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News Release

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FOR IMMEDIATE RELEASE June 21, 2021

Covered California Sets New Enrollment Record as Thousands Get Lower Premiums From the American Rescue Plan as June Deadline Approaches

Exchange Also Launches Full Offering of \$1 Plans for Thousands Who Received Unemployment Benefits in 2021

- A record 1.6 million people are actively enrolled in Covered California, including 139,000 who signed up for quality health care coverage since lower premiums became available through the American Rescue Plan.
- Covered California is also launching a provision that allows thousands of eligible Californians, who received unemployment insurance benefits at any point in 2021, to get the best coverage available for as low as \$1 per month.
- Consumers can use <u>Covered California's quick calculator</u> to easily find out if they benefit from the new \$1 per month provision.
- The next deadline for coverage is the end of the month: Consumers who enroll by June 30 will be insured starting July 1.

SACRAMENTO, Calif. — Covered California announced Monday that it has enrolled a record 1.6 million people, as thousands of consumers sign up for coverage due to the lower premiums provided by the American Rescue Plan. New data shows that over 139,000 people have signed up for a health plan through Covered California since the new and expanded financial help from the new law became available on April 12. The announcement comes just days after the U.S. Supreme Court rejected the latest challenge to the Patient Protection and Affordable Care Act.

"With the Supreme Court again ruling that the Affordable Care Act is the law of the land, and with the American Rescue Plan lowering premiums for thousands of Californians, it is easier than ever to get covered and stay covered," said Peter V. Lee, executive director of Covered California. "The next deadline is coming up, and Californians who sign up by the end of the month will begin benefiting from their more affordable coverage on July 1."

(more)

The record enrollment is being driven by the new financial help now available through the American Rescue Plan, which became available on April 12. Since then, 139,100 people have newly signed up, which is an increase of nearly 63,000 people in the past four weeks alone. Overall, a total of 246,640 people signed up for coverage between the end of open enrollment and June 16 (see Table 1: Consumer Plan Selections During Special Enrollment).

Before April 12	107,540
Since American Rescue Plan Benefits on April 12	139,100
Year-to-Date	246,640
Total Number of Actively Enrolled Consumers	1,591,800

Table 1: Consumer Plan Selections During Special Enrollment (Feb. 1 – June 16)

The American Rescue Plan provides new and expanded financial help to people who receive their health insurance through an Affordable Care Act marketplace like Covered California. The law means that many middle-income Californians can now get more help than ever before, since it ensures that everyone eligible will pay no more than 8.5 percent of their household income on their health insurance premiums. The law also dramatically lowers the cost of insurance for lower-income Californians, with the latest data showing that nearly 700,000 people now have quality coverage through brandname health plans for \$1 per month. While Covered California's special-enrollment period runs through the end of the year, consumers are encouraged to act now in order to start benefiting from the new law.

"The American Rescue Plan is making coverage more affordable than ever, and more and more Californians are getting high-quality coverage for just a dollar," Lee said. "The sooner you sign up, the sooner you can start saving and be covered, because we do not want anyone to be uninsured or leave money on the table."

Californians Who Received Unemployment Benefits Can Get Covered California's Best Plan for a Dollar a Month

There are 207,000 Covered California consumers who are currently enrolled in the best coverage that the exchange offers, known as Silver 94 plans. Plans in this metal tier include low premiums, \$5 copays to see a primary care provider, outpatient services that are not subject to a deductible, an annual deductible of \$75 and other cost-sharing benefits that lower the cost of coverage and increase access to care.

(more)

A provision of the recently enacted American Rescue Plan, officially launched by Covered California today, enables hundreds of thousands of people who received unemployment insurance benefits in 2021 to also get this level of high-value coverage for as little as \$1 per month.

"The help for those who received unemployment benefits is big and not tied to their income, but the potential of good deals is there for every Californian who needs health insurance," Lee said. "If you're uninsured you should check your options, because hundreds of thousands are qualifying for the best coverage we offer for as little as \$1 per month, while others are seeing reductions of hundreds of dollars per month on the plan they've already chosen."

Sheila from Indio is a Covered California enrollee who lost her job as a college professor during the pandemic. When she consulted with her insurance agent, Sheila discovered that she and her daughter now qualified for a Silver 94 plan, and their \$221 monthly premium would be dropping to just \$1 for the rest of 2021.

"We were so excited that's even a thing. My first thought was, 'I'm sure not me,'" Sheila told Covered California. "We spoke yesterday and heard that it would be me. I was floored; we were both astonished."

The most recent data from the Employment Development Department (EDD) shows that <u>569,000 Californians filed unemployment insurance claims in May</u> alone. Currently, about 10 percent of Covered California's enrollees — approximately 141,000 — have indicated they have received unemployment insurance benefits this year, meaning thousands more could be eligible for this new benefit. Covered California has partnered with EDD to inform unemployment insurance recipients through their online accounts of the new subsidies available.

"This is a tremendous opportunity for those who lost their jobs to get a quality health insurance plan at a price that has never been lower," Lee said. "Whether you or someone you know filed for unemployment this year, now is the time to check out your options and start saving now."

Covered California enrollees who are eligible for the \$1 per month plan and are currently enrolled in a Silver-tier product will automatically be placed into a Silver 94 plan with better coverage. However, Covered California is working to help the 58,000 Covered California enrollees who are eligible and currently enrolled in a non-Silver plan to consider changing their coverage to get an even better deal.

Consumers Can Quickly Find Out If They Are Eligible

Consumers can check their eligibility for big savings whether or not they have received unemployment insurance by using <u>Covered California's quick calculator</u>.

(more)

They will need to input their household income, ZIP code, their household size and the age of each family member and note whether they received unemployment benefits. Once completed, they will see how affordable a silver or bronze plan can be in their area.

be able to see what plans are available in their region and the cost of their monthly premium.

"The pandemic has highlighted the importance of quality health care, and whether you end up with a \$1 plan, are eligible for no-cost coverage through Medi-Cal or can save hundreds of dollars on your coverage, getting covered is the right thing for you and your family," Lee said.

Those interested in learning more about their coverage options can:

- Visit <u>www.CoveredCA.com</u>.
- Use the website to find local insurance agents or certified enrollers in community organizations who provide free and confidential assistance over the phone or in person, in a variety of languages.
- Have a certified enroller call them for free help.
- 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 <u>www.CoveredCA.com</u>.

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FOR IMMEDIATE RELEASE June 17, 2021

U.S. Supreme Court Rejects Latest Challenge to the Affordable Care Act and Preserves the Landmark Health Care Law for a Third Time

SACRAMENTO, Calif. — Covered California Executive Director Peter V. Lee applauded today's U.S. Supreme Court decision to dismiss challenges to the constitutionality of the Patient Protection and Affordable Care Act leaving the law intact to the benefit of millions of Americans.

"The Supreme Court – in rejecting claims challenging the constitutionality of the Affordable Care Act – has once again upheld the law that is helping millions of Americans benefit every day from health care coverage and broad consumer protections. It is time to move on, focus on improving the law and reach true universal coverage.

As U.S. Health and Human Services Secretary Xavier Becerra said when he led the coalition of states to protect the Affordable Care Act in court, '<u>This shouldn't</u> be a debate; the ACA has been the law for nearly a decade and is the backbone of our healthcare system.'

With today's high court ruling, and dramatic enrollment increases resulting from the promotion of coverage and new American Rescue Plan subsidies, it is time to stop making health coverage a political fight which has delayed progress and injected unneeded uncertainty into the lives of millions of Americans. The Affordable Care Act provides protection for over 130 million Americans with preexisting conditions, put in place an array of other standards to hold health plans accountable and brought coverage within reach to millions, now directly benefiting 31 million Americans, including nearly 6 million Californians. The law is here to stay, and our attention should be on effectively improving the health of Americans by making coverage more affordable, improving health care, and addressing issues of health equity and disparities. In California we have embraced the Affordable Care Act and implemented policies that put consumers first and remove barriers to care. Nationally, the new administration and Congress have leaned-in with new financial help through the American Rescue Plan that lower health insurance premiums for millions of Americans. -Today more Americans are seeing the benefits of the Affordable Care Act than ever before. This is the right direction for Americans across the country and Covered California will continue its work to build on the progress we have made together."

<u>Covered California is currently holding a special-enrollment period</u> to allow the uninsured, and those insured directly through a health insurance carrier, to sign up for coverage and benefit from the new and expanded financial help available through the American Rescue Plan. The law is dramatically lowering health care premiums and the most recent data from Covered California shows that 680,000 of its 1.55 million enrollees are signed up in quality plans that cost \$1 per month.

While the special-enrollment period runs through the end of the year, consumers need to enroll by June 30 if they want to maximize their savings and have coverage that starts on July 1.

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 <u>www.CoveredCA.com</u>.

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National Health Statistics Reports

Number 163 August 6, 2021

Geographic Variation in Health Insurance Coverage: United States, 2019

by Robin A. Cohen, Ph.D., Emily P. Terlizzi, M.P.H., Amy E. Cha, Ph.D., M.P.H., Michael E. Martinez, M.P.H., M.H.S.A., Van L. Parsons, Ph.D., Rong Wei, Ph.D., and Yulei He, Ph.D.

Abstract

Objectives—This report presents state, regional, and national estimates of the percentage of persons who were uninsured, had private health insurance coverage, and had public health insurance coverage at the time of the interview.

Methods—Data from the 2019 National Health Interview Survey were used to estimate health insurance coverage. Estimates were categorized by age group, state Medicaid expansion status, urbanization level, expanded regions, and state. Estimates by state Medicaid expansion status, urbanization level, and expanded regions were based on data from all 50 states and the District of Columbia. State estimates are shown for 32 states and the District of Columbia.

Results—In 2019, among persons under age 65, 12.0% were uninsured, 64.3% had private coverage, and 25.9% had public coverage at the time of the interview. Among adults aged 18–64 (working-age adults), the percent uninsured ranged from 12.4% for those living in large fringe (suburban) metropolitan counties to 17.5% for those living in nonmetropolitan counties. Working-age adults living in non-Medicaid expansion states (20.8%) were about twice as likely to be uninsured compared with those living in Medicaid expansion states (10.9%). Similar patterns were observed among children aged 0–17 years. The percentage of working-age adults who were uninsured was significantly higher than the national average (14.5%) in Florida (20.6%), Georgia (22.3%), Oklahoma (25.6%), and Texas (30.5%), and significantly lower than the national average in California (11.5%), Minnesota (6.9%), New York (7.4%), Ohio (10.8%), Pennsylvania (9.8%), and Wisconsin (7.7%). The percentage of people under age 65 who were uninsured was lowest in the New England region (4.6%).

Keywords: uninsured • private • public • state level • National Health Interview Survey

Introduction

Health insurance coverage in the United States is a key measure of health care access (1–3). Previous research based on national surveys has found geographic variation in insurance coverage in the United States by urbanization level, state Medicaid expansion status, region, and state (4-6). Population estimates of health insurance coverage at the state level are necessary for the development and assessment of federal and state health care coverage programs and policies (7-9). A recent study found that more than 4 million persons would gain coverage if the remaining non-Medicaid expansion states would fully implement a Medicaid expansion under the provisions of the Affordable Care Act (ACA) (10,11).

This report examines geographic variation in health insurance coverage in the United States in 2019. Estimates of the percentage of persons who were uninsured, had private coverage, and had public coverage at the time of the interview are presented by urbanization level, state Medicaid expansion status, expanded regions, and selected states. The primary focus of this report will be on persons under age 65, because nearly



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Disease Control and Prevention National Center for Health Statistics



all persons in the United States aged 65 and over are eligible for Medicare (12).

Methods

Data source

The estimates in this report are based on data from the Sample Adult and Sample Child modules of the 2019 National Health Interview Survey (NHIS), a nationally representative household survey of the U.S. civilian noninstitutionalized population. It is conducted continuously throughout the year by the National Center for Health Statistics (NCHS). In 2019, the NHIS questionnaire was redesigned to better meet the needs of data users. One sample adult from each household is randomly selected to answer detailed questions about his or her health. One sample child, if present, is also randomly selected from each household, and an adult knowledgeable and responsible for the child's health answers questions on behalf of the child. Interviews are conducted in respondents' homes, but follow-ups to complete interviews may be conducted over the telephone when necessary.

Both the Sample Adult and Sample Child modules have a full range of questions addressing health insurance, such as coverage status, sources of coverage, characteristics of coverage, and reasons for no coverage. Starting in 2019, changes were made to how the health insurance questions were administered. Although the flow and content of the questions pertaining to health insurance is similar to questions covered in the 1997-2018 NHIS Family Core, the main difference is that instead of asking about health insurance for all family or household members, health insurance information is collected about one adult and one child (if present) from each household.

The sample adult and sample child receive a similar set of health insurance questions, so the Sample Adult and Sample Child files can be combined to create a file that contains persons of all ages. Estimates are based on a combined file containing 42,331 persons (9,193 sample children and 33,138 sample adults). For 2019, the response rate for the Sample Child module was 59.1% and for the Sample Adult module was 59.1% (13). State identifiers were used to examine health insurance by state Medicaid expansion status, expanded regions, and states. These identifiers are not available on the NHIS public-use data files but are made available through the

files but are made available through the NCHS Research Data Center. For more information, see https://www.cdc.gov/ rdc/index.htm.

In this report, the term "working-age adults" refers to persons aged 18–64, and the term "children" refers to persons under age 18 years.

Insurance coverage

Persons were considered uninsured if, at the time of the interview, they did not have coverage through private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), military (TRICARE, Veterans Administration [VA], and CHAMP–VA), other state-sponsored health plans, or other government programs. Persons also were defined as uninsured if they only had Indian Health Service coverage or only had a private plan that paid for one type of service, such as dental, vision, or prescription drugs.

Private health insurance coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as dental, vision, or prescription drugs.

Public health plan coverage includes Medicaid, CHIP, state-sponsored or other government-sponsored health plans, Medicare, and military plans. A person may have both private and public coverage.

Definition of geographic terms

State Medicaid expansion status— Under provisions of ACA, states have the option to expand Medicaid eligibility to cover adults who have family incomes up to and including 138% of the federal poverty level. There is no deadline for states to choose to implement the Medicaid expansion, and they may do so at any time. As of January 1, 2019, 33 states and the District of Columbia had expanded Medicaid. Medicaid expansion states include: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, and West Virginia. The District of Columbia also has expanded Medicaid. States without expanded Medicaid include: Alabama, Florida, Georgia, Idaho, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Wisconsin, and Wyoming.

Urbanization level—In this report, urbanization level is measured using a condensed categorization of the NCHS urban-rural scheme (14,15). The NCHS urban-rural classification is based on metropolitan statistical area (MSA) status defined by the Office of Management and Budget according to published standards that are applied to U.S. Census Bureau data.

This report condenses the NCHS urban–rural classification into four categories: large central metropolitan (similar to inner cities), large fringe metropolitan (similar to suburbs), medium and small metropolitan, and nonmetropolitan (15,16). Large metropolitan areas have populations of 1 million or more. Metropolitan areas with populations of less than 1 million were classified as medium (250,000–999,999 population) and small (less than 250,000 population) metropolitan areas (15).

The MSA classification scheme used in this report is consistent with other NHIS reports and products (17,18). This classification is available on the publicuse data files (19).

Expanded regions—Expanded region classifications are based on a subdivision of the four Census regions (Northeast, Midwest, South, and West) into nine divisions. For this report, the nine Census divisions were modified by moving Delaware, the District of Columbia, and Maryland into the Middle Atlantic division. This approach was used previously by Holahan et al. (20):

> *New England*—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Middle Atlantic—Delaware, District of Columbia, Maryland, New Jersey, New York, and Pennsylvania

East North Central—Illinois, Indiana, Michigan, Ohio, and Wisconsin

West North Central—Iowa, Kansas, Nebraska, Minnesota, Missouri, North Dakota, and South Dakota

South Atlantic—Florida, Georgia, North Carolina, South Carolina, Virginia, and West Virginia East South Central—Alabama,

Kentucky, Mississippi, and Tennessee

West South Central—Arkansas, Louisiana, Oklahoma, and Texas Mountain—Arizona, Colorado, Idaho, Montana, Nevada, New

Mexico, Utah, and Wyoming *Pacific*—Alaska, California, Hawaii, Oregon, and Washington

State-level estimates—For this report, direct state-level estimates are provided for 32 states and the District of Columbia. No state-specific estimates are presented for Alaska, Hawaii, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, South Dakota, Utah, Vermont, West Virginia, and Wyoming because they did not meet the criteria for inclusion (see Technical Notes). Note that for specific age groups and domains (uninsured, private, and public), fewer state-level estimates may be provided because estimates may not meet additional criteria for inclusion. For example, for the

measure of uninsured children, state-level estimates are only provided for seven states.

Statistical analysis

Estimates by urbanization level, state Medicaid expansion status, and expanded regions are based on data from all 50 states and the District of Columbia. State estimates are shown for 32 states and the District of Columbia, which met the criteria for reporting and calculating state estimates described in more detail in the Technical Notes.

Percentages and 95% confidence intervals (CI) are presented for prevalence estimates of health insurance coverage based on questions about coverage at the time of the NHIS Sample Adult and Sample Child interviews. The 95% CIs were generated using the Korn-Graubard method for complex surveys (21). Estimates were calculated using the NHIS survey weights and are representative of the U.S. civilian noninstitutionalized population (13). In 2019, the weighting adjustment method changed from previous years to incorporate more robust multilevel models predictive of response propensity. Nonresponse-adjusted weights were further calibrated to U.S. Census Bureau population projections and American Community Survey 1-year estimates for age, sex, race and ethnicity, educational attainment, census division, and MSA status.

Point estimates and the corresponding variances were calculated using SUDAAN software version 11.0.0 (RTI International, Research Triangle Park, N.C.), a software package designed to account for the complex sampling design of NHIS. All estimates in this report met NCHS standards of reliability as specified in "National Center for Health Statistics Data Presentation Standards for Proportions" (22).

Respondents with missing data or unknown information were generally excluded from the analysis unless specifically noted. For the types of health insurance coverage shown in this report (uninsured, private, and public), the item nonresponse rate was about 0.5%.

Differences in percentages by state Medicaid expansion status were

evaluated using two-sided significance tests at the 0.05 level (*t* tests). Trends by urbanization level were evaluated using orthogonal polynomials in logistic regression. Differences between national and subnational estimates were tested for statistical significance to identify those expanded regions and states that differ significantly from the national average. The estimated standard error of the differences between state and national estimates accounted for nonindependence of state and national estimates by incorporating their covariance (and similarly for the difference between regional and national estimates).

Terms such as "higher than" and "lower than" indicate a statistically significant difference. Lack of comment regarding the difference between any two estimates does not necessarily mean that the difference was tested and found to be not significant. Furthermore, these tests did not take multiple comparisons into account. For more information on NHIS, estimation methods, and definition of terms, see Technical Notes at the end of the report.

Tables 1–3 show estimates by state Medicaid expansion status, urbanization level, region, state, and nationally of the percentages of persons who were uninsured, had private coverage, and had public coverage in 2019. Additionally, these estimates are presented by geographic subdivisions and nationally for persons of all ages who were uninsured, had private coverage, and had public coverage and are shown in Table I. In this report, tables are provided for reference and detailed results may not be discussed.

Results

National estimates of health insurance coverage

In 2019, among persons under age 65, 12.0% were uninsured, 64.3% had private coverage, and 25.9% had public coverage at the time of the interview (Figure 1). Children aged 0–17 years were less likely than adults aged 18–64 to be uninsured (5.1% and 14.5%, respectively) and have private coverage (55.6% and 67.5%, respectively),



Figure 1. Percentages of persons under age 65 who were uninsured, had private coverage, or had public coverage at the time of interview, by age group: United States, 2019

but they were more likely to have public coverage (40.9% and 20.4%, respectively).

National estimates of health insurance coverage by urbanization level

In 2019, among persons under age 65, health insurance coverage varied by urbanization level. Among adults aged 18-64, the percentage who were uninsured was lower for those living in large fringe metropolitan counties (12.4%) compared with those living in large central metropolitan counties (15.4%), and then increased with decreasing levels of urbanization (Figure 2). Working-age adults living in large fringe metropolitan counties (73.4%) were more likely to have private coverage than those living in large central metropolitan (67.6%), medium and small metropolitan (65.5%), and nonmetropolitan (61.1%)counties. Working-age adults living in large central (18.7%) and large fringe (17.0%) metropolitan counties were

less likely than those living in medium and small metropolitan (23.1%) and nonmetropolitan (24.5%) counties to have public coverage.

For children, the observed differences in the percentage of those who were uninsured between those living in large central, large fringe, and medium and small metropolitan counties (4.8%, 4.5%, and 5.0%, respectively) and those living in nonmetropolitan counties (6.9%) were not statistically significant (Figure 3). Children living in large fringe metropolitan counties (65.0%) were more likely than those living in large central metropolitan (54.5%), medium and small metropolitan (52.0%), and nonmetropolitan (49.0%) counties to have private coverage. Children living in large fringe metropolitan counties (31.5%) were the least likely to have public coverage compared with those living in large central metropolitan (42.1%), medium and small metropolitan (44.8%), and nonmetropolitan (46.6%)counties.

Health insurance coverage by state Medicaid expansion status

As of January 1, 2019, 33 states and the District of Columbia had expanded Medicaid. Among adults aged 18-64, those living in Medicaid expansion states were less likely to be uninsured (10.9%) and more likely to have private insurance (68.4%) and public coverage (23.2%)than those living in nonexpansion states (20.8%, 66.1%, and 15.4%, respectively) (Figure 4). Children living in Medicaid expansion states were less likely than those in nonexpansion states to be uninsured (3.8% compared with 7.1%) and more likely to have private insurance (57.9% compared with 51.9%) (Figure 5). The difference in public coverage for children between Medicaid expansion states (39.9%) and nonexpansion states (42.6%) was not statistically significant.



Figure 2. Percentage of adults aged 18–64 who were uninsured, had private coverage, or had public coverage, by urbanization level: United States, 2019

Figure 3. Percentage of children aged 0–17 years who were uninsured, had private coverage, or had public coverage, by urbanization level: United States, 2019



SOURCE: National Center for Health Statistics, National Health Interview Survey, 2019.



Figure 4. Percentage of adults aged 18–64 who were uninsured, had private coverage, or had public coverage, by state Medicaid expansion status: United States, 2019





Regional estimates of health insurance coverage

In 2019, for persons under age 65, percentages of uninsured persons in the South Atlantic (15.0%) and West South Central (22.1%) were significantly higher than the national average (12.0%), and percentages in the New England (4.6%), Middle Atlantic (7.8%), East North Central (9.2%), West North Central (9.5%), and Pacific (9.2%) regions were significantly lower than the national average (Table 1). Percentages for public coverage were significantly higher in the Middle Atlantic (28.4%), East South Central (31.8%), and Pacific (29.4%) regions than the national average (25.9%), and percentages in the East North Central (23.2%) and West North Central (18.7%) regions were significantly lower than the national average. Percentages of private coverage were significantly higher in the New England (74.3%), East North Central (70.1%), and West North Central (73.8%)regions than the national average (64.3%), and percentages were

significantly lower in the East South Central (58.0%) and West South Central (54.6%) regions than the national average.

State estimates of health insurance coverage

State-level estimates are shown for 32 states and the District of Columbia. Among adults aged 18-64, the percentage who were uninsured was significantly higher than the national average (14.5%) in Florida (20.6%), Georgia (22.3%), Oklahoma (25.6%), and Texas (30.5%), and significantly lower than the national average in California (11.5%), Minnesota (6.9%), New York (7.4%), Ohio (10.8%), Pennsylvania (9.8%), and Wisconsin (7.7%) (Figure 6, Table 2). Among adults aged 18–64, the percentage who had public coverage was significantly higher than the national average (20.4%) in California (24.1%), Kentucky (35.5%), Louisiana (37.2%), and New York (30.0%), and significantly lower than the national average in Florida (15.7%), Georgia (14.3%), Illinois

(15.2%), Minnesota (10.3%), Texas (13.1%), and Virginia (16.3%) (Figure 7, Table 2). Among adults aged 18–64, the percentages with private insurance were significantly higher than the national average (67.5%) in Illinois (73.4%), Minnesota (84.9%), and Wisconsin (79.2%), and significantly lower than the national average in Kentucky (53.4%), Louisiana (52.7%), and Texas (58.4%) (Figure 8, Table 2).

Among children aged 0-17, statelevel estimates for the percentage of uninsured children are shown for seven states (Table 3). The percentage of children without health insurance coverage was significantly higher than the national average (5.1%) in Texas (11.2%), and significantly lower than the national average in California (2.8%), Illinois (2.5%), New York (1.8%), and Virginia (2.5%). Among children, state-level estimates of public coverage are shown for 29 states and for private coverage, 28 states are shown. The percentage of children with public coverage was significantly higher than the national average (40.9%) in







Figure 7. Adults aged 18-64 who had public coverage at the time of interview: United States, 2019





California (45.8%) and Florida (48.3%), and significantly lower than the national average in Illinois (30.6%), Minnesota (17.9%), and Wisconsin (25.6%). The percentage of children with private coverage was significantly higher than the national average (55.6%) in Illinois (67.1%), Massachusetts (72.3%), Minnesota (77.9%), and Wisconsin (71.6%), and significantly lower than the national average in Florida (45.9%) and Texas (46.9%).

Summary

This report provides an overall picture of health insurance coverage in the United States by selected geographic subdivisions. In 2019, variation in health insurance coverage was found by urbanization level, state Medicaid expansion status, expanded regions, and selected states and the District of Columbia. Generally, persons living in Medicaid-expansion states, large fringe (suburban) metropolitan counties, and the New England and Middle Atlantic regions were the least likely to be uninsured. Variation in the percentage of uninsured persons was also observed among the selected states shown in this report.

Note that this report is not without some limitations. NHIS responses are self-reported, so they may be subject to recall bias. In addition, due to current design constraints of the 2019 NHIS, the report was only able to provide statelevel estimates for up to 32 states and the District of Columbia (See Technical Notes). For selected age groups and measures of coverage, fewer than 32 states and the District of Columbia are provided. For example, for the measure of uninsured among children, estimates are only shown for seven states.

One strength of NHIS is that it has a very low nonresponse rate to questions about the type of health insurance coverage (about 0.5%). Additionally, a feature that distinguishes NHIS estimates of health insurance coverage from other survey-based estimates is the use of responses to follow-up questions to evaluate the reliability of the reported health insurance coverage and resolve conflicting information (see National Health Interview Survey, Health Insurance Information: https://www.cdc. gov/nchs/nhis/insurance.htm).

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Table 1. Percentages (and 95% confidence intervals) of persons under age 65 who had private coverage, public health coverage, or were uninsured at the time of the interview, by urbanization level, state Medicaid expansion status, expanded regions, and selected states: United States, 2019

Selected geographic characteristics and Medicaid expansion status	Private ¹	Public ²	Uninsured ³
 Total ⁴	64.3 (63.3–65.3)	25.9 (25.1–26.7)	12.0 (11.4–12.6)
Lithanization laval ⁵			
	64.3 (62.8–65.8)	24.6 (23.3–25.9)	12.7 (11.7–13.7)
	/1.1 (69.3–72.9)	20.9 (19.5–22.4)	10.2 (9.2–11.3)
	61.7 (59.6–63.7)	29.2 (27.5–31.1)	11.6 (10.6–12.6)
Nonmetropolitan ⁹	57.7 (54.1–61.3)	30.6 (27.8–33.6)	14.6 (12.4–17.0)
State Medicaid expansion status ¹⁰			
Medicaid expansion states ¹¹	65.6 (64.4–66.8)	27.6 (26.5–28.7)	9.0 (8.5–9.7)
Non-Medicaid expansion states ¹²	62.1 (60.3–63.8)	23.0 (21.8–24.3)	17.0 (15.9–18.1)
Expanded regions ¹³			
New England	74.3 (70.6–77.8)	23.7 (20.4–27.2)	4.6 (3.5–5.8)
Middle Atlantic	66.1 (63.7–68.5)	28.4 (26.4–30.6)	7.8 (6.5–9.2)
East North Central	70.1 (67.7–72.5)	23.2 (20.9–25.6)	9.2 (7.9–10.6)
West North Central	73.8 (71.1–76.4)	18.7(16.5-21.1)	9.5 (7.8–11.4)
South Atlantic	62 2 (59 3-65 0)	25 1 (23 0-27 2)	15.0 (13.5–16.6)
East South Central	58.0 (54.4-61.6)	31.8 (28.8–34.9)	12.7 (10.5–15.3)
West South Central	54.6(51.0, 57.4)	25.0(20.0-54.3)	12.7 (10.3 - 10.3)
Mountain	64.2 (60.0, 68.2)	23.0(22.3-27.2)	22.1(20.1-24.3)
Desifie	64.2 (60.0-68.3)	24.9 (21.9-20.1)	14.0 (11.7–10.3)
	63.0 (60.5-65.5)	29.4 (27.2–31.0)	9.2 (8.2–10.2)
Selected states ¹⁴			
Alabama	62.9 (53.2–71.9)	30.1 (22.4–38.7)	10.8 (6.5–16.6)
Arizona	56.7 (48.1–65.1)	32.5 (25.4–40.2)	14.1 (9.6–19.6)
Arkansas	54.1 (41.5–66.4)	31.8 (21.8–43.3)	16.0 (9.4–24.7)
California	62.4 (59.3-65.4)	29.8 (27.1–32.6)	9.2 (8.0–10.5)
Colorado	70.4 (62.6–77.4)	22.0 (16.2–28.6)	10.2 (6.7–14.9)
Connecticut.	73.6 (64.1–81.7)	23.4 (16.3–31.8)	*
Delaware	69.6 (56.4-80.8)	22.0 (13.1–33.4)	*
District of Columbia	67.3 (53.3–79.3)	32.4 (21.3-45.2)	*
Florida	60.9 (56.4–65.3)	23.9 (20.9–27.2)	16.9 (13.9–20.3)
Georgia	60.0 (53.2–66.6)	23.5 (18.9–28.6)	18.3 (15.1–21.8)
Illinois	71.8 (67.6–75.7)	19.0 (15.7–22.6)	10.9 (8.5–13.6)
Indiana	70.4 (63.3–76.9)	22.3 (17.0–28.5)	9.5 (6.3–13.6)
Kentucky	49 7 (41 2–58 3)	40.6 (33.0-48.5)	11 1 (7 2–16 2)
Louisiana	51 4 (42 7–59 9)	40.6 (33.0–48.5)	9.6 (6.0–14.5)
Maryland	69.3 (59.8–77.8)	27 8 (20.3–36.3)	7.0 (3.6–12.0)
Massachusetts	73 3 (66 4–79 4)	27 1 (21 5-33 4)	28(12-55)
Michigan	65 9 (60 1-71 3)	28.8(23.7-34.4)	8 9 (6 3 12 2)
Minnesota	83.0 (76.3–88.5)	12 3 (8 0-17 0)	6.2 (3.5-10.1)
Missouri	60.5 (61.0, 76.3)	10.0(14.6, 26.1)	12.0 (8.2, 16.7)
	(01.3 - 70.3)	13.3 (14.0-20.1)	12.0(0.3-10.7)
	(01.1 + (01.1 - 12.2))	23.9(19.0-20.7)	10.3(7.4-14.2)
	62.3 (56.1-60.4)	35.6 (30.4–37.4)	0.0 (4.2-8.4)
	03.0 (55.4-71.2)	25.4 (19.6–31.7)	14.1 (10.8–18.0)
	67.1 (61.4-72.5)	20.7 (21.1–32.9)	9.3 (7.0-12.0)
	56.2 (46.9-65.3)	24.8 (17.9–32.7)	21.4 (15.6–28.1)
	61.5(52.7-69.7)	31.9 (24.8–39.8)	9.3 (5.6–14.2)
Pennsyivania	68.6 (64.4-72.6)	25.1 (21.4–29.2)	8.6 (6.0–11.9)
Knode Island	//.1 (63.8–87.3)	22.2 (12.9–34.2)	*
South Carolina	58.0 (48.8–66.9)	33.3 (25.7–41.5)	11.8 (7.5–17.4)
	64.9 (57.7–71.6)	24.9 (19.4–31.1)	12.7 (9.0–17.1)
Texas	55.0 (51.6–58.3)	22.0 (19.9–24.2)	24.8 (22.4–27.2)
Virginia	68.6 (63.3–73.5)	22.3 (18.1–27.0)	11.0 (8.1–14.4)
Washington	68.2 (61.3–74.6)	24.3 (19.0–30.3)	9.3 (6.2–13.2)
Wisconsin	77.1 (71.3–82.3)	17.7 (13.4–22.6)	6.7 (4.3–9.8)

Table 1. Percentages (and 95% confidence intervals) of persons under age 65 who had private coverage, public health coverage, or were uninsured at the time of the interview, by urbanization level, state Medicaid expansion status, expanded regions, and selected states: United States, 2019—Con.

