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COVERED CALIFORNIA

News Release

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FOR IMMEDIATE RELEASE
Jan. 12, 2021

Covered California Begins New Year With a Record Number of Plan Selections, Serving Those Hardest Hit by the Pandemic, as State Experiences Post-Holiday Surge of New COVID-19 Cases

- *Nearly 1.6 million Californians have renewed their coverage or enrolled for the first time for 2021 coverage, setting a new enrollment record in the midst of the worst COVID-19 spike since the beginning of the pandemic.*
- *The record enrollment total is 200,000 higher than the same time period last year, with significant portions of low-income consumers and communities of color, which are among the groups hardest hit by the COVID-19 pandemic.*
- *With a dramatic increase in post-holiday COVID-19 cases, Covered California and other state health leaders continue to encourage people to take precautions: wear a mask, wash your hands, watch your distance, stay home when you can, and get covered with a quality health insurance plan.*
- *Covered California's open-enrollment period runs through Jan. 31, and of the 2.7 million Californians who are uninsured, an estimated 1.2 million are eligible for financial help from Covered California or through Medi-Cal.*

SACRAMENTO, Calif. — Covered California announced on Tuesday that it has begun the New Year with a record number of people who have signed up for coverage amid a severe spike in COVID-19 cases across the state. A record 1.6 million Californians had either renewed their coverage or selected a plan during open enrollment for health insurance coverage starting Jan. 1, 2021. The total represents an increase of almost 200,000 (14 percent) over the same time period last year.

"With the pandemic continuing to surge across the state, now is not the time to be uninsured," said Peter V. Lee, executive director of Covered California. "We are in the

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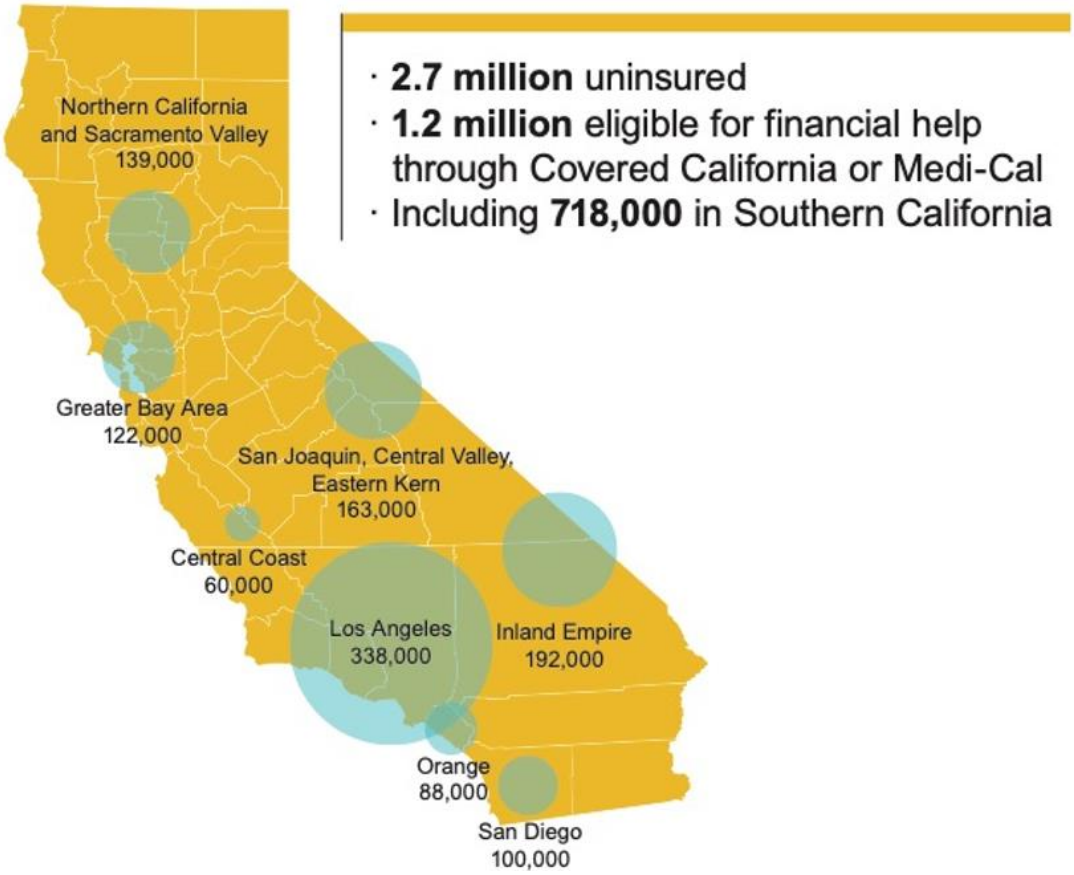
midst of a post-holiday surge, and we want to encourage anyone who needs health care coverage to check out their options and sign up so they can get covered in 2021."

More than 2.7 million Californians have been infected by the virus, and the death total is expected to surpass 30,000 today.

"While collectively we are all hands are on deck to distribute vaccines across the state, we cannot let our guard down during this rise in cases and hospitalizations because the ability to transmit the virus from one person to another is so high right now," said Dr. Mark Ghaly, the California Health and Human Services secretary and chair of the Covered California Board of Directors. "We all need to do our part to defeat this pandemic, and that means wearing a mask, staying home and getting covered with a quality health insurance plan."

Right now, of the 2.7 million Californians who are uninsured, an estimated 1.2 million are eligible for financial help through Covered California, or they qualify for low-cost or no-cost coverage through Medi-Cal. The largest portion of these uninsured who are eligible for help are in Southern California, with an estimated 718,000 people eligible for financial help in the Los Angeles, Inland Empire, Orange and San Diego metro areas (see Figure 1: Where California's Uninsured Who Are Eligible for Financial Help Live).

Figure 1: Where California's Uninsured Who Are Eligible for Financial Help Live



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“Most of the people who are uninsured who can get help do not know they are eligible for financial assistance, or they have not checked recently to see how affordable quality coverage can be,” Lee said. “No one should wait to sign up. Enroll now and tell your family and friends so we can make sure everyone possible has health insurance during this pandemic.”

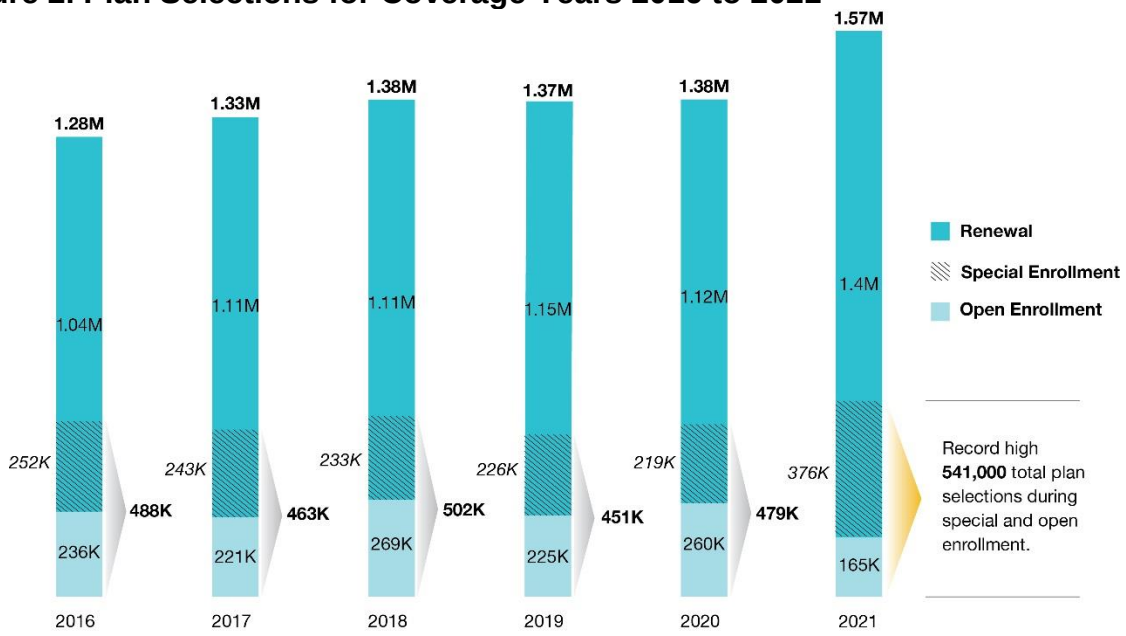
The most recent data shows that 1.4 million people, or nearly 90 percent of Covered California’s enrollees, are receiving some level of financial help that lowers the cost of their monthly premium by an average of nearly 80 percent.

Of those receiving financial help, almost half — over 640,000 — are benefiting from the state subsidy program launched in 2020 to make coverage more affordable, including 44,500 middle-income consumers who were previously ineligible for assistance because they exceeded the federal income requirements.

Record Plan Selections

The record number of consumers signing up for a plan comes after Covered California opened a special-enrollment period throughout the spring and summer and signed up hundreds of thousands of people who either did not have health insurance or lost their coverage due to the pandemic and recession. With this outreach, the total of those going into 2021 with coverage purchased during special enrollment in 2020 and those newly signing up during the current open-enrollment period totaled 541,000 — the largest figure for new sign-ups since the end of a preceding open-enrollment period in Covered California’s history (see Figure 2. Plan Selections for Coverage Years 2016 to 2021).

Figure 2. Plan Selections for Coverage Years 2016 to 2021[i1]



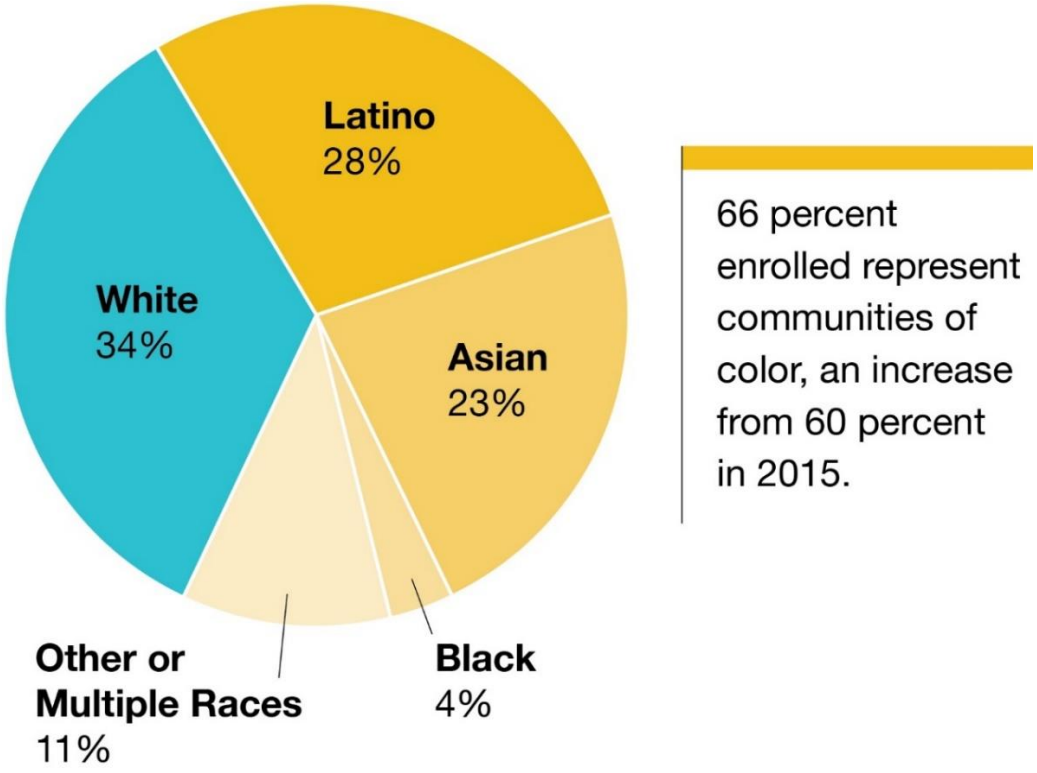
[1] “Special Enrollment” is a subset of the renewal population. For example, of the 1.4 million renewing consumers for 2021, 376,000 had newly signed up during the special-enrollment period during 2020.

While the number of plan selections — both overall and in the combined special enrollment and open-enrollment periods — is at a historic high, the new enrollment seen during the current open-enrollment period is down from the all-time high Covered California saw during this time last year. The biggest likely contributor to that change is that fact that many of those, who in prior years would have signed up during open enrollment, got coverage earlier during the special-enrollment period.

“When the pandemic began to hit California hard in the spring, Covered California opened its doors to every eligible consumer because it was the right thing to do,” Lee said. “This is a year like no other, but we are seeing Covered California meet the needs of those hardest hit by the COVID pandemic — including communities of color and lower-income Californians.”

Over the past six years, Covered California has seen a steady increase in the diversity of its new consumers who sign up during special and open enrollment. The data shows that nearly two-thirds (66 percent) are from communities of color, which represents an increase from 60 percent in 2015 (see Figure 3. Special and Open-Enrollment Plan Selections by Ethnicity).

Figure 3. Special and Open-Enrollment Plan Selections by Ethnicity[2]



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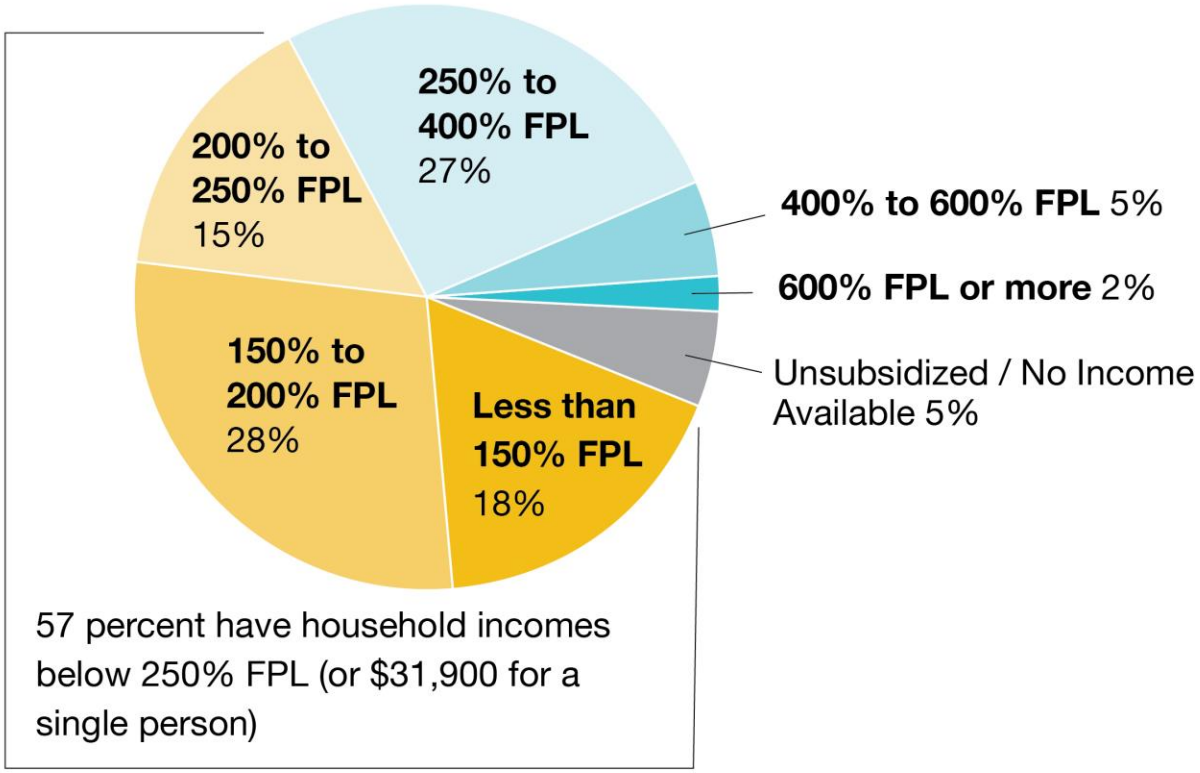
[2] All plan selections since the end of 2020 open enrollment through Dec. 31, 2020, including new enrollments during both 2020 special enrollment and 2021 open enrollment.

The data also highlights Covered California's critical role in helping low-income Californians — those hardest hit by the COVID pandemic — get access to necessary health care. Of the record number of plan selections, 57 percent of consumers have an annual household income of less than 250 percent of the federal poverty limit (FPL), which corresponds to just under $32,000 for a single person household (see Figure 4. Covered California 2021 Net Plan Selections by Income).

"These are Californians who are most vulnerable to the pandemic, many of them working hourly jobs or in the service industry, who have been hardest hit by the crisis," Lee said. "Covered California helps give them access to some of the best care in the country and the peace of mind in knowing that they have insurance to protect them if the worst happens."

Figure 4. Covered California 2021 Net Plan Selections by Income



Additionally, 44,500 middle-income Californians now benefit from the state subsidy program, which is the first in the nation providing financial assistance to consumers whose income exceeds the federal requirements. Under the landmark program, Californians earning up to $76,560 — or a family of four with a household income of up to $157,200 — may be eligible for financial help to lower the cost of their coverage.

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Shop and Compare

Those interested in applying for coverage can explore their options — and find out whether they are eligible for financial help — in just a few minutes by using the Shop and Compare Tool at CoveredCA.com. All they need to do is enter their ZIP code, household income and the ages of those who need coverage to find out which plans are available in their area.

Consumers who sign up by Jan. 31 will need to pay their first bill in order to have their coverage take effect on Feb. 1.

“Now is not the time to be sick and uninsured as California continues to endure the worst pandemic in modern history,” Lee said. “Don’t put yourself or your family at risk. Sign up now and be covered on Feb. 1.”

Lee added that, in light of the pandemic, Covered California will continue to evaluate what the agency may do after the Jan. 31 deadline if further action is needed to help Californians during this critical time.

Another important reason to sign up is that California’s individual mandate penalty remains in place for 2021. Consumers who can afford health care coverage, but choose to go without, could pay a penalty when filing their state income taxes in 2022. The penalty is administered by California’s Franchise Tax Board, and could be as much as $2,250 for a family of four.

Getting Help Enrolling

Consumers interested in learning more about their coverage options can:

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

About Covered California

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

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

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[i] Data through Dec. 31, 2020. Renewal data for 2021 reflect net plan selections as of this release. The final count of renewal plan selections reported at end of the open-enrollment period may be slightly lower due to lags in carrier transactions; based on 2020 plan year data patterns, the final number of net renewals *may* decrease an estimated 1.0 and 1.5 percent of renewals, or ~25,000 consumers from what is seen as of Dec. 31, 2020. Open enrollment began on Oct. 15 for the 2020 coverage year and Nov. 1 for 2021.

Fact sheet

2021 Special Enrollment Period in response to the COVID-19 Emergency

Jan 28, 2021 Affordable Care Act

The coronavirus disease 2019 (COVID-19) national emergency has presented unprecedented challenges for the American public. Millions of Americans are facing uncertainty and millions of Americans are experiencing new health problems during the pandemic. Due to the exceptional circumstances and rapidly changing Public Health Emergency (PHE) impacting millions of people throughout the US every day, many Americans remain uninsured or underinsured and still need affordable health coverage. In accordance with the Executive Order issued today by President Biden, the Centers for Medicare & Medicaid Services (CMS) determined that the COVID-19 emergency presents exceptional circumstances for consumers in accessing health insurance and will provide a Special Enrollment Period (SEP) for individuals and families to apply and enroll in the coverage they need. This SEP will be available to consumers in the 36 states served by Marketplaces that use the HealthCare.gov platform, and CMS will conduct outreach activities to encourage those who are eligible to enroll in health coverage. CMS strongly encourages states operating their own Marketplace platforms to make a similar enrollment opportunity available to consumers in their states.

Starting on February 15, 2021 and continuing through May 15, 2021, Marketplaces using the HealthCare.gov platform will operationalize functionality to make a SEP available to all Marketplace-eligible consumers who are submitting a new application or updating an existing application. These consumers will newly be able to access the SEP through a variety of channels: through HealthCare.gov directly, the Marketplace call center, or direct enrollment channels. Additionally, consumers can work with a network of over 50,000 agents and brokers who are registered with the Marketplace, along with over 8,000 trained assisters, ready to assist consumers with their application for coverage.

To promote the SEP and ensure that a broad and diverse range of consumers are aware of this implementation, CMS will conduct an outreach campaign in cooperation with community and stakeholder organizations, focused on education and awareness of this

new opportunity to enroll in English, Spanish and other languages. CMS outreach efforts will use a mix of paid advertising and direct outreach to consumers. Outreach efforts will include considerable awareness building efforts to encourage the uninsured and those who come to HealthCare.gov to explore coverage to continue the process and enroll. CMS plans to spend $50 million on outreach and education, on a mix of tactics to increase awareness, including advertisements on broadcast, digital, and an earned media.

Some consumers may already be eligible for other existing SEPs, Medicaid, or the Children's Health Insurance Program (CHIP) – they can visit HealthCare.gov now to find out if they can enroll even before this new SEP. Starting February 15, consumers seeking to take advantage of this SEP can find out if they are eligible by visiting HealthCare.gov, and are no longer limited to calling the Marketplace call center to access this SEP. Consumers who are eligible and enroll under this SEP will be able to select a plan with coverage that starts prospectively the first of the month after plan selection. Consumers will have 30 days after they submit their application to choose a plan. Current enrollees will be able to change to any available plan in their area without restriction to the same level of coverage as their current plan. In order to use this SEP, current enrollees will need to step through their application and make any changes if needed to their current information and submit their application in order to receive an updated eligibility result that provides the SEP before continuing on to enrollment. This SEP opportunity will not involve any new application questions, or require consumers or enrollment partners to provide any new information not otherwise required to determine eligibility and enroll in coverage. In addition, consumers won't need to provide any documentation of a qualifying event (e.g., loss of a job or birth of a child), which is typically required for SEP eligibility.

As always, consumers found eligible for Medicaid or CHIP will be transferred to their state Medicaid and CHIP agencies for enrollment in those programs.

To read the **executive order**, visit: https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-care-act/

To read the HHS **press release**, visit: https://www.hhs.gov/about/news/2021/01/28/hhs-announces-marketplace-special-enrollment-period-for-covid-19-public-health-emergency.html

For more information about the Health Insurance Marketplace®[1], visit: https://www.healthcare.gov/quick-guide/getting-marketplace-health-insurance/

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[1] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services

A federal government website managed and paid for by the U.S. Centers for Medicare & Medicaid Services.

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CCIIO Data Brief Series

Affordability in the Marketplaces remains an issue for Moderate Income Americans

January 2021

I. Overview

Ten years after the enactment of the Affordable Care Act (ACA), health care coverage remains unaffordable and out of reach for many Americans. While the ACA's premium tax credit subsidies lower the cost of premiums for some lower-income individuals, the initial implementation and structure of the ACA substantially increased the cost of health insurance premiums for middle-income individuals and families who do not qualify for the ACA's premium subsidies.[1] These people represent a portion of the approximately 30 million Americans who remain uninsured.

Affordability remains an issue across all insurance markets in the United States. Both the employer-sponsored market and the individual market have seen a significant rise in premiums since the ACA was passed. For example, annual premiums for single coverage for employer-sponsored insurance (ESI) increased 48 percent since 2010 and worker contributions have increased 38 percent over the same time period.[2] Premiums in the individual market increased by a much larger margin in just the first four years after the ACA's main health insurance market reform requirements took effect. Between 2013 and 2017, average individual market premiums in states with Exchanges using HealthCare.gov more than doubled.[3] While premiums have declined after CMS began implementing a number strategies to stabilize the market in 2017, premiums remain substantially higher than pre-ACA levels. In addition, across the health care sector, the underlying cost of health care continually outpaces inflation, which is unsustainable for the industry and the country.

This report provides data on the affordability of coverage available to people on the individual health insurance market - the market that was most heavily impacted by the ACA's new market reform requirements in 2014. Overall, the data in this report illustrate that affordable health coverage is not available for many consumers purchasing coverage on the individual market who do not qualify for the ACA's subsidies.

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[1] HHS, "Individual Market Premium Changes: 2013 – 2017", May 23, 2017. https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf

[2] Kaiser Family Foundation, "2020 Employer Health Benefits Survey." Oct 2020. https://www.kff.org/health-costs/report/2020-employer-health-benefits-survey/ (Figure 6.4)

[3] HHS, "Individual Market Premium Changes: 2013 – 2017", May 23, 2017. https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf

II. Measures of Affordability

There is no single definition of affordability in the context of health care. There are many factors to consider when measuring the affordability of health insurance coverage, such as family income, monthly premiums, and cost sharing requirements. As a practical matter, affordability is often measured by whether a household is able to cover their health care costs and also pay for necessities such as housing, transportation, and food.[4]

The tax code has provided a deduction for unreimbursed medical expenses that exceed a certain proportion of income, which recognizes a point at which medical expenses become excessive and warrant relief. This threshold began at 5.0 percent of net income in 1942, was later increased to 7.5 percent of adjusted gross income (AGI) in 1986, and the ACA then increased this threshold to 10 percent of AGI for individuals below age 65. Congress recently reduced the AGI level back to 7.5 percent starting in 2017.[5]

Under the ACA, an employer-sponsored health plan is deemed unaffordable to the employee for purposes of determining whether an individual offered employer-sponsored coverage may be eligible for premium tax credits if the employee's cost of the lowest cost self-only plan exceeds 9.78 percent of the employee's household income for 2020 (for 2021, this affordability test is set at 9.83% of household income). Whether or not this is the best baseline for assessing affordability remains an open question, but it is the current benchmark under the ACA.

Within this framework, this report analyzes affordability as an individual's potential premium and out-of-pocket costs, as well as regional variations in health care costs.

III. The ACA's Impact on Individual Market Premiums

As previously noted, average individual market premiums in states with Exchanges using HealthCare.gov more than doubled between 2013 and 2017. This increase in premiums is primarily due to the implementation of the ACA's insurance reforms in 2014, including decisions on how to implement these requirements. Actuaries have identified a number of ACA requirements that contribute to substantially higher premiums, including the closure of state high risk pools, mandated premium rating requirements including compressed age rating bands, a more generous set of mandated essential health benefits, health insurance taxes, and the Exchange user fees.[6]

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[4] Weiner, Janet et al. "What is 'Affordable' Health Care?" PennLDI. November 2018. https://ldi.upenn.edu/sites/default/files/pdf/Penn%20LDI%20and%20USofC%20Affordability%20Issue%20Brief_Final.pdf

[5] IRS "Medical and Dental Expenses," Publication 502, (2019). https://www.irs.gov/publications/p502

[6] *See* Milliman, Comprehensive Assessment of ACA Factors That Will Affect Individual Premiums in 2014, April 25, 2013.

Certain decisions on how to implement the ACA have also led to higher premiums, including decisions on Exchange implementation, the allowance of transitional policies, and the lack of Exchange verification of eligibility for special enrollment periods (SEP). Various decisions led to initial failures and ongoing glitches on Exchanges during the early years of implementation.[7] Research suggests these initial failures may have had long-term impacts on premiums and consumer welfare.[8] After insurers sent out cancelation notices for policies that did not meet the ACA's requirements in 2013, a policy decision was made to allow insurers to nonetheless continue renewing these "transitional" noncompliant policies. This decision likely kept healthier people from joining the individual market, contributing to substantial claims losses in 2014 and 2015, which contributed to substantial premium increases in 2016 and 2017.[9] Finally, early decisions allowed greater flexibility and lax enforcement of SEPs. This increased issuers' exposure to adverse selection by making it easier for people to time enrollment for only those months when they incurred health expenses.[10]

In addition to the ACA market reform requirements on insurance markets, the structure of the premium tax credit also encourages premium inflation because the amount of the subsidy is linked to the overall cost of the health plan. The ACA's subsidy structure subsidizes the full amount of premiums above a certain proportion of income on a sliding scale, which means the value of the premium tax credit subsidy effectively rises in lock step with rising premiums (see discussion below). This substantially reduces insurers' incentive to constrain premium growth because the federal government fully funds the premium increases for those who qualify for the ACA's subsidies. Research suggests this type of subsidy weakens competition, resulting in higher premiums and subsidy costs for the government.[11]

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[7] *See e.g.*, Office of Inspector General, HealthCare.gov: Case Study of CMS Management of the Federal Marketplace February 2016), available at https://oig.hhs.gov/oei/reports/oei-06-14-00350.pdf; and Minnesota Office of the Legislative Auditor, Evaluation Report: Minnesota Health Insurance Exchange (MNsure) (February 2015), available at https://www.auditor.leg.state.mn.us/ped/2015/mnsuresum.htm.

[8] See Amanda Kowalski, "The Early Impact of the Affordable Care Act State-by-State," National Bureau of Economic Research Working Paper 20597 (October 2014), available at https://www.nber.org/papers/w20597; and Florian Scheuer and Kent Smetters, "Could a website really have doomed the health exchanges? Multiple equilibria, initial conditions and the construction of the fine," National Bureau of Economic Research Working Paper 19835 (January 2014), available at https://www.nber.org/papers/w19835.

[9] Erik Huth and Jason Karcher, "A financial post-mortem: Transitional policies and the financial implications for the 2014 individual market," Milliman, July 20, 2016, available at https://www.milliman.com/en/insight/a-financial-post-mortem-transitional-policies-and-the-financial-implications-for-the-2014.

[10] *See* Laura F. Garabedian, et al., "Costs Are Higher For Marketplace Members Who Enroll During Special Enrollment Periods Compared With Open Enrollment," *Health Affairs*, Vol. 39, No. 8 (August 2018), available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01155; and Rebecca Diamond, et al., "Take-up, drop-out, and spending in ACA marketplaces," National Bureau of Economic Research Working Paper 24668 (May 2018), available at https://www.nber.org/papers/w24668;

[11] Sonia Jaffe and Mark Shepard, Price Linked Subsidies and Health Insurance Markups, HKS Working Paper No. RWP17-002 (January 24, 2017), available at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2910012.

IV. The ACA Subsidies

For lower-income people in need of health insurance, the ACA attempts to improve the affordability of coverage and access to care by offering premium subsidies to individuals with annual household incomes starting at 100 percent of FPL ($12,490) up to 400 percent of FPL ($49,960).[12] The subsidy amounts an individual can receive are based on income and decrease as household income increases. Under this structure, people are expected to pay a certain percent of income toward the premium of a benchmark plan (i.e. second lowest-cost silver plan), ranging from 2.07 percent of income at 100 percent of the federal poverty level (FPL) to 9.83 percent of income at 400 percent of FPL.[13] In addition, the ACA requires issuers to provide Cost Sharing Reductions (CSRs) to reduce out-of-pocket medical costs for enrollees who make between 100 and 250 percent FPL.[14] In effect, this structure establishes a sliding scale income-based affordability standard.

Despite these subsidies, coverage and care remain unaffordable for many, particularly for those who receive minimal or no financial assistance. Moderate-income consumers who make just over 400 percent of FPL do not qualify for cost sharing or premium subsidies and shoulder the full cost of high premiums. As the data in this report show, many of these consumers find themselves priced out of the market entirely.

V. The ACA's Subsidy Cliff

Health insurance premiums are not affordable for many people without access to subsidies. There is a steep difference in how much an individual with a household income over 400 percent FPL will pay in premiums compared to an individual with a lower household income. This is often referred to as the "subsidy cliff."[15] The subsidy cliff is steepest for older moderate-income consumers near retirement age.[16] As Figure 1 illustrates, premium prices for older, pre-Medicare moderate-income consumers far exceed the ACA-defined benchmark of no more than 9.83 percent of household income. For example, premium costs for a 60-year old earning just over 400 percent of FPL are on average 25.8 percent of their income. To put this in perspective, on average an older consumer with an annual income of $50,000 would pay $12,886 per year in premium costs (see Figure 1 below and Appendix IV for additional age bands).

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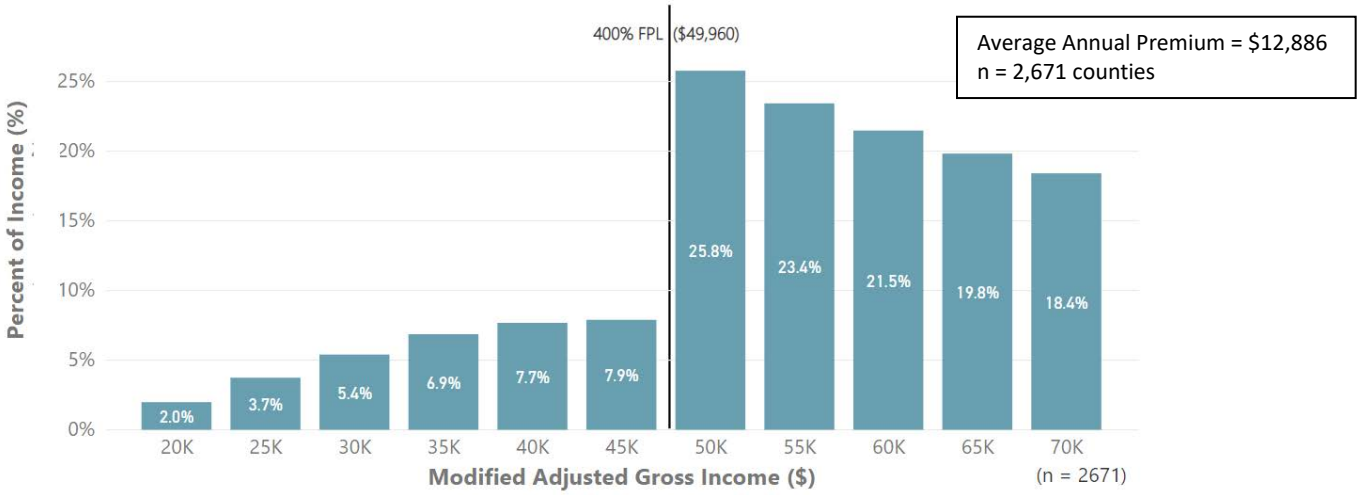
[12] Federal poverty levels from 2019, used to calculate premiums for plan year 2020.
[13] Internal Revenue Service, Revenue Procedure 2020-36, July 21, 2020, available at: https://www.irs.gov/pub/irs-drop/rp-20-36.pdf
[14] ACA § 1402; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans. 85 Fed. Reg. 29,164, 29,229-29,230. (May 14, 2020).
[15] Fehr, Rachel et al. "How Affordable are 2019 ACA Premiums for Middle-Income People?" Kaiser Family Foundation. March 5, 2019. https://www.kff.org/health-reform/issue-brief/how-affordable-are-2019-aca-premiums-for-middle-income-people/
[16] Federal Register/ Vol. 78, No. 39, 45 CFR Parts 144, 147, 150, 154 and 156 https://www.govinfo.gov/content/pkg/FR-2013-02-27/pdf/2013-04335.pdf

Figure 1 - Lowest-Cost Silver Plan Average Premium as Percentage of Income for 60-Year Olds[17]



This does not mean that younger consumers are impervious to the high cost of premiums and the subsidy cliff. For a 30-year old living in one of the top fifth highest cost counties in the U.S., the percent of household income spent on premiums increases from 8.4 percent to 14.8 percent when their income rises from just under 400 percent to just above 400 percent FPL (See Appendix II).

VI. Health Coverage Affordability: Regional Variation

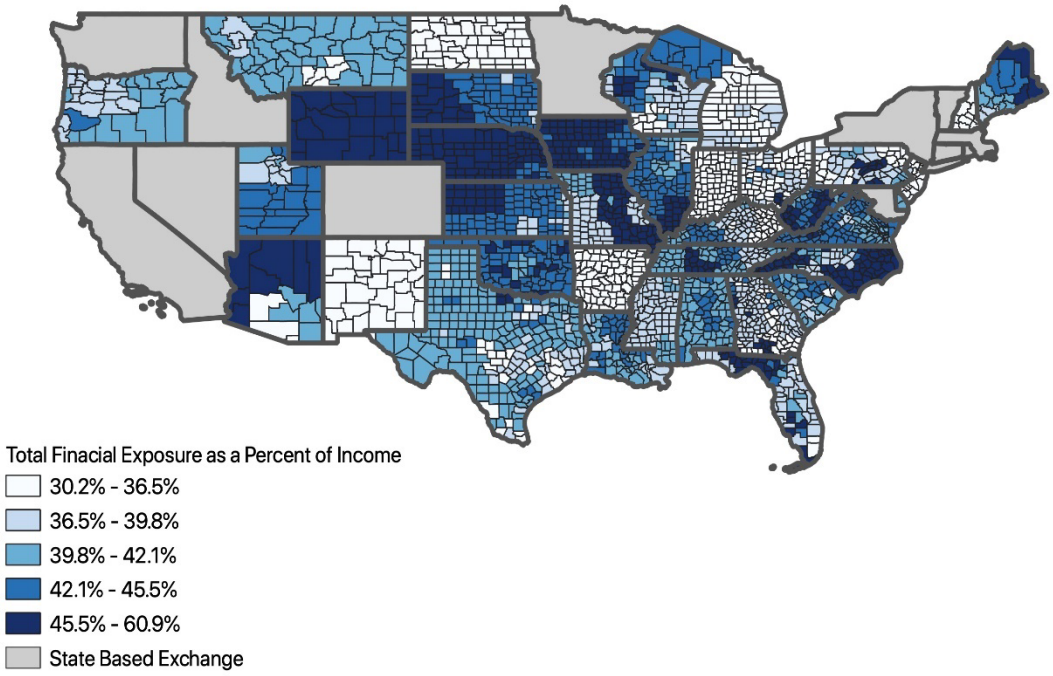
When assessing affordability of a health plan, an individual's maximum financial exposure under the plan, including premiums, deductibles, co-payments, and co-insurance should be taken into account. While only a small portion of people may reach this maximum level of financial exposure—the full premium and the maximum out-of-pocket limit—it represents the financial risk a high-cost health incident or chronic condition could impose on any individual.

When factoring in all these components, a 60-year-old individual earning $50,000 (too much to qualify for premium subsidies) with high health needs who reaches their maximum financial exposure may be required to pay between 30.2 percent and 60.9 percent of their total income for health insurance coverage and services, depending on where they live in the U.S. To be clear, healthier 60-year-olds with a moderate income may not pay this maximum amount each year, but this is the range of financial exposure. The map below (Figure 2) illustrates how the financial exposure for this population varies across the country, with consumers living in rural areas hit

[17] Calculated by determining the premiums that 60-year-olds at varying levels of household income would pay for an average of the lowest cost silver plan across all counties using the healthcare.gov platform excluding Alaska and Hawaii. Total of 2,671 counties were included. Calculation includes advanced premium tax credits for income levels under 400% of FPL. The data used is from 2020.

hardest. In addition, these older consumers are more vulnerable to reaching this maximum amount as they tend to have more complex medical needs.[18]

Figure 2: Maximum Financial Exposure as a Percent of Income for a 60-year-old earning $50,000 Compared at the County Level[19]



While Marketplace plans are costly for unsubsidized consumers, the financial burden is especially high for 60-year-old consumers living in areas of the country where premiums combined with out-of-pocket costs are most expensive. The disparity is stark. Figures 3 and 4 depict the range of financial exposure by income level for a 60 year old lining in the highest cost quintile of counties (Figure 3) and lowest cost quintile of counties (Figure 4). 60-year-old consumers living in counties with the highest cost have a maximum financial exposure that is close to 1.5 times higher than those living in the least expensive counties (see Appendices II and III for additional age bands). Specifically, the consumers in the most expensive counties could potentially spend, on average, 51.4 percent of their total income for health insurance coverage

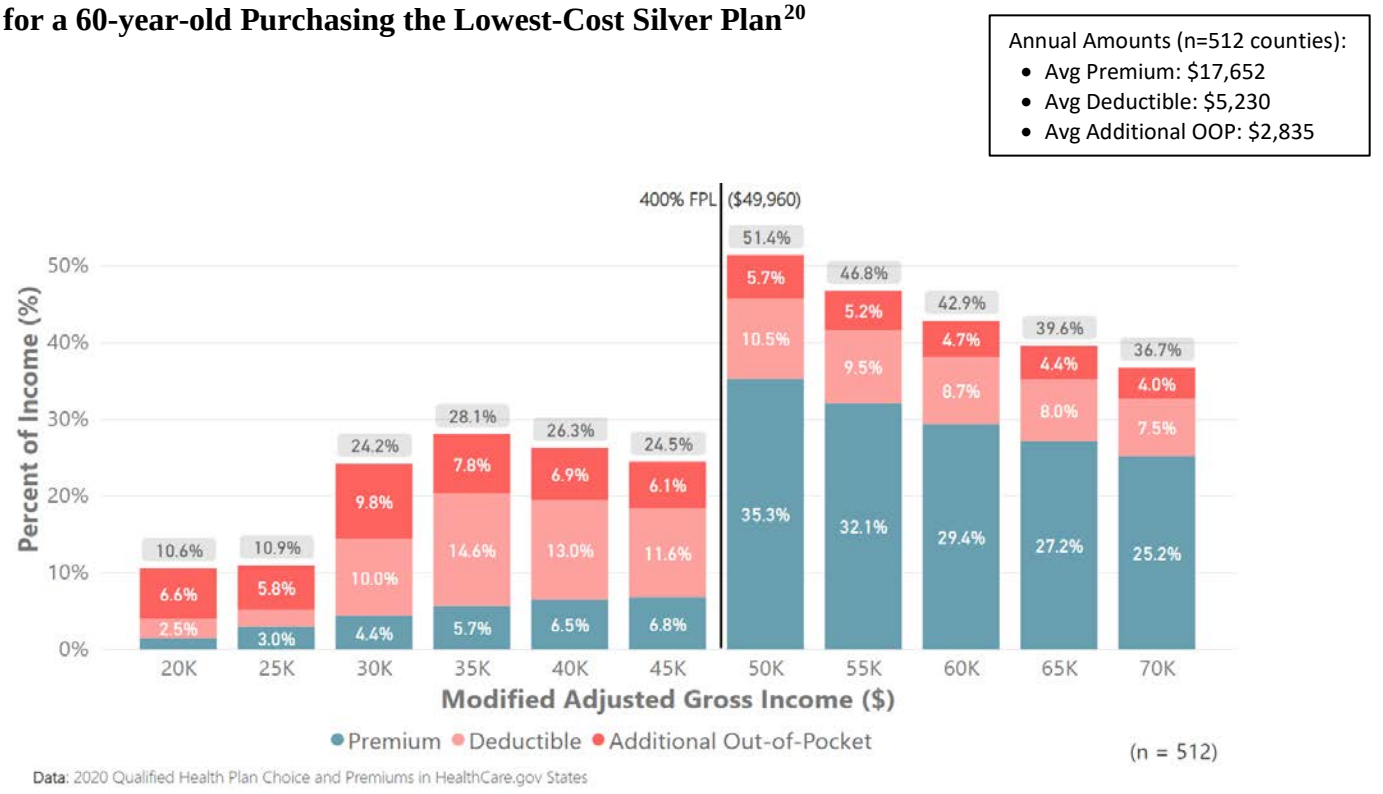
[18] Sawyer, Bradley & Gary Claxton. "How do health expenditures vary across the population?" Peterson-Kaiser Family Foundation. Jan. 16, 2019. https://www.healthsystemtracker.org/chart-collection/health-expenditures-vary-across-population/#item-start

[19] Maximum Financial exposure was calculated as the sum of the premium for the lowest cost silver plan in each county plus the maximum out-of-pocket limit associated with that specific plan. Given that this map shows the financial exposure of 60-year-olds making over 400% of FPL, advance premium tax credits (APTC) are not included in the calculation. Additionally, only states using the healthcare.gov platform (excluding Hawaii and Alaska) were included in this map for a total of 2,671 counties. The data used is from 2020.

and services if they reach their maximum financial exposure. In comparison, the consumers in counties with lower costs could potentially spend, on average, 34.6 percent of their income.

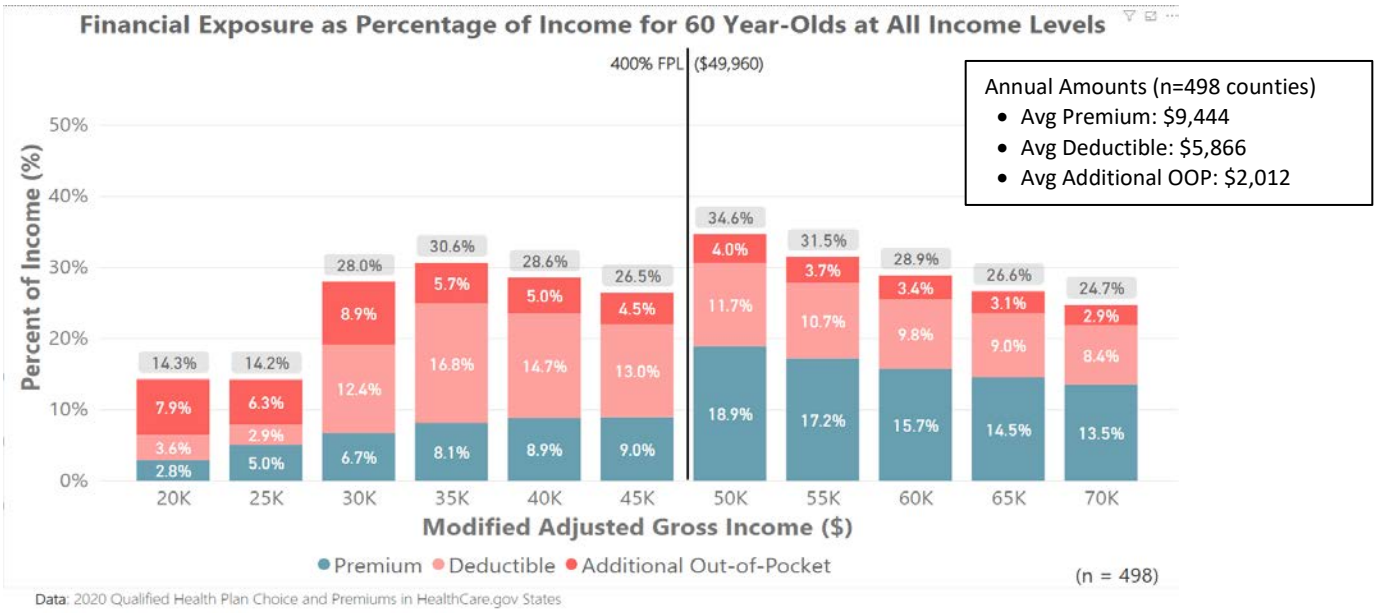
Figures 3 and 4 further illustrate that even for those older moderate-income consumers who receive some premium subsidy, if their annual income is too much to qualify for the CSR subsidy (i.e., household incomes higher than $31,225), their total financial exposure is high – often exceeding 25 percent of income in both the higher and lower cost counties.

Figure 3: Maximum Financial Exposure for Highest-Cost Counties as a Percent of Income for a 60-year-old Purchasing the Lowest-Cost Silver Plan[20]



[20] Figure 3 displays the premiums, deductibles and additional out of pocket costs that 60-year-olds at varying levels of income would pay for an average of the lowest cost silver plan across all counties using the healthcare.gov platform, excluding Alaska and Hawaii. Calculations include advanced premium tax credits for income levels under 400% of FPL and cost sharing reductions for income levels under 250% of FPL. Figure 3 only considers the top twenty percent of counties (n=512) using healthcare.gov platform where financial exposure for 60-year-olds with incomes more than 400% of FPL is greatest. The data used is from 2020.

Figure 4: Maximum Financial Exposure for Lowest-Cost Counties as a Percent of Income for a 60-year-old Purchasing the Lowest-Cost Silver Plan[21]



As noted, not all people reach the maximum out of pocket limit. In fact, most people, especially those who are healthier and younger, do not. For older enrollees in the individual market aged 55 to 64 who are considered healthy, approximately 1 in 10 would reach their deductible (on average $4,500). For those aged 55 to 64 who have one or more conditions that would characterize them as "unhealthy", approximately 4 in 10 would hit their deductible and an additional 1 in 10 would hit their maximum out-of-pocket limit ($8,150 for plan year 2020).[22]

While the figures in this report focus on the financial exposure of older non-subsidized adults, younger consumers are also at risk for a substantial level of financial exposure by income. However, as shown in Appendix 1, for younger consumers 30, 40 and 50 years of age, the potential for substantial financial exposure is relatively steady across incomes due to the fact that premiums account for a lower share of the maximum financial exposure.

[21] Figure 4 uses the same methodology as Figure 3 but only includes the bottom twenty percent of counties (n=498) where financial risk exposure is lowest. The data used in Figure 4 is from 2020.

[22] Derived by estimating claims expense for four population segments: healthy under 55, healthy over 55, unhealthy under 55, and unhealthy over 55. Modeled out-of-pocket costs (deductible, co-pay, coinsurance) for all segments using a typical lowest cost silver plan with a $4500 deductible, 10% coinsurance, and $8000 maximum out-of-pocket limit. The presence of one of the HHS-HCC model conditions, or Hierarchical Condition Categories was used to mark those in the population data set considered "unhealthy." HCCs include diagnoses/conditions like Cancer, Diabetes, HIV/AIDS, Pregnancy, Severe burns, and other such conditions with large, somewhat predictable costs. Source: Wakely ACA Database (WACA). WACA is an aggregated database based on de-identified CMS Enrollee-level External Data Gathering Environment (EDGE) Server input and output files (including enrollment, claims, and pharmacy data) from the 2017 benefit year submitted through April 2018, along with supplemental risk adjustment transfer and issuer-reported financial information, representing approximately 4 million lives from the individual ACA market. For further details please see https://www.wakely.com/services/product/wakely-aca-database-waca.

VII. CMS Progress

The data presented here indicates that moderate-income consumers who have household incomes just over 400 percent of the FPL and who do not qualify for the ACA's subsidies continue to struggle with health insurance costs as the cost of an individual market plan continues to increase. As outlined earlier, the implementation of the ACA's main health insurance market reform requirements are responsible for a portion of the rise in insurance costs. The fact that the underlying cost of health care continues to rise faster than inflation is also a substantial factor. Both of these factors pose a large barrier to affordability. However, in recent years CMS has taken substantial steps to mitigate the costly impact of the ACA on health insurance markets and address other longstanding issues in our health care system that are driving up costs.

While many of the ACA's cost drivers are built into the statute, there are opportunities to make coverage more affordable under the ACA. To reverse rising premiums and fewer choices on the individual insurance market, CMS has implemented regulations and policies to improve risk pools and increase competition among health insurers. New regulations have improved risk pools by encouraging individuals to maintain continuous coverage and providing states with new tools to stabilize their markets and deliver a more predictable regulatory framework.[23] CMS also implemented an outreach plan to bring insurers back into the individual market to increase competition to lower premiums. To promote competition on quality, CMS required Exchanges across the country to publicly display quality information for the 2020 plan year.[24] In addition, CMS approved 15 state reinsurance waivers, all of which drove insurance premiums down—in most cases by double digit percentages.[25]

[23] Patient Protection and Affordability Care Act; Market Stabilization, 82 Fed. Reg. 18346 (April 18, 2017), https://www.federalregister.gov/documents/2017/04/18/2017-07712/patient-protection-and-affordable-care-act-market-stabilization; Patient Protection and Affordable Care Act; Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16930 (April 17, 2018), https://www.federalregister.gov/documents/2018/04/17/2018-07355/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2019; and Patient Protection and Affordable Care Act; Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans, 85 Fed. Reg. 29164 (May 14, 2020), https://www.federalregister.gov/documents/2020/05/14/2020-10045/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2021,

[24] Quality Rating Bulletin. Centers for Medicare and Medicaid Services. https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/QualityRatingInformationBulletinforPlanYear2020.pdf. Published August 15, 2019.

[25] State Relief and Empowerment Waivers: State-based Reinsurance Programs. Centers for Medicare and Medicaid Services. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Data-Brief-June2020.pdf. Published June 2020.

As a result of these agency actions, more issuers are coming back to the market, increasing competition and bringing down premiums.[26] In 2021, average premiums for a benchmark plan sold on HealthCare.gov declined for the third straight year.[27]

As part of its comprehensive approach, CMS has also advanced a number of policies to address the rising cost of health care. These policies focus on empowering patients with better information to improve their decision-making to drive greater competition within the market. For instance, CMS finalized price transparency rule that requires hospitals to post a list of their standard charges[28] and requires most health insurance issuers and self-insured employer health plans to disclose their negotiated in-network rates and out-of-network payments on a public website, and provide cost-sharing liability information to participants.[29] CMS also finalized the Interoperability and Patient Access rule, which requires most health plans doing business in Medicare, Medicaid, and the Federal Marketplaces to share health claims data and other important information with their beneficiaries and enrollees..[30]

In addition, in an effort aimed at reducing regulatory barriers to care coordination and improving the coordination of patient care across care settings, CMS issued a final rule modifying implementation of the Stark Law[31] which presents significant opportunities for new value-based care arrangements that reduce burden on providers and protect patients from unnecessary services that drive up costs. All these measures will help lower the overall cost of health care and lead to lower premiums and lower out-of-pocket spending for consumers.

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[26] Increasing Competition on the Exchanges to Improve Consumer Choice and Affordability. Centers for Medicare and Medicaid Services. https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Issuer-Participation-in-the-Marketplace.pdf. Published October 30, 2020.

[27] Plan Year 2021 Qualified Health Plan Choice and Premiums in HealthCare.gov States. https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2021QHPPremiumsChoiceReport.pdf . Published November 23, 2020.

[28] Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 Fed. Reg. 65524 (Nov. 27, 2019), https://www.govinfo.gov/content/pkg/FR-2019-11-27/pdf/2019-24931.pdf.

[29] Transparency in Coverage, 85 Fed. Reg. 72158 (Nov. 12, 2020), https://www.federalregister.gov/documents/2020/11/12/2020-24591/transparency-in-coverage

[30] CMS, Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, and Health Care Providers, 85 Fed. Reg. 25510 (May 1, 2020), https://www.govinfo.gov/content/pkg/FR-2020-05-01/pdf/2020-05050.pdf.

[31] CMS, Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 85 Fed. Reg. 77492 (Dec. 2, 2020), available at: https://www.federalregister.gov/documents/2020/12/02/2020-26140/medicare-program-modernizing-and-clarifying-the-physician-self-referral-regulations

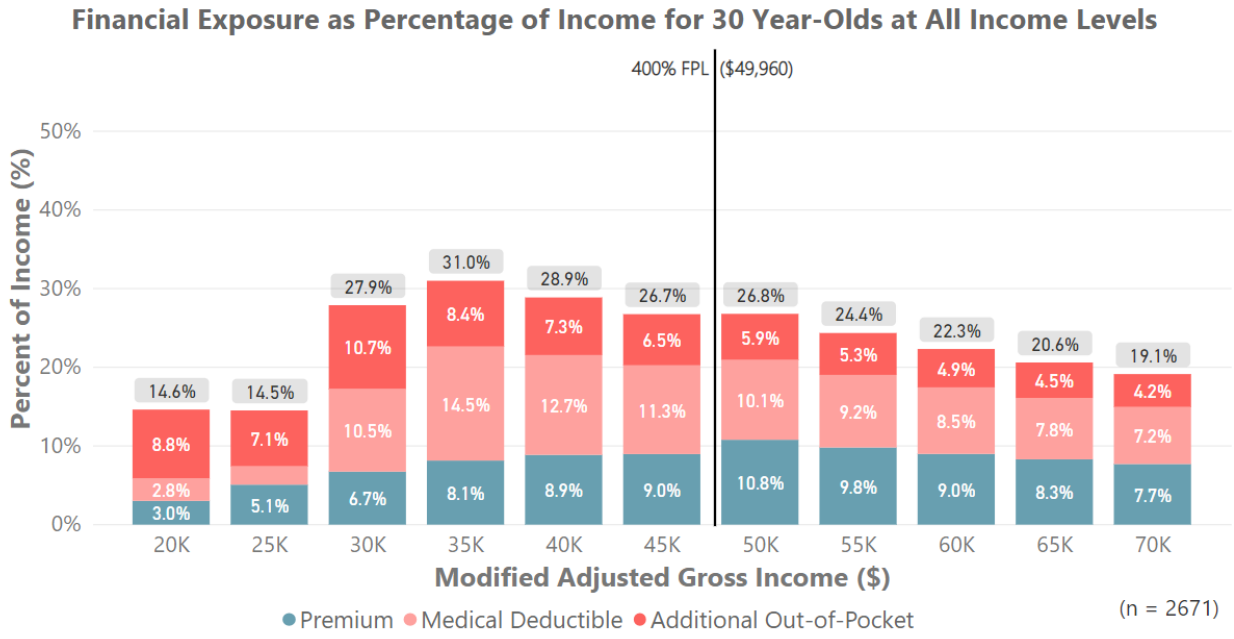
VIII. Conclusion

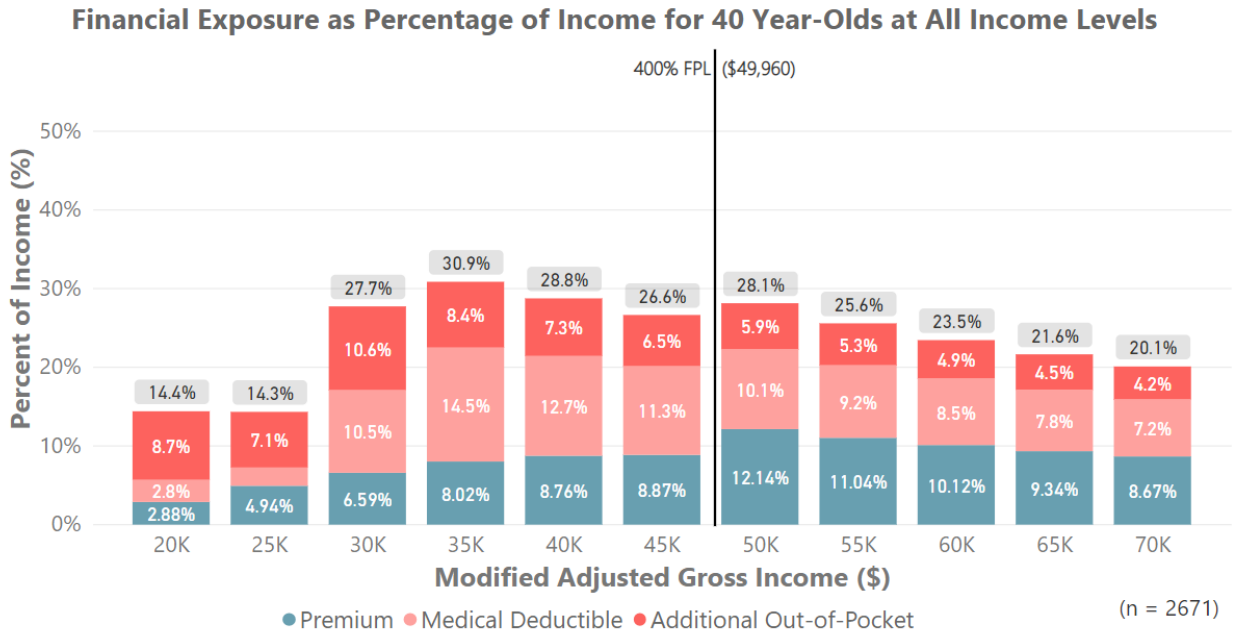
The data in this report shows that health coverage is not affordable for many middle-income Americans who do not qualify for premium subsidies. Affordability is a particular challenge for older Americans near retirement age and people living in rural areas.

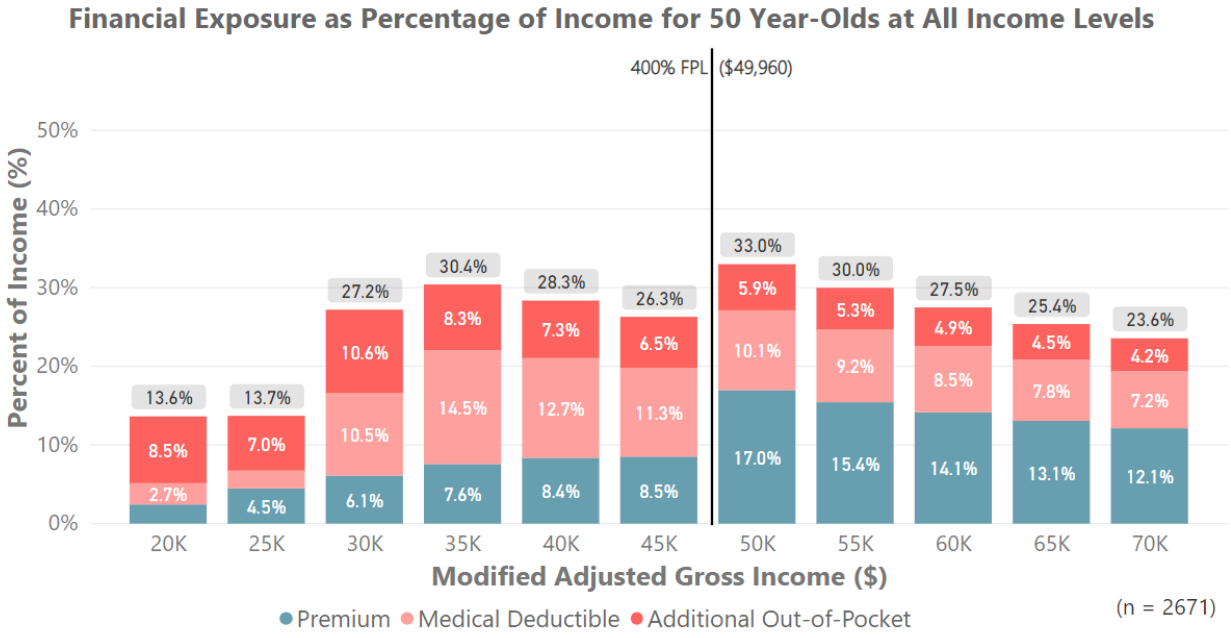
Although much work remains to make insurance more affordable for all Americans, over the past several years, CMS has made significant strides to improve the affordability of individual health insurance coverage for people who don't have access to employer coverage and don't qualify for premium subsidies. These actions include efforts to increase competition and consumer choice, reduce premium costs and the underlying cost of care throughout the United States. CMS continues to focus on providing systemic solutions to address the longstanding problems in the health care system and create more opportunities for all Americans to be able to access affordable care.

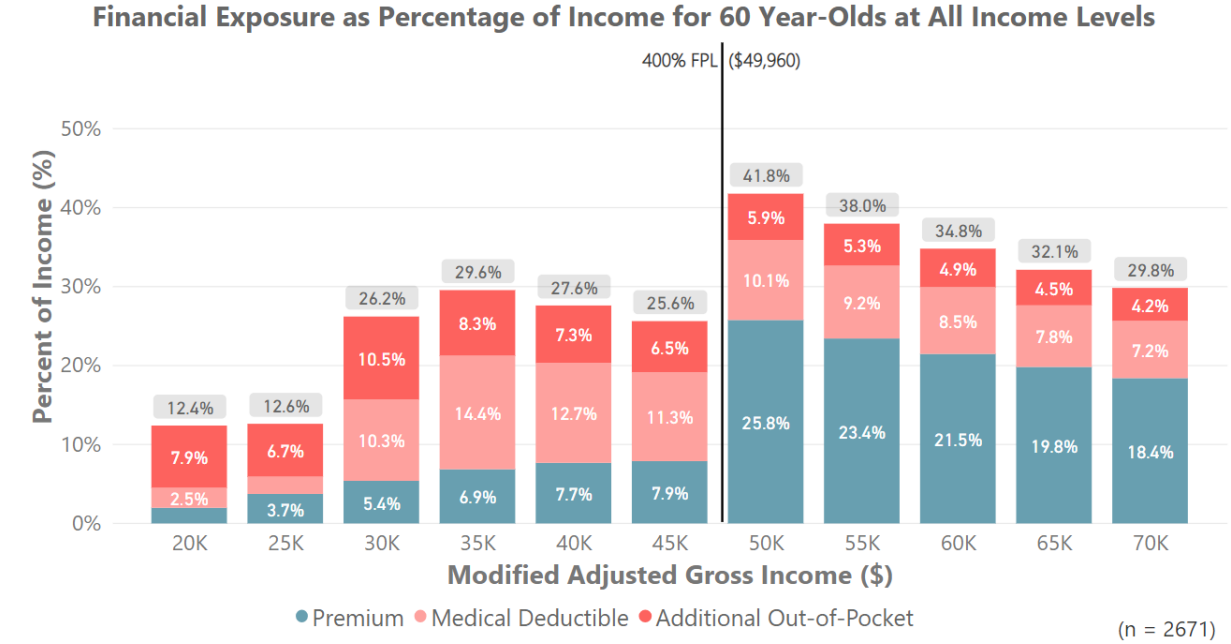
Appendix I: Average Financial Exposure as Percentage of Income by Age at All Income Levels*

**All appendices contain data for all counties in states that use the healthcare.gov platform except Hawaii and Alaska.*



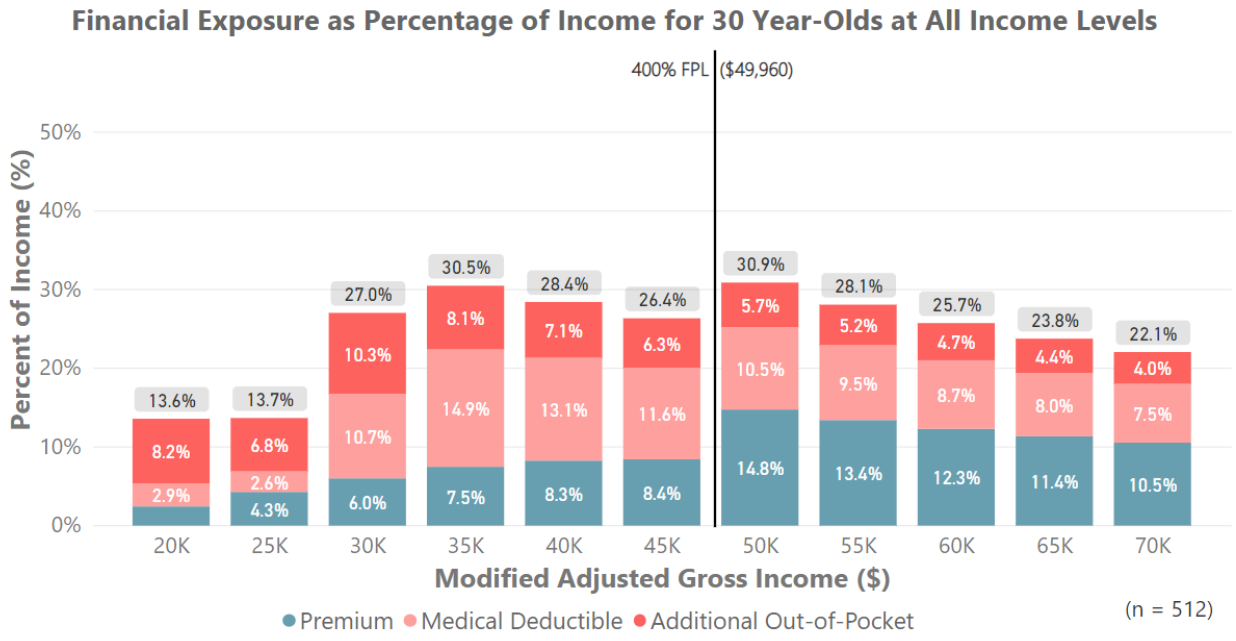


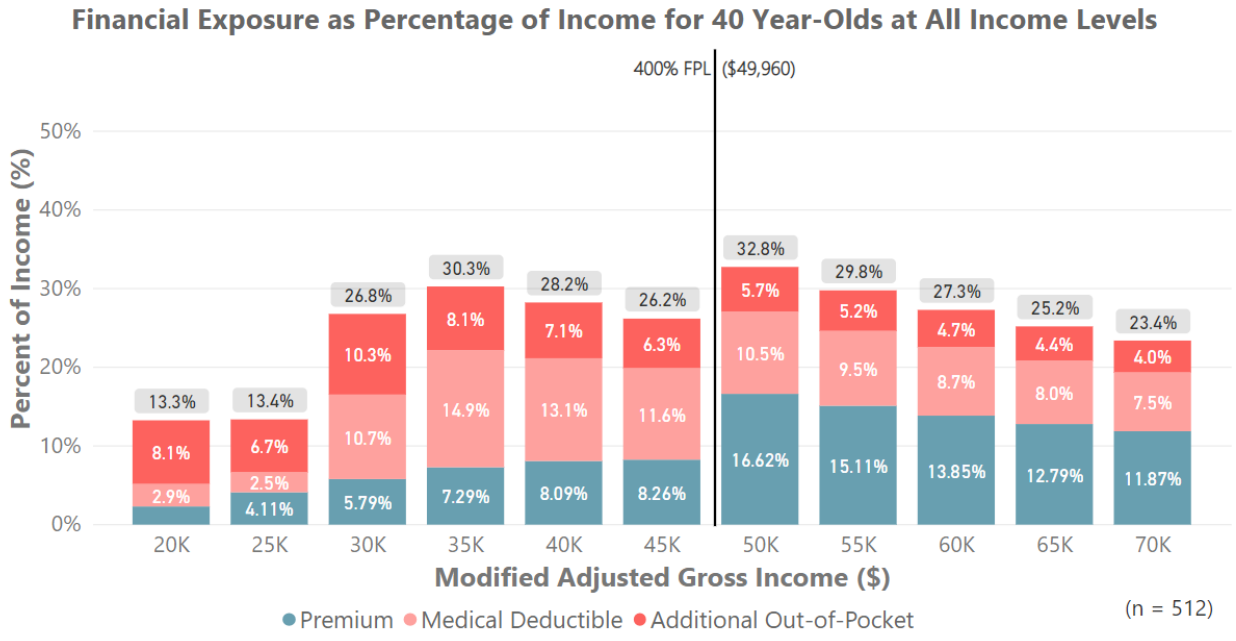




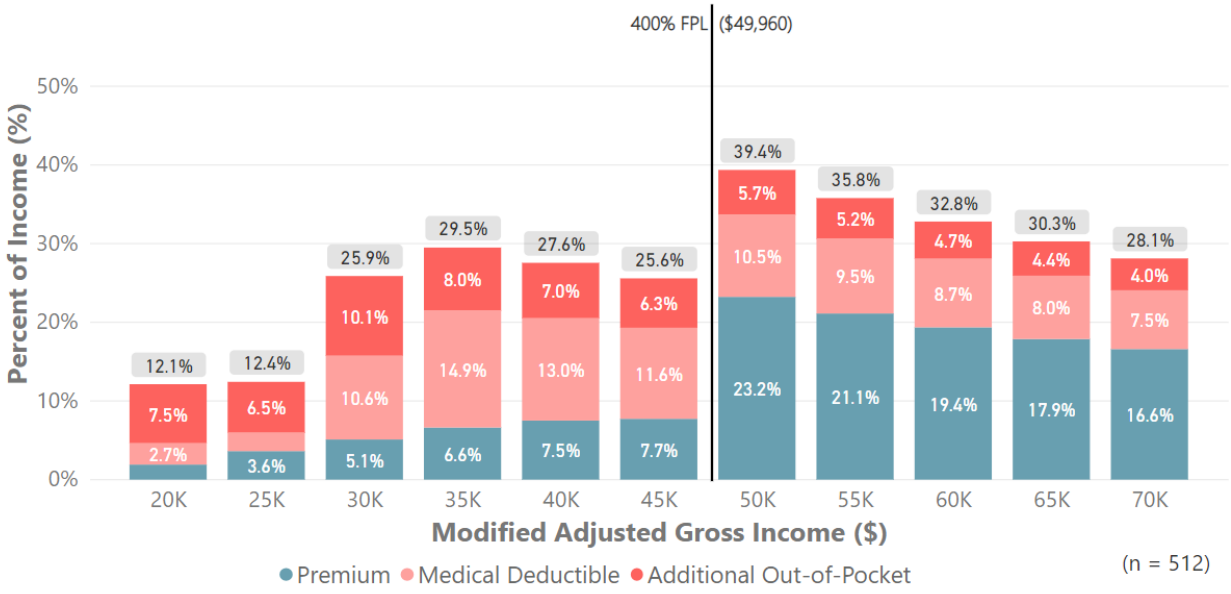
Data: 2020 Qualified Health Plan Choice and Premiums in HealthCare.gov States

Appendix II: Maximum Financial Exposure for Highest-Cost Counties as a Percent of Income by Age at All Income Levels Purchasing the Lowest-Cost Silver Plan

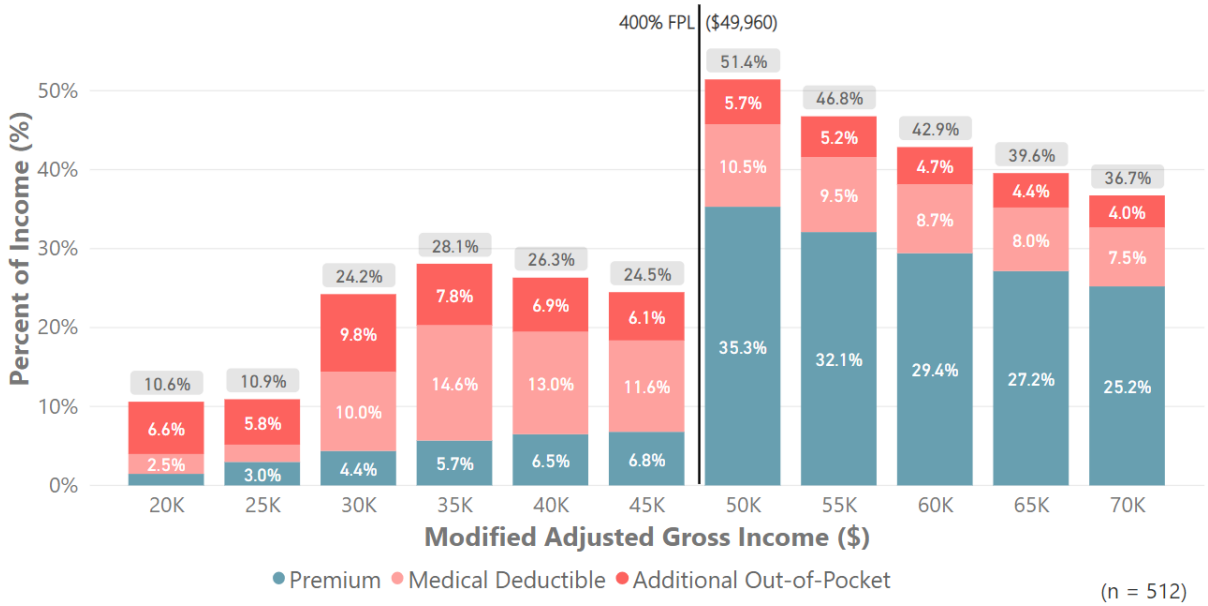




Financial Exposure as Percentage of Income for 50 Year-Olds at All Income Levels

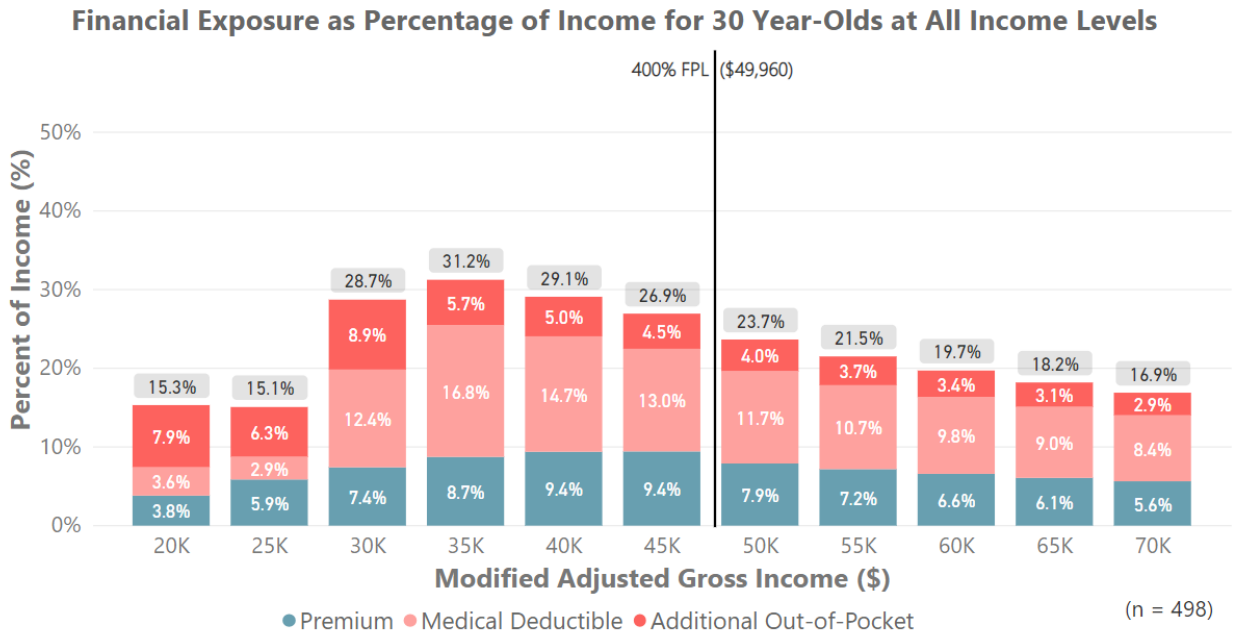


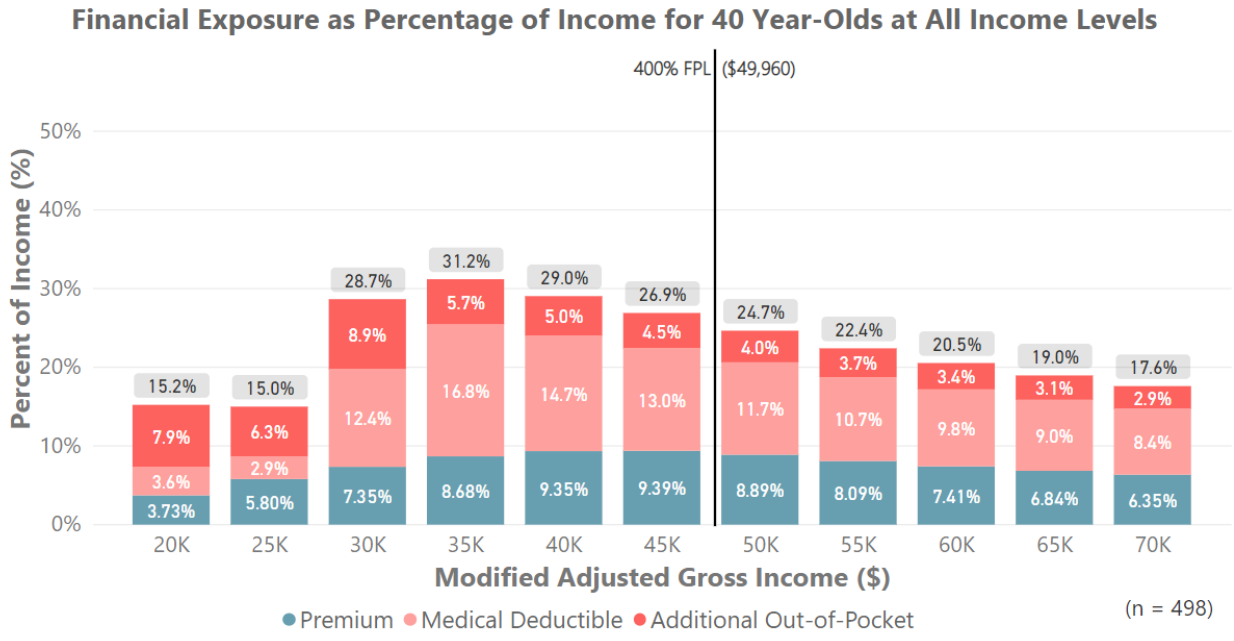
Financial Exposure as Percentage of Income for 60 Year-Olds at All Income Levels

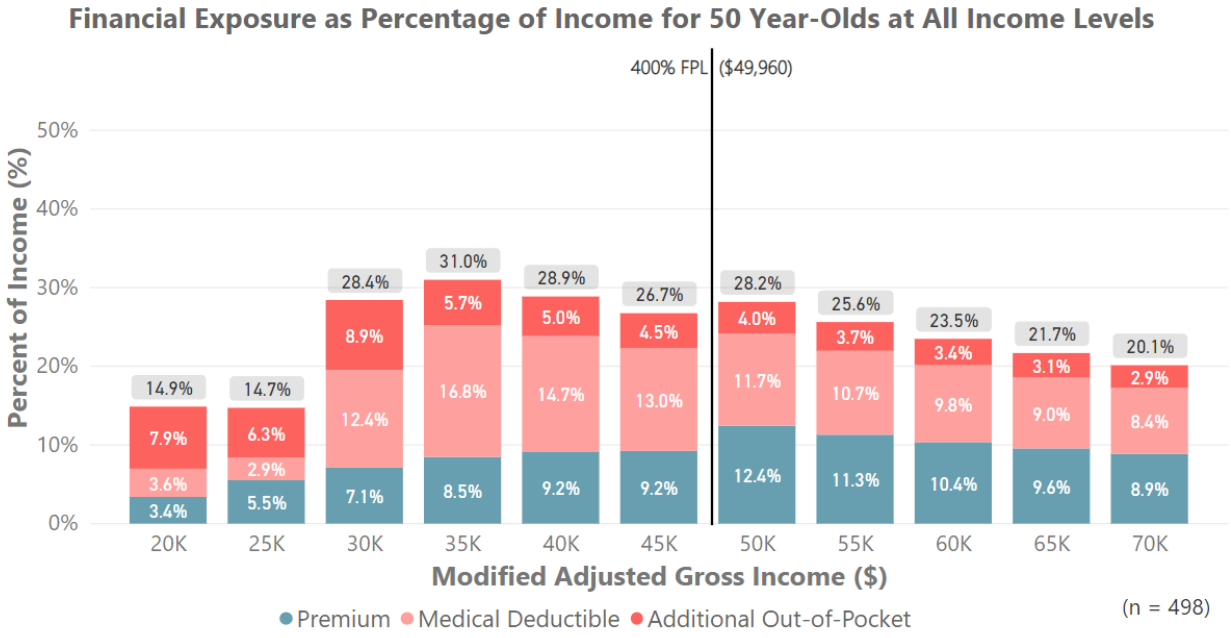


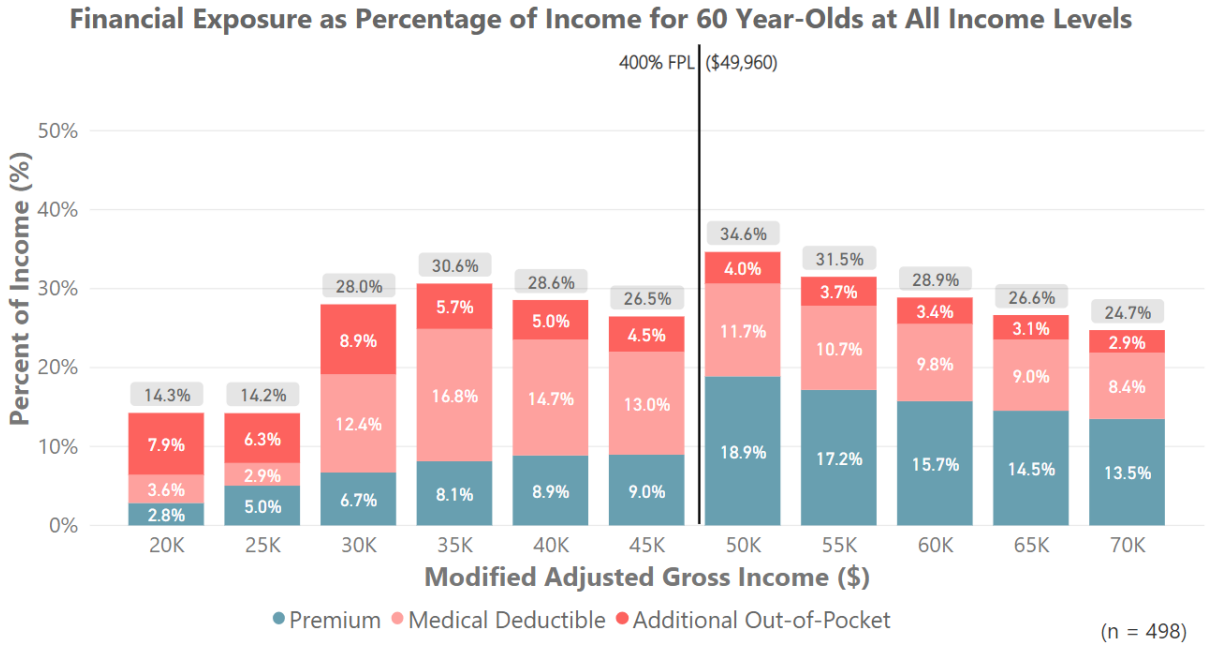
Data: 2020 Qualified Health Plan Choice and Premiums in HealthCare.gov States

