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Covered California Annual Report and Fiscal Year 2020-21 Budget

FINAL

July 16, 2020

COVERED CALIFORNIA

Covered California Annual Report and Fiscal Year 2020-21 Budget

The ***Covered California Annual Report and Fiscal Year 2020-21 Budget*** serves two purposes. First, it provides the annual report that provides the public, the governor and the Legislature of a summary of activities, challenges and accomplishments of the fiscal year we are finishing Fiscal Year 2019-20. This annual report is required pursuant to Section 100503 of the government code. The initial section of the report is the summary of that Annual Report and the first Appendix provides detail of expenses by program area and progress toward meeting our goals.

Covered California's annual budget is adopted by the board after review of proposed draft and adjustments based on comments from the broad and the public, as well as adjustments based on new information.

The budget process is based on established budget principles, processes and procedures to provide the highest levels of fiscal integrity, accountability, transparency and accuracy.

With this proposal to the Board, the proposed budget seeks to set out the most cost-effective and efficient level of resources that the organization needs to carry out its mission and goals.

Cover Image

The people featured on the cover are individuals who have benefited from these efforts. Their stories — and those of others told here https://www.coveredca.com/real-stories/ — go beyond the data to provide personal perspectives on what Covered California has achieved over the past five years.

July 16, 2020

Governor Gavin Newsom and Members of the California Legislature,

On behalf of the governing board of Covered California, and pursuant to Government Code Section 100503, I am pleased to present this report to the Governor and the Legislature which details Covered California's achievements and activities during fiscal year (FY) 2019-20 and outlines the budget for FY 2020-21 adopted by the board at its June 25, 2020 meeting.

Covered California remained on the forefront of improving coverage affordability; promoting enrollment and retention; and, responding to the impact of the COVID-19 pandemic throughout FY 2019-20. In 2020, Covered California implemented new state premium subsidies making coverage more affordable for low-income Californians, with our state becoming the first in the nation to provide financial assistance to middle-income consumers who do not receive any federal financial help. Covered California established a partnership with the Franchise Tax Board – which administers the new state-level individual mandate penalty enacted after federal action to reduce the federal penalty to $0 -- and made substantial investments in marketing and outreach so Californians were well informed of their coverage options. Taken together, these policies resulted in historically low premiums increases in 2020 and helped drive new enrollment growth in 2020 by 41 percent. Also, responding to the significant impact of the COVID-19 pandemic in 2020, Covered California launched a "special enrollment period" opening our doors to Californians in need of coverage, and signing up more than 175,000 Californians – twice as many as the same time period last year. Covered California continues to evaluate how it can reach and serve Californians who have been impacted by the health and economic impacts of COVID-19.

Looking ahead, Covered California enters FY 2020-21 with historically high enrollment, and in a strong financial position to continue meeting the needs of Californians. Our operating budget – which does not draw on state General Funds – remains focused on key areas that will assist us in meeting our mission including increased investments in information technology; marketing and outreach; and, policy, research, and effective plan management to inform national and state policy. We are planning to expand our outreach to make sure Californians impacted by the COVID-19 pandemic know of their opportunities to get affordable health care coverage. These increased investments and priorities come at the same time we are planning to lower the assessment on health plan premiums which fund Covered California's operating budget.

Covered California's work throughout FY 2019-20, and its budget for the upcoming fiscal year, reflects its ongoing commitment to putting consumers first, promoting enrollment, holding health plans accountable, and making the market work for California's consumers. We look forward to

our continued work with you to achieve these goals, particularly in a year of health crisis, and will be sure to report important developments to you as the year progresses.

Sincerely,

Peter V. Lee
Executive Director

Covered California Board and Senior Executive Management

Covered California Board of Directors

Dr. Mark Ghaly, Chair; Paul Fearer, Jerry Fleming,

Dr. Sandra Hernández, Art Torres

SENIOR EXECUTIVE MANAGEMENT

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Executive Director

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Chief Deputy Executive Director, Operations

Lisa Lassetter
Administrative Services Division Director and Deputy Chief Operations Officer

Jim Watkins
Financial Management Division Director and Chief Financial Officer

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Communications and Public Relations Division Director

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Brandon Ross
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Thien Lam
Program Integrity Division Director

Adrian Recio
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Terri Convey
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Plan Management Division Director

Mavilla Safi
Service Center Division Director

Colleen Stevens
Marketing Division Director

Covered California Annual Report and Fiscal Year 2020-21 Budget

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I. Covered California's Annual Report

Introduction

Covered California enters fiscal year (FY) 2020-21 on a foundation of seven years of experience implementing the Patient Protection and Affordable Care Act, and in a state that introduced bold policies in 2020 to enhance the affordability of coverage through new state subsidies as well as a statewide individual mandate penalty. These policies lowered premiums and made coverage more affordable for hundreds of thousands of people. Through these actions and many others, California has remained on the forefront of policies that build on the Affordable Care Act, and Covered California continues to serve as a proving ground for an effective and innovative state-based marketplace that puts consumers first.

While the crisis caused by COVID-19 continues to reshape the lives of people throughout our state, and the state of California faces its worst budget deficit in history, there is a critical need to expand economic and other assistance programs to millions of Californians who have lost their jobs and the health care coverage that came from their employer.[1] Studies show that the virus also disproportionately affects low-income families and communities of color, which spotlights the importance of Covered California's historic focus on health equity and disparities in care.[2]

With the proposed budget for FY 2020-21, Covered California proposes to lower its assessment on health plans while at the same time substantially expanding already robust marketing spending to meet the needs of Californians facing the loss of employer-based insurance coverage. This new spending is made possible by the fact that Covered California maintains sufficient cash reserves that give it the flexibility to help Californians get the care they need during a recession sparked by a pandemic.

In many ways, the pandemic has made clear the crucial importance of the Affordable Care Act's coverage expansions. California has in place an effective Medi-Cal program that stands ready to serve what could be millions more Californian beneficiaries. Covered California — an independent marketplace — has time and again made policy decisions and investments to promote a market that works for consumers and assures they get the care they need. With the proposed budget for FY 2020-21, Covered California proposes to make new investments aimed at increasing outreach and service levels to help consumers understand their health care options and get access to the care they need (Section II).

Covered California looks forward to continuing to deliver on its mission of increasing the number of insured Californians, improving health care quality, lowering costs, and reducing health disparities through an innovative, competitive marketplace that

[1] University of California Berkeley Labor Center, *Health coverage of California workers most at risk of job loss due to COVID-19*, May 2020. http://laborcenter.berkeley.edu/health-coverage-ca-workers-at-risk-of-job-loss-covid-19/.

[2] Kaiser Family Foundation, *Low-Income and Communities of Color at Higher Risk of Serious Illness if Infected with Coronavirus*, May 7, 2020. https://www.kff.org/disparities-policy/issue-brief/low-income-and-communities-of-color-at-higher-risk-of-serious-illness-if-infected-with-coronavirus/.

empowers consumers to choose the health plan and providers that give them the best value.

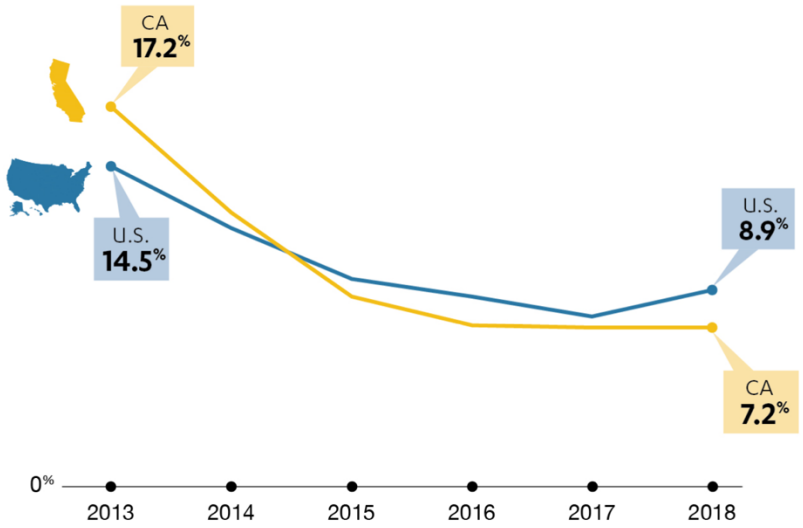
Protecting and Going Beyond the Affordable Care Act With New Policies in 2020

Since the launch of the Affordable Care Act, California has taken many steps to dramatically improve access to quality health care in the state. That endeavor is supported by the expansion of Medi-Cal, which currently provides health coverage to an estimated 36 million Californians[3], including more than 3.7 million people who are currently enrolled in Medi-Cal due to the Affordable Care Act expansion.[4] Since Covered California first opened its doors in 2014, more than 4.5 million people have been insured for at least one month directly through the exchange, and millions more have purchased coverage in the individual market off-exchange — benefiting from lower premiums driven by the healthier risk mix that is the result of Covered California's marketing and policies.

California's uninsured rate has dropped 10 points since 2013[5], the year prior to the implementation of the Affordable Care Act, which is the biggest decrease of any state in the nation (Figure 1). In recent years, California's uninsured rate held steady at 7.2 percent through 2018, which is in sharp contrast to the rest of the country, where the percentage of uninsured rose to 8.9 percent. [6]

[3] U.S. Census Bureau, *Health Insurance Coverage in the United States, 2018*, Sept. 2019. https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.
[4] Medi-Cal, *Fast Facts*, Dec. 2019.https://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_Dec_2019.pdf.
[5] U.S. Census Bureau, *Health Insurance Coverage in the United States: 2013*, Sept. 2014.https://www2.census.gov/library/publications/2014/demographics/p60-250.pdf.
[6] U.S. Census Bureau, *Health Insurance Coverage in the United States: 2018*, Sept. 2019.

Figure 1
Comparing California's Uninsured Rate to the Nation



Covered California's ability to serve Californians was solidified in the past fiscal year by a series of policies and decisions at the state and exchange level, which protect and go beyond the Affordable Care Act.

New Affordability Initiatives: Financial Help for the Middle Class and the Return of the Coverage Mandate

California enacted two new state affordability initiatives that took effect in 2020, championed by Gov. Gavin Newsom and the state Legislature, that were designed to lower costs and encourage enrollment — both protecting and going beyond the Affordable Care Act.

- **State Individual Mandate Penalty:** California initiated its own state individual mandate penalty, after the original penalty was zeroed-out through federal action. The federal action of removing the penalty in 2019 resulted in a significant drop in enrollment *and* in higher costs as health insurance companies priced for lower enrollment and a worsened risk mix. By instituting a state-level penalty, California reduced premiums by between 2 and 5 percent per carrier for the 2020 plan year as carriers predicted it would encourage more healthy consumers to sign up for coverage.
- **State Subsidies to Make Care More Affordable and Address the Affordable Care Act "Cliff" for Middle Class Californians:** The second initiative, proposed in 2019 and then implemented for the 2020 plan year, was a state subsidy program designed to make coverage more affordable for many low-income and middle-income consumers. Under the program, eligible low-income consumers — who either earn less than 138 percent of the federal poverty level (FPL) or between 200 percent and 400 percent of the FPL — would be able to receive state subsidies in addition to the federal tax credits they may receive. The

program also was the first in the nation to offer subsidies to eligible middle-income consumers who earned between 400 and 600 percent of the federal poverty level. These small-business owners, entrepreneurs, contractors and other middle-income earners were previously ineligible for financial assistance because they exceeded federal income requirements, which stopped federal assistance at 400 percent of the federal poverty level regardless of how much coverage cost the individual. In California, some consumers were paying 20, 25 and even 30 percent of their household income on health insurance premiums. Across the nation, many of these individuals have been priced out of coverage.

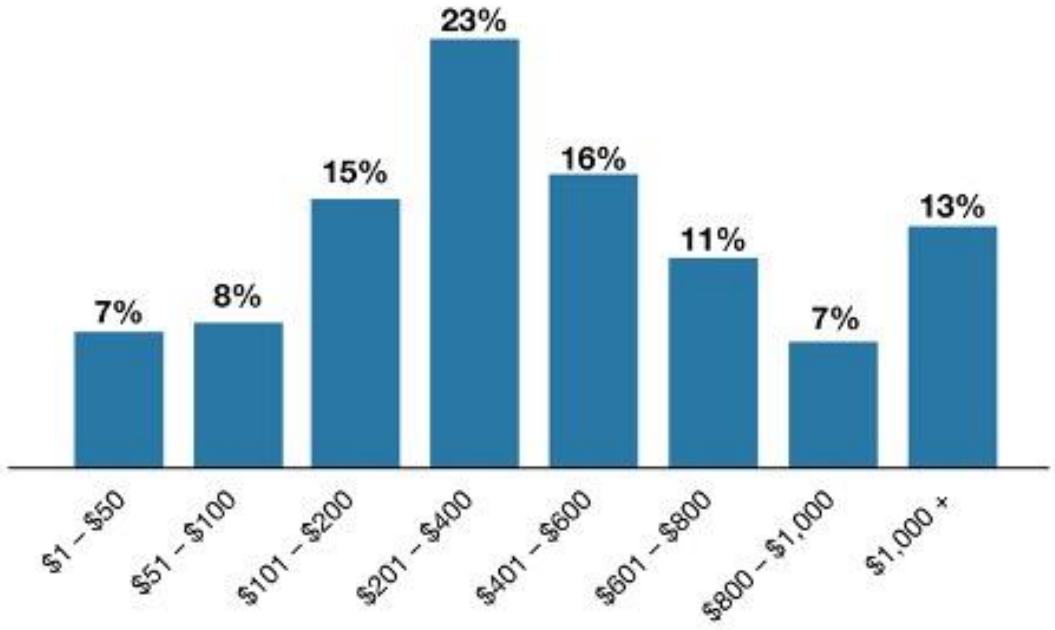
Policies and Outreach Made a Difference

The combined effects of these new policies and Covered California's robust marketing efforts — which included stepped-up investments to make sure Californians knew about the new state subsidies and the state penalty — paid off in lower premiums and significant growth in new enrollment.

- **Record-Low Rate Change and More Competition:** The two affordability initiatives were critical ingredients in helping Covered California negotiate its lowest rate change in history, and they continue to provide greater choice and stability in the marketplace. For the 2020 plan year, Covered California negotiated a 0.8 percent rate change. This low average rate increase benefited all consumers, including those not eligible for financial assistance. In addition, all 11 carriers returned to the market, and a major national plan expanded its coverage area. As a result, nearly all consumers would be able to choose from two or more carriers in 2020, 87 percent would have three choices or more, and 75 percent would have four or more choices.
- **Large Increase in New Enrollment:** With these consumer-oriented policies in place and Covered California's extensive outreach, California saw immediate results in the open-enrollment period for the 2020 plan year. More than 418,000 consumers signed up for coverage, which is 41 percent higher than last year's figure of 295,980 following the zeroing-out of the penalty.

Overall, Covered California finished open enrollment with more than 1.5 million plan selections, including approximately 625,000 new and renewing consumers who qualified to receive the new state subsidies. Of those, nearly 32,000 middle-income consumers qualified for the new financial help, which averaged $504 per month for eligible households, and lowered their monthly premium by half (Figure 2).

Figure 2
Distribution of California State Subsidies Among Eligible Middle-Income Households (400 to 600 Percent FPL)



Covered California Responds to the COVID-19 Pandemic

The Affordable Care Act created a safety net for consumers who lose their job-based health coverage. During the pandemic, California's unemployment rate jumped to a record 16.4 percent in April 2020[7]. As noted earlier, the University of California, Berkeley Labor Center estimated that 2.6 million people and their dependents also lost the health care coverage that came with those jobs.

Covered California was in the midst of a special-enrollment period focusing on continuing to educate Californians about the new state subsidies and the state penalty when it shifted to respond to the pandemic. On March 20, 2020, Covered California established a special-enrollment period for any eligible consumer who needed health insurance based on the COVID-19 pandemic. Covered California supported that special-enrollment period, which was announced to go until at least July 31, with $9 million in new advertising to inform consumers about their options and encourage them to enroll in health care coverage.[8] The latest data shows that more than 175,000 people

[7] Employment Development Department, *California unemployment rate lowers slightly to 16.3 percent in May,* June 19, 2020. https://edd.ca.gov/newsroom/unemployment-june-2020.htm.

[8] Covered California, *Covered California Launches New Ad Campaign That Focuses on the COVID-19 Pandemic and Encourages the Uninsured to Sign Up for Coverage,* May 4, 2020. 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/.

signed up coverage between March 20 and June 20, which is more than twice as many as people that signed up during the same time period the previous year.[9]

Covered California's experience in the past year — both implementing new state policies and responding to the new demands driven by COVID-19 and its economic impacts — is informing its plans for the coming year. That experience is also anchored by a set of strategic priorities and an approach to creating a consumer-driven market that holds health insurance companies accountable, which is being tested in new ways.

Covered California's Strategic Areas of Focus: Looking Back and Looking Ahead

Covered California's Annual Report and its budgets reflect the organization's strategic priorities. The budgets for the most recent and upcoming fiscal years are based on established principles and procedures that provide the highest levels of fiscal integrity, accountability, transparency and accuracy to allow Covered California to meet its goals and carry out its mission.

Covered California's strategic areas of focus were designed by the agency's management team and reviewed by the board to guide the organization while making decisions, setting priorities, determining initiatives and preparing annual budgets.

The five areas of strategic focus, and the three cross-cutting priorities that guide Covered California's work, with examples of efforts undertaken in the past year, are summarized in the pages that follow and described in more detail in Appendix A-1.

Strategic Priority: Affordable Plans

The Affordable Care Act opened the door to coverage for millions of Americans through three areas: expanding Medicaid to make it more available to low-income consumers; providing financial support to help consumers cover the cost of their monthly premiums; and including cost-sharing reductions that reduce the out-of-pocket costs for many low-income consumers. In 2020, California went above and beyond the Affordable Care Act to make coverage more affordable by establishing a state subsidy program and a state individual mandate.

The actions and policies enacted during FY 2019-20 build on the competitive marketplace that Covered California operates. Covered California also employs multiple tools to assure that the market is truly consumer driven and health insurance companies are held accountable. Unlike the federal exchange and most other state-based marketplaces, Covered California actively negotiates with plans on their premiums, network designs, delivery-system requirements and other key areas — while promoting a competitive marketplace — to provide the best value for consumers. The marketplace promotes consumer choice by creating a level playing field where consumers benefit from meaningful competition and expanded enrollment.

Consumer choice relies on plan participation with the need for a stable market that provides health insurance companies a level of certainty regarding the number and

[9] Covered California, *California Extends Special-Enrollment Deadline to Give Consumers More Time to Sign Up for Health Care Coverage During COVID-19 Pandemic,* June 23, 2020. https://www.coveredca.com/newsroom/news-releases/2020/06/12/covered-californias-enrollment-continues-to-surge-during-the-covid-19-pandemic/

health status of enrollees. Since the launch of Covered California for the 2014 coverage year, the exchange has had continuous participation by 10 health insurance companies, with the addition of an eleventh insurer in 2016. As noted earlier, nearly all consumers can choose from two or more carriers in 2020, 87 percent have three choices or more, and 75 percent have four or more choices.

In addition, Covered California established “patient-centered” benefit designs that are standardized across all health plans. Since the benefits in each metal tier are the same when it comes to co-pays, deductibles and other out-of-pocket costs, the health plans must compete on pricing and consumers can more easily comparison shop.

The patient-centered benefit designs also offer “first dollar” coverage for all outpatient services. Currently, more than 70 percent of Covered California enrollees are in plans in which most outpatient care, such as primary care visits, outpatient services and lab tests, is not subject to a deductible (Table 1).

Table 1
2020 Patient-Centered Benefit Designs and Medical Cost Shares

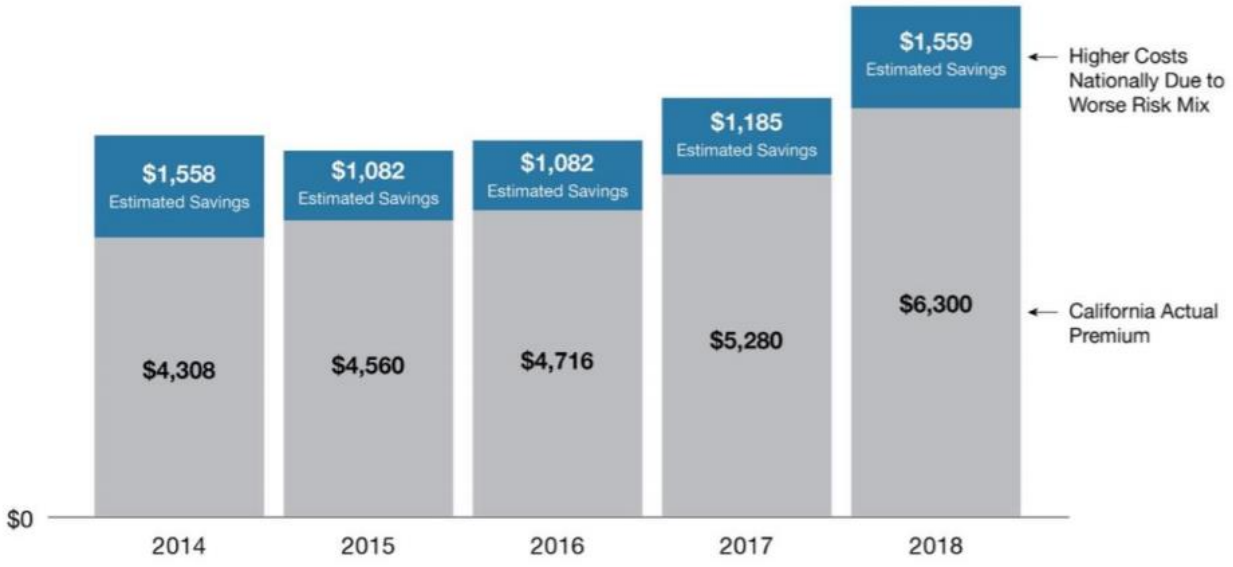
Coverage Category	Minimum Coverage	Bronze	Silver	Enhanced Silver 73	Enhanced Silver 87	Enhanced Silver 94	Gold	Platinum
Percent of cost coverage	Covers **0%** until out-of-pocket maximum is met	Covers **60%** average annual cost	Covers **70%** average annual cost	Covers **73%** average annual cost	Covers **87%** average annual cost	Covers **94%** average annual cost	Covers **80%** average annual cost	Covers **90%** average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	N/A	**$24,981 to $31,225 (>200% to ≤250% FPL)**	**$18,736 to $24,980 (>150% to ≤200% FPL)**	**up to $18,735 (100% to ≤150% FPL)**	N/A	N/A
Annual Wellness Exam	$0	$0	$0	$0	$0	$0	$0	$0
Primary Care Vist	After first 3 non-preventive visits, full cost per instance until out-of-pocket maximum is met	$65*	$40	$35	$15	$5	$30	$15
Urgent Care		$65*	$40	$35	$15	$5	$30	$15
Specialist Visit	Full cost per service until out-of-pocket maximum is met	$95*	$80	$75	$25	$8	$65	$30
Emergency Room Facility		40% after deductible is met	$400	$400	$150	$50	$350	$150
Laboratory Tests		$40	$40	$40	$20	$8	$40	$15
X-Rays and Diagnostics		40% after deductible is met	$85	$85	$40	$8	$75	$30
Imaging			$325	$325	$100	$50	$275 copay or 20% coinsurance***	$75 copay or 10% coinsurance***
Tier 1 (Generic Drugs)	Full cost per script until out-of-pocket maximum is met	$18**	$16**	$16**	$5 or less	$3 or less	$15 or less	$5 or less
Tier 2 (Preferred Drugs)		40% up to $500 after drug deductible is met	$60**	$55**	$25**	$10 or less	$55 or less	$15 or less
Tier 3 (Non-preferred Drugs)			$90**	$85**	$45**	$15 or less	$80 or less	$25 or less
Tier 4 (Specialty Drugs)			20% up to $250** per script	20% up to $250** per script	15% up to $150** per script	10% up to $150 per script	20% up to $250 per script	10% up to $250 per script
Medical Deductible	N/A	Individual: $6,300 Family: $12,600	Individual: $4,000 Family: $8,000	Individual: $3,700 Family: $7,400	Individual: $1,400 Family: $2,800	Individual: $75 Family: $150	N/A	N/A
Pharmacy Deductible	N/A	Individual: $500 Family: $1,000	Individual: $300 Family: $600	Individual: $275 Family: $550	Individual: $100 Family: $200	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	$8,150 individual only	$7,800 individual $15,600 family	$7,800 individual $15,600 family	$6,500 individual $13,000 family	$2,700 individual $5,400 family	$1,000 individual $2,000 family	$7,800 individual $15,600 family	$4,500 individual $9,000 family

Drug prices are for a 30 day supply.
* Copay is for any combination of services (primary care, specialist, urgent care) for the first three visits. After three visits, future visits will be at full cost until the medical deductible is met.
** Price is after pharmacy deductible amount is met.
*** See plan Evidence of Coverage for imaging cost share.

Through establishing true competition among health plans and the extensive marketing and outreach described in sections that follow, the state of California has routinely enrolled one of the healthiest consumer pools in the nation. Between 2014 and 2018, California's "State Average Plan Liability Risk Score" was among the five lowest in the nation.

A Covered California analysis shows that the state's healthier consumer pool meant the average annual premium for unsubsidized enrollees was $1,080 to $1,560 less than those enrollees would have paid if the risk mix had been similar to that seen in the rest of the nation (Figure 3).

Figure 3
California's Healthier Risk Mix Leads to Lower Premium Costs for Unsubsidized Enrollees



Note: In the period from 2014 to 2018, the cumulative average premium increase in California was one-third lower than the increase for the rest of the US: relative to 2014, the average premium in 2018 was 76 percent higher in the rest of the US, compared to 46 percent in California. In 2018, a large average premium increase was driven by the gross premium for the Covered California Silver tier (the most commonly chosen tier) increased by an additional 12.5% due to the elimination of the Cost-Sharing Reduction (CSR) payments from Centers for Medicare and Medicaid Services (CMS).

Strategic Priority: Assuring Consumers Get Needed Care

The Affordable Care Act also enacted landmark reforms designed to ensure that consumers had access to high-quality health care coverage.

- Guaranteed Issue and Renewal: Health insurance companies are required to enroll consumers regardless of their health status, age, gender or other factors.
- Protections for Pre-Existing Conditions: Health insurance companies cannot exclude, deny coverage or charge more based on a consumer's pre-existing conditions.
- Minimum Essential Coverage: Health insurance companies are required to cover categories of essential health benefits, ensuring comprehensive coverage when care is needed.
- No Annual or Lifetime Limits on Benefits Actuarial Value: Standardized the value of coverage by tiers so consumers know on average how much their plan will pay for health care costs.

In addition, California took additional steps to protect consumers who need care by banning the sale of short-term, limited-duration insurance plans; requiring Covered California's Certified Insurance Agents to disclose to consumers the risk of health-

sharing ministries; and prohibiting small businesses and those who are self-employed with no employees from enrolling in Association Health Plans.

The Affordable Care Act provides tools to ensure plans meet quality standards and spend the majority of premiums on health care. The law also provides flexibility for states to impose rigorous standards for qualified health plans to benefit consumers. Covered California holds health insurers accountable through an array of reporting and performance requirements:

- Selective contracting with plans: Covered California health plans must meet rigorous standards and demonstrate value to consumers. Covered California will reject applicants that do not demonstrate they can meet those standards or bring sufficient market value to consumers.
- Actively negotiating with plans on pricing: Covered California negotiates pricing on behalf of the consumer to provide the best value. The exchange also helps health insurance companies understand the overall health of enrollees so they can price right.
- Requires network design changes: Covered California's contracts require health insurance companies to adopt quality-improvement activities selected in collaboration with stakeholders, including:
    - Selecting providers based on quality.
    - Measuring and narrowing disparities in care, which will likely affect not only their Covered California enrollees, but also their estimated 19.5 million enrollees in California.

Covered California also requires insurers to promote advanced primary care as well as integrated and coordinated care because there is a documented association of these approaches with better care, and an increasing proportion of Covered California enrollees are receiving care through these approaches. Two of Covered California's qualified health plan issuers with integrated delivery systems, Kaiser Permanente and Sharp Health Plan, are ranked in the top 10 percent of all U.S. health insurers in most measures of quality. However, quality performance across the other nine insurers varied widely, which shows further improvement is possible.

Covered California also focuses on delivery reform to improve value and system performance, which has resulted in about 25 percent of enrollees being cared for in an accountable care organization in 2018, far exceeding state and national benchmarks.

In the summer of 2019, Covered California released the reports "Current Best Evidence and Performance Measures for Improving Quality of Care and Delivery System Reform" —which summarizes the expert evidence and measurement reviews performed by Health Management Associates (HMA) and PricewaterhouseCoopers (PwC) — and "Health Purchaser Strategies for Improving Quality of Care Delivery System Reform," which is PwC's assessment of other purchasers' contracting strategies. In December 2019, Covered California also published two reports describing activities and achievements of Covered California's first five years: "Covered California's First Five Years: Improving Access, Affordability and Accountability" and "Covered California

Holding Health Plans Accountable for Quality and Delivery System Reform," detailing how contracted health plans are held accountable for assuring quality care and advancing health care delivery reform.

Covered California launched workgroups in July 2019 that brought together consumer advocates, providers, health insurance company representatives and others to review the research findings and health plan performance to date and develop recommendations for the model contract refresh on quality and delivery-system improvement strategies. Due to the scope of the evidence and depth of analysis involved and impacts of the COVID-19 pandemic, Covered California is phasing in the contract-refresh process with modified requirements for plan year 2022 and working toward the full qualified health plan issuer model contract refresh in 2023. Among the ideas that Covered California is considering is establishing a "Quality Transformation Fund" that would move premiums (and hence "price position") among carriers based on their quality performance.

Strategic Priority: Effective Outreach and Education

Covered California's experience shows that a stable individual insurance market requires investments in marketing and outreach to attract a healthier consumer pool, lower premiums and encourage health insurance companies to participate in the market with more certainty and potential returns.[10] Effective marketing and outreach require a multifaceted approach grounded in solid research and a critical review of the return on investment.

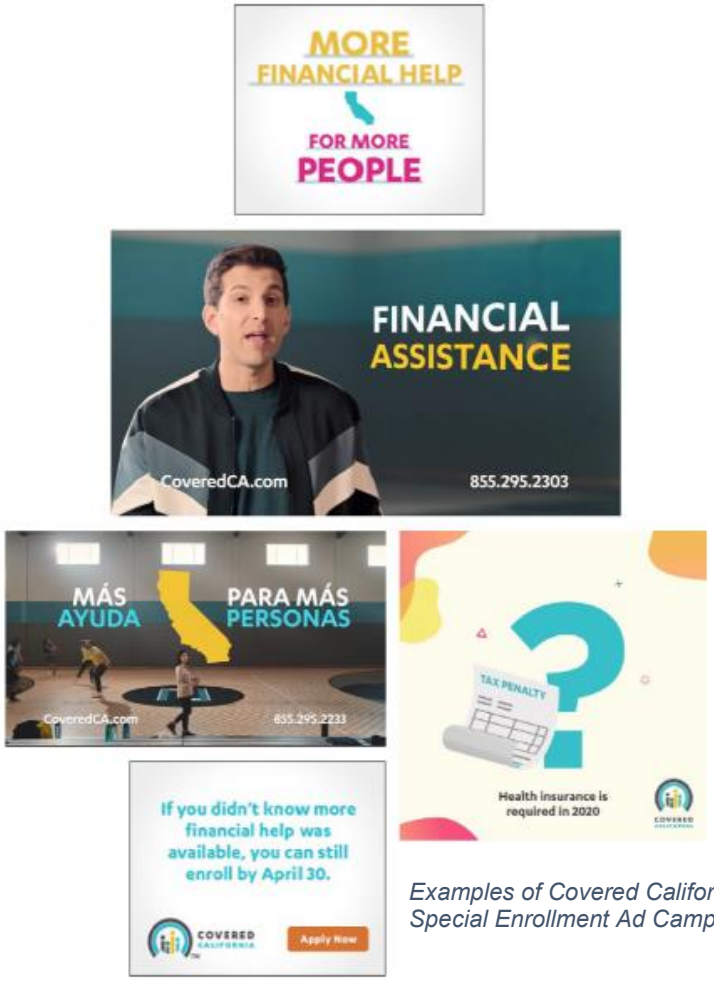
Covered California increased its marketing budget in FY 2019-20 to help inform consumers about the new state subsidy program and state individual mandate, as well as their options in response to the COVID-19 pandemic. Covered California also continues to build on the Affordable Care Act by making significant investments in marketing and outreach in order to promote stable enrollment, foster a healthy risk mix and lower premiums.

During the open-enrollment period for the 2020 plan year, Covered California's marketing and outreach efforts resulted in an estimated 2.7 billion impressions, meaning every California adult saw or heard the exchange's messaging an average of 89 times.

As a state-based exchange, Covered California oversees its own outreach efforts, including statewide advertising campaigns on numerous platforms and the funding of a network of more than 100 community groups through its Navigator program. In addition, Covered California coordinates with its contracted health insurance companies to maximize the positive impact of their marketing and agent-commission payments. Covered California works with these groups throughout the full three-month open-enrollment period and with increasing focus on year-round marketing during special enrollment to educate consumers about their health care options.

[10] Covered California, *Marketing Matters*, Sept. 2017. https://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf

Fiscal year 2019-20 presented two additional opportunities to reach out to consumers. Following open enrollment, Covered California estimated that 280,000 people — who were likely eligible for new state or existing federal subsidies — kept their "off-exchange" coverage and did not get any financial help to help them with the cost of their coverage. Most of these individuals earn under 400 percent of the federal poverty level and would be eligible for both the state and federal subsidies, while about 40,000 would be eligible to receive the new state subsidies for middle-income Californians. In an effort to reach those consumers, the exchange made the strategic decision to launch the first special-enrollment television ad campaign in its history.



Examples of Covered California's Special Enrollment Ad Campaign

The campaign, which was supplemented by radio and digital spots, promoted the special-enrollment period, which allowed consumers to sign up for coverage if they were unaware of the new financial help or new state penalty that went into effect in 2020.

The increased marketing and outreach paid immediate dividends, as the weekly average number of gross plan selections between Feb. 1 and March 19 was 24 percent higher than it was during the same time period the previous year.

During the current pandemic, Covered California also responded by spending $9 million on advertising campaigns to inform consumers of their options if they were uninsured or had lost their job-based coverage. The most recent data shows that more than 175,000 people have signed up for coverage during the COVID-19 special-enrollment period, at a pace that is more than two times higher than the same time the previous year.

As detailed in the budget, Covered California is working with its health insurance companies to increase their marketing and outreach efforts to supplement the work currently being done throughout the state.

Strategic Priority: Positive Consumer Experience

Covered California is committed to providing a positive experience to our consumers as we help them understand their health care options and get them access to the care they need. Ensuring consumers have a positive experience from initial enrollment to keeping their coverage is an important part of Covered California's broader goal of creating and maintaining a culture of coverage.

All divisions within Covered California strive to align their goals and initiatives to support this strategic priority. While much of this work is non-customer-facing and invisible to the consumer, it is critical to Covered California's efforts to ensure that its customers receive a positive experience.

The consumer-facing divisions, the Service Center and the Ombuds Office, work hard to serve Covered California consumers. During the COVID-19 pandemic, the service centers saw a significant surge in the need for consumer assistance. From July 2019 through March 2020, the service centers handled 1.9 million consumer inbound calls, with more than 1.1 million calls during open enrollment and the remainder during the expanded special-enrollment period. During this same period, the service centers completed more than 380,000 manual work streams, closed more than 27,000 escalations and complaints, and resolved more than 11,000 appeals. The Ombuds Office also saw a significant increase in calls for assistance, seeing double the number of calls over the previous year.

One of the important tools Covered California uses to measure consumer experience is focus group testing and customer surveys. In a recent post-call survey conducted during the height of the COVID-19 pandemic, over 87 percent of Covered California consumers said they were very satisfied, and 7 percent said they were satisfied with the service provided by Covered California's service center representatives. Despite the high volume of work, the Service Center continued to provide a positive consumer experience for Covered California's consumers.

In addition to the consumer-facing divisions, others that have core functions in supporting consumers include the Eligibility Branch of the Policy, Eligibility and Research division, and the Consumer Experience division. In the Eligibility Branch, a significant effort in the past year has focused on improving the notices received by consumers. Given the many legal requirements related to the form and content of enrollment and eligibility communications, the standard correspondence has frequently been far from as "consumer-friendly" as would be preferred. Efforts to revise and streamline notices have included conducting focus groups, testing reading levels and working with external partners and advocates to improve these important communications.

The Customer Care division has been leading an effort to map the full "consumer journey" to assess what parts of that process — from considering getting coverage, checking eligibility for financial help, picking the right plan and benefit level, and keeping and using coverage once enrolled — provide the biggest opportunities for improvement.

Strategic Priority: Organizational Excellence

Covered California is an independent public entity within state government that is accountable to a five-member board appointed by the governor and the Legislature. Two members are appointed by the governor: one by Senate Rules Committee and one by the Speaker of the Assembly. The Secretary of the Health and Human Services Agency, or another designee, serves as an ex-officio voting member of the board.

Covered California is funded entirely by a percentage assessment on health plan premiums. The budget for FY 2020-21 reflects the assessment fee rate for plan year 2021 being reduced to 3.25 percent of premiums from the 3.5 percent assessment levied in 2020. Since the cost of these assessments is spread across the entire individual market — both on-exchange enrollment and off-exchange enrollment into mirrored products that consumers purchase directly from Covered California's 11 carriers — this assessment fee rate will equate to an assessment of about 2.3 percent on all premiums in the individual market in 2020.

Together, these two elements allow Covered California to remain nimble in its actions and responses, which in turn help promote enrollment and save consumers money.

When it comes to organizational excellence, Covered California's approach pairs "operational excellence" with "people excellence." Covered California is committed to ensuring we maintain alignment in how we are organized, how we operate and how our team is engaged. Our strategic focus ensures it is not one system or approach over the other, but instead all systems, operations, organizations and people are able to work together in alignment.

Organizational excellence begins and ends with the people on our team. Covered California's success derives from the individual and team contributions of every single employee. Connecting employees to Covered California's mission and creating an environment in which employees are actively engaged, know they are valued resources whose work matters, and are proud to work for Covered California is of utmost importance. Covered California seeks to foster an inclusive growth-based culture, which includes a comprehensive employee engagement program, flexible work practices, development opportunities and access to best-in-class technology tools.

Covered California maintains a culture that values and engages our team and utilizes employee-engagement surveys designed to provide useful information that enables the department to identify meaningful opportunities for organizational improvement. Our structured approach is intended to empower our employees to bring their best to work every day and is designed to maximize quality, efficiency and problem-solving to improve the employee and consumer experience. This framework enables Covered California to focus on ensuring our employees are supported, valued and heard, which ultimately positively affects the consumer journey.

With the onset of COVID-19, Covered California took immediate but necessary action to comply with federal, state and county guidelines and mandates while still promoting the continuity of its mission-critical work. As part of our overall response to these unprecedented and challenging times, Covered California transitioned its workforce with a large-scale telework initiative — including moving virtually all of its more than 1,300

employees to working at home in a matter of weeks — and it will continue to remain nimble as it responds to the facility and staffing challenges resulting from this pandemic. Covered California remains committed to maintaining its resilience while using a response framework centered on successfully reacting, responding, safely returning and ultimately transforming how our work may be successfully conducted in the future.

These five strategic areas of focus are supported and complemented by the following crosscutting initiatives:

- Innovating for the long term and being nimble in the present.
- The lessons from the rapid movement of the entire organization to telework in response to the COVID-19 pandemic are now informing longer-term planning regarding the mix of on-site versus telework across all divisions.
- A consolidated enterprise information technology backup and disaster recovery solution is being implemented to more easily to manage and meet business continuity objectives in the event of a disaster.
- As we increasingly move from our on-premise systems and lengthy development processes to cloud solutions and agile development processes, Covered California can add additional tools to make decision-making and enrollment in health plans easier to understand and simpler to complete.

The Human Resources Branch has moved to the upcoming fiscal year the implementation of a department-wide information technology solution to automate and streamline human resources business processes (e.g., timekeeping, organizational chart management, training, hiring, onboarding/offboarding, benefits administration, performance management and reporting and analytics).

Using Covered California's experience to inform policy in California and nationally.

- Covered California shares its experience and lessons learned to help inform federal and state policy makers in the effort to improve access to meaningful, affordable universal coverage, reform the delivery system and advance quality and reductions in health disparities. In the 2019-20 fiscal year, this included assisting the assessment and design of the state subsidy program and the implementation of the state mandate. Covered California will build on this work for the long-term future of health care policy in California and the nation, given the new economic instability arising from the pandemic.
- As a data-driven organization, Covered California will continue to leverage internal and external expertise among its many stakeholders, academicians and private and public partners to practice evidence-based policy development that can aid health policy discussions not only in the state, but also throughout the nation.
- Continued partnerships and collaboration with other state-based exchanges will bolster Covered California's ability to inform state and federal policy, and maintaining this network is among the organization's top priorities short- and long-term.

Working in partnership with others to promote changes in care delivery that benefit all Californians.

- Covered California is actively working with both public purchasers — such as the Department of Health Care Services and CalPERS — and private purchasers to align its contractual expectations of health insurance companies to improve the delivery and quality of health care for all consumers in California.

II. Covered California's FY 2020-21 Proposed Operating Budget

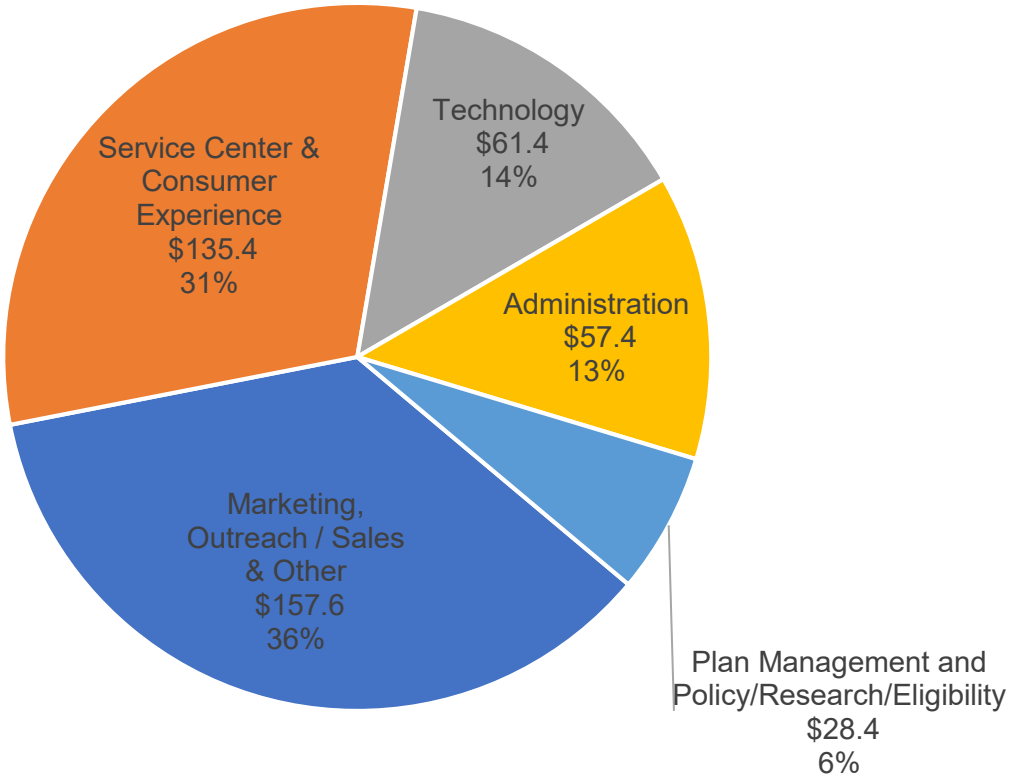
Throughout Covered California's history it has sought to demonstrate how a state can effectively expand health coverage while building on and extending the reach of the Affordable Care Act. As we enter the 2020-21 fiscal year, our nation, state and local communities are striving to contain the spread of the COVID-19 virus, which has prompted extreme job loss and an economic recession. The impacts are monumental. The state of California is facing a $54 billion budget deficit as it ramps up efforts to respond to the needs of millions of Californians while tax revenue is declining. More than 38 million Americans have lost their jobs, with over 3.8 million of those in California. In just two short months, California's unemployment rate has risen from February's record low of 3.9 percent to 15.5 percent in April.[11]

As millions of Americans lose jobs, they will also lose employer-sponsored insurance (ESI). Many more will be seeking coverage alternatives, and as they do so, they will transition to systems that may be unfamiliar to them, such as Covered California or Medi-Cal. These individuals and families will shift from one source of health care coverage to another during a very stressful time. Both Covered California and Medi-Cal will be challenged during this time of great need. It is with these new realities in mind that Covered California constructed its FY 2020-21 proposed budget.

Covered California proposes an operating budget for FY 2020-21 of $440.2 million that provides for 1,419 authorized positions (Figure 4). Operating expenses are assumed to grow by 16.1 percent over FY 2019-20 actual/forecasted operating expenses of $379.1 million (for budget details, see Section IV).

[11] "State Employment and Unemployment Summary. April 2020," U.S. Bureau of Labor Statistics, May 22, 2020. URL: https://www.bls.gov/news.release/laus.nr0.htm

Figure 4
Covered California's Proposed FY 2020-21 Operating Budget
Distribution by Major Functional Area
$440.2 Million
1,419 Authorized Staff
(Dollars in Millions)



Based on our proposed FY 2020-21 budget, Covered California projects enrollment will grow by 15.5 percent above the FY 2019-20 actual/forecasted level, rising from 1,389,107 to 1,603,850 average monthly enrollees. This added enrollment is projected to increase operating revenues by $47.6 million over the FY 2019-20 actual/forecasted. We are forecasting that overall operating revenues and other income will increase by 11.0 percent over FY 2019-20 actual/forecasted, with revenues/income rising from $376.2 million to $417.7 million (Table 2).

Table 2
Covered California
Condensed State of Revenues, Expenses and Change in Net Position
FY 2019-20 Actual/Forecasted vs. FY 2020-21 Proposed Budget
(Dollars in Millions)

	FY 2019-20 Actual/Forecasted	FY 2020-21 Proposed Budget	Difference
Authorized Positions	1,391	1,419	28
Average Monthly Enrollment	1,389,107	1,603,850	214,743
Per-Member-Per-Month Individual Medical	$ 20.96	$ 20.64	$ (0.32)
Plan Individual - Medical	16,669,289	19,246,198	2,576,909
Plan Individual - Dental	2,499,445	2,251,221	(248,224)
Plan CCSB - Medical & Dental	747,512	651,776	(95,736)
Operating Revenues	$ 369.2	$ 416.8	$ 47.6
Other Income - SMIF Interest	$ 6.9	$ 0.9	$ (6.1)
Total Revenues/Income	$ 376.2	$ 417.7	$ 41.5
Operating Expenses			
Personnel Services	$ (129.6)	$ (157.1)	$ (27.5)
Contracts >$1M	$ (177.0)	$ (222.7)	$ (45.7)
Other OE&E	$ (72.5)	$ (60.3)	$ 12.1
Total Operating Expenses	$ (379.1)	$ (440.2)	$ (61.1)
Overall Increase/(Decrease) In Net Position	$ (2.9)	$ (22.5)	$ (19.6)

Covered California's proposed FY 2020-21 budget projects $417.7 million in revenues and $440.2 million in operating expenses and proposes to use resources from its substantial cash reserves to finance the planned expenditures during this unprecedented time. Funding the difference between revenues/income and operating expenses for FY 2020-21 would require the use of $22.5 million in cash reserve funds (Table 2). Under the base forecast for the multi-year financial projections, Covered California would still maintain reserves that would cover more than nine months of annual budgeted operations for the foreseeable future (see Appendix III — Multi-Year Financial Projection), which the organization believes is a prudent level that would allow for an adjustment of either revenue or expenditures in the event of a significant deviation from budgetary expectations.

Covered California plans to enhance its spending in several key areas that are central to its mission. The FY 2020-21 proposed budget is based on providing resources needed to support Covered California's efforts to help Californians maintain their health care coverage during the uncertainty of the COVID-19 recession and reflects the organization's four priority areas of focus in FY 2020-21:

1. **Continue to Meet the Needs of Californians by Delivering on Covered California's Mission of Expanding Coverage and Promoting Quality Care**

   The proposed budget reflects Covered California's ongoing focus on fulfilling its core strategic priorities (for detailed discussion of Covered California's strategic priorities, (see Appendix A-I), while continuously improving performance, striving to ensure that:

   - Health care provided through contracted plans is affordable to consumers.
   - Once covered, consumers receive needed care on a timely basis that recognizes the diverse needs and backgrounds of Californians.
   - Consumers are provided the encouragement, education and outreach they need to find the coverage most suited to their needs and make informed decisions.
   - Consumers have a positive experience that motivates them to maintain their coverage.
   - Our organization develops the internal tools and processes to ensure organizational excellence and provide the resources to meet our goals and objectives.

   The proposed budget continues building on all aspects of the organization that promote an effective market for consumers, keep coverage affordable, and make sure that consumers can obtain needed care and have a positive experience working with Covered California. Central to these efforts is ensuring that our workforce has the tools and resources to do their jobs well. The new budget builds on past years' capacity and human capital with about $6 million focused on information technology improvements and upgrades that enable the entire organization to be more effective.

2. **Responding to the Recession by Ramping Up Outreach, Marketing and Service Capacity to Meet Californians' Needs**

   As people lose employer-sponsored insurance and individuals and families in the individual market experience income loss, Covered California will experience both in-flows and out-flows in enrollment. With the economic downturn, using multiple sources to inform its modeling, Covered California's base forecast is that effectuated enrollment would rise by roughly 16.9 percent over FY 2019-20 actual/forecasted totals, with a corresponding increase in revenues.

   New and increased enrollment, however, means a greater focus on reaching out to the many Californians needing coverage. Effective marketing, customer outreach and education will be keys to ensuring Californians are aware of the coverage resources available to them — including the recently adopted state subsidies that build on and go beyond the Affordable Care Act, along with the state penalty mandate that brings back a key element that fostered enrollment when implemented nationally in 2014. Based on this need, the budget reflects increased expenditures, including:

- Increasing spending in the Marketing, Outreach and Sales area to total more than $157 million (above the current fiscal year budget of $121 million), with the bulk of that increase being $30 million in new marketing/advertising incurred for year-round investments in special-enrollment period marketing and adding two new staff in the marketing area.[12]
- Increasing service capacity by investing roughly $13 million in additional surge staffing. While the overall costs for providing service center capacity are increasing by $20 million from the prior fiscal year, much of the non-surge capacity costs related to personnel expenses are not related to new staff.

The additional expenditures related to marketing and adding service surge capacity represent incremental expenses that are forecasted to be scaled back in future years as volume and need subside. In addition, throughout this experience, Covered California will also use this opportunity — or natural experiment — to test the efficacy of specific marketing tactics and strategies to assess their value. Covered California will test the value of marketing by varying the spend during the special-enrollment period to evaluate its impact on enrollment and inform future marketing spending. Similarly, Covered California will evaluate service center capacity and service levels to inform future plans for both staff and contracted support.

3. Building Capacity to Continue Informing National and State Policy and Develop Model Purchasing Practices

Roughly $2 million is targeted to building the capacity of the policy, evaluation and plan management functions that help drive performance, provide greater oversight of contracted health insurance companies, and frame Covered California's lessons for state and federal policy makers.

With the coming presidential election and a new Congress that will be taking a fresh look at how to potentially modify, improve and expand the Affordable Care Act, policy information will be critical. At the same time, Covered California's approach to holding health insurance companies accountable while cultivating health care improvement that can benefit all Californians is only beginning to show its benefits. More work needs to be done to inform state and federal policy makers on how to develop a consumer-driven model that fosters needed change in how health care is delivered. In this context, the budget reflects the additional investments needed to hold plans accountable and to foster change in the delivery system at large. In addition, Covered California is proposing to augment its analytic capabilities with additional research staff and access to health care data repositories and consulting services.[13]

[12] The proposed marketing expenditures are independent of any increased spending that Covered California may incur that could be funded directly by health plans that do not plan to meet their "minimum" required spending on Direct Response promotion. To the extent this policy is adopted by the Covered California board and health insurance companies plan to rely on Covered California to meet their required spending, Covered California's spending would be increased, which would be offset by new revenues from health plans.

[13] As described in Section-IV: Covered California's FY 2020-21 Proposed Operating Budget: Program Detail, these areas of focus are being bolstered with six new staff in the Policy and Research section who

4. Reprioritize Workplans and Deliverables Considering the COVID-19 Pandemic

The post-COVID-19 environment has resulted in new realities. The shift to telework and other factors have affected not only Covered California's productivity, but the pandemic has also had dramatic impacts on our contracted health plans' requiring changes in expectations and demands to allow for focus on high-priority areas. This necessitates modifying specific activities such as responding to legislative deliverables, contract refreshments and space-planning needs. Some activities will need to be delayed, and others may be modified given the new circumstances.

Across the organization, the total budget for personnel in the proposed FY 2020-21 is approximately $27.5 million greater than FY 2019-20 actual/forecasted (Table 2). However, this increase in personnel expenses is largely the result of a declining vacancy rate, commitments for prefunding of retiree health care, general salary increases, supplemental pension payments, and increases in employer health care contributions — which collectively account for $24.5 million of the $27.5 million increase in personnel expenses. Only $3 million of this increase is the result of proposed FY 2020-21 staffing augmentations, which totaled 28 positions (representing a 2 percent increase in total positions).[14]

The interest income generated from the Surplus Money Investment Fund (SMIF) is projected to decline significantly. As noted in Table 2, "Other Income — SMIF Interest," projected interest income is expected to drop from $6.9 million in FY 2019-20 actual/forecasted to $0.9 million in the FY 2021-22 proposed budget. This decrease reflects the recent reductions in the federal funds rate. On March 15, 2020, the Federal Reserve dropped interest rates to near zero to support the economy.

will provide capacity for increased analytic efforts to explore, support, and evaluate new initiatives. Five new staff in the Plan Management area will support quality management strategies, expand the clinical and senior leadership team, and support the core workload related to quality standards, program oversight, and increased engagement with qualified health plans. This new staffing will also support Covered California's continued efforts to inform state and national policy.

[14] Authorized staff positions are proposed to be increased by 28 positions (a 2 percent increase in staffing), with positions added in Information Technology, Policy, Plan Management, Marketing, Executive Office and Ombuds Office. These new positions are generally split between investments designed to provide core technology support that cuts across the organization. They build the capacity of Covered California to actively foster better care delivered by its contracted health plans, and to inform state and national policy.

III. Covered California's FY 2020-21 Proposed Capital Projects Budget

To better plan and manage capital asset acquisitions, Covered California maintains a separate capital projects budget that was established in FY 2017-18. Covered California currently leases space in numerous locations and maintains headquarters, service centers and field operations. These activities periodically require extensive capital asset acquisitions, which may include buildings, leasehold improvements, office furniture and other capital expenditures.

Under the accrual method of accounting using the economic resources focus, capital expenses are recorded as assets and are not expensed in the period purchased. These capital assets are then depreciated over their useful lives. However, because Covered California maintains and records its annual budget using the modified accrual method of accounting with a current resource focus, it expenses capital assets in the period acquired. This means that large capital acquisitions will materially alter the operating budget in those years in which capital expenses are incurred.

In order to eliminate these swings in operating expenditures from year to year, ensure proper capital asset planning and control, and more clearly report budgetary operating outcomes, Covered California has established a separate capital budgeting process. This process entails identifying capital asset resource funding, capital asset expenditures, and capital asset funding balances.

The capital projects resource funding may be derived from operating surpluses or through transfers from its cash reserve. Based on board resolutions through the enactment of its annual budget, the board will approve the fiscal year capital asset budget as well as identify the source of funding. Capital project budget resources will be approved after evaluating working capital, current ratio and statutorily required operational reserves.

Covered California's board adopted the following principles that guide the organization's management of the capital projects budgeting process, which will:

- Adhere to established Covered California contracting procedures.
- Be funded via an annual allocation.
- Be used for specific facility projects, subject to board review and approval. This includes cost to build, renovate or buy equipment, property, facilities and associated infrastructure and information technology.
- Be included in the annual budget with an accounting of amounts added and expended each fiscal year.
- Fluctuate as any prior and current fiscal year unexpected funds are carried over for use in future fiscal years.

The term "capital assets" includes land, improvements to land, easements, buildings, building improvements, vehicles, machinery, equipment, infrastructure and all other

tangible or intangible assets that are used in operations and that have initial useful lives extending beyond a single reporting period.

The cost of a capital asset should include ancillary charges necessary to place the asset into its intended location and condition for use. Ancillary charges include costs that are directly attributable to asset acquisition — such as freight and transportation charges, site preparation costs and professional fees.

Budget Highlights and Key Changes

In FY 2019-20, Covered California allocated $20 million to the Capital Reserve fund.

Covered California incurred $13.3 million in capital project expenses during FY 2019-20.

These expenses were incurred for:

- Refurbishing, building out and furnishing a new three-story building in Fresno to house Service Center staff for $10 million.
- Furnishing and installing networking equipment at Arden site totaling $1.1 million.
- Other expenditures and improvements of $2.2 million.

The approved FY 2019-20 budget authorized $12 million in spending for capital projects. Subsequent board resolutions increased the authorized spending amount to $14.3 million. Covered California recognized a favorable capital projects budget variance in FY 2019-20 of $1 million (Table 3).

Table 3
FY 2019-20 Actual/Forecasted Capital Projects Expenditures
Compared to FY 2019-20 Approved Budget Expenditures
(Dollars in Millions)

	FY 2019-20 Actual/Forecasted
Capital Projects Budget	14.3
Capital Projects Expenditures	(13.3)
Difference	1.0

Covered California ended FY 2019-20 with a capital projects budget balance of $46.7 million.

For fiscal year 2020-21, Covered California proposes to provide $20 million in capital resource funding. The capital projects resource funding will be provided through Covered California's cash reserves (Table 4). Covered California has budgeted $20 million in capital project-related expenditures for FY 2020-21. These capital project expenditures will include:

- Covered California has engaged CBRE, Inc. to provide real estate consulting services. CBRE will assist with the renewal of leases at all locations through 2022 and provide project and construction management services for the various tenant improvements associated with those lease renewals. Expenditures in FY 2020-21 are estimated at $250,000.
- The Expo, Response and Arden leases are set to expire on April 30, 2022. Since 2015, Covered California has collaborated with the Department of General Services to evaluate the possibility of consolidating its locations into a single headquarters facility. In 2018, CBRE, Inc. was hired to assist in the solicitation of leasing proposals for this facility, and negotiations are underway with a developer. Expenditures in FY 2020-21 are estimated at $2.8 million.
- The Fresno lease at 7201 N Palm Ave. expired on Oct. 31, 2019, and a new location was acquired in July 2019. A tenant improvement team started to develop the 247 E. Nees Ave. location. The goal is to have this tenant improvement completed by July 2020 to enable staff to move into the new building. Expenditures in FY 2020-21 are estimated at $8.7 million.
- The Rancho Cordova lease expires on July 30, 2020, and it will be renewed for eight years. An essential and critical aspect of the lease renewal includes the acquisition of space on the third floor, and tenant improvements to the new and existing space. Expenditures in FY 2020-21 are estimated at $1.6 million.

Table 4
Covered California Capital Project Budget
And Year-End Capital Project Resources
(Dollars in Millions)

	FY 2019-20 Actual/Forecasted	FY 2020-21 Proposed Budget	FY 2021-22 Projected	FY 2022-23 Projected
Opening Capital Projects Budget Resources	$ 40.0	$ 46.7	$ 46.7	$ 53.7
Transfer to Capital Projects Fund	$ 20.0	$ 20.0	$ 20.0	$ 20.0
Capital Projects Resources Available	$ 60.0	$ 66.7	$ 66.7	$ 73.7
Less: Capital Projects Expenditures for the Period	$ (13.3)	$ (20.0)	$ (13.0)	$ (13.0)
Year-End Capital Projects Resources	$ 46.7	$ 46.7	$ 53.7	$ 60.7

IV. Covered California's FY 2020-21 Proposed Operating Budget: Program Detail and Comparison to FY 2019-20 Actual/Forecasted

The program detail for Covered California's FY 2020-21 proposed operating budget provides information on staffing levels and expenditures for each of Covered California's five major functional areas and 19 divisions, comparing the FY 2019-20 approved budget and actual/forecasted operating expenses[15] to the FY 2020-21 proposed budget.

We start with a comparison of operating expenses for each of the five major functional areas. This provides the reader with a high-level overview of how Covered California's operating expenses will change between FY 2019-20 actual/forecasted and the proposed FY 2020-21 budget. We highlight significant differences in expenses within each functional area. We also provide a high-level view of how Covered California's total operating expenses varied between the FY 2019-20 approved budget, the FY 2019-20 actual/forecasted outcome and the proposed FY 2020-21 budget. This analysis focuses on two expense categories: personnel and all other operational expenses.

We then provide functional area and division-level program detail. Each section starts at the functional area and is followed by division-level summaries. Each division-level summary includes a brief description of the division, as well as budget highlights and the division's key objectives for FY 2020-21. The descriptions seek to show how the activities are aligned with Covered California's strategic priorities and provide the rationale for any significant increases in proposed expenditures and staffing included in the proposed budget.

The division-level information on operating expenses is categorized as follows: personnel services, which includes salary and benefits, and operating expenses, which includes expenses associated with contracts and other purchases. Allocated expenses refer to expenditures for information technology and other statewide shared enterprise expenses. These expenses are allocated to each program and are presented as separate line items within each division's program summary. Capital projects are budgeted separately and are presented in Section III — Covered California's FY 2020-21 Proposed Capital Projects Budget.

There are very few changes proposed in staffing for FY 2020-21. The proposed budget adds 28 new full-time positions that will increase the size of Covered California's staff by 2 percent. The Service Center will also be converting 30 permanent-intermittent positions to permanent-full time. Each division's personnel expenses display cost increases that reflect general and organization-wide cost drivers that are reflected in the workload budget. In FY 2020-21, these will include a scheduled 2.5 percent salary increase negotiated by the state of California with SEIU, pre-funding of retiree health care, supplemental pension contributions and a reduction in salary savings resulting from a decline in Covered California's vacancy rate during FY 2019-20. (For a full discussion of the workload budget and personnel expense increases, see Appendix A-V.)

[15] Actual/forecasted expenses consist of nine months of actual expenses and three forecasted months.

Table 5
Budget Area Cross-Walk to Covered California Divisions

Functional Area Description	Division
Plan Management and Policy/Eligibility Research	Plan Management
	Policy, Eligibility and Research Division
Marketing, Outreach/Sales and Related Programs	Marketing
	Outreach and Sales
	Program Integrity
	Communications and Public Relations
Service Center and Consumer Experience	Service Center
	Ombuds Office
	Customer Care
Technology	California Healthcare Eligibility, Enrollment and Retention System
	Information Technology
Administration	Business Services Branch
	Financial Management Division
	Human Resources Branch
	Office of Legal Affairs
	Covered California University
	Executive Office
	External Affairs
	Equal Employment Opportunity Office

Overall Changes in Operating Expenses Between FY 2019-20 Actual/Forecasted and the FY 2020-21 Proposed Budget by Functional Area

The proposed FY 2020-21 operating budget provides $440.2 million to carry out Covered California's mission. In addition to general salary increases, supplemental pension payments and pre-funding of retiree health care, changes also include increases to the areas of Marketing, Outreach/Sales and Other, Service Center and the Consumer Experience, Plan Management, Eligibility, Administration and Technology. The $440.2 million proposed budget for FY 2020-21 represents a $61.1 million (16.1 percent) increase over FY 2019-20 actual/forecasted expenses.

Below is a summary of the major changes for each functional area, which compares the FY 2020-21 proposed budget total operating expenses to the FY 2019-20 actual/forecast total operating expenses.

Table 6
Expenses by Major Program Group; FY 2019-20 Approved Budget, FY 2019-20 Actual and Forecasted, and FY Proposed Budget

Functional Area	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget	Difference
Plan Management and Policy/ Research/ Eligibility	$ 19.0	$ 28.4	$ 9.4
Marketing, Outreach/Sales	$ 126.4	$ 157.7	$ 31.2
Service Center and Consumer Experience	$ 120.5	$ 135.4	$ 14.9
Technology	$ 63.1	$ 61.4	$ (1.7)
Administration	$ 50.1	$ 57.4	$ 7.2
Total	**$ 379.1**	**$ 440.2**	**$ 61.1**

Note: The expenses presented in the table represent expenses after allocating Pro-Rata and IT.

Comparing FY 2019-20 Actual/Forecasted to the Proposed FY 2020-21 Budget by Expense Category

Personnel Expenses

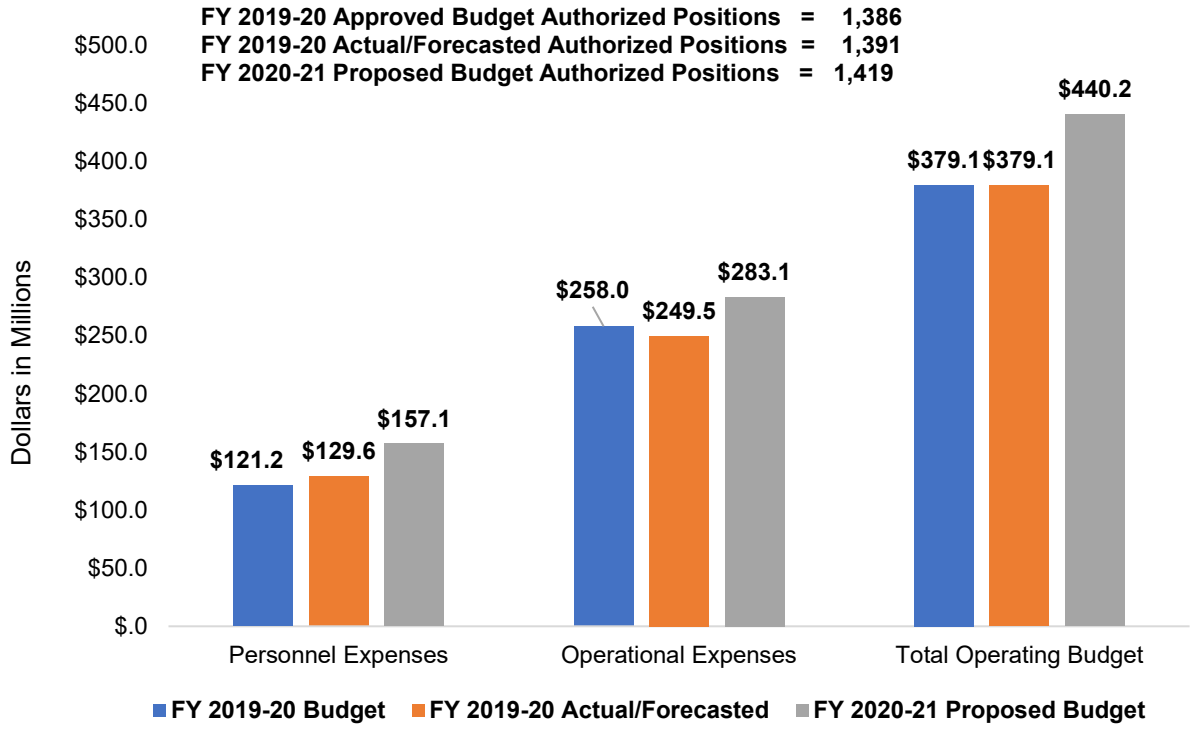
Proposed FY 2020-21 expenses for personnel are approximately $27.5 million greater than FY 2019-20 actual/forecasted. The increase in personnel expenses is largely the result of a declining vacancy rate, commitments for prefunding of retiree health care, general salary increases, supplemental pension payments and increases in employer health care contributions — which collectively account for $24.5 million of the $27.5 million increase in personnel costs (Figure 5). Only $3 million of this increase is the result of proposed FY 2020-21 staffing augmentations, which totaled 28 positions (representing a 2 percent increase in total positions).

The $3.3 million in additional staffing augmentations represents roughly 5 percent of the overall $60.1 million increase in budget augmentations.

Operational Expenditures

The proposed FY 2020-21 budget of $440.2 million includes all contract and operational expenses, such as paid media, CalHEERS, IT infrastructure, Service Center surge vendor, Navigators and Covered California for Small Business sales and administrative support. FY 2020-21's proposed overall operational expenses were $61.1 million greater than FY 2019-20. Roughly 86 percent of the increase is associated with Marketing, Outreach and Sales, and expanded customer service capacity (Figure 5).

Figure 5
Comparison of FY 2019-20 Actual/Forecasted Operating Expenses to FY 2020-21 Proposed Budget Expenses
(Dollars in Millions)



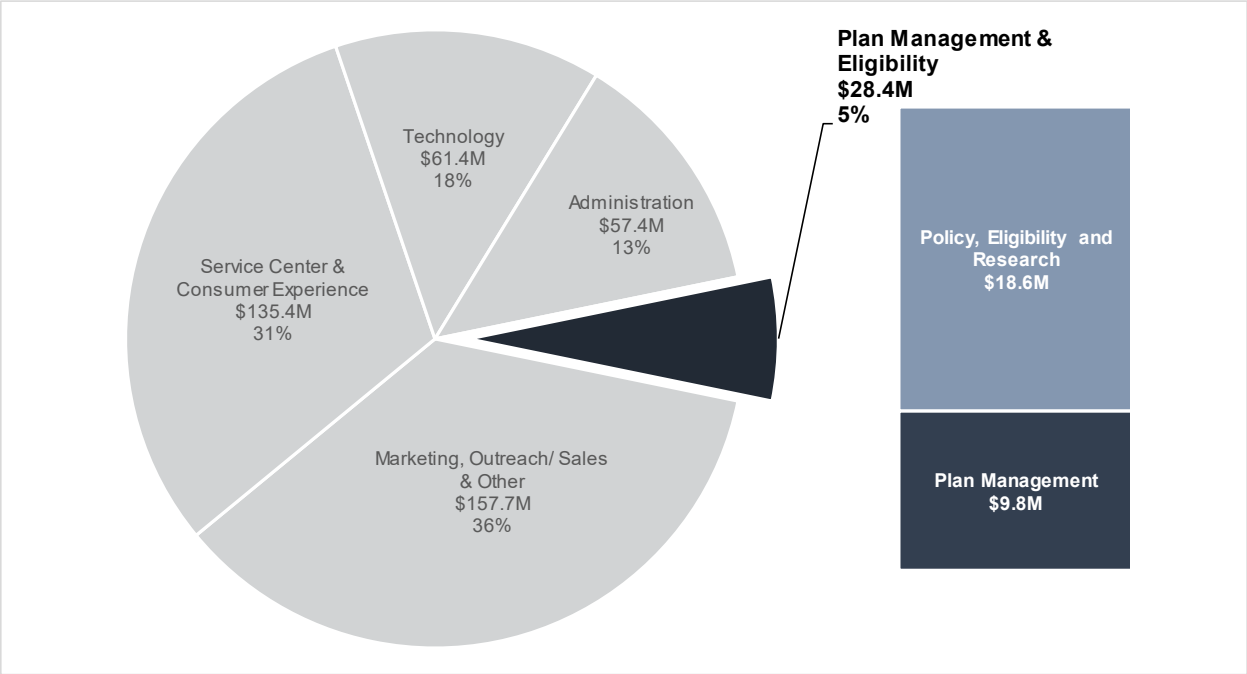
Plan Management and Policy, Eligibility and Research

Plan Management and the Policy, Eligibility and Research area includes the Plan Management division and the Policy, Eligibility and Research division and has a proposed budget for FY 2020-21 of $28.4 million (Figure 6).

Plan Management and Eligibility — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	87	89	100
Personnel Services	$ 10,019,900	$ 9,616,501	$ 13,095,880
Operating Expenses	$ 8,203,840	$ 7,369,621	$ 12,944,981
Total Expenses	**$ 18,223,740**	**$ 16,986,122**	**$ 26,040,861**
Information Technology Support	$ 1,227,397	$ 1,120,701	$ 1,221,572
ProRata / Sup. Pension Pay / Other	$ 993,793	$ 895,462	$ 1,115,935
Total Operating Costs	**$ 20,444,930**	**$ 19,002,284**	**$ 28,378,368**

Figure 6
Plan Management and Eligibility
FY 2020-21 Proposed Budget
(Dollars in Millions)



Plan Management Division

Division Description

The Plan Management division's purpose is to improve the cost, quality and accessibility of the health care delivered to consumers by selecting, negotiating with and holding Covered California's contracted health insurance companies accountable for delivering quality health care while fostering improvements in care delivery that can benefit all Californians.

Division Budget — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	41	41	46
Personnel Services	$ 5,107,007	$ 5,099,259	$ 6,473,194
Operating Expenses	$ 2,281,522	$ 1,685,560	$ 2,355,000
Total Expenses	**$ 7,388,529**	**$ 6,784,818**	**$ 8,828,194**
Information Technology Support	$ 578,428	$ 516,278	$ 561,923
ProRata / Sup. Pension Pay / Other	$ 418,240	$ 370,247	$ 411,893
Total Operating Costs	**$ 8,385,197**	**$ 7,671,343**	**$ 9,802,010**

Note: The Plan Management division has two exempt positions.[16]

Highlights for Proposed FY 2020-21 Budget and Key Changes

This budget includes a proposed increase from 41 to 46 authorized positions, with these five proposed positions supporting quality improvement strategies, developing quality standards, providing program oversight and engagement with health and dental insurance companies on quality measures, and performing audit functions related to performance metrics. This investment in staff will enhance Covered California's ability to hold its contracted health insurance companies accountable and has the potential to inform the wider California and national health policy.

Operating expenses are forecasted to rise from $1.7 million in FY 2019-20 actual/forecasted to $2.3 million in the FY 2020-21 proposed budget, which is the level of contracted services the division anticipates spending in the year. The major operating expenses proposed for FY 2020-21 include contracts for consulting services related to medical issues and analysis of health plan performance, which total about $1.2 million, and contracts for actuarial services totaling about $550,000.

Key Objectives for FY 2020-21

The Plan Management division will focus on the following core areas in the upcoming fiscal year:

[16] These two exempt positions include the chief medical officer (monthly salary: $30,211) and director of Plan Management (monthly salary: $15,120). This information is reported in compliance with Government Code 100503, Section 2(A).

- Conduct regular negotiating, oversight and accountability processes for the 11 contracted health plan issuers — as well as consider applications for new health issuers.
- Gain agreement with contracted health plan issuers and stakeholders on contractual revisions for the 2022 plan year that will lay the groundwork for major contract changes to take effect in the 2023 plan year. These changes are intended to promote quality and access of care.

In addition to core division functions and ongoing initiatives listed above, Plan Management anticipates these key new strategies in the upcoming fiscal year:

- Build upon lessons learned from its health plan issuer contracting experience, continue engaging with external stakeholders, and increase alignment with other purchasers to improve the value and quality of care delivered to individual market consumers and Californians in general. This will be accomplished through material changes in the contracted health plan issuer contracts for plan year 2022, transitioning to more significant changes for the 2023-25 contract term, guided by Covered California's vision for health care in 2030.
- In parallel with, and sometimes taking precedence over these efforts, Plan Management will work with its contracted health plan issuers, aligned purchasers and other interested stakeholders to ensure Covered California enrollees, and Californians in general, receive the best possible health care during the ongoing COVID-19 pandemic.

Policy, Eligibility and Research Division

Division Description

The Policy, Eligibility and Research division, through its Eligibility Branch, ensures appropriate implementation of program-eligibility rules. The Policy and Research Branch provides accurate, complete and timely policy and data analysis to support evidence-based decision-making, with a focus on analyzing both enrollment and the care provided by contracted health insurance companies to support Plan Management's work to hold them accountable.

Division Budget — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	46	48	54
Personnel Services	$ 4,912,893	$ 4,517,242	$ 6,622,686
Operating Expenses	$ 5,922,318	$ 5,684,061	$ 10,589,981
Total Expenses	**$ 10,835,211**	**$ 10,201,303**	**$ 17,212,667**
Information Technology Support	$ 648,968	$ 604,423	$ 659,649
ProRata / Sup. Pension Pay / Other	$ 575,553	$ 525,215	$ 704,042
Total Operating Costs	**$ 12,059,732**	**$ 11,330,941**	**$ 18,576,358**

Highlights for Proposed FY 2020-21 Budget and Key Changes

The FY 2020-21 proposed budget adds eight staff, with six new staff proposed for the Policy and Research section to provide capacity for increased analytic efforts to explore, support and evaluate new initiatives. The Eligibility Branch would add two additional analysts to continue to improve the quality assurance functions that help ensure that CalHEERS is delivering the correct eligibility for all consumer scenarios.

The Evaluation and Research Branch would also add contract funding to enhance the organization's ability to conduct policy-relevant research related to Covered California's innovative policy interventions.

The $5 million increase in operating expenses between FY 2019-20 actual/forecasted and the FY 2020-21 proposed budget is the result of postage expenses totaling $4.0 million; increased contract expenses for business associates totaling $250,000; funding allocated for data architect services for $250,0000; and $500,000 for future research and consulting.

The major operating expenses proposed for FY 2020-21 include:

- The Healthcare Evidence Initiative is a major effort to pool and analyze the claims and care experience of all Covered California enrollees across all of its contracted carriers. The data collection and evaluation of these data is done under a contract that is valued at approximately $2.1 million.
- Professional services associated with forecasting and modeling includes accessing data such as CHIS and CalSIM, with contracts totaling $1.0 million.

- Covered California maintains a consulting pool to access knowledge and skills not currently available within Covered California that are required throughout the year, with the resources available for this function totaling approximately $850,000.
- The other major operating expense for the division relates to the postage expense related to sending eligibility-related notifications to enrollees. In most years this expense runs about $3.5 million, but the FY 2020-21 proposed budget reflects an increase to $4.1 million, which is based on anticipated higher enrollment.

Key Objectives for FY 2020-21

The Policy, Eligibility and Research division will focus on the following core areas in the upcoming fiscal year:

- Act as an advisor and resource to management on the development, implementation and evaluation of program policies, including the coordination of the provision of input on federal and state exchange policy, rules and regulations.
- Manage data analytics strategy and infrastructure to create dashboards and custom evaluations of operations related to enrollment and eligibility.
- Lead modeling for policy design and data analysis for evaluation of new interventions in the marketplace.
- Coordinate with state departments to improve transitions of consumers between coverage through Medi-Cal and Covered California.
- Develop reports on critical issues to inform policy development and strategies.

In addition to core division functions and ongoing initiatives listed above, the Policy division anticipates these key new strategies in the upcoming fiscal year:

- Ensure that Covered California's application for coverage makes it as easy as possible for consumers to apply for coverage during the COVID-19 pandemic and growing recession by aligning income-reporting and application processes to address widespread losses of job-based coverage, and new categories of income (such as pandemic-specific unemployment insurance).
- Ensure that the second year of the new state subsidy program and the state mandate exemptions process are successfully implemented.
- Prepare for implementation of SB 260 (i.e., auto-enrollment of consumers transitioning from eligibility for Medi-Cal to Covered California).
- Provide timely analysis and research to support a new Congress about the experience of Covered California and how that may inform national policy.

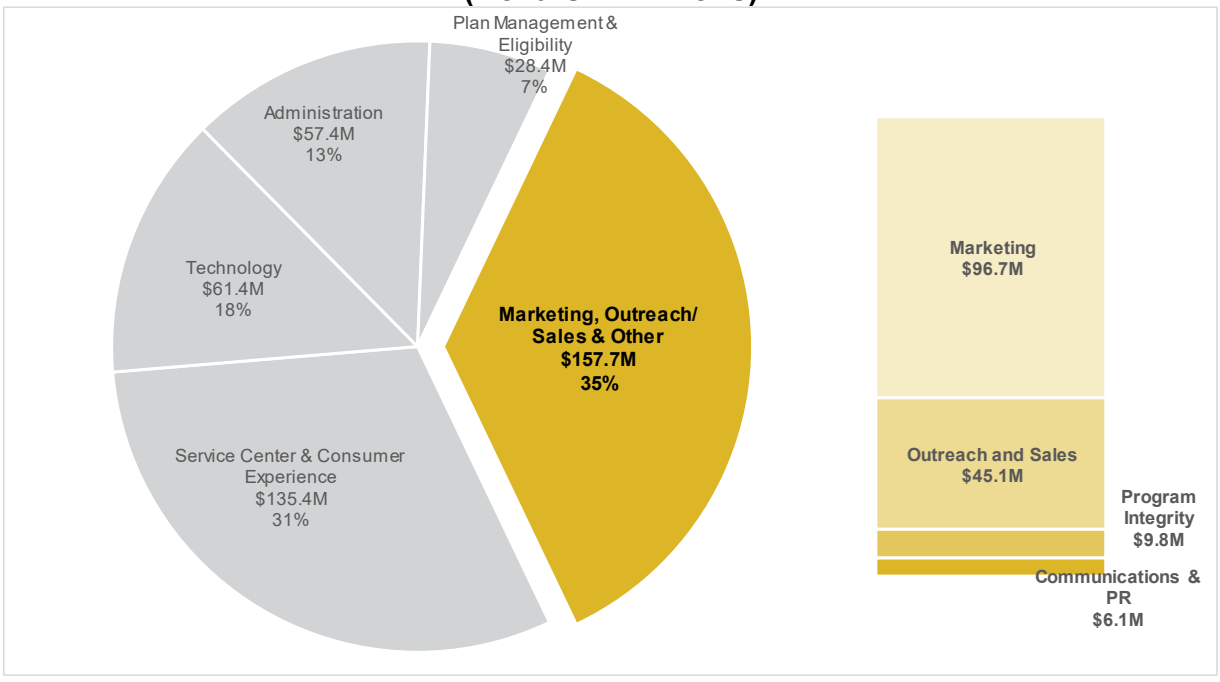
Marketing, Outreach/Sales

Marketing, Outreach/Sales area includes the following divisions: Marketing, Outreach and Sales, Program Integrity, and Communications and Public Relations. The total proposed budget for FY 2020-21 is $157.7 million (Figure 7).

Marketing, Outreach/Sales, Communications and Program Integrity — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	172	173	175
Personnel Services	$ 17,807,598	$ 17,482,538	$ 21,502,945
Operating Expenses	$ 94,436,029	$ 101,508,254	$ 128,689,322
Total Expenses	**$112,243,627**	**$118,990,792**	**$150,192,267**
Information Technology Support	$ 2,426,578	$ 2,178,441	$ 2,137,750
ProRata / Sup. Pension Pay / Other	$ 5,147,549	$ 5,233,991	$ 5,321,274
Total Operating Costs	**$119,817,753**	**$126,403,224**	**$157,651,291**

Figure 7
Marketing, Outreach/Sales and Other
FY 2020-21 Proposed Budget
(Dollars in Millions)



Marketing Division

Division Description

The Marketing division is responsible for implementing Covered California's comprehensive marketing campaign strategy to reach and motivate Californians to enroll in or renew health insurance through Covered California. Covered California's marketing and advertising efforts are anchored in and responsive to effectively reaching California's ethnic, cultural, regional and language diversity.

Division Budget — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	27	27	29
Personnel Services	$ 3,147,948	$ 3,169,594	$ 3,915,546
Operating Expenses	$ 63,054,992	$ 70,167,403	$ 89,343,702
Total Expenses	**$ 66,202,940**	**$ 73,336,997**	**$ 93,259,248**
Information Technology Support	$ 380,916	$ 339,988	$ 354,256
ProRata / Sup. Pension Pay / Other	$ 2,836,927	$ 3,042,205	$ 3,083,071
Total Operating Costs	**$ 69,420,783**	**$ 76,719,190**	**$ 96,696,574**

Note: The Marketing division has one exempt position[17]

Highlights for Proposed FY 2020-21 Budget and Key Changes

This budget includes a proposed increase from 27 to 29 positions, with the two positions assisting with the development and implementation of multi-media advertising campaigns for the open- and special-enrollment periods to reach the diverse populations of California.

The proposed budget builds on FY 2019-20, in which expenditures were significantly higher than the previous year and higher than budgeted as the organization reallocated spending to do additional marketing related to the new state subsidies and the individual mandate, as well as a major effort to reach out to Californians losing coverage due to the COVID-19 recession.

Not reflected in the FY 2019-20 actual/forecasted budget is an additional $3.25 million in marketing expenditures that Covered California expended on behalf of contracted health plans that agreed to support additional marketing and — rather than spend the funds directly — provided resources to Covered California. These resources were part of what freed up Covered California marketing resources for outreach during the COVID-19 special-enrollment period.

[17] The exempt position is director of Marketing (monthly salary: $14,167). This information is reported in compliance with Government Code 100503, Section 2(A).

Covered California plans to continue to use expanded income-targeting parameters to reach all subsidy-eligible populations, including middle-income consumers — including those newly eligible for Covered California and Medi-Cal because of the coronavirus pandemic. The $89.3 million in contracted expenses includes both creative development and placement of advertising through a range of mediums.

Given our increased investments in marketing, we will undertake a review of all acquisition costs, including those within our Outreach and Sales Division and by our certified health carriers, to develop for consideration various approaches, potential requirements on health insurance companies related to marketing and agent commissions, and funding methodologies that takes into account the assuring investments made to enroll and retain members by both Covered California and its health plans are appropriate.

Key Objectives for FY 2020-21

The Marketing division anticipates the following key focus areas in the upcoming fiscal year[1]:

- Open enrollment: Continue robust advertising and promotion with a dramatic increase of $38 million over FY 2018-19 budget allocations for advertising expenditures. Based on the proposed FY 2020-21 budget, the division expects to reach consumers more often during open enrollment, by nearly 50 percent from FY 2018-19 totals, estimating nearly 3 billion impressions in open enrollment during FY 2020-21, compared to 2 billion impressions in open enrollment during FY 2018-19. Stated another way, on average, every California adult will see Covered California messages approximately 94 times during the upcoming open-enrollment period, compared to 66 times during the FY 2018-19 open-enrollment period because of paid advertising. Examples of increases in member outreach comprehensive campaign during open enrollment include:
    - Sending at least 11 million emails, or 33 percent more than was sent in FY 2018-19.
    - Mailing more than 3.5 million letters and postcards, or 111 percent more than were mailed in FY 2018-19.
- Special enrollment: Substantially increase marketing efforts during FY 2020-21 special-enrollment periods from July through October and February through June, increasing media spending to about $3.5 million per month, more than a 600 percent increase over the average $500,000 per month spent during the same time period in FY 2018-19. Investing these additional resources in marketing and advertising is expected to generate 1 billion impressions, a 233 percent increase over FY 2018-19 levels, estimating on average every California adult will see Covered California messages 33 times during the special-enrollment months compared to 10 times during FY 2019-20. Increased member outreach during FY 2020-21 special-enrollment periods include additional efforts to educate existing members in plan use, managing their online account, and program benefits for maximizing renewal during open enrollment by:

- Sending at least 15 million emails, or 56 percent more than were sent in FY 2018-19.
- Mailing more than 1.5 million letters and postcards, or 8 percent more than were mailed in FY 2018-19.
- Transmitting about 1 million text messages (texting to members will be a new effort and investment during FY 2020-21 special enrollment).

Outreach and Sales Division

Division Description

The purpose of the Outreach and Sales division is to support the "on the ground" work to help Californians understand and enroll in coverage, in addition to supporting independent insurance agents, running a navigator program and operating the Covered California for Small Business program that helps small businesses find and enroll in coverage. The Outreach and Sales division has two parts: the individual market and Covered California for Small Business.

Division Budget — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	62	62	62
Personnel Services	$ 6,338,698	$ 6,541,688	$ 7,605,435
Operating Expenses	$ 26,957,037	$ 27,692,242	$ 35,164,620
Total Expenses	**$ 33,295,735**	**$ 34,233,930**	**$ 42,770,055**
Information Technology Support	$ 874,697	$ 780,713	$ 757,374
ProRata / Sup. Pension Pay / Other	$ 1,556,329	$ 1,534,031	$ 1,549,094
Total Operating Costs	**$ 35,726,761**	**$ 36,548,675**	**$ 45,076,523**

Note: The Outreach and Sales division has one exempt position[18].

Highlights for Proposed FY 2020-21 Budget and Key Changes

The increase in the Outreach and Sales division's operating expenses reflects the start of a Covered California investment over the next three fiscal years in improvements by Covered California for Small Business in the four major components of its operations: Agent Service Center, enrollment and eligibility, NFP, and sales and marketing. The increase in operating expenses of approximately $8.4 million reflects the difference between its current baseline spending and the increased investments beginning in FY 2020-21.

The major operating expenses proposed for FY 2020-21 include:

- The Outreach and Sales division anticipated $6.5 million associated with the competitively awarded funding of Covered California's Navigator program, which is a partnership with community organizations across the state who have experience in reaching and assisting California's diverse populations and have proven success enrolling consumers in health care programs. The Navigators are Certified Enrollment Counselors who assist consumers through a variety of outreach, education, enrollment, post-enrollment and renewal support services. They have expertise in eligibility, enrollment and program specifications and

[18] The exempt position is Individual and Small Business Outreach and Sales division director (monthly salary: $17,469). This information is reported in compliance with Government Code 100503, Section 2(A).

conduct public education activities to raise awareness of the availability of Covered California products.

- Covered California for Small Business administrative services are projected to total approximately $16.5 million. Covered California contracts with an administrative vendor to provide Agent Service Center, Enrollment and Eligibility, fiscal agent services, and Sales and Marketing.
- Marketing to promote enrollment in Covered California for Small Business is budgeted at about $1.3 million.

Key Objectives for FY 2020-21

The Outreach and Sales division will focus on the following core areas in the upcoming fiscal year:

- The Outreach and Sales division will continue its active outreach, communications and education programs to more than 10,000 certified enrollers who provide person-to-person enrollment assistance to more than 600,000 Californians who seek their guidance each year. The program upgrade will include improving virtual training programs and providing guidance and education that are especially relevant in today's environment where consumers need help and guidance on a real-time basis. In addition, we will review the appropriateness of our funding methodology and enrollment targets and consider alternative approaches as we continue to support the Navigator program.
- The Outreach and Sales division will continue its investment in improving operational efficiency, including a three-year expenditure of $8.5 million to upgrade Covered California for Small Business's enrollment and eligibility platform and processes. The improved capability will enable the program to efficiently and accurately on-board employer groups, employees and covered dependents into participating group health plans and is crucial to the program's future business growth. The investment provides for additional staffing, technology enhancements and long-term cost and quality control.

Communications and Public Relations Division

Division Description

The Communications and Public Relations division serves two functions. Through the Broadcast and Media Relations Branch, it links to broadcast, print and online media while also developing, coordinating and executing an extensive proactive program of media relations and public communications that support enrollment in Covered California. Through the Web and Administrative Branch, it develops an overarching strategy for Covered California's public-facing website content, which includes CoveredCA.com and HBEX.coveredca.com.

Division Budget — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	20	21	21
Personnel Services	$ 2,076,418	$ 2,173,772	$ 2,888,537
Operating Expenses	$ 2,690,000	$ 2,967,444	$ 2,736,000
Total Expenses	**$ 4,766,418**	**$ 5,141,216**	**$ 5,624,537**
Information Technology Support	$ 282,160	$ 264,435	$ 256,530
ProRata / Sup. Pension Pay / Other	$ 252,556	$ 257,337	$ 239,368
Total Operating Costs	**$ 5,301,134**	**$ 5,662,988**	**$ 6,120,435**

Note: The Communications and Public Relations division has two exempt positions[19].

Highlights for Proposed FY 2020-21 Budget and Key Changes

The major operating expense for the division consists of a contract with IPG for public relations, outreach and education services for a three to five year period beginning July 1, 2019, totaling $2.5 million per year. Covered California works with IPG to plan and execute earned media events to generate millions of impressions in state and national media. The main areas of work with IPG are: 1) large-scale event planning at locations throughout California to generate local news coverage at the start of open enrollment and during the final days before the deadline to enroll; 2) expert advice on reaching young Californians with digital public relations efforts in an ever-changing information environment; 3) assistance with target-segment media relations (i.e., Spanish-language phone banks, Asian-language press release translation, etc.); 4) national media research to inform Covered California's growing role in the national news conversation related to the Affordable Care Act; and, 5) research on the many new digital news platforms delivering information to California residents in their communities.

The increase in staffing from 20 to 21 resulted from adding one media specialist during FY 2019-20. The position focuses on producing "Real Stories" videos, depicting first-

[19] The exempt positions are director of Communications and Public Relations (monthly salary: $16,833) and deputy director for Communications and Public Relations (currently vacant). This information is reported in compliance with Government Code 100503, Section 2(A).

person accounts of Californians sharing their experiences as enrollees and the impact health insurance has had on their lives.

Key Objectives for FY 2020-21

The Communications and Public Relations division will focus on the following core areas in the upcoming fiscal year:

- Promote enrollment through extensive and innovative earned, owned and paid media efforts designed to educate consumers and the media about the value and importance of Covered California and the health care coverage options and financial assistance that it offers.
- Raise awareness of Covered California's efforts and results through proactive outreach to national and statewide news outlets as well as prominent health-related outlets.
- Improve the consumer experience of CoveredCA.com through evidence-based updates aimed at increasing understanding and ease of use.
- Provide communications expertise and support across the organization to further the goals of individual divisions, including writing, designing and developing messaging for significant publications such as the rate booklet, budget and annual report, issue briefs and external presentations.

Program Integrity Division

Division Description

The Program Integrity division serves two functions. Through its Reconciliation of Enrollment and Membership Unit, it ensures accuracy and alignment of data between Covered California and carrier systems and conducts system testing and performance review of CalHEERS. Through its Program Oversight and Compliance Unit, it conducts internal/external audits and assists all divisions in identifying and remediating enterprise-wide risks. The division encourages accountability, transparency, effectiveness, efficiency and risk management by independently reviewing key business areas to help ensure compliance with federal and state laws, regulations and policies.

Division Budget — Multi-Year View

Highlights for Proposed FY 2020-21 Budget and Key Changes

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	63	63	63
Personnel Services	$ 6,244,534	$ 5,597,484	$ 7,093,428
Operating Expenses	$ 1,734,000	$ 681,164	$ 1,445,000
Total Expenses	**$ 7,978,534**	**$ 6,278,648**	**$ 8,538,428**
Information Technology Support	$ 888,805	$ 793,305	$ 769,590
ProRata / Sup. Pension Pay / Other	$ 501,736	$ 400,417	$ 449,742
Total Operating Costs	**$ 9,369,075**	**$ 7,472,371**	**$ 9,757,760**

The proposed operating expenses for the FY 2020-21 proposed budget reflect two major areas:

- Consulting services related to programmatic and financial auditing, training, predictive analytics and other auditing support, which are projected to cost $750,000 in FY 2020-21.
- Fraud detection software and predictive analytics, which are estimated to costs $300,000in FY 2020-21.

The FY 2019-20 actual/forecasted operating expenses were less than the approved FY 2019-20 budget because some anticipated contracted services did not occur, including planned auditing consulting services, audit software that was not purchased and predictive analytics used to identify fraud totaling $250,000.

Key Objectives for FY 2020-21

The Program Integrity division will focus on the following core areas in the upcoming fiscal year:

- Ensure the accuracy of consumer financial-eligibility determinations between CalHEERS and the carrier systems.
- Streamline and enhance the CalHEERS testing processes.

- Refine and enhance data analytics to detect potential fraud, waste and abuse trends.
- Enhance and promote enterprise-wide risk management processes.

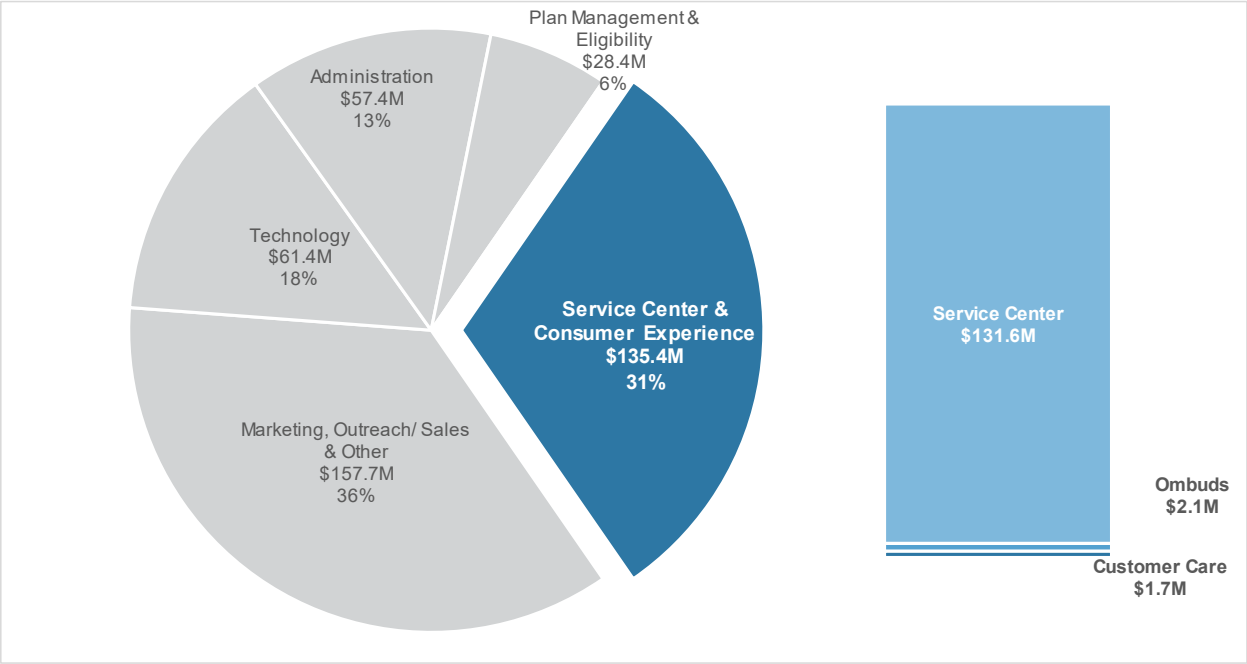
Service Center and Consumer Experience

The Service Center and Consumer Experience area includes the following divisions: Service Center, Ombuds Office and Customer Care. The total proposed budget for FY 2020-21 is $135.4 million (Figure 8).

Service Center and Consumer Experience — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	818	819	822
Personnel Services	$ 55,803,826	$ 62,729,476	$ 70,466,466
Operating Expenses	$ 36,380,991	$ 36,017,647	$ 43,930,841
Total Expenses	**$ 92,184,817**	**$ 98,747,124**	**$ 114,397,307**
Information Technology Support	$ 17,040,352	$ 15,812,966	$ 15,041,318
ProRata / Sup. Pension Pay / Other	$ 6,038,135	$ 5,901,261	$ 5,964,364
Total Operating Costs	**$ 115,263,304**	**$ 120,461,351**	**$ 135,402,988**

Figure 8
Service Center and Consumer Experience
FY 2020-21 Proposed Budget
(Dollars in Millions)



Service Center

Division Description

The Service Center provides comprehensive pre- and post-enrollment education and support to Covered California consumers by responding to consumer inquiries, enrolling consumers in health plans and promptly resolving challenges that prevent them from receiving health and dental benefits. These efforts ensure consumers receive the right care at the right time at an affordable price, retain coverage and are satisfied with Covered California products and services.

Division Budget — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	798	798	799
Personnel Services	$ 53,782,586	$ 60,460,299	$ 67,583,347
Operating Expenses	$ 35,671,991	$ 35,526,239	$ 43,489,841
Total Expenses	**$ 89,454,577**	**$ 95,986,538**	**$ 111,073,188**
Information Technology Support	$ 16,758,192	$ 15,548,531	$ 14,760,357
ProRata / Sup. Pension Pay / Other	$ 5,870,611	$ 5,740,657	$ 5,793,510
Total Operating Costs	**$ 112,083,380**	**$ 117,275,726**	**$ 131,627,055**

Highlights for Proposed FY 2020-21 Budget and Key Changes

The proposed budget includes an increase from 798 to 799 positions. The Service Center proposes to add one Career Executive Assignment-Level B (CEA B) and proposes to convert 30 existing permanent-intermittent program technician (PT) II positions to full-time PT II positions in both the Rancho Cordova and Fresno service centers. These permanent-intermittent positions are the consumer-facing staff in the service center, taking calls and processing enrollments for Covered California consumers.

The Service Center division is proposing an increase in the number of contracted customer service representatives available from the surge vendor to accommodate an increase in demand for information and assistance from individuals affected by the COVID-19 recession. The surge vendor, Faneuil, provides contracted customer service representatives who can be used during the busy open-enrollment periods and scaled back in the months following open enrollment, when demand for assistance decreases. The normal staffing level for surge support is contracted at a floor level of 250 staff, which grows to 600 to meet the high demands during open enrollment. The total engagement proposed for Faneuil in FY 2020-21 is $30.9 million, which includes $3.6 million for additional customer service representatives between July and October 2020 (reflecting an additional 225 staff for a total surge support staffing of 475), and an additional $8 million to hire and train customer service representatives who will be in place by November 2020 (reflecting an additional 400 staff during open enrollment for a total surge support staffing during this time of 1,000 positions).

These two proposed increases were actually partially implemented in FY 2019-20 — spending over the originally budgeted amounts for the surge contract — to address high demands in services with the implementation of the state subsidies and the state mandate. For FY 2020-21, these increases would represent a one-year increase in the Service Center division's operating expenses to have additional capacity to handle higher service demands during the recession, with the plan to conduct additional review of what levels of staffing are appropriate in future years and the balance between filling needs with Covered California staff and the more easily adjustable surge support through contracted services.

Additional major operating expenses proposed for FY 2020-21 include an interagency agreement with the California Department of Social Services, which provides appeals services to Covered California, for about $9 million, and interpreter services that total approximately $2.3 million.

Key Objectives for FY 2020-21

The Service Center division will continue its core focus on effectively responding to as many consumer inquiries as possible by leveraging all available planning tools and resources. The Service Center division uses forecasts, staffing models and workload plans to inform its work to balance priorities and optimize productivity and continue striving to increase consumer satisfaction. In FY 2019-20, the Service Center provided personal assistance 2.1 million times to consumers and an additional 2.2 million occasions of consumers being served through responses provided by the Integrated Voice Response automated response system that addresses consumers' issues with recorded messages.

Two of the key metrics considered by the Service Center in assessing its consumer service are rates of consumer satisfaction for people who complete calls and the abandonment rate, or the rate at which consumers decide not to wait to have their call answered by a service center representative.

For FY 2019-20, consumers registered a very high level of satisfaction in the services provided, stating they were "very satisfied" 88.5 percent of the time for callers in open enrollment and 86.8 percent for those calling during special enrollment. The Service Center's goal is to maintain the rate at which consumers who complete calls are "very satisfied" at or above the 85 percent mark in the coming year. Additional key deliverables for the upcoming fiscal year are:

- **Open Enrollment Support:** Service Center anticipates over 1.2 million consumer contacts during open enrollment through inbound calls and live chat interactions. This forecast is comparable to FY 2019-20 volumes. The division's goal is for the increased funding for surge positions to improve the consumer experience and enable more consumers to get services. In the very high call volume period of open enrollment, Covered California has always "staffed up" and at the same time recognized that it is not possible to meet standard service goals in a fiscally sound manner. With the surge staffing capacity and anticipated reductions in call handle times, the Service Center hopes to see a 24 percent improvement in meeting the service-level target related to the percentage of calls answered within 30 seconds during open enrollment from 26 percent to 33

percent. In addition, the improved service is hoped to reduce the abandonment rate during open enrollment from 17.6 percent to less than 13 percent (from 214,882 calls to approximately 157,000 calls), an estimated 27 percent reduction in the number of abandoned calls compared to FY 2019-20).

- **Expanded Special Enrollment Support:** Early projections anticipate almost 1.7 million consumer contacts during the special-enrollment period, which is forecasted to be a 26 percent or 300,000 call increase from FY 2019-20 volumes. Funding of additional resources should allow the Service Center to have resources where most needed to effectively handle the additional calls and maintain the abandonment rate from FY 2019-20 of 5.5 percent. There remains a high degree of uncertainty in planning for the volumes and types of calls for the coming year, including the unknown impact to call volumes because of the new Franchise Tax Board state subsidy form from February to April 2021. If disputes regarding the state subsidies occur at the same rate as do federal subsidies, the Service Center could see an increase of over 4,000 state disputes from the current 4,800 federal disputes, with those disputes generating service calls and, in some cases, escalation and appeals work.
- **Ancillary Service Center Functions:** In addition to inbound phone and live chat support, Service Center is responsible for the processing of enrollment verification documents, Certified Insurance Agent call center overflow support, appeals, escalations and subsidy tax disputes. The funding for additional inbound phone and live chat allows the Service Center to repurpose existing staff to support these ancillary programs during critical periods.

Ombuds Office

The Ombuds Office serves two functions. Through its Ombuds Affairs Unit, it provides consumers an objective, unbiased and accessible resource when other resolution or customer service channels have been exhausted. Through its Appeals Fulfillment Unit, it serves as an independent resource to implement Administrative Law Judge decisions following eligibility determination appeals. Together, these units identify systemic challenges and promote solutions to prevent issues from reoccurring to improve the overall experience of Covered California consumers.

Division Budget — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	13	13	15
Personnel Services	$ 1,181,028	$ 1,484,465	$ 1,779,841
Operating Expenses	$ 117,000	$ 74,089	$ 52,000
Total Expenses	**$ 1,298,028**	**$ 1,558,554**	**$ 1,831,841**
Information Technology Support	$ 183,404	$ 163,698	$ 183,236
ProRata / Sup. Pension Pay / Other	$ 88,986	$ 93,311	$ 100,606
Total Operating Costs	**$ 1,570,418**	**$ 1,815,563**	**$ 2,115,683**

Highlights for Proposed FY 2020-21 Budget and Key Changes

The Ombuds Office's FY 2020-21 budget proposes two positions, which increases overall staffing from 13 to 15. These positions will assist with customer inquiries and issues and fulfil the division's mission on resolving consumer issues and identifying systematic issues to promote solutions and to prevent them from reoccurring.

The office's major operating expenses proposed for FY 2020-21 include general expenses, which includes office supplies and training expenses.

Key Objectives for FY 2020-21

The Ombuds Office will focus on the following core areas in the upcoming fiscal year:

- Increase Ombuds Office education and outreach to reduce the number of erroneous referrals, calls and inquiries.
- Finalize root-cause analysis training and operationalize a process to identify systemic issues in accordance with the Ombuds Office's mission.
- Enhance and streamline the consumer's call experience by adding an Interactive Voice Response system and consumer feedback survey to the toll-free line.

Customer Care Division

Division Description

The Customer Care division's purpose is to optimize and enhance the consumer experience regardless of service channel (e.g., self-serve, through the Covered California Service Center, via a Covered California Licensed Agent or Certified

Enrollment Counselor). Ultimately, this work involves a high level of coordination, transparency and collaboration throughout the organization to understand and facilitate improvement of the consumer experience during all phases of the consumer journey. This effort is foundational to Covered California's purpose of making health insurance more affordable and easier to purchase for individuals and small businesses.

Division Budget — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	7	8	8
Personnel Services	$ 840,213	$ 784,712	$ 1,103,277
Operating Expenses	$ 592,000	$ 417,320	$ 389,000
Total Expenses	**$ 1,432,213**	**$ 1,202,032**	**$ 1,492,277**
Information Technology Support	$ 98,756	$ 100,737	$ 97,726
ProRata / Sup. Pension Pay / Other	$ 78,538	$ 67,293	$ 70,247
Total Operating Costs	**$ 1,609,506**	**$ 1,370,062**	**$ 1,660,250**

Highlights for Proposed FY 2020-21 Budget and Key Changes

The division's major operating expenses proposed for FY 2020-21 include customer care journey mapping contract totaling $375,000. A customer journey mapping is a visual representation of the process a customer goes through to achieve enrollment and health care coverage. This budget reflects an increase from seven to eight positions. This was the result of a re-allocated position from the Office of Legal Affairs during FY 2019-20 to play a key role in getting the initial journey-mapping vendor established.

Key Objectives for FY 2020-21

The Customer Care division will focus on the following core areas in the upcoming fiscal year:

- Develop and implement an organization-wide, multidisciplinary consumer-experience strategic approach to enhance overall consumer experience.
- Develop a dashboard of key performance metrics tracking satisfaction and effort indicators for the consumer journey and experience.
- Devise a governance process to address prioritization and alignment of consumer-experience initiatives.
- Foster and develop the voice of the customer through Covered California's innovation lab, the Creative Café.

Technology

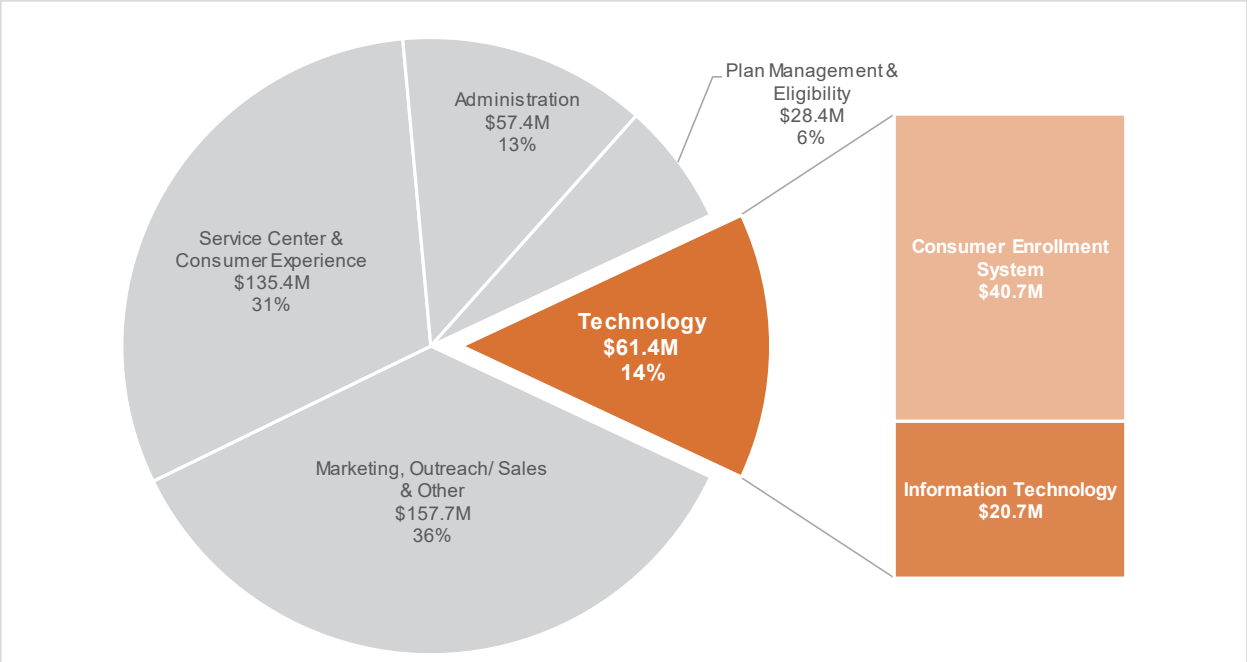
Division Description

Technology includes the Information Technology (IT) division and the consumer eligibility system, the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS). The proposed budget for FY 2020-21 is $61.4 million (Figure 9).

Technology— Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	82	84	94
Personnel Services	$ 10,527,630	$ 11,370,939	$ 15,308,340
Operating Expenses	$ 57,311,691	$ 48,944,775	$ 43,355,068
Total Expenses	**$ 67,839,321**	**$ 60,315,714**	**$ 58,663,408**
Information Technology Support	$ 1,156,857	$ 1,057,740	$ 1,148,277
ProRata / Sup. Pension Pay / Other	$ 1,831,300	$ 1,703,612	$ 1,559,418
Total Operating Costs	**$ 70,827,478**	**$ 63,077,067**	**$ 61,371,103**

Figure 9
Technology
FY 2020-21 Proposed Budget
(Dollars in Millions)



CalHEERS

Division Description

The California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) serves as a single system supporting eligibility and enrollment in Covered California and Medi-Cal. The Office of Systems Integration oversees the consumer-facing system running California's single streamlined application for all insurance affordability programs, including Medi-Cal.

CalHEERS is jointly sponsored by Covered California and the California Department of Health Care Services. The project is governed by an executive steering committee that represents each of the participating agencies and has guided the project since its inception.

Division Budget — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	0	0	-
Personnel Services	$ -	$ -	$ -
Operating Expenses	$ 54,294,132	$ 46,172,684	$ 40,665,068
Total Expenses	**$ 54,294,132**	**$ 46,172,684**	**$ 40,665,068**

Highlights for Proposed FY 2020-21 Budget and Key Changes

The Office of Systems Integration, on behalf of Covered California and the Department of Health Care Services, provides management and oversight of the maintenance, operations and ongoing development of CalHEERS. The cost of services is allocated between Covered California and the Department of Health Care Services using the cost allocation plan (CAP) approved by the Centers for Medicare and Medicaid Services. Under the current CAP, Covered California will be responsible for 12.59 percent of shared services. The CAP is updated annually based on enrollment in Covered California plans and Medi-Cal.

The fiscal year 2019-20 budget included additional one-time funding to support the initial setup of the state subsidy program. The FY 2020-21 proposed budget is projected to be $5.5 million less than FY 2019-20 actual/forecasted.

The major contracted operating expenses for CalHEERS consist of the interagency agreement with the Office of Systems Integration for the project management and oversight of the system.

Operating expenses drop from $60.3 million in FY 2019-20 actual/forecasted to $58 million in FY 2020-21 in the proposed budget due to the elimination of one-time IT expenditures related to system changes to CalHEERS for the state subsidy program and increased IT expenses. The $2.3 million drop in operating expenses represents the net effect of the reduction in CalHEERS and the increase in IT operating expenses.

Key Objectives for FY 2020-21

- Continue efforts to provide an integrated eligibility, enrollment, and retention solution that supports our sponsor organizations in delivering health services to consumers in collaboration with business partners throughout California.
- Continue to improve upon the most customer-centric portal and be a trusted leader in providing access to affordable, high-quality health services for all Californians.
- Deliver product features that are of the highest value as quickly as possible to enhance the business needs and user experience and increase stakeholder satisfaction.

In addition to the core division functions and ongoing initiatives listed above, CalHEERS anticipates these key new strategies in the upcoming fiscal year:

- Continuing efforts to move all CalHEERS infrastructure to the cloud, allowing the project to shut down on-premise data center hardware at a significant savings.
- Completing high-priority enhancements for counties (referred to as “Business Rules Exposure”).
- Completing the first piece of Senate Bill 260 for auto-enrollment of consumers moving from Medi-Cal to Covered California plans.
- Implementing the final pieces of the state subsidy program, including state tax reporting forms.

Information Technology Division

Division Description

The Information Technology (IT) division provides technology and security services to all Covered California divisions, consumers and stakeholders to support operations and enrollment services in a manner that is financially sustainable. This effort includes providing oversight of the ongoing development and operations of California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) for Covered California.

Three branches carry out specific functions in the Information Technology division, including the Information Security Branch, the Operations Branch for delivery of IT services, and Strategic Initiatives for project management and support for the full systems development lifecycle and support for analytics throughout the enterprise.

Division Budget — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	82	84	94
Personnel Services	$ 10,527,630	$ 11,370,939	$ 15,308,340
Operating Expenses	$ 3,017,559	$ 2,772,091	$ 2,690,000
Total Expenses	**$ 13,545,189**	**$ 14,143,030**	**$ 17,998,340**
Information Technology Support	$ 1,156,857	$ 1,057,740	$ 1,148,277
ProRata / Sup. Pension Pay / Other	$ 1,831,300	$ 1,703,612	$ 1,559,418
Total Operating Costs	**$ 16,533,346**	**$ 16,904,383**	**$ 20,706,035**

Note: The information Technology division has one exempt position[20].

[20] The exempt position is director of Information Technology (monthly salary: $20,356). This information is reported in compliance with Government Code 100503, Section 2(A).

Highlights for Proposed FY 2020-21 Budget and Key Changes

The FY 2020-21 proposed budget for Information Technology will increase from $17.1 million to $20.7 million, an increase of $3.6 million.

During FY 2019-20, the Information Technology division added two analysts. These mid-year additions were added to provide management and oversight of the defect-management process in CalHEERS.

This FY 2020-21 proposed budget requests 10 additional staff. The additional positions will support information security oversight and compliance responsibilities for the Covered California service centers, provide increased support at the Service Center service desk, provide additional network staff to support the large volume of work (maintenance and operations and new projects), maintain effective employee telework capability, and allow continued improvements to the website (including accessibility) and applications available internally and externally. To accommodate additional expenses related to Covered California's COVID-19 response, the Information Technology division postponed $2.8 million in other budget augmentation requests.

In FY 2020-21, the increases in proposed expenses for the Information Technology division include purchases of software, software licenses and systems maintenance.

These include:

- Chatbot development to facilitate customer support communication and reduce call volume and call time.
- E-signature capability.
- Software to enhance network and systems security.
- Technology that enables ADA compliance.
- Microsoft tools and licenses that further support telework, such as SharePoint, OneDrive and Microsoft Teams videoconferencing.

Key Objectives for FY 2020-21

- Provides oversight of the ongoing development and operations of CalHEERS, an automated system for Covered California and Medi-Cal that streamlines the resources in which consumers enroll in health care coverage.
- Provides information technology leadership, strategy and oversight for complex, consumer-facing information technology initiatives and directs high-level enterprise-wide policies and standards to ensure timely, cost-effective and regulatory compliant system implementation and operation.
- Oversees the implementation and adherence to policy standards and ensures Covered California's federal regulatory compliance and authority to operate and connect to all federal data services.
- Provides leadership and collaborates with other state and federal departments and works in a consultative fashion with other divisional directors within Covered California, advising on information technology-related solutions and strategy.

In addition to core division functions and ongoing initiatives listed above, the Information Technology division anticipates these key new strategies in the upcoming fiscal year:

- Supporting efforts to return staff to an office environment with modifications that may be needed.
- Coordinating with the Human Resources Branch to implement Human Capital Management.
- Supporting facility moves, especially a new Fresno location.
- Continuing work on enhancing the customer relationship management tools, chatbot, automated verifications, agent and navigator tools and data reporting.
- Executing knowledge transfer efforts to state staff within the Information Technology division.
- Continuing to expand data reporting and analytics throughout the organization.
- Continuing implementation of additional security enhancements, especially surrounding any needs for permanent "work from home" solutions.

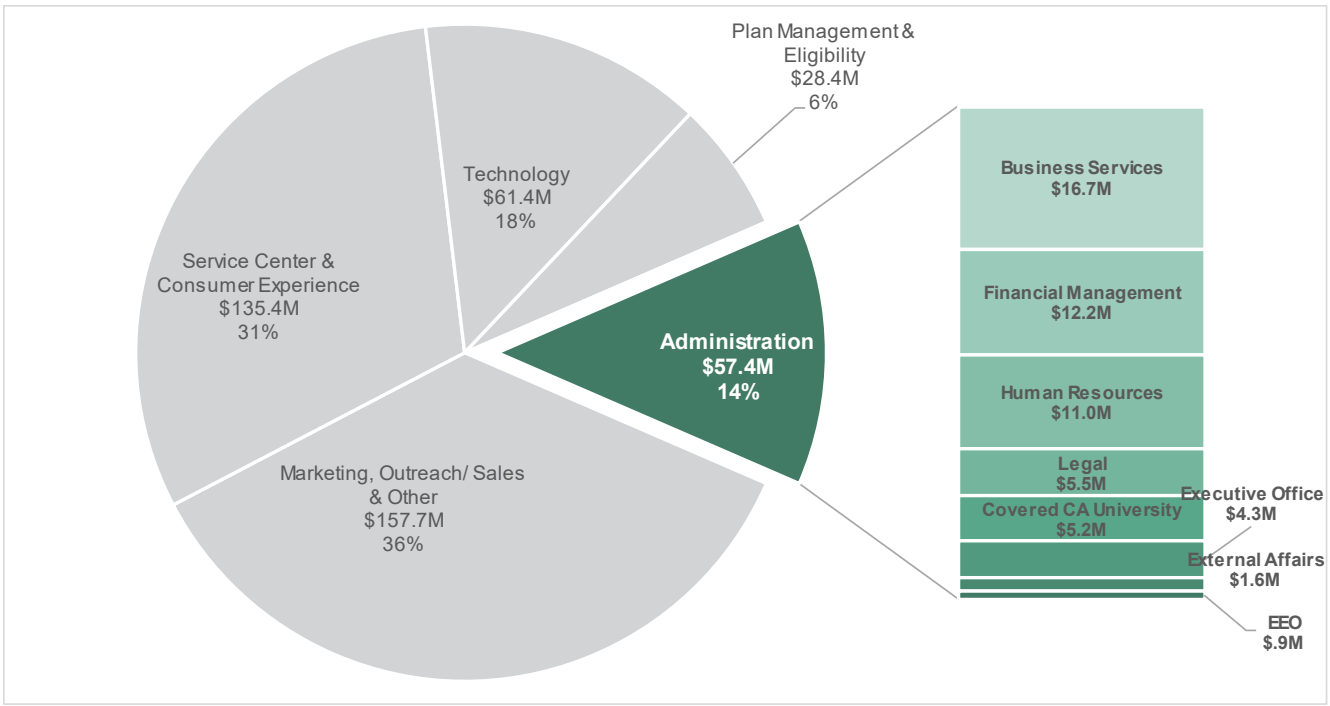
Administration

Administration includes the following program areas: the Executive Office, the Equal Employment Opportunity Office, the Office of Legal Affairs, the External Affairs division, the Financial Management division, the Business Services Branch, the Human Resources Branch and Covered California University. The total proposed budget for FY 2020-21 is $57.4 million.

Administration — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	227	226	228
Personnel Services	$ 26,516,990	$ 28,353,679	$ 32,777,204
Operating Expenses	$ 20,501,773	$ 16,586,665	$ 19,496,662
Total Expenses	**$ 47,018,764**	**$ 44,940,344**	**$ 52,273,866**
Information Technology Support	$ 3,202,518	$ 2,845,825	$ 2,785,183
ProRata / Sup. Pension Pay / Other	$ 2,570,844	$ 2,347,296	$ 2,315,762
Total Operating Costs	**$ 52,792,126**	**$ 50,133,464**	**$ 57,374,811**

Figure 10
Administration
FY 2020-21 Proposed Budget



Business Services Branch

Division Description

The Business Services Branch is responsible for providing guidance and consultation on contract and purchasing services; health, safety and wellness services; providing central support functions for administrative programs enterprise-wide; ensuring facilities are well maintained and secure, and managing our physical resources through facilities operations.

Division Budget — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	39	40	40
Personnel Services	$ 4,104,724	$ 4,411,670	$ 5,225,481
Operating Expenses	$ 9,799,360	$ 9,350,295	$ 10,336,245
Total Expenses	**$ 13,904,084**	**$ 13,761,965**	**$ 15,561,726**
Information Technology Support	$ 550,212	$ 503,686	$ 488,629
ProRata / Sup. Pension Pay / Other	$ 684,985	$ 651,447	$ 612,036
Total Operating Costs	**$ 15,139,281**	**$ 14,917,098**	**$ 16,662,390**

Highlights for Proposed FY 2020-21 Budget and Key Changes

The major operating expenses for the branch consist of the leasing of facilities. The major operating expenses proposed for FY 2020-21 include $8.3 million for leases and building maintenance; $845,000 for building security; and $380,000 for copying services.

The increase in staffing from 39 to 40 resulted from a mid-year transfer of an existing position from the Financial Management division during FY 2019-20.

Key Objectives for FY 2020-21

The Business Services division will focus on the following core areas in the upcoming fiscal year:

- Continue to improve the quality of services for all business services requests and successfully achieve all business services activities and implement all legislatively mandated policies and procedures.
- Provide ongoing support for staff working from home and oversee the return to the workplace meeting the safety needs of staff and the community related to COVID-19, including developing practical guidelines for working in the office and social distancing guidelines.
- Continue to build upon the health, safety and wellness practices that were established when responding to COVID-19.
- Develop physical space guidelines and a strategic master plan for Covered California's facilities in a post-COVID-19 world, including how much leased space will be needed moving forward.

- Develop electronic processes to streamline Business Services functions: contract signing, invoice processing, content management and more. As we move into a more telework-focused environment, there is a need to convert our manual paper processes into an electronic format.
- Implement the business continuity software that includes emergency notifications for employees. This will allow us to be more agile when responding to emergencies and notify staff in real-time.

Financial Management Division

Division Description

The Financial Management division plans, implements and guides all Covered California financial activities, including finance, accounting, forecasting, budgeting and governmental compliance. The division consists of two branches: Accounting and Accounting Systems Operations and Financial Planning and Forecasting Operations. Within those units lie critical accounting functions, including payroll, financial reporting, accounts receivable and payable, financial modeling, financial forecasting and financial systems.

Division Budget — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	58	57	57
Personnel Services	$ 6,709,557	$ 6,901,454	$ 8,230,393
Operating Expenses	$ 3,840,006	$ 2,409,335	$ 2,791,991
Total Expenses	**$ 10,549,563**	**$ 9,310,789**	**$ 11,022,384**
Information Technology Support	$ 818,265	$ 717,752	$ 696,296
ProRata / Sup. Pension Pay / Other	$ 595,728	$ 509,786	$ 513,065
Total Operating Costs	**$ 11,963,555**	**$ 10,538,328**	**$ 12,231,744**

Note: The Financial Management division has one exempt position[21].

Highlights for Proposed FY 2020-21 Budget and Key Changes

The largest element of the division's total operating expenses is associated with Robert Half accounting services and SQL programming for Covered California for Small Business, a FY 2020-21 budget estimate of $1.8 million. These expenses are down by $1 million from the FY 2019-20 approved budget, driven by lower than expected spending on Robert Half since the division has been transitioning many of the functions formerly performed by Robert Half in house. It is expected that Robert Half service expenses will continue to decline as the Financial Management division further develops internal capacity.

The division transferred a position to Business Services Branch during FY 2019-20, which dropped authorized positions from 58 to 57.

Key Objectives for FY 2020-21

The Financial Management division will focus on the following core areas in the upcoming fiscal year:

- Continue to provide Covered California partners and stakeholders with the financial and operational tools and resources needed to be well-informed leaders and effective decision makers. We provide data, information, analysis,

[21] The one position is chief financial officer (monthly salary: $15,000). This information is reported in compliance with Government Code 100503, Section 2(A).

knowledge and methods for our leaders to anticipate and respond effectively to the challenges facing Covered California.

Support Covered California's business needs by processing, recording and reporting on the financial condition and the resources available for Covered California to complete its mission.
Manage day-to-day accounting, including accounts receivable, accounts payable, payroll advances and payroll collections.
Evaluate Covered California's financial condition using ratio analysis, prepare annual financial statements in accordance with Generally Accepted Accounting Principles and collaborate with external auditors.

In addition to its core functions and ongoing initiatives listed above, the division anticipates these key new strategies in the upcoming fiscal year:

- Improve documentation and functionality of the accounting system by documenting key business processes to aid in system improvement and cross-training, and by developing formal written policies for high-risk areas to improve the integrity of financial assets and reduce risk.
- Strategically improve fiscal information to facilitate management decision-making by developing periodic financial reports to communicate organizational performance and develop key performance indicators to improve the ability to track performance.
- Improve budgeting and forecasting processes by strategically assessing the division's functional needs and actively recruiting and onboarding staff.
- Continue to refine the forecasting model after implementation of the state mandate, state subsidies and the current pandemic environment for improved accuracy and reliability.

Human Resources Branch

Division Description

The Human Resources Branch provides overall policy direction on human resource management and administrative support functions related to the management of employees via the following units: Labor Relations Office, Employment and Classification Services, Payroll and Benefits, Performance Management, Talent Acquisition and Operations and Disability Management.

Division Budget — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	52	52	52
Personnel Services	$ 4,864,971	$ 6,237,311	$ 6,533,371
Operating Expenses	$ 3,420,774	$ 1,495,024	$ 3,341,500
Total Expenses	**$ 8,285,745**	**$ 7,732,334**	**$ 9,874,871**
Information Technology Support	$ 733,617	$ 654,792	$ 635,217
ProRata / Sup. Pension Pay / Other	$ 485,137	$ 434,117	$ 462,243
Total Operating Costs	**$ 9,504,498**	**$ 8,821,243**	**$ 10,972,331**

Highlights for Proposed FY 2020-21 Budget and Key Changes

Operating expenses are forecast to rise from $1.5 million in FY 2019-20 to $3.3 million in FY 2020-21, with much of this increase associated with the purchase of the Human Capital Management (HCM) software solution to streamline and automate business processes. The Human Capital Management software was originally budgeted at $1.9 million for FY 2019-20, but the funds could not be spent in that fiscal year due to the length of time required to execute the contract. Accordingly, these funds will be allocated for HCM in the FY 20-21 proposed budget. Other major operating expenses proposed for FY 2020-21 include State Compensation Insurance Fund (SCIF) benefits of $420,000 and contracts with other related state departments, including the State Personnel Board, CalHR and EDD totaling $380,000.

Key Objectives for FY 2020-21

The Human Resources Branch will focus on the following core areas in the upcoming fiscal year:

- Assist with all talent acquisition and recruitment functions to ensure a diverse and qualified workforce while maintaining low vacancy rates throughout the organization.
- Coordinate and administer employee relations and labor relation policies and procedures and provide advice and assistance to managers and supervisors on employee complaints and grievances, work conditions, employee rights and management prerogatives and obligations.
- Provide consultative services to Covered California supervisors and managers throughout the life cycle of the hiring process, ensuring all merit selection and employment best practices, rules, regulations and authorities are followed.

- Provide consultation and training to managers and supervisors on employee performance, employment laws, rules and departmental policies.

In addition to its core functions and ongoing initiatives listed above, the branch anticipates these key new strategies in the upcoming fiscal year:

- Purchase and implement a Human Capital Management solution to automate and streamline business processes that include timekeeping and real-time leave balances; position control and organizational chart management; training and documentation compliance; recruitment, pre-hire processing, hiring, succession management, onboarding/offboarding; benefit administration; performance management; and reporting and analytics.
- The Performance Management Unit is working toward a shift in culture as it relates to managing the development and performance of all employees. The focus is to provide support, guidance and coaching to the organization's supervisors and managers to build supervisory relationships with employees that will contribute to a positive and effective work environment.
- Launch a new hiring process and training for hiring managers. The goal is to reduce the time to fill vacancies, use a proactive consultative approach to recruitment and use some of the lessons learned and innovative solutions to form the Hiring Process Transformation Workgroup.
- In partnership with Covered California University and Talent Management, strategize, gather ideas and create a new employee onboarding program to acquire the necessary knowledge and skills and to learn the organization culture to become an effective member.

Office of Legal Affairs

Division Description

The Office of Legal Affairs provides a wide range of legal services to all Covered California staff by giving preventive legal advice and consultation to ensure compliance with laws and to mitigate legal liability. The Office of Legal Affairs interfaces with state and federal regulatory agencies and provides legal advice on a variety of matters pertaining to Covered California and its programs, contracts and operations. The Office of Legal Affairs ensures that all legal agreements are fulfilled, and that Covered California operates within its legal authority. Additionally, the Office of Legal Affairs provides guidance on any statutes or regulations pertaining to Covered California.

Division Budget — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	25	24	24
Personnel Services	$ 3,265,196	$ 3,045,682	$ 3,580,449
Operating Expenses	$ 1,320,500	$ 1,306,241	$ 1,380,500
Total Expenses	**$ 4,585,696**	**$ 4,351,923**	**$ 4,960,949**
Information Technology Support	$ 352,700	$ 302,211	$ 293,177
ProRata / Sup. Pension Pay / Other	$ 258,386	$ 232,184	$ 226,328
Total Operating Costs	**$ 5,196,782**	**$ 4,886,318**	**$ 5,480,455**

Note. The Office of Legal Affairs has one exempt position[22].

Highlights for Proposed FY 2020-21 Budget and Key Changes

The major operating expenses proposed for FY 2020-21 include funding of the Legal Aid Society totaling $750,000; support from the California Attorney General Office totaling $150, 000; and outside legal counsel totaling $200,000.

This budget reflects a decrease of one position that was transferred to the Customer Care division in FY 2019-20 to support the consumer journey.

Key Objectives for FY 2020-21

The Office of Legal Affairs will focus on the following core areas in the upcoming fiscal year:

- Continue to provide legal support to all Covered California divisions to meet Covered California's vision and strategic pillars.
- Continue to support Covered California in response to COVID-19 pandemic by providing advice and counsel on federal and state stimulus and relief legislation, special-enrollment periods and consumer messaging.

[22] The one exempt position is director of the Office of Legal Affairs (monthly salary: $14,588). This information is reported in compliance with Government Code 100503, Section 2(A).

- Fully integrate the needs of the Office of Legal Affairs' appeals program into the CDSS Appeals Case Management System.

Covered California University

Division Description

The Covered California University is the enterprise training and knowledge management branch. The branch collaborates with programs and interacts across the organization, leveraging subject matter exerts in a vast array of disciplines, acts as a consultant on information dissemination and training initiatives, and maintains both written materials and training courses that support the organization and its partners. The branch administers the technology that supports information and training, including the Customer Relationship Management Knowledgebase and Absorb Learning Management System. The branch consists of the following sections: Training Design and Delivery Section, Knowledge Management Section and Operations and Special Projects.

Division Budget — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	31	31	31
Personnel Services	$ 3,187,370	$ 3,686,226	$ 4,051,052
Operating Expenses	$ 668,750	$ 720,368	$ 580,000
Total Expenses	**$ 3,856,119**	**$ 4,406,594**	**$ 4,631,052**
Information Technology Support	$ 437,348	$ 390,356	$ 378,687
ProRata / Sup. Pension Pay / Other	$ 243,970	$ 250,549	$ 235,133
Total Operating Costs	**$ 4,537,438**	**$ 5,047,499**	**$ 5,244,872**

Highlights for Proposed FY 2020-21 Budget and Key Changes

The major operating expenses proposed for FY 2020-21 include training through CalHR estimated to total $200,000 and training through outside contractors estimated to total $230,000.

The operating expenses budget for FY 2020-21 is projected to decline slightly from the FY 2019-20 actual/forecasted expenses. This is related to the elimination of a consulting contract with Leading Resources that will not be renewed in FY 2020-21.

Key Objectives for FY 2020-21

Covered California University will focus on the following core areas in the upcoming fiscal year:

- Continue to assess and provide training to all Covered California employees, service channels, vendors and partners through a variety of methods, including instructor-led training and eLearning using our Learning Management System.
- Research, develop and publish approved policy and procedure content in the form of task guides, talking points and Knowledge Base articles for use by the department to support consumers.

In addition to its core functions and ongoing initiatives listed above, Covered California University anticipates these key new strategies in the upcoming fiscal year:

- Expand CCU staff learning and develop competencies and skill sets, including Microsoft Suite, Snag-it, Adobe Suite and Camtasia, to support collaborative and virtual training programs.
- Advance learning platforms and accessibility for training opportunities, including virtual training, throughout the organization.
- Formalize organization change management structure, committee, change champion network and communication methods.
- Complete structural updates to all knowledge templates to improve usability for service center staff.
- Formalize feedback process for knowledge improvement using a knowledge feedback app, usability focus groups with leads and compliance consultations with quality assurance.

Executive Office

Division Description

The Executive Office develops organizational strategy and provides leadership direction in concert with the Covered California Board of Directors. Executive Office staff are responsible for Covered California's day-to-day operations and are tasked with facilitating and supporting Covered California's employees and a broad community of individuals and groups to provide customers (including staff, the board, stakeholders and the public) with the direction, information, tools and support they need. The Executive Office does this by mentoring, providing leadership, listening, learning and adjusting efforts to meet goals and serve consumers.

Talent management and succession planning provides strategic talent leadership to ensure Covered California is considered an employer of choice and can attract, develop, retain and recognize the best talent.

Division Budget — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	9	9	11
Personnel Services	$ 2,801,104	$ 2,566,374	$ 3,287,797
Operating Expenses	$ 1,040,883	$ 1,002,128	$ 714,676
Total Expenses	**$ 3,841,988**	**$ 3,568,503**	**$ 4,002,473**
Information Technology Support	$ 126,972	$ 113,329	$ 134,373
ProRata / Sup. Pension Pay / Other	$ 184,523	$ 165,757	$ 159,391
Total Operating Costs	**$ 4,153,482**	**$ 3,847,589**	**$ 4,296,237**

Note: The Executive division has five exempt positions[23].

[23] These five positions include executive director, monthly salary: $39,935; chief deputy executive director, Operations, monthly salary: $20,518; chief deputy executive director, Program, monthly salary: $24,838; chief deputy executive director, General Counsel, monthly salary: $21,039; and director, Administrative Services Division, monthly salary: $12,679. This information is reported in compliance with Government Code 100503, Section 2(A).

Highlights for Proposed FY 2020-21 Budget and Key Changes

This budget adds two additional staff and increases overall staffing from nine to 11 positions. These new positions will promote leadership needs and to assist with initiatives centered on ensuring Covered California is an employer of choice and can attract, develop, retain and recognize its talent.

Executive Office operating expenses are forecasted to drop from the FY 2019-20 actual/forecasted total of $1 million to about $700,000 in the FY 2020-21 proposed budget. Most of the reduction is due to reducing leadership and development training expenses. The major operating expenses proposed for FY 2020-21 include membership in business associations for collaboration totaling $126,000 and leadership training totaling $431,000.

Key Objectives for FY 2020-21

The Executive Office will focus on the following core areas in the upcoming fiscal year:

- Our world has changed overnight, and our Executive Office will continue its focus and efforts supporting and enhancing our resilient organization as we respond to the impacts of the coronavirus pandemic. Our COVID-19 response framework of “sticking to the science, sticking to the facts and sticking together” supports Covered California’s goals and objectives to successfully react, respond, reinvent and transform in this rapidly changing environment.
- The Executive Office will remain focused on both organizational resilience and individual wellbeing efforts as we transition into a new normal in order to continue to successfully deliver on our mission.

External Affairs

Division Description

External Affairs serves as Covered California's government and stakeholder relations liaison. External Affairs supports Covered California's policy and program development by representing the organization in complex and sensitive legislative, policy and administrative processes and by building collaborative relationships with elected officials, state and local agencies and stakeholders. External Affairs also proactively facilitates partnerships that encourage education, outreach and enrollment in Covered California.

Division Budget — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	9	9	9
Personnel Services	$ 1,176,228	$ 1,021,956	$ 1,337,543
Operating Expenses	$ 115,500	$ 46,320	$ 72,750
Total Expenses	**$ 1,291,728**	**$ 1,068,276**	**$ 1,410,293**
Information Technology Support	$ 126,972	$ 113,329	$ 109,941
ProRata / Sup. Pension Pay / Other	$ 78,022	$ 64,164	$ 70,383
Total Operating Costs	**$ 1,496,722**	**$ 1,245,769**	**$ 1,590,617**

Note: The External Affairs division has one exempt position[24]:

Highlights for Proposed FY 2020-21 Budget and Key Changes

The major operating expenses proposed for FY 2020-21 include general expenses totaling $34,000, training expenses totaling $22,000 and support for the tribal consultation totaling $10,000.

Key Objectives for FY 2020-21

External Affairs will focus on the following core areas in the upcoming fiscal year:

- Establish and implement a program focused specifically on effective external relations by building networks and bolstering outreach and education for both state and federal government officials and stakeholders.
- Fortify efforts to inform federal policy makers of Covered California and state policies that leverage and build on the Affordable Care Act and that provide a model for current and future policy change.
- Develop and disseminate timely and effective technical assistance to the administration and legislators as they consider policy and budgetary actions.

[24] The exempt position is director of External Affairs (monthly salary: $17,520). This information is reported in compliance with Government Code 100503, Section 2(A).

Equal Employment Opportunity Office

Divison Description

The Equal Employment Opportunity Office is responsible for implementing, coordinating and monitoring civil rights compliance for Covered California's workforce and consumers. The Equal Employment Opportunity Office ensures that Covered California is compliant with federal and state laws regarding diversity, equity and accessibility. The office also partners with other program areas to develop initiatives that increase accessibility and foster diversity. It reports on appointments, brings issues of concern regarding equal employment opportunity to the executive director, and recommends appropriate action.

Division Budget — Multi-Year View

	FY 2019-20 Approved Budget	FY 2019-20 Actual / Forecasted	FY 2020-21 Proposed Budget
Positions	4	4	4
Personnel Services	$ 407,841	$ 483,005	$ 531,118
Operating Expenses	$ 296,000	$ 256,955	$ 279,000
Total Expenses	**$703,841**	**$ 739,960**	**$810,118**
Information Technology Support	$ 56,432	$ 50,369	$ 48,863
ProRata / Sup. Pension Pay / Other	$ 40,094	$ 39,292	$ 37,183
Total Operating Costs	**$ 800,367**	**$ 829,621**	**$ 896,165**

Highlights for Proposed FY 2020-21 Budget and Key Changes

The major operating expenses proposed for FY 2020-21 include legal services totaling $220,000 and training totaling $30,000.

Key Objectives for FY 2020-21

The Financial Management division will focus on the following core areas in the upcoming fiscal year:

- Continue to support Covered California in the development of policies that foster accessibility, diversity and equity in the workplace.
- Enact updated Reasonable Accommodation and Equal Employment Opportunity policies for the department, with concurrent updates to Reasonable Accommodation and complaint forms in light of the COVID-19 pandemic.
- Respond to referrals or requests for Reasonable Accommodation, partnering with other units to ensure thorough and timely assistance, particularly considering the emergency telework arrangements of a majority of the workforce due to the COVID-19 response and the relocation of more than a third of the workforce to new office spaces.

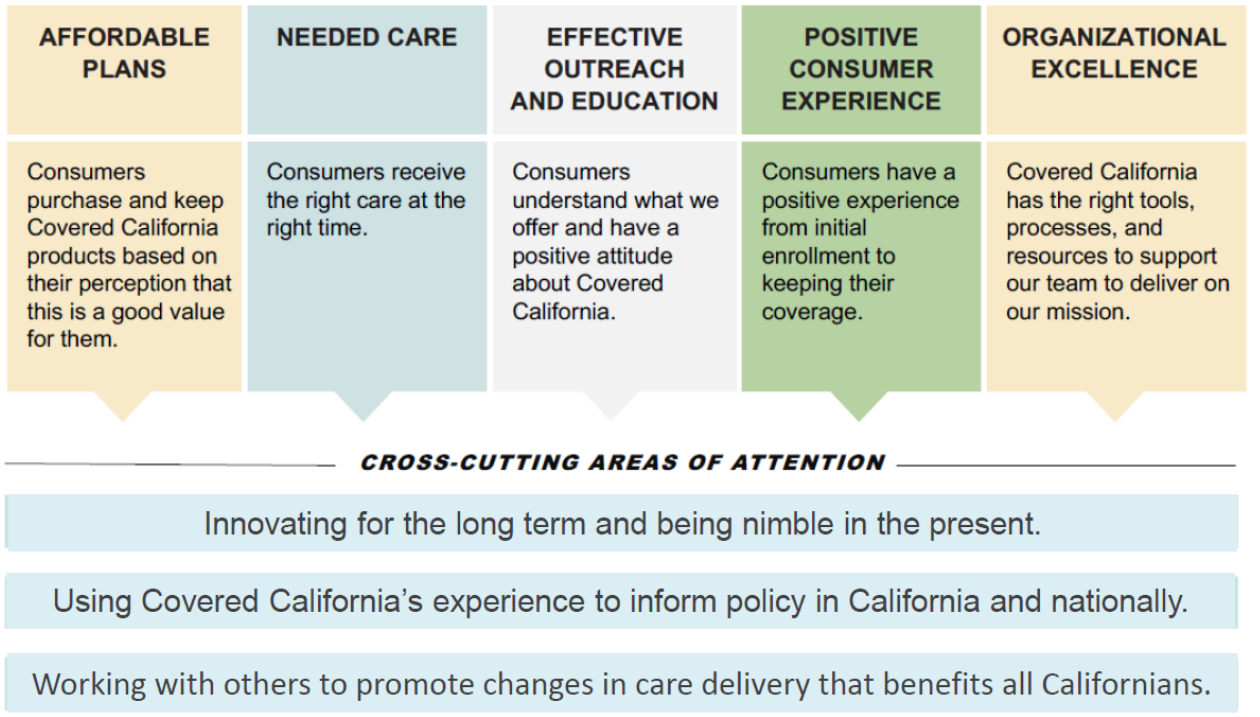
A-I. Covered California's Vision, Strategic Priorities and Detailed Program Accomplishments in FY 2019-20

California's mission is to improve health care quality, lower costs and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value. The broader context for that mission is a vision adopted by the Board of Directors for Covered California to improve the health of all Californians by assuring their access to affordable, high-quality care.

The Annual Report and the Covered California's annual budgets are reflections of how the organization addresses five key strategic priorities. The budget is built on a comprehensive planning process, which is governed by the strategic priorities that help guide the organization's allocation of resources. Covered California's strategic priorities were designed by the agency's management team and reviewed by the board to assist the organization while making decisions, setting priorities, determining initiatives and preparing annual budgets.

This section of the Annual Report and Budget introduces the five areas of strategic focus and the three cross-cutting priorities that guide Covered California's work, with a summary of how each of Covered California's 19 divisions performed in fiscal year 2019-20.

Covered California Strategic Priorities and Cross-Cutting Initiatives



The strategic priorities and how those strategies are broadly addressed are:

- **Affordable Plans**: Consumers purchase and keep Covered California products based on their understanding of how their coverage is a good value for them. The Affordable Plans strategic priority is reflected in Covered California as such:
    - Actively negotiating rates and benefits with carriers to provide consumers with the best value.
    - Investing in marketing and outreach to promote the value of coverage and maintain a healthy risk mix.
    - Offering patient-centered benefit designs to make care more affordable by increasing a consumer's understanding of benefits that maximize access to appropriate care.
- **Staying Healthy and Getting Needed Care:** Consumers receive the right care at the right time.
    - Working with all contracted qualified health plan issuers, in every corner of the state, to ensure consumers have ready access to doctors, hospitals and care.
    - Holding health insurance companies accountable for improving the care delivered, addressing disparities of care and moving to a patient-centered system that rewards quality and value, rather than being rewarded for quantity only.

- **Effective Outreach and Education**: Consumers understand what we offer and have a positive attitude about Covered California
    - Making significant investments in marketing and outreach to motivate consumers to enroll and maintain their insurance coverage.
    - Educating and supporting Covered California's 20,000 sales partners in order to promote enrollment and increase the number of insured Californians.
- **Positive Consumer Experience**: Consumers have a positive experience from initial enrollment to keeping their coverage.
    - Continuously surveying consumers and testing messages and materials to be sure complex health insurance and coverage issues are clearly communicated.
    - Operating and staffing service centers and working with 20,000 Certified Insurance Agents, enrollers and Navigators to assist consumers in a variety of languages.
    - Establishing an Ombuds Office and support for consumers seeking resolution of problems to have issues addressed at the lowest possible level.
- **Organizational Excellence**: Covered California has the right tools, processes and resources to support its team to deliver on its mission.
    - Operating as a fiscally sound, nimble enterprise that responds quickly to the changing environment in health care.
    - Supporting its staff with training, tools, automation and opportunities for growth and working across divisions.

These five pillars are supported and complemented by the following cross-cutting initiatives:

- **Innovating for the long term and being nimble in the present.**
    - Consumer journey mapping will inform efforts to continue to build consumer trust and loyalty, increase consumer growth and retention, elevate Covered California's brand and facilitate a transparent and aligned model of operational excellence.
    - A consolidated enterprise information technology backup and disaster recovery solution will be easier to manage and meet business continuity objectives in the event of a disaster.
- **Using Covered California's experience to inform policy in California and nationally.**
    - Covered California has worked with stakeholders and economists to develop options to improve affordability for low- and middle-income consumers and increase the number of people insured in the state. Covered California will build on the work reflected in the report "Options to

Improve Affordability in California's Individual Health Insurance Market" to examine how consumers would benefit from different approaches, as well as the costs required and their impact on the individual market.

- Covered California actively seeks opportunities to contribute to the policy-making discussions in California and Washington D.C. by sharing our experiences and analysis of how policy issues could affect the individual market and health care costs and quality more broadly.
- Covered California learns from and shares its experiences with other state-based marketplaces, academic institutions and private and public partners to practice evidence-based policy development.

- **Working in partnership with others to promote changes in care delivery that benefit all Californians.**
  - Expanding program oversight of quality standards and increasing engagement with carriers to develop programs that will improve the delivery and quality of health care to our consumers.
  - Covered California has interviewed national and state purchasers to consider how its contractual expectations of carriers can be aligned with others to promote more rapid and targeted changes in the delivery system to foster quality improvement and cost reductions.

Program Accomplishments

In describing the accomplishments of each of Covered California's 19 divisions, the division's work is framed by the roles each one plays in in promoting and advancing the vision and strategic priorities of Covered California. The divisions are listed in the same order as presented in Section –IV: Covered California's FY 2020-21 Proposed Operating Budget: Program Detail, and the accomplishments reflect activities from fiscal year 2019-20.

Plan Management Division

Division Description

The Plan Management division's purpose is to improve the cost, quality and accessibility of health care delivered to consumers by selecting, negotiating with and holding Covered California's contracted health insurance companies accountable for delivering quality health care while fostering improvements in care delivery that can benefit all Californians.

How Plan Management Supports Covered California's Goals and Strategic Priorities

- Annually certifies and recertifies health and dental plan issuers that promote rate moderation and meaningful plan options.
- Updates and develops new patient-centered benefit designs.
- Works closely with health plan issuers to ensure contract compliance and effective partnerships with regulators.
- Holds health plan issuers accountable for executing quality-improvement strategies promoting delivery system reform and assuring enrollees get timely high-quality care.
- Ensures enrollee access to primary care by providing support to navigate the health care system through patient-centered benefit designs and by requiring all health plan issuers to match a primary care clinician to every consumer.
- Reviews health plan issuer performance, sharing information and ideas and ultimately improving the products and services provided to enrollees through regular engagement, including in-person quarterly business review meetings with health plan issuers.
- Validates Systems for Electronic Rate and Form Filing (SERFF) templates submitted by health plan issuers on premium rates, plan benefit designs, provider networks, service areas and pharmaceutical formularies.

Key Objectives for FY 2019-20

- Negotiated premiums and service area changes and certified 11 health plan issuers for the 2020 plan year. For 2020, nearly all consumers can choose from two or more issuers, and 87 percent from three or more. The average 2020 premium rate increase was limited to 0.8 percent, which is the lowest change

since Covered California's launch, driven by new state affordability initiatives designed to lower costs and encourage enrollment.

- Negotiated premiums and service area changes and certified seven dental plan issuers for the 2020 plan year, with a total dental enrollment of 201,155. The average dental plan premium was reduced by 1.9 percent for 2020.
- Executed contracts for 11 qualified health plan issuers and seven qualified dental plan issuers, and in partnership with plan issuers and stakeholder advocates, established the 2021 standard benefit designs for health and dental benefits.
- Produced "Covered California's First Five Years: Improving Access, Affordability, and Accountability," which reported on the core approaches Covered California has used to improve health system performance:
    - Creating an effective consumer-driven marketplace.
    - Holding health insurance companies accountable for improving quality and advancing delivery reform.
    - Aligning efforts to foster systemic change.
    - Using data and evidence to drive continuous improvement.
- Produced "Covered California Holding Health Plans Accountable for Quality and Delivery System Reform, which reported on Covered California's efforts to assure quality care and promote effective care delivery by health plan issuers for their enrollees. This report identified numerous differences and accomplishments by health plan issuers across multiple domains and strategies, and identified key areas of focus for future contracting requirements and health plan issuer management by Covered California.

Policy, Eligibility and Research Division

Division Description

The Policy, Eligibility and Research division, through its Eligibility Branch, ensures appropriate implementation of program-eligibility rules. The Policy and Research Branch provides accurate, complete and timely policy and data analysis to support evidence-based decision-making, with a focus on analyzing both enrollment and the care provided by contracted health insurance companies to support Plan Management's work to hold health insurance companies accountable.

How the Policy, Eligibility and Research Division Supports Covered California's Goals and Strategic Priorities

- Acts as an advisor and resource to management on the development, implementation and evaluation of program policies, including the coordination of the provision of input on federal and state exchange policy, rules and regulations.
- Designs and provides advisory support on manual and automated eligibility processes, procedures and verifications.
- Creates and maintains Covered California individual market applications and consumer communications regarding eligibility and enrollment.
- Directs the Covered California Healthcare Evidence Initiative that analyzes consumer access to care through clinical, enrollment and qualitative survey data and identifies opportunities for improvements and organization-wide governance of high-priority, high-visibility research efforts.
- Manages the annual survey of members about their experiences with Covered California.
- Manages the data analytics strategy and infrastructure to create dashboards and custom evaluations of operations related to enrollment and eligibility.
- Leads modeling for policy design and data analysis for evaluation of new interventions in the marketplace.
- Coordinates with state departments to improve transitions of consumers between coverage through Medi-Cal and Covered California.
- Develops reports on critical issues to inform policy development and strategies.

Key Objectives for FY 2019-20

- Led the organization's efforts on the development, implementation and launch of the California premium subsidy program and exemptions to the California health care mandate.
- Provided technical assistance to the administration and the legislature to design policy for the new state subsidy program and mandate penalty.
- Prepared needed policies to implement the new state subsidy program and the state mandate exemptions process within months of enactment by the Legislature.
- Led the implementation of the new program in CalHEERS.
- Provided analytic support to describe the opportunity and assess take-up of the new subsidies, including designing a new state subsidy calculator tool to help brokers and certified enrollers preview which consumers would benefit most from the new subsidies (in partnership with the Outreach and Sales division and the Information Technology division).
- Fielded the 2020 Consumer Survey with a focus on first-in-the-nation state subsidies for consumers between 400 and 600 percent federal poverty level.
- With the Plan Management division, led initial implementation of newly enacted legislation (Assembly Bill 929) that enables Covered California's Healthcare Evidence Initiative to evaluate utilization and payment data for the individual market to ensure plan contracting and quality strategies are promoting high-value care and making measurable progress to address health disparities.
- Provided technical assistance to the Office of Statewide Health Planning and Development on the proposed Health Payments Database.
- Provided in-house program evaluation and analytics to assist in novel outreach innovations that boosted take-up, in partnership with the Marketing division and Service Center division.
- Developed and implemented several policy changes to increase positive consumer experiences, including effective Medicare transitions, by the development and testing of materials and consumer notices.
- Fostered and supported various cross-divisional workgroups and partnerships by providing technical assistance and expertise on various subjects and key objectives with internal and external stakeholders, including Franchise Tax Board, Department of Finance, Department of Healthcare Services, California Department of Social Services, Employment Development Department, California Public Employees Retirement System, CalHEERS, other state exchanges, and consumer advocacy groups.
- Provided technical assistance and coordination of the COVID-19 special-enrollment period.
- Led multi-divisional and multi-agency changes to CalHEERS, including:

- Continued user experience updates, featuring a complete overhaul on the account landing page to provide the most relevant information for consumers.
- Implemented new rules to ensure current consumers who are reported as enrolled in Medicare do not continue to receive financial assistance (reduces consumer tax implications).
- Implemented changes to how alimony income and deductions are reported to account for the changes in the law from the Tax Cuts and Jobs Act.
- Implemented emergency changes to provide guidance to consumers on how to report or not report income they receive as a result of the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act.
- Made significant changes to consumer notices, focusing on health literacy to reduce reading grade levels, length of notices and confusion to consumers.

Marketing Division

Division Description

The Marketing division is responsible for implementing Covered California's comprehensive marketing campaign strategy to reach and motivate Californians to enroll in or renew health insurance through Covered California. Covered California's marketing and advertising efforts are anchored in and responsive to effectively reaching California's ethnic, cultural, regional and language diversity.

How the Marketing Division Supports Covered California's Goals and Strategic Priorities

- Covered California's marketing campaigns are designed to build brand awareness and engagement to diverse population segments by emphasizing the value and benefits of health insurance.
- Positions Covered California as the place to get quality health coverage, financial assistance and free in-person enrollment assistance.
- Drives enrollment in Covered California by engaging with consumers at key decision points in the enrollment journey.
- Maximizes retention and renewal of existing membership through timely and relevant communications.

Key Objectives for FY 2019-20

- Developed and implemented an advertising camping for open enrollment to reach the diverse populations of California, including outreach to the general market in English, complemented by tailored in-language efforts in Spanish, Chinese (Cantonese and Mandarin), Korean, Vietnamese, Hmong, Laotian and Cambodian, as well as tailored in-culture efforts to reach African-American and LGTBQ segments. In response to new state subsidies, expanded income-targeting parameters in an effort to reach all subsidy eligible populations, including middle-income consumers.
- Successfully coordinated efforts with Franchise Tax Board (FTB) to educate consumers about the new health care mandate and associated penalty that resulted in an FTB-branded digital campaign and co-branded (FTB and Covered California) direct mail outreach to 2 million California households likely to be uninsured.
- With more resources than the prior year, moved quickly to enhance marketing efforts to help boost open-enrollment results. This included development of incremental media plans for December 2019 and January 2020, expansion of direct mail efforts to reach more prospects that are likely to be uninsured and coordination with health insurance companies for maximum impact. All open enrollment 2020 campaigns generated a total of 918 million TV advertisement views and 117 million radio ad listens. Paid search efforts and digital banners obtained 643 million views and 1.5 million clicks to view digital content and visit

the Covered California website, which contributed to a total of 460,552 new sign-ups for open enrollment 2020.

- Implemented a strategic social media plan, resulting in over 54 million views on posts across multiple social media platforms to educate consumers and encourage engagement, increasing awareness of coverage requirements and availability. Also assisted consumers via social media channels with more than 6,000 responses to enrollment-related issues and concerns.
- Deployed several key studies in 2019, which were shared internally and with health insurance companies to assist them in their marketing, and with advocates and partners for use in open enrollment 2020. These included a direct mail lift study to determine the impact of direct mail programs on enrollment; a quantitative study of 1,000 Californians about penalty/financial help awareness; qualitative/quantitative research about uninsured Californians in multiple languages; and email and direct mail communications tests to fine-tune best practices for mail/email outreach.
- Utilizing the above research, the retention and renewal program effectively targeted different populations by sending 18.8 million emails, 7.1 million letters and postcards and 2.9 million text messages in a comprehensive outreach campaign for both prospective and existing members of Covered California, contributing to more than 1.28 million enrollees renewing their membership for 2020.
- Promoted dental plan issuer offerings, contributing to nearly 285,000 dental plan selections during the open-enrollment and renewal periods.
- Along with the base plan for special enrollment, developed and implemented a tailored multi-media campaign — utilizing television for the first time outside open enrollment, for March and April 2020, to promote a special enrollment opportunity for those who were just learning about the new health care mandate, associated penalty or expanded financial help. This included messaging to inform prospective consumers via emails, text messages and letters sent via direct mail in English and Spanish that they could enroll.
- Upon news of COVID-19 and the resulting special-enrollment opportunity for consumers concerned about or affected by the pandemic, developed and implemented a tailored multi-media campaign, for May and June 2020, to help ensure eligible Californians could enroll in health coverage. This included informing prospective consumers with emails, text messages, and direct mail in English and Spanish, which reminded members about the importance of reporting changes due to job or income loss. Marketing partnered with the Employment Development Department to include a Covered California flyer in the first-issued unemployment check so those seeking health coverage would know we were available, along with Medi-Cal. And finally, Marketing implemented a COVID-19 social media campaign in English and Spanish on Facebook, Instagram and Twitter.

Outreach and Sales Division

Division Description

The purpose of the Outreach and Sales division is to support the “on the ground” work to help Californians understand and enroll in coverage, supporting independent insurance agents and running the Navigator program, as well as operating the Covered California for Small Business program that helps small businesses find and enroll in coverage. The Outreach and Sales division has two parts: the Individual Market and Covered California for Small Business.

How Outreach and Sales Supports Covered California’s Goals and Strategic Priorities

- Awards up to $6.5 million annually in Navigator program grant funds to eligible organizations based on the results of a competitive application process, measuring performance against targets and adjusting awards based on performance within the grant year. Funding for this program directly assists historically underserved, uninsured and hard-to-reach Californians with purchasing coverage and accessing health care.
- Develops and implements the sales strategy for the individual and small business exchanges, ensuring Californians receive a high-value enrollment experience and access to affordable and high-quality health insurance products.
- Connects Californians to professional help from certified agents and enrollers by maintaining web-hosted tools that enable consumers to request call-backs from agents and enrollers and search for enrollment storefronts and events in their local communities.

Key Objectives for FY 2019-20

Individual Market

The individual market sales channels are Certified Insurance Agents, Navigator Certified Enrollment Counselors, Certified Application Counselors, Plan-Based Enrollers and Medi-Cal Managed-Care Plan Enrollers. Sales channels enrolled 58 percent of new and renewed consumers in Covered California during open enrollment for 2019.

The individual market program consists of two branches:

- The **Sales Operations Branch** oversees the administration, system and analytic operation functions to ensure sales channels have met contractual requirements to collaborate with Covered California, have access to the application portal and are equipped with actionable data and resources to assist and enroll consumers.
- The **Sales Distribution Channel Branch** focuses on sales strategies, direct support to the sales channels, and strategic partnerships in communities throughout the state to develop new and innovative ways to connect consumers to coverage. The branch works closely with the sales partners to enroll and retain consumers and diverse populations.

Key Outreach and Sales Objectives for FY 2019-20

Individual Market

- Developed key insights and mapping to quantify and target the sales opportunity created by the new financial help available due to the new state subsidies. Used these insights in educational materials to share with certified enrollers.
- Optimized the certification process of agents to streamline onboarding of new agents and agencies. Extended agent contract amendment to ensure that agents fully disclose key differences between Covered California health insurance companies and health-sharing ministry products before selling a health sharing ministry product to a consumer.
- Successfully awarded a total of $6.4 million in grant funding for fiscal year 2019-20 to 41 community-based organizations and clinics to participate in the new performance-based 2019-22 grant period for the Navigator grant Program.
- Collaborated with the Communications and Public Relations division and deployed media integration strategy utilizing Certified Insurance Agents and community partner organizations to conduct in-language outreach and enrollment activities statewide.
- Coordinated and participated in community grassroots events reaching thousands of Californians across the state.
- Conducted statewide meetings and webinars to train thousands of certified agents and enrollers to support the 2020 open-enrollment period.

Covered California for Small Business (CCSB)

Covered California for Small Business advances the mission of Covered California by offering small businesses and their employees a competitive, not-for-profit marketplace, enabling employees to choose the health plan issuer, coverage, and providers that offer them the best value. Covered California for Small Business oversees all aspects of its exchange, including strategy, finance, sales, marketing, plan management, regulations, policy and operations.

Key Objectives for FY 2019-20

Covered California for Small Business

- Awarded a contract to a vendor to design and implement a new enrollment and account-management platform that will transform the employer and consumer experience.
- On track to exceed membership and revenue targets. CCSB now provides insurance coverage to over 7,400 small businesses and 62,000 people.

Communications and Public Relations Division

Division Description

The Communications and Public Relations division serves two functions. Through the Broadcast and Media Relations Branch, it links to broadcast, print and online media while also developing, coordinating and executing an extensive proactive program of media relations and public communications that support enrollment in Covered California. Through the Web and Administrative Branch, it develops an overarching strategy for Covered California's public-facing website content, which includes CoveredCA.com and HBEX.coveredca.com.

How the Communications and Public Relations Division Supports Covered California's Goals and Strategic Priorities

- Analyzes data, identifies potential newsworthy stories and provides regularly updated information to local, state and national media outlets. Creates a strategic approach for general press and prepares press releases, op-eds and speeches.
- Coordinates large-scale open-enrollment launch efforts and press conferences. Updates and enhances campaigns to reach audiences on social media platforms and traditional news media outlets. Additionally, builds capacity for video and visual content development to meet changing information-consumption habits.
- Provides spokesperson services in English, Spanish and other languages and executes communication plans to reach specific ethnic groups.
- Provides communication expertise, produces an employee newsletter and gives support to other divisions to further their goals, including writing and graphic design services for several major agency publications like the rate booklet, annual report and external presentations.
- Develops an overarching strategy for Covered California's public-facing website content, including CoveredCA.com and HBEX.coveredca.com. Enhances CoveredCA.com through user testing to ensure consumers find the information they need as they apply for coverage.

Key Objectives for FY 2019-20

- Through a wide range of media, promotion and events, generated more than 369 million impressions during the open-enrollment period.
- Conducted four large-scale media events featuring sports celebrities in Los Angeles, Pomona, San Diego and San Francisco in partnership with the new public relations firm (IPG). These events promoted open enrollment and educated consumers about the availability of new state subsidies to make health care more affordable, including subsidies for middle-income consumers. The campaign also carried messages about a new law restoring the penalty in California for those who can afford health insurance but choose not to buy it.
- Planned and executed 15 small-scale events at enrollment locations throughout California during November, December and January, including health clinics and insurance agencies where individuals can enroll.
- Issued more than 20 news releases (in English and Spanish) and coordinated and conducted more than 200 media interviews with Peter V. Lee and other spokespeople for Covered California.
- Coordinated and conducted phone banks in English and Spanish and expanded those efforts to conduct them for the first time this year in Cantonese, Vietnamese, Hmong and Punjabi. Also, piloted online Spanish-language phone banks on Facebook and YouTube channels in partnership with Univision.
- Conducted added-value interviews and expanded news integration efforts in partnership with other divisions to generate news coverage on programs tailored to African American audiences as well as programs reaching speakers of Spanish, Mandarin, Cantonese, Vietnamese, Farsi, Hmong and Punjabi.
- Distributed more than 20 print-ready articles and infographics in English, Spanish and Chinese that appeared in 110 regional, community and news publications, as well as digital news sites throughout the state. Articles reached Covered California's multicultural target segments including Latinos; Asian and Pacific Islanders (API) (including Chinese, Korean, Vietnamese, and Indian Americans, among others); African-Americans; and the LGBTQ community.
- Analyzed Covered California's consumer website for search engine optimization to improve discoverability by consumers searching for health insurance.
- Maintained the @CoveredCAnews Twitter handle, sending 175 tweets that generated over 400,000 impressions and drew 260 new followers, including a tweet about a national issue brief released in March that attracted 48,000 impressions.
- Piloted the inclusion of video segments in news releases, expanded use of Skype, Zoom and FaceTime to provide interviews to television stations across the state during the COVID-19 emergency and began planning for live-streamed Twitter feeds to enable live video access to major announcements.

Program Integrity Division

Division Description

The Program Integrity division serves two functions. Through its Reconciliation of Enrollment and Membership Unit, it ensures accuracy and alignment of data between Covered California and carrier systems and conducts system testing and performance review of CalHEERS. Through its Program Oversight and Compliance Unit, it conducts internal/external audits and assists all divisions in identifying and remediating enterprise-wide risks. The division encourages accountability, transparency, effectiveness, efficiency and risk management by independently reviewing key business areas to help ensure compliance with federal and state laws, regulations and policies.

How the Program Integrity Division Supports Covered California's Goals and Strategic Priorities

- Manages, monitors and oversees all data-integrity initiatives to preserve data consistency, and accuracy within the core systems of the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) and with external entities.
- Improves data accuracy and reliability to support Covered California as a data-driven, evidence-based organization for its policy advancements, operational improvements and strategic vision.
- Manages and oversees the user acceptance testing process by testing CalHEERS enhancements prior to implementation and resolving critical issues that may negatively affect consumers when they apply for and enroll in a Covered California plan.
- Conducts post-implementation review of CalHEERS functionalities to improve operational efficiencies and program compliance.
- Oversees and monitors an enterprise-wide risk-management reporting process to assist all divisions in their risk analysis and evaluation of organizational operations, internal controls, policies and procedures.
- Establishes safeguards by monitoring and overseeing an integrated and enterprise-wide fraud-management program, which requires collaboration and partnership with various internal and external entities.
- Manages and performs independent external and internal audit services to improve Covered California's operational efficiencies, effectiveness and program oversight.
- Improves compliance with federal and state regulations and mandates.

Key Objectives for FY 2019-20

- Improved and enhanced data integrity monitoring tools to proactively detect inconsistencies in consumer enrollment and financial information between the CalHEERS and carrier systems.

- Enhanced the CalHEERS testing process by reviewing over 2,000 test case scenarios, in order to validate key system functionalities.
- Identified and prioritized CalHEERS issues, of which 95 percent were resolved and implemented into the system.
- Examined more than 3,200 consumer cases during the post implementation review process, once CalHEERS changes were made.
- Monitored and tracked all risks and mitigation strategies related to the implementation of the new state subsidy program by promoting enterprise-wide transparency and awareness.
- Implemented system enhancements to streamline and improve the fraud, waste and abuse review process.
- Improved policies and procedures when performing internal audits to evaluate the effectiveness of Covered California's risk management, control and governance processes.

Service Center Division

Division Description

The Service Center provides comprehensive pre- and post-enrollment education and support to Covered California consumers by responding to consumer inquiries, enrolling consumers in health plans and promptly resolving challenges that prevent them from receiving health and dental benefits. These efforts ensure consumers receive the right care at the right time at an affordable price, retain coverage and are satisfied with Covered California products and services.

How Service Center Division Supports Covered California's Goals and Strategic Priorities

Key Objectives for FY 2019-20

- Handled 1,929,148 consumer inbound calls from July 2019 through March 2020, with more than 1,136,218 of these during open enrollment.
- Completed more than 379,697 manual work streams from July 2019 through March 2020 and continued to plan for ongoing workflow.
- Closed more than 26,967 escalations and formal complaints from July 2019 through March 2020.
- Closed more than 6,523 appeals from July 2019 through March 2020.
- Resolved informally more than 5,412 appeals from July 2019 through March 2020.
- Processed and resolved more than 4,830 IRS Form 1095-A disputes from July 2019 through March 2020.
- Provided assistance with 62,955 Certified Insurance Agent overflow inbound calls.
- Extended business hours: during the 2020 open-enrollment period, the Service Center, in partnership with the surge vendor, extended the business hours past the standard open enrollment hours of 8 a.m. to 8 p.m., Monday through Friday, to assist consumers:
    - Extended business hours until 10 p.m.: Dec. 10, Dec. 11, Dec. 12, Dec. 13, Dec. 14, Dec. 15, Dec. 19 and Jan. 29.
    - Extended business hours until midnight: Dec. 20, Jan. 30 and Jan. 31.

Ombuds Office

Division Description

The Ombuds Office serves two functions. Through its Ombuds Affairs Unit, it provides consumers an objective, unbiased and accessible resource when other resolution or customer service channels have been exhausted. Through its Appeals Fulfillment Unit, it serves as an independent resource to implement Administrative Law Judge decisions following eligibility determination appeals. Together, these units identify systemic challenges and promote solutions to prevent issues from recurring to improve the overall experience of Covered California consumers.

How Ombuds Office Supports Covered California's Goals and Strategic Priorities

- Serves as an objective resource in implementing eligibility decisions of appeals for Covered California as a result of Administrative Law Judge orders and assists consumers in understanding the outcomes and resolutions to their Covered California case.
- Works directly with the consumer, and the county if applicable, to make requested changes to the consumer's plan selections as a result of an appeals decision and ensures the organization remains in compliance with state law by implementing appeals decisions within the required timeframe.
- Works closely with Covered California consumer advocates, health insurers, the Department of Health Care Services, regulators and others to manage Covered California consumer resolutions.
- Assists consumers with proper and timely customer service through several customer-oriented channels and conducts evidence-based research to assist Covered California divisions in determining case resolutions.
- Analyzes data from the Ombuds Office, other Covered California divisions and external partners that serve Covered California consumers, to identify potential Covered California divisional changes.
- Shares objective findings and operational recommendations to Covered California and stakeholder groups and monitors the progress of each implemented recommendation.
- Identifies systemic issues and solutions to decrease enrollment barriers and enhance the overall consumer experience.

Key Objectives for FY 2019-20

- Handled a total of 3,381 calls through the toll-free Ombuds Office phone line from July 2019 through March 2020. Assisted consumers with 546 complex cases and an additional 515 consumers by providing information, answering inquiries, or referring consumers to an appropriate service channel from July 2019 through March 2020.
- Implemented 1,580 final appeals decisions ordered by an Administrative Law Judge from July 2019 through March 2020.

- Finalized the Ombuds inaugural report, which recaps the operations from the 2018 calendar year.
- With the Information Technology division, enhanced the Customer Relationship Management tool by transitioning to Salesforce and adding functionality such as privatizing Ombuds specific cases, auto-calculating milestones for decision compliance, and adding additional data fields to improve reporting.
- Implemented an electronic disclaimer process for consumers who need to select a plan during the appeal implementation process.
- Finalized processes to complete quality assurance and quality control checks on recorded phone calls to improve customer service.
- All customer service staff attended soft skills training via Covered California's Learning Management System.

Customer Care Division

Division Description

The Customer Care division's purpose is to optimize and enhance the consumer experience regardless of service channel (e.g., self-serve, through the Covered California Service Center, via a Covered California Certified Insurance Agent or Certified Enrollment Counselor). Ultimately, this work involves a high level of coordination, transparency and collaboration throughout the organization to understand and facilitate improvement of the consumer experience during all phases of the consumer journey. This effort is foundational to Covered California's purpose of making health insurance more affordable and easier to purchase for individuals and small businesses.

How the Customer Care Division Supports Covered California's Goals and Strategic Priorities

- Establishes and maintains department-wide relationships and creates cross-functional policies to facilitate a consistent and connected experience for Covered California consumers.
- Creates and maintains a consumer-centric culture across the organization.
- Elevates and centralizes policy formulation directed at improving the experience of its consumers.
- Develops external engagement and communication policies to engage external stakeholders, consumers, advocates and health plan issuers in the development and implementation of Covered California's consumer-experience strategic plan.
- Fosters and drives a culture of innovation in solving or resolving consumer experience initiatives and opportunities.

Key Objectives for FY 2019-20

- Began the development of a consumer-journey mapping Request for Proposal to understand Covered California consumer personas, document consumer journeys, present key findings and develop a multi-year consumer experience strategic roadmap.
- Acted as product Manager for CiCi, Covered California's virtual assistant, accountable for short-, mid- and long-term innovation, including predictive learning to deliver a personalized experience and possible integration into the single streamlined application.
- Began the development of a "Health of the Consumer" dashboard to catalog key performance indicators that contribute to Covered California's understanding of consumer experience.
- Secured a vendor to conduct an Insurance Marketplace Platform Assessment to better understand the newly launched CMS Enhanced Direct Enrollment interface.

- Created and sponsored the Covered California Creative Café, an innovation lab hosting brainstorming workshops, informal “what if” innovation discussions. Also hosted a variety of external subject matter experts discussing collaboration initiatives and best practices.
- Sponsored, facilitated and supported various projects and workgroups to resolve issues and improve the consumer experience.

California Healthcare Eligibility, Enrollment and Retention System (CalHEERS)

Division Description

The California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) serves as the consolidated system support for eligibility, enrollment and retention for the Covered California and Medi-Cal. The CalHEERS enrollment portal enables consumers to research, compare, check their eligibility for, and purchase health coverage in one place. The Office of Systems Integration (OSI) oversees the consumer-facing system that runs California's single streamlined application for all affordable insurance programs, including Medi-Cal.

CalHEERS is jointly sponsored by Covered California and the California Department of Health Care Services. The project is governed by an executive steering committee that represents each of the participating agencies and has guided the project since its inception.

How CalHEERS Supports Covered California's Goals and Strategic Priorities

- Enhancement, maintenance and operations of the CalHEERS solution to support eligibility determination and enrollment in Covered California and Medi-Cal.
- Acts as a liaison between sponsors and partner agencies at the federal and state level and the systems integrator for operational coordination and efficiency.
- Integrates with health insurance companies for enrollment.
- Handles federal and state reporting, management and interface responsibilities.
- Continues to implement operational improvements from the CalHEERS roadmap to ensure the organization's technical infrastructure is properly maintained and secured, supports capacity demands and achieves business goals.
- Appropriately equips authorized end users with the tools necessary to serve consumers effectively and to handle exception situations.
- Ensures business partners can receive, exchange and reconcile appropriate consumer information in a timely fashion.
- Strives to continuously streamline and enhance the consumer experience during enrollment and while transitioning between various programs available through the Affordable Care Act.

Key Objectives for FY 2019-20

- Implemented the state subsidy program to provide more-affordable health plans to more Californians.
- Processed more than 1.3 million renewals for the 2020 plan year.
- Processed more than 400,000 new enrollments during the 2020 open-enrollment period.
- Further enhanced the online application experience to continue to make the application as simple and informative as possible to customers.
- Integrated with a special-enrollment reason verification vendor to enhance program integrity.
- Added capabilities for community-based assisters to better manage their caseloads to serve consumers more efficiently.
- Improved benefit display during plan selection to better inform consumers of the benefits available to them under each health plan.
- Pushed notices to the cloud, saving $10 million in technology refresh costs.
- Migrated archived recordings to the cloud, resulting in $5 million in savings over the next 10 years.
- Moved non-production environments to the cloud, resulting in a 99 percent reduction in environment build time and saving $180,000/year in reduced hosting expenses.
- Released a new version of the consumer homepage and account summary pages, providing a greatly improved user experience for customers.
- Enhanced the handling of income and taxes to aid consumers in their application process.
- Improved integration with Service Center application and the CalHEERS application giving staff quicker access to information when handling calls.
- Completed Form 1095-A processing for the 2019 plan year on time, with a very small percentage of consumers requiring corrections.

Information Technology Division

Division Description

The Information Technology (IT) division provides technology and security services to all Covered California divisions, consumers and stakeholders to support operations and enrollment services in a manner that is financially sustainable. This effort includes providing oversight of the ongoing development and operations of California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) for Covered California.

Three branches carry out specific functions in the Information Technology division, including the Information Security Branch, the Operations Branch for delivery of IT services, and Strategic Initiatives for project management and support for the full systems development lifecycle and support for analytics throughout the enterprise.

How the Information Technology Division Supports Covered California's Goals and Strategic Priorities

- Provides governance and management over the Covered California Enterprise IT architecture and IT projects, including CalHEERS.
- Supports Covered California's business applications and technical solutions.
- Provides oversight of information technology security and privacy via the Centers for Medicare and Medicaid Services (CMS) MARS-E security and privacy framework, managing and submitting the various CMS-required security and privacy artifacts.
- Protects, stores, monitors and manages access and security of Covered California data assets.
- Manages the technical infrastructure and network for Covered California.
- Provides a centralized service desk for Covered California.
- Continuing work on enhancing the Customer Relationship Management tools, chatbot, automated verifications, agent and navigator tools and data reporting.
- Continuing to expand data reporting and analytics throughout the organization.
- Continuing implementation of additional security enhancements, especially surrounding any needs for permanent "work from home" solutions.

Key Objectives for FY 2019-20

- In March 2020, executed emergency plans to move the organization to a “work from home” model. This included changes to networks, developing a “work from home” model for service center representatives, working with federal partners for emergency change approvals, and putting virtual solutions in place for all internal meetings and board meetings.
- Worked with Covered California divisions to design, build and implement business solutions to support the state subsidy program, including calculators and tools for consumers to estimate subsidies and the impact of Health Reimbursement Accounts on premiums and online requests for exemptions from the new mandate.
- Continued work on enhancing the Customer Relationship Management tools available to service center representatives who assist consumers and agents. By the end of FY 2019-20, nine releases will have been completed that include enhanced integration with CalHEERS, secure notice generation to consumers, and many tools and enhancements to help service center representatives assist consumers more efficiently.
- Implemented enhanced analytics on our website and within CalHEERS. Rebuilt the Covered California chatbot, CiCi, including the addition of surveys, measurement dashboards, A/B testing, and numerous additional automated responses to high volume questions from consumers based on data collected. Before the end of FY 2019-20, we plan to add live hand-offs from the chatbot to Live Chat with service center representatives and Help on Demand to get consumers to a licensed and certified insurance agent if needed.
- Enhanced our Interactive Voice Response (IVR) system for consumers and our voice technologies. This resulted in reducing time to connect to agents and reducing outages by over 85 percent. In addition, moving forward, the cost and time to make changes in our IVR system is reduced by 75 percent.
- Provided oversight and resources for the transition of the maintenance and operations of the CalHEERS solution to a new systems integrator. This included our Information Security team preparing eight change-notification packages for the Centers for Medicare and Medicaid Services approval.
- Enhanced the automated solution for the processing of consumer verification documents with a goal of increasing automation. While we were able to increase the success of the automation, we will be continuing additional enhancements in FY 2020-21 to achieve our targeted goals of automating 40 percent of verification documents.
- For Covered California’s Certified Insurance Agents, implemented enhancements to allow integrated contract processing and training online in a single solution.
- Collaborating with the Human Resources Branch, completed the procurement for a new human capital management system with implementation next year.

- Implemented portfolio management practices across the organization. This will be an area of continued development in the coming year.
- Expanded data warehouse and analytics capabilities across the organization.
- Completed the balance of the IT infrastructure refresh, providing redundancy, enhanced security, and setting the stage for the organization to move to a more balanced refresh cycle.

Business Services Branch

Branch Description

The Business Services Branch is responsible for providing guidance and consultation on contract and purchasing services; health, safety and wellness services; providing central support functions for administrative programs enterprise-wide; ensuring facilities are well maintained and secure, and managing our physical resources through facilities operations.

How Business Services Branch Supports Covered California's Goals and Strategic Priorities

- Advances Covered California's mission by automating and streamlining business services-related functions to improve operational efficiency and effectiveness.
- Provides administrative processes and resources to ensure all procurement and contracting activities for Covered California are effective and responsible.
- Administers health, safety and wellness programs for Covered California employees, including injury and illness prevention, workplace violence and bullying prevention, ergonomics, and business continuity planning.
- Administers all enterprise-wide administrative services activities, including the Covered California Administrative Manual (CCAM), records management, forms management, recycling, asset management and space planning.
- Ensures all Covered California facilities are well maintained and secure, and that Covered California has the appropriate physical workspace to deliver on our mission.
- Continue to successfully achieve all business services activities and implement all legislatively mandated policies and procedures.

Key Objectives for FY 2019-20

- In collaboration with Financial Management division, continued efforts to improve upon processes associated with the FI$Cal accounting system.
- Provided contracting services for more than 15,000 Certified Insurance Agents; Certified Enrollment Entities; Navigators; health plans, dental plans and third-party administrators; personal services; operational services and non-monetary agreements.
- Processed more than 965 purchase orders for divisions' requests.
- Covered California's Wellness Program was recognized by CalHR as the top program in the state, and our Wellness Coordinator won CalHR's Wellness Coordinator of the Year award. Covered California ranks first in the Healthier U Connections total employee registration, and our program has been referred to as the "Gold Standard" by CalHR's statewide wellness coordinator.

- Continued to implement wellness initiatives including conducting a second Health Enhancement Research Organization (HERO) scorecard evaluation which revealed significant improvements related to wellness across the organization.
- Hosted our inaugural Wellness Fair at all worksites. Continued providing wellness seminars, blood pressure and preventive biometric health screenings, blood drives, flu clinics, mason jar salad and diet and nutrition educational events and activities, holiday food drives and employee walks, and coordinated to host instructor-guided meditation at all locations, which occur on a weekly basis.
- Activated the Emergency Operations Center in response to the pandemic of COVID-19 that affected all Covered California work locations. Employees were quickly provisioned to emergency telework. Facilitated the cross-division emergency response collaboration to ensure the continuity of operations.
- Executed a 10-year lease for the new Fresno location with a tentative move-in date of July 2020. Executed a two-year lease at Arden Way for the Plan Management division with a tentative move-in date of early July 2020. Executed a seven-year lease renewal for the Rancho Cordova service center, which includes additional space on the third floor for staff growth.

Financial Management Division

Division Description

The Financial Management division plans, implements and guides all Covered California financial activities, including finance, accounting, forecasting, budgeting and governmental compliance. The division consists of two branches: Accounting and Accounting Systems Operations and Financial Planning and Forecasting Operations. Within those units lie critical accounting functions, including payroll, financial reporting, accounts receivable and payable, financial modeling, financial forecasting and financial systems.

How Financial Managment Division Supports Covered California's Goals and Strategic Priorities

- Supports a culture of continuous improvement for budget, forecasting and accounting practices, policies, procedures and systems to better support division operations.
- Performs financial planning activities, including economic analysis, forecasting and dashboard reporting of revenues and expenditures. Additionally, analyzes the monthly and quarterly financial reports of various units and departments.
- Coordinating and preparing Covered California's forecasts, enrollment and revenue, and Annual Report.
- Provides support to promulgate Covered California's permanent regulations in accordance with the Administrative Procedures Act by developing regulatory economic and fiscal-impact analyses.
- Managing day-to-day accounting including: accounts receivable, accounts payable, payroll advances and payroll collections.
- Managing banking oversight and controls with the State Treasurers Office, the State Controller's Office and the Department of Finance.
- Processes general ledger and accounts payable transactions. Pays vendor invoices and employee travel expense claims. Receives, prepares and distributes payroll warrants.
- Performs accounts receivables and reconciliations for Covered California for Small Business (CCSB), which includes payments to carriers, general agents and agents for CCSB.
- Prepares budgetary and legislative annual financial statements in compliance with generally accepted accounting principles (GAAP) and collaborate with external auditors, and presenting annual financial statements to Board of Directors and the Centers for Medicare and Medicaid Services (CMS).

Key Objectives for FY 2019-20

- Designed, developed, and implemented an enrollment forecasting methodology. Additionally, established a virtual server capacity to enhance analytic capabilities.
- Prepared annual financial statements in accordance with Government Accounting Standards Board (GASB) pronouncements and Generally Accepted Accounting Principles (GAAP).
- Designed, developed and implemented a state subsidy payment system.
- Implemented paperless travel expense claiming system.
- Reconciled historical accounts receivable balances and reviewed with plan partners.
- Created policies for safeguarding state assets.
- Began to assess internal capacity, resources and operational weakness.

Human Resources Branch

Branch Description

The Human Resources Branch provides overall policy direction on human resource management and administrative support functions related to the management of employees via the following units: Labor Relations Office, Employment and Classification Services, Payroll and Benefits, Performance Management, Talent Acquisition and Operations and Disability Management.

How Human Resources Branch Supports Covered California's Goals and Strategic Priorities

- Provides consultative services to supervisors and managers throughout the life cycle of the hiring process, including advertising vacancies, recruiting top-tier talent, ensuring for a diverse and qualified workforce, adherence to all merit selection and employment best practices, rules, regulations and authorities.
- Dedicated to ensuring employees receive the benefits that are awarded to them through state and federal protected leave laws including the Family Medical Leave Act and California Family Rights Act, the addition of the Families First Coronavirus Response Act, and other applicable regulations and to reduce the human and fiscal cost of workplace disability.
- Coordinates and administers employee relations and labor relation policies. Represents Covered California in all labor relations activities with employee organizations, employee representatives and job stewards, and third-party reviewers/control agencies. Serves as Covered California's liaison and representative in labor-relations matters before the California Department of Human Resources and in hearings before arbitrators and the Public Employment Relations Board.
  Strives to foster excellence by empowering professional development and creating innovation solutions using services, tools and technology that bridge challenges and business needs to deliver a diversified, high-performing workforce.
- Collaborates with each division to continuously improve organizational culture and maintain a workplace that fosters a healthy, positive and respectful work environment.

Key Objectives for FY 2019-20

- Launched a cross-divisional Hiring Process Transformation Workgroup to study the current hiring process and make improvements for the entire organization. Introduced a Service Center Hiring Pilot to reduce time to fill from a goal of 72 days to 35 days.
  Assisted in the amendment of Conflict of Interest Code and which reduced number of filers and revised job descriptions as a result.
- Processed and approved 497 protected leave requests, 38 Workers' Compensation claims, 41 leaves of absence, seven limited term light duty assignments, and three catastrophic leave requests.
- Grew our talent pipeline to over 5,500 candidates, 339 of whom are bilingual in one of our seven core identified languages.
  Attended 36 professional, university, and diversity career fairs and engaged with 15,836 candidates.
- Increased our LinkedIn brand engagement rate by 144 percent since June 2019. Launched a Covered California Careers Instagram page and organically grew our following to 229 followers. Increased our Facebook Covered California Careers following to 1,235 followers.
- Launched a new Executive Recruitment Plan for executive hiring, as well as an executive recruitment brochure to market Covered California executive career opportunities.
- Developed and implemented the emergency telework process as a result of COVID-19.
- Significantly reduced the number of salary advances by implementing processes consistent with BU 1 and 4 MOUs.
- Partnered with program leadership to provide labor relations support for contractual matters on approximately 1,300 occasions.
- Provided approximately 2,500 coaching meetings to departmental managers and supervisors regarding difficult and complex employee performance matters.

Office of Legal Affairs

Division Description

The Office of Legal Affairs provides a wide range of legal services to all Covered California staff by giving preventive legal advice and consultation to ensure compliance with laws and to mitigate legal liability. The Office of Legal Affairs interfaces with state and federal regulatory agencies and provides legal advice on a variety of matters pertaining to Covered California and its programs, contracts and operations. The Office of Legal Affairs ensures that all legal agreements are fulfilled, and that Covered California operates within its legal authority. Additionally, the Office of Legal Affairs provides guidance on any statutes or regulations pertaining to Covered California.

How the Office of Legal Affairs Supports Covered California's Goals and Strategic Priorities

- Promulgates regulations with the Office of Administrative Law that incorporate Covered California's policies and procedures.
- Maintains the Covered California Privacy Office, which oversees the protection of consumers' personal information.
- Coordinates with the California attorney general on all litigation matters concerning Covered California.
- Responds to all Public Records Act requests on behalf of the entire department.
- Provides technical assistance on state and federal legislative proposals and analyzes and prepares comments on federal regulations and requests for information.
- Provides eligibility and enrollment appeals support, including representing Covered California at second-level eligibility and enrollment appeals in front of the federal Health and Human Services Agency.
- Provides general legal support to divisions and conducts preventive legal workshops designed to minimize litigation and legal liability by educating Covered California staff about the law (and changes in the law) and the legal implications of activities.
- Develops systems to monitor the volume and timeliness of legal services in the following areas: human resources, privacy, Public Records Act requests, and background checks.
- Conducts criminal background checks of all employees and contractors to protect and safeguard consumers and consumer information from unauthorized and illegal access to their personal information.