*Estimate is not shown because it does not meet National Center for Health Statistics standards of reliability.

¹Private health insurance coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as dental, vision, or prescription drugs. Persons with private coverage may also have public coverage.

²Public health plan coverage includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plans, Medicare, and military (TRICARE,

Veterans Administration [VA], and CHAMP–VA) plans. Persons with public coverage may also have private coverage. ³Persons were considered uninsured if they did not have coverage through private health insurance, Medicare, Medicaid, CHIP, military (TRICARE, VA, and CHAMP–VA), other state-sponsored health plans, or other government programs. Persons also were defined as uninsured if they only had Indian Health Service coverage or only had a private plan that paid for one type of service, such as dental vision or preservition drugs.

dental, vision, or prescription drugs. ⁴Includes all 50 states and the District of Columbia.

⁵Urbanization level is measured using metropolitan statistical area (MSA) status. The Office of Management and Budget defines MSAs according to published standards that are applied to U.S. Census Bureau data. Generally, an MSA consists of a county or group of counties containing at least one urbanized area with a population of 50,000 or more (see reference 14 in this report). See the Methods section in this report for more detail.

⁶Living within a large central MSA with a population of 1 million or more (similar to inner cities).

⁷Living within a large fringe MSA with a population of 1 million or more (similar to suburbs).

⁸Living within a medium and small MSA with a population of less than 1 million

9Not living in an MSA

¹⁰Under provisions of the Affordable Care Act of 2010 (Pub L No 111–148, Pub L No 111–152), states have the option to expand Medicaid eligibility to cover adults who have incomes up to and including 138% of the federal poverty level. There is no deadline for states to choose to implement the Medicaid expansion, and they may do so at any time. As of January 1, 2019, 33 states and the District of Columbia moved forward with Medicaid expansion.

¹¹For 2019, states moving forward with Medicaid expansion included: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, and West Virginia. The District of Columbia also moved forward with Medicaid expansion.

¹²For 2019, states not moving forward with Medicaid expansion included: Alabama, Florida, Georgia, Idaho, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Wisconsin, and Wyoming.
¹³The New England region includes: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. The Middle Atlantic region includes: Delaware, District of Columbia, Maryland,

¹³The New England region includes: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. The Middle Atlantic region includes: Delaware, District of Columbia, Maryland, New Jersey, New York, and Pennsylvania. The East North Central region includes: Illinois, Indiana, Michigan, Ohio, and Wisconsin. The West North Central region includes: Illinois, Indiana, Michigan, Ohio, and Wisconsin. The West North Central region includes: Illinois, Indiana, Michigan, Ohio, and Wisconsin. The West North Central region includes: Storik Central region includes: Ansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota. The South Atlantic region includes: Florida, Georgia, North Carolina, South Carolina, Virginia, and West Virginia. The East South Central region includes: Arkansas, Louisiana, Oklahoma, and Texas. The Mountain region includes: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming. The Pacific region includes: Alaska, California, Hawaii, Oregon, and Washington.

¹⁴Estimates are not shown for Alaska, Hawaii, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, South Dakota, Utah, Vermont, West Virginia, and Wyoming.

NOTES: Estimates may not add up to 100% because a person may have both private and public coverage. Estimates are based on household interviews of a sample of the U.S. civilian noninstitutionalized population.

SOURCE: National Center for Health Statistics, National Health Interview Survey, 2019.

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Table 2. Percentages (and 95% confidence intervals) of adults aged 18–64 who had private coverage, public health coverage, or were uninsured at the time of the interview, by urbanization level, state Medicaid expansion status, expanded regions, and selected states: United States, 2019

Selected geographic characteristics and Medicaid expansion status	Private ¹	Public ²	Uninsured ³
 Total ⁴	67.5 (66.6–68.5)	20.4 (19.6–21.1)	14.5 (13.9–15.2)
Lirbanization level ⁵			
	67.6 (66.1-69.1)	18.7 (17.5–19.9)	15.4 (14.2–16.6)
Large fringe metropolitan'	/3.4 (/1.6–/5.1)	17.0 (15.6–18.4)	12.4 (11.1–13.7)
Medium and small metropolitan ⁸	65.5 (63.5–67.4)	23.1 (21.5–24.9)	14.1 (12.9–15.4)
Nonmetropolitan ⁹	61.1 (57.7–64.4)	24.5 (21.7–27.4)	17.5 (15.1–20.2)
State Medicaid expansion status ¹⁰			
Medicaid expansion states ¹¹	68.4 (67.2–69.5)	23.2 (22.2–24.2)	10.9 (10.2–11.6)
Non-Medicaid expansion states ¹²	66.1 (64.4–67.7)	15.4 (14.3–16.6)	20.8 (19.5–22.2)
Expanded regions ¹³			
New England	75.5 (71.7–79.0)	21.3 (18.2–24.7)	5.7 (4.4–7.3)
Middle Atlantic	68.6 (66.1–71.0)	24 7 (22 6–26 8)	9 2 (7 8-10 9)
East North Central	72 0 (69 6–74 3)	19.6(17.5-21.8)	11 0 (9 6–12 6)
West North Central	77.1 (74.6-79.5)	13.7 (11.9–15.7)	11.3 (0.3-13.6)
	(74.0-79.0)	17.0(15.4, 10.0)	19 5 (16 9 20 4)
	00.7 (50.1 00.0)	17.2 (15.4–19.2)	16.5 (10.6-20.4)
	62.7 (59.1-66.2)	24.5 (21.3-27.9)	15.7 (13.0-18.7)
	58.0 (55.6–60.4)	16.9 (15.1–18.9)	27.1 (24.7–29.6)
	65.9 (61.8–69.9)	20.8 (17.9–23.9)	16.7 (14.1–19.4)
Pacific	66.9 (64.4–69.2)	23.6 (21.5–25.8)	11.4 (10.1–12.7)
Selected states ¹⁴			
Alabama	66.9 (57.5–75.3)	23.6 (16.5–31.9)	14.7 (9.3–21.7)
Arizona	61.8 (53.0–70.1)	25.8 (19.0–33.7)	15.4 (10.2–21.9)
Arkansas.	59.2 (46.6–71.0)	24.3 (15.2–35.6)	17.8 (10.2–27.8)
California	65.9 (62.9–68.8)	24.1 (21.5–26.9)	11.5 (10.0–13.1)
Colorado	71.9 (64.3–78.7)	18.4 (13.0–25.0)	12.8 (8.5–18.4)
Connecticut	77.9 (68.8-85.4)	17.2 (10.8–25.3)	*
Delaware	73.7 (61.0–84.0)	17.5 (9.4–28.5)	*
District of Columbia	66.4 (53.5-77.8)	33.0 (22.2-45.2)	*
Florida	66.0 (61.5-70.3)	15 7 (13 0–18 7)	20 6 (17 1-24 4)
Georgia	65 1 (58 4–71 4)	14.3 (10.3–19.1)	22.3 (18.3–26.8)
Illinois	73.4 (68.9–77.5)	15.2 (12.3–18.4)	13.7(10.6-17.2)
Indiana	72 7 (65 7–79 0)	18.6 (13.5-24.5)	10.6(6.9-15.4)
Kontucky	52 4 (45 0 61 8)	25 5 (29 1 42 5)	12.0 (9.2 19.9)
	53.4(45.0-01.0)	35.5 (20.1-45.5)	12.3 (0.3-10.0)
	52.7 (44.4-60.9)	57.2 (29.6–45.0)	12.2 (7.6–17.9)
	71.4 (62.1-79.6)	24.9 (17.0-33.5)	8.0 (4.4–14.0)
	/3.6 (66.9–/9.6)	26.3 (20.6–32.6)	
Michigan	67.7 (62.1–73.0)	24.5 (20.1–29.4)	11.1 (7.7–15.3)
Minnesota	84.9 (78.6–90.0)	10.3 (6.3–15.6)	6.9 (3.8–11.4)
Missouri	72.8 (65.5–79.3)	14.0 (9.4–19.8)	14.6 (10.1–20.1)
New Jersey	69.4 (63.5–74.9)	19.6 (15.0–24.8)	13.0 (9.4–17.4)
New York	65.0 (60.8–69.1)	30.0 (26.5–33.6)	7.4 (4.9–10.5)
North Carolina	67.8 (60.1–74.8)	18.0 (12.9–24.2)	17.8 (14.0–22.2)
Ohio	68.9 (63.7–73.8)	23.7 (18.5–29.6)	10.8 (8.3–13.8)
Oklahoma	60.8 (51.5-69.6)	15.2 (9.5–22.5)	25.6 (18.7-33.6)
Oregon	64.5 (56.0-72.5)	27.2 (20.3–35.0)	11.2 (6.9–17.0)
Pennsylvania.	71.3 (66.8–75.5)	21.1 (17.6–24.9)	9.8 (7.1–13.0)
Rhode Island	78.2 (65.7–87.8)	20.7 (11.7–32.5)	*
South Carolina	63.4 (54.5–71.6)	25.0 (18 2-32 9)	14.9 (9 7–21 4)
Tennessee	68 6 (61 6–75 0)	18 9 (13 9-24 7)	15 6 (11 2–20 8)
Texas	58.4 (55.4 - 61.4)	13 1 (11 /_15 1)	30 5 (27 7-33 4)
Virainia	72 0 (67 0 76 7)	16.2 (12.9, 20.2)	120(104 191)
Virginia	72.0 (07.0-70.7)	17.2 (10.6, 00.9)	11.6 (7.0, 10.0)
washinguun	/3.0 (0/.3-/9.0)	17.3 (12.0-22.8)	11.0 (7.9–16.2)
vvisconsin	/9.2 (/3.6–84.1)	14.7 (10.7–19.5)	7.7 (4.9–11.3)

Table 2. Percentages (and 95% confidence intervals) of adults aged 18–64 who had private coverage, public health coverage, or were uninsured at the time of the interview, by urbanization level, state Medicaid expansion status, expanded regions, and selected states: United States, 2019—Con.

*Estimate is not shown because it does not meet National Center for Health Statistics standards of reliability.

¹Private health insurance coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as dental, vision, or prescription drugs. Persons with private coverage may also have public coverage.

²Public health plan coverage includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plans, Medicare, and military (TRICARE,

Veterans Administration [VA], and CHAMP–VA) plans. Persons with public coverage may also have private coverage. ³Persons were considered uninsured if they did not have coverage through private health insurance, Medicare, Medicaid, CHIP, military (TRICARE, VA, and CHAMP–VA), other state-sponsored health plans, or other government programs. Persons also were defined as uninsured if they only had Indian Health Service coverage or only had a private plan that paid for one type of service, such as dental, vision, or prescription drugs.

dental, vision, or prescription drugs. ⁴Includes all 50 states and the District of Columbia.

⁵Urbanization level is measured using metropolitan statistical area (MSA) status. The Office of Management and Budget defines MSAs according to published standards that are applied to U.S. Census Bureau data. Generally, an MSA consists of a county or group of counties containing at least one urbanized area with a population of 50,000 or more (see reference 14 in this report). See the Methods section in this report for more detail.

⁶Living within a large central MSA with a population of 1 million or more (similar to inner cities).

⁷Living within a large fringe MSA with a population of 1 million or more (similar to suburbs).

⁸Living within a medium and small MSA with a population of less than 1 million

9Not living in an MSA.

¹⁰Under provisions of the Affordable Care Act of 2010 (Pub L No 111–148, Pub L No 111–152), states have the option to expand Medicaid eligibility to cover adults who have incomes up to and including 138% of the federal poverty level. There is no deadline for states to choose to implement the Medicaid expansion, and they may do so at any time. As of January 1, 2019, 33 states and the District of Columbia moved forward with Medicaid expansion.

¹¹For 2019, states moving forward with Medicaid expansion included: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, and West Virginia. The District of Columbia also moved forward with Medicaid expansion.

¹²For 2019, states not moving forward with Medicaid expansion included: Alabama, Florida, Georgia, Idaho, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Wisconsin, and Wyoming.
¹³The New England region includes: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. The Middle Atlantic region includes: Delaware, District of Columbia, Maryland,

¹³The New England region includes: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. The Middle Atlantic region includes: Delaware, District of Columbia, Maryland, New Jersey, New York, and Pennsylvania. The East North Central region includes: Illinois, Indiana, Michigan, Ohio, and Wisconsin. The West North Central region includes: Illinois, Indiana, Michigan, Ohio, and Wisconsin. The West North Central region includes: Illinois, Indiana, Michigan, Ohio, and Wisconsin. The West North Central region includes: Illinois, Indiana, Michigan, Ohio, and Wisconsin. The West North Central region includes: Illinois, Indiana, Michigan, Ohio, and Wisconsin. The West North Central region includes: Illinois, Indiana, Michigan, Okia, North Carolina, Virginia, and West Virginia. The East South Central region includes: Arlansas, Louisiana, Oklahoma, and Texas. The Mountain region includes: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming. The Pacific region includes: Alaska, California, Hawaii, Oregon, and Washington.

¹⁴Estimates are not shown for Alaska, Hawaii, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, South Dakota, Utah, Vermont, West Virginia, and Wyoming.

NOTES: Estimates may not add up to 100% because a person may have both private and public coverage. Estimates are based on household interviews of a sample of the U.S. civilian noninstitutionalized population.

SOURCE: National Center for Health Statistics, National Health Interview Survey, 2019.

Table 3. Percentages (and 95% confidence intervals) of children aged 0–17 years who had private coverage, public health coverage, or were uninsured at the time of the interview, by urbanization level, state Medicaid expansion status, expanded regions, and selected states: United States, 2019

Selected geographic characteristics and Medicaid expansion status	Private ¹	Public ²	Uninsured ³
 Total ⁴	55.6 (54.0–57.2)	40.9 (39.5–42.4)	5.1 (4.5–5.8)
Listenization laural5			
	/		
Large central metropolitan ⁶	54.5 (52.0–57.0)	42.1 (39.7–44.6)	4.8 (3.7–6.0)
	65.0 (62.0–67.9)	31.5 (28.8–34.4)	4.5 (3.4–5.8)
Medium and small metropolitan [®]	52.0 (49.0–55.0)	44.8 (42.0–47.7)	5.0 (4.1–6.1)
Nonmetropolitan ⁹	49.0 (43.8–54.2)	46.6 (41.7–51.5)	6.9 (4.8–9.7)
State Medicaid expansion status ¹⁰			
Medicaid expansion states ¹¹	57.9 (56.0-59.9)	39.9 (38.0-41.8)	3.8 (3.1-4.6)
Non-Medicaid expansion states ¹²	51.9 (49.3–54.5)	42.6 (40.2–45.0)	7.1 (5.9–8.3)
Expanded regions ¹³			
New England	70.6 (64.3–76.4)	30.9 (24.9–37.4)	0.9 (0.2–2.5)
Middle Atlantic	58.8 (54.9–62.7)	39.3 (35.3–43.4)	3.5 (2.2–5.3)
East North Central	65.0 (61.1–68.7)	33.0 (29.2–37.0)	4.1 (2.5–6.2)
West North Central	65.6 (60.8–70.2)	31 4 (26 4–36 6)	48(31-71)
South Atlantic	49 2 (44 9–53 5)	47 2 (43 3–51 0)	5 1 (3 5-7 0)
East South Central	45.7 (40.1-51.4)	50.9 (46.2–55.6)	4 9 (3 0-7 5)
West South Central	45.7 (40.1-51.4)	44.4 (20.0, 48.0)	10.2 (9.2, 12.0)
Meuntein	40.5 (41.8–51.3)	44.4 (39.9–40.9)	7.2 (4.6, 10.0)
	60.0 (54.2–65.6)	35.2 (31.1–39.5)	7.3 (4.6–10.9)
	52.4 (48.7–56.2)	45.6 (41.9–49.3)	3.0 (2.1–4.2)
Selected states ¹⁴			
Alabama	*	46.7 (32.1–61.7)	*
Arizona	46.3 (34.3–58.6)	46.3 (34.5–58.5)	11.4 (5.8–19.5)
Arkansas	*	*	*
California	52.4 (48.2–56.6)	45.8 (41.8–49.8)	2.8 (1.9–3.9)
Colorado	66.4 (54.5-77.0)	31.2 (21.0–42.9)	*
Connecticut	63.3 (48.4–76.4)	38.1 (24.9–52.7)	*
Delaware	*	*	*
District of Columbia	*	*	*
Florida	45.9 (38.9–53.0)	48.3 (42.2–54.5)	*
Georgia	46.5 (35.8–57.4)	48.5 (38.0–59.0)	7.4 (4.1–12.3)
Illinois	67.1 (60.0–73.8)	30.6 (23.8–38.1)	2.5 (0.9-5.1)
Indiana	64.8 (53.5–75.0)	31 7 (22 0-42 7)	*
Kentucky	39.3 (26.9–52.7)	54.8 (41.7–67.5)	*
Louisiana	47.4 (33.6–61.5)	50.6 (36.8–64.3)	*
Maryland	63.2 (48.2–76.5)	35.9 (22.9–50.6)	*
Massachusette	72 3 (61 3-81 6)	29.9 (20.4-40.9)	*
Michigon	(01.5-01.0)	23.3 (20.4-40.3)	*
Michigan	77.0 (66.0. 97.2)	40.4(30.3-30.9)	*
	77.9 (66.0-87.2)	17.9 (9.0–29.1)	*
	60.0 (48.3-70.9)	36.7 (26.2–48.2)	*
New Jersey	60.9 (52.3–69.0)	35.6 (27.7–44.1)	
	53.5 (46.6–60.4)	46.4 (39.3–53.6)	1.8 (0.6–4.0)
	52.0 (41.8–62.2)	45.6 (37.8–53.6)	
Ohio	62.0 (52.7–70.7)	35.0 (26.1–44.8)	*
Oklahoma	46.0 (32.7–59.7)	46.2 (33.1–59.7)	*
Oregon	53.5 (40.0–66.7)	44.3 (31.5–57.7)	*
Pennsylvania	61.5 (55.0–67.6)	35.9 (28.8–43.3)	*
Rhode Island	*	*	*
South Carolina	42.9 (28.9–57.7)	56.7 (42.0–70.5)	*
Tennessee	54.2 (42.9–65.2)	42.5 (31.8–53.6)	*
Texas	46.9 (41.7–52.1)	42.8 (37.7-47.9)	11.2 (8.8–13.9)
Virginia	58.6 (48.6-68.2)	39.9 (31.1–49.3)	2.5 (0.9–5.7)
Washington	54.0 (42.9-64.9)	42.5 (32.0–53.5)	*
Wisconsin	71.6 (61.9–80.0)	25.6 (17.6–34.9)	*

Table 3. Percentages (and 95% confidence intervals) of children aged 0–17 years who had private coverage, public health coverage, or were uninsured at the time of the interview, by urbanization level, state Medicaid expansion status, expanded regions, and selected states: United States, 2019—Con.

*Estimate is not shown because it does not meet National Center for Health Statistics standards of reliability.

¹Private health insurance coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as dental, vision, or prescription drugs. Persons with private coverage may also have public coverage.

²Public health plan coverage includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plans, Medicare, and military (TRICARE,

Veterans Administration [VA], and CHAMP–VA) plans. Persons with public coverage may also have private coverage. ³Persons were considered uninsured if they did not have coverage through private health insurance, Medicare, Medicaid, CHIP, military (TRICARE, VA, and CHAMP–VA), other state-sponsored health plans, or other government programs. Persons also were defined as uninsured if they only had Indian Health Service coverage or only had a private plan that paid for one type of service, such as dental vision or prescription drugs.

dental, vision, or prescription drugs. ⁴Includes all 50 states and the District of Columbia.

⁵Urbanization level is measured using metropolitan statistical area (MSA) status. The Office of Management and Budget defines MSAs according to published standards that are applied to U.S. Census Bureau data. Generally, an MSA consists of a county or group of counties containing at least one urbanized area with a population of 50,000 or more (see reference 14 in this report). See the Methods section in this report for more detail.

⁶Living within a large central MSA with a population of 1 million or more (similar to inner cities).

⁷Living within a large fringe MSA with a population of 1 million or more (similar to suburbs).

⁸Living within a medium and small MSA with a population of less than 1 million

9Not living in an MSA.

¹⁰Under provisions of the Affordable Care Act of 2010 (Pub L No 111–148, Pub L No 111–152), states have the option to expand Medicaid eligibility to cover adults who have incomes up to and including 138% of the federal poverty level. There is no deadline for states to choose to implement the Medicaid expansion, and they may do so at any time. As of January 1, 2019, 33 states and the District of Columbia moved forward with Medicaid expansion.

¹¹For 2019, states moving forward with Medicaid expansion included: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, and West Virginia. The District of Columbia also moved forward with Medicaid expansion.

¹²For 2019, states not moving forward with Medicaid expansion included: Alabama, Florida, Georgia, Idaho, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Wisconsin, and Wyoming.
¹³The New England region includes: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. The Middle Atlantic region includes: Delaware, District of Columbia, Maryland,

¹³The New England region includes: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. The Middle Atlantic region includes: Delaware, District of Columbia, Maryland, New Jersey, New York, and Pennsylvania. The East North Central region includes: Illinois, Indiana, Michigan, Ohio, and Wisconsin. The West North Central region includes: Illinois, Indiana, Michigan, Ohio, and Wisconsin. The West North Central region includes: Illinois, Indiana, Michigan, Ohio, and Wisconsin. The West North Central region includes: Storik Central region includes: Ansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota. The South Atlantic region includes: Florida, Georgia, North Carolina, South Carolina, Virginia, and West Virginia. The East South Central region includes: Arkansas, Louisiana, Oklahoma, and Texas. The Mountain region includes: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming. The Pacific region includes: Alaska, California, Hawaii, Oregon, and Washington.

¹⁴Estimates are not shown for Alaska, Hawaii, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, South Dakota, Utah, Vermont, West Virginia, and Wyoming.

NOTES: Estimates may not add up to 100% because a person may have both private and public coverage. Estimates are based on household interviews of a sample of the U.S. civilian noninstitutionalized population.

SOURCE: National Center for Health Statistics, National Health Interview Survey, 2019.

Technical Notes

Procedures for direct statelevel estimates from the National Health Interview Survey

General strategy

The National Center for Health Statistics (NCHS) only publishes a direct state-level estimate if the estimate meets NCHS acceptance criteria for measures of estimate uncertainty, for example, standard errors, relative standard errors, and confidence internal length. Depending on the state sample size, the measure being studied, and possible subdomain of interest, a state may have many publishable estimates, few, or none. The National Health Interview Survey (NHIS) is designed for estimation at the national level, and available statistical software packages (SAS Survey Procedures [SAS, Cary, N.C.] or SUDAAN [RTI International, Research Triangle Park, N.C.]), can be used directly to obtain point estimates along with standard errors. These software packages account for the complex sampling design of NHIS. However, with direct state-level estimation, more attention must be given to the state sampling procedure that produces the data. Historical experience with producing direct state-level estimates from NHIS has led to states being loosely categorized into three general classes, where each class has a strategy for the release of state estimates.

Historically, a strong relationship has existed between the order of states ranked by population size and the order of states ranked by sample size. Because estimator reliability tends to increase with sample size, a somewhat robust partition of states defined by grouped population size can be created. This population-based partition will assist in grouping states with similar design features and assigning strategies for state-level estimation.

State estimation classes and their general publication strategies are as follows.

State estimation class 1—Includes states with the largest populations and can be treated like the NHIS design, but with a smaller sample size. Publication criteria for the state will be the same as for the country.

State estimation class 2—Includes midsize populated states that often have design features and sample sizes that lead to estimated standard errors that are noticeably more variable than those corresponding to the larger populated states. The random nature of the standard error becomes a major consideration in evaluating a state's point estimate. For these midsize states, smoothed estimates of standard errors and other reliabilitybased calculations can be developed. With a smoothed component, publication criteria for the midsize states become the same as for the country.

State estimation class 3—Includes small-sized populated states that tend to be the lesser populated states or states that have small sample sizes or design features, for example, few clusters, highly nonuniform cluster sizes within strata, and large between-cluster variation within strata that are not directly amenable to producing reliable state estimates. These states may have many state-level estimates suppressed.

The three state classes will provide class-specific strategies for state reliability assessment, but special situations exist where the class strategies, if strictly followed, may indicate a publication suppression for a specific variable whose estimates may appear disproportionate compared with the totality of the state estimates. In these situations, subject-matter experts assess the issue and determine if the estimates can be published.

NHIS state estimation and adherence to NCHS standards for publication

The three state classes listed above are somewhat generic. For NHIS state estimation, the state categories listed above are refined to comply with the NCHS data presentation standards for proportions (22), (referred to as Standards). The Standards provide guidance in establishing the baseline criteria for reliability for NCHS-produced estimates of proportions. Each of the 50 states and the District of Columbia has its own sampling characteristics, and each must be assessed separately by the Standards. The Figure shows the steps that the estimates of each state and the District of Columbia must complete to meet publication standards.

Among the main Standards criteria is that the effective sample size of any domain of study should be at least 30. An effective sample size is a survey sample size adjusted downward due to sampling inefficiencies resulting from survey design clustering and survey weighting. A related measure is the design effect, *deff*, typically assumed to be greater than one for NHIS. This parameter defines the effective sample size,

$$n_{effective} = \frac{n}{deff},$$

where n is the number of unweighted survey observations upon which the estimate of interest is based. The state domains featured by NHIS almost always meet the "30" criteria.

•

- The degrees of freedom, df, is a design parameter that plays a key role in the Standards criteria. The df of a state is typically calculated by a rule-of-thumb measure: number of state primary sampling units minus the number of state strata. This parameter is a measure of stability of the estimated standard error. Statelevel inference using a state with df < 8 often leads to problematic statistical inference, especially when looking at state comparisons. For the NHIS state-level estimates, the policy has been to suppress estimates from these states. Note that this policy varies for different NCHS data systems. The estimates in small states in state estimation class 3 frequently have associated df < 8 and are subject to suppression.
- The assessment of a confidence interval is a central criterion of the Standards. The Standards now suggest using a design-adjusted confidence interval approach, the Korn–Graubard (K–G) version of the Clopper–Pearson confidence interval. The most commonly used "pass-or-fail" state-level criterion is the requirement that for a given estimated proportion, \hat{p} , the relative

Figure. Process for accessing statistical reliability of state-level estimates from the National Health Interview Survey



width of its K–G confidence interval is less than or equal to 1.30 (subject to the df < 8 criterion mentioned previously). Whether a state estimate in state estimation class 2 may be published is often decided by this criterion.

State estimation methods

The NHIS state-level procedure developed to determine whether an estimate may be published is motivated by the Standards criteria and by variations in state sampling design structures encountered with the 50 states and the District of Columbia within the general state classes described previously. Although the population size boundaries of states-large, medium, and small-can have somewhat subjective definitions, for NHIS, the break boundaries are defined by the procedure proposed for state Standards assessment. Generally, the 12 largest populated states-California, Florida, Georgia, Illinois, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Texas, and Virginia-have survey sample sizes of 500 or more and at least 25 degrees of freedom. Note that because NHIS is designed for a 10-year data collection, possible irregularities from the planned design can occur over this period, and sample size variations can occur. Internal empirical and simulation studies have demonstrated that these 12 individual states pass the Standards, and the simulations of the sampling properties of estimated proportions, for example, relative confidence interval widths, do not cause concerns for a wide range of statistical inference.

Although the remaining 38 states and the District of Columbia could be evaluated as having self-contained domains, internal empirical and simulation studies have suggested that some minor smoothing procedures may help overcome some issues resulting from smaller samples and lower levels of degrees of freedom.