Appendix III: Maximum Financial Exposure for Lowest-Cost Counties as a Percent of Income by Age at All Income Levels Purchasing the Lowest-Cost Silver Plan



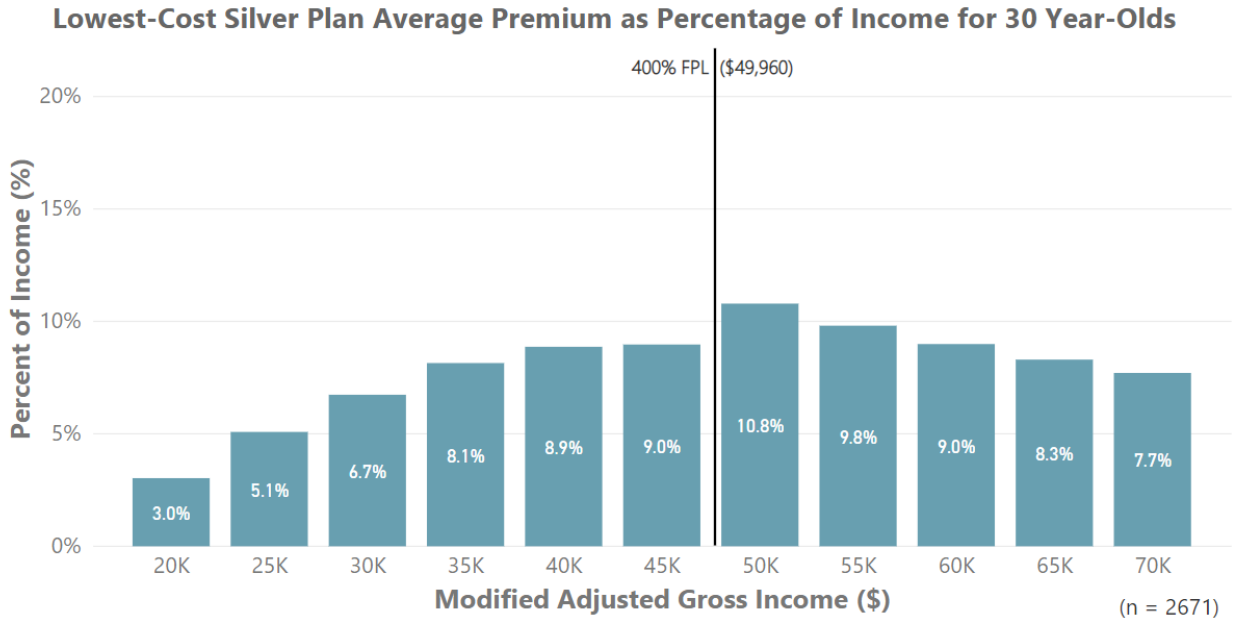


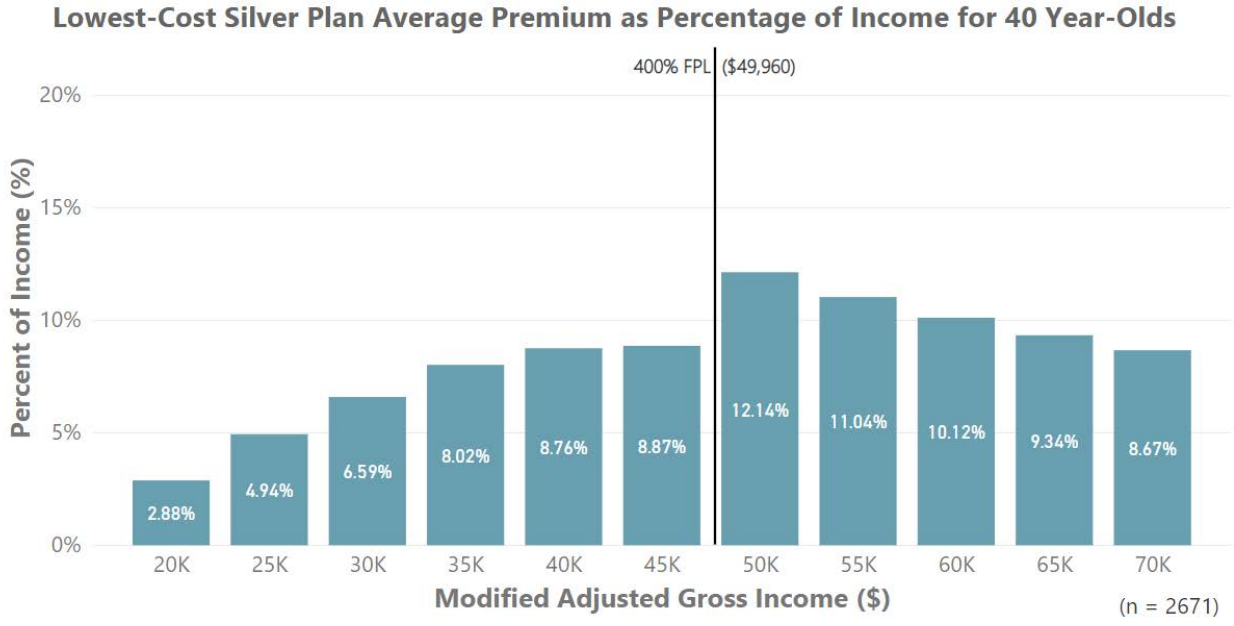


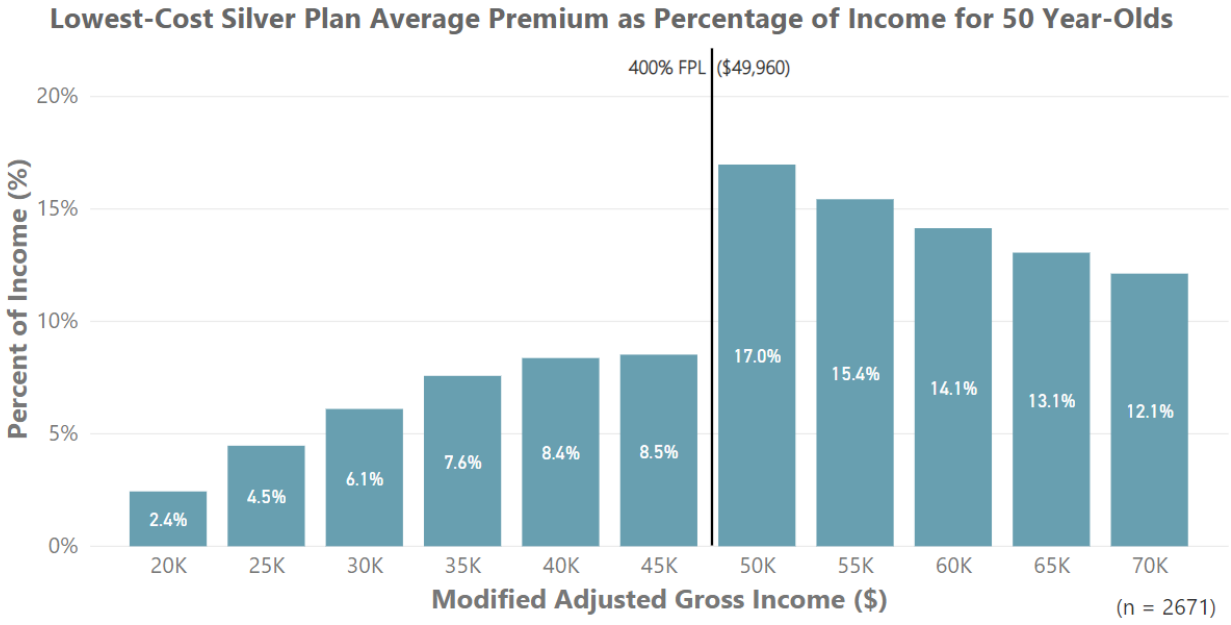


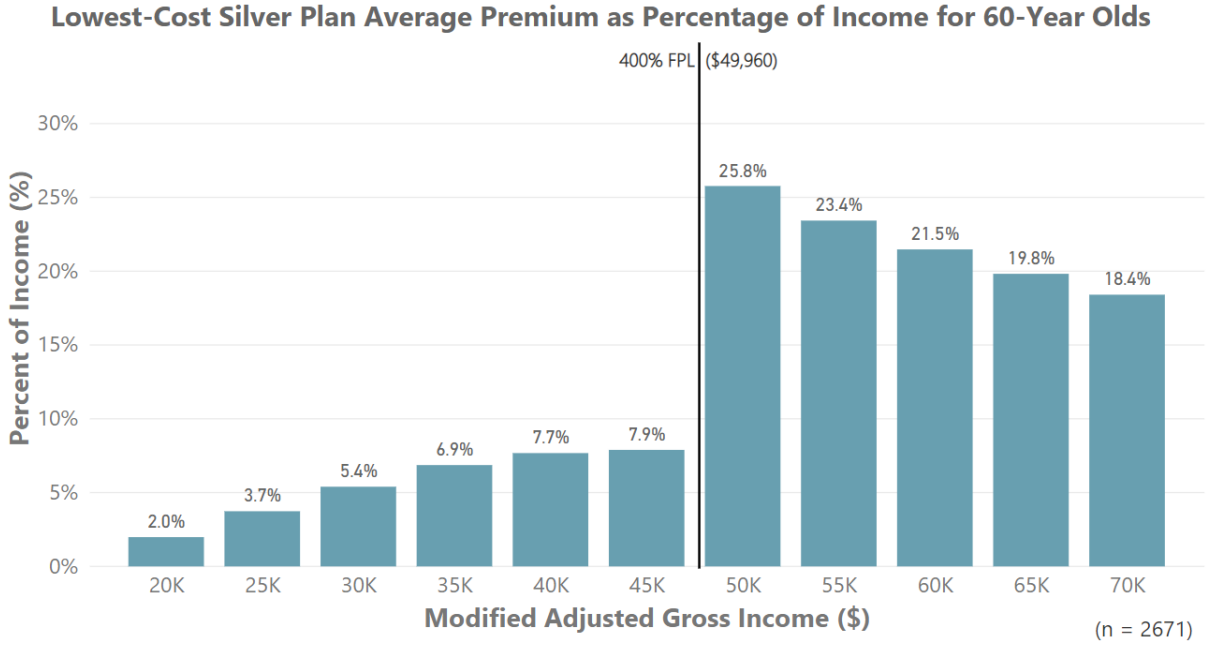
Data: 2020 Qualified Health Plan Choice and Premiums in HealthCare.gov States

Appendix IV: Lowest-Cost Silver Plan Average Premium as Percentage of Income by Age (30, 40, 50, & 60 year-olds)









Data: 2020 Qualified Health Plan Choice and Premiums in HealthCare.gov States

CCIIO Data Brief Series

The Unsubsidized Uninsured: The Impact of Premium Affordability on Insurance Coverage

January 2021

I. Overview

The Patient Protection and Affordable Care Act (ACA) established a set of provisions that changed the availability and affordability of health coverage for many Americans. The ACA's expansion of Medicaid eligibility to non-disabled adults, along with the introduction of premium tax credit subsidies to low- and middle-income Americans purchasing an individual market plan through an Exchange increased access to coverage for many people. However, other ACA requirements increased the cost of health insurance coverage and, in turn, reduced the affordability of health coverage for many other people—in particular people without access to employer-sponsored coverage and who earn too much money to qualify for the ACA's premium subsidies. This report takes a closer look at the unsubsidized population and the impact of increasing premiums on health coverage.

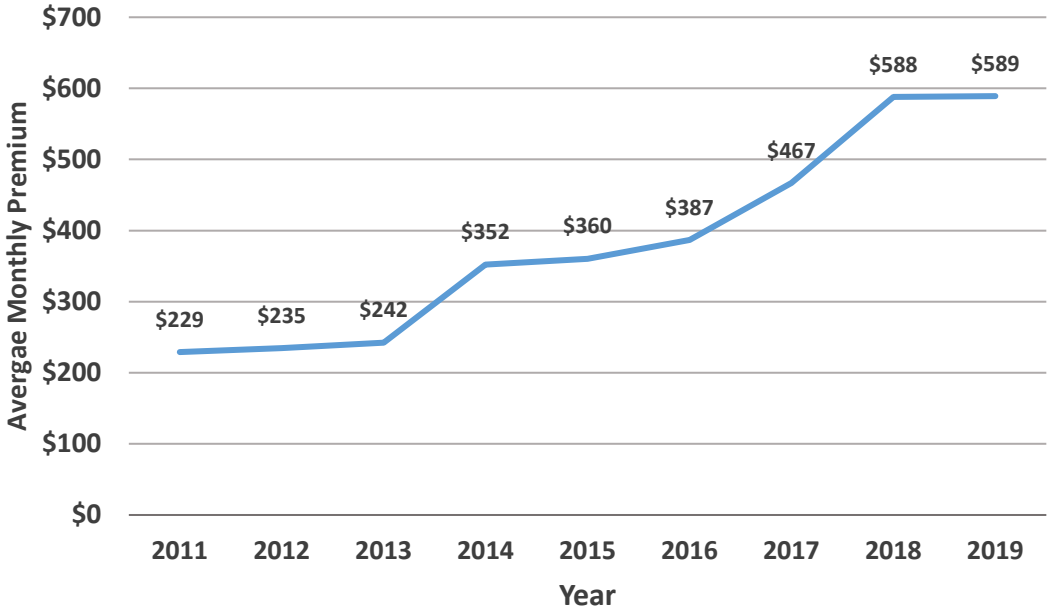
II. Premium Trends

Premiums increased substantially since the ACA's main insurance market reform requirements took effect in 2014. Some of these requirements include, but are not limited to, the closure of state high risk pools, premium rating requirements including compressed age rating bands, a more generous set of mandated essential health benefits, health insurance taxes, and the Exchange user fees.[1] As noted above, the ACA attempted to help offset premium costs for consumers by offering government subsidies to eligible individuals and families making 100 percent of the Federal Poverty Level ("FPL") up to 400 percent FPL to purchase health insurance coverage on the Health Insurance Marketplace®[2] (Marketplace).[3] The structure of the premium tax credit also encourages premium inflation because the amount of the subsidy is linked to the overall cost of the health plan.

As shown in Figure 1, average premiums increased substantially from the year before the ACA's main requirements took effect in 2013 to 2019, rising from $242 to $589—a 143 percent increase. This premium data represents the average premium people paid for coverage in individual health insurance market nationally. Without subsidies to offset the cost of these increasing premiums, emerging trends indicate that the unsubsidized populations are unable to afford health insurance and are increasingly becoming uninsured.

[1] *See* Milliman, Comprehensive Assessment of ACA Factors That Will Affect Individual Premiums in 2014, April 25, 2013.
[2] Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.
[3] 26 USC 36B(c)(1)(A).

Figure 1: Average Monthly Premiums, 2011 to 2019*



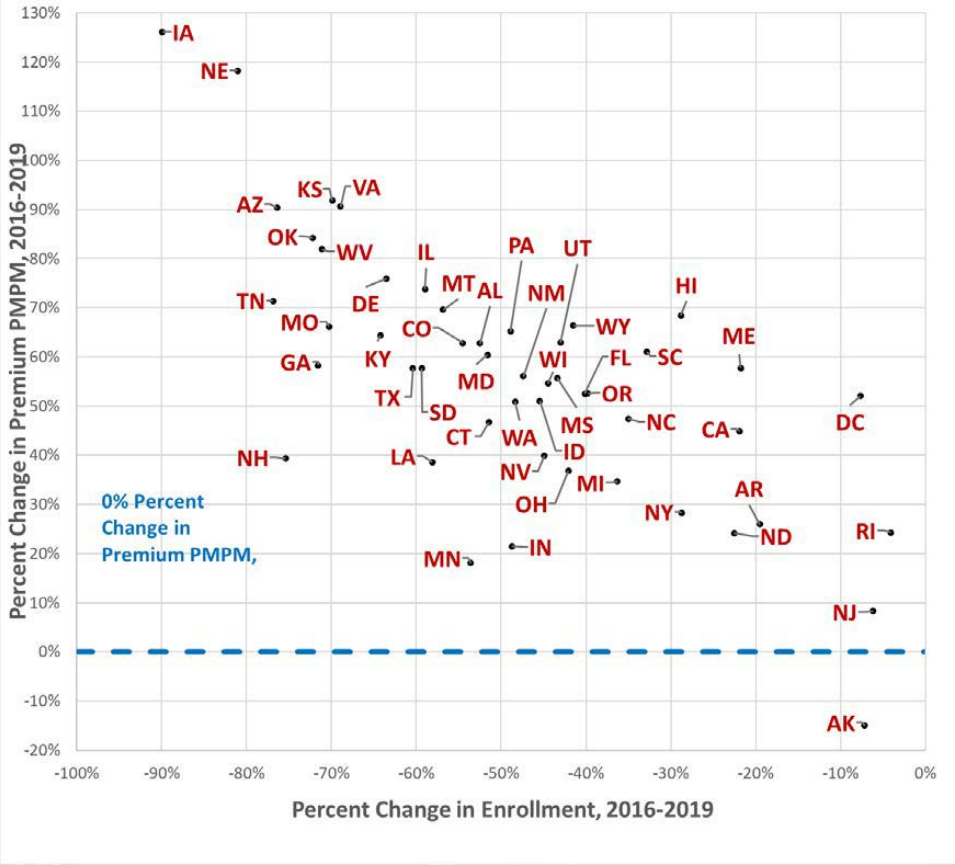
** Note: Data for 2011 through 2013 were sourced from CMS Medical Loss Ratio (MLR) data, which were collected starting in tax year 2011 from issuers to enforce ACA MLR requirements. Premium data for 2014 to 2019 in this chart are sourced from the ACA the risk adjustment program. Both data sources best reflect the premium for individual market that was available for purchase in the market for each respective year. After 2014, MLR data includes data from consumers in health plans that are not available to new consumers, including people who retained grandfathered plans and certain non-grandfathered plans that are not in compliance with certain ACA market reforms, also known as grandmothered plans.*

III. Decline in Unsubsidized Enrollment

At the same time premiums increased, enrollment in individual market plans among those people who purchase coverage without a premium subsidy (referred to as the "unsubsidized") declined. CMS regularly publishes data on enrollment trends among the subsidized and unsubsidized in the individual market.[4] Nationally, average premiums increased by 52% from 2016 to 2019, during that same period, the number of unsubsidized individuals and families enrolling in individual market plans fell from 6.2 million to 3.4 million, representing a decline in unsubsidized enrollment of 2.8 million people.

Looking at state level data shows a clear link between rising premiums and declining unsubsidized enrollment. As Figure 2 shows, from 2016 to 2019, states with larger declines in unsubsidized enrollment tended to experience a larger increase in average premiums. For example, Iowa, the state with the highest premium increase (from $408 to $923), also experienced the largest drop (90 percent) in its unsubsidized enrollment.

Figure 2: Change in State Average Premium vs. Change in Enrollment in the Unsubsidized Individual Market, 2016 to 2019

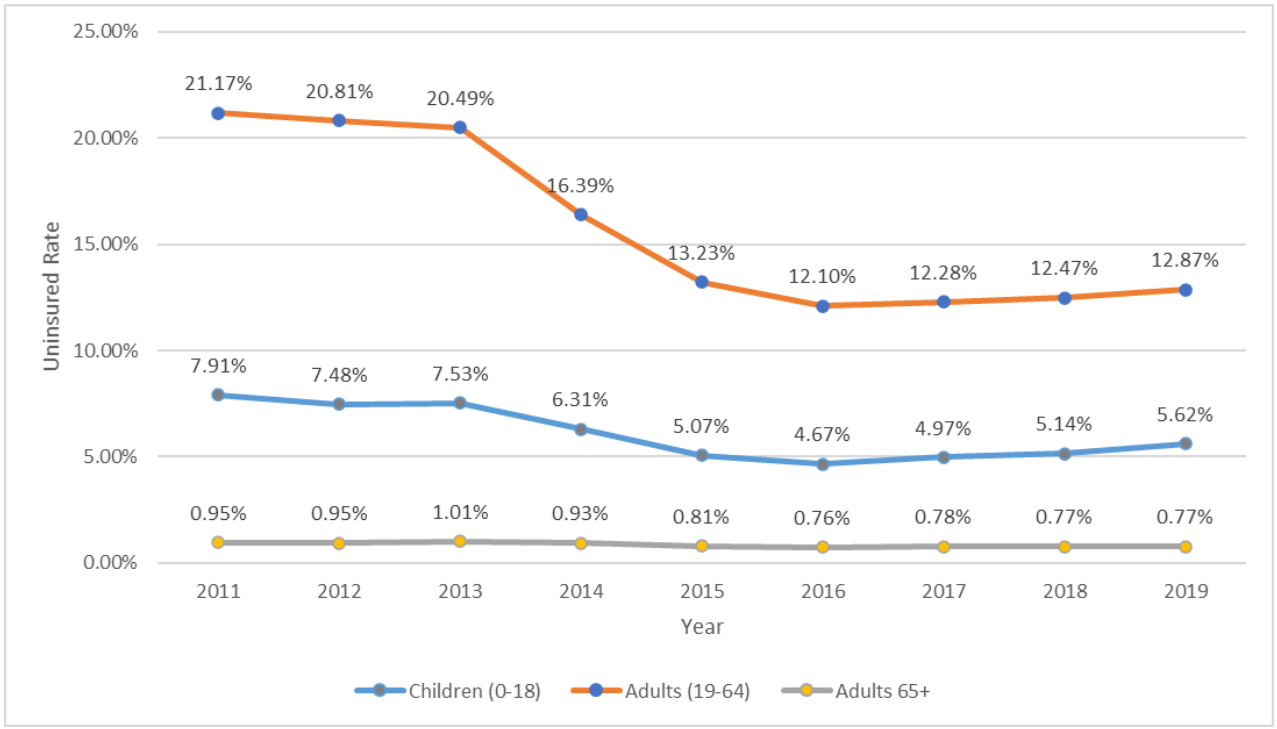


[4] Centers for Medicare & Medicaid Services, "Trends in Subsidized and Unsubsidized Enrollment." Oct. 9, 2020 at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Trends-Subsidized-Unsubsidized-Enrollment-BY18-19.pdf.

IV. Uninsured Trends

As premiums increased and unsubsidized enrollment declined, data from the U.S. Census Bureau show the number and rate of people without insurance has edged up. While the uninsured rate declined from 2013 to 2016 immediately after key provisions of the ACA expanded access to subsidized health coverage, Figure 3 shows that the uninsured rate then began to increase from 2016 to 2019. This increase in the uninsured rate occurred among both children and adults age 19 to 64. During this time, the number of uninsured under 65 years old increased by 2.26 million to 28.9 million people.[5] This includes an increase of roughly 678,000 uninsured children and 1.58 million uninsured working-age adults.

Figure 3: Uninsured Rate by Age, 2011 to 2019



Source: U.S. Census Bureau, American Community Survey (ACS) - 1-Year Estimates-Public Use Microdata Sample (2010-2019), MDAT (census.gov).

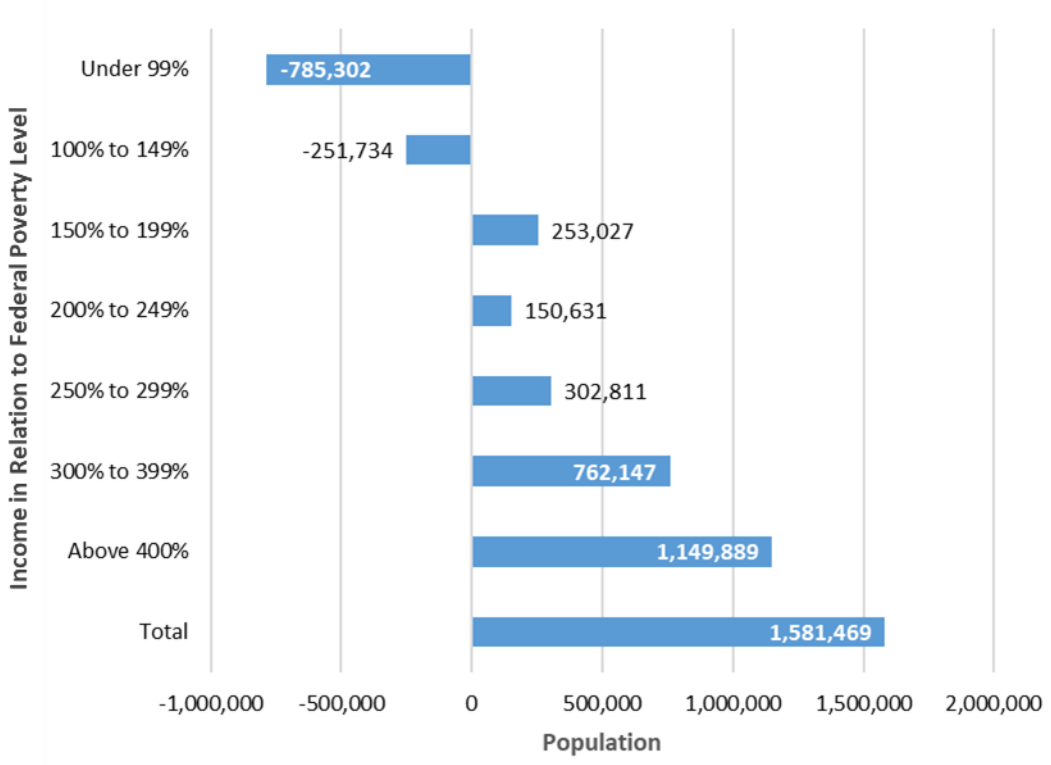
Comparing changes in the number of people with health insurance coverage by household income level shows that much of the increase in the number of uninsured under 64 from 2016 to 2019 occurred among people with household incomes too high to qualify for subsidized health coverage. Among people under 65 with household incomes above 400 percent of the FPL—the cutoff point to qualify for federal premium tax credits—the number of uninsured increased by 1.33 million from 2016 to 2019. This represents 59 percent of the increase in the number of uninsured over this time.

[5] U.S. Census Bureau, American Community Survey (ACS) - 1-Year Estimates-Public Use Microdata Sample (2010-2019), MDAT (census.gov).

Looking at adults age 19 to 64 reveals people with household incomes higher than 400 percent of FPL represent an even larger proportion of the increase in the uninsured for this population. At this income level, as shown in Figure 4, the number of uninsured adults age 19 to 64 increased by 1.15 million from 2016 to 2019—73 percent of the total increase. Appendix A provides further details on trends in the uninsured rates for this adult population nationally and by state from 2010 to 2019.

The change in the number of uninsured children by household income follows a more even distribution across incomes. However, children in households with incomes higher than 400 percent of FPL still represent a large share of the increase in the number of uninsured children, representing 27 percent of the increase. Appendix B includes additional charts that compare changes in the number and rate of uninsured among children and adults age 19 to 64.

Figure 4: Changes in the Number of Uninsured Adults Age 19 to 64 by Household Income Level, 2016 to 2019



Source: U.S. Census Bureau, American Community Survey (ACS) - 1-Year Estimates-Public Use Microdata Sample (2010-2019), MDAT (census.gov).

V. Affordability is a Key Factor in Recent Uninsured Trends

The fact that such a large proportion of the increase in the number of uninsured occurred among middle to higher income people who do not qualify for federal subsidies strongly suggests that the rising cost and declining affordability of health coverage for this population was a substantial factor contributing to the rise in the uninsured population from 2016 to 2019. This conclusion is consistent with survey data from the National Center for Health Statistics, which shows in 2019 over 70 percent of uninsured adults (ages 18 to 64) cited affordability as the primary cause for their being uninsured, making it the most common reason reported.[6] This is also consistent with a body of economic research that shows people are very price sensitive when making the decision to buy health coverage.[7]

VI. Conclusion

While CMS has made great strides to address the affordability issues facing the uninsured, there is more work to do to improve affordability and reduce the uninsured population. The unsubsidized population continues to struggle with the high cost of individual market plan premiums contributing to the increasing uninsured rate. Premiums are stabilizing but remain too expensive for Americans who are not eligible for premium subsidies. The ACA fails to support this population and its regulatory requirements ultimately raise premiums for consumers.

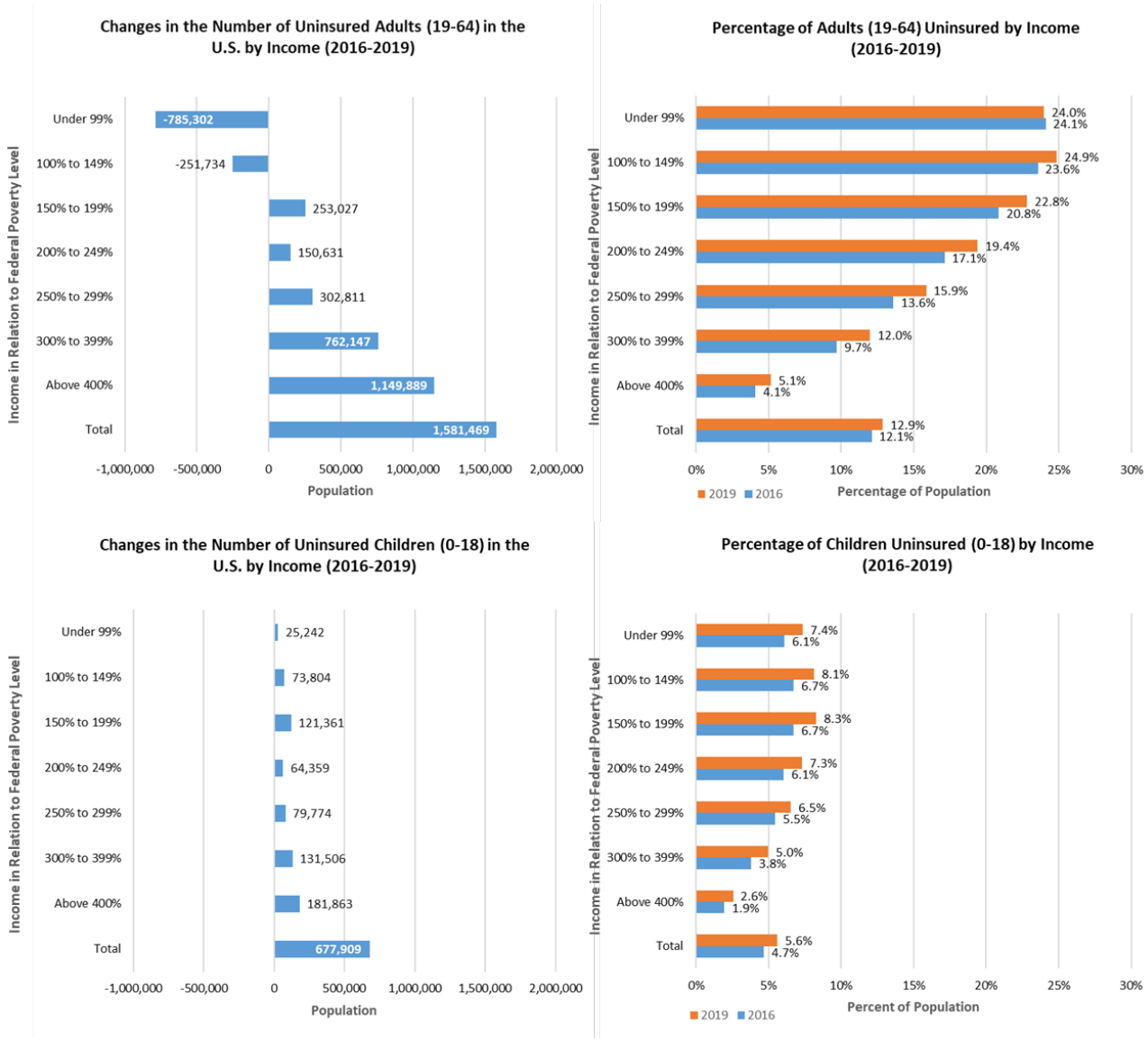
Long-term solutions lie in policies that make systemic changes to address the underlying issues causing premiums to increase. To that end, CMS has been advancing a number of policies using the tools available under current law to reduce the cost of care by, for example, encouraging more insurers to compete in the market, empowering patients to be value-conscious consumers by making quality and cost data transparent, and moving to value-based payments in our public programs. These are the types of policies that will ultimately deliver affordable health insurance options for all Americans.

[6] 2019 NHIS Survey: National Center for Health Statistics, 2019 NATIONAL HEALTH INTERVIEW SURVEY (NHIS), https://www.cdc.gov/nchs/nhis/2019nhis.htm.

[7] *See* Abraham, Jean, et al, "Demand for Health Insurance Marketplace Plans was Highly Elastic in 2014-2015, National Bureau of Economic Research (July 2017), https://www.nber.org/papers/w23597 (finding a one percent premium increase on the Exchanges reduced enrollment by 1.7 percent).

Appendix A: Uninsured Rate of Adults above 400 Percent FPL from 2010–2019 by State

State	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
United States	7.0	6.6	6.5	6.7	5.3	4.4	4.1	4.5	4.8	5.1
Alabama	5.16	6.11	5.00	5.42	5.11	3.80	4.06	4.63	4.87	5.15
Alaska	12.00	10.38	13.35	11.89	9.47	10.17	9.97	11.27	8.28	10.47
Arizona	7.56	8.32	7.38	7.28	6.55	5.63	5.16	5.54	6.21	6.47
Arkansas	7.98	6.47	7.22	8.59	5.28	4.59	4.60	4.61	4.92	3.87
California	8.50	8.03	7.73	8.15	6.02	4.24	3.64	4.06	4.43	4.69
Colorado	6.39	6.32	5.90	6.04	5.34	4.03	3.99	4.00	4.57	4.66
Connecticut	4.89	4.46	5.03	5.56	4.18	3.51	2.91	3.34	3.38	3.62
Delaware	6.02	6.86	3.88	5.32	4.39	3.95	3.09	2.82	4.15	4.21
District of Columbia	5.43	4.84	3.85	4.77	3.67	2.05	1.86	2.14	1.77	1.76
Florida	10.48	9.99	10.16	10.71	8.61	7.17	6.68	7.64	8.39	8.56
Georgia	7.86	7.87	7.34	8.09	6.13	5.45	5.53	6.43	7.30	6.65
Hawaii	6.19	4.15	3.38	4.28	2.81	2.53	2.18	2.70	2.77	3.43
Idaho	7.90	7.38	7.51	7.09	7.10	4.53	5.96	7.31	6.10	8.15
Illinois	6.22	5.64	5.73	5.86	4.68	3.19	2.94	3.15	3.61	4.35
Indiana	6.15	5.22	6.13	5.76	4.87	4.19	3.51	4.27	4.59	4.82
Iowa	2.96	3.64	3.24	3.57	2.45	1.87	2.39	1.98	2.36	2.89
Kansas	5.47	4.37	4.50	4.66	3.94	4.37	3.82	3.13	3.88	4.61
Kentucky	5.94	5.45	4.97	6.17	3.92	2.86	2.47	2.53	3.11	3.92
Louisiana	10.07	9.23	8.29	9.64	7.05	5.71	5.45	5.53	5.86	5.67
Maine	6.64	5.95	5.18	6.01	5.19	4.75	4.32	4.03	5.27	5.35
Maryland	5.49	5.60	5.27	6.18	4.22	3.00	3.25	3.46	3.46	3.88
Massachusetts	2.50	2.33	2.29	2.23	2.07	1.88	1.83	1.87	1.86	2.15
Michigan	5.94	5.35	5.34	4.92	4.11	2.92	2.59	2.61	3.04	3.37
Minnesota	4.16	3.41	3.43	3.48	2.57	2.01	2.19	1.94	2.22	2.67
Mississippi	8.32	8.31	7.62	8.86	6.14	5.32	5.14	5.45	7.25	7.56
Missouri	5.28	5.17	5.47	5.03	4.44	3.68	3.87	3.82	4.61	4.74
Montana	7.91	8.77	8.55	9.16	6.09	7.48	4.26	6.31	5.69	7.58
Nebraska	5.30	4.56	4.00	4.08	3.32	2.62	3.11	3.88	3.86	3.74
Nevada	11.15	9.81	9.18	10.28	8.48	5.33	6.01	7.16	7.86	7.24
New Hampshire	6.01	4.80	5.78	5.87	4.38	3.95	3.64	3.10	3.56	4.77
New Jersey	7.37	6.64	6.60	6.57	5.40	4.36	4.11	4.05	4.23	4.74
New Mexico	10.12	9.74	8.86	8.91	7.63	6.22	4.81	5.24	5.67	6.65
New York	7.43	6.68	6.19	6.36	5.06	4.67	3.83	3.84	3.63	4.09
North Carolina	6.10	6.02	6.49	5.91	5.09	4.45	4.17	4.79	4.99	5.80
North Dakota	3.41	4.37	5.42	3.71	2.74	5.04	3.24	3.21	4.05	4.13
Ohio	5.58	4.63	4.81	4.96	3.53	3.20	2.58	3.00	3.28	3.79
Oklahoma	8.88	7.85	8.80	9.09	6.57	7.00	6.81	8.19	7.47	8.46
Oregon	7.45	5.81	5.50	7.05	5.23	3.70	4.05	4.06	4.34	4.79
Pennsylvania	5.12	4.79	4.27	4.43	3.68	3.08	2.53	2.93	3.23	3.56
Rhode Island	5.38	6.05	5.57	6.23	5.26	3.06	2.21	2.53	2.57	2.70
South Carolina	7.44	7.21	7.51	7.03	6.32	5.03	5.36	5.37	5.80	6.39
South Dakota	3.74	5.28	6.66	4.42	4.57	4.06	4.31	2.82	4.35	4.95
Tennessee	6.68	5.81	6.25	5.91	5.13	4.35	4.15	5.35	5.47	5.31
Texas	9.90	9.65	9.74	9.69	8.19	7.26	7.38	8.29	8.74	9.37
Utah	7.34	6.63	6.19	6.74	5.74	4.55	4.48	4.61	5.48	4.92
Vermont	5.50	5.02	2.78	5.79	3.46	3.03	2.78	4.59	2.35	3.67
Virginia	5.39	5.06	5.09	5.63	4.92	4.45	3.79	4.17	4.20	4.33
Washington	6.28	5.87	6.40	6.68	4.37	3.25	2.79	3.55	4.02	3.56
West Virginia	7.91	7.58	5.96	6.45	5.08	4.39	3.31	4.45	4.08	4.46
Wisconsin	4.13	4.09	3.97	4.09	2.68	2.65	2.62	2.14	3.11	3.17
Wyoming	7.09	10.76	10.47	8.17	6.96	6.15	6.35	7.42	5.99	7.80



Source: U.S. Census Bureau, American Community Survey (ACS) - 1-Year Estimates-Public Use Microdata Sample (2010-2019), MDAT (census.gov).

DEPARTMENT OF HEALTH & HUMAN SERVICES
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Updated Summary Report of 2017 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers

Released: January 15, 2021

Updated: CMS is releasing an updated version of the Summary Report of 2017 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers that was originally released on August 1, 2019.[1] The purpose of releasing this updated report is to correct for a minor misassignment of hierarchy condition categories (HCCs) that occurred to certain issuers' 2017 benefit year HHS-RADV results which affected all 2017 benefit year HHS-RADV error rates used in the calculation of risk adjustment transfer adjustments. This misassignment is detailed in the January 15, 2021 memo entitled "Reissuing 2017 HHS Risk Adjustment Data Validation (HHS-RADV) Results".[2] While this issue did not change the risk pools impacted or the identification of outliers, it did cause small changes in the dollar amounts of the 2017 benefit year HHS-RADV adjustments to risk adjustment transfers for all issuers with transfer adjustments. This change is a very minor technical correction to the 2017 benefit year HHS-RADV results. This issue did not affect the 2017 benefit year HHS-RADV Default Data Validation Charge (DDVC) or DDVC allocation payment amounts. The 2017 benefit year HHS-RADV adjustments to risk adjustment transfers and DDVCs will be invoiced to issuers in February 2021. Updated 2017 benefit year HHS-RADV adjustments to 2017 benefit year and 2018 benefit year risk adjustment transfers are reflected in this report.

[1] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/BY2017-HHSRADV-Adjustments-to-RA-Transfers-Summary-Report.pdf
[2] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs

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I. Background

The Patient Protection and Affordable Care Act (PPACA) established a permanent risk adjustment program[3] to provide payments to health insurance issuers that attract higher-risk enrollees, such as those with chronic conditions, to reduce the incentives for issuers to avoid those enrollees, and to lessen the potential influence of risk selection on the premiums that issuers charge. The risk adjustment program is designed to support issuers offering a wide range of benefit designs that are available to consumers at an affordable premium. Consistent with section 1321(c)(1) of PPACA, the Department of Health and Human Services (HHS) is responsible for operating the program on behalf of any state that does not elect to do so. HHS operated risk adjustment in all 50 states and the District of Columbia in the 2017 benefit year.

To ensure the integrity of the HHS-operated program and to validate the accuracy of data submitted by issuers for use in transfer calculations, the Centers for Medicare & Medicaid Services (CMS) performs risk adjustment data validation in states where the HHS-operated program applies (HHS-RADV). HHS-RADV also ensures that issuers' actual actuarial risk is reflected in transfers and that the HHS-operated program assesses charges to issuers with plans with lower-than-average actuarial risk while making payments to issuers with plans with higher-than-average actuarial risk.

CMS is publishing an update to this first annual report on issuers' HHS-RADV adjustments to risk adjustment transfer results.[4] As the first non-pilot year, the 2017 benefit year HHS-RADV results will generally be used to adjust 2018 benefit year plan liability risk scores, resulting in adjustments to 2018 benefit year risk adjustment transfer amounts.[5] The one exception to the prospective

[3] See section 1343 of PPACA.
[4] CMS conducted two (2) pilot years for HHS-RADV for the 2015 and 2016 benefit years. The results of 2015 and 2016 benefit year HHS-RADV were not applied to adjust plan liability risk scores or risk adjustment transfers. In addition, 2017 benefit year HHS-RADV is a pilot year for Massachusetts issuers; therefore, these issuers' 2017 benefit year HHS-RADV results will not be applied to risk scores or transfers, and are not included in this report. See the HHS Notice of Benefit and Payment Parameters for 2020 (2020 Payment Notice), 84 FR 17454 at 17508 (April 25, 2019).
[5] 45 CFR 153.350(b) and (c).

application of HHS-RADV results is for exiting issuers,[6] whose 2017 HHS-RADV results will be used to adjust the issuers' 2017 benefit year risk adjustment plan liability risk scores, resulting in adjustments to 2017 benefit year risk adjustment transfer amounts in affected state market risk pools.[7] This report sets forth by HIOS ID and state market risk pool the applicable adjustments to 2018 and 2017 benefit year risk adjustment transfers based on the 2017 benefit year HHS-RADV results. This report displays the 2018 and 2017 benefit year risk adjustment transfer amounts that were provided in each year's respective summary report,[8,9] the adjusted transfer amount due to the application of HHS-RADV error rates, and the difference between the amounts that will be invoiced and paid. This report also includes information on 2017 benefit year default data validation charges under 45 C.F.R. § 153.630(b)(10) and allocations of those amounts. Issuers will also receive new issuer-specific transfer reports for the 2018 and 2017 benefit years on January 15, 2021, reflecting any updated adjustments to transfers that occurred as a result of addressing the misassignment issue for 2017 benefit year HHS-RADV. However, issuers will not receive new DDVC reports since those charges and allocation payments are not affected by the update. The data included in this report reflect amounts calculated based on the applicable methodologies established through notice with comment rulemaking,[10] prior to the resolution of all HHS-RADV discrepancies and related appeals, and are provided for informational purposes. These amounts do not constitute specific obligations of Federal funds to any particular issuer or plan.

The HHS-RADV error rate is calculated based on the methodology set forth in the 2019 Payment Notice, and is calculated by using failure rates specific to HCC groups and subsequently adjusting the issuer's risk score when the issuer's failure rate for a group of HCCs is statistically different from the weighted mean failure rate, or total failure rate, for that group of HCCs for all issuers who participated in the HHS-RADV process.[11] The HHS-RADV error rate represents the percent of an issuer's EDGE risk scores that are estimated to be in error after applying risk score adjustments to sampled enrollees identified as outliers in the HCC Groups and extrapolating the impact of those adjustments to the issuer's risk adjustment population.[12]

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[6] To be an exiting issuer, the issuer has to exit all of the market risk pools in the state (that is, not selling or offering any new plans in the state). If an issuer only exits some market risk pools in the state, but continues to sell or offer plans in others, it is not an exiting issuer. A small group issuer with off-calendar year coverage, who exits the small group market risk pool and only has small group carry-over coverage that ends in the next benefit year, and is not otherwise selling or offering new plans in any market risk pools in the state, would be an exiting issuer. See the 2020 Payment Notice, 84 FR at 17503.

[7] See the HHS Notice of Benefit and Payment Parameters for 2019 (2019 Payment Notice), 83 FR 16930 at 16965 (April 17, 2018).

[8] The Summary Report on Permanent Risk Adjustment Transfers for the 2018 Benefit Year can be found at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Report-Risk-Adjustment-2018.pdf.

[9] The Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year can be found at: https://downloads.cms.gov/cciio/Summary-Report-Risk-Adjustment-2017.pdf.

[10] See, e.g., the 2019 Payment Notice, 83 FR at 16961 – 16965, and the 2020 Payment Notice, 84 FR at 17495 – 17497.

[11] See the 2019 Payment Notice, 83 FR at 16961 – 16965.

[12] For additional detail related to the calculation of the HHS-RADV error rate, please refer to the HHS-RADV 2017 Benefit Year Protocols document, available in the REGTAP Library.

On May 31, 2019, HHS released the 2017 Benefit Year Risk Adjustment Data Validation (HHS-RADV) Final Results Report Suite. These reports included the publication of the HHS-RADV 2017 Benefit Year Final Results Memo,[13] as well as the release of Issuer-Specific Metrics Reports and Enrollee-Level Metrics Reports to issuers in the HHS-RADV Audit Tool. These reports included an overview of the 2017 benefit year HHS-RADV error rate results by providing the national program benchmarks, the estimated weighted risk score error rates by state market risk pool, HCC group definitions and issuer-specific error rate results from the 2017 benefit year HHS-RADV findings. Revised national program benchmarks were released on January 15, 2021 with this updated transfer adjustments summary report.[14]

As detailed in the August 1, 2019 version of this report, in the HHS-RADV 2017 Benefit Year Final Results Memo,[15] we predicted 85 issuers were exiting issuers. Of those 85 issuers, 27 were expected to be outliers and would have their 2017 benefit year RADV error rates applied to 2017 benefit year risk adjustment transfers. However, since releasing the "2017 Benefit Year HHS Risk Adjustment Data Validation Results" on May 31, 2019, we determined that only 81 issuers exited all market risk pools in the applicable state(s) in the 2018 benefit year. Of those 81 issuers, 24 are outliers and their 2017 benefit year HHS-RADV error rates have been applied to 2017 benefit year risk adjustment transfers in the affected state market risk pools. Otherwise, this report builds on the error rate results released in the May 2019 reports and updated results in the January 15, 2021 reports by applying those error rates to plan liability risk scores and recalculating risk adjustment transfers.

In the 2020 Payment Notice,[16] CMS updated the timeline for publication, collection, and distribution of HHS-RADV adjustments to risk adjustment transfers. Under the new schedule, CMS will delay the collection and distribution of the 2017 benefit year HHS-RADV adjustments to risk adjustment transfers and 2017 benefit year default data validation charges and payment allocations until the 2021 calendar year. The purpose of delaying the collection and distribution of the 2017 benefit year HHS-RADV adjustments to risk adjustment transfers until 2021 is to provide issuers with more options on how and when to account for financial impacts from HHS-RADV, in keeping with guidance from state departments of insurance, where applicable. To allow for these options, we updated the

[13] The 2017 Benefit Year HHS-RADV Results can be found at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/2017-Benefit-Year-HHS-Risk-Adjustment-Data-Validation-Resultspdf.pdf.

[14] As described in the January 15, 2021 memo entitled "Reissuing 2017 HHS Risk Adjustment Data Validation (HHS-RADV) Results", the 2017 benefit year HHS-RADV Error Rate results memo findings are not significantly changed as a result of the misassignment, but the national failure rate statistics changed very slightly. We detailed the difference in the January 15, 2021 memo entitled "Reissuing 2017 HHS Risk Adjustment Data Validation (HHS-RADV) Results". (https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs)

[15] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/BY2017-HHSRADV-Adjustments-to-RA-Transfers-Summary-Report.pdf.

[16] See 84 FR at 17506 – 17508.

Unified Rate Review Template (URRT) instructions[17] to permit issuers and states to consider HHS-RADV adjustment impacts on rates for the year when these amounts will be collected and disbursed (for example, issuers and states would have the option to consider the 2017 benefit year HHS-RADV adjustments in rate setting for the 2021 benefit year, instead of 2020 benefit year rate setting). We also updated the Medical Loss Ratio (MLR) Form Instructions for the 2018 Reporting Year to instruct issuers to report HHS-RADV adjustments and default data validation charges and payment allocations in the same MLR reporting year as the year when these amounts are collected and disbursed (for example, the 2017 benefit year HHS-RADV adjustments to risk adjustment transfers and 2017 default data validation charges and allocations would be reported in the 2021 MLR reporting year).[18] Additionally, this delay allows more time for HHS to work with issuers to resolve any HHS-RADV discrepancies and appeals, as a successful HHS-RADV appeal could affect the calculated risk score error rate and accompanying adjustments to transfers. The 2018 benefit year risk adjustment transfers (the amounts issued on June 28, 2019 in the summary report and provided to issuers) were invoiced and paid on the same schedule as prior years – that is, 2018 benefit year risk adjustment invoices were sent in August 2019 and payments began in September 2019.

II. HHS-RADV Summary Data

Under the methodology finalized in the 2019 Payment Notice, the 2017 benefit year HHS-RADV will result in only 59 of 146 state market risk pools having 2018 benefit year risk scores and transfers adjusted due to non-exiting outlier issuers, and 29 of the 149 state market risk pools having 2017 benefit year risk scores and transfers adjusted due to exiting outlier issuers. Below we set forth the detailed summary of the application of the updated 2017 HHS-RADV results on risk adjustment transfers. For information on the 2017 benefit year HHS-RADV error rate results, please refer the May 31, 2019 HHS-RADV 2017 Benefit Year Final Results Memo[19] and the January 15, 2021 memo entitled "Reissuing 2017 HHS Risk Adjustment Data Validation (HHS-RADV) Results".[20]

[17] Draft 2020 Unified Rate Review Instructions, available at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2020-Draft-URR-Instructions-508d.pdf.
[18] 2018 MLR Instructions, available at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2018-MLR-Form-Instructions.pdf.
[19] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/2017-Benefit-Year-HHS-Risk-Adjustment-Data-Validation-Resultspdf.pdf.
[20] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs

Table 1: HHS-RADV Summary Data[21]

SUMMARY DATA ELEMENT	2018 Benefit Year - Risk Adjustment Individual		2018 Benefit Year- Risk Adjustment Small Group		2018 Benefit Year- Risk Adjustment Catastrophic		2017 Benefit Risk Adjustment Individual		2017 Benefit Risk Adjustment Small Group		2017 Benefit Risk Adjustment Catastrophic	
Number of Issuers with Risk Adjustment Covered Plans that Participated in 2017 HHS-RADV	258	100.00%	473	100.00%	142	100.00%	391	100.00%	515	100.00%	176	100.00%
Number of Issuers with Adjusted Risk Adjustment Transfers Due to 2017 HHS-RADV	127	49.22%	329	69.56%	58	40.85%	161	41.18%	130	25.24%	47	26.70%
Number Issuers without Adjusted Risk Adjustment Transfers Due to 2017 HHS-RADV	131	50.78%	144	30.44%	84	59.15%	230	58.82%	385	74.76%	129	73.30%
Number of State Markets with Risk Adjustment Covered Plans	51	100.00%	49	100.00%	46	100.00%	51	100.00%	49	100.00%	49	100.00%
Number of State Markets with Adjusted Risk Adjustment Transfers Due to 2017 HHS-RADV	18	35.29%	31	63.27%	10	21.74%	15	29.41%	8	16.33%	6	12.24%
Number of State Markets without Adjusted Risk Adjustment Transfers Due to 2017 HHS-RADV	33	64.71%	18	36.73%	36	78.26%	36	70.59%	41	83.67%	43	87.76%

III. Updated Issuer-Specific Adjustments to 2018 Risk Adjustment Transfers Based on the Revised 2017 Benefit Year HHS-RADV Results

Below we set forth the updated 2018 benefit year risk adjustment transfer amounts adjusted for the revised 2017 benefit year HHS-RADV results by issuer. The "Adjustment Amount" represents the amount that issuers will be invoiced as a result of the 2017 benefit year HHS-RADV results being applied to the issuers' risk adjustment transfers.

Except for exiting issuers, the 2017 HHS-RADV error rates were applied to the 2018 benefit year plan level risk scores which then were used to calculate the adjusted 2018 risk adjustment transfers. Therefore, except for exiting issuers, we applied the 2017 HHS-RADV error rates by completing the following:

1. RADV Error Rate * BY2018 Risk Score without RADV Adjustment = X
2. BY2018 Risk Score without RADV Adjustment – X = BY2018 Risk Score with RADV Adjustment

[21] These numbers include the merged markets of Massachusetts and Vermont in the counts for the individual markets. As described in this report, 2017 benefit year HHS-RADV is a pilot year for Massachusetts issuers and Table 3 will separately provide the issuer-specific information for Vermont issuers only.

Then, we used the new risk scores (BY2018 Risk Score with RADV Adjustment) in the transfer calculation to determine the RADV adjusted transfer amount. Please see the July 23, 2019 webinar titled, "EDGE Server 32.0 Maintenance Release Preview & Review of 8/1/19 Risk Adjustment (RA) Reports with RA Data Validation (RADV) Adjustments to Transfers," for more information.[22]

These adjustment amounts represent the difference between issuers' risk adjustment transfers and the adjusted transfer amount due to the 2017 benefit year HHS-RADV. The adjustment amounts are the amounts that will be collected and paid in calendar year 2021, subject to any changes that may result from successful HHS-RADV discrepancies or related appeals.

If an issuer does not have enrollment in a state market risk pool, and thus, does not have a risk adjustment transfer in that risk pool, the issuer is not included in the applicable risk pool table(s) below.

"$0.00": We signify $0.00 for issuers where there is no adjustment being made because there are no error rates in the state market risk pool.

Table 2a: Updated Issuer-Specific 2017 HHS-RADV Adjustments to 2018 Risk Adjustment Transfers for Non-Merged Market States – Individual, Non-Catastrophic Market *(Appendix A)*

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2018 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS (Charges Collected in August 2019)[23]	2018 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
38344	Premera Blue Cross	AK	$0.00	$0.00	$0.00
46944	Blue Cross Blue Shield of Alabama	AL	$2,970,457.93	$2,970,457.93	$0.00
73301	Bright Health Insurance Company	AL	($2,970,457.94)	($2,970,457.94)	$0.00
37903	QualChoice Arkansas	AR	($5,937,801.90)	($5,937,801.90)	$0.00
62141	Centene Corporation	AR	($2,454,561.02)	($2,454,561.02)	$0.00
70525	QualChoice Arkansas	AR	($5,510,323.85)	($5,510,323.85)	$0.00

[22] Available at: https://www.regtap.info/uploads/library/RA_EDGE_32_Preview_RA_Transfer_072319_5CR_072519.pdf.
[23] The Summary Report on Permanent Risk Adjustment Transfers for the 2018 Benefit Year can be found at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Report-Risk-Adjustment-2018.pdf

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2018 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS (Charges Collected in August 2019)[23]	2018 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
75293	Arkansas Blue Cross and Blue Shield	AR	$13,902,686.73	$13,902,686.73	$0.00
53901	Blue Cross Blue Shield of Arizona, Inc.	AZ	($27,000,895.26)	($35,470,707.78)	($8,469,812.52)
91450	Centene Corporation	AZ	$24,194,445.65	$32,998,270.46	$8,803,824.81
97667	Cigna	AZ	$2,806,449.62	$2,472,437.30	($334,012.32)
10544	Oscar Health	CA	($36,095,547.24)	($37,208,702.60)	($1,113,155.36)
18126	Molina Healthcare	CA	($90,007,565.54)	($91,786,780.81)	($1,779,215.27)
27603	Anthem, Inc.	CA	($66,949,712.75)	($71,038,815.48)	($4,089,102.73)
40513	Kaiser Permanente	CA	($392,428,977.60)	($295,518,890.80)	$96,910,086.75
47579	Chinese Community Health Plan	CA	($29,879,702.32)	($30,351,892.76)	($472,190.44)
64210	Sutter Health Plan	CA	$1,482,469.03	$1,304,352.74	($178,116.29)
67138	Centene Corporation	CA	($61,735,560.70)	($69,483,405.07)	($7,747,844.37)
70285	Blue Shield of California	CA	$784,841,749.00	$741,137,858.50	($43,703,890.45)
84014	County of Santa Clara	CA	($21,489,152.48)	($22,002,728.30)	($513,575.82)
92499	Sharp Health Plan	CA	($5,020,442.08)	($6,542,367.59)	($1,521,925.51)
92815	Local Initiative Health Authority for Los Angeles County	CA	($79,090,312.24)	($111,563,130.10)	($32,472,817.87)
93689	Western Health Advantage	CA	($5,540,769.45)	($6,233,226.58)	($692,457.13)
99110	Centene Corporation	CA	$1,913,524.31	($712,271.20)	($2,625,795.51)
21032	Kaiser Permanente	CO	($63,140,864.67)	($52,604,452.33)	$10,536,412.34
31070	Bright Health Insurance Company	CO	($20,665,611.53)	($14,628,365.97)	$6,037,245.56
49375	Cigna	CO	$9,010,391.45	($20,736,121.00)	($29,746,512.45)
63312	Colorado Choice Health Plans	CO	$3,246,846.91	$4,289,173.22	$1,042,326.31
66699	Denver Health Medical Plan, Inc.	CO	$15,702,946.77	$16,906,607.60	$1,203,660.83
76680	Anthem, Inc.	CO	$49,427,489.22	$59,810,065.77	$10,382,576.55
97879	Rocky Mountain Health Care Options	CO	$6,418,801.86	$6,963,092.75	$544,290.89
75091	ConnectiCare, Inc.	CT	($718,321.15)	($517,845.11)	$200,476.04
76962	ConnectiCare, Inc.	CT	($15,387,332.35)	($15,503,640.61)	($116,308.26)

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86545	Anthem, Inc.	CT	$6,285,168.78	$6,223,579.27	($61,589.51)
94815	ConnectiCare, Inc.	CT	$9,820,484.66	$9,797,906.37	($22,578.29)
78079	CareFirst	DC	$5,656,379.30	$5,656,379.30	$0.00
86052	CareFirst	DC	($2,527,374.40)	($2,527,374.40)	$0.00
94506	Kaiser Permanente	DC	($3,129,004.89)	($3,129,004.89)	$0.00
76168	Highmark	DE	$0.00	$0.00	$0.00
16842	Blue Cross and Blue Shield of Florida	FL	$694,838,641.90	$695,692,313.70	$853,671.79
19898	AvMed, Inc.	FL	$5,378,911.17	$5,404,056.28	$25,145.11
21663	Centene Corporation	FL	($501,224,663.80)	($500,763,244.20)	$461,419.64
30252	Blue Cross and Blue Shield of Florida	FL	($182,573,673.80)	($181,749,795.90)	$823,877.88
36194	Health First, Inc.	FL	$8,486,520.28	$8,518,577.35	$32,057.07
48121	Cigna	FL	$5,635,093.58	$3,331,400.02	($2,303,693.56)
54172	Molina Healthcare	FL	($33,803,627.85)	($33,752,445.52)	$51,182.33
56503	Florida Health Care Plan, Inc.	FL	$3,262,798.65	$3,319,138.38	$56,339.73
49046	Anthem, Inc.	GA	$58,061,132.96	$58,061,132.96	$0.00
70893	Centene Corporation	GA	($26,833,209.41)	($26,833,209.41)	$0.00
83761	Alliant Health Plans	GA	$16,383,397.77	$16,383,397.77	$0.00
89942	Kaiser Permanente	GA	($47,611,321.34)	($47,611,321.34)	$0.00
18350	Hawaii Medical Service Association	HI	$15,441,123.76	$13,245,486.93	($2,195,636.83)
60612	Kaiser Permanente	HI	($15,441,123.75)	($13,245,486.94)	$2,195,636.81
93078	Medica Insurance Company	IA	$0.00	$0.00	$0.00
26002	SelectHealth	ID	$8,603,093.02	$8,603,093.02	$0.00
38128	Montana Health Cooperative	ID	($3,101,803.95)	($3,101,803.95)	$0.00
44648	Cambia Health Solutions	ID	$2,203,755.18	$2,203,755.18	$0.00
60597	PacificSource Health Plans	ID	$3,528,512.68	$3,528,512.68	$0.00
61589	Blue Cross of Idaho Health Service, Inc.	ID	($11,233,557.03)	($11,233,557.03)	$0.00
20129	Health Alliance Medical Plans, Inc.	IL	($6,824,096.13)	($11,703,804.12)	($4,879,707.99)

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27833	Centene Corporation	IL	($39,834,494.41)	($47,499,903.53)	($7,665,409.12)
36096	Health Care Service Corporation	IL	$102,754,252.50	$120,091,118.70	$17,336,866.14
53882	Cigna	IL	($56,095,661.94)	($60,887,411.03)	($4,791,749.09)
54192	CareSource	IN	($12,933,547.30)	($12,933,547.30)	$0.00
76179	Centene Corporation	IN	$12,933,547.39	$12,933,547.39	$0.00
18558	Blue Cross and Blue Shield of Kansas, Inc.	KS	($11,593,606.91)	($11,593,606.91)	$0.00
39520	Medica Insurance Company	KS	$2,779,948.57	$2,779,948.57	$0.00
80065	Centene Corporation	KS	$8,683,600.84	$8,683,600.84	$0.00
94248	Blue Cross and Blue Shield of Kansas City	KS	$130,057.47	$130,057.47	$0.00
36239	Anthem, Inc.	KY	($3,287,986.61)	($3,287,986.61)	$0.00
45636	CareSource	KY	$3,287,986.61	$3,287,986.61	$0.00
19636	Blue Cross Blue Shield of Louisiana	LA	($73,454,376.23)	($73,454,376.23)	$0.00
67243	Vantage Health Plan, Inc.	LA	($2,946,175.52)	($2,946,175.52)	$0.00
97176	Blue Cross Blue Shield of Louisiana	LA	$76,400,551.71	$76,400,551.71	$0.00
28137	CareFirst	MD	$31,193,835.23	$31,193,835.23	$0.00
45532	CareFirst	MD	$52,045,710.44	$52,045,710.44	$0.00
90296	Kaiser Permanente	MD	($119,992,217.30)	($119,992,217.30)	$0.00
94084	CareFirst	MD	$36,752,671.65	$36,752,671.65	$0.00
33653	Maine Community Health Options	ME	($17,598,622.74)	($17,598,622.74)	$0.00
48396	Anthem, Inc.	ME	$6,033,018.60	$6,033,018.60	$0.00
96667	HPHC Insurance Company, Inc	ME	$11,565,604.19	$11,565,604.19	$0.00
15560	Blue Cross Blue Shield of Michigan	MI	$105,190,784.70	$105,190,784.70	$0.00
29698	Priority Health	MI	($39,048,440.47)	($39,048,440.47)	$0.00
37651	Health Alliance Plan (HAP)	MI	($727,122.66)	($727,122.66)	$0.00
40047	Molina Healthcare	MI	($19,480,573.69)	($19,480,573.69)	$0.00
58594	Meridian Health Plan of Michigan, Inc.	MI	($6,714,520.68)	($6,714,520.68)	$0.00
60829	Physicians Health Plan	MI	($3,107,390.09)	($3,107,390.09)	$0.00

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67183	Total Health Care USA, Inc.	MI	($10,282,614.24)	($10,282,614.24)	$0.00
67577	Health Alliance Plan (HAP)	MI	$366,746.18	$366,746.18	$0.00
74917	McLaren Health Care	MI	($2,861,423.37)	($2,861,423.37)	$0.00
98185	Blue Cross Blue Shield of Michigan	MI	($23,335,445.65)	($23,335,445.65)	$0.00
31616	Medica Insurance Company	MN	$8,696,709.02	$8,696,709.02	$0.00
34102	HealthPartners Insurance Company	MN	($37,956,175.69)	($37,956,175.69)	$0.00
57129	Blue Cross Blue Shield of Minnesota	MN	$19,056,777.68	$19,056,777.68	$0.00
85736	UCare Minnesota	MN	$8,101,529.32	$8,101,529.32	$0.00
88102	PreferredOne Insurance Company	MN	$2,101,159.51	$2,101,159.51	$0.00
32753	Anthem, Inc.	MO	($16,066,943.61)	($16,069,676.04)	($2,732.43)
34762	Blue Cross and Blue Shield of Kansas City	MO	$247,623.50	$258,295.45	$10,671.95
74483	Cigna	MO	($38,548,201.00)	($38,552,251.52)	($4,050.52)
96384	Cox HealthPlans	MO	($1,075,774.51)	($1,075,963.15)	($188.64)
99723	Centene Corporation	MO	$55,443,295.58	$55,439,595.26	($3,700.32)
11721	Blue Cross Blue Shield of Mississippi	MS	$1,923,319.68	$1,923,319.68	$0.00
90714	Centene Corporation	MS	($1,923,319.68)	($1,923,319.68)	$0.00
23603	PacificSource Health Plans	MT	$590,688.46	($3,130,431.19)	($3,721,119.65)
30751	Health Care Service Corporation	MT	$29,940,321.60	$38,893,633.23	$8,953,311.63
32225	Montana Health Cooperative	MT	($30,531,010.08)	($35,763,202.01)	($5,232,191.93)
11512	Blue Cross Blue Shield of North Carolina	NC	$20,591,387.43	$20,591,387.43	$0.00
73943	Cigna	NC	($20,591,387.48)	($20,591,387.48)	$0.00
37160	Blue Cross Blue Shield of North Dakota	ND	$2,851,014.21	$2,851,014.21	$0.00
73751	Medica Insurance Company	ND	$522,839.25	$522,839.25	$0.00
89364	Sanford Health Plan	ND	($3,373,853.47)	($3,373,853.47)	$0.00
20305	Medica Insurance Company	NE	$0.00	$0.00	$0.00
59025	HPHC Insurance Company, Inc	NH	$21,829,761.45	$25,514,307.64	$3,684,546.19
75841	Centene Corporation	NH	$15,981,929.25	$14,656,157.14	($1,325,772.11)

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96751	Anthem, Inc.	NH	($37,811,690.72)	($40,170,464.79)	($2,358,774.07)
23818	Oscar Health	NJ	($12,464,783.91)	($9,577,574.61)	$2,887,209.30
41014	Cigna	NJ	$4,546,819.35	$5,006,697.42	$459,878.07
77263	UnitedHealth Group, Inc.	NJ	$25,373,426.55	$28,135,075.02	$2,761,648.47
77606	Independence Blue Cross	NJ	($5,659,848.57)	$1,359,704.91	$7,019,553.48
91661	Horizon Blue Cross Blue Shield of New Jersey	NJ	$88,470,083.03	$29,768,289.56	($58,701,793.47)
91762	Independence Blue Cross	NJ	($100,265,696.40)	($54,692,192.29)	$45,573,504.13
19722	Molina Healthcare	NM	($6,773,839.58)	($6,326,157.90)	$447,681.68
57173	Presbyterian Healthcare Services	NM	($904,288.89)	($723,571.11)	$180,717.78
72034	CHRISTUS Health	NM	($1,866,069.52)	($2,913,473.12)	($1,047,403.60)
75605	Health Care Service Corporation	NM	$7,281,914.06	$7,365,925.59	$84,011.53
93091	New Mexico Health Connections	NM	$2,262,283.93	$2,597,276.57	$334,992.64
41094	Hometown Health Plan, Inc.	NV	($2,139,297.98)	($2,139,297.98)	$0.00
45142	Centene Corporation	NV	$4,230,613.42	$4,230,613.42	$0.00
83198	UnitedHealth Group, Inc.	NV	$10,259,411.98	$10,259,411.98	$0.00
85266	Hometown Health Plan, Inc.	NV	$2,049,643.64	$2,049,643.64	$0.00
95865	UnitedHealth Group, Inc.	NV	($14,400,371.12)	($14,400,371.12)	$0.00
11177	Metro Plus Health Plan	NY	($11,803,134.05)	($12,550,294.00)	($747,159.95)
17210	Aetna, Inc.	NY	($55,658.26)	($61,113.42)	($5,455.16)
18029	Independent Health	NY	$8,789,894.18	$8,429,060.09	($360,834.09)
25303	New York State Catholic Health Plan, Inc.	NY	($80,436,254.12)	($85,656,444.99)	($5,220,190.87)
36346	HealthNow New York, Inc.	NY	$2,620,013.36	$896,168.74	($1,723,844.62)
44113	Anthem, Inc.	NY	$64,902,459.27	$62,643,480.15	($2,258,979.12)
49526	HealthNow New York, Inc.	NY	$8,479,909.82	$8,085,165.38	($394,744.44)
54235	UnitedHealth Group, Inc.	NY	$17,803,820.29	$17,195,330.94	($608,489.35)
54297	UnitedHealth Group, Inc.	NY	$571,111.59	$525,855.07	($45,256.52)
56184	MVP Health Plan, Inc.	NY	$10,299,387.41	$8,557,073.84	($1,742,313.57)

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61405	Healthfirst	NY	$25,712.60	$29,546.67	$3,834.07
73886	Crystal Run Health Plans	NY	$174,767.68	$165,943.64	($8,824.04)
74289	Oscar Health	NY	($45,701,824.52)	($47,610,342.59)	($1,908,518.07)
78124	Excellus Health Plan, Inc.	NY	$26,082,736.48	$44,728,125.46	$18,645,388.98
80519	Anthem, Inc.	NY	$437,830.63	$432,619.86	($5,210.77)
88582	EmblemHealth	NY	($4,659,562.93)	($6,230,885.86)	($1,571,322.93)
91237	Healthfirst	NY	($2,883,749.99)	($4,572,705.50)	($1,688,955.51)
94788	CDPHP Universal Benefits, Inc.	NY	$5,352,540.47	$4,993,416.35	($359,124.12)
28162	AultCare Insurance Company	OH	$3,907,368.13	$3,907,368.13	$0.00
29276	Anthem, Inc.	OH	$231,022.64	$231,022.64	$0.00
41047	Centene Corporation	OH	($3,756,152.59)	($3,756,152.59)	$0.00
45845	Oscar Health	OH	$19,440,763.53	$19,440,763.53	$0.00
52664	Summa Insurance Company	OH	$2,026,634.72	$2,026,634.72	$0.00
64353	Molina Healthcare	OH	$1,731,685.12	$1,731,685.12	$0.00
74313	Paramount Insurance Company	OH	($2,959,853.64)	($2,959,853.64)	$0.00
77552	CareSource	OH	$20,457,915.59	$20,457,915.59	$0.00
83396	The Health Plan of the Upper Ohio Valley	OH	($337,530.52)	($337,530.52)	$0.00
99969	Medical Mutual of Ohio	OH	($40,741,853.04)	($40,741,853.04)	$0.00
87571	Health Care Service Corporation	OK	($1,158,988.37)	($531,780.27)	$627,208.10
98905	CommunityCare	OK	$1,158,988.37	$531,780.29	($627,208.08)
10091	PacificSource Health Plans	OR	$1,327,547.94	$1,327,547.94	$0.00
10940	Centene Corporation	OR	$1,451,147.69	$1,451,147.69	$0.00
39424	Moda Health Plan, Inc.	OR	$34,933,476.71	$34,933,476.71	$0.00
56707	Providence Health & Services	OR	$498,299.06	$498,299.06	$0.00
63474	Cambia Health Solutions	OR	$2,796,331.22	$2,796,331.22	$0.00
71287	Kaiser Permanente	OR	($39,312,256.02)	($39,312,256.02)	$0.00
77969	Cambia Health Solutions	OR	($1,694,546.61)	($1,694,546.61)	$0.00

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16322	UPMC Health Plan	PA	($42,257,158.78)	($43,022,507.84)	($765,349.06)
22444	Geisinger Health System	PA	($34,028,135.82)	($34,556,981.97)	($528,846.15)
31609	Independence Blue Cross	PA	$69,336,559.46	$69,020,215.52	($316,343.94)
33709	Highmark	PA	$1,815,873.28	$1,807,290.57	($8,582.71)
33871	Independence Blue Cross	PA	($55,241,067.85)	($56,165,329.27)	($924,261.42)
38949	Highmark	PA	$6,792,794.49	$10,043,858.90	$3,251,064.41
45127	Capital Blue Cross	PA	$54,650,568.61	$54,238,416.33	($412,152.28)
53789	Capital Blue Cross	PA	($3,438,934.21)	($3,447,571.43)	($8,637.22)
55957	Highmark	PA	$425,782.43	$422,967.84	($2,814.59)
62560	UPMC Health Plan	PA	($6,317.68)	($6,319.96)	($2.28)
70194	Highmark	PA	$3,368,920.05	$3,198,419.02	($170,501.03)
75729	Geisinger Health System	PA	$192,036.81	$189,775.66	($2,261.15)
82795	Capital Blue Cross	PA	$128,095.67	$125,283.95	($2,811.72)
83731	Highmark	PA	($1,739,016.47)	($1,847,517.36)	($108,500.89)
15287	Blue Cross Blue Shield of Rhode Island	RI	$9,430,166.34	$9,430,166.34	$0.00
77514	Neighborhood Health Plan of Rhode Island	RI	($9,430,166.35)	($9,430,166.35)	$0.00
26065	BlueChoice HealthPlan of South Carolina, Inc.	SC	$8,866,099.87	$8,866,099.87	$0.00
49532	BlueChoice HealthPlan of South Carolina, Inc.	SC	($8,866,099.84)	($8,866,099.84)	$0.00
31195	Sanford Health Plan	SD	($7,461,533.88)	($7,461,533.88)	$0.00
60536	Avera Health Plans, Inc.	SD	$7,461,533.85	$7,461,533.85	$0.00
14002	BlueCross BlueShield of Tennessee	TN	$26,974,463.96	$26,974,463.96	$0.00
23552	Oscar Health	TN	($31,719,734.32)	($31,719,734.32)	$0.00
99248	Cigna	TN	$4,745,270.35	$4,745,270.35	$0.00
20069	Oscar Health	TX	($96,027,428.06)	($100,401,566.20)	($4,374,138.10)
26539	FirstCare Health Plans	TX	$16,234,137.21	$14,696,800.57	($1,537,336.64)
27248	Community Health Choice, Inc.	TX	$15,866,343.18	$8,119,028.27	($7,747,314.91)
29418	Centene Corporation	TX	($92,624,897.65)	($104,883,689.90)	($12,258,792.26)

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33602	Health Care Service Corporation	TX	$436,025,964.90	$504,727,185.90	$68,701,220.97
37755	Scott & White Health Plan	TX	$3,158,603.69	$3,069,751.87	($88,851.82)
40788	Scott & White Health Plan	TX	$11,014,728.45	$10,725,588.71	($289,139.74)
45786	Molina Healthcare	TX	($264,639,716.90)	($276,790,378.40)	($12,150,661.41)
46224	Community First Health Plans, Inc.	TX	$49,834.16	$47,615.18	($2,218.98)
66252	CHRISTUS Health	TX	($1,045,933.85)	($29,907,527.40)	($28,861,593.55)
71837	Sendero Health Plans, Inc.	TX	($20,613,016.90)	($21,938,378.53)	($1,325,361.63)
84479	Vista Health Plan, Inc.	TX	($7,398,618.25)	($7,464,430.18)	($65,811.93)
22013	Cambia Health Solutions	UT	$14,544,715.09	$12,905,434.62	($1,639,280.47)
34541	Cambia Health Solutions	UT	$46,352.18	$46,456.30	$104.12
42261	University of Utah Health Insurance Plans	UT	$33,373,024.41	$33,624,134.75	$251,110.34
68781	SelectHealth	UT	($47,964,091.71)	($46,576,025.69)	$1,388,066.02
10207	CareFirst	VA	$19,136,780.85	$19,136,780.85	$0.00
20507	Optima Health	VA	$91,862,379.48	$91,862,379.48	$0.00
37204	Piedmont Community Health Plan	VA	$8,717,225.07	$8,717,225.07	$0.00
40308	CareFirst	VA	$35,707,401.65	$35,707,401.65	$0.00
41921	Cigna	VA	($63,207,393.74)	($63,207,393.74)	$0.00
88380	Anthem, Inc.	VA	$20,032,856.47	$20,032,856.47	$0.00
95185	Kaiser Permanente	VA	($112,249,249.70)	($112,249,249.70)	$0.00
23371	Kaiser Permanente	WA	($12,893,384.72)	($12,893,384.72)	$0.00
38229	Health Alliance Medical Plans, Inc.	WA	$10,790.77	$10,790.77	$0.00
38498	Premera Blue Cross	WA	$2,919,205.50	$2,919,205.50	$0.00
49831	Premera Blue Cross	WA	$75,344,637.89	$75,344,637.89	$0.00
53732	Cambia Health Solutions	WA	($580,074.07)	($580,074.07)	$0.00
61836	Centene Corporation	WA	($24,040,639.81)	($24,040,639.81)	$0.00
69364	Cambia Health Solutions	WA	$1,248,238.49	$1,248,238.49	$0.00
71281	Cambia Health Solutions	WA	$2,267,268.38	$2,267,268.38	$0.00

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2018 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS (Charges Collected in August 2019)[23]	2018 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
80473	Kaiser Permanente	WA	($85,447,682.75)	($85,447,682.75)	$0.00
84481	Molina Healthcare	WA	$39,807,835.01	$39,807,835.01	$0.00
87718	Cambia Health Solutions	WA	$1,363,805.27	$1,363,805.27	$0.00
14630	Children's Community Health Plan	WI	$7,728,301.04	$6,808,006.16	($920,294.88)
20173	HealthPartners Insurance Company	WI	($4,408,529.63)	($3,770,598.55)	$637,931.08
37833	Quartz Health Solutions	WI	$12,018,705.84	$11,329,700.30	($689,005.54)
38166	Security Health Plan of Wisconsin, Inc.	WI	($31,141,286.48)	($32,239,293.54)	($1,098,007.06)
38345	Dean Health Plan, Inc.	WI	($28,521,370.59)	($29,476,362.18)	($954,991.59)
57845	Medica Insurance Company	WI	$11,448,650.79	$11,109,002.84	($339,647.95)
58326	MercyCare Insurance Company	WI	($3,292,088.52)	($3,462,679.50)	($170,590.98)
58564	Quartz Health Solutions	WI	$192,150.90	$184,089.47	($8,061.43)
81413	Network Health Plan	WI	$11,570,898.72	$18,004,256.66	$6,433,357.94
81974	Wisconsin Physicians Svc Insurance Corp	WI	$1,676,554.99	$1,659,331.98	($17,223.01)
84670	Wisconsin Physicians Svc Insurance Corp	WI	$312,176.35	$229,917.06	($82,259.29)
86584	Wisconsin Physicians Svc Insurance Corp	WI	($6,361,508.08)	($6,694,402.62)	($332,894.54)
87416	Common Ground Healthcare Cooperative	WI	$27,514,031.21	$25,194,614.54	($2,319,416.67)
94529	Group Health Cooperative of South Central Wisconsin	WI	$1,263,313.44	$1,124,417.30	($138,896.14)
31274	Highmark	WV	$9,997,096.13	$9,997,096.13	$0.00
50328	CareSource	WV	($9,966,234.51)	($9,966,234.51)	$0.00
72982	The Health Plan of the Upper Ohio Valley	WV	($30,861.62)	($30,861.62)	$0.00
11269	Blue Cross Blue Shield of Wyoming	WY	$0.00	$0.00	$0.00

Table 2b: Updated Issuer-Specific 2017 HHS-RADV Adjustments to 2018 Risk Adjustment Transfers for Non-Merged Market States – Catastrophic Risk Pool *(Appendix A)*

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2018 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS (Charges Collected in August 2019)[24]	2018 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
46944	Blue Cross Blue Shield of Alabama	AL	$13,570.07	$13,570.07	$0.00
73301	Bright Health Insurance Company	AL	($13,570.05)	($13,570.05)	$0.00
70525	QualChoice Arkansas	AR	$0.00	$0.00	$0.00
53901	Blue Cross Blue Shield of Arizona, Inc.	AZ	$0.00	$0.00	$0.00
10544	Oscar Health	CA	($1,147,602.38)	($1,207,844.22)	($60,241.84)
18126	Molina Healthcare	CA	($118,430.26)	($122,326.80)	($3,896.54)
27603	Anthem, Inc.	CA	$183,243.76	$123,322.37	($59,921.39)
40513	Kaiser Permanente	CA	($1,280,128.10)	($788,832.51)	$491,295.59
47579	Chinese Community Health Plan	CA	($3,554.88)	($3,949.06)	($394.18)
67138	Centene Corporation	CA	($293,685.53)	($304,151.99)	($10,466.46)
70285	Blue Shield of California	CA	$2,212,465.14	$2,048,852.98	($163,612.16)
84014	County of Santa Clara	CA	($156,889.52)	($162,510.87)	($5,621.35)
92499	Sharp Health Plan	CA	$178,174.84	$134,095.27	($44,079.57)
92815	Local Initiative Health Authority for Los Angeles County	CA	($66,294.41)	($70,470.48)	($4,176.07)
93689	Western Health Advantage	CA	($73,100.13)	($79,891.73)	($6,791.60)
99110	Centene Corporation	CA	$565,801.50	$433,707.02	($132,094.48)
21032	Kaiser Permanente	CO	($658,008.05)	($668,214.82)	($10,206.77)
31070	Bright Health Insurance Company	CO	($703,906.61)	($614,852.87)	$89,053.74
63312	Colorado Choice Health Plans	CO	($797,682.30)	($810,475.42)	($12,793.12)
76680	Anthem, Inc.	CO	($811,836.71)	($846,404.64)	($34,567.93)
87269	Anthem, Inc.	CO	$2,971,433.67	$2,939,947.76	($31,485.91)