Key Objectives for FY 2019-20

- Provided legal analysis and guidance on the program design for the new state subsidy program.

- Established the appeal rehearing process ensuring consumers' rights to appeal an eligibility determination for the new state subsidy program and exemption from the new minimum essential coverage individual mandate and successfully codified those policies in the California Code of Regulations.
- Provided technical assistance to the Legislature and Covered California on legislation to provide Covered California with the authority to collect data to drive change in the health care delivery system, while bringing transparency to health care costs.
- Amended Covered California's Conflict of Interest Code, set forth in the California Code of Regulations, to reflect the current designated employees and financial disclosure categories.

Covered California University

Branch Description

The Covered California University is the enterprise training and knowledge management branch. The branch collaborates with programs and interacts across the organization leveraging subject matter exerts in a vast array of disciplines, acts as a consultant on information dissemination and training initiatives, and maintains both written materials and training courses that support the organization and its partners. The branch administers the technology that supports information and training, including the Customer Relationship Management Knowledgebase and Absorb Learning Management System. The branch consists of the following sections: Training Design and Delivery Section, Knowledge Management Section and Operations and Special Projects.

How Covered California University Supports Covered California's Goals and Strategic Priorities

- Supports existing and new process and procedure discussions, capturing key elements and decisions from program and policy experts to create documentation.
- Maintains knowledge and university library records, including management of the CRM knowledge base to provide documentation and communication that support a consistent and responsive consumer journey.
- Supports Covered California programs to develop training courses that are mandatory and program specific to ensure employees are prepared to support Covered California's goals and initiatives.
- Ensures compliance of all Covered California mandatory training, tracks completions of external training, and provides regularly scheduled management reports of compliance.
- Provides training and readiness activities for consumer experience initiatives, special enrollment enhancements and all CalHEERS upgrades that affect Covered California staff, partners and consumers.
- Provides comprehensive courses to Service Center, Outreach and Sales, and vendors, including new-employee training, annual refresher and training for the Agent Call Center overflow.
- Leverages existing and new technologies, blended training delivery systems, to enhance all Covered California divisions and partners by providing opportunities for professional learning and growth.

Key Objectives for FY 2019-20

- Modified processes and developed task guides, talking points, instructor-led and virtual training content to support Covered California staff, external partners, and consumers during statewide regulation changes such as the state subsidy program and the COVID-19 pandemic response.

- Developed and implemented readiness communication, training and resources for high-risk organizational changes, including CalHEERS updates, Microsoft Teams implementation, and emergency telework, including enterprise announcements with links to external virtual course offerings and access to a library of over 200 online courses available in the LMS.
- Oversaw Service Center surge vendor staff readiness and training for more than 1,200 staff over a four-month period, increasing new-hire employee speed of adoption, utilization of tools and resources and staff productivity to support open enrollment.
- Obtained and delivered a total of 14 soft skill courses, 11 eLearning and three instructor-led, from support-center industry experts, ICMI, to equip Service Center staff with the resources and skills to provide a positive consumer experience.
- Launched a knowledge-article simplification project to better support Knowledge Base users, increasing user utilization and decreasing consumer case errors and average call handle time.
- Continued annual certification and recertification development and LMS support for over 12,000 community enrollment and certified insurance agents.
- Conducted and participated in external and internal LMS record reviews for accuracy and completeness, including a State Personnel Board (SPB) audit regarding state officials ethics, sexual harassment prevention, and leadership continuing education training requirements.
- Partnered with state and county training programs such as Department of Health Care Services (DHCS) for the development of Medi-Cal Eligibility Data System (MEDS) eLearning, County Children's Health Initiative Program (CCHIP) county programs for vendor CCHIP training, and Department of Motor Vehicles (DMV) to support and deliver training at DMV offices regarding Real ID requirements and processing.

Executive Office

Division Description

The Executive Office develops organizational strategy and provides leadership direction in concert with the Covered California Board of Directors. Executive Office staff are responsible for Covered California's day-to-day operations and are tasked with facilitating and supporting Covered California's employees and a broad community of individuals and groups to provide customers (including staff, the board, stakeholders and the public) with the direction, information, tools and support they need. The Executive Office does this by mentoring, providing leadership, listening, learning and adjusting efforts to meet goals and serve consumers.

Talent management and succession planning provides strategic talent leadership to ensure Covered California is considered an employer of choice and can attract, develop, retain and recognize the best talent.

How the Executive Office Supports Covered California's Goals and Strategic Priorities

- Develops and implements high-level strategies to ensure the availability of affordable health insurance and enhance quality and access.
- Makes major management decisions about the overall operations and resources of Covered California. Ensures that Covered California operates in a responsive, transparent and reliable manner.
- Acts as the main point of communication between the Board of Directors and Covered California's operations. Facilitates communication and productive relationships between the Board of Directors and various stakeholders, such as consumers, providers, health insurance companies and employers.
- Sponsors the Covered California Leadership Academy to ensure Covered California has a strong bench of future leaders who can navigate the organization through the complex changes and constant challenges facing state exchanges.
- Assists leadership in identifying common themes for improvement at the department and division level and creates an overall engagement strategy.
- Oversees responsibilities for ensuring that effective employee recognition is incorporated into the organizational culture in support of Covered California's strategic pillars and values.
- Develops, implements and monitors a workforce plan that aligns staffing and competencies with the department's current and future strategic business needs.
- Builds a targeted and sustainable succession plan for key senior roles.
- Conceptualizes, builds and rolls out learning solutions that center on career development and career ladders and increase the team's ability to be net talent exporters.

- Oversight responsibilities for the comprehensive career-development program. Such a program invests in the professional development of employees, which results in knowledge transfer throughout the department and increased employee engagement and retention. It prepares employees for career advancement within Covered California.

Key Objectives for FY 2019-20

- Oversaw efforts to learn from the launch of the new state subsidy program and penalty to launch a targeted special-enrollment period to build on the successful open-enrollment period.
- Launched the COVID-19 special-enrollment period, while overseeing the rapid shift of all staff to telework and maintaining support and engagement of staff through surveying, virtual all-staff meetings and support from all levels of supervisory staff.
- Successfully completed the second Covered California Academy program with a select group of managers and key staff who participated in 13 full-day classes over a period of six months. Enhanced resources and tools for academy alumni to continue learning and networking, connecting and engaging with fellow leaders. Launched the third cohort in spring 2020 and will reevaluate the delivery of the Academy given COVID-19 safe work practices.
- Enhanced two-way communication capabilities during “Covered California Live” all-staff monthly meetings centered on motivating, engaging and listening to employees. Successfully introduced and launched by-weekly Virtual All Staff meetings and a COVID-19 Hub on SharePoint for staff to stay connected amidst change and distance as a result of the COVID-19 response efforts.
- Continued efforts to enhance a recognition culture throughout the organization where employees feel appreciated for the work they do, and even more so when they go the extra mile. This includes strategies continuing to support the employee-recognition program that offers formal, informal and everyday acknowledgment.
- Implemented various strategies outlined in the 2017-20 Covered California workforce and succession plan outlining the strategic way forward to meet the human-capital management and workforce needs for Covered California. The plan is consumer focused, data driven, team based, continuously improving and based on population.
- Enhanced tools and resources for employees to deepen their understanding of self and others, making workplace interactions more effective.

External Affairs

Division Description

External Affairs serves as Covered California's government and stakeholder relations liaison. External Affairs supports Covered California's policy and program development by representing the organization in complex and sensitive legislative, policy, and administrative processes and by building collaborative relationships with elected officials, state and local agencies, and stakeholders. External Affairs also proactively facilitates partnerships that encourage education, outreach and enrollment in Covered California.

How External Affairs Supports Covered California's Goals and Strategic Priorities

External Affairs promotes Covered California's organizational excellence, provides outreach and education, and informs national and state health policy discussions through a variety of ways:

- Provides strategic representation to federal, state and local elected and administration officials to advance Covered California's organizational excellence, and to provide insight for the policymaking process.
- Proactively develops and maintains stakeholder relations to support and advance Covered California's mission and goals.
- Tracks state and federal legislation and helps develop technical assistance to inform the policy making process.
- Provides constituent correspondence and case-escalation resolution for cases brought forward by legislative offices, stakeholders and Covered California leadership and staff.
- Develops and implements governmental and stakeholder outreach and engagement strategies.
- Provides information, analysis and insight into the external perspective of Covered California to enable sound decision-making in support of organization objectives.
- Engages in and provides support for special projects and matters that involve multiple divisions within the organization.
- Serves as Covered California's liaison to California's Tribal governments.

Key Objectives for FY 2019-20

- Coordinated the development and approval of trailer bill language through a partnership with the Department of Finance and the Franchise Tax Board that established the state subsidy program, the individual shared responsibility mandate and penalty for California. The premium subsidy program will be in effect for the 2020, 2021 and 2022 plan years.
- Worked with health care advocates, health insurance companies and administration officials to address concerns and questions regarding the state subsidy and individual shared responsibility mandate program. Coordinated testimony on the program in the Assembly and Senate Budget Subcommittees on Health and Human Services.
- Worked with Franchise Tax Board (FTB) partners to ensure consistency in public messaging on the individual mandate and penalty. Spoke to FTB stakeholder groups including tax preparers and tax software companies to ensure that consumers were aware of the new laws.
- Provided technical assistance on bills regarding data sharing, actuarial value limits and open enrollment timing.
- Continued improvements of the Tribal Liaison program, including removal of the Tribal Advisory Workgroup from the purview of the board to allow for more frequent and robust workgroup meetings.
- Tracked and monitored legislation with potential impact on Covered California and consumers in the individual and small group market, including development of technical assistance to Congress and the California Legislature as needed.
- Engaged elected officials throughout California during the seventh open-enrollment period with the goal of promoting enrollment into health coverage. Participated in open-enrollment events with key influencers in the professional sports community, providing support to elected officials and staff attending the events.

Equal Employment Opportunity Office

Divison Description

The Equal Employment Opportunity Office is responsible for implementing, coordinating and monitoring civil rights compliance for Covered California's workforce and consumers. The Equal Employment Opportunity Office ensures that Covered California is compliant with federal and state laws regarding diversity, equity and accessibility. The office also partners with other program areas to develop initiatives that increase accessibility and foster diversity. It reports on appointments, brings issues of concern regarding equal employment opportunity to the executive director and recommends appropriate action.

How the Equal Employment Opportunity Office Supports Covered California's Goals and Strategic Priorities

- Advises and acts as a resource to management regarding equal employment opportunity and work-diversity laws and rules.
- Administers Covered California's equal employment opportunity program in accordance with applicable laws and internal policies.
- Responds to complaints regarding employment practices, language access and denial of services related to discrimination or unlawful harassment.
- Administers Covered California's Reasonable Accommodation program, ensuring appropriate processing of reasonable-accommodation requests in accordance with applicable laws and internal policies.
- Administers Covered California's Upward Mobility program to assist Covered California's employees in low-paying classifications transition to technical, professional, and administrative positions.

Key Objectives for FY 2019-20

- Maintain active membership in the Enterprise Risk Committee, offering perspective on civil rights, accessibility and other Equal Employment Opportunity-related risks. Utilize this this platform to escalate and resolve risks related to civil rights.
- Provide consultation to employees and managers who raised questions about accessibility and discrimination in the workplace. Investigate complaints and present findings for departmental action. Begin using the Discrimination Complaint Tracking System to track internal and external complaints.
- Coordinate the delivery of the mandated Sexual Harassment Prevention Training to Covered California's managers and staff to meet updated government code requirements.
- Provide department-wide training tailored to the roles and responsibilities of rank and file employees, supervisors and managers regarding Equal Employment Opportunity and Reasonable Accommodation.

A-II. Covered California's FY 2019-20 Budget Highlights and Projected Year-End Results

Fiscal year 2019-20 was eventful. During this year, Covered California implemented state subsidies and a state mandate. Covered California initiated several major actions throughout the year to increase enrollment and potentially alter the enrollment mix. These actions resulted in an effectuated enrollment that mirrored 2018, the year with its highest enrollment on record. While Covered California had a successful open-enrollment period, recognizing a 40 percent increase in new enrollment over 2019, and added enrollment throughout the special-enrollment period, it was also challenged like the rest of nation and world with the COVID-19 pandemic. Below are some Covered California budget highlights for FY 2019-20.

- Effective January 2020, California required its residents to have health insurance coverage — reinstating the federal penalty that was integral to the Affordable Care Act. California launched a state subsidy program that expanded the amount of financial help available to many consumers. The new state policies helped Covered California negotiate a rate change of only 0.8 percent for 2020. California extended its open-enrollment period through Jan. 31, compared to Jan. 15 last year — in dramatic contrast to the federal decision to have open enrollment close on Dec. 15.
- Covered California established a special-enrollment period for those who were unaware of the state penalty or the new financial help, allowing consumers to sign up for coverage through April 30. Covered California launched a new campaign to publicize the special-enrollment period, starting with social media messaging and consumer emails. Radio and digital ads were also aired to inform and educate the public.
- Covered California invested $121 million in marketing and outreach to help it maintain a consumer pool.
- Covered California responded to the COVID-19 national emergency by extending the open-enrollment period through June 30, 2020, and increasing marketing, outreach and service center support.
- Covered California kept its employees safe and successfully transitioned its entire workforce into a telework environment, investing in technology to keep employees productive.

The state subsidies and mandate are national innovations in health care affordability. However, since they were new initiatives, Covered California had little historical experience to draw on. This meant that implementing these initiatives and determining their impact on enrollment and revenue was uncertain and came with some risk. While Covered California did make use of expert consultation, great uncertainty remained as the budget was adopted and the fiscal year unfolded.

Covered California entered budget year 2019-20 aware of the possibility that enrollment targets might be missed. Predicting consumer behavior is always filled with uncertainty. Covered California evaluated several enrollment forecasts and developed pro forma

financial projections. These financial statements disclosed that there was a risk that Covered California would recognize an operating loss for the fiscal year; however, such a loss would not be substantial. On top of this uncertainty concerning enrollment associated with the state mandate and penalty, the COVID-19 national emergency began unfolding in the latter half of FY 2019-20.

As Covered California began producing its annual enrollment and revenue forecast this year, a spreading pandemic prompted public officials to impose sweeping restrictions that quickly brought about a sudden economic slowdown and a sharp rise in unemployment. The United States, as with all nations, faces unprecedented challenges in attempting to contain the spread of COVID-19. The COVID-19 virus has forced nations all over the world to shutter their economies with rapid urgency. This has resulted in millions of individuals losing jobs. Since mid-March, the United States has shed roughly 30 million jobs.

In early 2020, the COVID-19 pandemic began spreading in the United States. Since there are no known antivirals and vaccines at this time, the nation's response has focused on social distancing, shelter-in-place orders, and personal hygiene. In turn, by mid-March, California's economy had slowed considerably as many businesses closed or scaled back, except for essential services. This suppression of business activity has resulted in a severe economic slowdown and extreme job losses. On April 30 it was reported that in California, over the most recent eight weeks, 3.78 million workers — 19.6 percent of the workforce — had filed for unemployment.

In the second half of FY 2019-20, Covered California, like most firms and public agencies, had to traverse extraordinary terrain to keep employees safe, and also step up to a new role and responsibilities. This necessitated additional outlays for telework equipment, moving costs and developing new marketing and outreach efforts in the wake of the pandemic.

Like most entities coping with the pandemic, Covered California experienced unanticipated expenses in the latter half of fiscal year 2019-20. COVID-19 required additional expenses to ensure worker safety and fund marketing and outreach activities to aid individuals and families impacted by the sudden shock to the economy.

While Covered California recognized lower than expected enrollment during FY 2019-20 and incurred unexpected COVID-19 expenses, it will end FY 2019-20 financially healthy. Covered California's cash reserve is forecasted to total $404.2 million, which will fund approximately 11 months of budgeted operations. Covered California ends FY 2019-20 financially strong and enters FY 2020-21 in a position to provide a supporting role to all Californians during the COVID-19 pandemic.

The Covered California board-approved budget for FY 2019-20 was $391.1 million, with $379.1 million approved for operations and $14.3[25] million approved for capital projects. This included 1,386 staff positions[26] (Table 7). These budget resources were provided to implement a new state premium assistance program —including first in the nation

[25] The original board-approved capital projects budget was $12 million; however, subsequent board resolutions raised the capital projects budget to $14.3 million.
[26] During FY 2019-2020, five mid-year additions were made to positions: two in Policy, two in IT, and one in Communications and Public Relations.

financial support for middle-class Californians —and a state-level individual health insurance mandate, enroll Californians in coverage, provide a better consumer experience to applicants and enrollees, retain current enrollees and provide the tools to deliver on our mission.

Table 7
Covered California Board Approved Operating, Capital Projects, and Staffing Budgets for Fiscal Year 2019-20

	FY 2019-20 Approved Budget
Total Approved Operating Budget	379.1
Total Approved Capital Projects Budget	14.3
Total	**393.4**
Total Staff Positions	1,386

Covered California's forecasted financial outcome for FY 2019-20 discloses that it will recognize an overall decrease in net position of $2.9 million, which represents roughly 1.0 percent of total forecasted revenues. The decrease in overall net position is the result of lower enrollment relative to the budget.

Based on forecasts for the remainder of the fiscal year, it is estimated that Covered California's operating revenues and other income[27] will be $20.6 million lower than budgeted. Exchange-based individual medical plan revenues are forecasted to achieve 95.0 percent of both their budgeted enrollment and revenue target for the fiscal year. During the first half of the fiscal year (July to December), actual enrollment reached 99 percent of the levels forecasted in the budget, while in the second half of the year (January to June) enrollment is forecasted to achieve 93.0 percent of the levels projected in the budget.

Covered California is on target to recognize total operating expenditures that are $68,200 less than the board approved budget of $379.1 million.

Throughout FY 2019-20, Covered California adjusted its expense plan to meet the needs of the ever-changing environment. Covered California modified its spending plans in some areas to accommodate expenses in other areas. During the special-enrollment period, additional marketing expenses were incurred to ensure maximum consumer awareness of the state subsidies and health insurance mandate and penalty. In addition, in the latter half-of fiscal year 2019-20, Covered California recognized several unanticipated COVID-19-related expenses. These one-time expenses totaled $14.7 million.

Unanticipated COVID-19 expenses were primarily associated with additional marketing activities and service center efforts. In addition, Covered California also incurred expenses for cleaning office sites, and to transition its workforce into a telework

[27] Non-operating income represent interest income earned on short-term investment held in the state of California Surplus Money Investment Fund (SMIF).

environment. This resulted in moving expenses and the purchase of specific computer equipment to enable employees to work from home. If Covered California had not incurred these unanticipated COVID-19-related expenses, total operating expenses would have been $364.4 million, which would be $14.7 million less than the board-approved budget of $379.1 million.

In addition to these one-time COVID-19 related expenses, Covered California also incurred expenses related to the COVID-19 national emergency that resulted in losing productive work hours or a redirection of resources away from generally performed functions to COVID-19-related tasks. These expenses are estimated to total $9.6 million.

Personnel expenditures are forecasted to exceed budgeted expenditures by $8.4 million. Personnel expenses were higher than the amount budgeted. Expenditures associated with contracts greater than $1 million are expected to be less than budgeted by $6.1 million, while other equipment and expenses are forecasted to recognize a favorable budget variance of $2.3 million (Table 8).

Table 8
Statement of Revenue, Expenses and Changes in Fund Net Position and Enrollment
FY 2019-20 Actional/Forecasted and Variance
Budgetary-Legal Basis
(Dollars in Millions)

	FY 2019-20 Approved Budget	FY 2019-20 Actual/Forecasted	Difference
Average Monthly Enrollment	1,458,936	1,389,107	$ (69,829)
Per-Member-Per-Month FFS- Medical	$ 21.16	$ 20.96	$ (0.20)
Plan Individual - Medical - Total Member Mo.	17,507,232	16,669,289	$ (837,943)
Plan Individual - Dental - Total Member Mo.	2,422,177	2,499,445	$ 77,268
Plan CCSB - Medical & Dental - Total Member Mo.	691,639	747,512	$ 55,873
Operating Revenues			
Plan Assessments Individual - Medical	$370.4	$349.4	($21.0)
Plan Assessments Individual - Dental	$2.1	$2.0	($0.1)
Plan Assessments CCSB - Medical & Dental	$17.4	$17.8	$0.5
Total Operating Revenues	$389.9	$369.2	($20.6)
Other Income			
SMIF Interest	$0.0	$6.9	$6.9
Total Revenues/Income-All Sources	$389.9	$376.2	($13.7)
Operating Expenses			
Personnel Services	$121.2	$129.6	($8.4)
Contracts >$1M	$183.1	$177.0	$6.1
Other OE&E	$74.8	$72.5	$2.3
Total Operating Expenses	$379.1	$379.1	$0.1
Overall Increase/(Decrease) In Net Position	$10.7	($2.9)	($13.8)

A-III. Covered California's Enrollment and Revenue Forecast

Covered California's FY 2020-21 enrollment and revenue forecasts follow a 12-month period filled with significant and transformative events. These include the implementation of legislative initiatives designed to support marketplace enrollment and expand coverage in California, as well as the onset of a severe economic downturn resulting from emergency measures designed to halt the spread of the COVID-19 pandemic.

The implementation of a state individual mandate and penalty, together with new state subsidies and longer open- and special-enrollment periods and more-aggressive marketing and outreach efforts, increased the number of Californians obtaining health care coverage from Covered California-based health insurance companies. This is consistent with health care marketplace enrollment experience nationally, where better marketing and outreach and longer sign-up periods are associated with higher state plan selection rates[28] The expectation that these initiatives would bring younger and healthier individuals into plan risk pools, combined with Covered California's efforts to increase the number of competing carriers in its geographic service areas, moderated premium rate increases for 2020. This held premium growth to less than 1 percent over 2019. New plan selections were strong in early 2020 resulting in a substantial increase in effectuated enrollments compared to the year previous.

In mid-March 2020, reacting to the risk posed by the spreading COVID-19 pandemic, state and local leaders throughout California, and the nation, imposed social distancing restrictions that resulted in the immediate shuttering or scaling back of many businesses. Over a period of weeks, terminated and furloughed workers began filing initial unemployment claims in numbers that greatly exceeded initial unemployment claims made in any week during the Great Recession of 2007-09. A byproduct of this sharp unprecedented rise in unemployment will be the loss or disruption of health care coverage for millions of impacted workers and families. To assist them in maintaining their health care coverage, Covered California established a new broad special open-enrollment period, from March 20 through June 2020, and substantially expanded its outreach and customer support efforts.

Covered California's Enrollment Forecast

The enrollment forecast model developed by Covered California incorporates analysis of the California labor market over time and forecasts the slowdown in the economy and the loss of jobs, reduced hours and possible furloughs. Using the labor market analysis, Covered California evaluated in-flows into Covered California and out-flows from Covered California throughout the economic slowdown period modeled. The model factors in the likely extent to which, as individuals lose jobs, experience reduced work

[28] "ACA Marketplace Open Enrollment Numbers Reveal the Impact of State-Level Policy and Operational Choices on Performance," Rachel Schwab and Sabrina Corlette, The Commonwealth Fund, April 16, 2019. https://www.commonwealthfund.org/blog/2019/aca-marketplace-open-enrollment-numbers-reveal-impact.

hours, or are furloughed, those with employer-sponsored insurance (ESI) would lose that coverage.

In addition to the in-flows resulting from the loss of ESI, Covered California also evaluated individuals in the direct-purchase insurance (DPI) market. Within this group, both in-flows and out-flows will occur when an individual's or family's income declines due to the economic slowdown. Like those with ESI, these individuals will lose jobs throughout the economic slowdown. Some individuals who are currently enrolled in Covered California may exit due to income reductions that place them below the Medi-Cal income eligibility threshold. For others, the income loss may transition them into a lower federal poverty level (FPL) and more favorable credits. Finally, some may enroll into Covered California who are currently participating in the DPI market outside of the exchange, as their income loss drives them to seek coverage that is less costly.

Covered California modeled and evaluated these populations and developed scenarios that combine labor market analysis with Current Population Survey – Annual Social and Economic Supplement (CPS-ASEC) data to construct Covered California enrollment scenarios.

Incorporating the Impact of the Pandemic and Subsequent Economic Suppression

The model incorporated an analysis of the California labor market over time and forecasted the slowdown in the economy and the loss of jobs and reduced hours. The forecasts reflect modeling of three potential slow-downs:

- **V-Shaped Recovery:** The first scenario we modeled assumed a shorter "V-shaped" economic scenario, featuring a sharp decline in employment followed by a stronger, faster recovery. Under this scenario, unemployment rises to 22 percent during the second and third quarter of 2020 and then drops to 10 percent to 11 percent over the next six months, where it remains throughout 2021.
- **W-Shaped Recovery:** The second scenario we modeled assumed a more pessimistic L- or W-shaped recovery featuring a sharp economic decline, followed by a weaker partial recovery and then another decline with high and only gradually declining unemployment.
- **Economic Consensus:** The third scenario consolidated forecasts from major economic forecasting groups to develop labor market assumptions through 2022[29]. This scenario forecasts an economic decline and recovery more visually resembling a Nike Swoosh, with a very sharp decline featuring unemployment rates in the 22- to 23 percent range in the second quarter of 2020, followed by steadily falling unemployment during 2021, dropping to the 10 percent-11 percent range by the end of 2021.

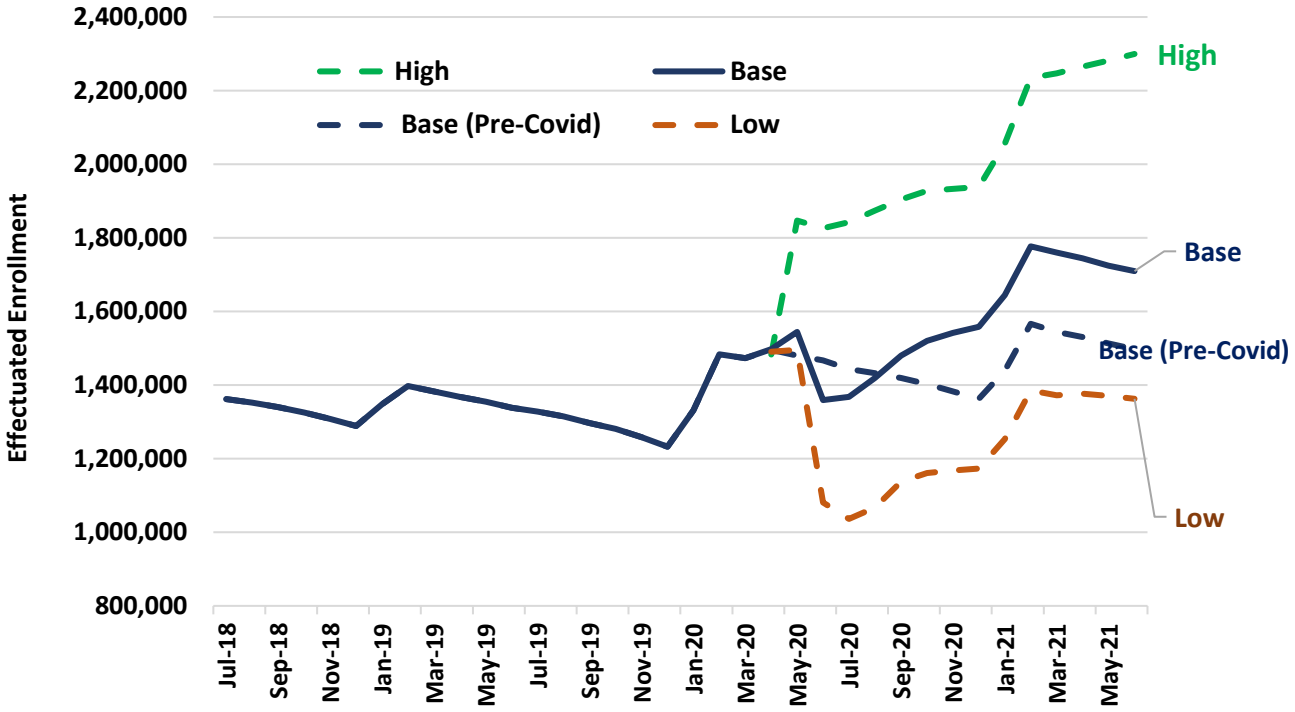
Enrollment Forecasts

To capture the full spectrum of possible enrollment outcomes, the forecasts includes an upper-bound estimate, baseline estimate and a lower-bound estimate. The upper- and

[29] These included the economic forecasting branches of the Congressional Budget Office, the International Monetary Fund, the Federal Reserve, Goldman Sachs, Morgan Stanley and Deloitte Consulting.

lower-bound estimates reflect the labor force impacts of a deeper recession, higher unemployment, and weaker, longer recovery. The more pessimistic set of employment assumptions utilized in this model generated a wider range of enrollment gains and losses than alternate model based on a shorter and stronger recovery. Given the uncertainty around COVID-19 and the development of a vaccine or effective treatments, we feel a number of outcomes are possible. Therefore, the wide range presented highlights the great uncertainty surrounding the future.

Figure 11
Trend in Enrollment with Forecasted Levels at the High; Base and Low Estimate; FY 2018-19 through FY 2020-21



The **base** enrollment forecast was derived by modeling changes in the labor force and sources of health care coverage based on our survey of unemployment projections through 2023 issued by major economic forecasting groups (the economic consensus forecast modeled and described above).

At the base estimate, average monthly enrollment in FY 2020-21 is forecasted to be 1,603,850, which would be 15.5 percent greater than the 1,389,107 forecasted for FY 2019-20 and represents an increase in average monthly enrollment of 214,742. The introduction of California's state mandate and penalty, combined with Covered California's extended open- and special-enrollment periods, boosted new-enrollee plan selections and effectuated enrollment in early 2020. Effectuated enrollments were roughly 95,000 members higher in February and March 2020 compared to the same months in 2019. This means that the beginning level of enrollment for FY 2020-21 will be at a substantially higher level compared to the start of FY 2019-20.

At the **high** estimate, average monthly enrollment in FY 2020-21 would be 2,066,992. The high-estimate model assumes that 69 percent of individuals losing employer-sponsored insurance and having incomes too high to qualify for Medi-Cal will enroll in Covered California health plans. It also assumes roughly a 15 percent net outflow from Covered California of individuals with direct-purchase insurance who lose jobs or income but remain above the Medi-Cal income threshold.

At the **low** estimate, average monthly enrollment in FY 2020-21 would fall to 1,238,530. The low-estimate model assumes that 25 percent of individuals losing employer-sponsored insurance and having incomes too high to qualify for Medi-Cal will enroll in Covered California health plans. It also assumes a 65 percent net outflow from Covered California of individuals with DPI who lose jobs or income but remain above the Medi-Cal income threshold.

Under all three forecasts, Covered California may experience changes in its enrolled population, as new, recession-affected individuals and households losing employer-based insurance enroll in Covered California plans, and existing enrollees losing jobs and income may qualify for Medi-Cal and leave of Covered California plans. This process may change the risk profile of the enrolled population as older individuals who are likely to have more income and greater medical needs will be more motivated to enroll, while younger, healthier enrollees with less income may transition to Medi-Cal.

As the economy begins to stabilize and gradually return to normal, new enrollments and enrollment terminations should return to their pre-pandemic levels. Most economic projections currently predict that following 2020's economic shock, levels of employment will steadily recover from 2021 to 2023. This is reflected in Covered California's enrollment projections.

Supported by California's mandate and penalty, as well as its subsidy program which is funded through 2022, the base forecast projects average monthly enrollment rising from 1,603,850 in FY 2020-21 to 1,667,342 in FY 2021-22 and falling slightly to 1,663,587 in FY 2022-23, as the economy recovers. The base enrollment projection reflects the board's approving the recommended reduction of the assessment on health plan premiums from 3.5 percent to 3.25 percent of premium for 2021, and forecasts a further reduction to 3 percent in 2022.

The state subsidy program has been funded by the Legislature through calendar year 2022. The non-renewal of the program in 2023 could have a somewhat negative impact on enrollment. As additional information becomes available, we will update our forecast for the potential impact of the elimination of the state mandate and subsidy programs.

In particular, the first in the nation expansion of subsidies for individuals earning more than 400 percent of the federal poverty level were intended to be a national model and signal for Congress to undertake needed expansion of the Affordable Care Act subsidies.

Covered California's Forecast Premium Projections

The two major drivers of increases or decreases in the premiums paid by Covered California enrollees are: (1) the annual changes in the prices of hospital and medical services, pharmaceutical agents, medical supplies and equipment; and (2) the risk mix

of the population covered. Premiums reflect variables, such as changes in the average age of enrolled beneficiaries, geographic differences in the price of medical services and competition among carriers. The average premium paid overall may decrease if substantial numbers of enrollees select new plans in a less expensive metal tier, or select a less expensive plan in the same metal tier offered by a different carrier.

In 2020, Covered California plan enrollees benefited from extremely modest increases in health plan premiums. Health insurance companies anticipated that the establishment of a new state health insurance mandate and tax penalty, combined with the introduction of the new state subsidy, would increase the proportion of younger, healthier enrollees in their risk pools, driving down the average medical spending per enrollee. Covered California's efforts to increase the number of carriers in its geographic service areas increased competition and consumer choice, which also had a moderating effect on increases in premiums.

Calendar year 2021 offers a somewhat different set of circumstances for considering changes to premiums. The demographic composition of Covered California plan enrollees is now subject to change as higher levels of unemployment mean potentially large numbers of Californians who previously had employer coverage seek Medi-Cal or coverage through Covered California. Covered California health plans will likely receive many new enrollees seeking subsidized replacement coverage for the employer-sponsored insurance that they lost due to layoffs or reduced work hours, while other individuals currently enrolled in Covered California and losing jobs and income may transition into Medi-Cal. Still others may transition into Covered California from the individual market as they seek federal and state credits through the exchange.

Estimates of changes in health insurance premiums developed before the COVID-19 outbreak serve as a baseline. Expectations of additional costs associated with the COVID-19 pandemic may result in insurers raising premiums in anticipation of higher medical costs, although the extent of these increases is unknown. Uncertainty over the eventual number of individuals becoming ill with the COVID-19 virus and requiring expensive treatment, the deferral of non-COVID health care services, as well as the length of the pandemic, has created challenges for health insurers as they attempt to determine the underlying costs that they will use to develop rates for 2021.

Other elements of uncertainty that insurers must evaluate include the costs of testing, as well as the cost of any vaccine developed to combat the virus, which may become available in late 2020 or 2021. Both have the potential to boost spending.

Insurers generally expect greater levels of medical spending in 2020 and 2021, although there is also a wide variation in estimates of the full magnitude of that spending as the length and severity of the outbreak is currently unknown. To the extent health insurance companies price the cost of uncertainty into their premiums for 2021, rates could be higher than they would be in a "normal" year. The potential that there will be a margin for uncertainty added to the pre-COVID-19 forecasted base also will consider the extent to which health insurance companies believe it is necessary to plan for a rebound in non-COVID-19 related health expenditures. In recent years, premium growth based on average annual health care price increases has been between 5.5 percent and 6 percent. Covered California will not complete its negotiations of rates for

2021 with health insurance companies until July 2020, after the budget is adopted. For forecasting purposes, the budgets were developed based on adding a margin for uncertainty of zero at the lower bound (6 percent premium growth), 2 percent at the base, or the midpoint estimate (8 percent premium growth), and 4 percent for the high estimate (10 percent premium growth).

As the pandemic and the uncertainty created by it eventually subside, and demand for medical services returns to pre-outbreak baseline levels, we would expect Covered California plans to reduce their premiums to a level near the overall growth in the cost of medical services. Covered California will continue its efforts to maintain balanced risk pools, foster competition, and enhance consumer choice in order to keep premiums as low as possible.

Table 9:
Projected Premium Growth Rates

Scenario	Plan Year 2020	Plan Year 2021	Plan Year 2022	Plan Year 2023
	Actual	Projected	Projected	Projected
High	.08 percent	8.0 percent	7.0 percent	6.0 percent
Base	.08 percent	8.0 percent	7.0 percent	6.0 percent
Low	.08 percent	8.0 percent	7.0 percent	6.0 percent

Table 10:
Individual Market Enrollment and Revenue Forecasts
Effectuated Enrollment
(Average Monthly Enrollment)

Scenario	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
High	1,389,107	2,066,992	1,958,545	1,882,868
Base	1,389,107	1,603,850	1,677,342	1,663,587
Low	1,389,107	1,238,530	1,394,127	1,450,247

Table 11
Plan Assessments
(Dollars in Millions)

Scenario	FY 2019-20*	FY 2020-21**	FY 2021-22**	FY 2022-23
High	$349,393,355	$480,957,856	$482,943,275	$475,366,113
Base	$349,393,355	$397,295,839	$420,613,952	$425,474,831
Low	$349,393,355	$297,458,989	$329,982,650	$350,098,121

* Actual
** Assessment fee lowered from 3.5 percent to 3.25 percent on Jan. 1, 2021.
***Assessment fee lowered from 3.25 percent to 3.0 percent on Jan. 1, 2022.

Covered California for Small Business Forecast

Covered California for Small Business is California's version of the Small Business Health Options Program (SHOP) established under the Affordable Care Act. It is a small-group health insurance program for employers with 100 or fewer employees who want to provide health or dental insurance, or both, to their employees.

Under the Affordable Care Act, the same essential set of regulations[30] applied to the individual market are also applied to the small-group market. These include: open enrollment, no exclusion of preexisting conditions, modified community rating (meaning that insurers cannot vary rates based on health status), a standard set of "essential health benefits," and a limit on the percentage of premium that insurers can devote to profits or overhead, known as a minimum "medical loss ratio".

Covered California for Small Business is one of several sources of health insurance within California's small-group market, which is defined as insurance purchased by businesses with 100 or fewer full-time equivalent employees. California's small-group market is estimated to provide coverage for over 2.3 million covered lives. In 2018, Covered California for Small Business provided insurance for roughly 3 percent of the small-group market.

Covered California for Small Business offers plans from six health insurance companies that are available to small employers for year-round enrollment. Employers can select from four levels of coverage — Bronze, Silver, Gold and Platinum — allowing them to tailor health insurance to their employees' specific needs. Employers may purchase health insurance with the help of a registered agent or broker. Smaller employers, those with 25 or fewer employees, may qualify for a Small Business Health Care Tax Credit to lower premium costs.

Beginning in 2017, the assessment rate for Covered California for Small Business plans was 5.2 percent of the gross premiums. This rate will continue for plan year 2021.

Since its inception in 2014, Covered California for Small Business has experienced steady growth in its number of participating employer groups and covered lives. Poised to continue gaining groups and members, Covered California for Small Business has recently encountered very strong headwinds as result of the COVID-19-induced recession.

The social distancing restrictions implemented in March by many state and local governments have affected many small businesses, resulting in their temporary closure or scaling back of operations. Businesses that required workers or customers to be in close physical proximity were the most heavily affected. Other businesses whose employees can work at home, or safely separated from customers or coworkers, have been less affected.

In 2020, Covered California's early forecasts expected that the upward trend in Covered California for Small Business enrollment would continue, as result of Covered California's ongoing efforts to improve and expand the selection of plans and coverage

[30] "The Rules for California Small Business Health Insurance," BenefitsCafe.com, March 2020. https://www.benefitscafe.com/Rules-for-California-Small-Business-Health-Insurance.pdf.

options for small employers. Those projections have recently been revised to incorporate the potential impact of the COVID-19 recession. Historically, small businesses have been more negatively affected by recession than larger enterprises. During the Great Recession of 2007-09, small businesses (defined as businesses with 250 employees or fewer) experienced disproportionate job loss compared to their share of total employment in the economy. Nationally, small businesses accounted for 45 percent of employment, but as the economy shed about 5 million jobs from 2008 to 2009, they accounted for 62 percent of the net job loss. Compared to the Great Recession, the early stages of the COVID-19 economic crisis suggest that job losses will fall even more disproportionately within the small business sector[31]. Job losses during the current recession are likely to exceed those of the previous recession[32], which unlike the present situation, did not feature social distancing restrictions.

Covered California is acting to assist Covered California for Small Business employer groups experiencing reduced business activity due to social distancing restrictions. Covered California for Small Business will allow small businesses an additional 30-day grace period to make their premium payments for the months of April and May 2020. Actions by the federal government and the Small Business Administration to extend eight weeks of cash-flow assistance through 100 percent federally guaranteed loans under the Paycheck Protection Program (PPP) may also help reduce the loss of small business jobs and health care coverage.

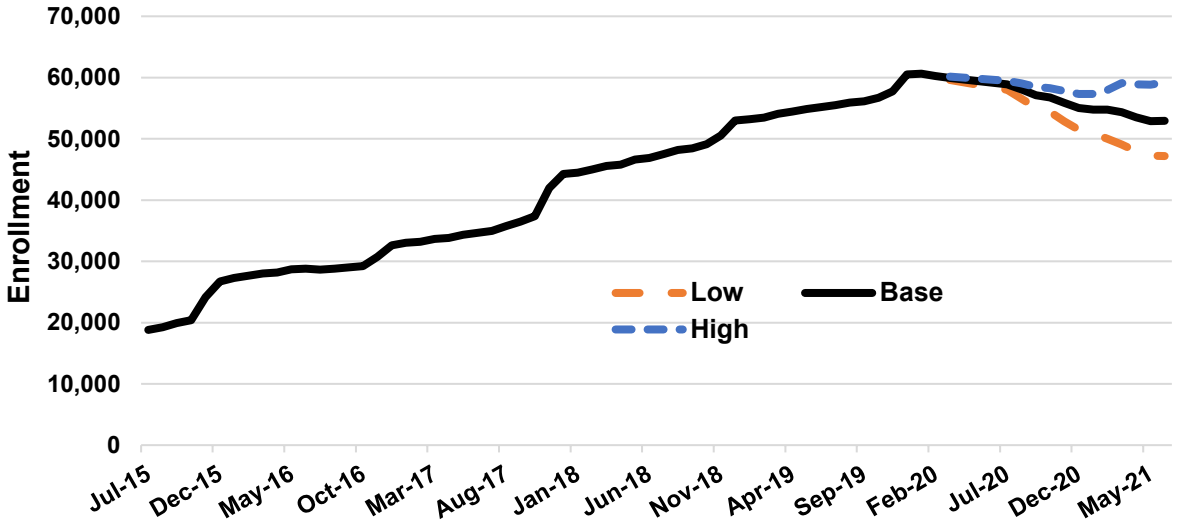
Enrollment and Revenue Forecast

The FY 2020-21 enrollment and revenue forecast for Covered California for Small Business (Covered California for Small Business) utilizes a conservative set of assumptions. The base and low estimates anticipate a decrease in both new enrollments and the retention rate for existing members. The high estimates assume only a small dip in enrollment through 2020 with a recovery to 2019 enrollment levels in 2021. All three scenarios assume increases in average premiums, including growth in medical costs of 8 percent in 2021, 7 percent in 2022, and 6 percent in 2023.

[31] "What the Great Recession can tell us about the COVID-19 small business crisis," March 25, 2020, The Brookings Institute. https://www.brookings.edu/blog/the-avenue/2020/03/25/what-the-great-recession-can-tell-us-about-the-COVID-19-small-business-crisis/.

[32] "An Analysis of Unemployment Insurance Claims in California During the COVID-19 Pandemic," California Policy Lab, April 2020. https://www.capolicylab.org/wp-content/uploads/2020/05/An-Analysis-of-Unemployment-Insurance-Claims-in-California-during-the-COVID-19-Pandemic.pdf?mod=article_inline.

Figure 12
Covered California for Small Business Enrollment FY 2015-16 to FY 2020-21



The **base** estimate scenario expects that Covered California for Small Business Covered California for Small Business plans will experience a decrease in new members and a decrease in the retention rate due to the impact of the COVID-19 recession. Under the base forecast, average monthly enrollment drops from 57,956 to 54,315, a 6.3 percent decrease compared to FY 2019-20, while revenue decreases by 0.7 percent compared FY 2019-20. The smaller decrease in revenue reflects an expected 8 percent increase in premiums in 2021.

The **high** scenario assumes a shorter, milder recession and faster V-shaped economic recovery. It forecasts a .06 percent increase in average monthly enrollment and a 6.2 percent increase in revenue compared FY 2019-20. Under this scenario, there is a slight decrease in new sales and the retention rate in plan year 2020, while in plan year 2021 new sales and the retention rate return to 2019 levels.

The **low**, or pessimistic enrollment alternative, assumes a longer, deeper recession and a weaker, more protracted recovery. Under the low scenario, average monthly enrollment falls by 12,645, a 22 percent decrease, and revenue declines by $1.4 million, or -7.7 percent.

Table 12:
Covered California for Small Business Enrollment and Revenue Forecasts
Effectuated Enrollment
(Fiscal Year End)

Scenario	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
High	62,293	59,121	63,377	68,907
Base	62,293	51,578	50,827	54,166
Low	62,293	45,414	43,112	45,263

Medical and Dental Plan Assessments

Scenario	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
High	$ 17,831,553	$ 18,812,600	$ 20,734,392	$ 23,329,150
Base	$ 17,831,553	$ 17,594,281	$ 17,405,449	$ 18,909,915
Low	$ 17,831,553	$ 16,345,457	$ 15,408,342	$ 16,527,415

Covered California's Individual Dental Plans for Children and Families

Covered California offers individual dental plans for children and families. Children's dental benefits are automatically included in the health plans offered through Covered California. For children who are insured by both a health plan and a family dental plan, the two plans will coordinate benefits. Dental coverage for adults is not an essential health benefit, so dental coverage for adults is offered separately from health insurance plans.

Covered California offers two types of dental plans: HMO (health maintenance organization) plans and PPO (preferred provider organization) plans. Participating dental carriers are Access Dental Plan, Anthem Blue Cross, California Dental Network, Delta Dental of California, Dental Health Services, Liberty Dental Plan and Premier Access.

The Covered California assessment fee for individual dental plans is the same as for individual medical plans, which is currently 3.5 percent and will be reduced to 3.25 percent in January 2021.

Enrollment and Revenue Forecasts

As with Covered California for Small Business, the enrollment forecast for individual dental plans employs a conservative set of assumptions reflecting uncertainty about the economy and its impact on levels of enrollment. Enrollment in Covered California individual dental plans is forecasted to average 189,941 members monthly in FY 2019-20 and fall by 1.2 percent to 187,602. From this level, enrollment is forecasted to grow by 5 percent in FY 2021-22, and 10 percent in FY 2022-23, rising in tandem with a recovering economy.

Assessment fee revenue from individual dental plans in FY 2020-21 is forecast to total $1.932 million, representing 0.4 percent of total Covered California revenue. Dental plan revenue will decline slightly in FY 2020-21, and rise again in FY 2021-22 and FY 2022-23.

Table 13
Individual Dental Plan Enrollment and Revenue Forecasts
Effectuated Enrollment

Scenario	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Base	**208,287**	**187,602**	**196,982**	**216,680**

Individual Dental Plan Assessments

Scenario	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Base	$ 2,023,257	$1,932,771	$ 2,029,410	$ 2,232,351

Table 14:
Assessment Fee Revenue

Market	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
On-Exchange Individual Market	$349,393,355	$397,295,839	$420,613,952	$425,474,831
Individual - Dental	$2,023,267	$1,932,771	$2,029,410	$2,232,351
Covered California for Small Business	$17,831,553	$17,594,281	$17,405,449	$18,909,915
Total Assessment Fee Revenue	$369,248,176	$416,822,891	$440,048,811	$446,617,097

A-IV. Covered California's Multi-Year Projection: FY 2019-20 to FY 2022-23

Covered California's multi-year financial plan projects revenue and expenditures for three years into the future, spanning from FY 2019-20 to FY 2022-23. The multi-year financial plan allows executives, the board and other stakeholders to see the implications of decisions made over time and consider a longer time horizon.

This multi-year financial projection helps policy makers evaluate expenditure commitments, enrollment trends and revenue trends. The multi-year financial plan also highlights anticipated fiscal risks and opportunities. The projection is used to identify major known fiscal conditions and project future conditions. Finally, the multi-year projection is a strategic planning tool for fiscal sustainability.

The multi-year financial projection is not a budget and does not include any proposed balancing solutions or modified service levels. Rather, it is a planning tool to for discovering opportunities and challenges over a longer time horizon.

Base Financial Projection Detail

The base estimate incorporates the impact of net increases in enrollment due to the slowing economy and recession triggered by COVID-19. Additionally, it reflects estimates of increases in the average premiums, including the growth in medical costs of 8 percent in 2021, 7 percent in 2022, and 6 percent in 2023. Authorized positions are assumed to remain at the FY 2020-21 proposed budget total of 1,419 throughout the projection span.

The base enrollment projection reflects board adoption of the proposal to reduce the assessment on individual market premiums to 3.25 percent for 2021, with the projections reflecting a further reduction to 3 percent in 2022. Covered California for Small Business plan assessments are assumed to remain at a level of 5.2 percent of premium for the duration of the forecast. The base projection reflects a $440.2 million proposed operating budget in FY 2020-21, including significant increases in incremental expenses related to the responding to the COVID-19 recession. Operating expenses for FY 2021-22 and FY 2022-23 would decline as spending to meet Californians' needs during the recession are pulled back. Operating expenses are forecast to be $428.9 million in FY 2021-22 and $430.5 million in FY 2022-23 (Table 15).

Under the base projection, individual medical plan average monthly enrollment is forecast to be 1,603,850 in FY 2020-21, 1,677,342 in FY 2021-22, and 1,663,587 in FY 2022-23.

Revenues and other incomes are projected to be lower than operating expenditures in FY 2020-21. This is primarily driven by the COVID-19 pandemic and Covered California's investment in marketing, consumer support and outreach during this unprecedent time. In FY 2020-21, Covered California is projected to generate $417.7 million in revenue/other income and $440.2 million in operating expenses. It will experience an overall decrease in net position of $22.5 million.

In FY 2021-22, revenues/other income are projected to rise to $440.9 million, while operating expenses fall to $428.9 million, reflecting the scaling back of COVID-19-

related activities. While operating expenses decline due to the reduction in COVID-19 expenses, they do reflect natural baseline growth associated with general inflation. In FY 2021-22 Covered California is projected to experience an overall increase in net position of $11.9 million. Authorized positions are assumed to remain at the FY 2020-21 proposed budget level of 1,419.

In FY 2022-23, revenues/other income are projected to rise to $448.7 million, while operating expenses are projected to increase modestly to $430.5 million, producing an overall increase in net position of $18.2 million. The modest increase in operating expenses is associated with general inflation and increases in personnel expenses. Authorized positions are assumed to remain at the FY 2020-21 proposed budget level of 1,419.

Covered California is projected to end FY 2022-23 with a cash reserve totaling $351.8 million, which would fund approximately nine months of annual budgeted operations, while Covered California's capital projects cash balance is projected to total $60.7 million (Table 16).

Table 15: Base
Covered California
Condensed Statement of Revenue, Expense, and Change in Net Position
Enrollment Estimate: for FY 2019-20, FY 2020-21, FY 2021-22, and FY 2022-23
(Dollars in Millions)

	FY 2019-20 Actual/Forecasted	FY 2020-21 Proposed Budget	FY 2021-22 Projected	FY 2022-23 Projected
Authorized Positions	1,391	1,419	1,419	1,419
Average Monthly Enrollment-Individual	1,389,107	1,603,850	1,677,342	1,663,587
Per-Member-Per-Month Individual Medical	$ 20.96	$ 20.64	$ 20.90	$ 21.31
Plan Individual - Medical	16,669,289	19,246,198	20,128,104	19,963,046
Plan Individual - Dental	2,499,445	2,251,221	2,363,782	2,600,160
Plan CCSB - Medical & Dental	747,512	651,776	605,423	629,339
Operating Revenues	$ 369.2	$ 416.8	$ 440.0	$ 446.6
Other Income - SMIF Interest	$ 6.9	$ 0.9	$ 0.8	$ 2.1
Total Revenues/Income - All Sources	$ 376.2	$ 417.7	$ 440.9	$ 448.7
Less: Operating Expenses	$ (379.1)	$ (440.2)	$ (428.9)	$ (430.5)
Overall Increase/(Decrease) In Net Position	$ (2.9)	$ (22.5)	$ 11.9	$ 18.2
Cash Reserve	$ 404.2	$ 361.7	$ 353.6	$ 351.8
Months of Budgeted Operations Funded	11	10	10	9

Note: Cash Reserve balance does not include dollars held in the Capital Projects fund. See Section VI. Covered California's FY 2020-21 Proposed Capital Projects Budget.

Table 16: Base
Covered California Cash Budget and Cash Reserve Balance

At June 30
(Dollars in Millions)

	FY 2019-20 Actual/Forecasted	FY 2020-21 Proposed Budget	FY 2021-22 Projected	FY 2022-23 Projected
Cash At Beginning of Year	$ 467.1	$ 450.9	$ 408.4	$ 407.3
Add Cash In-flows	$ 376.2	$ 417.7	$ 440.9	$ 448.7
Less: Cash Out-Flows	$ (392.4)	$ (460.2)	$ (441.9)	$ (443.5)
Cash at End of Year	$ 450.9	$ 408.4	$ 407.3	$ 412.5
Less: Cash For Capital Projects	$ (46.7)	$ (46.7)	$ (53.7)	$ (60.7)
Cash Reserve	$ 404.2	$ 361.7	$ 353.6	$ 351.8
Months of Budgeted Operations Funded	11	10	10	9

Low Financial Projection Detail

The low-enrollment projection reflects the uncertainty associated with the COVID-19 pandemic and the depth of the recession and recovery. The low enrollment scenario could result from federal policy decisions that direct more of those losing employer-sponsored insurance toward forms of coverage other than Covered California, such as fully subsidized COBRA, Medicare or Medicaid. In addition, individuals may be more likely to enroll into Medi-Cal instead of Covered California due to incongruent income determinations. The low-enrollment scenario assumes that average monthly enrollment falls to 1,238,530 in FY 2020-21.

This scenario includes increases in average premiums, including growth in medical costs of 8 percent in 2021, 7 percent in 2022, and 6 percent in 2023. The plan assessment rate reflects the approved reduction to 3.25 percent in 2021, with possible reductions to 3.0 percent 2022 and 2023. Authorized positions are assumed to remain at the FY 2020-21 proposed budget total of 1,419 throughout the projection span.

In the low financial projection scenario, the multi-year projection estimates total revenues/other income of $316.5 million in FY 2020-21, $347.9 million in FY 2021-22, and $369.8 million in FY 2022-23 (Table 17).

Over the four-year multi-year projection horizon under the low bound enrollment scenario —if there were no changes to its revenue or expenditures -—Covered California’s cash reserve is projected to drop from $404.2.3 million to $78.9 million. At $78.9 million, Covered California would be able to fund roughly two months of budgeted annual operations (Table 18).

The low scenario presents challenges, and Covered California would make deliberate actions to address these challenges before recognizing such significant impacts on its reserves. First, Covered California monitors enrollment trends throughout the entire fiscal year. Using a rolling forecast, it projects revenue trends as the enrollment data becomes available. This provides feedback that can be used to make course corrections. If enrollment levels are projected to fall below base levels, Covered California would take actions to reduce operating expenses or modifying revenues, or both, by increasing the assessments on health plan premiums.

Table 17: Low

Covered California
Condensed Statement of Revenue, Expense, and Change in Net Position
Enrollment Estimate: FY 2019-20, FY 2020-21, FY 2021-22, and FY 2022-23
(Dollars in Millions)

	FY 2019-20 Actual/Forecasted	FY 2020-21 Proposed Budget	FY 2021-22 Projected	FY 2022-23 Projected
	1,391	1,419	1,419	1,419
Average Monthly Enrollment-Individual	1,389,107	1,238,530	1,394,128	1,450,247
Per-Member-Per-Month Individual Medical	$ 20.96	$ 20.01	$ 19.72	$ 20.12
Plan Individual - Medical	16,669,289	14,862,359	16,729,530	17,402,959
Plan Individual - Dental	2,499,445	2,251,221	2,363,782	2,600,160
Plan CCSB - Medical & Dental	747,512	597,900	519,129	530,234
Operating Revenues	$ 369.2	$ 315.7	$ 347.4	$ 368.9
Other Income - SMIF Interest	$ 6.9	$ 0.8	$ 0.5	$ 0.9
Total Revenues/Income - All Sources	$ 376.2	$ 316.5	$ 347.9	$ 369.8
Less: Operating Expenses	$ (379.1)	$ (440.2)	$ (428.9)	$ (430.5)
Overall Increase/(Decrease) In Net Position	$ (2.9)	$ (123.7)	$ (81.0)	$ (60.7)
Cash Reserve	$ 404.2	$ 260.7	$ 159.7	$ 78.9
Months of Budgeted Operations Funded	11	7	4	2

Table 18: Low
Covered California Cash Budget and Cash Reserve Balance
At June 30
(Dollars in Millions)

	FY 2019-20 Actual/Forecasted	FY 2020-21 Proposed Budget	FY 2021-22 Projected	FY 2022-23 Projected
Cash At Beginning of Year	$ 467.1	$ 450.9	$ 307.4	$ 213.4
Add Cash In-flows	$ 376.2	$ 316.5	$ 347.9	$ 369.8
Less: Cash Out-Flows	$ (392.4)	$ (460.0)	$ (441.9)	$ (443.5)
Cash at End of Year	$ 450.9	$ 307.4	$ 213.4	$ 139.6
Less: Cash For Capital Projects	$ (46.7)	$ (46.7)	$ (53.7)	$ (60.7)
Cash Reserve	$ 404.2	$ 260.7	$ 159.7	$ 78.9
Months of Budgeted Operations Funded	11	7	4	2

High Financial Projection Detail

The high-enrollment scenario assumes that a greater percentage of those losing employer-sponsored insurance, as well as those insured with off-exchange plans, will seek more affordable options.

The high scenario includes increases in average premiums, including growth in medical costs of 8 percent in 2021, 7 percent in 2022, and 6 percent in 2023.

The plan assessment rate reflects the approved reduction to 3.25 percent, with the forecast reflecting an additional reduction to 3.0 percent in 2022. Authorized positions are assumed to remain at the FY 2020-21 proposed budget total of 1,419 throughout the projection span.

The high scenario projected enrollment gains above FY 2019-20 levels of 51 percent and an average monthly enrollment of 2,066,992 in FY 2020-21. Under the high enrollment and financial projection scenario, the multi-year projection estimates assessment revenues/other income of $502.6 million in FY 2020-21, $506.8 million in FY 2021-22, and $503.9 million in FY 2022-23 (Table 19).

Under the high scenario, Covered California is projected to recognize an increase in its overall net position for fiscal years 2020-21, 2021-22, and 2022-23 of $62.5 million, $77.8 million, and $73.4 million respectively. Covered California's cash reserves would fund 12 months of annual budgeted operations in FY 2020-21, 14 months in FY 2021-22, and 15 months in FY 2022-23 (Table 20).

Covered California's cash position would be greatly enhanced under the high scenario. If Covered California experienced enrollment levels reflected in the high scenario, it would assess its financial position and make decisions likely to affect both its revenues and expenditures. Given the increased revenue, it could consider lowering its assessment fee on health care premium. It may also likely experience additional expenses associated with the large enrollment increases, which would lead to additional operating expenses.

Table 19: High
Covered California
Condensed Statement of Revenue, Expense, and Change in Net Position — High Enrollment Estimate: FY 2019-20, FY 2020-21, FY 2021-22, and FY 2022-23
(Dollars in Millions)

	FY 2019-20 Actual/Forecasted	FY 2020-21 Proposed Budget	FY 2021-22 Projected	FY 2022-23 Projected
Authorized Positions	1,391	1,419	1,419	1,419
Average Monthly Enrollment-Individual	1,389,107	2,066,992	1,958,545	1,882,868
Per-Member-Per-Month Individual Medical	$ 20.96	$ 19.39	$ 20.55	$ 21.04
Plan Individual - Medical	16,669,289	24,803,904	23,502,540	22,594,416
Plan Individual - Dental	2,499,445	2,251,221	2,363,782	2,600,160
Plan CCSB - Medical & Dental	747,512	701,333	734,676	794,785
Operating Revenues	$ 369.2	$ 501.7	$ 505.7	$ 500.9
Other Income - SMIF Interest	$ 6.9	$ 0.9	$ 1.1	$ 2.9
Total Revenues/Income - All Sources	$ 376.2	$ 502.6	$ 506.8	$ 503.9
Less: Operating Expenses	$ (379.1)	$ (440.2)	$ (428.9)	$ (430.5)
Overall Increase/(Decrease) In Net Position	$ (2.9)	$ 62.5	$ 77.8	$ 73.4
Cash Reserve	$ 404.2	$ 446.8	$ 504.6	$ 558.0
Months of Budgeted Operations Funded	11	12	14	15

Table 20: High
Covered California Cash Budget and Cash Reserve Balance
At June 30
(Dollars in Millions)

	FY 2019-20 Actual/Forecasted	FY 2020-21 Proposed Budget	FY 2021-22 Projected	FY 2022-23 Projected
Cash At Beginning of Year	$ 467.1	$ 450.9	$ 493.5	$ 558.3
Add Cash In-flows	$ 376.2	$ 502.6	$ 506.8	$ 503.9
Less: Cash Out-Flows	$ (392.4)	$ (460.0)	$ (441.9)	$ (443.5)
Cash at End of Year	$ 450.9	$ 493.5	$ 558.3	$ 618.7
Less: Cash For Capital Projects	$ (46.7)	$ (46.7)	$ (53.7)	$ (60.7)
Cash Reserve	$ 404.2	$ 446.8	$ 504.6	$ 558.0
Months of Budgeted Operations Funded	11	12	14	15

A-V. Covered California's Planning and Budget Process for FY 2020-21

Budget Guiding Principles

Covered California is required to prepare an annual report to the governor and the Legislature. This written report focuses on the implementation and performance of Covered California's functions during the preceding fiscal year.

The budget process is facilitated by the Financial Management division, working closely with the executive leadership and all program areas. Covered California's board-adopted guiding financial principles include:

- Developing a budget that directly supports growth and retention of membership.
- Establishing organizational priorities that enable Covered California to serve as an effective example of how marketplaces can improve the cost and quality of health care.
- Ensuring the assessment fee places the lowest possible burden on consumers' premiums, has a path for decreasing over time and reflects savings to health plans compared to prior acquisition costs.
- Continuing to build infrastructure that can reduce future costs, support talent, succession plans, business continuity and legal compliance.
- Continuing to review programs to identify opportunities for efficiencies.
- Maintaining a reserve that is sufficient to cover financial obligations and allow for time to adjust revenue and expenditures in the event of an unanticipated fiscal event.
- Remaining financially nimble to assure the ability to transition should significant changes occur.

Budget Objectives

Budgeting represents the tactical application of an organization's business plan. Achieving the goals outlined in a strategic plan requires a budget that finances the business plan and establishes measures and indicators of performance. This allows Covered California executives, program managers, the board, and those charged with directing to make course changes throughout the fiscal year to achieve desired goals.

Covered California's budget:

- Facilitates planning of actual operations: The budget process requires managers to consider how conditions and the steps they may need to make may change throughout the fiscal year.
- Coordinates Covered California's activities: The budgeting process encourages program managers to develop relationships with other parts of the organization. This facilitates understanding of interactions among programs and how they support Covered California overall.
- Facilitates communication of budget plans to managers: An important aspect to the budget process is communicating Covered California's goals, plans and initiatives. The budgeting process encourages communication of individual program goals, plans and initiatives. These individual program goals, plans and initiatives roll up into Covered California's overall goals, plans and initiatives.
- Serves as a control device: The budget allows program managers to compare actual expenses with budget expenses to evaluate financial performance.
- Provides a tool for evaluating performance: The budget allows for assessing performance toward specific goals, objectives and strategies.

Budget Framework

Covered California's budget framework is constructed by developing a master budget. The master budget consists of:

1. An operating budget.
2. A capital budget.
3. A cash budget.

Workload Budget

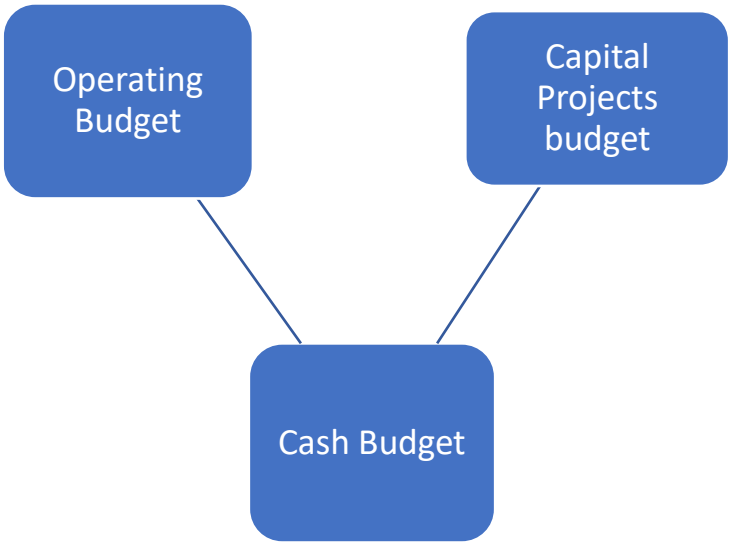
- *A workload budget reflects what a given program will cost next year under existing law and policy.*
- *A workload budget is defined as the budget year cost of currently authorized services, adjusted for changes in enrollment, caseload, or population, and other factors including inflation, one-time expenditures, federal and court-ordered mandates.*

Operating Budget: The operating budget presents Covered California's detailed plan of day-to-day operations. The operating budget presents revenues and expenses by major category. The operating budgeted is developed by starting with a workload budget and then adding budget concept statements (BCSs).

Capital Budget: The capital budget presents the fund sources and expenditures for capital assets. These capital assets may place major demands on Covered California's cash flows. The capital budget is designed to assess capital purchases, control risk, set priorities and facilitate planning of these major investments.

Cash Budget: The cash budget links the operating budget and capital budget together. The cash budget considers the timing of payments and the timing of receipt of cash from operating revenues. The cash budget allows management to assess Covered California's overall net position, cash reserves and capital condition (Figure 13).

Figure 13
Covered California's Budget Framework



Budget Process

Covered California's budget process involves broad and extensive planning that incorporates input from executives, board members, public stakeholders, and operational programs. The budget process commences with a thorough review of each program's current budget. Collaborating with each program, the Financial Management division's budget team reviews each budget line item and develops the **workload budget** for the upcoming budget year. The workload budget for the proposed FY 2020-21 represents anticipated expenditures for the FY 2020-21 budget year assuming no increases other than for inflation and natural growth. This represents a static budget, increased for inflation, continuing contract expenses, leases, or decreases for contract expirations, changes in contract priorities, anticipated wage increases and more.

In general, the **workload budget** takes the actual operating expenses for FY 2019-20 and expands it due to rising enrollment, caseload and population, as well as inflation and any new statutory requirements for a program. Also considered are changes in operations, such as reductions in the vacancy rate. It also reduces the budget for specific line items that may no longer apply to the budget period. For example, contracts may expire, and the associated funding is no longer needed.

In tandem with the establishment of the workload budget, Covered California executives, board members and various stakeholders work to establish priorities for the upcoming budget year. This process involves reevaluating Covered California's core principles, mission and pillars. It also entails assessing what was accomplished during the most recent fiscal year and evaluating the current environment.

> ***Budget Concept Statement (BCS)***
>
> *A budget concept statement is a formal document that is required when a Covered California program needs additional resources or a reduction in resources to change the level of service or funding for activities authorized by the Board or executive management, or to propose new program activities not currently authorized.*

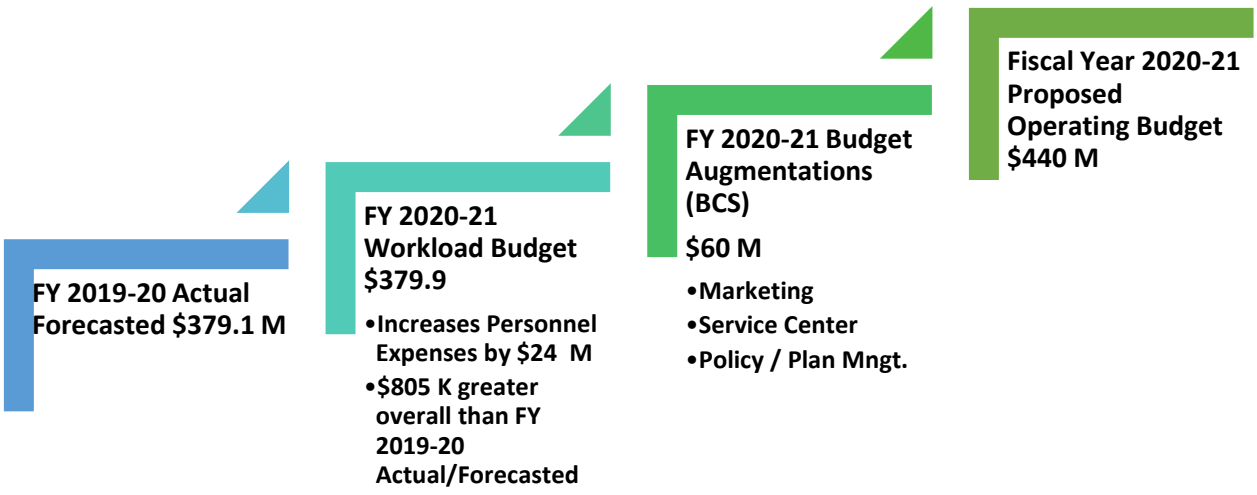
Some Covered California programs may make initial requests for resources, while some may remain static; resources may be adequate for what they intend to accomplish. Other programs may be implementing new policy initiatives, attempting to expand capacity to achieve specific goals, or working to close the gap between resources and workload.

Each program is required to submit a **budget concept statement** (BCS) that describes in detail their resource request. This may include a reduction in resources; however, this generally involves requesting new resources to meet changing workload as a result of budget priorities. The program must provide detailed analyses of workload, estimated contract costs and contract specifics such as the term of the contract. In addition, the program must justify the need for additional resources. In some cases, the justification may be due to a legislative mandate. In other cases, it may be the result of changing priorities and the establishment of a new initiative (e.g., state subsidies, mandate).

Each BCS is evaluated by Covered California's budget office. The submitted documentation is analyzed and monetized. Once all BCSs are summarized and estimated expenses are incorporated, prioritization begins. Because decisions must be made that are congruent with available Covered California financial resources, and Covered California's future financial condition is always considered in light of the current budget requests, much deliberation occurs. Each program justifies the need for the current budgetary resource request, and executive management makes the final decision. Some BCS requests may be modified, while others may be eliminated or delayed until next fiscal year.

Once final decisions have been made, the BCSs are combined with the workload budget to create the FY 2020-21 operating budget (Figure 14). This process is also followed for the capital projects budget.

Figure 14
Budget Process — Stages in Budget Development Process



FY 2020-21 Workload Budget

Covered California's **workload** budget for FY 2020-21 totals $379.9 million, an increase 0.2 percent, or $805,000 above actual operating expenses for FY 2019-20 actual/forecasted (Table 21). For this analysis, Covered California classified operating expenses into three major expense categories:

- Personnel expenses.
- Contracts greater than $1 million.
- Other operating expenses and equipment (OE&E).

The growth in operating expenses between the FY 2019-20 actual/forecasted and the FY 2020-21 workload budget was driven by the net effect of personnel expense increases and decreases in contracts greater than $1 million and other operating expenses and equipment (OE&E).

Personnel expenses grew by 18.7 percent between FY 2019-20 actual/forecasted and the FY 2020-21 workload budget, rising from $129.6 million to $153.8 million (Table 21). Roughly 60 percent of the increase was associated with staff benefits. This included a new commitment by the state to contribute to retiree health that equaled $260 per-employee-per-month and supplemental pension contributions. Salary and wages accounted for roughly 40 percent of the increase and was driven by merit raises, a 2.5 percent general salary increase, reduced salary savings, reclassification of positions

into higher salaried classifications, and retiree payouts. The decrease in "Contracts greater than $1 million" was primarily the result of a decrease in CalHEERS/OSI contract expenses, related to one-time expenses associated with implementing state subsidies. The "other OE&E" decrease in expenses was related to IT contracts that expired during FY 2019-20.

Table 21
Covered California
Analysis of Change in Operating Expenses
FY 2019-20 Actual vs. FY 2020-21 Workload Budget
(Dollars in Millions)

Expense Category	FY 2019-20 Actual/Forecasted	FY 2020-21 Workload Budget	Difference	% Change
Personnel	$129.6	$153.8	$24.2	18.7%
Contracts > $1 Million	$177.0	$169.8	($7.2)	-4.1%
Other OE&E	$72.5	$56.3	($16.2)	-22.3%
Total	$379.1	$379.9	$0.8	0.2%

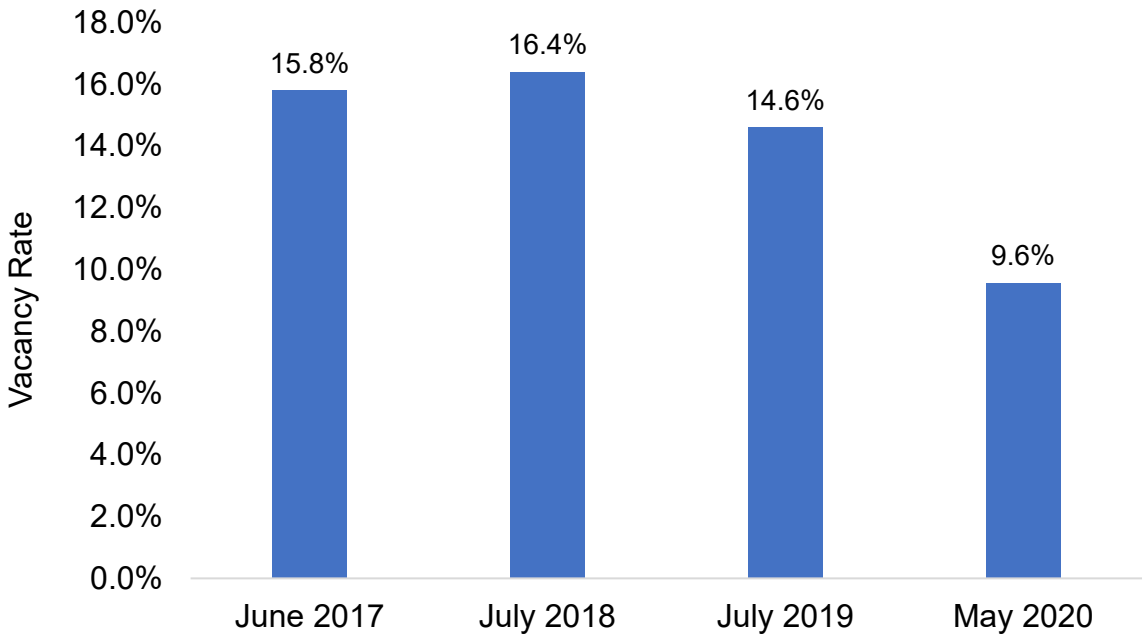
Personnel Expense Drivers

Vacancy Rate

Vacancies in authorized employee positions are a normal part of human resources management in both the public and private sectors. When employees move to other jobs or retire, it takes time to fill their positions, and when new positions are authorized, it takes time to fill them as well. The state's overall budget has included provisions for "salary savings" to account for the fact that departments cannot fill 100 percent of their positions all of the time. When a department requests funding for new positions in a budget change proposal, its request for funds to cover salaries and related costs generally is reduced by 5 percent. In subsequent years, augmentations to departments to cover the increasing costs of employee salaries also generally are reduced to take account of the 5 percent salary savings factor. Covered California also experiences vacancies and has recognized a declining vacancy rate over the past couple of years.

In June 2017, Covered California's vacancy rate was 15.8 percent, but by May 2020 the vacancy rate dropped to 9.6 percent (Figure 15). This represented a 6.2 percentage point decline from June 2017, or a 34.2 percent decline in the vacancy rate. While a drop in the vacancy rate is good for Covered California's overall operations, it does increase personnel expenses. Salary savings declines due to the lower vacancy rate. Given the current environment, it is anticipated that attrition rates will be lower than historical trend due to the economic slowdown.

Figure 15
Covered California's Overall Vacancy Rate at Specific Points in Time



In the FY 2019-20 budget, Covered California assumed salary savings of 12 percent, which was based on an expected vacancy rate of roughly 14 percent. However, throughout FY 2019-20, Covered California's vacancy rate continued to decline. Dropping from 14.6 percent in July 2019 to 9.6 percent by May 2020. While Covered California recognized only a portion of the declining vacancy rate in FY 2019-20, it will recognize the full effects of the reduced vacancy rate in FY 2020-21. Therefore, the FY 2020-21 workload budget was adjusted for this fact. After adjusting for the revised vacancy rate (9.4 percent), salary savings dropped from 12 percent to 5.8 percent. In turn, personnel expenses rose by $5.4 million.

Prefunding of Retiree Health Care

Commencing July 2018, the state and employees agreed to equally prefund retiree health care. The maximum contribution available to retired state employees has been the 100/90 formula. The state pays for 100 percent of the retiree's health care premiums and 90 percent of that of their dependents. Retired state employees are generally eligible to receive this contribution after 20 years of state service. Retired employees with 10 years of state service receive 50 percent of this amount, increasing 5 percent annually until the 100 percent level is earned. Most state retirees receive the full 100/90 contribution.

The amount of the employee and matching employer contributions required to prefund retiree health care was phased in over three years, with a gradual increase in the percent of pensionable compensation. Covered California's expense will be equal to 3.5 percent of PERS pensionable compensation in FY 2020-21, representing a 1.2 percent increase over FY 2019-20 (Table 22).

Table 22:
Prefunding of Retiree Health Care Percent Phase-In

Fiscal Year	Percent of Pensionable Compensation	Total FY Percent
July 2018	1.2 percent	1.2 Percent
July 2019	1.1 Percent	2.3 Percent
July 2020	1.2 Percent	3.5 Percent

Source: SEIU Contract. https://www.seiu1000.org/sites/main/files/file-attachments/seiu_master_agreement_2017_final1.pdf

Improving Affordability and Access to Health Care

All SEIU Local 1000 represented employees enrolled in a CalPERS health plan will receive a monthly payment of $260 commencing July 1, 2020. It is estimated that this will cost Covered California $1.9 million for FY 2020-21.

General Salary Increase

Effective July 1, 2020, all SEIU employees will receive a 2.5 percent salary increase. Covered California's expenses for FY 2020-21 total $88.0 million.

Supplemental Pension Payment

The state borrowed $6 billion from the state's portion of the Pooled Money Investment Account (PMIA) to make a supplemental payment to CalPERS[33]. This $6 billion contribution was made in addition to the actuarially required contributions to CalPERS — referred to as an "additional discretionary payment" to CalPERS. The loan would be repaid with interest each year. The rate would float (vary) with a two-year Treasury rate — specifically, an index based on the average yield of a range of Treasury securities, adjusted to the equivalent of a two-year maturity. Each state fund would begin making payments in 2018-19 and would later proportionally compensate the General Fund for their share of the interest and principal. In FY 2020-21, Covered California's portion totals $3.2 million.

Contribution for Employee's Health Care Premiums

The state pays a large share of state employee health premiums. The state's contribution is determined through a two-step process:

- Calculate Average Premium Cost: The state identifies the four health plans with the highest enrollment of state employees and calculates a weighted average of the premiums for these plans.
- Apply Contribution Rate: For most state employees, the state pays 80 percent of the average premium cost for the employee and 80 percent of the average

[33] *Repaying the CalPERS Borrowing Plan*, California Legislative Analyst's Office, April 4, 2018. https://lao.ca.gov/Publications/Report/3797.

additional costs for his or her dependents. This is referred to as the “80/80” formula.

Health care inflation results in additional benefit expenses for Covered California. In addition, the mix of employees, single individuals versus families with dependents, also affects benefit expenses.

Mid-Year Staff Additions

During FY 2019-20, Covered California added five (5) staff positions. These staff positions were added to Policy (2), Information Technology (2) and Public Relations and Communications (1).

Workload Budget

As noted prior, the workload budget represents the FY 2020-21 budget assuming no new policy initiatives and adjusted for inflation, caseload, etc. The FY 2020-21 workload budget totals $379.9 million. Personnel accounts for $153.8 million, or 40 percent of overall workload budget expenses. Contracts greater than $1 million accounts for $169.8 million and constitutes 45 percent of total workload budget expenses, while other operating expenses and equipment accounts for $56.3 million and 15 percent of overall workload budget expenses

Understanding Churn among California's Health Insurance Exchange Consumers

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[1] Covered California, [2] Slosar Research

BACKGROUND

Observed Churn in the Individual Market

- Since their inception, the individual marketplaces have experienced substantial turnover, or "churn," in enrollment.
- As has been documented, many enrollees have tenures lasting one year or less, and an estimated 35-40% of enrollees terminate their coverage in a given year (Apostle 2016, Lee et al. 2017, CMS 2017, Diamond et al. 2018).
- While some early modeling anticipated significant churn as a likely natural state of affairs for the marketplaces (see Dietz et al 2014), many observers have suggested that this churn is a sign of a problem because:
    - There is concern that this churn is a reflection of consumers' satisfaction with their coverage experience.
    - There is an assumption that many consumers' exiting the marketplaces are instead choosing to go uninsured, raising concerns about their continuity of care as well as the stability of the marketplaces themselves.

Gaps in Existing Literature

- To date, churn in the marketplaces is not an area that has received much attention in health policy research.
    - Most churn studies focus on churn in the Medicaid population and only tangentially touch on the marketplace consumer population (Sommers et al. 2016).
    - Some have documented churn in the federal marketplace (Apostle 2016, CMS 2017) and in California's exchange (Lee et al. 2017, Diamond et al. 2018), but a deeper understanding of its dynamics remain elusive and often overshadowed by assumptions.

STUDY OVERVIEW

Research Objectives

- Using Covered California as a case study, this study seeks to address these gaps by:
  - Documenting patterns of churn in Covered California's subsidized membership since its inception in 2014.
  - Assessing the extent to which churn among this population is associated with consumers leaving the marketplace to become uninsured.
  - Improving our understanding who leaves the exchange to go uninsured and explore preliminary hypotheses about what drives this behavior.

Unique Data Opportunity

- To achieve these objectives, we take advantage of Covered California's administrative data and consumer survey data:
  - Using Covered California's administrative data, we document patterns of termination and tenure among subsidized members from 2014 to 2019.
  - We use survey data from a representative, probability-based sample of verified Covered California members to document terminating members' sources of coverage after leaving the marketplace at some point during 2017 or 2018.
  - Using a large oversample of 2018 terminating members, we examine characteristics and behaviors of consumers who go uninsured, as well as their reasons for not re-enrolling.

DATA SOURCES

Covered California Administrative Data

- Provides individual-level enrollment data that spans the entire enrollment history of the exchange, 2014-2019.

California Health Coverage Survey

- An annual survey conducted by NORC at the University of Chicago for Covered California immediately following Open Enrollment.
- The survey data come from a probability-based, representative sample of Covered California's consumer groups:
  - Consumers who terminated their coverage after June 30th of the prior year.
  - Current year members who enrolled in or renewed coverage during Open Enrollment.
  - Consumers who applied for coverage during Open Enrollment but did not enroll.
- The survey uses a mail-to-web design and is administered in English and Spanish. Sampling eligibility criteria include:
  - Ages 18-64
  - Heads of households
  - Valid California mailing address
- Data used for this study comes from surveys fielded in 2018 and 2019.

The appendix includes additional information about the California Health Coverage Survey and limitations regarding the data used in this study.

FOCUS ON SUBSIDIZED MEMBERS

- In this study we examine terminating members who were eligible for subsidized coverage while enrolled with Covered California.
- In any given year, 86%-89% of Covered California's members are enrolled in subsidized coverage.
- For most terminating members, we do not have updated eligibility information for them once they leave the exchange. For the purposes of this study, we assume subsidy eligibility stays constant among terminating members who go uninsured or off-exchange, which is the more conservative assumption to make, but in reality, some of these consumers are likely no longer eligible to receive subsidies.

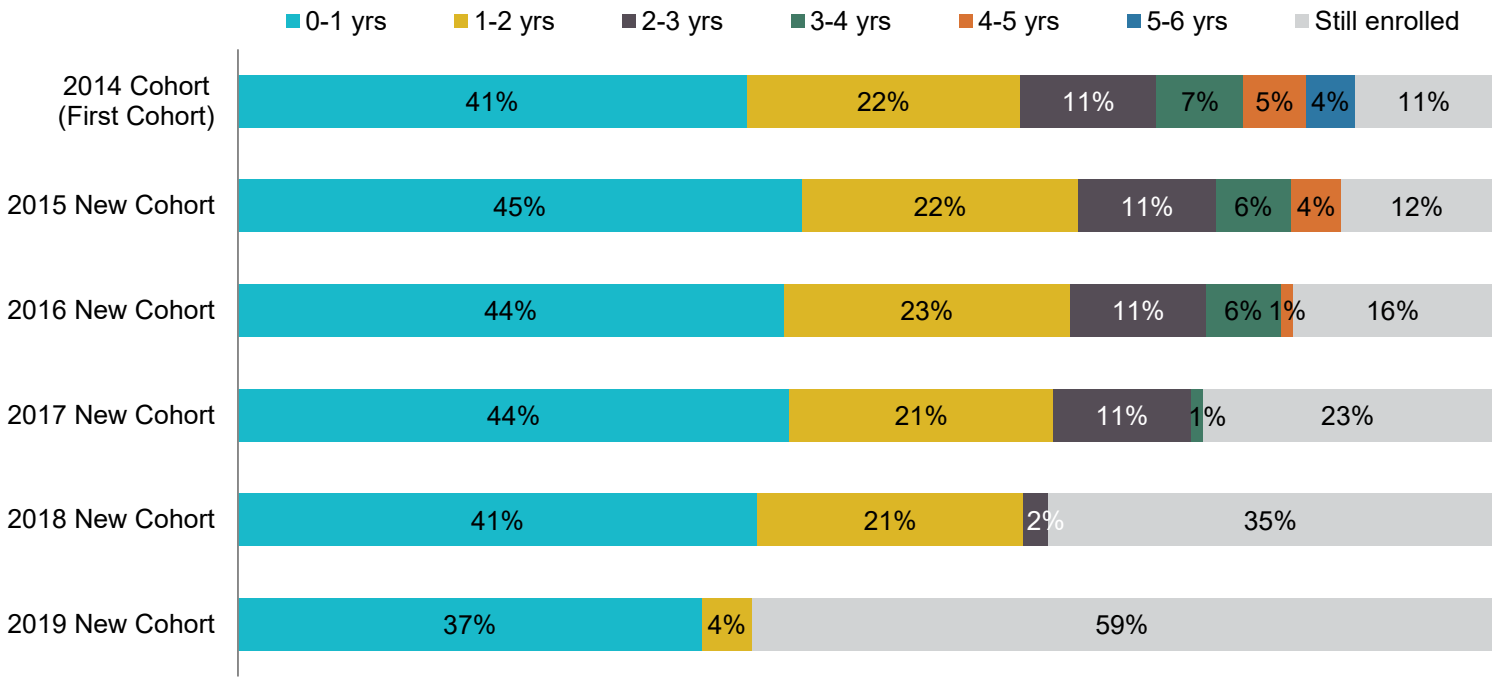
DOCUMENTING CHURN AMONG COVERED CALIFORNIA'S SUBSIDIZED MEMBERSHIP

Membership Tenure

- Figure 1 (on the following slide) presents patterns of tenure in Covered California's subsidized memberships for cohorts of new enrollees for each year from 2014 to 2019.
- Tenure is measured in months of continuous coverage, so that an individual can be counted multiple times if they terminate coverage and enroll in a plan through the exchange at a later date.
- Consistent with data on federal marketplace and state-based marketplace tenure, about two in every five enrollees leave Covered California within one year of enrolling.
- Approximately three of every five consumers leave the exchange within two years.
- Notably, these trends hold across new cohorts from all enrollment years.

DOCUMENTING CHURN

Figure 1. Membership Tenure among New Enrollee Cohorts, by Year



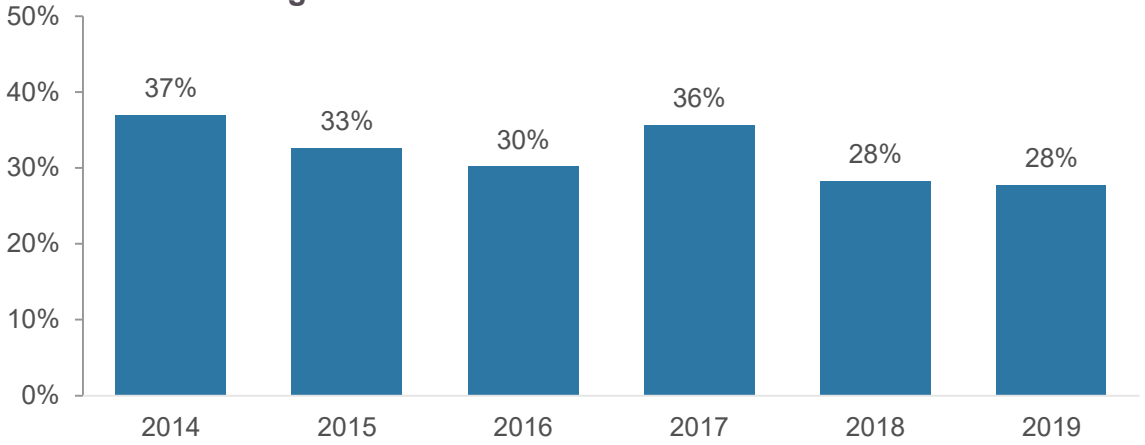
2014 n=1,204,994; 2015 n=719,016; 2016 n=620,118; 2017 n=530,741; 2018 n=552,326; 2019 n=456,946; includes all subsidized members with continuous enrollment that began at some point during the year in question. A member was considered "still enrolled" if they were an effectuated member in January 2020 as part of a single, continuous coverage period that began in the year in question.

DOCUMENTING CHURN

Annual Churn Rate

- Figure 2 shows Covered California's annual "churn rate" among the subsidized membership from 2014 to 2019. The churn rate represents the proportion of all members (including both new and renewing members) that terminate their coverage at some point during a given enrollment year – regardless of their membership tenure.
- Approximately one-third of subsidized members leaves the exchange in any given year, which is consistent with CMS's 2016 data on the federally-facilitated marketplace. This churn rate is also relatively stable over time.

Figure 2. Covered California Annual Churn Rate



2014 n=1,224,573; 2015 n=1,441,673; 2016 n=1,489,231; 2017 n=1,459,007; 2018 n=1,469,838; 2019 n=1,422,933.

DO TERMINATING MEMBERS GO UNINSURED?

Most Consumers are No Longer Eligible for Subsidized Individual Market Coverage

- Figure 3 on the following slide presents reported sources of coverage among 2017 and 2018 terminating members: 80%-87% report having another source of coverage.
- In fact, 75%-83% of terminating members are no longer part of the subsidy-eligible individual market because they enrolled in coverage through another source, such as employer-sponsored insurance or Medi-Cal.
- Another 4%-6% report having coverage through the off-exchange individual market and may still be eligible for subsidized on-exchange coverage.

A Small Share of Churning Consumers do Become Uninsured

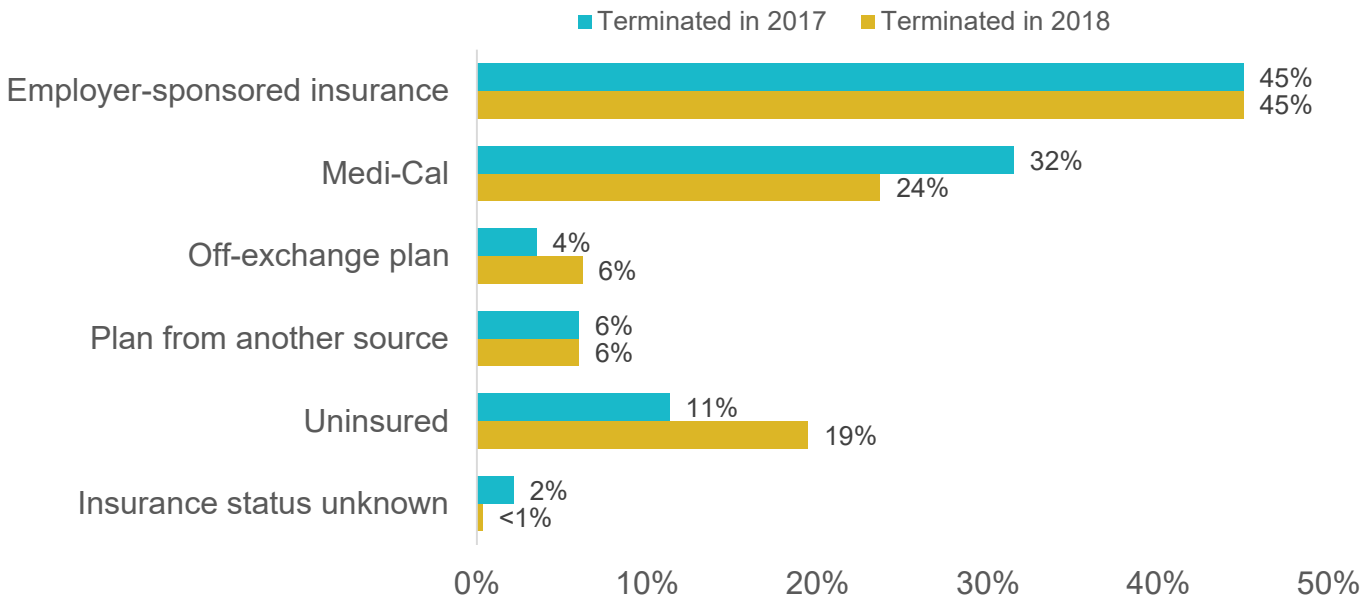
- Although most consumers report another source of coverage, 11% in 2018 and 19% in 2019 reported having no source of coverage.
- In 2019, the individual mandate penalty under the ACA was reduced to $0. While the total volume of terminations did not considerably increase during this same period, the share of terminations who reported being uninsured nearly doubled.

Putting it All Together: Terminating Churn Dynamics

- Figure 4 on Slide 9 aggregates terminating members' reported sources of coverage after Covered California across 2017 and 2018 to depict the broader churn of the marketplace.

MOST SUBSIDIZED TERMINATING MEMBERS ENROLL IN ANOTHER SOURCE OF COVERAGE

Figure 3. Sources of Coverage after Leaving the Marketplace, by Termination Year



*2017 & 2018 share of uninsured terminations statistically significant at p<0.05
2017 n=893; 95% CIs for key estimates: uninsured 9%-15%; off-exchange 2%-5%; ESI 40%-49%; Medi-Cal 27%-37%.

2018 n=3,372; 95% CIs for key estimates: uninsured 17%-22%; off-exchange 5%-8%; ESI 41%-48%; Medi-Cal 21%-27%.
Coverage source is self-reported current coverage source at the time of survey (during first quarter of the following year, immediately after OE5 & OE6).

CHURN DYNAMICS AMONG THE SUBSIDIZED MEMBERSHIP OVER TWO YEARS

Figure 4. Churn Dynamics as Reflected by Terminations of Subsidized Covered California Members, 2017 & 2018

Not shown: 1% of terminations with unknown insurance status. Percentages across years were aggregated by applying percentages of reported coverage (Slide 8) to the volume of terminations of subsidized terminations for the relevant year (2017 or 2018). Subgroup counts were combined to calculate proportions over the sum of the two years.

WHO TERMINATES AND BECOMES UNINSURED?

Churn Among Renewal Candidates

- While making up a small share of the overall churn, it is important to understand those who are going uninsured. To better understand the decision to terminate and go uninsured, we look specifically at 2019 rates of uninsurance among the group of “renewal candidates” who were subsidized in the prior year (2018).
- Renewal candidates are defined as 2018 members that meet the following two criteria:
  - Were enrolled in through December 31, 2018
  - Did not report having coverage through another source (e.g. ESI, Medi-Cal, or off-exchange coverage)
- Renewal candidates include two types of consumers:
  - Renewing members who were enrolled through December 31, 2018
  - Terminating members who were enrolled through December 31, 2018 and reported being uninsured after the 2019 Open Enrollment Period.
- Table 1 on the following slide presents the share within each subgroup of renewal candidates that went uninsured in 2019 instead of renewing coverage through Covered California.
  - Absent from the table are groups with differences that are not statistically significant from each other, including age, enrollee metal tier, and FPL.
  - Consistent with other literature on the uninsured, those with low expected utilization go uninsured at higher rates.
  - Similarly, those who report being previously uninsured have higher rates of again becoming uninsured, indicating that although outreach is necessary to bring the uninsured into the exchange, work must also be done to minimize future gaps in their coverage.

WHO TERMINATES AND BECOMES UNINSURED?

Table 1. Proportions of Renewal Candidates Going Uninsured

Group	Rate of Uninsurance	Group	Rate of Uninsurance
All Renewal Candidates	1.3%	**Race/Ethnicity**	
Health Plan Rating		Hispanic (n=572)	2.4%*
Low (n=688)	2.1%*	White (non-Hispanic) (n=512)	0.8%
Medium (n=589)	1.0%	Black (non-Hispanic) (n=183)	0.9%
High (n=508)	1.0%	Asian (non-Hispanic) (n=371)	1.0%
2018 Insurance Status		Other (non-Hispanic) (n=106)	1.0%
Uninsured part of 2018 (n=340)	3.2%*	**Subjective Health Literacy**	
Insured all of 2018 (n=1,486)	1.1%	Lowest level (n=104)	3.1%*
Expected Number of 2019 Doctor Visits		All others (n=1,703)	1.2%
None (n=294)	5.0%*	**Awareness of Individual Mandate Repeal**	
One visit (n=302)	1.3%	Aware (n=832)	2.4%*
Two or more visits (n=1,230)	0.9%	Unaware (n=530)	0.4%

COVERED CALIFORNIA

Note: Renewal candidates are consumers enrolled through the end of 2018 and either re-enrolled or terminated to become uninsured. The appendix provides wording of survey questions.

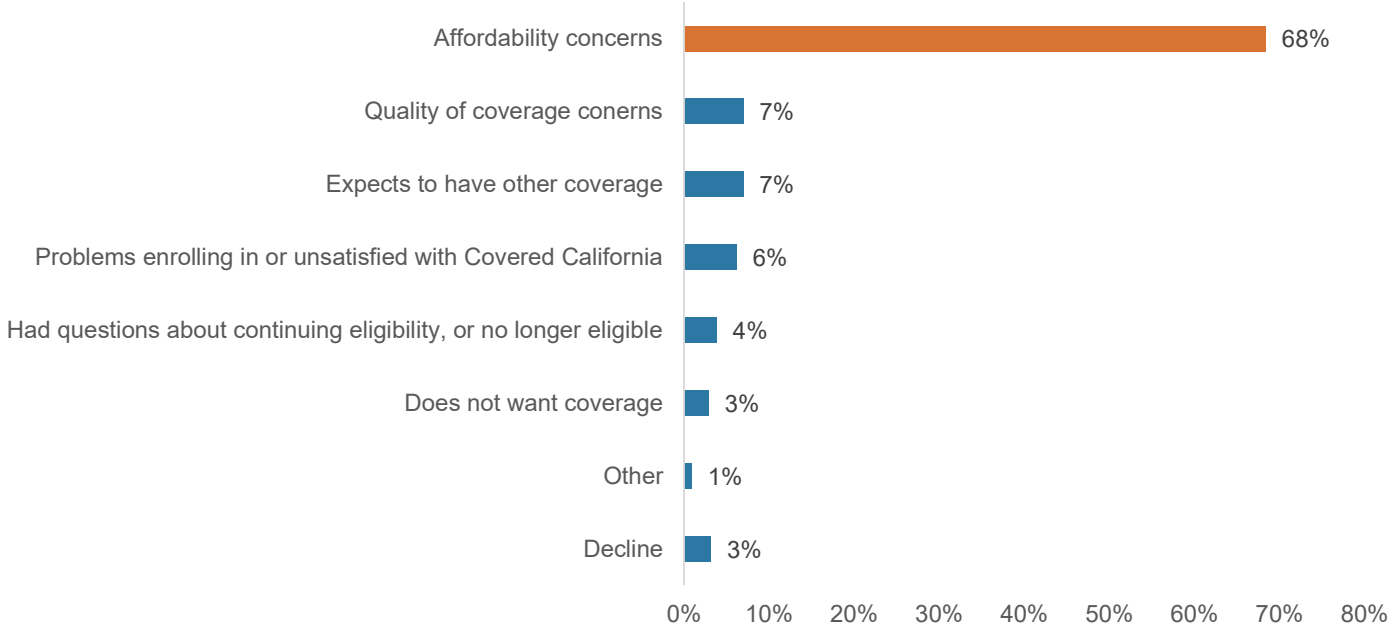
REASONS THAT UNINSURED RENEWAL CANDIDATES DID NOT RE-ENROLL

Affordability is Main Reason that Renewal Candidates do not Re-enroll in Coverage

- Figure 5 on the following slide summarizes the main self-reported reasons renewal candidates did not renew their coverage.
- This group of uninsured terminations overwhelmingly report that affordability concerns were the main reason for not renewing their coverage.
- Among those citing affordability as their main reason for terminating their coverage, 46% said that premiums costs were too high and another 30% reported that they could not afford to pay for their plan. Other affordability-related reasons include concerns about the cost of co-pays/deductibles and reports that they found a better deal off-exchange. (n=413)
- Other reasons cited for terminating include quality of coverage, with reasons such as unsatisfied with their network or the benefits available, and problems enrolling in Covered California, which include reasons such as difficulty finding information to complete enrollment or navigating the website.

AFFORDABILITY IS MAIN CONCERN AMONG RENEWAL CANDIDATES WHO GO UNINSURED

Figure 5. Main Reason for Not Renewing Covered California Plan in 2019



n=645; 95% CIs for key estimates: Affordability: 63%-73%; Quality 5%-10%; Other coverage: 4%-12%; Covered California: 6%-12%;

IMPLICATIONS FOR POLICY & PRACTICE

Most Churn is Here to Stay and Policy Should be Shaped with this in Mind

- Given the fragmented nature the health care system, churn is likely here to stay.
- Health insurance exchanges play a key role in assisting consumers as they navigate various forms of coverage. While this study focuses on individuals churning out of Covered California, most consumers who churn into Covered California are coming from other coverage sources outside the individual market, like ESI or Medi-Cal (data not presented).
- Knowing this phenomenon, policy should focus on facilitating consumers' transitions to and from individual market coverage, to minimize any gaps in coverage or the risk of going uninsured. Facilitating these transitions can start with the exchanges engaging in active, continuous outreach and education about subsidized individual market coverage to reach and inform new entrants to the ever-churning individual market.

Steps Taken in California to Address Churn

- California has taken a step in this direction, enacting a new state law in 2020 (SB 260, Hurtado), which requires auto-enrollment into the marketplace for those who lose Medicaid coverage, and enhanced outreach by health plans to consumers who are losing other commercial coverage. Further research is needed to asses on whether such policies can reduce the likelihood of individuals going uninsured while experience eligibility churn between sources of coverage.
- Affordability of the individual market continues to be a concern, especially among uninsured terminating members. In 2020, California implemented a new state subsidy program to provide new financial help, including extending premium subsidies that cap the cost of coverage based on income to those with income levels at 400%-600% FPL.

CONCLUSION

Churn is an Inherent Reality for the Marketplace

- Six years of administrative data from Covered California indicate that churn is an inherent feature of the exchange, with a fifth of consumers terminating within a year of signing up and a third of all consumers terminating over the course of the year.

Most Churn is driven by Consumers Gaining Coverage from Other Sources

- Much of this churn is the result of consumers no longer being eligible for individual market coverage, as 79% take up other sources of coverage outside of the individual market. Another 5% enroll in coverage off-exchange, with the remaining 15% going on to be uninsured.

Understanding Who is Becoming Uninsured

- Populations such as Hispanics and low health care utilizers are going on to be uninsured at higher rates. Further research is needed to understand whether there is an opportunity to improve retention among these groups.

Among the Small Share that goes Uninsured, Affordability is Key Issue

- Renewal candidates going on to be uninsured cite affordability as a main reason for ending their coverage. Many proposals to strengthen the ACA call for enhanced affordability measures, and more work should be done to see how California's new state subsidy program aided in minimizing churn among these groups.

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Acknowledgements

The authors wish to acknowledge NORC at the University of Chicago (NORC), which conducts the California Health Coverage Survey as part of a contract to support Covered California with program evaluation.

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APPENDIX

California Health Coverage Survey

- The survey sampled consumers who terminated their coverage after June 30th of the prior year. This sample is used to represent the full set of terminating members. Our comparisons of people who terminate before June 30th and after June 30th in Covered California's administrative data make us view this as a reasonable assumption.

- Relevant survey questions for Table 1:
    - *Awareness of individual mandate repeal:* Now, think about this year (2019). As far as you know, is it required by law for most people to have health insurance in 2019 or else pay a fine?
    - *Subjective health literacy*: How confident are you that you know most of the things you need to know about how health insurance works?
    - *Health plan rating:* Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan while enrolled in your plan through Covered California in 2018?
    - *Expected number of 2019 doctor visits:* How many times do you expect to go to a doctor's office or clinic to get health care for yourself this year? Think about the entire year (January 1 to December 31, 2019).

APPENDIX

Important Notes About the Data

- The intersection of administrative and survey data allow us to create a comprehensive view of churn in California's marketplace. However, Covered California's administrative data are shown on the individual level, while survey data only reflect heads of households, not all marketplace individuals.
- As a sensitivity check, we restricted our survey analysis to respondents with a household size of one to better reflect individual-level data and ensure that the trends of our analysis hold.

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Medicaid Managed Care Contract Language: Health Disparities and Health Equity
Prepared by Bailit Health

This document provides excerpts of health disparities and health equity contract language from Medicaid Managed Care (MMC) contracts from five states—Michigan, Minnesota, North Carolina, Ohio, Oregon—and Washington, D.C. as well as the contract for California's Health Exchange, Covered California. To identify state contracts to include, a select number of Medicaid managed care contracts were reviewed and a Google search was performed. The criteria for inclusion in this compendium were contracts that explicitly addressed health disparities and/or health equity. State contract examples were excluded if the contract only included minimal health disparities language related to federal rules for Medicaid managed care quality strategies[i]. The review was not comprehensive as it did not include every state managed care contract. The following are trends observed across the contracts reviewed:

- The contracts vary significantly from state to state both in terms of the approaches taken and the extent of direction given to MCOs. MMC contractual language related to health equity reflects this overall difference in state managed care approaches.
- The health equity-related language in the MMC contracts reviewed range from Minnesota, which requires that its contractor develop a quality improvement project to address health disparities, to Oregon, which has an entire 26-page Exhibit K dedicated to social determinants of health and equity requirements, and is separately attached.
- While most MMC contracts reference the concept of health equity, the contract requirements are primarily focused on the reduction of heath disparities within the contractor's Medicaid member population. Oregon is an exception and includes requirements that attempt to address social determinants of health and underlying power structures in the pursuit of health equity at a broader, community level.

In this document, each state's contract language is organized in a chart that begins with an overview of the contract language. Website links to the full contracts are included where available. Excerpts from the MMC contract language are organized into specific categories and measures identified by the state as equity or disparities measures. The categories may appear in a different order in the underlying MMC contract but are presented in this table in the following order as applicable to the MMC contract: General Language, Population/Community Health Management, Measurement and Data Analytics, Interventions, Monitoring Performance, Quality Improvement, Specialized Initiatives, and Other.

Support for this document was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

Contents

Michigan

Medicaid Health Plan (MHP) contract: https://www.michigan.gov/documents/contract_7696_7.pdf

Overview
Michigan's population health management strategy includes requirements related to disparities reduction and promotion of health equity. The state is using capitation withhold and quality-based auto-assignment programs to reward MHP performance in reducing racial disparities and improving regionally-defined performance. Contractors are required to perform data analytics to identify disparities and implement and report on the effectiveness of evidence-based interventions that are designed to reduce health disparities and to promote health equity. *Michigan Health Plan performance is evaluated on health equity HEDIS measures, among other performance measures. MI Medicaid Managed Care has a special low birth rate initiative related to reducing racial disparities in maternity outcomes.*
General Language
Contractor must provide the spectrum of primary and preventive care and use the principles of population health management to prevent chronic disease and coordinate care along the continuum of health and wellbeing. Effective utilization of these principles will maintain or improve the physical and psychosocial wellbeing of individuals through cost-effective and tailored health solutions, incorporating all risk levels along the care continuum. This includes the management of high-utilizers. Population health management also includes an overarching emphasis on health promotion and disease prevention and will incorporate community-based health and wellness strategies with a strong focus on the Social Determinants of Health, creating Health Equity, and supporting efforts to build more resilient communities.
Population/Community Health Management
X. Population Health Management **A. Data Aggregation, Analysis, and Dissemination** **1. General** a. Contractor recognizes that Population Health management interventions are designed to address the Social Determinants of Health, reduce disparities in health outcomes experienced by different subpopulations of Enrollees, and ultimately achieve Health Equity. b. Contractor must develop protocols for providing Population Health management services where telephonic and mail-based care management is not sufficient or appropriate, including the following settings: i. At adult and family shelters for Enrollees who are homeless ii. The Enrollee's home iii. The Enrollee's place of employment or school c. Contractor must implement the U.S. Department of Health and Human Services (DHHS) Office of Minority Health (OMH) National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care located at http://www.thinkculturalhealth.hhs.gov/.

MICHIGAN Continued

Measurement and Data Analytics

X. Population Health Management

A. Data Aggregation, Analysis, and Dissemination

2. Data Analysis to Support Population Health Management

Contract must utilize information such as medical and dental claims data, pharmacy data, and laboratory results, supplemented by UM data, Health Risk Assessment results and eligibility status, such as children in foster care, persons receiving Medicaid for the blind or disabled and CSHCS, to address Health Disparities, improve Community Collaboration, and enhance care coordination, care management, targeted interventions, and complex care management services for targeted populations including:

- Subpopulations experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level.
- Subpopulations demonstrating disparate levels of poor health outcomes or access issues based on factors such as race, ethnicity, gender, age, primary language, deaf and hard of hearing, ability, geographic location, or income level.

3. Data Submission and Data Reporting

Contractor must measure and report annually to MDHHS on the effectiveness of its evidence-based interventions to reduce Health Disparities by considering such measures as number of Enrollees experiencing a disparate level of social needs such as transportation, housing, food access, unemployment, or education level, number Enrollees participating in additional in-person support services such as Community Health Worker, patient navigator, MIHP, or health promotion and prevention program delivered by a community-based organization, and changes in Enrollee biometrics and self-reported health status.

Performance Monitoring

Appendix 4 – Performance Monitoring Standards

PURPOSE: The purpose of the performance monitoring standards is to establish an explicit process for the ongoing monitoring of health plan performance in important areas of quality, access, customer services and reporting. Through this appendix, the performance monitoring standards are incorporated into the Contract between the State of Michigan and Contracting Health Plans.
The process is dynamic and reflects state and national issues that may change on a year-to-year basis. Performance measurement is shared with Health Plans during the fiscal year and compares performance of each plan over time, to other health plans, and to industry standards, where available.

The Performance Monitoring Standards address the following:

- MDHHS Administrative Measures
- Healthy Michigan Plan (HMP) Measures
- Healthy Michigan Plan Dental Measures
- CMS Core Set Measures / Health Equity HEDIS / HEDIS / Managed Care Quality Measures

For each performance area, the following categories are identified:
Measure: Goal, Minimum Standard for each measure, Data Source, Monitoring Intervals, (annually, quarterly, monthly)

MICHIGAN Continued

Interventions

D. Providing Care Management Services and Other Targeted Interventions

2. Targeted Interventions for Subpopulations Experiencing Health Disparities:

- Contractor must offer evidence-based interventions that have a demonstrated ability to address Social Determinants of Health and reduce Health Disparities to all individuals who qualify for those services.
- Contractor must collaborate with its high volume primary care practices to develop, promote and implement targeted evidence-based interventions. To the extent that CHIRs are functioning within the Contractor's service area, the Contractor must collaborate with CHIRs to develop, promote, and implement these targeted evidence-based interventions.
- Contractor must fully and completely participate in the Medicaid Health Equity Project and report all required information to MDHHS within the specified timeframe.

See Appendix for Michigan's Health Equity HEDIS Performance Monitoring Standards for the 2019-2020 contract year.

Specialized Initiatives

FY18-FY20 Focus Bonus: Low Birth Weight (LBW) – Appendix 5B

In June 2017, the Michigan Medicaid Managed Care Plan Division (MCPD) identified Low Birth Weight (LBW) as a target outcome associated with the FY 2018 Pay for Performance (P4P) Initiative for the Medicaid Health Plans (MHPs). The LBW P4P initiative supports and aligns with the Medicaid Health Equity Project, which was initiated by MCPD in 2011 to promote health equity and monitor racial and ethnic disparities within the managed care population...The LBW-CH measure specification will be used to analyze and report state-wide Medicaid managed care data, which will be stratified by prosperity region and race/ethnicity. This breakdown of the date will identify health disparities and methods to improve quality care and services to pregnant women and infants. Project Goal: MCPD is launching this multi-year statewide Pay for Performance (P4P) initiative to align MDHHS efforts to promote health equity in maternity care and infant care.

For FY 2018, the goal is to involve the MHPs, existing home visiting programs, and community health worker programs to design and implement a meaningful P4P project. In order to improve infant health outcomes, the initiative will address documented health disparities and health inequities with particular focus on reducing the LBW-CH rate. The activities in FY18 will include identifying evidence-based, integrated models that address LBW through management of medical and social determinants of health. They will also incorporate parties who focus on maternity care to identify and implement models of choice through collaborative processes.

Other

Contractor must fully and completely participate in the Medicaid Health Equity Project and associated initiatives and report all required information to MDHHS within the specified timeline.

Minnesota

Minnesota DHS Contract for Prepaid Medical Assistance and MinnesotaCare:
https://mn.gov/dhs/assets/2020-fc-model-contract_tcm1053-413653.pdf

Overview
Minnesota requires at least one quality improvement project to address health disparities, and that a description of this project be published on the MCO's website. A listing of the MCOs quality improvement websites is included within the Appendix. Healthy disparities focused MCO quality improvement activities include: Blue Cross MN's program to increase colorectal cancer screenings among members of color; HealthPartners program to increase member's with disabilities access to dental care; and Hennepin Health's program to reduce racial disparities in depression management.
Quality Improvement
7.8 Annual Quality Program Update. Annually, the MCO shall demonstrate how the MCO's Quality Improvement Program identifies, monitors and works to improve service and clinical quality issues relevant to the MHCP Enrollees. The MCO shall submit, on or before May 1st of the Contract Year, a web site link to a public web page associated with the MCO describing quality improvement activities that have resulted 2020 Families and Children; MCO 2020 - 139 - in measurable, meaningful and sustained improved health care outcomes for the contracted populations. The MCO will describe the quality strategies, including quantitative evidence of improvements, lessons learned, and how the quality improvement outcomes will influence future activities. The web page must prominently feature the description of at least one quality improvement activity addressing health care disparities.

North Carolina

Medicaid Prepaid Health Plan Model Contract (not yet implemented):
https://files.nc.gov/ncdhhs/30-19029-DHB-1.pdf

Overview
North Carolina was expected to transition from fee for service to MMC. Their MMC RFP would have moved their Medicaid program to a capitated, full-risk managed care program where the contractors are referred to as Prepaid Health Plans (PHPs). The managed care awards, which included both regional and statewide contracts, were set to go live on 2/1/2020 but have been indefinitely delayed due to the North Carolina General Assembly failing to provide new spending or program authority to transition to managed care[1] as well as Medicaid MCO procurement protests.[2] *Promoting health equity through reduction of health disparities will be a focus within North Carolina's Quality Management and Quality Improvement requirements. PHPs will identify disparities and implement interventions through their population health management programs to reduce disparities.*
Measurement and Data Analytics
E. Quality and Value **1. Quality Management and Quality Improvement** **j. Disparities Reporting and Tracking** • The PHP shall report measures against a set of stratification criteria that may include, but is not limited to: race and ethnicity, geography, eligibility category, and age and gender where appropriate and feasible for many of the Quality Measures. • The PHP shall address inequalities as determined by the Department during review of the PHP's performance against disparity measures. The Department will define the disparity stratifications for each measure after Contract Award and annually thereafter.
Quality Improvement
E. Quality and Value **1. Quality Management and Quality Improvement** .. [NC] will work with the PHP to develop a data-driven, outcomes-based continuous quality improvement process that builds upon this history and focuses on rigorous outcome measurement against relevant targets and benchmarks, promotes equity through reduction or elimination of health disparities, and appropriately rewards PHPs and, in turn, providers for advancing quality goals and health outcomes. The PHP shall have a robust Quality Management and Improvement Program that will focus on health outcomes, not only healthcare process measures, and align with the NC Medicaid Quality Strategy and Quality Assessment and Performance Improvement (QAPI) Plan. The Quality Management and Improvement Program Plan shall include: • Mechanisms to conduct and assess performance improvement projects (PIPs) specified by the Department; • Mechanisms to assess the quality and appropriateness of care for Members with special health care needs

[1] https://medicaid.ncdhhs.gov/
[2] https://news.bloomberglaw.com/health-law-and-business/insight-its-a-legalpalooza-for-north-carolina-medicaid-managed-care-contracts

NORTH CAROLINA (Continued)
Quality Improvement (continued)
• Mechanisms to assess the quality and appropriateness of care provided to Members needing long-term services and supports, including assessment of care between settings and a comparison of services and supports received with those set forth in the Member's treatment/service plan; • Mechanisms to assess and process for identifying interventions to improve quality disparities based on age, race, ethnicity, sex, primary language, and by key population group (e.g., LTSS); • Mechanisms to incorporate population health programs targeted to improve outcomes measures; • Mechanisms for collection and submission of all quality performance measurement data required by the Department; • Mechanisms to detect both underutilization and overutilization of services; • Mechanisms for participation in efforts by the Department to prevent, detect, and remediate; critical incidents including those required for home and community-based waiver programs; • Mechanisms to assess and address health disparities at a statewide and regional level, including findings from the disparity report that PHPs are required to develop; • A Provider Support Plan (see additional details below in Section 11); and • The PHP's Contributions to Health-Related Resources in alignment with improvement in particular health outcomes outlined in the Quality Strategy. ii. Quality Assessment and Performance Improvement Plan c) The QAPI Plan must include the following elements: • Mechanisms to assess and process for identifying interventions to improve quality disparities based on age, race, ethnicity, sex, primary language, geography and by key population group (e.g., LTSS); • Mechanisms to assess and address health disparities, including findings from the disparity report that PHPs are required to develop;

Ohio

Medicaid Managed Care Plan (MCP) Agreement:
https://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/Medicaid-Managed-Care-Generic-PA.pdf

Overview
Ohio's Medicaid Managed Care Plans (MCPs) are required to identify health disparities in health care access, services and outcomes based on member demographic data. MCPs are required to address health disparities through their quality improvement requirements, which include implementing interventions and evaluating their success. Most of the health disparities language is in Appendix K: Quality Care.
General Language
Appendix K Quality Care **k. Addressing Health Disparities** According to the U.S. Department of Health and Human Services' Office of Minority Health, a health disparity is "a particular type of health difference closely linked with social or economic disadvantage." Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (e.g., race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory or physical disability; sexual orientation; or geographic location). Support of ODM's health equity efforts includes having MCP health equity representatives actively involved in improvement initiatives, determining the root cause of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts. These efforts move beyond agenda setting, and instead focus on the work needed for change to occur, and place greater responsibility for improvement on all parties participating in improvement efforts.
Measurement and Data Analytics
Appendix K Quality Care **k. Addressing Health Disparities** In support of ODM's effort to achieve health equity, the MCP shall collect and meaningfully use race, ethnicity and language data to identify and reduce disparities in health care access, services and outcomes. **7. Quality Improvement Program** <u>QI Initiative Staffing</u> i. Quality improvement teams shall be composed of MCP staff dedicated to the Ohio line of business that represent the following areas of expertise: • Continuous quality improvement, • Analytics, • Subject matter expertise in clinical and/or nonclinical improvement topic(s) being addressed through improvement efforts, • Health equity, • Member- and provider-perspectives; and • MCP policies and processes related to the improvement topic.

OHIO Continued

Quality Improvement Continued

Appendix K
Quality Care
ii. Required QI responsibilities include:

- Frequent and ongoing data analysis to quickly determine the effectiveness of interventions;
- Frequent communication with team members and the senior leadership team regarding the status of improvement projects, intervention successes and failures, data used to determine success, lessons learned, opportunities and progress;
- Analyzing data to identify disparities in services and/or care and tailoring interventions to specific populations when needed;

Quality Improvement Strategy
The MCP shall submit a clearly delineated, outcomes-driven strategy for improvement (e.g., work plan) as part of its annual QAPI submission. The strategy shall measure, analyze, and track performance indicators that reflect the ODM Quality Strategy population health focus, including: population streams (e.g., women of reproductive age, chronic conditions, and behavioral health), value-based purchasing strategies (e.g., comprehensive primary care, episode-based payments), and health equity focus.

QAPI Program Impact and Effectiveness
The MCP shall evaluate the impact and effectiveness of each effort within the QAPI program, including efforts to reduce health disparities. The MCP Medicaid Managed Care Appendix K Quality Care Rev. 1/2019 Page 149 of 218 shall update the QAPI program based on the findings of the self-evaluation and submit both the evaluation results and updates annually to ODM for review and approval following the template provided in the QAPI guidance document. Evaluation should, at a minimum, include:

- The outcomes and trended results of each improvement project, including documentation of successful and unsuccessful interventions
- The results of any efforts to support community integration for enrollees using long term services and supports; and
- How these results will be incorporated into the MCP's quality strategy.

Other

Appendix D Ohio Department of Medicaid (ODM) Responsibilities
ODM will provide the MCP linkages to organizations that can provide guidance on the development of effective strategies to eliminate health disparities

Oregon

Medicaid CCO 2.0 Contract: https://www.oregon.gov/oha/OHPB/CCODocuments/Final-CCO-contract-terms-for-5-year-contract-awardees.pdf

Overview
Oregon contracts with Coordinated Care Organizations (CCOs) to provide Medicaid managed care services to members in defined regions. In January 2020, 15 CCOs began service to Oregon Health Plan members across the State under its CCO 2.0 contracts. Oregon's CCO 2.0 contract requirements are intended to reduce health disparities, address the social determinants of health, and to promote health equity. The contract dedicates an entire section, Exhibit K, to requirements associated with SDOH and Health Equity. For ease of reading, Exhibit K has been attached in its entirety as an appendix to this document. The other requirements related to disparities or health equity that OR included in different sections of the contract are included in the table below. *The key requirements of the Oregon contract include: the creation of a Community Advisor Council to advise the Contractor on serving the health care needs of the entire community, working in partnership with public and community partners, the collection of demographic and health data and the creation of a community health improvement plan for not just members but for all of the communities within the contractor's service area, the development of a spending proposal to address housing and other SDOH-E priorities, the sharing of any quality incentive dollars received with the Contractor's community partners, and requirement to consider disparities in evaluations.*
General Language
Exhibit B –Statement of Work - Part 3 Patient Rights and Responsibilities, Engagement and Choice 1. **Member and Member Representative Engagement in Member Health Care and Treatment Plans.** Contractor shall actively engage Members, Member Representatives, and their families as partners in the design and implementation of Member's individual treatment and care plans, with ongoing consultation regarding individual and cultural preferences and goals for health maintenance and improvement. Contractor shall ensure that Member choices are reflected in the development of Treatment Plans and Member dignity is respected… Contractor shall demonstrate how it: • Engages Members to participate in development of holistic approaches to patient engagement and responsibility that account for SDOH and health disparities;
Measurement and Data Analytics
Exhibit B –Statement of Work - Part 8 Accountability and Transparency of Operations c. Contractor shall assist OHA with development and distribution of survey instruments and participate in other evaluation procedures established by OHA for evaluating Contractor's progress on payment reform and delivery system change including the achievement of benchmarks, progress toward eliminating health disparities, results of evaluations, customer satisfaction, use of Patient-Centered Primary Care Homes (PCPCHs), the involvement of local governments in governance and service delivery, or other developments as determined necessary by OHA its external review organizations, or any of its other designees, agents, or subcontractors (or any combination, or all, of them).

OREGON Continued

Quality Improvement

Exhibit B –Statement of Work - Part 10
Transformation Reporting, Performance Measures and External Quality Review

2. Transformation and Quality Strategy (TQS) Requirements

b. As set forth in the TQS Guidance Document, Contractor's TQS must include strategies and activities as required under the State's 1115 Waiver, 42 CFR §438.330 (a) and (b), and other federal obligations to improve certain elements of the services provided by Contractor to Members…as well as information about processes and procedures related to the TQS.

c. Accordingly, the TQS must include, without limitation the following:

(1) In accordance with the State's 1115 Waiver, strategies and related activities to improve Quality and appropriateness of care and Health Equity with respect to REAL+D, Cultural Competency, and CLAS standards and criteria.

4. Performance Measures: Quality Pool Incentive Payments

a. OHA has implemented a Quality Pool incentive payment program that is based on the Outcome and Quality Measures. The Quality Pool rewards all participating CCOs that demonstrate quality of care provided to their members as measured by their performance or improvement on the Outcome and Quality Measures.

b. Contractor will, if it meets certain metrics related to performance or improvement in a Measurement Year, receive a monetary Payment from the Quality Pool. Contractor shall create a written distribution plan for Quality Pool and Challenge Pool earnings.

The distribution plan must include: An overview of the methodology and/or strategy used to distribute quality pool earnings to Participating Providers, including Social Determinants of Health and Equity and public health partners, that provides information related to the Contractor's process of evaluating the contributions of Participating Providers and connecting those evaluations to distribution of funds;

5. Performance Measure Incentive Payments for Participating Providers

Contractor must offer correlative arrangements with Participating Providers (including Social Determinants of Health and Equity partners, public health partners, and other Health-Related services Providers as appropriate), providing monetary incentive payment arrangements with Providers that reflect priorities which align with the Quality Pool program for achieving the outcome and quality objectives. Contractor shall report these arrangements and amounts paid to OHA's Contract Administrator via Administrative Notice. Such arrangements and amounts paid shall be broken down by quarter and provided in an annual Report in a format determined by OHA (about which OHA shall advise Contractor's Contract Administrator via Administrative Notice) and sent to OHA in conjunction with the 4th Quarter reporting period.

6. Performance Improvement Projects

b. Contractor shall undertake PIPs that address at least four of the eight focus areas listed below... One of the four shall be the Statewide PIP…. In order to satisfy the requirements set forth in 42 CFR §438.358 and 438.330(a)(2) Contractor shall select an additional three (3) PIPs from the list as follows:

(8) Social Determinants of Health and Equity.

OREGON Continued

Performance Monitoring

Exhibit H – Value Based Payment

7. Interviews: VBP Arrangements and Data Reporting Contract Year One (2020)

In June of 2020, Contractor's executive leadership team shall engage in interviews with OHA to:… (b) Discuss outcome of Contractor's plan for mitigating adverse effects of VBPs and compare/describe any modifications to that which was included in the Application Contractor submitted in response to the RFA and those relating to VBP arrangements with Providers serving populations with complex care needs or those who are at risk for health disparities, or both complex care needs and being at risk for health disparities, and compare and describe any modifications to the plans;

8. VBP Data Reporting: Contract Year Two (2021)

In June of 2021, Contractor's executive leadership team must engage in interviews with OHA to: …(2) Discuss outcome of the Contractor's plan for mitigating adverse effects of VBPs on populations with complex care needs or those who are at risk for health disparities, or both complex care needs and being at risk for health disparities, and compare and describe any modifications to the plans;

Other

Exhibit B –Statement of Work - Part 4 Providers and Delivery System

10. Delivery System Dependencies

Intensive Care Coordination for Prioritized Populations and Members with Special Health Care Needs (1) Contractor shall prioritize working with Members who are eligible for ICC Services and communities experiencing health disparities (as identified in the Community Health Assessment). Contractor shall actively engage such Members in accessing and managing appropriate preventive, remedial and supportive care and services to reduce the use of avoidable Emergency Department visits and Hospital admissions.

Definitions

"**Health Equity**" means a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all sectors across Oregon, including Tribal governments, to address the equitable distribution or redistributing of resources and power and recognizing, reconciling and rectifying historical and contemporary injustices. **"Health Equity Plan"** means the Health Equity plan required to be drafted by Contractor and provided to OHA in accordance with Ex. K

"Social Determinants of Health and Equity" and **"SHOH-E"** each means the social, economic, and environmental conditions in which people are born, grow, work, live, and age. These conditions significantly impact length and quality of life and contribute to health inequities. Social Determinants of Health fall into the following domains: neighborhood and built environment, economic stability, education, and social and Community health [3].

"Learning Collaborative" means a program in which CCOs, State agencies, and PCPCHs that provide or perform the activities that serve Health System Transformation objectives, achieve, the purposes of the Contract, and share: (iii) best practices and emerging practices that increase access to Culturally and Linguistically Appropriate care and reduce health disparities;

[3] 410-141-3735

Washington, D.C.

D.C.'s current Medicaid Managed Care Organization (MCO) Contract is not posted publicly

Overview
Washington, DC's Medicaid Managed Care Organizations (MCOs) are required to identify health disparities in health care utilization and in health outcomes based on member demographic data including race/ethnicity, language, by DC ward and social determinants of health. MCOs are required to address health disparities through their quality improvement requirements, which include implementing interventions and evaluating their success.
General Language
SECTION C: Specifications/Work Statement C.1.2 The goal of the Medicaid Managed Care Program (MMCP) through this RFP is to promote healthy outcomes of the enrolled populations in the most cost-effective manner possible. The District's Medicaid population is diverse, including individuals with existing complex medical and social needs and those at high-risk or increasing risk for health care disparities. The low-income population may be impacted by a range of social factors, including homelessness that must be recognized within effective plans of care. The MMCP shall have a clear focus on achieving better health outcomes, health care innovation and cost-effective quality healthcare. It is the intent of this RFP to significantly strengthen the managed care delivery system for eligible DC residents who receive services through the DCHFP and Alliance.
Measurement and Data Analytics
C.5 Requirements **C.5.32 Quality Assessment and Performance Improvement (QAPI)** Analyzes data, including social determinants of health, to determine differences in quality of care and utilization, as well as the underlying reasons for variations in the provision of care to enrollees; C.5.32.3 CQI Plan Reducing racial, socioeconomic and ethnic disparities in health care utilization and in health outcomes. Comparing health care utilization data for Enrollees by Enrollee subgroups, such as, race/ethnicity, language, and by DC ward against prior year performance, and, where possible, against regional and national benchmarks; C.5.32.6 Performance Measures Contractor shall: identify disparities in health services and health outcomes between subpopulations/groups (race/ethnicity and language); identify social determinants of health; and identify the causes for health disparities.
Quality Improvement
C.5.32 Quality Assessment and Performance Improvement (QAPI) Develops system interventions to address the underlying factors of disparate utilization, health-related behaviors, and health outcomes, including but not limited to how they relate to high utilization of Emergency Services; C.5.32.6 Performance Measures Contractor shall: identify disparities in health services and health outcomes between subpopulations/groups (race/ethnicity and language); identify social determinants of health; and identify the causes for health disparities. The Contractor shall develop a plan of action and a timeline to remediate the social determinants of health and health disparities identified through targeted interventions and include this plan and timeline in the Contractor's QAPI program and CQI plan submissions to DHCF. This plan of action shall include a performance measurement and evaluation component, in coordination with section C.5.32.6.

Covered California

Covered California 2017 Individual Market QHP Issuer Contract, Attachment 7: Quality, Network Management, Delivery System Standards and Improvement Strategy:
https://hbex.coveredca.com/insurance-companies/PDFs/Attachment-7_2020_Clean_Final-Model.pdf

Covered California's QHP Measurement Specifications Appendix 2 to Attachment 7
https://hbex.coveredca.com/stakeholders/plan-management/PDFs/Jan-16-2018/Appendix-R-Attachment-7_Measurement-Specifications_2017-02-24.pdf

Covered California's QHP Performance Standards (Attachment 14):
https://hbex.coveredca.com/insurance-companies/PDFs/Attachment-14_2020_Clean_Final-Model.pdf

Overview

Covered California requires Qualified Health Plans (QHPs) to identify, track, trend, and report racial/ethnic and gender disparities in quality measures. This health care exchange has detailed performance specifications for its QHPs and has both financial incentives and penalties for QHPs based on performance to these specifications.

Covered California's QHP contract consists of a number of Attachments and Appendices. The sections most relevant to health equity are found in Attachment 7: Quality, Network Management, Delivery System Standards and Improvement Strategy, including Appendix 2 to Attachment 7 which includes measurement specifications for 41 QHP measures and Attachment 14 QHP Performance Standards. Each of these documents can be accessed via the links above.

As part of its quality measurement specifications and related reporting defined in Appendix 2, QHPs must report approximately half of the required QHP measures separately by race/ethnicity.

Covered California does not require implementation of specific interventions but encourages Contractors to meet the standards for NCQA's Multicultural Health Care Distinction. Covered California also identifies a path for expanding disparities-related requirements in the future.

Preamble: The mission of the California Health Benefit Exchange is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and Providers that give them the best value

The contractual requirements for Health Equity and Health Disparities are organized in Article 3 in Attachment 7 to Covered California Individual Market QHP Issuer Contract: Quality, Network Management, Delivery System Standards and Improvement Strategy.

ARTICLE 3: Reducing Health Disparities and Ensuring Health Equity
Mitigation of health disparities is central to the mission of Covered California, and the California Language Assistance Act adopted as SB 853 in 2003. In alignment with these principles, Covered California and Contractor recognize that promoting better health requires a focus on addressing health disparities and health equity. Covered California will require Contractor to track, trend and reduce health disparities with the phased approach outlined below.

COVERED CALIFORNIA CONTINUED

Measurement and Data Analytics

3.01 Measuring Care to Address Health Equity

Contractor must track and trend quality measures by racial or ethnic group, or both, and by gender for the Contractor's full book of business, excluding Medicare.

1) Identification:
   - (a) By year end 2019 and annually thereafter, Contractor must achieve eighty percent (80%) self-identification of racial or ethnic identity for Covered California enrollees.
   - (b) In the annual application for certification, Contractor will be required to report the percent of self-reported racial or ethnic identity for Covered California enrollees.
   - (c) To the extent Contractor does not have self-reported information on racial or ethnic identity, or both, it shall use a standardized tool for proxy identification through the use of zip code and surname to fill any gaps in information.
2) Measures for Improvement:
   - (a) Disparities in care by racial and ethnic identity and by gender will be reported annually by QHP Issuers based on its Enrollees. The tool for proxy identification shall be used to supplement self-reported racial or ethnic identity. Contractor agrees to work with Covered California to provide comparison reporting for its other lines of business where comparative data can offer meaningful reference points.
   - (b) Measures selected for improvement beginning in plan year 2017 include Diabetes, Hypertension, Asthma (control plus hospital admission rates), and Depression (HEDIS appropriate use of medications).
   - (c) Covered California will consider adding additional measures for plan year 2021 and beyond.

See Attachment 7 Appendix 2 for full list of Measures to be analyzed for disparities by QHPs.

3.03 Expanded Measurement

Contractor and Covered California will work together to assess the feasibility and impact of extending the disparity identification and improvement program over time. Areas for consideration include: 1) Income, 2) Disability status, 3) Sexual orientation, 4) Gender identity, 5) Limited English Proficiency.

Quality Improvement

NCQA Multicultural Health Care Distinction is encouraged but not required. Contract language:

3.04 NCQA Certification

Meeting the standards for Multicultural Health Care Distinction by NCQA is encouraged as a way to build a program to reduce documented disparities and to develop culturally and linguistically appropriate communication strategies. To the extent Contractor has applied for or received NCQA Certification, Contractor must provide this information with its annual application for certification. Covered California may publicly recognize this achievement and include it in information provided to consumers.

COVERED CALIFORNIA CONTINUED

Quality Improvement

QHPs are required to participate in one quality collaborative, Smart Care California, which addresses performance in populations/measures that have significant documented Health Disparities: C-section rates, prescription of opioids and appropriate treatment for low back pain/chronic pain. Contract language is below:

1.06 Participation in Collaborative Quality Initiatives
Covered California believes that improving health care quality and reducing costs can only be done over the long-term through collaborative efforts that effectively engage and support clinicians and other Providers of care. There are many established statewide and national collaborative initiatives for quality improvement that are aligned with priorities established by Covered California with requirements specified below.

1) Effective January 1, 2017, Contractor must participate in:
(a) Smart Care California: Sponsored by Covered California, DHCS, and CalPERS, this multi-stakeholder work group facilitated by the Integrated Healthcare Association (IHA), will provide guidance and steer the delivery system to drive appropriate use of C-sections, prescription of opioids, and low back pain. https://www.iha.org/our-work/insights/smart-care-california

i. The C-section work aligns with activities underway through the California Maternal Quality Care Collaborative (CMQCC) which provides statewide analysis of variation and promotes the appropriate use of C-sections with associated reductions in maternal and newborn mortality and morbidity. https://www.cmqcc.org/ (See Article 5, Section 5.03)

ii. A key element of the change for all three focus areas is promoting best practices through provider and consumer decision support, for example through the Choosing Wisely campaign from Consumer Reports. https://www.iha.org/our-work/insights/smart-care-california

Interventions

In 2019 Covered California began requiring QHPs to choose 1-2 disparities based on review of plan specific measurement across 14 measures selected by Covered California that are determined to be disparities sensitive by the National Quality Forum. The contract language for these requirements are below.

3.02 Narrowing Disparities
While Covered California and Contractor recognize that some level of disparity is determined by social and economic factors beyond the control of the health care delivery system, there is agreement that health care disparities can be narrowed through quality improvement activities tailored to specific populations and targeting select measures at the health plan level.

Covered California and the Contractor agree that collection of data on clinical measures for the purpose of population health improvement requires development and adoption of systems for enhanced information exchange (see Section 1.07).

COVERED CALIFORNIA--CONTINUED

Interventions (continued)

1) Contractor reported baseline measurements from plan years 2015, 2016, 2017, and 2018, on the measures listed in the Measurement Specifications document, based either on self-reported identity or on proxy identification on its Enrollees. Covered California anticipates that this baseline data may be incomplete. The Measurement Specifications document is posted on the Contractors extranet website provided by Covered California (Plan Home, in the Resources folder, Health Disparities Reduction – Measurement Specifications folder).

2) Targets for year end 2020 and for annual intermediate milestones in reduction of disparities will be established by Covered California based on national benchmarks, analysis of variation in California performance, best existing science of quality improvement, and effective engagement of stakeholders.

Other

Performance Guarantees outlined in Attachment 14 of the QHP contracts include the following TWO metrics related to health equity:

3.4a) Reducing Health Disparities – Attachment 7, Article 3, Sections 3.01 and 3.02 – 2% of total performance penalty for Group 3
Contractor will meet intermediate milestones for self-reported racial or ethnic identity by the end of 2018, and will meet the target of 80% self-reported racial or ethnic identity by the end of 2019. Contractor will continue to meet the 80% target during Measurement Year 2020.

Baseline data was used to set an incremental target for 2018 based on information submitted in 2016, 2017, and 2018 via the Applications for Certification for 2017, 2018, and 2019. Contractor and the Exchange have established a mutually agreed upon performance goal which will be documented in the Contractor's Quality Improvement Strategy. Data will be submitted by Contractor in a run chart demonstrating improvement in percentage of self-reported identity compared to baseline reported.

3.4b) Reducing Health Disparities – Attachment 7, Article 3, Sections 3.01 and 3.02 – 3% of total performance penalty for Group 3

Contractor reports required metrics across all lines of business excluding Medicare for diabetes, asthma, Hypertension, and depression by race/ethnicity. The Exchange and Contractor will select at least one, but not more than two disparity measures against which performance in 2020 will be assessed. If the Contractor selects two disparities measures for setting 2020 performance targets, the performance level will be assessed at 1.5% for each measure. Performance will be measured based upon the mutually-agreed upon milestones in the final, Disparity Intervention Proposal which shall be incorporated into this Attachment 14 without an amendment to the Contract.

Performance Requirements: No Assessment for Measurement Year 2017, 2018, 2019

Measurement Year 2020 Performance Levels:
Contractor does not select at least one disparity measure for reduction or does not meet mutually agreed upon milestone(s) selected for the 2020 disparity reduction target: 3% penalty
Contractor meets mutually agreed upon milestone(s) selected for the 2020 disparity target: 3% credit

COVERED CALIFORNIA (Continued)
Definitions
Health Disparities - Healthy People 2020 defines a health disparity as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”9 Racial and ethnic disparities populations include persons with Limited English Proficiency. (LEP). Health Equity - Healthy People 2020 defines health equity as the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.”

Appendix:

Michigan: Health Equity HEDIS Measures

HEALTH EQUITY HEDIS MEASURES

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
*Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Children three, four, five, and six years old receive one or more well child visits during measurement period.	**Informational Only**	MDHHS Data Warehouse	Monthly
*Chlamydia Screening in Women (Total)	Women enrolled in a health plan, ages 16 to 24, who were identified as sexually active and who had at least one (1) test for chlamydia during the measurement period	**Informational Only**	MDHHS Data Warehouse	Quarterly
*Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	Members ages 18 to 75, with Type 1 or Type 2 diabetes, who had an HbA1c test.	**Informational Only**	MDHHS Data Warehouse	Quarterly
*Cervical Cancer Screening	Women enrolled in a health plan, ages 21 to 64, who were screened for cervical cancer using either of the following criteria: • Women ages 21 to 64 who had cervical cytology performed every three (3) years • Women ages 30 to 64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every five (5) years	**Informational Only**	MDHHS Data Warehouse	Quarterly

(*) indicates that this measure is run with Symmetry

Minnesota: MCO Quality Improvement Websites

- Blue Plus: https://www.bluecrossmn.com/about-us/quality-improvement-program
- HealthPartners: https://www.healthpartners.com/hp/about/understanding-cost-and-quality/quality-improvement/index.html
- Itasca Medical Care: http://www.co.itasca.mn.us/657/Community
- Medica: https://www.medica.com/providers/quality-and-cost-programs/quality-improvement-program
- Hennepin Health: http://www.hennepinhealth.org/quality
- PrimeWest: https://primewest.org/annual-report
- South Country Health Alliance: http://mnscha.org/?page_id=5924
- UCare: https://www.ucare.org/About/Pages/QualityHighlights.aspx

[i] For example, managed care state quality strategies are required to include the state's plan to "identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status."(42 CFR 438.340 (b).

Nos. 19-840, 19-1019

In the Supreme Court of the United States

CALIFORNIA, ET AL., PETITIONERS / CROSS-RESPONDENTS

v.

STATE OF TEXAS, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

BRIEF FOR RESPONDENT / CROSS-PETITIONER STATES

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QUESTIONS PRESENTED

In 2010, Congress commanded almost every American to buy "minimum essential [health-insurance] coverage." Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119, § 1501(b) (codified at 26 U.S.C. § 5000A). In 2012, this Court held that "[t]he Federal Government does not have the power to order people to buy health insurance." *Nat'l Fed'n of Indep. Bus. v. Sebelius* (*NFIB*), 567 U.S. 519, 575 (2012). The Court upheld the law only because that mandate was attached to a revenue-producing penalty and thus could "reasonably be characterized as a tax." *Id.* at 574.

In 2017, Congress eliminated that tax. But it left undisturbed both the mandate itself and the ACA's inseverability clause—that is, the sections of the statute that declare the mandate "essential" to the ACA's operation. 42 U.S.C. § 18091(2)(I). The questions presented are:

1. Whether at least one respondent has standing to challenge the constitutionality of Congress's ongoing command that Americans buy health insurance.

2. Whether Congress may command Americans to buy health insurance other than as a trigger for a revenue-producing tax.

3. Whether, in light of Congress's decision in 2017 to eliminate any revenue-producing tax yet leave intact both the command and the inseverability clause, any provisions of the ACA remain operative.

4. Whether the district court properly declared the ACA invalid in its entirety and unenforceable anywhere.

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OPINIONS BELOW

The operative opinion of the court of appeals (Joint Appendix (JA) 374-489) is reported at 945 F.3d 355. The order of the court of appeals denying en banc rehearing (JA.490-91) is unreported. The opinion of the district court (Petition Appendix (PA)[1] 163a-231a) is reported at 340 F. Supp. 3d 579. The opinion and order entering partial final judgment (PA.117a-62a) is reported at 352 F. Supp. 3d 665.

JURISDICTION

The judgment of the court of appeals was entered on December 18, 2019 (PA.1a). The petitions of the state petitioners and the respondent/cross-petitioner States were granted on March 2, 2020. This Court has jurisdiction under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Pertinent constitutional and statutory provisions are reproduced in the Joint Appendix.

INTRODUCTION

In 2010, Congress ordered millions of Americans to "ensure that [they] . . . [are] covered under minimum essential [health-insurance] coverage." 26 U.S.C. § 5000A(a). Those who refused to comply were subject to a tax penalty. *NFIB*, 567 U.S. at 519. Though this Court determined that this provision was best understood as an unconstitutional command compelling Americans to enter the insurance market, *id.* at 561, it nonetheless upheld the mandate because, as it then existed, it was

[1] Any reference to "PA" will refer to the appendix to the petition in 19-840.

"fairly possible" to construe the mandate as a tax. *Id.* at 563.

In 2017, Congress amended section 5000A to set the tax penalty for violating the mandate to zero. That change made it impossible to fairly interpret section 5000A as a tax. As amended, section 5000A lacks the "essential feature" of any tax: It raises no revenue. It further lacks the other common characteristics of taxes that *NFIB* described—namely, it does not result in payments to the Treasury, does not discriminate between those who file tax returns and those who do not, and is not enforced by the IRS. 567 U.S. at 554-55. Without these characteristics, section 5000A is an unadorned command to Americans to participate in commerce. Such a command is unconstitutional. *Id.*

Petitioners appear to recognize as much, devoting the bulk of their arguments to severability. But there, too, Congress has spoken. Congress has deemed the mandate "essential" to the ACA, particularly the Act's community-rating and guaranteed-issue components. 42 U.S.C. § 18091(2)(I). Without the mandate, Congress determined, these major reforms do not work. On this, Congress should be taken at its word. Without this "three-legged stool," *Halbig v. Burwell*, 758 F.3d 390, 409 (D.C. Cir. 2014), *vacated on other grounds*, No. 14-5018, 2014 WL 4627181 (D.C. Cir. Sept. 4, 2014), the ACA's core changes to the Nation's insurance markets disintegrate. Whatever the merits of the ACA's remaining major and minor provisions, they do not provide the near-universal healthcare coverage that the ACA's drafters attempted to create. *King v. Burwell*, 135 S. Ct. 2480, 2487 (2015). They too must fall. *Id.*

In the end, petitioners defend the ACA as good policy, citing the current pandemic. Not only are those

policy arguments incorrect, but they miss the point. Policy considerations cannot create Article I power. The ACA contains an unconstitutional command that can no longer be saved as a tax. The ACA itself insists that its other major health-insurance reforms rise and fall with this unconstitutional command. And those reforms were the core of the ACA. *See King*, 135 S. Ct. at 2486. The policy merits of the ACA can neither save section 5000A nor sever what Congress expressly conjoined. *See Bostock v. Clayton County*, No. 17-1618, 2020 WL 3146686, *3 (U.S. June 15, 2020) ("When the express terms of a statute give us one answer and extratextual considerations suggest another, it's no contest. Only the written word is the law.").

STATEMENT

I. Background and Statutory Framework

A. The ACA

In 2010, Congress passed the ACA to achieve three express goals: (1) "near-universal [health-insurance] coverage," (2) "lower health insurance premiums," and (3) "creat[ion] [of] effective health insurance markets." 42 U.S.C. §§ 18091(2)(D), (F), (I). To achieve these goals, Congress created a complex latticework of "closely interrelated" provisions resting on three key features. *NFIB*, 567 U.S. at 691 (dissenting op.). Those features, described as a "three-legged stool,"[2] are: (1) a requirement that Americans buy minimum essential health insurance, known as the "individual mandate"; (2) a guaranteed-issue provision; and (3) a community-rating provision. *Id.* Along with these three key provisions, the ACA includes numerous subsidiary provisions designed either to

[2] *Halbig*, 758 F.3d at 409.

effectuate Congress's vision of universal coverage or to offset its staggering costs.

1. Individual mandate

At the heart of the ACA is a directive—labeled a "requirement"—that each "applicable individual shall . . . ensure that the individual . . . is covered under minimum essential coverage." 26 U.S.C. § 5000A(a). This coverage obligation, known as the "individual mandate," commands most Americans to procure qualifying health insurance.

As originally passed, section 5000A(b) imposed a tax penalty on many "applicable individual[s]" who failed to comply with the individual mandate. Congress labeled this tax penalty a "[s]hared responsibility payment," *id.*, providing: "If a taxpayer who is an applicable individual . . . fails to meet the requirement of subsection (a) . . . then . . . there is hereby imposed on the taxpayer a penalty with respect to such failure[]." *Id.* § 5000A(b)(1).

Some individuals who were subject to the mandate's command were nonetheless always exempt from the tax penalty. *See id.* §§ 5000A(e)(1)-(5). Five classes of people, including the poor and members of "an Indian tribe," fell into this category. *Id.* Nevertheless, these individuals have always been required to obtain "minimum essential coverage" in order to "comply with [the] mandate, even in the absence of penalties." CONGRESSIONAL BUDGET OFFICE, KEY ISSUES IN ANALYZING MAJOR HEALTH INSURANCE PROPOSALS 53 (Dec. 2008), https://tinyurl.com/CBO2008Report (CBO 2008 REPORT). Congress's reason for subjecting many individuals to the mandate, but not to the tax penalty, was sensible: For many people, especially the poor, imposing a tax penalty for failure to comply with the mandate would be unjust.

Congress nevertheless required those individuals to enroll in ACA-compliant health insurance. A core purpose of the ACA was to prevent the emergency-room cost-shifting problem—where individuals without health insurance obtain uncompensated care in an emergency room, inevitably requiring medical providers to increase costs for insured persons. *See* 42 U.S.C. §§ 18091(2)(A), (F), (I). Congress therefore mandated that penalty-exempt individuals obtain coverage and offered them the means to satisfy the mandate through the Medicaid system, 26 U.S.C. §§ 5000A(f)(1)(A)(i)-(iii), but excepted them from the tax penalty if they failed to comply with the mandate, *id.* § 5000A(e)(1). This tracked a CBO recommendation, which found that "[m]any individuals" subject to the mandate, but not the penalty, would nonetheless comply with the mandate and obtain coverage "because they believe in abiding by the nation's laws." CBO 2008 REPORT at 53.

Indeed, the tax penalty was never intended to be the only factor that would encourage Americans to comply with the individual mandate. The CBO identified at least three major factors that would ensure compliance: (1) "personal values" and "social norms" that lead "[m]any individuals and employers [to] comply ... because they believe in abiding by the nation's laws"; (2) provisions that make compliance easier, such as subsidies and exemptions; and (3) penalties for noncompliance. *Id.* at 50-53.

Congress took advantage of all three. In 2010, Congress found that the insurance "requirement, together with the[se] other provisions" of the ACA would lead to universal healthcare coverage and lower health-insurance premiums. 42 U.S.C. § 18091(2)(F).

2. Guaranteed issue and community rating

Congress required individual Americans to buy health insurance to sustain the ACA's most sweeping changes: the guaranteed-issue and community-rating requirements. *See id.* §§ 300gg to gg-4. The guaranteed-issue provision mandates that health-insurance companies "accept every employer and individual in the State that applies for . . . coverage," regardless of preexisting conditions. *Id.* § 300gg-1(a). The community-rating provision prohibits health insurers from charging higher rates to individuals within a given geographic area on the basis of their age, sex, health status, or other factors. *See id.* §§ 300gg, 300gg-4(a).

As the United States conceded in *NFIB*, the guaranteed-issue and community-rating provisions cannot function alone. Per the United States, "in a market with guaranteed issue and community rating, but without a minimum coverage provision, 'many individuals would wait to purchase health insurance until they needed care.'" Br. for Fed. Gov't on Severability 45, *NFIB v. Sebelius*, 567 U.S. 519 (2012) (*NFIB* Br.) (quoting 42 U.S.C. § 18091(a)(2)(I)). This "adverse selection" problem—where only individuals who need care purchase insurance—would cause premiums to "go up, further impeding entry into the market by those currently without acute medical needs, risking a 'marketwide adverse-selection death spiral.'" *Id.* at 46; 42 U.S.C. § 18091(2)(J).

Congress imposed the individual mandate to prevent this "death spiral" by requiring healthy individuals to purchase insurance, thus enabling insurance companies to continue to issue policies to those already sick. *NFIB* Br. 45-46. The D.C. Circuit thus described the individual-mandate, guaranteed-issue, and community-rating

provisions as a "three-legged stool[:] remove any one, and the ACA will collapse." *Halbig*, 758 F.3d at 409.

Congress recognized as much when it passed the ACA. The ACA's text confirms that "[t]he requirement [to buy health insurance] is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." 42 U.S.C. § 18091(2)(I). As the United States conceded in *NFIB*, these findings "effectively serve[] as an inseverability clause." *NFIB* Br. 26.

That is because, as the United States has acknowledged, "the minimum coverage provision is necessary to make effective the ACA's guaranteed-issue and community-rating insurance market reforms." *Id.* at 26. "Congress's findings expressly state that enforcement of" community rating and guaranteed issue "without a minimum coverage provision would *restrict* the availability of health insurance and make it *less* affordable—the opposite of Congress's goals in enacting the Affordable Care Act." *Id.* at 44-45. This hazard is why Congress repeatedly described minimum coverage "as 'essential'" to "the guaranteed-issue and community-rating reforms" in the ACA's text. *Id.* at 46-47.

3. Other chief provisions

The ACA's other chief provisions reinforced the broad health-insurance coverage that Congress anticipated would result from the individual-mandate, guaranteed-issue, and community-rating provisions. First, Congress defined the minimum essential coverage that it directed Americans to buy as including numerous "essential health benefits," including "ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder

services," and several other costly services. 42 U.S.C. § 18022(b)(1) (capitalization altered).

Congress then obliged employers to provide insurance satisfying the minimum-essential-coverage requirements to employees. 26 U.S.C. § 4980H. This "employer mandate" requires employers of 50 or more full-time employees to offer health insurance that satisfies the individual mandate's requirements if any employee qualifies for a subsidy to comply with the mandate. *See Id.* The employer mandate applies to government employers. *Id.* An employer's failure to offer insurance results in a penalty of thousands of dollars per employee, per year. *Id.* §§ 4980H(a), (b), (c)(1); 79 Fed. Reg. 8544, 8544 (Feb. 12, 2014).

To reach individuals not covered under the employer mandate, the ACA also substantially expanded Medicaid to enable low-income individuals to meet the minimum-essential-coverage requirements. States Br. 6. This expansion required, as a condition for all Medicaid funding, 42 U.S.C. § 1396c, that participating States provide the minimum essential coverage required by the mandate to all individuals under 65 earning income below 133% of the poverty line, *id.* §§ 1396a(a)(10)(A)(i)(VIII), 1396u-7(b)(5), 18022(b). It also made two new populations eligible for Medicaid: individuals under age 26 who were enrolled in federally funded Medicaid when they aged out of foster care, 42 U.S.C. § 1396a(a)(10)(A)(i)(IX); and children ages 6 to 18 who were eligible for the Children's Health Insurance Program (CHIP) prior to the ACA, *id.* § 1396a(a)(10)(A)(i)(VII)). And the ACA required States to determine eligibility for most populations by a single metric—Modified Adjusted Gross Income (MAGI), *id.* § 1396a(e)(14)—thereby further adding to Medicaid rolls

by increasing the pool of persons who meet Medicaid's income thresholds.

Congress also used the individual mandate's minimum-essential-coverage requirement to define many other obligations throughout the ACA. For example, the minimum-essential-coverage requirement defines insurance companies' disclosure obligations to their customers, 42 U.S.C. § 300gg-15, and employers' disclosure obligations to the IRS, 26 U.S.C. § 6056. And Congress used the same requirement to trigger individuals' ability to access public insurance exchanges, 42 U.S.C. § 18081; their right to receive public subsidies to buy insurance, 26 U.S.C. § 36B; and their obligation to pay a tax penalty if they fail to do so, *id.* § 5000A(c).

4. Minor provisions

Finally, the ACA includes a number of minor provisions that were "[o]ften . . . the price paid for [a legislator's] support of a major provision," *NFIB*, 567 U.S. at 704 (dissenting op.). These minor provisions include "a number of provisions that provide benefits to the State of a particular legislator," *id.*; a tax on medical devices, 26 U.S.C. § 4191(a); a mechanism to issue compliance waivers to States, 42 U.S.C. § 1315; and regulations on the display of nutritional content at restaurants, 21 U.S.C. § 343(q)(5)(H).

B. Impacts to state expenditures, programs, and insurance markets

States primarily interact with the healthcare system and individual-mandate-driven obligations imposed by the ACA in three capacities: as Medicaid participants, as sovereigns that regulate local health-insurance markets, and as large employers that provide employees with health-insurance coverage.

Medicaid Participants. The individual mandate has substantially increased States' Medicaid rolls and costs. Many individuals have met and will continue to meet their individual-mandate obligations by participating in Medicaid. *See, e.g.*, CBO 2008 REPORT at 9-10; CBO, REPEALING THE INDIVIDUAL HEALTH INSURANCE MANDATE: AN UPDATED ESTIMATE, at 1, 3 (Nov. 8, 2017), https://tinyurl.com/CBO2017Report (CBO 2017 REPORT). This costs States money because "Medicaid is funded by both the state and federal governments," with costs "determined by the caseload—the volume or number of individuals served" and "cost per client." JA.93-94.

Alongside the ACA's other requirements, the individual mandate burdens States in several ways. It increases the cost of covering each Medicaid client by requiring costly services; requires Medicaid to cover new groups of people; and it requires States to determine Medicaid eligibility using a measurement (MAGI) that does not include an individual's assets or certain types of income. 42 U.S.C. § 1396a(e)(14). Rising healthcare costs caused by the ACA likewise result in higher state Medicaid expenses.

Sovereigns. The individual mandate's minimum-essential-coverage requirement and associated provisions have significantly curtailed what healthcare policies States can adopt. Before the ACA, the States carefully crafted programs to respond to the unique public needs and preferences of their populations. For example, multiple States created high-risk pools that "operated as an insurer of last resort for people when private insurers refused to issue coverage to them due to expensive anticipated medical costs." JA.175. These programs "effectively managed the health-insurance needs of high-risk individuals," JA.121, while "keep[ing] high-cost

individuals from driving up premiums for insurance purchasers of average or good health," JA.175. *See* JA.110-11, 180. Similarly, States addressed cost-sharing for preventative services, treatment of preexisting conditions, and the ability to rescind health-insurance contracts for false statements in their comprehensive effort to make health-insurance markets work for everyone. JA.121-22.

The individual mandate's minimum-essential-coverage requirement, along with guaranteed issue and community rating, displaced virtually all of these policy choices. States instead now spend countless hours ensuring ACA compliance, including by creating programs to help individuals navigate the ACA, JA.108-13, providing direction to insurers, JA.122, and "reading and enforcing thousands of pages of federal regulations [and] guidance," JA.174. Likewise, States must maintain benefits programs for their employees that enable those individuals to comply with the mandate. 26 U.S.C. § 4980H.

The ACA harms States in other ways, too. Because of the ACA's burdensome regulations, many insurers have left state markets, scaled back their offerings, or otherwise limited their exposure to the individual market. JA.106, 137, 173-74. *Cf.* JA.117. United Health Care "withdrew from participation in the Arkansas exchange" "as a result of the ACA costs." JA.137. And "[i]n 2017, two major carriers"—Aetna and Blue Cross and Blue Shield—"exited Nebraska's individual market" because of significant financial losses, leaving only one major carrier in a State that had 30 major carriers in 2010. JA.173; *see also* JA.179 (explaining lack of competition), 132-34 (same). Even those States without significant carrier losses have had major carriers threaten to leave if the market continues to worsen. JA.106-08.

This flight of insurance carriers is part of a vicious cycle of rising premiums and healthcare costs. Premiums have consistently risen since the ACA was enacted. JA.118, 137. Indeed, the CBO's April 2018 "Budget and Economic Outlook: 2018 to 2028" estimates that, under current law, federal outlays for health-insurance subsidies and related spending will rise by about 60% over the next ten years. CBO, THE BUDGET AND ECONOMIC OUTLOOK: 2018 TO 2028 51 (April 2018), https://tinyurl.com/CBOBudgetEconOutlook-2018-2028. It is no surprise, then, that the only major carrier remaining in Nebraska's individual market raised premiums 31% in 2018 alone. JA.173-74.

The States are now attempting to do what they can to mitigate the harms caused by the ACA, re-stabilize markets, and make health insurance affordable. For example, in Missouri, a bipartisan committee voted to create the "Missouri Reinsurance Plan" to stabilize the individual-insurance market. *See* H.B. 2539, 99th Gen. Assem., 2d Reg. Sess. (Mo. 2017), https://tinyurl.com/Mo-HB2539-2017. Other States may find it necessary to enact similar programs if their insurance markets continue to deteriorate.

Large Employers. The ACA also affects States as large employers subject to the ACA's employer mandate. 26 U.S.C. § 4980H. Besides keeping up with rising healthcare costs generally, States have had to increase their plans' benefits to ensure that they meet "minimum essential coverage" requirements embedded in the individual and employer mandates. States have spent hundreds of millions of dollars to provide new benefits, such as coverage of dependents up to age 26 and no-cost-share coverage for certain preventative-care services. *See* JA.80-81, 139, 163-64, 183-84. They have also had to allow

employees who work between 30 and 40 hours per week to purchase insurance that complies with the mandate, increasing the number of individuals covered and, therefore, the States' costs. *See* JA.83, 160-62, 174. Some of these individuals would not purchase health coverage but for the individual mandate, increasing States' costs. JA.83. Moreover, due to medical inflation, States face the ACA's 40% excise tax if they cannot adjust or reduce plan costs (while still complying with the terms of the mandate). *See* JA.127-28. Alongside the minimum-coverage requirement, this steep surcharge makes it virtually impossible for States to avoid increased costs.

C. *NFIB v. Sebelius* and the Tax Cuts and Jobs Act of 2017

In 2012, before the individual mandate went into effect, this Court considered whether the Constitution empowered Congress to command individuals to buy insurance in the course of "[f]ederal regulation of the health insurance market." 42 U.S.C. § 18091(2)(H). The Court concluded that Congress could *not* do so as an exercise of its power to regulate interstate commerce. Though Congress may regulate the insurance market, the Court held, it may not "create the necessary predicate to the exercise of an enumerated power." *NFIB*, 567 U.S. at 560. Cognizant of its "duty to construe a statute to save it, if fairly possible," however, the Court upheld the minimum-essential-coverage requirement as a trigger for a tax, namely section 5000A's tax penalty. *Id.* at 574-75.

In 2017, Congress eliminated this Court's statutory "basis to adopt such a saving construction," *NFIB*, 567 U.S. at 575, by reducing the operative parts of section 5000A(c)'s tax penalty to "[z]ero percent" and "$0." Tax Cuts and Jobs Act of 2017 (TCJA), Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017). As petitioners

acknowledge, the TCJA left "every other provision of the ACA in place," including the individual-mandate, guaranteed-issue, and community-rating provisions, all of the other provisions that are triggered by the mandate, and the inseverability clause labeling the mandate essential. States Br. 36; *cf.* House Br. 39 (noting TCJA's "amendment of a single sentence"). Specifically, Congress preserved all of its earlier findings that the individual mandate "is an essential part of [the Government's] regulation of economic activity." 42 U.S.C. § 18091(2)(H).

As a result, the U.S. Code as it stands today includes the following: (1) a naked command to the American people to buy insurance and all associated obligations created by the ACA, (2) a penalty provision for failure to comply that raises no revenue, and (3) Congress's textual declarations that the individual mandate remains "essential" to the operation of the law.

II. Procedural History

The two individual and eighteen state respondents who brought this suit are among the many employers who continue to obey the law. The operative complaint documents the various harms they are suffering as a result. JA.29-70. They have pleaded five claims because the ACA, as amended, "forces an unconstitutional and irrational regime on the States and their citizens." JA.29, 61-67. Because the United States agrees that the minimum-essential-coverage requirement is unconstitutional, state petitioners intervened to defend the law. *Cf.* JA.18-19.

In December 2018, the district court granted respondents' request for a judgment declaring the individual mandate unconstitutional and the rest of the ACA inseverable from the mandate. PA.163a-231a. The court concluded that individual respondents have standing because they "are the object of the Individual Mandate"

and have been financially harmed by being compelled to buy insurance that they did not want. PA.181a-85a. Because Article III requires only one party to have standing, *Rumsfeld v. Forum for Acad. & Inst. Rights, Inc.*, 547 U.S. 47, 52 n.2 (2006), the district court did not address state respondents' standing. PA.184a-85a.

On the merits, the court concluded that the individual mandate was unconstitutional because the saving construction adopted by *NFIB* was no longer fairly possible after the TCJA. PA.185a-204a. As to remedy, the court noted that respondents (individual, state, and federal) "agree[d] . . . that the guaranteed-issue and community-rating provisions . . . are inseverable" from the individual mandate. PA.204a; *NFIB* Br. 44-54. The court focused on statutory text as well as the intent of Congress in 2010, which was the only valid and relevant expression of congressional intent as the 2017 amendment both rendered the statute unconstitutional and was passed through reconciliation, a procedure that reflects that Congress has reached agreement only on budgetary issues. Based on its analysis, the court determined that the remainder of the ACA was inseverable from the mandate as well. PA.204a-05a. At the request of the state petitioners, ROA.2667-73,[3] the district court entered a partial final judgment to allow immediate appeal and stayed litigation regarding respondents' remaining claims pending the outcome of that appeal. PA.117a-62a.

The Fifth Circuit broadly affirmed. In particular, the Fifth Circuit agreed that individual respondents have standing, JA.394, and further held that state respondents have standing based on their fiscal injuries as

[3] "ROA" refers to the record on appeal in *United States v. Texas*, No. 19-10011 (5th Cir.).

employers, JA.406. Without deciding whether the mandate injured States' sovereign rights to enforce their own laws, the Fifth Circuit concluded that "[t]he record is replete with evidence that the individual mandate itself has increased" state respondents' compliance costs, which satisfied Article III. JA.407-10 & nn.27-28. It then agreed with the district court on the merits, concluding that the individual mandate is unconstitutional. JA.414.

The Fifth Circuit declined to affirm, however, the district court's conclusion that the remainder of the ACA is inseverable from the unconstitutional mandate. The circuit court noted that the United States "ha[d] shifted their position on [severability and remedy] more than once." JA.386. At oral argument, the United States argued that under *Gill v. Whitford*, 138 S. Ct. 1916 (2018), remand was necessary because the appropriate remedy "should only reach ACA provisions that injure" respondents. JA.446. Because this remedial argument "came as a surprise" to state respondents, the Fifth Circuit ordered the district court to consider this new argument—including whether it was "timely raised"—in the first instance. JA.447.

SUMMARY OF ARGUMENT

I. The Fifth Circuit correctly applied this Court's well-established standing precedent. Indeed, petitioners do not even challenge most of its analysis. That the law requires individual respondents to purchase costly ACA-compliant healthcare coverage that they do not want satisifes Article III. Far from relying on a "chain of speculative inferences" (House Br. 25), state respondents also demonstrated standing by presenting reams of evidence below about the economic costs they have incurred due to the mandate and the obligations it triggers. That evidence is both uncontroverted and

consistent with the findings of the Congressional Budget Office. Such an economic harm satisifies Article III.

II. The ACA's individual mandate is unconstitutional. This Court already held in *NFIB* that the mandate's most natural reading is a command to buy insurance, and under that reading violates the Commerce and the Necessary and Proper Clauses. Because the mandate raises no revenue, it can no longer be read as a tax. The most natural reading is now the only permissible reading. Though this Court normally will construe a statute to avoid constitutional doubt, "[n]o matter how severe the constitutional doubt, courts may only choose between reasonably available interpretations of a text." *Whitman v. Am. Trucking Ass'n*, 531 U.S. 457, 471 (2001).

III. Statutory text directs this Court to declare the remaining major and minor provisions of the ACA unconstitutional. Both Congress and the Department of Justice have repeatedly described the mandate as essential to the ACA's community-rating and guaranteed-issue provisions. And this Court has observed that those provisions "would not work" without the mandate. *King*, 135 S. Ct. at 2487. Likewise, the various other provisions in the ACA—both major and minor—cannot operate in the manner Congress intended without the three-legged stool that props up the ACA's essential features.

IV. The district court correctly applied its ruling nationwide. The United States not only forfeited any objection to the scope of relief, it *affirmatively argued* that declaratory relief would operate as a nationwide injunction, thereby rendering narrower relief unnecessary. Moreover, because of the way Medicaid functions, if any declaratory relief were to apply only to

state respondents, they would be required to subsidize the continued operation of ACA programs in the rest of the country. That perverse result would not alleviate the economic injuries that brought state respondents to court in the first place.

ARGUMENT

I. Respondents Have Standing.

As petitioners do not dispute, the Fifth Circuit applied the correct standard to determine whether respondents have standing, namely by asking whether respondents have an injury that (1) is "actual or imminent, not 'conjectural' or 'hypothetical,'" (2) is fairly trace[able] to the challenged action of the defendant," and (3) "likely . . . will be redressed by a favorable decision." JA.393 (quoting, *inter alia*, *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560-61 (1992)). This is not a high bar, "requir[ing] no more than *de facto* causality." *Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2566 (2019) (quoting *Block v. Meese*, 793 F.2d 1303, 1309 (D.C. Cir. 1986) (Scalia, J.)). Because "legislatures[] do not generally resolve massive problems in one fell swoop," this Court also considers whether different provisions of an integrated regulatory scheme have worked together to harm the plaintiff. *Massachusetts v. EPA*, 549 U.S. 497, 499, 524 (2007); *see also, e.g.*, *United States v. Windsor*, 570 U.S. 744, 755 (2013); *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 683 (1987).

Before the district court and the Fifth Circuit, respondents demonstrated real-world costs stemming from the individual mandate and the ACA more broadly, including increased administrative costs, healthcare expenses, and compliance costs. *See, e.g.*, JA.83, 160-62, 174.

Petitioners hardly bother to dispute most of the Fifth Circuit's standing analysis. Instead, petitioners make two specific assertions, neither of which has merit. First, they claim that respondents lack standing because the individual mandate is no longer enforced through its tax penalty. But this overlooks that compliance with the mandate triggers direct costs to respondents—whether the IRS collects a shared-responsibility payment or not. These costs, traceable directly to the mandate, suffice for Article III. Second, trying to avoid this result, petitioners then demand ever-more-granular evidence of state respondents' injuries-in-fact. This argument ignores the forfeiture of proof-related issues in the district court, misstates the record, and misapprehends the law.

A. Article III is satisfied because the individual respondents have standing.

For the reasons set out in the individual respondents' brief, the courts below correctly concluded that they have standing to prosecute this action. Since only "one party with standing is sufficient to satisfy Article III's case-or-controversy requirement," *Rumsfeld*, 547 U.S. at 52 n.2, that is all the Court needs to proceed to the merits.

B. State respondents have standing.

State respondents have standing to pursue this action twice over: first, because multiple parts of the ACA, including the individual mandate, inflict a straightforward pocketbook injury on the States; and second, because the ACA impinges on their sovereign rights to enforce their laws.

1. The ACA inflicts classic pocketbook injuries on the States.

The individual mandate increases state outlays and regulatory burdens, creating an injury-in-fact. Further,

the mandate imposes "[a] fiscal injury resulting from the effects of a federal policy on choices by third parties." States Br. 21 (citing *Dep't of Commerce*, 139 S. Ct. at 2565-66). State respondents have demonstrated both kinds of injuries and therefore have standing.

a. As the Fifth Circuit correctly determined, the record is "replete with evidence that the individual mandate itself increased the cost[s]" to state respondents in at least six ways. JA.407.

First, for state respondents to have standing, there only needs to be a "substantial risk" of at least some additional costs as a result of the amended section 5000A. *Dep't of Commerce*, 139 S. Ct. at 2565. Evidence of such a risk was offered to Congress *before the amendment*, and presumably formed part of the basis of its decision. As the CBO has twice explained, at least some people obtain health insurance solely out of a "willingness to comply with the law." CBO 2017 REPORT at 1; *see also* CBO 2008 REPORT at 53 ("[m]any individuals" will comply with the mandate despite not being subject to a penalty). And the ACA specifically provides that enrolling in Medicaid—a program for which the States share coverage expenses for enrollees—complies with the mandate. 26 U.S.C. § 5000A(f)(1)(A)(ii). It follows that many individuals will do just what Congress expected and comply with the mandate by applying for and (if eligible) enrolling in Medicaid or CHIP. *See generally* 42 U.S.C. §§ 1396-1396w.

Second, as the Fifth Circuit explained, the individual mandate interacts with other provisions of the ACA to increase States' reporting costs. JA.407-10 & nn.27-28. Specifically, notwithstanding the TCJA, States must continue to comply with IRS reporting requirements occasioned by the ACA's mandate. *See* Pub. L. No. 111-148,

§ 1502(a), 124 Stat. at 250 (*codified at* 26 U.S.C. § 6055); *id.* § 1514(a), 124 Stat. at 256 (*codified at* 26 U.S.C. § 6056). These requirements have led to the ubiquitous Form 1095-B and 1095-C statements employees receive around tax time, filled with a series of check boxes indicating the months during which employees had ACA-compliant health coverage, so that employees filing their taxes can attest to being "covered under minimum essential coverage for such month," 26 U.S.C. § 5000A(a), and thus comply with the mandate.

These forms do not generate themselves. It is unquestionable that completing these required reporting forms for every employee "ha[s] been and continue[s] to be difficult and costly for employers."[4] *After AHCA Withdrawal, Eyes Turn to Executive Branch*, 25 No. 2 Coordination of Benefits Hndbk. Newsl. 8 (April 2017). Indeed, one commentator observed that the Form 1095 reporting requirements constitute the "greatest administrative burden imposed on employers since the Tax Payment Act of 1943 demanded payroll reporting."[5]

The IRS recognized the magnitude of this burden when it delayed implementation of the ACA's mandate-related reporting requirements for a year to allow employers "additional time to develop their systems for assembling and reporting the needed data."[6] As the IRS specifically explains, these returns are used in part "by

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[4] That state respondents have not precisely quantified these costs is irrelevant. That there is demonstrably *some* cost is enough. *See Dep't of Commerce*, 139 S. Ct. at 2565 (finding standing based on loss of unspecified federal funding).

[5] Adam Okun, Reporting Acrobatics, https://frenkelbenefits.com/blog/2015/07/20/reporting-acrobatics/ (July 20, 2015).

[6] IRS Notice 2013-45, 2013-31 I.R.B. 116, Q/A-1, at 2, https://www.irs.gov/pub/irs-drop/n-13-45.PDF.

individuals to show compliance with . . . the individual shared responsibility provision in section 5000A."[7]

These reporting requirements remain in place, even after elimination of the mandate's tax penalty. Employers can be sanctioned by the IRS for failing to submit adequate information. The current penalty for failure to file the necessary paperwork is $270 per employee with an annual cap of $3,275,500.[8] By regulation, the IRS may authorize the Department of Justice to seek enforcement of penalties assessed under the Internal Revenue Code in federal court. 26 C.F.R. § 301.7401–1.

In other words, state respondents are compelled under threat of government sanction to produce forms to enable individuals to comply with section 5000A's mandate. Publicly available sources reflect that the IRS "has been more aggressive recently in [enforcing] ACA reporting failures and in assessing ACA-related penalties," even since the district court ruled. *See, e.g.*, Ogletree Deakins, *An IRS Holiday Gift: 2019 Affordable Care Act Reporting Relief* (Dec. 10, 2019), https://tinyurl.com/yaef5yb8. This type of pervasive enforcement establishes state respondents' standing. *Cf. Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 164 (2014) ("[P]ast enforcement against the same conduct is good evidence that the threat of enforcement is not 'chimerical.'").

Third, and relatedly, the ACA forces state respondents to spend significant time, effort, and money to

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[7] IRS, *Questions and Answers on Information Reporting by Health Coverage Providers (Section 6055)*, https://tinyurl.com/hw64ex2 (last updated Apr. 3, 2020).

[8] IRS, *Information Reporting by Applicable Large Employers*, https://tinyurl.com/y9klkuza (last updated Apr. 3, 2020).

ensure that they meet the ACA's vast and complex rules and regulations. *See* JA.152-53, 174, 190-91.[9]

Fourth, the employer mandate—which is designed to ensure that most individuals satisfy the individual mandate through employer-sponsored insurance—forces state respondents to spend millions of dollars on expanded employee health-insurance coverage. Under the employer mandate, States must offer their full-time employees (and qualified dependents) "minimum essential coverage under an eligible employer-sponsored plan," or else pay a substantial tax penalty. 26 U.S.C. § 4980H(a). State respondents have complied with this mandate to avoid the penalty—but at significant cost. Texas has already spent $473.2 million in fiscal years 2011 through 2017 to provide new ACA-mandated employee health-insurance benefits. JA.86. Missouri estimated that keeping its Consolidated Health Care Plan compliant with the ACA would cost "nearly $3 million" in 2019, beyond millions already spent. JA.163. All state respondents are incurring these costs. *See, e.g.*, JA.184 (net financial impact to South Carolina from providing expanded ACA coverage from 2011 through 2017 was $29.2 million), 139, (Kansas); 186-90 (South Dakota). These are archetypal economic injuries that establish standing.

Fifth, the ACA requires States to expand Medicaid eligibility to allow low-income Americans to meet the individual mandate, thereby increasing States' Medicaid expenditures. Under the ACA, States must determine Medicaid eligibility using MAGI. *See* 42 U.S.C. § 1396a(e)(14). This statutory command adds hundreds

[9] Because the ACA's regulations carry significant penalties for noncompliance, the assertion by certain amici that no federal agency could bring an enforcement action against state respondents is mistaken. *See* Br. of Samuel Bray et al. at 3-4.

of thousands of individuals to state respondents' Medicaid rolls. *See* JA.91, 98-103, 152-54, 146-50.[10] So, too, does the ACA's command that States add to Medicaid individuals previously in foster care or CHIP. *See, e.g.*, JA.88-89, 91. This expansion of Medicaid rolls, occasioned by provisions designed to promote compliance with the individual mandate, predictably adds to state respondents' healthcare costs. *Dep't of Commerce*, 139 S. Ct. at 2566 (endorsing standing based "on the predictable effect of Government action on the decisions of third parties").

Finally, the ACA causes a pocketbook injury by forcing States to spend funds—and, in many instances, change state law—to fix problems, including market instability and rising healthcare costs, directly caused by the ACA in general and the individual mandate in particular. The ACA pressures States to stave off runaway healthcare costs, counter the threat of major insurance companies leaving the market, *and* otherwise minimize the ACA's harmful effects. *See, e.g.*, JA.106-08 (noting increase in insurer threats). States may do nothing and bear the ACA's full budgetary brunt, or they may enact new laws at substantial cost that they would not have but for the ACA's effects. Either way, States suffer an injury. *Cf. New York v. United States*, 505 U.S. 144, 188 (1992). Even if all the costs were avoidable, a forced choice between incurring financial costs and changing the law is an injury sufficient to support standing. *See*

[10] Indeed, the U.S. House conceded in the Fifth Circuit that "a State has standing to challenge a federal policy that *itself* expands the pool of beneficiaries eligible for a state benefit." House Br. 33, *Texas v. United States*, 945 F.3d 355 (5th Cir. 2019). This confirms the States' standing, as no one doubts that the MAGI provision expands Medicaid eligibility. *See Alaska Airlines*, 480 U.S. at 683.

Thomas v. Union Carbide Agric. Prods. Co., 473 U.S. 568, 582 (1985) (citing *Allen v. Wright*, 468 U.S. 737 (1984)); *see also Texas v. United States*, 809 F.3d 134, 157 (5th Cir. 2015) ("[T]reating the availability of changing state law as a bar to standing would deprive states of judicial recourse for many *bona fide* harms."), *aff'd by an equally divided court*, 136 S. Ct. 2271 (2016).

b. Petitioners neither challenged the factual sufficiency of this evidence nor offered contrary proof in the district court. JA.398. Instead, petitioners argued on appeal that respondents failed to present sufficiently granular evidence that the individual mandate caused their fiscal injury absent the now-zeroed tax penalty. *E.g.*, States Br. 22 (raising evidentiary objections), House Br. 28 (same). This argument fails for at least three reasons.

First, petitioners' myopic focus on the collection of the individual shared-responsibility payment as the only means of enforcement takes *NFIB* out of context. *See, e.g.*, States Br. 27 (quoting *NFIB*, 567 U.S. at 574). The individual mandate was not yet effective in 2012. 26 U.S.C. § 5000A(a). Standing analysis in such a pre-enforcement challenge focuses on the extent to which there is a "credible threat of prosecution" under the challenged statute. *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 298 (1979); *accord Susan B. Anthony List*, 573 U.S. at 159. In 2012, the only threat of prosecution was through the tax penalty, which this Court construed as a "lawful choice" between buying insurance or paying the tax. *NFIB*, 567 U.S. at 574. But this "is not a pre-enforcement challenge." JA.402. The individual mandate has been in effect for more than five years. As a result, the question is not how the United States threatened enforcement in 2012. Instead, the question is whether and

through what means the United States *has* enforced and continues to enforce the mandate today.

Second, because the mandate is in force, the Fifth Circuit properly looked not only to the costs imposed by section 5000A but also to the costs "created in part by the individual mandate's practical *interaction* with other ACA provisions." JA.410 n.29. Because "legislatures[] do not generally resolve massive problems in one fell swoop," courts consider whether different provisions of an integrated regulatory scheme have worked together to harm the plaintiff. *Massachusetts*, 549 U.S. at 499, 524; *see also, e.g.*, *Windsor*, 570 U.S. at 755; *Alaska Airlines*, 480 U.S. at 683.

Petitioners' contrary assertions depend on the incorrect premise that because the mandate lacks a specific penalty, it is not enforced. Almost since the Founding, this Court has recognized that "[a] law is an expression of the public will; which, when expressed, is not the less obligatory, because it imposes no penalty." *Ware v. Hylton*, 3 U.S. (3 Dall.) 199, 212 (1796); *see also, e.g.*, *Groves v. Slaughter*, 40 U.S. (15 Pet.) 449, 457 (1841). The law includes many instances where statutes are enforced through means other than direct penalties—*e.g.*, preemption provisions, statutes of limitations, self-executing treaties, and statutory definitions. A party suffering injury from such provisions alone or in combination may challenge the statute. *Alaska Airlines*, 480 U.S. at 683.

This Court's decision in *Windsor* demonstrates as much. There, a taxpayer sought to challenge the Defense of Marriage Act, 28 U.S.C. § 1738C, in an action for a tax refund under the marital exemption from the federal estate tax, 26 U.S.C. § 2056(a). Under the U.S. House's view here, the taxpayer should not have been permitted

to challenge DOMA because her tax claim "ha[d] no connection" to DOMA, which was in a completely different title of the U.S. Code. House Br. 31. There was, however, "no dispute" that Ms. Windsor had standing because "being forced to pay [the allegedly unconstitutional] tax causes a real and immediate economic injury." *Windsor*, 570 U.S. at 755 (quoting *Hein v. Freedom from Religion Found., Inc.*, 551 U.S. 587, 599 (2007) (plurality op.)). Here, the state respondents' injury stems from the mandate and other provisions—all of which, unlike DOMA and the tax code, were specifically designed to work in tandem.

Nor can the petitioners' argument be reconciled with *Alaska Airlines*. There, a group of airlines challenged various provisions of the Airline Deregulation Act on the basis that a *different* provision involving a legislative veto was unconstitutional and inseverable. *Id.* at 680. This Court agreed that the legislative-veto provision was unconstitutional but found it severable. *Id.* at 683. Critically, at no point did this Court question the airlines' standing or otherwise express doubt that it had jurisdiction. Petitioners cite *Alaska Airlines* repeatedly in support of their severability argument, all while failing to realize that it confirms jurisdiction here.

The authorities cited by the U.S. House (at 32) are not to the contrary. The plaintiffs in *DaimlerChrysler Corp. v. Cuno* tried to use their status as *municipal* taxpayers to challenge their *state* taxes. 547 U.S. 332, 351-52 (2006). The Court refused to allow them to use a federal court's pendent jurisdiction under *United Mine Workers v. Gibbs*, 383 U.S. 715 (1966), to evade Article III standing requirements. *Cuno*, 547 U.S. at 353-54. *Cuno* says nothing about how to analyze standing where two federal statutes work together to harm a plaintiff.

And *Davis v. FEC* supports respondents because it requires courts to examine how a challenged statute works in practice when assessing a plaintiff's standing. 554 U.S. 724, 733-34 (2008). The Fifth Circuit did precisely that.

Third, the U.S. House's complaint (at 28) about state respondents' supposed "failure to introduce any supporting evidence" that a "single person . . . enrolled in Medicaid, CHIP, or state-employer insurance for the reasons the state plaintiffs posit" misstates both the standard of proof and the record. As state petitioners concede, "state respondents were not required to identify any 'specific' individual who would enroll because of the amended [s]ection 5000A," only that there was "a 'substantial risk' that at least one such person would make that choice, causing them cognizable fiscal harm." States Br. 24 n.15 (quoting *Dep't of Commerce*, 139 S. Ct. at 2565)). And state respondents *did* offer evidence of a "substantial risk," *Dep't of Commerce*, 139 S. Ct. at 2565, summarized above (at 21-24; *see also* JA.407-10 & nn.27-28).

In any event, the record is more than sufficient to assure this Court of its jurisdiction in the absence of contrary evidence from petitioners. *United States v. Students Challenging Regulatory Agency Procedures*, 412 U.S. 669, 689 & n.15 (1973) (plurality op.); JA.408 ("[A]s even counsel for the [petitioner] states admitted at oral argument, nobody challenged [state respondents'] evidence as conclusory" or otherwise insufficient "in the district court or in the [circuit] court."). State respondents offered extensive evidence of the impact of the ACA, including the individual mandate, on their management of their internal affairs, which the Fifth Circuit summarized at length. JA.407-10 & nn.27-28. That is all Article III requires.

2. The ACA prevents States from enforcing their own laws and policies.

State respondents also have standing because the ACA—both its core individual mandate and the provisions that work in tandem—prevents them from applying their own laws and policies governing their own healthcare markets. Though the Fifth Circuit did not reach this ground because it found standing based on the States' pocketbook injuries, this Court has discretion to "affirm on any ground supported by the law and the record." *Upper Skagit Indian Tribe v. Lundgren*, 138 S. Ct. 1649, 1654 (2018).

It is well established that States have a sovereign interest in "the power to create and enforce a legal code." *Alfred L. Snapp & Son, Inc. v. Puerto Rico ex rel. Barez*, 458 U.S. 592, 601 (1982). Thus, whenever "a State is enjoined by a court from effectuating statutes enacted by representatives of its people, it suffers a form of irreparable injury." *Maryland v. King*, 567 U.S. 1301, 1301 (2012) (Roberts, C.J., in chambers) (quoting *New Motor Vehicle Bd. of Cal. v. Orrin W. Fox Co.*, 434 U.S. 1345, 1351 (1977) (Rehnquist, J., in chambers)).

That irreparable injury is no less real when a federal law—not a federal court—prevents a State from implementing its own laws and policy preferences. *Alfred L. Snapp & Son, Inc.*, 458 U.S. at 601; *see also, e.g.*, *Wyoming ex rel. Crank v. United States*, 539 F.3d 1236, 1242 (10th Cir. 2008) (applying *Snapp*).

The ACA's myriad requirements do just that. For example, Texas, among other states, established and operated high-risk insurance pools that "effectively managed the health-insurance needs of high-risk individuals." JA.121; *see also* Tex. Ins. Code §§ 1506.001-.205 (repealed 2015). These pools explicitly addressed difficult

and contentious issues such as the treatment of preexisting conditions and scope of coverage. *See* Tex. Ins. Code § 1506.155 (repealed 2015). But States like Texas can no longer craft their own solutions to these tricky policy issues. Instead, the ACA requires States to regulate the insurance market as the federal government sees fit.

II. The Individual Mandate Is Unconstitutional.

The Fifth Circuit correctly held that section 5000A is unconstitutional. Petitioners acknowledge that the only reason that the Court was able to uphold the mandate in 2012 was because it then bore the indicia of a tax. States Br. 8-9; House Br. 5. The TCJA squarely eliminated the features on which this Court relied in *NFIB*, and with it, the availability of the saving construction. Petitioners and their flurry of amici barely even attempt to defend the mandate's constitutionality, focusing entirely on severability. To the extent they muster a defense of the mandate, they misstate the law.

A. *NFIB* held that the Commerce Clause and the Necessary and Proper Clause do not permit Congress to mandate the purchase of health insurance.

In *NFIB*, this Court squarely held that Congress may not use its power to regulate interstate commerce to order Americans to buy health insurance—as it purported to do in section 5000A—any more than it can order them to buy a new car or broccoli. 567 U.S. at 547-61 (Roberts, C.J.) (holding law also exceeded power under Necessary and Proper Clause); *id.* at 657 (dissenting op.). Though Congress has "broad authority" to "regulate existing commercial activity," that authority does not extend to compelling individuals to create

commercial activity. *Id.* at 549, 552 (Roberts, C.J.); *id.* at 649-50 (dissenting op.).

The only reason that section 5000A survived was because it was "fairly possible" to read its minimum-essential-coverage mandate as the trigger for a tax. *Id.* at 563 (Roberts, C.J.). Key to that construction was that section 5000A, as a whole, had the "essential feature of any tax: It produces at least some revenue for the Government." *Id.* at 563-64 (citing *United States v. Kahriger*, 345 U.S. 22, 28 n.4 (1953), *overruled in part on other grounds*, *Marchetti v. United Sates*, 390 U.S. 39 (1968)).

Petitioners maintain that because this Court once found the mandate reasonably characterized as a tax, it must always be so understood. House Br. 15; *cf.* States Br. 27. But this Court's "interpretative decisions" are "subject (just like the rest) to congressional change." *Kimble v. Marvel Entm't, LLC*, 135 S. Ct. 2401, 2409 (2015).