The K–G confidence interval requires an effective sample size, $n_{effective}$, for a confidence interval to be computed. In its basic form,

$$n_{effective} = \frac{n}{\hat{d}eff}$$

where the measure \hat{deff} is an estimate of efficiency of the complex survey as measured by the complex design variance estimate compared with a simple random sample variance estimate of size *n*. This parameter is estimated by

$$\hat{d}eff = \frac{\hat{S}E(\hat{p})^2}{[\hat{p}(1-\hat{p})/n]}$$

The smoothed NHIS state method

Rather than using all raw forms for the 51 \hat{deff}_{state} 's the following smoothed forms are used:

- The raw \hat{deff}_{state} for the 12 largest states.
- For the other states and the District of Columbia let deff_{state} = unweighted average of the 12 largest deff_{state}'s.

When using this method, if \hat{deff}_{state}^s represents a smoothed design effect, then \hat{deff}_{state}^s will have less sampling variability than the original \hat{deff}_{state} , and so at the state level,

$$n_{effective}^{s} = \frac{n}{\hat{d}eff_{state}^{s}}$$

will have less sampling variability than the original

$$n_{effective} = \frac{n}{\hat{d}eff_{state}}$$

These results have been demonstrated in state simulations. Because the effective sample size is a required input to the K–G confidence interval procedure, using $n_{effective}^{s}$ increases the underlying reliability of the input measures. Although the Standards rule of possible suppression for states with fewer than 8 original degrees of freedom could be relaxed by using the smoothing technique, NCHS has decided to be conservative and suppress all states with the originally computed 7 or fewer degrees of freedom.

For this report, direct state-level point estimates and their standard errors and confidence intervals were calculated using SUDAAN software. The Taylor series linearization method was chosen for estimation of standard errors for the 12 states with the largest sample sizes. State-specific estimates are not presented for Alaska, Hawaii, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, South Dakota, Utah, Vermont, West Virginia, and Wyoming, because they did not have at least 8 degrees of freedom. For the remaining 20 states and the District of Columbia, an estimated design effect was used to calculate standard errors. Massachusetts was considered a special situation. This state had some small estimated proportions relative to the other states, which led to the state failing the relative confidence interval width criterion occasionally. Because the sample sizes and degrees of freedom appeared supportive of state estimation, a subjectmatter specialist reviewed the issue and determined that this state's estimates could be published. For a listing of the average design effects used in the standard error calculation in this report, see Table II.

A version of this direct state-level estimate methodology was used in previous reports (23), so allows for some continuity with previous reports on state estimates. This methodology for producing state-level estimates may be utilized for other measures available on NHIS.

Table I. Percentages (and 95% confidence intervals) of persons of all ages who had private coverage, public health coverage, or were uninsured at the time of the interview, by urbanization level, state Medicaid expansion status, expanded regions, and selected states: United States, 2019

Selected geographic characteristics and Medicaid expansion status	Private ¹	Public ²	Uninsured ³
Total ⁴	62.0 (61.1–62.9)	37.3 (36.6–38.1)	10.2 (9.7–10.7)
Urbanization level ⁵			
Large central metropolitan ⁶	60 9 (59 5-62 3)	34 1 (32 9-35 4)	11 2 (10 4-12 1)
Large fringe metropolitan ⁷	68 5 (66 9–70 1)	33.0 (31.6–34.3)	86(78-96)
Medium and small metropolitan ⁸	60.0 (58.2–61.8)	40.6 (39.0-42.1)	9.7 (8.9–10.6)
Nonmetropolitan ⁹	57.1 (53.8–60.3)	44.8 (42.3–47.3)	11.6 (9.9–13.6)
State Medicaid expansion status ¹⁰			
Medicaid expansion states ¹¹	63.5 (62.4-64.5)	39.1 (38.2-40.1)	7.7 (7.2–8.2)
Non-Medicaid expansion states ¹²	59.4 (57.8–61.0)	34.2 (33.0–35.4)	14.6 (13.6–15.6)
Expanded regions ¹³			
New England	71.1 (67.6–74.4)	36.0 (32.9–39.2)	3.8 (2.9–4.8)
Middle Atlantic	64.0 (61.8-66.1)	40.6 (38.8-42.4)	6.5 (5.4–7.6)
East North Central	68.9 (66.8–70.9)	35.1 (33.0–37.3)	7.8 (6.7–9.0)
West North Central	71.4 (68.7–74.0)	32.3 (29.5–35.2)	7.9 (6.5–9.5)
South Atlantic	59.2 (56.7–61.6)	37.4 (35.5–39.4)	12.6 (11.3–13.9)
East South Central	55.4 (52.2–58.5)	43.3 (40.2-46.3)	10.6 (8.7–12.8)
West South Central.	53.0 (50.5–55.5)	34.7 (32.7–36.8)	19.3 (17.5–21.2)
Mountain	60.8 (56.9–64.6)	36.4 (33.7–39.2)	11.8 (9.9–14.0)
Pacific	60.2 (58.1–62.4)	38.9 (36.9–40.9)	8.1 (7.2–9.0)
Selected states ¹⁴			
Alabama	57.0 (48.7–65.0)	43.8 (37.1–50.7)	8.8 (5.3–13.4)
Arizona	52.2 (44.7–59.6)	44.6 (38.5–50.9)	11.6 (8.0–16.1)
Arkansas	50.7 (40.5–60.9)	47.5 (39.1–56.0)	12.2 (7.3–18.7)
California	59.0 (56.3–61.6)	38.9 (36.5–41.3)	8.2 (7.2–9.4)
Colorado	67.4 (60.5–73.8)	34.2 (28.8–40.0)	8.4 (5.5–12.3)
Connecticut	67.9 (59.3–75.6)	34.3 (27.7–41.4)	4.2 (1.8–8.0)
Delaware	68.2 (56.7–78.3)	34.1 (25.4–43.7)	8.0 (3.7–14.7)
District of Columbia	64.6 (52.1–75.8)	38.9 (29.2–49.3)	3.0 (0.6–8.7)
Florida	55.5 (52.0–59.0)	38.6 (35.9–41.4)	13.8 (11.4–16.4)
Georgia	58.1 (51.9–64.2)	32.6 (28.0–37.5)	16.0 (13.3–19.1)
	69.7 (66.2–73.1)	32.5 (29.4–35.7)	9.1 (7.1–11.4)
Indiana	69.5 (63.1–75.4)	33.2 (28.1–38.6)	8.1 (5.4–11.6)
Kentucky	49.8 (42.2–57.3)	50.1 (43.9–56.4)	9.3 (6.1–13.6)
	50.0 (42.5-57.5)	49.6 (43.4–55.9)	8.0 (5.0–12.1)
Maryland	68.9 (60.5-76.5)	37.6 (30.9–44.8)	6.0 (3.1–10.3)
Massachusetts	72.2 (66.2–77.6)	37.6 (32.6–42.9)	2.4 (1.1–4.6)
	66.4 (61.5-71.1)	40.5 (35.8–45.4)	7.4 (5.2–10.2)
Minnesota	82.1 (76.3-87.0)	28.3 (23.4–33.7)	5.0 (2.8–8.1)
	65.5 (58.9–71.7)	33.3 (28.1–38.7)	10.0 (6.9–13.8)
	65.1 (60.2–69.8)	36.0 (31.9–40.3)	8.8 (6.3–11.9)
New York	61.2 (52.8, 68.2)	45.8 (42.9-48.7)	5.0 (3.5-7.0)
	01.2 (03.8 - 08.3)	35.8 (31.1-40.7)	12.3 (9.4–15.6)
	5.0(00.0-70.4)	36.3 (35.3-43.5)	0.1(0.2-10.3)
	54.5(40.2-02.0)	30.3 (29.9-43.1)	7.8 (4.9, 11.0)
	65.6(61.8,60.4)	43.2 (37.0-49.3)	7.0 (4.0 - 11.9)
Rhode Island	73 5 (62 2_82 9)	37 1 (28 1-46 8)	53(19-114)
South Carolina	57 8 (49 9-65 1)	46 2 (30 <u>8</u> -52 <u>8</u>)	9.6(6.2-14.1)
Tennessee	61 5 (55 2-67 5)	37 7 (32 7-43 0)	10.5(7.5-14.1)
Texas	53 5 (50 3-56 7)	30 8 (28 7-32 9)	22 1 (20 0-24 3)
Viroinia	66 1 (61 5–70 4)	36 5 (32 7-40 4)	8.9 (6.6–11.6)
Washington	66 4 (60 2-72 2)	34 5 (29 6-39 6)	8 0 (5 4-11 3)
Wisconsin	75.4 (70.1–80.1)	28.9 (24.6–33.4)	5.7 (3.7–8.4)

Table I. Percentages (and 95% confidence intervals) of persons of all ages who had private coverage, public health coverage, or were uninsured at the time of the interview, by urbanization level, state Medicaid expansion status, expanded regions, and selected states: United States, 2019—Con.

¹Private health insurance coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as dental, vision, or prescription drugs. Persons with private coverage may also have public coverage. ²Public health plan coverage includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plans, Medicare, and military (TRICARE,

Veterans Administration [VÅ], and CHAMP–VA) plans. Persons with public coverage may also have private coverage. ³Persons were considered uninsured if they did not have coverage through private health insurance, Medicare, Medicaid, CHIP, military (TRICARE, VA, and CHAMP–VA), other state-sponsored health plans, or other government programs. Persons also were defined as uninsured if they only had Indian Health Service coverage or only had a private plan that paid for one type of service, such as dental, vision, or prescription drugs.

⁴Includes all 50 states and the District of Columbia.

⁵Urbanization level is measured using metropolitan statistical area (MSA) status. The Office of Management and Budget defines MSAs according to published standards that are applied to U.S. Census Bureau data. Generally, an MSA consists of a county or group of counties containing at least one urbanized area with a population of 50,000 or more (see reference 14 in this report). See the Methods section in this report for more detail.

⁶Living within a large central MSA with a population of 1 million or more (similar to inner cities).

⁷Living within a large fringe MSA with a population of 1 million or more (similar to suburbs). ⁸Living within a medium and small MSA with a population of less than 1 million.

⁹Not living in an MSA.

¹⁰Under provisions of the Affordable Care Act of 2010 (Pub L No 111–148, Pub L No 111–152), states have the option to expand Medicaid eligibility to cover adults who have incomes up to and including 138% of the federal poverty level. There is no deadline for states to choose to implement the Medicaid expansion, and they may do so at any time. As of January 1, 2019, 33 states and the District of Columbia moved forward with Medicaid expansion.

¹¹For 2019, states moving forward with Medicaid expansion included: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia, Washington, and West Virginia. The District of Columbia also moved forward with Medicaid expansion.
¹²For 2019, states not moving forward with Medicaid expansion included: Alabama, Florida, Georgia, Idaho, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina,

¹²For 2019, states not moving forward with Medicaid expansion included: Alabama, Florida, Georgia, Idaho, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Wisconsin, and Wyoming.
¹³The New England region includes: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. The Middle Atlantic region includes: Delaware, District of Columbia, Maryland,

¹³The New England region includes: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. The Middle Atlantic region includes: Delaware, District of Columbia, Maryland, New Jersey, New York, and Pennsylvania. The East North Central region includes: Illinois, Indiana, Michigan, Ohio, and Wisconsin. The West North Central region includes: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota. The South Atlantic region includes: Florida, Georgia, North Carolina, South Carolina, Virginia, and West Virginia. The East South Central region includes: Alabama, Kentucky, Mississippi, and Tennessee. The West South Central region includes: Arkansas, Louisiana, Oklahoma, and Texas. The Mountain region includes: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming. The Pacific region includes: Alaska, California, Hawaii, Oregon, and Washington.

¹⁴Estimates are not shown for Alaska, Hawaii, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, South Dakota, Utah, Vermont, West Virginia, and Wyoming.

NOTES: Estimates may not add up to 100% because a person may have both private and public coverage. Estimates are based on household interviews of a sample of the U.S. civilian noninstitutionalized population.

SOURCE: National Center for Health Statistics, National Health Interview Survey, 2019.

Table II. Design effects used for standard error calculations of state estimates in Tables 1–3 and I, except for the 12 states with the largest populations

Table	Percentage estimate by age group	Average design effect based on 12 states with the largest populations ¹
1	Persons under age 65 with private coverage	3.46
1	Persons under age 65 with public coverage	2.92
1	Persons under age 65 who are uninsured	2.33
2	Adults aged 18–64 with private coverage	2.41
2	Adults aged 18-64 with public coverage	2.19
2	Adults aged 18-64 who are uninsured	1.99
3	Children aged 0–17 years with private coverage	2.22
3	Children aged 0-17 years with public coverage	2.16
3	Children aged 0-17 years who are uninsured	1.63
1	Persons of all ages with private coverage	3.46
1	Persons of all ages with public coverage	2.42
l	Persons of all ages who are uninsured	2.45

¹The states are California, Florida, Georgia, Illinois, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Texas, and Virginia. The design effect was defined as the ratio of the true standard error, accounting for the complex survey design, to the standard error for a simple random sample of the same size.

SOURCE: National Center for Health Statistics, National Health Interview Survey, 2019.

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CMS



Fact sheet

2021 Marketplace Special Enrollment Period Report

Jul 14, 2021 Affordable Care Act, Medicaid & CHIP

2021 Marketplace Special Enrollment Period Report

February 15 – June 30, 2021

Key Highlights of the 2021 SEP through June 30:

- Cumulative signups: Over 1.5 million Americans have signed up for new health insurance coverage through HealthCare.gov using the 2021 Marketplace Special Enrollment Period (SEP) between February 15 and June 30, 2021.
- Impacts of the American Rescue Plan Act of 2021 (ARP):
 - ARP has significantly lowered premiums after advance payments of premium tax credits (APTC) and out-of-pocket costs for consumers. For new consumers selecting plans during the SEP, the average monthly premium after APTC fell by 25 percent and the median deductible fell by nearly 90 percent since HealthCare.gov implemented the American Rescue Plan's more generous advance payments of premium tax credits (APTC) on April 1.
 - In addition, 2.5 million consumers have returned to the Marketplace since April
 1 and lowered their monthly premiums after APTC by 40 percent on average.
 - More than one-third (34 percent) of new and returning consumers have selected a plan for \$10 or less per month after APTC since April 1.
- Demographic Breakdown of 2021 SEP Consumers: For the second time, this report features new demographic breakdowns of plan selections during the 2021 SEP by gender, race and ethnicity.

The Centers for Medicare & Medicaid Services (CMS) reports that over **1.5 million Americans** have signed up for health insurance through HealthCare.gov since February **15**, 2021, the

start of the 2021 Marketplace Special Enrollment Period (SEP) opportunity became

available through HealthCare.gov, through June 30, 2021; with 373,000 consumers signing up for health insurance in the month of June. $\frac{1}{2}$

The number of new plan selections, from the start of the SEP opportunity on February 15, 2021 through June 30, 2021, represents a substantial increase in enrollment from the same period in 2020 and 2019, when 625,000 and 443,000 consumers signed up for Marketplace coverage, respectively.² In previous years, SEPs were available primarily only for qualifying life events, whereas this year, the Biden-Harris Administration opened a SEP available on HealthCare.gov in response to the COVID-19 Public Health Emergency.

Under the American Rescue Plan Act of 2021 (ARP), most consumers are now eligible for more generous advance payments of premium tax credits (APTC), which further reduce the portion of monthly premiums paid by consumers. Since HealthCare.gov implemented the expanded APTC amounts on April 1, 2021, **2.5 million consumers have returned to the Marketplace and reduced their monthly premiums after APTC by 40 percent**, from \$104 to \$62, on average, and **30 percent (735,000) of returning consumers newly selected plans for \$10 or less per month after APTC**.

The ARP also makes it more affordable for new consumers to purchase and use Marketplace coverage. For new consumers selecting plans under the SEP, the average monthly premium after APTC fell by 25 percent, from \$117 for those enrolling from February 15, 2021 through March 31 2021 to \$87 for those enrolling from April 1, 2021 through June 30, 2021, and 44 percent (487,000) of new consumers since April 1, 2021 selected plans for \$10 or less after APTC. The ARP also helped to lower out of pocket costs for many new consumers. The median deductible for new consumers during the SEP fell by nearly 90 percent, from \$450 prior to April 1, 2021 to \$50 for new consumers enrolling from April 1, 2021 through June 30, 2021.

Plan Selection and Application Activity	Feb. 15 – Jun. 30, 2021
New Plan Selections	1,522,283
New Consumers Requesting Coverage on an Application Submitted on or after February 15	2,818,837
Marketplace Eligible	2,392,534
Medicaid/CHIP Eligible	396,071

Call Center and Website Activity

Feb. 15 - Jun. 30, 2021

2021 Marketplace Special Enrollment Period Report | CMS

Call Center Volume	3,822,184
Calls with Spanish–Speaking Representative	455,159
HealthCare.gov Users	22,923,019
Window Shopping HealthCare.gov Users	1,303,448
CuidadoDeSalud.gov Users	1,082,379
Window Shopping CuidadoDeSalud.gov Users	
	57,532

¹ Cumulative plan selections from February 15, 2021 through June 30, 2021 reflect new plan selections net of terminations and cancellations during that period and count consumers that were not actively enrolled as of February 14, 2021. The June 1, 2021-June 30, 2021 total only reflects plan selection activity since June 1, 2021 and counts consumers who were not actively enrolled as of May 31, 2021.

²New Jersey and Pennsylvania transitioned to State-based Marketplaces in 2020, and Nevada transitioned to a State-

based Marketplace in 2019. Plan selections from these three states aren't included in this report

New Plan Selections by Gender (%)	Feb. 15 – Jun. 30, 2021	Feb. 15 – Jun. 30, 2020	Feb. 15 – Jun. 30, 2019
Female	54	55	56
Male	46	45	44

New Plan Selections by Ethnicity (%)	Feb. 15 – Jun. 30, 2021	Feb. 15 – Jun. 30, 2020	Feb. 15 – Jun. 30, 2019
Hispanic/Latino	11	10	11
Not Hispanic/Latino	49	50	54

https://www.cms.gov/newsroom/fact-sheets/2021-marketplace-special-enrollment-period-report-3

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Unknown	40	40	36

New Plan Selections by Race (%)	Feb. 15 – Jun. 30, 2021	Feb. 15 – Jun. 30, 2020	Feb. 15 – Jun. 30, 2019
African-American	7	6	6
Asian	3	4	4
White	33	37	43
Other Race ³	3	3	4
Unknown	54	50	43

New Plan Selections by State	Feb. 15 – Jun. 30,	Feb. 15 – Jun. 30,	Feb. 15 – Jun. 30,
	2021	2020	2019
Alaska	3,080	1,247	1,083
Alabama	30,845	10,916	7,339
Arkansas	14,228	5,245	4,970
Arizona	29,681	11,742	10,376
Delaware	4,479	2,255	1,623
Florida	413,409	179,869	120,513

³Other Race includes multiracial, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander.

2021 Marketplace Special Enrollment Period Report | CMS

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New Plan Selections by	Feb. 15 – Jun.	Feb. 15 – Jun.	Feb. 15 – Jun.
State	30,	30,	30,
	2021	2020	2019
Georgia	106,452	34,586	20,967
Hawaii	3,100	2,373	1,541
Iowa	11,390	5,678	4,746
Illinois	40,182	21,682	18,735
Indiana	20,467	10,408	9,223
Kansas	15,383	6,462	4,918
Kentucky	13,773	6,747	7,041
Louisiana	12,647	5,716	6,348
Maine	7,478	3,921	3,281
Michigan	35,632	19,415	16,857
Missouri	37,844	13,758	9,185
Mississippi	22,546	7,836	4,406
Montana	5,587	3,299	2,542
North Carolina	91,166	32,697	23,634
North Dakota	3,973	1,781	1,340
Nebraska	11,704	6,054	5,220
New Hampshire	6,697	3,786	3,166
New Mexico	6,646	2,625	2,428
Ohio	35,586	16,451	13,094
Oklahoma	29.858	15.610	11.084

https://www.cms.gov/newsroom/fact-sheets/2021-marketplace-special-enrollment-period-report-3
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Oregon	16,625	10,568	9,647
South Carolina	43,993	14,406	8,844
South Dakota	5,670	2,261	1,895
Tennessee	41,683	15,961	9,310
Texas	293,760	99,911	52,941
Utah	32,837	15,515	12,778
Virginia	40,069	16,662	15,287
Wisconsin	25,772	14,070	13,880
West Virginia	3,031	1,578	1,239
Wyoming	5,010	2,092	1,535
HealthCare.gov States Total	1,522,283	625,183	443,016

% of Consumers Newly Selecting Plans for \$10 or Less after APTC, April 1- June 30, 2021

State	New Consumers	Returning Consumers ⁴	Total
Alaska	27%	29%	28%

⁴ Represents consumers with an active plan selection as of March 31, 2021 who returned to the Marketplace and made a new plan selection (which could include re-selecting their current plan) during the period that had a premium

% of Consumers Newly Selecting Plans for \$10 or Less

after APTC, April 1- June 30, 2021

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		_	
Alabama	55%	34%	44%
Arkansas	29%	18%	22%
Arizona	24%	18%	20%
Delaware	19%	24%	22%
Florida	51%	34%	38%
Georgia	44%	36%	39%
Hawaii	20%	23%	22%
Iowa	41%	35%	37%
Illinois	17%	14%	15%
Indiana	19%	10%	13%
Kansas	35%	21%	26%
Kentucky	32%	19%	24%
Louisiana	26%	23%	24%
Maine	17%	25%	23%
Michigan	21%	19%	19%
Missouri	43%	27%	33%
Mississippi	58%	46%	50%
Montana	24%	23%	24%
North Carolina	50%	34%	40%
North Dakota	40%	33%	36%
Nebraska	49%	33%	39%
New Hampshire	13%	14%	14%

https://www.cms.gov/newsroom/fact-sheets/2021-marketplace-special-enrollment-period-report-3

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New Mexico	36%	23%	28%
Ohio	22%	14%	17%
Oklahoma	58%	26%	38%
Oregon	13%	15%	14%
South Carolina	47%	28%	35%
South Dakota	36%	27%	31%
Tennessee	45%	29%	36%
Texas	51%	27%	35%
Utah	47%	38%	41%
Virginia	35%	31%	33%
Wisconsin	25%	24%	25%
West Virginia	15%	12%	13%
Wyoming	50%	36%	43%
HealthCare.gov States Total	44%	30%	34%

of \$10 or less after APTC. Does not include returning consumers who had a premium of \$10 or less after APTC prior to April 1, 2021.

Glossary

New Plan Selections: The number of unique consumers who didn't have an active enrollment as of February 14, 2021, and made a plan selection on or after February 15, 2021, that is active as of the end of the reporting period. An active plan selection is one that is non-cancelled with an end date of December 31, 2021. While this plan selection metric is net of cancellations and terminations that occur during the reporting period, it doesn't represent effectuated enrollments because reconciliation activity may continue in later periods.

HealthCare.gov States: This report refers to the 36 states with Marketplaces that use the HealthCare.gov platform for the 2021 coverage year. The 36 states for 2021 include: Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

New Consumers Requesting Coverage on an Application Submitted on or after February 15: The number of unique consumers who submitted an application and are requesting coverage on or after February 15, 2021, and didn't have an active enrollment as of February 14, 2021. If determined eligible for Marketplace coverage, a consumer still needs to pick a health plan (i.e., plan selection) and pay their premium to have coverage (i.e., effectuate enrollment).

Marketplace Eligible: The number of unique new consumers requesting coverage on an application submitted on or after February 15, 2021 who are determined eligible to enroll in a Marketplace health plan, regardless of whether they applied for or are eligible for financial assistance.

Medicaid/CHIP Eligible: The number of unique new consumers requesting coverage on an application submitted on or after February 15, 2021 who are assessed or determined eligible for enrollment in Medicaid or the Children's Health Insurance Program (CHIP).⁵

Call Center Volume: The total number of calls received by the Marketplace call center, which supports HealthCare.gov, over the course of the reporting period. Calls with Spanish-speaking representatives are not included.

Calls with Spanish-Speaking Representative: The total number of calls received by the Marketplace call center, which supports HealthCare.gov, where consumers chose to speak with a Spanish-speaking representative over the course of the reporting period. These calls are not included in the Call Center Volume metric.

⁵ Individuals are generally identified in this report as eligible for either a QHP or Medicaid/CHIP, but there are cases where a consumer is considered eligible for both types of coverage or neither. As a result, the eligibility breakouts do not sum to the total number of consumers requesting coverage on applications submitted.

<u>HealthCare.gov</u> Users or <u>CuidadoDeSalud.gov</u> Users: These user metrics total how many unique users viewed or interacted with <u>HealthCare.gov</u> or <u>CuidadoDeSalud.gov</u>, respectively, over the course of the reporting period.

Window Shopping HealthCare.gov Users or CuidadoDeSalud.gov Users: These user metrics total how many unique users interacted with the window-shopping tool at <u>HealthCare.gov</u> or <u>CuidadoDeSalud.gov</u>, respectively, over the course of the reporting period. Users who window- shopped are also included in the <u>HealthCare.gov</u> or <u>CuidadoDeSalud.gov</u> user

total.

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Fact sheet

Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Proposed Rule

Jun 28, 2021 Billing & payments

In the Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond proposed rule released today, the Centers for Medicare & Medicaid Services (CMS) proposed standards for issuers, Exchanges, and Navigators. This rule is a continuation of the recent rulemaking process, as seen in <u>part 1</u> and <u>part 2</u> of the Health & Human Services (HHS) Notice of Benefit and Payment Parameters for 2022 final rule published on January 19 and May 5, 2021.

Overall, the proposed rule would expand access to health insurance coverage through the Exchanges by lengthening the annual open enrollment period, expanding Navigator duties, and minimizing burden and confusion for consumers. These changes further the Biden-Harris Administration's goals of providing greater access to coverage, improving affordability for consumers, and reducing burden for issuers and consumers.

Improving Access to Coverage

Navigator Duties

The Federally-facilitated Exchange (FFE) Navigator Program reaches vulnerable and underserved populations and is important to increasing awareness of coverage options available through the Exchanges, helping new consumers find affordable coverage that meets their needs, and narrowing health disparities. We propose to reinstate previous requirements that FFE Navigators provide consumers with information and assistance on post-enrollment topics, such as the eligibility appeals process, the Exchange-related components of the premium tax credit reconciliation process, and the basic concepts and rights of health coverage and how to use it. In addition, we propose to expand the interpretation of what activities are encompassed in the duty to provide consumers with information and assistance related to the basic concepts and rights of health coverage and how to use it.

2022 Open Enrollment

We are proposing_an extension of the annual individual market open enrollment period for 2022 and future benefit years to allow consumers more time to review plan choices, seek in-person assistance, and enroll in a plan that best meets their needs. We are proposing to amend the dates of the upcoming annual open enrollment period for all individual market Exchanges and off-Exchange individual market plans to November 1, 2021-January 15, 2022, and to apply these dates to future benefit years after 2022.

Monthly Special Enrollment Period (SEP) for Consumers with Household Income up to 150% of the Federal Poverty Level

To provide more opportunities for certain low-income consumers to access premium-free or very low-cost coverage made available by the American Rescue Plan Act of 2021, we are proposing to provide Exchanges the option to implement a monthly SEP for advance payments of the premium tax credit (APTC)-eligible consumers with a household income no greater than 150% of the federal poverty level.

<u>Federally-facilitated Exchange and State-based Exchange on the Federal Platform (SBE-FP) User Fees</u>

For the 2022 benefit year, we propose to increase the FFE user fee rate to 2.75% of premiums and the SBE-FP user fee rate to 2.25% of premiums. This increase from the rates currently finalized in part 1 of the 2022 Payment Notice – 2.25% and 1.75%, respectively – would account for an increase in funding for consumer information and outreach and the FFE Navigator program. These proposed rates are still lower than the current 2021 benefit year user fee rates.

Ensuring Affordability

SEP Clarification

To ensure consistent application of SEPs based on APTC eligibility across the Exchanges, we propose to clarify that, for purposes of the § 155.420 SEPs, an enrollee with a maximum APTC amount of zero dollars is not considered APTC-eligible, and an enrollee is not considered newly APTC-eligible when they become eligible for zero APTC after having

8/10/2021

1 Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and B...

previously been APTC-ineligible for another reason, such as having other minimum

essential coverage. This clarification will mitigate the potential risk of inconsistent interpretation of this eligibility requirement across different Exchanges and other stakeholder groups, such as agents, brokers, and Exchange enrollment assisters.

Separate Billing

We propose repealing the separate-billing regulation that requires individual market qualified health plan (QHP) issuers to send a separate bill for that portion of a policyholder's premium attributable to coverage for abortion services for which federal funding is prohibited, and to instruct such policyholders to pay for the separate bill in a separate transaction. Specifically, we propose to revert to and codify prior policy finalized in the preamble of the 2016 payment notice under which QHP issuers offering coverage of abortion services for which federal funding is prohibited have flexibility in selecting a method to comply with the separate-payment requirement under section 1303 of the Affordable Care Act (ACA). We believe the proposed changes offer issuers options for meaningful compliance with section 1303 of the ACA without imposing the operational and administrative burdens of the separate-billing policy, and without causing additional consumer confusion and loss of coverage.

State Options

Exchange Direct Enrollment Option Repeal

We propose to repeal the Exchange Direct Enrollment option. This option permits a state Exchange, SBE-FP, or an FFE state to facilitate enrollment of qualified individuals into individual market QHPs primarily through private-sector direct enrollment entities, including QHP issuers and web brokers, as well as agents and brokers. Under current regulations, this option will be available to state Exchanges beginning in plan year 2022, and to SBE-FP and FFE states beginning in plan year 2023. We believe repealing the Exchange Direct Enrollment option will best support the health care priorities of the Biden-Harris Administration. Since no state has yet expressed interest in implementing the Exchange Direct Enrollment option, we also believe that repealing it now will mitigate potential impacts to stakeholders.

