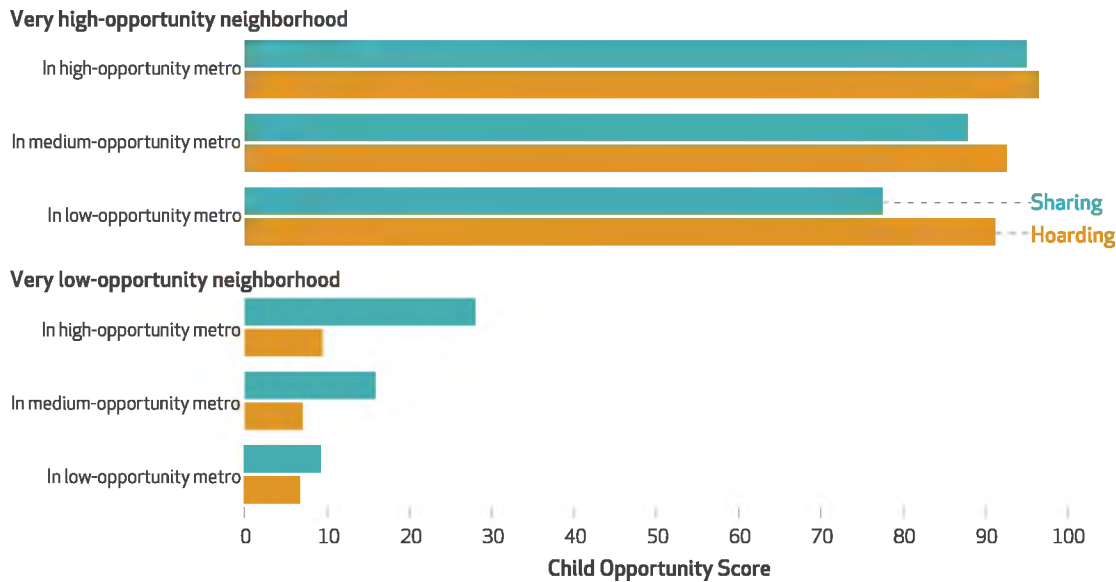
Despite these differences, inequities in child opportunity are larger within metropolitan areas than across the country. According to the analysis of variance, 91 percent of the variation in child opportunity happens within metropolitan areas, whereas only 9 percent happens between them.

Exhibit 1 stratifies metropolitan areas into three groups (low, medium, and high overall opportunity) based on their Child Opportunity Scores, and then further stratifies each group according to the size of their Child Opportunity Gap (difference in scores between very low-opportunity and very high-opportunity neighborhoods), categorized as hoarding (gaps of 80 or above) or sharing (gaps of less than 80).

Hoarding metropolitan areas have the worst conditions (lowest scores) for children living in the lowest-opportunity neighborhoods (exhibit 1). In hoarding areas, very low-opportunity neighborhoods have similar, very low scores regardless of the overall (median) opportunity in the metropolitan area. In contrast, in sharing areas, the scores for very low-opportunity neighborhoods are higher and are positively associated with the overall level of opportunity in the

EXHIBIT 1

Average scores of very low- and very high-opportunity neighborhoods, by overall metropolitan area opportunity level and hoarding or sharing status for the metropolitan area



SOURCE Opportunity Index 2.0, diversitydatakids.org (see note 32 in text). **NOTES** Authors' calculations. See online appendix A: Technical Appendix (see note 30 in text).

area.

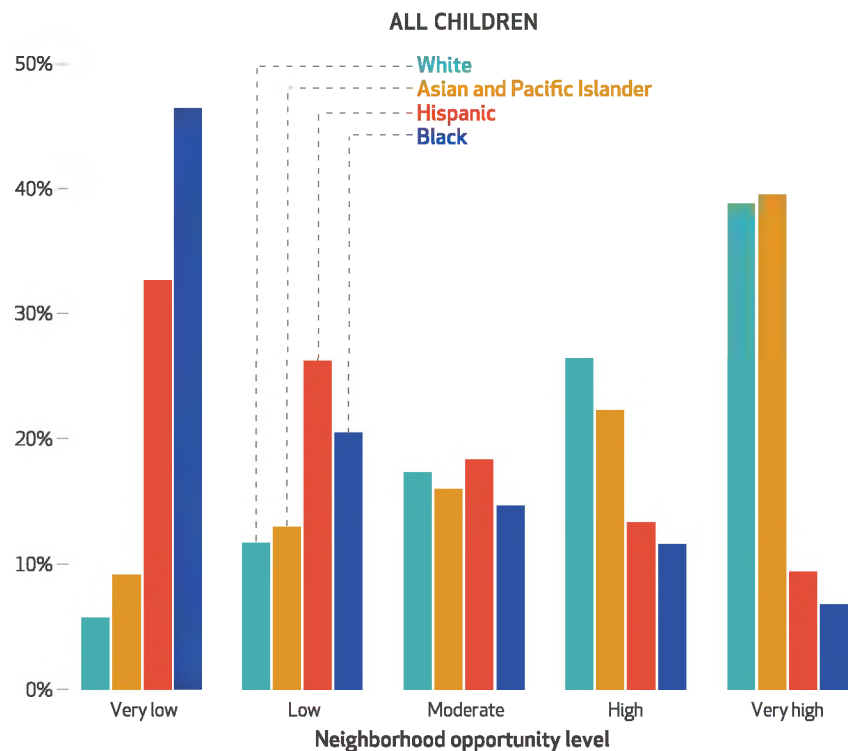
We examined racial/ethnic opportunity gaps, defined as the difference in the score of the typical White child's neighborhood and the score of the typical minority child's neighborhood. For the 100 largest metropolitan areas combined, the Child Opportunity Score for White children is 73 compared with 72 for Asian and Pacific Islander children, 33 for Hispanic children, and 24 for Black children.

Opportunity hoarding is positively associated with large gaps between White and Black or Hispanic children. The correlations between the Child Opportunity Gap and the Black-White and Hispanic-White gap are 0.81 and 0.72, respectively (data not shown). In a given metropolitan area, the wider the gap in scores between very low- and very high-opportunity neighborhoods, the larger the gap in the scores between the neighborhoods of White children and the neighborhoods of Black or Hispanic children. Although there are racial/ethnic gaps in all metropolitan areas, in hoarding areas Black and Hispanic children live in neighborhoods with much lower opportunity scores than White children do.

As shown in exhibit 2, non-Hispanic White (39 percent) and Asian and Pacific Islander (40 percent) children are concentrated in very high-opportunity neighborhoods, whereas Hispanic (33 percent) and Black (46 percent) chil-

EXHIBIT 2

Percent of all children across levels of neighborhood opportunity, by race/ethnicity (100 largest metropolitan areas combined)



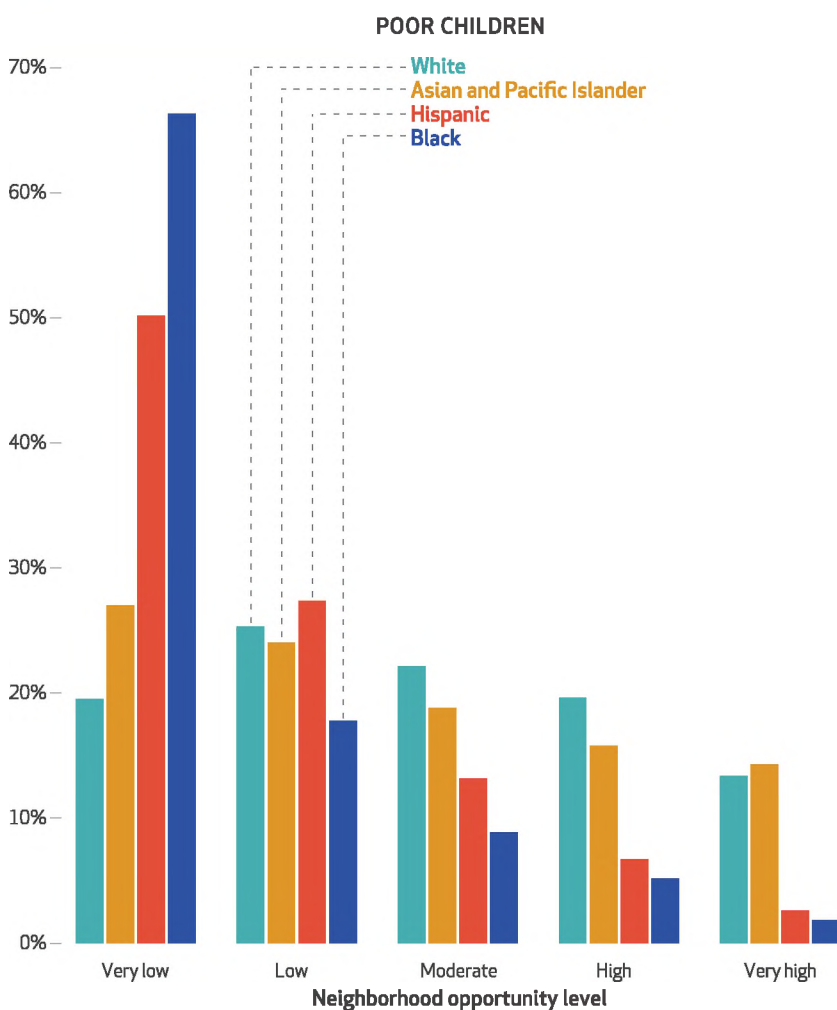
SOURCE Child Opportunity Index 2.0, diversitydatakids.org (see note 32 in text). Population data from the Census Bureau, American Community Survey 5-Year Summary Files for 2013–17. **NOTES** Authors' calculations. See online appendix A: Technical Appendix (see note 30 in text).

dren are disproportionately concentrated in very low-opportunity neighborhoods.

Family poverty can play a role in access to opportunity as a result of higher housing costs in high-opportunity neighborhoods. Therefore, we further stratified the distribution of children across opportunity levels by poverty status. We found vast racial/ethnic inequities in neighborhood opportunity among children in poverty. As shown in exhibit 3, 66 percent of poor Black children and 50 percent of poor Hispanic children live in very low-opportunity neighborhoods compared with 20 percent of poor White children.

EXHIBIT 3

Percent of poor children across levels of neighborhood opportunity, by race/ethnicity (100 largest metropolitan areas combined)



SOURCE Child Opportunity Index 2.0, diversitydatakids.org (see note 32 in text). Population and poverty data from the Census Bureau, American Community Survey 5-Year Summary Files for 2013–17.

NOTES Authors' calculations. See online appendix A: Technical Appendix (see note 30 in text).

Discussion

Our findings are consistent with prior research that suggests that residential segregation and neighborhood inequality by race/ethnicity largely play out at the metropolitan area level.^{40,41} We show that according to the Child Opportunity Index 2.0, a measure of inputs for healthy child development, inequities in child neighborhood opportunity mainly (91 percent) happen within metropolitan areas rather than across the country (data not shown).

Demographers, sociologists, and housing scholars have examined the problems of concentrated disadvantage, concentrated affluence, and opportunity hoarding.^{5,6,38} This is an important conceptual and policy issue. Both research and policy often focus on concentrated disadvantage and place-based interventions without acknowledging that concentrated disadvantage exists in the context of an unequal distribution of neighborhood resources in which the other end of the distribution is concentrated affluence. We add to this evidence by showing that metropolitan areas vary in the magnitude of their Child Opportunity Gap. In more than one-third of metropolitan areas, the gap between their very high- and very low-opportunity neighborhoods is larger than the gap across the entire national neighborhood distribution. We also document that larger Child Opportunity Gaps are associated with larger racial/ethnic inequities in neighborhood opportunity.

Policy Implications

Metropolitan areas are relatively small geographic areas where geographic redistribution of economic, educational, and health resources should be technically feasible. However, historically, US metropolitan areas have evolved toward high jurisdictional fragmentation—that is, they are divided into cities, towns, and municipalities. This fragmentation goes hand in hand with the ability of jurisdictions to enact barriers that exacerbate residential segregation, limit access to neighborhood opportunity, and impede policy and programmatic solutions at the metropolitan-area level.^{38,40,42} For example, high fragmentation is associated with zoning laws that preclude more multifamily and affordable housing in some jurisdictions, which disproportionately excludes Black and Hispanic children.^{43,44} Therefore, although neighborhood inequities are within metropolitan areas, policy solutions at higher levels of government are needed to mitigate the consequences of fragmentation. State zoning reform laws can limit the ability of lower jurisdictions to enact exclusionary zoning, and federal and state laws can reward the

development of affordable housing in higher-opportunity areas.⁴⁵

Although small relative to the overall public expenditures in their sector, there are emerging practices that acknowledge the importance of neighborhood context and seek to improve access to neighborhoods with conditions and resources favorable for healthy development. Relatedly, the use of indices to assess neighborhood conditions and guide interventions is gaining acceptance in some policy sectors such as fair housing and housing assistance for low-income families. For example, housing mobility programs use the metrics of neighborhood opportunity to provide low-income families that receive housing assistance with information about housing availability in neighborhoods with higher-performing schools, lower poverty rates, lower crime, and other features important for families with children.⁴⁶ A recent housing mobility policy demonstration allocates \$50 million for public housing agencies to develop programs to help low-income families access low-poverty, high-opportunity neighborhoods.⁴⁷ However, this represents only a small fraction of the total annual federal expenditures on tenant-based rental housing assistance programs (\$22.6 billion).⁴⁸

Some trends in the health sector may present openings for addressing neighborhood opportunity. Along with increasing attention to social determinants of health and social interventions, some health care systems are using neighborhood-level data to identify patients for targeted social risk screening and referrals to social services and to identify vulnerable communities.^{49,50} A few organizations offer promising practices by identifying and treating highly disadvantaged neighborhoods as “patients” to address social determinants.⁵¹

Community needs assessments and implementation of strategies to improve community conditions are encouraged or required in various policy sectors (for example, health, early childhood), but the use of neighborhood data or an

equity-focused analysis is not required. Before the Affordable Care Act (ACA), hospitals spent less than 6 percent of their community benefits on community health improvements.⁵² Hospitals are gradually moving toward more rigorous community needs assessments and implementation of community-level strategies, as mandated by the ACA.⁵³ It remains to be seen whether this will lead to larger investments in community health. A promising trend, however, is an increasing recognition that “place matters” not only as a marker of health risk but also as a focus for health interventions. For example, a forthcoming report from the surgeon general will highlight the connection between community health and economic prosperity and suggest that community-level interventions are needed to improve population health.⁵⁴

Conclusion

Neighborhood environment matters for child health and well-being. Therefore, to improve children’s health, the health sector should move beyond a focus on treating disease or modifying individual behavior to a broader focus on improving children’s neighborhood conditions. This will require the health sector to both implement place-based interventions and collaborate with other sectors such as housing to implement mobility-based interventions.

The health and economic crisis associated with coronavirus disease 2019 (COVID-19) has heightened awareness of racial/ethnic inequities and their connection to residential segregation.^{55,56} Although neighborhood measurement and interventions are still emerging practices in the health sector, the present crisis should strengthen our focus on reducing neighborhood inequities. Neighborhood indices such as the Child Opportunity Index can provide the health sector with a surveillance system of children’s neighborhood environments and help guide interventions. ■

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Ten Years of Messaging about the Affordable Care Act in Advertising and News Media: Lessons for Policy and Politics

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Abstract Messaging about the Affordable Care Act (ACA) has seemingly produced a variety of outcomes: millions of Americans gained access to health insurance, yet much of the US public remains confused about major components of the law, and there remain stark and persistent political divides in support of the law. Our analysis of the volume and content of ACA-related media (including both ads and news) helps explain these phenomena, with three conclusions. First, the information environment around the ACA has been complex and competitive, with messaging originating from diverse sponsors with multiple objectives. Second, partisan cues in news and political ads are abundant, likely contributing to the crystallized politically polarized opinion about the law. Third, partisan discussions of the ACA in political ads have shifted in volume, direction, and tone over the decade, presenting divergent views regarding which party is accountable for the law's successes (or failures). We offer evidence for each of these conclusions from longitudinal analyses of the volume and content of ACA messaging, also referencing studies that have linked these messages to attitudes and behavior. We conclude with implications for health communication, political science, and the future outlook for health reform.

Keywords media, advertising, health insurance, Affordable Care Act, politics

The decade since the passage of the Affordable Care Act (ACA) has produced a mixed bag of outcomes from the perspective of health communication. On the one hand, more than 20 million people became insured by 2016 as a result of the law's implementation (Obama 2016), although there is evidence of an erosion of these gains since 2017 (see, e.g., Griffith et al. 2020). The sheer volume of this increase is unprecedented in recent US

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history: millions of people gained insurance through Medicaid expansion, insurance newly available for young adults, and new plans available and subsidized on the individual marketplace. These increases in coverage reduced health care access disparities by income and race/ethnicity (Lipton, Decker, and Sommers 2019; Griffith et al. 2020; Kominski, Nonzee, and Sorensen 2017). Of course, some of these insurance gains can be attributed to specific policy mechanisms, such as changes in Medicaid eligibility and the availability of financial subsidies. Yet research also makes a strong case that messages conveyed via news media as well as strategic communication campaigns by federal, state, private, and nonprofit entities, also contributed to increases in rates of health insurance coverage (Karaca-Mandic et al. 2017; Gollust, Wilcock, et al. 2018; Goldin, Lurie, and McCubbin 2019; Shafer et al. forthcoming). These sources of public communication also helped to shape public awareness, information searching, and attitudes about the law (Shafer et al. 2018; Fowler et al. 2017; Sommers et al. 2015).

On the other hand, we end the decade observing a public as confused as ever about the ACA's provisions and its achievements (Brodie et al. 2020). In 2019, fewer than 6 in 10 Americans were aware that the ACA expanded Medicaid or that the law provides financial help to purchase insurance—estimates that are even lower than they were in 2010 (Brodie et al. 2020). In January 2018, just after passage of the tax law that repealed the penalty for the individual mandate, 17% of Americans believed that the ACA “has been repealed and is no longer in effect,” while an additional 14% didn’t know if it was still in effect (KFF 2018). A January 2017 poll found that 35% of respondents were unaware that “Obamacare” and the “Affordable Care Act” are names used for the same legislation (Dropp and Nyhan 2017). Public opinion data documents profound political polarization in perspectives on the law—with a partisan divide between the share of Democrats and Republicans having a favorable view of the ACA averaging 54 percentage points between 2010 and 2018 (Brodie et al. 2019). These persistent, polarized views may even have led to differential uptake of health insurance, with some evidence showing that Republicans were less likely to gain insurance via the Marketplace than Democrats (Lerman, Sadin, and Trachtman 2017; Sances and Clinton 2019). Here we seek to unpack how the media environment may have contributed to both (a) significant mobilization of the public to gain insurance, but also (b) persistent confusion and political polarization.

Our research team’s analyses of televised messaging offer a few important lessons for the health politics we observe at the end of the decade. By examining the volume and content of local television news as well as

television advertisements (ads) (including both health insurance and political campaign ads)—as we have done since 2013—we draw three conclusions about the media ecology that help explain these phenomena. First, the information environment is increasingly complex and remains competitive. Second, partisan cues are abundant even in news coverage, likely reinforcing polarized opinions about the ACA. Third, the partisan ACA-related discussion in political ads has notably changed over the decade. We present evidence for each of these conclusions and then draw implications for health policy, health communication, and the future outlook toward health reform.

Competitive Media Information Environment

The media ecosystem surrounding the ACA exemplifies a competitive information environment (Chong and Druckman 2007). Not only do news media tend to present the law using a horse-race or game frame—focusing on which political party is winning or losing related to the law’s implementation (Gollust et al. 2017)—but there is also competition with the news from other information sources seeking to persuade the public. These include ads by political candidates for office and ads promoting health insurance by government, nonprofits, and the private sector (Gollust et al. 2014).

Figure 1 displays the weekly volume of health insurance ads and political ads referencing health care (not exclusively the ACA), based on Wesleyan Media Project analyses of Kantar/CMAG data, across six Healthcare.gov open enrollment periods between 2013 and 2018. The volume of health insurance ad airings (the solid gray line) corresponds with the open enrollment periods, with highest peaks during these weeks in the late fall of each year.¹ Notably, because of the co-occurrence of the political campaign season (in 2014, 2016, and 2018) with the health insurance open enrollment periods, the volume of political ads referencing health care (the dashed line) reaches almost equivalent volumes in 2014 and 2016 to that for health insurance ads. Strikingly, the volume of health care–related messaging from campaign ads vastly exceeds the volume of health insurance–sponsored ads in 2018, as we discuss in more detail below.

1. The health insurance ads included in this graph include all sponsors, including ads for Medicare and private plans not available on the health insurance marketplace, so some of the spikes are attributable to the annual cycle of Medicare enrollment and employer-sponsored insurance open enrollment. That said, the volume of ads nonetheless likely provides a cue to consumers seeking marketplace insurance, and we have shown that health insurance ad volume is associated with consumers’ health insurance enrollment behaviors (Gollust, Wilcock, et al. 2018).

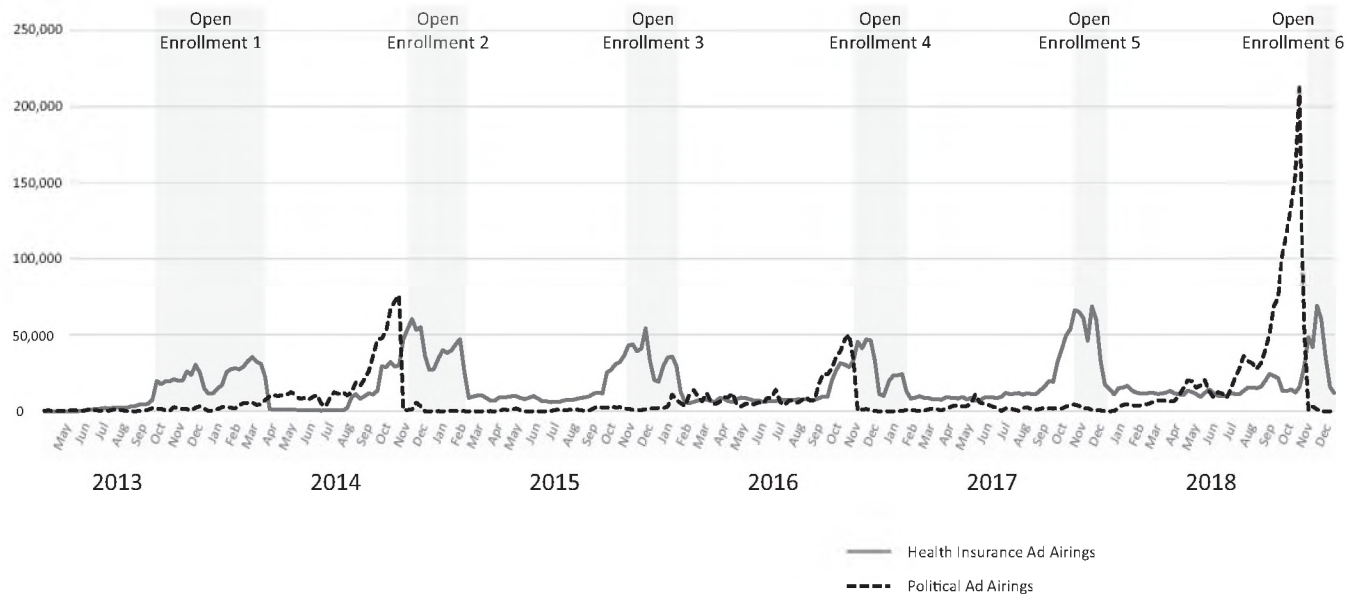


Figure 1 Weekly volume of health insurance ads and political ads that referenced health care, 2013–18.

Notes: Political ads include TV ads in federal or gubernatorial races on broadcast television, national network, and national cable that mention the issue of health care (as identified by Kantar/CMAG or Wesleyan Media Project).

Source: Kantar/CMAG, with analysis by the Wesleyan Media Project. Health insurance ads include all health insurance ad sponsors, including ads by federal, state, private insurers/brokers, and other (nonprofit) sponsors. This includes ads for Medicare and private plans not necessarily available on the Health Insurance Marketplace, as noted in footnote 1.

These aggregate patterns of volume, however, mask important changes in the composition of televised messages since the initial implementation of the ACA. First, immediately after the Trump inauguration in January 2017, the administration implemented both political messaging changes and administrative changes in ACA-related media investment, which appeared to contribute to declines in health insurance applications in the postinauguration period, particularly for HealthCare.gov states (i.e., those relying on the federally facilitated marketplace) (Anderson and Shafer 2019). Notably, the Trump administration zeroed out the budget for Healthcare.gov television advertising starting with the 2018 open enrollment period (Kliff 2017) and also reduced the grants available to health insurance navigator organizations, leaving fewer resources for marketing and outreach in states relying on the federally facilitated marketplace (Galewitz 2018). At the same time, the composition of health insurance ads was shifting, with a rising share of private insurance ads and diminishing proportion of advertising from federal sponsors (even before the full decline to zero in 2017) (Gollust, Baum, et al. 2018). Our own work also found that ads sponsored by insurance companies rarely referenced the health care law explicitly, and the proportion that did so declined over time (Barry et al. 2018; Gollust, Baum, et al. 2018). Thus, as federal ads disappeared and left the private sector to communicate about the ACA with rare mentions of the law itself, the paid media environment about health insurance plans appears to epitomize what has been referred to as a “submerged state” (Mettler 2011) where consumers are not made aware of the government’s role in facilitating and regulating the Marketplace (see also Shafer et al. forthcoming).

Changes in the ACA-related television (TV) news environment are also evident across the decade. Given that local TV news is the most preferred source of local news for Americans (Pew 2019a),² we conducted a content analysis of local evening TV news coverage of the ACA during the initial implementation period (October 2013 through April 2014), based on a sample derived from searches of health care and ACA-related keywords in

2. The media industry and audiences’ media consumption preferences changed somewhat over the decade following the ACA’s passage. Americans’ preferences for getting news online have increased, with 37% preferring online news (15% via social media, 23% via news websites or apps) in 2018, an increase from earlier years (Pew 2019b). Newspaper readership declined from 56% in the early 1990s to 29% in 2012 (Pew 2012); only 17% of Americans often relied on a local print newspaper in 2018 (Pew 2019a). However, local TV news was still the dominant source of news in 2019 just as it was in 2013: 38% of Americans reported they “often” tuned into local TV news in 2019 (and 86% said that they ever did so, more than any other source) (Pew 2019a) compared to 48% who reported regularly watching local news in 2012 (also the top source of news then) (Pew 2012).

local news closed captioning. We found that less than half of news coverage focused on health insurance plans available, while the remainder focused on political disagreements (Gollust et al. 2017). Substantial coverage was devoted to website glitches and number of enrollees to date, with fewer stories mentioning enrollment-related policy details. In fact, less than 7% of news stories mentioned subsidies available and a similar proportion mentioned (7%) or focused on (5%) Medicaid (Gollust et al. 2017).

In an effort to compare TV news coverage five years out from ACA implementation, we again implemented keyword searches from local evening television news closed captioning to identify stories about health insurance policy.³ Figure 2 displays the volume of evening news coverage of health insurance-related policy from July 30, 2018, to July 31, 2019, across all 210 US media markets. As shown in the figure, news attention to health insurance was event-centered, with news volume tracking key political and policy events: a sharp rise right around the November 8 midterm election, a dramatic drop until the end of the open enrollment on December 15, and spikes in coverage around the announcement of key events in the ongoing *Texas v. United States* court case on the constitutionality of the ACA.

Partisan Cues in News Are Abundant and Persistent over Time

Further examination of the news content about health insurance policy demonstrates that partisan cues, one strong signal of the politicization of health issues in news media (Fowler and Gollust 2015), are abundant in this coverage. As noted above, ACA news stories in 2013–14 frequently referenced political discussion over policy substance (Gollust et al. 2017). For the purpose of this commentary, we reexamined the 2013–14 news stories that were at least somewhat about health insurance plans (N = 1,153). Of these, almost half (49%) contained at least one reference to a person with a partisan identification—such as President Obama (or his administration) or another federal, state, or local elected official identified with their

3. We tracked news coverage from July 30, 2018, to July 31, 2019, using keyword searches in the TV Eyes database. The keywords we searched were different than the previous period to capture changes in the health policy discourse. The keyword searches we implemented were: (“affordable care act” OR “health insurance” OR medicaid OR medicare OR obamacare OR “obama care” OR “trump care” OR “universal healthcare” OR “universal health care” OR “single payer” OR [(“health care” OR healthcare) AND insurance]) AND (act OR bill OR initiative OR law OR legislation OR mandate OR policy OR reform).

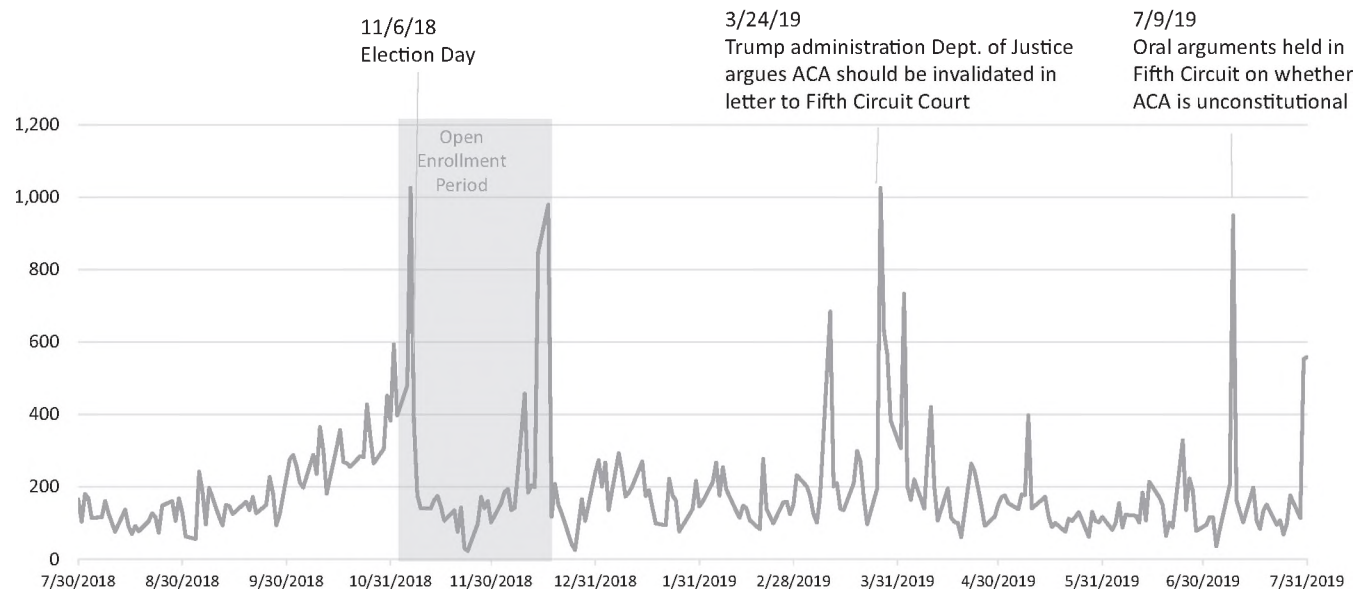


Figure 2 Local evening news keyword hits for health insurance topics, 2018–19.

Note: Data are from keyword hits of health insurance-related terms in closed captioning (see footnote 3) that aired on local evening news between July 30, 2018, and July 31, 2019.

Table 1 Topics of News Coverage in Local Evening News about Health Insurance Policy, 2018–19

Topic of coverage	Stories that mention topic, %	Stories that focus on this topic, %
<i>ACA-Related Topics</i>	55	25
Affordable Care Act or Obamacare	21	8
Open enrollment	9	7
Preexisting conditions	5	1
Medicaid (general)	36	13
<i>Other health insurance topics not directly related to the ACA</i>	48	21
Medicare	21	5
Medicaid work requirements	3	0
Medical bills/health care costs	15	5
Prescription drugs	13	7
Health insurance reform	8	3
Health insurance fraud	6	5

Note: Data are from a content analysis of 1,247 news stories about health insurance–related keywords (see footnote 4) that aired on local evening news from October 2018 through July 2019. All of the above topics were coded by research assistants, and each topic (mention and focus) had alpha statistics measuring inter-rater reliability that exceeded 0.65.

political affiliation. Digging deeper, 45% of news stories contained at least one reference to a Democratic official, 22% included at least one reference to a Republican official, and almost one in five news stories (19%) contained both a Democratic and Republican reference. These signals are important because partisan cues contribute to the public's tendency to accept (or reject) and interpret information according to their political predispositions (Druckman, Peterson, and Slothuus 2013)—meaning that partisanship may be particularly salient when the public interprets news about the ACA.

Turning now to the 2018–19 period of health insurance TV news, we also conducted a content analysis of a strategic sample of news coverage by creating a constructed week sample, similar to the method we employed in our previous study (Luke, Caburnay, and Cohen 2011), yielding a sample of 1,247 news stories.⁴ To compare news stories from the 2013–14 period

4. For each month from October 2018 through July 2019 when we had video data, we randomly selected a Monday through Friday from all dates available in the month to create a constructed week. A total of 2,063 keyword hits occurred on the 50 constructed week dates; 623 of them were advertisements, and 88 were not local news; another 105 had problems that prevented coding. This left 1,247 news stories in our sample.

Table 2 Partisan Cues in Local Evening News Coverage about Health Insurance Policy, 2018–19

	All stories Overall, % (N = 1247)	Within ACA-related stories	
		Mentioned ACA-related topic, % (N = 686)	Focused on ACA-related topic, % (N = 314)
<i>References to any partisan actor</i>	45	54	47
Trump	20	21	16
Republicans (not Trump)	17	23	21
Trump or Republicans	37	44	37
Democrats	30	34	30
References to Republicans (including Trump) and Democrats	23	24	21

Note: Data are from a content analysis of 1,247 news stories about health insurance–related keywords (see footnote 4) that aired on local evening news from October 2018 through July 2019.

(which all concerned the ACA) and the more extensive health insurance policy discussions in later news coverage, we divided 2018–19 evening news coverage in Table 1 into ACA related and not directly ACA related. News coverage still frequently featured the ACA, with 55% of news stories mentioning an ACA-related topic and 25% focusing on an ACA-related topic (although only 21% explicitly mentioned the ACA or Obamacare). Much more news coverage in 2018–19 mentioned Medicaid (36%, compared to only 7% of news coverage mentioning Medicaid in our 2013–14 study), and 13% of stories focused on Medicaid. This difference could be the result of much more substantive news coverage that surrounded the ACA repeal fights in 2017, as journalists seemed to learn to focus on policy detail (including Medicaid) (Rovner 2020). However, these differences could also be attributable to the change in our search terms. Other major health insurance policy topics that received at least moderate attention in TV news in the 2018–19 period included Medicare, health care costs, and prescription drugs.

Table 2 shows partisan cues in local TV news coverage of health insurance policy in 2018–19 to compare to the high frequency of ACA-related political discussion in 2013–14. The results indicate that references to any partisan actor persisted at almost the identical prevalence from 2013–14: as noted above, 49% of news stories in 2013–14 referred to at least one partisan actor, whereas 45% of 2018–19 news coverage referred to any

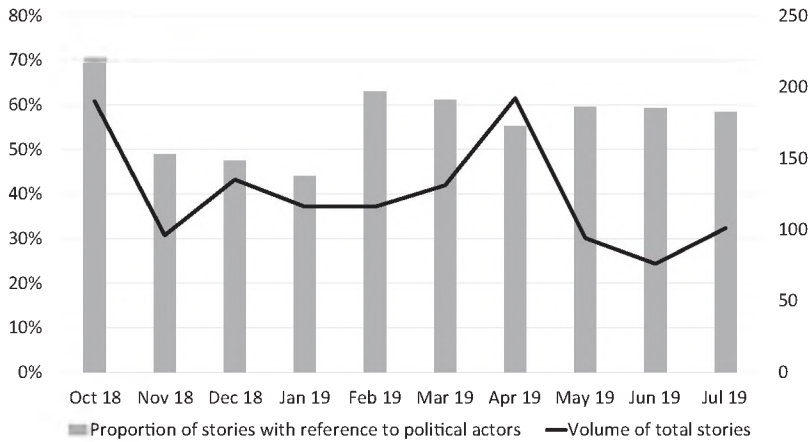


Figure 3 Proportion of news stories referencing political actors by month, 2018–19.

Notes: Data are from a content analysis of 1,247 news stories about health insurance–related keywords (see footnote 4) that aired on local evening news from October 2018 through July 2019.

partisan actor, and this rate was higher in stories that mention ACA-related topics (54%). Regardless of whether the story itself was linked to the ACA or not, about 20% of all health insurance policy stories referenced President Trump, 30% referenced at least one Democratic politician, and 23% referenced both parties (again, almost the same prevalence as in the earlier period). Notably, partisan references in news were not confined to election season but persist throughout the year (fig. 3). While it is perhaps obvious that discussions of health politics and policy would include partisan references, the high volumes we observed—half of all coverage—signifies that the public is exposed to persistent reminders that health insurance issues are politically partisan, and only half of stories discuss substantive health policy matters without reference to the political environment. These findings reinforce the idea that the politicization of health issues in news coverage is “sticky” and persistent over time, as we have also seen in the cases of mammography and the HPV vaccine (Fowler and Gollust 2015). This phenomenon could explain why even with new information and evidence consistently emerging about the law and its effects, opinion about the law prior to 2017 shifted little and remained polarized (Brodie et al. 2019). Political signals contribute to citizens using motivated reasoning (i.e., differentially weighing arguments that support an existing [often partisan] position, not logical deliberation)

in processing ACA-related information (Druckman, Peterson, and Slothuus 2013; Petersen et al. 2013), limiting the public's ability to incorporate or evaluate evidence about the ACA into updated judgments of government accountability (James and Van Ryzin 2017).

Changing Partisan Discussion about Health Care in Political Ads

While the above discussion demonstrates that the sheer *volume* of partisan references in health care news stayed consistent between 2013–14 and 2018–19, our analysis of partisan content and messaging in political ads reveals a different story. Indeed, the Wesleyan Media Project has documented dramatic shifts in both the volume and the tone of health care messaging in advertising for US House and US Senate races from 2008–18 (Fowler, Franz, and Ridout 2020). More specifically, as shown in Figure 4, while advertising for both parties discussed health care at roughly the same rate in 2008 (13% for pro-Republican advertising and 18% for pro-Democratic advertising), subsequent pro-Democratic messaging all but ran away from health care in the next several rounds of elections. From 2010 (just after the passage of the ACA) through the 2016 campaign, pro-Democratic advertising only obliquely referenced the law, if at all. This makes sense, given that the law did not have majority support during this time period (Brodie et al. 2020). By contrast, nearly a third of pro-Republican advertising took health care head-on between 2010 and 2014 with many ads explicitly promising to repeal, or repeal and replace, Obamacare. Following Republican attempts to follow through on this promise, however, Democrats placed health care messaging front and center in the 2018 campaign, following the law's growing popularity among the public (Brodie et al. 2020). This, combined with a large increase in advertising and the fact that pro-Republican mentions of health care stayed steady at roughly 30% of their advertising, meant that citizens were exposed to an unprecedented amount of political ad messaging on health care in the 2018 midterm election cycle, one that was often contested between parties. Although Republicans no longer touted repeal and replace in the same way, they often discussed government intervention in health care unfavorably and expressed concern for coverage of preexisting conditions. This means that many citizens were frequently exposed to two very different partisan stories about the ACA and the future direction of health insurance reforms. Political science research indicates that when candidates from different parties discuss the same issue (“issue convergence”), this can

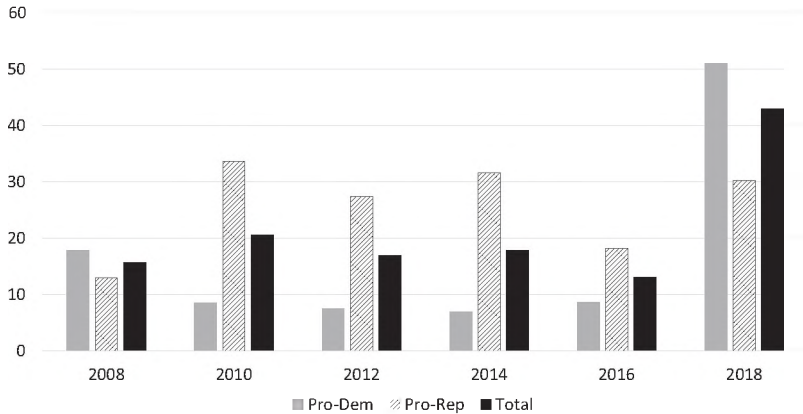


Figure 4 Change in volume of ads referencing health care in political advertising for House and Senate races, 2008–2018.

Notes: Figure includes airings from September 4 through Election Day for each year. Ads benefiting Democratic or Republican candidates are included in the Pro-Dem and Pro-Rep bars, and ads for third-party candidates are included in the total percentages.

Source: Wesleyan Media Project analysis of Kantar/CMAG data; 2008 data come from the Wisconsin Advertising Project.

sometimes confuse voters more than it helps boost knowledge or clarify positions (Lipsitz 2013).

Implications for Health Policy and Politics

As should now be clear, messaging about the ACA over the past decade has come from a variety of sources: citizens tuning in to television might have received information from local television news, from health insurance advertising and/or from campaign advertising—and potentially all three types of information during the same half-hour news segment. These competitive messages varied in goal (information versus persuasion), in content (substantive policy information versus cursory detail) and in the availability of relevant cues (pro-Republican messaging attacking government contrasted sharply with private insurance submerging the state while many news stories contained explicit partisan references). Behind these messages are multiple sources of information competing to shape public attitudes and behavior: policy, political, and corporate leaders all trying to educate and persuade the public at the same time—to buy a health insurance plan, to support the ACA (and candidates who do so), or to call on legislators to repeal the ACA (and shape their chances of reelection).

Further, the audiences affected by these messages are diverse. Some of the audience of ACA messaging includes those who could (and indeed, many did) benefit from new insurance options made available. Other audience members were not directly influenced by the law's individual market regulations or Medicaid expansion, yet were still exposed to a diverse array of messages with partisan signals and politicized content.

Considered together, all of these features of the media environment likely lead consumers to be confused about the law and its impact on regular people, and to interpret impact through a partisan lens, despite clear evidence of the ACA's success in contributing to increased rates of health insurance coverage. As Brodie and colleagues (2020) note, the partisan gap in favorability rose to 64 percentage points in 2019, with Democrats' favorable perceptions of the law increasing following repeal threats in 2017, while Republicans' views remained persistently unfavorable. And misperceptions have persisted, such as 57% incorrectly believing there was a governmental panel to make decisions about end-of-life in 2010, and 56% believing the same in 2019 (Brodie et al. 2020). As mentioned above, partisan cues in messaging encourage individuals to engage in motivated reasoning in the processing of new information (Druckman, Peterson, and Slothuus 2013; Petersen et al. 2013). Motivated reasoning likely limits the public's ability to incorporate or evaluate evidence into their judgments of government accountability (James and Van Ryzin 2017) or even recognize that popular elements (including guaranteed issue for people with pre-existing conditions or elimination of cost sharing for preventive services) are attributable to the ACA (Brodie et al. 2020). Public recognition is made even harder by private sector messaging that submerges the ACA role and by some Republican candidates' misleading political ads that describe support for insurance coverage for preexisting conditions, despite their position on the *Texas v. United States* case that would invalidate such protections. It's no wonder, then, that public perceptions of whether the ACA has helped or hurt Americans are filtered by partisanship, with 38% of Republicans in 2019 saying the ACA has hurt them, and only 8% of Democrats saying the same (Brodie et al. 2020).

Such intense polarization in the media environment contributes via policy feedback to dynamics that will likely shape the future direction of health reform efforts. A recent study demonstrates that polarized views about the law may have even contributed to insurance marketplace affordability and ultimately Republicans' experiences of the law. Trachtman (2019) describes a positive relationship between Republican vote share and growth in individual marketplace premiums; as more Republicans opt out, those that remain in the marketplace experience higher premiums, leading them to

support the law even less, and thus contributing to a reinforcing cycle of partisan policy feedback.

This finding is substantively important since public opinion data (as of 2019, before the COVID-19 pandemic) suggested that the top health care issue in 2020 for voters was around unacceptably high health insurance costs. In fact, the data indicated bipartisan unity over the importance and urgency of this problem for politicians to address (Blendon, Benson, and McMurtry 2019). However, given a decade of polarized messages about the ACA, the prevalence of partisan cues in news stories about health care policy (pervading even non-ACA-specific coverage), and continued competition over who owns the issue of health insurance entering the 2020 election, policy efforts to address health care costs may be hampered by messages that associate these issues with the ACA. Policymakers seeking additional health reforms will likely need to overcome a decade of partisanship in political messaging about the ACA to identify new communication strategies to reach the public, although the shifting political ground associated with COVID-19 may open the agenda in ways considered impossible before the spring of 2020. Similarly, communication research in both health and political communication subfields should continue to evaluate the content and effects of health policy messaging, and identify new evidence-based ways to overcome partisan motivated reasoning and boost public support for needed health policy reforms.

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The Potential and Realized Impact of the Affordable Care Act on Health Equity

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Abstract The Affordable Care Act (ACA) was designed with multiple goals in mind, including a reduction in social disparities in health care and health status. This was to be accomplished through some novel provisions and a significant infusion of resources into long-standing public programs with an existing track record related to health equity. In this article, we discuss seven ACA provisions with regard to their intended and realized impact on social inequalities in health, focusing primarily on socioeconomic and racial/ethnic disparities. Arriving at its 10th anniversary, there is significant evidence that the ACA has reduced social disparities in key health care outcomes, including insurance coverage, health care access, and the use of primary care. In addition, the ACA has had a significant impact on the volume/range of services offered and the financial security of community health centers, and through section 1557, the ACA broadened the civil rights landscape in which the health care system operates. Less clear is how the ACA has contributed to improved health outcomes and health equity. Extant evidence suggests that the part of the ACA that has had the greatest impact on social disparities in health outcomes—including preterm births and mortality—is the Medicaid expansion.

Keywords health policy, Affordable Care Act, health equity, health disparities, Medicaid expansion, community health centers, clinical preventive services, discrimination

Extensive research documents the serious population health problems afflicting the United States, including racial/ethnic, socioeconomic, and other types of social inequalities for almost every health behavior, condition, disease, and health indicator (Baiciu et al. 2017). The Patient Protection and Affordable Care Act (ACA) significantly overhauls public policies related

Table 1 Key Provisions in the Affordable Care Act Related to Health Equity Goals

Title	Provisions
Title 1: Quality, Affordable Healthcare for All Americans	Health insurance reforms and subsidies Section 1557—Nondiscrimination Provision
Title 2: The Role of Public Programs	Medicaid expansion Home visiting Reauthorization of Children's Health Insurance Program
Title 4: Prevention of Chronic Disease and Improving Public Health	Clinical preventive services coverage National prevention strategy
Title 5: Health Care Workforce	Community Health Center Fund
Title 9: Revenue Provisions	Nonprofit hospitals and community benefit
Title 10: Reauthorization of the Indian Health Care Improvement Act	Reauthorization of the Indian Healthcare Improvement Act

to health insurance and health care with a number of overarching goals, the most prominent being to improve the accessibility, affordability, and value of health insurance, and to improve health care quality, efficiency, and outcomes. The ACA, however, also reached beyond health care coverage to address health status disparities related to race/ethnicity, socioeconomic status, geography, and other social factors. Indeed, the ACA refers multiple times to the need to address underserved and “health disparities populations,” defined as identifiable social groups with significant differences in disease incidence/prevalence, morbidity, mortality, or survival compared to the general population.

As Grogan (2017) summarized, the ACA was designed to both explicitly and implicitly address health equity through many of its provisions. Some ACA reforms were designed to address inequities in the structures and processes of health care delivery; other reforms focused on more equitable distributions of specific “means and ends” (Grogan 2017). Although many ACA provisions are innovative and novel, this landmark legislation was also designed to build on and further strengthen a number of public programs with a documented track record of addressing health disparities. This includes the ACA’s reauthorization of the Children’s Health Insurance Program or CHIP (first enacted in 1997) and the Indian Health Care Improvement Act (first enacted in 1976). The ACA also provided major expansions of Medicaid, community health centers, legal protections against health care discrimination, and public health prevention efforts (Table 1).

In this article, as the ACA reaches its 10th anniversary, we review several components of the ACA in regard to their intended and realized impact on social inequalities in health care and health status outcomes, focusing primarily on socioeconomic and racial/ethnic disparities. We focus on seven key provisions that were either novel or involved a major infusion of resources: 1) health insurance reforms and subsidies; 2) the “Section 1557” nondiscrimination provision; 3) the Medicaid expansion; 4) home visiting programs; 5) first dollar coverage of clinical preventive services; 6) the Community Health Center Fund; and 7) nonprofit hospitals and community benefit.

FINDINGS

Title 1: Quality, Affordable Healthcare for All Americans

Health Insurance Reforms and Subsidies. The majority of evaluations of the ACA insurance reforms have analyzed health care coverage, access, and utilization outcomes rather than health status outcomes. Population-based data from multiple national sources reveals that the health insurance reforms and subsidies implemented through the ACA ushered in significant increases in health insurance coverage and access to care and decreased out-of-pocket costs and spending on premiums, especially for lower-income individuals (Glied, Solis-Roman, and Parikh 2016; Goldman et al. 2018). In a unique experimental study, Goldin, Lurie, and McCubbin (2019) found that an informational intervention aimed at people who paid the individual mandate tax penalty of the ACA (before it was rescinded) subsequently led to increased health insurance coverage, which in turn produced a small yet significant decrease in mortality among middle-aged adults.

Because ACA-related gains in coverage were greater for minority groups and people with incomes below 139% of the poverty level, social disparities in health insurance coverage have been significantly reduced (Chaudry, Jackson, and Glied, 2019; Chen et al. 2016). For example, the black/white gap in adult uninsured rates dropped by 4.1% between 2013 and 2018, and the Hispanic/white gap fell by 9.4% (Baumgartner 2020). In addition, the ACA appears to have also reduced racial/ethnic gaps in other measures of health care access, including having a usual source of care and foregoing care/prescriptions because of cost concerns.

Although racial/ethnic and socioeconomic gaps in health insurance coverage and care access narrowed in all states, reductions in disparities

were even greater in those states that expanded Medicaid (Griffith, Evans, and Bor 2017; Buchmueller et al. 2016), as discussed in more detail below. However, a 2020 report from the Commonwealth Fund suggests that progress in increasing health care access and reducing social disparities stalled after 2016 and has eroded since (Baumgartner 2020). Jost (2018) argues that since taking power in 2017, the Trump administration openly engaged in policy strategies that intentionally undermined and weakened the ACA. This includes reducing the tax penalty for not having health insurance to \$0, ending cost-sharing reduction subsidies to insurance plans in the exchanges, significantly reducing education and outreach efforts for Marketplace open enrollment, moves to create an individual insurance market that operates free of ACA reforms, and continuous negative comments in public statements and social media. While correlation is not causation, it is not surprising that gains in health insurance coverage in the US stalled right after President Trump—who actively campaigned against the ACA—took office.

Section 1557—Nondiscrimination Provision of the ACA. Within title 1 of the ACA, section 1557 further expands decades of civil rights law including the Civil Rights Act of 1964, the Rehabilitation Act of 1973—whose protections later would be incorporated into the Americans with Disabilities Act—and the Age Discrimination Act of 1975. Section 1557 builds on these legal watersheds by effectively reshaping civil rights law to fit a twenty-first century health care system (Rosenbaum 2016).

Section 1557 does two important things. First, it expands the range of protected classes to include discrimination on the basis of sex. Second, the law dramatically expands the reach of what is considered a federally assisted program to include contracts of insurance (previously understood to be exempt from the reach of prior antidiscrimination laws). In doing so, the new law encompasses not only Medicare, Medicaid, and CHIP but also federal funding in connection with health insurance purchased through the Marketplace. Furthermore, because civil rights law standards interpret their reach as “entity-wide,” 1557 applies to *all* health plans sold by large insurers, not only plans directly supported with public subsidies. Under this interpretation, tax-advantaged employer plans also are covered by this ACA legal provision.

Section 1557, like earlier civil rights laws, broadens the legal landscape in which the US health care system operates. As such, if left intact, it can be expected to further infuse and enforce “equal treatment” principles into the health system in many important ways. For example, the law already has had a significant, measurable effect on health insurance

and health care by barring coverage exclusions and discriminatory treatment against transgender persons as tantamount to unlawful discrimination on the basis of sex.

Title 2: The Role of Public Programs—Medicaid Expansion

The ACA provides significant incentives to states to expand their Medicaid programs to nearly all low-income adults up to 138% of the federal poverty level. There is clear and mounting evidence that expansion states have experienced significant increases in health care coverage and access to care. Miller and Wherry (2019) estimate that the Medicaid expansions increased health insurance coverage by 12% over the increase in nonexpansion states from title 1 provisions alone.

Guth and colleagues (2020) recently synthesized results from more than four hundred evaluation studies, with a key finding that state Medicaid expansions led to significant increases in health insurance coverage in “vulnerable” populations including low-income adults, people with HIV and substance use disorders, veterans, LGBTQ adults, and people in rural areas. This review also concluded that the Medicaid expansions have improved access to and affordability of care, use of health care services, and financial security among low-income populations.

Buchmueller and colleagues (2016) found that by 2014 state Medicaid expansions had significantly reduced racial/ethnic differences in health insurance rates within expansion states. More recent analyses confirm that the Medicaid expansions significantly reduced racial disparities in health insurance coverage nationwide (Baumgartner 2020). For example, the black/white percent coverage gap in expansion states dropped from 8.4 in 2013 to 3.7 in 2018; and the Hispanic/white coverage gap dropped from a 23.2% difference in 2013 to 12.2 in 2018. In fact, black adults in expansion states are now more likely to have insurance than white adults in non-expansion states (Baumgartner 2020)

The Medicaid expansions also reduced racial/ethnic disparities in such measures as having a consistent source of health care and foregoing needed care because of cost concerns (Baumgartner 2020). In terms of health status, expanding Medicaid has been associated with improvement in a number of important diseases and outcomes, including self-reported general health, cardiovascular disease, birth outcomes, and end-stage renal disease mortality (Guth et al. 2019). Studies have also demonstrated an association between ACA Medicaid expansion and a reduction in racial disparities in preterm birth, increased treatment for opioid addiction, and earlier diagnosis of certain types of cancers (Brown et al. 2019; Guth et al. 2019).

In addition, there is strong evidence that expanding Medicaid has saved lives. Miller and colleagues (2019) concluded that the Medicaid expansion reduced mortality among low-income “near-elderly” adults, and that an additional 15,600 deaths would have been averted between 2010 and 2014 if all states had expanded their Medicaid programs.

State Medicaid expansions have also had a positive impact on a number of economic outcomes, including state budget savings, revenue gains, and economic growth (Guth et al. 2019). For example, the Michigan Medicaid expansion produced an approximately 50% reduction in unpaid bills and uncompensated care costs for hospitals, and also produced fiscal benefits for the state including increased revenue from provider, sales, and income taxes (Levy et al. 2020).

The impact of expanding Medicaid on community health centers is also noteworthy. In expansion states, health centers have been able to increase the number of patients receiving behavioral health services, medication assisted treatment for opioid addiction, and coordinated care with social service providers. In addition, by further increasing health insurance coverage, health centers in expansion states are reporting significantly increased financial stability (Lewis et al. 2019).

Despite this progress, it is important to note that serious racial/ethnic and other social disparities in health insurance coverage still remain within and across states. Rates of uninsurance and racial disparities were, on average, smaller in the states that expanded Medicaid, especially among the early adopters. However, because a greater share of black, American Indian/Alaska Native, and Hispanic adults ages 18–64 live in states that have not expanded Medicaid (primarily southern states), they are more likely than whites nationwide to be uninsured (Artiga, Orgera, and Damico, 2019). For example, the 2018 uninsurance rates in Massachusetts (an early expansion state) were estimated as 2.08% for whites, 4.26% for blacks, 5.33% for Hispanics, and 4.22% for low-income adults, compared with Texas’s rates of 10.29% for whites, 15.29% for blacks, 27.29% for Hispanics, and 25.50% for low-income adults (Kiernan 2019). Also, as discussed above, it appears that progress in reducing racial/ethnic disparities in health insurance coverage stalled after the Trump administration took office in 2017 (Artiga, Orgera, and Damico, 2019).

Maternal, Infant, and Early Childhood Home Visiting Programs. Title 2 of the ACA created the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, allocating more than \$1.5 billion to states, territories, and tribal entities to fund evidence-based home visiting programs. Research has demonstrated that well-designed interventions with a

home visiting component have a positive impact on a number of maternal, child, and family outcomes, and are an especially important approach to increasing health equity in pregnancy outcomes and child health/development (Abbott and Elliott 2017). The MIECHV Program stipulates that 75% of the allocated federal funding must be used to support evidence-based home visiting models, with 18 models currently meeting this standard.

The MIECHV program is currently the largest source of funding for home visiting in the US, serving nearly 80,000 families in 2017 alone (Sandstrom 2019). A 2015 report to Congress evaluated 4 models that have been supported with MIECHV funds in 10 or more states: Early Health Start-Home Based Program Option, Healthy Families America, Nurse-Family Partnership, and Parents as Teachers (Michalopoulos et al. 2015). The evaluation concluded that the MIECHV Program is being implemented as designed, expanding evidence-based interventions in high-risk families and in communities explicitly targeting racial and ethnic disparities in child health and welfare.

The further dissemination of interventions shown to improve maternal, child, and family outcomes in low-income and minority populations has the potential to have a positive impact on health equity. Unfortunately, however, there is currently no evidence for such an impact. Although recipients of MIECHV funding are required to assess and report on performance in six different “benchmark domains,” programs are not required to assess and compare impact across sociodemographic subgroups (Sandstrom 2019).

Title 4: Prevention of Chronic Disease and Improving Public Health

Clinical Preventive Services Coverage. The ACA entails a clear emphasis on primary and secondary prevention and other public health approaches to improving health (Chait and Glied 2018). Our review focuses on the title 4 provision to increase insurance coverage for evidence-based clinical preventive services. Using value-based insurance design principles, the ACA established “first dollar” insurance coverage requirements for a wide range of clinical preventive services for children and adults, prohibiting deductibles or copayments for a defined set of evidence-based services. Such services include immunizations and screening tests for cancer, other chronic diseases, sexually transmitted infections and depression; smoking cessation interventions; obesity screening and counseling; and statins and other preventive medications (Lantz 2013; Chait and Glied 2018).

This ACA provision was built on a plethora of research demonstrating that consumer cost sharing plays a role in the underuse of effective clinical preventive services and the long-standing disparities in use by race/ethnicity and socioeconomic status. This reform is estimated to have provided more than 71 million people no-cost access to disease screenings, vaccines, and other important prevention services (Chait and Glied 2018). The impact of this reform on overall trends and social disparities in utilization, however, is not yet clear. While receipt of a number of clinical preventive services has increased over the past decade across socio-demographic groups, most of these increases appear to be the continuation of trends that started before the ACA (Chait and Glied 2018). Also, it is challenging to disentangle the impact of the ACA's provisions regarding clinical preventive services from expanded health insurance coverage in general.

Nonetheless, some findings to date are encouraging. Han and colleagues (2015) reported that, among private insurance enrollees, the use of flu shots, blood pressure monitoring, and cholesterol screening increased significantly post ACA. Sabik and Adunlin (2017) found that cancer screening and early-stage diagnosis increased in the Medicaid expansion population and also among Medicare beneficiaries who did not have preventive service coverage before the ACA. Snyder and colleagues (2018) reported that the ACA significantly reduced out-of-pocket costs for contraception and increased the use of long-acting reversible contraception methods.

A national survey conducted in 2013 revealed that only about one-third of US adults (36.5%) knew that the ACA requires insurance companies to cover clinical preventive services without cost sharing, and that there was significant mistrust of how the government determines which preventive services have sufficient research or evidence behind them (Lantz et al. 2016). Consumer knowledge and understanding of this provision of the ACA is likely an ongoing issue.

Title 5: Health Care Workforce

Community Health Center Fund. Community health centers are a long-standing and increasingly important part of the health care safety net. Extensive research continues to show health centers' positive impact on multiple measures of access and health status (Saloner, Wilk, and Levin 2020). Within the ACA, the Community Health Center Fund created a 5-year funding authorization to extend the reach and impact of the federal community health center program (Rosenbaum 2017). This authorization was extended in 2015 and again in 2018, growing from \$1 billion in 2011 to \$4 billion in 2019.

The ACA operates in two structural ways to build on the long-standing record of health centers (Rosenbaum et al. 2019). First, the law transformed the grants provided to health centers for basic operational support from an annual discretionary spending model into a multiyear mandatory program. Spending was also set at a level that enabled existing health centers to sustain their operations yet also underwrite a major expansion in service capacity and the scope of care. Second, the ACA Medicaid expansion had the indirect effect of insuring millions of community health center patients, thereby strengthening clinical care capacity and significantly increasing the revenue health centers need to provide and expand services. As a result, while the Health Center Fund has strengthened all health centers, those in Medicaid expansion states show even greater increases in size and service capacity (Lewis et al. 2019).