Congress has now removed an essential feature on which this Court relied in characterizing section 5000A as a tax—the revenue-producing shared-responsibility payment—while retaining the features that made it an unconstitutional command. *Compare NFIB*, 567 U.S. at 566 (Roberts, C.J.), *with* 26 U.S.C. § 5000A(b). Whether this Court can preserve this unconstitutional command through a saving construction now is a separate question, which must be analyzed under the text as it currently exists. *Cf. Gross v. FBL Fin. Servs., Inc.*, 557 U.S. 167, 173-78 (2009).

B. In light of the TCJA, it is no longer "fairly possible" to save the mandate as a tax.

The TCJA removed the textual hook that allowed this Court to construe the mandate as a tax. The Tax Clause grants to Congress the power to "lay and collect Taxes

. . . to pay the Debts and provide for the common Defence and general Welfare of the United States." U.S. CONST. ART. I, § 8, cl. 1. But no matter Congress's goals, a statute is only valid under the Tax Clause if it is "productive of some revenue" for the Government. *Sonzinsky v. United States*, 300 U.S. 506, 514 (1937). Following the 2017 amendment, the provision no longer produces revenue, so the saving construction adopted in *NFIB* is no longer available. *Cf.*, *id.*; *In re Kollock*, 165 U.S. 526, 536 (1897). Petitioner makes three arguments to the contrary. None has merit.

First, contrary to the U.S. House's assertion (at 15), section 5000A did not forever become a tax because *NFIB* held that the 2010 version could be reasonably characterized as such. When a statute materially changes, this Court is free to once again interpret the statute given that change. *Kimble*, 135 S. Ct. at 2409. In *NFIB*, in order to save the mandate from unconstitutionality, 567 U.S. at 564, 566 (Roberts, C.J.), this Court construed the combination of a mandate to buy minimum essential coverage with a tax penalty to create a tax, *id.* at 570 (same). But the canon of constitutional avoidance does not permit this Court to take a view of the statute that is not a "reasonably available interpretation[] of [its] text." *Whitman*, 531 U.S. at 471; *Boumediene v. Bush*, 553 U.S. 723, 787 (2004).

In its post-amendment form, section 5000A contains no revenue-producing penalty, and thus cannot reasonably be viewed as tax—or as a choice between buying insurance or paying a tax. *Contra* House Br. 16; State Br. 27. As amended, it is "fairly possible" to interpret section 5000A only as a "command to buy insurance." *NFIB*, 567 U.S. at 574 (Roberts, C.J.). Far from an "implausible" construction, House Br. 17, this has always been the

most "natural[]" reading of the individual mandate. *NFIB*, 567 U.S. at 574 (Roberts, C.J.). Now it is the only possible reading.

Second, petitioners assert that because section 5000A lacks an enforcement provision, it is hortatory and no longer depends on an enumerated power. States Br. 32; House Br. 15. But neither component of this assertion is true. The individual mandate is written with the imperative "shall," which, according to petitioner's own authority, "is a word of command, and one which has always or which must be given a compulsory meaning: denoting obligation." BLACK'S LAW DICTIONARY 1499 (9th ed. 2009); States Br. 30. As petitioners' authority explains, the best meaning of "shall" is "the mandatory sense that drafters typically intend." BLACK'S LAW DICTIONARY 1499.

Even if "shall" could be seen as hortatory, Congress has no police power; it cannot do *anything* without an enumerated power. *See, e.g.*, *United States v. Morrison*, 529 U.S. 598, 617-18 (2000); *id.* at 639 (Souter, J., dissenting) ("The premise that the enumeration of powers implies that other powers are withheld is sound."). That Congress has purported to pass (supposedly) nonbinding laws and concurrent resolutions that fall outside the scope of its enumerated authority "does not, by itself, create power" to do so. *Medellin v. Texas*, 552 U.S. 491, 531-32 (2008).

Third, the individual mandate does not remain a tax for purposes of the Tax Clause merely because Congress chose to zero out section 5000A's formula rather than deleting it entirely. *Contra* House Br. 35-36; States Br. 32-33. This Court has already rejected the notion that Congress's label makes something a tax. As Chief Justice Roberts explained in *NFIB*, while Congress is free to label a provision a "tax" for some purposes, such as the

Anti-Injunction Act, this Court's *constitutional* analysis regarding whether a provision is a tax and how it works is functional in nature. *See, e.g.*, *Okla. Tax Comm'n v. Jefferson Lines, Inc.*, 514 U.S. 175, 182-83 (1995) (discussing tax functionalism in Commerce Clause context); *Polar Tankers, Inc. v. City of Valdez*, 557 U.S. 1, 8-9 (2009) (Tonnage Clause). And analyzed functionally, a tax of zero dollars is no tax at all. *E.g.*, *Dep't of Revenue of Montana v. Kurth Ranch*, 511 U.S. 767, 778 (1994) (noting taxes and fines share the critical features of "generat[ing] government revenues").

Petitioners' appeal to the Tax Clause and Necessary and Proper Clause is equally unavailing. They maintain that the zero-revenue mandate may be upheld because Congress "retain[ed] the structure of section 5000A in case Congress chose for policy reasons to raise the tax payment in the future."[11] House Br. 37. "Preserving that option would seem to be the most sensible and efficient course," state petitioners claim, because it would allow future Congresses to pass a tax more easily through the rules of budgetary reconciliation. States Br. 33.

This argument proves too much. The Necessary and Proper Clause enables Congress to employ convenient and useful means "for carrying into Execution [a] foregoing Power." U.S. CONST. art. I, § 8, cl. 18. But Congress cannot pass a noneffective law (*e.g.*, a zero-revenue "tax" structure), and justify an unconstitutional law (*i.e.*,

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[11] Petitioners fail to realize that to the extent this possibility is true, it only reinforces respondents' standing claims. After all, the federal government is free to raise or reinstate taxes retroactively. *United States v. Carlton*, 512 U.S. 26, 30 (1994). The prospect of a retroactive return of the mandate's tax penalty could explain in part why many Americans feel compelled to obey section 5000A even absent a penalty. *See generally* CBO 2008 REPORT.

the mandate) as necessary to execute a power it has, by definition, *not* exercised yet (*e.g.*, the power to tax). *See generally United States v. Kebodeaux*, 570 U.S. 387, 402 (2013) (Roberts, C.J., concurring in judgment) ("[T]he Necessary and Proper Clause authorizes congressional action 'incidental to [an enumerated] power.'") (quoting *M'Culloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 418 (1819)). Stated differently, an otherwise unconstitutional act of Congress cannot be "incidental to" the exercise of an enumerated power if Congress has not exercised that enumerated power in the first place. If Congress could pass a placeholder statute that might be used to exercise an enumerated power in the future, then justify an unconstitutional law as necessary and proper to that possible future exercise of congressional power, the Necessary and Proper Clause would not be an *incidental* exercise of power, but a freestanding one. That is not how our Constitution works. *Id.*

State petitioners' invocation of legislative ease (at 33-34) misses the point. Our Constitution made passing legislation, and particularly taxes, difficult *by design*. *E.g.*, THE FEDERALIST No. 62 (C. Rossiter, ed. 1961) (Madison); *INS v. Chadha*, 462 U.S. 919, 950 (1983).

Nor, contrary to state petitioners' claims (at 34), would adopting state respondents' position render unconstitutional taxes with deferred start dates or taxes intended to deter particular conduct. Congress typically passes taxes with deferred start dates to allow parties and agencies to adjust their behavior and to facilitate the administration of that tax. *See, e.g.*, *NFIB*, 567 U.S. at 567. Such a delay is at least an appropriate exercise of Congress's power under the Necessary and Proper

Clause.[12] Here, however, petitioners seek to expand that principle to the notion that Congress *has* passed a tax because it *could* pass a tax. They cite no authority for such a proposition.

Because the individual mandate is not currently a tax, it must be supported by some other enumerated power. *Morrison*, 529 U.S. at 617-18. The best and only remaining interpretation is that section 5000A commands Americans to buy insurance. And this Court has already held that "[t]he Federal Government does not have the power to order people to buy health insurance." *NFIB*, 567 U.S. at 575. Therefore, the mandate is unconstitutional.

III. The Mandate Is Not Severable.

Perhaps anticipating that this Court will hold the mandate unconstitutional, petitioners devote the greatest portion of their briefs (House Br. 38-50; States Br. 35-48) to urging this Court to sever the unconstitutional mandate from the ACA. But while this Court prefers to sever unconstitutional provisions from laws when possible, *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 328-29 (2006), the statutory text makes that impossible here. Congress deliberately designed the ACA and its goal of expanding healthcare coverage around the individual mandate. Without the mandate, the guaranteed-issue and community-rating provisions not only

[12] Whether a delayed tax is itself constitutional under the taxing power is a closer question, but one the Court need not reach. State respondents' claim does not turn, as state petitioners suggest (at 34), on whether a tax that currently raises no revenue is still a tax. It turns on whether a something that never purported to be a tax, and which now raises no revenue, can nonetheless be interpreted as a tax in order to justify an otherwise impermissible congressional action. It cannot.

malfunction, but result in the opposite of what Congress intended. Reply Br. for Fed. Gov't on Severability 10, *NFIB v. Sebelius*, 567 U.S. 519 (2012). Without this operational core, the ACA's other major provisions shift healthcare benefits and burdens across the sector with little rhyme or reason. Moreover, the miscellaneous ACA provisions would bear no resemblance to what Congress passed in the first place.

To avoid this result, petitioners alternate between focusing on Congress's intent and the text of the ACA. While this Court typically turns to congressional intent when analyzing severability, *Murphy v. NCAA*, 138 S. Ct. 1461, 1482 (2018); *Alaska Airlines,* 480 U.S. at 684; *Champlin Ref. Co. v. Corp. Comm'n of Okla.*, 286 U.S. 210, 234-35 (1932), the most important source to discern that intent is the text. *E.g.*, *Bostock*, 2020 WL 3146686, at *12 (rejecting argument based on Congress's decision *not* to amend text). And both intent and text show the mandate cannot be severed from (1) the ACA's community-rating and guaranteed-issue provisions, (2) its remaining major provisions, or (3) its minor or ancillary provisions.

A. The individual mandate is not severable from the guaranteed-issue and community-rating provisions.

1. Congress clearly expressed how it viewed the relationship between the individual mandate and the guaranteed-issue and community-rating provisions—and it did so in the ACA's text. For a decade, Congress has found that "[t]he requirement [to buy health insurance] is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." 42 U.S.C. § 18091(2)(I). This

Court takes such an inseverability clause as powerful evidence of Congress's intent and the appropriate remedy—here, refusing to sever the mandate. *See Hellerstedt v. Whole Women's Health*, 136 S. Ct. 2292, 2319 (2016).

For a decade, the United States has recognized section 18901 as "effectively . . . an inseverability clause." *NFIB* Reply Br. 10. With good reason. As the United States told this Court in *NFIB*, "the minimum coverage provision is necessary to make effective the [ACA's] guaranteed-issue and community-rating insurance market reforms." *NFIB* Br. 26. "Congress's findings expressly state that enforcement of [community rating and guaranteed issue] without a minimum coverage provision would restrict the availability of health insurance and make it less affordable—the opposite of Congress's goals in enacting the Affordable Care Act." *Id.* at 44-45. This is so because, "in a market with guaranteed issue and community rating, but without a minimum coverage provision, 'many individuals would wait to purchase health insurance until they needed care.'" *Id.* at 45 (quoting 42 U.S.C. § 18091(2)(I)). This "adverse selection" problem would cause premiums to "go up, further impeding entry into the market by those currently without acute medical needs, risking a 'marketwide adverse-selection death spiral.'" *Id.* (quoting Alan Monheit, et al., *Community Rating and Sustainable Individual Health Insurance Markets in New Jersey*, HEALTH AFFAIRS 167, 169 (July/Aug. 2004)); *see also* 42 U.S.C. § 18091(2)(J).

Congress based these findings on the States' significant experience. Prior to the ACA, "a number of States had enacted guaranteed-issue and community-rating requirements without a minimum coverage provision." *Id.* at 47. Overall, "premiums increased and coverage

decreased" in these States, the very adverse-selection problem the ACA expressly identifies. *NFIB* Br. at 48-50. Hence this grave warning in the Congressional Record: "'if [Congress] put' . . . guaranteed issue and community rating [on the insurance industry, it] 'must also mandate the individual to be insured or the market will blow up.'" *Id.* at 47 (quoting *Health Reform in the 21st Century: Insurance Market Reforms: Hearing Before the House Comm. on Ways & Means*, 111th Cong., 1st Sess. 9 (2009) (Prof. Uwe E. Reinhardt)); *id.* at 47-48 (collecting similar statements).

Sensibly, Congress concluded that the individual mandate's minimum-coverage requirement was "'essential'" to "the guaranteed-issue and community-rating reforms." *Id.* at 46-47. In sum, "without a minimum coverage provision, the guaranteed-issue and community-rating provisions would drive up costs and reduce coverage, the opposite of Congress's goals." *Id.* at 26. To prevent that result, the mandate orders "healthy individuals" into the health insurance market, "broaden[ing] the health insurance risk pool" to create "effective health insurance . . . products." 42 U.S.C. § 18091(2)(I). For that reason, the D.C. Circuit has described these three provisions as "like the legs of a three-legged stool[:] remove any one, and the ACA will collapse." *Halbig*, 758 F.3d at 409.

Section 18091 makes plain that Congress believed that the community-rating and guaranteed-issue provisions are "so interwoven" with the mandate "that they cannot be separated" or "stand" alone, *Hill v. Wallace*, 259 U.S. 44, 70 (1922), providing reason enough to declare those provisions inseverable based upon Congress's explicit statutory text. *NFIB*, 567 U.S. at 586 (Roberts, C.J.); *id.* at 645-46 (concurring op.); *see*

Bostock, 2020 WL 3146686, at *3, 12; *Zobel v. Williams*, 457 U.S. 55, 65 (1982). There could be no clearer statement of Congress's view that the mandate is not severable from the community-rating and guaranteed-issue provisions. That is what the district court concluded. So too should this Court.

2. Petitioners and their amici raise four arguments about why this Court should ignore Congress's intent as expressed in the text of the ACA. Each is meritless.

First, they assert that the "Court rendered the findings irrelevant" as a matter of law "when it held in *NFIB* that the minimum coverage provision as it was originally codified could not be sustained under the Commerce Clause." States Br. 42. That is contrary to the position taken by the United States for a decade, *NFIB* Reply Br. 26, and how this Court has treated congressional findings in the past—namely as fully operative parts of the statute. *See, e.g.*, *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 590 (1999) (deriving definition of "disability" from congressional findings).[13]

Second, state petitioners assert (at 44) that congressional findings should be considered evidence of only the Congress's intent in 2010 because Congress often does not change legislative findings. State petitioners can hardly support this bold claim: They cite only a statute related to the Y2K bug, 15 U.S.C. § 6601(a), while overlooking that the statute sought to address the risks of

[13] *Yazoo & M.V.R. Co. v. Thomas*, 132 U.S. 174, 188 (1889), is not to the contrary because it addressed how statutory findings should be treated as a matter of *Mississippi* law. ANTONIN SCALIA & BRYAN A. GARNER, READING LAW: THE INTERPRETATION OF LEGAL TEXTS 218 n.2 (2012) (citing 1 JOSEPH STORY, COMMENTARIES ON THE CONSTITUTION OF THE UNITED STATES § 459, at 326 (2d ed. 1858)).

that potential glitch. Y2K Act, Pub. L. 106-37, 113 Stat. 185 (1999). Both the statutory findings *and* its operative provisions ceased to have meaning after the Y2K threat necessarily expired in 2000.

But congressional findings, when subject to constitutional requirements of bicameralism and presentment, become the law of the land. This Court treats them as such, turning to those findings even when Congress has since amended a challenged provision. *E.g.*, *Coleman v. Court of Appeals of Maryland*, 566 U.S. 30, 37-39 (2012) (plurality op.); *Holder v. Humanitarian Law Project*, 561 U.S. 1, 29 (2010); *Gonzales v. Raich*, 545 U.S. 1, 20-21 & nn. 20 & 32 (2005); *Gen. Dynamics Land Sys., Inc. v. Cline*, 540 U.S. 581, 587-90 (2004); *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 29 n.28 (1976). As a legal matter, petitioners' argument is an appeal to desuetude, which has been discredited as a means of statutory interpretation. SCALIA & GARNER, *supra*, at 337 (noting that only one state "hold[s] that desuetude invalidates"). Moreover, Congress *does* amend statutory findings where they are no longer relevant. *E.g.*, ADA Amendments Act of 2008, Pub. L. 110-325, 122 Stat. 3554-55, § 3 (effective Jan. 1, 2009); Belarus Democracy and Human Rights Act of 2011, Pub. L. 112-82, 125 Stat. 1863.

Congress ostensibly agreed with these findings in 2017, as the TCJA changed the individual mandate while retaining these findings in full.[14] The TCJA merely reduced the individual mandate's associated tax-penalty formula to "[z]ero percent" and "$0," TCJA, Pub. L. 115-97, § 11081, 131 Stat. 2054, 2092 (2017). It did not alter the ACA's structure. Section 5000A(a) still requires "[a]n

[14] At the very least, by acting through a mechanism that is reserved solely for budgetary questions, Congress (as an entity) did not express a collective *disagreement* with these findings.

applicable individual" to "ensure that the individual . . . is covered under minimum essential coverage." And the ACA's express statutory findings—including, notably, that the mandate to purchase insurance is "essential" to the ACA's operation, 42 U.S.C. § 18091(2)(I)—also remain. These laws do not expire by passage of time, SCALIA & GARNER, *supra*, at 337, nor do the United States' concessions in *NFIB*, *NFIB* Reply Br. 26, and again here, *see* JA.384.

Third, petitioners maintain that the Court should disregard Congress's findings because they were no longer true by 2017. House Br. 46; States Br. 44 & n.17. This Court has occasionally disregarded congressional fact findings because it concludes the facts found are contrary to the record. *Gonzales v. Carhart*, 550 U.S. 124, 165-66 (2007). However, petitioners do not cite—and state respondents are not aware of—a single case where this Court disregarded findings from Congress *about how it intended the statute to function*.[15]

Finally, petitioners and their amici disregard the best evidence of *Congress's* intent, as codified in the ACA, in favor of cherry-picked statements that individual members of Congress made. Statements of individual

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[15] Petitioners and their amici further ask this Court to ignore Congress's findings based on economic studies neither raised before the district court nor included in the record. *E.g.*, House Br. 47-48 (citing Bipartisan Economic Scholars Cert-Stage Br. 20-21); Blue Cross Br. 7. As before, petitioners seek to add evidence to the record they declined to raise in district court; as before, this Court should refuse petitioners' attempt. *McCoy v. Massachusetts Inst. of Tech.*, 950 F.2d 13, 22 (1st Cir. 1991) ("It is hornbook law that theories not raised squarely in the district court cannot be surfaced for the first time on appeal."); *see also, e.g.*, *Pac. R.R. v. Ketchum*, 101 U.S. (11 Otto.) 289, 296 (1879) ("We take a case on appeal as it comes to us in the record, and receive no new evidence.").

legislators cannot change the meaning of the text adopted by both chambers of Congress and signed by the President. SCALIA & GARNER, supra, at 369-90 (discussing "[t]he false notion" that "floor speeches are worthwhile aids in statutory construction"); *contra* House Br. 17-18 (misciting SCALIA & GARNER). The only text that passed *those* hurdles says that the individual mandate is essential. 42 U.S.C. § 18091(2)(I); *NFIB* Reply Br. 26. That text must prevail, *Bostock*, 2020 WL 3146686, at *3, and this Court should conclude it cannot sever these provisions from the mandate.

B. The individual mandate is not severable from the other major provisions of the ACA.

The broader statutory language demonstrates that the individual mandate is not severable from the other major provisions of the ACA. The Court makes two inquiries to determine if an unconstitutional provision is inseverable. *First*, provisions are inseverable if they would not "function in a *manner* consistent with the intent of Congress" absent the unconstitutional provision. *Alaska Airlines*, 480 U.S. at 685. If the operation of the unconstitutional provision is "so interwoven with" the intended operation of other provisions "that they cannot be separated," none will stand. *Hill*, 259 U.S. at 70.

Second, provisions are inseverable if "the Legislature would not have enacted [them] . . . independently of" the provisions found unconstitutional, even if those provisions operated in some otherwise meaningful way. *Alaska Airlines*, 480 U.S. at 684. In examining this question, the Court looks not (as petitioners would ask) to isolated floor statements by individual members of Congress. Instead, it looks to whether the statute at issue "embodie[s] a single, coherent policy" or a "predominant purpose," and whether the unconstitutional provisions

are necessary to that purpose. *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999). To sever the "essential" individual mandate, 42 U.S.C. § 18091(2)(I), from the rest of the ACA's major provisions, both tests must be satisfied. *NFIB*, 567 U.S. at 692-94, 695 (dissenting op.).

The remaining major provisions are similarly inseverable because they effectuate the near-universal healthcare coverage that the mandate requires. These provisions are predominantly located in Title I of the ACA and are identified in detail in the *NFIB* dissent. 567 U.S. at 691-703. These provisions include "mandates and other requirements; comprehensive regulation and penalties; some undoubted taxes; and increases in some governmental expenditures, decreases in others." *NFIB*, 567 U.S. at 694 (dissenting op.). As the *NFIB* dissent noted, these provisions work "to balance the costs and benefits affecting each set of regulated parties." *Id.* Because that balance would be fundamentally altered by removing the individual mandate, the ACA's remaining major provisions are inseverable from that individual mandate. *Cf. Alaska Airlines*, 480 U.S. at 685; *New York*, 505 U.S. at 187.

C. The individual mandate is not severable from the minor provisions of the ACA.

Finally, for similar reasons, the district court correctly declared inseverable all minor provisions scattered throughout the 900-page ACA. *See NFIB*, 567 U.S. at 704-06 (dissenting op.). The ACA's minor provisions include, for example, a tax on medical devices, 26 U.S.C. § 4191(a), a mechanism for the Secretary to issue States compliance waivers, 42 U.S.C. § 1315a, regulations on the display of nutritional content at restaurants, 21 U.S.C. § 343(q)(5)(H), and "a number of provisions that

provide benefits to the State of a particular legislator"—which were "[o]ften . . . the price paid for [the legislator's] support of a major provision," *NFIB*, 567 U.S. at 704 (dissenting op.). Each of the ACA's minor provisions fails at least one part of the standard for assessing severability.

The first part of the severability analysis—whether the provisions would "function in a *manner* consistent with the intent of Congress" absent the invalid provisions, *Alaska Airlines*, 480 U.S. at 685—renders inseverable all miscellaneous "tax increases," like the medical-device tax, *NFIB*, 567 U.S. at 705 (dissenting op.). Without the ACA's major provisions, "the tax increases no longer operate to offset costs, and they no longer serve the purpose in [its] scheme of 'shared responsibility' that Congress intended." *Id.* This part also invalidates the ACA's lingering administrative measures, like provisions for States to obtain compliance waivers from the Secretary, *see* 42 U.S.C. § 1315a, since these would serve no meaningful purpose. *Cf. Williams v. Standard Oil Co. of La.*, 278 U.S. 235, 238, 243 (1929).

The second part of the standard—"whether Congress would have enacted the remaining provisions standing alone"—renders inseverable all other minor provisions, like the regulation of nutritional displays and the "provisions that provide benefits to the State of a particular legislator." *NFIB*, 567 U.S. at 693, 704 (dissenting op.). "There is no reason to believe that Congress would have enacted them independently," *id.* at 705, given that they are "mere adjuncts of the [main] provisions of the law," *Williams*, 278 U.S. at 243, and only (if at all) tangentially further the law's main purpose of near-universal affordable care.

The district court faithfully applied the above principles—including the statutory inseverability clause—to reach the correct conclusion: No portion of the ACA is severable from the mandate. The Fifth Circuit should have affirmed that judgment.

IV. The Declaratory Judgment Should Apply Nationwide.

The district court declared the individual mandate unconstitutional and inseverable from the remainder of the ACA. PA.232a. Consistent with state respondents' request for relief, that declaratory judgment carried nationwide effect. The Fifth Circuit should have affirmed that judgment in its entirety.

Instead, the Fifth Circuit vacated the district court's remedial determination based in part on a new argument that the federal government raised for the first time on appeal. In district court, the federal government expressly argued that the injunctive relief that state respondents had requested was not warranted because a declaratory judgment "would be adequate relief against the government," JA.337, and "a declaratory judgment is the functional equivalent of an injunction against the federal government," ROA.2722. At oral argument before the district court, the federal government again insisted that it would treat its declaration *like* the nationwide injunction that state respondents had requested.[16] That concession is consistent with how courts and commentators have viewed declarations against government actors. *Cf. Pub. Serv. Comm'n of Utah v. Wycoff Co.*, 344

[16] *Cf.* Oral Argument at 50:25-38, *Texas v. United States*, 945 F.3d 355 (5th Cir. 2019) (No. 19-10011), www.ca5.uscourts.gov/OralArgRecordings/19/19-10011_7-9-2019.mp3 (describing oral concession to the district court).

U.S. 237, 247 (1952); *Florida ex rel. Bondi v. U.S. Dep't of Health and Human Servs.*, 780 F. Supp. 2d 1307, 1315-16 (N.D. Fla. 2011); Samuel L. Bray, *The Myth of the Mild Declaratory Judgment*, 63 DUKE L.J. 1091, 1093 & n.9 (2014) (citing *inter alia* PETER H. SCHUCK, SUING GOVERNMENT: CITIZEN REMEDIES FOR OFFICIAL WRONGS 14-15 (1983)).

On appeal, the federal government changed its position and argued for a narrower remedy. The Fifth Circuit remanded in part to allow the district court to address this new argument in the first instance. JA.447. It should not have done so because arguments about scope of remedy raised for the first time on appeal are not properly before the appellate court. *See* DOUGLAS LAYCOCK, ET AL., MODERN AMERICAN REMEDIES: CASES AND MATERIALS 955 (4th ed. 2010) ("[T]he court and the other litigants relied by continuing to litigate; courts will not retry a case to correct an error that could have been corrected when it was made.") (citing *Kontrick v. Ryan*, 540 U.S. 443, 458 n.13 (2004)). Moreover, as Justice Thomas recently recognized in a different context, "it has long been the rule that a party may not appeal" from the conclusion of a district court if "the party consented to the judgment against it." *Microsoft v. Baker*, 137 S. Ct. 1702, 1717 (2017) (Thomas, J., concurring) (collecting cases). The Fifth Circuit should have affirmed the district court's remedial order rather than remanding to allow the United States to raise arguments that it could have raised—but did not raise—in district court.

Furthermore, the district court was correct to declare the entire ACA unconstitutional and unenforceable nationwide: Such a declaration is both equitable and necessary to "provide complete relief to the plaintiffs." *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979); *see also*

Madsen v. Women's Health Ctr., Inc., 512 U.S. 753, 765 (1994). Invalidating the ACA in a more limited geographic area would force citizens of the respondent States to heavily subsidize other States with their general tax dollars. For example, citizens and entities in the respondent States would have their tax dollars collected and spent in accordance with ACA programs such as the Prevention and Public Health Fund, *see* 42 U.S.C. § 300u-11, and the Community Health Center Fund, *see id.* § 254b-2. Yet none of those funds would be spent in the respondent States.

Less-than-nationwide relief would effectively allow a transfer of hundreds of millions of dollars from the prevailing States to either cross-respondent or non-party States. Far from redressing state respondents' injuries, such limited relief would *exacerbate* their injuries by forcing them to pay for programs and services they no longer receive because they prevailed in showing those programs and services to be inseverable from the unconstitutional individual mandate. Such a result is plainly inequitable.

CONCLUSION

The judgment of the court of appeals should be affirmed in part and reversed in part.

Respectfully submitted.

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JUNE 2020

Nos. 19-840 and 19-1019

In the Supreme Court of the United States

STATE OF CALIFORNIA, ET AL., PETITIONERS

v.

STATE OF TEXAS, ET AL.

STATE OF TEXAS, ET AL., PETITIONERS

v.

STATE OF CALIFORNIA, ET AL.

ON WRITS OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENTS

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QUESTIONS PRESENTED

1. Whether the plaintiffs have standing to challenge the application of certain provisions of the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119.

2. Whether, as a result of the elimination of the monetary penalty for noncompliance with the ACA's minimum-essential-coverage requirement, 26 U.S.C. 5000A(a), that requirement is no longer a valid exercise of Congress's legislative authority.

3. Whether, if the minimum-essential-coverage requirement is now invalid, the remainder of the ACA's provisions are inseverable from it.

PARTIES TO THE PROCEEDING

Petitioners in No. 19-840 are the States of California, Connecticut, Delaware, Hawaii, Illinois, Minnesota, New Jersey, New York, North Carolina, Oregon, Rhode Island, Vermont, Virginia, and Washington, the Commonwealth of Massachusetts, the District of Columbia, and Andy Beshear, the Governor of Kentucky, all of which intervened in the district court and were appellants in the court of appeals; and the States of Colorado, Iowa, Michigan, and Nevada, which intervened as defendants in the court of appeals. Respondents in No. 19-840 are the United States of America, the United States Department of Health and Human Services, the United States Internal Revenue Service, Alex Azar II, in his official capacity as Secretary of Health and Human Services, and Charles P. Rettig, in his official capacity as the Commissioner of the Internal Revenue Service, all of which were defendants in the district court and filed a notice of appeal but argued in defense of the district court's decision in the court of appeals; the United States House of Representatives, which intervened as a defendant in the court of appeals; and the States of Texas, Alabama, Arizona, Arkansas, Florida, Georgia, Indiana, Kansas, Louisiana, Mississippi by and through Governor Phil Bryant, Missouri, Nebraska, North Dakota, South Carolina, South Dakota, Tennessee, Utah, and West Virginia, and Neill Hurley and John Nantz, all of which were plaintiffs in the district court and appellees in the court of appeals.

Petitioners in No. 19-1019 are the States of Texas, Alabama, Arizona, Arkansas, Florida, Georgia, Indiana, Kansas, Louisiana, Mississippi by and through Governor Phil Bryant, Missouri, Nebraska, North Dakota, South Carolina, South Dakota, Tennessee, Utah, and

West Virginia, and Neill Hurley and John Nantz, all of which were plaintiffs in the district court and appellees in the court of appeals. Respondents in No. 19-1019 are the United States of America, the United States Department of Health and Human Services, the United States Internal Revenue Service, Alex Azar II, in his official capacity as Secretary of Health and Human Services, and Charles P. Rettig, in his official capacity as the Commissioner of the Internal Revenue Service, all of which were defendants in the district court and filed a notice of appeal but argued in defense of the district court's decision in the court of appeals; the States of California, Connecticut, Delaware, Hawaii, Illinois, Minnesota, New Jersey, New York, North Carolina, Oregon, Rhode Island, Vermont, Virginia, and Washington, the Commonwealth of Massachusetts, the District of Columbia, and Andy Beshear, the Governor of Kentucky, all of which intervened in the district court and were appellants in the court of appeals; and the States of Colorado, Iowa, Michigan, and Nevada, and the United States House of Representatives, which intervened as defendants in the court of appeals.

The State of Wisconsin was originally a plaintiff in the district court but later sought and was granted dismissal from the appeal.

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In the Supreme Court of the United States

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STATE OF TEXAS, ET AL., PETITIONERS

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STATE OF CALIFORNIA, ET AL.

ON WRITS OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENTS

OPINIONS BELOW

The amended opinion of the court of appeals (J.A. 374-489) is reported at 945 F.3d 355. The memorandum opinion and order of the district court granting partial summary judgment (Pet. App. 163a-231a) is reported at 340 F. Supp. 3d 579.[1] The order of the district court granting a stay and partial final judgment (Pet. App. 117a-162a) is reported at 352 F. Supp. 3d 665.

[1] Unless otherwise indicated, this brief refers to the appendix to the petition for a writ of certiorari in No. 19-840.

JURISDICTION

The judgment of the court of appeals was entered on December 18, 2019. The petition for a writ of certiorari in No. 19-840 was filed on January 3, 2020, and the conditional cross-petition for a writ of certiorari in No. 19-1019 was filed on February 14, 2020. The petitions were granted on March 2, 2020. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Pertinent constitutional and statutory provisions are reproduced in the addendum to this brief. App., *infra*, 1a-24a.

STATEMENT

1. The Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119, established a framework of economic regulations and incentives that restructured the health-insurance and healthcare industries. See J.A. 376. Among many other provisions, Title I of the ACA, 124 Stat. 130, enacting 26 U.S.C. 5000A, see ACA § 1501(b), 124 Stat. 244, contains a "[r]equirement to maintain minimum essential coverage," 26 U.S.C. 5000A (emphasis omitted), which is colloquially known as the "individual mandate," *e.g.*, J.A. 375; see also ACA § 10106(b), 124 Stat. 909. Subsection (a) of Section 5000A provides that certain individuals "shall * * * ensure" they are "covered under minimum essential coverage." 26 U.S.C. 5000A(a). Subsection (b) imposes "a penalty," denominated as a "[s]hared responsibility payment," on certain taxpayers who "fail[] to meet the requirement of subsection (a)." 26 U.S.C. 5000A(b) (emphasis omitted). And subsection (c) specifies "[t]he amount of the penalty imposed" for noncompliance. 26 U.S.C. 5000A(c). As originally enacted, the

penalty was "calculated as a percentage of household income, subject to a floor based on a specified dollar amount and a ceiling based on the average annual premium the individual would have to pay for qualifying private health insurance." *National Fed'n of Indep. Bus.* v. *Sebelius*, 567 U.S. 519, 539 (2012) (*NFIB*); see ACA §§ 1501(b), 10106(b)(2) and (3), 124 Stat. 244, 909-910 (26 U.S.C. 5000A(c) (Supp. V 2011)).

In addition to the individual mandate, the ACA includes a number of other provisions addressing the health-insurance and healthcare sectors. For example, the "guaranteed-issue" provisions prohibit insurers from denying coverage because of an individual's medical condition or history. J.A. 376; see 42 U.S.C. 300gg-1, 300gg-3, 300gg-4(a). And the "community-rating" provisions prohibit insurers from charging higher premiums because of an individual's risk profile, including medical condition or history. J.A. 376; see 42 U.S.C. 300gg(a)(1), 300gg-4(b). Because the ACA prevented insurers from setting premiums based on risk, Congress expressly found that the individual mandate was "essential" to (among other things) the operation of the guaranteed-issue and community-rating provisions and that in tandem with other ACA provisions it would "broaden the health insurance risk pool." ACA §§ 1501(a)(2), 10106(a), 124 Stat. 243, 908 (42 U.S.C. 18091(2)(I)).

Other provisions enacted by Title I impose prohibitions on coverage limits, requirements to cover dependent children, and essential benefits packages for insurance plans. 42 U.S.C. 300gg-11, 300gg-14(a), 18022. Title I also created insurance exchanges to allow consumers to shop for insurance plans and provided subsidies and tax incentives. 42 U.S.C. 18031-18044 (creation of

insurance exchanges); 26 U.S.C. 36B, 45R, 4980H (tax changes). Other Titles of the ACA enacted a number of other changes, including expanding the Medicaid program (Title II, 124 Stat. 271), amending the Medicare program (Title III, 124 Stat. 353), enacting a range of prevention programs (Title IV, 124 Stat. 538), and imposing anti-fraud requirements (Title VI, 124 Stat. 684).

2. In *NFIB*, this Court addressed whether the individual mandate was a valid exercise of Congress's legislative authority. A majority of the Court concluded that the individual mandate could not be sustained as a valid exercise of Congress's authority under the Constitution's Commerce Clause, Art. I, § 8, Cl. 3, or Necessary and Proper Clause, Art. I, § 8, Cl. 18. *NFIB*, 567 U.S. at 547-561, 574 (opinion of Roberts, C.J.); *id.* at 649-660 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting (joint dissent)); see *id.* at 572 (opinion of the Court). As the Chief Justice explained, "the power to regulate" commerce "assumes there is already something to be regulated." *Id.* at 550 (opinion of Roberts, C.J.). But "[t]he individual mandate," he observed, "does not regulate existing commercial activity": it "compels individuals to *become* active in commerce by purchasing a product." *Id.* at 552; see *id.* at 548-558. And although the Court's "jurisprudence under the Necessary and Proper Clause * * * ha[s] been very deferential to Congress's determination that a regulation is 'necessary,'" the Chief Justice explained that the individual mandate could not be sustained under that Clause because it purported to "create the necessary predicate to the exercise of an enumerated power." *Id.* at 559-560; see *id.* at 558-561.

A different majority of the Court determined, however, that the individual mandate could be construed as

an exercise of Congress's taxing power to save the mandate from unconstitutionality. *NFIB*, 567 U.S. at 563-574. The Chief Justice noted that "[t]he most straightforward reading of the mandate is that it commands individuals to purchase insurance." *Id.* at 562 (opinion of Roberts, C.J.). But in his opinion for the Court, the Chief Justice concluded that the shared-responsibility payment also could "reasonably be characterized as a tax" that the "Constitution permits." *Id.* at 574. The Court found that construction "reasonabl[e]" based on a "functional" analysis of the "'shared responsibility payment.'" *Id.* at 563, 565, 574 (brackets and citation omitted); see *id.* at 563-570. Among other things, the Court observed that the shared-responsibility payment "yield[ed] the essential feature of any tax: It produces at least some revenue for the Government." *Id.* at 564.

3. a. In December 2017, Congress enacted the Tax Cuts and Jobs Act (TCJA), Pub. L. No. 115-97, Tit. I, 131 Stat. 2054. Among other things, the TCJA eliminated the shared-responsibility payment as of January 1, 2019. § 11081, 131 Stat. 2092. It did so by reducing the amount of the required payment specified in Section 5000A(c) to zero. See *ibid.* (setting the percentage of income used to calculate the penalty at "Zero percent," setting the "applicable dollar amount" in 26 U.S.C. 5000A(c)(3)(A)—the figure used to calculate the minimum penalty—at "$0," *ibid.*, and eliminating the formula in 26 U.S.C. 5000A(c)(3)(D) (Supp. V 2017) for indexing that figure). The TCJA did not otherwise modify Section 5000A.

Following the TCJA's enactment, several plaintiffs, including Texas, 17 other States, and two individuals, brought this suit challenging the constitutionality of the

individual mandate and the enforceability of the remainder of the ACA. J.A. 383. Count I of their complaint alleged that Congress's elimination of the penalty abrogated the basis of *NFIB*'s saving construction of the individual mandate—as an exercise of Congress's taxing power—and they argued that the remainder of the ACA is inseverable from the mandate. *Ibid.*; see J.A. 61-63. Count I sought a declaratory judgment to that effect and a permanent injunction. J.A. 63. The other counts challenged the ACA and implementing regulations on other grounds and sought various declaratory and injunctive relief. J.A. 63-67. The plaintiffs also requested a preliminary injunction. Pet. App. 177a. The federal government agreed that the individual mandate is no longer constitutional and argued that the guaranteed-issue and community-rating requirements are inseverable from it. J.A. 383-384. California, 15 other States, and the District of Columbia intervened to defend the ACA. J.A. 384 & n.10.

b. The district court converted the plaintiffs' request for a preliminary injunction into a motion for partial summary judgment, over the intervenor States' objection. Pet. App. 165a; see J.A. 370-372. In an extensive opinion, the court denied the request for a preliminary injunction but granted the plaintiffs partial summary judgment on their claim (Count I) that the individual mandate is invalid and that all other ACA provisions are inseverable from it. Pet. App. 163a-231a. Following a detailed review of the ACA, *NFIB*, and the TCJA, *id.* at 165a-175a, the court held that the plaintiffs had standing to challenge the mandate, *id.* at 181a-185a, and that the mandate is no longer constitutional in light of the TCJA's elimination of the penalty, *id.* at 185a-204a. The court observed that *NFIB*'s reasoning

"compels the conclusion that the Individual Mandate may no longer be upheld under the Tax Power," and it "remains unsustainable under the Interstate Commerce Clause." *Id.* at 164a.

The district court additionally concluded that "the Individual Mandate is inseverable from the ACA's remaining provisions." Pet. App. 165a; see *id.* at 204a-231a. The court reasoned that "the 2010 Congress expressed through plain text an unambiguous intent that the Individual Mandate not be severed from" the rest of the ACA; that "this text-based conclusion is further compelled by two separate * * * decisions" from this Court—*NFIB* and *King* v. *Burwell*, 135 S. Ct. 2480 (2015); and that "the 2017 Congress had no intent with respect to the Individual Mandate's severability" that could displace that earlier intent. Pet. App. 208a, 214a, 228a; see *id.* at 208a-231a.

c. All parties agreed that the district court's decision should not take effect pending appeal. See D. Ct. Doc. 213-1, at 8-9 (Dec. 17, 2018); D. Ct. Doc. 216, at 6-8 (Dec. 21, 2018); D. Ct. Doc. 217, at 2 (Dec. 21, 2018). The court entered a partial final judgment as to Count I, declaring the individual mandate unconstitutional and inseverable from the remainder of the ACA, Pet. App. 116a, 120a-123a, but it stayed the judgment and further proceedings pending appeal, *id.* at 114a-115a, 120a, 123a-162a.[2]

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[2] In its brief addressing further proceedings, the federal government stated that issuance of a partial final judgment under Federal Rule of Civil Procedure 54(b) would be inappropriate in the case's then-current posture because no single claim had been completely resolved. D. Ct. Doc. 216, at 7-8, 13. The government understood the complaint's counts as asserting only a single claim under alternative legal theories and seeking various other forms of relief, which

4. a. The federal government and the intervenor States appealed. See J.A. 385. Several additional States moved unopposed in the court of appeals for permissive intervention, seeking to join California and the other States that had intervened in the district court to defend the ACA. Colorado et al. C.A. Mot. to Intervene 6-7 (Jan. 31, 2019); see J.A. 385 & n.12. The court of appeals granted their motion. 2/14/19 C.A. Order 2.

The United States House of Representatives also moved to intervene in the appeal as of right or, alternatively, for permissive intervention. House C.A. Mot. to Intervene 5-20 (Jan. 7, 2019); see J.A. 385. The court of appeals granted the House permissive intervention. 19-841 Pet. App. 113a-114a.

In addition, while the appeal was pending, the federal government notified the court of appeals that it had concluded that all of the ACA's remaining provisions are inseverable from the individual mandate. J.A. 385. The government advanced that position in the appeal. See Gov't C.A. Br. 36-49. The government, however, contended that any relief should be limited only to what is necessary to remedy the plaintiffs' own injuries. *Id.* at 26-29; see J.A. 385-386, 446-448.

b. A divided panel of the court of appeals affirmed in part and vacated in part. J.A. 374-448.

i. The court of appeals first concluded that at least the federal government and the intervenor States had

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the court had not addressed. *Ibid.* As the government explained in the court of appeals, however, the district court's issuance of a partial final judgment as to Count I "foreclosed any further remedial proceedings with respect to that count" and reflected a different view of the complaint's other counts as distinct claims. Gov't C.A. Br. 4 n.1. In light of that development, the government agreed that the court of appeals had jurisdiction. *Ibid.*

standing to appeal. J.A. 387-392. Turning to the district court's jurisdiction, the court of appeals determined that both the individual and State plaintiffs had standing to bring this lawsuit. J.A. 392-413. It agreed with the district court that "the undisputed evidence showed that the individual mandate caused" the individual plaintiffs two injuries—a "financial injury" of being forced to obtain insurance and an "increased regulatory burden"—which "a favorable judgment would redress." J.A. 396-397; see J.A. 396-406. The court of appeals additionally found that the State plaintiffs have standing because the ACA causes them "fiscal injuries as employers" subject to various ACA requirements. J.A. 406; see J.A. 406-413. But it observed that, "even if the state plaintiffs did not have standing, this case could still proceed because the individual plaintiffs have standing," J.A. 406 n.26, and vice versa, see J.A. 406 n.25.

On the merits, the court of appeals held that the individual mandate is no longer "a constitutional exercise of congressional power." J.A. 414; see J.A. 414-426. It observed that "[a] majority" of this Court in *NFIB* had held that the mandate could not be sustained under the Commerce or Necessary and Proper Clauses and had "save[d] the individual mandate from unconstitutionality" only by "[r]ead[ing]" the individual mandate "together with the shared responsibility payment * * * as a legitimate exercise of Congress' taxing power." J.A. 415, 417-418. "Now that the shared responsibility payment amount is set at zero" under the TCJA, the court of appeals reasoned, that "saving construction is no longer available." J.A. 419; see J.A. 419-426.

The court of appeals then turned to "whether, or how much of, the rest of the ACA is severable from" the individual mandate. J.A. 427. But the court did not decide that question. Instead, it "remand[ed] to the district court to undertake two tasks." *Ibid.*

First, the court of appeals determined that the district court had not undertaken the "analysis required by severability doctrine" under this Court's precedents. J.A. 430; see J.A. 444-445. The court explained that the severability inquiry here "involves a challenging legal doctrine applied to an extensive, complex, and oft-amended statutory scheme," and it was "not persuaded that the approach to the severability question set out in the district court opinion satisfie[d] that need." J.A. 434.

Second, the court of appeals directed the district court to consider the federal government's argument that relief should be confined to redressing the plaintiffs' injuries. J.A. 446-448. The court of appeals explained that "[t]he relief the plaintiffs sought in the district court was a universal nationwide injunction," and although the district court had not granted injunctive relief, it had entered "a judgment declaring the entire ACA 'invalid.'" J.A. 446. And the court of appeals asserted that "[t]he district court did not have the benefit of considering" the government's argument that "the declaratory judgment should only reach ACA provisions that injure the plaintiffs." J.A. 446-447. The court of appeals "agree[d]" with the federal government "that remand is appropriate for the district court to consider" that question "in the first instance." J.A. 447.

ii. Judge King dissented. J.A. 449-489.

Judge King concluded that none of the plaintiffs had standing to challenge the individual mandate. J.A.

452-467. She reasoned that the individual plaintiffs' asserted financial injury—the cost of obtaining health insurance—was "self-inflicted" because they could "disregard" the individual mandate "without consequence." J.A. 455, 461. She also concluded that the State plaintiffs lacked standing because the evidentiary record did not support their various alleged injuries. J.A. 462-467.

On the merits, Judge King concluded that the individual mandate remains constitutional. J.A. 467-474. "Now that Congress has zeroed out" the shared-responsibility payment, she reasoned, the individual mandate "does nothing," and merely "affords individuals the same choice individuals have had since the dawn of private health insurance, either purchase insurance or else pay zero dollars." J.A. 467-468.

As to severability, Judge King "agree[d] with much of" the majority's analysis but concluded that a remand was unnecessary. J.A. 474. She observed that "[s]everability is a question of law that [an appellate court] can review de novo," and, in her view, Congress's elimination of the shared-responsibility payment demonstrated that it "believed the ACA could stand in its entirety without the unenforceable coverage requirement." J.A. 474; see J.A. 474-488.

c. Following a request for a poll on whether to rehear the case en banc, the court of appeals denied rehearing. J.A. 490. Six of the 14 judges who voted would have granted rehearing en banc. J.A. 491.

SUMMARY OF ARGUMENT

I. The court of appeals correctly concluded that Article III jurisdiction exists over this case. The individual plaintiffs have shown that the ACA's insurance-reform provisions injure them by limiting their options with regard to insurance coverage and by raising their

costs. Accordingly, they have standing to challenge the enforcement of those provisions. And on the merits, they can claim that the reason those provisions cannot be enforced is because they are inseverable as a statutory matter from the individual mandate, which they contend is unconstitutional in light of the TCJA's elimination of the penalty. But the relief the Court orders should be limited to redressing the injury actually incurred—that is, the relief should reach only the enforcement of the ACA provisions that injure the individual plaintiffs.

II. The individual mandate no longer can be sustained as a valid exercise of Congress's Article I authority. A majority of this Court determined in *National Federation of Independent Business* v. *Sebelius*, 567 U.S. 519 (2012), that neither the Commerce Clause nor the Necessary and Proper Clause authorizes the mandate. The Court upheld the mandate only by adopting a saving construction of 26 U.S.C. 5000A, characterizing the mandate as the predicate to a tax. But Congress has now eliminated the tax, removing the basis for that construction.

The contrary arguments advanced by the intervenor States and House lack merit. Their contention that the mandate may still be viewed as the predicate to a tax of zero dollars is incorrect. Under *NFIB*'s functional approach, a statute that imposes no tax liability on anyone cannot be sustained as a tax. And the contention that the mandate may be upheld either because it is now simply precatory or because it still offers individuals a choice between obtaining insurance and refraining from doing so cannot be squared with the statutory text.

III. The individual mandate cannot be severed from the remainder of the ACA. Congressional findings incorporated into the ACA's text clearly indicate that Congress would not have adopted the guaranteed-issue and community-rating provisions absent the individual mandate's requirement to purchase insurance. This Court recognized the interrelatedness of these three provisions in *NFIB* and *King* v. *Burwell*, 135 S. Ct. 2480 (2015). And Congress's 2017 amendment does not alter the severability analysis because it left intact the critical statutory findings about the interconnectedness of these provisions—findings that were and remain the functional equivalent of an inseverability clause.

The ACA's remaining provisions are likewise inseverable, because it is evident that Congress would not have enacted them without the individual mandate and the guaranteed-issue and community-rating provisions. The *NFIB* joint dissent would have so held, and that conclusion is still equally valid today. Nothing the 2017 Congress did demonstrates it would have intended the rest of the ACA to continue to operate in the absence of these three integral provisions. The entire ACA thus must fall with the individual mandate, though the scope of relief entered in this case should be limited to provisions shown to injure the plaintiffs.

ARGUMENT

I. THIS COURT HAS JURISDICTION TO REACH THE QUESTIONS PRESENTED ADDRESSING THE MERITS AND SEVERABILITY

The court of appeals correctly concluded that this suit presents an Article III case or controversy. The individual plaintiffs have shown that they are injured by at least some ACA provisions—namely, various provisions regulating health-insurance plans that limit the

range and terms of plans the individual plaintiffs may obtain and that increase their costs of obtaining coverage. They thus have standing to challenge the enforcement of those provisions. And on the merits, they can argue that those insurance-reform provisions cannot be enforced because (1) those provisions (and indeed the entire ACA) are inseverable from the individual mandate, and (2) the mandate is now unconstitutional as a result of Congress's elimination in the TCJA of the penalty for noncompliance. The individual plaintiffs can make this merits argument regardless of whether they would have Article III standing to challenge the individual mandate by itself. But if successful, any remedy—whether a declaratory judgment or injunction—must be limited to enforcement of the insurance reforms and other ACA provisions that injure the individual plaintiffs.

A. The Plaintiffs Have Standing To Challenge Only Those ACA Provisions That Injure Them And May Seek Relief Only To Redress Their Own Cognizable Injuries

The plaintiffs bore the "burden of establishing their standing" by showing "'personal injury'" that is "'fairly traceable to the defendant's allegedly unlawful conduct and likely to be redressed by the requested relief.'" *DaimlerChrysler Corp.* v. *Cuno*, 547 U.S. 332, 342 (2006) (citation omitted). That showing must be claim-specific, because "standing is not dispensed in gross." *Town of Chester* v. *Laroe Estates, Inc.*, 137 S. Ct. 1645, 1650 (2017) (quoting *Davis* v. *FEC*, 554 U.S. 724, 734 (2008), in turn quoting *Lewis* v. *Casey*, 518 U.S. 343, 358 n.6 (1996)). "[A] plaintiff must demonstrate standing for each claim he seeks to press and for each form of relief that is sought." *Ibid.* (citation omitted).

So, too, any judicial "remedy must of course be limited to the inadequacy that produced the injury in fact that the plaintiff has established," *Cuno*, 547 U.S. at 353 (quoting *Lewis*, 518 U.S. at 357), and cannot go beyond redressing the plaintiff's own injury, see *Gill* v. *Whitford*, 138 S. Ct. 1916, 1929-1931 (2018); *Summers* v. *Earth Island Inst.*, 555 U.S. 488, 494-497 (2009). "The actual-injury requirement would hardly serve [its] purpose . . . of preventing courts from undertaking tasks assigned to the political branches, if once a plaintiff demonstrated harm from one particular inadequacy in government administration, the court were authorized to remedy *all* inadequacies in that administration." *Cuno*, 547 U.S. at 353 (quoting *Lewis*, 518 U.S. at 357) (brackets omitted). Longstanding principles of equity likewise limit relief to what is needed to redress the plaintiff's own injuries. See *Lewis*, 518 U.S. at 359-360; *Califano* v. *Yamasaki*, 442 U.S. 682, 702 (1979).

This Court's decisions accordingly make clear that a plaintiff injured by one action of a defendant—such as a particular practice, or a specific provision of law—may not seek redress against other actions that do not harm the plaintiff. For example, in *Lewis*—a suit by prisoners challenging various prison practices—this Court held that Article III permitted relief only to redress the one practice (regarding literacy services) that had been found to injure a named plaintiff. 518 U.S. at 358. The other practices the plaintiffs attacked "ha[d] not been found to have harmed any plaintiff in th[e] lawsuit." *Ibid.* The Court declined to consider the provisions allowing those practices and "eliminate[d] [them] from" the injunction the lower courts had issued. *Ibid.*

Similarly, in *Printz* v. *United States*, 521 U.S. 898 (1997), this Court held that certain provisions of a federal statute requiring state and local authorities to conduct background checks on prospective handgun purchasers were unconstitutional. *Id.* at 933-935. The plaintiffs—local officials required to conduct the background checks—attempted to leverage the invalidity of that requirement to challenge other provisions of the statute that did not apply to them, on the ground that they were inseverable from the background-check requirement. See *id.* at 934-935. The Court declined to consider that additional argument. *Id.* at 935. The plaintiffs' severability arguments concerning those other provisions raised "important questions," but the Court "ha[d] no business answering them" because those other provisions did not "burden" any plaintiff in the litigation. *Ibid.* The Court therefore "decline[d] to speculate regarding the rights and obligations of parties not before the Court." *Ibid.* The Court distinguished the situation before it from *New York* v. *United States*, 505 U.S. 144, 186-187 (1992), in which the Court, after holding invalid a statutory provision that affected the plaintiffs, then "address[ed] [the] severability" of other provisions of the statute that also "affected the plaintiffs." *Printz*, 521 U.S. at 935; see *Murphy* v. *NCAA*, 138 S. Ct. 1461, 1485-1487 (2018) (Thomas, J., concurring).

B. The Individual Plaintiffs May Challenge The ACA's Insurance-Reform Provisions As Inseverable From The Individual Mandate

The parties and courts below disputed the plaintiffs' standing to challenge the individual mandate. Compare, *e.g.*, J.A. 392-413 (court of appeals majority), Pet. App. 181a-185a (district court), with J.A. 452-467 (King,

J., dissenting). And neither court below comprehensively determined which if any other ACA provisions "actually injure the plaintiffs." J.A. 447 (remanding for the district court to consider the federal government's arguments addressing this issue). But at a minimum, as the government explained below, the individual plaintiffs have demonstrated standing to challenge certain interrelated insurance-reform provisions of the ACA that restrict their insurance options and raise their costs of obtaining coverage. See Gov't C.A. Br. 23-24. That is sufficient to establish Article III jurisdiction. And in pressing that challenge, the individual plaintiffs may advance, and this Court may consider, legal arguments that (1) the individual mandate is invalid and (2) all other ACA provisions, including the insurance-reform provisions that injure the individual plaintiffs, are inseverable from it.

1. The two individual plaintiffs presented evidence that they are injured by provisions of the ACA that preclude them from obtaining insurance plans they prefer and that increase their costs of obtaining coverage. The ACA contains a number of provisions that regulate the terms and premiums of health-insurance plans. Certain ACA provisions directly prescribe coverage requirements and essential benefits. See 42 U.S.C. 300gg-11, 300gg-14(a), 18022. And the guaranteed-issue and community-rating provisions, see 42 U.S.C. 300gg(a)(1), 300gg-1, 300gg-3, 300gg-4(a) and (b), limit insurers' ability to set premiums based on the health of the insured. Those requirements bar individuals from obtaining plans that do not meet the applicable criteria. And they operate to increase the cost of obtaining insurance for some individuals, such as relatively young and

healthy individuals, who otherwise could obtain less expensive coverage.

The individual plaintiffs are self-employed individuals who are subject to the ACA's insurance-reform provisions and are ineligible for subsidies to purchase health insurance. See J.A. 71, 75. One of the individuals, John Nantz, is the founder of a management-consulting business. J.A. 71. He averred in his sworn declaration that he is "young and in good health," has no dependents, and would prefer to obtain a high-deductible plan priced according to his actuarial risks—an option not available to him under the ACA. J.A. 73; see J.A. 71-73. The other individual, Neill Hurley, is the owner of a consulting business and is married with two dependent children. J.A. 75. He averred that, as a result of the ACA, his monthly premiums have increased dramatically, he has been unable to obtain a plan that would accept all of his family's health providers, and the quality of services from providers that accept his family's new plan is lower than it previously was. J.A. 76-77. Hurley stated that, were he "not limited to the plans provided through the federal health insurance marketplace," he "would purchase reasonably priced insurance coverage that allowed [him] to access care locally from [his] preferred service providers." J.A. 77.

The individual plaintiffs' factual averments of those financial and other consequences stemming from the ACA's insurance-reform provisions were considered in the district court, which adjudicated the plaintiffs' relevant claim in a summary-judgment posture without any conflicting evidence. And neither the evidence itself nor the district court's decision to resolve the case on summary judgment was challenged in the court of appeals or is challenged in this Court. See *Lujan* v. *Defenders*

of Wildlife, 504 U.S. 555, 561 (1992) ("[E]ach element" of standing "must be supported in the same way as any other matter on which the plaintiff bears the burden of proof, *i.e.*, with the manner and degree of evidence required at the successive stages of the litigation," including at the summary-judgment stage by "'set[ting] forth' by affidavit or other evidence 'specific facts.'") (citation omitted). The facts plaintiffs aver establish a cognizable injury traceable to the insurance-reform provisions. Because "[a]t least one plaintiff * * * ha[d] standing to seek * * * relief" from the application of the insurance-reform provisions, *Town of Chester*, 137 S. Ct. at 1651, the district court had jurisdiction over the plaintiffs' suit to that extent. And because "at least one" party in the appeal has standing to pursue that claim, neither the court of appeals nor this Court need examine whether the State plaintiffs may also seek the same relief. *Horne* v. *Flores*, 557 U.S. 433, 445 (2009). Although the court of appeals did not rely on that ground in holding that the district court had jurisdiction, that aspect of its judgment may be affirmed "on any ground permitted by the law and the record." *Dahda* v. *United States*, 138 S. Ct. 1491, 1498 (2018) (citation omitted).

2. In challenging the insurance-reform provisions, the individual plaintiffs may contend that (1) the individual mandate—which also applies to them—is now invalid and (2) all other provisions of the ACA are inseverable from it. Although those contentions also implicate other ACA provisions, they are the premises of the individual plaintiffs' challenge to the insurance-reform provisions that injure them. The relevant claim of their complaint alleged that the entire ACA "must be invalidated in whole" because the mandate is now "unconstitutional" and "[t]he remainder of the ACA," including

the insurance-reform provisions, is categorically "non-severable" from the mandate. J.A. 63; see J.A. 61-63. In making those arguments, the individual plaintiffs "seek[] to vindicate [their] own interests." *Phillips Petroleum Co.* v. *Shutts*, 472 U.S. 797, 805 (1985).

This case is effectively the inverse of *Printz*, where the Court declined to allow the plaintiffs to leverage the invalidity of a provision that did injure them to attack other provisions that did not injure them. 521 U.S. at 935; see p. 16, *supra*. Here, the plaintiffs challenge the insurance-reform provisions that do injure them, and the basis for their challenge is that the insurance-reform provisions are inseverable from the mandate, which is invalid. This case thus mirrors *Alaska Airlines, Inc.* v. *Brock*, 480 U.S. 678 (1987). In that case, several airlines contended that statutory provisions establishing certain protections for airline employees should be invalidated because the statute also contained an invalid legislative-veto provision, which the airlines contended was inseverable from the employee-protection provisions. *Id.* at 680-683. Although the Court did not expressly address the airlines' standing to make that argument, it considered and rejected the argument on the merits. *Id.* at 684-697.

Similarly, in the circumstances of this case, this Court can address both merits questions presented without determining whether the individual or State plaintiffs independently have standing to challenge the individual mandate. Regardless of whether the individual plaintiffs would have standing to challenge the mandate itself, the Court may pass upon their argument that the mandate is invalid because that is also a premise of their challenge to the insurance-reform provisions that injure

them.[3] Or, to put it differently, to enter judgment for the plaintiffs on that claim the district court necessarily had to conclude both that the mandate is invalid and that it is not severable from the remainder of the ACA. This Court may now review those conclusions.

To be sure, no plaintiff could obtain—and no federal court could issue—judicial *relief* against enforcement of any ACA provision that has not been shown to injure that plaintiff. See *Lewis*, 518 U.S. at 358. As the government explained in the court of appeals, although the logic of the plaintiffs' legal argument calls into doubt the enforceability of myriad other ACA provisions, they could not obtain a declaratory judgment or injunction directed to those provisions unless they demonstrated that such relief is necessary to redress their own cognizable injuries. See Gov't C.A. Br. 26-29. For example, if this Court accepts both premises of the individual plaintiffs' legal argument challenging the insurance-reform provisions, its *reasoning* would bear on the remainder of the ACA as a matter of precedent. But any *relief* issued as part of a judgment would be limited to enforcement of the provisions that have been shown to injure the individual plaintiffs.

For the same reasons, the Court may consider only arguments by the plaintiffs that implicate the insurance-reform provisions (and any other provisions that the Court finds injure the plaintiffs). The Court thus may consider the plaintiffs' categorical argument that all ACA provisions are inseverable from the individual mandate, because that argument directly bears on the

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[3] Similarly, the Court need not decide whether the same would be true of a plaintiff who is not subject to the individual mandate, because the individual plaintiffs here are subject to it.

insurance-reform provisions. In the lower courts, however, the plaintiffs also argued that various particular ACA provisions that do not appear to affect the individual plaintiffs are inseverable for more specific reasons that do not apply to the insurance-reform provisions. See, *e.g.*, State Plaintiffs C.A. Br. 49-50 (arguing that certain "minor" ACA provisions such as a medical-device tax are inseverable because they no longer serve their specific intended purposes without the mandate). As the government observed at the petition stage, the Court would have no occasion to consider such arguments unless it first determined that a plaintiff has standing to challenge those other provisions. See 19-840 Gov't Br. in Opp. 17.

3. The intervenor States' and House's arguments that the individual plaintiffs lack standing are substantially premised on their merits arguments that the individual mandate does not, in fact, impose any obligation on the individual plaintiffs. See Intervenor States Br. 18; House Br. 20-23. Thus, the intervenor States and the House do not actually contend that the Court must refrain from determining the central question whether, post-TCJA, the mandate must be construed to impose an obligation to purchase insurance. Rather, they merely contend that this Court must resolve the question under the label of "jurisdiction" rather than "merits." See *Bolivarian Republic of Venezuela* v. *Helmerich & Payne Int'l Drilling Co.*, 137 S. Ct. 1312, 1319 (2017) ("[M]erits and jurisdiction will sometimes come intertwined."); 13B Charles Alan Wright et al., *Federal Practice and Procedure*, § 3531.15 (3d ed. 2008) ("Despite the admonition that Article III standing issues must be resolved before approaching the merits," some circumstances "may justify a single inquiry, even if the conclusion that

standing must be denied is indistinguishable from a ruling on the merits."); see also House Br. 22 (agreeing that the Court can "determin[e] whether Section 5000A required the individual plaintiffs to purchase insurance"). Accordingly, this Court need not address hypotheticals regarding constitutional challenges to unrelated provisions that do not affect the plaintiffs. See House Br. 33. Instead, the Court can and should straightforwardly resolve the individual plaintiffs' claim that the mandate unconstitutionally requires them to purchase insurance and is inseverable from the ACA's insurance-reform provisions that prohibit them from obtaining the type of health insurance they would prefer at a cost they would prefer.[4]

II. THE INDIVIDUAL MANDATE IS NO LONGER A VALID EXERCISE OF CONGRESS'S AUTHORITY

On the merits, the district court and the court of appeals correctly determined that the individual mandate is no longer a valid exercise of Congress's legislative authority in light of Congress's elimination of the penalty for noncompliance. J.A. 414-426; Pet. App. 185a-204a. That conclusion follows from this Court's reasoning in *National Federation of Independent Business* v. *Sebelius*, 567 U.S. 519 (2012), which held that the mandate could be construed and sustained only as an exercise of Congress's taxing power based on a "functional" analysis of the penalty, its statutory context, and its practical

[4] For the same reasons, the individual plaintiffs have standing to obtain an injunction barring enforcement against them of the insurance reforms that injure them. The district court thus had authority to instead enter a declaratory judgment of that scope. Cf. Samuel L. Bray et al. Amicus Br. 2-4.

operation. *Id.* at 565; see *id.* at 563-570. The same functional analysis demonstrates that the *NFIB* Court's saving construction of the individual mandate as a tax is no longer tenable. The intervenor States' and House's contrary arguments in support of the mandate are incorrect.

A. The Individual Mandate No Longer Can Be Construed And Upheld As A Valid Exercise Of Congress's Taxing Power Because Congress Eliminated The Tax

1. In *NFIB*, this Court upheld the individual mandate imposed by 26 U.S.C. 5000A solely on the ground that the mandate, in combination with the shared-responsibility payment Congress imposed for noncompliance, was a valid exercise of Congress's power to "lay and collect Taxes," U.S. Const. Art. I, § 8, Cl. 1. See *NFIB*, 567 U.S. at 563-574. As the Chief Justice observed in his separate opinion, that is not "[t]he most straightforward reading of the mandate," which "reads more naturally as a command to buy insurance than as a tax." *Id.* at 562, 574 (opinion of Roberts, C.J.). "After all, it states that individuals 'shall' maintain health insurance." *Id.* at 562. But the Court adopted a saving construction of the mandate—as providing the predicate to a tax, see *id.* at 563-570 (opinion of the Court)—because a majority of the Court concluded that "Section 5000A would * * * be unconstitutional if read as a command." *Id.* at 575 (opinion of Roberts, C.J.); see *id.* at 547-561, 574; *id.* at 649-660 (joint dissent).

a. The Chief Justice explained that the Commerce Clause does not authorize a command to buy insurance because that Clause "grants Congress the power to '*regulate* Commerce,'" not the power "to *compel* it." *NFIB*, 567 U.S. at 550, 555 (opinion of Roberts, C.J.) (quoting U.S. Const. Art. I, § 8, Cl. 3); see *id.* at 548-558. The

Clause's "language," he observed, "reflects the natural understanding that the power to regulate assumes there is already something to be regulated," and thus "[t]he power to *regulate* commerce presupposes the existence of commercial activity." *Id.* at 550. The Chief Justice concluded that the individual mandate, if construed as a command, would exceed that authority because it "does not regulate existing commercial activity." *Id.* at 552. Instead, he observed, the individual mandate "compels individuals to *become* active in commerce by purchasing a product." *Ibid.* For this reason, the Chief Justice found inapposite the Court's precedents construing the Commerce Clause to authorize Congress to regulate existing "activities that 'have a substantial effect on interstate commerce.'" *Id.* at 549 (quoting *United States* v. *Darby*, 312 U.S. 100, 119 (1941)).

The Chief Justice further concluded that the Necessary and Proper Clause does not authorize Congress to enact a command that individuals buy insurance. *NFIB*, 567 U.S. at 558-561 (opinion of Roberts, C.J.). That Clause's grant of "power to 'make all Laws which shall be necessary and proper for carrying into Execution' the powers enumerated in the Constitution," *id.* at 559 (quoting U.S. Const. Art. I, § 8, Cl. 18), he observed, "vests Congress with authority to enact provisions 'incidental to the enumerated power, and conducive to its beneficial exercise,'" *ibid.* (quoting *McCulloch* v. *Maryland*, 17 U.S. (4 Wheat.) 316, 418 (1819)) (brackets omitted). Although this Court's "jurisprudence under the Necessary and Proper Clause * * * ha[s] been very deferential to Congress's determination that a regulation is 'necessary,'" *ibid.*, the Chief Justice determined that the individual mandate exceeded even those broad

limits, *id.* at 560-561. Unlike enactments the Court had previously sustained under the Necessary and Proper Clause—which were all "exercises of authority derivative of, and in service to, a granted power"—he reasoned that "[t]he individual mandate * * * vests Congress with the extraordinary ability to create the necessary predicate to the exercise of an enumerated power." *Id.* at 560. The Chief Justice concluded that, "[e]ven if the individual mandate is 'necessary' to the Act's insurance reforms, such an expansion of federal power is not a 'proper' means for making those reforms effective." *Ibid.*

The four Justices who issued the joint dissent agreed with the Chief Justice that the individual mandate could not be sustained under the Commerce Clause or Necessary and Proper Clause. *NFIB*, 567 U.S. at 649-660 (joint dissent). A majority of the Court thus concluded that the mandate was not justified under either of those Clauses and would have upheld the Eleventh Circuit's judgment to that extent. See *id.* at 572 (opinion of the Court) ("The Court today holds that our Constitution protects us from federal regulation under the Commerce Clause so long as we abstain from the regulated activity.").

b. A different majority of the Court determined that, to save the individual mandate from unconstitutionality, the mandate could be construed as an exercise of Congress's taxing power. *NFIB*, 567 U.S. at 563-574. As the Chief Justice observed, the federal government had argued in the alternative that the "mandate c[ould] be regarded as establishing a condition—not owning health insurance—that triggers a tax—the required payment to the" Internal Revenue Service (IRS). *Id.* at

563 (opinion of Roberts, C.J.). The government contended that, because the ACA imposed as a "consequence" for "not maintain[ing] health insurance" an obligation to "make an additional payment to the IRS when [a person] pays his taxes," the mandate could be viewed "not [as] a legal command to buy insurance" but as "in effect just a tax hike on certain taxpayers who do not have health insurance." *Id.* at 562-563. And because "every reasonable construction must be resorted to, in order to save a statute from unconstitutionality," *id.* at 563 (quoting *Hooper* v. *California*, 155 U.S. 648, 657 (1895)), the Court considered that alternative reading, see *id.* at 563-574.

On that issue, the Court concluded (in an opinion by the Chief Justice) that the shared-responsibility payment for those who do not maintain coverage prescribed by the individual mandate could "reasonably be characterized as a tax." *NFIB*, 567 U.S. at 574; see *id.* at 563-574; 26 U.S.C. 5000A(b)(1) and (3), (c)(1) and (2). The Court acknowledged that the ACA "describe[d] the payment as a 'penalty,' not a 'tax.'" *NFIB*, 567 U.S. at 564. But it explained that the "label" alone was not dispositive and that the Court's precedents called for a "functional approach" that focuses on "practical characteristics" of an enactment to determine whether it can be sustained as a tax. *Id.* at 564-565. "The same analysis," the Court held, "suggests that the shared responsibility payment may for constitutional purposes be considered a tax" on those who lack insurance, not as a sanction for violating a command. *Id.* at 566; see *id.* at 563-570.

Applying that "functional approach," the *NFIB* Court explained that the shared-responsibility payment "looks like a tax in many respects." 567 U.S. at 563, 565.

Among other things, the Court observed that it was "paid into the Treasury by 'taxpayer[s]' when they file their tax returns"; "its amount [wa]s determined by such familiar factors as taxable income, number of dependents, and joint filing status"; it was "enforced by" the IRS, which "must assess and collect it 'in the same manner as taxes'"; and it "yield[ed] the essential feature of any tax," *i.e.*, "[i]t produce[d] at least some revenue for the Government," and was "expected to raise about $4 billion per year by 2017." *Id.* at 563-564 (citation omitted; first set of brackets in original). The Court also noted that the shared-responsibility payment resembled financial obligations the Court had previously upheld as taxes (rather than penalties) in other respects, including its size, the lack of a scienter requirement, and limitations on the means by which the IRS could enforce it. See *id.* at 566. Because of the nature and operation of the financial obligation Section 5000A imposed for noncompliance with the mandate, the Court held, "§ 5000A need not be read to do more than impose a tax," which "Congress had the power to impose." *Id.* at 570. The Court further concluded that the tax also comported with the Constitution's other limitations on taxes. *Id.* at 570-574.

2. As the courts below correctly determined, the saving construction of Section 5000A that the Court adopted in *NFIB* is no longer tenable in light of Congress's subsequent action in the TCJA. See J.A. 419-426, Pet. App. 139a-141a. Because it cannot reasonably be interpreted as a tax, the mandate in its current form exceeds Congress's enumerated powers.

As amended, Section 5000A preserves the "[r]equirement to maintain minimum essential coverage." 26 U.S.C. 5000A (emphasis omitted). And it continues to use the

language of legal command, specifying that covered individuals "shall * * * ensure" that they obtain "minimum essential coverage." 26 U.S.C. 5000A(a). In its current form, as when the Court considered the provision in *NFIB*, Section 5000A thus is most "naturally" read "as a command to buy insurance." *NFIB*, 567 U.S. at 574 (opinion of Roberts, C.J.); see *id.* at 562.

Critically, however, the linchpin of *NFIB*'s saving construction of the mandate as merely a predicate for tax liability, see 567 U.S. at 563-570, has been eliminated. Section 5000A cannot be read today as "establishing a condition—not owning health insurance—that triggers a tax," *id.* at 563 (opinion of Roberts, C.J.), because the tax no longer exists. In the TCJA, effective January 1, 2019, Congress replaced the existing percentage of income used to calculate the shared-responsibility payment with "Zero percent," and it set the figure used to calculate the minimum penalty (the "applicable dollar amount," 26 U.S.C. 5000A(c)(3)(A) and (D) (2012 & Supp. V 2017)) at "$0." TCJA § 11081, 131 Stat. 2092.

As the court of appeals explained, the same functional analysis that the Court applied in *NFIB* to conclude that the mandate could reasonably be interpreted as the basis for a tax therefore compels the opposite conclusion today. See J.A. 419-420. A penalty of zero does not "look[] like a tax" in *any* "respect[]." *NFIB*, 567 U.S. at 563. Under Section 5000A as it now stands, nothing is "paid into the Treasury by 'taxpayers' when they file their tax returns." *Ibid.* (brackets omitted). Nothing is "determined by such familiar factors as taxable income, number of dependents, and joint filing status," because the amount owed is always zero. *Ibid.* The mandate is no longer "enforced by" the IRS; it is

not "assess[ed] and collect[ed]" at all, much less "'in the same manner as taxes.'" *Id.* at 563-564 (citation omitted). And, perhaps most significantly, it does not "yield[] the *essential feature* of any tax," because it does not—indeed, under the current statute's terms, cannot—"produce[]" any "revenue for the Government." *Id.* at 564 (emphasis added).

Without any financial obligation imposed on those who do not maintain the "minimum essential coverage" that Section 5000A "[r]equire[s]," 26 U.S.C. 5000A (emphasis omitted), Section 5000A as it stands today cannot reasonably be construed as "impos[ing] a tax" for failing to do so. *NFIB*, 567 U.S. at 570. The mandate thus no longer can be upheld as the predicate to an "exaction" that "Congress had the power to impose * * * under the taxing power." *Ibid.* Instead, absent any tax for which it can serve as a trigger, the mandate's direction that a covered individual "shall * * * ensure that the individual * * * is covered under minimum essential coverage," 26 U.S.C. 5000A(a), can be understood only as a straightforward command to maintain such coverage. The statute thus must be "read to declare that failing to" maintain minimum essential coverage "is unlawful." *NFIB*, 567 U.S. at 568. As this Court held in *NFIB*, that command is unconstitutional. *Id.* at 572.

3. The intervenor States and House argue that *NFIB* definitively interpreted Section 5000A as affording a choice between maintaining insurance coverage and paying a tax—not as a freestanding command to maintain coverage—and that the TCJA did not abrogate that interpretation. Intervenor States Br. 26; House Br. 35. They observe that the only change the TCJA made to Section 5000A was to reduce the amount of the shared-responsibility payment to zero, leaving

the rest of the provision intact—including the text of the mandate and the text imposing a penalty on individuals who do not comply with the mandate's requirement. See Intervenor States Br. 28; House Br. 36. But that targeted amendment fundamentally changed the statute by removing the "essential feature" on which *NFIB*'s interpretation rested. 567 U.S. at 564. The Court's construction of the mandate as the predicate to a tax hinged critically on the existence of the "exaction" that produced "revenue." *Id.* at 564; see *id.* at 563-570.

Eliminating that exaction renders *NFIB*'s interpretation inapplicable. Under the "functional approach" that this Court's precedents prescribe and that *NFIB* applied, 567 U.S. at 565, reducing the shared-responsibility payment amount to zero for all individuals in all circumstances going forward is the equivalent of eliminating the payment altogether. Just as the Court determined that "practical" considerations supported classifying the shared-responsibility payment as a tax despite the statute's express description of that payment as a "penalty," *id.* at 564-565, so too the practical reality following the TCJA is that Section 5000A no longer imposes any tax on any individual.

The intervenor States nevertheless insist that Section 5000A can "still be upheld as a lawful exercise of Congress's taxing powers, albeit one whose practical application is currently suspended." Intervenor States Br. 32. They contend that the statute "retains many of the features that *NFIB* looked to in construing it as a tax," including "references to taxable income, number of dependents, and joint filing status" in the formula for calculating the payment. *Id.* at 33. But the TCJA eliminated entirely "the essential feature of any tax" that *NFIB* identified—the "produc[tion] [of] * * * revenue."

567 U.S. at 564. Indeed, the TCJA rendered parameters for calculating and enforcing the shared-responsibility payment irrelevant. The references to income, dependents, and filing status in the formula are immaterial because, regardless of those variables, the formula now calculates the same result—a payment of zero—for every individual.

The intervenor States also attempt to analogize Section 5000A sans penalty to taxes that yield no or little revenue. Intervenor States Br. 32-34. The intervenor States point to taxes that have delayed effective dates or are suspended temporarily and taxes that are in force but yield no revenue because no taxpayer engages in the conduct that triggers the tax (*e.g.*, because the tax itself deters the conduct, or the conduct is also a criminal offense). *Ibid.* Those analogies are inapt. Unlike delayed or suspended taxes that will fail to generate revenue in a particular period, Section 5000A permanently eliminates the duty to pay a penalty. It will never again generate tax revenue absent a further Act of Congress reinstating the penalty. And unlike taxes that produce no revenue because no taxpayer engages in the taxed conduct, Section 5000A generates no revenue regardless of how many individuals fail to maintain the insurance coverage required by the mandate.

In all events, the intervenor States' reading of Section 5000A as affording individuals a choice between maintaining insurance coverage and not maintaining coverage—with no tax liability either way—cannot justify upholding the mandate as an exercise of Congress's power to "lay and collect Taxes," U.S. Const. Art. I, § 8, Cl. 1. Similarly, the suggestion that "the greater power to enact a statute imposing a tax surely includes a lesser

power to reduce the tax to zero while leaving its structure in place," Intervenor States Br. 33-34, reduces to the illogical contention that Congress may exercise its taxing power without actually imposing any taxes.

B. The Individual Mandate Cannot Be Upheld As A Precatory Expression Of Congressional Sentiment Or As A Valid Exercise Of Congress's Authority Under The Necessary And Proper Clause Or The Commerce Clause

Tellingly, although they claim that the TCJA did not alter the constitutional analysis set out by this Court in *NFIB*, the intervenor States and House primarily defend the amended statute on grounds other than the power to impose taxes.

1. The intervenor States and House's lead argument is that the mandate is hortatory and thus need not rest on any source of lawmaking power. For example, the intervenor States argue that Congress enacted a "precatory provision" that is permissible "even where it addresses a subject on which Congress could not legislate with binding effect." Intervenor States Br. 32; see House Br. 35-36. The intervenor States and House thus interpret the mandate to lack any legal effect.

That characterization of the individual mandate cannot be squared with the statutory text. Section 5000A(a) states that "[a]n applicable individual *shall* * * * ensure that the individual * * * is covered under minimum essential coverage for such month," 26 U.S.C. 5000A(a) (emphasis added)—not that the individual "should" do so or that Congress would prefer that they do so. "[T]he word 'shall' usually connotes a requirement," *Kingdomware Techs., Inc.* v. *United States*, 136 S. Ct. 1969, 1977 (2016), and it "normally creates an obligation impervious to judicial discretion," *ibid.* (quoting *Lexecon Inc.* v. *Milberg Weiss Bershad Hynes &*

Lerach, 523 U.S. 26, 35 (1998)). Nothing in Section 5000A(a) indicates that Congress diverged from that ordinary understanding of the term, and "[t]he most straightforward reading of the mandate is that it commands individuals to purchase insurance." *NFIB*, 567 U.S. at 562 (opinion of Roberts, C.J.). Law-abiding citizens must comply with statutory commands whether or not any specific penalties are imposed for noncompliance.

Had Congress instead intended the mandate merely to encourage maintaining coverage or to convey Congress's own policy views, it easily could have done so—as illustrated by statutes the intervenor States and House cite, Intervenor States Br. 32; House Br. 35-36. In 4 U.S.C. 8, Congress provided that "[n]o disrespect should be shown to the flag of the United States of America," and it set forth more than a dozen specific practices that variously either "should" or "should never" be used in displaying the flag. *Ibid.* In 22 U.S.C. 7674, Congress stated that "[i]t is the sense of Congress that United States businesses should be encouraged to provide assistance to sub-Saharan African countries to prevent and reduce the incidence of HIV/AIDS in sub-Saharan Africa," and it identified one particular mechanism for providing such assistance that "United States businesses should be encouraged to consider." *Ibid.* And in 15 U.S.C. 7807, Congress provided that "States should enact the Uniform Athlete Agents Act of 2000." Each of those provisions contrasts starkly with Section 5000A(a), which states what covered individuals "shall" do.

At bottom, the contention of the intervenor States and House is that, without any enforceable sanction, the practical effect of Section 5000A is equivalent to a

sense-of-the-Congress resolution. But Section 5000A's text cannot fairly be construed as a suggestion. It most naturally conveys a "command." *NFIB*, 567 U.S. at 562 (opinion of Roberts, C.J.). And the reading of the mandate as a predicate to a tax that the Court adopted in *NFIB* based on context and the saving canon is no longer possible. See pp. 23-33, *supra*. As Section 5000A now stands, it must be read as creating a legal obligation that Congress lacks authority to impose.

2. The House alternatively argues that if the individual mandate "requires an enumerated power, the Court should still uphold it because it is necessary and proper to the exercise of Congress's power to lay and collect taxes," as "it retains the architecture of the tax upheld in *NFIB*." House Br. 37; see Intervenor States Br. 33. That theory—which permits the mandate's continued existence based solely on the hypothetical possibility that Congress might take *future action*—is incorrect. Retaining the individual mandate is unnecessary to enable Congress to reestablish a tax that currently does not exist. With or without the mandate, reinstating the tax would require future legislative action by Congress. And because this Court already found that the mandate would be unconstitutional if construed as a freestanding command, leaving the mandate in place purportedly to streamline hypothetical future legislation would be profoundly improper.

3. Finally, neither the intervenor States nor the House renews arguments made below that the individual mandate can be sustained under Congress's commerce power. See House C.A. Br. 40. That implicit concession is proper. This Court in *NFIB* held that neither the Commerce Clause nor the Necessary and Proper Clause authorized Congress to impose a legally binding

command to obtain health insurance as a freestanding regulation. See 567 U.S. at 547-561, 574 (opinion of Roberts, C.J.); *id.* at 649-660 (joint dissent). That conclusion rested on the nature and effects of what Congress sought to regulate—failure to maintain insurance coverage—not that the sanction it had imposed was too great or that the mandate would have been lawful with a smaller or no shared-responsibility payment. See *id.* at 572 (opinion of the Court) ("The Court today holds that our Constitution protects us from federal regulation under the Commerce Clause so long as we abstain from the regulated activity.").

III. THE INDIVIDUAL MANDATE IS NOT SEVERABLE FROM THE REST OF THE ACT

Where a statutory provision is unconstitutional, determining whether the remainder of the statutory scheme should remain in effect requires an inquiry into legislative intent. The severability inquiry typically requires asking "whether Congress would have wanted the rest of [a statute] to stand, had it known that" one or more particular provisions of the statute would be held invalid. *NFIB*, 567 U.S. at 587 (opinion of Roberts, C.J.). While the "normal rule is that partial, rather than facial, invalidation is the required course," *Free Enter. Fund* v. *Public Co. Accounting Oversight Bd.*, 561 U.S. 477, 508 (2010) (citation and internal quotation marks omitted), courts must deem provisions inseverable where doing so implements Congress's evinced intent—for example, if the provisions' continued enforcement would result in "a scheme sharply different from what Congress contemplated," *Murphy*, 138 S. Ct. at 1482. After all, courts "cannot rewrite a statute and give it an effect altogether different from that sought by the measure viewed as a whole." *Ibid.* (citation omitted).

A. The Individual Mandate Is Inseverable From The Guaranteed-Issue And Community-Rating Provisions

1. Even though the guaranteed-issue and community-rating provisions are constitutionally valid when standing on their own, it is evident that Congress would not "have wanted" them to stand without the individual mandate. See *NFIB*, 567 U.S. at 587 (opinion of Roberts, C.J.).

a. That these provisions are inseverable is evident from the enacted text of the ACA, where Congress expressly found that the individual mandate is essential to the operation of the guaranteed-issue and community-rating provisions. See Pet. App. 209a ("Those findings are not mere legislative history—they are enacted text that underwent the Constitution's requirements of bicameralism and presentment."). "[I]f there were no requirement" to purchase insurance, Congress concluded, "many individuals would wait to purchase health insurance until they needed care." 42 U.S.C. 18091(2)(I). But "[b]y significantly increasing health insurance coverage," the mandate, "together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums." *Ibid.* For that reason, Congress concluded, the individual mandate is "*essential to* creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Ibid.* (emphasis added); see 42 U.S.C. 18091(2)(J) ("The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.").

In expressly finding a critical link between these three provisions, Congress looked to States' prior experiences in restructuring their health-insurance laws. Congress was well aware, in particular, that in some States guaranteed-issue and community-rating requirements "had an unintended consequence: They encouraged people to wait until they got sick to buy insurance." *King* v. *Burwell*, 135 S. Ct. 2480, 2485 (2015). The "adverse selection" of disproportionately ill people purchasing insurance forced insurers to raise premiums, which in turn resulted in "even more people wait[ing] until they became ill to buy it." *Id.* at 2485-2486. Congress was concerned about the resulting "economic 'death spiral,'" and thus looked to the experience of Massachusetts, which paired guaranteed-issue and community-rating provisions with tax credits and a requirement to purchase health insurance. *Id.* at 2486; see 42 U.S.C. 18091(2)(D) (explicitly relying on Massachusetts' experience).

b. This Court has repeatedly recognized that Congress viewed the guaranteed-issue and community-rating provisions as necessarily intertwined with the individual mandate. All nine Justices indicated as much in *NFIB*. See 567 U.S. at 548 (opinion of Roberts, C.J.) ("The guaranteed-issue and community-rating reforms * * * exacerbate" the "problem" of "healthy individuals who choose not to purchase insurance to cover potential health care needs," and "threaten to impose massive new costs on insurers. * * * The individual mandate was Congress's solution to these problems."); *id.* at 597-598 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part) ("[T]hese two provisions, Congress comprehended, could not work effectively unless individuals were given a powerful incentive to obtain insurance. * * * [G]uaranteed-

issue and community-rating laws alone will not work."); *id.* at 698 (joint dissent) ("[I]mpos[ing] risks on insurance companies and their customers"—including the community-rating and guaranteed-issue provisions—"[w]ithout the Individual Mandate * * * would undermine Congress' scheme of shared responsibility.") (internal quotation marks omitted). Indeed, the government's briefing in *NFIB* agreed that both the guaranteed-issue and community-rating provisions were inseverable from the individual mandate. Gov't Br. on Severability at 44-55, *NFIB*, *supra* (Nos. 11-393 and 11-400).

And in *King*, this Court again acknowledged that "[t]hese three reforms are closely intertwined" and that "Congress found that the guaranteed issue and community rating requirements would not work without the coverage requirement." 135 S. Ct. at 2487.

c. The TCJA does not alter what Congress said in the ACA about how these three provisions are inextricably intertwined. While the TCJA eliminated the mandate's tax penalty, it did not eliminate the mandate itself, which still "[r]equire[s]" that individuals "shall" purchase health insurance. 26 U.S.C. 5000A(a) (emphasis omitted). And critically, the TCJA left in place Congress's findings that the mandate's "requirement" to purchase insurance is "essential" to the operation of the guaranteed-issue and community-rating provisions. 42 U.S.C. 18091(2)(I). By retaining the mandate (even without a penalty) and leaving undisturbed its prior express findings, Congress adhered to the view that the individual mandate and guaranteed-issue and community-rating provisions are interrelated. That indicates Congress's intent: Congress would not have "wanted" the guaranteed-issue and community-rating provisions "to

stand alone," either in 2010 or in 2017. *Murphy*, 138 S. Ct. at 1483.

2. The intervenor States and House push back, arguing that the 2017 Congress necessarily intended the guaranteed-issue and community-rating provisions to remain even if the mandate were invalidated because Congress left those provisions (and the rest of the ACA) intact while eliminating the mandate's penalty. See Intervenor States Br. 36-37; House Br. 40-42. But this argument overlooks that Congress retained the mandate itself, that Congress in 2017 did not expressly address what should happen if the mandate were later judicially invalidated, and that Congress instead left in place the 2010 findings that the mandate is essential to the guaranteed-issue and community-rating provisions. And although the intervenor States and House contend that Members of Congress would have been indifferent if the mandate were invalidated after the penalty was eliminated, they provide no evidence that Congress as a whole shared their pessimistic view that most American citizens would flout a mandatory requirement to purchase insurance simply because that legal duty is not backed by an enforcement penalty.

Even if that is what some Members of Congress would have wanted, it is not what Congress as a whole did. Congress left undisturbed the ACA's clear statement that the individual mandate is essential to the guaranteed-issue and community-rating provisions. Although the intervenor States and House do not label it this way, they are in effect arguing that Congress repealed its existing findings in Section 18091(2) by implication. But "repeals by implication are not favored and will not be presumed unless the intention of the legislature to repeal is clear and manifest," *National Ass'n of*

Home Builders v. *Defenders of Wildlife*, 551 U.S. 644, 662 (2007) (brackets, citation, and internal quotation marks omitted), and "will only be found where provisions in two statutes are in irreconcilable conflict, or where the latter Act covers the whole subject of the earlier one and is clearly intended as a substitute," *Branch* v. *Smith*, 538 U.S. 254, 273 (2003) (opinion of Scalia, J.) (citation and internal quotation marks omitted). Here, Congress as a whole has nowhere demonstrated a clear and manifest intent to overturn its prior findings that the individual mandate and the guaranteed-issue and community-rating provisions must operate together. This is so because the elimination of the mandate's penalty neither conflicts with nor substitutes for the ACA's findings about the relationship between the mandate's requirement and the insurance-reform provisions. The presumption against implied repeals thus requires the Court to give effect to the ACA's statutory findings.

The intervenor States and House try to minimize the import of the statutory findings by suggesting that they were designed for a different purpose or that they have been superseded by subsequent events. Intervenor States Br. 41-44; House Br. 44-46. As to the first point, this Court should not ignore the factual findings simply because they were not specifically directed toward severability; as part of the ACA's text, they remain an important indicator of Congress's understanding of whether these various provisions are capable of functioning independently. As to the second point, neither the establishment and development of insurance marketplaces nor the change to the mandate's penalty sheds any light on Congress's intent regarding the interplay among the relevant provisions—especially given that Congress originally structured the mandate's penalty to change

over time, see 26 U.S.C. 5000A(c)(2)(B) and (3)(A)-(B) (2012).

More generally, the intervenor States and House contend that the intent of the 2010 Congress should be ignored because the constitutional infirmity did not arise until 2017. But as they properly recognize, the repeal of the tax was not itself unconstitutional; rather, it is the interaction between the ACA and TCJA that renders the individual mandate invalid. Thus, the focus is not exclusively on the 2010 Congress or the 2017 Congress, as the current statutory scheme is the product of enactments by both bodies. And the combined intent is clear: the 2010 Congress viewed the operation of the mandate as inextricably intertwined with the operation of the guaranteed-issue and community-rating provisions, and the 2017 Congress did not disturb that understanding—but rather ratified it—by retaining the findings while eliminating the penalty.

Ultimately, the findings in 42 U.S.C. 18091(2) are no different from a targeted inseverability clause. The government in *NFIB* recognized as much. See Gov't Br. on Severability at 52, *NFIB*, *supra* (Nos. 11-393 and 11-400) ("The question of severability is one of congressional intent, and Congress expressly found that the minimum coverage provision is 'essential' to the guaranteed-issue reforms. 42 U.S.C.A. 18091(a)(2)(I)."). If Congress had framed its findings as an inseverability clause, this Court would apply it—whether or not the Court independently believed that Congress's expression of intent made sense or achieved the wisest legislation. Cf. *Zobel* v. *Williams*, 457 U.S. 55, 64-65 (1982) (explaining the Court "need not consider" other alternatives that the legislature could have adopted where

"the legislation expressly provides that invalidation of any portion of the statute renders the whole invalid").

Here, Congress did not speak in general terms about the severability of provisions or applications. It instead addressed a specific issue that is directly relevant to severability: that the individual mandate is essential to the guaranteed-issue and community-rating provisions. That only makes Congress's intent *more* clear. Giving effect to Congress's statutorily codified expression of its intent may or may not achieve what its Members expected in 2017 when they amended the ACA—depending on whether they perceived the issue and wanted the findings to control—and there were likely Members on all sides. But this Court would not pause over Members' subjective intentions in applying an express inseverability clause, and the result should be no different when Congress expresses its intent with respect to a specific issue that is directly relevant to severability and then leaves that intent undisturbed during subsequent amendments.

B. The ACA's Remaining Provisions Are Inseverable

1. Once the individual mandate and the guaranteed-issue and community-rating provisions are invalidated, the remainder of the ACA should not be allowed to remain in effect. As noted above, this Court may consider the inseverability of, and award relief concerning, other ACA provisions only insofar as such provisions injure the plaintiffs. But the government will address the whole Act here, both because at least some other insurance reforms do injure the individual plaintiffs, see pp. 16-19, *supra*, and because an argument for the inseverability of those provisions likewise applies to other ACA provisions. And the Court may benefit from a complete

analysis should it conclude that additional discrete provisions of the ACA injure any of the plaintiffs.

As explained by the joint dissenters in *NFIB*—the only Justices to reach the issue of whether the rest of the Act could be severed from the individual mandate and the guaranteed-issue and community-rating provisions—the ACA's interlocking web of provisions cannot function as Congress intended absent that core triad. 567 U.S. at 691-707 (joint dissent). Eliminating those three provisions would in turn "rewrite [the] statute," *Murphy*, 138 S. Ct. at 1482 (citation omitted), by fundamentally altering the ACA's other insurance reforms, which were premised on the availability of uniform plans to all potential purchasers of insurance in the individual and small-group markets. As even the amicus curiae appointed in *NFIB* to argue *in favor of* severability acknowledged, "the effects of invalidating the guaranteed issue and community rating provisions could not easily be limited to just those provisions." Court-Appointed Amicus Br. Supporting Complete Severability at 46, *NFIB*, *supra* (Nos. 11-393 and 11-400).

For example, the ACA created insurance "exchanges" where individuals could purchase insurance. "A key purpose of an exchange is to provide a marketplace of insurance options where prices are standardized regardless of the buyer's pre-existing conditions." *NFIB*, 567 U.S. at 702 (joint dissent). Without the community-rating provisions, which generally prohibit altering the price of insurance based on the buyer's health condition, "[t]he prices would vary from person to person," and "the exchanges cannot operate in the manner Congress intended." *Id.* at 702-703. And without the insurance

exchanges, there would be no basis for requiring employers to make a payment to the federal government if they do not offer insurance to employees and those employees then purchase insurance on the exchange. See 26 U.S.C. 4980H; *NFIB*, 567 U.S. at 703 (joint dissent).

The ACA's tax credits suffer a similar fate absent the three central provisions. As *King* recognized, "the guaranteed issue and community rating requirements * * * only work when combined with the coverage requirement and the tax credits." 135 S. Ct. at 2494. "Without the community-rating insurance regulation, * * * the average federal subsidy could be much higher; for community rating greatly lowers the enormous premiums unhealthy individuals would otherwise pay." *NFIB*, 567 U.S. at 701 (joint dissent). "The result would be an unintended boon to insurance companies, an unintended harm to the federal fisc, and a corresponding breakdown of the 'shared responsibility' * * * that Congress intended." *Id.* at 702.

Similarly, the ACA included a panoply of other insurance regulations and taxes, such as coverage limits, requirements to cover dependent children, and restrictions on high-cost insurance plans. See *NFIB*, 567 U.S. at 698 (joint dissent) (citing 26 U.S.C. 4980I; 42 U.S.C. 300gg-11, 300gg-14(a)). These regulations all indisputably impose "higher costs for insurance companies." *Ibid.* The ACA's design contemplated that these costs would be offset in part by the individual mandate, which would increase the number of individuals enrolled in insurance, and by federal subsidies. See *id.* at 698-699. Allowing these provisions to continue in effect without the interdependent provisions already discussed would create a potentially unstable insurance market—unlike anything that Congress intended. *Id.* at 699.

As the joint dissent also explained, the ACA's cost-saving measures are linked to provisions that reduce uncompensated care. The ACA "reduces payments by the Federal Government to hospitals by more than $200 billion over 10 years." *NFIB*, 567 U.S. at 699 (joint dissent). These reductions were palatable only because other provisions in the ACA were expected to lead to "[n]ear-universal coverage" that would "offset the government's reductions in Medicare and Medicaid reimbursements to hospitals." *Ibid.* There is no indication that Congress would have cut payments without providing hospitals with an opportunity to receive offsetting revenue, particularly where doing so could have dramatic effects—including raising the costs of care and insurance premiums borne by consumers—and contravene the Act's goals. See *id.* at 699-700.

These reductions in federal payments were in turn designed to "offset the $434-billion cost of the Medicaid Expansion," *NFIB*, 567 U.S. at 700 (joint dissent), and there is no indication that Congress would have enacted legislation that greatly increased the federal deficit if the reductions in federal spending were invalidated. There is no tension between this conclusion and the *NFIB* majority's conclusion that the Medicaid expansion should be allowed to take effect even if it could not be a condition on the remainder of a State's Medicaid allotment. A less extensive expansion of Medicaid than Congress intended does not contravene Congress's objectives in the same way as would the system-wide rebalancing of costs and benefits that the intervenor States and House urge here.

That leaves the ACA's comparatively "minor," ancillary provisions. *NFIB*, 567 U.S. at 704 (joint dissent).

Some of those provisions interact with the major provisions just discussed, and thus would not act in the manner that Congress intended once the major provisions are invalidated. See *id.* at 705 (discussing tax increases that offset costs imposed by health-insurance reforms). There are other provisions that might be able to operate in the manner that Congress intended when viewed in isolation, but the question of congressional intent as to those provisions is complicated by the sprawling nature of the ACA. In this unique context, comparatively "minor," ancillary provisions that were tacked on to the bill should be held inoperative once the core provisions have been struck down because "[t]here is no reason to believe that Congress would have enacted them independently." *NFIB*, 567 U.S. at 705 (joint dissent).[5]

2. The court of appeals criticized the district court for failing to engage in a sufficiently detailed inquiry into the various aspects of the statute. J.A. 441-445. But in *NFIB* four Justices of this Court determined that a similar inquiry was sufficient. No further analysis is necessary; once the individual mandate and the guaranteed-issue and community-rating provisions are invalidated, the remainder of the ACA cannot survive.

For their part, the intervenor States and House emphasize that Congress declined to repeal additional provisions of the ACA before eliminating the mandate's penalty. See Intervenor States Br. 46-47; House Br. 41-42. But this history does not speak to the relevant

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[5] The House asserts that "[t]he United States made a diametrically opposed argument" in *Seila Law LLC* v. *CFPB*, No. 19-7 (argued Mar. 3, 2020). House Br. 49 n.11. But that is clearly incorrect because Congress in the Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203, 124 Stat. 1376, included an *express severability clause*, 12 U.S.C. 5302.

question here—namely, what Congress would have wanted if the mandate itself were invalidated *as well as* the guaranteed-issue and community-rating provisions. On that question, the best guides for this Court's analysis are the substantive connections between the various provisions of the ACA as recognized by the joint dissenters in *NFIB*. If this Court concludes that, notwithstanding the legislative background invoked by the intervenor States and House, Congress's statutory findings tie the invalid mandate to the guaranteed-issue and community-rating provisions, then it necessarily follows that the rest of the ACA must also fall—which is a text- and structure-based conclusion that the invoked legislative background cannot undermine.

CONCLUSION

The judgment of the court of appeals should be affirmed insofar as it held that the individual mandate is unconstitutional, and this Court should further hold that the insurance provisions injuring the individual plaintiffs are inseverable from the mandate and the remainder of the Act. This case should then be remanded for consideration of the scope of appropriate relief redressing plaintiffs' injuries.

Respectfully submitted.

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JUNE 2020

APPENDIX

1. U.S. Const. Art. I, § 8, Cl. 1 provides:

The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States; but all Duties, Imposts and Excises shall be uniform throughout the United States;

2. U.S. Const. Art. I, § 8, Cl. 3 provides:

To regulate Commerce with foreign Nations, and among several States, and with Indian Tribes;

3. U.S. Const. Art. I, § 8, Cl. 18 provides:

To make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers, and all other Powers vested by this Constitution in the Government of the United States, or in any Department or Officer thereof.

4. 26 U.S.C. 5000A provides:

Requirement to maintain minimum essential coverage

(a) Requirement to maintain minimum essential coverage

An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual,

is covered under minimum essential coverage for such month.

(b) Shared responsibility payment

(1) In general

If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

(2) Inclusion with return

Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(3) Payment of penalty

If an individual with respect to whom a penalty is imposed by this section for any month—

(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

(c) Amount of penalty

(1) In general

The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) Monthly penalty amounts

For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

(A) Flat dollar amount

An amount equal to the lesser of—

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) Percentage of income

An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

(i) 1.0 percent for taxable years beginning in 2014.

(ii) 2.0 percent for taxable years beginning in 2015.

(iii) Zero percent for taxable years beginning after 2015.

(3) Applicable dollar amount

For purposes of paragraph (1)—

(A) In general

Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $0.

(B) Phase in

The applicable dollar amount is $95 for 2014 and $325 for 2015.

(C) Special rule for individuals under age 18

If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the

applicable dollar amount for the calendar year in which the month occurs.

(4) Terms relating to income and families

For purposes of this section—

(A) Family size

The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(B) Household income

The term "household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(C) Modified adjusted gross income

The term "modified adjusted gross income" means adjusted gross income increased by—

(i) any amount excluded from gross income under section 911, and

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

(d) Applicable individual

For purposes of this section—

(1) In general

The term "applicable individual" means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

(2) Religious exemptions

(A) Religious conscience exemptions

(i) In general

Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that—

(I) such individual is a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and is adherent of established tenets or teachings of such sect or division as described in such section; or

(II) such individual is a member of a religious sect or division thereof which is not described in section 1402(g)(1), who relies solely on a religious method of healing, and for whom the acceptance of medical health services would be inconsistent with the religious beliefs of the individual.

(ii) Special rules

(I) Medical health services defined

For purposes of this subparagraph, the term "medical health services" does not include routine dental, vision and hearing services, midwifery services, vaccinations, necessary medical services provided to children, services required by law or by a third party, and such other services as the Secretary of Health and Human Services may provide in implementing section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act.

(II) Attestation required

Clause (i)(II) shall apply to an individual for months in a taxable year only if the information provided by the individual under section 1411(b)(5)(A) of such Act includes an attestation that the individual has not received medical health services during the preceding taxable year.

(B) Health care sharing ministry

(i) In general

Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

(ii) Health care sharing ministry

The term "health care sharing ministry" means an organization—

(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

(III) members of which retain membership even after they develop a medical condition,

(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

(3) Individuals not lawfully present

Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

(4) Incarcerated individuals

Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) Exemptions

No penalty shall be imposed under subsection (a) with respect to—

(1) Individuals who cannot afford coverage

(A) In general

Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B) Required contribution

For purposes of this paragraph, the term "required contribution" means—

(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual

(without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

(C) Special rules for individuals related to employees

For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to[1] required contribution of the employee.

(D) Indexing

In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for "8 percent" the per-

[1] So in original. Probably should be followed by "the".

centage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(2) Taxpayers with income below filing threshold

Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

(3) Members of Indian tribes

Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

(4) Months during short coverage gaps

(A) In general

Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

(B) Special rules

For purposes of applying this paragraph—

(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

(ii) if a continuous period is greater than the period allowed under subparagraph (A), no

exception shall be provided under this paragraph for any month in the period, and

(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

(5) Hardships

Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

(f) Minimum essential coverage

For purposes of this section—

(1) In general

The term "minimum essential coverage" means any of the following:

(A) Government sponsored programs

Coverage under—

(i) the Medicare program under part A of title XVIII of the Social Security Act,

(ii) the Medicaid program under title XIX of the Social Security Act,

(iii) the CHIP program under title XXI of the Social Security Act or under a qualified CHIP look-alike program (as defined in section 2107(g) of the Social Security Act),

(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;[2]

(v) a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary,

(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers);[3] or

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note).

(B) Employer-sponsored plan

Coverage under an eligible employer-sponsored plan.

(C) Plans in the individual market

Coverage under a health plan offered in the individual market within a State.

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[2] So in original. The semicolon probably should be a comma.

[3] So in original. The semicolon probably should be a comma.

(D) Grandfathered health plan

Coverage under a grandfathered health plan.

(E) Other coverage

Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

(2) Eligible employer-sponsored plan

The term "eligible employer-sponsored plan" means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

(3) Excepted benefits not treated as minimum essential coverage

The term "minimum essential coverage" shall not include health insurance coverage which consists of coverage of excepted benefits—

(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(4) Individuals residing outside United States or residents of territories

Any applicable individual shall be treated as having minimum essential coverage for any month—

(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

(5) Insurance-related terms

Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

(g) Administration and procedure

(1) In general

The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) Special rules

Notwithstanding any other provision of law—

(A) Waiver of criminal penalties

In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) Limitations on liens and levies

The Secretary shall not—

(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

(ii) levy on any such property with respect to such failure.

5. 42 U.S.C. 18091 provides:

Requirement to maintain minimum essential coverage; findings

Congress makes the following findings:

(1) In general

The individual responsibility requirement provided for in this section (in this section referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) Effects on the national economy and interstate commerce

The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement

has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) The economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.

(F) The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

(G) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The

requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

(I) Under sections 2704 and 2705 of the Public Health Service Act [42 U.S.C. 300gg-3, 300gg-4] (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

(J) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) Supreme Court ruling

In United States v. South-Eastern Underwriters Association (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.

6. Pub. L. No. 115-97, Tit. I, 131 Stat. 2054 provides in pertinent part:

* * * * *

SEC. 11081. ELIMINATION OF SHARED RESPONSIBILITY PAYMENT FOR INDIVIDUALS FAILING TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) IN GENERAL.—Section 5000A(c) is amended—

(1) in paragraph (2)(B)(iii), by striking "2.5 percent" and inserting "Zero percent", and

(2) in paragraph (3)—

(A) by striking "$695" in subparagraph (A) and inserting "$0", and

(B) by striking subparagraph (D).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2018.

* * * * *

7. 26 U.S.C. 5000A (2012) provides in pertinent part:

Requirement to maintain minimum essential coverage

* * * * *

(c) Amount of penalty

(1) In general

The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of—

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) Monthly penalty amounts

For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

(A) Flat dollar amount

An amount equal to the lesser of—

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) Percentage of income

An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

(i) 1.0 percent for taxable years beginning in 2014.

(ii) 2.0 percent for taxable years beginning in 2015.

(iii) 2.5 percent for taxable years beginning after 2015.

(3) Applicable dollar amount

For purposes of paragraph (1)—

(A) In general

Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $695.

(B) Phase in

The applicable dollar amount is $95 for 2014 and $325 for 2015.

(C) Special rule for individuals under age 18

If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

(D) Indexing of amount

In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $695, increased by an amount equal to—

(i) $695, multiplied by

(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting "calendar year 2015" for "calendar year 1992" in subparagraph (B) thereof.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(4) Terms relating to income and families

For purposes of this section—

(A) Family size

The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(B) Household income

The term "household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(C) Modified adjusted gross income

The term "modified adjusted gross income" means adjusted gross income increased by—

(i) any amount excluded from gross income under section 911, and

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

* * * * *

The Commonwealth Fund

Regulatory Changes to Medicare in Response to COVID-19

August 4, 2020 | **Jennifer Podulka** and **Jonathan Blum**

ABSTRACT

- **Issue**: The COVID-19 pandemic prompted Congress and the Trump administration to rapidly waive or change existing Medicare regulations, providing unprecedented flexibility to help health care providers, Medicare Advantage plans, and Part D plans respond to the public health emergency.
- **Goals**: Track and categorize these regulatory changes, describe the benefits and risks of the changes, and describe the possible effects on the Medicare program if the temporary policies are made permanent.
- **Methods**: Analysis of COVID-19-related legislative, regulatory, and subregulatory changes to existing Medicare regulations issued January 1, 2020, through July 24, 2020.
- **Key Findings**: Congress and the administration modified 212 policies. The majority of changes addressed Medicare's conditions of participation for health care providers (55) and hospital regulation and financing (60). About two-thirds of the policies were

implemented under 1135 waiver authority (137), and most are expected to expire in the future (203).

- **Conclusion**: Many important, long-standing beneficiary protections and controls to reduce inappropriate Medicare spending have been temporarily waived by extensive regulatory changes. Any changes considered for extension should be studied to assess their long-term benefits and potential consequences. The effects of these policies should also be studied to determine what actions should be immediately taken to respond to future public health emergencies.

Introduction

As the COVID-19 pandemic started to spread, Congress and the Trump administration responded with a series of legislative, regulatory, and subregulatory changes to the Medicare program that were designed to provide relief from certain Medicare rules in order to assist health care providers, Medicare Advantage organizations, and Part D plans in responding to the pandemic. Some of these changes waived conditions of Medicare participation to enable patients to be treated in alternative care settings. Other changes permitted physicians and other providers to receive Medicare reimbursements for telemedicine services.

KEY COVID-19-RELATED CHANGES

Medicare reimbursement for telehealth is temporarily permitted for more types of clinicians and services, including:

- **Telephone visits**
- **Physician supervision services**
- **Urban and rural areas**
- **New sites, including patients' homes.**

Hospitals can temporarily provide services in alternative care sites, including:

- **Other health care facilities**
- **Expansion sites (such as hotels or community facilities)**
- **Patients' homes (for some services).**

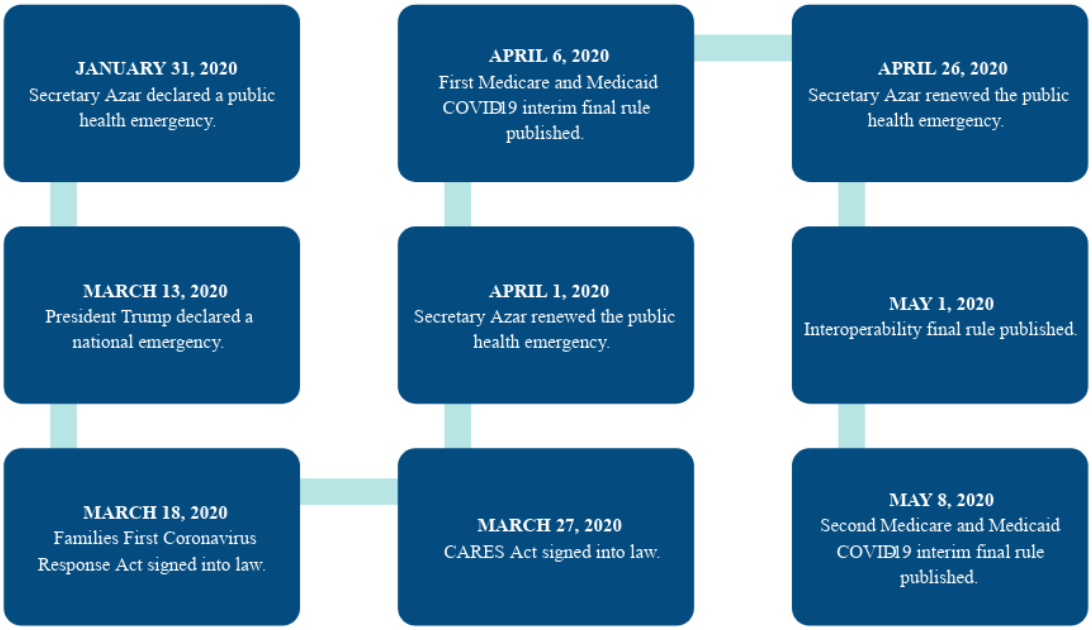
Licensed providers can temporarily provide services outside of their state of enrollment.

Between January 1 and July 24, 2020, over 200 Medicare legislative and regulatory changes were made in response to COVID-19 (Exhibit 1). In addition, the Centers for Medicare & Medicaid Services (CMS) has issued subregulatory guidance on a near-weekly basis during this time to provide additional flexibility to providers and Medicare plans.

Health Management Associates (HMA) catalogued the array of COVID-19-related regulatory changes during this time period and categorized them according to their characteristics, including types of providers and plans affected, effective date, and expected duration. This information is available in the companion policy tracker, which will be periodically updated.

Exhibit 1

Timeline of Major Medicare COVID-19-Related Legislative and Regulatory Changes



Source: Jennifer Podulka and Jonathan Blum, Regulatory Changes to Medicare in Response to COVID-19, (Commonwealth Fund, August 2020).

HHS'S AND CMS'S REGULATORY AUTHORITY

Section 1135 of the Social Security Act (SSA) is the foundation of the Department of Health and Human Services' (HHS's) legal authority for responding to public health emergencies.[1] Section 1135 waivers require both a declaration of national emergency or disaster by the president and a public health emergency determination by the HHS secretary.[2] President Trump declared a national emergency on March 13, 2020, effective March 1, 2020.[3] HHS Secretary Azar declared a public health emergency on January 31, 2020, effective January 27, 2020.[4]

Under SSA Section 1135, the Secretary can temporarily waive or modify certain Medicare, Medicaid, Children's Health Insurance Program (CHIP), and Health Insurance Portability and Accountability Act (HIPAA) requirements.[5] The Secretary cannot waive Medicare coverage or payment rules, but some of the permitted waivers or modifications may have an indirect effect on the application of Medicare fee-for-service coverage or payment rules.[6]

In addition to the 1135 waivers, HHS and the Centers for Medicare and Medicaid Services (CMS) exercised 1812(f) and 1877(g) waivers and agency authority to waive or modify policy or procedural norms (for example, expediting enrollment applications, adjusting timelines or requirements for Innovation Center models). [7] CMS has also announced that the agency will exercise its discretion to refrain temporarily from enforcing certain regulatory requirements during the emergency. CMS also released two interim final rules with comment periods to make policy and regulatory revisions to the Medicare program (and other programs) in response to the COVID-19 public health emergency (Exhibit 1).

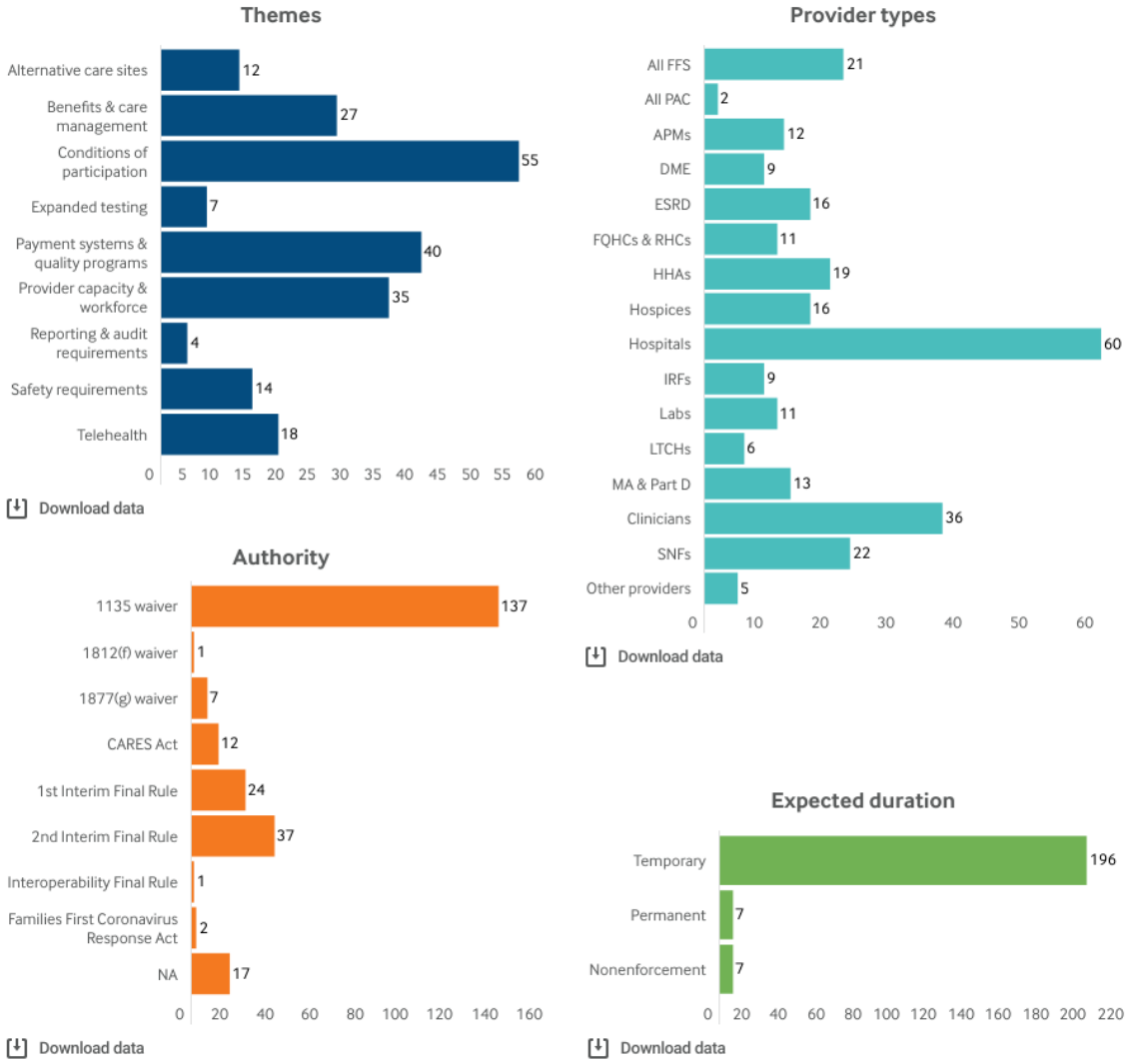
Key Findings

Our analysis found that actions taken by Congress and the administration in response to the COVID-19 pandemic affected virtually all types of health care providers and health plans that participate in the Medicare program (Exhibit 2). To date, efforts have been concentrated on hospital providers, accounting for 60 of the 212 policy actions.

We organized the policies into nine themes. According to our categorization, actions taken by Congress and the administration primarily addressed conditions of participation requirements for Medicare providers (55). The next most common themes were payment systems and quality programs (40) and provider capacity and workforce (35).

Exhibit 2

Characteristics of COVID-19-Related Regulatory Changes



Note: There were 212 total regulatory changes. The number of changes by provider type and authority is greater than the total number of regulatory changes because each change could affect more than one type of provider and be included in more than one change action. "Nonenforcement" changes are those where CMS indicated that the agency was not changing existing regulations but would temporarily cease to enforce the regulations.

*Abbreviations (alphabetical order): alternative payment model (APM), durable medical equipment (DME), end-stage renal disease (ESRD), federal qualified health centers (FQHCs), fee-for-service (FFS), home health agency (HHA), inpatient rehabilitation facility (IRF), long-term care hospital (LTCH), Medicare Advantage (MA), post-acute care (PAC), rural health clinic (RHC), and skilled nursing facility (SNF).

Source: Jennifer Podulka and Jonathan Blum, Regulatory Changes to Medicare in Response to COVID-19, (Commonwealth Fund, August 2020).

Nearly all these policy actions (203) are currently expected to be temporary (Exhibit 2), absent further Congressional or administration action. Seven of the actions were not direct changes to or waivers of regulations; instead CMS indicated that, for a limited time, it would not enforce the existing regulations.

Most policies (145) were implemented through HHS's various waiver authorities (Exhibit 2). CMS implemented 61 changes through two interim final rules with comment periods. Most, but not all, of the changes included an indication of the effective date and end date.

Most of the changes (179) went into effect sometime during March and many (130) are expected to be in effect through the duration of the public health emergency.[8]

Discussion

Since the COVID-19-related changes have been in effect for several months, key questions include:

1. How were the regulatory changes designed to help the health care system respond to the current public health emergency?
2. What are the potential positive and negative impacts of these regulatory changes on Medicare beneficiaries' access to care?
3. What was the purpose of the existing, pre-COVID Medicare regulations?
4. If the temporary COVID-19-related regulatory changes become permanent, how can the public have meaningful input on the potential positive and negative consequences?

The nine themes that HMA assigned to each of the regulatory changes help to address the first question. In general, the regulatory changes were designed to assist health care systems in testing and treating a surge of COVID-19 patients and in enabling health care providers to continue treating Medicare patients under social distancing requirements. With more than 200 individual regulatory changes, there is a wide range of specific intended benefits (Exhibit 3).

Most changes to Medicare regulations bring both potential positive and negative impacts for Medicare beneficiaries and the health care systems that provide care to them. In response to the second question, Exhibit 3 highlights some potential positive and negative impacts for Medicare beneficiaries. For example, even highly necessary and appropriate changes, like increased COVID-19 testing, come with potential drawbacks for beneficiaries, such as the risk of surprise billing and high cost-sharing amounts.

As to the third question, Exhibit 3 indicates that existing Medicare regulations that have been temporarily or permanently waived by COVID-19-related changes fulfill critical public policy purposes for the program, such as:

- ensuring that beneficiaries have access to certain items and services
- ensuring that providers comply with measures to protect patients
- deterring fraud, abuse, and overuse
- protecting patients from serious harm.

It is also important to note that Medicare regulations, under normal circumstances, go into effect only after going through an established notice-and-comment rulemaking process, which enables stakeholders to raise questions and provide input that the agency can use to determine the best course of action. HHS and CMS may waive or modify this process if they can demonstrate good cause, such as public emergencies.

While the majority of COVID-19-related regulatory changes were declared to be temporary when they were announced, the administration has indicated plans to make some permanent.[9] Changes that have proved popular with providers and patients are likely candidates, such as expanded reimbursement for telemedicine services. Stakeholders have expressed eagerness to learn which changes may become permanent, and the administration has taken actions to gather input on these decisions. On June 23, 2020, CMS announced the creation of a new division in the agency, the Office of Burden Reduction and Health Informatics, which is tasked with continuing "to explore innovative ways to address regulatory reform and burden reduction."[10]

Exhibit 3

Summary of COVID-19-Related Regulatory Change Themes

Theme	Purpose of existing regulations	Intended benefit of changes	Potential impact on beneficiaries
Alternative care sites	Set payment rates and clinical requirements for different facility types based on their unique features	Ensure capacity to handle a potential surge of COVID-19 patients through temporary expansion sites	Pro: Provides more choice in sites to access care Con: Patients may not know facility and may be surprised by billing and cost-sharing rates
Benefits and care management	Ensure that beneficiaries have access to certain items and services and quality of care from Medicare providers, facilities, and plans	Cover new services, modify requirements for services, remove prior authorization requirements, and ease requirements for patient assessments and care plans	Pro: Easier access is given to prescription drugs and testing Con: Some patient rights are curtailed, and there is a risk of reduced quality of care
Conditions of participation	Define facility types by characteristics and ensure that providers comply with measures to protect patients and program spending	Ease or waive requirements providers must meet to participate in Medicare	Pro: Access to providers is maintained or expanded Con: Increases risk of reduced quality and risk of fraud, waste, and abuse
Expanded testing	Not applicable	Enable more COVID-19 testing at more locations	Pro: Provides more access to testing Con: Increases risk of surprise billing and cost sharing
Payment systems and quality programs	Ensure that Medicare pays providers appropriately; deters fraud, abuse, and overuse; and incentivizes payment systems to reward value	Waive some payment system and quality requirements to maintain or increase provider payments	Pro: Maintained or expanded access to providers Con: Increases risk of reduced quality of care and higher cost-sharing
Provider capacity and workforce	Limit the provision of some services to certain types of providers	Remove scope-of-practice and other barriers for clinicians to treat patients	Pro: Maintained or expanded access to providers Con: Increases risk of reduced quality of care
Reporting and audit requirements	Collect information to improve Medicare program and deter fraud, abuse, and overuse	Limit collection of some information and pause audit activity	Pro: New reporting will yield more information Con: Reporting cuts will yield less information
Safety requirements	Protect patients from serious harm (for example, fires, health care–acquired infections)	Temporarily suspend some safety requirements to reduce provider responsibility and facility traffic	Pro: Provides potential for facilities to focus more on COVID-19 Con: Increases risks to patient safety
Telehealth	Limit use of telehealth to services that may be better suited to the technology and deter fraud, abuse, and overuse	Increase use of telehealth for clinicians to provide services and supervision	Pro: Maintained or expanded provider access; no exposure to risk of COVID-19 infection Con: Increases potential of reduced quality, surprise billing, and cost-sharing

Note: This table summarizes characteristics that are generally shared across changes within each theme category. For more information on individual changes, see the companion policy tracker.

Source: Jennifer Podulka and Jonathan Blum, Regulatory Changes to Medicare in Response to COVID-19, (Commonwealth Fund, August 2020).

It may be necessary to let certain temporary waivers expire, possibly even before conclusion of the public health emergency if the continued threat of possible patient harm outweighs the potential benefits of the policy waiver, such as reducing the overall number of people coming through health care facilities. For example, policymakers may need to significantly limit the duration of the waivers related to on-time preventive maintenance of dialysis machines and scheduled fire inspections.

To answer the fourth question, it will be essential to make use of the unique opportunity presented by the temporary policy changes to study their impact, especially any unintended consequences. These analyses should compare the trade-offs in positive and

negative consequences for beneficiaries (including populations such as dual-eligibles), providers, and taxpayers. The analytic results, along with stakeholder comments, should be part of regular notice-and-comment rulemaking to determine which regulatory changes should be made permanent.

Conclusion

In response to the COVID-19 public health emergency, Congress and the Trump administration made an unprecedented number of legislative, regulatory, and subregulatory changes to the Medicare program. While these policy actions were designed to address urgent concerns — protecting beneficiaries' access to care through use of alternative care settings and Medicare-reimbursed telemedicine services, as well as supporting provider and health plan responses through temporary relief from certain requirements — the actions come with the risk of negative outcomes. Those risks include trading the important, long-standing beneficiary protections and Medicare spending controls included in the original regulations for policies that may, on balance, prove less preferable.

As the COVID-19 pandemic continues, policymakers and stakeholders should carefully assess both the benefits and unintended consequences of these policy actions for patients' access to care and the ability of providers to provide high-quality care. The analyses and stakeholder input should inform the regular notice-and-comment rulemaking process to ensure that any permanent regulatory changes improve the Medicare program. In addition, the effects of these policies should be carefully studied to help determine the best way to prepare for future public health emergencies.

How This Study Was Conducted

Health Management Associates reviewed the COVID-19- related legislative, regulatory, and subregulatory changes to the Medicare program that occurred between January 1, 2020, and July 24, 2020. We catalogued these changes and categorized them according to their characteristics, including types of providers and plans affected, effective date, and expected duration. This information is available in the companion policy tracker.

The authors thank Narda Ipakchi, Zach Gaumer, Yamini Narayan, and Elaine Henry, all of HMA, for their contributions to the policy tracker.

The mission of the Commonwealth Fund is to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, and people of color. Support for this research was provided by the Commonwealth Fund. The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

Supported in part by a grant from The SCAN Foundation – advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. For more information, visit www.TheSCANFoundation.org.

1. "Public Health Emergency: Legal Authority," U.S. Department of Health and Human Services, September 18, 2019;."Public Health Emergency: Waiver or Modification of Requirements Under Section 1135 of the Social Security Act," U.S. Department of Health and Human Services, March 13, 2020.

[2] "Emergency Authority and Immunity Toolkit: Waiver Authority in National Emergencies," Association of State and Territorial Health Officials, May 2013.

[3] National emergencies remain in effect for one year unless ended sooner by Congress or the administration.

[4] Public health emergencies remain in effect for 90 days. The HHS Secretary most recently renewed the public health emergency on July 23, 2020, effective July 25, 2020. https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-23June2020.aspx

[5] Association of State and Territorial Health Officials, "Emergency Authority and Immunity Toolkit: Waiver Authority in National Emergencies."

[6] Centers for Medicare and Medicaid Services, *Medicare Fee-for-Service: Additional Emergency and Disaster-Related Policies and Procedures That May Be Implemented Only with a § 1135 Waiver*, (CMS, March 15, 2019).

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Publication Details

Publication Date: August 4, 2020

Editor: Maggie Van Dyke

Citation:
Jennifer Podulka and Jonathan Blum, *Regulatory Changes to Medicare in Response to COVID-19* (Commonwealth Fund, Aug. 2020). https://doi.org/10.26099/xfeh-hh07

Topics

COVID-19 Medicare

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DOI: 10.1377/hlthaff.2019.01155
HEALTH AFFAIRS 39,
NO. 8 (2020): 1354–1361

Costs Are Higher For Marketplace Members Who Enroll During Special Enrollment Periods Compared With Open Enrollment

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ABSTRACT More than 20 percent of Affordable Care Act (ACA) exchange market (Marketplace) members insured by a large national insurer in 2015 and 2016 enrolled during a special enrollment period (SEP), defined as any enrollment outside the annual open enrollment period. These members were younger and had approximately 34 percent higher average monthly total costs than members who enrolled during open enrollment. SEP members had 69–114 percent higher inpatient costs and 11–19 percent higher emergency department costs than open enrollment members. Higher costs, especially among a slightly younger population, may suggest potential adverse selection among SEP members, which could contribute to increased premiums and insurer exit from ACA Marketplaces. Although SEP members had a shorter average enrollment length per calendar year, they were more likely than open enrollment members to stay insured through the end of the calendar year and to renew in a Marketplace plan offered by the insurer in the following year. However, renewing SEP and open enrollment members were older, sicker, and costlier than nonrenewing members of both enrollee types, which suggests that healthier members are switching carriers or leaving the market over time. Additional research is urgently needed to inform evidence-based policy regarding Marketplace risk adjustment and SEP eligibility rules and to improve outreach to people who are eligible for SEP enrollment.

Adverse selection, the phenomenon in which people are more likely to enroll in a health insurance plan when they have a medical need,[1] has the potential to threaten the stability of the Affordable Care Act (ACA) exchanges, or Marketplaces. Adverse selection, combined with lower-than-expected enrollment and the inability to accurately predict risk adjustment payments,[2,3] makes it difficult for insurers to set premiums to cover member costs. High unanticipated costs could induce health insurers either to increase premiums, which would increase expenses both for unsubsidized Marketplace members and for the federal government (for subsidized Marketplace members), or to leave the Marketplaces.[3] Members who enroll during special enrollment periods (SEPs), as opposed to open enrollment periods, may contribute to adverse selection.[3,4] An individual or family is eligible to enroll in a Marketplace plan outside of the annual open enrollment because of qualifying life events, including changes in insurance coverage (for example, job loss), household (that is, marriage, birth, death), residence, income, citizenship, and incarceration.[5,6] Similar ACA policies apply to nongroup plans outside the Marketplaces as well. Industry re-

ports[7,8] and other analyses[9] suggest that SEP Marketplace members have higher costs and shorter enrollment lengths, and a recently published paper found underpayment of risk adjustment for SEP members compared with open enrollment members.[4] Furthermore, it is estimated that fewer than 15 percent of people eligible for SEPs actually apply for Marketplace coverage.[10] This indicates adverse selection if people with greater health care needs are more motivated to overcome the administrative barriers to prove a qualifying event.

In 2015 large national insurers estimated that as many as 30 percent of their Marketplace members enrolled during an SEP;[7,8] previously conducted comparisons of open enrollment members versus SEP members[5,7,8] have not used nationally representative data and have not reported costs by type of utilization. The objective of our study was to provide an independent analysis of SEP enrollment rates, using administrative and claims data from a large national health plan that participated in the federally run Marketplace in twenty-four states in 2015 and 2016, to examine whether SEP and open enrollment members differed with respect to demographics, enrollment length, probability of remaining enrolled at the end of the calendar year, total costs, and costs by type of utilization, and to determine whether these differences suggest adverse selection among SEP members. We also examined a cohort of 2015 members who renewed in 2016 to examine whether year-to-year patterns of enrollment suggest adverse selection in the Marketplaces.

Study Data And Methods

DATA SOURCE We used member-level administrative and claims data for the 2015 and 2016 plan years from Optum's deidentified Clinformatics Data Mart database, which includes approximately 1.5 million unique members younger than age sixty-five who were enrolled in Marketplace plans offered by a large national commercial insurer in 2015 ($n = 732,597$) and 2016 ($n = 722,221$). These data include enrollment information and all medical and pharmacy claims. We used a vendor-provided field that estimates total costs per service and that is standardized across time and geography. The insurer offered exchange plans in twenty-four states using the federal Marketplace during the study period and then dropped out of most Marketplaces in 2017.

COVERAGE PERIODS The 2015 open enrollment period ran from November 15, 2014, to February 15, 2015, and the 2016 open enrollment period ran from November 1, 2015, to January 31, 2016. Coverage began on the first day of the following month for members who signed up between the first and fifteenth days of the month (for example, coverage started February 1 if the member signed up January 15). For those signing up between the sixteenth and last days of the month, coverage began on the first day of the second following month (for example, coverage started March 1 if a member signed up January 16). In each calendar year (2015 or 2016), members with a plan start date between January 1 and March 1 were classified as enrolling during an open enrollment period; otherwise, they were classified as enrolling during an SEP. The coverage period for both open enrollment and SEPs extends until the end of the calendar year (that is, December 31) in which a member enrolled unless they choose to disenroll before then. Members are free to disenroll at any time without financial penalty and often do so for reasons such as gaining employer coverage from a new job, becoming eligible for Medicaid or Medicare, moving, or deciding to become uninsured.

ANALYSES In our main analyses we examined members' demographic characteristics, enrollment length, prescription drug use, and costs in the first exchange enrollment period with this particular insurer during the study period (that is, new Marketplace enrollees in 2015 and 2016) in each year. We also examined these variables for 2016 renewers, whom we defined as the subset of members who enrolled in either open enrollment or an SEP in 2015, remained enrolled in December 2015, and renewed during the 2016 open enrollment, and compared them with 2015 enrollees who did not renew in the 2016 open enrollment (2015 nonrenewers) and with new 2016 Marketplace enrollees.

We first analyzed the percentage of Marketplace plan members who enrolled during an SEP. Using two-sample *t*-tests and chi-square tests on SEP members versus open enrollment members, we then compared demographics (that is, age and sex), number of days from enrollment to disenrollment within the calendar year, the percentage of members who remained enrolled at the end of the calendar year (that is, in December), and average monthly total costs both in aggregate and by category (outpatient, inpatient, and emergency department). We examined both the enrollment length and the percentage remaining enrolled at the end of the calendar year because SEP members, by definition, are enrolled for fewer months in the calendar year. In our analysis of renewers, we compared 2015 costs for 2015 new members who did not renew in 2016 (that is, 2015 nonrenewers) versus 2015 costs for 2015 new members who renewed in 2016 (that is, 2016 renewers). We also compared 2016 costs for 2016 renewers ver-

sus 2016 costs for 2016 new members.

As a measure of morbidity, we examined the number of drug classes dispensed in the first month and in the first two months of enrollment (for members with at least two months of enrollment), using the American Society of Health-System Pharmacists Pharmacologic-Therapeutic Classification system.[11] We also identified women of childbearing age (ages 19–44) who were pregnant or delivered a baby, using diagnosis (that is, *International Classification of Diseases*, Ninth Revision; *International Statistical Classification of Diseases and Related Health Problems*, Tenth Revision), diagnosis-related group, and procedure codes,[12,13] and we calculated the percentage of pregnant women among SEP enrollees versus open enrollment enrollees. Although childbirth is an SEP-qualifying event for the federal Marketplace, pregnancy is not: Coverage begins after the child is born and does not cover prenatal care and delivery, which are predictable and costly types of utilization.[5,14] Therefore, any differences in pregnancy rates between SEP and open enrollment members could be evidence of adverse selection.

LIMITATIONS Our study had multiple limitations. We were limited to data from one insurance carrier, and our results might not be generalizable to other insurers who participate in the federal or state-run Marketplaces. We did not have data on members before and after their enrollment with this particular insurer, which meant that we were unable to distinguish whether members were new enrollees in the Marketplace or whether they were previously enrolled in the Marketplace via a different insurer (that is, they were plan switchers). However, the data provide insights into one insurer's experiences regarding costs, utilization, and sustainability in twenty-four states using the federally run Marketplace. Finally, we could not differentiate between subsidized and unsubsidized enrollees or Marketplace plan type (bronze, silver, or gold).

Study Results

During the two study years, 21.6 percent of Marketplace members enrolled during an SEP (24.6 percent in 2015 and 18.5 percent in 2016). Compared with open enrollment members, SEP members were younger (mean age, 36.6 versus 41.1 years in 2015, $p < 0.001$; 33.8 versus 40.1 years in 2016, $p < 0.001$), and the age difference remained significant even when we excluded infants who were SEP eligible at birth (data not shown). There were no differences by sex: 55.5–55.7 percent of members in both enrollment populations were female in both years (exhibit 1).

As expected, SEP members had a shorter average length of enrollment compared with open enrollment members (137 versus 242 days in 2015, $p < 0.001$; 146 versus 278 days in 2016, $p < 0.001$). However, SEP members were more likely than open enrollment members to still be enrolled at the end of the calendar year (64.4 percent versus 51.2 percent in 2015, $p < 0.001$;

EXHIBIT 1

Demographics, enrollment length, and prescription drug use for new Marketplace members, by enrollment period, 2015 and 2016

	2015 new enrollees (n = 732,597)				2016 new enrollees (n = 722,221)			
	Open enrollment		SEP		Open enrollment		SEP	
	Number[a]	Percent/ SD[b]	Number[a]	Percent/ SD[b]	Number[a]	Percent/ SD[b]	Number[a]	Percent/ SD[b]
N (% of year total)	552,405	75.4	180,192	24.6	588,758	81.5	133,463	18.5
Age, mean (SD)	41.1	(16.5)	36.6	(18.1)****	40.1	(17.6)	33.8	(18.9)****
Female (%)	306,935	55.6	100,356	55.7****	327,205	55.6	74,054	55.5****
Days of enrollment, mean (SD)	242	(118.0)	137	(74.3)****	278	(112.6)	146	(76.9)****
Enrolled in December of contract year (%)	282,561	51.2	116,139	64.4****	354,223	60.2	85,841	64.3****
2016 renewers[c] (%)	178,036	32.2	75,302	41.8****	—[d]	—[d]	—[d]	—[d]
Pregnant women (%)	4,126	0.7	1,322	0.7	5,492	0.9	1,119	0.8**
No. of drug classes in first 2 months of enrollment, mean[e] (SD)	1.2	(2.5)	1.4	(2.8)****	1.6	(2.9)	1.6	(3.0)

SOURCE Authors' analysis of individual-market enrollment and claims data from a large national health plan that participated in the federally run Marketplace in twenty-four states in 2015 and 2016. **NOTE** p values for differences between special enrollment period (SEP) and open enrollment within that year. [a]Numbers in this column represent the count unless row labels indicate they are the mean. [b]Numbers in this column represent percent of column totals unless row labels indicate they are standard deviations (SDs). [c]2016 renewers are the subset of 2015 members who enrolled in either the 2015 open enrollment period or SEP, remained enrolled in December 2015, and reenrolled during the 2016 open enrollment period. [d]Not applicable. [e]Among members enrolled for a minimum of two months (sample size is in online appendix exhibit 1; see note 15 in text). **$p < 0.05$ ****$p < 0.001$

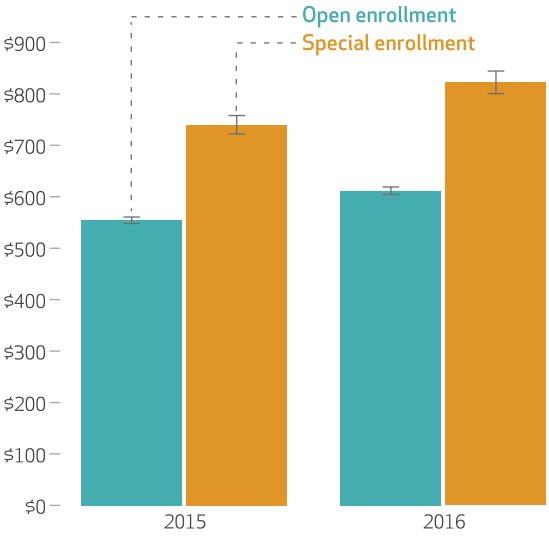
64.3 percent versus 60.2 percent in 2016, $p < 0.001$). Among those insured in 2015, SEP members were more likely than open enrollment members to reenroll during open enrollment in 2016 (41.8 percent versus 32.2 percent, $p < 0.001$) (exhibit 1).

SEP members had significantly higher average monthly total costs than open enrollment members ($185.91 more per member per month in 2015, $p < 0.001$; $210.70 more in 2016, $p < 0.001$), representing approximately 34 percent higher total costs in both years (exhibit 2). SEP members had significantly higher average monthly emergency department total costs ($17.04 more per member per month in 2015, $p < 0.001$; $7.80 more in 2016, $p < 0.001$), representing 11–19 percent higher costs than those of open enrollment members. SEP members also had large and significantly higher average monthly inpatient total costs ($97.65 more per member per month in 2015, $p < 0.001$; $164.68 more in 2016, $p < 0.001$), representing 69–114 percent higher costs than those of open enrollment members (exhibit 3). There was no consistent difference in average monthly outpatient costs between SEP members and open enrollment members (SEP members had $6.86 higher per member per month costs in 2015 [$p < 0.001$] and $8.36 lower per member per month costs in 2016 [$p < 0.001$]) (exhibit 3). In both years there were similar proportions of pregnant women among both groups of members (0.7 percent for both groups in 2015, $p = 0.57$; 0.8 percent versus 0.9 percent in 2016, $p < 0.05$) (exhibit 1). The results for average number of prescription drug classes, a proxy for morbidity, were mixed. Compared with open enrollment members, SEP members filled prescriptions for slightly more drug classes in the first two months of enrollment in 2015 (1.4 versus 1.2, $p < 0.001$), but the average was the same (1.6) for both groups in 2016 (exhibit 1).

As mentioned earlier, 32.2 percent of 2015 open enrollment members and 41.8 percent of 2015 SEP members renewed coverage with the insurer during 2016 open enrollment (and were defined as 2016 renewers). Compared with 2016 open enrollment new enrollees, 2016 renewers were slightly older; were more likely to be female; filled prescriptions from more drug classes; and had higher total, emergency department, and inpatient monthly 2016 costs (see online appendix exhibit 1).[15] Differences between SEP and open enrollment members persisted within the 2016 renewer cohort. Compared with 2016 renewers who initially enrolled during the 2015 open enrollment, 2016 renewers who initially enrolled during the 2015 SEP were younger, had higher 2016 costs (total, emergency department, inpatient, and outpatient), and were less likely to be enrolled at the end of 2016 (the opposite of our finding among new enrollees; see appendix exhibit 1).[15] Compared with 2015 nonrenewers (that is, members who enrolled during the 2015 open enrollment or the SEP and did not reenroll in 2016), 2016 renewers were older, were more likely to be female, filled prescriptions from more drug classes, and had higher total 2015 monthly costs (appendix exhibit 1).[15] A small portion of 2015 Marketplace members dropped coverage before December 2015 and reenrolled in the 2016 open enrollment or remained enrolled through December 2015 and reenrolled in the SEP in 2016. Although we excluded these members from the analysis of renewers (that is, our cohort of 2016 renewers only included 2015 members who were enrolled in December 2015 and reenrolled during the 2016 open enrollment period), they are unique groups that warrant further investigation.

EXHIBIT 2

Average monthly total costs for new Marketplace members, by enrollment period, 2015 and 2016



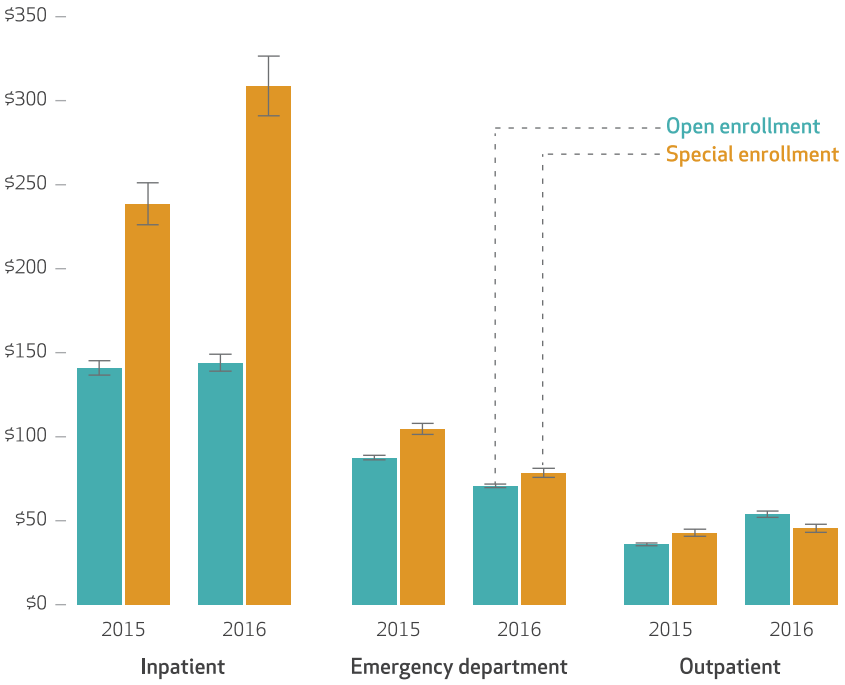
SOURCE Authors' analysis of individual-market enrollment and claims data from a large national health plan that participated in the federally run Marketplace in twenty-four states in 2015 and 2016. **NOTE** Error bars indicate 95% confidence intervals.

Discussion

More than 20 percent of Marketplace plan members from a large national health insurer enrolled during an SEP; these members were younger and had approximately 34 percent higher average monthly total costs than open enrollment members in 2015 and 2016. Higher costs,

EXHIBIT 3

Average monthly costs by utilization category for new Marketplace members, by enrollment period, 2015 and 2016



SOURCE Authors' analysis of individual-market enrollment and claims data from a large national health plan that participated in the federally run Marketplace in twenty-four states in 2015 and 2016. **NOTE** Error bars indicate 95% confidence intervals.

especially among a slightly younger population, may suggest potential adverse selection among SEP members, which could contribute to increased premiums and insurer exit from vulnerable Marketplaces. These findings provide independently conducted evidence about one large national insurer's Marketplace experience that corroborates industry reports regarding the percentage of members enrolling during SEPs and their higher costs.[7,8] Our results highlight how increased costs from SEP enrollees could be detrimental to health plans, especially if risk adjustment algorithms underpay for these enrollees.[4]

Prior analyses of enrollment duration have examined only the length of enrollment of SEP versus open enrollment members per calendar year. This approach is misleading, as SEP members, by definition, enroll later in the calendar year. We found that although SEP members had a shorter average enrollment length per calendar year, they were more likely than open enrollment members to stay insured through the end of the calendar year, and they were also more likely to renew in a Marketplace plan offered by the insurer in the following year. This suggests that many SEP enrollees are joining midyear intending to stay covered beyond the end of the year, instead of enrolling for a time-limited health care need. Almost half (40–49 percent) of open enrollment members and more than a third (36 percent) of SEP members in our study population did not stay enrolled through the end of the year (exhibit 1), which suggests that short-term enrollment and churn are common in both enrollee populations. However, recent research on Marketplace enrollees suggests that short enrollment length is more predictive of higher monthly costs for SEP members than it is for open enrollment members.[4] Therefore, a 2017 policy to include enrollment duration in risk adjustment algorithms, which did not take into account whether or not a member enrolled in an SEP, will likely result in continued underpayment for SEP members.[4]

Our finding that members who were older, sicker, and costlier in 2015 were more likely to renew in 2016 also raises concern about possible adverse selection among renewers. Among the 2016 renewers, SEP enrollment in the prior year was associated with higher costs and therefore should be considered in risk adjustment models. Compared with 2016 new members, 2016 renewing members (that is, those who originally joined in 2015) were older and had higher total monthly costs. Our results regarding the renewing members are similar to those of another study that found that Marketplace members who maintain coverage throughout the year have more serious health care needs than those who drop coverage.[9] More research is needed to assess selection effects for members who switch between different insurers on the Marketplaces; we were unable to distinguish switchers from those leaving the Marketplaces, as our data included only one insurer.

Our study is the first to compare costs by category for SEP and open enrollment Marketplace members. The higher monthly costs for SEP members compared with open enrollment members were mostly driven by 69–114 percent higher inpatient costs among SEP members. Higher inpatient costs could be indicative of an SEP population that is sicker, on average, or by a preponderance of SEP members who enroll in anticipation of a discretionary medical procedure. Although both types of members contribute to adverse selection, they would require different policy levers to reduce the impact on the Marketplace. Additional research is needed to inform evidence-based policy regarding Marketplace risk adjustment, SEP eligibility rules and determination, and strategies to increase awareness of SEPs for eligible people.

Future studies should assess the timing of health care use (for example, shortly after enrollment versus later in the contract year) and type

(for example, discretionary versus nondiscretionary) among SEP versus open enrollment members to determine the extent of adverse selection in the SEP group. These analyses could inform policies to better predict and address the health needs of members who enroll during SEPs. For instance, it may be that SEP-eligible members are, on average, sicker than open enrollment members, as SEP members recently experienced major life events that may be correlated with poorer health, such as job loss or loss of Medicaid coverage—the two most common reasons for SEP enrollment.[16] If this is the case, improving the risk adjustment process to cover costs for these more vulnerable members would be warranted. Our analysis of number of prescription drug classes filled by both groups of members had mixed results (exhibit 1); therefore, a more detailed analysis is needed to understand the health care needs of the SEP population. If the higher SEP member costs are driven by anticipated discretionary use (for example, orthopedic surgery or infertility treatment),[17] then stricter SEP eligibility criteria or time-dependent coverage restrictions would be a potential policy solution. We found that the pregnancy rate among both groups of members was similar (exhibit 1), suggesting that SEP adverse selection is not occurring for this particular group. Further research should examine the health and market implications of including pregnancy as an SEP qualifying event.[18,19] In addition, future research is needed to understand the implications of extending SEP eligibility for unexpected events that cause people to lose employment or have health shocks, such as the COVID-19 pandemic.[20]

If higher costs for SEP members are not covered by risk adjustment, insurers could respond by raising premiums, attempting to reduce SEP enrollment by not advertising its availability, or limiting the generosity of plan offerings. The potential impact on premiums is nuanced. For the 87 percent of Marketplace members[21] who receive premium tax credits (which reflects the difference between an individual or family's premium cap and the premium of the benchmark silver plan in the market),[22] an across-the-board increase in premiums would have limited impact but would increase the federal government's spending on subsidies. However, increased premiums would be experienced by unsubsidized Marketplace members and individual-market members who get coverage outside of the Marketplaces. Future research is needed to examine SEP versus open enrollment differences in member characteristics, enrollment length, utilization, and costs among unsubsidized versus subsidized Marketplace members and in the individual market outside of the Marketplaces.[23] If SEP members are sicker, on average, as suggested by their higher inpatient and emergency department costs, they may tend to choose more generous gold and platinum plans or those with large networks. Future research should also examine the metal tier of plans that SEP and open enrollment members choose. From an insurer's perspective, the higher costs of SEP members may be mitigated if these costs are offset by higher average premiums or are adequately accounted for in risk adjustment.

Researchers and policy makers should also examine whether a 2018 federal policy that added more stringent preenrollment verification for SEP Marketplace eligibility affects access to health insurance and the sustainability of Marketplace plans.[24–26] Although tighter criteria for SEP eligibility may reduce adverse selection in the Marketplaces, they may also create an overwhelming administrative burden for an already vulnerable population undergoing major life transitions and deter healthier members (who would improve the risk profile of the member population) from enrolling in a Marketplace plan. Alternatively, tighter SEP eligibility criteria may lead members who would have otherwise enrolled in the SEP to enroll during open enrollment, which would reduce differences between the two enrollee populations but would not change the overall Marketplace risk profile.

There is also a need for further research to understand reasons for low uptake among people who are SEP eligible and the health needs of SEP-eligible people who do not enroll. If SEP-eligible people who do not enroll are indeed healthier than those who do, then evidence-based policies to encourage greater enrollment in this population may result in lower average costs for SEP enrollees. Loss of employer-sponsored insurance resulting from job loss is the most common reason to become SEP eligible.[10] Younger, and presumably healthier, people are more likely than older adults to lose employer-sponsored coverage throughout the year and become SEP eligible, but evidence suggests that older adults are more likely to enroll in Marketplace plans.[27] Targeted outreach and enrollment strategies for the SEP-eligible population could include providing laid-off workers with insurance navigators or brokers and partnering with state workforce agency programs.[10] Similarly, targeted interventions for people who become SEP eligible as a result of loss of Medicaid eligibility, the second most common reason for SEP eligibility, could also increase enrollment in SEPs and provide coverage to a potentially vulnerable population in transition. However, little is known about the health needs of people

who lose Medicaid eligibility and about how increasing their enrollment would affect the risk profile of Marketplace members. It will also be important to examine how the repeal of the individual mandate penalty (which went into effect in 2019)[28] affects Marketplace uptake among SEP-eligible people. Without the mandate requiring healthy people to have coverage, the potential for adverse selection in both enrollee groups is greater.

After a volatile start to the ACA, the Marketplaces generally began to stabilize in 2017, as the insurers that remained in the Marketplaces became profitable,[29] and in 2019 and 2020 more insurers entered the Marketplaces or expanded their geographic service areas and reduced annual premium increases.[30,31] However, potential adverse selection among SEP enrollees could remain a concern to the extent that it contributes to insurers raising premiums to unaffordable levels or exiting the Marketplaces, particularly in already-vulnerable markets. There is considerable variability in the number of insurers that participate in the Marketplace in each state, as well as concern about a lack of competition in many Marketplaces,[31] which increases premiums and decreases affordability, particularly for unsubsidized Marketplace members.[32–34] Furthermore, areas with fewer insurers participating in the Marketplaces are more likely to be rural and lower income, leaving the most vulnerable people in the more volatile markets.[32] The national insurer represented in our study data, which exited almost all Marketplaces in 2017, disproportionately participated in markets with few insurers.[35] Our study sample also included only federally run Marketplaces, which are more likely to have fewer insurers and to have experienced a decline in enrollment since 2017, a trend not seen in state-based Marketplaces.[32]

Conclusion

Our study provides independent evidence that Marketplace members who enroll during a special enrollment period have different demographics and health care costs compared with members who enroll during open enrollment. Higher average health care costs among SEP members suggest adverse selection. Although the increased probability that SEP members remain enrolled throughout the contract year and renew coverage the following year mitigates concerns about short-term enrollment in this population,[7,8] it raises concerns about sustainability if costlier SEP members are more likely than healthier members to stay in the market over time. Additional research is urgently needed to inform evidence-based policy regarding Marketplace risk adjustment, SEP eligibility rules, and targeted SEP marketing and outreach efforts to ensure that Marketplace plans remain both accessible for people undergoing major life transitions and affordable for all. ■

This research was previously presented as a poster at the AcademyHealth Annual Research Meeting in Washington, D.C., June 3, 2019. J. Frank Wharam plays a clinical role at Atrius Health. Alison Galbraith plays a clinical role at Boston Children's Hospital. This work was funded by a Department of Population Medicine Faculty Grant.

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NASHP

States Launch Initiatives to Address Racial Inequities Highlighted by COVID-19

August 3, 2020 / by Elinor Higgins

COVID-19 has illuminated racial and ethnic disparities across the country and simultaneously created new momentum for state leaders to address the root causes of racial inequity. COVID-19 case data [https://www.nashp.org/how-states-report-covid-19-data-by-race-and-ethnicity/] has made the disparities — driven by systemic racism [https://www.urban.org/features/structural-racism-america] and inequitable economic and social conditions [https://www.brookings.edu/blog/up-front/2019/02/15/how-racial-and-regional-inequality-affect-economic-opportunity/] — increasingly blatant. In response to the dual crises of racism and COVID-19, many state leaders are working to address the inequities leading to disproportionate outcomes for communities of color.

A new section of the National Academy for State Health Policy's (NASHP) interactive map, How States Collect Data, Report, and Act on COVID-19 Racial and Ethnic Disparities [https://www.nashp.org/how-states-report-covid-19-data-by-race-and-ethnicity/] , highlights how states are approaching this issue. Eighteen states have activated task forces to address the high rates of COVID-19 cases and deaths in communities of color and their recommendations include:

- Additional protections and compensation for employees who are put at increased risk of COVID-19 due to the nature of their jobs;
- Additional collection, analysis, and transparent release of COVID-19 demographic data;
- Targeted distribution of personal protective equipment (PPE), testing, and treatment resources to communities most impacted by COVID-19;
- Formal methods for the incorporation of community-based organizations and community voices into state and local decision-making processes;
- Increased efforts to make COVID-19 informational materials multi-lingual and accessible;

- Increased focus on data collection and analysis to identify those most impacted by COVID-19; and
- Increased public health funding and the continuation of services that support and prioritize communities of color.

NASHP will continue to monitor state task forces to identify recommendations that are incorporated into state policy. States are also using new funding streams, implementing innovative technology solutions, and targeting resources to where they are most needed:

- **North Carolina:** The North Carolina Department of Health and Human Services (NCDHHS) awarded grants [https://www.ncdhhs.gov/news/press-releases/ncdhhs-selects-organizations-address-impact-covid-19-latinx-community] to five local organizations to help address the disparate impact that COVID-19 is having among the state's Latinx communities. Additionally, Gov. Roy Cooper issued an executive order [https://governor.nc.gov/news/governor-cooper-signs-executive-order-address-disproportionate-impact-%EF%BB%BF-covid-19-communities] to address the disproportionate impact of COVID-19 on communities of color. The order:
  - Tasks the North Carolina Pandemic Recovery Office with ensuring the equitable distribution of pandemic relief funds;
  - Prioritizes historically underutilized businesses for state contracts and resources for recovery;
  - Directs NCDHHS to ensure all communities have access to COVID-19 testing and related health care; and
  - Directs the Division of Emergency Management to continue coordinating efforts to protect the food supply chain and support feeding operations at food banks and school systems, and the North Carolina National Guard to assist with mass testing of food processing and migrant farm workers.

- **Virginia:** Gov. Ralph Northam announced a pilot program [https://www.governor.virginia.gov/newsroom/all-releases/2020/may/headline-856730-en.html] in Richmond to increase access to PPE in underserved communities. The new Health Equity Leadership Task Force [https://www.governor.virginia.gov/media/governorvirginiagov/dei/documents/Commonwealth-of-Virginia-Equity-Leadership-Task-Force_Website-information2pdf] is leveraging

data to prioritize areas experiencing disproportionate impacts of COVID-19 and working with the City of Richmond to establish policies and programs that include an equity lens.

- **Ohio:** A new position [https://coronavirus.ohio.gov/wps/portal/gov/covid-19/resources/news-releases-news-you-can-use/efforts-improve-minority-health] will be created within the Ohio Department of Health dedicated to social determinants of health and opportunity. This position will build on existing efforts and work directly with local communities on their specific long-term health needs and Ohio's response to COVID-19. This position will also collect data to inform best practices and assist in implementation of the Minority Health Strike Force [https://coronavirus.ohio.gov/wps/portal/gov/covid-19/resources/news-releases-news-you-can-use/efforts-improve-minority-health] 's recommendations.
- **Illinois:** The Illinois Department of Public Health created a multi-departmental COVID-19 equity team [https://www.nprillinois.org/post/illinois-targets-covid-19-disparities-among-blacks-pritzker-won-t-say-when-schools-might-re#stream/0] to address health disparities. The equity team has launched a COVID-19 text messaging system, which includes an option for Spanish-speakers. Illinois residents can opt-in to receive text messages and obtain the most accurate information about the coronavirus and how to protect themselves.
- **Louisiana:** Gov. John Bel Edwards announced [https://gov.louisiana.gov/index.cfm/newsroom/detail/2473] he is making $500,000 from the Governor's COVID-19 Response Fund available to the Louisiana COVID-19 Health Equity Task Force to examine the causes and possible solutions to the high rate of deaths within Louisiana's African American community and other impacted populations.
- **Massachusetts:** Gov. Charlie Baker signed a bill into law [https://www.mass.gov/news/governor-baker-files-covid-19-data-collection-bill] that requires the collection of vital public health data — information that would provide additional detail about the impact of COVID-19 on minority communities — and establishes a COVID-19 Equity Task Force.
- **Washington, DC:** The Equity, Disparity Reduction, and Vulnerable Populations Committee is part of Reopen DC's advisory group. The committee assembled a set of recommendations [https://coronavirus.dc.gov/sites/default/files/u65602/02.%20Equity%20and%20Vulnerable% describing how to ensure equity during reopening. O

- **West Virginia** [illegible] Department of Health and Human Resources also announced plans to increase testing [https://dhhr.wv.gov/News/2020/Pages/Testing-Opportunities-for-Minorities-and-Other-Vulnerable-Populations.aspx] opportunities for minority populations and other vulnerable populations in counties that have both a large minority population and evidence of COVID-19 transmission.

The disproportionate impact of COVID-19 [https://www.nashp.org/how-states-report-covid-19-data-by-race-and-ethnicity/] makes it more clear than ever that racism is a public health issue [https://www.apha.org/topics-and-issues/health-equity/racism-and-health/racism-declarations] with implications for state health policy. As states continue to grapple with COVID-19, many, like those in the examples above, are focusing on how to address immediate disparities related to the pandemic.

States are beginning the process of setting in place strategies to address the preexisting racial and ethnic disparities that worsen outcomes for people of color. New positions dedicated to addressing social determinants of health and opportunity; multi-departmental equity teams; enhanced collection and reporting of data; and public health services that support and prioritize communities of color are key strategies to ensure equity issues remain part of states' agendas. NASHP will continue to track how states approach this work and how they measure change and success over time.

Support for this work was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the foundation. Thanks to NASHP's Population Health Team [https://www.nashp.org/policy/population-health/] for their contributions to this analysis.

States, Federalism, and Medicaid

Have the ACA's Exchanges Succeeded? It's Complicated

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Abstract The fight over health insurance exchanges epitomizes the rapid evolution of health reform politics in the decade since the passage of the Affordable Care Act (ACA). The ACA's drafters did not expect the exchanges to be contentious because they would expand private insurance coverage to low- and middle-income individuals who were increasingly unable to obtain employer-sponsored health insurance. Instead, exchanges became one of the primary fronts in the war over Obamacare. Have the exchanges been successful? The answer is not straightforward and requires a historical perspective through a federalism lens. What the ACA has accomplished has depended largely on whether states were invested in or resistant to implementation, as well as individual decisions by state leaders working with federal officials. Our account demonstrates that the states that have engaged with the ACA most consistently appear to have experienced greater exchange-related success. But each aspect of states' engagement with or resistance to the ACA must be counted to fully paint this picture, with significant variation among states. This variation should give pause to those considering next steps in health reform, because state variation can mean innovation and improvement but also lack of coverage, disparities, and diminished access to care.

Keywords Affordable Care Act, health insurance exchanges, federalism

The fight over health insurance exchanges epitomizes the rapid evolution of health reform politics in the decade since the passage of the Affordable Care Act (ACA). The ACA's drafters did not expect the exchanges to be contentious but, rather, saw them as "a conservative means to a liberal end" because they would expand private insurance coverage to low and middle income individuals who were increasingly unable to obtain employer-

Journal of Health Politics, Policy and Law, Vol. 45, No. 4, August 2020
DOI 10.1215/03616878-8255577

sponsored health insurance (Jones, Bradley, and Oberlander 2014: 103). The exchanges were supposed to be set up by states to facilitate competition among commercial insurers by stimulating the individual and small group insurance markets. Instead, exchanges became one of the primary fronts in the war over Obamacare.

Most of the individual elements of the exchanges—insurance regulation and consumer protections, pooling the uninsured together to give them greater purchasing power, income-related subsidies to help people with modest incomes afford coverage, a standard benefit package, and choice among private insurance plans—were not controversial.[1] Versions of these ideas had been included in health reform proposals by prominent Republicans such as Richard Nixon, George H. W. Bush, Mitt Romney, and Paul Ryan. Yet, the Obama administration faced a surprising degree of resistance, namely, from Republican leaders, when it came time to implement the exchanges.

Have the exchanges been successful? The answer is not straightforward and requires a historical perspective through a federalism lens. What the ACA has accomplished has depended largely on whether states were invested in or resistant to implementation, as well as individual decisions by state leaders working with federal officials. Cross-state comparisons show adopting a suite of policies designed to reduce the uninsured rate—such as investing in outreach, establishing a state-based exchange, and Medicaid expansion—resulted in stronger insurance markets. But these options rely heavily on local political will.

We begin by highlighting how and why states made key decisions; then we discuss the metrics that should be used to evaluate the impact of the exchanges. These two sections lead to the conclusion that the exchanges have been least impactful in the states that used the exchange as an opportunity to oppose the law's existence and most successful where leaders cooperated with the Obama administration—or at least got out of the way. We conclude by considering the future of the exchanges in the next chapter of health reform.

1. In addition, new federal rules established consumer protections such as essential health benefits that all qualified health plans (QHPs) must cover to be sold on an exchange, including services commonly excluded in the pre-ACA individual market, such as maternity care, mental health care, and pediatric dental services. QHPs also could not impose annual or lifetime limits or exclude those with preexisting conditions. Plans were to be kept affordable through community rating, a 3:1 rating band, cost-sharing reductions, and premium tax credits that fluctuate based on individual income and the price of benchmark plans. Plans were also standardized across four "metal" tiers of actuarial value.

Fifty Reenactments of the ACA Fight

The Obama administration's central goal for the ACA was to move toward universal coverage with at least some bipartisan support. Developments at the state level suggested that exchanges were an important component of a bipartisan strategy to achieving that goal. Ed Haislmaier (2006) of the Heritage Foundation said of the 2006 Massachusetts health reform—largely constructed around the first statewide insurance exchange—that governors and legislators would be "well advised to consider this basic model as a framework for health care reform in their own states." Utah, one of the most conservative states in the country, followed this blueprint and passed Utah H.B. 188 in 2009 to create an exchange for small businesses, with 96.3% of Republicans voting in favor. Polling suggested that more than half of Republicans supported the idea of providing tax credits to help people buy insurance in a state-based exchange (KFF 2010). Yet, by the time open enrollment began for the ACA in October 2013, 34 states had rejected control of their exchange.

For many reasons, giving states a major role in the creation of exchanges seemed like a good idea, including that the ACA might not have been enacted any other way. When the bill that ultimately became the law passed the Senate on December 24, 2009, Democrats had exactly 60 seats, meaning they could not spare a single vote and still overcome the threat of a Republican filibuster. Relying on the joint federal/state governance of federalism gave conservative Democrats a response to anyone describing the bill as a national government takeover. However, Scott Brown's election in Massachusetts a few weeks later meant that Democrats had lost their filibuster-proof majority, and passing the bill in December with state-based exchanges was the only path to enacting health reform.

Tim Jost was correct when he warned in 2009 that giving states a prominent role in implementation would open the door to 50 reenactments in state capitals of the fight Congress had just experienced (see Jost 2010). Federalism was a political pressure-release valve that made enactment possible but also dramatically complicated the politics of implementation. The law's drafters assumed that virtually every state would adopt at least a bare minimum approach to implementing its own exchange and that blue states would use their flexibility to innovate beyond the ACA. Initially, conservatives seemed to see things the same way: in 2010, 49 states began planning for a state-based exchange, including applying for and receiving $1 million federal planning grants and running local stakeholder engagement processes (Jones 2017).

Immediate Complications in Implementation

The 2010 election was the first milestone in the fight over the exchanges and the ACA's implementation. The growing Tea Party movement focused on gubernatorial and state legislative races, successfully turning blue states red and making red states redder, shifts that signaled ACA implementation might be tested. But even then, it would have been difficult to predict the intensity of opposition that would soon be leveled against the ACA and the assumption that states would want to run their own exchanges. Yet, despite the common narrative of Republicans opposing President Obama, the main partisan split in many states was not between Republicans and Democrats but within the Republican Party (Jones, Bradley, and Oberlander 2014).

Kansas offers a dramatic example of the Republican evolution. The outgoing governor was a Democrat, whose administration applied for a $31.5 million grant to be an innovator state in developing an exchange (Jones 2017). By the time the Department of Health and Human Services (HHS) considered the state's grant application in late 2010, Republican Sam Brownback had been elected governor but had not yet taken office. Brownback vehemently opposed the ACA's passage as a US Senator, and HHS wanted assurance that if they awarded Kansas the money, he would not get in the way. Governor Brownback promised HHS that Kansas would implement the ACA and be a lead exchange development state (Jones 2017).

Governor Brownback spent the first half of 2011 defending his decision to conservative groups, who felt betrayed by his cooperation with the Obama administration. He argued that, although he supported the lawsuit challenging its constitutionality, the ACA was still the law of the land. Taking money from the Obama administration was a subversive act to implement Obamacare "the Kansas way." Tea Party activists in his state and across the country disagreed. In August 2011, Governor Brownback's chief of staff and nearly a dozen Republican legislators from Kansas attended the annual meeting of the American Legislative Exchange Council (ALEC) in which Ed Haislmaier—who had described Governor Romney's law in Massachusetts as a blueprint for states to follow just five years earlier—argued that the exchanges were a frontline for opposing Obamacare. He called for "house by house, floor by floor, room by room combat" on Obamacare (Mooney 2011). Days later, Governor Brownback announced he was rejecting the HHS grant and would not build an exchange.

The year 2012 was similarly tumultuous in the fight over health insurance exchanges across the country. Some Republicans signaled they were

open to creating a state-run marketplace but preferred to wait until the Supreme Court ruled in *NFIB v. Sebelius*. They did not want to undermine the lawsuit that many of them had supported and did not want to devote resources to implementing a law that they hoped would be invalidated. The Court's June 28 decision upholding the constitutionality of the individual mandate came one day before HHS's deadline for states to apply for the major grant to build information technology infrastructure in time for the start of open enrollment in October 2013. The Obama administration moved the deadline back to November, hoping that more states would pursue an exchange. But leaders in red states decided to wait until after the 2012 election, hoping Mitt Romney would be elected and follow through with his promise to undo the ACA. By the time election occurred, many leaders felt it was too late or refused to implement exchanges as an act of resistance galvanized by the Court's rendering Medicaid expansion optional. For most, the decision to delay had become a de facto decision to default to the federal exchange (Jones 2017).

Who Gets to Decide?

In many states the decision over whether or not to create an exchange came down to a fight over who decides. Seemingly mundane features of institutional design shaped the power dynamics between key players. For example, the New Mexico legislature meets for only 2 months every year and must focus in even-numbered years on the budget and bills introduced by the governor. Though states had more than 3 years to set up an exchange, the New Mexico legislature effectively had only brief windows in 2011 and 2013 to make this decision. New Mexico passed enabling legislation in March 2013, but the first decision of the newly created exchange oversight board was to default to the federal website because no time remained to develop state-specific technology.

Similarly, 10 states have insurance commissioners that are independently elected rather than appointed by the governor (Morton 2013). Mississippi's insurance commissioner, Mike Chaney, did not support the ACA but believed Mississippi would be in a better position if its exchange was regulated at the state level. Mississippi Governor Phil Bryant initially stayed out of the way, and HHS indicated it would work directly with Chaney. However, Bryant bowed under Tea Party pressure and threatened that his Medicaid agency would refuse to cooperate with the insurance department's exchange. The Obama administration reluctantly sided with Bryant, making Mississippi the only state to have an application for a state-based exchange rejected by the federal government (Jones 2017).

The need to fight on so many fronts was one important factor in the Obama administration's disastrous launch of HealthCare.gov on October 1, 2013, but many others contributed. This included the challenge of integrating databases from across multiple arms of government and a misguided reliance on Medicare.gov as a model for the website. But ultimately the site was launched successfully and became one of the centerpieces of the ACA. In the next section, we investigate the evidence of exchange success by looking beneath national statistics to unearth the importance of state participation.

The Record to Date

The goal of the exchanges was to improve coverage, access, affordability, and quality of benefits while maintaining sufficient commercial insurer competition to drive value. Initial enrollment in the exchanges was considerably lower than early estimates predicted due to technological glitches with HealthCare.gov and state-based exchange platforms, as well as the unaffordability of coverage options for higher-earning groups. The ACA had envisioned states taking the lead in advertising during open enrollment and so had not allocated much money to the federal government for this purpose. Former members of the Obama administration started Enroll America to go door to door and sign people up for coverage in large states that had rejected control of their exchange, such as Florida, North Carolina, and Texas. The Centers for Medicare and Medicaid Services had to take money from other ACA programs such as the Prevention Fund to pay for advertising.

Younger adults enrolled in coverage at lower rates than predicted, contributing to disappointing enrollment figures and risk pools that lacked healthier enrollees (Kliff 2014). By the end of 2013, politicians and pundits created a swirling sense that the exchanges were an impending disaster, with House Speaker John Boehner declaring he did not think the exchanges in particular and the ACA in general were "ever going to work" (Parkinson 2013).

Despite these dismal predictions, after a rocky start exchange enrollment increased and premiums were lower than predicted (Glied, Arora, and Solis-Roman 2015). Between 2013 and 2016, the portion of the total US population covered by nongroup private coverage grew from 3% to 7% (KFF 2017). This increase might seem modest, but one estimate suggests that nearly 40% of ACA-related coverage gains in 2014 were driven by the premium subsidies offered in the exchanges (Frean, Gruber, and Sommers 2016).

From 2016 to 2019, exchange enrollment slightly declined nationally. Considerable volatility in premiums arose as the Trump administration eliminated the cost-sharing reduction payments, slashed funding for enrollment assistance, and expanded access to ACA-noncompliant plans, and then Congress zeroed out the penalty for the individual mandate (KFF 2019). The exchanges have been remarkably resilient to these attacks due to strategic state responses and the enduring value of exchange coverage. For example, in response to the elimination of cost-sharing reduction payments, many states increased the price of their benchmark silver plan, a strategy known as "silver loading." Because federal premium tax credits are calculated using the price of the second-lowest silver-tier plan, this strategy recouped the lost federal cost-sharing reduction payments in the form of tax credit dollars and helped stabilize exchange markets.

Paradoxically, the elimination of the cost-sharing reduction payments has increased exchange enrollment and lowered premium costs for many low- to middle-income consumers (CBO 2018). In 2018, zero-premium coverage was available to over half of exchange enrollees (Branham and DeLeire 2019). In 2019, average premiums fell for the first time since the ACA was implemented, though prices have increased for higher-income consumers ineligible for federal subsidies (KFF 2019). More insurers entered the exchanges than exited in 2019, and nationwide, premiums are expected to decrease slightly in 2020 (Fehr, Cox, and Levitt 2018; Fehr et al. 2018; Scott 2019). The beneficial effects of silver loading may have weakened what could have been a series of fatal blows to the exchanges. Trump administration policies have put the exchanges to an important test: without a mandate and with cheaper, skimpier plans just a click away, do consumers abandon exchange coverage? The evidence suggests many have decided to stay.

Yet national statistics mask significant state-level heterogeneity. Despite the federal policies designed to regulate the cost and quality of insurance options sold through the exchanges, variations in implementation efforts drive stark differences in coverage, access, competition, and affordability by state. The Supreme Court in 2015 could have dramatically raised the stakes of state decisions had it concluded in *King v. Burwell* that tax credits were available only in states that ran their own exchange. Even so, one study found that premium subsidies were nearly twice as effective at increasing health insurance coverage rates in states that opted to establish their own exchange rather than use the federal exchange (Frean, Gruber, and Sommers 2016). Larger effects of premium tax credits in states with local exchanges reflect a host of state-level factors that enhance take-up

of subsidized insurance. States that run their own exchanges benefit from greater customization and the opportunity to integrate enrollment infrastructure efforts across state programs. Under state or state-federal partnership exchange models, states conduct marketing, outreach, and consumer assistance and run their own online eligibility and enrollment platforms.

State-run outreach efforts have become critical to stabilizing exchanges in recent years as the Trump administration drastically cut funding for open enrollment advertising and consumer assistance programs. In 2017, nearly 800 counties in states with federally facilitated exchanges did not have any federally funded navigation services (Galewitz 2018). In contrast, states that have state-based exchanges were able to supplant federal funding with local funds. In California, healthy risk pools and an above-average insurance sign-up rate are due in part to the state's considerable expenditures on outreach (Corlette and Schwab 2018). State leaders elected in 2018 recognized the potential benefits of local exchange administration, as five additional states have indicated intent to transition part or all of their exchange infrastructure to the state level by 2020–22 (Schwab and Volk 2019).

Whether a state adopted Medicaid expansion is another important decision that effects the stability of exchanges, as expansion states were more likely than nonexpansion states to have more carriers participating in their markets, lower premiums, and healthier risk pools (Gabel et al. 2018; Han et al. 2015; Semanskee, Cox, and Levitt 2016; Sen and DeLiere 2016). This correlation may be due to Medicaid expansion offering an alternative source of coverage for individuals with greater health needs, which kept potentially higher-cost individuals out of state exchanges, Medicaid managed care organizations having more experience covering lower-income and higher-need populations, and less disruptive insurance coverage churn. State investment in Medicaid enrollment outreach also raised awareness of all insurance options, public and private.

Carrier participation also differs widely by region. In 2019, a third of rating regions had only one participating insurer, with the majority concentrated in southern, rural states with lower median incomes (Gabel et al. 2018). Markets with more competition offer enhanced consumer choice and lower premiums, which increases enrollment (Van Payrs 2018). However, insurers that have maintained financial viability in the exchanges have largely done so through selective contracting for lower rates with a narrow network of providers. Exchange plans with limited networks are a concern nationally, as limited provider options may impose barriers to

timely access to care. Narrow networks are an even greater concern in rural regions where provider shortages already existed.

Despite the successes some states have experienced, exchanges have some shortcomings that impact all states. For example, affordability remains an issue nationally, with nearly half of exchange enrollees exposed to full cost sharing and nearly 90% of those in the exchanges enrolled in high-deductible health plans (Dolan 2016). Out-of-pocket prescription drug costs are double those of the average employee plan (Thorpe, Allen, and Joski 2015). Further, actuarial values represented by metallic tiers in qualified health plans are realized for only a small proportion of enrollees with enough health care spending for their insurer to pay their allocated portion of the costs. Because of this, most exchange enrollees pay for the majority of their care out of pocket (Polyakova, Hua, and Bundorf 2017). Again, states vary in their efforts to rein in premium costs, with 12 states establishing reinsurance programs through section 1332 state innovation waivers to encourage insurer participation, spur competition, and offer lower-priced plans to consumers.

While national- and state-level challenges exist, the exchanges still represent improvement relative to the unregulated, expensive, and inequitable insurance markets that existed before the ACA. The ACA was created to deal with high rates of uninsurance among low- to middle-income workers who were left out of private and public options, and the exchanges have created coverage where none existed. But was the political turmoil avoidable, or was it inherent in the federalism structure of the ACA? We explore these questions next.

Learning from the ACA and the Future of Federalism in Health Reform

The ACA was designed to foster near-universal insurance coverage, and its approach to that goal was to devise federal baselines above which states would operate. Federalism was a politically pragmatic choice that seemed necessary to gathering votes for the law's passage and a structural governance choice that is often a default approach in American health reform. Federalism also predictably results in variability. While variation can translate into policy successes or failures, variation in health policy often leads to inequitable policy across states and disparities across populations.

States were supposed to run the exchanges because states historically have regulated insurance. But, the ACA's implementation has been inconsistent with its statutory design. The political litmus test of resistance

to the ACA, combined with opposition through litigation, has made it so the states that ordinarily prioritize their own sovereign lawmaking authority decided to reject federal policy, and federal power actually expanded within their borders through the federal exchange. The adaptive, negotiated, dynamic federalism that HHS and states engaged in to create something between the federal- and state-run exchanges was not the federalism of the ACA as enacted but developed organically as a response to implementation hurdles (Gluck and Huberfeld 2018). These negotiations have not reflected the Supreme Court's constitutional concern—that states could not fend for themselves—in striking down the Medicaid expansion as "coercive" in *NFIB v. Sebelius*. Rather, this dynamic federalism demonstrated states are adept at making demands and extracting compromises from HHS, learning from other states, negotiating, and finding a way to get a little more.

Our account of the exchange implementation dynamics illuminates that no federal health care takeover has occurred. Indeed, the unevenness of state exchange implementation may indicate that the federal law of the ACA does not go far enough in creating a strong national baseline, precisely because this variability has weakened the policy goal of universal coverage. Varying levels of success across states reflect the design of the federal law. But states' successes and failures also reflect the negotiations that occurred to implement the ACA, which included state policy decisions to support or thwart the ACA at every stage. Notably, HHS Secretary Kathleen Sebelius and other officials in the Obama administration accepted state participation in many forms, regardless of the ACA's statutory design, so that hybrid and partnership exchanges also developed. These were not specifically contemplated by the ACA but arose in response to the political resistance to the law that was itself undermined by state insurance commissioners' and health care stakeholders' desire to see the law implemented. Perhaps most surprising, the vast majority of states have a hand in running the exchange in their own markets, whether or not they established any kind of state-based, partnership, hybrid, or other exchange.

So whether the ACA's new exchanges were successful very much depends on where one looks, as states both implemented and undercut the ACA during the Obama administration. Some states that tried to create their own exchanges failed, while other states that appeared hostile on the surface actually worked with the Obama administration behind the scenes. For example, both Oregon and Florida rely on the federal exchange platform, but their politics and policy desires have been very different, with

Oregon reliably counting as "blue" (tried to create an exchange but failed) and Florida counting as "red" (never created its own exchange). In other words, the federalism story is much more complex than the standard account that two-thirds of states did not implement state-based exchanges. The fact of a state relying on the federal exchange does not begin to tell us everything about that state's engagement with the ACA or whether or why that state experienced significant increases in coverage.

Further, resisting creation of a state-run exchange was just one way that states undermined the ACA during the Obama administration. For example, we noted above that the interplay between exchanges and Medicaid expansion has been important. While nearly half of the individuals who are uninsured could enroll through an exchange with federal tax subsidies, these remaining uninsured are living in Medicaid nonexpansion states—states that have resisted ACA implementation in all of its federalism dimensions. These ACA-hostile states have higher rates of uninsurance and poorer performance on the other metrics of health policy success. Yet, paradoxically, some states also worked with HHS to expand Medicaid and implement exchanges with state-specific names and special rules attuned to the politics of the state—though these were acts of state resistance to Obamacare (similar to Governor Brownback's vision described above), ultimately such engagement helped facilitate the exchanges' success.

The Trump administration made no secret of its hostility to the law; President Trump's first executive order was a directive to limit the regulatory scope of the ACA. The administration took steps to thwart the ACA's goal of universal coverage, such as cutting navigator funding, decreasing advertising for open enrollment, limiting the open enrollment period, and destabilizing the small markets of the exchanges by allowing short-term plans to be sold as ACA compliant. The administration has been undermining exchange enrollment while at the same time allowing states to create barriers to Medicaid expansion enrollment for the people newly eligible under the ACA, such as work requirements—again, the fate of the exchanges and Medicaid expansion have been intertwined.

Despite the challenging road to implementation and multiple legislative attacks, the exchanges have become a standard building block of the American health insurance architecture. In fact, the Republican replacement bills, such as the American Health Care Act of 2017, included the same basic framework of an exchange with consumer protections and premium tax credits. The House Republican bill did include important changes at the margins, such as increasing the rating band to 5:1 and tying

premiums to age instead of income, but these were not supported by Senate Republicans. And, these were not legally or structurally significant changes relative to what the ACA already created—a federalism-dependent, highly regulated, publicly supported insurance market.

Yet, the role of federalism in the success or failure of the exchanges is ultimately hard to measure, in part because states' policy choices have cut both ways. Some states undercut the law during the early years, leading to challenges to the law, such as *NFIB v. Sebelius* and *King v. Burwell*. States also limited the reach of the federal exchange by enacting nullification laws, which were of no legal consequence but contributed to public confusion about the ACA's existence. And states' refusal to engage with HHS publicly also undermined accountability for the exchange implementation, which made it harder for voters to know who was responsible for the law's successes and failures.

For all of this confusion and resistance, the nation's uninsurance rate at the end of the Obama administration was the lowest it had ever been, at 8.6% by some measures. While the exchanges do not cover a large percentage of the population, they provide subsidized access to insurance markets for those who have been stuck outside of both public and private insurance, playing a key role in expanding coverage for low-income and part-time workers.

Conclusion

The fight over health insurance exchanges over the last 10 years is a fascinating case study in what happens when preferences over policy and federalism conflict with partisan goals. Exchanges were initially a bipartisan idea that became ideologically charged only as they became wrapped in the broader party politics of Obamacare. After congressional Republicans failed to block the ACA's passage, some of their state-level counterparts used their role in implementing the exchanges to attempt post-enactment obstructionism that they hoped would unravel the entire law, even if it meant forgoing funding and ceding control to the federal government. Perhaps this was a risk they were willing to take, given that they did not truly oppose the idea of an exchange.

Our account demonstrates that the states that have engaged with the ACA most consistently appear to have experienced greater exchange-related success. But each aspect of states' engagement with or resistance to the ACA must be counted to fully paint this picture, with significant variation between states. This variation should give pause to those considering

next steps in health reform, because state variation can mean innovation and improvement but also lack of coverage, disparities, and diminished access to care.

The 2020 presidential election approaches as we contemplate the ACA's signing anniversary. Throughout the primary debates, a core group of Democratic contenders have advocated for an incremental health reform approach that builds on the exchanges, not just by expanding the exchanges' tax subsidies but also by building the public option so quickly discarded in 2009. Some have advocated for dismantling the private provision of health insurance altogether. President Trump has said he will have a new health reform proposal in January 2021, with no further detail, but if 2017 is a guide, a new proposal is unlikely to include a dismantling of the exchanges. In fact, the Trump administration has tried to use the messiness of federalism and the fight over exchanges to both blame-shift and credit-claim, that is, taking credit for any positive developments—such as decreases in premiums—and blaming President Obama, congressional Democrats, and state leaders for any struggles.

Regardless of how new health reform proposals play out, a certain portion of health care decision making is nearly guaranteed to be punted to the states. (Even Senator Bernie Sanders's Medicare for All bill keeps the Medicaid program for long-term care coverage.) As we've learned from the ACA's exchanges, state-level cooperation and opposition are likely to play a major role in shaping the success or failure of future health reform.

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Race, Policy Feedbacks, and Political Resilience

Race, Politics, and the Affordable Care Act

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Abstract The political processes surrounding the Affordable Care Act (ACA) offer valuable lessons about race and politics in the United States. In particular, the ACA underscores a critical tension between politics and policy in a racialized polity: even when policies are intended to target and address racial disparities, politics can undermine the steps necessary to do so. Close scrutiny of the ACA during its first decade reveals how race intersects with politics to render public policy less equitable and more vulnerable to erosion. Ultimately, this analysis points to the ways that racialized political processes are formidable barriers to equitable material outcomes. By examining such processes and making them visible, this article elucidates the possibilities, limits, and contours of public policy as a mechanism for achieving racial justice.

Keywords Affordable Care Act, race, politics

Analyzing the political processes surrounding the Affordable Care Act (ACA) can teach us valuable lessons about race and politics in the United States. In particular, the ACA underscores a critical tension between politics and policy in a racialized polity:[1] even when policies are intended to winnow racial disparities, politics can undermine the steps necessary to do so. Close attention to the implementation of the ACA reveals how race intersects with politics to render public policy less equitable. Only by

1. Following Gotham (2000) and Bonilla-Silva (1997), I define racialization as economic, social, and political processes by which "people are sorted into racial categories, resources are distributed along racial lines, and state policy shapes and is shaped by the racial contours of society" (Gotham 2000: 293).

Journal of Health Politics, Policy and Law, Vol. 45, No. 4, August 2020
DOI 10.1215/03616878-8255481

scrutinizing such processes can we discern how policies and politics might be wielded to achieve racial justice in health care.

The ACA and Racial Inequality

The ACA was designed to reduce health inequities based on race and ethnicity (Ossei-Owusu 2016). The text of the original bill (Pub. L. No. 111–148. 3–23–2010) contained 34 references to "disparities," 28 references to either "discrimination" or "non-discrimination," 33 instances using either the word *racial* or *race*, and 35 instances using either the word *ethnicity* or *ethnic*. Though Barack Obama's approach to advancing his policy goals was often deracialized, the explicit emphasis on race in the ACA reveals a pronounced goal of diminishing racial disparities (Gillion 2016; Lewis, Dowe, and Franklin 2013). Such intentions notwithstanding, the ACA reflects an incongruity between politics and policy. On the one hand, health care politics became more deeply racialized during the presidency of Barack Obama and has remained so (Banks 2014; Fiscella 2016; Knowles, Lowery, and Schaumberg 2010; Maxwell and Shields 2014; McCabe 2019; Mitchell and Dowe 2019; Morone 2018; Tesler 2012). On the other hand, ACA policy was a harbinger of racial promise. Even in the face of antagonistic racial politics, with white Americans disproportionately opposing Obamacare, the policies of the ACA had "the potential to truly alter the landscape of racial and ethnic health disparities in the United States" (Mitchell 2015: e-66). Indeed, from the vantage point of those concerned with the legacy of racism in the United States, the ACA was viewed as "a stealthy civil-rights achievement of the Obama presidency, promising to make health care less of a financial burden, end disparities in health-care coverage, ease barriers to access for people of color, and subsidize preventative health-care services that proved especially lacking in black neighborhoods" (Newkirk 2016).