Section 1332 State Innovation Waiver Policies

HHS and the Department of the Treasury (collectively, the Departments) propose modifications to section 1332 State Innovation Waivers implementing regulations, including changes to many of the policies and interpretations of the statutory guardrails recently 8/10/2021

Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and B...

codified in part 1 of the 2022 payment notice final rule, as well as new information

regarding the process for amendments and extensions of approved section 1332 waivers. The changes in the rule, if finalized, would supersede and replace those outlined in the October 2018 "State Relief and Empowerment Waivers" guidance, and repeal the previous codification of *those* guardrail interpretations in part 1 of the 2022 payment notice final rule. The Departments also propose to modify regulations to set forth flexibilities in the public-notice requirements and post-award public participation requirements for section 1332 State Innovation Waivers under future emergent situations, if certain criteria are met. The Departments also propose in this rule processes and procedures for amendments and extensions for approved waiver plans. Through section 1332 waivers, the Departments aim to assist states with developing health insurance markets that expand coverage, lower costs, and ensure that health care truly is accessible for all Americans.

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June 5, 2021

HP-2021-13

Health Coverage Under the Affordable Care Act: Enrollment Trends and State Estimates

Based on enrollment data from late 2020 and early 2021, approximately 31 million people were enrolled in Marketplace or Medicaid expansion coverage related to provisions of the Affordable Care Act (ACA), the highest total on record.

KEY POINTS

- The Affordable Care Act (ACA) created new pathways to coverage via health insurance Marketplaces and Medicaid expansion in participating states, which both took effect beginning in 2014.
- As of the most recently available administrative data, 11.3 million consumers were enrolled in Marketplace plans as of February 2021, and 14.8 million people were newly enrolled in Medicaid via the ACA's expansion of eligibility to adults as of December 2020. In addition, 1 million individuals were enrolled in the ACA's Basic Health Program option, and nearly 4 million previously-eligible adults gained coverage under the Medicaid expansion due to enhanced outreach, streamlined applications, and increased federal funding under the ACA.
- Across these coverage groups, 31 million Americans were enrolled in coverage related to the ACA, representing the highest total on record.
- In addition, the ACA also enables young adults to stay on their parents plans until age 26, and more than 1 million new consumers have signed up for Marketplace plans during the 2021 Special Enrollment Period since February 15, 2021.
- All 50 states and the District of Columbia have experienced substantial reductions in the uninsured rate since 2013, the last year before full implementation of the ACA.

OVERVIEW

The enactment of the Affordable Care Act (ACA) in 2010¹ was the largest expansion of coverage in the U.S. health care system since the passage of Medicare and Medicaid in 1965. A comprehensive health care reform law, the ACA expanded health insurance coverage to millions of Americans through two main pathways:

- Providing tax credits to consumers with incomes between 100% and 400% of the federal poverty level (FPL) to lower the cost of individual market health insurance purchased through new state Marketplaces;² and
- Expanding Medicaid eligibility to adults with incomes up to 138% FPL, in participating states.³

The ACA also invested in outreach to help eligible individuals enroll in coverage and streamlined the application process for Medicaid.

The impact of the ACA on the number of uninsured Americans has been substantial. Between 2010 and 2016 the number of nonelderly uninsured adults decreased by 41 percent, falling from 48.2 million to 28.2 million.⁴ This Issue Brief presents current estimates of enrollment in health insurance coverage obtained through the ACA Marketplaces and the Medicaid expansion and the subsequent reductions in state-level uninsured rates since the ACA was implemented in 2014.

METHODS

For both Marketplace and Medicaid expansion enrollment, we present the most recent administrative data with state-by-state totals from the Centers for Medicare & Medicaid Services (CMS), as well as historical national totals for the years 2014-2020.

Current Marketplace enrollment estimates are for February 2021 coverage and reflect effectuated enrollment counts calculated using the number of individuals with an active policy at any point during that month who had paid their first month's premium, if applicable. Effectuated enrollment totals are included from both States with Marketplaces using the HealthCare.gov platform and those with State-based Marketplaces.

Medicaid enrollment estimates are state-reported counts of unduplicated individuals enrolled in the state's Medicaid program through the Medicaid Budget and Expenditure System (MBES). The most recent Medicaid enrollment data are from December 2020. For states that have expanded Medicaid, the enrollment data provide specific counts for the number of individuals enrolled in the new expansion adult eligibility group, referred to as the "adult group," with separate totals for those who became newly eligible under the ACA expansion, as well as those who would have been eligible for coverage prior to the ACA but are now part of the adult group. State Medicaid expenditure reports are generally submitted to CMS within 30 days following the end of each quarter. Some states, however, submit their expenditure reports later; accordingly, these results should be considered preliminary.

Minnesota and New York have also implemented the Basic Health Program (BHP) option under the ACA to cover individuals with incomes between 138-200% FPL. We report annual average BHP enrollment, as reported to CMS by the states.

Estimates on the uninsured come from the American Community Survey (ACS), the largest national survey of households. The Census Bureau surveys almost 300,000 households each month for the ACS and collects health insurance and demographic data, along with other types of information. Uninsured rates for the full state population of all ages come from the ACS's public data tables for 2013 and 2019 (the most current year of ACS data available), which we used to compare state-by-state changes in uninsured rates since the implementation of the ACA.⁵

RESULTS

Figure 1 and Table 1 present national ACA-related enrollment for 2014-2021. As of February 2021, 11.3 million consumers had enrolled and effectuated health insurance coverage through the Marketplaces. This estimate does not include individuals who have signed up for coverage during the COVID Special Enrollment Period (SEP) for HealthCare.gov that began on February 15, 2021, and runs through August 15, 2021. Since the SEP began and new outreach funds were also made available, over 1 million additional consumers have signed up for a health plan through HealthCare.gov.⁶ This total does not include any impact from expanded SEP opportunities offered by the 15 State-Based Marketplaces in 2021.

At the close of 2020, an estimated 14.8 million newly-eligible adults were enrolled in Medicaid coverage through the adult group created by the ACA expansion, as shown in Table 1. An additional estimated 3.9 million people were enrolled in the Medicaid expansion adult group under the ACA who would have been eligible for Medicaid before the ACA. The ACA, however, simplified Medicaid enrollment for these individuals and made permanent under federal law some state-specific coverage expansions that pre-dated the ACA (e.g., coverage under a section 1115 demonstration project). To date, 37 states and the District of Columbia have adopted the ACA Medicaid expansion of coverage to adults.⁷

Two states – Minnesota and New York – have also implemented the Basic Health Program (BHP) option under the ACA, with enrollment totaling approximately 1.0 million in early 2021.

Taken together, these results indicate that overall enrollment in Marketplace coverage, Medicaid expansion, and the Basic Health Program for 2021 was approximately 31 million people, the highest enrollment total since the ACA was enacted.



Figure 1. ACA-Related Enrollment: Marketplace, Medicaid Expansion, and the Basic Health Program, 2014-2021

Note: See Table 1 for additional details on time frame and definition for each enrollment category.

Year	Marketplace Enrollment*	Medicaid Expansion Group, Newly-Eligible#	Medicaid Expansion Group, Previously Eligible	BHP Enrollment†	TOTAL
2014	6,337,860	4,214,218	2,047,055	0	12,599,133
2015	10,187,197	9,103,944	3,002,271	358,000	22,651,412
2016	11,115,044	11,135,415	3,473,065	654,000	26,377,524
2017	10,330,759	12,229,576	3,524,856	772,000	26,857,191
2018	10,643,786	12,338,135	3,305,210	798,000	27,085,131
2019	10,579,744	12,201,118	3,247,188	833,000	26,861,050
2020	10,673,516	12,300,921	3,241,535	866,000	27,081,972
2021	11,290,546	14,849,998	3,890,934	961,000	30,992,478

Table 1. ACA-Related Enrollment: Marketplace, Medicaid, and the Basic Health Program (BHP), 2014-2021

Notes:

* Marketplace effectuated enrollment figures for 2014 and 2015 are as of 12/31/2014 and 3/31/2015 respectively, versus February coverage as of 3/15 for 2016-2021. Marketplace enrollment data for 2014-2015 are lower quality due to the manual payment processing system in place for those years. 2014 and 2015 Marketplace enrollment figures are published here:

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-

<u>Products/Effectuated Quarterly Snapshots</u>. February 2016-2021 data are from the CCIIO Enrollment Payment System and beginning in 2017 have been published in the Effectuated Enrollment Snapshot for the respective year.

Medicaid enrollment data, 2014-2020, are from the February monthly enrollment (ever enrolled during the month) for the expansion adult eligibility group, as reported by states through the Medicaid Budget and Expenditure System (MBES). 2021 Medicaid enrollment data are from December 2020 monthly enrollment, as this is the most recent available monthly enrollment count from MBES. Published reports and detailed data information for Medicaid enrollment data, including caveats, can be found at: https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/medicaid-enrollment-data-collected-through-mbes/index.html

† BHP programs did not start until 2015. BHP enrollment data are based on average monthly (for Minnesota) or quarterly (for New York) projected enrollment submitted by the states to CMS in advance of the applicable quarter and are rounded to the nearest thousand. BHP enrollment data for 2021 is through May 2021.

Table 2 presents enrollment estimates by state for Marketplace and Medicaid coverage, plus uninsured rates before and after the ACA. Figure 2 illustrates the percentage change in the uninsured rate from 2013-2019 for each state. Nationally, the uninsured rate has decreased 5.3 percentage points (from 14.5% to 9.2%) since the ACA coverage provisions were implemented in 2014. All states experienced reductions in their uninsured rates, with 7 states – CA, KY, NY, OR, RI, WA, WV, all of which expanded Medicaid – reducing their uninsured rate by at least half. The uninsured rate in 2019 varied widely across the country. Massachusetts had the lowest uninsured rate at 3.0% and experienced one of the smaller relative reductions under the ACA because it had already implemented large coverage expansions prior to 2014. Texas had the highest uninsured rate at 18.4%. State decisions regarding the ACA Medicaid expansion are a main driver of this variability. The Census Bureau's gold-standard estimates of the uninsured population, which come from the ACS, are not yet available for 2020.

The ACA is a wide-ranging law, and these estimates are a conservative estimate of the law's impact on health insurance coverage for several reasons. First, the total does not include the impact of the COVID Special Enrollment Period in 2021. Second, the total does not include the provision of the ACA that took effect in 2010 allowing young adults to remain on their parents' plans until age 26, which previous research estimated led to more than 2 million young adults gaining insurance.⁸ Finally, the streamlining of Medicaid applications, enhanced outreach, and expanded eligibility led to increased enrollment even among children and parents who were eligible for Medicaid through traditional pre-expansion pathways, a phenomenon referred to as the "welcome mat" effect. Thus, 31 million likely underestimates the total effect of the ACA on coverage.

Table 2: Marketplace Enrollment, Medicaid Expansion Enrollment, and Uninsured Rates by State

Evrollment, Newly Elighle, Jebrury 2021* December 2020# 2013 2019 Alabama 159,136 N/A 13.6 9.7 Alaska 16,780 63,339 18.5 12.2 Arkona 143,964 164,269 17.1 11.3 Arkonsa 60,258 306,497 16.0 9.1 Colorado 151,342 479,375 14.1 8.0 Connecticut 95,713 280,326 9.4 5.9 Delaware 23,889 10,994 9.1 6.6 District of Columbia 15,822 7.856 6.7 3.5 Florida 20,19,631 N/A 18.8 13.4 Hawali 20,191 24,869 6.7 4.2 Idano 66,422 89,933 16.2 10.8 Indiana 124,979 447,750 14.0 8.7 Idwa 5,580 17,7317 8.1 5.0 Kansas 82,771 <td< th=""><th>State</th><th>Marketplace Effectuated</th><th>Medicaid Expansion,</th><th colspan="2">Uninsured Rate (%)†</th></td<>	State	Marketplace Effectuated	Medicaid Expansion,	Uninsured Rate (%)†	
February 2021* December 2020# 2013 2019 Alabana 159,136 N/A 13.6 9.7 Alaska 16,780 63,539 18.5 12.2 Artznaa 143,964 164,269 17.1 11.3 Artznas 60,258 306,497 16.0 9.1 Calfornia 1,583,781 40,074,553 17.2 7.7 Colorado 16,1,342 479,375 14.1 8.0 Connecticut 95,713 280,326 9.4 5.9 District of Columbia 15,822 72,856 6.7 4.2 Idaho 66,422 89,933 16.2 10.8 Idaho 66,422 89,933 16.2 10.8 Idaho 20,18,631 N/A 12.0 8.7 Idava 21,47,97 447,750 14.0 8.7 Idava 20,193 74,859 15.0 10.8 Illinois 20,437 77,817 8.1 5.0		Enrollment,	Newly Eligible,		
Akbama 159,136 N/A 13.6 9.7 Alaska 16780 65,539 18.5 12.2 Arkonsa 143,964 164,269 17.1 11.3 Arkansa 60,258 306,497 16.0 9.1 California 1,583,781 4,074,553 17.2 7.7 Connecticut 95,213 280,226 9.4 5.9 Delaware 23,889 10,994 9.1 6.6 District of Columbia 15,822 72,856 6.7 3.5 Florida 2,018,631 N/A 18.8 13.4 Hawaii 20,011 24,869 6.7 4.2 Idaho 66,422 89,933 16.2 10.8 Illinois 270,823 703,749 12.7 7.4 Indiare 124,979 447,750 14.0 8.7 Iowa 54,820 177,817 8.1 5.0 Kansas 82,971 N/A 12.2 8.0 <th></th> <th>February 2021*</th> <th>December 2020#</th> <th>2013</th> <th>2019</th>		February 2021*	December 2020#	2013	2019
Alaska 16,780 63,539 18.5 1.2.2 Arizona 143,964 164,676 17.1 11.3 Arkanass 60,258 306,497 16.0 9.1 California 1,583,781 4,074,553 17.2 7.7 Colorado 161,142 473,375 14.1 8.0 Connecticut 95,213 280,326 9.4 5.9 Delavare 23,889 10,994 9.1 6.6 District of Columbia 15,82,2 72,856 6.7 3.5 Florida 2,018,631 N/A 18.8 13.4 Hawaii 20,011 24,866 6.7 4.2 Idaho 66,422 89,933 16.2 10.8 Illinois 270,823 703,749 12.7 7.4 Iowa 54,820 177,171 8.1 5.0 Kanasa 82,971 N/A 12.3 9.2 Kentucky 70,680 512,712 14.4 8.0 <td>Alabama</td> <td>159,136</td> <td>N/A</td> <td>13.6</td> <td>9.7</td>	Alabama	159,136	N/A	13.6	9.7
Arizona 143,964 164,269 17.1 11.3 Arkansas 60,258 306,647 16.0 9.1 California 1,583,781 4,074,553 17.2 7.7 Colorado 161,342 473,375 14.1 8.0 Connecticut 95,213 280,326 9.4 5.9 Delaware 23,889 10,994 9.1 6.6 District of Columbia 15,822 72,856 6.7 3.5 Florida 2,018,631 N/A 18.8 13.4 Hawaii 20,191 24,869 6.7 4.2 Idaho 66,422 89,933 16.2 10.8 Illinois 270,823 703,749 12.7 7.4 Indiana 124,979 447,750 14.0 8.7 Kansas 82,971 N/A 12.3 9.2 Kentuky 70,680 612,712 14.3 6.4 Lousiana 75,289 56,615 10.2 6.0<	Alaska	16,780	63,539	18.5	12.2
Arkanss 60,258 306,497 16.0 9.1 California 15,83,781 4,074,553 17.2 7.7 Colorado 161,342 479,375 14.1 8.0 Connecticut 95,213 280,325 9.4 5.9 Delaware 23,889 10,994 9.1 6.6 District of Columbia 15,822 72,856 6.7 3.5 Florida 2,018,631 N/A 18.8 13.4 Hawaii 2,019 24,869 6.7 4.2 Idaho 66,422 89,933 16.2 10.8 Illinois 270,823 703,749 12.7 7.4 Indiana 124,979 447,750 14.0 8.7 Iowa 54,820 177,817 8.1 5.0 Kentucky 70,680 612,712 14.3 6.4 Louisian 75,829 596,87 10.6 8.9 Maryland 154,815 366,815 10.2 6.0<	Arizona	143,964	164,269	17.1	11.3
California 1,583,781 4,074,553 17.2 7.7 Colorado 161,342 479,375 14,1 8.0 Connecticut 95,213 280,326 9.4 5.9 Delaware 23,889 10,994 9.1 6.6 District of Columbia 15,822 72,856 6.7 3.5 Florida 20,18,631 N/A 18.8 13.4 Hawaii 20,191 24,869 6.7 4.2 Idaho 66,422 89,933 16.2 10.8 Illinois 270,823 703,749 12.7 7.4 Indiana 124,979 447,750 14.40 8.7 Iowa 54,820 17,7117 8.1 5.0 Kansas 82,971 N/A 12.3 9.2 Kentucky 70,680 612,712 14.3 6.4 Louisian 76,289 598,589 16.6 8.9 Maryand 154,815 366,815 10.2 6.0 <td>Arkansas</td> <td>60,258</td> <td>306,497</td> <td>16.0</td> <td>9.1</td>	Arkansas	60,258	306,497	16.0	9.1
Colorado 16.1.342 479.375 14.1 8.0 Connecticut 95.213 280.326 9.4 5.9 Delaware 23.889 10.994 9.1 6.6 District of Columbia 15.822 72.856 6.7 3.5 Florida 20.18,631 N/A 20.0 13.2 Georgia 482,350 N/A 18.8 13.4 Hawaii 20.191 24,869 6.7 4.2 Idaho 66.422 89.933 16.2 10.8 Illinois 270,823 703,749 12.7 7.4 Iowa 54.820 177,817 8.1 5.0 Kansas 82,971 N/A 12.3 9.2 Kentucky 70,680 512,712 14.3 6.4 Louisiana 76,289 59.8589 16.6 8.9 Maryland 154,815 366,815 10.2 6.0 Massachusetts 259,677 0 3.7 3.0 <td>California</td> <td>1,583,781</td> <td>4,074,553</td> <td>17.2</td> <td>7.7</td>	California	1,583,781	4,074,553	17.2	7.7
Connecticut 95,213 200,326 9.4 5.9 Delaware 23,889 10,994 9.1 6.6 District of Columbia 15,822 72,855 6.7 3.5 Florida 20,18,631 N/A 18.8 13.4 Hawaii 20,191 24,869 6.7 4.2 Idaho 66,422 89,933 16.2 10.8 Illinois 270,823 703,749 12.7 7.4 Indiana 124,979 447,750 14.0 8.7 Iowa 54,820 177,817 8.1 5.0 Kansas 82,971 N/A 12.3 9.2 Kentucky 70,680 66,21 10.8 10.2 6.0 Maine 55,502 57,803 11.2 8.0 0 3.7 3.0 Michigan 249,353 810,068 11.0 5.8 3.3 10.0 10.0 Mississippi 99,897 N/A 17.1 13.0	Colorado	161,342	479,375	14.1	8.0
Delaware 33.89 10.994 9.1 6.6 District of Columbia 15.822 72,856 6.7 3.5 Florida 2,018,631 N/A 20.0 13.2 Georgia 482,350 N/A 18.8 13.4 Hawali 20.191 24,869 6.7 4.2 Idaho 66,422 89,933 16.2 10.8 Illinois 270,823 70,3749 12.7 7.4 Indiana 124,979 447,750 14.0 8.7 Iowa 54,820 177,817 8.1 5.0 Kantucky 70,680 612,712 14.3 6.4 Louisiana 75,520 57,603 11.2 8.0 Marine 55,502 57,803 11.0 5.8 Mininesota ¹ 106,138 229,649 8.2 4.9 Mississipi 99,897 N/A 17.1 13.0 Mississipi 99,897 N/A 13.3 8.3 <td>Connecticut</td> <td>95,213</td> <td>280,326</td> <td>9.4</td> <td>5.9</td>	Connecticut	95,213	280,326	9.4	5.9
District of Columbia 15,822 72,856 6.7 3.5 Florida 2,018,631 N/A 18.8 13.4 Hawaii 20,191 24,869 6.7 4.2 Idaho 66,422 89,933 16.2 10.8 Illinois 270,873 703,749 12.7 7.4 Indiana 124,979 447,750 14.0 8.7 Iowa 54,820 177,817 8.1 5.0 Kansas 82,971 N/A 12.3 9.2 Kentucky 70,680 66,27.12 14.3 6.4 Louisiana 76,289 598,589 16.6 8.9 Mariand 154,815 366,6815 10.2 6.0 Massachusetts 259,677 0 3.7 3.0 Michigan 249,353 810,068 11.0 5.8 Minesota ¹ 106,188 229,649 8.2 4.9 Mississippi 99,897 N/A 13.0 10.0	Delaware	23.889	10.994	9.1	6.6
Florida 2,018,631 N/A 20.0 13.2 Georgia 482,350 N/A 18.8 13.4 Hawali 20,191 24,669 6.7 4.2 Idaho 66,422 89,933 16.2 10.8 Illinois 270,823 703,749 12.7 7.4 Indiana 124,979 447,750 14.0 8.7 Iowa 54,820 177,817 8.1 5.0 Kansas 82,971 N/A 12.3 9.2 Kentucky 70,680 612,712 14.3 6.4 Louisiana 76,289 598,589 16.6 8.9 Maryland 154,815 366,815 10.2 6.0 Marsachusetts 259,677 0 3.7 3.0 Minesota³ 106,138 229,649 8.2 4.9 Mississippi 9,9897 N/A 17.1 13.0 Mississippi 9,987 N/A 17.1 13.0 N	District of Columbia	15.822	72.856	6.7	3.5
Georgia 482,350 N/A 18.8 13.4 Hawaii 20,191 24,869 6.7 4.2 Idaho 66,422 89,933 16.2 10.8 Illinois 270,823 703,749 12.7 7.4 Iowa 54,820 177,817 8.1 5.0 Kansas 82,971 N/A 12.3 9.2 Kentucky 70,680 612,712 14.3 6.4 Louisiana 76,289 598,589 16.6 8.9 Marie 55,502 57,803 11.2 8.0 Maryland 154,815 366,815 10.2 6.0 Michigan 249,333 810,068 11.0 5.8 Missispipi 99,897 N/A 17.1 13.0 Motissauri 200,588 N/A 13.0 10.0 Motanea 41,842 100,485 16.5 8.3 New Hampshire 44,228 69,814 10.7 6.3	Florida	2.018.631	N/A	20.0	13.2
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Illinois D70,823 T03,749 12.7 7.4 Indiana 124,979 447,750 14.0 8.7 Iowa 54,820 177,817 8.1 5.0 Kansas 82,971 N/A 12.3 9.2 Kentucky 70,680 612,712 14.3 6.4 Louisiana 76,289 598,589 16.6 8.9 Maine 55,502 57,803 11.2 8.0 Maryland 154,815 366,815 10.2 6.0 Massachusetts 259,677 0 3.7 3.0 Milinesota ¹ 106,138 229,649 8.2 4.9 Missouri 200,588 N/A 13.0 10.0 Montana 41,842 100,485 16.5 8.3 Nevada 79,976 275,436 20.7 11.4 New Hampshire 44,228 69,814 10.7 6.3 New Jersey 257,819 622,526 13.2 7.9	Idaho	66 422	89 933	16.2	10.8
Indiana 124,979 147,750 14.0 8.7 Iowa 54,820 177,817 8.1 5.0 Kansas 82,971 N/A 12.3 9.2 Kentucky 70,680 612,712 14.3 6.4 Louisiana 76,289 598,589 16.6 8.9 Marine 55,502 57,803 11.2 8.0 Maryland 154,815 366,815 10.2 6.0 Massachusetts 259,677 0 3.7 3.0 Michigan 249,353 810,068 11.0 5.8 Minnesota ¹ 106,138 229,649 8.2 4.9 Missispipi 99,897 N/A 17.1 13.0 Missouri 200,588 N/A 13.0 10.0 Montana 41,842 100,485 16.5 8.3 Newada 79.976 275,436 20.7 11.4 New Hampshire 44,228 69,814 10.7 6.3 <td>Illinois</td> <td>270 823</td> <td>703 749</td> <td>12.7</td> <td>7 4</td>	Illinois	270 823	703 749	12.7	7 4
Invarian Invariant Invariant <thinvariant< th=""> Invariant <thinvariant< th=""> <thinvariant< th=""> <thinv< td=""><td>Indiana</td><td>124 979</td><td>447 750</td><td>14.0</td><td>87</td></thinv<></thinvariant<></thinvariant<></thinvariant<>	Indiana	124 979	447 750	14.0	87
NNA Disc Disc Disc Disc Disc Disc Kansas 82,971 N/A 12.3 9.2 Kentucky 70,680 612,712 14.3 6.4 Louisiana 76,289 598,589 16.6 8.9 Maine 55,502 57,803 11.2 8.0 Maryand 154,815 366,815 10.2 6.0 Massachusetts 259,677 0 3.7 3.0 Michigan 249,353 810,068 11.0 5.8 Minesota ¹ 106,138 229,649 8.2 4.9 Mississippi 99,897 N/A 13.0 10.0 Motana 41,842 100,485 16.5 8.3 Nebraska 83,275 27,938 11.3 8.3 New Jersey 257,819 622,526 13.2 7.9 New Hersico 38,922 285,557 18.6 10.0 New York ² 197,083 395,785	lowa	54 820	177 817	81	5.0
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Name Product Product <thproduct< th=""> <thproduct< th=""> <thprod< td=""><td>Kentucky</td><td>70 680</td><td>612 712</td><td>14.3</td><td>5.2 6.4</td></thprod<></thproduct<></thproduct<>	Kentucky	70 680	612 712	14.3	5.2 6.4
Doublinity Triangle for the second seco	Louisiana	76,289	598 589	16.6	8 G
Mane D,D2 D,D3 112 0.0 Maryland 154,815 366,815 10.2 6.0 Massachusetts 259,677 0 3.7 3.0 Michigan 249,353 810,068 11.0 5.8 Minnesota ¹ 106,138 229,649 8.2 4.9 Mississippi 99,897 N/A 17.1 13.0 Missouri 200,588 N/A 13.0 10.0 Montana 41,842 100,485 16.5 8.3 Nebraska 83,275 27,938 11.3 8.3 New Hampshire 44,228 69,814 10.7 6.3 New Jersey 257,819 622,526 13.2 7.9 New Mexico 38,922 28,557 18.6 10.0 New York ² 197,083 395,785 10.7 5.2 North Carolina 501,252 N/A 15.6 11.3 North Carolina 161,639 N/A 17.7 <	Maine	55 502	57 803	11.0	8.0
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Interset 125,07 10 1.7 5.8 Michigan 249,353 810,068 11.0 5.8 Minnesota ¹ 106,138 229,649 8.2 4.9 Mississippi 99,897 N/A 17.1 13.0 Missouri 200,588 N/A 13.0 10.0 Montana 41,842 100,485 16.5 8.3 Nebraska 83,275 27,938 11.3 8.3 New Hampshire 44,228 69,814 10.7 6.3 New Harsey 257,819 622,526 13.2 7.9 New Mexico 38,922 285,557 18.6 10.0 New York ² 197,083 395,785 10.7 5.2 North Carolina 501,252 N/A 15.6 11.3 North Dakota 21,822 22,864 10.4 6.9 Ohio 187,869 561,735 11.0 6.6 Oklahoma 161,639 N/A 17.7 <t< td=""><td>Massachusetts</td><td>259 677</td><td>0</td><td>2 7</td><td>3.0</td></t<>	Massachusetts	259 677	0	2 7	3.0
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		20,313	N/A	13.4	12.3

Notes:

1 - Minnesota has also created a Basic Health Program (BHP) under the ACA, which had 104,125 enrollees as of April-May 2021.

2 - New York has also created a BHP under the ACA, which had 898,891 enrollees as of April-May 2021.

* Marketplace Data: Effectuated enrollment, which is a count of individuals with an active policy at any point in the month of February 2021, who had paid their first month's premium, if applicable, as of March 15, 2021.

Medicaid Data: Monthly enrollment of newly eligible population as reported in December 2020 on the CMS-64, updated in May 2021. Awaiting state reporting, enrollment reasonableness review is in progress. Enrollment only applicable for states that have expanded their Medicaid programs to Adults with incomes up to 138% FPL (the "adult group"). For the states that have not expanded Medicaid their enrollment is noted as "N/A." Massachusetts and Vermont already offered subsidized coverage to those with incomes below 138% FPL, so they are listed as having 0 newly-eligible adults, even though they have implemented the ACA's Medicaid expansion.

⁺ Uninsured Rates: American Community Survey, "Health Insurance Coverage Status and Type of Coverage by State and Age for All People", 2013,2019: <u>https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.2013.html</u> <u>https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.2019.html</u>



Figure 2: Relative Reduction in the Uninsured Rate by State, 2013 to 2019

Notes:

Percent change based on uninsured rate for the full population (all ages) in each state, comparing 2013 to 2019. See Table 2 for additional details.

ENDNOTES

¹ As amended by the Health Care and Education Reconciliation Act of 2010.

² Individuals with incomes greater than 400% FPL can purchase coverage through the Marketplaces but did not originally qualify for subsidies. Under the American Rescue Plan individuals with incomes above 400% FPL are now eligible for subsidies.

³ The ACA established a Medicaid eligibility level of 133% FPL for children, pregnant women, and adults as of January 2014, and included a standard income disregard of five percentage points of the federal poverty level, which effectively raises this limit to 138% FPL Medicaid. ACA Medicaid expansion to adults with incomes up to 133% FPL is a state option, and as of May 2021, 37 states and the District of Columbia had chosen to do so.

⁴ Finegold K, Conmy A, Chu RC, Bosworth A, and Sommers, BD. *Trends in the U.S. Uninsured Population, 2010-2020*. (Issue Brief No. HP-2021-02). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. February 11, 2021. <u>https://aspe.hhs.gov/system/files/pdf/265041/trends-in-the-us-uninsured.pdf</u>

⁵ Census Bureau, American Community Survey, Health Insurance Coverage Status and Type of Coverage by State and Age for All People, 2013, 2019 <u>https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.2013.html</u> <u>https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.2019.html</u>

⁶ HHS, May 11, 2021 Statement by HHS Secretary Xavier Becerra on One Million Sign-Ups on HealthCare.gov During Special Enrollment Period [Press Release] <u>https://www.hhs.gov/about/news/2021/05/11/statement-by-hhs-secretary-xavier-becerra-on-one-million-sign-ups-on-healthcare-during-special-enrollment-period.html</u>

⁷ Oklahoma voters approved a ballot initiative in 2020 to expand Medicaid. Enrollment in the Medicaid expansion began June 1, 2021 and coverage will begin July 1, 2021. Missouri voters approved a ballot initiative in 2020 to expand Medicaid. Missouri withdrew its State Plan Amendments related to expansion in May 2021.