As a result of these investments, between 2010 and 2017 the number of health centers increased by 59%, the number of patients served increased by 43%, and there was a significant increase in centers offering mental health and substance abuse services (Rosenbaum et al. 2019). Hatch and colleagues (2018) found that the ACA, through both the Community Health Center Fund and the Medicaid expansion, increased patient visits by 19%, including increased utilization of primary care services and patient supports such as interpreters, transportation services, and connections to social and legal services.

Previous research has demonstrated that community health centers have contributed to reducing socioeconomic, geographic, and racial/ethnic disparities in health care access/utilization and some key health outcomes (Saloner, Wilk, and Levin 2020). Expanding the number of health centers and people served through the ACA is likely to have further strengthened and enhanced this legacy of impact on health equity, although empirical studies are currently lacking.

Title 9: Revenue Provisions

Nonprofit Hospitals and Community Benefit. The ACA added a section to the Internal Revenue Code that contains new requirements for nonprofit hospitals in regard to their reporting of community benefits to qualify for tax-exempt status. These requirements bring greater fairness to the treatment of medically indigent patients. They also effectively redefine the role of tax-exempt hospitals as community public health actors beyond their traditional role as a source of clinical care. This redefinition takes the form of an obligation to conduct a community-health-needs assessment (CHNA)

at least every 3 years, and to accompany this assessment with an annual strategy for meeting identified community needs. Although the law does not require hospitals to align their own community benefit expenditures with identified community health needs, the CHNA amendments in essence ensure that hospitals will look beyond their own priorities to those of the community.

Current research does not suggest that this provision has had a significant impact on how nonprofit hospitals engage in and report their community benefit activities to the IRS. Early research by Young and colleagues (2018) found that in 2014, nonprofit hospitals had increased their average spending for all community benefits from 7.6% to 8.1% of operating expenses, with no change in direct spending on community health. IRS data continue to demonstrate that the vast majority of community benefit spending is on uncompensated care, graduate medical education, and research. Rozier, Goold, and Singh (2019) argue that community health improvements and health equity could become a more central focus of hospital community benefit, but only if hospitals are encouraged to embrace these objectives beyond the nudges from the ACA.

While the national data are not positive, there are some encouraging and innovative examples of hospitals investing in local community health. For example, Bon Secours Mercy Health in Baltimore is investing in affordable housing in its neighboring community. Also, the University of Michigan health system offers grants to local nonprofit organizations with high-quality proposals for addressing social determinants of health issues identified in the local community needs assessment. For communities in which a local hospital has made a significant investment in addressing some kind of social disparity, the impact could be significant. Rigorous evaluations of local efforts are needed.

DISCUSSION

The ACA was designed with multiple goals in mind, including a reduction in social disparities in health care and health status outcomes. This was to be accomplished through some novel provisions and also a significant reinfusion of resources into long-standing public programs with an existing track record of progress toward health equity. As such, the potential for the ACA to achieve its intended goals related to “health disparities populations” is strong.

Arriving at its 10th anniversary, there is significant evidence that the ACA has indeed reduced social disparities in some key health care

outcomes, including health insurance coverage, health care access, the use of primary care, and some specific clinical preventive services. Less clear is how the ACA has contributed to improved health outcomes and health equity. The evidence to date suggests that the part of the ACA that has had the greatest impact on health outcomes (including mortality) and social disparities in health is the Medicaid expansion.

Evaluating the impact of the ACA on gains in health equity is quite challenging for several reasons. First, many studies of the impact of the ACA have not conducted the requisite subgroup analyses to determine if racial and other social disparities are narrowing or widening underneath more general findings and trends. Longitudinal data with adequate sample sizes for subgroup analyses by race, ethnicity, income, or educational status is challenging to find. Additional research explicitly focused on the impact of the ACA on disparities and relative gains/impact by race, ethnicity, and other social markers is sorely needed.

Second, synergies between different parts of the ACA make it difficult for evaluation research to detect the specific impact of individual components. It could be that the evidence for the Medicaid expansions is the most robust because this provision has not been implemented in all states and thus allows for more rigorous evaluation research through natural experiments. Third, rather than being novel, many provisions in the ACA build on prior investments in prevention and the health care safety net for underserved populations, which have already been demonstrated to have important impacts on health outcomes and social disparities. Researchers have not focused on reworking the case in the context of reauthorization or continued funding through the ACA.

Although there are many reasons to believe that the ACA has made significant contributions toward health equity in the US, such progress is extremely challenging. It is sometimes the case that interventions that create overall improvements in population health serve to widen rather than narrow disparities in the near term, as majority populations are often the first to be exposed to and benefit from new technologies, programs, and policy reforms.

In addition, as discussed above, since the Trump administration took office in 2017, the ACA has been undermined and weakened in myriad administrative and legal ways, including the rollback of the tax penalty of the individual mandate, restricting outreach and marketing for Marketplace open enrollment, the gutting of the Prevention Fund, and some proposed changes to section 1557. As Michener (2020) argues, even when *policies* are explicitly and intentionally designed to target racial and socioeconomic disparities, *politics* often intercedes to undermine and reverse progress.

After the initial success of the ACA in increasing health insurance coverage and other outcomes, in the single year between 2017 and 2018, the uninsured rate went back up 7.5% (or 25.6 million people), with larger increases in minority populations (Berchick, Barnett, and Upton 2019). Using the lens of racialized political processes, Michener (2020) reveals how race intersected with politics to drive policy creation and change during the first decade of the ACA, making this large public policy less equitable and more vulnerable to erosion.

One final yet important note: Although high-quality and affordable health care is necessary for population health improvement, it is not sufficient for preventing or significantly reducing social inequalities in health. The upstream drivers of health inequity—the macro-level factors that create systems of disadvantage and structural discrimination (including racism)—are not the primary focus of the ACA. Significant investments are also needed in the upstream social determinants of health, such as high-quality educational systems, employment and income security, affordable housing, safe environments, and institutions free from racism/discrimination (Lantz, Lichtenstein, and Pollack 2007). Key provisions in the ACA can assist in the journey toward high-quality health care and positive health outcomes for all, but are insufficient for addressing the fundamental social, economic, and political factors that drive health inequity in the first place (Link and Phelan 1995).

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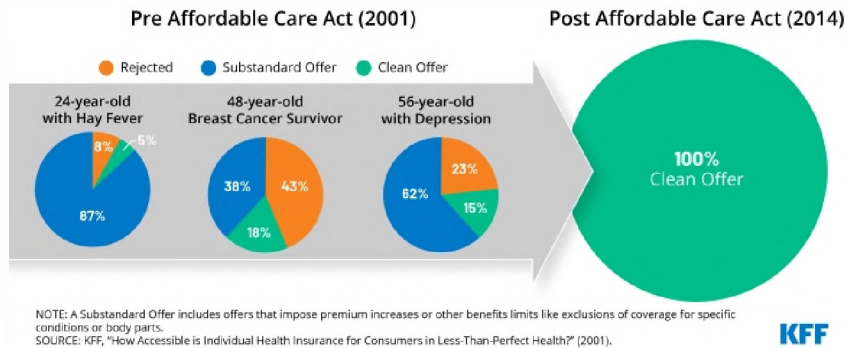
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How Health Insurers Responded to Applicants with Pre-existing Conditions Before and After the Affordable Care Act


Published: Sep 30, 2020



Insurer Responses to Hypothetical Applications for Individual Health Insurance Before and After the Affordable Care Act



(https://www.kff.org/wp-content/uploads/2019/09/TWITTER-Health-Insurance-2001-versus-post-ACA_1-3.png)

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The fate of the Affordable Care Act (ACA) is again in doubt, with the Supreme Court set to hear arguments in *California v. Texas* (<https://www.kff.org/health-reform/issue-brief/explaining-california-v-texas-a-guide-to-the-case-challenging-the-aca/>) days after the Presidential election. With protections for people with pre-existing conditions ([among others](https://www.kff.org/health-reform/issue-brief/potential-impact-of-california-v-texas-decision-on-key-provisions-of-the-affordable-care-act/)) at risk, it is worth revisiting what it was like for people with pre-existing conditions to obtain coverage before this law.

Pre-ACA, health insurance in the individual market was medically underwritten in most states. That means applicants could be turned down, charged more, have their pre-existing condition excluded, or face other limits on covered benefits based on their health status. More than **50 million Americans** (<https://www.kff.org/health-reform/issue-brief/pre-existing-condition-prevalence-for-individuals-and-families/>) have a condition, such as diabetes or past heart attack, that would have made them "uninsurable" in the pre-ACA individual market. Taking into account less severe conditions, such as asthma or high cholesterol, millions more have pre-existing conditions that would make it harder to buy medically underwritten coverage.

In 2001, KFF [examined](https://www.kff.org/health-costs/report/how-accessible-is-individual-health-insurance-for/) how individual market insurers would treat applications from people in less than perfect health. In one scenario, a young woman with Hay Fever was rejected 8% of the time. The vast majority (87%) of offers she did receive surcharged premiums or put limits on her benefits, including riders to eliminate coverage for her Hay Fever, prescription drugs, or her upper respiratory system. In another scenario, a seven-year breast cancer survivor was denied coverage 43% of the time; on 39% of her applications she was offered policies with surcharged premiums or benefit limits including permanent exclusion of cancer coverage. Yet another applicant with HIV was denied 100% of the time.

By contrast, the ACA prohibits individual market insurers from denying coverage or charging higher premiums based on health status. It also prohibits pre-existing condition exclusion periods and requires policies to cover essential benefits.

Source

[How Accessible is Individual Health Insurance for Consumers in Less-Than Perfect Health?](https://www.kff.org/health-costs/report/how-accessible-is-individual-health-insurance-for/) (https://www.kff.org/health-costs/report/how-accessible-is-individual-health-insurance-for/)

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U.S. Health Reform—Monitoring and Impact

Marketplace Coverage Enrollment by Metal Tier, 2016–18: Trends in States Using the Healthcare.gov Enrollment Platform

September 2020

By Erik Wengle and Linda J. Blumberg



Robert Wood Johnson
Foundation

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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

The health insurance markets established by the Affordable Care Act (ACA) offer plans in four actuarial value tiers (bronze at 60 percent, silver at 70 percent, gold at 80 percent, and platinum at 90 percent). These plans, which meet essential health benefit standards and comply with various consumer protection regulations,¹ have made the marketplaces a central component of the U.S. health coverage landscape. The ACA's marketplaces provide a structured environment in which insurers can compete for consumers, and consumers can compare health insurance benefits, out-of-pocket costs, and premiums, using the standardized information provided for each plan offered. In addition, coverage sold through the marketplaces can be purchased using federal income-related subsidies (premium tax credits and cost-sharing reductions), which are tied to the premium of the second-lowest-cost silver plan offered where the consumer resides (called the benchmark premium). Those wishing to purchase a more costly plan than the benchmark plan must pay the full difference; thus, insurers have strong incentives to keep premiums down. Premiums, out-of-pocket costs, perceived quality (e.g., provider networks, speed of reimbursement), and expectations of health care service use drive consumers' decisions about which plan to select. Yet, until recently, little data had been available about consumers' health plan choices; data released in late 2019 can help policymakers better understand consumer purchasing decisions and help indicate whether consumers have sufficient information

and assistance required to make informed decisions about enrolling in health coverage.

A consumer's choice among the insurance plan actuarial value options available affect their finances and access to medical care. This is particularly true because the ACA makes marketplace premium subsidy-eligible enrollees with incomes below 250 percent of the federal poverty level (FPL) eligible for additional cost-sharing subsidies **only if they enroll in silver-tier coverage**. But even consumers ineligible for these cost-sharing subsidies may not fully understand the trade-offs between premiums and out-of-pocket cost exposure without sufficient guidance. Understanding consumer purchasing choices can help policymakers and marketplace staff create tools and materials to better aid consumers in purchasing the health insurance coverage best suited to their needs.

With new data released by the Centers for Medicare & Medicaid Services in late 2019, we can now examine metal-tier enrollment trends over time in the 39 states relying on the Healthcare.gov platform in 2018. In this paper, we use these new data to analyze the changes in metal-tier enrollment from 2016 to 2018 across all the Healthcare.gov states, combined and by state. This analysis covers a unique period in the marketplaces' relatively brief history, when certain policy changes artificially altered relative premiums across coverage tiers.

BACKGROUND

The ACA has led to significant coverage expansion in the United States, particularly via the Medicaid eligibility expansions in 36 states (including the District of Columbia) and the subsidized nongroup marketplaces (sometimes called individual purchase marketplaces). Beginning in late 2017 and having the greatest initial impact on the 2018 plan year, several administrative changes affected the marketplaces and altered consumer preferences for marketplace plans in different actuarial value tiers.

First, starting in late 2017, the U.S. Department of Health and Human Services stopped directly reimbursing insurers for cost-sharing reductions provided to the marketplace enrollees with the lowest incomes.² But because insurers were still required to offer cost-sharing-reduction plans to eligible consumers, insurers began incorporating the costs of these subsidies into the premiums they charge for nongroup market plans.

Many states' departments of insurance instructed insurers to add the expected costs of the cost-sharing subsidies to the premiums for their silver plans, an approach called "silver loading." In addition to increasing the presubsidy premium for marketplace silver plans to the greatest extent of any policy option (as opposed to spreading the costs more broadly across the premiums of plans in other tiers of coverage), this approach increased premium tax credits the most, because the ACA ties tax credits' dollar amount to the second-lowest-priced silver premium in a consumer's area of residence. The increase in the premium tax credits affected all people eligible for premium tax credits (those with incomes up to 400 percent of FPL), not just those eligible for cost-sharing subsidies. In other states where departments of insurance required that expected cost-sharing subsidy costs be spread over multiple coverage tiers, premium tax credits increased but not to the same degree. In still other states, departments of insurance provided no guidance at all, and insurers made independent decisions about how to adjust premiums to compensate for the removal of reimbursement for cost-sharing subsidies. Departments of insurance in 26 of the 39 Healthcare.gov states instructed nongroup insurers to load the costs associated with these cost-sharing subsidies into silver plan premiums alone.³

Second, the administration widened the allowable variation around each actuarial value tier, allowing insurers to create plans with values up to 4 percentage points below the target actuarial value instead of the previous 2 percentage points; values can also reach 2 percentage points above the target, as was previously the case. For example, under the new rules, a silver plan could be designed to have an actuarial value between 66 percent and 72 percent; previously, it would have

had to fall between 68 percent and 72 percent. In essence, insurers could then offer coverage of lower value than was the case previously.

The third change was the introduction of a new actuarial value tier of coverage, called expanded bronze, starting with the 2018 plan year. In this new tier, insurers can offer plans with actuarial value ranging from 56 percent to 65 percent, allowing insurers to offer bronze plans with some services covered before the deductible. With the previous actuarial value constraints, providing services before the deductible would push the actuarial value of the plan above the range allowed for bronze plans. Of the 39 Healthcare.gov states, 27 offered expanded bronze plans in 2018.

Together, these three policy changes may have substantially decreased the attractiveness of the ACA's standard silver coverage, particularly for people ineligible for marketplace subsidies. Silver loading increased not only the pre-subsidy premiums in the silver tier but the size of subsidies per enrollee, making coverage in other tiers more affordable than they had been previously. Allowing bronze plans to be designed with lower actuarial values than originally intended permitted insurers to construct plans with higher cost-sharing requirements but lower premiums than they would have provided otherwise. With some consumers choosing plans largely based on the direct premium they would pay, more people may be taking up these lower-value plans. In addition, for consumers wary of large deductibles, the expanded bronze plans occupy a middle ground: they have lower value than the standard silver but allow some limited coverage (e.g., for a specified number of physician office visits or generic drugs) before satisfying the plans' large deductibles.

Bronze plans expose consumers with significant health care needs to larger financial burdens than do plans in the higher actuarial value tiers, so consumer advocates are wary of incentives that would increase enrollment in such plans. People with moderate incomes enrolling in coverage with high out-of-pocket costs may be unable to access medical care when needs arise. Additionally, one of the most frequent consumer complaints regarding marketplace coverage has been the relatively high out-of-pocket costs facing many enrollees ineligible for cost-sharing subsidies. Therefore, incentives that increase enrollment in the lowest levels of coverage could increase dissatisfaction with marketplace coverage, particularly if consumers were unclear *a priori* about the financial exposure they would face with substantial medical needs. Though many analysts have suspected these policy changes led to a shift in marketplace enrollment across actuarial value tiers, up until recently, they lacked sufficient data to assess this.

METHODS

Between spring 2018 and fall 2019, the Center for Consumer Information and Insurance Oversight released datasets on insurers and enrollment in ACA marketplace plans. The data include states with federally facilitated marketplaces and those with state-based marketplaces hosted on the federal platform. The issuer-level enrollment data include two sets of information for each year, one with state-level enrollment by plan and another with issuer level enrollment by county. The county enrollment data also include enrollees' demographic information, such as their age, sex, and income level. We analyze the three most recent years of data available, 2016, 2017, and 2018, with a particular focus on 2017 and 2018 because of little difference in enrollment by actuarial value tier between 2016 and 2017. We use the dataset that measures enrollment at the plan and state levels because the county-level data exclude enrollment by actuarial value tier.

The Center for Consumer Information and Insurance Oversight state-level data include limited variables: state, plan ID, and enrollment numbers. We merged this dataset with Healthcare.gov federally facilitated marketplace public use files to attach plan details to each observation, including actuarial value tier. To understand observed shifts in enrollment tiers between 2017 and 2018, we consulted information on the instructions state departments of insurance gave nongroup market insurers once the federal government halted cost-sharing reduction payments.³ We calculate state average lowest-premium bronze, second-lowest-premium silver (the premium tax credit benchmark), and lowest-premium gold plans, weighted by rating region population. To do so, we use population data from the U.S.

Census Bureau and plan premiums from the Healthcare.gov public use files.

The Center for Consumer Information and Insurance Oversight dataset does not enable us to analyze enrollment by actuarial value tier at the county or marketplace rating region levels. Consequently, we cannot relate premiums, which vary by rating region, with enrollment by actuarial value tier at that same level. Instead, we show how enrollment by tier varies with state premium averages. Though less precise, this approach still provides insights into consumer choice dynamics.

Given this data constraint, and for illustrative purposes only, we also calculate the postsubsidy premium faced by an illustrative person; for each of the 420 rating regions in Healthcare.gov states in 2018, we compute the premium tax credit available to a single 40 year-old-with income at 200 percent of FPL, using that rating region's benchmark premium. We then assess whether the illustrative person could use their tax credit to obtain a bronze plan for a \$0 premium, a bronze plan for a premium of less than \$100 per year, a gold plan for \$0, or a gold plan for a premium lower than the benchmark premium. We summarize this information by state, weighting the information for each rating region by the share of that state's population residing there. In this way, we can express the share of each state's population for which our illustrative person could obtain the example plans at the specified price. States that provide low-cost coverage options of different types to greater shares of our illustrative people may help explain the dynamics of consumer choices by actuarial value tier in 2018.

FINDINGS

Changes in Relative Premiums between Tiers Set the Stage for Marketplace Enrollment Shifts

In 2018, the percent increase in national silver benchmark premiums moved such premiums farther from bronze premiums and closer to gold premiums than they had been in 2017 (table 1). On average, silver benchmark premiums were 21 percent above the lowest-premium bronze plans available to consumers in 2017, but such premiums were 38 percent higher than the lowest-premium bronze plans by 2018. Relatedly, silver benchmark premiums were, on average, 23 percent below the lowest-premium gold plans available to consumers in 2017; in 2018, benchmark premiums were, on average, only 9 percent below gold plan

premiums. As described earlier, this shift in premiums for silver coverage relative to those for bronze and gold resulted from widespread silver loading in 2018.

We now shift to discussing how this 2018 change affected the relative affordability of different coverage levels by state that year. The relative pricing of coverage tiers strongly relates to state decisions about how insurers should accommodate for the elimination of direct federal reimbursement for cost-sharing subsidies. Also at play are other competitive concerns and varying responses to the general policy uncertainty around the future of the ACA, however. Table 2 displays population-weighted average 2018 total premiums for a 40-year-old nongroup marketplace enrollee in each

Table 1. Average Benchmark Silver Premiums as a Percentage of the Lowest Bronze and Gold Premiums across All Rating Regions in Healthcare.gov States, 2017 and 2018

	2017	2018
Benchmark silver premium/Lowest bronze premium	121%	138%
Benchmark silver premium/Lowest gold premium	77%	91%

Source: Authors' calculations based Healthcare.gov data on premiums.

Note: We estimate national average values by first computing the ratios of benchmark silver premiums to bronze and gold premiums in each rating region and then computing the national average using rating region population as weights.

Healthcare.gov state at three coverage tiers: benchmark (second-lowest-premium silver), lowest-premium bronze (including expanded bronze if it was the lowest-priced bronze plan available), and lowest-premium gold. These are the premiums facing enrollees ineligible for premium tax credits (i.e., the total premium) and wishing to enroll in coverage in these insurance tiers. We also show the state's average tax credit for an illustrative single, 40-year-old marketplace enrollee with income at 200 percent of FPL to provide insight into the typical options facing different consumers. The next columns provide estimated average shares of each state's population living in areas where the illustrative person could, after tax credits, have obtained a bronze plan for \$0, a bronze plan for less than \$100 per year, a gold plan for \$0, or a gold plan for less than the cost of the benchmark silver plan.

As noted previously, the dollar amount of premium tax credits increased the most in states where insurers loaded their full anticipated costs of cost-sharing subsidies exclusively into their silver-level premiums (rows shaded in silver Table 2). This generally made gold and bronze coverage more attractive than they had been the prior year. More people could use their premium tax credits to enroll in bronze coverage for no or very small direct premium contributions, meaning the bronze tier's higher deductibles, cost-sharing requirements, and out-of-pocket maximums were less likely to dissuade potential enrollees. In fact, in 360 of the 420 rating regions in Healthcare.gov states, a 40 year old individual at 200 percent of FPL could enroll in the lowest-cost bronze plan for \$0 after premium tax credits; these rating regions account for 80.5 percent of the population across the Healthcare.gov states. Plus, the post-subsidy household premium contributions required to enroll in gold coverage fell with the higher tax credits, making gold coverage more attractive to consumers too. In 17 rating regions (4.5 percent of the population in Healthcare.gov states), the lowest-cost gold premium was \$0 for our illustrative person, and in 98 rating regions (14.4

percent of Healthcare.gov states' population) the gold plan would cost the illustrative person less annually than the benchmark plan.

In 2018, our illustrative enrollee could have used their tax credit to cover the full premium for a bronze plan in 29 of the 39 Healthcare.gov states, regardless of where they lived in those states. In another 3 states, at least 80 percent of the state population lived in areas where our illustrative consumer could have enrolled in a free bronze plan. In all but 3 Healthcare.gov states, the illustrative person, who has a low income, could have gotten a free bronze plan in at least some areas of the state.

Throughout Wyoming, the illustrative consumer could have enrolled in the lowest-priced gold plan in their area using only their tax credit. The same was true in portions of 6 additional states (Georgia, Illinois, New Mexico, Pennsylvania, Texas, and Wisconsin). In 11 states (Florida, Georgia, Hawaii, Illinois, Kansas, Michigan, New Mexico, Pennsylvania, Texas, Wisconsin, and Wyoming), the illustrative consumer could have enrolled in a gold plan for less than the cost of enrolling in the benchmark silver plan, after using their tax credit. This means the higher-value gold plan was available for 4.02 percent of income or less—the percentage-of-income cap for someone with income at 200 percent of FPL. On the other end of the spectrum, our illustrative consumer living in Indiana and Mississippi would have found coverage the least affordable by any of these metrics; nowhere in either state would such a person be able to obtain a bronze plan premium for less than \$100 annually or a gold plan for 4.02 percent of their income or less. In both states, the departments of insurance instructed insurers to spread the costs associated with cost-sharing subsidies across all coverage tiers, keeping silver plan premiums as low as possible and minimizing the increases in the premium tax credits available to their enrollees.

Table 2: State Population–Weighted Average Annual Premiums and Advanced Premium Tax Credits for an Illustrative Consumer in Healthcare.gov States, 2018

*Illustrative consumer is a 40-year-old single person with income of 200 percent of the federal poverty level (\$24,120)**

State	State Population–Weighted Average				Share of State Population Living in Areas Where Illustrative Consumer Could Obtain			
	Lowest Bronze Premium	Benchmark Premium (Second-Lowest Silver)	Lowest Gold Premium	Value of APTC	Lowest-Premium Bronze Plan for \$0	Lowest-Premium Bronze Plan for <\$100 Annually	Lowest-Premium Gold Plan for \$0	Lowest-Premium Gold Plan for Lower Premium than Benchmark Plan
Healthcare.gov states	\$4,073	\$5,826	\$6,470	\$4,855	80.5%	87.8%	4.5%	14.4%
Alabama	\$4,244	\$6,667	\$6,989	\$5,697	100.0%	100.0%	0.0%	0.0%
Alaska	\$6,477	\$8,728	\$9,347	\$7,517	100.0%	100.0%	0.0%	0.0%
Arizona	\$4,755	\$6,206	\$7,532	\$5,236	84.8%	100.0%	0.0%	0.0%
Arkansas	\$3,558	\$4,373	\$4,910	\$3,403	0.0%	14.6%	0.0%	0.0%
Delaware	\$5,678	\$7,089	\$8,473	\$6,120	100.0%	100.0%	0.0%	0.0%
Florida	\$3,820	\$5,717	\$5,861	\$4,748	100.0%	100.0%	0.0%	15.6%
Georgia	\$4,946	\$5,863	\$7,185	\$4,894	26.1%	33.0%	4.6%	10.4%
Hawaii	\$4,028	\$5,473	\$5,385	\$4,358	100.0%	100.0%	0.0%	100.0%
Illinois	\$4,163	\$5,855	\$6,345	\$4,886	100.0%	100.0%	9.1%	15.6%
Indiana	\$3,553	\$4,132	\$5,484	\$3,162	0.0%	0.0%	0.0%	0.0%
Iowa	\$6,623	\$9,072	\$9,081	\$8,103	100.0%	100.0%	0.0%	0.0%
Kansas	\$4,143	\$5,825	\$5,355	\$4,856	100.0%	100.0%	0.0%	100.0%
Kentucky	\$3,490	\$4,814	\$5,677	\$3,845	100.0%	100.0%	0.0%	0.0%
Louisiana	\$4,373	\$5,840	\$6,630	\$4,870	100.0%	100.0%	0.0%	0.0%
Maine	\$4,506	\$6,905	\$7,622	\$5,935	100.0%	100.0%	0.0%	0.0%
Michigan	\$2,970	\$4,418	\$4,551	\$3,448	100.0%	100.0%	0.0%	14.4%
Mississippi	\$5,568	\$6,234	\$7,780	\$5,265	0.0%	0.0%	0.0%	0.0%
Missouri	\$4,402	\$6,246	\$8,625	\$5,276	80.7%	80.7%	0.0%	0.0%
Montana	\$4,162	\$6,265	\$6,982	\$5,295	100.0%	100.0%	0.0%	0.0%
Nebraska	\$6,489	\$9,080	\$9,186	\$8,110	100.0%	100.0%	0.0%	0.0%
Nevada	\$4,067	\$5,173	\$5,648	\$4,204	100.0%	100.0%	0.0%	0.0%
New Hampshire	\$4,692	\$5,696	\$6,283	\$4,726	100.0%	100.0%	0.0%	0.0%
New Jersey	\$3,859	\$4,928	\$7,757	\$3,959	100.0%	100.0%	0.0%	0.0%
New Mexico	\$3,769	\$5,093	\$4,148	\$4,124	100.0%	100.0%	49.3%	100.0%
North Carolina	\$5,509	\$7,421	\$7,872	\$6,452	100.0%	100.0%	0.0%	0.0%
North Dakota	\$3,121	\$3,711	\$4,704	\$2,742	9.4%	9.4%	0.0%	0.0%
Ohio	\$3,331	\$4,370	\$4,970	\$3,400	59.6%	88.8%	0.0%	0.0%
Oklahoma	\$4,640	\$7,899	\$7,956	\$6,929	100.0%	100.0%	0.0%	0.0%

Table 2, continued

State	State Population-Weighted Average				Share of State Population Living in Areas Where Illustrative Consumer Could Obtain			
	Lowest Bronze Premium	Benchmark Premium (Second-Lowest Silver)	Lowest Gold Premium	Value of APTC	Lowest-Premium Bronze Plan for \$0	Lowest-Premium Bronze Plan for <\$100 Annually	Lowest-Premium Gold Plan for \$0	Lowest-Premium Gold Plan for Lower Premium than Benchmark Plan
Oregon	\$3,440	\$4,745	\$4,999	\$3,776	100.0%	100.0%	0.0%	0.0%
Pennsylvania	\$4,104	\$6,307	\$5,557	\$5,337	100.0%	100.0%	44.0%	100.0%
South Carolina	\$4,400	\$6,288	\$6,597	\$5,318	100.0%	100.0%	0.0%	0.0%
South Dakota	\$4,543	\$5,941	\$6,688	\$4,972	100.0%	100.0%	0.0%	0.0%
Tennessee	\$4,928	\$8,891	\$10,958	\$7,921	100.0%	100.0%	0.0%	0.0%
Texas	\$3,943	\$4,853	\$5,229	\$3,883	82.6%	82.6%	1.7%	9.1%
Utah	\$3,594	\$6,599	\$7,377	\$5,629	100.0%	100.0%	0.0%	0.0%
Virginia	\$4,725	\$6,291	\$7,556	\$5,322	100.0%	100.0%	0.0%	0.0%
West Virginia	\$5,436	\$6,386	\$8,237	\$5,416	44.4%	73.0%	0.0%	0.0%
Wisconsin	\$4,467	\$6,284	\$6,190	\$5,315	100.0%	100.0%	13.6%	66.5%
Wyoming	\$6,925	\$10,329	\$8,522	\$9,359	100.0%	100.0%	100.0%	100.0%

Source: Authors' calculations based on Healthcare.gov data on premiums. Poverty guidelines are from <https://aspe.hhs.gov/2017-poverty-guidelines>.

Notes: APTC = advanced premium tax credit. For the 26 states with grey shading, state nongroup insurers were instructed to silver load, or add the costs of cost-sharing reductions into silver plans; silver-loading status is from a Commonwealth Fund report available at <https://www.commonwealthfund.org/blog/2017/states-step-protect-consumers-wake-cuts-aca-cost-sharing-reduction-payments>.

* This person has an income of \$30,120 in Alaska and \$27,720 in Hawaii, because both states follow alternate federal poverty guidelines.

Enrollment by Coverage Tier Shifted Significantly in 2018
Marketplace Enrollment by Coverage Tier across Healthcare.gov States, 2016 to 2018

Table 3 shows aggregate marketplace enrollment by metal tier in 2016, 2017, and 2018 across states relying on Healthcare.gov. We include the number of enrollees in each tier, the share of marketplace enrollees in each tier, and the percentage-point change in the distribution of enrollment by tier over time. Total marketplace enrollment in Healthcare.gov states declined modestly each year from 2016 to 2018, including drops of 7 percent and 3 percent in 2017 and 2018. Across all three years, silver-level coverage dominated, ranging from about two-thirds to three-quarters of total enrollment. Of the three tiers, bronze had the second highest enrollment, accounting for more than 20 percent of enrollees in each year. Bronze coverage was followed by gold-level coverage, which ranged from 3 percent to almost 7 percent of marketplace enrollees across these years, respectively. Catastrophic coverage (limited to people below age 29

and those without coverage deemed affordable to them) and platinum-level coverage each accounted for less than 1 percent of enrollees in each year.

Across all the Healthcare.gov states, the distribution of enrollment across actuarial value tiers shifted little from 2016 to 2017. In 2017, the share of marketplace enrollees choosing silver-level coverage increased by about 3.5 percentage points, from just under 72 percent to about 75 percent. Over the same period, enrollment in the higher-value gold and platinum plans fell modestly.

Overall between 2017 and 2018, however, a large share of marketplace enrollment in Healthcare.gov states shifted out of silver-level coverage; the total share of enrollees in silver coverage fell by almost 11 percentage points, to less than 65 percent of total enrollment. This substantial shift in 2018 is consistent with expectations that silver loading made other coverage levels significantly more attractive than silver coverage.

Table 3: Health Coverage Enrollment across States Using the Healthcare.gov Enrollment Platform, by Metal Tier, 2016–18

Metal Tier	2016		2017		2018		Change, 2016 to 2017		Change, 2017 to 2018	
	Enrolled	Share Enrolled in Each Tier	Enrolled	Share Enrolled in Each Tier	Enrolled	Share Enrolled in Each Tier	Enrolled	Percentage-Point Change in Enrollment Share	Enrolled	Percentage-Point Change in Enrollment Share
Catastrophic	80,725	0.8%	62,138	0.7%	49,635	0.6%	-18,587	-0.1%	-12,503	-0.1%
Bronze	2,042,567	20.7%	1,919,806	20.9%	1,590,313	17.9%	-122,761	0.3%	-329,493	-3.1%
Expanded bronze	N/A	N/A	N/A	N/A	932,781	10.5%	N/A	N/A	932,781	10.5%
Silver	7,069,352	71.6%	6,882,930	75.1%	5,722,426	64.3%	-186,422	3.5%	-1,160,504	-10.7%
Gold	609,755	6.2%	284,117	3.1%	581,032	6.5%	-325,638	-3.1%	296,915	3.4%
Platinum	72,292	0.7%	20,747	0.2%	16,905	0.2%	-51,545	-0.5%	-3,842	0.0%
National total enrollment (Healthcare.gov states only)	9,874,691	100.0%	9,169,738	100.0%	8,893,092	100.0%	-704,953	0.0%	-276,646	0.0%

Source: Center for Consumer Information and Insurance Oversight issuer enrollment data, available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/issuer-level-enrollment-data>.

Notes: Twenty-six departments of insurance in the 39 Healthcare.gov states instructed their nongroup insurers to silver load, or add the the costs of these cost-sharing subsidies into silver plans.

N/A: Expanded Bronze plans were not available in 2016 and 2017

Gold plan enrollment increased modestly as a share of total enrollment, and bronze-level coverage increased substantially via the expanded bronze tier introduced for the first time in some states in 2018. Compared with 2017, an additional 600,000 people enrolled in bronze plans in 2018 (taking traditional and expanded bronze enrollment together), despite total marketplace enrollment falling by almost 705,000 people that year. As a share of total enrollment, bronze enrollment rose from just under 21 percent to more than 28 percent of total marketplace enrollment when including expanded bronze. Yet, enrollment in the original bronze tier fell in 2018, and the newly available expanded bronze plans accounted for more than one-third of total bronze enrollment.

The expanded bronze tier proved popular in the 27 Healthcare.gov states where they were available in 2018. In 14 of those states, expanded bronze plans accounted for at least 10 percent of total marketplace enrollment that year (data not shown) and for more than 20 percent of enrollment in Michigan (24 percent), New Jersey (23 percent), Florida (22 percent), New Mexico and Nevada (both at 21 percent), and South Carolina and Maine (both at 20 percent).

Gold plan enrollment increased modestly from 2017 to 2018, from 3.1 percent to 6.5 percent of marketplace enrollment. This increase restored the market share gold enrollment held in 2016, following a noticeable drop in 2017, which likely

resulted from large, across-the-board premium increases that year.⁴

Enrollment in catastrophic and platinum plans has remained extremely low compared with enrollment in other coverage tiers; neither accounted for even 1 percent of marketplace enrollment over the three study years. Catastrophic plans were offered in 34 of the 39 Healthcare.gov states in 2018, up somewhat from 29 states in 2017. Because catastrophic plans are only offered to enrollees under age 29 and those without other options deemed affordable to them, this low enrollment is expected.

In 2018, platinum plans were offered in only eight Healthcare.gov states. Insurers do not have to offer platinum coverage as a condition of participation in the marketplaces, and many have chosen not to do so. Because this coverage tier has low out-of-pocket requirements, it is seen as attracting a disproportionate number of people with high medical needs. As such, platinum plans tend to be unattractive for insurers. Their higher premiums also make them less attractive to consumers.

Marketplace Enrollment by Coverage Tier and State

Table 4 shows the state-by-state breakdown of marketplace enrollment by actuarial value tier from 2016 to 2018, and Table 5 shows percentage-point changes in the distribution of enrollment across coverage tiers between 2016 to 2017 and 2017 to 2018. Again, states that instructed their insurers to silver load premiums in 2018 are shaded in silver.

Between 2016 and 2017, enrollment shifted little by actuarial value tier. But in states that experienced sizable shifts across metal tiers, such changes were primarily increases in the share of enrollees purchasing silver coverage. Of the 38 states with Healthcare.gov data in both 2016 and 2017 (Kentucky converted from a state-based marketplace to a federally facilitated marketplace in 2017, so the dataset has no 2016 data for Kentucky), 22 experienced increases in silver enrollment relative to other tiers, ranging from a 1 percentage-point increase in South Carolina to 11 percentage-point increases in Arizona and Indiana. Shares of enrollees choosing silver-level coverage fell in only 13 states, and in those states, shifts out of silver coverage were much smaller; silver coverage decreased by a low of 1 percentage point in Louisiana and Utah and a high of 3 percentage points in Alaska, Montana, Nevada, and Oklahoma.

Between 2017 and 2018, however, the typical shifts in enrollment across tiers differed completely. In 33 of the 39 Healthcare.gov states, the share of marketplace enrollees in silver plans decreased between the 2017 and 2018 plan years. The median decrease in silver coverage was 12 percentage points, but the largest shifts out of silver coverage occurred in Wyoming and New Mexico, where silver plans' share of total

enrollment fell by 36 and 32 percentage points. Following that, the share of marketplace enrollment in the silver tier fell 20 or more percentage points in Iowa (20 points), South Carolina (22 points), Hawaii (22 points), and Pennsylvania (27 points).

As expected, states instructing insurers to silver load tended to see larger drops in silver enrollment, because the approach drove silver premiums, and thus subsidies, higher. Of the 19 states where the silver tier's share of marketplace enrollment dropped by more than 10 percentage points, 15 had silver loaded. Still, the magnitude of the shifts varied across silver-loading states, and some states that took other approaches also experienced large shifts out of the silver tier.

In 2018, enrollment shifts out of silver-level coverage increased the shares of enrollment in bronze- and gold-level coverage, but shifts to bronze were generally larger. Notable exceptions, however, are Wyoming, where coverage shifted out of both silver and bronze and into gold coverage, and Kansas, New Mexico, and Pennsylvania, where shifts into gold coverage heavily dominated as well. In states that had large enrollment shifts out of silver-level coverage but did not silver load, such movements were generally increases in enrollment in bronze plans, especially in Montana, North Carolina, and South Dakota.

Table 4: Health Coverage Enrollment in States Using the Healthcare.gov Enrollment Platform, by Metal Tier, 2016–18

State	Metal Tier	2016		2017		2018		Percentage-Point Change, 2017 to 2018	
		Enrolled	Share	Enrolled	Share	Enrolled	Share	Enrolled	Share
Alaska	Catastrophic	116	1%	N/A	N/A	N/A	N/A	0	0%
	Bronze	9,680	47%	9,589	52%	10,339	54%	750	2%
	Silver	10,095	49%	8,611	46%	7,841	41%	-770	-6%
	Gold	650	3%	377	2%	1,061	6%	684	3%
	Total	20,541	100%	18,577	100%	19,241	100%	664	0%
Alabama	Catastrophic	2,139	1%	1,682	1%	1,587	1%	-95	0%
	Bronze	13,819	7%	13,966	8%	17,985	10%	4,019	3%
	Silver	163,864	87%	160,164	89%	144,114	83%	-16,050	-6%
	Gold	8,176	4%	4,655	3%	10,697	6%	6,042	4%
	Platinum	808	0%	N/A	N/A	N/A	N/A	0	0%
	Total	188,806	100%	180,467	100%	174,383	100%	-6,084	0%

Table 4, continued

State	Metal Tier	2016		2017		2018		Percentage-Point Change, 2017 to 2018	
		Enrolled	Share	Enrolled	Share	Enrolled	Share	Enrolled	Share
Arkansas	Catastrophic	502	1%	462	1%	368	1%	-94	0%
	Bronze	14,722	19%	13,244	18%	16,951	24%	3,707	5%
	Silver	54,373	71%	53,899	75%	52,240	73%	-1,659	-2%
	Gold	7,234	9%	4,558	6%	2,308	3%	-2,250	-3%
	Total	76,831	100%	72,163	100%	71,867	100%	-296	0%
Arizona	Catastrophic	4,243	2%	1,584	1%	531	0%	-1,053	-1%
	Bronze	46,221	22%	36,125	21%	49,151	28%	13,026	8%
	Silver	134,524	64%	130,427	75%	116,222	67%	-14,205	-7%
	Gold	25,085	12%	6,389	4%	6,839	4%	450	0%
	Platinum	1,654	1%	N/A	N/A	N/A	N/A	0	0%
	Total	211,727	100%	174,525	100%	172,743	100%	-1,782	0%
Delaware	Catastrophic	160	1%	180	1%	165	1%	-15	0%
	Bronze	6,630	21%	7,657	27%	7,235	30%	-422	2%
	Silver	19,199	62%	17,842	64%	15,316	63%	-2,526	-1%
	Gold	4,039	13%	2,251	8%	1,476	6%	-775	-2%
	Platinum	865	3%	N/A	N/A	N/A	N/A	0	0%
	Total	30,893	100%	27,930	100%	24,192	100%	-3,738	0%
Florida	Catastrophic	9,639	1%	3,073	0%	1,182	0%	-1,891	0%
	Bronze	259,966	15%	275,227	16%	536,933	30%	261,706	13%
	Silver	1,403,977	79%	1,383,771	81%	1,211,789	67%	-171,982	-14%
	Gold	70,483	4%	29,255	2%	56,383	3%	27,128	1%
	Platinum	26,167	1%	12,979	1%	9,197	1%	-3,782	0%
	Total	1,770,232	100%	1,704,305	100%	1,815,484	100%	111,179	0%
Georgia	Catastrophic	7,417	1%	6,651	1%	2,747	1%	-3,904	-1%
	Bronze	87,416	16%	69,191	14%	68,565	15%	-626	1%
	Silver	433,261	78%	398,120	83%	353,868	78%	-44,252	-5%
	Gold	30,697	5%	6,198	1%	24,626	5%	18,428	4%
	Platinum	N/A	N/A	401	0%	2,207	0%	1,806	0%
	Total	558,791	100%	480,561	100%	452,013	100%	-28,548	0%
Hawaii	Catastrophic	50	0%	75	0%	155	1%	80	0%
	Bronze	2,675	15%	3,836	18%	5,460	26%	1,624	8%
	Silver	13,182	72%	15,171	72%	10,596	50%	-4,575	-22%
	Gold	1,358	7%	1,296	6%	4,036	19%	2,740	13%
	Platinum	1,086	6%	797	4%	1,010	5%	213	1%
	Total	18,351	100%	21,175	100%	21,257	100%	82	0%

Table 4, continued

State	Metal Tier	2016		2017		2018		Percentage-Point Change, 2017 to 2018	
		Enrolled	Share	Enrolled	Share	Enrolled	Share	Enrolled	Share
Iowa	Catastrophic	132	0%	887	2%	607	1%	-280	0%
	Bronze	16,385	27%	15,350	27%	21,602	41%	6,252	14%
	Silver	39,465	66%	39,783	71%	26,293	50%	-13,490	-20%
	Gold	3,646	6%	164	0%	3,774	7%	3,610	7%
	Platinum	17	0%	10	0%	N/A	N/A	-10	0%
	Total	59,645	100%	56,194	100%	52,276	100%	-3,918	0%
Illinois	Catastrophic	1,951	0%	780	0%	1,291	0%	511	0%
	Bronze	120,879	29%	114,224	31%	130,907	38%	16,683	6%
	Silver	246,955	60%	235,882	65%	185,333	54%	-50,549	-11%
	Gold	42,107	10%	12,240	3%	28,203	8%	15,963	5%
	Total	411,892	100%	363,126	100%	345,734	100%	-17,392	0%
Indiana	Catastrophic	908	0%	399	0%	N/A	N/A	-399	0%
	Bronze	68,890	34%	41,901	23%	42,845	26%	944	2%
	Silver	122,870	61%	127,916	72%	117,214	70%	-10,702	-1%
	Gold	9,947	5%	8,187	5%	6,909	4%	-1,278	0%
	Total	202,615	100%	178,403	100%	166,968	100%	-11,435	0%
Kansas	Catastrophic	N/A	N/A	568	1%	751	1%	183	0%
	Bronze	22,784	21%	26,098	25%	26,697	27%	599	2%
	Silver	73,734	69%	68,042	66%	47,934	48%	-20,108	-18%
	Gold	8,547	8%	7,849	8%	23,467	24%	15,618	16%
	Platinum	1,495	1%	N/A	N/A	N/A	N/A	0	0%
	Total	106,560	100%	102,557	100%	98,849	100%	-3,708	0%
Kentucky	Catastrophic	N/A	N/A	860	1%	852	1%	-8	0%
	Bronze	N/A	N/A	19,009	21%	33,123	34%	14,114	14%
	Silver	N/A	N/A	67,007	73%	55,972	58%	-11,035	-14%
	Gold	N/A	N/A	5,360	6%	6,132	6%	772	1%
	Total	N/A	N/A	92,236	100%	96,079	100%	3,843	0%
Louisiana	Catastrophic	1,208	1%	759	1%	N/A	N/A	-759	-1%
	Bronze	42,710	21%	33,248	24%	31,817	30%	-1,431	7%
	Silver	149,776	72%	100,344	71%	66,355	63%	-33,989	-8%
	Gold	11,953	6%	4,733	3%	6,443	6%	1,710	3%
	Platinum	2,632	1%	1,500	1%	547	1%	-953	-1%
	Total	208,279	100%	140,584	100%	105,162	100%	-35,422	0%

Table 4, continued

State	Metal Tier	2016		2017		2018		Percentage-Point Change, 2017 to 2018	
		Enrolled	Share	Enrolled	Share	Enrolled	Share	Enrolled	Share
Maine	Catastrophic	737	1%	1,027	1%	921	1%	-106	0%
	Bronze	19,941	22%	22,106	27%	31,238	41%	9,132	14%
	Silver	64,292	72%	57,934	70%	42,611	55%	-15,323	-15%
	Gold	4,122	5%	1,874	2%	2,277	3%	403	1%
	Total	89,092	100%	82,941	100%	77,047	100%	-5,894	0%
Michigan	Catastrophic	3,950	1%	3,464	1%	2,838	1%	-626	0%
	Bronze	91,690	25%	101,075	30%	124,104	41%	23,029	11%
	Silver	246,523	67%	215,649	65%	159,559	53%	-56,090	-12%
	Gold	21,812	6%	11,043	3%	13,269	4%	2,226	1%
	Platinum	3,275	1%	532	0%	180	0%	-352	0%
	Total	367,250	100%	331,763	100%	299,950	100%	-31,813	0%
Missouri	Catastrophic	1,204	0%	1,473	1%	117	0%	-1,356	-1%
	Bronze	74,840	26%	73,813	29%	67,252	28%	-6,561	-1%
	Silver	197,419	68%	171,139	68%	167,741	70%	-3,398	2%
	Gold	15,051	5%	3,845	2%	3,150	1%	-695	0%
	Platinum	887	0%	N/A	N/A	N/A	N/A	0	0%
	Total	289,401	100%	250,270	100%	238,260	100%	-12,010	0%
Mississippi	Catastrophic	695	1%	349	0%			-349	0%
	Bronze	11,016	11%	8,188	10%	3,698	5%	-4,490	-6%
	Silver	81,318	84%	70,994	89%	77,049	95%	6,055	6%
	Gold	2,973	3%	581	1%	365	0%	-216	0%
	Platinum	649	1%	N/A	N/A	N/A	N/A	0	0%
	Total	96,651	100%	80,112	100%	81,112	100%	1,000	0%
Montana	Catastrophic	643	1%	558	1%	552	1%	-6	0%
	Bronze	23,260	39%	23,716	44%	24,013	48%	297	4%
	Silver	32,904	55%	28,243	52%	17,793	36%	-10,450	-17%
	Gold	3,119	5%	1,554	3%	2,047	4%	493	1%
	Total	59,926	100%	54,071	100%	50,098	100%	-3,973	0%
North Carolina	Catastrophic	8,251	1%	8,959	2%	8,906	2%	-53	0%
	Bronze	101,724	17%	90,800	17%	113,523	22%	22,723	5%
	Silver	465,608	78%	428,009	80%	370,730	71%	-57,279	-9%
	Gold	20,441	3%	9,290	2%	30,362	6%	21,072	4%
	Platinum	3,545	1%	N/A	N/A	N/A	N/A	0	0%
	Total	599,569	100%	537,058	100%	523,521	100%	-13,537	0%

Table 4, continued

State	Metal Tier	2016		2017		2018		Percentage-Point Change, 2017 to 2018	
		Enrolled	Share	Enrolled	Share	Enrolled	Share	Enrolled	Share
North Dakota	Catastrophic	619	3%	639	3%	571	2%	-68	0%
	Bronze	5,940	25%	5,892	25%	6,577	28%	685	3%
	Silver	12,649	53%	13,498	57%	13,565	57%	67	0%
	Gold	4,882	20%	3,602	15%	3,069	13%	-533	-2%
	Total	24,090	100%	23,631	100%	23,782	100%	151	0%
Nebraska	Catastrophic	1,272	1%	784	1%	718	1%	-66	0%
	Bronze	30,281	33%	26,646	31%	39,256	43%	12,610	12%
	Silver	57,015	62%	59,013	68%	47,345	52%	-11,668	-16%
	Gold	3,809	4%	281	0%	3,735	4%	3,454	4%
	Total	92,377	100%	86,724	100%	91,054	100%	4,330	0%
New Hampshire	Catastrophic	1,127	2%	1,296	2%	1,031	2%	-265	0%
	Bronze	20,137	34%	18,277	32%	14,937	31%	-3,340	-1%
	Silver	31,912	53%	32,341	57%	30,020	62%	-2,321	5%
	Gold	5,720	10%	3,619	6%	2,254	5%	-1,365	-2%
	Platinum	970	2%	894	2%	N/A	N/A	-894	-2%
	Total	59,866	100%	56,427	100%	48,242	100%	-8,185	0%
New Jersey	Catastrophic	2,303	1%	2,071	1%	2,715	1%	644	0%
	Bronze	45,599	15%	46,251	15%	63,699	23%	17,448	7%
	Silver	226,281	74%	242,673	81%	209,302	75%	-33,371	-6%
	Gold	23,971	8%	9,502	3%	5,171	2%	-4,331	-1%
	Platinum	6,433	2%	N/A	N/A	N/A	N/A	0	0%
	Total	304,587	100%	300,497	100%	280,887	100%	-19,610	0%
New Mexico	Catastrophic	339	1%	182	0%	109	0%	-73	0%
	Bronze	11,936	21%	12,277	22%	13,069	25%	792	3%
	Silver	36,680	63%	36,931	67%	18,363	35%	-18,568	-32%
	Gold	8,557	15%	5,611	10%	20,333	39%	14,722	29%
	Platinum	374	1%	N/A	N/A	N/A	N/A	0	0%
	Total	57,886	100%	55,001	100%	51,874	100%	-3,127	0%
Nevada	Catastrophic	633	1%	1,028	1%	432	0%	-596	-1%
	Bronze	21,470	22%	26,276	28%	32,824	36%	6,548	8%
	Silver	69,867	71%	64,342	68%	54,534	60%	-9,808	-8%
	Gold	4,681	5%	3,241	3%	3,708	4%	467	1%
	Platinum	2,145	2%	N/A	N/A	N/A	N/A	0	0%
	Total	98,796	100%	94,887	100%	91,498	100%	-3,389	0%

Table 4, continued

State	Metal Tier	2016		2017		2018		Percentage-Point Change, 2017 to 2018	
		Enrolled	Share	Enrolled	Share	Enrolled	Share	Enrolled	Share
Ohio	Catastrophic	3,466	1%	1,867	1%	2,403	1%	536	0%
	Bronze	87,905	33%	70,236	28%	100,609	42%	30,373	14%
	Silver	152,098	57%	164,037	65%	120,792	51%	-43,245	-14%
	Gold	20,944	8%	15,025	6%	13,264	6%	-1,761	0%
	Platinum	625	0%	N/A	N/A	N/A	N/A	0	0%
	Total	265,038	100%	251,165	100%	237,068	100%	-14,097	0%
Oklahoma	Catastrophic	236	0%	36	0%	262	0%	226	0%
	Bronze	46,437	30%	52,332	35%	45,791	30%	-6,541	-5%
	Silver	101,300	65%	92,853	63%	99,771	66%	6,918	3%
	Gold	7,303	5%	3,022	2%	6,368	4%	3,346	2%
	Total	155,276	100%	148,243	100%	152,192	100%	3,949	0%
Oregon	Catastrophic	1,417	1%	679	0%	296	0%	-383	0%
	Bronze	44,896	27%	55,231	33%	59,961	37%	4,730	4%
	Silver	100,898	61%	100,376	61%	85,520	53%	-14,856	-8%
	Gold	17,191	10%	9,075	5%	16,537	10%	7,462	5%
	Total	164,402	100%	165,361	100%	162,314	100%	-3,047	0%
Pennsylvania	Catastrophic	3,125	1%	2,371	1%	2,193	1%	-178	0%
	Bronze	71,696	15%	40,086	9%	61,368	15%	21,282	6%
	Silver	350,527	72%	352,912	82%	227,168	55%	-125,744	-27%
	Gold	52,960	11%	33,096	8%	120,798	29%	87,702	22%
	Platinum	7,373	2%	2,302	1%	977	0%	-1,325	0%
	Total	485,681	100%	430,767	100%	412,504	100%	-18,263	0%
South Carolina	Catastrophic	1,560	1%	1,455	1%	1,718	1%	263	0%
	Bronze	17,546	8%	15,852	7%	59,047	28%	43,195	20%
	Silver	204,922	88%	191,772	89%	144,213	67%	-47,559	-22%
	Gold	9,387	4%	6,276	3%	8,791	4%	2,515	1%
	Total	233,415	100%	215,355	100%	213,769	100%	-1,586	0%
South Dakota	Catastrophic	344	1%	446	1%	481	2%	35	0%
	Bronze	5,599	19%	7,430	24%	11,834	37%	4,404	13%
	Silver	21,544	75%	22,936	73%	18,948	59%	-3,988	-14%
	Gold	1,246	4%	647	2%	793	2%	146	0%
	Total	28,733	100%	31,459	100%	32,056	100%	597	0%

Table 4, continued

State	Metal Tier	2016		2017		2018		Percentage-Point Change, 2017 to 2018	
		Enrolled	Share	Enrolled	Share	Enrolled	Share	Enrolled	Share
Tennessee	Catastrophic	2,149	1%	2,616	1%	234	0%	-2,382	-1%
	Bronze	70,113	26%	59,288	25%	54,093	23%	-5,195	-2%
	Silver	188,111	69%	170,293	72%	175,364	75%	5,071	3%
	Gold	9,340	3%	2,768	1%	3,392	1%	624	0%
	Platinum	1,229	0%	N/A	N/A	N/A	N/A	0	0%
	Total	270,942	100%	234,965	100%	233,083	100%	-1,882	0%
Texas	Catastrophic	8,028	1%	2,578	0%	5,750	1%	3,172	0%
	Bronze	328,193	26%	261,578	22%	320,170	29%	58,592	7%
	Silver	866,868	67%	871,712	74%	703,778	64%	-167,934	-11%
	Gold	78,868	6%	38,788	3%	75,648	7%	36,860	4%
	Platinum	4,993	0%	N/A	N/A	N/A	N/A	0	0%
	Total	1,286,950	100%	1,174,656	100%	1,105,346	100%	-69,310	0%
Utah	Catastrophic	642	0%	850	0%	1,092	1%	242	0%
	Bronze	28,865	14%	52,259	25%	110,845	54%	58,586	29%
	Silver	150,251	74%	152,709	73%	120,052	59%	-32,657	-15%
	Gold	21,635	11%	2,680	1%	3,022	1%	342	0%
	Platinum	777	0%	N/A	N/A	N/A	N/A	0	0%
	Total	202,170	100%	208,498	100%	204,985	100%	-3,513	0%
Virginia	Catastrophic	6,964	2%	6,923	2%	3,951	1%	-2,972	-1%
	Bronze	95,543	22%	88,002	21%	99,070	26%	11,068	5%
	Silver	308,094	70%	318,030	75%	260,985	68%	-57,045	-6%
	Gold	30,174	7%	12,713	3%	16,626	4%	3,913	1%
	Platinum	1,975	0%	924	0%	2,261	1%	1,337	0%
	Total	442,750	100%	426,592	100%	382,893	100%	-43,699	0%
Wisconsin	Catastrophic	2,302	1%	2,324	1%	2,030	1%	-294	0%
	Bronze	60,866	23%	68,726	27%	77,663	34%	8,937	7%
	Silver	191,021	71%	176,953	69%	119,848	52%	-57,105	-17%
	Gold	12,492	5%	9,210	4%	29,642	13%	20,432	9%
	Platinum	2,318	1%	408	0%	526	0%	118	0%
	Total	268,999	100%	257,621	100%	229,709	100%	-27,912	0%
West Virginia	Catastrophic	119	0%	106	0%	79	0%	-27	0%
	Bronze	7,216	18%	7,828	24%	8,690	31%	862	8%
	Silver	27,626	71%	22,777	69%	17,745	64%	-5,032	-5%
	Gold	4,218	11%	2,363	7%	1,082	4%	-1,281	-3%
	Total	39,179	100%	33,074	100%	27,596	100%	-5,478	0%

Table 4, continued

State	Metal Tier	2016		2017		2018		Percentage-Point Change, 2017 to 2018	
		Enrolled	Share	Enrolled	Share	Enrolled	Share	Enrolled	Share
Wyoming	Catastrophic	135	1%	97	0%			-97	0%
	Bronze	7,081	27%	6,976	27%	4,486	17%	-2,490	-10%
	Silver	18,349	69%	17,825	69%	8,543	33%	-9,282	-36%
	Gold	937	4%	899	3%	12,975	50%	12,076	46%
	Total	26,502	100%	25,797	100%	26,004	100%	207	0%

Source: Center for Consumer Information and Insurance Oversight issuer enrollment data, available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/issuer-level-enrollment-data>.

Notes: Platinum plans are excluded when a state does not offer them in the specified tier. For the 26 states with grey shading, state nongroup insurers were instructed to silver load, or add the costs of cost-sharing reductions into silver plans; silver-loading status is from a Commonwealth Fund report available at <https://www.commonwealthfund.org/blog/2017/states-step-protect-consumers-wake-cuts-aca-cost-sharing-reduction-payments>.

Table 5: Percentage-Point Changes in the Share of Marketplace Enrollees in Bronze, Silver, and Gold Plans in States Using the Healthcare.gov Enrollment Platform, 2016–17 and 2017–18

States shown in descending order by the size of state shift out of silver tier coverage between 2017 and 2018

State	Percentage Point Change in Share of Marketplace Enrollment, 2016 to 2017			Percentage Point Change in Share of Marketplace Enrollment, 2017 to 2018		
	Bronze	Silver	Gold	Bronze	Silver	Gold
Wyoming	0%	0%	0%	-10%	-36%	46%
New Mexico	2%	4%	4%	3%	-32%	29%
Pennsylvania	-5%	10%	10%	6%	-27%	22%
Hawaii	4%	0%	0%	1%	-22%	13%
South Carolina	0%	1%	1%	20%	-22%	1%
Iowa	0%	5%	5%	14%	-20%	7%
Kansas	4%	-3%	-3%	2%	-18%	16%
Montana	5%	-3%	-3%	4%	-17%	1%
Wisconsin	4%	-2%	-2%	7%	-17%	9%
Nebraska	-2%	6%	6%	12%	-16%	4%
Utah	11%	-1%	-1%	29%	-15%	0%
Maine	4%	-2%	-2%	14%	-15%	1%
Florida	1%	2%	2%	13%	-14%	1%
Kentucky	N/A	N/A	N/A	14%	-14%	1%
Ohio	-5%	8%	8%	14%	-14%	0%
South Dakota	4%	-2%	-2%	13%	-14%	0%
Michigan	5%	-2%	-2%	11%	-12%	1%
Illinois	2%	5%	5%	6%	-11%	5%
Texas	-3%	7%	7%	7%	-11%	4%
North Carolina	0%	2%	-2%	5%	-9%	4%

Table 5, continued

State	Percentage Point Change in Share of Marketplace Enrollment, 2016 to 2017			Percentage Point Change in Share of Marketplace Enrollment, 2017 to 2018		
	Bronze	Silver	Gold	Bronze	Silver	Gold
Louisiana	3%	-1%	-1%	7%	-8%	3%
Nevada	6%	-3%	-3%	8%	-8%	1%
Oregon	6%	-1%	-1%	4%	-8%	5%
Arizona	-1%	11%	11%	8%	-7%	0%
Virginia	-1%	5%	5%	5%	-6%	1%
New Jersey	0%	6%	6%	7%	-6%	-1%
Alabama	0%	2%	-2%	3%	-6%	4%
Alaska	4%	-3%	-1%	2%	-6%	3%
West Virginia	5%	-2%	-2%	-10%	-5%	-3%
Georgia	-1%	5%	-4%	1%	-5%	4%
Arkansas	-1%	4%	4%	5%	-2%	-3%
Indiana	-11%	11%	11%	2%	-1%	0%
Delaware	6%	2%	-5%	2%	-1%	-2%
North Dakota	0%	5%	-5%	3%	0%	-2%
Missouri	4%	0%	-4%	-1%	2%	0%
Tennessee	-1%	3%	-2%	-2%	3%	0%
Oklahoma	5%	-3%	-3%	-5%	3%	2%
New Hampshire	-1%	4%	-3%	-1%	5%	-2%
Mississippi	-1%	4%	-2%	-6%	6%	0%

Source: Center for Consumer Information and Insurance Oversight issuer enrollment data, available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/issuer-level-enrollment-data>.