In retrospect, some of these expectations proved true. The ACA reduced racial/ethnic disparities in health insurance coverage, access to care, and health care utilization (Buchmueller et al. 2016; Chaudry, Jackson, and Glied 2019; Chen at al. 2016; Gutierrez 2018; Lipton, Decker, and Sommers 2019; McMorrow et al. 2016; Park et al. 2018). The reduction of insurance coverage gaps was one of the most salient ways that the ACA had a salutary effect on racial inequity. Between 2013 and 2017, the coverage gap between black and white Americans declined from 11.0 to 5.3 percentage points (Chaudry, Jackson, and Glied 2019). Similarly, during the same period, the coverage gap between Hispanics and non-Hispanic whites dropped from 25.4 to 16.6 percentage points.

Despite such good news, the story of race and the ACA is not a straightforward narrative of success. Racial imbalances in health care access and quality persist in the post-ACA era (Artiga, Orgera, and Damico 2019; Buchmueller et al. 2016; Yue, Rasmussen, and Ponce 2018). Moreover, the progress of the ACA in lessening racial disparities has begun to plateau or reverse (Artiga, Orgera, and Damico 2019). Insurance coverage is again a good example. After the above-mentioned improvements in coverage rates between 2013 and 2017, the overall uninsured rate rose from 7.9% in 2017 to 8.5% in 2018 (Berchick, Barnett, and Upton 2019). Hispanic Americans were most affected, with a 1.6–percentage-point increase in their uninsured rate.

To better understand this and other shortcomings of the ACA with respect to racial equity, we must look to politics. Doing so uncovers distinctive patterns that have stunted the ACA's ability to properly function as a "civil rights achievement." In this vein, I make two observations. First, even the most salient inequality-reducing feature of the ACA—Medicaid expansion—has endured politically induced variation, attenuating its effectiveness in diminishing racial disparities. Second, beyond Medicaid expansion, many of the numerous features of the ACA that explicitly target racial disparities have proven unstable or limited because their implementation has been contingent on political conditions.

The common thread uniting both of these points is that racialized politics constrains American public policy as a tool for equity. To detail this claim more precisely, I delineate complex and consequential connections between race, policy, and politics in American health care.

The Racialized Politics of Medicaid Expansion

As it was originally designed, one of the ACA's boldest and most promising mechanisms for reducing racial inequities was the expansion of Medicaid. Per the initial formulation of the ACA, Medicaid expansion would have offered public health insurance to all Americans with incomes at or below 138% of the federal poverty line. To secure the participation of every state, the federal government brandished both a carrot and a stick. The carrot consisted of generous federal funding that would cover 100% of the costs of expansion for nearly 3 years (from the beginning of 2014 through the end of 2016) and then gradually phase down to 90% by 2020. The stick meant that states refusing expansion would forfeit all of their federal Medicaid funding (not just the extra expansion resources). This combination of

incentives and sanctions was intended to ensure the geographic consistency of Medicaid expansion, an outcome that would have been a major departure from the norm. Prior to the enactment of the ACA, access to Medicaid was limited and highly unequal (Michener 2018). Variable categorical eligibility criteria at both the national and state levels meant that program benefits were heterogeneous across groups (with children, the elderly, pregnant women, and other specific groups often receiving more generous benefits) and across states (with some locales offering a wider scope of benefits and broader eligibility criteria than others). If Medicaid expansion had proceeded as originally planned, this patchwork policy design would have been augmented with a more standardized national approach applied to all Americans at or below 138% of the federal poverty line. Though the planned expansionary tack was not explicitly race based, the outsized presence of blacks and Latinos among the population of Americans living in or near poverty (e.g., 20% of Medicaid beneficiaries are black and 30% are Latino; KFF n.d.) meant that uniform national expansion of Medicaid would have had inequality-reducing racial effects.

Despite the initial objectives of the ACA, political processes fundamentally altered its course. Just over 2 years after the passage of the law (and before its full implementation), the Supreme Court issued a decision declaring Medicaid expansion partially unconstitutional. In *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012), the court held that by threatening noncompliant states with the loss of all Medicaid funds, the 2010 expansion was coercive. The *Sebelius* decision transformed the trajectory of the ACA, empowering states to eschew the expansion if they saw fit to do so. Many states did. Decisions about whether to expand largely (though not entirely) fell along partisan lines (Barrilleaux and Rainey 2014; Callaghan and Jacobs 2016; Jacobs and Callaghan 2013). States with Democratic legislative majorities and Democratic executives adopted the expansion most swiftly, while states with divided governments or Republican legislative majorities were less likely to do so, particularly in the South.

The intercession of the Supreme Court in the *Sebelius* case was consistent with the enduring role of federalism in the American political system, specifically with regard to health care, and especially concerning racialized resources (Michener 2018). People of color have long been disproportionately disadvantaged by federalism (Brown 2003; Lieberman and Lapinski 2001; Lowndes, Novkov, and Warren 2008; Miller 2008; Riker 1964; Soss, Fording, and Schram 2011; Tani 2016). Indeed,

federalism "has been one of the chief bulwarks of racial domination in the United States" (Brown 2003: 56). Particularly (but not exclusively) with respect to health care policies, racial disparities have been the frequent outcome of enhancing state discretion (Michener 2018). Given this larger national historical context, the court's decision in *Sebelius* had clear negative implications for the racial equitability of health resources.

The most concrete upshot of *Sebelius* is that many southern states have been able to evade Medicaid expansion (see fig. 1). The resulting racial distributional patterns have been stark. A 2015 Kaiser Family Foundation report (Artiga, Damico, and Garfield 2015) found that more than 60% of uninsured poor black adults excluded from Medicaid due to states' refusal to expand (i.e. those in the coverage gap) lived in just four southern states: Georgia (19%), Texas (16%), Florida (14%), and Louisiana (11%). Among Latinos, the patterns were even more striking. Nearly 8 in 10 Latinos in the coverage gap resided in just two states: Texas (52%) and Florida (27%). More generally, many of the southern states that declined to adopt were places with large shares of blacks (Mississippi, 38%; Louisiana, 32%; Georgia, 31%; Alabama, 27%; South Carolina, 27%) or Latinos (Texas, 40%; Florida, 26%). Ultimately, the racial demographics of the South have meant that the concentration of nonexpansion states in the region is a source of significant racial inequality in health care access.

Crucially, this inequity was induced by racialized political decisions. Numerous studies have demonstrated this. Lanford and Quadagno (2015) found that racial resentment was closely linked to Medicaid expansion, with lower racial sympathy and higher racial resentment (on the state level) correlated with stronger resistance to Medicaid expansion. Grogan and Park (2017) found that Medicaid expansion was racialized in terms of public support (with whites much less likely to support expansion) and policy adoption (with state expansion decisions positively correlated with white opinion but uncorrelated with nonwhite support). Grogan and Park also found that when the size of the black population increased and white support was relatively low, states were significantly less likely to expand Medicaid. This helps us to make sense of nonexpansion in southern states with significant health care needs but large black populations. Racial representational disparities combined with racial differences in policy preferences have been barriers to Medicaid expansion. As a result, there are significantly higher proportions of uninsured Americans in nonexpansion states, with the largest and most evident disadvantages among people of color (see fig. 2).

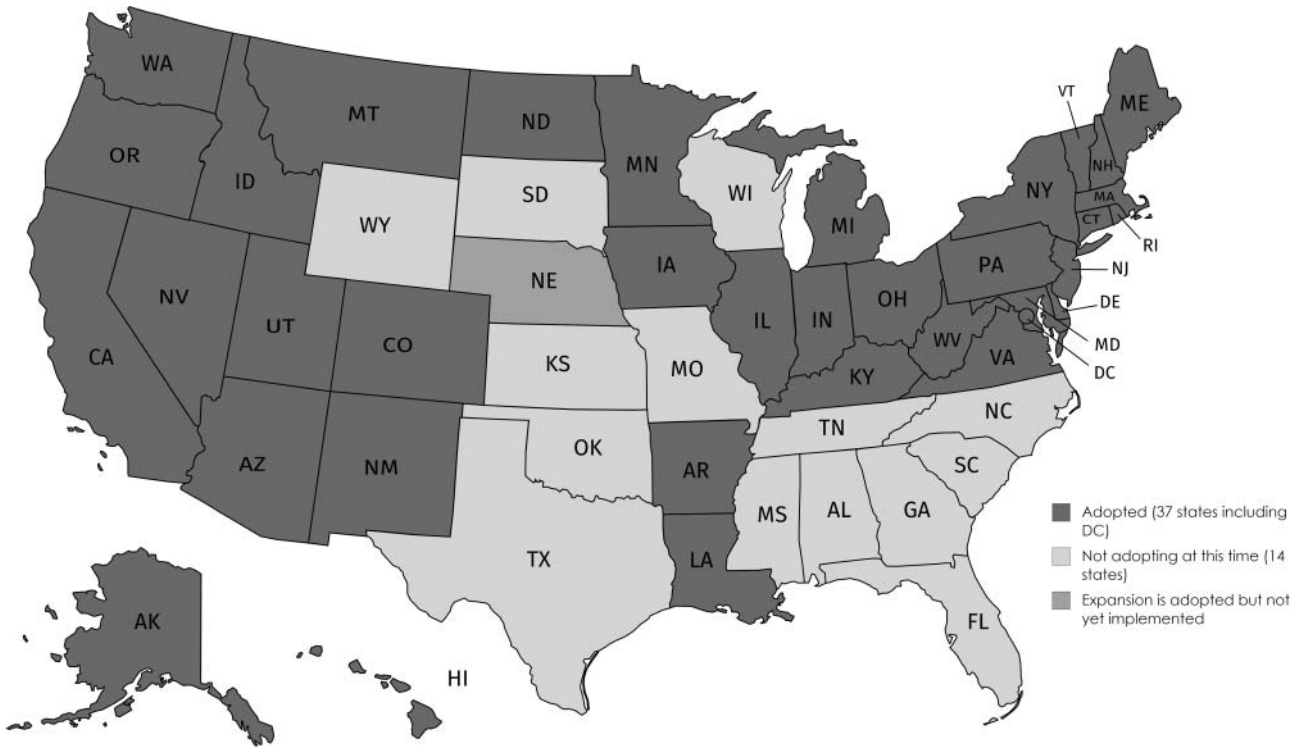

Figure 1 Status of State Medicaid Decisions (as of January 2020)

Source: Map created using mapchart.net under CC BY-SA 4.0.

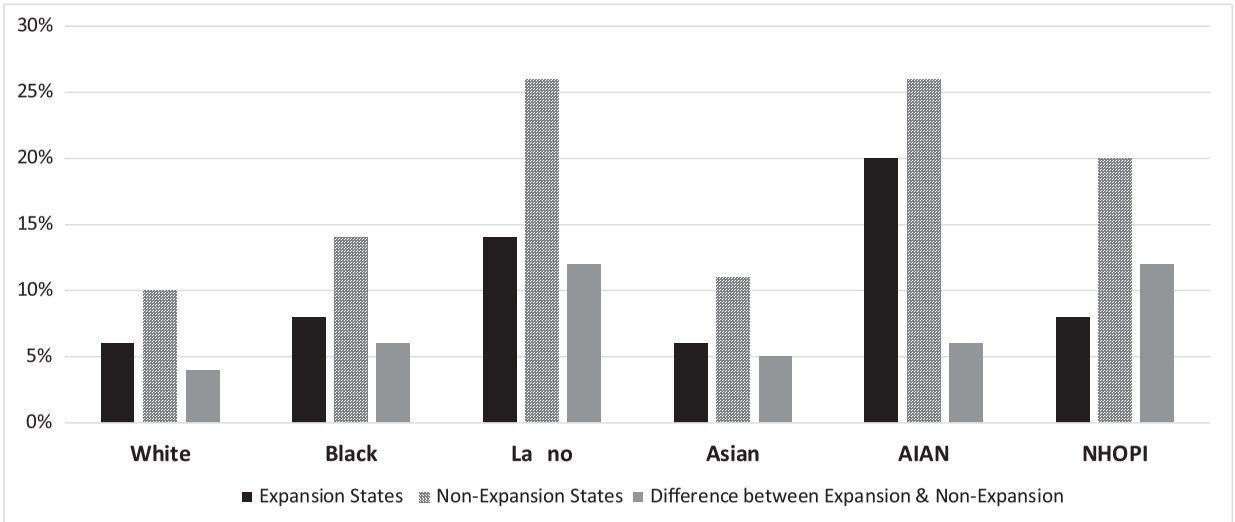

Figure 2 Uninsured Rate among Nonelderly by Race/Ethnicity and State Medicaid Expansion Status

Notes: NHOPI = Native Hawaiians and Other Pacific Islanders; AIAN = American Indians and Alaska Natives. All values reflect the statistically significant difference between expansion and nonexpansion states at the $p < 0.05$ level.

Source: Kaiser Family Foundation analysis of the 2017 American Community Survey.

The Racialized Politics of Medicaid Demonstration Waivers

State Medicaid demonstration (section 1115) waivers are also crucial elements of the ACA with implications for race and politics. Waivers provide states with the flexibility to implement new policies that (ostensibly) benefit state residents. In the post-ACA era, waivers have offered states an avenue for shaping Medicaid to suit their political prerogatives. In particular, section 1115 waivers have allowed Republicans who may otherwise be loath to adopt Medicaid expansion to do so, thus providing insurance to thousands of low-income state residents while signaling a distance from the Democrats who passed the ACA. The unprecedented uses of 1115 waivers in the post-ACA period are racialized as a result of racial disproportionalities in Medicaid, broader economic and social inequities, and racial biases at the root of policies such as work requirements.

Arkansas is a prime illustration. In March 2018 the state proposed the Arkansas Works program via an amendment to a prior section 1115 waiver. The previous waiver (2013) had already placed Arkansas at the vanguard of innovation through a Medicaid demonstration that created what came to be known as the "private option."[2] By initiating Arkansas Works, the 2018 amendment to the initial waiver went in a very different direction, heavily focusing on work-reporting requirements. The Centers for Medicare and Medicaid Services approved the proposal, ushering in a key change: a "work and community engagement" requirement for members of the expansion group under age 50. This necessitated that during any given month beneficiaries must either meet an exemption (e.g., medially frail, pregnant, etc.) or complete 80 hours of qualifying activities, including employment, education, and community service.

The most prominent result of this policy was massive coverage loss. In just 7 months more than 18,000 people were disenrolled (Wagner and Schubel 2019). Early research surveying low-income Arkansans has confirmed that work-reporting requirements are associated with a substantial loss of Medicaid coverage, a rise in the percentage of uninsured persons, and no significant changes in employment (Sommers et al. 2019). Most germane, the case of Arkansas epitomizes the significance of race in

2. Arkansas's initial 2013 Medicaid expansion (under Democratic governor Mike Beebe) occurred through a 1115 waiver that allowed the use of state Medicaid funds to provide premium assistance to eligible beneficiaries, enabling them to purchase private health insurance via the state health insurance marketplace. This allowed Arkansas to insure roughly 220,000 Medicaid beneficiaries via commercial provider networks.

understanding Medicaid waivers. Racial disproportionalities in the state's Medicaid program mean that black Americans are particularly vulnerable to the negative effects of Arkansas Works (Michener 2019; Sommers et al. 2019). Though black people account for less than 13% of the US population and only 15% of Arkansas residents, they make up 26% of Medicaid beneficiaries in the state. This means that 47% of black Arkansans rely on Medicaid (compared to 25% of white Arkansans and 31% of Latino Arkansans). Any policy that results in the large-scale loss of Medicaid coverage is likely to have lopsided racial consequences. Indeed, consistent with this expectation, recent analyses of the effects of work requirements in the Supplemental Nutrition Assistance Program and Temporary Assistance to Needy Families show that for both programs black Americans were unevenly affected by work requirements (Brantley, Pillai, and Ku 2019; Hall and Burrowes 2019). These studies suggest that, even beyond Arkansas, work requirements do not bode well for racial equity.[3]

Over and above racial disproportionalities in Medicaid, broader social and economic racial biases also shape the effects of work requirements. For example, research demonstrates how detrimental a criminal record is to labor market outcomes, especially for black people (Pager 2008). In a state like Arkansas, the incarceration rate for blacks is very high relative to whites, making a criminal record a barrier to employment for significant subsets of black Arkansans (see fig. 3). By necessitating employment as a qualification for receiving Medicaid, work requirements can thus intersect with disparities in other institutional venues (labor market, criminal justice system) to spread disadvantage across arenas.

Even beyond the disadvantage of a criminal record, compelling evidence points to wide-ranging racial discrimination in low-wage labor markets (Bertrand and Mullainathan 2004; Pager, Bonikowski, and Western 2009). The black unemployment rate is regularly twice that of white unemployment (Wilson 2019). Conditioning Medicaid benefits on seeking and finding work is more burdensome to racially marginalized populations facing significant structural obstacles to employment.

Race is also an imperative aspect of the politics of Medicaid demonstration waivers because the assumptions buoying support for policies like work requirements are themselves racialized. Many Americans

3. Medicaid work requirements have been approved in ten states: Arizona, Arkansas, Indiana, Kentucky, Michigan, New Hampshire, Ohio, Utah, South Carolina, and Wisconsin. In four of these, work requirements have been set aside by state courts (Kentucky, Arkansas, Michigan, and New Hampshire). In several others, they have not yet been implemented (Arizona, Wisconsin, Utah, and Ohio). Numerous other states have pending waivers that await approval, including several states with substantial black populations (Mississippi, Georgia, and Tennessee).

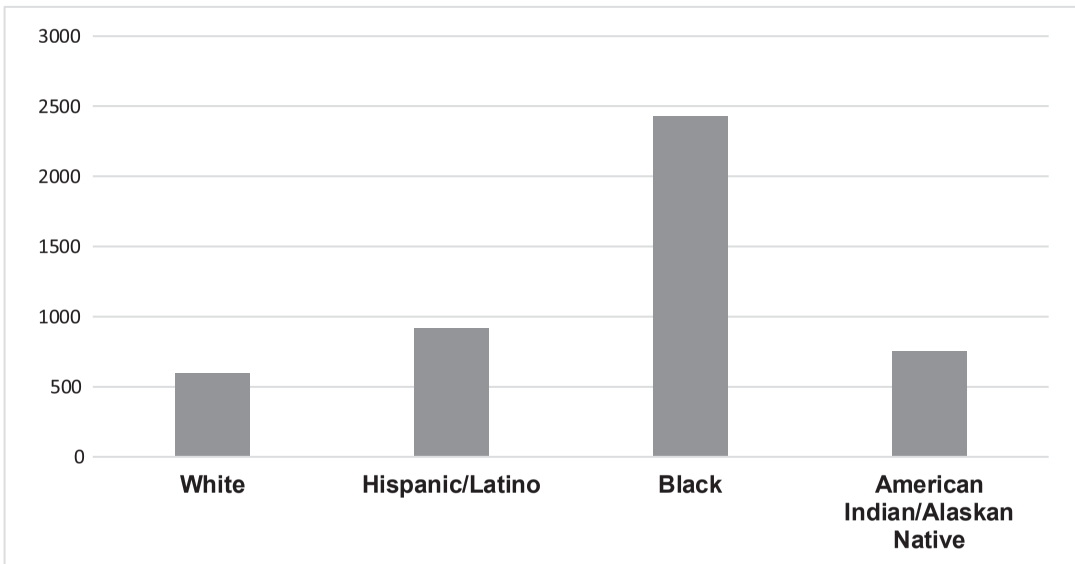

Figure 3 Arkansas Incarceration Rates by Race/Ethnicity

Source: Prison Policy Initiative.

overestimate the presence of black people on welfare rolls (Delaney and Edwards-Levy 2018). Racial stereotypes about undeserving black people taking advantage of government largesse underlie widespread opposition to public benefits, motivating support for policies that make those benefits harder to get (Brown-Iannuzzi et al. 2019; Gilens 1999).

Race and the ACA: Beyond Expansion

Many ACA provisions directly targeted racial disparities. These policies cover a gamut of issues, but their overarching goal is to explicitly marshal the resources of the federal government to reduce health disparities. Three illustrative initiatives in the ACA include:

1. Consistent and systematized health data collection by race, ethnicity, and language
2. Increased racial and ethnic diversity in the health care workforce
3. Nondiscrimination in health programs and activities

All three policy emphases reflect potential mechanisms for advancing health equity (Andrulis et al. 2013; Bristow, Butler, and Smedley, 2004; Dovidio and Fiske 2012; Ulmer, McFadden, and Nerenz 2009).

As some of the ACA's most targeted efforts to confront racial inequality, the implementation and politics of these policies are instructive. Table 1 summarizes some specific statutes, identifies the entities responsible for implementing them, and details the funding associated with each.[4] The key takeaway is that implementation is highly contingent on political conditions (e.g., the positioning of federal bureaucrats, and recurring appropriations). Given this reality, ACA statutes directly confronting race (those with the most overt "civil rights" implications) have been acutely vulnerable to "inconsistent and fluctuating levels of federal engagement" (King 2017: 357). This has been especially true in the hyperpolarized partisan political environment that shapes ACA implementation (Béland, Rocco, and Waddan 2015). The consequence has been "the slowing down or outright death of federal civil rights activism" because the "enforcement of policy is weak. Many of the institutional reforms and national standards needed for amelioration are often given insufficient resources for effective implementation" (King 2017: 357–58). A closer look at the trajectory of the data collection, workforce diversification, and nondiscrimination initiatives underscores this.

4. Table 1 does not provide an exhaustive accounting of all relevant provisions. The ACA contains a vast array of policies, and even those highlighted here are more detailed and nuanced than there is space to elaborate.

Table 1 Policy Design of Key Race-Specific ACA Provisions

Policy	Issue	Section	Implementation	Funding
Require population surveys to collect data on race, ethnicity, and language	Data collection	4302	Office of the National Coordinator for Health Information Technology	As necessary
Collect disparities data in Medicaid and CHIP	Data collection	4302	Health and Human Services (HHS) Secretary	As necessary
Monitor health disparities in federally funded programs	Data collection	4302	HHS Secretary	As necessary
Increase diversity among primary care providers	Workforce diversity	5301	HHS Secretary	$125 million (2010)
Increase diversity among long-term care providers	Workforce diversity	5302	HHS Secretary	$10 million (2011–13)
Increase diversity among dentists	Workforce diversity	5303	HHS Secretary	$30 million (2010)
Increase diversity among mental health providers	Workforce diversity	5306	HHS Secretary	$25 million (2010–13)
Increase diversity in nursing professions	Workforce diversity	5309	HHS Secretary	$35,500 per student (2010–11)
Support for low-income health profession/home care aid training	Workforce diversity	5507	HHS and Department of Labor	$85 million (2010–18)
Nondiscrimination in federal health programs and exchanges	Discrimination	1557	HHS Secretary	Unspecified

Source: Affordable Care Act; Andrulis et al. 2010

Race/Ethnicity Data Collection

Section 4302(a) of the ACA stipulates that the Department of Health and Humans Services (HHS) secretary "shall ensure that, by not later than 2 years after the date of enactment of this title, any federally conducted or supported health care or public health program, activity or survey (including Current Population Surveys and American Community Surveys conducted by the Bureau of Labor Statistics and the Bureau of the Census) collects and reports, to the extent practicable—(A) data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants." The objective of this statute was to "support a more focused national strategy to eliminate health and health care disparities among Medicaid and CHIP enrollees" (Burwell 2014: 2).

Particularly crucial is that the main implementing authority is the HHS secretary—a salient and high-profile political appointee. Between 2010 and 2016, when HHS was run by appointees of President Barack Obama, there was significant federal activity related to enforcing section 4302. The *Federal Register* recorded 15 rules that cited section 4302, most between 2012 and 2016 (National Archives n.d.). In the 3–year period following that (between the time the Trump administration took control of HHS in January 2017 and early January 2020) only three rules have cited section 4302. While race/ethnicity data have "remained largely incomplete," there is little indication that data collection remains a federal priority (Ng et al. 2017). Near exclusive reliance on the HHS, a politically salient bureaucracy run by a political appointee, has limited the effectiveness of section 4302.

Workforce Diversity

The ACA contains numerous provisions to enhance racial diversity within the American health care workforce. Many have proven difficult to implement. Even during the Obama administration, a polarized Congress refused to appropriate $3 million to establish the National Health Care Workforce Commission as stipulated by ACA section 5101. Securing appropriations for other aspects of the law related to workforce diversity has been similarly challenging. Statutes related to workforce diversity remain either unfunded or underfunded.[5] Such programs are supported "in

5. One important exception worth studying further is the Health Profession Opportunity Grant, authorized via section 5507 of the ACA. This grant project has received consistent funding from Congress.

intent" by the ACA but have perennially faced severe resource constraints (Andrulis et al. 2013). The shift in federal priorities since the election of President Trump has further imperiled funding. The fiscal year 2020 budget proposal for HHS proposed eliminating $88 million for diversity training and $151 million for nursing workforce development (DHHS n.d.). Given continued partisan polarization, it is not at all clear "whether the resources and political will to support a broad spectrum of critical programs and actions will be sufficient to meet service goals and people's need" (Andrulis et al. 2013).

Nondiscrimination

Section 1557, the nondiscrimination provision of the ACA, prohibits discrimination in health care programs on the basis of race. Building on existing federal civil rights laws, section 1557 extends nondiscrimination protections to individuals participating in "any health program or activity, any part of which is receiving Federal financial assistance." Though 1557 did not mandate follow-up regulatory activity, the Obama administration reinforced the law by proposing a "final rule" for implementation (81 C.F.R. 31375). Among other things, the final rule required that covered entities post notices of nondiscrimination in the top 15 languages spoken statewide. These requirements were most directly relevant to people with limited English proficiency, a population that is 88% nonwhite (Batalova and Zong 2016).

Section 1557 has been directly undermined by shifting political winds. In May 2019, the Office for Civil Rights and HHS proposed to revise the final rule issued by the Obama administration in 2016 (National Archives 2019). The 2019 iteration of the rule repealed requirements "to mail beneficiaries, enrollees, and others, notices concerning non-discrimination and the availability of language assistance services." To justify this change, the Office for Civil Right and HHS point to Executive Order 13765, "Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal" (2017). This order asserts the federal government's goal of curtailing the financial burdens of the ACA and directs executive branch agency heads in charge of ACA enforcement to "exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act that would impose a fiscal burden."

There is not yet any accounting of the precise effects of such regulatory change on racial health disparities. The larger point, however, is that the

politics of the ACA regulatory process unraveled antidiscrimination policies that many people saw as a step forward for racial equity. Indeed, HHS received nearly 156,000 comments responding to its 2019 regulatory change. A (unsystematic) review of these comments indicates that many of them were in opposition to the rule. Yet, the scope that the ACA left for regulatory and bureaucratic maneuvering enabled important policies to be tightly tethered to political conditions.

Conclusion

In a polity where race is a political flashpoint, ACA policies meant to (indirectly or directly) address racial disparities were politically significant steps. Yet, those steps were deeply precarious. In this way, the ACA epitomizes a difficult problem in American politics: the distance between policy intentions and policy outcomes cannot be bridged without attending to the constraints of profoundly racialized social, economic, and political systems.

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Promise, Performance, and Litigation

Ten Years Later: Reflections on Critics' Worst-Case Scenarios for the Affordable Care Act

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Abstract The primary goals of the Affordable Care Act (ACA) were to increase the availability and affordability of health insurance coverage and thereby improve access to needed health care services. Numerous studies have overwhelmingly confirmed that the law has reduced uninsurance and improved affordability of coverage and care for millions of Americans. Not everyone believed that the ACA would lead to positive outcomes, however. Critics raised numerous concerns in the years leading up to the law's passage and full implementation, including about its consequences for national health spending, labor supply, employer health insurance markets, provider capacity, and overall population health. This article considers five frequently heard worst-case scenarios related to the ACA and provides research evidence that these fears did not come to pass.

Keywords health reform, health insurance coverage, access to care, health care costs

The primary goals of the Affordable Care Act (ACA) were to increase the availability and affordability of health insurance coverage and thereby improve access to needed health care services. The law included numerous provisions aimed at achieving these goals, but the major coverage components were an expansion of Medicaid to adults with incomes at or below 138% of the federal poverty level and the introduction of federal and state-based insurance marketplaces where low- to moderate-income Americans could purchase subsidized private coverage. Among other things, the highly regulated marketplaces increased risk sharing between healthy and sick consumers and eliminated explicit price discrimination based on

Journal of Health Politics, Policy and Law, Vol. 45, No. 4, August 2020
DOI 10.1215/03616878-8255421

health status. The law also included an extension of dependent coverage to young adults ages 19–25. Each of these provisions was reinforced by a requirement that most Americans have health insurance coverage or pay a penalty (Kaiser Family Foundation 2013).

The implementation of these provisions has evolved considerably in the 10 years since the law was passed. In 2012, the Supreme Court ruled the individual mandate to be constitutional and made adoption of the Medicaid expansion optional for states. As of January 2020, 35 states and the District of Columbia have implemented the ACA Medicaid expansion (Kaiser Family Foundation 2020). Nebraska also passed a ballot initiative supporting expansion but has thus far not implemented expansion, nor is it clear that they will do so. In 2017, the Tax Cuts and Jobs Act eliminated the penalty associated with the requirement to maintain health insurance coverage and thereby effectively eliminated the individual mandate. In addition, the marketplaces have experienced multiple threats to their stability but completed their seventh open enrollment period in December 2019, with 2020 insurer participation up and premiums modestly lower, on average, than in 2019 (Holahan, Wengle, and Elmendorf, 2020).

Numerous studies of the effects of the ACA have overwhelmingly confirmed that the law has reduced uninsurance and improved affordability of coverage and care for millions of Americans (Gruber and Sommers 2019; McMorrow and Polsky 2016). Approximately 20 million people gained health insurance under the law (NCHS 2019), and there is particularly strong evidence that the Medicaid expansion has improved access to and affordability of health care services for low-income adults (Antonisse et al. 2019). Moreover, the Medicaid expansion has improved both hospital and consumer finances (Blavin 2016; Caswell and Waidmann 2019; Hu et al. 2018), and evidence continues to roll in on the law's benefits for specific subgroups of the population, such as racial and ethnic minorities (Wehby and Lyu 2018; Yue, Rasmussen, and Ponce 2018), women and new mothers (Johnston et al. 2018; Daw and Sommers 2019; Gordon et al. 2020), as well as on nonhealth outcomes such as evictions (Zewde et al. 2019).

The mounting evidence on the positive impacts of the ACA stands in stark contrast to some of the predictions from a decade ago suggesting dramatic negative consequences of the law for US health care and the economy. Critics raised numerous concerns in the years leading up to its passage and full implementation, including about its consequences for national health spending, labor supply, employer health insurance markets, provider capacity, and overall population health. Those ideologically

opposed to the law voiced these concerns most frequently, but some warnings also came from less partisan sources. In this article, we consider five frequently heard early warnings related to the ACA and provide research evidence that indicates these worst fears did not come to pass. We conclude by discussing where the ACA came up short and consider the lessons learned from a decade of debate, implementation, and evaluation of the law, as well as the implications of these lessons for current debates over appropriate next steps.

Scenario 1: The ACA Will Add to the Deficit and Make National Health Spending Growth Unsustainable

Often one of the biggest points of contention for any major legislative proposal is its cost, and the ACA was no exception. While the official projections by the Congressional Budget Office (CBO) and Joint Committee on Taxation in 2010 and 2011 predicted a net decrease in the deficit as a result of the ACA, they did project increases in federal health spending of $900 billion over 10 years (Elmendorf 2011). Moreover, Centers for Medicare and Medicaid Services (CMS) projections also predicted an overall increase in national health expenditures of $311 billion over 10 years (Foster 2010).

Opponents focused on these projected increases in federal health care spending, ignoring the offsetting spending cuts and tax increases, to claim that the law would add to the federal deficit. In 2011, for example, the Heritage Foundation reported that the marketplace subsidies would "harm the economy by increasing the national deficit" and that "since many of the beneficiaries will be in the upper middle class, Obamacare's subsidies represent a reckless addition to the welfare state" (Winfree 2011).

Despite these criticisms, the ACA included a number of cost-containment provisions, including pilot programs aimed at restructuring the way providers are paid, a tax on overly generous health plans (the so-called Cadillac tax), an Independent Payment Advisory Board intended to rein in Medicare costs, and incentives for nongroup market insurers to compete for enrollees on price. Even so, many observers believed that the increased use of health care services associated with more generous insurance coverage would lead to faster health spending growth and could ultimately crowd out spending on other important services.

Even without the implementation of the Independent Payment Advisory Board or the Cadillac tax, neither of which was ultimately put in place, critics' warnings about the cost of the law were overstated. The ACA did

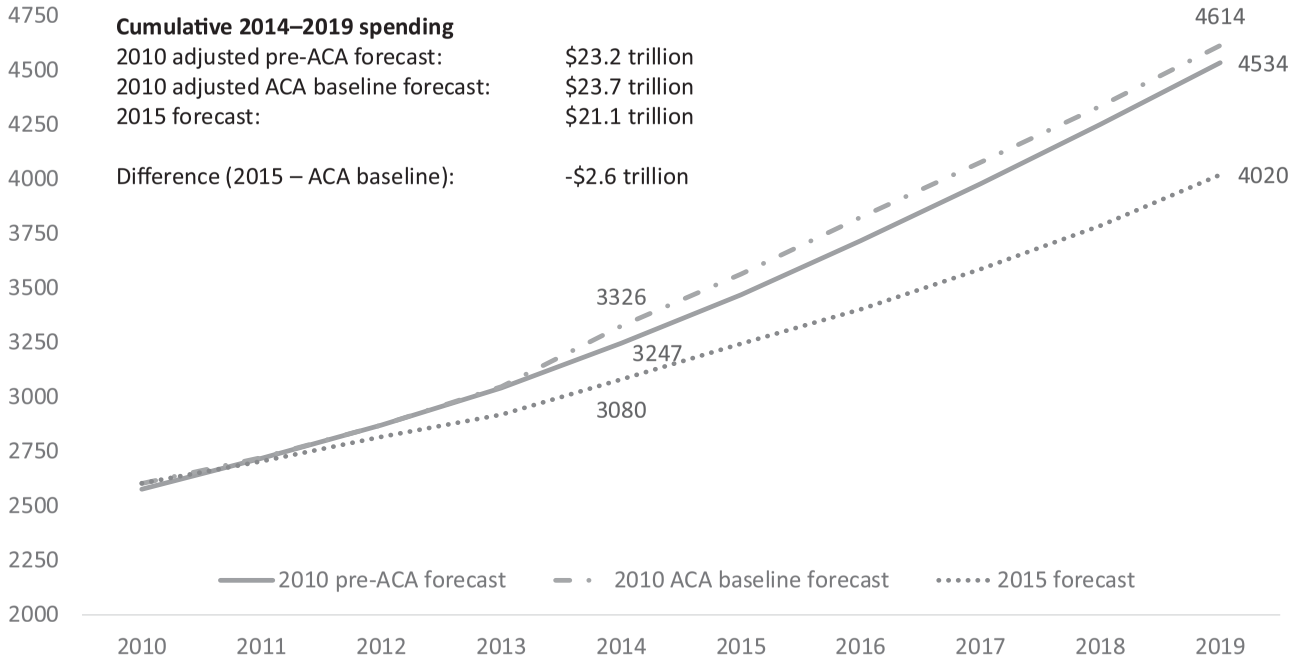

Figure 1 National Health Expenditure Projections ($ Billions), 2010–2019

Notes: Authors' analysis of Centers for Medicare and Medicaid Services national health expenditure projections. Adjusted forecasts reflect alternative scenarios that assume the cuts to physician payments under the sustainable growth rate are replaced with a rate freeze. The 2015 forecast reflects a permanent fix under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

Source: Urban Institute (McMorrow and Holahan 2016).

increase federal spending, but by 2017 the CBO and Joint Committee on Taxation estimated that the increases were lower than originally anticipated. For example, at the time the law was passed, the federal cost of the insurance coverage provisions was projected to be $214 billion in 2019, and in March 2017 that projection was revised downward to $148 billion, a reduction of about one-third (CBO 2017). Moreover, national health spending projections have also fallen since the ACA was passed. In 2010, CMS projected that national health spending from 2014 to 2019 would be $23.7 trillion under the ACA (fig. 1). By 2015, however, CMS had revised its projections and estimated that national health spending from 2014 to 2019 would be $21.1 trillion, or $2.6 trillion lower than in the ACA baseline forecast (McMorrow and Holahan 2016).

While some of this reduction in projected spending can be attributed to the Supreme Court decision making the Medicaid expansion optional and lower than anticipated take-up of marketplace coverage, the broader slowdown in health spending growth that began in 2008 and continued well past the end of the recession is a more important factor. The causes of slower health spending growth over this period are not fully understood but likely include the sluggish economic recovery, the rise of high deductible health plans, and strong state Medicaid cost containment efforts. The precise contribution of the ACA to slower spending growth has not been confirmed, but there are reasons to believe it played a role (Cutler and Sahni 2017; Emanuel 2016). Thus, with the federal cost of the law coming in lower than anticipated and no evidence that the ACA led to faster national health spending growth, early fears about rising deficits and insufficient cost containment provisions in the law have largely been alleviated. Real concerns remain, however, about the efficiency of spending in the health care system more generally.

Scenario 2: The ACA Will Suppress Labor Supply

Another widely held concern about the law surrounded its potential effects on the labor market. There were several provisions of the ACA that economists believed could suppress the labor supply. For example, the income eligibility thresholds to qualify for Medicaid expansion and marketplace subsidies create a potential scenario where working less could result in a net benefit for individuals if they became eligible for one of these subsidized programs. Moreover, the employer mandate created incentives for employers to shift their workforce toward greater use of part-time employees, and other tax increases under the law had the potential to suppress productivity.

Early estimates from CBO projected a loss of approximately 800,000 jobs under the ACA, mostly a result of workers choosing to supply less labor, and updated estimates in 2014 nearly tripled that number (CBO 2014b). This became one of the rallying cries of those opposed to the law. A *Forbes* article published in February 2014 concluded: "The bottom line is that the ACA will result in the equivalent of 2.9 million or more fewer working Americans. No amount of hand-waving by the law's proponents can avoid this inconvenient truth" (Conover 2014).

Since then, numerous studies have examined the effects of the dependent coverage expansion and the Medicaid expansion on employment, hours worked, wages, and earnings and have found no evidence to support the predictions described above (Abraham and Royalty 2017; Garrett, Kaestner, and Gangopadhyaya 2017; Kaestner et al. 2017). At least two studies have also considered the effects of marketplace subsidies on labor supply and have found no significant effects (Cucko, Rinz, and Solow 2017; Duggan, Goda, and Jackson 2019). Furthermore, studies examining the potential shift to part-time employment or a trend toward early retirement under the ACA found no evidence to support these claims (Levy, Buchmueller, and Nikpay 2018; Moriya, Selden, and Simon 2016). Overall, the evidence is remarkably consistent across studies looking at the various policy mechanisms and using different outcomes and data sources. While the economic theory supporting a concern about labor supply effects was sound, the evidence suggests that the assumptions used to predict the magnitude of the effects did not adequately reflect the full range of factors beyond health insurance that affect employer and employee preferences.

Scenario 3: The ACA Will Destroy the Employer Health Insurance Market

The components of the law that strengthened and subsidized the private nongroup insurance market contributed to fears about the future of the employer-sponsored health insurance market. When the law was passed in 2010, approximately 57% of nonelderly Americans received health insurance from their employer or that of a family member (fig. 2). The subsidized insurance marketplaces under the ACA presented an alternative to employer coverage and created potential incentives for employers to stop offering coverage to their employees. These incentives were strongest for employers of lower-wage workers who would be eligible for Medicaid or the most generous premium and cost-sharing subsidies under the law. If many employers were to stop offering insurance to their workers, many

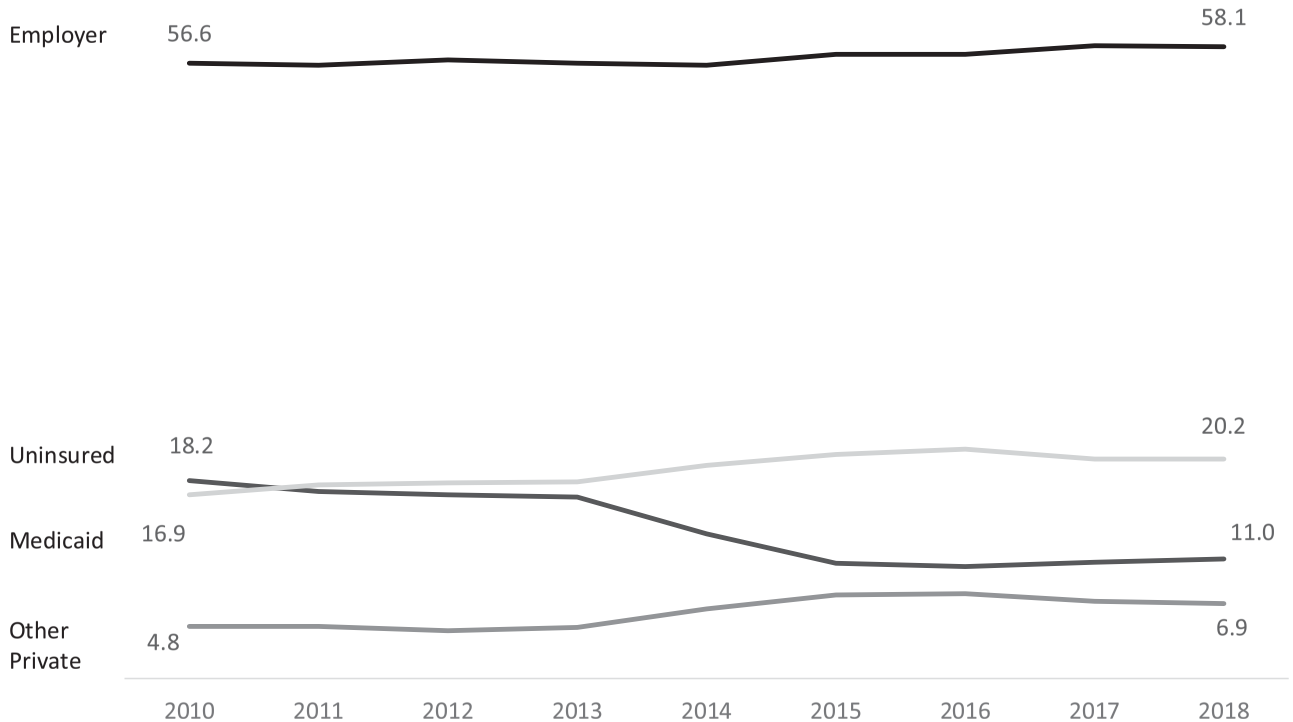

Figure 2 Percent of Nonelderly US population (< 65 Years), by Coverage Type, 2010–2018

Source: National Center for Health Statistics, 2019; National Health Interview Survey: Long-Term Trends in Health Insurance Coverage, 1968–2018.

people would find their source of coverage disrupted and the government cost of the law could increase due to larger numbers of workers and their dependents enrolling in federally subsidized marketplace coverage or Medicaid. As a result, the ACA included a provision to encourage employers to continue to offer coverage. Employers with more than 50 full-time-equivalent employees would pay a $2,000 penalty per worker if they did not offer coverage and one or more employees received a premium subsidy in the marketplace (there is no penalty for workers enrolling in Medicaid). In addition, the ACA did not alter the significant tax advantage of employer-sponsored insurance that predated the law.

The most dramatic predictions suggested extremely widespread dropping of employer coverage. A study by the American Action Forum predicted that as many as 35 million Americans would lose their employer-sponsored coverage, with an associated increase in federal premium subsidies of $1.4 trillion (Holtz-Eakin and Smith 2010). In July 2013, leaders of three major unions seized on this message and sent a letter to Congress claiming that the law's incentives were causing "nightmare scenarios" and would "destroy the very health and wellbeing of our members along with millions of other hardworking Americans" (Gara 2013). Official projections from the CBO (2014a) were much more modest but still predicted employer coverage losses of approximately 6 million people by 2016. In contrast, in 2012, Urban Institute researchers estimated that employer-sponsored insurance would *increase* modestly under the ACA (by less than 3%), due in large part to the individual mandate and persistent tax incentives (Blumberg et al. 2012).

Far from the nightmare scenario predictions, both early and sustained evidence suggests that the employer-sponsored insurance market has remained large and strong under the ACA. Blavin et al. (2015) found no evidence of declines in employer offer, take-up, or coverage rates through 2014, and consistent evidence since then has found stable if not rising rates of employer coverage (Shartzer, Blavin, and Holahan 2018). By 2018, the rate of employer coverage among the nonelderly population was 58.1% compared to 56.6% in 2010 (fig. 2). A strong economy, the law's individual mandate, the continued tax advantage of employer coverage, and turbulence in the marketplaces have likely contributed to the strength and stability of employer coverage in recent years, but there is certainly no evidence to support widespread dropping of coverage under the law.

In addition to fears of employers dropping their health insurance plans, there were also concerns that the Medicaid expansion would cause newly eligible individuals to drop their employer coverage in favor of the more

affordable public plan. This "crowd-out" of existing employer coverage is a cause for concern to some because, were it to occur, the federal cost of the law would increase without covering additional individuals. There would be value, however, to low-income people obtaining very comprehensive coverage at little to no cost to the household, since it would improve their health insurance affordability and access to care, potentially improving their downstream health outcomes as well. There is some evidence of displacement of private insurance under the ACA's Medicaid eligibility expansion, but the magnitude of the estimates varies widely, and the results are often imprecise. The smallest estimates indicate virtually no evidence of crowd-out (Frean, Gruber, and Sommers 2017), while the largest indicate significant crowd-out in 2015 that then declined over time (Miller and Wherry 2019). Thus, with no evidence of net declines in employer coverage under the ACA and modest evidence of crowd-out due to the Medicaid expansion, it is clear that the employer-sponsored insurance market remains strong, despite the critics' worst fears.

Scenario 4: Provider Capacity Will Be Insufficient to Meet Demand under the ACA

Despite criticisms on many other fronts, most observers seemed to agree that the ACA would succeed in its effort to increase the number of insured Americans. There was considerable disagreement, however, on whether that coverage would actually provide access to care or improved health. In particular, there was a great deal of concern that the supply and distribution of health care providers would be insufficient to meet the increased demand created by the newly insured. A 2013 *Forbes* article, for example, warned that "America is suffering from a doctor shortage. An influx of millions of new patients into the healthcare system will only exacerbate that shortage—driving up the demand for care without doing anything about its supply" (Pipes 2013). Also in 2013, Joseph Antos argued in this journal that this issue would be particularly problematic for the Medicaid population. Low provider payment rates have historically kept many providers from accepting Medicaid patients, so "putting millions of additional people into a program that has been struggling with access to care for the past forty-five years is likely to result in worsening access for those who are currently enrolled in Medicaid" (Antos 2013).

The ACA included several provisions aimed at shoring up provider access, including a temporary increase in Medicaid fees and increased federal funding for community health centers. A study using a "secret

shopper" analysis in 10 states found increased appointment availability for Medicaid patients and stable appointment availability for privately insured patients following the ACA (Polsky et al. 2017). The researchers in this study posed as Medicaid or privately insured patients new to the practice at which they sought an appointment but did not provide further details about their coverage. Moreover, when considering the potential spillover effects of the eligibility expansion on those who were insured prior to the ACA, Carey, Miller, and Wherry (2018) found that Medicare enrollees did not experience any adverse effects of the ACA Medicaid expansion on their access to care. To our knowledge, there is currently no evidence on how the expansion affected access for those who were already enrolled in Medicaid prior to the expansion.

A few studies have found evidence consistent with provider capacity constraints. The same secret shopper study that found increased appointment availability overall found that wait times increased for both Medicaid and privately insured patients (Polsky et al. 2017). Two studies using data from the National Health Interview Survey also found evidence among low-income adults that the Medicaid expansion increased reports of delaying care due to wait time for an appointment and problems finding a provider who could see them (Miller and Wherry 2017; Selden, Lipton, and Decker 2017). These access problems were not trivial in magnitude through 2015, with the share reporting care delays due to appointment wait times increasing by almost one-third (Miller and Wherry 2017), but when data through 2017 were added these access problems had diminished (Miller and Wherry 2019). Moreover, considerable evidence has shown that the ACA Medicaid expansion had a positive effect on having a usual source of care and use of preventive services so any delays or wait times due to capacity constraints did not appear to prevent the law from improving access to and utilization of care for those it targeted (Antonisse et al. 2019; Simon, Soni, and Cawley 2017; Sommers et al. 2015).

Scenario 5: The ACA Will Not Improve, and May Actually Be Harmful to, Population Health

At the end of the day, insurance coverage and even access to and use of health care services do not guarantee good health outcomes, and concerns about the ACA's impact on population health were widespread. Those generally supportive of the law feared that, despite its best intentions, the ACA would not actually move the needle on health outcomes. Some of these concerns were reinforced by the lack of clinical improvement found

in a study of the Oregon Health Insurance Experiment (Baicker et al. 2013), as well as growing evidence on the social determinants of health. Recognizing that there are many and varied contributors to good health, even supporters believed that the ACA coverage expansion was necessary but potentially not sufficient to meaningfully improve health status (McMorrow 2010).

In contrast, some of the law's fiercest critics believed that the law would actually harm people's health. Perhaps the most extreme example was Sarah Palin's claim that the law would effectively institute "death panels," or groups of bureaucrats tasked with deciding who was worthy of care (Kessler 2012). But the more insidious claims focused on Medicaid and misinterpreted research evidence to claim that Medicaid was worse than no coverage at all (Carroll and Frakt 2017). Unlike Palin's obviously sensationalist comments, these claims have been made by respected scholars and were used to argue against the ACA more generally (Gottlieb 2011), and then to argue against expanding Medicaid once the Supreme Court made the expansion optional (Antos 2013).

Thus far, the evidence for positive health effects of the ACA Medicaid expansion is weaker than that for coverage or affordability of care, but several important findings have emerged (Allen and Sommers 2019). Several early studies found small or no effects on self-reported general or mental health status (Courtemanche et al. 2018; Miller and Wherry 2017), while others have found improvements in self-reported health and reductions in psychological distress (McMorrow et al. 2017; Simon, Soni, and Cawley 2017). With respect to improved clinical outcomes, researchers found improved blood pressure control among community health center patients, but no improvement for diabetes (Cole et al. 2017). There is also recent evidence that Medicaid expansion improved surgical outcomes for several common conditions, seemingly driven by earlier presentation for care (Loehrer et al. 2018).

When considering mortality, perhaps the ultimate health outcome, there is emerging evidence that the ACA has, in fact, saved lives. Recent work using survey data linked with death records has attributed a 9% reduction in mortality among low-income adults to the Medicaid expansion (Miller et al. 2019), and another study capitalizing on an Internal Revenue Service experiment found that coverage gains for middle-aged adults under the ACA reduced their mortality (Goldin, Lurie, and McCubbin 2019). Thus, despite somewhat inconsistent evidence across a variety of populations and health outcomes, there is little or no evidence to support the claim that the ACA Medicaid expansion has harmed health, and the weight of the evidence appears to indicate health improvements.

Discussion

We have argued above that the ACA failed to live up to its critics' worst fears when it came to cost, labor market effects, the demise of employer coverage, provider capacity constraints, and population health. We must also acknowledge, however, where the ACA underperformed the expectations set by some of its advocates. First, a commonly heard argument for expanding coverage was that it would actually save money by reducing reliance on emergency departments (ED) and improving access to preventive care. While insurance coverage does generally increase use of preventive services, it does not necessarily reduce use of the ED or reduce costs (Russell 2010). Like other services, ED visits typically become less expensive to the consumer after they gain insurance, and when a service becomes less expensive, people tend to use more of it. This pattern was seen following the Oregon health insurance expansion (Taubman et al. 2014), and there is evidence that ED use increased under the ACA Medicaid expansion as well (Garthwaite et al. 2019; Nikpay et al. 2017). This should not be interpreted as a failure of the ACA but, rather, a failure of those promoting an unrealistic outcome.

Second, and more important, despite the ACA's many successes, coverage and care remain unaffordable for too many Americans, particularly many of those who rely on the individual health insurance market. The ACA's marketplaces were intended to provide an affordable option for individuals and families with low to moderate incomes and no access to employer or public coverage. For many marketplace enrollees, this option has improved access to and affordability of care (Kirby and Vistnes 2016; McMorrow et al. 2016). But for those eligible for small premium subsidies or none at all, coverage in the marketplace can be quite expensive (Holahan, Blumberg, and Wengle 2017). Moreover, when individuals seek lower premiums to increase affordability, they generally face high deductibles and other cost-sharing requirements (Gunja et al. 2016). The fundamental driver of high insurance costs is, of course, the high cost of health care itself, so truly delivering on the promise to make health care affordable for all Americans will likely require tackling this head on, as well as funding additional subsidies.

As the 2020 presidential campaign heats up and we begin to debate the merits of various health reform proposals, we should take at least two lessons from over 10 years of ACA debate, implementation, and evaluation. First, one should not take individual projections of costs or other outcomes too literally but, rather, consider the range of estimates and

potential outcomes. As we have seen with the ACA, not all predictions will be realized, so it is important not to focus too much attention on any one predicted benefit or cost of a specific proposal. Second, while predictions and projections are an important part of the process of developing and implementing reform proposals, the only way to truly know the effects of a particular policy is to wait for the evidence. And on that front, researchers have delivered a tremendous body of work that should allow anyone interested to form a robust and nuanced opinion of the ACA's successes and failures, and with time, we should expect the same of any future reforms.

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Acknowledgments

The authors are grateful to all of the researchers who have contributed to such a strong evidence base on the effects of the Affordable Care Act, and to Caroline Elmendorf for excellent research assistance. This work was supported by the Robert Wood Johnson Foundation. The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funder.

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Race, Policy Feedbacks, and Political Resilience

The ACA a Decade In: Resilience, Impact, and Vulnerabilities

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Abstract A decade after its enactment, the Affordable Care Act remains both politically viable and consequential, despite Republican efforts to end it. The law's impact on insurance coverage is substantial but remains distant from universal coverage, while its contributions to cost control are at best limited. National public opinion data collected by the author in 2018 reveal both strengths and vulnerabilities in the act.

Keywords Affordable Care Act, public opinion, insurance coverage, cost containment

Those familiar with the film *Apollo 13* will recall the scene. Having suffered a nearly disastrous explosion en route to the moon, and after a slingshot around it to return to Earth, the crew of the hobbled spacecraft had to execute a near perfect manual burn to set a viable course for Earth reentry. If they hit the atmosphere with too steep a trajectory, the capsule and crew would incinerate. Too shallow, they would bounce off the atmosphere and disappear into the oblivion of space. Given the fortunate ending, we know that they successfully navigated into what *Apollo 13* Commander Jim Lovell described as that "very narrow pie-shaped wedge."

Were Lovell a health policy historian, he could have been recounting the passage of the Affordable Care Act (ACA) in 2010. Numerous past health care reform initiatives had bounced off the governing system's unresponsive firmament, ignored, lost without a trace in the political ether. Other proposals, like Bill Clinton's Health Security Act, had slammed into an unforgiving political atmosphere, burning up and leaving damaging debris in their wakes. The ACA, however, found the path to enactment, the very

Journal of Health Politics, Policy and Law, Vol. 45, No. 4, August 2020
DOI 10.1215/03616878-8255517

first reform legislation to secure floor votes in the House and Senate. Even in the best overall political-institutional context for enacting health care reform in US history, the pie-shaped wedge was truly narrow (Peterson 2019: chap. 11). Passage came in the Senate by overcoming a filibuster with no votes to spare. Final approval in the House rested on just a three-vote margin.

Legislative enactment is but a necessary, not sufficient, outcome. Achieve policy goals is the point. Not even designed to orbit the earth, Alan Shepard's first US manned space flight in 1961 may have seemed intended to do nothing more than thrust a live American into weightlessness and return him alive and unharmed to the ground, but even that mission was part of an orchestrated plan to fulfill national objectives framed by the Cold War competition with the Soviet Union and eventual advances in science. The ACA's political success, however thrilling given its uniqueness, would have meaning only if it had a demonstrable positive impact on the health care system. As with all health care reform initiatives, its two most prominent objectives were to expand substantially insurance coverage and to do something meaningful to rein in rising health care costs, joined by features aimed to promote higher-quality care, invigorate the health professions, and advance population health (Kaiser Family Foundation 2010). At the 10–year mark since its passage, assessment of the ACA confronts three core questions. First, did the law really survive intact its fiery plunge through the intensely partisan and resistant political atmosphere of contemporary America? Second, how well has it fulfilled the promise to enlarge markedly the ranks of the insured population and set a course for universal coverage? Third, how effectively has it put in place mechanisms to contain growing health care expenditures—overall, for government budgets and taxpayers, and out-of-pocket for individuals and families.

The answers in all three respects are mixed. In part that reflects positive returns. The ACA has revealed perhaps surprising resilience, put insurance cards into the hands of millions previously outside the system, and even contributed to some degree of reduced financial burdens. At the same time, all of these gains have been incomplete, remain vulnerable, and are threatened by underlying forces in the political economy. The path to a more secure future for either the ACA or a more ambitious successor is far from clear.

Political Resilience

In the history of American social benefit programs, the ACA has proven to be one of the most susceptible to disruption and outright repeal, risking

joining the Medicare Catastrophic Coverage Act of 1989 on the ash heap of domestic policy (Peterson 2018b). A social policy program that cannot manage to stay in the statute books is not one of consequence. The enactment of the ACA on those meager entirely party-line margins arguably did much to fuel the Tea Party mobilization on the right. That in turn helped enable the 2010 midterm electoral wave that allowed Republicans not only to recapture the majority in the House of Representatives but also to assume a commanding position in the states—state legislatures flipped from 54% Democratic control to 52% in Republican hands, governorships went from 52% blue to 58% red, and the GOP gained the trifecta of unified government in 40% of the states.[1] While the new Republican House majority immediately launched repeated efforts to repeal or eviscerate Obamacare, their fellow partisans in the states initiated collective lawsuits against it and blocked the Medicaid expansions that had been made voluntary by the US Supreme Court's ruling in *NFIB v. Sebelius* (567 U.S. 519 [2012]).

For much of 10 years since the statute's enactment, its political health looked precarious. It decidedly lacked the popular acclaim of the sort that arose to undergird programs like Social Security and Medicare. The Kaiser Family Foundation has fielded monthly national tracking polls throughout this period, including fairly regularly taking the temperature of the ACA in the body politic by asking the question: "As you may know, a health reform bill was signed into law in 2010. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?" (Kaiser Family Foundation 2019b). Although health care reform in general and even President Obama's proposed plan had enjoyed net support of 30 percentage points and higher, in the month after formal passage the ACA mustered a positive view from only 46% of the respondents, disfavor from 40%, and a "don't know" opinion from 14%. Late the following year the ACA was held in particularly low regard, with only one-third supportive and just over half now disapproving. Later still, from February 2013 to November 2014 those with a favorable view stayed in the 30% range, including in the low 30% range following the disastrous rollout of HealthCare.gov, the federal website for enrolling in the newly available market exchange plans. For a substantial part of the last decade the law was underwater in public opinion.

Three interrelated events saved the ACA from this unstable purgatory. First, ongoing Democratic control of the Senate until 2015 and President

1. These data were assembled from various election results reported at ballotpedia.org and the National Conference of State Legislatures (ncsl.org).

Barack Obama's reelection to a second term lasting through 2016 meant that Republican efforts at repeal could not succeed until at least 3 years after the full implementation of the ACA's coverage benefits and preexisting condition protections. Consistent with the positive policy-feedback literature and unlike the case with the Medicare Catastrophic Coverage Act, that was sufficient time to anchor the program in the public's expectations and the interests of such stakeholders as insurers, hospitals, and other providers (Peterson 2018b).

Second, the explicit Republican campaign in 2017 to abolish the law—the principal legislative activity of the year, at least until the passage of the Tax Cuts and Jobs Act in December—accorded the public every reason to pay attention to the coverage expansions and protections afforded by the ACA and rise in their defense. Congressional Budget Office (2017) scoring of the Republican plans, which went beyond repeal to curtailing long-standing Medicaid coverage, revealed that 23 million people would lose insurance. More would be uninsured than before the ACA's enactment. Preexisting condition protections would also be largely undone. At the time of the 2016 election, in the Kaiser Family Foundation survey the public's views of the ACA split 43% favorable and 45% unfavorable. Soon after Senator John McCain famously gave the thumbs down to the Senate version of repeal and replace in July 2017, helping defeat it, public support had turned favorable at 52% to 39%. Tracking the same respondents through five waves in a panel study from 2010 to 2018, Jacobs, Mettler, and Zhu (2019: 913) also show a marked increase in support for the law.

In 2018 Darin DeWitt and I designed a health care policy and politics module for that year's Cooperative Congressional Election Study (CCES), a national survey of public attitudes built around common content and the specific investigations of 60 research teams (Ansolabehere, Schaffner, and Luks 2019; Peterson 2018a). Each team's module is administered to a nationally representative sample of about 1,000 respondents. We asked about a large number of specific provisions in health care legislation, without identifying which were associated with the ACA and which derived from the Republican proposals. Of the eight that tracked with actual features of the ACA, despite the ambiguity about the law as a whole, all drew supermajorities of public support, ranging from 60% to 80% (mean, 69.4%). Even the most redistributive and likely to be especially contentious—having Medicaid cover all low-income uninsured adults and providing subsidies to Americans of modest means to buy private insurance—garnered endorsement from over 60% of the respondents.

Third, beyond advocating dismantling the ACA, Republicans weakened their political standing even further by offering replacement approaches that alienated the public and influential interests. When we asked respondents in the 2018 CCES whether they had a generally favorable or unfavorable opinion of the Republican proposals, among the 80% who expressed an opinion, only one-third were supportive and two-thirds opposed. Of the five provisions in our survey associated with the 2017 Republican plans, public support averaged 39.6%. The only one to attract majority support would allow insurers to sell plans that traded lower premiums for higher out-of-pocket costs and uncovered services. At the same time, though, 65.6% of our sample favored a provision that would "require insurers in the individual and small group health insurance markets to cover" the list of 10 "essential benefits" formally included in the ACA, which only 13.1% opposed. With respect to Medicaid, only 35.5% supported denying coverage to able-bodied adults and fewer still (28.1%) agreed with capped federal financial allocations to the states joined with greater state flexibility to determine whom and what to cover. The Republican's legislative efforts also antagonized almost the entire domain of stakeholder interests, many of which had been that party's past allies in health care reform debates. The final GOP initiative of 2017, drafted by Republican Senators Lindsay Graham (SC) and Bill Cassidy (LA), was publicly endorsed by just five conservative groups and opposed by 114 organizations, including most of the provider community and the health insurance industry (Bajaj and Thompson 2017; Zernike, Abelson, and Goodnough 2017).

Opponents to the ACA have nonetheless been able to weaken the ACA and perhaps set the stage for its ultimate downfall. The Trump administration has taken a number of executive actions that have lessened its coverage and protections, leading, among other things, to a couple million people joining the uninsured population (Galewitz 2019). The Tax Cuts and Jobs Act of 2017 did not formally terminate the individual mandate to have insurance coverage, but it did zero out the associated penalty administered through the tax collection system (Jost 2017). That, in turn, has provided a foundation for the statutory interpretation claim, in *Texas v. United States* pursued by 20 Republican state attorneys general and accepted by a federal district court judge in Texas, that the rest of the law depends on the mandate and thus must be declared invalid. The case will be decided by the US Supreme Court (Keith 2019).

Considering the public confusion about what the ACA includes and does, the extreme partisan polarization surrounding the law, the dramatic shifts in the nation's electoral winds at both the national and state level, the

myriad court challenges and resistance to full implementation in many of the states, and every effort of President Trump's administration to use executive actions to debilitate one of his predecessor's primary legislative achievements, it may be surprising that the ACA remains viable and functioning 10 years out. When NASA's Houston Control scrambled to save the *Apollo 13* crew, striving through creative adaptation to keep the astronauts alive and give them a shot at a safe return, the motivating dictum was "failure is not an option" (SpaceActs, n.d.). Given what the Congressional Budget Office and other analysts calculated would be the consequence of the ACA's demise, perhaps it applies equally in this case.

The ACA's Impact on Insurance Coverage

The primary mission of the ACA was to make substantial progress toward addressing the outlier status of the United States as the world's sole democracy and developed economy that did not reach anything proximate to universal health care coverage. The estimated consequences of repeal—the millions who would be kicked off the insurance roles—suggest that the progress toward that objective was substantial. A variety of metrics can be used to capture the size of the uninsured population—for example, at the time queried, for some portion of the year, and for longer than a year—and by all of them the implementation of the new health care law had fairly quick and significant effects. The National Health Interview Survey revealed that in 2015, halfway toward this 10–year anniversary, those with an episode of being uninsured during some period in the year fell from 24.4% to 18.1%, and the long-term uninsured dropped from 15.7% to just 9.1% (Cohen, Martinez, and Zammitti 2016). Moreover, the percentage uninsured dropped by a third to a half for every demographic group, from those that had the highest rates when the ACA was enacted (e.g., Hispanics and young adults) to those already at the low end (e.g., children and whites overall) (Garrett and Gangopadhyaya 2016). After 2015 the uninsured percentage continued to fall, reaching the lowest points in 2016–17, with the population-wide figure below 8%. Then came subsequent increases, returning to 8.5% overall, or 27.5 million individuals (Keith 2019). Not only is that a reversal, but even the moment of glory in 2016 was a far cry from the international standard of universal coverage.

The previous singular effort to expand insurance coverage came in 1965 with the enactment of Medicare and Medicaid. I estimate that, with about half the elderly and measurably few of the poor having either private or public benefits of any kind before their enactment, by 1975 the two

programs had brought coverage to about 35 million Americans who would otherwise have been entirely uninsured, roughly 16% of the nation's population (Kaiser Family Foundation 2013; Mikulic 2019; Moon 1996). In 2010, that was the natural limit of what even a truly universal program could accomplish. "Only" 16% of the population—about 49 million people—were still uninsured. The ACA by 2016 cut that percentage roughly in half. That may seem less consequential than Medicare and Medicaid, but it is important to keep two other factors in mind. First, the services covered and financial protections provided by Medicare and Medicaid fell far short of today's typical employer-sponsored plans, inclusive of additional ACA provisions like prohibitions on annual or lifetime caps, free preventive services, or the 10 essential benefits required of ACA exchange plans. Second, Medicare's restriction to one age group and Medicaid's coverage of only certain categories of the poor meant that they, unlike the 2010 law, did not create even a potential pathway to universal coverage, if only for US citizens and lawful permanent residents.

Going forward, however, there are at least three fundamental threats to what the ACA has accomplished in coverage. One reflects the fact that possession of an insurance card does not mean that one is well insured and without barriers to needed health care services. The ACA has done nothing to reduce the aggregate percentage of what the Commonwealth Fund identifies as the "underinsured"—those facing out-of-pocket costs so significant that they lead to foregoing primary or specialist medical care, missing treatments, or not filling prescriptions. The 2018 aggregate figure of 45% for adults 19–64 years old was unchanged from 2010 (Collins, Bhupal, and Doty 2019).

The other two are inherent in the structure of the ACA itself. To avoid major political roadblocks, the architecture of the law—unlike past comprehensive reform plans from President Truman to President Clinton—is predicated on minimizing disruptions in the existing system (Peterson 2019: chap. 11). It keeps largely intact employer-sponsored insurance, Medicare, and Medicaid and builds on them to expand coverage. Cracks in those underpinnings to the insurance system could undermine the ACA coverage model. The ongoing financial viability of employer-sponsored insurance for both employers and employees, for example, might well be questioned. As of 2018 the mean total annual premium for a single employee in the United States came close to $8,000; for family coverage it was just shy of $20,000. On average, the employee premium contribution and deductible hit 11.5% of median household income (Collins, Radley, and Baumgartner 2019).

The public perceives that there is a broad set of risks to the system. In our 2018 CCES survey, we asked the respondents whether seven changes occurring in the realm of employment and insurance, such as contracting out jobs, would result in "certain failure" of employer-sponsored insurance, pose a "threat" to it, or not be a problem. Individually the "certain failure" responses fell below a third, but in total 60% selected that category for at least one of the seven factors. In the meantime, the current Medicare program and its financial stability remain caught in the maw of the nation's polarized politics, while the eligible population grows dramatically with the aging of the baby boom generation (Aaron and Lambrew 2008).

The ACA has one other feature, compelled by contemporary political forces, that stands in the way of ever achieving universal coverage. It explicitly prohibits the inclusion of undocumented immigrants, which in 2017 the Pew Research Center estimated to be 10.5 million individuals or roughly 4 in 10 of the currently uninsured (Passel 2019). In our 2018 CCES survey, there was strong opposition—58.9% to 22.2%—to "allow[ing] undocumented immigrants to receive financial help from the government to buy health insurance," much less be given access to direct benefit programs like Medicaid.

The ACA's Impact on Health Care Costs

The ACA also had the stated mission of tackling the high cost of health care in the United States. As President Obama himself put it in his September 2009 health care speech to a joint session of Congress,

> There is the problem of rising costs. We spend one-and-a-half times more per person on health care than any other country, but we aren't any healthier for it. . . . Our health care system is placing an unsustainable burden on taxpayers. When health care costs grow at the rate they have, it puts greater pressure on programs like Medicare and Medicaid. . . . Put simply, our health care problem is our deficit problem. Nothing else even comes close.

Pass his health care reform initiative, he pronounced, and "it will slow the growth of health care costs for our families, our businesses, and our government" (Obama 2009). The president's senior advisers and a number of allies in the analytical community often repeated various versions of the refrain that provisions in the law would "bend the cost curve" (e.g., Orszag and Emanuel 2010: 602). Campaigning for the presidency, candidate Obama projected that his health care plan would "cut the cost of a typical

family's premiums by $2,500" (best understood in relation to what premiums would otherwise be) (Kessler 2012).

The problem is that the law was simply devoid of the kind of cost-control mechanisms, from budgets to rate setting, that had proven effective abroad or in some states and were included in some form in previous reform proposals like President Bill Clinton's Health Security Act (Peterson 2019: chaps. 4, 10). Because every dollar of expenditure is a dollar of income for someone in the system, aggressive restraints on spending would seriously pinch influential stakeholders whose political support was needed (Evans 1997). In addition, what most voters worry about is what they pay out of pocket, rather than system totals (Blendon et al. 2006). The drafters of the ACA turned to less empirically proven but conceptually attractive devices to lower costs through the more hidden-hand approach of enhanced efficiency, such as incentives, deterrents, and competition; and a more effective delivery system, such as through coordination of care and investments in innovation (Oberlander 2011; White 2018). Oberlander (2011) aptly captured the experimental and scattershot methods in the ACA as "throwing darts," looking with more optimism than conviction to see which ones might actually land on the target and score (see also Marmor, Oberlander, and White 2009).

Right from the start many specialists in the health policy field, especially those with eyes on the comparative experience, did not expect this eclectic collection of technical remedies, disincentives, funding streams, and demonstration projects to have much sway on the costs borne by any of the payers in the health care system (Gusmano 2011; Marmor, Oberlander, and White 2009; Oberlander 2011; White 2018). The intervention with likely the farthest-reaching impact—the so-called Cadillac tax that was claimed, with considerable controversy, to discourage excessively generous employer-sponsored insurance plans—was set to begin fully 8 years after enactment of the law (2018), then was delayed by congressional action until 2022, and now is at risk of repeal (in July 2019 the US House of Representatives voted 419–6 to kill it) (Gusmano 2011; Luthi 2019; Oberlander 2011; White 2018). The only other provision that had some real regulatory teeth and might have been consequential for at least its target of Medicare spending, the Independent Payment Advisory Board and its implementation tools, was never allowed to become operational before it was terminated by Public Law No. 115–123, the Bipartisan Budget Act of 2018, (Oberlander and Spivack 2018).

That is not to say that passage of the ACA had demonstrably no bearing on the costs of health care. In the years immediately following enactment,

there appeared to be a slowing down in medical inflation and reduced rates of growth in per capita national health expenditures, private health insurance premiums, and Medicare and Medicaid spending (Hartman et al. 2018; Peterson 2019: chap. 11). By some estimates, "total health care costs were almost $650 billion less than anticipated" in pre-ACA 2010 projections (Glickman, DiMagno, and Emanuel 2019: 1151). It is difficult, however, to disentangle the lingering effects of the Great Recession of 2008–9, the influence of the ACA, and the role of other dynamics in the health care system (Blumenthal, Stremikis, and Cutler 2013; White 2018). Moreover, the system-wide metrics of swelling costs since full implementation of the law in 2013 show some signs of returning to the earlier patterns (Peterson 2019: chap. 11; Sisko et al. 2019). Premiums and deductibles for employer-sponsored coverage have climbed as well as in recent years, well over growth rates in median income, and include shifting burdens to workers' wallets (Collins, Radley, and Baumgartner 2019; Kaiser Family Foundation 2019a). As desired by the Obama administration, health care system features like electronic health records and accountable care organizations have soared. For electronic health records, just under half of physician offices used them in 2010, compared to nearly 9 in 10 in 2017, and accountable care organizations have leapt from 58 in 2011 to 1,011 in 2018, about half involving Medicare and Medicaid (Muhlestein et al. 2018; Office of National Coordinator for Health Information Technology 2017). Over a third of health care payments in that latest year fit with value-based payment models (Lagasse 2018). And yet all of that modernization of the US health care system has come without clear or consistent beneficial financial effects (e.g., Schultze and Fry 2019). One area where one can have some confidence is that the Medicaid expansion feature of the ACA mitigated to some extent financial burdens on the poor and diminished the previous regressivity of American health care financing (Jacobs and Selden 2019; McKenna, Alcala, and Grande 2018).

Conclusion

Passage of the ACA 10 years ago depended on setting a precise political course with little margin for error. The calculations that made that possible instilled the law with greater political resiliency than might have been imagined at the time, but also assured that its mission to drive toward universal coverage and constrain health care expenditures, including at the level of families and individuals, would produce mixed results at best and be weighted toward coverage expansions rather than cost control. The

Republican Party of the twenty-first century, in full display during the repeal efforts of the 115th Congress (2017–18), has abandoned the commitments of some past leaders to expanded insurance and comprehensive access to medical care—themes promoted in the 1970s and 1990s by President Richard Nixon, Senate Republican Leader Robert Dole, and Senators John Chafee and Jim Jeffords—focusing instead on promoting health plans with lower premiums but limited benefits, private market competition, and restricted federal spending (Peterson 2019: chap. 12). With the impossibility of serious Republican partners and the inherent shortcomings of the ACA architecture to address coverage and costs, Democrats entered the 2020 election season—the law's tenth birthday—debating whether the ACA offered a viable foundation for a substantially more expansive next step or whether it was necessary to hearken back to President Truman and the party's original pledge of tax-payer-financed national health insurance under the current rubric of "Medicare for All." If it is the latter, will such an initiative hit the political atmosphere too directly, burning up on entry and thwarting capture of the White House in the next presidential election? Or will it skip off a resistant atmosphere, summarily rejected like most past reform efforts? Or will it pass through, dented, singed, and missing some pieces, but landing functional on the health policy terrain? Those will be the central questions of the next decade in health care reform.

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Promise, Performance, and Litigation

The ACA's Choice Problem

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Abstract The Affordable Care Act (ACA) is in many ways a success. Millions more Americans now have access to health care, and the ACA catalyzed advances in health care delivery reform. Simultaneously, it has reinforced and bolstered a problem at the heart of American health policy and regulation: a love affair with choice. The ACA's insurance reforms doubled down on the particularly American obsession with choice. This article describes three ways in which that doubling down is problematic for the future of US health policy. First, pragmatically, health policy theory predicts that choice among health plans will produce tangible benefits that it does not actually produce. Most people do not like choosing among health plan options, and many people—even if well educated and knowledgeable—do not make good choices. Second, creating the regulatory structures to support these choices built and reinforced a massive market bureaucracy. Finally, and most important, philosophically and sociologically the ACA reinforces the idea that the goal of health regulation should be to preserve choice, even when that choice is empty. This vicious cycle seems likely to persist based on the lead up to the 2020 presidential election.

Keywords Affordable Care Act, ACA, choice, managed competition, health insurance

The Affordable Care Act (ACA) is in many ways a success. Millions more Americans now have access to health care, and it catalyzed advances in delivery reform. Simultaneously, the ACA has reinforced and bolstered a problem at the heart of American health policy and regulation: a love affair with choice. More specifically, the problem is sanctifying the idea that choice of health insurance plans is valuable. When it comes to some aspects

Journal of Health Politics, Policy and Law, Vol. 45, No. 4, August 2020
DOI 10.1215/03616878-8255445

of their health care, people may genuinely appreciate options and being able to make choices that leave them better off. Some people care about selecting a doctor they like and trust or who is convenient to their home or work. Many people care about reproductive choice. Most of us value the ability to decline care we don't want. But very few people value choosing a health plan, in and of itself.

The ACA's insurance reforms doubled down on the particularly American obsession with choice. This article describes three ways in which that doubling down is problematic for the future of US health policy. First, pragmatically, health policy theory predicts that choice among health plans will produce tangible benefits that it does not in fact produce. Most people do not like choosing among health plan options, and many people—even if well educated and knowledgeable—do not make good choices. Second, creating the regulatory structures to support choices has built and reinforced a massive market bureaucracy, which I describe in detail elsewhere (Hoffman 2019b). Finally, and most important, philosophically and sociologically the ACA reinforces the idea that the goal of health regulation should be to preserve choice, even when that choice is empty. This vicious cycle seems likely to persist based on the lead up to the 2020 presidential election.

The Pragmatic Problem with Choice of Health Plan

Mostly simply, the problem of choice of health plan is that it does not—and cannot—work in practice as anticipated in theory. The primary goal of the ACA was to reduce the number of uninsured and underinsured Americans through two main pathways: a Medicaid expansion and making individual (nongroup) health insurance more accessible and affordable.

The policy design that motivated the latter—the expansion of the individual market—was modeled off of a similar reform in Massachusetts in 2006 and based loosely on the theory of managed competition, most often associated with Stanford economist Alain C. Enthoven (1978a, 1978b, 1993). The oversimplified idea is that when consumers choose among health plans in a marketplace that is carefully regulated, they will make choices based on their preferences. Since most people will presumably choose plans where they get better care at lower costs, insurers will design and offer higher-value plans to compete for their business.

Enthoven (1978b: 718) initially called the idea "Consumer-Choice Health Plan" and explained, "What distinguishes [this plan] from the others is that it seeks to give the consumer a choice from among alternative

systems for organizing and financing care, and to allow him to benefit from his economizing choices." For example, Enthoven (1978a: 652) stated that if people wanted a plan that prioritized better access to home health care or ambulatory care over, for example, hospitalization, they could choose it.

Enthoven's implicit assumption was that a tightly managed plan with an integrated delivery system, like a staff-model health maintenance organization, would prevail. He imagined plans where primary care providers would benefit financially if they reduced their patients' excessive use of expensive specialty and inpatient care. If this reduction lowered plan spending but not quality, people would increasingly want these plans. Enthoven (1978b: 715) sought to mobilize choice in part to correct the thorny problems of overreliance on specialists and fee-for-service medicine.

Managed competition has influenced nearly every major health financing reform effort of the past decades. It graduated to the policy main stage in the early 1990s, when it was incorporated into the blueprint for President Clinton's attempt at health reform, the Health Security Act (H.R. 3600, 103d Cong. [1993–94]). Although that reform failed, the idea lived on in the design of the Medicare Part D prescription drug coverage and Medicare Advantage, where Medicare beneficiaries can choose among plans administered by private health insurance companies.

Most recently, managed competition emerged in the ACA's health insurance exchanges, or Marketplace, where people could shop for plans. The ground rules for insurers were similar to what Enthoven (1978b: 713–14) described in his first blueprint, mandating that they accept any applicant during an open enrollment period (guaranteed issue), requiring "community-rated" premiums that do not vary based on health status, and placing limits on out-of-pocket spending. Like Enthoven's vision, the ACA was designed with the idea that consumers' choices would drive value in a managed, competitive insurance marketplace.

The problem for the ACA, and with all of the versions of managed competition prior, is that it does not work as imagined. The reasons are many. The first problem is a flawed market, where choices do not resound as clearly as Enthoven envisioned. He imagined consumers' signals to insurers would prompt insurers to transform health care financing and delivery. Although less true when Enthoven first wrote, providers have accreted substantial market power through consolidation, undermining insurers' negotiating power.[1]

1. Vogt and Town (2006: 1, 6) document changes in concentration during the 1990s. Gaynor and Town (2012) report that hospital consolidation increased the price of hospital care and sometimes decreases quality. Dafny (2014: 198) states that "the last hospital-merger wave (in the 1990s) led to substantial price increases with little or no countervailing benefit."

The ACA, as designed, only exacerbates this power imbalance. Managed competition relies on having multiple insurers competing for customers, but the more insurers there are in the Marketplace, the less any one of them enrolls enough subscribers to gain bargaining power. Furthermore, the ACA's exchanges reach a small slice of the population: initial best-case scenario estimates were about 24.7 million people enrolled by 2019 (CBO 2010). Actual annual enrollment to date is less than half that number (Kaiser Family Foundation 2019). With enrollees divided among 50 states, insurers gain little leverage to negotiate with behemoth hospital systems.

Even without faulty markets, the second major problem would be fatal: Enthoven's idealized consumer, who chooses smartly among plans, does not—and will never—exist (Glied 2007). This problem is multilayered. First, neoclassical economics assumes that consumers have well-ordered preferences, or "tastes," that are genuinely aligned with their interests. Yet, people do not have exogenous preferences among systems of financing and organizing care. Most people have never experienced home health care or ambulatory care versus hospitalization. It is difficult to get a sense of willingness to pay for something that is intangible.

Second, if people did have well-ordered preferences, most would struggle to translate them into plan choice. Most people do not understand the basic and defining features of health insurance plans, such as how much a plan costs and what benefits are covered (Garnick et al. 1993: 206). In a survey of insured adults, only 14% correctly answered four simple multiple-choice questions about cost-sharing features, such as a deductible, that are central to understanding the value of the plan (Loewenstein et al. 2013: 855). Yet, people overestimated their understanding, which suggests many would not seek help or education even if offered.

Third, choosing a health plan requires making calculations regarding deductibles, cost sharing, premiums, and probability that exceed many Americans' literacy and numeracy skills (Nelson et al. 2008; Peters and Levin 2008; Reyna et al. 2009: 945–46). Even college-educated Americans show surprisingly high levels of error on simple arithmetic tests (Nelson et al. 2008: 263).

Fourth, even without these fundamental problems, choosing health insurance has all of the telltale characteristics that impair rational decision making, sometimes referred to as cognitive biases. For example, people are overly optimistic about their own health (Weinstein 1980), which could prompt them to underinvest in health insurance. People also struggle to

factor risk into decision making, an element central, of course, to health insurance choices.[2] This explains in part why young, healthy people may forgo buying health insurance, even when it's cheap.

Not surprisingly, a volume of empirical work documents that people, regardless of education, income, or smarts, routinely make poor choices among health plans. These poor choices persist even when options are simplified. And they persist even in the face of substantial choice architecture and simplification to improve decision making, which caused Bhargava and Loewenstein (2015: 2506) to conclude that "the main barrier to financially efficient choice was not the number of options confronting employees, nor the transparency of their presentation, but rather the . . . lack of basic understanding of health insurance."

A few representative studies, among the many dozens documenting this unyielding failure, illustrate the problem. One study simulated the purchase of an ACA plan using only participants who passed a screening test for basic insurance literacy (Johnson et al. 2013). These more-literate-than-average subjects still selected the best choice only about half of the time. Wharton business school students got it wrong over one-quarter of the time. Short of defaulting people into the right option, choice architecture tools, like just-in-time calculators and tutorials, produced little improvement.

As another example, in the University of Michigan employee plan, over one-third of enrollees selected a plan that was identical to another option in every way except that it had a more restricted provider network (Sinaiko and Hirth 2011: 453). There was no scenario in which a worker would be better off enrolled in this plan, yet a large number of employees selected it. Another study of a large US firm found that most employees chose a worse option and, as a result, paid on average 24% more than they should have on premiums (Bhargava, Loewenstein, and Sydnor 2017: 1325). Lower-income employees were more likely to make a bad choice.

Similar results occur in the Medicare market, where beneficiaries choose among private prescription drug plans. One study revealed that 73% of enrollees could have chosen a plan with lower premiums with no risk of spending more on prescription drugs during the year (Abaluck and Gruber 2011: 379). Another estimated that less than 10% of enrollees in Medicare drug plans choose their least-expensive option (Heiss et al. 2012).

2. Kahneman and Tversky (1979: 264) indicate that people make choices inconsistent with their own expected utility when navigating risky options.

Once Medicare beneficiaries choose plans, they usually do not switch during subsequent open enrollment periods (Koma et al. 2019), even when they would be made better off by doing so (Afendulis, Sinaiko, and Frank 2017).

People choose ACA plans that will cost them more in the long run (Avalere Health 2015; Fung et al. 2017). As many as one-third of people enroll in a plan with the lowest monthly premiums but that make them ineligible for significant cost-sharing reductions that would limit their out-of-pocket spending when they use care. Others choose health plans that are not aligned with their own stated medical needs and preferences. One simulation of an ACA exchange found that 40% of respondents chose a plan that would cost them at least $500 more than another option based on their self-reported health needs (Barnes, Hanoch, and Rice 2014: 67). In a different simulated study, only one-third of respondents chose the cost-minimizing plan, based on their own anticipated medical care need (Bhargava, Loewenstein, and Benartzi 2017). Forty-three percent of people overinsured, on average overspending by 24% or $1324 on premiums, and nearly a quarter underinsured. The authors estimated that if all people buying plans on the ACA exchanges had similar error rates as the study population, "the result would be roughly $7.1 billion of excess spending each year, borne by a population with low to moderate incomes" (10).

Thus, managed competition, in practice, is not fostering meaningful choice or making people better off.

The Bureaucratic Problem with Choice of Health Plan

These choice-venerating policies, in turn, create larger institutional problems, what I call health care's market bureaucracy (Hoffman 2019b). Markets do not exist in isolation (Vogel 2018). Regulations determine the bounds of competition (Marone 1994). Establishing these bounds for the ACA exchanges was a major lift, guided by no less than 100 pages of the ACA and Herculean regulatory efforts interpreting these pages. To set up and run the ACA exchanges, the federal government has spent tens of billions of dollars (Mach and Redhead 2014), and states have spent additional billions of dollars; California estimates annual costs of $350 million to run its exchange (Covered California 2018).

When exchanges falter or ground rules change, updates have required armies of health regulators, reams of regulation, and seemingly endless evaluation and adjustment by technocratic experts (Hoffman 2019a).

Under the Obama administration alone, the Department of Health and Human Services issued 24 new rules and 64 guidance documents on the exchanges,[3] with parallel efforts in many states. The Trump administration continues apace, undoing much of the Obama administration's rules.

Even more, health care's market bureaucracy amasses equally within the walls of private industry (McMaken 2015). The exchanges rely on private insurer participation, and their costs of operating, including high profits and salaries, is part of the cost of the market-based bureaucracy. It is unsurprising that the administrative costs of the US health care system well outpace those of its peers (Frakt 2018).

Furthermore, the exchanges have commanded oversized technocratic analysis of their successes and shortcomings, consuming the time and energy of talented researchers and think tanks. Scholars, news outlets, and policy makers obsess over every twist and turn, from an insurer joining or dropping out to the ups and downs of premium prices. The *New York Times* alone published over 300 articles on the ACA exchanges from 2010 to 2016 (Hoffman 2019b).

The result is a market-lubricating regulatory scaffold—a bureaucracy perhaps larger than what a direct regulatory approach would produce, and equally vulnerable to capture, or perhaps even more so because, by definition, private industry holds the reins to success. Yet, this expensive tinkering provides insurance for a mere 3% of the population and sets them up to make poor plan choices.

The ACA perpetuates health care's market bureaucracy, yet it is only a small part of it. Managed competition has equally informed the design of the Medicare supplemental market, including Medicare Advantage, Medigap, and the Medicare Part D market. Beyond insurance, an equally futile market bureaucracy grew from consumer-driven approaches to medical care choices. There regulatory scaffolding supports policies attempting with little success to incentivize patients to make good choices to reduce their use of low-value care or to find lower-priced providers (Hoffman 2019b). Likewise, modern antitrust regulation attempts, also with little success, to generate market dynamics that will drive higher-value health care. As antitrust expert Thomas Greaney (2009: 225) described, "Properly applied, antitrust law should promote decentralized decision-making by market participants while encouraging efficient combinations that serve consumer welfare." These policies all privilege market choice

3. CMS n.d. counts listings under "Health Insurance Marketplaces" through calendar year 2016.

and dynamics to achieve larger health policy goals. In turn, regulatory structures focus on scaffolding, lubricating, and repairing markets that in theory will enable people to choose what they value most, even though this theory repeatedly falls short in application.

The ACA has continued to build the market bureaucracy. Although 20 million more Americans now have health insurance, about half through the exchanges, the ACA arguably paved a painful and expensive path to this end.

The Sociological Problem with Choice of Health Plan

The market bureaucracy, in turn, feeds a modern American obsession with choice. Pouring effort into regulatory structures aimed at bolstering choice perpetuates the idea that choice should be the ultimate goal.

This veneration of choice as *the* American value has been building since at least the 1960s. Early kernels in health care might be traced to reproductive and civil rights activists, and legal cases like *Griswold v. Connecticut* in 1965 (381 U.S. 479, 483) and *Roe v. Wade* in 1973 (410 U.S. 113, 170), which favored individual control through a language prohibiting government intrusion over individual reproductive choices. Choice defined the early disability rights movement and demands for independent living and self-direction instead of institutionalization (Administration for Community Living, n.d.). It echoes in works like *Our Bodies Ourselves*, published in 1970 by the Boston Women's Health Collaborative, seeking to help women find self-empowerment over their bodies (Our Bodies, Our Selves, n.d.).

In health care, the sanctification of choice is in part a reaction to a system in which what patients wanted long came second. For most of the twentieth century, doctors controlled medical care decisions. Then, central planning and managed care emerged to address high spending in the 1970s and 1980s, and regulators and insurers gained decisional control. When those efforts fell short, consumer choice grew as something of a "sacred value" (Tetlock 2003). Informed consent evolved and aimed to put medical decisions back in the hands of patients. Market-based policies grew up in parallel, which elevated individual choice, defined by buying power.

Yet, this veneration of choice has arguably gone too far. A world of increasing market choices is actively making people worse off (Schwartz 2004). Not only do people often make poor choices, but people also dread making choices. Thirty percent of respondents to one survey reported they would rather prepare their taxes than navigate health insurance

(eHealthinsurance 2008). The very existence of a market-based system can be contrary to what makes people, at least some people, feel better off. One study revealed that, although the idea of choice was associated with positive attributes for middle-class respondents, working-class respondents associated it with negative attributes and difficulty (Stephens, Fryberg, and Markus 2011).

Choice can also obfuscate what people collectively value and impede productive policies. Studies show that activating the idea of choice can decrease support for policies promoting equality and societal benefits (Savani, Stephens, and Markus 2011). The ACA offers an illustration of this idea. Although it might have been otherwise (Hoffman 2011), the downfall of the ACA's individual mandate came in part because it sought to achieve a collective goal through individual action. It prompted Americans to focus on their own bottom line—exactly how much an insurance policy cost and what it provided in return—instead of on the goal of universal access to health care. Choice centered the policy discussion in the wrong ideological place. The ACA's health insurance reforms make this same mistake more broadly. They elevate the idea that choice of health plan is in and of itself an important goal. In turn, regulatory efforts futilely attempt to achieve this goal, without question.

Yet, at the end of the day, most Americans do not care if their insurance comes from Aetna or Blue Cross. Many people do not know their own plan deductible—if they know what a deductible is—and many would struggle to weigh a choice between a plan with a $10 copay or 10% coinsurance. Most people do, however, care about access to good doctors and hospitals. And Americans do care that they and others can get access to necessary health care without going broke. The most important collective goals may have very little to do with choice, and it will be necessary to move choice aside to understand this reality.

The Post-ACA Horizon for Choice

As the ACA turns 10, we can celebrate that it brought deep national attention to the goal of universal coverage, even if it has not yet achieved it. It also provides a moment to reflect on whether choice should remain the guiding light going forward.

As candidates gear up for the 2020 election, they risk perpetuating the reverence of choice. Candidates who want to build on the ACA's infrastructure sell choice, advocating for a public option for more choice. Perhaps most evident, Pete Buttigieg called for "Medicare for all who want

it." He asserted that if Medicare is the best option, people will choose it, and it will slowly displace inferior private plans. Vice President Joe Biden calls for "giving Americans a new choice, a public health insurance option like Medicare." (Biden for President 2019).

Part of why these candidates sell choice is to differentiate themselves from advocates for a single-payer plan. Choice serves as a euphemistic promise to enfranchised Americans with gold-plated health insurance to let them keep their plans, as well as a balm to others who are loyal to their plans, whether their plans deserve such loyalty or not, or who are fearful of change. Candidates know and bank on the resonance of choice among voters—a resonance crafted through years of careful public-relations campaigns by opponents to single-payer health care (Potter 2020)—even among candidates who understand that choice is a largely empty promise. Proponents of Medicare for All also reinforce the centrality of choice, either by selling this idea based on choice of doctor, which Medicare for All would enhance for many people, or by crafting transition plans that look like opting into Medicare for All.

Choice keeps its stronghold in part based on the narrative that what Americans want is too heterogeneous to be captured by any one solution. Yet, even at this moment when democracy limps along, democratic deliberation over health care priorities is vibrant, and sometimes reveals shared ground. Without overemphasizing the extent of such shared ground since Americans are clearly divided on many critical aspects of health policy, the places of shared commitments could suggest a basis for policy-making priorities. For example, widespread outrage over exorbitant drug pricing and the bind in which it has put many American families is clear. Americans identified lowering drug prices as a top 2017 congressional priority (Council of Economic Advisers 2018). Likewise, in the summer of 2017, public outcry arose against the newly elected Republican Congress's effort to repeal the ACA (Sessions, Cassidy, and Goodman 2017), suggesting at least high-level support for greater access.

The fight over Medicaid expansion reinforces this theme. The ACA intended to require states to expand Medicaid access to anyone earning up to 138% of the federal poverty level, but the ACA's first major legal challenge, *NFIB v. Sebelius*, effectively made this expansion optional. As of September 2018, 34 states and the District of Columbia had expanded (Kaiser Family Foundation 2018).

In the more conservative opt-out states, voters have begun to directly override their representatives' decision not to expand Medicaid in these states through ballot initiatives (Antoinisse and Rudowitz 2019). Maine

passed a ballot initiative to expand Medicaid in November 2017 and voters in Idaho, Nebraska, and Utah followed in November 2018. These ballot initiatives suggest that voters value access to medical care in their communities, especially for lower-income community members. For these initiatives to pass required people who would not directly benefit personally to vote in favor. When the populace expresses shared commitments, whether in abstract terms like valuing access or concrete terms like lower drug prices, it is the job of elected representatives to overcome political barriers to respond. Yet, to the contrary and reflective of deep political dysfunction, legislatures and governors in Medicaid ballot-initiative states dig in their heels deeper to resist expansion, and Congress stalls out again and again on drug pricing reforms. We then turn futilely back to markets with the hope that they will fix the things that our politicians are increasingly unable and unwilling to fix.

Bureaucracy is inevitable, but it should bolster a health care system that can fulfill, rather than frustrate, what people and communities genuinely care about. Looking slightly under the surface suggests that what people really care most about is not always choice and that it is time to refocus health regulation on realizing other shared values.

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Race, Policy Feedbacks, and Political Resilience

The Affordable Care Act and Mass Policy Feedbacks

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Abstract The Affordable Care Act (ACA) has allowed researchers to examine mass policy feedback effects—how public policies affect individuals' attitudes and political behaviors—in real time while using causal models. These efforts help address criticisms of the extant feedbacks literature and have revealed new policy feedback effects and new information on the conditions under which policy feedbacks occur. The ACA case also raises empirical and theoretical questions about the types of data needed to assess feedback effects, the magnitude of policy effects required for detection, the time frame in which feedbacks occur, and the suitability of various empirical approaches for assessing policy feedback effects. Thus, the ACA not only adds an important empirical case to the study of policy feedbacks but also helps refine policy feedback theory.

Keywords Affordable Care Act, policy feedbacks, political behavior, public opinion

For scholars of policy feedbacks, the implementation of the Affordable Care Act (ACA) held great theoretical and empirical promise. Those who study how public policies might reshape politics had an opportunity to evaluate the effects of a major new policy in real time and to employ causal methods, addressing past concerns with this body of research. The possibility that the ACA case might reveal new types of feedbacks or new mechanisms was exciting as well.

Thus far, scholars have uncovered some positive attitudinal effects: those with personal experience getting new or improved health insurance coverage are more favorable toward the law; and some positive behavioral effects: those personally affected are more likely to vote. But the effects are modest and sometimes temporary or contradictory (in some analyses

Journal of Health Politics, Policy and Law, Vol. 45, No. 4, August 2020
DOI 10.1215/03616878-8255493

recipient political participation declines). We may need to reconsider what types of social policy benefits *can* produce feedback effects, yielding more nuanced theory.

Concerns with Policy Feedbacks Theory and the ACA's Possible Contributions

A burgeoning literature examines public policies not just as outcomes of political processes but also as inputs. Existing policies may reshape the political environment and subsequent policy making by altering the resources and interests and mobilizing capacities of political actors at both the elite and mass levels (Béland 2010; Campbell 2012). Empirical cases of mass public reactions to social welfare policy and beyond (e.g., Simonovits et al., forthcoming) have accrued, typically showing that policies have resource and "interpretive" effects (Pierson 1993) that can be positive or negative, boosting or undermining recipients' rates of political participation or altering their preferences on public policies.

Despite theoretical and empirical advances, the policy feedbacks literature has faced both limitations and criticism. One critique warns that researchers have selected on the dependent variable, looking for cases of apparent feedbacks and then reading backward into the historical record. In many cases, we know where we have ended up and we look to program parameters and experiences to explain these patterns. The ACA promised a prospective opportunity to see what happens when Americans receive new social policy benefits—a more rigorous test in which hypothesis development preceded outcome measurement, not vice versa.

A related critique is that much policy feedbacks work has utilized observational data. Scholars have tried to strengthen causal inference, using longitudinal research designs, instrumental variables models, matching techniques, and so on, but concerns about selection and other threats to inference remain. The attitudinal and behavioral effects attributed to public policies could arise instead from preexisting characteristics of the target populations. With the quasi-experimental rollout of many of its provisions, the ACA provided an opportunity for stronger causal inference.

ACA Mass Policy Feedback Effects Thus Far

Regarding political behavior feedbacks, scholars have examined three aspects of the ACA: the Medicaid expansion, the expansion of private insurance through the Health Insurance Marketplace, and the dependent

care provision allowing those under 26 to remain on their parents' insurance. Most of this work has examined policy effects on voter turnout and registration, and the findings are modest and mixed. Studies using aggregate data found that the extension of insurance coverage has increased political participation, but those using individual-level data found no effect on participation.

Haselswerdt (2017) found that aggregate turnout in House races declined less from the 2012 presidential election to the 2014 midterm in states that had expanded Medicaid, compared to those that had not. Clinton and Sances (2018) compared counties in expansion and nonexpansion states sharing a border and found that voter registration and turnout among low-income citizens under 65, the target population, increased in expansion-state counties, particularly those with a high share of eligible citizens (although the turnout effect fades over time). Courtemanche, Marton, and Yelowitz (2019) examined the effect of both Medicaid expansion and private insurance expansion via the Marketplace and the individual mandate (in place until the penalty was zeroed out by the December 2017 Tax Cuts and Jobs Act). Using individual-level participation data and estimated insurance coverage, they found that the ACA's effects were small and statistically insignificant. Chattopadhyay (2017) compared political participation among those just above and below the dependent care provision age threshold and found little effect.

Scholars have speculated on the mechanisms linking the ACA and political behavior, although existing data do not permit their rigorous evaluation. One possibility is that, in providing health insurance, the ACA may improve physical health, which is associated with greater political participation (Burden et al. 2017; Gollust and Rahn 2015; Pacheco and Fletcher 2015). Or it may boost mental health diagnosis and treatment, as did the Oregon Health Plan lottery, or reduce stress and anxiety by improving low-income families' financial stability (Baicker et al. 2013), allowing them to pursue the "luxury good" of political participation (Rosenstone and Hansen 1993).

A second mechanism could be political engagement, including political interest, knowledge, and efficacy (Verba, Schlozman, and Brady 1995) or positive "interpretive effects" (Pierson 1993). Gaining insurance through the ACA might increase recipients' sense of stake in public affairs (Clinton and Sances 2018) or make recipients feel more incorporated into the polity as deserving citizens (Pierson 1993) or more grateful to government in a way that enhances civic engagement (Mettler 2005).

A third possible mechanism is mobilization. Under the 1993 National Voter Registration Act, social assistance agencies, including the health exchanges and Medicaid offices, are required to offer voter registration, which may explain increased turnout in the Medicaid expansion states (Clinton and Sances 2018). After the 2016 election ushered in unified Republican control of government and threats to repeal the ACA, grassroots groups emerged to defend the law (Gose and Skocpol 2019; Meyer and Tarrow 2018). Policy threat can boost participation among social program recipients (Campbell 2003), although even here the evidence is mixed; for example, previous Medicaid cuts, such as Tennessee's 2005 rollback, resulted in greater turnout declines in the counties with the largest disenrollment (Haselswerdt and Michener 2019).

A new feedback effect that has emerged in the ACA case is backlash. The ACA was debated, passed, and implemented during a time of great partisanship; there is a 60– to 70–point gulf between Republicans and Democrats in favorability toward the legislation. So strong are partisan feelings that take-up varies by party identification: not only do many Republicans oppose the law even if they might benefit from it (Kliff 2016), but also Republicans in need of insurance are less likely to sign up if they encounter the government interface (healthcare.gov) than a private one (healthsherpa.com) (Lerman, Sadin, and Trachtman 2017). Some of the increased political participation after ACA implementation apparently comes from those who opposed the reform (Haselswerdt 2017; McCabe 2016). In fact, Fording and Patton (forthcoming) show that public backlash in conservative Medicaid expansion states induced lawmakers to impose new forms of conditionality on Medicaid receipt, such as work requirements, and that such policies are spreading even to states that did not expand Medicaid to begin with.

Policy feedback scholars have also examined whether implementation of the ACA would change attitudes toward the law. Perhaps favorability would rise once people gained insurance through its provisions (Jacobs and Mettler 2011) and once others realized that the worst predictions of the law's detractors did not materialize. At the same time, there were reasons to believe implementation would not change attitudes. Earlier reforms of welfare and Medicare had failed to alter attitudes, among either beneficiaries or the broader public (Morgan and Campbell 2011; Soss and Schram 2007). Partisanship often overwhelms personal experience to begin with as a factor in public preferences, and the highly partisan environment surrounding the ACA may have heightened that effect (Patashnik and Zelizer 2013). In addition, the law's complex and often hidden

design elements might undermine the possibilities for attitudinal change (Chattopadhyay 2018, 2019).

Prior to implementation, symbolic factors such as partisanship, racial attitudes, and government trust dominated ACA attitudes. During the 2009–10 debate, party identification was more important in determining support or opposition to the reform than were demographic factors suggesting a material stake, including age, income, or race (Kriner and Reeves 2014). Racial attitudes were also highly correlated with ACA support (Henderson and Hillygus 2011; Tesler 2012). Panel data from the 2010–14 preimplementation period similarly showed that Republicans and those with low trust in government were more likely to say that the ACA was increasing their tax burden (Jacobs and Mettler 2016, 2018).

After implementation began, modest evidence of increased support among those benefiting from the law's provisions—an attitudinal policy feedback—emerged. Fewer survey respondents said the law had no effect on health care access (Jacobs and Mettler 2016). The gap between Republicans and Democrats in ACA favorability was smaller among those who gained insurance through the Marketplace than among those with employer-based insurance (McCabe 2016). Between 2010 and 2017, Medicaid expansion made lower-income Americans more favorable toward the ACA, with effects stronger among nonwhites and Democrats (Hopkins and Parish, forthcoming). Those with personal or family experience gaining insurance, using subsidies, or getting prescription drug help as senior citizens were more likely to say the ACA has had a favorable impact on health access (Jacobs and Mettler 2018). Those buying insurance in the Marketplace were more positive toward the ACA than those who remained uninsured, as were those in their early sixties whose insurance premiums were newly capped by the law (Hobbs and Hopkins 2019). At the same time, those purchasing insurance on the exchanges who experienced local premium spikes became less favorable toward the ACA (Hobbs and Hopkins 2019).

The political environment mattered—pro-ACA announcements by governors in one state increased public support for the law in nearby states (Pacheco and Maltby 2017)—as did political threat: pooled 2009–17 data showed that after the 2016 election made Republican repeal threats credible, ACA approval was higher (and support for repeal lower) in Medicaid expansion states compared to nonexpansion states, especially among lower-education nonsenior adults (Sances and Clinton 2019).

Thus, evidence both from panel surveys (Jacobs and Mettler 2016) and causal analyses (Hobbs and Hopkins 2019; Sances and Clinton 2019)

shows that personal experience altered attitudes toward the ACA. In some instances, the benefits conferred are tangible, visible, and large enough (Citrin and Green 1991) to enhance political participation and to induce protective stances, especially in the face of policy threat. And the ACA has highlighted a previously unrecognized phenomenon, political backlash, useful for explaining greater participation by a law's opponents. That said, in many instances these feedback effects are small in magnitude, contradictory in direction, and in some cases, temporary.

Why Haven't More Feedbacks Emerged?

Scholars have begun to speculate about the modest size of policy feedbacks arising from the ACA. The ACA's hidden design elements—using private insurance to spread coverage in the Marketplace, in the dependent coverage provision, in Medicaid managed care—makes it difficult for recipients to connect their health insurance experience to government activity, undercutting attitudinal or behavioral change (Chattopadhyay 2018, 2019; see also Béland, Rocco, and Waddan 2019). The facts that important policy decisions were devolved to the state level and that some state implementation choices increased public support for the ACA while others decreased it suggest that federalism can undermine policy feedbacks (Pacheco and Maltby 2019). Another possibility is that, while the vociferous public debate over the ACA may have enhanced feedback effects by informing people about the law, it may also have heightened the influence of partisanship and motivated reasoning over personal experience as a factor in attitudes and behaviors around the law (Patashnik and Zelizer 2013). Because the ACA's target populations—low-income or young in many cases—are marginal voters to begin with, the benefits may have been insufficient to push them permanently over the participatory hump, explaining why some of the participation increases have been only temporary (Clinton and Sances 2018). Oberlander and Weaver (2015) argued the ACA has suffered "self-undermining policy feedbacks" for reasons like those above, which concern beneficiaries themselves, as well as additional factors, such as concentrated losses and festering grievances among significant groups like taxpayers and employers, persistent political incentives for key elites to criticize the law's provisions and characterize its beneficiaries as undeserving, and the law's vulnerability to legal challenge.

These observations strike me as correct, but I believe ACA feedback effects have been modest for additional reasons. Some of these factors are specific to the ACA or to health policy. Yet others have larger theoretical and empirical implications for policy feedbacks scholarship.

First, we may be looking at the wrong political acts. Most analyses of behavioral feedbacks have focused on voter registration and turnout, the acts that are the most common and have the best data availability. But voting is driven not just by resources but especially by civic duty (Verba, Schlozman, and Brady 1995), so it may not be the most sensitive instrument for assessing a resource effect arising from a new social policy benefit. The vote is also a blunt instrument with little information-carrying capacity (Verba, Schlozman, and Brady 1995). Political acts that are more policy specific, such as contacting elected officials or protest, may be better measures of policy feedback. Anecdotal evidence suggests that Republicans' ACA repeal attempts spurred protest activity (e.g., Gose and Skocpol 2019), but we lack the data to systematically assess that possibility, hence scholars' emphasis so far on voting.

Second, it may be that the ACA is simply less capable of producing policy feedback effects than are other policies. To Chattopadhyay's points about the ACA's fractured design undermining possible feedback effects, I add the visibility of fellow recipients. That the ACA provides different policy fixes for different types of people getting health insurance from different sources undermines the proximity and visibility that seem to fuel some feedback effects. Consider senior citizens receiving Social Security and Medicare. They can readily recognize one another. They are also numerous, located everywhere, and in some places even live together. But ACA beneficiaries cannot identify each other. Some get health insurance because they are newly eligible for Medicaid, some because they were previously eligible but newly signed up, some because they are newly purchasing private plans on exchanges, with or without government subsidies, and some because they can stay on their parents' private health insurance until age 26. Such individuals are scattered everywhere, concentrated nowhere. There are few mechanisms—either through the programs themselves or through mobilizing organizations, which barely exist—for such individuals to recognize one another and work together. Such organizations are crucial for both asking people to participate and explaining to them the stakes of public debates. Even if mobilizing organizations were to emerge, they would have difficulty identifying potential members. Health politics may be unique because health has a private cast that may undermine public efforts at mobilization and because health concerns often do not align with other forms of identity (Carpenter 2012). On top of those complicating factors, the ACA's fractured policy design heightens informational and mobilizational barriers.

A third and related point is that the ACA may be less likely to create feedback effects because its benefits are too modest and its policy mechanisms too indirect. Consider Social Security: The program's retirement benefits are large enough to solve, mostly, the problem of senior poverty (although pockets of poverty remain, especially among women, ethnic and racial minorities, and older seniors). They also address the underlying problem of retirement security directly, with cash delivered to the household budget. Or consider food stamps: They vary in size with income, and even the maximum benefit was never intended to cover 100% of recipients' food purchases. The mechanism, however, is direct: an EBT card that is used to purchase food, alleviating hunger.

In contrast, consider health insurance: What people really want is health security—access to affordable health insurance and medical care—but the ACA falls short of its promise for many, solving so little of the underlying problem.[1] One shortcoming is the magnitude of its benefits: the subsidies on the exchanges are too small to make insurance affordable for many, and the law has failed to stem rising deductibles and underinsurance in the employer market. Inadequate health insurance means continued health insecurity for many Americans. The other problem is the indirectness of the mechanism, a phenomenon inherent to health insurance, not just the ACA. Compared to a direct mechanism like injecting cash or cash equivalents into the household budget, health insurance provides financial security more indirectly. Ideally health insurance is complete enough not to cripple households' budgets with unaffordable out-of-pocket costs; ideally health insurance provides sufficient access to health care to support work or whatever activity makes for the household budget. But both of these linkages between health insurance and financial security are probabilistic. The more a program falls short of its goals, whether through the inadequacy of the benefit or the indirectness of its mechanism, the less its feedback-generating capacity.

Fourth, it is worth underlining the effects of heightened partisanship and polarization on the ACA's ability to generate feedback effects (Oberlander and Weaver 2015; Patashnik and Zelizer 2013). Ordinary people, for whom politics and policy are a sideshow in life, need help interpreting political events and policy changes. High levels of partisanship and polarization mean the public has been continually bombarded with conflicting messages on the ACA from elites, including a highly critical stream from the political Right. The benefits of the ACA are thus disputed in the public

1. Thanks to Jon Oberlander for his comments on this paragraph.

realm, likely undermining the development of support among beneficiaries, whose personal experience is tarnished, and among nonbeneficiaries, who, lacking personal experience, were suspicious to begin with. It is easier for a reform to become the new normal when elite messages are more consistently supportive.

Fifth, and most important for policy feedbacks theory, is the role of time. Feedback effects may be modest thus far because of the relatively short time the ACA has been in existence. If the linkage between the ACA and increased political activity is the resource of improved health then it could take years for improved health to materialize, as the Oregon Health Plan experience suggests (Baicker et al. 2013).

More profoundly, thinking about time raises some serious questions about the use of causal models—or at least the types of causal models we have been using—to detect feedback effects. The ACA has facilitated the causal analysis of policy feedback effects, which I applaud. But many causal models presume immediate effects: recipients get a new benefit, and now they instantly have new interests, or they instantly receive and internalize "interpretive" messages about their worth as citizens that should influence their attitudes and behaviors in the short term. That is, many extant causal models presume a type of flip-the-switch effect. But is that what happens? Do we really think that people adopt a new set of interests, or recognize a new set of citizenship messages, that quickly? Some factors can change in the short term, such as the resource factors feeding into political participation. But other factors underlying political participation and especially political attitudes are less conducive to immediate change. Something else to ponder: we know that aggregate opinion change typically comes about through cohort replacement, not individual-level change, which suggests the flip-the-switch effect may be rare indeed.[2]

Moreover, the short time frame of many causal models measures only the "feed," not the "back," and hence does not encapsulate a complete expression of policy feedbacks theory. If we think that feedbacks happen in a cyclical, iterative fashion, with policies changing attitudes and behaviors, which in turn reverberate through the political system to produce new policies, then causal models may capture only one-half of one iteration of the cycle, too short term to capture the full phenomenon. In addition, some mechanisms connecting a policy with political behaviors and attitudes may take longer to materialize than others. Consider my analysis of the role of Social Security in boosting senior citizens' political participation, which

2. Many thanks to Julianna Pacheco for this observation.

showed that these effects grew iteratively over decades (Campbell 2003). It took time for the resource effect to grow, as more seniors were eligible for retirement benefits and as they grew more generous. It took time for mobilizing entities to focus on seniors as a political constituency worthy of outreach efforts. It took even more time for seniors' outsized sense of political efficacy to develop, as they observed their bursts of participation aimed at protecting the program recognized and rewarded by politicians. Clearly causal models deserve a place in policy feedbacks work—we must know that an effect we observe is truly due to the policy itself and not competing factors—but we must also recognize the limits of causal models and utilize them in conjunction with other methods of assessing the relationships between public policies and public behaviors and attitudes over time.

Future Research in Mass Policy Feedbacks

The ACA has added an important case of policy feedback, providing a new example of threat as a motivator and revealing a new phenomenon—backlash—to look for in other policy areas. We see yet again the toll that obscured, complicated policy designs (especially privatized designs) take on individuals' ability to recognize the government role in their public policy experiences and to defend it. And we have the welcome extension of causal models to this empirical area, where they have been sorely needed.

But the ACA case also shows that scholars of policy feedback still have work to do. We need to think more deeply about what causal models imply about the timing and nature of policy feedbacks. We need more data, both survey data and qualitative data, that follow individuals' program experiences and evolving thinking and behavior and that follows mobilizing organizations and their strategies. As always, we need more analyses that show both that policies influence attitudes and behaviors and that, in turn, those altered attitudes and behaviors reshape the political environment and influence subsequent rounds of policymaking. In this regard I commend the work of Fording and Patton (forthcoming), which shows that Medicaid expansion by Republican governors angered Republican voters in their states (the feed), which induced those governors to impose work requirements to retroactively limit Medicaid expansion (the back). And "the back" has continued: states newly adopting Medicaid expansion have decided to impose work requirements from the outset, and even states that never adopted Medicaid expansion have decided to impose work requirements on their existing programs. This scholarship confirms the value of the policy

feedback approach, which I hope the ACA—the most important social policy change in a generation—will continue to foster.

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Acknowledgments

I thank Jon Oberlander, Julianna Pacheco, and Jacqueline Chattopadhyay for their very helpful comments on an earlier version of the manuscript.

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Race, Policy Feedbacks, and Political Resilience

The Affordable Care Act's Enduring Resilience

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Abstract The Affordable Care Act (ACA) has taken numerous blows, both from the courts and from opponents seeking to undermine it. Yet, due to its policy design and the political forces the ACA has unleashed, the law has shown remarkable resilience. While there remain ongoing efforts to undo the ACA, the smart money has to be on its continued existence.

Keywords Affordable Care Act, health reform, politics

Following the 2016 election, I was quoted in the *Washington Post* as saying the Affordable Care Act (ACA) "as we know it would seem to be toast" (Goldstein 2016). Though the ACA has indeed been altered by the Trump administration and Congress since that election, this quote turned out to be a bit of an overstatement. The ACA is certainly still alive and has shown remarkable resilience since its enactment, reflecting its policy design, changes made legislatively and by the courts, and the politics surrounding it.

The 2012 Supreme Court Decision

The first hit the ACA took was the 2012 Supreme Court decision in *NFIB et al v. Sebelius*. In that decision, the court upheld the constitutionality of the law's individual mandate but ruled that the expansion of Medicaid to all individuals with incomes up to 138% of the federal poverty level would have to be voluntary for states (US Supreme Court 2012). This decision significantly changed the course of the ACA. Currently, 14 states have not

Journal of Health Politics, Policy and Law, Vol. 45, No. 4, August 2020
DOI 10.1215/03616878-8255529

adopted the Medicaid expansion—even though the federal government will pay 90% of the cost—leaving many people below poverty in those states with no affordable health coverage (KFF 2019d).

The ACA has certainly been less effective at increasing health insurance coverage without all states expanding Medicaid. However, many blue states as well as red states have chosen to expand Medicaid, often with federal waivers such as work requirements to put a more conservative imprint on expansion. It is hard to say for sure what effect the Court's decision has had on the politics of the ACA. On the one hand, if all states had been required to expand Medicaid, it might have built an even bigger and stronger constituency for the law. On the other hand, it is quite possible that requiring recalcitrant states to expand would have generated an even stronger backlash against the ACA and made it less politically sustainable. Giving states a choice over whether to expand Medicaid means that those that make that choice may in the end be more invested in the law. This played out during the 2017 effort to repeal and replace the ACA, including rolling back the Medicaid expansion, when a number of Republican governors who had expanded Medicaid weighed in against repeal.

Large Premium Increases and Insurer Exits

In the first few years of the ACA's full implementation starting in 2014, premiums in the Health Insurance Marketplace were generally lower than expected (Levitt, Cox, and Claxton 2016). However, it turned out that premiums were too low, as insurers misestimated costs, particularly related to the relative shares of enrollees with and without preexisting conditions, and many insurers lost money in the Marketplace as a result (Levitt, Cox, and Claxton 2017). This produced a significant market adjustment, as insurers raised premiums substantially and many exited the ACA Marketplace and the individual market generally going into 2017. The average benchmark premium increased by 20% nationally for 2017 (KFF 2019b), and the share of Marketplace enrollees with a choice of only one insurer increased from 2% in 2016 to 21% in 2017 (Fehr, Kamal, and Cox 2019).

The ACA seemed on the ropes, but the structure of the law's premium subsidies has promoted stability in the market, making it resilient to premium increases. The framers of the ACA structured the subsidies, which are available to Marketplace enrollees with incomes from 100% to 400% of the federal poverty level, so that they could say that no one would have to pay a premium of more than 9.5% of their income (and many would pay less). The subsidies are calculated based on a benchmark premium in each

geographic area: the second lowest-cost plan offered at the "silver" level of coverage. Enrollees are expected to pay a defined percentage of their income to enroll in that benchmark plan (ranging from 2% to 9.5% in 2014, with small changes over time based on increases in private insurance premiums relative to income), and a federal income tax credit covers the rest.

The result is that Marketplace enrollees eligible for subsidies—85% of all enrollees (KFF 2019c)—are insulated from premium increases. No matter how much the benchmark premium increases, federal premium subsidies rise to cover the difference, leaving enrollees paying approximately the same percentage of their income. (From a fiscal perspective, of course, federal spending for those subsidies increases.)

This subsidy structure has proven quite powerful. It has helped keep Marketplace enrollment stable, even in the face of large premium increases, protecting the market from a premium "death spiral" that would result if too many healthy people dropped out. It has also protected the Marketplace from the risk of so-called bare counties with no insurers participating at all. There is a strong incentive for an insurer to enter a market with no other plans, knowing that even with very high premiums, subsidized enrollees will not have to pay them.

The Repeal-and-Replace Debate

With the election of Donald Trump in 2016 and Republicans in charge of both the House and the Senate, "repeal and replace" of the ACA became a top priority going into 2017. It was during this period that the ACA exhibited its political resilience.

The House, after first abandoning the effort and then returning to it later, passed a version of repeal and replace that quickly proved quite controversial. The Congressional Budget Office (CBO) projected that the bill, which repealed the ACA's Medicaid expansion and substantially altered the premium subsidies, would result in 23 million more people uninsured by 2026 (CBO 2017a). Key to the bill's passage was a compromise worked out between moderate and conservative Republicans that would have allowed states to waive the ACA's benefit requirements and under certain circumstances community rating (which prohibits insurers from charging sicker people more than those who are healthy). President Trump, who celebrated the House bill's passage in a Rose Garden event, later called the bill "mean" (Kenny 2017). The Senate was ultimately unable to pass a bill and the repeal and replace effort died.

Many factors no doubt contributed to the failure of Republicans in Congress and President Trump to repeal and replace the ACA, but two elements of the law emerged as crucial to its staying power and decisive to moderate Republican swing votes in the Senate: the expansion of Medicaid and protections for people with preexisting conditions. Health industry groups and governors (including Republican governors) rallied to support the Medicaid expansion and oppose provisions that would have capped federal funding for the Medicaid program more generally and reduced spending substantially over time. People with preexisting conditions and their family members showed up at town hall meetings. Forty-five percent of nonelderly families have at least one adult with a preexisting condition that would have led to a decline of individual health insurance before the ACA (Claxton et al. 2019), and they proved to be a powerful and sympathetic voice in the debate.

Indeed, it was during the repeal-and-replace debate that the political tide for the ACA began to turn, with more Americans viewing it favorably than unfavorably (KFF 2019a). Republican efforts to repeal and replace the ACA, and in particular weaken protections for people with preexisting conditions, played a big role in the 2018 midterm election, helping Democrats retake the majority in the House.

Individual Mandate Repeal

While Republicans were unsuccessful at repealing the ACA itself, they did at the end of 2017 repeal the most unpopular part of the law, the so-called individual mandate. (Technically, the mandate to have health insurance or pay a penalty still exists, but the penalty is now zero.)

The ACA guaranteed access to coverage for people with preexisting conditions but needed to ensure that healthy people would enroll as well to avoid a premium death spiral. The law included a "carrot" (premium subsidies) as well as a "stick" (the individual mandate). CBO (2017b) predicted that repeal of the individual mandate penalty would push individual market premiums up by 10% and result in a significant increase in the number of people uninsured (4 million in 2019, rising to 13 million by 2027). (CBO later indicated that it believed the individual mandate was not as important as originally expected and repealing it would have more modest effects [Antos and Capretta 2018].)

Repeal of the individual mandate penalty did, in fact, have an upward effect on individual insurance market premiums (Kamal et al. 2018), but at least so far the effects on the number of people uninsured have not been as dire as expected. It may be that the ACA's "carrot" was more powerful than

its "stick." Interestingly, repeal of the individual mandate may give the ACA even greater political resilience, jettisoning its most unpopular and controversial provision, as long as the Marketplace continues to function in a sustainable way.

Administrative Actions to Undermine the ACA

President Trump has taken a number of administrative actions to undermine the ACA, including expanding short-term plans that do not have to follow any of the ACA's rules and as a result offer much lower premiums to people without preexisting conditions (Levitt et al. 2018), as well as dramatically reducing outreach and funding for enrollment navigators (Pollitz, Tolbert, and Diaz 2019). A number of states have blunted these efforts by restricting short-term plans and maintaining funding for outreach in the exchanges they operate themselves (and additional states are moving to run their own exchanges).

Perhaps the president's highest-profile effort to undermine the health law was terminating federal payments to health insurers for cost-sharing reduction (CSR) subsidies. In addition to means-tested premium subsidies, the ACA required Marketplace insurers to offer reduced patient cost sharing for lower-income enrollees in silver-level plans. The federal government reimbursed insurers for the cost of providing this reduced cost sharing. The Republican majority in the House had sued the Obama administration, arguing that payments for the CSR subsidies were not properly authorized. President Trump threatened to cut off the CSR payments to insurers, saying it would cause the ACA to "implode" (Pear and Kaplan 2017). After numerous such threats, the president ultimately terminated the payments in October 2017.

However, rather than causing the ACA Marketplace to collapse, the cutoff of the cost-sharing subsidy payments allowed insurers to hold enrollees harmless, and even in some cases make them better off, through what became known as "silver loading." Insurers compensated for the loss of the federal cost-sharing subsidy payments by increasing silver premiums, based on the fact that the reduced cost sharing for lower-income enrollees is available only in silver plans. The premium for the lowest-cost silver plan increased by an average of 32% nationwide in 2018, compared to a 17% increase for less generous bronze plans and 18% for more generous gold plans (Semanskee, Claxton, and Levitt 2018).

Because the ACA's premium subsidies are tied to silver plans, those subsidies increased dramatically. Subsidized enrollees covered by silver plans were held harmless, and those choosing to sign up for bronze or gold

plans saw their premiums net of subsidies fall. This effort to undermine the ACA backfired because of the structure of the law's premium subsidies. Enrollment among subsidized individuals has held steady at over 8 million people (Fehr, Cox, and Levitt 2019). Insurers are also returning to the ACA Marketplace and in many cases lowering premiums (Fehr, Kamal, and Cox 2019a), having increased profits substantially with recent premium increases (Fehr, Kamal, and Cox 2019b). Nationally, the benchmark premium decreased by an average of 3.5% in 2020.

Continuing Challenges

While the ACA has withstood multiple blows and remained standing, it is not working as well as its framers originally hoped and faces continuing challenges. With 14 states still not expanding Medicaid, 2.5 million uninsured people with incomes below poverty are not eligible for Medicaid but also not eligible for ACA premium subsidies (Garfield, Orgera, and Damico 2019). And, while people eligible for subsidies have been shielded from premium increases—some a result of the structure of the ACA, and others a result of actions taken by Congress and the Trump administration—middle-class people not eligible for subsidies have taken the full brunt of those increases. Individual market enrollment among those not receiving subsidies fell precipitously from 6.4 million in 2015 to 3.9 million in 2018 (Fehr, Cox, and Levitt 2019).

President Trump has continued to vow to repeal and replace the ACA after the 2020 election if he is reelected and Republicans control Congress (Cunningham 2019). And an ongoing lawsuit, supported by the Trump administration, threatens to overturn the ACA in its entirety, including protections for people with preexisting conditions and the expansion of Medicaid. However, with the knocks the law has taken and the resilience it has shown, the smart money would have to be on its continued existence.

■ ■ ■

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Comparative Perspectives

What Is the Affordable Care Act a Case of? Understanding the ACA through the Comparative Method

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Abstract International comparisons of US health care are common but mostly focus on comparing its performance to peers or asking why the United States remains so far from universal coverage. Here the authors ask how other comparative research could shed light on the unusual politics and structure of US health care and how the US experience could bring more to international conversations about health care and the welfare state. After introducing the concept of casing—asking what the Affordable Care Act (ACA) might be a case of—the authors discuss different "casings" of the ACA: complex legislation, path dependency, demos-constraining institutions, deep social cleavages, segmentalism, or the persistence of the welfare state. Each of these pictures of the ACA has strong support in the US-focused literature. Each also cases the ACA as part of a different experience shared with other countries, with different implications for how to analyze it and what we can learn from it. The final section discusses the implications for selecting cases that might shed light on the US experience and that make the United States look less exceptional and more tractable as an object of research.

Keywords ACA, comparative politics, health care reform

During debates on the Affordable Care Act (ACA), reforms in the legislation were frequently compared to health systems in other countries. On the pro-reform side, comparative data from health systems around the world were used in political debate to demonstrate how comparatively expensive yet mediocre US health care had become and to argue the case for reform (Peterson 2011). Among the ACA's opponents, images of "socialist" or authoritarian health care systems were used to invoke fear

Journal of Health Politics, Policy and Law, Vol. 45, No. 4, August 2020
DOI 10.1215/03616878-8255589

about the ACA and what it would mean for the future role of the federal government (Ehlke 2011). Commentators continued to talk about Canadian-, Singaporean-, French-, or Dutch-style health care or "single payer" or "universal health care," without much context or analysis (Brown 2012; Marmor, Freeman, and Okma 2005). This tendency lives on in discussions about the ACA and ideas like "Medicare for all." Phrases like *single payer* are still incorrectly used by the Left as shorthand for "good health care system" (Greer, Jarman, and Donnelly 2019; Sparer, Brown, and Jacobs, 2009).

It might be a good time, therefore, to revisit the question of how best to compare the US health care system to those in other countries. Ten years after the passage of the ACA, how should we make sense of the reforms from a comparative perspective? Can we make such comparisons truly meaningful when the United States seems to be, at least superficially, an "exceptional case"?

Understanding something as complex as the ACA, or US health care policy, in a comparative context is a significant endeavor that few have undertaken (Marmor and Klein 2012; Tuohy 1999, 2018; White 2013). But we can apply some thinking from comparative social inquiry to make the process easier. The following sections draw from literature on the comparative method in order to think about how we might define the ACA as a phenomenon and how we might compare it to other cases. A vast, cross-disciplinary body of literature in the social sciences examines different ways to define, select, and compare cases. Although this body of work is far too voluminous to examine extensively here, we provide some useful starting points for generating comparative insights that can help us to understand the ACA in a new light.

Casing as an Act of Research

One of the first things that comparative scholars will often do when working on a project is to try to construct a "case" by figuring out the boundaries of the phenomenon to be studied. Ragin (1992) describes the process of constructing a case, or "casing," as a fundamental act of research. Researchers move back and forth between considering their case in the light of relevant theoretical ideas and empirical evidence in a process known as retroduction (Ragin 2011). This is far closer to the actual practice of research than much of the standard discussion of inductive and deductive research. In reality, most findings are not driven by the testing of a prior induction or the atheoretical induction of facts. They come from

researchers who realize what is truly interesting about their topic as they move more deeply into both relevant theory and their case. Casing permits what we most want: the identification of portable causal arguments that can be convincingly used in some cases, as well as the scope of conditions under which they cannot be used (Falleti and Lynch 2009). When investigating complex social phenomena, the process of casing will almost certainly continue throughout the study, with researchers refining the boundaries of what their case is as their understanding grows.

With these insights in mind, how should we begin to "case" the ACA? After a decade of complex implementation, the ACA is much more than the law itself or the surrounding political debate. Put more specifically, what is the ACA a case of? What kinds of theory illuminate it, and what kinds of theory does it build? In the context of current debates in comparative politics, some promising ways to case the ACA include defining it as complex legislation, path dependency, demos-constraining institutions, deep social cleavages, segmentalism, persistence of the welfare state, or mandatory private insurance. These case definitions are by no means exhaustive. In a real study, researchers would change their conceptual understanding of the case throughout the project through the process of gathering and synthesizing information. Nevertheless, running through some examples is perhaps the best way to show how casing the ACA might work in practice. Each of these different casings highlights a dimension of US health care politics with international equivalents.

Uniquely Complex Legislation

For example, is the ACA a case of an American style of uniquely complex legislation? An increasing number of scholars have written about how public policy in the United States (especially health policy) is needlessly complex and builds in layers of interests at the expense of accountability, traceability, effectiveness, or efficiency. Whether we call it the delegated welfare state (Morgan and Campbell 2011), the submerged welfare state (Mettler 2011), the hidden welfare state (Howard 1999), or kludgeocracy (Teles 2012), the complexity of US social policy and its pernicious effects are a focus of much scholarship today (Greer 2018). The ACA is certainly a case of a very complex and indirect piece of legislation. Even politically and administratively simpler coverage mechanisms, such as extension of state insurance regulation, were complex and largely disguised from voters who might give politicians credit (Béland, Rocco, and Waddan 2016).

This intuition and extensive exploration of policy dynamics in the United States have not, however, been matched with efforts to see if US policy is indeed such an outlier in complexity, and why. US policy making is more elaborate than that of the Westminster systems, such as those in the United Kingdom or Canada. But are US policy processes really more complex and riddled with rent seekers than public policy making in France, or more obscure and ineffective than public policy processes in Italy? For that matter, is the relative simplicity of Westminster policymaking matched by relatively simpler policies?

One reason these authors give for the complexity of public policy is the fragmentation of the US political system, combined with its enormously dense interest group infrastructure, which means that interest groups can defend themselves against efforts to rationalize the system or effectively contain costs. Much of the complexity of the ACA comes from Democrats' decision to sidestep conflict by leaving most of the previous system in place (Oberlander 2016), which helped secure passage and make implementation possible at the price of extending the complexity of health policy. In a variant of this argument, Drutman (2015) persuasively argues that lobbyists, eager to demonstrate their return on investment, might also be making all policy more complex than it needs to be. This might help explain the lobby-filled US health care world, but it might also explain EU policy making, where legislation is just as complex, with just as many lobbyists eager to demonstrate the need for lobbying.

Path Dependency

Most of the authors in the literature on complex public policy point to interest group activity as a key driver of the complexity they identify. But if the ACA, and US politics and public policy in general, are more complex than other countries with more waste, then maybe it is too simple to blame only interest groups. A powerful explanation for the complexity and partiality of US coverage politics can be found in path dependency, a concept with a particularly strong lineage in comparative politics research. The case is perhaps best put in the case of US health policy by Mayes (2004). Path dependency arguments emphasize the extent to which decisions at one time lock in costs and benefits and trigger positive- and negative-sum dynamics. Even if another approach would be better, the costs of transitioning to it are now so big that it is impossible, and we need not look to further explanations such as partisanship or interest groups in understanding why. In other words, once you have taken the wrong turn, turning around and going back

hours later is so costly that you don't. Thus, for example, one might argue that once Medicare or employer-sponsored health care were established in policy, they created their own constituencies among elites and the public, became harder to reform, and jointly became an obstacle to a coverage reform. The evidence for such a thesis is not hard to find (e.g., Campbell 2003; Gottschalk 1999; Klein 2003; Mettler and Soss 2004; Oberlander 2003; Quadagno 2005; Tuohy 1999).

Path dependency arguments are powerful in explaining that divergence sometimes just *is*. At the same time, path dependency arguments also have some weaknesses that comparative politics scholars have been trying to address (Mahoney and Thelen 2015). First, while they produce an interesting search for critical junctures in history, they do less explanatory work now—each country ends up on its own path. Second, this search for critical junctures can turn into a swamp (Brown 2010): At what point, exactly, did the United States embark irrevocably on the path leading to today? Was any particular trajectory a necessary result of a given event? Third, there is no guarantee that any given policy triggers a self-reinforcing feedback loop (Oberlander and Weaver 2015). Those opposed to the policy and its effects might be able to mobilize against it and make countervailing policies that just lead to stalemate or to policy cycling (Tuohy 2018).

Demos-Constraining Institutions

If the ACA is more, or differently, kludgeocratic, delegated, and submerged than the policy of other countries—it is certainly less universal—and if the difference is not just due to history, then is the outcome because of the number and strength of demos-constraining institutions, which explicitly constrain democracy, in the US political system (Stepan and Linz 2011)? Demos-constraining institutions can work in two ways. One is through federal-level veto points (e.g., the Supreme Court, the independence of two legislative branches and the executive, or the filibuster). The other is through fragmentation (e.g., dividing the people into multiple jurisdictions, such as 50 states and about 90,000 local governments), which promotes intergovernmental competition and raises the costs of enacting policy by demanding enactment in more jurisdictions. Medicaid expansion in the ACA showed them working together: one veto player, the Supreme Court, rewrote the law to make expansion optional for states, which created 50 new venues in which to contest the policy. American demos-constraining institutions are both strikingly numerous by international standards and, in many cases, particularly strong, as with the absurdly malapportioned

Senate, its filibuster, or the Electoral College (Stepan and Linz 2011). It thus should be no surprise that the United States has such a problem of political, social, and economic inequality: its institutions impede the most effective action against such problems (Stepan and Linz 2011).

The United States is certainly poor at delivering policy outcomes that reflect the overall preferences of its population. Page and Gilens (2017) contentiously argued that there was no relationship between the percentage of the American public who support a policy and its likelihood of passage. There is no clear comparative literature that tells us whether the United States is more or less responsive than other countries. The ACA in this perspective, though, is not particularly ambitious legislation compared to universal health care, but it is something like the best that could be got through American political institutions as they currently stand (Tuohy 2018). This account is highly plausible and fits with studies of other complex and demos-constraining political environments, such as Brazil (Arretche 2013; Segatto and Béland 2019) and the European Union (Héritier 1999; Obinger, Leibfried, and Castles 2005). In those polities, any kind of policy success depends on creativity and clever bypasses of demos-constraining institutions—a phenomenon that Americanists recognize as "unorthodox lawmaking" (Sinclair 2016).

Deeper Social Cleavages

Of course, these demos-constraining institutions, from the beginning, have been sustained by those who do not benefit from more democracy, including slaveholders and the beneficiaries of Jim Crow, as well as other interests that would not benefit from the passage of popular redistributive policies. So perhaps both the institutions and the policies reflect deeper social cleavages, notably those of race and perhaps also of class. This perspective flips the preceding one, as when Riker (1964: 155) said of state's rights that "if one disapproves of racism, one should disapprove of federalism." If American institutions developed as a long series of compromises with antidemocratic or undemocratic forces that are still at work today, should we instead focus on those forces and view institutions as endogenous to that explanation?

Marx (1998), for example, shed considerable light on the United States by comparing it to two other countries with similar legacies of white supremacy: Brazil and South Africa. Lieberman (2009) likewise demonstrated the negative effects of racial hierarchies and politics on AIDS policies with an argument that could well apply to the US. There certainly is persuasive evidence that the ACA was "racialized" in the eyes of many

whites (Grogan and Park 2017; Tesler 2011) and that this is part of a larger rise of white identity and nationalism (Maxwell and Shields 2019; Morone 2018). From this perspective, the United States is in a catch-22: racism that manifests in inherited institutions, in public opinion, and in organized political forces impedes redistribution even when it would be in most whites' interests, but at the same time it is a redistributive welfare state that enables progress toward racial equity (Katznelson 2005; Lieberman 1998).

Through that lens, the ACA, while it extends coverage and promotes equity in a variety of ways (Grogan 2017), is still only a partial coverage extension by the standards of other rich countries, and it came with a furious and racialized backlash. Perhaps it could be read as just another episode in intertwined battles over race and redistribution, or another case of the extension of universal social programs that follows on a democratic advance. The backlash against the ACA, which cost Democrats congressional seats in 2010 (Nyhan et al. 2012; Saldin 2011), could in this casing be read as another one of the backlashes that follow on civil rights victories. Pursuing the implications of all the work identifying race as a key variable in America health politics drives the casing process, and comparisons, in new comparative directions—toward the other societies marked by industrial chattel slavery and racial hierarchy, which are found principally in the New World, rather than long established states in a European continent marked by centuries of state and nationalist efforts to create homogeneity. It equally, though, raises complex questions of causality, since institutions are not perfect reflections of today's politics, and in public opinion beliefs about race work through complex ideas of "deservingness" (Lynch and Gollust 2010).

Segmentalism

Another, related way to view the extension of health care access in the United States is as part of a push, led by the Left, to reduce segmentalism (sometimes also known as stratification) in health care policy. In this case, Latin American or some East Asian countries, rather than European ones, might be the most useful comparators (Haggard and Kaufman 2008). Latin America and southern Europe have histories of "segmentalist" systems in which particular groups have different health care access, with some groups, such as the workers of the most favored companies, enjoying good benefits and some others frozen out entirely or dependent on a thin public safety net (Martínez Franzoni and Sánchez-Ancochea 2018). By such a definition, the United States is, like Chile, Brazil, or Mexico, a country whose politics are shaped by a segmentalist legacy and where the debate is about

whether and how to universalize its health services (Greer, Jarman, and Donnelly 2019; Greer and Méndez 2015).

Persistence of the Welfare State

But despite being flawed and hard to claim credit for, and being caught in a backlash of tremendous force, the ACA persists. Is the ACA best viewed as a case of the persistence of the welfare state? Since the 1980s, scholars of comparative welfare states found not so much a rollback as a slowing of the extension of the welfare state in what is known as the "new politics" of welfare (Pierson 1996). The basic logic is that in any system it is hard to take away benefits that people currently enjoy (Brooks and Manza 2007). Veto points in the institutions will make it harder to shrink the welfare by empowering both interests that oppose cuts and interests that block change or extension. If the program does lose its effectiveness, it probably will not be through big legislative changes. Rather, it will suffer "policy drift," in which failure to update a policy means that over time it ceases to fulfill, and perhaps even undermines, its original goals (Hacker 2004). Of course, the argument that politicians will avoid overt retrenchment is a poor fit with the actual experience of the ACA, which *was* almost repealed despite obvious political and policy reasons not to (Hacker and Pierson 2018). America's numerous veto points just barely saved the ACA, but from a partisan assault whose magnitude most theorists of new politics would hardly have expected.

Comparing the ACA to Other Cases

The next step in applying the comparative method is to select further cases for comparison. Once researchers have at least some preliminary understanding of what the ACA is a case of, they can begin to think about it not just as a case in isolation but as part of a constellation of cases that can be grouped into sets or categorized in different ways. In other words, how does the ACA, as a case of X, relate to other cases of X? What dimensions of the US experience allow us to create meaningful comparisons that contribute to our international as well as US expertise?

Again, selecting cases is an act of research. Case selection is a preoccupation of literature in comparative politics because it is central to the credibility of the findings, shapes the kinds of lessons that might be learned, and above all, determines the scope conditions for any generalization. Done badly, comparative analysis can degenerate into simple impressionistic analogy. Efforts to develop an approach to case selection based on

frequentist statistical methods (King, Keohane, and Verba 1994) also tend to fail (Brady and Collier 2010) because treating qualitative comparison simply as a way to address "small *n* problems" does not exploit the richness of a case as a set of interacting variables. More productive efforts to develop case selection have focused on just that richness: identifying subtler ways that variables interact within cases over time in order to tease out configurations of variables and their effects.

Attention to case selection equally allows us to identify less valid inferences. For example, there are probably too many UK-US comparisons, since a shared language and an English tendency to borrow fashionable American phrases like *population health* and *accountable care organizations* can distract from the fact that in important respects they are very different polities. The highly centralized, executive-focused United Kingdom, the size of the public National Health Service systems, and the strong concept of positive social citizenship among UK citizens all make it more of a contrast than a suitable comparison with the United States. It is highly unlikely, for example, that endless debates about putative "Americanization" of the British health system have brought much clarity to UK policy conversations (Powell, Béland, and Waddan 2018).

Each of the six "casings" of the ACA we identify above points to a different set of comparisons that would shed light on the US experience and future, while contributing to an international conversation. If the question is just how distinctively complex US legislation is and why, then cases from the Netherlands, Switzerland, and Italy can teach us about the politics of complexity. If the question is about how path dependency works, then identifying similar cases at key junctures can be illuminating, for example, Canada in the 1970s (Maioni 1998). If the question is how demos-constraining institutions shape the United States and how they may be worked around, then the veto-ridden European Union is a case, as well as other wealthy states such as Switzerland, where policy making is built around anticipation and management of vetoes. If the question is how to understand deep social cleavages, particularly the changing racial politics of health in divided societies, then a more delicate operation is needed to seek lessons from quite distant countries, such as Brazil or South Africa, where racial inequalities and politics are important to any distributive question. If the question is how to understand segmentalist legacies, adding an international dimension to the extensive literature on path-dependent and interest-group-reinforced segmentalism in the United States, then relevant cases would be countries that substantially overcame segmentalism (e.g., Spain and Brazil; Linos 2013) and ones that failed to do so, as well as the hybrids that have evolved (Wong 2004).

Once we "case" the ACA, then we can see it in a new light and see what lessons can be exchanged with the rest of the world. It might not be comfortable to compare the United States to Brazil or South Africa, or an easy research project to figure out Japanese health care financing and politics in order to shed light on the experience of others (Schoppa 2006; White 2013), but those projects can be revealing if done with rigorous attention to case selection and inference.

Conclusion

Comparisons of the US health system are often made with an overt agenda, typically of showing its extraordinary expense, inequity, and mediocre results (Cohn 2009; Reid 2010; Schneider et al. 2017). While understanding these differences may be important, viewing the United States as an exceptional case, or just a poor performer, constrains our thinking about both health problems and potential solutions.

To the extent that the United States is a case of a system with too many veto players, we can expect partial and fragmentary legislation, but equally, the experiences of other countries show that complexity and indirection of the ACA and much US policy might not be inevitable. The United States stands out relative to European countries for the depth and historical importance of its domestic racial cleavage and its segmentalism, but those phenomena are also ones that many Latin American and southern European countries face and are addressing in their politics. In other words, if the United States is cased carefully, there is scope to introduce new thinking about the ACA and the rest of the world into our health policy research.

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JUL, 31, 2020

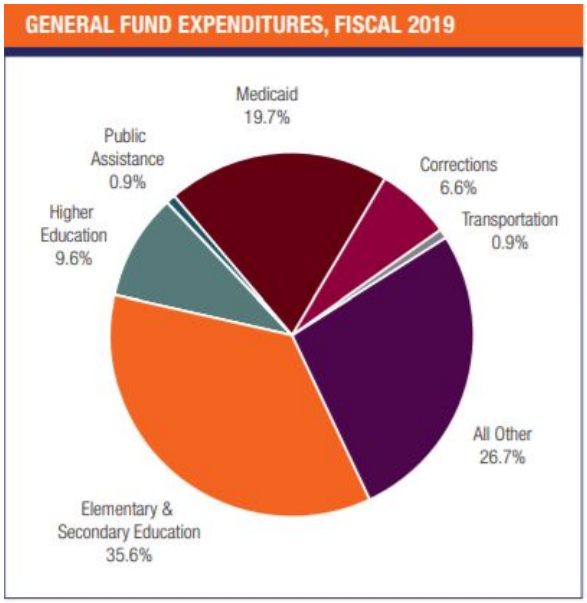
State Budget Actions in Response to COVID-19 and the Impact on State Health Programs

Sally Mabon, Marissa Korn and Heather Howard, State Health and Value Strategies

The COVID-19 public health crisis has triggered an economic crisis: roughly one out of every five workers claimed unemployment insurance (https://www.nytimes.com/live/2020/07/23/business/stock-market-today-coronavirus) for the week ending July 4. As a result of the twin crises, states are experiencing severe declines in tax revenue, with projections (https://www.shvs.org/wp-content/uploads/2020/05/Analyzing-the-Fiscal-Impact-of-COVID-19.pdf) indicating between 5 and 15 percent reductions in revenue for fiscal year (FY) 2020 and reductions of 10 to 25 percent for FY 2021. These dramatic declines in revenue come at the same time that states are facing significant expenditures related to the public health crisis.

To date, the federal government has provided fiscal relief through several stimulus bills, including a temporary 6.2 percentage point increase (https://www.shvs.org/covid-19-cms-issues-guidance-for-states-about-new-increased-medicaid-and-chip-matching-rate/) in the regular Federal Medical Assistance Percentage (FMAP) in the Families First Coronavirus Response Act (FFCRA). The House of Representatives passed additional relief, the Health and Economic Recovery Omnibus Emergency Solutions (Heroes) Act (https://www.congress.gov/bill/116th-congress/house-bill/6800), on May 15, which included an additional increase to the FMAP, but the Senate has not acted on relief legislation. With federal unemployment benefits expiring at the end of July, Congress is currently negotiating a new stimulus package, and it is not yet clear what form of financial relief for states will be included in this next round of stimulus legislation.

Given that health care programs make up a significant portion of state budgets, those programs are likely to be in the crosshairs as states meet their constitutional and statutory obligations (https://www.ncsl.org/documents/fiscal/StateBalancedBudgetProvisions2010.pdf) to balance their budgets. This is particularly true for Medicaid, which accounts for 19.7 percent (https://www.nasbo.org/reports-data/state-expenditure-report) of state general fund spending, second only to elementary and secondary education. Moreover, the Medicaid program is countercyclical (https://www.kff.org/coronavirus-covid-19/issue-brief/early-look-at-medicaid-spending-and-enrollment-trends-amid-covid-19/): in economic downturns, spending on the program increases as incomes fall and more people become eligible for the safety net program.



Source: https://www.nasbo.org/reports-data/state-expenditure-report (source:%20https://www.nasbo.org/reports-data/state-expenditure-report)

This expert perspective provides a snapshot of how states are navigating the fiscal challenges of the COVID-19 pandemic in the context of balanced budget requirements, given declining revenues and rising spending demands, with a specific focus on the implications for health programs. The strategies that states employ to address the fiscal fallout of COVID-19, outlined below, will have significant and long-lasting implications for critical health care and safety net programs.

States Address the Immediate Crisis: Closing the Gap in Fiscal Year 2020

Faced with forecasts of significant deficits (https://www.cbpp.org/research/state-budget-and-tax/states-grappling-with-hit-to-tax-collections?link_id=4&can_id=d4a82a2c449baf4b1548db358c8f1d60&source=email-thanks-for-tuning-in-3&email_referrer=email_836888&email_subject=thanks-for-tuning-in) for FY 2020, which for most states ended June 30, 2020, several states took steps to cut expenditures before the end of the fiscal year. Approaches varied among states, depending on the size of the projected deficit, with some imposing hiring freezes while others reduced spending on programs. Implications for health care programs varied, with some states implementing across the board cuts, while other states opted to hold health care harmless.

Addressing Shortfalls By Cutting Spending

Indiana imposed cost saving measures (https://www.in.gov/sba/files/FMC%202020-2%20-%20Cost%20Saving%20Measures.pdf) in April, including hiring freezes (with the exception of COVID-19 related hires), while in **Missouri**, Governor Mike Parson made four rounds of reductions (https://oa.mo.gov/budget-planning/budget-information/2020-budget-information) to spending beginning the first of April, totaling $431 million.

Several states took actions to close FY 2020 budget deficits that had implications for health care programs. In **Ohio**, Governor DeWine announced (https://coronavirus.ohio.gov/wps/portal/gov/covid-19/resources/news-releases-news-you-can-use/state-budget-impact) at the beginning of May that the state was forecasting fiscal year 2020 revenues to be down by $775 million or more and as a result would be making an equivalent reduction in General Fund expenses, including a reduction of $210 million to the state's Medicaid program.

Governor Jared Polis of **Colorado** issued an Executive Order (https://www.colorado.gov/governor/sites/default/files/inline-files/D%202020%20050%20Budget.pdf) specifying spending reductions totaling $228.7 million. Because Colorado is a fee-for-service state, included in the Executive Order was $183 million allocated to the state's Medicaid program that went unspent as a result of low utilization of health care during the pandemic. **Michigan** lawmakers closed (https://www.mlive.com/public-interest/2020/07/more-health-school-spending-in-2020-budget-revised-by-michigan-legislature-wednesday.html?utm_source=National+Conference+of+State+Legislatures&utm_campaign=578e48eaa5-23_JULY_2020_NCSL_TODAY&utm_medium=email&utm_term=0_1716623089-578e48eaa5-377769944) a $2.2 billion budget gap by supplanting state general funds with federal coronavirus aid, freeing up $195 million in general funds that the state had appropriated for its share of Medicaid expenses.

Passing Supplemental or Temporary Budgets

Washington, which experienced the first major outbreak of COVID-19 in the U.S., passed a supplemental budget at the onset of the outbreak. To reduce spending, Governor Jay Inslee used his line item veto (https://www.governor.wa.gov/news-media/inslee-trims-2020-supplemental-operating-budget-address-financial-impact-covid-19) to cut a total of $235 million in funding from the supplemental budget for "less-urgent" increases to programs and services

New Jersey was the only state that elected to extend its fiscal year. Governor Murphy, Senate President Sweeney, and Assembly Speaker Coughlin announced (https://nj.gov/governor/news/news/562020/approved/20200401a.shtml) on April 1 that the state was postponing the end of fiscal year 2020 from June 30 to September 30, and the state enacted a three month budget through September 30.

States Prepare for a Recession

States are confronting significant uncertainty about the state of the economy and the pandemic as they begin FY 2021, which for almost all states began July 1, 2020. Faced with projections (https://www.cbpp.org/research/state-budget-and-tax/states-grappling-with-hit-to-tax-collections) of state budget shortfalls exceeding 20 percent for FY 2021, states are employing a range of strategies to prepare for the uncertainty they face this fiscal year and the likelihood of double-digit deficits. States are by necessity looking to cut spending on health care given that it comprises a significant share of state spending.

Building in Flexibilities

New York, which began the 2021 fiscal year on April 1, passed a budget in late March that enacted a new budget modification process (https://cbcny.org/research/statement-new-york-state-fiscal-year-2021-enacted-budget) to adjust for revenue shortfalls or potential federal assistance. Prior to COVID-19, the state was projecting a budget deficit of $7 billion, which was later revised to $15 billion. The new budget modification requires the Division of the Budget (DOB) to notify the legislature of a one percent revenue shortfall or overspending and provides authority to DOB to make cuts if the legislature does not adopt its own plan for addressing the shortfall within 10 days.

Several states passed short-term spending for FY 2021 to allow for updates to their revenue forecasts, with an eye to incorporating additional federal relief to offset cuts. **Vermont** passed a budget for the first quarter (https://ljfo.vermont.gov/assets/Uploads/1d98831069/Senate_H_961_Q1_Highlight_Doc.pdf) of the 2021 fiscal year, with the intention to develop the full fiscal year budget in August when the state will have refined its revenue projections. **Massachusetts**, **Pennsylvania**, **Rhode Island** and **South Carolina** passed (http://budgetblog.nasbo.org/budgetblogs/blogs/brian-sigritz/2020/06/26/states-work-to-finalize-fiscal-2021-budgets-update) continuing resolutions or temporary budgets for the first several months of FY 2021.

Planning for Significant Reductions

Governor Kate Brown of **Oregon** announced (https://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=36599) on May 11 that she had asked agencies to develop plans for a 17 percent reduction in FY 2021. Anticipating severe reductions in revenue collections, the state of **Washington's** Office of Financial Management directed agencies (https://www.ofm.wa.gov/budget/state-budgets/state-agency-fiscal-year-2021-savings-options?utm_medium=email&utm_source=govdelivery) to identify options to reduce fiscal year 2021 spending by 15 percent.

In some states, the pandemic has only accelerated budget shortfalls. Before the pandemic, **Wyoming** was grappling with a projected deficit as its key revenue source of mineral development had declined. As one of the states projecting a very significant decline in revenues (a nearly one billion dollar shortfall for the general fund), the Governor announced deep budget cuts (https://governor.wyo.gov/media/news-releases/2020-news-releases/budget-cuts-approved-by-governor-gordon-total-more-than-250-million) for the current two-year budget cycle, including a nine percent cut to total spending for the state's Department of Health. The budget cuts also require state employee layoffs and human resources personnel consolidation across agencies.

Drawing from Rainy Day Funds

Pulling from discretionary funds or drawing dollars from rainy day funds are additional strategies states are employing to address significant budget shortfalls. For instance, **Colorado** shored up their budget by redirecting funds (https://khn.org/news/colorado-like-other-states-trims-health-programs-amid-health-crisis/?utm_campaign=KHN%3A%20Topic-based&utm_medium=email&_hsmi=91520585&_hsenc=p2ANqtz-9SRfb3rrDU2OAhNGSEXv-gUF2ICLSbIxvQw_vaa1eT-Q9ZoAtxgcmpvVeib6i4nz2IxpTlVk6aEOTbTnweLK0MzT5sew&utm_content=91520585&utm_source=hs_email) from marijuana taxes and tobacco settlement funds.

Furloughing Staff

Several states have also instituted employee furloughs. The governor of **Washington** directed agencies (https://www.governor.wa.gov/sites/default/files/directive/20-08%20Furloughs%20and%20General%20Wage%20Increases%20%28tmp%29.pdf) to implement furloughs, while the governor of **New Jersey** signed legislation (https://nj.gov/governor/news/news/562020/approved/20200702d.shtml) that will facilitate the furloughing of public workers in lieu of layoffs. Additionally, **Nevada** has implementedfurloughs (https://carsonnow.org/story/07/19/2020/nevada-lawmakers-finish-special-session-pass-major-budget-cuts-education-state-serv)

hiring freezes to help address the state's revenue shortfall. The Governor of **Wyoming** also implemented (https://governor.wyo.gov/media/news-releases/2020-news-releases/budget-cuts-approved-by-governor-gordon-total-more-than-250-million) mandatory furlough days for executive branch employees on the higher end of the pay scale.

States Grapple with Cuts to Health Care

As states look to reduce expenditures, and in the absence of additional federal support, they may find they have little choice but to make cuts to the Medicaid program, given that it comprises a significant portion (https://www.nasbo.org/reports-data/state-expenditure-report) of state budgets.

Looking to Health Care for Savings

Because of the maintenance of effort (MOE) requirement in FFCRA (https://www.shvs.org/covid-19-cms-issues-guidance-for-states-about-new-increased-medicaid-and-chip-matching-rate/#_ftn4), states cannot make changes to eligibility and premiums for Medicaid beneficiaries and instead may turn to cutting provider rates as a cost-saving mechanism. The Governor of **Florida**, for example, vetoed provider rate increases (https://www.flgov.com/wp-content/uploads/2020/06/2020-Veto-List.pdf) for those who care for people with disabilities, while **Colorado** enacted (https://www.colorado.gov/pacific/sites/default/files/FY%202020-21%20Long%20Bill%20Overview.pdf) a reduction in rates paid to providers who care for a subset of the state's elderly. While reducing reimbursement rates for Medicaid providers could result in state savings, it may also exacerbate health inequities by shrinking the pool of providers who accept Medicaid and curtailing access to the critical safety net program.

Another opportunity for savings is increasing co-pays for Medicaid beneficiaries: **Colorado** approved (https://www.colorado.gov/pacific/sites/default/files/FY%202020-21%20Long%20Bill%20Overview.pdf) an increase in member co-pays to the federal maximum permitted, which yields savings of $2.14 million to the General Fund in FY 2021 and FY 2022.

States may also look to include changes to managed care capitation rates or finding other savings within their managed care contracts, such as recouping funds under Medical Loss Ratio (MLR) standards (https://www.cbpp.org/research/health/options-to-reduce-state-medicaid-costs-managed-care-medical-loss-ratio). **Hawaii**, which faces an estimated (https://www.cbpp.org/research/state-budget-and-tax/states-grappling-with-hit-to-tax-collections?link_id=4&can_id=d4a82a2c449baf4b1548db358c8f1d60&source=email-thanks-for-tuning-in-3&email_referrer=email_836888&email_subject=thanks-for-tuning-in) 24 percent decline in revenues for FY 2021, announced (https://medquest.hawaii.gov/en/about/recent-news/2020/QI_Contract_Rescind.html) that it was rescinding newly-awarded contracts to managed care organizations in light of the public health crisis and an increase in enrollment. As more states are required to impose reductions, other states may defer re-procurements.

Reversing Proposed Coverage Expansions

Aligning with the budget recommendation (https://www.tn.gov/content/dam/tn/finance/budget/documents/overviewspresentations/FY21JuneAdjusmentSchedule060420.pdf) of **Tennessee** Governor Bill Lee, state lawmakers passed a revised spending plan for FY 2021 in late June eliminating the full $6.6 million in funding (https://wpln.org/post/after-stalemate-between-house-and-senate-the-tennessee-general-assembly-settles-on-deep-spending-cuts/) for a pilot program that would have expanded postpartum Medicaid coverage (https://www.tn.gov/governor/news/2020/2/3/gov--bill-lee-delivers-2020-state-of-the-state-address.html) for low-income mothers from two months to a full year after giving birth.

Citing budget concerns, the Governor of **Oklahoma** pulled plans (https://www.usnews.com/news/best-states/oklahoma/articles/2020-05-21/oklahoma-governor-vetoes-bill-to-fund-his-medicaid-plan?src=usn_tw) to expand Medicaid to hundreds of thousands of low-income residents, vetoing a bill that would have funded the state's share of the expansion. Despite these developments, Oklahomans later voted through a ballot measure (https://www.ok.gov/elections/Election_Info/State_Question_info.html) on June 30 to expand Medicaid without block grants or work requirements.

Cuts to Behavioral Health

A number of states have also been forced to slash funding (https://www.statnews.com/2020/07/16/opioid-overdoses-have-skyrocketed-amid-the-coronavirus-but-states-are-nevertheless-slashing-addiction-treatment-program-budgets/) for behavioral health services. **Colorado** has cut (https://coloradosun.com/2020/06/22/opioid-crisis-after-coronavirus/) $26 million in funds allocated for behavioral health for FY 2021, while **Florida** (https://www.flgov.com/wp-content/uploads/2020/06/2020-Veto-List.pdf), **Georgia** (https://opb.georgia.gov/budget-information/budget-documents/appropriations-bills), and **Utah** (https://le.utah.gov/~2020S5/bills/sbillenr/SB5001.pdf) have cut funding for substance use disorder programs.

Behavioral and mental health advocates have expressed concern (https://khn.org/news/colorado-like-other-states-trims-health-programs-amid-health-crisis/?utm_campaign=KHN%3A%20Topic-based&utm_medium=email&_hsmi=91520585&_hsenc=p2ANqtz-9SRfb3rrDU2OAhNGSEXv-gUF2ICLSbIxvQw_vaa1eT-Q9ZoAtxgcmpvVeib6i4nz2IxpTlVk6aEOTbTnweLK0MzT5sew&utm_content=91520585&utm_source=hs_email) that these cuts may have long-term repercussions, particularly as the pandemic has only increased the need for behavioral health services.

Working to Shield Health Care Programs From Cuts

Following the conclusion of a special session of the legislature, Governor Steve Sisolak of **Nevada** signed the FY 2021 budget which restored (http://gov.nv.gov/News/Press/2020/Governor_Sisolak_releases_statement_on_conclusion_of_31st_Special_Session/) funding to the Department of Health and Human Services which was facing a cut of $233 million. Among the funding restored was $49 million for the Medicaid program and $7.4 million for mental health services. Nonetheless, the DHHS budget was subject to the largest cut, a reduction of nearly $173 million.

Texas Governor Gregg Abbott directed state agencies and higher education institutions to reduce spending by five percent. While the directive excluded (https://gov.texas.gov/news/post/governor-abbott-lt-governor-patrick-speaker-bonnen-direct-state-agencies-to-reduce-budgets-by-five-percent) CHIP and Medicaid eligibility and benefits from such spending reductions, proposed cuts from the Texas Health and Human Services Commission do include spending reductions (https://hhs.texas.gov/sites/default/files/documents/about-hhs/budget-planning/20-21-biennium-budget-reduction-plan.pdf) for women's health, child abuse protection, and services for adults and children with disabilities.

In May, Governor Gavin Newsom of **California** introduced a revised budget (http://www.ebudget.ca.gov/FullBudgetSummary.pdf) with proposed cuts to education and health care to address the economic downturn resulting from COVID-19; however, in late June, the Governor and California legislative leaders agreed to a budget that avoided the most severe cuts (https://www.gov.ca.gov/2020/06/22/governor-newsom-senate-president-pro-tempore-atkins-and-assembly-speaker-rendon-issue-statement-on-budget-agreement/) to health coverage and benefits. The budget did, however, eliminate funding (https://www.latimes.com/california/story/2020-06-26/california-will-use-surplus-cash-delay-school-funds-in-budget-sent-to-newsom) for an expansion of Medicaid to undocumented Californians aged 65 and older.

Even in light of budget challenges, some states are working to preserve funding for health care services. **Virginia** identified emergency support (http://www.dmas.virginia.gov/files/links/5402/Virginia%20Medicaid%20Announces%20Emergency%20Support%20for%20Providers.pdf?utm_source=Weekly+Updates&utm_campaign=c734a4fc75-EMAIL_CAMPAIGN_2020_7_6&utm_medium=email&utm_term=0_e0e125bf79-c734a4fc75-366862633) for providers, redirecting dollars in the FY2020 budget to fund a 29 percent rate increase to primary care doctors, pediatricians, and other providers of general health services to Medicaid members through June 30, 2020.

States Look to the Future: Urging Federal Support and Convening Special Sessions

Faced with potential budget shortfalls totaling $290 billion (https://www.cbpp.org/research/state-budget-and-tax/states-continue-to-face-large-shortfalls-due-to-covid-19-effects) in FY 2021, states are calling for additional aid from the federal government and taking action to address looming deficits by convening special legislative sessions.

Urging Federal Action

While the federal government intervened to provide fiscal relief (https://www.shvs.org/covid-19-cms-issues-guidance-for-states-about-new-increased-medicaid-and-chip-matching-rate/) in the form of a temporary 6.2 percentage point increase in the FMAP in FFCRA, states have requested an additional increase (https://medicaiddirectors.org/wp-content/uploads/2020/04/NAMD-Medicaid-Requests-for-COVID-19-Legislation.pdf) to support the surge in enrollment in the Medicaid program. As mentioned above, while the Heroes Act includes an additional increase in the FMAP, it is not yet clear from the debate in Congress whether an increase will be included in the next stimulus bill.

Governor J.B. Pritzker of **Illinois,** in the press release (https://www2.illinois.gov/dceo/Media/PressReleases/Pages/PR20200610-1.aspx) announcing he had signed the FY 2021 budget passed by the legislature,underscored that he and other governors were urging Congress to pass additional fiscal relief for state and local governments. Illinois is projecting (http://cgfa.ilga.gov/Upload/2020-MAY%20Updated%20FY%202021%20Revenue%20Estimate%20and%20Revised%20FY%202020%20Revenue%20Up....pdf) a deficit in FY 2021 of $4.23 billion. While the FY 2021 budget passed on June 10 includes reductions totaling $340 million, it also authorizes the state to borrow from the Federal Reserve's new Municipal Liquidity Facility (https://www.federalreserve.gov/monetarypolicy/muni.htm) with possibly a plan to repay (https://www.pewtrusts.org/en/research-and-analysis/articles/2020/06/09/states-contemplate-borrowing-to-help-manage-pandemics-fiscal-impact) the borrowed funds with future federal aid.

Governor Kate Brown of **Oregon** in her press release (https://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=36599) announcing the state's FY 2021 budget stated that whether the state would need to follow through on a 17 percent reduction would depend on whether the federal government provides additional aid to states. She emphasized in the press release that she will continue to work with Oregon's congressional delegation to advocate for additional federal funds.

Calling Special Legislative Sessions

States have convened special legislative sessions to appropriate funding for COVID-19 relief and address revenue shortfalls. In 2019, 16 states with biennial budget cycles passed budgets for FY 2021 (https://www.ncsl.org/research/fiscal-policy/fy-2021-state-budget-status.aspx), and those states, if they have not already announced plans to re-examine their budgets, will likely face the need to reconvene their legislature to address projected deficits.

For example, **Oregon**, which operates on a biennial budget, passed a two-year budget in 2019. After highlighting in early May that the state was facing far lower than projected revenues and would likely need to implement budget cuts, Governor Kate Brown announced (https://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=36789) on June 16 that she would call a special session of the legislature to reconvene (https://www.statesmanjournal.com/story/news/politics/2020/07/27/covid-19-oregonians-respond-proposed-state-budget-cuts-legislature-special-session-nears-salem/5509247002/) within the first two weeks of August. Governor Ralph Northam of **Virginia** also called for the state legislature to reconvene for a special session (https://www.washingtonpost.com/local/virginia-politics/northam-calls-legislature-back-to-address-budget-upended-by-coronavirus-racial-injustice-issues/2020/07/17/fe832312-c834-11ea-8ffe-372be8d82298_story.html)on August 18 to address the state budget.

The **New Mexico** Legislature convened a special session (https://www.governor.state.nm.us/2020/06/17/governor-includes-business-and-tax-relief-public-safety-reform-election-changes-other-items-for-special-session/) to revise the state's budget in light of an estimated $2 billion budget gap resulting from a decline in state revenues. New Mexico Governor Michelle Lujan Grisham authorized an amended state budge (https://www.governor.state.nm.us/2020/06/30/gov-signs-budget-adjustment-bill/)t on June 30, restoring funding for certain priorities by vetoing more than $30 million in cuts. On June 18, the Governor of **Utah** called the state legislature into a fifth special session (https://governor.utah.gov/2020/06/16/governor-calls-special-session/), later signing legislation (https://governor.utah.gov/2020/06/25/governor-signs-11-bills/) that balanced the state budget and spared education and social services from the most severe (https://www.sltrib.com/news/politics/2020/06/18/house-speaker-predicts/) cuts.

Looking Ahead

States are only beginning to grapple with the budgetary impacts of COVID-19 and the ensuing recession, which could continue even after the public health crisis abates. Absent additional federal relief, states will have difficult choices to make as they seek to balance their budgets in the face of rising spending demands and falling tax revenues. This will mean unprecedented pressures on health programs, especially Medicaid, at the very time these programs are needed more than ever.

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July 30, 2020

Emergency Special Enrollment Period Would Boost Health Coverage Access at a Critical Time

By Sarah Lueck and Matt Broaddus

Twenty-seven percent more people used special enrollment periods (SEPs) to sign up for plans in the federal marketplace in early 2020 compared to the same period in 2019.[1] While this is significant, far more people with health and financial worries during the COVID-19 pandemic likely would enroll in federal marketplace plans if given the chance.

With typical SEPs mainly available to those losing other health coverage, many people losing their jobs or much of their income in this crisis won't qualify this year for marketplace coverage unless the Trump Administration provides an emergency SEP. Many people who are otherwise eligible for significant financial assistance in the federal marketplace (HealthCare.gov) will not be able to access it because they cannot enroll in a marketplace plan. Congress should direct the Administration to make marketplace coverage broadly available by creating an emergency SEP, especially given widespread support for the idea from patient groups, health care providers, state officials, employers, and the health insurance industry.

Many states that established emergency SEPs in their own state-run marketplaces have seen SEP growth far surpassing that of HealthCare.gov, even though smaller shares of the people losing their jobs in these states qualify for financial assistance to help pay for coverage. (Instead, more qualify for Medicaid or other health programs.) SEP growth in these state-run marketplaces is a sign that an emergency SEP could help expand enrollment in HealthCare.gov states as well.

Many Ineligible for Marketplace Coverage Without an Emergency SEP

SEPs allow people to sign up for marketplace plans outside the yearly open enrollment period that occurs each fall. The last open enrollment, for 2020 plans, had already ended when the pandemic and job losses hit the United States.

Typically, SEPs are only available to people who experience certain life events, such as losing other coverage, having a baby, or moving to a new geographic area. The COVID-19 crisis has

[1] "Special Trends Report: Enrollment Data and Coverage Options for Consumers During COVID-19 Public Health Emergency," Centers for Medicare & Medicaid Services, June 2020, https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SEP-Report-June-2020.pdf.

harmed some people who, under current federal rules, are not eligible for a marketplace SEP — even if their income drops and they newly meet income criteria for premium tax credits and cost-sharing reductions available with marketplace plans. People who lose their jobs or experience a sharp drop in income but were already uninsured will not qualify to enroll through HealthCare.gov. (An SEP is already available in all states to people who lose health coverage through a job, but not to people who lost a job but not health coverage.) Among people who have lost their jobs in this economic crisis, most did not previously have coverage through their job, a Commonwealth Fund survey found.[2]

And even for people who qualify for an SEP, following through to enrollment can be challenging. First, they must know where and how to apply for coverage, but many people are not familiar with the marketplaces or the situations that trigger an SEP. Second, they usually have a 60-day deadline, so they lose their opportunity if they delay enrolling in the months after they lose their job-based health coverage. Third, to apply, people must supply all the usual information needed for an eligibility determination as well as details related to SEPs, such as when they lost other coverage. Often, they must supply documents (such as a letter from a former employer or health insurer) to verify that they are eligible for an SEP, creating an additional barrier. Earlier this year, in response to the COVID-19 emergency, HealthCare.gov was allowing people to attest to their eligibility rather than requiring paper documents to prove SEP eligibility, but it has now reportedly resumed requiring documentation from many people applying for SEPs.[3]

State Experiences Suggest Emergency SEPs Can Improve Access

Most states that fully run their own health insurance marketplaces (rather than relying on HealthCare.gov) quickly implemented time-limited emergency SEPs in response to the public health crisis. (This includes 11 states and Washington, D.C. — all state-based marketplaces except Idaho.)

Figure 1 compares SEP enrollments in 2020 (from the end of open enrollment through May) to 2019 SEP enrollments during similar periods, in most states that operate their own marketplaces and across states that use HealthCare.gov. Six of the states (including D.C.) that operate their own marketplaces and created emergency SEPs saw enrollment surge far beyond the federal marketplace's 27 percent increase. (For two of states that run their own marketplaces, data are unavailable.) In Connecticut, SEP enrollments increased 97 percent in the first five months of 2020 compared to 2019. In Rhode Island they increased 92 percent, and in California 79 percent. (See Figure 1 and Appendix 1.)

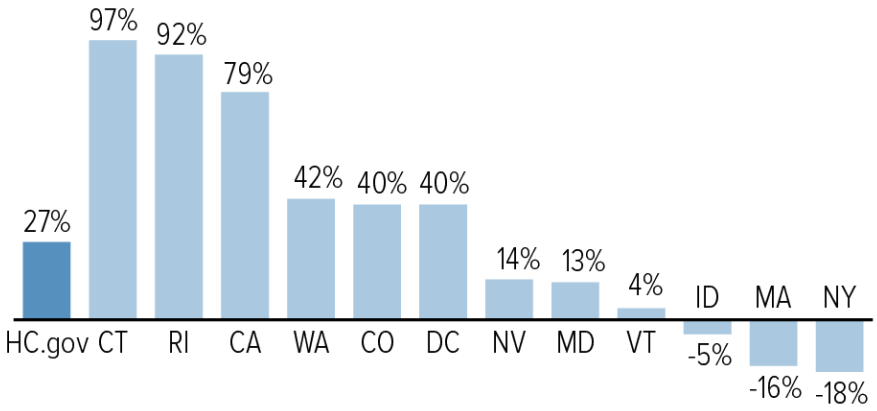
[2] Sara R. Collins *et al.*, "An Early Look at the Potential Implications of the COVID-19 Pandemic for Health Insurance Coverage," Commonwealth Fund, June 23, 2020. https://www.commonwealthfund.org/publications/issue-briefs/2020/jun/implications-covid-19-pandemic-health-insurance-survey.

[3] "Want a SEP? You'll have to schlep…CMS ends application streamlining on HealthCare.gov," xpostfactoid blog, July 24, 2020, https://xpostfactoid.blogspot.com/2020/07/want-sep-youll-have-to-schleppcms-ends.html.

FIGURE 1

Special Enrollments Surged in Several State-Based Marketplaces

Percent change in SEP use, from end of open enrollment through May, 2020 vs. 2019



Note: Special enrollment periods (SEPs) let people who experience certain life events such as losing other coverage enroll in a marketplace plan. HC.gov reflects an aggregate estimate for all 38 states operating their marketplace through HealthCare.gov in 2020. All state-based marketplaces except Idaho's created an emergency SEP to let more people qualify amid COVID-19.

Source: CBPP research, Kaiser Family Foundation analysis, and Centers for Medicare & Medicaid Services' data.

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These increases are especially striking because, all else equal, these states would have been expected to see much *smaller* increases in SEP enrollments than the HealthCare.gov states. Unemployment rates were similar on average across these states and the HealthCare.gov states. Meanwhile, a smaller fraction of uninsured people and/or newly unemployed people in these higher-enrollment states are eligible for marketplace coverage.

That's primarily because all of these states adopted the Affordable Care Act's expansion of Medicaid to low-income adults. In Medicaid expansion states, most people with incomes between 100 to 138 percent of the poverty line are eligible for Medicaid, whereas they are eligible for marketplace coverage and financial assistance in non-expansion states. Across all HealthCare.gov states, including the 15 states that have not implemented the Medicaid expansion, about 37 percent of the people losing their jobs are eligible for marketplace coverage with premium tax credits, the Kaiser Family Foundation estimates. By comparison, about 19 percent of the people losing jobs in all states that run their own marketplaces are eligible for premium tax credits. (See Figure 2.) People can enroll in Medicaid at any time during the year and do not need an SEP.[4] Many state-based

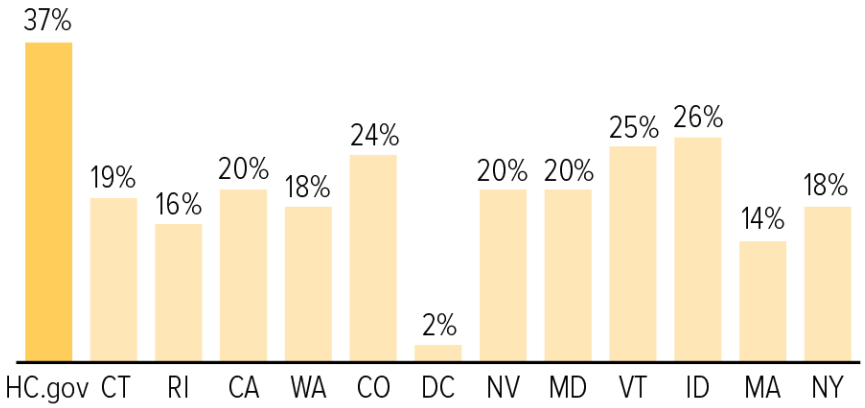
[4] Beyond Medicaid expansion, some states that run their own marketplaces also have broader eligibility in Medicaid or other health programs that reduce the population eligible for marketplace subsidies and in need of SEPs. New York and Minnesota implemented the Basic Health Program, an option under the Affordable Care Act that allows states to provide more affordable coverage to people between 138 percent and 200 percent of the federal poverty level, who would otherwise be eligible for marketplace subsidies. Like Medicaid, Basic Health doesn't require an SEP.

marketplace officials report that, as a result of the economic crisis, many of the people who are seeking health coverage have incomes low enough to qualify for Medicaid, rather than marketplace financial assistance.

FIGURE 2

Adults Who Lost Jobs in HealthCare.gov States Are Likelier to Need an SEP to Access Coverage

Share of adults who lost jobs and are eligible for marketplace premium tax credits vs. Medicaid or other programs that don't require an SEP



Note: Special enrollment periods (SEPs) let people who experience certain life events such as losing other coverage enroll in a marketplace plan. HC.gov reflects an aggregate estimate for all 38 states operating their marketplace through HealthCare.gov in 2020. All state-based marketplaces except Idaho's created an emergency SEP to let more people qualify amid COVID-19.

Source: Kaiser Family Foundation estimates of coverage eligibility among people losing jobs between March 1, 2020 and May 2, 2020 and their family members.

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Of course, not all states that created emergency SEPs saw enrollment gains. And many factors influence SEP enrollment levels from year to year.

In Massachusetts and New York, which reported reductions in SEP enrollment compared to last year, fewer transitions into the marketplaces from Medicaid are one likely reason. Federal COVID-19 legislation currently prevents anyone from losing Medicaid eligibility, minimizing this category of SEP enrollments into marketplaces while also helping protect people from becoming uninsured.[5] While this dynamic exists in every state, states with Medicaid expansion and highly integrated eligibility systems, such as Massachusetts and New York, should see the biggest impact on their SEP totals. Normally, when people in these states lose Medicaid and become eligible for a marketplace plan, they are granted an SEP and transition promptly into the new coverage. Exchange officials in Massachusetts and New York said this type of SEP, normally a significant portion of SEP enrollment, is down compared to past years as people are remaining enrolled in Medicaid instead.

[5] 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.

(In Massachusetts, people transitioning from Medicaid normally account for about a third of monthly SEP enrollments.)

Meanwhile Idaho — the only state with its own marketplace that did not create an emergency COVID-19 SEP — saw SEP enrollments drop, a major reason for which is that the state implemented Medicaid expansion beginning January 1, 2020. That significantly reduced the number of people eligible for marketplace coverage compared to the previous year.

And in states where SEP enrollments did rise substantially, the emergency SEP was not the only factor. For example, California's new health insurance mandate and supplemental state subsidies likely boosted its SEP enrollments. Such enrollments were higher in 2020 than in 2019 even before the start of the pandemic, but the increase was much greater after the state created its COVID-19 SEP. California also conducted significant outreach to inform the public about the emergency SEP, as did Nevada and several other states.[6]

Nonetheless, the data from state-based marketplaces reinforce a commonsense conclusion: giving people more opportunities to enroll in coverage and making it easier for them to do so leads to more people getting health insurance.

COVID-19 Legislation Should Include an Emergency SEP

The House included a new marketplace SEP, which would last for eight weeks, as part of the Heroes Act, the COVID-19 relief package it passed in May. Legislation is needed because the Trump Administration rejected using its administrative authority to set up a new SEP in federal marketplace states, despite broad support for the idea. In the next COVID-19 relief package, Congress should ensure that more people enroll in comprehensive health coverage this year by establishing a new SEP for people living in federal marketplace states.

[6] Rachel Schwab, Justin Giovannelli, and Kevin Lucia, "During the COVID-19 Crisis, State Health Insurance Marketplaces are Working to Enroll the Uninsured," Commonwealth Fund blog, May 19, 2020, https://www.commonwealthfund.org/blog/2020/during-covid-19-crisis-state-health-insurance-marketplaces-are-working-enroll-uninsured.

Appendix

The federal government, as part of a data release on special enrollments, reported that from the end of the open enrollment period through May, SEP sign-ups increased 27 percent in the 38 states that use HealthCare.gov. To compare this to SEP sign-ups in state-based marketplaces, we obtained similar data from ten states and D.C. through publicly available reports and/or by contacting the state-based marketplaces. There are, however, differences in how states collect and report the data that could affect the accuracy of the comparisons. Below are notes on the data and sources:

- Time periods differ for SEP data from different states. For HealthCare.gov states and some state-run marketplaces where open enrollment ended in December, SEP data begin in December or January. Other states with their own exchanges had longer open enrollment periods, so their SEP growth was calculated for a shorter period of time, beginning after the open enrollment period ended.
- States differ in how they report their enrollment data, with some reporting plan selections and others reporting effectuated enrollments.
- California's publicly available data run through May 16, rather than through the end of that month.[7]
- Colorado's data were obtained from the state exchange and run from mid-January through May.
- Connecticut's data were obtained from the state exchange and run from mid-December through May.
- Washington, D.C.'s data were obtained from the state exchange and run from mid-February through May.
- Idaho's data were obtained from the state exchange and run from January through May.
- Maryland's data were obtained from the state exchange and publicly available reports and run from January through May.[8]
- Massachusetts' publicly available data cover the period from February through May.[9]
- Minnesota's exchange reported 20,500 plan signups from January through May 2020 but comparable data for 2019 were not available as of publication.
- Nevada's publicly available data cover the period from mid-December through May.[10]
- New York's data were obtained from the state exchange and run from February through May.

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[7] See "Executive Director's Report," May 21, 2020. https://board.coveredca.com/meetings/2020/May%202020%20Meeting/PPT.ED%20Report.May%202020_5-21_12.30_NEW%20PHONE%20NUMBER.pdf.

[8] "Maryland Health Connection Data Report," May 31, 2020. https://www.marylandhbe.com/wp-content/uploads/2020/06/Executive-Report_05312020.pdf.

[9] "Health Connector Summary Reports" for 2019 and 2020 are available in meeting records at https://www.mahealthconnector.org/about/board-meetings.

[10] For 2019 data, when Nevada used HealthCare.gov, see the federal "Special Trends Report," *op cit*. Data for 2020 were published by the Silver State Health Insurance Exchange, June 8, 2020, https://d1q4hslcl8rmbx.cloudfront.net/assets/uploads/2020/06/SEP_Report_V6.pdf.

- Rhode Island's data were obtained from the state exchange and run from February through May.
- Vermont's data were obtained from the state exchange, run from February through May, and represent households rather than individuals.
- Washington State's data were obtained from exchange staff and publicly available reports and run from January through May.[11]

TABLE 1

Change in Special Enrollments, 2019 to 2020

State	2019 SEP enrollment	2020 SEP enrollment	% change, SEP enrollment
California	107,170	191,380	79%
Colorado	28,161	39,332	40%
Connecticut	3,491	6,868	97%
D.C.	2,015	2,828	40%
Idaho	8,907	8,458	-5%
Maryland	39,012	44,007	13%
Massachusetts	70,737	59,264	-16%
Nevada	6,600	7,556	14%
New York	40,000	33,000	-18%
Rhode Island	2,466	4,725	92%
Vermont	1,679	1,749	4%
Washington State	29,052	41,242	42%
Federal marketplace states	704,106	892,141	27%

Source: CBPP research and Centers for Medicare and Medicaid Services' data.

[11] "Supplemental Report: Uninsured Special Enrollment Period," Washington Health Benefit Exchange, June 2020, https://www.wahbexchange.org/wp-content/uploads/2020/06/Supplemental-report_uninsured-FINAL.pdf.

Peterson-KFF
Health System Tracker

COVID-19 repercussions may outweigh recent gains in U.S. health system performance

By Rabah Kamal, Cynthia Cox, Daniel McDermott, and Nisha Kurani *KFF*

Briefs | **Quality of Care**

Posted: July 23, 2020

To monitor the performance of the U.S. health system, our Health System Dashboard includes more than 50 indicators across four domains: health spending, quality of care, access & affordability, and health & wellbeing. The dashboard examines trends in the U.S. health system, compares the U.S. to a group of other similarly large and wealthy countries (identified based on median GDP and median GDP per capita), and highlights differences across demographic characteristics. In this brief, we look at the bigger picture of what these data convey about how well the health system is performing, and how the coronavirus pandemic may affect key indicators.

Broadly speaking, health outcomes and quality of care in the U.S. have improved in many areas, although often more slowly than comparable countries and with some recent worsening. In recent years, indicators of longevity and disease burden have worsened in the U.S., partly driven by the opioid crisis. While many comparable countries saw slight declines in life expectancy in 2015, those countries have since rebounded. The U.S. life expectancy rate, however, has plateaued and dropped since 2014. With respect to spending, the rate of health spending growth in the U.S. has recently slowed and is now similar to comparable countries, although the U.S. continues to spend much more on healthcare, both as a percent of GDP and per person. Healthcare access and affordability has continued to improve on gains made under the Affordable Care Act.

Importantly, the coronavirus pandemic and corresponding economic crisis threatens to exacerbate recent declines. While the exact impact is not yet known, effects from the crises may worsen health outcomes and disparities, increase the uninsured rate in the U.S., and lower life expectancy.

Based on data available through 2018 or earlier years, the following findings highlight recent trends across 10 key indicators of health system performance and outline potential effects of the pandemic and economic downturn. Visit the Health System Dashboard for more in-depth exploration of these and other telling analyses.

HEALTH & WELLBEING

1. Life expectancy at birth generally improved over the past several decades in the U.S., rising by 4.9 years since 1980. However, life expectancy has declined slightly in recent years, driven by increased mortality rates for certain causes, including drug overdoses and suicides. Furthermore, comparable countries have an average life expectancy of 82.3 years - nearly four years longer than the U.S. life expectancy of 78.6 years - and the gap is growing. The COVID-19 pandemic is ongoing, and although its full impact will take time to assess, the death toll could reduce average life expectancy in the U.S. and other countries. Additionally, the pandemic has exacerbated inequalities underlying long-standing health disparities, and it has thus disproportionately affected Black, American Indian and Alaska Native, and Hispanic communities. Any impact it has on life expectancy may be more pronounced among these groups.

2. Disease burden, a measure that accounts for both longevity and quality of life, has improved over the past quarter century, dropping 12% between 1990 and 2017, with particular improvement for circulatory diseases. However, in the past few years the disease burden rate has worsened in the U.S. (driven by substance use disorders and an uptick in injuries) while continuing to improve in similar countries. As of 2017, disease burden was higher in the U.S. than in any other comparable country. Importantly, the U.S. has relatively high rates of disease burden attributable to some of the health conditions that put people at high risk of serious illness from COVID-19: cardiovascular diseases, chronic respiratory diseases, and diabetes. Though data are not yet available, the pandemic is likely to increase disease burden in all countries as more people contract the virus.

QUALITY OF CARE

3. Despite some progress, the U.S. continues to lag behind comparable countries in preventing deaths that in many cases could have been averted by timely and effective healthcare. The Healthcare Quality and Access (HAQ) Index reflects the rate of deaths amenable to healthcare with a score from zero (lower quality) to 100 (higher quality). The U.S. has an HAQ Index rating of 88.7, ranking the lowest among comparable countries (average a score of 93.7). Although the U.S. has made progress in reducing deaths amenable to healthcare, this improvement has not kept pace with similar countries. The COVID-19 pandemic has overburdened hospitals in certain parts of the U.S. and several other countries, which will make it more difficult for some patients to access timely care and, as a result, potentially worsen the rate of deaths amenable to healthcare.

4. Compared to the average of comparable countries, potentially preventable hospital admissions rates are higher in the U.S. for several diseases that could possibly be prevented or treated in a non-emergency setting, including for congestive heart failure (88% higher), asthma (8% higher), and diabetes (53% higher). Hypertension is an exception, as U.S. admission rates are 12% lower than the comparable country average. While the U.S. rate of potentially preventable hospital admissions has improved over the time (decreasing 32% from 2000 to 2015), hospitalizations from COVID-19 may outweigh these gains. Additionally, the pandemic may limit access and use of preventive care that helps reduce hospital admissions.

5. The occurrence of hospital-acquired conditions (e.g., surgical infections or medication errors) has improved, declining 13% from 2014 to 2017. It is not clear if the pandemic will impact the rate of hospital-acquired conditions. However, the new coronavirus currently poses an infection risk for both hospital patients and staff, particularly if there is limited availability of personal protective equipment.

ACCESS & AFFORDABILITY

6. Due to gains in health coverage as a result of the Affordable Care Act, the uninsured rate among the nonelderly dropped from 18% in 2010 to 11% in 2018. Even with about 90% of the total U.S. population now insured and with coverage trending upward prior to the pandemic, the U.S. coverage rate is lowest among comparable countries, most of which have universal coverage. Further, the U.S. uninsured rate may rise as people lose employer-based coverage because of the pandemic and associated economic downturn.

7. Fewer adults are reporting problems paying medical bills. From 2011 to 2018, the share of people reporting difficulty paying medical bills dropped by more than a quarter. However, medical bills remain a top concern for many Americans, and this could worsen with the pandemic. Recent legislation made COVID-19 testing free at the point of service, and many insurers initially waived cost sharing for COVID-19 treatment, making it an option for self-insured employers (who cover most people with employer-based coverage) to offer the benefit. However, some of these insurers stopped waiving cost sharing for COVID-19 treatment in June. Additionally, the Department of Health and Human Services indicated it intends to cover uncompensated COVID-19 care for uninsured patients through the Coronavirus Aid, Relief, and Economic Security (CARES) Act Provider Relief Fund. Nonetheless, individuals – specifically those who are uninsured – may still face unaffordable medical bills

for any treatment they receive. KFF analysis has found that the total cost of an inpatient admission for severe COVID-19 could be over $88,000 in the large employer market, and that out-of-pocket costs for these enrollees could exceed $1,300.

8. While the share of adults delaying or foregoing needed care due to costs dropped 4 percentage points from 2009 to 2017, there was a small increase from 2017 to 2018. COVID-19 may portend additional increases if there are widespread barriers to accessing testing and treatment for COVID-19. Additionally, greater job or income loss will create more strained financial resources for many individuals and families.