8 Uberoi, N., Finegold, K., & Gee, E. (March 3, 2016). Health insurance coverage and the Affordable Care Act, 2010-2016. Washington (DC): Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Accessed at: <u>https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf.</u>

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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JAMA Health Forum.

JAMA Forum

Evidence-Based Health Policy in the Biden-Harris Administration

Rebecca L. Haffajee, PhD, JD, MPH; Benjamin D. Sommers, MD, PhD

In its first 6 months, the Biden-Harris Administration has tackled a range of critical health policy challenges. From the outset, the Administration made clear its commitment to science, issuing a memorandum prioritizing scientific integrity and evidence-based policy making. Within the US Department of Health and Human Services (HHS), the Office of the Assistant Secretary for Planning and Evaluation (ASPE) is at the forefront of the effort to use science, data, and evidence to guide policy. Sometimes called HHS's think tank, ASPE and its team of policy analysts, economists, public health professionals, clinicians, and more are tasked with supporting the Secretary of the HHS by providing analysis and evidence to guide the Department's efforts. On a range of policy priorities—including the COVID-19 pandemic and recovery, behavioral health and the drug overdose crisis, health insurance coverage expansion, and the continued reckoning with structural racism and other health care inequities—ASPE has been working to support an evidence-based agenda at the HHS.

Pandemic response has been a top priority since day 1 of the administration, with the HHS playing a central role in coordinating federal health efforts. To support a national vaccination campaign, ASPE has analyzed survey data on COVID-19 vaccine hesitancy, and generated state, county, and local estimates to assist with outreach. This analysis showed a marked reduction in hesitancy rates among young adults and Black people since January 2021, but hesitancy remains a challenge in many regions.¹ Reports describing the disproportionate effect of COVID-19 in communities of color have helped highlight the need for targeted efforts to improve health equity in the pandemic response.² In addition, ASPE has tracked some of the less direct but still sizable effects of the pandemic on health care. Reports examining the large increase in telehealth use in 2020, as well as health spending and utilization during 2020, indicate the degree to which the pandemic created substantial changes in usual patterns of care.³

Another ASPE effort is analyzing evidence on behavioral health and disability during the pandemic and beyond. The office has documented substantially higher rates of COVID-19 and double the mortality rate among Medicare fee-for-service beneficiaries with dementia compared with those without dementia.⁴ Homebound patients have faced acute challenges during COVID-19, as shown in ASPE's work on barriers to vaccine access due to living alone or lacking technology, and workforce shortages that intensified because of reimbursement and safety obstacles. COVID-19 has exacerbated the persistent overdose crisis, which now extends beyond opioids to multiple drugs of concern. ASPE work is at the frontier of these trends, identifying promising state and community efforts to address stimulant use and barriers to effective responses, such as limited knowledge about effective therapies and a dearth of funding for social supports.⁵ And although substance use disorder treatment has increased in recent years, the need for treatment remains high and is growing. ASPE continues to track trends in behavioral health utilization and assess effects of policies such as the HHS buprenorphine prescribing guidelines issued in April 2021, designed to augment the number of prescribers available to deliver opioid use disorder medication treatment.

Another key priority for the Biden-Harris Administration is expanding health insurance coverage. An executive order directed HHS to examine policies related to Medicaid and health insurance Marketplace coverage, and ASPE's work has provided important data in these areas. Evidence reviews on issues such as health insurance churning and state demonstration programs describe some of the challenges in keeping people enrolled in stable coverage over time. Reports on

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coverage trends and ASPE public-use datafiles describe uninsured individuals and where they live, to support outreach efforts for enrollment and research.

Most recently, the provisions of the American Rescue Plan Act of 2021 (ARP) took effect, along with increased HHS funding for "navigators" and outreach to help consumers sign up for health care through the Affordable Care Act (ACA). ASPE analyses show that the ARP's enhanced and expanded subsidies to people obtaining coverage on the Marketplace enable 3 in 5 uninsured consumers and 4 in 5 current enrollees to find a zero-premium plan (after premium tax credits) on HealthCare.gov.⁶ Overall, the Administration has taken a strong evidence-based approach to coverage expansion—through aggressive outreach to consumers combined with improved affordability, both shown by prior research as keys to increasing coverage rates. Most recently, a report indicated that enrollment in coverage related to the ACA—namely Medicaid expansion and Marketplace insurance—had reached 31 million, an all-time high.⁷

Yet concerning disparities remain in access to services as well as health outcomes across populations, making equity a central focus for the administration. President Biden issued an executive order to advance racial equity and support for underserved communities through the federal government, as well as an executive order to ensure an equitable response to COVID-19 response and recovery.

The HHS and other federal agencies are implementing these executive orders. Along with the Assistant Secretary of Health, ASPE co-chairs the HHS Health Disparities Council, which is committed to advancing health equity for all—with an emphasis on groups that have historically been marginalized, including people of color, the LGBTQ+ community, religious minorities, and rural populations. As noted above, ASPE has tracked disparities in COVID-19 rates of infections, hospitalizations, deaths, and vaccinations, showing consistently worse outcomes for communities of color. ASPE has also documented racial and ethnic disparities in economic opportunity during COVID-19, showing that women of color have been particularly hard hit in employment losses and experienced a slower recovery than other groups.⁸ Social determinants of health, including employment and poverty, interrelate to health inequities in important ways; for instance, ASPE has shown that social determinants of health are associated with increased incidence of mental health conditions during COVID-19, and that people with a history of homelessness have greater prevalence of many chronic conditions, such as alcohol and opioid abuse, viral hepatitis, and repeat head injuries.⁹

Using rigorous science and evaluation to guide decision-making in areas of HHS authority is critical to accomplishing administration priorities. In all of HHS's work, having high-quality data is the first step—whether conducting analysis to document disparities or more broadly to inform evidence-based decision-making. A co-chair of the HHS Data Council and home to the Secretary's Patient Centered Outcomes Research Trust Fund, building data capacity and promoting scientific integrity are also key parts of ASPE's role. In all of these areas, ASPE's mission is to serve the Secretary of HHS in providing these science and data-driven insights, to advance sound and meaningful policies.

ARTICLE INFORMATION

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Estimated Plan Enrollment Outcomes After Changes to US Health Insurance Marketplace Automatic Renewal Rules

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Abstract

IMPORTANCE The American Rescue Plan increases premium subsidies for health insurance marketplace enrollees, potentially leading to situations in which enrollees could switch to other health care plans with lower premiums and less cost sharing (ie, deductibles and copayments). Current policy defaults enrollees to their current health care plan if they automatically renew their coverage, which may cause them to stay in health care plans that, because of the American Rescue Plan, are now dominated in that they have higher premiums and cost sharing than other options.

OBJECTIVE To estimate the extent to which a smart default policy could reduce US health insurance marketplace enrollees' cost sharing and premiums.

DESIGN, SETTING, AND PARTICIPANTS Using 2018 individual enrollment data and 2021 premium data from California's marketplace and the American Rescue Plan premium tax credit subsidy schedule, this economic analysis estimated the characteristics of enrollees' default health care plans if they defaulted into 2021 health care plans under current and smart default policies. The analysis was conducted from March 20 to April 8, 2021.

MAIN OUTCOMES AND MEASURES Characteristics of enrollees' default health care plans under current and smart default policies, including net premiums, plan levels, and cost sharing.

RESULTS The analytic sample consisted of 748 087 Covered California enrollees from 2018 (mean [SD] age, 44.80 [13.72] years; 408 410 [54.6%] women). Under current policy with the enhanced subsidies implemented under the American Rescue Plan, 5.8% of sample enrollees would default into dominated health plans. Of these enrollees, 98.0% would have incomes below 250% of the federal poverty level. A smart default policy would lead to a mean \$102.47 decrease in monthly premiums (95% CI, \$103.84-\$101.10), a mean \$1960 reduction in individual annual medical deductibles (95% CI, \$1991-\$1928), and a \$49.56 reduction in specialty prescription copays (95% CI, \$49.77-\$49.34).

CONCLUSIONS AND RELEVANCE The findings of this economic analysis suggest that a smart default policy could avoid defaulting lower-income marketplace enrollees to objectively inferior health care insurance plans and may lead to large reductions in lower-income enrollees' deductibles, copayments, and maximum out-of-pocket amounts. Implementation of a smart default policy could enable marketplace administrators to reduce the prevalence of underinsurance among lower-income marketplace enrollees.

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Key Points

Question Is a smart automatic renewal policy that defaults US health insurance marketplace enrollees to more generous health care plans with equivalent or lower premiums associated with enrollees' health care costs?

Findings In this economic analysis of US marketplace health care plan choices under the American Rescue Plan, 5.8% of 748 087 California marketplace enrollees currently default to dominated health care plans with higher premiums and cost sharing; more than 98.0% of enrollees have low incomes. By comparison, an alternative smart default system would default many enrollees to more generous plans with approximately \$100 lower monthly premiums and almost \$2000 lower deductibles.

Meaning Policy makers should consider implementing smart defaults for future marketplace automatic reenrollment.

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

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Introduction

More than 12 million people are currently insured through the health insurance marketplaces created by the Patient Protection and Affordable Care Act (ACA).¹ As more enrollees depend on the marketplaces for health insurance in the long term, policies that affect year-over-year enrollment are increasingly important. Automatic reenrollment, which allows enrollees to stay insured between years without making active annual plan selection decisions, may be the most important of these policies. Automatic reenrollment typically defaults enrollees to the same plan in which they were enrolled in the previous year.

Allowing enrollees to automatically reenroll in their coverage presents trade-offs. One study² found that automatic reenrollment increases year-over-year health insurance retention by 30 percentage points. A total of 3 945 010 (32.8%) of all enrollees during the 2021 open enrollment period were automatically reenrolled.³ Passive reenrollment into a default plan can cause returning enrollees to reenroll in a plan that has higher premiums and less generous benefits than other available health plans. This phenomenon, known as dominated health plan choice, is a common occurrence in private health insurance markets, including the health care marketplaces.⁴⁻⁸

The American Rescue Plan (ARP), signed into law in March 2021, increased premium tax credit subsidies through 2022. These subsidies reduce marketplace plans' premiums for qualifying enrollees. For example, under the ACA, an individual earning 150% of the federal poverty level (FPL) would pay \$50 per month for a benchmark silver plan, a standard marketplace plan. Under the ARP, the same individual would pay \$0 for the same plan.⁹ The premium of the bronze plan, on the other hand, is not affected by the ARP subsidies because it was already priced at \$0 after subsidies under the ACA. Although a price-sensitive, lower-income marketplace enrollee may prefer a zero-dollar premium, high-deductible bronze plan over a \$50-monthly premium, low-deductible silver plan under the ACA subsidy regimen, the new ARP subsidies change this calculus by reducing the silver premium to zero. There is no reason to select the bronze plan over the silver plan with the ARP subsidies, because they have equivalent premiums and the silver plan requires less cost sharing—the bronze plan is dominated by the silver plan. The ARP increases premium tax credit subsidies relative to the ACA for all income levels (**Table 1**).

Table 1. Expected Income Contribution Percentages and Amounts for 2021 Under the Affordable Care Act (ACA) and American Rescue Plan (ARP) Subsidy Schedules^a

Household income	Expected income contribution, % ^b		Expected contribution amount, \$ ^c	
% of federal poverty level	ACA	ARP	ACA	ARP
100	2.07	0	22.01	0
133	3.10	0	43.84	0
150	4.14	0	66.03	0
200	6.52	2.00	138.66	42.53
250	8.33	4.00	221.44	106.33
300	9.83	6.00	313.58	191.40
350	9.83	7.25	365.84	269.82
400	9.83	8.50	418.10	361.53

^a Data from the Congressional Budget Office cost estimate of the reconciliation recommendations for the House Ways and Means Committee.

^b The expected income contribution percentage is the percentage of a modified adjusted gross income that a household must pay to purchase the benchmark silver plan available to them in their state's marketplace, after applying premium tax credit subsidies. Premium tax credit subsidies cap the premium of the benchmark silver plan to ensure that the household's premium is equal to its expected income contribution percentage. Premium tax credit subsidies may be applied to any marketplace plan, except catastrophic coverage.

^c The expected income contribution amount is the monthly amount (ie, monthly premium) a household must pay to purchase the benchmark silver plan available to them in their state's marketplace, after applying premium tax credit subsidies.

The ARP's increased premium tax credit subsidies may increase dominated health plan choice. Of particular concern are marketplace enrollees who selected low-premium but high-cost-sharing bronze plans in previous years. After premium tax credits are applied, zero-premium bronze plans are currently available to 42.0% of eligible marketplace enrollees; this percentage will increase under the ARP.¹⁰⁻¹² Although bronze plans' lower premiums are highly attractive to marketplace enrollees,¹² bronze plans have higher deductibles, out-of-pocket maximums, and copayments than plans in other levels (ie, bronze, silver, gold, or platinum).¹³ However, if the enrollee does not log back into the marketplace to review how plans' premiums have changed under the ARP, they may stick with the dominated bronze plan.

Dominated health care plan choice is especially concerning for lower-income marketplace enrollees, who are also eligible for cost-sharing reduction subsidies.¹⁴ These subsidies, which can only be applied to silver plans, reduce cost sharing (ie, deductibles, maximum out-of-pocket amounts, and copayments) such that silver plans offer far more financial protection than bronze plans for lower-income enrollees. For example, the bronze plan's deductible is \$6300, whereas the silver plan's deductible is \$150. However, lower-income marketplace enrollees are less likely to review changes in their health plan choices from year to year, instead relying on automatic reenrollment, and therefore are more likely to remain with their previous health care plan despite potentially large benefits to changing their plan.¹⁵⁻¹⁸

In this analysis, we used marketplace enrollment data from California's marketplace to estimate how many enrollees will be defaulted to dominated health care plans under current automatic reenrollment policies with ARP subsidies. We propose an alternative smart default policy that would default enrollees to nondominated health care plans.¹⁹ We then estimate how the implementation of this policy would affect the affordability of and financial protection offered by marketplace health care plans. Last, we project how many enrollees would benefit from such a change in the 36 states using the HealthCare.gov marketplace.

Methods

Data and Sample

For this economic evaluation, our primary data sources were 2018 individual enrollment data and 2021 plan offering data from California's health insurance marketplace, Covered California. Approximately 1.6 million people are insured with Covered California health plans.²⁰ These data are particularly useful for identifying dominated health plan choices because California standardizes health plan cost sharing within a hierarchy of levels, meaning that cost sharing is always reduced as plan level increases (eg, silver plans always have lower deductibles than bronze plans).²¹ This study was deemed exempt from approval and informed consent by the University of Pittsburgh Institutional Review Board because the data are publicly available and deidentified. We followed the Consolidated Health Economic Evaluation Reporting Standards (CHEERS) reporting guideline.²²

We imposed 3 sample restrictions. First, we limited the sample to Covered California enrollees who were enrolled in a Covered California plan in 2018 and were eligible to be defaulted to a health care plan in the following year. Second, we limited the sample to enrollees who received ACA premium subsidies, because unsubsidized enrollees did not face dominated health care plan choices. Third, we excluded American Indian/Alaska Native enrollees, because these enrollees have different cost-sharing subsidies than the rest of the population.²³

We also used aggregate 2020 enrollment data from the Centers for Medicare & Medicaid Services to estimate the total number of marketplace enrollees on the federally facilitated marketplace, HealthCare.gov, who could be affected by dominated defaults without a smart default policy. These data report the total number of HealthCare.gov enrollees at the plan-level income band in 2020 for each state.²⁴

Dominated Health Care Plans and Smart Defaults

We considered an enrollee's default health plan to be dominated when the enrollee could be defaulted to another health plan with more generous cost sharing without increasing their premium or changing their insurance company or provider network (group of health care practitioners) because these could be a key motivation for the enrollee's initial choice of the plan (eAppendix in the Supplement).

We defined smart defaults as a default plan assignment algorithm that avoids defaulting enrollees to dominated health plans.^{2,19} Under current policy, enrollees are defaulted to their current plan in the following year.² A smart default policy would determine whether an enrollee's current plan would be a dominated health care plan in the following year. If the enrollee's current plan would be dominated in the following year, the enrollee would be defaulted to their current plan, as is the case under current policy. If the enrollee's current plan would be dominated in the following year, the enrollee would be dominated in the following year, the enrollee would be defaulted to their current plan, as is the case under current policy. If the enrollee's current plan would be dominated in the following year, the enrollee would be defaulted to the following year, the enrollee would be defaulted to the following year, the enrollee would be defaulted to the following year, the enrollee would be defaulted to the following year, the enrollee would be defaulted to the following year, an enrollee covered by the bronze plan with a \$0-monthly premium and a \$6300 annual deductible would not be defaulted to the silver plan that, under ACA, had a \$50-monthly premium and a \$150 deductible. However, under ARP, the same silver plan has a \$0 premium. Under the smart default policy with ARP subsidies, the enrollee would be defaulted to the silver plan.

Outcome Measures

Our outcomes were the characteristics of enrollees' default health care plans. These attributes included premiums, plan levels, medical and prescription deductibles, out-of-pocket maximums, and copayments for primary and specialty care. We also reported the demographic characteristics of enrollees that would be affected by a smart default policy, including the plan level of the enrollee's health care plan from the previous year, enrollee income as a percentage of the FPL, age, sex, and whether the individual enrolled with other household members.

Statistical Analysis

We identified whether enrollees in our sample would be defaulted to a dominated health care plan, if they were defaulted to 2021 health plans, under 4 different policy regimens: (1) ACA premium tax credit subsidies with current default policy, (2) ACA premium tax credit subsidies with smart defaults, (3) ARP premium tax credit subsidies with current default policy, and (4) ARP premium tax credit subsidies with smart defaults. We did so by imputing each enrollee's 2021 premium tax credit under the ACA and ARP subsidy schedules listed in Table 1. We based these calculations, as the marketplaces themselves do, on each enrollee's age, household income, household size, and the marketplace health care plans available to them.^{11,25}

We then identified enrollees whose default plans met the criteria to be dominated as described above. We applied smart defaults to enrollees in dominated plans under the ARP, assigning them new default health care plans per the smart default algorithm (ie, the plan from the same insurer with the same provider network that has the most generous cost sharing but would not result in a premium increase, after applying premium tax credits). We then calculated the statistical difference between the plan characteristics of these enrollees' default plans under current default policy and smart default policy using 2-tailed *t* tests.

Last, we projected the number of HealthCare.gov enrollees who would be defaulted to dominated marketplace plans under the ARP without a smart default policy. We did so by multiplying the percentage of enrollees assigned to dominated default plans in our Covered California analysis by the number of HealthCare.gov enrollees. We adjusted for differences in FPL and plan level enrollment in California relative to the 36 states that use HealthCare.gov. For more details on this calculation, see eTable 1 in the Supplement. All analyses were conducted with Stata SE software, version 16.0 (StataCorp). A 2-sided *P* < .05 indicates statistical significance.

Results

Our analytic sample consisted of 748 087 Covered California enrollees from 2018 (mean [SD] age, 44.80 [13.72] years; 408 410 [54.6%] women and 339 666 [45.4%] men). In 2018, 55.0% of returning enrollees in our sample automatically renewed their coverage. We estimated that, were these enrollees to be defaulted to the 2021 equivalents of their current plans with historical ACA subsidies, 24 417 (3.3%) of them would be defaulted to dominated health care plans. Under the augmented ARP subsidies, we estimated that 43 345 (5.8%) of the sample enrollees would be defaulted to dominated health care plans, an increase of 2.4 percentage points and a 77.5% increase in dominated default plan assignments.

Table 2 gives the demographic characteristics of the overall sample and those enrollees who would be defaulted to dominated health care plans with ACA and ARP subsidies. More than 98.0% of enrollees who would be defaulted to dominated health care plans had incomes less than 250% of the FPL-\$32 200 for an individual and \$66 250 for a family of 4²⁶—under the ACA and the ARP subsidies. Under ACA subsidies, 91.7% of enrollees defaulted to dominated health care plans were enrolled in gold or platinum plans with comparatively low cost sharing. Under ARP subsidies, 43.8% of enrollees who would be defaulted to dominated health plans were enrolled in less generous bronze plans with relatively high deductibles, copayments, and maximum out-of-pocket amounts (ie, less generous cost sharing).

The **Figure** illustrates how the default plan levels of enrollees in dominated health care plans would change by transitioning from current default policy to smart default policy (see eTable 2 in the Supplement for the number of enrollees moving plan tiers under the smart default policy). Under current default policy with ARP subsidies, 43.8% of enrollees in dominated plans would be defaulted

Table 2. Dominated Default Plan Assignments Under the Affordable Care Act (ACA) and the American Rescue Plan (ARP)^a

	No. of enrollees (% of sam	iple)	
		Enrollees defaulted to do	minated health plans
Demographic characteristic	Overall (N = 748 087)	ACA (n = 24 417)	ARP (n = 43 345)
FPL, %			
138-150	155 803 (20.8)	6570 (26.9)	11 533 (26.6)
>150-200	276 563 (37.0)	17 434 (71.4)	27 353 (63.1)
>200-250	152 262 (20.4)	326 (1.3)	3809 (8.8)
>250-400	163 459 (21.9)	87 (0.4)	650 (1.5)
Age, y			
0-17	16351(2.2)	138 (0.6)	172 (0.4)
18-34	236 376 (31.6)	9610 (39.4)	17 694 (40.8)
35-49	176754 (23.6)	6333 (25.9)	11 104 (25.6)
≥50	318 606 (42.6)	8336 (34.1)	14 375 (33.2)
Sex			
Female	408 410 (54.6)	13 131 (53.8)	21 578 (49.8)
Male	339 666 (45.4)	11 285 (46.2)	21765 (50.2)
Enrollment unit ^b			
Single	606 251 (81.0)	19 462 (79.7)	36 832 (85.0)
Family	141 836 (19.0)	4955 (20.3)	6513 (15.0)
Plan level ^c			
Bronze	206 868 (27.7)	1994 (8.2)	18 965 (43.8)
Silver no CSR	51 333 (6.9)	2 (0.0)	51 (0.1)
Silver CSR 73	63 231 (8.5)	24 (0.1)	543 (1.3)
Silver CSR 87	194 183 (26.0)	6 (0.0)	1357 (3.1)
Silver CSR 94	131 554 (17.6)	0	0
Gold	76 176 (10.2)	20 150 (82.5)	20 188 (46.6)
Platinum	24742 (3.3)	2241 (9.2)	2241 (5.2)

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Abbreviations: CSR, cost-sharing reduction; FPL, federal poverty level.

- ^a Under the current policy, households are defaulted to their health care plan from the previous year.
 A health care plan is dominated if there is another within-network health plan available that has the same or a lower premium and is of a higher plan level (ie, lower deductibles and copayments). Data are from 2018 Covered California administrative enrollment data and 2021 Covered California premiums.
- ^b An enrollment unit of single means the enrollee is covered by themselves. An enrollment unit of family means 2 or more family members are covered under the same health care plan.
- ^c Cost-sharing reduction subsidies reduce cost sharing and increase actuarial value for households that earn between 100% and 250% of the FPL who purchase a silver plan in 3 tiers: households earning 100% to 150% of the FPL qualify for 94% actuarial value plans (Silver CSR 94), households earning 151% to 200% of the FPL qualify for 87% actuarial value plans (Silver CSR 87), and households earning 201% to 250% of the FPL qualify for 73% actuarial value plans (Silver CSR 73). Standard silver plans without CSR benefits have 70% actuarial value and are available to households with incomes above 250% of the FPL.

to dominated bronze plans with 60% actuarial value. Under the smart default policy, 79.2% of them would be defaulted to significantly more generous silver cost-sharing reduction plans with 87% or 94% actuarial value. In addition, under the current policy, 46.6% of enrollees in dominated plans would be defaulted to dominated gold plans. With smart defaults, they would have their deductibles, copayments, and maximum out-of-pocket amounts reduced by being defaulted to silver plans with cost-sharing reduction subsidies.

Table 3 indicates how smart defaults would change default plan characteristics for enrollees defaulted to dominated plans under the ARP, relative to current default policy. The percentage of affected enrollees with a \$1 premium would increase from 52.9% to 68.4% under the smart default policy. These \$1 premiums would be \$0 in most other states; California has a premium floor of \$1, resulting from a mandate that its marketplace insurers provide abortion coverage.^{11,27} Among affected enrollees with a net premium higher than \$1, mean monthly premiums would decrease by \$102.47 (95% CI, \$101.10-\$103.84), from \$148.03 to \$76.85. Single enrollees would see a mean \$1960 reduction in medical deductibles (95% CI, -\$1991 to -\$1928), a mean \$164.51 reduction in prescription deductibles (95% CI, -\$166.99 to -\$162.03), and a mean \$4978 reduction in maximum out-of-pocket amounts (95% CI, -\$5000 to -\$4956). Smart defaults would also effect a mean \$32 reduction in primary care copayments (95% CI, -\$32.17 to -\$31.84) and a mean \$49.56 reduction in specialist copayments (95% CI, -\$49.77 to -\$49.34), an approximately two-thirds reduction in copayments compared with baselines of \$46.47 for primary care copayments and \$75.21 for specialist copayments.

We projected that approximately 327 000 enrollees in the 36 states using the HealthCare.gov marketplace, or approximately 4.4% of subsidized enrollees, will be defaulted to dominated health care plans under the current policy. Our projections indicate that approximately 319 000 (97.0%) of these enrollees have incomes below 250% of the FPL, and 230 000 (70.0%) are enrolled in bronze plans (eTable 1 in the Supplement).

Discussion

This economic evaluation of dominated marketplace health care plan choice under the ARP estimates that the percentage of enrollees defaulted to dominated health care plans will increase by nearly 80% because of the changes in premium tax credits from the ARP, potentially affecting more



Data are from 2018 Covered California administrative enrollment data and 2021 Covered California premiums. Sample consists of 43 345 Covered California enrollees who would be assigned to dominated default health plans in 2021 under the American Rescue Plan, per the simulation discussed in the Methods section. The left side of the figure shows the plan levels of sample enrollees' default plans under current default policy. The right side of the figure shows the plan levels of sample enrollees' default plans under smart default policy. In all cases, the smart default policy defaults sample enrollees to more generous plan levels without increasing their premiums.

Figure. Changes in Actuarial Value of Default Health Plans Under the American Rescue Plan With Smart Defaults

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than 327 000 marketplace enrollees nationwide. Nearly half of the affected enrollees in our analysis were enrolled in bronze plans, suggesting that a smart default policy could switch many of these overwhelmingly lower-income enrollees from bronze plans with high deductibles to silver plans with cost-sharing reduction subsidies that drastically reduce and, in some cases, even eliminate deductibles and copayments. A smart default policy would also reduce the mean premium paid by these households by approximately \$102 per month.

Table 3. Changes in Default Health Care Plan Characteristics Under Smart Default Policy^a

	Mean (n = 43 345 enrollees) ^b			
	Current	Smart		
Plan characteristic	policy	policy	Difference (95% CI) ^c	P value
Default monthly premiums ^d				
Premium of \$1, %	52.9	68.4	15.6 (15.2 to 15.9)	<.001
Premium, \$	70.36	25.06	-45.31 (-45.99 to -44.62)	<.001
Premium if>\$1, \$	148.03	76.85	-102.47 (-103.84 to -101.10)	<.001
Plan level, % ^e				
Bronze	43.8	0.0	-43.8 (-44.2 to -43.3)	<.001
Silver no CSR	0.1	1.3	1.2 (1.1 to 1.4)	<.001
Silver CSR 73	1.3	6.5	5.3 (5.0 to 5.6)	<.001
Silver CSR 87	3.1	59.4	56.3 (55.8 to 56.8)	<.001
Silver CSR 94	0.0	26.4	26.4 (26.0 to 26.8)	<.001
Gold	46.6	2.3	-44.3 (-44.8 to -43.8)	<.001
Platinum	5.2	4.0	-1.1 (-1.4 to -0.9)	<.001
Deductible for medical, \$ ^f				
Single	3096	1136	-1960 (-1991 to -1928)	<.001
Family	2938	2423	-515 (-634 to -395)	<.001
Deductible for prescription, \$ ^f				
Single	245.11	80.59	-164.51 (-166.99 to -162.03)	<.001
Family	231.87	172.57	-59.30 (-68.74 to -49.86)	<.001
Maximum out-of-pocket cost, \$ ^f				
Single	7828	2850	-4978 (-5000 to -4956)	<.001
Family	15 547	5866	-9681 (-9781 to -9580)	<.001
Copayment, \$				
Primary care	46.47	14.47	-32.00 (-32.17 to -31.84)	<.001
Specialist	75.21	25.65	-49.56 (-49.77 to -49.34)	<.001

Abbreviation: CSR, cost-sharing reduction.

^a Data are from 2018 Covered California administrative enrollment data and 2021 Covered California premiums.

- ^b The enrollment unit of 36 832 enrollees was single (ie, 1 enrollee per health plan); the enrollment unit of 3014 enrollees was family (ie, >1 enrollee per health plan).
- ^c Differences are calculated using bivariate 2-tailed *t* tests.
- ^d Premiums are reported as the monthly premium of the enrollee's default plan, net of subsidies. The first row reports the percentage of enrollees with a default monthly premium equal to \$1 per person. The second row reports mean default monthly premiums. The third row reports mean default monthly premiums, conditional on premiums being greater than \$1 per person.
- ^e Cost-sharing reduction subsidies reduce cost sharing and increase actuarial value for households that earn 100% to 250% of the federal poverty level who purchase a silver plan in 3 tiers: households earning 100% to 150% of the federal poverty level qualify for 94% actuarial value plans (Silver CSR 94), households earning 151% to 200% of the federal poverty level qualify for 87% actuarial value plans (Silver CSR 87), and households earning 201% to 250% of the federal poverty level qualify for 73% actuarial value plans (Silver CSR 73). Standard Silver plans without CSR benefits have 70% actuarial value and are available to households with incomes above 250% of the federal poverty level.
- ^f Medical deductibles, prescription deductibles, and maximum out-of-pocket amounts all differ, depending on whether the enrollment unit is single (1 enrollee) or family (2 or more enrollees). These plan characteristics are reported for the subsamples who experience them (eg, single medical deductibles are reported for the 36 832 single enrollees and family medical deductibles are reported for the 3014 family enrollees).