Notes: N/A is not available; the dataset lacks 2016 data for Kentucky because the state operated a state-based marketplace with its own website that year. Bronze share includes expanded bronze plans. For the 26 states with grey shading, state nongroup insurers were instructed to silver load, or add the costs of cost-sharing reductions into silver plans; silver-loading status is from a Commonwealth Fund report available at <https://www.commonwealthfund.org/blog/2017/states-step-protect-consumers-wake-cuts-aca-cost-sharing-reduction-payments>.

Change in share may not sum to 0 because we exclude catastrophic and platinum because of their low enrollment.

CONCLUSION AND DISCUSSION

In 2018, silver-tier premiums increased relative to other marketplace premiums in most states. This change resulted from the administration's decision to stop directly reimbursing insurers for cost-sharing subsidies and from most states' subsequent decisions to have insurers add those costs to their silver-tier premiums instead. Other states had insurers spread those costs across all coverage tiers, which led to more proportionate increases in premiums across coverage tiers, whereas other states left insurers to make such decisions independently. All of these approaches increased the dollar value of marketplace premium subsidies, and such increases were generally largest in states that silver loaded.

The popular state decision to silver load reduced many subsidized consumers' required premium contributions for bronze-tier coverage to very low levels—sometimes to \$0. The decision also reduced the additional premiums required to enroll in more generous gold-tier coverage (relative to standard silver coverage). Consequently, the share of marketplace enrollees choosing silver-tier plans decreased significantly in 2018, whereas bronze and gold plan enrollment increased. Still, silver remained the highest-enrollment tier (64 percent) in 2018, down from 75 percent in 2017. Bronze plans (both traditional and expanded bronze) enrolled 28 percent of marketplace consumers in 2018, while gold plans enrolled 7 percent.

Shifts from silver- to bronze-tier coverage pose risks for consumers. Specifically, bronze plans' low- or no-cost premiums are hard to resist for increasing numbers of people struggling to afford needed health care. However, premium tax credit eligible people with incomes below 250 percent of FPL (\$61,500 for a family of four in 2018) are also eligible for out-of-pocket costs subsidies only if they enroll in silver tier marketplace coverage. If they select bronze coverage for its lower premiums, they forgo this additional assistance.

That many consumers may be unaware of the financial implications of enrolling in a bronze plan instead of a silver

plan at least partially owes to the administration having dramatically reduced funding for enrollment assisters. Shifting to bronze coverage could be detrimental for enrollees' finances and health statuses. For example, an individual with an income of 175 percent of FPL could have faced an out-of-pocket maximum of \$7,350 in a bronze plan, as opposed to \$1,950 in a silver cost-sharing reduction plan.⁵ Even people who have somewhat higher incomes and are ineligible for cost-sharing subsidies may have made potentially detrimental decisions because they did not understand the trade-offs between lower premiums and higher out-of-pocket costs. Such trade-offs will always be greatest for those with the greatest health care needs.

The pricing and enrollment dynamics described here remain true for 2020 and beyond, highlighting the need for additional support for consumers navigating the trade-offs between premiums and out-of-pocket costs and their potential consequences for financial well-being and access to medical care. With data for additional years that allow us to track enrollment choices for consumers with different income levels and health care needs, we could better assess whether cuts in consumer assistance have hampered effective decisionmaking about which health plan to enroll in. If enrollment by tier remains relatively constant over time, as it had before the administrative changes mentioned here, that may indicate consumers are comfortable with shifts to lower tiers of coverage, or that they still lack awareness about other options that may better meet their needs. The latter may be the case for consumers found to be forgoing substantial cost-sharing subsidies for somewhat lower premiums. If another shift occurs and substantial shares of enrollees return to silver-tier coverage, it may indicate that consumers were not happy with bronze coverage relative to higher actuarial value plans, and additional assistance and education tools could facilitate more informed decisionmaking by future health insurance consumers.

ENDNOTES

1. Examples include guaranteed issue and renewal, modified community rating, cost-sharing limits, and prohibitions on preexisting condition exclusions.
2. U.S. Department of Health and Human Services. *Trump Administration Takes Action to Abide by the Law and Constitution, Discontinue CSR Payments*. Washington: U.S. Department of Health and Human Services; 2017. <https://www.hhs.gov/about/news/2017/10/12/trump-administration-takes-action-abide-law-constitution-discontinue-csr-payments.html>. Published October 12, 2017. Accessed September 10, 2020.
3. Corlette S, Lucia K, Kona M. (2017). States step up to protect consumers in wake of cuts to ACA cost-sharing reduction payments. *To the Point* (blog), Commonwealth Fund. <https://www.commonwealthfund.org/blog/2017/states-step-protect-consumers-wake-cuts-aca-cost-sharing-reduction-payments>.
4. Holahan J, Blumberg LJ, Wengle E. Changes in marketplace premiums, 2017 to 2018. Urban Institute. <https://www.urban.org/research/publication/changes-marketplace-premiums-2017-2018>. Published March 21, 2018. Accessed September 10, 2020.
5. This comparison is for a person in Miami. The bronze plan selected is the lowest-cost bronze plan available there, and the silver cost-sharing reduction variant is for the benchmark offering.

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Affordability in the ACA Marketplace Under a Proposal Like Joe Biden's Health Plan

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Issue Brief

The Affordable Care Act (ACA) has led to historic decreases in the uninsured rate, but about 11% of non-elderly Americans (<https://www.kff.org/policy-watch/what-we-do-and-dont-know-about-recent-trends-in-health-insurance-coverage-in-the-us/>) remain uninsured and the ACA Marketplaces can have high premiums and deductibles. Left out of the ACA's affordable coverage expansion are those who buy their own insurance on the individual market but are ineligible for financial assistance. The ACA's premium tax credits hold down premium payments for Marketplace shoppers whose incomes are between one and four times (<https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/>) the federal poverty level (\$12,490 – \$49,960 for an individual in 2020). This subsidy structure has led to a lack of affordable individual market coverage options for people below poverty who live in states that do not expand Medicaid, and people shopping for their own coverage with incomes just above 400% of poverty across all states. In addition, people who are eligible for 'affordable' employer-sponsored insurance are ineligible for marketplace subsidies under current law. However, workers can be required to contribute as much as 9.78% of their household income for self-only coverage under an 'affordable' job-based plan, an amount much greater than some low-wage workers would have to pay for a subsidized marketplace plan were they eligible, and there is no limit on what workers with families might have to pay in premiums for employer coverage.

In years when there have been steep increases in exchange premiums, those receiving a subsidy have been protected from premium hikes, while those ineligible for subsidies face the full increase and may be priced out of coverage. Enrollment in the individual market (<https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/>) increased from about 11 million before the ACA to a peak of 17 million in 2015 and 2016. Steep premium increases for the 2017 and 2018 plan years coincided with sharp reductions in signups, particularly among people not receiving subsidies. Currently, more than 13 million people are enrolled in individual market coverage.

Additionally, high deductibles have created affordability challenges even for those with premium subsidies. The ACA includes an additional type of financial assistance, called a cost-sharing subsidy, which brings down deductibles and copayments, but only Marketplace purchasers whose incomes are between 1 and 2.5 times the poverty level are eligible for this help. People outside of this income range typically face deductibles of several thousand dollars or more, with silver (mid-level plan) deductibles reaching an average of about \$4,450 (<https://www.kff.org/slideshow/cost-sharing-for-plans-offered-in-the-federal-marketplace-2014-2020/>) for a single person in 2020. High deductibles can also discourage people from enrolling in coverage in the first place.

While there is general agreement that high premiums and deductibles for those without a subsidy are critical problems facing the ACA Marketplace, the 2020 presidential candidates differ in their proposed solutions. President Trump has advocated repeal of the ACA and his administration currently supports a lawsuit that would overturn (<https://www.kff.org/health-reform/issue-brief/explaining-texas-v-u-s-a-guide-to-the-case-challenging-the-aca/>) the law. If successful, the lawsuit could lead to significant coverage losses (<https://www.kff.org/health-reform/fact-sheet/potential-impact-of-texas-v-u-s-decision-on-key-provisions-of-the-affordable-care-act/>). President Trump has also expanded the availability of short-term plans, which have 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 ACA-compliant plans because they do not have to follow the ACA's rules, particularly coverage of pre-existing conditions. Short-term plans do not qualify for ACA premium subsidies, but the Trump administration has issued guidance allowing state waivers that would redirect premium subsidies to short-term plans under certain circumstances.

Former Vice President Joe Biden, on the other hand, has supported building on the ACA framework (<https://joebiden.com/healthcare/>) by expanding subsidies and creating a new public option. While Biden's public option proposal has received significant attention, his proposal to expand ACA premium subsidies has not been the subject of much public discussion or analysis, especially his plan to extend eligibility for subsidies to people with employer coverage. In this analysis, we examine current insurance

affordability challenges under the ACA, and the effects of a proposal like Biden's to expand subsidies for people currently purchasing Marketplace or employer coverage. We find that:

- The cost of ACA Marketplace coverage would be lower for nearly all current Marketplace enrollees, as well those who are currently priced out of the market.
- A 40-year-old making \$50,000 would go from paying \$522 per month for the second-lowest cost gold plan to paying \$354 per month under a Biden-like proposal, a savings of \$168 (or 32%) per month.
- More than 12 million people with employer-based insurance would pay a smaller share of their income towards premiums by switching into a Marketplace plan under premium caps similar to those Biden has proposed.

While a proposal like Biden's would make coverage more affordable for a significant number of people, they would also increase federal spending, which we do not attempt to estimate here. The Biden campaign has estimated that Biden's health plan would more than double federal Marketplace spending over 10 years.

How Affordable are Marketplace Plans under Current Law?

The map below shows premium affordability for people with various incomes and ages under current law. The ACA provides sliding scale subsidies that cap an individual's required premium contribution toward a benchmark plan (the second-lowest-cost silver plan) at a certain percent of one's income. The amount of premium tax credit equals the actual cost of the benchmark plan minus the individual's required contribution. Premium tax credits are available to Marketplace purchasers whose incomes are between 100% and 400% of the federal poverty level. Cost-sharing reductions are available to Marketplace shoppers who have incomes between 100% and 250% of poverty. Those whose income is below 150% of poverty receive the most generous cost-sharing assistance, though in states that have expanded Medicaid most of this group are enrolled in Medicaid rather than the Marketplace.

Marketplace participants can apply their premium tax credits to other plans that are more or less expensive than the benchmark plan. For example, someone may decide to enroll in the cheapest bronze plan offered on the marketplace and, if the premium tax credit amount equals or exceeds the cost of that plan, she can enroll for free. Approximately 4.7 million (<https://www.kff.org/private-insurance/issue-brief/how-many-of-the-uninsured-can-purchase-a-marketplace-plan-for-free-in-2020/>) uninsured individuals were eligible for zero premium bronze plans at the start of 2020. The tradeoff, however, is that bronze plans typically have much higher deductibles (\$6,500 on average (<https://www.kff.org/slideshow/cost-sharing-for-plans-offered-in-the-federal-marketplace-2014-2020/>)). Cost-sharing subsidies are only offered through silver-tier marketplace plans. A consumer might also decide to enroll in a plan that costs more than the benchmark plan – for example, she might prefer a more expensive gold plan with a lower

deductible; on average, gold plan deductibles are about \$1,500 per year for an individual. If so, the net premium payment after applying the tax credit will be more than the benchmark plan would have cost.

For people receiving both premium and cost-sharing assistance, ACA Marketplace plan subsidies are more comprehensive. For example, the average 60-year-old making \$20,000 (160% of poverty) pays \$77 per month (less than 5% of their income) on a silver plan, and has a deductible of less than \$800.

Those with higher incomes who are still within the subsidy range face higher costs. For example, at a \$49,000 income (392% of poverty), the typical 60-year-old would pay \$399 per month (just under 10% of their income) with a typical deductible approaching \$4,450 for the same silver plan. This person is still receiving a monthly subsidy of \$579 for help paying the premium, but they are not eligible for a reduced deductible.

Marketplace shoppers who are not eligible for any assistance face high and rising costs. If a 60-year-old's income is \$50,000 (just over 400% of poverty), she is no longer eligible for subsidies and would have to pay full price for a silver plan – \$979 per month, or 23% of her income, with a deductible of about \$4,450. This is an example of the so-called “subsidy cliff,” described more below and shown in Figure 3. The subsidy cliff is less pronounced for younger enrollees. People ineligible for subsidies can reduce premium costs by choosing a less expensive bronze plan, though this would not necessarily eliminate the subsidy cliff. The national average premium for the lowest cost bronze plan in 2020 for a 60-year old costs \$622 per month, or nearly 15% of gross income for someone earning \$50,000 (Figure 3). In addition, deductibles under bronze plans are even higher, averaging \$6,506 in 2020.

Figure 1

What Changes would Biden Make to ACA Marketplace Subsidies?

In this portion of the analysis, we focus on the effects of Joe Biden's health plan on people who are currently purchasing their own coverage, or who would be purchasing this coverage but have been priced out. Biden has proposed building on the ACA by increasing the amount of financial assistance and expanding subsidy eligibility beyond the current range of 100-400% of poverty for Marketplace purchasers. In his plan, Biden would peg the benchmark for premium tax credits to the second-lowest cost gold plan instead of the current silver benchmark, meaning premium subsidies would be higher and Marketplace purchasers could more easily afford a lower-deductible plan.

Biden would reduce the maximum premium contribution cap to 8.5% of an enrollee's income for a benchmark gold plan (currently the cap on enrollees' contributions toward the benchmark silver plan is just under 10% of income). He would also remove

the upper income limit on premium subsidies, extending the new 8.5% premium cap to higher-income enrollees, and so eliminating the “subsidy cliff.”

The Biden plan presumably would lower the required contribution for subsidy-eligible individuals at all income levels. Though his plan does not specify amounts, this analysis assumes required contribution amounts described in [H.R. 1884](#)

([https://www.congress.gov/bill/116th-congress/house-bill/1884/text?](https://www.congress.gov/bill/116th-congress/house-bill/1884/text?q=%7B%22search%22%3A%5B%22hr1884%22%5D%7D&r=1&s=1)

[q=%7B%22search%22%3A%5B%22hr1884%22%5D%7D&r=1&s=1](https://www.congress.gov/bill/116th-congress/house-bill/1884/text?q=%7B%22search%22%3A%5B%22hr1884%22%5D%7D&r=1&s=1)), a measure passed in the House of Representatives in 2020 that also caps required individual premium contribution amounts at 8.5% of income and eliminates the subsidy cliff. In this bill, for example, people with income of 160% FPL, who must contribute 4.59% of their income toward the cost of the benchmark plan under current law, would only have to contribute 2.4% of their income toward the cost of the benchmark plan.

In addition, Biden would allow workers with an offer of job-based coverage to enroll in Marketplace plans with subsidies if that would be a better deal. Under current law, employees qualify for Marketplace subsidies only if their employer's plan is deemed unaffordable or does not satisfy minimum coverage requirements. Employer coverage is considered unaffordable if the worker's premium contribution for self-only amounts to more than 9.78% of household income. The affordability test for employer-sponsored coverage offered to family members also is based on the cost of self-only coverage. As a result, if an employer pays the full premium for its workers but contributes nothing toward the cost of family coverage, family members are still considered to have an offer of “affordable” employer-sponsored coverage and so are ineligible for Marketplace subsidies; this is sometimes referred to as “the family glitch.” (See below for analysis of how many people with employer coverage could benefit from this change.)

Biden would also create a public option that would be open to all Marketplace participants. People who live in states that have not adopted the ACA Medicaid expansion and who make less than 138% of the poverty line would be automatically enrolled in the public option with no premium. The public plan would also negotiate payment rates with doctors and hospitals with a goal of reducing overall health plan costs.

Biden's campaign estimates that his plan would bring the uninsured rate down to 3%. In addition to the subsidy expansion and public option components of his plan, Biden has said that he would reinstate the individual mandate penalty, pass legislation to protect patients from surprise bills, block mergers that threaten competition in the health care industry, and allow the federal government to negotiate pharmaceutical prices.

How would a proposal like Biden's affect premiums for people buying their own coverage?

We find that, by implementing a proposal like Biden's to benchmark premium tax credits to the cost of more generous gold plans and capping premium payments at 8.5% of income, many individuals currently purchasing their own insurance could pay lower premiums for more generous coverage.

Average premium changes: On average across the U.S., a 40-year-old person making \$20,000 (160% of poverty) would go from paying \$139 to \$39 per month for the second-lowest cost gold plan. A 40-year-old making \$45,000 (360% of poverty) would go from paying \$429 per month for the second-lowest cost gold plan under current law to \$296 per month under a Biden-like proposal, a savings of 31% or \$133 per month. A 40-year-old who makes \$50,000, and thus is currently unsubsidized, would go from paying \$522 per month to paying a subsidized premium of \$354 for a gold plan.¹

The savings would be largest for older enrollees whose incomes are just above the current subsidy threshold. For example, a 60-year-old making \$50,000 (just over 400% of the poverty line) would go from paying an average of \$1,029 per month (25% of income) to \$354 (8.5% of income) for a gold plan, a savings of 66% (Table 1).

Table 1: National Average Change in Monthly Premium and Annual Deductible for Enrollee at \$50,000 Income (Just over 400% of Poverty)

	Bronze Plan (Typical Deductible of \$6,500)			Gold Plan (Typical Deductible of \$1,500)	
	Current Law	Biden's Proposal	% Change	Current Law	Biden's Proposal
60 year old	\$622	\$30	-95%	\$1,029	\$354
40 year old	\$324	\$160	-51%	\$522	\$354
27 year old	\$272	\$186	-32%	\$437	\$349

Note: This table shows enrollment-weighted average premiums for the lowest-cost bronze plan and the second-lowest cost county, based on premiums in effect in 2020. The payment for the second-lowest cost gold plan under the Biden plan would be capped at 8.5% of one's income. Estimated costs of bronze plans do not take into account any impact of the new public plan premiums or subsidy amounts.

Importantly, in addition to lowering what people would pay in premiums for marketplace plans, the Biden proposal would mean that many people could more easily afford to purchase more generous Marketplace plans with lower deductibles. For example, using national average Marketplace plan premiums, a 40-year-old making \$50,000 (just above the subsidy range under current law) would go from paying \$522 per month (nearly 13% of her income) to paying \$354 per month (8.5% of her income, a savings of 32%) for a gold plan with a typical deductible of about \$1,500.

County-by-county premium changes: The cost difference is particularly dramatic for middle-income enrollees who are older and those living in rural areas, where premiums tend to be higher. On average, a 60-year-old making \$50,000 would go from paying \$888 per month (21.3% of her income) for a silver plan to \$354 monthly (8.5% of her income) for a gold plan. A 40-year-old making \$50,000 in Floyd County, Georgia,

would go from paying \$896 monthly (21.5% of her income) for the second-lowest cost gold plan to paying \$354 monthly (8.5% of her income), a yearly savings of \$6,504. The map below shows the effects on premiums of a plan that benchmarks premium subsidies to the second-lowest cost gold plan in each county, caps premium payments at 8.5% of income, and further enhances premium subsidies for the current subsidy-eligible population (Figure 2).

It is important to note that the premium estimates in this paper do not account for the potential impact of Biden's proposed public option plan on Marketplace subsidies and the net cost for a non-benchmark plan. It is not yet known how the public option will be factored into the benchmark plan calculations or the extent to which the public option plan will be able to negotiate lower payment rates with doctors or hospitals, both of which could impact pricing across the Marketplace. These limitations are discussed further in the methods section.

Figure 2²

```
var divElement = document.getElementById('viz1601305833479'); var vizElement =
divElement.getElementsByTagName('object')[0];
vizElement.style.width='810px';vizElement.style.height='827px'; var scriptElement =
document.createElement('script'); scriptElement.src =
'#8217
(#8217);';
vizElement.parentNode.insertBefore(scriptElement, vizElement);
```

Elimination of the “subsidy cliff”: Savings are most pronounced for older, middle- and upper-middle income enrollees because, under Biden's proposal, there would no longer be a subsidy cliff. Currently, the subsidy cliff is most extreme for older enrollees due to age rating: On average, a 60-year-old making just above the subsidy range pays 15% of their income for a bronze premium, but this payment would drop to around 1% of their income under Biden's plan as the enrollee would become eligible for financial assistance (Figure 3). Premium subsidies would gradually taper off at higher incomes where they are no longer needed to make plans affordable.

Figure 3

Biden's proposed changes would have varying impacts in different parts of the country, depending in large part on the prices of gold plans currently, and what those prices are relative to the cost of other metal tiers. In general, the largest gains in affordability would go to middle and upper-middle-income, older enrollees living in rural areas since this group typically pays the highest premiums under current law, and to many people below the poverty line who live in states that have not expanded Medicaid

(those in the "Medicaid gap" (<https://www.kff.org/report-section/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-data-and-methods/>)) since they are currently not eligible for Marketplace subsidies despite their low incomes.

Since Biden's plan does not place an upper income limit on subsidy eligibility, an older adult in Lowndes County, Georgia, where gold plans are the most expensive in the country, could theoretically receive a subsidy even if their income exceeds \$300,000 per year. Currently, under the ACA, a hypothetical 64-year-old with a \$300,000 income in Lowndes County, Georgia would pay (<https://www.healthcare.gov/see-plans/>) \$2,692 per month for a gold plan, or 11% of their income; this would drop to \$2,125 (8.5% of their income) under a plan like Biden's. This is an extreme hypothetical scenario and it is unlikely a person with this income would be purchasing their own coverage, but it demonstrates how unaffordable premiums can be under current law for people who are not receiving subsidies.

Premium subsidy changes for other groups: Adults who are in the Medicaid coverage gap – whose income is too low to qualify for Marketplace subsidies and who live in states that have not expanded Medicaid (<https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>) – would see the largest gains in affordability under the Biden plan. They would be eligible for, and automatically enrolled in, the new public plan option for zero premium. For example, a 60-year-old making \$10,000 per year (80% of poverty) and living in a non-expansion state would go from having to pay \$687 per month for the lowest-cost bronze plan currently available (over 80% of their income) to having the option of at least one plan with no premium under Biden's proposal. Changes in affordability for coverage gap individuals are not reflected in the map in Figure 2.

Other enrollees may see no change to their premium contribution or could theoretically see premium increases in rare cases. People living in certain areas where gold plans already cost less than 8.5% of their income may not see much change in their own premium contributions. Subsidies may actually shrink in counties where, due to a practice called "silver loading" (<https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/>), gold plans are currently cheaper than the benchmark silver plan. For example, a 40-year-old making \$40,000 in Fremont County, Wyoming, would go from paying \$197 (5.9% of income) to \$243 (7.3% of income) per month for the second-lowest cost gold plan. We use current day premiums as the basis of this analysis but, if Biden's proposal ultimately becomes law, the practice of silver loading might also change or end.

Additionally, some states already have used state-only funds to supplement marketplace subsidies and/or extend them to more people. For example, California uses state dollars to extend Marketplace subsidies to people earning up to 600% of the

poverty line. If Biden's proposal ultimately were enacted, it is unclear whether states like California, Vermont, and Massachusetts would continue offering additional subsidies, so we do not factor in state-sponsored subsidies in Biden's proposal.

How could a proposal like Biden's affect premiums for people who enroll in coverage through an employer?

Biden's proposal would allow those with an offer of employer-sponsored insurance to buy into the Marketplace. While the figures above illustrate how premiums would change only for people currently eligible to buy subsidized marketplace plans, there would also be substantial savings for many who currently have employer plans.

Biden's health care proposal would eliminate the ACA's "firewall" and "family glitch," which make workers and their family members ineligible for premium tax credits if any worker in the family is offered "affordable" health insurance through their employer. Instead, people who are offered insurance through their work would be allowed to enroll in the public option plan and be eligible for Marketplace premium subsidies. Employer-based coverage is the largest source of insurance for non-elderly people in the U.S., and introducing the option to choose subsidized Marketplace coverage over an offer of job-based insurance could improve the affordability of coverage for many individuals and households, particularly those with lower-income workers (<https://www.healthsystemtracker.org/brief/how-affordability-of-health-care-varies-by-income-among-people-with-employer-coverage/>) who would otherwise qualify for substantial marketplace subsidies.

Figure 4: 12.3 Million people with ESI could save money on premiums by switching to a Marketplace plan with Biden's proposed premium caps

We estimate that 12.3 million people who currently have employer-based insurance are paying a larger portion of their income towards premiums than they would be if they purchased a Marketplace plan under premium caps comparable to what Biden has proposed, which would be no more than 8.5% of household income. While 12.3 million constitutes less than 10% of total enrollment in employer-sponsored coverage today, it exceeds the number of people who were enrolled in marketplace plans at the start of the year (11.4 million (<https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>)).

In addition to comparing premiums, people deciding whether to switch from employer coverage to a marketplace plan might also consider the relative level of cost-sharing. Today, gold Marketplace plans (the new benchmark plan under the Biden proposal) have annual deductibles averaging about \$1,500, compared to an average single

deductible (<https://www.kff.org/report-section/ehbs-2019-section-7-employee-cost-sharing/>) of \$1,655 for people in employer plans that had an annual deductible in 2019. In 2019, 28% of covered workers (<https://www.kff.org/report-section/ehbs-2019-section-7-employee-cost-sharing/>) were enrolled in a job-based plan with a deductible of \$2,000 or more. Low-income workers with employer coverage could also qualify for cost-sharing reductions that would lower deductibles for Marketplace plans.

The decision to switch from employer-based coverage to a Marketplace plan might also take into account a comparison of provider networks. The majority of Marketplace plans today are closed network (e.g., HMO) or narrow network plans that limit an enrollee's choice of doctors and hospitals. Under the Biden proposal, a new public option would be offered through the Marketplace and administered by the traditional Medicare program, whose provider network (<https://www.kff.org/medicare/issue-brief/primary-care-physicians-accepting-medicare-a-snapshot/>) includes nearly every hospital and physician in the U.S.

Discussion

ACA Marketplace premiums have fallen a bit, on average, (<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>) over the last two years. However, premiums and cost-sharing for even the least expensive ACA plans remain unaffordable for some middle-income people, particularly older people who face higher premiums, and impoverished people in states without Medicaid expansion. The more than two million people (<https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>) who fall into the Medicaid coverage gap in states that have not expanded Medicaid face the most pressing affordability challenges, since they are not eligible for either Marketplace subsidies or Medicaid despite living below the poverty line. Many enrollees who currently receive premium subsidies are ineligible for much or any cost sharing reductions, and as a result, often face high deductibles that may limit how often they can afford to actually use their insurance. High deductibles could also discourage some people from buying coverage in the first place. Additionally, people with an employer offer that costs nearly 10% of their income for self-only coverage are currently not eligible for Marketplace subsidies, even if that plan cannot affordably (<https://www.kff.org/report-section/the-coverage-provisions-in-the-affordable-care-act-an-update-expanding-coverage/>) cover the worker's entire household.

Joe Biden proposes to expand ACA subsidies, which would lower the cost of Marketplace coverage for nearly all potential enrollees, including many uninsured people who have been priced out of the Marketplace altogether. Older, middle- and upper-middle-income people would see substantial savings under these proposals: an average 60-year-old making \$50,000 (just above the current subsidy threshold) would see their Marketplace premiums decrease by 95% for a bronze plan and by 66% for a

lower-deductible gold plan. Premiums would fall dramatically in West Virginia, Georgia, Wyoming, Missouri, South Dakota, and Nebraska, since unsubsidized Marketplace premiums are currently unaffordable in many rural parts of these states. Allowing people with employer-sponsored insurance to buy into the public option and purchase subsidized Marketplace coverage also has the potential to improve the affordability of health insurance for millions of people who are currently tied to their employer's plan.

With these expanded subsidies and the creation of a public option, Biden's proposal would increase the cost of operating the Marketplace. In 2019, the federal government spent ([https://www.kff.org/health-reform/state-indicator/average-monthly-advance-premium-tax-credit-aptc/?](https://www.kff.org/health-reform/state-indicator/average-monthly-advance-premium-tax-credit-aptc/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)

[currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D](https://www.kff.org/health-reform/state-indicator/average-monthly-advance-premium-tax-credit-aptc/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D))

nearly \$55 billion in premium subsidies for Marketplace enrollees, and the Congressional Budget Office projects that the government will spend about \$610 billion total (<https://www.cbo.gov/system/files/2020-01/56020-CBO-Outlook.pdf>) on Marketplace subsidies between 2021 and 2030. This figure would likely increase significantly under Biden's proposed changes, driven in part by those who transition from employer-sponsored insurance to the individual market. Biden's campaign estimates that his health care plan, including the public option and the subsidy expansion, would cost an additional \$750 billion (<https://apnews.com/24b2aa65a45040c08f1457875cf23bde>) over 10 years. Biden plans to pay for the plan by raising income taxes on high-income people and raising the capital gains tax.

In contrast to Biden's plan to build on the ACA, President Trump has supported proposals to repeal and replace the ACA. The Trump administration has focused on addressing affordability problems by loosening regulations on short-term, limited duration health plans that generally have lower premiums than ACA-compliant coverage, in large part because these plans can exclude people with pre-existing conditions and may not cover certain services (<https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>), thus shifting higher out-of-pocket costs to those who are sick. The Trump administration also supports a lawsuit that seeks to overturn (<https://www.kff.org/health-reform/issue-brief/explaining-texas-v-u-s-a-guide-to-the-case-challenging-the-aca/>) nearly all parts of the ACA and, without a replacement plan, would lead to significant coverage losses (<https://www.kff.org/health-reform/fact-sheet/potential-impact-of-texas-v-u-s-decision-on-key-provisions-of-the-affordable-care-act/>).

Appendix

Appendix Table 1: Change in Monthly Bronze Premium under Biden's Proposal

Income	FPL	Lowest Bronze (Current Law)			Lowest Bronze (Proposed Changes)		
		27 year old	40 year old	60 year old	27 year old	40 year old	60 year old
\$20,000	160%	\$5	\$3	\$1	\$0	\$0	\$0
\$25,000	200%	\$37	\$24	\$3	\$0	\$0	\$0
\$30,000	240%	\$91	\$73	\$14	\$12	\$4	\$0
\$35,000	280%	\$156	\$136	\$41	\$45	\$26	\$0
\$40,000	320%	\$209	\$194	\$82	\$88	\$62	\$2
\$45,000	360%	\$234	\$232	\$116	\$135	\$107	\$10
\$50,000	400%	\$272	\$324	\$622	\$186	\$160	\$30
\$60,000	480%	\$274	\$331	\$666	\$231	\$223	\$71
\$70,000	560%	\$274	\$331	\$680	\$253	\$273	\$122
\$80,000	641%	\$274	\$331	\$687	\$265	\$301	\$182
\$90,000	721%	\$274	\$331	\$687	\$270	\$316	\$245
\$100,000	801%	\$274	\$331	\$687	\$273	\$325	\$308

Note: This table shows enrollment-weighted average premiums for the lowest-cost bronze plan. The payment for the second-lowest cost gold plan is set as a certain percent of one's income. However, the lowest-cost bronze plan payment could change, depending on how insurers and the public option plan are priced relative to the gold benchmark.

Appendix Table 2: Change in Monthly Gold Premium under Biden's Proposal

Income	FPL	Second-Lowest Gold (Current Law)			Second-Lowest Gold (Proposed Changes)		
		27 year old	40 year old	60 year old	27 year old	40 year old	60 year old
\$20,000	160%	\$128	\$139	\$213	\$39	\$39	\$39
\$25,000	200%	\$191	\$202	\$275	\$83	\$83	\$83
\$30,000	240%	\$254	\$265	\$339	\$140	\$140	\$140
\$35,000	280%	\$321	\$333	\$405	\$192	\$193	\$193
\$40,000	320%	\$373	\$391	\$464	\$243	\$243	\$243
\$45,000	360%	\$398	\$429	\$505	\$296	\$296	\$296
\$50,000	400%	\$437	\$522	\$1,029	\$349	\$354	\$354
\$60,000	480%	\$439	\$529	\$1,075	\$395	\$419	\$425
\$70,000	560%	\$439	\$529	\$1,089	\$417	\$470	\$496
\$80,000	641%	\$439	\$529	\$1,095	\$428	\$498	\$567
\$90,000	721%	\$439	\$529	\$1,095	\$434	\$513	\$637
\$100,000	801%	\$439	\$529	\$1,095	\$436	\$522	\$707

Note: This table shows enrollment-weighted average premiums for the second-lowest cost gold plan. The payment for the second-lowest cost gold plan is set as a certain percent of one's income. However, the lowest-cost bronze plan payment could change, depending on how insurers and the public option plan are priced relative to the gold benchmark.

Methods

We analyzed data from the 2020 Individual Market Medical files to determine premiums and the benchmark amounts to calculate premium tax credits for the scenarios presented. These files are available at data.healthcare.gov (<https://data.healthcare.gov/>). Premiums for state-based Marketplaces are from KFF analysis of data received from Massachusetts Health Connector, Covered CA, and KFF analysis of data published by HIX Compare from the Robert Wood Johnson Foundation. This analysis only includes on-exchange plans. Off-exchange plans generally have similar premiums to on-exchange plans with the exception of silver plans, which often include an additional premium load on-exchange only to account for cost-sharing reductions insurers must provide to some exchange enrollees.

All averages are weighted by county-level 2019 plan selections. 2019 plan selections come from the 2019 Marketplace Open Enrollment Period County-Level Public Use file provided by CMS, available [here](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2019_Open_Enrollment) (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2019_Open_Enrollment). In states running their own exchanges, we gathered county-level plan selection data where

possible and otherwise estimated county plan selections based on the county population in the 2010 Census and total state plan selections in the 2019 OEP State-Level Public Use File provided by CMS, available [here \(https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2019_Open_Enrollment.html\)](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2019_Open_Enrollment.html).

The premium caps used to model Biden's proposal are shown in Table 3.

Table 3: Premium Cap, by Income

Income % Poverty	Premium Cap	
	Current Law, 2020 (% of income for 2nd lowest cost silver plan)	Biden's Proposal (% of income for 2nd lowest cost gold plan)
Under 100%	No Cap	0% (in public option)
100% – 138%	2.06%	0% (in public option)
138% – 150%	3.09% – 4.12%	1% – 2%
150% – 200%	4.12% – 6.49%	2% – 4%
200% – 250%	6.49% – 8.29%	4% – 6%
250% – 300%	8.29% – 9.78%	6% – 7%
300% – 400%	9.78%	7% – 8.5%
Over 400%	No Cap	8.5%

Note: Note that tax credits for the 2020 benefit year are calculated using 2019 federal poverty guidelines.

Source: Kaiser Family Foundation

This analysis has some limitations. While Biden also supports a new public option, the premium payments shown in this paper do not account for the public option. The Biden plan does not specify two details about the public plan that we would need to know to estimate how the public plan could impact Marketplace subsidies and, in particular, an individual's net cost for a non-benchmark plan. First, the Biden plan, does not specify how much lower public plan provider payments might be compared to those paid by commercial insurers today. To the extent a public option negotiates lower payment rates for doctors and hospitals, the premium for the public option would be lower and might also lead competing private health insurance plans to lower their premiums. In addition, the Biden plan does not explain how the public option would be factored into the benchmark plan calculations. If the public plan is counted in determining the second-lowest-cost gold plan, and if the public plan premium is cheaper than the second-lowest-cost commercial gold plan, then the amount of premium tax credit dollars would be reduced for everyone. This would not affect what people pay for the benchmark plan – that amount is always equal to a sliding-scale percentage of household income. But it could increase what people pay for plans other than the benchmark plan because an individual's payment for all other plans equals

the plan's actual premium minus the premium tax credit for that individual. Because we did not take into account effects of a new public plan offering, the figures in this analysis could overstate the cost of a bronze plan in some cases.

We used data from the 2019 Current Population Survey to estimate the number of people with employer-based insurance who are paying a higher share of their income on premiums now than they would be if they switched to a Marketplace plan under premium caps comparable to what Biden has proposed. To do so, we aggregated income and premium payments at the tax unit level. To reflect 2020 values, we adjusted tax unit income for inflation and adjusted tax unit premium payments using the average growth in employer sponsored premiums from KFF's Employer Health Benefits Survey, depending on whether the tax unit had single or family coverage. We then deflated tax unit premiums to reflect the tax unit's current after-tax premium based on the unit's marginal tax rate and payroll tax liability. We used this adjusted premium value to calculate the share of the unit's income that was going towards premiums, and compared that percentage to the premium caps that would apply to the unit as outlined in HR. 1884 (Appendix Table 3).

Endnotes

Issue Brief

1. A person making \$50,000 is currently eligible for subsidies only in California, as the state funds additional subsidies for those who make less than 600% of poverty. Vermont and Massachusetts also provide additional state-funded subsidies to Marketplace enrollees, but these subsidies do not extend above 400% of poverty.

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2. The payment for the second-lowest cost gold plan is set as a certain percent of one's income. However, the lowest-cost bronze plan payment could change under Biden's proposal, depending on how the public option plan is priced relative to the gold benchmark.

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Health Update

September 28, 2020

CA Approves New Parity Law Expanding Coverage Obligations for Mental Health and SUD Treatment

By [Joseph E. Laska](#), Partner, [Healthcare Litigation](#) | [Nathaniel A. Cohen](#), Associate, [Healthcare Litigation](#) | [Jessamyn E. Vedro](#), Associate, [Healthcare Litigation](#)

On September 25, 2020, Governor Newsom signed Senate Bill 855 into law. SB 855 fundamentally alters California's regulation of mental health and substance use disorder (MH/SUD) treatment, and it applies to all California health plans and disability insurance policies issued, amended or renewed on or after January 1, 2021. This alert analyzes how the bill impacts current law and the operations of health plans and health insurers. All payors operating in California should be aware of SB 855 and its implications for product design, utilization management and other areas of MH/SUD benefit administration.

SB 855 amends existing California statutes and adds provisions relating to coverage of MH/SUD treatment to both the Health & Safety Code (which governs healthcare service plans in California) and the Insurance Code (which governs health insurers in California). Among other changes, SB 855:

1. Expands the scope of coverage mandates in the California Mental Health Parity Act;
2. Mandates a new, uniform definition of "medically necessary treatment of a mental health or substance use disorder";
3. Prohibits "discretionary clauses" in health plan contracts;
4. Establishes new obligations for payors to arrange for out-of-network coverage of MH/SUD services;
5. Prohibits plans and insurers from limiting MH/SUD benefits or coverage to short-term or acute treatment;
6. Prohibits plans and insurers from rescinding prior authorization for MH/SUD services after services are rendered;
7. Establishes new internal compliance requirements and disclosure obligations; and
8. Establishes new enforcement authority for the Department of Managed Health Care (DMHC) and the Insurance Commissioner.

While the final version of the bill does not establish a private civil cause of action for violation of its provisions, SB 855 authorizes regulatory actions and penalties, and it may also give rise to civil litigation under existing statutes, such as California's Unfair Competition Law, Bus. & Prof. Code §§ 17200 et seq.

History and Purpose of SB 855History and Purpose of SB 855

SB 855 was introduced in the California Senate by Senator Scott Wiener on January 14, 2020. The bill posits that prior state and federal legislation—including the California Mental Health Parity Act, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), and the Patient Protection and Affordable Care Act—do not sufficiently mandate coverage of MH/SUD conditions in health plans and health insurance policies. See SB 855 Sections 1(a)–(c). The bill states that it seeks to combat social problems relating to mental health and substance use disorders by expanding the California Mental Health Parity Act to require coverage of all such disorders, including at “intermediate levels of care,” such as residential treatment. Id. Sections 1(d)–(j).

The California Senate voted to pass SB 855 on June 25, 2020 and referred the bill to the California Assembly. After further amendments and passage of a revised bill in the Assembly, SB 855 passed both chambers on August 30, 2020. The bill was enrolled on September 3, 2020 and sent to the Governor’s desk. The Governor signed SB 855 on September 25, 2020.

Notable Provisions of SB 855

The following sections address some notable provisions of SB 855 that health plans and insurers should be aware of.

- **SB 855 expands the scope of MH/SUD services that plans and insurers must cover under the same terms and conditions applied to other medical conditions**

Existing state law requires health plans and insurers to provide coverage for a specified list of severe mental illnesses on the “same terms and conditions” as other medical services. SB 855 now requires parity of coverage for all mental health and substance use disorders, as defined in SB 855.¹

SB 855 defines “mental health and substance use disorders” as those conditions listed in the most recent edition of either the International Classification of Diseases or the Diagnostic and Statistical Manual of Mental Disorders. SB 855 also broadens the terms and conditions to which the parity requirement applies, mandating parity as to maximum annual and lifetime benefits, copayments and coinsurance, deductibles, and out-of-pocket maximums, but also stating that its parity requirements are “not limited to ... patient financial responsibilities.” It is unclear how the expanded parity requirements reflected in SB 855 will be applied to coverage terms beyond the scope of patient financial responsibility.

As a practical matter, these new provisions may not materially expand the scope of coverage because the federal MHPAEA, which applies to most health plans, already mandates coverage of a similar scope of disorders, as well as parity in coverage beyond patient financial responsibilities. This federal parity standard has proven difficult to apply to specific coverage provisions and has led to significant litigation on the issue. SB 855 similarly may lead to increased disputes concerning parity compliance under the new, complex and expanded state laws.

- **SB 855 establishes a uniform definition of medical necessity for MH/SUD services**

SB 855 establishes detailed, uniform standards for evaluating the medical necessity of MH/SUD services, which are explicitly modeled on rulings in *Wit, et al. v. United Behavioral Health, et al.* and *Wit, et al. v. United Behavioral Health, et al.*, No. 14-cv-02346-JCS (N.D. Cal.), an ongoing trial-level federal lawsuit.² SB 855 requires all California health plans and insurers to ensure that any plan-specific definitions and utilization review guidelines applicable to coverage of MH/SUD services are consistent with the definitions and coverage standards set forth in SB 855.

The bill defines “medically necessary treatment of a mental health or substance use disorder” as “a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms” that is:

9. “In accordance with the generally accepted standards of mental health and substance use disorder care”;
10. “Clinically appropriate in terms of type, frequency, extent, site, and duration”; and
11. “Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.”³

SB 855 further defines the “generally accepted standards of mental health and substance use disorder care” to mean “standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment[,]” which can be found in “peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling” approved by the FDA.⁴

When conducting utilization review of MH/SUD services, SB 855 requires that plans and insurers use “criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.”⁵ While earlier versions of the bill identified specific sources by name, the final bill does not. In instances where no criteria or guidelines mandated by SB 855 apply, plans or issuers may apply other criteria that are consistent with “generally accepted standards” as defined in SB 855.⁶

- **SB 855 prohibits “discretionary clauses” in health plan contracts**

SB 855 renders “void and unenforceable” any clauses in health plan contracts that “have the effect of conferring discretion on a health care service plan or other claims administrator to determine entitlement to benefits or interpret contract language that, in turn, could lead to a deferential standard of review by a reviewing court.”⁷

This provision appears to be directed to plans governed by the federal Employee Retirement and Income Security Act (ERISA), which applies to most private employer-based coverage. While discretionary clauses are prohibited in health insurance policies under existing law, discretionary clauses in health plans have been permitted and are very common. As a result, courts reviewing health plans' discretionary coverage determinations under ERISA-governed plans have generally applied a deferential standard of review. Under SB 855, courts may now conclude that those determinations should be reviewed de novode novo, without any deference to the decisions of plan administrators.

- **SB 855 creates an obligation for health plans and insurers to “arrange coverage” of out-of-network MH/SUD services**

SB 855 requires plans and insurers to “arrange coverage” of out-of-network services if medically necessary treatment is not available in network.⁸ This includes, but is not limited to, “providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards.” In addition, health plans and insurers must ensure that “[t]he enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.”

While the full effect of this provision is uncertain—particularly in light of undefined phrases such as “providing services to secure ... out-of-network options” and “medically necessary followup services”—it is likely that this provision will affect the relationship between health plans and insurers and out-of-network MH/SUD providers. Health plans and insurers should anticipate litigation concerning the scope and extent of these new affirmative obligations.

- **SB 855 bans limitations on coverage for mental health and substance abuse disorders to “short-term or acute treatment”**

SB 855 states that “a [health plan or insurer] shall not limit benefits or coverage for mental health and substance use disorders to short-term or acute treatment.”⁹ The bill does not specify whether it prohibits a plan or insurer from limiting an individual member’s treatment to short-term or acute treatment, or whether it invalidates plan terms that restrict coverage to short-term treatment on a blanket basis. SB 855 does not define “short-term or acute treatment.”

- **SB 855 prohibits plans and insurers from rescinding authorization for MH/SUD services after the services have been provided**

SB 855 requires plans and insurers to pay for MD/SUD treatment authorized in advance, even if the coverage is subsequently rescinded, canceled, or modified, and even if the plan or insurer subsequently determines that it had authorized the treatment in error.¹⁰ Once a provider renders preauthorized services “in good faith and pursuant to this authorization[,]” the plan or issuer may not rescind authorization “for any reason[.]”

This provision closely tracks other provisions in the Health & Safety Code and the Insurance Code,¹¹ so is unclear what, if any, additional effect this provision will have. This provision may lead to litigation concerning payment of claims in the face of eligibility issues or other problems discovered by the plan or issuer after authorization is granted.

- **SB 855 establishes new disclosure and internal compliance requirements**

SB 855 also imposes a suite of new internal compliance requirements.¹² Under the new law, health plans and health insurers must:

- Sponsor a formal education program “by nonprofit clinical specialty associations” to educate staff and contractors regarding claims review, utilization review, and medical necessity determinations under the new standards mandated by SB 855;
- Make the education program available to contracted healthcare providers, members, and “other stakeholders”;
- Provide clinical review criteria and training materials to providers and members at no cost;
- “Track, identify, and analyze” how clinical review criteria are used in coverage determinations and in any administrative appeal process;
- Conduct interrater reliability testing to ensure consistency in utilization management and medical necessity determinations;
- Run interrater reliability reports “about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities”; and
- Perform remediation functions if the plan or insurer does not achieve interrater reliability pass rates of at least 90%.

Plans and insurers already conduct interrater reliability testing and must meet certain standards for URAC and NQUA accreditation. However, SB 855 may open the door to litigation and regulatory penalties based on inadequate testing or failure to achieve certain results.

- **SB 855 establishes new enforcement authority for the DMHC and the Department of Insurance**

SB 855 permits the DMHC to assess administrative penalties for violations of new Health & Safety Code Section 1374.721, consistent with its authority under Health & Safety Code Section 1368.04, in addition to other existing remedies.¹³

In addition, under new Insurance Code Sections 10144.5(j) and 10144.52(i), the Commissioner may assess a penalty for violation of either section, up to \$5,000 per violation, or \$10,000 if the violation is “willful.”¹⁴

Opposition to SB 855 Opposition to SB 855

During the legislative process, the DMHC opposed passage of SB 855 unless certain provisions were amended or removed from the bill—including the restriction on discretionary clauses in health plans, the new definition of medical necessity for MH/SUD services, and the requirement that health plans and insurers arrange for out-of-network MH/SUD services—based primarily on overbreadth and difficulty of enforcement.¹⁵ Notably, these reservations from one of the key regulatory agencies tasked with enforcing the new bill did not prevent Governor Newsom from signing it.

Conclusion

Now that SB 855 has been signed into law, health plans and health insurers operating in California should act quickly to ensure that their products and utilization management procedures conform with its provisions. Health plans and insurers should also be prepared for increased litigation and regulatory action based on these new requirements.

¹See SB 855 Section 4, new Health & Safety Code § 1374.72(a)(2); SB 855 Section 7, new Insurance Code § 10144.5(a)(2).

²See SB 855 §§ 1(k)–(m).

³SB 855 Section 4, new Health & Safety Code § 1374.72(a)(3)(A); SB 855 Section 7, new Insurance Code § 10144.5(a)(3)(A).

⁴see also SB 855 Section 5, new Health & Safety Code § 1374.721(f)(1); SB 855 Section 8, new Insurance Code § 10144.52(f)(1); see also SB 855 Section 4, new Health & Safety Code § 1374.72(a)(5); SB 855 Section 7, new Insurance Code § 10144.5(a)(5).

⁵SB 855 Section 5, new Health & Safety Code § 1374.721(b); SB 855 Section 8, new Insurance Code § 10144.52(b).

⁶SB 855 Section 5, new Health & Safety Code § 1374.721(c); SB 855 Section 8, new Insurance Code § 10144.52(c).

⁷SB 855 Section 2, new Health & Safety Code §§ 1367.045(a)–(b).

⁸See SB 855 Section 4, new Health & Safety Code § 1374.72(d); SB 855 Section 7, new Insurance Code § 10144.5(d).

⁹SB 855 Section 4, new Health & Safety Code § 1374.72(a)(6); SB 855 Section 7, new Insurance Code § 10144.5(a)(6).

¹⁰SB 855 Section 4, new Health & Safety Code § 1374.72(a)(8); SB 855 Section 7, new Insurance Code § 10144.5(a)(8).

¹¹See Health & Safety Code § 1371.8; Insurance Code § 796.04.

¹²See SB 855 Section 5, new Health & Safety Code § 1374.721(e); SB 855 Section 8, new Insurance Code § 10144.52(e).

¹³SB 855 Section 5, new Health & Safety Code § 1374.721(i).

¹⁴SB 855 Section 7, new Insurance Code § 10144.5(j); SB 855 Section 8, new Insurance Code § 10144.52(i).

¹⁵See, e.g., California Assembly, Committee on Health, Legislative Analysis of SB 855 (Aug. 4, 2020), at p. 15.

NASHP

How States Can Advance Health Equity while Addressing Health System Costs

September 28, 2020 / by Adney Rakotoniaina

States have long faced budget limitations, a history of systemic racism, and a mandate to contain costs while maintaining access to quality care. COVID-19 has exacerbated these issues as state revenues decline and communities of color are disproportionately impacted [<https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html>] by the pandemic. These challenges raise an important question – how does a state advance health equity while addressing health system costs?

The rising cost of health care has created an additional barrier to accessing quality care, particularly for racial/ethnic minorities. In 2018, 13 percent of White patients reported going without needed care due to its prohibitively high cost. For nearly every other racial/ethnic group, this number ranged from 17 to 21 percent [<https://www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-coverage-access-to-and-use-of-care/>].

One contributing factor is that people of color are disproportionately uninsured. Not only are the uninsured solely responsible for their medical costs, but they are charged a higher rate for their care without the advantage of an insurer's negotiated pricing with providers. Additionally, as millions of people [https://www.urban.org/sites/default/files/publication/101946/unemployment-health-insurance-and-the-covid-19-recession_1.pdf] have lost insurance coverage due to pandemic-related job loss, there remains a clear need for strategies that lower health care system costs rather than simply through insurance coverage.

Leveraging Payment Systems to Enable Community Investments

One such strategy discussed by state leaders at the National Academy for State Health Policy's (NASHP) recent annual conference is a [global hospital budget](https://www.nashp.org/addressing-and-reducing-health-care-costs-in-states-global-budgeting-initiatives-in-maryland-massachusetts-and-vermont/) approach. Under this system, a state works with a hospital to determine the hospital's allowed revenues for the year. As implemented in Maryland, a hospital's deviation from its allowed revenues – whether by surplus or deficit – by more than a narrow 0.5 percent margin resulted in penalties against the hospital's budget the following year.

Through this approach, a state offers predictable payments to hospitals and incentivizes them to avoid excess costs. While fee-for-service hospitals across the country express concerns of closures due to unpredictable revenue from the pandemic-related pause in elective procedures, participating global budget hospitals in Maryland have been able to rely on more consistent revenue despite a decline in care utilization.

This predictability better enables hospitals to retain revenue and invest those funds within the community to address the upstream determinants of health, as [required](https://www.nashp.org/identifying-gaps-in-federal-oversight-of-hospitals-community-benefit-investments-opportunities-for-state-policy/) of tax-exempt hospitals under community benefit laws. While research shows the majority of nonprofit hospitals do not address health disparities in their investments, [Maryland](https://www.nashp.org/states-explore-pivoting-hospital-community-benefit-requirements-to-address-disparities-exposed-by-covid-19/) is one of the states working to pivot hospital investments to meet equity goals. Maryland requires nonprofit hospitals to submit an annual report that includes a list of its community benefit initiatives and the cost of each one.

At NASHP's conference, Katie Wunderlich, executive director of the Maryland Health Services Cost Review Commission, described a Baltimore hospital that has reduced its inpatient footprint and increased its spending on substance use disorder counseling, a healthy food market, and job training. Investments in the socioeconomic resources needed to foster good health (such as [healthy housing](https://www.nashp.org/policy/population-health/housing-and-health/)), nutritious

food, and sufficient income) are particularly important in communities of color, which have been historically deprived of these resources.

Just as global budgets enable hospitals to invest retained revenue in their communities, a growing number of states are utilizing cost-growth benchmark programs [<https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/>] to avoid unnecessary public spending on health care, which can instead be invested in services beyond the scope of clinical care.

Utilizing Cost-Containment Strategies to Improve Chronic Care Management

While acute care provided in clinical settings is important for improving health, chronic conditions such as cardiovascular disease and cancer encompass a growing share of patient care needs and costs [<https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm>], particularly for patients of color. Managing these conditions – and preventing the costly care associated with them – require the engagement of the state, public and commercial payers, hospital and non-hospital providers, and community organizations alike.

Cost-growth benchmarks, in which a state sets a limit on annual per capita health spending growth, operate statewide and engage all stakeholders in managing a state's total cost of care. State leaders can also use these as tools to improve health outcomes by including quality benchmarks.

Multiple entities work with the state oversight agency to set and meet these cost and quality benchmarks statewide, enhancing transparency, efficiency, and shared accountability for health care spending and quality. When it created its benchmark program through an executive order [<https://governor.delaware.gov/executive-orders/eo25/>], Delaware established eight quality benchmarks, including:

- **Adult obesity** – A long-term benchmark of no more than 27.4 percent of adults with a body mass index greater than or equal to 30 kg/m².
- **Physical activity among high school students** – A long-term benchmark of at least 48.7 percent of students engaging in physical activity for greater than or equal to 60 minutes per day five days a week.

- **Statin therapy for patients with cardiovascular disease** – A long-term benchmark of 82.1 percent of commercially insured and 68.3 percent of Medicaid-enrolled, at-risk individuals adhering to medication compliance greater than or equal to 80 percent of the treatment period.
- **Persistence of beta blocker treatment after a heart attack** – A long-term benchmark of 91.9 percent of commercially insured and 83.9 percent of Medicaid-enrolled individuals age 18 and older receiving beta-blockers for six months after discharge

Similarly, Maryland's new total cost-of-care model seeks to reduce the burden of chronic disease – particularly diabetes – through a focus on chronic care management. The goal is to help providers pay specific attention to and provide additional resources for communities disproportionately affected by chronic diseases.

While meeting these statewide benchmarks would not inherently address equity issues within these health outcomes, the inclusion of these quality benchmarks can contain costs through effective management and prevention of chronic conditions. In turn, it would reduce health care spending among Black and Latinx adults as they are the most likely to suffer from cardiovascular disease [<https://www.cdc.gov/nchs/hus/spotlight/HeartDiseaseSp>], risk factors, such as hypertension and obesity. As racial/ethnic minorities disproportionately lack health insurance coverage, it is crucial to prevent the development of inequitable health outcomes before costly clinical care intervention is needed, in addition to effectively managing these conditions in clinical settings.

As racial and ethnic minorities disproportionately lack health insurance coverage, it is crucial to prevent the development of inequitable health outcomes before costly clinical care intervention is needed, in addition to effectively managing these conditions in clinical settings.

Moving forward, states can use global budgets and cost-growth benchmarks as strategies to advance health equity while addressing health system costs. As states search for ways to better ingrain health equity into payment systems, these strategies offer states the ability to retain much needed revenues, focus upstream spending in non-clinical settings, better enable hospital community benefit spending, and manage chronic conditions that disproportionately impact people of color.

NASHP will be following the cost and health equity implications of these, and other, state efforts. For additional tools to help address health system costs, explore NASHP's [Model Act to Ensure Financial Transparency in Hospitals and Health Care Systems](https://www.nashp.org/an-act-to-ensure-financial-transparency-in-name-of-states-hospitals-and-health-care-systems/) [https://www.nashp.org/an-act-to-ensure-financial-transparency-in-name-of-states-hospitals-and-health-care-systems/], designed to help state policymakers and the public access detailed hospital financial information to better analyze a hospital's assets as well as its expenses and liabilities. Additionally, NASHP is also following [state efforts to address health inequities](https://www.nashp.org/states-launch-initiatives-to-address-racial-inequities-highlighted-by-covid-19/) [https://www.nashp.org/states-launch-initiatives-to-address-racial-inequities-highlighted-by-covid-19/] highlighted by COVID-19.

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Health System Tracker

What drives health spending in the U.S. compared to other countries

By Nisha Kurani and Cynthia Cox



Briefs | Health Spending

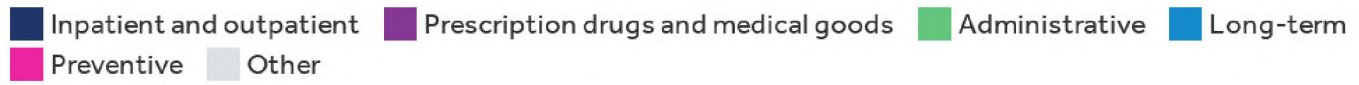
Posted: September 25, 2020

The United States spends significantly more on healthcare than comparable countries, and yet has worse health outcomes. Much of the national conversation has focused on spending on prescription drugs and administrative costs as the primary drivers of health spending in the U.S. President Donald Trump has signed executive orders with broad directives to lower prescription drug costs primarily in the Medicare program, and Democratic Presidential candidate Joe Biden's healthcare plan also aims to lower prescription drug costs by giving the federal government authority to negotiate prices for all purchasers. While it is true that many brand-name prescription drugs are priced higher in the U.S. than in peer countries, health spending data indicates that other spending categories - particularly hospital and physician payments - are greater drivers of health spending.

This brief examines the drivers of health spending and differences between the U.S. and other nations in Organisation for Economic Co-operation and Development (OECD) that are similarly large and wealthy (identified based on median gross domestic product (GDP) and median GDP per capita, for countries that have available data). In 2018, the U.S. spent nearly twice as much per capita on health as comparable countries. Most of the additional dollars the U.S. spends on health compared to peer nations goes to providers for inpatient and outpatient care. The U.S. also spends more on administrative costs, but perhaps not as much as people think, and spends significantly less on long-term care.

The U.S. spends twice as much as comparable countries on health, driven mostly by higher payments to hospitals and physicians

Healthcare spending per capita, by spending category, 2018



United States (Total: \$10,637 per capita)



Comparable Country Average (Total: \$5,527 per capita)



Note: Comparable countries include Austria, Belgium, Canada, France, Germany, Netherlands, Sweden, Switzerland, and the United Kingdom.

Source: KFF analysis of OECD Health Statistics

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In 2018, the U.S. spent nearly twice as much on health per person as comparable countries (\$10,637 compared to \$5,527 per person, on average).

The largest category of health spending in both the U.S. and comparable countries was spending on inpatient and outpatient care, which includes payments to hospitals, clinics, and physicians for services and fees such as primary care or specialist visits, surgical care, and facility and professional fees (see Methods for more details). Americans spent \$6,624 per person on inpatient and outpatient care while comparable countries spent an average of \$2,718 per person, a difference of \$3,906 per person. Patients in the U.S. have shorter average hospital stays and fewer physician visits per capita, while many hospital procedures have been shown to have higher prices in the U.S.