[24] The Summary Report on Permanent Risk Adjustment Transfers for the 2018 Benefit Year can be found at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Report-Risk-Adjustment-2018.pdf

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2018 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS (Charges Collected in August 2019)[24]	2018 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
76962	ConnectiCare, Inc.	CT	$76,196.63	$76,196.63	$0.00
86545	Anthem, Inc.	CT	($76,196.63)	($76,196.63)	$0.00
86052	CareFirst	DC	($1,942.43)	($1,942.43)	$0.00
94506	Kaiser Permanente	DC	$1,942.43	$1,942.43	$0.00
76168	Highmark	DE	$0.00	$0.00	$0.00
36194	Health First, Inc.	FL	$129,549.12	$129,549.12	$0.00
56503	Florida Health Care Plan, Inc.	FL	($129,549.12)	($129,549.12)	$0.00
49046	Anthem, Inc.	GA	$331,380.84	$331,380.84	$0.00
89942	Kaiser Permanente	GA	($331,380.84)	($331,380.84)	$0.00
18350	Hawaii Medical Service Association	HI	$0.00	$0.00	$0.00
93078	Medica Insurance Company	IA	$0.00	$0.00	$0.00
26002	SelectHealth	ID	$344,101.21	$344,101.21	$0.00
38128	Montana Health Cooperative	ID	($496,792.03)	($496,792.03)	$0.00
60597	PacificSource Health Plans	ID	($23,494.22)	($23,494.22)	$0.00
61589	Blue Cross of Idaho Health Service, Inc.	ID	$176,185.02	$176,185.02	$0.00
20129	Health Alliance Medical Plans, Inc.	IL	($87,405.68)	($96,341.89)	($8,936.21)
36096	Health Care Service Corporation	IL	$87,405.68	$96,341.91	$8,936.23
17575	Anthem, Inc.	IN	$0.00	$0.00	$0.00
39520	Medica Insurance Company	KS	$0.00	$0.00	$0.00
36239	Anthem, Inc.	KY	($124,574.42)	($124,574.42)	$0.00
45636	CareSource	KY	$124,574.42	$124,574.42	$0.00
28137	CareFirst	MD	($252,534.35)	($252,534.35)	$0.00
90296	Kaiser Permanente	MD	$252,534.34	$252,534.34	$0.00
33653	Maine Community Health Options	ME	$73,118.04	$73,118.04	$0.00
48396	Anthem, Inc.	ME	($73,118.05)	($73,118.05)	$0.00
15560	Blue Cross Blue Shield of Michigan	MI	$1,992,383.31	$1,992,383.31	$0.00
37651	Health Alliance Plan (HAP)	MI	($403,824.00)	($403,824.00)	$0.00
58594	Meridian Health Plan of Michigan, Inc.	MI	($283,789.07)	($283,789.07)	$0.00

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2018 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS (Charges Collected in August 2019)[24]	2018 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
60829	Physicians Health Plan	MI	($7,762.09)	($7,762.09)	$0.00
67577	Health Alliance Plan (HAP)	MI	($85,130.90)	($85,130.90)	$0.00
74917	McLaren Health Care	MI	($126,212.31)	($126,212.31)	$0.00
98185	Blue Cross Blue Shield of Michigan	MI	($1,085,664.93)	($1,085,664.93)	$0.00
31616	Medica Insurance Company	MN	($245,950.60)	($245,950.60)	$0.00
34102	HealthPartners Insurance Company	MN	$423,710.64	$423,710.64	$0.00
85736	UCare Minnesota	MN	($171,322.08)	($171,322.08)	$0.00
88102	PreferredOne Insurance Company	MN	($6,437.94)	($6,437.94)	$0.00
32753	Anthem, Inc.	MO	$443,822.96	$443,822.96	$0.00
96384	Cox HealthPlans	MO	($443,822.95)	($443,822.95)	$0.00
30751	Health Care Service Corporation	MT	$170,427.51	$207,009.98	$36,582.47
32225	Montana Health Cooperative	MT	($170,427.51)	($207,009.99)	($36,582.48)
11512	Blue Cross Blue Shield of North Carolina	NC	$0.00	$0.00	$0.00
37160	Blue Cross Blue Shield of North Dakota	ND	($80,707.67)	($80,707.67)	$0.00
73751	Medica Insurance Company	ND	($21,463.60)	($21,463.60)	$0.00
89364	Sanford Health Plan	ND	$102,171.27	$102,171.27	$0.00
20305	Medica Insurance Company	NE	$0.00	$0.00	$0.00
96751	Anthem, Inc.	NH	$0.00	$0.00	$0.00
23818	Oscar Health	NJ	($1,257,453.81)	($1,003,759.29)	$253,694.52
91661	Horizon Blue Cross Blue Shield of New Jersey	NJ	$799,884.21	$505,565.92	($294,318.29)
91762	Independence Blue Cross	NJ	$457,569.61	$498,193.37	$40,623.76
57173	Presbyterian Healthcare Services	NM	$16,956.39	$18,419.11	$1,462.72
72034	CHRISTUS Health	NM	($29,785.53)	($31,862.30)	($2,076.77)
75605	Health Care Service Corporation	NM	$317.37	$513.57	$196.20
93091	New Mexico Health Connections	NM	$12,511.78	$12,929.61	$417.83
33670	Anthem, Inc.	NV	$669,932.01	$669,932.01	$0.00
41094	Hometown Health Plan, Inc.	NV	($53,877.48)	($53,877.48)	$0.00
60156	Anthem, Inc.	NV	($171,935.19)	($171,935.19)	$0.00

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2018 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS (Charges Collected in August 2019)[24]	2018 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
83198	UnitedHealth Group, Inc.	NV	($243,827.61)	($243,827.61)	$0.00
85266	Hometown Health Plan, Inc.	NV	($135,190.06)	($135,190.06)	$0.00
95865	UnitedHealth Group, Inc.	NV	($65,101.69)	($65,101.69)	$0.00
11177	Metro Plus Health Plan	NY	($3,719.40)	($3,780.63)	($61.23)
18029	Independent Health	NY	($8,736.39)	($9,340.23)	($603.84)
25303	New York State Catholic Health Plan, Inc.	NY	$713,113.34	$693,078.96	($20,034.38)
44113	Anthem, Inc.	NY	$488,384.09	$478,874.44	($9,509.65)
54235	UnitedHealth Group, Inc.	NY	$55,763.24	$55,008.47	($754.77)
56184	MVP Health Plan, Inc.	NY	$185,141.06	$182,853.52	($2,287.54)
73886	Crystal Run Health Plans	NY	($3,719.83)	($3,727.53)	($7.70)
74289	Oscar Health	NY	($1,981,657.28)	($2,074,402.36)	($92,745.08)
78124	Excellus Health Plan, Inc.	NY	$209,262.74	$339,702.91	$130,440.17
80519	Anthem, Inc.	NY	$25,253.67	$25,110.78	($142.89)
88582	EmblemHealth	NY	$211,275.05	$208,640.27	($2,634.78)
91237	Healthfirst	NY	$114,947.49	$113,371.95	($1,575.54)
94788	CDPHP Universal Benefits, Inc.	NY	($5,307.76)	($5,390.57)	($82.81)
28162	AultCare Insurance Company	OH	($61,446.45)	($61,446.45)	$0.00
45845	Oscar Health	OH	$103,786.13	$103,786.13	$0.00
52664	Summa Insurance Company	OH	($9,288.23)	($9,288.23)	$0.00
99969	Medical Mutual of Ohio	OH	($33,051.46)	($33,051.46)	$0.00
87571	Health Care Service Corporation	OK	$253,036.50	$261,887.86	$8,851.36
98905	CommunityCare	OK	($253,036.50)	($261,887.86)	($8,851.36)
10091	PacificSource Health Plans	OR	$119,312.71	$119,312.71	$0.00
71287	Kaiser Permanente	OR	($119,312.71)	($119,312.71)	$0.00
16322	UPMC Health Plan	PA	($234,769.70)	($234,769.70)	$0.00
22444	Geisinger Health System	PA	$378,002.60	$378,002.60	$0.00
31609	Independence Blue Cross	PA	($71,546.50)	($71,546.50)	$0.00
33709	Highmark	PA	($69,515.64)	($69,515.64)	$0.00

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2018 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS (Charges Collected in August 2019)[24]	2018 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
36247	Highmark	PA	$114,006.43	$114,006.43	$0.00
53789	Capital Blue Cross	PA	($88,303.03)	($88,303.03)	$0.00
70194	Highmark	PA	$16,738.60	$16,738.60	$0.00
83731	Highmark	PA	($44,612.77)	($44,612.77)	$0.00
26065	BlueChoice HealthPlan of South Carolina, Inc.	SC	$383,316.89	$383,316.89	$0.00
49532	BlueChoice HealthPlan of South Carolina, Inc.	SC	($383,316.85)	($383,316.85)	$0.00
31195	Sanford Health Plan	SD	($95,138.05)	($95,138.05)	$0.00
60536	Avera Health Plans, Inc.	SD	$95,138.05	$95,138.05	$0.00
23552	Oscar Health	TN	$0.00	$0.00	$0.00
20069	Oscar Health	TX	($2,510,025.16)	($2,574,197.67)	($64,172.51)
33602	Health Care Service Corporation	TX	$2,236,795.14	$2,441,129.43	$204,334.29
66252	CHRISTUS Health	TX	$273,230.06	$133,068.25	($140,161.81)
68781	SelectHealth	UT	$0.00	$0.00	$0.00
10207	CareFirst	VA	$244,161.59	$244,161.59	$0.00
37204	Piedmont Community Health Plan	VA	$51,747.25	$51,747.25	$0.00
88380	Anthem, Inc.	VA	$511,061.29	$511,061.29	$0.00
95185	Kaiser Permanente	VA	($806,970.12)	($806,970.12)	$0.00
23371	Kaiser Permanente	WA	($1,247.56)	($1,247.56)	$0.00
80473	Kaiser Permanente	WA	$1,247.57	$1,247.57	$0.00
14630	Children's Community Health Plan	WI	$661,681.63	$661,227.31	($454.32)
20173	HealthPartners Insurance Company	WI	($72,840.76)	($70,901.17)	$1,939.59
37833	Quartz Health Solutions	WI	$13,923.63	$13,763.81	($159.82)
38166	Security Health Plan of Wisconsin, Inc.	WI	$97,161.77	$96,766.05	($395.72)
38345	Dean Health Plan, Inc.	WI	($458,253.69)	($458,511.91)	($258.22)
57845	Medica Insurance Company	WI	($66,453.75)	($66,568.58)	($114.83)
58564	Quartz Health Solutions	WI	($6,989.33)	($6,990.34)	($1.01)
81974	Wisconsin Physicians Svc Insurance Corp	WI	$28,699.56	$28,685.93	($13.63)
84670	Wisconsin Physicians Svc Insurance Corp	WI	($6,783.62)	($6,825.44)	($41.82)

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2018 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS (Charges Collected in August 2019)[24]	2018 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
86584	Wisconsin Physicians Svc Insurance Corp	WI	($35,895.13)	($35,908.93)	($13.80)
87416	Common Ground Healthcare Cooperative	WI	($144,217.99)	($144,679.47)	($461.48)
94529	Group Health Cooperative of South Central Wisconsin	WI	($10,032.30)	($10,057.30)	($25.00)
31274	Highmark	WV	$0.00	$0.00	$0.00

Table 2c: Updated Issuer-Specific 2017 HHS-RADV Adjustments to 2018 Risk Adjustment Transfers for Non-Merged Market States – Small Group Market *(Appendix A)*

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2018 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS (Charges Collected in August 2019)[25]	2018 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
11082	Aetna, Inc.	AK	$40,127.64	$40,127.64	$0.00
38344	Premera Blue Cross	AK	$124,518.87	$124,518.87	$0.00
73836	Moda Health Plan, Inc.	AK	($368,683.53)	($368,683.53)	$0.00
80049	UnitedHealth Group, Inc.	AK	$204,037.00	$204,037.00	$0.00
46944	Blue Cross Blue Shield of Alabama	AL	$2,587,809.53	$2,587,809.53	$0.00
68259	UnitedHealth Group, Inc.	AL	($920,615.54)	($920,615.54)	$0.00
69461	UnitedHealth Group, Inc.	AL	($1,087,485.53)	($1,087,485.53)	$0.00
93018	Viva Health, Inc.	AL	($579,708.41)	($579,708.41)	$0.00

[25] The Summary Report on Permanent Risk Adjustment Transfers for the 2018 Benefit Year can be found at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Report-Risk-Adjustment-2018.pdf .

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2018 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS (Charges Collected in August 2019)[25]	2018 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
13262	Arkansas Blue Cross and Blue Shield	AR	($123,494.18)	($123,494.18)	$0.00
22732	UnitedHealth Group, Inc.	AR	($49,392.31)	($49,392.31)	$0.00
37903	QualChoice Arkansas	AR	($789,051.87)	($789,051.87)	$0.00
65817	UnitedHealth Group, Inc.	AR	($76,204.39)	($76,204.39)	$0.00
70525	QualChoice Arkansas	AR	($1,025,680.23)	($1,025,680.23)	$0.00
75293	Arkansas Blue Cross and Blue Shield	AR	$2,168,296.90	$2,168,296.90	$0.00
81392	UnitedHealth Group, Inc.	AR	($104,473.88)	($104,473.88)	$0.00
23307	Humana, Inc.	AZ	($3,153,194.10)	($3,182,768.13)	($29,574.03)
23435	Aetna, Inc.	AZ	($17,945.39)	($17,976.93)	($31.54)
40702	UnitedHealth Group, Inc.	AZ	($4,877,936.03)	($4,885,882.79)	($7,946.76)
51485	Centene Corporation	AZ	($627,530.71)	($646,513.86)	($18,983.15)
53901	Blue Cross Blue Shield of Arizona, Inc.	AZ	($5,431,749.22)	($5,539,463.62)	($107,714.40)
66105	Humana, Inc.	AZ	$252,810.18	$493,980.35	$241,170.17
70904	WMI Mutual Insurance Company	AZ	($42,142.13)	($42,152.33)	($10.20)
77349	Aetna, Inc.	AZ	($2,341,079.20)	($2,363,839.79)	($22,760.59)
78611	Aetna, Inc.	AZ	$48,109.07	$47,704.34	($404.73)
82011	UnitedHealth Group, Inc.	AZ	$13,350,964.36	$13,140,186.97	($210,777.39)
84251	Aetna, Inc.	AZ	$2,374,554.63	$2,350,932.46	($23,622.17)
86830	Cigna	AZ	($20,983.13)	($21,720.01)	($736.88)
91450	Centene Corporation	AZ	$369,862.42	$551,465.17	$181,602.75
97667	Cigna	AZ	($77,490.30)	($77,527.82)	($37.52)
98971	UnitedHealth Group, Inc.	AZ	$193,749.58	$193,575.89	($173.69)
10544	Oscar Health	CA	($70,829.72)	($75,727.43)	($4,897.71)
20523	Aetna, Inc.	CA	($9,898,601.63)	($11,085,285.09)	($1,186,683.46)
27330	Kaiser Permanente	CA	$816,618.51	$741,339.67	($75,278.84)
27603	Anthem, Inc.	CA	$207,309,138.80	$184,642,750.60	($22,666,388.22)
40513	Kaiser Permanente	CA	($336,899,630.60)	($257,322,757.60)	$79,576,872.95
40733	Aetna, Inc.	CA	$23,304,514.98	$21,923,846.31	($1,380,668.67)

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47579	Chinese Community Health Plan	CA	($2,611,734.33)	($2,716,456.76)	($104,722.43)
49116	UnitedHealth Group, Inc.	CA	($27,618,293.15)	($32,221,630.18)	($4,603,337.03)
56887	Ventura County Health Care Plan	CA	($50,222.32)	$66,492.84	$116,715.16
64210	Sutter Health Plan	CA	($14,253,113.23)	($15,776,924.99)	($1,523,811.76)
64618	National Health Insurance Company	CA	$64,847.12	($243,902.36)	($308,749.48)
67138	Centene Corporation	CA	($13,034,288.60)	($16,306,333.33)	($3,272,044.73)
70285	Blue Shield of California	CA	$142,662,341.10	$109,868,739.90	($32,793,601.22)
92499	Sharp Health Plan	CA	($7,933,606.37)	($9,415,103.00)	($1,481,496.63)
93689	Western Health Advantage	CA	$2,733,591.76	$843,366.99	($1,890,224.77)
95677	UnitedHealth Group, Inc.	CA	$2,858,307.23	($3,400,844.12)	($6,259,151.35)
99110	Centene Corporation	CA	$32,620,960.82	$30,478,428.48	($2,142,532.34)
21032	Kaiser Permanente	CO	($21,002,872.22)	($21,042,863.04)	($39,990.82)
35944	Kaiser Permanente	CO	($224,427.30)	($224,519.08)	($91.78)
39041	Aetna, Inc.	CO	$770,501.86	$770,018.10	($483.76)
39670	Aetna, Inc.	CO	($354.98)	($355.09)	($0.11)
59036	UnitedHealth Group, Inc.	CO	($11,714,412.68)	($11,725,041.37)	($10,628.69)
63312	Colorado Choice Health Plans	CO	($967,769.71)	($970,364.04)	($2,594.33)
67879	UnitedHealth Group, Inc.	CO	$26,367,792.75	$26,304,727.09	($63,065.66)
74320	Humana, Inc.	CO	($1,251,588.11)	($1,258,420.13)	($6,832.02)
76680	Anthem, Inc.	CO	($7,830,843.01)	($7,835,108.55)	($4,265.54)
79509	Humana, Inc.	CO	$554,361.09	$722,869.97	$168,508.88
80208	Rocky Mountain Health Care Options	CO	$342,485.82	$342,103.98	($381.84)
87269	Anthem, Inc.	CO	$14,907,759.98	$14,874,315.12	($33,444.86)
97879	Rocky Mountain Health Care Options	CO	$49,366.43	$42,636.96	($6,729.47)
29462	UnitedHealth Group, Inc.	CT	($6,804,964.22)	($7,138,924.22)	($333,960.00)
39159	Aetna, Inc.	CT	$2,341,215.85	$833,982.65	($1,507,233.20)
49650	UnitedHealth Group, Inc.	CT	($897,268.86)	($1,209,929.55)	($312,660.69)
71179	UnitedHealth Group, Inc.	CT	($3,998,843.33)	($4,720,955.54)	($722,112.21)

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75091	ConnectiCare, Inc.	CT	($59,871.13)	($53,747.15)	$6,123.98
76962	ConnectiCare, Inc.	CT	($228,096.34)	($228,984.61)	($888.27)
86545	Anthem, Inc.	CT	$13,684,351.63	$12,972,780.33	($711,571.30)
89130	HPHC Insurance Company, Inc	CT	($2,980,597.53)	$398,012.71	$3,378,610.24
94815	ConnectiCare, Inc.	CT	$113,129.12	($161,238.42)	($274,367.54)
95882	HPHC Insurance Company, Inc	CT	($1,169,055.15)	($690,996.45)	$478,058.70
21066	UnitedHealth Group, Inc.	DC	($824,856.28)	($847,511.79)	($22,655.51)
41842	UnitedHealth Group, Inc.	DC	($278,492.64)	($275,277.53)	$3,215.11
73987	Aetna, Inc.	DC	$335,841.89	$335,924.22	$82.33
75753	UnitedHealth Group, Inc.	DC	($23,064.00)	($22,770.28)	$293.72
77422	Aetna, Inc.	DC	$283,513.19	$283,748.08	$234.89
78079	CareFirst	DC	$10,183,042.72	$10,191,216.93	$8,174.21
86052	CareFirst	DC	($6,650,691.31)	($6,640,957.16)	$9,734.15
94506	Kaiser Permanente	DC	($3,025,293.55)	($3,024,372.51)	$921.04
29497	Aetna, Inc.	DE	($112,942.63)	($636,542.38)	($523,599.75)
61021	UnitedHealth Group, Inc.	DE	($1,000,858.99)	($990,034.19)	$10,824.80
67190	Aetna, Inc.	DE	$268,135.29	$287,063.66	$18,928.37
76168	Highmark	DE	$1,121,672.60	$1,666,108.16	$544,435.56
97569	UnitedHealth Group, Inc.	DE	($276,006.27)	($326,595.24)	($50,588.97)
16842	Blue Cross and Blue Shield of Florida	FL	$24,548,332.72	$24,935,775.82	$387,443.10
18628	Aetna, Inc.	FL	$8,637,491.76	$8,692,467.61	$54,975.85
19898	AvMed, Inc.	FL	$4,017,215.48	$4,205,883.84	$188,668.36
23841	Aetna, Inc.	FL	$2,176,135.48	$2,185,318.61	$9,183.13
30252	Blue Cross and Blue Shield of Florida	FL	($9,056,277.03)	($8,856,179.43)	$200,097.60
35783	Humana, Inc.	FL	($6,830,380.68)	($6,660,696.29)	$169,684.39
36194	Health First, Inc.	FL	($1,306,645.92)	($1,266,850.60)	$39,795.32
42204	UnitedHealth Group, Inc.	FL	($98,778.52)	($105,639.69)	($6,861.17)
43839	UnitedHealth Group, Inc.	FL	$3,424,089.93	$3,687,854.17	$263,764.24

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56503	Florida Health Care Plan, Inc.	FL	$367,271.93	$389,437.88	$22,165.95
66966	Capital Health Plan	FL	($5,382,760.20)	($1,245,597.13)	$4,137,163.07
68398	UnitedHealth Group, Inc.	FL	($6,372,816.64)	($6,026,122.60)	$346,694.04
77150	Health First, Inc.	FL	($291.31)	$20,128.66	$20,419.97
80779	UnitedHealth Group, Inc.	FL	($13,684,180.57)	($19,522,197.44)	($5,838,016.87)
99308	Humana, Inc.	FL	($438,406.63)	($433,583.42)	$4,823.21
13535	UnitedHealth Group, Inc.	GA	$911,383.68	$946,453.69	$35,070.01
30552	UnitedHealth Group, Inc.	GA	($5,103,000.19)	($4,971,554.67)	$131,445.52
37001	Humana, Inc.	GA	$790,920.55	$797,793.88	$6,873.33
43802	UnitedHealth Group, Inc.	GA	$1,409,608.01	$402,475.36	($1,007,132.65)
49046	Anthem, Inc.	GA	$18,327,398.65	$18,619,579.14	$292,180.49
82302	Kaiser Permanente	GA	$51,281.79	$51,424.36	$142.57
82824	Aetna, Inc.	GA	($1,029,523.48)	($1,015,605.49)	$13,917.99
83761	Alliant Health Plans	GA	($1,424,401.11)	($1,410,068.15)	$14,332.96
83978	Aetna, Inc.	GA	$3,124,824.43	$3,159,233.04	$34,408.61
89942	Kaiser Permanente	GA	($4,935,164.80)	($4,901,029.82)	$34,134.98
93332	Humana, Inc.	GA	($12,123,327.28)	($11,678,701.25)	$444,626.03
18350	Hawaii Medical Service Association	HI	$14,026,813.76	$12,343,895.74	($1,682,918.02)
54179	UnitedHealth Group, Inc.	HI	($42,614.64)	($24,303.04)	$18,311.60
56682	Hawaii Medical Assurance Association	HI	$46,587.65	$64,353.42	$17,765.77
60612	Kaiser Permanente	HI	($11,519,220.44)	($9,144,649.29)	$2,374,571.15
95366	University Health Alliance (UHA)	HI	($2,511,566.30)	($3,239,296.80)	($727,730.50)
18973	Aetna, Inc.	IA	$296,408.40	$294,984.35	($1,424.05)
25896	Wellmark, Inc.	IA	($7,296,763.77)	($7,345,077.34)	($48,313.57)
27651	Quartz Health Solutions	IA	($201,797.97)	($179,087.15)	$22,710.82
50735	Medical Associates Health Plans	IA	$380,331.77	$585,767.12	$205,435.35
56610	UnitedHealth Group, Inc.	IA	($530,684.05)	($541,597.69)	($10,913.64)
72160	Wellmark, Inc.	IA	$11,693,682.82	$11,548,605.38	($145,077.44)

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74406	Wellmark, Inc.	IA	($965,657.78)	($966,370.00)	($712.22)
74980	Avera Health Plans, Inc.	IA	$175,763.58	$175,102.01	($661.57)
77638	Health Alliance Medical Plans, Inc.	IA	($30,426.76)	($22,471.52)	$7,955.24
78252	Aetna, Inc.	IA	($108,601.34)	($109,013.08)	($411.74)
85930	Sanford Health Plan	IA	$97,609.88	$97,431.90	($177.98)
87928	Wellmark, Inc.	IA	($577,751.06)	($578,382.58)	($631.52)
88678	UnitedHealth Group, Inc.	IA	($2,932,113.68)	($2,959,891.52)	($27,777.84)
26002	SelectHealth	ID	($448,196.27)	($433,348.20)	$14,848.07
38128	Montana Health Cooperative	ID	($156,457.18)	($156,196.63)	$260.55
43541	National Health Insurance Company	ID	($118,607.96)	($199,345.75)	($80,737.79)
44648	Cambia Health Solutions	ID	($555,585.77)	($526,604.52)	$28,981.25
45059	Aetna, Inc.	ID	($37,369.57)	($37,324.39)	$45.18
50118	UnitedHealth Group, Inc.	ID	($39,261.09)	($38,976.56)	$284.53
60597	PacificSource Health Plans	ID	($1,068,685.11)	($1,064,344.84)	$4,340.27
61175	Aetna, Inc.	ID	($1,056.38)	($3,469.88)	($2,413.50)
61589	Blue Cross of Idaho Health Service, Inc.	ID	$2,425,219.41	$2,459,610.84	$34,391.43
20129	Health Alliance Medical Plans, Inc.	IL	($305,889.08)	($685,521.97)	($379,632.89)
24301	Medical Associates Health Plans	IL	($155,180.69)	($101,370.23)	$53,810.46
34446	UnitedHealth Group, Inc.	IL	$1,082,034.65	($2,290,405.58)	($3,372,440.23)
36096	Health Care Service Corporation	IL	$6,819,981.00	$29,589,430.99	$22,769,449.99
42529	UnitedHealth Group, Inc.	IL	($3,158,371.33)	($4,026,592.24)	($868,220.91)
54322	MercyCare Insurance Company	IL	($128,031.82)	($106,911.80)	$21,120.02
58239	UnitedHealth Group, Inc.	IL	($1,157,909.54)	($2,423,687.74)	($1,265,778.20)
58288	Humana, Inc.	IL	($121,554.50)	($1,007,174.38)	($885,619.88)
68303	Humana, Inc.	IL	($635,932.73)	($1,662,540.77)	($1,026,608.04)
72547	Aetna, Inc.	IL	$928,837.97	$571,889.46	($356,948.51)
92476	UnitedHealth Group, Inc.	IL	($3,093,873.26)	($17,751,352.38)	($14,657,479.12)
99129	Aetna, Inc.	IL	($74,110.68)	($105,763.30)	($31,652.62)

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17575	Anthem, Inc.	IN	$7,270,575.40	$7,244,431.41	($26,143.99)
32378	Aetna, Inc.	IN	($346,996.78)	($364,013.41)	($17,016.63)
33380	Indiana University Health	IN	($265,760.65)	($266,559.12)	($798.47)
36373	UnitedHealth Group, Inc.	IN	$147,741.02	$147,697.20	($43.82)
43442	Humana, Inc.	IN	($1,113,912.68)	($1,029,950.86)	$83,961.82
50816	Physicians Health Plan of Northern Indiana, Inc.	IN	($3,051,303.81)	($3,057,284.87)	($5,981.06)
67920	Southeastern Indiana Health Organization	IN	$232,857.81	$232,694.90	($162.91)
72850	UnitedHealth Group, Inc.	IN	($2,650,111.25)	($2,681,456.33)	($31,345.08)
99791	Humana, Inc.	IN	($223,089.05)	($225,558.90)	($2,469.85)
18558	Blue Cross and Blue Shield of Kansas, Inc.	KS	($7,891,084.80)	($7,891,084.80)	$0.00
19968	Humana, Inc.	KS	$3,574,503.60	$3,574,503.60	$0.00
27811	Blue Cross and Blue Shield of Kansas, Inc.	KS	($902,058.17)	($902,058.17)	$0.00
49857	Humana, Inc.	KS	$144,832.97	$144,832.97	$0.00
57850	Aetna, Inc.	KS	$127,918.88	$127,918.88	$0.00
84600	Aetna, Inc.	KS	($131,441.85)	($131,441.85)	$0.00
94248	Blue Cross and Blue Shield of Kansas City	KS	$2,569,889.67	$2,569,889.67	$0.00
94968	UnitedHealth Group, Inc.	KS	$2,507,439.83	$2,507,439.83	$0.00
15411	Humana, Inc.	KY	($1,069,657.08)	($1,063,054.96)	$6,602.12
23671	UnitedHealth Group, Inc.	KY	($2,484,842.49)	($2,482,029.72)	$2,812.77
28773	UnitedHealth Group, Inc.	KY	($269,089.85)	($284,399.48)	($15,309.63)
34822	Aetna, Inc.	KY	($7,384.36)	($7,766.20)	($381.84)
36239	Anthem, Inc.	KY	$3,598,355.49	$3,604,024.47	$5,668.98
40586	Baptist Health Plan	KY	($480,698.92)	($480,630.50)	$68.42
45920	UnitedHealth Group, Inc.	KY	$713,317.03	$713,856.54	$539.51
14030	Aetna, Inc.	LA	($20,691.77)	($20,661.90)	$29.87
19636	Blue Cross Blue Shield of Louisiana	LA	($5,295,041.84)	($4,644,235.74)	$650,806.10
38499	UnitedHealth Group, Inc.	LA	($198,092.80)	($192,687.80)	$5,405.00

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44965	Humana, Inc.	LA	($2,000,144.94)	($1,680,280.42)	$319,864.52
53946	UnitedHealth Group, Inc.	LA	($713,411.75)	($1,542,092.37)	($828,680.62)
67243	Vantage Health Plan, Inc.	LA	$404,024.11	$425,877.51	$21,853.40
69842	UnitedHealth Group, Inc.	LA	($913,127.93)	($2,366,103.25)	($1,452,975.32)
81941	Aetna, Inc.	LA	($56,697.06)	($59,195.62)	($2,498.56)
97176	Blue Cross Blue Shield of Louisiana	LA	$8,793,183.93	$10,079,379.70	$1,286,195.77
23620	UnitedHealth Group, Inc.	MD	$3,509,627.72	$3,509,627.72	$0.00
28137	CareFirst	MD	($12,256,680.53)	($12,256,680.53)	$0.00
31112	UnitedHealth Group, Inc.	MD	($6,116,663.64)	($6,116,663.64)	$0.00
45532	CareFirst	MD	$9,815,643.05	$9,815,643.05	$0.00
65635	UnitedHealth Group, Inc.	MD	$2,396,160.88	$2,396,160.88	$0.00
66516	Aetna, Inc.	MD	$98,363.58	$98,363.58	$0.00
70767	Aetna, Inc.	MD	$203,769.25	$203,769.25	$0.00
72375	UnitedHealth Group, Inc.	MD	($8,302,972.30)	($8,302,972.30)	$0.00
90296	Kaiser Permanente	MD	($4,857,082.47)	($4,857,082.47)	$0.00
94084	CareFirst	MD	$15,509,834.51	$15,509,834.51	$0.00
11593	HPHC Insurance Company, Inc	ME	$1,883,154.12	$1,883,154.12	$0.00
33653	Maine Community Health Options	ME	($3,607,861.15)	($3,607,861.15)	$0.00
48396	Anthem, Inc.	ME	$1,867,113.25	$1,867,113.25	$0.00
53357	Aetna, Inc.	ME	$1,062,166.72	$1,062,166.72	$0.00
73250	Aetna, Inc.	ME	($132,556.45)	($132,556.45)	$0.00
90214	UnitedHealth Group, Inc.	ME	($888,085.43)	($888,085.43)	$0.00
96667	HPHC Insurance Company, Inc	ME	($183,930.99)	($183,930.99)	$0.00
15560	Blue Cross Blue Shield of Michigan	MI	$9,330,777.06	$9,330,777.06	$0.00
20662	Physicians Health Plan	MI	($91,947.03)	($91,947.03)	$0.00
29241	Priority Health	MI	$283,794.39	$283,794.39	$0.00
29698	Priority Health	MI	($4,945,191.84)	($4,945,191.84)	$0.00
37651	Health Alliance Plan (HAP)	MI	$2,632,134.00	$2,632,134.00	$0.00

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52670	UnitedHealth Group, Inc.	MI	($22,687.16)	($22,687.16)	$0.00
60829	Physicians Health Plan	MI	$283,872.67	$283,872.67	$0.00
62294	Humana, Inc.	MI	($212,427.29)	($212,427.29)	$0.00
63631	UnitedHealth Group, Inc.	MI	($1,052,224.36)	($1,052,224.36)	$0.00
67183	Total Health Care USA, Inc.	MI	$216,255.75	$216,255.75	$0.00
67577	Health Alliance Plan (HAP)	MI	$946,943.33	$946,943.33	$0.00
74917	McLaren Health Care	MI	$372,435.74	$372,435.74	$0.00
95233	Paramount Insurance Company	MI	$175,307.30	$175,307.30	$0.00
98185	Blue Cross Blue Shield of Michigan	MI	($7,917,042.60)	($7,917,042.60)	$0.00
31616	Medica Insurance Company	MN	$5,075,139.49	$5,075,139.49	$0.00
49316	Blue Cross Blue Shield of Minnesota	MN	$21,729,013.18	$21,729,013.18	$0.00
52346	Sanford Health Plan	MN	($27,433.11)	($27,433.11)	$0.00
57129	Blue Cross Blue Shield of Minnesota	MN	($5,354,512.26)	($5,354,512.26)	$0.00
70373	Quartz Health Solutions	MN	($582,451.59)	($582,451.59)	$0.00
79888	HealthPartners Insurance Company	MN	($18,216,645.22)	($18,216,645.22)	$0.00
85654	HealthPartners Insurance Company	MN	($962,178.52)	($962,178.52)	$0.00
88102	PreferredOne Insurance Company	MN	($1,606,215.80)	($1,606,215.80)	$0.00
97624	PreferredOne Insurance Company	MN	($54,716.13)	($54,716.13)	$0.00
30613	Humana, Inc.	MO	($772,207.54)	($2,868,463.64)	($2,096,256.10)
32753	Anthem, Inc.	MO	$2,912,857.47	$2,791,853.66	($121,003.81)
32898	Aetna, Inc.	MO	($5,917.99)	($5,948.67)	($30.68)
34762	Blue Cross and Blue Shield of Kansas City	MO	$1,607,854.39	$4,320,315.84	$2,712,461.45
48161	Aetna, Inc.	MO	$153,964.44	$145,255.82	($8,708.62)
95426	UnitedHealth Group, Inc.	MO	($2,677,703.50)	($3,148,408.61)	($470,705.11)
96384	Cox HealthPlans	MO	($1,218,847.28)	($1,234,604.48)	($15,757.20)
11721	Blue Cross Blue Shield of Mississippi	MS	($531,168.38)	($531,168.38)	$0.00
26781	UnitedHealth Group, Inc.	MS	($81,430.37)	($81,430.37)	$0.00
48963	Humana, Inc.	MS	$327,880.85	$327,880.85	$0.00

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61794	UnitedHealth Group, Inc.	MS	($62,475.45)	($62,475.45)	$0.00
97560	UnitedHealth Group, Inc.	MS	$488,406.29	$488,406.29	$0.00
98805	UnitedHealth Group, Inc.	MS	($141,212.92)	($141,212.92)	$0.00
23603	PacificSource Health Plans	MT	($5,934,314.84)	($10,937,274.40)	($5,002,959.56)
30751	Health Care Service Corporation	MT	$6,014,895.53	$11,100,710.46	$5,085,814.93
32225	Montana Health Cooperative	MT	($62,043.60)	($130,971.78)	($68,928.18)
46621	UnitedHealth Group, Inc.	MT	($18,537.12)	($32,464.38)	($13,927.26)
11512	Blue Cross Blue Shield of North Carolina	NC	$17,062,842.61	$17,016,182.67	($46,659.94)
43283	FirstCarolinaCare Insurance Company	NC	($433,074.57)	($296,378.00)	$136,696.57
54332	UnitedHealth Group, Inc.	NC	($12,037,981.33)	($12,075,710.22)	($37,728.89)
58658	UnitedHealth Group, Inc.	NC	$438,483.42	$426,371.66	($12,111.76)
61644	Aetna, Inc.	NC	$1,439,519.22	$1,437,409.16	($2,110.06)
61671	Aetna, Inc.	NC	($40,666.89)	($60,189.06)	($19,522.17)
69347	UnitedHealth Group, Inc.	NC	($6,402,728.61)	($6,421,280.59)	($18,551.98)
72487	UnitedHealth Group, Inc.	NC	($26,393.62)	($26,405.68)	($12.06)
37160	Blue Cross Blue Shield of North Dakota	ND	$267,203.98	$267,203.98	$0.00
39364	Medica Insurance Company	ND	$799,368.01	$799,368.01	$0.00
73751	Medica Insurance Company	ND	($55,815.83)	($55,815.83)	$0.00
89364	Sanford Health Plan	ND	($1,010,756.17)	($1,010,756.17)	$0.00
29678	Blue Cross and Blue Shield of Nebraska	NE	($3,226,100.90)	($3,174,964.46)	$51,136.44
44751	UnitedHealth Group, Inc.	NE	$116,037.13	($9,544.91)	($125,582.04)
44794	Aetna, Inc.	NE	($83,103.64)	($83,024.99)	$78.65
59699	Aetna, Inc.	NE	$258,836.04	$259,384.99	$548.95
73102	UnitedHealth Group, Inc.	NE	$2,934,331.44	$3,008,149.35	$73,817.91
51889	UnitedHealth Group, Inc.	NH	($900,627.37)	($957,635.80)	($57,008.43)
57601	Anthem, Inc.	NH	$291,430.77	$17,271.46	($274,159.31)
59025	HPHC Insurance Company, Inc	NH	($1,247,814.96)	$2,164,516.67	$3,412,331.63
71616	HPHC Insurance Company, Inc	NH	$4,286,970.65	$3,817,669.02	($469,301.63)

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86365	Tufts Associated Health Maintenance Organization Inc.	NH	($5,688,716.74)	($6,681,370.08)	($992,653.34)
96751	Anthem, Inc.	NH	$3,258,757.67	$1,639,548.70	($1,619,208.97)
13953	Horizon Blue Cross Blue Shield of New Jersey	NJ	$639,252.23	($12,606.54)	($651,858.77)
23458	Cigna	NJ	$246,920.35	$287,766.27	$40,845.92
23818	Oscar Health	NJ	($589,030.10)	($379,679.34)	$209,350.76
41014	Cigna	NJ	($4,392.03)	$311.46	$4,703.49
48834	UnitedHealth Group, Inc.	NJ	$23,931.63	($397,887.55)	($421,819.18)
77263	UnitedHealth Group, Inc.	NJ	$3,357,783.37	$40,833,369.32	$37,475,585.95
77606	Independence Blue Cross	NJ	($8,352,634.74)	($4,875,155.65)	$3,477,479.09
82884	Aetna, Inc.	NJ	($688,016.88)	($531,606.27)	$156,410.61
89217	Aetna, Inc.	NJ	$1,204,355.50	$7,450,030.27	$6,245,674.77
91661	Horizon Blue Cross Blue Shield of New Jersey	NJ	($2,025,116.43)	($63,738,173.82)	($61,713,057.39)
91762	Independence Blue Cross	NJ	$6,186,947.05	$21,363,631.76	$15,176,684.71
42776	True Health New Mexico, Inc.	NM	($3,779,296.30)	($3,779,296.30)	$0.00
52744	Presbyterian Healthcare Services	NM	$2,468,687.49	$2,468,687.49	$0.00
57173	Presbyterian Healthcare Services	NM	($5,048,220.08)	($5,048,220.08)	$0.00
75605	Health Care Service Corporation	NM	$5,562,429.10	$5,562,429.10	$0.00
90762	UnitedHealth Group, Inc.	NM	$887,189.83	$887,189.83	$0.00
93091	New Mexico Health Connections	NM	($90,790.05)	($90,790.05)	$0.00
16698	Universal Health Services, Inc.	NV	$75,897.60	$80,053.31	$4,155.71
19298	Aetna, Inc.	NV	$16,000.02	($30,047.93)	($46,047.95)
20895	Humana, Inc.	NV	($10,810.69)	($10,662.62)	$148.07
27990	Aetna, Inc.	NV	$399,435.39	$403,334.54	$3,899.15
33670	Anthem, Inc.	NV	$4,411,822.33	$4,418,776.21	$6,953.88
41094	Hometown Health Plan, Inc.	NV	($972,202.42)	($971,013.03)	$1,189.39
42313	WMI Mutual Insurance Company	NV	($31,659.03)	($31,657.33)	$1.70
60156	Anthem, Inc.	NV	$222,963.26	$223,333.99	$370.73

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68524	Universal Health Services, Inc.	NV	($126,074.19)	($145,174.05)	($19,099.86)
74222	UnitedHealth Group, Inc.	NV	$431,277.67	$440,041.62	$8,763.95
83198	UnitedHealth Group, Inc.	NV	$1,198,631.09	$1,220,069.86	$21,438.77
85266	Hometown Health Plan, Inc.	NV	($2,068,164.03)	($2,061,094.90)	$7,069.13
93696	Humana, Inc.	NV	($52,975.09)	($52,916.40)	$58.69
95865	UnitedHealth Group, Inc.	NV	($3,494,141.98)	($3,483,043.26)	$11,098.72
11177	Metro Plus Health Plan	NY	($3,851,357.07)	($3,916,040.00)	($64,682.93)
17210	Aetna, Inc.	NY	($9,821,211.60)	($34,279,133.02)	($24,457,921.42)
18029	Independent Health	NY	$4,115,450.69	$1,828,930.90	($2,286,519.79)
36346	HealthNow New York, Inc.	NY	($3,184,196.48)	($22,566,821.19)	($19,382,624.71)
43477	Crystal Run Health Plans	NY	($3,177,418.69)	($3,811,182.84)	($633,764.15)
44113	Anthem, Inc.	NY	($5,714,320.48)	($7,253,183.42)	($1,538,862.94)
49526	HealthNow New York, Inc.	NY	$17,456,253.28	$14,244,892.34	($3,211,360.94)
54297	UnitedHealth Group, Inc.	NY	($293,055.46)	($458,717.46)	($165,662.00)
56184	MVP Health Plan, Inc.	NY	($2,321,891.48)	($2,495,994.99)	($174,103.51)
61405	Healthfirst	NY	($14,820,874.83)	($14,710,277.73)	$110,597.10
73886	Crystal Run Health Plans	NY	($2,566,891.21)	($2,633,049.96)	($66,158.75)
74289	Oscar Health	NY	($29,336,231.80)	($29,793,623.22)	($457,391.42)
78124	Excellus Health Plan, Inc.	NY	($31,514,039.17)	$72,713,017.09	$104,227,056.30
80519	Anthem, Inc.	NY	($2,825,520.88)	($3,014,713.97)	($189,193.09)
82483	North Shore-LIJ Health System	NY	($14,940,535.65)	($15,367,080.74)	($426,545.09)
85629	UnitedHealth Group, Inc.	NY	$132,045,665.20	$88,102,355.69	($43,943,309.47)
88582	EmblemHealth	NY	($35,223,647.37)	($36,346,805.94)	($1,123,158.57)
89846	MVP Health Plan, Inc.	NY	$2,946,107.83	($1,423,050.65)	($4,369,158.48)
92551	CDPHP Universal Benefits, Inc.	NY	$8,771,887.75	$7,124,862.07	($1,647,025.68)
94788	CDPHP Universal Benefits, Inc.	NY	($5,744,172.30)	($5,944,382.95)	($200,210.65)
28162	AultCare Insurance Company	OH	($1,454,223.77)	($1,566,308.99)	($112,085.22)
29276	Anthem, Inc.	OH	$12,900,070.02	$10,053,753.56	($2,846,316.46)

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33232	UnitedHealth Group, Inc.	OH	($1,040,419.00)	($1,158,475.57)	($118,056.57)
33931	UnitedHealth Group, Inc.	OH	($491.07)	($70,717.59)	($70,226.52)
52664	Summa Insurance Company	OH	($304,820.71)	($456,876.40)	($152,055.69)
56726	UnitedHealth Group, Inc.	OH	$352,489.35	$119,885.13	($232,604.22)
61724	UnitedHealth Group, Inc.	OH	($10,482,677.83)	($4,447,822.13)	$6,034,855.70
66083	Humana, Inc.	OH	($4,203,609.22)	($5,052,724.01)	($849,114.79)
67129	Aetna, Inc.	OH	($788,559.01)	($939,640.23)	($151,081.22)
74313	Paramount Insurance Company	OH	($661,961.10)	($834,975.93)	($173,014.83)
80627	Medical Mutual of Ohio	OH	$6,096,462.44	$5,279,417.76	($817,044.68)
83396	The Health Plan of the Upper Ohio Valley	OH	($371,942.60)	($381,231.99)	($9,289.39)
84867	Aetna, Inc.	OH	($178,955.27)	($317,695.43)	($138,740.16)
97596	Humana, Inc.	OH	$143,109.66	($216,075.41)	($359,185.07)
98810	The Health Plan of the Upper Ohio Valley	OH	($3,810.87)	($9,205.07)	($5,394.20)
99969	Medical Mutual of Ohio	OH	($661.13)	($1,307.66)	($646.53)
45480	UnitedHealth Group, Inc.	OK	($650,887.48)	($1,314,798.84)	($663,911.36)
66946	Aetna, Inc.	OK	$630,528.36	$491,354.05	($139,174.31)
76275	Aetna, Inc.	OK	($32,404.33)	($39,610.33)	($7,206.00)
85757	UnitedHealth Group, Inc.	OK	($2,208,570.70)	($6,049,264.21)	($3,840,693.51)
87571	Health Care Service Corporation	OK	$8,197,993.56	$17,988,921.31	$9,790,927.75
87698	CommunityCare	OK	$246,602.02	($611,959.57)	($858,561.59)
98905	CommunityCare	OK	($6,183,261.46)	($10,464,642.51)	($4,281,381.05)
10091	PacificSource Health Plans	OR	($1,968,392.50)	($1,971,286.47)	($2,893.97)
10940	Centene Corporation	OR	$3,135,992.86	$3,134,435.06	($1,557.80)
33375	Samaritan Health Plans	OR	($24,009.77)	$29,062.23	$53,072.00
39424	Moda Health Plan, Inc.	OR	$960,838.09	$959,164.42	($1,673.67)
56707	Providence Health & Services	OR	$3,098,932.80	$3,079,022.26	($19,910.54)
71287	Kaiser Permanente	OR	($4,315,928.24)	($4,323,928.33)	($8,000.09)
77969	Cambia Health Solutions	OR	$234,440.60	$220,653.50	($13,787.10)

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90175	UnitedHealth Group, Inc.	OR	($1,121,873.62)	($1,127,122.72)	($5,249.10)
16322	UPMC Health Plan	PA	$7,071,176.72	$7,071,176.72	$0.00
18939	Aetna, Inc.	PA	$733,546.51	$733,546.51	$0.00
22444	Geisinger Health System	PA	($860,275.55)	($860,275.55)	$0.00
23489	UnitedHealth Group, Inc.	PA	($10,425,381.90)	($10,425,381.90)	$0.00
31609	Independence Blue Cross	PA	$12,569,176.11	$12,569,176.11	$0.00
33709	Highmark	PA	$2,786,959.62	$2,786,959.62	$0.00
33871	Independence Blue Cross	PA	($18,786,717.09)	($18,786,717.09)	$0.00
33906	Aetna, Inc.	PA	($144,915.20)	($144,915.20)	$0.00
45127	Capital Blue Cross	PA	$5,325,755.03	$5,325,755.03	$0.00
53789	Capital Blue Cross	PA	($541,934.02)	($541,934.02)	$0.00
55957	Highmark	PA	$4,624,619.74	$4,624,619.74	$0.00
62560	UPMC Health Plan	PA	$5,111.22	$5,111.22	$0.00
64844	Aetna, Inc.	PA	($314,285.45)	($314,285.45)	$0.00
70194	Highmark	PA	$191,350.00	$191,350.00	$0.00
75729	Geisinger Health System	PA	($3,883,200.50)	($3,883,200.50)	$0.00
79279	Highmark	PA	$1,903,032.94	$1,903,032.94	$0.00
79962	Highmark	PA	($19,336.60)	($19,336.60)	$0.00
82795	Capital Blue Cross	PA	($234,681.64)	($234,681.64)	$0.00
15287	Blue Cross Blue Shield of Rhode Island	RI	$3,591,069.90	$3,591,069.90	$0.00
26322	Tufts Associated Health Maintenance Organization Inc.	RI	($1,351,775.43)	($1,351,775.43)	$0.00
77514	Neighborhood Health Plan of Rhode Island	RI	($780,268.97)	($780,268.97)	$0.00
79881	UnitedHealth Group, Inc.	RI	$1,548.02	$1,548.02	$0.00
90010	Tufts Associated Health Maintenance Organization Inc.	RI	($1,004,532.31)	($1,004,532.31)	$0.00
90117	UnitedHealth Group, Inc.	RI	($456,041.11)	($456,041.11)	$0.00
22369	Aetna, Inc.	SC	$119,628.51	$96,551.14	($23,077.37)

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26065	BlueChoice HealthPlan of South Carolina, Inc.	SC	$3,744,553.27	$3,756,234.20	$11,680.93
38408	Aetna, Inc.	SC	($336,490.07)	($336,437.46)	$52.61
49532	BlueChoice HealthPlan of South Carolina, Inc.	SC	($2,353,796.43)	($2,346,445.67)	$7,350.76
57860	UnitedHealth Group, Inc.	SC	($143,529.51)	($142,815.66)	$713.85
64146	UnitedHealth Group, Inc.	SC	($1,030,365.90)	($1,027,086.57)	$3,279.33
31195	Sanford Health Plan	SD	($403,695.00)	($403,695.00)	$0.00
50305	Wellmark, Inc.	SD	$2,386,070.74	$2,386,070.74	$0.00
60536	Avera Health Plans, Inc.	SD	($1,528,211.85)	($1,528,211.85)	$0.00
62210	DAKOTACARE	SD	($625,396.21)	($625,396.21)	$0.00
96594	Medica Insurance Company	SD	$171,232.26	$171,232.26	$0.00
10958	UnitedHealth Group, Inc.	TN	($3,587,647.91)	($3,587,647.91)	$0.00
14002	BlueCross BlueShield of Tennessee	TN	$1,653,288.73	$1,653,288.73	$0.00
31552	Aetna, Inc.	TN	$69,013.33	$69,013.33	$0.00
69443	UnitedHealth Group, Inc.	TN	$1,986,498.22	$1,986,498.22	$0.00
82120	Humana, Inc.	TN	($121,152.25)	($121,152.25)	$0.00
26539	FirstCare Health Plans	TX	($958,404.05)	($1,766,363.23)	($807,959.18)
30609	Memorial Hermann Health Plan	TX	$68,101.63	($270,951.79)	($339,053.42)
32673	Humana, Inc.	TX	$4,085,927.83	($4,095,752.29)	($8,181,680.12)
33602	Health Care Service Corporation	TX	$14,312,148.36	$41,946,037.77	$27,633,889.41
37392	Universal Health Services, Inc.	TX	$6,606.34	$3,427.40	($3,178.94)
37755	Scott & White Health Plan	TX	($59,639.22)	($392,728.35)	($333,089.13)
40220	UnitedHealth Group, Inc.	TX	($4,712,317.54)	($5,502,582.49)	($790,264.95)
40788	Scott & White Health Plan	TX	($5,352,063.99)	($6,704,998.89)	($1,352,934.90)
41541	Memorial Hermann Health Plan	TX	($4,397,930.39)	($4,839,460.86)	($441,530.47)
41549	FirstCare Health Plans	TX	$210,011.64	$151,467.77	($58,543.87)
58840	Aetna, Inc.	TX	($89,513.07)	($92,245.02)	($2,731.95)
63141	Humana, Inc.	TX	$1,889,041.23	$781,474.67	($1,107,566.56)
75394	Aetna, Inc.	TX	($14,927.01)	($15,591.68)	($664.67)

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81795	Arkansas Blue Cross and Blue Shield	TX	($411,652.41)	($481,972.30)	($70,319.89)
84479	Vista Health Plan, Inc.	TX	($613,682.59)	($620,988.44)	($7,305.85)
91716	Aetna, Inc.	TX	$2,613,076.23	$2,243,284.82	($369,791.41)
98809	UnitedHealth Group, Inc.	TX	($6,574,783.21)	($20,342,057.19)	($13,767,273.98)
22013	Cambia Health Solutions	UT	$3,909,241.48	($312,706.85)	($4,221,948.33)
29031	National Health Insurance Company	UT	$310,578.40	$359,974.39	$49,395.99
38927	Aetna, Inc.	UT	$540,988.46	$427,753.51	($113,234.95)
46958	Humana, Inc.	UT	$259,046.42	$288,648.03	$29,601.61
48588	Aetna, Inc.	UT	$32,072.51	$35,209.65	$3,137.14
66413	UnitedHealth Group, Inc.	UT	($145,260.78)	($127,108.90)	$18,151.88
68781	SelectHealth	UT	($4,945,384.47)	($957,199.50)	$3,988,184.97
80043	WMI Mutual Insurance Company	UT	$105,237.61	$97,604.60	($7,633.01)
97462	UnitedHealth Group, Inc.	UT	($66,519.59)	$187,825.02	$254,344.61
10207	CareFirst	VA	($10,247,905.68)	($10,247,905.68)	$0.00
12028	Aetna, Inc.	VA	$772,242.77	$772,242.77	$0.00
15668	Piedmont Community Health Plan	VA	($29,834.22)	($29,834.22)	$0.00
16064	Anthem, Inc.	VA	$34,692,673.65	$34,692,673.65	$0.00
20507	Optima Health	VA	$1,608,428.89	$1,608,428.89	$0.00
24251	UnitedHealth Group, Inc.	VA	($3,486,542.45)	($3,486,542.45)	$0.00
25978	UnitedHealth Group, Inc.	VA	($20,749,680.38)	($20,749,680.38)	$0.00
37204	Piedmont Community Health Plan	VA	($262,186.93)	($262,186.93)	$0.00
38234	Aetna, Inc.	VA	($759,247.74)	($759,247.74)	$0.00
38599	UnitedHealth Group, Inc.	VA	($1,615,867.33)	($1,615,867.33)	$0.00
40308	CareFirst	VA	$7,781,463.42	$7,781,463.42	$0.00
86443	Aetna, Inc.	VA	($1,481,565.58)	($1,481,565.58)	$0.00
88380	Anthem, Inc.	VA	$998,967.68	$998,967.68	$0.00
89242	Optima Health	VA	$1,522,053.38	$1,522,053.38	$0.00
89498	UnitedHealth Group, Inc.	VA	($108,151.74)	($108,151.74)	$0.00

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93187	Aetna, Inc.	VA	$1,054,527.80	$1,054,527.80	$0.00
95185	Kaiser Permanente	VA	($9,689,375.41)	($9,689,375.41)	$0.00
18699	UnitedHealth Group, Inc.	WA	($1,341,884.18)	($1,341,884.18)	$0.00
23371	Kaiser Permanente	WA	($3,657,269.59)	($3,657,269.59)	$0.00
25768	Kaiser Permanente	WA	($4,992,680.95)	($4,992,680.95)	$0.00
34673	Aetna, Inc.	WA	($366,590.04)	($366,590.04)	$0.00
36026	Centene Corporation	WA	($288,951.99)	($288,951.99)	$0.00
38229	Health Alliance Medical Plans, Inc.	WA	($5,724.50)	($5,724.50)	$0.00
43861	UnitedHealth Group, Inc.	WA	$118,146.09	$118,146.09	$0.00
49831	Premera Blue Cross	WA	$3,093,511.71	$3,093,511.71	$0.00
69364	Cambia Health Solutions	WA	$317,350.23	$317,350.23	$0.00
71281	Cambia Health Solutions	WA	$748,518.52	$748,518.52	$0.00
80473	Kaiser Permanente	WA	($10,095,568.45)	($10,095,568.45)	$0.00
87718	Cambia Health Solutions	WA	$16,471,143.18	$16,471,143.18	$0.00
16245	Group Health Cooperative of Eau Claire	WI	($1,196,870.81)	($1,199,226.05)	($2,355.24)
20173	HealthPartners Insurance Company	WI	($296,017.71)	($116,125.13)	$179,892.58
35334	MercyCare Insurance Company	WI	($94,516.90)	($106,774.11)	($12,257.21)
37833	Quartz Health Solutions	WI	($5,224,771.62)	($5,249,131.25)	($24,359.63)
38166	Security Health Plan of Wisconsin, Inc.	WI	($1,691,592.15)	($1,703,114.28)	($11,522.13)
38345	Dean Health Plan, Inc.	WI	($6,338,051.44)	($6,353,717.69)	($15,666.25)
38752	Aetna, Inc.	WI	$29,916.71	$29,652.37	($264.34)
39924	UnitedHealth Group, Inc.	WI	($37,450.12)	($52,332.19)	($14,882.07)
47342	Health Tradition Health Plan	WI	$118,753.37	$116,323.09	($2,430.28)
55103	Humana, Inc.	WI	$177,593.35	$170,795.92	($6,797.43)
57637	Medica Insurance Company	WI	($625,541.33)	($635,602.15)	($10,060.82)
58326	MercyCare Insurance Company	WI	($1,389,818.88)	($1,393,352.00)	($3,533.12)
58564	Quartz Health Solutions	WI	($170,774.98)	($173,299.39)	($2,524.41)
59158	UnitedHealth Group, Inc.	WI	$9,584,255.60	$9,514,369.23	($69,886.37)

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2018 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS (Charges Collected in August 2019)[25]	2018 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
64772	Medical Associates Health Plans	WI	($196,113.26)	($152,499.25)	$43,614.01
79475	Anthem, Inc.	WI	$4,273,040.52	$4,247,094.40	($25,946.12)
80180	UnitedHealth Group, Inc.	WI	$919,901.43	$909,846.14	($10,055.29)
81413	Network Health Plan	WI	$7,786.09	$35,136.56	$27,350.47
81974	Wisconsin Physicians Svc Insurance Corp	WI	$2,201,467.48	$2,194,912.63	($6,554.85)
84670	Wisconsin Physicians Svc Insurance Corp	WI	($1,295,179.06)	($1,298,740.67)	($3,561.61)
86584	Wisconsin Physicians Svc Insurance Corp	WI	($1,408,082.52)	($1,410,188.43)	($2,105.91)
87416	Common Ground Healthcare Cooperative	WI	($318,092.97)	($319,727.96)	($1,634.99)
90028	Anthem, Inc.	WI	($511,202.16)	($511,940.63)	($738.47)
91058	Quartz Health Solutions	WI	($1,022,422.73)	($1,022,964.51)	($541.78)
91604	Humana, Inc.	WI	$4,562,844.51	$4,541,896.46	($20,948.05)
94529	Group Health Cooperative of South Central Wisconsin	WI	($59,060.24)	($61,291.10)	($2,230.86)
31274	Highmark	WV	$3,099,105.05	$3,114,923.96	$15,818.91
44434	Aetna, Inc.	WV	($5,767.62)	($5,927.26)	($159.64)
50318	Aetna, Inc.	WV	$43,735.44	$44,029.61	$294.17
59772	The Health Plan of the Upper Ohio Valley	WV	($718,990.72)	($717,819.24)	$1,171.48
72982	The Health Plan of the Upper Ohio Valley	WV	($261,919.75)	($260,937.22)	$982.53
77060	UnitedHealth Group, Inc.	WV	($1,908,349.20)	($1,902,075.57)	$6,273.63
95628	UnitedHealth Group, Inc.	WV	($247,813.25)	($272,194.30)	($24,381.05)
11269	Blue Cross Blue Shield of Wyoming	WY	$468,478.40	$468,478.40	$0.00
49714	UnitedHealth Group, Inc.	WY	($468,478.46)	($468,478.46)	$0.00

Issuer-Specific 2017 HHS-RADV Adjustments to 2018 Risk Adjustment Transfers for Merged Market States

While there were no changes to the 2017 benefit year HHS-RADV Adjustments to 2018 Risk Adjustment Transfers for Merged Market States, we are repeating this information in this report.

Vermont and Massachusetts are the only states considered to have merged markets for purposes of the HHS-operated risk adjustment program.[26] As set forth in the 2020 Payment Notice,[27] we exercised our enforcement discretion to provide Massachusetts issuers[28] with a non-adjustment pilot year for the 2017 HHS-RADV. Therefore, while Massachusetts issuers received the 2017 benefit year HHS-RADV error rate results, these issuers will not have their plan liability risk scores or transfers for Massachusetts state market risk pools adjusted based on the 2017 benefit year HHS-RADV results. In addition, as described in the HHS-RADV 2017 Benefit Year Final Results Memo, Massachusetts issuers' failure rates were excluded from the calculation of the national program benchmarks for the 2017 benefit year HHS-RADV to avoid potential distortion in the national metrics. Therefore, Vermont is only the merged market included in the 2017 HHS-RADV results and only Vermont's issuers are included in Table 3 for the 2017 benefit year HHS-RADV adjustments to 2018 benefit year risk adjustment transfer calculations.

[26] See https://www.regtap.info/uploads/library/RA_GuidanceMergedMarkets2017_030118_5CR_030118.pdf.
[27] See 84 FR at 17508 – 17509.
[28] Participation in HHS-RADV is based on HIOS IDs and not parent companies. Therefore while some issuers' parent companies in Massachusetts may have previously participated in HHS-RADV in other states under other issuer HIOS IDs, no issuer HIOS IDs in Massachusetts previously participated in the HHS-operated risk adjustment program, including the pilot years of HHS-RADV.

Table 3: Updated Issuer-Specific 2017 HHS-RADV Adjustments to 2018 Risk Adjustment Transfers for Merged Market States – Merged Market and Catastrophic Risk Pool *(Appendix B)*[29]

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2018 HHS RISK ADJUSTMENT TRANSFER AMOUNT FOR MERGED MARKET BEFORE RADV ADJUSTMENTS (Charges Collected in August 2019)[30]	2018 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT FOR MERGED MARKET (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT FOR MERGED MARKET (Charges Collected in Calendar Year 2021)	2018 HHS RISK ADJUSTMENT TRANSFER AMOUNT FOR CATASTROPHIC RISK POOL BEFORE RADV ADJUSTMENTS (Charges Collected in August 2019)[31]	2018 HHS RISK ADJUSTMENT TRANSFER RADV ADJUSTED ISSUER TRANSFER AMOUNT FOR CATASTROPHIC RISK POOL (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT FOR CATASTROPHIC RISK POOL (Charges Collected in Calendar Year 2021)
13627	Blue Cross Blue Shield of Vermont	VT	$15,926,267.33	$15,926,267.33	$0.00	$2,439.68	$2,439.68	$0.00
77566	MVP Health Plan, Inc.	VT	($15,926,267.34)	($15,926,267.34)	$0.00	($2,439.68)	($2,439.68)	$0.00

IV. Updated Exiting Issuers and Issuer-Specific Adjustments to 2017 Benefit Year Risk Adjustment Transfers Based on the Revised 2017 Benefit Year HHS-RADV Results

Below we set forth the updated 2017 benefit year risk adjustment transfer amounts adjusted to reflect exiting issuers' revised 2017 benefit year HHS-RADV results. For 2017 benefit year HHS-RADV, issuers that exited all of the markets and risk pools in the state

[29] Massachusetts and Vermont are considered to have a merged market for purposes of the risk adjustment program. See https://www.regtap.info/uploads/library/RA_GuidanceMergedMarkets2017_030118_5CR_030118.pdf. Table 3 only includes Vermont issuers for 2017 benefit year HHS-RADV adjustments to 2018 benefit year risk adjustment transfer calculations, as applicable. As described earlier in this report, 2017 benefit year HHS-RADV is a pilot year for Massachusetts issuers.

[30] The Summary Report on Permanent Risk Adjustment Transfers for the 2018 Benefit Year can be found at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Report-Risk-Adjustment-2018.pdf.

[31] Id.

for 2018 benefit year risk adjustment[32] that had a non-zero risk score error rate (i.e., that are identified as outliers) resulted in an adjustment to 2017 benefit year risk scores and risk adjustment transfers in those state market risk pools.[33] The adjustment amounts are the amounts that will be collected and paid in calendar year 2021, subject to any changes that result from successful HHS-RADV discrepancies or related appeals.

2017 HHS-RADV error rates for exiting outlier issuers were applied to the issuers' 2017 benefit year plan level risk scores, which then were used to calculate the adjusted 2017 risk adjustment transfers in the affected state market risk pools. Therefore, we applied the 2017 HHS-RADV error rates for exiting issuers by completing the following:

1. RADV Error Rate * BY2017 Risk Score without RADV Adjustment = X
2. BY2017 Risk Score without RADV Adjustment – X = BY2017 Risk Score with RADV Adjustment

Then, we used the revised adjustments to risk scores (BY2017 Risk Score with RADV Adjustment) in the transfer calculation to determine the RADV adjusted transfer amount. Please see the July 23, 2019 webinar titled, "EDGE Server 32.0 Maintenance Release Preview & Review of 8/1/19 Risk Adjustment (RA) Reports with RA Data Validation (RADV) Adjustments to Transfers," for more information.[34]

These adjustment amounts represent the difference between issuers' risk adjustment transfers and the adjusted transfer amount due to HHS-RADV.

"$0.00": We signify $0.00 for issuers where there is no adjustment being made because there are no error rates in the state market risk pool.

We do not provide any tables related to the 2017 HHS-RADV adjustments to 2017 risk adjustment transfers for merged market states as there were no outliers in Vermont that resulted in adjustments to 2017 benefit year transfers.[35]

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[32] As noted earlier in the report, we were predicting that 85 issuers exited all state markets in the 2018 benefit year and had non-zero error rates. We subsequently found that some of these issuers did not exit all state risk pools and therefore their 2017 benefit year HHS-RADV results were applied to the 2018 benefit year risk adjustment transfers.

[33] As finalized in the 2020 Payment Notice (84 FR 17454 at 17503) for the 2018 benefit years HHS-RADV and beyond, only those exiting issuers who are identified as having a positive risk score error rate outlier will be adjusted.

[34] Available at: https://www.regtap.info/uploads/library/RA_EDGE_32_Preview_RA_Transfer_072319_5CR_072519.pdf.

[35] As described earlier in this report, 2017 HHS-RADV is a pilot year for Massachusetts issuers.

Table 4a: Updated Issuer-Specific 2017 HHS-RADV Adjustments to 2017 Risk Adjustment Transfers for Non-Merged Market States – Individual, Non-Catastrophic Market *(Appendix C)*

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2017 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS[36]	2017 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
38344	Premera Blue Cross	AK	$0.00	$0.00	$0.00
46944	Blue Cross Blue Shield of Alabama	AL	($172,651.78)	($172,651.78)	$0.00
68259	UnitedHealth Group, Inc.	AL	$172,651.77	$172,651.77	$0.00
37903	QualChoice Arkansas	AR	($5,733,419.10)	($5,733,419.10)	$0.00
60079	Aetna, Inc.	AR	($2,159.13)	($2,159.13)	$0.00
62141	Centene Corporation	AR	($15,559,654.63)	($15,559,654.63)	$0.00
65817	UnitedHealth Group, Inc.	AR	$40,617.57	$40,617.57	$0.00
70525	QualChoice Arkansas	AR	$1,885,571.16	$1,885,571.16	$0.00
75293	Arkansas Blue Cross and Blue Shield	AR	$19,369,044.15	$19,369,044.15	$0.00
53901	Blue Cross Blue Shield of Arizona, Inc.	AZ	($36,394,767.43)	($36,394,767.43)	$0.00
66105	Humana, Inc.	AZ	$5,133.15	$5,133.15	$0.00
78611	Aetna, Inc.	AZ	$2,317,108.78	$2,317,108.78	$0.00
86830	Cigna	AZ	$13,317,786.40	$13,317,786.40	$0.00
91450	Centene Corporation	AZ	$24,347,486.57	$24,347,486.57	$0.00
97667	Cigna	AZ	($3,909,461.51)	($3,909,461.51)	$0.00
98971	UnitedHealth Group, Inc.	AZ	$316,714.04	$316,714.04	$0.00
10544	Oscar Health	CA	($5,073,314.32)	($5,073,314.32)	$0.00
18126	Molina Healthcare	CA	($227,305,096.10)	($227,305,096.10)	$0.00
27603	Anthem, Inc.	CA	$18,851,598.10	$18,851,598.10	$0.00
40025	Cigna	CA	$6,187,132.36	$6,187,132.36	$0.00
40513	Kaiser Permanente	CA	($253,758,713.00)	($253,758,713.00)	$0.00
47579	Chinese Community Health Plan	CA	($25,468,006.71)	($25,468,006.71)	$0.00
64210	Sutter Health Plan	CA	($5,592.79)	($5,592.79)	$0.00
67138	Centene Corporation	CA	($56,357,115.65)	($56,357,115.65)	$0.00

[36] The Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year can be found at: https://downloads.cms.gov/cciio/Summary-Report-Risk-Adjustment-2017.pdf.

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2017 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS[36]	2017 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
70285	Blue Shield of California	CA	$556,877,993.10	$556,877,993.10	$0.00
84014	County of Santa Clara	CA	($10,849,875.42)	($10,849,875.42)	$0.00
92499	Sharp Health Plan	CA	($3,271,307.16)	($3,271,307.16)	$0.00
92815	Local Initiative Health Authority for Los Angeles County	CA	($33,290,976.46)	($33,290,976.46)	$0.00
93689	Western Health Advantage	CA	($7,436,667.02)	($7,436,667.02)	$0.00
99110	Centene Corporation	CA	$40,899,940.99	$40,899,940.99	$0.00
21032	Kaiser Permanente	CO	($64,470,053.20)	($64,358,716.44)	$111,336.76
28700	US Health Group	CO	$705,442.11	$705,685.75	$243.64
31070	Bright Health Insurance Company	CO	($6,192,240.81)	($6,182,558.33)	$9,682.48
41341	UnitedHealth Group, Inc.	CO	$513,957.68	$196,032.27	($317,925.41)
49375	Cigna	CO	$22,598,354.54	$22,671,402.23	$73,047.69
59036	UnitedHealth Group, Inc.	CO	($409.55)	($409.06)	$0.49
63312	Colorado Choice Health Plans	CO	$4,006,490.21	$4,023,295.80	$16,805.59
66699	Denver Health Medical Plan, Inc.	CO	$7,494,680.72	$7,497,430.27	$2,749.55
74320	Humana, Inc.	CO	$10,910.29	$10,913.72	$3.43
76680	Anthem, Inc.	CO	$31,056,713.10	$31,152,381.22	$95,668.12
87269	Anthem, Inc.	CO	$841,867.43	$842,098.64	$231.21
97879	Rocky Mountain Health Care Options	CO	$3,434,287.39	$3,442,443.83	$8,156.44
39159	Aetna, Inc.	CT	$956,418.14	$962,034.06	$5,615.92
40591	UnitedHealth Group, Inc.	CT	($8,237.12)	($1,066,797.26)	($1,058,560.14)
75091	ConnectiCare, Inc.	CT	($203,668.61)	($202,437.01)	$1,231.60
76962	ConnectiCare, Inc.	CT	($11,984,032.56)	($11,354,927.05)	$629,105.51
86545	Anthem, Inc.	CT	$14,076,814.79	$14,588,356.09	$511,541.30
87354	Cigna	CT	$1,281,052.22	$948,498.18	($332,554.04)
94815	ConnectiCare, Inc.	CT	($4,118,346.92)	($3,874,726.93)	$243,619.99
78079	CareFirst	DC	$6,500,181.23	$6,500,181.23	$0.00
86052	CareFirst	DC	($3,723,041.82)	($3,723,041.82)	$0.00
94506	Kaiser Permanente	DC	($2,777,139.42)	($2,777,139.42)	$0.00

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2017 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS[36]	2017 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
29497	Aetna, Inc.	DE	($595,457.11)	($587,375.98)	$8,081.13
67190	Aetna, Inc.	DE	($2,660,555.55)	($2,652,881.37)	$7,674.18
76168	Highmark	DE	$3,336,393.06	$3,363,336.73	$26,943.67
89587	UnitedHealth Group, Inc.	DE	($80,380.41)	($123,079.37)	($42,698.96)
16842	Blue Cross and Blue Shield of Florida	FL	$666,342,217.60	$667,155,034.00	$812,816.38
18628	Aetna, Inc.	FL	$504,174.05	$508,072.47	$3,898.42
19898	AvMed, Inc.	FL	($12,556,467.84)	($12,503,697.48)	$52,770.36
21663	Centene Corporation	FL	($298,557,758.50)	($298,347,113.30)	$210,645.16
23841	Aetna, Inc.	FL	$4,120,333.01	$4,122,509.80	$2,176.79
30252	Blue Cross and Blue Shield of Florida	FL	($49,062,378.52)	($48,488,803.01)	$573,575.51
35783	Humana, Inc.	FL	$25,090,635.59	$25,117,906.38	$27,270.79
36194	Health First, Inc.	FL	$9,690,044.27	$9,719,538.62	$29,494.35
40442	US Health Group	FL	$164,128.35	$164,221.51	$93.16
48121	Cigna	FL	$5,272,866.93	$5,279,616.84	$6,749.91
54172	Molina Healthcare	FL	($344,043,435.20)	($343,755,481.60)	$287,953.57
56503	Florida Health Care Plan, Inc.	FL	($5,552,422.56)	($5,512,484.07)	$39,938.49
57451	Aetna, Inc.	FL	($2,054,259.40)	($4,101,813.67)	($2,047,554.27)
68398	UnitedHealth Group, Inc.	FL	$642,322.46	$642,493.68	$171.22
43802	UnitedHealth Group, Inc.	GA	$113,969.19	$113,983.71	$14.52
49046	Anthem, Inc.	GA	$47,917,689.27	$48,086,911.81	$169,222.54
50491	Cigna	GA	($1,249,023.17)	($1,405,745.85)	($156,722.68)
70893	Centene Corporation	GA	($60,098,840.93)	($60,029,811.02)	$69,029.91
82824	Aetna, Inc.	GA	($2,889,480.32)	($2,888,441.76)	$1,038.56
83761	Alliant Health Plans	GA	$27,509,496.26	$27,532,467.26	$22,971.00
83978	Aetna, Inc.	GA	$3,738,221.30	$3,741,132.86	$2,911.56
89942	Kaiser Permanente	GA	($21,710,418.97)	($21,687,394.69)	$23,024.28
93332	Humana, Inc.	GA	$5,988,482.80	$5,990,344.47	$1,861.67
95852	UnitedHealth Group, Inc.	GA	$679,904.44	$546,553.08	($133,351.36)
18350	Hawaii Medical Service Association	HI	$26,012,660.70	$26,012,660.70	$0.00

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2017 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS[36]	2017 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
60612	Kaiser Permanente	HI	($26,012,660.70)	($26,012,660.70)	$0.00
18973	Aetna, Inc.	IA	($11,142,633.62)	($11,142,633.62)	$0.00
25896	Wellmark, Inc.	IA	$799,924.59	$799,924.59	$0.00
27651	Quartz Health Solutions	IA	($661,826.98)	($661,826.98)	$0.00
72160	Wellmark, Inc.	IA	$10,322,659.48	$10,322,659.48	$0.00
74406	Wellmark, Inc.	IA	($431,036.41)	($431,036.41)	$0.00
87928	Wellmark, Inc.	IA	($406,804.09)	($406,804.09)	$0.00
93078	Medica Insurance Company	IA	$1,519,717.15	$1,519,717.15	$0.00
26002	SelectHealth	ID	$7,551,524.90	$7,551,524.90	$0.00
38128	Montana Health Cooperative	ID	($9,609,851.76)	($9,609,851.76)	$0.00
44648	Cambia Health Solutions	ID	$729,602.33	$729,602.33	$0.00
59765	Cambia Health Solutions	ID	($4,297,893.26)	($4,297,893.26)	$0.00
60597	PacificSource Health Plans	ID	$3,063,266.71	$3,063,266.71	$0.00
61589	Blue Cross of Idaho Health Service, Inc.	ID	$2,563,351.03	$2,563,351.03	$0.00
20129	Health Alliance Medical Plans, Inc.	IL	($11,663,474.42)	($11,507,126.74)	$156,347.68
27833	Centene Corporation	IL	($77,760,248.04)	($77,683,906.48)	$76,341.56
35670	Aetna, Inc.	IL	$806,358.56	$811,382.50	$5,023.94
36096	Health Care Service Corporation	IL	$145,478,236.20	$146,496,112.50	$1,017,876.30
53882	Cigna	IL	($53,357,618.05)	($53,318,856.94)	$38,761.11
58288	Humana, Inc.	IL	($2,473,593.04)	($2,458,313.50)	$15,279.54
72547	Aetna, Inc.	IL	$15,187.22	$15,196.53	$9.31
78463	UnitedHealth Group, Inc.	IL	($461,475.84)	($1,563,948.46)	($1,102,472.62)
82506	US Health Group	IL	$254,252.40	$254,398.30	$145.90
96601	Aetna, Inc.	IL	$868,303.50	$659,690.43	($208,613.07)
99129	Aetna, Inc.	IL	($1,705,928.50)	($1,704,628.04)	$1,300.46
17575	Anthem, Inc.	IN	$46,155,733.81	$42,959,424.61	($3,196,309.20)
33380	Indiana University Health	IN	($8,594,425.99)	($8,998,819.03)	($404,393.04)
36373	UnitedHealth Group, Inc.	IN	$125,632.53	$123,989.34	($1,643.19)
54192	CareSource	IN	($15,998,467.00)	($18,113,310.02)	($2,114,843.02)

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2017 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS[36]	2017 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
62033	MDwise	IN	$5,435,307.07	$13,943,273.41	$8,507,966.34
76179	Centene Corporation	IN	($27,123,780.39)	($29,914,558.36)	($2,790,777.97)
18558	Blue Cross and Blue Shield of Kansas, Inc.	KS	$8,529,904.66	$8,529,904.66	$0.00
27811	Blue Cross and Blue Shield of Kansas, Inc.	KS	($19,756,554.76)	($19,756,554.76)	$0.00
39520	Medica Insurance Company	KS	$8,197,651.06	$8,197,651.06	$0.00
61430	Aetna, Inc.	KS	($167,200.33)	($167,200.33)	$0.00
65598	Aetna, Inc.	KS	$143,993.50	$143,993.50	$0.00
84600	Aetna, Inc.	KS	($79,236.89)	($79,236.89)	$0.00
94248	Blue Cross and Blue Shield of Kansas City	KS	$3,131,442.74	$3,131,442.74	$0.00
15411	Humana, Inc.	KY	$444,123.60	$449,471.33	$5,347.73
23671	UnitedHealth Group, Inc.	KY	$29,230.72	$29,256.34	$25.62
34822	Aetna, Inc.	KY	($182,910.40)	($182,753.80)	$156.60
36239	Anthem, Inc.	KY	$10,657,590.47	$10,937,113.74	$279,523.27
45636	CareSource	KY	($11,176,017.97)	($11,077,958.51)	$98,059.46
47949	UnitedHealth Group, Inc.	KY	$227,983.57	($155,129.16)	($383,112.73)
19636	Blue Cross Blue Shield of Louisiana	LA	($53,282,415.08)	($53,282,415.08)	$0.00
38499	UnitedHealth Group, Inc.	LA	$354,326.24	$354,326.24	$0.00
44965	Humana, Inc.	LA	($34,530,601.67)	($34,530,601.67)	$0.00
67243	Vantage Health Plan, Inc.	LA	($1,189,558.38)	($1,189,558.38)	$0.00
81941	Aetna, Inc.	LA	($402,292.63)	($402,292.63)	$0.00
97176	Blue Cross Blue Shield of Louisiana	LA	$89,050,541.52	$89,050,541.52	$0.00
28137	CareFirst	MD	$3,217,822.52	$3,946,359.98	$728,537.46
31112	UnitedHealth Group, Inc.	MD	$14,453.38	$14,474.82	$21.44
32812	Cigna	MD	$1,904,673.46	$771,767.93	($1,132,905.53)
45532	CareFirst	MD	$40,093,075.58	$40,205,828.03	$112,752.45
90296	Kaiser Permanente	MD	($76,101,694.49)	($75,889,404.39)	$212,290.10
94084	CareFirst	MD	$30,871,669.58	$30,950,973.66	$79,304.08
33653	Maine Community Health Options	ME	$12,970,061.86	$12,970,061.86	$0.00
48396	Anthem, Inc.	ME	($7,710,588.40)	($7,710,588.40)	$0.00

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73250	Aetna, Inc.	ME	($861,856.86)	($861,856.86)	$0.00
96667	HPHC Insurance Company, Inc	ME	($4,397,616.66)	($4,397,616.66)	$0.00
15560	Blue Cross Blue Shield of Michigan	MI	$115,031,970.70	$115,031,970.70	$0.00
29698	Priority Health	MI	($50,997,480.83)	($50,997,480.83)	$0.00
37651	Health Alliance Plan (HAP)	MI	($10,195,686.56)	($10,195,686.56)	$0.00
40047	Molina Healthcare	MI	($25,628,299.06)	($25,628,299.06)	$0.00
46275	Humana, Inc.	MI	$473,453.01	$473,453.01	$0.00
58594	Meridian Health Plan of Michigan, Inc.	MI	($7,211,452.51)	($7,211,452.51)	$0.00
60829	Physicians Health Plan	MI	($4,085,881.10)	($4,085,881.10)	$0.00
67183	Total Health Care USA, Inc.	MI	$1,465,615.31	$1,465,615.31	$0.00
67577	Health Alliance Plan (HAP)	MI	($1,338,157.26)	($1,338,157.26)	$0.00
74917	McLaren Health Care	MI	$1,155,665.51	$1,155,665.51	$0.00
81068	Aetna, Inc.	MI	$136,145.62	$136,145.62	$0.00
98185	Blue Cross Blue Shield of Michigan	MI	($18,805,892.83)	($18,805,892.83)	$0.00
31616	Medica Insurance Company	MN	$1,026,285.49	$1,026,285.49	$0.00
34102	HealthPartners Insurance Company	MN	($11,779,708.00)	($11,779,708.00)	$0.00
49316	Blue Cross Blue Shield of Minnesota	MN	$576,069.02	$576,069.02	$0.00
57129	Blue Cross Blue Shield of Minnesota	MN	$18,188,214.99	$18,188,214.99	$0.00
65847	Medica Insurance Company	MN	$4,736,082.02	$4,736,082.02	$0.00
85654	HealthPartners Insurance Company	MN	($32,581,892.54)	($32,581,892.54)	$0.00
85736	UCare Minnesota	MN	$16,940,395.77	$16,940,395.77	$0.00
88102	PreferredOne Insurance Company	MN	$2,894,553.23	$2,894,553.23	$0.00
30613	Humana, Inc.	MO	($953,788.23)	($953,788.23)	$0.00
32753	Anthem, Inc.	MO	($16,369,614.91)	($16,369,614.91)	$0.00
34762	Blue Cross and Blue Shield of Kansas City	MO	$11,830,633.92	$11,830,633.92	$0.00
44240	Aetna, Inc.	MO	$26,201,662.68	$26,201,662.68	$0.00
44527	Aetna, Inc.	MO	$38,054,998.21	$38,054,998.21	$0.00
48161	Aetna, Inc.	MO	$902,121.89	$902,121.89	$0.00
74483	Cigna	MO	($55,179,640.61)	($55,179,640.61)	$0.00