Automatic reenrollment is essential for maintaining health insurance enrollment because it allows people to stay insured if they simply continue to pay their premium. However, not having to pay attention to yearly changes in health care plan offerings can cause enrollees to overlook plans with lower premiums and more generous benefits.¹⁹ Prior research^{18,28,29} has found that the psychological and time costs required to search for a new health care plan are particularly costly to individuals with low socioeconomic status. This finding is particularly concerning for dominated health care plan choice in the marketplaces because this analysis found that nearly all the enrollees who will default to dominated health care plans under the ARP have incomes under 250% of the FPL.

The current policy that defaults lower-income enrollees to dominated bronze plans with high deductibles is likely to underinsure marketplace enrollees.²⁴ A smart default policy would switch lower-income enrollees from bronze to silver plans with cost-sharing reduction subsidies. Reducing deductibles and copayments in this manner would likely lead to better health outcomes. For example, high deductibles and copayments have been shown to delay or prevent patients from filling prescriptions for cancer, diabetes, and other life-threatening conditions.³⁰⁻³³ By removing lower-income marketplace enrollees from bronze plans, which are similar to high-deductible health care plans, smart defaults could reduce inequities in health care use experienced by lower-income populations.³⁴ In addition, reducing deductibles and out-of-pocket maximums can offer protection against bankruptcy for patients with chronic health conditions.³⁵

Limitations

This study has 3 main limitations. First, the analysis is limited to Covered California's 2018 enrollment data. However, Covered California is the largest marketplace in the US, and its characteristics likely lead to conservative estimates of the effects of dominated defaults for 2 reasons. California standardizes deductibles and copayments across plan levels and limits the number of plans insurers may offer, which may make plan selection easier and thereby reduce dominated health care plan enrollment. California's robust marketplace outreach also may reduce dominated health plan enrollment—the 36 states using the HealthCare.gov platform have had limited enrollee outreach since 2017.^{7,36,37}

A second limitation is that 2022 premium data are not yet available. However, marketplace premiums have not changed significantly during the last several years, even in 2021 after the COVID pandemic.³⁸ Should this trend continue, use of 2022 premium data rather than 2021 premium data would have a negligible effect on this analysis.

A third limitation is the possibility that enrollees may be more likely to switch health care plans in response to the passage of the ARP.³⁹ Such switching could diminish the importance of smart defaults. However, previous analyses^{7,17,40-42} have found that enrollees, particularly lower-income ones, are not highly responsive to changes in year-over-year premiums or responsive to advertising or nudges.

Conclusions

The findings of this economic analysis suggest that the US federal and state marketplaces should consider implementing smart defaults for future health insurance marketplace automatic reenrollment. A smart default policy avoids defaulting lower-income marketplace enrollees to objectively inferior health care insurance plans. In so doing, a smart default policy may lead to large reductions in lower-income enrollees' deductibles, copayments, and maximum out-of-pocket amounts. Smart defaults may reduce underinsurance for hundreds of thousands of lower-income Americans, potentially enabling access to lifesaving medical care, minimizing cost barriers to accessing health care, and reducing the probability of health care-related bankruptcy. Premiums would also be reduced and, in some cases, eliminated. Although marketplace enrollees are free to opt out of their default plans, more than 80% of them do not. Smart defaults are therefore a powerful

tool for policy makers to shape health insurance plan selection. In conclusion, implementation of a smart default policy would enable marketplace administrators to reduce the prevalence of underinsurance among lower-income marketplace enrollees.

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SUPPLEMENT.

eAppendix. Matching Similar Plans

eTable 1. Estimated Dominated Health Plan Default Assignments for HealthCare.gov Enrollees Under the American Rescue Plan

eTable 2. Plan Tier Movement for Covered California Enrollees Under Smart Default Policy

Center for American Progress

How States Can Build on the ACA To Improve Affordability and Lower Health Care Costs

By Maura Calsyn July 15, 2021

The health care portions of the American Rescue Plan (ARP) include the first-ever federal expansion of the Affordable Care Act (ACA).¹ The law increases financial assistance for people already purchasing health care coverage through the ACA's marketplaces and extends assistance to millions of Americans with incomes above the original ACA eligibility limits. While this federal action is significant, state action remains necessary. States should view the new changes made by the ARP as an opportunity for additional reforms.

Multiple states have already implemented or are advancing proposals to improve health care affordability and increase enrollment in the individual market.² These efforts—which include public options and other related reforms to lower prices in the private market—are a critical piece of broader efforts to address the coverage and affordability barriers across the health care system.

Specifically, states can consider additional financial assistance to lower deductibles and other out-of-pocket costs for people with lower incomes. Moreover, they should work to lower the underlying prices in the commercial health care market, given that the ARP's changes are an important step to improving affordability but do not address the underlying reason why premiums and other health care expenses are often too expensive. Not only are these reforms vital to further improving affordability, but they are also critical to ensuring that health care expansions are sustainable.³

This issue brief outlines ways in which states can use the ARP as a starting point for additional reforms, as well as how the changes made to the ACA give states additional flexibility and additional federal funding to help offset state costs in implementing these reforms. As a result, states are in an excellent position to adopt policies that increase coverage and improve affordability, both of which are critical steps that would improve health outcomes and reduce health disparities.

The Affordable Care Act and the American Rescue Plan

Under the ACA, people with family incomes from 100 percent to 400 percent of the federal poverty level (FPL) who purchase marketplace coverage qualify for tax credits to help them afford their premiums.⁴ These premium tax credits limit the amount that individuals or families pay for a silver plan on the marketplace to a percentage of their income. The ACA also includes cost-sharing reductions that lower copayments and deductibles for people whose incomes are from 100 percent to 250 percent of the FPL. This structure creates a significant affordability cliff at 400 percent of the FPL, as those with incomes higher than that limit struggle to afford unsubsidized premiums.⁵

To address this issue, the ARP builds on the ACA by extending tax credits to those making more than 400 percent of the FPL. Families with incomes higher than 400 percent of the poverty level now qualify for tax credits that limit their net premium for a silver plan to no more than 8.5 percent of their income.⁶ The ARP also increases the tax credit amount for those with incomes from 100 percent to 400 percent of the FPL.⁷ Additionally, it allows people who received unemployment at any point during 2021 to enroll in a silver plan without any premiums and with additional cost-sharing subsidies.⁸ Notably, the ARP's changes will remain in place through the 2022 plan year.

The Congressional Budget Office (CBO) has estimated that together, these changes will increase enrollment in the marketplaces by about 1.7 million people in 2022 and reduce net premiums for most people enrolled in marketplace coverage.⁹ Moreover, the CBO expects that about two-thirds of the new enrollees will be people with incomes higher than 400 percent of the FPL.¹⁰ In April 2021, the first month in which the ARP's increased tax credits were offered, 1.9 million consumers returned to the marketplace to claim the new expanded tax credits, saving an average of 40 percent on their monthly premiums.¹¹ In the same month, many of the nearly 470,000 new marketplace enrollees also benefited from the tax credits; on average, premiums for new consumers decreased by more than 25 percent and deductibles for new consumers dropped by nearly 90 percent.¹²

State actions to improve affordability and expand coverage

Since 2014, when the ACA's marketplaces went into effect, a number of states have taken steps to further lower premiums and out-of-pocket costs for those purchasing marketplace coverage, as well as offer financial assistance to those whose incomes are higher than 400 percent of the FPL.¹³ Similar to the ARP's affordability provisions, both reinsurance and additional supplemental financial assistance lower consumers' costs by increasing federal and state health care funding while also improving the risk pool.

Other types of reforms, including public options and related proposals, also target the underlying prices of medical services.

State reinsurance programs

Today, 14 states have reinsurance programs through which insurers are reimbursed for coverage of very high-cost marketplace enrollees.¹⁴ Because insurers do not have to worry about factoring those expenses into their premiums, reinsurance programs lower premiums. This, in turn, can improve the individual market's risk pool, as healthy people—especially those whose incomes do not qualify them for premium tax credits—will be more likely to enroll if the premiums are more affordable.¹⁵ And because premiums are lower, the federal government's spending on premium tax credits is also reduced.¹⁶

During the first three years of the marketplaces, the ACA included temporary risksharing programs, including a federal reinsurance program. Since then, states that have moved forward with their own reinsurance programs have kept premiums lower than states that have not.¹⁷ Some states, such as Alaska and Maryland, have reduced average unsubsidized premiums by nearly 40 percent in the early years of reinsurance implementation. While the rates of premium savings have varied widely across states, according to The Commonwealth Fund, "In most states, reinsurance has produced an annual reduction in premiums of more than 10 percentage points."¹⁸

Supplemental financial assistance

In addition to reinsurance programs, a number of states have supplemented the ACA's financial assistance, both by extending premium tax credits above 400 percent of the FPL and by supplementing those already receiving federal tax credits.¹⁹ For example, California, New Jersey, and Vermont marketplace enrollees qualify for additional state-funded assistance with their premiums.²⁰ In addition to premium tax credits, Massachusetts and Vermont supplement the ACA's cost-sharing reductions, which reduce the size of deductibles as well as lower cost sharing.²¹ Bolstering cost-sharing reductions is particularly important to address affordability for individuals whose incomes fall around 250 percent of the FPL, the income cutoff for this assistance.²²

Unsurprisingly, lower net premiums and more affordable coverage attract additional, healthier enrollees, again improving the individual market's risk pool.²³ For example, Massachusetts has the lowest uninsured rate in the nation and some of the lowest marketplace premiums.²⁴

State public options and related reforms

Public options and other similar reforms add a publicly backed health insurance plan as an option for marketplace enrollees. Washington state's Cascade Care is the first such approach to be implemented.²⁵ Beginning in the 2021 plan year, marketplace enrollees in the state can select public option standardized plans with lower deductibles and additional pre-deductible services. In order to keep these plans affordable, the state sets an aggregate provider payment amount of 160 percent of Medicare rates.²⁶ Because the payment limits are in aggregate, some providers may receive higher or lower payments. There is also a payment floor for primary care physicians and some hospitals in underserved areas to ensure that these providers receive adequate payments.²⁷ Private insurers can also offer these standardized benefit plans. However, Washington did not meet the premium savings goal of 5 percent to 10 percent during the first enrollment period.²⁸ Despite this adjustment period, the public option standardized plans cost less than privately offered standardized plans in nearly every county in which they are offered.²⁹

Nevada and Colorado have followed Washington in passing affordability laws that also target underlying prices. Similar to Washington's program, the Nevada law sets a premium reduction target and a payment floor based on Medicare rates.³⁰ The law also sets a target of 2026 for the Nevada marketplace to operate a public plan and would require that providers participate in the public plan as a condition of their participation in the state's Medicaid program and state employee health plan.

The Colorado Health Insurance Option requires private insurers to offer standardized benefit plans in the individual and small group markets in every county in which the insurer already participates.³¹ The law also sets premium reduction targets. If insurers fail to meet these targets, the Colorado Division of Insurance will hold a public hearing and, depending on its finding, may set provider payment rates in order to reach the target or to meet network adequacy requirements. The state would set payment rates above a floor based on a percentage of Medicare rates.

As Washington, Colorado, and Nevada demonstrate, most public option and related proposals have a focus on reducing the price of medical services and passing those savings on to consumers through lower premiums or out-of-pocket costs. Moreover, this approach can have a ripple effect by increasing competition and efficiencies across the private market. If the public option offers marketplace consumers a lower-cost, high-quality coverage option, other plans will need to negotiate lower payment amounts and offer robust benefits and strong networks in order to attract enrollment.

It is unsurprising that health care industry groups have largely opposed reforms that target the high prices of health care items and services. For this reason, any claim by the industry that the ARP has made additional state action unnecessary should be viewed with caution. In fact, the opposite is true: Now that the federal government has taken some of the pressure of needing to improve premium affordability off states, they can focus on other coverage and affordability priorities, such as lowering cost sharing, improving plan benefits, and tackling the underlying cost of care.

Next steps for states

States have a variety of options available to improve affordability and expand coverage. In addition, depending on the specific reforms a state adopts and how much they collectively lower health care costs, states can receive pass-through funding from the federal government to help pay for these coverage and affordability improvements.

The Affordable Care Act's Section 1332 waivers

Under Section 1332 of the Affordable Care Act, states can request federal approval for state innovation waivers. States may waive certain provisions of the ACA as long as the changes are within four so-called guardrails, which require that health care coverage is "at least as comprehensive and at least as affordable as would be provided absent the waiver, provides coverage to a comparable number of residents of the state as would be provided coverage absent a waiver, and does not increase the federal deficit."³²

If a state waiver will lower federal spending—for example, by lowering premiums—states can receive the federal savings as pass-through funding, which in turn can offset some of the state's costs in enacting the reforms.³³ The state's passthrough payment is the difference between the total amount of the premium tax credits, cost-sharing reductions, and small-business tax credits that the federal government would have spent without the Section 1332 waiver and the total amount of those same tax credits and cost-sharing reductions with the Section 1332 waiver in place.³⁴ Pass-through payments are calculated annually based on state-submitted data on rates and enrollment.

To date, Section 1332 waivers have been approved in 15 states,³⁵ 14 of which have used their waiver to implement state-level reinsurance programs.³⁶ Given the Trump administration's opposition to the ACA, it is unsurprising that in recent years, states have largely limited their waivers to reinsurance programs instead of more innovative approaches to strengthening the law.³⁷ But other state changes to the ACA that decrease premiums should also result in pass-through funding. For instance, Colorado's initial public option legislation, drafted prior to the ARP, recognized this opportunity. It would have required the state to apply for a 1332 waiver and use most of the pass-through funding to offset the expense of new premium tax credits for those families with incomes higher than 400 percent of the poverty level.³⁸

States can now look to the federal government as a partner committed to strengthening the ACA instead of sabotaging the law. Moreover, the ARP's enhanced premium tax credits and its expansion to those earning more than 400 percent of the FPL, as well as the resulting increased enrollment in marketplace coverage, will increase the amount of pass-through payments that states can expect for the next two years.
Federal regulatory steps that can assist states and consumers

In 2018, the Trump administration released guidance that replaced the Obama administration's 2015 guidance on Section 1332 waivers.³⁹ The new guidance encouraged states to submit waivers that would undermine the ACA's consumer protections.⁴⁰ Using this guidance, the Trump administration approved a waiver from Georgia that would have, among other provisions, removed the state from HealthCare.gov.⁴¹ Prior to the end of the Trump administration, the 2022 Notice of Benefit and Payment Parameters adopted the 2018 interpretation of Section 1332's guardrails.⁴² The Biden administration then issued a "regulatory freeze" that covered the final rule, as well as an executive order revoking the 2018 guidance.⁴³ The Biden administration subsequently issued a proposed rule to rescind the Trump administration's 1332 regulation.⁴⁴ The proposed rule is largely consistent with the Obama administration's 2015 guidance.

The proposed rule restores critical consumer protections; for instance, states must once again consider a waiver's impact on vulnerable and underserved residents. The proposed rule also seeks comments on how states could use 1332 waivers to focus on equity and expand access to comprehensive coverage. The proposed rule does not, however, propose to modify the interpretation of budget neutrality, which states have cited as a potential barrier to reforms that would increase enrollment.⁴⁵ The Biden administration could assist states by interpreting its definition of budget neutrality to clarify that reforms that reduce premiums—and as a result boost enrollment—are permissible, even if federal costs increase due to new enrollment. This interpretation would be consistent with Medicaid budget neutrality requirements for that program's Section 1115 demonstration waivers, under which states ask for approval to test Medicaid policies that differ from federal statutory requirements.⁴⁶

In addition, the Biden administration can act within its existing authority to fix the so-called family glitch. Fixing the glitch would allow family members of a person with employer-sponsored insurance to qualify for subsidized marketplace coverage if the job-based coverage is unaffordable for the entire family.⁴⁷ Changing this would eliminate another affordability challenge facing states and potentially increase the amount of a state's pass-through payment.

State-specific assessments

Because each state has its own specific affordability and coverage challenges, a necessary first step to developing state-level reforms is understanding the barriers to health care coverage and access across the state. For example, knowing the number of uninsured residents alone is insufficient. Instead, policymakers must have a clear picture of who in the state is uninsured, including by income, immigration status, age, and geography. In addition, states should evaluate which insured individuals face affordability challenges because of issues such as high deductibles.

With this information, each state can tailor its reforms to address its specific challenges. For example, if a large portion of the uninsured are eligible for existing subsidies or Medicaid, a state may wish to focus on enrollment outreach and education about the ARP's existing subsidies. Or if a state analyzes its data and realizes that its residents are underutilizing key health care services, it can design a standardized benefit package that dramatically reduces or eliminates cost sharing for those services.

In particular, states with high numbers of undocumented immigrants should consider how best to cover these individuals given that the ACA prohibits premium tax credits and other financial assistance to this group. California, for instance, previously submitted a Section 1332 waiver to allow undocumented immigrants to purchase coverage through Covered California—the state's marketplace—without federal assistance.⁴⁸ Yet the state withdrew the waiver request just before the start of the Trump administration.⁴⁹ A similar waiver, combined with reinsurance to lower overall premiums, would be a helpful start to improving coverage rates among undocumented immigrants.

States wishing to pursue a public option must undertake additional evaluations. A key issue in any public option design is the amount that providers will be paid when they care for enrollees. States should survey the provider payment and plan choice landscape as an initial step in developing a public option. Furthermore, they should consider reducing unwarranted price variation across providers, as well as examine ways to support providers who are essential to underserved populations. A public option design that accounts for those essential providers—while also setting overall payment rates based on Medicare rates—can lower premiums, improve affordability, and be a critical first step to addressing health disparities.⁵⁰

States that have conducted these analyses prior to the ARP should reconsider how the law's changes may alter their priorities. For instance, states that had previously planned or implemented an expansion of premium tax credits to individuals above 400 percent of the FPL could decide to instead reinvest the pass-through payments in additional affordability measures for lower-income residents—for example, by providing additional cost-sharing reductions or bolstering the generosity of benchmark plan benefits.

Conclusion

States were leaders in advancing critical affordability reforms even before the coronavirus pandemic. Now, it is time for action from an administration and congressional leaders similarly invested in improving the ACA. The ARP provides critical, temporary new federal funding that can help with these efforts. But Congress must act to make these changes permanent, as states will feel more confident investing in bold changes if they have certainty that the enhanced ARP subsidies will remain in place.

Legislation, such as the Improving Health Insurance Affordability Act,⁵¹ can increase federal assistance for cost-sharing expenses and allow states to turn their focus to more expansive reforms such as public options. Moreover, additional federal regulatory action to clarify the scope of Section 1332 can further support innovative state health care reforms.

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INERTIA, MARKET POWER, AND ADVERSE SELECTION IN HEALTH INSURANCE: EVIDENCE FROM THE ACA EXCHANGES

Evan Saltzman Ashley Swanson Daniel Polsky

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Inertia, Market Power, and Adverse Selection in Health Insurance: Evidence from the ACA Exchanges Evan Saltzman, Ashley Swanson, and Daniel Polsky NBER Working Paper No. 29097 July 2021 JEL No. G22,I11,I13,L1

ABSTRACT

We study how inertia interacts with market power and adverse selection in managed competition health insurance markets. We use consumer-level data to estimate a model of the California ACA exchange, in which four firms dominate the market and risk adjustment is in place to manage selection. We estimate high inertia costs, equal to 44% of average premiums. Although eliminating inertia exacerbates adverse selection, it significantly reduces market power such that average premiums decrease 13.2% and annual per-capita welfare increases \$902. These effects are substantially smaller in settings without market power and/or risk adjustment. Moreover, converting the ACA's premium-linked subsidies to vouchers mitigates the impact of inertia by reducing market power, whereas reducing high consumer churn in the ACA exchanges increases the impact of inertia by enhancing market power. The impact of inertia is not sensitive to provider network generosity, despite greater consumer attachment to plans with more differentiated provider networks.

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Ashley Swanson Graduate School of Business Columbia University 3022 Broadway, Uris Hall 621 New York, NY 10027 and NBER ats2180@gsb.columbia.edu Daniel Polsky Carey Business School Department of Health Policy and Management Bloomberg School of Public Health Johns Hopkins University 624 N. Broadway, Room 661 Baltimore, MD 21205 polsky@jhu.edu Managed competition is increasingly common in U.S. health insurance markets, such as the Medicare Advantage and Medicare Part D programs for seniors and the Affordable Care Act (ACA) individual health insurance exchanges (HIXs) (Einav and Levin, 2015).¹ Insurance markets with managed competition aim to leverage the advantages of competition among private firms by promoting consumer choice while limiting firm incentives to engage in risk selection and offer substandard benefit packages (Enthoven, 1993). Common elements include consumer choice among qualifying plans, regulations that set baseline benefits, and policies that promote competition and limit incentives for risk selection. The efficient functioning of these markets is important not only for consumer welfare, but also for the prudent allocation of significant government expenditures. Successful implementation depends on the interaction of three critical and interconnected factors: the incentive and ability of consumers to choose high-value options, the participation and competition of firms, and policies in place to manage adverse selection.

We explore the interaction of these three factors in the ACA exchanges. Choice and information frictions can undermine the market forces underlying managed competition's presumed advantages by eroding insurers' incentives to issue high-value options. We examine this issue by focusing on the role of inertia, the persistence of health plan choices over time despite changes in premiums and health plan offerings. Inertia could reduce consumer welfare by inducing consumers to remain in suboptimal plans and by reducing insurers' incentives to lower premiums.² However, inertia may also mitigate the effects of adverse selection (Handel, 2013). The balance of these forces depends on the extent of competition (Polyakova, 2016) and on policies in place to manage risk selection, such as risk adjustment (Geruso et al., 2019; Mahoney and Weyl, 2017).

We analyze the premium, enrollment, and welfare impacts of inertia in the ACA setting. The ACA's architects designed the exchanges with the intent to encourage frictionless consumer choice and robust insurer competition.³ We provide new evidence on the presence and magnitude of choice

¹Although managed competition is relatively new in the U.S., health insurance systems in the Netherlands, Germany, and Switzerland have relied on managed competition for decades.

²Researchers have documented the presence and magnitude of inertia in the employer group setting (Handel, 2013), in the Medicare Part D market (Ericson, 2014; Fleitas, 2017; Ho et al., 2017; Polyakova, 2016), in Medicare Advantage (Miller, 2019), and in the ACA exchanges (Drake et al., 2021). These papers, and our own, lie at the intersection of broader literatures on choice frictions as a source of welfare loss and market power in health insurance (Abaluck and Adams, 2018; Abaluck and Gruber, 2011, 2016; Aizawa and Kim, 2018; Cebul et al., 2011; Bhargava et al., 2017; Ketcham et al., 2015; Kling et al., 2012), and on the effects of inertia on competition in markets other than health insurance (Dube et al., 2009; Farrell and Klemperer, 2007; Hortacsu et al., 2017; Luco, 2019).

³To facilitate choice, they standardized key plan features, allowed consumers to shop and enroll online, and provided access to choice assistance from professional navigators. To encourage firm participation and limit adverse selection, ACA policies introduced risk corridors, reinsurance, and risk adjustment, and mandated and subsidized insurance purchase. In practice, several of these design elements have disappeared or been eroded in the seven years since the exchanges opened.

frictions in this environment, and on how important features of the ACA exchange mediate their effects on social welfare. In doing so, we contribute to a burgeoning literature on the early successes and failures of the new insurance marketplaces established by the ACA (Abraham et al., 2017; Sen and DeLeire, 2018; Diamond et al., 2021; Drake, 2019; Panhans, 2019; Polsky et al., 2016; Tebaldi, 2020), as well as the broader empirical literature on managed competition markets such as Medicare Part D (Decarolis et al., 2020), Medicare Advantage (Curto et al., 2020; Miller et al., 2019), and the pre-ACA Massachusetts exchange (Ericson and Starc, 2015, 2016; Geruso et al., 2019; Hackmann et al., 2015; Shepard, 2016).

To study the impact of inertia in the ACA exchanges, we estimate a model of consumer plan choice and insurer pricing. Our model endogenizes consumer choices, premiums, plan risk, and claims. The model explicitly allows for both moral hazard and adverse selection and incorporates key ACA policies such as risk adjustment and premium subsidies. Our approach is similar to those in Starc (2014) and Tebaldi (2020) and builds directly on the model in Saltzman (2021).

We estimate our model using consumer-level administrative data from the ACA exchange in California. Our data contain nearly ten million consumer plan choices across a variety of local insurance market settings between 2014 and 2018, the first five years of the exchange. The California ACA exchange is an important market for understanding the individual exchanges because it accounts for 13% of nationwide enrollment (Kaiser Family Foundation, 2020). It is also a useful market for exploring inertia because plan financial characteristics are standardized, limiting the number of plan attributes consumers need to compare. Descriptive evidence suggests inertia is high. Nearly 80% of renewing enrollees remained in the same plan, 91% chose a plan in the same metal tier, and 87% stayed with the same insurer. New enrollees paid lower premiums than renewing enrollees and firms with higher market shares raised premiums more in the subsequent year.

To quantify the equilibrium effects of inertia, we estimate a structural model of the California ACA exchange. We address potential endogeneity of plan premiums by exploiting variation created by exogenous ACA regulations, including the phase-in of the individual mandate penalty and the time-varying kinks in the ACA penalty and subsidy formulas. We identify inertia by leveraging two key features of the ACA setting captured by our data: (1) every consumer in our model makes at least one "active" decision, either when the exchanges opened in 2014 or in a subsequent year; and (2) some consumers make additional active decisions if their previous plans cease being offered.

We use our estimated model to simulate the impact of inertia under observed and alternative market conduct and policy scenarios. We make three primary contributions to the literature: (1) we estimate the magnitude of inertia and how its elimination would impact equilibrium premiums, plan choices, and welfare in the observed ACA setting; (2) we document how and why the impact

of eliminating inertia would change if firm market power and/or the risk adjustment policy in place to manage adverse selection were to be removed; and (3) we provide insight into how three policydriven features of managed competition in insurance markets, including the design of premium subsidies, consumer churn between markets, and provider network generosity, interact with inertia.

We find that inertia, measured as the annual cost of switching to a new plan, is \$2,324 for the average consumer or approximately 44% of the average premium. Higher-income consumers and adults over age 55 have switching costs of about \$3,700, whereas young adults between ages 18 and 34 have switching costs of about \$1,500. We also find lower inertia in Asian and Hispanic households and higher inertia in non-Hispanic White households. While these estimated switching costs are quite large, they are consistent with previous estimates in the literature (Drake et al., 2021; Handel, 2013; Polyakova, 2016).

Next, we use the estimated model to simulate the impact of inertia under alternative scenarios. The switching frictions underlying inertia may include time costs of comparing complex features of alternative plans and hassle costs associated with completing paperwork and changing providers. We simulate setting switching costs to $zero^4$ and find average premiums would decrease by 13.2%. Annual per-capita social welfare would increase by \$902 and annual total social welfare would increase by \$2.13 billion. Our baseline welfare analysis follows the literature in assuming that revealed preference can be used to calculate consumer surplus, and that inertia impacts choices but not welfare. When inertia is eliminated, some consumers choose less generous coverage (2%) and others forgo insurance entirely (3%); substantial errors in consumers' valuation of insurance (Abaluck et al., 2021) would amplify the welfare losses due to drops in enrollment. Our qualitative conclusions are largely robust to whether inertia is considered a choice error or a true welfare-relevant switching cost: the welfare effect of eliminating inertia remains positive provided no more than 80% of inertia represents a true switching cost.

The impact of inertia is substantially smaller when firm market power and/or risk adjustment are removed. If firms price at average cost, eliminating inertia would result in only 0.9% lower average premiums and a \$547 increase in annual per-capita social welfare. This result demonstrates how firms exploit inertia as a source of market power, as previously explored by Ho et al. (2017) and Polyakova (2016).⁵ Without risk adjustment in place to mitigate the effects of selection, eliminating inertia would result in 10.9% lower average premiums and a \$658 increase in annual

⁴In reality, there is likely no single intervention that would eliminate inertia, but several policies may reduce it, including alerts regarding product characteristics, information provision, and modified defaults. See, e.g., Domurat et al. (2021) and Kling et al. (2012).

⁵Our model does not incorporate dynamic firm pricing in response to consumer inertia (Dube et al., 2009; Ericson, 2014; Fleitas, 2017; Miller, 2019). We consider this an important area for future work on the ACA setting.

per-capita social welfare. The premium decrease is smaller than in the ACA setting because removing risk adjustment leads to premium dispersion (i.e., less generous plans become cheaper and more generous plans become more expensive) and significant shifts in enrollment from more generous plans to less generous plans. Eliminating inertia without risk adjustment in place therefore results in smaller incremental premium decreases and enrollment shifts. In the absence of *both* market power and risk adjustment, eliminating inertia would decrease average premiums by 2.9% and increase annual per-capita social welfare by only \$250. These results complement prior work on the interactions between risk adjustment and market power (Mahoney and Weyl, 2017).

Our simulation results also demonstrate how three policy-driven features of the ACA environment interact with inertia. First, the ACA exchanges feature premium subsidies that are linked to premiums. Price-linked subsidies reduce price competition (Einav et al., 2019; Jaffe and Shepard, 2020; Polyakova, 2016; Tebaldi, 2020) and hence exacerbate market power from inertia. We simulate the effect of inertia under a voucher or fixed government subsidy and find a significantly smaller impact than under price-linked subsidies. Eliminating inertia with fixed subsidies results in a 8.9% decrease in average premiums and a \$532 increase in annual per-capita social welfare. Another prominent feature of the ACA setting that interacts with inertia is consumer churn into and out of the market (Diamond et al., 2021). In our data, 26% of enrollees exit the ACA marketplace each year due to exogenous reasons such as receiving an offer for employer-sponsored insurance or becoming eligible for Medicaid. In contrast to price-linked subsidies, high churn mitigates the effect of inertia on firms' market power. We simulate the elimination of inertia without churn in the market and find a larger impact than with churn. Average premiums would decrease by 16.8% and annual per-capita social welfare would increase by \$966. Finally, we study whether the impact of inertia is sensitive to provider network generosity. We quantify the impacts of network breadth and network inclusivity (Graves et al., 2020), the degree to which the providers in a plan's network are shared with other plans in the market, on inertial behavior. This analysis complements prior work that studies the mechanisms underlying inertia in insurance and other settings (Abaluck and Adams, 2018; Brot-Goldberg et al., 2021; Drake et al., 2021; Heiss et al., 2016; Hortacsu et al., 2017; Luco, 2019). We find network inclusivity slightly reduces inertia, suggesting that provider preference may keep consumers in their plans. However, eliminating only the part of inertia not driven by network inclusivity yields similar estimates as in our main results.