Similarly, many prescription drugs cost more in the U.S. than the same drugs do in other comparable nations. When we look at drugs treating different diseases, we find that certain drugs treating arthritis, blood clots, HIV, and more were found to be higher in the U.S. than in comparable countries. In 2018, the U.S. spent \$1,397 per capita on prescription drugs and other medical goods (including over-the-counter and clinically-delivered pharmaceuticals as well as durable and non-durable medical equipment) while comparable countries spent \$884 per capita on average, a difference of \$513. The Trump administration has introduced various proposals to reduce prescription drug pricing - including an international pricing model that would benchmark certain prices in Medicare to those of comparable countries - however, most of the plans have not yet been implemented. Even if per capita prescription drug pricing is lowered and closer to that of comparable countries, that difference would make only a dent in the overall difference in health spending.

Spending on health administration was over four times more per person in the U.S. than in comparable countries: \$937 compared to \$201 per person, respectively, a difference of \$736. Administrative costs include spending on running governmental health programs and overhead from insurers but exclude administrative expenditures from healthcare providers. Roughly half (53%) of administrative spending in the U.S. is from private health insurance costs, while the remainder are from governmental health programs such as Medicaid and Medicare.

The U.S. also spent more on preventive care than peer nations - \$309 compared to \$175 per capita, on average, a difference of \$134; activities captured in this spending category vary amongst countries, but in the U.S. it generally consists of public health activities, including preventive health programs and education for

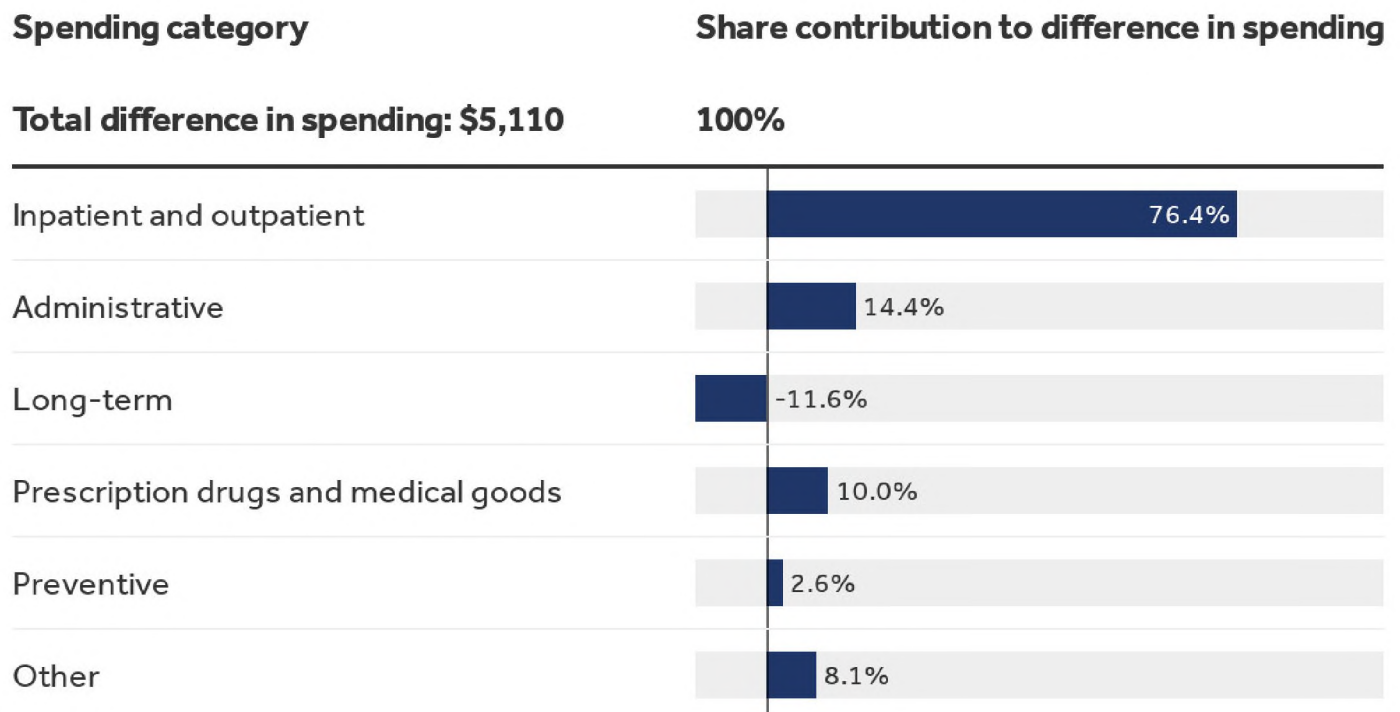
immunizations, disease detection, emergency preparedness, and more.

Meanwhile, the only category of spending in which the U.S. spends *less* than most comparable countries on a per person basis is long-term care (\$516 in the U.S. vs \$1,111 per capita in comparable countries, on average). Long-term care spending includes health and social services provided in long-term care institutions such as nursing homes as well as home- and community-based settings.

Spending in the “other” category includes ancillary services, and other types of care and medical goods uncaptured in the other spending categories.

The main driver of relatively high health spending in the U.S. is the cost of inpatient and outpatient care

Distribution of difference in per capita health spending between the U.S. and comparable countries, by spending category, 2018



Comparable countries include Austria, Belgium, Canada, France, Germany, Netherlands, Sweden, Switzerland, and the United Kingdom.

Source: KFF analysis of OECD Health Statistics.

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Health System Tracker

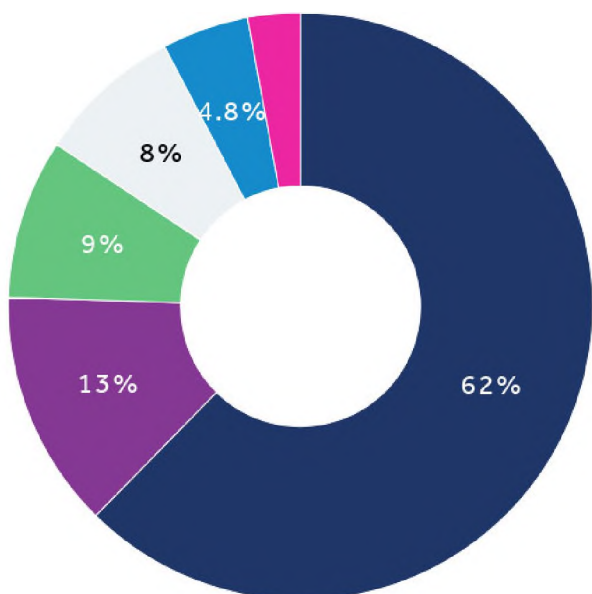
Health costs in the U.S. were \$5,110 more per person than costs in similarly large and wealthy countries. The difference in spending on inpatient and outpatient care was \$3,906 per person, accounting for over three-quarters (76%) of the difference in spending between the U.S. and comparable countries. The U.S. spent \$736

more per person on administrative costs compared to comparable countries, which represented 14% of the difference in overall spending. The additional dollars the U.S. also spent on medical goods and drugs than comparable countries accounted for 10% of the overall difference in spending.

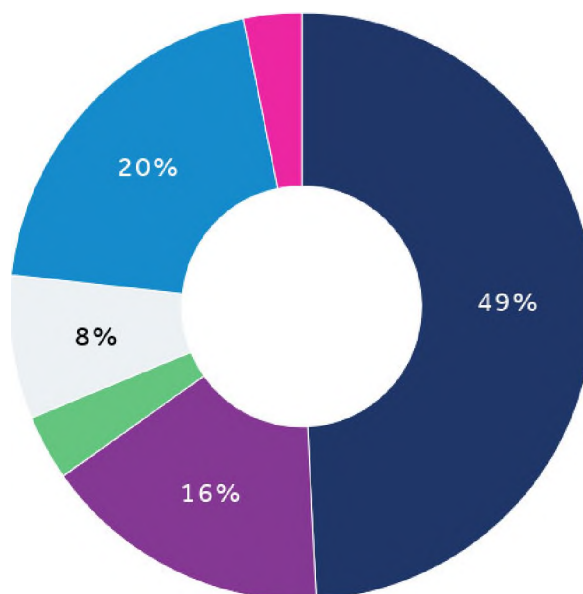
Inpatient and outpatient care represent a greater share of health spending in the U.S. compared to peer countries

Distribution of health spending, by spending category, 2018

■ Inpatient and outpatient
 ■ Prescription drugs and medical goods
 ■ Administrative
■ Other
 ■ Long-term
 ■ Preventive



United States (Total: \$10,637 per capita)



Comparable Country Average (Total: \$5,527 per capita)

Note: Values are normalized to 100%. Comparable countries include Austria, Belgium, Canada, France, Germany, Netherlands, Sweden, Switzerland, and the United Kingdom.

Source: KFF analysis of OECD Health Statistics

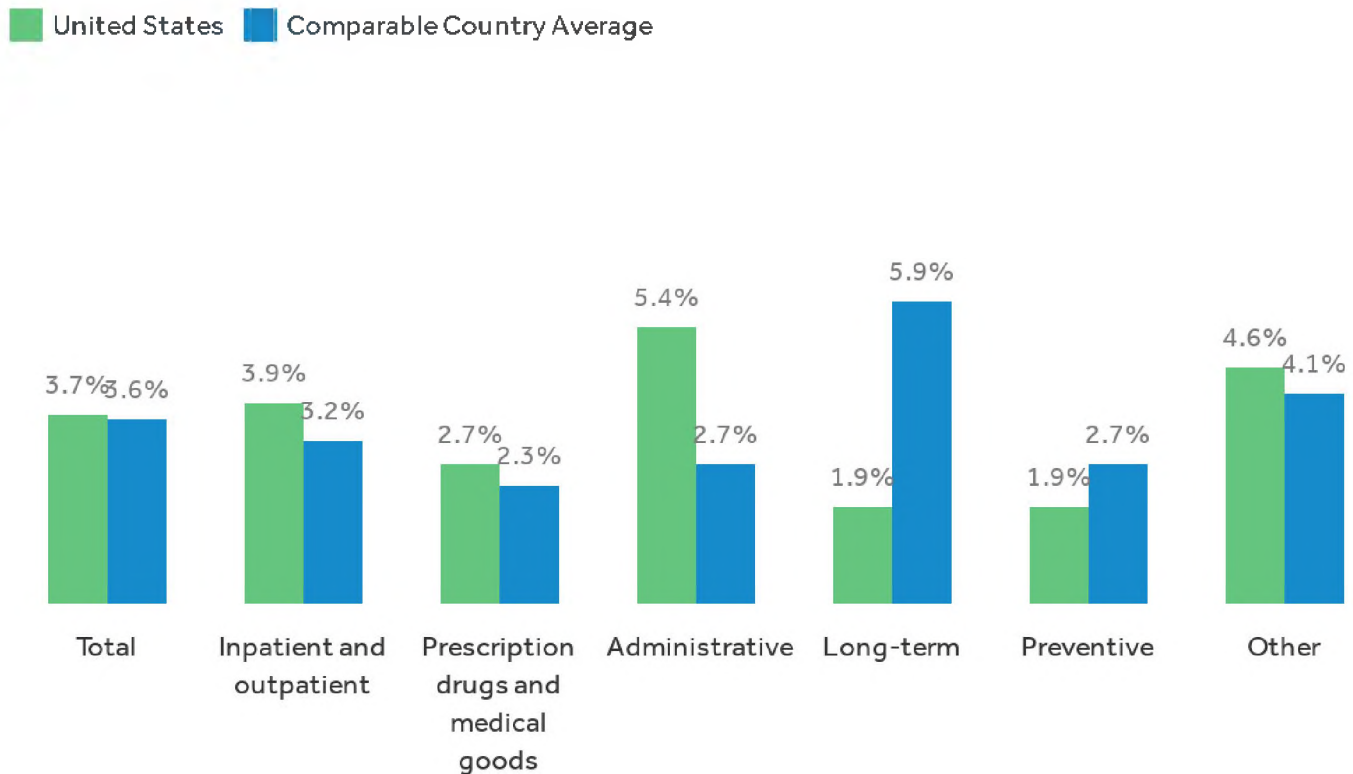
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In 2018, inpatient and outpatient care represented 62% of total health spending in the U.S. and 49% of spending in comparable countries, on average. While long-term care accounted for the second-smallest category of spending in the U.S. (4.8% of overall spending), it represented the second-largest category of spending in comparable countries (20% of overall spending). Administrative costs represent about 9% of overall health spending in the U.S. compared to 3.6% on average in comparable countries.

Although the U.S. spends more per person on prescriptions drugs and medical goods, these costs represented a slightly smaller share of total spending as compared to the comparable country average in 2018 (13% and 16%, respectively).

Over the past decade, per capita health spending has grown at similar rates for the U.S. and comparable countries, but the change in dollars is significantly different

Average annual growth rate in health spending from 2008 to 2018



Note: Comparable countries include Austria, Belgium, Canada, France, Germany, the Netherlands, and Sweden.

Source: KFF analysis of OECD data

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Health System Tracker

Between 2008 and 2018, health spending grew at a similar rate in both the U.S. and comparable countries (3.7% and 3.6%, respectively). However, since spending in the U.S. was significantly higher to begin with, the rate amounted to roughly twice as much in spending in dollars in the U.S. compared to comparable countries. The same is true for the growth in many specific spending categories. (This chart breaks from those presented earlier as it does not include data from Switzerland or the United Kingdom, since they did not report all spending categories in 2008. See methods.)

In the U.S., the largest growth in terms of dollar value was for spending on inpatient and outpatient care, which grew by \$2,089 per capita between 2008 and 2018 (i.e., 3.9% growth). In comparable countries, the largest contributor to the growth in spending was also inpatient and outpatient care (which grew by 3.2%), but the dollar increase (\$712 per capita) was smaller than in the U.S.

Notably, growth in spending on long-term care represented a far smaller share of spending growth in the U.S. versus comparable countries (1.9% vs 5.9%, respectively). Long-term care can be expensive or hard to access in the U.S. for many patients. Meanwhile, spending on administrative costs in the U.S. saw the greatest growth rate

at 5.4% over this period, while administrative costs in comparable countries grew at half that rate, at 2.7%.

Discussion

Political discourse on health spending often focuses on prescription drug prices and administrative costs as being the primary drivers of high health spending in the U.S. compared to other nations. Current policy proposals aim to address prescription drug pricing. Drug prices are, indeed, higher in the U.S. than in other high-income countries, but as this analysis shows, reducing drug spending alone would have a comparatively smaller effect on the gap between health costs in the U.S. and comparable countries. The biggest contributor to the difference in costs between the U.S. and peer nations is spending on inpatient and outpatient care. Yet, people in the U.S. use less care and have worse health outcomes than those in peer nations.

Methods

We analyzed health expenditure and financing data from the Organization for Economic Co-operation and Development (OECD) for 10 countries, including the U.S., in 2018. Data consisted of current expenditures on health expressed as per capita, current prices, current purchasing power parity (PPP), in U.S. dollars. Data in this analysis is rounded. Comparable country data was taken by averaging spending data from countries that have above median GDP and above median GDP per capita (Austria, Belgium, Canada, France, Germany, Netherlands, Sweden, Switzerland, and the United Kingdom). Australia and Japan were not included due to gaps in data on categories of spending for 2018. The United Kingdom and Switzerland did not have spending data on inpatient and outpatient care for 2008, and therefore were excluded from the analysis of growth rates between 2008 and 2018.

Current expenditures on health consisted of spending as a function of inpatient curative and rehabilitative care, outpatient curative and rehabilitative care, long-term care, ancillary services, medical goods, preventive care, governance and health system and financing administration, and other health services. In our analysis, "other" consists of other health services, ancillary services, and uncategorized spending, which is the difference between the sum of all categories and the total spending. Inpatient and outpatient care have been combined due to differences in when the same service may be performed inpatient versus outpatient depending on the country. The OECD defines outpatient care as care that "comprises medical and ancillary services delivered to a patient who is not formally admitted to a facility and does not stay overnight." Long-term care services may be provided by hospitals, nursing homes, doctors' offices, homes or other places. Medical goods consist of over-the-counter drugs, prescription drugs, other pharmaceuticals used for clinical purposes, and goods used for clinical purposes, such as hearing aids, glasses, prosthetics, and medical technical devices.

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Cost of Health Services

Health Spending

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Catastrophic Health Expenditures Across Insurance Types and Incomes Before and After the Patient Protection and Affordable Care Act

Charles Liu, MD, MS; Karan R. Chhabra, MD, MSc; John W. Scott, MD, MPH

Introduction

One decade after passage of the Patient Protection and Affordable Care Act (ACA), despite substantial gains in insurance coverage, health care affordability remains a major concern among US residents.¹ Premiums are increasingly unaffordable, and underinsurance—incomplete financial protection despite coverage—is increasingly common.² Although previous research has shown that the ACA's Medicaid expansions decreased out-of-pocket spending among low-income adults,³ broader trends in out-of-pocket spending have not been well characterized. We thus sought to analyze changes in financial risk protection associated with ACA implementation across all income strata and insurance types.

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

Methods

We obtained income, insurance coverage, and spending data from a nationally representative sample of adults aged 20 to 64 years in the Medical Expenditure Panel Survey, collected from 2010 to 2017. Our primary outcome was catastrophic health expenditures, defined with the World Health Organization threshold of calendar-year out-of-pocket plus premium spending exceeding 40% of postsubsistence income⁴ (calendar-year income minus typical food and housing expenditures from the Bureau of Labor Statistics⁵). Interrupted time series analysis was used to evaluate changes in the rate of catastrophic expenditures, with an inflection point in January 2014, the start of full ACA implementation.² Individuals were stratified for analysis by quartile of household income as a percentage of the federal poverty level and by insurance type (eFigure in the Supplement). We also analyzed individuals across insurance types within the lowest income quartile.

Analyses were performed with multivariable linear regression models adjusted for sociodemographic characteristics, self-reported health, and Census region (eTable in the Supplement). We adjusted for inflation using the Consumer Price Index.⁶ Cluster-robust standard errors and survey weights for national estimates were used, with a 2-tailed *P* value threshold of .05. Analysis was conducted with Stata/SE version 16.1.

This study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline for cohort studies.

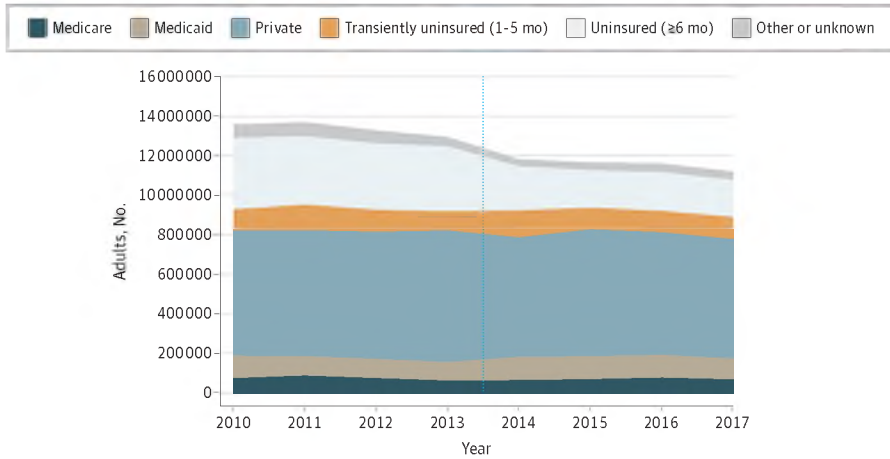
Results

We identified 159 941 survey respondents (49.1% men; mean age, 41.8 years [SD, 12.6 years]), representing 186 million individuals annually after survey weighting. The number of uninsured nonelderly adults declined from 42.9 million (23.5%) in 2010 to 27.9 million (14.8%) in 2017, whereas those with Medicaid coverage increased from 11.0 million (6.0%) to 18.3 million (9.7%) (*P* < .001). Coverage gains were concentrated in the 2 lower income quartiles, in which the uninsured rate decreased from 44.1% to 28.6% (lowest quartile) and 27.0% to 18.7% (*P* < .001).

The number of adults experiencing catastrophic expenditures yearly declined from 13.6 million (7.4%) in 2010 to 11.2 million (5.9%) in 2017 (*P* < .001) (Figure 1). Privately insured adults composed 46.4% of catastrophic expenditure cases in 2010 and 53.6% in 2017 (*P* < .001).

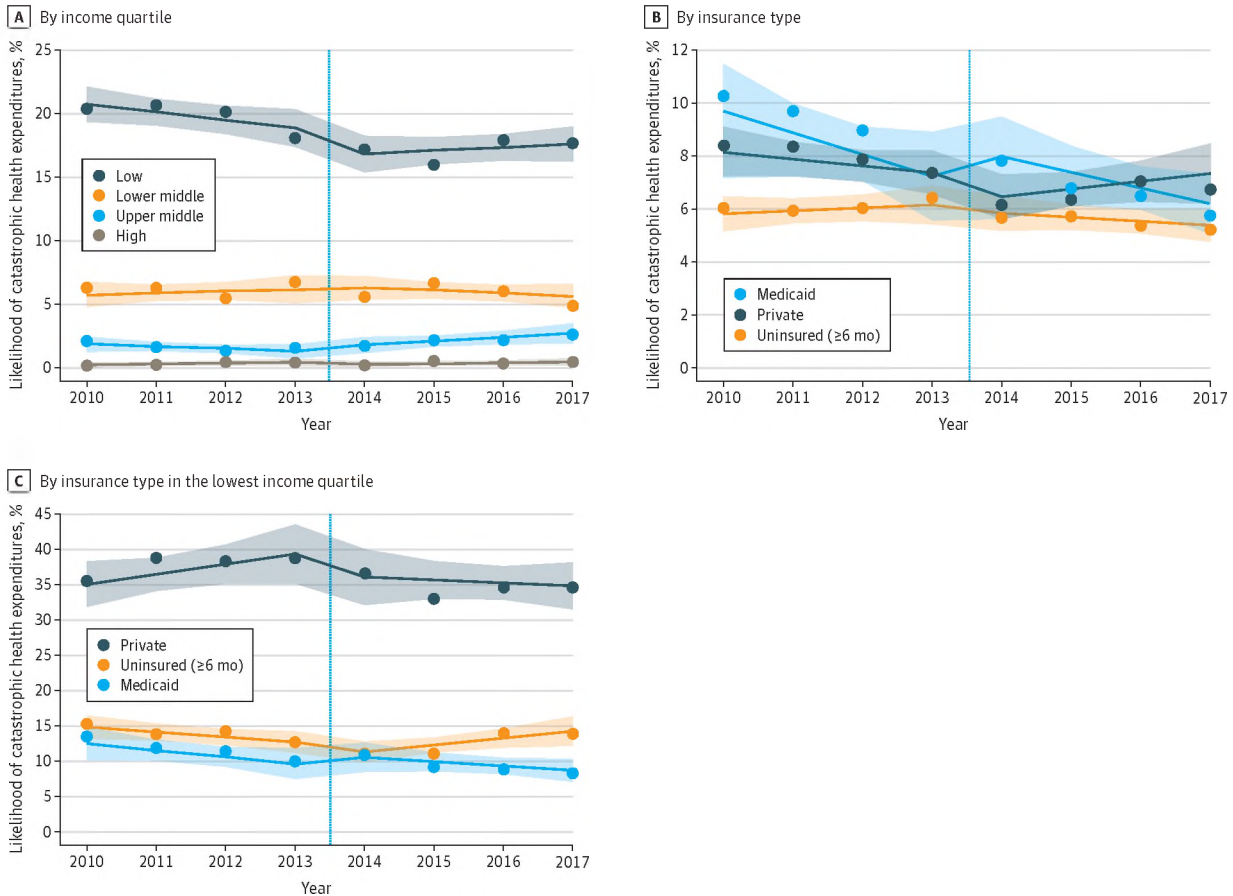
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Figure 1. Number of Adults Aged 20 to 64 Years Experiencing Catastrophic Health Expenditures, by Insurance Type



The total sample included 159 941 patients, and the weighted sample included 186 048 287 per year. Insurance type was defined as uninsured (≥6 months), transiently uninsured (1-5 months), or, given year-round coverage, as the insurer with the greatest share of calendar-year health care expenditures. Other or unknown includes individuals with year-round Veterans Affairs or Tricare coverage, or year-round insurance coverage from an unknown source. The vertical line indicates the date of Patient Protection and Affordable Care Act implementation.

Figure 2. Changes in Likelihood of Catastrophic Health Expenditures Among Adults Aged 20 to 64 Years, by Income Quartile, Insurance Type, and Insurance Type Within the Lowest Income Quartile



For clarity, only the 3 most common insurance types are shown. A and B, The sample included 159 941 patients, and the weighted sample included 186 048 287 per year. C, The sample included 57 224 patients, and the weighted sample included 46 518 845 per

year. Markers indicate mean likelihood; lines, best fit line; shaded areas, 95% CIs; and vertical line, Patient Protection and Affordable Care Act implementation.

In our interrupted time series analysis, individuals in the lowest income quartile experienced a 2.3 percentage point decrease in likelihood of catastrophic expenditures (95% CI, -4.6 to -0.1) (Figure 2A), whereas no change was observed in other income quartiles. Stratified by insurance type, privately insured individuals experienced no change in catastrophic expenditures (adjusted change, -0.2 percentage point; 95% CI, -1.4 to 1.0) (Figure 2B). Finally, in our subanalysis of the lowest income quartile, privately insured individuals again experienced no change (adjusted change, -2.8 percentage points; 95% CI, -9.5 to 3.8) (Figure 2C), and in fact had the highest rate of catastrophic spending in 2017 (34.6% vs 8.3% among Medicaid enrollees and 13.9% among the uninsured).

Discussion

ACA implementation was associated with 2 million fewer US adults with catastrophic expenditures each year. Financial protection improved for the lowest income quartile, which was one of the ACA's principal aims. However, improvements were not observed in higher income quartiles or among the privately insured, who represent an increasing share of those experiencing catastrophic expenditures. Among individuals in the poorest quartile, the privately insured are the most vulnerable, with one-third experiencing catastrophic spending annually. These findings help to explain why so many US residents, including those with insurance, continue to worry about their ability to afford needed care.

Limitations include changing patient composition within insurance groups, meaning our analysis evaluates financial protection currently conferred by each insurance type, rather than the effect of gaining coverage. Also, because the Medical Expenditure Panel Survey does not quantify unpaid bills or medical debt, our analysis likely underestimates patients' true financial hardship. Last, changes in catastrophic spending could have gone undetected in subgroups with small sample size, such as low-income privately insured individuals.

Despite large coverage gains, 11 million US adults, including 6 million with private insurance, continue to experience catastrophic health expenditures annually. These figures are likely to increase as millions lose employment or require unexpected medical care because of coronavirus disease 2019. Health reform should move beyond expanding insurance coverage alone to address persistently high out-of-pocket spending among the insured.

ARTICLE INFORMATION

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SUPPLEMENT.

eFigure. Flow diagram for determination of insurance type

eTable. Covariates used for adjustment in interrupted time series analysis

September 23, 2020

Health Care Lifeline: The Affordable Care Act and the COVID-19 Pandemic

Testimony of Aviva Aron-Dine, Vice President for Health Policy, CBPP Before the House Energy and Commerce Subcommittee on Health

Chairwoman Eshoo, Ranking Member Burgess, and members of the committee, thank you for the opportunity to testify before you today. My name is Aviva Aron-Dine. I am the Vice President for Health Policy at the Center on Budget and Policy Priorities (CBPP), a non-profit, non-partisan policy institute located in Washington. The Center conducts research and analysis on a range of federal and state policy issues affecting low- and moderate-income families. Previously, I served in government in a number of roles, including as the chief economist at the White House Office of Management and Budget (OMB), as Acting Deputy Director of OMB, and as a Senior Counselor at the Department of Health and Human Services (HHS), where my portfolio included Affordable Care Act (ACA) implementation and Medicaid, Medicare, and delivery system reform policy.

The title of today's hearing is apt: the ACA, along with the broader Medicaid program, is indeed providing a lifeline for millions during the COVID-19 pandemic and recession. We would be in a stronger position to address these crises had the law been fully implemented nationwide and if policies adopted over the past four years hadn't chipped away at ACA coverage gains and protections. But we would be in a far weaker position if the law had been repealed in 2017 or if it is struck down in court, as the Administration and 18 state attorneys general continue to urge. Going forward, there are many opportunities for Congress to continue to strengthen our health care safety net for this and future crises.

Coverage Programs Are Growing to Meet Need

As we are all well aware, the COVID-19 pandemic has brought economic devastation in its wake, with tens of millions of people losing their jobs or experiencing sharp reductions in income. Alongside increases in other forms of hardship, the deep recession is putting upward pressure on the uninsured rate, since job losses cause people to lose job-based coverage, and income losses can make it hard for them to pay premiums (whether for employer or individual market health plans). While the precise magnitude is uncertain, data confirm that large numbers of people have lost job-based coverage since the start of the recession.¹ These losses are likely to grow.

¹ Kaiser Family Foundation analysis, drawing on data from the National Association of Insurance Commissioners, shows a 1.3 percent drop in fully insured group market coverage from March through June. If extrapolated to the full

Medicaid has long played a critical role in protecting coverage during recessions, especially for children. During the Great Recession period, much of the loss in private coverage was offset by an increase in public coverage, resulting in a net coverage loss of about 5 million people, much smaller than the drop in private coverage. The children’s uninsured rate remained stable (and then fell following the enactment of children’s coverage improvements at the start of 2009).²

But prior to the ACA, many of the people most vulnerable to losing their jobs during recessions were excluded from Medicaid. In the typical state, parents were ineligible for Medicaid if their income was above about two-thirds of the poverty line, while adults without children were not eligible for Medicaid at all. For adults with incomes too high to qualify for Medicaid and without coverage through their jobs, individual market plans were generally unsubsidized, expensive, full of benefit gaps, and often unavailable altogether to people with pre-existing health conditions.

With Medicaid expansion and the ACA marketplaces now offering coverage to this group, we’d expect health coverage programs to be even more responsive to need during this recession than in the past. Data on Medicaid enrollment suggest this is indeed the case. Overall Medicaid enrollment has risen by 8.3 percent through July in 30 states for which the Center has been able to obtain data, and by 9.4 percent through August (with data available for 13 states). Meanwhile, expansion enrollment has risen by 13.2 percent through July across 18 states and by 14.8 percent through August (with data available for ten states). (See Figure 1.)³ If one were to extrapolate the July figures nationwide, they would imply that total enrollment has risen by about 6 million people, with about a quarter enrolling through expansion.

Evidence suggests mid-year sign-ups for ACA marketplace coverage have risen as well, particularly in state-based marketplaces that created special enrollment opportunities and conducted

market, that would imply a roughly 2 million drop in employer coverage, though coverage losses among workers at self-insured firms may have been smaller. Urban Institute analysis of Census Household Pulse survey data shows a 3.3 million drop in job-based coverage from late April/early May through July, although the underlying data are quite noisy. The drop in job-based coverage is likely to grow over time, because people who lose their jobs do not always immediately lose their coverage and because a larger share of early job losses during the pandemic were temporary layoffs, while a larger share of subsequent job losses were permanent. Even so, coverage losses may be smaller than some initially expected, because job losses in the recession to date have been unusually concentrated among low-wage workers who did not have coverage to start with. See Cynthia Cox and Daniel McDermott, “What Have Pandemic-Related Job Losses Meant for Health Coverage?” Kaiser Family Foundation, September 11, 2020, <https://www.kff.org/policy-watch/what-have-pandemic-related-job-losses-meant-for-health-coverage/> and Anuj Gangopadhyaya, Michael Karpman, and Joshua Aarons, “As the COVID-19 Recession Extended into the Summer of 2020, More Than 3 Million Adults Lost Employer-Sponsored Health Insurance Coverage and 2 Million Became Uninsured,” Urban Institute, September 2020, <https://www.urban.org/sites/default/files/publication/102852/as-the-covid-19-recession-extended-into-the-summer-of-2020-more-than-3-million-adults-lost-employer-sponsored-health-insurance-coverage-and-2-million-became-uninsured.pdf>.

² These calculations are based on the National Health Interview Survey.

³ These figures update those published in Matt Broaddus, “Medicaid Enrollment Continues to Rise,” Center on Budget and Policy Priorities, September 9, 2020, <https://www.cbpp.org/blog/medicaid-enrollment-continues-to-rise>. Methodology and sources can be found in Aviva Aron-Dine, Kyle Hayes, and Matt Broaddus, “With Need Rising, Medicaid Is At Risk for Cuts,” Center on Budget and Policy Priorities, July 22, 2020, <https://www.cbpp.org/research/health/with-need-rising-medicaid-is-at-risk-for-cuts>.

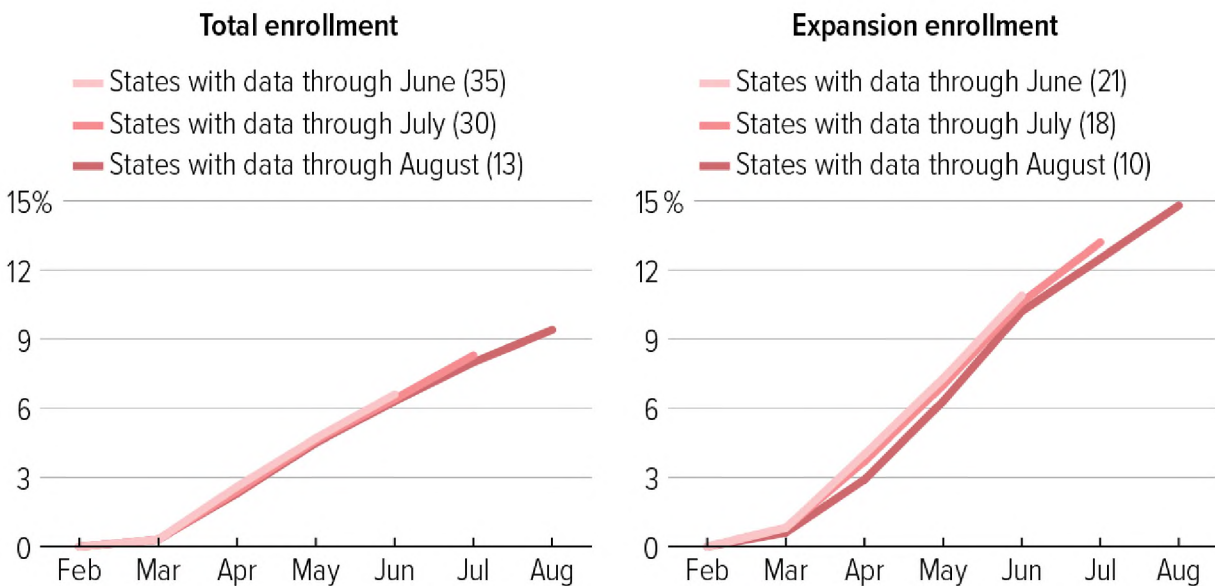
other outreach during the pandemic.⁴ It's worth noting that, during a recession, we would expect more people to enter the marketplaces after losing employer coverage but would also expect fewer people to enter from Medicaid and more people to shift from marketplace to Medicaid coverage. Thus, *total* marketplace enrollment might not rise (or rise only a little), even though the marketplace is playing a critical role for people losing employer coverage.

The hope is that, as solid data on 2020 uninsured rates become available, they will confirm that the ACA's improvements to the health safety net are largely working as intended, and coverage losses will be smaller than during the Great Recession period.⁵

FIGURE 1

Medicaid Enrollment Rising Steadily in COVID-19 Recession, With Especially Rapid Growth in Expansion Enrollment

Percent growth since February



Source: Enrollment data from state agency websites. Figures in parentheses indicate the number of states with available data.

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⁴ Sarah Lueck and Matt Broaddus, “Emergency Special Enrollment Period Would Boost Health Coverage Access at a Critical Time,” Center on Budget and Policy Priorities, July 30, 2020, <https://www.cbpp.org/research/health/emergency-special-enrollment-period-would-boost-health-coverage-access-at-a-critical>.

⁵ Of the established federal health insurance surveys, the first data on post-pandemic coverage will come from the National Health Interview Survey, which generally releases second-quarter estimates in mid-November. While the Census Household Pulse survey (a new survey introduced during the pandemic) provides an initial glimpse at trends since late April/early May, the health coverage numbers in the new survey have fluctuated significantly from week to week. However, the Urban Institute analysis of these data referenced above does find that increases in public coverage have offset well over half the loss in job-based coverage among adults in states that have expanded Medicaid, which is a larger share than for adults nationwide during the Great Recession.

Policies Undermining ACA and Medicaid Have Weakened Response to Crisis

Fewer people had coverage at the start of the pandemic, and more will become uninsured during the downturn, due both to some state policymakers' refusal to take up the ACA's expansion of Medicaid and to federal policies that have undermined Medicaid and the ACA marketplaces. The consequence is that more people will go without needed care or will incur unaffordable medical expenses during the crisis. Higher uninsured rates also weakened the response to the pandemic, since some people without health insurance may forgo testing or treatment for COVID-19.⁶

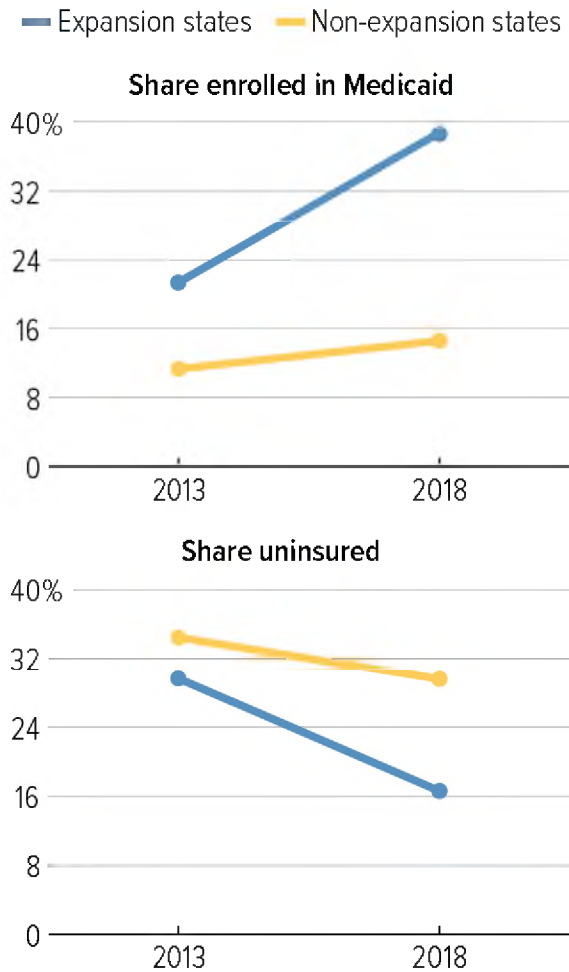
Non-Expansion States Less Prepared for Crisis

Prior to the crisis, 3.9 million people were uninsured due to state decisions not to expand Medicaid, the Urban Institute estimates.⁷ Black and Hispanic people are more likely to reside in states that have not expanded Medicaid and are less likely to have other sources of coverage, so they make up a disproportionate share of this group: more than half, compared to less than a third of the U.S. population.

State decisions not to expand have heavily impacted low-income workers such as home health aides, hospital workers, grocery store workers, public transit and truck drivers, food production and pharmaceutical manufacturing workers, pharmacy workers, and warehouse workers — the “essential workers” whose jobs have often put their health at risk during the pandemic. The uninsured rate for low-income

FIGURE 2

Medicaid Expansion Boosts Coverage for Low-Income Essential Workers



Note: “Low-income essential workers” refers to essential or front-line workers – those likely required to go to work despite stay-at-home orders – with incomes up to 200 percent of poverty. States can expand Medicaid coverage to low-income adults under the Affordable Care Act. Expansion took effect in 2014.

Source: CBPP analysis of Census Bureau data

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⁶ An April Gallup survey found that 14 percent of Americans would forgo care for COVID-19 symptoms due to cost, with higher percentages for groups with higher uninsured rates. 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>.

⁷ Michael Simpson, “The Implications of Medicaid Expansion in the Remaining States: 2020 Update,” Urban Institute, June 2020, https://www.urban.org/sites/default/files/publication/102359/the-implications-of-medicaid-expansion-in-the-remaining-states-2020-update_0.pdf.

people with these jobs was about twice as high in non-expansion states than in expansion states, prior to the pandemic.⁸ (See Figure 2.)

Non-expansion states' already higher uninsured rates are also likely to *increase* more during the downturn, since many people losing coverage will fall into the coverage gap, ineligible for Medicaid but with incomes too low to qualify for marketplace premium tax credits. Uninsured rates for unemployed adults fell in both expansion and non-expansion states between 2013 and 2018, due to the availability of marketplace coverage, but they fell but far more dramatically in expansion states. (See Figure 3.) Prior to the pandemic, more than 40 percent of unemployed adults in non-expansion states were uninsured, over twice the rate in expansion states.⁹

Federal Policies Have Eroded ACA Coverage Gains

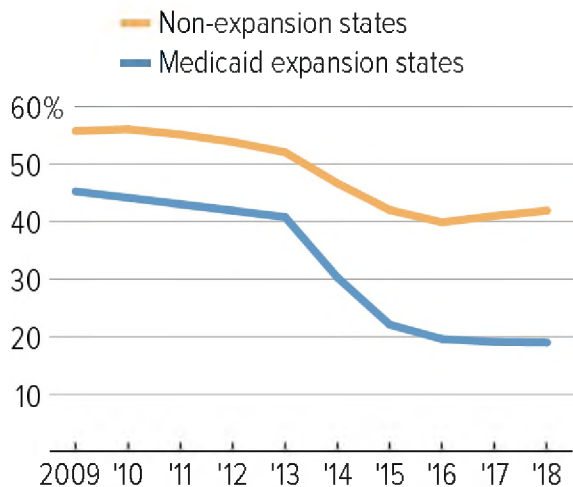
Meanwhile, Census data released last week show that the number of Americans nationwide without health insurance rose by 2.3 million between 2016 and 2019, including an increase of over 700,000 in the number of uninsured children.¹⁰ (See Figure 4.) This erosion happened during a period when the unemployment rate fell substantially and several states were implementing Medicaid expansion, meaning that we would have expected the uninsured rate to fall, or at least remain stable.

Among the policies likely contributing to the increase were:

- **The Administration's policies toward immigrants, including the so-called "public charge" rule.** These policies have created a climate of fear among families that include immigrant members, deterring some eligible people from enrolling in Medicaid or marketplace

FIGURE 3

Uninsured Rate for Unemployed Adults Fell Sharply in States Adopting Medicaid Expansion



Note: Estimates are for adults aged 19 through 64. States can expand their Medicaid program to low-income adults under the Affordable Care Act.

Source: Urban Institute using American Community Survey data

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⁸ For an explanation of how we define low-income essential workers, see Jesse Cross-Call and Matt Broaddus, "States That Have Expanded Medicaid Are Better Positioned to Address COVID-19 and Recession," Center on Budget and Policy Priorities, July 14, 2020, <https://www.cbpp.org/research/health/states-that-have-expanded-medicaid-are-better-positioned-to-address-covid-19-and>.

⁹ 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.

¹⁰ For additional discussion, see Matt Broaddus and Aviva Aron-Dine, "Uninsured Rate Rose Again in 2019, Further Eroding Earlier Progress," Center on Budget and Policy Priorities, September 15, 2020, <https://www.cbpp.org/research/health/uninsured-rate-rose-again-in-2019-further-eroding-earlier-progress>.

coverage.¹¹ Hispanic adults, Hispanic children, and children not born in the United States—groups disproportionately affected by this chilling effect — all experienced much larger-than-average increases in uninsured rates in 2019, with Hispanic people experiencing by far the largest increase of any racial or ethnic group.

- **State policies, some encouraged or required by the Administration, that have made it harder for people to get and stay covered through Medicaid.**¹² For example, states have introduced new procedures requiring people to provide additional paperwork or document eligibility more often.¹³ Consistent with administrative data, the Census data show a large decline in Medicaid coverage over the last couple years. They also show an increase in uninsured rates for low-income people in 2019, refuting the claim that Medicaid enrollment declines were largely driven by people finding other coverage.
- **The ACA’s individual mandate penalty (the requirement that people have health coverage or pay a fee) was repealed starting in 2019.** This likely contributed to the increase in uninsured rates for middle-income people evident in the Census data.
- **Cuts to outreach and enrollment assistance.** In 2017, the Administration cut outreach and enrollment assistance by 80-90 percent. It has maintained those meager funding levels since, despite new evidence that outreach leads people to enroll in coverage, improving their health and even saving lives.¹⁴

The Administration also refused to make use of ACA coverage programs to respond to the crisis. In particular, despite recommendations and requests from governors of both parties, insurers, consumer advocates, and others, the Administration chose not to create an emergency special enrollment period for marketplace coverage. This likely reduced the number of people enrolling in HealthCare.gov this spring and summer. It barred the door to people who were already uninsured but experienced income losses that newly qualified them for premium tax credits, while making enrollment more complicated and confusing for people losing job-based coverage (who qualify for a special enrollment period, but one with more complex rules than a blanket emergency option).¹⁵

¹¹ See for example Hamutal Bernstein, Dulce Gonzalez, Michael Karpman, and Stephen Zuckerman, “Amid Confusion over the Public Charge Rule, Immigrant Families Continued Avoiding Public Benefits in 2019,” Urban Institute, May 18, 2020, <https://www.urban.org/research/publication/amid-confusion-over-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-2019>.

¹² For further discussion, see Matt Broaddus, “Research Note: Medicaid Enrollment Decline Among Adults and Children Too Large to Be Explained by Falling Unemployment,” Center on Budget and Policy Priorities, July 17, 2019, <https://www.cbpp.org/research/health/medicaid-enrollment-decline-among-adults-and-children-too-large-to-be-explained-by> and Samantha Artiga and Olivia Pham, “Recent Medicaid/CHIP Enrollment Declines and Barriers to Maintaining Coverage,” Kaiser Family Foundation, September 24, 2019, <https://www.kff.org/medicaid/issue-brief/recent-medicaid-chip-enrollment-declines-and-barriers-to-maintaining-coverage/>.

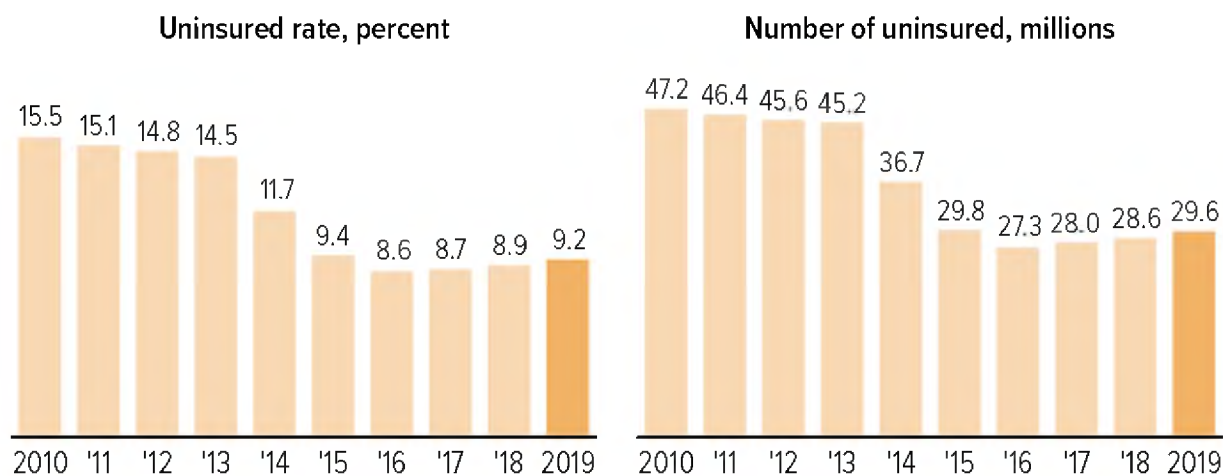
¹³ See for example, Lexi Churchill, “The Trump Administration Cracked Down on Medicaid. Kids Lost Insurance,” *Pro Publica*, October 31, 2019, <https://www.propublica.org/article/the-trump-administration-cracked-down-on-medicaid-kids-lost-insurance>.

¹⁴ Jacob Goldin, Ithai Z. Lurie, and Janet McCubbin, “Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach,” National Bureau of Economic Research Working Paper 26533, December 2019, <https://www.nber.org/papers/w26533>.

¹⁵ See Sarah Lueck and Matt Broaddus, “Emergency Special Enrollment Period Would Boost Health Coverage Access at a Critical Time,” Center on Budget and Policy Priorities, July 30, 2020, <https://www.cbpp.org/research/health/emergency-special-enrollment-period-would-boost-health-coverage-access-at-a-critical>.

FIGURE 4

Progress on Health Coverage Has Eroded in Recent Years



Source: Census Bureau, American Community Survey

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Instead, the Administration relied on resources from the CARES Act Provider Relief Fund to reimburse providers for certain COVID-19-related expenses for people who are uninsured. Not only does this approach leave out people with other health care needs, it has also fallen far short of health insurance coverage even for people with COVID-19. Uninsured patients with COVID-19 report incurring large bills for expenses that don't qualify for reimbursement (such as treatment for other conditions while hospitalized due to COVID) or simply because providers failed to make use of the fund.¹⁶ Meanwhile, the fund had paid out less than \$800 million for uninsured patients' care through mid-September.

ACA Repeal Would Make Things Far Worse

While Administration policies contributed to coverage losses that have eroded about 10 percent of the ACA's coverage gains, the uninsured rate remains far below pre-ACA levels. But on November 10, the Administration, along with a group of 18 states, will argue before the Supreme Court that it should strike down the entire ACA.¹⁷

¹⁶ Abby Goodnough, "Trump Program to Cover Uninsured COVID-19 Patients Falls Short of Promise," *New York Times*, August 29, 2020, <https://www.nytimes.com/2020/08/29/health/Covid-obamacare-uninsured.html>.

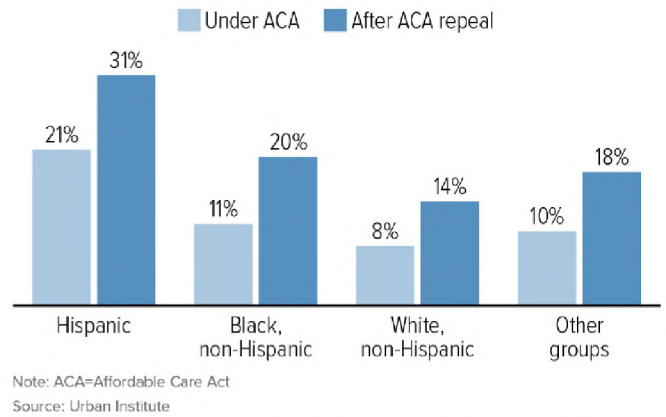
¹⁷ For background on the lawsuit, see Center on Budget and Policy Priorities, "Suit Challenging ACA Legally Suspect But Threatens Loss of Coverage for Tens of Millions," updated August 21, 2020, <https://www.cbpp.org/research/health/suit-challenging-aca-legally-suspect-but-threatens-loss-of-coverage-for-tens-of>.

A decision striking down the ACA would end Medicaid expansion, eliminate the marketplaces and premium tax credits, end protections for people with pre-existing health conditions, and eliminate the requirement that insurers let young adults remain on their parents plans until age 26. As a result, prior to the pandemic, Urban Institute researchers projected that striking down the law would cause 20 million people to lose coverage, increasing the uninsured rate by nearly two-thirds.¹⁸ While all racial and ethnic groups would experience large coverage losses, nearly 1 in 10 Black people and 1 in 10 Hispanic people were projected to lose coverage, compared to 1 in 16 whites. (See Figure 5.) Today, striking down the law would cause even larger coverage losses, since, as discussed above, the recession is causing many more people to turn to ACA coverage programs for help.

FIGURE 5

ACA Repeal Would Cause Especially Large Coverage Losses Among Black and Hispanic People

Uninsured rate among non-elderly people, based on pre-COVID-19 projections



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Sudden coverage losses on this scale would be completely unprecedented. And they would be all the more devastating this year or next given that the nation will still be still grappling with the pandemic and many of those losing coverage will also be struggling to afford food, rent, and other necessities due to the economic downturn.

Striking down the ACA would also weaken coverage for those who have it, further undermining the response to the pandemic and worsening access to care and financial hardship more broadly.¹⁹ For example, it would:

¹⁸ Jessica Banthin *et al.*, “Implications of the Fifth Circuit Decision in *Texas v. United States*,” Urban Institute, December 2019, https://www.urban.org/sites/default/files/publication/101361/implications_of_the_fifth_circuit_court_decision_in_texas_v_united_states_final_121919_v2.pdf.

¹⁹ For additional discussion, see Tara Straw and Aviva Aron-Dine, “Commentary: ACA Repeal Even More Dangerous During Pandemic and Economic Crisis,” Center on Budget and Policy Priorities, June 24, 2020, <https://www.cbpp.org/health/commentary-aca-repeal-even-more-dangerous-during-pandemic-and-economic-crisis>

- Eliminate the ACA’s prohibitions on denying coverage or charging higher premiums to people with pre-existing conditions, at a time when millions of people will have just acquired a new pre-existing condition: having had COVID-19.
- Allow insurers to rescind coverage if someone develops health problems that could be linked to an undisclosed pre-existing condition, including if a person develops a condition that could be a long-term consequence of having had COVID-19.
- End the requirement that all insurance cover preventive services, including vaccines, without cost sharing, at a time when the nation hopes to be working to vaccinate much or all of the population.
- Allow insurers to impose annual and lifetime limits on benefits and exclude coverage for essential health benefits, such as maternity care, prescription drugs, or substance use treatment.
- Cut funding for Centers for Disease Control and Prevention public health efforts.

Strengthening Health Coverage Programs for This and Future Crises

There are many ways Congress could strengthen health coverage programs for this and future crises.

Additional Coverage Expansions

While the national uninsured rate was 9.2 percent in 2019, seven states and the District of Columbia had uninsured rates of about 5 percent or less: Massachusetts, D.C., Rhode Island, Hawaii, Vermont, Minnesota, Iowa, and New York. All of these states have expanded Medicaid, and many have additional policies in common:²⁰

- Most provide some form of additional financial assistance to moderate-income people, on top of the ACA’s premium tax credits.²¹ (California is now doing this as well.)
- Most have adopted policies to make it easier for people to get or keep Medicaid and/or marketplace coverage. For example, six have state-based marketplaces, some of which undertake additional outreach compared to HealthCare.gov. Four make it possible for moderate-income people to enroll in coverage year-round, versus just during the annual open enrollment period (or by qualifying for a targeted special enrollment period).²² And New York provides 12 months of continuous eligibility for both adults and children in Medicaid.

²⁰ These policies are, of course, not the only reasons for these states’ low uninsured rates, but examining the policies the states have in common is still instructive.

²¹ Massachusetts and Vermont provide additional financial assistance to lower-income marketplace consumers; D.C. extends Medicaid eligibility above 138 percent of the poverty line; and Minnesota and New York provide more affordable coverage to lower-income people through Basic Health Programs. Hawaii, meanwhile, has more stringent requirements for employers to offer coverage than apply nationally under the ACA.

²² For a discussion of Massachusetts’ approach and implications for federal policy, see 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>.

- All of these states have opted to waive restrictions on Medicaid coverage for children who have a lawfully present immigration status, and some have filled in coverage gaps for certain other groups that do not meet the immigration-related eligibility restrictions. (Nationally, uninsured rates for immigrants, including naturalized citizens and non-citizens who are lawfully present, are higher than for other groups.)
- Most prohibit or limit substandard plans that do not meet ACA coverage standards.

These policies are certainly not all that is needed to achieve universal, high-quality health coverage. But federal policies along these lines could be adopted and implemented quickly. They would sharply reduce uninsured rates, both during the current crisis and going forward, and would better prepare us for future economic downturns, by improving coverage options for people without employer plans and by making it easier for people to transition among different forms of coverage. And, if premium tax credit improvements were adopted and implemented quickly, that would also provide timely, targeted support to the economy, by increasing disposable income for moderate-income people very likely to spend the additional funds.

Many of these policies are included in H.R. 1425, the Patient Protection and Affordable Care Enhancement Act, passed by the House in June. That bill would also create new financial incentives for the remaining states to expand Medicaid, and it would make premium tax credits available to middle-income people for whom marketplace premiums cost more than 8.5 percent of income.

Protecting Medicaid By Addressing the State Budget Crisis

Just as important, Congress also needs to prevent the existing health coverage safety net from fraying under strain from the recession. As discussed above, Medicaid is playing a critical role in covering both adults and children impacted by the downturn, through both expansion and the pre-ACA Medicaid program. States have also used Medicaid authorities to meet other needs resulting from the pandemic. For example, some states have increased payments to nursing homes or home- and community-based services (HCBS) providers, broadened access to HCBS, and expanded the use of telehealth.²³

But increased need for Medicaid coverage and new demands related to the pandemic coincide with a historic state budget crisis. State revenues have already fallen sharply, and states are projecting large budget shortfalls for this and the next fiscal year.²⁴

²³ Jessica Schubel, “States Are Leveraging Medicaid to Respond to COVID-19,” Center on Budget and Policy Priorities, updated September 2, 2020, <https://www.cbpp.org/research/health/states-are-leveraging-medicaid-to-respond-to-covid-19>.

²⁴ See, for example, Lucy Dadayan, “State Tax Revenues Surged in July 2020, But Cumulatively Are Down During COVID-19 Period,” Urban Institute, September 16, 2020, https://www.urban.org/sites/default/files/2020/09/16/monthlystrh_july2020.pdf and Center on Budget and Policy Priorities, “States Grappling with Hit to Tax Collections,” updated August 24, 2020, <https://www.cbpp.org/research/state-budget-and-tax/states-grappling-with-hit-to-tax-collections>.

FIGURE 6

Many States Cut Medicaid During Prior Economic Downturns

Number of states making Medicaid cuts in each state fiscal year



Note: Graph shows years in which states faced significant budget shortfalls during and following recessions; data for 2002 are not available.

Source: Kaiser Family Foundation

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The state budget crisis could easily produce a serious health care crisis as well. During past budget crises, states restricted Medicaid eligibility, including for seniors, people with disabilities, and pregnant women; made it harder for eligible people to get and stay covered; eliminated or cut key benefits; and cut payments to physicians, hospitals, nursing homes, and other providers. (See Figure 6.) They also cut non-Medicaid health programs. For example, during the Great Recession period, state-funded behavioral health programs were often targeted for cuts, with roughly 3 in 4 states cutting mental health budgets in each of 2009, 2010, and 2011.²⁵

Early in the pandemic, with bipartisan leadership from this committee, Congress did two very important things. First, it adopted a 6.2 percentage-point increase in the Medicaid match rate (FMAP) for the duration of the public health emergency, providing about \$40 billion per year in aid to states.

²⁵ Aviva Aron-Dine *et al.*, “Larger, Longer-Lasting Increases in Federal 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>.

Second, it tied those additional federal funds to protections for Medicaid beneficiaries. States receiving the additional funds cannot introduce new eligibility restrictions.²⁶ They also cannot take away people’s coverage during the public health emergency. That continuous coverage requirement is a version of the continuous eligibility policies many states already apply to children, which research has shown improve coverage and access to care by preventing children from losing Medicaid and becoming uninsured due to paperwork barriers and short-term income fluctuations.²⁷

But as the state budget crisis continues and more states exhaust options to delay budget cuts, the 6.2 percentage point FMAP increase — about half the maximum increase Congress provided during the Great Recession — is now insufficient. A number of states have already made or are considering Medicaid cuts, including reductions in provider payments, reversals of planned and needed coverage improvements (such as extensions of post-partum Medicaid coverage), and furloughs and hiring freezes impacting eligibility workers, which will likely delay access to coverage for some applicants. States are also cutting behavioral health programs and, even in the midst of the pandemic, are cutting their public health budgets.²⁸

Congress should heed recommendations from the National Governors Association, the National Association of State Medicaid Directors, health plans, providers, consumer advocates, and many others and provide additional federal Medicaid funding to help states weather the crisis. The best way to structure this additional assistance would be to tie the amount and duration of the increased federal funding to state unemployment rates and to make these unemployment rate triggers *permanent*. That way, federal Medicaid match rates would rise automatically in future recessions, then fall back to normal once state economies and budgets have recovered. Legislation introduced in the House (H.R. 6539 and H.R. 6379) and in the Senate (S. 4108) provides a model for how to do this.

In providing additional assistance, Congress should also maintain strong protections for beneficiaries. These “maintenance of effort” protections are critical to ensuring that the additional funding achieves the goal of protecting health coverage during the ongoing public health and economic crises, even as it helps states avoid cuts to Medicaid provider payments, non-Medicaid health programs, education, and other critical services.

²⁶ A similar rule in place during the Great Recession explains why far fewer states restricted eligibility during the Great Recession than during the shallower recession of the early 2000s, as shown in Figure 6. Aviva Aron-Dine, “Medicaid ‘Maintenance of Effort’ Protections Crucial to Preserving Coverage,” Center on Budget and Policy Priorities, May 13, 2020, <https://www.cbpp.org/blog/medicaid-maintenance-of-effort-protections-crucial-to-preserving-coverage>.