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96384	Cox HealthPlans	MO	($4,486,372.84)	($4,486,372.84)	$0.00
11721	Blue Cross Blue Shield of Mississippi	MS	($3,256,377.37)	($3,256,377.37)	$0.00
48963	Humana, Inc.	MS	$6,306,573.00	$6,306,573.00	$0.00
90714	Centene Corporation	MS	($3,114,444.88)	($3,114,444.88)	$0.00
97560	UnitedHealth Group, Inc.	MS	$64,249.25	$64,249.25	$0.00
23603	PacificSource Health Plans	MT	($4,285,653.39)	($4,285,653.39)	$0.00
30751	Health Care Service Corporation	MT	$30,794,654.82	$30,794,654.82	$0.00
32225	Montana Health Cooperative	MT	($26,509,001.44)	($26,509,001.44)	$0.00
11512	Blue Cross Blue Shield of North Carolina	NC	$32,023,793.52	$33,143,358.76	$1,119,565.24
40411	Cigna	NC	$1,957,591.49	$803,767.13	($1,153,824.36)
54332	UnitedHealth Group, Inc.	NC	$754,873.06	$755,133.05	$259.99
61671	Aetna, Inc.	NC	$501,186.87	$504,582.33	$3,395.46
73943	Cigna	NC	($35,237,444.92)	($35,206,841.26)	$30,603.66
37160	Blue Cross Blue Shield of North Dakota	ND	$2,750,180.76	$2,750,180.76	$0.00
73751	Medica Insurance Company	ND	($1,475,727.34)	($1,475,727.34)	$0.00
89364	Sanford Health Plan	ND	($1,274,453.42)	($1,274,453.42)	$0.00
15438	Aetna, Inc.	NE	$573,062.47	$573,062.47	$0.00
20305	Medica Insurance Company	NE	($2,937,542.90)	($2,937,542.90)	$0.00
29678	Blue Cross and Blue Shield of Nebraska	NE	$5,775,059.68	$5,775,059.68	$0.00
44751	UnitedHealth Group, Inc.	NE	$213,968.17	$213,968.17	$0.00
44794	Aetna, Inc.	NE	($3,624,547.39)	($3,624,547.39)	$0.00
59025	HPHC Insurance Company, Inc	NH	$15,811,230.04	$15,811,230.04	$0.00
61163	Minuteman Health, Inc.	NH	($38,885,008.22)	($38,885,008.22)	$0.00
75841	Centene Corporation	NH	$14,425,154.93	$14,425,154.93	$0.00
96751	Anthem, Inc.	NH	$8,648,623.23	$8,648,623.23	$0.00
13953	Horizon Blue Cross Blue Shield of New Jersey	NJ	($5,937.30)	($5,937.30)	$0.00
41014	Cigna	NJ	$2,587,703.78	$2,587,703.78	$0.00
48834	UnitedHealth Group, Inc.	NJ	$96,093.94	$96,093.94	$0.00
77263	UnitedHealth Group, Inc.	NJ	$31,378,919.89	$31,378,919.89	$0.00

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77606	Independence Blue Cross	NJ	($7,033,856.81)	($7,033,856.81)	$0.00
89217	Aetna, Inc.	NJ	$6,713,943.10	$6,713,943.10	$0.00
91661	Horizon Blue Cross Blue Shield of New Jersey	NJ	$3,376,653.92	$3,376,653.92	$0.00
91762	Independence Blue Cross	NJ	($37,113,520.52)	($37,113,520.52)	$0.00
19722	Molina Healthcare	NM	$5,154,966.12	$5,154,966.12	$0.00
57173	Presbyterian Healthcare Services	NM	($738,102.52)	($738,102.52)	$0.00
72034	CHRISTUS Health	NM	($7,412,563.84)	($7,412,563.84)	$0.00
75605	Health Care Service Corporation	NM	$3,719,974.71	$3,719,974.71	$0.00
93091	New Mexico Health Connections	NM	($724,274.47)	($724,274.47)	$0.00
16698	Universal Health Services, Inc.	NV	$5,049,894.84	$5,049,894.84	$0.00
17255	UnitedHealth Group, Inc.	NV	($1,538,805.73)	($1,538,805.73)	$0.00
19298	Aetna, Inc.	NV	($449,129.16)	($449,129.16)	$0.00
27990	Aetna, Inc.	NV	$1,028,592.55	$1,028,592.55	$0.00
33670	Anthem, Inc.	NV	($811,805.88)	($811,805.88)	$0.00
41094	Hometown Health Plan, Inc.	NV	($1,005,757.73)	($1,005,757.73)	$0.00
60156	Anthem, Inc.	NV	$1,775,925.90	$1,775,925.90	$0.00
83198	UnitedHealth Group, Inc.	NV	$13,134,965.71	$13,134,965.71	$0.00
85266	Hometown Health Plan, Inc.	NV	$1,217,613.00	$1,217,613.00	$0.00
95865	UnitedHealth Group, Inc.	NV	($18,401,493.55)	($18,401,493.55)	$0.00
11177	Metro Plus Health Plan	NY	($7,912.85)	$46,787.59	$54,700.44
17210	Aetna, Inc.	NY	$330,822.61	$331,300.30	$477.69
18029	Independent Health	NY	$9,054,688.45	$9,088,487.65	$33,799.20
25303	New York State Catholic Health Plan, Inc.	NY	($81,004,537.36)	($80,649,383.27)	$355,154.09
26420	UnitedHealth Group, Inc.	NY	$367,545.01	$367,975.22	$430.21
36346	HealthNow New York, Inc.	NY	$1,687,787.31	$1,700,402.91	$12,615.60
49526	HealthNow New York, Inc.	NY	$10,409,776.24	$10,471,200.68	$61,424.44
54235	UnitedHealth Group, Inc.	NY	$11,645,271.44	$11,696,396.54	$51,125.10
56184	MVP Health Plan, Inc.	NY	$12,971,573.95	$13,162,848.94	$191,274.99
57165	Affinity Health Plan, Inc.	NY	$1,216,922.20	($811,002.51)	($2,027,924.71)

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61405	Healthfirst	NY	($72,418.18)	($72,200.60)	$217.58
73886	Crystal Run Health Plans	NY	$259,652.05	$260,809.43	$1,157.38
74289	Oscar Health	NY	($45,394,698.32)	($45,228,531.37)	$166,166.95
78124	Excellus Health Plan, Inc.	NY	$30,048,692.69	$30,215,626.75	$166,934.06
80519	Anthem, Inc.	NY	$60,231,777.17	$60,645,615.25	$413,838.08
82483	North Shore-LIJ Health System	NY	($5,095,394.66)	($4,900,387.71)	$195,006.95
88000	EmblemHealth	NY	$2,323,376.04	$2,328,114.65	$4,738.61
88582	EmblemHealth	NY	$3,637,372.98	$3,749,918.76	$112,545.78
91237	Healthfirst	NY	($21,412,607.34)	($21,247,150.79)	$165,456.55
94788	CDPHP Universal Benefits, Inc.	NY	$8,802,310.45	$8,843,171.46	$40,861.01
23340	Medical Mutual of Ohio	OH	($1,559,070.25)	($1,559,070.25)	$0.00
26734	Premier Health Plan, Inc.	OH	$832,327.96	$832,327.96	$0.00
28162	AultCare Insurance Company	OH	$1,990,967.55	$1,990,967.55	$0.00
29276	Anthem, Inc.	OH	$28,243,218.13	$28,243,218.13	$0.00
41047	Centene Corporation	OH	($12,855,020.92)	($12,855,020.92)	$0.00
52664	Summa Insurance Company	OH	($1,032,792.61)	($1,032,792.61)	$0.00
61724	UnitedHealth Group, Inc.	OH	$2,162.05	$2,162.05	$0.00
64353	Molina Healthcare	OH	$583,153.97	$583,153.97	$0.00
66083	Humana, Inc.	OH	$1,093,725.07	$1,093,725.07	$0.00
67129	Aetna, Inc.	OH	($214,115.68)	($214,115.68)	$0.00
74313	Paramount Insurance Company	OH	($3,185,766.61)	($3,185,766.61)	$0.00
77552	CareSource	OH	($11,275,315.32)	($11,275,315.32)	$0.00
80627	Medical Mutual of Ohio	OH	$4,294,065.62	$4,294,065.62	$0.00
83396	The Health Plan of the Upper Ohio Valley	OH	($130,108.37)	($130,108.37)	$0.00
99969	Medical Mutual of Ohio	OH	($6,787,430.79)	($6,787,430.79)	$0.00
45480	UnitedHealth Group, Inc.	OK	$37,146.38	$37,146.38	$0.00
87571	Health Care Service Corporation	OK	$2,803,057.22	$2,803,057.22	$0.00
87698	CommunityCare	OK	($64,916.06)	($64,916.06)	$0.00
98905	CommunityCare	OK	($2,775,287.55)	($2,775,287.55)	$0.00

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10091	PacificSource Health Plans	OR	($305,362.22)	($305,362.22)	$0.00
10940	Centene Corporation	OR	$945,952.06	$945,952.06	$0.00
30969	Zoom Health Plan, Inc.	OR	($1,043,941.28)	($1,043,941.28)	$0.00
32536	ATRIO Health Plans	OR	($497,295.72)	($497,295.72)	$0.00
39424	Moda Health Plan, Inc.	OR	$40,965,920.36	$40,965,920.36	$0.00
56707	Providence Health & Services	OR	($26,777,703.76)	($26,777,703.76)	$0.00
63474	Cambia Health Solutions	OR	$5,642,914.94	$5,642,914.94	$0.00
71287	Kaiser Permanente	OR	($22,661,412.02)	($22,661,412.02)	$0.00
77969	Cambia Health Solutions	OR	$3,730,927.68	$3,730,927.68	$0.00
16322	UPMC Health Plan	PA	($40,050,668.48)	($40,050,668.48)	$0.00
22444	Geisinger Health System	PA	($13,135,095.92)	($13,135,095.92)	$0.00
31609	Independence Blue Cross	PA	$54,047,462.13	$54,047,462.13	$0.00
33709	Highmark	PA	$11,504,376.97	$11,504,376.97	$0.00
33871	Independence Blue Cross	PA	($66,630,300.85)	($66,630,300.85)	$0.00
36247	Highmark	PA	$148,509.80	$148,509.80	$0.00
38949	Highmark	PA	$644,235.37	$644,235.37	$0.00
45127	Capital Blue Cross	PA	$40,434,004.32	$40,434,004.32	$0.00
53789	Capital Blue Cross	PA	($5,866,130.41)	($5,866,130.41)	$0.00
55957	Highmark	PA	$1,201,208.49	$1,201,208.49	$0.00
62560	UPMC Health Plan	PA	($5,886.15)	($5,886.15)	$0.00
64844	Aetna, Inc.	PA	($1,378,243.73)	($1,378,243.73)	$0.00
70194	Highmark	PA	$29,655,144.26	$29,655,144.26	$0.00
75729	Geisinger Health System	PA	$541,607.30	$541,607.30	$0.00
82795	Capital Blue Cross	PA	($567,694.83)	($567,694.83)	$0.00
83731	Highmark	PA	($10,542,528.19)	($10,542,528.19)	$0.00
15287	Blue Cross Blue Shield of Rhode Island	RI	$7,559,388.24	$7,559,388.24	$0.00
77514	Neighborhood Health Plan of Rhode Island	RI	($7,559,388.24)	($7,559,388.24)	$0.00
26065	BlueChoice HealthPlan of South Carolina, Inc.	SC	$14,592,529.77	$14,592,529.77	$0.00
38408	Aetna, Inc.	SC	$105,711.19	$105,711.19	$0.00

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49532	BlueChoice HealthPlan of South Carolina, Inc.	SC	($15,792,089.83)	($15,792,089.83)	$0.00
54362	Cigna	SC	$1,093,848.73	$1,093,848.73	$0.00
31195	Sanford Health Plan	SD	$4,000,082.85	$4,000,082.85	$0.00
60536	Avera Health Plans, Inc.	SD	($4,000,082.83)	($4,000,082.83)	$0.00
14002	BlueCross BlueShield of Tennessee	TN	$66,286,360.53	$66,286,360.53	$0.00
16348	TRH Health Insurance Company	TN	$1,916,790.86	$1,916,790.86	$0.00
31552	Aetna, Inc.	TN	$954,059.54	$954,059.54	$0.00
69443	UnitedHealth Group, Inc.	TN	$200,952.91	$200,952.91	$0.00
82120	Humana, Inc.	TN	$1,862,944.11	$1,862,944.11	$0.00
99248	Cigna	TN	($71,221,107.95)	($71,221,107.95)	$0.00
20069	Oscar Health	TX	($20,970,453.39)	($20,946,980.86)	$23,472.53
26539	FirstCare Health Plans	TX	$12,588,640.95	$12,608,263.30	$19,622.35
27248	Community Health Choice, Inc.	TX	($59,874,848.39)	($59,754,447.80)	$120,400.59
29418	Centene Corporation	TX	($116,719,209.40)	($116,558,835.10)	$160,374.25
30609	Memorial Hermann Health Plan	TX	$1,901,887.54	$1,903,475.27	$1,587.73
32673	Humana, Inc.	TX	$18,814,281.10	$18,823,591.10	$9,310.00
33602	Health Care Service Corporation	TX	$391,256,155.60	$391,701,890.30	$445,734.68
37392	Universal Health Services, Inc.	TX	($1,213,902.42)	($1,207,120.49)	$6,781.93
37755	Scott & White Health Plan	TX	$18,561,976.21	$18,570,029.42	$8,053.21
40788	Scott & White Health Plan	TX	$3,350,387.50	$3,353,974.25	$3,586.75
41541	Memorial Hermann Health Plan	TX	($4,443,725.72)	($4,438,575.43)	$5,150.29
45786	Molina Healthcare	TX	($222,244,309.40)	($222,066,334.60)	$177,974.76
53799	US Health Group	TX	$231,461.53	$231,519.47	$57.94
55409	Cigna	TX	$20,442,380.27	$20,451,473.04	$9,092.77
63141	Humana, Inc.	TX	$337,247.99	$337,319.64	$71.65
66252	CHRISTUS Health	TX	($100,680.80)	($74,005.23)	$26,675.57
71837	Sendero Health Plans, Inc.	TX	($47,487,185.15)	($47,460,368.54)	$26,816.61
76589	Cigna	TX	$1,631,979.13	$581,898.53	($1,050,080.60)
84479	Vista Health Plan, Inc.	TX	($4,184,090.16)	($4,183,232.08)	$858.08

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91716	Aetna, Inc.	TX	$8,122,006.86	$8,126,465.77	$4,458.91
18167	Molina Healthcare	UT	($38,365,114.25)	($38,349,724.58)	$15,389.67
22013	Cambia Health Solutions	UT	$11,172,822.02	$11,175,228.77	$2,406.75
34541	Cambia Health Solutions	UT	$72,747.01	$72,755.94	$8.93
38927	Aetna, Inc.	UT	$397,572.17	$397,642.30	$70.13
42261	University of Utah Health Insurance Plans	UT	$12,948,787.52	$12,951,061.15	$2,273.63
43129	UnitedHealth Group, Inc.	UT	$266,955.52	$214,056.25	($52,899.27)
68781	SelectHealth	UT	$13,506,230.05	$13,538,980.11	$32,750.06
10207	CareFirst	VA	$8,484,380.17	$8,485,180.88	$800.71
12028	Aetna, Inc.	VA	($44,021,240.56)	($44,016,641.38)	$4,599.18
15668	Piedmont Community Health Plan	VA	$2,370,808.07	$2,371,000.97	$192.90
20507	Optima Health	VA	$52,892,124.19	$52,894,710.67	$2,586.48
37204	Piedmont Community Health Plan	VA	($2,167,299.99)	($2,167,034.43)	$265.56
38234	Aetna, Inc.	VA	$53,041.42	$53,042.46	$1.04
38599	UnitedHealth Group, Inc.	VA	($2,460,386.68)	($2,459,468.26)	$918.42
40308	CareFirst	VA	$22,764,894.63	$22,765,896.39	$1,001.76
41892	UnitedHealth Group, Inc.	VA	($118,274.41)	($152,766.91)	($34,492.50)
41921	Cigna	VA	($27,484,113.37)	($27,483,291.42)	$821.95
88380	Anthem, Inc.	VA	$7,236,340.94	$7,253,271.02	$16,930.08
93187	Aetna, Inc.	VA	$19,071,999.00	$19,074,852.42	$2,853.42
95185	Kaiser Permanente	VA	($36,622,273.37)	($36,618,752.52)	$3,520.85
18581	Community Health Plan of Washington	WA	$2,779,989.83	$2,779,989.83	$0.00
23371	Kaiser Permanente	WA	($6,824,739.36)	($6,824,739.36)	$0.00
25768	Kaiser Permanente	WA	$5,453,365.74	$5,453,365.74	$0.00
38229	Health Alliance Medical Plans, Inc.	WA	$12,593.61	$12,593.61	$0.00
38498	Premera Blue Cross	WA	($7,097,575.96)	($7,097,575.96)	$0.00
43861	UnitedHealth Group, Inc.	WA	$50,200.73	$50,200.73	$0.00
49831	Premera Blue Cross	WA	$28,293,767.22	$28,293,767.22	$0.00
53732	Cambia Health Solutions	WA	$4,394,628.82	$4,394,628.82	$0.00

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61836	Centene Corporation	WA	($32,733,328.75)	($32,733,328.75)	$0.00
69364	Cambia Health Solutions	WA	$3,684,375.67	$3,684,375.67	$0.00
71281	Cambia Health Solutions	WA	$3,592,257.89	$3,592,257.89	$0.00
80473	Kaiser Permanente	WA	($49,034,125.60)	($49,034,125.60)	$0.00
84481	Molina Healthcare	WA	($1,116,871.00)	($1,116,871.00)	$0.00
87718	Cambia Health Solutions	WA	$48,545,461.30	$48,545,461.30	$0.00
14630	Children's Community Health Plan	WI	$5,304,975.21	$5,283,175.83	($21,799.38)
20173	HealthPartners Insurance Company	WI	($2,249,707.06)	($2,257,809.59)	($8,102.53)
37833	Quartz Health Solutions	WI	$18,218,032.49	$18,129,643.66	($88,388.83)
38166	Security Health Plan of Wisconsin, Inc.	WI	($12,010,107.04)	($12,204,569.04)	($194,462.00)
38345	Dean Health Plan, Inc.	WI	($28,126,200.27)	($28,293,769.58)	($167,569.31)
39924	UnitedHealth Group, Inc.	WI	$79,772.76	$79,682.36	($90.40)
47342	Mayo Clinic Health System	WI	($8,912,149.17)	($8,970,654.66)	($58,505.49)
52697	Molina Healthcare	WI	$273,647.15	($135,607.83)	($409,254.98)
57845	Medica Insurance Company	WI	$2,621,416.11	$2,566,558.86	($54,857.25)
58326	MercyCare Insurance Company	WI	($5,487,189.38)	($5,509,213.80)	($22,024.42)
58564	Quartz Health Solutions	WI	$383,811.56	$381,833.00	($1,978.56)
79475	Anthem, Inc.	WI	$10,173,169.63	$10,080,676.91	($92,492.72)
81413	Network Health Plan	WI	$18,489,433.27	$18,415,442.08	($73,991.19)
81974	Wisconsin Physicians Svc Insurance Corp	WI	$1,865,873.23	$1,861,375.98	($4,497.25)
84670	Wisconsin Physicians Svc Insurance Corp	WI	$1,019,628.73	$1,012,235.43	($7,393.30)
86584	Wisconsin Physicians Svc Insurance Corp	WI	($7,945,062.24)	($8,003,085.26)	($58,023.02)
87416	Common Ground Healthcare Cooperative	WI	$76,217.13	($100,529.87)	($176,747.00)
91058	Quartz Health Solutions	WI	$3,179,091.75	$4,632,946.99	$1,453,855.24
91604	Humana, Inc.	WI	$2,752.07	$2,747.95	($4.12)
94529	Group Health Cooperative of South Central Wisconsin	WI	$3,042,594.06	$3,028,920.59	($13,673.47)
31274	Highmark	WV	$9,416,972.44	$9,416,972.44	$0.00
44434	Aetna, Inc.	WV	($240,460.81)	($240,460.81)	$0.00

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50328	CareSource	WV	($8,801,964.64)	($8,801,964.64)	$0.00
72982	The Health Plan of the Upper Ohio Valley	WV	($374,546.95)	($374,546.95)	$0.00
11269	Blue Cross Blue Shield of Wyoming	WY	$0.00	$0.00	$0.00

Table 4b: Updated Issuer-Specific 2017 HHS-RADV Adjustments to 2017 Risk Adjustment Transfers for Non-Merged Market States – Catastrophic Risk Pool *(Appendix C)*

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2017 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS [37]	2017 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
46944	Blue Cross Blue Shield of Alabama	AL	$0.00	$0.00	$0.00
70525	QualChoice Arkansas	AR	($24,504.01)	($24,504.01)	$0.00
75293	Arkansas Blue Cross and Blue Shield	AR	$24,504.00	$24,504.00	$0.00
53901	Blue Cross Blue Shield of Arizona, Inc.	AZ	$0.00	$0.00	$0.00
10544	Oscar Health	CA	($178,930.08)	($178,930.08)	$0.00
18126	Molina Healthcare	CA	($126,121.18)	($126,121.18)	$0.00
27603	Anthem, Inc.	CA	($1,671,110.00)	($1,671,110.00)	$0.00
40513	Kaiser Permanente	CA	($1,655,166.09)	($1,655,166.09)	$0.00
47579	Chinese Community Health Plan	CA	($4,537.34)	($4,537.34)	$0.00
67138	Centene Corporation	CA	($88,776.91)	($88,776.91)	$0.00
70285	Blue Shield of California	CA	$4,078,016.98	$4,078,016.98	$0.00
84014	County of Santa Clara	CA	($149,939.32)	($149,939.32)	$0.00
92499	Sharp Health Plan	CA	($454,317.61)	($454,317.61)	$0.00
92815	Local Initiative Health Authority for Los Angeles County	CA	($41,906.25)	($41,906.25)	$0.00

[37] Ibid.

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2017 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS [37]	2017 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
93689	Western Health Advantage	CA	($78,817.84)	($78,817.84)	$0.00
99110	Centene Corporation	CA	$371,605.58	$371,605.58	$0.00
21032	Kaiser Permanente	CO	($529,642.62)	($522,656.64)	$6,985.98
31070	Bright Health Insurance Company	CO	($1,444,024.58)	($1,441,336.08)	$2,688.50
41341	UnitedHealth Group, Inc.	CO	$664,572.71	$621,453.18	($43,119.53)
63312	Colorado Choice Health Plans	CO	$295,544.01	$299,077.83	$3,533.82
76680	Anthem, Inc.	CO	($1,516,774.26)	($1,505,794.66)	$10,979.60
87269	Anthem, Inc.	CO	$2,530,324.80	$2,549,256.36	$18,931.56
40591	UnitedHealth Group, Inc.	CT	($11,624.14)	($13,448.35)	($1,824.21)
76962	ConnectiCare, Inc.	CT	($65,803.71)	($65,015.92)	$787.79
86545	Anthem, Inc.	CT	$77,427.82	$78,464.27	$1,036.45
86052	CareFirst	DC	$2,142.18	$2,142.18	$0.00
94506	Kaiser Permanente	DC	($2,142.18)	($2,142.18)	$0.00
76168	Highmark	DE	$0.00	$0.00	$0.00
18628	Aetna, Inc.	FL	$3,291.40	$3,291.40	$0.00
35783	Humana, Inc.	FL	$281,746.71	$281,746.71	$0.00
36194	Health First, Inc.	FL	($187,145.21)	($187,145.21)	$0.00
56503	Florida Health Care Plan, Inc.	FL	($97,892.89)	($97,892.89)	$0.00
49046	Anthem, Inc.	GA	($831,656.66)	($831,656.66)	$0.00
89942	Kaiser Permanente	GA	$221,373.55	$221,373.55	$0.00
93332	Humana, Inc.	GA	$610,283.11	$610,283.11	$0.00
18350	Hawaii Medical Service Association	HI	$0.00	$0.00	$0.00
18973	Aetna, Inc.	IA	($154,460.80)	($154,460.80)	$0.00
27651	Quartz Health Solutions	IA	($3,310.46)	($3,310.46)	$0.00
93078	Medica Insurance Company	IA	$157,771.27	$157,771.27	$0.00
26002	SelectHealth	ID	$128,202.40	$128,202.40	$0.00
38128	Montana Health Cooperative	ID	($220,730.62)	($220,730.62)	$0.00

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60597	PacificSource Health Plans	ID	($40,488.63)	($40,488.63)	$0.00
61589	Blue Cross of Idaho Health Service, Inc.	ID	$133,016.84	$133,016.84	$0.00
20129	Health Alliance Medical Plans, Inc.	IL	($78,603.46)	($78,603.46)	$0.00
36096	Health Care Service Corporation	IL	$65,358.61	$65,358.61	$0.00
58288	Humana, Inc.	IL	$13,244.83	$13,244.83	$0.00
17575	Anthem, Inc.	IN	$0.00	$0.00	$0.00
39520	Medica Insurance Company	KS	$217,292.28	$217,292.28	$0.00
94248	Blue Cross and Blue Shield of Kansas City	KS	($217,292.29)	($217,292.29)	$0.00
15411	Humana, Inc.	KY	($101,817.11)	($101,817.11)	$0.00
36239	Anthem, Inc.	KY	($54,832.40)	($54,832.40)	$0.00
45636	CareSource	KY	$156,649.50	$156,649.50	$0.00
44965	Humana, Inc.	LA	$0.00	$0.00	$0.00
42690	Blue Cross Blue Shield of Massachusetts, Inc.	MA	$293,121.44	$293,121.44	$0.00
59763	Tufts Health Public Plans, Inc.	MA	$52,884.08	$52,884.08	$0.00
73331	Minuteman Health, Inc.	MA	($331,089.85)	($331,089.85)	$0.00
88806	Fallon Health & Life Assurance Company	MA	($14,915.67)	($14,915.67)	$0.00
28137	CareFirst	MD	($166,411.99)	($166,411.99)	$0.00
90296	Kaiser Permanente	MD	$166,411.98	$166,411.98	$0.00
33653	Maine Community Health Options	ME	$77,398.92	$77,398.92	$0.00
48396	Anthem, Inc.	ME	($77,398.92)	($77,398.92)	$0.00
15560	Blue Cross Blue Shield of Michigan	MI	$2,097,903.42	$2,097,903.42	$0.00
37651	Health Alliance Plan (HAP)	MI	($813,903.65)	($813,903.65)	$0.00
46275	Humana, Inc.	MI	($369,552.25)	($369,552.25)	$0.00
58594	Meridian Health Plan of Michigan, Inc.	MI	($14,891.83)	($14,891.83)	$0.00
60829	Physicians Health Plan	MI	($4,920.24)	($4,920.24)	$0.00
67577	Health Alliance Plan (HAP)	MI	($22,352.26)	($22,352.26)	$0.00
74917	McLaren Health Care	MI	($8,459.60)	($8,459.60)	$0.00

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98185	Blue Cross Blue Shield of Michigan	MI	($863,823.58)	($863,823.58)	$0.00
34102	HealthPartners Insurance Company	MN	($25,623.49)	($25,623.49)	$0.00
49316	Blue Cross Blue Shield of Minnesota	MN	$7,742.76	$7,742.76	$0.00
65847	Medica Insurance Company	MN	$279,392.44	$279,392.44	$0.00
85654	HealthPartners Insurance Company	MN	($539,198.50)	($539,198.50)	$0.00
85736	UCare Minnesota	MN	$244,878.27	$244,878.27	$0.00
88102	PreferredOne Insurance Company	MN	$32,808.51	$32,808.51	$0.00
30613	Humana, Inc.	MO	$15,772.32	$15,772.32	$0.00
32753	Anthem, Inc.	MO	$387,467.61	$387,467.61	$0.00
34762	Blue Cross and Blue Shield of Kansas City	MO	($296,453.99)	($296,453.99)	$0.00
96384	Cox HealthPlans	MO	($106,785.94)	($106,785.94)	$0.00
48963	Humana, Inc.	MS	$0.00	$0.00	$0.00
30751	Health Care Service Corporation	MT	($10,026.79)	($10,026.79)	$0.00
32225	Montana Health Cooperative	MT	$10,026.79	$10,026.79	$0.00
11512	Blue Cross Blue Shield of North Carolina	NC	($21,491.14)	($21,491.14)	$0.00
61671	Aetna, Inc.	NC	$21,491.13	$21,491.13	$0.00
37160	Blue Cross Blue Shield of North Dakota	ND	$42,670.26	$42,670.26	$0.00
73751	Medica Insurance Company	ND	($40,724.05)	($40,724.05)	$0.00
89364	Sanford Health Plan	ND	($1,946.20)	($1,946.20)	$0.00
20305	Medica Insurance Company	NE	$190,606.17	$190,606.17	$0.00
29678	Blue Cross and Blue Shield of Nebraska	NE	($113,196.61)	($113,196.61)	$0.00
44794	Aetna, Inc.	NE	($77,409.57)	($77,409.57)	$0.00
61163	Minuteman Health, Inc.	NH	($223,778.01)	($223,778.01)	$0.00
96751	Anthem, Inc.	NH	$223,778.01	$223,778.01	$0.00
77263	UnitedHealth Group, Inc.	NJ	$135,262.47	$135,262.47	$0.00
91661	Horizon Blue Cross Blue Shield of New Jersey	NJ	($281,401.15)	($281,401.15)	$0.00
91762	Independence Blue Cross	NJ	$146,138.68	$146,138.68	$0.00

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57173	Presbyterian Healthcare Services	NM	$164,082.29	$164,082.29	$0.00
72034	CHRISTUS Health	NM	($81,199.73)	($81,199.73)	$0.00
75605	Health Care Service Corporation	NM	($14,139.39)	($14,139.39)	$0.00
93091	New Mexico Health Connections	NM	($68,743.15)	($68,743.15)	$0.00
17255	UnitedHealth Group, Inc.	NV	$5,066.24	$5,066.24	$0.00
33670	Anthem, Inc.	NV	($4,120.62)	($4,120.62)	$0.00
41094	Hometown Health Plan, Inc.	NV	$2,857.02	$2,857.02	$0.00
60156	Anthem, Inc.	NV	$113,626.18	$113,626.18	$0.00
83198	UnitedHealth Group, Inc.	NV	($69,448.78)	($69,448.78)	$0.00
85266	Hometown Health Plan, Inc.	NV	($16,510.04)	($16,510.04)	$0.00
95865	UnitedHealth Group, Inc.	NV	($31,470.00)	($31,470.00)	$0.00
11177	Metro Plus Health Plan	NY	($673.05)	($670.28)	$2.77
18029	Independent Health	NY	($41,108.33)	($41,049.60)	$58.73
25303	New York State Catholic Health Plan, Inc.	NY	($68,821.19)	($68,032.67)	$788.52
54235	UnitedHealth Group, Inc.	NY	$201,457.96	$201,542.60	$84.64
56184	MVP Health Plan, Inc.	NY	$227,294.13	$227,458.80	$164.67
57165	Affinity Health Plan, Inc.	NY	($9,053.66)	($17,227.23)	($8,173.57)
73886	Crystal Run Health Plans	NY	$46,962.41	$46,976.43	$14.02
74289	Oscar Health	NY	($2,548,523.34)	($2,543,640.25)	$4,883.09
78124	Excellus Health Plan, Inc.	NY	$241,179.00	$241,442.08	$263.08
80519	Anthem, Inc.	NY	$1,195,768.40	$1,197,149.52	$1,381.12
82483	North Shore-LIJ Health System	NY	$270,509.71	$270,799.25	$289.54
88582	EmblemHealth	NY	$385,464.07	$385,617.22	$153.15
91237	Healthfirst	NY	$54,814.97	$54,884.62	$69.65
94788	CDPHP Universal Benefits, Inc.	NY	$44,728.90	$44,749.49	$20.59
28162	AultCare Insurance Company	OH	$189,196.19	$189,196.19	$0.00
29276	Anthem, Inc.	OH	($295,516.66)	($295,516.66)	$0.00

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52664	Summa Insurance Company	OH	$70,520.24	$70,520.24	$0.00
66083	Humana, Inc.	OH	($100,862.83)	($100,862.83)	$0.00
99969	Medical Mutual of Ohio	OH	$136,663.04	$136,663.04	$0.00
87571	Health Care Service Corporation	OK	$184,776.81	$184,776.81	$0.00
98905	CommunityCare	OK	($184,776.82)	($184,776.82)	$0.00
10091	PacificSource Health Plans	OR	$68,966.56	$68,966.56	$0.00
71287	Kaiser Permanente	OR	($68,966.56)	($68,966.56)	$0.00
16322	UPMC Health Plan	PA	($245,097.73)	($245,097.73)	$0.00
22444	Geisinger Health System	PA	$98,741.81	$98,741.81	$0.00
31609	Independence Blue Cross	PA	$68,085.16	$68,085.16	$0.00
33709	Highmark	PA	($56,425.98)	($56,425.98)	$0.00
36247	Highmark	PA	$2,681.50	$2,681.50	$0.00
53789	Capital Blue Cross	PA	$132,015.20	$132,015.20	$0.00
26065	BlueChoice HealthPlan of South Carolina, Inc.	SC	$155,325.74	$155,325.74	$0.00
49532	BlueChoice HealthPlan of South Carolina, Inc.	SC	($155,325.75)	($155,325.75)	$0.00
31195	Sanford Health Plan	SD	$101,329.31	$101,329.31	$0.00
60536	Avera Health Plans, Inc.	SD	($101,329.32)	($101,329.32)	$0.00
16348	TRH Health Insurance Company	TN	($362,534.51)	($362,534.51)	$0.00
69443	UnitedHealth Group, Inc.	TN	$3,048.60	$3,048.60	$0.00
82120	Humana, Inc.	TN	$359,485.91	$359,485.91	$0.00
20069	Oscar Health	TX	($605,086.40)	($605,086.40)	$0.00
32673	Humana, Inc.	TX	($170,401.72)	($170,401.72)	$0.00
33602	Health Care Service Corporation	TX	$546,164.31	$546,164.31	$0.00
66252	CHRISTUS Health	TX	$229,323.80	$229,323.80	$0.00
43129	UnitedHealth Group, Inc.	UT	$2,763.83	$1,315.13	($1,448.70)
68781	SelectHealth	UT	($2,763.83)	($1,315.13)	$1,448.70
10207	CareFirst	VA	($229,982.09)	($229,941.30)	$40.79

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12028	Aetna, Inc.	VA	($153,979.49)	($153,880.25)	$99.24
15668	Piedmont Community Health Plan	VA	($17,466.39)	($17,466.01)	$0.38
37204	Piedmont Community Health Plan	VA	$190,704.53	$190,717.51	$12.98
41892	UnitedHealth Group, Inc.	VA	($4,188.89)	($4,678.13)	($489.24)
88380	Anthem, Inc.	VA	$850,406.29	$850,659.56	$253.27
93187	Aetna, Inc.	VA	($134,922.39)	($134,866.23)	$56.16
95185	Kaiser Permanente	VA	($500,571.55)	($500,545.15)	$26.40
23371	Kaiser Permanente	WA	($21,035.24)	($21,035.24)	$0.00
80473	Kaiser Permanente	WA	$21,035.25	$21,035.25	$0.00
20173	HealthPartners Insurance Company	WI	($6,841.59)	($6,843.08)	($1.49)
37833	Quartz Health Solutions	WI	($39,129.01)	($39,147.85)	($18.84)
38166	Security Health Plan of Wisconsin, Inc.	WI	$295,788.25	$295,635.70	($152.55)
38345	Dean Health Plan, Inc.	WI	($351,306.72)	($351,444.64)	($137.92)
47342	Mayo Clinic Health System	WI	$18,880.18	$18,855.07	($25.11)
57845	Medica Insurance Company	WI	$212,870.25	$212,784.95	($85.30)
58564	Quartz Health Solutions	WI	($14,589.90)	($14,591.38)	($1.48)
79475	Anthem, Inc.	WI	($144,042.04)	($144,094.43)	($52.39)
81974	Wisconsin Physicians Svc Insurance Corp	WI	($12,145.47)	($12,146.39)	($0.92)
84670	Wisconsin Physicians Svc Insurance Corp	WI	$124,623.45	$124,601.91	($21.54)
86584	Wisconsin Physicians Svc Insurance Corp	WI	($53,717.21)	($53,720.77)	($3.56)
87416	Common Ground Healthcare Cooperative	WI	$583.10	$433.59	($149.51)
91058	Quartz Health Solutions	WI	($21,874.57)	($21,222.67)	$651.90
94529	Group Health Cooperative of South Central Wisconsin	WI	($9,098.74)	($9,100.00)	($1.26)
31274	Highmark	WV	$0.00	$0.00	$0.00
11269	Blue Cross Blue Shield of Wyoming	WY	$0.00	$0.00	$0.00

Table 4c: Updated Issuer-Specific 2017 HHS-RADV Adjustments to 2017 Risk Adjustment Transfers for Non-Merged Market States – Small Group Market *(Appendix C)*

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2017 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS [38]	2017 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
11082	Aetna, Inc.	AK	$70,609.53	$70,609.53	$0.00
38344	Premera Blue Cross	AK	$1,615,253.34	$1,615,253.34	$0.00
73836	Moda Health Plan, Inc.	AK	($744,336.01)	($744,336.01)	$0.00
80049	UnitedHealth Group, Inc.	AK	($941,526.90)	($941,526.90)	$0.00
46944	Blue Cross Blue Shield of Alabama	AL	$1,662,986.37	$1,662,986.37	$0.00
68259	UnitedHealth Group, Inc.	AL	($1,698,227.57)	($1,698,227.57)	$0.00
69461	UnitedHealth Group, Inc.	AL	$737,981.76	$737,981.76	$0.00
93018	Viva Health, Inc.	AL	($702,740.49)	($702,740.49)	$0.00
13262	Arkansas Blue Cross and Blue Shield	AR	($251,058.68)	($251,058.68)	$0.00
22732	UnitedHealth Group, Inc.	AR	($815,079.73)	($815,079.73)	$0.00
37903	QualChoice Arkansas	AR	($69,936.67)	($69,936.67)	$0.00
65817	UnitedHealth Group, Inc.	AR	($102,649.81)	($102,649.81)	$0.00
70525	QualChoice Arkansas	AR	$86,895.32	$86,895.32	$0.00
75293	Arkansas Blue Cross and Blue Shield	AR	$1,570,738.41	$1,570,738.41	$0.00
81392	UnitedHealth Group, Inc.	AR	($260,744.68)	($260,744.68)	$0.00
89365	Federated Mutual	AR	($158,164.22)	($158,164.22)	$0.00
23307	Humana, Inc.	AZ	($5,736,667.03)	($5,736,667.03)	$0.00
40702	UnitedHealth Group, Inc.	AZ	($5,694,852.10)	($5,694,852.10)	$0.00
51485	Centene Corporation	AZ	($1,365,785.00)	($1,365,785.00)	$0.00
53901	Blue Cross Blue Shield of Arizona, Inc.	AZ	($3,329,219.82)	($3,329,219.82)	$0.00
66105	Humana, Inc.	AZ	($302,647.69)	($302,647.69)	$0.00
70904	WMI Mutual Insurance Company	AZ	($36,649.03)	($36,649.03)	$0.00

[38] Ibid.

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2017 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS [38]	2017 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
78611	Aetna, Inc.	AZ	($33,786.35)	($33,786.35)	$0.00
82011	UnitedHealth Group, Inc.	AZ	$14,363,165.23	$14,363,165.23	$0.00
84251	Aetna, Inc.	AZ	$2,467,840.53	$2,467,840.53	$0.00
86830	Cigna	AZ	$52,403.83	$52,403.83	$0.00
91450	Centene Corporation	AZ	($558,508.96)	($558,508.96)	$0.00
97667	Cigna	AZ	($66,654.76)	($66,654.76)	$0.00
98971	UnitedHealth Group, Inc.	AZ	$241,361.02	$241,361.02	$0.00
20523	Aetna, Inc.	CA	$2,470,342.58	$2,470,342.58	$0.00
27330	Kaiser Permanente	CA	($522,993.35)	($522,993.35)	$0.00
27603	Anthem, Inc.	CA	$199,093,880.90	$199,093,880.90	$0.00
40513	Kaiser Permanente	CA	($312,634,716.40)	($312,634,716.40)	$0.00
40733	Aetna, Inc.	CA	$21,228,443.49	$21,228,443.49	$0.00
47579	Chinese Community Health Plan	CA	($1,735,919.63)	($1,735,919.63)	$0.00
49116	UnitedHealth Group, Inc.	CA	($40,820,010.32)	($40,820,010.32)	$0.00
56887	Ventura County Health Care Plan	CA	$437,280.32	$437,280.32	$0.00
64210	Sutter Health Plan	CA	($19,235,294.27)	($19,235,294.27)	$0.00
64618	National Health Insurance Company	CA	$20,242.71	$20,242.71	$0.00
67138	Centene Corporation	CA	($10,309,372.85)	($10,309,372.85)	$0.00
70285	Blue Shield of California	CA	$136,636,289.30	$136,636,289.30	$0.00
92499	Sharp Health Plan	CA	($11,382,088.75)	($11,382,088.75)	$0.00
93689	Western Health Advantage	CA	$1,548,274.43	$1,548,274.43	$0.00
95677	UnitedHealth Group, Inc.	CA	$11,181,620.54	$11,181,620.54	$0.00
99110	Centene Corporation	CA	$24,024,021.19	$24,024,021.19	$0.00
21032	Kaiser Permanente	CO	($18,589,487.41)	($18,907,577.17)	($318,089.76)
35944	Kaiser Permanente	CO	($15,842.45)	($16,585.35)	($742.90)
39041	Aetna, Inc.	CO	$652,076.33	$645,019.13	($7,057.20)
59036	UnitedHealth Group, Inc.	CO	($10,897,579.97)	($10,970,271.31)	($72,691.34)

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63312	Colorado Choice Health Plans	CO	($88,342.46)	($112,928.09)	($24,585.63)
67879	UnitedHealth Group, Inc.	CO	$27,848,932.06	$27,458,396.80	($390,535.26)
74320	Humana, Inc.	CO	$1,303,275.80	$1,233,339.10	($69,936.70)
76680	Anthem, Inc.	CO	($9,609,395.96)	($9,644,013.55)	($34,617.59)
79509	Humana, Inc.	CO	$628,256.15	$624,260.14	($3,996.01)
80208	Rocky Mountain Health Care Options	CO	$442,306.66	$1,747,213.54	$1,304,906.88
87269	Anthem, Inc.	CO	$10,911,231.01	$10,590,167.37	($321,063.64)
97879	Rocky Mountain Health Care Options	CO	($2,585,429.76)	($2,647,020.65)	($61,590.89)
29462	UnitedHealth Group, Inc.	CT	$4,912,295.94	$4,912,295.94	$0.00
39159	Aetna, Inc.	CT	$5,859,129.11	$5,859,129.11	$0.00
49650	UnitedHealth Group, Inc.	CT	$423,792.00	$423,792.00	$0.00
71179	UnitedHealth Group, Inc.	CT	($144,694.33)	($144,694.33)	$0.00
75091	ConnectiCare, Inc.	CT	$14,877.22	$14,877.22	$0.00
86545	Anthem, Inc.	CT	$3,667,865.78	$3,667,865.78	$0.00
89130	HPHC Insurance Company, Inc	CT	($8,968,585.94)	($8,968,585.94)	$0.00
94815	ConnectiCare, Inc.	CT	($5,570,057.74)	($5,570,057.74)	$0.00
95882	HPHC Insurance Company, Inc	CT	($194,622.18)	($194,622.18)	$0.00
21066	UnitedHealth Group, Inc.	DC	($472,015.89)	($472,015.89)	$0.00
41842	UnitedHealth Group, Inc.	DC	$1,562,031.69	$1,562,031.69	$0.00
73987	Aetna, Inc.	DC	$154,887.96	$154,887.96	$0.00
75753	UnitedHealth Group, Inc.	DC	($627,818.41)	($627,818.41)	$0.00
77422	Aetna, Inc.	DC	($533,232.20)	($533,232.20)	$0.00
78079	CareFirst	DC	$10,874,396.62	$10,874,396.62	$0.00
86052	CareFirst	DC	($9,350,612.52)	($9,350,612.52)	$0.00
94506	Kaiser Permanente	DC	($1,607,637.27)	($1,607,637.27)	$0.00
29497	Aetna, Inc.	DE	($1,014,864.19)	($1,014,864.19)	$0.00
61021	UnitedHealth Group, Inc.	DE	($444,816.07)	($444,816.07)	$0.00

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67190	Aetna, Inc.	DE	$923,437.73	$923,437.73	$0.00
76168	Highmark	DE	$696,498.63	$696,498.63	$0.00
97569	UnitedHealth Group, Inc.	DE	($160,256.14)	($160,256.14)	$0.00
16842	Blue Cross and Blue Shield of Florida	FL	$19,195,173.11	$19,195,173.11	$0.00
18628	Aetna, Inc.	FL	$11,932,273.20	$11,932,273.20	$0.00
19898	AvMed, Inc.	FL	$801,626.31	$801,626.31	$0.00
23841	Aetna, Inc.	FL	$2,358,859.29	$2,358,859.29	$0.00
30252	Blue Cross and Blue Shield of Florida	FL	($18,541,996.03)	($18,541,996.03)	$0.00
35783	Humana, Inc.	FL	($11,862,572.41)	($11,862,572.41)	$0.00
36194	Health First, Inc.	FL	($1,751,296.18)	($1,751,296.18)	$0.00
42204	UnitedHealth Group, Inc.	FL	($114,840.94)	($114,840.94)	$0.00
43839	UnitedHealth Group, Inc.	FL	$5,273,063.15	$5,273,063.15	$0.00
56503	Florida Health Care Plan, Inc.	FL	($1,611,145.68)	($1,611,145.68)	$0.00
66966	Capital Health Plan	FL	($237,935.62)	($237,935.62)	$0.00
68398	UnitedHealth Group, Inc.	FL	($1,823,207.54)	($1,823,207.54)	$0.00
77150	Health First, Inc.	FL	$774,154.89	$774,154.89	$0.00
80779	UnitedHealth Group, Inc.	FL	($4,192,749.99)	($4,192,749.99)	$0.00
99308	Humana, Inc.	FL	($199,405.64)	($199,405.64)	$0.00
12442	Nippon Life Benefits	GA	$224,509.54	$224,515.66	$6.12
13535	UnitedHealth Group, Inc.	GA	$2,042,988.05	$2,043,278.92	$290.87
30552	UnitedHealth Group, Inc.	GA	($4,149,929.77)	($4,149,040.95)	$888.82
37001	Humana, Inc.	GA	$542,258.43	$542,326.08	$67.65
38835	Federated Mutual	GA	($111,539.18)	($111,377.35)	$161.83
43802	UnitedHealth Group, Inc.	GA	$991,363.39	$991,479.05	$115.66
49046	Anthem, Inc.	GA	$8,334,877.82	$8,337,787.80	$2,909.98
63411	Anthem, Inc.	GA	$707,351.80	$707,385.66	$33.86
82302	Kaiser Permanente	GA	$12,306.97	$12,307.64	$0.67

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82824	Aetna, Inc.	GA	$426,428.16	$426,928.18	$500.02
83761	Alliant Health Plans	GA	$710,630.46	$710,729.85	$99.39
83978	Aetna, Inc.	GA	$10,449,185.82	$10,450,620.24	$1,434.42
89942	Kaiser Permanente	GA	($3,750,814.09)	($3,750,456.32)	$357.77
93332	Humana, Inc.	GA	($16,404,683.09)	($16,399,665.61)	$5,017.48
95852	UnitedHealth Group, Inc.	GA	($24,934.27)	($36,818.73)	($11,884.46)
18350	Hawaii Medical Service Association	HI	$14,385,070.83	$14,385,070.83	$0.00
54179	UnitedHealth Group, Inc.	HI	$2,818.12	$2,818.12	$0.00
56682	Hawaii Medical Assurance Association	HI	($110,321.26)	($110,321.26)	$0.00
60612	Kaiser Permanente	HI	($11,982,455.73)	($11,982,455.73)	$0.00
95366	University Health Alliance (UHA)	HI	($2,295,111.97)	($2,295,111.97)	$0.00
18973	Aetna, Inc.	IA	($448,020.13)	($448,020.13)	$0.00
25896	Wellmark, Inc.	IA	($874,643.55)	($874,643.55)	$0.00
27651	Quartz Health Solutions	IA	($106,991.78)	($106,991.78)	$0.00
41397	Federated Mutual	IA	($642,170.51)	($642,170.51)	$0.00
50735	Medical Associates Health Plans	IA	$237,745.57	$237,745.57	$0.00
51474	Pekin Life Insurance Company	IA	($73,617.11)	($73,617.11)	$0.00
56610	UnitedHealth Group, Inc.	IA	$414,993.95	$414,993.95	$0.00
72160	Wellmark, Inc.	IA	$3,386,559.75	$3,386,559.75	$0.00
74406	Wellmark, Inc.	IA	($400,870.42)	($400,870.42)	$0.00
74980	Avera Health Plans, Inc.	IA	$111,050.48	$111,050.48	$0.00
77638	Health Alliance Medical Plans, Inc.	IA	($34,436.34)	($34,436.34)	$0.00
78252	Aetna, Inc.	IA	($106,451.56)	($106,451.56)	$0.00
85930	Sanford Health Plan	IA	($52,263.31)	($52,263.31)	$0.00
87928	Wellmark, Inc.	IA	($237,880.07)	($237,880.07)	$0.00
88678	UnitedHealth Group, Inc.	IA	($1,173,004.93)	($1,173,004.93)	$0.00
26002	SelectHealth	ID	($238,815.95)	($238,815.95)	$0.00

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38128	Montana Health Cooperative	ID	($120,655.28)	($120,655.28)	$0.00
43541	National Health Insurance Company	ID	($276,891.35)	($276,891.35)	$0.00
44648	Cambia Health Solutions	ID	$2,293,255.45	$2,293,255.45	$0.00
45059	Aetna, Inc.	ID	($10,101.50)	($10,101.50)	$0.00
50118	UnitedHealth Group, Inc.	ID	$1,625.12	$1,625.12	$0.00
60597	PacificSource Health Plans	ID	($1,864,614.35)	($1,864,614.35)	$0.00
61175	Aetna, Inc.	ID	$135,535.65	$135,535.65	$0.00
61589	Blue Cross of Idaho Health Service, Inc.	ID	$80,662.21	$80,662.21	$0.00
18389	Pekin Life Insurance Company	IL	($137,667.78)	($137,640.84)	$26.94
20129	Health Alliance Medical Plans, Inc.	IL	($1,292,207.35)	($1,290,598.61)	$1,608.74
24301	Medical Associates Health Plans	IL	$56,930.97	$57,060.68	$129.71
34446	UnitedHealth Group, Inc.	IL	$711,640.34	$716,424.56	$4,784.22
35670	Aetna, Inc.	IL	($168,289.40)	($168,216.20)	$73.20
36096	Health Care Service Corporation	IL	$6,201,452.87	$6,327,299.14	$125,846.27
42529	UnitedHealth Group, Inc.	IL	($2,457,421.07)	($2,456,805.19)	$615.88
54322	MercyCare Insurance Company	IL	($110,789.80)	($110,768.63)	$21.17
58239	UnitedHealth Group, Inc.	IL	($1,315,014.25)	($1,314,380.53)	$633.72
58288	Humana, Inc.	IL	($1,685,150.33)	($1,684,580.80)	$569.53
66143	Federated Mutual	IL	($2,017,781.03)	($2,017,092.58)	$688.45
68303	Humana, Inc.	IL	$7,796.46	$9,922.09	$2,125.63
72547	Aetna, Inc.	IL	$2,648,862.56	$2,650,143.46	$1,280.90
78463	UnitedHealth Group, Inc.	IL	($151,696.14)	($279,205.16)	($127,509.02)
92476	UnitedHealth Group, Inc.	IL	$78,898.64	$93,021.52	$14,122.88
96601	Aetna, Inc.	IL	$38,569.24	$13,492.02	($25,077.22)
99129	Aetna, Inc.	IL	($408,133.93)	($408,074.99)	$58.94
11104	Federated Mutual	IN	$851,008.13	$851,008.13	$0.00
17575	Anthem, Inc.	IN	$7,413,866.40	$7,413,866.40	$0.00

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32378	Aetna, Inc.	IN	($247,035.83)	($247,035.83)	$0.00
33380	Indiana University Health	IN	($649,334.41)	($649,334.41)	$0.00
36373	UnitedHealth Group, Inc.	IN	$249,036.85	$249,036.85	$0.00
43442	Humana, Inc.	IN	($161,650.57)	($161,650.57)	$0.00
50816	Physicians Health Plan of Northern Indiana, Inc.	IN	($1,565,817.43)	($1,565,817.43)	$0.00
72850	UnitedHealth Group, Inc.	IN	($6,119,832.00)	($6,119,832.00)	$0.00
79828	Pekin Life Insurance Company	IN	($61,075.00)	($61,075.00)	$0.00
96992	Aetna, Inc.	IN	($15,458.23)	($15,458.23)	$0.00
99791	Humana, Inc.	IN	$306,292.27	$306,292.27	$0.00
18558	Blue Cross and Blue Shield of Kansas, Inc.	KS	($1,394,664.85)	($1,394,664.85)	$0.00
19968	Humana, Inc.	KS	$1,327,962.27	$1,327,962.27	$0.00
27811	Blue Cross and Blue Shield of Kansas, Inc.	KS	($1,970,523.23)	($1,970,523.23)	$0.00
49857	Humana, Inc.	KS	$367,312.94	$367,312.94	$0.00
57850	Aetna, Inc.	KS	($78,377.66)	($78,377.66)	$0.00
84600	Aetna, Inc.	KS	$198,720.74	$198,720.74	$0.00
94248	Blue Cross and Blue Shield of Kansas City	KS	($225,128.83)	($225,128.83)	$0.00
94968	UnitedHealth Group, Inc.	KS	$2,137,648.09	$2,137,648.09	$0.00
96352	Federated Mutual	KS	($362,949.52)	($362,949.52)	$0.00
15411	Humana, Inc.	KY	($754,945.32)	($754,945.32)	$0.00
23671	UnitedHealth Group, Inc.	KY	($2,775,937.89)	($2,775,937.89)	$0.00
28773	UnitedHealth Group, Inc.	KY	$55,109.62	$55,109.62	$0.00
34822	Aetna, Inc.	KY	($10,396.35)	($10,396.35)	$0.00
36239	Anthem, Inc.	KY	$5,247,388.21	$5,247,388.21	$0.00
40586	Baptist Health Plan	KY	($1,352,232.72)	($1,352,232.72)	$0.00
45920	UnitedHealth Group, Inc.	KY	($408,985.74)	($408,985.74)	$0.00
14030	Aetna, Inc.	LA	$172,687.57	$172,687.57	$0.00
19636	Blue Cross Blue Shield of Louisiana	LA	($6,522,359.29)	($6,522,359.29)	$0.00

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22381	Aetna, Inc.	LA	($4,874.45)	($4,874.45)	$0.00
38499	UnitedHealth Group, Inc.	LA	$324,017.56	$324,017.56	$0.00
44965	Humana, Inc.	LA	($4,426,481.25)	($4,426,481.25)	$0.00
53946	UnitedHealth Group, Inc.	LA	($827,048.55)	($827,048.55)	$0.00
67243	Vantage Health Plan, Inc.	LA	($38,945.89)	($38,945.89)	$0.00
69842	UnitedHealth Group, Inc.	LA	($837,243.34)	($837,243.34)	$0.00
81941	Aetna, Inc.	LA	($27,929.35)	($27,929.35)	$0.00
97176	Blue Cross Blue Shield of Louisiana	LA	$12,188,176.95	$12,188,176.95	$0.00
23620	UnitedHealth Group, Inc.	MD	($1,662,966.04)	($1,662,966.04)	$0.00
28137	CareFirst	MD	($12,483,594.92)	($12,483,594.92)	$0.00
31112	UnitedHealth Group, Inc.	MD	($3,588,788.99)	($3,588,788.99)	$0.00
45532	CareFirst	MD	$13,745,924.10	$13,745,924.10	$0.00
65635	UnitedHealth Group, Inc.	MD	($488,948.72)	($488,948.72)	$0.00
66516	Aetna, Inc.	MD	$2,377,136.80	$2,377,136.80	$0.00
70767	Aetna, Inc.	MD	$1,211,146.12	$1,211,146.12	$0.00
72375	UnitedHealth Group, Inc.	MD	($6,571,521.73)	($6,571,521.73)	$0.00
72564	Evergreen Health Cooperative, Inc.	MD	($12,551,664.04)	($12,551,664.04)	$0.00
90296	Kaiser Permanente	MD	$263,770.53	$263,770.53	$0.00
94084	CareFirst	MD	$19,749,506.92	$19,749,506.92	$0.00
11593	HPHC Insurance Company, Inc	ME	$1,241,361.85	$1,241,361.85	$0.00
33653	Maine Community Health Options	ME	($1,702,853.02)	($1,702,853.02)	$0.00
48396	Anthem, Inc.	ME	($927,203.64)	($927,203.64)	$0.00
53357	Aetna, Inc.	ME	$3,984,269.79	$3,984,269.79	$0.00
73250	Aetna, Inc.	ME	$395,130.30	$395,130.30	$0.00
90214	UnitedHealth Group, Inc.	ME	$167,711.97	$167,711.97	$0.00
96667	HPHC Insurance Company, Inc	ME	($3,158,417.23)	($3,158,417.23)	$0.00
15560	Blue Cross Blue Shield of Michigan	MI	$16,230,778.52	$16,230,778.52	$0.00

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20662	Physicians Health Plan	MI	$204,843.49	$204,843.49	$0.00
29241	Priority Health	MI	$1,803,921.66	$1,803,921.66	$0.00
29698	Priority Health	MI	($5,987,520.32)	($5,987,520.32)	$0.00
37651	Health Alliance Plan (HAP)	MI	$1,944,439.11	$1,944,439.11	$0.00
52670	UnitedHealth Group, Inc.	MI	($47,492.44)	($47,492.44)	$0.00
60829	Physicians Health Plan	MI	($382,929.45)	($382,929.45)	$0.00
62294	Humana, Inc.	MI	($233,939.90)	($233,939.90)	$0.00
63631	UnitedHealth Group, Inc.	MI	$638,220.56	$638,220.56	$0.00
67183	Total Health Care USA, Inc.	MI	$799,156.44	$799,156.44	$0.00
67577	Health Alliance Plan (HAP)	MI	($290,117.39)	($290,117.39)	$0.00
74917	McLaren Health Care	MI	($2,230,256.84)	($2,230,256.84)	$0.00
82649	Federated Mutual	MI	($4,225,646.90)	($4,225,646.90)	$0.00
95233	Paramount Insurance Company	MI	$514,863.12	$514,863.12	$0.00
98185	Blue Cross Blue Shield of Michigan	MI	($8,738,319.69)	($8,738,319.69)	$0.00
31616	Medica Insurance Company	MN	$4,249,844.27	$4,249,844.27	$0.00
49316	Blue Cross Blue Shield of Minnesota	MN	$27,191,741.94	$27,191,741.94	$0.00
52346	Sanford Health Plan	MN	($35,741.68)	($35,741.68)	$0.00
57129	Blue Cross Blue Shield of Minnesota	MN	($1,736,470.54)	($1,736,470.54)	$0.00
60769	Federated Mutual	MN	($4,695,175.01)	($4,695,175.01)	$0.00
70373	Quartz Health Solutions	MN	($140,404.30)	($140,404.30)	$0.00
79888	HealthPartners Insurance Company	MN	($20,639,939.50)	($20,639,939.50)	$0.00
85654	HealthPartners Insurance Company	MN	($243,046.42)	($243,046.42)	$0.00
88102	PreferredOne Insurance Company	MN	($4,018,305.68)	($4,018,305.68)	$0.00
97624	PreferredOne Insurance Company	MN	$67,496.94	$67,496.94	$0.00
30613	Humana, Inc.	MO	($2,632,385.19)	($2,632,385.19)	$0.00
32753	Anthem, Inc.	MO	$2,252,545.70	$2,252,545.70	$0.00
32898	Aetna, Inc.	MO	$7,690.31	$7,690.31	$0.00

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34762	Blue Cross and Blue Shield of Kansas City	MO	($193,169.87)	($193,169.87)	$0.00
44527	Aetna, Inc.	MO	($283,399.25)	($283,399.25)	$0.00
48161	Aetna, Inc.	MO	($165,381.25)	($165,381.25)	$0.00
64701	Federated Mutual	MO	($86,018.29)	($86,018.29)	$0.00
95426	UnitedHealth Group, Inc.	MO	$3,411,247.92	$3,411,247.92	$0.00
96384	Cox HealthPlans	MO	($2,311,130.13)	($2,311,130.13)	$0.00
11721	Blue Cross Blue Shield of Mississippi	MS	$297,010.36	$297,010.36	$0.00
26781	UnitedHealth Group, Inc.	MS	($101,762.79)	($101,762.79)	$0.00
38420	Federated Mutual	MS	$388,021.97	$388,021.97	$0.00
48963	Humana, Inc.	MS	($121,751.15)	($121,751.15)	$0.00
61794	UnitedHealth Group, Inc.	MS	($100,970.75)	($100,970.75)	$0.00
97560	UnitedHealth Group, Inc.	MS	($245,314.69)	($245,314.69)	$0.00
98805	UnitedHealth Group, Inc.	MS	($115,232.97)	($115,232.97)	$0.00
23603	PacificSource Health Plans	MT	($5,022,612.65)	($5,022,612.65)	$0.00
30751	Health Care Service Corporation	MT	$5,135,778.09	$5,135,778.09	$0.00
32225	Montana Health Cooperative	MT	($195,493.29)	($195,493.29)	$0.00
46621	UnitedHealth Group, Inc.	MT	$82,327.89	$82,327.89	$0.00
11512	Blue Cross Blue Shield of North Carolina	NC	$20,825,917.17	$20,825,917.17	$0.00
24588	Federated Mutual	NC	($874,338.96)	($874,338.96)	$0.00
43283	FirstCarolinaCare Insurance Company	NC	($320,037.63)	($320,037.63)	$0.00
54332	UnitedHealth Group, Inc.	NC	($6,813,683.01)	($6,813,683.01)	$0.00
56346	Aetna, Inc.	NC	($496.55)	($496.55)	$0.00
58658	UnitedHealth Group, Inc.	NC	($1,500,782.33)	($1,500,782.33)	$0.00
61644	Aetna, Inc.	NC	($1,882,911.96)	($1,882,911.96)	$0.00
61671	Aetna, Inc.	NC	($829,824.11)	($829,824.11)	$0.00
69347	UnitedHealth Group, Inc.	NC	($8,505,943.13)	($8,505,943.13)	$0.00
72487	UnitedHealth Group, Inc.	NC	($55,295.84)	($55,295.84)	$0.00

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94459	Aetna, Inc.	NC	($42,603.88)	($42,603.88)	$0.00
37160	Blue Cross Blue Shield of North Dakota	ND	$2,043,714.04	$2,043,714.04	$0.00
39364	Medica Insurance Company	ND	($637,918.70)	($637,918.70)	$0.00
73751	Medica Insurance Company	ND	($86,298.47)	($86,298.47)	$0.00
89364	Sanford Health Plan	ND	($1,319,496.88)	($1,319,496.88)	$0.00
15438	Aetna, Inc.	NE	$14,624.59	$14,624.59	$0.00
29678	Blue Cross and Blue Shield of Nebraska	NE	($714,347.89)	($714,347.89)	$0.00
44751	UnitedHealth Group, Inc.	NE	($43,093.51)	($43,093.51)	$0.00
44794	Aetna, Inc.	NE	$265,150.75	$265,150.75	$0.00
47340	Federated Mutual	NE	($1,319,469.39)	($1,319,469.39)	$0.00
59699	Aetna, Inc.	NE	($456,978.76)	($456,978.76)	$0.00
73102	UnitedHealth Group, Inc.	NE	$1,925,330.62	$1,925,330.62	$0.00
79636	Aetna, Inc.	NE	$328,783.58	$328,783.58	$0.00
19304	Maine Community Health Options	NH	($1,293,589.13)	($1,293,589.13)	$0.00
51889	UnitedHealth Group, Inc.	NH	$364,513.29	$364,513.29	$0.00
57601	Anthem, Inc.	NH	$759,048.06	$759,048.06	$0.00
59025	HPHC Insurance Company, Inc	NH	$118,817.56	$118,817.56	$0.00
61163	Minuteman Health, Inc.	NH	($293,882.39)	($293,882.39)	$0.00
71616	HPHC Insurance Company, Inc	NH	$5,080,495.90	$5,080,495.90	$0.00
86365	Tufts Associated Health Maintenance Organization Inc.	NH	($3,348,102.95)	($3,348,102.95)	$0.00
96751	Anthem, Inc.	NH	($1,387,300.35)	($1,387,300.35)	$0.00
13953	Horizon Blue Cross Blue Shield of New Jersey	NJ	$1,115,236.51	$1,115,236.51	$0.00
23458	Cigna	NJ	$217,002.69	$217,002.69	$0.00
41014	Cigna	NJ	$3,366.75	$3,366.75	$0.00
48834	UnitedHealth Group, Inc.	NJ	($302,711.61)	($302,711.61)	$0.00
77263	UnitedHealth Group, Inc.	NJ	$1,457,595.19	$1,457,595.19	$0.00
77606	Independence Blue Cross	NJ	($9,703,381.35)	($9,703,381.35)	$0.00

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82884	Aetna, Inc.	NJ	($815,321.12)	($815,321.12)	$0.00
89217	Aetna, Inc.	NJ	$17,195,074.72	$17,195,074.72	$0.00
91661	Horizon Blue Cross Blue Shield of New Jersey	NJ	($6,676,264.86)	($6,676,264.86)	$0.00
91762	Independence Blue Cross	NJ	($2,490,596.93)	($2,490,596.93)	$0.00
52744	Presbyterian Healthcare Services	NM	$672,331.61	$672,331.61	$0.00
57173	Presbyterian Healthcare Services	NM	($4,442,995.57)	($4,442,995.57)	$0.00
75605	Health Care Service Corporation	NM	$7,701,312.01	$7,701,312.01	$0.00
90762	UnitedHealth Group, Inc.	NM	$828,620.79	$828,620.79	$0.00
93091	New Mexico Health Connections	NM	($4,759,268.82)	($4,759,268.82)	$0.00
16698	Universal Health Services, Inc.	NV	($555,120.90)	($531,731.96)	$23,388.94
19298	Aetna, Inc.	NV	($69,808.57)	($69,423.02)	$385.55
20895	Humana, Inc.	NV	$2,000,275.66	$2,002,281.08	$2,005.42
27990	Aetna, Inc.	NV	$781,825.42	$793,089.56	$11,264.14
33670	Anthem, Inc.	NV	$4,092,200.53	$4,113,341.85	$21,141.32
41094	Hometown Health Plan, Inc.	NV	($776,624.92)	($774,257.34)	$2,367.58
42313	WMI Mutual Insurance Company	NV	($21,536.82)	($21,532.73)	$4.09
60156	Anthem, Inc.	NV	($439,987.99)	($439,457.99)	$530.00
68524	Universal Health Services, Inc.	NV	($29,878.10)	($29,664.15)	$213.95
74222	UnitedHealth Group, Inc.	NV	$571,308.18	$588,492.00	$17,183.82
83198	UnitedHealth Group, Inc.	NV	$4,088,798.50	$4,142,669.17	$53,870.67
85266	Hometown Health Plan, Inc.	NV	($3,351,456.33)	($3,334,983.16)	$16,473.17
93696	Humana, Inc.	NV	$24,841.71	($156,532.50)	($181,374.21)
95865	UnitedHealth Group, Inc.	NV	($6,314,836.45)	($6,282,290.86)	$32,545.59
11177	Metro Plus Health Plan	NY	($2,523,089.40)	($2,523,089.40)	$0.00
17210	Aetna, Inc.	NY	($24,893,594.73)	($24,893,594.73)	$0.00
18029	Independent Health	NY	$2,789,569.19	$2,789,569.19	$0.00
26420	UnitedHealth Group, Inc.	NY	($15,650,018.65)	($15,650,018.65)	$0.00

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36346	HealthNow New York, Inc.	NY	($3,910,003.77)	($3,910,003.77)	$0.00
43477	Crystal Run Health Plans	NY	($3,430,021.04)	($3,430,021.04)	$0.00
44113	Anthem, Inc.	NY	($8,047,316.48)	($8,047,316.48)	$0.00
49526	HealthNow New York, Inc.	NY	$12,255,694.66	$12,255,694.66	$0.00
54297	UnitedHealth Group, Inc.	NY	($685,924.84)	($685,924.84)	$0.00
56184	MVP Health Plan, Inc.	NY	($2,573,281.38)	($2,573,281.38)	$0.00
61405	Healthfirst	NY	($1,609,973.24)	($1,609,973.24)	$0.00
70552	Independent Health	NY	($220,552.47)	($220,552.47)	$0.00
73886	Crystal Run Health Plans	NY	($2,467,863.91)	($2,467,863.91)	$0.00
74289	Oscar Health	NY	($2,693,856.05)	($2,693,856.05)	$0.00
78124	Excellus Health Plan, Inc.	NY	($38,167,966.89)	($38,167,966.89)	$0.00
80519	Anthem, Inc.	NY	($953,457.67)	($953,457.67)	$0.00
82483	North Shore-LIJ Health System	NY	($115,673,281.80)	($115,673,281.80)	$0.00
85629	UnitedHealth Group, Inc.	NY	$216,646,628.90	$216,646,628.90	$0.00
88582	EmblemHealth	NY	($16,953,145.40)	($16,953,145.40)	$0.00
89846	MVP Health Plan, Inc.	NY	($6,415,625.80)	($6,415,625.80)	$0.00
92551	CDPHP Universal Benefits, Inc.	NY	$18,455,306.91	$18,455,306.91	$0.00
94788	CDPHP Universal Benefits, Inc.	NY	($3,278,226.08)	($3,278,226.08)	$0.00
28162	AultCare Insurance Company	OH	($3,118,584.55)	($3,121,390.59)	($2,806.04)
29276	Anthem, Inc.	OH	$10,008,430.38	$10,022,808.85	$14,378.47
33232	UnitedHealth Group, Inc.	OH	($2,513,809.68)	($2,512,720.92)	$1,088.76
52664	Summa Insurance Company	OH	$2,334,600.30	$2,335,670.10	$1,069.80
56073	Nippon Life Benefits	OH	($153,447.55)	($191,078.61)	($37,631.06)
56726	UnitedHealth Group, Inc.	OH	$269,433.07	$271,056.58	$1,623.51
61724	UnitedHealth Group, Inc.	OH	($8,829,403.93)	($8,821,589.52)	$7,814.41
66083	Humana, Inc.	OH	($4,615,446.20)	($4,611,106.99)	$4,339.21
67129	Aetna, Inc.	OH	$2,799,635.03	$2,801,973.37	$2,338.34

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74313	Paramount Insurance Company	OH	($1,828,122.77)	($1,826,939.35)	$1,183.42
80627	Medical Mutual of Ohio	OH	$4,284,125.78	$4,286,998.77	$2,872.99
83396	The Health Plan of the Upper Ohio Valley	OH	($263,052.24)	($262,990.87)	$61.37
84867	Aetna, Inc.	OH	$1,146,032.43	$1,148,865.17	$2,832.74
96800	Federated Mutual	OH	$867,188.44	$867,902.93	$714.49
97596	Humana, Inc.	OH	($259,546.93)	($259,477.77)	$69.16
98810	The Health Plan of the Upper Ohio Valley	OH	($114,480.88)	($114,458.84)	$22.04
99969	Medical Mutual of Ohio	OH	($13,550.70)	($13,522.31)	$28.39
27243	Federated Mutual	OK	($698,392.63)	($698,392.63)	$0.00
45480	UnitedHealth Group, Inc.	OK	($728,410.36)	($728,410.36)	$0.00
66946	Aetna, Inc.	OK	$648,062.09	$648,062.09	$0.00
76275	Aetna, Inc.	OK	($70,529.35)	($70,529.35)	$0.00
85757	UnitedHealth Group, Inc.	OK	($1,601,671.72)	($1,601,671.72)	$0.00
87571	Health Care Service Corporation	OK	$13,223,428.85	$13,223,428.85	$0.00
87698	CommunityCare	OK	($584,470.82)	($584,470.82)	$0.00
98905	CommunityCare	OK	($10,188,016.10)	($10,188,016.10)	$0.00
10091	PacificSource Health Plans	OR	($590,613.51)	($590,613.51)	$0.00
10940	Centene Corporation	OR	$1,411,965.85	$1,411,965.85	$0.00
30969	Zoom Health Plan, Inc.	OR	($47,429.53)	($47,429.53)	$0.00
32536	ATRIO Health Plans	OR	($114,168.93)	($114,168.93)	$0.00
33375	Samaritan Health Plans	OR	($263,003.04)	($263,003.04)	$0.00
39424	Moda Health Plan, Inc.	OR	$2,003,095.16	$2,003,095.16	$0.00
56707	Providence Health & Services	OR	($5,056,044.70)	($5,056,044.70)	$0.00
71287	Kaiser Permanente	OR	($2,666,857.84)	($2,666,857.84)	$0.00
77969	Cambia Health Solutions	OR	$4,319,033.74	$4,319,033.74	$0.00
85804	Premera Blue Cross	OR	($309,202.59)	($309,202.59)	$0.00
90175	UnitedHealth Group, Inc.	OR	$1,313,225.62	$1,313,225.62	$0.00

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16322	UPMC Health Plan	PA	$14,426,473.48	$14,528,532.12	$102,058.64
18939	Aetna, Inc.	PA	$2,311,667.27	$2,322,390.16	$10,722.89
22444	Geisinger Health System	PA	($3,011,309.33)	($3,003,711.16)	$7,598.17
23489	UnitedHealth Group, Inc.	PA	($3,796,481.64)	($3,766,403.26)	$30,078.38
31609	Independence Blue Cross	PA	$23,633,710.00	$23,758,279.84	$124,569.84
33709	Highmark	PA	$3,076,954.64	$3,092,857.02	$15,902.38
33871	Independence Blue Cross	PA	($26,864,029.70)	($26,685,747.00)	$178,282.70
33906	Aetna, Inc.	PA	($690,056.70)	($689,393.26)	$663.44
38949	Highmark	PA	($6,441.92)	($6,439.58)	$2.34
45127	Capital Blue Cross	PA	($8,577,374.68)	($8,448,861.58)	$128,513.10
53789	Capital Blue Cross	PA	($35,498.14)	($34,110.08)	$1,388.06
55957	Highmark	PA	$3,813,377.42	$3,826,179.03	$12,801.61
62560	UPMC Health Plan	PA	($787,776.06)	($783,207.12)	$4,568.94
64844	Aetna, Inc.	PA	($572,086.93)	($568,182.40)	$3,904.53
70194	Highmark	PA	($490,971.88)	($489,804.24)	$1,167.64
75729	Geisinger Health System	PA	($1,756,898.95)	($1,742,866.27)	$14,032.68
79279	Highmark	PA	$810,774.18	$813,228.49	$2,454.31
79962	Highmark	PA	$337,505.66	$345,772.33	$8,266.67
80148	Federated Mutual	PA	($1,134,407.04)	($1,694,689.45)	($560,282.41)
82795	Capital Blue Cross	PA	($244,449.07)	($244,328.38)	$120.69
93838	Aetna, Inc.	PA	($442,680.89)	($529,495.13)	($86,814.24)
15287	Blue Cross Blue Shield of Rhode Island	RI	$3,559,663.89	$3,559,663.89	$0.00
26322	Tufts Associated Health Maintenance Organization Inc.	RI	$278,234.36	$278,234.36	$0.00
77514	Neighborhood Health Plan of Rhode Island	RI	($1,074,790.09)	($1,074,790.09)	$0.00
79881	UnitedHealth Group, Inc.	RI	($1,468,832.70)	($1,468,832.70)	$0.00
90010	Tufts Associated Health Maintenance Organization Inc.	RI	($1,502,319.69)	($1,502,319.69)	$0.00

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2017 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS [38]	2017 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
90117	UnitedHealth Group, Inc.	RI	$208,044.26	$208,044.26	$0.00
22369	Aetna, Inc.	SC	($46,085.53)	($46,085.53)	$0.00
26065	BlueChoice HealthPlan of South Carolina, Inc.	SC	$118,981.64	$118,981.64	$0.00
33609	Federated Mutual	SC	$481,646.67	$481,646.67	$0.00
38408	Aetna, Inc.	SC	$601,211.28	$601,211.28	$0.00
49532	BlueChoice HealthPlan of South Carolina, Inc.	SC	($2,819,874.07)	($2,819,874.07)	$0.00
56262	Aetna, Inc.	SC	($8,127.82)	($8,127.82)	$0.00
57860	UnitedHealth Group, Inc.	SC	$1,559,813.53	$1,559,813.53	$0.00
64146	UnitedHealth Group, Inc.	SC	$112,434.18	$112,434.18	$0.00
31195	Sanford Health Plan	SD	$1,512,973.27	$1,506,496.78	($6,476.49)
50305	Wellmark, Inc.	SD	($613,210.39)	($751,711.92)	($138,501.53)
60536	Avera Health Plans, Inc.	SD	$612,558.50	$598,432.35	($14,126.15)
62210	DAKOTACARE	SD	($2,184,194.55)	($2,192,432.00)	($8,237.45)
64255	Federated Mutual	SD	$688,173.51	$855,654.12	$167,480.61
96594	Medica Insurance Company	SD	($16,300.37)	($16,439.30)	($138.93)
10958	UnitedHealth Group, Inc.	TN	($4,929,876.45)	($4,929,876.45)	$0.00
14002	BlueCross BlueShield of Tennessee	TN	$4,087,116.16	$4,087,116.16	$0.00
31552	Aetna, Inc.	TN	$785,422.50	$785,422.50	$0.00
69443	UnitedHealth Group, Inc.	TN	$1,516,088.98	$1,516,088.98	$0.00
82120	Humana, Inc.	TN	($981,121.25)	($981,121.25)	$0.00
83463	Federated Mutual	TN	($477,630.04)	($477,630.04)	$0.00
19046	Federated Mutual	TX	($744,994.75)	($744,994.75)	$0.00
26539	FirstCare Health Plans	TX	($2,819,555.63)	($2,819,555.63)	$0.00
30609	Memorial Hermann Health Plan	TX	($311,435.09)	($311,435.09)	$0.00
32673	Humana, Inc.	TX	($15,674,526.26)	($15,674,526.26)	$0.00
33602	Health Care Service Corporation	TX	$33,259,053.53	$33,259,053.53	$0.00
37392	Universal Health Services, Inc.	TX	($72,628.80)	($72,628.80)	$0.00

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37755	Scott & White Health Plan	TX	($1,430,111.18)	($1,430,111.18)	$0.00
40220	UnitedHealth Group, Inc.	TX	($6,215,486.23)	($6,215,486.23)	$0.00
40788	Scott & White Health Plan	TX	($5,042,519.55)	($5,042,519.55)	$0.00
41541	Memorial Hermann Health Plan	TX	($4,715,315.48)	($4,715,315.48)	$0.00
41549	FirstCare Health Plans	TX	$605,495.00	$605,495.00	$0.00
58840	Aetna, Inc.	TX	($111,217.24)	($111,217.24)	$0.00
63141	Humana, Inc.	TX	$2,109,414.43	$2,109,414.43	$0.00
81795	Arkansas Blue Cross and Blue Shield	TX	($832,423.12)	($832,423.12)	$0.00
84479	Vista Health Plan, Inc.	TX	($128,477.28)	($128,477.28)	$0.00
91716	Aetna, Inc.	TX	$5,071,449.95	$5,071,449.95	$0.00
98809	UnitedHealth Group, Inc.	TX	($2,946,722.44)	($2,946,722.44)	$0.00
22013	Cambia Health Solutions	UT	$3,870,922.81	$3,870,922.81	$0.00
29031	National Health Insurance Company	UT	($74,294.23)	($74,294.23)	$0.00
38927	Aetna, Inc.	UT	$217,841.39	$217,841.39	$0.00
46958	Humana, Inc.	UT	$163,456.94	$163,456.94	$0.00
48588	Aetna, Inc.	UT	($83,041.19)	($83,041.19)	$0.00
66413	UnitedHealth Group, Inc.	UT	($864,688.72)	($864,688.72)	$0.00
68781	SelectHealth	UT	($2,356,545.20)	($2,356,545.20)	$0.00
80043	WMI Mutual Insurance Company	UT	$206,488.13	$206,488.13	$0.00
97462	UnitedHealth Group, Inc.	UT	($1,080,139.96)	($1,080,139.96)	$0.00
10207	CareFirst	VA	($4,366,772.65)	($4,366,772.65)	$0.00
12028	Aetna, Inc.	VA	($880,771.28)	($880,771.28)	$0.00
13433	Federated Mutual	VA	$1,095,131.58	$1,095,131.58	$0.00
15668	Piedmont Community Health Plan	VA	($278,384.93)	($278,384.93)	$0.00
16064	Anthem, Inc.	VA	$29,718,722.06	$29,718,722.06	$0.00
20507	Optima Health	VA	$1,366,648.47	$1,366,648.47	$0.00
24251	UnitedHealth Group, Inc.	VA	($1,164,298.16)	($1,164,298.16)	$0.00

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25978	UnitedHealth Group, Inc.	VA	($15,882,113.33)	($15,882,113.33)	$0.00
37204	Piedmont Community Health Plan	VA	$14,704.38	$14,704.38	$0.00
38234	Aetna, Inc.	VA	($4,630,850.39)	($4,630,850.39)	$0.00
38599	UnitedHealth Group, Inc.	VA	($409,229.55)	($409,229.55)	$0.00
40308	CareFirst	VA	$6,845,846.25	$6,845,846.25	$0.00
86443	Aetna, Inc.	VA	($5,284,239.31)	($5,284,239.31)	$0.00
88380	Anthem, Inc.	VA	($1,168,438.09)	($1,168,438.09)	$0.00
89242	Optima Health	VA	$2,231,078.26	$2,231,078.26	$0.00
89498	UnitedHealth Group, Inc.	VA	($681,832.69)	($681,832.69)	$0.00
93187	Aetna, Inc.	VA	($319,335.77)	($319,335.77)	$0.00
95185	Kaiser Permanente	VA	($6,205,864.80)	($6,205,864.80)	$0.00
18699	UnitedHealth Group, Inc.	WA	($1,438,898.34)	($1,438,898.34)	$0.00
23371	Kaiser Permanente	WA	$275,729.11	$275,729.11	$0.00
25768	Kaiser Permanente	WA	($6,706,193.20)	($6,706,193.20)	$0.00
34673	Aetna, Inc.	WA	$1,131,688.41	$1,131,688.41	$0.00
36026	Centene Corporation	WA	($548,464.31)	($548,464.31)	$0.00
43861	UnitedHealth Group, Inc.	WA	($220,209.58)	($220,209.58)	$0.00
49831	Premera Blue Cross	WA	($644,749.68)	($644,749.68)	$0.00
69364	Cambia Health Solutions	WA	$1,720,636.06	$1,720,636.06	$0.00
71281	Cambia Health Solutions	WA	$2,163,889.80	$2,163,889.80	$0.00
80473	Kaiser Permanente	WA	($8,754,028.28)	($8,754,028.28)	$0.00
87718	Cambia Health Solutions	WA	$13,020,600.03	$13,020,600.03	$0.00
16245	Group Health Cooperative of Eau Claire	WI	($1,239,388.66)	($1,249,519.16)	($10,130.50)
20173	HealthPartners Insurance Company	WI	$227,450.53	$220,947.54	($6,502.99)
35334	MercyCare Insurance Company	WI	($81,685.94)	($82,246.43)	($560.49)
37833	Quartz Health Solutions	WI	$1,865,999.48	$1,806,757.98	($59,241.50)
38166	Security Health Plan of Wisconsin, Inc.	WI	($2,511,457.29)	($2,560,024.36)	($48,567.07)

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38345	Dean Health Plan, Inc.	WI	($5,173,583.17)	($5,245,912.54)	($72,329.37)
38752	Aetna, Inc.	WI	$107,001.11	$85,689.04	($21,312.07)
39924	UnitedHealth Group, Inc.	WI	$214,826.18	$213,907.88	($918.30)
47342	Mayo Clinic Health System	WI	($2,118,411.54)	($2,147,074.70)	($28,663.16)
55103	Humana, Inc.	WI	($1,529,425.10)	($1,560,568.98)	($31,143.88)
57637	Medica Insurance Company	WI	($1,520,111.28)	($1,575,289.80)	($55,178.52)
58326	MercyCare Insurance Company	WI	($508,151.26)	($524,260.58)	($16,109.32)
58564	Quartz Health Solutions	WI	($459,204.39)	($474,396.24)	($15,191.85)
59158	UnitedHealth Group, Inc.	WI	$13,431,753.56	$13,136,072.22	($295,681.34)
64772	Medical Associates Health Plans	WI	$36,879.48	$32,518.69	($4,360.79)
69424	Pekin Life Insurance Company	WI	($9,309.07)	($9,367.01)	($57.94)
79475	Anthem, Inc.	WI	$2,748,145.84	$2,624,732.37	($123,413.47)
80180	UnitedHealth Group, Inc.	WI	($629,373.19)	($684,698.12)	($55,324.93)
81413	Network Health Plan	WI	$92,947.34	$92,569.20	($378.14)
81974	Wisconsin Physicians Svc Insurance Corp	WI	$4,710,915.04	$4,664,842.44	($46,072.60)
84670	Wisconsin Physicians Svc Insurance Corp	WI	($1,760,934.64)	($1,782,477.43)	($21,542.79)
86584	Wisconsin Physicians Svc Insurance Corp	WI	($760,833.45)	($767,990.59)	($7,157.14)
87416	Common Ground Healthcare Cooperative	WI	($1,227,873.58)	($1,240,704.84)	($12,831.26)
90028	Anthem, Inc.	WI	($271,658.90)	($276,121.83)	($4,462.93)
91058	Quartz Health Solutions	WI	($4,613,827.70)	($3,529,739.41)	$1,084,088.29
91604	Humana, Inc.	WI	($127,138.18)	($253,755.58)	($126,617.40)
92708	Federated Mutual	WI	$766,361.14	$760,591.23	($5,769.91)
94529	Group Health Cooperative of South Central Wisconsin	WI	$340,087.80	$325,519.13	($14,568.67)
14414	Federated Mutual	WV	($52,357.99)	($52,357.99)	$0.00
31274	Highmark	WV	$1,295,933.51	$1,295,933.51	$0.00
44434	Aetna, Inc.	WV	$68,744.42	$68,744.42	$0.00
50318	Aetna, Inc.	WV	($571,666.67)	($571,666.67)	$0.00

HIOS ID	HIOS INSURANCE COMPANY NAME	STATE	2017 HHS RISK ADJUSTMENT TRANSFER AMOUNT BEFORE RADV ADJUSTMENTS [38]	2017 HHS RISK ADJUSTMENT RADV ADJUSTED ISSUER TRANSFER AMOUNT (Total Issuer Transfer Amount)	ADJUSTMENT AMOUNT (Charges Collected in Calendar Year 2021)
59772	The Health Plan of the Upper Ohio Valley	WV	($614,364.72)	($614,364.72)	$0.00
72982	The Health Plan of the Upper Ohio Valley	WV	$165,210.86	$165,210.86	$0.00
77060	UnitedHealth Group, Inc.	WV	($50,782.51)	($50,782.51)	$0.00
95628	UnitedHealth Group, Inc.	WV	($240,716.99)	($240,716.99)	$0.00
11269	Blue Cross Blue Shield of Wyoming	WY	($623,916.29)	($623,916.29)	$0.00
44325	Aetna, Inc.	WY	$244,027.31	$244,027.31	$0.00
49714	UnitedHealth Group, Inc.	WY	$308,081.87	$308,081.87	$0.00
79022	Aetna, Inc.	WY	$71,807.08	$71,807.08	$0.00

V. Default Data Validation Charge

While there were no changes to the 2017 benefit year default data validation charges (DDVC) or DDVC payment allocations, we are repeating this information in this report.