HEALTH SPENDING

9. Health spending per person has grown steeply from $355 per capita in 1970 to $11,172 in 2018. On average, other wealthy countries spend less than half as much per person. This spending differential is primarily because of higher prices for healthcare in the U.S., as utilization is similar – and in some cases lower – in the U.S. For the last decade though, per capita spending in the U.S. has grown at an average rate of 3.6% per year, which is similar to that of comparable countries. It is unclear how the COVID-19 pandemic will affect health spending overall. While the costs of care related to the pandemic will be high, the pandemic has also resulted in widespread cancellation or postponement of regularly scheduled treatments, such as elective procedures, preventive care, and other non-urgent care. These delays and cancellations have a downward effect on total health spending that may offset at least some of the high cost of treating patients with COVID-19.

10. Health spending has historically grown faster than the economy, but the difference has moderated in recent years. U.S. health consumption expenditures accounted for 17.7% of GDP in 2018 – much more than comparable countries, where health spending averages 10.4% of GDP. Both GDP and health spending will likely change because of the pandemic. People also tend to use less healthcare during times of economic downturn, resulting in slower health spending growth.

DISPARITIES IN HEALTH SYSTEM PERFORMANCE

Although there is general improvement across many indicators, there are often disparities across racial or ethnic groups, genders, age, health status, and income levels. In 2017, while life expectancy among White people in the U.S. was similar to the national average of 78.6 years, life expectancy was 3.7 years shorter than average among Black people and 3.2 years longer among Hispanic people. In 2018, 15.4% of all non-elderly adults reported difficulty paying medical bills, with a substantial gap between lower- and higher-income adults: 23.3% of those who earn below 200% of the Federal Poverty Level reported difficulty paying medical bills, compared to 11.6% of those earning 200% FPL and above. Where possible, dashboard data are broken out across demographic groups to highlight these disparities. These and other health disparities may very well worsen due to the pandemic. COVID-19 and the economic downturn has disproportionately impacted Black, American Indian and Alaska Native, Hispanic, and low-income people in the U.S.

Some cross-national differences in health outcomes and costs may be due to a variety of social, economic, and environmental factors that influence health and are not solely or directly influenced by the health system. The dashboard, therefore, also includes indicators relating to health determinants to offer context, and a separate chart collection and brief explore social determinants of health in the U.S. and comparable countries in more detail.

The dashboard is a starting point for exploring unfolding trends, and it is important to keep in mind that not all indicators will change at the same pace, particularly with so many unknowns surrounding the current pandemic and economic crisis. Visit the Health System Dashboard for a more in-depth exploration of these other telling trends.

Methods

Where possible, we compare the U.S. to other similarly large and wealthy countries as measured by median GDP and median GDP per capita. These countries are: Australia, Austria, Belgium, Canada, France, Germany, Japan, the Netherlands, Sweden, Switzerland, and the United Kingdom.

Data were collected and analyzed by researchers at KFF using a variety of data sources (which can be found for specific indicators in the indicator page on the dashboard). The dashboard includes more than 50 indicators of health system performance, organized into four domains – a structure based largely on the framework put forth in the National Academy of Medicine's 2015 Vital Signs: Core Metrics for Health and Health Care Progress. Indicators on the dashboard were selected through consultation with other experts in the field and a review of various additional sources of data on quality and outcomes measurement, including (among others): National Quality Forum; Healthcare Effectiveness Data and Information Set (HEDIS); Consumer Assessment of Healthcare Providers and Systems (CAHPS); America's Health Rankings; Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); CMS Hospital Compare; US News and World Report; America's Health Insurance Plans (AHIP)/CMS Core Quality Measures Collaborative; Commonwealth Fund; as well as a review of sources for data on health spending, such as the Bureau of Economic Analysis (BEA), National Health Expenditure Accounts (NHEA), and the Medical Expenditure Panel Survey (MEPS). The Healthcare Quality and Access (HAQ) Index is a metric developed by the Institute for Health Metrics and Evaluation and based on the Global Burden of Disease (GBD) study.

The dashboard is limited to some extent by what data are available at the health system level, particularly for indicators of health system quality (see our in-depth discussion here). While health spending, access, and health status data are more readily available and standardized, some indicators of quality of care are less standardized and often only available nationally for the Medicare population. The quality measures included in the dashboard were selected through consultation with a number of experts in the field and present a comprehensive look at treatment outcomes, patient safety, appropriateness of treatments, use of preventive services, and the resources of the health system.

SHARE

Access to Care | Affordability | COVID-19 | Health Outcomes | Health Spending | Treatment Outcomes

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The Crises — and Opportunities — of the COVID-19 Pandemic

July 23, 2020

| David Blumenthal, Elizabeth Fowler, Melinda K. Abrams, and Sara R. Collins

The Issue

The coronavirus pandemic has created four interconnected crises that compound and reveal the underlying problems in our health care system. But in doing so, it also has highlighted reforms that could help the way we handle future epidemics and meet the health care needs of all Americans.

The Crises

- *Insurance coverage*. The sudden surge in unemployment has caused many millions of people to lose job-based health insurance. While some will regain coverage, a significant number will become uninsured. The Affordable Care Act (ACA) can help people who lose job-based insurance, but the federal government has not taken advantage of the law.

- *Provider losses.* While the coronavirus has increased demand for acute care and overtaxed some hospitals, a steep drop in demand for routine services has reduced providers' revenue and even threatened the viability of hospitals and practices.
- *Racial and ethnic disparities in health care.* Blacks constitute 13 percent of the U.S population but account for 20 percent of COVID-19 cases and more than 22 percent of deaths. Latinos account for 18 percent of the population and almost 33 percent of new cases. Our system disproportionately fails to insure and provide access to care for people of color, resulting in higher rates of illness, including COVID-19.
- *Public health crisis.* The U.S. lacks a functional national system for responding to pandemics and failed to quickly identify and control the spread of coronavirus. Testing was not widely available early on, and we were late to impose physical distancing guidelines. To date, neither of these strategies has been implemented adequately.

We may now have the opportunity to reform a flawed health care system that made the novel coronavirus far more damaging in the United States than it had to be.

The Opportunities

The pandemic may open the way to either major reform or meaningful incremental changes. These could include:

- Building on and fully enforcing the ACA, including having the federal government cover the full costs of expanding Medicaid eligibility and enhancing subsidies for marketplace coverage.
- Moving toward alternative payment models like capitation to help ensure a predictable stream of revenue to providers that isn't linked to the volume of services delivered.
- Addressing inequities in health care by continuing to expand access to coverage, supporting safety-net facilities and small community providers, and requiring that health professionals attend antibias training.
- Improving our public health response by rigorously testing, contact-tracing, and isolating infected people.
- Passing federal legislation that would: establish a national public health information system with real-time data on disease prevalence; expand federal funding for developing

and distributing new diagnostic tests, treatments, and vaccines; require states to adopt measures to contain the spread of infection; and allow licensed health professionals to participate in cross-state telemedicine.

Publication Details

Publication Date: July 23, 2020

Contact: Bethanne Fox, Vice President, Outreach and Strategy, The Commonwealth Fund

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Summary Writer: Deborah Lorber

Citation:
David Blumenthal et al., "Covid-19 — Implications for the Health Care System," *New England Journal of Medicine,* published online July 22, 2020. https://doi.org/10.26099/ptbr-6c27

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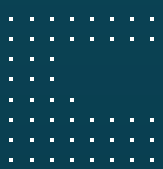
U.S. Health Reform—Monitoring and Impact

Comparison of 2017 to 2018 Changes in Insurance Coverage Across Surveys

July 2020

By Joshua Aarons and Laura Skopec



Robert Wood Johnson Foundatio

Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

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**.

IN BRIEF

- Despite improvements in the economy between 2017 and 2018, two national surveys (the American Community Survey and Current Population Survey) showed increasing uninsurance among nonelderly Americans, while one survey showed no statistically significant change in the uninsured rate (National Health Interview Survey).
- According to both the American Community Survey and the Current Population Survey, Medicaid coverage fell between 2017 and 2018, perhaps reflecting increasing incomes.
- The three surveys found mixed results for private insurance coverage. The American Community Survey showed increases in employer coverage between 2017 and 2018 and declines in private nongroup coverage. In contrast, the Current Population Survey and the National Health Interview Survey showed no change in employer-sponsored coverage or private nongroup coverage.

INTRODUCTION

This brief compares changes in health coverage between 2017 and 2018 as measured by the American Community Survey (ACS), the Current Population Survey (CPS), and the National Health Interview Survey (NHIS). Estimates of health insurance coverage vary across surveys because of differences in question design, question order, sampling strategy, and sample size.[1] Additionally, surveys request information about health insurance coverage questions from different time frames, such as coverage at the time of the survey or over the past calendar year.

Prior research found increasing uninsurance as measured by the ACS between 2016 and 2017, despite economic improvements.[2] Our analysis of the 2018 ACS found insurance coverage continued declining between 2017 and 2018,[3] though at a slower rate than reported by the U.S. Census Bureau using the CPS.[4] These declines in coverage occurred despite economic improvements such as increasing household incomes,[5] increasing employment,[6] and falling poverty,[7] which we would expect to increase coverage rates.[8,9]

However, health insurance gains from these economic improvements may have been offset to some degree by losses of Medicaid coverage due to increasing incomes and changes in health insurance marketplace policies that may have limited enrollment. Between 2017 and 2018, funding for federal marketplace navigators and outreach programs fell.[10] In addition, the Trump Administration ceased making cost-sharing reduction payments to marketplace insurers in 2018 while the law continued to require those insurers to offer reduced cost-sharing to low-income enrollees, substantially increasing premiums for enrollees ineligible for income-based subsides.[11] Finally, in 2018, the marketplace open enrollment window lasted only six weeks, from November 1 to mid-December, compared to a three-month open enrollment window in prior years.[12] In addition, an aggressive, albeit ultimately unsuccessful, legislative effort to repeal the Affordable Care Act (ACA) led to considerable confusion among consumers that may have reduced 2018 enrollment.[13]

This brief explores how coverage changes between 2017 and 2018 compare among the ACS, CPS, and NHIS. Comparing across multiple surveys allows for triangulation of the likely "true" change in uninsurance, Medicaid, and private non-group coverage between 2017 and 2018.

DATA AND METHODS

Data Sources

The ACS is conducted annually by the Census Bureau through the mail with in-person follow-up for non-respondents. The ACS has the largest sample size of any survey collecting health insurance information, sampling approximately 3 million Americans per year, making it particularly strong for state and sub-state estimates of health insurance coverage.

The CPS is a telephone-based and in-person monthly survey conducted by the Census Bureau. Every March, the CPS fields the Annual Social and Economic Supplement, a survey of 75,000 households collecting detailed information on social and economic characteristics including poverty and health insurance coverage. The CPS has significant strengths in income and poverty reporting, but concerns about the long recall period for the CPS may make its estimates of health insurance coverage weaker than other surveys.

The NHIS is an in-person survey of 35,000 households per year containing about 87,500 Americans. It is conducted by the National Center for Health Statistics, a division of the U.S. Centers for Disease Control and Prevention. The NHIS' strength is its highly-detailed coverage questions, which assess marketplace coverage and high-deductible health plans. However, the NHIS has a smaller sample size than other national surveys, making it more difficult to detect small changes in coverage. Additionally, the public release file of the NHIS does not report state of residence, which means that state-level policies, such as Medicaid expansion, cannot be matched to respondents.

Methods

We obtained all data through the University of Minnesota's Integrated Public Use Microdata Series, which harmonizes variables across years.[14] We focus our analyses on the civilian, noninstitutionalized, nonelderly population from birth to age 64.

For each survey, we counted income by health insurance units (HIUs), which represent household or family units typically eligible to purchase health insurance together. For the ACS and NHIS, the Urban Institute develops HIUs using the family relationship questions. For the CPS, our HIU measure is similar to the Census Bureau's definition of a subfamily, which may include "a married couple with or without children, or a single parent with one or more own never-married children under 18 years old." We define the units to include members of a subfamily who may be covered under one health insurance policy (e.g., policyholders, spouses, and dependent children younger than 19). We calculated HIU income relative to poverty by dividing the unit's income (or imputed income in the NHIS) by the appropriate federal poverty level (FPL) for that year.

Because respondents can report multiple types of health insurance coverage on each survey, we assigned respondents to a single coverage type based on the following hierarchy: employer-sponsored insurance (ESI); Medicaid or CHIP; Medicare, Veterans Affairs, or military health care; private nongroup; and uninsured. Respondents who reported only Indian Health Service coverage are considered uninsured. We examined the rate of coverage through Medicaid, ESI, and private nongroup insurance, as well as the uninsurance rate.

We determined Medicaid expansion status as of July 1, 2018, for all surveys to ensure consistency.[15] However, the NHIS does not include state identifiers on public use files, so estimates by Medicaid expansion status are not presented here for that data set.

Differences in Coverage Reporting Across Surveys

The three surveys do not ask about health insurance in the same manner, leading to differences in estimates of coverage types and uninsurance. The CPS collects information on health insurance as part of its Annual Social and Economic Supplement each March that includes information on coverage at the time of the survey and during the prior year. Our estimates reflect the share of the nonelderly who were uninsured or had a particular insurance type for the entire calendar year in 2017 and 2018. However, the CPS estimates of full-year coverage closely track estimates of point-in-time coverage from other surveys, suggesting that respondents may be reporting their most common coverage status instead of all coverage over the past year due to the long recall period.

In contrast, the ACS insurance questions are point-in-time and the survey is mailed throughout the year, so our estimates reflect the average level of point-in-time coverage for 2017 and 2018. The ACS health insurance questions also do not specify state-specific names for Medicaid and CHIP programs, leading to overreporting of private nongroup coverage and underreporting of Medicaid on the ACS.[16,17,18] Our estimates of coverage type from the ACS have been adjusted to correct for known inaccuracies in survey-based estimates of health insurance coverage.[19]

The NHIS asks detailed questions of all family members about health insurance coverage at the time of the survey on the Family Core questionnaire, and the questionnaire also assesses full-year uninsurance. Due to the extra level of detail in the questions on current insurance, we use the point-in-time estimates from the NHIS.

RESULTS

Changes in uninsurance between 2017 and 2018

As shown in Table 1, the ACS and CPS found statistically significant increases in the uninsured rate between 2017 and 2018 for the nonelderly (birth to age 64) and for nonelderly adults (aged 19 to 64). The CPS also found statistically significant increases in the uninsured rate for children (birth to age 18). However, the magnitude of the increases in uninsurance rates as measured by the CPS are larger than the ACS. The NHIS found increases in uninsurance among the nonederly, children, and adults, but these changes were not statistically significant. The NHIS has a far smaller sample size than the ACS and CPS. Therefore, the NHIS point estimates of changes in uninsurance rates (which are essentially identical to those of the ACS) have larger standard errors than the ACS point estimates and are correspondingly less likely to be identified as statistically significant.

Table 1: Changes in the Uninsured Rate by Age Group and Survey, 2017-2018

	ACS (Time of Survey)			CPS (Uninsured all year)			NHIS (Time of Survey)		
	2017	2018	Change	2017	2018	Change	2017	2018	Change
Nonelderly (0-64)	10.2%	10.4%	0.2**	9.2%	10.0%	0.7**	10.0%	10.2%	0.2
Children (0-18)	4.7%	4.8%	0.1	5.0%	5.5%	0.6*	5.2%	5.3%	0.1
Adults (19-64)	12.4%	12.6%	0.2**	11.0%	11.7%	0.8**	11.9%	12.1%	0.2

Sources: American Community Survey data are from the 2017 and 2018 one-year Public Use Microdata Samples. Current Population Survey health insurance data are from the 2017 and 2018 Current Population Survey Annual Social and Economic Supplement. National Health Interview Survey health insurance data come from the 2017 and 2018 National Health Interview Survey Family Core questionnaire. All data were downloaded from IPUMS.org.
Notes: We imposed the following coverage type hierarchy: Employer-sponsored insurance, Medicaid or CHIP, Medicare, Veterans Affairs, or Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (not shown); private nongroup; and uninsured.
/ Change is statistically significant at the 0.05/0.01 level.*

By income, the ACS and CPS showed increases in the uninsured rate for those with HIU incomes at or above 138 percent of the Federal Poverty Level (FPL), which is roughly the cutoff for Medicaid eligibility in Medicaid expansion states. The increases were larger in the CPS for those with incomes between 138 and 399 percent of the FPL (0.8 percentage points) and individuals with incomes at or above 400 percent of the FPL (1.0 percentage points) than in the ACS (0.6 and 0.3 percentage points, respectively) (Table 2). The NHIS found no significant changes in the uninsured rate for any income group. However, the NHIS point estimates (although statistically insignificant) were most similar to those of the CPS for the lowest and highest income groups.

Table 2: Changes in the Uninsured Rate by Income and Survey for the Nonelderly (0-64), 2017-2018

	ACS (Time of Survey)			CPS (Uninsured all year)			NHIS (Time of Survey)		
	2017	2018	Change	2017	2018	Change	2017	2018	Change
All incomes	10.2%	10.4%	0.2**	9.2%	10.0%	0.7**	10.0%	10.2%	0.2
<138% FPL	16.8%	16.8%	0.0	16.3%	16.9%	0.7	16.4%	17.1%	0.7
138-399% FPL	11.3%	11.9%	0.6**	11.0%	11.9%	0.8**	13.2%	12.7%	-0.4
400%+ FPL	3.1%	3.4%	0.3**	2.4%	3.4%	1.0**	6.6%	7.1%	0.6

Sources: American Community Survey data are from the 2017 and 2018 1-year Public Use Microdata Samples. Current Population Survey health insurance data are from the 2017 and 2018 Current Population Survey Annual Social and Economic Supplement. National Health Interview Survey health insurance data come from the 2017 and 2018 National Health Interview Survey Family Core questionnaire. All data were downloaded from IPUMS.org.
Notes: FPL is the federal poverty level. We imposed the following coverage type hierarchy: Employer-sponsored insurance, Medicaid or CHIP, Medicare, Veterans Affairs, or Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (not shown); private nongroup; and uninsured.
/ Change is statistically significant at the 0.05/0.01 level.*

Changes in Medicaid, employer-sponsored coverage, and private nongroup coverage between 2017 and 2018

Between 2017 and 2018, the ACS and CPS showed significant decreases in Medicaid coverage for all nonelderly. The CPS also showed a significant decrease in coverage for nonelderly adults and changes in coverage in the CPS were larger for both nonelderly adults (-0.6 percentage points) and all nonelderly (-0.6 percentage points) than in the ACS (-0.3 percentage points for both) (Table 3). The ACS, CPS, and NHIS all showed non-significant decreases in Medicaid coverage among children (-0.7 and -0.4 percentage points, respectively). The NHIS reported decreases in Medicaid coverage among the nonelderly and nonelderly adults as well, though these were not statistically significant.

Table 3: Changes in the Medicaid Coverage Rate by Age Group and Survey, 2017-2018

	ACS (Time of Survey)			CPS (Any Time During Year)			NHIS (Time of Survey)		
	2017	2018	Change	2017	2018	Change	2017	2018	Change
Nonelderly (0-64)	22.5%	22.2%	-0.3**	18.9%	18.3%	-0.6**	18.6%	18.4%	-0.2
Children (0-18)	41.9%	41.6%	-0.3	33.5%	32.8%	-0.7	33.4%	33.0%	-0.4
Adults (19-64)	14.6%	14.3%	-0.3	13.1%	12.5%	-0.6**	12.6%	12.5%	-0.1

Sources: American Community Survey data are from the 2017 and 2018 one-year Public Use Microdata Samples. Current Population Survey health insurance data are from the 2017 and 2018 Current Population Survey Annual Social and Economic Supplement. National Health Interview Survey health insurance data come from the 2017 and 2018 National Health Interview Survey Family Core questionnaire. All data were downloaded from IPUMS.org.
Notes: We imposed the following coverage type hierarchy: Employer-sponsored insurance, Medicaid or CHIP, Medicare, Veterans Affairs, or Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (not shown); private nongroup; and uninsured.
/ Change is statistically significant at the 0.05/0.01 level.*

Between 2017 and 2018, as employment increased, the ACS showed an increase in the share of the nonelderly with employer-sponsored insurance (ESI) among the nonelderly (0.4 percentage points) and nonelderly adults (0.4 percentage points) (Table 4). Both the CPS and NHIS did not find any statistically significant changes in ESI between 2017 and 2018, however, suggesting any true changes in ESI coverage were likely small.

Table 4: Changes in the Employer-Sponsored Coverage by Age Group and Survey, 2017-2018

	ACS (Time of Survey)			CPS (Any Time During Year)			NHIS (Time of Survey)		
	2017	2018	Change	2017	2018	Change	2017	2018	Change
Nonelderly (0-64)	57.6%	58.0%	0.4**	61.0%	60.7%	-0.2	60.1%	60.4%	0.2
Children (0-18)	48.3%	48.7%	0.4	54.5%	54.3%	-0.2	53.3%	53.0%	-0.3
Adults (19-64)	61.3%	61.8%	0.4**	63.6%	63.3%	-0.3	62.9%	63.3%	0.4

Sources: American Community Survey data are from the 2017 and 2018 one-year Public Use Microdata Samples. Current Population Survey health insurance data are from the 2017 and 2018 Current Population Survey Annual Social and Economic Supplement. National Health Interview Survey health insurance data come from the 2017 and 2018 National Health Interview Survey Family Core questionnaire. All data were downloaded from IPUMS.org.
Notes: We imposed the following coverage type hierarchy: Employer-sponsored insurance, Medicaid or CHIP, Medicare, Veterans Affairs, or Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (not shown); private nongroup; and uninsured.
/ Change is statistically significant at the 0.05/0.01 level.*

Between 2017 and 2018, the ACS showed declining private nongroup coverage for the nonelderly (-0.2 percentage points) and nonelderly adults (-0.3 percentage points) (Table 5).

The CPS and NHIS showed no significant changes from 2017 to 2018 for nongroup coverage.

Table 5: Changes in the Nongroup Coverage by Age Group and Survey, 2017-2018

	ACS (Time of Survey)			CPS (Any Time During Year)			NHIS (Time of Survey)		
	2017	2018	Change	2017	2018	Change	2017	2018	Change
Nonelderly (0-64)	6.8%	6.6%	-0.2**	6.8%	6.8%	0.0	6.4%	6.4%	-0.1
Children (0-18)	3.4%	3.3%	-0.1	4.6%	4.9%	0.3	3.9%	4.1%	0.2
Adults (19-64)	8.2%	7.9%	-0.3**	7.6%	7.5%	-0.1	7.5%	7.3%	-0.2

Sources: American Community Survey data are from the 2017 and 2018 one-year Public Use Microdata Samples. Current Population Survey health insurance data are from the 2017 and 2018 Current Population Survey Annual Social and Economic Supplement. National Health Interview Survey health insurance data come from the 2017 and 2018 National Health Interview Survey Family Core questionnaire. All data were downloaded from IPUMS.org.
Notes: We imposed the following coverage type hierarchy: Employer-sponsored insurance, Medicaid or CHIP, Medicare, Veterans Affairs, or Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (not shown); private nongroup; and uninsured.
/ Change is statistically significant at the 0.05/0.01 level.*

From 2017 to 2018, states that did not expand Medicaid coverage under the ACA had larger increases in uninsurance than Medicaid expansion states. In the ACS, uninsurance increased by 0.3 percentage points in non-expansion states and 0.1 percentage points in Medicaid expansion states (the latter not statistically significant). According to the CPS, uninsurance increased 1.0 percentage points in non-expansion states compared to 0.5 percentage points in Medicaid expansion states.

Table 6: Changes in Uninsurance for the Nonelderly (0-64) by State Medicaid Expansion Status and Survey, 2017-2018

	ACS (Time of Survey)			CPS (Uninsured All Year)		
	2017	2018	Change	2017	2018	Change
Medicaid expansion states	7.6%	7.7%	0.1	6.8%	7.3%	0.5 **
Nonexpansion states	14.3%	14.6%	0.3**	13.1%	14.1%	1.0 **

Sources: American Community Survey data are from the 2017 and 2018 1-year Public Use Microdata Samples. Current Population Survey health insurance data are from the 2017 and 2018 Current Population Survey Annual Social and Economic Supplement. National Health Interview Survey health insurance data come from the 2017 and 2018 National Health Interview Survey Family Core questionnaire. All data were downloaded from IPUMS.org.
Notes: We imposed the following coverage type hierarchy: Employer-sponsored insurance, Medicaid or CHIP, Medicare, Veterans Affairs, or Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (not shown); private nongroup; and uninsured.
/ Change is statistically significant at the 0.05/0.01 level.*

CONCLUSION

The ACS and CPS showed increases in uninsurance for the nonelderly between 2017 and 2018 despite economic improvements. The NHIS data showed increases in uninsurance consistent with the ACS data, but its smaller sample size increased the threshold needed to show significance. Both the ACS and CPS indicated that the coverage losses were concentrated among those with HIU incomes at or above 138 percent of the FPL, suggesting they were likely not eligible for Medicaid. The ACS and CPS both found statistically significant decreases in Medicaid coverage among nonelderly adults and the nonelderly overall, perhaps due to increasing employment and higher HIU incomes.

The ACS, CPS, and NHIS differed in estimated changes in private coverage between 2017 and 2018, however. In the ACS, increasing employer sponsored coverage between 2017 and 2018 was offset by losses of private non-group coverage as well as losses of Medicaid coverage. In contrast, the CPS and NHIS showed no statistically significant change in employer-sponsored coverage or private non-group coverage between 2017 and 2018. In the CPS, increases in uninsurance were driven by losses of Medicaid coverage.

Overall, despite a strong economy and growing labor force, uninsurance rates increased in the United States between 2017 and 2018, a consistent story across the three surveys, although the increase was not measured as statistically significant in one of them due to a smaller sample size. Increased employment and incomes likely reduced the number of individuals eligible for and enrolled in Medicaid coverage. Only the ACS showed a significant increase in employer-sponsored insurance, but these gains were not sufficient to offset losses of private non-group and Medicaid coverage.

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The authors are grateful to Linda Blumberg for her thoughtful comments and editorial assistance provided by McCabe Message Partners.

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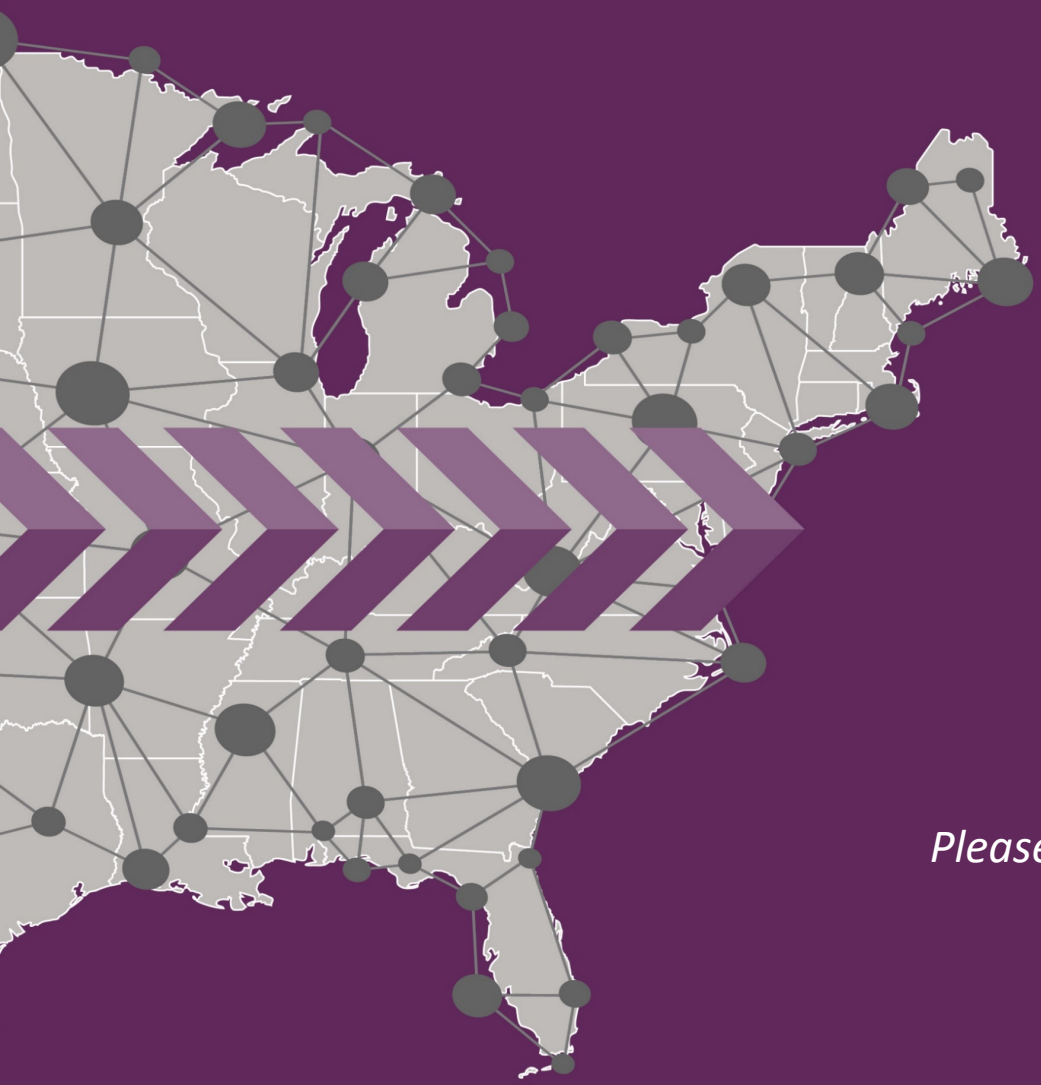


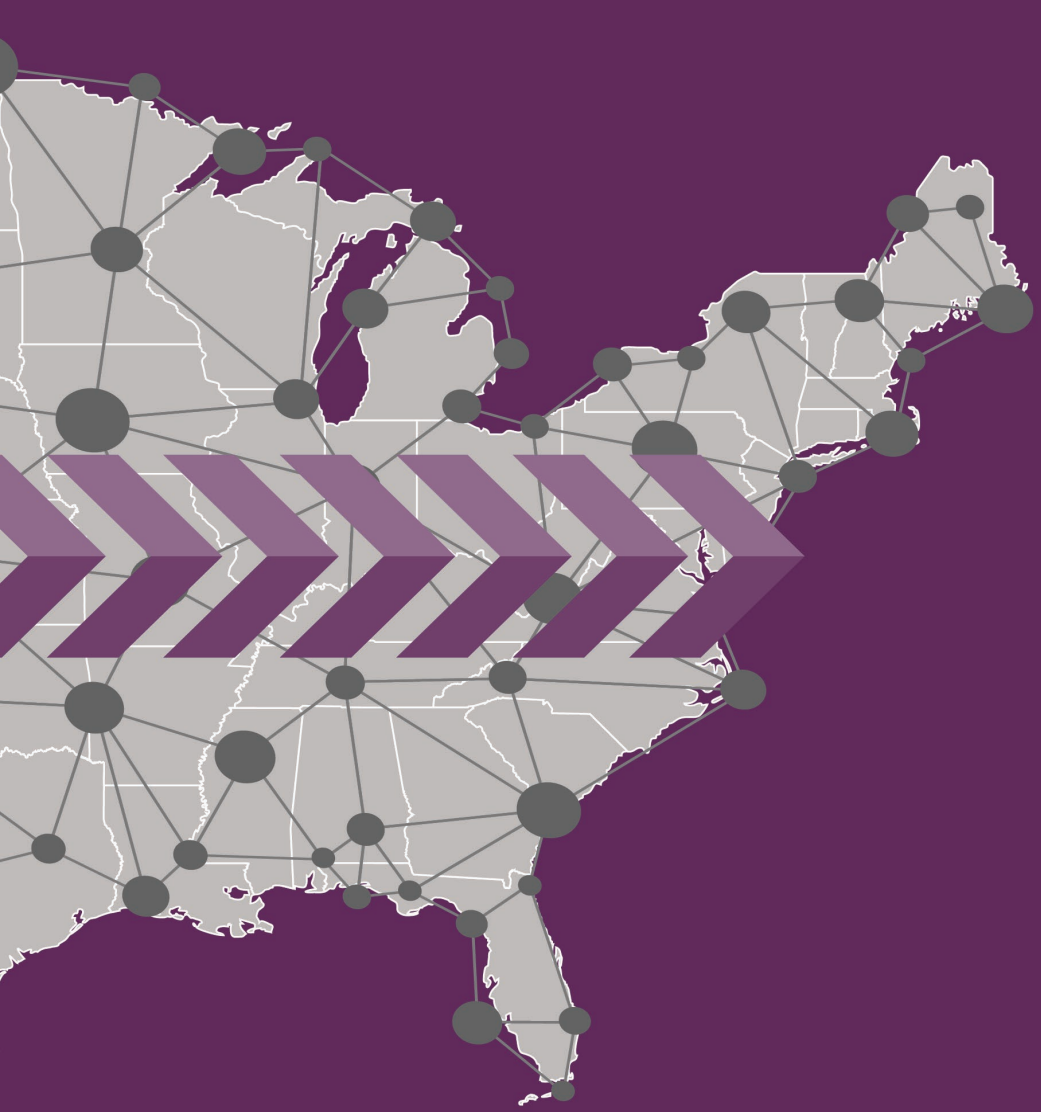
Preparing for OEP 2021: Designing Your Open Enrollment Campaign

July 22, 2020, 1:00 PM ET

Please stand by, this webinar will begin shortly

STATE Health & Value STRATEGIES COVID-19

A grantee of the Robert Wood Johnson Foundation



Preparing for OEP 2021: Designing Your Open Enrollment Campaign

Julie Bataille

July 22, 2020

STATE Health & Value STRATEGIES

Driving Innovation Across States

A grantee of the Robert Wood Johnson Foundation

About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@princeton.edu.

Support for this webinar was provided by the Robert Wood Johnson Foundation.
The views expressed here do not necessarily reflect the views of the Foundation.

Housekeeping Details

All participant lines are muted. If at any time you would like to submit a question, please use the Q&A box at the bottom right of your screen.

After the webinar, the slides and a recording will be available at **www.shvs.org**.

COVID-19 Resources for States

State Health and Value Strategies has created an accessible one-stop source of COVID-19 information for states at www.shvs.org/covid19/. The webpage is designed to support states seeking to make coverage and essential services available to all of their residents, especially high-risk and vulnerable people, during the COVID-19 pandemic.

About GMMB

GMMB is a full-service communications firm dedicated to creating real and lasting positive change in the world. We work on behalf of several of the world's largest foundations, leading public interest groups and trade associations, federal and state government agencies, and corporations. For more than 25 years, we have been on the front line of issue-based communications, earning a reputation for shaping public opinion by developing research-based communications strategies that achieve real results. For more information, visit www.gmmb.com

Overview

As we enter the upcoming open enrollment period, the environment around health care and health insurance in our country continues to shift. Today, we will explore how the impacts of COVID-19 should inform marketplaces' tactical campaign approaches for virtual outreach and partnership engagement, digital and social platform usage, paid advertising, and earned media, hearing insights from several state officials from Marketplaces along the way.

State of Play

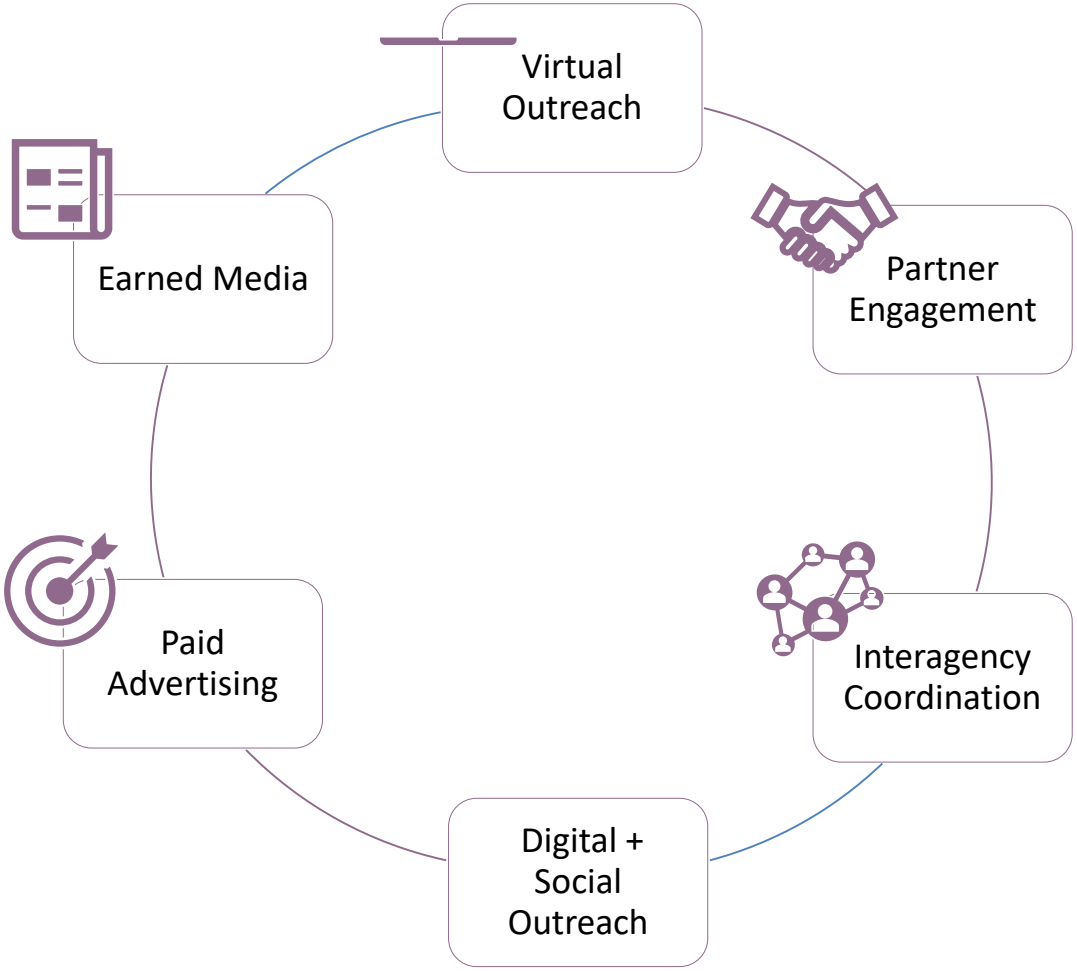
OEP Context

- COVID-19 Emergency SEPs established and extended
- New customer bases, need to reach those disproportionately impacted by the pandemic
- Increased consumption of online media, consumers feeling personal impacts of COVID-19
- Remote workplace and ongoing personal impacts of COVID-19

Recommendation

- Draw on SEP lessons learned for OEP
- Adjust messaging to meet the moment
- Adapt for COVID-19 landscape shifts in consumer behavior and mindset
- Prepare field for operational realities of more virtual engagement and churn

Designing an Integrated Marketing and Outreach Effort in a Virtual Environment



Partner Engagement

Meaningful partner relationships continue to be critical for community outreach

- Recognize operational reality of partner organizations
- Continuously explore new outreach tactics and expand partner networks to stay relevant and engaged
- Embed community perspectives to help ensure a culturally competent approach and authenticity
- Create a centralized online location to distribute content

Partner Engagement in New York

Virtual Outreach

Adapt traditional in-person awareness events for an online audience

- Leverage virtual channels and technology to engage key communities
- Plan ahead
- Keep in mind, timing matters
- Focus on advance promotion to increase participation

Virtual Events in Colorado

Virtual Pride Events: 5k Run, Yoga, Crossfit

Virtual Events in Colorado

Virtual Town Hall With Kevin Patterson
CEO, Connect for Health Colorado

CONNECT for HEALTH COLORADO

As part of our *member exclusive* town hall series, we are excited to bring you this opportunity to learn, ask questions, and hear about everything Connect for Health Colorado has been working on in the past few months.

Kevin Patterson, CEO, will be joining us to provide an update and address Club 20 members in this hour long *Virtual* Town Hall. Kevin has served in his role since 2015 and was formerly Governor Hickenlooper's interim chief of staff, interim executive director of three state agencies (OIT, DOLA, and CO Energy Office), and has held leadership roles for the city and county of Denver in the Budget Office, Planning Department, Human Services Department, and more.

Please Join Us!
Wednesday July 22nd at 4:00 pm

Held via Zoom
(link will be emailed to you after registration)

Advanced Registration is REQUIRED

Register Here

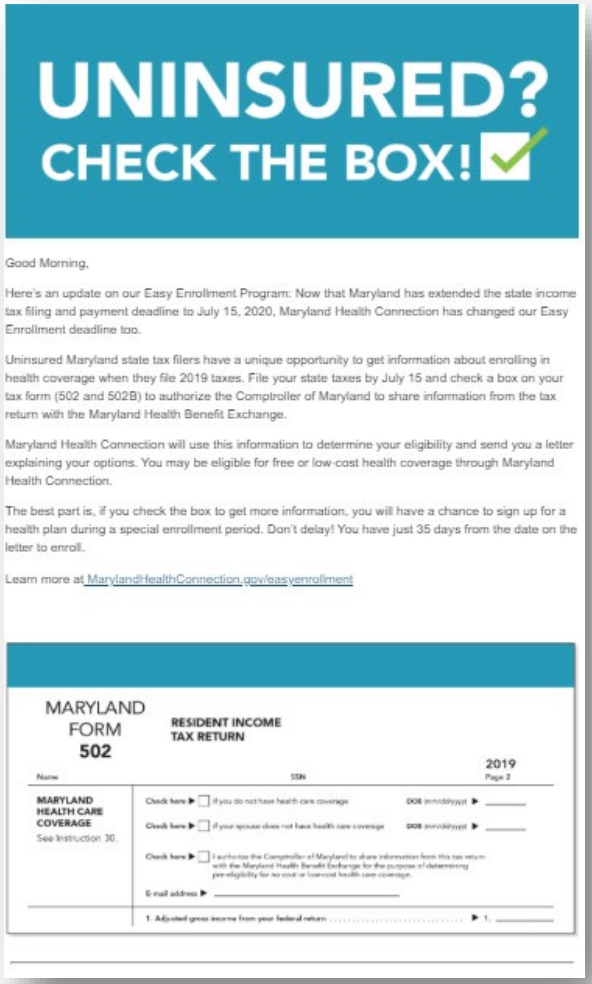
Club 20 | www.club20.org

Interagency Coordination

COVID-19 has created opportunities for unique interagency coordination

- Medicaid agencies conducting consumer outreach
- Unemployment agencies/Departments of Labor that may provide a touch point to uninsured consumers
- County health agencies that can provide a touch point during COVID-19 testing and treatment
- Other state agencies as they reopen will provide ongoing consumer touchpoints to share general health insurance enrollment information

Department of Labor + The Comptroller Partnerships in Maryland



UNINSURED?
CHECK THE BOX!

Good Morning,

Here's an update on our Easy Enrollment Program: Now that Maryland has extended the state income tax filing and payment deadline to July 15, 2020, Maryland Health Connection has changed our Easy Enrollment deadline too.

Uninsured Maryland state tax filers have a unique opportunity to get information about enrolling in health coverage when they file 2019 taxes. File your state taxes by July 15 and check a box on your tax form (502 and 502B) to authorize the Comptroller of Maryland to share information from the tax return with the Maryland Health Benefit Exchange.

Maryland Health Connection will use this information to determine your eligibility and send you a letter explaining your options. You may be eligible for free or low-cost health coverage through Maryland Health Connection.

The best part is, if you check the box to get more information, you will have a chance to sign up for a health plan during a special enrollment period. Don't delay! You have just 35 days from the date on the letter to enroll.

Learn more at MarylandHealthConnection.gov/easyenrollment

MARYLAND FORM 502 **RESIDENT INCOME TAX RETURN** 2019

Name SSN Page 2

MARYLAND HEALTH CARE COVERAGE See Instruction 30.

Check here ▶ ☐ if you do not have health care coverage DOB (mm/dd/yyyy) ▶ _____

Check here ▶ ☐ if your spouse does not have health care coverage DOB (mm/dd/yyyy) ▶ _____

Check here ▶ ☐ I authorize the Comptroller of Maryland to share information from this tax return with the Maryland Health Benefit Exchange for the purpose of determining pre-eligibility for no cost or low-cost health care coverage.

E-mail address ▶ _____

1 Adjusted gross income from your federal return ▶ 1 _____

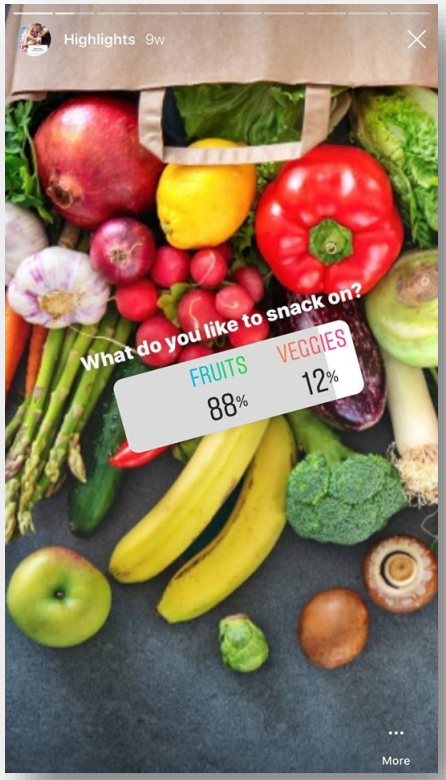
Leveraging Digital + Social

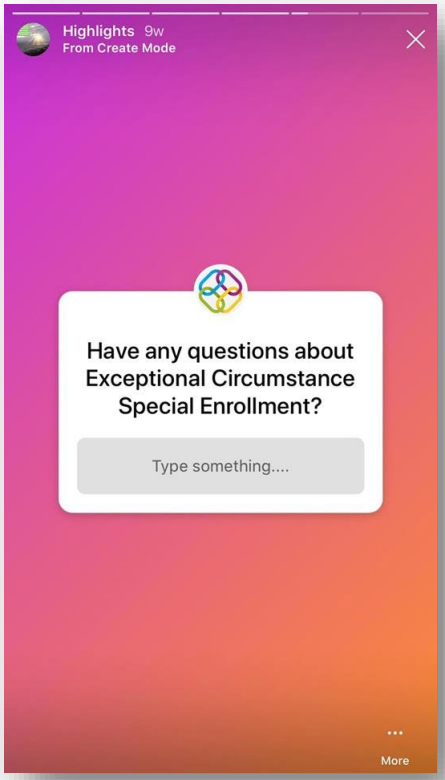
Digital and social outreach will continue to be critical in a virtual enrollment environment

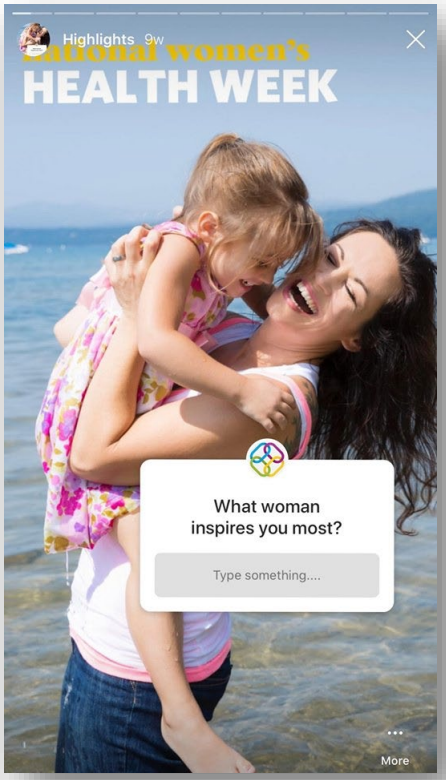
- Platform selection:
  - Facebook and Instagram for reaching consumers
  - Twitter and LinkedIn for reaching issue experts and policymakers
  - Zoom/WebEx for webinars and virtual information sharing
- Leverage texting or email marketing for direct to consumer outreach
- Engage trusted voices (e.g. micro-influencers) to deliver authentic, credible messaging with key communities

Social Engagement in Nevada

Social Engagement in Nevada







Email Marketing in Rhode Island

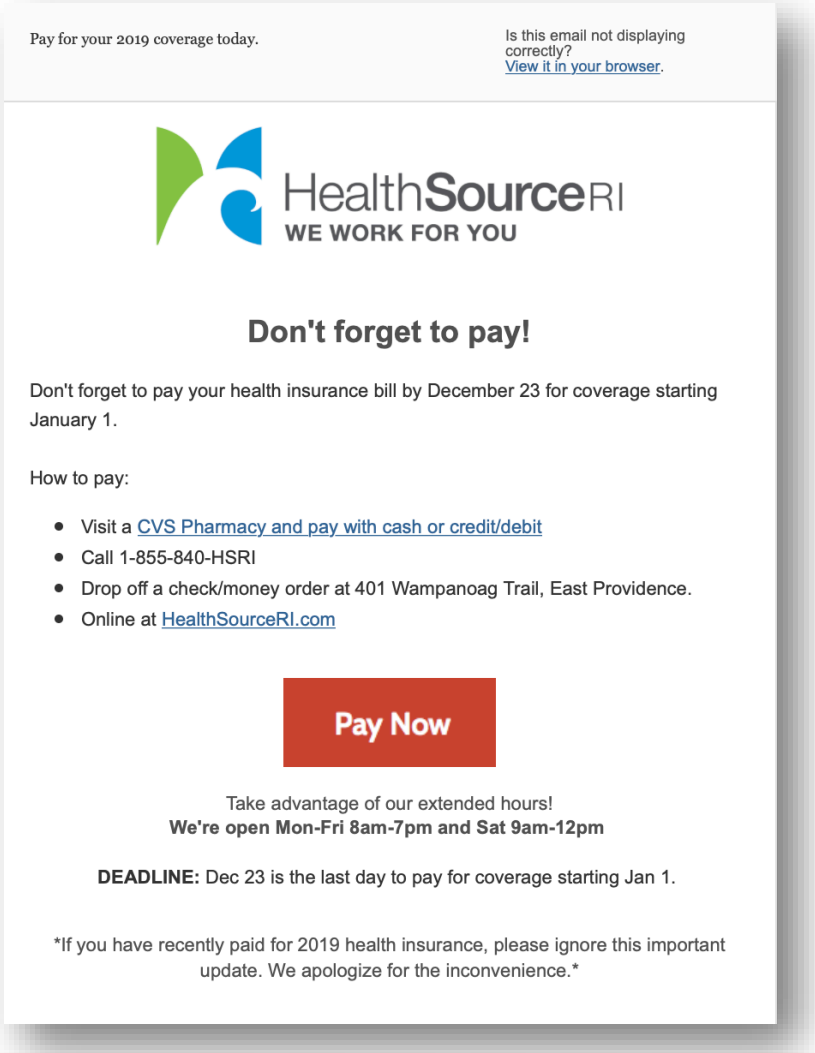
Pre-OEP

- Encourage all customers to update information, explore virtual events, and visit new webpage
- Email auto-renewal eligible customers
- Email customers whose plans have changed

During OEP

- Email and text all customers with timeframe reminders
- Email customers with virtual info session information
- Email customers who have started but not completed the enrollment processed
- Email previous customers in zip codes hardest hit by COVID and with highest uninsured rates

Email Marketing in Rhode Island



Pay for your 2019 coverage today.

Is this email not displaying correctly?
View it in your browser.

HealthSourceRI
WE WORK FOR YOU

Don't forget to pay!

Don't forget to pay your health insurance bill by December 23 for coverage starting January 1.

How to pay:

- Visit a CVS Pharmacy and pay with cash or credit/debit
- Call 1-855-840-HSRI
- Drop off a check/money order at 401 Wampanoag Trail, East Providence.
- Online at HealthSourceRI.com

Pay Now

Take advantage of our extended hours!
We're open Mon-Fri 8am-7pm and Sat 9am-12pm

DEADLINE: Dec 23 is the last day to pay for coverage starting Jan 1.

If you have recently paid for 2019 health insurance, please ignore this important update. We apologize for the inconvenience.

Advertising Considerations

Since COVID-19, consumption of digital media platforms has increased, including a 46% increase in Connected TV

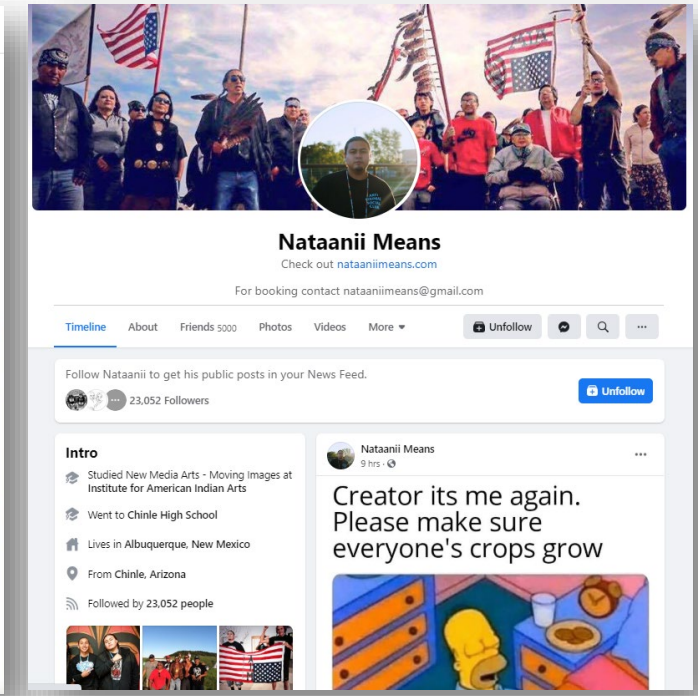
- Base paid media allocations on available budget, timing of elections, and consumption habits

- Questions to consider:
  - How will you allocate resources across different target audience groups, including existing consumers, new consumers?
  - Which channels will you prioritize for traffic driving?
  - Which channels will you prioritize for raising awareness?
  - How will your buy reflect changes in consumer media consumption habits?

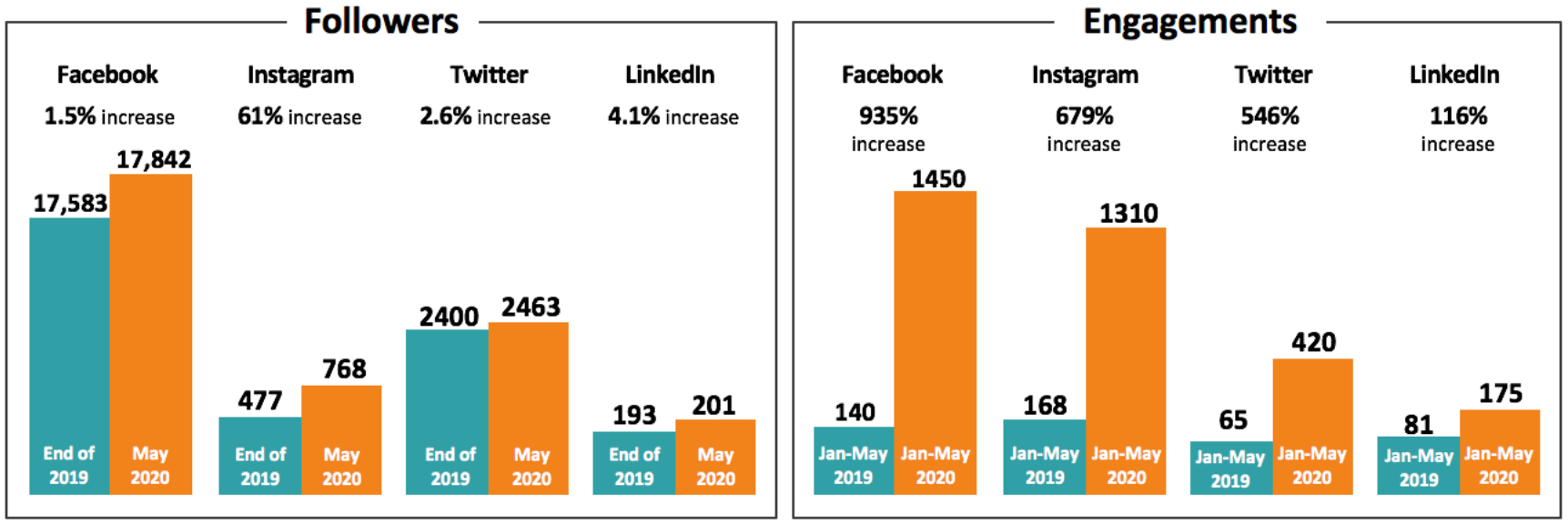
Leveraging Micro-Influencers in New Mexico

Tatanka Means
&
Nataanii Means

Over 57,000 followers on FB combined*



Leveraging Micro-Influencers in New Mexico



Earned Media

Earned media successes during COVID-19 SEPs shows effectiveness of pegging opportunities to environment

- Proactive ways in
  - Connect OEP timeline to need for health insurance
  - Showcase OEP readiness/operational changes
  - Testimonial content promotion – enrollment stories
  - Emphasize deadlines

- Leverage trusted messengers and voices

Key Takeaways

- Meet the moment and be ready to adjust in real time
- Recognize new audience behaviors and media consumption patterns
- Engage partners and messengers to reach key communities authentically

Resources

- Job Loss Toolkit – Connect for Health Colorado
- Virtual Outreach + Events Strategy Deck – Connect for Health Colorado
- Easy Enrollment Letter – Maryland Health Connection
- Easy Enrollment Social Graphic – Maryland Health Connection
- Easy Enrollment Reminder Mailer – Maryland Health Connection
- Social Content Strategy Deck – Nevada Health Link
- Social Media Toolkit Page – Nevada Health Link
- Email Marketing Strategy Deck – HealthSource Rhode Island
- Enrollment Flyer (English) – HealthSource Rhode Island
- Enrollment Flyer (Spanish) – HealthSource Rhode Island
- Digital Outreach Strategy Deck – beWellnm

Questions

The slides and a recording of the webinar will be available at www.shvs.org after the webinar

Thank You

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An Early Look at 2021 Premium Changes on ACA Exchanges and the Impact of COVID-19 on Rates

Daniel McDermott (https://www.kff.org/person/daniel-mcdermott/), **Nicolas Shanosky,**

Rachel Fehr (https://www.kff.org/person/rachel-fehr/), **and**

Cynthia Cox (https://www.kff.org/person/cynthia-cox/) (https://twitter.com/cynthiaccox)

Published: Jul 21, 2020

Each year, insurers planning to offer health plans on the Affordable Care Act (ACA) marketplaces must submit filings to state regulators detailing their plan offerings and justifying their premiums for the upcoming year. Rates and participation are not finalized until late summer and not all are publicly available until early fall, but preliminary filings provide a glimpse into the assumptions insurers are making about the effects the coronavirus pandemic will have on health costs, enrollment and utilization in 2021.

In this brief, we summarize preliminary premium rate filings in the 10 states and the District of Columbia where filings have been made publicly available in a way that allows us to see how premiums are calculated. We reviewed published filings for the overall average premium increase across all plans and any language or estimate attributing a portion of the rate change to the impacts of the coronavirus pandemic. Thus far, many rate changes for 2021 appear to be moderate, with increases or decreases of a few percentage points. However, because many insurers have not yet incorporated a rate impact from the pandemic, it is too soon to say how Marketplace premiums will change next year.

We find that overall proposed rate changes range from a 12.0% decrease to a 31.8% increase, with more than half falling between a 2.0% decrease and 6.0% increase. Of the 63 filings reviewed for this brief, 27 (43%) elected not to factor in potential coronavirus-related costs to their initial proposed premiums due to uncertainty, citing a lack of information and the evolving nature of the pandemic. Many insurers also noted that the economic impacts of the pandemic will have volatile effects on enrollment in 2021, causing enrollees to move in and out of the market in ways that couldn't yet be accurately predicted. These insurers indicated that they would continue to monitor the pandemic and potentially revise their proposed rates based on their experience and as more data become available.

23 of the 63 filings (37%) included information on the projected effects of the pandemic on their rates for next year. Among these insurers, the expected impact of COVID-19 on 2021 premiums ranges from a 1.2% decrease to an 8.4% increase, with more than half falling between 1.0% and 4.0% increases. Most noted that the pandemic would put both upward and downward pressure on costs for 2021. Insurers commonly referenced increased testing, the potential for widespread vaccination, and the return of delayed medical services as reasons to expect increased claims costs in 2021. Other insurers noted that claims costs could be dampened in 2021 due to deferred or avoided care conditions other than COVID-19 that would result from a second wave of infections, highlighting that these premium adjustments are made using highly uncertain assumptions about the pandemic which vary from insurer to insurer. (For more discussion on these upward and downward effects, see our earlier brief (https://www.healthsystemtracker.org/brief/how-health-costs-might-change-with-covid-19/).) A few insurers estimated that these factors would cancel each other out and the net impact of COVID-19 on 2021 premiums would be zero. Others did not mention the pandemic in their filings.

The following table details overall rate changes among publicly available filings and any factor attributable to COVID-19:

Table 1: Proposed Rate Increase and COVID-19 Factor

State/Insurer	Proposed Rate Increase	Impact of COVID-19 on Rates
District of Columbia		
CareFirst HMO (Blue Choice)	14.7%	Not yet factored in
CareFirst PPO	-0.6%	Not yet factored in
Kaiser Foundation Health Plan	-1.97%	Not yet factored in
Hawaii		
Hawaii Medical Service Association	-2.0%	No mention
Kaiser Foundation Health Plan	-1.06%	No mention
Kentucky		
Anthem Health Plans of Kentucky	16.62%	4.5%
Care Source Kentucky	5.3%	Redacted
Maine		
Anthem Health Plans of Maine	-1.1%	2.5%
Harvard Pilgrim Health Plan	0.4%	Not yet factored in
Maine Community Health Options	-10.2%	-1.2%
Maryland		
CareFirst Blue Choice	-1.1%	Not yet factored in
CareFirst CFMI	-12.0%	Not yet factored in
CareFirst GHMS	-12.0%	Not yet factored in
Kaiser Foundation Health Plan	-11.0%	Not yet factored in
Optimum Choice (UnitedHealthcare)	New Entrant	Redacted
Michigan		
Blue Care Network of Michigan	2.5%	No mention
Blue Cross Blue Shield of Michigan	1.7%	No mention
Oscar Insurance Company	6.0%	4.0%
McLaren Health Plan Community	-2.0%	Not yet factored in
Meridian Health Plan of Michigan	2.7%	8.6%
Molina Healthcare of Michigan	0.4%	Not yet factored in
Physicians Health Plan	3.1%	3.0%
Priority Health Insurance	-0.12%	Not yet factored in
Total Health Care USA	-0.39%	Not yet factored in
New Mexico		

Molina Healthcare of New Mexico	-0.17%	Redacted
New Mexico Health Connections	31.8%	Redacted
Blue Cross Blue Shield of New Mexico (HCSC)	3.56%	Redacted
True Health	4.0%	No mention
Friday Health Plans	New Entrant	Not yet factored in
Western Sky Ambetter	New Entrant	Not yet factored in
New York		
Capital District Physicians Health Plan	4.26%	0.0%
Health Insurance Plan of Greater New York (Emblem)	9.5%	2.0%
Excellus	1.51%	0.5%
Fidelis (NY Quality Healthcare Corp)	18.82%	8.4%
Healthfirst PHSP, Inc.	2.36%	0.0%
Healthnow New York	-1.94%	2.0%
HealthPlus HP (formerly Empire)	16.64%	5.15%
IHBC	-3.67%	0.0%
MetroPlus	9.58%	2.1%
MVP Health Care	6.74%	1.6%
Oscar	19.1%	7.4%
UnitedHealthcare of New York	13.79%	1.0%
Oregon		
Bridgespan Health Company	11.1%	Not yet factored in
Kaiser Foundation Health Plan of the Northwest	-3.51%	Not yet factored in
Moda	4.7%	0.9%
PacificSource Health Plans	4.2%	Not yet factored in
Providence Health Plan	2.4%	1.0%
Regence Blue Cross Blue Shield	2.5%	Not yet factored in
Vermont		
Blue Cross Blue Shield of Vermont	6.34%	Not yet factored in
MVP Health Care	7.34%	1.3%
Washington		
Bridgespan Health Company	0.03%	Not yet factored in
Regence BlueShield	-2.71%	Not yet factored in
Lifewise Health Plan of Washington	3.44%	Not yet factored in

Premera Blue Cross	-8.99%	Not yet factored in
Providence Health Plan	2.99%	No mention
Regence Blue Cross Blue Shield of Oregon	-4.71%	Not yet factored in
Kaiser Foundation Health Plan of Washington	-4.87%	Not yet factored in
Kaiser Foundation Health Plan of the Northwest	-1.93%	No mention
Molina Healthcare of Washington	0.27%	3.0%
Community Health Network of Washington	New Entrant	No mention
UnitedHealthcare of Oregon	New Entrant	2.5%
Coordinated Care Corporation	2.1%	Not yet factored in
PacificSource Health Plans	3.54%	Not yet factored in
Overall		
25th percentile	**-1.5%**	**1.0%***
Median	**2.4%**	**2.0%***
75th percentile	**5.3%**	**3.5%***

*Among plans that estimated impact of COVID-19.

SOURCE: KFF analysis of insurer rate filings to state regulators.

The impacts of COVID-19 on rates indicated in the table above primarily reflect adjustments that insurers have made to their expected claims costs for 2021. In addition, some insurers also noted that the heightened uncertainty caused by the pandemic would impact their 2021 experience in other ways, but it was not possible to determine exactly what share of these impacts were attributable to the pandemic and what share were due to other factors, so they are not accounted for in the table. For example, some insurers added extra amounts to their contingency or risk charges to compensate them for taking the additional risk posed by COVID-19, like especially volatile enrollment or unexpectedly high hospitalization rates.

As a number of insurers have not yet incorporated rate impacts of the pandemic in their overall rate changes for 2021, the rates initially proposed are likely to change over the course of state review. We expect to update this table when filings in more states become available and when insurers update their rate requests.

Methods

Data were collected from health insurer rate filing submitted to state regulators. These submissions are publicly available for the states we analyzed. Most rate information is available in the form of a SERFF filing (System for Electronic Rate and Form Filing) that includes a base rate and other factors that build up to an individual rate.

The Henry J. Kaiser Family Foundation Headquarters: 185 Berry St., Suite 2000, San Francisco, CA 94107 | Phone 650-854-9400

Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW, Washington, DC 20005 | Phone 202-347-5270

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The Commonwealth Fund

Gap Closed: The Affordable Care Act's Impact on sA na ricans' Health Coverage

July 21, 2020

| Mu nir Gu Zuja , Jes Baumgartner, rAav Shah, David C. Radley , nd Sara R. Collins F

Introduction

Eli ating giracial inequities in insurance coverage was one of the he Affordable Care Act (ACA). Prior to the law, people of color were uninsured at significantly higher rates than whites. Recent research has indicated that these gaps have narrowed, although re ma ining disparities within the Black, Latino, and Native A mer ican/Alaska Native co ies nit starkly exposed during the COVID-19 pande mi c.

Asian A are the fastest-growing racial or ethnic group in the United States. Surveys and research analyses often group Asian A ricans with other races or ethnicities, limiting what we know about the way this group experiences health care. Asian A mer icans are composed of more than 50 distinct ethnicities with significant socioeconomic diversity. Chinese, Indian, and Filipino F Americans are the three largest groups.

After implementation of the ACA, the uninsured rate declined among all races and ethnicities through 2016. Prior research has reported on the reduction and elimination of coverage disparities between Asian American and white adults, including significant gains among the

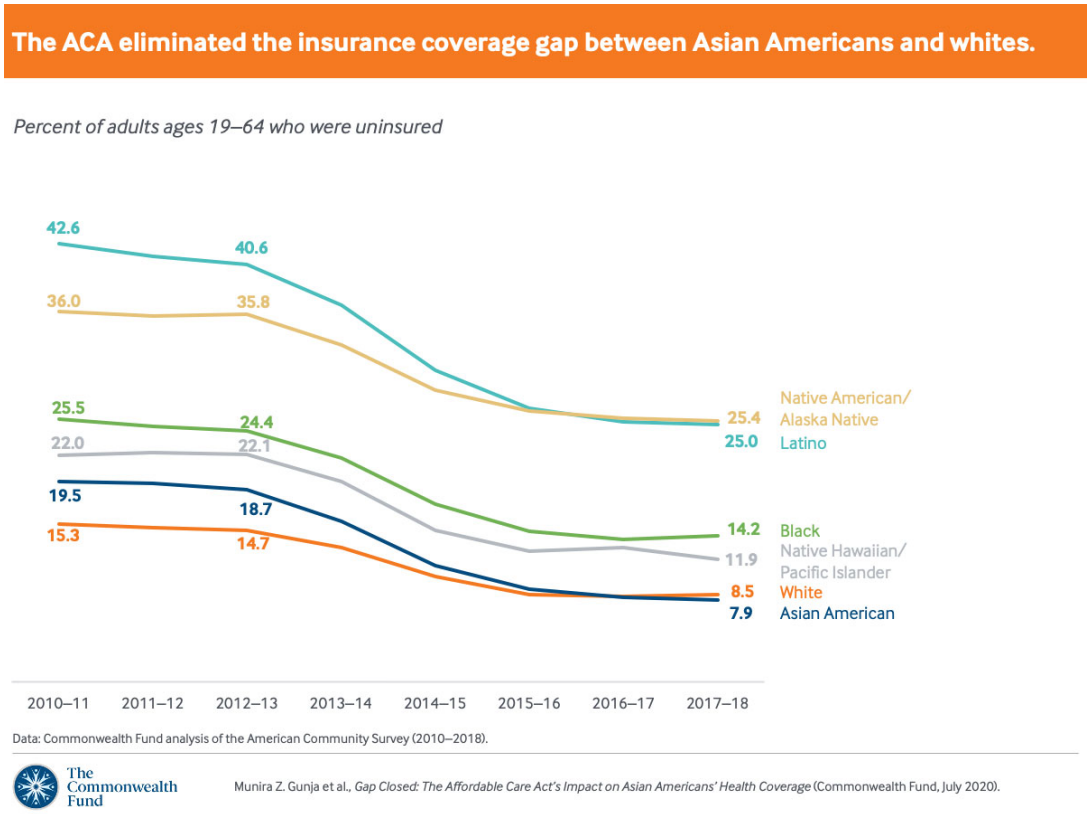
l we -inc i me i p pulat n. Ind th s b i f we bu l n th se p evi eus i find ngs by xt nd analysis of different Asian A ican ethnicities throug h 2018 and exploring the reduction in disparities by income, insurance type, and Medicaid expansion. Specifically, we use two-year rolling averages to review:

- Insurance coverage rates for Asian Americans compared to other races and ethnicities, as well as rates for specific Asian American ethnicities and subpopulations.
- Coverage trends among different income groups and those living in Medicaid expansion states to better understand specific effects of ACA provisions on the Asian American population.

Understanding the effects of the ACA on Asian American coverage can provide important insights for eliminating re ma ing coverage inequities for Black, Latino, and other racial and ethnic communities — at a moment when racial injustice has been laid bare. It also can help us identify re ining cov erage challenges for different Asian A am populations mo ing v forward.

Key Highlights

- The ACA helped eliminate the coverage gap between Asian American and white adults. In 2010–2011, Asian Americans were significantly more likely to be uninsured compared to whites. By 2017–2018, Asian A est uninsured rate of any ra cial or ethnic group in the U.S. Uninsured rates have fallen among all Asian American subgroups since the passage of the ACA, but not uniformly. Korean, Vietnamese, and other Asian Americans were significantly more likely to be uninsured in 2017–2018, co to Indian, Chinese, and mp Filipino Americans.
- Since the passage of the ACA, the coverage disparity between Asian Americans and whites was eliminated across all income categories through coverage gains within Medicaid, the individual and ACA marketplaces, and employer-based insurance. The largest reduction in disparities occurred within the subgroup of adults earning between 138 percent and 399 percent of the federal poverty level ($16,753 to $48,439 for an individual in 2018).
- The vast majority of Asian Americans live in Medicaid expansion states, which has helped to F drive down their overall uninsured rate. But since the passage of the law, the coverage gap has been eliminated between Asian Americans and white adults in both expansion and nonexpansion states.



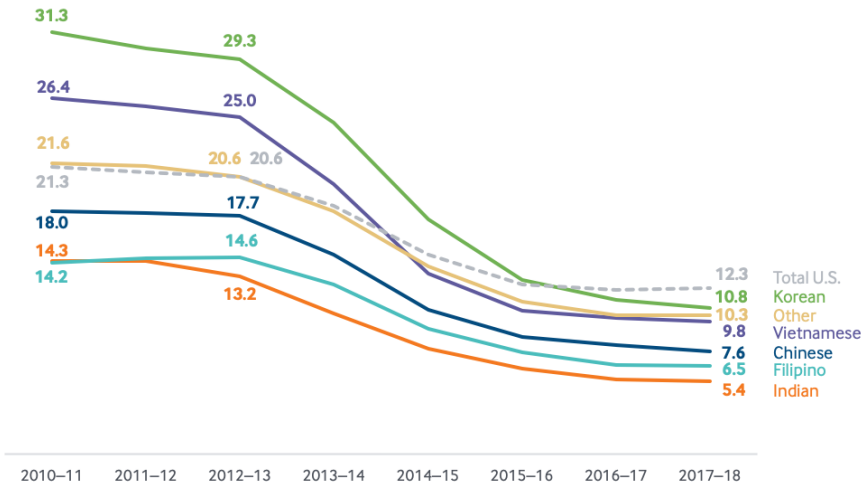
Add to ChartCart

In 2010–2011, prior to the ACA's coverage expansions, working-age Asian Americans were more likely to be uninsured compared to whites, and had the second-lowest uninsured rate compared to all other races and ethnicities, including Black and Latino adults. The coverage disparity between Asian Americans and whites stood at 4.2 percentage points, with 19.5 percent of Asian Americans uninsured compared to 15.3 percent of whites. By 2017–2018, the gap had disappeared. The uninsured rate among Asian Americans improved by more than 11 percentage points, dropping their overall uninsured rate to 7.9 percent, the lowest rate of any racial or ethnic group, including whites.

For the full period, Native Hawaiians/Pacific Islanders and Native Americans/Alaska Natives had significantly higher uninsured rates than Asian Americans. These two groups are often grouped with Asian Americans for purposes of survey research.

Uninsured rates across all Asian American subpopulations dropped, with Indians the least likely to be uninsured by 2017–2018.

Percent of adults ages 19–64 who were uninsured



Data: Commonwealth Fund analysis of the American Community Survey (2010–2018).

The Commonwealth Fund

Munira Z. Gunja et al., *Gap Closed: The Affordable Care Act's Impact on Asian Americans' Health Coverage* (Commonwealth Fund, July 2020).

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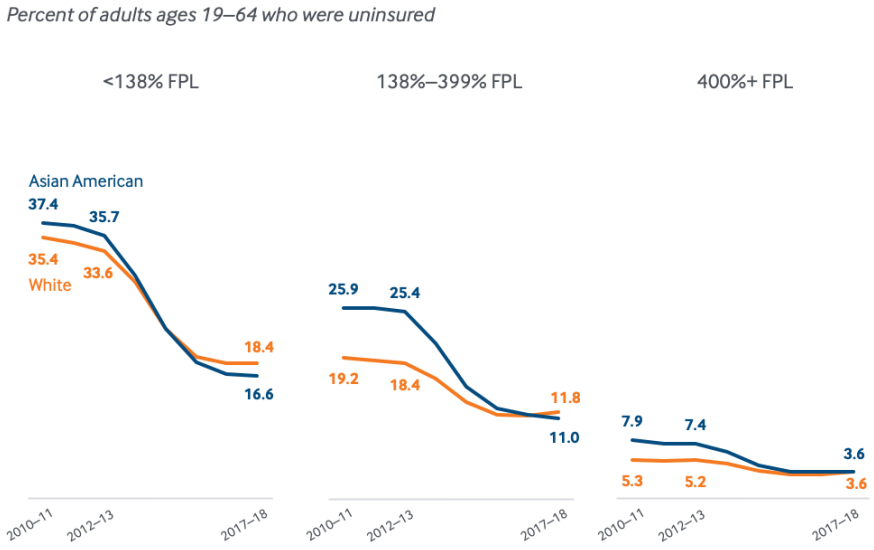
We examined Asian Americans by six differenF subgroups: IndianF Chinese, Filipino, Korean, Vietnamese, and other Asian Americans, which include over 15 additional ethnicities. All these populations experienced at least a 7 percentage-point decline in the uninsured rate since 2010–2011, but gains varied. Koreans experienced a 20.5-point drop in their uninsured rate, compared to a 7.7-point drop among Filipinos.

Although coverage gains occurred across all subgroups, Korean, Vietnamese, and other Asian Americans were still significantly more likely to be uninsured in 2017–2018 compared to Indian, Chinese, and Filipino Americans. F

The Asian American–white coverage disparity had been eliminated across all poverty categories by 2017–2018.



Note: FPL = federal poverty level.
Data: Commonwealth Fund analysis of the American Community Survey (2010–2018).

The Commonwealth Fund

Munira Z. Gunja et al., *Gap Closed: The Affordable Care Act's Impact on Asian Americans' Health Coverage* (Commonwealth Fund, July 2020).

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We compared uninsured rates of Asian A mericans and it s wh r es different inco me brackets to better highlight the i mp f specific ACA provisions. Disparities that existed before the ACA was imple ted have closed within each inco me through the size of the coverage gains varied across the levels.

Less than 138 percent of the poverty level. Adults who earn less than 138 percent of the federal poverty level ($16,753 for an individual and $34,638 for a fa 2018) ma eligible for different for ms depending on their state of residence and i mmi gration status.

Adults within this income range who are lawfully present and live in states that expanded Me dicaid under the ACA are eligible to enroll in their state's d Me i d program. As of 2018, 77 percent of the Asian American population lived in states that had expanded d caid. Adults in Me i nonexpansion states are eligible for subsidies through the ACA e l e ey earn more than 100 percent of poverty and do not have an affordable offer of employer coverage. F Importantly, lawfully present i mmi ts who are in the five-year waiting period for Me dicaid are eligible for subsidies even if they earn below 100 percent of poverty.

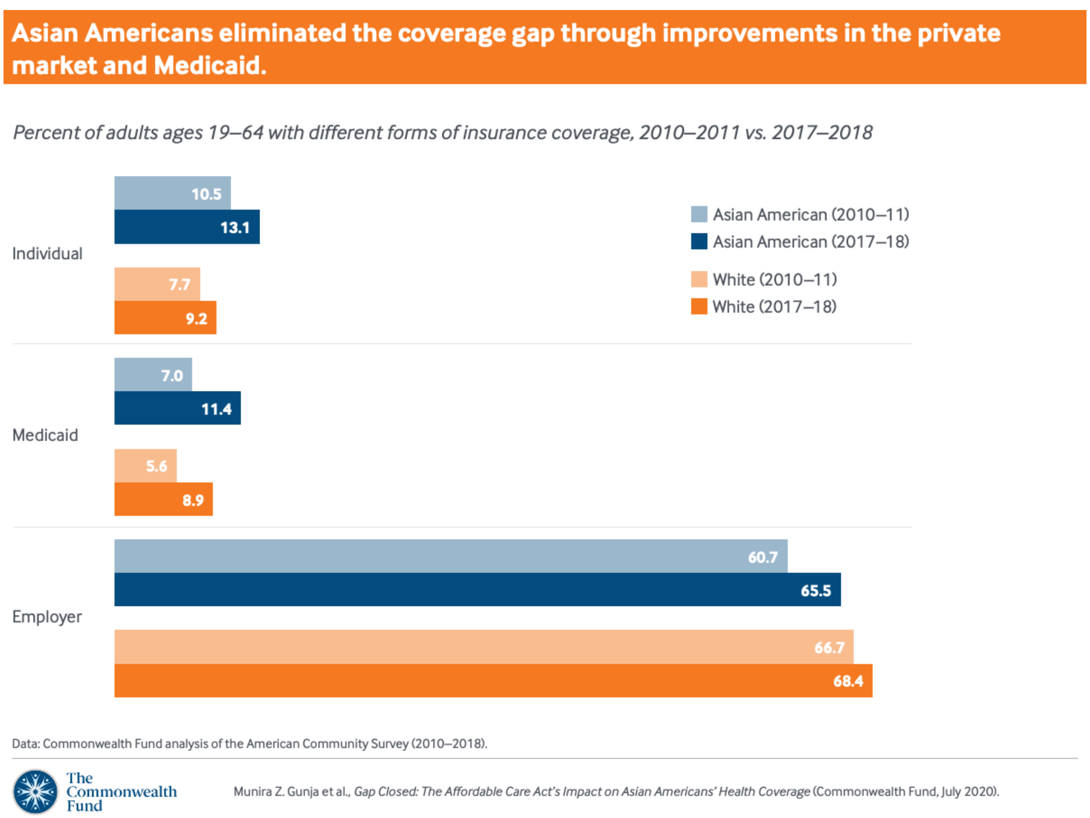
In 2010–2011, Asian A h er likely to be uninsured compared to whites (37.4% to 35.4%). However, by 2017–2018, the gap between Asian Americans and whites reversed, with whites more likely to be uninsured than Asian Americans. F

38 ercent to 399 ercent of the overty level. AF lts who earn between 100 percent and 399 percent of poverty ($12,140–$48,439 for an individual and $25,100–$100,149 for a fa of four in 2018) and are legally present in the United States may be eligible for subsidized health insurance through the ACA marketplaces. This group also may include lawfully present adults with incomes under 138 percent of poverty who are in the five-year waiting period to enroll in Medicaid and are eligible to enroll in subsidized coverage through the marketplace.

The Asian American–white coverage disparity within this income group started at 6.7 percentage points in 2010–2011; but by 2017–2018, the gap had closed, and Asian A me r were no mo ikelyre to be uninsured than whites.

400 percent or of the poverty level. Adults who earn 400 percent or more of poverty can enroll in coverage through the es, but they are not eligible for subsidies. The ACA ma age de c more accessible and comprehensive even for those not eligible for subsidies through the ban on preexisting condition exclusions, communi ty rating, and other insurance et refor ms. E ven prior to the imple me ntation of the ACA, uninsured rates had consistently been lower for this income group across all races and ethnicities (data not shown).

The Asian A merican–white coverage disparity within this inco me group was 2.6 percentage points in 2010–2011. By 2017–2018, the disparity had been eli minated and the uninsured rate for whites and Asian A mericans was the same . F



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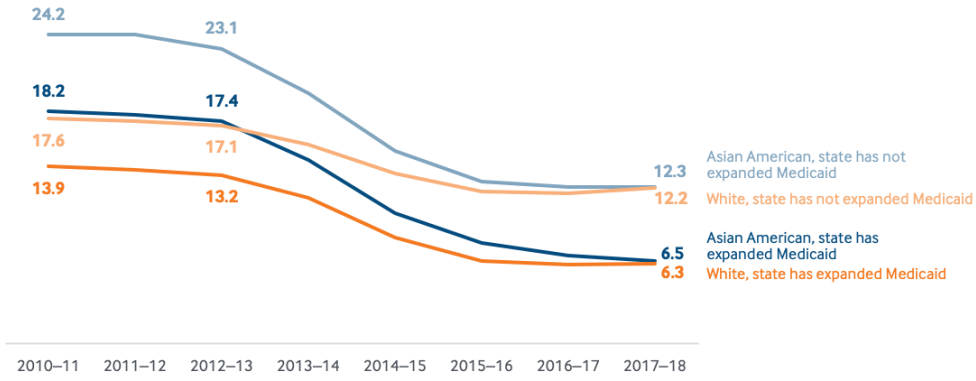
A ia A ame rica a dult eli i e mi ted the coverage gap w th wh individual market, Medicaid, and employer-sponsored insurance. These i eme e e m larger than those reported by whites.

The share of Asian Americans in these forms of coverage increased between 2010–2011 and 2017–2018. These data are consistent with other research showing that Asian Americans are geographically concentrated within Medicaid expansion states and are effectively accessing the Me a dic id and individual insurance e ACA's ma rketplaces two important coverage.

Increases in employer-sponsored insurance can be linked to ACA coverage require me nts for F individuals and employers, as well as overall i mp rove me nts in the economy, which spurred emp loyment growth. F

In states that expanded Medicaid eligibility as well as states that did not, Asian Americans experienced greater gains in health insurance coverage compared to whites.

Percent of adults ages 19–64 who were uninsured



Data: Commonwealth Fund analysis of the American Community Survey (2010–2018).

The Commonwealth Fund

Munira Z. Gunja et al., *Gap Closed: The Affordable Care Act's Impact on Asian Americans' Health Coverage* (Commonwealth Fund, July 2020).

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In Me icaid expansion states as well as nonexpansion states, Asian A d larger F coverage gains comp red to whites in both relative and absolute terms. As a result, the coverage disparity between the two groups has been eli nated across both groups of states. Still, whites and Asian A me ans in states that haven't expanded Me dicaid uninsured at higher rates than those in states that have expanded.

Policy I mp lications F

he ffordable Care ct's coverage ex ansions have i ved health insurance coverage for Asian Americans and all racial and ethnic groups. However, notable disparities remain, particularly a mola ngaBinoks, Lative A atives, and Native Alaska N Hawaiians/Pacific Islanders. Asian American adults entered 2010 with relatively low uninsured rates — the second-lowest behind whites. Benefiting from the ACA's coverage expansions, by 2018 Asian Americans had the lowest uninsured rate of any racial or ethnic group. However, the coverage disruptions from COVID-19 ffect coverage in this co nity, the une mp loy rate for Asian Americans soared to 15 percent in y iti, over half of M nority-owned mi businesses are owned by Asian A an ich ma put this group at increased risk of losing their businesses and coverage in the pandemic-driven recession.

The Asian A r can progress has been driven by gains across both public and private insurance plans, with nearly identical coverage i rovem in Me a dic id expansion and n nexpansion states (although uninsured rates are mu ch higher in nonexpansion states a ng all groups, mo including Asian Ame a ric ns). Even though the coverage gap between white and Asian A me ri an adults has been eli ated since the ACA, coverage gains vary a ng the no o us distinct Asian A an subpopulations, and ma icans Asian A thout health insurance r coverage.

Coverage gains for all Americans have generally stalled since 2016 for four distinct reasons:

- Lack of Me dicaid expansion in 14 states.
- Affordability barriers in private insurance and particularly for people whose income xceeds the eligibility threshold for marketplace subsidies (400% of poverty).
- Congressional and executive branch actions, including immigration policies that have reduced enrollment in both Medicaid and marketplace plans.
- The fact that undocu n d i mmi ts are ineligible for d Me coverage; or an estimated 1.7 million Asian A ricans are undocumented.

With Black, Latino, and other communities still facing significant gaps, there are nu me r us policy options for covering o me re ple with health insurance coverage:

Expand Me dicaid in nonexpansion states. Research shows that 81 percent of Asian A n derly adults me currently live in states that have expanded i o nt of the overall Me d caid, co adult population, mei than these co i ies have disproportionately benefited from this key ACA coverage provision. In contrast, only 54 percent of Black adults live in these states, which has limited the equity effects of the ACA for the Black community.

The expansion of Me dicaid in additional states without barriers such as work requirements could i mpro ve coverage even more, as would congressional proposals that seek to eli mi nate the Me dicaid expansion gap with federal solution. This is particularly true in states with substantial

si n me n (mi d Bl ck) popul tions such s Tex s Florid nd Georgi . T rgeted Medicaid expansions to include undocumented populations, such as California's recent legislation, also could have a dramatic impact for Asian Americans in certain states.

Extend and enhance marketplace subsidies. Premium contributions for marketplace are capped at 2.1 percent to 9.78 percent of income for people between 100 percent and 400 percent of poverty ($26,200 to $104,800 for a family of four in 2020). However, affordability continues to be the most often-cited reason why people don't enroll in coverage through the marketplaces. Those who earn above 400 percent of poverty are not eligible for tax credits and may spend well beyond 9.78 percent of their income on premiums. Extending the upper income limit beyond 400 percent of poverty and enhancing subsidies for those under 400 percent of poverty would provide relief to people who find their coverage unaffordable.

Provide funding and support for community-based outreach and marketplace navigation assistance in all states. Previous research has found that investing in effective community-based outreach and navigation efforts with cultural and language-specific strategies likely increases enrollment in Medicaid and the ACA marketplaces. The Trump administration has drastically reduced funding for navigators and advertising since 2017, potentially limiting the reach of these groups to enroll underrepresented populations. If funding continues to be limited, state policymakers could fund local groups that serve Asian Americans and other targeted racial and ethnic communities.

Continue to collect and analyze Asian American subpopulation data. Section 4302 of the ACA requires federal data collection efforts to collect information on race, ethnicity, and other demographics, with the aim of reducing U.S. health disparities. Our analysis shows that there is significant heterogeneity in insurance coverage rates among different subgroups within the broader Asian American population. Collecting and analyzing subpopulation data has been noted as an important goal in the past and continues to be critically important to inform policymaking.

H W WE NDU TED THIS STUDY

This study uses 2010–2018 data from the American Community Survey (ACS) to look at the percentage of uninsured adults ages 19–64.

The ACS is a large federal survey conducted by the U.S. Census Bureau that is used to track demographic characteristics of the U.S. population, including respondents' insurance coverage status and their primary type of health insurance coverage (for example, employer-based, Medicaid). The ACS samples approximately 3.5 million individuals each year, with annual response rates over 90 percent. The Census Bureau makes approximately two-thirds of ACS response records available to researchers in the Public Use Microdata Sample (ACS PUMS).

Analytical Approach

We stratified survey respondents by their self-reported race or ethnicity: white (non-Hispanic), Black (non-Hispanic), Hispanic (any race), Asian American, American Indian/Alaska Native, and Native Hawaiian or Pacific Islander. We also stratified by income categories and specific Asian American ethnicities: Indian, Chinese, Korean, Filipino, Vietnamese, and other. (Note: a small number of respondents self-identified as having multiple Asian ethnicities. These individuals are included in estimates for all Asian Americans, but are not included in exhibits that separate each ethnicity.) We calculated national rolling two-year averages for the uninsured rate from 2010–2011 to 2017–2018 to ensure sufficient sample size, stratified by race and ethnicity. We also calculated the average annual uninsured rate for Asian American and white adults from 2010–2011 to 2017–2018 across two categories of states:

- **The Medicaid expansion group included the 31 states that, along with the District of Columbia, had expanded their Medicaid programs under the ACA as of January 1, 2018.**
- **The nonexpansion group comprised the 19 states that had not expanded Medicaid as of January 1, 2018. Maine and Virginia are considered nonexpansion states in this analysis because they both implemented their Medicaid expansions in 2019.**

Reported values for expansion/nonexpansion categories are averages across survey respondents, not averages of state rates.

Estimates derived from the ACS PUMS were suppressed if unweighted cell counts had a relative standard error greater than 30 percent.

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Publication Details

Publication Date: July 21, 2020

Contact: Munira Z. Gunja, Senior Researcher, Health Care Coverage and Access, The Commonwealth Fund

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Editor: Maggie Van Dyke

Citation:
Munira Z. Gunja et al., *Gap Closed: The Affordable Care Act's Impact on Asian Americans' Health Coverage* (Commonwealth Fund, July 2020). https://doi.org/10.26099/3nfg-9r27

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NASHPA

States Confront Current and Future Insurance Coverage Challenges A as Pandemic Persists

July 21, 2020 / by Maureen Hensley-Quinn and Christina Cousart

State Medicaid, children's health insurance programs (CHIP) and health insurance marketplaces strive to prepare for an expected increase in the demand for their services as they navigate a world roiled by COVID-19, an economic downturn and ensuing budget A crises, and unpredictable federal relief efforts.

Officials are trying to gauge the effects on individuals' access to affordable health coverage as federal stimulus assistance, like the additional unemployment benefit, winds down. Adding to the uncertainty is how long the federal government will continue the public health emergency declaration, which allows states to employ many coverage flexibilities, particularly in Medicaid, to maintain individual coverage. Though they do not know when the public health emergency may end, state officials are already trying to prepare for it.

Background

Currently, there are two federal national emergency orders in place. On Jan. 31, 2020, US Department of Health and Human Services (HHS) Secretary Alex Azar declared a public health emergency and on March 13, 2020, President Trump signed an order proclaiming the COVID-19 pandemic a national emergency. The two declarations triggered a series of actions, including empowering HHS to temporarily waive or modify requirements for Medicaid, CHIP, and the Health Insurance Portability and Accountability Act (HIPAA). Together, these emergency authorities allow states to leverage Medicaid and CHIP Disaster Relief state plan amendments [https://www.nashp.org/state-medicaid-and-chip-strategies-to-protect-coAverage-during-covid-19/] to make changes to help consumers access and maintain coverage, including using Medicaid's presumptive eligibility to expedite enrollment and waive premium and copayment requirements for Medicaid and CHIP, critical for those with reduced incomes due to the pandemic.

#NASHPCONF20 Examines Medicaid and Marketplace Coverage Register today [https://www.nashp.org/events/nashpconf20/registration-fees/] .

The Role of Marketplaces in Re-Envisioning Commercial Health Insurance Post COVID-19 [https://www.nashp.org/events/nashpconf20/agenda/#toggle-id-4]

1:10-2:10 p.m. (ET) Tuesday, Aug. 18, 2020

Medicaid in an Era of Policy Unpredictability and Enrollment Shifts [https://www.nashp.org/events/nashpconf20/agenda/#toggle-id-12]

2:30-3:30 p.m. (ET) Wednesday, Aug. 19, 2020

Additionally, there have been federal aid laws passed with provisions to further protect individuals' coverage. For example, the Families First Coronavirus Relief Act [https://www.congress.gov/bill/116th-congress/house-bill/6201/text] (enacted March 18, 2020) provides an additional 6.2 percent in federal matching funds (FMAP) to state Medicaid programs that meet the law's maintenance of effort criteria, which includes not disenrolling anyone retroactive to March 18, 2020 through the public health emergency.

Due to the freeze on Medicaid disenrollments, state officials tell the National Academy for State Health Policy (NASHP) that their programs are serving more individuals than this time last year. However, even with enrollment simplifications, many states report they have not had big increases in Medicaid or CHIP enrollees. There are exceptions, Washington State officials report significant increases in Medicaid enrollment since March. Kentucky has also experienced steady new Medicaid enrollment, with state officials reporting "hundreds of thousands" of newly enrolled individuals. But many more state Medicaid and CHIP programs have been trying to prepare for an increased enrollment that has not yet materialized. States have faced the challenge of requesting that state funds be made available before they are needed during a state budget crisis in order to meet the anticipated demand.

The delay in Medicaid enrollment has surprised many state officials and national stakeholders. There continues to be massive job losses that threaten the availability of employer-sponsored insurance (ESI) – the source of health insurance for the majority of Americans. Without regular income, many may be unable to afford coverage on their own. However, some of these employees may qualify for coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), which allows former employees to purchase A

coverage un er the health plan offere by their former employers for up to 36 months. Federal law requires that COBRA must be offered by business with 20 or more employees. Most states require smaller employers to also offer continuation coverage, including COBRA-like policies, in Arizona, Maryland, Massachusetts, Minnesota, New York, Rhode Island, South Dakota, Tennessee, Texas, and Vermont.

What Happens when COBRA Ends?

Recent Department of Labor guidance [https://www.dol.gov/newsroom/releases/ebsa/ebsa20200428] extends the period during which employees may elect COBRA (normally limited to 60 days after they receive their notice of COBRA eligibility), giving individuals up to 60 days after the end of the current national emergency to elect COBRA coverage. The guidance also allows for deferral of COBRA premium payments during the national emergency – however individuals are required to pay back deferred premiums once the emergency ends. These delays in coverage election and payment periods offer consumers greater flexibility in choosing COBRA coverage, but may also strain employer resources and disrupt employer markets as employers grapple with other challenges brought on by the pandemic.

It is also unclear if COBRA would be affordable for most eligible employees. While some employers may offer to pay all or some of a former employee's COBRA expenses, in most cases employees are required to bear the full brunt of the cost of these plans. With average premiums costs [https://www.kff.org/other/state-indicator/single-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22%3A%22Total%20Annual%20Premium%22% exceeding $500 per month, this may be an untenable expense for newly unemployed individuals. However, federal aid laws and emergency declarations extended support for maintaining commercial – including employer-sponsored insurance – as well. For example, many of the commercial insurance requirements [https://www.nashp.org/new-state-insurance-requirements-in-response-to-covid-19/] put in place (e.g., extension of grace periods) by state agencies are also tied to the declared national emergency and are set to sunset within a given period (usually 30 days) after the emergency ends.

As a result, officials suspect that some individuals and families are still enrolled in their commercial health insurance plans, benefiting from protections like the premium grace period, that allows them to sustain coverage even if they cannot pay. This is a temporary solution and unfortunately, many may find themselves seeking alternative health coverage options when the period of protection ends. Under the Affordable Care Act, A

individuals and amilies who may not be eligible or Medicaid, may success ully find coverage through the health insurance marketplaces.

Will Marketplaces Become the Safety Net?

State-based marketplaces (SBMs) have also been changing enrollment policies, preparing for and experiencing new enrollment. For example, many SBMs created new special enrollment periods (SEPs) [https://www.nashp.org/thousands-flock-to-health-insurance-marketplaces-as-coverage-shifts-due-to-covid-19/] to ensure that uninsured individuals who did not enroll during the traditional annual open enrollment period have access to advanced premium tax credits (APTC) – if eligible – and enroll in a marketplace plan. Some SBM officials have reported substantial enrollment hikes – from thousands to hundreds of thousands of new enrollees – which highlights the important role marketplaces are playing as millions of individuals and families experience job losses and income fluctuations. This coverage is filling the gap between employer-sponsored and Medicaid coverage.

One reason individuals and families could be maintaining their employer-sponsored coverage through COBRA or qualifying for APTC, rather than seeking Medicaid coverage, is the "bonus" unemployment income made available under the Coronavirus Aid, Relief, and Economic Security Act [https://www.nashp.org/cares-act-funds-help-consumers-but-create-health-coverage-eligibility-challenges-for-states/] (CARES Act [https://www.congress.gov/bill/116th-congress/house-bill/748?q=%7B%22search%22%3A%5B%22hr+748%22%5D%7D&s=1&r=1]). The additional $600 per week in unemployment payments must be treated differently when determining eligibility for Medicaid versus APTCs, which presented a significant challenge for eligibility systems. However, that bonus income is only available through July 31, 2020, at which point individuals may not be able to afford COBRA and may seek marketplace coverage, some already enrolled in a QHP may become eligible for an increased APTC, and others may be eligible for Medicaid depending their circumstances.

- Another new federal aid program, the Paycheck Protection Program (PPP), established to provide loans to small businesses that can be used to pay for payroll costs, including health benefits of workers, may be helping to keep individuals on their ESI A as well. Businesses that receive these loans are eligible for loan forgiveness if they meet certain requirements including:
- Retention of the same number of full-time equivalent (FTE) employees that they had prior to onset of the pandemic (if FTEs were reduced prior to receipt of the loan they A

must be reh red dur ng the loan per od to meet th s requ rement);

- That 60 percent of PPP funds are used to cover payroll expenses. PPP loans can be used to cover either an 8- or 24-week period extending no later than Dec. 31, 2020.

However, a recent estimate released by the Congressional Budget Office [https://www.cbo.gov/system/files/2020-06/56376-GDP.pdf] projected that it may take nearly a decade for the US economy to recover from the economic fallout of this pandemic. These PPP requirements are only short-term fixes and without sustained support or success in curbing new COVID-19 cases, these businesses may not be able to sustain their employees' ESI for long. The end result may again be more individuals and families seeking publicly subsidized coverage.

An Uncertain Future

As states try to anticipate the needs of their residents, there is much that cannot be predicted about individuals' and families' finances given the employment fluctuations, which in turn impact their access to affordable coverage options. Today, all focus is on whether the HHS Secretary will extend the public health emergency declaration beyond July 25, 2020 when it is currently scheduled to expire. Administration officials have indicated support for extending the declaration and state leaders have expressed why an extension [https://www.nga.org/news/press-releases/governors-call-on-the-administration-to-renew-the-public-health-emergency/] is needed.

Even if the public health emergency is extended, there are mounting questions about whether or how states should relax any changes put in place under the emergency period. State officials also question the federal government's expectation that state systems rapidly revert back to prior policies. While these measures were always intended to be temporary, when these policies are terminated at the end of the national emergency, thousands could face more restrictive coverage and higher cost-sharing policies at a time of economic uncertainty brought about by the pandemic.

The Centers for Medicare & Medicaid Services has provided states with some information about how to retain some of the Medicaid [https://www.medicaid.gov/state-resource-center/downloads/allstatecall-20200616.pdf] and CHIP [https://www.medicaid.gov/state-resource-center/downloads/allstatecall-20200623.pdf] flexibilities, but additional guidance is needed to assist states, particularly related to eligibility determinations. For example, when the requirement to freeze Medicaid disenrollments ends, states will need to begin conducting eligibility redeterminations again. States are estimating thousands of A

individuals urrently enrolled in Medi aid ould lose their overage. This would be potentially problematic for:

- Consumers who could lose coverage;
- Providers whose patients could not pay for care; and
- States whose increasingly limited resources resulting from furloughs and layoffs due to the budget crisis would generate serious administrative burdens.

Many questions remain about how to best handle consumers who may be at risk of losing coverage once the public health emergency ends.

As COVID-19 cases continue to rise in the United States, now more than ever it is important for individuals to have a secure source of health care coverage. States are working diligently to get people the access to health coverage and resources needed in immediate response to the pandemic. However, states are also looking ahead, and bracing for the future when federal programs and deadlines end, yet residents' need for insurance coverage persists.

NASHP will continue to track states' efforts as they continue to modify their coverage programs in response to the ongoing pandemic. A

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REPORT Public Health

A Comparative Analysis of Policy Approaches to COVID-19 Around the World, with Recommendations for U.S. Lawmakers

July 20, 2020 Over an hour read

Authors:
Kevin Dayaratna, Patrick Tyrrell and Andrew Vanderplas

SUMMARY

Since COVID-19 became a global pandemic in March 2020, countries around the world have taken various approaches to contain the proliferation of the virus. Three Heritage Foundation analysts examine the approaches of 10 countries with differing levels of economic freedom. These countries have taken vastly different approaches with varying degrees of success. This research finds that full lockdowns, such as those implemented in the United States and Italy, are not as effective as the more targeted approaches taken in other countries, such as South Korea and Iceland. The authors conclude their analysis with a number of recommendations for lawmakers in the United States.

KEY TAKEAWAYS

Lives and livelihoods are not competing priorities; policymakers should focus efforts on fighting localized outbreaks, while executing a comprehensive strategy.

Countries around the world have taken different approaches, with varying success, to manage COVID-19, some with strict lockdowns and others with targeted measures.

Sweeping lockdown orders did not result in better outcomes than more targeted measures, such as isolation of the sick, mass testing, and contact tracing.

The spread of COVID-19, the disease caused by the new SARS-CoV-2 coronavirus, became a serious concern worldwide in March 2020, when on March 11, the World Health Organization (WHO) designated COVID-19 to be a pandemic.[1]

Now present in more than 200 countries, having infected more than 13 million people—with the Johns Hopkins Coronavirus Resource Center now reporting that over 570,000 of those coronavirus cases have ended in death—the epidemic has become the top priority of policymakers all across the globe.[2]

Given that it will take time to develop a vaccine for this novel virus, and that many experts believe that the virus is still in the early stages of its progression, it is important to examine different policy approaches to combatting the epidemic. This Special Report examines the various approaches different countries have taken, as well as approaches here in the United States. The Special Report elucidates which policies have been successful so far and could potentially be adapted in other countries to save as many lives and livelihoods as possible.

Naturally, various countries began their experience with COVID-19 at slightly different times, and many varying demographic, medical, and geographic factors have affected the proliferation of the virus in different countries. Italy, for example, has a greater portion of elderly citizens than other countries, and Iceland has a much younger population. In the United States, large segments of the population suffer from pre-existing conditions, such as diabetes and obesity, both of which are linked to significantly higher rates of COVID-19 deaths than for those without comorbidities. The United States leads the world in obesity at about 33 percent of the population, while in Sweden the number is around 12 percent. Separately, some countries have a greater population in urban centers versus rural areas, facilitating greater spread of the virus.[3]

While these many differences make it difficult to isolate single policies as the sole cause of varying outcomes in different countries, these comparisons are necessary to determine which factors to control for and, ultimately, which policies work best. This Special Report begins with a discussion of the situation here in the United States, and continues with a discussion of the circumstances and approaches in several other countries with varying levels of economic freedom as identified in The Heritage Foundation's Index of Economic Freedom.[4]

This Special Report concludes with several recommendations for U.S. policymakers to improve outcomes related to the COVID-19 pandemic.

U.S. Analysis

The United States has a population of more than 329 million people. The first reported case of COVID-19 in the United States was on January 21, 2020, in Washington State,[5]

although—as is the case in other countries—the first actual case may never be pinpointed, and the virus is now known to have been circulating before this day.[6]

Cases and deaths quickly grew during the first few months of the year.[7]

As of June 27, 2020, there have been 2,467,837 confirmed COVID-19 cases (0.75 percent of the U.S. population) and 125,039 deaths attributed to the disease (about 5 percent of the confirmed cases, and 0.04 percent of the U.S. population).[8]

Although all 50 states have reported cases of COVID-19, the distribution has been much more heavily concentrated in some places than in others, as Maps 1-4 illustrate.

As depicted in Maps 2 and 4, as of June 4, 2020, the outbreak was predominant in a few hot spots—chiefly the densely populated areas of New York City and its surroundings along with

nearby New Jersey.[9]

The nearby New England states—Massachusetts, Rhode Island, and Connecticut—and areas down to Washington DC, have also been hit hard by the virus.[10]

The Mardi Gras festival in New Orleans in February contributed to Louisiana being the sixth-most COVID-19-infected state by number of cases per one million people (as of June 28, 2020).[11]

Delaware, Illinois, Maryland, Arizona, and Nebraska had the seventh-most through 11th-most COVID-19 cases per million people among the 50 states (as of June 28).[12]

President Donald Trump issued a ban on travelers from China to the U.S. on January 31, 2020 —29 days before the first known U.S. death was to be documented.[13]

Travelers from Iran were banned on February 29.[14]

When the WHO declared COVID-19 a worldwide pandemic on March 11, President Trump imposed further travel restrictions, halting travel from mainland Europe, and on March 16 from the U.K. and Ireland as well.[15]

The White House Coronavirus Task Force, federal agencies, state governments, and local governments across the country have worked together planning how to flatten the curve of COVID-19 cases. During this time, a legion of health care workers, the Armed Forces, first responders, the U.S. Army Corps of Engineers, and other Americans have been caring for the

afflicted, building and providing facilities, such as temporary hospitals, and handling logistics to fight the disease.[16]

Social distancing, mask wearing, stay-at-home orders, and business-closure regulations have varied over time and from state to state during the pandemic, with some of the strictest orders taking place in California, Michigan, and Washington State.[17]

Michigan's governor recently faced a public backlash for what many residents saw as draconian orders, including that all public and private gatherings of any size be banned, and that visiting a friend's or relative's home other than to provide care for them or their pets was not allowed.[18]

Several sheriffs in Michigan and Washington State announced that they would not enforce their governors' stay-at-home orders.[19]

Some states have imposed travel restrictions as well. For example, the State of Florida required incoming travelers from certain COVID-19 hotspots to self-quarantine for 14 days or until they left the state.[20]

Also, while Florida required COVID-19 screening for staff at long-term care facilities to protect elderly residents, New York State, New Jersey, and Michigan initially required hospitals to return all COVID-19 patients from nursing homes to the facilities from which they came.[21]

The trajectory of COVID-19 cases and deaths have varied from state to state and from city to city, with the largest death counts thus far mounting in New York and New Jersey, as well as Massachusetts, Illinois, Pennsylvania, Michigan, Connecticut, California, and Florida,[22]

whereas Wyoming and Alaska have experienced 14 and 20 deaths, respectively (as of June 28), since the pandemic began.[23]

Americans, in many regards, have cooperated well and voluntarily followed social-distancing guidelines and other measures intended to mitigate the proliferation of COVID-19. For instance, a report from the Centers for Disease Control and Prevention that looked at four U.S. metropolitan areas from February 26 to April 1 found that in each area people were already increasingly limiting their movements outside their homes before their state or local government issued a stay-at-home order.[24]

As of May 4, 2020, the daily number of deaths, new cases, and COVID-19-related hospitalizations in New York City, as well as many other areas of the country, were falling.[25]

While any loss of life is truly devastating, the conscientious efforts of millions of Americans engaging in better hygiene practices and adherence to social-distancing guidelines have prevented additional deaths than would have otherwise occurred over that same period of time.[26]

On April 16, President Trump announced guidelines to re-open the economy, which encouraged states to make data-based decisions for opening segments of their economies in

three phases.[27]

Georgia was the first state to announce plans to enter phase one, and did so on April 24, relaxing its stay-at-home orders while allowing some kinds of businesses to re-open. Oklahoma and Alaska joined Georgia in loosening their restrictions that same day, with Tennessee, Mississippi, and Montana following a few days later. By May 18, most states had partially re-opened their economies and had set dates to open them further.[28]

The battle against the coronavirus in the U.S. is far from over, and policymakers should focus their efforts on fighting localized outbreaks, while continuing to execute a comprehensive strategy that makes good use of finite local and federal resources. As the National Coronavirus Recovery Commission has recommended, "governors and local leaders should work with their local private-sector institutions (including businesses and core representatives of civil society like churches and community organizations) to take the lead on restarting economic and core social activities, and they should do so as quickly as possible."[29]

International Analysis

In the subsequent sections, we discuss the management and the outcomes of COVID-19 in other countries. Table 1 provides a list of several basic COVID-19-related statistics for the countries examined in this Special Report.

Tables 2 and 3 and Chart 1 depict the differences amongst the various countries in confirmed cases and deaths of the countries considered in this study.

As Chart 1 shows, the United States has the most confirmed COVID-19 cases as a percentage of its population of the countries considered in this report. Sweden has the second-largest percentage, followed by Iceland, Italy, Germany, Norway, Australia, South Korea, and New Zealand, respectively. (China and Iran are known to have suffered a significant number of cases and deaths, but reliable statistics are not available for those two countries.) Regarding deaths, however, the story is quite different. Of the countries considered here, Italy has the most deaths as a percentage of its population, followed by Sweden, the United States, Germany, Norway, Iceland, South Korea, New Zealand, and Australia. Note, however, that none of these countries exceeds 0.8 percent of its population in terms of confirmed cases, and none exceeds 0.1 percent of its population in terms of deaths.

In the following sections we discuss the different approaches these countries have taken to combat the spread of the virus.

Italy. Italy, which ranks as "moderately free" in The Heritage Foundation's Index of Economic Freedom,[30]

has a population of slightly more than 60 million people. Parts of the country have been hit particularly hard by COVID-19. One reason appears to be that Italy has an older population than the rest of the countries in this study, with more than 23 percent of the population above the age of 65—1.6 percent percentage points above Germany, the country in this study with the second-oldest population. Italy's first COVID-19 case was on January 31 from a couple visiting Rome, and afterwards the virus quickly spread throughout the country.[31]

As of June 27, 2020, the country has 239,961 cases and more than 34,708 deaths (0.4 percent and 0.06 percent of the population, respectively).[32]

Italy has 20 distinct regions. The virus is present throughout the country and is now most heavily prevalent in the regions of Lombardy, Emilia Romagna, and Piedmont, the three of which together comprise over 60 percent of the country's cases. The region of Lombardy, where the first case occurred, as of June 23 carries 93,173 cases (39 percent of the country's cases) and 16,579 deaths (47 percent of the country's deaths)—the most of all of Italian regions.[33]

Early on, the region focused only on testing symptomatic cases. On February 23, 2020, after the virus had proliferated significantly, the Italian government implemented "red zones" in 11 municipalities within the Lombardy region that had at least one COVID-19 case, permitting people to exit their homes only for essential activities, such as going to the grocery store or pharmacy. Cases and deaths, however, continued to grow, and, two weeks later, on March 8, 2020, the entire region of Lombardy, as well as five additional regions, implemented similar lockdown measures.[34]

Two days later, Prime Minister Giuseppe Conte announced a nationwide lockdown.[35]

Seven days later, the country issued quarantine orders requiring all people entering the country to self-quarantine for 14 days either at home or in a hotel.[36]

Despite the nationwide lockdown, some regions within Italy handled the virus in a markedly different manner from the approach taken in Lombardy. For example, the neighboring northern region of Veneto pursued widespread testing of symptomatic and asymptomatic cases early on during the pandemic. The region also engaged in proactively tracing contacts and other potential positive cases. If a particular individual tested positive for COVID-19, then everyone in the associated household as well as all neighbors were tested, or self-quarantined if testing kits were unavailable. The region also strongly emphasized at-home care, and whenever possible, samples were collected from a patient's home before being sent to local labs.[37]

The small town of Vo within Veneto tested all 3,000 of its inhabitants, 3 percent of whom were deemed to have the virus. All of those testing positive were quarantined, and the epidemic was extinguished from the region quickly thereafter.[38]

The differences between the approaches and outcomes in Lombardy and Veneto are profound. As Chart 2 illustrates, Lombardy has more than double the number of cases on a per capita basis than Veneto, with four times the number of deaths.[39]

In Lombardy, the hospital system had become overwhelmed, with doctors lamenting that they were not able to provide adequate care to patients.[40]

Two other regions of Italy—Emilia Romagna and Tuscany—followed Veneto's approach to implement more aggressive testing. Both regions have noted significantly fewer cases and deaths on per capita basis than Lombardy, as Chart 2 illustrates.[41]

Although the cases and deaths in Italy have declined substantially, the country is still consistently reporting new cases and deaths. In particular, from June 1 to June 27, fewer than 600 new cases have been reported per day and fewer than 90 people have died per day as a result of COVID-19.[42]

As of April 24, the country had begun to ease its lockdown restrictions, and, as of June 3, the country began to ease travel restrictions as well.[43]

Throughout the spring, the Italian government sought the implementation of a smartphone app to track movements of COVID-19 carriers to aid with contact tracing. Many Italians appear to be setting aside privacy concerns, however, and the app, called Immuni, was released in June 2020 and had more than two million downloads in the first 10 days of its release.[44]

South Korea. South Korea has a population of 51 million inhabitants and ranks "mostly free" in The Heritage Foundation's Index of Economic Freedom.[45]

Given the country's geographic location, it has a significant amount of interaction with China both economically and politically.[46]

In fact, China is the country's number one trade partner.[47]

South Korea confirmed its first case of COVID-19 on January 20, 2020.[48]

On March 21, the South Korean government implemented a strict social-distancing policy and banned religious and sporting events. The beginning of the school year, which typically starts in March, was repeatedly postponed.[49]

Despite these policies, COVID-19 cases grew in the ensuing weeks, and as of June 27, there were 12,653 confirmed cases and 282 deaths, less than 0.03 percent and 0.0006 percent of the

country's population, respectively.[50]

All people arriving in South Korea from abroad are required to quarantine for 14 days upon arrival, either at their own local residence or, if they do not have one, a government-designated isolation center, and are required to download a contact-tracing app on their smartphone.[51]

After the outbreak of Middle East Respiratory Syndrome (MERS) in South Korea in 2015, the South Korean government implemented a number of reforms to enable the country to handle disease outbreaks better. In fact, just one week after the country's first official COVID-19 case, South Korean medical officials met with representatives from a number of private medical companies to develop and rapidly expand testing capability. As a result, within weeks of the outbreak in China, four Korean companies had manufactured tests based on recommendations from the WHO, and Korea was able to issue more than 90 times as many tests on a per capita basis than the United States did during the week of March 8, 2020.[52]

Given that over 35 people died in Korea during the MERS outbreak of 2015, both public and private officials had a vested interest in developing and approving high-quality tests.[53]

In South Korea, people are advised to call a national public health hotline when they first show symptoms of COVID-19. Hotline staffers assess symptoms and decide if the patient is suspected of infection. Those suspected of being infected are directed to a COVID-19 testing site. Those who test positive are treated in an isolated setting—either in a hospital or a

government-sponsored isolation center, depending on severity and location—to stop further infection.[54]

This approach has allowed many of South Korea's retail shops, restaurants, and businesses to remain open during the crisis, with significant precautions and closures in certain areas deemed necessary.[55]

Private entities, such as hotels, offices, and large organizations, use thermal cameras to identify people with fevers. Restaurants check people's temperatures before admitting them.[56]

Additionally, South Korea also engages in detailed contact tracing. If an individual tests positive for COVID-19, government health authorities use phone records, car-GPS records, bank transactions, credit card records, and CCTV footage to trace their paths, identify contacts, and advise them to get tested.[57]

Smartphone apps are available that have the ability to warn users if they are within a particular vicinity of areas where people who tested positive for COVID-19 have been.[58]

Public officials also actively disinfect areas where the virus is suspected to have spread.[59]

Authorities send regional text alerts, notifying people living near others who have tested positive for COVID-19. Although names are not shared in these text messages, they do

contain a link to a website containing information about the person's age group and places he or she recently visited.[60]

This approach is consistent with long-used manual contact tracing. Regardless, some have argued that the use of technology to engage in contact tracing results in an overly intrusive approach that risks invasion of privacy.[61]

In May, South Korea experienced a small resurgence in cases in Seoul, and as a result, bars and clubs in the capital were temporarily shut down.[62]

Over 200 schools were also closed shortly after re-opening, given the increase in cases.[63]

Regardless, South Korea's measures are curbing the spread of COVID-19 better than the measures of many other countries. Specifically, in May and June, the number of daily new cases declined to fewer than 80. (In February and March, the country sometimes incurred more than 500 new cases per day.) Additionally, since June, the country has incurred fewer than two COVID-19 deaths per day.[64]

Iceland. With 364,000 inhabitants, Iceland has the smallest population of all the countries examined here and ranks "mostly free" in The Heritage Foundation's Index of Economic Freedom.[65]

Iceland did not impose a nationwide lockdown and, like in South Korea, many shops and businesses remained open, with the exception of those in the Húnaþing Vestra municipality.[66]

The country did, however, prohibit gatherings of more than 20 people, and closed secondary schools as well as universities.[67]

Citizens were also asked to engage in social distancing of two meters.[68]

The country had its first COVID-19 case on February 29, 2020, and as of June 27, the country had a total of 1,832 cases and ten deaths, less than 0.54 percent and 0.003 percent of the nation's population, respectively.[69]

From March 20 on, entry was prohibited for non-essential travelers from outside the European Union, the European Economic Area, the European Free Trade Association, and the United Kingdom, and as of April 24, the Icelandic government has required that those arriving into the country from abroad be quarantined for 14 days.[70]

Two big factors that differentiate Iceland from other countries are its massive testing and the fact that its authorities engage in strict digital contact tracing via an app called Rkning C-19. Once downloaded, the app garners data from other phones in the area that make it easier to trace contacts of those infected.[71]

Iceland's COVID-19 contact-tracing team uses data from the app as well as manual methods to determine who might have come in contact with COVID-19-positive individuals.[72]

As of April 25, 2020, Iceland had tested more than 10 percent of its population for the virus, far more than other countries.[73]

Working with the Icelandic biopharmaceutical company deCODE genetics, Iceland has engaged in large-scale testing to understand the prevalence of COVID-19 amongst various demographics throughout its society. The process has found some very interesting results, including that about 50 percent of COVID-19 positive people in Iceland were asymptomatic at the time of testing, and that there are at least 40 different mutations of the coronavirus.[74]

A recent study published in the New England Journal of Medicine indicates that the measures the Icelandic government took may have contained the virus.[75]

Iceland appears to be turning the corner with fewer than six new cases a day since May 1 (as of June 27, 2020), a 90 percent drop since late March. During the entire pandemic there have been 10 deaths as of June 27, 2020 (less than 0.03 percent of the entire country's population) due to COVID-19, with the most recent death occurring on April 20, 2020.[76]

As of June 15, the country began to ease COVID-19-related restrictions, including for tourists, and test visitors for COVID-19 upon arrival.[77]

Australia. Australia has a population of about 25.2 million people and ranks "free" in The Heritage Foundation's Index of Economic Freedom.[78]

The country had its first confirmed case of COVID-19 in late January 2020.[79]

As of June 27, 2020, there have been 7,595 confirmed COVID-19 cases (about 0.03 percent of Australia's population), and 104 deaths attributed to the disease (0.0004 percent of the population).[80]

State and territorial governments in Australia work with the Australian government, sharing information and moving resources where they need to go in order to treat the afflicted and mitigate the spread of the disease. On January 29, with the number of confirmed cases at about 10 people, Australia began quarantining all passengers arriving from China's Hubei province for 14 days upon their arrival in Australia in cooperating hotels. Beginning on February 1, all non-Australians who had been in mainland China since February 1 were not allowed to enter Australia.[81]

On March 20, Australia closed its borders. Only Australian citizens, legal residents, and immediate family members could travel to Australia, and must quarantine for 14 days within a government-approved facility. A number of hotels across Australia agreed to provide the appropriate facilities, and quarantine requirements are managed by state and territory governments with Australian government support.[82]

The Australian government released a coronavirus-tracking cellphone app called CovidSafe on April 26, which only lets the government track those who voluntarily download and install it. Although downloading and using CovidSafe is voluntary, on May 1, Prime Minister Scott Morrison said that federal social-distancing restrictions will not be fully removed until enough Australians download CovidSafe.[83]

The app uses Bluetooth signals to log if two people have been in close proximity to each other if someone tests positive for COVID-19; health officials are able to track the infected person's past history and find who else should be tested. Many have voiced privacy concerns although using the app is voluntary, arguing that the technology used has the potential to be misused by government in the future and asking for its source code to be formally made inaccessible to law enforcement.[84]

Initial interest in CovidSafe soared, with over 2 million voluntary downloads occurring within the first few hours of its launch.[85]

The approach of the Australian government has been to respect the freedom of the people in the country more so than in many other countries, including neighboring New Zealand.[86]

Policies and measures used to mitigate the virus have varied by state or locality within Australia, but all of Australia's states and internal territories have had social-distancing restrictions in place at some level during the pandemic.[87]

The Australian government has encouraged schools to remain open for in-person classes as much as possible, although the decision to stay open or not is made locally and has varied a great deal within Australia.[88]

Restaurants and bars have been open for takeout, allowing many restaurant workers to keep their jobs. Important industries, such as construction and mining, have been allowed to continue operating, and as a result many businesses and jobs that would have been lost in a more severe economic lockdown continue to exist. By May 1, 2020, the number of new cases in Australia was holding relatively steady at around 15 new cases per day, which was down from a high of 468 on March 28.[89]

The end of June saw a slight uptick in the number of daily new cases, with 53 on June 28, the highest number since April 17.[90]

New Zealand. New Zealand has a population of about 4.9 million people and ranks "free" in The Heritage Foundation's Index of Economic Freedom.[91]

New Zealand had its first confirmed case of COVID-19 on February 28, 2020.[92]

As of June 27, 2020, there have been 1,172 confirmed COVID-19 cases (about 0.02 percent of the New Zealand population), and 22 deaths attributed the disease (0.0005 percent of the New Zealand population).[93]

On March 28, when the number of confirmed cases was 102, New Zealand began its strictest alert level, which is COVID-19 Alert Level 4. The country remained at Level 4 through April 27, lowering its alert level to Level 3 that day. Both Levels 3 and 4 highly restrict New Zealanders' economic freedom and travel. During this time foreigners have not been allowed to enter New Zealand. Citizens returning to New Zealand must remain isolated in a government-approved facility for 14 days. Those experiencing COVID-19 symptoms are sent to separate isolation centers. On March 29, New Zealand had its first known COVID-19-related death.[94]

The New Zealand Ministry of Health released a digital contact-tracing app called NZ COVID Tracer earlier this year. As of June 16, 2020, more than 558,000 people have downloaded the app. To enable people to use the app, businesses and organizations are provided with an official quick response (QR) code. People who enter or exit the premises of these companies are encouraged to scan the building's QR code to develop a log of their travels. Users can also sign up to receive alerts when a person with COVID-19 has been in the same location as they have. Users who are recognized as having a confirmed or likely case of COVID-19 are encouraged to disclose their check-ins with the Ministry of Health to assist contact tracers in identifying others who might potentially be infected.[95]

Daily new cases and deaths have declined in recent weeks in New Zealand, with new cases falling to single digits and no reported deaths in June (through June 27).[96]

However, New Zealand's period of lockdown enacted a heavy toll on its economy. Its strong fiscal position and government budget surpluses it has had in recent years have helped it to pay out billions of dollars in temporary wage subsidies to prevent mass unemployment, and over half the nation's workforce relied on government transfers during the lockdown.[97]

However, businesses in New Zealand are now in a precarious situation. Greg Harford, of Retail NZ, an advocate for retailers, explained it this way recently to a New Zealand

newspaper:

Sales across the sector have collapsed and, even online trading, which has been permitted since last Monday, is not delivering sales that will allow retailers to recover from the economic carnage of the last few weeks…. The Covid-19 restrictions will mean that the survival of many retail businesses is on a knife-edge. The wage subsidy has effectively kept many people employed in retail, but it is likely that we will see a wave of redundancies across the sector when that subsidy runs out.[98]

New Zealand had been on Alert Level 1 since June 8. At Alert Level 1, New Zealanders can return to work and school, play sports and engage in domestic travel without restrictions, and can gather in groups with no size limitations. The borders of New Zealand remain closed to almost all travelers.[99]

China. China has a population of 1.4 billion people and ranks "mostly unfree" in The Heritage Foundation's Index of Economic Freedom.[100]

The first human cases of COVID-19 were in the Hubei province of China, in the city of Wuhan (population, about 9.8 million), in December 2019.[101]

Subsequent work has traced back the origin of the virus in humans to as early as November 17.[102]

As of June 28, 2020, there had been 84,745 official COVID-19 cases in China (about 0.006 percent of the population of China), and 4,641 officially reported deaths from the disease (about 0.0003 percent of the population of China).[103]

China first alerted the WHO of 41 cases of what are now known to have been COVID-19 on December 30, 2019,[104]

although the virus had been circulating for at least several weeks prior. On January 11, 2020, China had its first known COVID-19-related death.[105]

Then, on January 23,[106]

with the number of confirmed cases at 571[107]

(revised higher since), the city of Wuhan was placed under strict quarantine. The rest of the Hubei province entered quarantine days later.

Decisions made by the Chinese government indicate that it did not prioritize preventing the virus from spreading across its borders. As a result, international travelers from China would ultimately spread the coronavirus across the globe. In particular, Wuhan's former mayor stated that five million people left Wuhan before the lockdown there went into effect. The number of five million has been questioned by Derek Scissors, a China expert at the American Enterprise Institute,[108]

as that number is significantly higher than the number of people who left Wuhan in previous years during the period. Regardless, it is safe to say that millions traveled from Wuhan to other places in China, and tens of thousands to destinations outside China.[109]

After the quarantine of Hubei went into effect, domestic flights within China were greatly limited,[110]

but China complained when Italy, the U.S., and Australia banned flights from China.

As Bloomberg reports: "Vice Foreign Minister Qin Gang met with Italy's ambassador on Feb. 6 to protest the halt to flights, and the Foreign Ministry later said in a statement that China is 'strongly dissatisfied with the overreaction and restrictions of the Italian side.'"[111]

Rome was one of just three European cities that had direct flights from Wuhan before Italy halted them[112]

(the other two are Paris and London), and it has a large population of Chinese workers[113]

and others who would make their way from Wuhan to Italy before the flights were grounded on January 23.[114]

The lockdown on Wuhan was lifted on April 8.[115]

The Chinese communist government has a long history of human rights violations. It should therefore not come as a surprise to anyone that during the Wuhan quarantine, entire apartment buildings where the virus was thought to have been present were sometimes welded shut[116]

with families and pets inside them. Additionally, American journalists have been expelled[117]

from China for reporting on the authoritarian regime's suppression and cover-ups during its response to the virus, and Chinese citizens who said what the government did not want them to say have disappeared.[118]

Still others were censored, such as Dr. Li Wenliang, who was forced by Communist Party of China disciplinary officials to write a statement criticizing himself for spreading rumors because he spoke publicly about the existence of the virus in its early days. Dr. Li later became infected with COVID-19 from one of his patients, and subsequently died from the disease.[119]

China's COVID-19 statistics should be viewed cautiously due to the government's long-standing lack of transparency.[120]

In fact, one well-respected expert on China calculates that the Chinese government has underreported the number of COVID-19 cases outside of Hubei province by more than 2,900,000 cases—a factor of more than 100.[121]

If reported, the additional 2,900,000 cases would change the percentage of people in China who have had the virus from 0.006 percent of the population to 0.2 percent, which, if the case fatality ratio is the same as reported for Hubei province (6.62 percent as of June 28),[122]

would indicate that at least 191,980 more Chinese have died from the virus, which future historians will need to verify.

Iran. Iran, a country of 82.4 million people, ranks as repressed" in The Heritage Foundation's Index of Economic Freedom.[123]

The country reported its first two cases[124]

of COVID-19, and also the first two deaths from the disease, on February 19, 2020. By June 28, there were 222,669 reported cases (0.27 percent of Iran's population), and 10,508 deaths (0.013 percent of the people in Iran, and 4.7 percent of reported cases).[125]

Researchers have estimated, however, that Iran's government had probably underreported cases by 2 million cases as early as March 9 (roughly 2.4 percent of all of the people in Iran), and have argued that the undercount by that date may plausibly have been as many as 6.4 million cases (about 7.8 percent of Iranians).[126]

Initially, Iran's government downplayed and hid the extent of COVID-19's death and destruction; Iran's totalitarian rulers contributed to the virus spreading in the country because —as Heritage Foundation experts have explained—of their desire to, "project total control and invincibility, and to avoid damaging the regime's political, ideological, and economic interests."[127]

The representative of Iranian Supreme Leader Ayatollah Ali Khamenei in the city of Qom, for example, continued to urge pilgrims[128]

from around the world to flock to Qom's religious shrines, which many visitors believe have healing powers and have been known to lick the walls of, even though the Iranian regime already knew that Qom was the epicenter of the COVID-19 outbreak. In fact, two days after the government announced the first two deaths from COVID-19 on February 19, mass graves in Qom the size of a 100-yard football field could already be seen in satellite imagery.[129]

It was not until March 17, 2020,[130]

when the number of reported cases was 16,169[131]

(though the real number was probably much higher),[132]

that Iran's government changed course and shuttered the city of Qom's shrines, moved universities across Iran to online education, closed major shopping malls, shut down subway service in some cities, and took other measures to inhibit the spread of the disease.[133]

The Iranian regime regularly accuses[134]

the United States and Israel of bringing COVID-19 to Iran as an "ethnic weapon" targeting Iranians based on their genetics, and appears in its overall response to be at least as concerned with assigning false blame for the disease as in doing things to prevent it from continuing.

Norway. Norway has a population of approximately 5.4 million and ranks "mostly free" in The Heritage Foundation's Index of Economic Freedom.[135]

The country had its first confirmed COVID case on February 26, 2020, and as of June 27, has had 8,815 cases (0.16 percent of its population) and 249 deaths (0.0046 percent of its population), respectively.[136]

Norway enacted a country-wide lockdown on March 12, approximately two weeks after the first reported case (on February 26), when a Norwegian returned from China. Airports and

seaports were shut down to foreigners as of March 16. The lockdown includes the nationwide closure of schools, universities, restaurants, gyms, resorts, and cultural centers.[137]

The Norwegian government also enlisted Home Guard soldiers to help control the border with Finland and the inner and outer Schengen area.[138]

After February 27, all foreign arrivals were required to undergo a 14-day quarantine.[139]

The government reports that most confirmed cases during the early days of the outbreak within the country had been the result of Norwegians travelling abroad or those in close contact with travelers.[140]

About 60 percent of the country's cases are in the capital, Oslo, and neighboring Viken County as of June 27, 2020. Each of Norway's 11 counties has recorded at least 100 positive test results.[141]

On April 6, Health Minister Bent Høie declared the country has the virus under control and that "every person infected with the coronavirus most likely is now infecting 0.7 other people."[142]

Subsequently, Prime Minister Solberg began recommending that all citizens use an app, Smittestopp, to help trace cases and further quell the spread of the virus. By April 24, it was

reported that 1.4 million people had downloaded Smittestopp, despite serious concerns over data privacy in the tracing software.[143]

On June 12, however, Norway's data-protection agency announced that Smittestopp would be suspended due to the privacy questions and low numbers of active users. As of June 15, The Guardian reported that only 600,000 Norwegians out of the country's 5.4 million inhabitants were using the app.[144]

The Norwegian government enacted an economic stimulus (starting March 13) to fight the negative effects of COVID-19 and the shutdown measures.[145]

The stimulus includes compensation schemes for failing businesses, reductions in some taxes, and extensions for unemployment benefits.[146]

The stimulus is reported to be worth $10 billion, which equals approximately slightly over $1,800 per capita.[147]

From a public health perspective, Norway's situation appears to be improving, with daily new cases having dropped by over 90 percent from the beginning of April through June 27, 2020. and with daily deaths now appearing in the single digits, down from a high of 13 on April 15.[148]

Prime Minister Solberg announced the easing of restrictions on some schools and businesses to take effect April 20.[149]

The 14-day quarantine period for foreign arrivals has been recently reduced to 10 days for people entering from certain countries.[150]

In early May, the Norwegian public health authority released a report that concludes that the virus was not initially spreading as fast in Norway as had been feared, and that the lockdown was actually ordered after the virus had already been waning.[151]

According to Camilla Stoltenberg, the director of Norway's public health agency, "Our assessment now, and I find that there is a broad consensus in relation to the reopening, was that one could probably achieve the same effect—and avoid part of the unfortunate repercussions—by not closing. But, instead, staying open with precautions to stop the spread."[152]

Sweden. Sweden has a population of about 10.3 million and ranks "mostly free" in The Heritage Foundation's Index of Economic Freedom.[153]

Sweden's first confirmed case of COVID-19 was on January 31 in a woman in Jönköping County who was tested for COVID-19 after returning from Wuhan on January 24. She initially reported being symptom-free upon her return to Sweden, kept herself quarantined due to the news at the time, and ultimately developed symptoms.[154]

It was not until February 26 that a second case was confirmed after an asymptomatic man returned from a trip to Italy.[155]

The rate of infections rose quickly, hitting 1,000 by March 16 and 10,000 by April 12. As of June 27, Sweden has reported 65,137 infections and 5,280 deaths, 0.65 percent and 0.05 percent of the country's population, respectively.[156]

While Sweden does have a higher percentage of deaths than Norway and Finland, for example, the country also has a lower rate than many Western European countries, such as Belgium, Italy, the U.K., and Spain, all of which practiced more severe lockdown measures.[157]

Sweden has faced mixed responses of international derision and praise for a comparatively hands-off approach to mitigating COVID-19 infections. Although the Swedish government did ban large public gatherings, visits to elderly care homes, and some travel into the country in late March, most businesses and travel remain open and available.[158]

Still, travel and mobility has been reduced by as much as 75 percent or more in some areas by overwhelmingly voluntary means.[159]

Sweden has faced some criticism because its death rate per capita is higher than that of any other Scandinavian country. However, over 50 percent of the nation's cases come from Stockholm and Västra Götaland Counties.[160]

As of May 14 according to the Swedish Public Health Agency, over 48 percent of the country's deaths were in nursing homes.[161]

The strategist behind the response is Sweden's head epidemiologist, Anders Tegnell. Instead of mandating the closure of schools, recreation facilities, and restaurants, the government is recommending that its citizens follow safety guidelines that include social distancing and protection for the elderly.[162]

Tegnell says the current approach aims to slow the spread of infection so that health services are not overwhelmed while decreasing the likelihood of a subsequent wave of infection.[163]

One of the top epidemiologists in the world has argued that Sweden has chosen the right path to mitigate potential disaster.[164]

Tegnell has also suggested that lockdown measures are not the right approach for a long-term solution. In an interview on April 28, Tegnell said that
… up to 25% of people in Stockholm have been exposed to coronavirus and are possibly immune. A recent survey from one of our hospitals in Stockholm found that 27% of staff there are immune…. Coronavirus is not something that is just going to go away. Any country that believes it can keep it out will most likely be proven wrong at some stage. We need to learn to live with this disease.[165]

The Swedish government also hopes to mitigate as much economic fallout as possible over the longer term.[166]

Many other countries are coming to terms with the worst self-imposed economic damage in history as a result of broadly enforced lockdowns to deal with COVID-19. If successful, Sweden's strategy will put the country in a better position to rebound economically.[167]

Governmental policies are currently in the works to alleviate business impacts and cushion the blow to separated workers. For instance, the Swedish government will cover up to 50 percent of failing businesses' wage costs to allow them to retain their employees.[168]

Other measures include deferments on value-added taxes.[169]

Additionally, Swedish mandatory social security contributions have been reduced for both businesses and employers. The government is also covering temporary sick-leave costs usually covered by employers. Extra funding for job training and job-matching services, as well as overall increases in public-services spending to match demand throughout the country are among the main focuses for emergency spending.[170]

Germany. Like Sweden, Germany ranks "mostly free" in The Heritage Foundation's Index of Economic Freedom.[171]

With a population of 83.7 million, Germany began early tracking of COVID-19 cases, which has helped to keep the fatality rate low through tracing the contacts of carriers. Early widespread testing was also implemented, including that of asymptomatic individuals.[172]

Although some argue that this approach is a leading reason for Germany's low fatality rate and lessened stress on the health care system, the head of Germany's disease center has urged leaders to stop the testing of asymptomatic cases to avoid a shortage of supplies.[173]

The country had its first confirmed case on January 27, 2020, and as of June 27, Germany has reported 193,243 cases and 8,954 deaths (0.23 percent and 0.01 percent of the country's population respectively).[174]

These statistics correspond to roughly 11 deaths per 100,000 people compared to approximately 52 in Sweden, 65 in the U.K., and 46 in France.[175]

These methods determined that many early transmissions occurred among young vacationers in Austrian and northern Italian ski resorts (frequented heavily by German tourists).[176]

The first peer-to-peer transmission in Germany was traced to an auto-plant worker from the Webasto Group in January, spreading the virus to co-workers in Stockdorf after returning from China.[177]

Early on, each of Germany's 16 states was itself responsible for deciding on their lockdown measures, although the nationwide social-distancing policies were mandated by Chancellor Angela Merkel on March 22.[178]

Each German state enacted some form of assembly restriction and various business restrictions.[179]

Most schools were shut down in March and some states, such as Bavaria and the Saarland, did pursue state-wide lockdown measures.[180]

Germany began restricting travel in mid-March and started slowly reopening to travelers on June 15.[181]

During the early months of the pandemic, German officials used manual contact-tracing methods, via phone calls by public health officials, advising people who have been in contact with COVID-19 positive people to self-quarantine and, if they develop symptoms, to get tested.[182]

Despite most Germans supporting a gradual re-opening of the economy as of April 24, government officials had warned that the virus was here to stay and they must not lower their guard. Fifty-three percent of German citizens approve of the partial re-opening of schools, and 94 percent agreed that large events should be banned until August, according to a ZDF poll in late April.[183]

Germany passed a stimulus package in late March to offset economic disruptions caused by the pandemic. The measures total almost $1.1 trillion and include liquidity payments for small companies and simplified avenues for unemployment benefits.[184]

Like many European nations, Germany has worked to build a smartphone app designed to trace and report COVID-19 infections, although privacy concerns made a centralized approach to the app unlikely to please Germans. Many argued that too much information in the hands of German authorities could be used after the national emergency for unclear purposes.[185]

Despite these concerns, on June 16, the German government unveiled the Corona-Warn App.[186]

As of June 25, 12 million Germans downloaded the tracker, more than any other country in Europe.[187]

Amongst the country's 16 states, the states of Bavaria, North-Rhine Westphalia, and Baden-Wurttemberg constitute over 65 percent of the country's cases and 68 percent of the country's deaths (as of June 27, 2020).[188]

However, the country's situation is improving, and by June 27 a reduction in daily cases by more than 70 percent, and a reduction in daily deaths of over 95 percent since April 15 had been achieved.[189]

Analysis of Policies from Abroad

Table 4 provides a list of several additional COVID-19-related statistics that allow comparison across countries. In particular, these figures permit readers to assess COVID-19 cases and deaths per 100,000 people and per 1 million people across international borders with respect to population density.

As the statistics in Table 4 show, the number of confirmed cases, on a per capita basis, is 88 percent higher in the U.S. than Italy. Italy, however, which has a relatively large share of elderly in its population, has a higher per capita death total at 0.06 percent of its population. This rate is more than 1.5 times higher than the per capita death total in the U.S.

Nevertheless, there are many important factors that are not completely apparent from these aggregate numbers. For instance, regionally between these two countries, the two worst rates of COVID-19 deaths per 100,000, are in the Lombardy region of Italy and the state of New Jersey, followed by the Aosta Valley region of Italy and New York State.[190]

Even within New York, it is clear that New York City is responsible for a disproportionate share of cases and deaths.[191]

Moreover, these aggregate figures do not shed light on the importance of age and underlying health problems. Globally, the virus is much more dangerous and deadly for older people, particularly those with serious health conditions including diabetes and hypertension.[192]

According to research by the International Long Term Care Policy Network, for countries that have had at least 100 COVID-19 deaths and that provide official data, COVID-related deaths among nursing home residents (as a percentage of total deaths) range from 19 percent in Hungary to 62 percent in Canada.[193]

Moreover, for younger healthy members of the population, particularly in the U.S., COVID-19 is much less deadly than initially feared.[194]

In fact, the COVID-19 pandemic—though it is clearly not over—appears to be much less lethal than one of the most deadly respiratory virus pandemics in modern history: the Spanish flu of 1918.[195]

The Spanish flu lasted from early 1918 to late 1919 and infected over 500 million people worldwide. The Spanish flu was also deadly, with estimates of deaths as high as 50 million worldwide.[196]

The flu most likely did not originate in Spain but, like other flus, may have circulated among birds for many years before its outbreak in humans.[197]

In fact, according to a 2006 study, the virus is still identifiable in the ice and cold water of lakes near Siberia where large numbers of migratory birds visit.[198]

Chart 3 compares death rates from COVID-19 and the Spanish flu amongst the countries examined in this study.[199]

These results demonstrate how much more deadly the Spanish flu was than COVID-19 has been so far. In particular, in the United States, deaths due to Spanish flu as a percentage of the population were over 13 times higher than deaths due to COVID-19 thus far. In order for COVID-19 to kill the same fraction of the United States population as the Spanish flu did, American COVID-19 deaths would have to rise by over 1.5 million people.

In fact, in other countries, the Spanish flu killed even higher percentages of the population than COVID-19 has thus far; for example, in Iceland, the percentage of the population killed by the Spanish flu was over 150 times higher than the percentage of the population killed by COVID-19 so far. In New Zealand, the percentage of the population killed by Spanish flu was over 1,000 times that of COVID-19 as of June 27, 2020.

Although the Spanish flu and COVID-19 are two different illnesses, and although COVID-19 is still ongoing, these disparities in mortality statistics as a percentage of these countries' populations are also a testament to how societies have evolved over the past century. In the United States, for example, over the past hundred years, life expectancy has increased more than 40 percent, and per capita real income in the U.S. has increased over 500 percent.[200]

It is well understood that as societies grow wealthier, they are more capable of adapting to adverse situations.[201]

Additionally, economic growth has resulted in improvements to medical technology and living conditions among many other factors.[202]

Many societies are thus much better equipped now to deal with a serious health emergency than in the past.

Comparison of COVID-19 Management Across Countries. As this analysis indicates, the different countries studied in this Special Report have taken different approaches to handling the pandemic, all with varying degrees of success. One can compare the effects of these different policies by quantitatively examining a number of important factors.[203]

Charts 4 and 5 depict cases and deaths (per 100,000) in the countries looked at in this study on a daily basis.

As observed in the previous section, different countries started battling COVID-19 on different dates—ranging from potentially as early as November (or even earlier) in China to late February in Iceland, New Zealand, and Norway. Furthermore, heterogeneity amongst different countries (due to date of occurrence of their first case, differences in urbanization, culture, travel patterns, geography, and population density) has likely affected the proliferation of the virus.

Regardless, as Charts 4 and 5 illustrate, some countries thus far have done much better than others in managing the proliferation of COVID-19. In particular, for every 100,000 members of the population, South Korea, Italy, Iceland, Norway, New Zealand, and Australia averaged fewer than 0.5 new COVID-19 cases per day (per 100,000 population) from June 1 to June 27.[204]

Over this same time horizon, Germany had an average of 0.52 new cases per day (per 100,000 population), followed by the United States, averaging 7.81 new cases per day from June 1 through June 27 (per 100,000, and then Sweden, averaging 10.29 new cases per day during this same period per 100,000). Additionally, South Korea, Italy, Iceland, Norway, New Zealand, and Australia have all averaged less than 0.1 new deaths per day (per 100,000) over

the same time period.. The United States and Sweden, however, have exceeded this threshold over the same time horizon, averaging 0.23 and 0.32 new deaths per day (per 100,000), respectively.

A Comparison of Australia and New Zealand. A comparison of the approaches taken and the consequent outcomes in New Zealand and Australia is especially informative because of several key similarities between the two countries. Both Australia and New Zealand are island nations with similar climates and with similar distances to the rest of the world. Both nations closed their borders entirely to visitors from other countries at the same time (on March 19 in New Zealand and March 20 in Australia).[205]

Additionally, as illustrated in Table 4, both countries have lower levels of population density (nine and 18 people per square kilometer, respectively) than the other countries in this study. The first confirmed people to have the virus in both countries arrived on international flights, and had traveled through virus hotspots, Wuhan and Iran. (Australia's first confirmed cases of coronavirus were on January 25,[206]

when four men, all of whom had recently traveled to Wuhan, were diagnosed with the virus. The men had arrived in Australia on separate flights in the days leading up to January 25. New Zealand's first reported case was on February 28, when a native New Zealander returned home after visiting Iran.)[207]

As of May 29, Australia reported that 62.2 percent of its confirmed cases of COVID-19 were acquired overseas.[208]

New Zealand reported that 38 percent of its confirmed or probable cases were acquired overseas.[209]

Australia's median age was reported by its census bureau to be 36.4 in 2016,[210]

and New Zealand's, a similar, 37.4 in 2018.[211]

As of June 27, both countries have had very similar percentages of their populations test positive for COVID-19—7,595 cases in Australia (about 0.03 percent of Australia's total population), and 1,172 cases in New Zealand (about 0.024 percent of New Zealand's population). Both have brought the number of reported cases per day to near zero. (Australia has confirmed an average of 33 new COVID-19 cases per day for the seven days ending on June 28,[212]

whereas New Zealand averaged fewer than two new cases per day over that time period.)[213]

While both countries have limited the health damage caused by COVID-19, Australia, unlike New Zealand, has also limited economic damage by making an effort not to infringe on the economic freedom of Australians or close their businesses when it has not been necessary to do so. For example, the Australian government has encouraged schools to remain open for in-classroom learning if possible,[214]

whereas the New Zealand government outlawed in-classroom learning nationwide. (With local Australian governments or individual schools making the final call, different schools within Australia have been open for in-classroom learning, or shut down with a high degree of variability by date range and school.) Similarly, Australia has allowed many businesses to operate throughout the pandemic, including mining, construction, and restaurants for takeout. New Zealand's economic lockdown, by contrast, was more severe than Australia's, stopping virtually all businesses from operating until very recently, for example not allowing physical interaction with customers. (See Text Box 2.)[215]

Despite these differences, New Zealand and Australia appear to have mitigated the spread of COVID-19 to a similar extent. Yet, due to the New Zealand government's harsher restrictions on business activity, its economy is expected to shrink by about twice as much in the first half of calendar year 2020 as Australia's. The consensus forecast among major banks in New Zealand is that the economy will contract by close to 20 percent in the second quarter of 2020.[216]

The Reserve Bank of Australia expects the Australian economy to shrink by only 10 percent in the first and second quarters of 2020 combined, with the bulk of the decline coming in the second quarter.[217]

New Zealand's government has predicted that the jobless rate in New Zealand might rise to 13.5 percent (from 4 percent at the end of 2019),[218]

while Australia's central bank estimates that Australia's unemployment rate will only about double (from the end of 2019) to 10 percent by the end of June 2020.[219]

A Comparison of the United States and Other Countries. Table 5 provides a comparison of the different policies pursued by the countries in this study. As Charts 4 and 5 illustrate, since June 1, with the exception of Sweden, the United States is currently experiencing more reported cases and deaths on a per capita basis than any of the other countries considered in this study. In particular, over this time, the United States has had more than 25 times the number of average daily new known cases (per 100,000) than South Korea, New Zealand, Iceland, or Australia, and over 200 times the number of average daily new deaths (per 100,000).[220]

Over this same time period, the United States has had 17 times as many average known daily new cases (per 100,000) than Italy, and 2.8 times as many average daily new deaths (per 100,000).

Both the United States and Italy have also pursued similar policies in their attempts to deal with COVID-19. In particular, more than 40 of the 50 states instituted stay-at-home orders at various times during the spring.[221]

These policies of strict stay-at-home orders bear similarity to those of the Lombardy region of Italy, which, as discussed earlier, accounts for by far the largest share of deaths and cases in Italy. New York Governor Andrew Cuomo (D) noted that six weeks after stay-at-home orders were instituted, 66 percent of COVID-19 hospitalizations were from people adhering to those orders.[222]

One plausible reason for the continuing spread during lockdowns is that people with mild cases of COVID-19 (that do not involve hospitalization) isolate at home, possibly transmitting the virus to family members.[223]

Regardless, none of the 50 U.S. states has implemented approaches similar to those taken in some of the other Italian regions, such as Veneto, which has also pursued mass testing and aggressive contact tracing instead of purely relying on strict lockdowns. As discussed in this Special Report, however, some countries, such as South Korea and Iceland, have pursued mass testing and aggressive contact tracing without relying on nationwide lockdowns at all. In fact, as Table 4 illustrates, South Korea, the most densely populated country of all the countries examined in this study and thus most prone to virus proliferation, has instead relied heavily on extensive testing, contact tracing, and isolating the sick. From June 1 to June 27, the country reported fewer than 70 new cases per day and single-digit deaths daily, throughout the entire population. The United States, on the other hand, during this same time has had on average 90 times as many daily cases (per 100,000) and 200 times as many daily deaths (per

100,000) than South Korea has had despite the fact that, as illustrated in Table 4, South Korea has a population density 14 times that of the United States. U.S. lawmakers would thus do well to learn from the South Korean approach, especially in those regions of the U.S. that have high population densities.

Although mass testing is a key component of successfully containing the virus, the amount of testing offered varies tremendously amongst the countries looked at in this study. (See Charts 6 and 7.)

As Charts 6 and 7 illustrate, the United States leads the world in the number of COVID-19 tests given. Additionally, the United States has given more tests on a per capita basis than all of the countries looked at in this study with the exception of Iceland. In fact, Iceland is far ahead of the rest of the world with its mass testing aided by deCODE genetics, having performed over 20,000 tests per 100,000 people as of June 21, more than double that of the United States.[224]

However, South Korea had performed more tests on a per capita basis earlier during the pandemic than any of the countries in this study, but it now performs less than all the other countries. This drop-off is largely due to the country's rapidly deployed testing program at the beginning of the epidemic.[225]

In fact, during the week of March 8, 2020, South Korea had performed more than 90 times the number of COVID-19 tests than the United States had, and more than double that of Iceland. The aggressive approach that South Korea took early on dramatically slowed down the spread of the virus throughout the country. The tactic was so successful, in fact, that South Korea had a surplus of test kits in April, and started exporting those kits to other countries, including to the United States.[226]

One of the main reasons that the United States had difficulty engaging in mass testing early on in the pandemic was that excessive regulation made it very difficult to produce a sufficient number of test kits. Specifically, the Food and Drug Administration (FDA), which has a lengthy approval process to bring any test to market, initially granted emergency use authorization (EUA) only to the Centers for Disease Control and Prevention (CDC) to develop and perform COVID-19 tests.[227]

Although universities and the private sector were anxious to develop tests early on, the FDA and CDC warned these entities not to perform their own testing without FDA authorization.[228]

Aside from the fact that the first batch of CDC test kits were faulty,[229]

the cumbersome process associated with getting FDA authorization prevented the U.S. from having a useable supply of tests.[230]

Dr. Helen Chu of the University of Washington, for instance, developed her own tests early on in the pandemic, but both the CDC and the FDA refused to give her authorization to use them. Concerned about the spread of the virus, on February 25, she and her colleagues began performing COVID-19 tests anyway without government approval. They quickly found a positive case and informed state officials that the virus had likely been spreading in the Seattle area undetected. The CDC and FDA subsequently ordered her to stop giving these tests as they were privately developed. Only on February 29 did the FDA announce that it would begin to fast-track EUA for privately developed tests.[231]

The success against the spread of COVID-19 in South Korea and Iceland, where many businesses have remained open during the pandemic and people have generally not been told to stay inside their homes, indicate that the stay-at-home orders may not necessarily mitigate the virus better than more targeted measures that include isolation of the sick, mass testing, and contact tracing. Similarly, the results in Australia and New Zealand, two countries that are similar in many ways, indicate that the most restrictive lockdown approach is not superior to one that includes less severe measures. Finally, while some have criticized Sweden's less restrictive approach because it has more per capita deaths than some of its neighbors, Sweden's strategy, according to state epidemiologist Tegnell, is designed for a better long-term outcome that lessens the likelihood of a subsequent wave .[232]

Moreover, as also discussed earlier, Sweden does have lower deaths on a per capita basis than several other Western European countries that relied on more severe lockdown measures, such as Belgium, Italy, the U.K., and Spain.

The following points are the main insights from this analysis:
Heterogeneity amongst different countries likely contributes to differences in the spread and proliferation of COVID-19.
The United States had significant difficulty with testing early on due to excessive regulation, preventing it from being able to implement an aggressive testing and tracing program.
The United States currently has more confirmed cases on a per capita basis than all the other developed countries examined in this Special Report.
Amongst the developed countries considered in this Special Report, the United States leads the world in COVID-19 tests given and ranks second to Iceland.
On a per capita basis, the United States has given less than half the number of tests than has Iceland.
Medical research indicates that COVID-19 deaths occur disproportionately among the elderly and those with comorbidities.
Some countries that eschewed lockdown policies and relied on more targeted approaches, such as South Korea and Iceland, have experienced outcomes even better than those that have relied on the more severe lockdown approach.

The United States, which has pursued state-wide lockdowns, has one-fourteenth the population density of South Korea, yet on a per capita basis, has had more than 90 times as many daily cases and more than 200 times as many daily deaths since June 1.

Cases and deaths in the United States, however, have been highly concentrated in a few, mostly heavily populated, areas, so successful approaches to fighting the disease cannot be one-size-fits-all. What works in New York City differs from what is needed in sparsely populated regions, such as Wyoming.

The fact that Australia and New Zealand, two similar countries, approached the COVID-19 pandemic so differently, yet had similar outcomes, suggests that alternatives to the most restrictive forms of lockdowns have merit, even in the short run.

Policy Recommendations for the United States

Maintaining a strong economy and protecting public health are not mutually exclusive policy goals. As discussed in the previous sections, a number of countries, such as South Korea and Iceland, are containing COVID-19 considerably better than the United States without shutting down their economies. In fact, many elements of the approach used in places like South Korea can be adapted within America's borders to help the U.S. do a better job of dealing with COVID-19. In particular, the data show that policymakers and the Administration should:

Protect those who are at greatest risk—the elderly and those with underlying medical conditions. Government measures must be both geographically targeted and demographically targeted. Seniors and those with chronic illnesses are at heightened risk from COVID-19 and public policy should urge people with these risk factors to continue to avoid exposure to the contagion. These policies should not put healthy Americans who are younger than 55 under restrictive lockdowns, except in infection hot spots.[233]

Implement enhanced public health interventions in communities where infection rates are high. Lockdown orders have been intended to buy time, not to reverse the pandemic. In heavily hit areas, officials should increase testing capacity, implement large-scale contact tracing,[234]

and create temporary isolation centers in which the infected can recover without endangering others. In certain situations, lawmakers can also introduce travel bans to prevent the proliferation of the virus from hotspots to other communities.

Encourage the private sector to develop and support voluntary isolation centers. Policymakers can learn from the South Korean approach, which uses isolation centers to prevent COVID-19 patients from spreading the virus. The use of isolation centers to quarantine potential COVID-19 patients as well as those with mild symptoms on a voluntary basis has been suggested in previous Heritage Foundation research.[235]

Lawmakers can encourage private-sector industries that are currently suffering major setbacks to help in this process. For example, since the hotel industry has incurred significant setbacks due to the virus, one option is to encourage hotels themselves to become isolation centers.[236]

The cruise industry, which has also suffered major setbacks, could also provide docked cruise ships for a similar purpose.[237]

The Trump Administration and state governors should discuss with private insurance companies, as well as the Centers for Medicare and Medicaid Services, the idea of reimbursing patient stays in isolation centers, as they already do for many other medical treatments and procedures.[238]

Improve upon voluntary randomized testing to understand asymptomatic rates. Testing in various areas of the United States, as well several other countries, suggests that there is a non-trivial asymptomatic prevalence of the disease.[239]

For a variety of reasons, it is paramount to garner an accurate sense of the prevalence of asymptomatic carriers of COVID-19. First, the prevalence of asymptomatic cases enables researchers to better understand case fatality rates of COVID-19, as higher asymptomatic rates lower the overall case fatality rates of the disease.[240]

Second, epidemiological models, on which policymakers rely heavily, cannot make accurate forecasts without proper assumptions, including asymptomatic case rates.[241]

Third, and most important, asymptomatically infected individuals may unknowingly spread the disease to others, including the most vulnerable. The Trump Administration should discuss the idea of pursuing voluntary randomized testing to get a better sense of these numbers with local communities and major laboratory companies, such as Quest and LabCorp. The CDC, and even local hospital systems, should pursue such efforts with local public health departments.

Use the Defense Production Act (DPA) to expand testing capabilities. If the Administration believes that private industry is not responding appropriately, President Trump should invoke the DPA as needed to help improve laboratory capacity to ensure adequate testing. The 1950 DPA enables the President to "invoke a broad set of authorities to influence domestic industry in the interest of national defense. The authorities can be used across the federal government to shape the domestic industrial base so that, when called upon, it is capable of providing essential materials and goods needed for the national defense." The act was signed into law by President Harry Truman and was intended to be applied to "national defense;" however, Congress has considerably broadened the concept of national defense to apply to a variety of circumstances including national emergencies.[242]

Extensive testing allows the infected to be identified and isolated without having to lock down the entire country. As areas of the country begin to re-open their economies, the demand for testing will increase significantly.

Conclusion

Countries around the world have pursued a variety of policies to deal with the COVID-19 pandemic, and policymakers now have more than five months of data from which to learn. This Special Report presents a comprehensive analysis of those policies to guide policymakers as they develop better and evolving responses to the COVID-19 pandemic. The evidence suggests that, among other important findings, broad lockdown orders that fail to focus primarily on the most vulnerable members of the population—particularly the elderly—have not produced superior outcomes to less restrictive policies.

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DOI: 10.1377/hlthaff.2020.01265

Contraceptive Mandate, ACA Final Rules, And COVID-19

The Supreme Court upheld broad exemptions to the Affordable Care Act contraceptive mandate; new ACA rules were finalized.

BY KATIE KEITH

The Supreme Court upheld broad religious and moral exemptions to the Affordable Care Act's (ACA's) contraceptive coverage mandate. Health care stakeholders weighed in on *California v. Texas*, which is pending before the Supreme Court. In the meantime, congressional Democrats advanced new legislation to build upon the ACA, incentivize states to expand their Medicaid programs, and address the coronavirus disease 2019 (COVID-19) crisis. The Department of Health and Human Services (HHS) finalized the 2021 payment rule and changes to nondiscrimination protections while issuing new guidance and flexibility in response to the pandemic.

Contraceptive Mandate Exemptions Set To Take Effect

In *Little Sisters of the Poor v. Pennsylvania*, the Supreme Court—by a vote of 7–2—upheld two Trump-era rules that broadly exempt employers from complying with the contraceptive mandate when they object for religious or moral reasons. Justice Clarence Thomas wrote the majority opinion, reversing a decision from the Third Circuit Court of Appeals.

The Supreme Court ruled that the government has the authority to adopt broad religious and moral exemptions under the ACA and that the rules did not violate the Administrative Procedure Act (although further litigation is expected). Congress could have chosen to limit the Health Resources and Services Administration's (HRSA's) authority as it did in other parts of the ACA's preventive services statute, Justice Thomas observed. But it did not do so. As a result, HRSA has "virtually unbridled discretion" to determine what counts as preventive care and screenings—and its discretion is "equally unchecked in other areas, including the ability to identify and create exemptions" from its guidelines.

The two rules will go into effect. Objecting employers can decline to cover contraceptives, with no assurance that employees and students can access these services. The Supreme Court did not rule on whether the exemptions were authorized or required by the Religious Freedom Restoration Act.

Opening Briefs In *Texas*

California v. Texas was initially filed by twenty Republican state attorneys general or governors and two individuals after Congress zeroed out the individual mandate penalty in 2017. They argued that the penalty-less mandate is no longer enforceable as a tax and thus no longer constitutional. Because the mandate is "essential" to the rest of the ACA, the plaintiffs asked that the entire law be struck down. The administration of President Donald Trump sided with the plaintiffs, first in part and later in whole.

A federal district court in Texas agreed with the plaintiffs and declared the entire ACA invalid. In a 2–1 decision, the Fifth Circuit Court of Appeals agreed that the mandate was unconstitutional but remanded the case for a more thorough analysis on severability.

A coalition of twenty-one Democratic attorneys general and governors, led by California, and the US House of Representatives quickly appealed the Fifth Circuit's decision to the Supreme Court. The Supreme Court agreed to hear *Texas* during its next term.

In opening briefs, the California-led states and House made the same arguments as before the lower courts. They argued that the plaintiffs in *Texas* do not have standing to sue. They also argued that the individual mandate remains constitutional, but even if the mandate is held unconstitutional, it is severable from the rest of the ACA.

These arguments were echoed in at least thirty-eight amicus briefs from a wide array of stakeholders, including health insurers, hospitals, AARP, patient advocates, public health experts, Republican and Democratic state officials, and a bipartisan group of economists and scholars. The briefs warned of devastating consequences if all or parts of the ACA are deemed invalid and emphasized the importance of the ACA to the nation's COVID-19 response.

Opening briefs from the Texas-led coalition of states, two individuals, and the Trump administration struck a decidedly different tone. These parties maintained their position that the entire ACA should be declared invalid. Although not all briefs argued each point, they collectively argued that the plaintiffs have standing, the individual mandate is unconstitutional and inseverable from the rest of the ACA, and the district court correctly declared the ACA to be invalid nationwide. The briefs barely mentioned the COVID-19 crisis, referring to it as an "extratextual consideration" to be disregarded.

The litigation is ongoing. Briefing will continue throughout the summer, and oral argument will be held this fall. A decision is expected in 2021.

Democrats Push New Coverage Proposals

As the Supreme Court considers the ACA's fate, Democrats in Congress continued to introduce new legislation to

expand on the ACA, make changes to Medicaid, and respond to COVID-19.

Prior coronavirus relief packages have been relatively limited in making coverage improvements. Prior bills required insurers to temporarily cover COVID-19 testing and a future vaccine and authorized a temporary increase in federal matching funds for state Medicaid programs, among other changes. In implementing these bills, the Trump administration concluded that insurers and employers are not required to pay for back-to-work or general COVID-19 screening tests. These important changes notwithstanding, Congress has not otherwise addressed the affordability of coverage, banned surprise medical bills, or addressed high cost sharing.

The Health and Economic Recovery Omnibus Emergency Solutions Act, passed by the House in mid-May, would address most of these gaps. Among other changes, the act would authorize a special enrollment period for ACA coverage and Medicare; require broader coverage of treatment, vaccines, and testing; authorize a new risk corridors program; subsidize premiums for the continuation of job-based coverage; and further increase federal matching funds for state Medicaid programs.

Separately, the House passed the Patient Protection and Affordable Care Enhancement Act. The bill would extend ACA subsidies to higher income brackets; make Marketplace subsidies more generous; eliminate the "family glitch;" rescind various Trump-era policy changes; and provide funding for outreach, reinsurance or subsidy programs, and new state-based Marketplaces. In addition to incentivizing Medicaid expansion, the bill would require states to provide a year of postpartum Medicaid eligibility and a year of continuous coverage for Medicaid and Children's Health Insurance Program beneficiaries. The federal government would be authorized to negotiate with drug manufacturers on prices for certain drugs used by Medicare beneficiaries.

Neither bill is expected to be taken up by the Republican-controlled Senate. The House Energy and Commerce Committee also released a detailed investigative report on misleading practices used by insurers and brokers that offer short-term plans, a type of plan promoted by the Trump administration as an alternative to ACA coverage.

HHS Finalizes Payment Rule For 2021 And Nondiscrimination Changes

HHS finalized its latest-ever notice of benefit and payment parameters rule in May 2020. The rule included largely technical changes for the 2021 plan year in areas such as the Marketplaces and the risk-adjustment program. Where HHS made changes, it was generally to extend effective dates for various policies, and several changes expected for 2021 were pushed to the 2022 plan year. HHS also extended some rate review deadlines in light of the COVID-19 crisis.

HHS did not move forward with proposed changes to the automatic reenrollment process after overwhelming opposition from commenters who believed that the changes would have caused confusion and coverage losses. States will have to comply with new essential health benefits reporting requirements beginning in 2021. Insurers will have to deduct prescription drug rebates from the medical loss ratio, with the goal of more accurately reflecting insurers' spending on prescription drugs. And HHS adopted changes to recalibration in the risk-adjustment program.

Separately, HHS revised its prior interpretation of the ACA's chief nondiscrimination provision, Section 1557. Despite receiving nearly 200,000 comments, HHS finalized the proposed rule virtually unchanged. Among other changes, the rule eliminates nondiscrimination protections based on sex stereotyping, gender identity, and association; the requirement that covered entities include translated taglines in communications to consumers; requirements to publicly post information about Section 1557; and the definitions section of the current rule (thereby eliminating definitions of key terms such as "covered entity"). HHS also eliminated sexual orientation and gender identity protections from other regulations, such as nondiscrimination standards for qualified health plans.

HHS finalized the Section 1557 rule mere days before the Supreme Court issued its decision in *Bostock v. Clayton County, Georgia.* By a vote of 6–3, the Supreme Court concluded that Title VII of the Civil Rights Act of 1964 prohibits employment discrimination against lesbian, gay, bisexual, and transgender people. *Bostock* calls major parts of the new Section 1557 rule into question because HHS relied on a definition of sex discrimination that the Supreme Court resoundingly rejected.

From here, litigation will continue; the new Trump-era rule has already been challenged in court.

More Federal Guidance On ACA And COVID-19 Delays

HHS also released a new proposed rule on risk-adjustment data validation methodology. Separately, the Internal Revenue Service issued a new proposed rule that would allow employers to reimburse employees for fees for direct primary care and health care sharing ministries through a health reimbursement arrangement.

HHS has delayed enforcement of various ACA requirements in light of COVID-19. The effective date of the "double billing" rule—where insurers must send (and enrollees must pay) two separate monthly bills for abortion services and all other services—was delayed to late August 2020. HHS also offered flexibility on Basic Health Program requirements and deadlines for interoperability, risk adjustment, and quality reporting. The Departments of Labor and Treasury separately extended certain time frames for group health plans to provide flexibility to employees losing job-based coverage. Additional short guidance documents were issued on utilization management and enhanced direct enrollment.

HHS also deemed New Hampshire's application to develop a state-based reinsurance program as complete. If the application is approved, New Hampshire would join twelve others with similar programs. ■

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REPORT Health Care Reform

Telehealth in the Pandemic and Beyond: The Policies That Made It Possible, and the Policies That Can Expand Its Potential

July 20, 2020 30 min read

Authors:
Marie Fishpaw and Stephanie Zawada

SUMMARY

The COVID-19 outbreak has ushered in an unprecedented acceleration in the use of telehealth services. Telehealth gives patients who have few local providers more health care options and allows them to avoid waiting rooms and other contact while receiving care. Widespread user satisfaction with telehealth during the pandemic suggests that many medical practices will continue to offer telehealth services beyond the pandemic. Continued reforms can build on this successful telehealth model and expand its potential for enhancing health care options through sustained innovation.

KEY TAKEAWAYS

Lawmakers have helped patients to access medical care more easily by temporarily lifting regulations on telehealth, leading to rapid growth in its adoption.

Telehealth gives patients who have few local providers more health care options and allows them to avoid waiting rooms and other contact while receiving care.

Policymakers should make the initial regulatory relief permanent and offer more reforms to encourage continued use and innovation.

The COVID-19 outbreak has ushered in an unprecedented acceleration in the use of telehealth services. Multiple health care systems and private telehealth companies have reported increases in use ranging from 100 percent to more than 4,300 percent since the pandemic began.[1]

This was facilitated by policy changes when Congress, the Trump Administration, and individual states rapidly took several steps[2]

to expand access to telehealth services by temporarily removing barriers to its adoption as part of the initial response to the pandemic. With this temporary regulatory relief, combined with strong consumer demand for remote health care services, the amount, and use of, telehealth services has grown rapidly as a result. Widespread patient satisfaction with telehealth during the pandemic[3]

suggests that many physician practices will continue to offer telehealth services beyond the pandemic. Continued reforms can build on this successful telehealth model and expand its potential for enhancing health care options through sustained innovation.

Telehealth is adjusting the focus of health care delivery in the U.S. to be more patient-centered, allowing patients to talk to doctors where and when they want to—supplemented by

medical devices from home. Telehealth allows patients to get care from medical professionals remotely by phone or video, and to use medical tools at home, such as personal electrocardiogram (EKG) devices that connect to mobile phones.[4]

Telehealth helps patients to avoid crowded waiting rooms, where they may be needlessly exposed to other sick people. These features have made it an essential aspect of health care provision in the midst of the COVID-19 outbreak. Beyond the pandemic, telehealth can offer patients benefits over traditional care delivery methods: It allows patients to avoid taking the time to travel to and wait in a physical office; increases access to health care (especially helpful in locations with a shortage of physicians or specialists); and facilitates more routine monitoring of chronic health conditions.

Policymakers should build on these initial successes with further action to remove additional barriers to the adoption of telehealth services and continued innovation. Such actions should focus on freeing physicians to deliver care, and freeing patients to seek care remotely—with flexibility to use the most innovative technologies as they evolve, when clinically appropriate. Specifically, federal and state policymakers should foster continued adoption and lay the conditions for continued innovation in telehealth by:

Making regulatory relief provided during COVID-19 permanent;[5]

Updating payment reimbursement policies to emphasize flexibility over parity with traditionally delivered care;

Encouraging both adoption and future innovation of telehealth by defining it in ways that emphasize medical-provider flexibility and discretion;

Enabling patients to use telehealth easily by removing state and federal barriers that limit where patients can receive care; and

Examining whether there is a need to update patient-data-privacy protections.[6]

Telehealth on the Rise before COVID-19

Prior to COVID-19, telehealth use and interest had been growing for several years. Use in non-hospital settings has surged in popularity, increasing by 1,393 percent from 2014 to 2018.[7]

The demand for care on the patient's terms, particularly outside of hospitals with a reduced risk of exposure to harmful bacteria and viruses, is strong.

This growth is tied to benefits for both patients and doctors. According to the 9th Annual Vitals Wait Time Report, over half of patients reporting limited access to medical care responded that they have left a doctor's office due to long wait times, a phenomenon that leads to lower patient-satisfaction with providers.[8]

Telehealth can address this problem by reducing the time that patients spend traveling to, and waiting in, a doctor's office while reducing the time that providers spend collecting patient records[9]

and preparing rooms between patient visits. According to a survey by Penn Medicine of almost 800 gastroenterology and hepatology patients, 67 percent of patients felt that their telemedicine appointment was "good/better" than traditional visits, with 96 percent saying they were "satisfied/very satisfied with medical care."[10]

In response to this demand, providers and insurers are adapting. As of 2019, over 90 percent of mid-size to large-size employers intend to offer, by the end of 2020, telemedicine in their employee health plans.[11]

Seventy-six percent of hospitals are already offering at least one type of telehealth service.[12]

With growing interest in the remote delivery of health care services, it is no surprise that 69 percent of physicians surveyed in the Telehealth Index: 2019 Physician Survey reported a willingness to use telehealth.[13]

The growth in use of telemedicine also was facilitated by policymakers who removed regulatory barriers to its adoption. In 2019, for example, 35 states finalized 54 regulations and passed 113 bills.[14]

Twenty-three states[15]

took the critical step of addressing medical-licensing regulations that limited patients to seeing only those doctors who were licensed to practice medicine in the state in which in which the patient is located[16]

(a clear relic of the pre-Internet era, made obsolete by technology that allows patients to meet with doctors remotely, regardless of location).

Telehealth and the COVID-19 Pandemic

The value of telehealth services during a pandemic is clear. They enable patients to seek care and use clinical-grade tools at home, such as remote EKGs or diabetes monitors, facilitating social distancing and avoiding unnecessary visits by tracking and treating symptoms remotely —all of which reduce the risk of viral transmission for patients and medical staff and conserve masks and other personal protective equipment.

Patient use of telehealth services has grown rapidly during the pandemic at a wide range of facilities, with further growth expected. The number of Medicare beneficiaries using telehealth services during the pandemic increased 11,718 percent in just a month and a half.[17]

The Harvard Business Review reported that Boston Children's Hospital "was doing more telemedicine visits during any given day in late March than it had during the entire previous year."[18]

From March 25 to April 20, the Cancer Treatment Centers of America found an 80-fold increase in telehealth visits, and scheduled over 7,000 telehealth visits into June.[19]

Some providers and patients, especially in rural areas, do not have reliable Internet access, so they consult primarily by phone, without video. Use of remote glucose-monitoring devices saw significant growth, with analysts expecting market growth for the devices alone to reach mid-double-digits this year,[20]

with the telehealth market as a whole expected to grow over 80 percent year over year.[21]

While many doctors are hearing positive feedback from patients,[22]

others are still adjusting to the new surge in demand. Providers are limited by the technology that they or their patients have available for use. Some patients do not have access to video calls, so some providers are conducting consultations primarily by phone.[23]

Given this variation, policymakers would be wise to ensure that regulations provide medical providers maximum flexibility to use tools the provider thinks will serve their patients.

Policy Changes Enabling Telehealth Adoption as Part of the COVID-19 Response

As part of the response to the pandemic, policymakers moved to "clear out as many regulatory barriers standing in the way of access to telemedicine as possible."[24]

Key issues addressed include allowing patients to see doctors across state lines and from their homes, removing barriers to paying or reimbursing medical professionals who practice telehealth, and making it easier to access telehealth tools, such as those to monitor glucose levels remotely.[25]

Making It Easier for Patients to See Doctors from Home and Across State Lines. Both federal and state policymakers took steps to remove regulatory barriers that made it harder for patients to see their doctors of choice from their homes. Congress allowed[26]

the Centers for Medicare and Medicaid Services (CMS) to temporarily lift the restriction that limits the delivery of telehealth to Medicare patients residing in rural communities, allowing Medicare patients across the country to receive telehealth services at home during the pandemic.[27]

The CMS waived Medicare rules that prevented physicians who are licensed in one state from practicing telemedicine in another.[28]

The agency lifted location requirements for telehealth reimbursement that required that the patient reside in a rural area and receive care at a specific health care facility. The CMS also encouraged states to reimburse medical professionals for telehealth services in their Medicaid programs, and noted the changes that states can make without obtaining federal approval.[29]

All 50 states and the District of Columbia expanded access to telehealth services for either, or both, Medicaid and privately insured patients for the duration of the emergency, implementing changes to facilitate the ability of insurers to implement more widespread use of telehealth services among privately insured patients.[30]

In one example, Minnesota's legislature passed an emergency bill amending the state's definition of telemedicine to categorize a patient's home as an authorized "originating site" through February 1, 2021.[31]

Kansas, Florida, Missouri, Tennessee, and Vermont permitted physicians who are licensed out of state to offer remote services for Medicaid patients,[32]

while New Jersey expedited licensing for out-of-state providers.[33]

Removing Barriers to Payment. Both private companies and policymakers made it easier to access telemedicine via private coverage, Medicare, and Medicaid.

Private Coverage. Private insurers expanded telemedicine services and provider networks for their beneficiaries, by waiving cost-sharing for visits conducted using specific telemedicine platforms. Congress, too, helped by amending the Internal Revenue Code to permit a "high-deductible health plan (HDHP) with a health savings account (HSA) to cover telehealth services prior to a patient reaching the deductible."[34]

Under current law, an individual can only make tax-free contributions to an HSA if he or she is: (1) covered by a qualified HDHP and (2) does not have other insurance that pays for expenses below the HDHP's deductible. The CARES Act clarifies that those restrictions do not apply to instances where the HDHP, or other coverage, reimburses telehealth services before the enrollee reaches the HDHP's deductible.[35]

Medicare. The CMS issued several temporary reforms to expand telehealth access in Medicare, including by temporarily reducing or waiving cost-sharing for telehealth visits paid by federal health care programs. First, the CMS repeatedly updated the definitions of providers and services[36]

that can offer telehealth services,[37]

and announced that it is "changing its process [for adding new services to the telehealth Medicare service list] during the emergency, and will add new telehealth services on a sub-regulatory basis, considering requests by practitioners now learning to use telehealth as broadly as possible."[38]

Second, the U.S. Department of Health and Human Services (HHS) changed its policies. Key steps here include authorizing Medicare to reimburse telehealth visits in lieu of in-person office, hospital, and other types of visits with a wide range of providers.[39]

The CMS also decided to reimburse telehealth "at the same rate as regular, in-person visits,"[40]

bundle payment for telemedicine services into pre-existing Medicare CPT codes for over 80 different medical services,[41]

and—based on reports from multiple medical organizations explaining that "[m]any patients, especially seniors, have access to phones but not video-enabled telehealth apps"—increased reimbursement rates for audio-only visits. Finally, the CMS stated that, for services performed during the pandemic, it will not audit reimbursement claims to ensure that a prior relationship existed between the provider and patient, a requirement during non-pandemic times.

Further, the HHS said that it will exercise its enforcement discretion and waive potential penalties for violations of federal patient privacy laws against health care providers that service patients through "widely available communications apps, such as FaceTime or Skype, when used in good faith for any telehealth treatment or diagnostic purpose, regardless of whether the telehealth service is directly related to COVID-19"[42]

—which allows providers to treat patients remotely using generally available software.

Medicaid. All 50 states and the District of Columbia issued temporary policy updates related to telehealth for Medicaid patients.[43]

As of May 7, 2020, 48 states and the District of Columbia "issued guidance related to the expansion or reimbursement of telehealth services in Medicaid" while 38 states and the District of Columbia included guidance for audio-only Medicaid telehealth services.[44]

Also as of May 7, 38 states and the District of Columbia are mandating payment parity for Medicaid telehealth services.[45]

Washington State purchased a limited number of Zoom software licenses to allow physicians to help Medicaid patients access telehealth visits.[46]

Other states took a narrower approach to temporary relief. For example, Indiana limits telemedicine for Medicaid patients to live video-only communication.[47]

Maine requires that services be conducted in real time, and allows use of phone calls only when a video call is not possible.[48]

Arkansas permits only live video and phone calls, and requires that physicians have access to a Medicaid patient's personal health record.[49]

These narrower approaches can limit a patient's ability to see doctors in ways that work for both the patient and the doctor.

Enabling More Use of Remote Monitoring Devices. The U.S. Food and Drug Administration (FDA) issued guidance to manufacturers suspending the requirement that they obtain prior approval for hardware or software modifications that enhance the remote-monitoring capabilities of various non-invasive patient-monitoring devices. The guidance also allows manufacturers to market for home use some monitoring devices previously approved only for use in hospitals or other health care facilities. This guidance applies to types of devices and types of modifications that do not entail patient safety concerns, and for the duration of the current public health emergency.[50]

What Policymakers Can Do Next to Remove Barriers to Long-Adoption and to Support Innovation

Telehealth is adjusting the focus of health care delivery in the U.S. to be more patient-centered, allowing patients to visit doctors where and when they want to—supplemented by medical devices at home. Its impact can improve the delivery of health care in the U.S. after the pandemic passes—if policymakers can get the regulatory conditions right. Absent action, temporary regulatory relief provided during the pandemic will revert to prior law, and patients will have to forego much of the increased telehealth flexibility they experienced during the pandemic. Moreover, the regulatory relief provided to date—while helpful—leaves some barriers in place that also should be removed as soon as possible in order to (1) help with the pandemic response, and (2) facilitate a permanent, clinically reasonable adoption of remote health care delivery.

As policymakers consider next steps, they should make temporary relief permanent, while looking ahead to the future with additional reforms. Policymakers should use flexible regulatory approaches to allow providers and patients to continue to use today's technologies and adopt new ones as innovators create them and doctors and patients find them to add value. Such an approach would be rooted in the recognition that America's medical professionals are among the world's best trained and America's medical device approval process is the world's gold standard. This approach would also facilitate continued innovation in telehealth, allowing greater adoption of existing tools that supplement a remote clinical visit by allowing patients who need chronic care to use devices at home to supplement remote visits. One can imagine, for example, a mother who fits a camera device to her phone to allow a doctor to see inside her child's ear remotely to check on an ear infection. The potential uses are wide ranging and will emerge over time as patients and doctors work together to deliver care via telemedicine. No one can enumerate all of the possible uses at this time, and it is wise for policymakers to build flexibility into regulatory definitions of telehealth to allow health care providers to adopt new technologies as they become available and, in the case of devices, the FDA approves their use.

To advance these principles, federal and state policymakers should:

Update Reimbursement Policies and Allow Reimbursement-Rate Flexibility for Telehealth. Since telehealth is a rapidly evolving field with constant innovation in the development of new and better software, devices, processes, and clinical applications, the economics of telehealth will also be shifting at a rapid pace, and in ways that are currently unknowable for the foreseeable future. Consequently, policymakers need to ensure that providers and payers have sufficient flexibility to continually revise and update payment arrangements in response.

During the pandemic, the CMS has temporarily instituted reimbursement for telehealth "at the same rate as regular, in-person visits."[51]

Multiple states have temporarily required equal reimbursement rates for telehealth services rendered to Medicaid and privately insured patients.

While payment parity for telehealth certainly incentivizes wider and quicker adoption, going forward, policymakers should take a more flexible approach to revising and updating reimbursement rates for telehealth services. Such an approach would take a middle ground between two approaches to this question, one which emphasizes paying less for care delivered via telehealth (on the theory that costs should be less because, for example, a doctor does not have to come into an office) and those that emphasize paying the same for care delivered via telehealth (on the theory that this will promote faster adoption).[52]

Policymakers' goal beyond this immediate pandemic response should be to allow the space for health care providers and private payers to sort through these questions over time.

To advance this goal, policymakers could look to a model policy in Utah, which permits certain providers to request reimbursement from health plans covering public employees for "medically appropriate telemedicine services at a commercially reasonable rate."[53]

This reimbursement strategy is flexible and allows providers and payers to negotiate specific reimbursement amounts for different telehealth services to best serve individual patients.

Encourage Adoption of Existing Telehealth Tools and Future Innovation of New Telehealth Tools by Updating Definitions of "Telehealth." Policymakers should pay particular attention to statutory and regulatory definitions, as the approach taken here will have significant ramifications for adoption and innovation, now and in the future.

Definitions continue to vary across states and the federal government, with some using more restrictive or flexible approaches. For example, while the CMS recognizes the form of telemedicine that includes automated diagnostic and management tools, known as asynchronous telemedicine, as an eligible form of care, not every state does—thereby preventing patients and doctors from easily adopting new technology as it emerges.[54]

One such tool, Zipnosis, which includes an asynchronous form of telemedicine in its platform known as an "adaptive interview" that adjusts its diagnostic questions to patient responses in real time, saw a 3,600 percent increase in visits during the first 11 days of the pandemic in the United States. Of these visits, 88.2 percent were asynchronous and required only 1.5 minutes of clinical work per patient.[55]

Usage could very well have been higher—with more patients benefitting—if regulations had allowed more people to engage. Other emerging tools that can improve treatment and save money are similarly caught in this regulatory catch-22. [56]

The varied types of available telehealth services demonstrate that there is no one-size-fits-all solution for every patient or every disease. For instance, a virtual check-in consisting of a phone call may not be clinically appropriate or necessary for a certain patient, but a telehealth visit with real-time video and audio might be. Further, not every patient will need, or be suited for using, any given telehealth tool, but those who are should be able to work with their medical care provider to choose appropriate telehealth care treatments.

Rather than requiring that specific types of telehealth be reimbursed, state and federal policymakers should update definitions to be flexible and broad enough to allow physicians to choose options, as the technologies evolve, that will benefit an individual patient over the course of his disease diagnosis, treatment, and management. Such an approach would balance the need to adopt existing tools, while encouraging room for future innovation. Definitions should reinforce the patient–physician relationship to ensure that patients receive appropriate care. Building flexibility into definitions of telehealth would reduce the time that providers and patients have to wait in order to benefit from market-based innovation and competition that delivers the newest technologies with low-cost and high-value potential. Patients and providers should not have to wait for telehealth definitions to be updated, for example, before private and public insurance plans pay for the use of new devices that have obtained FDA approval.

Remove Barriers That Make It Hard for Patients to Receive Care at their Home or Other Locations of their Choice. Policymakers should eliminate requirements that prevent patients from receiving telehealth services from the doctor of their choice at home or another place of the patient's choosing. These reforms would increase access to primary and specialty care for patients in both urban and rural areas. Policymakers should start by making the steps taken in this direction during the initial response to the pandemic permanent. Congress should make permanent temporary waivers (by CMS) of location requirements mandating that a Medicare patient be at a designated facility or in a rural area to receive telehealth services, as well as requirements that an in-person physician–patient relationship be established before telemedicine can be practiced by the physician. States also should review their laws and health care programs and permanently address any similar barriers.

Remove Barriers That Make It Hard for Patients to See Licensed Providers of Their Choice Remotely Across State Lines. While some steps have been taken to allow patients to see out-of-state providers remotely, federal and state rules governing out-of-state telehealth licensure need to be reformed to improve access and care coordination across state lines. Such reforms have the potential to help patients in areas with a physician shortage access care.[57]

Additionally, the National Academy of Medicine found that many community hospitals would benefit from expert telehealth consults to support care for patients during the COVID-19 pandemic.[58]

To start, policymakers should make actions taken during the pandemic permanent. Congress should codify the actions taken by the CMS under emergency authority that permit out-of-state physicians to see Medicare patients remotely. So, too, should the states that waived in-state licensure requirements for out-of-state physicians to practice telehealth.

Beyond this, state policymakers should also permit out-of-state physicians to offer telehealth services to Medicaid patients as well as to all privately and self-insured patients. One example is Georgia's approach, which grants a license to out-of-state telehealth practitioners licensed in other states.[59]

Alternatively, Congress might consider permitting federal health care programs to reimburse participating providers for telehealth services in cases where the enrollee does not reside in a state where the provider is licensed.[60]

Examine Whether There Is a Need to Update Patient Data Privacy Protections. Every medical provider is covered by federal law, the Health Insurance Portability and Accounting Act (HIPAA), which grants privacy protections to patients in the use of their health data. Written largely before the Internet age began, HIPAA does not explicitly include specific provisions related to telehealth. For the duration of the pandemic, the HHS chose to waive potential penalties for violations of federal patient privacy laws against health care providers who service patients via "widely available communications apps, such as FaceTime or Skype, when used in good faith for any telehealth treatment or diagnostic purpose, regardless of whether the telehealth service is directly related to COVID-19."[61]

While these platforms have security features to protect privacy, news reports suggest that providers and Members of Congress question whether these protections are sufficient, raising concerns both over privacy protection and whether providers could face future legal risks using these tools once the pandemic passes.[62]

If these concerns continue and escalate, they could jeopardize future use and adoption of telehealth services. Congress and the HHS should consider whether existing patient privacy laws and regulations need to be updated in order to accommodate the growth of telemedicine.

Conclusion

Temporary policy reforms implemented during the COVID-19 public health emergency have accelerated the adoption of telehealth. Going forward, federal and state policymakers should approach regulatory and statutory reform surrounding telehealth with the goals of enabling physicians and patients to conduct medical visits remotely, and of doctors using new innovations when clinically appropriate for an individual patient. Such changes will continue to help the U.S. health care system move toward a patient-centered footing—long after the pandemic has ended.

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[1] Teladoc reported that visits more than doubled by April 15 from early March; Amwell reported a 158 percent increase in app usage nationwide and 650 percent increase in Washington state alone; 98Point6 reported a 200 percent increase in app usage since January, with one-third of all visits being COVID-19-related (according to the company); Zipnosis' telemedicine platform reported a 3,600 percent increase in use during the first 11 days of the outbreak in the U.S.; and NYU Langone reported an increase in urgent and non-urgent telemedicine care by 683 percent and 4,345 percent, respectively. See Heather Landi, "Teladoc Anticipates Q1 Revenue to Reach $180M Boosted by Surge in Telehealth Visits," FierceHealthcare, April 15, 2020, https://www.fiercehealthcare.com/tech/teladoc-anticipates-q1-revenue-to-reach-180m-boosted-by-surge-telehealth-visits (accessed July 16, 2020); Alejandra O'Connell-Domenech, "Interest in Telemedicine in New York Grows During Coronavirus Outbreak," amNY, March 27, 2020, https://www.amny.com/coronavirus/interest-in-telemedicine-in-new-york-grows-during-coronavirus-outbreak/ (accessed July 16, 2020); Kevin J. Ryan, "Telehealth Startups Rake in Money During the Pandemic," Inc., April 17, 2020, https://www.inc.com/kevin-j-ryan/telehealth-companies-venture-capital-funding-covid-19.html (accessed July 16 2020); Shaina Heberden, "COVID-19 Update: The Numbers Don't Lie," Zipnosis Blog, April 9, 2020, https://www.zipnosis.com/blog/covid-19-the-numbers-

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For example, the Coronavirus Preparedness and Response Supplemental Appropriations Act, enacted on March 6, 2020, allowed the Centers for Medicare and Medicaid Services (CMS) to temporarily lift the restriction that limits telehealth to Medicare patients residing in rural communities, allowing Medicare patients across the country to receive telemedicine using different tools at home during the pandemic. Through the Coronavirus Aid, Relief, and Economic Security (CARES) Act enacted on March 27, 2020, Congress temporarily allowed individuals with high-deductible health plans (HDHPs) to use health savings account (HSA) funds for telehealth services and other remote care services without first meeting the deductible. Additionally, all 50 states and the District of Columbia expanded access to telemedicine for either or both Medicaid and privately insured patients for the duration of the emergency, implementing similar changes in their Medicaid programs or modifying state laws that restricted the ability of insurers to implement more widespread use of telemedicine among privately insured patients. The Heritage Foundation's fall 2018 Graduate Fellow in Health Policy proposed many of these reforms in December 2018. See Stephanie J. Zawada, "Telemedicine: The Promise and the Performance," Heritage Foundation Backgrounder No. 3373, December 17, 2018, https://www.heritage.org/sites/default/files/2018-12/BG3373_0.pdf (accessed June 25, 2020), including updating telemedicine definitions, reimbursing telemedicine at the same rate as in-person visits, expanding licensing to allow out-of-state physicians to practice across state lines, bundling Common Procedural Technology (CPT) codes to include telemedicine, and allowing patients to use their HSAs for telemedicine before the high deductible is met.