²⁷ Judith Solomon, “Continuous Coverage Protections in Families First Act Prevent Coverage Gaps by Reducing ‘Churn,’” Center on Budget and Policy Priorities, July 16, 2020, <https://www.cbpp.org/research/health/continuous-coverage-protections-in-families-first-act-prevent-coverage-gaps-by>.

²⁸ Aviva Aron-Dine, Kyle Hayes, and Matt Broaddus, “With Need Rising, Medicaid Is at Risk for Cuts,” Center on Budget and Policy Priorities, July 22, 2020, <https://www.cbpp.org/research/health/with-need-rising-medicaid-is-at-risk-for-cuts>.

Potential Impact of California v. Texas Decision on Key Provisions of the Affordable Care Act

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Issue Brief

The Supreme Court will review the constitutionality of the Affordable Care Act (ACA) this November in *California v. Texas* (known as *Texas v. U.S.* in the lower courts). Late last year, a federal appeals court panel (<http://www.ca5.uscourts.gov/opinions/pub/19/19-10011-CV0.pdf>) ruled that the ACA's individual mandate is unconstitutional, since Congress has set the mandate tax penalty to zero. The case was brought by a number of (<https://www.kff.org/health-reform/issue-brief/explaining-texas-v-u-s-a-guide-to-the-5th-circuit-appeal-in-the-case-challenging-the-aca/>) Republican state officials and two individuals, who argue that the rest of the ACA is not severable from the mandate and should therefore be invalidated. The Trump administration now argues that nearly all of the ACA should be found invalid but that the courts should prohibit it from enforcing only the provisions found to harm the individual plaintiffs. It previously argued that only the ACA's pre-existing condition protections should be overturned.¹ Pending a final decision on the case, the Trump administration has continued to enforce the ACA.

The ACA's reforms affect nearly every American in some way, and a Supreme Court decision that invalidated the ACA would have complex and far-reaching impacts throughout the health care system. While the ACA's changes to the individual insurance market – including protections for people with pre-existing conditions and premium subsidies for low and modest income people – have been the focus of much policy debate and media coverage, the law made many other sweeping changes. These include: the expansion of Medicaid eligibility for low-income adults; required coverage of preventive services with no cost-sharing in private insurance, Medicare, and for those enrolled in the Medicaid expansion; new national initiatives to promote public health and quality of care; and a variety of tax increases to finance these changes. The number of uninsured Americans decreased by 20 million (<https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>) from 2010 to 2016 as the ACA went into effect, but has since increased by 2.3 million from 2016 to 2019 (<https://www.kff.org/policy-watch/what-we-do-and-dont-know-about-recent-trends-in-health-insurance-coverage-in-the-us/>).

The following table summarizes the major provisions of the ACA, illustrating the breadth of its changes to the health care system, and public attitudes towards those changes. If all or most of the ACA is struck down, many of these provisions could be

eliminated.

Due to differences in populations and policies across states, the potential repeal of the ACA would play out differently from state to state. For example, over 50 million people had a declinable health condition in 2018, including over a third of the population in West Virginia, Arkansas and Mississippi. The appendix shows the state-by-state impacts of these key ACA provisions. A link to state-level data is included in the table below when data are available.

Browse Key Provisions by Category:

- [Expanded Eligibility for Health Coverage](#)
- [Federal Minimum Standards for Private Health Insurance](#)
- [Other Provisions Affecting Employers/Group Health Plans](#)
- [Consumer Assistance](#)
- [Other Medicaid Provisions](#)
- [Medicare Provisions](#)
- [Additional Provisions](#)

Expanded Eligibility for Health Coverage

Key Provisions	Impact
Medicaid Eligibility Expansion	
<ul style="list-style-type: none"> Medicaid eligibility is expanded to include adults with income up to 138% FPL; however, the Supreme Court ruling in 2012 essentially made Medicaid expansion optional for states. The federal government paid 100% of the cost of the expansion initially; this share phased down to 93% in 2019 and 90% in 2020 and beyond 	<ul style="list-style-type: none"> In June 2019, there 14.8 million (https://www.kff.org/health-reform/state-indicator/enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22) Medicaid expansion enrollees in the 34 states and DC that had adopted Medicaid expansion. Of these enrollees, 12 million were newly eligible due to the ACA's Medicaid expansion. <p>[View state level data (https://www.kff.org/report-section/potential-impact-of-california-v-texas-decision-on-key-provisions-of-the-affordable-care-act-appendix/#tableone)]</p>
Subsidies for Nongroup Health Insurance	
<ul style="list-style-type: none"> Eligible individuals who buy coverage through the Marketplace receive subsidies based on income: premium tax credits for those with income 100- 	<ul style="list-style-type: none"> As of February 2020, 9.2 million (https://www.cms.gov/sites/default/files/2019-08/2019%20TABLE-Effectuated-Enrollment.pdf) Marketplace enrollees received 5.3 million (https://www.cms.gov/sites/default/files/2019-08/2019%20TABLE-Effectuated-Enrollment.pdf) received cost-sharing reductions In 2020, there are about 0.9 million (https://www.cms.gov/Research-Statistics-Trends-and-Reports/Marketplace-Products/2019-Open-Enrollment) people enrolled in Marketplace Health Plans in Minnesota (83,200) and New York (796,998) <p>[View state level data (https://www.kff.org/report-section/potential-impact-of-california-v-texas-decision-on-key-provisions-of-the-affordable-care-act-appendix/#tableone)]</p>

400% FPL;
cost-sharing
subsidies for
those with
income 100-
250% FPL

- States can also elect to run a subsidized Basic Health Plan for people with income between 133%-200% FPL

Dependent Coverage to 26

- All non-grandfathered private group and non-group health plans must extend dependent coverage to adult children up to the age of 26

- About 2.3 million (<https://aspe.hhs.gov/system/files/pdf/111826/ACA%20health%20insurance%20c>) young adults gained coverage as a result of this provision

Health Insurance Marketplace

- Establish new marketplaces where qualified health plans are offered to individuals
- Marketplaces certify that qualified health plans

- 10.7 million (<https://www.kff.org/other/state-indicator/effectuated-marketplace-er-currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%2>) had effectuated coverage through the Marketplace as of the first quarter
- 67% (<https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-a>) Marketplace enrollees will have a choice of three or more insurers in 2020
- 26 insurers (<https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-a>) are entering state Marketplaces for 2020
- Individual market gross profit margins (<https://www.kff.org/private-insurance/issue-brief/individual-market-performance-in-early-2019/>) have been higher, on average, in 2019

meet all ACA requirements, provide subsidies to eligible individuals, operate a website to facilitate application and comparison of health plans, provide a no-wrong-door application process for individuals to determine their eligibility for financial assistance, and provide in-person consumer assistance through navigators

was implemented

[\[View state level data \(https://www.kff.org/report-section/potential-impact-of-california-provisions-of-the-affordable-care-act-appendix/#tableone\)\]](https://www.kff.org/report-section/potential-impact-of-california-provisions-of-the-affordable-care-act-appendix/#tableone)

Federal Minimum Standards for Private Health Insurance

Key Provisions	Impact	Public Opinion
Protections for Pre-existing Conditions		
<ul style="list-style-type: none"> • All non-grandfathered plans are prohibited from discriminating against individuals based on their health status • Insurers in the non-group, small group, and large group market must guarantee issue coverage • Large group, small group, and non-group health plans are prohibited from applying pre-existing condition exclusions • Insurers in the non-group and small group market may not vary premiums based on health status or gender or any other factor except: • Premiums can vary by age (by a factor of 3:1), geography, family size, and tobacco use 	<ul style="list-style-type: none"> • 54 million (https://www.kff.org/health-reform/issue-brief/pre-existing-condition-prevalence-for-individuals-and-families/) people (27% of the non-elderly population) have a pre-existing condition that would have been deniable in the pre-ACA individual market • 45% (https://www.kff.org/health-reform/issue-brief/pre-existing-condition-prevalence-for-individuals-and-families/) of non-elderly families have at least one adult member with a pre-existing condition <p>[View state level data (https://www.kff.org/report-section/potential-impact-of-california-v-texas-decision-on-key-provisions-of-the-affordable-care-act-appendix/#tabletwo)]</p>	<ul style="list-style-type: none"> • Majorities say it is “very ACA provisions prohibit denying coverage (72% (64%) remain in place if unconstitutional (July 2019: reform/poll-finding/kff-health-reform-poll-november-2019/) • 62% overall (75% of Dem not want to see the Sup protections for people v established by the ACA (https://www.kff.org/health-reform/poll-november-2019/) • 57% of Americans say s a pre-existing health co (https://www.kff.org/health-reform/poll-april-2019/) • 57% are “somewhat wo (35%) that they or a far the Supreme Court ove condition protections ((https://www.kff.org/health-reform/poll-january-2020/) • 62% are “very worried” (18%)” that they or a far afford coverage in the fi overturns ACA’s pre-exi: 2019) (https://www.kff.org/health-reform/poll-april-2019/)

Key Provisions	Impact	Public Opinion
Protections for Pre-existing Conditions		
<ul style="list-style-type: none"> Rescission of coverage is prohibited in the non-group, small group, and large group market 		
Preventive Services		
<ul style="list-style-type: none"> All non-grandfathered group and non-group plans must cover preventive health services without cost sharing Covered services include breast, colon, and cervical cancer screening, pregnancy-related services including breastfeeding equipment rental, contraception, well-child visits, adult and pediatric immunizations, and routine HIV screening. In addition, it was recently recommended that pre-exposure 	<ul style="list-style-type: none"> 87% (http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2019) of covered workers with employer-sponsored insurance (approximately 133 million people) were enrolled plans that must provide free preventive services as of 2019 12.7 million (https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/) people were enrolled in individual market plans required to provide free preventive services, as of February 2019 14.8 million enrollees in Medicaid expansion states received coverage for preventive services in 2019 Prior to the ACA, 1 in 5 women (https://www.kff.org/womens-health-policy/fact-sheet/preventive-services-for-women-covered-by-private-health-plans-under-the-affordable-care-act/) reported that they postponed or went without preventive care due to cost The share of reproductive age women with private insurance reporting that their insurance covered the full costs of their prescription contraception rose (https://www.kff.org/womens-health-policy/issue-brief/womens-sexual-and- 	<ul style="list-style-type: none"> 89% say it is “very important” (27%) that the private health insurance for most preventive services remains in place if the ACA is repealed (https://www.kff.org/health-reform/issue-brief/potential-impact-of-california-v-texas-decision-on-key-provisions-of-the-affordable-care-act/?utm_campaign=ACA-2019)

Key Provisions	Impact	Public Opinion
<p>prophylaxis (PREP) to prevent HIV infection be</p>	<p>reproductive-health-services-key-findings-from-the-2017-kaiser-womens-health-survey/) from 45% in 2013 to 75% in 2017</p>	
<p>included as well and if finalized, would be offered at no cost</p>	<p>View state level data (https://www.kff.org/report-section/potential-impact-of-california-v-texas-decision-on-key-provisions-of-the-affordable-care-act-appendix/#tabletwo)</p>	

Essential Health Benefits

<ul style="list-style-type: none"> All ACA compliant health plans in the individual and small group market must cover 10 categories of essential health benefits (EHB), including hospitalization, outpatient medical care, maternity care, mental health and substance abuse treatment, prescription drugs, habilitative and rehabilitative services, and pediatric dental and vision services 	<ul style="list-style-type: none"> In 2013, before the ACA EHB requirements took effect, 75% (https://www.kff.org/health-reform/issue-brief/would-states-eliminate-key-benefits-if-ahca-waivers-are-enacted/) of non-group health plans did not cover maternity care, 45% did not cover substance use disorder treatment, and 38% did not cover mental health services 	<ul style="list-style-type: none"> 66% of the public (81% of Reps) say they want the continue to require health plans to cover a certain set of benefits (https://www.kff.org/health-reform/issue-brief/would-states-eliminate-key-benefits-if-ahca-waivers-are-enacted/)
<p>Annual and Lifetime Limits</p>		

Key Provisions	Impact	Public Opinion
Protections for Pre-existing Conditions		
<ul style="list-style-type: none"> All group and non-group plans (including grandfathered) are prohibited from placing lifetime limits on the dollar value of coverage for essential health benefits. In addition, all non-grandfathered group and non-group plans are prohibited from placing annual dollar limits on coverage of essential health benefits 	<ul style="list-style-type: none"> Prior to the ACA, in 2009, <u>59%</u> (https://www.kff.org/health-costs/report/employer-health-benefits-annual-survey-archives/) of covered workers' employer-sponsored health plans had a lifetime limit 153 million (https://www.kff.org/report-section/ehbs-2019-summary-of-findings/) people (57% of the U.S (https://www.kff.org/uninsured/report/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act/), non-elderly population) had employer coverage as of 2019 <p>[View state level data (https://www.kff.org/report-section/potential-impact-of-california-v-texas-decision-on-key-provisions-of-the-affordable-care-act-appendix/#tabletwo)]</p>	<ul style="list-style-type: none"> 62% of the public say it of the ACA that prohibit companies from setting will spend on your cove in place if the law is rule (https://www.kff.org/health-poll-july-2019/) 51% of the public say it of the ACA that prohibit companies from setting will spend on your cove if the law is ruled uncon (https://www.kff.org/health-poll-july-2019/)
Cap on Out-of-Pocket Cost Sharing		

Key Provisions	Impact	Public Opinion
Protections for Pre-existing Conditions		
<ul style="list-style-type: none"> • All non-grandfathered private health plans must limit cost sharing for essential health benefits covered in network • The annual maximum for 2020 is \$8,150 for an individual; \$16,300 for family coverage 	<ul style="list-style-type: none"> • Prior to the ACA, in 2009, <u>19%</u> (https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-7-employee-cost-sharing/attachment/figure-7-43-2/) of covered workers had no limit on out-of-pocket expenses. Among those with out-of-pocket maximums, not all expenses counted toward the limit. For example, in 2009, among workers in PPOs with an out-of-pocket maximum, 85% were in plans that did not count prescription drug spending when determining if an enrollee had reached the out-of-pocket limit 	
Minimum Medical Loss Ratios		

Key Provisions	Impact	Public Opinion
Protections for Pre-existing Conditions		
<ul style="list-style-type: none"> Require all non-grandfathered private plans to pay a minimum share of premium dollars on clinical services and quality Insurers must provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets 	<ul style="list-style-type: none"> In total, over \$5 billion (https://www.kff.org/private-insurance/issue-brief/data-note-2019-medical-loss-ratio-rebates/) in medical loss ratio rebates have been issued across (https://fas.org/sgp/crs/misc/R42735.pdf) the individual, small group, and large group markets, from 2012 to 2019 (based on insurer financial results from the 2011-2018 plan years) <p>[View state level data (https://www.kff.org/report-section/potential-impact-of-california-v-texas-decision-on-key-provisions-of-the-affordable-care-act-appendix/#tabletwo)]</p>	<ul style="list-style-type: none"> 62% of the public (68% of Reps) say they favor regulations that require insurers to spend too little money on administrative costs and too much on administrative costs for their customers a rebate (https://kaiserfamilyfoundation.files.wordpress.com/2017/08/1478281main.pdf)
Consumer Information and Transparency		

Key Provisions	Impact	Public Opinion
Protections for Pre-existing Conditions		
<ul style="list-style-type: none"> All non-grandfathered health plans must provide a brief, standardized summary of coverage written in plain language All non-grandfathered health plans must periodically report transparency data on their operations (e.g., number of claims submitted and denied) 	<ul style="list-style-type: none"> Transparency data collected by CMS for PY 2017 indicate that, on average, healthcare.gov issuers <u>deny 18%</u> (https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/) of in-network claims, and that consumers rarely appeal denied claims 	<ul style="list-style-type: none"> 79% of the public have of Dems, 78% of Inds, 6 (https://kaiserfamilyfoundati f.pdf)

Other Provisions Affecting Employers/Group Health Plans

Key Provisions	Impact	Public Opinion
Large Employer Mandate		
<ul style="list-style-type: none"> Requires employers with at least 50 full time workers to provide health benefits or pay a tax penalty 		<ul style="list-style-type: none"> Favored by a ma parties: 69% ove favorable view, i of Dems, 61% of Reps (November 20 (https://www.kff.org/reform/poll-finding/tracking-poll-nover-priorities-congress-medicaid-expansior
Waiting Periods		
<ul style="list-style-type: none"> Employers that impose waiting periods on eligibility for health benefits (e.g., for new hires) must limit such periods to no more than 90 days 	<ul style="list-style-type: none"> Prior to the ACA, in 2009, <u>29%</u> (https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-3-employee-coverage-eligibility-and-participation/attachment/figure-3-13/) of covered workers faced a waiting period of 3 months or more 	

Consumer Assistance

Key Provisions	Impact	Public Opinion
State Consumer Assistance Programs		
<ul style="list-style-type: none"> • Authorize federal grants for state Consumer Assistance Programs (CAPs) to advocate for people with private coverage. • Notice of claims denials by non-grandfathered private plans must include information about state CAPs that will help consumers file appeals 	<ul style="list-style-type: none"> • CAPs were established in most states in 2010, though no appropriations for CAPs have since been enacted. Today <u>36 CAPs</u> (https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc) are in operation • A <u>report</u> (https://www.cms.gov/CCIIO/Resources/Files/Downloads/csg-cap-summary-white-paper.pdf) on the first year of CAP operations found the programs helped 22,814 individuals successfully challenge their health plan decisions and obtained more than \$18 million on behalf of consumers 	

Other Medicaid Provisions

Key Provisions	Impact
Simplification of Enrollment Processes	
<ul style="list-style-type: none"> States are required to simplify Medicaid and CHIP enrollment processes and coordinate enrollment with state health insurance exchanges 	<ul style="list-style-type: none"> Prior to the ACA in 2013, 27 states had an asset test and 6 required face-to-face interviews for parents; only 36 states had an online Medicaid application. <u>As of January 2020</u> (https://www.kff.org/coronavirus-covid-19/report/medicaid-and-chip-eligibility-enrollment-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey/), individuals can apply for Medicaid online and by telephone in all states for the first time. All states had eliminated asset tests and face-to-face interviews
Long-term Care Services and Supports	
<ul style="list-style-type: none"> Expands financial eligibility for 1915(i) home and community-based services (HCBS), creating a new eligibility pathway to allow people not otherwise eligible to access full Medicaid benefits, allows states to target services to specific populations, 	<ul style="list-style-type: none"> 11 states (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/) elected the option to expand eligibility for 1915(i) HCBS services as of 2018. 81,000 individuals received services and over \$641 million was spent on these services As of 2018, 8 states (https://www.kff.org/medicaid/report/medicaid-home-and-community-based-services-results-from-a-50-state-survey-of-enrollment-spending-and-program-policies/) elected the option to cover attendant care services. 392,700 individuals received services and \$8.6 billion was spent on these services <p><u>[View state level data (https://www.kff.org/report-section/potential-impact-of-california-v-texas-decision-on-key-provisions-of-the-affordable-care-act-appendix/#tablethree)]</u></p>

and expands the services covered

- Creates a new Medicaid state plan option to cover attendant care services and supports with 6% enhanced FMAP

Behavioral Health Parity

- Mental health and substance use disorder services must be included in Medicaid Alternative Benefit Packages (ABPs) provided to Medicaid expansion adults and other adults, and the services must be covered at parity with other medical benefits

- [14.8 million \(https://www.kff.org/health-reform/state-indicator/medicaid-expansion-currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22\)](https://www.kff.org/health-reform/state-indicator/medicaid-expansion-currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22) Medicaid expansion enrollees receive services through an ABP

[\[View state level data \(https://www.kff.org/report-section/potential-impact-of-california-v-on-key-provisions-of-the-affordable-care-act-appendix/#tablethree\)\]](https://www.kff.org/report-section/potential-impact-of-california-v-on-key-provisions-of-the-affordable-care-act-appendix/#tablethree)

Medicaid Eligibility for Former Foster Care Youth up to Age 26

- Requires states to provide Medicaid to young adults ages 21 through 26 who were formerly in foster care.

Medicaid Drug Rebate Percentage

- Increase Medicaid drug rebate percentage for most brand name drugs to 23.1% and increase Medicaid rebate for non-innovator multiple source drugs to 13%. Extend drug rebate program to Medicaid MCOs
- [CBO \(https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50_effectsofacarepeal.pdf\)](https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50_effectsofacarepeal.pdf) estimated federal savings of \$38 billion over 10 years from Medicaid prescription drug provisions in the ACA, including increases in rebate percentage

Medicare Provisions

Key Provisions	Impact	Public Opinion
Part D Coverage Gap ²		
<ul style="list-style-type: none"> Gradually close the Medicare Part D coverage gap (“doughnut hole”): Phase down the beneficiary coinsurance rate for brand and generic drugs in the Medicare Part D coverage gap from 100% to 25% by 2020 Require drug manufacturers to provide a 50% discount on the price of brand-name and biologic drugs in the coverage gap Reduce the growth rate in the catastrophic coverage threshold amount between 2014 and 2019 to provide additional protection to enrollees with high drug costs 	<ul style="list-style-type: none"> 46 million people were enrolled in Medicare Part D in 2020 In 2018, nearly 5 million Part D enrollees without low-income subsidies (LIS) had spending in the coverage gap and received manufacturer discounts averaging \$1,184 on brand-name drugs Reinstating the coverage gap would increase costs incurred by Part D enrollees who have relatively high drug spending <p><u>View state level data (https://www.kff.org/report-section/potential-impact-of-california-v-texas-decision-on-key-provisions-of-the-affordable-care-act-appendix/#tablefour)</u></p>	<ul style="list-style-type: none"> 81% of the public (of seniors) has a favorable view that “the law gradually closes the Medicare prescription drug ‘doughnut hole’ or ‘coverage gap’ so people on Medicare will no longer be required to pay the cost of their medications when reach the gap” (<u>Nov (https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-november-2018-priori-congress-future-aca-medicaid-expansion/)</u>)
Preventive Services		
<ul style="list-style-type: none"> Eliminate cost sharing for Medicare covered preventive services. 	<ul style="list-style-type: none"> 60 million people have access to free preventive services; of these, Medicaid pays Medicare cost sharing for about 9 million dual eligibles (<u>https://www.cms.gov/Medicare-Medicaid-</u> 	

Authorize coverage of annual comprehensive risk assessment for Medicare beneficiaries

Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Data-and-Statistical-Resources)

Cost Sharing in Medicare Advantage (MA)

- Prohibit MA plans from imposing higher cost-sharing requirements than traditional Medicare for chemotherapy, renal dialysis, skilled nursing care, and other services deemed appropriate by the Secretary of HHS. This prohibition was extended to most Medicare-covered services

- 24 million (<https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/>) people enrolled in Medicare Advantage plans in 2020
- View state level data (<https://www.kff.org/report-section/potential-impact-of-california-v-texas-decision-on-key-provisions-of-the-affordable-care-act-appendix/#tablefour>)

Restructure Medicare Advantage Payments

- Reduce federal payments to Medicare Advantage plans to bring payments closer to the average Medicare spending for beneficiaries in traditional Medicare
- Provide quality-based bonus payments to

- CBO estimated (<https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50252-effectsofacarepeal.pdf>) repeal of the ACA Medicare Advantage payment changes would increase Medicare spending by about \$350 billion over 10 years (2016-2025)
- 74 percent (<https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/>) of Medicare Advantage enrollees were in plans that were eligible for bonus payments in 2019; Bonus payments summed to \$6.3 billion in 2018

<p>Medicare Advantage plans</p> <ul style="list-style-type: none"> Require Medicare Advantage plans to maintain a medical loss ratio of at least 85 percent; the administration extended this requirement to all Part D plans 	<p>(https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage/)</p> <ul style="list-style-type: none"> Higher Medicare spending would increase Medicare premiums and deductibles for beneficiaries and accelerate the insolvency of the Medicare Hospital Insurance Trust Fund 	
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Other Provider Payments

<ul style="list-style-type: none"> Reduce the rate at which Medicare payment levels to hospitals, skilled nursing facilities, hospice and home health providers, and other health care providers are updated annually Reduce Medicare Disproportionate Share Hospital (DSH) payments that help to compensate hospitals for providing care to low-income and uninsured patients Allow providers organized as Accountable Care Organizations (ACOs) that meet quality thresholds to 	<ul style="list-style-type: none"> <u>CBO estimated</u> (https://www.cbo.gov/publication/50252) repeal of the ACA provider payment reductions would increase Medicare spending by another approximately \$350 billion over 10 years (2016-2025) Eliminating the Medicare Shared Savings Program ACOs could affect around <u>10 million Medicare beneficiaries</u> (https://www.kff.org/faqs-medicare-accountable-care-organization-aco-models/) who were attributed to a MSSP ACO, as of 2018 Higher Medicare spending would increase Medicare premiums and deductibles for beneficiaries and accelerate the insolvency of the Medicare Hospital Insurance Trust Fund <p><u>View state level data</u> (https://www.kff.org/report-section/potential-impact-of-california-v-texas-decision-on-key-provisions-of-the-affordable-care-act-appendix/#tablefour)</p>	
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share in cost savings they achieve for the Medicare Program

Medicare Income-Related Premiums³

<ul style="list-style-type: none"> • Freeze threshold for income-related Medicare Part B premiums for 2011 through 2019 • Establish new income-related premium for Part D, with the same thresholds as the Part B income-related premium 	<ul style="list-style-type: none"> • As originally enacted in the ACA, <u>CBO estimated</u> (https://www.cbo.gov/publication/21351) \$35.7 billion in savings from these provisions over 10 years • According to Medicare’s actuaries, 3.6 million people paid an income-related Part B premium and 3.0 million paid an income-related Part D premium in 2018 <p><u>[View state level data (https://www.kff.org/report-section/potential-impact-of-california-v-texas-decision-on-key-provisions-of-the-affordable-care-act-appendix/#tablefour)]</u></p>	
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Additional Provisions

Beyond coverage-related provisions, the ACA made numerous other changes in federal law to safeguard individual civil rights, authorize new programs and agency activities, and finance new federal costs under the law. The Court ruling finding the ACA unconstitutional could also result in an end to these provisions. They include:

Nondiscrimination

The ACA prohibits discrimination against individuals on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities, under Section 1557, which builds on long-standing and familiar Federal civil rights laws. In addition to enforcement (<https://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html>) by the Office of Civil Rights at the US Department of HHS, individuals can file a civil lawsuit to challenge a nondiscrimination violation under Section 1557.

Regulations implementing Section 1557 issued by the Obama Administration further defined these protections to include gender identity and pregnancy status. One federal district court has vacated the gender identity and pregnancy protections in the regulations, while other courts have relied on Section 1557 itself to grant relief to individuals alleging discrimination based on gender identity. In June 2020, the Trump

Administration finalized changes (<https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/>) to the regulations that eliminated protections for gender identity and sex stereotyping; adopted blanket abortion and religious freedom exemptions for health care providers; and eliminated or substantially changed provisions on health insurance benefit design; language access; notices, grievance procedures, and enforcement; and which entities are covered by Section 1557. The Administration also has eliminated explicit nondiscrimination protections related to gender identity and sexual orientation in separate regulations governing Medicaid managed care entities, state Medicaid programs, PACE organizations, group and individual health insurance issuers, marketplaces, qualified health plan issuers, and agents and brokers that assist with marketplace applications and enrollment.

Just after the Administration published the final rule, the Supreme Court ruled that sex discrimination includes sexual orientation and gender identity in the employment context. Based on that decision, two federal courts issued nationwide preliminary injunctions blocking parts of the final rule: NY and DC courts blocked provisions excluding sex stereotyping from the definition of sex discrimination, and the DC court also blocked the religious freedom exemption. The NY court is now considering whether to block other provisions of the rule, and other lawsuits are pending.

FDA Approval of Biosimilars

The ACA authorized the U.S. Food and Drug Administration (FDA) to approve generic version of biologics (biosimilars) and grant biologics manufacturers 12 years of exclusive use before generics can be developed. As of November 2019, the FDA has approved

(<https://www.fda.gov/drugs/developmentapprovalprocess/howdrugsaredevelopedandapproved/approvalapplications/therapeuticbiologicapplications/biosimilars/ucm580432.htm>) 25 biosimilar products used in the treatment of cancer, rheumatoid arthritis, and other health conditions.

Innovation Center

The law also established an Innovation Center within the Center for Medicare and Medicaid Services (CMS) to test, evaluate and expand different payment structures and methods to save costs while maintaining or improving quality of care. Payment and delivery system models (<https://innovation.cms.gov/>) supported by the Innovation Center focus on Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), for example, include care delivery for children (<https://innovation.cms.gov/initiatives/integrated-care-for-kids-model/>) and pregnant women (<https://innovation.cms.gov/initiatives/maternal-opioid-misuse-model/>) affected by the opioid crisis, and models to reduce prescription drug costs.

Prevention and Public Health Fund

The ACA established the Prevention and Public Health Fund with a permanent annual appropriation to support activities related to prevention, wellness and public health activities. The law appropriated \$7 billion annually through 2015 and \$2 billion for each fiscal year thereafter, although Congress has since voted several times to redirect (https://www.apha.org/-/media/files/pdf/factsheets/200129_pphf_factsheet.ashx) a portion of funds from the Prevention and Public Health Fund for other purposes. Fund resources support (<https://www.hhs.gov/open/prevention/index.html>) federal, state, and local programs to fight obesity, curb tobacco use, prevent the onset of chronic conditions such as diabetes and heart disease, promote immunization, detect and respond to infectious diseases and other public health threats, and other initiatives.

Nonprofit Hospitals

The ACA set new requirements (<https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r>) for non-profit hospitals in order to retain their tax exempt status. These include a requirement to conduct a community needs assessment every 3 years and adopt a strategy to meet identified needs. Hospitals also must adopt and widely publicize financial assistance policies on the availability of free or discounted care and how to apply. In addition, hospitals must limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and must make reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions.

Breastfeeding breaks & separate rooms

Employers with 50 or more employees must now provide adequate break time for breastfeeding women and a private space that is not a bathroom for nursing and pumping.

Menu labeling

Restaurants and retail food establishments with 20 or more locations and owners of 20 or more vending machines must include nutrition information, including calories, for their standard menu items.

Revenue Provisions

Some of the revenue provisions enacted under the ACA remain in effect but presumably would end if the law were found unconstitutional. For example, the ACA included a tax on pharmaceutical (<https://www.irs.gov/affordable-care-act/annual-fee-on-branded-prescription-drug-manufacturers-and-importers>) manufacturers and importers (generating annual fees of \$2.8 billion in 2019 and thereafter). Financing provisions also included a 10% tax on indoor tanning services (<https://www.irs.gov/businesses/small-businesses-self-employed/indoor-tanning-services-tax-center>), and limits on the deductibility of compensation of insurance company executives

(<https://www.irs.gov/instructions/i1120>) (limited to \$500,000 per individual per year). Under the ACA, the **Medicare payroll tax** (<https://www.irs.gov/affordable-care-act/affordable-care-act-tax-provisions>) was increased for high income earners (over \$200,000 by individuals, \$250,000 for married couples filing jointly), and a new 3.8% tax on **net investment income** (<https://www.irs.gov/individuals/net-investment-income-tax>) applied for higher income taxpayers. Initially, the ACA imposed a so-called **Cadillac tax** (<https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/congress-delays-cadillac-tax-until-2022.aspx>) on high-value employer-sponsored health plans, a tax on **health insurers** (<https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010>), and a new **medical device** (<https://www.irs.gov/newsroom/medical-device-excise-tax-frequently-asked-questions>) excise tax of 2.3%, but Congress repealed all three of these taxes in a December 2019 budget deal.

Appendices

Appendix

Appendix Tables

- [Appendix Table 1: Enrollment in ACA Coverage, By State, Latest Year Available](#)
- [Appendix Table 2: Federal Minimum Standards for Private Coverage, By State, Latest Year Available](#)
- [Appendix Table 3: Medicaid Provisions, By State, Latest Year Available](#)
- [Appendix Table 4: Medicare Provisions, By State, Latest Year Available](#)

Notes:

Medicaid Expansion Enrollment includes the total number of individuals who are enrolled in the ACA expansion group. This total includes 12 million individuals who are newly-eligible under the ACA pathways. State decisions about adopting the Medicaid expansion are as of August 17, 2020. More information is available at KFF's **Medicaid Expansion Tracker** (<https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>).

Marketplace Enrollment includes the number of individuals who had an active marketplace policy as of February 2020, and who paid their premium (thus effectuating their coverage) as of March 15, 2020.

Consumers with household incomes 100-400% of the federal poverty level may qualify for an Advance Premium Tax Credit (APTC), which helps make their coverage more affordable throughout the year by lowering their share of monthly premium costs.

CSRs are available to people who have incomes 100-250% of the federal poverty level and who enroll in a silver plan through the Marketplace.

*Coverage under Medicaid expansion became effective January 1, 2020 in Utah. Three states (Missouri, Nebraska and Oklahoma) have adopted Medicaid expansion but not yet implemented it. More details available at KFF's [Medicaid Expansion Tracker](https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/). (<https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>)

Sources:

[Medicaid Expansion Enrollment](https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) ([https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?](https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)

[currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D](https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)):

Kaiser Family Foundation analysis of Medicaid enrollment data collected from the Centers for Medicare and Medicaid Services (CMS) Medicaid Budget and Expenditure System (MBES).

[Marketplace Enrollment and Financial Assistance](https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) ([https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/?](https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)

[currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D](https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)):

Early 2020 Effectuated Enrollment Snapshot, Centers for Medicare and Medicaid Services (CMS), July 23, 2020.

Notes:

States totals may not sum to national total due to rounding.

Employer Sponsored Insurance Enrollment includes those covered through a current or former employer or union, either as a policyholder or as a dependent.

Marketplace Enrollment includes the number of individuals who had an active marketplace policy as of February 2020, and who paid their premium (thus effectuating their coverage) as of March 15, 2020.

Medicaid Expansion Enrollment includes the total number of individuals who are enrolled in the ACA expansion group. This total includes 12 million individuals who are newly-eligible under the ACA pathways. State decisions about adopting the Medicaid expansion are as of August 17, 2020. More information is available at KFF's [Medicaid Expansion Tracker](https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/) (<https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>).

Cells labelled 'Insufficient Data' in the rebates column indicate that insurers representing more than 10% of state enrollment have not filed MLR data.

*Coverage under Medicaid expansion became effective January 1, 2020 in Utah. Three states (Missouri, Nebraska and Oklahoma) have adopted Medicaid expansion but not yet implemented it. More details available at KFF's [Medicaid Expansion Tracker](https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/) (<https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>).

Sources:

[Prevalence of Pre-Existing Conditions](https://www.kff.org/health-reform/issue-brief/pre-existing-condition-prevalence-for-individuals-and-families/) (<https://www.kff.org/health-reform/issue-brief/pre-existing-condition-prevalence-for-individuals-and-families/>): Kaiser Family Foundation analysis of data from National Health Interview Survey and the Behavioral Risk Factor Surveillance System.

[Employer Sponsored Insurance Enrollment](https://www.kff.org/other/state-indicator/total-population/?dataView=0¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) (<https://www.kff.org/other/state-indicator/total-population/?dataView=0¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>): Kaiser Family Foundation estimates based on the Census Bureau's American Community Survey, 2018.

[Marketplace Enrollment](https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) (<https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>): Early 2020 Effectuated Enrollment Snapshot, Centers for Medicaid and Medicare Services (CMS), July 23, 2020.

[Medicaid Expansion Enrollment](https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) (<https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>): Kaiser Family Foundation analysis of Medicaid enrollment data collected from the Centers for Medicare and Medicaid Services (CMS) Medicaid Budget and Expenditure System (MBES).

[MLR](https://www.kff.org/private-insurance/issue-brief/data-note-2019-medical-loss-ratio-rebates/) (<https://www.kff.org/private-insurance/issue-brief/data-note-2019-medical-loss-ratio-rebates/>): Kaiser Family Foundation analysis of rebate submissions by insurers to CMS.

Notes:

Medicaid Expansion Enrollment includes the total number of individuals who are enrolled in the ACA expansion group. This total includes 12 million individuals who are newly-eligible under the ACA pathways. State decisions about adopting the Medicaid expansion are as of August 17, 2020. More information is available at KFF's [Medicaid Expansion Tracker](https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/). (<https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>)

NR indicates state did not report data. Included in 1115 indicates that state was unable to report state plan services separately from Section 1115 waiver services. Blank cell indicates state does not elect option.

*Coverage under Medicaid expansion became effective January 1, 2020 in Utah. Three states (Missouri, Nebraska and Oklahoma) have adopted Medicaid expansion but not yet implemented it. More details available at KFF's Medicaid Expansion Tracker.

**Data is from 2016.

Sources:

Medicaid Expansion Enrollment ([https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?](https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)

[currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D](https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)):

Kaiser Family Foundation analysis of Medicaid enrollment data collected from the Centers for Medicare and Medicaid Services (CMS) Medicaid Budget and Expenditure System (MBES).

HCBS Enrollment (<https://www.kff.org/report-section/medicaid-home-and-community-based-services-enrollment-and-spending-appendix-tables/>): KFF Medicaid HCBS Program Surveys, FY 2018.

Notes:

U.S. totals exclude territories.

Sources:

Medicare Advantage Enrollment: CMS Enrollment Dashboard Data File 08-19-2020, "Hospital and Med Monthly Counts", data for March 2020.

Part D Coverage Gap Spending: KFF analysis of 2018 Medicare prescription drug event claims for a 20 percent sample of Medicare beneficiaries from the CMS Chronic Conditions Data Warehouse.

ACO Assigned Beneficiaries: KFF analysis of Medicare Shared Savings Program data from CMS, 2018.

Part B Income Related Premiums: CMS Program Statistics, Centers for Medicare & Medicaid Services, Office of Enterprise Data and Analytics, Chronic Conditions Data Warehouse, 2018.

Endnotes

Issue Brief

1. A number of Democratic state AGs are defending the ACA as interveners in the case, arguing in part that Congress intended to keep the ACA in place when it set the individual mandate penalty to zero while leaving the rest of the law intact.

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2. Some of the coverage gap provisions were subsequently modified by the Bipartisan Budget Act of 2018. The BBA closes the Part D coverage gap in 2019 instead of 2020 by accelerating a reduction in beneficiary coinsurance from 30 percent to 25 percent in 2019; also increases the discount provided by manufacturers of brand-name drugs in the coverage gap from 50 percent to 70 percent, beginning in 2019. In 2019 and later years, Part D plans will cover the remaining 5 percent of costs in the coverage gap, which is a reduction in their share of costs (down from 25 percent).

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3. Some of the Medicare income-related premium provisions have been modified by subsequent laws. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) made changes to Medicare's income-related premiums by requiring beneficiaries with incomes above \$133,500 (\$267,000 for married couples) to pay a larger share of Part B and Part D program costs than under the original MMA and ACA provisions. Under MACRA, beginning in 2018, beneficiaries with incomes above \$133,500 and up to \$160,000 (\$267,000-\$320,000 for married couples) were required to pay 65 percent of Part B and Part D program costs, up from 50 percent prior to 2018, while beneficiaries with incomes above \$160,000 and up to \$214,000 (\$320,000-\$428,000 for married couples) were required to pay 80 percent of Part B and Part D program costs, up from 65 percent. The most recent change to Medicare's income-related premiums was incorporated in the Bipartisan Budget Act of 2018 (BBA). This change will affect beneficiaries with incomes above \$500,000 (\$750,000 for married couples) by requiring them to pay 85 percent of program costs beginning in 2019, up from 80 percent prior to 2019.

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Effects of the ACA Medicaid Expansion on Racial Disparities in Health and Health Care

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Executive Summary

The [disparate impacts of the COVID-19 pandemic on people of color](https://www.kff.org/coronavirus-policy-watch/growing-data-underscore-communities-color-harder-hit-covid-19/) (<https://www.kff.org/coronavirus-policy-watch/growing-data-underscore-communities-color-harder-hit-covid-19/>) have exposed and compounded underlying racial/ethnic [disparities in health and health care](https://www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/) (<https://www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/>). These disparities include longstanding higher uninsured rates among people of color that contribute to barriers to care and, ultimately, worse health outcomes. The Affordable Care Act (ACA) coverage expansions, including the [Medicaid expansion](https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/) (<https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>) to low-income adults, provide an opportunity to reduce disparities in coverage, which [research](https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/) (<https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>) suggests may contribute to reductions in disparities access to care and health outcomes.

This issue brief builds on a [previous literature review](https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/) (<https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/>) that broadly investigated the effects of Medicaid expansion by examining how the expansion has affected racial disparities in health coverage, access to care, health outcomes, and economic outcomes. It is based on a review of 65 studies published beginning in January 2014 (when the coverage provisions of the ACA went into effect) through July 2020. This brief groups outcomes into four broad categories: coverage; access to and use of care; health outcomes and quality of care; and economic measures. Key findings include (Figure 1):

- Most of the 29 studies that examined how Medicaid expansion has affected disparities in health coverage found it helped narrow but did not eliminate racial disparities in health coverage.
- The 24 studies that examined how Medicaid expansion affected access to and use of care generally found expansion was associated with improvements in these

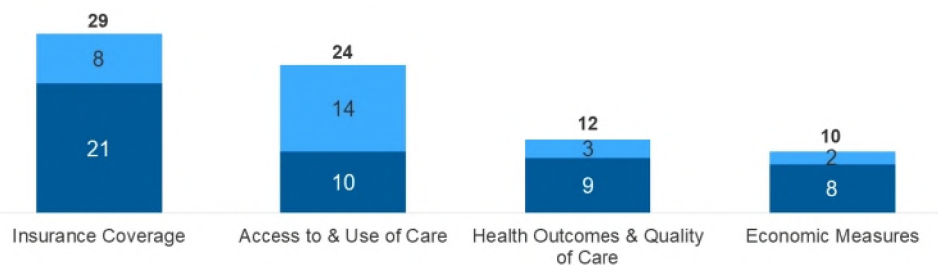
measures for some groups but more limited evidence that it reduced racial disparities that existed prior to expansion.

- Some studies find that Medicaid expansion was associated with narrowed disparities in health outcomes for Black and Hispanic individuals, particularly for measures of maternal and infant health.
- The limited number of studies that considered effects of expansion on disparities in economic measures had mixed results but suggested some narrowing of differences in the payer mix for provider reimbursement for health care services (the proportion of uninsured patients vs. Medicaid patients) by patient race/ethnicity and for measures of individual economic well-being.

Figure 1

Impact of Medicaid Expansion on Racial/Ethnic Disparities

■ # of studies that find no positive effect on disparities
 ■ # of studies that find disparities decreased for one or more groups and/or measures



NOTES: Studies may have findings in multiple areas and be counted in multiple bars. Many studies have mixed findings; for example, finding a decrease in disparities for one racial/ethnic group but no effect on disparities among other groups.
 SOURCE: KFF analysis of 65 studies of the impact of state Medicaid expansion published between January 2014 and July 2020.



Figure 1: Impact of Medicaid Expansion on Racial/Ethnic Disparities

Together these findings illustrate that Medicaid expansion has contributed to reductions in longstanding racial disparities in health coverage. They further suggest that, while increased coverage can help improve access to care and contribute to improvements in health, coverage alone is not enough to eliminate disparities in these measures. This finding reflects that a broad range of social and economic factors (<https://www.kff.org/policy-watch/health-disparities-symptom-broader-social-economic-inequities/>) beyond health coverage influence and drive health. As such, the findings point to the importance of ongoing efforts to address health disparities considering a broad array of factors within and outside the health sector, including historic and ongoing racism and discrimination.

Issue Brief

Introduction

This issue brief builds on a [previous literature review](https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/) (<https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/>) that broadly investigated the effects of Medicaid expansion by examining how the expansion has affected racial disparities in health coverage, access to care, health outcomes, and economic outcomes. It is based on KFF's review of 65 studies which examined the impacts of Medicaid expansion by race/ethnicity and were published beginning in January 2014 (when the coverage provisions of the ACA went into effect) through July 2020.¹ This brief groups findings into four broad categories: coverage; access to and use of care; health outcomes and quality of care; and economic measures. (Appendix A provides a list of citations for each of the included studies, grouped by the four categories of findings.) Across categories, most research focused on disparities for Black and Hispanic individuals, leaving significant gaps in research to understand impacts for other groups of color.

This review only discusses findings related to changes in racial/ethnic disparities associated with Medicaid expansion. An additional body of work has examined effects of the ACA broadly and suggests significant decreases in disparities following the ACA, but did not examine effects of the Medicaid expansion specifically or differential effects by state Medicaid expansion status. While these studies are not included in this brief, expansion may have played a significant role in the effects found in these studies. (See Methods for more details.)

Key Findings: Effects of Medicaid Expansion

Disparities in Health Coverage

Across the 29 studies that examined how Medicaid expansion has affected disparities in health coverage, 21 found that Medicaid expansion helped narrow but did not eliminate racial/ethnic disparities in health coverage. Studies varied in the groups they examined and the metrics they included to assess coverage. Some of these studies had mixed results; for example, finding disparities narrowed for one racial/ethnic group but that expansion had no effect on or widened disparities for another group. Similarly, findings sometimes varied by measure; for example, some studies found disparities in uninsured rates decreased but those in Medicaid coverage did not, or vice versa. The few studies that did not find expansion had any positive effect on coverage disparities (including a few that found increased disparities) generally considered effects for a targeted population or only used data from the first year of expansion. [2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18,19,20,21,22](#)

Most studies examined changes in coverage disparities for Black and Hispanic individuals but did not provide findings for other groups of color. There was slightly stronger and more consistent evidence of narrowed coverage disparities for Black individuals compared to Hispanic individuals. A smaller number of studies considered how expansion affected coverage disparities for other groups of color, and

findings for these groups were mixed.^{[23,24,25,26](#)} A few studies further found variation in how Medicaid expansion affected coverage disparities by country of origin, language, and gender.^{[27,28,29](#)}

Several studies found decreased racial/ethnic coverage disparities among cancer patients and survivors. Specifically, studies suggest that expansion was associated with decreased coverage disparities among Black and Hispanic patients with newly diagnosed cancer; patients with lung, breast, or prostate cancer; patients with head and neck cancer; and women with endometrial cancer.^{[30,31,32,33,34,35](#)} Study authors explain that racial/ethnic disparities in cancer care and outcomes are longstanding and may be mitigated by increases in insurance coverage.

Disparities in Access to and Use of Care

Most of the 24 studies that examined how Medicaid expansion affected access to and use of care found that it was generally associated with improvements in these measures for some groups but more limited evidence that it reduced disparities that existed prior to the expansion. Ten studies found that Medicaid expansion was associated with narrowed disparities in at least one measure of access for at least one group of color. Within these studies, findings often varied by racial/ethnic group and measure; for example, finding reductions in disparities for some groups and in some measures but not others. The remaining studies did not find expansion reduced access disparities. Two studies found disparities widened for one more or more measures due to larger improvements among White individuals compared to people of color.^{[36,37](#)} Most studies considered disparities for Black and Hispanic individuals; few considered effects for other groups.^{[38,39,40,41,42,43,44,45,46,47,48,49,50,51,52,53,54,55,56,57,58,59](#)} Studies focused on several types of measures:

- **Access to primary care:** While most studies found overall improvements in the share of people having a usual source of care, a personal doctor, and a recent doctor's visit, they generally did not find expansion was associated with narrowed racial disparities in these measures or had mixed findings across groups, with improvements for one group but not another.^{[60,61,62,63,64,65](#)}
- **Affordability of care:** Studies generally found improvements in affordability of care across groups, but mixed findings regarding effects on disparities. Several studies found that expansion decreased the gap between Black and White individuals in ability to afford care, but studies generally did not find a narrowing of disparities in affordability between Hispanic and White individuals.^{[66,67,68,69,70,71,72,73](#)}
- **Receipt of preventive care:** In contrast to narrowed disparities in coverage among cancer patients associated with expansion, studies did not find expansion was associated with reduced disparities in cancer screening rates, cancer stage at diagnosis, and utilization of cancer surgery.^{[74,75,76,77](#)} One study also found that expansion did not affect disparities in receipt of the flu shot, while other studies found it was associated with narrowed disparities in HIV testing rates and in

perforated appendix admission rates (which provide insight into the extent to which patients are able to obtain care earlier to prevent perforation).^{78,79,80}

- **Utilization of health care services:** Most studies that consider utilization of services such as surgery for specific conditions find no effect of expansion on disparities.^{81,82,83,84,85,86,87,88} In contrast, a few studies found decreased disparities for at least one racial group in utilization of other specific services, including heart transplant listing rates, high-risk cancer surgery, and receipt of naltrexone or counseling without medication to address opioid use disorder (although this final study also suggested that White adults were more likely than adults of color to receive buprenorphine for opioid use disorder).^{89,90,91}

Disparities in Health Outcomes & Quality of Care

Studies suggest that Medicaid expansion narrowed disparities in some health outcomes for Black and Hispanic individuals, particularly related to infant and maternal health. Research in these areas generally did not examine effects for other groups of color. Studies suggest larger improvements for Black and, in some cases, Hispanic individuals as compared to White individuals in rates of infant mortality and other adverse birth outcomes and maternal mortality, helping to narrow but not eliminating disparities in these measures.^{92,93,94,95,96} Other studies also found disparities narrowed for at least one group in measures of self-reported health and one-year mortality among end-stage renal disease patients initiating dialysis, but findings were mixed across groups.^{97,98,99} Other research found no effect on survival rates among women with endometrial cancer across racial/ethnic groups.¹⁰⁰ No studies found increased disparities in health outcomes, although two studies found increased disparities in certain measures of quality of hospital care.^{101,102}

Disparities in Payer Mix and Other Economic Outcomes

The limited number of studies that considered effects of expansion on disparities in economic measures had mixed results but suggested some narrowing of differences in the payer mix for provider reimbursement for health care services (the proportion of uninsured patients vs. Medicaid patients) by patient race/ethnicity and for measures of individual economic well-being. Research found greater increases in Medicaid-insured visits and/or decreases in uninsured visits among people of color compared to White people for a variety of specific conditions, although a few other studies suggested that expansion had no effect on or widened disparities in reimbursement patterns for other conditions.^{103,104,105,106,107,108,109,110} A few studies examined disparities in employment and other measures of individual economic well-being. For example, studies suggested that expansion was associated with gains in employment, student status, and volunteerism that reduced racial disparities.^{111,112} However, findings varied across racial and ethnic groups.¹¹³ Overall, research in this area remains limited.

Conclusion

Prior to the ACA, there were significant disparities in health and health care. The ACA Medicaid expansion provided an opportunity to reduce longstanding disparities in health coverage, which may contribute to improvements in and narrowed disparities in access to and use of care and health outcomes. This review of the literature finds that Medicaid expansion has helped to narrow but has not eliminated disparities in coverage. It also shows that Medicaid expansion was associated with improvements in measures of access to care, use of care, health outcomes, and certain economic measures across racial/ethnic groups, but its effects on disparities were often mixed across groups and/or measures. This review further shows that most studies only examined effects for Black and Hispanic individuals, leaving continued gaps in data and research for other groups.

Together these findings illustrate that the Medicaid expansion has contributed to reductions in longstanding racial disparities in health coverage. They further suggest that, while increased coverage can help improve access to care and contribute to improvements in health, coverage alone is not enough to eliminate disparities in these measures. This finding reflects that a broad range of social and economic factors (<https://www.kff.org/policy-watch/health-disparities-symptom-broader-social-economic-inequities/>) beyond health coverage and health care influence and drive health. As such, the findings point to the importance of ongoing efforts to address health disparities considering a broad array of factors within and outside the health sector, including historic and ongoing racism and discrimination.

Methods

This literature review includes studies, analyses, and reports published by government, research, and policy organizations using data from 2014 or later. This brief includes studies that examine impacts of the Medicaid expansion by race/ethnicity (even if impacts on racial/ethnic disparities were not the primary focus of the study). It excludes studies on impacts of ACA coverage expansions generally (not specific to Medicaid expansion alone), studies investigating potential effects of expansion in states that have not (or had not, at the time of the study) expanded Medicaid, and reports from advocacy organizations and media sources.

To collect relevant studies, we conducted keyword searches of PubMed and other academic health/social policy search engines as well as websites of government, research, and policy organizations that publish health policy-related research. We also used a snowballing technique of pulling additional studies from reference lists in previously collected studies. While we tried to be as comprehensive as possible in our inclusion of studies and findings that meet our criteria, it is possible that we missed some relevant studies or findings. For each study, we read the final paper/report and summarized the population studied, data and methods used, and findings. In instances of conflicting findings within a study, or if a reviewer had questions about specific findings, multiple reviewers read and classified the study to characterize its findings. In the issue brief text, findings are broken out and reported separately in four broad categories: Medicaid expansion's impact on coverage disparities; disparities in access to and use of care; disparities in health outcomes and quality of care; and disparities in economic metrics. Studies may be cited in multiple categories or in multiple places within a category. Appendix A provides a list of citations for each of the included studies, grouped by the four categories of findings.

Appendix

Appendix A: Studies by Topic

- Coverage
- Access to and Use of Care
- Health Outcomes and Quality of Care
- Economic Measures

Coverage

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Endnotes

Issue Brief

1. Studies measured effects on racial and ethnic disparities in several ways, including assessing whether modeled effects of Medicaid expansion were larger for people of color compared to White people, comparing trends in expansion vs. non-expansion states by race and ethnicity, and examining trends within an expansion state by race and ethnicity.

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As the COVID-19 Recession Extended into the Summer of 2020, More Than 3 Million Adults Lost Employer-Sponsored Health Insurance Coverage and 2 Million Became Uninsured

Evidence from the Household Pulse Survey, April 23–July 21, 2020

Anuj Gangopadhyaya, Michael Karpman, and Joshua Aarons

Timely Analysis of Immediate Health Policy Issues

SEPTEMBER 2020

The COVID-19 pandemic has had dire economic consequences. As of the week ending August 15, 2020, 29.2 million Americans were receiving unemployment insurance benefits, compared with 1.6 million Americans at that point a year ago.¹ The unemployment rate rose from 3.5 percent in February to 14.7 percent in April and was 8.4 percent in August.² Because most Americans under age 65 get health insurance coverage through their or a family member's employer, many people in families losing jobs are also at risk of losing coverage. Historically, increases in unemployment rates have led to increased uninsurance.³ Though recent evidence suggests the Affordable Care Act (ACA) may have weakened the link between jobs and insurance coverage,⁴ the scale of the current recession threatens employer-sponsored insurance (ESI) for millions of workers and their families. Many of these people may struggle to find replacement coverage because they are unfamiliar with or ineligible for Medicaid or subsidized health plans through the health insurance marketplaces, or because they cannot afford premiums even if eligible for marketplace premium tax credits.

Though several studies have projected the recession could have profound effects on insurance coverage,^{5,6,7,8} rapid-response surveys suggest coverage changed minimally during the initial months of the crisis, between March and May 2020.^{9,10,11} However, these estimated changes do not match the historically

large number of jobs lost during this period, which may be explained by several factors. First, the jobs that were initially lost during this period may have been less likely to offer ESI. Second, many workers may have been placed on temporary layoffs during the recession's initial months, during which their ESI may have been sustained. Third, respondents may not immediately know their coverage status following job loss. However, as the recession prolongs and potentially affects a broader range of workers, ESI losses may become more rapid.

In this brief, we use the U.S. Census Bureau's Household Pulse Survey to assess how coverage changed as the COVID-19 recession extended into the summer months. We do not assess total changes in coverage occurring because of the pandemic's effects. The Census Bureau developed the Household Pulse Survey to assess changes in household employment, spending, food security, health care access, and health in real time as the pandemic and recession unfold. The Household Pulse Survey was first fielded April 23, five weeks after the initial record-breaking surge in weekly unemployment insurance claims starting March 21, by which point at least 26 million people had filed unemployment insurance claims. Therefore, this study analyzes changes in coverage occurring *after* the pandemic's initial shocks.

We focus on changes in ESI, Medicaid and other public coverage, marketplace and other private nongroup coverage,

and uninsurance between the first two waves of the Household Pulse Survey (fielded April 23–May 12) and the most recent two waves of the survey (fielded July 9–21) among adults ages 18 to 64. Between these dates, an additional 28 million Americans filed unemployment insurance claims, but the rate of weekly claims filings steadily decreased. The unemployment rate gradually decreased during this period as well. Nonetheless, these three months represent uncharted territory for U.S. labor markets and therefore for insurance coverage. We find the following:

- An estimated 3.3 million nonelderly adults lost ESI between late April/early May and mid-July. This represents a 1.7 percentage-point decline, from 67.1 percent to 65.4 percent. Public coverage and uninsurance both increased by about 1 percentage point, from 14.1 percent to 15.2 percent for public coverage and from 12.9 to 13.9 percent for uninsurance. The increase in uninsurance represents an estimated 1.9 million additional adults without coverage. We observe no significant change in private nongroup coverage over this period.
- Hispanic adults and non-Hispanic Asian adults saw the largest declines in ESI. Among Hispanic adults, an estimated 1.6 million lost ESI over this period, a 4.3 percentage-point decline. Among non-Hispanic Asian adults, ESI declined by an

estimated 7.6 percentage points, or about 800,000 adults. The share of Hispanic adults with public coverage increased 2.5 percentage points, but uninsurance increased by 3.8 percentage points, representing 1.4 million newly uninsured Hispanic adults. The share of non-Hispanic Asian adults with public coverage increased by 5.0 percentage points.

- We estimate that the number of adults ages 18 to 39 with ESI fell by 2.2 million. Among these adults, uninsurance increased by 1.5 percentage points, but public and private nongroup coverage changed little. Uninsurance did not significantly increase for adults ages 40 to 64, who experienced a 1.8 percentage-point increase in public coverage.
- Nearly all ESI losses observed in the survey (90 percent) occurred among men, 3.0 million of whom lost ESI. Approximately 2.3 million men became uninsured during this period, their uninsurance rate increasing by 2.4 percentage points.
- About 2.1 million adults with a high school degree or less education lost ESI, a 2.8 percentage-point decline for the group. Public coverage among this group climbed by 2.5 percentage points, and uninsurance increased by 1.6 percentage points, equal to 1.2 million more adults without coverage.
- In states that did not expand Medicaid under the ACA, the share of people with ESI fell 2.1 percentage points (1.5 million adults) and the share uninsured increased by 1.7 percentage points (1.1 million adults). In states that expanded Medicaid, the share with ESI fell 1.4 percentage points (1.8 million adults). Though we observe corresponding increases in public coverage and uninsurance in expansion states, these changes are statistically insignificant.

Our analysis of the Census Bureau's Household Pulse Survey suggests that between April 23 and July 21, ESI coverage decreased broadly across most

demographic groups, and such losses were greatest among Hispanic adults, younger adults, men, and adults with a high school degree or less education. As temporary layoffs potentially evolve into permanent job losses, ESI coverage losses could become more widespread. Consequently, federal subsidies for marketplace plans and state Medicaid programs could face additional pressure to prevent rising uninsurance rates. Fiscal and monetary policies intended to support labor markets and reduce unemployment rates, if successful, could help prevent ESI loss.

Our findings indicate that groups experiencing larger losses in ESI coverage experienced corresponding increases in public coverage or uninsurance rates, with smaller observed changes in private nongroup coverage rates. Policies that could blunt the likelihood of ESI losses leading to further increases in uninsurance include expanding Medicaid under the ACA in the 12 states that have not yet done so, extending the income eligibility range for premium subsidies for marketplace plans, and increasing the subsidy amount for marketplace plans.

Data and Methods

Our analysis draws on public use microdata from the Census Bureau's Household Pulse Survey, which measures the COVID-19 pandemic's effects on U.S. households.¹² The survey is designed to produce representative estimates for adults ages 18 and older living in housing units at the national and state levels and in the 15 largest metropolitan statistical areas.^{13,14} Participants are sampled from housing units in the Census Bureau's Master Address File, which are matched with email addresses and phone numbers from the Census Bureau's Contact Frame. Via email or text message, sampled households are asked to complete the online survey. Survey weights adjust for household nonresponse, coverage of housing units in the sampling frame, number of adults per household, and the demographic characteristics of adults within each state, based on age, sex, race/ethnicity, and educational attainment.