Pursuant to 45 C.F.R. § 153.630(b)(10), HHS will assess a default data validation charge if an issuer of a risk adjustment covered plan fails to engage an initial validation auditor or to submit the results of an initial validation audit to HHS. The default data validation charge generally utilizes the same calculation methodology as the risk adjustment default charge.[39] As indicated in the 2020 Payment Notice, HHS will not collect and distribute the 2017 benefit year default data validation charges and payment allocations until the 2021 calendar year.[40]

The total default data validation charge for a risk adjustment covered plan equals a per-member per-month (PMPM) amount multiplied by the plan's enrollment – either provided by the issuer or sought from other reliable sources when issuer-reported data was not available. HHS will use enrollment numbers from the benefit year being audited for purposes of calculating the default data

[39] The default data validation charge is calculated in the same manner as the risk adjustment default charge under 45 CFR 153.740(b) except that the default data validation charge is based on enrollment for the benefit year being audited. See the 2020 Payment Notice, 84 FR at 17495 – 17497.
[40] See 84 FR at 17506 – 17507.

validation charge. The PMPM charge for a plan is equal to the product of the statewide average premium PMPM for a risk pool and the 90th percentile plan risk transfer amount for the benefit year of risk adjustment data validation, expressed as a percentage of the respective statewide average PMPM premiums for the risk pool. The nationwide percentile only reflects plans in states where HHS is operating the risk adjustment program and is calculated based on the absolute value of plan risk transfer amounts. The determined PMPM amount is then multiplied by the noncompliant plan's enrollment to establish the plan's total default data validation charge.

All compliant risk adjustment covered plans in the state market risk pool of at least one noncompliant issuer will receive a portion of the default data validation charges collected from the noncompliant issuer(s). We allocate default data validation charges collected from noncompliant plans in the state market risk pool among the compliant plans in the state market risk pool in the applicable benefit year in a manner that is proportional to each compliant plan's relative revenue requirement, as calculated under the transfer formula relative to the market average of these products.[41] For the 2017 benefit year HHS-RADV, the default data validation charge uses 2017 benefit year risk adjustment data. Below we set forth information on the 2017 benefit year default data validation charges which will apply to the 2017 benefit year of HHS-RADV.

Table 5: HHS Default Data Validation Charge Summary Data

SUMMARY DATA ELEMENT	TOTALS
Number of Issuers Receiving a Default Data Validation Charge	2
Percent of All Issuers of Risk Adjustment Covered Plans Subject to 2017 Benefit Year HHS-RADV that Received a Default Data Validation Charge	0.34%

[41] For issuers owed a default data validation charge allocation payment amount (or any payment amount) that is less than $1.00, CMS will hold payment until after the release of sequestration funds after FY2021, so that issuers can receive the full amount (pending collections).

Table 6: HHS Default Data Validation Charge *(Appendix D)*

HIOS ID	HIOS INSURANCE COMPANY NAME RECEIVING DEFAULT DATA VALIDATION CHARGE	STATE	RISK POOL	DEFAULT DATA VALIDATION CHARGE AMOUNT
18389	Pekin Life Insurance Company	IL	Small Group	($133,528.26)
79828	Pekin Life Insurance Company	IN	Small Group	($79,046.64)

Table 7: HHS Default Data Validation Charge Allocation *(Appendix E)*

HIOS ID	HIOS INSURANCE COMPANY NAME RECEIVING PAYMENT FROM DEFAULT DATA VALIDATION CHARGE	STATE	RISK POOL	DEFAULT DATA VALIDATION CHARGE ALLOCATION AMOUNT
20129	Health Alliance Medical Plans, Inc.	IL	Small Group	$1,407.14
24301	Medical Associates Health Plans	IL	Small Group	$ 113.47
34446	UnitedHealth Group, Inc.	IL	Small Group	$4,184.68
35670	Aetna, Inc.	IL	Small Group	$64.03
36096	Health Care Service Corporation	IL	Small Group	$110,075.26
42529	UnitedHealth Group, Inc.	IL	Small Group	$538.66
54322	MercyCare Insurance Company	IL	Small Group	$18.51
58239	UnitedHealth Group, Inc.	IL	Small Group	$554.31
58288	Humana, Inc.	IL	Small Group	$498.20
66143	Federated Mutual	IL	Small Group	$602.21
68303	Humana, Inc.	IL	Small Group	$1,859.22
72547	Aetna, Inc.	IL	Small Group	$1,120.28
78463	UnitedHealth Group, Inc.	IL	Small Group	$71.41
92476	UnitedHealth Group, Inc.	IL	Small Group	$12,353.01
96601	Aetna, Inc.	IL	Small Group	$16.28
99129	Aetna, Inc.	IL	Small Group	$51.56
11104	Federated Mutual	IN	Small Group	$2,728.21
17575	Anthem, Inc.	IN	Small Group	$29,298.78
32378	Aetna, Inc.	IN	Small Group	$238.53

HIOS ID	HIOS INSURANCE COMPANY NAME RECEIVING PAYMENT FROM DEFAULT DATA VALIDATION CHARGE	STATE	RISK POOL	DEFAULT DATA VALIDATION CHARGE ALLOCATION AMOUNT
33380	Indiana University Health	IN	Small Group	$327.11
36373	UnitedHealth Group, Inc.	IN	Small Group	$75.14
43442	Humana, Inc.	IN	Small Group	$34.14
50816	Physicians Health Plan of Northern Indiana, Inc.	IN	Small Group	$5,266.91
72850	UnitedHealth Group, Inc.	IN	Small Group	$36,354.34
96992	Aetna, Inc.	IN	Small Group	$2.10
99791	Humana, Inc.	IN	Small Group	$4,721.39

VI. HHS-Operated Risk Adjustment Program State-Specific Data *(Appendices F and G)*

In *Appendices F and G*, we set forth the risk adjustment state averages after application of the revised 2017 benefit year HHS-RADV error rates with billable member months for the 2018 and 2017 benefit years, respectively. *Appendices F and G* includes the state average monthly premiums by state market risk pool (catastrophic, individual non-catastrophic, small group, and merged), the state average plan liability risk score by state market risk pool, state average allowable rating factor by state market risk pool, state average actuarial value by state market risk pool, state average induced demand factor by state market risk pool, and billable member months. We note that some data elements in *Appendices F and G* may not match the state risk pool averages found in issuers' system generated reports or final transfers in state risk pools that had a material discrepancy resulting in payment adjustments after the calculation of risk adjustment transfers. We also provide a description below of the calculations for state average premium, state average plan liability risk score, state average plan liability risk score after RADV, state average allowable rating factor, state average actuarial value, state average induced demand factor, and billable member months.

DATA ELEMENT	DESCRIPTION
State Average Monthly Premium	The state average premium for state market risk pool is the weighted average monthly premium for the state market risk pool, weighted by plan share of statewide enrollment in the state market risk pool. Beginning in the 2018 benefit year, a 14 percent administrative cost adjustment is applied to the state average monthly premium. This value is used in the state payment transfer formula calculations for risk adjustment payments and charges.
State Average Monthly Premium Before Adjustment	The state average premium for state market risk pool is the weighted average monthly premium for the state market risk pool, weighted by plan share of statewide enrollment in the state market risk pool before the 14 percent administrative cost adjustment is applied. This value is for informational purposes only and not used in the calculation of risk adjustment payments and charges.

DATA ELEMENT	DESCRIPTION
State Average Plan Liability Risk Score (PLRS)	The state average PLRS is calculated as the summed products of PLRS and billable member months for all plans within the state market risk pool divided by total billable months for all plans within the state market risk pool.
State Average Plan Liability Risk Score (PLRS) After RADV	The state average PLRS is calculated as the summed products of PLRS after the application of RADV error rates and billable member months for all plans within the state market risk pool divided by total billable months for all plans within the state market risk pool.
State Average Allowable Rating Factor (ARF)	The state average ARF is calculated as the summed products of ARF and billable member months for the plans within the state market risk pool divided by total billable member months for all plans in the state market risk pool.
State Average Actuarial Value (AV)	The state average AV is calculated as the summed products of AV and billable member months for the plans within the state market risk pool divided by the total billable member months within the state market risk pool. AV corresponds with metal and catastrophic tiers as follows: * Catastrophic: 0.57 * Bronze: 0.60 * Silver: 0.70 * Gold: 0.8 *Platinum: 0.90
State Average Induced Demand Factor (IDF)	The state average IDF is calculated as the summed products of IDF and billable member months for the plans within the state market risk pool divided by the total billable member months within the state market risk pool. IDF corresponds with metal and catastrophic tiers as follows: *Catastrophic: 1.00 *Bronze: 1.00 *Silver: 1.03 *Gold: 1.08 *Platinum: 1.15
Billable Member Months	Billable member months are the member months of an individual or family policy that are included when setting the policy's premium rate.

Press release

CMS Continues Building Better, More Affordable Insurance Marketplace with Payment Notice for 2022 Coverage Year

Jan 14, 2021 Affordable Care Act

The Centers for Medicare & Medicaid Services (CMS) today issued a rule finalizing a number of proposed provisions for the annual Notice of Benefit and Payment Parameters for 2022 (the 2022 payment notice), continuing the agency's efforts to build a better and more affordable insurance marketplace for Americans. CMS anticipates continuing to review comments and finalizing other proposed policies in a second final rule to be published at a later date. Working to address comments and feedback from the public after publishing the proposed 2022 payment notice in November 2020, CMS is using this first final rule to tackle a number of critical priorities. Today's rule finalizes changes to reduce consumer costs, empower states to develop their own unique plans, accelerate innovation, and clarify program requirements.

"Since 2017, premiums are down, coverage options are up, and we have stabilized the individual market with better care at lower costs," said CMS Administrator Seema Verma. "The actions we're taking today ensure these improvements can continue tomorrow, because we must never be satisfied when too many Americans still cannot afford coverage in the individual market."

The policies and parameters announced today give consumers, insurers, and other stakeholders across the health care industry ample time to prepare for implementing top priorities in 2022. Those priorities include:

- **Lower premiums.** For 2022, CMS will reduce the user fee for qualified health plans (QHPs) sold through a Federally-facilitated Exchange (FFE) from 3.0% to 2.25% of premium. This is an additional reduction beyond the 0.5 percentage point reduction in the user fee rate included in the 2020 payment notice. CMS also is finalizing a reduction in the user fee for issuers offering plans through State-based Exchanges that use the federal platform (SBE-FPs) from 2.25% to 1.75% of premium. In years past, including 2020 and 2021, this

provision has been key to reducing insurance premiums to deliver an 8% average premium reduction across states with exchanges using HealthCare.gov since the 2018 coverage year. These reductions reflect successful cost-saving measures CMS implemented over the past several years to strengthen program integrity and improve technological infrastructure.

- **Flexibility to help states develop their own health care programs that meet unique local needs.** Implemented through 1332 waivers, this update solidifies an important opportunity for states to waive certain statutory requirements to create health programs tailored to their own citizens, subject to federal approval. The final rule codifies in regulatory text guidance published in 2018 to give states greater certainty over how the federal government will evaluate and monitor section 1332 waivers moving forward.
- **New options for states to develop next generation Exchanges that leverage web-brokers and insurance issuers for the direct purchase of QHPs.** This approach would rely on web-brokers and issuers to serve as the primary consumer-facing means to apply for and enroll in individual market QHPs through the Exchange. Under these options, Exchanges would retain responsibility for ensuring that participating web brokers and insurers meet all applicable consumer protections, as well as remain responsible for making all eligibility determinations, performing required verifications of consumer application information, and meeting all statutory and regulatory requirements for operating an Exchange.
- **Protective provisions for consumers covered through certain health reimbursement arrangements (HRAs).** HRAs are an alternative to "traditional" group health plans that allow employers to provide defined pre-tax reimbursements to employees for qualified medical expenses, including monthly premiums. In response to questions and confusion regarding policy, the 2022 payment notice clarifies that issuers of individual market QHPs must accept premium payments made by or on behalf of an enrollee in connection with an individual coverage health reimbursement arrangement (individual coverage HRA) or qualified small employer health reimbursement arrangement (QSEHRA).
- **Greater clarity on building plans that lack a traditional provider network.** Some insurance plans do not use a provider network, meaning they do not vary benefits based on whether enrollees receive services from an "in-network" or "out-of-network" provider. To address lingering confusion regarding regulatory requirements that might limit plan innovations, the 2022 payment notice clarifies that, to have such plans certified as QHPs, issuers of these plans need not pursue compliance with network adequacy requirements applicable to QHPs, since their benefits do not vary based on a provider's network status.

To view the final rule, click here: https://www.federalregister.gov/documents/2021/01/19/2021-01175/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2022

For a fact sheet on this final rule, please visit: https://www.cms.gov/newsroom/fact-

For a fact sheet on this final rule, please visit: https://www.cms.gov/newsroom/fact-sheets/notice-benefit-and-payment-parameters-2022-final-rule-fact-sheet

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
200 Independence Avenue, SW
Washington, DC 20201

FACT SHEET

January 14, 2021

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Notice of Benefit and Payment Parameters for 2022 Final Rule Fact Sheet

The Notice of Benefit and Payment Parameters for 2022 final rule finalizes some of the standards included in the proposed rule for states, Exchanges, and issuers in the individual and small group markets. These changes further the Administration's goals of lowering premiums, enhancing the consumer experience, and reducing regulatory burden. CMS anticipates issuing further rulemaking to address the Notice of Benefit and Payment Parameters for 2022 proposals that were included in the proposed Notice of Benefit and Payment Parameters for 2022 but were not included in this final rule.

Lowering Premiums

FFE and SBE-FP User Fees

For the 2022 benefit year, HHS is finalizing a user fee rate of 2.25 percent of premiums for issuers offering plans through a Federally-facilitated Exchange (FFE), and a user fee rate of 1.75 percent of premiums for issuers offering plans through State-based Exchanges on the Federal Platform (SBE-FP). These rates reflect a 0.75 percentage point decrease from the FFE and SBE-FP user fee rates HHS finalized for the 2021 benefit year. These rate decreases reflect cost-saving measures implemented over the last several years to reduce user fee burden on consumers and create downward pressure on premiums.

Enhancing the Consumer Experience

Establishment of the Exchange Direct Enrollment Option

HHS is finalizing the proposal to establish in regulation a new option by which a State Exchange, SBE-FP or FFE state may facilitate enrollment of qualified individuals into individual market qualified health plans (QHPs) primarily through approved private-sector, direct enrollment (DE) entities (such as QHP issuers and web brokers). Under this new "Exchange Direct Enrollment option" (DE option), instead of a single, Exchange enrollment website, an SBE, SBE-FP or FFE state that is approved by HHS to implement the DE option will approve DE entities to operate private-sector websites through which consumers can apply for and enroll

in QHP coverage offered through the Exchange, as well as receive a determination of eligibility for QHP coverage, advance premium tax credit (APTC) and cost-sharing reductions (CSRs) from the Exchange (if otherwise eligible).

Under the DE option, the Exchange will remain responsible for building and/or maintaining back-end eligibility and enrollment system functionality to which approved DE entities' consumer-facing websites will connect, providing standardized comparative QHP information, making eligibility determinations, and meeting all other applicable Exchange statutory and regulatory requirements. For SBE-FP and FFE states that are approved to implement the DE option, HealthCare.gov will continue to provide the same standardized comparative QHP information available today to assist consumers shopping for coverage. State Exchanges approved to implement the DE option must have at least one DE partner that can display and allow for enrollment in all QHPs available in the state, as well as meet other critical federal requirements for HHS approval to participate in the FFE DE program. State Exchanges may elect this option beginning with the 2022 plan year, and FFE and SBE-FP states may elect this option beginning with the 2023 plan year. For an FFE or SBE-FP state that elects and is approved by HHS to implement the DE option for the 2023 plan year, HHS will collect FFE-DE or SBE-FP-DE user fees from issuers participating in the Exchange at the rate of 1.5 percent of premiums charged. Additional programmatic guardrails and operational parameters may be expanded upon and addressed in more detail in future rule making, particularly those related to the consumer experience and ongoing oversight.

Individual Coverage Health Reimbursement Arrangements and Qualified Small Employer Health Reimbursement Arrangements

HHS is finalizing a proposal that will require individual market QHP issuers to accept payments made on behalf of an enrollee from an individual coverage health reimbursement arrangement (individual coverage HRA) or qualified small employer health reimbursement arrangement (QSEHRA) when such payments are made using any of the payment methods that QHP issuers are required to accept under existing rules. The finalized rule includes changes to the regulatory text to specify that, in addition to accepting direct payments from an individual coverage HRA or QSEHRA, QHP issuers must also accept premium payments that are made directly by enrollees who are enrolled in an individual coverage HRA or QSEHRA, and clarify that QHP issuers are required to accept payments from individual coverage HRAs or QSEHRAs only when such payments are made using a method that the QHP issuer is already required to accept.

Reducing Regulatory Burden

Section 1332 Application, Monitoring and Compliance, and Periodic Evaluations

HHS and the Department of the Treasury (collectively, the Departments) are finalizing a proposal, with modifications in response to comments, to codify many of the policies and interpretations outlined in the 2018 "State Relief and Empowerment Waivers" guidance (83 FR 53575) into section 1332 regulations.

These regulations govern section 1332 waiver application procedures, monitoring and compliance, and periodic evaluation requirements. The Departments believe this policy will give

states greater certainty regarding how the Departments will apply section 1332's statutory guardrails when determining whether a state's waiver proposal can receive and maintain approval. It will also mitigate risk that substantial state taxpayer funds and other state resources will be spent preparing and submitting incomplete waiver applications or proposals that are not approvable.

Network Adequacy

HHS is finalizing a revision to the QHP network adequacy regulation clarifying that a QHP that does not vary benefits based on whether a covered service is furnished by a provider with whom the QHP has a network participation agreement is not required to comply with the network adequacy standards to be certified as a QHP. This clarification that QHP network adequacy requirements do not apply to indemnity plans makes explicit what issuers commonly understood already. Thus, finalization of this clarification will not have a substantive impact on QHP certification requirements for these plans.

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CCIIO DATA BRIEF SERIES

Impact of Enhanced Direct Enrollment During the Open Enrollment Period for 2021 Coverage

JANUARY 2021

The successful full-scale implementation of Enhanced Direct Enrollment (EDE) over the past two years has yielded outstanding results for the Federally-facilitated Marketplace. When the first two partners went live in December 2018, EDE opened a new pathway for consumers to enroll in a qualified health plan (QHP) directly through an approved QHP issuer or web-broker website without the need to be redirected to HealthCare.gov. During the recently ended Open Enrollment Period (OEP) for 2021 coverage (2021 OEP), the EDE pathway more than doubled the number of consumers who selected a plan from the prior OEP—increasing from approximately 521,000 to 1,130,000 plan selections. In addition to this boost in plan selections, increased utilization of the EDE pathway led to a number of other positive trends. In particular, compared to non-DE enrollment channels (the HealthCare.gov website and call center), the EDE pathway attracted a higher proportion of new consumers and increased the percentage of returning consumers who made active plan selections during the 2021 OEP as compared to the 2020 OEP.

BACKGROUND

Direct Enrollment (DE) has been a consumer shopping option in the Federally-facilitated Marketplace (FFM) since the initial 2014 OEP.[1] Through DE, a consumer can use a third party site that belongs to a DE partner (either a QHP issuer or a web-broker) to shop for and select a QHP without using HealthCare.gov to facilitate that plan selection. Before enrolling, the FFM must determine the consumer's eligibility for Exchange coverage. Upon request, the FFM will also determine the consumer's eligibility for financial assistance.

The past few years have seen a transformation in the eligibility determination process for DE. Originally, a consumer would start on a DE partner's site, be redirected to HealthCare.gov to complete an application and receive an eligibility determination, and then be redirected back to the partner's site to select a QHP and enroll. The so-called "double redirect" process characteristic of the original version of DE, which we refer to as Classic DE, still exists. EDE offers a more streamlined pathway to enroll. EDE leverages information exchange standards known as application programming interfaces (APIs), which allow an EDE partner to create their own user-facing application that aligns with the FFM single streamlined application and accesses the FFM services created for that streamlined application. Through this connection to eligibility services, EDE partners obtain an eligibility determination from the FFM for the consumer without the cumbersome process of redirecting the consumer to and from HealthCare.gov. Using the EDE pathway, consumers and those assisting them can now enjoy a seamless user experience by avoiding the double redirect for a smoother enrollment process.

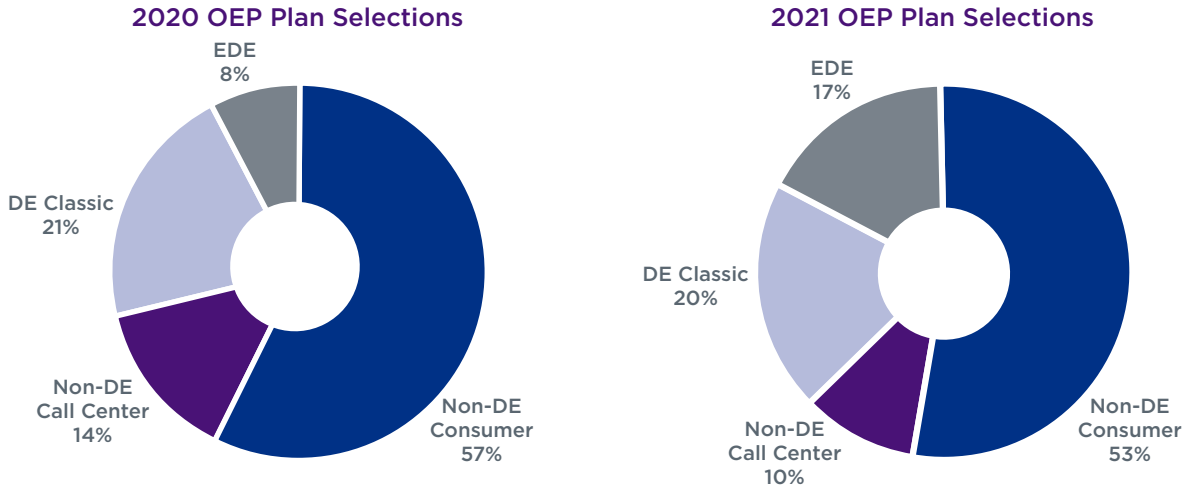
[1] When we use the term Federally-facilitated Marketplace (FFM) in this briefing paper, we are including State-based Marketplaces on the Federal Platforms (SBE-FPs) which use the exact same technology and pathways.

Implementation of EDE came with stricter requirements than had previously existed for Classic DE, principally because the EDE process allowed qualified websites to obtain the eligibility determinations through direct access to FFM eligibility services. Prospective EDE entities need to demonstrate that their websites can ask the eligibility questions in a manner that achieves reliable responses, correctly display Federal eligibility determinations to consumers, and comply with applicable QHP plan display requirements. EDE entities also need to demonstrate compliance with stringent privacy and security standards. Moreover, their sites are subject to ongoing compliance reviews. CMS also began enforcing many of the same website review requirements for entities using Classic DE concurrent with EDE implementation, as well as requiring compliance with applicable privacy and security standards.

ENHANCED DIRECT ENROLLMENT PATHWAY SAW DRAMATICALLY INCREASED USE DURING 2021 OEP

DE (including both Classic DE and EDE) saw dramatically greater utilization during the 2021 OEP, increasing from 29 percent of active 2020 plan selections to 37 percent for 2021 (Figure 1). The entire increase is attributable to the fact that use of the EDE pathway more than doubled, representing 17 percent of active 2021 plan selections, up from 8 percent in 2020. This increase in the percentage of enrollments through DE has occurred at the same time the number of EDE partners has grown. EDE more than quadrupled the number of participating private sector entities in the EDE program from 9 in 2019 (2 primary partners and 7 upstream issuers leveraging those platforms) to 43 in 2021 (10 primary partners and 33 upstream issuers leveraging those platforms).

FIGURE 1
OEP Plan Selections by Channel / 2020 vs. 2021 OEPs



Enhanced Direct Enrollment is a Driving Force in New Consumer Plan Selections

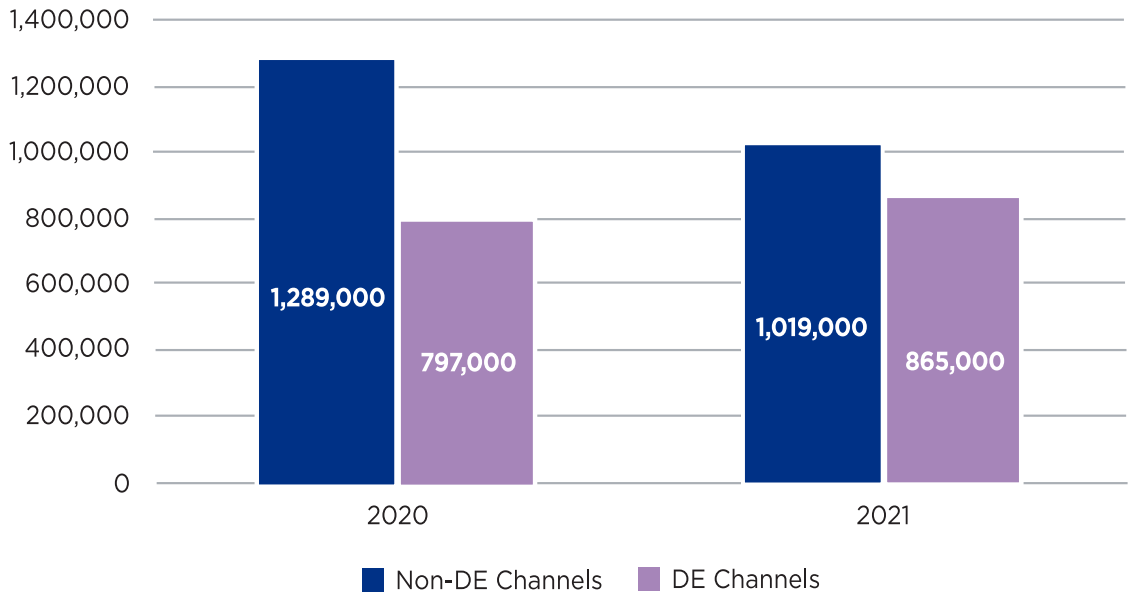
As was the case during the 2020 OEP, the DE pathways continue to be the source of a high percentage of new consumer plan selections on the FFM. Since individual-market health insurance coverage provides transitory coverage for many consumers, each year the FFM needs to enroll nearly 2 million new consumers[2] in coverage to sustain its size, and the DE pathways are increasingly helping to achieve that threshold. Continuing the increase in new consumers using the DE pathways seen between the 2019 and 2020 OEPs, the number of new consumer plan selections using the DE pathways increased between the 2020 and 2021 OEPs by 9 percent[3] to 865,000, as

[2] During the past three OEPs (2019-2021), the FFM has seen 8.4 million, 8.3 million, and 8.3 million plan selections, respectively, maintaining a relatively consistent level of plan selections. In those same years, the FFM reached those numbers with 2.0 million, 2.1 million, and 1.9 million new consumers making those selections, respectively. See https://www.cms.gov/newsroom/fact-sheets/final-weekly-enrollment-snapshot-2019-enrollment-period, https://www.cms.gov/newsroom/fact-sheets/2020-federal-health-insurance-exchange-enrollment-period-final-weekly-enrollment-snapshot, and https://www.cms.gov/newsroom/fact-sheets/2021-federal-health-insurance-exchange-weekly-enrollment-snapshot-final-snapshot.

[3] All comparisons with 2020 plan selections include the states of New Jersey and Pennsylvania in the 2020 data. Those two states, representing 7% of total FFM enrollment, were no longer on the FFM platform in 2021, leading to an expectation of lower numbers of plan selections in 2021.

shown in Figure 2. EDE was the driving force behind this increase, with an 87 percent increase in the number of new consumer plan selections during the 2021 OEP as compared with last year. New consumer plan selections through non-DE channels dropped by about 21 percent during the 2021 OEP as compared with 2020. As a result, the DE pathways represented 46 percent of new consumer enrollments, up from 38 percent last year.

FIGURE 2
New Consumer Plan Selections by Channel / 2020 vs. 2021 OEPs



Enhanced Direct Enrollment Increases Rate of Active Plan Selections among Returning Enrollees

The DE pathways are also driving more returning consumers to make active plan selections. An active plan selection ensures that the FFM has the consumer's most current income information when calculating advance premium tax credit eligibility. Active plan selections also make it more likely that the consumer ends up selecting a plan that best meets their needs—taking into account the latest premiums, benefit structures, networks, and formularies—and ultimately remains enrolled.

In the 2021 OEP, DE experienced a 38 percent increase in the number of active plan selections by returning consumers as compared to last year, as shown in Figure 3. While Classic DE had a minor increase of 2 percent, most of the increase in the number of active plan selections by returning consumers was again driven by EDE, which jumped by over 140 percent. The overall number of returning consumers making active plan selections through both of the DE pathways increased by 425,000 during the 2021 OEP. This increase builds on last year's OEP, in which the DE pathways brought in nearly 800,000 new consumers, mainly through agents and brokers. Those new consumers became part of the agents and brokers' client base, increasing the number of consumers with whom they had a relationship and who they could directly contact to renew in coverage.

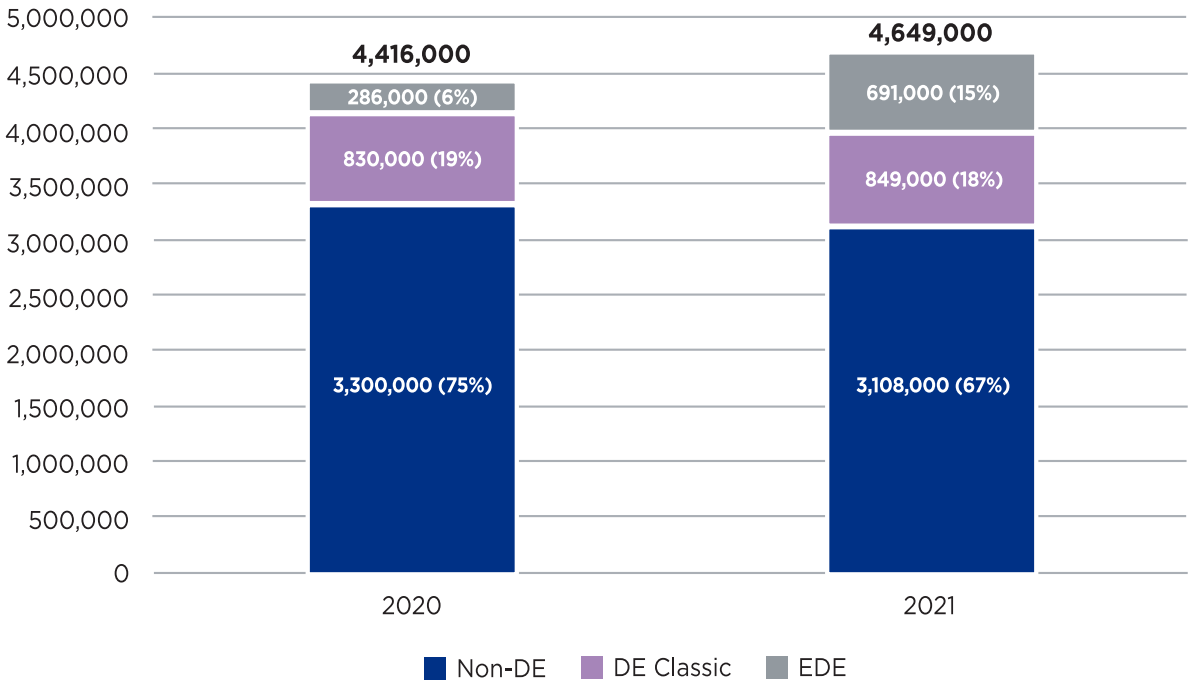
Meanwhile, returning consumers making active plan selections through non-DE channels declined by 6 percent, or about 192,000 consumers. The net effect of all of this activity was a slight increase in the percent of returning consumers making active plan selections, increasing from 71 percent during the 2020 OEP to 73 percent during the 2021 OEP.

Direct Enrollment Pathways Have More Consistency in Consumer Plan Selection Patterns

Through the years that CMS has operated 45-day OEPs (2018-2021), a distinct pattern has become apparent for consumers who come directly to HealthCare.gov to select a plan. The first day of the OEP, and first week as a whole, have higher numbers of plan selections than average. The average daily plan selection activity wanes with each passing week in November, until Thanksgiving week when it predictably bottoms out. Plan selections recover the week following Thanksgiving and continue to increase up through the end of the OEP (December 15), with the final days seeing a tremendous increase in activity. As indicated in Figure 4, the 2021 OEP demonstrated the typical pattern of consumer traffic direct to the HealthCare.gov website.

Using the first five weeks[4] to establish the average prior to the predictable surge of consumers in the last 10 days of the OEP, consumer activity dropped for three weeks (deviating around the average), dropped dramatically Thanksgiving week and rose the week thereafter. As compared to the first five-week average during the 2021 OEP, the sixth week showed a 72 percent increase in daily plan selections and the final three days showed a 434 percent jump, the annual "deadline surge."

FIGURE 3
Active Returning Consumer Plan Selections by Channel / 2020 vs. 2021 OEPs

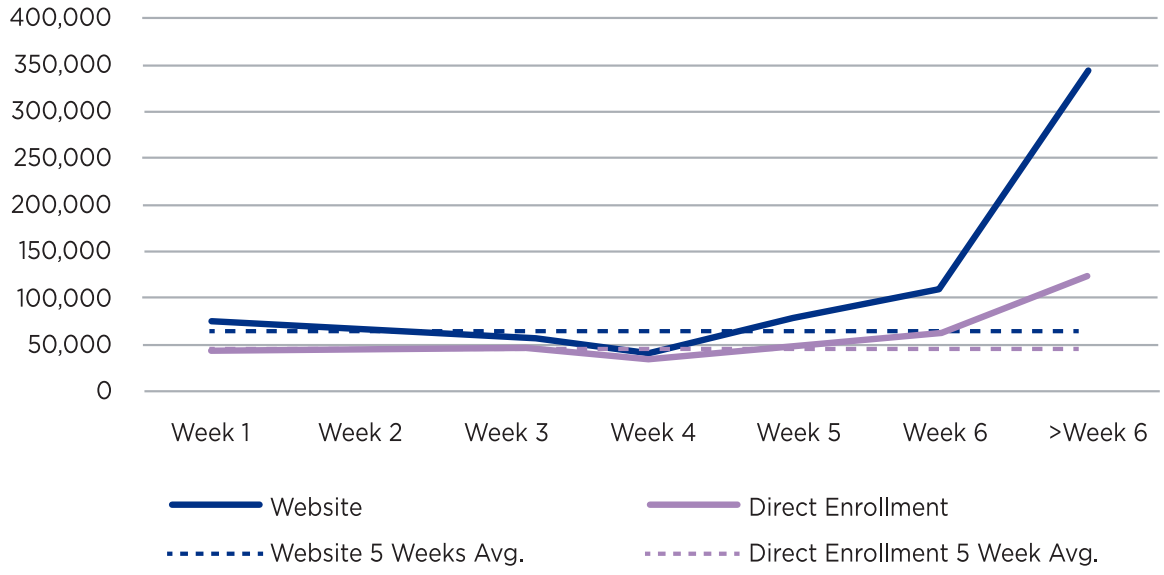


The DE pathways show a much more consistent level of activity throughout the OEP as compared with consumers coming to HealthCare.gov, with daily plan selection levels remaining right around the average for the first five weeks. The DE pathways see a deadline surge towards the end of the OEP, but not nearly as pronounced as HealthCare.gov traffic. Compared to the first five-week average, the daily DE plan selection increased by 42 percent in the sixth week and by 177 percent in the last three days of the OEP. The overall smoother pattern and more moderate deadline surge likely stems from the preponderance of agents and brokers using the DE pathways. Agents and brokers often schedule time with returning members to renew their coverage and need to work throughout the OEP to reach all of their returning consumers. In addition, since agents and brokers are a finite human resource, they need to spread the work out, as there is a limit to how many consumers they can serve in the closing days of open enrollment.

The increased use of the DE pathways and corresponding decrease in plan selections made using non-DE channels (e.g., Healthcare.gov and the FFM call center) appears to have incrementally shifted plan selections to earlier in the OEP. This year, the first five weeks of the OEP had 186,000 more plan selections than last year, while the final 10 days of the OEP had 155,000 fewer plan selections (Figure 5). The DE pathways also yielded 865,000 new consumers this year, leading to an expectation of even greater numbers of returning consumers through the DE pathways next year.

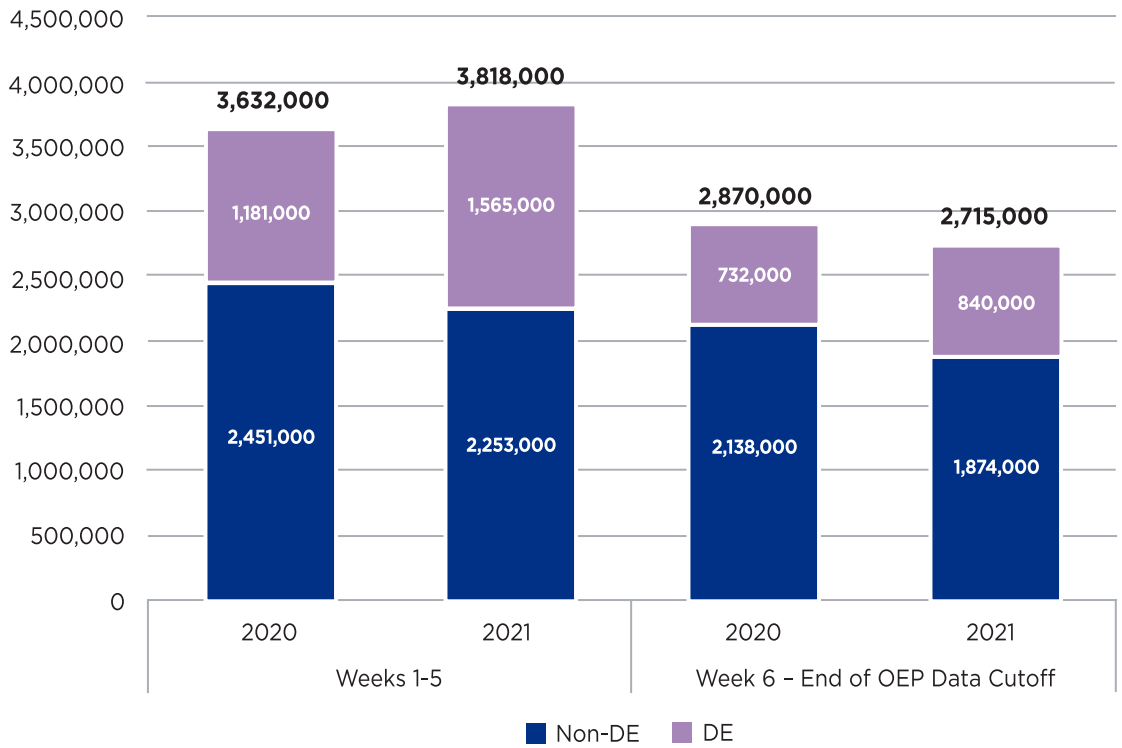
[4]The weeks shown in Figures 4 and 5 (and described in the text) represent seven-day periods, not the weeks as presented in the OEP Snapshots. Therefore, Week 1 is November 1-7, Week 2 November 8-14, etc. Use of full weeks allows more like-to-like comparison, since the Snapshots represent different time periods between 2020 and 2021.

FIGURE 4
Average Daily Plan Selections by Channel / 2021 OEP



Therefore, we expect that this pattern could continue next year, further reducing the number of consumers in the deadline surge and improving the overall experience for consumers. This also means more consumers who receive help through an agent or broker may make their plan selection decisions well before the pressure to choose by the OEP deadline hits. Both of these have positive connotations for the health and growth of FFM enrollment.

FIGURE 5
Plan Selections by Week and Channel / 2020 vs. 2021 OEPs



You can read more about EDE and the third-party entities CMS has approved to use the EDE pathway at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/EDE-ApprovedPartners.

The JAMA Forum

Trade-offs in Public Health Insurance Design

Katherine Baicker, PhD

The importance of access to health care and the financial protections that insurance should provide have never been more salient, and the potential consequences of the costs and gaps within the patchwork system in the US have never been more dire. Would the US population be better off with a simple, single-payer, uniform Medicare-for-all type of insurance plan?

Trade-offs abound in policy decisions about health insurance. Although the advantages of moving to such a single-payer plan might be appealing, there are large hidden costs that must be considered.

First, having a single health insurance plan to cover the heterogeneous US population can actually make people worse off than tailoring the generosity of benefits to different people's needs and preferences. In work I carried out with Mark Shepard, PhD, now at the Kennedy School at Harvard University, and Jonathan Skinner, PhD, at Dartmouth College, we highlight that the costs of having a uniform public insurance benefit have increased dramatically since Medicare's advent in 1965.

One reason for the sharp increase in the costs of having a uniform public insurance benefit is the dramatic advances in health care within the last half century, with many more intensive—and costly—treatments now available. Providing all the care that might possibly be available is a much more expensive proposition now, necessitating forgoing many other things. A second reason is the substantial growth of income inequality. A person with a high income might be willing to devote resources to expensive care of only minimal health benefit, whereas a person with a lower income may need to devote those same resources to housing or education. A third reason is that, as tax rates have risen, the economic cost of raising funds to cover public insurance programs has become much larger.

All of this means that providing the same public insurance plan to everyone would leave segments of the population worse off. This could be higher-income groups, if the public benefit is limited and they are prohibited from going around it; or lower-income groups, if the benefit is comprehensive and too few resources are left to be devoted elsewhere. An alternative that might be better for everyone would be a basic public health plan available to all coupled with increased spending on other social insurance programs for lower-income groups, with the option to augment those benefits with privately purchased wraparound plans—more like the Medicaid-for-all who want it proposal.

A second factor in evaluating the costs and benefits of having a single plan is the trade-offs that are inherent to insurance plan design. Different people value different features in their health insurance, even if the overall generosity of the plan is held constant. Of course, most would prefer lower costs and broader coverage, all else being equal. Although most want the same care but at a lower price, lower cost sharing means higher premiums, whereas narrower networks can lower premiums.

Amitabh Chandra, PhD, at the Kennedy School and the Business School at Harvard University and I explored the answers given by a nationally representative survey sample about what features in a health insurance plan were most important to those surveyed, focusing on the trade-offs among elements such as lower copayments, more expansive networks, lower premiums, and more comprehensive coverage. People were remarkably divided in their preferences about those dimensions, and given the option, they would make different choices about their insurance coverage.

The impetus for a single-payer plan is often not only the hope of reducing costs but also the goal of expanding coverage. The same survey suggests that altruistic concern for other individuals' access to care, encouragingly, cuts across the political aisle. Faith in whether the government or the private sector is best able to effectively provide that care is much more sharply divided.

Another potential drawback of having a single plan is that competition among plans has the potential to drive down costs and accelerate innovation. This requires true competition within the insurer market, as well as among clinicians, hospitals, and

other health care facilities, which is not the case in many parts of the country. There is genuine debate to be had about the potential for the introduction of a public option to increase choice and competition to promote higher value.

The costs of a single, expansive public program point to the potential benefits of giving enrollees a choice among insurance options—free or heavily subsidized for lower-income populations—to expand coverage while allowing people to make choices that reflect their priorities and drive value. There is an example along these lines in the Medicare Advantage system already in place, and most patients enrolled in Medicaid receive their insurance through privately managed plans.

None of this is meant to say that the current system is serving the US population well now. Individuals are paying more and getting less than they should—and this is particularly true for vulnerable populations. Instead, acknowledging the societal value of expanding coverage and increasing affordability, as well as the unavoidable tradeoffs involved in the design of public programs, would move the country toward implementing a fiscally sustainable, high-value public insurance safety net. ■

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February 25, 2021

House Bill Gives States Incentive to Quickly Expand Medicaid, Cover Millions of Uninsured

By Jesse Cross-Call

A provision in the House economic relief bill would give the 14 states that haven't yet implemented Medicaid expansion under the Affordable Care Act (ACA) a strong new financial incentive to do so.[1] The COVID-19 pandemic and recession have made access to health care — including Medicaid — even more critical, and more than 4 million uninsured people in the states that haven't expanded could gain coverage if all remaining states acted.

States that have expanded Medicaid have dramatically lowered their uninsured rates; the people gaining coverage are healthier and more financially secure as a result; and expansion has reduced long-standing racial disparities in health outcomes, coverage, and access to care. It also has produced net savings for many states. Not only does the federal government pay most of the cost of expansion coverage, but expansion produces offsetting state savings, such as reducing spending on uncompensated care and increasing revenue from the taxes that some states impose on health plans and providers.

Despite the evidence of expansion's benefit to people and state budgets, some state officials in non-expansion states still claim that their state can't afford the modest amount of money a state must contribute.[2] Under the provision in the House bill, states that newly expand Medicaid would receive a 5-pecentage-point increase in their federal medical assistance percentage (or FMAP) for two years. The additional federal dollars from this increase would *exceed the full state cost of covering the expansion group* in each of the holdout states.

If enacted, the House provision should settle the argument about whether a state can afford expansion and push the remaining states to adopt expansion quickly.

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[1] Tara Straw *et al.*, "Health Provisions in House Relief Bill Would Improve Access to Health Coverage During COVID Crisis," Center on Budget and Policy Priorities, updated February 19, 2021, https://www.cbpp.org/research/health/health-provisions-in-house-relief-bill-would-improve-access-to-health-coverage.

[2] See, for example, Emily Wagster Pettus, "Mississippi Senate rejects proposals to expand Medicaid. Here's what lawmakers said," *Clarion Ledger*, February 10, 2021, https://www.clarionledger.com/story/news/politics/2021/02/10/medicaid-expansion-mississippi-proposals-rejected/4466402001/.

Provision Would Make Medicaid Expansion Even Better Deal for States

Under the ACA, the federal government pays 90 percent of the cost of the people enrolled in expansion coverage. By comparison, the FMAP for other Medicaid enrollees varies between 50 and 78 percent, depending on the state.

State and independent analyses, including in states such as Arkansas, Kentucky, Louisiana, Michigan, Montana, and Virginia, have consistently showed expansion produced net savings for many states.[3] That's because, in addition to the generous FMAP, expansion allows states to spend less on programs related to the uninsured (such as uncompensated care) and collect more revenue from taxes on the managed care plans through which many Medicaid beneficiaries get their coverage. Indeed, expansion states saw "no significant changes in spending from state revenues associated with Medicaid expansion" compared to non-expansion states, according to a comprehensive analysis of state budget data in the *New England Journal of Medicine*. The analysis found "no evidence that Medicaid expansion forced states to cut back on spending on other priorities."[4]

The House provision would make this deal even better for states. Newly expanding states would receive a 5-percentage-point increase in their FMAP for all *non*-expansion enrollees, who account for most of a state's Medicaid enrollees and costs. The increase would begin the first day of the quarter that expansion begins and last for two years. If, for example, a state decided to expand and began coverage on July 1, 2021, the state would get the higher FMAP through June 2023. (See Appendix Table 1 for estimates of additional federal funds by state.)

This increase would come on top of the 6.2-percentage-point FMAP increase that all states will receive for the duration of the public health emergency under last year's Families First Act, which will provide $86 billion in additional federal Medicaid dollars in 2020 and 2021.[5] (The Biden Administration has indicated it will continue the public health emergency at least through 2021.)

Adopting Medicaid Expansion Would Deliver Health Coverage to Millions, Reduce Racial Disparities in Health

More than 4 million uninsured people could gain Medicaid coverage if the remaining states expanded.[6] In addition to rapid gains in health coverage, taking up the expansion would help the states:

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[3] 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/research/health/medicaid-expansion-continues-to-benefit-state-budgets-contrary-to-critics-claims.

[4] 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*, June 11, 2020, https://www.nejm.org/doi/full/10.1056/NEJMp2007124.

[5] Jennifer Sullivan, "States to Get Enhanced Medicaid Funding Through 2021," Center on Budget and Policy Priorities, February 1, 2021, https://www.cbpp.org/blog/states-to-get-enhanced-medicaid-funding-through-2021.

[6] Rachel Garfield, Kendal Orgera, and Anthony Damico, "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid," Kaiser Family Foundation, January 21, 2021, https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

- **Bring relief to front-line workers and others most at risk during the pandemic and recession.** Hundreds of thousands of people in the holdout states who could gain Medicaid coverage are at elevated risk of contracting, being hospitalized for, or dying from COVID-19. They include 640,000 people working in essential and front-line jobs such as grocery store workers and home health aides, 500,000 people with disabilities, and 926,000 people aged 50-64.[7] People with low incomes have higher rates of asthma, heart disease, and other health conditions that raise their risk of becoming seriously ill or dying from COVID-19; expansion can connect them with coverage and help them access needed care.
- **Reduce long-standing racial disparities in coverage and access to care.** Eleven of the 14 non-expansion states are in the South, and 60 percent of those who would gain coverage are people of color,[8] a group particularly harmed by COVID-19. (See Figure 1.) Black, Hispanic, and Indigenous people are being hospitalized and dying from the virus at the highest rates.[9] While expansion won't eliminate these and other long-standing racial disparities, experience from other states shows that it narrows disparities in coverage and access to care and improves health outcomes among people of color.[10]
- **Bring a significant amount of new federal funding into their state.** Even without the House provision, expansion would provide a financial windfall to states that newly expand: if all the holdout states adopted the expansion, they would bring an additional $30 billion into their economies each year, the Urban Institute projects.[11]

  As explained above, the House provision would provide an infusion of federal funding *on top* of what a state typically receives when it expands Medicaid. Those added federal dollars exceed what a state would receive if the temporary FMAP increase applied to the Medicaid expansion group; they also exceed the full cost of covering the expansion group over the first two years. This two-year window would take states through the period when demand for Medicaid will be highest due to the pandemic and recession. The added funds would free up state funds, allowing states to plug holes in other parts of their budgets caused by the economic crisis and avoid cuts to Medicaid, education, and other public services.

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[7] Jesse Cross-Call and Matt Broaddus, "States That Have Expanded Medicaid Are Better Positioned to Address COVID-19 and Recession," Center on Budget and Policy Priorities, July 14, 2020, https://www.cbpp.org/research/health/states-that-have-expanded-medicaid-are-better-positioned-to-address-covid-19-and.

[8] "Who Could Get Covered Under Medicaid Expansion? State Fact Sheets," Kaiser Family Foundation, February 10, 2021, https://www.kff.org/medicaid/fact-sheet/uninsured-adults-in-states-that-did-not-expand-who-would-become-eligible-for-medicaid-under-expansion/.

[9] "Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity," Centers for Disease Control and Prevention, updated February 18, 2021, https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html.

[10] Jesse Cross-Call, "Medicaid Expansion Has Helped Narrow Racial Disparities in Health Coverage and Access to Care," Center on Budget and Policy Priorities, October 21, 2020, https://www.cbpp.org/research/health/medicaid-expansion-has-helped-narrow-racial-disparities-in-health-coverage-and.

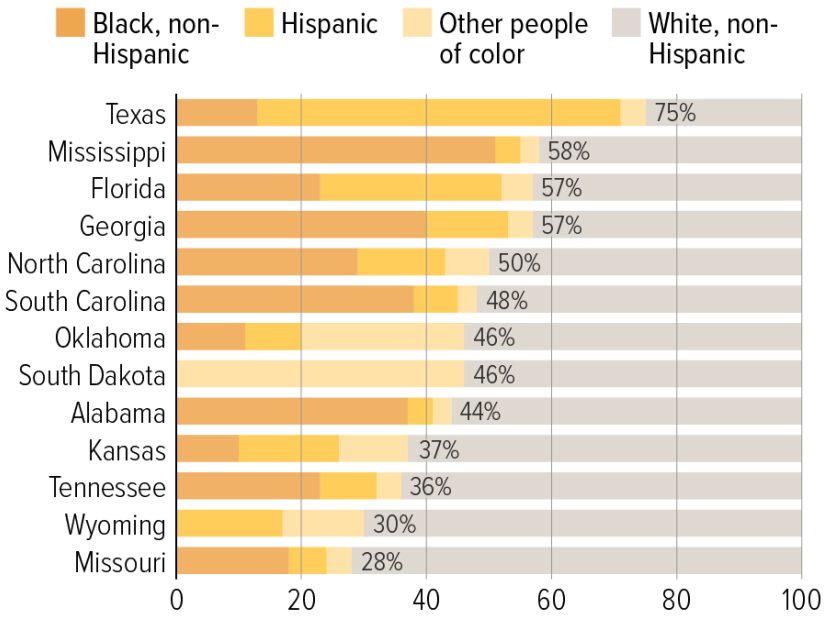
[11] Michael Simpson, "The Implications of Medicaid Expansion in the Remaining States: 2020 Update," Urban Institute, June 9, 2020, https://www.urban.org/research/publication/implications-medicaid-expansion-remaining-states-2020-update.

As existing expansion states have shown, a state that decides to adopt the expansion can implement it quickly and get people enrolled in coverage, especially if the state begins making system changes as soon as it announces its intention to expand. For example, Alaska's expansion took effect just a month and a half after Governor Bill Walker announced the state's intention to expand. In Maine, expansion enrollment began one week after Governor Janet Mills signed an executive order to start implementation. A new expansion state could also utilize some of the strategies that other states have used to enroll people quickly, such as automatically enrolling people from other federal programs like the Supplemental Nutrition Assistance Program (SNAP), enrolling parents based on their children's Medicaid eligibility, and expanding presumptive eligibility.[12]

FIGURE 1

Many Black, Hispanic People Would Benefit From Further State Medicaid Expansions

Share of uninsured people of color who would become eligible for Medicaid



Note: These states and Wisconsin have not implemented the Affordable Care Act's option to expand Medicaid to cover low-income adults. While Wisconsin has not adopted the expansion, it provides coverage to low-income adults with incomes below the poverty line through a waiver. 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.

Source: Kaiser Family Foundation based on 2019 Census Bureau data. Missouri and Oklahoma are based on 2018 Census Bureau data.

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[12] Presumptive eligibility allows hospitals, clinics, and other entities to screen individuals for Medicaid eligibility and temporarily enroll those who appear eligible; individuals can then submit a full Medicaid application for ongoing coverage. Jessica Schubel, "States Can Quickly Expand Medicaid to Provide Coverage and Financial Security to Millions," Center on Budget and Policy Priorities, updated April 30, 2020, https://www.cbpp.org/research/health/states-can-quickly-expand-medicaid-to-provide-coverage-and-financial-security-to.

Conclusion

Given the pandemic and recession, it is more important than ever that the remaining states adopt the Medicaid expansion and extend health coverage to some of their most vulnerable residents. The House provision provides a powerful financial incentive for these states to move quickly. And while some expansion opponents might point to the two-year duration of the added federal funds as a reason not to expand, that concern would be unfounded. The House provision would give states that expand in the coming years a windfall of additional federal dollars in the near term, while the enhanced federal funds for Medicaid expansion itself ensure the program will be sustainable over the longer term.

Appendix

APPENDIX TABLE 1

State Estimates of Increase in Federal Funding From Higher FMAP Under House Proposal

State	Additional federal funding due to FMAP increase (in $millions)
Alabama	940
Florida	3,540
Georgia	1,880
Kansas	330
Mississippi	890
Missouri	1,730
North Carolina	2,430
Oklahoma	860
South Carolina	960
South Dakota	180
Tennessee	1,660
Texas	5,970
Wisconsin*	1,000
Wyoming	120

*The Wisconsin estimate assumes that childless adults currently enrolled in BadgerCare are moved to the Medicaid expansion population, which means they are not included in the House proposal's FMAP increase. Wisconsin would receive the higher, expansion population FMAP for covering this population rather than the base FMAP, but the additional funds Wisconsin would receive from that shift are not shown here.

Note: FMAP = federal medical assistance percentage. Our estimates are based on baseline Medicaid spending figures that account for increased Medicaid expenditures during the COVID-19 pandemic. All estimates are rounded to the nearest $10 million. The listed states have not implemented Medicaid expansion.

Source: CBPP analysis using Urban Institute estimates of Medicaid spending (2020) and Congressional Budget Office (CBO) baseline data.

For fiscal year 2021 through fiscal year 2023 expenditures, we inflate 2020 total traditional (non-expansion group and non-disproportionate-share-hospital) Medicaid spending from the Urban Institute using CBO's baseline estimates. We assume the federal share of all traditional Medicaid spending is increased by 5 percentage points from July 1, 2021 through July 1, 2023 for those states that have yet to implement the Medicaid expansion to low-income adults permitted under the Affordable Care Act.

Expanding Premium Tax Credits to Middle-Income Families Would Reduce the Number of People Uninsured and Increase Marketplace Enrollment

Jessica Banthin and Michael Simpson

February 2021

Most people under age 65, even if they are ineligible for Medicaid or some other public program, are eligible for various tax subsidies such as exclusions, deductions, and credits that reduce the cost of purchasing private health insurance. One group excluded from receiving tax subsidies under current law is people without access to an offer of employer-sponsored insurance (ESI) and whose incomes exceed the eligibility threshold for premium tax credits in the Marketplace.[1] In this brief, we analyze a policy that would expand Marketplace premium tax credits to some people in this group.

Most people with family incomes from 400 to 600 percent of the federal poverty level (FPL) are covered by health insurance through an employer-sponsored plan.[2] The small share of people in this group without access to coverage through an employer generally purchase a plan in the nongroup market, but some are uninsured. In the nongroup market, however, people must pay the full gross premium of any plan they choose because they are ineligible for the premium tax credits that reduce out-of-pocket premiums for people with lower incomes enrolling in coverage through the Marketplaces. Under current law, premium tax credits are available in the Marketplaces only for people with incomes from 100 to 400 percent of FPL who also meet other requirements. A policy that expands premium tax credits by raising the eligibility cutoff from 400 to 600 percent of FPL would lessen the financial burden of high premiums for such families and increase Marketplace enrollment for this group.

A potential drawback of expanding premium tax credit eligibility to those with incomes up to 600 percent of FPL is that some employers might stop offering ESI to their workers. Small employers, in particular, are potentially the most likely to stop offering insurance, because their workforces tend to be lower income than those of large employers, and they are exempt from the employer responsibility

requirements of the Affordable Care Act (ACA). Were employers to stop offering insurance because of an expansion of premium tax credits to higher-income workers, not all of their workers would necessarily enroll in alternative insurance options through the nongroup market or other public programs. If enough employers were to stop offering health insurance coverage to their workers, then the expansion policy might result in an increase in the number of uninsured, the opposite of its intended effect. However, as we detail below, we find such concerns unwarranted.

We find expanding premium tax credits to families with incomes up to 600 percent of FPL would reduce the number of people uninsured while substantially increasing Marketplace-based nongroup insurance coverage. Our results show very few employers currently offering insurance to their workers would find it advantageous to stop offering coverage if tax credits were expanded in this way. Our results are also consistent with evidence that employers have not responded to the ACA by dropping coverage: Ever since the ACA was first proposed, some policymakers have worried the subsidies available in the nongroup market would encourage employers to stop offering ESI to their employees. Contrary to that prediction, however, research shows most employers responded to the ACA by increasing the rates at which they offer insurance to their employees, and total ESI coverage has increased since 2014 (Gangopadhyaya and Garrett 2020; McMorrow, Blumberg, and Holahan 2020).

The policy examined here would make Marketplace coverage more affordable and eliminate the subsidy cliff (the abrupt elimination of premium tax credits) that occurs at the current cutoff threshold of 400 percent of FPL. Under current law, as a family's income increases by $1 above 400 percent of FPL, their premium tax credit falls from as much as several thousand dollars (depending on family size and age of the family members) to $0. Such cliffs can create disincentives for families to take on more work or switch to higher-paying jobs, because the loss of federal subsidies would worsen their net finances. The policy proposed here would shift the subsidy cliff to higher income levels, reducing its size and affecting fewer people.

A Reform to Expand Eligibility for Premium Tax Credits

The policy we analyze would expand the population eligible for premium tax credits under the ACA from individuals and families with incomes from 100 to 400 percent of FPL to those with incomes from 400 to 600 percent of FPL. If the policy were implemented in 2020, premiums for the Marketplace benchmark plan for newly eligible households would have been limited to 9.78 percent of income, matching the percentage-of-income limit applied to enrollees with incomes from 300 to 400 percent of FPL.[3] The subsidy shrinks as incomes rise, so the new subsidies would be smaller than those available to lower-income families. Other eligibility exclusions under current law would still apply: immigrants without documentation, people with an ESI offer deemed affordable to them, and people eligible for Medicaid, the Children's Health Insurance Program, or Medicare would be ineligible.

The policy is intended to extend tax subsidies to one of the few groups of people without widespread access to subsidies under current law and improve affordability for those paying very high

premiums.[4] We expect the policy would modestly increase overall insurance coverage. Though the uninsurance rate is already quite low in this income group, the policy would increase coverage by attracting some people into the Marketplace who have found ACA-compliant insurance unaffordable and chosen to either remain uninsured or purchase non-ACA-compliant insurance, such as short-term, limited-duration (STLD) policies.

ACA-noncompliant plans have lower premiums than ACA-compliant plans, but they typically exclude coverage for preexisting conditions and limit or exclude coverage for certain services, such as prescription drugs, maternity care, mental health treatment, and substance use disorder treatment. Such plans can end up costing families more if they are unlucky enough to experience an illness that requires treatment not covered under the minimal benefits in the STLD plan.

By specifying a cap on the percentage of income households are asked to spend on nongroup insurance premiums, premium tax credits under the ACA are structured so that as incomes rise, the amount of the subsidy falls and the amount paid directly by the enrollee increases. Under the policy analyzed here, Marketplace enrollees with incomes from 400 to 600 percent of FPL would pay more for the same coverage and receive smaller subsidies than similar families with lower incomes.[5] For example, a family of two 45-year-olds with family income just below 400 percent of FPL ($68,960 in 2020) would pay $6,744 annually for the average benchmark plan (table 1). A similar family with income just below 500 percent of FPL ($86,200 in 2020) would receive no subsidy today: under current law they would pay the full premium, or $11,600 annually, for the average benchmark plan. Under a policy of expanded eligibility for tax credits, the same family with income just below 500 percent of FPL would pay $8,430 in premiums annually. A similar family with income just below 600 percent of FPL ($103,440 in 2020) would pay $10,116 annually.

As noted above, under current law, some families face a subsidy cliff at 400 percent of FPL. When their income falls at or just below that level, they are eligible for tax subsidies to purchase insurance, but if they earn just a few dollars more than that threshold, they are ineligible for any subsidy. If the example family above earned a few dollars more than $68,960, they would lose their premium tax credit of $6,744 and be faced with the full cost of coverage—in this case, about $11,600.

By extending the cutoff on premium tax credit eligibility to 600 percent of FPL, the reform would reduce the size of the cliff and the number of people facing it. First, there are fewer families and individuals with incomes near 600 percent of FPL than with incomes near 400 percent of FPL, so fewer people would be potentially exposed to the cliff.[6] Second, the size of the cliff, measured by the value of premium tax credits, shrinks as incomes rise. Fewer families with incomes above 400 percent of FPL would face a full premium exceeding 9.78 percent of their income.[7] In the example above, for instance, a family with income slightly exceeding 400 percent of FPL would lose $4,856 in annual insurance subsidies under current law (table 1). Under the reform, a family with income slightly exceeding 600 percent of FPL would lose only about one-third that amount, $1,484 in annual insurance subsidies.[8]

TABLE 1

Household Premium Contributions for an Illustrative Marketplace Benchmark Plan under Current Law versus under a Reform Extending Eligibility for Premium Tax Credits to 600 Percent of FPL for a Family of Two 45-Year-Olds, by Family Income Relative to FPL, 2020

Income as a percentage of FPL	Income	Income cap under current law	Household premium contribution under current law	Premium assistance credit
Under current law				
150%	$25,860	4.12%	$1,065	$10,535
200%	$34,480	6.49%	$2,238	$9,362
250%	$43,100	8.29%	$3,573	$8,027
300%	$51,720	9.78%	$5,058	$6,542
400%	$68,960	9.78%	$6,744	$4,856
500%	$86,200	NA	$11,600	$0
600%	$103,440	NA	$11,600	$0
Under reform				
500%	$86,200	9.78%	$8,430	$3,170
600%	$103,440	9.78%	$10,116	$1,484

Source: Authors' calculations using data from the Health Insurance Policy Simulation Model, 2020.
Notes: FPL = federal poverty level. NA = not applicable. A full (pretax credit) premium is based on the national average of the second-lowest-priced silver plan premium in each rating region. Income dollar amounts are measured as modified adjusted gross income, consistent with Affordable Care Act eligibility determination rules.

Methods

For this analysis, we use the Health Insurance Policy Simulation Model (HIPSM), a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options (Buettgens and Banthin 2020). The model simulates household and employer decisions and models how changes in one insurance market sometimes cause changes in other markets. HIPSM is based on two years of the American Community Survey, which provides data on a large, representative sample of families. For this analysis, we also incorporate data from the Tax Policy Center to estimate (1) federal and state marginal tax rates and (2) the value of the tax exclusion for ESI.

To model firms' decisions to offer ESI to their workers, we group workers with the same employment characteristics, such as firm size and industry, into synthetic firms. The distribution of synthetic firms mimics the known distribution of employers by size, industry, region, and baseline ESI offer status. We simulate firm decisions about ESI offers in response to policy changes. Based on economic theory and evidence, HIPSM assumes firm decisions will reflect the combined preferences and characteristics of the workers in each firm and their dependents, who might also obtain coverage through the employer. Firm responses are benchmarked to estimates drawn from the literature that show smaller firms are much more elastic in response to changes in costs than are larger firms (Buettgens and Banthin 2020).

Employers' Decisions about Offering Coverage to Employees

Consistent with economic research and the approaches taken by other microsimulation modelers, such as the Congressional Budget Office and the Joint Committee on Taxation, we assume employers aim to attract the best available workers at the lowest possible cost by offering a mix of cash wages and noncash benefits such as vacation time, retirement benefits, and health insurance (CBO 2012). Because health insurance is a popular benefit and most eligible workers take up coverage when it is offered, many employers include health insurance in employee compensation. When employers offer insurance to their workers, they effectively lower their employees' health insurance costs, because it is more costly for employees to purchase coverage independently. Medium and large employers can offer insurance to their workers for a much lower administrative cost than that for similar coverage in the nongroup market (McCue, Hall, and Liu 2013); the administrative cost for ESI is typically less than half the administrative cost of similar coverage in the nongroup market. In addition, when workers receive health insurance through their jobs, the value of this benefit is not counted as income for tax purposes. Employer and, often, employee contributions to health insurance premiums are excluded from income when calculating income and payroll taxes owed.[9] The value of the tax exclusion increases with the income (and marginal tax rate) of the worker. For higher-income workers, this tax subsidy can add up to as much as 40 percent of the cost of premiums, when accounting for both federal and state taxes (CBO 2012; Maag et al. 2012).[10]

In addition to attracting workers, employers have another incentive to offer health insurance to their employees. Under current law, employers with more than 50 workers may be subject to penalties if they do not offer health insurance to their employees that meets minimum standards. The penalties may be imposed if any worker enrolls in Marketplace coverage and receives a premium tax credit. However, the availability of premium tax credits in the Marketplace weighs against a firm's decision to offer health insurance, because the subsidies are limited to families who lack an offer of affordable coverage from an employer and have incomes from 100 to 400 percent of FPL. An employer with a low-wage workforce may decide against offering health insurance so its employees would be eligible for Marketplace subsidies.

Again using an example of a family of two 45-year-olds, table 2 shows ESI subsidies are typically larger than Marketplace subsidies for higher-wage workers, even under a policy that would extend Marketplace subsidy eligibility up to 600 percent of FPL. Table 2 compares the costs of a typical ESI plan with an actuarial value of 85 percent with an average benchmark plan in the Marketplace with an actuarial value of 70 percent. In our example, the ESI premium is $18,000 (including both employer and employee contributions), and expected out-of-pocket costs are about $3,100 for the example family. The Marketplace plan has a premium of $11,600, and expected out-of-pocket costs are $2,700.

TABLE 2

Comparison of Costs of ESI and Marketplace Coverage for a Family of Two 45-Year-Olds under a Reform Extending Eligibility for Premium Tax Credits to 600 Percent of FPL, by Family Income Relative to FPL, 2020

Income as a percentage of FPL	Income	Marginal tax rate	Subsidy for ESI Due to Tax Exclusion (85% AV ESI plan)[a]	Marketplace Subsidy under Reform (70% AV silver plan)[b]
300%	$51,720	34%	$6,100	$6,500
400%	$68,960	34%	$6,100	$4,900
500%	$86,200	35%	$6,300	$3,200
600%	$103,440	41%	$7,300	$1,500

Source: Authors' calculations using data from the Health Insurance Policy Simulation Model and the Tax Policy Center, 2020.
Notes: ESI = employer-sponsored insurance. FPL = federal poverty level. AV = actuarial value. Marginal tax rates include federal income and payroll taxes plus representative state income taxes. State income taxes are from an example state (New Jersey) with a marginal income tax rate slightly above the national average. Some states have no income tax, and others have marginal tax rates greater than those used in this example. The subsidy for ESI due to tax exclusion would be smaller in states with low rates and greater in states with high rates.
[a] The example ESI plan has an $18,000 total annual premium (including both employer and employee contributions) before subsidies.
[b] The example silver plan has an $11,600 annual premium before subsidies.

The ESI plan has a higher premium because it has a higher actuarial value than the Marketplace plan, which translates into lower cost sharing in the form of deductibles and copayments. The typical ESI plan may also have a larger provider network and fewer utilization-management restrictions, and it may pay higher prices to providers than does the Marketplace benchmark plan. Despite the typical ESI plan's higher actuarial value, its expected out-of-pocket costs are also higher than those for a Marketplace plan. These higher out-of-pocket costs reflect higher utilization levels, higher provider payments, and the preferences of workers enrolled in such coverage. Some workers, especially those who are older or in poor health, prefer the more expensive health plan if they can afford it because it provides more coverage and choices. In contrast, younger and healthier workers may not want to pay more for a generous health plan they are less likely to use.

Table 2 also shows that the subsidy for ESI due to the tax exclusion grows from $6,100, if the example family's income equals 300 percent of FPL, to $7,300, if the couple's income equals 600 percent of FPL. As noted above, the ESI tax subsidy grows with income and with the level of the benefit, creating an incentive for employers to offer generous health insurance to their employees. In the example, premium tax credits would decline from $6,500 for a family with income equaling 300 percent of FPL to $1,500 for a family with income equaling 600 percent of FPL. Couples with incomes equaling 300 percent of FPL receive a larger subsidy in the Marketplace, whereas those with incomes equaling 500 and 600 percent of FPL receive substantially larger subsidies for ESI than for Marketplace coverage.

Expanding Marketplace subsidies is unlikely to cause many employers to stop offering coverage to their employees because of (1) the substantial value of the ESI subsidy under the current tax structure

and (2) stable rates of employers offering coverage after ACA implementation. In 2013, the year before implementation of most of the ACA's coverage reforms, about 85 percent of all employers offered health insurance to their employees; offer rates remained steady in the wake of the newly available Marketplace subsidies (Gangopadhyaya and Garrett 2020; McMorrow, Blumberg, and Holahan 2020; Miller, Keenan, and Vistnes 2019). Over 2014 and 2015, some small firms (50 or fewer workers) that had previously offered insurance dropped coverage, while others that had not offered insurance began offering it, resulting in stable patterns of coverage among small firms (Vistnes et al. 2017). Among medium-size firms (51 to 100 workers), about 27 percent added and 3 percent dropped offers of coverage during this period. Ninety-eight percent of large firms (100 or more workers) offered insurance in 2013. Between 2014 and 2018, offer rates increased among both medium and large firms (Miller, Keenan, and Vistnes 2019).

Results

Under a reform that extends eligibility for ACA premium tax credits up to 600 percent of FPL, we find the number of people uninsured would fall by 116,000, a 0.4 percent decrease (table 3). In addition, 48,000 people with noncompliant coverage, such as STLD plans, would gain ACA-compliant coverage by enrolling in Marketplace plans. Some enrollees in noncompliant coverage are attracted to such plans by their lower premiums. Under reform, when many of these enrollees would become newly eligible for premium tax credits that reduce premiums for Marketplace plans, many would therefore switch to the more comprehensive ACA-compliant plans. Together, these effects would move 164,000 people into plans providing minimum essential coverage.

The reform analyzed would also increase the number of people receiving tax credits to purchase nongroup insurance in the Marketplace by 1.0 million, or 11.0 percent. This number would include both those newly enrolling in Marketplace coverage and 720,000 people who were already buying nongroup insurance outside the Marketplace who do not qualify for a tax credit under current law. Total private nongroup coverage, including both subsidized and unsubsidized enrollment, would increase by 313,000 people, or 2.1 percent. We project no meaningful changes in coverage for those with Medicaid, Children's Health Insurance Program, or other public coverage.

Under reform, we estimate 153,000 fewer people would have ESI, a 0.1 percent decrease (table 3). This group includes both those who would newly choose to enroll in nongroup coverage and those who would become uninsured once their firms stop offering health insurance coverage in response to the expanded eligibility for subsidies.[11] More than two-thirds of the people switching out of ESI (about 110,000 people) would become newly eligible for Marketplace subsidies, even though the so-called "firewall," or prohibition against workers with offers of affordable employer coverage from receiving Marketplace subsidies, would remain in place under this policy. People leaving ESI include those whose firms stop offering health coverage and those whose firms still sponsor health insurance, but whose offers are not deemed affordable. Given the new subsidy, these workers and their dependents would find Marketplace insurance more attractive even as their employers continue offering

insurance. The workers who leave ESI because their employers stop offering health insurance are examined more closely in table 4.

TABLE 3

Health Insurance Coverage for the Nonelderly under Current Law and a Reform Extending Eligibility for Premium Tax Credits to 600 Percent of FPL, 2020

	Prepandemic Baseline		Extend ACA Premium Tax Credit Eligibility to 600% of FPL		Change		
	1,000s of people	%	1,000s of people	%	1,000s of people	Percentage point	%
Insured (MEC)	**244,346**	**88.7**	**244,510**	**88.8**	**164**	**0.1**	**0.1**
Employer	151,117	54.9	150,964	54.8	-153	-0.1	-0.1
Private nongroup	15,131	5.5	15,444	5.6	313	0.1	2.1
Subsidized	9,435	3.4	10,469	3.8	1,033	0.4	11.0
Unsubsidized	5,696	2.1	4,976	1.8	-720	-0.3	-12.6
Medicaid/CHIP	69,478	25.2	69,482	25.2	3	0.0	0.0
Other public	8,619	3.1	8,619	3.1	0	0.0	0.0
Uninsured (no MEC)	**31,128**	**11.3**	**30,964**	**11.2**	**-164**	**-0.1**	**-0.5**
Uninsured	28,596	10.4	28,480	10.3	-116	0.0	-0.4
Noncompliant nongroup	2,532	0.9	2,485	0.9	-48	0.0	-1.9
Total	**275,474**	**100.0**	**275,474**	**100.0**	**0**	**0.0**	**0.0**

Source: Authors' calculations using data from the Health Insurance Policy Simulation Model, 2020.
Notes: ACA = Affordable Care Act. FPL = federal poverty level. MEC = minimum essential coverage. CHIP = Children's Health Insurance Program. Results simulated for 2020 on prepandemic baseline.

TABLE 4

Health Insurance Coverage for People in Families Affected by an Employer Dropping Health Insurance, 2020

	Prepandemic Baseline	Extend ACA Premium Tax Credit Eligibility to 600% of FPL	Change	
	1,000s of people	1,000s of people	1,000s of people	%
Insured (MEC)	**106**	**91**	**-15**	**0.1**
Employer	57	17	-41	-0.1
Private nongroup	13	37	23	2.1
Medicaid/CHIP	32	34	3	0.0
Other public	4	4	0	0.0
Uninsured (no MEC)	**17**	**31**	**15**	**-0.5**
Uninsured	15	30	15	-0.4
Noncompliant nongroup	1	1	0	-1.9
Total	**123**	**123**	**0**	**0.0**

Source: Authors' calculations using data from the Health Insurance Policy Simulation Model, 2020.
Notes: FPL = federal poverty level. MEC = minimum essential coverage. CHIP = Children's Health Insurance Program. Results simulated for 2020 on prepandemic baseline.

We estimate firms employing about 50,000 workers would stop offering insurance because of this policy.[12] However, not all of those workers and their dependents are enrolled in an employer plan under current law. In table 4, we provide a closer look at the resulting changes in coverage among those workers and their family members, a group totaling 123,000 people. We estimate less than half of this group (57,000 workers and dependents) are enrolled in ESI under current law. Others are enrolled in nongroup coverage (13,000) and Medicaid (32,000), whereas 15,000 are uninsured (table 4). Also, some families that would lose coverage under the policy would have access to another offer of ESI through a spouse, which we estimate most would take up. Under the policy, we estimate 41,000 people would ultimately lose ESI coverage. Of those losing ESI, 23,000 would move to nongroup coverage and 3,000 would enroll in Medicaid. We expect 15,000 people would become uninsured.