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Upon administering over 3.5 million telemedicine surveys during the pandemic, Press Ganey learned that "clinicians are successfully meeting patients' interpersonal communication needs in this new model." Press Ganey, "The Rapid Transition to Telemedicine: Insights and Early Trends," May 19, 2020, https://www.pressganey.com/about/news/press-ganey-releases-landmark-telemedicine-report-revealing-new-consumer-insights-for-providers-to-meet-patients-evolving-needs (accessed July 11, 2020).

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"Telehealth" and "telemedicine" are technically different but often are used interchangeably. To the extent that differences are drawn, "telehealth" is generally a broader term that encompasses all forms of remotely delivered health care, including, for example, a patient using a medical device such as an EKG connected to his phone, or a doctor remotely monitoring a patient's health data. "Telemedicine" is a form of telehealth that refers to a visit with a health provider for the purpose of seeking health care using means, such as a phone call or video call. This Backgrounder uses the broader term "telehealth," consistent with recent U.S. congressional actions, while noting the importance of policymakers using definitions going forward that emphasize flexibility in interpretation rooted in an approach that trusts doctors and patients to work together to decide which treatments are clinically appropriate and desirable.

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U.S. Health Reform—Monitoring and Impact

Effects of Medicaid Health Plan Dominance in the Health Insurance Marketplaces

June 2020

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Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

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

Medicaid insurers, managed-care organizations that offered coverage through Medicaid programs before 2014 but had not sold insurance in private insurance markets until then, have become increasingly dominant in many of the Affordable Care Act (ACA) health insurance marketplaces across the country. In 2020, Medicaid insurers are offering marketplace coverage in 255 of the 502 rating regions nationwide, and the regions in which the plans participate span 29 states and account for nearly two-thirds of the U.S. population.[1] Medicaid insurers also frequently offer the lowest-premium plans on the marketplace; in 2020, they offered the lowest-cost silver plan in 59 percent of the regions they participated in.[1] Over the past few years, Medicaid insurers nationwide have expanded their footprints in the marketplaces, including by entering new markets previously dominated by a single insurer.[2]

Prior research indicates that the presence of a Medicaid insurer in the marketplace tends to be associated with lower premiums and smaller premium increases.[1] A recent study of premiums and insurer participation in U.S. marketplaces between 2017 and 2020 found that states with the lowest-cost silver premiums usually had at least one participating Medicaid insurer, several competing insurers, or both.[2] Two factors associated with lower premiums among Medicaid insurers are their tendencies to have narrower networks and to contract with providers willing to accept lower payment rates. Lower premiums have benefits for both marketplace competition and for consumers. However, health system stakeholders have raised concerns, particularly in the early years of ACA marketplace operations, about the potential negative consequences of Medicaid insurer participation in the market, namely consumer access concerns related to limited networks, provider concerns related to inadequate reimbursement, and concerns that a Medicaid insurer's presence would drive competing commercial insurers out of the market.[3]

In this brief, we examine the effects of Medicaid insurer participation on health insurance marketplaces, focusing on six state marketplaces in different U.S. regions. The brief is based on discussions with more than 20 health system stakeholders in the six states, discussions which explored how Medicaid insurers function in the marketplace and the advantages and disadvantages associated with their presence.

METHODS

For this study, we selected six states with one or more Medicaid insurers participating in the marketplace for the 2020 plan year: Arkansas, California, Florida, New York, Ohio, and Washington. Table 1 provides background information on the marketplaces and Medicaid managed-care environments in these states. In four of the six study states, every marketplace rating area had at least one participating Medicaid insurer in 2020 (Table 1, fifth column), and in three of those four states, a Medicaid insurer offered the lowest-cost silver plan in every rating area (seventh column). For study states with available marketplace enrollment data, the proportion of total marketplace enrollment attributed to a Medicaid insurer in 2018 ranged from roughly one-third (Florida) to nearly two-thirds (Ohio). Five of the six states have robust Medicaid managed-care programs, with at least three-quarters of Medicaid beneficiaries enrolled in a comprehensive, risk-based managed-care program (eleventh column).

We conducted 21 structured telephone interviews with key stakeholders in the six study states between December 2019 and February 2020. Interviewees included representatives

from state departments of insurance, hospital associations, medical or primary care provider associations; insurance brokers; and consumer advocates (we did not speak to all of these stakeholders types in all states). We asked interviewees for their observations about (1) how Medicaid insurer participation influenced marketplace dynamics, including whether and how Medicaid insurers' price positions affected their market share, and (2) the pricing and participation strategies of their marketplace competitors. We also asked for their perspectives on the differences between Medicaid insurers' and commercial competitors' marketing strategies, business models, network types, and consumer complaints.

Table 1: Health Insurance Marketplace and Medicaid Managed Care Characteristics in Six Study States

State	Marketplace								Medicaid Managed Care	
	Total number of insurers in state marketplace	Marketplace rating areas					Enrollment in 2018		Number of Medicaid MCOs in 2017	Percent of state Medicaid enrollment in risk-based managed care
		Total number of rating areas	Has participating Medicaid insurer		Lowest-cost silver plan offered by Medicaid insurer		Total marketplace enrollment	Share enrolled with Medicaid insurers		
			2019	2020	2019	2020				
Arkansas	4	7	7	7	7	7	71,867	41%	N/A	N/A[1]
California	12	19	14	14	5	4	N/A	N/A	23	80%[2]
Florida	9	67	26	30	14	7	1,815,484	30%	16	81%
New York	15	8	8	8	7	6	N/A	N/A	22	74%
Ohio	10	17	16	17	12	17	237,968	64%	6	83%
Washington	9	9	9	9	9	9	N/A	N/A	6	88%

Notes: MCO = managed-care organization.
[1] Arkansas only recently (late 2019) began enrolling Medicaid beneficiaries in risk-based managed care. At the time of this writing, risk-based managed-care enrollment was limited to people with significant developmental disabilities or serious behavioral health problems in the state.
[2] California's total Medicaid MCO count includes six health insuring organizations, member plans in California's county-organized health systems.
N/A: Not Applicable
Sources: Medicaid MCO data were taken from https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/.
Marketplace data were taken from Healthcare.gov for federally facilitated marketplaces and from state marketplace platforms for state-based marketplaces.
Enrollment numbers taken from Urban Institute analysis of the Centers for Medicare & Medicaid Services' Center of Consumer Information and Insurance Oversight marketplace issuer-level enrollment data, available at https://www.cms.gov/CCIIO/Resources/Data-Resources/issuer-level-enrollment-data.

FINDINGS

Medicaid insurers are a critical and competitive option in health insurance marketplaces.

Across the six states we studied, Medicaid insurers participate in 80 of 127 marketplace rating regions (Table 1). In 54 of these 80 regions, a Medicaid insurer offers the lowest-cost silver plan (Table 1). Medicaid insurers, representing both national chains and local "homegrown" managed-care organizations, have been increasingly participating in the marketplaces, expanding their coverage areas in some states and entering others where they have no prior experience. Ambetter, a product of the Centene Corporation, has entered the marketplace in numerous states (including Arkansas) where it had no previous Medicaid business. A health insurance broker in Arkansas compared Ambetter to a commercial competitor, USAble (an Arkansas Blue Cross Blue Shield affiliate), noting that while USAble had implemented steep price increases prior to 2020, Ambetter's prices remained static. Arkansas stakeholders felt the introduction of Ambetter was crucial for the marketplace because it offered consumers a more affordable option. Ohio interviewees reported a similar dynamic: CareSource had participated in Ohio's marketplace since its 2014 launch, offering a low-cost option early on. Another Medicaid insurer, Molina, joined a few years later, giving consumers an additional, more affordable option. Ohio respondents all indicated that offering consumers additional lower-priced choices in the market was hugely beneficial. The marketplaces incentivize insurers to compete against one another to offer the lowest-cost plans and thus gain enrollment. When asked about Medicaid insurers' impact on marketplace dynamics, an interviewee in Washington said, "I think that they push the competition, as they're supposed to. I don't think the [commercial] carriers like losing business to them, so they watch them pretty carefully."

Medicaid insurers' business models are the key to their competitive edge.

Leveraging Provider Networks

Medicaid insurers have leveraged their existing business models and provider relationships to enter and thrive in the marketplaces. One way they have succeeded is by initially introducing closed provider networks that are narrower than their competitors' in exchange for favorable provider payment rates. This trend has been growing in health insurance marketplaces and in private health coverage products overall, but the entrance and expanded presence of Medicaid insurers in the marketplaces may be accelerating it. A California interviewee credited the narrow networks with keeping premium increases low year after year, noting that "every one of our [marketplace] plans has had narrow networks day one. And that's part of what has been a factor in California's success. We've had relatively little rate increases across all of our plans." Another interviewee in Washington noted, "In Washington, [the Medicaid insurers] were the ones who immediately went to [evidence-based] managed-care, they went to tighter networks and promoted that." By moving the marketplace toward a more managed-care setting, Medicaid insurers have controlled costs and kept premiums low.

Many Medicaid insurers have built their marketplace business on preexisting relationships with providers serving their Medicaid managed-care enrollees. These relationships have advantages and disadvantages for insurers, because Medicaid and marketplace contracts with providers are typically negotiated jointly. With millions of enrollees in Medicaid managed-care programs, Medicaid participation may account for a significant share of insurers' businesses, particularly in expansion states. Many interviewees observed that Medicaid insurers leverage this by guaranteeing providers a large volume of Medicaid patients in exchange for lower payment rates. But, providers can also use jointly negotiated Medicaid and marketplace contracts to their advantage. As one interviewee in Washington observed, "They're going to have relationships between the Medicaid products and exchange products. For example, [two Medicaid insurers] backed off offering bronze products in the marketplace, because their providers in Medicaid complained about bad debt, and they basically said, 'If we're going to continue to get bad debt from marketplace customers, we're going to ask for a better deal on Medicaid.'"

Lower Administrative Costs

Another feature of Medicaid insurers' business models that contributes to lower pricing is their tendency to have lower administrative costs than their commercial counterparts. Commercial insurers must spend resources developing plan designs and tend to have larger marketing budgets. Medicaid insurers spend less on actuaries and developing alternative plan designs, which are not required in Medicaid managed care. Medicaid insurers do not require the amount of resources commercial networks do for processing claims or maintaining networks (which are generally smaller). However, a leaner administrative base can mean Medicaid insurers may sometimes lack the infrastructure needed to handle the influx of covered lives and new systems involved in marketplace participation.

More Reliance on Utilization Review

Because of their history of operating as managed-care organizations for Medicaid programs, Medicaid insurers are familiar with utilization review methods and have applied this to their marketplace products. Most interviewees indicated that Medicaid insurers tend to have more stringent utilization review measures than commercial competitors, though a few said there were no differences in this area. Interviewees suggested Medicaid insurers were more likely to have stricter prior authorization and STEP therapy requirements and that Medicaid insurers have adopted more comprehensive care management practices. When asked about utilization control measures for Medicaid insurers versus those for commercial insurers, a New York interviewee said, "Yes, [measures for Medicaid insurers] are a little tighter. We see more denials… and more restrictive networks for ancillary services too." That interviewee also observed that commercial insurers have adopted tighter utilization management, seemingly in response to Medicaid insurers' policies.

Broker Commissions

Medicaid insurers might now pay higher broker commissions for marketplace products, at least in the states we studied. Historically, Medicaid insurers have not engaged with brokers in the marketplace, considering them unnecessary for boosting enrollment.[4] However, the brokers we interviewed reported that Medicaid insurers have increased broker compensation to attract a broader pool of enrollees. Some interviewees indicated that the higher commission intended to get brokers' attention, reporting that brokers had virtually ignored Medicaid insurers in the early years of marketplace operations. Adding this incentive has boosted enrollment in these plans. When asked about Medicaid insurers' broker commissions, an Ohio broker reported, "At the beginning, no [we did not get a commission from Medicaid insurers], but as time has progressed, the marketplace business in Ohio is more popular than it was a few years ago. The compensation rates [between Medicaid and commercial insurers] are now very close, if not identical."

Familiarity with Covering Enrollees with Lower Incomes and Continuity across Programs

Serving Medicaid and marketplace enrollees offers distinct

advantages for Medicaid insurers by helping former Medicaid enrollees gain and maintain enrollment. By offering marketplace plans, Medicaid insurers can provide continuous coverage to people who may transition (sometimes called "churning") between Medicaid and the marketplace. In states that expanded Medicaid (which include all states we studied except Florida), a portion of the Medicaid population (e.g., seasonal workers) becomes eligible for marketplace coverage during the year because of income fluctuations. This is beneficial to Medicaid insurers' business models and consumers alike. Specifically, Medicaid insurers participating in the marketplace can also cover an entire family even when its members are eligible for different insurance programs, simplifying health coverage navigation and making it easier for families to receive optimal care. For instance, a family might have children enrolled in Medicaid or the Children's Health Insurance Program (CHIP) (because children are typically eligible for these programs at higher income levels than are adults) and parents enrolled in a marketplace plan. As one interviewee explained, "I think [Medicaid insurers in the marketplace] are serving a population that hasn't been as well served in the past from a price point. There is a lot more continuity in families…children who are on CHIP, a natural evolution is that those parents will be on a [marketplace] plan with same network, same delivery system."

Finally, many Medicaid insurers have a public mission to provide coverage to lower-income populations. As such, these insurers are a natural fit for the marketplace. The marketplace population tends to have lower incomes and have a similar risk profile and set of needs as the Medicaid population. Many Medicaid insurers offer wraparound services common in the Medicaid program but typically unavailable in commercial insurance plans. Some Medicaid insurers offer transportation to and from medical appointments and have a greater focus on care coordination, such as referral systems to social services like counseling, employment, housing, and legal resources. Some interviewees noted that this familiarity with serving a lower-income population has enabled Medicaid insurers to better manage premium increases and maintain profitability while serving new enrollees who were previously uninsured or had limited access to care. Discussing insurers faced with covering a lower-income population buying coverage through the marketplace, an Arkansas provider said,

> "Our traditional insurance companies, they were a little panicked. They had no idea how to even plan for taking care of a population they had never paid any attention to. I think that probably meant that they had higher premiums. [By comparison, the Medicaid insurer's] premiums have been lower…because their business model helped them know better how to plan for this population."

Medicaid insurers have largely evolved and adapted to the commercial marketplace, and interviewees perceived few differences between these insurers' plans and those of traditional commercial insurers.

Most interviewees noted that though there may have been some key differences between Medicaid insurers and commercial insurers in the early years of ACA marketplace implementation, those differences have largely diminished. When considering networks, provider rates, benefit designs, and marketing practices, one California broker said that they "don't really see much of a distinction at all" between the two types of insurers.

Network Breadth

Interviewees commented that Medicaid insurers' networks have slowly evolved to more closely resemble commercial networks: after having a high volume of federally qualified health centers and Medicaid providers in earlier years, to now including a broader range of providers. A state regulator in Washington suggested this growth was partly owed to insurers' need to comply with network adequacy requirements and expand networks that were originally "too tight." In other states, such as Arkansas, state law dictates a broader provider mix. One Arkansas law requires health insurers to accept a medical provider in their network if that provider agrees to the insurer's terms and conditions.[5] This "any willing provider" law covers licensed physicians and many types of specialists, including physical therapists, dentists, optometrists, psychologists, licensed professional counselors, long-term care facilities, rural health clinics, and licensed certified social workers. Though some hospital and provider associations still believe Medicaid insurers' networks are narrower than those of their commercial counterparts, most other stakeholders said the industry as a whole has been moving toward narrower network offerings to control costs. A Florida broker explained that even large insurers that started with broad national networks, like Anthem, are adopting smaller, localized networks. In this way, the insurers seem to be meeting in the middle, as Medicaid insurers' networks expand and traditional commercial insurers' networks contract.

Reimbursement

When asked whether the rates Medicaid insurers pay their marketplace network providers are most similar to Medicaid, Medicare, or commercial rates, interviewees answered differently. A few hospital association representatives said Medicaid insurers' reimbursement rates in the individual market are higher than Medicaid rates but lower than traditional commercial rates. Still, one association representative cautioned that rates would ultimately depend on how dominant an insurer is in the market; a smaller insurer

would likely have to pay providers more to entice their participation in the network compared to a larger insurer, which might have more leverage to negotiate lower rates. In Arkansas and New York, interviewees indicated that Medicaid insurers' physician reimbursement rates are increasingly nearing commercial rates to attract provider participation. As one interviewee explained, "Medicaid plans are paying more and more and more to catch up with commercial insurers." Yet other interviewees estimated that these reimbursements may be closer to Medicare rates, particularly for hospitals. These contrasting views stem from the fact that information on provider reimbursement rates is not publicly available. So, though pinpointing where Medicaid insurers' marketplace reimbursement rates fall on the spectrum is difficult, the general consensus is rates have increased in recent years.

Benefit Design

Because the ACA requires coverage of certain health services in the health plans sold through the marketplace, interviewees reported few differences between competing insurers' benefit designs. One Florida broker explained that complying with the state's benchmark plan forces insurers to offer benefit packages that "are almost virtually identical." Similarly, California requires all marketplace insurers to offer standard patient-centered benefit designs,[6] so the plans are considered "100 percent equal." If anything, stakeholders suggested Medicaid insurers sometimes offer more generous benefits than traditional commercial insurers. Anecdotally, Medicaid insurers were more likely to cover certain services before deductible than their commercial counterparts, in addition to covering the social services described earlier. For example, in Ohio, Medicaid insurers reportedly tend to cover more dental, vision, and primary care, as well as fitness memberships.

Marketing and Advertising

Interviewees mostly agreed that Medicaid and commercial insurers market and advertise their products similarly. They felt that the Medicaid insurers in their state did not target advertising to a particular demographic; rather, they said all marketplace insurers have focused marketing efforts on price point and brand-name recognition. Some interviewees suggested commercial insurers seem to use more sophisticated advertising, such as social media and television commercials, compared with the Medicaid insurers that, at least in some states, advertise more on the radio, at community events, and through public transit ads. However, most interviewees noted that any advertising differences between the two "types" of insurers are nominal. As one state-based marketplace official put it, "There's not any systemic difference around marketing spend because every one of our plans [regardless of "type"] approaches marketing somewhat differently."

Overall, when asked to explore the differences between Medicaid and commercial insurers, interviewees cited few distinguishing factors. One state regulator concluded that the Medicaid plans are "very confident" in what they are doing, and another said that now "they are just another plan on the marketplace."

Early skepticism regarding how Medicaid Insurers would compete in the commercial market has largely dissipated.

When Medicaid insurers first entered the individual market, many worried that they might lack the infrastructure or experience to serve a new consumer market, their networks might be too narrow, and their lower prices might drive other insurers to exit the market. However, interviewees specified that these concerns have largely not been realized.

No Significant Consumer Complaints

According to most interviewees, consumers enrolled in Medicaid insurers' plans have few complaints. When complaints do arise, they are not specific to the Medicaid insurers but are more broadly tied to insurance affordability issues and the gradual narrowing of networks across all insurers. For example, an Ohio insurance broker lamented, "[People] are not completely happy with their health insurance under any circumstances…[but] these [Medicaid] carriers are no different."

On the other hand, interviewees representing provider and hospital associations reported hearing complaints not from consumers but from their provider members, regarding the Medicaid insurers' payment rates and infrastructures. Stakeholders in Ohio reported a disconnect in payment negotiations that can strain the payer-provider relationship; Medicaid insurers tend to advocate for payment rates resembling those in the Medicaid program, because most of their business is rooted in Medicaid. In contrast, providers often seek reimbursement rates closer to those in other commercial plans, because they view the Medicaid insurers as any other private payer selling in the individual market. This perception has caused tension with providers who believe Medicaid insurers can no longer claim to be public payers. In Florida, these conflicting views have caused "major payment issues" and have been an "administrative nightmare" for some providers who believe the payment rates are insufficient. One medical association also noted that it can be more difficult for providers to "[get] in touch with the right person" working for a Medicaid insurer, because the Medicaid plans tend to be smaller and have less infrastructure than commercial insurers' plans. A provider association in Washington agreed with these

sentiments, saying the administrative processes of securing a first payment or getting prior authorization from a Medicaid insurer can be more challenging. Despite these challenges, no interviewees reported hearing complaints about the benefits or comprehensiveness of Medicaid insurers' plans.

State regulators reported that they have not had to step in and take much action against Medicaid insurers. Florida regulators have been pleasantly surprised by how well Medicaid insurers have integrated into a new market, describing them as responsive in addressing issues, such as early concerns related to network adequacy. Some respondents believe that because these insurers are accustomed to the highly regulated Medicaid market, they are used to operating within strict parameters and can easily adapt to changes in annual requirements. One California broker explained, "They know the regulators will come after them and…they just have checks in place."

No Indications of Undermining Competition

Most interviewees agreed that Medicaid insurers' increasing presence has not caused other traditional commercial insurers to drop out of the market or scale back their participation. One broker noted that two new insurers joined Washington's marketplace in 2020,[7] even though Medicaid insurers, like Molina, are prevalent there. Interviewees also cited other states where commercial insurers were continuing to expand their presence. A Florida regulator noted, "We've had a lot of big carriers coming in…none of the big carriers…have been leaving, they have been increasing." Some states have regulations in place to deter insurers from dropping out. In New York, interviewees cited the governor's 2017 executive order warning that insurers dropping out of the individual market might jeopardize other contracts with the state.[8] Though interviewees acknowledged that some insurers left the marketplaces early on because of financial losses and closures, the majority said these departures had nothing to do with a Medicaid insurer's presence.

Rather, the stakeholders interviewed like having Medicaid insurers in their markets but understand that robust participation might be impossible for many of them. One state-based marketplace official explained that it can be daunting for these plans, whose core business is in the Medicaid program, to pour resources into doing a small amount of business in the individual market. Others argued that provider contracting is becoming more difficult for Medicaid and commercial insurers as providers seek greater reimbursement and insurers struggle to contain health care costs. Interviewees said this reality is likely to have a larger impact on insurer participation than on the type of insurers selling in the market.

Many stakeholders felt positively about Medicaid insurers, believing such plans benefit consumers and add value to the market.

Overall, interviewees expressed positive impressions of the Medicaid insurers participating in their states' marketplaces, citing more advantages than disadvantages. Most noted that greater competition is valuable and that consumers benefit when there are more choices of competitively priced products. They suggested Medicaid insurers often provide options that are more affordable for consumers ineligible for subsidies. However, some interviewees remain skeptical of the broader impacts of Medicaid insurers' lower pricing. When considering whether a commercial insurer would lower its premiums to compete with a Medicaid insurer, one Ohio broker argued, "I think they'll walk away from the market before they would lower their prices." Thus, stakeholders see value in Medicaid insurers' more affordable products but believe these insurers' ability to influence other commercial insurers' pricing is limited.

Regulators appreciated the continuity Medicaid insurers have brought to their markets. They were quick to note that Medicaid insurers "stuck around" in the early years of marketplace implementation. One regulator expressed gratitude for these insurers, saying, "We appreciate that Celtic, in its various forms, has stayed around while some of our other carriers—Humana and United[Health Group]—haven't." As Medicaid insurers have continued participating in counties that would otherwise have had no insurers offering plans, they have brought greater stability to regulators' marketplaces. One Ohio broker reported that if the Medicaid insurers had not been part of the marketplace in 2019, the state could have had as many as 20 bare counties. With relief, this broker reflected, "I can't stress enough…thank goodness they are here."

From a consumer perspective, the continuity that Medicaid insurers provide for people who churn between Medicaid and the marketplace is no small matter. Across the board, broker interviewees explained that consumers' top concerns when selecting a plan are price and the ability to stay with their current health care providers. Brokers reported that familiarity with their insurers and their provider networks plays a major role in consumers' enrollment decisions. For consumers who maintain access to their current providers, this makes better care coordination possible.

Few respondents could identify any disadvantages of having Medicaid insurers in their marketplaces, though some expressed concerns with their narrower networks, provider reimbursement rates, and administrative processes. In some cases, issues tied to these concerns were so problematic

early on that interviewees believed some providers still view Medicaid insurers as carrying "a bit of a reputation" even if the issues were resolved years ago. However, by and large, interviewees cited no ongoing disadvantages of Medicaid insurers' increased marketplace participation nor any inadequacies of their plans. As one state regulator summarized, "We have requirements. So long as they're meeting those requirements, we're happy to have them as a choice."

CONCLUSION

Medicaid insurers are becoming increasingly dominant in the ACA's marketplaces and have grown to compete effectively with traditional commercial insurers. By employing tighter networks, leveraging lower provider rates, and keeping their administrative costs down, these insurers have taken their experiences from the Medicaid program and applied them successfully in the individual market. Moreover, they have started adopting some commercial insurers' practices, such as paying broker commissions, engaging in more marketing and advertising, and slowly increasing their payments to providers. Early on, stakeholders were skeptical of Medicaid insurers' ability to enter a new market, but initial concerns with their networks, pricing, and impact on other insurers' participation have largely dissipated. In fact, many feel there are no longer major distinctions between Medicaid and commercial insurers in the marketplaces. Most interviewees have positive perceptions of Medicaid insurers, crediting their ability to increase choice and affordability in the individual health insurance market.

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The authors are grateful to Linda Blumberg and John Holahan for their thoughtful comments and for our interviewees for who generously shared their time and expertise with us.

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Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

Changes in Health Insurance Coverage Due to the COVID-19 Recession: Preliminary Estimates Using Microsimulation

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JULY 2020

Introduction

The novel coronavirus outbreak resulted in extensive business shutdowns and stay at home orders that upended the U.S. economy in just a few weeks. Job losses soared in March and April 2020: The number of people unemployed in the United States soared to a record-breaking 23.1 million. By April, the official unemployment rate reached 14.7 percent—and would have approached 20 percent had it been adjusted to include people out of work for unspecified reasons.[1] Despite some employment gains in May and June, most economists forecast a long and slow economic recovery. Certain industries, such as restaurants, travel, and hospitality, will likely be affected by the ongoing health risks posed by the coronavirus for months or years to come, until an effective vaccine is widely available.

For some people, losing their job means losing the health insurance coverage they had through their job. Thus, employment losses of this magnitude have potentially profound effects on insurance coverage for many Americans. In this analysis, we use the most recent data on the characteristics of people who have lost their jobs during the pandemic to reveal how the general economic slowdown has spread beyond the industries initially affected by COVID-19-related shutdowns, which are less likely to provide employees health coverage, to sectors where job-based insurance is more common, such as health care and state and local governments.

The economic disruption caused by COVID-19 is a test of the safety net health insurance programs created under the Affordable Care Act (ACA). Loss of income and access to employer-sponsored insurance means unemployed workers may become eligible for one of the two major subsidized coverage programs established by the ACA: the Medicaid expansion for people with low incomes, which is available in 35 states and the District of Columbia, and the ACA marketplaces, which offer premium tax credits to purchase private nongroup plans available nationwide.

Uncertainty surrounds the economic and health insurance coverage effects of the COVID-19 pandemic. In this paper, we use microsimulation to take full advantage of the limited information currently available. Our microsimulation model, the Health Insurance Policy Simulation Model (HIPSM), incorporates data on employment losses by industry, state, and demographic characteristics regularly published by the US Department of Labor (DOL) as it tracks the economic recession's impact on workers. HIPSM already includes detailed information on more than 6 million sample individuals, including the industry or occupation they work in, their access to employer-sponsored insurance coverage, their income, and other sociodemographic information. Thus, we can simulate employment losses that match actual employment losses reported by DOL. From there, we estimate resulting changes in eligibility for and enrollment in new insurance coverage.

We estimate the effects of the COVID-19 recession on insurance coverage during the most affected period, the last three quarters of 2020. Our estimates can be interpreted as applying to the average month in this period. However, the duration of the recession is highly uncertain. To project employment losses for this period, we peg the number of those losing employment in our model to such projections from the Congressional Budget Office, averaged over the last three quarters of 2020.

We find that 48 million people will live in families with a worker who experiences a COVID-19-related job loss in the last three quarters of 2020. Of them, 10.1 million lose employer coverage tied to that job. We estimate 32 percent of these people switch to another source of employer coverage through a family member, 28 percent enroll in Medicaid, and 6 percent enroll in the nongroup market, mainly in marketplace coverage with premium tax credits. Still, we estimate 3.5 million people in this group become uninsured.

We estimate that these changes are offset somewhat by coverage transitions among other people; in particular, about 500,000 people uninsured before the pandemic become eligible for Medicaid and enroll. After accounting for all transitions in coverage due to COVID-19-related employment losses, we estimate that 7.3 million fewer people have employer-based coverage; 4.3 million more people enroll in Medicaid or the Children's Health Insurance Program (CHIP), a 6.1 percent increase; and 2.9 million people become uninsured, a 10.0

percent increase. Enrollment in nongroup coverage increases by just 200,000 people on net, because 700,000 people newly enroll but are offset by the 500,000 other people who leave their prepandemic nongroup coverage (most of whom move to Medicaid because of lost income).

Our projections align with growing evidence that the COVID-19 recession is unlike previous recessions and is disproportionately affecting workers paid low wages[2]—many of whom are not covered by health insurance through their jobs.

Methods

Simulating the effects of the COVID-19 recession on insurance coverage involves three broad steps. The first is incorporating reported employment losses into our microsimulation model using multiple recent data sources from DOL.[3] In the second step, we calculate the loss of income and employment-based coverage that follow from the loss of employment. Some workers who lose their jobs have access to employer-sponsored coverage through a family member, and we estimate a high share of those workers take up this option when it becomes available. Last, after accounting for changes in income (including possible receipt of unemployment insurance) and in access to offers of employer coverage, we recalculate each person's eligibility for subsidized health insurance coverage and simulate their enrollment into the programs for which they are eligible.

The severity and duration of the COVID-19 recession are uncertain. Thus, we control our estimates of total employment losses to projections from the Congressional Budget Office, using the average for the last three quarters of 2020: 22.4 million workers unemployed or leaving the labor force.[4] When estimating changes in insurance coverage, it is important to account for workers who lose their jobs and leave the labor force, not just those who report looking for work. Our 22.4 million estimate is close to the total number of people who were officially counted as unemployed in April 2020: 23.1 million. Conversely, our estimate is somewhat higher than the number of continuing unemployment insurance claims continuing to be paid as of June 18, 2020: 20.5 million. But, it is much smaller than the still-growing sum of unemployment insurance claims filed since the recession began; more than 40 million claims were filed between mid-March and May 28, but that number may include people who filed more than one claim or who have already returned to work.

We estimate that fewer people will become uninsured in the wake of the COVID-19 recession than do several earlier studies. Our estimates differ from those of two other microsimulation studies that assumed greater employment losses.[5,6] Our results also differ from a study based on evidence of the relationship between changes in unemployment and employer-based coverage from previous recessions and recoveries.[7] The COVID-19 recession appears to differ dramatically from previous ones in its sudden and disproportionate effects on certain sectors of the economy while other sectors are unchanged. Employment losses are also unlike previous recessions, hitting workers with low wages and low educational levels more severely than others. These workers are less likely to have employer-based coverage through their jobs and more likely to be enrolled in Medicaid before the pandemic than other workers.[8,9] We discuss more fully how our estimates differ from others in the discussion section. We also provide additional details on our key assumptions and the development of our estimates in the Appendix.

Results

People in families experiencing a COVID-19-related job loss. We estimate that in the last three quarters of 2020, 48 million nonelderly people live in families with a worker who will experience a COVID-19-related job loss. Yet, as shown in Figure 1, only a small fraction of those people and their family members were covered by insurance tied to the lost job (21 percent, or 10.1 million people). Larger shares of these workers and their family members were covered by Medicaid or CHIP (27 percent, or 12.7 million people) or an employer plan through another family member's job (34 percent, or 16.6 million people). Whereas 2.4 million (5 percent) of these people were enrolled in the nongroup market, about 4.7 million (10 percent) were uninsured.

Our projections reflect that COVID-19-related job losses disproportionately affect workers paid low wages and families with low incomes. We estimate that 35 percent of workers who experience a COVID-19-related job loss had health insurance to cover themselves through their jobs (data not shown), but they did not always use it to cover their family members. In families with low incomes, children may be eligible for CHIP, and other adult family members may rely on their own jobs to secure employer-based coverage or go uninsured.

Focusing on the 10.1 million people who lose employer coverage because of a COVID-19-related job loss in the last three quarters of 2020, we estimate that just over one-third have access to employer-based insurance through a family member, and a high share of those people make the switch. Consequently, we estimate that 32 percent remain in employer-based insurance (Figure 2). About 28 percent enroll in Medicaid or CHIP, and 6 percent enroll in nongroup coverage, mainly marketplace coverage with premium tax credits. However, about one-third, or 3.5 million people, become uninsured. About 55 percent of the people who become uninsured are eligible for, but do not use, subsidized coverage through the marketplace or Medicaid.

Employer-sponsored coverage. After accounting for the transitions in coverage described above and coverage changes among other people without employer-based coverage before the pandemic, we estimate that 7.3 million fewer people will be enrolled in employer-sponsored insurance coverage across the last three quarters of 2020 (Table 1). This number reflects a net change in coverage and is shown in comparison with the number of people enrolled in employer-sponsored coverage in early 2020, before the pandemic. Employer-based coverage would have decreased even further if more newly unemployed workers had had coverage through their jobs before the crisis.

Figure 1. Health Insurance Coverage Prior to Pandemic Among Those with Subsequent Job Loss in Family, 2020

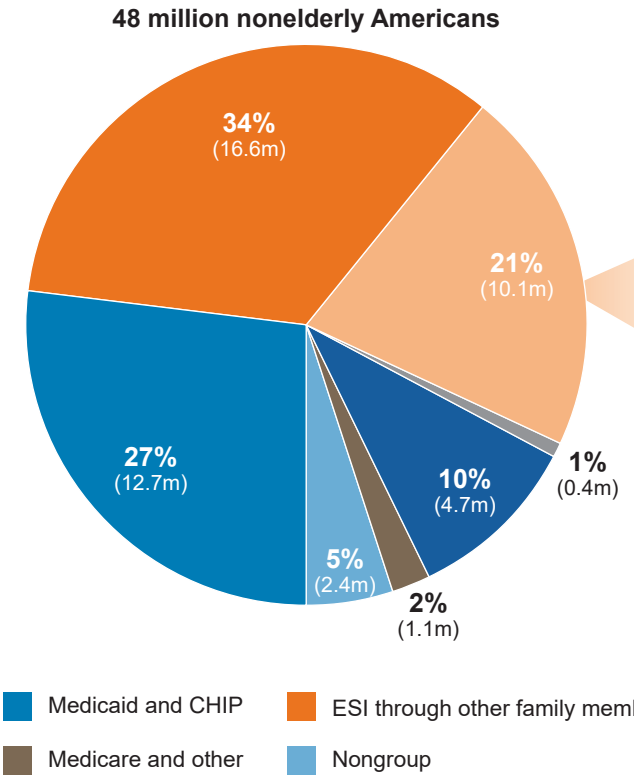
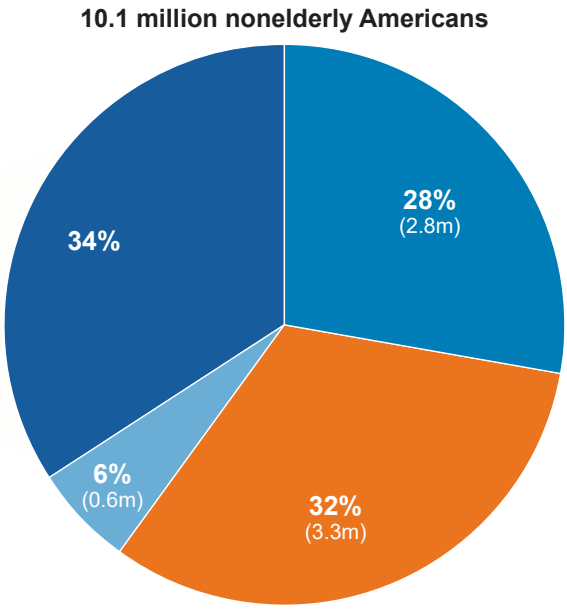
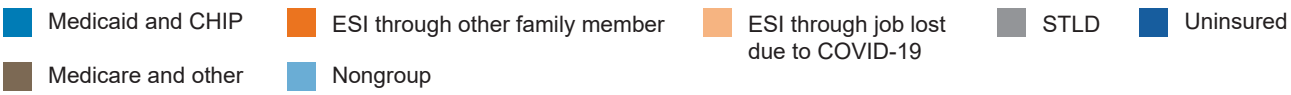


Figure 2. Post Job Loss Coverage Among Workers and Family Members Losing ESI Due to COVID-19 Recession, 2020





Source: Urban Institute's Health Insurance Policy Simulation Model
Notes: Estimates can be interpreted as applying to the average month in the last three quarters of 2020. ESI is employer-sponsored insurance, STLD is short-term limited duration plans, CHIP is Children's Health Insurance Program

Medicaid and CHIP. At the national level, we project Medicaid/CHIP enrollment increases by 4.3 million people, or 6.1 percent, across the last three quarters of 2020 (Table 1). As discussed above, some workers who lose their jobs and become unemployed or leave the labor force become newly eligible for Medicaid coverage because of their income loss. Their children may also be newly eligible for Medicaid or CHIP. Other new enrollees previously had nongroup coverage but became eligible for Medicaid after losing their job and income.

Temporary provisions available during the public health emergency, such as continuous eligibility, also contribute to increased Medicaid and CHIP enrollment. This provision applies if a state accepts additional federal funding via an increased matching rate for traditional Medicaid eligibility categories under the Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security, or CARES, Act.[10] Without the continuous eligibility provision, some people would have disenrolled from Medicaid and CHIP, or been found ineligible and automatically disenrolled, reducing average monthly enrollment figures.

Nongroup coverage. Small net changes in nongroup coverage conceal larger movements in and out of this market which encompasses the ACA marketplaces (both with or without subsidies), the Basic Health Program (available in New York and Minnesota), and ACA-compliant plans sold outside the marketplaces. We estimate that nongroup coverage increases by just 200,000 people on net. This number can be divided into a net increase of 400,000 people covered by plans with premiums tax credits and a net decrease of 200,000 people covered by plans without premium tax credits. Behind these net changes, we estimate that 700,000 people newly enroll in nongroup coverage because of COVID-19-related losses of income and access to employer-based coverage, whereas 500,000 people with nongroup coverage before the pandemic move into Medicaid coverage.

Other factors not estimated in our model may also affect enrollment in the nongroup market. In some cases, employers have continued to pay their employees' health insurance premiums even while workers were furloughed for multiple months.[11] Insurers also report using strategies to help employers and their workers retain group coverage during the recession.[12] In other cases, uninsured workers expecting to return to work when economic activity resumes

Table 1. Health Insurance Coverage among the Nonelderly U.S. Population under Current Law and Changes Due to COVID-19 Recession, 2020

	Prepandemic		COVID 19 Recession		Change	
	# Millions	% dist	# Millions	% dist	# Millions	% change
Insured (Minimum Essential Coverage)	**244.3**	**88.7%**	**241.5**	**87.7%**	**-2.8**	**-1.1%**
Employer	151.1	54.9%	143.9	52.2%	-7.3	-4.8%
Nongroup, ACA-compliant	15.1	5.5%	15.3	5.6%	0.2	1.3%
With premium tax credits*	9.4	3.4%	9.9	3.6%	0.4	4.4%
Without premium tax credits*	5.7	2.1%	5.5	2.0%	-0.2	-3.9%
Medicaid/CHIP	69.5	25.2%	73.7	26.8%	4.3	6.1%
Other	8.6	3.1%	8.6	3.1%	0.0	0.0%
No Minimum Essential Coverage	**31.1**	**11.3%**	**33.9**	**12.3%**	**2.8**	**9.0%**
Uninsured	28.6	10.4%	31.5	11.4%	2.9	10.0%
Short-term, limited duration plans	2.5	0.9%	2.5	0.9%	-0.1	-2.3%
Total	**275.5**	**100.0%**	**275.5**	**100.0%**	**0.0**	**0.0%**

Source: Health Insurance Policy Simulation Model.
Notes: % dist. is percent distribution. ACA is Affordable Care Act. CHIP is Children's Health Insurance Program. Other coverage includes Medicare and other public insurance programs.
Estimates can be interpreted as applying to the average month in the last three quarters of 2020.
** Coverage through the Basic Health Program is combined with nongroup with premium tax credits. Nongroup plans with no premium tax credits include plans sold within and outside the ACA marketplace.*

may find it difficult to estimate their annual income and may therefore avoid applying for income-related assistance. Premium tax credits in the marketplace are based on estimated annual income, and excessive tax credits must be paid back when the year's income tax return is due the following April. In addition, those who enroll in a marketplace plan midyear face a large deductible with fewer months in which to exceed it. In those cases, the value of the plan's partial-year coverage may be significantly lower than its structure would imply. Consequently, if unemployment remains high at the end of the calendar year, the demand for marketplace coverage may increase to a much greater extent during the 2021 open enrollment period.

Uninsured. We estimate that the number of uninsured people increases by 2.9 million on net, to 31.5 million, in the last three quarters of 2020. The total number of uninsured people represents 11.4 percent of the nonelderly U.S. population. This net figure is somewhat smaller than the 3.5 million people who become uninsured after losing their job (Figure 2), because about 500,000 people who were uninsured before the pandemic become eligible for and enroll in Medicaid after employment losses.

Effects by State Expansion Status

In Table 2, we show estimated net changes in insurance coverage separately for DC and the 35 states that expanded Medicaid under the ACA (expansion states) and for the 15 states that have not done so (nonexpansion states).[13] Across the last three quarters of 2020, the total nonelderly population living in expansion states (180.2 million) is nearly double that living in nonexpansion states (95.2 million). In both Medicaid expansion and nonexpansion states, more than half of the nonelderly population had employer-based coverage before the pandemic, and we estimate both groups see net declines in employer coverage in the last three quarters of 2020. Expansion states had slightly higher levels of employer coverage than nonexpansion states before the pandemic (55.6 percent versus 53.4 percent), and they are estimated to experience slightly larger declines in this type of coverage because of the recession (-5.2 percent versus -3.9 percent). Larger percent declines in employer coverage in expansion states owe to the disproportionate concentration of job losses and higher rates of prepandemic employer-based insurance in those states.

The national increase in Medicaid and CHIP enrollment hides how such enrollment varies by state Medicaid expansion status. Medicaid is more broadly available to low-income adults in families with a COVID-19-related job loss if they live in DC or one of the 35 expansion states. Because of the COVID-19 recession, Medicaid and CHIP enrollment increases by 7.3 percent (3.7 million people) in expansion states during the last three quarters of 2020. In contrast, Medicaid and CHIP enrollment increases by only 3.1 percent (600,000 people) in nonexpansion states, because of much stricter eligibility rules.

Changes in nongroup coverage also vary by state expansion status. In expansion states, nongroup enrollment declines slightly, by 1.8 percent, or 200,000 people, on net. As noted earlier, this

Table 2. Health Insurance Coverage among the Nonelderly U.S. Population under Current Law and Changes Due to COVID-19 Recession, by State Medicaid Expansion Status, 2020

	Prepandemic		COVID 19 Recession		Change	
	# Millions	% dist	# Millions	% dist	# Millions	% change
Expansion States						
Insured (Minimum Essential Coverage)	**164.4**	**91.2%**	**162.6**	**90.2%**	**-1.8**	**-1.1%**
Employer	100.3	55.6%	95.0	52.7%	-5.3	-5.2%
Nongroup, ACA-compliant	9.1	5.0%	8.9	4.9%	-0.2	-1.8%
With premium tax credits*	5.1	2.8%	5.2	2.9%	0.1	1.0%
Without premium tax credits*	3.9	2.2%	3.7	2.1%	-0.2	-5.4%
Medicaid/CHIP	50.1	27.8%	53.7	29.8%	3.7	7.3%
Other	5.0	2.7%	5.0	2.7%	0.0	0.0%
No Minimum Essential Coverage	**15.9**	**8.8%**	**17.6**	**9.8%**	**1.8**	**11.1%**
Uninsured	14.8	8.2%	16.6	9.2%	1.8	12.1%
Short-term, limited duration plans	1.0	0.6%	1.0	0.5%	0.0	-3.2%
Total	**180.2**	**100.0%**	**180.2**	**100.0%**	**0.0**	**0.0%**
Non Expansion States						
Insured (Minimum Essential Coverage)	**80.0**	**84.0%**	**78.9**	**82.9%**	**-1.0**	**-1.3%**
Employer	50.8	53.4%	48.8	51.3%	-2.0	-3.9%
Nongroup, ACA-compliant	6.1	6.4%	6.4	6.7%	0.4	5.8%
With premium tax credits*	4.3	4.5%	4.7	4.9%	0.4	8.5%
Without premium tax credits*	1.7	1.8%	1.7	1.8%	0.0	-0.6%
Medicaid/CHIP	19.4	20.4%	20.0	21.0%	0.6	3.1%
Other	3.7	3.8%	3.7	3.8%	0.0	0.0%
No Minimum Essential Coverage	**15.3**	**16.0%**	**16.3**	**17.1%**	**1.0**	**6.8%**
Uninsured	13.8	14.5%	14.8	15.6%	1.1	7.7%
Short-term, limited duration plans	1.5	1.6%	1.5	1.6%	0.0	-1.8%
Total	**95.2**	**100.0%**	**95.2**	**100.0%**	**0.0**	**0.0%**

Source: Health Insurance Policy Simulation Model.
Notes: % dist. is percent distribution. ACA is Affordable Care Act. CHIP is Children's Health Insurance Program. The Basic Health Program is combined with ACA Marketplace with premium tax credits;
Compliant nongroup plans sold outside the marketplace are combined with nongroup, ACA-compliant coverage without tax credits.
When the COVID-19 recession began, 15 states had not adopted Medicaid expansion; they are Alabama, Florida, Georgia, Kansas, Missouri, Mississippi, Oklahoma, Tennessee, North Carolina, South Carolina, South Dakota, Texas, Wisconsin, and Wyoming, as well as Nebraska, where expanded Medicaid eligibility will take effect in late 2020.
Estimates can be interpreted as applying to the average month in the last three quarters of 2020.
Other coverage includes Medicare and other public insurance programs.

net decline results from the increase in new nongroup enrollment being more than offset by people moving from their prepandemic nongroup coverage and into Medicaid after losing income. In contrast, nongroup enrollment grows by 5.8 percent (400,000 people) in nonexpansion states since fewer people move out of prepandemic nongroup coverage into Medicaid which is not generally available. People whose incomes newly fall into the range between 100 and 138 percent of the federal poverty level as a result of COVID-19-related job loss are eligible for marketplace premium tax credits if they live in nonexpansion states, and Medicaid if they live in expansion states.

We estimate that the number of people who lose employer coverage because of the COVID-19 recession in expansion states will be more than double that in nonexpansion states (5.3 million versus 2.0 million) over the last three quarters of 2020. In expansion states, 1.8 million more people become uninsured, about a third of the number of people losing employer coverage. In nonexpansion states, 1.1 million more people become uninsured, but that constitutes more than half the number of people losing employer coverage. Because of additional coverage losses resulting from the current crisis, the uninsured constitute 9.2 percent and 15.6 percent of the nonelderly populations in expansion and nonexpansion states during the last three quarters of 2020. Without expanded Medicaid eligibility in the latter states, current law provides few coverage options to people losing their jobs.

Limitations

Our projections of the COVID-19 recession's effects on insurance

coverage are based on the best presently available data. In these volatile times, however, we face several uncertainties when estimating insurance coverage. First, data are not yet available on the number of people who lost employer coverage when they lost their jobs; we estimate this change based on the known characteristics of the people losing employment.

Second, we match the distribution of job losses in our simulation model to the distribution of job losses in May provided by the Bureau of Labor Statistics (BLS). Certain areas of the country, such as the Northeast, were hit harder earlier in the pandemic, and the characteristics of workers losing jobs reflect this. If job losses shift disproportionately to other states (e.g., in the South) later in the year, we may see different patterns of employment losses that do not match earlier data. This would affect the distribution of insurance coverage overall and our estimated differentials between expansion and nonexpansion states.

Third, tremendous uncertainty surrounds the pandemic itself, how seriously it will continue to affect people and how their behavior will change, when a vaccine will be available, and how fast the economy may recover as a result. Unanticipated shifts in any of these factors would change our estimates. Consequently, we label these estimates as preliminary, expecting to update them later. Our findings represent estimated outcomes under current law. If additional legislation is passed by Congress and signed into law, outcomes will vary from our estimates.

Discussion

Though the COVID-19 pandemic has upended the economy and is causing hardship nationwide, we estimate that losses of employer-based coverage will be lower than some expect across the last three quarters of 2020, because employment losses have been disproportionately concentrated among workers who did not have access to employer-based coverage before the pandemic. These estimates align with evidence that the COVID-19 recession is hitting people with low incomes and less educational attainment the hardest. Our estimates are also consistent with findings from recent surveys. One survey found most households experiencing a job loss had not been receiving coverage through the affected job but were instead covered though another job, enrolled in subsidized coverage, or uninsured.[14] A second survey found that in the early months of the COVID-19 recession some adults whose families lost jobs have also lost employer-based coverage but such coverage changes have not yet resulted in significant increases in the number of uninsured. Resulting increases in Medicaid/CHIP and nongroup coverage that vary by state expansion status are consistent with our results.[15]

Our analysis projects that the ACA health insurance safety net is working as intended in states that expanded Medicaid eligibility, better protecting people from uninsurance. People living in states that have refused to expand Medicaid, however, are less protected. As noted, we estimate that about 34 percent of the number of people losing employer coverage become uninsured in expansion states, while about 55 percent of the number losing employer coverage become uninsured in nonexpansion states.

We project that net additional enrollment in nongroup coverage in 2020 because of COVID-19 recession will be low for several reasons. First, a substantial number of nongroup enrollees become eligible for Medicaid once they suffer income losses, particularly in expansion states. In addition, many employers and insurers have tried to help enrollees maintain employer-based insurance during the economic downturn, but those strategies likely cannot be sustained through the end of the year. Workers who expect to return to work in the fall may not have prioritized taking up nongroup coverage. This may be particularly true for workers concerned that accepting income-based subsidized coverage could mean they must pay back part of that assistance when filing their taxes the following April, if their incomes have increased to typical levels. In addition, starting coverage in the middle of the plan year reduces the value of that coverage, because people are less likely to meet their annual deductibles in the remaining months of 2020.

The findings from this analysis differ from those in an earlier Urban Institute study.[7] We find that 2.9 million people will become uninsured because of the COVID-19 recession, whereas the earlier study estimated that 5.1 million people could become uninsured in its base scenario (and 8.5 million in its high scenario) if unemployment rose to 15 percent, the scenario most comparable to our economic assumptions. The earlier study used alternative econometric models to estimate the historical relationship between employer-based coverage and the unemployment rate, and then used recent data to estimate the resulting insurance status of those projected to lose employer coverage. In contrast, this analysis relies on HIPSM, an Urban Institute microsimulation model, and was produced in June 2020 using May data on job losses and the characteristics of affected workers. As described in more detail in the Appendix, we impute job losses to workers matching the reported distribution of characteristics and compute eligibility for Medicaid and marketplace subsidies for each individual in the model. We then use the model's information on prior insurance coverage to estimate the new set of insurance choices. Last, we use individual and family preferences for insurance to simulate decisions to enroll in new coverage options. To the extent that the current recession differs from previous recessions, microsimulation can take better advantage of available data and capture those differences to a greater degree than an econometric model based on historical relationships. If the current recession evolves to be more similar to prior recessions than the most recent data indicate, the microsimulation approach could lead to greater bias than the econometric approach.

Appendix

We produced the estimates for this report using the Health Insurance Policy Simulation Model, a detailed microsimulation model of the health insurance system designed to estimate the cost and coverage effects of proposed health care policy options. HIPSM is based on two years of data from the American Community Survey, which provides a representative sample of families constituting more than 6 million individuals. The sample is reweighted

to reflect more recent information on income and demographics and aged to future years using recent American Community Survey data and projections from the Urban Institute's Mapping America's Futures program. We regularly update the model to reflect the latest published Medicaid and marketplace enrollment and costs in each state. In this analysis, the version of HIPSM used for the prepandemic coverage baseline incorporates information on enrollment and premiums at the end of the open enrollment period in early 2020.[16]

HIPSM is designed to incorporate timely, real-world data when they are available. Here, we incorporate the latest detailed information on employment losses by industry, state, and demographic characteristics collected from multiple sources and released by DOL.[3] Thus, recent data on actual employment losses are the foundation for our estimates of changes in insurance coverage due to the COVID-19 recession.

As noted, simulating the effects of the COVID-19 recession on insurance coverage involves three broad steps. The first is incorporating reported employment losses into our microsimulation model. We model total employment losses to capture increases in the numbers of people exiting the labor force and of people counted as unemployed (i.e., actively seeking work). We use those data to impose employment losses from monthly BLS employment situation reports on the individuals in our data, selecting people by their reported industry, occupation, educational attainment, sex, and full-/part-time work status. We also match our distribution of employment losses by state to that from BLS state employment and unemployment reports. We control our estimates of total employment losses to projections from the Congressional Budget Office, finding that 22.4 million workers will be unemployed or have left the labor force during the last three quarters of 2020.[4]

In the second step, we calculate the losses of income and employment-based coverage that follow from the loss of employment. We assume workers who lose their jobs also lose the income associated with it, but many workers will apply for and receive unemployment insurance (UI). We assume 66 percent of workers eligible for benefits receive them, based on historical evidence of low receipt, adjusted for newly expanded eligibility and other incentives to apply.[17] We apply state and federal rules in calculating UI payments, because states vary considerably in their rules and in the number of weeks unemployed workers can collect UI benefits. We also apply recent federal rules that affect UI payments: The CARES Act extended UI by 13 weeks beyond existing state limits and increased such weekly payments by $600 through July 31, 2020. It also expanded eligibility for UI to self-employed workers, such as taxi drivers. We follow federal rules on how various UI payments are counted toward eligibility for Medicaid and marketplace subsidies.

No data are currently available on the number of people who have lost both their job *and* their employer-based insurance. We rely on the underlying data in our model to estimate how many workers who lose their jobs also lose access to employer-sponsored insurance. In our earlier work, we found that just 23 percent of workers in industries most vulnerable to high levels of job losses at that start of the pandemic were covered by employer-sponsored insurance through their own jobs.[18] In this analysis, we find that 35 percent of workers who have lost their jobs were covered by their own employer-sponsored insurance (data not shown). Not all of these newly unemployed workers will lose their employer coverage immediately: Some employers are continuing to pay premiums on behalf of their furloughed employees. Some employers are using loans from the Paycheck Protection Program to pay health insurance premiums, but that money may eventually run out. Some businesses will return to full capacity, but others will not. Our projections assume all unemployed workers who remain out of work eventually lose their employer coverage from their previous jobs.

Some workers who lose their jobs have access to employer-sponsored coverage through a family member. Based on past observed behavior and preferences incorporated in our model, we estimate that a high share of people with this option take it up when it is available. We simulate this in our model, accounting for differences in premiums and plan generosity between the family member's offer and the coverage lost. In this analysis, we project that about 3.3 million workers and family members switch to another source of employer insurance (Figure 2). Thus, they do not appear in Table 1 as having lost employer coverage because that table reflects net changes in sources of coverage.

In the final step, after accounting for changes in income and in access to offers of employer coverage, we recalculate each person's eligibility for subsidized health insurance coverage. Our model estimates people's enrollment responses to the new set of insurance choices they face, including enrollment in employer-sponsored insurance (if available), Medicaid, CHIP, the Basic Health Program, and nongroup insurance coverage (including marketplace plans), as well as uninsurance. Our model is based on evidence drawn from a vast literature on insurance choices, observed preferences, and take-up elasticities. We also compared our results with more recent Medicaid enrollment data in the states for which they were available. In the 16 states for which we had enrollment data, Medicaid enrollment increased by 5.3 percent, on average, from February to May. Our model predicts additional Medicaid enrollment due to the COVID-19 recession, an eventual 6.1 percent increase. This is consistent with data from DOL and BLS showing the bulk of job losses occurred in May and that employment may have started improving in late May and June.

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The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.

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Jessica Banthin and Matthew Buettgens are Senior Fellows, Michael Simpson is a Principal Research Associate, Linda J. Blumberg is an Institute Fellow, and Robin Wang is a Research Analyst, all in the Urban Institute's Health Policy Center. The authors are grateful for comments from Bowen Garrett, John Holahan, Genevieve Kenney, and Steve Zuckerman and editorial assistance from Rachel Kenney.

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July 15, 2020

States That Have Expanded Medicaid Are Better Positioned to Address COVID-19 and Recession

By Jesse Cross-Call and Matt Broaddus

The 35 states (plus the District of Columbia) that have implemented the Affordable Care Act's (ACA) Medicaid expansion are better positioned to respond to the COVID-19 public health emergency and to prevent the ensuing economic downturn from worsening access to care, financial security, health outcomes, and health disparities. The 15 remaining states should act swiftly to implement expansion to help their residents weather the crisis.

Expansion states entered the crisis with much lower uninsured rates than non-expansion states, due in large part to expansion. That's important for public health because people who are uninsured may forgo testing or treatment for COVID-19 due to concerns that they cannot afford it, endangering their health while slowing detection of the virus' spread. Expansion — which provides coverage to non-elderly adults with incomes below 138 percent of the poverty line (about $17,600 for a single adult) — has given Medicaid coverage to over 12 million people. At least 4 million uninsured adults would become eligible for Medicaid coverage if the remaining states expanded, a number likely to increase due to the recession.

Many people who could gain coverage through expansion are those at elevated risk from the virus, whether because they face a high risk of becoming infected or a high risk of serious illness if they do. Expanding Medicaid in the remaining states could cover 650,000 currently uninsured "essential or front-line workers" — those who have jobs that likely require them to show up for work regardless of stay-at-home orders or other restrictions, such as hospital workers, home health aides, and grocery store workers. Prior to the COVID-19 crisis, the uninsured rate for low-income workers in these jobs was 30 percent in non-expansion states, nearly double the rate in expansion states. (See Figure 1.) Expanding Medicaid in the remaining states would also provide coverage to millions of older adults, people with disabilities, and others with underlying health conditions that increase their risk of complications from the disease. (See Appendix 1 for estimates by state.)

Expansion has also helped narrow racial and ethnic disparities in both health coverage and access to care. That puts expansion states in a better position to respond to the higher COVID-19 infection and mortality rates that Black and Hispanic people and American Indians and Alaska Natives are experiencing in many places; nationwide, for example, the mortality rate for Black people is more than twice as high as most other groups. Expansion does not eliminate these disparities, which are tied to longstanding racial, economic, and health system inequities, but it does

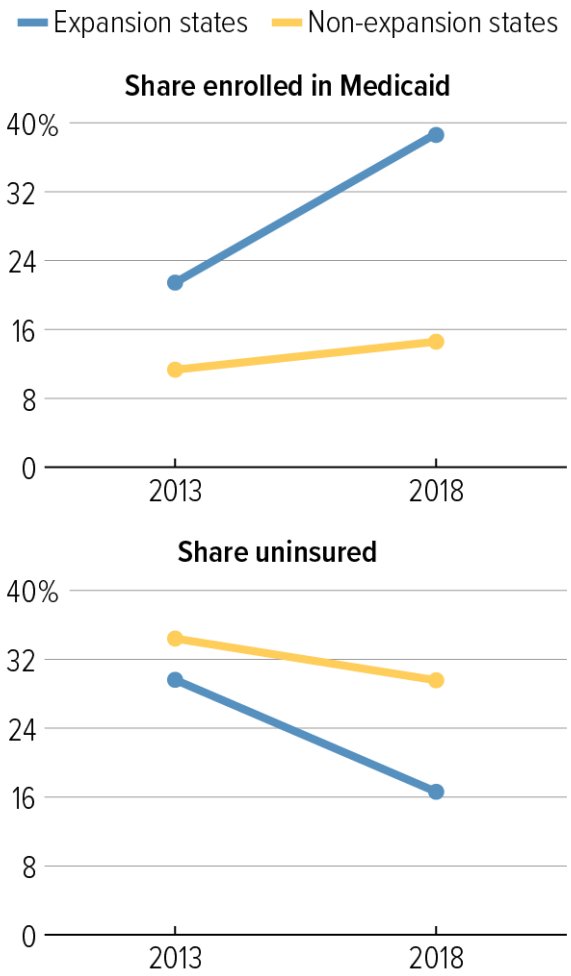
allow people to access treatment for COVID-19, as well as for underlying health conditions that may worsen its effects. If the remaining states expanded, the majority of the uninsured people gaining Medicaid eligibility would be people of color. In particular, Black people would comprise 23 percent of those gaining eligibility and Hispanic people would comprise 29 percent, according to Kaiser Family Foundation estimates.

Medicaid expansion can also help prevent the recession from increasing uninsured rates and thereby worsening access to care, financial hardship, health outcomes, and health disparities. Already, as many as 27 million people may have lost job-based health coverage as a result of the recession, Kaiser Family Foundation researchers estimate. Urban Institute researchers project that 40 percent of people losing job-based coverage in non-expansion states will become uninsured, compared to 23 percent in expansion states, largely because fewer will qualify for Medicaid. By providing health coverage for people who lose their jobs or experience sharp drops in income, expansion can also help prevent this recession from widening racial gaps in access to coverage and care, as the Great Recession did.

Since the federal government pays 90 percent of the cost of expansion, increased Medicaid coverage comes at little upfront cost to states, even if more people need coverage because of the recession. Moreover, many states have seen offsetting savings from expansion, for example due to reduced uncompensated care costs for public hospitals, reduced costs for safety net health programs (especially behavioral health), and increased revenue from taxes on providers and managed care plans. Since the recession will increase uninsured rates, uncompensated care costs, and costs for safety net health programs, expansion's offsetting savings will grow along with its gross costs. And the billions of dollars in additional federal funds that will flow to expansion states will provide valuable fiscal stimulus that will help preserve jobs.

FIGURE 1

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

Expansion Has Improved Coverage, Access to Care, Financial Security, and Health Outcomes

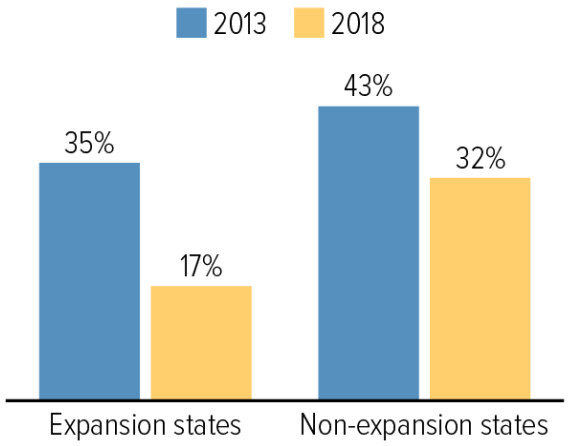
While all states have seen uninsured rates fall since the ACA's major coverage provisions took effect in 2014, states that expanded Medicaid have made the greatest progress in increasing health coverage. In 2018 the uninsured rate among low-income, non-elderly adults in expansion states was 17 percent, compared to 32 percent in non-expansion states, a 52 percent versus a 24 percent decline from 2013. (See Figure 2.)[1] Prior to the onset of the pandemic and recession, over 12 million newly eligible people had health coverage through the Medicaid expansion. Another 4 million uninsured people would gain eligibility for Medicaid coverage if all states expanded. (For an explanation of this and other estimates, see Appendix 1. Estimates for non-expansion states include Nebraska and Oklahoma, where voters have passed initiatives adopting expansion, but it has not yet been implemented.)

A large body of research shows Medicaid expansion beneficiaries are using coverage to obtain cancer screenings, prescription drugs, and treatment for chronic health conditions that they would not otherwise receive.[2] And these improvements in access to care have led to better health outcomes, such as improvements in self-reported health, decreases in the share of low-income adults screening positive for depression, and notably, fewer premature deaths. (See Figure 3.) Medicaid expansion saved the lives of at least 19,200 adults aged 55 to 64 over the four-year period from 2014 to 2017, a study by University of Michigan, National Institutes of Health, Census Bureau, and University of California Los Angeles researchers finds.[3] Conversely, 15,600 older adults died prematurely because of state decisions not to expand Medicaid. The lifesaving impacts of Medicaid expansion are large: an estimated 39 to 64 percent reduction in annual mortality rates for older adults gaining coverage.

FIGURE 2

Expansion States Saw Large Drop in Uninsured Rates

Uninsured rate among non-elderly adults with incomes below 200% of poverty line



Note: States can expand their Medicaid program 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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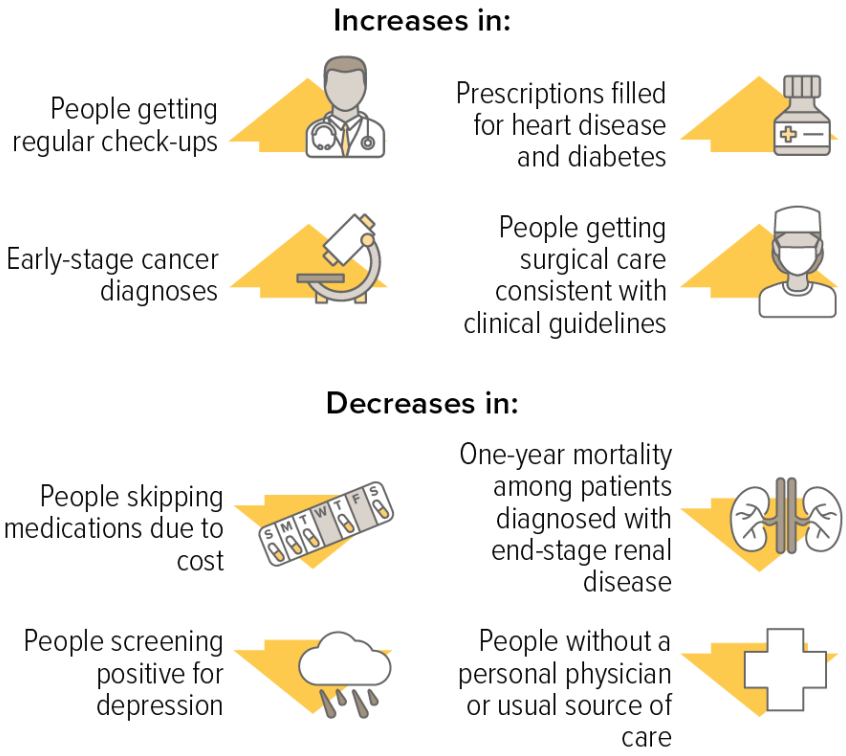
FIGURE 3

Medicaid Expansion Has Saved 19,200 Lives Over Four Years, Study Shows

The lifesaving effects of expansion are no surprise, since other studies find that expansion leads to:



Source: Ghosh et al. 2019, Loehrer et al. 2018, Miller et al. 2019, Sommers et al. 2016, Soni et al. 2017, Swaminathan et al. 2018

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Medicaid expansion is also a powerful anti-poverty tool: it reduces the medical debt of low-income Americans, improves access to credit, and significantly reduces housing evictions for renters.[4]

Expansion Covers — or Could Cover — Many People at Elevated Risk From COVID-19

Among those covered through expansion are many people at elevated risk of contracting, being hospitalized for, or dying from COVID-19.

on Budget and Policy Priorities, November 6, 2019, https://www.cbpp.org/research/health/medicaid-expansion-has-saved-at-least-19000-lives-new-research-finds.

[4] See Center on Budget and Policy Priorities, "Chart Book: The Far-Reaching Benefits of the Affordable Care Act's Medicaid Expansion," updated November 6, 2019, https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicaid.

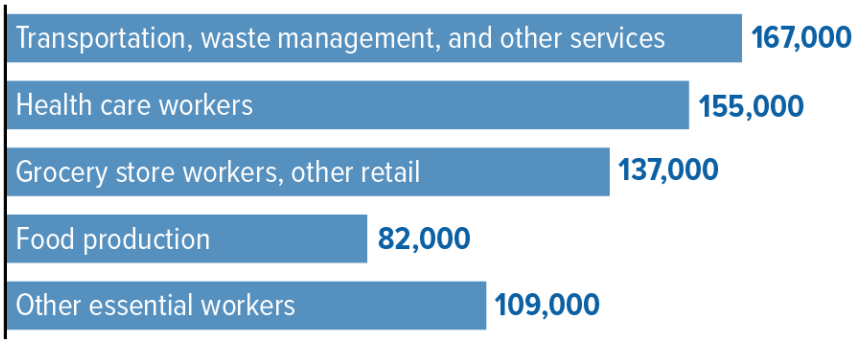
Expansion is a crucial source of health coverage for people working in essential or front-line industries: people whose jobs likely require them to show up for work regardless of stay-at-home orders or other restrictions, such as hospital workers, home health aides, food manufacturers, grocery store workers, farm workers, pharmaceutical manufacturers and pharmacy workers, bus drivers and truck drivers, and warehouse workers.[5] Among low-income workers in these jobs, many are not offered job-based coverage or, if they are, cannot afford the premiums.

Some 30 percent of low-income workers with such jobs (those with incomes below 200 percent of the poverty line) were uninsured in non-expansion states in 2018, compared to 17 percent in expansion states, a sharp drop in expansion compared to non-expansion states since 2013, the last year before expansion was implemented. (See Figure 1.) Over the same period, Medicaid coverage rates for these workers rose sharply in expansion states compared to non-expansion states.

If the remaining states expanded Medicaid, we estimate that over 650,000 essential or front-line workers who are currently uninsured would become eligible for Medicaid coverage. (See Figure 4 and Appendix 1, Table 3.)

FIGURE 4

Over 650,000 Uninsured Essential Workers Could Gain Medicaid Coverage if Holdout States Adopted Expansion



Note: "Essential workers" refers to essential or front-line workers likely required to go to work despite stay-at-home orders. Fifteen states have not implemented the Affordable Care Act's option to expand their Medicaid program to cover low-income adults.

Source: CBPP analysis of Census Bureau data

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[5] We define adults in an essential or front-line industry as those working in any of the following industry categories: essential food production, essential manufacturing (including medicine), essential public services (including civic and public safety), essential transportation, essential utilities, essential warehousing, front-line health care services, front-line retail, and front-line services (including transportation). This definition is imperfect — it undoubtedly excludes some workers who have been required to show up for work while stay-at-home orders are in effect, while including some who have been furloughed or able to work remotely. But we believe it provides a reasonable window into current and potential health coverage for essential or front-line workers.

Medicaid expansion also provides health insurance coverage for people with underlying health conditions or demographic characteristics that make them more likely to get seriously ill if they contract COVID-19. For example, over 30 percent of non-elderly adults with incomes below $25,000 a year have an underlying health condition like heart disease, asthma, or diabetes that makes them more likely to get seriously ill, compared to 21 percent of all such adults.[6] Studies in Michigan and Ohio suggest that the majority of Medicaid expansion enrollees have a chronic condition that could put them at elevated risk from the virus, such as hypertension, asthma, or a heart condition.[7]

If the remaining states implemented expansion, we estimate that 940,000 uninsured people aged 50 to 64 would become eligible for Medicaid coverage, as would more than 500,000 people with disabilities (see Appendix 1, tables 1 and 2).

Expansion States Likely to Maintain Higher Coverage Levels During Recession

This recession will be the first in which the ACA's major coverage provisions are in place. Medicaid expansion states are better positioned to maintain the high health coverage levels they achieved since the ACA took effect, while non-expansion states will likely experience larger uninsured rate increases.

Severe and sustained unemployment is expected through 2021 as a result of the public health and economic crises caused by COVID-19. The unemployment rate will peak at over 14 percent later this year, the Congressional Budget Office (CBO) projects, and will still stand at 7.6 percent at the end of 2021.[8] Already, as many as 27 million people may have lost job-based health coverage due to the recession, Kaiser Family Foundation researchers estimate.[9]

In Medicaid expansion states, many of those losing jobs and employer-based coverage will qualify for Medicaid. In non-expansion states, however, many low-income people will fall into the "coverage gap" — ineligible for Medicaid but with incomes too low to qualify for subsidized marketplace coverage. The median income limit for parents to qualify for Medicaid in non-expansion states is about 40 percent of the poverty line, or an annual income of less than $9,000 for a family of three. Of the 15 remaining non-expansion states, only one (Wisconsin) provides any

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[6] Wyatt Koma *et al.*, "Low-Income and Communities of Color at Higher Risk of Serious Illness if Infected with Coronavirus," Kaiser Family Foundation, May 7, 2020, 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/.

[7] University of Michigan Institute for Healthcare Policy and Innovation, "2017 Healthy Michigan Voices: Follow-Up Survey Report," December 30, 2018, https://www.michigan.gov/documents/mdhhs/2017_HMV_Follow-Up_Survey_Report_-_12-18_647386_7.pdf; and Ohio Department of Medicaid, "2018 Ohio Medicaid Group VIII Assessment: A Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment," August 2018, https://www.medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf.

[8] Congressional Budget Office, "An Update to the Economic Outlook: 2020 to 2030," July 2020, https://www.cbo.gov/system/files/2020-07/56442-CBO-update-economic-outlook.pdf.

[9] Rachel Garfield *et al.,* "Eligibility for ACA Health Coverage Following Job Loss," Kaiser Family Foundation, May 2020, https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/.

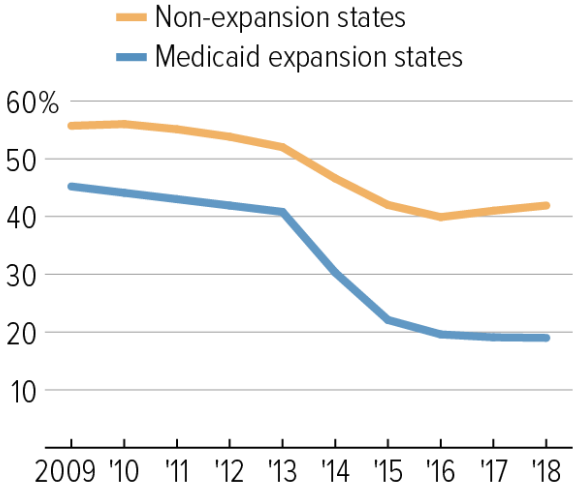
Medicaid coverage to adults without dependent children.[10] Even those near-poor adults who qualify for marketplace coverage are more likely to remain uninsured than if their states expanded Medicaid, since marketplace premiums, even with financial assistance, are high relative to their monthly incomes.[11]

An Urban Institute analysis found that the uninsured rate among unemployed adults dropped sharply in expansion states compared to non-expansion states after implementation of the ACA's major coverage expansions in 2014.[12] (See Figure 5.) In 2018, the uninsured rate among unemployed adults in expansion states was 19 percent, versus 42 percent in non-expansion states. Consistent with that analysis, another Urban Institute analysis projects that 23 percent of people losing job-based coverage in expansion states will become uninsured, compared to 40 percent in non-expansion states.[13]

In pre-ACA recessions the number of adults without any health coverage rose faster than the number of adults in Medicaid.[14] In non-expansion states the current recession will likely

FIGURE 5

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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[10] Rachel Garfield, Kendal Orgera, and Anthony Damico, "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid," Kaiser Family Foundation, January 14, 2020, https://www.kff.org/report-section/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-issue-brief/.

[11] Enhanced unemployment insurance benefits enacted as part of federal COVID-19 response legislation are temporarily lifting many unemployed workers in non-expansion states out of the coverage gap and into the income range where they can qualify for subsidized marketplace coverage. But these enhanced benefits are scheduled to end at the end of July, many low-wage workers do not receive unemployment insurance, and many will find marketplace premiums unaffordable (even with subsidies).

[12] 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.

[13] Bowen Garrett and Anuj Gangopadhyaya, "How the COVID-19 Recession Could Affect Health Insurance Coverage," Urban Institute, May 2020, https://www.urban.org/sites/default/files/publication/102157/how-the-covid-19-recession-could-affect-health-insurance-coverage_0.pdf.

[14] John Holahan and Bowen Garrett, "Rising Unemployment, Medicaid and the Uninsured," Kaiser Family Foundation, January 2009, https://www.kff.org/wp-content/uploads/2013/03/7850.pdf.

look much like previous ones, but in expansion states it will look very different, given Medicaid's availability to far more adults.[15]

And expansion's benefits extend beyond the adults it directly covers: it will be important for preserving children's health coverage as well. A large and growing body of evidence shows that children are more likely to have health insurance coverage if their parents are eligible for coverage. For example, recent analysis of data from the Oregon Health Insurance Experiment examined how offering Medicaid coverage to adults influenced coverage for children. Under Oregon's pre-ACA policy, a subset of potentially eligible adults were selected at random (by lottery) to receive Medicaid coverage. Even though children were eligible for Medicaid regardless, children in households with lottery winners were significantly more likely to be enrolled.[16]

This suggests that when families lose employer-based coverage during the recession, children are more likely to stay covered in expansion states, where the whole family will be eligible for Medicaid, than in non-expansion states where the parents are ineligible.

Prior to the economic crisis, expansion covered several million parents, and another 1.1 million uninsured parents would gain Medicaid eligibility if all states expanded.[17] (See Appendix 1, Table 4.) Of note, the Urban Institute estimates that more than a quarter of those losing employer-based coverage due to the recession will be children whose parents lose their jobs.[18]

Expansion Narrows Racial Health Disparities, Can Help Keep the Recession From Widening Them

Racism, economic and health system inequities, limitations on immigrants' eligibility for Medicaid and other public health coverage, and numerous other factors have resulted in longstanding, harmful racial disparities in coverage and access to care. Those disparities, while still significant, have narrowed since the ACA's major coverage provisions took effect in 2014.

The gap in uninsured rates between white and Black adults shrunk by 51 percent in expansion states (versus 33 percent in non-expansion states), while the gap between white and Hispanic adults shrunk by 45 percent in expansion states (27 percent in non-expansion states). The ACA, and particularly Medicaid expansion, also helped narrow racial disparities in those not seeking care due to cost.[19] (See Figure 6.)

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[15] Paul D. Jacobs, Steven C. Hill, and Salam Abdus, "Adults Are More Likely to Become Eligible for Medicaid During Future Recessions If Their State Expanded Medicaid," *Health Affairs*, January 2017, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1076.

[16] Adam Sacarny, Katherine Baicker, and Amy Finkelstein, "Out of the Woodwork: Enrollment Spillovers in the Oregon Health Insurance Experiment," National Bureau of Economic Research, March 2020, https://www.nber.org/papers/w26871.pdf.

[17] Our estimates of the number of parents who could be covered through expansion include some non-parent adults living with children. See the Appendix for details.

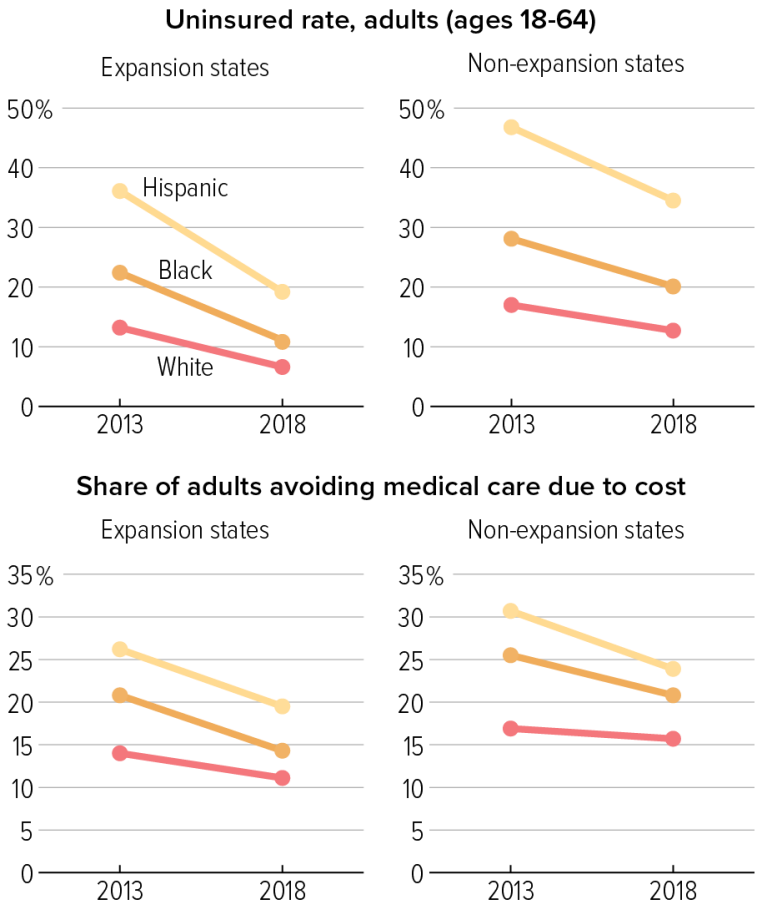
[18] Garrett and Gangopadhyaya.

[19] Jesse C. Baumgartner *et al.*, "How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care," Commonwealth Fund, January 16, 2020, https://www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowed-racial-ethnic-disparities-access.

Medicaid expansion has also helped lower uninsured rates among American Indians and Alaska Natives. Their non-elderly adult uninsured rate fell from 31 percent in 2013 to 20 percent in 2017 in expansion states, while declining only slightly in non-expansion states.[20]

FIGURE 6

Medicaid Expansion Reduced Racial and Ethnic Disparities in Both Coverage and Access to Care



Note: ACA = Affordable Care Act. Black and white racial categories exclude those identifying as Hispanic; Hispanic can include any race.

Source: Census' 2013 and 2018 American Community Surveys (uninsured rate), and Commonwealth Fund (share avoiding care)

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These improvements in coverage and access to care will be crucial as the COVID-19 crisis continues, as available data show that infection rates and deaths in most states are higher among Black and Hispanic people and American Indians and Alaska Natives.[21] For example, Black people

[20] Kaiser Family Foundation, "Health and Health Care for American Indians and Alaska Natives (AIANS) in the United States," May 10, 2019, https://www.kff.org/infographic/health-and-health-care-for-american-indians-and-alaska-natives-aians/.

[21] The data thus far are incomplete and cases may have been disproportionately undercounted in communities of color. For more information, see Monica Webb Hooper, Anna María Nápoles, and Eliseo J. Pérez-Stable, "COVID-19 and Racial/Ethnic Disparities," *JAMA*, May 11, 2020, https://jamanetwork.com/journals/jama/fullarticle/2766098.

make up a disproportionate share of known COVID-19 cases in 30 out of 48 states (including D.C.) reporting such data; Hispanic people make up a disproportionate share in 37 of 45 states reporting the relevant data; and American Indians and Alaska Natives make up a disproportionate share in 10 of 33 states.[22] Overall, the share of Black people in the United States who have died from COVID-19 is more than twice the share of most other groups, and death rates for Indigenous people are also particularly high.[23]

Expansion does not eliminate these disparities, which are tied to longstanding racial, economic, and health system inequities, but it does allow people to access treatment for COVID-19, as well as for underlying health conditions that may worsen its effects.

Expansion can help keep the recession from worsening health disparities. There is clear evidence that the COVID-19 recession is already hitting people with low incomes and people of color especially hard: more than half of adults in lower-income households, and 44 percent of Black and 61 percent of Hispanic adults, say they or someone in their household has lost a job or taken a pay cut due to COVID-19, according to a recent Pew Research Center survey.[24]

During the Great Recession, Black people saw an especially sharp rise in uninsured rates, and both Black and Hispanic people saw a disproportionate increase in the share of people unable to access needed care due to cost.[25] As discussed above, in expansion states, this recession will differ from the last one in that most newly uninsured adults and others seeing large drops in income will be eligible for Medicaid coverage, but non-expansion states will likely see uninsured rate rises more similar to past recessions.

Of the uninsured people who would gain Medicaid eligibility if the remaining states expanded, 29 percent are Hispanic and 23 percent are Black, according to Kaiser Family Foundation estimates.[26] (See Figure 7 for estimates by state.) People of color make up a disproportionate share of those who could gain coverage through expansion, compared to their share of the population across the

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[22] Kaiser Family Foundation, "COVID-19 Cases by Race/Ethnicity," updated July 6, 2020, https://www.kff.org/other/state-indicator/covid-19-cases-by-race-ethnicity/.

[23] APM Research Lab, "The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the United States," accessed July 8, 2020, https://www.apmresearchlab.org/covid/deaths-by-race.

[24] Kim Parker, Juliana Menasce Horowitz, and Anna Brown, "About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID-19," Pew Research Center, April 21, 2020, https://www.pewsocialtrends.org/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-covid-19/. See also LaDonna Pavetti and Peggy Bailey, "Boost the Safety Net to Help People With Fewest Resources Pay for Basics During the Crisis," Center on Budget and Policy Priorities, April 29, 2020, https://www.cbpp.org/research/poverty-and-inequality/boost-the-safety-net-to-help-people-with-fewest-resources-pay-for?.

[25] National Health Interview Survey data show that the uninsured rate for Black people rose by 24 percent between 2007 and 2010, compared to a 9 percent increase for white people. While the uninsured rate for Hispanic people did not rise disproportionately, the share of people skipping needed care due to cost rose 45 percent for Black people, 23 percent for Hispanic people, and 13 percent for white people.

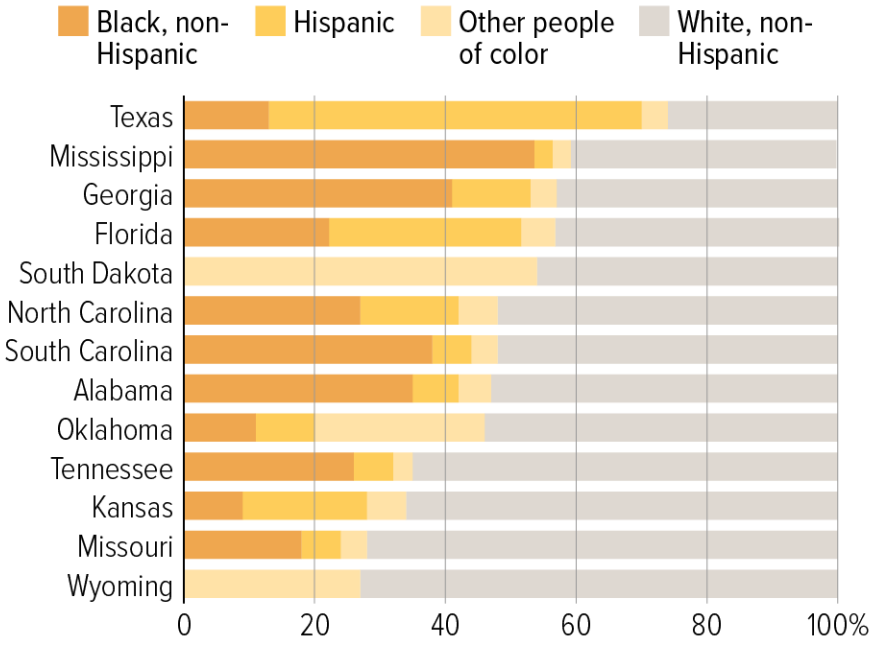
[26] Kaiser Family Foundation, "Who Could Medicaid Expansion Reach in All States?" January 23, 2020, http://files.kff.org/attachment/fact-sheet-medicaid-expansion-US.

remaining non-expansion states. They are also disproportionately likely to reside in states that have not yet expanded Medicaid.

FIGURE 7

Many Black, Hispanic People Would Benefit From Further State Medicaid Expansions

Share of uninsured adults who would become eligible for Medicaid, by race and ethnicity



Note: Estimates by subgroup are not available for South Dakota and Wyoming, so the "other people of color" category represents all people of color, including Black and Hispanic people. Fifteen states have not implemented the Affordable Care Act's option to expand their Medicaid program to cover low-income adults.

Source: Kaiser Family Foundation based on 2018 Census Bureau data

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Rise in Expansion Enrollment Likely to Cost States Little

Since Medicaid expansion coverage took effect in 2014, it has produced *net savings* for many state budgets, state and independent analyses have found. That's because, for starters, states face little upfront cost for expansion coverage. The federal government paid the entire cost of expansion coverage from 2014 to 2016, and while the federal share of costs began dropping in 2017, in 2020 and in each year going forward the federal government will pay 90 percent of those costs. (By comparison, the federal government pays between 50 and 78 percent of a state's costs for covering other Medicaid eligibility groups.)

Meanwhile, expansion produces offsetting budget savings for many states and, in some instances, increases revenues. For example, as more people gain coverage, hospitals' uncompensated care costs

— and thus, for some states, payments to hospitals to help cover those costs — fall. These savings alone could offset more than one-third of the upfront cost of expansion across the 15 states that have not yet adopted or implemented it, the Urban Institute estimates.[27] States also spend less on programs serving people with behavioral health needs since Medicaid paid for their treatment, and less on corrections as federal Medicaid dollars paid a greater share of the inpatient hospital costs of inmates eligible for and enrolled in Medicaid. And, in states that tax managed care plans serving Medicaid beneficiaries, increased enrollment generates revenue gains that further offset the cost of expansion.[28]

A recent analysis of state budget data published in the *New England Journal of Medicine* found that while expansion states experienced Medicaid spending growth 24 percent higher than non-expansion states from 2013 to 2018, federal dollars entirely paid for this spending increase, "with no significant changes in spending from state revenues associated with Medicaid expansion," compared to states that did not adopt expansion — including for 2017 and 2018, after the federal matching rate fell.[29] Further, there is "no evidence that Medicaid expansion forced states to cut back on spending on other priorities, such as education, transportation, or public assistance," the authors found.

While this analysis predates the COVID-19 public health and economic crises, the same budgetary dynamics should operate during the recession. With millions of people losing their jobs or experiencing sharp income reductions, expansion enrollment and states' upfront costs will indeed rise. But the offsetting savings will grow, too. That's because, without Medicaid expansion, higher uninsurance due to the recession will increase demand (and therefore state spending) for state-funded programs serving the uninsured, like uncompensated care pools and behavioral health programs. In expansion states, Medicaid will instead serve much of this demand, with the federal government paying 90 percent of the cost.

Some states have dedicated funding sources for their Medicaid expansions that are tied to enrollment and utilization — such as increased assessments on health care providers and the managed care plans that serve Medicaid enrollees — which will generate more revenue as enrollment increases, making it likely they'll continue to cover the entire cost of expansion.[30]

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[27] 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.

[28] See Jesse Cross-Call, "Medicaid Expansion Continues to Benefit State Budgets, Contrary to Critics' Claims," Center on Budget and Policy Priorities, October 9, 2018, https://www.cbpp.org/health/medicaid-expansion-continues-to-benefit-state-budgets-contrary-to-critics-claims; and Mark Hall, "Do states regret expanding Medicaid?" Brookings Institution, March 26, 2018, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2018/03/26/do-states-regret-expanding-medicaid/.

[29] Jonathan Gruber and Benjamin D. Sommers, "Paying for Medicaid — State Budgets and the Case for Expansion in the Time of Coronavirus," *New England Journal of Medicine*, March 31, 2020, https://www.nejm.org/doi/full/10.1056/NEJMp2007124.

[30] Mattie Quinn, "As Federal Medicaid Money Fades, How Are States Funding Expansion?" *Governing*, July 23, 2018, https://www.governing.com/topics/health-human-services/gov-medicaid-expansion-funding-states.html.

In addition, the economic stimulus that the infusion of federal dollars Medicaid expansion provides is especially valuable during a recession. A 2014 study by the Council of Economic Advisers found that Medicaid expansion would likely create or save over 350,000 jobs among states that adopted it while the economy was still recovering from the Great Recession from 2014 to 2016.[31] Newly adopting expansion could provide similar benefits to the remaining non-expansion states during the current economic downturn.

[31] Council of Economic Advisers, "Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid," July 2014, https://obamawhitehouse.archives.gov/sites/default/files/docs/missed_opportunities_medicaid_0.pdf.

Appendix 1: Uninsured People Who Would Gain Medicaid Eligibility if the Remaining States Adopted Expansion, by State

APPENDIX TABLE 1

Uninsured People Who Would Become Eligible for Medicaid Coverage if the Remaining States Expanded, by Gender and Age

State	Total	Female	Male	19 to 29	30 to 39	40 to 49	50 to 64
Non-expansion states	4,006,000	2,044,000	1,961,000	1,220,000	1,018,000	833,000	935,000
Alabama	193,000	93,000	101,000	61,000	49,000	39,000	43,000
Florida	693,000	349,000	344,000	193,000	166,000	149,000	184,000
Georgia	411,000	213,000	198,000	125,000	103,000	85,000	98,000
Kansas	77,000	39,000	38,000	28,000	19,000	14,000	16,000
Mississippi	144,000	73,000	71,000	51,000	33,000	26,000	33,000
Missouri	164,000	80,000	84,000	53,000	43,000	29,000	40,000
Nebraska	51,000	26,000	26,000	17,000	14,000	11,000	9,000
North Carolina	344,000	173,000	171,000	96,000	93,000	72,000	83,000
Oklahoma	151,000	75,000	76,000	44,000	38,000	30,000	39,000
South Carolina	154,000	72,000	82,000	49,000	29,000	32,000	44,000
South Dakota	27,000	12,000	15,000	10,000	7,000	6,000	4,000
Tennessee	191,000	90,000	101,000	53,000	41,000	41,000	55,000
Texas	1,368,000	730,000	637,000	426,000	371,000	294,000	277,000
Wisconsin	21,000	10,000	11,000	6,000	6,000	*	5,000
Wyoming	14,000	7,000	7,000	6,000	*	*	*

* We do not report estimates that are based on an unweighted sample of fewer than 40 people.
Source: CBPP analysis using Urban Institute estimates, and the Census Bureau's American Community Survey data. See Appendix 2 for further details.

APPENDIX TABLE 2

Uninsured People With Disabilities Who Would Become Eligible for Medicaid Coverage if the Remaining States Expanded

State	People with a disability
Non-expansion states	**508,000**
Alabama	32,000
Florida	82,000
Georgia	49,000
Kansas	15,000
Mississippi	27,000
Missouri	28,000
Nebraska	8,000
North Carolina	44,000
Oklahoma	29,000
South Carolina	26,000
South Dakota	*
Tennessee	34,000
Texas	128,000
Wisconsin	*
Wyoming	*

* We do not report estimates that are based on an unweighted sample of fewer than 40 people.
Source: CBPP analysis using Urban Institute estimates and the Census Bureau's American Community Survey data. See Appendix 2 for further details.

APPENDIX TABLE 3

Uninsured People Working in an Essential or Front-Line Industry Who Would Become Eligible for Medicaid Coverage if the Remaining States Expanded

State	People working in an essential or front-line industry
Non-expansion states	**650,000**
Alabama	25,000
Florida	113,000
Georgia	62,000
Kansas	14,000
Mississippi	22,000
Missouri	34,000
Nebraska	8,000
North Carolina	57,000
Oklahoma	22,000
South Carolina	23,000
South Dakota	5,000
Tennessee	26,000

APPENDIX TABLE 3

Uninsured People Working in an Essential or Front-Line Industry Who Would Become Eligible for Medicaid Coverage if the Remaining States Expanded

State	People working in an essential or front-line industry
Texas	226,000
Wisconsin	*
Wyoming	*

* We do not report estimates that are based on an unweighted sample of fewer than 40 people.
Source: CBPP analysis using Urban Institute estimates and the Census Bureau's American Community Survey data. See Appendix 2 for further details.

APPENDIX TABLE 4

Uninsured Parents Who Would Become Eligible for Medicaid Coverage if the Remaining States Expanded

State	Parents
Non-expansion states	1,118,000
Alabama	45,000
Florida	164,000
Georgia	123,000
Kansas	26,000
Mississippi	32,000
Missouri	45,000
Nebraska	15,000
North Carolina	102,000
Oklahoma	39,000
South Carolina	25,000
South Dakota	7,000
Tennessee	20,000
Texas	535,000
Wisconsin	7,000
Wyoming	*

* We do not report estimates that are based on an unweighted sample of fewer than 40 people.
Source: CBPP analysis using Urban Institute estimates and the Census Bureau's American Community Survey data. See Appendix 2 for further details.

Appendix 2: Explanation of Estimates

We use 2018 American Community Survey data (ACS) from the Census Bureau (the most recent available) to estimate how many adults currently without health insurance coverage would gain Medicaid eligibility in each state if the remaining 15 states implemented expansion and to estimate the *share* of these Medicaid expansion adults in various demographic categories.

We first identify Medicaid expansion-eligible adults in the survey data. Potential Medicaid expansion adults are defined as those who are uninsured, who are aged 19 to 64, who do not earn Supplemental Security Income, who have not given birth to a child within the last 12 months, who are not Medicare enrollees, who have income below 138 percent of the federal poverty line, and who, if they are parents, have incomes too high to qualify for Medicaid in their states today.[32] While this definition is our best approximation of the group of non-elderly adults likely eligible for Medicaid were their state to expand coverage, it does not fully capture Medicaid eligibility requirements. In particular, we are not able to identify adults ineligible for Medicaid due to their immigration status.

We use the Census Bureau survey data to estimate the distribution of this group by the following categories: gender, age group, disability status, parental status, and whether they work in an essential or front-line industry. We use the Census Bureau definition for people with a disability: those who either are deaf or have serious difficulty hearing, are blind or have serious difficulty seeing, have serious cognitive impairment, have serious difficulty walking or climbing stairs, have difficulty dressing or bathing, or have difficulty doing basic activities. We define parents as adults Census categorizes as reference persons of a household, spouses of reference persons, subfamily heads, and spouses of subfamily heads and who are living in the home with either a biological child, adopted child, stepchild, or grandchild under age 19.

We define adults in an essential or front-line industry as those working in any of the following industry categories: essential food production, essential manufacturing (including medicine), essential public services (including civic and public safety), essential transportation, essential utilities, essential warehousing, front-line health care services, front-line retail, and front-line services (including transportation). This definition is imperfect — it undoubtedly excludes some workers who have been required to show up for work while stay-home orders are in effect, while including some who have been furloughed or able to work remotely. But we believe it provides a reasonable window into current and potential health coverage for essential or front-line workers.

Estimates in the tables above exclude any demographic category for any state with an unweighted sample of less than 40 individuals in the survey data.

Our estimates differ from other recent estimates of the impact of Medicaid expansion for various reasons. The Urban Institute estimates that about 4 million uninsured people would gain *health*

[32] 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.

insurance coverage if all remaining states expanded.[33] Compared to our estimate of uninsured people gaining *Medicaid eligibility*, Urban's estimate takes into account that not all newly eligible uninsured people would enroll, but also that expanding Medicaid would lead some already eligible people to enroll in Medicaid coverage (for example, children of newly eligible parents, as discussed above).

The Kaiser Family Foundation estimates that about 4.4 million uninsured people would have gained coverage had all states expanded Medicaid prior to the current public health and economic crisis.[34] Modest differences from our estimates reflect different approaches to identifying likely Medicaid-eligible individuals using the information available in the Census data.

[33] Rachel Garfield, Kendal Orgera, and Anthony Damico, "The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid," Kaiser Family Foundation, January 14, 2020, https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

Robert Wood Johnson Foundation
Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

Adults in Families Losing Jobs during the Pandemic Also Lost Employer-Sponsored Health Insurance

Michael Karpman, Stephen Zuckerman, and Graeme Peterson

July 2020

The recession caused by the COVID-19 pandemic is expected to lead to losses of employer-sponsored health insurance coverage (ESI) and a rise in uninsurance (Banthin et al. 2020; Garfield et al. 2020; Garrett and Gangopadhyaya 2020). These coverage losses would test the health care safety net established by the Affordable Care Act (ACA).[1] Further, the strength of this safety net varies across states: adults who lose ESI in the 15 states that have not expanded Medicaid under the ACA face greater challenges finding replacement coverage (Garfield et al. 2020).[2]

Early data have provided mixed signals on how the recession is affecting health insurance coverage. In this brief, we provide the first nationally representative estimates of changes in coverage during the initial months of the recession. We focus on changes occurring between late March/early April and mid-to-late May for all adults ages 18 to 64 and for those whose families lost jobs because of the pandemic, both nationally and within states that have expanded Medicaid under the ACA (hereafter called expansion states) and states that have not done so (hereafter called nonexpansion states). Our analysis uses longitudinal data from the first wave of the Urban Institute's Coronavirus Tracking Survey, fielded May 14 through 27, 2020, and the Health Reform Monitoring Survey (HRMS), fielded March 25 through April 10, 2020.[3] The tracking survey respondents are a subset of the HRMS participants, allowing us to monitor how the pandemic has affected these adults over time. We find the following:

- Though coverage did not change between March/April and May for the overall sample, adults in families losing jobs reported a 4.9 percentage-point decline in ESI during this period, from

59.0 percent to 54.1 percent, and a 3.5 percentage-point increase in private nongroup coverage, from 7.9 percent to 11.4 percent.

- Among adults in families losing jobs in Medicaid expansion states, the share reporting ESI fell 4.2 percentage points,[4] from 61.2 percent to 56.9 percent, between March/April and May. The share of these adults reporting Medicaid/CHIP coverage increased 2.0 percentage points, from 14.5 percent to 16.5 percent. Uninsurance remained unchanged in these states, both overall and among those in families losing jobs.
- Uninsurance increased by 1.4 percentage points among adults in nonexpansion states, from 15.7 percent to 17.0 percent. Among adults in families losing jobs in these states, ESI coverage fell by 6.2 percentage points, from 54.2 percent to 48.0 percent, and nongroup coverage increased by 7.0 percentage points.

These findings suggest the ACA may be protecting adults who lose jobs during the pandemic from becoming uninsured, even as the administration filed a brief supporting a challenge to the law before the Supreme Court.[5] If the challenge succeeds, approximately 20 million Americans will be at risk of becoming uninsured (Holahan, Blumberg, and Buettgens 2019).

Background

Because of social distancing efforts needed to slow transmission of the novel coronavirus, the economy suffered approximately 22 million job losses between February and April 2020, which was followed by a rebound of 7.5 million jobs between April and June.[6] The official unemployment rate increased from 3.5 percent in February to 11.1 percent in June, and would have been about 1 percentage point higher in June if not for a misclassification of unemployed workers on temporary layoffs. These job losses raised concerns that many adults receiving health insurance coverage through their employer or a family member's employer were at risk of losing coverage (Banthin et al. 2020; Blumberg et al. 2020; Garfield et al. 2020; Garrett and Gangopadhyaya 2020).

Recent survey and administrative data provide mixed evidence of how coverage has changed since the COVID-19 recession began. The Census Bureau's new Household Pulse Survey shows the uninsurance rate for adults ages 18 to 64 was relatively stable between April 23–May 5 (12.6 percent) and June 18–23 (12.8 percent).[7] The shares of nonelderly adults reporting private and public coverage were also essentially unchanged. However, the Household Pulse Survey was first fielded more than a month after millions of people had already lost jobs because of the pandemic. Other survey data suggest some adults lost coverage before the Household Pulse Survey was fielded. An April 24–26, 2020, survey of English-speaking adults by the State Health Access Data Assistance Center found that 4.0 percent of adults ages 18 and older, which would equal approximately 10 million people, reported losing health insurance coverage since the pandemic began, either because their employer-based coverage ended or they had to cancel coverage to pay for other expenses.[8] Administrative data also show accelerated Medicaid and Marketplace enrollment.[9]

Other data sources suggest two potential explanations for the discrepancy between widespread job losses reported in federal surveys and the minimal changes in health insurance coverage in the Household Pulse Survey: (1) many people losing jobs were not covered by insurance through those jobs, and (2) those who were covered by ESI may be able to maintain their insurance during a temporary layoff. The recession has disproportionately affected workers with low incomes (Karpman et al. 2020), who are less likely than workers with higher incomes to have access to ESI (Johnston et al. 2020). A simulation of coverage changes based on the characteristics of people losing employment during the pandemic suggests only one in five workers and their family members in this group had ESI coverage through a lost job (Banthin et al. 2020). Similarly, a recent Commonwealth Fund survey found that most households experiencing lost jobs or furloughs had not been receiving coverage through the affected job but were instead covered through a job not affected by the pandemic, enrolled in Medicaid, Medicare, or nongroup coverage, or uninsured (Collins et al. 2020).

Coverage losses may also lag behind job losses because most of the unemployed have been on temporary layoff during the first months of the recession. Between February and June 2020, the number of such workers increased from 801,000 to 10.6 million, whereas the number of people with permanent job losses increased from 1.3 million to 2.9 million.[10] Other workers have had work hours reduced but remain connected to their employers. Employers who instituted temporary layoffs or furloughs are likely keeping affected workers on their company health plans until they can more fully assess how consumer demand will recover (Lucia et al. 2020). The Commonwealth Fund survey supports this conclusion: among households receiving coverage from a job affected by layoffs or furloughs during the pandemic, just over half of respondents and/or their spouses or partners were still receiving coverage from that job at the time of the survey (Collins et al. 2020).

Study design. This brief examines how health insurance coverage among nonelderly adults changed between late March/early April and mid-to-late May, approximately two months into the COVID-19 recession. We emphasize changes in coverage rather than coverage levels, which often vary across survey programs because of differences in survey design (Au-Yeung and Hest 2019). We report percentage-point changes statistically different from zero at or below the 5 percent level and provide a 95 percent confidence interval (CI) for key estimates.

We focus on changes among all nonelderly adults who participated in both the March/April HRMS and the May tracking survey and among a subset of these adults who reported in May that they or someone in their family lost or were laid off from a job because of the pandemic. We provide estimates for these groups at the national level and in the 35 states (plus the District of Columbia) that have implemented Medicaid expansion under the ACA and the 15 states that have not (AL, FL, GA, KS, MO, MS, NC, NE, OK, SC, SD, TN, TX, WI, and WY).[11]

Our analysis focuses on the share of adults with the following coverage types:

- ESI, including coverage through the military (e.g., TRICARE, CHAMPVA, or VA health care)
- Medicaid, the Children's Health Insurance Program (CHIP), or other state- or government-sponsored insurance based on income or disability (hereafter called Medicaid/CHIP)
- private nongroup coverage, including health plans purchased in or outside the ACA's health insurance Marketplaces
- uninsurance, including coverage solely through the Indian Health Service

In the notes for each figure, we present the shares of adults with Medicare or who were insured but whose type of coverage could not be identified (hereafter called a "nonspecified coverage type"). Because adults could report more than one coverage type, and because of challenges identifying coverage type in surveys, we use a logical editing process for assigning coverage to people reporting more than one coverage type. We provide further detail on this process in the data and methods section at the end of this brief.

Results

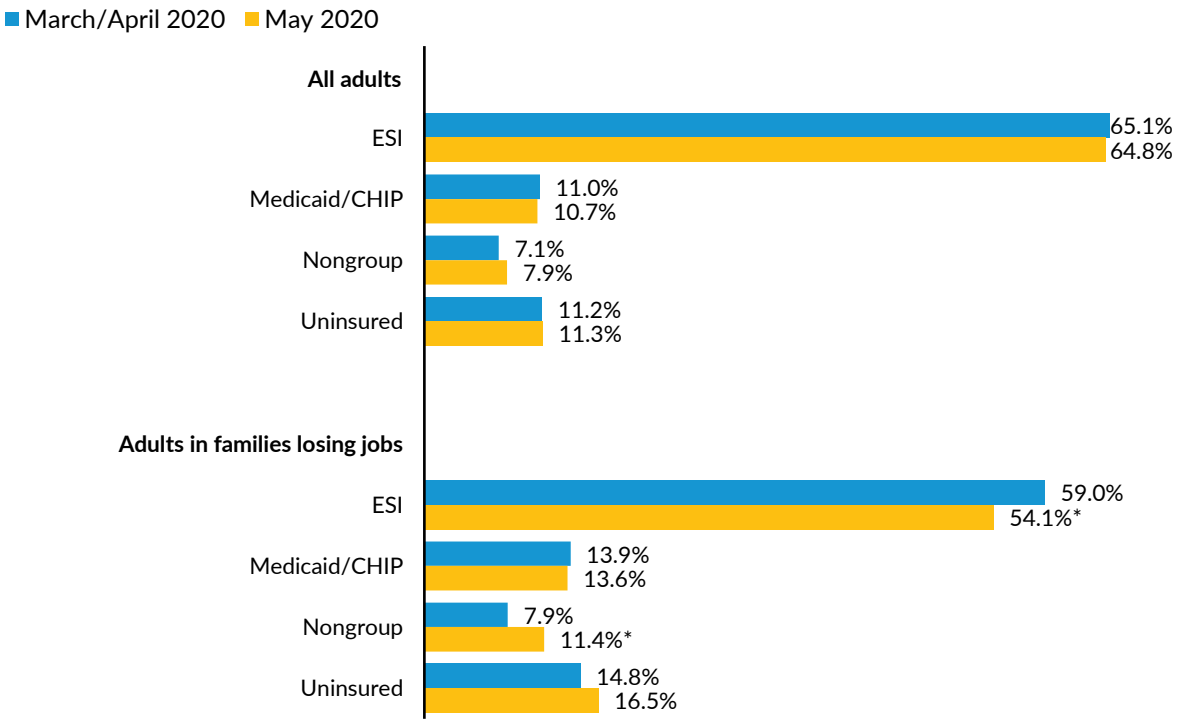
Though coverage did not change between March/April and May among the overall sample, adults in families losing jobs reported a decline in ESI and an increase in private nongroup coverage during this period.

Among the national sample of nonelderly adults, we did not find statistically significant changes in any coverage examined or in the share of adults who were uninsured. Figure 1 shows that the share of adults reporting ESI held steady at about 65 percent, and the uninsurance rate remained at about 11 percent.

However, among the adults in families losing jobs because of the pandemic, the share reporting ESI declined by 4.9 percentage points (95% CI, [-7.9, -1.9]), from 59.0 percent in March/April to 54.1 percent in May. This change coincided with a 3.5 percentage-point increase (95% CI, [0.7, 6.2]) in the share of these adults reporting private nongroup coverage, from 7.9 percent to 11.4 percent. Though the share of adults in families losing jobs who reported being uninsured increased from 14.8 percent to 16.5 percent, this change was not statistically significant.

FIGURE 1

Health Insurance Coverage among Adults Ages 18 to 64, Overall and among those in Families Losing Jobs Because of the Coronavirus Outbreak, March/April and May 2020



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Sources: May estimates are from the Urban Institute Coronavirus Tracking Survey, wave 1. March/April estimates are from the Urban Institute Health Reform Monitoring Survey (HRMS).
Notes: ESI is employer-sponsored insurance. CHIP is the Children's Health Insurance Program. For all adults, *n* = 4,352. For adults in families losing jobs, *n* = 811. We define family as the respondent, their spouse or partner, and any of their children or stepchildren under 19 who live with them. The Coronavirus Tracking Survey was conducted May 14 through 27, 2020, and 93.1 percent of respondents completed the survey by May 20. The HRMS was conducted March 25 through April 10, 2020, and 74.5 percent of respondents completed the survey by March 31. Tracking survey respondents were sampled from the participants in the March/April HRMS. Estimates are not shown for the shares of adults with Medicare (4.3 percent in March/April, 4.2 percent in May) and adults insured with a nonspecified coverage type (1.3 percent in March/April, 1.1 percent in May).
* May estimate differs significantly from March/April estimate at the 0.05 level, using two-tailed tests.

Among adults in families losing jobs in Medicaid expansion states, the share reporting ESI fell between March/April and May, and the share reporting Medicaid/CHIP increased. Uninsurance remained unchanged in these states, both overall and among those in families losing jobs.

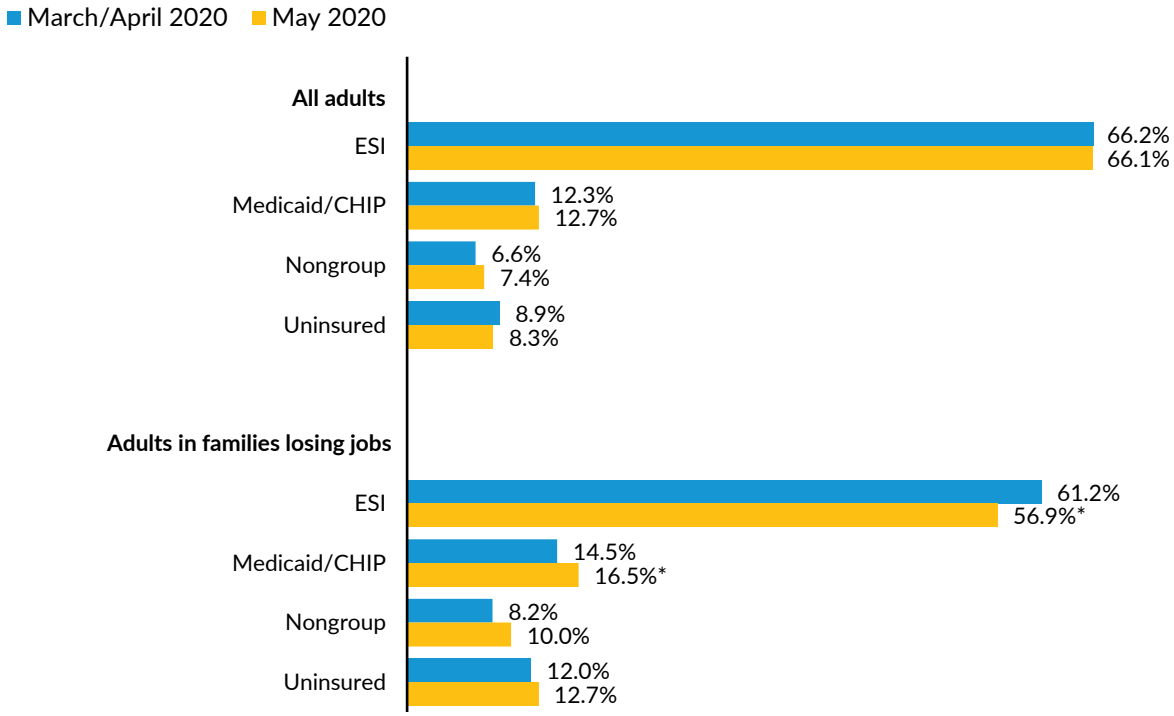
Changes in coverage for adults in Medicaid expansion states were similar to the national-level results: the share of adults in expansion states with ESI remained unchanged at about 66 percent, and Medicaid/CHIP coverage, nongroup coverage, and uninsurance did not change significantly (figure 2).

More than one in six adults in expansion states reported that they or a family member lost or were laid off from a job because of the pandemic (17.7 percent; data not shown). Among the adults in families losing jobs in expansion states, the share with ESI fell by 4.2 percentage points (95% CI, [-7.6,

-0.9]), from 61.2 percent in March/April to 56.9 percent in May. This decline was partially offset by a 2.0 percentage-point increase (95% CI, [0.1, 4.0]) in Medicaid/CHIP coverage, from 14.5 percent to 16.5 percent. The smaller increases in nongroup coverage and uninsurance were not statistically significant.

FIGURE 2

Health Insurance Coverage among Adults Ages 18 to 64 in Medicaid Expansion States, Overall and among Those in Families Losing Jobs Because of the Coronavirus Outbreak, March/April and May 2020



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Sources: May estimates are from the Urban Institute Coronavirus Tracking Survey, wave 1. March/April estimates are from the Urban Institute Health Reform Monitoring Survey (HRMS).

Notes: ESI is employer-sponsored insurance. CHIP is the Children's Health Insurance Program. We define family as the respondent, their spouse or partner, and any of their children or stepchildren under 19 who live with them. For all adults, *n* = 2,841. For adults in families losing jobs, *n* = 549. State Medicaid expansion status is based on having implemented Medicaid expansion under the Affordable Care Act by March 2020. The Coronavirus Tracking Survey was conducted May 14 through 27, 2020, and 93.1 percent of respondents completed the survey by May 20. The HRMS was conducted March 25 through April 10, 2020, and 74.5 percent of respondents completed the survey by March 31. Tracking survey respondents were sampled from the participants in the March/April HRMS. Estimates are not shown for the shares of adults with Medicare (4.6 percent in March/April, 4.4 percent in May) and adults insured with a nonspecified coverage type (1.4 percent in March/April, 1.1 percent in May).

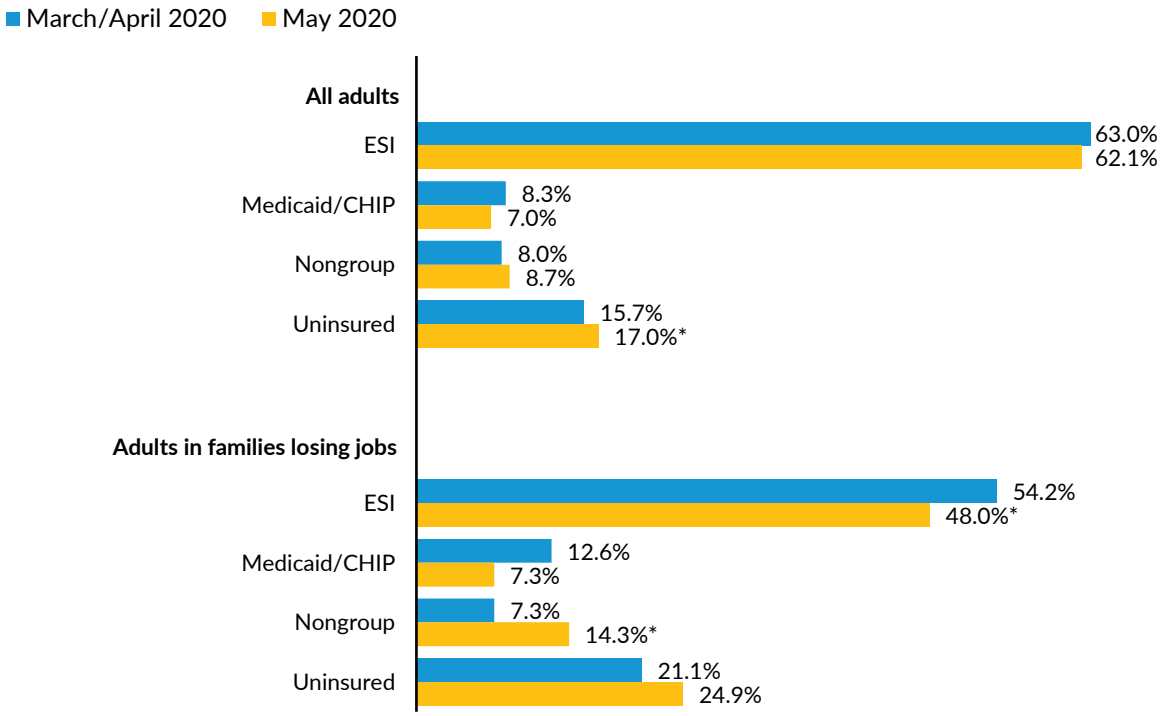
* May estimate differs significantly from March/April estimate at the 0.05 level, using two-tailed tests.

Uninsurance increased among adults in nonexpansion states. Among adults in families losing jobs in these states, the share reporting ESI fell, and the share reporting nongroup coverage increased.

In contrast to adults in Medicaid expansion states, those living in nonexpansion states reported a 1.4 percentage-point increase in uninsurance (95% CI, [0.3, 2.4]), from 15.7 percent to 17.0 percent (figure 3). Estimated changes in other coverage types were not statistically significant. However, the small but insignificant declines in ESI and Medicaid/CHIP coverage exceeded the small but insignificant increase in nongroup coverage, thereby increasing estimated uninsurance.

FIGURE 3

Health Insurance Coverage among Adults Ages 18 to 64 in Medicaid Nonexpansion States, Overall and among Those in Families Losing Jobs Because of the Coronavirus Outbreak, March/April and May 2020



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Sources: May estimates are from the Urban Institute Coronavirus Tracking Survey, wave 1. March/April estimates are from the Urban Institute Health Reform Monitoring Survey (HRMS).
Notes: ESI is employer-sponsored insurance. CHIP is the Children's Health Insurance Program. We define family as the respondent, their spouse or partner, and any of their children or stepchildren under 19 who live with them. For all adults, *n* = 1,511. For adults in families losing jobs, *n* = 262. State Medicaid expansion status is based on having implemented Medicaid expansion under the Affordable Care Act by March 2020. The Coronavirus Tracking Survey was conducted May 14 through 27, 2020, and 93.1 percent of respondents completed the survey by May 20. The HRMS was conducted March 25 through April 10, 2020, and 74.5 percent of respondents completed the survey by March 31. Tracking survey respondents were sampled from the participants in the March/April HRMS. Estimates are not shown for the shares of adults with Medicare (3.9 percent in March/April, 4.0 percent in May) and adults insured with a nonspecified coverage type (1.2 percent in both March/April and May).
* May estimate differs significantly from March/April estimate at the 0.05 level, using two-tailed tests.

Roughly the same shares of adults in expansion and nonexpansion states reported that they or a family member lost or were laid off from a job (15.9 percent in nonexpansion states versus 17.7 percent in expansion states, shares that were not statistically different; data not shown). Among adults in families losing jobs in nonexpansion states, the share reporting ESI fell by 6.2 percentage points (95% CI, [-12.1, -0.4]), from 54.2 percent to 48.0 percent. The share of these adults reporting nongroup coverage increased by 7.0 percentage points (95% CI, [0.3, 13.7]), from 7.3 percent to 14.3 percent. The reported 3.9 percentage-point increase (95% CI, [-0.2, 7.9]) in the share of these adults who were uninsured was not statistically significant at the 95 percent confidence level ($p = 0.06$). Additionally, the decline in Medicaid/CHIP coverage for these adults was not statistically significant at the 95 percent and 90 percent confidence levels. Because of the relatively small sample of adults in families losing jobs in nonexpansion states, we have less confidence in the magnitude of estimated changes in coverage for this group than we have in estimated changes for adults in families losing jobs in expansion states.

Discussion

Though the overall shares of nonelderly adults with ESI and other types of coverage were stable between March/April and May 2020, some adults whose families lost jobs during the pandemic also lost ESI. However, these coverage changes have not yet been large enough to move the needle on overall ESI and uninsurance rates during this period: adults in families losing jobs constitute only about 17 percent of all adults, and a majority of those adults have thus far retained ESI coverage. Others have kept prior coverage or found new coverage through the nongroup market or Medicaid/CHIP. These findings help reconcile stable coverage found in the Census Bureau's Household Pulse Survey with other survey data finding some adults have lost insurance because of the pandemic.[12] Our findings are also consistent with other data indicating that many households losing jobs either retained coverage through lost jobs or never had coverage through those jobs (Banthin et al. 2020; Collins et al. 2020).

We find differences by state Medicaid expansion status in how coverage changed between March/April and May. Though adults whose families lost jobs in both groups of states reported declines in ESI, those in expansion states reported increased enrollment in Medicaid/CHIP, which may have prevented an increase in uninsurance for these adults. In contrast, adults in families losing jobs in nonexpansion states saw a significant rise in nongroup coverage, but it was not enough to offset an overall increase in uninsurance in these states. These differences may at least partially relate to the interaction between Medicaid and the $600 weekly benefit supplement for unemployment insurance recipients authorized by the Coronavirus Aid, Relief, and Economic Security, or CARES, Act. Regular unemployment insurance benefits are counted as income when determining eligibility for both Medicaid and Marketplace subsidies, but the temporary benefit supplement is only counted as income for Marketplace subsidies. Relatively few people at risk of losing ESI will be eligible for Medicaid in nonexpansion states, but the majority will be eligible for Marketplace subsidies (Blumberg et al. 2020;

Garfield et al. 2020). However, even with ACA subsidies, some adults losing both employment and job-based coverage may forgo health insurance if they cannot afford the premiums.

Modest changes in health insurance coverage following widespread job losses in the first months of the COVID-19 recession likely partially owe to most of the unemployed having been on temporary layoff as of May 2020. If employers do not see consumer demand recover, however, many of these temporary job losses may become permanent, which would have spillover effects on ESI. The most recent economic projections from the Congressional Budget Office estimate that the average unemployment rate will exceed 9 percent in 2021, and without further congressional action, high rates of long-term unemployment could roll back some of the coverage gains made under the ACA (CBO 2020). Such coverage losses would exacerbate the growing health care access challenges that have emerged during the pandemic. A separate analysis of the Coronavirus Tracking Survey data finds that nearly half of adults in families losing work or work-related income because of the pandemic reported that someone in their family did not get care because they could not afford it or because they were afraid of being exposed to coronavirus (Gonzalez et al. 2020).

Though the CARES Act and the earlier Families First Coronavirus Response Act required health insurers to cover testing for COVID-19 without cost sharing, neither law included provisions to expand health insurance for workers and family members losing ESI. However, Congress is considering additional relief legislation that could provide a new opportunity to protect unemployed people and their families against coverage losses. The House recently passed the Health and Economic Recovery Omnibus Emergency Solutions Act, which would further increase the Medicaid matching rate, establish special enrollment periods for Medicare and the Marketplaces, and increase funding for Marketplace outreach and enrollment assistance. It would also cover 100 percent of premiums for COBRA coverage until January 31, 2021, for newly unemployed or furloughed workers and their families who received coverage through their employer. Though subsidizing COBRA premiums would help many people stay covered under their existing health plans, it would not help workers who were not covered by ESI or workers whose employers stop offering coverage or close entirely because of the recession (Straw, Lueck, and Aron-Dine 2020). Expanding Medicaid and Marketplace subsidy eligibility and increasing Marketplace subsidies could complement this approach to ensure a more robust safety net for people at risk of losing coverage, helping them maintain access to care during the pandemic (Blumberg and Mann 2020; Blumberg et al. 2020; Gangopadhyaya and Garrett 2020).

Even as some lawmakers consider strengthening the ACA safety net during the pandemic, recent challenges to the ACA that will ultimately be decided by the Supreme Court once again place the law at risk of being overturned. Overturning the ACA could lead to approximately 20 million nonelderly people in the US becoming uninsured, a number that could be much higher during the pandemic (Holahan, Blumberg, and Buettgens 2019).

Data and Methods

This brief uses data from the first wave of the Urban Institute's Coronavirus Tracking Survey, a nationally representative, internet-based survey of nonelderly adults designed to assess the impact of the COVID-19 pandemic on adults and their families and how those impacts change over time. A total of 4,352 adults ages 18 to 64 participated in the first wave, which was fielded May 14 through 27, 2020, with 93.1 percent of respondents completing the survey between May 14 and 20. The respondents were sampled from the 9,032 adults who participated in the most recent round of the HRMS, which was fielded March 25 through April 10, 2020. The HRMS sample is drawn from Ipsos's KnowledgePanel, the nation's largest probability-based online panel. The panel is recruited from an address-based sampling frame covering 97 percent of US households and includes households with and without internet access. Participants can take the survey in English or Spanish.

The tracking survey includes an oversample of non-Hispanic Black and Hispanic HRMS participants. Survey weights adjust for unequal selection probabilities and are poststratified to the characteristics of the national nonelderly adult population based on benchmarks from the Current Population Survey and American Community Survey. The margin of sampling error, including the design effect, for the full sample of adults in the first wave of the tracking survey is plus or minus 1.9 percentage points for a 50 percent statistic at the 95 percent confidence level. The second wave of the tracking survey will be fielded in the summer of 2020. Additional information about the March/April 2020 HRMS and the questionnaires for the HRMS and first wave of the Coronavirus Tracking Survey can be found at hrms.urban.org.

In both the March/April HRMS and the May Coronavirus Tracking Survey, respondents received a question, adapted from the American Community Survey, about their current health insurance coverage. Respondents could report more than one type of coverage, and those who did not report any coverage were asked to verify if they have health insurance. We used additional follow-up questions to determine whether respondents enrolled in their health plan through the Marketplace; whether they enrolled in a private plan through the Marketplace; whether they are covered under certain state programs; and the name of the health plan for their main source of coverage.

Because respondents could report more than one coverage type, we established a hierarchy of responses to assign coverage types so that coverage estimates sum to 100 percent: ESI/military coverage; Medicare; Medicaid/CHIP; nongroup coverage; and other, nonspecified coverage. To address the challenges associated with identifying health insurance coverage type in surveys (Call et al. 2013; Klerman et al. 2009; Pascale 2008; Pascale, Fertig, and Call 2019), we used a logical editing process to identify the most likely type of health insurance coverage held by respondents, based on the information they provided in the survey (Blavin, Karpman, and Zuckerman 2016). However, there is still measurement error in survey estimates of coverage type, particularly in reports of private nongroup coverage (which can be purchased through government-run Marketplaces with public subsidies) and Medicaid coverage (which is often provided through private Medicaid managed-care plans).

Estimates from this brief are not directly comparable to estimates from previous HRMS analyses because of a change in the coverage editing process for respondents who reported having insurance but did not report a specific coverage type and who did not enroll in a health plan through the Marketplace. Under the previous approach, these respondents were identified as insured with a nonspecified coverage type if they reported having a deductible. The updated approach only assigns nonspecified coverage to these respondents if they report the name of a health plan that provides a valid form of comprehensive health insurance coverage. Based on this update, respondents reporting plans that do not offer comprehensive health insurance (e.g., health care sharing ministries) are considered uninsured, yielding slightly higher estimates of uninsurance in this brief than in previous analyses of the HRMS. Under this updated coverage editing approach, estimates of the share of uninsured nonelderly adults in previous rounds of the HRMS would be 1 to 2 percentage points higher than under the previous approach.

Notes

1 Larry Levitt, "COVID-19 and Massive Job Losses Will Test the US Health Insurance Safety Net," *JAMA Health Forum*, May 28, 2020, https://jamanetwork.com/channels/health-forum/fullarticle/2766729.

2 The ACA expanded eligibility for Medicaid to nonelderly adults with family incomes up to 138 percent of the federal poverty level (FPL) and provided people with incomes up to 400 percent of FPL with subsidies for private nongroup health plans sold through health insurance Marketplaces. However, in states that did not expand Medicaid, parents must typically have much lower incomes to qualify for Medicaid (as low as 17 percent of FPL for parents in Texas), and adults without dependent children are generally ineligible, creating a coverage gap for adults with incomes above the Medicaid eligibility threshold but below the eligibility threshold for Marketplace premium tax credits (100 percent of FPL). See "Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level," Henry J. Kaiser Family Foundation, accessed July 1, 2020, https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level.

3 Of the 4,352 respondents to the first wave of the tracking survey, 93.1 percent completed the survey between May 14 and 20. Of the 9,032 respondents to the March/April 2020 Health Reform Monitoring Survey, 74.5 percent completed the survey between March 25 and 31.

4 Because of rounding, some percentage-point change estimates do not exactly match the difference between the two rounded percentages for March/April and May.

5 Meagan Flynn and Tim Elfrink, "Trump Administration Asks Supreme Court to Strike Down Obamacare," *Washington Post*, June 26, 2020, https://www.washingtonpost.com/nation/2020/06/26/trump-obamacare-supreme-court-brief.

6 Bureau of Labor Statistics, "The Employment Situation," news release, July 2, 2020, https://www.bls.gov/news.release/archives/empsit_07022020.pdf.

7 "Health Insurance Coverage – Household Pulse Survey," National Center for Health Statistics, accessed July 6, 2020, https://www.cdc.gov/nchs/covid19/pulse/health-insurance-coverage.htm.

8 Colin Planalp, Giovann Alarcon, and Lynn A. Blewett, "Coronavirus Pandemic Caused More Than 10 Million US Adults to Lose Health Insurance," State Health Access Data Assistance Center, May 14, 2020, https://www.shadac.org/news/SHADAC_COVID19_AmeriSpeak-Survey.

9 Joan Alker, "Medicaid Enrollment Appears to Be Accelerating," *Say Ahhh! Blog*, Georgetown University Health Policy Institute, Center for Children and Families, June 18, 2020, https://ccf.georgetown.edu/2020/06/18/medicaid-enrollment-appears-to-be-accelerating/; "Special Trends Report: Enrollment Data and Coverage Options for Consumers during the COVID-19 Public Health

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[10] Bureau of Labor Statistics, "The Employment Situation," July 2, 2020.

[11] In November 2018, Nebraska voters approved a ballot initiative to expand Medicaid, but implementation has been delayed until October 2020. Oklahoma voters approved a June 30, 2020, ballot initiative that will expand Medicaid by July 2021. Wisconsin has used state funds to expand Medicaid for adults with incomes below the federal poverty level.

[12] Planalp, Alarcon, and Blewett, "Coronavirus Pandemic Caused More Than 10 Million US Adults to Lose Health Insurance," State Health Access Data Assistance Center.

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Stephen Zuckerman is a senior fellow and vice president for health policy at the Urban Institute. He has studied health economics and health policy for 30 years and is a national expert on Medicare and Medicaid physician payment, including how payments affect enrollee access to care and the volume of services they receive. He is currently examining how payment and delivery system reforms can affect the availability of primary care services and studying the implementation and impact of the Affordable Care Act. Before joining Urban, Zuckerman worked at the American Medical Association's Center for Health Policy Research. He received his PhD in economics from Columbia University.

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Acknowledgments

This brief was funded by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at urban.org/fundingprinciples.

The authors gratefully acknowledge helpful comments on earlier drafts from Jessica Banthin, John Holahan, and Genevieve M. Kenney, and thank Rachel Kenney for her careful editing.

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Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

Almost Half of Adults in Families Losing Work during the Pandemic Avoided Health Care Because of Costs or COVID-19 Concerns

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July 2020

The COVID-19 pandemic and resulting economic downturn are posing new challenges for families seeking health care. Not only have many providers rescheduled patient visits or closed their practices because of the pandemic, but patients have also shied away from seeing their regular physicians (Hamel et al. 2020).[1] In addition, significant material hardship among the large number of adults whose families have lost jobs or work-related income during the pandemic makes it difficult for families to afford the care they need (Karpman et al. 2020).

Forgone or delayed care because of cost or fear of exposure to the novel coronavirus will not affect everyone the same way. Relatively healthy people can skip some basic health care services without adverse consequences. Moreover, not all health care is equally important: prepandemic evidence suggests a large share of US spending on health care is low value or unnecessary (Carroll 2017; Mehrotra and Prochazka 2015; Shrank, Rogstad, and Parekh 2019).[2] However, when people with chronic conditions forgo care, deleterious and potentially avoidable health effects can emerge that may be harder to treat later. Similarly, people have fewer opportunities to receive important health screenings and other preventive care during the pandemic, leading to delayed detection of serious health problems, like cancer, and to increased risk of preventable health problems. Evidence already shows children are missing regularly scheduled immunizations, and pediatricians and other health providers are struggling to get them back on track (Santoli et al. 2020).[3] Fears about exposure may be strongest among people experiencing acute health care problems, who worry about going to an emergency department and making contact with COVID-19 patients. Some anecdotal reports suggest this is leading to an increase in deaths at home from heart attack and stroke,[4] and emerging

evidence shows the number of people treated at hospitals has dropped relative to prepandemic figures (Garcia et al. 2020; Hartnett et al. 2020; Jiang et al. 2020).

In this brief, we examine health care affordability problems and avoidance of care due to concerns about exposure to the novel coronavirus during the pandemic. To do so, we use new data from the first wave of the Urban Institute's Coronavirus Tracking Survey, a nationally representative survey of nonelderly adults conducted May 14 through 27, 2020. Anecdotal and quantitative evidence show forgone or delayed care amid the pandemic, including recent polls capturing patients' reluctance to visit health care providers because of concerns about exposure to the coronavirus.[5] Our data add to that body of work by highlighting the groups of people disproportionately affected.

We first consider whether adults in families who have lost work or work-related income are more likely to report that they or a family member have forgone care because of costs or fear of exposure to the virus than those who have not experienced employment disruptions. These adults and their families are already facing the financial consequences of the pandemic and may face further health consequences if they are more likely to skip needed care. We then examine forgone care reported by adults in families losing work or work-related income, including those in families with low incomes, where someone is uninsured, where someone has a chronic condition, or that include children under age 19.

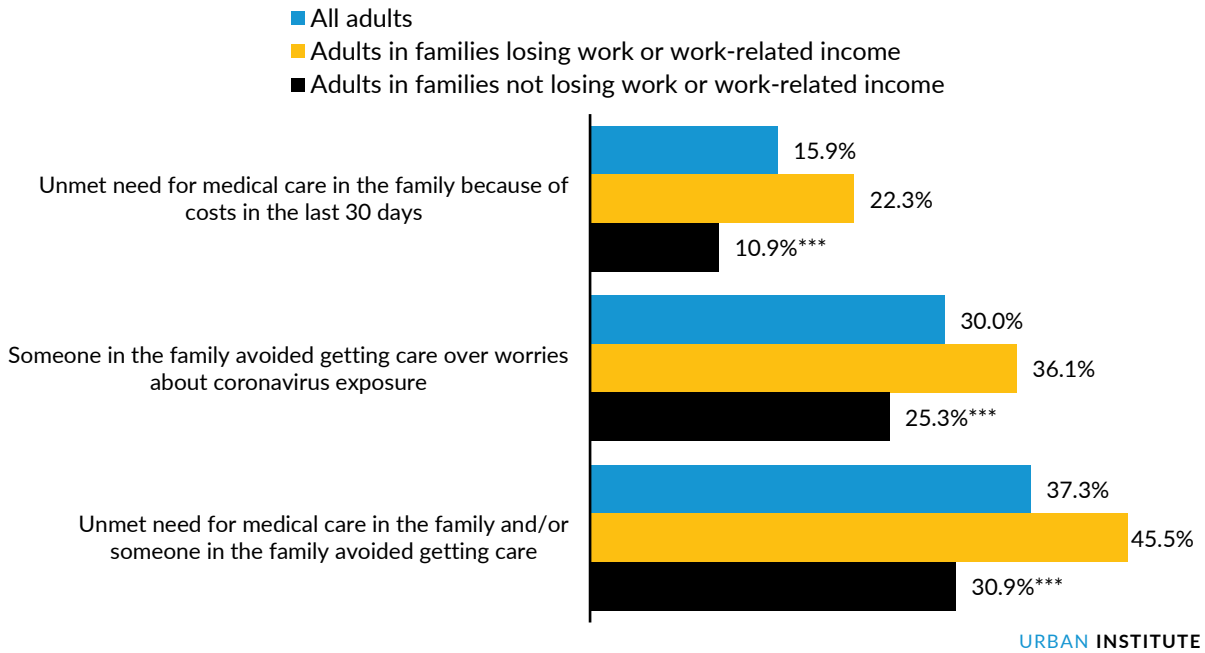
Results

Almost half (45.5 percent) of adults in families losing work or work-related income reported unmet need for medical care in the family because of costs in the 30 days before the survey and/or avoidance of care because of concerns about exposure to the coronavirus.

Overall, 15.9 percent of nonelderly adults reported unmet need for medical care in the family because of costs in the last 30 days; 30.0 percent reported that someone in the family avoided getting care at a doctor's office, clinic, hospital, or other health care provider because of worries about coronavirus exposure; and 37.3 percent reported one or both of these issues (figure 1). Adults in families losing work or work-related income because of the outbreak fared worse: They were more likely than adults whose families did not lose work or income to report that their families had unmet need for medical care because of costs (22.3 percent versus 10.9 percent) and that someone in the family avoided getting care because of coronavirus concerns (36.1 percent versus 25.3 percent).[6] They were also nearly 15 percentage points more likely to report one or both of these reasons for avoiding care than adults whose families have not lost work or income (45.5 percent versus 30.9 percent).[7]

FIGURE 1

Unmet Need for Medical Care in the Family and Avoidance of Care Due to Coronavirus Concerns Reported by Adults Ages 18 to 64, Overall and by Whether Someone in the Family Lost Work or Work-Related Income Because of the Coronavirus Outbreak, May 2020



Source: Urban Institute Coronavirus Tracking Survey, wave 1.
Notes: Unmet need for medical care is reported for the past 30 days and includes prescription drugs; general doctor visits; specialist visits; medical tests, treatment, or follow-up care; dental care; mental health care or counseling; and treatment or counseling for alcohol or drug use. The measure on avoidance of care does not have a reference period. We define family as the respondent, their spouse or partner, and any of their children or stepchildren under 19 who live with them. The survey was conducted May 14 through 27, 2020, and 93.1 percent of respondents completed the survey by May 20.
*/**/*** Estimate differs significantly from adults in families losing work or work-related income at the 0.10/0.05/0.01 level, using two-tailed tests.

Among adults in families losing work or work-related income because of the outbreak, more than half of those with lower incomes and those with uninsured family members, those in families with chronic conditions, and parents living with children under 19 were in families that avoided health care because of cost or concerns about exposure to the coronavirus.

To assess the compounded impacts of lost employment and forgone health care during the pandemic, we now focus solely on adults in families losing work or work-related income. Among this group, about one in three adults (34.4 percent) in families where someone is uninsured reported unmet need for medical care in the family because of costs in the 30 days before the survey, compared with about one in five (19.4 percent) adults in families where everyone has health insurance. Close to one in three (31.4 percent) adults with lower incomes (family income below 250 percent of the federal poverty level) reported unmet need for medical care in the family, compared with 13.5 percent for those with higher incomes (at or above 250 percent of the federal poverty level). This

figure was 28.9 percent for adults in families where someone has a chronic condition, which was nearly twice as high as that for adults in families where no one has a chronic condition (15.9 percent). Parents living with children under 19 were also more likely than adults not living with children under 19 to report an unmet need for care (28.6 percent versus 18.5 percent). By race/ethnicity, roughly equal shares of Hispanic adults and non-Hispanic Black adults reported unmet need for care because of costs (28.5 percent and 28.1 percent); these adults were also about 10 percentage points more likely to report going without care for cost reasons than non-Hispanic white adults (18.2 percent). As shown in table 1, Hispanic adults in families with noncitizens and in families where all members are citizens reported similar unmet needs for care because of costs (28.2 percent versus 28.8 percent).

TABLE 1

Share of Adults Ages 18 to 64 Whose Families Lost Work or Work-Related Income Because of the Coronavirus Outbreak Reporting Unmet Need for Medical Care and Avoidance of Care in the Family, by Reason for Not Getting Care, May 2020

	Reason for Not Getting Care		
	Costs	Coronavirus exposure concerns	Cost and/or exposure concerns
Family health insurance status			
Someone in the family is uninsured^	34.4%	33.2%	50.6%
All family members are insured	19.4%***	36.8%	44.3%*
Family income			
Below 250% of FPL^	31.4%	42.5%	55.3%
At or above 250% of FPL	13.5%***	29.9%***	36.0%***
Chronic conditions in the family			
Someone has a chronic condition^	28.9%	41.0%	52.9%
No one has a chronic condition	15.9%***	31.3%***	38.3%***
Presence of children in the family			
Any children^	28.6%	45.2%	57.3%
No children	18.5%***	30.6%***	38.4%***
Race/ethnicity and family citizenship status			
Non-Hispanic white^	18.2%	32.8%	40.8%
Non-Hispanic Black	28.1%***	39.3%*	48.9%**
Hispanic	28.5%***	41.4%***	53.3%***
Any noncitizen in the family	28.2%***	42.0%**	53.4%***
All family members are citizens	28.8%**	40.8%**	53.2%***

Source: Urban Institute Coronavirus Tracking Survey, wave 1.

Notes: FPL = federal poverty level. Unmet need for medical care because of costs is reported for the past 30 days and includes prescription drugs; general doctor visits; specialist visits; medical tests, treatment, or follow-up care; dental care; mental health care or counseling; and treatment or counseling for alcohol or drug use. The measure on avoidance of care does not have a reference period. Citizens are both US-born and naturalized citizens. Estimates for other race (non-Hispanic adults who are not Black or white or are more than one race) are suppressed because of sample size restrictions. We define family as the respondent, their spouse or partner, and any of their children or stepchildren under 19 who live with them. The survey was conducted May 14 through 27, 2020, and 93.1 percent of respondents completed the survey by May 20.

*/**/*** Estimate differs significantly from reference group (^) at the 0.10/0.05/0.01 level, using two-tailed tests.

Among adults in families losing work or work-related income, certain adults were more likely to report that someone in the family avoided getting care because of worries about coronavirus exposure: those in families with low incomes (42.5 percent), those in families where someone has a chronic condition (41.0 percent), and parents (45.2 percent). In contrast, 29.9 percent of adults with higher incomes, 31.3 percent of adults in families where no one has a chronic condition, and 30.6 percent of people not living with children under 19 reported avoidance of care because of worries about exposure to the coronavirus. Additionally, Hispanic adults and non-Hispanic Black adults were more likely to report avoiding care than non-Hispanic white adults (41.4 percent and 39.3 percent versus 32.8 percent). We find no significant differences by family health insurance status in the share of adults reporting avoided medical care because of exposure concerns.

Finally, 57.3 percent of parents living with children under 19 in families that lost work or income reported an unmet need for medical care because of costs and/or avoiding getting care because of coronavirus concerns, as did 55.3 percent of adults with lower incomes, 53.3 percent of Hispanic adults, 48.9 percent of non-Hispanic Black adults, and 52.9 percent of adults in families where someone has a chronic condition. Adults in families where someone is uninsured were about 6 percentage points more likely than those in families where everyone has health insurance to report either or both of these issues (50.6 percent versus 44.3 percent). Among adults not losing work or work-related income, similar patterns hold for those in families where someone has a chronic condition, parents of children under 19, adults with lower incomes and uninsured family members, and Hispanic adults (data not shown).

Discussion

The unprecedented decline in economic activity because of the current public health crisis threatens to worsen existing health care disparities and upend family financial stability for many, especially those who lose employment. Our findings show that nonelderly adults in families losing work or work-related income because of the COVID-19 pandemic are more likely to face health care affordability challenges than adults in families not experiencing these negative economic effects. Among adults losing work or work-related income, more than one in five report that their family had an unmet need for medical care because of costs in the month before the survey. Within this group, adults in families where someone is uninsured reported much higher unmet need for care because of costs than those in families where everyone is insured, illustrating the protective role health insurance plays in promoting access to needed health care. Though health care affordability was a pressing concern before the pandemic, the currently elevated need for health care brings these challenges to the fore. Affordability concerns and disruptions in care may worsen as the health insurance coverage many families get through their employers terminates because of job loss (Karpman, Zuckerman, and Peterson 2020).

In addition to affordability challenges, many nonelderly adults and their families are also forgoing potentially critical health care over fears of being infected with the novel coronavirus. Nearly one in three adults reported that someone in their family did not get health care because of concerns about

exposure. Among adults in families losing work or work-related income, these concerns were more prevalent among people in families with chronic conditions, parents living with children under 19, adults with low incomes, and adults who are Black or Hispanic.

Avoiding or delaying needed health care, especially for people with ongoing medical needs or who have experienced the outbreak's negative economic consequences, could adversely affect individual long-term health and widen racial/ethnic and socioeconomic health disparities that existed before the pandemic (Weinstein et al. 2017). Though medical visits among older patients appear to be rebounding to prepandemic volumes, visits for specialties, such as behavioral health and pediatrics, remain well below the baseline (Mehrotra et al. 2020). For children, missing needed medical visits to ensure healthy growth and development risks negative long-run effects on their health and well-being. Emerging evidence shows reductions in vaccinations ordered for and administered to children and declines in well-child visits, placing children and others in the community at risk for otherwise preventable diseases (Santoli et al. 2020).[8]

These findings show that addressing both affordability and exposure concerns is necessary for ensuring that people receive the health care they need during the pandemic. The next relief package negotiated by Congress offers a critical opportunity to help families afford care. One key element of improving affordability will be protecting people losing both their jobs and their health insurance coverage from becoming uninsured. But even among those who can maintain coverage, reduced incomes will make it harder to pay for out-of-pocket health care costs associated with deductibles, copayments, and other cost-sharing requirements under their health plans. The Health and Economic Recovery Omnibus Emergency Solutions, or Heroes, Act passed by the House would protect coverage and improve affordability for many people losing employer-sponsored insurance by fully subsidizing premiums for COBRA coverage until January 31, 2021. Other strategies, such as rapid Medicaid eligibility expansions, more generous premium tax credits and cost-sharing reductions for Marketplace plans, and expanded eligibility for those Marketplace subsidies, would be needed to reach people who are neither covered by an employer plan nor eligible for COBRA (Blumberg and Mann 2020; Blumberg et al. 2020). Continuation of the emergency assistance authorized by the Coronavirus Aid, Recovery, and Economic Security, or CARES, Act—which included a $600 weekly supplement for unemployment insurance benefits and direct cash payments to US households—would also mitigate the negative impact of the recession on families' abilities to pay for health care.

In addition to ensuring fewer people lose health insurance coverage and the ability to afford care when they lose their jobs, reducing the extent to which people forgo needed health care will also require lowering transmission risks during health care encounters. Though the CARES Act addressed shortages in personal protective equipment by including provisions to purchase and distribute these essential supplies (Moss et al. 2020), shortfalls are still being reported and will likely worsen with recent upticks in COVID-19 cases.[9] In the Heroes Act, proposed federal policies to address these concerns include expanded workplace safety protections specific to coronavirus, including for health care facilities, and an increase in the production and supply of emergency medical supplies, including personal protective equipment.[10] Providers are also ramping up protective measures for patients and

staff, such as limiting the number of patients in their waiting rooms, requiring patients to wear face coverings, and screening patients for COVID-19 symptoms by phone before patients enter their offices.[11] Reestablishing regular care-seeking behavior will require keeping COVID-19 case numbers low, as well as ensuring COVID-19 testing is widely available and affordable and that it produces quick results. These and other policies that make care affordable and safe to access will be critical to ensuring families, particularly those losing jobs, get the medical care they need during the pandemic.

Data and Methods

This brief draws on data from the first wave of the Urban Institute's Coronavirus Tracking Survey, a nationally representative, internet-based survey of nonelderly adults designed to assess the impact of the COVID-19 pandemic on adults and their families and how those impacts change over time. A total of 4,352 adults ages 18 to 64 participated in the first wave, which was fielded May 14 through 27, 2020, with 93.1 percent of respondents completing the survey between May 14 and 20. The respondents were sampled from the 9,032 adults who participated in the most recent round of the Urban Institute's Health Reform Monitoring Survey (HRMS), which was fielded March 25 through April 10, 2020. The HRMS sample is drawn from Ipsos's KnowledgePanel, the nation's largest probability-based online panel. The panel is recruited from an address-based sampling frame covering 97 percent of US households and includes households with and without internet access. Participants can take the survey in English or Spanish.

The tracking survey includes an oversample of non-Hispanic Black and Hispanic HRMS participants. Survey weights adjust for unequal selection probabilities and are poststratified to the characteristics of the national nonelderly adult population based on benchmarks from the Current Population Survey and American Community Survey. The margin of sampling error, including the design effect, for the full sample of adults in the first wave of the tracking survey is plus or minus 1.9 percentage points for a 50 percent statistic at the 95 percent confidence level. The second wave of the tracking survey will be fielded in the summer of 2020. Additional information about the March/April 2020 HRMS and the questionnaires for the HRMS and first wave of the Coronavirus Tracking Survey can be found at hrms.urban.org.

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Acknowledgments

This brief was funded by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at urban.org/fundingprinciples.

The authors gratefully acknowledge helpful comments on earlier drafts from Stacey McMorrow, and thank Rachel Kenney for her careful editing.

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July 8, 2020 | Insights & Analysis | State Policy

Exchanges May Add More than 1 Million New Enrollees due to COVID-19

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Summary

Affordable Care Act (ACA) exchanges have seen a significant uptick in enrollment, especially from those losing employer-sponsored coverage or who were previously uninsured. However, different approaches to special enrollment periods (SEPs) leave many with limited opportunities to enroll.

Exchange enrollment has remained very stable over the last several years, with nearly 11 million individuals enrolled in exchange plans at the beginning of 2020. However, exchanges are now experiencing significant mid-year enrollment increases, especially since March. The health, economic, and employment effects of COVID-19 and the Public Health Emergency (PHE) are leading tens of millions of individuals to consider new coverage options. With unemployment rates at or near 10% in almost all states, many consumers have been separated from their previous employer-sponsored plans. The economics of Medicaid eligibility in many states and the recent boost to unemployment assistance indicate that many are turning to the exchanges for coverage. In fact, Avalere's proprietary COVID-19 enrollment model estimates an increase in exchange enrollment. This increased enrollment is likely to last for some time given the "stickiness" of exchange coverage and the availability of premium subsidies. This increased market size may lead more issuers to begin offering or expand their marketplace plan offerings.

State and Federal Reports Show over 750K New Exchange Enrollees

A new report from HealthCare.gov shows that nearly half a million (487,000) enrollees have newly enrolled in exchange coverage using the loss of coverage SEP since December 18, when the annual open enrollment period (OEP) closed in the 38 states that use HealthCare.gov. This is 46% higher than the rate of use for that SEP reason for the same time in 2019 and higher than any period outside of the annual OEP since the exchanges launched in 2014. April saw a substantial increase in the use of the loss of coverage SOP when 154,000 individuals enrolled, a 139% increase from April 2019. In total this year, 892,141 individuals have used an SEP to enroll in coverage through HealthCare.gov, a substantial increase from SEP enrollment through May in each of the 3 previous years (which has averaged 330,708 for the loss of coverage SEP and 650,605 overall).

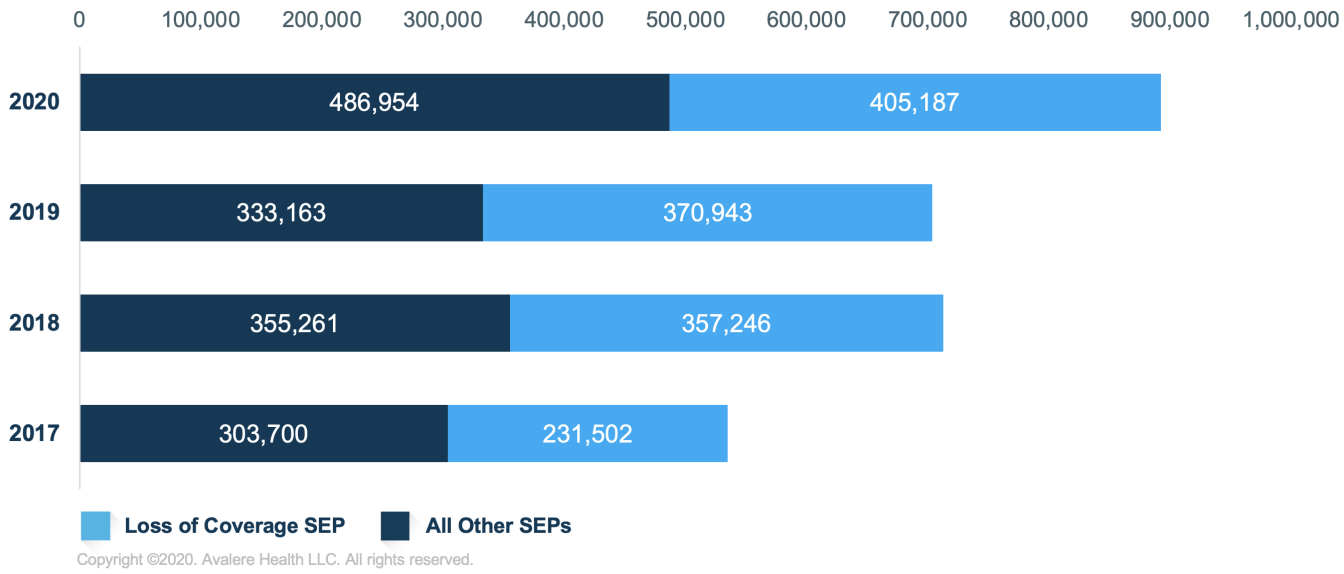

Figure 1. SEP Enrollment through HealthCare.gov, 2017–2020

Figure 1. SEP Enrollment through HealthCare.gov, 2017–2020

Accounts for SEP enrollment from the end of OEP through May. Source: CMS Special Trends Report: Enrollment Data and Coverage Options for Consumers During the COVID-19 Public Health Emergency, June 2020.

In the 12 states plus DC that operate their own state-based exchanges (SBE), almost 263,000 individuals have newly signed up for coverage since March. However, enrollment numbers have only been publicly released for 8 of the 12 SBEs. Therefore, the number enrolling through the SBEs is likely higher. In CA alone, nearly 250,000 new enrollees have enrolled through Covered California since its OEP closed on January 31. Of those, 175,000 (or 88%) have enrolled since

March.

Not Everyone Has the Same Opportunities to Enroll in Exchange Coverage

Individuals cannot choose to enroll in exchange coverage at just any given point in time. Instead, individuals require a SEP-qualifying event to enroll outside of the annual OEP. There are several qualifying events, including loss of current ACA-compliant coverage, a change in economic circumstances (e.g., significant changes in income), a permanent move to a new state or part of a state with new plans, or a unique exchange-granted SEP. Thus, those affected by COVID-19 who did not have employer-sponsored coverage may not qualify for the loss of coverage SEP and may not have any other qualifying event that will allow them to enroll. This can leave many with fewer coverage options.

While several states have recently expanded SEP enrollment options, the ability of individuals to newly enroll in exchange coverage has not been uniformly granted in all states. In response to the PHE, 12 of the 13 SBEs (all but ID) and DC created COVID-19-specific SEPs. These SEPs allow individuals to newly enroll in coverage outside of annual OEP, even if they do not qualify for other SEP-triggering events. Though ID did not create a COVID-19-specific SEP, the state relaxed enrollment guidelines for individuals who lost employer-sponsored insurance due to termination, furlough, or layoff. Even so, these COVID-19-specific SEPs periods are time limited. The SEPs for CA, DC, MD, MA, NY, and VT remain open, while those in CO, CT, MN, NV, RI, and WA have all ended.

The federal government has not created a COVID-19-specific SEP on HealthCare.gov, which could lead to lower exchange enrollment, particularly for individuals previously without employer-sponsored coverage. Additionally, 13 of these 38 states have not expanded Medicaid, which could leave many consumers without options to access coverage. While recent legislation passed in the US House of Representatives (H.R. 6800) would require HealthCare.gov to open an 8-week SEP, that bill has not yet been considered in the Senate.

Table 1. State-Based Exchange COVID-19 SEP Duration and Enrollment

State	COVID-19 SEP Enrollment Deadline	SBE COVID-19 SEP Enrollment	SEP Enrollment as a % of 2020 OEP Enrollment
DC*	September 15	N/A**	N/A
VT*	August 14	N/A**	N/A
CA*	July 31	175,030 (as of June 20)	+11.4%
MA*	July 23	20,000 (as of April 28)	+6.2%
MD*	July 15	14,000 (as of June 8)	+8.8%
NY*	July 15	N/A**	N/A

State	COVID-19 SEP Enrollment Deadline	SBE COVID-19 SEP Enrollment	SEP Enrollment as a % of 2020 OEP Enrollment
NV	May 15	5,479	+7.7%
WA	May 8	22,000	+10.4%
CO	April 30	14,263	+8.5%
RI	April 30	N/A**	N/A
MN	April 21	14,000	+8.1%
CT	April 17	1,920	+2.0%

*Enrollment is ongoing, and numbers are preliminary

**N/A indicates the state has not publicly released preliminary or final exchange enrollment data during the SEP.

Exchange Enrollment May Reduce Care Access for Some

Shifts in enrollment patterns have a variety of implications for consumers, including access to providers or therapies (especially for those with certain conditions), affordability of products and services, opportunities to choose a new plan, and the diversity of plan options available to consumers in specific geographic areas. Avalere's analysis of exchange coverage, benefit, and formulary data show that exchange coverage is often unlike employer-sponsored insurance, though it was intended to be similar to employer plans. These analyses show that, compared to employer market coverage, the types of exchange plans with the highest levels of enrollment can have fewer covered benefits, tighter networks, more limited formularies, and higher cost sharing. Even for individuals who are able to enroll in exchange coverage, the transition from employer-sponsored coverage to the exchanges is not seamless, and can have implications for access and affordability. Importantly, even where coverage is similar, the requirement to meet new deductible and out-of-pocket spending limits and satisfy new care management requirements (like step therapy or prior authorization) could create gaps in care.

Given that exchange enrollees tend to maintain their exchange coverage in subsequent years, the political and judicial climate concerning the ACA may result in new access and plan affordability changes for exchange enrollees. For instance, the 2020 election and the forthcoming Supreme Court ruling on the ACA could also affect whether consumers can choose to remain on exchange coverage or plans choices available to them (such as a public option). Given uncertainties at the federal level, there is a significant opportunity for states to act.

This could be through codifying aspects of the ACA into state law or helping to protect consumer affordability and access (e.g., network adequacy, cost-sharing limitations, new premiums subsidies, and changes to SEP eligibility). However, very few states have taken a broad approach to these state actions. The 2020 election and growing market and economic uncertainties may

prompt states to take an even more active role.

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RESEARCH BRIEF

Investing in the Future of Health Care

A Strategic Assessment of Federally Funded Health Services Research and Primary Care Research

Since its emergence in the 1960s, health services research (HSR) has provided insights to improve the delivery of care and the health of patients. Primary care research (PCR) also has emerged as a distinct field, improving our understanding of the part of the health care system in which most people receive care. Many federal agencies are involved in funding HSR and PCR. To better understand the breadth, scope, and impact of this investment, Congress directed the Agency for Healthcare Research and Quality (AHRQ) to commission an independent assessment of federally funded HSR and PCR spanning the U.S. Department of Health and Human Services (HHS) and Department of Veterans Affairs (VA). AHRQ contracted with the RAND Corporation to conduct this study.

The RAND team formed two technical expert panels (one for HSR and one for PCR), conducted 50 interviews across a diverse sample of five stakeholder groups, and performed a systematic environmental scan of federal research grants and contracts to assess the following topics:

- **breadth and focus** of federal agency research portfolios in HSR and PCR
- **overlap and coordination** among federal agency research portfolios
- **impacts** of federally funded HSR and PCR
- **gaps and prioritization** of federally funded HSR and PCR
- options for **improving the outcomes, value, and impact** of future federally funded HSR and PCR.

KEY FINDINGS

- The health services research (HSR) and primary care research (PCR) portfolios of federal agencies have distinct focus areas based on their individual congressional authorizations, missions, and operational needs.
- Research funded by agencies on similar topics is mostly complementary, but potential overlaps in HSR and PCR portfolios need to be more proactively identified.
- Federally funded HSR and PCR have a wide range of impacts that are often cumulative across agency research portfolios.
- The variety of gaps in HSR and PCR reflect the challenge of improving U.S. health care, which requires new research approaches and strategies to prioritize research efforts.

Findings

Federal agency portfolios have distinct focus areas

Eight agencies within the study scope have portfolios in HSR and PCR, with each agency shaping its portfolio around specific focus areas that address its individual congressional authorization, mission, and operational needs. Portfolios tend to differ along three main dimensions—the scope of the health care system examined (settings, populations), research objectives, and key research audiences. For example, the portfolios of AHRQ, the National Institutes of Health (NIH), and the Centers for Disease Control and Prevention (CDC) each have relatively broad but differing scopes:

- **AHRQ:** Study participants across the range of stakeholder groups emphasized AHRQ's unique and central role in HSR and PCR (see Figure 1). As the only federal agency with statutory authorization to generate HSR, AHRQ focuses on health care system outcomes, evidence syntheses, and dissemination of innovations across settings and populations. The agency also serves as the home for federal PCR, although it does not receive targeted funding for this latter mission.
- **NIH:** NIH's portfolio of HSR and PCR addresses a similarly broad scope of health care, but its research tends to be organized around specific diseases, body systems, or populations.
- **CDC:** CDC's portfolio of HSR and PCR is organized around diseases, conditions, and injuries, while also focusing on prevention and health promotion across community and health care settings.

The portfolios of other agencies tend to focus on specific health care settings or populations (e.g., the Centers for Medicare and Medicaid Services on care for its beneficiaries, VA on veterans' health care and health outcomes, the Health Resources and Services Administration on safety net services and the health care workforce, and the Administration for Community Living on elderly and disabled individuals) or research audiences (e.g., the Assistant Secretary for Planning and Evaluation on federal policymakers).

Agency research on similar topics is mostly complementary, but overlap in portfolios needs to be identified more proactively

While acknowledging that multiple agencies may fund research on similar topics, stakeholders noted that such overlap is typically complementary—that is, it addresses different facets of a topic or combines resources on an underfunded topic. See Figure 2.

Participants observed that federal agencies tend to be relatively adept at coordinating with other agencies regarding areas of overlap—once the overlap in portfolios is recognized. However, the discovery of overlap in research portfolios was described as "sporadic," "accidental," or occurring "by happenstance." Coordination is especially challenging for federal PCR, which lacks dedicated funding to support coordination of research across agencies.

FIGURE 1
AHRQ's Unique and Central Role

The impacts of HSR and PCR are often cumulative across agency portfolios

Stakeholders described a variety of impacts associated with HSR and PCR, ranging from contributions to scientific and professional knowledge to changes in health care systems and services, new health care policies, and improved patient and societal outcomes.

The range of impacts is rarely realized by a single project but instead tends to accumulate across studies and agency portfolios. Case illustrations of cumulative impact described in the RAND team's report include federally funded studies and interventions to combat health care–associated infections and efforts to refine and disseminate the patient-centered medical home model in primary care.

Study participants also identified barriers to achieving impact, including a lack of investment in high-risk studies—which offer potential for high value by demonstrating novel approaches. In addition, study participants noted frequent areas of disconnect between research results and health care practice.

Many of the gaps in HSR and PCR reflect the challenge of improving U.S. health care

Study participants identified several research gaps driven by the complexity and pace of change in the U.S. health system. A key challenge involves the difficulty of parsing out how multiple, evolving features of the health care system (e.g., the way care is financed or how it is delivered) affect the different outputs and outcomes of care (e.g., quality, access, cost, equity, health outcomes).

Participants noted other general gaps related to producing timely results for improving health care delivery, developing methods suited to studying the complex dynamics of health care change, and communicating results in ways that are helpful for guiding implementation of new practices. They also described the need for research that better leverages digital health technologies and uses theory to connect findings and advance knowledge on health care improvement.

Key gaps noted for PCR included the lack of research on the core functions of primary care in holistically treating and managing patients' health; instead, much current research focuses on screening or managing specific conditions in primary care settings. Participants also called for research on optimizing the role of primary care within newer models of integrated care in the wider health care system.

FIGURE 2

Overlap in Research Is Complementary

> I kind of think of it as **like a nice Venn diagram**, where there is overlap and it **creates that sweet spot, where everybody is doing what they're supposed to be doing**, based on their mandate as an agency. When there is a sweet spot, **that's where action and change can really take place**. I think there should be some overlap, quite frankly.
>
> –Consumer group stakeholder

Recommendations

Based on analysis of results and suggestions of the technical expert panels and interview participants, the RAND study team proposed the following recommendations.

Cross-cutting recommendations for federally funded HSR and PCR

Improve the relevance and timeliness of research

- Create funding mechanisms that support more rapid, engaged research approaches, such as embedded research and learning health system models.
- Expand funding to refine mixed qualitative and quantitative research methods suited to generating evidence on the implementation of change in complex health systems.
- Create funding mechanisms that support innovative, high-risk, high-reward research.

Disseminate and communicate results that are actionable and findable

- Train and assist researchers in effectively communicating results in formats that can readily be used by health care delivery stakeholders.
- Fund research to identify the most-effective channels through which to communicate research results for different audiences and users.
- Require researchers to consider implementation issues early in study design and explicitly apply theories of change to help connect disparate results.
- Expand funding for the synthesis of evidence across projects.

Improve cross-agency prioritization and coordination processes

- Initiate a strategic planning process across federal agencies to prioritize HSR investments.
- Establish a review process and data systems to proactively identify areas of potential overlap across agency portfolios.
- Maintain AHRQ as an independent agency within HHS to serve as the funded hub of federal HSR to ensure its unique and central role in the field.

PCR-specific recommendations

- Initiate a strategic planning process across federal agencies to prioritize PCR investments, and include relevant PCR stakeholders.
- Establish a review process to proactively identify areas of potential overlap across agency research portfolios, focused on maximizing the limited federal funding available for PCR.
- Provide targeted funding for a hub for federal PCR to adequately support research on the core functions of primary care and its role in the wider health care system and to coordinate PCR across federal agencies.

Conclusion

The results of this study provide a balanced, evidence-based understanding of federally funded HSR and PCR that policymakers can use in shaping the future of these federal research programs. The study distinguishes the strengths and contributions of HHS agencies and VA to the federal HSR and PCR enterprise and offers insights on how to improve these research programs to serve the needs of the rapidly evolving U.S. health care system.

This brief describes research conducted in RAND Health Care and documented in *Health Services and Primary Care Research Study: Comprehensive Report*, by Peter Mendel, Courtney A. Gidengil, Andrada Tomoaia-Cotisel, Sean Mann, Adam J. Rose, Kristin J. Leuschner, Nabeel Shariq Qureshi, Vishnupriya Kareddy, Jessica Sousa, and Daniel Kim, RR-3229-AHRQ, 2020 (available at www.rand.org/t/RR3229). To view this brief online, visit www.rand.org/t/RBA623-1. The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors. **RAND®** is a registered trademark.

July 2020

USC Schaeffer
Leonard D. Schaeffer Center
for Health Policy & Economics

Economic Studies
at BROOKINGS

EDITOR'S NOTE

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

ACKNOWLEDGEMENTS

The author thanks Kathleen Hannick for superb research assistance and thoughtful feedback on this work. Brieanna Nicker and Spoorthi Kamepalli also provided valuable contributions.

Executive Summary

The Affordable Care Act, building on decades of prior law, took important steps to establish a comprehensive regulatory structure that sets minimum standards for health care coverage. Despite those achievements, it remains possible for Americans to become enrolled in plans that do not meet the standards articulated in the ACA. This analysis explores these gaps in regulation and describes what can be done to close them.

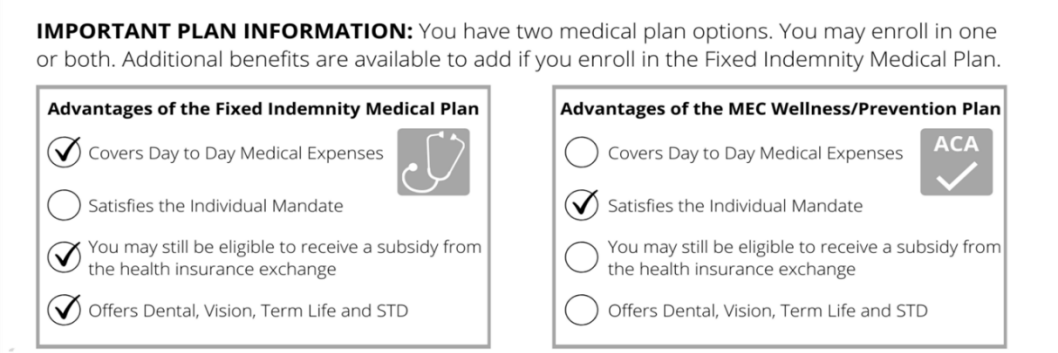
We define good health care coverage as a plan that reflects three key attributes: it (1) covers a comprehensive array of health care services without regard to individuals' pre-existing conditions, (2) has a benefit design that ensures consumers must bear only a reasonable share of health care costs, and (3) is offered by a financially solvent entity within a stable system for pooling risk. Federal law attempts to achieve these objectives, in partnership with state insurance regulators, by regulating the benefits that employers provide to their employees and the insurance products that carriers sell to individual consumers.

Health plans that don't meet these standards are problematic for two reasons. First, consumers enrolled in such plans can face catastrophic financial risk if they have a significant health care need and may find their insurance of limited value. This is a particularly acute problem in market segments that use "post-claims underwriting" to exclude coverage for pre-existing conditions, since it makes it very difficult for consumers to evaluate coverage before enrolling. Second, non-compliant plans can use their low premiums to "cherry pick" healthy consumers away from broader and more regulated risk pools. This allows healthy individuals to access lower-cost plans (because they need not pool their risk with sicker people) but drives up costs for everyone that remains in the regulated market.

Gaps in the regulation of employer health coverage: There are three major gaps in federal regulation of employer health plans. The broadest and most significant is that while employer plans are subject to many regulatory standards, there is no provision in federal law that requires employer health plans to cover a comprehensive array of benefits. Most employers do provide a fairly comprehensive package in order to attract and retain employees, but even otherwise generous plans often exclude specific services or drugs. Further, the ACA's employer mandate incentivizes employers to offer some form of coverage, even for low wage workers where a comprehensive benefit package is not economically viable, which leads to some employers offering extremely limited benefit packages. Indeed, some employers offer plans that cover *only* the ACA's mandated preventive services, and no other benefits.

Second, federal law defines certain kinds of employer plans as "excepted benefits" and then exempts them from most federal regulation, even when they resemble a traditional plan. In particular, fixed indemnity plans are considered excepted benefits because they pay on a "per time period" basis, rather than paying based on actual medical costs incurred. But modern indemnity policies have developed detailed rubrics for payment, paying specific amounts "per day" an individual receives a particular health care service or "per month" they fill a prescription for a specific class of drugs. This benefit can come to look very much like regular health coverage, despite not being subject to otherwise applicable standards. While systematic data are not available, there is ample anecdotal evidence of employers offering the majority of their health care benefit through an unregulated fixed indemnity policy. A somewhat common approach appears to combine a *very* limited regulated plan (e.g. one covering only preventive services) with an excepted benefit fixed indemnity plan that offers all other benefits subject to various limitations and exclusions. Three other types of excepted benefits policies – accident, critical illness, and (to a lesser extent under current regulations) group supplemental coverage – could also serve the same function as fixed indemnity plans in this arrangement.

Replica plan documents combining a fixed indemnity and traditional benefit



Source: Reddit.

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Finally, gaps in federal law enable small employers to avoid risk-pooling provisions that are generally intended to ensure pooling of risk across all small employers in a state. Small employers can leave the insurance market entirely by choosing to self-insure, and vendors across the country now sell "level-funding" plans that are stylized as a self-insurance arrangement with reinsurance coverage but in fact look very much like insurance. In addition, the federal government has attempted to facilitate small employers buying their coverage through "associations" that exclude them from the small group market, though some of those regulations have been enjoined by a federal court.

Gaps in the regulation of individual coverage: The market for individual coverage also features significant regulatory gaps. Plans that *are* subject to regulation are covered by a comprehensive scheme that satisfies the three criteria for "good" coverage described above; problems emerge from the many ways in which entities can offer coverage outside of that framework. The most familiar problem in the current market is short-term limited-duration plans. A provision in federal law exempts short-term plans from regulation but fails to define the phrase "short-term." Current regulations take an expansive view, encompassing plans up to three years in duration. These plans can discriminate based on health status, exclude or cap major benefits, and impose very high cost-sharing, leaving consumers surprised by very large bills and pulling healthy enrollees from the regulated market.

Individual market regulation also provides an exemption for excepted benefits, which creates a similar loophole to that seen in employer coverage. New individual market fixed indemnity carriers offer benefit schedules with *thousands* of different payment amounts associated with receipt of specific medical services (with amounts paid directly to providers, just like standard health insurance). Even traditional carriers offer fixed indemnity benefits that pay on a highly detailed rubric, which varies with the severity of the hospitalization or outpatient service and the specific providers involved in care. Excepted benefits for accident and critical illness policies offer the same potential, and there is some evidence of misuse of accident policies. As with short-term plans, these types of excepted benefit policies discriminate against those with pre-existing conditions, leave consumers exposed to very high costs, and erode the regulated market's risk pool.

Another gap arises because federal regulation of individual market benefits turns on what is considered "health insurance" under state law. A benefit that looks like health insurance and doesn't fit into either of the regulatory exceptions described above can still be exempt from regulation if it is not considered a health insurance product that must be offered by a health insurance issuer under state law. Some states *deliberately* engineer exceptions from federal regulation in this way, using state law to classify health coverage offered by their state Farm Bureau as "not insurance." Other exceptions arise more organically. When colleges and universities offer benefits to their students without involving an insurer, i.e. self-insured student health plans, the coverage is not considered insurance

and therefore not regulated under state or federal law. Health-care sharing ministries also offer an unusual benefit structure that can often evade regulation, despite the fact that their benefit looks very much like traditional coverage and is not closely linked to shared religious beliefs or practices. Moreover, the challenges associated with these benefit forms have worsened since the ACA's individual mandate penalty was reduced to $0. Just as these policies are considered "not insurance" for purposes of federal regulation, many of them were also considered "not insurance" under the mandate, thus deterring some uptake while the mandate remained in force.

So, what can be done? Policymakers can consider federal legislation, state legislative or regulatory action, or federal administrative tools that do not require new statutes.

Comprehensive federal legislation: Federal legislators could close each of the gaps described above. Specifically, comprehensive federal legislation would take six steps:

- Require employer health plans to cover essential health benefits at a minimum actuarial value. This will ensure that all employer health plans indeed offer a comprehensive benefit package.

- Redefine excepted benefits (in both the employer and individual markets) to reflect benefits that truly deserve exemption from federal law. Legislators should reshape the exemption for the types of supplemental coverage most prone to abuse by requiring a truly distinct policy form and by requiring that enrollees have another source of coverage of all EHB. They should also limit excepted benefits to plans that are not intended to duplicate, mimic, or supplant regulated benefits, to deter future attempts to evade regulation.

- End the exclusion of short-term limited-duration insurance from the definition of health insurance coverage. All plans should be subject to the same standards, regardless of contract length.

- Modify the federal definition of health insurance coverage and health insurance issuer to bring "not insurance" within the federal regulatory environment. Legislation could define all non-employer benefits or payments for medical care as insurance that must be offered by an issuer. This would require states to update their own legislation but would preserve full state control over risk bearing entities. Alternatively, federal law could allow "not insurance" to exist outside the state-federal regulatory partnership but nonetheless directly apply federal standards to these plans.

- Limit stop-loss coverage so that an employer arrangement will not be considered self-insurance unless the employer bears significant risk. Existing model legislation from the National Association of Insurance Commissioners could be updated and adapted to federal law.

- Codify provisions in federal regulations and guidance that can limit some forms of abuse, including standards related to association health plans and some limits related to insured student coverage.

This suite of reforms would generally ensure that any benefit that "looked like" health coverage was subject to minimum standards. On its own, while these policies would benefit many, they would also be expected to have negative impacts on some stakeholders, such as increasing costs for some employers, inducing other employers to drop health coverage rather than offer a comprehensive benefit, and increasing premiums for individuals who currently buy unregulated insurance. Other policy tools are available to mitigate those consequences, and indeed, they will be the result of *any* attempt to close gaps in the regulation of health benefits.

Options for states: In the absence of new federal legislation, there are important opportunities for states to take action to protect consumers and strengthen risk pooling:

- Limit the reach of short-term plans, either by prohibiting their sale, prohibiting pre-existing discrimination in short-term plans, or limiting them to just 3 months.

- Reign in problematic excepted benefit policies. States can bar the sale of fixed indemnity, accident, and critical illness policies that look too much like traditional health insurance. They can also impose a requirement that enrollees carry other coverage. And states can attempt to take enforcement action against the pairing of insured fixed indemnity plans with very skinny traditional employer plans as a violation of the prohibition on benefits that are coordinated with an exclusion.

- States should avoid enacting legislation authorizing Farm Bureau plans.

- Limit Health Care Sharing Ministries through legislative and enforcement tools. State laws that exempt HCSMs from regulation as insurance can be tightened or repealed, and states can take enforcement action against fraudulent HCSMs.

- Regulate self-insured student health plans and stop-loss coverage. States can require that colleges and universities offering self-funded benefits meet certain substantive standards, and they can prohibit stop-loss plans with very low attachment points.

- Regulate MEWAs to limit fraud and insolvency in this market segment.

- Oversee agent and broker conduct. States can place limits on the ways that licensed agents and brokers sell non-compliant forms of coverage.

Options for federal regulators: Finally, just as states have options in the absence of new federal legislation, so, too, does the federal government:

- Restrict short-term plans to less than 3 months. It would be straightforward for the federal government to reinstate 2016 regulations adopting this limited definition.

- Narrow the reach of fixed indemnity, critical illness, and accident excepted benefit policies by adopting a more detailed regulatory definition. While some regulatory approaches are foreclosed by a 2016 court decision, other options remain available. Specifically, regulators should require that these policies be structured in ways that distinguish them from health coverage, rather than allowing them to vary payments based on health care services.

- Define "licensed under state law" broadly in determining who is an issuer, limiting states' ability to deliberately promote unregulated forms of "not insurance." Specifically, the federal government could construe state *authorization* of Farm Bureau products as a form of state licensure, bringing the plans under the umbrella of existing law.

- Regulate the conduct of brokers subject to federal standards. Tens of thousands of agents and brokers, including major online vendors, receive an annual certification from the federal government or a state-based Marketplace that permits them to sell subsidized coverage through the federal or state Marketplace. These certifications could be limited to those who agree to limitations on the marketing and sale of non-compliant forms of coverage.

Within any given state, these tools have a more limited reach than the full toolbox available to state regulators, but of course would have national scope.

Contents

What does "good health coverage" mean?

This analysis provides a comprehensive review of the gaps in federal regulation for health coverage. It describes the ways in which, despite the achievements of the Affordable Care Act, it remains possible for Americans to become enrolled in sub-standard health plans – and what can be done to close the gaps. But to understand the ways in which "bad" health coverage proliferates, it is useful to start with an overview of what it means to have "good" health coverage. (In this paper, the terms "health benefit," "health plan," and "health coverage" are used interchangeably to refer to the general concept of health care coverage, while the terms "insurance" and "group health plan" are reserved for more technically precise contexts, as described below.)

For purposes of this analysis, we view three types of protections as critical to high quality health coverage:

- ***Covers major medical needs:*** It is perhaps somewhat obvious that a good health benefit needs to include coverage for a broad array of health care expenses. If a plan were to exclude cancer care, then a patient diagnosed with cancer would discover that while she "had" health coverage, she was in fact going to have to pay completely out of pocket for her treatment. Therefore, the plan should include all the types of medically necessary care a person may need.

  In some markets for health coverage, plans are required to cover a complete array of health services referred to as the "Essential Health Benefits" (EHB) package. The EHB package includes ten major categories of benefits, like hospital care, doctors' visits, prescription drugs, and emergency room care.[1] In other contexts, plans naturally cover a broad range of benefits even without a legal requirement to do so. However, there are cases where plans offer limited benefits, as we will see below.

  It is also essential that plans not discriminate against consumers based on their pre-existing health conditions, so that all benefits under the plan are available to all consumers on the same terms.

- ***Provides meaningful financial protection:*** The plan must provide a meaningful degree of financial protection and not leave individuals exposed to an unreasonable share of health care costs. It is not enough that the plan include cancer care in its covered benefits if the consumer is still responsible for paying, say, 50% of the hundreds of thousands of dollars in costs she incurs in the course of treating cancer.

  Two specific kinds of financial protections are especially critical. The plan must not impose a lifetime or annual cap on the amount of care the plan will cover, and conversely, the plan must include a reasonable out-of-pocket limit that caps consumers' total annual exposure to cost sharing. Together, these two protections ensure that the health benefit transfers financial risk from the individual to the plan. In addition, a plan requirement to meet a minimum actuarial value can further ensure broad financial protection (though an out-of-pocket limit also imposes an actuarial value floor). All three of these requirements appear in parts of federal law, though they do not apply to all health coverage products.

[1] Under current law, EHB does not include adult dental care, adult vision care, or long-term care services. Many have argued that the concept of EHB should be expanded, particularly with respect to dental services. See Jane Koppelman, "Efforts to Expand Access to Oral Health Care to Continue in 2019," Pew Charitable Trusts, January 15, 2019, https://www.pewtrusts.org/en/research-and-analysis/articles/2019/01/15/efforts-to-expand-access-to-oral-health-care-to-continue-in-2019.

Note that there is a separate question of whether the numeric thresholds that cap out-of-pocket spending and establish a minimum actuarial value ensure adequate financial protection, which this piece does not address. Certainly, additional protection may be necessary to ensure truly meaningful coverage,[2] especially for low-income families, but for purposes of this paper the limits of existing law are used as a floor.

- ***System stability:*** Health coverage relies on a third-party assuming risk of high health care spending for a pool of people. Consumers cannot rely on their coverage if that entity lacks the financial resources to bear this risk. Further, the way in which risk is pooled is significant. If markets face unmanaged adverse selection or segmentation of high and low risk individuals, consumers' coverage cannot be offered at reasonable prices and ultimately will not be stable.

  Therefore, the regulatory regime governing health benefits needs to ensure that the entity bearing the risk has adequate resources to meet anticipated needs. It must also ensure some reasonable mechanism for risk sharing that is not subject to "cherry-picking." In some segments of the market this means pooling risk across a very broad market, but, at a minimum, risk must be pooled at a level that ensures a sustainable benefit.

Figure 1 summarizes these protections. Note that these standards are not the only goals of health coverage regulation. Other consumer protections – such as requiring no or low cost-sharing for specific services, the right to appeal decisions made by a health plan, network adequacy standards, or oversight of utilization management practices – are also valuable for consumers. And, of course, the ultimate premium for the coverage is of critical importance. However, the three concepts established above can form a minimum threshold for creating adequate coverage and for defining the product that policymakers want to make available at an affordable price.

Figure 1: Policies that can ensure good health coverage

Covers health care needs	Coverage of Essential Health Benefits (EHB) No pre-existing condition discrimination
Provides financial protection	Prohibits lifetime and annual limits Requires out-of-pocket limit Minimum actuarial value
System stability	Solvency protections Establishes effective risk pooling

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There are several different reasons to be concerned about consumers becoming enrolled in coverage that fails to comply with these standards. First, the consumer herself can face significant adverse consequences in the form of unexpected or cripplingly large medical bills. We may be especially concerned when consumers unknowingly take on such risk, believing themselves to have purchased more adequate coverage than they actually have. But there is also reason to be troubled by the existence of these products at all. A large behavioral economics literature has established that consumers are

[2] See, e.g., Liz Hamel, Cailey Muñana, and Mollyann Brodie, "Kaiser Family Foundation/LA Times Survey Of Adults With Employer-Sponsored Insurance," *Kaiser Family Foundation*, May 2, 2019, https://www.kff.org/report-section/kaiser-family-foundation-la-times-survey-of-adults-with-employer-sponsored-insurance-section-2-affordability-of-health-care-and-insurance.

especially bad at making decisions that involve risk. Consumers struggle with adequately understanding risks, especially for "highly technical products" such as health insurance.[3]

Further, when plans exclude coverage based on pre-existing conditions, it arguably becomes impossible for consumers to know the nature of their coverage. Whether a health care need arises from a pre-existing condition is something that often cannot be known in advance, and many plans engage in lengthy post-claims underwriting processes to determine the scope of an exclusion only after a consumer has become ill.[4] A plan can evaluate the value of these exclusions at the level of an entire population, but an individual consumer simply cannot know what coverage they are "giving up" to a general pre-existing condition exclusion. In addition, consumers who are under-insured generate uncompensated care burdens for health care providers when they incur costs not covered by their limited insurance products.

Finally, sub-standard plans can be problematic because they undermine structures for pooling risk. Lower quality plans are much more attractive to relatively healthy people, since sicker individuals seek out more comprehensive benefits. Further, many plans that fall into regulatory gaps expressly exclude people with pre-existing conditions, or charge them much higher prices compared to healthy people. As a result, gaps in regulation will often pull healthy individuals out of the regulated risk pool with lower prices for more limited benefits, which drives up prices in the more generous and regulated segment of the market. This can be a burden for consumers who face higher premiums, and to the extent the government is subsidizing coverage in the regulated market segment, it imposes fiscal costs as well.

The next section describes how federal law attempts to protect consumers and markets from these risks by applying the three types of protections that are critical to good coverage.

How are federal and state health care laws structured?

Three primary laws establish the basic structure for federal regulation of health benefits. At the highest level: the McCarran-Ferguson Act of 1945 establishes that states will be the primary regulators of insurance; the Employee Retirement Income Security Act of 1974 (ERISA) regulates health benefits offered by employers (regardless of whether the employer buys insurance within a state or offers a self-insured benefit); and Title XXVII of the Public Health Service Act (PHSA) establishes a definition of health insurance and a set of minimum federal standards that apply to insurance, even as states continue to be the primary regulators.[5]

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[3] See, e.g., Howard Kunreuther and Mark Pauly, "Behavioral Economics of Multiperiod Insurance Purchasing Behavior: The Role of Emotions," 12 FOUNDATIONS AND TRENDS IN MICROECONOMICS 109 (December 2018), http://dx.doi.org/10.1561/0700000069; Andreas Richter, Jochen Ruß, and Stefan Schelling, "Insurance Customer Behavior: Lessons from Behavioral Economics, 22 RISK MANAGEMENT AND INSURANCE REVIEW 189 (July 2019) https://onlinelibrary.wiley.com/doi/abs/10.1111/rmir.12121; Gregory Elliehausen, "Behavioral Economics, Financial Literacy, and Consumers' Financial Decisions," *Federal Reserve Board*, October 15, 2018, https://files.consumerfinance.gov/f/documents/cfpb_elliehausen-written-statement_symposium-behavioral-economics.pdf, Anthony D. Cox, Dena Cox, and Gregory Zimet, Understanding Consumer Responses to Product Risk Information," 70 JOURNAL OF MARKETING 79. (January 2006), www.jstor.org/stable/30162074.

[4] See "Shortchanged: How the Trump Administrations Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk," *U.S. House of Representatives*, June 2020, https://drive.google.com/file/d/1uiL3Bi9XV0mYnxpyaIMeg_Q-BJaURXX3/view; Gary Claxton et al., "Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA," *Kaiser Family Foundation*, December 12, 2016, https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/.

[5] More specifically, the McCarran-Ferguson Act directs that insurance will be regulated by the "several States," but that federal law will apply to the extent it "specifically relates to the business of insurance." 15 U.S.C. § 1012. It provides only this general instruction, and not a more detailed roadmap. (The statute arose from concerns about the application of federal antitrust statutes to insurance.) ERISA regulates how employers may provide health benefits to their employees, and it includes parallel modifications to the Internal Revenue Code to clarify the terms on which health benefits are excluded from

Very roughly, that means that federal law regulates how employers provide benefits to their employees, while states, subject to federal standards, regulate insurance companies that sell insurance plans to individuals or to employers. Many of the substantive standards applied to the employer under ERISA and to insurance companies that sell coverage to employers under the PHSA are the same. The Affordable Care Act (ACA) and numerous other federal laws have modified ERISA and the PHSA to add new substantive standards within this framework, and those protections are codified within ERISA and the PHSA. The ACA also added some relevant policies that are codified outside ERISA and the PHSA.