The initial survey was fielded weekly between April 23 and July 21, 2020, and fielding for additional weeks resumed in mid-August.¹⁵ The field period for the first "week" was April 23 to May 5 but fielding for subsequent weeks lasted six days. Before August, households completing an interview in one week remained in the sample for the next two weeks. Weekly weighted response rates for this internet-based survey were typically about 3 percent, much lower than those of other major federal surveys.¹⁶ The sample size varies from a low of about 42,000 respondents in week two to a high of about 133,000 in week three, with an average weekly sample size of about 90,000.¹⁷

Our analysis focuses on adults ages 18 to 64, who are most likely to experience changes in health insurance coverage during the pandemic, because nearly all adults ages 65 and older are covered by Medicare. We focus on changes in the share of adults who report being covered by the following types of health insurance at the time of the survey: ESI, including TRICARE; public coverage, including Medicare, Medicaid, and Veterans Affairs coverage; private nongroup coverage, including marketplace coverage; and uninsurance. Because respondents could select multiple coverage types, we establish a hierarchy of responses so estimates sum to 100 percent.¹⁸ Respondents are considered uninsured if they do not identify either ESI, public, or private nongroup coverage. Those who only select Indian Health Service coverage are considered uninsured. One limitation of this analysis is that reported health insurance coverage types are measured with significant error in surveys.^{19,20,21} Though respondents tend to report ESI accurately, greater measurement error occurs in reports of public coverage and private nongroup coverage.²² Moreover, measures of coverage type in the Household Pulse Survey are not subject to the detailed verification and editing typically used in annual federal surveys.²³

In addition, between 8 percent and 11 percent of nonelderly Pulse survey respondents do not answer the

insurance coverage questions across survey weeks.²⁴ However, Pulse survey weights are intended to represent a consistent population when applied to all respondents, including those with missing coverage responses. Consequently, using the Pulse survey weights to assess changes in insurance coverage is problematic, because changes in the estimated number of people with each coverage type could be driven by fluctuations in missing responses across weeks. To address this issue, we reweight the set of respondents who answered the coverage questions in each week to total to the average sum of the Pulse weight (i.e., including those with missing responses to coverage questions) for the

same state, age group (18–39, 40–64), educational attainment (high school degree or less, some college or more), and racial/ethnic group (non-Hispanic white, nonwhite or Hispanic) across all fielded weeks. This ensures that among those responding to insurance coverage questions, the population totals and demographic characteristics of respondents evaluated in each survey week are consistent within each of these state, racial/ethnic, age, and education combinations. We estimate standard errors for coverage change estimates using the Pulse survey replicate weights, which we adjust to account for our reweighting approach.

Findings

Between late April/early May and mid-July, more than 3 million adults lost employer-sponsored insurance, and such losses were concentrated among Hispanic adults, young adults, men, and adults who did not attend college.

As shown in Table 1, we first assess changes in ESI between April 23–May 12 (weeks 1 and 2 of the Pulse survey) and July 9–21 (weeks 11 and 12) overall and by key demographic groups. In the initial weeks of the Pulse survey, an estimated 67.1 percent of nonelderly adults had health insurance coverage through an employer. By weeks 11 and 12 of the survey, this estimate fell 1.7 percentage

Table 1. Employer-Sponsored Health Insurance Coverage among Adults Ages 18 to 64, by Selected Characteristics, Late April/Early May to Mid-July 2020

	Percent with ESI			Number with ESI (Millions)		
	April 23-May 12	July 9-21	Percentage-point change	April 23-May 12	July 9-21	Change
Overall	67.1%	65.4%	-1.7**	132.1	128.8	-3.3**
Race/ethnicity^a						
Non-Hispanic white	71.7%	70.8%	-0.8	82.6	81.7	-1.0
Non-Hispanic Black	58.7%	60.2%	1.5	14.6	15.0	0.4
Hispanic	57.0%	52.7%	-4.3**	21.1	19.5	-1.6**
Non-Hispanic Asian	76.0%	68.5%	-7.6**	8.4	7.6	-0.8**
Age						
18–39	63.3%	61.0%	-2.4**	57.7	55.6	-2.2**
40–64	70.4%	69.3%	-1.1	74.3	73.2	-1.1
Gender						
Male	69.3%	66.2%	-3.1**	66.8	63.8	-3.0**
Female	65.0%	64.7%	-0.3	65.3	65.0	-0.3
Education						
High school degree or less	55.1%	52.3%	-2.8**	41.4	39.2	-2.1**
Some college or more	74.5%	73.6%	-1.0**	90.7	89.5	-1.2**
Children in household						
No children in household	68.2%	66.5%	-1.7**	72.9	71.0	-1.8**
Children in household	65.9%	64.2%	-1.7**	59.3	57.7	-1.6**
State Medicaid expansion status						
Has not expanded Medicaid	65.0%	62.9%	-2.1**	44.3	42.8	-1.5**
Expanded Medicaid	68.2%	66.8%	-1.4**	87.8	85.9	-1.8**

Source: Weeks 1, 2, 11, and 12 of the U.S. Census Bureau's Household Pulse Survey.

Notes: ESI = employer-sponsored insurance. Differences in columns may not be equal to reported change due to rounding.

**Denotes significance at the $p < 0.05$ level.

^aNon-Hispanic respondents of other races or more than one race are included in the overall analysis but not represented as a residual category.

points to 65.4 percent, meaning an estimated 3.3 million people lost ESI during this period.

For both non-Hispanic white and non-Hispanic Black adults, we did not observe statistically significant changes in ESI over the study period. However, Hispanic adults experienced an estimated 4.3 percentage-point decline in ESI, and non-Hispanic Asian adults experienced an estimated 7.6 percentage-point decline in ESI, equal to 1.6 million and 800,000 adults, respectively.

ESI losses were concentrated among younger adults ages 18 to 39. We estimate this group experienced a 2.4 percentage-point decline in ESI over this period, equal to 2.2 million people. An additional 1.1 million people between the ages of 40 and 64 also lost ESI, though the estimate for older adults ages 40 to 64 is not statistically different from zero. ESI losses are overwhelmingly concentrated among men rather than women, with an estimated 3 million men losing such coverage over this period.

In the initial weeks of the survey, 55.1 percent of people with a high school degree or less education received

insurance coverage through an employer, compared with 74.5 percent of those with some college or more education. For those with a high school degree or less education, the share with ESI fell to 52.3 percent by mid-July, equal to an estimated 2.1 million people. People with some college or more education also experienced a significant, but smaller, 1 percentage-point decline in ESI.

Though the reduction in ESI was partially offset by a rise in public coverage, the number of uninsured adults increased by nearly 2 million. Groups that faced the largest ESI losses also saw the largest increases in uninsurance.

In this section, we assess how Medicaid and other public coverage, private nongroup coverage (including coverage through the ACA's marketplaces), and uninsurance changed between the beginning and ending weeks (weeks 1, 2, 11, and 12) of Phase 1 of the Pulse survey. ESI losses could result in increased take-up of Medicaid, depending on state eligibility rules. Moreover, losing job-based coverage initiates a special enrollment period, in which individuals can purchase a plan on the ACA's

marketplace outside of the marketplace's usual open enrollment period, possibly with subsidized premiums and cost-sharing depending on one's projected household income for the year. However, some adults losing ESI will be ineligible for Medicaid or marketplace subsidies, and others may be eligible but unfamiliar with these options or reluctant to apply.²⁵ In addition, job losses could make it more difficult to afford even subsidized marketplace plan premiums; for these adults, losing ESI could ultimately mean becoming uninsured.

In Table 2, we present the overall shares and numbers of nonelderly adults reporting each coverage type in the first two and the final two weeks of Phase 1 of the survey. Between late April/early May and mid-July, the share of nonelderly adults with public coverage increased from 14.1 percent to 15.2 percent, meaning 2.2 million people gained public coverage over this period. Though the share of adults with private nongroup coverage did not change significantly, uninsurance increased from 12.9 percent to 13.9 percent. Thus, we estimate that 1.9 million people became uninsured during the study period. In Appendix Tables 1 and 2, we present the

Table 2. Changes in Health Insurance Coverage among Adults Ages 18 to 64, Late April/Early May to Mid-July 2020

	ESI	Public	Private nongroup	Uninsured
Share covered (percent)				
April 23-May 12	67.1%	14.1%	5.9%	12.9%
July 9-21	65.4%	15.2%	5.5%	13.9%
Percentage-point change	-1.7 **	1.1 **	-0.4	1.0 **
Total enrolled (millions)				
April 23-May 12	132.1	27.8	11.6	25.4
July 9-21	128.8	30.0	10.8	27.3
Change	-3.3 **	2.2 **	-0.8	1.9 **

Source: Weeks 1, 2, 11, and 12 of the U.S. Census Bureau's Household Pulse Survey.

Notes: ESI = employer-sponsored insurance.

**Denotes significance at the $p < 0.05$ level.

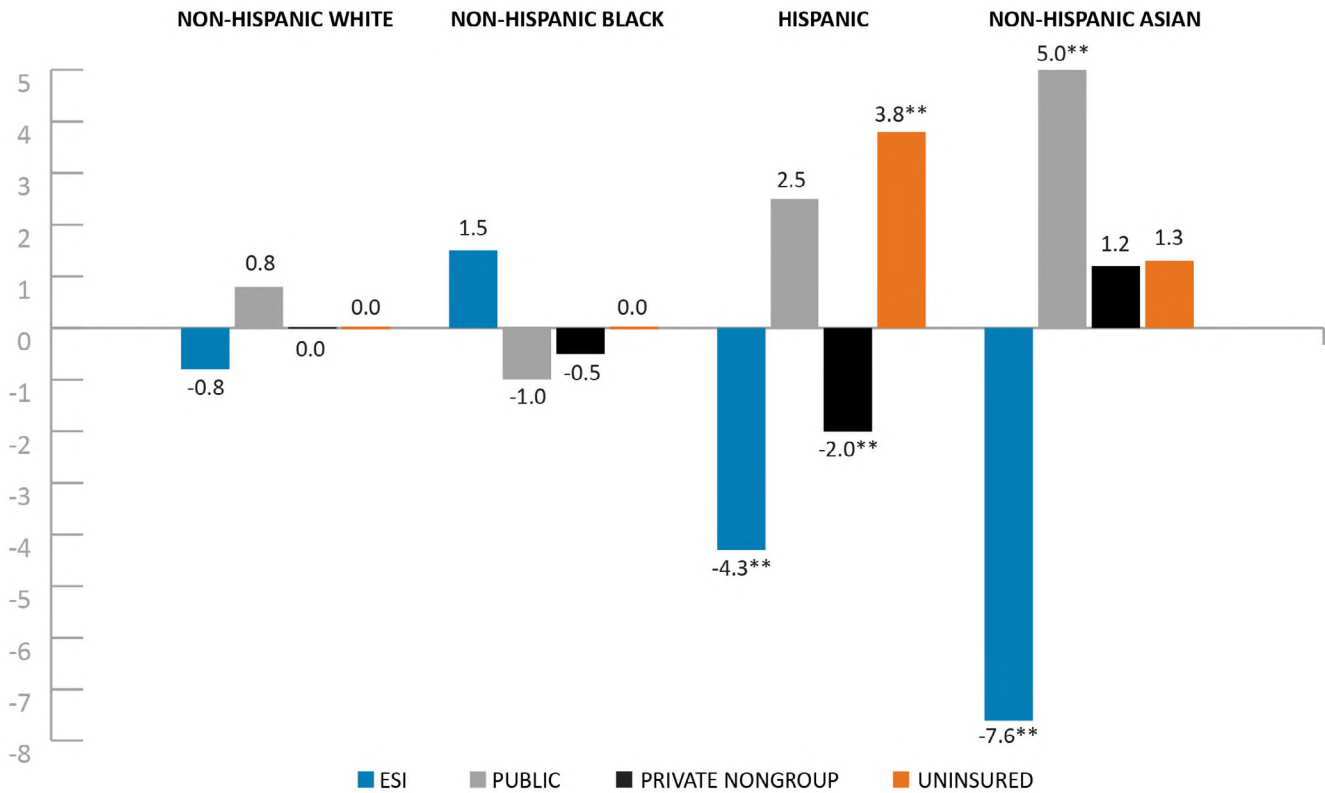
shares and estimated population totals enrolled in each coverage type across these survey weeks and for each major demographic group.

We next highlight changes in coverage type by race and ethnicity (Figure 1). As shown in Table 1, ESI coverage changed little among non-Hispanic white and non-Hispanic Black adults. Figure 1 shows these respondents

faced few corresponding changes in other coverage categories as well. Conversely, Hispanic and non-Hispanic Asian adults experienced large decreases in ESI coverage. For Hispanic adults, their 4.3 percentage-point drop in ESI was accompanied by an additional 2.0 percentage-point decline in private nongroup coverage, equaling roughly 800,000 adults losing private nongroup coverage. These

losses in private coverage were partially offset by an estimated 2.5 percentage-point increase in public coverage, but this change is statistically insignificant. Thus, uninsurance among Hispanic adults increased by an estimated 3.8 percentage points, or about 1.4 million people, over this period. Non-Hispanic Asian adults, who experienced a 7.6 percentage-point decrease in ESI, also saw a 5.0 percentage-point increase

Figure 1. Percentage-Point Changes in Health Insurance Coverage among Adults Ages 18 to 64, by Race and Ethnicity, Late April/Early May to Mid-July 2020



Sources: Weeks 1, 2, 11, and 12 of the U.S. Census Bureau’s Household Pulse Survey.
 Notes: ESI = employer-sponsored insurance. Percentage points represent changes in health insurance coverage between April 23-May 12 and July 9-21.
 **Denotes significance at the $p < 0.05$ level.

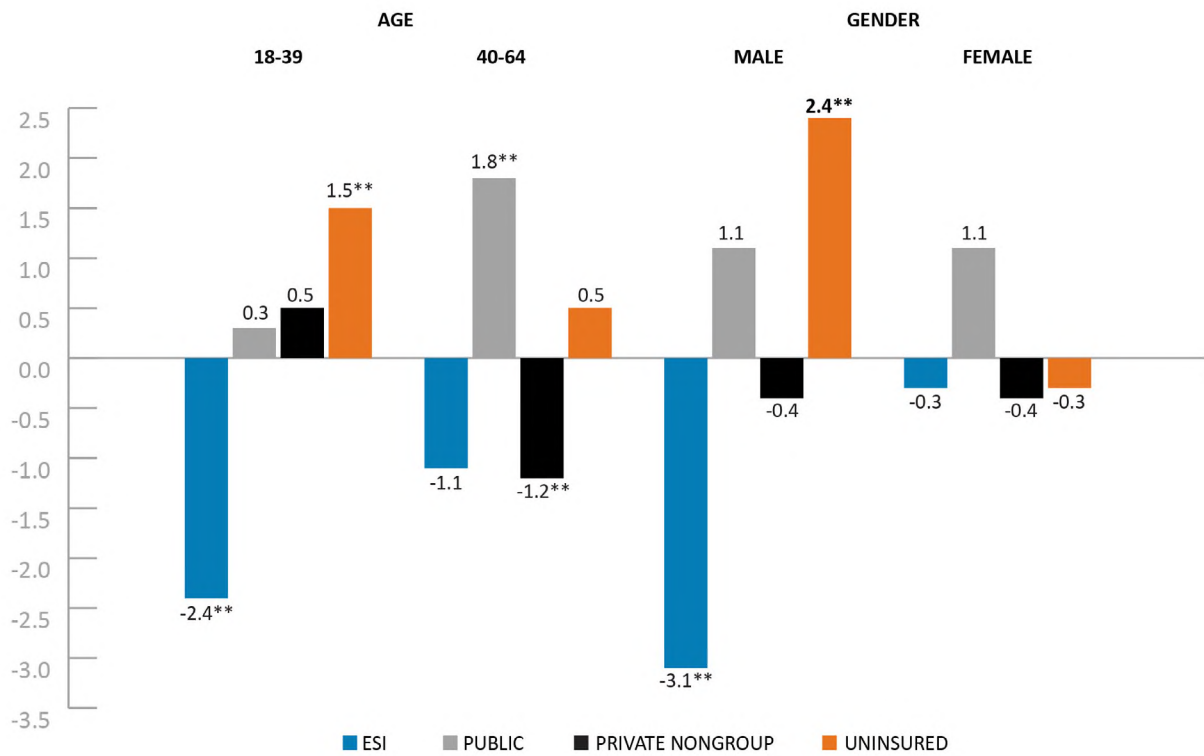
in public coverage and no significant change in private nongroup coverage or uninsurance.

Figure 2 presents changes in coverage by age group and gender. For younger adults ages 18 to 39, 2.2 million of whom lost ESI, we observe small and insignificant changes in public coverage and private nongroup coverage but a 1.5 percentage-point increase in uninsurance,

representing 1.3 million more of these adults becoming uninsured. Older adults ages 40 to 64 saw a smaller estimated change in ESI but also reported significant losses of private nongroup coverage. For these adults, public coverage increased by an estimated 1.8 percentage points and uninsurance changed little over this period. As noted earlier, ESI losses were concentrated among men rather than women. We also estimate men

experienced a 1.1 percentage-point increase in public coverage, nearly no changes in private nongroup coverage, and a significant 2.4 percentage-point increase in uninsurance, representing 2.3 million men becoming uninsured. Across all categories, coverage changed little for women and all estimated changes were statistically insignificant.

Figure 2. Percentage-Point Changes in Health Insurance Coverage among Adults Ages 18 to 64, by Age and Gender, Late April/Early May to Mid-July 2020

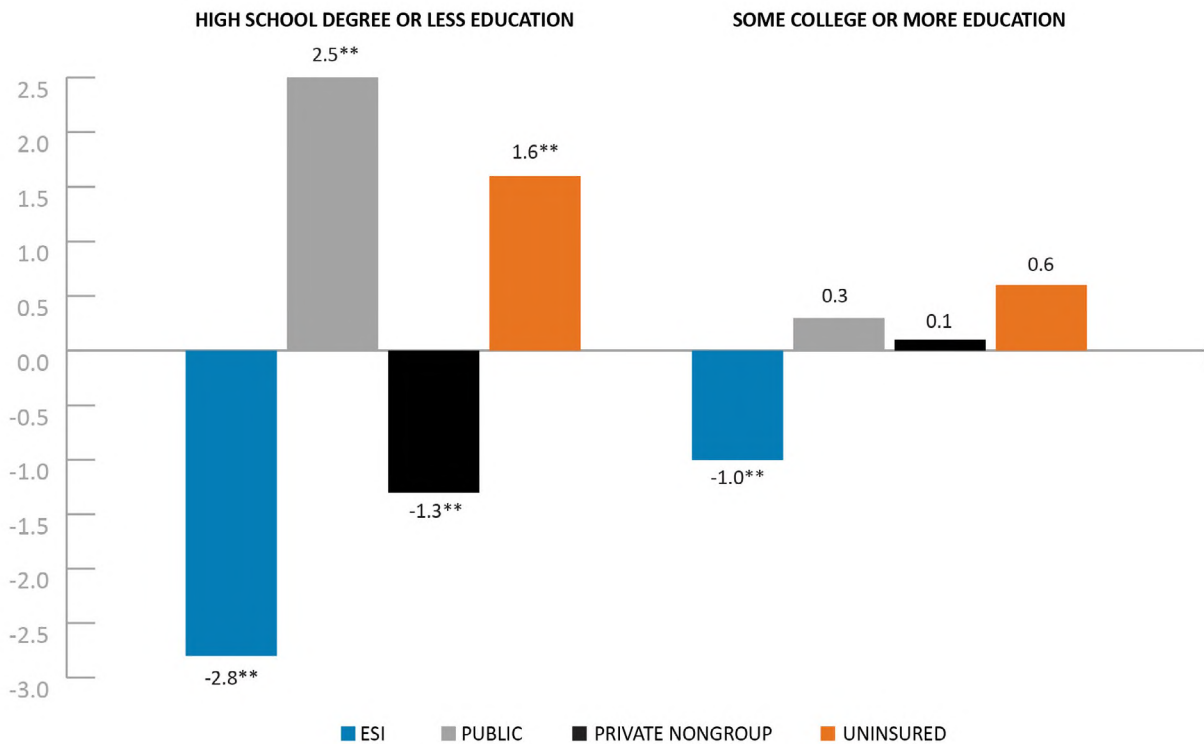


Sources: Weeks 1, 2, 11, and 12 of the U.S. Census Bureau's Household Pulse Survey.

Notes: ESI = employer-sponsored insurance. Percentage points represent changes in health insurance coverage between April 23-May 12 and July 9-21.

**Denotes significance at the $p < 0.05$ level.

Figure 3. Percentage-Point Changes in Health Insurance Coverage among Adults Ages 18 to 64, by Educational Attainment, Late April/Early May to Mid-July 2020



Sources: Weeks 1, 2, 11, and 12 of the U.S. Census Bureau's Household Pulse Survey.

Notes: ESI = employer-sponsored insurance. Percentage points represent changes in health insurance coverage between April 23-May 12 and July 9-21.

**Denotes significance at the $p < 0.05$ level.

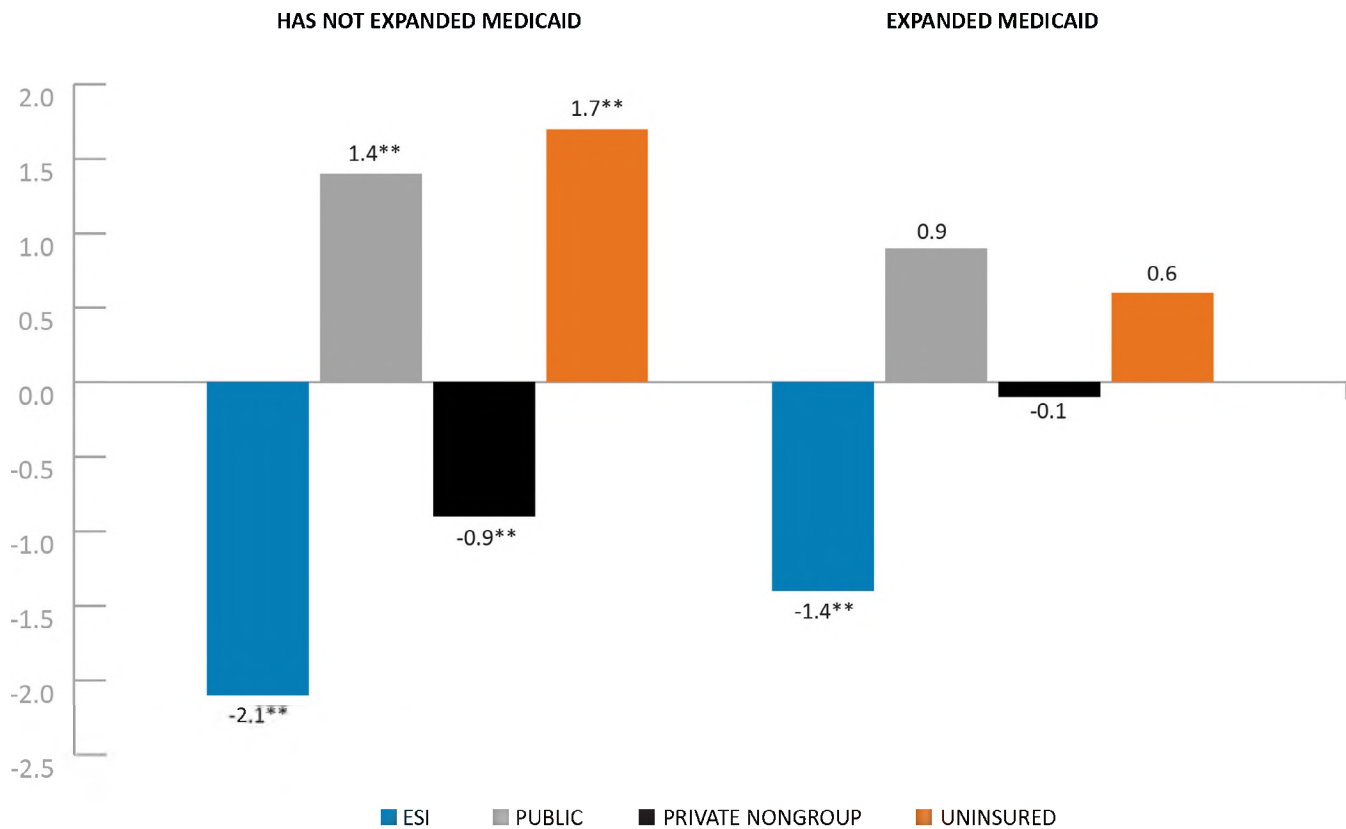
Figure 3 shows estimated changes in coverage types by educational attainment. Nonelderly adults with a high school degree or less education experienced an estimated 2.8 percentage-point decline in ESI (equal to about 2.2 million adults), along with a 2.5 percentage-point increase in public coverage (1.8 million adults), a 1.3 percentage-point decline in private nongroup coverage (1.0 million adults), and a 1.6 percentage-point increase in uninsurance (1.3 million adults). Despite estimating that 1.2 million adults with some college or more education lost ESI, we detect no significant changes in their other coverage types over our study period.

ESI losses occurred across states, and uninsurance increased in states that did not expand Medicaid under the ACA.

Between late April/early May and mid-July, the share of adults with ESI fell in states that did and did not expand Medicaid under the ACA (Medicaid expansion and nonexpansion states). Though estimated ESI losses were greater in nonexpansion states than in expansion states over this period (Table 1), we find that differences by state expansion status were statistically insignificant. Figure 4 shows that adults in nonexpansion states experienced a 2.1 percentage-point

decline in ESI (1.5 million people), as well as a 1.4 percentage-point increase in public coverage and a 0.9 percentage-point decline in private nongroup coverage. Uninsurance increased by 1.7 percentage points, representing an estimated 1.1 million additional adults without coverage in these states. In Medicaid expansion states, the share of adults with ESI fell 1.4 percentage points (1.8 million adults), public coverage increased by 0.9 percentage points, and private nongroup coverage remained virtually unchanged. Though uninsurance increased by 0.6 percentage points in expansion states (800,000 adults), this change was statistically insignificant.

Figure 4. Percentage-Point Changes in Health Insurance Coverage among Adults Ages 18 to 64, by State Medicaid Expansion Status, Late April/Early May to Mid-July 2020



Sources: Weeks 1, 2, 11, and 12 of the U.S. Census Bureau’s Household Pulse Survey.

Notes: ESI = employer-sponsored insurance. Percentage points represent changes in health insurance coverage between April 23-May 12 and July 9-21.

**Denotes significance at the $p < 0.05$ level.

Discussion

The Household Pulse Survey offers a snapshot of how health insurance coverage changed between April 23–May 12 and July 9–21, 2020, as the COVID-19 recession extended into the summer and millions of adults remained unemployed. We estimate that during these three months, the number of nonelderly adults with ESI fell by 3.3 million, while the number of uninsured adults increased by 1.9 million. These coverage losses have been concentrated among men, Hispanic adults, younger adults, and adults who have not attended college. ESI coverage losses have occurred in both states that did and did not expand Medicaid under the ACA.

However, these estimates do not reflect overall coverage changes that have occurred during the recession up to this point. Both unemployment claims and monthly employment survey data show most job losses occurred in March and early-to-mid April, before the Pulse survey was first fielded,^{1,26} and other rapid-response surveys indicate coverage had already begun to shift before April 23. In a State Health Access Data Assistance Center survey, which was fielded April 24–26 and had about 1,000 respondents, 4 percent of adults ages 18 and older reported losing health insurance during the early months of the pandemic because their employer-based coverage ended or they had to cancel their coverage.¹¹ The survey did not, however, determine whether these adults became uninsured.

In addition, an Urban Institute tracking survey that followed a sample of more than 4,000 nonelderly adults between March 25–April 10 and May 14–27 found that, though overall coverage levels were roughly stable during this period, ESI declined by 5 percentage points among adults in families losing jobs (from 59 percent to 54 percent) and uninsurance increased overall in states that have not expanded Medicaid.⁹

The gradual changes in health insurance coverage found in the above mentioned surveys and the Pulse survey partially owe to the disproportionate impact of the recession on workers with low incomes,²⁷ who were less likely to be covered by ESI before the pandemic began.²⁸ A Commonwealth Fund survey, fielded May 13–June 2, found that fewer than half of adults reporting they or their spouse or partner lost a job or were furloughed during the pandemic were covered by health insurance through the affected job.¹⁰

Even when accounting for these job loss patterns, rapid-response survey data suggest some of the coverage losses projected in earlier studies^{5,6} have not yet materialized.²⁹ This may owe to the unique labor market effects of the COVID-19 recession, in which more than 70 percent of unemployed workers who lost jobs were on temporary layoff as of mid-July.³⁰ Yet, these labor market circumstances also suggest many people remain at risk of losing coverage

as the recession continues and more job losses become permanent. The declining unemployment rate between April and July largely reflects a decline in the number of workers on temporary layoff (from 18 million to 9 million), which coincided with an increasing number facing permanent job loss (from 2 million to 3 million). Thus, changes in ESI and other insurance coverage types may not closely correspond with month-to-month changes in overall unemployment rates.

With continued weakness in the labor market, federal and state policymakers will need to act to prevent job losses from leading to further increases in uninsurance. At the federal level, expanded subsidies for marketplace coverage and restoration of funding for outreach and enrollment assistance can help more unemployed adults afford premiums and navigate their coverage options. At the state level, additional Medicaid expansions can prevent adults from falling into an assistance gap, where they are ineligible for both Medicaid and marketplace subsidies. Indeed, ballot measures to expand Medicaid under the ACA passed in two states (Missouri and Oklahoma) as the pandemic and recession have deepened. Ultimately, stemming coverage losses will require improved efforts to reduce transmission of the novel coronavirus so that more segments of the economy can reopen safely and foster a sustained labor market recovery.

Appendix Table 1. Share of Adults Ages 18 to 64 with Selected Health Insurance Coverage Types, by Selected Characteristics, Late April/Early May to Mid-July 2020

	Share with each coverage type							
	ESI		Public		Private nongroup		Uninsured	
	April 23-May 12	July 9-21	April 23-May 12	July 9-21	April 23-May 12	July 9-21	April 23-May 12	July 9-21
Overall	67.1%	65.4%	14.1%	15.2%	5.9%	5.5%	12.9%	13.9%
Race/ethnicity^a								
Non-Hispanic white	71.7%	70.8%	12.0%	12.9%	6.2%	6.2%	10.1%	10.1%
Non-Hispanic Black	58.7%	60.2%	21.1%	20.1%	3.6%	3.1%	16.5%	16.6%
Hispanic	57.0%	52.7%	16.5%	19.0%	6.5%	4.5%	20.0%	23.8%
Non-Hispanic Asian	76.0%	68.5%	7.6%	12.6%	6.0%	7.2%	10.4%	11.8%
Age								
18–39	63.3%	61.0%	15.6%	16.0%	5.0%	5.5%	16.1%	17.5%
40–64	70.4%	69.3%	12.8%	14.6%	6.6%	5.4%	10.2%	10.7%
Gender								
Male	69.3%	66.2%	10.6%	11.7%	6.1%	5.7%	14.0%	16.3%
Female	65.0%	64.7%	17.5%	18.6%	5.7%	5.2%	11.9%	11.5%
Education								
High school degree or less	55.1%	52.3%	20.2%	22.7%	5.7%	4.4%	19.0%	20.6%
Some college or more	74.5%	73.6%	10.3%	10.6%	6.0%	6.1%	9.2%	9.7%
Children in household								
No children in household	68.2%	66.5%	11.9%	13.6%	7.2%	6.5%	12.7%	13.4%
Children in household	65.9%	64.2%	16.6%	17.2%	4.4%	4.2%	13.1%	14.5%
State Medicaid expansion status								
Has not expanded Medicaid	65.0%	62.9%	9.9%	11.2%	7.3%	6.4%	17.8%	19.5%
Expanded Medicaid	68.2%	66.8%	16.4%	17.3%	5.1%	5.0%	10.3%	10.9%

Sources: Weeks 1, 2, 11, and 12 of the U.S. Census Bureau's Household Pulse Survey.

Notes: ESI is employer-sponsored insurance.

** Denotes significance at the $p < 0.05$ level.

^aNon-Hispanic respondents of other races or more than one race are included in the overall analysis but not represented as a residual category.

Appendix Table 2. Number of Adults Ages 18 to 64 with Selected Health Insurance Coverage Types, by Selected Characteristics, Late April/Early May to Mid-July 2020

	Number of people with each coverage type (millions)							
	ESI		Public		Private nongroup		Uninsured	
	April 23- May 12	July 9-21	April 23- May 12	July 9-21	April 23- May 12	July 9-21	April 23- May 12	July 9-21
Overall	132.1	128.8	27.8	30.0	11.6	10.8	25.4	27.3
Race/ethnicity^a								
Non-Hispanic white	82.6	81.7	13.9	14.8	7.2	7.2	11.6	11.6
Non-Hispanic Black	14.6	15.0	5.2	5.0	0.9	0.8	4.1	4.1
Hispanic	21.1	19.5	6.1	7.1	2.4	1.7	7.4	8.8
Non-Hispanic Asian	8.4	7.6	0.8	1.4	0.7	0.8	1.2	1.3
Age								
18–39	57.7	55.6	14.2	14.5	4.6	5.1	14.7	16.0
40–64	74.3	73.2	13.6	15.4	7.0	5.7	10.7	11.3
Gender								
Male	66.8	63.8	10.2	11.2	5.9	5.5	13.5	15.7
Female	65.3	65.0	17.6	18.7	5.7	5.2	11.9	11.6
Education								
High school degree or less	41.4	39.2	15.2	17.0	4.3	3.3	14.2	15.5
Some college or more	90.7	89.5	12.6	12.9	7.3	7.5	11.2	11.8
Children in household								
No children in household	72.9	71.0	12.7	14.5	7.7	7.0	13.5	14.3
Children in household	59.3	57.7	14.9	15.4	4.0	3.8	11.8	13.0
State Medicaid expansion status								
Has not expanded Medicaid	44.3	42.8	6.7	7.7	5.0	4.3	12.1	13.3
Expanded Medicaid	87.8	85.9	21.1	22.3	6.6	6.4	13.2	14.0

Sources: Weeks 1, 2, 11, and 12 of the U.S. Census Bureau's Household Pulse Survey.

Notes: ESI is employer-sponsored insurance.

** Denotes significance at the $p < 0.05$ level.

^aNon-Hispanic respondents of other races or more than one race are included in the overall analysis but not represented as a residual category.

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- ²⁵ Medicaid eligibility for nondisabled, nonpregnant adults varies by whether a state expanded Medicaid under the ACA. In expansion states, nearly all of these adults with incomes up to 138 percent of the federal poverty level (FPL) are eligible for Medicaid. In nonexpansion states, adults not living with dependent children are generally ineligible for Medicaid, and income eligibility thresholds for parents living with children are often very low (e.g., 17 percent of FPL in Texas and 18 percent of FPL in Alabama; see Medicaid income eligibility limits for parents, 2002–2020. Henry J. Kaiser Family Foundation website.) In both groups of states, lawfully residing immigrant adults must typically wait five years after they receive qualified status before qualifying for Medicaid. Adults ineligible for Medicaid can qualify for marketplace premium tax credits if their incomes are between 100 and 400 percent of FPL (138 to 400 percent of FPL in Medicaid expansion states) and they do not have an affordable coverage offer through an employer (defined as a plan in which the premium for the individual does not exceed 9.78 percent of household income). Lawfully residing immigrants ineligible for Medicaid because of immigration status qualify for premium tax credits even if their incomes are below 100 percent of FPL.
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Women's importance in enacting, implementing, and defending the Affordable Care Act

Nancy-Ann DeParle and Jeanne Lambrew

SEPTEMBER 2020

A

decade after it was signed into law, the Affordable Care Act's story is still being written. Currently, our nation is locked in a battle with COVID-19—over 190,000 Americans have died and some 40 million have lost their jobs. The Affordable Care Act (ACA) has proven, yet again, important to our nation's health—in this case, through its long-time support for the public health system as well as its coverage policy. In addition to millions who

gained Medicaid as a result of the law, half a million people signed up for coverage in May due to the ACA's special enrollment period. Also, yet again, the law's survival is threatened by a Supreme Court challenge and President Trump's persistent vows to "terminate" it. But one aspect of the ACA is locked in: it is the most significant reform legislation in recent American history.



Explanations proliferate about why President Barack Obama and the 116th Congress succeeded in health reform, while other efforts over many decades failed. Major proposals to change the United States' health system have been prominent in presidential campaigns and platforms for the last century, suggesting that prioritization alone is insufficient.¹ President Obama's focused, effective, and values-driven leadership is often—and rightly—credited with the successful passage of the ACA. Close collaboration between the Democratic-led White House and Congress and a shared sense of urgency were also critical.^{2,3,4}

As first-hand participants, we see another factor missing from evaluations so far: the singular role of women. Here, we review the leadership of women in devising, passing, implementing, and defending the ACA, and offer a perspective on why women made a difference.

Women's role in enacting the ACA

The administration

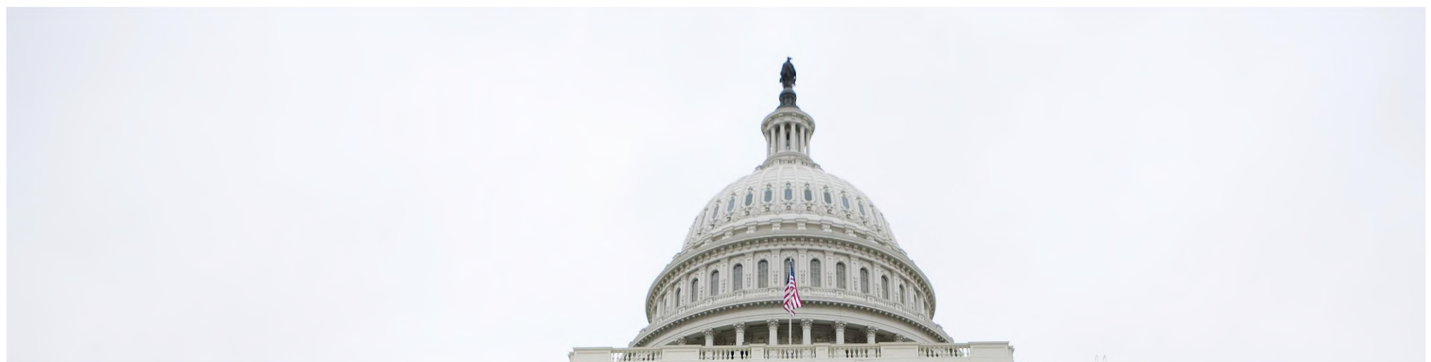
A few weeks into his presidency, President Obama replaced his initial choice to shepherd health reform, former Senator Tom Daschle, with two women: Kathleen Sebelius as secretary of Health and Human Services (HHS) and Nancy-Ann DeParle as the director of the White House Office of Health Reform. Sebelius, a former Kansas governor, led outreach efforts, marshalled the resources of HHS, and testified before Congress. DeParle, a former administrator of the Centers for Medicare & Medicaid Services (CMS), managed the White House and interagency process, helped bridge the House-Senate differences, and served as the president's point person. An executive order created

both the White House Office of Health Reform and one at HHS, which Jeanne Lambrew, a former Office of Management and Budget (OMB) and HHS health policy leader, was set to run from the start.

As one of President Obama's top priorities, health reform drew attention from virtually all senior White House staff, as well as dozens of junior staff, who participated in weekly and sometimes daily meetings to work through the ACA's design, provide support to congressional staff in analyzing its impact, consider hundreds of amendments during committee markups, and manage public engagement. The HHS Office of Health Reform staffed this effort, and each major affected agency had experts on call.

Maintaining focus and cohesion in the White House and across the sprawling executive branch was challenging, especially with escalating opposition from the public, insurers, businesses, and advocates for other priorities. And while there was no visible disagreement within the administration about the primacy of health reform among President Obama's domestic initiatives, two sometimes conflicting groups coalesced among those working on it: one dubbed the "Health Team" (because it included HHS and White House Office of Health Reform staff) and the other known as the "Economic Team" (because it included OMB, National Economic Council, Council of Economic Advisors, and Treasury Department staff). To some extent, this infighting is typical of life in the West Wing, but it was notable and somewhat discomfiting that the sparring occurred along gender lines: the Health Team was comprised mostly of women and the Economic Team mostly of men.

The agita largely subsided after the passage of the ACA, as some of the Economic Team departed and others stepped up to help with implementing and defending the law. But the disproportionate role of women in the ACA persisted.





Speaker of the House Nancy Pelosi unveils the House Democrat's Healthcare plan on Capitol Hill in Washington October 29, 2009. REUTERS/Joshua Roberts (UNITED STATES POLITICS HEALTH)

The Congress

Back to 2009: in Congress, Senate Majority Leader Harry Reid (D-Nev.) garnered 60 votes for passage on December 24 of that year, despite having none to spare. Yet, House Speaker Nancy Pelosi (D-Calif.) arguably had the hardest task. She had to convince the House to abandon its own hard-wrought bill to vote for the Senate's version as modified by a reconciliation bill. She defused dozens of landmines on issues ranging from abortion to Medicare payment adequacy. The portrait of indefatigability, she was determined to pass the ACA against all odds: "We'll go through the gate. If the gate's closed, we'll go over the fence. If the fence is too high, we'll pole vault in. If that doesn't work, we'll parachute in, but we're going to get health care reform passed for the American people."

Behind the scenes, four out of the five authorizing committees had women as their health policy directors (Karen Nelson, Cybele Bjorklund, Michelle Varnhagen, and Liz Fowler) as did Senator Reid (Kate Leone) and House Majority Whip Steny Hoyer (D-Md.) (Liz Murray).⁵ They led the work of drafting the legislation, assessing amendments, securing timely estimates from the Congressional Budget Office, and engaging extensively with stakeholders.

They were remarkably and, in our experience, atypically collaborative. Three House committees delivered on Pelosi's rare directive to develop a single cross-committee bill; the Senate, in contrast, had to merged two different committee bills that diverged in meaningful ways. The unusual degree of collegiality was encouraged by constant communication. Drawing on the lesson from President

Lyndon B. Johnson taped to Nancy-Ann's desk,⁶ she and Jeanne led House-Senate "bicam" meetings and calls multiple times a week—at key junctures, every morning at 9 a.m. and every night at 9 p.m.—to stay coordinated, resolve problems, and assign work.

Stakeholders

Outside of government, women led some of the key stakeholder groups making the hardest decisions to get the law passed. Sister Carol Keehan of the Catholic Health Association endorsed the ACA, with the support of thousands of nuns, despite the Catholic Church's opposition to its abortion compromise. On the other side of that particular issue, Cecile Richards of Planned Parenthood and leaders of other women's groups supported the bill despite deep misgivings about that same compromise. Nancy Nielsen, MD, as president of the American Medical Association, helped persuade the AMA's leadership to support the ACA even though it failed to solve a long-standing Medicare reimbursement problem for physicians. Among many other women, Nancy LeaMond of AARP, Karen Ignagni of America's Health Insurance Plans, and Anna Burger and Mary Kay Henry of SEIU (Service Employees International Union), stand out for their work to sustain their organizations' support for the law.

Women's roles in ACA implementation and defense

Of course, the story of the ACA did not end with its passage. Implementation was similarly fraught and also largely led by women; Secretary Sebelius and Marilyn Tavenner, the confirmed administrator of the Centers for Medicare and Medicaid Services (CMS) after the ACA's passage. After the rough roll-out of HealthCare.gov, two new women stepped up: Sylvia Burwell as secretary of HHS and Kristie Canegallo as the first White House deputy chief of staff for Implementation. They helped forge systems, processes, and default policies and practices—many of which continue today. Women were leaders and drivers of the ACA legislative teams (e.g., Dana Singiser, Amy Rosenbaum), and communications teams (e.g., Anita Dunn, Linda Douglass, Stephanie Cutter, Tara McGuinness). And from the first to last day in the White House, Valerie Jarrett and Cecilia Munoz, through the Office of Public Engagement and Domestic Policy Council, contributed in numerous ways, not least by supporting women in this unusually demanding workplace.

The ACA drama continued beyond the Obama administration. In 2017, when Senator John McCain (R-Ariz.) cast his "thumbs down" vote against repeal, he followed women stalwarts Senators Susan

Bollins (R-Maine) and Lisa Murkowski (R-Alaska). (Notably, the only Republican Senator to vote for a version of the ACA in 2009 was Olympia Snowe from Maine.)



Senator Susan Collins (R-ME) and Senator Lisa Murkowski (R-AK) on Capitol Hill ahead of a vote on health care legislation on July 27, 2017. (REUTERS)

Women's role in failed health reform efforts

The outsized role of women differentiates the ACA from other reform efforts. Few women appear in the narratives of the failed health initiatives of Presidents Truman, Nixon, and Trump.⁷ President Clinton's 1993-94 attempt was led by First Lady Hillary Rodham Clinton; Donna Shalala was secretary of HHS; and we (Nancy-Ann and Jeanne) participated at OMB and HHS. Women were well—but not disproportionately—represented. Importantly, the White House point person (Ira Magaziner) and all congressional leaders and the majority of the staff were men. Similarly, President Trump's 2017 effort to repeal the ACA was engineered by HHS Secretary Tom Price, OMB Director Mick Mulvaney, and White House staffer Andrew Bremberg. Seema Verma, the CMS administrator, was the only visible woman. In Congress, the majority leaders and committee chairs were all male. Indeed, a veteran House staffer observed that while women were largely absent from the Republicans' ACA repeal effort, they were present in force in the successful passage of the Republican tax cut bill in 2017, arguably the Trump administration's top legislative accomplishment.

Men's role in the ACA history

To be sure, many male colleagues were instrumental in the ACA's passage and perseverance, starting with the extraordinary leadership of President Obama. Within the administration, Phil Schiliro, director of the White House Office of Legislative Affairs, orchestrated the legislative strategy; Michael Hash steered policy as the deputy of the White House and HHS Offices of Health Reform; Mark Childress, Pete Rouse, Denis McDonough, Rahm Emanuel, David Axelrod, Jim Messina, Jason Furman, and Jeff Zients played instrumental roles in strategy and problem-solving at moments of crisis. Solicitor General Don Verilli's successful defense of the ACA at the Supreme Court in 2012 literally saved the law. And in Congress, too many men participated in the ACA history to name—including then-Senate Majority Leader Reid and three House and two Senate committee chairs—as well as long-time health staff person to Speaker Pelosi, Wendell Primus.

Discussion

It may be a coincidence that health reform happened just at the time when representation of women at the highest levels of government increased. The prevalence of women in the ACA's history reflects trends in public policy⁸ as well as in medicine.⁹ That said, in our experience, the large share of women involved in health reform made a qualitative difference. The women we worked with displayed extraordinary dedication and perseverance, sticking with the work for prolonged periods of time and when others wanted to “cut losses” and secure smaller, easier gains such as universal coverage limited to children. They tended to manage their own egos and those of others, which may be why few appear in narratives on health reform to date. We also found that women tended to stay longer at the proverbial table, willing to seek compromise consistent with bold goals. That said, we are not experts on political science or gender studies: we were participants and, being women ourselves, are biased. We also hope that our views do not reinforce stereotypes, especially since exceptions—women who did not fit our characterization as well as men who did—were common.

That said, if asked, “Did women's involvement make a difference in the ACA's success?” Our answer, unequivocally, is yes. Certainly, many men invested years of their lives to passing the ACA. But women drove the policy development and the process day in and day out from January 2009 through the bill's passage in March 2010. They led implementation and were key at critical moments

in its defense to this day with Speaker Pelosi's House defending the law at the Supreme Court. In the past decade, these women kept their eyes on the prize: passage and implementation of historic health reform that had eluded presidents and Congresses for generations.

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This piece is part of 19A: The Brookings Gender Equality Series. [Learn more about the series and read published work »](#)

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Nancy-Ann DeParle is a managing director at Consonance Capital Partners. She served as Assistant to the President and Deputy Chief of Staff for Policy in the Obama White House from 2011-January 2013. Prior to that role, she served as Counselor to the President and Director of the White House Office of Health Reform (2009-2011) spearheading efforts to enact the Affordable Care Act and managing the initial implementation of the law. From 1997-2000, DeParle served as Administrator of the Health Care Financing Administration, which is now the Centers for Medicare and Medicaid Services, and has held numerous other leadership positions in health policy, including Commissioner of the Tennessee Department of Human Services. DeParle is currently director for CVS health and HCA.



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Jeanne Lambrew is the commissioner of the Maine Department of Health and Human Services. Lambrew previously held senior positions at the White House for ten years and the U.S. Department of Health and Human Services (HHS) for four years. From 2011 to January 2017, she worked at the White House as the Deputy Assistant to the President for health policy and helped ensure execution of the president's health policy agenda, including the implementation and defense of the Affordable Care Act. From 2009 to 2010, Lambrew was the Director of the HHS Office of Health Reform. In that role, she coordinated work toward passage and the implementation of the Affordable Care Act.

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What We Do and Don't Know About Recent Trends in Health Insurance Coverage in the US

Rachel Garfield (<https://www.kff.org/person/rachel-garfield/>) (<https://twitter.com/RachelLGarfield>) and **Jennifer Tolbert** (<https://www.kff.org/person/jennifer-tolbert/>)
Sep 17, 2020



The usually highly anticipated release of the Census Bureau's annual health insurance estimates, which occurred this past Tuesday for 2019 data, felt a bit different this year. While researchers and policymakers are accustomed to dealing with somewhat outdated data from federal surveys, the unprecedented social and economic changes that have occurred since the data were collected amplified the time lag and made the estimates seem even older than in past years. Current data on insurance coverage in the US is needed to design an adequate response to the pandemic and economic crisis, but the 2019 estimates still provide a useful baseline for interpreting what's happening during the pandemic.

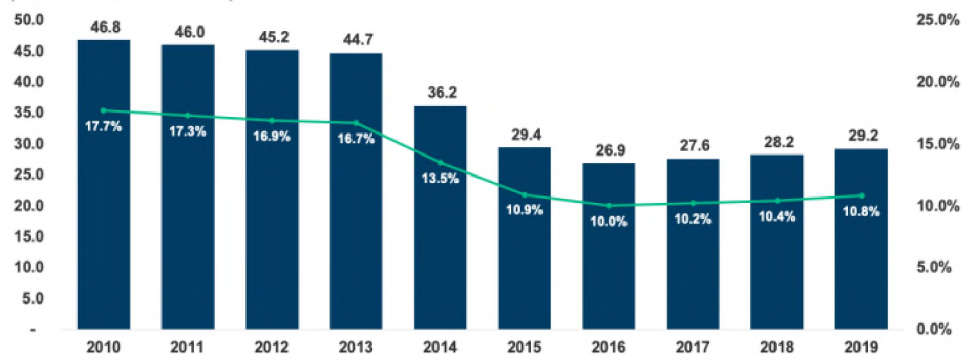
Prior to the pandemic, the uninsured rate had been increasing incrementally for several years despite an improving economy. After historic declines

(<https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>) in the number of uninsured people and the uninsured rate following the adoption and implementation of the 2010 Affordable Care Act (ACA), resulting in nearly 20 million more people covered through 2016, the number and rate of nonelderly uninsured people began to increase in 2017. The uninsured count grew from 26.7 million (10.0%) in 2016 to 27.6 million (10.2%) in 2017, 28.2 million (10.4%) in 2018, and, as was announced this week, **29.2 million (10.8%)** (<https://www.census.gov/library/publications/2020/demo/p60-271.html>) in 2019 (Figure 1).

Figure 1

Number of Uninsured and Uninsured Rate among the Nonelderly Population, 2010-2019

(Number of uninsured in millions)



NOTE: Includes nonelderly individuals ages 0 to 64.

SOURCE: Katherine Keisler-Starkey and Lisa N. Bunch, *Health Insurance Coverage in the United States: 2019*, US Census Bureau, September 15, 2020.

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Figure 1: Number of Uninsured and Uninsured Rate among the Nonelderly Population, 2010-2019

The 2.3 million person growth in the number of uninsured occurred despite improvements in several household economic measures

(<https://www.census.gov/library/publications/2020/demo/p60-270.html>), including median household income, earnings, and poverty and despite small gains in employer-based coverage over this period, which were offset by declines in Medicaid and direct purchase coverage. This pattern likely reflects a combination of factors, including rollback of outreach and enrollment efforts for ACA coverage, changes to Medicaid renewal processes, public charge policies, and elimination of the individual mandate penalty for health coverage. Notably, recent declines in coverage have occurred among both adults and children.

Because most people in the US still get their health coverage as a fringe benefit of a job, the recent economic downturn may disrupt coverage for millions of people. The economic fallout of the coronavirus pandemic has led to historic levels of job loss, with over 50 million people (<https://www.kff.org/other/state-indicator/unemployment-claims/?activeTab=graph¤tTimeframe=0&startTimeframe=23&selectedDistributions=initial-unemployment-claims&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22collid%22:%22Location%22,%22sort%22:%22asc%22%7D>) filing for unemployment insurance benefits since March 21st. Prior to the pandemic, nearly six in ten nonelderly people in the US received their health coverage through their job or a family member's job. Early KFF estimates (<https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/>) of the implications of job loss found that nearly 27 million people were at risk of losing employer-sponsored health coverage due to job loss. Other modeled estimates (https://www.urban.org/sites/default/files/publication/102777/making-sense-of-competing-estimates_1.pdf) similarly predict millions losing employer health coverage, though the scale varies somewhat. Many of these people may have retained their coverage, at least in the short

term, under furlough agreements or employers continuing benefits after layoffs. Indeed, recent KFF analysis (<https://www.kff.org/policy-watch/what-have-pandemic-related-job-losses-meant-for-health-coverage/>) of enrollment in the fully-insured group market found that enrollment in that market declined by just 1.3% from March to June 2020. Employer-based insurance losses could mount if unemployment remains high.

The availability of health coverage through the Affordable Care Act during this economic downturn means people losing their coverage have other options, but policy actions to scale back the ACA may mean people are unaware of or have difficulty accessing that coverage. Expanded coverage through Medicaid in the 37 states that have implemented the Medicaid expansion along with the availability of subsidized and unsubsidized coverage through the Marketplaces will enable many people losing their job-based insurance to retain health coverage. Following enrollment declines in 2018 and 2019, recent data (<https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/>) indicate Medicaid enrollment increased by 2.3 million or 3.2% from February 2020 to May 2020. Additionally, as of May 2020, enrollment data (<https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SEP-Report-June-2020.pdf>) reveal nearly 500,000 people had gained Marketplace coverage through a special enrollment period (SEP), in most cases due to the loss of job-based coverage. The number of people gaining Marketplace coverage through a SEP in April 2020 was up 139% compared to April 2019 and up 43% in May 2020 compared to May 2019. While millions of people are gaining coverage through Medicaid and the Marketplaces, reductions in outreach and enrollment assistance (<https://www.kff.org/health-reform/issue-brief/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need/>) have reduced the availability of on-the-ground assistance for consumers who have lost coverage meaning many others may not be enrolling because they are not aware this coverage is available or don't know how to enroll.

The pandemic has disrupted not only people's health coverage but also the ability of federal surveys to measure coverage. Understanding real-time changes in insurance coverage is a key input into policy actions to address the implications of the pandemic on people's health and well-being. However, to date, limited data is available on this topic. Large national surveys—those typically used as the basis for such information—are lagged, with the most recent data (https://www.cdc.gov/nchs/data/nhis/earlyrelease/Quarterly_Estimates_2020_Q11-508.pdf) reflecting the first quarter of 2020, just prior to the pandemic. Many real-time surveys have faced challenges of high rates of survey nonresponse (<https://www.census.gov/content/dam/Census/library/working-papers/2020/demo/sehsd-wp2020-10.pdf>) (not responding to the survey at all) particularly among populations most likely affected by the economic downturn, or unusually high rates of item nonresponse (skipping particular survey questions). In the Census Bureau's Household Pulse Survey, designed to provide quick turnaround data on issues related to the pandemic, most weeks had a larger number of responses of "don't know" or "did not report" to the question about health coverage than the number of uninsured. These measurement challenges may reflect people's confusion

about their current coverage amidst layoffs and job uncertainty or operational challenges (<https://www.census.gov/content/dam/Census/library/working-papers/2020/demo/sehspd-wp2020-13.pdf>) in administering surveys that ask about health coverage (e.g., inability to conduct in person surveys).

While current survey data is limited and administrative and claims data are showing only moderate shifts in coverage, it is likely that large shifts in health coverage in the US are underway or imminent given loss of employment in recent months. It is possible that many of the people in families experiencing job loss were already uninsured, but given that prior to the pandemic the uninsured population in a family with a full-time worker totaled 20.2 million, there are still people among the 50 million who filed for unemployment benefits that may lose their employer coverage if they do not regain their jobs. In the midst of a health and economic crisis, the gap in real-time data to assess changes in health coverage poses a challenge.

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Report BROOKINGS

COVID outcomes update: Health and employment impacts in the US compared to other countries

[Harry J. Holzer](#) Wednesday, September 16, 2020

Editor's Note:

This piece is a follow-up to the report published in June 2020, "[The COVID-19 crisis: How do U.S. employment and health outcomes compare to other OECD countries?](#)"

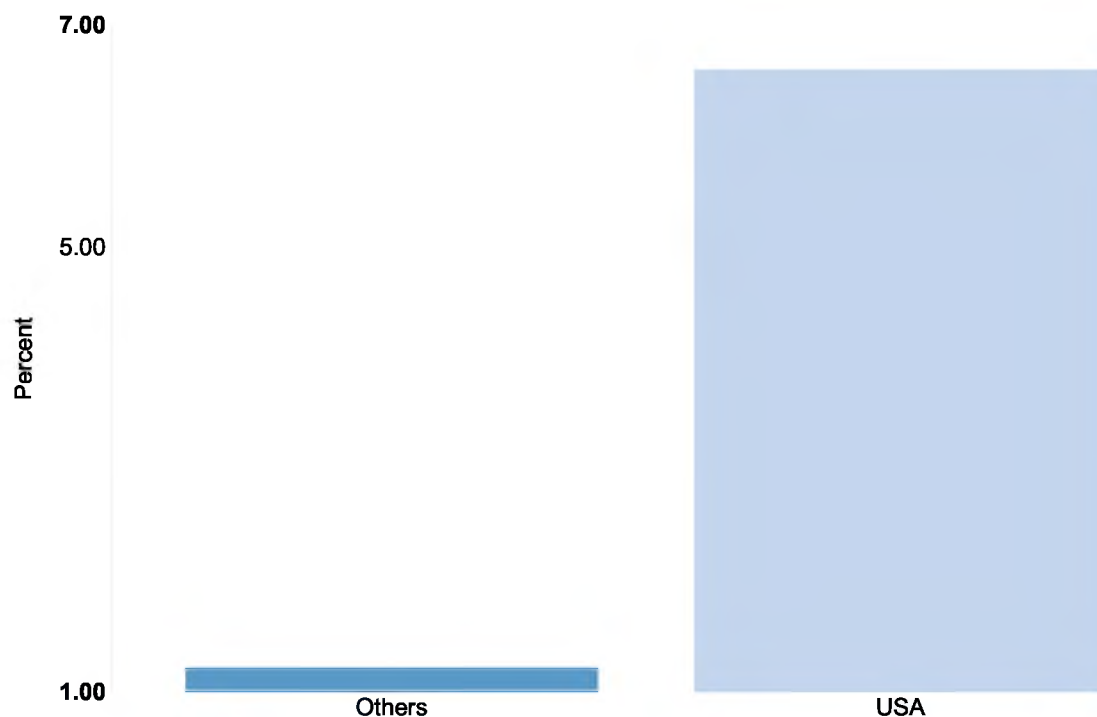
In the past three to four months, the U.S. economy has recovered somewhat from the COVID-19-induced employment troughs observed in April, while the virus caseloads and deaths at first declined and then surged again, starting in June. However, the partial recovery of U.S. labor markets in the late spring and summer, and more recent trends in virus cases and deaths, do not change the fundamental fact that both *employment and health outcomes for the U.S. during the pandemic have been worse than in almost any other high-income country in the world.*

This brief presents an update of [my earlier analysis](#) showing unemployment rates as of April, and virus caseloads and deaths as of late May. This time, I focus on changes in unemployment rates from January of this year through July, the most recent month for which virtually all of these countries report monthly unemployment data (though they are now available for August in the U.S.).^[1] I also present virus caseloads and deaths for virtually each country, as of September 9. Like the earlier brief, I present data for total virus cases and deaths per capita, as well as new cases and deaths per capita (now from a seven-day moving average). And I report some virus data for the U.S. (relative to other countries) as of July 15, so that we can compare employment and health outcomes for similar points in time. The sources of these data are the same as for the earlier brief.^[2]

Figure 1 presents a summary comparison of unemployment rate increases between January and July 2020 in the U.S. to the mean increase across the other OECD countries in part A, and a comparison of new virus cases and deaths per capita in part B. Table 1 presents similar unemployment rate increases between January and each month from April through July in the U.S. and the other OECD countries (in Part A), as well as both total and new virus caseloads and deaths per capita in the US and the other countries (in part B).^[3]

Figure 1A

Differences in January-July unemployment rate: US v. other wealthy OECD countries (pop. > 4 million)

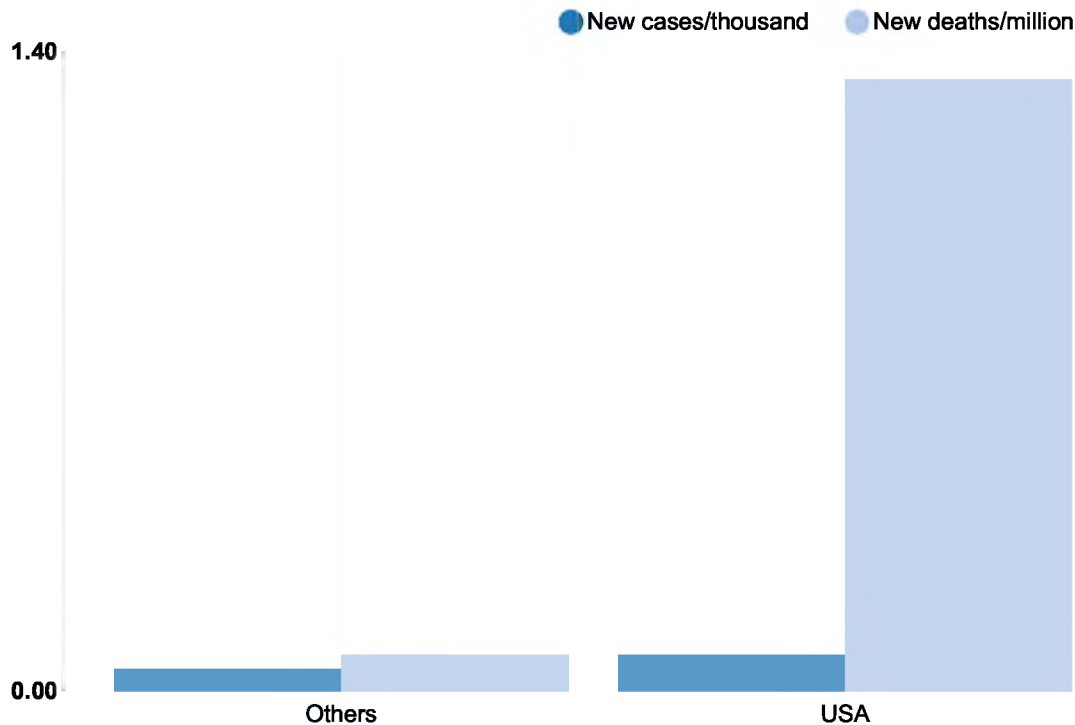


The sample of countries includes the 25 richest OECD countries (in per capita terms) with at least 4 million people. Countries reporting unemployment quarterly rather than monthly and Saudi Arabia (for which few economic data are available in 2020) are excluded.