These changes in coverage would increase federal spending by $4.0 billion. Premium tax credit spending would increase by $4.5 billion, or 8 percent, but would be offset somewhat by a $0.5 billion drop in spending on uncompensated care as the number of people uninsured falls. The increase in the federal deficit from the additional spending would also be offset by $0.3 billion in increased federal revenues, because people who lose ESI are expected to receive higher taxable wages in lieu of employer-paid premiums.

Discussion

We find a policy that extends premium tax credits to people with incomes up to 600 percent of FPL would reduce the number of people uninsured by 116,000 and newly provide minimum essential coverage to almost another 50,000 people currently buying lower-value STLD plans. It would also improve affordability of coverage among targeted families without access to affordable employer-sponsored coverage and reduce the subsidy cliff by shifting it to 600 percent FPL and decreasing its size. Expanding eligibility for premium tax credits as described here is a relatively small reform that would cost $4.0 billion in federal spending.

We estimate about 15,000 people would become newly uninsured under this reform, about 6,000 of whom have incomes below 400 percent of FPL. Most of these 15,000 people would be eligible for subsidized coverage in the Marketplace. If this premium tax credit expansion were combined with other reforms, however, that number might be reduced. For example, a reform that increases outreach and enrollment assistance to people eligible for subsidized coverage but uninsured could reduce the number of people becoming uninsured. Also, firms that do not offer ESI might assist employees in signing up for Marketplace coverage or Medicaid, further increasing coverage.

In addition to immediate effects on affordability and coverage, the policy may have longer-term effects that would promote competitiveness and stability in nongroup insurance markets. The number of people receiving premium tax credits through the Marketplace would increase notably by 1.0 million, or more than 10 percent. The larger market size might encourage insurers to newly enter the market, expand their existing participation to new rating areas, or increase plan offerings.

Notes

[1] Self-employed people in this group may benefit from the self-employment tax deduction of health insurance premiums.

[2] For a family of two adults, this FPL represents income between $67,640 and $101,460.

[3] These caps change slightly from year to year. In 2021, the cap is 9.83 percent of income.

[4] A small number of self-employed people take advantage of the deduction for health insurance allowed under current law.

[5] Families are referred to here as being similar if they have the same number of members of the same age and live in the same premium rating region.

[6] According to the Health Insurance Policy Simulation Model, 2.6 million people under age 65 have incomes between 395 and 405 percent of FPL, including 143,000 uninsured people and 131,000 people with nongroup coverage. About 1.3 million people in this age range have incomes between 595 and 605 percent of FPL, including 44,000 uninsured people and 43,000 people with nongroup coverage.

[7] People who might face premiums exceeding 9.78 percent of their income include those who are older, have large families, or live in geographic areas with higher premiums.

[8] Elimination or reduction of the premium tax credit subsidy cliff would reduce disincentives to work for people with incomes near the cliff, but other incentives could offset this change for people in the new subsidy income range. People leaving ESI to take up the nongroup subsidy would see an increase in their effective marginal tax rate as they lose the tax preference for their health premiums.

[9] Employee contributions to Flexible Spending Accounts, Health Savings Accounts, and Health Reimbursement Arrangements are also excluded from income and payroll taxes. See "Reduce Tax Subsidies for Employment-Based Health Insurance," Congressional Budget Office, December 13, 2018, https://www.cbo.gov/budget-options/54798.

[10] This estimate reflects savings after accounting for federal and state income and payroll taxes and uses New Jersey to represent the median state tax rate.

[11] This group also includes a very small number of people who would enroll in Medicaid.

[12] About 95 percent of those firms are estimated to have fewer than 25 employees.

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February 17, 2021

House Relief Package Would Help Millions and Bolster the Economy

By CBPP Staff

The House's emerging economic relief package would provide needed help to tens of millions of people, reduce high levels of hardship, help school districts address student learning loss, and bolster the economy. While some modifications will likely be made as the legislation is finalized, Congress should move quickly to enact a relief package that reflects the priorities in this package, which is modeled on President Biden's American Rescue Plan.

The economy remains weak, the jobs recovery has lost momentum, and there are nearly 10 million fewer jobs than in February of 2020.[1] Black and Latino unemployment is 9.2 percent and 8.6 percent, respectively, well above the white unemployment rate of 5.7 percent — which itself is too high. The economy won't return to its full potential until 2025, the Congressional Budget Office projects; the number of people employed won't return to pre-pandemic levels until 2024; and unemployment won't fall below 4 percent until 2026.[2]

Hardship remains extraordinary; it's particularly acute among Black, Latino, and Indigenous people and immigrants; and households with children also have been particularly hard hit.[3] Nearly 83 million adults (35 percent of all adults) reported between January 20 and February 1 that their household found it somewhat or very difficult to cover usual expenses in the past seven days, and that figure rises to 42 percent for adults living with children. Some 24 million adults (11 percent) said their household sometimes or often didn't have enough to eat, rising to 15 percent among adults in households with children. An estimated 13.2 million adults in rental housing (nearly 20 percent of adult renters) said they were not caught up on rent, rising to 26 percent among adult renters with children. The extent and severity of hunger, eviction, homelessness, and other hardship in the days

[1] Chad Stone, "Jobs Recovery Still Long Way Off, Especially for Low-Wage Workers and Workers of Color," Center on Budget and Policy Priorities, February 5, 2021, https://www.cbpp.org/blog/jobs-recovery-still-long-way-off-especially-for-low-wage-workers-and-workers-of-color.

[2] Joel Friedman, "Budget Resolution Marks Important Step Toward Urgently Needed COVID Relief," Center on Budget and Policy Priorities, February 3, 2021, https://www.cbpp.org/blog/budget-resolution-marks-important-step-toward-urgently-needed-covid-relief.

[3] Center on Budget and Policy Priorities, "Tracking the COVID-19 Recession's Effects on Food, Housing, and Employment Hardships," updated February 11, 2021, https://www.cbpp.org/research/poverty-and-inequality/tracking-the-covid-19-recessions-effects-on-food-housing-and.

ahead will depend on whether policymakers provide robust relief that reaches those in need (and on the pandemic's trajectory and the economy's pace of recovery).

It is critical that policymakers act to reduce high levels of hardship, take the public health steps needed to end the pandemic, and put the nation on the best possible path for a strong and equitable recovery.

The House package includes key provisions to meet these goals, including:

- Expanded and extended unemployment benefits;
- Expansions in the Child Tax Credit and Earned Income Tax Credit;
- Continuation of key food assistance provisions now in place and new investments in WIC;
- Expansions in health coverage;
- Increased housing assistance;
- Fiscal aid for states, territories, tribes, and localities;
- Funding for K-12 schools; and
- Emergency funds to help families facing hardship.

The package includes other provisions as well, including a new round of stimulus payments, public health investments, a minimum wage increase, paid leave provisions, additional child care funding, and aid to businesses. These are not covered in this paper.

Unemployment Benefits

The House package would extend critical unemployment benefits that are helping jobless workers pay their bills and care for their families.[4]

Not only are there now 9.9 million fewer jobs than in February of 2020, but a disproportionate number of job losses over the past year are in industries that pay low wages. (See Figure 1.) Since the steep job losses of last spring, workers of color and those without a bachelor's degree have endured a far slower jobs recovery than white workers and college graduates. The lowest-paying industries accounted for 31 percent of all jobs in February of 2020, but 57 percent of jobs lost since then.

The December relief package reinstated a federal unemployment benefit increase, provided more weeks of benefits so that jobless workers wouldn't lose them while the nation struggled with COVID-19 and its economic fallout, and continued the Pandemic Unemployment Assistance (PUA) program, which expands benefit eligibility to more jobless workers. These provisions are slated to expire in mid-March, and the House package would extend them to the end of August (and increase the federal benefit supplement, from $300 per week to $400). The August cutoff, however, is

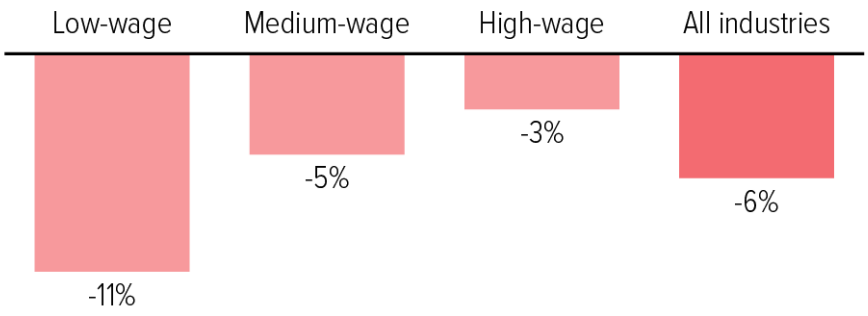
[4] Chad Stone, "COVID Relief Package Includes Important Unemployment Benefit Extensions, But Duration Should Be Extended," Center on Budget and Policy Priorities, February 9, 2021, https://www.cbpp.org/blog/covid-relief-package-includes-important-unemployment-benefit-extensions-but-duration-should-be.

problematic compared to the end-of-September date in President Biden's plan. Unemployment, particularly among workers of color and workers without a college degree, will likely remain elevated in the fall; extending benefits through September better aligns with a time when — unlike August — Congress will be in session and focused on budget matters (with the fiscal year ending on September 30) and thus well positioned to extend benefits if necessary. The August timing makes a benefit lapse, which would hurt families and disrupt states' ability to administer jobless programs, likelier.

FIGURE 1

Job Losses Largest in Low-Wage Industries

Percent change in number of jobs, February 2020 to January 2021



Note: Industries were ranked by average wages in February 2020 and divided into three groups containing roughly the same number of jobs.

Source: CBPP calculations of Bureau of Labor Statistics data

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Tax Credits

The House package would make the full Child Tax Credit available to 27 million children in families with low or no income, increase the size of the Child Tax Credit, and provide an expanded Earned Income Tax Credit (EITC) for far more low-paid adults without minor children at home — driving a historic reduction in child poverty and providing timely income support for millions of people.[5] (See Appendix Tables 1 and 2 for state-by-state data.)

Together, the Child Tax Credit and EITC now lift more children above the poverty line (5.5 million) than any other program. The House package would make the full Child Tax Credit available to children in families with low or no earnings, raise the maximum credit from $2,000 to $3,000 per child and $3,600 for children under age 6, and extend the credit to 17-year-olds. The increase in the maximum amount would begin to phase out for heads of households making $112,500 and married couples making $150,000. The proposal would lift 4.1 million additional children above the poverty line — cutting the number of children in poverty by more than 40 percent — and lift 1.1 million children above half the poverty line (referred to as "deep poverty"). Among the children that the

[5] Chuck Marr *et al.,* "House Ways and Means COVID Relief Bill Includes Critical Expansions of Child Tax Credit and EITC," Center on Budget and Policy Priorities, February 9, 2021, https://www.cbpp.org/research/federal-tax/house-ways-and-means-covid-relief-bill-includes-critical-expansions-of-child.

Child Tax Credit expansion would lift above the poverty line, some 1.2 million are Black, 1.7 million are Latino, 148,000 are Asian American, and 887,000 are white.[6]

The House package also would raise the EITC for low-paid working adults who are not raising children at home and now get only a tiny credit. It would raise the maximum EITC for these "childless adults" from about $530 to about $1,500, raise the income cap for them to qualify from about $16,000 to at least $21,000, and expand eligible childless workers to include younger adults aged 19-24 who aren't full-time students and those 65 and over. That would provide timely income support to over 17 million people who work for low pay, including the 5.8 million childless workers aged 19-65 (excluding full-time students aged 19-23) who are now the lone group that the federal tax code taxes into, or deeper into, poverty.

These expansions would help push against racial disparities. Currently about *half* of all Black and Latino children get only a partial Child Tax Credit or no credit at all because their families' incomes are too low to qualify for the full credit. This design flaw in the current Child Tax Credit comes on top of longstanding employment discrimination, unequal opportunity in education and housing, and other factors that leave more Black and Latino households struggling to make ends meet. Similarly, the current EITC for adults without minor children at home is tiny, leaving low-paid workers, who because of these inequities are disproportionately workers of color, with inadequate wage supplements.

Food Assistance

The House package would extend and expand nutrition assistance to help address today's extraordinarily high levels of hunger and hardship.[7]

The number of households struggling to put enough food on the table spiked last spring due to COVID-19, remained nearly three times its pre-pandemic levels over the summer, and rose even higher in late 2020. Food hardship has disproportionately affected households with children, especially Black and Latino households. Between 7 and 11 million children live in a household in which the children didn't eat enough in the last seven days because they couldn't afford enough food, compared to 1.1 million children in December of 2019. The current figure includes 28 percent of children in Black and Latino households, compared to 10 percent in white households.

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[6] Racial and ethnic categories do not overlap. Figures for each racial group such as Black or Asian American do not include individuals who identify as people of Latino ethnicity. Latino includes all people of Hispanic, Latino, or Spanish origin regardless of race. Figures for children who identify as American Indian or Alaska Native (AIAN) alone are not shown because of concerns about sample size and data reliability and because limiting the figures to a single race and ethnicity has particularly strong implications for the estimated size of the AIAN population. About 180,000 children who identify as AIAN alone or in combination, regardless of Latino ethnicity, would be lifted above the poverty line by the House's Child Tax Credit expansion. Following the mutually exclusive approach used for other racial and ethnic groups, about 70,000 children who identify as AIAN alone, not Latino, would be lifted above the poverty line by the House's Child Tax Credit expansion.

[7] Joseph Llobrera, "COVID Relief Bills Respond to Extraordinarily High Food Hardship," Center on Budget and Policy Priorities, February 9, 2021, https://www.cbpp.org/blog/covid-relief-bills-respond-to-extraordinarily-high-food-hardship; Dottie Rosenbaum *et al.,* "Food Assistance in COVID Relief Bills Would Reduce Hardship, Provide Economic Stimulus," Center on Budget and Policy Priorities, February 10, 2021, https://www.cbpp.org/research/food-assistance/food-assistance-in-covid-relief-bills-would-reduce-hardship-provide.

The House package would extend, through September, a 15 percent increase in SNAP benefits from December's relief package that is slated to expire in June — likely before the economy has recovered and while food insecurity remains high. (See Appendix Table 3 for state-by-state impacts.) It would allow states to continue, through the summer, the Pandemic EBT (P-EBT) program, which provides grocery benefits to replace meals that children miss when they do not attend school or child care in person. Extending this benefit through the summer is important, providing a bridge to help families until school reopens, hopefully fully in-person, in September.

The package also would provide funds to modernize the WIC nutrition program for low-income women, infants, and children, support innovative service delivery, and temporarily raise the amount of fruit and vegetables that participants can get. These steps would improve a critical program that has been proven to boost health and cognitive outcomes for children but served fewer individuals in fiscal year 2020 than the prior year despite the surge in food hardship during the pandemic. And it would add $1 billion to the capped block grants for food assistance that Puerto Rico, American Samoa, and the Northern Mariana Islands receive instead of SNAP, enabling them to better meet their residents' food assistance needs over the next several years.

Health

The House package would make comprehensive health coverage more affordable and accessible for millions of people during the current crisis.[8]

Comprehensive health coverage is important under any circumstances because it improves people's access to care, financial security, and health outcomes. But preserving and extending coverage is even more important now, during COVID-19 and its economic fallout, because it would shield families from financial hardship and support public health efforts, easing people's access to testing, treatment, and vaccines. Those who have low incomes or are uninsured, in particular, have faced unprecedented challenges. The relief measures that policymakers enacted over the last year in response to COVID-19 and its fallout did not extend health coverage or make it more affordable.

To make marketplace coverage more affordable, the House package would eliminate or vastly reduce premiums for many people with low or moderate incomes who enroll in plans through the Affordable Care Act (ACA) marketplaces and would provide new help to people with somewhat higher incomes who face high premiums. (See Figure 2.) This provision would lower premiums for most current marketplace enrollees and expand coverage to 1.3 million people who would otherwise be uninsured.[9] In addition, the bill would improve affordability and decrease the number of uninsured people by:

[8] Sarah Lueck, "Bigger Tax Credits, More Medicaid Expansion Would Make Health Coverage More Accessible and Affordable," Center on Budget and Policy Priorities, February 10, 2021, https://www.cbpp.org/blog/bigger-tax-credits-more-medicaid-expansion-would-make-health-coverage-more-accessible-and; Tara Straw *et al.,* "Health Provisions in House Relief Bill Would Improve Access to Health Coverage During COVID Crisis," Center on Budget and Policy Priorities, February 10, 2021, https://www.cbpp.org/research/health/health-provisions-in-house-relief-bill-would-improve-access-to-health-coverage.

[9] Congressional Budget Office, "Reconciliation Instructions of the House Committee on Ways and Means," Cost Estimate, February 15, 2021, https://www.cbo.gov/system/files/2021-02/hwaysandmeansreconciliation.pdf.

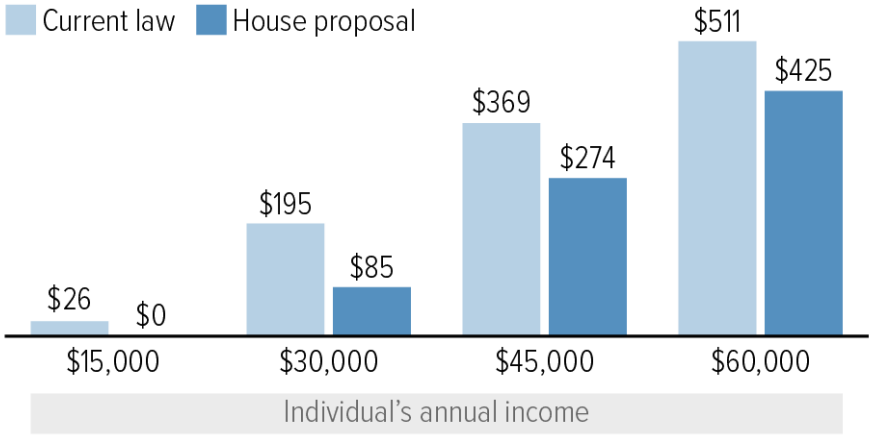
- protecting marketplace enrollees, especially those whose income fluctuated last year, from having to repay large portions of their federal premium tax credits;
- making it easier for those getting unemployment benefits to afford coverage; and
- assisting people who recently lost their job and want to continue their current coverage to afford so-called "COBRA" coverage through September.

In addition, the package would increase financial incentives for the 14 states that have not implemented the ACA's Medicaid expansion to do so, which would provide critical coverage to nearly 4 million uninsured people (if all states adopted the expansion). And it would strengthen Medicaid coverage in other ways — for instance, with higher federal matching funds to help more people with disabilities get services in the community instead of nursing homes, with a new state option to extend Medicaid or Children's Health Insurance Program coverage to 12 months after childbirth for postpartum people, and with letting Medicaid cover health services for the 30 days before people leave jail or prison to improve the coordination of their health services as they prepare to return home.

FIGURE 2

Proposal in House Ways and Means COVID Relief Legislation Would Make Marketplace Coverage More Affordable

Monthly premium for benchmark marketplace coverage for a 45-year-old, based on national average premium



Source:CBPP calculations based on House Ways and Means Committee COVID relief legislation

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Housing

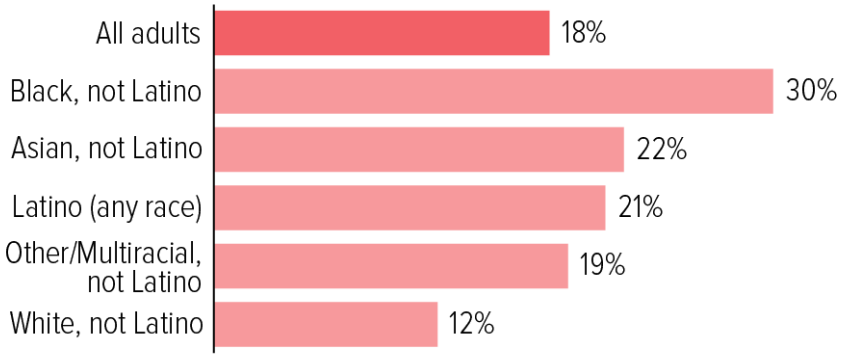
The House package includes critical housing assistance for millions who are struggling to pay rent and avoid eviction, and badly needed funds for communities to address homelessness during the pandemic.[10]

As noted, some 13.2 million adults — nearly 1 in 5 adult renters — report that they are not caught up on their rent, and renters likely already owe tens of billions in back rent and will need more help paying rent in the coming months. (See Figure 3.) Nearly 5 million renters say they have lost employment income and expect to be evicted soon. Struggling renters are disproportionately households with children and people of color, particularly people who are Black or Latino. Communities are struggling to provide safe, non-congregate shelter and housing options to the more than half-million people experiencing homelessness. Evictions and homelessness may exacerbate the spread of COVID-19 and cause severe hardship.

FIGURE 3

Nearly 1 in 5 Renters Not Caught Up on Rent During Pandemic, With Renters of Color Facing Greatest Hardship

Share of adult renters saying their household is not caught up on rent



Note: Other/Multiracial, not Latino = people identifying as American Indian, Alaska Native, Native Hawaiian or Pacific Islander, or more than one race. Chart excludes renters who did not respond to the question.

Source: CBPP analysis of Census Bureau Household Pulse Survey tables for January 20 - February 1, 2021

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The House package provides critical relief to reduce evictions and other housing-related hardship. This relief will supplement $25 billion in rental assistance aid in December's relief package (which will likely help only a fraction of those behind on rent) as well as the Biden Administration's action to extend a Centers for Disease Control and Prevention order prohibiting most evictions through

[10] Douglas Rice and Ann Oliva, "Housing Assistance in House COVID Bill Would Prevent Millions of Evictions, Help People Experiencing Homelessness," Center on Budget and Policy Priorities, February 8, 2021, https://www.cbpp.org/research/housing/housing-assistance-in-house-covid-bill-would-prevent-millions-of-evictions-help.

the end of March. The House package builds upon these efforts by providing $19 billion in emergency rental assistance for low-income renters who have lost income or are experiencing other hardship and risk losing their housing; $5 billion for Housing Choice Vouchers for people recovering from homelessness and for renters at greatest risk of homelessness; $5 billion for homelessness assistance through the HOME Investment Partnerships Program; $750 million in housing aid for tribal nations and Native Hawaiians; $139 million for rural housing assistance; and $100 million for housing counseling services for renters and homeowners. It also provides $10 billion to help homeowners who are experiencing financial hardship due to COVID-19 maintain their mortgage, tax, and utility payments and avoid foreclosure and displacement.

State Fiscal Aid

The House package would provide $350 billion to help states, localities, tribal governments, and territories address their sizable revenue shortfalls and added costs.[11]

State revenue for 2021 is down an estimated 6 percent below pre-pandemic projections, and municipal revenue fell 13 percent (and county revenue by a similar percentage) since COVID-19 hit. States, localities, tribal nations, and territories face $300 billion in total revenue shortfalls through fiscal 2022 (or $225 billion if they spend their $75 billion in reserves), but these estimates don't include a host of pandemic-related state and local costs — fighting COVID-19 (e.g., with more protective equipment, testing, and tracing); providing services during the pandemic (e.g., by training and equipping public employees); and helping people and businesses facing extreme hardship (e.g., through emergency mental health programs and food assistance for families that need it).

Of the $350 billion in aid, states would get $195.3 billion. Each state would receive $500 million plus its share of the remainder based on its share of the nation's jobless workers. Municipalities and counties would get $130.2 billion ($65.1 billion each) — with a municipality's allocations based largely on its population and poverty, and county allocations based on each county's share of the nation's population. Tribal nations would get $20 billion, and territories would get $4.5 billion.

Schools

The House package includes President Biden's proposal for $130 billion in new, flexible funds for school districts over the next three-and-a-half school years — the largest-ever one-time federal investment in K-12 education, but entirely appropriate in light of school funding needs and the impact the pandemic has had on student learning.[12]

Historically, K-12 schooling has been funded overwhelmingly by states and localities; they currently provide 92 percent of funding, with the federal government providing the rest. COVID-19, however, forced states to cut funding and created enormous financial and educational challenges that states and localities will be hard pressed to meet over the next several years without federal

[11] Michael Leachman, "House Budget Bill Provides Needed Fiscal Aid for States, Localities, Tribal Nations, and Territories," Center on Budget and Policy Priorities, February 10, 2021, https://www.cbpp.org/research/state-budget-and-tax/house-budget-bill-provides-needed-fiscal-aid-for-states-localities.

[12] Nicholas Johnson and Victoria Jackson, "House Bill to Implement Biden COVID-Relief Plan Includes Much-Needed K-12 Funding," Center on Budget and Policy Priorities, February 9, 2021, https://www.cbpp.org/research/state-budget-and-tax/house-bill-to-implement-biden-covid-relief-plan-includes-much-needed.

assistance. As noted, states, localities, tribal nations, and territories face a $300 billion revenue shortfall through fiscal 2022 that, if not offset with more federal funding, will mean more school funding cuts. K-12 funding comprises about 26 percent of state budgets and states will find it very hard to fully shield that funding while meeting their balanced-budget requirements. Even before COVID-19, schools endured years of inadequate and inequitable funding. Some 15-20 states were still providing less funding for K-12 schools when the pandemic hit than before the Great Recession of a decade ago in per-pupil, inflation-adjusted terms. When COVID-19 hit, schools were employing 77,000 fewer teachers and other workers while educating 1.5 million more children.

The CARES Act of March provided $13.2 billion for K-12 education and December's package provided another $54 billion, but schools will need far more to pay for distance learning, safe in-person instruction, caring for students' physical and mental health, and, most significantly, making up for learning loss. Schools need to close the "digital divide," so all students and teachers have access to devices and connectivity. They need to safely operate in-person schools, which will require plexiglass shields, hand sanitizer, more custodial staff, and more buses and drivers to maintain social distancing. A quarter of schools have no full- or part-time nurse, and most schools lack counselling support to help students navigate the mental-health challenges of returning to school. Many schools will need to add staff and/or portable classrooms to reduce class size to meet social distancing guidelines.

But beyond the costs of operating remotely and in person, the House bill's funds would enable school districts to make critical investments to address the widespread learning loss that the pandemic and remote learning have caused. Students on average will likely lose nine months of learning by the end of the 2020-21 school year, McKinsey & Company estimates, and students of color may well lose a full year on average. With resources, schools can lengthen school days and the school year and invest in high-quality tutoring to help students — over the course of the next couple of years — recover what they have lost. The costs of addressing all these needs could easily top $100 billion over the next few years, based on estimates from the Learning Policy Institute and McKinsey.[13] Along with the $130 billion, the House package includes "maintenance of equity" provisions that require states to avert funding cuts to schools and school districts with high numbers of poor children.

Emergency Funds

The House package includes a new $1 billion TANF Pandemic Emergency Fund to enable states, tribes, and territories to help families with the lowest incomes cover their additional pandemic-driven expenses and avert eviction and other real hardships.[14]

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[13] Emma Dorn *et al.,* "COVID-19 and Learning Loss — Disparities Grow and Students Need Help," McKinsey & Company, December 8, 2020, https://www.mckinsey.com/industries/public-and-social-sector/our-insights/covid-19-and-learning-loss-disparities-grow-and-students-need-help; Michael Griffith, "What Will It Take to Stabilize Schools in the Time of COVID-19?" Learning Policy Institute, May 7, 2020, https://learningpolicyinstitute.org/blog/what-will-it-take-stabilize-schools-time-covid-19.

[14] LaDonna Pavetti, "Pandemic Emergency Fund Would Help Families With Lowest Incomes," Center on Budget and Policy Priorities, February 10, 2021, https://www.cbpp.org/blog/pandemic-emergency-fund-would-help-families-with-lowest-incomes.

Hardship is particularly high among families with children, raising serious concerns about the long-term consequences for children's health and academic outcomes. Nearly half of all children live in households that are having trouble covering usual expenses, and more than 4 in 10 children in rental housing live in a household that either isn't getting enough to eat or isn't caught up on rent.

States (along with tribes and territories) could use the new fund to provide households with non-recurrent, short-term benefits — that is, benefits that: (1) address a specific crisis or episode of need; (2) don't meet recurring or ongoing needs; and (3) don't extend beyond four months. States could direct funds to the families that most need them, and states need not limit payments to families receiving TANF cash assistance. Indeed, in states in which few families get TANF, states could reach more needy families by targeting a broader set of them (such as SNAP families with children). States also could use the funds, for instance, to help families that don't get emergency housing assistance pay their back rent and avoid eviction, or help families fleeing domestic violence cover their moving costs and initial rental payments.

Appendix

APPENDIX TABLE 1

Estimated Number of Children Who Would Benefit From House Ways and Means Child Tax Credit Expansion, by State

State	Children under 17 left out of the full $2,000 Child Tax Credit who would benefit from expansion	Children under 18 lifted above the poverty line by expansion	Children under 18 lifted above or closer to the poverty line by expansion	Children under 18 who would benefit from expansion	Share of children under 18 who would benefit from expansion
Total U.S.	27,000,000	4,140,000	9,894,000	65,694,000	90%
Alabama	479,000	80,000	162,000	1,021,000	94%
Alaska	52,000	12,000	21,000	167,000	91%
Arizona	690,000	112,000	238,000	1,508,000	93%
Arkansas	324,000	48,000	94,000	661,000	94%
California	3,527,000	553,000	1,689,000	7,865,000	88%
Colorado	345,000	57,000	132,000	1,109,000	89%
Connecticut	199,000	29,000	79,000	608,000	83%
Delaware	67,000	10,000	24,000	183,000	90%
District of Columbia	52,000	8,000	25,000	94,000	76%
Florida	1,733,000	272,000	698,000	3,837,000	92%
Georgia	1,042,000	171,000	354,000	2,274,000	91%
Hawai'i	92,000	14,000	43,000	278,000	92%
Idaho	154,000	17,000	37,000	410,000	94%
Illinois	986,000	153,000	338,000	2,543,000	89%
Indiana	556,000	80,000	175,000	1,453,000	93%
Iowa	198,000	25,000	48,000	669,000	93%
Kansas	219,000	29,000	57,000	652,000	93%
Kentucky	421,000	69,000	143,000	931,000	93%
Louisiana	529,000	94,000	188,000	1,028,000	94%
Maine	75,000	10,000	21,000	229,000	91%
Maryland	353,000	52,000	158,000	1,125,000	85%
Massachusetts	355,000	55,000	161,000	1,105,000	81%
Michigan	810,000	117,000	249,000	1,970,000	92%
Minnesota	321,000	44,000	85,000	1,126,000	88%
Mississippi	350,000	57,000	116,000	677,000	96%
Missouri	505,000	73,000	153,000	1,262,000	92%
Montana	78,000	10,000	21,000	210,000	93%
Nebraska	141,000	18,000	36,000	434,000	93%

APPENDIX TABLE 1

Estimated Number of Children Who Would Benefit From House Ways and Means Child Tax Credit Expansion, by State

State	Children under 17 left out of the full $2,000 Child Tax Credit who would benefit from expansion	Children under 18 lifted above the poverty line by expansion	Children under 18 lifted above or closer to the poverty line by expansion	Children under 18 who would benefit from expansion	Share of children under 18 who would benefit from expansion
Nevada	272,000	40,000	86,000	634,000	94%
New Hampshire	52,000	8,000	20,000	222,000	87%
New Jersey	560,000	89,000	257,000	1,608,000	82%
New Mexico	244,000	32,000	71,000	454,000	95%
New York	1,546,000	242,000	680,000	3,564,000	87%
North Carolina	924,000	137,000	307,000	2,088,000	92%
North Dakota	40,000	4,000	10,000	157,000	92%
Ohio	948,000	132,000	278,000	2,372,000	92%
Oklahoma	398,000	63,000	113,000	895,000	94%
Oregon	292,000	40,000	92,000	779,000	90%
Pennsylvania	892,000	140,000	311,000	2,368,000	90%
Rhode Island	67,000	8,000	23,000	185,000	91%
South Carolina	475,000	68,000	151,000	1,025,000	94%
South Dakota	67,000	10,000	19,000	197,000	93%
Tennessee	633,000	95,000	212,000	1,394,000	93%
Texas	3,091,000	503,000	1,079,000	6,696,000	92%
Utah	235,000	32,000	69,000	860,000	94%
Vermont	30,000	4,000	8,000	105,000	91%
Virginia	530,000	85,000	249,000	1,591,000	86%
Washington	478,000	66,000	159,000	1,437,000	88%
West Virginia	169,000	23,000	50,000	346,000	94%
Wisconsin	368,000	46,000	94,000	1,159,000	92%
Wyoming	35,000	3,000	11,000	128,000	95%

Notes: Based on economy as of 2016-2018 using tax year 2020 tax rules and incomes adjusted to 2020 dollars. Children left out receive less than full $2,000 per child because their parents lack earnings or have earnings that are too low.

Source: For children left out of the full $2,000 Child Tax Credit, Tax Policy Center national estimate allocated by state based on CBPP analysis of American Community Survey (ACS) data for 2016-2018. For remaining columns, CBPP analysis of the March 2019 Current Population Survey (national estimate) allocated by state based on CBPP analysis of ACS data for 2016-2018. Poverty calculations also use U.S. Census Bureau Supplemental Poverty Measure research files for the ACS.

APPENDIX TABLE 2

Childless Workers Who Would Benefit From House Ways and Means EITC Expansion, by State

State	Estimated Number of Childless Workers Benefiting From EITC Expansion
Total U.S.	17,354,000
Alabama	288,000
Alaska	41,000
Arizona	381,000
Arkansas	184,000
California	1,847,000
Colorado	299,000
Connecticut	154,000
Delaware	49,000
District of Columbia	33,000
Florida	1,310,000
Georgia	572,000
Hawai'i	69,000
Idaho	109,000
Illinois	620,000
Indiana	383,000
Iowa	181,000
Kansas	169,000
Kentucky	272,000
Louisiana	298,000
Maine	93,000
Maryland	257,000
Massachusetts	294,000
Michigan	603,000
Minnesota	289,000
Mississippi	177,000
Missouri	361,000
Montana	84,000
Nebraska	104,000
Nevada	169,000
New Hampshire	71,000
New Jersey	356,000
New Mexico	135,000
New York	915,000
North Carolina	603,000

APPENDIX TABLE 2

Childless Workers Who Would Benefit From House Ways and Means EITC Expansion, by State

State	Estimated Number of Childless Workers Benefiting From EITC Expansion
North Dakota	41,000
Ohio	695,000
Oklahoma	237,000
Oregon	264,000
Pennsylvania	700,000
Rhode Island	49,000
South Carolina	317,000
South Dakota	53,000
Tennessee	396,000
Texas	1,404,000
Utah	139,000
Vermont	40,000
Virginia	419,000
Washington	360,000
West Virginia	111,000
Wisconsin	321,000
Wyoming	38,000

Note: Childless workers who would benefit from the House EITC expansion are those aged 19 and over (excluding full-time students 19-24).

Source: CBPP estimates based on the U.S. Census Bureau's 2016-2018 American Community Survey and March 2019 Current Population Survey, using 2020 tax parameters and incomes adjusted to 2020 dollars.

APPENDIX TABLE 3

Estimated Increase in SNAP Benefits, by State, From 15 Percent Increase in Maximum Benefit

			Under a 15% Increase in SNAP Maximum Benefits		
State	Number of SNAP Participants in Latest Month With Available Data[a] (thousands)	Average Monthly Benefit Increase Per Person	Estimated Total Monthly Benefit Increase Statewide (millions)	Estimated Total 3-month Benefit Increase Statewide (millions)	Share of Increase Going to Households With Income Below 50 Percent of Federal Poverty Level
Alabama	794	$27	$21	$64	43%
Alaska	74	$37	$3	$8	50%
Arizona	909	$27	$24	$73	45%

APPENDIX TABLE 3

Estimated Increase in SNAP Benefits, by State, From 15 Percent Increase in Maximum Benefit

State	Number of SNAP Participants in Latest Month With Available Data[a] (thousands)	Under a 15% Increase in SNAP Maximum Benefits: Average Monthly Benefit Increase Per Person	Estimated Total Monthly Benefit Increase Statewide (millions)	Estimated Total 3-month Benefit Increase Statewide (millions)	Share of Increase Going to Households With Income Below 50 Percent of Federal Poverty Level
Arkansas	392	$27	$11	$32	40%
California	4,305	$27	$117	$351	53%
Colorado	498	$27	$14	$41	40%
Connecticut	365	$28	$10	$30	34%
Delaware	126	$27	$3	$10	37%
District of Columbia	132	$28	$4	$11	60%
Florida	3,505	$27	$96	$289	31%
Georgia	1,875	$27	$51	$152	47%
Hawaii	179	$50	$9	$27	38%
Idaho	138	$27	$4	$11	34%
Illinois	1,905	$27	$52	$155	41%
Indiana	664	$27	$18	$53	38%
Iowa	377	$27	$10	$31	34%
Kansas	202	$27	$5	$16	36%
Kentucky	628	$27	$17	$51	45%
Louisiana	1,013	$27	$27	$82	50%
Maine	157	$27	$4	$13	20%
Maryland	798	$27	$22	$66	36%
Massachusetts	890	$28	$25	$74	33%
Michigan	1,264	$27	$35	$104	33%
Minnesota	442	$27	$12	$36	35%
Mississippi	423	$27	$11	$34	44%
Missouri	702	$27	$19	$57	41%
Montana	96	$27	$3	$8	34%
Nebraska	154	$27	$4	$12	37%
Nevada	484	$27	$13	$39	42%
New Hampshire	70	$27	$2	$6	18%
New Jersey	788	$27	$21	$64	27%

APPENDIX TABLE 3

Estimated Increase in SNAP Benefits, by State, From 15 Percent Increase in Maximum Benefit

State	Number of SNAP Participants in Latest Month With Available Data[a] (thousands)	Under a 15% Increase in SNAP Maximum Benefits: Average Monthly Benefit Increase Per Person	Estimated Total Monthly Benefit Increase Statewide (millions)	Estimated Total 3-month Benefit Increase Statewide (millions)	Share of Increase Going to Households With Income Below 50 Percent of Federal Poverty Level
New Mexico	448	$27	$12	$36	40%
New York	2,743	$28	$76	$227	28%
North Carolina	1,463	$27	$40	$119	39%
North Dakota	47	$27	$1	$4	40%
Ohio	1,401	$27	$38	$114	36%
Oklahoma	626	$27	$17	$50	46%
Oregon	671	$28	$19	$56	38%
Pennsylvania	1,834	$27	$50	$151	29%
Rhode Island	138	$28	$4	$12	37%
South Carolina	604	$27	$16	$49	45%
South Dakota	76	$27	$2	$6	43%
Tennessee	912	$27	$25	$74	48%
Texas	3,703	$27	$99	$296	43%
Utah	171	$26	$5	$14	39%
Vermont	68	$28	$2	$6	18%
Virginia	753	$27	$20	$61	43%
Washington	951	$28	$26	$79	34%
West Virginia	305	$27	$8	$25	44%
Wisconsin	738	$27	$20	$60	30%
Wyoming	28	$27	$1	$2	39%
Guam	46	$38	$2	$5	44%
Virgin Islands	25	$35	$1	$3	65%

Notes:

[a] The latest month for which USDA has published data on the number of SNAP participants in every state is September 2020. For many states, however, we have compiled more recent data from publicly available information. The figures in this table are the most recent available for each state as of early February, except that we use the USDA September 2020 figure if the state-reported data differ substantially from the USDA data.

Sources: CBPP analysis of fiscal year 2018 SNAP USDA Household Characteristics data and recent administrative data that states post publicly or report to USDA, https://www.fns.usda.gov/pd/supplemental-nutrition-assistance-program-snap.

Congressional Proposals Could Improve Coverage Affordability and Access for Millions

February 12, 2021 / by Christina Cousart

Last week, Congress released a series of legislative proposals designed to respond to COVID-19's ongoing public health and economic crises. The proposed legislation, expected to be voted on in early March, is a direct response to the Biden Administration's American Rescue Plan [https://www.whitehouse.gov/briefing-room/legislation/2021/01/20/president-biden-announces-american-rescue-plan/] and includes several provisions that could significantly impact eligibility and coverage sold through the health insurance marketplaces.

Tax Credit Increases for Purchasing Coverage through Marketplaces

The legislative proposals would institute a significant increase in tax credits available to consumers to help them pay for coverage sold through the health insurance marketplaces. Currently, premium tax credits (PTCs) are available to individuals and households who earn between 100 to 400 percent of the federal poverty level (FPL) and who purchase coverage through the health insurance marketplaces. (During 2021, individuals earning $12,880 to $51,520 or a family of four earning $26,500 to $106,000 a year would qualify for tax credits.)

Tax credits are allocated on a sliding, income-based scale so individuals and families are only required to pay 2 to 9.5 percent of their income for insurance (based on the cost of a second-lowest cost silver-level health plan available to that household).

The proposed changes increase the amount of PTCs available by both reducing the required contribution percentages to zero to 8.5 percent and by eliminating the 400 percent of FPL income cap, so that no household would be required to pay more than 8.5 percent of its income for coverage sold through a marketplace.

A recent report [https://www.urban.org/sites/default/files/publication/103604/cost-and-coverage-implications-of-five-options-for-increasing-marketplace-subsidy-generosity.pdf] estimated similar changes could increase marketplace enrollment by more than 4 million individuals. The change would be retroactively applied, meaning individuals would be eligible for the additional subsidy amount retroactive to Jan. 1, 2021. These changes would be temporary, only applying to tax years 2021 and 2022. In addition, the proposal would create a new eligibility category whereby any individual receiving unemployment benefits in 2021 would be eligible for the maximum amount of PTC available. Specifically, the change would require that any income above 133 percernt of FPL be disregarded for the purposes of PTC calculation.

In a recent letter to Congressional leaders [https://www.nashp.org/nineteen-state-based-marketplaces-agree-with-proposal-to-expand-federal-help-to-lower-health-coverage-costs-for-millions/] , 19 state-based marketplace (SBM) leaders agreed that policies that enhanced subsidies and removed the income cap would be some of the most effective tools to improve coverage affordability and access. However, significant work to make these changes will be required. Marketplaces must rapidly update eligibility and enrollment systems, modify consumer shopping tools such as cost calculators and websites, and conduct the education and outreach necessary to make consumers aware of the changes. The proposed legislation [https://docs.house.gov/meetings/IF/IF00/20210211/111190/BILLS-117SubtitleArth.pdf] includes $20 million in grants to the SBMs to make the necessary IT changes.

Protections for Individuals who Misestimated 2020 Income

The Congressional proposals include a provision that would protect consumers from tax penalties related to receipt of an inaccurate amount of PTCs. PTCs are calculated based on an estimate of an individual's expected income for the upcoming tax year. Typically, consumers who underestimate their incomes and receive more PTCs than they should have are subject to a financial penalty of up to $2,700 for incomes up to 400 percent of FPL. There is no penalty cap for individuals earning above 400 percent FPL.

The proposal recognizes the unprecedented unpredictability of many individuals' income in during the pandemic and waives penalties for the 2020 tax year. Concerns about excessive penalties and income miscalculations in 2020 were raised by SBM leaders in a letter sent to the Treasury Department and Internal Revenue Services (read their letter [https://www.nashp.org/wp-content/uploads/2020/06/SBM-Treasury-COVID-Letter_FINAL.pdf] here [https://www.nashp.org/wp-content/uploads/2020/06/SBM-Treasury-COVID-Letter_FINAL.pdf]).

Congressional committees are currently finalizing legislative language and could vote as soon as early March. If passed, the federal government and the SBMs will need to work at a rapid pace to make the policy and system changes necessary for implementation. SBM officials are also making plans to adopt changes that will enable access to more affordable coverage for the populations they serve.

The National Academy for State Health Policy will continue to monitor and report on the proposed legislation as it moves through Congress and the SBMs as they begin the groundwork necessary to implement the proposals.

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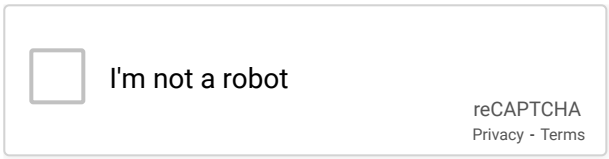

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Health Care and Employer Groups Announce Principles to Protect Patients and Achieve Universal Coverage

Affordable Coverage Coalition Lays out Path to Expand Coverage

WASHINGTON – Today, a broad coalition of health care and employer groups called for achieving universal health coverage by expanding financial assistance to consumers, bolstering enrollment and outreach efforts, and taking additional steps to protect those who have lost or are at risk of losing employer-based coverage because of the economic downturn caused by the COVID-19 pandemic.

The Affordable Coverage Coalition encompasses groups representing the nation's doctors, hospitals, employers and health insurance providers that collectively serve hundreds of millions of American patients, consumers and employers. The joint commitment by such a broad array of interests is a significant milestone on the path toward universal coverage, which has remained an elusive goal within the U.S. healthcare system.

"While we sometimes disagree on important issues in health care, we are in total agreement that Americans deserve a stable health care market that provides access to high-quality care and affordable coverage for all," the organizations said in a joint statement of principles. "Achieving universal coverage is particularly critical as we strive to contain the COVID-19 pandemic and work to address long-standing inequities in health care access and outcomes."

Kim Keck, president and CEO of the Blue Cross Blue Shield Association said, "While the country has made enormous strides in expanding coverage over the past decade, we must close the remaining gaps. Having health coverage means people can get the care they need, when they need it, so they can live healthier, more secure lives."

The groups included in the coalition are: America's Health Insurance Plans, American Academy of Family Physicians, American Benefits Council, American Hospital Association, American Medical Association, Blue Cross Blue Shield Association, Federation of American Hospitals, and U.S. Chamber of Commerce.

The organizations support the following steps to make health coverage more accessible and affordable:

- Protect Americans who have lost or are at risk of losing employer-provided health coverage from becoming uninsured.
- Make Affordable Care Act (ACA) premium tax credits and cost-sharing reductions more generous, and expand eligibility for them.
- Establish an insurance affordability fund to support any unexpected high costs for caring for those with serious health conditions or to otherwise lower premiums or cost-sharing for ACA marketplace enrollees.
- Restore federal funding for outreach and enrollment programs.
- Automatically enroll and renew individuals eligible for Medicaid and premium-free ACA marketplace plans.
- Provide incentives for additional states to expand Medicaid, in order to close the low-income coverage gap.

Read the full statement of principles.

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About America's Health Insurance Plans

AHIP is the national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers. Visit www.ahip.org for more information.

About American Academy of Family Physicians

Founded in 1947, the AAFP represents 136,700 physicians and medical students nationwide. It is the largest medical society devoted solely to primary care. Family physicians conduct approximately one in five office visits -- that's 192 million visits annually or 48 percent more than the next most visited medical specialty. Today, family physicians provide more care for America's underserved and rural populations than any other medical specialty. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care. To learn more about the specialty of family medicine, the AAFP's positions on issues and clinical care, and for downloadable multi-media highlighting family medicine, visit www.aafp.org/media. For information about health care, health conditions and wellness, please visit the AAFP's award-winning consumer website, www.familydoctor.org.

About American Benefits Council

The American Benefits Council is a public policy organization whose members include over 220 of the world's largest corporations, as ranked by Fortune and Forbes. Collectively, the Council's members either directly sponsor or administer health and retirement benefits for virtually all Americans covered by employer-sponsored plans.

About American Hospital Association

The American Hospital Association (AHA) is a not-for-profit association of health care provider organizations and individuals that are committed to the health improvement of their communities. The AHA advocates on behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups. Founded in 1898, the AHA provides insight and

education for health care leaders and is a source of information on health care issues and trends. For more information, visit the AHA website at www.aha.org.

About American Medical Association

The American Medical Association is the physicians' powerful ally in patient care. As the only medical association that convenes 190+ state and specialty medical societies and other critical stakeholders, the AMA represents physicians with a unified voice to all key players in health care. The AMA leverages its strength by removing the obstacles that interfere with patient care, leading the charge to prevent chronic disease and confront public health crises, and, driving the future of medicine to tackle the biggest challenges in health care.

About Federation of American Hospitals

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 tax-paying community hospitals and health systems throughout the United States. Our members include hospitals in urban and rural America, as well as inpatient rehabilitation, psychiatric, long-term acute care and cancer hospitals. These tax-paying hospitals account for nearly 20% of U.S. hospitals and serve their communities proudly while providing high-quality health care to their patients. For more information visit – FAH.org

About U.S. Chamber of Commerce

The U.S. Chamber of Commerce is the world's largest business organization representing companies of all sizes across every sector of the economy. Our members range from the small businesses and local chambers of commerce that line the Main Streets of America to leading industry associations and large corporations. They all share one thing: They count on the U.S. Chamber to be their voice in Washington, across the country, and around the world. For more than 100 years, we have advocated for pro-business policies that help businesses create jobs and grow our economy.

ABOUT BLUE CROSS BLUE SHIELD ASSOCIATION

The Blue Cross and Blue Shield Association is a national federation of 35 independent, community-based and locally operated Blue Cross and Blue Shield companies that collectively provide health care coverage for one in three Americans. BCBSA provides health care insights through The Health of America Report series and the national BCBS Health Index[sm]. For more information on BCBSA and its

member companies, please visit BCBS.com. We also encourage you to connect with us on Facebook, check out our videos on YouTube and follow us on Twitter.

Blue Cross Blue Shield Association
February 10, 2021

MEDIA CONTACTS

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March 3, 2021

Blue Cross Blue Shield Association Statement on Suspension of Contributions to Lawmakers Voting Against Accepting Electoral College Results
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Blue Cross Blue Shield Association Statement on the Congressional End of the Year Package
December 22, 2020

The Blue Cross Blue Shield Association Reports Steep Decline in Childhood Vaccinations Due to COVID-19 Pandemic, Putting Community Protection at Risk
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March 1, 2021
Blue Cross and Blue Shield of Illinois

   

Cost and Coverage Implications of Five Options for Increasing Marketplace Subsidy Generosity

Linda J. Blumberg, Matthew Buettgens, Clare Wang Pan, and Robin Wang

February 2021

An estimated 21 million people have gained health insurance coverage under the Affordable Care Act (Blumberg et al. 2020). Since 2014, the law's expansion of Medicaid eligibility (taken up by 37 states and pending in 2 more as of February 2021) and provision of subsidies for modest-income people purchasing private nongroup insurance coverage have been the two largest sources of coverage increases. And though national surveys show affordability of coverage has improved and households' concerns with health care financial burdens have decreased significantly,[1] nonetheless, affordability remains the greatest barrier to further gains in coverage (Haley and Wengle 2021; Pollitz et al. 2020).

Some uninsured people are likely unaware of the availability of subsidized insurance and their eligibility for it, but cost remains a barrier for many (Haley and Wengle 2021). Evidence indicates program participation among those eligible for free or almost free public insurance through Medicaid and the Children's Health Insurance Program (CHIP) is high (Simpson 2020), as is enrollment among those eligible for the most generous Marketplace subsidies. However, the value of these subsidies declines with income, and subsidies are unavailable for those with incomes above 400 percent of the federal poverty level (FPL). Thus, enrollment in subsidized coverage is lower among people with higher incomes. For example, consistent with public Marketplace data on enrollment by income group, the Urban Institute estimates more than 60 percent of otherwise uninsured people with incomes below 200 percent of FPL and eligible for Marketplace subsidies enroll in such coverage, compared with only 24 percent of their counterparts with incomes between 200 and 400 percent of FPL (data not shown).

But, even among some enrolled in subsidized Marketplace coverage, out-of-pocket cost requirements (i.e., deductibles, coinsurance, copayments) can pose significant barriers to accessing care (KFF 2020).

Consequently, policy experts and policymakers have proposed enhancing the generosity of Marketplace subsidies and extending them to more people, such as those with incomes above 400 percent of FPL.[2] The trade-offs of enhancing Marketplace subsidies are clear: More generous subsidies and expanded eligibility will reduce both the number of uninsured people and the financial burdens on enrollees. However, the greater the generosity of the subsidies and the more people eligible, the higher the cost to the government.

Research and real-world experience are also clear: Universal coverage cannot be reached through generous subsidies alone. Some people will remain uninsured even if coverage is offered at no cost to enrollees. Still, increased assistance, coupled with substantial education and outreach efforts and qualified enrollment assistance, will increase insurance coverage. And, lower out-of-pocket cost requirements will provide greater access to care for people with modest incomes.

Here, we explore the implications of five alternative Marketplace subsidy schedules, all providing more generous premium tax credit and cost-sharing assistance than that available under current law. All options would extend financial assistance to those with incomes above 400 percent of FPL, but how much they increase assistance for people in different income groups varies. We show the implications of each alternative subsidy schedule for overall insurance coverage, coverage by income group, and federal government costs. Each approach would also provide additional financial assistance to those enrolled in nongroup insurance coverage, and we provide findings for that population as well.

This brief does not address one of the most significant health insurance gaps under current law: that facing many adults with incomes below the federal poverty level who live in states that have not expanded Medicaid eligibility under the ACA. Adults in these states who are not categorically eligible for Medicaid under pre-ACA rules and have incomes too low to qualify for Marketplace assistance are denied eligibility for Medicaid because their states have chosen not to expand eligibility to them. Other Urban Institute analyses provide estimates of the implications of these states expanding or extending subsidized coverage to this population through the Marketplaces (Blumberg et al. 2019; Buettgens 2021).

Methods

The estimates presented here are produced using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM). HIPSM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options. The model simulates household and employer decisions and models the way changes in one insurance market interact with changes in other markets. HIPSM is designed for quick-turnaround analyses of policy proposals. It can be rapidly adapted to analyze various new scenarios—from novel health insurance offerings and strategies for increasing affordability to state-specific proposals—and can describe the effects of a policy option over several years.

HIPSM is based on two years of the American Community Survey, which provides a representative sample of families large enough for us to produce estimates for individual states and smaller regions, such as cities. The model is designed to incorporate timely, real-world data to the extent they are available. In particular, we regularly update the model to reflect published Medicaid and Marketplace enrollment and costs in each state. Results from HIPSM simulations have been favorably compared with actual policy outcomes and other respected microsimulation models, as assessed by outside experts (Glied, Arora, and Solís-Román 2015). A detailed description of HIPSM can be found on the Urban Institute website (Buettgens and Banthin 2020).

All estimates are for US residents under age 65, and reforms are presented as if fully implemented in 2022.

For this analysis, we assume the Medicaid enhanced federal medical assistance percentage and maintenance-of-effort provisions in the Families First Coronavirus Response Act would have expired before 2022. However, in a letter to governors sent in late January 2021, the acting secretary of the US Department of Health and Human Services indicated the public health emergency declaration will be extended through calendar year 2021.[3] This means the maintenance-of-effort requirement, which prohibits states from disenrolling Medicaid enrollees unless they request it, will last through January 2022, and the enhanced federal medical assistance percentage will be available through March 2022. Consequently, Medicaid enrollment will be notably higher in early 2022 than indicated in our estimates. However, it will decline to the levels we show later in the year. Also, the federal government will pay a higher share of Medicaid costs in the first quarter of 2022 than we indicate.

Policies Simulated

Consistent with current law, the alternative subsidy schedules we analyze are structured as premium tax credits and cost-sharing reductions. The premium tax credits limit the share of income a single person or family must pay to enroll in benchmark insurance coverage. Under current law, the benchmark plan is the silver plan (70 percent actuarial value) with the second-lowest premium offered in an enrollee's area of residence. Under each alternative option, the benchmark plan would be the second-lowest-premium gold plan (80 percent actuarial value) offered in an area of residence. People choosing to enroll in a lower-priced plan would pay less, and those choosing a more expensive plan would pay the full difference between their plan's premium and that for benchmark coverage.

Cost-sharing subsidies are available to income-eligible people enrolling in benchmark *level* coverage (i.e., silver today, but gold under the alternatives estimated). These subsidies increase the actuarial value of the insurance enrollees receive for the premiums they pay for benchmark-level coverage, thereby lowering household out-of-pocket costs associated with the coverage.

Table 1 shows premium tax credit and cost-sharing schedules under current law and the five alternative options modeled.

TABLE 1

Current-Law and Alternative Marketplace Subsidy Schedules Modeled

	Premium Tax Credit Percentage-of-Income Limits for Benchmark Coverage					
	Current law	Option 1	Option 2	Option 3	Option 4	Option 5
Benchmark plan	**Silver**	**Gold**	**Gold**	**Gold**	**Gold**	**Gold**
Income (% of FPL)						
< 138	2.07	0.0–1.0	0.0	0.0	0.0	0.0
138–150	3.10–4.14	1.0–2.0	0.0	0.0	0.0	0.0
150–200	4.14–6.52	2.0–4.0	0-3.0	0-3.0	0.0–3.0	0.0–3.0
200–250	6.52–8.33	4.0–6.0	3.0-4.0	3.0–4.0	3.0–4.0	3.0-4.0
250–300	8.33–9.83	6.0–7.0	4.0–6.0	4.0–6.0	4.0–6.0	4.0–6.0
300–400	9.83	7.0-8.5	6.0–8.5	6.0–8.5	6.0–8.5	6.0–8.5
400–500	—	8.5	8.5–10.0	8.5	8.5–10.0	8.5–10.0
500–600	—	8.5	10.0–12.0	8.5	10.0–12.0	10.0
600+	—	8.5	12.0	8.5	12.0	10.0
	Cost-Sharing Reductions: Actuarial Value of Plan Provided to Eligible Enrollees in Benchmark-Level Plans (%)					
	Current Law	Option 1	Option 2	Option 3	Option 4	Option 5
Income (% of FPL)						
< 138	94	95	94	94	95	94
138–150	94	95	94	94	95	94
150–200	87	95	87	87	95	87
200–250	73	90	87	87	90	87
250–300	70	90	87	87	90	87
300–400	70	85	80	80	85	80
400–500	70	80	80	80	80	80
500–600	70	80	80	80	80	80
600+	70	80	80	80	80	80

Source: Current-law premium tax credit percentage-of-income limits are data provided by the Internal Revenue Service and available at https://www.irs.gov/pub/irs-drop/rp-20-36.pdf.

Notes: FPL = federal poverty level. Dashes are used for the income ranges ineligible for premium tax credits under current law.

All reform options simulated maintain current-law prohibitions on providing Marketplace subsidies to people not legally residing in the US, people with offers of employer-sponsored insurance deemed affordable in the family, and people eligible for public insurance coverage. The only people with incomes below the federal poverty level eligible for Marketplace subsides are those who have legally immigrated to the US within the prior five years and would be eligible for Medicaid if they had been in the US longer.

Results

Coverage

Under current law, we estimate 30.8 million people will be uninsured in 2022, approximately 11 percent of the nonelderly population (table 2). An additional 2.6 million people are estimated to have short-term, limited-duration plans, which do not comply with ACA regulatory rules, such as coverage of essential health benefits, guaranteed issue to all applicants, and modified community rating.[4] Thus, an estimated 33.3 million nonelderly people will go without minimum essential coverage in 2022.

All of the alternative premium tax credit schedules and cost-sharing subsidy schedules simulated are more generous than those offered under current law. However, their generosity varies at different points in the income distribution. Options 2 through 5 are more generous than option 1 for those with incomes up to 400 percent of FPL, and options 1 and 3 are more generous for those with incomes above 400 percent of FPL. Options 1 and 4 include more generous cost-sharing subsidies for people with incomes up to 400 percent of FPL than do options 2, 3, and 5.

Though the generosity of the alternative schedules differs by income, each option would significantly increase the number of people with insurance coverage. Across the five options, the number of people uninsured would fall by 4.2 to 4.4 million. The largest decrease would result from option 1, under which approximately 4.4 million fewer people would be uninsured and another 160,000 people would move from short-term, limited-duration plans to minimum essential coverage. Consequently, the uninsurance rate would fall to about 9.5 percent of the nonelderly population.

TABLE 2

Coverage among the Nonelderly Population under Current Law and Alternative Subsidy Schedules, 2022

Coverage under current law and reforms (thousands of people)

	Current law	Option 1	Option 2	Option 3	Option 4	Option 5
Insured (minimum essential coverage)	**244,113**	**248,629**	**248,368**	**248,413**	**248,638**	**248,385**
Employer	*149,325*	*148,272*	*148,588*	*148,563*	*148,238*	*148,580*
Private nongroup	*14,960*	*20,198*	*19,637*	*19,703*	*20,240*	*19,660*
Basic Health Program	864	*866*	866	866	*866*	866
Marketplace with PTC	8,483	*14,034*	13,119	13,616	*13,698*	13,304
Marketplace without PTC	1,268	*1,015*	1,086	1,024	*1,058*	1,062
Non-Marketplace	4,346	*4,283*	4,567	4,197	*4,619*	4,428
Medicaid/CHIP	*71,162*	*71,494*	*71,479*	*71,482*	*71,494*	*71,480*
Other public	*8,665*	*8,665*	*8,665*	*8,665*	*8,665*	*8,665*
Uninsured (no minimum essential coverage)	***33,333***	***28,817***	***29,078***	***29,033***	***28,808***	***29,061***
Uninsured	30,766	26,413	26,598	26,560	26,433	26,583
Short-term, limited-duration plans	2,567	2,405	2,480	2,473	2,375	2,478
Total	**277,446**	**277,446**	**277,446**	**277,446**	**277,446**	**277,446**

Change from current law (thousands of people)

	Current law	Option 1	Option 2	Option 3	Option 4	Option 5
Insured (minimum essential coverage)	**—**	**4,516**	**4,256**	**4,300**	**4,525**	**4,272**
Employer	—	*-1,053*	*-738*	*-763*	*-1,087*	*-745*
Private nongroup	—	*5,237*	*4,677*	*4,743*	*5,280*	*4,700*
Basic Health Program	—	2	2	2	2	2
Marketplace with PTC	—	5,551	4,635	5,133	5,215	4,821
Marketplace without PTC	—	-253	-181	-244	-210	-206
Non-Marketplace	—	-63	221	-148	273	83
Medicaid/CHIP	—	*332*	*317*	*320*	*332*	*318*
Other public	—	*0*	*0*	*0*	*0*	*0*
Uninsured (no minimum essential coverage)	**—**	**-4,516**	**-4,256**	**-4,300**	**-4,525**	**-4,272**
Uninsured	—	-4,353	-4,168	-4,206	-4,333	-4,183
Short-term, limited-duration plans	—	-163	-87	-94	-192	-89
Total	**—**	**0**	**0**	**0**	**0**	**0**

Change from current law (%)

	Current law	Option 1	Option 2	Option 3	Option 4	Option 5
Insured (minimum essential coverage)	**—**	**1.8**	**1.7**	**1.8**	**1.9**	**1.8**
Employer	—	*-0.7*	*-0.5*	*-0.5*	*-0.7*	*-0.5*
Private nongroup	—	*35.0*	*31.3*	*31.7*	*35.3*	*31.4*
Basic Health Program	—	0.2	0.2	0.2	0.2	0.2
Marketplace with PTC	—	65.4	54.6	60.5	61.5	56.8
Marketplace without PTC	—	-19.9	-14.3	-19.2	-16.6	-16.3
Non-Marketplace	—	-1.5	5.1	-3.4	6.3	1.9
Medicaid/CHIP	—	*0.5*	*0.4*	*0.5*	*0.5*	*0.4*
Other public	—	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*
Uninsured (no minimum essential coverage)	**—**	**-13.5**	**-12.8**	**-12.9**	**-13.6**	**-12.8**
Uninsured	—	-14.2	-13.5	-13.7	-14.1	-13.6
Short-term, limited-duration plans	—	-6.3	-3.4	-3.7	-7.5	-3.5
Total	**—**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Source: Health Insurance Policy Simulation Model, 2021.

Notes: PTC = premium tax credit. CHIP = Children's Health Insurance Program. A dash indicates the column heading does not apply. Reforms simulated in 2022.

The Uninsured by Income Group

Table 3 shows the number of uninsured in four income groups under current law and each alternative subsidy schedule analyzed. Under any option, the largest reductions in the number of uninsured people would occur within the 200 to 400 percent of FPL income group; roughly 2.5 million additional people in that group would have insurance coverage, about a 30 percent increase. This increase is

largest because all of the alternative schedules would provide significantly more financial assistance for this income group, which has a large number of uninsured people (8.1 million) under current law.

TABLE 3

The Uninsured Nonelderly Population under Current Law and Alternative Subsidy Schedules, 2022

	Income Group				
	< 138% of FPL	138–200% of FPL	200–400% of FPL	> 400% of FPL	All incomes
Current law					
Thousands of people	13,523	5,057	8,062	4,124	30,766
Percentage of income group	16.5	16.4	11.0	4.5	11.1
Option 1					
Thousands of people	13,251	4,395	5,523	3,244	26,413
Percentage of income group	16.1	14.2	7.6	3.6	9.5
Change from current law					
Thousands of people	-272	-663	-2,539	-880	-4,353
Percent	-2.0	-13.1	-31.5	-21.3	-14.2
Option 2					
Thousands of people	13,252	4,469	5,592	3,285	26,598
Percentage of income group	16.1	14.5	7.6	3.6	9.6
Change from current law					
Thousands of people	-271	-589	-2,470	-839	-4,168
Percent	-2.0	-11.6	-30.6	-20.4	-13.5
Option 3					
Thousands of people	13,252	4,469	5,592	3,246	26,560
Percentage of income group	16.1	14.5%	7.7	3.6	9.6
Change from current law					
Thousands of people	-271	-589	-2,470	-877	-4,206
Percent	-2.0	-11.6%	-30.6	-21.3	-13.7
Option 4					
Thousands of people	13,252	4,378	5,521	3,283	26,433
Percentage of income group	16.1	14.2%	7.6	3.6	9.5
Change from current law					
Thousands of people	-271	-680	-2,542	-841	-4,333
Percent	-2.0%	-13.4	-31.5	-20.4	-14.1
Option 5					
Number	13,252	4,469	5,592	3,270	26,583
Percent of income group	16.1	14.5	7.7	3.6	9.6
Change from current law					
Thousands of people	-271	-589	-2,470	-854	-4,183
Percent	-2.0	-11.6	-30.6	-20.7	-13.6

Source: Health Insurance Policy Simulation Model, 2021.

Notes: FPL = federal poverty level. Reforms simulated in 2022.

The next largest reduction in uninsurance would occur among people in families with incomes over 400 percent of FPL. Each alternative schedule would make people in this income group eligible for Marketplace subsidies for the first time, but the number of uninsured people in this income group under current law is about half that in the 200 to 400 percent of FPL group. Uninsurance would fall by

840,000 to 880,000 people in this higher-income group, a roughly 20 percent reduction relative to current law.

The number of uninsured people with incomes below 138 percent of FPL would change little for several reasons. First, the approach analyzed here does not fill in the Medicaid eligibility gap in the 14 states that have not expanded Medicaid eligibility under the ACA. People with incomes from 138 to 200 percent of FPL would also make modest gains in coverage under these alternative schedules. Marketplace enrollment is already high among those with incomes below 200 percent of FPL, who are eligible for subsidies under current law. Thus, potential gains in health coverage from increasing subsidies for this group are limited.[5]

Spending

Table 4 shows the implications of each option for health care spending by households, federal and state governments, employers, and providers (in the form of uncompensated care) in 2022.

Households. Premium spending would fall under each option, leading to household premium savings ranging from $6.4 billion under option 1 to $9.1 billion under option 3, the most generous of the premium tax credit schedules. Out-of-pocket spending would increase under each option, as more people are insured and more nongroup insurance enrollees face lower cost-sharing requirements, leading both groups to use more medical care than they do under current law. The five options simulated use only two different cost-sharing schedules, and either would increase household spending by less than 1 percent overall. National household health care spending would fall by $5.0 to $8.1 billion, depending on the option. Option 4 offers households the greatest savings and option 2 offers the least, yet all alternatives would lead to significant savings for nongroup insurance enrollees relative to current law.

Federal government. Additional federal government spending would be $23.0 billion (under option 1) to $25.7 billion (under option 4) higher than under current law, depending on the option. The more generous premium tax credits, which are more costly to provide than the more generous cost-sharing subsidies, account for most of increased spending under each option. Federal spending on Medicaid/CHIP would increase very modestly, mostly from more adult Marketplace applicants discovering that their children are eligible for Medicaid or CHIP. As coverage increases under any option, the demand for uncompensated care decreases, leading to some federal savings that offset the cost increases of publicly subsidized programs. We estimate the full potential federal savings on uncompensated care, but decreased demand does not translate directly to decreased spending on uncompensated care. Explicit policy action is required to fully realize these savings.

TABLE 4

Health Care Spending for the Nonelderly Population under Current Law and Alternative Subsidy Schedules, 2022

Spending under current law and reforms (millions of dollars)

	Current law	Option 1	Option 2	Option 3	Option 4	Option 5
Household						
Premiums	300,270	293,821	292,511	291,175	292,029	292,052
Other health care spending	287,587	287,858	290,392	290,453	287,720	290,411
Subtotal	*587,856*	*581,680*	*582,903*	*581,629*	*579,749*	*582,463*
Federal government						
Medicaid/CHIP	376,113	377,907	377,831	377,849	377,903	377,838
Marketplace PTC and reinsurance	59,591	78,877	81,879	83,725	81,406	82,464
Marketplace CSR	0	7,756	4,798	4,798	7,796	4,798
Uncompensated care	31,400	25,597	25,856	25,745	25,691	25,827
Subtotal	*467,105*	*490,137*	*490,364*	*492,118*	*492,796*	*490,928*
State government						
Medicaid/CHIP	199,944	200,714	200,684	200,693	200,711	200,689
Marketplace PTC	398	0	0	0	0	0
Marketplace CSR	46	0	0	0	0	0
Reinsurance	357	0	0	0	0	0
Uncompensated care	19,625	15,998	16,160	16,091	16,057	16,142
Subtotal	*220,370*	*216,713*	*216,844*	*216,783*	*216,768*	*216,830*
Employers						
Premium contributions	800,116	794,048	795,866	795,713	793,865	795,819
Providers						
Uncompensated care	27,475	22,397	22,624	22,527	22,480	22,598
Total, all payers	2,102,923	2,104,975	2,108,602	2,108,769	2,105,658	2,108,639

Change from current law (millions of dollars)

	Current law	Option 1	Option 2	Option 3	Option 4	Option 5
Household						
Premiums	—	-6,448	-7,759	-9,094	-8,240	-8,218
Other health care spending	—	272	2,805	2,867	133	2,825
Subtotal	—	*-6,177*	*-4,954*	*-6,228*	*-8,107*	*-5,393*
Federal government						
Medicaid/CHIP	—	1,794	1,717	1,736	1,789	1,725
Marketplace PTC and reinsurance		19,286	22,288	24,134	21,815	22,873
Marketplace CSR	—	7,756	4,798	4,798	7,796	4,798
Uncompensated care	—	-5,803	-5,545	-5,656	-5,709	-5,574
Subtotal	—	*23,032*	*23,259*	*25,013*	*25,691*	*23,823*

	Current law	Option 1	Option 2	Option 3	Option 4	Option 5
State government						
Medicaid/CHIP	—	771	741	749	768	745
Marketplace PTC	—	-398	-398	-398	-398	-398
Marketplace CSR	—	-46	-46	-46	-46	-46
Reinsurance	—	-357	-357	-357	-357	-357
Uncompensated care	—	-3,627	-3,465	-3,535	-3,568	-3,484
Subtotal	—	*-3,658*	*-3,526*	*-3,587*	*-3,602*	*-3,540*
Employers						
Premium contributions	—	-6,068	-4,250	-4,403	-6,251	-4,296
Providers						
Uncompensated care	—	-5,078	-4,852	-4,949	-4,996	-4,877
Total, all payers	**—**	**2,052**	**5,679**	**5,847**	**2,735**	**5,716**

Change from current law (%)

	Current law	Option 1	Option 2	Option 3	Option 4	Option 5
Household						
Premiums	—	-2	-3	-3	-3	-3
Other health care spending	—	0	1	1	0	1
Subtotal	—	*-1*	*-1*	*-1*	*-1*	*-1*
Federal government						
Medicaid/CHIP	—	0	0	0	0	0
Marketplace PTC and reinsurance		32	37	40	37	38
Marketplace CSR	—	—	—	—	—	—
Uncompensated care	—	-18	-18	-18	-18	-18
Subtotal	—	*5*	*5*	*5*	*6*	*5*
State government						
Medicaid/CHIP	—	0	0	0	0	0
Marketplace PTC	—	-100	-100	-100	-100	-100
Marketplace CSR	—	-100	-100	-100	-100	-100
Reinsurance	—	-100	-100	-100	-100	-100
Uncompensated care	—	-18	-18	-18	-18	-18
Subtotal	—	*-2*	*-2*	*-2*	*-2*	*-2*
Employers						
Premium contributions	—	-1	-1	-1	-1	-1
Providers						
Uncompensated care	—	-18	-18	-18	-18	-18
Total, all payers	**—**	**0**	**0**	**0**	**0**	**0**

Source: Health Insurance Policy Simulation Model, 2021.

Notes: CHIP = Children's Health Insurance Program. PTC = premium tax credit. CSR = cost-sharing reduction. A dash in the current law column indicates the column is irrelevant to measuring change. A dash in the percent change row for Marketplace CSRs indicates a percent change cannot be calculated because the current-law value is zero. Reforms simulated in 2022.

We also assume state-specific reinsurance programs, to which the federal government currently contributes some pass-through funds to account for premium tax credit savings, would be eliminated under each option. We assume this because reinsurance programs currently subsidize premiums for people paying the full costs associated with nongroup insurance coverage. Because the reform options considered here would provide premium subsidies for people with incomes above 400 percent of FPL spending more than a specified percentage of income, the reinsurance programs would no longer be needed.

State government. A few state governments provide supplemental Marketplace subsidies to some residents, and the reforms considered here would allow them to save those state funds. Though state Medicaid/CHIP spending would increase slightly, as explained above, state savings resulting from the decrease in demand for uncompensated care could more than offset it. Consequently, state government spending on health care is estimated to decrease by roughly $3.5 billion under each option. However, state spending on uncompensated care does not automatically fall commensurate with decreased demand for it; to fully realize such savings, state policymakers must act to decrease spending on uncompensated care.

Employers. We estimate modest declines in employer-sponsored insurance coverage as the generosity of nongroup subsidies increases under the reform options. Consequently, we estimate employer spending on health insurance premiums would fall by about 1 percent under each option.

Providers. Provider in-kind spending on uncompensated care is estimated to be directly related to the number of uninsured people in the US. As coverage increases with greater subsidy generosity, demand for uncompensated care will fall. We estimate provider spending on uncompensated care would fall by approximately $5.0 billion nationally under each reform approach.

Average household spending by nongroup enrollees. Table 5 shows average household spending on premiums and out-of-pocket costs for people enrolled in nongroup insurance coverage under current law and each alternative subsidy schedule. Spending is computed as the per person average within each household for people with nongroup insurance coverage under current law and each reform option.

In 2022, average per person household premium spending for nongroup coverage under current law is estimated to be $2,768 and average out-of-pocket spending on health care is estimated to be $2,157, totaling just under $5,000. Each alternative subsidy schedule analyzed would lower average total household health care spending for nongroup insurance enrollees by more than $1,100 annually, with most of those savings attributable to lower household premium contributions. Option 4, which heavily subsidizes costs for the lowest-income enrollees and uses the more generous cost-sharing subsidy schedule of the two analyzed, would lead to the largest average savings, almost $1,400 per year. Option 2, the approach that would use the same premium tax credit schedule as option 4 but with a less generous cost-sharing subsidy, would lead to the smallest average savings, $1,182.

TABLE 5

Average per Person Household Spending on Premiums and Out-of-Pocket Health Care Costs for Nonelderly People with Nongroup Coverage under Current Law and Alternative Subsidy Schedules, 2022

	Premiums	Out-of-Pocket Costs	Total
Current Law			
Dollars	2,768	2,157	4,926
Option 1			
Dollars	1,850	1,813	3,663
Change from current law			
Dollars	-919	-344	-1,263
Percent	-33.2	-15.9	-25.6
Option 2			
Dollars	1,799	1,945	3,744
Change from current law			
Dollars	-970	-212	-1,182
Percent	-35.0	-9.8	-24.0
Option 3			
Dollars	1,728	1,949	3,677
Change from current law			
Dollars	-1,040	-208	-1,249
Percent	-37.6	-9.7	-25.3
Option 4			
Dollars	1,761	1,802	3,563
Change from current law			
Dollars	-1,008	-355	-1,363
Percent	-36.4	-16.5	-27.7
Option 5			
Dollars	1,774	1,946	3,721
Change from current law			
Dollars	-994	-211	-1,205
Percent	-35.9	-9.8	-24.5

Source: Urban Institute Health Insurance Policy Simulation Model, 2021.
Note: Reforms simulated in 2022.

Table 6 shows the same measure, average total household health care spending for nongroup enrollees, but the averages are computed separately for three income groups. We find different subsidy schedules would lead to different distributions of savings across nongroup enrollees with different incomes. For example, options 1 and 3 would provide the largest premium subsidies to enrollees with higher incomes, resulting in the group with incomes above 400 percent of FPL saving the most, on average, under these approaches. Option 4 provides the most generous premium and cost-sharing subsidies to enrollees with lower incomes and would therefore lead to the highest average savings for people with incomes below 400 percent of FPL. On average, option 1's higher cost-sharing subsidies offset its somewhat lower premium subsidies for enrollees with lower incomes relative to other reform options.

Enrollment in gold plans would be expected to increase substantially, whereas enrollment in silver plans could fall, because the premium tax credits and cost-sharing assistance would be tied to the higher-value coverage under all approaches. Bronze-plan enrollment could also be expected to fall, because the more generous assistance would make this coverage less attractive for many current enrollees. However, the number of people able to enroll in bronze plans for no premium contribution would increase significantly under these approaches. Increased education and enrollment assistance would be necessary to ensure prospective and current enrollees (1) understand the trade-offs in premiums and out-of-pocket liabilities of choosing different actuarial-value plans and (2) can make enrollment decisions best suited to their needs.

TABLE 6

Average per Person Household Spending on Premiums and Out-of-Pocket Health Care Costs for Nonelderly People with Nongroup Coverage under Current Law and Alternative Subsidy Schedules, by Income Group, 2022

	Income Group			
	< 200% FPL	200–400% FPL	> 400% FPL	All incomes
Current Law				
Average household spending	2,482	5,339	8,919	4,926
Option 1				
Average household spending	1,837	3,503	6,799	3,663
Change from current law				
Dollars	-645	-1836	-2121	-1263
Percent	-26.0	-34.4	-23.8	-14.2
Option 2				
Average household spending	1,833	3,503	7,142	3,744
Change from current law				
Dollars	-649	-1836	-1777	-1182
Percent	-26.2	-34.4	-20.4	-24.0
Option 3				
Average household spending	1,833	3,504	6,814	3,677
Change from current law				
Dollars	-649	-1836	-2105	-1249
Percent	-26.1	-34.4	-23.6	-25.3
Option 4				
Average household spending	1,655	3,271	7,113	3,563
Change from current law				
Dollars	-827	-2068	-1807	-1363
Percent	-33.3	-38.7	-20.3	-27.7
Option 5				
Average household spending	1,833	3,503	7,028	3,721
Change from current law				
Dollars	-650	-1836	-1891	-1205
Percent	-26.2	-34.4	-21.2	-24.5

Source: Urban Institute Health Insurance Policy Simulation Model, 2021.

Notes: FPL = federal poverty level. Reforms simulated in 2022.

Conclusion

Evidence shows many uninsured people find the insurance coverage available to them too expensive to purchase, even though the ACA has lowered those costs for many and reduced other barriers to accessing coverage (Haley and Wengle 2021; Pollitz et al. 2020). Some uninsured people may find premiums affordable but opt to remain uninsured because out-of-pocket costs are unaffordable. In other words, the premiums do not purchase coverage they can use.

Here we have delineated the coverage and health care spending implications of five premium tax credit and cost-sharing subsidy options for enhancing Marketplace financial assistance. Enhancing the generosity of these subsidies alone would not address all of the coverage gaps identified under current law, such as those related to states that have not expanded Medicaid, high premiums in noncompetitive insurer and provider markets, and high premiums facing some with employer-based insurance offers. However, any of these approaches could reduce the number of uninsured Americans by more than 4 million people. The largest number of newly insured people would be those with modest incomes, 200 to 400 percent of FPL, who are eligible for Marketplace financial assistance today but for whom that assistance is limited. Still, under any of these approaches, almost 1 million of the newly insured would be people with middle incomes (over 400 percent of FPL), who are currently ineligible for any assistance at all.

Accounting for potential offsets due to reduced demand for uncompensated care, we estimate $23 to $26 billion in additional spending in 2022 would be necessary to implement one of these options. This roughly equals $289 to $322 billion over 10 years, depending on the approach chosen. As noted, however, federal uncompensated care spending would not fall automatically with the decrease in demand for such care when coverage expands; fully realizing these federal savings requires policy action.

The value of the increase in federal spending would be increased numbers of people insured and significantly reduced financial burdens for those already enrolled in nongroup insurance coverage, with savings averaging more than $1,000 per year per nongroup enrollee.

These reforms can be implemented quickly (i.e., the 2022 plan year), because they would constitute only a change in computation of subsidies and eligibility; the structure in which they would be used is already in place. Marketplace insurers would need to develop new cost-sharing reduction plans to correspond to the new subsidy schedule chosen. Enrollment would be expected to shift away from bronze and silver plans to gold plans.

Notes

[1] See, for example, Glied, Ma, and Borja (2017) and Long and colleagues (2017).

[2] See, for example, Blumberg and Holahan (2015) and Jost and Pollack (2015). See also the Patient Protection and Affordable Care Enhancement Act, H.R. 1425, 116th Cong. (2020), and the Consumer Health Insurance Protection Act of 2019, S. 1213, 116th Cong. (2019).

[3] Norris Cochran (acting secretary, US Department of Health and Human Services), letter to governors regarding the public health emergency, January 22, 2021, https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf.

[4] Such noncompliant coverage is ineligible for premium tax credits or cost-sharing reductions.

[5] We estimate the participation rate for those eligible for Marketplace subsidies with incomes below 200 percent of FPL is around 62 percent. This is high, considering participation rates for adults eligible for free or nearly free Medicaid coverage under the ACA's Medicaid expansion are around 73 percent (Buettgens 2021).

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Policy Alert

Akin Gump
STRAUSS HAUER & FELD LLP

Affordable Care Act: Executive Actions and Legislative Outlook

February 3, 2021

On January 28, 2021, President Biden issued an Executive Order on Strengthening Medicaid and the Affordable Care Act, responsive to Democrats' longstanding commitment to "roll back Trump's health care sabotage [of the Affordable care Act (ACA)] and expand coverage." The Executive Order (EO) is simply the first step; the Biden-Harris administration will now turn to implementing the EO while pursuing its immediate priority of responding to the COVID-19 pandemic. Stakeholders may see delays with implementation. The Department of Health and Human Services (HHS) and its operating division, the Centers for Medicare & Medicaid Services (CMS), are, at the date of publishing, significantly understaffed with few political appointees who typically play critical roles in policy development and implementation. When they are appointed, they will be working to implement a sweeping range of executive actions, including ongoing initiatives in response to the COVID-19 pandemic.