Taken together, our results present new evidence on how inertia, competition, and adverse selection interact in an important health insurance marketplace. Policies targeting inertia, such as signup simplification and plan standardization, may be most effective in markets such as the ACA exchanges where firms have market power and adverse selection is managed with measures such as risk adjustment. Our paper also clarifies how subsidy design, consumer churn, and provider network regulation may mediate the effects of inertia. Switching to a fixed subsidy design would mitigate the effects of inertia because it would reduce firm market power. Conversely, policies mitigating consumer churn such as expanding subsidy eligibility to those with access to employersponsored insurance or implementing the ACA's Basic Health Program (BHP) could exacerbate the effects of inertia by enhancing firm market power over inertial enrollees. Lastly, our results suggest that regulations regarding provider network breadth would not substantially change the impact of inertia.

This paper is organized as follows. Section 1 describes the data and provides descriptive evidence of inertia. Section 2 presents our empirical demand model and estimates. Section 3 simulates the impact of inertia in the ACA exchanges on premiums, enrollment, claims, and welfare. Section 4 concludes.

1 Data and Setting

A central component of the ACA was the establishment in 2014 of state-based and federallyfacilitated exchanges for non-group health insurance, in which eligible consumers choose among qualified health plans and purchase plans with federal subsidies. In this paper, we analyze enrollment data and insurer rate filings from the California ACA exchange from 2014-2018.⁶ The enrollment data contain plan choices for each enrollee-year, as well as enrollee demographic characteristics such as age, geographic location, and income. The insurer rate filings contain plan-yearmarket-level information on administrative costs, enrollee claims, risk adjustment transfers, and reinsurance. The following two subsections provide more detail on each dataset and descriptive evidence of inertia.

1.1 Premiums and Enrollment

We analyze consumer-level enrollment data from the California ACA exchange for the 2014 through 2018 plan years. Table 1 summarizes enrollee choices and characteristics. Any citizen or legal resident can enroll in an ACA exchange plan. However, in practice, the rules governing the availability of subsidies imply that the exchanges primarily serve individuals without access to affordable employer- or government-sponsored insurance. We refer to these individuals as "exchange-eligible." These eligibility rules were put into place to limit the cost of the ACA and avoid crowd-out

⁶We rely on the same data as in Saltzman (2021).

of other sources of insurance coverage, including employer- or government-sponsored insurance. A significant consequence of these restrictions is high consumer churn, which we investigate below. The ACA contained a provision for states to establish a Basic Health Program that would reduce churn between Medicaid and the ACA exchanges, but only New York and Minnesota have implemented a BHP program as of 2021.⁷

Appendix A details how we construct the exchange-eligible population. Briefly, we begin with the set of consumers who *ever* enrolled in a California ACA plan. For years when the consumer is not enrolled in an ACA plan, we impute whether the consumer was exchange-eligible, given their age, gender, race, income, and household size. This imputation exercise draws on a prediction model trained on observed coverage status transitions (i.e., ACA exchange insurance, employer-sponsored insurance, government-sponsored insurance, and no insurance) in individual-level panel data from the U.S. Census Bureau's Survey of Income and Program Participation (SIPP) (U.S. Census Bureau, 2019).

Approximately two-thirds of eligible consumers chose an exchange plan in our sample. Enrollment increased steadily from 62% to 70% of eligible consumers between 2014 and 2018. The ACA mandates that most consumers purchase coverage or pay a penalty; exceptions are made for people with valid reasons, such as having income below the threshold for filing taxes or lacking access to a plan that costs less than 8% of household income. In 2014, the penalty was \$95 or 1% of income, whichever was larger. The penalty increased each year until 2016, when it was \$695 or 2.5% of income, whichever was larger. In 2019, the penalty was set to zero following passage of the Tax Cuts and Jobs Act of 2017.

Approximately 52% of enrollees were female, 39% were non-Hispanic white, and 50% were over age 45. Exchange enrollees tended to have relatively low incomes: half of enrollees in our sample had incomes below 200% of the federal poverty level (FPL), and 90% had incomes below 400% of the FPL. Nearly 90% of enrollees received premium subsidies.⁸ As we discuss in more detail in the next section, premium subsidies are linked to premiums in the silver tier and shield consumers from premium volatility.

⁷The BHP program covers consumers with incomes between the 138% of FPL Medicaid threshold to 200% of FPL in a Medicaid-type plan with lower premiums and cost sharing than an ACA exchange plan. The program reduces churn for people with income close to the 138% of FPL Medicaid threshold because transitions between Medicaid and the BHP are relatively seamless. Although churn may increase for consumers with income around 200% of FPL, income fluctuations are generally more prevalent in lower-income populations.

⁸Premium subsidies are available to citizens and legal residents with income between 100% and 400% of FPL who do not qualify for Medicaid and do not have an affordable offer of insurance from their employer. Most California consumers who have income under 138% of FPL qualify for Medicaid. An employer-sponsored insurance plan was considered affordable in 2014 if the employee's contribution to the plan was below 9.5% of household income.

	2014	2015	2016	2017	2018	Overall
Market Size	2,197,669	2,420,764	2,461,389	2,444,685	2,429,209	11,953,716
Total Enrollment	1,362,316	1,639,923	1,702,160	1,697,074	1,710,469	8,111,942
Metals						
Catastrophic	1.0%	0.8%	1.0%	1.1%	1.2%	1.0%
Bronze	23.7%	25.2%	26.3%	26.7%	28.9%	26.3%
Silver	63.9%	63.8%	63.7%	63.8%	54.7%	61.9%
Gold	6.0%	5.5%	5.1%	5.2%	11.2%	6.6%
Platinum	5.4%	4.7%	3.9%	3.2%	3.9%	4.2%
Insurers						
Anthem	29.7%	27.9%	25.1%	17.5%	4.7%	20.6%
Blue Shield	27.8%	25.9%	28.9%	25.5%	31.4%	27.9%
Health Net	19.4%	16.6%	11.9%	10.5%	14.0%	14.3%
Kaiser	17.7%	24.1%	24.0%	28.9%	34.1%	26.1%
Other	5.5%	5.4%	10.1%	17.6%	15.7%	11.1%
Network Type						
НМО	43.1%	48.3%	46.5%	58.4%	64.3%	52.5%
РРО	56.9%	51.7%	53.5%	41.6%	35.7%	47.5%
Income						
138% FPL or less	4.7%	3.5%	3.3%	4.0%	4.0%	3.8%
138% FPL to 150% FPL	14.1%	14.3%	14.6%	14.7%	14.4%	14.4%
150% FPL to 200% FPL	32.8%	32.8%	31.9%	30.3%	28.8%	31.3%
200% FPL to 250% FPL	16.8%	16.7%	16.3%	16.3%	16.7%	16.6%
250% FPL to 400% FPL	22.4%	23.4%	23.6%	23.6%	25.8%	23.8%
400% FPL or greater	9.3%	9.3%	10.3%	11.0%	10.3%	10.1%
Subsidy Status						
Subsidized	89.6%	88.8%	87.5%	86.5%	87.3%	87.9%
Unsubsidized	10.4%	11.2%	12.5%	13.5%	12.7%	12.1%
Age						
0-17	5.7%	6.0%	6.2%	6.7%	7.3%	6.4%
18-25	11.1%	11.3%	11.1%	10.7%	10.5%	10.9%
26-34	16.3%	16.9%	17.4%	17.6%	17.7%	17.2%
35-44	16.6%	15.9%	15.3%	15.1%	15.2%	15.6%
45-54	24.4%	23.5%	22.8%	22.2%	21.4%	22.8%
55+	25.8%	26.3%	27.2%	27.8%	27.9%	27.1%
Gender						
Female	52.6%	52.2%	51.9%	52.2%	52.5%	52.3%
Male	47.4%	47.8%	48.1%	47.8%	47.5%	47.7%
Race						
Asian	22.8%	21.8%	22.0%	22.6%	23.0%	22.4%
Black/African American	2.7%	2.5%	2.4%	2.4%	2.4%	2.5%
Hispanic	27.5%	28.2%	28.0%	28.3%	28.4%	28.1%
Non-Hispanic White	39.4%	39.5%	39.6%	38.5%	37.1%	38.8%
Other Race	7.7%	7.9%	7.9%	8.2%	9.1%	8.2%

Table 1: Plan Choices and Enrollee Demographics

Table summarizes enrollee plan choices and demographic distributions using California administrative data. The total market size is imputed using data from the SIPP as discussed in Appendix A.

Like many U.S. health insurance markets, the ACA exchanges are concentrated (Dafny, 2015). In our sample, four large insurers—Anthem Blue Cross, Blue Shield of California, Health Net, and Kaiser—covered 89% of exchange enrollees. Those insurers had dominant positions throughout our sample, with one exception: Anthem's market share declined sharply after it exited all but 3 of the 19 California markets in 2018. The collective market share of the 9 small regional insurers increased from 5% in 2014 to 16% in 2018.⁹

Exchange plans are grouped into four "metal" tiers with differing levels of actuarial value (AV): bronze (60% AV), silver (70% AV), gold (80% AV), and platinum (90% AV). The plan AV defines the percentage of total covered costs for which a plan pays. For example, enrollees in a plan with 70% actuarial value are responsible for 30% of the costs of all covered benefits they incur, on average. Over 60% of enrollees chose a silver plan because access to cost sharing reductions (CSRs) that reduce copays, coinsurance, and deductibles requires enrollment in a silver plan. CSRs increase the silver plan AV from 70% to 73%, 87%, or 94%, depending on the consumer's income. CSRs are not available to households with income exceeding 250% of FPL. Roughly two-thirds of consumers in our data can access CSRs. In many states, insurers have flexibility in how they design plans' costsharing features to achieve a given AV. However, the California exchange has standardized all plans in the same metal tier to have identical cost sharing.¹⁰ In addition to the "metal" plans, catastrophic plans with much higher deductibles are available to individuals under age 30, but represented only 1% of enrollment share in our sample. California exchange consumers had an average of 27 plans offered by 4.75 insurers to choose from, though there was considerable heterogeneity in choice set sizes. Los Angeles County residents could choose from as many as 45 plans offered by 7 insurers, whereas residents in rural areas of Northern California could choose from as few as 5 plans offered by a single insurer.

Figure 1 summarizes annual enrollment transitions across metal tiers and insurers. Two important features of the California exchange in 2014-2018 stand out. First, consumer churn was substantial. Approximately 35% of enrollees in year t were not enrolled in year t + 1. Transitions out of enrollment could be due to "Ineligibility" (approximately 26% of enrollees lost exchange eligibility due to exogenous factors, such as a change in labor market status or Medicaid eligibility), or to "Uninsurance" (approximately 9% of enrollees remained eligible, but dropped coverage for other reasons). This phenomenon was relatively stable across metal tiers and insurers, though consumers were most likely to drop coverage if they were previously enrolled in a bronze plan. Second, plan

⁹These firms were Chinese Community Health Plan, Contra Costa, L.A. Care Health Plan, Molina Healthcare, Oscar, Sharp Health Plan, United Healthcare, Valley Health Plan, and Western Health Advantage.

¹⁰The 2019 benefit design is available at https://www.coveredca.com/PDFs/2019-Health-Benefits-table.pdf

switching was relatively rare despite highly volatile premiums during our study timeframe. Among consumers that renewed coverage in our sample, approximately 79% chose last year's plan, 91% chose a plan from the same metal tier as last year's plan, and 87% chose a plan from the same insurer as last year's plan. Switching from Anthem to Blue Shield was slightly more common because Anthem exited most California markets in 2018 and many previous Anthem enrollees subsequently opted into Blue Shield. This high degree of inertia may reflect the role of defaults. At the end of each plan year, current enrollees are sent a renewal notice. Those who do not actively change plans are automatically enrolled into their current plans for the next plan year. In sum, the low levels of switching between plans suggest that inertia was high, but high consumer churn into and out of the market may have muted some of the effects of inertia.

Table 2 summarizes average premium spending by year and enrollment status. The average household paid a subsidized monthly premium of \$136, which is approximately 31% of the average unsubsidized premium of \$434. Households who switched plans paid \$134 on average and consumers choosing a plan for the first time paid \$130 on average. Although this descriptive evidence does not adjust for differences in the premiums available to incumbent enrollees and to new enrollees and switchers, it suggests consumers may benefit from annually reviewing their plan options. Another notable feature of the data is that unsubsidized premiums increased sharply in 2018, largely as a result of the Trump Administration's decision to halt government funding of CSRs. Because insurers were still legally required to provide CSRs even after direct government funding was eliminated, they covered expenses through higher premiums. Many states (including California) responded by promoting the "silver loading" strategy, which encouraged insurers to only increase silver plan premiums to cover the cost of having to fund CSRs. Because premium subsidies are linked to silver plan premiums (see discussion of equation (2) below), consumers received larger premium subsidies under this strategy and paradoxically paid lower subsidized premiums in 2018.

Firms may exploit consumer inertia by more aggressively increasing premiums on plans with greater market share. To understand whether firms engage in this behavior, Table 3 presents the results of descriptive regressions of yearly (percentage) premium changes (t to t + 1) on lagged (year t) market share, controlling for plan generosity using the plan's actuarial value, the plan's risk score, an HMO dummy, and firm and market fixed effects. The first column indicates that a 10 percentage point increase in lagged plan market share is associated with an additional 1 percentage point increase in the year-to-year premium growth rate. This association could be driven by different cost trends among plans with greater enrollment, or by different cost trends in relatively concentrated markets. The third column sheds light on these potential mechanisms by including firm and market fixed effects, and indicates a strikingly similar pattern: a 10 percentage point in-



Figure 1: Annual Enrollee Plan Transitions by Metal and Insurer

Figure reports enrollee transitions between plan years by metal tier (top panel) and insurer (bottom panel). Each bar shows the share of enrollees with the insurance status in year t, indicated on the categorical horizontal axis, who transition to the indicated insurance status in year t + 1. In addition to choosing an exchange plan, consumers can be either uninsured, but eligible for the exchange, or ineligible for the exchange. For the sake of brevity, we combine bronze and catastrophic enrollment and label it "bronze"; this has little material impact, as only 1% of sample enrollees chose catastrophic plans.

	Subsidized Premiums			Unsubsidized Premiums		
	All	New	Switchers	All	New	Switchers
Average Premium						
2014	\$117	\$117		\$379	\$379	
2015	\$125	\$124	\$128	\$392	\$364	\$398
2016	\$136	\$133	\$127	\$405	\$365	\$392
2017	\$154	\$148	\$142	\$447	\$395	\$445
2018	\$145	\$146	\$133	\$535	\$474	\$539
Overall	\$136	\$130	\$134	\$434	\$390	\$463

Table 2: Average Premium Spending By Year and Enrollment Status

Table reports the enrollment-weighted average premium paid by California households, with and without premium subsidies. Table compares average premiums for all enrollees, enrollees joining the exchange for the first time, and consumers choosing a new plan.

crease in lagged plan market share is associated with an additional 1.3 percentage point increase in the year-to-year premium growth rate. This is consistent with inertia being a significant source of firm market power.

	(1)	(2)	(3)
Firm fixed effects		\checkmark	\checkmark
Market fixed effects			\checkmark
Lagged Market Share	0.099***	0.135***	0.135***
	(0.034)	(0.034)	(0.034)
Risk Score	0.017**	0.017**	0.018***
	(0.008)	(0.007)	(0.007)
HMO	-0.046^{***}	-0.013^{*}	-0.010
	(0.004)	(0.007)	(0.007)
AV	0.037	0.019	0.014
	(0.045)	(0.038)	(0.038)
Observations	1,326	1,326	1,326

Table 3: Effect of Plan Market Share on Percentage Premium Increase

Notes: Robust standard errors are in parentheses (* indicates statistical significance at the 10% level, ** at the 5% level, and *** at the 1% level). Table displays the results of regressing the plan premium increase between years t and t + 1, in percentage terms, on the plan's market share in year t and a set of controls. Observations are at the plan-year-market level.

1.2 Claims and Risk Adjustment

We also use insurer rate filings from California's Department of Managed Care to obtain financial information on medical claims, reinsurance¹¹, and risk adjustment (Department of Managed Health Care, 2016). For each of these financial variables, we observe the average (or per-member per-month) amount and total amount for each plan sold in each year and market. The rate filing data are used for estimating plan risk and claims.

Under the ACA, risk adjustment redistributes money from firms drawing below-average risk customers to firms drawing above-average consumers. Transfers between firms must sum to zero, which differs from Medicare Advantage (MA) where risk adjustment payments to MA plans are tied to Traditional Medicare and are usually positive. The objectives of risk adjustment are to prevent unraveling of generous options and to disincentivize firms from attempting to select the lowest-risk consumers (known as "cherry-picking") as a means of reducing costs. All metal plans in the state's individual market, including off-exchange plans, are in the same risk adjustment pool. Catastrophic plans are risk-adjusted separately. Figure 2 summarizes risk adjustment transfers in our sample by metal tier. The most generous tier of platinum plans *received* substantial risk adjustment transfers whereas the least generous tier of bronze plans *paid* risk adjustment transfers. This is consistent with more generous plans in the ACA exchanges being adversely selected.

2 Model and Estimation

We construct a two-stage model where insurers first set premiums and households then select plans. Our model closely follows the one in Saltzman (2021). We present and estimate our model starting with household plan selection.

2.1 Demand

In our demand model, households select the plan maximizing their (indirect) utility

$$U_{ijt} \equiv \beta_i^p p_{ijt}(\mathbf{p}_t) + \beta_{ij}^y y_{ij(t-1)} + x'_{ij}\beta^x + w'_{it}\beta^w + \xi_j + \epsilon^d_{ijt}$$
(1)

where \mathbf{p}_t is the base premiums for all plans in year t, $p_{ijt}(\mathbf{p}_t)$ is consumer *i*'s premium as a function of plan *j*'s base premium, $y_{ij(t-1)}$ is a lagged choice indicator, x_{ij} is observable non-premium plan characteristics such as the plan AV and network type, w_{it} is the vector of household demographics

¹¹Reinsurance was in effect for 2014-2016 and helped insurers cover consumers with the highest utilization. The nationwide budget was \$10 billion in 2014, \$6 billion in 2015, and \$4 billion in 2016.

Figure 2: Average Risk Adjustment Received (Paid) By Plans in Each Metal Level



Notes: Figure shows the per-member per-month risk adjustment transfer for plans in each metal tier. A positive transfer indicates that a plan received a transfer because its enrollees had above-average risk, whereas a negative transfer indicates a plan paid a transfer because its enrollees had below-average risk.

summarized in Table 1, ξ_j is unobserved plan characteristics, and ϵ_{ijt}^d is an error term. The premium parameter $\beta_i^p = \beta^p + w'_{it}\phi$ is a function of household demographics and the inertia parameter $\beta_{ij}^y = \beta^y + x'_{ij}\kappa + w'_{it}\nu$ is a function of both plan characteristics and household demographics. Premium subsidies decrease the premium $p_{ijt}(\mathbf{p}_t)$ paid by the household and CSRs increase the plan AV in equation (1). Define $U_{i0t} = \beta_i^p \rho_{it} + \epsilon_{i0t}$ as the utility of the outside option (i.e., forgoing insurance), where ρ_{it} is the household's penalty for not having insurance.

2.1.1 Premium Subsidies and Regulation

The household premium including subsidies is

$$p_{ijt}(\mathbf{p}_t) = \max\left\{\underbrace{\sigma_{it}p_{jmt}}_{\text{full}} - \underbrace{\max\{\sigma_{it}p_{bmt} - \zeta_{it}, 0\}}_{\text{premium subsidy}}, 0\right\}$$
(2)

where p_{jmt} is the plan base premium, p_{bmt} is the benchmark plan base premium, and ζ_{it} is the income contribution limit. The unsubsidized premium equals the product of the plan base premium and the household-specific rating factor σ_{it} . The rating factor characterizes the limited ways in which insurers' premiums can vary with household characteristics. ACA premiums can only vary by age, tobacco usage, and geography. The ratio of premiums for a 64-year-old vs. a 21-year-old cannot be greater than 3-to-1. California is one of several states that prohibits tobacco rating. The California exchange is divided into 19 rating areas within which premiums cannot vary, conditional on age.

The ACA's premium subsidy is designed to limit the household's outlay for the benchmark plan to a certain percentage of its income. It is computed as the difference between the benchmark plan premium ($\sigma_{it}p_{bmt}$) and the income-based contribution limit ζ_{it} . The benchmark plan is the plan with the second-lowest premium in the household's choice set and can vary between households because of partial firm entry and heterogeneous pricing across state rating areas. The income-based contribution limit was 2% of income for consumers with income of 100% of the federal poverty level (FPL) and 9.5% of income for consumers with income of 400% of FPL in 2014 (these percentages change slightly each year). For example, a single consumer earning 100% of FPL (\$11,670 in 2014) would have a contribution limit of \$233 per year or \$19 per month; the consumer's monthly premium subsidy would be \$181 if the full benchmark plan premium were \$200. This \$181 subsidy could be used for any metal plan (catastrophic plans do not qualify for subsidies). If some bronze plans have a full premium below \$181, the subsidy would be reduced to ensure the household's premium is nonnegative. Many consumers may therefore have access to "free" plans, a fact which we exploit to identify the premium parameter β_i^p as discussed in the next subsection.

2.1.2 Demand Estimation and Identification

To estimate the demand parameters, we assume the error term ϵ_{ijt}^d has the generalized extreme value distribution such that equation (1) defines a nested logit choice model at the consumer level. We create two nests, including one with all available exchange plans and a second with the outside option. Following Train (2009), the household choice probabilities are then:

$$q_{ijt}(\mathbf{p}_t;\boldsymbol{\beta}) = \frac{e^{V_{ijt}(\mathbf{p}_t)/\lambda} \left(\sum_j e^{V_{ijt}(\mathbf{p}_t)/\lambda}\right)^{\lambda-1}}{1 + \left(\sum_j e^{V_{ijt}(\mathbf{p}_t)/\lambda}\right)^{\lambda}}$$
(3)

where $V_{ijt}(\mathbf{p}_t) \equiv \beta_i^p p_{ijt}(\mathbf{p}_t) + \beta_{ij}^y y_{ij(t-1)} + x'_{ij}\beta^x + w'_{it}\beta^w + \xi_j$. The vector of utility weights is $\boldsymbol{\beta} = (\beta_i^p, \beta_{ij}^y, \beta^x, \beta^w)$ and λ is the nesting parameter. As discussed in Section 2.2 below, we estimate the model using a two-step feasible generalized method of moments (GMM) estimator.

Subsidized premiums vary at the household, market, and insurer level. A natural concern is that premiums are endogenous and correlated with unobserved plan quality, which might reflect customer service or provider networks. We include insurer-market fixed effects to control for timeinvariant plan quality. Conditional on those fixed effects, there are multiple additional sources of plausibly exogenous variation for identification of the premium parameter β_i^p . First, the phasing in of the mandate penalty between 2014 and 2016 and elimination of the penalty in 2019 creates exogenous variation in premiums relative to the outside option. Second, nonlinearities in equation (2) create exogenous premium variation between plans within a given household's choice set. For example, some bronze plans are available free to some households because the subsidy exceeds the full premium due to exogenous household characteristics; the set of free plans varies across household characteristics, market, and time.

Another identification challenge we face is that persistence in plan choices may reflect persistent unobserved preference heterogeneity, rather than inertia. We identify the inertia parameter β_{ij}^y by leveraging two key features of our empirical setting. First, because we observe the first year of exchange's enrollment, every consumer in our data made at least one active choice upon entry, either in 2014 or in a subsequent year when the consumer first became eligible for exchange coverage. This allows us to compare, for example, 2015 enrollment decisions for consumers enrolled in a Health Net silver plan in 2014 with those of consumers ineligible for the exchange in 2014. The differential market shares of the Health Net silver plan in 2015 across these two groups provides evidence regarding the existence and extent of inertia. Although newly-eligible enrollees in 2015 may have different preferences than 2014 enrollees, we can leverage this type of identification across multiple years and across enrollees initially enrolled in many different plan types. Second, some consumers made additional active decisions if their previous plans were no longer offered or if they were prohibited from purchasing their previous plans (e.g., young adults cannot buy a catastrophic plan upon turning 30). The most prominent example of this phenomenon occurred when Anthem exited most markets in 2018. Intuitively, we can compare the 2018 plan choices of 2017 Anthem enrollees, in markets where Anthem remained vs. those where Anthem exited.

2.1.3 Demand Results

We estimate the utility weights in equation (1) using a 5% sample of the data.¹² Table 4 summarizes the out-of-sample fit of our model, for four different specifications. Specification 1 is the most parsimonious and models choices as a function of all plan and enrollee characteristics, including insurer fixed effects. Specification 2 adds interactions between premium and household characteristics (i.e., allowing low-income families to be more price-sensitive) and between lagged plan choice and both plan and household characteristics (i.e., allowing inertia to be higher among older consumers, or among Blue Shield enrollees). Specification 3 controls for insurer-market fixed effects. Specifications (1)-(3) are estimated on the pooled 5% sample; specification 4 estimates the model separately for 4 age-income combinations.¹³ For each specification, we compare the model predictions to the observed data in a hold-out sample not used in estimation. Specification 2 results in a better out-of-sample fit than specification 1, particularly for matching the share of enrollment by metal tier. Including insurer-market fixed effects (specification 3) does not yield any appreciable gains in fit. Specification 4 matches enrollment by metal tier slightly better than specification 2, but performs worse in matching plan switching rates and adds considerable computational complexity for our subsequent analyses. We consider specification 2 to be our most preferred and use this specification for all subsequent analyses in this paper. Detailed parameter estimates are available in Appendix Table A1.

The first four columns of Table 5 display price elasticities of demand by household characteristics. We show both own-premium elasticities and elasticities of exchange coverage overall. The sensitivity of a subsidized consumer's demand to a premium change is

 $^{^{12}}$ We also estimated the model on larger samples and obtained nearly identical estimates. We encountered significant computational challenges using samples larger than 5% of the data. Therefore, we perform the estimation with a 5% sample.

¹³These combinations are (1) below age 45 and income below 200% of FPL; (2) below age 45 and income above 200% of FPL; (3) above age 45 and income below 200% of FPL; and (4) above age 45 and income above 200% of FPL.

		Estimated Model				
	Data	(1)	(2)	(3)	(4)	
Specification						
Interactions	N/A		\checkmark	\checkmark	\checkmark	
Insurer-Market FEs	N/A			\checkmark		
Age-Income	N/A				\checkmark	
Enrollment						
Total Enrollment	1,751,574	1,747,292	1,747,161	1,747,140	1,747,311	
Bronze	27.5%	25.5%	26.6%	26.5%	27.6%	
Silver	61.9%	62.3%	62.6%	62.6%	61.9%	
Gold	6.4%	7.2%	6.5%	6.6%	6.5%	
Platinum	4.1%	4.9%	4.3%	4.4%	4.0%	
Anthem	20.8%	20.6%	20.7%	20.7%	20.7%	
Blue Shield	27.7%	27.5%	27.4%	27.3%	27.4%	
Health Net	14.3%	14.5%	14.5%	14.5%	14.4%	
Kaiser	26.0%	25.9%	25.9%	25.9%	26.1%	
Other Insurer	11.3%	11.5%	11.6%	11.5%	11.4%	
Switching Rate	17.4%	15.2%	15.3%	15.2%	14.4%	

Table 4: Assessing Out-Of-Sample Model Fit

Notes: Table compares our data to the out-of-sample fit of 4 alternative specifications of utility equation (1). All specifications were estimated using a 5% sample of the data. The first panel defines the specification for each of the 4 models. Specifications (2)-(4) include interaction terms between 1) the premium and household characteristics; and 2) the lagged choice variable and household characteristics; and 3) the lagged choice variable and product characteristics. Specification (3) also includes insurer-market fixed effects. Specification (4) estimates the model separately for 4 age-income bins (age above and below 45, income above and below 200% of FPL). The second panel reports average annual enrollment, market shares by metal level and insurer, and the percentage of renewing consumers who switched plans.

$$\frac{\partial q_{ikt}(\mathbf{p}_t)}{\partial p_{jmt}} = \sum_{l \in J_{mt}} \frac{\partial q_{ikt}(\mathbf{p}_t)}{\partial p_{ilt}(\mathbf{p}_t)} \frac{\partial p_{ilt}(\mathbf{p}_t)}{\partial p_{jmt}}$$

for all plans j, k, with¹⁴

$$\frac{\partial p_{ilt}(\mathbf{p}_t)}{\partial p_{jmt}} = \begin{cases} 0 & l = j, j = b\\ \sigma_{it} & l = j, j \neq b\\ -\sigma_{it} & l \neq j, j = b\\ 0 & l \neq j, j \neq b \end{cases}$$
(4)

Intuitively, a small premium increase for a non-benchmark plan leads to consumers paying more for only that plan. However, a small premium increase for the benchmark plan increases the consumer's subsidy. This implies that the consumer's contribution to the benchmark plan is unchanged. However, because of the larger subsidy, the consumer would then pay less for all non-benchmark plans.

Our elasticity estimates are similar to previous estimates (Domurat, 2018; Drake, 2019; Saltzman, 2019; Tebaldi, 2020). Consumers with lower incomes and younger consumers are more priceelastic.

The last column of Table 5 presents the annual switching costs implied by our parameter estimates. On average, consumers were willing to pay \$2,324 more in annual premiums to remain in their previous plan, rather than switching to another plan with identical characteristics. Higherincome consumers and adults over age 55 had switching costs of about \$3,700, whereas young adults (ages 18-34) had switching costs of about \$1,500. We also find that consumers were more attached to some plans than others, though these differences were not as stark. For example, "the Blues"—Anthem Blue Cross and Blue Shield of California—were associated with larger switching costs.