Author's analysis of Trading Economics Data

Figure 1B

Differences in virus outcomes: US v. other wealthy OECD countries (pop. >4 million)



The sample of countries is the same as in part A, except that Hong Kong has been eliminated. New cases and deaths are now defined as 7-day moving averages.

Author's analysis of Johns Hopkins University Coronavirus Resource Center data.

The data in Figure 1 and Table 1 on unemployment rates indicate the following:

- Unemployment rates in the U.S. rose by over 11 percentage points between January and April before falling by 4.5 percentage points from April to July;
- Unemployment rates rose, on average, by much less in the other OECD countries, and then fell modestly after April;
- *The January-April increase in the U.S. was 11 times larger than the average of other OECD country increases, and the January-July increase in the U.S. remained five times larger than the average of the others.*

The most recent unemployment rate for the U.S., for the month of August, declined by nearly two percentage points. Assuming that such rates continued to slowly decline in the rest of the OECD, the increases in the U.S. would now likely be four times higher than in the OECD, rather than five times.

The data on new viruses and caseloads in the U.S. and the other OECD countries indicate the following:

- Overall virus cases per capita in the U.S. are now over four times higher in the U.S. than in the average high-income OECD country, while total deaths per capita are over twice as high; and
- *New virus cases in September in the U.S. are 60 percent higher than in the average OECD country, and new deaths are five times higher.*

Table 1

**Changes in Economic and Virus Outcomes:
US v. Other OECD Countries (Population > 4 million)**

Unemployment Rates (%)	Others	USA
Jan – Mar 2020	0.31	0.8
Jan – Apr 2020	0.98	11.1
Jan – May 2020	1.41	9.7
Jan – Jun 2020	1.32	7.5
Jan – Jul 2020	1.22	6.6
Virus Cases and Deaths		
Cases/1,000	4.44	19.11
Deaths/1,000	0.23	0.57
New Cases/1,000	0.05	0.08
New Deaths/1,000,000	0.26	1.34

Note: The sample of countries includes the 25 richest OECD countries (in per capita terms) with at least 4 million people. Countries reporting unemployment quarterly rather than monthly and Saudi Arabia (for which few economic data are available) are excluded. Unemployment rates are obtained from Trading Economics (www.tradingeconomics.com) on September 9. COVID-19 case numbers are obtained from Johns Hopkins University Coronavirus Resource Center (www.coronavirus.jhu.edu) on September 9. “New cases” and “new deaths” are defined as 7-day moving averages. The sample of countries for virus cases and deaths is the same as for unemployment, except that it excludes Hong Kong, for which these data are not available.

The country-specific data on unemployment rates and virus cases/deaths for each individual country appear in the Appendix table (part A for unemployment rates and part B for virus data). These results show the following:

- The unemployment rate increase of 6.6 percentage points in the U.S. between January and July is the largest of any high-income country in the OECD;
- Total per capita virus cases are higher in the U.S. than in any other wealthy OECD country, and total deaths per capita here are higher than in all but four; and
- The new per capita caseload is the highest in the US except for two other OECD countries, while new deaths per capita are highest in the U.S. except for one (Israel).

In sum, the partial recovery of U.S. labor markets in the late spring and summer, and more recent trends in virus cases and deaths, do not change the fundamental fact that was apparent in my earlier brief: *both U.S. employment and health outcomes during the pandemic have been worse than what we find in virtually all other high-income countries around the world.*

Some questions and a few caveats are now in order. First, is it more appropriate to use employment outcomes rather than other economic data, like real GDP changes or household income? And, if so, is the unemployment rate the best labor market indicator to use?

I believe the answers to these questions are “yes” and “yes,” though measured unemployment rates are far from perfect. It is true that changes in real GDP in the U.S. have been more in line with those of other OECD countries; and household incomes had been maintained until recently because of relief through the CARES Act from last spring, especially through enhanced Unemployment Insurance benefits (from the Pandemic Unemployment Assistance and Pandemic Unemployment Compensation programs, or PUA and PUC).

But employment changes are an immediate and growing concern to many workers, who now risk permanent job separation more than before. Other countries have made much greater use than we have of payroll subsidies that keep workers connected to their jobs; in the U.S., the Payroll Protection Program (PPP) has expired, and was never as widely used as comparable programs in most other countries. Also, the \$600 increases in weekly PUC payments have expired, and now are reduced to just \$300 per week (on top of being only temporarily funded from disaster assistance funds). So unemployment has become a much graver concern in the U.S. than it was last spring.

And the unemployment rate is the single employment measure most widely and frequently reported by OECD countries. In the U.S., despite the well-known limitations of the unemployment rate (known as “U3” in the monthly reports of the BLS), it has trended fairly consistently with other measures like the employment-to-population ratio and changes in payroll jobs over the past several months.^[4]

Another question about the results presented is that they reflect somewhat different time periods – with the labor market data for July and the COVID-19 cases/deaths in September. In each case, I have presented the most recently available data. But it is natural to ask whether there is at least a *correlation* between employment and COVID-19 cases in the same time period, if not a more causal one.

To ascertain the extent to which such a correlation exists, I have compiled similar data on COVID-19 cases and deaths across these countries, but as of July 15 rather than September 9. The earlier data actually tell a worse story. New cases at that point are .203 per thousand, substantially higher than those we observe in September, and new deaths

are 2.92 per million – more than twice higher than the 1.34 per million we observe in September. Both numbers in July are higher than what we find for almost any other high-income OECD country.

So, if increases in unemployment rates and new virus caseloads/deaths are correlated across the U.S. and other countries at similar times, do we believe the virus rates are *causing* higher unemployment here? Here again the likely answer is probably “yes,” at least to some extent. Our virus caseloads in the U.S. began rising in mid-June, and death rates began rising again in July, after falling through much of the late spring. At about the same time, our labor market recovery began to flatten – with job growth and unemployment declines peaking in June and falling in July.^[5] Economists at the Federal Reserve Bank, among many others, also found a flattening recovery around that time, and linked it to a resurgence of virus cases.^[6]

One final question remains that I addressed in my earlier brief in June: had the U.S. achieved the same lower unemployment rate and virus deaths as the other OECD countries, how many more jobs would American workers now have, and how many lives would have been saved? My calculations indicate that:

- An equivalent increase in the unemployment rates of the US and other wealthy OECD countries would have meant that *at least 8.6 million more Americans would be employed today*,^[7] and
- An equivalent increase in our death rates would translate into *112,540 American lives that would have been saved*.

Summary

In a brief I released in early June, I reported that the U.S. unemployment rate had risen by vastly more than those of almost all other wealthy OECD countries, and our virus caseloads and deaths per capita were higher, as of April 2020.

Our labor market has recovered somewhat since that time, though progress in fighting the virus has been uneven. Comparing recorded unemployment rates as of July in the U.S. and other wealthy OECD countries, we find that the vastly larger increases in unemployment

in the U.S. has declined somewhat relative to other countries, though ours remains much higher. And, comparing virus caseloads/deaths between the U.S. and other wealthy countries indicates much worse outcomes here as well, especially when we compare the most recent trends.

Furthermore, there is good reason to believe that our limited progress in fighting the COVID-19 virus has at least partially caused our continuing high unemployment rate. Had we been as successful in each measure as the other OECD countries, nearly nine million more Americans would be employed and over 100,000 would still be alive.

Looking at other economic measures, like real GDP or household income, would not generate as large a contrast between the U.S. and these other countries. But employment is a very meaningful measure – all the more so as relief efforts in the U.S. for unemployed workers have weakened and as more laid off workers become permanently unemployed. And the monthly unemployment rate is the most frequently reported measure of employment across OECD countries.

At least by these measures, the U.S. has experienced the worst of both worlds – very high unemployment and very high virus caseloads and deaths – during the COVID-19 pandemic.^[8]

Appendix Table 1: USA v. Other and OECD Countries (Population > 4M): Employment and Virus Outcomes in 2020

Part A. Unemployment Rates in 2020 (%)

Country	Jan	Mar	Apr	May	Jun	Jul
Ireland	4.9	5.3	5.4	4.8	5.0	5.1
Switzerland	2.6	2.9	3.3	3.4	3.2	3.2
Norway	3.7	3.6	4.1	4.6	5.2	—
USA	3.6	4.4	14.7	13.3	11.1	10.2
Hong Kong	3.4	4.2	5.2	5.9	6.2	6.1

Netherlands	3.0	2.9	3.4	3.6	4.3	4.5
Denmark	3.7	4.1	5.4	5.6	5.5	5.2
Austria	8.7	12.2	12.8	11.5	10.1	9.2
Germany	3.2	3.5	4.0	4.2	4.3	4.4
Sweden	7.5	7.1	8.2	9.0	9.8	8.9
Australia	5.3	5.2	6.2	7.1	7.4	7.5
Belgium	5.1	5.1	5.3	5.4	5.5	5.5
Canada	5.5	7.8	13.0	13.7	12.3	10.9
Finland	7.2	7.3	8.1	10.6	7.9	7.7
UK	3.9	3.9	3.9	3.9	3.9	—
Italy	9.5	8.4	7.3	8.5	9.3	9.7
South Korea	4.0	3.8	3.8	4.5	4.3	4.2
Japan	2.4	2.5	2.6	2.9	2.8	2.9
Czech Republic	3.1	3.0	3.4	3.6	3.7	3.8
Israel	3.6	3.4	3.5	4.3	4.6	4.6

Note: The sample of countries includes the 25 richest OECD countries (in per capita terms) with at least 4 million people. Countries reporting unemployment quarterly rather than monthly and Saudi Arabia (for which few economic data are available) are excluded. Unemployment rates are obtained from Trading Economics (www.tradingeconomics.com) on September 9.

Appendix Table 1 (Cont'd)

Part B. Virus Cases in USA v. Other OECD Countries

Country	Cases/1,000	New Cases/1,000	Deaths/1,000	New Deaths/1,000,000
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Ireland	6.14	0.062	0.363	0.204
Switzerland	5.21	0.028	0.235	0.465
Norway	2.15	0.019	0.049	0
USA	19.11	0.080	0.573	1.344
Netherlands	4.67	0.064	0.037	0.058
Denmark	3.30	0.043	0.11	0
Austria	3.34	0.058	0.083	0.111
Germany	3.05	0.016	0.112	0.060
Sweden	8.57	0.015	0.584	0.100
Australia	1.04	0.004	0.031	0.433
Belgium	7.75	0.032	0.862	0.261
Canada	3.60	0.039	0.244	0.186
Finland	1.52	0.002	0.061	0
UK	5.23	0.037	0.615	0.472
Italy	4.64	0.023	0.589	0.166
South Korea	0.42	0.003	0.007	0.059
Japan	0.58	0.004	0.011	0.166
Czech Republic	2.79	0.109	0.041	0.374
Israel	16.00	0.417	0.121	1.628

Note: The sample here is the same as in Part A, except it excludes Hong Kong, for which virus data are not available. COVID-19 case numbers are obtained from Johns Hopkins University Coronavirus Resource Center (www.coronavirus.jhu.edu) on September 9. “New cases” and “new deaths” are defined as 7-day moving averages.

Footnotes

1. Four of the original countries report only quarterly unemployment data, and I have removed them from the sample.
2. The unemployment data appear in the online website Trading Economics (<https://tradingeconomics.com/country-list/unemployment-rate?continent=europe>). The virus caseloads

and death data appear in the Johns Hopkins University coronavirus website:

(<https://coronavirus.jhu.edu/data/new-cases>). Data on unemployment rates for each country appear in the former website, except for the UK and Norway (since unemployment rates there were not yet available for July). Data on virus cases and deaths appear at the latter website except for Hong Kong, which no longer appears in these data.

3. 3 The means of unemployment rates and virus caseloads/deaths across the other OECD countries are unweighted, rather than weighted by country population. This enables each country to count equally in comparison to the U.S.
4. 4 In April, the unemployment rate peaked at 14.7 percent, the employment/population ratio bottomed out at 51.3 percent, and payroll jobs had dropped to 130.3 million. By July, all three measures had recovered by approximately 40 percent, relative to their values in January or February.
5. 5 In June, the unemployment rate fell by 2.2 percentage points, compared to May, while employment/population rose by 2.2 percentage points and payrolls grew by 4.8 million. In July, unemployment dropped by 0.9 percentage points, the employment rate rose by just 0.5 points, and payrolls by 2.3 million.
6. 6 For instance, see the comments made by Fed chairman Jay Powell in late July:
<https://www.marketwatch.com/story/fed-sees-some-pickup-in-economy-but-maintains-dovish-policy-stance-2020-07-29>
7. 7 The 8.6 million job figure assumes a constant labor force participation rate, though we know our labor force participation rate has declined. Had there been no labor force decline, the higher number of employed workers would be 8.9 million. Since the other OECD countries likely suffered some labor force reductions as well, the true higher number of jobs that would exist in the U.S. is likely somewhere in between 8.6 and 8.9 million.

COVID-19 Racial Disparities in Testing, Infection, Hospitalization, and Death: Analysis of Epic Patient Data

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Summary

Summary

This analysis builds on a continually growing body of research (<https://www.kff.org/disparities-policy/issue-brief/racial-disparities-covid-19-key-findings-available-data-analysis/>) on racial disparities in COVID-19 by examining testing, infection, hospitalization, and death by race and ethnicity among patients in the Epic health record system. It contributes to the research in this area by providing insight into the experiences of a large patient population across a range of states and health systems, examining variation in the level of care patients required at the time they tested positive for COVID-19 by race and ethnicity, and assessing the extent to which underlying sociodemographic characteristics and health conditions explain racial disparities in hospitalization and death. Overall, it shows that, despite being at increased risk of exposure to the virus, people of color did not have markedly higher testing rates compared to White patients and were more likely to be positive when tested and to require a higher level of care at the time they tested positive. Moreover, it builds on previous research showing people of color have higher rates of hospitalization and death due to COVID-19 by finding that these disparities persist after controlling for sociodemographic characteristics and underlying health conditions. Key findings include:

- **Differences in testing rates by race and ethnicity were small, but people of color were more likely, compared to White patients, to be positive when tested and to require a higher level of care at the time they tested positive for COVID-19.** Although there were not large differences in testing by race and ethnicity, among those tested, Hispanic patients were over two and a half times more likely to have a positive result (311 per 1,000) and Black and Asian patients were nearly twice as likely to test positive (219 and 220 per 1,000, respectively) compared to White patients (113 per 1,000). Further, larger shares of Black, Hispanic, and Asian patients were in an inpatient setting when they tested positive for COVID-19 compared to White patients, and they also were more likely to require oxygen or ventilation at the time of diagnosis.

- **Black, Hispanic, and Asian patients had significantly higher rates of infection, hospitalization, and death compared to their White counterparts.** The infection rate for Hispanic patients was over three times higher than the rate in White patients (143 vs. 46 per 10,000), and the rate among Black patients was over two times as high (107 per 10,000). The hospitalization rate for Hispanic patients was more than four times as high as the rate in White patients (30.4 vs. 7.4 per 10,000), and the rate in Black patients was over three times as high (24.6 per 10,000). Death rates for both groups were over twice as high as the rate for White patients (5.6 and 5.6 compared to 2.3 per 10,000). Asian patients also faced significant disparities in these measures.
- **Racial disparities in hospitalization and death persisted among positive patients even after controlling for certain sociodemographic factors and underlying differences in health, with Asian patients exhibiting the highest relative risk.** Among patients who tested positive for COVID-19, Black, Hispanic, and Asian patients remained at higher risk for hospitalization and death compared to White patients with similar sociodemographic characteristics and underlying health conditions. Asian patients were at the highest risk relative to White patients, followed by Hispanic and Black patients.

As previously documented (<https://www.kff.org/coronavirus-covid-19/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/>), the higher infection rate among people of color likely reflects their increased risk of exposure to coronavirus due to their work, living, and transportation situations. They are more likely to be working in low-income jobs that cannot be done from home, to be living in larger households in densely populated areas, and to utilize public or shared modes of transportation. Despite being at increased risk of exposure to the virus, people of color did not have markedly higher testing rates compared to White patients and were more likely to be positive when tested and to require a higher level of care at the time they tested positive for COVID-19. These findings suggest that people of color may face increased barriers to testing that contribute to delays in them obtaining testing until they are in more serious condition.

The higher hospitalization and death rates among patients of color, in part, reflect higher infection rates and higher rates of underlying health conditions (<https://www.kff.org/coronavirus-covid-19/issue-brief/low-income-and-communities-of-color-at-higher-risk-of-serious-illness-if-infected-with-coronavirus/>) as well as social and economic inequities and barriers to care. However, the persistence of disparities after controlling for COVID-19 infection, certain sociodemographic factors, and underlying health conditions show that differences in these underlying factors do not fully explain the disparities in hospitalization and death. This finding suggests that other factors, including racism and discrimination, are negatively affecting their health outcomes through additional avenues.

Together, the findings point to the importance of considering health equity in COVID-19 response and relief efforts and health care more broadly, and, in particular, improving access to testing before individuals develop severe illness in order to slow the spread of infections. They also illustrate the importance of considering a wide array

of factors both within and beyond the health care system and addressing structural and systemic racism and discrimination as root causes as part of efforts to address health disparities. These efforts will be key for narrowing the disparate effects of COVID-19, ensuring equitable distribution of treatments and a vaccine as they are developed, and preventing widening disparities in health care more broadly looking forward.

Issue Brief

Introduction

A continually growing body of research (<https://www.kff.org/disparities-policy/issue-brief/racial-disparities-covid-19-key-findings-available-data-analysis/>) consistently shows people of color are bearing a disproportionate burden of COVID-19 cases, deaths, and hospitalizations and that they may face barriers to testing. For example, KFF analysis (<https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address-coronavirus/>) of state reported data shows that Black individuals account for more cases and deaths relative to their share of the population in most states reporting data. Other analysis of state-reported data (<https://www.apmresearchlab.org/covid/deaths-by-race>) finds higher mortality rates among Black and American Indian and Alaska Native (AIAN) people, disparities for Asian and Native Hawaiian and Pacific Islander (NHOPI) individuals in certain areas, and a recent rise in mortality rates for NHOPI and Hispanic people. Data (<https://www.cdc.gov/coronavirus/2019-ncov/covid-data/images/July-28-Race-Ethnicity-COVIDNet.jpg>) also show that Black, Hispanic, and AIAN people are at increased risk of hospitalization due to COVID-19. Information on testing by race and ethnicity has been limited but suggests people of color may face increased barriers to testing.

This analysis builds on this body of research by examining COVID-19 testing, infection, hospitalization, and death as of July 2020 by race and ethnicity among active patients in the Epic health record system, which includes 53 health systems representing 399 hospitals across 21 states (see Methods for more details). It contributes to the research in this area by providing insight into the experiences of a large patient population across a range of states and health systems, examining variation in the acuity of patients by race and ethnicity at the time they test positive for COVID-19, and assessing whether racial disparities in hospitalization and death persist after controlling for sociodemographic characteristics and underlying health conditions.

Overview of the Epic Patient Population

The analysis is based on Epic Health Research Network (EHRN) and KFF analysis of data for roughly 50 million patients in the Epic health record system who have interacted with the health system in the past two years and have known race and ethnicity. Findings are presented for Black, Hispanic, Asian, and White patients. Due to data

limitations, we do not present findings for smaller population groups, including AIAN and NHOPI patients, or people who report multiple races. As availability of data for smaller population groups increases over time, it may allow for future analyses focused on the experiences of these populations.

The Epic active patient population includes somewhat higher shares of Black and White patients and lower shares of Hispanic and Asian patients compared to the total U.S. population. For example, among the Epic active patient population, 15% of patients are Black, 10% are Hispanic, 3% are Asian and 69% are White. Among the total U.S. population, 13% of individuals are Black, 19% are Hispanic, 6% are Asian, and 60% are White. Just over half of the active patient population is female (54%), similar to the share of the overall U.S. population (51%). The active patient population includes a smaller share of children under age 19 compared to the total population (13% vs. 24%) and a larger share of adults age 65 or older (24% vs. 16%).

Key Findings

We examined overall rates of testing, infection, hospitalization and death associated with COVID-19 among the total active population by race and ethnicity. In addition, we assessed the share of positive cases among individuals tested and the level of care individuals required at the time they tested positive by race/ethnicity.

Testing, Positivity Rates, and Level of Care at Time Tested

There were small differences in rates of testing by race and ethnicity. Black and Hispanic patients were slightly more likely to be tested compared to White patients (489 and 461 vs. 408 per 10,000) while the testing rate among Asian patients was lower compared to White patients (345 vs. 408 per 10,000) (Figure 1).

Figure 1: COVID-19 Testing Rate among Active Epic Patients by Race/Ethnicity, as of July 2020

Among those tested, Black, Hispanic, and Asian patients were more likely than White patients to test positive for the virus. Hispanic patients had the highest positivity rate, which was over two and half times higher than the rate for White patients (311 vs. 113 per 1,000) (Figure 2). Black and Asian patients were nearly twice as likely to test positive (219 and 220 per 1,000, respectively) compared to White patients (113 per 1,000).

Figure 2: Positive COVID-19 Test Rate Among Active Epic Patients by Race/Ethnicity, as of July 2020

Black, Hispanic, and Asian patients also required a higher level of care at the time they tested positive for COVID-19 compared to White patients. Larger shares of Black, Hispanic, and Asian patients were in an inpatient setting when they tested positive for COVID-19 compared to White patients (Figure 3). They also were more likely to require oxygen or ventilation at the time of they tested positive.

Figure 3: Level of Care at Time Patient Tested Positive for COVID-19 among Active Epic Patients by Race/Ethnicity, as of July 2020

Infection, Hospitalization, and Death Rates

Overall, Black, Hispanic, and Asian patients had significantly higher rates of infection compared to White patients. Infection rates among Black and Hispanic patients were over two and three times higher, respectively, compared to the rate for White patients (107 and 143 vs. 46 per 10,000) (Figure 4). The infection rate among Asian patients was also significantly higher than the rate for White patients (76 vs. 46 per 10,000).

Figure 4: COVID-19 Cases among Active Epic Patients by Race/Ethnicity, as of July 2020

Black, Hispanic, and Asian patients also had significantly higher rates of hospitalization and death due to COVID-19 compared to White patients. The hospitalization rates for Black and Hispanic patients were over three and four times higher, respectively, compared to the rate for White patients (24.6 and 30.4 vs. 7.4 per 10,000), and their death rates were over twice as high as the rate for White patients (5.6 and 5.6 vs. 2.3 per 10,000) (Figure 5). Asian patients also faced significant disparities in these measures.

Figure 5: COVID-19 Hospitalization and Death Rates among Active Epic Patients by Race/Ethnicity, as of July 2020

Risk of Hospitalization and Death by Race/Ethnicity

Building on our examination of hospitalization and death rates, we conducted statistical analysis to assess whether racial disparities in hospitalization and death persist after controlling for certain sociodemographic characteristics and underlying conditions that are known to increase risk of illness and death. This analysis provides insight into the extent to which racial disparities in hospitalization and death are explained by differences in these underlying factors.

In this analysis, we controlled for age, sex, and health conditions that a previous [EHRN analysis](https://ehrn.org/effect-of-comorbidities-on-hospitalization-and-death-in-covid-19-patients/) (<https://ehrn.org/effect-of-comorbidities-on-hospitalization-and-death-in-covid-19-patients/>) had identified as being significantly associated with higher risk of hospitalization and death (including, hypertension, diabetes, heart failure, chronic obstructive pulmonary disease (COPD), cerebrovascular disease or stroke, and obesity). We also controlled for social vulnerability based on where each person lives, using the CDC's [Social Vulnerability Index](https://svi.cdc.gov/) (<https://svi.cdc.gov/>). The CDC's Social Vulnerability Index identifies the level of social vulnerability associated with a census area based on 15 social factors, including poverty, income, employment, education, age, household composition, housing, transportation, and racial/ethnic distribution. It was developed to help public health officials and emergency response planners identify and map the communities that will most likely need support before, during, and after a hazardous event.

Among patients who tested positive for COVID-19, people of color remained at increased risk for hospitalization and death after controlling for sociodemographic factors and underlying health conditions. Asian patients were at the highest risk relative to White patients, followed by Hispanic and Black patients. Specifically, Asian patients were 57% more likely to be hospitalized and 49% more likely to die than White patients with the same age, sex, social vulnerability, and comorbidities (Figure 6). Similarly, Hispanic patients were 53% and 30% more likely to be hospitalized and die compared to White patients with similar characteristics and underlying health conditions, and Black patients were 33% and 19% more likely to be hospitalized and die after controlling for these factors. These findings show that differences in these underlying sociodemographic factors and health conditions do not fully explain the higher rates of hospitalization and death experienced by people of color. They suggest that other factors, including racism and discrimination, are negatively affecting COVID-19 health outcomes through additional avenues that are not captured by these measures, as discussed further below.

Figure 6: Risk of Hospitalization and Death among Epic Patients who Tested Positive for COVID-19

Implications

Consistent with other research, these findings show that, among patients across a range of health systems and states, people of color were at significantly increased risk for infection from coronavirus compared to their White counterparts. As previously [documented \(https://www.kff.org/coronavirus-covid-19/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/\)](https://www.kff.org/coronavirus-covid-19/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/), people of color face increased risk of exposure to coronavirus due to their living, working, and transportation situations. They are more likely to be working in low-income jobs that cannot be done from home, to be living in larger households in densely populated areas, and to utilize public or shared modes of transportation.

Despite being at increased risk of exposure to the virus, people of color did not have markedly higher testing rates compared to White patients and were more likely to be positive when tested and to require a higher level of care at the time they tested positive for COVID-19. These findings suggest that people of color may face increased barriers to testing that contribute to delays in them obtaining testing until they are in more serious condition compared to White patients. Other [research \(https://www.kff.org/report-section/racial-disparities-in-covid-19-key-findings-from-available-data-and-analysis-issue-brief/\)](https://www.kff.org/report-section/racial-disparities-in-covid-19-key-findings-from-available-data-and-analysis-issue-brief/) suggests that people of color may face longer wait and travel times to access testing and have more limited access to testing within their neighborhood. Moreover, people of color are more likely to be [uninsured \(https://www.kff.org/coronavirus-covid-19/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/\)](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 to face other barriers to health care, which may contribute to delays in obtaining testing or treatment. The findings from this analysis may understate barriers to testing as they represent active patients who are already connected to a health care system. Individuals who are not connected to a health system or provider may face further barriers to testing and care.

The findings build on previous studies that show people of color are at significantly increased risk for hospitalization and death due to COVID-19 and that these disparities persist after controlling for sociodemographic characteristics and underlying health conditions. These findings, in part, reflect their higher infection rates and [higher rates of underlying health conditions \(https://www.kff.org/coronavirus-covid-19/issue-brief/low-income-and-communities-of-color-at-higher-risk-of-serious-illness-if-infected-with-coronavirus/\)](https://www.kff.org/coronavirus-covid-19/issue-brief/low-income-and-communities-of-color-at-higher-risk-of-serious-illness-if-infected-with-coronavirus/) that increase their risk of experiencing serious illness if they are infected with the virus. They also may reflect increased barriers to care, which can result in them delaying care and ultimately experiencing

more serious conditions. However, this analysis further shows that racial disparities persist among patients who tested positive for COVID-19 after controlling for age, sex, social vulnerability, and comorbidities. Given that **a wide body of research** (<https://www.healthaffairs.org/doi/10.1377/hblog20200630.939347/full/>) has demonstrated that racial health disparities are not driven by biologic differences, this finding suggests that there are other ways racism and discrimination may be negatively affecting COVID-19 health outcomes that are not captured by these measures. For example, research shows that people of color receive **poorer quality of care** (<https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrd/2018qdr.pdf>). It also shows that the **health care system's** (<https://www.abfe.org/wp-content/uploads/2016/11/The-Health-Care-Institution-Population-Health-and-Black-Lives.pdf>) historic mistreatment and abuse of communities of color and ongoing bias and discrimination among providers contribute to negative patient experiences and mistrust of the health care system. Research further suggests that chronic exposure to racism and discrimination create physiological or hormonal responses that negatively affect health (i.e., **weathering** (<https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2004.060749>)).

In sum, consistent with a **growing body of research** (<https://www.kff.org/disparities-policy/issue-brief/racial-disparities-covid-19-key-findings-available-data-analysis/>), these findings show that people of color are bearing a disproportionate burden of negative health outcomes related to the COVID-19 pandemic at every stage – rates of infection, access to testing, and severity of illness and death. Other analysis also shows that the pandemic is taking a **larger economic toll** (<https://www.axios.com/coronavirus-economy-jobs-unemployment-racial-disparities-29e3c6c4-bb43-4eaf-bf90-04697ca66b2d.html>) on people of color. While these disparities, in part, reflect social and economic inequities and underlying differences in health, the findings also show that they are not fully explained by these differences. Together, the findings point to the importance of considering health equity in COVID-19 response and relief efforts and health care more broadly, and, in particular, improving access to testing before individuals develop severe illness in order to slow the spread of infections. They also illustrate the importance of efforts to address disparities considering a wide array of factors both within and beyond the health care system and addressing structural and systemic racism and discrimination as root causes. These efforts will be key for narrowing the disparate effects of COVID-19, ensuring equitable distribution of treatments and a vaccine as they are developed, and preventing widening disparities in health care more broadly looking forward.

Methods

The analysis is based on EHRN and KFF analysis of data from the Epic health record system, which includes data for patients from 53 health systems representing 300 hospitals across 21 states. Overall, the system includes data for roughly 55 million active patients. Active patients include those who have interacted with the health

system in the past two years, as indicated by either a face-to-face visit or an order placed in their chart. The analysis was restricted to the 89% of active patients who had known race/ethnicity, resulting in a total of roughly 50 million active patients included in the analysis.

The analysis presents findings for Black, Hispanic, Asian, and White patients. Due to data limitations, we do not present findings for smaller population groups, including AIAN and NHOPI patients, or people who report multiple races. As availability of data for smaller population groups increase over time, it may allow for future analysis focused on the experiences of these populations.

We examined testing, infection, hospitalization, and death rates related to COVID-19 among active patients. In addition, we identified the level of care required at the time a patient tested positive for COVID-19 by race and ethnicity.

Further, we performed statistical analysis using data from 332,956 people who tested positive for COVID-19 to examine increased risk of hospitalization and death for Black, Hispanic, and Asian patients relative to White patients after controlling certain sociodemographic characteristics and health conditions known to increase risk of illness and death.

Specifically, we controlled for age, sex, and health conditions that a previous [EHRN analysis](https://ehrn.org/effect-of-comorbidities-on-hospitalization-and-death-in-covid-19-patients/) had identified as being significantly associated with higher risk of hospitalization and death. These conditions included hypertension, diabetes, heart failure, chronic obstructive pulmonary disease (COPD), cerebrovascular disease or stroke, and obesity. The prior EHRN analysis also suggested a significant risk for patients who were immunocompromised. However, that condition was not included in the model due to continued refinements in the definition of an immunocompromised state. In addition, we controlled for social vulnerability based on where each person lives, using the CDC's [Social Vulnerability Index](https://svi.cdc.gov/). The CDC's Social Vulnerability Index identifies the level of social vulnerability associated with a census area based on 15 social factors, including poverty, income, employment, education, age, household composition, housing, transportation, and racial/ethnic distribution. It was developed to help public health officials and emergency response planners identify and map the communities that will most likely need support before, during, and after a hazardous event. Statistical controls were performed using Cox Proportional Hazards models using 95% confidence intervals.

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Endnotes

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NOV, 06, 2020

Advances in States' Reporting of COVID-19 Health Equity Data

Emily Zylla & Sydney Bernard, SHADAC

Throughout the coronavirus pandemic SHADAC has been tracking which states are regularly reporting data that could help shed light on the health equity issues of this crisis (<https://www.shvs.org/states-reporting-of-covid-19-health-equity-data/>). Collecting disaggregated demographic data on the impact of COVID-19 is one way to [advance health equity during response efforts \(https://www.shvs.org/five-key-questions-state-health-officials-can-ask-right-now-to-advance-health-equity-during-covid-19-response-efforts/\)](https://www.shvs.org/five-key-questions-state-health-officials-can-ask-right-now-to-advance-health-equity-during-covid-19-response-efforts/). We have found that all states are reporting some data on the coronavirus (COVID-19) outbreak (<https://www.shvs.org/state-covid-19-data-dashboards/>), but the type and granularity of information varies considerably across states. In this expert perspective we provide updated interactive maps that explore the current status of all 50 states and the District of Columbia's reporting of COVID-19 case and death data breakdowns by age, gender, race, ethnicity, and health care workers; and provide an update on the status of states' reporting of hospitalization and testing data by demographic categories. We also highlight examples of states that are undertaking new, or additional, COVID-19 related data collection, reporting, or research activities to understand health disparities across populations. Finally, we summarize new federal guidance related to COVID-19 data reporting.

Current Status of COVID-19 Health Equity Reporting

The number of states reporting disaggregated COVID-19 case and mortality data has increased significantly since the start of the pandemic. All states now report race or ethnicity data for either COVID-19 cases or mortalities, a marked improvement from back in April when just over half (27) of states were reporting COVID-19 cases by race, and only 22 states were reporting COVID-19 deaths by race. Additionally, at the beginning of the epidemic only three states reported information about how the distribution of cases by race/ethnicity compared to the state's underlying population distribution. To date, 45 states are reporting their data in this way, which is helpful for understanding the extent to which COVID-19 is disproportionately impacting certain populations.

At the start of the pandemic 13 states were reporting COVID-19 cases by residence type, and only six states were reporting deaths by residence type. Today, all states report cases and deaths by residence type. Similarly, the number of states reporting the number of health care workers with positive COVID-19 cases has increased from 10 to 26, and the number of states reporting COVID-19 deaths by underlying conditions has increased from 4 to 18.

States report case and death data at varying levels of geography. All states report case data at least the county level, and 16 of those states also report case data the zip code level. Only two states do not report death data by county (Kansas and Rhode Island), and only five states report deaths at the zip code level.

We expect that as states work to comply with the new federal reporting guidance (see below), the number of states reporting disaggregated case and testing data by various indicators will continue to increase. The number of states reporting disaggregated hospitalization and testing data, however, remains low, just over half (28) of states reporting hospitalization breakdowns and only 12 states reporting some type of testing data breakdowns.

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The maps below show how states are reporting disaggregated data for positive COVID-19 cases (Figure 1) and COVID-19 mortality data (Figure 2), and can be filtered to highlight which states are reporting by each health equity category. States marked by a darker shade of color are reporting more data breakdown categories than lighter-shaded states. Clicking on a state provides a link to each state's data-reporting website along with more detailed information about which breakdowns a state is reporting.

Figure 1.

Health Equity Categories COVID-19 data reporting.

Health Equity Reporting by States: COVID-19 Case Data

Reporting Breakdown Types

Inclusive All Values

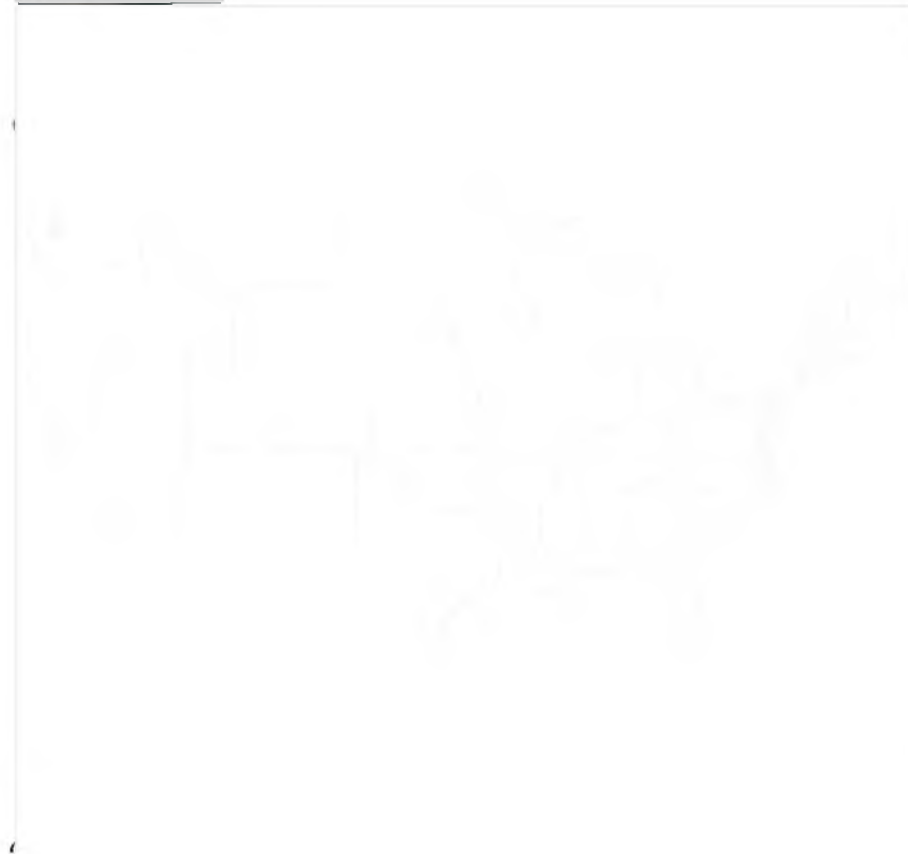


Figure 2.

Health Equity Reporting by States: COVID-19 Death Data

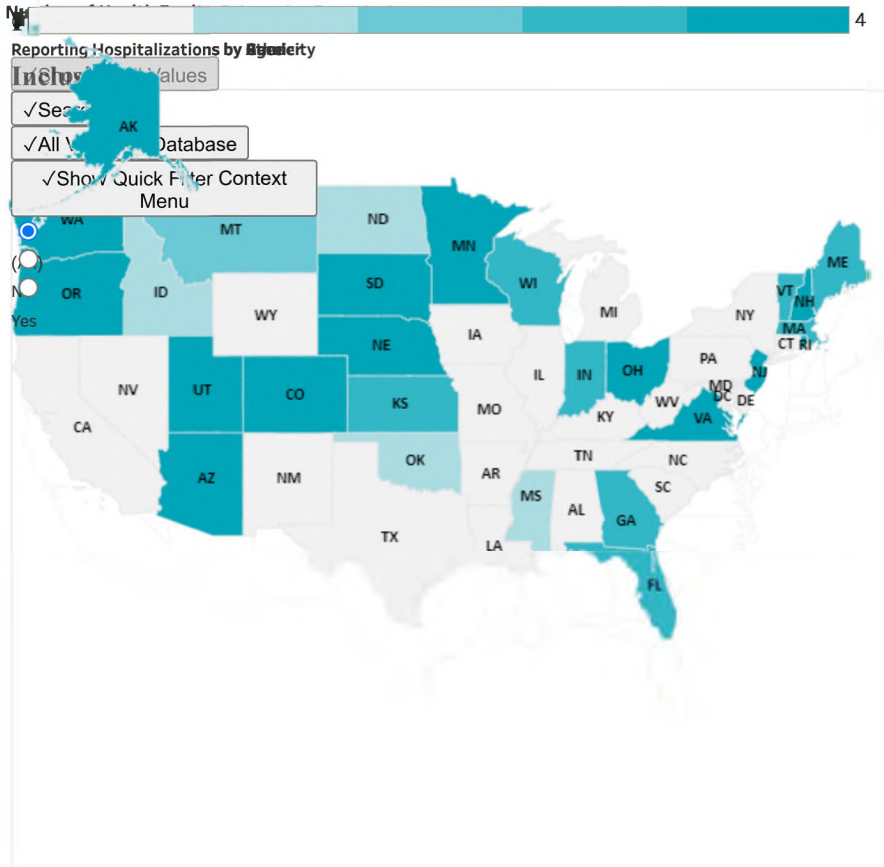


Hospitalizations

In our scan, we identified 28 states that are reporting hospitalization data for some sub populations, and of those only 23 are reporting hospitalization data by race or ethnicity. (Figure 3.)

Figure 3.

Health Equity Categories COVID-19 data reporting.



Testing

Our scan revealed nine states that are providing testing information by age or gender, and only six—Delaware, Illinois, Indiana, Kansas, Nevada, and Utah are also disaggregating testing data by race and ethnicity.

New COVID-19 Related Health Equity Data Activity

In addition to the newly required demographic data above, several states are exploring, or beginning to report, additional data. For example:

- Effective October 6th, California instituted a new health equity metric (<https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/CaliforniaHealthEquityMetric.aspx>) which will be used (along with other metrics) to determine county's reopening tier. This metric measures COVID testing positivity rate in the county's most disadvantaged neighborhoods, as defined as being in the lowest quartile of the Healthy Places Index census tracts. These neighborhoods cannot significantly lag behind the county's overall county test positivity rate. Depending a county's size it will need to meet the health equity metric and/or demonstrate targeted investments to eliminate disparities in levels of transmission.
- On September 8th, California (https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=2019202005B932) became the first state in the nation to require the collection of **sexual orientation and gender identity data** for all COVID-19 patients.
- Pennsylvania announced (<https://www.governor.pa.gov/newsroom/gov-wolf-announces-inclusion-of-gender-identity-sexual-orientation-or-expression-in-covid-19-data-collection/>) it will work with a new data collection platform to collect **sexual orientation and gender identity data**.
- Minnesota (<https://mndps.maps.arcgis.com/apps/opsdashboard/index.html#/f28f84968c1148129932c3bebb1d3a1a>) is reporting **language** needs for positive cases interviewed and language by county of residence
- Washington (<https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/data-tables/COVID-19MorbidityMortalityRaceEthnicityLanguageWASate.pdf>) is reporting case counts by **language** spoken.
- Massachusetts signed into law an act (<https://malegislature.gov/Bills/191/H4672/BillHistory?pageNumber=2>) addressing COVID-19 data collection, requiring the Department of Public Health to compile, collect, and report several demographic factors, including whether an individual hospitalized **speaks English as a second language**.

A number of states have also formed health equity task forces, several of which are charged with looking at what additional data could be collected and reported. For example:

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- Colorado: (<https://covid19.colorado.gov/covid-19-in-colorado/health-equity-response-team>) A COVID-19 Health Equity Response Team, headed by the Office of Health Equity, was formed to look at inequities and ways to prevent gaps from widening during the pandemic. One of the Response Team's tasks is to ensure racial and ethnicity COVID-19 data are accessible, transparent and used in decision-making.
- Indiana: (<http://iga.in.gov/documents/6f1d48ec>) A legislative task force, led by the Indiana Black Legislative Caucus and in collaboration with the Interagency State Council on Black and Minority Health, the Indiana State Department of Health Office of Minority Health, and the Indiana Minority Health Coalition, was charged with studying racial disparities in health care and health care outcomes as it relates to COVID-19. The Task Force recommended (<https://assets.indianahousedemocrats.org/members/Publications/IndianaHealthDisparitiesTaskForceDeliverablesReport.pdf>) the collection, stratification, analysis and reporting of race, ethnicity and preferred language data; and recommended action plans and annual reports of race, ethnicity, and preferred language outcomes.
- Louisiana (<http://www.sus.edu/page/louisiana-covid19-health-equity-task-force>): A COVID-19 Health Equity Task Force examined how health inequities are affecting communities that are most impacted by the coronavirus. The Task Force's Subcommittee on COVID-19 Data and Analysis made several recommendations in its report (<https://www.sus.edu/assets/LaCOVID/AUGUST-COVID-Task-Force-Subcommittee-Reports.pdf>), including: establishing standardized protocols to ensure that information is consistently collected across the multiple testing sites, especially those pertaining to racial and ethnic identity; ensuring data collection occurs in collaboration with trusted organizations, e.g. tribal organizations and faith-based organizations or nonprofits within the Asian community; creating a data warehouse where harmonized data can be easily extracted for analysis; and allocating resources allocated to the Louisiana Department of Health to accomplish these goals.
- Michigan: (https://www.michigan.gov/mdhhs/0,5885,7-339-71551_5460_99929---,00.html) The Michigan Coronavirus Task Force on Racial Disparities serves as an advisory board within the state's Department of Health and Human Services. Among several charges, the Task Force will: study racial disparities of COVID-19 in Michigan and recommend action to overcome the disparities; recommend actions to increase transparency in reporting data regarding the racial and ethnic impact of COVID-19 and remove barriers to accessing physical and mental health services; and ensure stakeholders are informed, educated, and empowered with information on the racial disparities of COVID-19.
- New Hampshire (<https://www.dhhs.nh.gov/omh/covid19-equity-response.htm>): The Governor's COVID-19 Equity Response Team was charged with developing a recommended strategy to address the disproportionate impacts of the COVID-19 pandemic. Initial recommendations (<https://www.governor.nh.gov/sites/g/files/ehbemt336/files/documents/equity-response-team.pdf>) included: Adopting and following best practices (outlined in the report) for equitable data collection, analysis, dissemination and utilization; dedicating staff with specific expertise in equitable data best practice methodologies; and developing internal protocols that require the use of a vetted and approved Equity Review Tool analysis for all programmatic and policy work.
- Ohio (<https://coronavirus.ohio.gov/wps/portal/gov/covid-19/families-and-individuals/MHSF/COVID-19-Minority-Health-Strike-Force>): The Minority Health Strike Force was charged with addressing the disproportionate impact of COVID-19 on minority populations in the state. The strike force was comprised of four subcommittees: data and research; education and outreach; health care; and resources. The groups' Blueprint report (<https://coronavirus.ohio.gov/static/MHSF/MHSF-Blueprint.pdf>) included data-specific recommendations to improve data collection and reporting; to have state agencies develop dashboards to monitor inequities and disparities; and to consider the need for sufficient samples to identify disparities in groups with small population sizes. The Governor's subsequent Executive Response (<https://coronavirus.ohio.gov/static/MHSF/Executive-Response.pdf>) included a commitment to: collect state-level health care quality information stratified by race, ethnicity, and language data; identify the contributing and confounding factors affecting health disparities; identify and targeting the resources where interventions may be best applied; the adoption of standards by state agencies to achieve a normalized set of data that uses the same categorization scheme; and to establish evaluation criteria of impacts to inform policy.
- Pennsylvania (<https://www.media.pa.gov/Pages/Lieutenant-Governor-Details.aspx?newsid=104>): The Pennsylvania COVID-19 Response Task Force on Health Disparity is charged with identifying obstacles that cause disparity for marginalized populations. The group collaborated with community members, stakeholders, and legislators to send recommendations (<https://www.governor.pa.gov/wp-content/uploads/2020/08/20200813-COVID-19-Health-Disparity-Report.pdf>) to the Governor for addressing issues related to a higher incidence of COVID-19 among minorities. The group recommended instituting a statewide standard around racial/ethnic data collection that mirrors the standards in the Affordable Care Act, and disaggregating Asian health data.
- Tennessee (<https://www.tn.gov/health/health-program-areas/dmhde/covid-19-health-disparity-task-force.html>): The Tennessee Department of Health, Office of Minority Health, launched a statewide Health Disparities Task Force to: examine existing data, monitor trends, and hear from those living, working and serving Tennessee communities to generate responsive solutions and policies to reduce health disparities.
- Vermont: (<https://governor.vermont.gov/press-release/governor-phil-scott-establishes-racial-equity-task-force>) A Racial Equity Task Force will undertake projects designed to promote racial, ethnic and cultural equity, including evaluating

structures of support for racially diverse populations, with a focus on the racial disparities in health outcomes highlighted by COVID-19. It will submit recommendations to the Governor on the COVID-19 project by August 15.

CARES Act Reporting Requirements

In March 2020 Congress passed, and the President signed, the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The statute required "every laboratory that performs or analyzes a test that is intended to detect SARSCoV-2 or to diagnose a possible case of COVID-19" to report the results from each such test to the Secretary of the Department of Health and Human Services (HHS), and authorized HHS to prescribe the form and manner of such reporting. On June 4, HHS released new guidance (<https://www.hhs.gov/sites/default/files/covid-19-laboratory-data-reporting-guidance.pdf>) outlining the data elements required for reporting, which included, among other elements:

- Patient age
- Patient race
- Patient ethnicity
- Patient sex
- Patient residence zip code
- Patient residence county
- If the patient is employed in health care
- If the patient is a resident in a congregate care setting (including nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting)
- If the patient is hospitalized
- If the patient is pregnant

The guidance also indicates that additional data elements may be requested by state, local, or federal health departments at any time. If required data elements are not available, providers, laboratories and public health departments are encouraged to leverage resources like state, regional, or national Health Information Exchanges or Networks to obtain missing, required information. Reporting of these data elements must begin no later than August 1, 2020. While this guidance applies to all laboratories, it does not require states or local public health departments to report COVID-19 mortality data by any specific demographic breakdowns.

Policies to Address Surprise Billing Can Affect Health Insurance Premiums

Erin L. Duffy, PhD, MPH; Bich Ly, BA; Loren Adler, MS; and Erin Trish, PhD

Surprise medical bills, which can occur in emergencies or when patients at in-network facilities are treated by out-of-network professionals, have drawn increasing public and policy attention. Although the main focus has been protecting patients from receiving these unfair—and potentially large—surprise bills, policies addressing surprise billing may affect health insurance premiums more broadly.

Most surprise bills are generated by emergency and ancillary providers, such as radiologists, anesthesiologists, pathologists, emergency physicians, emergency ground ambulances, and emergency outpatient facilities.¹⁻³ Unlike most medical services, for which patients have an opportunity to seek in-network providers, patients generally are not able to choose these emergency and ancillary providers. As a result, these providers can often remain out of network without significantly reducing their patient volume. Not only can this lead to patients receiving surprise bills, but evidence suggests that the ability to surprise-bill creates leverage that enables these providers to obtain higher in-network payments.⁴⁻⁶ For example, in a letter to Congress, the CEO of TeamHealth, a large emergency physician staffing company, plainly acknowledged that “balance billing...is a contract leveraging tool.”⁷

The expense of these high in-network payments is passed on to consumers and taxpayers through the cost of health insurance premiums. Therefore, although the surprise bills themselves are burdensome to individual patients, the higher in-network payments resulting from this leverage have a broader impact on total health care spending for consumers.

A federal policy eliminating surprise bills would influence in-network payments for this subset of providers and, in turn, influence health insurance premiums. To assess the impact of a federal surprise billing law on premiums, it is critical to quantify the share of total health plan medical claims spending attributable to the subset of services most likely affected, for which only partial estimates are available in the existing literature (to our knowledge).⁷

In this study, we evaluate the proportion of total medical health plan spending on ancillary and emergency services with the highest prevalence of surprise billing. This includes services performed by

ABSTRACT

OBJECTIVES: To quantify the proportion of health plan spending on services for which surprise billing is common—provided by radiologists, anesthesiologists, pathologists, emergency physicians, emergency ground ambulances, and emergency outpatient facilities—and estimate the potential impact of proposed policies to address surprise billing on health insurance premiums.

STUDY DESIGN: Analysis of 2017 commercial claims data from the Health Care Cost Institute, comprising 568.5 million claims from 44.8 million covered lives in 3 large US insurers: UnitedHealthcare, Aetna, and Humana.

METHODS: We calculate the share of total health plan claims spending attributable to ancillary and emergency services. Next, we estimate the premium impact of proposed federal policies to address surprise billing, which, by removing provider leverage stemming from the ability to surprise-bill, could reduce in- and out-of-network payments for these services, in turn affecting premiums. Specifically, we model the premium impact of reducing payment for these services (1) by 15% and (2) to 150% of traditional Medicare payment rates.

RESULTS: More than 10% of health plan spending is attributable to ancillary and emergency services that commonly surprise-bill. Reducing payment for these services by 15% would reduce premiums by 1.6% (\$67 per member per year), and reducing average payment to 150% of traditional Medicare rates—the high end of payments to other specialists—would reduce premiums by 5.1% (\$212 per member per year). These savings would reduce aggregate premiums for the nation’s commercially insured population by approximately \$12 billion and \$38 billion, respectively.

CONCLUSIONS: Addressing surprise billing could substantially affect commercial insurance premiums.

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TAKEAWAY POINTS

Proposed surprise-billing legislation would not only protect patients from unexpected out-of-pocket expenses, but also likely affect negotiated payments for the ancillary and emergency services that generate most surprise bills.

- ▶ More than 10% of commercial health care spending is attributable to services for which surprise billing is common: those provided by radiologists, anesthesiologists, pathologists, emergency physicians, emergency ground ambulances, and emergency outpatient facilities.
- ▶ Eliminating provider leverage stemming from the ability to surprise-bill could reduce commercial insurance premiums by as much as 5.1%, or \$212 per member per year. This could reduce aggregate premiums by approximately \$38 billion for the nation's commercially insured population.

emergency medicine professionals, radiologists, anesthesiologists, and pathologists (ERAP), as well as emergency outpatient facilities and emergency ground ambulance services. Then, we estimate the impact that potential changes in payments for these services would have on health insurance premiums.

METHODS

We analyze 2017 commercial claims data from the Health Care Cost Institute (HCCI), comprising 568.5 million claims from 44.8 million covered lives (equating to 36 million member-years) in 3 of the 5 largest US insurers: UnitedHealthcare, Aetna, and Humana.⁸ More than 90% of observed claims were in network, although there is variation across these provider types (eAppendix A [eAppendices available at ajmc.com]). We compute total plan-paid spending on professional, facility, and pharmaceutical services per member per year. We then calculate plan-paid spending attributable to ERAP professional services, identified using 2 methods: (1) HCCI provider categories and (2) Current Procedural Terminology (CPT) codes generally billed by these specialties.⁹ We also calculate the share of total plan-paid spending per member per year on outpatient emergency facility claims and emergency ground ambulance services identified by CPT codes, as recent evidence suggests that these services would be affected by surprise-billing legislation.^{2,3} Then, we estimate the impact of 2 potential changes in payments for ERAP, outpatient emergency facility, and emergency ground ambulance services on insurance premiums. We assume a baseline medical loss ratio of 90% in these estimations to align with the average ratio among large group plans, and that nonmedical spending is unchanged by policies.¹⁰

First, we analyze the impact of a 15% reduction in average payments for these services, in line with the Congressional Budget Office–estimated effects of surprise-billing legislation proposed by the Senate Health, Education, Labor, and Pensions Committee.¹¹ This proposed legislation would prohibit surprise billing and require minimum out-of-network payments equal to a health plan's median in-network payments for similar services in the same geographic region.

Second, we estimate the effects of a policy that would have the

effect of reducing payment rates for ERAP professionals and emergency service providers to 150% of Medicare's reimbursement rates for the same service. We choose this level because it is roughly the upper bound of average markups for specialists not commonly involved in surprise billing.¹²⁻¹⁴ In contrast, multiple studies estimate average in-network payments at roughly 300% of Medicare for emergency physicians, 200% of Medicare for radiologists, and 350% of Medicare for both anesthesiologists and pathologists.^{7,12,15,16} Medicare payments are intended to reflect the relative cost of

providing care, and excess commercial markups observed among ERAP professionals and emergency service providers may be driven by their ability to surprise-bill. Therefore, we expect that a policy such as network matching¹⁷—by eliminating provider leverage stemming from the ability to surprise-bill—could result in negotiated payments with markups over Medicare more similar to these other types of specialists. Although it is impossible to predict the precise magnitude of prices resulting from these policies, we estimate the premium impact of reducing average payments for these services to 150% of Medicare payments.

In this analysis, we do not compute payments as a fraction of Medicare's payment rates for each service in our data but, rather, use estimates from the literature described previously. For example, we assume that such a policy would reduce spending on radiology services by one-fourth, from 200% to 150% of Medicare's rates. For emergency ground ambulance services, we estimate that commercial plans currently pay approximately 170% of Medicare's rates (eAppendix B). We assume that emergency facility payments would face the same reduction as emergency physician payments.

RESULTS

We find that ERAP professional services account for 7.0% to 8.6% of total plan spending in 2017, depending on the definition (Table). Outpatient emergency facility claims account for an additional 3.1% of plan spending, and emergency ground ambulance services comprise 0.3% of plan spending. Average annual plan spending per member-year is \$4161 among plans in our data set, with approximately \$290 to \$357 spent on ERAP professional services, \$127 spent on emergency facilities, and \$13 spent on emergency ground ambulances.

We estimate that a 15% reduction in payments to ERAP professionals corresponds to a 0.9% to 1.2% (approximately \$37-\$50 per member-year) reduction in annual premiums per enrollee (Figure). If average in-network payments for ERAP professionals declined to 150% of Medicare rates, premiums would decline by 3.1% to 3.6% (approximately \$129-\$150 per member-year), all else staying equal.

Including emergency facilities and emergency ground ambulance services, the estimated premium reduction would increase to 1.4% to

1.6% (approximately \$58-\$67 per member-year) under the 15% payment reduction scenario and 4.5% to 5.1% (approximately \$187-\$212 per member-year) if payments declined to 150% of Medicare. Applying these premium reductions to the US commercially insured population (approximately 177 million individuals),¹⁸ we estimate that 1.6% and 5.1% reductions in insurance premiums would yield a total savings of \$12 billion and \$38 billion, respectively.

DISCUSSION

The financial burden of surprise bills for individual patients has captured public attention, but this study illustrates that provider leverage derived from the ability to surprise-bill has broader effects on health care spending—resulting in commercial health insurance premiums as much as 5% higher than they otherwise would be in the absence of this market failure. Our estimates are roughly in line with others in the literature.^{7,11}

This growing body of research indicates that policies to address surprise billing would address an important market failure that has enabled emergency and ancillary services providers to command high payment rates. Removing the ability to surprise-bill patients reduces leverage for this subset of providers in their payment negotiations with health plans. Several federal proposals employ payment standards or arbitration processes that additionally require insurers to make a minimum payment to out-of-network providers. Other policy approaches would instead address surprise medical bills by imposing “network matching” requirements, whereby emergency, ancillary, and similar professional services delivered through in-network facilities could no longer be billed on an out-of-network basis; in turn, providers of such services would have to negotiate payment with the facility and/or health plans that the facility accepts, with the ability to surprise-bill now eliminated.¹⁷

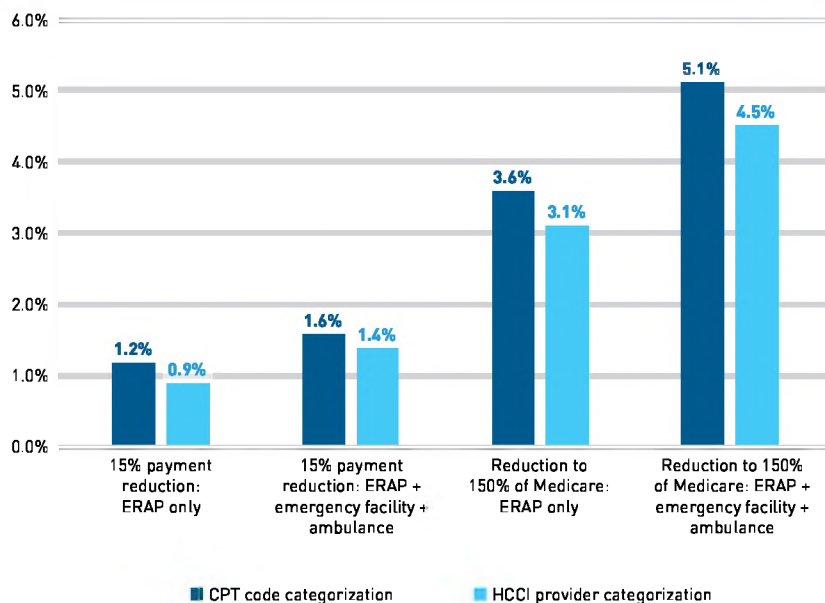
The net premium impact of any proposal would depend on the regulatory approach and generosity of any required minimum payments from health plans to out-of-network providers. If a policy were to base payment standards on something that is generally higher than payment rates today, such as provider charges, it could actually increase health insurance premiums.