To consider an example, the ACA prohibits most health plans from imposing a lifetime dollar limit on covered benefits. This is accomplished as follows:

- A provision in ERISA prohibits employers from including a lifetime limit in the benefits its employees receive.[6]
- A provision in the PHSA prohibits health insurance contracts offered by insurance companies from imposing a lifetime limit. This language applies to insurance companies when they sell contracts directly to individual consumers, and when they sell insurance contracts to employers. Note that the protection in the employer market duplicates the ERISA protection: if an employer arranged with an insurance company to provide coverage for employees that *did* include a lifetime limit, then the employer would be violating ERISA and the insurance company would be violating the PHSA.
- States are generally responsible for enforcing the requirement against insurance companies. State insurance departments will license health insurance companies and monitor the products they sell to ensure that lifetime limits are not included.

Each of these federal laws and the interaction between them is described in more detail below, first addressing regulation of employer benefits and then turning to regulation of insurance markets.

Regulation of employer health benefits

This section describes how employer benefits are regulated under federal law. It begins by laying out how ERISA defines employer benefits that are subject to regulation, and then describes the relevant substantive standards imposed under ERISA. Finally, it briefly addresses the role of the ACA's employer mandate in encouraging employers to offer coverage.

ERISA definitions

ERISA adopts a broad definition of health benefits that are subject to regulation. This is important; it ensures that employers cannot avoid the standards of the law by structuring their benefit in a novel way or buying it from a particular kind of vendor.

Specifically, ERISA regulates "employee welfare benefit plans." An employee welfare benefit plan is defined very broadly as "any plan, fund, or program" that provides retirement benefits or benefits related to, among other things, "medical, surgical, or hospital care or benefits."[7] Any employer welfare benefit plan is subject to a variety of requirements related to transparency and financial management.

Further, ERISA defines a "group health plan" as an employee welfare benefit plan that "provides medical care… to employees or their dependents." Medical care is in turn defined broadly as "the

income. The Health Insurance Portability and Accountability Act of 1999 (HIPAA) established a set of standards for health benefits and applied them to health insurance regulated by the states through the newly enacted Title XXVII of the PHSA and to employer plans through modifications to ERISA and the Internal Revenue Code.

[6] Formally, the ERISA provision is a cross-reference to the PHSA provision.

[7] ERISA § 3 (29 U.S.C. § 1002).

diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body," or transportation related to the same.[8] Group health plans are subject to ERISA's substantive standards related to health care coverage, though some group health plans can be classified as excepted benefits and exempted from some of these standards, as discussed further below. Group health plans can be self-funded (or self-insured), where the employer bears the risk for plan benefits directly, or the employer can buy an insurance plan from an insurance company to deliver the benefit. In either case, the employer is offering a group health plan that is subject to regulation under ERISA. That is, whenever an employer offers a "program" that is related to the "diagnosis, cure, mitigation, treatment, or prevention of disease" it will be a "group health plan" under ERISA.

ERISA protections

ERISA applies a series of consumer protections to group health plans that are not excepted benefits. Some of these directly implement the standards for "good" health coverage enumerated above (though ERISA includes other consumer protections beyond those enumerated here):

- ***Covers health care needs:*** Plans may not discriminate based on pre-existing conditions in plan benefits. However, plans are not required to cover essential health benefits, though many do so.

- ***Provides meaningful financial protection:*** Plans may not impose lifetime or annual limits on the benefits they cover. Further, they must include an out-of-pocket limit on cost-sharing expenses (not to exceed $8,150 for self-only coverage in 2020). There is no minimum actuarial value standard, though other laws create an incentive to meet a minimum AV, as discussed below.

- ***System stability:*** ERISA's transparency and financial management standards are intended to ensure that when an employer promises to provide a benefit to its employees, it is able to meet its commitments. While there are no formal "solvency" requirements, the fiduciary obligations imposed by the law generally ensure sufficient plan resources to pay health care claims. ERISA does not include requirements related to risk pooling.

Employer responsibility requirement

Outside of ERISA, employers with more than 50 full-time employees are also subject to the Affordable Care Act's employer mandate. This requires employers to offer coverage that meets certain standards in the benefit structure (which go beyond the minimum requirements for a group health plan under ERISA) or pay a penalty if any of their workers receive federal subsidies to buy individual market plans. These additional standards include offering coverage with an actuarial value of 60% and charging employees premiums that are sufficiently affordable for them. There are two "tiers" to the mandate penalty: large employers owe a smaller fee if they offer some form of coverage (other than excepted benefits) but that coverage does *not* meet the standards of the mandate, and they owe a larger fee if they offer no coverage at all.[9] Thus, the standards of the employer mandate: (1) generally encourage but do not require employers to offer coverage that meets a minimum actuarial value and (2) incentivize offering some form of coverage over nothing at all.

Regulation of the insurance market

[8] ERISA § 733(a) (29 U.S.C. § 1191b(a)).
[9] For details on calculation of the mandate penalty, see Internal Revenue Service, "Types of Employer Payments and How They Are Calculated," https://www.irs.gov/affordable-care-act/employers/types-of-employer-payments-and-how-they-are-calculated (last visited June 23, 2020).

We turn now to regulation of the insurance market. This section explains the relationship between state and federal law, then turns to the definitions applied to federal regulation of insurance and the substantive standards applied.

State and federal law

Federal regulation of insurance is structured differently from regulation of employer group health plans. Under the McCarran-Ferguson Act, states are the primary regulators of insurance. Until the 1990s, there was very little federal regulation of health insurance products. However, through the enactment of HIPAA in 1996, the federal government adopted a series of substantive standards that would apply to most health insurance products sold by health insurance companies. Since then, the ACA and other federal statutes have set forth additional protections.

Those standards, codified in Title XXVII of the PHSA, apply to insurance companies when they sell insurance to employers in the group market and when they sell directly to consumers in the individual market. Many standards in the PHSA apply in both the group and individual markets, though some provisions apply only to certain market segments.

Federal law provides that states generally should be the enforcers of these provisions through state laws that require insurance companies to comply with the federal standards.[10] Some states accomplish this by codifying the specific provisions of the PHSA into their own state codes, while others simply provide the state insurance department authority to enforce federal law. Federal law also establishes that the federal government will enforce the PHSA standards only if the state has failed to "substantially enforce" them. Currently, the federal government enforces the PHSA in four states: Missouri, Oklahoma, Texas, and Wyoming.[11]

PHSA definitions

The substantive provisions in the PHSA apply to "health insurance coverage," which is defined within PHSA § 2791. Critically, health insurance is not defined primarily based on an objective assessment of the product being sold; instead, it turns in large part on what entity is selling the benefit. Specifically, the law defines "health insurance coverage" as "benefits consisting of medical care… offered by a health insurance issuer." A "health insurance issuer" is "an insurance company, insurance service, or insurance organization… which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance."[12]

That means that the standards of the PHSA apply to an entity that is regulated as an insurance company (or "issuer") under state law whenever that issuer sells a product that involves medical care. However, federal law does *not* apply to entities that are not issuers under state law – even if those entities offer something that would otherwise be considered "health insurance coverage" and is functionally identical to health insurance. This creates an unusual relationship between state and federal law: a state's definition of who is an issuer under state law defines the reach of federal law.

Moreover, like ERISA, insurance law also exempts certain benefits from regulation (even when they are considered "health insurance coverage"): "excepted benefits" and "short-term limited-duration" plans are exempted from substantive regulation. These exemptions are discussed in more detail below.

PHSA and insurance law protections

[10] PHSA § 2721 (42 U.S.C. § 300gg-21).
[11] Id., U.S. Centers for Medicare & Medicaid Services, "The Center for Consumer Information & Insurance Oversight," https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/compliance (last visited June 24, 2020).
[12] PHSA § 2791 (29 U.S.C. § 300gg-91).

Some substantive standards of the PHSA apply to group and individual market insurance, while others apply only to certain markets. In particular, the PHSA divides insurance into three markets. Individual market coverage is sold directly to individuals, small group market coverage is sold to employers with 50 or fewer employees, and large group coverage is sold to employers with more than 50 employees. Most employees covered by group insurance are in the large group market. Under the PHSA, coverage is only "group" coverage when sold to employers who are buying coverage for their employees. Other kinds of groups (like a university arranging coverage for its students or members of an affinity organization) cannot purchase group coverage – they are considered part of the individual market.

As in ERISA, the PHSA substantive protections (which do not apply to excepted benefits or short-term plans) include many of the standards necessary for good health insurance coverage:

- ***Covers health care needs:*** Insurance in the individual and small group market must cover all EHB. Insurance in the large group market, although tending to be comprehensive, is not required to cover all EHB. In addition, individual and small group insurance cannot impose any form of discrimination based on pre-existing conditions. Insurance in the large group market can charge *employers* different prices based on the health needs of the employer's population as a whole but cannot discriminate against individual enrollees.

- ***Provides meaningful financial protection:*** As under ERISA, plans in all markets may not impose lifetime or annual limits and must include a reasonable out-of-pocket limit on household expenses, not to exceed $8,150 for self-only coverage in 2020. In addition, plans in the individual and small group market must meet a minimum actuarial value standard of 60%; there is no actuarial value minimum in the large group market.

- ***System stability:*** The PHSA sets up a series of requirements related to the pooling of risk in the individual market and in the small group market that requires risk be pooled at the level of the entire state. In contrast, the PHSA does not impose risk pooling requirements in the large group market. Finally, while not contained within the PHSA, state law does regulate the solvency of health insurance issuers to ensure plans can meet their obligations to pay benefits, and these standards apply across all three markets.

Summary

Figure 2 summarizes the application of the relevant laws across employer coverage and individual market insurance.

Figure 2: Application of protections to individual and employer insurance

		ERISA regulated employer plans (other than excepted benefits)	PHSA regulated individual market insurance (other than excepted benefits and short-term plans)
Health care needs	Coverage of Essential Health Benefits (EHB)	Common, but not generally required; is required for small groups purchasing insurance	Required
	No pre-existing condition discrimination	Required	Required
Financial protection	Prohibits lifetime and annual limits	Required	Required
	Requires out-of-pocket limit	Required	Required
	Minimum actuarial value	Common, encouraged by employer mandate for large employers, but not generally required; is required for small groups purchasing insurance	Required
System stability	Solvency protections	Insured benefits must meet solvency standards under state law; all plans subject to ERISA fiduciary requirements	Plans must meet solvency standards under state law
	Sharing of risk across many individuals	Risk pooling generally at the level of single employer; risk pooling across entire state for small groups purchasing insurance	Plans share risk across entire state

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What are the gaps in regulation of health care coverage?

We now turn to a systematic overview of the gaps in this regulatory regime that allow sub-standard health plans to persist. We first address benefits provided by employers and then turn to individual insurance.

Gaps in regulation of employer health benefits

There are three ways in which regulation of employer-provided health benefits is incomplete: (1) federal law fails to apply certain substantive protections at all, (2) the statute exempts "excepted benefits" from coverage in ways that create opportunities for abuse, and (3) small employers can use several pathways avoid the risk pooling provisions of federal law. Each of these is discussed below.

Failure to require coverage of EHB and of a minimum actuarial value

The most significant gap in regulation of employer health benefits is analytically straightforward: federal law simply fails to apply certain key standards to employer benefits. Most importantly, employers are not required to offer plans that include coverage of the full range of health care benefits contained within the essential health benefits package. Insurance companies that sell plans to small employers (those with fewer than 50 employees) are required to cover EHB, but this is only a small segment of the market.[13] As a result, it is legally permissible for all large employer group health plans and those small employers who self-insure to exclude coverage for, e.g., prescription drugs or physical therapy. Similarly, these employers are permitted to cover a benefit only very narrowly, by, for example, covering only one round of chemotherapy or only a few days of hospitalization.[14]

Similarly, employer health plans are not required to satisfy minimum actuarial value standards. Large employers are encouraged to offer plans with an AV of at least 60% that include some hospital and outpatient care to comply with the employer mandate, and insurers that sell coverage to small employers must satisfy a 60% AV standard.[15] But large employers that are willing to pay penalties under the employer mandate and small employers that self-insure rather than buying coverage from an insurance company can offer plans with very low AVs that entirely exclude any category of benefit.

In practice, most employers do offer coverage for much of the EHB package at moderately generous AVs. Employers offer health benefits in order to attract workers, and so they generally want to offer a benefit that satisfies employee needs. Further, the tax exclusion for employer health benefits encourages employers to provide a benefit at least as rich as the marginal employee will value. As a result, a plan that completely excludes cancer care or prescription drugs will not thrive in much of the labor market.

However, an employer that is otherwise offering otherwise generous coverage may find it attractive to exclude a specific high cost service likely to be used by a small and predictable group of enrollees. For instance, a survey of employers found that in 2018, 45% of very large employers excluded coverage for Applied Behavior Analysis, a treatment for children with autism.[16] Expensive new drugs to cure

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[13] As of 2016, only 14 million people were covered in the small group market. Mark Hall and Michael McCue, "The Health of the Small-Group Insurance Market," *The Commonwealth Fund*, October 26, 2018, https://www.commonwealthfund.org/publications/issue-briefs/2018/oct/health-small-group-insurance-market.

[14] There are some limits on employers' exclusion of particular benefits. The Mental Health Parity and Addiction Equity Act (MHPEA) incorporates provisions into ERISA and the PHSA that prohibit some kinds of exclusionary benefit designs with respect to mental health care (though it remains permissible for employers to completely exclude all mental health benefits). The Pregnancy Discrimination Act generally requires coverage of pregnancy if a plan includes other hospital benefits. In addition, the Americans with Disabilities Act prohibits employers from discriminating against people with disabilities, and a benefit exclusion targeted at a specified health condition could be problematic under these laws. But these are weak limits and restrain employer behavior only at the margins.

[15] The EHB, AV, and out-of-pocket limit protections are analytically related. All employers are required to impose an out-of-pocket limit below $8,150 on benefits they cover. If an employer was also required to cover the full EHB package, then the out-of-pocket limit requirement would automatically ensure that the health benefit has an AV close to 60%. However, if the employer is not required to cover all EHB, then it can offer a plan that, e.g., does not cover hospital or emergency care. Such a plan can satisfy the out-of-pocket limit standard with an AV well below 60% (because consumer's exposure to spending on the excluded hospital and emergency care is infinite). Conversely, if a plan is not required to cover EHB but does want to achieve a 60% AV, then it must cover an array of EHB – but not the full package. Notably, HHS and Treasury have also said that for a plan to satisfy the 60% standard of the employer mandate, it must cover some outpatient and hospital care, but that does not include the full value of these benefits contained with the EHB package. The EHB requirement also interacts with the prohibition on lifetime and annual limits. Plans are prohibited from placing lifetime and annual *dollar* limits on benefits, but they are permitted to apply visit limits, such as covering only 10 physical therapy appointments per year. When plans are required to cover EHB, the EHB standards generally prevent the plan from applying stringent visit limits. But when not required to cover EHB or to satisfy a generous AV, a plan can impose visit limits that mean a benefit is "included" but consumers still face significant cost exposure, such as covering only three days of hospitalization.

[16] Beth Umland, "Beyond Autism Awareness: Making ASD Acceptance Part of Your Well-being Program," *Mercer*, April 4, 2019, https://www.mercer.us/our-thinking/healthcare/beyond-autism-awareness-making-asd-acceptance-part-of-your-well-being-program.html.

Hepatitis C were brought to market in early 2014, but employers generally excluded the benefit for at least the first 18 months, and some still do not cover the drugs today.[17]

In a more extreme cases, some employers may feel compelled to offer a health benefit but will not face market pressure to offer a robust plan. In particular, the ACA's employer mandate can create an incentive to offer *some* type of health coverage for low wage workers, even when the labor market will not support offering a more complete health plan. In that case, employers may offer a "skimpy" plan that does not cover anything approaching the full set of EHB and instead provides only a minimal benefit (or may offer such a plan in combination with other benefits).

Comprehensive data are not available, but very limited group health plans that fail to cover meaningful benefits do exist. A survey by the National Business Group on Health in 2014 found that as many as 16% of very large employers were considering offering benefits that failed to cover at least 60% of the value of the EHB package,[18] though that likely overstates the number that actually did so. A preliminary search of available plan offerings reveals many vendors that offer very thin benefits to employers. One plan covers doctors' visits, generic drugs, and some outpatient care, but excludes all brand-name drugs and services like diagnostic imaging and physical therapy, and covers only three days of hospital care –- and that is one of the more generous plans in this category.[19] Other vendors offer plans that cover *nothing* except the ACA's required preventive care benefits; a plan like this would be expected to have an AV of far less than 5%.[20]

As expected, press reports have uncovered examples of enrollees of such plans being denied care. For example, after breaking her wrist, a Minnesota woman discovered that her employer "health plan" covered only preventive services, and did not include coverage for hospital services or doctors' visits.[21] That is, the failure under current law to apply EHB and AV standards to employer plans means that while many employees generally receive adequately comprehensive benefits, significant gaps persist and leave workers and their families exposed.

Excepted benefits

While federal law does not require large employers to cover a broad array of benefits, it does place relatively stringent rules on the financial protection that must be provided once a plan has decided to cover a particular benefit. Regulated group health plans may not impose lifetime or annual dollar limits on covered benefits, and they must cap consumer out-of-pocket spending on covered benefits at $8,150 per person per year (for 2020) – generally ensuring that catastrophic financial risk is transferred from the individual to the plan with respect to covered benefits. But these standards do not apply to plans that are considered "excepted benefits."

Recall that ERISA defines "group health plan" very broadly as any employer "plan, fund, or program" that involves "medical… care or benefits". But ERISA then exempts certain kinds of "excepted benefits" from its substantive requirements.[22] The statute defines four categories of excepted benefits and some specific types of coverage within each category, and provides authority for the federal agencies to

[17] Judith Graham, "Medicaid, Private Insurers Begin To Lift Curbs On Pricey Hepatitis C Drugs," *Kaiser Health News,* July 5, 2016, https://khn.org/news/medicaid-private-insurers-begin-to-lift-curbs-on-pricey-hepatitis-c-drugs/.
[18] Stephen Miller, "Employers Adjust Health Benefits for 2015," *SHRM,* August 15, 2014, https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/2015-health-benefits.aspx.
[19] Fundamental Care, "Limited-Day Health Plans for Employers," https://www.fundamentalcare.com/limited-day-plans (last visited June 22, 2020).
[20] Magnacare, "MEC Minimum Essential Coverage Plans," https://www.magnacare.com/archive-healthplanmgmt/mec/ (last visited June 22, 2020).
[21] Jay Hancock, "Surprise! Some Job-Based Health Plans Don't Cover Hospitalization," *NPR*, June 18, 2015, https://www.npr.org/sections/health-shots/2015/06/18/415289504/surprise-some-job-based-health-plans-dont-cover-hospitalization.
[22] See ERISA § 732(c) (29 U.S.C. § 1191a(c)); ERISA § 733(c) (29 U.S.C. § 1191b(c)); 45 C.F.R. § 146.145; 29 C.F.R. § 2590.732.

define additional types of coverage within each category. The four categories as defined under current regulations are described below and listed in Figure 3:

- ***Medical benefit is secondary or incidental***: This category includes things like workers compensation benefits, disability income coverage, auto insurance, and travel insurance. These are policies where the plan might cover some medical care, but the primary purpose of the benefit is not insurance against medical costs. Many secondary or incidental benefits are enumerated in the statute, and the agencies have authority to add additional benefits by regulation.

- ***Limited excepted benefits*:** Under the statute, limited excepted benefits are dental, vision, and long term care, as well as "other similar, limited benefits" defined by the federal government in regulation, as long as they are "offered separately" from a traditional group health plan. The agencies have used their regulatory authority to add several types of limited excepted benefits including Flexible Spending Arrangements (FSAs), employee assistance programs that meet certain conditions, and certain narrowly defined Health Reimbursement Arrangements (HRAs).

- ***Noncoordinated excepted benefits:*** ERISA also exempts "coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance." Named illness policies, also called dread disease or critical illness plans, pay out upon a particular diagnosis like cancer or a heart attack. Fixed indemnity or hospital indemnity policies pay an amount for each day or month a person is sick, hospitalized, or receiving medical care. The excepted benefit plan must be separate from and not coordinated with a primary group health plan.[23]

- ***Supplemental excepted benefits:*** Finally, the statute defines coverage intended to supplement Medicare or military health coverage, and subject to regulation under those programs, as an excepted benefit, along with "similar" coverage intended to supplement a group health plan. The federal government has specified that group supplemental coverage must be intended to fill in cost-sharing in a traditional group plan or cover benefits other than EHB that a traditional plan doesn't cover, or both.

There are good policy reasons for exempting certain types of benefits from ERISA's substantive regulations. Group health plans are subject to fairly detailed regulation of the content of the plan, and some types of employer benefits include coverage for medical care but are not really the sort of plan that anyone would consider "health coverage." Indeed, a workers' compensation or auto insurance policy may sometimes pay for medical care, but it should not generally be subject to health coverage regulations. Similarly, Medigap plans that supplement Medicare coverage are subject to an entirely separate set of regulations and are intended to be limited in scope.

[23] Federal law also contains a set of standards that define certain benefits as exempt only if they are, variously, under a "separate policy, certificate, or contract of insurance" and/or "not an integral part" of another plan. See PHSA § 2721(c) (42 U.S.C. § 300gg-21(c)). The requirement that certain benefits be insured may provide some assurance of solvency, but in general these standards are no longer especially relevant to the way employers design their benefits and are not discussed here.

Figure 3: Excepted benefits under ERISA and the employer insurance market

Secondary or incidental excepted benefits	Workers compensation Disability income replacement insurance Auto insurance Accident-only insurance Liability or credit insurance On-site medical clinics Travel insurance
Limited excepted benefits	Dental coverage Vision coverage Long term care coverage FSAs Employee assistance programs Some HRAs
Noncoordinated excepted benefits	Critical illness policies Fixed or hospital indemnity
Supplemental excepted benefits	Medicare supplemental coverage TRICARE supplemental coverage Coverage supplemental to a group health plan

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However, the exception from regulation does create opportunities to skirt protections that otherwise should apply. Plans consisting solely of excepted benefits do not "count" for purposes of the ACA's employer mandate. Therefore, large employers generally do not face strong incentives to evade regulation by offering *only* an excepted benefit plan, since costs-savings would be offset by employer mandate penalties.

But it can be attractive to use some kinds of excepted benefit policies alongside a traditional group health plan. The full suite of ERISA protections will still apply to the traditional plan, but the excepted benefit may impose lifetime and annual limits, is not required to include an out-of-pocket cap, and can use medical underwriting to deny benefits or charge more to individuals based on their health conditions. This could allow an employer to, e.g., place most specialty drug coverage outside the standard plan and provide coverage through an excepted benefit plan – where patients in need of these drugs could face an annual limit or even be denied coverage based on their health status.

Across the categories of excepted benefit coverage, four particular types are most susceptible to this kind of abuse, because they have the potential to "look" the most like a traditional health plans: critical illness, accident, fixed indemnity, and, to a lesser degree, group supplemental coverage.

Critical illness and accident policies

Critical illness policies pay benefits when consumers are diagnosed with a "specified disease" – most commonly cancer, but they are available for other conditions as well. A 2018 survey of employers found that 43% offered critical illness policies,[24] and others were considering the benefit for future years. These plans are generally marketed to "fill in" health plan cost-sharing and compensate for missed work in the event of a diagnosis. But it could be attractive for employers to exclude or limit care for a named condition from their primary plan and offer a separate critical illness policy associated with that condition – where the benefit could be subject to lifetime and annual limits, health status exclusions, and other limitations not permitted in regulated coverage. Similarly, accident policies pay claims when individuals experience injuries, but certain services could be relegated to a separate accident policy. It does not appear that employers are engaged in this behavior using critical illness and accident policies to a meaningful degree today, but it remains a potential loophole.

Fixed indemnity and other supplemental plans

With respect to fixed indemnity policies, there is evidence of ongoing abuse in the employer market. As noted above, an indemnity policy pays "a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred." In theory, the benefit replaces lost income or fills in cost-sharing. But in practice, many fixed indemnity policies are structured quite a bit like a typical health insurance plan.

Specifically, modern indemnity plans develop very detailed rubrics for determining payment amounts. These plans pay an amount per time period *if a specific medical treatment is received*. Example indemnity plans offered in the group market include benefits like:

- $1,200 per month an individual is receiving chemotherapy,
- $100 per month an individual is taking anti-nausea medicine,
- $200 per day a patient gets an X-ray,
- $75 per day a person gets a clinical lab test,
- 70% "co-insurance" per day an individual fills a prescription for generic prescription drugs.[25]

While the amounts paid in these examples are sometimes lower than what true health coverage would pay, the structure mimics traditional benefits. The requirement that the benefit be paid on a "per time period" basis does not really constrain design; it has become fairly formulaic.

Therefore, employers can use a fixed indemnity policy with an elaborate payment rubric to offer a benefit that "looks like" typical health coverage but is not regulated as such. The most attractive arrangement for employers seeking to avoid regulation is to offer a fairly limited traditional plan, which satisfies the employer mandate, alongside an indemnity plan that offers benefits with limits and exclusions not otherwise allowed.[26] Federal law attempts to limit some of this behavior by only

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[24] Willis Towers Watson, "Voluntary Benefits Now Viewed as Essential, Willis Towers Watson Survey Finds," April 10, 2018, https://www.willistowerswatson.com/en-US/News/2018/04/voluntary-benefits-now-viewed-as-essential-willis-towers-watson-survey-finds.

[25] Aflac, "Cancer Protection Assurance Cancer Indemnity Insurance," http://www.aflacclients.com/MicrositePDF/MicrositePDFs/CANCER/CancerProtectionAssurance/Option2/DC.pdf (last visited June 22, 2020); Aflac, "Accident Advantage Accident-Only Supplemental Only Insurance," http://www.aflacclients.com/MicrositePDF/MicrositePDFs/Accident/AA/Option3/DC.pdf (last visited June 22, 2020); Stivers Staffing Services, "Limited Benefit & Self-Funded Minimum Essential Coverage Enrollment Guide," https://imgur.com/a/lLeHk (last visited June 22, 2020).

[26] See, e.g., Meyers Glaros, "Insurance, Tailored For You," https://meyersglaros.com, (last visited June 22, 2020).

excepting indemnity and critical policies on the condition that they are not "coordinated" with an exclusion in a primary plan, but that is a very weak limit that does not seem to hold much force in practice (though could perhaps be better enforced to deter some abusive behavior, as discussed below).

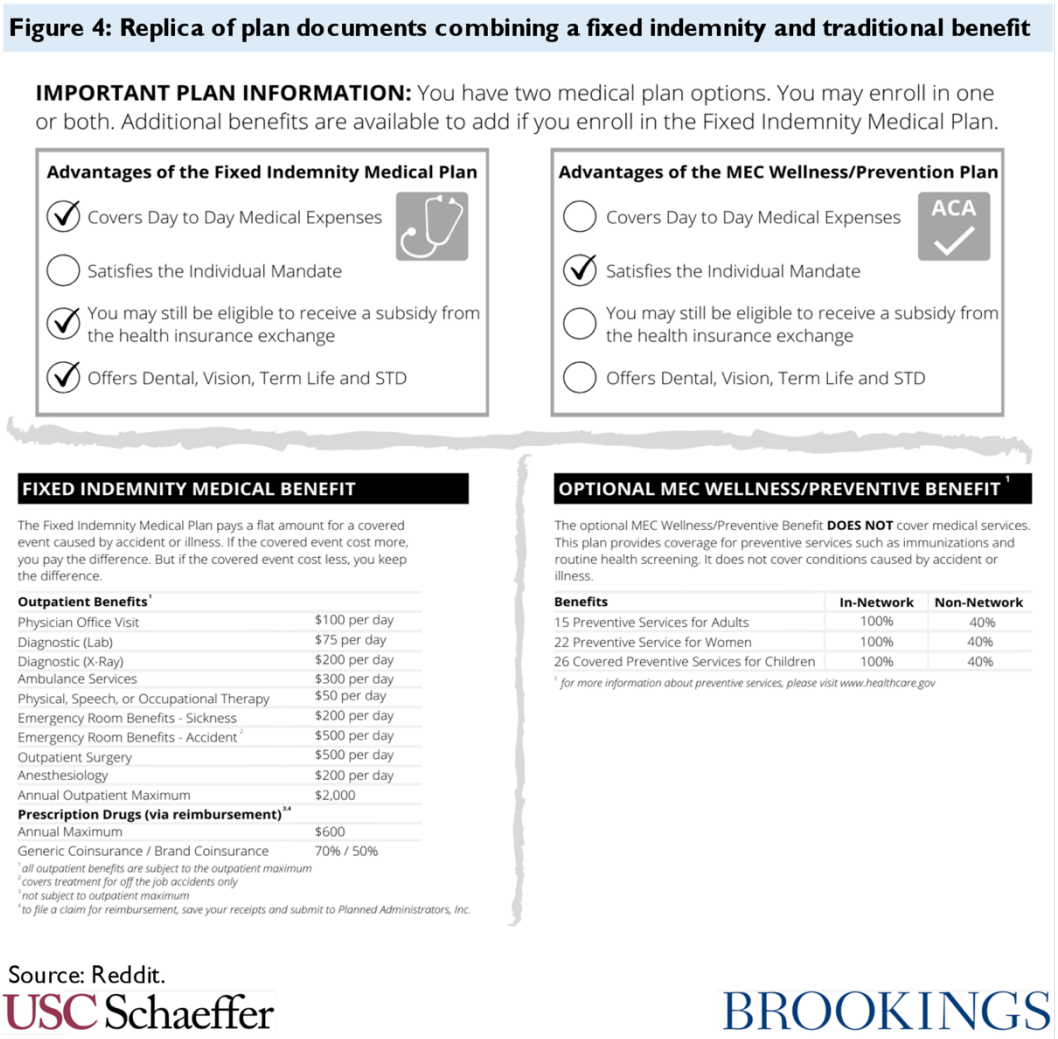
Indeed, while systematic data are not available, there is ample anecdotal evidence of employers combining fixed indemnity and traditional plans in problematic ways. In press reports and in social media forums where consumers offer details about their own insurance offers, you can find examples of employees offered an indemnity plan as if it is the primary form of health coverage. A seemingly common scheme,[27] with plan documents recreated from an image provided on social media as shown in Figure 4, operates as follows:

- The employer offers an extremely thin traditional health plan (often covering only ACA preventive services), satisfying its obligations under the employer mandate to offer some form of coverage.
- The employer places all other benefits in a fixed indemnity plan that mimics traditional insurance, but with a variety of limitations that would not be permitted in a traditional plan, like lifetime and annual limits and uncapped consumer exposure to out-of-pocket costs, or even pre-existing condition exclusions.
- The employee premiums can be structured to discourage enrollment in even the extremely limited traditional regulated plan. In a plan brochure from 2017, employees were charged $58 per month for self-only enrollment in the plan that covered *only* preventive services, and about $80 per month for self-only enrollment in the fixed indemnity plan.

Other variations exist. Some employers appear to offer a slightly more comprehensive traditional plan, covering, for example, outpatient services in the traditional plan, but hospital services in the indemnity plan. Plans can add dental and vision services to the indemnity plan or as a separate excepted benefit. But in all of these cases, employees are offered the fixed indemnity plan as if it were health coverage.

[27] See, e.g., Jaie Avila, "Show Me Your Bill Helps Wipe Out $70K in Charges After Heart Attack," *News 4 San Antonio*, October 10, 2019, https://news4sanantonio.com/news/trouble-shooters/show-me-your-bill-helps-wipe-out-70k-in-charges-after-heart-attack; Reddit, "UHC MEC Plan worth it?," October 24, 2008, https://www.reddit.com/r/HealthInsurance/comments/72gdsi/uhc_mec_plan_worth_it/.; Reddit, "I feel like my employer is deliberately giving me misleading information about my health insurance and I need your help," February 9, 2009, https://www.reddit.com/r/personalfinance/comments/7jlv89/i_feel_like_my_employer_is_deliberately_giving_me/.; Reddit, "I'm a temp worker and I think I'm getting screwed over," February 9, 2009, https://www.reddit.com/r/personalfinance/comments/3q0khk/im_a_temp_worker_and_i_think_im_getting_screwed/.

Figure 4: Replica of plan documents combining a fixed indemnity and traditional benefit



IMPORTANT PLAN INFORMATION: You have two medical plan options. You may enroll in one or both. Additional benefits are available to add if you enroll in the Fixed Indemnity Medical Plan.

Advantages of the Fixed Indemnity Medical Plan

- ☑ Covers Day to Day Medical Expenses
- ☐ Satisfies the Individual Mandate
- ☑ You may still be eligible to receive a subsidy from the health insurance exchange
- ☑ Offers Dental, Vision, Term Life and STD

Advantages of the MEC Wellness/Prevention Plan

ACA

- ☐ Covers Day to Day Medical Expenses
- ☑ Satisfies the Individual Mandate
- ☐ You may still be eligible to receive a subsidy from the health insurance exchange
- ☐ Offers Dental, Vision, Term Life and STD

FIXED INDEMNITY MEDICAL BENEFIT

The Fixed Indemnity Medical Plan pays a flat amount for a covered event caused by accident or illness. If the covered event cost more, you pay the difference. But if the covered event cost less, you keep the difference.

Outpatient Benefits[1]	
Physician Office Visit	$100 per day
Diagnostic (Lab)	$75 per day
Diagnostic (X-Ray)	$200 per day
Ambulance Services	$300 per day
Physical, Speech, or Occupational Therapy	$50 per day
Emergency Room Benefits - Sickness	$200 per day
Emergency Room Benefits - Accident[2]	$500 per day
Outpatient Surgery	$500 per day
Anesthesiology	$200 per day
Annual Outpatient Maximum	$2,000
Prescription Drugs (via reimbursement)[3,4]	
Annual Maximum	$600
Generic Coinsurance / Brand Coinsurance	70% / 50%

[1] *all outpatient benefits are subject to the outpatient maximum*
[2] *covers treatment for off the job accidents only*
[3] *not subject to outpatient maximum*
[4] *to file a claim for reimbursement, save your receipts and submit to Planned Administrators, Inc.*

OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT [1]

The optional MEC Wellness/Preventive Benefit **DOES NOT** cover medical services. This plan provides coverage for preventive services such as immunizations and routine health screening. It does not cover conditions caused by accident or illness.

Benefits	**In-Network**	**Non-Network**
15 Preventive Services for Adults	100%	40%
22 Preventive Service for Women	100%	40%
26 Covered Preventive Services for Children	100%	40%

[1] *for more information about preventive services, please visit www.healthcare.gov*

Source: Reddit.

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Note that some of this same potential for abuse is also associated with the exception for coverage offered supplemental to a group health plan. Existing regulations limit group supplemental coverage to filling in cost-sharing for *already covered* benefits or covering non-EHB services. Therefore, it would generally not be permissible to exclude an EHB like specialty drugs or hospitalization from a traditional plan and cover it instead through a supplemental plan. However, visit limits or very high cost-sharing in the typical group plan coupled with a supplemental plan could facilitate some otherwise impermissible benefit designs, and, perhaps more importantly, the regulatory restrictions could be weakened.

Small group induced utilization

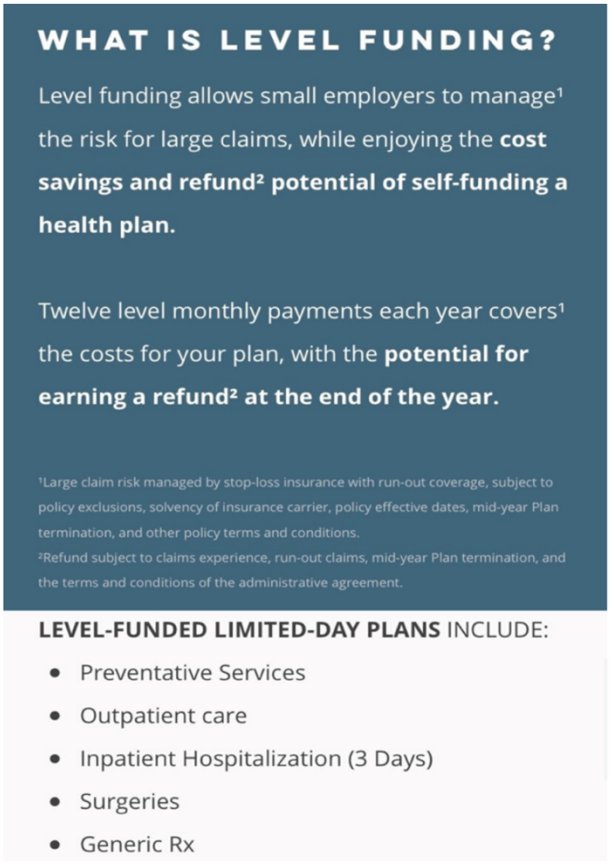
Finally, for a completely different set of reasons, small employers offering some sort of secondary coverage – whether fixed indemnity, critical illness, accident, or group supplemental – may be able to distort risk pooling in the small group insurance market. In particular, more generous insurance policies generally have higher premiums not only because the plan pays out higher amounts per service received, but also because lower cost-sharing leads to induced utilization – enrollees using more services because cost-sharing is lower. A supplemental policy could allow a small employer to buy a small group insurance plan with higher cost-sharing from its insurance company, but then provide enrollees the experience of lower cost-sharing through supplemental coverage. This would result in all small group market enrollees in the state bearing the costs of induced utilization, rather than the

individual firm. As above, this use of excepted benefits does not seem common, but it remains a potential loophole.

Evading protections in the small group market

Another problematic form of coverage arises from attempts by small employers to avoid offering an insurance plan that is considered part of the small group market. Recall that all group health plans (that are not excepted benefits) are subject to the general standards of ERISA, but small employers that buy insured coverage are generally required to comply with additional requirements, including covering all EHB, meeting a minimum AV, and being part of a risk pool with all other small groups in the state. Small employers need not comply with these standards if they self-insure their benefits by bearing risk themselves rather than purchasing an insurance product, but for most small employers, truly bearing the risk of employees' health costs is impractical. Nonetheless, some small employers – especially those with relatively healthy workforces – may wish to offer benefits that are less comprehensive than EHB or to avoid having to pool risk with firms with sicker workers. Gaps in existing regulation make that possible through two primary paths: "level-funding" plans and multiple-employer, or association, plans.

Figure 5: Sample level funding plan materials



Source: fundamentalcare.com

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"Level-funding" arrangements allow a small employer to offer a benefit that is technically considered a self-insured plan but functions almost exactly like an insured product. These plans are built around a stop-loss product. Almost all self-insured employers, of any size, purchase stop-loss coverage (also called reinsurance), which covers a portion of their health care claims if beneficiaries' costs are far higher than expected. Level funding arrangements twist this approach significantly, offering stop-loss that kicks in at such low thresholds that the employer does not bear any meaningful amount of risk.[28] Instead, small employers are guaranteed that they will pay only a fixed ("level") amount per month. Part of the small employer's monthly payment is considered a premium for stop-loss coverage, and part goes towards claims. From the small employer's perspective, then, this functions exactly as a health insurance product – but the employer is charged a monthly amount that considers only their own health care costs, not that of the whole pool, and the plan need not comply with the regulatory standards for small group insurance.[29] This increases costs for other small groups and enables employees of small employers to become enrolled in coverage that does not include all EHB. Indeed, some offerings to small employers combine level-funding arrangements with benefits far skimpier

[28] See U.S. Department of Labor, "Guidance on State Regulation of Stop-Loss Insurance," November 6, 2014, https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/14-01.
[29] See Sabrina Corlette, Jack Hoadley, Kevin Lucia, and Dania Palanker, "Small Business Health Insurance and the ACA: Views from the Market 2017," *Urban Institute*, July 2017, https://www.urban.org/sites/default/files/publication/92291/2001459_small_business_health_insurance_and_the_aca_views_from_the_market_2017_0.pdf.

than the full EHB package that the small employer would be required to cover if purchasing coverage in the small group market, as shown in Figure 5.

Another tool that can achieve the same objectives is if small employers are able to purchase coverage as if they were a large group. Federal law allows employers to join together in a multiple employer welfare arrangement (MEWA), which is sometimes also known as an Association Health Plan (AHP). A detailed review of the federal and state law regulating MEWAs and AHPs is beyond the scope of this piece.[30] For our purposes, it is sufficient to note that, prior to 2018, federal guidance generally treated each member of the association as a separate employer.[31] Therefore, small employers buying coverage through one of these arrangements were usually treated as part of the small group market, which generally limited the appeal of this type of coverage.

However, a 2018 rulemaking – which has been largely enjoined by a federal court – would make it easier for all the members of an association to be treated as a single large group.[32] This would make MEWA arrangements that qualify as AHPs under the rule far more attractive to small employers. As with level funding plans, if this rule were in effect, it would enable small employers to purchase coverage that does not cover all EHB and to avoid being priced with their state's full small group market risk pool, exposing their employees to sub-par coverage and increasing small group premiums. The enjoined rules would also allow self-employed individuals to be considered part of the large group market, which would increase premiums in the individual market as well. Historically, the MEWA market has also featured a significant risk of insolvency and fraud among entities that "look like" health insurance but are in fact not fully regulated as such and often lack the resources to pay member health care claims. States have tools to ensure the financial stability of MEWAs, but not all states take advantage of them.[33]

Therefore, as long as the 2018 AHP rule is enjoined, the existence of MEWA-related regulatory gaps will likely have limited impact. However, if the rule were to be reinstated, AHPs serving small employers could undermine small group market risk pooling and protections, driving some small employers to fraudulent or insolvent MEWA offerings.

Summarizing the gaps in the employer market

ERISA adopts a broad view of what constitutes a "group health plan," and therefore clearly brings all employer offerings within its framework regardless of the benefit structure or the vendor selected. However, the discussion above reveals three major gaps within that framework, as shown in Figure 6. First, some important substantive protections to ensure high quality health coverage are simply never

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[30] See Julie Mix McPeak, Eric A. Cioppa, Raymond G. Farmer, Gordon I. Ito, National Association of Insurance Commissioners to Office of Regulations and Interpretations, "Definition of Employer—Small Business Health Plans RIN 1210-AB85," March 6, 2018, https://www.naic.org/documents/index_health_reform_section_180306_comments_assoc_plan_nprm.pdf; Mila Kofman, Eliza Bangit, and Kevin Lucia, "MEWAs: The Threat of Plan Insolvency and Other Challenges," *The Commonwealth Fund*, March 2004, https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2004_mar_mewas__the_threat_of_plan_insolvency_and_other_challenges_kofman_mewas_pdf.pdf; Brief of Amici Curiae Health Policy Scholars, New York v. Department of Labor, https://affordablecareactlitigation.files.wordpress.com/2019/07/dcc-health-policy-history-scholars-amicus.pdf

[31] Gary Cohen, "Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations," *Department Of Health & Human Services*, September 1, 2011, https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf.

[32] "Definition of "Employer" Under Section 3(5) of ERISA-Association Health Plans," 83 Fed. Reg. 28912 (June 21, 2018), https://www.federalregister.gov/documents/2018/06/21/2018-12992/definition-of-employer-under-section-35-of-erisa-association-health-plans; New York v. Department of Labor, 363 F. Supp. 3d 109 (D.D.C. 2019), https://affordablecareactlitigation.files.wordpress.com/2019/03/5940153-0-12659.pdf.

[33] Mila Kofman, Eliza Bangit, and Kevin Lucia, "MEWAs: The Threat of Plan Insolvency and Other Challenges," *The Commonwealth Fund*, March 2004, https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2004_mar_mewas__the_threat_of_plan_insolvency_and_other_challenges_kofman_mewas_pdf.pdf.

applied to employer plans, leaving most employers free under ERISA to offer benefits that do not include all EHB and do not satisfy a minimum AV standard. Second, the law includes defined regulatory exemptions for "excepted benefits" that are not subject to the substantive standards that otherwise apply, and this creates potential pathways for abuse. Finally, federal law adopts a set of standards for risk pooling by small employers but does not always adopt sufficiently strong guardrails to ensure risk stays in the appropriate pool – and the routes out of the appropriate pool create additional financial risk.

Figure 6: Gaps in regulation of the employer market

Substantive protections not applied uniformly

- EHB requirement does not apply to group health plans outside the small group market
- Minimum actuarial value standard is not required of group health plans

Skirting application of substantive protections

- Fixed indemnity plans offer benefits similar to traditional insurance and yet are treated as excepted benefits
- These plans offer an opportunity to segment benefits, so that coverage (or coverage for a particular condition or treatment) can be subject to underwriting or avoid financial protections

Undermining system stability

- Fixed indemnity and supplemental coverage can undermine small group market risk pooling by misallocating cost of induced utilization
- MEWAs and AHPs and self-funding arrangements offer ways to for small groups to be treated as large groups, undermining the small group risk pool and creating financial risks for the employer and its enrollees.

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Gaps in regulation of individual coverage

We turn now to the gaps in regulation of the coverage sold directly to individuals. The problems here are somewhat different from the problems of the employer market. Unlike the employer market, in the individual insurance market substantive regulations guaranteeing good coverage apply fairly completely to plans that are regulated by federal law. Regulated individual market insurance must offer essential health benefits without discriminating based on pre-existing conditions, limit consumers' financial exposure with an out-of-pocket limit, prohibit lifetime and annual dollar limits, meet a minimum AV, and operate within a framework that ensures solvency and risk pooling. However, there is an array of excepted and unregulated market segments that leave individuals exposed to major gaps.

There are two ways in which the coverage sold to individuals can evade regulation. The first is by offering insurance that fits within a regulatory exception named in federal law, which exempts the plan from complying with the individual market protections. The second is by offering coverage that is not

formally considered individual market "insurance" at all and is therefore entirely exempt from regulation despite functioning like a health insurance product. Each of these paths is described below.

Regulatory exceptions

Recall that the provisions of federal law regulating insurance products appear within the Public Health Service Act, as modified by the Affordable Care Act. The PHSA includes longstanding exemptions from regulation for short-term limited-duration insurance and excepted benefits.

Short-term plans

The most familiar regulatory exception is a provision that exempts "short-term limited-duration insurance" from the definition of individual market coverage.[34] Because it is not considered individual market coverage, it is not subject to any of the substantive standards described above. Federal statute does not define "short-term limited-duration insurance," but federal regulations have offered a definition that has been subject to change over time. Prior to enactment of the Affordable Care Act, the regulations defined a short-term plan as a plan lasting less than 12 months, after taking account any options for renewal.[35] After the passage of the ACA, and in light of several new provisions in federal law that generally treat three months as a "short" interval with respect to health coverage, the federal government defined short-term coverage to include only plans lasting less than three months, after taking account of any renewals.[36] However, in 2018, the Trump Administration modified these regulations again, defining short-term coverage as plans lasting up to three *years*: an initial term of 12 months plus two renewals.[37] Some states have regulated short-term plans, as discussed further below, but coverage consistent with the federal definition is available in 26 states.[38]

Short-term coverage need not comply with any of the federal standards in the PHSA. These plans may deny coverage or charge more to individuals with pre-existing conditions, exclude essential health benefits, impose annual or lifetime limits, or leave out-of-pocket costs uncapped. And they do. Because short-term plans can last up to three years, they can compete effectively with traditional plans for all enrollees, not just those who need temporary coverage. Therefore, these plans can attract relatively healthy consumers with the low costs that come from excluding sick enrollees and from offering more limited benefits. Many researchers have offered detailed analyses of the short-term plan market that has emerged since the implementation of the 2018 regulatory change. For example, a Kaiser Family Foundation analysis of short-term plans found that 43% do not cover mental health needs, 62% do not cover substance abuse services, and 71% do not cover prescription drugs.[39] None of the plans in their analysis cover maternity care. Cost-sharing in these plans sometimes exceeds $20,000 per person per policy period (compared to the $8,150 limit for regulated coverage), and annual and lifetime limits are

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[34] PHSA § 2791(b)(5) (42 U.S.C. § 300gg-91(b)(5)).
[35] Prior to the ACA, classifying coverage as short-term was far less consequential, since it was not until the ACA that significant substantive regulations applied to individual coverage. "Interim Rules for Health Insurance Portability for Group Health Plans," 62 Fed. Reg. 16894 (April 8, 1997), https://www.federalregister.gov/documents/1997/04/08/97-8275/interim-rules-for-health-insurance-portability-for-group-health-plans.
[36] "Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance," 81 Fed. Reg. 75316 (October 31, 2016), https://www.federalregister.gov/documents/2016/10/31/2016-26162/excepted-benefits-lifetime-and-annual-limits-and-short-term-limited-duration-insurance.
[37] "Short-Term, Limited-Duration Insurance," 83 Fed. Reg. 38212 (August 3, 2018), https://www.federalregister.gov/documents/2018/08/03/2018-16568/short-term-limited-duration-insurance.
[38] Justin Giovannelli, Kevin Lucia, and JoAnn Volk, "States Work to Make Individual Market Health Coverage More Affordable, But Long-Term Solutions Call for Federal Leadership," *The Commonwealth Fund*, January 2020, https://www.commonwealthfund.org/sites/default/files/2020-01/Giovannelli_states_indiv_market_coverage_affordable_ib.pdf.
[39] Karen Pollitz, Michelle Long, Ashley Semanskee, and Rabah Kamal, "Understanding Short-Term Limited Duration Health Insurance," *Kaiser Family Foundation*, April 23, 2018, https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/.

common.[40] All of these plans entirely exclude individuals with significant pre-existing conditions, exclude coverage for services associated with past health care needs for people they do cover, and charge more based on health status.

Other researchers have demonstrated that entities marketing short-term plans often do not disclose the limitations of these plans. Consumers searching for health coverage online are presented with web advertisements that direct them to online vendors selling short-term plans.[41] Site names and branding are often designed to mimic the federal HealthCare.gov website, such that consumers have no reason to think they are buying non-compliant forms of coverage. Many sites that appear in searches related to purchasing health coverage are "lead generators" that ask consumers to provide contact information that the site then shares with health insurance agents.[42] Agents contact the consumer and sell them products over the phone; the agent is paid a commission by the insurance vendor. A small scale secret-shopper survey revealed that agents selling coverage over the phone promoted short-term coverage even for consumers whose incomes qualified them for generous subsidies to purchase compliant coverage, that agents declined to provide written materials that would disclose plan limitations, and that consumers were pressured to make a quick decision to purchase coverage in the absence of written material about the plan.[43] These problems appear particularly acute during the COVID-19 pandemic.[44] At least one company has been sued by consumers and state regulators over its marketing of short-term plans.[45]

In this climate, it is no surprise that consumers are unaware of the limitations of their plans. A Montana man was left with $43,000 in medical bills associated with testicular cancer after his coverage was rescinded, a form of pre-existing condition discrimination in which coverage is canceled retroactively.[46] A Pennsylvania man was surprised when eye surgery associated with a pre-existing condition was excluded, since he was not aware his coverage had such limitations.[47] A woman in Ohio faced $48,000 in bills for a knee replacement – and has foregone needed surgery on the other knee – because she was led to believe her short-term plan was regulated coverage.[48]

Excepted benefits

While short-term limited-duration plans have received the most attention, there are other similar market segments that evade regulation. Specifically, federal law also exempts excepted benefits as defined in the statute from complying with standards that otherwise apply to individual market

[40] Gabriela Dieguez and Dane Hansen, "The Impact Of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market," *Milliman,* February 25, 2020, https://us.milliman.com/en/Insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market; see also See "Shortchanged: How the Trump Administrations Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk," *U.S. House of Representatives*, June 2020, https://drive.google.com/file/d/1uiL3Bi9XVomYnxpyaIMeg_Q-BJaURXX3/view.

[41] U.S. Senator Bob Casey, "Health Care Sabotage Online: A Warning to Consumers," October 2019, https://www.casey.senate.gov/download/casey-report-on-health-care-sabotage-online.

[42] Sabrina Corlette, Kevin Lucia, Dania Palanker, and Olivia Hoppe, "The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses," *Robert Wood Johnson Foundation & Urban Institute*, January 31, 2019, https://www.rwjf.org/en/library/research/2019/01/the-marketing-of-short-term-health-plans.html.

[43] Id.

[44] Christen Linke Young and Kathleen Hannick, "Misleading Marketing of Short-Term Health Plans Amid COVID-19," *Brookings Institution*, March 24, 2020, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/03/24/misleading-marketing-of-short-term-health-plans-amid-covid-19/.

[45] GlobeNewswire, "HIIQ Resolves Legacy regulatory matter in the State of Washington," January 02, 2020, https://www.globenewswire.com/news-release/2020/01/02/1965684/0/en/HIIQ-Resolves-Legacy-regulatory-matter-in-the-State-of-Washington.html.

[46] Noam N. Levey, "Skimpy Health Plans Touted by Trump Bring Back Familiar Woes for Consumers," *Los Angeles Times*, April 2, 2019, https://www.latimes.com/politics/la-na-pol-trump-shortterm-health-insurance-consumer-problems-20190402-story.html.

[47] U.S. Senator Bob Casey, "Health Care Sabotage Online: A Warning to Consumers," October 2019, https://www.casey.senate.gov/download/casey-report-on-health-care-sabotage-online.

[48] Reed Abelson, "Florida Company Sued Over Sales of Skimpy Health Plans," *The New York Times*, June 12, 2019, https://www.nytimes.com/2019/06/12/health/insurance-lawsuit-obamacare.html.

coverage. Excepted benefits in the individual and employer markets are generally defined in analogous ways under the statute and implementing regulations, though some specific kinds of excepted benefits applicable to employers have no logical analogue in the individual market and are not reflected in individual market regulations, as shown in Figure 7.

Figure 7: Excepted benefits in the individual market

Secondary or incidental excepted benefits	Workers compensation
	Disability income replacement insurance
	Auto insurance
	Accident-only insurance
	Liability or credit insurance
	On-site medical clinics
	Travel insurance
Limited excepted benefits	Dental coverage
	Vision coverage
	Long term care coverage
Noncoordinated excepted benefits	Critical illness policies
	Fixed or hospital indemnity
Supplemental excepted benefits	Medicare supplemental coverage
	TRICARE supplemental coverage
	Coverage supplemental to a group health plan

Benefits excepted in the employer market with no analogue in the individual market: FSAs, employee assistance programs, and some HRAs.

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As we saw above, while the exemption for excepted benefits may be intended to encompass plans that are very different from traditional health coverage, in fact, products can be designed to classify as an excepted benefit while offering a benefit design very similar to health coverage – thus evading regulation under federal law while competing for healthy consumers.

Similar to the employer context, the most significant opportunity is associated with fixed indemnity coverage, defined in federal regulations as coverage that pays a "fixed dollar amount per period… without regard to the amount of benefits provided," but in practice benefits scale with services received. Perhaps the most extreme example can be found in a relatively new online vendor that allows consumers to customize exactly which benefits they want covered from a list of *thousands* of potential options.[49] The coverage offers an extraordinarily detailed payment rubric, accessed via app, that informs enrollees what they will be paid "per day" they receive that particular service. (Unsurprisingly, there is limited transparency in the product design, and it is difficult to find information on the exact reimbursement rates without completing a coverage application.)

[49] Ron Hurtibise, "Cheaper than Obamacare? Budget-Priced Plans can Cost Far More if you Get Sick," *South Florida Sun Sentinel*, November 8, 2019, https://www.sun-sentinel.com/business/fl-bz-should-middle-income-earners-consider-obamacare-alternatives-20191108-wqam2vgmsvbhxg044xi53qb704-story.html.

This sort of plan design is not limited to new online vendors; major brand name carriers also offer such plans. For example, one fixed indemnity plan from a major carrier (available in 37 states) has a detailed rubric for determining payment in the event of hospitalization, varying payment based on the setting and the providers involved in care, as shown in Figure 8.[50] The plan even has a provider network: hospitals and other providers have agreed to offer their services to plan enrollees at discounts, which presumably align with the plan's payment formula, and the plan pays directly to providers.

Figure 8: Sample individaul market fixed indemnity benefit schedule

Hospital & Ambulance Benefits			Choice Value	Choice Plus	Select Value	Primary Preferred	Select Preferred	Premier Plus
Inpatient Hospital Confinement (unlimited)		We pay:	$1,000 per day	$2,000 per day	$3,000 per day	$4,000 per day	$5,000 per day	$5,000 per day
Increasing Injury Reimbursement* (unlimited) Inpatient Hospitalization Benefits increase 25% each year, years 2-5, for injury-related hospital stays.	Year 2	We pay:	$1,250 per day	$2,500 per day	$3,750 per day	$5,000 per day	$6,250 per day	$6,250 per day
	Year 3		$1,500 per day	$3,000 per day	$4,500 per day	$6,000 per day	$7,500 per day	$7,500 per day
	Year 4		$1,750 per day	$3,500 per day	$5,250 per day	$7,000 per day	$8,750 per day	$8,750 per day
	Year 5		$2,000 per day	$4,000 per day	$6,000 per day	$8,000 per day	$10,000 per day	$10,000 per day
Inpatient Hospital Intensive Care Unit (ICU) or Critical Care Unit (CCU) (maximum per confinement)		We pay:	$2,000 per day (31 days)	$4,000 per day (31 days)	$6,000 per day (31 days)	$2,000 per day (60 days)	$2,000 per day (60 days)	$10,000 per day (31 days)
			ICU/CCU benefit amounts are in addition to Inpatient Hospital Confinement benefits.					
Inpatient Physician Visits (maximum during Inpatient Hospital Confinement)		We pay:	$100 per visit (1 visit per day)	$100 per visit (1 visit per day)	$100 per visit (1 visit per day)	$100 per visit (1 visit per day)	$100 per visit (1 visit per day)	$100 per visit (2 visits per day)
Emergency Room (maximum per calendar-year)		We pay:	$200 per day (2 days)	$200 per day (2 days)	$300 per day (2 days)	$300 per day (3 days)	$300 per day (3 days)	$500 per day (2 days)
Ambulance-Ground or Water (maximum per calendar-year)		We pay:	$500 per trip (1 trip)	$500 per trip (1 trip)	$500 per trip (1 trip)	$500 per trip (1 trip)	$500 per trip (1 trip)	$1,000 per trip (1 trip)
Ambulance-Air (maximum per calendar-year)		We pay:	$5,000 per trip (1 trip)	$5,000 per trip (1 trip)	$5,000 per trip (1 trip)	$5,000 per trip (1 trip)	$5,000 per trip (1 trip)	$5,000 per trip (1 trip)

* Not available in OH.

Source: uhone.com

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This is not *exactly* like traditional health insurance and is not a perfect substitute for traditional benefits. Most importantly, of course, it lacks the consumer protections necessary for quality coverage. Pre-existing conditions are excluded from coverage, and it still leaves individuals exposed to very significant out-of-pocket costs – the amounts shown in the Figure above may be sufficient to pay for the average hospital stay, but not a very complex one. Nonetheless, it shares many features with a traditional health plan. Some individuals (especially healthier people) might deliberately select this benefit, and unsuspecting consumers could easily be steered toward it without fully appreciating the limitations. Indeed, one fixed indemnity product website answers the question "Is this insurance?" by explaining, "Yes, it is! [Our product] pays fixed amounts for every medically necessary service, procedure and drug except for maternity."[51]

Just as with short-term plans, there is ample anecdotal evidence of consumers who are surprised by the limitations of their coverage, often because of misleading agent and broker sales practices. A professor in Pennsylvania found herself facing $20,000 in medical bills after a partial amputation of her foot; she expected her health plan to cover the benefit and was not aware she had enrolled in a fixed indemnity plan that would exclude costs arising from her pre-existing diabetes.[52] Another Pennsylvania woman was surprised to discover her health coverage was actually a fixed indemnity plan that would cover only $2,000 towards her tens of thousands of dollars in hospital bills after an

[50] United Healthcare, "Hospital & Doctor Fixed Indemnity Insurance," https://www.uhone.com/filehandler.ashx/?FileName=45173-G201912.pdf (last visited June 23, 2020).
[51] Sidecar Health, "Start Your Health Insurance Now," https://app.sidecarhealthinsurance.com/signup/packages (image on file with authors).
[52] Sarah Gantz, "Villanova Prof Contracted Sepsis and Needed an Amputation — and Her Health Plan Wouldn't Pay," *The Philadelphia Inquirer*, April 5, 2019, https://www.inquirer.com/health/obamacare-skimpy-health-plan-villanova-professor-20190405.html.

injury.[53] She thought she had purchased fully regulated coverage through the federal HealthCare.gov website but was misled by a broker's website and a phone conversation with a salesperson. A man in Texas detailed the lengths to which an insurance agent went to sell him a fixed indemnity plan, rushing to complete a sale without, in the consumer's view, any disclosure of plan limitations.[54] When reporters contacted the agent, he seemed surprised that anyone would be unhappy with the benefit design.

As we saw with employers, other excepted benefit plans – accident and critical illness policies – could also design their benefits in this way. In the employer context, abuse of these benefit forms seems largely theoretical; in the individual market, there is some evidence it is beginning to become real. Widely available accident insurance plans pay an amount associated with having a particular type of injury, coupled with additional payments based on the type of medical care received. One plan from a major national carrier pays $200 for a concussion, plus $200 for an Emergency Room visit, $250 for a CT scan, and $65 for a follow-up visit with the neurologist.[55] These amounts are lower than the prices for those health care services, but the design mimics a health benefit and could certainly scale up. It is harder to find problematic critical illness policies – the most widely available policies do seem to pay a large lump sum at diagnosis – but there is little reason to doubt that such policy forms could exist, particularly if other options to offer non-compliant coverage are foreclosed. Indeed, combination critical illness and accident policies could replicate nearly everything covered by traditional plans. Further, existing federal regulations contain essentially no guardrails about the form these products must take, defining accident policies as "coverage only for accident (including accidental death and dismemberment)," and critical illness policies as "coverage only for a specified disease or illness (for example, cancer policies)," as long as they are not coordinated with a group health plan.

Unregulated markets

Until this point, we have considered gaps in regulation of individual coverage that arise because federal law has expressly exempted a form of coverage from oversight, and entities classify their product as exempted within those definitions. We turn now to a very different kind of gap in the regulation of health coverage: forms of individual coverage that are not considered "insurance" at all – and therefore are beyond the reach of the regulatory scheme.

In the employer market, any time an employer offers a benefit that involves health care, it is a "group health plan" that must either comply with applicable standards or be classified as an excepted benefit. (Even when small employers try to avoid the risk pooling provisions of federal law, they are still group health plans subject to regulation as such). Not so in the individual market. In federal law, health insurance coverage means "benefits consisting of medical care… offered by a health insurance issuer." A health insurance issuer is an entity that is "licensed to engage in the business of insurance in a State and which is subject to State law that regulates insurance." So, if an entity is not considered a "health insurance issuer" under state law (and no employer is involved), then that entity can offer coverage without coming under the umbrella of federal regulation.

States generally do take a broad view of what constitutes "insurance" in their state. They want to ensure that when a third party accepts risk for health care costs, its financial affairs are subject to review by the state insurance commissioner. Therefore, states generally treat certain sorts of transactions as insurance contracts that *require* licensure as an issuer and oversight of the product being sold. In all states, if a payday lender attempted to sell a product that offered protection against medical costs but

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[53] Sarah Gentz, "A Philly Woman's Broken Back and $36,000 Bill show how some Health Insurance Brokers Trick Consumers into Skimpy Plans," *The Philadelphia Inquirer*, November 14, 2019, https://www.inquirer.com/health/consumer/limited-benefit-skimpy-health-plans-sales-pitch-20191114.html.
[54] Jenny Deam, "Risky Business: Buying Health Insurance in the New Age of Deregulation," *Houston Chronicle*, November 27, 2019, https://www.houstonchronicle.com/business/article/Risky-Business-Buying-health-insurance-in-the-14865415.php.
[55] United Healthcare, "Accident SafeGuard," https://www.uhone.com/filehandler.ashx/?FileName=43936C1-G201712.pdf (last visited June 22, 2020).

claimed it was not a health insurance issuer and therefore not selling health insurance coverage, state law would take a different view: it would say that a transaction is an insurance contract, and the payday lender must become licensed as an insurance issuer and have the product regulated as insurance if it wants that health care product to be for sale.

In this way, state and federal law are usually in balance. States generally want to define the types of transactions that constitute insurance broadly, and federal law requires that once the state starts regulating the issuer and the product, federal protections will apply. Problems emerge when the type of transaction an entity engages in is able to slip through state law definitions of insurance, and when states *deliberately* write their insurance laws so that a product that otherwise would be considered insurance is expressly defined as "not insurance."

In either case, consumers can become enrolled in something that seems like "health coverage" but is in fact not regulated as such. The sections that follow consider three existing examples – Farm Bureau plans, health care sharing ministries, and self-insured student health plans – and then offers a brief discussion of the potential for future abuse.

Farm Bureau plans

Three states authorize the state Farm Bureau to sell a product that looks quite a bit like health insurance, but state law defines as *not* health insurance and therefore not subject to state or federal insurance law. Tennessee has provided for such plans since 1993, defining the Farm Bureau as a "not-for-profit membership services organization."[56] The Farm Bureau thus offers a benefit to its members (i.e. anyone who pays an annual fee) in the form of a medically underwritten health care benefit. Individuals must pass a health care screening to be allowed to enroll in the plan, and pre-existing conditions are excluded from coverage. Likewise, the plans do not cover all Essential Health Benefits. Maternity services are subject to a waiting period and are only available if an entire family is covered, not just a single adult. Mental health and substance use disorder services do not appear to be covered, and there are significant limitations in coverage of benefits like habilitative and rehabilitative coverage.

For benefits that are covered and for those that are healthy enough to enroll, some of the Tennessee Farm Bureau plans offer cost-sharing that resembles what an enrollee would experience in regulated sections of the market, while other plans require about 85% more exposure to out-of-pocket costs than would be allowed in regulated plans, with out-of-pocket limits as high as $15,000 per person.[57] The Tennessee plans do not have annual and lifetime limits (though they could). That is, while the coverage available is somewhat more robust than the thinnest versions of coverage described above, these plans suffer from some of the same exclusions and potential gaps in coverage as short-term plans and similar benefits. Moreover, just as we saw above, these plans exclude pre-existing conditions from coverage and allow only healthy individuals to enroll, relegating higher cost enrollees to the regulated segments of the market and driving up premiums in the regulated risk pool.

Tennessee was the first state to authorize this "not insurance" model of insurance. Enrollment in Tennessee Farm Bureau plans has grown since enactment of the ACA, and other states have followed

[56] Sabrina Corlette and Kevin Lucia, "What's Going on in Tennessee? One Possible Reason for Its Affordable Care Act Challenges," *Georgetown University Health Policy Institute*, April 11, 2017, http://chirblog.org/whats-going-tennessee-one-possible-reason-affordable-care-act-challenges/.
[57] See Farm Bureau Health Plans, "Enhanced Choice Services", https://www.fbhealthplans.com/SiteMedia/Documents/Schedule_of_Benefits/Enhanced-Choice.pdf (last visited June 26, 2020); Farm Bureau Health Plans, "Core Choice Services", https://www.fbhealthplans.com/SiteMedia/Documents/Schedule_of_Benefits/Core-CHOICE.pdf (last visited June 26, 2020).

suit.[58] Iowa passed its own Farm Bureau legislation in 2018,[59] and Kansas passed similar legislation in 2019.[60] Plans available in Kansas are nearly identical to those in Tennessee and use the same policy forms and exclusion language.[61] Farm Bureau plans in Iowa are structured a bit differently.[62] As in Tennessee and Kansas, they are only available to those who can pass the underwriting screen, and enrollees with pre-existing conditions are excluded. For the benefits that are covered for those healthy enough to enroll, however, plans cover benefits that are similar to regulated plans and appear to include most of the full EHB package, including maternity and mental health. Some plans do have out-of-pocket limits somewhat higher than allowed in the regulated market ($10,000 for a single person), and all plans are subject to a $3 million lifetime limit.

Therefore, in the three states that allow them today, Farm Bureau plans suffer from some gaps in coverage that leave individual enrollees exposed, and significant harms arise from the fact that they pull healthy individuals out of the regulated risk pool.

Health care sharing ministries

Another problematic form of "not insurance" is coverage offered by health care sharing ministries (HCSMs). This is a loosely defined market segment, but it generally means a group of individuals with some sort of religious affiliation who agree to share health care costs with one another. No insurance company is involved, so the coverage can evade being considered health insurance coverage subject to regulation.

In their original incarnation, HCSMs would ask members to contribute directly to one another's medical bills with monthly mailers listing claims in need of reimbursement. Indeed, some early state laws attempting to define the relationship between HCSMs and the state insurance code characterized the organizations as "religious publications," because the primary tool they used to share health care costs were mailings that would "match[] subscribers with the present ability to pay with subscribers with present financial or medical need."[63]

Over time, some HCSMs have evolved to look much more like regular health care coverage. A mid-2000s legal dispute involved an HCSM that would collect all medical bills their members incurred in a month, divide total costs by their number of enrollees (weighted by household characteristics), and ask each enrollee to contribute their share of those costs.[64] Today, certain HCSMs have shed all but the most formulaic pretense of directly sharing costs between members. Instead, they charge advertised monthly amounts to enrollees based on characteristics like age and sex. They structure their benefits with deductibles, co-pays, per-service allowed amounts, networks – and pre-existing condition exclusions as well as annual and lifetime limits. Indeed, the only reference to the "sharing" nature of the benefit is the fact that the plan disclaims any obligation to fully comply with the terms of

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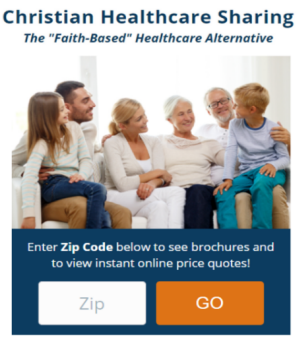
[58] Sabrina Corlette and Kevin Lucia, "What's Going on in Tennessee? One Possible Reason for Its Affordable Care Act Challenges," *Georgetown University Health Policy Institute*, April 11, 2017, http://chirblog.org/whats-going-tennessee-one-possible-reason-affordable-care-act-challenges/.
[59] Sarah Lueck, "Kansas Bill Would Harm People With Pre-Existing Conditions," *Center on Budget and Policy Priorities*, April 10, 2019, https://www.cbpp.org/blog/kansas-bill-would-harm-people-with-pre-existing-conditions.
[60] Alice Mannette, "Seeking Affordable Care, Kansas Farmers Explore KFB Health Offering," *The Hutchinson News*, October 20, 2019, https://www.hutchnews.com/news/20191020/seeking-affordable-care-kansas-farmers-explore-kfb-health-offering.
[61] Kansas Farm Bureau Health Plans, "Individual & Family," https://www.kfbhealthplans.com/individual-family (last visited June 22, 2020).
[62] Farm Bureau Health Plans, "Outline Of Coverage For Farm Bureau Health Plans 2019 Plan Year," https://www.iowafbhealthplan.com/page/file?path=Files%2Fwebsite%2FFiles%2FM9319667_08_18_v5_10_01_18_FINAL.PDF (last visited June 22, 2020).
[63] See, e.g., Kentucky v. Reinhold, 325 S.W.3d 272 (Supreme Court of Kentucky 2010), available at https://scholar.google.com/scholar_case?case=12027759278514462230&q=Commonwealth+of+Kentucky+v.+E.+John+Reinhold+D/B/A+American+Evangelistic+Association&hl=en&as_sdt=20006&as_vis=1.
[64] Diana B. Henriques, "Ministry's Medical Program Is Not Regulated," *The New York Times,* October 20, 2006, https://www.nytimes.com/2006/10/20/business/20religion.html.

its benefit design, instead asserting that payment depends on other enrollees making "voluntary" contributions. Nor are they necessarily particularly rooted in a religious tradition. Some HCSMs do limit enrollment to those with shared faith commitments. For others, plan documents may be sprinkled with biblical quotes and enrollees might "agree" to a set of faith-based principles, but there is nothing linking enrollees beyond having clicked on the same paid advertisement in their web-browser. Figure 9 shows excerpts from one HCSM's website and plan documents.

Figure 9: Excerpts from sample health care sharing ministry plan documents



Individual Sharing Amount (ISA)	✔ $5,000 / $10,000
Specialists	✔ $75 Visit Fee ✔ Hospitalization or Post Outpatient Surgery
Emergency Room	✔ $300 Visit Fee
Diagnostic/X-Ray/Labs	✔ 100% after ISA is met, up to Maximum Sharing Limit ✔ Outpatient: Pre-Admission and Post In-Patient
In/Outpatient Surgery Life threatening emergency immediately available.	✔ 100% after ISA up to Maximum Sharing Limit ✔ 2 month waiting period
Hospitalization	✔ 100% after ISA up to Maximum Sharing Limit
Maximum Limit Per Incident	✔ $150,000 / $250,000 / $500,000
Lifetime Sharing Maximum	✔ $300,000 / $500,000 / $1,000,000

Note: If you join this organization instead of purchasing health insurance, you will be considered uninsured. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance.

Source: christianhealthplans.com

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Unsurprisingly, there is widespread anecdotal evidence of consumers caught in these gaps. An 8-year-old boy who suffered an aneurism exceeded the $250,000 limit of his family's HCSM.[65] A New Hampshire man was surprised when a back injury was treated as a pre-existing condition.[66] State regulators in Washington state identified three different consumers enrolled in the same HCSM who were left with thousands of dollars in medical bills after their HCSM failed to pay for services.[67] A Connecticut consumer had $280,000 in unpaid bills that the HCSM claimed were associated with a pre-existing condition.[68] Consumers have even reported difficulties with getting small bills for flu shots and lab tests paid, generating marks against their credit.[69]

There is nothing in federal law that requires HCSMs be exempt from state insurance law. However, there are a variety of reasons that HCSMs may be treated as "not insurance." First, HCSMs argue that they are truly not insurance: they do not claim to assume risk (and, in fact, insist that they are not responsible for paying medical bills in full); they merely provide a way to share resources among a group of people. In addition, 30 states have passed laws that expressly exempt HCSMs from state

[65] Reed Abelson, "It Looks Like Health Insurance, but It's Not," *The New York Times*, January 2, 2020, https://www.nytimes.com/2020/01/02/health/christian-health-care-insurance.html.
[66] Todd Bookman, "Regulators Allege Christian-Based Health Care Provider Broke State, Federal Rules," *NPR*, November 25, 2019, https://www.npr.org/2019/11/25/780612410/regulators-allege-christian-based-health-care-provider-broke-state-federal-rules.
[67] JoNel Aleccia, "'Sham' Sharing Ministries Test Faith Of Patients And Insurance Regulators," *Kaiser Health News*, May 17, 2019, https://khn.org/news/sham-sharing-ministries-test-faith-of-patients-and-insurance-regulators/.
[68] State of Connecticut Insurance Department, "Commissioner Mais Takes Action to Protect Consumers Against Unauthorized Insurance Company," December 3, 2019, https://portal.ct.gov/CID/News-Releases/Press-Releases/Press-Releases-20191203.
[69] Reed Abelson, "It Looks Like Health Insurance, but It's Not," *The New York Times*, January 2, 2020, https://www.nytimes.com/2020/01/02/health/christian-health-care-insurance.html.

insurance regulation.[70] States vary widely in how they define HCSMs, and it is not at all clear that all modern HCSMs necessarily satisfy the definition that some states use, but the entities seem to treat themselves as exempt regardless of the particularities of state law. Next, the individual mandate of the ACA exempted consumers from paying mandate penalties if they were enrolled in an HCSM that met a federal definition: the entity must be a non-profit that has been in continuous existence since 1999, and members must "share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs." While the individual mandate is no longer in effect, several of the 30 states noted above use the federal individual mandate language to define the exemption from state insurance law. And even in states that do not expressly exempt HCSMs or that use a different state law definition, the entities tend to argue that the federal individual mandate language indicates a federal intent to exempt HCSMs that satisfy the federal definition from state insurance regulation. HCSMs may also argue that as religious entities, the federal Religious Freedom Restoration Act exempts them from compliance with the federal Public Health Service Act insurance reforms that states enforce.

Student health plans and similar "self-funded" benefits

Student health insurance plans are another place where we can find health care coverage that is "not insurance" under state law. Colleges and universities typically offer a health care benefit for their students, and many require students to enroll or document that they have another source of coverage. Even though a group of students are enrolled in the coverage, this is not a group health plan under federal law because it is not offered by an employer to its employees. Therefore, a student health plan is considered individual coverage.

One model is for a college or university to arrange with an insurance company that the insurer will provide coverage to the students under specified terms. This is health insurance in the individual market; formally, the insurance contract is between the student and the insurance company. Because it is health insurance in the individual market, it will generally be subject to all of the standards that otherwise apply to individual market coverage, like the requirement to cover EHB and the prohibition on annual limits.

Federal law specifies that nothing in the ACA "shall be construed to prohibit an institution of higher education… from offering a student health insurance plan."[71] Since 2011, the federal government has interpreted that language to authorize the waiver of ACA individual market provisions as applied to insured student health plans if applying the provision would make it effectively impossible for the coverage to be offered. The federal government has used this authority sparingly. They have waived only requirements that would otherwise compel the plan to be available to non-students and the requirement to pool risk with other individual market plans.[72] Therefore, insured student health plans must, for example, cover EHB, refrain from discrimination based on pre-existing conditions, and comply with all financial protections (though they are not subject to individual market risk pooling).[73] They will generally comply with our definition of good health coverage.

However, colleges and universities have another option that does not result in such comprehensive application of protections. If, instead of arranging for an insurance company to offer coverage, the

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[70] JoAnn Volk, Emily Curran, and Justin Giovannelli, "Health Care Sharing Ministries: What Are the Risks to Consumers and Insurance Markets?," *The Commonwealth Fund*, August 8, 2018, https://www.commonwealthfund.org/publications/fund-reports/2018/aug/health-care-sharing-ministries.

[71] ACA § 1560(c) (42 U.S.C. § 18118).

[72] Subsequent rules allowed plans to vary their actuarial value as long as they maintained an AV of at least 60%. "Student Health Insurance Coverage," 77 Fed. Reg. 16453, (March 21, 2012), https://www.federalregister.gov/documents/2012/03/21/2012-6359/student-health-insurance-coverage.

[73] Students are generally healthier than the average member of the population, so the exclusion from the risk pool will have some adverse impact on other segments of the market. However, because coverage *within* the student health plan is high quality and because the plan is not individually cherry-picking healthy students, nor may it charge sicker students higher prices, the negative impact is limited.

university finances the coverage itself, state law will generally not consider that insurance. That is, unlike the payday lender in our example above, state law will not take the view that the benefit the university is providing to its students is a "health insurance" product that can only be offered by a "health insurance issuer" – because the university is self-funding and bearing the risk itself. And as above, if it is exempt from state law, it will also be exempt from federal law, and thus free to exclude or limit benefits.

On the one hand, available evidence suggests that this affects only a limited number of institutions; the federal government in 2011 estimated that only 200,000 students were enrolled in self-funded student plans.[74] On the other hand, there is reason to be concerned about the quality of benefits provided in these plans. A currently available self-insured student health plan has a $400,000 annual limit (and found itself the subject of public outcry after it attempted to require students to enroll even if they also had Medicaid coverage).[75] Similarly, prior to implementation of the ACA's prohibition of lifetime limits in insured student health plans, a major flagship public university offered an insured benefit with a $300,000 lifetime limit (and this plan also found itself facing public scrutiny after a student with cancer exceeded this cap), suggesting lifetime and annual limits in unregulated student health plans could be widespread.[76] These plans are also free to exclude benefits or impose pre-existing condition limitations, though there is less evidence that they have done so.

This same model can arise in other situations where an entity other than an employer is "self-funding" benefits. For example, participants in AmeriCorps (in both the VISTA and NCCC programs) are offered health benefits that do not cover pre-existing conditions.[77] AmeriCorps participants are not technically employees of the program, so the coverage is not an employer group health plan. And because no issuer is involved, it also not health insurance coverage; therefore, it is not regulated and is free to impose these exclusions. The program fully discloses these exclusions, and therefore most participants with any significant health needs likely obtain coverage through the regulated segments of the market. This avoids blindsiding consumers with unexpected bills, but shifts costs onto the regulated risk pool.

Future potential

Farm Bureau plans, HCSMs, and self-insured student health plans are the most prominent existing examples of "not insurance" forms of individual coverage. But there is significant future opportunity for other forms of abuse, particularly given the status of the ACA's individual mandate.

While the ACA's individual mandate penalty was in effect, it deterred a robust market for "not insurance" forms of coverage. To comply with the mandate, an individual was required to obtain specific qualifying forms of coverage, which included regulated employer and individual market coverage, coverage through specified public programs, and HCSMs meeting the federal definition. Other forms of coverage that existed outside the regulated environment, like self-insured student health plans or other HCSMs, could apply to the federal government to be deemed a qualifying form of coverage. To grant these applications, the government required coverage to comply with key ACA standards, like the prohibitions on annual and lifetime limits and pre-existing condition exclusions,

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[74] "Student Health Insurance Coverage," 77 Fed. Reg. 16453, (March 21, 2012), https://www.federalregister.gov/documents/2012/03/21/2012-6359/student-health-insurance-coverage.
[75] Brigham Young University-Idaho Student Health Plan 2019-2020, "Student Health Plan 2019-2020," https://www.dmba.com/nsc/handbooks/student/hbbyuid2019.pdf (last visited June 22, 2020); Courtney Tanner, "BYU-Idaho No Longer Accepts Medicaid, and Some Students Are Dropping out of School," *The Salt Lake Tribune*, November 22, 2019, https://www.sltrib.com/news/education/2019/11/22/byu-idaho-no-longer/.
[76] Sarah Kliff, "Arijit Guha, Student Who Battled Aetna Over Cancer Coverage, Dies," *The Washington Post*, March 25, 2013, https://www.washingtonpost.com/news/wonk/wp/2013/03/25/arijit-guha-student-who-battled-aetna-over-cancer-coverage-dies/.
[77] VISTA Campus 2020, "Health Care Benefits," https://www.vistacampus.gov/members/benefits-of-service/healthcare-benefit (last visited June 22, 2020); AmeriCorps, "AmeriCorps Healthcare Benefits Plan and the Affordable Care Act," https://www.nationalservice.gov/sites/default/files/documents/NCCC%20Healthcare%20Election%20Info_0.pdf (last visited June 22, 2020).

and substantial coverage of EHB; if coverage could not meet those standards, it would not satisfy the individual mandate.[78] Therefore, while non-compliant forms of "not insurance" were not illegal under federal law, enrollees would have to pay mandate penalties, making them somewhat less attractive alternatives to regulated coverage. Now that the penalty has been reduced to $0, it will no longer deter these coverage forms, which could lead to further proliferation.

This creates significant opportunities for states seeking to undermine the ACA's protections. Additional states could authorize Farm Bureau plans. States could adopt the Farm Bureau model to authorize other kinds of membership entities to offer plans, like the Chamber of Commerce or the Junior League. Indeed, states *themselves* could begin selling coverage to individuals without pre-existing conditions, and the product would be entirely unregulated under federal law.

Additionally, these variants do not necessarily require state law authorization. Any membership entity could begin offering benefits to its members that include payment for medical services and try to claim it was not an issuer under state law but was instead "self-insuring" a benefit. For example, a ski resort could sell a season pass that included lift tickets as well as reimbursement for up to $300,000 in medical expenses (whether or not connecting to skiing) for those without pre-existing conditions. A health system could offer a subscription service that covered all hospital services – essentially a scaled-up version of concierge primary care services that exist today. A church could offer medically underwritten reimbursement for the health care claims of members who have paid a membership fee, foregoing even the pretense of a HCSM. State law will have widely varying tolerance for these arrangements; an aggressive state insurance regulator relying on clear state law could likely defeat all of them, but in other states, they may simply fall through gaps in the text of state statute or the attention of state regulators.

What can be done?

The discussion above reveals that while federal law provides a foundation for the regulation of health coverage, major gaps persist. We turn now to the options available to policymakers who wish to plug these holes. We first consider what a comprehensive federal legislative fix would entail, and then turn to options available to states and to federal regulators in the absence of new federal legislation.

The discussion that follows assumes an intent to ensure that all benefits that "look like" health coverage are in fact subject to the protections of federal law that establish comprehensive coverage, with meaningful financial protection, offered in a stable way with appropriate pooling of risk. On its own, while these policies will benefit many, they would also be expected to have negative impacts on some stakeholders, such as increasing costs for some employers, inducing other employers to drop health coverage, and increasing premiums for some people who currently buy non-compliant insurance. Other policy tools are available to mitigate those consequences – including changes to the structure of the employer mandate and more generous subsidies for those purchasing individual market coverage – but they are not discussed here.

Federal legislation

Comprehensive federal legislation to close the gaps in our existing regulation of health insurance would require 6 steps:

1. Require all employer health plans to cover essential health benefits at a minimum actuarial value.
2. Redefine excepted benefits (in both the employer and individual markets) to more narrowly reflect benefits that truly deserve exemption from federal law.

[78] 26 U.S.C. § 5000A(f)(1)(E).

3. End the exclusion of short-term limited-duration insurance from the definition of health insurance coverage.
4. Simplify and strengthen federal definitions of health insurance coverage and health insurance issuer.
5. Establish that an arrangement will not be considered "self-insurance" unless the employer bears a significant share of risk.
6. Codify federal regulations and guidance that prevent additional gaps.

Each of these strategies is described below.

Require all employers to cover EHB at a minimum AV

Modifying federal law such that all group health plans (other than excepted benefits) are required to cover EHB and comply with an AV limit would be a significant policy change, but it would be technically straightforward. Section 2707 of the Public Health Service Act requires all individual and small group market plans to cover EHB; this language could be modified to apply to group health plans and the large group market, and incorporated into ERISA in the same way as all other substantive group health plan standards. Similarly, Section 2707 could be modified to impose an actuarial value floor of 60%.[79] (There is no policy justification for requiring all group health plans to be at a specific "metal level.") Conforming changes to the employer mandate should be made to reflect the fact that plans with an AV below 60% will no longer be available.

Under current regulations, the exact set of benefits that constitute essential health benefits vary by state, which can theoretically pose a problem for employer group health plans that self-insure and are not linked to any state's insurance market. However, federal regulations already specify that, for a variety of other purposes, a self-insuring employer can elect to have its compliance with federal requirements judged against the EHB package of any state, and the same standard could easily be applied here. The one area where it may be prudent to provide additional flexibility to group health plans in complying with EHB is in design of their prescription drug benefit. Formulary limitations that are not otherwise permitted in EHB plans may be appropriate if the requirement to cover EHB were scaled to a much larger group of beneficiaries, to avoid giving pharmaceutical manufacturers additional leverage in price negotiations.

Policymakers should also consider the appropriate access standards. While employers need not be subject to network adequacy standards, it may be prudent to incorporate some minimum concept of benefit access into a requirement to cover EHB. This would establish a relatively low bar that the plan needs to provide access to some relevant providers but would not establish numeric standards or other specific tests. The federal government has done this in other contexts where it is enforcing a requirement against all employer plans, including in defining what it means to "cover" preventive services, and in explaining the interaction between reference pricing benefits designs and the out-of-pocket limit requirement.[80]

In general, the most significant impact of this policy would be on the very limited plans described above that fall far short of comprehensively covering EHB. However, many employers that otherwise offer reasonably generous coverage would have to make modest changes in their benefits to comply with this standard by, for example, more completely covering habilitative and rehabilitative services.

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[79] As noted above, a 60% AV floor is not necessary if a plan is also required to cover EHB and comply with the existing out-of-pocket limit requirement; it would largely be a matter of symmetry and of simplifying employer mandate enforcement.
[80] Department of Labor, "FAQs About Affordable Care Act Implementation (Part XII)," February 20, 2013, https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-xii.pdf; Department of Labor, "FAQs About Affordable Care Act Implementation (Part XIX)," May 2, https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-xiX.pdf.

Redefine excepted benefits

Closing the gaps associated with excepted benefits can be best accomplished by largely rewriting the applicable statutory language defining excepted benefits in both the employer and individual markets, with a number of specific objectives. A proposed rewrite that accomplishes these objectives appears in the Appendix.

First, fixed indemnity, critical illness, and accident policies should be defined narrowly to give more meaning to the ways in which they must be distinct from regulated coverage and to prevent payment schedules that are linked to the medical care received. (See specific language in the Appendix and in the discussion of regulatory options, *infra*.) Equally important, these plans should be limited to those who have already have another form of coverage that includes the complete EHB package. This prevents individual market issuers from marketing fixed indemnity, accident, or critical illness policies as a substitute for traditional insurance, and it keeps employers from offering an excepted benefit policy that imposes limits not otherwise allowed in lieu of traditional coverage.[81]

Second, with respect to all excepted benefits, the statutory language should only offer an exception to the extent the excepted benefit does not duplicate, supplant, or mimic the benefits of a traditional health plan. That is, the statutory language should provide an opportunity for federal (or state) regulators to enforce against benefits that claim to be exempt from the statute but are in fact trying to avoid substantive regulation. For example, if an auto-insurance policy were to develop an extensive "add on" to their traditional coverage that looked like a health plan or a policy attempted to classify itself as long-term care despite covering an array of acute care services, this sort of language would render it no longer an excepted benefit.

Third, a redrafted statute should remove language that provides federal regulators expansive authority to define new excepted benefits. This will require codifying the exception for the types of excepted benefits that are enumerated in regulations but not currently referenced in the statute (like employee assistance programs and flexible spending arrangements). The primary use of this authority in recent years has been to create new tax expenditures through various account-based benefits, and it also continues to create opportunities to inappropriately expand excepted benefits to evade substantive regulation. Codifying the existing excepted benefits while closing off the opportunity to create new variants should strike an appropriate balance.[82]

Fourth, policymakers should strike the excepted benefit for group supplemental coverage. There is limited policy justification for offering supplemental coverage outside of a regulated employer plan; employers can offer multiple plan options and allow enrollees to select the appropriate package while retaining full protections across their entire set of benefits. (In the alternative, if this exception were retained, then the limits in existing regulations should be codified, as described below, and the requirement to have other EHB coverage should be applied here as well.)

In addition, policymakers may wish to consider prohibiting the use of fixed indemnity and other forms of supplemental coverage for employers in the small group market in order to avoid employers shifting costs of induced utilization. Finally, while not directly related to the closing gaps in regulation, the

[81] Note that if employer plans are generally required to cover EHB in their non-excepted benefit group health plans, then it may become more attractive for employers to offer fixed indemnity plans as an alternative to a traditional benefit – making the requirement to have other coverage important. On the other hand, if federal law is not changed to require EHB in employer plans, then it remains attractive to segment certain benefits into a fixed indemnity, critical illness, or accident policy, making it particularly important to enforce the standard that the other coverage specifically must cover EHB.

[82] The text that appears in the appendix does not codify the existing excepted benefit for certain Health Reimbursement Arrangements (HRAs). The author has previously argued that this is an inappropriate use of existing statutory authority and, in any case, the purpose of these arrangements is to promote the purchase of sub-standard short-term plans. Christen Linke Young, Matthew Fiedler, and Jason Levitis, "The Trump Administration's Final HRA Rule: Similar to the Proposed but Some Notable Choices," *Brookings Institution*, June 14, 2019, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/06/14/the-trump-administrations-final-hra-rule-similar-to-the-proposed-but-some-notable-choices/.

statute's existing reliance on exempting benefits only when offered in specific policy forms (like a separate contract of insurance) could be streamlined by a general requirement that all excepted benefits be offered "separate from" traditional benefits.

End the short-term plan exclusion

In addition to closing the regulatory loopholes associated with excepted benefits in both the group and individual markets, policymakers should end the exclusion from regulation for short-term limited-duration benefits. The language in Section 2791(b)(5) that defines short-term plans as not included in the definition of individual market coverage should simply be struck from the statute.

An alternative approach would retain the existing exemption but define short-term plans as coverage not exceeding 3 months in duration (including any renewals), though there is little policy justification for subjecting even very limited short-term plans to a different set of regulatory standards than other coverage.

Define health insurance and health insurance issuer

It is also important to close down the potential for unregulated forms of "not insurance" to proliferate. While one could imagine legislation that tried to close loopholes associated with specific forms of coverage that have entered the market today, a stronger approach would foreclose the possibility of offering any kind of unregulated product. There are two general paths that could accomplish this objective: modifying federal definitions to bring all coverage into the existing regulatory framework or adopting a stand-alone requirement that all coverage comply with key protections.

The first option would modify federal definitions of "health insurance issuer" and "health insurance coverage" under the PHSA, effectively requiring that only those authorized to operate as an issuer under state law could offer a benefit that looked like health insurance. Under current law, "health insurance coverage" is "benefits consisting of medical care" that are offered by a "health insurance issuer." A "health insurance issuer" is defined as an entity "licensed to engage in the business of insurance in a State."

A modified definition must do three things. First, it should establish that "health insurance coverage" is *any* benefits or payments for medical care that are not otherwise regulated (regardless of who offers the benefit or how the risk is transferred). Second, it should exempt from this definition specific forms of otherwise regulated coverage, including group health plans, Medicare and Medicaid, and military and veterans' coverage – to avoid applying the Public Health Service Act protections to these other forms of regulated coverage. Finally, it should establish that a health insurance issuer is any entity that offers health insurance coverage. Illustrative text appears in the appendix.

These three steps would make illegal all forms of health care risk-bearing or reimbursement by third parties that fall outside a group health plan or a regulated market. This would include all Farm Bureau plans, self-funded student health plans (or other self-funded benefits like AmeriCorps plans), and most self-insured multiple-employer welfare arrangements (MEWAs) and association health plans (AHPs). It would also include Health Care Sharing Ministries regardless of the nature of their benefits. Recall that because HCSMs disclaim any responsibility for paying claims in full – and instead reimburse only to the extent of the resources available – they insist that they are not insuring any risks. But a modified definition as described above would make that type arrangement illegal by saying that if an entity wants to reimburse for health care services by pooling resources across many people, it *must* do so as an insurance contract that is obliged to play claims. All of these entities would only be permitted to exist to the extent that state law allows them to operate as issuers, in which case they would be required to offer fully compliant benefits.

If policymakers wished to allow relatively compliant forms of these coverage to exist outside the insurance market, they could add additional, very tightly constrained exemptions from the definition of health insurance coverage. For example, the definition could exempt self-insured student health plans only so long as the coverage complies with protections related to EHB, pre-existing condition discrimination, annual and lifetime limits, an out-of-pocket maximum, and AV. An exemption for narrowly defined MEWAs may also be desired.[83] HCSMs and Farm Bureau-type plans should generally not be permitted to continue to exist outside the insurance market; these entities could certainly qualify as issuers under state law and participate in the individual market, but there is no reason they should be allowed to continue to offer discriminatory and otherwise non-compliant coverage. As such, the language in federal law defining HCSMs should be struck.[84]

Modifying the definitions of "health insurance coverage" and "health insurance issuer" will require significant conforming amendments in the insurance laws of nearly all states – but would leave states fully in control of licensing entities to bear risk and regulating issuers (as more broadly defined). That is, despite the short-term disruption for states, this is arguably the approach for regulating forms of "not insurance" that is most consistent with the spirit of the PHSA's approach to federalism. However, a less disruptive alternative is available.

Specifically, a second option would leave the existing structure of the PHSA unchanged but adopt a freestanding requirement that any "benefits or payments for medical care" that are not otherwise regulated still must comply with substantive protections of the PHSA. The federal government should be provided authority to enforce these standards, just as they enforce standards in the four states that do not enforce PHSA protections today, and language should clarify that states remain free to bring these types of benefits under their own definitions of insurance and issuer. Illustrative language appears in the appendix. Under this language MEWAs could operate largely as they do today, and self-insured student health plans could operate provided they offered a compliant benefit design free of annual limits and other limitations. Farm Bureau plans and HCSMs would be allowed to operate, but they would be required to offer compliant benefits and stop discriminating based on pre-existing conditions. Federal law should also address whether these entities must assume responsibility for paying claims in full, or if they would be permitted to operate as HCSMs do today and pay benefits only up to the amount of voluntary contributions.

This second approach still leaves some gaps in the regulation of these entities. Federal regulators would not oversee the solvency of these entities, and they would remain outside the "single risk pool" for purposes of risk-sharing – meaning these unregulated market segments would still pose risks of insolvency for enrolled consumers and could cause adverse selection against the regulated risk pool. But once compliance with substantive protections (including a prohibition on pre-existing condition discrimination) is required, these alternative forms of coverage would compete on something more closely resembling a level playing field. This should make them less attractive as tools to evade regulation and generally limit the impact of these coverage forms.

Require self-funding arrangements to involve true risk bearing

To protect small group market risk-pooling, federal law should also restrict "level-funding" arrangements (or other problematic self-insurance arrangements) by limiting stop-loss coverage, such that the self-insuring employer is required to bear a meaningful amount of risk. Since the 1990s, the National Association of Insurance Commissioners (NAIC) has endorsed model state legislation that prohibits entities from offering stop-loss coverage with very low attachment points.[85] (The dollar

[83] If all group health plans are required to offer EHB, then MEWAs become a less attractive tool to undermine protections. Solvency concerns would still exist.
[84] Language directly applying these standards to HCSMs may also be appropriate, to avoid any claims that federal law does not apply under the Religious Freedom Restoration Act.
[85] National Association of Insurance Commissioners, "NAIC Model Laws, Regulations, Guidelines and Other Resources," July 2002, https://www.naic.org/store/free/MDL-092.pdf?64.

figures used in this model legislation are likely far too low, but the structure applies at any dollar amount.) Because the federal government does not directly regulate insurance, it cannot precisely replicate this approach; however, the federal government can define stop-loss coverage with attachment points below a specific threshold as coverage in the group market, which would achieve the same objective.

Specifically, if the federal government pursues either approach described in the preceding section to limit "not insurance" forms of coverage, it can simply add an exemption for stop-loss coverage, only to the extent that the policy has attachment points that exceed thresholds established by the federal government in regulation, as illustrated in the appendix. This establishes that other forms of stop-loss coverage should be treated as regulated coverage. Alternatively, or additionally, the federal definitions related to employer coverage that appear in PHSA 2791(e) (and parallel statutes) could include a new paragraph noting that stop-loss coverage with attachment points below thresholds established by the federal government should be considered coverage in the group market.[86]

Codify important components of regulations and guidance

Finally, the discussion in this paper illustrates three places where existing regulations prevent gaps, but the federal statute is perhaps less clear. A comprehensive legislative effort to close gaps should codify those protections.

First, policymakers should codify the "look through" guidance that was in force prior to 2018, which provides that members of an association generally continue to be treated as individuals, small groups, or large groups depending on their own status, despite purchasing coverage through an association.[87] This will make unregulated association or MEWA coverage less attractive as a tool for evading regulation.

Second, recall that federal agencies have narrowly interpreted an ACA provision that provides authority to waive the application of insurance market standards to insured student health plans. That narrow view should be codified. Specifically, ACA 1560(c) should be modified to exempt student health plans only from the requirement to cover non-students and the requirement to pool risk with other individual market plans, rather than a blanket rule of construction that could be subject to a more expansive interpretation.[88]

Finally, we saw that current regulations define group supplemental coverage as an excepted benefit only to the extent that it covers non-EHB or fills in cost-sharing for otherwise-covered EHB. This standard has likely prevented group supplemental coverage from mutating in a way similar to the fixed indemnity plans that are being offered as the employer's main source of health benefits. The simplest

[86] This type of regulation would not foreclose one option for small business that wish to leave the small group health insurance market: transferring their workforce to a Professional Employer Organization (PEO). In this arrangement, a large third-party staffing firm, the PEO, becomes the official employer of the small business's staff, for all formal purposes, like taxes and workers compensation, not just health insurance.

[87] Gary Cohen, "Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations," *Department of Health & Human Services*, September 1, 2011, https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf.

[88] Federal law also contains a confusing provision related to self-funded non-federal governmental plans (i.e. self-funded benefits offered by state and local governments). Longstanding law allowed these plans to opt-out of certain federal insurance standards that predate the ACA, like the requirement to cover two nights in the hospital after a baby is born. The ACA modified the language of the opt-out provision, and it also modified the numbering of the various subparts of the PHSA – but made typographical errors in each that render it impossible to say which provisions are eligible for opt-out. Federal agencies have interpreted the language to allow opt-out of only pre-ACA provisions. Future federal regulators might try to argue that these plans could in fact opt-out of other provisions as well, though that would not be well supported by the statute. Nonetheless, there is an ambiguity here that should be corrected, more to correct an error than prevent future abuse. "Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond," 79 Fed. Reg. 30239, (May 27, 2014), https://www.federalregister.gov/documents/2014/05/27/2014-11657/patient-protection-and-affordable-care-act-exchange-and-insurance-market-standards-for-2015-and#p-210.

approach, as described above, would be to simply eliminate group supplemental coverage as a category of excepted benefits, but if it is retained, the limits of existing regulation should be codified in PHSA § 2791(c).

Options for states under current law

In the absence of new federal legislation, states governments can act to protect their consumers and their insurance markets, and many have done so. While states cannot comprehensively address all forms of problematic coverage, a menu of targeted tools is available. States can:

1. Restrict short-term plans.
2. Restrict indemnity and other problematic and excepted benefit plans and enforce existing limits.
3. Refrain from adopting legislation authorizing Farm Bureau plans.
4. Modify or restrict state law definitions of HCSMs, and/or enforce against HCSMs under existing state law.
5. Regulate self-funded student health plans and stop-loss coverage.
6. Regulate MEWAs.
7. Monitor and regulate agent and broker conduct with respect to non-compliant coverage forms.

Additional detail on each of these policies follows.

Restrict short term plans

Federal law allows short-term plans with an initial term of less than 12 months, plus two renewals, but states need not tolerate this definition. In fact, 25 states already restrict short-term plans further.[89] Some states entirely prohibit the sale of short-term plans. Others allow short-term plans to be sold but prohibit pre-existing condition discrimination and apply other consumer protections, which has essentially the same effect. Additional states use the pre-2018 federal rule and limit short-term plans to less than 3 months (including renewals). Still others restrict short-term plans to a contract period somewhat shorter than federal law allows, such as 6 or 12 months inclusive of renewals, and others limit "stacking" – a practice in which a broker sells multiple consecutive short-term plans at the same time.

States that have not adopted restrictions on short-term plans can do so, and states that have put in place limits of 12, 6, or even 3 months can consider tightening their policies.

Restrict excepted benefits, including fixed indemnity

The abusive forms of excepted benefits policies described above are regulated in the insurance market of a state (even though they are not required to comply with health insurance consumer protections). Because they are a form of insurance, policy forms must be approved by the state; therefore, states have tools to disallow the sale of problematic plans.

Some of the most problematic and newer fixed indemnity policies, with thousands of different payments for specific services, can be – and have been – rejected by motivated state regulators, because they stray so far from any understanding of what distinguishes indemnity coverage from a traditional plan. Many states also have existing authority to reject indemnity policies that have a somewhat less radical design but still vary payment substantially based on health care services

[89] Justin Giovannelli, Kevin Lucia, and JoAnn Volk, "States Work to Make Individual Market Health Coverage More Affordable, But Long-Term Solutions Call for Federal Leadership," *The Commonwealth Fund*, January 2020, https://www.commonwealthfund.org/sites/default/files/2020-01/Giovannelli_states_indiv_market_coverage_affordable_ib.pdf.

received, and some states do reject policies with certain characteristics. Should more problematic behavior attempt to shift into accident and critical illness policy forms (as may be likely if other routes to offer non-compliant coverage were foreclosed) states could also use existing authority to disapprove abusive policy forms.

And of course, state legislators can also adopt new legislation that directly limits the form that these types of policies could take. States could adopt state law requirements like the proposed federal legislation described above, allowing carriers to sell fixed indemnity and other products only when payment does not vary with the type of health care services received and only to consumers who otherwise have comprehensive coverage. These requirements could apply to indemnity products sold to individuals and to employers; states cannot regulate the employer directly, but they can regulate the insurance product sold by a fixed indemnity carrier in the employer market.

States may also have a tool to attempt enforcement against employers' combination of a very skimpy traditional plan with a fixed indemnity plan that serves as the primary source of coverage for employees. Recall that fixed indemnity plans are only excepted benefits to the extent they are "not coordinated" with an "exclusion" in another plan. There is little evidence that this has been an effective tool for deterring problematic employer offerings. However, state regulators could certainly make a case that the ways in which some employers combine benefits today violates this standard. The argument would be buttressed by the way in which benefits are presented – with the fixed indemnity product clearly being marketed as a complement to the exclusions in the skinny plan. (See *supra* Figure 4.) As above, states can enforce against the fixed indemnity carrier, not the employer, but that would still prevent this type of coverage from being offered.

Avoid Farm Bureau plans

States that wish to limit non-compliant coverage in their market should not adopt state legislation authorizing "not insurance" forms of coverage, like Farm Bureau plans, and existing law should be repealed.

Restrict Health Care Sharing Ministries

States also have tools to regulate Health Care Sharing Ministries. Recall that 30 states have state law that exempts certain HCSMs from being treated as insurance, but entities offering HCSMs often sell plans in all states without regard to the specifics of state law definitions. Therefore, at a minimum, states can take enforcement action against HCSMs that offer benefits that do not comply with the terms for state law exemption. For example, four states that exempt HCSMs have nonetheless taken enforcement action against the same entity for offering a benefit that operates outside the terms of the state law exemption.[90] Texas state law exempts from the definition of insurance "faith-based non-profit organizations that operate only to facilitate the sharing of medical expenses among participants,"[91] but the state has successfully blocked operation of a HCSM that is effectively operated by a for-profit company that uses up to 70% of its revenue for profit and administrative costs.[92] This same entity is embroiled in a legal dispute with the state of Washington; the exemption from Washington state law is contingent on a HCSM having been in continuous existence since 1999, a condition that the state claims this entity cannot satisfy. States can maintain familiarity with the

[90] Maryland, New Hampshire, Texas, and Washington state have argued that this HCSM does not qualify for state law exemption; Colorado and Connecticut have also enforced against this same company. See JoAnn Volk, Justin Giovannelli, and Christina L. Goe, "States Take Action on Health Care Sharing Ministries, But More Could Be Done to Protect Consumers," *The Commonwealth Fund*, February 19, 2020, https://www.commonwealthfund.org/blog/2020/states-take-action-health-care-sharing-ministries-more-could-be-done-protect-consumers.
[91] See First Amended Petition Seeking Injunctive Relief, Civil Penalties, Temporary Restraining Order and Temporary Injunction, Texas v. Aliera Healthcare, Inc., No. D-1-GN-19-003388 (July 11, 2019) (available at https://www.tdi.texas.gov/news/2019/documents/Aliera-First-Amd-Petition-July-2019.pdf).
[92] Texas Department of Insurance, "State Files Lawsuit Against Aliera Healthcare," July 19, 2019, https://www.tdi.texas.gov/news/2019/tdi05172019-faq.html.

HCSMs that are offering benefits to their residents and take swift enforcement action to obtain information needed to verify compliance with state law and block sales from entities that don't meet state definitions.

States can also modify their state law exemptions to require registration with state regulators, disclosure of financial statements, and particular marketing practices and disclosures.[93] These sorts of transparency tools would make it easier to identify entities that were out-of-compliance with the substantive standards of state law. And state law substantive standards could also be modified to ensure that entities that receive exemption as HCSMs have true "sharing" features in their benefit design and that members are meaningfully connected by religious beliefs.

More aggressive tools are also available if states wish to foreclose most or all HCSM activity in their state. Twenty-one states do not expressly exempt HCSMs under the state law definition of insurance; those states could bring an enforcement action against any HCSM claiming that the entity was selling a product that must be treated as insurance under state law. Recent enforcement activity has largely been focused on entities with marketing practices so aggressive as to support claims of fraud, but states could certainly broaden their scope. States could also write state law to expressly treat HCSMs as insurance, disallowing the dodge by which HCSMs disclaim responsibility for paying bills and therefore say they have not taken any insurance risk because they are merely pooling resources. Alternatively, state law could simply prohibit HCSMs from discriminating based on pre-existing conditions, as proposed legislation in Connecticut would do, which would likely shut down the market in the state while not technically prohibiting these entities.[94]

As noted above, in response to this sort of aggressive action, HCSMs may claim, variously, that state law is preempted by the federal individual mandate language or that they are not insurance because they do not take risk. States would have their own defenses, including that some states courts have treated "normal" HCSMs as insurance since at least the mid-2000s, and that the claim for preemption based on the individual mandate language requires unsupported interpretative leaps.[95]

Regulate student health plans and stop-loss coverage

States can restrict potentially problematic forms of self-insurance. Self-insured student health plans are not regulated as insurance, but colleges and universities are themselves regulated by state government. Therefore, a state can directly regulating the benefits made available to students. For example, Massachusetts requires all colleges and universities to make available a student health plan that, among other things, does not discriminate based on pre-existing conditions and does not impose annual or lifetime limits.[96] Consumer representatives to the NAIC have recommended that states take this or a similar approach.[97]

The NAIC has also offered model legislation for state regulation of stop-loss coverage to protect the small group market. (Stop-loss coverage is not regulated as health insurance, but it is usually subject

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[93] JoAnn Volk, Justin Giovannelli, and Christina L. Goe, "States Take Action on Health Care Sharing Ministries, But More Could Be Done to Protect Consumers," *The Commonwealth Fund*, February 19, 2020, https://www.commonwealthfund.org/blog/2020/states-take-action-health-care-sharing-ministries-more-could-be-done-protect-consumers.

[94] Connecticut General Assembly, "An Act Requiring Health Care Sharing Ministries To Comply With The Patient Protection And Affordable Care Act," https://cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&bill_num=SB-209 (June 23, 2020).

[95] Michael Rowden v. American Evangelical Association, No. BDV-2006-109 (January 2, 2001) (available at https://csimt.gov/wp-content/uploads/INS-2006-109-OVM.pdf)

[96] Commonwealth Health Insurance Connector Authority, "Student Health Insurance Program," June 28, 2019, https://www.mass.gov/doc/956-cmr-8-student-health-insurance-program/download.

[97] National Association of Insurance Commissioners, "Implementing the Affordable Care Act's Insurance Reforms: Consumer Recommendations for Regulators and Lawmakers," August 2012, https://www.naic.org/documents/committees_conliaison_1208_consumer_recs_aca.pdf.

to state regulation as property insurance.) The NAIC recommends that states simply prohibit the sale of stop-loss coverage with attachment points below certain threshold, though, as noted above, the thresholds used in existing model legislation may be too low. Some states also prohibit the sale of stop-loss coverage entirely to certain small employer groups or require it be rated in a manner similar to health insurance in the small group market.[98] These policies sharply limit "level-funding" or other small employer self-funding arrangements in those states.

Regulate MEWAs

As noted above, MEWAs and AHPs are problematic because they allow small employers to exit the small group market, and because they involve unregulated entities bearing health care costs – exposing enrollees to risks of fraud and insolvency. Since 1983, federal statute has granted states the authority to regulate self-insured MEWAs as risk-bearing entities (and the state can regulate the insurer offering insured MEWAs). Following significant fraud and insolvency in these markets throughout the 1990s, state regulators developed tools to oversee these forms of coverage, though not all states have adopted them.[99] As interest in opportunities to avoid small group market regulation and risk pooling increases, states can ensure they have full authority to regulate the solvency of MEWAs.

Recall, also, that recent federal rules have attempted to expand the circumstances under which small employers (and individuals) could purchase coverage as if they were part of the large group market – but those rules have been enjoined by a federal court. If that rule were to be reinstated, then states could attempt to use their authority over MEWAs to prevent entities in their state from making available offerings that undermine risk pooling.

Regulate agents and brokers

Finally, states have a powerful opportunity to protect consumers through regulation of agent and broker conduct. We saw above that many forms of non-compliant coverage offered to individuals – short-term, fixed indemnity, and HCSM plans – are aggressively marketed by agents and brokers who may not disclose the coverage limitations. This includes individual agents and brokers, who work one-on-one with a consumer, as well as online web-brokers that operate technology platforms for the sale of insurance.

Non-compliant products tend to pay much higher commissions to agents and brokers than regulated plans, at least in part because they are medically underwritten and spend a much higher percentage of premium revenue on administrative costs (like broker commissions) and offeror profits as opposed to medical costs.[100] This can create powerful incentives to steer all healthy consumers towards non-compliant coverage forms, even if the individual could pay comparable or lower premiums for comprehensive coverage using subsidies under the ACA. Indeed, one small scale secret-shopper

[98] National Association of Insurance Commissioners, "Stop Loss Insurance, Self-Funding and the ACA," 2015, https://www.naic.org/documents/SLI_SF.pdf.

[99] Mila Kofman, Eliza Bangit, and Kevin Lucia, "MEWAs: The Threat of Plan Insolvency and Other Challenges," *The Commonwealth Fund*, March 2004, https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2004_mar_mewas__the_threat_of_plan_insolvency_and_other_challenges_kofman_mewas_pdf.pdf.

[100] See, e.g., Kevin Lucia, Sabrina Corlette, Dania Palanker, Olivia Hoppe, "Views From the Market: Insurance Brokers' Perspectives on Changes to Individual Health Insurance," *Urban Institute*, August 15, 2018, https://www.urban.org/research/publication/views-market-insurance-brokers-perspectives-changes-individual-health-insurance; https://www.commonwealthfund.org/blog/2020/states-take-action-health-care-sharing-ministries-more-could-be-done-protect-consumers; Julie Appleby, "Short-Term Health Plans Boost Profits For Brokers And Insurers," *NPR*, December 21, 2018, https://www.npr.org/sections/health-shots/2018/12/21/678605152/short-term-health-plans-boost-profits-for-brokers-and-insurers.

analysis found that half of brokers steered subsidy-eligible but healthy consumers away from comprehensive coverage; one noted "Obamacare is only for sick people."[101]

Agents and brokers are directly licensed and regulated by state insurance regulators. Therefore, states can put in place – and enforce – a variety of requirements for those that sell non-compliant coverage forms. Illinois has required brokers to read specific disclosures about pre-existing conditions and other limitations to consumers;[102] California has required certain brokers to screen for ACA subsidy eligibility and make eligible consumers aware of the benefits of subsidized options.[103] Alaska and Texas are enforcing a requirement that brokers selling HCSMs are *themselves* liable for certain unpaid claims because HCSMs are not insurance.[104]

Aggressive state regulators could combine all of these features. They could require that all brokers screen for subsidy eligibility and inform consumers of the results, and require specific verbal disclosure of the limits of non-compliant coverage forms (perhaps including illustrative examples to better help consumers process information about risk). Brokers could be required to contact existing consumers in non-compliant coverage forms during the annual open enrollment period to make them aware of the opportunity to switch to comprehensive coverage. They could establish annual reporting on sales of compliant and non-compliant coverage forms to monitor statewide trends and potentially as a tool to direct enforcement activity. Web-brokers could be subject to additional oversight of the way materials are presented to consumers.

Options for the federal government under current law

Current law also provides several options for enhanced federal regulation:

1. Restrict short-term plans to less than 3 months.
2. Narrow the reach of fixed indemnity, critical illness, and accident excepted benefit policies by adopting a more detailed regulatory definition.
3. Define "licensed under state law" broadly in determining who is an issuer.
4. Regulate the conduct of brokers subject to federal standards.

Restrict short-term plans

The federal government can dramatically restrict the market for short-term plans by for modifying the regulatory definition, returning to a definition that limits these plans to three months.[105] Some consumers may still elect these unregulated plans during short coverage gaps, but short-term plans would no longer compete with regulated benefits for most health plan consumers.

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[101] Sabrina Corlette, Kevin Lucia, Dania Palanker, and Olivia Hoppe, "The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses," *Urban Institute*, January 31, 2019, https://www.rwjf.org/en/library/research/2019/01/the-marketing-of-short-term-health-plans.html.

[102] Id.

[103] Covered California, "Covered California Policy And Action Items," November 21, 2019, https://board.coveredca.com/meetings/2019/11-21%20Meeting/PPT.Policy%20and%20Action.Nov%202019.FINAL.1025.pdf.

[104] Justin Giovannelli, Kevin Lucia, and JoAnn Volk, "States Work to Make Individual Market Health Coverage More Affordable, But Long-Term Solutions Call for Federal Leadership," *The Commonwealth Fund*, January 2020, https://www.commonwealthfund.org/sites/default/files/2020-01/Giovannelli_states_indiv_market_coverage_affordable_ib.pdf.

[105] In litigation that is currently before the D.C. Circuit, a group of health plans argues that limiting short-term plans to three months in duration is the only permissible interpretation in light of other provisions in the ACA. See *Association for Community Affiliated Plans v. Department of Treasury* 392 F. Supp. 3d 22 (D.D.C. 2019), available at https://scholar.google.com/scholar_case?case=15889321369186939868&q=Association+for+Community+Affiliated+Plans+&hl=en&as_sdt=20006&as_vis=1.

Narrow certain excepted benefits

As discussed above, fixed indemnity, accident, and potentially critical illness policies have increasingly come to resemble "typical" health insurance, despite the fact that they are classified as excepted benefits.

The federal government has previously tried – and failed – to more stringently regulate fixed indemnity coverage in the individual market. In 2014, the government adopted a regulation that required fixed indemnity coverage in the individual market to be limited to individuals who had purchased another form of comprehensive coverage.[106] Fixed indemnity carriers sued, arguing that the statute did not permit HHS to limit who could enroll in fixed indemnity coverage, and a federal appeals court agreed.[107] This, therefore, forecloses the simplest pathway to limit the scope of these policy forms.

However, other options remain available to the federal government. In striking down the 2014 rule, the courts held that the government could not create "additional criteria" for fixed indemnity coverage. But the agencies still have the authority to define the features that distinguish fixed indemnity coverage from non-excepted traditional coverage. Indeed, problems arise precisely because fixed indemnity plans in today's market are *not* easily distinguished from regulated forms of coverage. Therefore, the federal government can pursue regulations that more carefully explain the characteristics that make a policy a fixed indemnity (or accident or critical illness) policy rather a traditional form of health insurance.

Current group market regulations explain that fixed indemnity coverage "must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred."[108] Today's fixed indemnity carriers interpret this language to allow them to vary payment based on any medical care received, as long as they don't vary based on the specific costs the enrollee is billed for the service. That is, they say a "day" where you visit the emergency room and receive an X-ray is a different kind of illness than a "day" where you visit the emergency room and don't get an X-ray and therefore it merits a different payment amount. Fixed indemnity carriers have simply appended the phrase "per day" to an otherwise traditional health coverage benefit design. There is no reason to believe the statute compels such an expansive reading of what it means to be fixed indemnity coverage.

A more precise regulatory definition could foreclose this sort of benefit design. For example, the regulations could specify that fixed indemnity coverage "must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred, the services received, the severity of the illness, injury, or diagnosis, or other characteristics particular to a course of treatment." This would shift fixed indemnity coverage back towards a form that more closely aligns with the common law understanding of indemnification.

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[106] "Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond," 79 Fed. Reg. 30239 (May 27, 2014), https://www.federalregister.gov/documents/2014/05/27/2014-11657/patient-protection-and-affordable-care-act-exchange-and-insurance-market-standards-for-2015-and.

[107] Central United Life v. Burwell, 827 F.3d 70 (D.C. Cir. 2016), https://www.cadc.uscourts.gov/internet/opinions.nsf/3766CC3E5DD5914085257FE30050BBA1/$file/15-5310-1622677.pdf.

[108] 45 C.F.R. § 146.145 The individual market definition adopted in conjunction with the 2014 regulatory changes is phrased slightly differently, referring to "a fixed dollar amount per period of hospitalization or illness and/or per service (for example, $100/day or $50/visit) regardless of the amount of expenses incurred." 45 C.F.R. § 148.220 (emphasis added). Prior to 2014, the group and individual definitions were the same. The addition of the "per service" language was premised on the expectation that coverage would not be available to those that did not have traditional coverage, and therefore there was little need to guard against fixed indemnity coverage that mirrored traditional benefits. This change should also be reversed.

The same language could be incorporated into the regulatory definition of accident and critical illness coverage. A critical illness policy could be defined as "coverage for only a specified disease or illness (for example, cancer-only policies), provided that payment does not vary with the services received, the severity of the illness, injury, or diagnosis, or other characteristics particular to a course of treatment," and accident coverage could be defined as "Coverage only for accident (including accidental death and dismemberment), provided that payment does not vary with the services received, the severity of the illness, injury, or diagnosis, or other characteristics particular to a course of treatment."

As with states, federal regulators could also attempt to better enforce existing regulations that prohibit fixed indemnity (and critical illness) policies from being "coordinated with an exclusion" in the primary plan, which may help deter some behavior where employers pair traditional and fixed indemnity coverage.

These changes would not completely foreclose abuse in the excepted benefits market, but they would reduce direct competition between these policy forms and traditional insurance.

Broadly define the "business of insurance"

The federal government may also have tools to eliminate or restrict the loophole associated with Farm Bureau plans. Recall that these plans are authorized in state legislation and they are loosely supervised by state insurance regulators. For example, in all three states the plans are required to file annual actuarial certifications. Yet state law defines these plans as "not insurance" and not subject to the state insurance code.

However, the federal government has at least a plausible argument that under these facts Farm Bureau plans *are* in fact health insurance coverage offered by a health insurance issuer – and therefore subject to current law protections. Under current law, an issuer is an entity that is "licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance." Farm Bureau plans have been authorized by the state to offer a product that insures families against the risk of catastrophic health care claims, which can arguably be construed as a form of "licens[ure] to engage in the business of insurance." And state law does restrict their behavior in offering the benefit in at least some ways, which can arguably be construed as "state law which regulates insurance." This is admittedly a leap from existing interpretation of the definition of health insurance issuer, but especially if faced with further proliferation of this benefit form, it is a possible federal policy tool.

The federal government may also have a related argument that states that authorize Farm Bureau plans are failing to "substantially enforce" PHSA requirements. Federal law provides that the federal government shall become responsible for enforcement if a state "has failed to substantially enforce a provision (or provisions) [of federal law] with respect to health insurance issuers in the State." By writing state law to deliberate exclude a benefit from regulation, states are arguably running afoul of this standard, which could support additional federal action.

Expand federal broker regulation

As noted above, states are primarily responsible for licensing and regulating insurance agents and brokers. However, the federal government does have some opportunity to supervise the conduct of agents and brokers and web-brokers. In particular, the Federally Facilitated Marketplace (FFM), i.e. HealthCare.gov, sets standards for the agents and brokers that want to sell federal Marketplace coverage to consumers. The federal government certified more than 48,000 agents and brokers in

2019.[109] State-based Marketplaces (SBMs) set their own standards for agents and brokers, but SBMs are themselves regulated by the federal government.

Therefore, the federal government has the opportunity to adopt a broad code of conduct for agents and brokers that want to interact with either the FFM or an SBM. In order to be licensed to sell Marketplace coverage, agents and brokers could be required to adhere to standards that limit the ways they market non-compliant coverage forms to consumers. These restrictions would not reach brokers that elect to forego any formal relationship with the Marketplace, but they would nonetheless shape a significant fraction of the market.

At the extreme, Marketplace-licensed agents and brokers could be prohibited from selling non-compliant coverage forms at all. Such a prohibition may be particularly appropriate for online web-brokers that receive extensive support from the government. More limited policies are also available. Licensed agents and brokers could be required to provide specific disclosures to consumers considering such coverage, make sure all consumers are aware of the differences between compliant and non-compliant coverage, and report to the Marketplace on sales of non-compliant coverage. Indeed, the California SBM requires that certified brokers who also sell certain types of non-compliant policies must assess eligibility for financial assistance and disclose limitations before selling a non-compliant plan; the federal government could also adopt such a rule.[110] Web-brokers could also be subject to more stringent regulation in how non-compliant coverage forms are displayed and marketed.

Certainly, these types of standards for agent and broker conduct would go beyond the federal government's traditional role. However, in today's market, the federal government provides billions of dollars in subsidies linked to the purchase of insurance through Marketplaces, and it surely has an expanded interest in how the entities that market (and profit from their marketing of) such coverage engage in these activities.

Conclusion

Forms of sub-standard or unregulated coverage exist across our markets for health coverage. Benefits offered by employers to their employees can be problematic because they do not cover a robust array of benefits, use regulatory exceptions to avoid complying with financial protections, or undermine policies that are supposed to promote risk-sharing in the small group markets. Benefits sold directly to individuals suffer from gaps, because they are classified as short-term or excepted benefits forms of insurance, or because they are not treated as insurance at all. The federal government has legislative tools to close each of these gaps, and states and federal regulators can take meaningful action even in the absence of new federal legislation.

[109] U.S. Centers for Medicare & Medicaid Services, "Agent and Broker Program Overview," July 2019, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/AB-Summit-Agent-and-Broker-Overview.pdf.
[110] Covered California, "Covered California Policy And Action Items," November 21, 2019, https://board.coveredca.com/meetings/2019/11-21%20Meeting/PPT.Policy%20and%20Action.Nov%202019.FINAL.1025.pdf.

Appendix: Illustrative Statutory Language

Excepted benefits

The text below is an illustrative set of modifications to the definition of excepted benefits in PHSA § 2791(c) that would implement the policy changes suggested above. Parallel modifications would be needed at § 2721(c), other PHSA cross references, and throughout ERISA and the IRC. (Paragraph 14, below, should arguably appear only in ERISA, but is included here for simplicity.) This illustrative language does not mark all deletions or reorganizations of existing text, but significant new statutory text is indicated in underline.

"(c) EXCEPTED BENEFITS.—For purposes of this title, the term "excepted benefits" means benefits under one or more (or any combination thereof) of the following, only to the extent the benefit is offered separate from and does not duplicate, supplant, or mimic the benefits otherwise provided under this title:

(1) Disability income insurance.
(2) Coverage issued as a supplement to liability insurance.
(3) Liability insurance, including general liability insurance and automobile liability insurance.
(4) Workers' compensation or similar insurance.
(5) Automobile medical payment insurance.
(6) Credit-only insurance.
(7) Coverage for on-site medical clinics.
(8) Travel insurance.
(9) Limited scope dental or vision benefits.
(10) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.
(11) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).
(12) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code.
(13) Supplemental coverage described in subparagraph (A) that meets all of the requirements of subparagraph (B).

(A) Coverage described:

(i) Coverage only for accident,
(ii) Coverage only for a specified disease or illness, or
(iii) Hospital indemnity or other fixed indemnity insurance.

(B) Requirements:

(i) The coverage is provided only to individuals enrolled in other coverage that includes the essential health benefit package as defined in section 2707(a) of this title,
(ii) The coverage is not coordinated with an exclusion in any other plan; and
(iii) The coverage does not vary payment with the services received, the severity of the illness, injury, or diagnosis, or other characteristics particular to a course of treatment.

(14) Coverage that meets the requirements of subparagraph (A) or (B) and is provided in addition to coverage not consisting solely of excepted benefits:

(A) Health flexible spending arrangements as defined in section 106(c)(2) of the Internal Revenue Code; or
(B) Benefits provided under employee assistance programs for which no premiums, cost-sharing, or other employee contributions are required and which do not provide significant benefits in the nature of medical care."

Definitions of health insurance coverage and health insurance issuer

The text below modifies federal definitions of "health insurance coverage" and "health insurance issuer" to generally prohibit entities other than licensed issuers from offering coverage, as described above. Parallel modifications would be needed to definitions in ERISA and to ERISA's definition of a multiple employer welfare arrangement. This illustrative language does not mark all deletions or reorganizations of existing text, but significant new statutory text is indicated in underline.

"(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—

(1) HEALTH INSURANCE COVERAGE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term "health insurance coverage" means benefits or payments for medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care).

(B) EXCEPTIONS.—Such term shall not include:

(i) A group health plan,

(ii) Coverage provided under title XVIII, XIX, or XXI of the Social Security Act,

(ii) Coverage provided under chapter 55 of title 10, United States Code,

(iv) Coverage provided under part 2 of title 38, United States Code,

(v) A health plan under section 2504(e) of title 22, United States Code,

(vi) The Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Pub. L. 103-337),

(vii) Coverage offered by an institution of higher education (as such term is defined for purposes of the Higher Education Act of 1965) to its enrollees where the institution bears meaningful financial risk for the costs of coverage, provided that such coverage complies with the requirements of sections 2704, 2705, 2707, and 2711 of this title, or

(viii) Stop-loss coverage, provided that the policy has individual and aggregate attachment points that exceed thresholds established by the Secretary.

(2) HEALTH INSURANCE ISSUER.—The term "health insurance issuer" means an insurance company, insurance service, insurance organization (including a health maintenance organization, as defined in paragraph (3)), or any other entity that makes available health insurance coverage. Such term does not include a group health plan."

Freestanding application of requirements to unregulated coverage

As an alternative to modifying PHSA definitions, the text below adds a new section the PHSA that would broadly establish that otherwise unregulated coverage forms must comply with certain substantive standards, enforced by the federal government. The substantive standards should include at least the minimum set of protections to prevent truly abusive benefit forms, but could also encompass a broader set to create an equal playing field. Conforming edits should be made to PHSA section 2723(b)(2) to reflect federal enforcement authority, and ERISA and the IRC.

"Sec. 2796. APPLICATION OF PROTECTIONS TO BENEFITS OTHER THAN HEALTH INSURNACE COVERAGE

(a) IN GENERAL.—Except as provided in subsection (b), all benefits or payments for medical care that are not health insurance coverage under this title must comply with the standards of sections 2701, 2704, 2705, 2707, [2708, 2709,] 2711, [2712, 2713, 2719A, 2725, 2726, 2727, 2729, and 2751].

(b) EXCEPTIONS.—This section shall not apply to:

(1) A group health plan,

(2) Coverage provided under Title XVIII, XIX, or XXI of the Social Security Act,

(3) Coverage provided under chapter 55 of title 10, United States Code,
(4) Coverage provided under part 2 of title 38, United States Code,
(5) A health plan under section 2504(e) of title 22, United States Code,
(6) The Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Pub. L. 103-337), or
(7) Stop-loss coverage, provided that the policy has individual and aggregate attachment points that exceed thresholds established by the Secretary.

(c) SECRETARIAL ENFORCEMENT.—Pursuant to section 2723 (b), the Secretary shall enforce these requirements insofar as they relate to the issuance, sale, renewal, and offering of such benefits.

(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit the authority of states to define or regulate health insurance coverage, health insurance issuers, or entities offering benefits or payments for medical care."

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

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The Commonwealth Fund

e Affordablen Care Act's ssing Consensus p Mi

July 2, 2020

| Adrianna McIntyre, Robert J. Blendon , John M. Benson and Eric C. Schneider, M.D.

The Issue

Ten years after the Affordable Care Act (ACA) beca s lth reform legislation in decades has yet to garner the support of a s m of A r me ica During this presidential ca mph aig sca ls to ransform U.S. health care, potentially upending the system upon which the ACA was built. Drawing on findings from a national public opinion survey, researchers from Harvard University and the Co onwealth mm Fund exa ed alues, att tudes, and experiences associated with co ng preferences mp eti regarding the direction of health reform in the United States.

Wh at the Study Fd

- One-third of Americans say that keeping and i mp roving the ACA is their direction for health system refor m.
- The remaining two-thirds are equally divided between wanting to replace the ACA with a "Medicare for All" type of reform and giving individual states the authority and funding to chart their own path to reform.
- Those who favor the Medicare for All approach are more likely than those who favor keeping or i mp ving the ACA to rate the health care system as fair or poor (75% vs. 66%, p = .01) and more likely to have an unfavorable opinion of employer-based insurance (41% vs. 27%, p < .001). In both cases, these opinions are informed by personal experience with the health care p system.
- People who favor a state-based option over the ACA are more likely to rate the health care system as good or excellent (48% vs. 33%, p < .001) and less likely to have unfavorable views of employer-based insurance (14% vs. 27%, p < .001).

R sp nd n s wh fav r Medicar f r All shar many c mmon valu s and attitud s with r spond nts who want to build on th ACA . . . but t nd to b more dissatisfied with their own experiences with the current health care system.

Share

The Big Picture

Those who prefer the ACA as a foundation for future health reforms are generally more content with the status quo compared to those who favor Medicare for All. Although a majority of ACA supporters believe it's the government's responsibility to make sure all Americans have health insurance and would be willing to pay more in taxes to ensure everyone has coverage, these beliefs are more pronounced among people who prefer Medicare for All.

Meanwhile, the roughly one-third of Americans who favor leaving health care policy to the states are "much more staunchly opposed to growing governmental power and paying taxes to support universal coverage," the researchers say.

The Bottom Line

Despite their differences over which policy to pursue, people in favor of improving the ACA and people who prefer Medicare for All both agree that the U.S. needs to get to universal coverage.

Publication Details

Publication Date: July 2, 2020

Contact: Bethanne Fox, Vice President, Outreach and Strategy, The Commonwealth Fund

Email: bf@cmwf.org

Summary Writer: Christopher Hollander

Citation:
Adrianna McIntyre et al., "The Affordable Care Act's Missing Consensus: Values, Attitudes, and Experiences Associated with Competing Health Reform Preferences," *Journal of Health Politics, Policy and Law,* published online June 19, 2020. https://doi.org/10.26099/daag-h677

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Universal Coverage

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The Commonwealth Fund

U.S. Health Reform—Monitoring and Impact

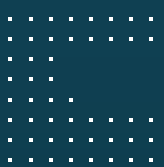
The COVID-19 Pandemic – Insurer Insights Into Challenges, Implications, and Lessons Learned

June 2020

By Kevin Lucia, Linda J. Blumberg, Emily Curran, John Holahan, Erik Wengle, Olivia Hoppe, Sabrina Corlette

Robert Wood Johnson Foundatio

Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.



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 novel coronavirus (COVID-19) pandemic has placed enormous pressure on virtually all facets of U.S. society, including the economy, family livelihoods, the health of millions of people, and the health care system. Much attention has appropriately been placed on the efforts of health care providers to deliver care to those infected with COVID-19. However, less is known about the experiences of the health insurers who reimburse the health care providers for the care they deliver, as well as insurers' insights into what the pandemic might mean for public and private insurance coverage, insurance premiums, and benefits going forward. We discussed issues related to the pandemic with representatives from 25 insurers from April 16 - June 9, 2020. Their impressions of the ongoing ramifications of the pandemic and their response to the crisis are summarized here*:

- Insurers entered the COVID-19 crisis in a strong financial position and, as a result, have been able to assist providers and consumers financially by decreasing paperwork barriers and making it easier to access care faster.
- While the majority of insurers expect the economic downturn and rising unemployment rates to have a significant impact on their employer business, most have not yet seen a significant drop in coverage among employer clients, especially those offering large group coverage. Insurers are most concerned for their small employer clients and expect that many will drop coverage as federal support declines and the crisis persists.
- Insurers anticipate large increases in individual marketplace enrollment in the coming months, though this enrollment has been slow to materialize so far. Insurers are taking steps to prepare for members' coverage transitions and believe their companies are ready to absorb higher enrollment, if and when it comes.
- Insurers' Medicaid enrollment is increasing at a faster pace than their marketplace enrollment, though still at a slower-than-expected rate. Insurers are split on whether their states' Medicaid programs are prepared to process and serve a potential influx of enrollees.
- Insurers have taken a number of steps to assist providers who are struggling financially, including accelerating payments, offering loan assistance support, and making payments on value-based contracts, regardless of initial targets. Insurers have concerns about how the crisis might affect their longer-term relationships with providers, including whether it will trigger increased consolidation, cost shifting, and demands for higher reimbursement.
- Insurers' experience with COVID-19-related costs thus far leads them to believe that the financial impact on 2021 costs (and thus premiums) is likely to be minimal. However, insurers face a significant degree of uncertainty that could impact premiums in the long run, including whether they will be required to cover multiple COVID-19 diagnostic tests, as well as antibody tests, and how much elective and deferred care will return.

*This report reflects federal and state policies and interview findings as of June 9, 2020. Policies and industry trends may have evolved since this date.

- Most insurers feel that the COVID-19 crisis has not prompted a need to change benefit designs to any great degree, though they believe that telehealth benefits are here to stay and the use of alternative care settings will likely expand.
- Insurers acknowledge that changes to the health care system are needed to address health disparities, especially racial and ethnic disparities, but they are unsure of where to begin, how to finance these efforts, and how to spark meaningful change.
- Though insurers have only begun to identify "lessons learned" from the early phases of the pandemic, this experience has better prepared them to some extent for what is to come.

BACKGROUND AND APPROACH

In January 2020, the first confirmed case of coronavirus was reported in the U.S. and the World Health Organization declared the coronavirus spread to be a public health emergency of international concern.[1] By March, the U.S. led the world in coronavirus infections[2] and, as of June 2020, the disease has infected over two million individuals in the U.S. and over 115,000 have died as a result.[3] As the virus spread, Americans' day-to-day lives changed dramatically. Individuals in most states were placed under stay-at-home orders, schools transitioned to online environments, and consumers' engagements with the health care system were significantly restricted as hospitals and providers prepared to triage a surge in individuals with COVID-19 infections. As the crisis continues, it has forced the health care system to confront critical issues in operations, including a shortage of personal protective equipment (PPE) and the availability and affordability of testing for COVID-19 detection and treatment for those with and without health coverage. It has also spurred difficult economic realities, leading to historic job losses and the potential for loss of health insurance coverage.

Many experts predicted early on that large numbers of workers and their family members would lose or be required to change their health insurance coverage as they experienced job and income losses due to the pandemic.[4] But, a change in coverage might not mean a drop in coverage. Unlike earlier economic crises, the existence of the Affordable Care Act (ACA) could help to blunt some of the coverage losses due to COVID-19, thanks to the availability of subsidized marketplace plans and expanded Medicaid programs (in most states). As one analysis shows, the share of the unemployed who are uninsured fell dramatically (about 20 percentage points) after the ACA's coverage reforms were implemented, predominantly through higher levels of Medicaid and nongroup insurance coverage.[5] As a result, it is safe to anticipate that pandemic-related decreases in employer-based insurance could lead to higher levels of Medicaid and marketplace subsidy eligibility and enrollment.[6]

As consumers transition between job-based and other coverage options, it is important to understand the role that the insurance industry has played in responding to the COVID-19 crisis and its experience to date. Almost immediately, many insurers took steps to ease consumers' issues with access to care by covering and waiving cost sharing for COVID-19 testing; some did the same for the services needed to treat COVID-19.[7] Many also tried to make it easier for providers to focus on patient care by reducing administrative burdens.[8] Although many insurers took these steps voluntarily, federal and state regulators also issued benefit and coverage mandates to ensure that consumers were obtaining COVID-19 care without financial barriers.[9] In just a few months, the insurance industry has witnessed the profound impact of COVID-19 on the health care system, as utilization of non-COVID-19 related medical care has dropped precipitously, some providers have struggled to remain financially viable, and employers have struggled to keep their employees' health plans intact. During this time, insurers have adjusted benefits to permit broader use of telemedicine, offered flexible financial arrangements for those unable to pay their premiums, and invested in community efforts that may help to address some of the root causes of disparate COVID-19 outcomes.

In many ways, health insurers are in a uniquely advantageous position to provide early insights into the implications of the pandemic, as they interact directly with health care providers, employers, government officials, and consumers. While company strategies vary, insurer experiences in employer, nongroup, and Medicaid markets allow them to assess how coverage is shifting across markets, how costs associated with testing and treatment are affecting overall health care spending, the extent to which different types of providers are experiencing financial distress, and how federal and state regulators and program administrators have and have not been prepared to assist. Their experiences to date can help inform policies that could improve our ability to respond to future pandemics, economic downturns, or other disruptions.

To better understand early insights into the implications of the pandemic on the health coverage system from the perspective of insurers, we conducted structured interviews with executives of 25 insurance companies collectively representing private markets of all sizes in all states and the District of Columbia. The companies included for-profit insurers operating nationally or across multiple states; nonprofits operating regionally or locally and at least one local insurer in each of the following states: California, Colorado, Georgia, Illinois, Louisiana, New York, Virginia, and Washington. Interviews were conducted from April 16 through June 9, 2020.

FINDINGS

Insurers Are Well-Positioned Financially to Navigate the Crisis, At Least For Now

While hospital and health systems have struggled financially during the crisis to afford the costs of providing additional care to patients and equipment to providers,[10] health insurers have largely not been financially burdened by COVID-19, to date. As the crisis emerged, insurers reported that they successfully transitioned the majority of their staff to work from home and collaborate through a virtual environment. Insurers explained that there were few hiccups, if any, in continuing their regular operations and sales. To prepare for a potentially high volume of COVID-19-related claims, insurers reported acting quickly to strengthen their financial footing. For example, some reported preparing for the worst by enhancing their liquidity, drawing down additional lines of credit, and taking stock of their reserves. Even before the COVID-19 crisis had fully materialized in the U.S., many for profit insurers had previously publicly reported strong revenue gains at the close of the first quarter of financial earnings for 2020.[11]

Insurers, therefore, went into the crisis on solid financial ground and their financial position has continued to strengthen as the crisis has continued. Most insurers we interviewed reported that as much as 30 to 40 percent of elective care has been deferred, resulting in substantially less overall spending than in a typical year. In addition to spending less overall, insurers' COVID-19-related claims have been lower than anticipated and, to date, they have not had to dip into the financial resources that they secured in March. While this trend in claims could change at any moment, no insurer we interviewed expressed concern with their current financial standing. Because of this strong positioning, insurers were able to assist providers and consumers financially by decreasing paperwork barriers, such as prior authorization requirements, and making it easier to access care faster. Some insurers used their excess cash to support their primary care providers and hospitals with advances or other support, while others redistributed their higher-than-expected revenues in the form of premium rebates to consumers. As one insurer put it: "Without being in good financial shape, we couldn't have done that."

Employer Business Remains Surprisingly Stable, but Concerns that Small Employer Clients will Drop Coverage Persist

Employer Business Remains Stable

As the COVID-19 crisis evolved, the majority of insurers expected that the economic downturn and rising unemployment rates would have a significant impact on their employer business. However, despite unemployment rates reaching the highest levels since the Great Depression,[12] most insurers interviewed were surprised to report that they have not yet seen a significant drop in coverage among their employer clients. One insurer who expected to see "material membership reductions" instead stated being simply "shocked and not sure what to make" of their employer business remaining so stable. Another insurer described that the number of employers dropping coverage is no higher than what they would expect to see in a regular quarter. A third insurer claimed that its steady employer-based enrollment simply does not "correlate" with the rising unemployment rate.

Although insurers did not yet have data to fully understand why the employer block of business has remained largely unchanged during the crisis, many offered explanations as to why this trend might be occurring. For one, insurers were quick to point out that many of the sectors hit hardest by the crisis, including the entertainment, retail, and restaurant industries, tend not to offer health insurance benefits in the first place. Next, despite the challenging economic circumstances, insurers described a "hold-on mentality," with some of their employer clients having a "degree of optimism that the lock down will lift and there will be a return toward normalcy." Early in the crisis, some employers believed that the economic rebound would be faster than that experienced during the 2008 financial crisis. Therefore, instead of letting employees go, many employers have embraced the concept of "furloughing" staff, meaning they are no longer on payroll but are allowed to maintain benefits, including eligibility for the group health plan. As one insurer described: "There's at least an interest with some of these groups to – even if they've reduced hours – continue making premium payments for employees' health care coverage." Several insurers conveyed that many employers are "just trying to support employees as

best they can." Further, many insurers were confident that at least some of these impacts have been stalled by a significant number of their at-risk employer clients taking advantage of the Payment Protection Program (PPP), established by the CARES Act.[13] One insurer stated that the PPP was "working, that the money made available to small employers has been helping, and gives them extra cash to continue paying for insurance." Still, some interviewees cautioned that furloughs could turn into permanent layoffs and cause a meaningful change in their employer business in the coming months.

For most insurers, if a significant number of employer clients drop coverage, the loss of revenue would have a greater impact than other crisis-related factors. Insurers, anticipating "dire losses" in their employer business at the start of the crisis, have offered employers mid-year open enrollment periods, more flexible payment arrangements, and longer premium "grace periods" than those required under state law. Among the insurers that have extended their grace periods, most report that an increasing number of employers are taking advantage of the flexibility. Some insurers have quietly implemented a company policy to not terminate employer clients for lack of payments during the first few months of the crisis. As one insurer put it: "We've been clear that our top goal is to keep [] employees in the group sector . . . because we would prefer they stay in the group market than chance them going to the individual market and never coming back." However, insurers expressed concern that as federal PPP funding dries up, "customers' ability to pay premium[s] might get harder." For example, one insurer worried whether "companies will be able to sustain [their plans through] June and July."

Small Employer versus Large Employer Book of Business

Overall, insurers expressed far more concerns about the future of their small employer clients – defined, in most states, as those with 50 or fewer employees – than their large employer clients. For the most part, the insurers reported that their large employer clients have maintained their plans and interviewees expressed little concern about upcoming coverage losses. Still, some characterized large employers' experience thus far as a bit of a mixed bag, with one insurer depicting a "tale of two cities." This insurer noted that some sectors, such as technology firms, have actually been "growing by tens of thousands" during the crisis, while other large employer clients, like school districts, were "shrinking slightly." A number of insurers explained that if their large employer clients were experiencing financial difficulties, they were more likely to seek modifications to their policies (e.g., reducing benefits, increasing cost-sharing) than to drop coverage altogether. As noted above, many insurers indicated that it was in their best interest to accommodate these modification requests, when possible.

Insurers also raised few solvency concerns about their self-funded clients. One insurer noted that while self-funded plans are "not completely immune to economic stresses," it has seen some actually expand coverage of services, like telehealth, during the outbreak. Another insurer posited that self-funded employers might stand to gain during the crisis "to the extent that their claims savings are bigger than any of the direct COVID[-19] costs."

On the other hand, insurers expressed numerous concerns with their small employer clients. As one insurer described: "Small businesses are cash business[es], they're month to month, and, even in a good economy, they go bankrupt." While most insurers did not have a confident estimate of the number of small employers that are likely to drop coverage, early indications suggest that a wave of disruption is on the way. First, many insurers reported that a higher number of small employer clients than usual are already in payment delinquency, in one case, double the number than in a typical year. Second, a few insurers reported an abnormal increase in calls from their small employer clients. For example, one insurer that predominantly sells to small businesses said: "We didn't have a huge disruption initially but we are [now] having a lot of [small] employer groups calling and saying, 'What kind of payment plan can I do?'" Some insurers have already started to see their small employer numbers decline. Most insurers expect these declines to continue as clients exhaust their PPP benefits and reach the end of their grace periods.

Increased Enrollment in the Individual Market is Expected, But Large Increases Have Not Yet Materialized

While many insurers we spoke with anticipate large increases in individual marketplace enrollment in the coming months, this additional enrollment has been slow to materialize. Voicing a common observation, one insurer explained that despite offering a special enrollment period for individual market coverage: "We haven't seen many [new enrollees]. The unemployment rate went up significantly, but we haven't seen people yet migrating . . . we expect that to change over the next few months." Insurers expressed similar sentiments about the individual market as they did with the employer market, noting that the use of PPP funds and furloughing has likely created a lag in coverage transitions.

For those insurers who *are* beginning to see coverage changes, some are taking steps to ensure a smooth transition. For example, they have deployed agents or brokers to give departing employees information on marketplace policies as they disenroll from employer plans. Others are offering

websites that allow people to directly enroll in marketplace coverage. As one insurer explained, "We built a cross-channel opportunity and website communication tools to help group customers and people being laid off, furloughed, or let go from group insurance understand what's available in the individual market, commercial market, and Medicaid." This insurer felt that it is "a big part" of their role to help customers understand what their options are (and presumably to encourage them to remain with the insurer through its marketplace offerings). Another insurer described working with the business community to make sure they are aware that the marketplace remains an option for employees losing employer-based coverage. Many insurers also applauded the outreach efforts made by state-based marketplaces that have been promoting special enrollment period opportunities for uninsured individuals and lamented the absence of such efforts on the part of the federally facilitated marketplace (FFM). Interviewees were concerned that the FFM had not led an outreach campaign during the crisis to inform individuals who have lost jobs that they are likely to be eligible for financial help, have access to numerous coverage options, and need to act within a 60-day special enrollment window to obtain marketplace coverage.

At least two insurers with whom we spoke sell short-term plans as well as marketplace coverage, and were directing employees to both types of plans. Short-term plans are not guaranteed issue and set premiums based on an applicant's health status. They may appear low cost for the young and healthy compared to more comprehensive coverage, but they do not cover the ACA's essential health benefit requirements and often come with substantial limits and exclusions on benefits. Enrollees in these plans are also not eligible for the premium tax credits that are offered for marketplace plans.

Most insurers felt that the state-based marketplaces and their own companies are prepared to handle a large influx of individual market applicants, if and when demand materializes. Some pointed to the IT preparedness and regular testing conducted by their state-based marketplaces, while others praised the executive staff at these marketplaces, saying they are easy to communicate with and anxious to address any technical problems that arise. Many likened the potential influx of applicants to the heavier enrollment they experience towards the end of the annual open enrollment period. Multiple insurers raised concerns for their members living in FFM states. As one explained, "The FFM, of course, has downgraded its call center and its system is on life support. And so I think that, if they had a big surge, it might be a little more difficult." Another commented that the Centers for Medicare and Medicaid Services (CMS) had asked them to keep volume *off* the FFM, explaining, "They're not ramped up."

Overall, insurers were confident about the ability of their plans to absorb higher enrollment. In fact, some national insurers had already been planning to expand their footprint in the marketplaces, and the pandemic has not altered those plans. A few insurers noted that the summer months are also the time in which they typically begin to hire seasonal staff to prepare for the fall open enrollment period. One explained that they "ramp up starting in August for open enrollment . . . [and] bring in hundreds of temporary staff" to assist with the process. This year, these "ramp ups" will coincide with potentially new COVID-19-related applicants; staff will likely need to manage this volume in a work-from-home environment.

Medicaid Enrollment Is On The Rise, But Even Larger Increases Are Expected

In some states, insurers reported that Medicaid enrollment is increasing at a faster pace than marketplace enrollment, though still at a slower-than-expected rate. Insurers universally felt that Medicaid enrollment increases will ultimately far outpace marketplace increases in the states that have expanded Medicaid, given the reduced incomes resulting from widespread job losses, Medicaid's greater affordability and comprehensiveness, and the fact that the program does not have a limited enrollment period. However, insurers reported that enrolling in Medicaid may be taking a back seat to consumers' other needs, such as unemployment compensation and food stamps. Another suggested that, given shelter in place orders, people were not enrolling in Medicaid unless and until they were sick. Some insurers also indicated that there is still confusion among employees as to whether they and their family members are even eligible for Medicaid, especially since some unemployment checks provide higher payments than some employees' typical salaries. They suggested that more education was needed to explain what income did and did not count for purposes of determining program eligibility.

When asked whether states' Medicaid programs were prepared to process and serve a potential influx of enrollees, insurers had mixed reactions. Insurers in states that had expanded Medicaid after the start of the 2014 reforms felt that the systems and marketplaces were particularly well prepared for a large influx of applicants. One insurer stated that all the Medicaid plans in their state would eagerly take on additional enrollment. There was also little concern about insurers' networks being able to manage large numbers of new Medicaid enrollees. However, some acknowledged that providers would likely not be happy about so many individuals shifting from private coverage to Medicaid, due to the latter's lower reimbursement rates. A small number of insurers expressed some apprehension about whether their

states' old Medicaid IT platforms and enrollment systems would be able to efficiently handle high demand. And many insurers acknowledged the financial toll that COVID-19 is likely to have on state budgets, including the impact an explosion of new Medicaid enrollees could have on already-strained finances.

Some Providers Are In Financial Trouble And There Are Concerns about Further Consolidation

The COVID-19 crisis has had a significant negative financial impact on physicians and hospitals. As office visits and elective procedures were halted during the stay-at-home orders, many providers saw their revenue fall dramatically. This has affected both hospitals and physicians, though the impacts have not been felt equally. Physician practices who are not providing direct COVID-19 treatment or testing and who have been largely restricted by law from providing non-essential care have seen significant reductions in revenue. This has been particularly true of primary care physicians and obstetrician-gynecologists. Smaller independent physician practices of all specialties have also been hard-hit as the CARES Act's Provider Relief Fund dollars were mostly targeted at supporting major hospital systems. One insurer noted, "When the CARES Act got put together, the medical societies . . . got shut out behind the hospitals." Federal lawmakers have reported that some providers treating vulnerable populations, such as federally qualified health centers (FQHCs), and other safety net providers have not yet received money from the CARES Act, though the Department of Health and Human Services recently announced plans to allocate additional funds to these providers in future rounds of federal relief.[14]

Beyond the lack of stimulus funding, physician practices have also had to grapple with other operational issues. For instance, many providers quickly switched to providing telehealth services for patients in part because it allowed them to maintain some source of income. However, some providers were reluctant or unable to make the full transition to telemedicine. Insurers mentioned several reasons why some providers did not take up telehealth, including that some did not have the technology and systems in place to make this transition swiftly or easily. Others providers feel that in-person visits are crucial to achieving a positive outcome.

In order to aid providers, many insurers have taken or are considering taking a number of actions. In addition to providing advanced payments and reducing administrative burdens, as mentioned earlier, insurers have worked to process claims faster to ensure that reimbursements flow to providers as quickly as possible. Some insurers mentioned that they were making payments on value-based contracts, regardless of whether the quality or cost-savings targets had been met. For instance, one insurer described paying up-front the rate consistent with practices' previous year's metrics, instead of setting payments to be made in 2021 based on 2020 performance, as originally planned. If a provider ends up exceeding its prior year's targets it will receive additional payments, and if they end up not performing as well, they still get to keep the initial payment. The same insurer noted that their providers using capitated payments were faring substantially better since the capitated payments were being made on schedule and were not dependent on the utilization of services. As a result of the crisis, several insurers said that in future negotiations they would encourage more of their network providers to move to capitated rates because it would both help to contain costs in typical years and provide support in the event of future crises or a second wave of COVID-19. Some insurers reported that providers themselves have expressed growing interest during the pandemic in moving to capitated payments.

Though insurers are making these funding sources and loan assistance support available to independent practices in their networks, many interviewees were surprised that provider take-up of such support has not been higher. Only a few insurers we spoke with indicated that the demand from their providers for these resources was high, while the majority of insurers said that it was not. While our respondents could not identify the reasons for varied demand, many suspected that providers were taking advantage of either the PPP or the Provider Relief Fund, preferring to take federal bailout dollars over money from insurance companies.

Many of the insurers we spoke with expressed concerns about how the crisis could affect their longer-term relationships with providers. There was widespread worry that this pandemic would exacerbate existing problems, in particular that it would lead to more consolidation among providers. With large numbers of independent practices currently under financial strain, more could be open to offers to merge with large hospital systems. Virtually all insurers indicated that, based on experience, this consolidation would translate into demands for higher reimbursement rates as larger practices and health systems gain greater negotiating leverage. However, at least one factor has the potential to mitigate such an outcome. One insurer reported that private equity groups – who, in recent years, have been buying up physician practices and emergency department services – have also been struggling with the economic fallout of COVID-19. Large hospital systems that might want to acquire more physician practices have also been affected. This means there are fewer entities with the financial capital to buy smaller independent practices. Still, the financial incentives are strong

for independent practices to band together or to join larger health systems in order to weather this and future crises.

A number of insurers also said they were worried about cost shifting, even though some studies have shown that payment rate reductions in public programs do not lead to higher prices in private insurance.[15] However, assuming large job losses lead to a substantial shift from enrollment in employer-based plans to Medicaid and marketplace coverage (both of which tend to pay providers at lower rates than commercial insurers in the employer market), insurers worry that hospitals and providers may make up lost revenue by increasing the prices charged to commercial insurers. One large national insurer reported that they have already been asked by providers to renegotiate rates mid-contract to increase payment rates. Providers may feel that they have increased leverage right now to negotiate, since insurers are largely unable to terminate a relationship with a hospital in the middle of the pandemic. Indeed, some insurers and hospitals that have been publicly engaged in contract disputes since before the outbreak have put these disputes on hold so that consumers can continue to receive in-network care during the emergency.[16]

A handful of insurers we spoke with stated that labs have started to increase their billing rates for COVID-19 testing, another way they have been able to make money since federal law requires insurers cover and waive cost-sharing for COVID-19 testing and related services.[17] Finally, one insurer predicted that if provider practices fail, there could be provider supply shortages among at least some specialties and primary care. Although this viewpoint was not widespread, it is important to consider the potential effects this could have on access to care during the pandemic as well as in the future.

Cost of COVID-19-Related Care Thus Far Has Been Lower Than Initially Feared, Implying Low Premium Increases For 2021

In The Short Term, The Financial Impact of COVID-19 on Insurers is Likely to Be Minimal

The general consensus from insurers is that overall claims are currently down substantially as non-urgent medical care and COVID-19-related costs are less than expected. First, care utilization dropped dramatically in the early phase of the crisis. While some insurers anticipate that claims for elective procedures will rise by the end of 2020, they still expect claims for elective care to be down 20-30 percent for the year. Most agreed that deferred and elective care will not come back "one-for-one" in 2020, and that services like dental cleanings and rehabilitation appointments might be skipped altogether. In some cases, treatment may no longer be needed, such as for a minor back injury that has since healed. Second, while the treatment of COVID-19 cases has led to some new costs for insurers, most indicated that these costs have not been as high as originally expected. There is considerable geographic variation in COVID-19-related costs, with testing and treatment costs in New York, for example, being much greater than in other states. Even in New York, costs upstate have been low compared to the costs highly concentrated in New York City. However, since many people diagnosed with COVID-19 have been instructed to stay at home and quarantine, most patients have imposed very little costs on insurers. For those that are hospitalized, insurers report that treatment costs tend to range from $50,000 to $100,000 per episode. For example, one insurer described having a high volume of members being hospitalized and requiring ventilators early on in the crisis and said that those costs were much greater than for an average case of pneumonia. But the insurer noted that over time, the treatments for COVID-19 have become more standardized and care more efficient, leading to a reduced need for ventilators and more predictable costs. Overall, respondents generally indicated that the costs of hospitalizations have been manageable and that the financial impact in 2020 has been "minimal" to date.

Factors That Might Influence Premiums in the Long Run

Still, insurers emphasized that they continue to face a significant degree of uncertainty, such as: When, and how severe, will a second wave of COVID-19 be? When will consumers feel safe seeking non-COVID-19 related care again? How many employers will drop coverage? Will they be required to cover testing costs for millions of asymptomatic people?

Coverage of Testing

Insurers consistently voiced concerns that as COVID-19 testing ramps up and if individuals begin receiving multiple diagnostic tests as well as antibody tests, testing costs could skyrocket, particularly if they must continue to waive cost-sharing. While the cost of each test is relatively low, the potential utilization is enormous. For example, one smaller insurer explained that while it has spent only $5 million on COVID-19-related costs to date, "If every one of [its] members gets tested this year, it's going to be about $140 million. A totally different scale." The cost per test may also increase. CMS is reimbursing approximately $100 per laboratory test administered to Medicare enrollees,[18] and the largest labs are charging cash prices for those receiving tests that range from $50 to $200.[19] As noted above, some providers are charging commercial insurers many times those prices. A number of insurers mentioned that employers could begin testing workers daily as a condition of re-opening, and that demand for antibody tests could soar as well. One insurer explained:

"A big unknown for us and all blocks of business is how much utilization there is going to be on antibody tests. That could be a significant cost that nobody planned for." While the majority of insurers support "paying for testing in clinical situations when it's needed and ordered by the practitioner to diagnose and treat individuals," they argued that regular and widespread testing for surveillance purposes should be considered a public health expenditure.

Elective and Deferred Care

While many elective procedures postponed during the crisis are generally expected to be provided in the future, the timing is unclear. Some providers are informing insurers they will perform elective surgeries on weekends to "catch up" once the demand returns. In some geographic areas, that has already happened. One insurer reported, "We are seeing a rapid return of non-COVID-19 services, so I don't know where we will land. We doubt that the amount of care will come back to 100 percent, but we do see it coming back rapidly." There is also some concern that individuals who delayed care for chronic conditions during the pandemic could end up being sicker, adding to aggregate costs.

Actuarial Uncertainties

Insurers broadly expect 2021 premium increases to be modest or even zero, although many reported that their actuaries are modeling a wide range of possibilities. Insurers' general consensus is that COVID-19 infections could decrease in the latter half of the year, but then re-surge in 2021. But, if this is the case, insurers expect that social distancing measures would be implemented much more widely and quickly than in 2020. To the extent that COVID-19 cases increase significantly in 2021, insurers predict that non-COVID-19 care would fall off again as it did in 2020. One respondent stated, "In 2020, non-urgent care costs decreased faster than COVID-19 costs were increasing. But we need to set 2021 premiums based on expected 2021 claims. In general, we do not expect a repeat of 2020."

Because of such projections, while 2021 premiums had not yet been set at the time of our discussions, our sources anticipated that any premium increases in 2021 would be small. Some insurers did, however, articulate a worst-case scenario in which the number of COVID-19 cases could be much higher if people became less committed to social distancing, that testing for both infections and antibodies could greatly expand, and that it would not be as feasible to defer as much non-COVID-19 care compared to the experience thus far. If this situation materialized, costs in both late 2020 and 2021 could be much higher than generally expected. When asked what 2021 expenses would look like, one insurer summarized: "We are doing a ton of scenario planning. If anybody's going to be honest, they are going to say, 'I don't know; there are so many variables.'" Due to these uncertainties, some insurers have worked with state regulators to ensure that they are able to revise their 2021 proposed premium rates, if a major resurgence of COVID-19 occurs over the summer or there are policy changes requiring them to expand coverage (e.g., mandates to cover asymptomatic testing).

Telehealth Is Here to Stay And the Use of Alternative Care Settings May Expand

Benefit Designs

Hardly any insurers felt that the COVID-19 crisis has prompted a need to change their benefit designs to any great degree. Beyond waiving cost sharing for COVID-19 testing and treatment and temporarily reducing the use of utilization management tools like prior authorizations, the majority of insurers reported that their benefit designs are comprehensive and have worked well during this period. At the beginning of the crisis, a few insurers expressed a willingness to adapt their designs, if needed, as one insurer described: "We'll see what COVID[-19] demands." But, ultimately, only a few insurers saw the need to make immediate changes, such as more clearly stating when prior authorization applies in consumers' policy documents and allowing early pharmacy refills for policyholders needing to self-quarantine.

At the same time, the pandemic has caused some insurers to question how much of the health care services delivered today are "really needed." For example, one insurer noted: "If we see a 40-50 percent drop in claims costs [for] deferred care, what does that really say about what is core health care?" Another insurer characterized the COVID-19 crisis as "a big experiment in rationing," since most consumers have only been able to access care if it is an emergency or COVID-19-related. While not yet clear whether the deferral of services is leading to worse health outcomes or whether some of this deferred care is needed – just not right now, some insurers suspect that at least some of these services are not truly medically necessary. A few insurers plan to analyze utilization patterns during the pandemic to better understand what services are or are not needed, and hope that this experience will drive a conversation about over-consumption in the health care system today.

Once the COVID-19 crisis lessens and the temporary regulatory changes made to benefit designs are lifted, one insurer also noted that there will be a need to re-educate consumers on their benefits. For example, this insurer worried that there may be "lots of complaints and confusion and appeals" once cost sharing is imposed again, and that

"resetting customer's expectations is going to be really tough." While consumer-friendly tools like flexible spending accounts were adopted for some during the outbreak and economic downturn, many of these policies will not be carried into 2021. The insurer expects that it will be hard to message to consumers why their benefits are reverting to pre-crisis levels.

Telehealth

Though aspects of insurers' emergency response, like cost-sharing waivers, will likely be rolled back as the crisis subsides, insurers were united in stating that telehealth benefits are here to stay. For years, telehealth services have been promoted as an avenue to improve access to care, particularly in rural areas where meeting with a health professional in-person can be challenging. However, providers and consumers alike have been slow to adapt to and use these services.[20] Insurers echoed this sentiment, saying that while they have offered generous telehealth policies before, the take up has been minimal and when it came to adoption "providers were not there." Now, telehealth is being used like never before. As the COVID-19 crisis emerged, some health systems reported that their use of telehealth escalated from 700 video visits a month to 70,000 a week and that the number of providers engaged grew from 50 to 7,000.[21] Across the board, insurers explained that most once-reluctant providers quickly moved to telehealth as the virus spread and office visits were restricted. One insurer quantified, "We did more telehealth in April than all of 2019."

In part, this shift was driven by many insurers reimbursing telehealth visits near or on par with office visits, otherwise referred to as "paying at parity." The majority of insurers we interviewed reported that telehealth payment parity was one of the first things providers asked for as the crisis set in. These payments have helped providers who have struggled financially. A number of insurers pointed to the speed at which mental health visits in particular transitioned to telehealth platforms. For instance, while some forms of elective care are down as much as 50 percent, one insurer commented that their mental health claims are down just 10 percent. This insurer described that "mental health providers flipped over to telehealth so quickly that they were able to keep assisting members and keep their doors open." In addition to providing a steady stream of revenue for providers, several insurers commented that their members have largely enjoyed using telehealth. Many insurers pointed to the convenience that telehealth offers and the potential that it can help providers to reach consumers who otherwise might delay or forgo a needed consultation. While insurers acknowledge that telehealth will not completely replace office visits, they agreed that the COVID-19 crisis has moved the platform forward in a significant way. Despite the medical field operating on a "fairly traditional model," one insurer best summarized: "I think this is probably the event that forced a change. I think a lot of people won't go back."

Still, insurers' praises of telehealth were not without reservation. Insurers raised a number of questions and concerns about the expanded use of telehealth, including whether the services will be subject to fraud and abuse, how to promote quality, how to protect patients' privacy, and how telehealth regulations that were relaxed during the emergency will be reinstated after the crisis wanes. Some contemplated the challenges of making telehealth available in areas where consumers do not have access to high speed internet and whether this discrepancy further exacerbates health care inequities in the system. Also chief among these concerns is whether insurers will continue to be required to reimburse telehealth near or at parity. Some insurers argued that a phone call consultation should not be reimbursed at the same rate as an office visit. Several insurers said that while payment parity makes sense during a public health emergency, reimbursements should ultimately reflect services rendered, and services delivered over the phone and computer versus in-person can be significantly different. Finally, many insurers commented that there is a risk that telehealth drives up costs and further contributes to overutilization. For example, one insurer described that telehealth should not be "additive," saying that the company has already seen instances of providers calling consumers to schedule telehealth visits when only laboratory testing was needed. Insurers shared the perspective that telehealth visits should follow medical necessity guidelines.

Alternative Care Settings

The crisis has also highlighted the opportunity to treat patients in alternative care settings that are often less costly and more convenient than receiving care in a hospital. When the crisis began, there were concerns that hospitals might be overrun with patients needing COVID-19 care. To make space and preserve resources, insurers and providers worked together to move patients who were not infectious out of the hospital. For example, one insurer noted easing administrative requirements so that patients could more readily be transferred out of hospital inpatient beds and into post-acute care settings, when appropriate. These efforts helped to keep patients without COVID-19 symptoms safe, while freeing up beds in hospitals for those who needed COVID-19-related care.

Insurers reported that similar efforts have continued in recent months, with much care now being delivered in alternative care settings, including patient's homes, sub-acute facilities like skilled nursing facilities, long-term acute care hospitals, and rehab centers. As one insurer described: "You don't always

have to go into a medical clinic to get your service." This insurer explained that it is now providing more home health services including patient monitoring, so that its members can avoid inpatient care. Another insurer pointed to the availability of "corner stores" that offer diagnostic testing and vaccinations. One insurer even argued that providers' rates for rendering home care "should be increased," saying: "We want to move the needle, keep people in the community, keep people in their home, so we're going to have to pay those providers, those support systems, to do that."

Insurers Acknowledge: Changes to the Health Care System Are Needed to Address Health Disparities, but Unsure Where to Begin

The United States' health care system is plagued with health disparities, in which individuals' health, access to care, and care experiences can differ based on their race/ethnicity, socioeconomic status, gender, sexual orientation, age, and/or disability status.[22] The COVID-19 crisis has, once again, exposed these glaring health disparities, especially racial and ethnic disparities, as Black individuals have suffered a disproportionate share of COVID-19 illnesses and deaths.[23]

The insurers we interviewed reported that they are aware of the racial and ethnic disparities in the health care system, and some are taking steps, albeit limited ones, to address these shortcomings. Some insurers highlighted their efforts to reach out to members facing higher-risk of poor health outcomes and use data to determine where disparities exist to better target their initiatives. For instance, one insurer described using data to drive where it implements its pregnancy and chronic disease management initiatives. Another insurer, reflecting on their Black, Latino, and Pacific Islander populations being hardest hit by COVID-19, said that "a big lesson" learned during this crisis is the need to reach out to consumers in those populations with multiple chronic conditions "a lot sooner" to ensure they have access to needed care. One insurer emphasized the work they have done to form a diverse network of providers so that patients of minority groups feel comfortable seeking care. One insurer felt that they had already made meaningful strides in reducing inequities, saying: "We have multi-lingual and disciplinary staff, we do translation, we welcome people into the system with[out] documentation or insurance already."

Yet insurers acknowledged they need to do more, but few had a clear vision of where to start. Some insurers pointed to their recent investments in social determinants of health (SDOH) – factors like economic stability, education, food, housing, transportation, and health coverage – which contribute to disparities.[24] Still, for commercial insurers these investments are largely done through insurers' philanthropic arms, and not reflected in benefit design or payment policies.[25] For many insurers, the COVID-19 crisis has underlined the need for continued investment in these areas. For example, one insurer lamented: "[T]elling people to shelter at home is great unless you're homeless or unless you live in a congregated living situation." For this insurer, the crisis has "reinforced" the connection between health and socioeconomic status and has made the company question how it can better integrate social factors into its approach, such as through food and housing investments. Another insurer reported that one out of three of its members has pre-diabetes, so nutrition is a "huge aspect" they hope to address.

However, it is not always clear how to finance and ramp up these initiatives. As one insurer put it: "We've been talking about social determinants of health for a long time, but no one has quite figured out how to pay for addressing them." At least one insurer questioned the potential for real change. As a health plan with just four million members, it asked: "Can we pull this off on our own? Can we accomplish this by ourselves?" Candidly, one insurer explained that their company is "still at a definitional phase" of determining what their work to address equality and disparities will look like.

Insurers Are Starting to Consider Early Lessons Learned

Insurers commonly maintain risk management programs, a key component of which is the assessment of their business continuity and financial solvency in the event of a pandemic. However, it is unlikely any such programs could have anticipated the multitude of business and financial decisions that insurers had to make in response to COVID-19. Many insurers voluntarily took action to expand coverage and reduce other barriers to care before being required to by federal or state law. However, the subsequent federal and state legislative and regulatory response to the pandemic has left some insurers concerned.

First, without a coordinated and comprehensive federal response to coverage issues, insurers that operate in multiple states were faced with trying to navigate different state emergency orders and state insurance department requirements. The diverse approaches across states created challenges for some of these multi-state insurers that were trying to quickly develop uniform policies for all of their members. For example, two insurers noted that some states required insurers to file amendments to their policies and provider contracts in order to waive cost-sharing, expand telehealth availability, or pay telehealth at parity. While these insurers respected the need for regulatory oversight of benefits, they commented that the administrative hurdle of re-filing ultimately served to "hamstring" the insurers from acting faster. In an emergency setting, these insurers

questioned how regulators could adapt these processes to more quickly "get the people care they need or providers the payments that they need."

Second, many insurers recognized that in a crisis, regulators and legislators need to make decisions quickly, but one insurer argued that this does not always lead to "good policy." This insurer pointed to state mandates that dropped cost sharing for certain services which "feel good and sound good" in the moment, but are not necessarily helpful in the long-term. They explained that "when [policy makers] say no cost sharing, it doesn't mean that the share goes away, it means the insurer has to pay for it." Ultimately, these costs are passed onto consumers in the form of higher rates.

Finally, in some states, insurers suggested that they were left out initially of emergency response discussions, some even months into the crisis. Though insurers acknowledged a need for the medical and scientific community to act first and get a handle on the outbreak, one insurer reported that they continued to be left out of policy discussions that informed that state's response to coverage and payment issues. This insurer felt "sidelined" and argued that their state took a less than ideal approach, especially since the payment of health care services is critical to consumers feeling comfortable seeking critical COVID-19 testing and treatment services. "We really had to push our way into a conversation," one insurer said. In another state, insurers continued to be frustrated with the "lack of dialogue" between state officials and insurers. For some insurers, the lack of engagement and outreach from officials has been perplexing and a missed opportunity, since insurers maintain critical information on their members. This information could have helped states in their emergency responses by aiding in contact tracing, providing a clearer understanding of health needs in the community, and better identifying at-risk individuals.

Looking forward, insurers have just begun to consider "lessons learned" from the early phases of the pandemic. One insurer volunteered that "we're all feeling our way through" and that no insurer was "as prepared as it could [have been] because no one thought [a pandemic] would happen to this degree." Another noted, from a policy perspective, "it feels like we should have all of this ready to go [for the next pandemic]." In fact, some insurers were already discussing how to best prepare for the next wave of COVID-19, such as by documenting all of the company's action to date to inform the development of a "pandemic response plan."

CONCLUSION

The COVID-19 outbreak has had a profound impact on day-to-day life, with repercussions that are likely to be felt for some time. Amidst this crisis, the health care system and its providers and insurers have stepped up in an immediate and substantial way. Insurers are and can continue to play a meaningful role supporting providers on the front lines and ensuring that consumers can access affordable and necessary health care services. Most insurers entered the crisis in a strong financial position, which allowed them to reduce cost barriers to care and offer financial support to providers. Despite early predictions that COVID-19 would drive massive losses in employer-based coverage, it appears that many employers have kept workers enrolled in benefits longer than anticipated. However, as the crisis goes on and federal stimulus funding dries up, many in the insurance industry believe that significant coverage disruptions are inevitable. Beyond coverage implications, COVID-19 has sparked important conversations within insurance companies about the consumption of health care in the United States, the use of technology to deliver services, and the critical need to acknowledge and address the racial and ethnic disparities that plague the health care system. Though no one can predict how the COVID-19 crisis will evolve, lessons learned from insurers' early experience have already better prepared them to some extent for what is to come.

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The authors thank Tyler Thomas for his research support, Camille Ahearn for copyediting, as well as the many sources who took the time to discuss these issues with us.

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he preliminary reported impact of COVID 1 on ACA premiums

A look at the impact of COVID 19 on proposed 2021 ACA market premiums in six states and D.C.

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mily DeAngelis

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xpected costs related to COVID 19 in 2021 may increase or decrease health insurance premiums in the Patient Protection and Affordable Care Act (ACA) commercial markets. When setting premiums for 2021, health insurers will consider a variety of factors related to COVID 19, including the acute treatment and vaccination for COVID 19, changes in access - and demand for healthcare, lasting impacts on population health, - economic impacts on enrollment and utilization of care, disruptions to - provider networks, and other operational impacts.[1] -

he National Association of Insurance Commissioners (NAIC) has released a template to assist state regulators in their reviews of 2021 premium impact assumptions for COVID 19. he template outlines pricing considerations such as COVID 19 treatment and testing; - additional telehealth services and the replacement of in person services by telehealth; other conditions and care caused by COVID 19; pent up demand resulting from delayed 2020 services; 2021 delayed/canceled services; population movements in and out of the ACA market; and new vaccines or treatments.[2]

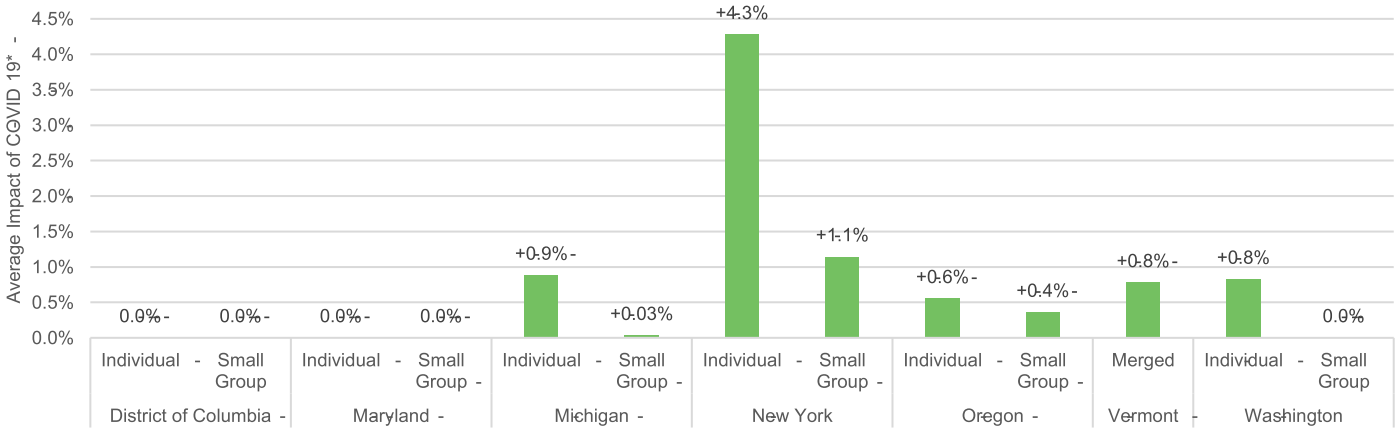
As of June 15, 2020, six states and the District of Columbia (D.C.) have publicly released preliminary ACA premium rates for 2021. his paper - examines the reported impact of COVID 19 on these rates. Based on these preliminary filings, we found that health insurers assumed that COVID 19 would increase premiums by an average of 0% to 4.3% for 2021, depending on the state and market. However, many regulators have already indicated they will allow additional adjustments after the original filings, and health insurers have noted that they will continue to monitor the pandemic and may adjust 2021 premiums as new information becomes available.

he minimal average adjustment to 2021 premiums may be a result of large cost reductions insurers are experiencing in 2020 as elective procedures are postponed and patients shy away from nonemergency care. For instance, since the medical loss ratio (MLR) calculation used for determining premium rebates is based on a three year average, insurers may reduce the level of conservatism when setting their 2021 premiums if they are anticipating paying out MLR rebates because of lower than expected claims in 2020.[3,4]

Preliminary reported COVID 19 premium increases are minor for 2021

he preliminary impact insurers have built into their 2021 premiums for COVID 19 varies by state and market. Figure 1 illustrates the average insurer assumed impact on 2021 premiums attributed to COVID 19 by state

FIGURE 1: MARKET SUMMARY OF THE REPORTED IMPACT OF COVID-19 ON PRELIMINARY 2021 ACA PREMIUM RATES -



* Average impact based on the insurer assumed premium impact of COVID 1 weighted based on 2 2 enrollment by health insurer, excluding new insurers and insurers that did not publicly uantify a rate impact due to COVID 1 in their rate filing materials

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and market, weighted by 2020 enrollme nt by he alth nsurer within each market. he highest average rket increase ascribed to Ca OV ID 19 is New York's individual where an insurer wit high enrollme nt - included an impact of over 8 %.across Na ny of the ma rkets assumed a pre mi e ur ase due to C OV ID 19.

Of e th m 18 kets we reviewed, four have no pre c tt t C OV ID 19, stating that the filings did not include any explicit adjustme nts to pre mi for C ms Ca y of the 18 surers in these ts. -ma rke Because we relied on 2020 enrollme t to develop our weighted averages, insurers that are new to the market are excluded from ese averages. In Ma ryland, e.g., a mp le, Figu es 1 and 2 i d ca e a 0.0 because all renewing insurers assumed no impact, but one new insurer entering the individual market assumed a 2% impact to premium and is not - reflected in Figures 1 or 2. -

Insurers submitting rate filings in both the individual and s ll group ma ma ets w within a state tended to assu me similar i acts for C mp OV both their individual and s ll group premiu ma ma ffe ces shown in - Figure 1 between a state's individual and s ll markets are largely due to differing insurers in each market as well as varying market shares a mo insu ers within each market. -

Insurers' assume d i of C mp Ca act ID 19 ma e y vary by state due to s vera factors, including the spread of the pande within the state. Figure 2 compares the insurer assu me d pre t mi u ga ainst the mp state's C ID 9 c la On on d infe tion rate one week before the market's filing deadline, reflecting insurers' latest view of the pande c mi

FIGURE 2: COVID-19 2021 REPORTED PREMIUM IMPACT AND CUMULATIVE CONFIRMED INFECTION RATE BY STATE AND MARKET

STATE	MA RKET	AVERAGE PREMIUM I MP ACT *	COVID-19 INFECTION RATE** -	DATE OF INFECTI ON RATE** -
DC -	Ind. / S.G. -	0.0%	0.5%	4/24/2020 -
MD	Ind. / S.G. -	0.0%	0.3%	4/24/2020 -
MI	Ind.	0.9%	0.6%	6/3/2020
MI	S. G.	% 0 03	0 5%	5/6/2020 -
NY -	Ind. / S.G. -	1.9%	%	1.7 5/11/2 2 0 0
				5
V -	Merged	0.8%	.1% 0 -	5/1/2 2 0 0
WA -	Ind. / S.G. -	.	0 3% .	5/14/2020 -

* Average impact based on the insurer assumed premium i mpact of COVID 19 weighted on 2020 enrollment by health insurer, excluding new insurers and insurers that did not publicly quantify a rate i mp e tac C du OV ID 19 in rate filing materials. -

** Infection rates are cumulative confirmed infection rates as of one week before the filing deadline for the state and market. For Michigan, the filing deadline varied between the individual and small group markets.

FIGURE 3: DISTRIBUTI ON OF FILIN GS BY PRELI MIN IMP CT AN 2021

C OV ID-19 RATE I	MP ACT FILIN C GS NT
N/A* -	1 2 - % 17
0% mi u m i mp a t a ribu ed to -	1 7 %56
0.1% 1.0%	9 - % 7
1.1% 2.0%	10 - % 8
2.1% 3.0%	7 - % 6
3.1% 5.0% -	3 - % %2 - av rage
Gr eater than 5.0	% % - - 5 -

* Includes rate filings that did not publicly quantify a rate i due to COVID 19.

during rate develop [5] Of the states that have eeleas mi nary ID 19 on filings, New York had the highest C OV d Confirme d infe tion rate one week prior to the state's filing deadline. i ings for 2020 Coverage 29 f l in the New York ACA ma Group individual and s ll group mp t ma ve rke s, 19 ha assumed an increase to 2021 premiu ms due to COVID 19, with an enrollment weighted average increase of 1.9% across the individual and - s ma group rkets. Among the other states, there is no clear relationship between confir d infection rate and reported premium adjustment.

C ID OV 19 pricing approaches

Gi en the high degree of uncertainty surrounding the costs related to COVID 19 in 2021, there are several approaches for pricing 2021 premium ates to reflect the impact o COVID 19.

"WAIT AND SEE" APPROACH

his was a common approach among health insurers in the markets that - have released preli ry rate filings. Figure 3 shows that over half of filings included in our study assu me ve t id mpt for C ID 19 OV - their 2021 premium rates. Of these, many insurers stated in their actuarial memorandums that they intend to update their assumptions as - new infor ma tion becomes available during the rate review process.

Some state regulators, including the Colorado Division of Insurance, have indicated that an amen ded f will be permitted to reflect changes in C OV aID 19 ssu s later in the rate review p ocess.[6] Rate review timelines vary by state, and the extent to which changes in preliminary assumptions are allowed by state regulators differ, but the final deadline - for issuers participating in federally facilitated exchanges to revise their Qu ed Health Plan (QH lica) ap is August 26, 2020.[7]

BEST ESTIMATE APPROACH

Ot er insurers incorporated their best esti ma tes of projected c to COVID 19 in 2021 into their rates. Insurers that included a best esti ma related to COVID 19 often included qualitative and quantitative - developme t of several factors, such as the anticipated cost of services

[5] Cumulative positive COVID 19 cases as of one week before each state's filing deadline retrieved June 24, 2020, from https://covidtracking.com/. State populations retrieved June 24, 2020, from https://www.census.gov/quickfacts/ .

[6] Colorado Division of Insu rance (May 18, 2020). 2021 ACA Rate Filing Procedures for Colorado. Retrieved June 18, 2020, fro m https://drive.google.com/file/d/1OfPFihQzoiBlNnVCy0Y6qqd8OPwpXR9_/view?usp=sharing.

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deferred from 2020 to 2021 and estimates of vaccination and testing costs and utilization. Some insurers chose this approach at their own discretion, but those filing in New York, for exa e mp l ,were requ ired to populate state required exhibits explicitly stating their assumed impact of C OV ID 19 on 2021 projected costs.

ASSU NO I ME MP ACT GI VEN DE GR EE OF UNCERTAINTY

Several insurers also rationalized no i c C OV ID 19 1n 202 mp a t of premi u ums due to such a high degree of uncertainty and potential offsetting factors. he pricing considerations surrounding COVID 19 ma y increase or decrease 2021 costs.[8] For these reasons, nu me insurers ous have justified attributing no i mp act to 2021 premi ums for COVID 19.

STATE RE GU LAT OR S PRESCRIBE COVID-19 ADJUST ME NT

Finally, state regulators s a main y al o play role prescribing the adjust insurers build into their 2021 pre a C mi OV u ID m 19 ra tes for the Mi Department of Insurance and Financial Services (DIFS) released a bulletin specifying that it will review prelimi ry rate filings and deter mi ne the lev any insurers' C ers.[9] OV According to DIFS, outlying i amp cts "could result in enrollme t n shifts a mo ng issuers which could negatively i mp act the DIFS's focus is on maintaining a co titive ma rket with actuarially sound rates.

Although not publicly stated, it is also possible that so e nce insu rance stat regulators may have instructed insurers that they do not expect filings for ACA coverage to include significant rate increases due to C OV ID 19.

Methodology and data sources

We r e viewed publicly available preli r e ilings for ACA t coverage effective January 1, 2021, that were released as of June 15, 2020, including actuarial memo Unified Rate Review tems (URR s), regulator press releases, and other is included ma terials. h

filings for D.C. and the following states: Maryland, Michigan, New York, Oregon, Vermont, and Washington. For each filing, we recorded the insurer's assumed imp act of C OV ID 19 on proposed premi m rates, as well as the justification for the impact provided in the actuarial memorandu for health insurers that explicitly included an impact for C OV ID 19. We also recorded each insurer's current 2020 enrollme nt fro Worksheet 2 of the URR .

Caveats and li s

In preparing this report, we relied on publicly available preli nary rate filing materials for 2021 released by state regulators. his data represents a li ted subset of states with ACA markets, and our findings and conclusions will change as mo re states release rate filing ma terials. Final approved rate filing materials, including the i mpact of COVID 19 on final pre le, may vary fro , m a prelims due to actions by state regulators and/or health insurers to change pre um ra tes. he i mpact of C OV ID 19 on 2021 pre mi ums represents insurers current expectations for the ACA t New data on the spread of C OV ID 19 in the United States is still eme rging actions taken by govern me nt authorities, au the healthcare system, and patients related to the COVID 19 pandemic are rapidly changing. Consequently, insurers' expectations of the impact of C OV ID 19 o 2021 pre will evolve as new infor t n beco ma io m available and new actions are taken by the authorities and other stakeholders.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Dane Hansen and Andrew Bochner are members of the A me rican Academy of Actuaries and meet the qualification standards for performing the analyses in this report and rendering the actuarial opinions contained herein.

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[8] Mi on Hall, J. Ma wski, ., & Norris, D., op cit.

[9] State of Michigan Depart nd Financial Services of Insurance a lletin 2020 24 INS. Retrieved June 15, 2020, from https://www.michigan.gov/documents/difs/Bulletin_2020 24 INS_689766_7.pdf.

Health Research Institute

Medical cost trend: Behind the numbers 2021

Medical cost trend in the midst of the COVID-19 pandemic

June 2020

pwc

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Heart of the matter

The COVID-19 pandemic has reshaped US healthcare. Virtual care has skyrocketed. People are largely avoiding in-person visits and procedures. Providers across the nation are facing a liquidity crisis as non-COVID-19 patient volumes plummeted starting in late March and only started to slowly rebound in mid-May.[1] Pharmaceutical companies experiencing delays in clinical trials have had to reevaluate them and take some of them virtual.[2]

At the same time, the pandemic has shocked the US and global economy and changed the working world. US gross domestic product (GDP) contracted at an annual rate of 5% in the first quarter and is expected to shrink by double digits in the second quarter.[3] Retail sales fell precipitously in March and April and started to recover in May.[4] Unemployment of almost 15% in April surpassed the peak unemployment of the Great Recession of 10% in October 2009, improving slightly to 13% in May.[5] Nearly 20 million people could lose their employer-sponsored health insurance.[6] Employees who can work from home have been doing so, circumstances that may continue for many after the recession. Nearly half of chief financial officers (CFOs) surveyed by PwC in early May said their companies are planning to make remote work a permanent option for some roles.[7]

Employer healthcare spending could fall in calendar year 2020 compared with 2019, and then rebound in 2021. How much it falls in 2020 and rebounds in 2021 is subject to many variables, complicated by the pandemic. For 2021, PwC's Health Research Institute (HRI) has formulated three scenarios to help guide employers and health plans as they determine medical cost trend. A high-spending scenario, in which spending grows significantly higher in 2021 after being down in 2020, forecasts a 10% medical cost trend. A medium-spending scenario, in which spending grows at roughly the same rate in 2021 as it did from 2014 to 2019, projects a 6% medical cost trend. And a low-spending scenario, in which spending remains dampened in 2021, translates to a 4% medical cost trend.

Beyond the direct impacts of the pandemic and the economic downturn, HRI identified two inflators that are expected to drive spending in 2021:

COVID-19 boosts mental health utilization. Employers have made mental health a priority over the past few years by expanding mental health benefits and working to dispel the stigma around mental health conditions.[8] The COVID-19 pandemic, with its attendant anxiety and social isolation, likely will drive further demand for mental healthcare at a time when employers are eager to expand access.

New specialty drugs and expanding indications for approved specialty drugs increase spending. Most medications in the pipeline are specialty drugs.[9] Some of those drugs are curative gene therapies that could come with multimillion-dollar price tags. Existing specialty drugs also are driving spending as the conditions for which they are approved expands.

While spending may be up in 2021 over 2020, HRI identified two bright spots for spending in 2021:

Telehealth goes mainstream. Telehealth has been gaining ground slowly for years. COVID-19 forced its rapid adoption by both consumers and clinicians, many of whom had never used it before. In 2021, HRI expects telehealth to settle in as a viable and desirable alternative to in-person care, saving employers and health plans on the episodic cost of care delivered virtually.

Networks narrow out of necessity. Employers are eyeing narrow provider networks; over a quarter of employers have been considering them for the past few years.[10] Some of those employers may move to a narrow network plan in 2021 as COVID-19 and the related economic downturn force employers to shed costs and make healthcare providers more willing in the short term to give price concessions or take on more risks in exchange for predictable cash flows, if it helps them get patients to return for care.