Congress, by contrast, may move more swiftly. With opportunities to utilize the budget reconciliation process, the annual appropriations process and other pending health care measures as potential vehicles, it is likely Democrats will seek to pass legislative provisions bolstering the ACA. Navigating slim majorities in both chambers, Democrats will turn to enhancing the ACA after working to advance a shared legislative agenda for economic and COVID-19 relief. This alert provides an overview of both the ACA EO and its implications, as well the legislative outlook for ACA-related legislation in Congress.

Special Enrollment Period and ACA Marketing

The ACA EO requires the Secretary of HHS to "consider establishing a Special Enrollment Period…through the Federally Facilitated Marketplace…." On the day the EO was signed, HHS announced a Special Enrollment Period (SEP) in response to the COVID-19 emergency, to begin February 15, 2021, and end May 15, 2021. Currently, 30 states have Federally Facilitated Marketplaces where HHS performs all marketplace functions. Six states (AK, KY, ME, NM, OR and VA) have State-Based Marketplaces that rely on federal platforms. It is not clear whether these states are covered by the EO, though some have indicated they will comply. The remaining 14 states (CA, CO, CT, DC, ID, MD, MA, MN, NV, NJ, NY, PA, RI, VT and WA) and the District of Columbia are responsible for all marketplace functions and therefore are not

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covered by the EO. At least two states, California and Washington, have announced they will conduct SEPs, and other states are expected to follow suit.

The Biden-Harris administration is seeking to bolster ACA-related marketing efforts that had been significantly curtailed in recent years, and it will have additional monetary resources to do so. A recent estimate from the Kaiser Family Foundation indicated the Trump administration refrained from spending the full amount of available funding from marketplace user fee revenue on the order of approximately $400 million annually between Fiscal Years 2018 to 2020. Because this funding carries over, the current administration reportedly has at its disposal $1.2 billion to "support marketplace enrollment, including navigator consumer assistance, marketing and outreach, the HealthCare.gov marketplace website, and the federal marketplace call center."

ACA Executive Order Implementation: Review of Regulations and Potential Rulemaking

The ACA EO directs the Secretaries of HHS, the Treasury and Labor and "all other executive departments and agencies with authorities and responsibilities related to Medicaid and the ACA" to conduct an "immediate review" of agency actions to determine whether they are inconsistent with the administration's stated policy of support for the ACA. The EO directs agencies to examine policies or practices that might undermine protections for people with preexisting conditions, including COVID-19 complications; demonstrations and waivers that may reduce coverage or undermine ACA or Medicaid; policies or practices that could undermine health insurance markets; policies or practices that could present unnecessary barriers to access for Medicaid or ACA coverage; and policies or practices that may make coverage more expensive.

The EO further directs that, upon identifying these policies, the agencies shall consider whether to suspend, revise or rescind them and consider whether to take further action to "more fully" enforce the Administration's policy of support for the ACA.

However, while the Biden-Harris administration has self-styled its flurry of executive actions as reminiscent of President Franklin Delano Roosevelt, it faces significant challenges in the execution of the orders. The first obstacle is prioritization. Some of President Biden's earliest executive actions were focused on fighting the COVID-19 pandemic, emphasizing the importance of the pandemic response to the administration. While the President's pandemic orders have redesigned the response's decision-making structure, the operational details will likely still fall to HHS and its operating divisions, consuming limited staff time and potentially leading to bottlenecks with key decision-makers.

The administration's ACA agenda also may be delayed as a result of a "skeleton" staff. Compliance with the ACA EO will require a thorough analysis of existing rules and extensive policy and technical decision-making. It falls to political appointees within HHS to make those decisions. These staff members are not Senate-confirmed, yet they are critical in monitoring the rulemaking process on a daily basis and driving the policy-level decisions to guide the agency's career technical experts as they draft regulatory language. To date, few political appointees have taken positions in HHS, including CMS, where the bulk of the ACA EO's implementation will occur.

While the lack of lower- and mid-level political staff presents an obstacle to the quick implementation of the Biden-Harris administration's health care agenda, the total lack of Senate-confirmed leadership may increase the risk of delay. The Senate is not expected to begin formal confirmation hearings for HHS Secretary-designate Xavier Becerra until after the impeachment trial of former President Donald Trump. President Biden's nominee for Deputy Secretary, Andrea Palm, has yet to receive a Senate hearing.

President Biden also has not nominated a CMS Administrator, nor has he announced the leadership of any of the agency's centers and offices—in particular, the Director of the Center for Consumer Information and Insurance Oversight (CCIIO), which manages many aspects of the ACA. With positions in the Immediate Office of the HHS Secretary, the Office of the CMS Administrator and the Office of the CCIIO Director all empty, and given policy-makers' immediate focus on the broader pandemic response, it seems likely that the administration will be hard-pressed to deliver quickly on its ACA policy goals.

Legislative Outlook

With two opportunities to utilize the budget reconciliation process (for Fiscal Years 2021 and 2022)—allowing them to bypass Republican opposition—congressional Democrats are likely to act both to shore up the existing ACA and to enhance the health law.[1] On February 1, 2021, House Budget Committee Chairman John Yarmuth (D-KY) released the text of the House budget resolution, the first step in the budget reconciliation process. The budget resolution contains instructions to committees, allowing the committees to consider legislation pursuant to those instructions. Among the goals of the resolution, according to Chairman Yarmuth is to "expand access to … affordable health care…." Likewise, on February 2, 2021, Senate Budget Committee Chairman Bernard Sanders (D-VT) released the text of the Senate budget resolution for Fiscal Year 2021. According to Chairman Sanders, the resolution will "enable the Senate to expand Medicaid."

Details remain sketchy regarding the nature and extent of the ACA-related policies that will be included in the first round of budget reconciliation. To help understand the universe of policies that could be considered, and are likely to be considered in the future, stakeholders might look to the House-passed Patient Protection and Affordable Care Act Enhancement Act (H.R. 1425, 116th Congress), sponsored by Rep. Angie Craig (D-MN). The bill is the latest iteration of congressional Democrats' years-long effort to bolster the ACA. Similar legislation has been introduced in the Senate in the 117th Congress by Sen. Mark Warner (D-VA).

The bill is comprehensive and builds upon the ACA in several ways. It rescinds Trump administration rules viewed as inconsistent with the ACA, including the expansion of short-term, limited-duration health insurance plans and changes to the premium adjustment percentage. Importantly, it expands premium tax credits beyond 400 percent of the federal poverty level (FPL) and reduces the amount of income required to be paid toward health insurance premiums, effectively increasing the subsidy amount.

The bill addresses the so-called "family glitch" by providing that an offer of employer-sponsored coverage does not preclude eligibility for premium subsidies. The bill

establishes a $10 billion annual Health Insurance Affordability Fund, beginning in 2022, which states may use to lower costs through reinsurance and other means. The legislation defers to CMS to develop an application process and allocation methodology for the fund. It provides $200 million to state-based marketplaces in the form of two-year grants; $200 million to promote innovation among states to increase coverage; $100 million annually for ACA-related marketing; and $100 million for ACA navigators (drawn from health insurance user fees).

The bill further promotes Medicaid expansion through a carrot-and-stick approach. Like the original ACA, the bill provides for the federal government to offset 100 percent of the cost of Medicaid expansion, reduced to 90 percent after three years (beginning the year the state began the expansion). The bill also would penalize non-expansion states by reducing their federal medical assistance percentage (FMAP) by one-half percent each quarter, up to ten percent, and requiring reporting to the federal government related to the number of uninsured individuals in those states.

Finally, the legislation contains several provisions unrelated to the ACA. It permanently authorizes the Children's Health Insurance Program, increases postpartum Medicaid eligibility, increases Medicaid reimbursement for primary care physicians who treat Medicaid patients, and extends Medicaid to U.S. territories. The final title of the bill is taken from Title I of the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3, 116th Congress), which the Democratic-led House passed in 2019. Specifically, these provisions would eliminate the Medicare Part D noninterference clause, allowing the federal government to negotiate drug prices and set an average international market price for some drugs.

[1] Under the Congressional Budget Act of 1974, the budget reconciliation process may only be used to consider policies with a direct effect on federal spending, and the determination as to whether a policy can be considered under the process is made by the President of the Senate, in consultation with the Senate Parliamentarian.

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Federal and State Special Enrollment Periods Increase Access to Insurance Coverage

March 12, 2021
by Christina Cousart

Last week, the Biden Administration launched a special enrollment period (SEP) for uninsured individuals to sign up for health insurance coverage in the 36 states that use the federal marketplace (healthcare.gov). This move follows earlier actions by the 13 state-operated marketplaces that have already extended enrollment periods to give individuals and families more time to shop for and enroll in coverage.

Both actions are designed to address COVID-19 pandemic's impact on rising unemployment and loss of employer-provided insurance. Typically, the annual enrollment season for health insurance coverage sold through the marketplaces runs from Nov. 1 to Dec. 15. Starting last year, state-based marketplaces (SBMs) took the lead to extend their enrollment capacity to help consumers economically impacted by the pandemic.

To date, thirteen have extended their 2021 open enrollment periods to give consumers more time to enroll, and seven recently announced they are opening new SEPs for uninsured individuals to enroll in coverage, most in alignment with the new federal SEP ordered by President Biden to ensure consistency of messaging and mitigate confusion among consumers seeking coverage. The federal SEP will run from Feb. 15 to May 15. (For more information about SBM enrollment period changes view this NASHP chart).

Without the SEPs, individuals could only enroll in coverage if they qualified for a special enrollment period triggered by a major life event (e.g., birth, death, marriage) or exceptional circumstance. States with SBMs have the flexibility and authority to set their own health insurance marketplace enrollment periods tailored to the needs of their populations and capacities of their insurers and insurance markets.

Opening enrollment eases the process for individuals to procure needed coverage, especially for the millions of individuals who have found themselves recently uninsured and navigating the unfamiliar landscape of buying coverage through the individual market. The 13 SBMs (12 states and Washington, DC) leveraged this authority last year to open SEPs in response to the pandemic, enabling over

300,000 individuals to enroll in health insurance at a time when economic and public health uncertainties were driving an acute need for coverage. (For more on SBM actions to open SEPs read the NASHP blog, Thousands Flock to Health Insurance Marketplaces as Coverage Shifts due to COVID-19.)

Exchanges Become Trusted Sources of COVID-19 Information

Beyond simply opening SEPs, SBMs are evolving as trusted sources of information and are using their platforms to amplify messaging related to COVID-19 testing, treatment, and vaccinations. At minimum, most SBMs have created new resource pages dedicated to sharing local and national updates related to the virus (read NASHP's blog, State-Based Marketplaces Lead in Increasing Access to Coverage during COVID-19). In other examples:

- MNsure's Twitter page hosts state-branded reminders of the importance of masking;
- Your Health Idaho has used its Instagram page to promote information from Idaho's vaccine advisory committee; and
- Maryland Health Connect interlaces messaging related to COVID-19 testing, treatment, and wellness with information detailing how to shop for coverage.

Most have also partnered closely with their departments of insurance to ensure coordinated messaging describing what is covered under an individual's insurance plan, especially in relation to COVID-19 testing, treatment, and vaccination, such as Pennie's (Pennsylvania's marketplace's) comprehensive COVID-19 FAQs, which make clear that customers should not pay any out-of-pocket costs for the COVID-19 vaccine.

SBMs are also looking for additional opportunities to leverage their community partnerships to help spread important messages, recognizing the importance of working with trusted community leaders especially at a time when face-to-face communication is limited.

For example, Washington, DC's marketplace partnered with local agencies and community groups to host a virtual town hall addressing communities of color, COVID-19 vaccine mistrust, and insurance enrollment. The program was designed to help dispel misinformation and mistrust in the health care system, note the disproportionate impact of COVID-19 on communities of color, and stress the importance of enrolling in quality, affordable coverage.

As more information is available about COVID-19 vaccination and services in their states, SBMs are poised to help spread critical messages. Similarly, the National Academy for State Health Policy (NASHP) will continue to monitor and provide updated information as the SBMs wrap up their open

enrollment periods, open new special enrollment periods, and increase their efforts to help address evolving COVID-19 needs.

This chart describes the regular and special enrollment periods when individuals may sign up for health insurance coverage through either the federal marketplace (healthcare.gov, which 36 states use) or state-operated marketplaces (used by 14 states and Washington, DC).

Marketplace	Original 2021 Open Enrollment Period	2021 COVID-19 Special Enrollment Period (SEP)
Federally facilitated marketplace (36 states)	Nov. 1 – Dec. 15, 2020	Feb. 15 – May 15, 2021*
State-Operated Marketplaces		
California	Nov. 1, 2020 – Jan. 31, 2021	Feb. 1 – May 15, 2021
Colorado	Nov. 1, 2020 – Jan. 15, 2021	Feb.8 – May 15, 2021
Connecticut	Nov. 1, 2020 – Jan. 15, 2021	Feb. 15 – April 15, 2021
DC	Nov. 1, 2020 – Jan. 31, 2021	Jan. 1 – March 31, 2021**
Idaho	Nov. 1 – Dec. 31, 2020	March 1 – 31, 2021
Maryland	Nov. 1 – Dec. 15, 2020	Jan. 1 – May 15, 2021
Massachusetts	Nov. 1, 2020 – May 23, 2021	
Minnesota	Nov. 1 – Dec. 22, 2020	Feb. 16 – May 17, 2021
Nevada	Nov. 1, 2020 – Jan. 15, 2021	Feb. 15 – May 15, 2021
New Jersey	Nov. 1, 2020 – Jan. 31, 2021	Feb. 1 – May 15, 2021
New York	Nov. 1, 2020 – May 15, 2021	
Pennsylvania	Nov. 1, 2020 – Jan. 15, 2021	Feb. 15 – May 15, 2021

Rhode Island	Nov. 1, 2020 – Jan. 23, 2021	Feb. 1 – May 15, 2021
Vermont	Nov. 1, 2020 – Dec. 15, 2020	Feb. 16 – May 14, 2021
Washington State	Nov. 1, 2020 – Jan. 15, 2021	Feb. 15 – May 15, 2021

*Heathcare.gov opened a special enrollment period as a result of President Biden's Jan. 28, 2021 executive order designed to strengthen Medicaid and the Affordable Care Act enrollment.

**Washington, DC will extend its COVID-19 SEP for the duration of its Public Health Emergency.

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An Overview of the Group Health Plan Provisions of the Consolidated Appropriations Act and the Final Transparency in Coverage Regulations

MARY E. POWELL AND SARAH KANTER

JANUARY 2021

The Consolidated Appropriations Act, 2021 (the CAA) contains numerous provisions that impact group health plans. At a high level, these CAA provisions can be broken into three main categories: (1) reducing Out-of-Network (OON) costs for enrollees, (2) providing transparency regarding costs, and (3) permissive changes that allow participants enhanced access to amounts salary reduced to a Health Care Flexible Spending Account (HCFSA) and a Dependent Care Flexible Spending Account (DCFSA). This article will provide an overview of the first two categories. For information regarding the CAA's provisions related to HCFSAs and DCFSAs please see our January 6 Special Alert. In addition, in keeping with the theme of transparency, near the end of 2020 the Departments of Labor, Treasury, and Health and Human Services (HHS) issued the final "Transparency in Coverage" regulations, which include their own set of new disclosure requirements for group health plans — and this article will also provide an overview of these new rules.

Many of the provisions in the CAA are effective in 2022 (although some are effective in 2021). It is critical that plan sponsors have a basic understanding of these CAA provisions (as well as the Transparency in Coverage regulations) because they will necessitate amending vendor contracts and are likely to increase plan expenses in the next several years. We have included certain "action items" for plan sponsors throughout this article, to highlight the steps we recommend that plan sponsors take now to ensure plans will be compliant with these new requirements when they do go into effect.

The No Surprises Act

The *No Surprises Act* is intended to protect consumers from certain surprise medical bills, and it sets up an independent dispute resolution process between the plan and the out-of-network (OON) provider to resolve payment disputes. It also contains other provisions impacting group health plans, as explained below.

The *No Surprises Act* applies to both fully insured and self-funded group health plans, including grandfathered plans (referred to below as "Plan" or "Plans"). It does not appear to apply to excepted benefits (such as Employee Assistance Programs). The provisions in the *No Surprises Act* are very complex, and more guidance will be needed from the Departments of Labor, Treasury and HHS with regard to its implementation. Below is a high-level overview of its key provisions.

Preventing Surprise Medical Billing (Applies to plan years beginning on and after January 1, 2022)

Participants will be protected from surprise medical bills that could arise from OON emergency care, certain ancillary services provided by OON providers at an in-network facility (e.g., an anesthesiologist), and OON care provided at in-network facilities without the patient's informed consent.[1] For these services, a participant will be required to pay only the in-network cost-sharing amount, which must be applied to the participant's deductible and out-of-pocket maximums (OOPM) under the Plan. Providers will not be able to "balance bill" participants for the remaining amounts.[2]

Air Ambulance Claims. If a Plan covers in-network air ambulance services, then participants can only be required to pay the in-network cost-sharing amount for an air ambulance, and those amounts paid will be applied to the participant's deductible and OOPM under the Plan. Air ambulance providers will not be able to balance bill participants for the remaining amounts. Plans will be required to provide detailed reports on air ambulance claims to the federal government. Note: This provision does not apply to ground ambulance claims.

Independent Dispute Resolution. For the OON claims described above, the Plan must make initial payment or issue a denial to the provider within 30 days of receiving the provider's bill. If there is no agreement on the amount owed, the OON claim may be submitted to arbitration initiated by the Plan or the provider (referred to as "Independent Dispute Resolution").[3] The party who loses at arbitration must pay the entire cost of arbitration.

TH COMMENT: While in most cases the participant will only be paying the in-network costs, the Plan will be paying the OON costs. This will increase Plan costs. The idea behind this, beyond protecting individual consumers, may be that the Plan is in a better position to negotiate these large OON bills; so over time, these OON costs may come down.

ACTION ITEMS:

- For self-funded plans with third-party administrators (TPAs), agreements must be revised to include the quick payment/denial provisions, payment of arbitration costs, and the reporting requirements for air ambulance services.
- For both insured and self-funded plans, begin discussion with insurers/TPAs to determine the expected increase in cost due to these new requirements.

- Plan documents and Summary Plan Descriptions (SPDs) will need to be revised to include these new provisions.

Other Provisions in the No Surprises Act

Transparency Regarding In-Network and OON Deductibles and Out-of-Pocket Limits (Effective for plan years beginning on or after January 1, 2022). A physical or electronic identification card for Plan coverage must disclose:

- In-network and out-of-network deductibles;
- Any OOPM for the Plan coverage; and
- A telephone number and website address through which an enrollee may seek assistance (e.g., information related to in-network hospitals and urgent care facilities).

ACTION ITEM: Plan sponsors will need to ensure that agreements with an insurance carrier and/or TPA require compliance with this new rule.

Protections Against Provider Discrimination (Effective Date Not Known). The Patient Protection and Affordable Care Act (ACA) contained a provision that prohibited discrimination against "any willing provider." The applicable agencies never issued regulations implementing this provision, and instead stated that the statutory language was sufficiently clear. Congress apparently did not agree, as the CAA requires that the agencies propose regulations no later than January 1, 2022, and issue final regulations no later than six months after comments are received. It is unclear what this will mean for Plans.

Advanced Explanation of Benefits, if Requested, for Scheduled Services (Effective for plan years beginning on or after January 1, 2022). Upon request, Plans must send participants an advanced explanation of benefits (EOB) before scheduled care. In most cases, this advanced EOB is due at least 3 business days before such service is to be furnished, but not later than 1 business day after the date of such scheduling.[4] This EOB must include a list of information including,

- whether or not the provider or facility is in-network;
  - if in-network, the contracted rate under the Plan for such services (based on billing and diagnostic codes);
  - if out-of-network, a description of how the individual can obtain information on in-network providers of those services;
- a good faith estimate of the cost received by the provider or facility based on the billing and diagnostic codes;
- the amount the Plan is responsible for paying;
- a good faith estimate of the amount of any cost-sharing the enrollee must pay;
- a good faith estimate of the amount the enrollee has incurred toward meeting the limit of financial responsibility under the Plan (i.e., the deductible and OOPM);

- in the case of a service subject to medical management techniques (e.g., step therapy, prior authorization), a disclaimer that the service is subject to medical management; and
- a disclaimer that the information is only an estimate and subject to change.

TH COMMENT: This advanced EOB will provide participants with insight on the additional costs that come with using an OON provider.

ACTION ITEMS:

- Plan sponsors will need to ensure that their TPA and/or insurance carrier will comply with these requirements. Agreements for self-funded plans must be updated to include advanced EOBs, and should specify which entity is responsible for penalties and costs associated with not providing this advanced EOB (or providing incorrect information).
- The TPA or plan sponsor should also consider how the method for requesting these advanced EOBs will be communicated to participants, including a statement that the information is only an estimate and could change.

Continuity of Care (Effective for plan years beginning on or after January 1, 2022). For a "continuing care patient" who is receiving certain types of in-network care, the Plan must provide 90 days of continued in-network coverage to the participant if his/her treating in-network provider leaves the network (or 90 days from the date that the participant is no longer a continuing care patient, whichever is earlier). A continuing care patient is a person who is: (1) undergoing a course of treatment for a serious and complex condition from the provider or facility; (2) undergoing a course of institutional or inpatient care from the provider or facility; (3) scheduled to undergo nonelective surgery from the provider; (4) pregnant and undergoing a course of treatment for pregnancy from the provider; or (5) determined to be terminally ill and is receiving treatment for such illness from the provider or facility. This requirement does not apply to for-cause terminations of a provider.

TH COMMENT: This will have a cost impact on the Plan. While the participant is only paying the in-network costs, the provider will be OON — and the Plan must pay the additional OON costs.

ACTION ITEMS:

- Understand how the TPA or carrier will communicate this to impacted enrollees;
- Update the SPD to explain this rule; and
- Understand the cost impact of this rule.

Price Comparison Tool (Effective for plan years beginning on or after January 1, 2022). A Plan must offer price comparison guidance by phone and also make available on the Plan website a price comparison tool that allows a Plan enrollee to compare the amount of cost-sharing that an individual would be responsible for paying with respect to a specific item or service — factoring in Plan year, geographic region and participating providers.

TH COMMENT: Plan sponsors may believe that the TPA or insurance carrier already has this kind of tool. However, we do not believe that most of the current price comparison tools includes information for all services.

ACTION ITEMS:

- Determine how any comparison tool currently offered by a TPA or carrier must be updated to comply with this requirement, and the costs associated with that update; and
- Update TPA agreements to address who is responsible for major errors contained in the tool, and specify what kind of disclaimer language should be included with the price comparison tool.

Provider Directories (Effective for plan years beginning on or after January 1, 2022). Plans must ensure that their in-network directories are up-to-date (and can be relied upon) and that participants can access the directory online or by phone. The Plan must include a process for verifying the accuracy of the provider information in-cluded in the directory at least every 90 days, and have a procedure in place for removing a provider or facility if the Plan has been unable to verify the provider or facility's information. If a participant requests information via phone regarding whether a provider is in-network, the Plan must respond in writing (or electronically — as preferred by the participant) within one business day (and this communication must be maintained in the individual's file for at least 2 years).

The Plan must also establish a database on the public website of the Plan (or issuer) that contains a list of each provider and facility that has a direct or indirect contractual relationship with the plan; and directory information (name, address, specialty, phone number and digital contact information for the provider). A participant who relies on any inaccurate provider directory information will be responsible for only the in-network cost-sharing amount.

TH COMMENT: Again, this can create increased costs for the Plan. An error relied on by the participant means that he/she will only be paying the in-network cost sharing, but the Plan will be paying an OON bill.

ACTION ITEMS:

- TPA agreements will need to be revised to include this service, as well as a provision indemnifying the Plan against any additional costs due to an error in the directory.
- The TPA agreement should specify that the TPA will maintain the response communication for the required period, and that any such documentation will be provided to the next TPA.

Additional Transparency Requirements in the CAA

As noted above, in addition to the *No Surprises Act*, the CAA contained a number of separate provisions that are also intended to increase transparency regarding costs and coverage. These requirements are explained below.

Removal of Gag Clauses (appears to be effective now)

Plans cannot enter into any agreement with healthcare providers, network of providers, TPAs or others who offer access to a network of providers, if that contract would, directly or indirectly, preclude the Plan from:

- disclosing provider-specific cost or quality-of-care information or data, through a consumer engagement tool or other means, to referring providers, the plan sponsor, enrollees, or individuals eligible to become enrollees;
- electronically accessing de-identified claims information (in accordance with HIPAA, GINA and the ADEA); and
- sharing the above information with a business associate.

The agreement can allow the provider or network to include reasonable restrictions on public disclosure of the information. The Plan must submit an annual attestation to HHS that the plan is in compliance with these requirements.

TH COMMENT: Gag clauses are in many TPA agreements. For example, the TPA agreement may state that the Plan will pay at the "PPO Rates" but those rates and how they are determined are categorized as "proprietary information" or "confidential information."

ACTION ITEM: Closely review TPA agreements for gag clauses, which must be removed.

Information about Direct and Indirect Compensation (Applies to contracts that are executed or renewed on and after December 27, 2021)

The ERISA prohibited transaction rules limit the types of transactions that an ERISA plan can enter into with a "party in interest" (which includes service providers). There is an exemption under ERISA Section 408(b)(2) that allows a plan to pay "reasonable compensation" to a party in interest. There are specific regulations implementing ERISA Section 408(b)(2) for retirement plans, but not for health and welfare plans. The CAA has now added specific disclosure requirements for group health plans so that a contract for brokerage services[5] or consulting[6] will only be considered "reasonable" if certain disclosures are made by the service provider to the plan. This requirement only applies to contracts where the service provider reasonably expects to receive $1,000 or more in compensation (direct or indirect) in connection with providing the services. Specifically, these rules will require the disclosure of, among other things, whether the service provider will provide fiduciary services, the direct and indirect compensation received by brokers and consultants related to the health plan, such as for steering plans to certain vendors. For example, a consultant may receive a commission or production bonus from a TPA for the placement of business with that TPA. This type of compensation must now be disclosed to the plan sponsor. It is notable that this new rule does not apply to insurance carriers or pharmaceutical benefits managers (PBMs).

This information must be disclosed to the responsible plan fiduciary before the contract is entered into, extended or renewed. The plan fiduciary must be notified of any change to the required disclosures no later than 60 days from the date that the service provider is informed of the change. There is a good faith reliance standard in the rule for the responsible plan fiduciary, but it must take reasonable steps to obtain missing information and correct any incorrect information

upon discovery. If that fails, the plan fiduciary must provide notice to the DOL (containing specific information) and consider terminating the contract.

It appears that this rule applies only if ERISA plan assets are used. If the plan is funded by a trust, then in most cases ERISA plan assets will be used. What if there is no trust? Note that participant contributions are plan assets. Generally, plan assets must be held in trust. However, if the *sole* reason that a plan would be considered funded (and need a trust) is the presence of participant contributions under a cafeteria plan, the plan will be deemed to be unfunded for trust purposes (DOL Technical Release 92-01). This does not mean that there are no plan assets. Rather, the DOL Technical Release says that the DOL will not enforce the trust requirement solely because there are participant contributions.

Example: Assume that there is no trust, the health plan is fully-insured and part of the premiums are paid by participants. Also assume that the broker is paid commissions from the insurance carrier for the placement of that plan. Are plan assets involved because the commission is likely paid based on the insurance premium payments — which are in part paid by participant contributions (plan assets)? We believe the answer is yes. For a self-funded plan that does not have a trust, what if certain administrative costs are used in determining the premium — are plan assets involved? Again, we believe that the answer is yes.

We expect that the DOL will issue detailed regulations about this rule.

TH COMMENT: Guidance from the DOL will be critical because we are concerned that brokers and consultants may try to claim that all costs are paid by the employer and no plan assets are involved. When similar rules were issued for retirement plans, it was the basis for many class action lawsuits regarding unreasonable costs and fees paid by plan assets, so it will be important for plan sponsors to understand the amount of indirect compensation paid to these providers.

ACTION ITEMS:

- Locate and review all broker and consultant agreements with the group health plan and determine when they renew; and
- Begin discussions with brokers and consultants regarding these provisions and the necessary changes that will need to be made to the agreements.

Mental Health Parity and Addiction Equity Act —Transparency (Effective February 10, 2021)

Health plans that provide both medical/surgical benefits and mental health/substance abuse benefits, and which impose nonquantitative treatment limitations (NQTLs) on mental health/substance abuse benefits, must perform and document a detailed comparative analysis. This analysis must be made available to a state authority, DOL or HHS beginning 45 days after the enactment of the CAA (February 10, 2021), but only upon request from one of those agencies. We believe that a request by a government agency for this documentation will likely be triggered by a participant complaint.

The CAA contains detailed and specific rules about what must be contained in the comparative analysis. If the applicable agency reviews the comparative analysis and determines that the plan

is not in compliance, the plan must specify the actions it will take to be in compliance and, within 45 days, provide the agency with a new comparative analysis that demonstrates compliance. Following the 45-day corrective action period, if the applicable agency makes a final determination that the plan is not in compliance, then not later than 7 days after such determination, the agency shall notify all individuals enrolled in the plan that the plan is not in compliance.

TH COMMENT: The comparative analysis requirements in the CAA are long and complicated. The plan sponsor must ensure that it has entered into a contract with a vendor that can complete this analysis in the timeframes required. A failure to meet these rules will cause the agency to inform all participants of the plan's non-compliance — which we believe will likely lead to class action lawsuits against the plan.

ACTION ITEMS:

- Ensure that the plan has a vendor that will provide this comparative analysis.
- Be prepared to respond to a request for documentation.

Reporting on Drug Prices (effective December 27, 2021, and each June 1 thereafter).

Group health plans must provide to the Departments of Labor, Treasury and HHS certain information regarding costs associated with the plan's prescription drug benefit. The first report will be due by December 27, 2021, and subsequent reports will be due no later than June 1 of every subsequent year. The information that must be included in this report includes:

1. the beginning and end dates of the plan year;
2. the number of participants and beneficiaries,
3. each state in which the plan is offered
4. the 50 brand prescription drugs most frequently dispensed (including number of paid claims for those drugs),
5. the 50 most costly prescription drugs by annual spend (including the annual spend amount for those drugs),
6. the 50 prescription drugs with the greatest increase in plan expenditures,
7. information about the total spending on health care services,
8. the average monthly premium paid by employers and employees,
9. the impact on premiums of rebates, coupons, other similar renumeration paid by drug manufacturers to the plan; and
10. any reduction in premiums and out-of-pocket costs associated with rebates, fees or other remuneration described in #9.

The CAA requires that HHS make available on its website a report on prescription drug reimbursements under health plans, prescription drug pricing trends, and the contribution of prescription drug costs to premium increases or decreases under such plans. This information is to be aggregated in a way that no plan-specific information will be made public.

TH COMMENT: This is a game changer. A plan sponsor should use this information in any future request for proposal (RFP). It should also use this information to revise what it pays for current prescription drugs — and even which prescription drugs are included on the formulary. We expect that plaintiffs' lawyers will also be looking carefully at this data as a basis for class action lawsuits. Many plans have a high deductible which must be paid before most plan coverage begins. Plaintiffs' lawyers may be looking for information to determine if participants are grossly overpaying for prescription drugs prior to reaching the deductible.

ACTION ITEM: Agreements with TPAs and PBMs will need to be revised to include this reporting service.

Transparency in Coverage Regulations — Separate from the CAA

Prior to the passage of the CAA, the Departments of Labor, Treasury and HHS issued final regulations regarding transparency of health plan costs. For group health plans there are two main aspects of the regulations that are explained below. Note that these rules do not apply to excepted benefits (such as vision or dental), retiree-only plans or grandfathered plans.

These new rules include a safe harbor for sponsors of fully insured plans if there is a written agreement with the health insurer to provide this information. There is not any similar relief for self-funded health plans.

Negotiated In-Network and Out-of-Network Allowed Amounts (Effective for plan years beginning on and after January 1, 2022). Plans must publicly post three machine-readable files:

#1 *In-Network File* — All applicable rates (negotiated rates and fee schedules) with in-network providers

#2 *Out-of-Network Allowed Amount File* — Data outlining the historical allowed amounts for covered items and services provided by OON providers

#3 *Prescription Drug File* — Negotiated rates and historical net prices for prescription drugs furnished by in-network providers

This information must be updated monthly and made publicly available on the plan's website free of charge. Individuals should be able to access the files without having to log-in. The rule includes specific requirements for each file.

TH COMMENT: First, this obligation is a huge burden on plans. Plan sponsors should be looking for vendors that can fulfill this obligation. Second, this is a game changer. This will be the first time that a plan sponsor will be able to obtain data on what other plan sponsors are paying for these services. This should, in the long run, bring down health plan costs. Plan sponsors are currently flying blind in RFPs, not knowing what the price should be for services. Plan sponsors are currently in a cycle in which the TPA or insurance carrier proposes highly marked-up prices and the plan sponsor tries to negotiate those down. The amount of the price decrease that can be negotiated is usually based primarily on the size and sophistication of that plan sponsor. Hopefully, access to this kind of database will break that cycle and provide plan sponsors with an advantage in future negotiations with service providers.

ACTION ITEM: TPA, insurance carrier and PBM contracts will need to be amended to comply with these new rules, and the negotiation process should begin early in 2021.

Disclosure of Cost Information (phased in over time, starting with plan years beginning on and after January 1, 2023). Upon request by an enrollee, health plans must disclose estimates of cost-sharing for covered healthcare items and services from a particular provider. The goal is to enable enrollees to obtain an estimate of out-of-pocket expenses in advance of the services. This will be phased in over time. This information must be first available for a specific list of 500 items and services as of January 1, 2023, with information for all items and services as of January 1, 2024.

Plans must disclose the cost-sharing estimates through a user-friendly online service tool and also paper. This information is only available to current enrollees. The tool should provide information for a specific in-network provider or all in-network providers. The tool should take into account different cost-sharing based on multi-tier networks and place-based settings (such as outpatient versus a hospital). The tool must also include the ability to search for OON services and providers.

An enrollee may request that this be in paper form, limited to information for up to 20 providers per request, and the information must be mailed or emailed within 2 business days of the request.

There are seven content elements that must be disclosed on request:

- Estimated cost-sharing liability based on actual rates, allowed amounts, and individual-specific cost-sharing limits (can provide a range)
  - Does not include premiums or balance billing for OON
- Accumulated amounts
  - The amount that the individual has already paid towards the plan's deductible and OOPM
  - Reflect any progress towards reaching a treatment limit (such as number of therapy visits)
- In-network rates for covered items and services
  - This is required even if that rate does not impact the individual's cost-sharing liability
  - For prescription drugs, it is the negotiated rate (not required to disclose the rebates, discounts, or price concessions)
- Out-of-Network Allowed Amounts
- Items and services content list for a bundled payment
  - This is a list of all of the items and services reflected in the cost-sharing estimate for a bundled payment
- A notice of prerequisites to coverage
  - Such as prior authorization or step-therapy
- Disclosure notice

ACTION ITEMS:

- Understand the requirements of these rules;
- Determine who within the organization will be responsible for ensuring that the plan sponsor has engaged the vendors needed for it to comply with these rules; and
- Create a budget for compliance with these rules.

Conclusion

These rules have gone a bit under the radar. All of the above rules were issued in 2020 (prior to Joe Biden becoming President), but it was late in the year when the nation was focused on COVID-19, the holidays and the Presidential election. We believe that these rules will have a significant impact on health plan coverage — more than anything else we have seen since the passing of the ACA. It is a heavy lift for plans for the next few years. Plan sponsors should be sure that they have a basic understanding of the rules so that they can create workstreams and budgets as soon as possible in 2021.

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[1] There is an exception for nonemergency services provided by OON providers at in-network facilities if the patient knowingly and voluntarily agrees to use the OON provider. In that circumstance, the provider is obligated to notify the patient prior to the scheduled services regarding estimated cost and identifying available in-network options. The "knowing and voluntary consent exception" will not apply if: (1) there is no in-network provider available in the facility; (2) the care is for unforeseen or urgent services; or (3) the provider is an ancillary provider that a patient typically does not select (e.g., a radiologist or anesthesiologist).

[2] Currently, OON providers often "balance bill" participants the difference between the amount paid by the participant's group health plan and the amount charged by the provider. These balance-billed amounts can be very substantial.

[3] Insured group health plans may be subject to state laws that regulate the way certain OON claims are resolved. If a state does not have such a law, then the provisions in the CAA will apply. The provisions in the CAA will apply to self-funded group health plans.

[4] In the case of a service scheduled at least 10 business days before the service is performed, the EOB must be furnished not later than 3 business days after the date of the scheduling or request.

[5] The new rule applies to brokerage services provided to an ERISA group health plan with respect to the selection of, among other things, insurance (including vision and dental), recordkeeping services, medical management vendors, benefits administration, stop-loss insurance, and pharmacy benefits management services.

[6] The new rule applies to consulting services provided to an ERISA group health plan related to, among other things, the development or implementation of plan design, insurance selection, and recordkeeping.

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Many Uninsured Adults Have Not Tried to Enroll in Medicaid or Marketplace Coverage

Findings from the September 2020 Coronavirus Tracking Survey

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The size of the uninsured population declined significantly following implementation of the coverage provisions of the Affordable Care Act (ACA) in 2014 but has grown in recent years. In 2019, an estimated 28.9 million nonelderly adults and children were uninsured, an increase of 2.2 million since 2016 (Tolbert and Orgera 2020). The economic downturn caused by the COVID-19 pandemic has resulted in steep increases in unemployment and related losses of employer-sponsored insurance (ESI; Fronstin and Woodbury 2020).[1] Though some losing ESI during the pandemic have enrolled in coverage through Medicaid and the ACA Marketplaces to avoid becoming uninsured, eroding ESI rates mean increases in uninsurance are unlikely to reverse, and could accelerate, during the current recession (Banthin and Holahan 2020; Banthin et al. 2020; Corallo and Rudowitz 2020; Gangopadhyaya, Karpman, and Aarons 2020; Garfield et al. 2020; Karpman and Zuckerman 2020).

Lack of awareness or understanding of publicly subsidized coverage options among the uninsured may result in people not enrolling in programs for which they qualify. This may be especially true for those newly losing ESI, who may have little prior experience with subsidized coverage. After large investments in outreach and enrollment assistance when the ACA was enacted, the Trump administration dramatically cut public education and enrollment support. Erosion of ESI and declining incomes during the pandemic will likely make millions of people eligible for publicly subsidized coverage, but they will need to understand their options and may need help enrolling to avoid becoming uninsured.

In this brief, we assess awareness of and experiences with publicly subsidized coverage options among adults who were uninsured in September 2020. To do so, we analyze data from the second wave of the Urban Institute's Coronavirus Tracking Survey, fielded September 11 through 28, 2020. We find that though some uninsured adults were aware of publicly subsidized coverage options, critical knowledge gaps remained, and many uninsured people had not attempted to enroll in coverage for which they may be eligible. We also find perceptions of Marketplace affordability and eligibility for Medicaid and the Children's Health Insurance Program (CHIP) may keep some people from enrolling. Our main findings are as follows:

- Some uninsured adults are unfamiliar with the Marketplaces and available financial assistance to subsidize purchasing such coverage. In September 2020, only about half of uninsured adults (53.9 percent) had heard a lot or some about the Marketplaces. Just under two-thirds of uninsured adults (64.9 percent) had heard nothing or only a little about financial assistance for Marketplace coverage.
- Almost half of uninsured adults familiar with Marketplace health plans had not looked for information on them, most commonly because of cost concerns.
- Just 29.3 percent of uninsured adults had tried to obtain Medicaid/CHIP coverage. Most commonly, those who did not try to obtain Medicaid/CHIP did not think they would qualify.
- Nearly half of all uninsured adults (47.0 percent) had neither looked for information on Marketplace coverage nor tried to obtain Medicaid/CHIP.
- Of all uninsured adults, only about 2 in 10 had both sought information about Marketplace coverage and tried to obtain Medicaid/CHIP; about 3 in 10 uninsured adults had done one or the other.

To avoid large increases in uninsurance as the pandemic continues, federal and state governments will need to boost awareness and understanding of Marketplace and Medicaid/CHIP coverage and provide more enrollment assistance, particularly for those who may be qualifying for the first time. Raising awareness of available financial assistance and simplifying enrollment processes may also help. Policymakers have indicated interest in increasing opportunities to enroll; for instance, the Biden administration has just announced a proposal to extend the federal Marketplace open enrollment period to ensure more people needing coverage during the public health crisis can obtain it.[2] If combined with substantial government outreach efforts and the administration's proposal to enhance the generosity of and expand eligibility for premium tax credits during the pandemic, these proposals could make inroads with the largest segment of uninsured adults, those who may qualify for Marketplace subsidies but have been dissuaded from seeking information about or enrolling in Marketplace coverage over cost concerns (Gunja and Collins 2019).

Background

Families with an uninsured person have several coverage options. For uninsured people previously covered by ESI before a job loss, COBRA coverage can extend ESI for up to 18 months. But, it requires former employees to pay the full cost of coverage, which can be prohibitively expensive, especially given income losses (Garfield et al. 2020).[3] Medicaid and CHIP allow enrollment on the basis of income for those who meet citizenship and immigration status requirements, including children, whose median Medicaid/CHIP threshold is 255 percent of the federal poverty level (FPL); adults with incomes below 138 percent of FPL in the 37 states (including the District of Columbia) that had adopted the ACA's Medicaid expansion option by 2020; and some parents with very low incomes in the remaining states that have not expanded Medicaid, hereafter called "nonexpansion states" (Brooks et al. 2020). Beneficiaries can also enroll on the basis of disability or pregnancy. Additionally, Marketplaces allow enrollment during defined open enrollment periods and temporary special enrollment periods for those with a qualifying event, such as job or insurance loss. And people with incomes between 100 and 400 percent of FPL who do not qualify for Medicaid/CHIP can receive tax credits to make Marketplace coverage more affordable; additional cost-sharing subsidies are available for those with incomes below 250 percent of FPL.[4] So, depending on a person's state of residence, income, and immigration status, one may either be eligible for Medicaid/CHIP, eligible for advanced premium tax credits through the Marketplaces, or ineligible for subsidized coverage (Gunja and Collins 2019; Pollitz and Claxton 2020).[5]

However, even those eligible for subsidized coverage may face multiple barriers to enrollment. Research shows few uninsured people report not needing or wanting insurance; rather, they face other obstacles to obtaining and affording coverage (Tolbert and Orgera 2020). According to focus groups with uninsured people conducted during the pandemic, many uninsured adults desire coverage and see its benefits, but seeking coverage is a lower priority than more immediate needs, such as replacing lost income.[6] Moreover, to enroll in such coverage, people must know about and understand the available options. Many adults have low health insurance literacy, meaning they lack familiarity with health insurance concepts and terms.[7] Though awareness of financial assistance for coverage under the ACA has grown in recent years, recent survey data show fewer people are aware of the Marketplaces than are aware of Medicaid (Collins et al. 2015; Pollitz et al. 2020; Saloner et al. 2020). And barriers extend beyond awareness: in one recent study, most uninsured adults who tried to obtain coverage reported finding at least one of the enrollment steps somewhat or very difficult (Pollitz et al. 2020). Moreover, some people report not knowing if they will qualify for or be able to afford Medicaid or Marketplace coverage, concerns that may be even more relevant during the pandemic and recession, with incomes in flux and worries about adding new monthly expenses, such as premiums for coverage (Collins et al. 2015).[8]

In this brief, we use data from the Urban Institute's Coronavirus Tracking Survey, conducted in September 2020, to assess awareness of publicly subsidized coverage options and experiences seeking to obtain these forms of coverage among uninsured adults. Our findings indicate that as the

pandemic continues in 2021, further efforts will be needed to inform uninsured people about coverage options, available financial assistance, eligibility requirements, and how to enroll in coverage.

Results

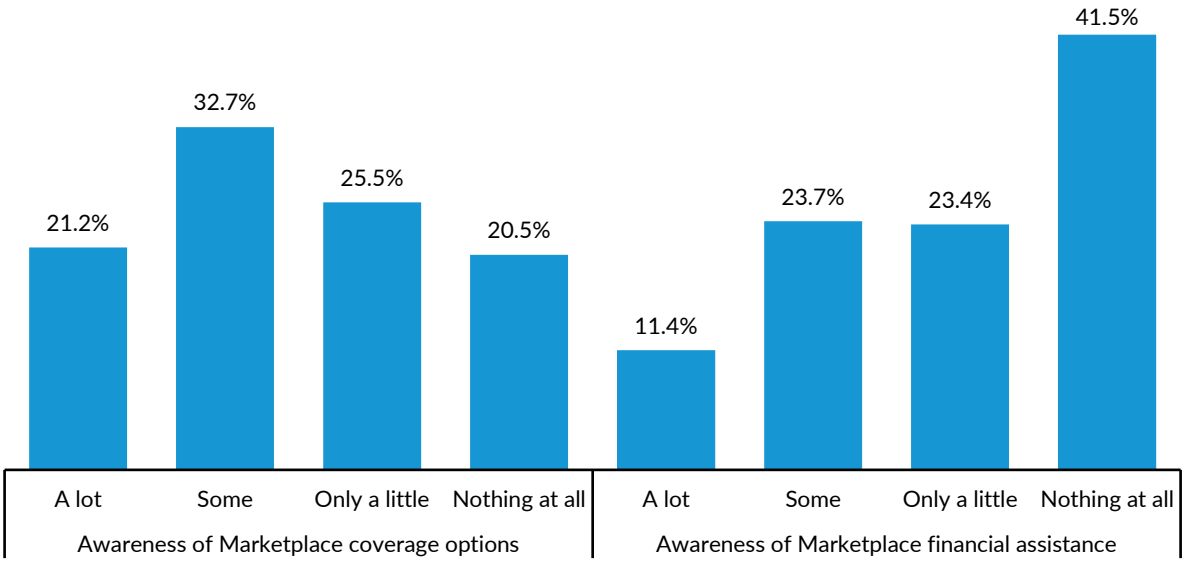
Many uninsured adults are unfamiliar with the health insurance Marketplaces and available financial assistance for purchasing such coverage.

Though the ACA's Marketplaces have existed since 2014, only about half of adults who were uninsured in September 2020 reported having heard a lot (21.2 percent) or some (32.7 percent) about them; the remainder knew only a little (25.5 percent) or nothing at all (20.5 percent), as shown in figure 1.[9]

An even greater share of uninsured adults was unaware of subsidies to make Marketplace premiums and out-of-pocket costs more affordable. Only about one in three uninsured adults reported hearing a lot (11.4 percent) or some (23.7 percent) about this financial assistance, whereas the majority heard only a little (23.4 percent) or nothing at all (41.5 percent).

FIGURE 1

Awareness of Marketplace Health Plans and Financial Assistance among Uninsured Adults Ages 18 to 64, September 2020



URBAN INSTITUTE

Source: Urban Institute Coronavirus Tracking Survey, wave 2.

Notes: X-axis labels are responses to two questions: "How much have you heard about the health insurance Marketplaces, which can be used to shop for health insurance and compare prices and benefits?" And, "Some people are able to get subsidies for premiums and out-of-pocket health care costs in the health insurance Marketplaces. How much, if anything, have you heard about these subsidies?" The survey was conducted September 11 through 28, 2020, and 91 percent of respondents completed

the survey by September 17. Respondents for whom Marketplace knowledge and experiences were not assessed or who did not respond to the questions (16.3 percent) are excluded.

Many uninsured adults who are familiar with the Marketplaces have not looked for information on Marketplace health plans, most commonly because of cost concerns.

Just over half of uninsured adults familiar with Marketplace health plans had sought information about them; an estimated 55.1 percent reported they had looked for information on Marketplace plans, whereas 44.9 percent had not.

Moreover, uninsured adults most commonly reported cost as their reason for not seeking information on or enrolling in Marketplace coverage. Among the 55.1 percent who had looked for information on Marketplace plans, more than 7 in 10 (42.2 percent of all uninsured adults familiar with Marketplace plans) reported they did not enroll because of cost, or because they could not afford a plan or qualify for subsidies. And among the 44.9 percent who had not looked for information about enrolling, more than half (28.4 percent of all uninsured adults familiar with Marketplace plans) did not look for information because they believed the cost would be too high or they would be unable to afford the coverage.

For some, low awareness of financial assistance for purchasing Marketplace coverage may correspond with perceiving such coverage as unaffordable. This suggests public education about subsidies could expand interest in enrolling. For others, coverage may be unaffordable even with financial assistance. Though subsidies make coverage more affordable for those who qualify, Marketplace premiums can be as high as nearly 10 percent of family income (for those with incomes between 300 and 400 percent of FPL). In addition, subsidies are not provided to those with incomes at or above 400 percent of FPL, meaning Marketplace coverage can be costly even for those with moderate incomes.[10]

TABLE 1

Experiences Looking for Marketplace Coverage among Uninsured Adults Ages 18 to 64 Familiar with Such Coverage, September 2020

	Percent
Looked for information on Marketplace health plans	**55.1**
Did not enroll because cost was too high, they cannot afford the insurance, or they did not qualify for subsidized coverage	42.2
Did not look for information on Marketplace health plans	**44.9**
Did not look because cost was too high or they cannot afford the insurance	28.4

Source: Urban Institute Coronavirus Tracking Survey, wave 2.

Notes: Reasons for not enrolling in or seeking information on Marketplace health plans are responses to the following questions: "What is the main reason why you have not enrolled in a health insurance plan in the Marketplace?" And, "Which of the following is the main reason that you have not looked for information on health insurance plans in the Marketplace?" The survey was conducted September 11 through 28, 2020, and 91 percent of respondents completed the survey by September 17.

People familiar with Marketplace plans have at least a little awareness of the Marketplaces. Respondents for whom Marketplace knowledge and experiences were not assessed or who did not respond to the questions (16.3 percent) are excluded.

Just 29.3 percent of uninsured adults had tried to obtain Medicaid/CHIP coverage. Most commonly, those who did not apply did not think they would qualify.

Only about 3 in 10 adults who were uninsured in September 2020 had tried to obtain Medicaid/CHIP. The most commonly reported barrier to enrolling was not qualifying for coverage; 19.9 percent of all uninsured adults did not enroll for this reason. Similarly, those who had not tried to obtain coverage most commonly believed they would not qualify (39.8 percent of all uninsured adults).

Some adults may indeed not qualify for Medicaid, especially those in nonexpansion states, where nonpregnant, nondisabled adults without children cannot qualify for Medicaid at any income level, and the median parental Medicaid eligibility threshold is just 41 percent of FPL (Brooks et al. 2020). In addition, federal regulations prohibit undocumented noncitizens and many legally present noncitizens from enrolling. Of the adults identified as uninsured in the Coronavirus Tracking Survey, 44.6 percent reported incomes at or below 138 percent of FPL, just 12.0 percent reported incomes above 400 percent of FPL, and 77.8 percent were citizens (data not shown). Thus, though some uninsured adults are, in fact, ineligible for Medicaid, many uninsured adults may qualify (Collins, Gunja, and Doty 2017).

TABLE 2

Experiences Trying to Obtain Medicaid/CHIP among Uninsured Adults Ages 18 to 64, September 2020

	Percent
Tried to obtain coverage through Medicaid/CHIP	**29.3**
Did not enroll because they were told they were ineligible	19.9
Did not try to obtain coverage through Medicaid/CHIP	**70.7**
Did not think they were eligible or told they were told ineligible	39.8

Source: Urban Institute Coronavirus Tracking Survey, wave 2.

Notes: CHIP = Children's Health Insurance Program. The table shows responses to the question, "Have you tried to obtain coverage through Medicaid, Medical Assistance (MA), the Children's Health Insurance Program (CHIP), or any kind of state or government-sponsored assistance plan based on income or a disability?" Reasons for not enrolling in or trying to obtain coverage are responses to the following questions: "What is the main reason you are not currently enrolled in Medicaid, MA, CHIP, or another state or government-sponsored assistance plan?" And, "What is the main reason you did not try to obtain coverage through Medicaid, MA, CHIP, or another state or government-sponsored assistance plan?" The survey was conducted September 11 through 28, 2020, and 91 percent of respondents completed the survey by September 17. Respondents for whom Medicaid/CHIP knowledge was not assessed or who did not respond to the questions (16.2 percent) are excluded.

Overall, nearly half of uninsured adults had not tried to obtain either Marketplace or Medicaid/CHIP coverage. Only about 2 in 10 uninsured adults had sought information about Marketplace coverage and tried to obtain Medicaid/CHIP, and about 3 in 10 had only looked for information about one or the other.

Table 3 combines reported experiences seeking both Marketplace and Medicaid/CHIP coverage among adults who were uninsured in September 2020. Nearly half of uninsured adults who reported their experiences said they had not sought Marketplace or Medicaid/CHIP coverage (47.0 percent).[11] That nearly half of uninsured adults had not attempted to enroll in these plans suggests major coverage gains could be achieved with additional program awareness and enrollment assistance. About one in five uninsured adults (21.1 percent) reported having sought information on both Marketplace and Medicaid/CHIP coverage. We find 23.4 percent of uninsured adults had tried to obtain information about Marketplace coverage but not Medicaid/CHIP, and a smaller share (8.4 percent) had tried to obtain Medicaid/CHIP but had not looked for information on Marketplace coverage.

TABLE 3

Experiences Seeking Marketplace and Medicaid/CHIP Coverage among Uninsured Adults Ages 18 to 64, September 2020

	Percent
Has not looked for information on Marketplace coverage or tried to obtain Medicaid/CHIP	47.0
Has looked for information on Marketplace coverage and has tried to obtain Medicaid/CHIP	21.1
Has looked for information on Marketplace coverage but has not tried to obtain Medicaid/CHIP	23.4
Has tried to obtain Medicaid/CHIP but has not looked for information on Marketplace coverage	8.4

Source: Urban Institute Coronavirus Tracking Survey, wave 2.

Notes: CHIP = Children's Health Insurance Program. See the endnotes for how we constructed this hierarchy. Not seeking Marketplace coverage includes not having heard of Marketplace coverage. The survey was conducted September 11 through 28, 2020, and 91 percent of respondents completed the survey by September 17. Respondents for whom either Medicaid/CHIP or Marketplace knowledge was not assessed or who did not respond to the questions (16.7 percent) are excluded.

Discussion

Findings from the Coronavirus Tracking Survey indicate nearly half of adults who were uninsured in September 2020 had not sought Marketplace or Medicaid/CHIP coverage. Many were unfamiliar with the health insurance Marketplaces—especially with the availability of financial assistance for such coverage—or did not believe they would qualify for Medicaid/CHIP. As policymakers craft policies to minimize coverage losses during the pandemic and recession and to reverse the coverage declines since 2016, these findings show the importance of raising awareness about available coverage options

among uninsured people, informing them about eligibility rules and affordability, and helping them enroll in coverage.

Various recent policy choices could be contributing to difficulties navigating the health insurance coverage landscape, including for people recently losing ESI, who may have less knowledge of available subsidized coverage options. The Trump administration cut outreach and enrollment funding, such as that for advertising the availability of coverage through federal Marketplaces and for health insurance navigators, who are often instrumental to Medicaid and Marketplace enrollment (Pollitz et al. 2020).[12] Several recent federal and state-level policy discussions and decisions may be further confusing consumers about coverage options or deterring them from seeking coverage, including consideration of ACA repeal, proposals for restrictions on Medicaid (e.g., work requirements and other administrative hurdles), elimination of federal coverage mandate penalties, easing of restrictions on less comprehensive plans, and expansion of the "public charge" rule to consider public benefits use among some immigrant families (Artiga and Pham 2019; Bernstein et al. 2019; Haley et al. 2020; Pollitz et al. 2020).

As the pandemic continues, the new administration, Congress, and states officials could enact several policies to improve awareness and accessibility of Marketplace and Medicaid/CHIP coverage.

Expanding outreach and enrollment assistance. The Biden administration could boost awareness of coverage options and increase enrollment assistance through policies such as restoring navigator and outreach funding to at least prior levels, or increasing them further, and advertising the extended federal Marketplace open enrollment period that they have recently proposed to increase opportunities to enroll in coverage during the continuing pandemic.[13]

Targeted messaging and assistance emphasizing the benefits of coverage and how to enroll could also help; research indicates messages promoting the peace of mind gained through enrollment and protections for preexisting conditions can encourage enrollment during the public health crisis, and state-specific consumer guidance may also be needed bolster enrollment, given policy differences across states.[14] It will also be important to notify consumers about the comprehensiveness of Medicaid/CHIP and Marketplace plans relative to short-term plans, which lack the ACA's consumer protections (Corlette et al. 2019; Pollitz et al. 2020).

State-based Marketplaces have helped bridge federal marketing gaps by advertising extended special enrollment periods following the onset of the pandemic, establishing new marketing campaigns, and conducting targeted outreach, such as through unemployment assistance departments.[15] Additionally, the federal government did not advertise Healthcare.gov to those who have lost coverage during the pandemic, leaving such advertising to states. However, with state budgets strained by the pandemic-related recession, such efforts may not be sustainable, possibly necessitating federal funding.

Expanding awareness and understanding of available coverage options may also help reduce health disparities; research shows lack of awareness of Marketplace coverage and confusion about health insurance terminology are high among Hispanic/Latinx and Black adults, groups also

experiencing worse effects of the current recession on their families' finances (Collins, Gunja, and Doty 2017; Karpman, Zuckerman, and Kenney 2020; Villagra et al. 2019).

Improving affordability of coverage and knowledge of financial assistance. Consistent with other research (Collins, Gunja, and Doty 2017), we find low awareness of financial assistance for purchasing Marketplace coverage in September 2020. Cost was the most commonly reported reason for not seeking information or enrolling in such coverage. Cost concerns may be particularly high during the pandemic and recession; about half of Marketplace enrollees in March/April 2020 reported worrying about their inabilities to afford premiums because of the pandemic (Pollitz et al. 2020).

Efforts to better inform potential Marketplace enrollees about the income ranges for which subsidies are available could help reduce knowledge gaps, especially for those whose incomes are fluctuating after a recent job loss.[16] Policymakers could also act to increase affordability of coverage (Cox et al. 2020): As part of an additional $1.9 trillion pandemic stimulus plan, President Biden has proposed increasing financial assistance to make Marketplace premiums more affordable. States could also consider offering additional financial assistance, as in Massachusetts and California, which could increase take-up among people with moderate incomes (Aron-Dine and Broaddus 2019). Removing restrictions on Marketplace financial assistance for families whose access to employer coverage is deemed affordable by the ACA could also make more people eligible for financial assistance. In addition, President Biden has proposed subsidization of COBRA as part of his broader relief package, which could improve COBRA affordability but would be limited to those who recently lost employer-sponsored coverage.

Expanding and communicating Medicaid/CHIP eligibility levels. The most commonly reported barrier to seeking or enrolling in Medicaid/CHIP coverage was ineligibility or perceived ineligibility. Many uninsured adults, especially those in nonexpansion states and noncitizens, are ineligible for Medicaid because of income- and immigration-related restrictions. To remove this barrier, adoption of the expansion in additional states and loosening of rules prohibiting some noncitizens from enrolling in Medicaid are necessary. Still, others could also benefit from better knowledge of Medicaid eligibility requirements.

Over decades, research has shown that though awareness of and interest in Medicaid/CHIP are high and perceptions of the programs are generally positive, confusion about eligibility requirements may deter families from seeking coverage (Kenney, Haley, and Tebay 2004; Pollitz et al. 2020). Communication during the pandemic about the immediate availability of Medicaid/CHIP after job loss through trusted information sources, such as health care providers, employers, schools, and other public programs, and specific outreach and enrollment efforts to reach underserved communities could also help (Artiga, Rudowitz, and Tolbert 2016).

In addition, the new administration has expressed willingness to reverse the public charge rule.[17] But even if it is reversed, communication about immigration requirements and clarification that Medicaid/CHIP enrollment among eligible individuals would not risk their or their family members' immigration statuses will be essential to reaching and enrolling immigrant families. Further,

Medicaid/CHIP enrollment increases are already straining states' budgets (NCSL 2020). Thus, additional state fiscal relief will be needed to support increased enrollment, in addition to the temporary increase in the federal Medicaid/CHIP matching rate enacted in the Families First Coronavirus Response Act for states meeting certain conditions (e.g., not disenrolling beneficiaries from Medicaid during the public health emergency).[18]

Simplifying enrollment systems and improving perceptions of enrollment processes. Maintaining simplified Marketplace and Medicaid/CHIP enrollment processes and adapting to changing circumstances during the pandemic are critical. Research shows nearly 4 in 10 adults who applied for or renewed Medicaid during the pandemic had difficulties navigating enrollment procedures (Pollitz et al. 2020). And perceptions about complex application processes are a barrier to seeking Medicaid, especially for those who have recently faced challenges applying for unemployment insurance and do not want to navigate another bureaucratic system.[19]

States can take advantage of flexibilities allowed in Medicaid to simplify enrollment, such as increasing usage of online and phone application processes, allowing self-attestation of eligibility criteria, and extending presumptive eligibility to allow more entities to screen for temporary eligibility while full applications are processed (Dolan and Artiga 2020).[20] Simplifications could also benefit (1) those already enrolled in Medicaid who have not recently faced renewal but will need to recertify eligibility when the public health emergency ends and (2) people whose fluctuating incomes may mean they shift in and out of Medicaid and Marketplace eligibility (Manatt 2020). Some states are also improving procedures that will expand access to Marketplace coverage, such as through extending special enrollment periods and reducing administrative burdens.[21]

The large reductions in uninsurance resulting from efforts before and under the ACA to increase awareness of subsidized coverage and simplify enrollment, including streamlined enrollment and renewal processes, outreach campaigns, funding for health insurance navigators and community-based organizations, and elimination of administrative hurdles, suggest efforts to make enrollment easier could contribute to coverage gains (KFF 2013).

Data and Methods

This brief uses data from the second wave of the Urban Institute's Coronavirus Tracking Survey, a nationally representative internet-based survey of nonelderly adults designed to assess how the COVID-19 pandemic is affecting adults and their families and how those effects change over time. A total of 4,007 adults ages 18 to 64 participated in the second wave, fielded September 11 through 28, 2020; 91 percent of respondents completed the survey by September 17. This analysis is based on the 437 respondents who were uninsured and responded to questions about awareness of and experiences with Marketplace and Medicaid/CHIP coverage. Respondents for both waves were sampled from the 9,032 adults who participated in the most recent round of the 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 Coronavirus Tracking Survey includes an oversample of Black and Hispanic/Latinx 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. We also adjust the September tracking survey weights to address differential nonresponse among participants in the March/April HRMS. Because nonresponse in the September survey is greater among HRMS participants experiencing negative employment effects and material hardship during the pandemic and these effects differ based on demographic characteristics, we adjust the weights so work status and employment and hardship outcomes reported in March/April among the September sample are consistent with outcomes reported among the full March/April HRMS sample both overall and within key demographic subgroups. These adjustments make the September tracking survey sample better represent the sample initially drawn in March/April and mitigate nonresponse bias in estimated changes over time in the pandemic's effects.

The margin of sampling error, including the design effect, for the full sample of adults in the second wave of the tracking survey is plus or minus 2.0 percentage points for a 50 percent statistic at the 95 percent confidence level. Additional information about the March/April 2020 HRMS and the questionnaires for the HRMS and first and second waves of the Coronavirus Tracking Survey can be found at hrms.urban.org.[22]

Notes

1 Bureau of Labor Statistics, "The Employment Situation in October 2020," November 6, 2020, https://www.bls.gov/news.release/pdf/empsit.pdf.

2 Amy Goldstein, "Biden to Reopen ACA Insurance Marketplaces as Pandemic Has Cost Millions of Americans Their Coverage," *Washington Post*, January 25, 2021, https://www.washingtonpost.com/health/biden-to-reopen-aca-insurance-marketplaces-as-pandemic-has-cost-millions-of-american-their-coverage/2021/01/25/ccfc2402-5e74-11eb-9061-07abcc1f9229_story.html.

3 "FAQs on COBRA Coverage Continuation Health Coverage for Workers," US Department of Labor, accessed December 14, 2020, https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/cobra-continuation-health-coverage-consumer.pdf.

4 Individuals must also be US citizens or lawfully present noncitizens to be eligible for advanced premium tax credits and cost-sharing reductions.

5 Undocumented noncitizens are further barred from purchasing unsubsidized Marketplace coverage.

6 PerryUndem and Betty & Smith, "Results from Focus Groups with Uninsured Individuals: Enrolling in Marketplace Coverage," September 2020, https://www.dropbox.com/s/7soa9nwmutheb4a/Focus%20Group%20Report_Final%209%2029.pdf?dl=0; and PerryUndem and Betty & Smith, "Results from Focus Groups with Uninsured Individuals: Enrolling in Medicaid," September 2020, https://www.dropbox.com/s/zmrt4dfizx0owd9/MOP_Focus%20Group%20Report_Final.pdf?dl=.

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[8] PerryUndem and Betty & Smith, "Results from Focus Groups With Uninsured Individuals: Enrolling in Marketplace Coverage," and "Results from Focus Groups with Uninsured Individuals: Enrolling in Medicaid."

[9] Distributions are calculated among those for whom the survey assessed awareness and/or experiences and who replied using the relevant categories shown.

[10] For instance, subsidies range from 2.06 to 9.78 percent of income in 2020. See Holahan, Wengle, and Elmendorf (2020).

[11] We combined information on experiences with Marketplace and Medicaid/CHIP coverage, classifying uninsured respondents into one of four mutually exclusive categories: (1) familiar with and has looked for information on Marketplace and has tried to obtain Medicaid/CHIP, (2) familiar with and has looked for information on Marketplace but has not tried to obtain Medicaid/CHIP, (3) has tried to obtain Medicaid/CHIP but is not familiar with or has not looked for information on Marketplace, and (4) is unfamiliar with or has not looked for information on Marketplace and has not tried to obtain Medicaid/CHIP.

[12] Timothy Jost, "CMS Cuts ACA Advertising by 90 Percent amid Other Cuts to Enrollment Outreach," *Health Affairs Blog*, August 31, 2017, https://www.healthaffairs.org/do/10.1377/hblog20170901.061790/full/; Asian and Pacific Islander Health Forum, "HHS Announces Navigator Funding with Deep Cuts," news release, September 12, 2018, https://www.apiahf.org/press-release/navigator-cuts/; Karen Pollitz and Jennifer Tolbert, "Data Note: Further Reductions in Navigator Funding for Federal Marketplace States," October 13, 2020, Henry J. Kaiser Family Foundation, https://www.kff.org/private-insurance/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/; and Katie Keith, "CMS to Maintain Navigator Funding at $10 Million for 2020, 2021," *Health Affairs Blog*, May 9, 2019, https://www.healthaffairs.org/do/10.1377/hblog20190529.659554/full/.

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[15] Rachel Schwab, Justin Giovanelli, and Kevin Lucia, "During the COVID-19 Crisis, State Health Insurance Marketplaces Are Working to Enroll the Uninsured," *To the Point* (blog), Commonwealth Fund, May 19, 2020, https://www.commonwealthfund.org/blog/2020/during-covid-19-crisis-state-health-insurance-marketplaces-are-working-enroll-uninsured.

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[20] Rebecca Landucci, Jennifer E. Moore, Clare C. Brown, Caroline E. Adams, Nicole Truhe, and Mark Larson, "How States Are Facilitating Medicaid Enrollment during COVID-19—and How They Can Do Even More," *Health Affairs Blog*, June 17, 2020, https://www.healthaffairs.org/do/10.1377/hblog20200612.887360/full/; and Ian Hill, Jennifer M. Haley, and Emily Burroughs, "Medicaid and CHIP Flexibility Can Help Safeguard Americans during the COVID-19 Crisis," *Urban Wire* (blog), Urban Institute, March 19, 2020,

https://www.urban.org/urban-wire/medicaid-and-chip-flexibility-can-help-safeguard-americans-during-covid-19-crisis.

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[22] Knowledge of and experiences with Medicaid/CHIP and Marketplace coverage were obtained from respondents thought to be uninsured or living with an uninsured person during survey administration. Recoding of coverage after survey administration (e.g., for people who reported having an insurance type later recoded as not being considered comprehensive insurance coverage) meant some respondents did not receive these questions. In addition, some respondents did not answer every question. Consequently, our analysis is based on only those who were considered uninsured during survey administration and responded to each question.

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COMMENTARY

Optimizing Health And Well-Being For Women And Children

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ABSTRACT **The health and well-being of childbearing women and children in the US should set a world standard. However, women and children in the US experience higher rates of morbidity and mortality than women and children in almost all other industrialized countries, with marked racial and ethnic disparities. The unfolding effects of the coronavirus disease 2019 (COVID-19) pandemic have highlighted such disparities. In this article, which is part of the National Academy of Medicine's Vital Directions for Health and Health Care: Priorities for 2021 initiative, we draw on a life-course framework to highlight promising interventions and recommend key improvements in programs and policies to optimize health and well-being among women and children in the US. The recommendations address ensuring access, transforming health care, and addressing social and environmental determinants.**

The high rate of maternal mortality in the US, which is twice as high as in the United Kingdom or Canada, is a national disgrace.[1] From 2000 to 2014 maternal mortality in the US more than doubled, while most other countries reported significant declines.[2] Each year, more than 700 women in the US die during pregnancy and childbirth, and more than 50,000 pregnant women experience a life-threatening complication. Maternal mortality is associated with racial, ethnic, socioeconomic, and geographic disparities. For example, African American women are more than three times as likely to die during pregnancy and childbirth as White women—a gap that has not narrowed in decades.[3]

Because of socioeconomic disparities, disadvantaged women enter pregnancy with fewer resources. For instance, disadvantaged women may have lower educational attainment and lower income and lack the emotional and financial support of a partner. They also have higher rates of preexisting morbidity such as cardiovascular conditions, obesity, and diabetes. The impact of such maternal factors varies by race and ethnicity; cardiovascular conditions account for the majority of deaths among non-Hispanic Black women.[4]

Preconception morbidity leads to higher rates of pregnancy complications including hemorrhage, infection, hypertensive disease, and premature delivery.[5] One in ten newborns in the US are born preterm—the highest proportion of any developed nation—with major differences by race and ethnicity.[6] Prematurity is the leading cause of infant mortality and a contributor to lifelong morbidity. Thus, maternal health and well-being, reflecting experiences throughout the life course, may determine the health of the next generation and, ultimately, the health of the nation.

Another challenge to maternal health is the fact that nearly 70 percent of pregnant women take prescription medications for acute or chronic conditions during pregnancy, yet very few medications have Food and Drug Administration approval for use during pregnancy.[7] The lack of robust human safety data regarding the use of medications during pregnancy complicates the

management of preexisting conditions as well as illnesses diagnosed during pregnancy, which may harm pregnant women and fetuses alike.

Children and youth in the US experience higher rates of poor health and developmental outcomes, including developmental disorders, mental health conditions, severe asthma, and obesity, as well as other correlates of poor health, including poverty, hunger, poor educational outcomes, and adolescent incarceration, than their counterparts in other countries.[8] Low-income children in the US have higher rates of developmental, mental, and behavioral health conditions—and greater severity of these conditions—than non-low-income children.[9] The impact of adverse health extends into adulthood, as young adults (ages 15–24) in the US have higher mortality rates than their counterparts in other Organization for Economic Cooperation and Development countries.[10] The pattern of increased mortality continues throughout adulthood; this underscores the importance of addressing the health needs of infants, children, adolescents, and young adults to improve long-term health outcomes.

Stresses in early life, including adverse childhood experiences (ACEs) such as child maltreatment, poverty, and parental loss, affect health outcomes and are associated with morbidity and mortality during adulthood.[11] The prevalence of adverse experiences varies by ethnicity and socioeconomic status; Black, Hispanic, and low-income children have much higher rates of ACEs.[12] This finding has particular importance in the context of a country with an increasingly ethnically diverse population. In 2018 the US population of young children (younger than age five) was already "majority minority," with a distribution of 50 percent non-Hispanic White, 26 percent Latinx, 14 percent non-Hispanic Black, 5 percent non-Hispanic Asian, 0.8 percent non-Hispanic American Indian and Alaska Native, 0.2 percent non-Hispanic Hawaiian and other Pacific Islander, and 4 percent two or more races.[13]

The coronavirus disease 2019 (COVID-19) pandemic puts further stress on children's health. Recent studies have reported major increases in children's mental health issues,[14] and the pandemic has highlighted racial and ethnic disparities in disease burden and mortality. Health care has transformed rapidly, with widespread implementation of telehealth, but an unintended consequence is lower rates of critical childhood immunizations, which require in-person visits.[15] The educational disruption experienced by children and youth also will likely have long-term consequences. Furthermore, young families, especially among communities of color, are particularly vulnerable to economic losses from the pandemic and the associated effects on housing, nutrition, and parental well-being.

The importance of accumulated life-course experiences on long-term health and well-being is supported by a large, growing body of literature. The life-course framework uses a longitudinal perspective to assess the role of hereditary, physiologic, psychologic, and environmental influences on health. As individuals grow and mature, they experience positive and negative impacts on health, development, and social-emotional functioning. Furthermore, children experience critical periods during which positive and negative experiences have particularly strong and lasting effects. Poorer outcomes occur in the context of exposure to negative events with insufficient resources to buffer their effects. Familial support is critical during early childhood, but other factors can ameliorate adverse events, such as neighborhood characteristics (schools, recreation, and well-stocked stores) and specific policies and programs (access to health care through public insurance, educational policies, financial support, and adequate housing).

In this fashion, social determinants affect health over the course of a person's life. Childhood trauma has been linked to chronic health problems into adulthood, with time-specific effects of toxic social or interpersonal experiences.[16] Many women enter childbearing age with lengthy histories of ill health and adversity, often beginning during childhood. During pregnancy, the accumulation of poor health and adverse experiences affects intrauterine growth, emotional health, and nutrition status.[17] For women of color, the experience of racism contributes to accelerated aging or "weathering,"[18] which in turn contributes to the development of chronic health conditions. Weathering may help explain the elevated risk for maternal and infant mortality among African American women, even college-educated women—a risk that socioeconomic status does not explain.[19]

In this article, part of the National Academy of Medicine's Vital Directions for Health and Health Care: Priorities for 2021 initiative, which aims to provide expert guidance on several focus areas for US health policy, we use a life-course perspective to highlight promising interventions and recommend key improvements in programs and policies to optimize health and well-being among women and children in the US.[20] We provide targeted recommendations that are eminently achievable, as well as "moonshot" recommendations that are more sweeping and transformative. All of our recommendations are intended to optimize the health of women and children so that the US sets a global standard.

Initiatives To Improve Maternal Health

Data from the Centers for Disease Control and Prevention (CDC) indicate that nearly two-thirds of maternal mortality is preventable.[21,22] In general, the underlying factors contributing to preventable maternal mortality relate to errors at the level of the clinician, health care facility, and health system, such as inadequate training, missed or delayed diagnoses, delayed or ineffective responses to complications, poor communication, and ineffective coordination of care.[22]

Quality improvement strategies can improve maternity care and outcomes. In 2006 the California Maternal Quality Care Collaborative, in collaboration with the state's Department of Public Health and others, launched an initiative to improve the quality and safety of maternity care. The statewide effort focused on the implementation of "maternal safety bundles," a curated set of best practices, protocols, checklists, and other resources focused on improving the 4Rs: readiness, recognition, response, and reporting. The Postpartum Hemorrhage Bundle required the creation of well-stocked hemorrhage carts (readiness), tools to measure blood loss (recognition), early use of uterotonic medications (response), and mandatory reporting to a centralized data center (reporting). In a controlled trial involving 147 hospitals, implementation of the Postpartum Hemorrhage Bundle resulted in a 20.8 percent reduction in severe maternal morbidities compared with a 1.2 percent reduction among control hospitals.[23] From 2006 to 2013 maternal mortality in California decreased by 57 percent, and maternal mortality among Black women decreased by nearly 50 percent.[24]

In 2015 the federal Maternal and Child Health Bureau established the Alliance for Innovation on Maternal Health to disseminate and scale California's success to other states. Championed by the American College of Obstetricians and Gynecologists and implemented in collaboration with twenty-five national organizations, the alliance has engaged 33 states and more than 1,400 hospitals in implementing maternal safety bundles, with the goal of engaging every birthing hospital in the US and achieving a 50 percent reduction in maternal mortality by 2025.[25]

Reducing and eradicating maternal deaths in the US will require improving the quality and safety of maternity care as well as women's health across the life course. A first step is providing women with access to comprehensive health services, including primary and preventive care, preconception and interconception care, and family planning. Healthy Start is a promising federal program that takes a comprehensive, community-based approach to improving perinatal outcomes in 100 at-risk communities by promoting women's health before, during, and beyond pregnancies; strengthening families and communities; and addressing social determinants of health.[25] Recognizing that many maternal health disparities are rooted in institutionalized racism, advocates have recently called for a redesign of intervention programs from a reproductive justice framework, which maintains that "reproductive safety and dignity [depend] on having the resources to get good medical care and decent housing, to have a job that [pays] a living wage, to live without police harassment, to live free of racism in a physically healthy environment."[26]

Interventions To Improve Child Health

Improving child health, development, and well-being involves providing services across sectors, including the health, education, child welfare, and justice sectors. A succession of National Academies reports, beginning with *From Neurons to Neighborhoods*[27] to, most recently, *Vibrant and Healthy Kids*,[28] have summarized the substantial literature that documents the positive effects of early childhood education and family support on cognitive abilities and educational success, which translates into long-term economic well-being, including reduction in justice system involvement and incarceration.[29,30] Home visiting services for families contribute to improved cognitive development and, in some cases, improved trajectories for parents.[31] Paid family leave also improves birth outcomes.[32]

The *Vibrant and Healthy Kids* report reviewed an array of programs, including economic, family support, health care, and early education programs, to assess their effectiveness.[28] Multiple programs, including nutrition support through the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); income support such as the Child and Dependent Care Credit and the Earned Income Tax Credit; and adequate health insurance, have demonstrated improvements in the health of parents and health and developmental outcomes for children. Despite this success, most programs other than health insurance have reached only half of eligible households.[33] Bringing these programs to scale will have substantial impact on the health and well-being of children and youth.

Issues In Access To Care

For women and children, access to medical care is one buffer against poor health. However, dis-

We believe that the health and well-being of women and children in the US should set the world's standard.

advantaged women experience limited access to care and are more likely to have an unplanned pregnancy, partly reflecting inadequate preconception care and family planning. They are also more likely to start prenatal care later than more advantaged peers and to deliver in hospitals with lower quality-of-care indicators.[34]

Despite the gains in coverage provided by the Affordable Care Act (ACA), in 2018 there were 10.8 million women ages 19–64 who lacked insurance, including more than a million poor women who lived in states that did not expand Medicaid.[35] Furthermore, many childbearing women who reside in nonexpansion states lose Medicaid coverage at sixty days postpartum. In addition, recent changes in Medicaid eligibility, such as work requirements, have reduced women's enrollment in the program.[36]

Changes affecting the ACA include the expansion of short-term health plans that are not required to comply with coverage and benefit requirements and the exemption of employers from providing contraceptive coverage on the basis of a company's religious or moral objections. Efforts to defund Planned Parenthood could further restrict women's access to preventive services, preconception and interconception care, and family planning.

Medicaid and its partner program, the Children's Health Insurance Program (CHIP), are essential for children. Approximately one-third of US children and youth have public insurance.[37] Medicaid differs substantially from Medicare because states are required to provide some funding and because states control many program elements, including eligibility and benefits. Medicaid pays providers at rates typically one-third lower than Medicare payments, making many providers unwilling to accept Medicaid-insured patients.[38]

In addition, access to oral health services is important for children because dental caries is the most common chronic disease of childhood.[39] Despite Medicaid coverage of oral health services under the Early and Periodic Screening, Diagnostic, and Treatment benefit, fewer than half of all children on Medicaid receive dental services in a given year.[40]

Policy Recommendations

We believe that the health and well-being of women and children in the US should set the world's standard. Specifically, no woman in the US should die from a preventable complication of pregnancy or childbirth, and children should live in a society that allows them to thrive and maximize their full potential.

To achieve these goals, we recommend applying a life-course perspective from preconception to pregnancy and at all life stages including fetal development, childhood, adolescence, and adulthood. This perspective promotes family-centered design and equity by acknowledging and addressing adversity and disparities across the life course. We recommend improving access to care, transforming health care delivery and financing, and addressing social and environmental drivers of health. Achieving these goals requires fundamental components such as the collection of robust data to inform research and policy, attention to safety and accountability, and sustained research into effective programs and implementation. Building broad programs to achieve equity and diminish disparities, integrate health care with other sectors, and transform health care to population health models will require corresponding changes in the workforce.

We categorize our recommendations as targeted and moonshot. The targeted recommendations focus on existing programs and policies and are eminently achievable. The moonshot recommendations are transformative and broadly impactful, and they and require support and resources from multiple sectors.

TARGETED RECOMMENDATIONS

▶ **DATA:** The CDC should expand support of maternal mortality review committees to all fifty states and the District of Columbia. The Enhancing Reviews and Surveillance to Eliminate Maternal Mortality program should be expanded throughout the country.

Federal data sets should harmonize the definitions used to delineate subpopulations of children, resulting in more consistent groupings based on race and ethnicity, age, and clinical characteristics. Data sets should be integrated across data sources, and longitudinal studies are needed to assess the determinants of child and adult health outcomes.

▶ **SAFETY:** The Maternal and Child Health Bureau should expand its support of the Alliance for Innovation on Maternal Health program to

achieve the goals of applying maternal safety bundles to every birthing hospital and a 50 percent reduction in maternal mortality by 2025.

For children, the Department of Health and Human Services and the Agency for Healthcare Research and Quality should ensure the nationwide adoption of safety interventions in all sectors of the health care system and conduct research to address gaps related to quality and safety.

▶ **RESEARCH:** Congress should support the Task Force on Research Specific to Pregnant and Lactating Women, which was established through the 21st Century Cures Act of 2016. The task force's goal is to remove regulatory barriers that prohibit pregnant women from participating in research and to require the drug development industry to include pregnant women in clinical trials.

The National Institutes of Health and other funders should enhance support for studies to identify the mechanisms that link adverse events during early childhood to health outcomes across the life course and assess the relative effectiveness of prevention versus intervention strategies.

MOONSHOT RECOMMENDATIONS

▶ **ENSURE ACCESS:** Society must ensure that women, their partners, and children have access to high-quality comprehensive health services across the life course. Care should be patient and family centered and emphasize preventive services, with culturally and linguistically appropriate outreach and services. Access strategies should address racial and ethnic disparities. Specific strategies include Medicaid expansion; providing a public option in the ACA Marketplace; enforcing the ACA's coverage and benefits requirements, which require insurance plans to provide maternity care, mental health, and women's preventive services; limiting restrictions on employers' exemptions for contraceptive coverage; and repealing the Hyde Amendment, which prohibits the use of federal funds to pay for abortion except in certain instances.

All children should have access to health care services that emphasize the prevention of adversity and ill health. Coverage should ensure access to behavioral and mental health and oral health services. Children with special health care needs require integrated, coordinated care and habilitative services.