TABLE. Share of Total Insurer Spending on ERAP Services Using 2 Identification Strategies

Provider category (CPT code categorization)	Share of total insurer spending	
	CPT code categorization	HCCI provider categorization
ERAP professionals		
Emergency medicine (99281-99285, 99291-99292)	1.5%	1.2%
Radiology (70010-79999, G6001-G6017, R0070-R0076)	2.3%	1.4%
Anesthesiology (00100-01999)	2.4%	2.4%
Pathology (80047-89398, P2028-P9615)	2.4%	2.0%
Sum of ERAP professional spending	8.6%	7.0%
Emergency outpatient facility		
Emergency outpatient facility (99281-99285, 99291-99292)		3.1%
Emergency ground ambulance		
Emergency ground ambulance (A0425, A0427, A0429, A0432-A0434)		0.3%
Total		
Total sum	12.0%	10.4%

CPT, Current Procedural Terminology; ERAP, emergency medicine professionals, radiologists, anesthesiologists, and pathologists; HCCI, Health Care Cost Institute.

FIGURE. Estimated Reductions in Insurance Premiums Associated With Changes in Payment for Ancillary and Emergency Services That Commonly Surprise-Bill



CPT, Current Procedural Terminology; ERAP, emergency medicine professionals, radiologists, anesthesiologists, and pathologists; HCCI, Health Care Cost Institute.

Limitations

These findings may not be generalizable beyond the 3 insurers we study, and we do not describe variation in effects across local markets. We may misattribute services to ERAP professionals, although consistent findings using 2 approaches suggest robustness. We analyze only 2 potential policy scenarios within a wider range of approaches.

TRENDS FROM THE FIELD

Although economic theory lends some intuition to the effect that different policies might have, the precise effects of different approaches on provider prices are highly uncertain and we do not account for potential secondary effects such as provider consolidation. There is also some uncertainty surrounding status quo commercial payment levels. Additional specialties may be affected by surprise-billing legislation, which would further magnify premium impacts. For example, legislation may affect inpatient facility spending incurred by patients admitted through the emergency department, but we conservatively exclude such spending from our calculations.

CONCLUSIONS

Providers affected by surprise-billing regulation—ERAPs, emergency outpatient facilities, and emergency ground ambulances—comprise more than 10% of total plan spending. Policies addressing surprise billing can meaningfully influence commercial insurance premiums. A well-designed policy to address this market failure could therefore reduce consumer health care spending. ■

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eAppendix A. Provider Network Status Summary

Provider Category (CPT Code Categorization)	CPT Code Categorization, % of claims in sample			HCCI Provider Categorization, % of claims in sample*		
	In- network	Out-of- network	Missing network	In- network	Out-of- network	Missing network
Emergency Medicine (99281-99285, 99291-99292)	74.2%	17.2%	8.6%	78.3%	14.2%	7.5%
Radiology (70010 – 79999, G6001 – G6017, R0070 – R0076)	93.5%	3.5%	3.0%	92.6%	4.7%	2.7%
Anesthesiology (00100 – 01999)	85.5%	8.5%	6.0%	87.1%	7.6%	5.3%
Pathology (80047 – 89398, P2028 - P9615)	94.4%	3.8%	1.8%	92.2%	5.6%	2.2%
Emergency Outpatient Facility (99281-99285, 99291-99292)	92.8%	5.0%	2.2%			
Emergency Ground Ambulance (A0425, A0427, A0429, A0432-A0434)	13.8%	42.5%	43.7%			
Total Sample	92.2%	4.9%	2.9%	90.2%	6.5%	3.3%

*Total sample network composition applying HCCI provider categorization includes the CPT-based definitions for emergency outpatient facility and emergency ground ambulance.

eAppendix B. Status Quo Emergency Ground Ambulance Commercial Payment to Medicare Payment Ratio

We were unable to identify recent estimates of the ratio of commercial allowed amounts to Medicare allowed amounts for emergency ground ambulance services, so we computed our own estimates using 2017 HCCI commercial claims and the Centers for Medicare and Medicaid Services' (CMS) *Medicare Provider Utilization and Payment Data: Physician and Other Supplier Public Use Files* for calendar year 2017.¹ The following HCPCs Codes were included in the analysis:

1. A0427 – Advanced Life Support Level 1, emergency transport
2. A0429 – Basic Life Support, emergency transport
3. A0432 - Paramedic Intercept (PI), rural area transport furnished by a volunteer ambulance company
4. A0433 – Advanced Life Support Level 2
5. A0434 - Specialty Care Transport (SCT)

First, we computed the average ratio of allowed amounts to charges for both commercial and Medicare services using the HCCI and CMS data, weighting by claim volume. We calculated that the average Medicare allowed amount to charge ratio is 0.418 and the average commercial allowed amount to charge ratio is 0.710. In other words, on average, Medicare pays 41.8% of billed charges and commercial health plans pay 71.0% of billed charges for emergency ambulance services.

Then, applying these values, we estimated the ratio of commercial allowed amounts to Medicare allowed amounts as:

$$\begin{aligned} & (\text{commercial allowed amount/commercial charge})/(\text{Medicare allowed amount/Medicare charge}) \\ & = 0.710 / 0.418 \\ & = 1.70 \end{aligned}$$

We concluded that commercial health plans have allowed amounts roughly 170% of Medicare allowed amounts, and we employed this status quo value in our estimates of policy impact on insurance premiums.

¹ Medicare provider utilization and payment data: physician and other supplier. CMS. Updated November 19, 2019. Accessed January 10, 2020. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Physician-and-Other-Supplier>

NASHP

States Explore Pivoting Hospital Community Benefit Requirements to Address Disparities Exposed by COVID-19

September 11, 2020 / by Anne DeBiasi, Jill Rosenthal and Allie Atkeson

States are eager to address the inequities driving disparities in COVID-19 outcomes among racial and ethnic minorities and other historically marginalized populations. One lever available to state policymakers is to require nonprofit hospitals to address health inequities in the community investments they must make in exchange for their significant tax exemptions.

Federal regulations

[\[https://www.nashp.org/states-work-to-hold-hospitals-accountable-for-community-benefits-spending/\]](https://www.nashp.org/states-work-to-hold-hospitals-accountable-for-community-benefits-spending/)

currently do not require nonprofit hospitals to address health disparities in their community benefit investments and research shows the majority do not. However, some states and hospitals are going beyond federal requirements to pivot hospital community benefit investments toward equity goals, particularly in light of COVID-19. Their initiatives

What are federal community benefit requirements?

In exchange for their federal tax-exempt status, nonprofit hospitals must conduct community health needs assessments every three years and provide community benefits. As the health care landscape changes, state policymakers are revisiting state policy levers to ensure that hospitals' investments align with community needs and state health priorities, including addressing underlying inequities exposed by the pandemic.

demonstrate that state-level community benefit regulations are an opportunity to:

- Align hospital investments with the needs of their communities;
- Address the lack of focus on equity in existing community benefit strategies and investments; and
- Ensure responsible use of the nonprofit hospital charitable tax exemption.

How Hospitals Address COVID-19 Inequities

Hospitals are on the front lines of this pandemic; many struggle to meet surge demands for care, which are straining hospital staff and budgets. Despite these challenges, some hospitals are also reaching out to their communities and creating partnerships to improve access to COVID-19 testing and treatment for populations that have been disproportionately impacted.

The Catholic Health Association [<https://www.chausa.org/communitybenefit/what-counts>] has outlined how hospitals can shift their community benefit programs to respond to the pandemic through community health improvement activities, such as:

- Promoting awareness and education activities for the community and first responders (e.g., telephone hotlines, public service announcements, and media responses);
- Charging only nominal fees for services or screenings for COVID-19 and flu immunizations, and improving access through mobile units and off-site testing;
- Having executive and other employee time dedicated to planning for and recovering from the public health emergency;
- Providing community mental health services;
- Launching interventions to address the social needs of the community (e.g., social and environmental improvements, such as reducing food and housing insecurity); and
- Establishing command centers specific to disaster readiness.

These community health improvement activities have the potential to help address the underlying inequities leading to disparities in COVID-19 and other health outcomes. This represents a sea change as most hospitals have not addressed the equity concerns [<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0033>] that communities raise, and community health improvement activities represent only 0.37 percent of total community benefit spending, according to 2014 IRS data [<https://www.chausa.org/docs/default-source/community-benefit/report-to-congress-on-private-tax-exempt-taxable-and-government-owned-hospitals.pdf?sfvrsn=0>].

There are some examples of hospitals that do address COVID-19 inequities through community health improvement services. These bright spots exemplify the importance of:

- Responding to community health needs identified by community residents;
- Partnering with community-based organizations that serve and have the trust of historically marginalized populations; and
- Leveraging hospital data to identify needs, as well as the critical importance of addressing social determinants of health, such as education and employment.

These examples demonstrate ways that hospitals can address equity.

- Children’s Hospital of Philadelphia [<https://www.chop.edu/centers-programs/healthier-together/about>] partnered with the Philadelphia Housing Authority (PHA) and a local catering company to provide free family dinners at two PHA locations in West Philadelphia from April through June.
- MetroHealth [<https://www.aha.org/other-resources/2020-03-19-metrohealth-and-partners-deliver-fresh-produce-during-pandemic>] (Cleveland) Institute for HOPE and the Greater Cleveland Food Bank are partnering to deliver fresh produce directly to patients’ homes. The hospital identified patients who most need the food deliveries by looking at its top utilizer zip codes and identifying people who had been regularly visiting its on-site food distribution.
- Kaiser Permanente [<https://www.aha.org/other-resources/2020-03-19-kaiser-permanente-earmarks-1m-homeless-covid-19-response>] has dedicated \$1 million to increase capacity for preventing and treating COVID-19 among the

homeless. Kaiser has partnered with National Health Care for the Homeless Council to make grants to local homeless shelters to increase their capacity for services and outreach.

Community Benefit Obligations of Nonprofit Hospitals during the Pandemic

Nonprofit hospitals have a mandated Internal Revenue Service (IRS) obligation to provide community benefit, even if they are struggling to meet the demands of COVID-19. In 2011, hospitals benefited from at least \$24.6 billion [<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.1424>] in tax exemptions, according to a 2015 analysis that used the most recent data available. In lieu of these taxes, hospitals are required to provide community benefits.

According to a recent study

[<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2766544>], community benefit spending remained flat between 2011 and 2017, and community benefits may shrink as hospitals grapple with diminishing bottom lines amid the pandemic.

Every three years, the IRS requires nonprofit hospitals to complete a community health needs assessment (CHNA) with input from a public health department and medically underserved, low-income, and minority populations in their communities.

It is particularly challenging to engage residents and community leaders in this time of social distancing when many hospital staff are working at or over capacity to respond to COVID-19. Some nonprofit hospitals have been granted an extension [<https://www.aha.org/news/headline/2020-07-15-irs-extends-deadline-hospitals-complete-community-health-needs-assessments>] until the end of the year to complete their scheduled CHNAs. Others may choose to do a limited or rapid needs assessment to update their pre-COVID-19 assessments. However, if CHNAs are not completed or are not updated to take COVID-19 into account, it raises the question of how hospitals will respond to urgent community needs and continue to meet the requirements of their tax-exempt status.

CHNAs have been the key method states have used to ensure that hospital community benefit investments are directed toward current community needs, as expressed *by* communities. Some states, as detailed below, go beyond the federal

requirements through legislation and licensure to explicitly require that hospitals tie their community benefit implementation plans to their needs assessments. As COVID-19 reveals long-standing health inequities, it is more important than ever that hospitals work with residents to identify and address community needs and underlying inequities.

Currently, a focus on equity in community benefit strategies and investments in CHNAs is lacking – though equity is raised when assessing community needs. A [2016 study](https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0033) [<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0033>] of urban nonprofit hospital CHNAs found that 65 percent cited health disparities or health equity explicitly, 100 percent referenced health equity implicitly, and 75 percent reported that external stakeholders identified health equity as a need. Yet, only 46 percent prioritized health equity in their CHNAs and a mere 9 percent of the hospitals' implementation strategies included activities explicitly designed to improve health equity.

States are beginning to address this disconnect because equity is a demonstrated, high-priority need that the pandemic has laid bare. Community benefit is a lever states are beginning to pull.

Current State Efforts to Leverage Community Benefit Investments

States are continuing, even now, to leverage hospital community benefit requirements and hold hospitals accountable to invest in community health improvement. They're using a variety of state levers, including state licensure and certificate/determination-of-need approval processes.

This is especially important now because charity care – a component of community benefit – may increase due to the economic downturn. States that want hospital community benefit programs to also focus on addressing community needs and social determinants of health will need tools to communicate their expectations and monitor modifications.

States are going beyond the federal community benefit requirements to ensure:

- Authentic and meaningful community engagement and input;
- A focus on identifying, tracking, and reducing disparities identified in CHNAs;

- Community benefit spending advances state priorities as identified in CHNAs and statewide health improvement plans;
- Hospitals work with public health to align assessment and tap the capacity of public health to address health equity and social determinants of health;
- Investments in equity are in alignment with state-supported, local, cross-sector collaboratives addressing health equity; and
- Hospital community benefit reporting that makes transparent the connection between real investments and identified community needs.

Ensuring Authentic and Meaningful Community Engagement and Input

States can work to ensure that hospitals truly seek out and act [<https://www.nashp.org/how-states-keep-community-at-the-center-of-hospitals-community-health-needs-assessments/>] on meaningful input from a wide range of community representatives. Prior to the outbreak of COVID-19, Maryland enacted legislation [<http://mgaleg.maryland.gov/mgaweb/legislation/details/SB0774?ys=2020RS>] (effective July 1, 2020) requiring its Health Services Cost Review Commission to establish a Community Benefit Reporting Workgroup and to adopt regulations based on workgroup recommendations. This law expands on the federal requirements for community engagement by requiring that the workgroup *include* people impacted by hospital community benefit spending. The law also requires hospitals to not only solicit and take into account input from individuals who represent the interests of their communities, but also to conduct their CHNAs *in consultation with community members* [<https://www.nashp.org/wp-content/uploads/2019/04/State-Requirements-or-Guidelines-for-Community-Involvement-in-Community-Health-Needs-Assessments-4-10-2019.pdf>], which may look different due to COVID-19, but remains critical.

In addition, four states (California, New Hampshire, New York, and Rhode Island) statutorily require that certain communities or groups, such as community organizations, members of the public, or racial and ethnic minorities, be represented [<https://www.nashp.org/how-states-keep-community-at-the-center-of-hospitals-community-health-needs-assessments/>] in the CHNA, above and beyond what the federal government requires. A Texas statute encourages hospitals to consult with certain groups or entities when assessing community needs.

Researchers have also recommended that states require engagement of community members and organizations in the development of community benefit implementation plans [<https://journalofethics.ama-assn.org/article/how-should-nonprofit-hospitals-community-benefit-be-more-responsive-health-disparities/2019-03>], in addition to the CHNA.

Community health improvement initiatives are proven to be more effective when communities are engaged [https://www.researchgate.net/publication/273495641_The_effectiveness_of_community_analysis] throughout the process. The examples above illustrate some strategies for engaging the community in needs assessment and are feasible even during a pandemic. Hospitals can develop partnerships with community organizations that serve and have the trust of vulnerable communities. They can also analyze patient data to identify needs and combine them with direct input from community members.

Identifying and Tracking Reductions in Disparities in CHNAs

Maryland requires CHNAs to describe a hospital's effort to track and reduce disparities in the community. Requiring efforts to address health disparities as part of state community benefit requirements is a critical policy to improve equity [<https://journalofethics.ama-assn.org/article/how-should-nonprofit-hospitals-community-benefit-be-more-responsive-health-disparities/2019-03>], yet is not a federal requirement nor are disparities even mentioned in the federal regulations.

Addressing Community Needs and Advancing State Priorities

States are working to ensure that community benefit implementation plans address the needs identified by the CHNA process using strategies for engaging the community in needs assessment. Maryland's new law requires hospitals to submit an annual report describing how each of the activities undertaken by the hospital addresses the community health needs of the hospital's community, a description of gaps in the availability of providers to serve the community, and a list of the unmet community health needs identified in the most recent CHNA. Although this law is new, other states may find it a useful model for tying community benefit investments to documented needs.

Some states have aligned their community benefit requirements with State Health Improvement Plans (SHIPs) developed by public health departments. New York [<https://www.hilltopinstitute.org/wp-content/uploads/publications/CommunityBenefitStateLawProfiles-January2015.pdf>] requires that hospital Community Health Improvement Plans specifically address goals contained in its SHIP, known as the Prevention Agenda 2019-2024 [https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/]. New York also requires hospitals to report their community benefit spending, and how it relates to its prevention agenda. Improvement plan.

Massachusetts [<https://www.nashp.org/wp-content/uploads/2019/04/State-Requirements-or-Guidelines-for-Community-Involvement-in-Community-Health-Needs-Assessments-4-10-2019.pdf>] has aligned community benefit requirements with state health priorities by tying the Department of Public Health's Determination of Need process to standards for community engagement and social determinant of health investing. While the process is currently underway, the Massachusetts Attorney General's office is considering how to give nonprofit hospitals the flexibility to bring an equity lens to addressing the needs revealed by COVID-19.

Promoting Collaboration with Public Health Departments

New York encourages hospitals to work with public health departments on both their CHNAs and the related community health improvement plans. This link to public health is a key policy to ensure the capacity to address health equity, which is a foundational principle [<https://www.healthypeople.gov/2020/about-healthy-people/development-healthy-people-2030/framework>] of public health. The authors of the 2016 study of CHNAs [<https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0033>] conclude that hospitals might have the will to promote health equity, but not necessarily the know-how.

Working with public health departments is also important to reduce duplication, considering both nonprofit hospitals and public health departments conduct regular community health needs assessments. Maryland requires hospitals to consider the most recent community needs assessment developed by the state or local health department when identifying community health needs. Five states go

further [<https://www.nashp.org/how-states-keep-community-at-the-center-of-hospitals-community-health-needs-assessments/>] (ME, MA, NH, NY, and TX), requiring or encouraging local public health officials to be involved in the community needs assessment process.

Aligning Community Benefit with Local Health Improvement Coalitions

In 2015, Rhode Island began implementing [Health Equity Zones](http://www.amchp.org/AboutAMCHP/Newsletters/Pulse/Pages/Building-Healthy-Communities.aspx) [<http://www.amchp.org/AboutAMCHP/Newsletters/Pulse/Pages/Building-Healthy-Communities.aspx>] (HEZs) which now exist in 10 communities across the state [https://health.ri.gov/programs/detail.php?pgm_id=1108]. HEZs [<https://health.ri.gov/publications/brochures/HealthEquityZones.pdf>] are geographic areas where the Rhode Island Department of Health invests a blend of funding streams to address differences in health outcomes. Local, cross-sector coalitions conduct a collaborative, community-driven needs assessment and implement a plan to address the identified needs. For example, the Southside, Elmwood, and West End Health Equity Zone in Providence galvanized residents to advocate for housing as a social determinant of health, achieving the remediation of several blighted properties, hosting a Neighborhood Housing Summit, and advancing equitable housing policy.

Rhode Island [<https://www.phi.org/press/investing-in-community-through-rhode-islands-health-equity-zones/>] (prior to COVID-19) required two hospitals to invest in their local HEZs and collaborate with them on their CHNAs as a condition of approval for changes sought under the Hospital Conversions Act, which governs changes in hospital ownership and significant reductions in certain hospital services. Although not directly tied to community benefit, the advent of [Rhode Island's Health Equity Measures](https://health.ri.gov/publications/reports/2020CommissionForHealthAdvocacyAndEquityL) [<https://health.ri.gov/publications/reports/2020CommissionForHealthAdvocacyAndEquityL>] this year creates additional opportunities for alignment between the HEZs, the state's health equity goals, measures, and hospital community benefit.

Establishing Transparent Reporting that Ties Investments to Community Need

Maryland requires nonprofit hospitals to submit an annual community benefit report including a list of the initiatives that were undertaken by the hospital and the cost of each. New York asks hospitals to report itemized community benefit

spending. [Connecticut \[https://www.milbank.org/2019/07/states-put-hospital-community-benefits-requirements-to-work-for-population-health-improvement/\]](https://www.milbank.org/2019/07/states-put-hospital-community-benefits-requirements-to-work-for-population-health-improvement/), as a part of its certificate-of-need process, similarly requires that hospitals identify community benefit dollars spent on specific needs identified in their CHNAs. [New Hampshire and Vermont \[https://www.nashp.org/states-use-a-sharper-lens-to-scrutinize-nonprofit-hospitals-community-benefit-spending/\]](https://www.nashp.org/states-use-a-sharper-lens-to-scrutinize-nonprofit-hospitals-community-benefit-spending/) also require hospitals to report community needs from the most recent CHNA and tie these to community benefit spending.

The Way Forward

COVID-19 has drastically altered the health care landscape in the United States. As states struggle with reduced budgets and revenue, they need to leverage every resource available for community health improvement, particularly for the most vulnerable residents. Hospitals are on the frontline in communities, leading testing and treatment. Community benefit provisions hold nonprofit hospitals accountable for investing in communities in return for the federal tax breaks they receive. As hospitals pivot community benefit investments to respond to COVID-19, states can ensure that the underlying inequities exposed by the pandemic are addressed. States can develop strategies that hold hospitals accountable while balancing the many COVID-19-related demands. States can and are going beyond federal community benefit regulations to ensure that the associated investments are responsive to the needs of their most at-risk populations to reduce glaring inequities and move, ultimately, toward long-term resilience for all communities.

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SEP, 11, 2020

Updating the Essential Health Benefit Benchmark Plan: An Unexpected Path to Fill Coverage Gaps?

Sabrina Corlette, Georgetown Center on Health Insurance Reforms and Joel Ario, Manatt Health

On August 28, 2020, the U.S. Department of Health & Human Services (HHS) approved (<https://www.cms.gov/newsroom/press-releases/cms-approves-new-essential-health-benefit-benchmarks-michigan-new-mexico-and-oregon>) new essential health benefit (EHB) benchmark plans for Michigan (<https://www.cms.gov/files/document/82820-mi-ehb.pdf>), New Mexico (<https://www.cms.gov/files/document/82820-nm-ehb.pdf>), and Oregon (<https://www.cms.gov/files/document/82820-or-ehb.pdf>), bringing to five (with Illinois (https://downloads.cms.gov/cciio/State%20Required%20Benefits_IL.PDF) and South Dakota (<https://www.cdc.gov/drugoverdose/data/statedeaths/drug-overdose-death-rate-increase-2013-2017.html>)) the number of states that have revised their benchmarks in recent years. Although many stakeholders were concerned (<http://chirblog.org/future-affordable-care-act-president-trump-stakeholders-respond-proposed-2019-marketplace-rule-part-ii-consumer-advocates/>) that new rules for EHB benchmark selection adopted in the 2019 Notice of B

and Payment Parameters (<https://www.govinfo.gov/content/pkg/FR-2018-04-17/pdf/2018-07355.pdf>) (NBPP) would result in less generous benefits, these five states have modestly enhanced their benefit packages to address perceived gaps in coverage.

Moreover, these states have added benefits without triggering the Affordable Care Act (ACA) provision requiring states to defray (<https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Defrayal-State-Benefits.pdf>) any additional premium costs associated with new mandated benefits. That requirement would have applied if these states had added new benefits through legislative or regulatory action “separate from an EHB-benchmark plan selection process (<https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Defrayal-State-Benefits.pdf>).” In effect, the new benchmark selection process has created a safe harbor for expanding benefits, albeit within the limited parameters of the 2019 NBPP.

Essential Health Benefits: Statutory and Regulatory Background

The ACA requires insurers in the individual and small-group markets to cover a minimum set of ten (<https://www.healthcare.gov/coverage/what-marketplace-plans-cover/>) essential health benefits. The scope of the benefit package must be equal to that provided under a “typical” employer plan, and must take into account the health care needs of diverse segments of the population, including women, children, and persons with disabilities. The law further requires the HHS to “periodically review” the EHB package and update it to “address any gaps in access to coverage or changes in the evidence base.”

Under the previous administration, HHS largely delegated (https://www.ecfr.gov/cgi-bin/text-id.x?SID=459b60173363d23e0d6d8798479aa769&mc=true&node=se45.2.156_1100&rqn=div8) this responsibility to the states, but also required states to honor the statutory requirement that EHBs be equal to those in a typical employer plan. At the time, the typical individual market plan was significantly less generous than the typical group plan, so HHS required each state to select an existing health plan from one of 10 different group plan options to serve as a “benchmark (<https://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf>)” plan. These 10 options include:

- The largest three small-group plans available in the state;
- The largest three state employee health plans;
- The three largest national Federal Employees Health Benefits Program plan options; or
- The state’s largest commercial HMO.

The specific items and services covered under that benchmark plan would constitute the EHB in that state, although in practice many states had to supplement or adjust their benchmark to ensure coverage of all ten statutorily prescribed benefit categories, particularly for pediatric oral and vision and habilitative benefits.

While the requirement that ACA benefits mirror group benefits was designed to improve comprehensiveness of individual market plans, the ACA included another provision to deter states from adding new benefits by requiring that they pay any additional premium cost

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[SID=459b60173363d23e0d6d8798479aa769&mc=true&node=se45.2.155_1170&rgn=div8](https://www.ecfr.gov/cgi-bin/text-idx?SID=459b60173363d23e0d6d8798479aa769&mc=true&node=se45.2.155_1170&rgn=div8))

associated with any state benefit mandate enacted after December 31, 2011. This provision did not have any impact at first since the first benchmarks were state plans in existence before the 2011 deadline, and the Obama Administration did not require any state to defray costs as benchmarks were updated. Beginning in 2021, however, HHS has put states on notice that the agency will be looking more closely, with states required to submit reports annually (<https://www.shvs.org/the-final-2021-notice-of-benefit-and-payment-parameters-implications-for-states/>) listing any benefit mandates that exceed EHB.

In the 2019 NBPP, the federal Administration loosened the rules

(<https://www.govinfo.gov/content/pkg/FR-2018-04-17/pdf/2018-07355.pdf>) governing updates to the EHB package. Specifically, the rules gave states three new options for selecting a benchmark plan:

- Select a benchmark plan used by another state during the 2017 plan year;
- Replace one or more categories of EHBs with the same category or categories of EHB used in another state for the 2017 plan year; or
- Otherwise select a set of benefits to constitute the State's benchmark plan.

In addition, state benchmark selections must pass two tests. First, the statute requires that the scope of benefits be equal to those in a "typical" employer plan. Second, the 2019 NBPP states that the benchmark plan cannot "exceed the generosity" of either the benchmark plan for plan year 2017 or any of the 10 benchmark plan options the state had available for 2017. In effect, the former requirement sets a floor for the generosity of the EHB package (though the floor is potentially lower than before because states can look to employer plans in other states if they find the employer plans in their own state to be too generous). The latter requirement sets the ceiling; it only allows a state to increase the value of its EHB if the current benchmark is not the most generous of the 10 in-state options. The 2019 NBPP also allowed states to permit insurers to substitute actuarially equivalent items and services across the different benefit categories (excepting pharmacy benefits).

Most commentators on the 2019 NBPP thought the new rules tilted the playing field toward less generous EHBs. That may indeed be the long-term impact, especially since states can go outside the benefit norms in their own state to find a less generous employer plan from another state. Conversely, a state cannot look to other states to find a more generous benchmark; each state is limited to the generosity of in-state plans. Nevertheless, there are now five states that have used the new process and every one of them has used it to increase benefits.

States are Using New EHB Flexibility to Fill Gaps in their Benchmark Plans

Of these five states, four (Illinois, Michigan, New Mexico, and Oregon) have used the new process for updating the EHB benchmark plan to enhance coverage of treatments for substance use disorders (SUDs) and/or to encourage the use of non-opioid pain treatment. This is not surprising given the rising death count

(<https://www.cdc.gov/drugoverdose/data/statedeaths/drug-overdose-death-rate-increase-2013-2017.html>) from SUDs, and the medical consensus that two effective responses are to decrease barriers to medication assisted treatment (MAT) and increase access to naloxone to reverse overdoses.

The state benefit expansions have not been limited to treatment for SUDs. South Dakota, after an analysis of gaps in its benchmark plan, expanded coverage of treatments for Autism Spectrum Disorder (ASD), while New Mexico's gap analysis led the state to end coverage limits on prosthetics, expand coverage of testing for heart disease, and increase eligibility for weight loss treatment. See table below. No state has yet permitted its insurers to substitute benefits across the EHB benefit categories.

State Changes to the Essential Health Benefits Benchmark Plan, for Plan Years 2020-2022

State	Changes to Benchmark Plan Coverage	Applicable Plan Years
Illinois	<p>Adds:</p> <ul style="list-style-type: none"> At least one intranasal opioid reversal agent (naloxone) A topical anti-inflammatory medication for acute and chronic pain Telepsychiatry care <p>Limits:</p> <ul style="list-style-type: none"> Opioid prescriptions for acute pain to no more than 7 days <p>Removes:</p> <ul style="list-style-type: none"> Barriers to medication-assisted treatment (MAT) of opioid use disorder, such as prior authorization 	2020-2022
Michigan	<p>Adds:</p> <ul style="list-style-type: none"> At least one intranasal opioid reversal agent (naloxone) <p>Removes:</p> <ul style="list-style-type: none"> Barriers to MAT for opioid use disorder, such as prior authorization 	2022
New Mexico	<p>Adds:</p> <ul style="list-style-type: none"> Artery Calcification Testing Weight loss treatment for obese members Opioid Reversal Agents (naloxone) Anti-Hepatitis C Agents <p>Removes:</p> <ul style="list-style-type: none"> Benefit limits on prosthetics 	2022
Oregon	<p>Adds:</p> <ul style="list-style-type: none"> Up to 20 spinal manipulation visits per year Up to 12 acupuncture visits per year At least one intranasal opioid reversal agent (naloxone) <p>Removes:</p> <ul style="list-style-type: none"> Barriers to MAT for opioid use disorder, such as prior authorization 	2022
South Dakota	<p>Adds:</p> <ul style="list-style-type: none"> Applied Behavioral Analysis for the treatment of ASD 	2021-2022

To achieve federal approval of their new state benchmark plan, each state was required to demonstrate, through an actuarial analysis:

- that the plan is at least equal in scope to the typical employer plan and
- that it does not exceed the generosity of the most generous plan among the comparison set of 10 benchmark plan options for 2017.

The states must also provide an opportunity for public comment on their proposed changes to the benchmark plan.

Because all five states added to their base-benchmark plan, which was itself one of the group market benchmark options, they automatically satisfied the first test. For the second test, Illinois' actuaries determined that the five changes to the benchmark plan would not have a "material" impact on the premium. Actuaries for South Dakota, Michigan, New Mexico and Oregon concluded that while the new benefits would add to the benchmark plan's value, it would still not exceed the generosity of the most generous of the state's 10 benchmark plans. It is worth noting that this will only work for states that do not already use the most generous of their 10 benchmark options, and benefit enhancements will generally be relatively limited since differences in actuarial value between benchmark options tend to be small.

Looking Ahead

Since 2012, many states have been cautious about subjecting plans to new benefit mandates, out of concern that they will need to defray the additional cost. State bills to add new mandates have often either exempted ACA-regulated plans completely or included provisions sun-setting the mandate if it triggers a defrayal obligation. Yet Illinois, Michigan, New Mexico, Oregon, and South Dakota have successfully added new benefits to their EHB benchmark plans without being required to pick up the cost.

They did so by following the federally-prescribed pathway for updating the EHBs and demonstrating, through actuarial analyses, that the overall value of the new benchmark plan would not exceed the generosity of the most generous benchmark option in their state. Although many patient and consumer advocates feared the 2019 NBPP would result in less generous coverage, so far, the opposite has occurred. And federal regulators have not only approved (<https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb>) these enhanced benchmark plans, but have explicitly informed (<https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Defrayal-State-Benefits.pdf>) states that those who follow the EHB update pathway will not trigger any defrayal obligation. The deadline for submitting a proposed EHB benchmark plan for plan year 2023 will be on May 7, 2021. Although many months away, states interested in improving their EHB benchmark plan to fill gaps in consumers' access to services or to reflect changes in medical evidence may want to begin the necessary analyses soon.

The authors thank JoAnn Volk and Justin Giovannelli for their thoughtful review and comments on this post.

What Have Pandemic-Related Job Losses Meant for Health Coverage?

Cynthia Cox (<https://www.kff.org/person/cynthia-cox/>) (<https://twitter.com/cynthiacox>) and **Daniel McDermott** (<https://www.kff.org/person/daniel-mcdermott/>)
Sep 11, 2020



The coronavirus pandemic has caused a sharp increase in unemployment across the country. The unemployment rate peaked at 14.7% in April and remained above 10% until very recently. In the United States, health insurance and employment often go hand-in-hand: With the [majority](https://www.kff.org/other/state-indicator/adults-19-64/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) (<https://www.kff.org/other/state-indicator/adults-19-64/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>) of working age adults receiving coverage through an employer-sponsored plan, people who lose work due to the pandemic also risk losing their health coverage when they might need it most. An earlier [KFF brief](https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/) (<https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/>), based on unemployment figures through the start of May, estimated that roughly 27 million people were at risk of losing their job-based coverage when they or family members lost their jobs. However, at the time, it was unclear what decisions employers were making about whether to keep their workers covered (e.g. by keeping furloughed workers on health plans or by helping employees pay for COBRA continuation coverage).

Data has now become available that provide a glimpse into what has happened to enrollment among employer plans since the start of the pandemic. Surprisingly, in comparison to the nearly 9% drop in employment from March to June, early data suggests that employers had kept coverage rates remarkably steady, at least through mid-summer. We examined data that insurance companies submit to the National Association of Insurance Commissioners, compiled by Mark Farrah Associates, finding that enrollment in the fully-insured group market dropped by just 1.3% from the end of March through the end of June (Figure 1).

Figure 1

Change in Overall Employment and Fully-Insured Group Market Enrollment, March to June 2020



Note: Change in enrollment calculated only for plans that reported data for the first two quarters of 2020.
Source: Bureau of Labor Statistics and KFF analysis of data from Mark Farrah Associates Health Coverage Portal TM.



Figure 1: Change in Overall Employment and Fully-Insured Group Market Enrollment, March to June 2020

Part of the explanation for this apparent discrepancy could be that many of the people who lost employment were never enrolled in employer-based coverage in the first place, as [lower-wage workers](https://www.kff.org/report-section/ehbs-2019-section-3-employee-coverage-eligibility-and-participation/#figure39) are less likely to be covered by their employer's plan. Even so, there are some reasons this 1.3% drop may even overstate employer coverage losses during the early months of the pandemic. For years, the fully-insured group market has gradually shrunk: While the 1.3% is the largest drop in recent years and is likely largely driven by job losses, over the last several years we have seen enrollment drops from the first to second quarter of the year ranging from 0.3% to 0.7% in the fully-insured market. Also, though we do not have data on self-funded plan enrollment rates, there are reasons to suspect the types of companies that self-insure (which tend to be larger companies) were better able to weather the early financial hits and might have had fewer job losses or might have been in a better position to let their employees retain their health benefits.

The relatively low coverage losses through the end of June are consistent with data showing growth in [Medicaid enrollment](https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/) through May and relatively flat Marketplace enrollment, not yet indicative of big losses in employer coverage. If there were large coverage losses in the employer market, we previously estimated that 85% would have been eligible to move to Medicaid or the ACA Marketplaces.

From discussions with employers and benefit consultants, we have heard that some employers elected to keep furloughed workers enrolled in health coverage. As the pandemic continues it's unclear how long this can continue. Data from [BLS show](https://www.bls.gov/news.release/empsit.t11.htm) that temporarily laid-off workers made up the

vast majority of the unemployed in the spring and early summer. However, temporary layoffs have decreased, while the number of permanent job losses has increased through the summer. If this trend continues, we could see larger coverage losses later this year.

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Making Sense of Competing Estimates: The COVID-19 Recession's Effects on Health Insurance Coverage

Jessica Banthin and John Holahan

AUGUST 2020

Since March 2020, millions of U.S. workers have lost their jobs in the wake of the COVID-19 recession. Most workers in the United States get health insurance coverage through their jobs, so policymakers are looking for answers to two main questions: How many workers losing their jobs are also losing their health insurance? And how many workers losing their employer-based coverage will become uninsured? Several estimates have been published in recent months, but they vary widely and are difficult to reconcile. Because definitive data on changes in coverage are not yet available, projections can supply useful information for policymakers. But, the value of these competing estimates lies in their transparent use of available data and careful presentation of final results in the context of considerable uncertainty about when and how insurance coverage will change as a result of the COVID-19 recession.

Introduction

We discuss four analyses of the effects of the COVID-19 recession on employment-based health insurance coverage and the number of uninsured people in 2020 that were published between early May and mid-July of 2020. This is not a comprehensive list of published reports on the topic.¹ We selected these four reports because they came out early, received some media attention, or represent a certain methodological approach. Also, in these four analyses the authors are reasonably transparent about their data and methodologies, allowing us to compare their key assumptions. One of us is an author of one of these reports. The early release of projections can be helpful to policymakers, especially in the face of so much uncertainty as we are experiencing during the coronavirus pandemic. Thus, early projections that provide partial answers to the main questions can still be valuable. To help

policymakers use those early projections, however, it is important for the authors to define where their estimates fit into the larger picture of what remains unknown.

A key reason for widely varying projections, is that not all of these studies fully address the two main policy questions: how many people will lose employer-sponsored insurance and how many people will become uninsured as a result of the COVID-19 recession. One study estimates how many people will lose insurance coverage tied to a lost job, and how many of them are likely to be eligible for subsidized coverage, but stops short of projecting how many people will become uninsured (KFF). Additionally, one study focuses exclusively on the affected workers (Families USA), whereas the others include workers and family members covered as dependents under workers' health insurance policies. While all of these types of estimates can

Study name	Citation
Urban Institute 1	Garrett B, Gangopadhyaya A. How the COVID-19 recession could affect health insurance coverage. Urban Institute. May 4, 2020. https://www.urban.org/research/publication/how-covid-19-recession-could-affect-health-insurance-coverage .
KFF (Henry J. Kaiser Family Foundation)	Garfield R, Claxton G, Levitt L. Eligibility for ACA health coverage following job loss. Henry J. Kaiser Family Foundation. May 13, 2020. https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/ .
Urban Institute 2	Banthin J, Simpson M, Buettgens M, Blumberg LJ, Wang R. Changes in health insurance coverage due to the COVID-19 recession: Preliminary estimates using microsimulation. Urban Institute. July 13, 2020. https://www.urban.org/research/publication/changes-health-insurance-coverage-due-covid-19-recession .
Families USA	Dorn S. <i>The COVID-19 Pandemic and Resulting Economic Crash Have Caused the Greatest Health Insurance Losses in American History</i> . New York: Families USA; July 17, 2020. https://familiesusa.org/resources/the-covid-19-pandemic-and-resulting-economic-crash-have-caused-the-greatest-health-insurance-losses-in-american-history/ .

Table 1. Select Outcomes from the Four Studies

	Urban Institute 1	KFF	Urban Institute 2	Families USA
Number of workers losing jobs	23.4 million (15% unemployment rate)	31 million	22.4 million	21.9 million
Number of people living in families with a job loss	Not estimated	78 million	48 million	Not estimated
Number of people losing employer-based coverage	17.7–30.0 million workers and dependents	27 million workers and dependents	10.1 million workers and dependents	5.4 million workers (no estimate of affected dependents)
Number of people becoming uninsured	5.1–8.5 million workers and dependents	Not estimated	2.9 million	5.4 million workers (no estimate of affected dependents)
Number of uninsured people gaining Medicaid after job loss	Not estimated	Not estimated	500,000	Not estimated
Whether other transitions in coverage are modeled	No	No	Yes	No

Source: Authors' analysis of the above-named studies, listed as they appear in the table: Garrett B, Gangopadhyaya A. [How the COVID-19 recession could affect health insurance coverage](#). Urban Institute. 2020; Garfield R, Claxton G, Levitt L. [Eligibility for ACA health coverage following a job loss](#). Henry J. Kaiser Family Foundation. 2020; Banthin J, Simpson M, Buettgens M, Blumberg LJ, Wang R. [Changes in health insurance coverage due to the COVID-19 recession: Preliminary estimates using microsimulation](#). Urban Institute. 2020; Dorn S. [The COVID-19 Pandemic and Resulting Economic Crash Have Caused the Greatest Health Insurance Losses in American History](#). New York: Families USA; 2020.

Note: KFF is Henry J. Kaiser Family Foundation.

be useful, policymakers would ideally like to know the effects of job loss on both workers and the family members covered by workers' employment-related coverage. And to consider whether additional policy responses are needed, policymakers also want to know how well existing programs, such as Medicaid and the marketplaces, are replacing lost employer-based coverage.

Another major reason for the disparate projections is that the analyses vary in their methods along several dimensions. First, they differ by their assumptions about the extent of future employment losses. Although employment data are released monthly, and unemployment insurance claim filings are released weekly, there is much uncertainty regarding the extent of employment losses due to the COVID-19 recession. A second major difference between the studies is their assumptions regarding the timing of coverage effects, whether insurance losses happen immediately or over many months or years. One study assumes coverage losses have already occurred (Families USA), while two studies focus on the remainder of 2020 (KFF, Urban 2), and one study takes a longer time horizon and estimates

coverage changes will play out over several months to a year (Urban 1).

Third, studies also differ in their completeness. Only one of the four analyses models all possible transitions in coverage due to COVID-19-related employment losses. Unlike the other studies, the Urban 2 study estimates that some previously uninsured workers become eligible for and enroll in Medicaid following a job loss. A complete picture of the effects of the COVID-19 recession on insurance coverage would ideally include all transitions in coverage, including workers who lost their jobs but did not hold employer-based coverage before the pandemic.

We probably will not fully understand actual shifts in insurance coverage until 2021, when results from large federal household surveys conducted in 2020 are released. Even then, some of the effect of the economic disruption due to the coronavirus pandemic may continue through 2021, and not be evident until 2022. One such survey is the National Health Interview Survey, which yields one of the most reliable estimates of the number of uninsured people in the United States. In the meantime, we can glean

information from other household surveys, such as the Health Reform Monitoring Survey, the Commonwealth Fund survey, and the U.S. Census Bureau's Household Pulse Survey. However, though these surveys provide estimates in a more timely way, their smaller sample sizes and shorter questionnaires provide more limited insights into how coverage is changing. Over the coming months, we will also learn about increases in Medicaid and marketplace enrollment from administrative data released by state and federal agencies and insurers. Higher enrollment rates in those two programs may reflect two trends—reductions in income due to job loss and reductions in employer-provided health insurance.

We first present the headline estimates from each of the four studies, including brief comments on their modeling approach and the completeness of their estimates. We next discuss how differences in underlying assumptions, modeling approaches, and use of available data contribute to differing projections of the number of people losing employer-sponsored health insurance and the number of people who become uninsured. Following that, we summarize

early results from recent household surveys and discuss whether those results support estimates from the four studies. We conclude with a discussion of the value of studies like these when definitive information is not yet available.

Major Findings from the Four Studies

Urban Institute 1

This study, the earliest of the four studies examined, estimated changes in health insurance coverage under 15 percent, 20 percent, and 25 percent unemployment rates. For this comparison we restrict our focus to the 15 percent unemployment scenario because that is closest to current measures of unemployment. The authors provided two sets of point estimates based on two different econometric models of the relationship between unemployment rates and employer-based coverage from historical data. The authors found that 17.7 or 30 million people would lose employer-provided health insurance if unemployment rose to 15 percent under the two versions of their model (Table 1, row 3). These coverage losses lead to an estimated 5.1 or 8.5 million people becoming uninsured over several months to a year after the initial job losses (Table 1, row 4).

This study is the only one of the four to use an econometric approach to estimate the effects of the COVID-19 recession on coverage. The study defined two alternative econometric models to estimate the historical relationship between employer-based coverage and the unemployment rate. The authors then used data from 2014 to 2018 to estimate the resulting insurance status of people projected to lose employer coverage as a result of job loss. The estimates of the number of people losing employer-based coverage and eventually becoming uninsured are somewhat higher than those in the second Urban Institute report described below. This is most likely because past recessions affected a wider range of workers and more workers with employment-based coverage than the current recession has thus far.

One advantage of projections based on econometric models using historical

data is in their timely publication, before extensive contemporaneous data on the current recession is available. Another advantage is that their estimates summarize broad labor market characteristics and patterns that typically follow recessions, for example declines in hours worked or declines in eligibility for employer-based coverage. Also, the econometric model estimates reflect longer term impacts than the estimates of the other studies discussed here. A potential limitation of this approach is how much the COVID-19 recession varies from earlier recessions. Early evidence indicates the current recession is unlike previous recessions and is disproportionately affecting certain sectors of the economy while other sectors are relatively unchanged.

We anticipate that many workers who lose their jobs and employer-sponsored insurance will find other sources of coverage, so in addition to those two key questions, policymakers also want to know how many will enroll in subsidized coverage through Medicaid or the marketplaces. Urban 1 and Urban 2, unlike the other two studies discussed here, both provide estimates of changes in Medicaid and marketplace enrollment as a result of the COVID-19 recession, in addition to their main findings on the number losing ESI and becoming uninsured.

Henry J. Kaiser Family Foundation

In mid-May 2020, the Henry J. Kaiser Family Foundation (KFF) released a report that found nearly 78 million people lived in a family in which someone lost a job between February and May 2020 (Table 1, row 2). They estimate nearly 27 million people would lose employment-based health insurance in May because of that job loss (Table 1, row 3). The authors estimated that nearly 80 percent of the 27 million people losing ESI would be eligible for subsidized coverage through Medicaid or the marketplace. However, the authors refrained from estimating how many people would take up that coverage. Research has shown that people eligible for subsidized coverage do not always take it up; take-up varies by program and age of the enrollee, and it

is always less than 100 percent. Take-up can also vary by awareness of options, access to enrollment portals, and ease of sign-up, among many other factors. Thus, the KFF study provided early estimates of the potential number of uninsured but did not completely answer the second question asked by policymakers: How many of those losing employer-based coverage will likely become uninsured?

The study used an ACA eligibility model calculator developed by KFF. The authors applied the model to data from the 2018 ACS, which were then aged forward to match 2020 state populations. The authors note the ACS data do not distinguish between policyholders and covered dependents within a family, so they made assumptions to account for this lack of information. Later, we examine how these assumptions differ from those in the second Urban Institute study we describe.

Urban Institute 2

This study used detailed U.S. Bureau of Labor Statistics (BLS) data by industry, occupation, and demographic characteristics of reported employment losses through May 2020. The study projected that during the last three quarters of 2020 (the initial COVID-19 period), 48 million nonelderly people will live in a family with a worker estimated to lose their job because of the COVID-19 shutdowns and recession (Table 1, row 2). The study also found that the COVID-19 recession as of May 2020, unlike previous recessions, is disproportionately affecting workers paid low wages. Based on the published characteristics of workers losing jobs at that point in the recession, the authors estimated that many of these workers did not have employment-based coverage through their own jobs. They estimated 10.1 million people will lose employer-based coverage because of a job loss (Table 1, row 3), but many of them find other sources of coverage: about 32 percent switch to another employer-based policy in the family, and 28 percent enroll in Medicaid. Still, 3.5 million are projected to become uninsured. As noted, this is the only study of the four that also examined other insurance coverage transitions beyond those between ESI

coverage and other types. The authors estimated that in the last three quarters of 2020, about 500,000 uninsured people will become eligible for and enroll in Medicaid after they or a family member lose a job, offsetting slightly the number of people newly becoming uninsured. Thus, this study estimated the net increase in the number of uninsured people to be 2.9 million, accounting for all transitions in coverage (table 1, row 4).

This study relies on the Health Insurance Policy Simulation Model (HIPSM), supplementing the model with data from BLS on the characteristics of workers losing employment between February and May 2020. HIPSM is a powerful analytic tool, a detailed microsimulation model of the health insurance system designed to estimate the cost and coverage effects of proposed health care policy options. Models such as HIPSM are few in number because they require a large investment of resources to build and maintain. HIPSM is based on two years of data from the American Community Survey (ACS), which allows it to create a synthetic version of the health insurance system for US residents below age 65, populated by a representative sample of families constituting more than 6 million individuals.² The model thus captures a range of unmeasured correlations between employment, income, family structure, demographics and insurance coverage. Compared with other approaches, a sophisticated microsimulation model like HIPSM can take advantage of available micro data, meaning individual level data on who is losing employment, use that to simulate how each individual's eligibility for public insurance programs changes, and then model the ensuing transitions in coverage, providing a complete picture of potential changes. As mentioned above, Urban 2 and Urban 1 both provide estimates of changes in Medicaid and marketplace enrollment, in addition to their main findings on changes in number with ESI and the number of uninsured.

Families USA

On July 13, 2020, Families USA released a report that found that the number of uninsured workers increased by 5.4 million between February and May

2020 (Table 1, row 4),³ following losses of employment for 21.9 million workers. Unlike the other three studies discussed in this report, the Families USA study assumes that coverage losses have already occurred. Also, it does not incorporate the dependents of workers who were covered by the employer-sponsored insurance. Incorporating dependents would likely increase the estimated effects by an additional number of people, somewhere between 50 to 100 percent of the number of workers.

The analytic approach used in the Families USA report is straightforward. They produced these results by using the BLS data on changes in employment, unemployment, and labor force participation by state from February through May 2020, combining them with coverage estimates from an earlier paper by Gangopadhyaya and Garrett, which preceded and relates to the first Urban Institute study discussed in this report.⁴ Families USA calculated the number of people in each state moving from employed to unemployed or not in the labor force and simply applied uninsurance rates derived in Gangopadhyaya and Garrett to the number of people in each of those categories. Using ACS data on insurance coverage from 2008 to 2018, Gangopadhyaya and Garrett found that unemployed workers and non-elderly adults not in the labor force are less likely to become uninsured now than before the ACA, because of the expansion of Medicaid eligibility in most states and the introduction of marketplaces with subsidized coverage. Specifically, Gangopadhyaya and Garrett found that the 2014–18 uninsurance rate was 29.8 percent for unemployed people and 17.5 percent for those not in the labor force.

The Families USA study reflects how the consequences of losing a job have changed on average since implementation of the ACA. But the analysis does not account for the unusual nature of the current recession and its disproportionate effects on workers with low wages, people who are less likely to have held employer-provided insurance before their job loss. Gangopadhyaya and Garrett's average uninsurance rates following a job loss reflected the 2014–2018 period and these rates may

not apply to workers losing jobs in 2020 due to the pandemic. This recession also seems to have an unusual timeline, because many workers are reporting that their employer-provided insurance is continuing while they are temporarily furloughed from their jobs. This may change in coming months. The Families USA projection that 5.4 million workers have already lost their insurance is not consistent with emerging evidence from household surveys, but it may be a better projection for later in 2020 depending upon the evolution of the recession.

Differences between the Studies' Key Assumptions

Number of workers losing jobs. One basic reason for these studies' differing estimates is their underlying assumptions of employment losses due to the COVID-19 recession (Table 1, row 1). This is a central assumption and directly affects each study's estimate of the number of people losing employer-provided health insurance. During the early months of the current recession it appeared to many observers of the US economy that labor market effects would be very severe. But some jobs returned after March and April 2020. Though we do not know whether employment losses will grow larger, data released in early August shows there were 16.3 million unemployed people and 7.7 million people out of the labor force who want a job as of July 2020.⁵

One of the earliest studies, KFF assumed a higher number of workers losing their jobs than the other studies, and this is one reason for its higher estimate of the number of people losing employer-provided coverage. The KFF authors summed the number of initial unemployment claims filed between March 7 and May 2, 2020, to reach the estimate of 31 million people losing their jobs. The second Urban Institute report described assumed 22.4 million workers lose their jobs, a very similar number to that in the Families USA analysis (21.9 million workers). The first Urban Institute study presented is the only study discussed here to offer multiple results depending on the unemployment level and included results for 15, 20, and 25 percent unemployment rates. To compare

this study with others, an unemployment rate of 15 percent translates to about 23.4 million workers as of March 2020.

Characteristics of people losing jobs. The second Urban Institute study presented incorporated the characteristics of those currently losing jobs to a greater degree than the other studies. Using a microsimulation model allowed the authors to incorporate a level of detail unachievable with econometric models. Moreover, the authors can update their estimates easily if the characteristics of those losing jobs changes. Both the first Urban Institute study presented and the Families USA study implicitly assumed workers currently losing jobs are similar to those losing jobs in past recessions. But the characteristics of people becoming unemployed thus far in 2020 appear to differ from data used in those two studies. In particular, the health insurance coverage distribution of those losing jobs in the current recession appears to differ from past recessions. If the recession continues, however, the characteristics of those who become unemployed and who leave the labor force could change.

Another unusual aspect of the current recession is the large number of workers on temporary furlough, many of whom may retain their employer-provided health insurance. The second Urban Institute analysis we described, using a microsimulation model, assumed roughly one-quarter of unemployed workers would keep their employer-sponsored insurance through the end of 2020. Two of the other studies do not appear to adjust for this pattern. The first Urban Institute study, using a regression model, presents its projections as longer-term effects that take place several months to a year after the change in employment levels, so the time horizon extends beyond the likely furlough period.

Number of people with employer-based coverage tied to a lost job. A major difference between the KFF study and second Urban Institute study begins with their estimated number of people living in families with a COVID-19-related job loss and receiving coverage through that job (Table 1, rows 2 and 3). KFF estimated that 78 million people live in families with a COVID-19-related job

loss and about 27 million of those people were covered by employer-sponsored insurance through that job, a share of 35 percent. The second Urban Institute study estimated that 48 million people live in families with a COVID-19-related job loss and 10.1 million of those people were covered by employer-sponsored insurance through that job, a share of 21 percent. Urban Institute thus assumed a smaller share of workers and dependents received coverage through the lost job than did KFF.

It is not clear which of these assumptions is more accurate. One of the challenges in estimating the impact of job losses on employment-based coverage is the lack of detailed information in the ACS on relationships within families and how individual family members are covered. In other words, the data do not identify which worker is a policyholder and which other family members are covered as dependents under each worker's plan. Researchers develop their assumptions based on research and data from other household surveys that contain such information. For example, workers with low incomes are more likely to live in families with a mix of insurance plans.⁶⁷ This could mean the children in a low-income household are enrolled in the Children's Health Insurance Program, whereas the working adults may opt for self-only coverage through their job-based plan.

Estimates including family members. Three of the four studies estimate the number of workers and family members likely to lose employer-sponsored coverage because of a pandemic-related job loss, ranging from 10.1 million to 30.0 million people. The Families USA study does not produce a comparable estimate, however, because it does not include family members in its estimates. Families USA found that 5.4 million workers have lost coverage in 2020; the total number losing coverage would be much greater than that, however, since some workers cover family members.

Completeness of estimates regarding all transitions in coverage. Only one study, the second Urban Institute study presented, which is based on a complex microsimulation model, estimated all

transitions in coverage that could flow from the extensive employment losses reported to date. For example, that study estimated that 500,000 uninsured workers become eligible for and enroll in Medicaid after losing their jobs. This movement partially offsets the number of people who become uninsured in the wake of a job loss. The study also estimated the transitions into and out of the marketplace. Though net growth in the marketplace is estimated to be quite low (200,000 people in 2020), that figure hides much larger gross enrollment increases of 700,000 and gross exits of 500,000 (data not shown). Many people exiting the marketplace are estimated to enroll in Medicaid, because their job losses lead to changes in program eligibility. Including estimates of all transitions in coverage help policymakers understand how the safety net is estimated to be working.

Presentation of estimates in the context of uncertainty. Three of the four studies carefully couched their estimates as the COVID-19 recession's potential impacts on insurance coverage. The Families USA study, on the other hand, estimated 5.4 million workers had already lost their employer-sponsored health insurance before the report's publication.⁸ Such statements are misleading, and the analysis is undermined by emerging data that contradict the estimates, as shown below.

Emerging Evidence from Household Surveys

The analytic efforts described above are especially important when so little definitive data are currently available on changes in insurance coverage in the wake of employment losses beginning in March and April 2020. Some evidence is emerging, however, from recent surveys, but none have found large increases in uninsured at this point in the recession.

Urban Institute researchers recently released a brief that used data from the HRMS, conducted between March 25 and April 10, 2020, and the first wave of the Coronavirus Tracking Survey, conducted between May 14 through 27, 2020.⁹ The Coronavirus Tracking Survey is part of the HRMS and is designed to monitor how the pandemic is affecting

adults over time. The tracking survey found no changes in employer-sponsored insurance or in the number of uninsured people for the overall sample of adults. However, for those in families losing jobs, employer-sponsored insurance dropped by 4.9 percentage points. That reduction in coverage was considerably offset by a 3.5 percentage-point increase in private nongroup coverage. The uninsured rate for adults in families losing jobs increased from 14.8 percent to 16.5 percent, but the change was not statistically significant. Among states that did not expand eligibility for Medicaid under the ACA, however, there was a very small but statistically significant increase in the overall number of uninsured adults (1.3 percentage points).

The Commonwealth Fund conducted a telephone survey of 2,271 adults ages 18 and older from May 13 through June 2, 2020.¹⁰ Among adults who reported that either they or their spouse or partner had a job loss or furlough, 59 percent did not have coverage through that job. Of the remaining 41 percent who had such coverage, 53 percent had been furloughed and still maintained coverage through that job. Smaller shares reported having employer coverage through another job, a spouse, COBRA, Medicaid, or the marketplaces. Thus, only a small percentage of people losing jobs (21 percent of 41 percent) became uninsured because they lost employer-sponsored insurance. However, if furloughed workers lose their jobs permanently, uninsurance could change significantly.

The results of these two surveys suggest many people who have lost jobs during the pandemic either did not have

insurance through their jobs to begin with or have maintained employer-sponsored insurance because of a furlough or through a family member or COBRA. Increases in Medicaid or marketplace coverage were generally small. Finally, a third survey, the U.S. Census Bureau's Household Pulse Survey, conducted between April 23 and May 5 and between July 9 to 14 found little net change in private or public coverage or in the uninsurance rate.¹¹ The survey may have missed an increase in uninsurance, because the first wave was conducted just after the sharp increase in unemployment in March/April. However, given the other survey results, significant shifts in coverage may not have occurred yet.

Conclusion

We do not yet know how many people will lose both their jobs and health insurance coverage during the COVID-19 recession, and definitive data will not be available until next year. Though employment rebounded somewhat after the huge job losses in March and April 2020, the economic recovery is uncertain and depends on the course of the coronavirus and efforts to mitigate its spread. Recent household surveys with smaller sample sizes than federal surveys have, however, indicated that net changes in insurance coverage thus far have been small. Without definitive data on how health insurance coverage is currently changing and will change in the coming months, models that predict the effects of widespread employment losses on coverage play an important role in alerting policymakers to potential outcomes. To better understand widely varying estimates, however, it would be

helpful for authors to define where their estimates fit into the larger picture of what remains unknown.

We find these studies' estimates differ for various reasons. One is the studies' different assumptions of the number of workers losing their jobs. Another is the degree to which the studies' analytic approaches incorporated emerging data on the specific characteristics of those losing employment in 2020, or otherwise adjusted for the specific characteristics of the COVID-19 recession relative to past recessions. A third are varying assumptions on the number of family members covered by workers' policies. One study goes further than the others, estimating all coverage transitions following the loss of employment, including movements from uninsurance or nongroup coverage to Medicaid, which effect final estimates, and matter to state and federal policymakers.

The value of these early estimates will only be known once we can measure how well they approximate more definitive data released in the coming months and years. Early evidence indicates there have not yet been large losses of coverage, suggesting that studies predicting smaller changes in the number of uninsured people may be more accurate than those predicting large increases. The four studies compared here present varying estimates of what may happen to the health insurance coverage of people affected by the current recession. In all cases, the authors have included information on their data, methods, and assumptions, enabling us to compare results across studies.

ENDNOTES

- 1 We exclude estimates produced without documentation of data and methods, including those from a report by Health Management Associates. See Health Management Associates. COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, by State. 2020. <https://www.healthmanagement.com/wp-content/uploads/HMA-Estimates-of-COVID-Impact-on-Coverage-public-version-for-April-3-830-CT.pdf>. Published April 3, 2020. Accessed July 23, 2020.
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- 8 Gangopadhyaya and Garrett (note 4 above) did not present their estimates, used in the Families USA report, as certain.
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- 10 Summarized in the Karpman, Zuckerman, and Peterson analysis above.
- 11 Health insurance coverage—Household Pulse Survey—COVID-19. Centers for Disease Control and Prevention website. <https://www.cdc.gov/nchs/covid19/pulse/health-insurance-coverage.htm>. Updated July 22, 2020. Accessed July 27, 2020.

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