Uncertainty remains about the impacts of COVID-19 and the economic downturn on healthcare spending in 2021. The health of the overall population could worsen slightly as individuals delay needed care in the midst of the pandemic, pushing up future healthcare costs. The number of individuals with employer-sponsored insurance is declining, driving down provider revenues that have already taken a hit from COVID-19. Looking beyond spending, COVID-19 and the resulting economic downturn likely will transform aspects of the healthcare system.

Medical cost trend

The pandemic has raised many questions about employer healthcare spending in 2020 and 2021. How much will COVID-19 testing and treatment add to employer spending? How much care will be deferred, how much will come back, and will care delays result in poorer health? How will the economic downturn—employment losses, decreases in disposable household income and more—affect healthcare spending?

In interviews conducted in March, April and May, health plan actuaries from 12 national and regional payers told HRI that they remained unsure about the pandemic's impact on healthcare spending now and projected medical cost trend for 2021. Despite the uncertainty, employers and payers will need to decide what medical cost trend to use when determining next year's premiums. The unprecedented drop in healthcare utilization in 2020 that resulted from COVID-19 complicates this calculation.

Because of the drop in employer healthcare spending in the first half of 2020 and the uncertainty around spending in the second half of the year, HRI is projecting 2021 medical cost trend relative to 2020 estimated healthcare costs, normalizing for COVID-19, rather than actual 2020 costs. HRI has developed three scenarios to guide employers and health plans as they determine 2021 medical cost trend: a high, medium and low trend scenario (see Figure 1 and Appendix: Employer per capita spending scenarios). Trend could range from 4% to 10%, numbers on each end of the range that have not been seen for over a decade.

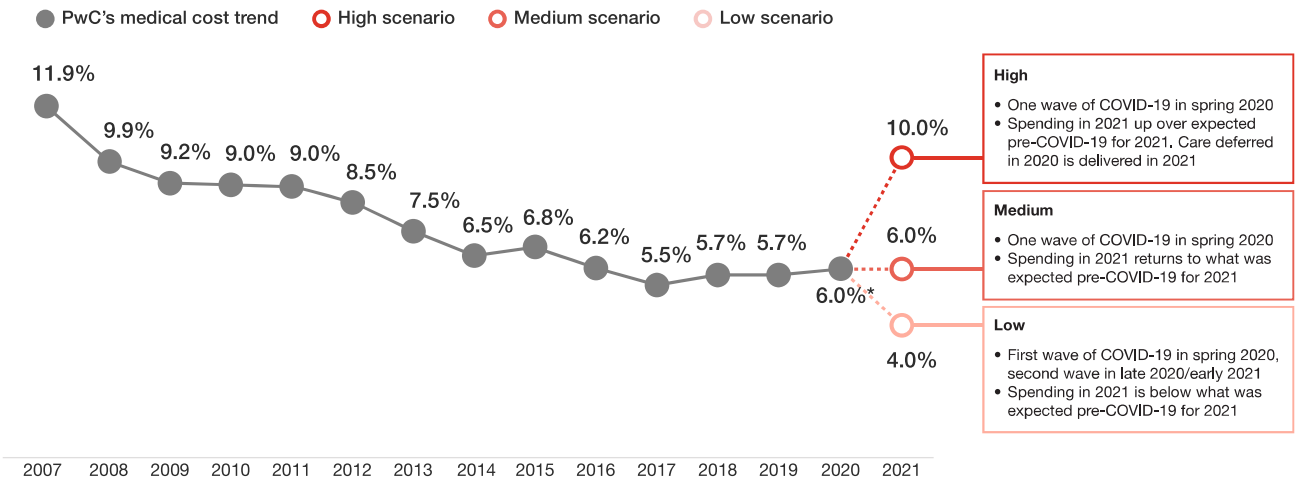
Every year, the medical cost trend varies by individual employer. In 2021, HRI also expects to see more variation geographically as some areas are affected more by COVID-19 than others.

What is medical cost trend?

Medical cost trend is the projected percentage increase in the cost to treat patients from one year to the next, assuming that benefits remain the same. While it can be defined in several ways, this report estimates the projected increase in per capita costs of medical services and prescription medicine that affect commercial insurers' large group plans and large, self-insured businesses. Insurance companies use the projection to calculate health plan premiums for the coming year. For example, a 5% trend means that a plan that costs $10,000 per employee this year would cost $10,500 next year. The cost trend, or growth rate, is influenced primarily by:

- Changes in the price of medical products and services and prescription medicines, known as unit cost inflation.
- Changes in the number or intensity of services used, or changes in per capita utilization.

Figure 1: Medical cost trend could range from 4% to 10% in 2021



Source: PwC Health Research Institute medical cost trends, 2007-21
*Note: The 6% trend shown for 2020 was projected in PwC Health Research Institute's "Medical Cost Trend: Behind the Numbers 2020" report in June 2019. This number does not reflect the impacts of COVID-19 on 2020 employer healthcare spending. Actual spending in 2020 likely will be lower than in 2019, because of the care deferred during the COVID-19 pandemic. Please refer to the Appendix and the "Macrotrends" section of this report for a deeper discussion of the impacts of COVID-19 on 2020 employer healthcare spending.

Macrotrends

COVID-19 upends employer healthcare spending

Employers are incurring unplanned COVID-19 testing and treatment costs in 2020, and those costs likely will continue in 2021.[11] The CARES Act, a $2 trillion federal aid package signed into law in March, requires employers to cover COVID-19 testing with no cost sharing for individuals enrolled in their health plans.[12] Testing costs could add up in 2020 and 2021, especially if employers incorporate frequent testing for COVID-19 into plans to help employees return to work. In interviews, executives with health plans and employer coalitions told HRI that in 2020, for employer large group plans, these unplanned costs are expected to be more than offset by the savings from delayed care during the pandemic (see Figure 2). Some payers are already sharing these savings with fully insured large group customers: UnitedHealthcare will give a 5% to 20% discount on premium billings in June, while Premera Blue Cross of Mountlake Terrace, Washington, will provide a one-time credit of up to 15% on August premiums.[13] Employers and payers expect an increase in spending in 2021 as the demand for care returns.

Utilization plummets

"What makes COVID-19 so fascinating is the way it affects both supply and demand," said Paul Hughes-Cromwick, co-director of sustainable health spending strategies at the Altarum Institute, a Michigan-based nonprofit health research organization focused on Medicaid and Medicare, in an interview with HRI. Supply, in the form of health services, has been constrained as many providers closed their doors for non-emergent visits and procedures starting in mid-March to prepare for the potential surge of patients with COVID-19 and to prevent the spread of the disease. Many states, including Texas and New York, temporarily mandated that all non-emergent surgeries and procedures be postponed.[14] Patient demand for certain services—such as non-emergent surgeries, diagnostic procedures and wellness visits—disappeared overnight as stay-at-home orders and fear of catching COVID-19 kept people away from the doctor. Fifty-seven percent of individuals with employer-based insurance surveyed by HRI in early April said they were worried about getting care during the COVID-19 pandemic.[15]

Early estimates show significant drops in care volumes starting in mid-March. A study by the Commonwealth Fund found that visit volumes for ambulatory practices declined by 60% between early March and early April.[16] Ambulatory healthcare services lost 1.2 million jobs between March and April, after adding nearly 2 million jobs between January 2010 and February 2020, according to the US Bureau of Labor Statistics.[17] Medical device sales have also plummeted along with demand for implants, instruments and devices as surgeries and procedures were postponed or canceled.[18]

Figure 2: COVID-19 costs and savings for employers

Impact on spending compared with prior year

Category	2020	2021
Non-emergent visits and procedures	↓ Delayed and forgone visits and procedures	↑ Return of some visits and procedures delayed from 2020
Telehealth	↑ Rise in telehealth visits, replacing many in-person visits; currently being reimbursed at the same rate as in-person visits in most cases because of a lack of prior telehealth contracts with providers	↓ Telehealth in place of in-person visits, assuming lower reimbursement rate than in-person visits
COVID-19 testing	↑ Costs from COVID-19 testing that were not budgeted	? Depends on how much testing is done in 2021 compared with 2020
COVID-19 treatment	↑ Costs from treatment that were not budgeted	↓ Treatment-related costs come down as we see fewer cases and get better at treating them
COVID-19 vaccine	? Unlikely that a vaccine will be ready for broad use by the end of the year	↑ Cost of vaccinating most employees and their family members

Source: PwC Health Research Institute interviews with executives at employer coalitions, healthcare coalitions and health plans between March and May 2020

In a recent survey by HRI, 22% of individuals with employer-based insurance reported that they had delayed some care since March 1 and that they still had not received it as of early May.[19] On average, those individuals said they had delayed 71% of the care they would have received since March 1 (see Figure 3).

Individuals with complex chronic conditions on employer-sponsored insurance were more likely to have delayed care than those in other groups, HRI found. Getting these people in for necessary care is important for their health and for employer spending. On average, people with complex chronic illnesses cost employers eight times more than healthy individuals, with an average annual cost per person of over $11,000—a number that could balloon even higher if their illness is left unmanaged for too long.[20] "We could see the population risk increase for 2021 if members with chronic conditions are not able to manage their health as effectively in 2020 due to COVID-19," said Amy Yao, senior vice president and chief actuary at Blue Shield of California, in an interview with HRI.

Getting patients to return for care remains top of mind for providers that have suffered significant revenue loss and liquidity issues over the past few months.[21] As providers across the US resume non-emergent medical services, it remains unknown how much demand will return and when. "Some people are assuming that all you have to do is open back up and everything will be fine," said Hughes-Cromwick. "It is one thing to throw a party; you still need people to attend the party."

Of the 22% of individuals with employer-based insurance surveyed by HRI who have delayed care since March 1, 50% have rescheduled some or all of that care. Forty-six percent have not rescheduled but plan to do so.[22]

Doctors will play an important role in getting patients to return. When asked what would encourage them to reschedule delayed care, respondents said they were looking for communication about safety from their physicians first and then the Centers for Disease Control and Prevention (CDC) (see Figure 4).[23] Still, just 14% of individuals with employer-based insurance surveyed by HRI said they have received health information from their health system during the pandemic.[24] As a trusted source, providers have an opportunity to better communicate with their patients during the pandemic.

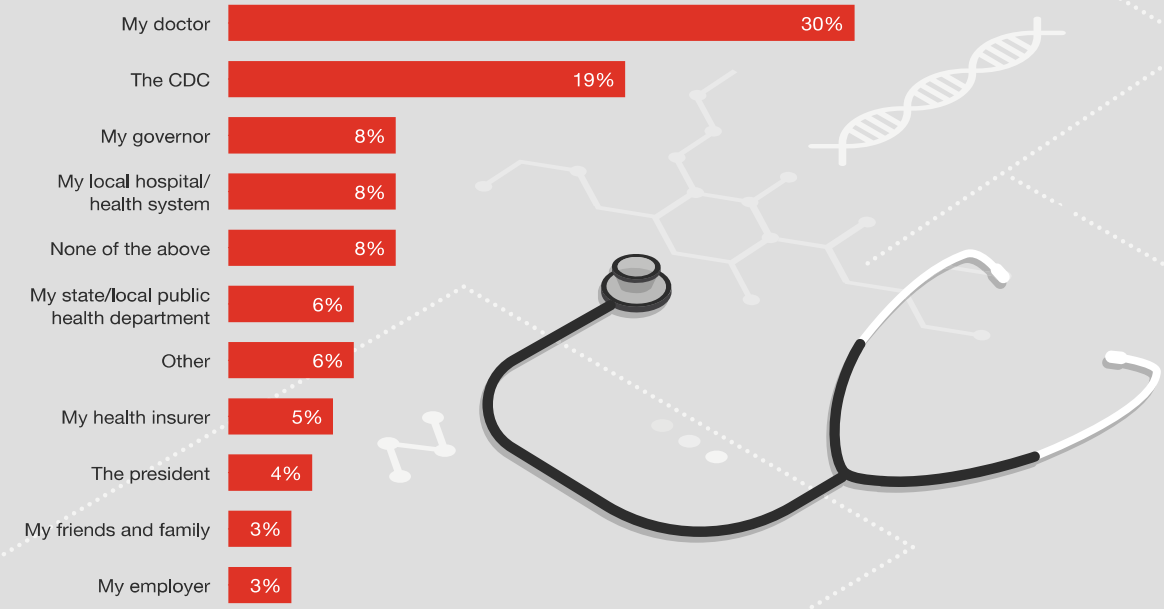
Figure 3: Individuals with complex chronic conditions on employer-sponsored insurance were most likely to have delayed care, delaying two-thirds of their care between March and early May

			Employer-sponsored insurance by consumer group					
	All consumers	Employer-sponsored insurance (ESI)	Complex chronic	Chronic	Mental health	Healthy family	Healthy skeptics	Healthy enthusiasts
Consumer group as a % of ESI	N/A	100%	5%	55%	3%	23%	9%	5%
Care delayed and not received since early March	25%	22%	32%	24%	23%	22%	17%	16%
Average portion of care delayed	67%	71%	67%	74%	62%	72%	66%	73%
Rescheduled	50%	50%	54%	50%	47%	62%	40%	40%
Planning to reschedule	45%	46%	43%	47%	53%	32%	50%	56%

Source: PwC Health Research Institute consumer survey, Apr 28 - May 8, 2020 and PwC Health Research Institute analysis of Medical Expenditure Panel Survey data for individuals with employer-based insurance, 2015-17

Note: Six of the seven HRI consumer groups are shown in this breakdown of employer-sponsored insurance by consumer group. The frail elderly consumer group is excluded as this consumer group generally does not apply to individuals with employer-sponsored coverage.[25]

Figure 4: Individuals with employer-based insurance are looking for reassurance from their doctor and the CDC before rescheduling care they have delayed



Source: PwC Health Research Institute consumer survey, April 28-May 8, 2020

Prices may increase

COVID-19 likely also will affect healthcare prices in the long and short terms. Providers are focused on stemming immediate losses and may be more open than they were pre-pandemic to price concessions and value-based arrangements, especially if it helps them drum up business to cover their fixed costs. Such arrangements could include risk sharing, in which the provider takes on some financial risk for patient outcomes, or capitation, in which the provider is paid a monthly fee to manage the total cost of care for a patient.

Once providers have been able to recover most of their volumes and are in a position to negotiate new rates with payers, employers might expect to see two COVID-19-related price increases hit healthcare spending starting in 2021. First, providers will continue to incur increased costs to prepare for future waves of COVID-19. For example, hospitals have spent an estimated $550 million per month during the pandemic to support front-line hospital workers with childcare, housing, transportation, and medical screening and treatment for COVID-19 for those workers.[26] The American Hospital Association estimates that hospitals will have spent an additional $2.4 billion between March and June 2020 on personal protective equipment (PPE) alone because of an increased need for PPE and higher costs of PPE as the result of shortages.[27] Second, it may cost more to provide in-person care safely, and to fewer patients, while the threat of the coronavirus remains. For example, Loyola Medicine of Maywood, Illinois, is testing all patients for COVID-19 24 hours before undergoing an elective procedure; requiring masks for patients, visitors, employees and physicians; and following CDC standards for facility deep cleaning with increased frequency and attention to surfaces that are frequently touched—all steps that protect patients and providers while adding costs.[28] Social distancing guidelines along with the time needed to deep-clean between patients could also limit the number of people that can be seen each day.

Economic impacts of COVID-19

COVID-19 disrupts the economy

US GDP fell at an annual rate of 5% in the first quarter of 2020.[29] The impacts of COVID-19 on the second quarter are expected to be more severe. More than 20 million people lost their jobs in April, and the unemployment rate rose to nearly 15% after remaining below 5% since late 2015.[30] By some measures, the economy improved in May. Retail sales began to bounce back after falling fast in March and April, and

unemployment dropped to 13%.[31] Yet in testimony to the Senate Banking Committee in mid-June, Federal Reserve Chairman Jerome Powell warned that "until the public is confident that this disease is contained, a full recovery is unlikely."[32]

A recent analysis by the Brookings Institution provides a few different recovery scenarios. On one end, Brookings offers a positive scenario in which US GDP rebounds higher than pre-pandemic expectations as a result of pent-up demand. On the other end, a pessimistic view envisions the pandemic dampening US GDP permanently, leading to growth that is lower than pre-pandemic expectations.[33]

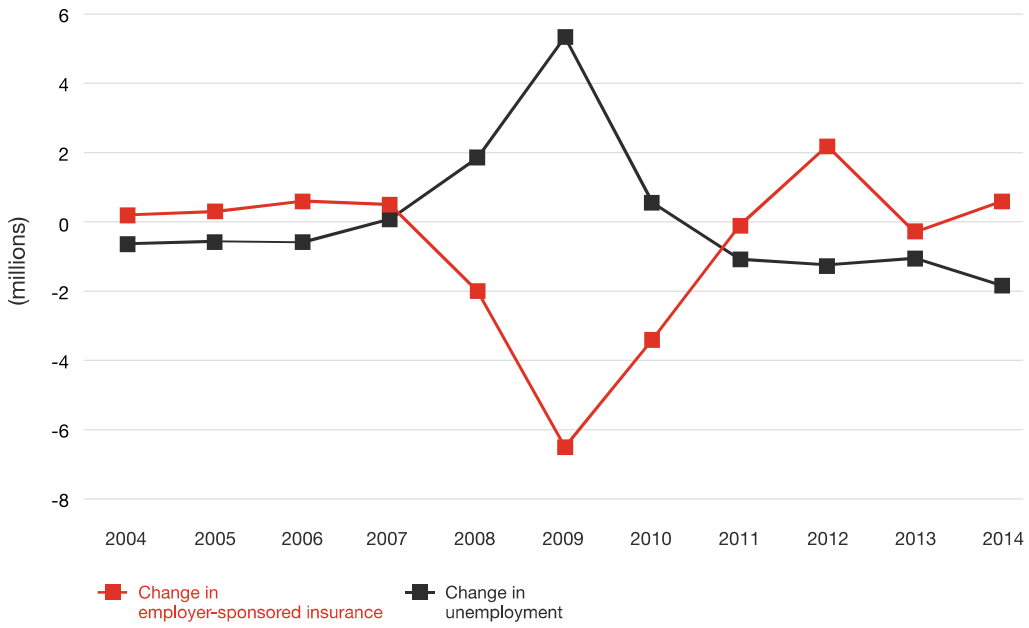
Much uncertainty remains about how to safely reopen the economy and return employees to work. Two-thirds of CFOs surveyed by PwC in early May said they were very confident they could provide a safe working environment.[34] Yet 51% of employees who have been forced to stop working or to work remotely said the fear of getting sick at the workplace would prevent them from returning.[35]

Employer-based insurance declines, number of uninsured climbs

An HRI analysis of the relationship between unemployment and employer-sponsored health insurance during the Great Recession, from 2007 to 2010, found that for every person who became unemployed, on average 1.5 people lost employer-sponsored health coverage (see Figure 5). Applying this to the Congressional Budget Office estimate that unemployment could average 11.6% in 2020, the number of unemployed this year could increase nearly 13 million on average, leading to over 18 million people losing employer-based coverage, or roughly 10.5% of people who had such coverage before the pandemic.[36]

Figure 5: During the Great Recession, unemployment increased by 8 million and employer-sponsored health insurance dropped by over 11 million

Change in the number of unemployed individuals compared with change in the number of individuals with employer-sponsored health insurance



Source: PwC Health Research Institute analysis of CMS national health expenditure data and Bureau of Labor Statistics current population survey data[37]

During the Great Recession, the number of uninsured individuals rose by nearly 6 million.[38] Today, that number is going up again as a result of the current economic downturn, but the increase may be blunted by individuals enrolling in Medicaid, plans sold on the Affordable Care Act (ACA) individual market, association health plans or short-term, limited duration insurance.[39] Employers also should expect an uptick in the number of people who opt to continue their coverage via the Consolidated Omnibus Budget Reconciliation Act (COBRA), which allows temporary extension of employer-sponsored coverage paid for by the employee.[40] While there is the potential for some adverse risk selection to COBRA by those who are older and may incur more healthcare spending, selection of COBRA plans may be driven less by health status, as it was in the past, and more by income level—whether the individual can get cheaper coverage through Medicaid or the ACA exchange. "Subsidized coverage on the exchange is almost always cheaper than COBRA," said Michael Thompson, president and CEO of the Washington, DC-based National Alliance of Healthcare Purchaser Coalitions, in an interview with HRI.

Health insurers should consider proactive outreach to their members losing employer-sponsored coverage to help those members enroll in other plans they offer, such as managed Medicaid or exchange plans. Providers should evaluate how a decrease in patients with employer-sponsored insurance coupled with an increase in patients who are uninsured or on Medicaid will affect their revenue.

US healthcare spending sank with the economy

Historically, changes in healthcare spending growth have lagged behind shifts in the general economy, especially ebbs and flows in disposable personal income.[41] According to the CMS Office of the Actuary, as the income growth rate increases or decreases, the health spending growth rate tends to follow in the same direction, but with a lag over several years.[42] In the case of an economic slowdown, when growth in the overall economy slows, private health spending typically doesn't slow as rapidly and health spending becomes a larger share of the economy.[43] Then as the economy recovers, health spending's share tends to stabilize.[44] The pandemic downturn appears to be different. Both supply of and demand for health services have been constrained since state and local governments began issuing stay-at-home orders in mid-March. As a result, many providers are struggling financially. A lack of financial viability may lead some providers to consider being acquired, potentially driving deals in the second half of 2020 and into 2021.

Factors affecting 2021 medical cost trend

Inflator: COVID-19 boosts mental health utilization

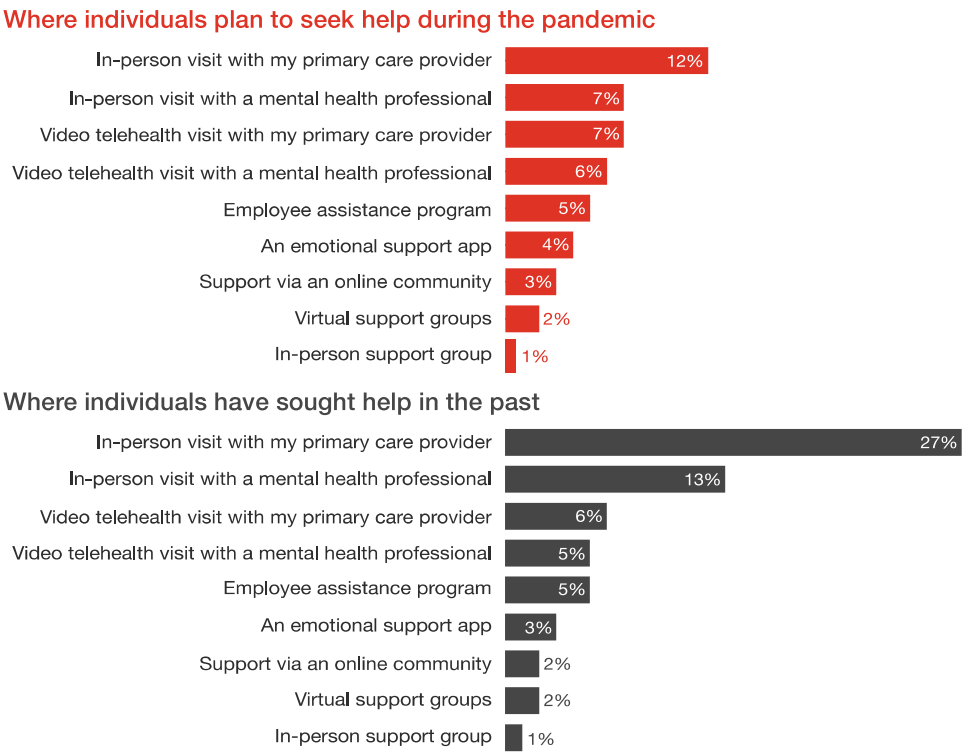
In 2021, HRI expects increased utilization of mental health services as employees tap resources for mental health conditions, including new ones stemming from the pandemic.

Employers have invested more in mental health in recent years. They are offering disease management programs, addressing stigmas and integrating mental healthcare into primary care at worksite clinics.[45] The Health Care Cost Institute's 2018 study on healthcare spending by employer-sponsored plans found that spending on psychiatry services rose 43% from 2014 to 2018. Spending on mental health admissions rose 33% on a per-person basis from 2014 to 2018.[46]

Demand for mental health services likely will grow even faster as a result of COVID-19 and the associated economic impact. Between 2017 and 2018, one in five American adults reported having a mental illness.[47] In a survey by the Kaiser Family Foundation conducted in late March 2020, after the pandemic had triggered stay-at-home orders, widespread layoffs and general anxiety over the spread of the virus, 45% of adults reported that their mental health had been negatively affected.[48] Americans told the Kaiser Family Foundation and HRI, in a series of surveys, that they were struggling with sleep, diet, exercise and too much time spent on technology.[49]

Some individuals with employer-based insurance have sought help. In a recent survey conducted by HRI, 12% of consumers with employer-based insurance said they sought help for their mental health as a result of the pandemic.[50] An additional 18% reported plans for accessing care for mental health needs.[51] Individuals with employer-sponsored insurance are not as willing to get help in person during the pandemic as they were before (see Figure 6). But many are equally or more willing to seek care via telehealth, employee assistance programs, emotional support apps and online communities than they were before the pandemic.

Figure 6: Willingness to seek help for mental health virtually during the pandemic has increased while willingness to seek it in person has decreased



Source: PwC Health Research Institute consumer survey, April 28-May 8, 2020
Note: Consumers were asked to select all services they had used for help with mental health issues in the past five years and that they plan to use to help manage anxiety, stress or other mental health issues resulting from the COVID-19 pandemic. If no services applied, consumers selected "I have not used/do not plan to use any of these." As such, the options presented here will not total 100%.

Many employees have more mental health options than ever. Ninety-six percent of employers surveyed by PwC offered an employee assistance program in 2020; 71% offered stress management programs.[52] Nine percent of individuals with employer-based insurance reported that they were offered new mental health or stress-related benefits as a result of the COVID-19 pandemic.[53]

Mental health has been a leader in the movement to telehealth. One review of commercial and Medicare Advantage telemedicine claims data by researchers from Harvard University and the University of Pittsburgh found that more than 50% of visits conducted between 2005 and 2017 were for mental health.[54] Excellus BlueCross BlueShield of Rochester, New York, estimated that 40% or roughly 16,000 of its telemedicine visits between Jan. 1 and April 3 were for behavioral health services.[55]

Employers may push for mental healthcare to be delivered via telehealth beyond the COVID-19 pandemic, especially if it improves access that historically has been constrained.[56] Seventeen percent of consumers with employer-sponsored insurance who were surveyed by HRI in early April used telehealth for mental health during the COVID-19 pandemic; 26% of all consumers with employer-sponsored insurance said they would consider using telehealth for mental health in the future.[57] Employers also like the potential to measure the effectiveness of the care being delivered. "With virtual care, there is an opportunity to ask consumers a standardized set of questions at the baseline visit and at preset intervals. Capturing these data will allow employers to see how those who engage in behavioral health progress over time," said Brian Marcotte, former president and CEO of the Business Group on Health, in an interview with HRI.

Some employers are expanding access to mental health support via digital platforms such as Ginger, Calm and Happify Health. Happify Health uses scientific research from positive psychology, cognitive behavioral therapy and mindfulness to improve mental and physical health through its virtual care and digital therapeutic products.[58] Happify Health's products incorporate Anna, a digital mental health coach powered by augmented intelligence that connects conversationally with Happify's users to deliver personalized behavioral interventions.[59] Happify's digital therapeutic products can be used to manage mild to moderate anxiety and depression or used with other therapies to treat and manage more severe anxiety, depression and related medical conditions.[60] "The primary shortage in telemedicine for mental health is not digital

technology; it is qualified professionals on the other end," said Chris Wasden, head of Happify Digital Therapeutics and a board member of the Digital Therapeutics Alliance, in an interview with HRI. "Fully digital companies like Happify can address some issues just as effectively as, and with better consistency than, a human being, without the staffing constraints."

Employers and payers are willing to spend money on mental health. An individual with a complex chronic illness and mental illness costs employers 1.5 times more per year than someone with a complex chronic illness alone and 12 times more per year than a healthy person without a chronic, complex chronic or mental illness (see Figure 7).

Boston-based Harvard Pilgrim Health Care offers a phone-based therapy program through a partnership with its behavioral healthcare vendor.[61] The program has shown early promise for members with cardiac conditions and anxiety. "It can be hard to distinguish between a heart attack and an anxiety attack," said Dan Rachfalski, senior vice president and chief actuary at Harvard Pilgrim Health Care, in an interview with HRI. "If someone with a heart condition is experiencing chest pain, they will go to the ER and often will be admitted for observation. If you can provide patients with the tools to manage their anxiety, some of these ER visits and inpatient stays might be avoided."

Implications

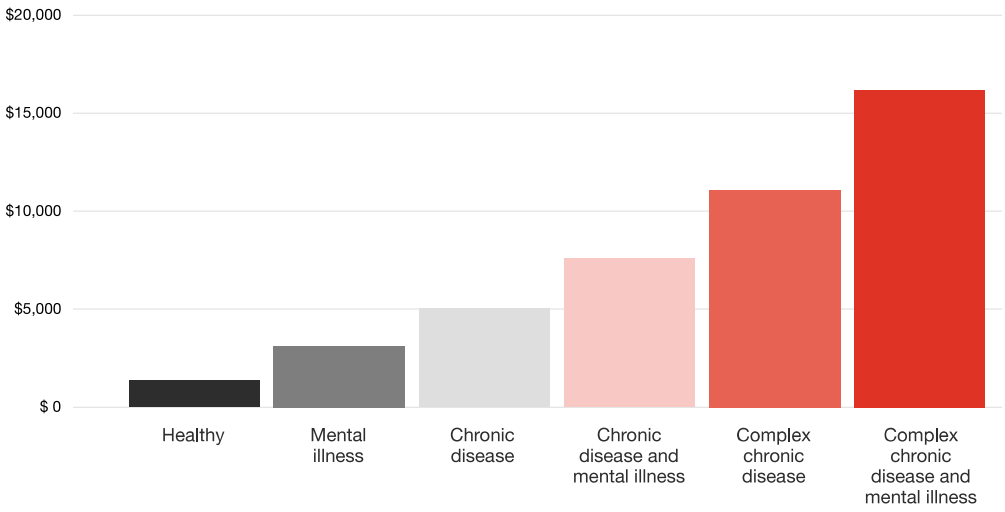
Payers/employers: Take inventory of virtual mental health offerings to ensure sufficient access to virtual care and support. Communicate these virtual options early and often to employees and members. Encourage the use of telehealth for mental health through plan design. Consider reducing or waiving cost sharing on telehealth visits for mental health, something temporarily allowed on high-deductible health plans by the CARES Act.[62]

Providers: Build out virtual mental health services and integrate them with broader primary care services to improve health outcomes and spending on individuals with a comorbid mental health condition.[63] Screening for depression and anxiety is more important than ever given the toll the pandemic has taken on people's mental health. Providers should consider expanding these screenings beyond annual checkups to all patient visits.

Pharmaceutical and life sciences companies: Partner with digital mental health companies to support medication adherence and enhance outcomes. Sanofi and Happify Health have partnered to help patients with multiple sclerosis manage and improve their psychological outcomes and in turn improve treatment adherence.[64] Consider outcomes-based contracts with employers and payers for the diseases and related treatments targeted by partnerships with digital mental health companies.

Figure 7: Employers spend 12 times more per year on individuals with a complex chronic illness and mental illness than they do on healthy individuals

Average annual per capita spending for individuals with employer-based insurance, 2015-17



Source: PwC Health Research Institute analysis of Medical Expenditure Panel Survey data for individuals with employer-based insurance, 2015-17

Factors affecting 2021 medical cost trend

Inflator: New specialty drugs and expanding indications for approved specialty drugs increase spending

Specialty drug spending likely will continue to grow in 2021, driven by new, high-priced drugs entering the market, including curative but expensive gene therapies. Expanding indications for existing FDA-approved specialty drugs will also increase spending.

Spending on specialty drugs has increased significantly in recent years and remains a concern for employers. Specialty drugs, while expensive by nature, also are typically high impact—vastly improving quality of life or even curing illnesses, some of which previously lacked a treatment or cure.[65] Figuring out how to pay for these innovations is a challenge for employers and the broader US health system.[66] Ninety-five percent of employers surveyed by PwC ranked managing specialty drug cost trend as a top five pharmacy concern.[67] Specialty drug spending as a share of total retail drug spending for employers grew from 21% in 2010 to 58% in 2017.[68]

The growth rate for retail drug spending for private insurance is expected to tick up slightly in 2021, to 2.6% from 1.5% in 2020.[69] In interviews, health plan actuaries told HRI that the growth rate for spending on office-administered drugs, many of which are specialty drugs, is expected to be higher. The Health Care Cost Institute's 2018 study on healthcare spending by employer-sponsored plans found that spending on administered drugs increased by $108 per person between 2014 and 2018.[70] In 2018, administered drugs were the third largest source of spending in the category of professional services, making up 14% of that spending.[71]

Specialty drugs also make up an increasing share of the pipeline. Sixty-two percent of the drugs estimated for release in 2020 and 73% estimated for release in 2021 are specialty drugs, according to an HRI analysis of OptumRx's brand pipeline forecast from the first quarter of 2020.[72] Of the 234 drugs estimated for release in 2020 or 2021, 11 are gene therapies.[73] These therapies likely will come with a high price tag, similar to the four gene therapies on the market in the US.[74]

Because of the pandemic, the FDA postponed some meetings scheduled for March or April related to the review of a new drug or device.[75] The agency reported that as of mid-April, it had met review program goals for new prescription drug and biologic approvals.[76] However, in an FAQ issued in late May,

the FDA acknowledged that it may not be able to meet review goal dates indefinitely as it allocates resources to work related to COVID-19.[77]

One gene therapy that may be approved in late 2020 is BioMarin Pharmaceutical's Roctavian, an investigational gene therapy for hemophilia A patients.[78] The therapy could enable the body to produce a blood clotting factor for patients with hemophilia A who are missing this factor or have low levels of it.[79] Roctavian would be administered via a one-time infusion, potentially replacing regimens that can include frequent at-home administration of clotting factor treatments.[80] Price estimates for the gene therapy range from $2 million to $3 million for the one-time treatment, in line with the $2.1 million cost of AveXis' Zolgensma, a one-time gene therapy treatment for spinal muscular atrophy in children under 2 years old, which made it to the market in 2019.[81]

While the per-treatment cost of Zolgensma and Roctavian may be similar, the annual cost of Roctavian to the US health system may be much higher in the next few years because of the number of hemophilia A patients who could be treated (see Figure 8). In an April earnings call, Vasant Narasimhan, CEO of Novartis, which owns AveXis, said that about 100 patients are being treated with Zolgensma each quarter in the US under the current indication.[82] Comparatively, around 20,000 people in the US with hemophilia A could be eligible for treatment with Roctavian, plus an estimated 400 babies born with the condition each year.[83]

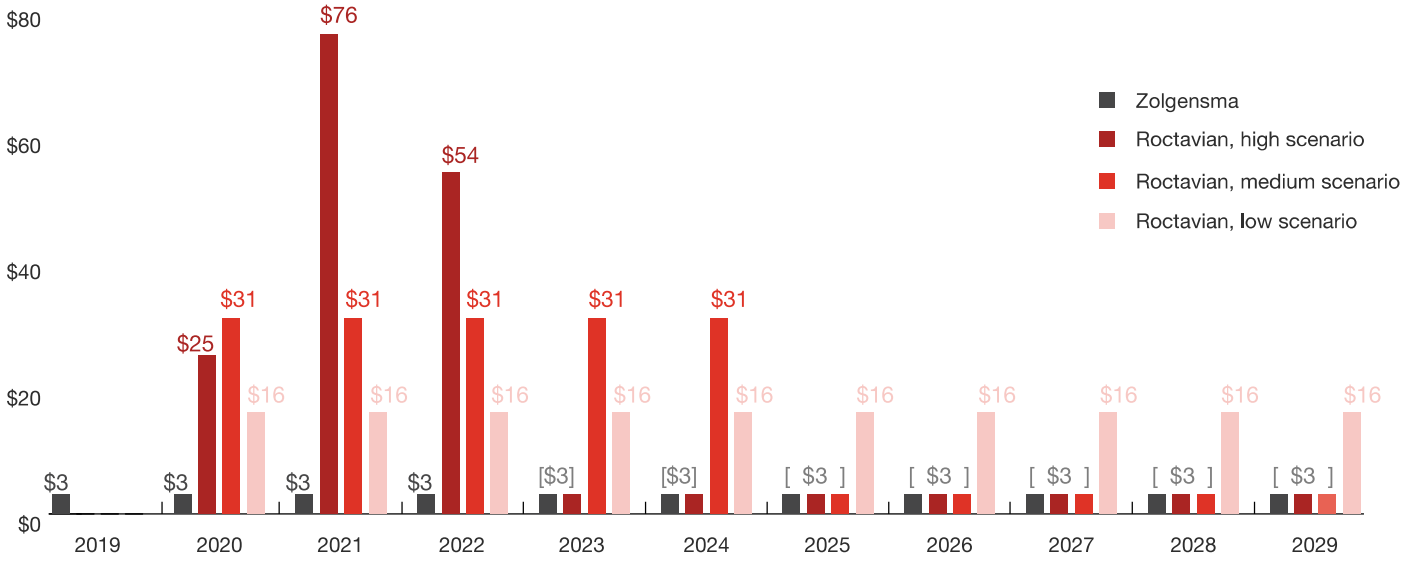
"Right around the corner are a number of drugs with price tags that will blow our minds," said Michael Thompson of the National Alliance of Healthcare Purchaser Coalitions. "With many drugs now costing in the hundreds of thousands of dollars and some costing $1 million or more, there will be more scrutiny around whether the evidence supports the price."

Expanding indications for existing specialty drugs also are driving spending. "The million-dollar therapies are certainly eye-catching," said Mike Hartjes, vice president of employer group actuarial and analytic services at Humana, in an interview with HRI. "Other specialty drugs without the million-dollar price tag often start out treating a narrow range of ailments, such as a certain type of cancer, and then get used more broadly over time. These drugs are used by far more patients and will continue to drive spending."

Take the anti-PD(1)/PDL(1) class of drugs used to treat a variety of cancers. The first of these drugs—Merck's Keytruda and Bristol-Myers Squibb's Opdivo—were initially approved by the FDA in the second half of 2014 for a type of metastatic melanoma.[92] As of May 6, 2020, Keytruda was FDA-approved for 22 indications; Opdivo for 13.[93] As the number of FDA-approved indications for this class of drugs has grown, so have annual sales (see Figure 9). Keytruda and Opdivo are projected to be among the top five selling drugs by sales dollars in the US and globally by 2024.[94]

Figure 8: Two gene therapies could collectively cost the US health system up to nearly $80 per American in 2021

Projected annual cost per American: Zolgensma vs. Roctavian



Source: PwC Health Research Institute analysis of the potential cost of Zolgensma and Roctavian to the US health system on a per capita basis. See endnotes 84-91.
*Each scenario noted under brackets is $3 per American per year
Note: Zolgensma launched in the US in 2019, and Roctavian is expected to receive FDA approval in the second half of 2020. This figure analyzes the projected annual cost per American of Zolgensma and Roctavian and does not take into account cost savings seen by patients, employers and payers after the treatment is given.

Implications

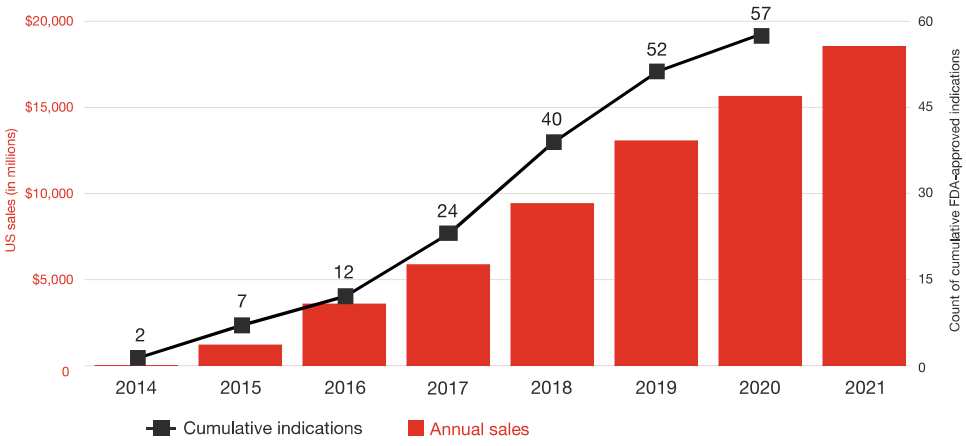
Payers/employers: Self-insured employers and payers should evaluate their abilities to cover new, high-priced therapies and consider partnering with other organizations such as financial institutions, pharmaceutical companies and even other payers with the balance sheet to weather one-time treatment costs of $1 million or more. Under Cigna's Embarc Benefit Protection, employers or other health plans would pay a set monthly fee to Cigna to cover two gene therapies—Luxturna and Zolgensma—at no additional cost to the employer or other health plan and with no out-of-pocket spending for the patient, while also supporting the patient throughout the course of treatment.[95]

Providers: Work with payers and employers to mitigate spending growth on administered drugs, most of which are high-priced specialty drugs, by delivering those therapies in the safest, lowest cost setting. During the COVID-19 pandemic, this could mean moving treatments completely out of the inpatient setting to an outpatient clinic, physician's office or even the patient's home. This could benefit the individuals with employer-based insurance who said that they or someone in their household regularly receives in-office or in-hospital treatments—nearly 60 percent of them said these routine treatments had been delayed because of COVID-19.[96]

Pharmaceutical and life sciences companies: Before the launch of a new drug, especially one with a price tag in the millions, engage with payers and employers on pricing and financing.[97] Make the case for the long-term cost savings. Consider alternative payment models, or a combination of models, to ease the financial burden on payers and employers: for example, a combination of a mortgage model that spreads the cost of an expensive therapy over time along with a health outcomes-based contract that offers full or partial reimbursement if patients don't respond to the therapy or reach a targeted health outcome.[98] Communicate the differentiating factors of new specialty drugs, especially if they are competing with other drugs that are already approved.

Figure 9: New indications for five cancer drugs have boosted sales since 2014

Anti-PD(1)/PDL(1) cumulative indications compared with annual sales



Source: PwC Health Research Institute analysis of GlobalData's Drug Sales and Consensus Forecast data for US-based sales of anti-PD(1)/PDL(1)s, Drugs@FDA data for anti-PD(1)/PDL(1)s and OptumRx's first quarter 2020 brand pipeline forecast.[99]
Note: This analysis included sales and FDA-approved indications for Keytruda, Opdivo, Tecentriq, Imfinzi and Libtayo. The cumulative number of indications includes each unique indication by drug. If two drugs in this class are approved for the same indication, that indication is counted twice. The FDA-approved anti-PDL(1) Bavencio was excluded from this analysis because no specific US sales data were available. The number of approved indications for 2020 includes four additional indications expected to be approved by the FDA for Imfinzi, Keytruda and Opdivo in 2020, according to the OptumRx first-quarter 2020 brand pipeline forecast.

Factors affecting 2021 medical cost trend

Deflator: Telehealth goes mainstream

While many questions remain as to what care will look like post-pandemic, most executives with health plans and employer coalitions interviewed by HRI agree that telehealth is here to stay. In 2021, HRI expects telehealth to put the brakes on medical cost trend as it replaces more costly in-person visits and lowers spending on downstream services and diagnostics.

Telehealth has grown slowly but steadily over the past decade. That changed in March as the federal government announced physical distancing guidelines and governors and mayors across the country asked, and in some places required, residents to stay at home to stop the spread of COVID-19.[100]

Health systems and physicians groups scrambled to move in-person visits to virtual as the pandemic hit the US (see Figure 10). A survey of physicians conducted by Merritt Hawkins in mid-April found that 48 percent are treating patients through telemedicine, up from 18 percent in 2018.[101]

Employers understand the benefits of telehealth. Ninety-five percent of employers surveyed by PwC in spring 2020 offered telemedicine through either their medical vendor or a carve-out vendor, up from 56% in 2016.[102] Sixty-four percent of employers surveyed by PwC in 2019 set employee cost sharing lower for telemedicine visits than in-person visits.[107] Yet adoption by employees remained low: Only 15% of consumers with employer-based insurance surveyed by HRI in early April reported using a video telehealth visit before the COVID-19 pandemic.[108]

Still, as in-person visits have been canceled or delayed en masse, consumer adoption of telehealth appears to be shifting dramatically. HRI estimates that 9 million Americans with employer-sponsored insurance may have used telehealth for the first time during the COVID-19 pandemic, based on findings from its April consumer survey.[109]

Many commercial insurers and large self-insured employers have waived cost sharing on telehealth visits, and these policies also may be encouraging consumers to try it out. The CARES Act allows employers to temporarily waive cost sharing for telehealth on high-deductible health plans.[110] In an analysis of recent press releases issued by 25 national and regional health plans, HRI found that 21 temporarily waived cost sharing for all telehealth visits on their fully insured large group plans (see Figure 11).

The federal government and some states have eased the transition to telehealth for providers financially. CMS is temporarily allowing providers to bill telehealth visits for Medicare beneficiaries at the same rate as an in-person visit.[111] Texas and Massachusetts issued temporary regulations requiring equal reimbursement between telehealth and in-person visits by commercial plans regulated by the state, including fully insured employer large group plans.[112] And some commercial payers are following suit: Aetna and Humana are reimbursing telehealth visits with in-network providers at the same rate as in-office visits.[113]

Looking ahead to 2021, executives with employer coalitions, healthcare coalitions and health plans told HRI that they see two opportunities for cost savings with telehealth. One is lower prices per visit compared with in-person visits. The second is savings from fewer diagnostics resulting from telehealth visits compared with in-person visits. In a 2017 analysis by Anthem comparing 4,600 telehealth visits with 55,000 in-person visits across multiple settings for the same conditions, telehealth visits resulted in fewer lab tests for pharyngitis, sinusitis, bronchitis and urinary tract infection relative to in-person visits to a primary care department, retail health clinic, urgent care center or emergency department.[114] Similarly, for bronchitis and sinusitis, telehealth visits resulted in lower imaging rates

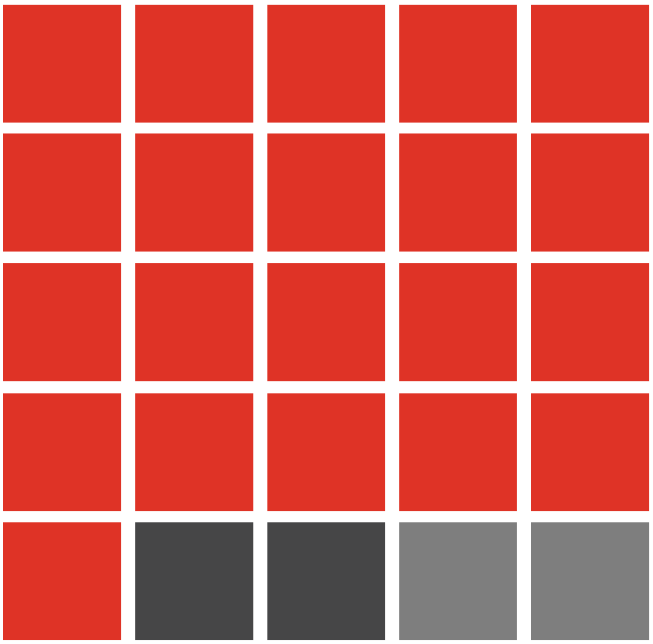
Figure 10: Care went mostly virtual in March, and providers had to scale up quickly

Organization	Telehealth results
Memorial Care Fountain Valley, CA	Implemented videoconferencing platform for patients in March; seeing more than 1,000 patients per week.
Teladoc Purchase, NY	Recorded roughly 2 million visits in the first quarter, up 92% from the first quarter of 2019.
Cleveland Clinic Cleveland, OH	Outpatient visits conducted remotely grew from 2% of total visits in early March to 75% in mid-April.
MDLive Miramar, FL	Daily visits were up by about 50% week over week in March, reaching 20,000 visits per day.

Source: See endnotes 103-106.

Figure 11: Most commercial insurers are temporarily waiving cost sharing on telehealth visits during the COVID-19 pandemic

Telehealth services: Coverage and cost sharing by health plan



Covers all services and waives all cost sharing

Covers some but not all services; waives cost sharing for covered services

Does not waive cost sharing for any services or is silent on cost sharing

Source: PwC Health Research Institute analysis of health plan press releases for 25 national and regional payers as of June 18, 2020. See endnotes 115-141.

relative to in-person visits.[142] Overall, the study estimated telehealth visits for the same conditions to be $162 cheaper than a visit to a primary care provider and $1,735 cheaper than a visit to an emergency department.[143]

"There is no going back on telehealth. And we have to figure out the proper reimbursement for it going forward," said Mary Grealy, president of the Healthcare Leadership Council, a coalition of payer, provider and pharmaceutical and life sciences executives based in Washington, DC, in an interview with HRI.

While many payers are reimbursing providers for telehealth visits at the same rate as in-person visits, this was not always the case. Before the COVID-19 pandemic, 42 states and the District of Columbia had laws addressing commercial payer telehealth reimbursement policies.[144] Of those, only five—Delaware, Georgia, Hawaii, Minnesota and New Mexico—required equal reimbursement for in-person and telehealth visits.[145]

Finding the right reimbursement rate for payers and providers is important and could be influenced by the downstream savings. "Understanding the episodic cost of telehealth visits—whether a prescription was written, an X-ray ordered, a blood draw ordered for labs, or an in-person follow-up visit is required—is crucial to understanding whether there are true cost savings compared to in-person visits," said Brian Renshaw, vice president and CFO of clinical solutions at Indianapolis-based Anthem, in an interview with HRI.

Some have expressed concerns that increased convenience will increase utilization and, in turn, spending. Even if telehealth increases utilization, many payers see the platform as an opportunity to get members the right care at the right time in the right place while also saving the member and the employer money. Many consumers are on board: 27% with employer-sponsored insurance said they would consider using telehealth for emergency situations, even if they have never used it before.[146] "Where medically appropriate, telehealth may help some patients avoid the ER," said Kassie Maroney, vice president of commercial markets actuarial at Health Care Service Corp., a health insurance company based in Chicago that operates Blue Cross Blue Shield plans in five states, in an interview with HRI. "You can pay for several telemedicine visits for the same cost as one trip to the ER."

Implications

Payers/employers: With telehealth utilization likely to remain up over pre-pandemic levels, payers should review their telehealth contracts and determine whether contracting with a national telehealth provider, local providers or both best fits the needs of its members. Payers also should consider the creation of virtual provider networks—something that may appeal to large employers with geographically dispersed employees. Payers can also help employers increase utilization of telehealth. Doing so may help them reduce absenteeism caused by employees taking time off for in-person visits.

Providers: The pivot to telehealth caught many providers and telehealth providers off-guard and unprepared to scale to high volume. Providers should reevaluate telehealth solutions with the expectation that this channel for care delivery may be the new normal. Providers will need to redesign the patient experience for a post-pandemic world around a heavily virtual system that is able to address chronic conditions and more complicated patients. They will need to redeploy resources and workforce to virtual health.

Pharmaceutical and life sciences companies: In 2018, only 8% of R&D executives surveyed by HRI said their companies had conducted a clinical trial that included remote clinical data collection outside a medical facility.[147] Post-pandemic, companies should prepare for virtual clinical trials to become the norm. Virtual trials could lead to faster drug development, by allowing for faster collection of some data and more frequent gathering of information about patients.[148] Additionally, diagnostics companies may need to rethink how they connect with physicians and payers to ensure that appropriate tests get ordered, completed and reimbursed when patients are seen virtually.

Factors affecting 2021 medical cost trend

Deflator: Networks narrow out of necessity

Hesitant to unload more costs on employees, employers are looking for ways to curb healthcare spending beyond traditional cost sharing. Employers increasingly are eyeing narrow network health plans, which limit the list of providers that employees or their families can see in-network, in exchange for lower premiums.[149] This shift could accelerate in 2021 as the economic fallout from the COVID-19 pandemic continues.

Studies of ACA marketplace plans, which have been faster to implement narrow networks, have found that limited choice creates cost savings. In a 2017 study on narrow network silver-tier marketplace plan premiums in eight states, researchers from Harvard and Northwestern universities found that plans with narrow physician and hospital networks were 16% cheaper than those with broad physician and hospital networks. The researchers also found that narrowing just one type of network was associated with a 6% to 9% decrease in premiums.[150]

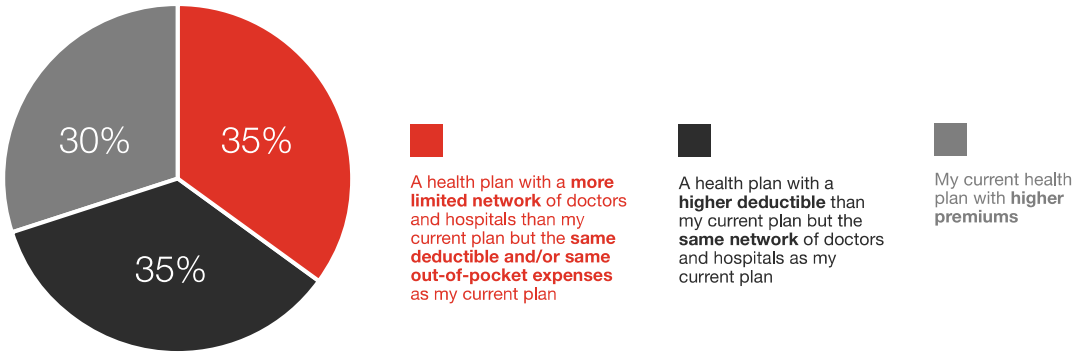
Amid the recession and with a focus on liquidity and the bottom line, employers likely will be looking for ways to save money while protecting employees' health. Narrow networks may help them do both. According to PwC's 2020 Touchstone survey of employers, 15% of respondents offered a narrow network.[151] Employers with more than 5,000 employees were more likely to pursue the strategy: 28% reported that they offered these networks in 2020.[152]

In March, Walmart, which covers more than a million employees and their family members through its health plans, announced its intention to expand on its network strategies.[153] The company already has seen positive results with its national Centers of Excellence program, which allows employees and family members with Walmart health plans to have certain surgeries and treatments at designated facilities throughout the US at generally no cost to them.[154] Under a new program, Walmart said it would pilot "curated physician networks" for eight specialties in three local markets in Arkansas, Florida and Texas starting in 2020.[155]

Some employees are open to the idea of the narrow network. Thirty-five percent of individuals with employer-sponsored insurance surveyed by HRI said that, to prevent an increase in premiums next year, they would choose a health plan with a more limited network of doctors and hospitals than their current plan, assuming the deductible and out-of-pocket costs remained unchanged (see Figure 12). But employers may still want to offer a narrow network plan as an option rather than a full replacement. Sixty-five percent of individuals with

Figure 12: Thirty-five percent of individuals with employer-sponsored health insurance would choose a narrow network plan next year to avoid higher premiums

Which of the following would you be most likely to select next year if it meant you could prevent an increase in your monthly premiums?



Source: PwC Health Research Institute consumer survey, April 28-May 8, 2020

employer-sponsored insurance surveyed by HRI said they would take an increase in their premiums or deductible and out-of-pocket costs over limiting their network of doctors and hospitals.[156]

As the pandemic eventually subsides and business returns closer to normal, a potential surge in deal activity could occur as struggling providers consider being acquired. HRI previously found that provider consolidation and physician employment tend to drive prices higher, at least in the short term.[157] Deals completed in late 2020 and in 2021 could mean higher prices starting in 2022. Narrow networks could be a defensive strategy for payers and employers to fend off higher prices from more highly consolidated providers. Creating a narrow network and taking on more risk for patient health outcomes in exchange for predictable cash flows could also be an offensive strategy for providers as they look to recover revenue lost from care deferred during the first wave of the pandemic and prepare for a potential second wave.

Implications

Payers/employers: Fallout from the COVID-19 pandemic could make 2021 the year of the narrow network. Plans that have embraced narrow networks for their individual exchange businesses may be well-positioned to roll out those networks on a broader scale for commercial large group business. Employers will need analytic capabilities to understand costs to inform strategy and a clear communication strategy to show value to employees, who may be skeptical of their value.

Providers: Providers positioning for inclusion in narrow networks will need to demonstrate quality while managing cost. They should pursue deals that help them build primary care networks that can address patients' whole health needs, including addressing the social factors affecting their health, and triage patients to the lowest cost setting appropriate for their health issue.

Pharmaceutical and life sciences companies: As narrow provider networks become more popular, providers may be shouldering more risk on treatment and patient outcomes. This could affect prescribing patterns and, in turn, how pharmaceutical companies promote their products to providers. Pharmaceutical companies should find the most effective ways to demonstrate their drugs' value and look for opportunities to collaborate with providers on population health management.[158]

Conclusion

Many factors that were driving or dampening spending before COVID-19 will continue, either accelerated or decelerated by COVID-19

Mental health utilization was expected to rise before the pandemic and is expected to go up even faster as a result of the pandemic.

Specialty drug spending is increasing as new drugs and new indications for existing drugs get approved. After postponing some review meetings in March and April, the FDA was caught up on approvals as of mid-April. While additional delays could occur as a result of the pandemic, they are unlikely to tamp down spending in a meaningful way.

Telehealth was slowly gaining traction before COVID-19. Overnight, the pandemic transformed it into the preferred way to deliver and receive care when possible—a preference that should have long-lasting impacts.

More payers and providers may join forces to create narrow networks. As more **narrow network** options become available, more employers likely will adopt them.

As the unemployment rate rises, the number of individuals with employer-sponsored insurance will decrease while the number of people who are uninsured or on Medicaid will increase—putting the brakes on revenue across the healthcare industry and prompting payers, providers, and pharmaceutical and life sciences companies to rethink their revenue mix and cost structure.

How exactly COVID-19 will affect employer healthcare spending in 2020 and 2021 remains unknown. Whether the changes in consumer health behavior resulting from the pandemic, including decreased use of the emergency room and increased use of telehealth, are here to stay and what impact they will have on employer healthcare spending also are unknown.[159] But healthcare will look different after the pandemic.

Appendix: Employer per capita spending scenarios

In interviews, health plan actuaries told HRI that before the COVID-19 pandemic, health plans expected 2021 medical cost trend to be in line with the expected 2020 medical cost trend. In light of the pandemic, HRI was told that healthcare spending in 2020 likely will be lower than the expected trend of 6% and that spending likely will rise in 2021. But exactly how low spending will wind up in 2020 and then rise in 2021 will be determined by many variables. To illustrate this, HRI developed three employer per capita spending scenarios that align with the three medical cost trend scenarios (see Figure 13). A high scenario assumes a full but slower recovery to expected (baseline) spending in the absence of COVID-19 by January followed by an increase in spending over expected spending in 2021 due to the return of care previously delayed, resulting in a 10% medical cost trend in 2021. A medium spending scenario assumes a quick and full recovery to expected spending in 2020, resulting in a 6% medical cost trend in 2021. And a low spending scenario assumes a second wave of COVID-19 that continues to dampen spending below expectations in 2020 and 2021, resulting in a 4% medical cost trend in 2021.

The baseline spending in the absence of COVID-19 (in red) is used to contrast against the impact of the COVID-19 pandemic (in black) under three different scenarios (see charts in Figure 13 on the following pages). The pandemic in all cases is modeled in the same way at first with a precipitous fall in spending on healthcare starting in March 2020 as the savings from care deferred by individuals with employer-sponsored insurance outweighs the cost of treating COVID-19 for the same population. In each case, the COVID-19 impact on spending reaches its low point relative to expected spending in April, with spending at 50% of the previously expected baseline. Each scenario illustrates the impact of a possible course for the pandemic. These scenarios are not intended to be exhaustive of all potential spending scenarios.

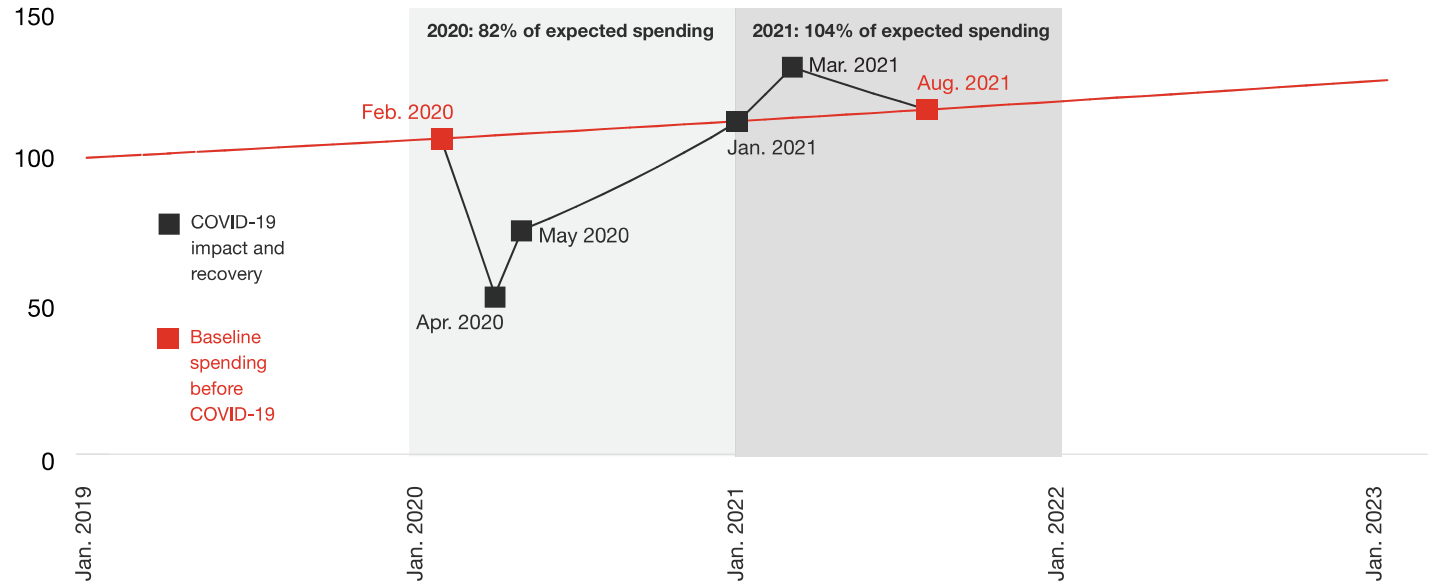
Assumptions used in all three spending scenarios:

- The charts presented show the trend line for medical spending per individual in employer-sponsored health insurance plans.
- Baseline spending is indexed to 100 in January 2019, growing at a 6% annual growth rate for 2019-23, compounded monthly.
  - For ease of comparison, the baseline spending is shown to grow at a constant percentage each month, averaging 6% growth for the year.
  - The baseline spending from January 2019 to January 2023 (shown as a red line in each chart) is meant to be only a rough guide of expectations for actuaries and economists before the pandemic and does not represent specific spending amounts or the growth rate for any particular insurer or employer.
- Under each scenario, under the pandemic, spending begins to fall below the baseline in March 2020: 75% of baseline spending assumed for March (shown as a black line in each chart).
- Spending bottoms out in April 2020: 50% of baseline spending assumed for April.
- Spending bounces back fairly quickly in May 2020: 70% of baseline spending assumed for May.
- Spending recovery after May 2020 varies among the scenarios. The spending recovery assumptions for each scenario are noted next to each one below.
- All three scenarios assume that eventually spending returns to the baseline growth rate. HRI acknowledges that spending may instead settle into a new growth rate at some point in the future that could be more or less than the baseline growth rate assumed in these scenarios of 6% annually.

Figure 13: Employer per capita spending will recover, but when and how much are still unknown (1 of 3)

High scenario

One wave of COVID-19 in spring 2020, recovery to the baseline by 2021 and spending above the baseline in 2021 as care deferred in 2020 is delivered



Assumptions

- One wave of COVID-19: Spending dips in March 2020, bottoms out in April and bounces back in May.
- Spending recovery continues at a slower rate from June to January 2021.
- Spending fully recovers to the baseline in January.
- Spending starts to rise above the baseline in February, peaking at 115% of expected spending in March 2021.
- Spending begins to come back down in April 2021, returning to the baseline in August 2021.

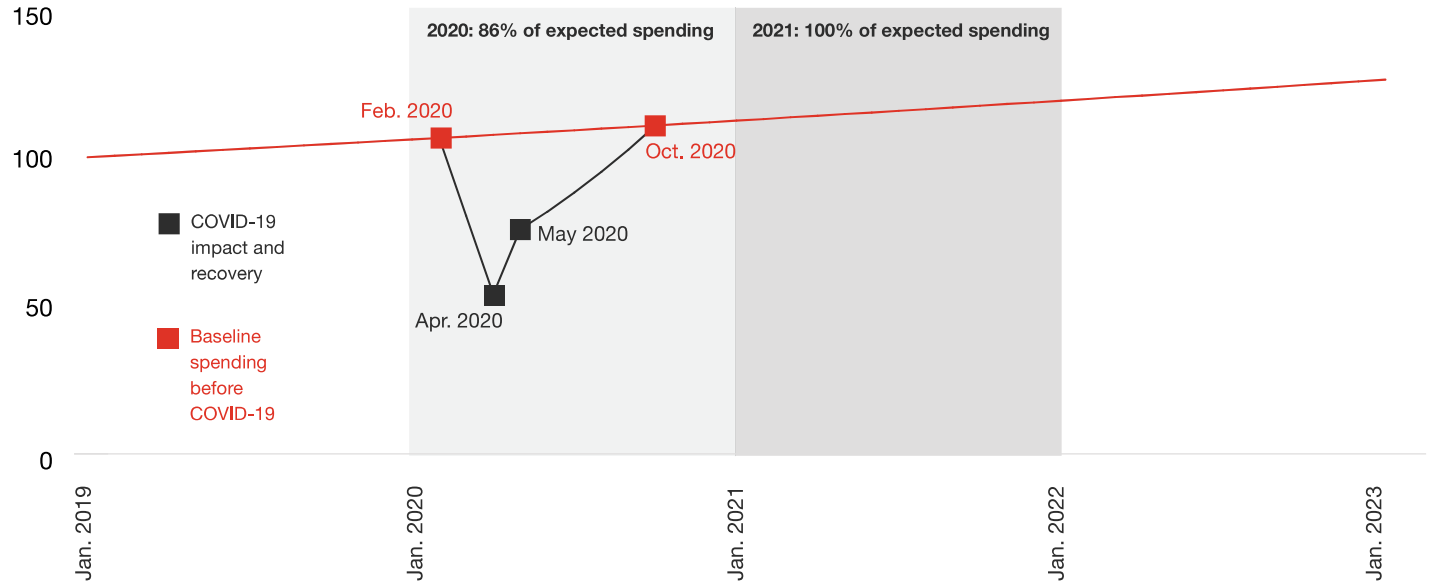
Key takeaways

- 82% of expected spending would occur in 2020.
- 104% of expected spending would occur in 2021.
- Medical cost trend for 2021 would rise to 10%.

Figure 13: Employer per capita spending will recover, but when and how much are still unknown (2 of 3)

Medium scenario

One wave of COVID-19 in spring 2020, recovery to the baseline in 2020



Assumptions

- One wave of COVID-19: Spending dips in March 2020, bottoms out in April and bounces back in May.
- Spending recovery continues at a slower rate from June to October.
- Spending fully recovers to the baseline in October.

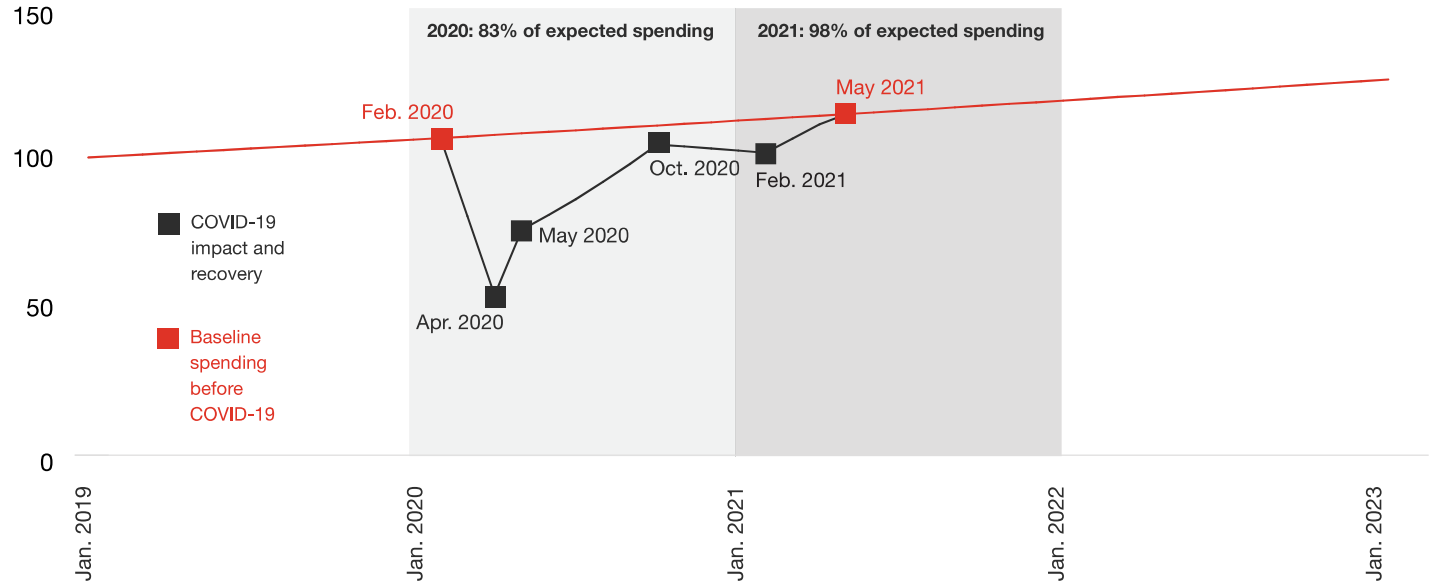
Key takeaways

- 86% of expected spending would occur in 2020.
- 100% of expected spending would occur in 2021.
- Medical cost trend for 2021 would go back to the baseline of 6%.

Figure 13: Employer per capita spending will recover, but when and how much are still unknown (3 of 3)

Low scenario

One wave of COVID-19 in spring 2020 and a second wave in late 2020/early 2021, with a full recovery to the baseline in 2021



Source: PwC Health Research Institute modeling of potential COVID-19 employer per capita healthcare spending scenarios
Note: The scenarios shown above for healthcare spending were modeled on the approach taken by Louise Sheiner and Kadija Yilla of the Hutchins Center on Fiscal & Monetary Policy at the Brookings Institution to model the impacts of COVID-19 and post-pandemic recovery on GDP.[160]

Assumptions

- First wave of COVID-19: Spending dips in March 2020, bottoms out in April and bounces back in May.
- Spending recovery continues at a slower rate from June to October.
- Second wave of COVID-19 hits before spending fully recovers.
- Second wave: Spending dips in November and continues to fall, but at a slower rate than during the first wave, December to February 2021.
- Spending bottoms out in the second wave in February at 90% of baseline spending.
- Spending recovery begins in March 2021 with complete recovery to the baseline by May 2021.

Key takeaways

- 83% of expected spending would occur in 2020.
- 98% of expected spending would occur in 2021.
- Medical cost trend for 2021 would fall to 4%.

Endnotes

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About this research

Each year, PwC's Health Research Institute (HRI) projects the growth of private medical costs in the coming year and identifies the leading trend drivers. Health insurance companies use medical cost trend to help set premiums by estimating what this year's health plan will cost next year. In turn, employers use the information to make adjustments in benefit plan design to help offset cost increases. The report identifies and explains what it refers to as "inflators" and "deflators" to describe why and how the healthcare spending growth rate is affected.

This forward-looking report is based on the best available information through June 2020. HRI conducted 23 interviews from February through May 2020 with health industry executives, health benefits experts and health plan actuaries whose companies cover more than 90 million employer-sponsored large group members about their estimates for 2021 and the factors driving those trends.

Included are findings from PwC's 2020 Health and Well-being Touchstone Survey of 440 employers from 35 industries, and two national consumer surveys conducted by HRI: one of 10,000 US consumers on the effects of the COVID-19 pandemic on health behavior, fielded between April 2 and 17, 2020, and a second survey of 2,500 US consumers on health behaviors and health spending decisions, fielded between April 28 and May 8, 2020. HRI also examined government data sources, journal articles and conference proceedings in determining the 2021 growth rate.

"Behind the Numbers 2021" is HRI's 15th report in this series.

About the PwC network

At PwC, our purpose is to build trust in society and solve important problems. We're a network of firms in 157 countries with more than 276,000 people who are committed to delivering quality in assurance, advisory and tax services. Find out more and tell us what matters to you by visiting us at pwc.com.

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PwC's HRI provides new intelligence, perspectives and analysis on trends affecting all health-related industries. HRI helps executive decision-makers navigate change through primary research and collaborative exchange. Our views are shaped by a network of professionals with executive and day-to-day experience in the health industry. HRI research is independent and not sponsored by businesses, government or other institutions.

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Updated June 23, 2020

Aggressive State Outreach Can Help Reach the 12 Million Non-Filers Eligible for Stimulus Payments

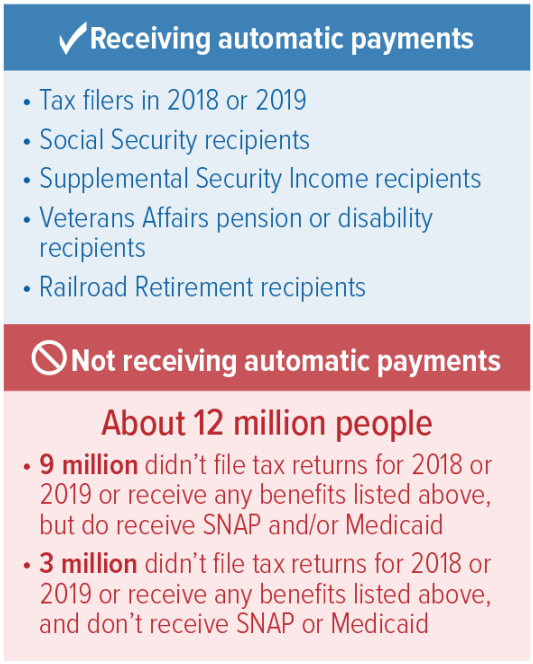
By Chuck Marr, Kris Cox, Kathleen Bryant, Stacy Dean, Roxy Caines, and Arloc Sherman

About 12 million Americans risk missing out on the stimulus payments provided through the recent CARES Act because they, unlike millions of people who are receiving the payments automatically from the IRS, must file a form by October 15 to receive it this year, or file a 2020 tax return next year to receive it in 2021. (This estimate, based on CBPP analysis of Census data, is approximate; please see Appendix II for our methodology.)[1] This group includes very low-income families with children, people who have been disconnected from work opportunities for a long period, and many low-income adults not raising children in their home.

Governors and other state officials can play a central role in reaching these 12 million individuals, up to 9 million of whom — roughly 3 in 4 — participate in SNAP (formerly food stamps) or Medicaid, which states and counties administer.[2]

This group of non-filers eligible for payments are disproportionately people of color because they are likelier to have lower incomes due to historical racism and ongoing bias and discrimination. Twenty-seven percent of the 9 million people are Black — higher than their share of the U.S. population (12 percent)

Through SNAP and Medicaid, States Can Reach Many Not Receiving *Automatic* Stimulus Payments



Source: CBPP analysis of the U.S. Census Bureau's Current Population Survey for 2015-2017, with corrections for underreported SNAP and SSI from the Department of Health and Human Services/Urban Institute Transfer Income Model (TRIM)

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[1] These estimates are affected by underreporting of income and benefits, recent changes in program participation, and other data limitations.

[2] We focus on SNAP and Medicaid because they are the two programs with the broadest eligibility and enrollment and with funding structures that allow them to serve all eligible persons who apply. Many people eligible for the stimulus

— while another 19 percent are Latino. Ensuring that low-income people of color receive the payments for which they qualify is especially important given emerging evidence that they are being hit hardest by both the economic and health effects of the pandemic.

The IRS, working with the Social Security Administration, Department of Veterans Affairs, and Railroad Retirement Board, has been automatically delivering the CARES Act stimulus payments (technically called Economic Impact Payments or EIPs) to tens of millions of people who regularly file federal income taxes or receive certain federally administered benefits, such as Social Security, Supplemental Security Income (SSI), Railroad Retirement, or Veterans Affairs pension or disability benefits. Eligible adults receive $1,200 plus $500 for each eligible child.

But the automatic payment method *misses* about 12 million people — adults and children — because they aren't required to file federal income tax returns due to their low incomes and they do not participate in one of those specified, federally administered programs.[3] Together, these people are eligible to receive $12 billion in payments. (See Table 1 for state-by-state estimates.)

To receive the payments this year, these individuals must provide their information to the IRS no later than October 15 through either a 2019 tax return or the IRS "Non-Filer" tool, a simplified online form for people not required to file a tax return.[4] The tool requires a user to create an online account, enter certain personal information (including direct deposit information, if available), verify their email address, and submit the form. The IRS plans to issue all payments before the December 31, 2020 deadline in the CARES Act.

An aggressive outreach program is needed at the state and local levels to inform eligible individuals, who by definition have very low incomes, that they are eligible and to help them undertake the required steps. Such outreach efforts will benefit both individuals and communities. The payments are considerable, both for the recipients and by other standards of assistance; in some states, the amount of money at stake is as much as ten times the state's total annual cash assistance to families with children. These funds would go to extremely low-income individuals and families at a time when need is rising due to the pandemic. And ensuring these people apply for and receive the

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payments who are enrolled in SNAP and/or Medicaid also participate in other state-operated programs, most notably cash assistance through Temporary Assistance for Needy Families.

[3] The IRS issued over 159 million payments to households as of June 3, which includes both automatic payments and payments to people who provided their information through the Non-Filer form. The Government Accountability Office estimated that 4.3 million of these payments were sent to non-filers as of May 22, and the House Ways and Means Committee estimated that 10.7 million non-filers may not yet have completed the Non-Filer form, implying 15 million non-filers in total. Our estimate of 12 million people refers to those who did not *qualify* for an automatic payment from the IRS; it thus differs slightly from the 10.7 million estimate by including some non-filers who already submitted the Non-Filer form to apply for the payment. Differences in the year of the data, data sources, and methodology may also help account for the different estimates. Our estimates suggest that *up to* 12 million people risk missing out if they don't fill out the Non-Filer form by October 15 (if they haven't already) or file a 2020 tax return next year. House Committee on Ways and Means, "Economic Impact Payments Issued to Date," June 5, 2020, https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/2020.06.04%20EIPs%20Issued%20as%20of%20June%204%20FINAL.pdf

[4] Internal Revenue Service, "Non-Filers: Enter Payment Info Here," updated May 18, 2020, https://www.irs.gov/coronavirus/non-filers-enter-payment-info-here. People who miss the October. 15 deadline can also file a 2020 tax return (in early 2021) to receive the payment next year.

payments for which they qualify will also benefit local and state economies, in which much of the money will be spent.

Governors and other state officials can play a vital role in reaching the 12 million eligible people. The health and human services agencies that administer SNAP and Medicaid are uniquely positioned to reach, using established communication channels, the subgroup of 9 million people who participate in those two programs. Governors and state agencies can also do much to reach the other 3 million eligible people, who generally do not receive state or federal benefits. Public education efforts and partnerships with key stakeholder groups, such as service providers for people experiencing homelessness, will be critical to connecting people to the $1,200 payments.

In addition, if federal policymakers issue additional stimulus payments to boost economic demand and reduce hardship, state efforts now to connect eligible low-income individuals with the tax system should pay dividends in helping these people access any future rounds of payments.

Background on Stimulus Payments

The CARES Act, signed into law on March 27, includes stimulus payments to support overall consumer demand amidst historic job losses and business closures and to help families deal with the fallout from the COVID-19 crisis. The payments are designed to be significant — $1,200 per adult ($2,400 for a married couple) and $500 per dependent child — and broad-based; unlike the payments provided during the Great Recession,[5] they are available to people with the lowest incomes. Moreover, there is no earnings test, so people with zero earnings are eligible for the full amounts. The payments begin phasing out at incomes of $150,000 for married couples, $112,500 for heads of households, and $75,000 for singles. Unfortunately, the law unreasonably excludes certain groups from the payments. Immigrant families (except for certain military families) are ineligible if any adult or spouse (if filing jointly) lacks a Social Security number. Also ineligible are 17-year-olds, college students whom their parents can claim as dependents, and adult dependents.

To deliver these payments to the nation's roughly 300 million eligible people, policymakers chose the IRS, which has contact with a large share of the population. The payments, therefore, are designed as a tax credit. They are "fully refundable," meaning that eligible households receive the full amount regardless of what — if anything — they pay in federal income tax. Importantly, because the country is in the middle of a crisis, the law instructs the Secretary of the Treasury (who oversees the IRS) to deliver the payments "as rapidly as possible."

The IRS, working with other agencies, has been delivering the payments using a generally step-by-step approach, starting with payments to the people easiest to reach. First up were people who filed federal income tax returns in 2018 or 2019 and for whom the IRS had direct deposit information. Then, the IRS began working with the Social Security Administration and the Railroad Retirement Board to automatically deliver payments to retirees and persons with disabilities who receive Social Security or Railroad Retirement benefits but do not typically file tax returns. Next up for automatic payments were recipients of SSI or veterans' pension or disability benefits who do not file tax returns.

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[5] Internal Revenue Service, "Economic Stimulus Payments On The Way; Some People Will See Direct Deposit Payments Today," April 28, 2008, https://www.irs.gov/pub/irs-news/ir-08-066.pdf.

For these groups, the process of delivering payments has gone relatively smoothly, especially considering the depleted state of the IRS after nearly a decade of funding cuts.[6] The challenge now is to ensure that the remaining 12 million people, who neither file federal income tax returns nor receive certain federal benefits, receive the payments for which they are eligible "as rapidly as possible," as the law mandates. In addition to developing the "Non-Filer" tool described above for people who don't typically file tax returns, the IRS has expanded its outreach efforts beyond its usual partners to reach non-filers with low incomes and those in the military, veteran, and homeless communities.[7] But many non-filers are not connected to traditional channels of information and are likely to miss out on payments without additional efforts.

Remaining 12 Million Eligible People Have Very Low Incomes

By definition, the estimated 12 million people not receiving payments automatically have very low incomes because they aren't required to file federal income tax returns.[8] Only people with annual income *above* the following levels have a legal obligation to file a return for 2020: $12,400 for singles, $18,650 for heads of household (such as a single parent with children), and $24,800 for married couples.[9] (Many people with incomes below those thresholds do file federal income tax returns in order to claim the Earned Income Tax Credit [EITC] or Child Tax Credit. Low-income families with children have an incentive to file a return to claim these tax credits, as do adults not raising children in their homes, though to a lesser degree.[10])

The 12 million group is predominantly non-elderly. Many senior citizens are receiving automatic payments because they receive Social Security, Railroad Retirement, SSI, or veterans' pensions or disability benefits. Up to 1 million seniors, though, may be eligible for payments but do *not* receive them automatically.

The outstanding payments amount to roughly $12 billion nationally, which — if delivered and spent — would not only reduce hardship but also give state and local economies a much-needed boost (See Appendix Table 1 for an estimate of outstanding payments and amounts by state).

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[6] Samantha Washington, "IRS Stimulus Glitches Show Cost of Earlier Cuts," Center on Budget and Policy Priorities, April 28, 2020, https://www.cbpp.org/blog/irs-stimulus-glitches-show-cost-of-earlier-cuts.

[7] Charles Rettig, "A message from the Commissioner – Economic Impact Payments: IRS helping 150 million Americans one payment at a time," Internal Revenue Service, April 14, 2020, https://www.irs.gov/newsroom/a-message-from-the-commissioner-economic-impact-payments-irs-helping-150-million-americans-one-payment-at-a-time.

[8] An early, tentative estimate by the New America Foundation found that 6 million people would miss out on automatic payments because they aren't required to file tax returns. Estimating this population is difficult and, as the New America authors acknowledge, estimates are subject to uncertainty. Tara Dawson McGuinness and Gabriel Zucker, "Congress Appropriated $300 Billion in Relief Payments to Individuals and Families – but Poor Delivery May Prevent Tens of Millions of Americans from Ever Accessing Them," New America, April 8, 2020, https://www.newamerica.org/public-interest-technology/reports/relief-payments-poor-delivery-may-prevent-tens-of-millions-of-americans-from-accessing/.

[9] People with self-employment income greater than $400 are also required to file tax returns.

[10] Nina Olson, "Earned Income Tax Credit: Making the EITC Work for Taxpayers and the Government," Internal Revenue Service: National Taxpayer Advocate, June 2019, https://taxpayeradvocate.irs.gov/Media/Default/Documents/2020-JRC/JRC20_Volume3_Final.pdf. Our 12 million estimate excludes people who likely qualify for these credits.

SNAP and Medicaid Agencies Can Reach About 9 Million Eligible People Not Receiving Automatic Payments

We estimate that approximately 9 million of the 12 million people who won't automatically receive the payments receive state- or county-administered benefits such as SNAP or Medicaid, a fact that underscores the key role for state government in reaching this group. (See Figure 1.) They have low incomes and are among those who most need the payments to cover essential expenses. The payments for which they qualify, worth a combined $9 billion, represent a significant sum both individually and collectively. In Alabama and North Carolina, for example, their payments total an estimated $209 million and $324 million, respectively, or *nine to ten times* the amount of basic cash assistance those states provide annually through their Temporary Assistance for Needy Families (TANF) programs ($20 million and $37 million), our estimates suggest.[11]

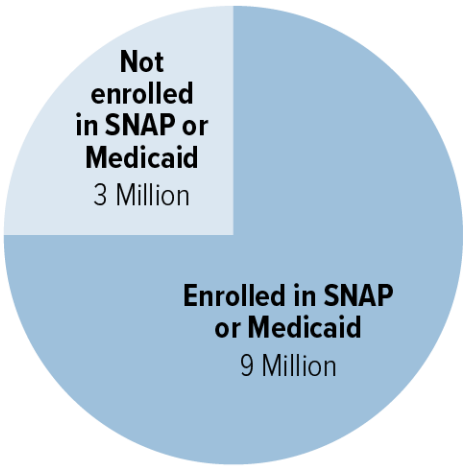
While many SNAP and Medicaid recipients file federal income tax returns and hence will receive their payments automatically, state agencies are the primary organizations able to reach those who don't file.[12] State agencies are uniquely placed to use existing contact information to alert eligible people about the payments and connect them with services to help them obtain their payment.[13]

As state agencies reach out to the 9 million people, the following groups would be useful targets for outreach efforts:

- **Very low-income children.** About 3.2 million of the 9 million people — that is, more than one-third — are under age 17, which exceeds their share of the U.S.

FIGURE 1

States Can Use SNAP and Medicaid to Reach Most of 12 Million People Not Receiving Automatic Stimulus Payments



Source: CBPP analysis of the U.S. Census Bureau's Current Population Survey for 2015-2017, with corrections for underreported SNAP and Supplemental Security Income from the Department of Health and Human Services/Urban Institute Transfer Income Model (TRIM).

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[11] Center on Budget and Policy Priorities, "State Fact Sheets: How States Spend Funds Under the TANF Block Grant," updated February 25, 2020, https://www.cbpp.org/research/family-income-support/state-fact-sheets-how-states-spend-funds-under-the-tanf-block-grant.

[12] SNAP and Medicaid know which of their participants have income through Social Security, SSI, Veterans Affairs, and the Railroad Retirement Board and therefore are likely receiving their payment automatically. They will not know which households are receiving the payment because the household filed a federal tax return in one of the last two years.

[13] Because SNAP and Medicaid assistance units don't align precisely with tax filing units (that is, people who appear on the same tax return), agency efforts may reach people in multiple tax units, with each tax unit eligible for a payment. For

population overall (22 percent).[14] (See Figure 2.) Roughly 1 in 5 of the households that include these children participate in TANF as well as SNAP and/or Medicaid.

- **Adults not raising children in their home.** More than 40 percent of the 9 million people are adults without children under age 17. Roughly one-quarter of these childless adults are themselves under age 25, and could include youth aging out of foster care, low-income students, and others struggling to get by on their own. Another third of these childless adults are between 50 and 65, and might include people with limited job skills or disabilities.
- **People of color.** Twenty-seven percent of the 9 million people are Black — higher than their share of the U.S. population (12 percent) — while another 19 percent are Latino. Forty-eight percent are non-Latino white, making them the largest single racial-ethnic group, but this share is lower than in the U.S. population (61 percent). Ensuring that low-income people of color receive the payments for which they qualify is especially important given emerging evidence that they are being hit hardest by both the economic and the health effects of the pandemic.[15]
- **People with lower education levels.** Some 19 percent of the 9 million people have no family member with a high school degree, almost three times the rate in the general population. People with less education are among those especially vulnerable during the current crisis: almost half of people with a high school degree or less have had someone in their household lose a job or hours due to the pandemic, and two-thirds report having insufficient savings to cover three months of bills and expenses in an emergency.[16]
- **People lacking secure housing.** Many individuals who do not have permanent housing have very low incomes and are likely to be among the non-filer population.

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example, a SNAP household might include a mother and child who are doubled up in the same apartment with the grandmother and an elderly aunt. This household could represent three tax filing units — each eligible for a payment — but just one SNAP household if the four individuals purchase and prepare food together.

[14] These children may include dependents of people who received automatic payments. Adult recipients of Social Security, Railroad Retirement, SSI, and veterans' pension or disability benefits received a payment for themselves but have to file a 2020 tax return to receive the additional $500 for their dependent, where applicable.

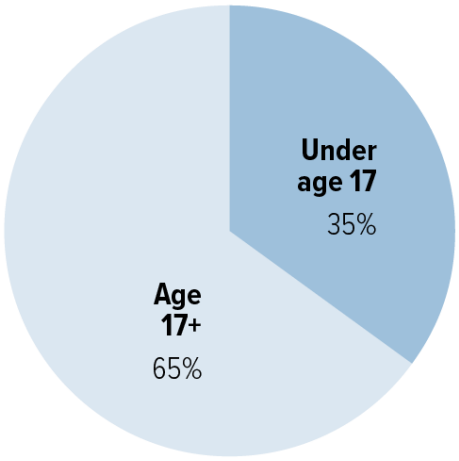
[15] Kim Parker, Juliana Menasce Horowitz, and Anna Brown, "About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID-19," Pew Research Center, April 21, 2020, https://www.pewsocialtrends.org/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-covid-19/; Centers for Disease Control and Prevention, "COVID-19 in Racial and Ethnic Minority Groups," updated April 22, 2020, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html.

[16] Parker, Menasce Horowitz, and Brown, *op. cit.*

FIGURE 2

Outreach Through SNAP and Medicaid to People Not Receiving Automatic Stimulus Payments Would Benefit Many Children

Individuals not receiving automatic payments who participate in SNAP and/or Medicaid, by age group



Source: CBPP analysis of the U.S. Census Bureau's Current Population Survey for 2015-2017, with corrections for underreported SNAP and Supplemental Security Income from the Department of Health and Human Services/Urban Institute Transfer Income Model (TRIM).

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Table 1 gives state-by-state estimates of the number of individuals among the 9 million non-filers who receive SNAP and/or Medicaid, and the resulting funds that would flow into state economies if payments reached all of them. (Appendix Table 1 shows state-by-state estimates of the number of individuals and the payment amounts among the 12 million non-filers. Appendix Table 2 shows more detailed state-by-state estimates of the subgroup of roughly 6.5 million SNAP recipients who were likely missed by automatic payments.)

TABLE 1

Estimated Adults and Children Missed by Automatic Payments Who Receive SNAP and/or Medicaid Benefits

	Total individuals	Potential total payments (in millions of dollars)
United States	**9,270,000**	**$9,000**
Alabama	220,000	$209
Alaska	26,000	$24
Arizona	200,000	$198
Arkansas	110,000	$101
California	1,082,000	$1,035

TABLE 1

Estimated Adults and Children Missed by Automatic Payments Who Receive SNAP and/or Medicaid Benefits

	Total individuals	Potential total payments (in millions of dollars)
Colorado	*	*
Connecticut	*	*
Delaware	27,000	$28
District of Columbia	35,000	$35
Florida	750,000	$742
Georgia	383,000	$365
Hawaii	33,000	$33
Idaho	*	*
Illinois	312,000	$309
Indiana	162,000	$146
Iowa	*	*
Kansas	*	*
Kentucky	171,000	$162
Louisiana	233,000	$ 221
Maine	*	*
Maryland	*	*
Massachusetts	159,000	$158
Michigan	308,000	$293
Minnesota	*	*
Mississippi	145,000	$133
Missouri	143,000	$140
Montana	19,000	$18
Nebraska	*	*
Nevada	87,000	$83
New Hampshire	*	*
New Jersey	186,000	$182
New Mexico	105,000	$101
New York	625,000	$616
North Carolina	340,000	$324
North Dakota	16,000	$15
Ohio	394,000	$358
Oklahoma	130,000	$126
Oregon	118,000	$113
Pennsylvania	363,000	$337
Rhode Island	30,000	$31

TABLE 1

Estimated Adults and Children Missed by Automatic Payments Who Receive SNAP and/or Medicaid Benefits

	Total individuals	Potential total payments (in millions of dollars)
South Carolina	213,000	$194
South Dakota	27,000	$24
Tennessee	215,000	$ 213
Texas	685,000	$624
Utah	*	*
Vermont	14,000	$13
Virginia	191,000	$177
Washington	185,000	$179
West Virginia	100,000	$94
Wisconsin	*	*
Wyoming	*	*

*Sample size too small. See the Appendix tables for other state-by-state estimates. Source: CBPP analysis of the U.S. Census Bureau's Current Population Survey for 2015-2017, with corrections for underreported SNAP and SSI from the Department of Health and Human Services/Urban Institute Transfer Income Model (TRIM).

While the 9 million people receiving SNAP and/or Medicaid will be the easiest for states to reach, 3 million other people eligible for payments may be outside the reach of SNAP and Medicaid state agencies. More than half of them are non-elderly adults not raising children at home.[17] Though some may receive other state- or locally administered benefits or be connected to community-based organizations, overall this group tends to be less connected to services and can include people experiencing job or earnings loss, housing insecurity, or homelessness.

Payments for This Group Can Provide Effective Economic Stimulus

The CARES Act payments are a key pillar of the federal fiscal stimulus measures designed both to help families cope with the loss of jobs and income in the pandemic and to offset the strong downward pressure on the overall economy. The payments for the 12 million people at risk of missing out on them would be particularly effective in boosting economic activity because these individuals have very low incomes and tend to live close to the edge, spending (rather than saving) any additional money they receive. High-income people, in contrast, tend not to live paycheck to paycheck and save at relatively high levels.

[17] Some childless adults whom our estimates classify as not participating in SNAP may *now* participate because the program's three-month time limit for adults aged 18-50 who aren't employed or raising minor children has temporarily been suspended during the public health emergency. See Ed Bolen, "Unemployed Workers Can Get SNAP During Health Emergency," Center on Budget and Policy Priorities, April 2, 2020, https://www.cbpp.org/blog/unemployed-workers-can-get-snap-during-health-emergency.

Payments to very low-income people are among the most effective ways to stimulate the economy during a recession, a Congressional Budget Office (CBO) analysis issued during the Great Recession found.[18] CBO estimated that a tax cut for high-income people would yield 20 to 60 cents of economic activity (measured by gross domestic product) for every dollar of cost, because relatively few of those recipients would spend the money. By contrast, a tax cut for low- and moderate-income people would generate 60 cents to $1.50 of economic activity per dollar of tax cut. CBO also estimated that an added dollar of SNAP or unemployment insurance would generate 80 cents to $2.10 in economic activity; these types of stimulus are so effective because both groups tend to be highly cash-constrained. The 12 million eligible people discussed in this report are arguably even more cash-constrained, so delivering payments to this group would be extremely effective stimulus.

Governors and State SNAP, Medicaid Agencies Have Key Role

Governors and state agencies that administer SNAP and Medicaid can play a central role in raising awareness about the payments and connecting non-filers with assistance in getting them. Governors can direct agencies to use available resources to identify individuals eligible for the payments and provide support to help this vulnerable group apply. They also can use their leadership positions to educate the public and organize statewide outreach efforts; governors have led many past outreach efforts, such as campaigns to promote federal tax refunds, children's health care coverage, and immunization campaigns. Governors can drive such efforts through their chief-executive authority, their convening power, and by leveraging their ability to drive significant earned and unearned media interest (that is, through traditional press stories and paid advertising). In states that administer SNAP and/or Medicaid at the county level, county leaders can play a similar role.

State agencies administering SNAP and Medicaid also can help identify people eligible for the payments and educate them about their eligibility and how to claim the funds. Though many of these agencies face overwhelming workloads now, incorporating this outreach into their regular activities would yield a high impact at relatively low cost. These agencies have daily contact with program participants by phone, in person, or in writing.

Many states have online portals where SNAP or Medicaid recipients can manage their benefits or report changes; 17 states have already posted to their websites basic information about the payments and how to apply (see Appendix III), and other states could as well.[19] For example, states can link to the IRS website and its online form for non-filers to complete in order to receive their payment. States also can provide educational and outreach materials to other government and nonprofit service providers. Some states provide application kiosks and staff to assist applicants in their office lobbies. While most state health and human services offices are currently closed, as they reopen they could provide access to the IRS Non-Filer form, as well.

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[18] All multipliers from Congressional Budget Office, "Estimated Impact of the American Recovery and Reinvestment Act on Employment and Economic Output From April 2010 Through June 2010," August 2010, https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/reports/08-24-arra.pdf. The U.S. Department of Agriculture's (USDA) most recent estimates find that every dollar in new SNAP benefits spent when the economy is weak and unemployment is elevated would increase gross domestic product by $1.54. See Patrick Canning and Rosanna Mentzer Morrison, "Quantifying the Impact of SNAP Benefits on the U.S. Economy and Jobs," USDA, Economic Research Service, July 18, 2019, https://www.ers.usda.gov/amber-waves/2019/july/quantifying-the-impact-of-snap-benefits-on-the-us-economy-and-jobs/.

Moreover, state agencies have contact information for program participants and have many opportunities for direct communication with those potentially eligible. They are in direct written contact through text, email, and regular mail regarding the participants' SNAP or Medicaid benefits and could insert information about how to apply for the payments with those routine communications. (For example, in an email to 93,000 individuals in households participating in SNAP and TANF about the availability of free tax preparation services through VITA, Connecticut Governor Ned Lamont and the Department of Social Services included information about the EIP.) Agencies are also routinely in contact with some participants over the phone, particularly through their call centers. Some of the eligible group will have in-depth interactions with these agencies; for example, a large majority of families participating in state cash assistance programs will likely be in touch with their caseworker over the summer months to renew their benefits or address other issues. This type of interaction represents an excellent opportunity for the state to explain a family's potential eligibility for the payment and help them apply.

Millions of other individuals contact states via phone or the internet every day. While waiting on hold at a call center or conducting business online, they could receive information about the payments and how non-filers can apply. Local human services offices generally inform their eligibility workers and call center staff about other community resources available to families, such as local food banks and other community-based resources, and states could include information about the payments in their materials for eligibility workers so they can provide accurate information.

To contact some non-filers who might not be connected to SNAP or Medicaid, such as very low-income adults without children and people who lack secure housing (including those who are homeless), state agencies can also ask their contracted service providers and other community partners to reach out. The combined efforts of state and community organizations can vastly increase the number of eligible people who actually receive their payments.

Governors and state agencies can also help potentially eligible non-filers connect with third-party organizations that can help them apply accurately and free of charge. Unscrupulous entities and individuals may try to scam individuals out of their payment; states can use their communication networks to help push against these fraudulent efforts and direct eligible individuals to trusted helpers and to correct information.

Community-Based Organizations and Local Officials Also Vital

Community-based organizations and local officials can also play a vital role in helping connect non-filers to economic impact payments. Both serve as essential outreach channels for the EITC and other public awareness campaigns. Community organizations such as community action agencies, faith-based organizations, and religious institutions are connected to many of the 3 million non-filers who don't participate in SNAP or Medicaid, so they are key avenues for outreach. In addition, organizations providing critical services such as food banks and health care likely interact with harder-to-reach populations that state agencies and other outreach channels may miss. Some community-based organizations have staff who can help people complete the IRS Non-Filer form, which is especially valuable for people without internet access.

Local officials have established platforms they can use to share information about the payments and how to get them. Mayors and city, county, and town officials are attuned to the needs of their

communities and are already working to address challenges that non-filers may face, including homelessness, language barriers, and lack of internet access. Local officials have connections with various entities that can disseminate information, such as school districts and utility companies. In addition to publicizing information about the payments, local officials can help inform people of local sources for help from community organizations.

Assistance in Accessing Payments Can Increase Receipt

To receive a payment this year, individuals not receiving a federally administrated benefit must provide their information to the IRS no later than October 15[t] through either a tax return or a simplified IRS online form for people who aren't required to file a tax return, known as the "Non-Filer" tool.[20] The tool requires a user to create an online account, enter personal information (including direct deposit information, if available), verify their email address, and submit the form. Some individuals who do not typically file a return may find this process hard to complete without assistance even during normal times, and especially during a pandemic.

While the simplified form requires much less information than filing a full tax return, individuals must have internet access, an email address, a direct deposit account or an address to which the payment can be delivered, and facility with the online form and account. For individuals with little or no income, disabilities, or limited contact with public agencies, any of these elements may be challenging.

Normally, agencies could direct people to free taxpayer assistance services such as Volunteer Income Tax Assistance (VITA) sites for help. With most VITA sites closed due to COVID-19, some are offering online services to low-income taxpayers during the pandemic to help filers and non-filers navigate their IRS requirements. Since the IRS is not currently processing paper tax returns, all non-filers will have to submit their information electronically in order to receive their payment in a timely manner. Many non-filers will need help from agencies or these online tax assistance services to submit complete and accurate tax forms and avoid delays with their payment.

The most expedient way to receive a payment is through direct deposit to a bank account, a financial payment app (such as Venmo, PayPal, or Cash App), or a prepaid debit card. When individuals include their direct deposit information on their simplified form, the IRS typically delivers the payment within one to two weeks if no errors arise with the routing information. For individuals for whom the IRS does not receive direct deposit information the IRS will mail a paper check or, in some cases, a prepaid debit card.[21]

Many non-filers may need assistance establishing a bank account or an alternative account that can receive direct deposits. An estimated 14 percent of people with incomes below $40,000 are "unbanked" (meaning they lack a checking, savings, or money market account), and the share is

[20] Internal Revenue Service, "Non-Filers: Enter Payment Info Here," updated May 18, 2020, https://www.irs.gov/coronavirus/non-filers-enter-payment-info-here. People who miss the October. 15 deadline can also file a 2020 tax return (in early 2021) to receive the payment next year.

[21] Department of the Treasury, "Treasury is Delivering Millions of Economic Impact Payments by Prepaid Debit Card," May 18, 2020, https://home.treasury.gov/news/press-releases/sm1012.

likely even higher among non-filers who do not regularly receive federal benefit payments.[22] Bank accounts through certain institutions can be opened online. Several financial apps also address this gap and provide avenues for people to receive direct deposits to their account within the app.

[22] Board of Governors of the Federal Reserve, "Report on the Economic Well-Being of U.S. Households in 2019, Featuring Supplemental Data from April 2020," May 2020, https://www.federalreserve.gov/publications/files/2019-report-economic-well-being-us-households-202005.pdf.

Appendix I

Appendix Table 1 displays state-by-state estimates of the 12 million people eligible for payments based on nationally representative survey data. See Appendix II for more detail.

APPENDIX TABLE 1

Estimated Adults and Children Missed by Automatic Payments

	Total individuals	Potential total payments (in millions of dollars)
United States	**12,399,000**	**$12,000**
Alabama	267,000	$264
Alaska	32,000	$31
Arizona	267,000	$274
Arkansas	143,000	$137
California	1,484,000	$1,499
Colorado	152,000	$160
Connecticut	108,000	$109
Delaware	34,000	$37
District of Columbia	46,000	$47
Florida	991,000	$1,017
Georgia	505,000	$506
Hawaii	50,000	$53
Idaho	42,000	$44
Illinois	392,000	$401
Indiana	214,000	$206
Iowa	64,000	$65
Kansas	100,000	$103
Kentucky	209,000	$206
Louisiana	303,000	$302
Maine	*	*
Maryland	147,000	$157
Massachusetts	223,000	$232
Michigan	369,000	$361
Minnesota	122,000	$127
Mississippi	185,000	$180
Missouri	197,000	$202
Montana	25,000	$25
Nebraska	*	*
Nevada	112,000	$112
New Hampshire	*	*
New Jersey	276,000	$287

APPENDIX TABLE 1

Estimated Adults and Children Missed by Automatic Payments

	Total individuals	Potential total payments (in millions of dollars)
New Mexico	124,000	$124
New York	814,000	$834
North Carolina	471,000	$474
North Dakota	24,000	$24
Ohio	489,000	$466
Oklahoma	165,000	$166
Oregon	158,000	$159
Pennsylvania	449,000	$438
Rhode Island	37,000	$39
South Carolina	273,000	$262
South Dakota	34,000	$32
Tennessee	280,000	$288
Texas	1,024,000	$1,010
Utah	57,000	$58
Vermont	17,000	$16
Virginia	321,000	$326
Washington	228,000	$228
West Virginia	115,000	$112
Wisconsin	140,000	$142
Wyoming	16,000	$16

*Sample size too small.

Source: CBPP analysis of the U.S. Census Bureau's Current Population Survey for 2015-2017, with corrections for underreported SNAP and Supplemental Security Income from the Department of Health and Human Services/Urban Institute Transfer Income Model (TRIM).

Appendix Table 2 displays state-by-state estimates of the subgroup of the 9 million people eligible for payments who receive SNAP (whether or not they receive Medicaid) based on administrative data.

APPENDIX TABLE 2

Estimated People Missed By Automatic Payments Who Receive SNAP Benefits

	Households	Individuals		Potential value of payments
	Total	Total	Under 17 years	In millions of dollars
United States	**3,270,000**	**6,534,000**	**3,024,000**	**$5,700**
Alabama	45,500	99,600	47,700	$86
Alaska	7,900	17,700	7,700	$16
Arizona	68,500	133,000	56,300	$120
Arkansas	20,800	46,800	23,500	$40
California	543,600	1,095,100	548,900	$930
Colorado	35,200	78,700	42,200	$65
Connecticut	39,100	65,400	22,800	$63
Delaware	11,300	22,800	11,100	$20
District of Columbia	13,200	23,500	9,300	$22
Florida	245,800	437,400	184,000	$396
Georgia	151,800	330,400	158,500	$286
Hawaii	12,100	22,800	9,500	$21
Idaho	7,300	18,800	10,800	$15
Illinois	172,000	315,900	129,200	$289
Indiana	34,600	79,200	39,900	$67
Iowa	26,300	55,600	27,900	$47
Kansas	9,100	21,600	11,800	$18
Kentucky	49,700	95,900	36,400	$90
Louisiana	48,300	113,300	60,400	$94
Maine	6,900	14,900	6,900	$13
Maryland	67,300	121,800	50,000	$111
Massachusetts	56,100	108,200	48,200	$96
Michigan	93,500	159,100	53,100	$154
Minnesota	26,100	49,500	27,100	$40
Mississippi	41,600	88,800	40,800	$78
Missouri	38,400	86,300	45,700	$72
Montana	5,100	11,600	5,400	$10
Nebraska	9,600	20,900	11,000	$17
Nevada	38,300	69,700	28,400	$64

APPENDIX TABLE 2

Estimated People Missed By Automatic Payments Who Receive SNAP Benefits

	Households	Individuals		Potential value of payments
	Total	Total	Under 17 years	In millions of dollars
New Hampshire	4,400	9,900	4,900	$8
New Jersey	66,800	139,800	76,800	$114
New Mexico	27,000	56,800	25,200	$51
New York	188,600	351,200	152,500	$315
North Carolina	120,900	241,400	110,200	$213
North Dakota	3,400	8,400	4,400	$7
Ohio	92,900	179,800	78,100	$161
Oklahoma	31,100	74,000	38,200	$62
Oregon	50,600	92,700	34,400	$87
Pennsylvania	105,500	211,700	95,200	$187
Rhode Island	11,200	19,900	7,700	$18
South Carolina	58,500	134,200	68,900	$113
South Dakota	5,500	13,900	7,600	$11
Tennessee	80,700	161,400	70,100	$145
Texas	290,500	610,000	300,700	$521
Utah	13,900	33,200	18,600	$27
Vermont	2,500	5,100	2,300	$4
Virginia	53,000	126,000	65,700	$105
Washington	68,900	118,800	47,100	$110
West Virginia	25,100	50,800	20,600	$47
Wisconsin	34,800	67,800	28,500	$61
Wyoming	1,800	4,700	2,500	$4

Source: CBPP analysis of USDA SNAP Household Characteristics data for fiscal years 2016-2018.

Note: We estimate that about 12 million people will be missed by automatic payments; of these, about 9 million people receive SNAP and/or Medicaid. The figures shown here represent the subgroup of the 9 million who receive SNAP, whether or not they receive Medicaid.

Appendix II: Estimating the Outreach Population for Economic Impact Payments

Table 1 in this paper and Appendix Table 1 both rely on nationally representative survey data to estimate the number of individuals eligible for Economic Impact Payments while excluding those likely to receive those payments automatically because they filed federal income taxes[23] or participate in federal benefit programs (Social Security, Railroad Retirement, SSI, or veterans' pensions or disability benefits). The estimates are approximate and are affected by underreporting of income and benefits, recent changes in program participation, and other data limitations.

Data reflect the population, economy, and program participation patterns of 2015 through 2017 and are from CBPP's analysis of the Census Bureau's Current Population Survey (CPS) Annual Social and Economic Supplement, adjusted to correct for underreporting of SNAP and SSI participation in the CPS using baseline data from the Transfer Income Model Version 3 (TRIM 3). TRIM 3 is developed and maintained by the Urban Institute with primary funding from the Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (HHS/ASPE). To improve the reliability of the state estimates, we average together three years of data (2015 through 2017), the most recent available from TRIM. We exclude immigrant families likely to be ineligible due to lacking a Social Security number.

Our SNAP results in Appendix Table 2 are from CBPP's analysis of USDA SNAP household characteristics data for fiscal years 2016-2018. Because of data limitations (SNAP records do not include annual income or tax filing status), we limit the sample to those making less than the tax filing threshold on a monthly basis and exclude those who might qualify for the EITC or Child Tax Credit based on earnings, monthly income, age, and family composition; we also exclude family members of certain SNAP-ineligible immigrants who didn't report a Social Security number. To err on the conservative side, the figures exclude families that receive SNAP for less than 12 months because such families are especially likely to have worked and earned more in the months before entering the program, and thus to have filed taxes for the year. The figures also (conservatively) exclude families where any family member received Social Security, SSI, or veterans' pensions or disability benefits.

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[23] The CPS does not ask respondents about their income taxes, but the Census Bureau estimates taxes and tax filing status from survey data on income, age, and family relationship. We start with Census tax status indictors and modify them to include additional potential tax dependents not captured in the Census tax model. For example, we count elderly parents who live with their higher-earning children as dependents if they meet IRS dependency rules. Also, when college students live with no family members, we assume their parents claim them as dependents if the students are under age 24, attend school full time, and have income below $4,150 in 2018 dollars. These adjustments raise the estimated number of filers, spouses, and dependents in tax year 2017 from 286 million using Census' tax indicators to 291 million, which is closer to the actual figure of 293 million listed by IRS (https://www.irs.gov/pub/irs-soi/17in23ar.xls). The remaining persons — that is, those not considered to be a tax filer, spouse, or dependent, totaling 31.7 million in the CPS data for 2017 — are the non-filing population. Of those, an estimated 12 million are eligible for Economic Impact Payments and we consider them the outreach population.

As a check, we modeled the outreach population in another Census survey, the Survey of Income and Program Participation, which has better data on which college students can be claimed as dependents (as well as on certain other elements of the calculation, such as immigration status and who receives Social Security benefits). Those calculations also show about 12 million people in the outreach population nationwide in 2016.

Appendix III: Resources

Federal Agency Information

- IRS Non-Filer tool: https://www.irs.gov/coronavirus/non-filers-enter-payment-info-here
- IRS E-file 2019 tax return: https://www.irs.gov/filing/free-file-do-your-federal-taxes-for-free
- IRS Volunteer Income Tax Assistance (VITA) locator: https://irs.treasury.gov/freetaxprep/
- Social Security Administration: https://www.ssa.gov/coronavirus/#anchorA
- Department of Veterans Affairs: https://www.va.gov/coronavirus-veteran-frequently-asked-questions/

National Organization Information:

- Virtual Volunteer Income Tax Assistance help: www.getyourrefund.org
- E-File 2019 tax return: MyFreeTaxes.com
- CBPP EIP outreach information: www.eitcoutreach.org/coronavirus
- University of Michigan stimulus payment guide (applicable nationwide): https://poverty.umich.edu/stimulus-checks/
- City of Durham, NC stimulus payment guide (applicable nationwide): https://www.getyour1200durham.org/

State health and human service agency information (examples):

- California: https://www.ftb.ca.gov/about-ftb/newsroom/covid-19/help-with-covid-19.html#COVID-19-Economic-impact-payments-CARES-Act
- Connecticut: https://portal.ct.gov/DRS/COVID19/DRS-COVID-19-Response-FAQ#FSC
- Florida: https://floridarevenue.com/childsupport/compliance/Pages/economic_impact_payment_offsets.aspx
- Hawaii: https://tax.hawaii.gov/covid-19/
- Illinois: https://www2.illinois.gov/rev/Pages/Information-Regarding-Federal-Economic-Impact-Payments.aspx
- Maine: https://www.maine.gov/dhhs/ofi/dser/stimulus-faq.shtml
- Michigan: https://www.michigan.gov/documents/difs/Stimulus_Info_687081_7.pdf
- Nevada: https://dwss.nv.gov/Support/FAQs_Economic_Impact_Payments/
- New Hampshire: https://www.dhhs.nh.gov/dcss/documents/bcss-fto-and-ui-042020.pdf

- New Jersey: https://covid19.nj.gov/faqs/nj-information/general-public/how-does-the-cares-act-stimulus-package-help-me-or-my-business-how-do-i-get-my-economic-impact-payment
- New York: https://www.tax.ny.gov/press/alerts/stimulus-checks-information.htm
- North Carolina: https://files.nc.gov/ncdhhs/NC2020-Stimulus-Updated-FAQs.pdf
- North Dakota: https://www.nd.gov/tax/covid-19-tax-guidance/
- Pennsylvania: https://www.dhs.pa.gov/providers/Providers/Pages/economic-stimulus.aspx
- Rhode Island: http://www.tax.ri.gov/Advisory/ADV_2020_17.pdf
- Vermont: https://dcf.vermont.gov/dcf-blog/covid19-payments

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 Unites 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

Journal of Health Politics, Policy and Law, Vol. 45, No. 5, October 2020
DOI 10.1215/03616878-8543298

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.

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 expansions 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 nonexpansion 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 sociodemographic 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 the 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 reproving 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 uninsurance 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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Acknowledgments

Graduate students Wendy Hawkins and Tory Lowy provided valuable research assistance. Sarah Rosenbaum gives special thanks to the RCHN Community Health Foundation, whose ongoing gift to the department's Geiger Gibson Program in Community Health Policy has provided core support over so many years of research and scholarship focusing on medical underservice and health equity.

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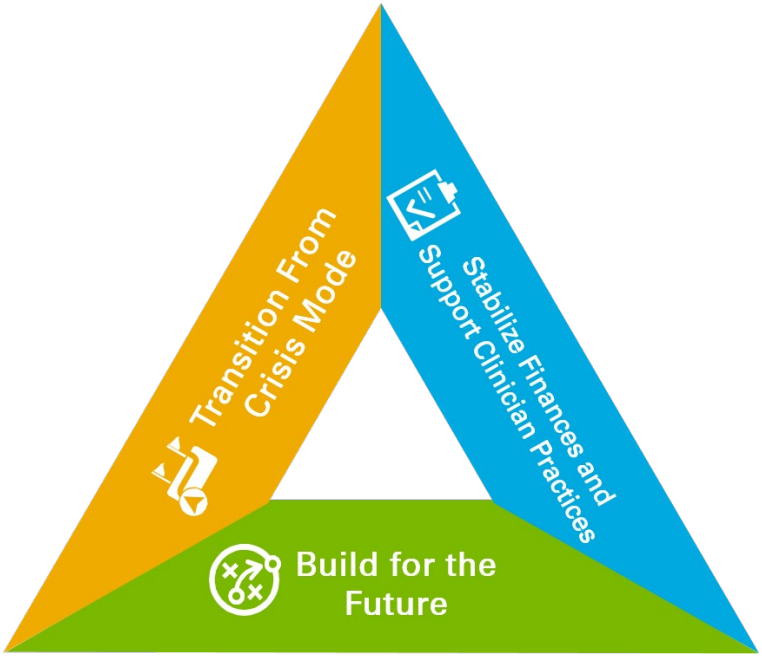
JUNE 2020

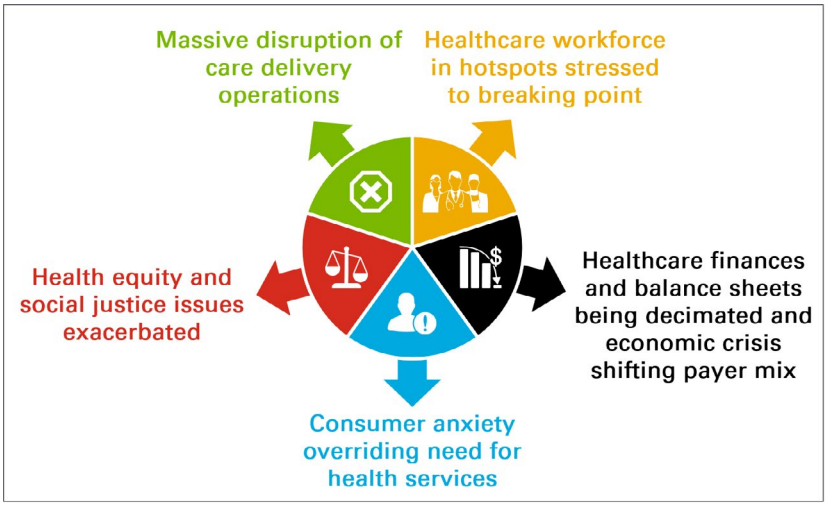
Emergence From COVID-19: Imperatives for Health System Leaders



Emergence From COVID-19: Imperatives for Health System Leaders

The COVID-19 crisis has brought great adversity, and our health systems and academic centers are responding with innovation. Policymakers have rapidly lifted myriad barriers to providing care in innovative and novel ways, and health systems have rapidly scaled up virtual care, hospital-at-home programs and home-based care. Telehealth video and phone visits have ballooned from the tens or hundreds to many thousands per day at major institutions, prompting rapid acceleration in digital patient engagement. Health systems with population health capabilities have used them to manage patients through the crisis. Those with health plans have benefited from the financial diversification. And those with well-developed post-acute programs have helped patients successfully through the transitions among hospital, skilled nursing and home.

Challenges for Leaders

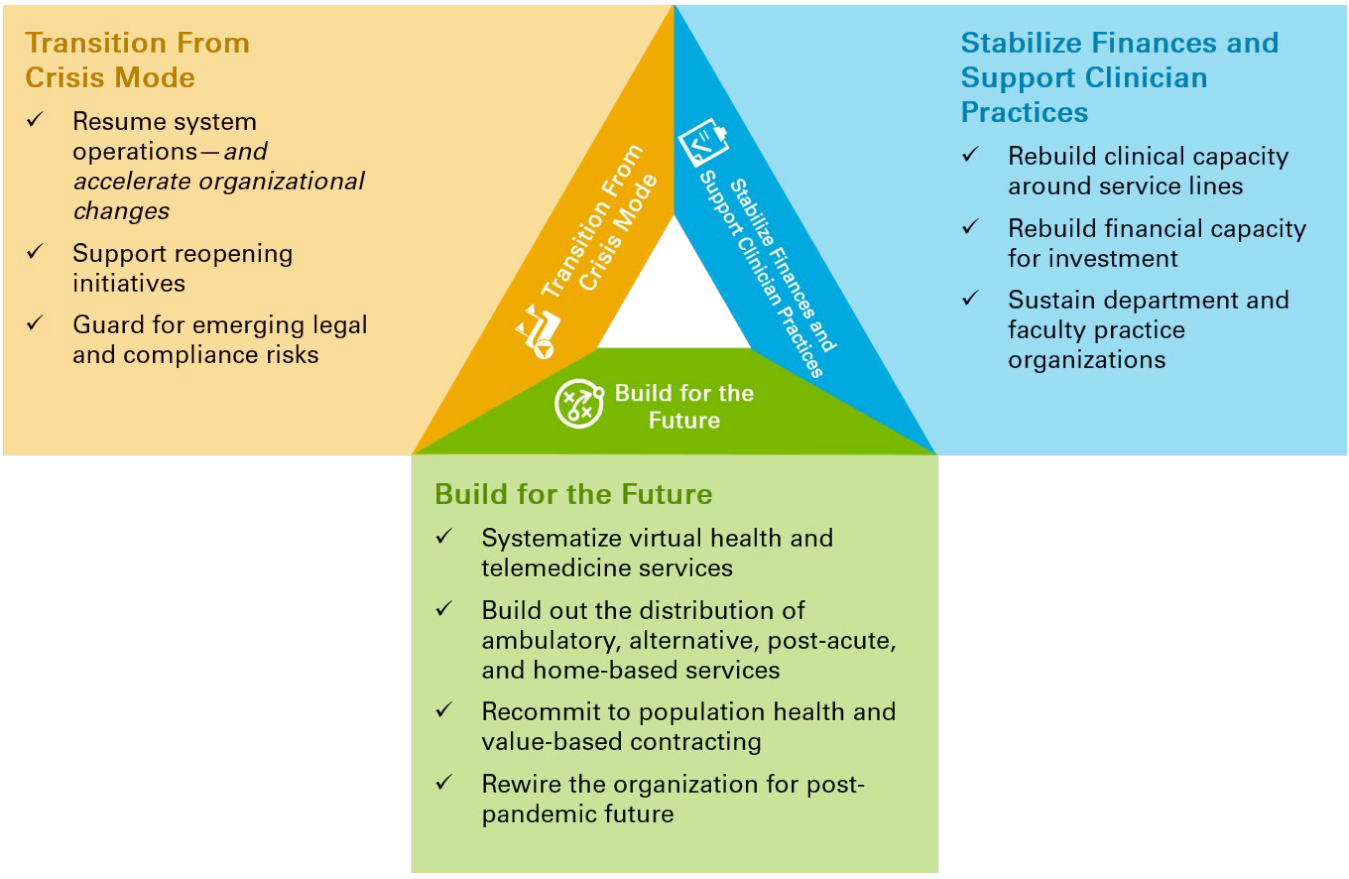


During the crisis, important changes have begun to be made in typically unwieldy health system organization structures. Operational and policy decisions have been made quickly and nimbly. Coordination and communication processes have been vastly enhanced under the pressure of immediate needs. The priorities of recent weeks have focused on protecting health workers, acquiring PPE and special supplies, ramping up telehealth, establishing COVID-19 units, managing clinic closures and reopenings, and myriad other complex undertakings. Every health system leadership team should challenge itself to self-assess its performance. How did we do? What could we have done better? Are we working effectively with our community on deep health equity and social justice issues? What changes in how we work should we keep—and accelerate? Emergence from the crisis offers the leadership of health systems and academic centers a profound opportunity to reflect on how to remake themselves as stronger, more effective, more engaged and more resilient institutions.[1]

The immediate imperatives are to safely resume elective clinical services, stabilize finances and support physician practices to get back to a semblance of normal operations. This work must occur while health systems are simultaneously continuing to manage COVID-19 cases, preparing for subsequent infection waves, engaging with the community to prevent further spread and preparing the organization for future unknowns. Clearly communicating the "new" experience that can be expected in accessing healthcare facilities for services is essential to alleviate patient anxieties and rebuild patient volumes. More fundamentally, successful post-COVID-19 strategy will be based on whether the health system is positioned as a leader for positive change within the community, and early steps to support safe reopening will be instrumental in achieving this objective.

A next priority is shoring up tertiary and quaternary services where academic health centers and large health systems have a natural advantage and which provide the margins that sustain academic and community missions. Service excellence and clinical integration will be essential ingredients. The collapse in current year financials and the dismal forecast for future margins will require rebuilding financial capacity for investment and near-term attention to realizing operational efficiencies, cost reductions and workflow realignments to facilitate throughput.

Imperatives for Health System Leaders



Longer term, the focus will be on building the next-generation distributed, highly interconnected, community engaged and extensively digital system of care, which will be the lynchpin of a resilient health system. This ambitious agenda will require rewiring the organization structure to align with the new priorities and emerging demands, and the need for greater resilience in the face of future black swan events.

Recommendations for Health System Leaders

Transition From Crisis Mode	
✓ Resume system operations—*and accelerate organizational changes*	Working toward more resilient models and accelerating organization change and high-performance teamwork should be constant themes as leadership teams reopen and rebuild.
✓ Support reopening initiatives	Embrace local/regional leadership responsibility with county and state health officials to accelerate return-to-work opportunities, including comprehensive health system reopening and community engagement to promote health equity.
✓ Guard for emerging legal and compliance risks	Conduct comprehensive risk and compliance audits to minimize post-apex litigation and compliance issues; develop comprehensive position and related strategy/tactics that inform response to emerging legal issues arising from pandemic response.
Stabilize Finances and Support Physician Practices	
✓ Rebuild clinical capacity around service lines	Plan, organize and implement program and service line efforts with precision.
✓ Rebuild financial capacity for investment	Reorient strategic plans to be financially accretive during a possibly extended period of disruption and industry realignment.
✓ Sustain department and faculty practice organizations	Align clinical enterprise governance, organization and funds flow to ensure long-term viability of the clinical departments.
Build for the Future	
✓ Systematize virtual health and telemedicine services	Prioritize building the capability to design and scale new digitally enabled care models that leverage telehealth and digital health technologies, and deploy those care models throughout the health system with the ability to refine and improve them continuously over time.
✓ Build out the distribution of ambulatory, alternative, post-acute and home-based services	Create a true system of care by developing and scaling ambulatory and home-based care capabilities and forming the necessary linkages and interdependencies with hospital and other site-based care.
✓ Recommit to population health and value-based contracting	Do not allow short-term disruptions in revenues and costs to derail the health system from advancing population health-centric care models and continuing efforts toward accountable care.
✓ Rewire the organization for post-pandemic future	Evaluate the performance of your organization during the crisis and make changes to strengthen the ability to successfully execute as the emergency fades.

Transition From Crisis Mode

Resume System Operations—*and Accelerate Organizational Changes*

As health systems and research programs reopen and (incrementally) return to pre-COVID-19 activity levels, they must be hyper-focused on ensuring a safe environment, including formalized patient and staff testing protocols and implementing protocols to reassure anxious patients while at the same time operating within a new—constrained—economic reality. Most health systems will need to operate distinct "COVID-19-safe" patient care environments so as to expedite access and address consumer concerns regarding safety, likely resulting in a "90% economy"[2] for healthcare. COVID-19 testing at scale with a range of tests will be essential.[3] Extraordinary attention to patient communications and pinpoint attention to patient throughput and flow will be needed given requirements for enhanced safety protocols. These activities should be accompanied by a close evaluation of organizational and team performance during the crisis. Beneficial changes in organizational process including cross-organization communication, team process and nimble decision making should be accelerated. Where individuals have stepped up and shown leadership, new roles can be defined so they can continue to grow as leaders.

Critical Issues

- Rebuilding confidence and trust, welcoming patients back, and communicating to patients and communities that it is safe to seek routine and nonemergent healthcare services. Patient flow needs to be redesigned to include socially distant registration and check-in, effective PPE for patients and staff from screening through treatment, and specialized sanitation procedure subsequent to patient encounters.
- Providing—and communicating—a COVID-19-safe environment will require testing multiples greater than current levels. Some institutions are choosing to test their entire workforce.[4]
- High throughput management balanced with enhanced safety protocols to rapidly address backlogs of postponed cases in a balanced manner. Coordination of unit and operating room (OR) partitioning and duplication to provide asymptomatic patients COVID-19-safe assurance while simultaneously continuing to treat COVID patients.
- Workplace efforts to manage burnout while non-COVID-19 volumes ramp up to fill empty clinics and beds.

Priority Questions

- Do we have a service partitioning and patient flow plan that can assure patients a COVID-19-safe environment?
- How many tests per day can we do and how does that compare to second/third-wave estimates?
- Are we managing the burnout in our workforce effectively? Do we have the human resources for a full return to work?
- Do we have multiple contingency plans for maintaining elective operations in the event of significant subsequent waves?
  - Do we have a continuous executive and manager "lessons learned" process in place to appreciate the full dimensions of our response and organizational performance?

Recommendation: Working toward more resilient models and accelerating organization change and high performance teamwork should be constant themes as leadership teams reopen and rebuild.

Transition From Crisis Mode

Support Reopening Initiatives

Restarting the economy as safely as possible is the top priority for state and local governments, which presents both opportunities and challenges for delivery systems. Health systems are pivotal partners for reopening efforts: They are often the largest employers in the region, they have the resources and expertise to manage infection control and reopen elective services, and they will prove pivotal in the ongoing need for continuous and expanded COVID-19 testing and contact tracing. In several states, leading health systems have assisted the public health authorities to clear testing backlogs. In a number of the announced university campus reopening plans, such as those at the University of Florida, UC San Diego and the University of Alabama, academic centers are leading these efforts with program organization, testing and contact tracing. Health systems will also partner with employers on return-to-work strategies as a form of direct contracting. The multistate membership-based primary care practice One Medical is offering this as a service to its employer customers,[5] while United Airlines has partnered with the Cleveland Clinic and Clorox in a program called "United CleanPlus" intended to "ease the fears" of nervous flyers.[6] Reopening also requires taking care to promote and ensure health equity, particularly with respect to broadening community-based testing, access for vulnerable populations, protection for frontline workers, and working closely with trusted community partners.

Critical Issues

- Health equity and social justice issues have been exacerbated and have come to the fore during the pandemic. Restarting the economy will also need to begin to address underlying issues that include access to healthcare and coverage issues.
- Health systems will need to continue to scale up testing capacity.
- Health systems will be asked to provide community-level testing beyond their workers and patients so as to support return-to-work efforts in their communities. Most Academic Health Systems (AHSs) also are safety net facilities, and they will need to consider how best to support vulnerable populations that are most susceptible to continuing infection spread. Engaging more broadly with FQHC's and community organizations will be an important dimension.
- Electronic tracking and contact tracing will become more prevalent. Health systems will need to determine whether to require the use of these by faculty and staff so as to better manage workplace infection subsequent waves. Planning for the careful integration of these tools by Human Resources departments should be an early priority.

Priority Questions

- Is our institution fully aligned with regional reopening initiatives?
- Are we able to expand our testing capacity to support community-based and/or campus requirements?
- Can we strengthen the relationships we have with FQHCs and rural centers so as to support enhanced testing and contact tracing in high-risk settings?
- What assistance should we be providing to independent physician practices affiliated with our health system to enable them to reopen more rapidly and effectively, in line with our own efforts?

Recommendation: Embrace local/regional leadership responsibility with county and state health officials to accelerate return to work opportunities, including comprehensive health system reopening and community engagement to promote health equity.

Transition From Crisis Mode

Guard for Emerging Legal and Compliance Risks

Rapidly changing guidance, temporary regulatory flexibilities, changes in employment law, payment revisions, and challenging operational and ethical issues require continuous attention and dedication from health system legal and compliance teams. Managing litigation risks related to staff support, patient care and regulatory issues arising from COVID-19 should be top of mind for all health systems.

Critical Issues

- Legislation and guidance have been rapidly developed during the crisis and have changed over the short time periods after emergency programs were enacted, resulting in lack of clarity around obligations of provider organizations with respect to accepting government funds and potential related risks under the False Claims Act.
- New waiver authorities and guidance are being released daily, if not more frequently, which have sweeping implications for health system compliance programs and policies and procedures.
- Federal and state guidance is not always in sync or may be changing on different timelines.
- As large employers, major real estate holders and the frontline COVID-19 response service providers, health systems need to navigate a suddenly even more complex legal landscape.

Priority Questions

- Have we evaluated the legal and regulatory requirements of participating in COVID-19 relief funding programs?
- What is the impact of reporting some aspects of our COVID-19 response as charity care and/or community benefit or failing to do so?
- Are there any unforeseen risks from COVID-19 response that we need to be considering, such as:
  - The potential for false statements in connection with certifications required to accept federal funds and the associated auditing and reporting requirements and audit strategies related to making use of temporary regulatory flexibility around workforce, care locations and administrative oversight—federal, state;
  - Lawsuits and federal and state agency action related to staff (adequacy of PPE, testing) and potential discrimination against patients based on race or economic status (admission, testing, etc.); and
  - Federal and state investigations regarding infection control practices?
- Which components of regulatory flexibility—e.g., telehealth, alternative care settings—provided during the public health emergency will be retained post-pandemic, and what are the compliance issues we should be monitoring, such as:
  - Income tax implications of temporary arrangements entered into under Stark waivers, e.g., assistance to physicians constituting taxable income;
  - Ensuring that arrangements addressing emergency capacity are not determined to result in market collusion;
  - Addressing privacy implications of expanded use of telehealth and alternative care settings;
  - Developing reopening plans that ensure safety and standards of care and mitigate negligence claims including a comprehensive review of operating, financial and compliance policies in the "post-public health emergency" world;
  - Refining programs and services as required to address removal of temporary flexibilities, seeking assistance in how to "undo" contracts or other arrangements entered into under the Stark waivers, or understanding of the risks associated with not undoing them; and
  - Assessing the legal and regulatory environment relative to anticipated health system consolidation, e.g., antitrust, deal terms, as new affiliation, partnership and acquisition, as opportunities are identified?

Recommendation: Conduct comprehensive risk and compliance audit to minimize post apex litigation and compliance issues; develop comprehensive position and related strategy/tactics that inform response to emerging legal issues arising from pandemic response.

Stabilize Finances and Support Physician Practices

Rebuild Clinical Capacity Around Service Lines

Academic centers and large health systems make the vast majority of their margin on a small subset of services and cases paid by commercial plans, which then subsidize their losses on most other cases and from government payors. These few cases are typically high-complexity cancer, heart, neurosurgery and neurology, orthopedics, and transplant and are typically procedural in nature. The reluctance of consumers to travel will further erode international and national draw but also increase the potential for recapturing cases currently migrating out of state or region for care. As states begin to reopen, there will be tremendous competition for these high-margin, high-acuity cases, necessitating an intensive focus on program and service line effectiveness. Simultaneously and due in part to productivity incentives, tertiary hospitals will rapidly fill with backlogged cases that might be better seen in an alternative site—or could have been a preventable admission. Academic centers will need to facilitate the greatest access combined with excellent clinical management if they are to maintain and build their competitive position. Health systems will seek to capitalize on their clinically integrated networks and information systems to bring patients back into their service lines. Independent hospitals and practices will be the likely losers in this competition.

Critical Issues

- Health system finances will be dependent on capturing (elective) volumes in programs of distinction, which will necessitate superior performance in service line management.
- During the several months of the most intensive phase of the pandemic (between four and six months) significant numbers of patients deferred regular screening, diagnostic evaluation or treatments, resulting in a significant backlog of services to be delivered as states and health systems reopen. Accelerating the ability to see patients effectively will be an important priority for leading health systems.
- Backlog surgical cases will likely exceed OR capacity, resulting in potentially lengthy wait times for patients, who may choose to seek care elsewhere.
- Significant changes in the surgical schedule—including running ORs later and over the weekend—may be required to meet patient demand for medically necessary procedures and to address pent-up demand.
- Ambulatory surgical centers (ASCs) will be advantaged given the likely reluctance of patients to be treated at hospital facilities.

Key Questions

- Do we know what our backlog is in each program and have an approach to manage it?
- Do we have an oversight structure in place to manage backlog?
- Are we prepared to sustainably maintain our telemedicine services in our programs? Have we integrated fully as multidisciplinary care teams for our service lines?
- Where is our surgical capacity located, and how much ambulatory surgical capacity can we bring on line? What is our ability to extend our OR schedules?

Recommendation: Plan, organize and implement program/service line efforts with precision.

Stabilize Finances and Support Physician Practices

Rebuild Financial Capacity for Investment

Health systems are experiencing steep revenue and income declines due to the margin lost from elective services deferred to provide capacity for COVID-19 patients. AHSs and large health systems are individually losing hundreds of millions and collectively billions of dollars as their revenue has plummeted while they maintained most of their cost structure. Moody's estimates that the postponement of elective services reduces not-for-profit hospital revenue by between 25 percent and 40 percent per month. CARES Act funding has provided a modest benefit, on the order of 10 percent to 20 percent of lost revenues for some institutions. Hospitals and health systems are not expecting a V-shaped recovery. In addition to lost revenue due to pausing electives, health systems are simultaneously expecting a significant shift in payer mix to Medicaid and uninsured resulting from the spike in unemployment. Unlike many independent hospitals, most academic health systems and larger health systems have sufficient liquidity to survive through this crisis. Indeed, the largest health systems have so much cash on their balance sheets that they are drawing media scrutiny (and ire) for receiving stimulus support.[7] However, their ability to invest will be severely curtailed, and for many leaders the top priority will be to rebuild the balance sheet. Many institutions have reduced nonessential expenses, announced compensation reductions for leadership, instituted salary freezes, implemented voluntary or forced furloughs and reduction in hours, and halted retirement contributions, and are pausing capital investments. Further cost reductions will likely be necessary, extending to reengineering service delivery, tightly managing the revenue cycle, cancelling planned capital projects and taking a sharper view of expansion initiatives.

Critical Issues

- Hospitals and health systems are experiencing large financial losses due to COVID-19 and are likely to see these exacerbated through 2021 and beyond by payer-mix shifts due to an economic recession. These factors will result in dilution of balance sheet strength.
- The short-term priority is to ensure adequate cash flow to maintain operations and address existing debt covenants. For health systems, as is the case for many companies nationally, "cash is king."
- CARES Act funding will be important but only one component of a financial recovery plan.
- Intensely close attention to financial operations and a comprehensive reevaluation of all strategic priorities will be essential. Pre-COVID-19 strategic investments including acquisitions will need thorough review.

Priority Questions

- What is our cost-reduction program and how much will it yield? Are we making deliberate decisions regarding continuation or closure of nonprofitable programs and locations?
- Do we have enough liquidity to address near-term requirements? Should we explore measures to improve cash, including real estate asset management?
- Can we accelerate our system integration and improve our operating results by eliminating redundancies?
- Are all our investments and potential acquisitions accretive at this time? If not, should we proceed? What is the post-COVID-19 strategic rationale?
- Should we consider merger to strengthen our access to capital?

Recommendation: Reorient strategic plans to be financially accretive during a possibly extended period of disruption and industry realignment.

Stabilize Finances and Support Physician Practices

Sustain Department and Faculty Practice Organizations

Successful academic health systems are characterized by strong clinical departments, which have robust finances and reserves, and are growing clinically and academically. The pandemic has hit clinical departments especially hard, as their clinical revenue has evaporated and they are burning through their reserves. Financial viability is further stressed by research and academic funding delays and program cancellations. Many practices also face the need to pay back Medicare advanced payments. Due to affiliation restrictions, faculty practices have generally not been eligible for Paycheck Protection Program (PPP) federal stimulus loans for small businesses. As departments and faculty practices exhaust their resources, they will increasingly turn to their affiliated hospital and health system for financial support. Now is the time to complete the transition to the highly aligned clinical enterprise with transparent funds flow, excellent accountability systems and well-considered decision processes. Those not organized in this manner should consider the current crisis as an important opportunity to do so, as ensuring that departments and the faculty practice emerge robustly will be essential to the health system's and medical school's ability to weather the next chapter.

Critical Issues

- Faculty practice plans (FPPs) are experiencing decreased cash flow from elective procedures, reduced office visits and ancillary revenue decline. RVU-based faculty compensation plans are likely to result in sharply lower compensation during the current and coming fiscal years.
- Ongoing financial losses for clinical departments in a largely fee-for-service payment schema on already low-margin businesses make (even favorable) Medicare advanced payment loans a challenging proposition.
- Consumer reluctance to advance even their needed appointments and procedures will combine with payer mix changes related to the dramatic increase in unemployment to cause continuing financial distress.
- In addition, non-COVID-19 research funding may be constrained; university funds will be stressed by the delays in campus reopening; and philanthropic support may or may not be forthcoming, all of which will create uncertainty in the financial forecast.

Priority Questions

- Are we fully taking advantage of all FPP funding opportunities? Such as:
  - Medicare Advance Payments (check)
  - CARES Act "Provider Relief Fund"
  - Medicare and Medicaid payment enhancements
  - Small Business Administration PPP and Main Street Lending Program loans
  - Health system provided low- or no-interest loans to departmental practices under coronavirus Stark waiver flexibility
- Are we prepared for a rapid reopening with an orientation to the high-volume clinical management needed to address the backlog of appointments and procedures required by our patients?
- Are we accelerating the development of a more integrated and aligned clinical enterprise in terms of management, governance, operational efficiencies and funds flow?
  - Amongst the clinical departments so as to build a more sustainable group practice that supports all its constituents
  - With the health system in order to align into a comprehensive and financially stronger clinical enterprise

Recommendation: Align clinical enterprise governance, organization and funds flow to ensure long term viability of the clinical departments.

Build for the Future

Systematize Virtual Health and Telemedicine Services

Out of sheer necessity, many health systems have quickly stood up or rapidly expanded telehealth offerings to enable continuity of care to patients who are unable or unwilling to receive in-person care due to social distancing requirements or other limitations or constraints. Initial data show an exponential increase in telehealth utilization with some health systems seeing a 10x–100x increase in average daily telehealth volume from pre-pandemic levels. Health systems have made years of progress in advancing their telehealth capabilities in mere weeks, and it is clear that virtual care is here to stay for the long term. However, health systems will need to quickly transition their telehealth programs from "crisis mode" and fundamentally rethink how they deliver care in the future by designing, testing and scaling digitally enabled care models that meaningfully improve patient experience and clinical outcomes at a lower cost.

Critical Issues

- Health systems have needed to scale telehealth offerings over a period of days and weeks during the COVID-19 pandemic out of sheer necessity and in many cases have "bolted on" telehealth capabilities.
- Providers will need to assess whether their current emergency telehealth infrastructure will meet future needs and if not, make the necessary changes to ensure that telehealth and digital health platforms are designed, configured and integrated to support long-term clinical and operational requirements.
- Health systems will need to move beyond early telehealth offerings such as virtual urgent care to fundamentally rethink the way they deliver care and design clinically proven digitally enabled care models that effectively integrate remote and in-person care and demonstrably improve quality and outcomes. These models will vary by specialty, condition and setting of care, and each will have its own unique clinical and financial value proposition.
- In most health systems, providers have not received adequate training in how to most effectively deliver care remotely and will need to be trained or retrained in the most effective telehealth care delivery techniques.
- In response to COVID-19, telehealth reimbursement has increased dramatically in Medicare, commercial plans and Medicaid; though in many cases these reimbursement changes may be temporary.
- Additional regulatory flexibilities such as enforcement discretion of the HIPAA rules and cross-state licensure are tied to federal and state public health emergencies and are unlikely to be sustained long term.

Priority Questions

- Do we have telehealth and digital health platforms that can be scaled and seamlessly integrated with our electronic health record (EHR) and other core systems to effectively and comprehensively meet our clinical and operation needs for the next five years?
- Do we have sufficient expertise in telehealth and digital health within our organization or do we need to bring in new talent?
- What steps are we taking to redefine our relationships with patients and families by communicating with them on a proactive basis through new digital technologies in support of their efforts to improve their health status?
- Do we have the clinical redesign capability and resources necessary to reimagine how we deliver care in a manner that fully leverages all that telehealth and digital health have to offer?
- Once new digitally enabled care models are designed, tested and validated, do we have the operational capability to disseminate and scale these models consistently throughout our clinical enterprise?
- Do our primary payors provide adequate reimbursement for telehealth services? Do we need to renegotiate any of our commercial contracts to ensure temporary telehealth coverage is sustained in the future?
- Have we fully aligned our telehealth and digital health platforms with our post-COVID-19 consumer engagement and branding strategies?

Recommendation: Prioritize building the capability to design and scale new digitally enabled care models that leverage telehealth and digital health technologies and deploy those care models throughout the health system with the ability to refine and improve them continuously over time.

Build for the Future

Build Out the Distribution of Ambulatory, Alternative, Post-Acute and Home-Based Services

During the COVID-19 emergency, many health systems, especially those in hot spots, have needed to rapidly establish the ability to provide care on a distributed basis. In some cases, this takes the form of hospital-at-home programs in which hospital-level care is provided in the home by leveraging home-based care, remote sensor technology and traditional video telehealth. In other cases, systems may be providing primary or chronic disease care in the home. While these models have primarily been expanded due to social distancing restrictions, many providers have long sought to expand their ambulatory and home-based offerings for cost and patient convenience reasons but have not done so due to unattractive reimbursement. During the crisis, payors—and especially Medicare—have afforded unprecedented flexibility to provide care in nontraditional locations. Health systems should seize this moment to rethink their care delivery models by developing and expanding clinical services on a distributed basis and in the home. In doing so, health systems should challenge themselves to seamlessly integrate these services into existing facility-based service portfolios to ensure that the resulting system of care is greater than its component parts.

Critical Issues

- Many hospital systems have aggregated the component parts of an integrated delivery system, but few have seamlessly integrated these assets into a true system of care that is greater than the sum of its parts.
- Independent physician practices, ambulatory surgery centers and imaging centers are in significant financial distress due to decreased cash flow from reduced office visits and elective procedures.
- Care will increasingly move from institutional settings—hospitals, long-term care facilities and ambulatory clinics—into the home.
- Over the past decade, hospital-at-home programs have demonstrated strong outcomes and high patient satisfaction, evolving as monitoring and remote consult technologies—and consumer expectations—have advanced. But so far, reimbursement has lagged behind. In response to COVID-19, reimbursement for home-based-care models has increased dramatically under Medicare, commercial plans and Medicaid, though in many cases these reimbursement changes may be temporary.
- Health systems will need to develop their distributed ambulatory and home-based networks in concert with their digital platforms (see imperative #7).
- Given the challenges and limitations of institutionally based post-acute and long-term care, it seems that more and more of this care will be provided in the home. While ensuring strong partnerships with long term care (LTC) and post-acute care facilities is critical, it is equally essential to envision a future in which a significant share of this care is provided at home.

Priority Questions

- Do we have a strategy for sustaining and scaling the delivery of care in alterative settings after the pandemic, with a focus on home-based primary and chronic disease care, remote monitoring, and hospital at home?
- Does our current financial model support a strategy for sustaining and scaling delivery of care in alternative settings? If not, how can we evolve our financial model so that a robust platform of distributed clinical services is financially accretive?
- Do we have sufficient ambulatory and home-based clinical capacity now, or do we need to acquire, recruit and/or contract for that capacity?
- Do we have the right system culture, operational infrastructure and processes in place to enable a broadly distributed system of care?

Recommendation: Create a true system of care by developing and scaling ambulatory and home based care capabilities and forming the necessary linkages and interdependencies with hospital and other site based care.

Build for the Future

Recommit to Population Health and Value-Based Contracting

Over the past decade, health systems have been testing different value-based contracting models in support of the Triple Aim framework. The public health emergency period has exposed cost structures and drastically reduced revenues for hospitals, physician practices and many ancillary service providers, which will likely temporarily derail current value-based models, as regional benchmarks, quality metrics and even patient attribution have to be reconsidered and reset to avoid negative and unintended consequences. Clinicians in Alternative Payment Model value-based arrangements are deeply concerned that they will incur substantial losses as a direct result of COVID-19.[8] At the same time, they have been better prepared, with more completely developed telehealth infrastructure, established connectivity with social workers and therapists, and enhanced relationships and tools to serve patients in their homes. This period has also placed a spotlight on health disparities, community-level variations in access and health status, and the criticality of addressing social determinants of health, demonstrating the need for—and power of—nimbler and patient-centric access to healthcare services, underscoring the benefit of a stronger population health infrastructure and payment model.

Critical Issues

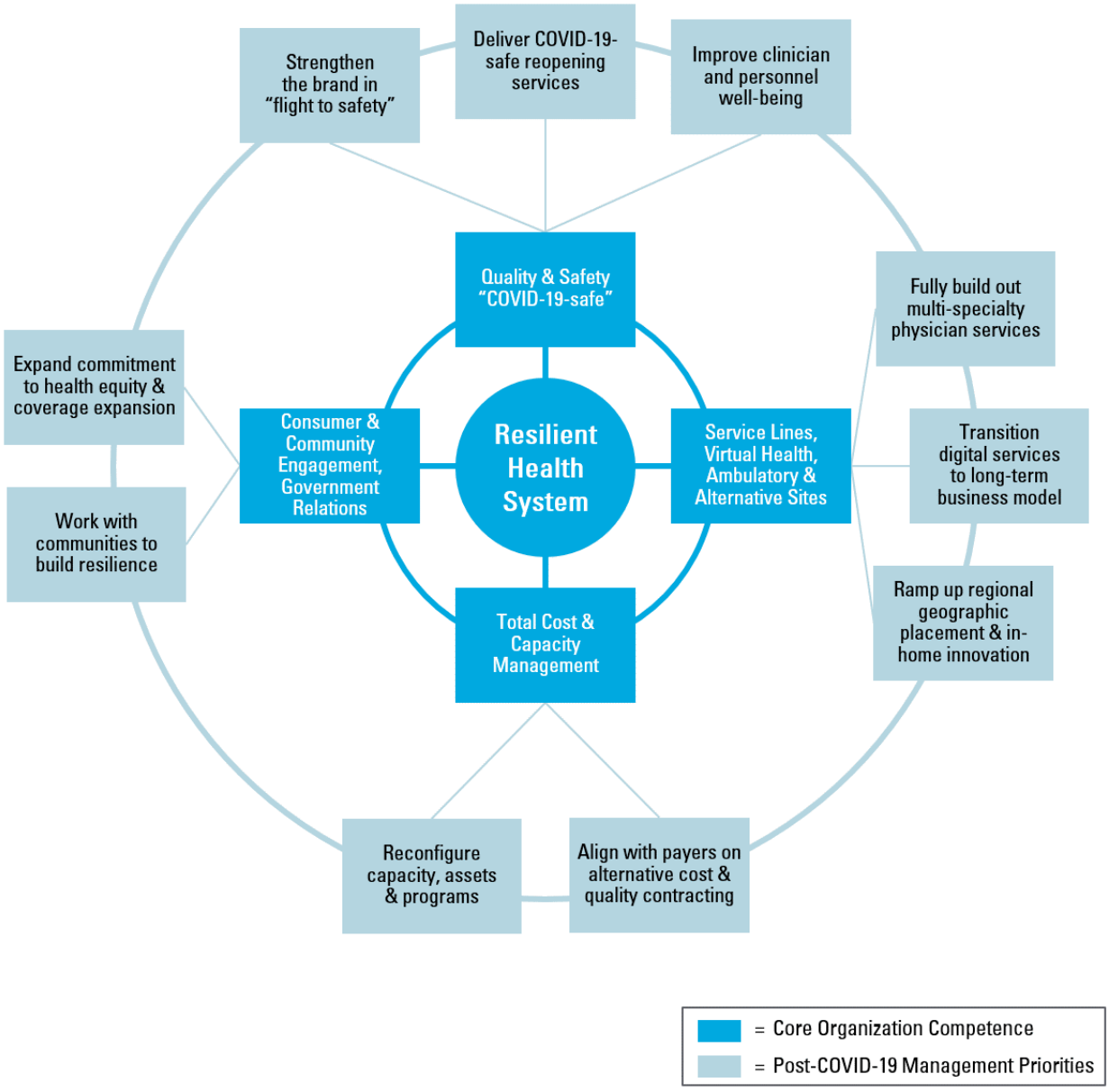
- The pandemic and resulting financial crisis in healthcare necessitate evaluating the COVID-19 impact on at-risk entities with downside risk arrangements, though the impact will vary greatly depending on regional circumstances and the contracting model specifics.
- Quality targets and reporting deadlines as well as provision of preventative care will be hugely disrupted; cost-savings targets will be missed, and efforts to amend benchmarks are likely to be distorted, which will have implications for the next 12–24 months.
- At a macro level, the faults of the current U.S. healthcare payment model—where hospitals cannot survive without high-margin procedures and supplemental payments and many patients, from the underinsured to those with high-deductible plans are hesitant to seek treatment due to lack of clarity in out-of-pocket costs—are brought into sharp focus due to the current emergency, raising larger questions about how care should be paid for.

Key Questions

- What is our process to systematically evaluate our current value-based contracts and renegotiate with payers for the near term as well as to rethink our risk approach for the midterm?
- How can health system population health investments be leveraged to develop data-driven and community-based-resource informed abilities to "cohort" vulnerable patients, including the elderly and those with chronic diseases, and provide targeted resources to support those groups?
- What elements must be included in contracts going forward, including risk corridors and emergency clauses?
- How should we rethink our total cost-of-care models given alternate settings of care and telehealth? Do we have the necessary data analytics and financial modeling capabilities?
- How should we leverage the recent disruptions to redesign our care models and radically rethink consumer convenience?
- How do we leverage our current population health investments, and where and how should we expand our capabilities to identify and meet the care needs of our most vulnerable populations?

Recommendation: Do not allow short term disruptions in revenues and costs to derail the health system from advancing population health centric care models and continuing efforts toward accountable care.

Illustrative Post-Pandemic Management Agenda



This diagram provides an illustration of how to align post-pandemic organization-building efforts. At the center is the organization-building objective: enhanced resiliency in preparation for the continuing demands of COVID-19 and future unknowns. Immediately linked, and drawing from the lessons of pandemic operations, critical competencies span multiple teams and organizational units within the system. Each of these in turn drives post-pandemic projects that enable enhanced resiliency while simultaneously strengthening the organization's ability to sustain its long-term missions and emerge as a stronger institution.

Build for the Future

Rewire the Organization for Post-Pandemic Future

Health system strategy post-COVID-19 will seem familiar: Build a diversified and distributed health system. Achieve regional scale. Optimize commercial insurance and manage network leakage. Keep costs down and throughput high. Connect with your patients and engage deeply with the community. Transition from bricks and mortar to digital and leverage the power of analytics. So what will be different? For one, the execution risk just got substantially greater. Patient concerns about hospital care may linger, requiring institutions to rethink their "hub and spoke" distributed care models. Hospital acquisition just became riskier than digital, home and ambulatory expansion. Dilutive acquisitions that consume capital will be less viable. Consumer unwillingness to travel may render national Centers of Excellence strategies less relevant. The benefits of "system-ness" will seem greater. Diversification of revenues will take on increasing value, from capture of the premium dollar to enhanced commercialization and venture activity. Clinician and staff morale emerging from the crisis may be low, and significant attention must be paid to optimizing their experience. Heightened understanding of the interrelationship between health equity and social justice will necessitate a more activist agenda on the part of boards and health system leadership, underpinned by excellent analytics and research on disparities. Combined with weakened finances resulting from the crisis, the complexity of managing these issues will put a very significant premium on successful execution and excellent teamwork. Creating a new agenda that inspires positive energy will be imperative. Leaders should rewire their organization to emphasize essential competencies and formalize a management agenda for emergence that accelerates system development while concurrently maintaining organizational gains realized during the crisis.

Critical Issues

- Organizational silos inhibit effective response. Academic health systems benefit from clinical enterprise alignment and integration.
- Partnership is more powerful than parochialism. The health equity issues that surfaced during COVID-19 require active partnership with trusted community leaders and institutions.[9]
- Culture trumps strategy. Never has this maxim been truer than during the current crisis and looking toward the future. The hallmarks of the best institutional responses during the crisis have been strong and ethical leadership, effective teamwork with competence at every level, caring for every person in the organization, and decisive and wise use of scarce resources.

Priority Questions

- How has our organization performed during the crisis? What have we learned about our system and our community during the crisis? Which parts of our system were resilient and which were not? How do these lessons inform our future organization development?
- What steps are we taking to define in a new way our relationship with the communities we serve? Are we taking responsibility as an important leader in strengthening the neighborhoods most immediately surrounding us by supporting food security efforts, availability of housing, employment opportunities, and education and training programs?
- Where are there silos that we need to breakdown so as to optimize our ability to fully recover and thrive in the "new normal"?
- How well did we perform on health equity issues? Did we serve our diverse populations well? Provide interpretative services when needed?
- Are we well organized into teams aligned with pivotal elements of our organization so we can emerge with greater strength post-COVID-19?
- Have we successfully managed the cultural transition to a highly digital system, or will we rapidly revert once the emergency fades?

Recommendation: Evaluate the performance of your organization during the crisis and make changes to strengthen the ability to successfully execute as the emergency fades.

[1] See the articulation of this point of view in "How Academic Health Systems Can Move Forward Once COVID-19 Wanes"; Steven D. Shapiro, MD; Paul B. Rothman, *JAMA*. Published online May 20, 2020. https://jamanetwork.com/journals/jama/fullarticle/2766527.

[2] https://www.economist.com/briefing/2020/04/30/the-90-economy-that-lockdowns-will-leave-behind.

[3] See, for instance, https://www.apsf.org/novel-coronavirus-covid-19-resource-center/preoperative-covid-testing-examples-from-around-the-u-s/#stanford.

[4] "Coronavirus: Stanford Health Care hospitals resume almost all procedures after widespread employee testing," *The Mercury News*, May 4, 2020. https://www.mercurynews.com/2020/05/04/coronavirus-stanford-health-care-hospitals-resume-almost-all-procedures-after-widespread-employee-testing/.

[5] 10X Genomics and One Medical announced the two organizations are partnering to pioneer a path toward the safe return to work by deploying a comprehensive approach to COVID-19 testing, digital employee symptom screening, and seamless access to remote and in-person care. https://www.sfchronicle.com/bayarea/article/Bay-Area-companies-grapple-with-challenges-of-15307153.php.

[6] https://www.united.com/ual/en/us/fly/travel/united-cleanplus.html.

[7] "Wealthiest Hospitals Got Billions in Bailout for Struggling Health Providers – Twenty large chains received more than $5 billion in federal grants even while sitting on more than $100 billion in cash," *New York Times*, May 25, 2020. https://www.nytimes.com/2020/05/25/business/coronavirus-hospitals-bailout.html.

[8] "Could coronavirus derail the decades-long shift to value-based care?" Healthcare Dive, April 15, 2020. https://www.healthcaredive.com/news/could-coronavirus-derail-the-decades-long-shift-to-value-based-care/575938/; "The Risk of Remaining in the Medicare Shared Savings Program During the COVID-19 Pandemic," R. Mechanic, Health Affairs Blog, May 30, 2020. https://www.healthaffairs.org/do/10.1377/hblog20200528.214278/full/.

[9] "Why is my community suffering more from COVID-19?"; M. Fair, MD, MPH, Senior Director, Health Equity Partnerships and Programs, AAMC, May 20, 2020. https://www.aamc.org/news-insights/why-my-community-suffering-more-covid-19.

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GRIST

Justices' Title VII ruling on LGBTQ bias has health benefit impacts

By Katharine Marshall and Kaye Pestaina
June 15, 2020

In this article

Federal protections against workplace sex discrimination extend to gender identity and sexual orientation, the Supreme Court today ruled in a ground-breaking decision on Title VII of the 1964 Civil Rights Act (CRA) (*Bostock v. Clayton Cty., Ga.*, No. 17-1618 (U.S. June 15, 2020)). The ruling will have an immediate impact on human resource policies — including employers' efforts to advance diversity and inclusion — and employee benefits. While Title VII governs day-to-day workplace issues like hiring, firing, compensation, promotions and harassment, the law's benefit implications sometimes get overlooked. This GRIST focuses on the impact of today's decision for employer-sponsored health plans and other healthcare mandates.

Scope of Title VII protections at issue

For employers with 15 or more employees, Title VII bans discrimination on the basis of race, color, religion, sex and national origin in hiring, firing, compensation, and other terms, conditions or privileges of employment. Employment terms and conditions include employer-sponsored healthcare benefits. Historically, not all authorities have agreed that Title VII protects LGBTQ workers against discrimination.

Evolving legal interpretations

Many federal courts and the Equal Employment Opportunity Commission (EEOC) — the primary federal agency enforcing Title VII — have taken the position that LGBTQ discrimination is sex discrimination prohibited by Title VII. They have reasoned that gender identity, transgender status and sexual

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orientation discrimination is sex discrimination because it involves sex-based considerations about nonconformance with gender norms and sex stereotypes.

In 2014, the Department of Justice (DOJ) concluded that a straightforward reading of Title VII's ban on discrimination "because of sex" includes discrimination because of an employee's gender identity as a member of a particular sex or as someone who is transitioning or has transitioned to another sex.

The current administration has taken a different approach, rolling back or rescinding prior agency guidance recognizing gender identity as a protected class under federal civil rights laws. In briefs filed with the Supreme Court, the DOJ and the EEOC argued that Title VII does not prohibit discrimination based on sexual orientation or gender identity, including transgender status. Instead, Title VII's ban on discrimination "because of sex" only bars employers from treating members of one sex — biologically male or female — differently from members of the opposite sex. Discrimination against gay or transgender people because they don't conform to sex-based stereotypes does not by itself violate Title VII. A LGBTQ worker would have to demonstrate that an employer treated members of one sex less favorably than members of the opposite sex in the same position.

Today's Supreme Court decision

Whether Title VII prohibits employment discrimination based on sexual orientation and gender identity, or sex stereotyping were the questions before the Supreme Court this term in three cases (*Bostock v. Clayton Cty., Ga.*, No. 17-1618; *Altitude Express Inc. v. Zarda*, No. 17-1623; *R.G. & G.R. Harris Funeral Homes v. EEOC*, No. 18-107):

- **Sexual orientation discrimination.** In two consolidated cases, Donald Zarda, a sky diving instructor, and Gerald Bostock, a child welfare services coordinator, each sued their employer for firing them because of their homosexuality. In Zarda's case, the 2nd US Circuit Court of Appeals held that discrimination based on sexual orientation violates Title VII's ban on sex discrimination (*Zarda v. Altitude Express Inc.*, 883 F.3d 100 (2d Cir. 2018)). However, the 11th Circuit in Bostock's case came to a different conclusion, finding Title VII does not prohibit discrimination based on sexual orientation (*Bostock v. Clayton Cty., Ga.*, 894 F.3d 1335 (11th Cir. 2018)).

- **Transgender bias.** In the third case, Aimee Stephens alleged that she was fired from her position as funeral director because she is transgender. The 6th Circuit in Stephens's case found that Title VII's protections can apply to transgender employees (*EEOC v. R.G. & G.R. Harris Funeral Homes, Inc.*, 884 F.3d 560 (6th Cir. 2018)).

In the cases before the Supreme Court this term, the workers argued that discrimination based on sexual orientation or transgender status is discrimination based on sex in violation of Title VII. In each case, the workers argued they were fired because they did not conform to sex-based stereotypes.

Until now, the Supreme Court had never explicitly addressed the application of Title VII to LGBTQ workers. However, the justices have found that employment discrimination based on sexual stereotypes — such as assumptions or expectations about how a person of a certain sex should dress and behave — violates Title VII (*Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989)). The Supreme Court has also found that an individual can file a claim of same-sex sexual harassment under Title VII (*Oncale v. Sundowner Offshore Servs.*, 523 U.S. 75 (1998)).

Addressing all three cases in one opinion today, the Supreme Court held:

> [D]iscrimination based on homosexuality or transgender status necessarily entails discrimination based on sex; the first cannot happen without the second.

Implications for employer group health plans

Discrimination on the basis of sex in employment, including benefits, has been prohibited for over 55 years by Title VII. In 1978, the Pregnancy Discrimination Act (PDA) amended Title VII to include pregnancy discrimination as prohibited sex discrimination. As a result, employer-sponsored health plans must cover pregnancy, childbirth and related medical conditions in the same way and to the same extent as other medical conditions. In 1983, the Supreme Court ruled that Title VII requires an employer-sponsored group health plan to extend equally comprehensive coverage to both sexes and cannot discriminate on sex-based characteristics (*Newport News Shipbuilding Co. v. EEOC*, 462 U.S. 669 (1983)).

While today's ruling is about wrongful employment termination, the decision has implications for employer-sponsored health plans and other benefits. For example, employers may want to adjust group health plan coverage of gender dysphoria and related services, including gender-affirmation surgeries; review and compare benefits for same-sex and opposite-sex spouses; and review the need for gender assignment as an identifier in benefit plan administration. Regardless of today's decision, however, employers can always maintain more expansive benefit and nondiscrimination policies and practices than what federal or state law requires.

Same-sex spousal coverage issues

In *Obergefell v. Hodges* (576 U.S. 644 (2015)), the Supreme Court held that all states must issue same-sex marriage licenses and recognize same-sex marriages validly established elsewhere. The ruling essentially extended marital rights under state laws to same-sex couples in all states. But beyond the state-law implications, *Obergefell* didn't directly address private-sector employment practices. Employers with self-funded group health plans could still offer coverage only to opposite-sex spouses and exclude same-sex spouses from coverage. Nonetheless, a 2018 Kaiser Family Foundation study found that nearly two-thirds (63%) of employers offering health insurance to opposite-sex spouses also offered coverage to same-sex spouses, with large employers almost uniformly offering this benefit.

Before today's ruling, federal legal challenges to an employer's group health plan exclusion of same-sex spouses have asserted a Title VII claim, alleging the exclusion is prohibited sexual orientation discrimination. With today's decision, these challenges now have clear legitimacy under Title VII.

Transgender coverage issues

The term transgender describes a person whose gender identity does not match the gender assigned at birth or does not align with traditional notions of expression of masculinity and femininity. Not all people who identify as transgender have gender dysphoria — a behavioral health diagnosis contained in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) — that requires treatment. Nor do all individuals with gender dysphoria want or need surgical interventions. The process of transitioning is different for each person; what is medically necessary for one person might not be for another. For some, transitioning might only involve changing a name or gender designation. Others may rely on hormones to change features. Some people may require a change to primary sex characteristics, known as gender-affirmation surgery.

Federal challenges to denied benefits for gender dysphoria and gender-affirmation surgery have often come under Title VII of the CRA and Section 1557 of the Affordable Care Act (ACA). Plan beneficiaries argue that Title VII's sex discrimination protections bar employers from discriminating based on gender identity in benefits. Relying on ACA Section 1557, beneficiaries argue that gender identity discrimination — specifically an exclusion of transgender-related services — in health programs and activities receiving federal funds is prohibited. Today's decision will bolster Title VII challenges to transgender benefit exclusions and make reliance on Section 1557 less important for employment discrimination claims.

The cases decided by the Supreme Court today don't specifically address group health plan coverage, but they do create a heightened compliance risk for plans that cover and treat individuals differently based on sexual orientation and/or gender identity. For example, denial of gender-affirmation services deemed medically necessary for an individual diagnosed with gender dysphoria, even though the same services would be covered if deemed medically necessary for a different condition, raises Title VII risks.

Access to transgender care

Treatment for gender dysphoria can involve multiple practitioners over a course of years, with mental health therapy, psychotherapy, hormone therapy and a range of possible surgeries. Mercer's 2019 National Survey of Employer-Sponsored Health Plans found that only 33% of employers with 500 or more employees provided coverage for gender-affirmation surgery, although this figure rose to 69% of employers with 20,000 or more workers. Among employers covering this surgery, many also offer benefits for behavioral health/counseling (80%), hormone therapy (66%) and other associated services (50%).

State insurance mandates. Although state insurance laws don't apply to self-insured ERISA plans, these mandates continue to apply to fully insured plans. The Movement Advancement Project reports that nearly half of all states prohibit insurers from imposing blanket coverage exclusions for items and services related to gender transition. These laws reflect the principle that medically necessary services, including gender-affirmation surgery to treat gender dysphoria, should qualify for the same coverage as medically necessary services for other medical and behavioral health conditions. Along with Washington, DC, states that prohibit blanket coverage exclusions are shown in the following table.

States banning transgender exclusions in health insurance				
California	Colorado	Connecticut	Delaware	Hawaii
Illinois	Maine	Maryland	Massachusetts	Michigan
Minnesota	Montana	Nevada	New Hampshire	New Jersey
New Mexico	New York	Oregon	Pennsylvania	Rhode Island
Vermont	Virginia	Washington		

Several states have also issued insurance guidance on how treatment for gender dysphoria, including medically necessary transgender surgery, applies under the ACA, the Mental Health Parity and Addiction Equity Act (MHPAEA), and related state laws.

Potential federal barrier. Even when a group health plan covers transgender services, access to care can be a challenge. Lack of knowledge about the health needs and concerns of transgender individuals, as well as discrimination in healthcare services, can make it difficult to find compassionate, well-informed practitioners. Under a 2019 final rule from the Department of Health and Human Services (HHS), healthcare workers can refuse to provide services on religious and moral grounds. Although three different district courts have put the final rule on hold, the cases are on appeal. Nevertheless, the Office of Civil Rights (OCR) has used its enforcement authority on at least one occasion to demand changes to a state insurance mandate related to abortion services. Critics are concerned the rule exacerbates access to care barriers for the LGBTQ community and others.

ACA Section 1557 nondiscrimination issues

With the Supreme Court confirming Title VII protections for LGBTQ employees, the ACA's Section 1557 nondiscrimination provision takes on less importance for employees seeking health plan coverage for medical care related to gender dysphoria. Although none of the cases decided today raised Section 1557 issues, the Supreme Court's opinion could influence how lower courts and HHS interpret the scope of this provision's protections.

Section 1557 statutory protections. ACA Section 1557 bans discrimination based on sex (as well as race, age, disability, color and national origin) in health programs and activities receiving federal funds, including providers, hospitals and medical systems. The nondiscrimination provision derives from a number of federal statutes including the Title VI and Title IX of the CRA, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973. Title VI of the CRA bars race, color and national origin discrimination in federally funded programs and activities. Title IX, added to the CRA by the Education Amendments of 1972, extends Title VII's sex nondiscrimination standards to federally funded educational programs and activities. The ACA states that the enforcement mechanisms under these other federal laws apply to address violations of Section 1557. The statute also gives HHS authority to create implementing regulations.

Initial Section 1557 regulations. Final 2016 regulations interpreted Section 1557 to prohibit discrimination based on gender identity, gender expression and transgender status in healthcare, including insurers and even some group health plans. Examples of group health plans subject to Section 1557 include retiree medical plans receiving federal funds, employee plans of hospitals receiving Medicare funding and any plan of an insurer participating on the public exchanges. The regulations also confirmed a private right to sue and seek damages for Section 1557 violations to the same extent as provided under the federal statutes on which Section 1557 is based.

Under these rules, a group health plan subject to Section 1557 couldn't categorically exclude or limit coverage for all health services related to gender-affirmation surgery. Plans covered by Section 1557 also could not impose additional cost sharing or other discriminatory restrictions on health services related to gender dysphoria. Healthcare providers likewise couldn't discriminate against or deny care to transgender individuals. While a federal district court invalidated parts of the nondiscrimination regulations, the matter is on appeal, and individuals have continued to bring lawsuits alleging Section 1557 discrimination when a plan categorically excludes gender-affirmation services.

New Section 1557 regulations. Revised regulations, slated for publication in the June 19 *Federal Register,* remove the healthcare and health coverage protections for transgender individuals and limit the entities subject to Section 1557. Among other significant departures from the 2016 rules, the new final rule:

- Removes language recognizing individuals' right to sue and obtain monetary damages for violations (although this right may exist in the statute)
- Eliminates the gender-identity and sex-stereotyping nondiscrimination requirements for healthcare providers
- Expands healthcare providers' ability to refuse to provide care they find objectionable on religious or moral grounds

- States that Section 1557 does not apply to employer-sponsored group health plans that do not receive federal financial assistance and are not principally engaged in the business of providing healthcare

Future of Section 1557 regulations. The 2020 final rule will undoubtedly face an immediate court challenge seeking a nationwide injunction and eventual invalidation. After today's Supreme Court decision, HHS may have difficulty justifying the removal of transgender protections from the Section 1557 regulations. Today's ruling will also influence the outcome of Section 1557 discrimination claims in federal courts. A number of lower courts have found that a health plan's exclusion of procedures and services related to gender-affirming surgery can constitute sex discrimination prohibited by Section 1557. Today's ruling on Title VII's scope may support similar ACA Section 1557 claims. However, now that the Supreme Court has said Title VII protects transgender individuals from discrimination, reliance on Section 1557 may become less important for disputes involving employment-based coverage.

Mental health parity issues

MHPAEA, which applies to group health benefits for most employers, doesn't mandate coverage of gender dysphoria or gender-affirmation surgery or require employers to provide a particular set of benefits. However, certain limits on behavioral health treatments for gender dysphoria could violate the law if they are not on par with the limits on medical/surgical benefits.

Examples of unlawful limits include a blanket exclusion for gender transition services or financial limits on coverage. Lifetime or annual dollar limits on the services may be problematic under MHPAEA. In addition, medical-management standards — like medically necessary criteria — for gender dysphoria treatments and related services can't be more stringent than the standards for other covered medical conditions. This means a blanket exclusion of gender-affirmation surgery as cosmetic would be impermissible.

Today's decision doesn't change these MHPAEA requirements. Employers reviewing a group health plan's coverage of gender dysphoria in light of today's decision should keep federal parity requirements in mind.

ACA preventive care provision

An interagency FAQ in 2015 (Q5 of ACA Implementation FAQs, Part XXVI) clarified that health plans can't limit sex-specific recommended preventive care based on an individual's sex assigned at birth, gender identity or recorded gender. This guidance is unaffected by today's decision. Employer-sponsored group health plans should continue to comply with the ACA's preventive care requirements.

Discrimination prohibited in federal contracts

Since 2014, Executive Order 11246 has barred federal contractors and subcontractors from discriminating against LGBTQ workers. The order — which historically prohibited discrimination on the basis of race, color, religion, sex and national origin — was amended in 2014 by Executive Order 13672, which added gender identity and sexual orientation to the list. The executive order is unaffected by today's decision. Entities seeking federal contracts must confirm compliance with the order in the contracting process.

State nondiscrimination laws

Today's Title VII decision is particularly impactful for LGBTQ individuals working in states without statutory protections against sexual orientation and gender identity discrimination. Of the estimated 8.1 million LGBTQ workers in the United States, nearly half live in states without statutory protections against sexual orientation and gender identity discrimination in employment, according to a report from the Williams Institute, part of the University of California at Los Angeles School of Law. Those individuals can now look to Title VII for protection from employment discrimination.

State nondiscrimination laws generally apply to employers within that jurisdiction and may extend protections to LGBTQ workers beyond what federal civil rights laws provide. Twenty-two states, Puerto Rico and Washington, DC, ban employment discrimination based on sexual orientation and gender identity, while one state — Wisconsin — prohibits only sexual orientation discrimination, according to the Human Rights Campaign. The following table lists jurisdictions banning both types of employment discrimination.

Jurisdictions barring sexual orientation and gender identity discrimination by employers				
California	Colorado	Connecticut	Delaware	Hawaii
Illinois	Iowa	Maine	Maryland	Massachusetts
Minnesota	Nevada	New Hampshire	New Jersey	New Mexico
New York	Oregon	Puerto Rico	Rhode Island	Utah
Vermont	Virginia	Washington state	Washington, DC	

The Williams Institute reports that agencies in three other states — Michigan, Montana and Pennsylvania — have interpreted the state's nondiscrimination laws to prohibit sexual orientation and/or gender identity discrimination in employment. In these and other states without explicit statutory protections, 12 have gubernatorial executive orders protecting LGBTQ state government employees and, in some cases, state government contractors from discrimination. These states are Alaska, Arizona, Indiana, Kansas, Kentucky, Michigan, Missouri, Montana, North Carolina, Ohio, Pennsylvania and Virginia.

These state nondiscrimination laws may require employers to extend benefits on the same terms to same-sex and opposite-sex spouses and may prohibit a fully insured employer plan from denying or limiting health coverage for gender-transition items or services. These laws could also apply to state and local governments and church plans that are not subject to ERISA, as well as self-insured plans if ERISA's preemption of state law does not apply.

The state laws explicitly protecting LGBTQ workers from discrimination are unlikely to change as a result of today's decision. However, the ruling could influence agency or judicial interpretation of parallel state civil rights statutes that don't have explicit LGBTQ protections. In addition, state government policy is always subject to change with a change in administration.

Employer considerations

Today's Title VII decision will have far-reaching consequences for employers and the workforce that go well beyond benefits and could influence how other federal and state sex nondiscrimination laws apply to sports, schools and public accommodations. For now, employers evaluating existing limits on health coverage for same-sex spouses or gender-transition services in light of today's decision need to keep in mind not just Title VII but also other federal and state laws protecting the LGBTQ community. When designing benefits, employers should seek out clinical expertise and carrier positions and keep diversity and inclusion goals in sight. Employers can always maintain nondiscrimination policies and practices broader than what federal or state law requires.

Here are some things for employers to do in light of today's decision:

- Review anti-harassment and other workplace policies and training programs on LGBTQ issues, taking applicable federal and state laws into consideration.
- For employers that are federal contractors or subcontractors, ensure compliance with the ongoing contracting requirements prohibiting LGBTQ discrimination.
- For employers receiving federal funding for their health plans or other health activities, follow developments in the ACA Section 1557 nondiscrimination guidance.
- Review group health plan coverage for same-sex spouses, services related to gender dysphoria and gender-affirmation surgeries. Consider state coverage mandates for fully insured plans, MHPAEA compliance challenges, and risk of employment discrimination claims under state or federal laws.
- Review the group health plan's provider network for adequate access to providers supportive of and knowledgeable about LGBTQ healthcare. Consider a provider directory identifying practitioners welcoming LBGTQ patients and/or with expertise in LGBTQ health-related expertise.

- Review benefit administration gender-assignment requirements, and consider options for more inclusive descriptors.
- Review disability plan coverage for temporary disability due to gender-affirmation surgeries.
- Review employee assistance programs or other support-service vendors (e.g., digital behavioral health) for offerings specific to the needs of LGBTQ members.
- Consider family-planning benefits within the group health plan and elsewhere that include LGBTQ employees. A 2018 LGBTQ Family Building Survey from the Family Equality Council indicated up to 3.8 million LGBTQ millennials were considering expanding their families, with many expecting to use assisted reproductive technology, foster care or adoption.
- Employers with strongly held religious beliefs should consult with legal counsel if they wish to exclude treatments for gender dysphoria, including but not limited to gender-affirmation surgeries, in the group health plan.

Related resources

Non-Mercer resources

- *Bostock v. Clayton Cty., Ga.*, No. 17-1618 (U.S. June 15, 2020)
- Final Section 1557 regulations: Nondiscrimination in health and health education programs or activities (Federal Register prepublication draft, June 12, 2020)
- Equality maps: Healthcare laws and policies (Movement Advancement Project, June 2, 2020)
- State maps of LGBTQ employment laws and policies (Human Rights Campaign, April 15, 2020)
- LGBTQ protections from discrimination: Employment and public accommodations (Williams Institute, April 2020)
- LGBTQ discrimination, subnational public policy and law in the United States (Williams Institute, January 2020)
- US solicitor general's amicus brief in *Bostock v. Clayton County* and *Altitude Express v. Zarda* (US Supreme Court, Aug. 23, 2019)
- Brief for federal respondent in *R.G. & R.G. Harris Funeral Homes v. EEOC* (US Supreme Court, Aug. 16, 2019)

- Brief for respondents in *Altitude Express v. Zarda* (US Supreme Court, June 26, 2019)
- Brief for respondent Aimee Stephens in *R.G. & G.R. Harris Funeral Homes v. EEOC* (US Supreme Court, June 26, 2019)
- Proposed Section 1557 revised rule: Nondiscrimination in health and health education programs or activities (June 14, 2019)
- Final rule: Protecting statutory conscience rights in health care (Federal Register, May 21, 2019)
- Brief for petitioner in *Bostock v. Clayton County* (US Supreme Court, May 25, 2018)
- Memorandum: Revised treatment of transgender employment discrimination claims under Title VII of the Civil Rights Act of 1964 (Office of the US Attorney General, Oct. 4, 2017)
- Original Section 1557 final rule: Nondiscrimination in health and health education programs or activities (Federal Register, May 18, 2016)
- FAQs about ACA implementation (Part XXVI) (Labor Department, HHS and IRS, May 11, 2015)
- What you should know: The EEOC and the enforcement protections for LGBT workers (EEOC, May 4, 2015)
- Memorandum: Treatment of transgender employment discrimination claims under Title VII of the Civil Rights Act of 1964 (Office of the US Attorney General Dec. 15, 2014)

Mercer Law & Policy resources

- Healthcare law and policy outlook for 2020 (Feb. 18, 2020)

Other Mercer resources

- Does your health plan meet the needs of transgender individuals? (March 27, 2019)
- Changes signal shift in diversity and inclusion benefits (Sept. 6, 2018)

Note: Mercer is not engaged in the practice of law, accounting or medicine. Any commentary in this article does not constitute and is not a substitute for legal, tax or medical advice. Readers of this article should consult a legal, tax or medical expert for advice on those matters.

NASHP

Proposed IRS Rule Would Incentivize Health Care Sharing Ministries and Direct Primary Care Arrangements

June 15, 2020 / by Christina Cousart

Last week, the Internal Revenue Service (IRS) released a proposed rule [https://www.federalregister.gov/documents/2020/06/10/2020-12213/certain-medical-care-arrangements] that would for the first time allow tax deductions for money spent for certain health care programs and arrangements, including direct primary care arrangements and health care sharing ministries.

The changes appear designed to incentivize and promote programs that may supplement – but in some cases are misconstrued as an alternative to – health insurance. These options do not provide comprehensive benefits and lack many safeguards that ensure access to services while also protecting consumers from financial liability for excessive costs of care. Comments on the proposed rule are due by Aug. 10, 2020 and may be submitted here [https://www.federalregister.gov/documents/2020/06/10/2020-12213/certain-medical-care-arrangements] .

The Rise of Health Insurance "Alternatives"

Rising health care costs and coverage have made health insurance too expensive for many Americans. This has driven many Americans to seek alternate ways to access the care they need. One option that has gained popularity in recent years is health care sharing ministries, organizations whose members who share a common set of religious or ethical beliefs come together to share medical expenses. It is estimated [http://ahcsm.org/about-us/data-and-statistics/] that nearly 1 million individuals currently participate in health ministries across 29 states.

Similarly, direct primary care arrangements (DPCAs) have also gained popularity. In a DPCA, a patient contracts directly with a primary care provider, or group of primary care providers, to access services at a set annual or periodic fee. These arrangements eliminate use of a third-party (a health insurer) in negotiations over care and cost, though in some cases may serve as a supplement to an individual or employer's health insurance policy. Contracts vary as to what services might be covered under each DPCA, such as number of visits or laboratory service costs. Rarely do they include the type of specialty care services that may be necessary for treatment of diseases. More than 300,000 individuals participate in DCPAs [https://www.dpcare.org/about] in 48 states and Washington, DC.

Because of the limited scope of DPCA and health ministries, they are typically not classified as health insurance under state and federal laws. This means that they are exempt from many laws and regulations that govern health insurance coverage, including consumer protection laws such as mandated coverage of certain benefits (like hospitalizations) and protections for those with pre-existing conditions. These consumer laws also include financial protections like caps on out-of-pocket consumer spending and requirements that compel health insurers to spend at least 80 percent of payments they collect toward care received by members.

Direct primary care is a financial arrangement made directly between a patient and health care provider. The arrangements are separate from, though sometimes can supplement, health insurance.

Health care sharing ministries are non-insurance entities whose members *share common beliefs and share medical expenses.*

Neither of these alternative plans provide comprehensive health coverage that insurance plans are required to provide.

In 2019, monthly health insurance premiums on the individual insurance market averaged $580 per month per person, or $6,060 per year. *Source: Kaiser Family Foundation, May 2020* [https://www.kff.org/private-insurance/issue-brief/individual-insurance-market-performance-in-2019/]

Proposed Regulatory Changes

During annual tax filings, individuals may opt to either take a standardized deduction or itemize their applicable deductions. Those who opt to itemize deductions may include medical expenditures as part of their deductions *if* those expenses total more than 10 percent of the individual's (or household's) income. Allowable medical expenses include payments made for:

- The diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body;
- Transportation to essential for medical care;
- Qualified long-term care services; and
- Insurance covering medical care or qualified long-term care (Internal Revenue Code § 213(d))

The rule proposes to include DPCAs and ministries as allowable medical care expenses for the purposes of tax deductions. Specifically, the rule interprets the definition of "insurance covering medical care" to include ministries and, in some cases, DPCAs. DPCAs would also qualify as payments made for "diagnosis, cure, etc. of disease". In addition, the rule clarifies that payments made to government-sponsored health care programs, such as Medicare, Medicaid, the Children's Health Insurance Program (CHIP), TRICARE, and the Veteran's Health Program, would count as payments toward insurance and so could be included as medical care deductions. These changes would take effect as for the tax year following adoption of the final rule (likely tax year 2021).

As elaborated in the proposed rule, the classification of ministries and some DPCAs as insurance relies heavily on existing regulations governing tax deductions, which

broadly define health insurance to include insurance that covers medical care and contracts "for membership in an association furnishing cooperative or so-called free-choice medical service". This definition differs from other common definitions of insurance, including the Employee Retirement Income Security Act (ERISA) and the Public Health Service Act (PHS Act), which define insurance as "benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or a health maintenance organization (HMO) contract offered by a health insurance issuer."

> In 2019, the standard deduction [https://www.investopedia.com/terms/s/standarddeduction.asp] was $12,200 for a single individual and $18,659 for a head of household). Approximately one-third of tax filers [https://www.taxpolicycenter.org/briefing-book/what-are-itemized-deductions-and-who-claims-them#:~:text=In%20recent%20years%2C%20about%2030,and%20medical%20and%20dental%2 opt to itemize their deductions. The majority of which are high-income earners (with incomes exceeding $500,000 per year) who have greater ability to spend income above the standard threshold.

The proposed rule clarifies that its definition of insurance should have no bearing on whether health ministries should be considered insurance under other state or federal laws. However, the changes have implications for how DPCAs and ministries would be treated in relation to other programs designed to support consumer spending on health care services, specifically health reimbursement arrangements (HRAs) and health savings accounts (HSAs). Because of the changes in how health ministries and DPCAs would be classified under this proposed rule:

- Health ministry participants could not contribute toward an HRA; and
- Neither DPCA nor ministry participants could contribute toward an HSA (with some narrow exceptions allowed for limited DPCAs). However, an HRA may be used to provide reimbursement for a DPCA.

Potential Impact of Proposed Changes

The changes proposed under the rule may have limited actual impact on consumers, in part because of the high threshold for spending consumers must meet to make it worth itemizing their deductions (see box). Because of this threshold, these deductions are unlikely to have any bearing for low-income earners, including those who qualify for Medicaid and CHIP and could, technically, deduct spending related to those programs as clarified under the proposed regulation. Furthermore, it is unlikely that spending on health ministries or DPCAs alone could push an individual above the standard deduction threshold. Monthly fees for DPCAs [https://www.statnews.com/2018/09/06/direct-primary-care-doctors-patients/#:~:text=In%20a%20nutshell%2C%20direct%20primary,mostly%20basic%20prima range from $50 to $200 per month. Spending on health ministries varies, with one report [https://www.healthinsurance.org/other-coverage/healthcare-sharing-ministries-a-leap-of-faith/#:~:text=A%20single%2050%2Dyear%2Dold,range%20from%20%24301%20to%20%24 indicating that spending could range from a few hundred dollars to up to $1,000 per month depending on factors including age and household size.

Nonetheless, the idea of the deduction may entice more individuals to participate in these plans. While health ministries and DPCAs may serve a role in *supplementing* how consumers access or pay for care, there are growing concerns about their effect on consumers and health care markets when purchased in lieu of health insurance coverage. For example, these consumers will not be included in health insurance risk pools. This could result in higher premiums for those who remain in the market, as there will fewer individuals to spread risk.

Especially concerning are increasing reports of health ministries engaged in marketing practice that mislead consumers [https://www.commonwealthfund.org/publications/fund-reports/2018/aug/health-care-sharing-ministries] into thinking that their products are comparable to health insurance. However, because these products do not guarantee coverage of certain costs or services, they may leave consumers on the hook for high medical expenses. States, including Nevada [http://doi.nv.gov/News_Notices/Press_Releases/Don%E2%80%99t_be_fooled_by_claims_compliant_%E2%80%9Clook-alike%E2%80%9D_health_insurance_products/],

have issued broad warnings to consumers about health ministries [http://doi.nv.gov/News_Notices/Press_Releases/Don%E2%80%99t_be_fooled_by_claims_compliant_%E2%80%9Clook-alike%E2%80%9D_health_insurance_products/] and regulators in California [http://www.insurance.ca.gov/0400-news/0100-press-releases/2020/release026-2020.cfm#:~:text=Department%20Issues%20Cease%20and%20Desist%20Order%20to%20P, Colorado [https://drive.google.com/file/d/1usc5RlAer15TyLolVbb57YmSyWuSBVPs/view], Connecticut [https://portal.ct.gov/-/media/CID/1_Orders/Order-MC-19-109.pdf?la=en], Maryland [https://insurance.maryland.gov/Pages/newscenter/NewsDetails.aspx?NR=2020249], New Hampshire [https://www.nh.gov/insurance/documents/press-relase-aliera-cease-desist-10-30-19.pdf], New York [https://khn.org/morning-breakout/new-york-subpoenas-business-that-markets-christian-cost-sharing-ministry-as-substitute-for-health-coverage/], Texas [https://www.tdi.texas.gov/news/2019/tdi05172019.html], Rhode Island [https://www.wpri.com/news/call-12-for-action/ri-warns-of-fraudulent-health-care-plan/], Vermont [https://dfr.vermont.gov/press-release/dfr-orders-unlicensed-entities-cease-and-desist] and Washington [https://www.insurance.wa.gov/news/kreidler-bans-trinity-healthshare-collects-150000-fine?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=] State have taken aggressive actions, including issuing cease-and-desist orders, against one ministry for deceptive practices.

The National Academy for State Health Policy will monitor states' responses to the proposed regulation. Final comments on the proposed rule are due Aug. 10, 2020. The full text of the rule can be found here [https://www.federalregister.gov/documents/2020/06/10/2020-12213/certain-medical-care-arrangements].

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