We recommend strengthening public insurance (Medicaid/CHIP) for children through structural change. First, Medicaid should ensure universal coverage for all children from birth through age twenty-one years. Second, Medicaid for children and youth should transform to a fully federally financed program to reduce the

All children should have access to health care services that emphasize the prevention of adversity and ill health.

burden on states and facilitate the development of national standards with physician payment rates comparable to those of Medicare. States often struggle to balance their budgets, which is related, in part, to the fact that Medicaid consumes a sizable proportion of the budget (15 percent, on average) and because demand for services increases when revenues plummet, such as during the COVID-19 pandemic.[41] Federalizing the Medicaid program for children and youth would generate some additional costs. However, at this time, only about 10 percent of the total federal spending on health care is allocated to children and youth, and a new program could be gradually implemented. Under this construct, families could maintain employer-based insurance with the understanding that the federalized program could support them if needed. Third, Medicaid should expand its focus on population health, including focusing on upstream prevention of poor health, incentivizing transformation of health care, and promoting cross-sector collaboration.

▶ **TRANSFORM HEALTH CARE DELIVERY AND FINANCING:** The health care sector has witnessed much experimentation with value-based payment arrangements and population health. Defining value in child and adolescent health care requires different metrics from those applied to adults. For example, cost savings will accrue over the long term and may return to nonhealth sectors such as education and juvenile justice.[42] Innovative multidisciplinary models of team care, often supported by Medicaid programs, may include staff members who connect enrollees with community resources, expand the use of technology—including telemedicine—and proactively monitor health and disease. Teams could expand capacity in behavioral and mental health, improve coordination and management of chronic conditions, and focus attention on the

social drivers of health. The Department of Health and Human Services, including the Centers for Medicare and Medicaid Services, should support new programs to improve and transform the content, delivery, organization, and financing of health services for women and children, including preconception, prenatal, postpartum, and pediatric care.

▶ **ADDRESS SOCIAL AND ENVIRONMENTAL FACTORS:** Improving women's and children's health requires systematic, coordinated efforts across several sectors, including health, education, justice, and social services. For example, efforts to reduce poverty should strengthen household income through expansion of the Earned Income Tax Credit and the Child and Dependent Care Tax Credit and conversion of the Child Tax Credit, which lowers the tax that families pay, into a child allowance, which would apply to all families whether or not they pay taxes.[43] Efforts to enhance family resiliency require new paid family leave policies, expanded programs for child care, and enhanced access to early childhood education. Programs to enhance family stability should explicitly address the need for stable housing. Successful nutrition programs such as SNAP, WIC, and school-based meals, which currently reach only a fraction of eligible households, should be brought to scale.[28] Recent events, including the COVID-19 pandemic, have highlighted inequities in most of the programs noted here, and we call for acknowledging and addressing disparities to achieve equity.

Conclusion

Women and children in the US face challenges to optimal health and well-being. In this article we have outlined a set of policies and programs focused on access to health care, health care transformation, and attention to social drivers of health for women and children. Our recommendations are highly relevant for an administration and Congress that are prepared to address inequities and make meaningful, lasting improvements for women, children, families, and the entire country. ■

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WHITE PAPER

Summary of Select Provisions of HHS' Final 2022 Notice of Benefit and Payment Parameters and Other Key Regulations

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On January 14, 2021, the Department of Health and Human Services (HHS) released the final Notice of Benefit and Payment Parameters for 2022 in the Federal Register.[1] The notice includes important rules and parameters for the operation of the individual and small group health insurance markets in 2022 and beyond. This paper summarizes key provisions of the final notice and other related information recently released by HHS. Not all of the topics raised in the proposed 2022 Payment Notice were included in the final Payment Notice released in January. Forthcoming regulations are expected to address the remaining topics that were not addressed in this rule. The Appendix includes a table that lists which topics were finalized in the current Final Rule and which are expected to be finalized by the new Administration. Additionally, with the change in Administrations happening, some of the provisions finalized could be altered in future regulations before they go into effect.

Overview

The following highlights the key changes included in the 2022 final Payment Notice. More information on these and other changes follow.

1. **Direct-Enrollment Flexibilities:** HHS finalized allowing states to end state-sponsored online enrollment portals (e.g., opt out of Healthcare.gov) and allow for enrollees to only have the ability to enroll into an on-Exchange plan through direct enrollment (DE) entities. HHS will also allow DE entities more flexibility as to what information they share with potential enrollees.

2. **User Fees:** HHS lowered user fees to issuers to 2.25% for issuers in the Federally-facilitated Exchanges (FFE) and 1.75% in State-based Exchanged that utilize the Federal Platform (SBE-FPs).

[1] Department of Health and Human Services, "The Final Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022", https://www.federalregister.gov/public-inspection/2021-01175/patient-protection-and-affordable-care-act-benefit-and-payment-parameters-for-2022-updates-to-state

3. **1332 Waiver Regulation:** HHS incorporated its 2018 guidance on 1332 Waiver into regulation.

Exchange Establishment Standards (Direct Enrollment)

HHS finalized two major changes to increase the importance of direct enrollment for the Exchanges. First, HHS will allow states to elect not to have a state-sponsored online portal (i.e., Healthcare.gov or a state exchange portal) for enrollment and instead only have enrollment via DE. If a state selects this type of Exchange model individuals could only enroll in Exchange coverage through a DE entity (for example a web-broker or an issuer). This option will be available for State-Based Exchanges (SBE) in 2022 and for Healthcare.gov states in 2023. These new exchange types will have "-DE" appended to the end of their current acronym (SBE-DE, FFE-DE, and SBE-FP-DE).

The other major change would allow for greater flexibility in how DE entities display information on QHPs. The regulation would allow DE entities to exclude some information on QHPs that it cannot sell. For example, if a web-broker does not have a relationship with a particular issuer, it would not have to display certain information about that issuer's plans.

The prior regulations required that product choices be separated across three different web pages by product type as follows:

- QHPs On-Exchange
- Off Exchange QHPs and non-QHPs other than excepted benefits (such as vision plans or specific disease plans)
- All other products, including excepted benefits

HHS relaxed this requirement under certain circumstances. In particular, On and Off Exchange plans (other than excepted benefits) can be on the same page to accommodate HRA arrangements where an employee would need to compare On and Off Exchange options. This is because a prior an employee may not know if they a better net premium will be found Off Exchange (where the employee may be eligible to have premium subsidies via HRA) or On Exchange (where the employee may be eligible for Federal Premium Tax Credits). Despite being the policy being finalized, comments were generally negative from the public on this topic.

User Fees

HHS reduced user fees for issuers in states that utilize Healthcare.Gov. In particular, HHS will charge issuers in FFE 2.25% (down from 3.0%) and 1.75% in SBE-FP states (down from 2.5%). If a state selects the Exchange-DE option, HHS will only charge a user fee of 1.50%.

1332 Regulations

HHS codified the existing guidance issued in October 2018 regarding 1332 waiver applications into regulation (no modifications from current guidance). In particular, this would codify the current Administration's interpretation of the 1332 guardrails (for example loosening the coverage and affordability requirements). It would also would require notice and comment for the new Biden Administration to change the 1332 waiver rules.

If you have any questions or to follow up on any of the concepts presented here, please contact any of the following authors:

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Appendix: Breakdown of Policies Included in Final Rule

Policy Issue	Included in Final Payment Notice	In Proposed Rule but Excluded in Final Payment Notice
Direct-Enrollment Flexibilities	X	
Risk Adjustment		X
User Fees	X	
PBM Reporting		X
MLR		X
1332 Waivers	X	
Cost-Sharing Requirements (e.g., MOOP)		X
Eligibility Requirements		X

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COMMENTARY

Vital Directions For Health And Health Care: Priorities For 2021

ABSTRACT In 2016, in anticipation of the US presidential election and forthcoming new administration, the National Academy of Medicine launched a strategic initiative to marshal expert guidance on pressing health and health care priorities. Published as Vital Directions for Health and Health Care, the products of the initiative provide trusted, nonpartisan, evidence-based analysis of critical issues in health, health care, and biomedical science. The current collection of articles published in *Health Affairs* builds on the initial Vital Directions series by addressing a set of issues that have a particularly compelling need for attention from the next administration: health costs and financing, early childhood and maternal health, mental health and addiction, better health and health care for older adults, and infectious disease threats. The articles also reflect the current experience with both the coronavirus disease 2019 (COVID-19) pandemic and the health inequities that have been drawn out sharply by COVID-19, as well as the implications going forward for action.

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With its congressional charter as advisor to the nation and in anticipation of the 2016 US presidential election and forthcoming new administration, in 2016 the National Academy of Medicine launched a strategic initiative to marshal expert insights on health and health care priorities. Published as Vital Directions for Health and Health Care, the products of the initiative provided trusted, nonpartisan, evidence-based analysis of critical issues in health, health care, and biomedical science.

In its initial series, the project engaged more than 150 experts, who undertook analysis of compelling policy opportunities across nineteen key areas important to progress in three domains: better health and well-being, high-value health care, and strong science and technology.[1] The resulting framework from this initiative is organized into eight crosscutting policy directions for all levels of leadership, including four action priorities (pay for value, empower people, activate communities, and connect care) and four essential infrastructure needs (measure what matters most, modernize skills, accelerate real-world evidence, and advance science). Together, these policy directions serve as a foundation for the US to achieve its vision for a health system that performs optimally in improving the health of the population; promoting, protecting, and restoring the health of individuals; and helping each person reach their full potential for health and well-being.[2]

Since the 2016 publication of Vital Directions, much has happened in health and health care, underscoring concerns about the nation's persistent challenges related to maternal mortality, child health and development, behavioral health, the opioid crisis, and pervasive health inequities, among others. These developments, coupled with the emergence of severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) and the coronavirus disease 2019 (COVID-

19) pandemic, in the context of another US presidential election, prompt the need for renewed assessment of health care priorities and guidance. In addressing these challenges, the next administration must combat the health disparities that have negatively affected Black people, Indigenous people, and other people of color for decades and prioritize the pursuit of health equity for all Americans.[3] The COVID-19 pandemic has further exacerbated racial health inequities across public health and health care systems in the US.

This collection of articles published in *Health Affairs* builds on the initial Vital Directions series by selecting a set of issues with a particularly compelling need for leadership and decision making at multiple levels. Accordingly, the articles highlight five topical areas: health costs and financing, early childhood and maternal health, mental health and addiction, better health and health care for older adults, and infectious disease threats. All of these articles highlight the crosscutting theme of the disproportionate negative impact of health inequities on vulnerable and underserved populations and the importance of giving the highest priority to eliminating these inequities. The articles also reflect the current experience with the COVID-19 pandemic at the time of writing and the implications for action going forward.

An Unprecedented Juncture

During the past four years the US health system has confronted unprecedented challenges and uncertainties. The period began with heated debate about the repeal of the Affordable Care Act of 2010, and the law's implementation and revision remain active topics of discussion and debate. Then 2019–20 saw the emergence of COVID-19 and the dramatic escalation of public attention to long-standing racial and ethnic disparities in society as a whole, with health care being an arena where those disparities are particularly pronounced.

A persistent and serious challenge has been health care expenditures,[4] with US health expenditures as a proportion of gross domestic product continuing to far outstrip comparable expenditures in other Organization for Economic Cooperation and Development countries. To compound the problem, Americans continue to have worse health outcomes even in the face of such high expenditures, including lower life expectancy, higher suicide rates, and a higher chronic disease burden, with people of color suffering disproportionately.[5] Partly as a result of high costs, access to care is often limited and unequal. Of the estimated 20.3 million Americans with substance use disorder, 89.8 percent did not receive treatment in 2018.[6] Disparities between racial groups in maternal mortality persist, with mortality rates for non-Hispanic Black women remaining more than double those of their non-Hispanic White counterparts.[7]

The tragedy of these disproportionate burdens has been underscored in the experience of the COVID-19 pandemic. As of January 5, 2021, the Centers for Disease Control and Prevention (CDC) reported 20,732,404 cumulative COVID-19 cases and 352,464 total deaths due to SARS-CoV-2 in the US.[8] In addition to pandemic-related morbidity and mortality, US unemployment rates reached a peak of 14.7 percent in April 2020 and continued to persist at a higher-than-average rate of 6.7 percent as of November 2020.[9] Furthermore, the associated school closures have disrupted the education of millions of American children.[10] COVID-19 also has exacerbated health disparities in the US. Black, Indigenous, Pacific Islander, and Latino Americans are proportionately more likely than White Americans to die from COVID-19,[11] accentuating the urgency of the need for action to address health inequities. An effective approach will require multisector collaboration that considers the social determinants of health, confronts economic inequities, and rejects policies that perpetuate structural racism.

High-Priority Challenges

Each of the five topical articles published in Vital Directions: Priorities for 2021 reviews the status and trends for the problem, the priorities involved, an analysis of approaches, and reflections on strategies to address the problem. Of particular importance, as reflected throughout all of the articles, is the clear and urgent obligation for the US to turn its full attention to the growing problem of health inequities and to the structural racism that perpetuates such disparities.

HEALTH COSTS AND FINANCING: CHALLENGES AND STRATEGIES Despite high health care expenditures,[12] Americans generally experience poorer health outcomes compared with their counterparts in other high-income countries.[5] Not surprisingly, many Americans are concerned about US health care costs, making health reform one of the most prominent current political issues.[13] The COVID-19 pandemic has highlighted the weaknesses of the US health system and exacerbated already prevalent health disparities across the nation.[14,15] Rising numbers of uninsured people[16] that have worsened during the pandemic,[17] high costs of novel therapeutics,[12] and access barriers underscore the need

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for health reform. The article "Health Costs and Financing: Challenges and Strategies for a New Administration," by William Shrank and colleagues, takes a deeper look into these issues and provides recommendations to improve the efficacy and efficiency of the US health care system in the context of the COVID-19 pandemic and beyond, with explicit consideration of how to address disparities in outcomes to improve equity in doing so.[18]

Given the high costs and substandard health outcomes of the US health system, ensuring effective and high-value health care for all Americans must be a top priority for the next administration. There is an urgent need to provide more equitable access to affordable health care in the interest of national public health. To achieve these goals, the US will need to develop innovative ways of improving access to coverage, address health provider workforce shortages in areas such as primary care,[17] and reform health care payment methods. Recent shifts to value-based payment have sometimes resulted in significant savings, especially models that move farther away from fee-for-service payment.[19] A continued shift to alternative payment methods, including population-based payment with an emphasis on accountability for addressing health disparities, may decrease future costs while improving care.[20]

As part of these reforms, there are clear opportunities for telehealth services, therapeutic innovations, and health care data sharing. Although telehealth visits have significantly increased since the beginning of the COVID-19 pandemic[21] and multiple payers have expanded reimbursement for these services,[22] future telehealth regulations and reimbursement remain uncertain. The federal government will also need to reexamine the regulatory and reimbursement frameworks for medical therapeutics and health care data with a focus on supporting value and encouraging innovative models of care. The cost of therapeutics is not always aligned with the benefits they provide, and high prices limit access to pharmaceuticals for many Americans.[23] Patients also experience difficultly in gaining access to their own health information because of a lack of robust data systems accessible to both public and private providers.[24] To address these challenges, Shrank and colleagues present near-term opportunities to improve access, affordability, and equity, as well a list of recommendations for key elected officials and political appointees.

OPTIMIZING HEALTH AND WELL-BEING FOR WOMEN AND CHILDREN Women and children continue to experience high rates of morbidity and mortality in the US, which are further intensified by racial inequities.[25] More than 700 women die each year in the US during pregnancy and childbirth, and non-Hispanic Black women are more than twice as likely to die during pregnancy and childbirth as White women.[26] The US also has high rates of prematurity—at a rate of one in ten newborns—which is a leading cause of infant mortality and lifelong morbidity. Compared with their peers in other countries, US children experience higher rates of poor health outcomes, such as developmental problems, mental health conditions, and severe asthma, coupled with and worsened by social and environmental stressors such as poverty and hunger. Notably, the prevalence of adverse childhood outcomes is higher for Black, Hispanic, and low-income children regardless of race or ethnicity.[27]

To address these issues, the article by Elena Fuentes-Afflick and colleagues, titled "Optimizing Health and Well-Being for Women and Children," adopts a life-course perspective to assess both causes for and solutions to issues in child and maternal health.[28] This framework underscores the impacts of both positive and negative cumulative health outcomes through multiple phases of life from preconception to adulthood and highlights the interrelatedness of each developmental phase. As the authors of this article express, "Maternal health and well-being . . . may determine the health of the next generation and, ultimately, the health of the nation." The cumulative impacts of poor health outcomes in early childhood reverberate throughout the life course.

The authors note that prevention is key to improving maternity care and health outcomes for childbearing women. Several state-level and national strategies, such as the California Maternal Quality Care Collaborative and the Maternal and Child Health Bureau's Alliance for Innovation in Maternal Health, use a quality improvement approach to improve health outcomes. Addressing coverage gaps in health care can also reduce ma-

ternal mortality; in 2018 there were 10.8 million uninsured adult women, and more than one million women in poverty fell into the ACA's "coverage gap" between Medicaid and subsidized Marketplace eligibility.[29] The authors note that the US should set the world's standard for promoting the health and well-being of women and children, and they provide recommendations for a health system that leads to successful outcomes by focusing on targeted and moonshot recommendations. The targeted recommendations focus on existing policies or programs that are eminently achievable, which include the following elements: data, safety, and research. The moonshot recommendations, which are transformative and require endorsement, support, and resources from multiple sectors, include the following elements: ensuring access, transforming health care delivery and financing, and addressing social and environmental factors.

TRANSFORMING MENTAL HEALTH AND ADDICTION SERVICES Behavioral health, mental health, and addiction significantly affect society in the US and around the world. As of 2018, 20.3 million Americans (ages twelve and older) had a substance use disorder, and 47.6 million American adults suffered from at least one mental illness.[6] Although the US has made some strides in improving access to treatment for behavioral health conditions, significant gaps in care remain. Barriers to quality care are particularly high for people of color and people with socioeconomic disadvantage, emphasizing the need for special consideration of vulnerable populations in policies relevant to behavioral health.[30] Improving mental health and addiction treatment for all Americans requires combating stigma and promoting evidence-based, comprehensive care. In their article, "Transforming Mental Health and Addiction Services," Margarita Alegría and colleagues discuss the most pressing needs in behavioral health care and offer policy solutions that call for a reconceptualization of the behavioral health care system to prioritize the social needs of patients and to foster greater support of the behavioral health workforce.[31]

Current behavioral health interventions often focus on volume of services and symptom reduction as a benchmark for success. However, given scientific advancements and improvements in patient-centered care, people with mental illness are increasingly in recovery and able to live full lives despite their symptoms. Thus, it is possible to move beyond symptom reduction and to emphasize everyday functioning and societal involvement in behavioral health care.[32] A shift toward prioritizing social context and addressing the social needs of patients with behavioral health conditions will be a vital part of behavioral health care going forward. Further, improving functional outcomes requires transforming the behavioral health system to meet patients "where they are" in terms of physical location and their current acceptance of their illness. Promotion of community-based organization outreach,[33] telehealth services,[34] and home visiting programs[35] to augment behavioral health care presents an opportunity to expand patient enrollment in care and diagnose disease sooner.

US leaders must address the preventable health disparities that negatively affect millions of Americans.

Another pressing need in the advancement of mental health and addiction care is decriminalization of people who have behavioral health conditions, based on the recognition that addiction is a brain disease.[36] Such change is urgently needed both to improve health outcomes and because people of color are disproportionately negatively affected by the criminal justice system.[37] Efforts to improve behavioral health outcomes should include a reconfiguration of the crisis response system with a workforce trained in deescalation tactics instead of criminalization.[38]

ACTUALIZING BETTER HEALTH AND HEALTH CARE FOR OLDER ADULTS By 2040, people ages sixty-five and older are predicted to account for 21.6 percent of the US population, and resources will need to be appropriately allocated to ensure that they receive person-centered, high-quality care.[39] The COVID-19 pandemic has further exposed the consequences of fragmented and unequal care for older adults, as well as the enduring impacts of structural racism. To address systemic inequities and to address many of the challenges facing older adults, it is imperative to take a population health approach. By actualizing this vision of population health for older adults, the nation can address many of the outstanding challenges and issues faced by older Americans.

In their article, "Actualizing Better Health and Health Care for Older Adults," Terry Fulmer and colleagues address core challenges facing

health and health care for older adults, ranging from recruitment in the geriatrics workforce a nd digital health barriers to the importance of age-friendly public health systems and addressing social isolation.[40] As the population of older adults continues to rise during the next decade, it will be important that the geriatrics workforce—ranging from specialists to caregivers—expands to meet the increase in demand for care. As of 2018 the older adult population in the US was 49.2 million; however, there were only 3,590 full-time practicing geriatricians.[41] Equally important are the issues faced by the geriatrics workforce—especially issues worsened or brought on by the COVID-19 pandemic, which range from burnout[42] to specific hardships faced by nursing home staff and paid caregivers. A disproportionate number of all deaths from COVID-19 in the US are tied to nursing facilities, and working in these facilities increases the risk for transmission to exposure among patients and staff.

Telehealth is an important innovation, especially within the context of the pandemic, to increase access to care. However, barriers remain for engagement via virtual platforms, including limited digital health literacy, unequal access to technology, design barriers, and integration of telehealth with other services needed for effective care. An additional concern for care delivery for older adults is that public health funding is often disease or condition specific rather than population focused, yet the development of age-friendly health systems is integral to promoting healthy aging. Redesigning long-term services and supports is also a critical challenge that must be addressed, especially given that twelve million adults are living with serious illness. Innovative long-term care should provide more support for older adults remaining at home and aging in place. The disproportionate mortality rates resulting from COVID-19, particularly in nursing homes, also highlight the importance of improving care quality in long-term care facilities and other community living arrangements.

To address these challenges, the authors identify six vital directions to improve the care and quality of life for older Americans: create an adequately prepared workforce for the health care of older people; strengthen the role of public health; promote equity and address the social determinants of health; develop, evaluate, and implement new approaches to the delivery of health care for older adults that incorporate evidence-based telehealth and technology; allocate resources to support person-centered care including palliative and end-of-life care; and redesign the structure and financing of long-term services and supports, including nursing home and community care.

INFECTIOUS DISEASE THREATS: A REBOUND TO RESILIENCE During the past five years there have been increasingly serious infectious disease threats in the US and globally, ranging from new foodborne and drug-resistant pathogens to antimicrobial resistance and vectorborne diseases such as Zika. However, COVID-19 in particular has tested the US response and resilience to global threats, revealing the importance of national and international coordinated responses to pandemics. The economic, political, and social impacts of COVID-19 will continue to demand ongoing attention in 2021, remaining significant challenges. Further responses should aim to improve resilience against future infectious disease threats.

In "Infectious Disease Threats: A Rebound to Resilience," Peter Daszak and colleagues outline key lessons learned from more than a century of pandemics and those yet to be learned from the COVID-19 experience.[43] Infectious disease epidemics and pandemics result in dire health, social, and economic consequences, with significant impacts on underserved and disenfranchised communities. In particular, the COVID-19 pandemic has disproportionally affected hospitalization and mortality rates for communities of color, people with disabilities, people in detention, and elderly populations.

Daszak and colleagues propose six critical steps to build resilience to address the current pandemic and also to prepare for future infectious disease threats. These recommendations call for launching an expert Pandemic Preparedness and Response Commission, reinforcing a science-based approach to public health policy, and increasing federal funding to agencies involved in pandemic preparedness and control. Across all of these recommendations, and especially for an effective response to COVID-19, structural changes to the US public health system and infrastructure are essential to addressing infectious disease threats, as is collaboration among federal agencies and state governments. The authors maintain that evidence-based national leadership, in coordination with public health guidance, is critical to preventing and containing pandemics. The role of the US as global leader in pandemic response and recovery not only protects Americans in the short and long term but also promotes global health security in the face of potential future threats.

Health Equity: The Most Vital Direction For 2021

The unacceptable health inequities that persist in the US today, compounded by the enormous

and uneven impact of the COVID-19 pandemic, emphasize the need and the opportunity for the next administration to address the fundamental challenges that the nation faces in health and health care. US leaders must address the preventable health disparities that negatively affect millions of Americans and regain the public's trust in health science. Across the articles contained in the 2021 Vital Directions series is the clear message to the nation—and those stewarding health policy—that the most fundamental obligation is to view health system reform through a health equity lens. It is incumbent on all involved to advance an evidence-based and population-engaged assessment of the equity implications of every policy, program, and activity in the health sector, including those related to payment reform; reach and operation of the digital health infrastructure; links among health care, public health, and social services; the adequacy and nature of the workforce; and the focus and conduct of health and biomedical research. With myriad interacting public and private players and policies shaping health and health outcomes, the health sector cannot in isolation correct health, social, and racial inequities. But those of us in the health field—clinicians, patients, health organizations, public health and social service agencies, payers, manufacturers, and policy makers—constitute a powerful force for leadership. Testament to the importance of that leadership is the core message of Vital Directions 2021, and it is a message that will be prominent as the National Academy of Medicine works with partners throughout the nation to ensure that every American reaches their full potential for health and well-being. ■

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Claims Denials and Appeals in ACA Marketplace Plans

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ISSUE BRIEF

In this report, we analyze transparency data released or updated in 2020 by the Centers for Medicare and Medicaid Services (CMS) to examine claims denials and appeals among issuers offering individual market coverage on HealthCare.gov; data are from plan years 2018 and 2019. The Affordable Care Act (ACA) requires transparency data reporting by non-grandfathered group health plans and by individual market plans offered on and off of the Marketplace. We find that, across HealthCare.gov issuers with complete data, about 17% of in-network claims were denied in 2019, and about 14% of in-network claims were denied by issuers in 2018, with rates for specific issuers varying significantly around these averages.

In 2019, issuer denial rates ranged from less than 1% to more than 50%. Average denial rates also varied based on plan metal levels – 15% for bronze, 14% for gold, 18% for silver, and 20% for catastrophic plans in 2019.

The federal government now requires HealthCare.gov issuers to report reasons for claims denials at the plan level. Of all denials with reasons reported for 2019, about 18% were denied because the claim was for an excluded service; about 9% were denied due to prior authorization or lack of referral, and less than 1% were denied based on medical necessity. The remaining plan-reported denials (72%) were denied for other reasons.

We also find that consumers rarely appeal claims denials to their issuers, and when they do, issuers usually uphold their original decision. In 2019, HealthCare.gov consumers appealed just over one-tenth of one percent of denied in-network claims, and issuers upheld 60% of those appeals.

ACA transparency data has the potential to reveal information about health plan coverage and operations that might not otherwise be readily apparent from plan documents. For example, data could reveal the incidence of “surprise medical bills” and patient cost liability for such claims from one plan to another. Data could also be used to develop tools to help consumers evaluate marketplace plan options, comparing claims payment practices in addition to price. Transparency data could also inform oversight activities by regulators. To date, however, ACA transparency data

requirements have not been fully implemented. Data that are collected are not audited and appear to contain some reporting inconsistencies. And, federal regulators have not used transparency data for oversight or for the development of any consumer information tools.

ACA Transparency Data

The Affordable Care Act (ACA) requires periodic data reporting by non-grandfathered group health plans and health insurance issuers in the individual and group markets.[1] (https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/view/footnotes/#footnote-508628-1) Data on the following is required in the statute:

- Claims payment policies and practices
- Periodic financial disclosures
- Data on enrollment
- Data on disenrollment
- Data on the number of claims that are denied
- Data on rating practices
- Information on cost-sharing and payments with respect to any out-of-network coverage
- Information on enrollee and participant rights under this title
- Other information as determined appropriate by the Secretary

The law requires these data to be available to state insurance regulators and to the public.

Partial implementation of ACA transparency data reporting began several years ago. To date, reporting is required only by issuers for qualified health plans they offer on HealthCare.gov. Issuers report only on the number of in-network claims denied, the number of denied claims that are appealed, and the outcome of appeals.[2] (https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/view/footnotes/#footnote-508628-2) Data are reported in aggregate at the issuer level. In addition, starting in 2018, data are reported at the health plan level, and certain reasons for claims denials are also now reported at the plan level. CMS does not collect data on all of the fields enumerated in the ACA, including out-of-network claims submitted or enrollee cost sharing and payments for out-of-network claims. Nor has it required any further detailed reporting (e.g., on claims or appeals by type of service or diagnosis.) To date, ACA transparency data are not reported by other non-group plans or employer-sponsored plans.

Recently, the Trump Administration issued a final regulation (https://www.federalregister.gov/documents/2020/11/12/2020-24591/transparency-in-coverage) requiring all non-grandfathered plans – including those sponsored by employers or offered by issuers outside of HealthCare.gov – to report billed charges and negotiated allowed amounts for covered items and services beginning in 2023. The regulation invokes ACA transparency data reporting authority, but does not require plans to report prices to CMS; instead, price data must be posted online by each plan sponsor and issuer, making it unlikely that the price data across plans and issuers will be compiled into a single public use file provided by the federal government.

Analysis of Transparency Data

This brief focuses primarily on transparency data for the 2019 calendar year submitted by major medical plans offered to individuals on HealthCare.gov. Our analysis excludes stand-alone dental plans and issuers with incomplete data or very low enrollment, as well issuers for SHOP marketplace plans. The methods section details our rules for inclusion. Public use files with reported transparency data for calendar years 2019 (https://download.cms.gov/marketplace-puf/2021/transparency-in-coverage-puf.zip) and 2018 (https://download.cms.gov/marketplace-puf/2020/transparency-in-coverage-puf.zip) were posted online by CMS.[3] (https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/view/footnotes/#footnote-508628-3) From the public use files, we have developed working files that are posted with this report. A previous KFF report (https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/) summarized transparency data reported for the 2015-2017 plan years.

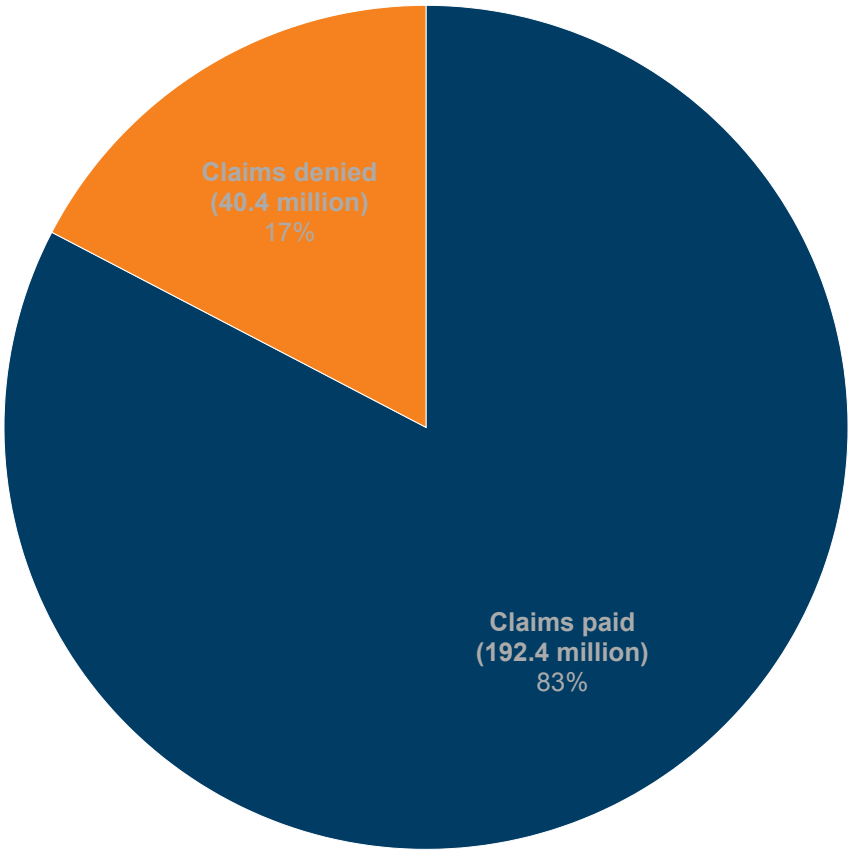
Claims submitted and denied

Of the 181 major medical issuers in healthcare.gov states included in the transparency data, 122 show complete data on in-network claims received and denied for the 2019 plan year. Together these issuers reported 232.8 million in-network claims received, of which 40.4 million were denied, for an average in-network claims denial rate of 17.4% (Figure 1).

Figure 1

On average, healthcare.gov issuers deny 17% of in-network claims

Share of 232.8 million in-network claims denied in 2019



SOURCE: CMS Transparency in coverage data for 2019 plan year • PNG

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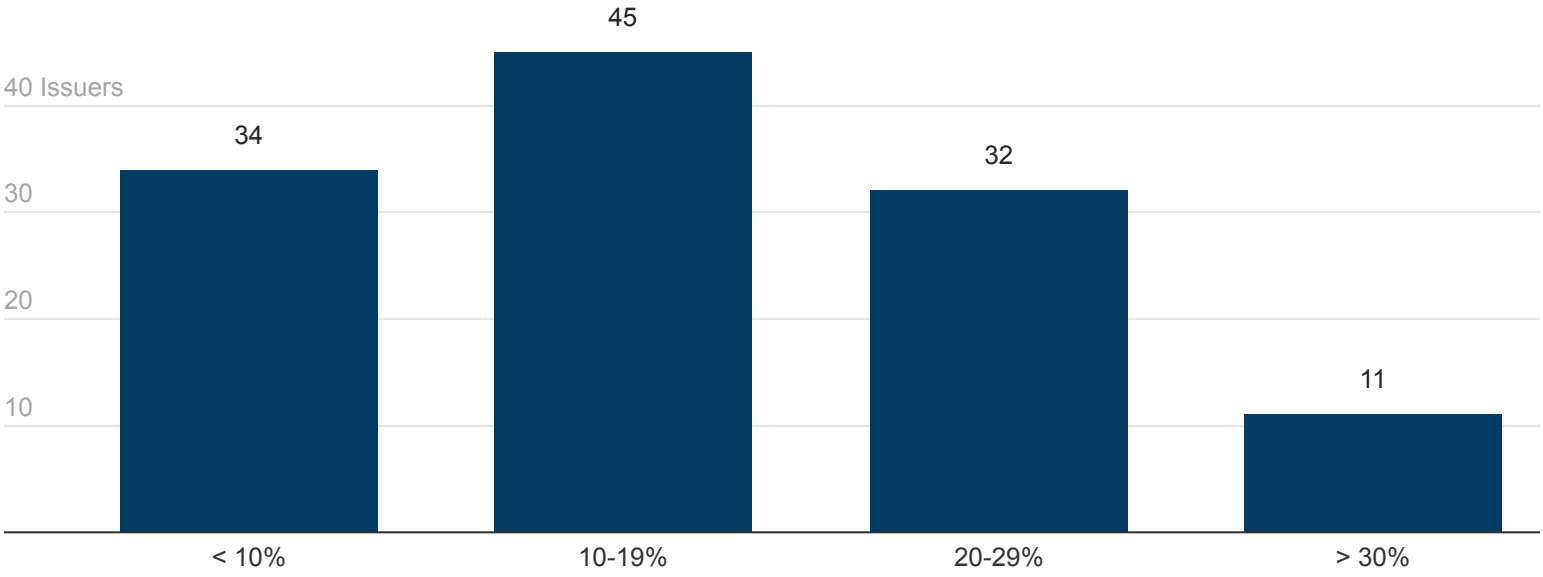
Denial rates by issuers varied widely, ranging from 1% to 57% of in-network claims. Overall for 2019, 34 of the 122 reporting Healthcare.gov major medical issuers had a denial rate for in-network claims of less than 10%. Another 45 reporting issuers denied 10%-20% of in-network claims that year, 32 issuers denied 20%-30%, and 11 issuers denied more than 30% of in-network claims (Figure 2). Issuers that report denying one-third or more of all in-network claims were Blue Cross Blue Shield (BCBS) of Tennessee (57%), Anthem BCBS of Georgia (40.5%), Anthem BCBS of Maine (40.4%), Anthem BCBS of Ohio, (39.5%), Anthem BCBS of Virginia, (36.2%), Anthem BCBS of New Hampshire, (35.2%), and Anthem BCBS of Kentucky (33.3%).

On average, claims denial rates are similar to those reported in earlier years, although for some issuers, reported denial rates have varied over time. For example, Blue Cross Blue Shield of Florida reported an in-network claims denial rate of less than 5% in 2017, 2018, and 2019, while Blue Cross Blue Shield of Tennessee reported a claims denial rate of 15% in 2017, 17% in 2018, and 57% in 2019.

Figure 2

Denial rate for in-network claims by healthcare.gov issuers, 2019



SOURCE: CMS Transparency in coverage data for 2019 plan year. • PNG

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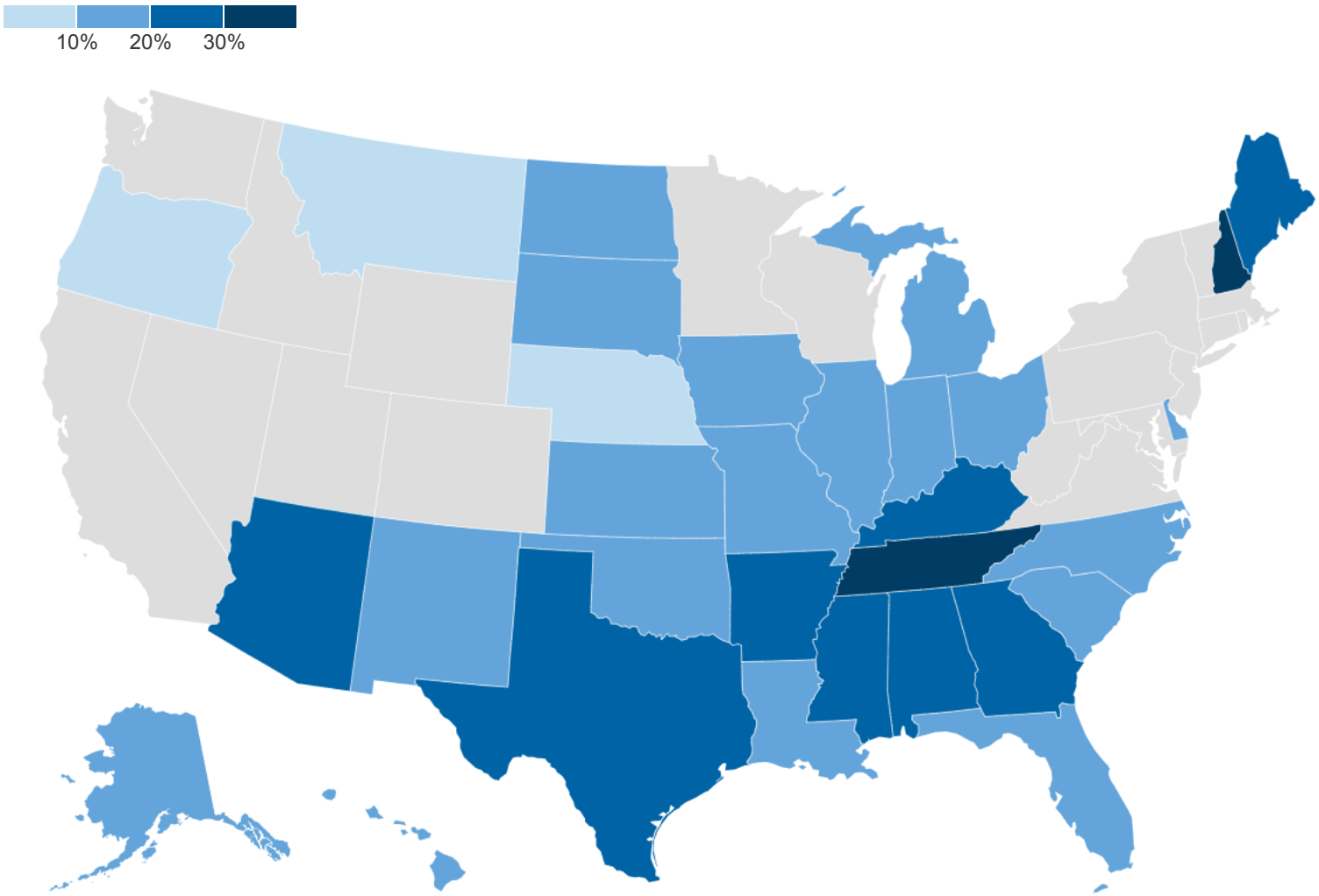
Denial rates also vary from state to state (Figure 3). In states where multiple issuers participate in the marketplace, the average denial rate sometimes obscures variation among issuers. For example, in Florida, where the average denial rate for in-network claims was 11%, rates for the seven issuers ranged from less than 5% to nearly 24%.

Figure 3

Average denial rate for in-network claims by healthcare.gov issuers, by state, 2019



NOTE: States are shown in gray if they are state-based exchanges or if 60% or more of the enrollment in that state is missing from this analysis (either because issuers are missing from the CMS transparency data or because issuers have missing or invalid data).
SOURCE: CMS Transparency in coverage data for 2019 plan year. • PNG

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A variety of factors could explain the variation in denial rates across issuers and markets, including but not limited to differences in:

- Issuer reporting methods, for example, in how to count partial approvals
- Provider knowledge about which claims will be covered and how to properly submit claims
- Limits (e.g. day or visit limits) on covered services
- Degree to which issuers' automated claims processing systems routinely deny certain claims
- Determination of medical necessity

Depending on the nature of the denial, consumers may or may not be held harmless. If the consumer is not held harmless, she could face significant financial liability.

Plan Level Data on Claims Denials

Issuers were required to begin reporting data on claims payment practices at the plan level for the 2018 plan year. By 2019, there are signs that issuers are not reporting plan level data consistently.

Of the 131 issuers reporting aggregate data on in-network claims received and denied for 2019, 121 also reported data at the plan level for the 2019 plan year. Of those, for 82 issuers, the aggregated number of claims received at the issuer level is the same as or similar to the sum of claims received reported at the plan level. Ten issuers report data on claims received at the issuer level, but report no plan level data. Finally, issuers are now required to report plan level data on the reasons for denied claims.

We reviewed plan level claims data for 1,714 plans offered on HealthCare.gov in 2019. Plan denial rates averaged 17%, and ranged from 0% to more than 60%. Average denial rates were somewhat different based on the plan metal level. On average, silver plans show a denial rate of about 18%, compared to 20% for catastrophic plans, 14% for gold plans, and nearly 15% for bronze plans.[4] (https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/view/footnotes/#footnote-508628-4)

HealthCare.gov plans are also required to report on certain categories of reasons for in-network claims denials:

- denied due to prior authorization or referral
- denied due to an out-of-network provider
- denied due to an exclusion of a service
- denied based on medical necessity (claims for other-than behavioral health services)
- denied based on medical necessity (claims for behavioral health service)
- denied for other reasons

Transparency data reporting instructions (https://www.qhpcertification.cms.gov/s/Transparency%20in%20Coverage) require that the total number of plan-level claims denied in a year "should also be accounted for in the six denial reason categories… however, the totals [from the six denial reason categories] will not add up to the total number of plan level claims denied." That is because "denied out-of-network claims" is included in one of the reason categories. Keeping out-of-network claims denials separate, we added the number of in-network claims denials reported by plans for the other five reason categories. Then we calculated the share of total in-network denials attributable to each of the five reason categories for in-network claims denials. (Table 1)

Table 1: Plan-Reported In-network Claims Denied, Total and by Reason Category, 2019

Total Denied In-Network Claims	Sum of In-network Denials for 5 Reasons	Denied for Referral, Pre-Authorization	Denied as Excluded Service	Denied for Medical Necessity (non-behavioral health)	Denied for Medical Necessity (behavioral health)	All Other Reasons
36 million	35.6 million	3.3 million (9%)	6.5 million (18%)	0.25 million (0.7%)	0.04 million (0.1%)	25.5 million (72%)

We observe the following from transparency data on reasons for claims denials:

- 18% of plan-reported denied claims were denied because the service was not a covered service
- 9% of plan-reported denials were because the claim lacked a required referral or preauthorization
- Fewer than 1% of plan-reported denied claims were denied on the basis of medical necessity
- 72% of denied in-network claims were denied for some other reason

Plans denied in-network claims for these five reasons at different rates, suggesting that more detailed reporting or investigations could yield meaningful information to regulators as well as consumers. For example, while medical necessity denials appear to be rare, in some plans that is not the case. Seventeen plans reported that medical necessity denials of non-behavioral health service account for 10 percent or more of all reported denials (compared to an average rate of seven-tenths of one percent across all reporting plans). And 4 plans (offered by a single insurer) report that denials of behavioral health claims for medical necessity reasons accounted for more than 5% of all reported in-network claims denials, compared to an average rate of one-tenth of one percent across all reporting plans.

That nearly three-quarters of in-network claims (more than 25 million in 2019) were denied for "some other" reason indicates there is more to learn about why plans deny in-network claims. The state of Connecticut, for example, has long required transparency data reporting of state-licensed insurers and includes results in an annual report card on health insurers. Denial reasons reported by Connecticut insurers account for nearly half of all denied claims reported in the 2019 report card. (Table 2)

Table 2: Claims Denials and Reasons, Connecticut Report Card, 2019

Total Denied Claims Reported by 14 Issuers	Denied Because Service Not Covered	Denied Based on Medical Necessity	Denied Because Claimant Not Enrolled	Denied Based on Incomplete Information	Denied for Duplicate Claim	All Other Reasons
2.2 million	0.18 million (8%)	0.04 million (1.7%)	0.29 million (13%)	0.27 million (12%)	0.28 million (13%)	1.1 million (52%)

SOURCE: Consumer Report Card on Health Insurance Carriers in Connecticut, October 2020. Available at https://portal.ct.gov/-/media/CID/1_Reports/2020-ConsumerReportCard.pdf (https://portal.ct.gov/-/media/CID/1_Reports/2020-ConsumerReportCard.pdf)

Federal transparency reporting on denial of out-of-network claims does not provide meaningful information at this point. Plans are not required to report on the total number of out-of-network claims submitted, so a denial rate for out-of-network claims cannot be calculated from the data.

Finally, there appear to be inconsistencies in the reporting of reasons for claims denials by HealthCare.gov plans. Though CMS instructions require that the total denied in-network claims be reflected in the denials reported by reason, totals don't always match denials reported in the reason categories: — 123 plans report substantially fewer total denied in-network claims than they report in the five in-network reason categories; 457 plans report substantially more total in-network denials than they report in the reason categories. Auditing of transparency data by CMS could possibly improve the quality and consistency of reporting.

Appeals

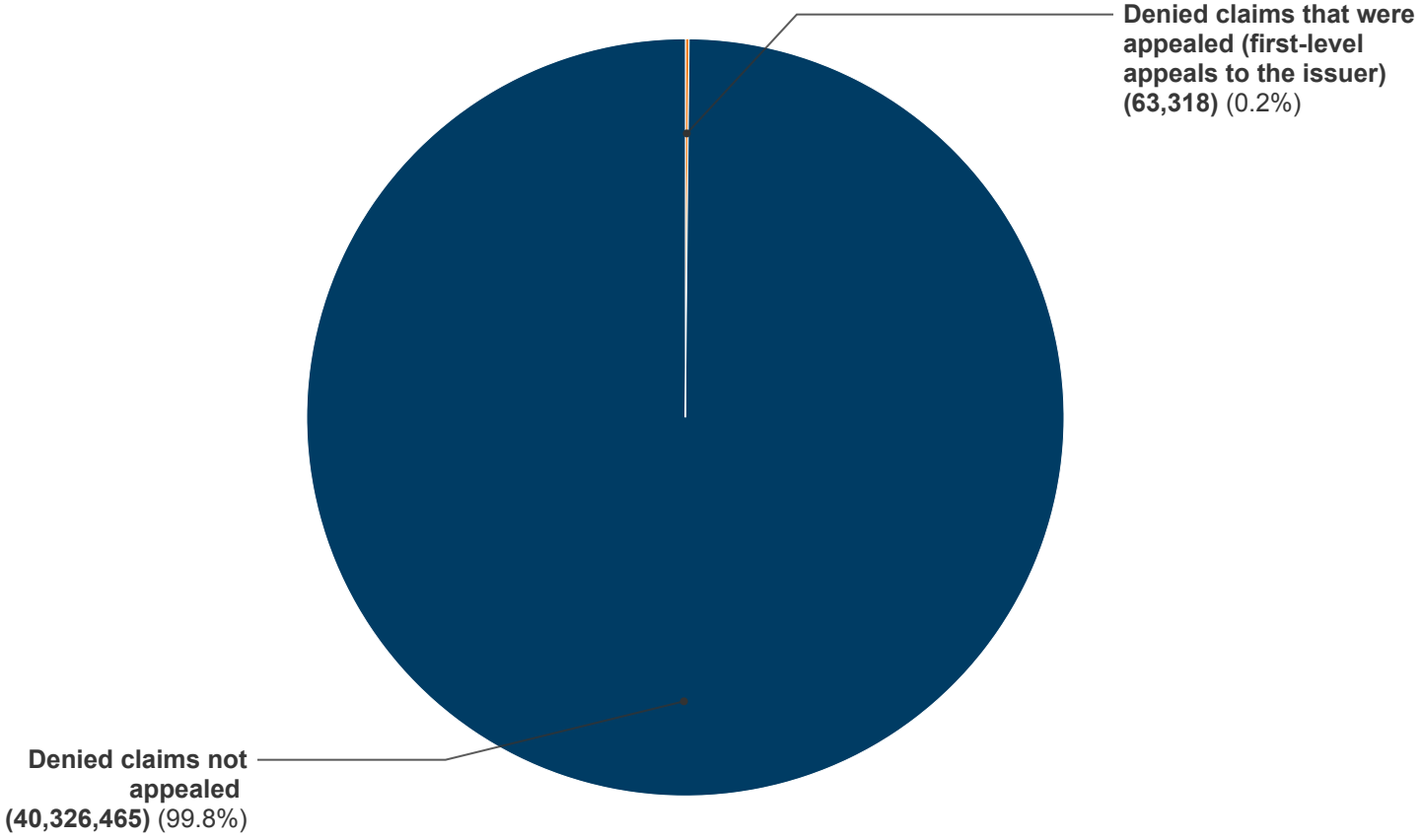
The ACA transparency data show the number of denied claims that were appealed to the plan (internal appeals), the number of internally appealed denials that were overturned by the issuer, the number of external appeals made by consumers, and the number of externally appealed denials that were overturned. The CMS public use files suppress values lower than 10.

Consumers rarely appeal denied claims. In 2019, 119 major medical issuers show data values on submitted, denied, and appealed in-network claims. Together they denied more than 40 million claims, of which consumers appealed fewer than 64,000 – an appeal rate of less than two-tenths of one percent (Figure 4). Transparency data from earlier years show similarly low appeal rates.

Figure 4

Consumers rarely appeal denied health insurance claims

Share of 40.4 million denied claims appealed by consumers in 2019 through internal isser appeals process



NOTE: This figure only includes denied claims for issuers that show data on appealed claims.
SOURCE: CMS Transparency in coverage data for 2019 plan year. • PNG

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Issuers uphold most denials that are appealed. In 2019, about 40% of denials that enrollees appealed internally to their health plans were overturned. The overturn rate of appealed claims denials varied by issuer. Among 119 issuers whose appeals outcomes data were not suppressed, the overturn rate ranged from less than 15 percent to over 90 percent.

The ACA guarantees external appeal rights to enrollees in all non-grandfathered private health plans. When issuers uphold denials at the internal appeal level, consumers have the option of requesting an independent review by an outside entity, whose decision is binding.

However, consumers seldom avail themselves of external review. Of 55 issuers that reported data on external appeals requested in 2019, just 31 reported more than 10 external appeals; 24 issuers reported zero external appeals, 67 additional issuers had data suppressed because the number of external appeals filed was less than 10. Even if a value of 9 were assumed for each of the suppressed data fields, fewer than 1 in 20,000 denied claims made it to external review. Under federal regulations, consumers are only eligible for external review if their claim was denied based on medical necessity or related, clinical reasons. As noted above, insurers rarely deny claims based on medical necessity. Under some state laws, all denied claims are eligible for external appeal.

Discussion

Transparency data offers insights into how health plans work in practice. However, five years into implementation, ACA transparency data reporting remains limited in its content and its uses. CMS does not require reporting by HealthCare.gov issuers on all of the transparency data required under the ACA. The agency does not audit transparency data reported by issuers, even though reporting inconsistencies seem apparent. Transparency data are posted online, but not made available by the federal government in a format useable for consumers or used to develop tools consumers could use to recognize and evaluate material differences in plan choices. In addition, the federal government does not collect ACA transparency data from employer plans or other issuers subject to the ACA requirements.

An Inspector General report (https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf) found Medicare Advantage plans deny 8% of claims, on average. By contrast, HealthCare.gov plans, on average, report denying about 17% of in-network claims; with some issuers fewer than 10% of in-network claims while others deny one-third or more. While these differences in denial rates might reflect inconsistencies in data reporting, at least in part, they also could signal differences in the reliability of coverage that health plans offer. Such differences could materially affect consumers, and regulators could investigate and address them more than they do currently.

Data also show that consumers rarely appeal claims denied by their health plans. The Affordable Care Act established statewide ombudsman, or consumer assistance programs (https://www.cms.gov/CCIIO/Resources/Files/Downloads/csg-cap-summary-white-paper.pdf), to help consumers file appeals for denied claims. These programs were established in most states and territories in 2010 and 36 remain in effect, but they have not received federal funding since 2012.

Recently federal policymakers have taken other steps to promote price transparency within private health plans, to protect patients and require annual reporting on surprise medical bills, and to promote the transparency and accuracy of health plan provider networks and directories. For each of these policy priorities, ACA transparency data reporting could be implemented more completely to yield information helpful to regulators and to consumers.

METHODS (HTTPS://WWW.KFF.ORG/REPORT-SECTION/CLAIMS-DENIALS-AND-APPEALS-IN-ACA-MARKETPLACE-PLANS-METHODS/) ›

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By Matthew Buettgens, Fredric Blavin, and Clare Pan

The Affordable Care Act Reduced Income Inequality In The US

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ABSTRACT **Income inequality estimates based on traditional poverty measures do not capture the effects of health care spending and health insurance. To explore the distributional effects of the Affordable Care Act's (ACA's) expansion of health benefits and the resulting income inequality, this study used alternative income measures that incorporate the value of the ACA's health insurance changes under the law. The study simulated the impact of the ACA on income inequality in 2019 compared with a scenario without the ACA. We found that the ACA reduced income inequality and that the decrease was much larger in states that expanded Medicaid than in states that did not. We also decomposed the effect of the ACA on inequality by race/ethnicity, age, and family educational attainment. The ACA reduced inequality both across groups and within these groups. With efforts to repeal the ACA—specifically, *California v. Texas*—having shifted from Congress to the courts, it remains important to consider the consequences of fully repealing the ACA, which would likely reverse reduced inequality observed under the law.**

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Income inequality is growing in the United States and is a cause for concern. Wealth concentration was high in the beginning of the twentieth century before falling from 1929 to 1978, but it has continuously increased since then.[1] For example, the share of national income among the poorest half of the US population steadily declined from more than 20 percent in 1980 to 13 percent in 2016, and the income share among the top 1 percent doubled from around 10 percent in 1980 to 20 percent in 2016.[2] In addition to the political, economic, and social concerns related to rising economic inequality, there is also a growing literature linking income inequality to health disparities.[3,4]

The Affordable Care Act (ACA) ushered in the biggest health insurance coverage expansion in the US health care system since the creation of Medicare and Medicaid in 1965 and may have redistributed income between different populations. After implementation of the ACA, the number of people without health insurance in the US declined by 13.3 million from late 2013 through 2017.[5] However, the uninsured population rose by 1.9 million between 2017 and 2018, to 27.5 million people.[6] Enrollment in Medicaid and the Children's Health Insurance Program (CHIP) increased by about 16.6 million (29.2 percent) between 2013 and December 2017,[7,8] and as of the 2018 plan year, 11.8 million people were enrolled in health plans through federal or state-based Marketplaces.[9] Coverage gains mirrored states' decisions to expand Medicaid eligibility, as the decline in uninsurance was significantly larger in states that expanded than in states that did not.[10–14] Given the large and growing cost of health care—the overall level of health care spending in the United States was $3.6 trillion in 2018, or 17.7 percent of the economy[15]—it is important to understand how the changes in health insurance programs under the ACA affect-

ed income inequality.

We investigated the impact the ACA has had on income inequality, considering the new health coverage benefits and government revenue needed to finance them. Although most analyses on inequality focus on earnings or other forms of income,[16] this study incorporated a broader measure of income that shows how government taxes and transfers affect real resources. This measure is based on the health-inclusive poverty measure, developed by Sanders Korenman and Dahlia Remler,[17] and includes the value of Medicaid and CHIP benefits, financial assistance for health insurance premiums provided by the government or employers, and the value of health insurance in reducing families' risk for high out-of-pocket health care spending. We also accounted for the tax revenue needed to pay for the ACA's health benefits.

To demonstrate the impact of ACA on income inequality at a point in time, we used the Urban Institute's Health Insurance Policy Simulation Model to replicate health coverage and costs under the ACA based on the most recent available enrollment data and compared these estimates to a simulated baseline scenario without the ACA. Simulating health coverage in 2019 without the ACA is not the same as simply going back to health coverage in 2013; the simulation model allowed us to incorporate changes in demographic, economic, and other contextual factors during the period and to measure these elements consistently in the presence and absence of the ACA.

Other analyses have assessed how the ACA would reduce income inequality by providing benefits to and increasing household incomes for the lower half of the income distribution.[18,19] However, the estimates in this study provide a more comprehensive picture of the impact of the ACA on inequality. First, prior studies assessed only the potential effects of the ACA on resource inequality, whereas this study allows us to compare two scenarios at the same point in time. Second, our resource measure accounts for the value of key health coverage components—consistent with the health-inclusive poverty measure—that other studies do not account for. Third, we show how inequality changes both within and between various subpopulations, such as racial and ethnic groups.

Study Data And Methods

SIMULATION OF SCENARIOS The Health Insurance Policy Simulation Model is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed policy options. The model has been used extensively to estimate the cost and coverage implications of health reforms at the national and state levels and has been widely cited, including in the Supreme Court's majority opinion in *King v. Burwell*.[20] Unlike survey data, which are published after a time lag of at least a year, the simulation model allows us to incorporate 2019 data from Medicaid and Marketplace enrollment in each state. Survey data also generally underreport Medicaid enrollment and lack details such as whether a family received premium tax credits. Additional information on the Health Insurance Policy Simulation Model is in the online appendix.[21]

Although individual records in the Health Insurance Policy Simulation Model are based on two years of data from the American Community Survey, we regularly update the model to reflect published Medicaid and Marketplace enrollment and costs in each state. The enrollment experience in each state under current law affects how the model simulates policy alternatives. The current version of the model is calibrated to state-specific targets for Marketplace enrollment after the 2019 open enrollment period, 2019 Marketplace premiums, and late 2018 Medicaid enrollment from the Centers for Medicare and Medicaid Services (CMS) monthly enrollment snapshots.[22,23] Because no data are currently available on off-Marketplace or non-ACA-compliant nongroup coverage, these were simulated by the model.

We used the Health Insurance Policy Simulation Model to simulate health coverage and costs among nonelderly adults both under the ACA as implemented and under a scenario in which the ACA had not been implemented. We simulated the impact of the coverage provisions of the ACA, comparing it with insurance coverage and health care spending without the ACA at the national and state levels. The current-law estimates account for the federal individual mandate penalties being set to $0 beginning in plan year 2019, as well as Massachusetts, New Jersey, and Washington, D.C., having their own individual mandate penalties. The current-law estimates also incorporate other recent policy changes, including the expanded availability of short-term, limited-duration policies; a shortened annual open enrollment period; and reduced funds for outreach and enrollment assistance.

We treated states (Idaho, Nebraska, and Utah) in which the ACA Medicaid expansion had been approved by ballot initiative in November 2018 but not yet implemented by the beginning of 2019 as nonexpansion states.

To develop estimates of the impact of the ACA on income inequality, we compared estimates from the current-law scenario with estimates

from a simulated baseline scenario without the ACA. This baseline scenario was drawn from the approach used in a recent Health Insurance Policy Simulation Model analysis that estimated the impact of ACA repeal on health insurance coverage and costs.[24] We assumed that the seven states with substantial Medicaid coverage expansions for adults before the ACA (Arizona, Delaware, Hawaii, Massachusetts, New York, Vermont, and Wisconsin) could return to pre-ACA eligibility levels. For this to happen, CMS would have to approve new Medicaid Section 1115 waivers. If such waivers are not approved, ACA repeal would result in substantially greater losses of coverage in these states.

INCOME MEASURES No commonly used income measure considers the full monetary value of health coverage under the ACA. Both the Census Bureau's official poverty measure and family modified adjusted gross income as a percentage of the Department of Health and Human Services Poverty Guidelines (the income measure on which program eligibility is based) omit noncash benefits, such as health insurance coverage, which can reduce out-of-pocket health spending or lower the risk of having to pay very high medical expenses.

For this analysis we created two alternative income measures. The first measure is consistent with the Census Bureau's Supplemental Poverty Measure, which reduces income by deducting out-of-pocket health care spending.[25] As a more comprehensive alternative, we created a measure consistent with the health-inclusive poverty measure,[17] which includes the value of Medicaid and CHIP benefits, financial assistance for health insurance premiums provided by the government or employers, and the value of health insurance in reducing families' risk for high out-of-pocket health care expenses. We also accounted for the tax revenue needed to pay for the ACA's health benefits.

We first explored the ACA's impact on income inequality using the Supplemental Poverty Measure concept. The Supplemental Poverty Measure extends the Census Bureau's official poverty measure by taking into account many government programs (but not Medicare, Medicaid, or subsidized health care programs) designed to assist low-income individuals and families that are not included in the official poverty measure. The Supplemental Poverty Measure includes the sum of cash income, plus noncash benefits that families can use to meet their needs, minus taxes (or plus tax credits), work expenses, medical expenses (out-of-pocket medical expenses and premiums), and child support paid.[25] To construct a measure similar to the Supplemental Poverty Measure that deducts these same medical expenses, we constructed the family's modified adjusted gross income from pretax income components reported on the American Community Survey and deducted the out-of-pocket expenses for health insurance premiums and health care costs (net cost-sharing subsidies received in the Marketplace).

However, the major limitation of the Supplemental Poverty Measure is that it does not incorporate the value of Medicaid benefits and the receipt of financial assistance to pay for health insurance premiums. We used the concept of the health-inclusive poverty measure to fill this gap by adding family health insurance benefits to family resources. To create our health-inclusive poverty measure, we started with the Supplemental Poverty Measure and made the following modifications. First, we added the receipt of financial assistance to pay for health insurance premiums. This includes the part of the family's health insurance premiums paid for by the government through premium tax credits or by employer contributions to employer-sponsored insurance premiums.

Second, we added the fungible Medicaid benefit, where the amount of the Medicaid benefit cannot exceed income. The fungible value approach adds the dollar value of the Medicaid benefit to income to the extent that having the insurance would free up resources that would have been spent on medical care.[26] Unlike the Census Bureau, we did not include food and housing cost requirements in our definition of *fungible value* because they are not available in the American Community Survey data.

Third, we added a valuation of the financial risk associated with high medical expenses. Finally, we subtracted the family's share of new federal and state spending under the ACA, allocated by federal and state income tax incidence. New government spending under the ACA includes the federal and state shares of the cost of new Medicaid enrollment because of the ACA and federal premium tax credits for Marketplace coverage. This modification to income is not incorporated in the original health-inclusive poverty measure.

Additional details on these income components and on how we created a measure consistent with the health-inclusive poverty measure are in the appendix.[21] Details on how the original health-inclusive poverty measure was constructed and its context can be found elsewhere.[17]

MEASURES OF INEQUALITY We began by assessing differences in inequality between scenarios with and without the ACA by computing our modified measure of modified adjusted gross income within income percentiles, a common statistic used in analyzing inequality. However,

inequality can be presented more concisely as an index. The most widely used index, the Gini index, ranges from 0 (perfect equality) to 1 (maximum inequality) and is derived from the Lorenz curve, which measures the difference between the cumulative income distribution and a perfectly equal income distribution.[27] For this analysis we used the Theil index because it has an important decomposition property that the Gini index lacks.[28] Similar to the Gini index, the Theil index measures the difference between the cumulative income distribution and a perfectly equal distribution. The Theil index also ranges from 0 to 1, with higher values indicating greater inequality, but it allows researchers to decompose inequality that occurs within demographic groups and across groups (for example, the White-Black income gap).[29] This allowed us to examine changes in inequality by race/ethnicity, age, and family educational attainment. More information on the Theil index is in the appendix.[21]

Study Results

We first compared the overall results using the Supplemental Poverty Measure and health-inclusive poverty measure definitions. Next, using the health-inclusive poverty measure, we analyzed the overall impact of the ACA separately for states that expanded Medicaid under the ACA and states that did not. Finally, using the health-inclusive poverty measure, we decomposed inequality in both expansion and nonexpansion states by race/ethnicity, age, and family educational attainment.

ALTERNATIVE MEASURES Appendix table 1 compares the impact of the ACA on inequality across the Supplemental Poverty Measure and health-inclusive poverty measure definitions.[21] Under the Supplemental Poverty Measure–like income measure, those with the lowest incomes as a percentage of the federal poverty level see their incomes increase under the ACA, whereas those at middle and higher incomes see little change. Those in the lowest-income group—many of whom gained Medicaid coverage under the ACA—are better off because their out-of-pocket health spending is reduced and they do not pay private health insurance premiums. Middle-income groups gain no income benefit under the ACA. For the Marketplace enrollees with premium tax credits in this group, the Supplemental Poverty Measure deducts insurance premiums from income and incorporates reductions in out-of-pocket spending, but the premium tax credits are not counted as income. Those with high incomes do not qualify for ACA programs, so the Supplemental Poverty Measure registers virtually no change for them.

The effects of the ACA on income inequality are clearer using the modified health-inclusive poverty measure. Income gains for those in the lowest-income groups are even larger because this measure adds the fungible value of Medicaid to income. In addition, those in the middle-income groups see gains in income under the ACA because premium tax credits for Marketplace coverage are counted. Those with the highest incomes are less well off under the ACA because their taxes help pay for the ACA's benefits, but their incomes are too high to qualify for those benefits.

For the rest of this analysis, we use the more comprehensive health-inclusive poverty measure–based definition to analyze the impact of the ACA on inequality.

INCOME INEQUALITY AND MEDICAID EXPANSION In exhibit 1 we show the impact of the ACA on income inequality, nationwide and by Medicaid expansion status. For those in these lowest-income percentiles, gaining Medicaid coverage virtually eliminated out-of-pocket health care spending; thus, the ACA increased average income as a percentage of the federal poverty level by 18.8 percent, 13.0 percent, 8.4 percent, and 8.4 percent among those in the tenth, twentieth, thirtieth, and fortieth income percentiles, respectively. Our model results are consistent with recent studies of the ACA's impact on affordability and access to health care.[30,31]

Average income increased by smaller margins under the ACA among those at the fiftieth (2.2 percent) and sixtieth (0.5 percent) income percentiles and slightly decreased among those in the top three percentiles. Overall, the ACA, relative to a scenario without the ACA, reduced income inequality by 10.6 percent as measured by the Theil index.

The bottom two panels of exhibit 1 show the impact of the ACA separately for states that have expanded Medicaid eligibility and those that have not. The ACA had a far larger impact on health coverage in expansion states than nonexpansion states. Thus, the gains in health benefits, declines in out-of-pocket spending, and changes in risk premiums—key components of our modified health-inclusive poverty measure—were also much larger in expansion states. In contrast, the funding of those benefits is allocated by income tax, which was far more even across expansion and nonexpansion states. Funding of benefits varied between the two groups only as much as they differed in income distribution and state tax rates.

These factors explain the major differences in changes in income inequality under the ACA be-

EXHIBIT 1

Income distribution among nonelderly adults with and without the Affordable Care Act (ACA), by income percentile and state Medicaid expansion status, 2019

	Income distribution (percentile)									Theil index
	10th	20th	30th	40th	50th	60th	70th	80th	90th	
NATIONWIDE										
Without ACA (% FPL)	70	125	177	233	294	368	457	576	797	0.384
With ACA (% FPL)	87	143	194	244	301	370	455	572	790	0.347
Difference										
Percentage points	16.3	18.6	16.2	11.5	6.7	1.9	−1.3	−3.5	−7.0	−0.037
Percent	18.8	13.0	8.4	8.4	2.2	0.5	−0.3	−0.6	−0.9	−10.6
MEDICAID EXPANSION STATES										
Without ACA (% FPL)	72	129	184	242	307	384	476	600	830	0.386
With ACA (% FPL)	93	149	201	254	314	386	474	596	822	0.345
Difference										
Percentage points	20.8	20.2	16.3	11.6	6.8	1.9	−1.3	−3.4	−7.5	−0.041
Percent	22.4	13.5	8.1	4.6	2.2	0.5	−0.3	−0.6	−0.9	−11.9
NONEXPANSION STATES										
Without ACA (% FPL)	68	117	167	218	274	341	424	533	735	0.376
With ACA (% FPL)	78	133	182	229	281	343	422	530	728	0.347
Difference										
Percentage points	9.1	15.4	14.7	11.3	6.5	1.7	−1.9	−3.7	−7.0	−0.029
Percent	11.7	11.6	8.1	4.9	2.3	0.5	−0.4	−0.7	−1.0	−8.3

SOURCE Authors' analysis of the Health Insurance Policy Simulation Model, 2019. **NOTES** Income is defined to be consistent with the health-inclusive poverty measure. FPL is federal poverty level.

tween expansion and nonexpansion states. First, using the Theil index, the decline in income inequality under the ACA was much higher in expansion states than in nonexpansion states: The Theil index decreased by 11.9 percent for expansion states compared with 8.3 percent for nonexpansion states. Second, looking at income percentiles, the increases in income under the ACA were much larger at the bottom two percentiles in expansion states compared with nonexpansion states. This is due to greater gains in benefits and declines in out-of-pocket spending for Medicaid enrollees in expansion states. Third, in the fortieth and fiftieth income percentiles, the ACA had comparable impacts on income in expansion and nonexpansion states. This is largely because many households in these percentiles receive tax credits for Marketplace health coverage in both groups of states. Finally, in the highest-income percentiles, the ACA was associated with reductions in income in both expansion and nonexpansion states because federal Medicaid expansion costs are funded by households in these income groups across all states.

INCOME INEQUALITY AND RACE/ETHNICITY Using the health-inclusive poverty measure–based income definition, in exhibits 2, 3, and 4 we decompose the total change in inequality under the ACA by race/ethnicity, age, and family educational attainment, respectively. More detailed estimates of the levels of inequality with and without the ACA and the distribution of between-group inequality versus within-group inequality are in the appendix.[21]

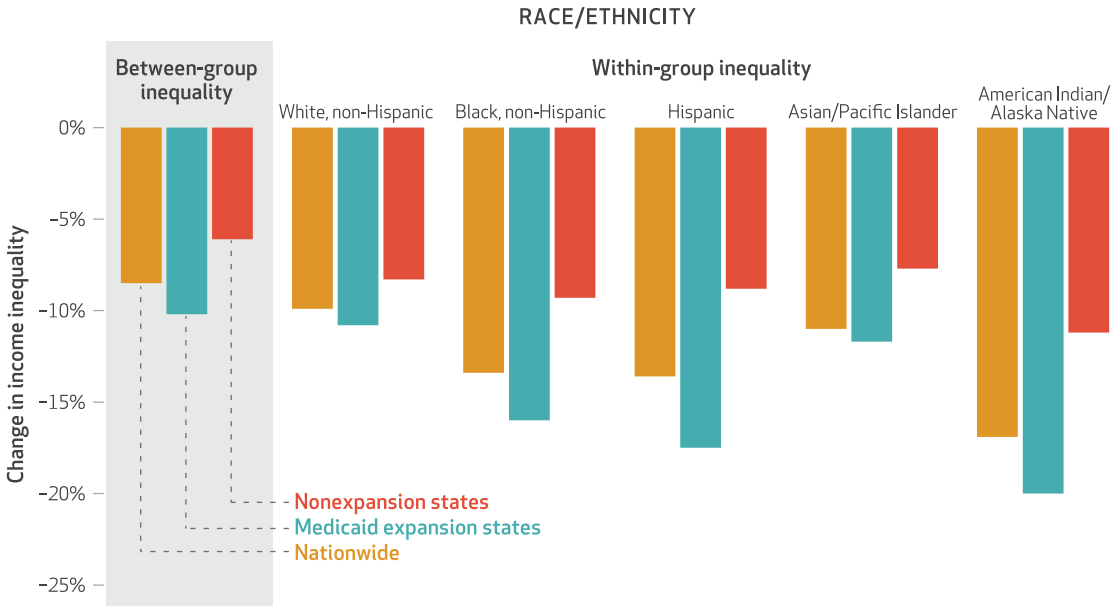
Overall, estimates in exhibit 2 show that the ACA reduced between-group inequality by 8.5 percent, with larger reductions seen in expansion states (10.2 percent) than in nonexpansion states (6.1 percent). Inequality under the ACA also significantly declined within each racial/ethnic group, with larger declines seen in Medicaid expansion states. American Indians/Alaska Natives, Hispanics, and Black non-Hispanics generally saw the largest decreases in within-group inequality. Between-group income inequality (for example, differences in income between the five racial/ethnic groups) made up only about 6 percent of total inequality, whereas within-group inequality made up roughly 94 percent of total inequality, as shown in appendix table 2.[21]

Indian Health Service funding was not included in our analysis. However, this program has a fixed annual budget that generally does not change with the availability of other funding for health coverage. Thus, the greater availability of Medicaid coverage, and to a lesser extent Marketplace coverage, to American Indians/Alaska Natives under the ACA represents a true increase in health benefits.

INCOME INEQUALITY AND AGE Similar to the estimates by race and ethnicity, most of the total age-related income inequality fell within age groups (94 percent), rather than between them

EXHIBIT 2

Percent changes in income inequality among nonelderly adults under current law versus Affordable Care Act (ACA) repeal, by race/ethnicity, 2019

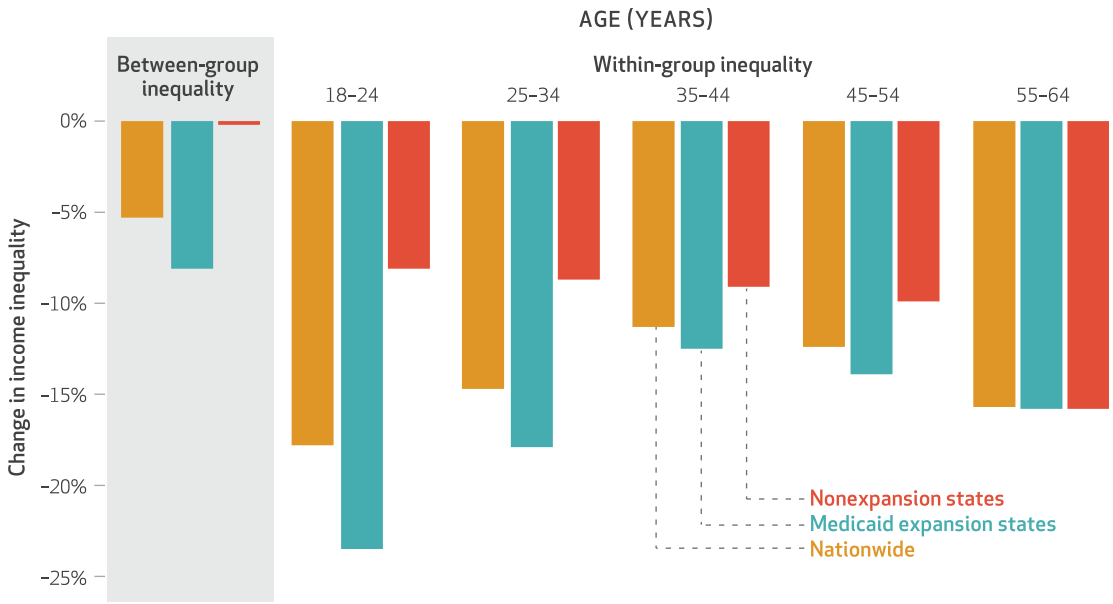


SOURCE Authors' analysis of the Health Insurance Policy Simulation Model, 2019. **NOTES** Income is defined to be consistent with the health-inclusive poverty measure. We use the Theil index to measure income inequality, as explained in the text.

(6 percent). However, that is largely because of our choice to use only five age groups to simplify the presentation (appendix table 3).[21] Overall, between-group inequality declined by 5.3 percent under the ACA, with large reductions in expansion states (8.1 percent) and no change

EXHIBIT 3

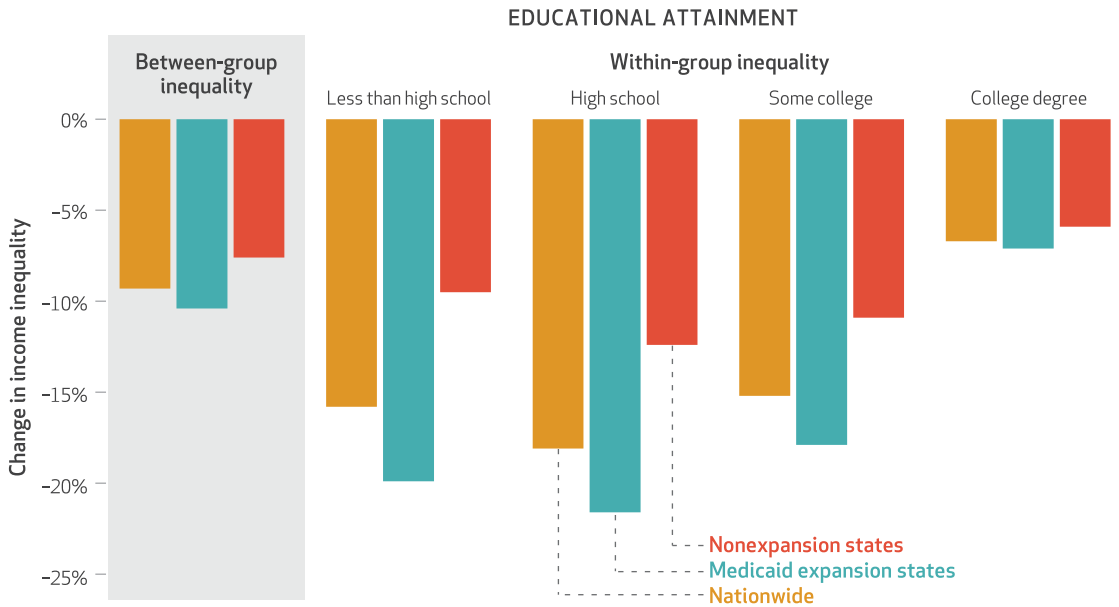
Percent changes in income inequality among nonelderly adults under current law versus Affordable Care Act (ACA) repeal, by age, 2019



SOURCE Authors' analysis of the Health Insurance Policy Simulation Model, 2019. **NOTES** Income is defined to be consistent with the health-inclusive poverty measure. We use the Theil index to measure income inequality, as explained in the text.

EXHIBIT 4

Percent changes in income inequality among nonelderly adults under current law versus Affordable Care Act (ACA) repeal, by family educational attainment, 2019



SOURCE Authors' analysis of the Health Insurance Policy Simulation Model, 2019. **NOTES** Income is defined to be consistent with the health-inclusive poverty measure. We use the Theil index to measure income inequality, as explained in the text.

in nonexpansion states (exhibit 3).

Within-group inequality nationwide also declined by at least 10 percent for each age category, with larger reductions seen in expansion states across most categories. In expansion states, the youngest age group experienced the largest decline (23.5 percent) in within-group inequality under the ACA. In contrast, in nonexpansion states, adults ages 55–64 experienced the largest decline (15.8 percent) in within-group inequality, whereas young adults were less affected. This largely reflects the age distribution of Marketplace enrollees, who are older, and Medicaid enrollees, who are younger (exhibit 3).

INCOME INEQUALITY AND EDUCATIONAL ATTAINMENT Looking at family educational attainment, we found that between-group inequality made up more than a fifth of total inequality, which is a much higher share than for race/ethnicity and age (appendix table 4).[21] Exhibit 4 shows that under the ACA, between-group educational attainment inequality declined by 9.3 percent. Within-group inequality declined for each educational attainment group, with larger reductions seen in expansion states. For both expansion and nonexpansion states, the largest decrease in within-group inequality was among those with a high school education, with large declines among those with some college education and those with less than a high school education as well. The smallest declines in inequality were among those with a college degree.

We also computed Gini indices for each characteristic value (appendix tables 2–4).[21]. In every case, changes in the Gini index showed a decline in inequality under the ACA.

Discussion

This analysis focused on how changes in health insurance coverage and spending under the ACA affected the distribution of income and resources in the US, considering various monetary benefits associated with health insurance. Overall, we found that that the ACA significantly reduced income inequality. Inequality decreased both in states that have expanded Medicaid and in those that have not, although the impact was larger among expansion states. We also found that the ACA reduced income inequality within and between groups defined by race/ethnicity, age, and family educational attainment, with larger declines in inequality occurring in Medicaid expansion states.

These findings provide additional insight into the effect of potential repeal of the ACA. Despite the reluctance of Congress to take up repeal-and-replace legislation since the failure of several proposals in 2017, it remains important to consider the consequences of repealing the law. Efforts to repeal and replace the ACA have shifted to the courts, specifically with *California*

v. Texas.[32] The plaintiffs in this case argued that because the Tax Cuts and Jobs Act of 2017 set the ACA's individual mandate penalty to zero dollars, the entire ACA cannot operate or be sustained. Therefore, they argued that the ACA should be invalidated or effectively repealed in its entirety. The US Supreme Court held oral arguments on this case November 10, 2020, with a decision expected by summer 2021.

Eliminating the ACA would significantly change the distribution of health insurance coverage and allocation of health care spending in the US. Based on a newly developed projection that accounts for the coronavirus disease 2019 (COVID-19) pandemic, more than twenty million people would lose health insurance, primarily through decreases in Medicaid and nongroup coverage, if the ACA were to be repealed.[33] Although eliminating the ACA would decrease federal and state spending, it would also significantly increase uncompensated care costs and the medical financial burden for families, particularly those with low and middle incomes, who were the chief beneficiaries of the ACA. This would primarily occur through the repeal of Medicaid expansion, which has been shown to increase the financial security of the newly insured[34,35] and improve hospital finances through lowered uncompensated care costs.[36,37]

Eliminating the ACA could also worsen other outcomes, such as access to primary care and prescription drugs and self-reported health. Prior studies found that through 2015, the ACA substantially increased the share of nonelderly people who reported having a personal physician (3.5 percentage points) and easy access to medicine (2.4 percentage points) and decreased the share who reported being in fair or poor health (3.4 percentage points) and who reported that they could not afford care (5.5 percentage points) relative to the pre-ACA trend.[31,38,39]

In addition, between the third quarter of 2013 and the first quarter of 2017, there were significant increases in the shares of adults with a usual source of care and with a routine checkup in the past year, whereas the shares of adults reporting an unmet need for medical care because of cost and problems paying family medical bills both declined.[40]

Without the valuable components of health insurance coverage provided by the ACA, income inequality as measured inclusive of various health coverage benefits would revert to pre-ACA levels. The ACA reduced income inequality between racial/ethnic groups, age groups, and people of higher and lower educational attainment. Overturning the law would put these gains in serious jeopardy. ■

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