Our estimates of inertia are large relative to annual premiums—\$2,324 is 44% of the average enrollee's \$5,307 in annual premium expenditures. Handel (2013) estimates a switching cost of \$2,032 per enrollee-year for employer-sponsored health insurance coverage and Polyakova (2016) estimates switching costs of \$400-\$600 per enrollee-year for Medicare Part D, which covers only prescription drugs.

¹⁴The formula assumes that the subsidy does not exceed the full, unsubsidized premium.

	Own-Premium		Exchange Coverage		
	Elasticity	Semi- Elasticity	Elasticity	Semi- Elasticity	Annual Plan Switching Cost
Overall	-7.76	-14.87	-0.24	-0.56	\$2324
Income (% of FPL)					
0-250	-8.23	-15.84	-0.26	-0.60	\$2064
250-400	-6.92	-13.53	-0.22	-0.51	\$2648
400+	-5.47	-10.99	-0.17	-0.42	\$3750
Gender					
Female	-7.43	-14.27	-0.23	-0.53	\$2400
Male	-8.14	-15.51	-0.25	-0.58	\$2274
Age					
0-17	-10.59	-18.48	-0.33	-0.69	\$1663
18-34	-11.56	-20.17	-0.36	-0.75	\$1513
35-54	-8.25	-14.38	-0.26	-0.53	\$ 2148
55+	-5.33	-9.26	-0.16	-0.34	\$3710
Race/Ethnicity					
Asian	-8.69	-16.45	-0.27	-0.62	\$1778
Black	-7.55	-14.45	-0.24	-0.54	\$2217
Hispanic	-9.27	-17.46	-0.29	-0.65	\$1769
Other	-7.04	-13.56	-0.22	-0.51	\$2458
Non-Hispanic White	-6.83	-13.20	-0.21	-0.49	\$2653
Household Size					
Single	-7.75	-14.85	-0.24	-0.56	\$2410
Family	-7.77	-14.89	-0.24	-0.56	\$2164
Insurer					
Anthem					\$2564
Blue Shield					\$3080
Kaiser					\$2204
Health Net					\$2061
Other Insurer					\$1910
HMO					
Non-HMO					\$2021
НМО					\$2805

Table 5: Elasticities and Annual Switching Costs

Notes: Table reports elasticities and switching costs by demographic group. The first and second columns consider how a plan's demand responds to a change in its own (unsubsidized) premium. The third and fourth columns consider how total exchange enrollment responds to a change in all exchange premiums. The semi-elasticities defined in the second and fourth columns are calculated for a \$100 change in annual premiums. The fifth column reports the annual cost of a household switching to a new plan, which equals $-12\frac{\beta_{ij}^{u}}{\beta_{i}^{p}}$. All plan means are computed using market shares as weights.

2.2 Supply

In the first stage where firms set premiums, we account for the complex regulatory and subsidy structure in the ACA exchanges. Firms set the base premium p_{jmt} for each plan j that they sell to maximize expected profit

$$\pi_{ft}(\mathbf{p}_t) = R_{ft}(\mathbf{p}_t) - C_{ft}(\mathbf{p}_t) + RA_{ft}(\mathbf{p}_t) + RI_{ft}(\mathbf{p}_t) - V_{ft}(\mathbf{p}_t) - FC_{ft}.$$
 (5)

Expected profit includes total premium revenue $R_{ft}(\mathbf{p}_t)$, total claims $C_{ft}(\mathbf{p}_t)$, risk adjustment received $RA_{ft}(\mathbf{p}_t)$, reinsurance received $RI_{ft}(\mathbf{p}_t)$, variable administrative costs $V_{ft}(\mathbf{p}_t)$ such as commissions, and the fixed cost FC_{ft} of participating in the marketplace.

Our model endogenizes risk adjustment transfers. Using our notation, we can write the average plan risk adjustment formula used in the ACA exchanges (as specified in Pope et al. (2014)'s first appendix) as

$$ra_{jmt}(\mathbf{p}_t) = \left(\frac{r_{jmt}(\mathbf{p}_t)\sum_{m\in M, l\in J_{mt}}q_{lmt}(p)}{\sum_{m\in M, l\in J_{mt}}r_{jmt}(\mathbf{p}_t)q_{lmt}(\mathbf{p}_t)} - \frac{h_j\sum_{m\in M, l\in J_{mt}}q_{lmt}(p)}{\sum_{m\in M, l\in J_{mt}}h_lq_{lmt}(\mathbf{p}_t)}\right)\overline{p}$$

where $r_{jmt}(\mathbf{p}_t)$ is the risk score determined by CMS as a function of the plan AV and enrollee characteristics, h_j is an expected utilization factor set by regulation that captures the plan AV and moral hazard, and \overline{p} is the weighted market average premium. The total transfer $RA_{jmt}(\mathbf{p}_t)$ equals

$$RA_{jmt}(\mathbf{p}_t; \boldsymbol{\theta}) = ra_{jmt}(\mathbf{p}_t)q_{jmt}(\mathbf{p}_t) = [rs_{jmt}(\mathbf{p}_t) - us_{jmt}(\mathbf{p}_t)]R_t(\mathbf{p}_t; \boldsymbol{\beta})$$
(6)

The firm's total transfer $RA_{ft}(\mathbf{p}_t) = \sum_{m \in M, j \in J_{fmt}} RA_{jmt}(\mathbf{p}_t)$. Total premium revenue in the market is $R_t(\mathbf{p}_t) = \sum_f R_{ft}(\mathbf{p}_t; \boldsymbol{\beta})$. The plan's "risk share" $rs_{jmt}(\mathbf{p}_t)$ accounts for adverse selection, moral hazard, and plan AV, whereas the plan's utilization share accounts for moral hazard and plan AV. Thus, the plan's relative risk due to adverse selection is captured by the difference between the plan's risk share and utilization share. The plan's risk share of total claims $rs_{jmt}(\mathbf{p}_t)$ in formula (6) then equals:

$$rs_{jmt}(\mathbf{p}_t) = \frac{r_{jmt}(\mathbf{p}_t)q_{jmt}(\mathbf{p}_t)}{\sum_{m \in M, l \in J_{mt}} r_{lmt}(\mathbf{p}_t)q_{lmt}(\mathbf{p}_t)}$$

where J_{mt} is all plans offered in market m and year t. Although plan risk scores are not directly observed in our data, we observe all other variables in formula (6) and can hence back out the plan risk scores from equation (6). The plan's "utilization share" $us_{jmt}(\mathbf{p}_t)$ equals:

$$us_{jmt}(\mathbf{p}_t) = \frac{h_j q_{jmt}(\mathbf{p}_t)}{\sum_{m \in M, l \in J_{mt}} h_l q_{lmt}(\mathbf{p}_t)}$$

If the risk share exceeds the utilization share, then the plan has high risk compared to expected uti-

lization and it receives a transfer from the risk adjustment program. If the utilization share exceeds the risk share, then the plan has low risk compared to expected utilization and it pays a transfer.

The first-order conditions corresponding to equation (5) are:

$$MR_{jmt}(\mathbf{p}_t) + MRA_{jmt}(\mathbf{p}_t) = (1 - \iota_{ft})MC_{jmt}(\mathbf{p}_t) + MV_{jt}(\mathbf{p}_t)$$
(7)

where ι_{ft} is the AV of the reinsurance contract. Note that this solution accounts for portfolio effects in which each firm internalizes the effects of one plan's premium on the enrollment in other plans it offers. Detailed formulas for marginal revenue $MR_{jmt}(\mathbf{p}_t) \equiv \frac{\partial R_{ft}(\mathbf{p}_t)}{\partial q_{jmt}(\mathbf{p}_t)}$, marginal claims $MC_{jmt}(\mathbf{p}_t) \equiv \frac{\partial C_{ft}(\mathbf{p}_t)}{\partial q_{jmt}(\mathbf{p}_t)}$, marginal transfers $MRA_{jmt}(\mathbf{p}_t) = \frac{\partial RA_{ft}(\mathbf{p}_t)}{\partial q_{jmt}(\mathbf{p}_t)}$, and marginal variable administrative costs $MV_{jt}(\mathbf{p}_t)$ are given in Appendix B. To reduce the computational burden of estimating and using the model for counterfactual simulations, we assume firm entry decisions are exogenous. In alternative market and policy settings, firms may decide to enter or exit specific markets or the exchange altogether, and any such shifts in market participation may have implications for our welfare estimates in the next section. Our analysis should thus be considered partial equilibrium.

We use our enrollment and insurer rate filing data to estimate every term in equation (7). Our strategy is to write equation (7) in terms of the household choice probabilities $q_{ijt}(\mathbf{p}_t)$, plan risk scores $r_{jmt}(\mathbf{p}_t)$, and plan average claims $c_{jmt}(\mathbf{p}_t)$. We calculate the household choice probabilities using equation (3). We do not observe all of the enrollee characteristics used by regulators to compute plan risk scores, and our simulations require a model of how counterfactual enrollment patterns will impact plans' risk scores and claims. Accordingly, we predict risk scores as a function of plan AV and observed household characteristics using the following estimating equation:

$$\ln r_{jmt}(\mathbf{p}_t;\boldsymbol{\beta},\boldsymbol{\gamma}) = \sum_{d\in D} \gamma^d s_{djmt}(\mathbf{p}_t;\boldsymbol{\beta}) + MT'_j \gamma^{MT} + \epsilon^r_{jmt}.$$
(8)

where $s_{djmt}(\cdot)$ is the share of plan j's enrollment with demographic characteristic d, MT_j is a vector of metal fixed effects, and ϵ_{jmt}^r is the error term. The parameter vector $\boldsymbol{\gamma} = (\gamma^d, \gamma^{MT})$ captures how plans' risk scores scale with demographic variables and plan generosity. We predict average claims using the estimating equation:

$$\ln c_{jmt}(\mathbf{p}_t;\boldsymbol{\beta},\boldsymbol{\gamma},\boldsymbol{\theta}) = \theta^r \ln r_{jmt}(\mathbf{p}_t;\boldsymbol{\beta},\boldsymbol{\gamma}) + x'_j \theta^x + \theta^u u_t + n'_m \theta^n + \epsilon^c_{jmt}$$
(9)

where x_j is an HMO dummy, u_t is a linear trend, n'_m are market fixed effects, ϵ^c_{jmt} is an error term, and $\boldsymbol{\theta} = (\theta^r, \theta^x, \theta^u, \theta^n)$ are parameters to be estimated.

We estimate the model parameters using four groups of moments: (1) moments that match the predicted household choice probabilities from equation (3) with the observed plan choices; (2) moments that match observed and predicted risk scores in equation (8); (3) moments that match observed and predicted average claims in equation (9); and (4) the first-order conditions in equation (7). Because there are more moment conditions than parameters, we use two-step feasible GMM to estimate the model parameters.

Table 6 summarizes our estimates of the parameters γ and θ . As expected, risk scores are increasing monotonically across the metal tiers. The bottom panel reports the estimated coefficients in the claims equation. If the predicted risk score increases by one percent, average claims are also predicted to increase by about one percent. For plans with the same risk score, HMOs are predicted to have 12% lower average claims, which is similar to the efficiency advantage of HMOs used in Cutler and Reber (1998). Predicted claims are also increasing about 1.3% each year.

Disk Soone Danamate		Avanaga Claima	$\mathbf{D}_{anamatons}(0)$	
Kisk score Parameters (γ)		Average Claims Parameters (0)		
Silver	0.568***	Log Risk Score	1.035***	
	(0.030)		(0.005)	
Gold	0.783***	HMO	-0.122^{***}	
	(0.052)		(0.008)	
Platinum	1.109***	Trend	0.013***	
	(0.053)		(0.002)	
Share Ages 18 to 34	-0.819^{*}	Anthem	0.272***	
	(0.462)		(0.018)	
Share Ages 35 to 54	-0.783	Blue Shield	0.175***	
	(0.681)		(0.020)	
Share Hispanic	-1.199***	Kaiser	0.203***	
	(0.222)		(0.022)	
		Health Net	0.092***	
			(0.018)	

 Table 6: Supply Parameter Estimates

Notes: Robust standard errors are in parentheses (*** indicates statistical significance at the 1% level, ** at the 5% level, and * at the 10% level).

3 Counterfactual Simulations

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The key focus of our paper is a series of simulation exercises in which we use the above model estimates to: (1) estimate the effect of removing inertia on equilibrium premiums, enrollment, and welfare in the observed ACA setting; (2) evaluate how the effects of eliminating inertia would change in the absence of firm market power and/or risk adjustment; and (3) provide insight into how three significant features in managed competition—the design of premium subsidies, consumer churn between markets, and provider network generosity, each of which is sensitive to policy choices—interact with inertia.

3.1 Simulation Methodology

We assumed that the observed ACA premiums define a Nash equilibrium that satisfies the firms' first-order conditions for profit maximization (i.e., equation (7)) to estimate the model. This equilibrium occurs in the ACA setting where consumers have inertia, firms have market power, and risk adjustment is in effect. In our main simulation analysis, we construct counterfactual scenarios that involve combinations of three changes: eliminating inertia, eliminating risk adjustment, and eliminating firm market power. We simulate the elimination of inertia by setting the lagged choice variables in the consumer's utility function to zero and re-solving for the equilibrium premiums. We simulate the elimination of risk adjustment by removing the marginal transfer from the first-order conditions and re-solving for the equilibrium premiums. We simulate the vector of premiums that sets the profit for each plan equal to zero. We run every simulation once for the years 2015-2018 and report a simple average across years.

We also conduct three analyses where we (1) eliminate the ACA's endogenous subsidy; (2) eliminate consumer eligibility churn; and (3) consider the extent to which provider network attachment drives the impact of inertia. We simulate the replacement of the ACA's endogenous subsidy with an exogenous subsidy or voucher by not allowing the observed ACA subsidy to adjust with premiums in alternative scenarios. This change implies that subsidies will remain fixed if all market premiums increase, thus raising consumers' out-of-pocket premiums. It also changes firms' first-order conditions. Mathematically, equation (4) simplifies to

$$\frac{\partial p_{ilt}(\mathbf{p}_t)}{\partial p_{jmt}} = \begin{cases} \sigma_{it} & l=j\\ 0 & l\neq j \end{cases}.$$
(10)

We simulate the elimination of consumer eligibility churn by assuming that, for each year pair t and t + 1, all consumers eligible in year t maintain eligibility for the exchange in year t + 1. We then re-solve for the equilibrium premiums. Lastly, we explore whether provider network attachment is a key driver of inertia by re-estimating our entire model with additional interactions between the lagged choice indicator variable and two network variables: network breadth (i.e., the percentage of providers covered in the market (Polsky et al., 2016)) and network inclusivity (i.e., the number

of providers within each network that overlap with other insurers' networks, as a percentage of the total possible number of shared connections (Graves et al., 2020)).¹⁵ A limitation of this sensitivity analysis is that provider network data are unavailable for approximately 20% of plans, requiring us to drop these plans.

For each simulation, we compute total social welfare in year t as $SW_t \equiv CS_t + \pi_t - \delta * GS_t$, where CS_t is consumer surplus, π_t is total firm profit, and GS_t is total government spending adjusting by a factor δ to account for the deadweight loss of taxation. We let $\delta = 1.3$ following Hausman and Poterba (1987) and Decarolis et al. (2020). Consumer surplus is

$$CS_t = -\sum_{i \in I} \frac{1}{\beta_i^p} \ln \left(e^{\beta_i^p * \rho_{it}} + \left(\sum_{j \in J} e^{V_{ijt}(\mathbf{p}_t)/\lambda} \right)^\lambda \right) - \tau \sum_{j \in J} \left[q_{ijt}(\mathbf{p}_t) * \frac{\beta_{ij}^y * y_{ij(t-1)}}{-\beta_i^p} \right] . (11)$$

where the premium parameter β_i^p is in dollars (not hundreds of dollars as in Table 6) and τ is the fraction of inertia that is assumed to be an error. The first term of equation (11) is the standard nested logit formula for consumer surplus and the second term of equation (11) "corrects" the first term to reflect the fraction τ of inertia that is an error. The parameter $\tau = 0$ if inertia is a true switching cost (e.g., the effort associated with researching plans and re-enrolling) and $\tau = 1$ if inertia is the result of behavioral error (e.g., inattention) that impacts choices, but not welfare (Handel and Schwartzstein, 2018). We assume $\tau = 1$ in our main analysis, but consider the sensitivity of our results to $\tau < 1$. Formula (11) assumes consumer welfare is accurately measured using consumers' revealed preferences.¹⁶

We compute firm profit using equation (5). Government spending equals the sum of premium subsidies, CSRs, and uncompensated care for the uninsured, minus revenue collected from the mandate penalty. Premium subsidy spending is the sum of subsidies received by each consumer in equation (2). Spending on CSRs is computed as

$$CSR_t = \sum_{i \in I, j \in J} s_j^g q_{ijt}(p; \beta) c_{jmt}(\mathbf{p}_t; \beta, \gamma, \theta)$$

where s_i^g is the expected share of claims paid by the government for plan j.¹⁷ Coughlin et al.

¹⁵There is little variation in network breadth and inclusivity variables over time, implying that the level variables are absorbed into the insurer-market fixed effects. We therefore focus on the interaction terms.

¹⁶Our model assumes that we can use revealed preference to measure consumer surplus. That is, other than the decision frictions or mistakes associated with inertia, consumers correctly value health coverage and its consequences for their health and mortality. If consumers underestimate the value of health insurance, our welfare calculations could underestimate the reduction in consumer surplus that results from consumers exiting the exchange.

¹⁷Ignoring moral hazard, the government's expected outlay is 94 - 70 = 24% of claims for the 94% CSR plan, 87 - 70 = 17% of claims for the 87% CSR plan, and 73 - 70 = 3% of claims for the 73% CSR plan. To account for moral hazard, we follow Pope et al. (2014) and assume there is no moral hazard for consumers in the 73% plan, while

(2014) estimate the per-capita amount of medical costs paid by the government on behalf of the nonelderly uninsured to be \$2,025. Uncompensated care spending is calculated as the product of \$2,025 inflated to the timeframe of this study using data from the National Health Expenditure Accounts (Centers for Medicare and Medicaid Services, 2018) and the change in the uninsured population's risk score. Penalty revenue collected by the government equals $\sum_{i \in I} q_{i0t} \rho_{it}$, where q_{i0t} is the household's probability of choosing the outside option.

3.2 Simulation Results: Removing Inertia in the ACA Environment

We summarize our key simulation results on premiums, coverage, claims, and welfare in Figures 3-5; more detailed results are available in Appendix Table A2. Figure 3 summarizes the effects of removing inertia on average premiums (panel a), enrollment (panel b), and claims (panel c). Figure 4 summarizes the same results by metal tier. The left-most bars and lines in each figure summarize the Base (ACA) setting where firms have market power and risk adjustment is in place. Panel (a) of Figure 3 indicates that eliminating inertia in the Base setting results in a large decrease (13.2%) in equilibrium premiums. This result suggests that inertia is a significant source of firm market power. The premium decrease is due to firms re-pricing; average premiums would decrease only slightly if consumers re-sorted, holding premiums fixed (see Appendix Table A2). Panel (a) of Figure 4 shows that these premium changes occur fairly evenly across the metal tiers.

Panel (b) of Figure 3 indicates that eliminating inertia leads to a 3.1% decline in total exchange enrollment in the Base setting. This result suggests that for a small share of exchange enrollees, forgoing exchange coverage is optimal in the absence of inertia. Panel (c) of Figure 3 shows that average claims decline by 3.9% in the Base setting if inertia is removed. This relatively small effect is driven both by reductions in claims within each metal tier that occur when consumers select less costly plans within tier (see panel (c) of Figure 4) and by consumers shifting from more generous metal tiers (e.g., platinum) and to less generous metal tiers (e.g., bronze) (see panel (b) of Figure 4).¹⁸

The top panel of Figure 5 shows that removing inertia increases average annual per-capita social welfare by \$902 in the Base setting after the deadweight loss of taxation factor δ is applied to government spending.¹⁹ Consumers benefit by reoptimizing plan selection and from reduced

consumers in the 87% and 94% plans increase consumption by 12%. Including moral hazard, the $s_j^g = 26.88\%$ for the 94% CSR plan, $s_j^g = 19.04\%$ for the 87% CSR plan, and $s_j^g = 3\%$ for the 73% CSR plan.

¹⁸The large differences in premiums and claims across metal levels makes the scale of the vertical axes in Figure 4 fairly large, and the effects of inertia visually small by comparison. See Appendix Table A2 for these effects in dollar terms.

¹⁹All dollar values are reported in Appendix Tables A3 and A4.



Figure 3: Impact of Inertia on Average Premiums, Coverage, and Claims by Setting











Notes: Figure reports the impact of inertia on average premiums (panel a), share of eligible consumers enrolled in an exchange plan (panel b), and average claims (panel c) by simulated setting. The base setting corresponds to the ACA where firms have market power and risk adjustment is in place. Three modifications to the base setting are considered, including: (1) eliminate risk adjustment; (2) eliminate market power; and (3) eliminate both risk adjustment and market power.



Figure 4: Impact of Inertia on Premiums, Coverage, and Claims by Metal and Setting

(c) Average Claims

Notes: Figure reports the impact of inertia on average premiums (panel a), share of exchange enrollment (panel b), and average claims (panel c) by metal tier and simulated setting. The base setting corresponds to the ACA where firms have market power and risk adjustment is in place. Three modifications to the base setting are considered, including: (1) eliminating risk adjustment; (2) eliminating market power; and (3) eliminating both risk adjustment and market power. Average platinum premiums and claims are capped at \$800 in the eliminate risk adjustment setting for presentational purposes.

premiums. Taxpayers benefit primarily through reductions in premium subsidy spending. Welfare gains for consumers and taxpayers more than offset the \$221 decrease in per-capita firm profit.

The bottom panel of Figure 5 shows how consumer surplus and net social welfare vary with the proportion of inertia τ that is assumed to be the result of a behavioral error (the top panel assumes $\tau = 1$). The positive social welfare impact of eliminating inertia in the Base scenario is fairly robust; over 81% of inertia would have to represent a true switching cost for the social welfare change to be negative.

3.3 Simulation Results: Removing Inertia, Market Power, and Risk Adjustment

Next, we evaluate the effects of removing inertia in the absence of risk adjustment and/or market power. Panel (a) in Figure 3 shows that premium decreases are substantially smaller in the alternative settings than the 13.2% decrease in the Base setting. Removing inertia reduces average premiums by 10.9% in a counterfactual setting without risk adjustment, 0.9% in a counterfactual setting without firm market power, and 2.9% in a counterfactual setting without risk adjustment or firm market power. Panel (b) of Figure 3 indicates total enrollment declines are similar in the three counterfactual settings.

Risk adjustment leads to premium compression across metal tiers, whereas oligopoly competition leads to heterogeneous markups within metal tiers. When risk adjustment and market power are removed, there are accordingly disparate patterns of consumer sorting across versus within metal tiers. Removing inertia amplifies these patterns of consumer sorting and in turn leads to very different premium impacts of inertia across settings. First, consider the effect of removing risk adjustment alone (i.e., with inertia and with market power). Removing risk adjustment eliminates the transfer payments from plans with lower-than-average risk (e.g., bronze) to plans with higher-thanaverage risk (e.g., platinum). As expected, this exacerbates adverse selection across plans, inducing a steeper gradient in premiums across metal tiers (Figure 4, panel a), and a similarly steep gradient in claims across metal tiers (Figure 4, panel c). In equilibrium, this leads to bronze plans increasing market share from 27% to 40%, while the market share of the gold and platinum tiers combined nearly unravels from 10% to 1% (Figure 4, panel b). Eliminating inertia in the absence of risk adjustment then has a somewhat smaller effect on average premiums than in the Base setting. This is because removing risk adjustment on its own leads to dramatic shifts in enrollment away from the gold and platinum tiers, and to drops in bronze and silver premiums. The incremental effect of removing inertia is then layered on top of those effects, generating slightly smaller additional pre-



Figure 5: Impact of Inertia on Average Annual Per-Capita Welfare by Setting

(a) Change in Consumer Surplus, Profit, Government Spending, and Social Welfare



(b) Sensitivity of Welfare to Whether Inertia Is True Switching Cost

Notes: Figure reports the impact of inertia on average annual per-capita welfare by simulated setting. Panel (a) displays consumer surplus, firm profit, government spending (including premium subsidies, CSRs, mandate penalties collected, and uncompensated care), and net social welfare for each simulated scenario. Net social welfare calculation applies the deadweight loss of taxation to government spending before aggregating. Panel (b) shows how consumer surplus and net social welfare vary with the proportion of inertia τ that is the result of a behavioral error (the first panel assumes $\tau = 1$).
mium decreases and enrollment shifts. For example, the combined gold and platinum tiers' market share declines 1.9 percentage points in the Base setting when inertia is eliminated, but only 0.5 percentage points in this setting.

Next, consider the effect of removing market power alone (i.e., with inertia and with risk adjustment). As expected, removing market power decreases premiums in all metal tiers (Figure 4, panel a) and increases enrollment in the market (Figure 3, panel b). The premium decreases vary significantly within metal tiers depending on which plans have higher markups in the Base setting. Because some silver and platinum plans have particularly high markups in the Base setting (Figure 4, panel a), consumers sort into these plans and away from bronze plans when market power is removed (Figure 4, panel b). Eliminating inertia then enhances this pattern of consumer substitution from less generous to more generous tiers. The combined gold and platinum market share declines by 1.9 percentage points in the Base setting, but increases by 4.6 percentage points in the setting without market power. Given that the more generous tiers are adversely selected, this increase in market share leads to further decreases in premiums (Figure 4, panel a) and claims (Figure 4, panel c) in the gold and platinum tiers. On net, eliminating inertia without firm market power has a minimal impact on average premiums because it shifts demand towards cheaper plans within the more expensive gold and platinum tiers.

Given the very different interactions risk adjustment and market power have with inertia on their own, we would expect eliminating inertia without risk adjustment or market power to have an intermediate effect on premiums. Indeed, premiums decline in all metal tiers when both risk adjustment and market power are removed, but the gradient in premiums across metal tiers is considerably steeper (Figure 4, panel a). Consequently, the enrollment shifts associated with eliminating risk adjustment alone and market power alone are both present when risk adjustment and market power are removed. Bronze plan market share expands, but so does gold and platinum market share. Eliminating inertia enhances these demand shifts. Hence, eliminating inertia without risk adjustment and market power has a smaller impact on average premiums than in the setting without risk adjustment, but a larger impact than in the setting without market power.²⁰

Eliminating inertia has the largest impact on social welfare in the Base setting. The top panel of Figure 5 indicates that when inertia is eliminated, per-capita social welfare increases \$902 in the Base setting, compared to \$658 in the absence of risk adjustment, \$547 in the absence of mar-

²⁰Appendix Table A5 provides further insight into this phenomenon; when inertia is removed in a scenario without market power, consumer sorting into lower-cost plans within metal tier causes monthly premiums to decrease by \$38 in the platinum tier if risk adjustment is applied, but by \$74 in the platinum tier if risk adjustment is not applied. Adverse selection *across* metal tiers then causes platinum premiums to rise by \$15 if risk adjustment is applied, and by \$67 if risk adjustment is not applied.

ket power, and \$250 in the absence of both market power and risk adjustment. Consumer surplus changes are similar in all four settings, in part because the ACA's endogenous subsidies shield consumers from premium changes. However, taxpayers fare far worse in the counterfactual settings because the average premium reductions are smaller than in the Base setting, resulting in substantially smaller reductions in government subsidy spending. In fact, government subsidy spending slightly increases in the setting where both risk adjustment and market power are eliminated because of an increase in silver plan premiums (recall that the ACA's endogenous subsidy is tied to the second-cheapest silver plan premium).

In the bottom panel of Figure 5, eliminating inertia is much less likely to be welfare-improving. For example, in contrast to the Base scenario, eliminating inertia in a setting without risk adjustment and market power would result in a negative welfare impact if only about 25% of inertia represents a true switching cost. In this setting, removing inertia would reduce welfare by \$709 if all of inertia were a true switching cost. Thus, there are settings in which "nudging would hurt" in the California exchange as in Handel (2013)'s analysis of employer-based health insurance. This sensitivity exercise demonstrates that the ranking of inertia's impact on social welfare is preserved for all values of τ . Eliminating inertia in the Base setting has the largest welfare *benefit* if inertia is purely a behavioral error and the smallest welfare *cost* if inertia is a true switching cost.

3.4 Simulation Results: Inertia Interactions with Subsidy Design, Consumer Churn, and Provider Networks

Finally, we explore how several policy-driven features of the ACA environment interact with inertia. First, we convert the ACA's endogenous, price-linked subsidy to an exogenous subsidy or voucher. Second, we eliminate churn in exchange eligibility. Third, we evaluate the impact of provider networks on inertia by removing only the part of inertia not driven by provider network inclusivity. The results are presented in Figure 6.

Eliminating inertia when subsidies are set exogenously at the observed ACA subsidy has a smaller overall impact than in the Base setting where subsidies are endogenous.²¹ This is because switching from endogenous subsidies to exogenous subsidies already reduces firm market power. Converting the ACA's endogenous subsidy to an exogenous subsidy reduces average premiums by \$2 per month. This premium decrease would be significantly larger in a market with less competition than in the California exchange, particularly if only one firm participated and could exert full control over the benchmark premium; see, e.g., Jaffe and Shepard (2020). With exogenous subsid

²¹See Appendix Tables A6 and A7 for dollar values.

dies, average premiums fall by 8.7% (panel a) and exchange coverage falls by 1.3% (panel b) when inertia is eliminated. The reduction in coverage is less than half of the 3.1% reduction in the Base setting. The elimination of inertia is more beneficial for consumers with an exogenous subsidy because consumers fully benefit from premium savings associated with switching plans (panel c). Conversely, government spending is largely unchanged when we remove inertia because subsidy levels are fixed. Annual per-capita social welfare increases by only \$532, compared with \$902 in the Base setting.

Eliminating inertia in a market without churn has a larger impact than in the Base setting where churn is significant.²² This is because eliminating eligibility churn increases the proportion of inertial enrollees over whom incumbent insurers have greater market power; on its own, eliminating churn causes average premiums to increase from \$442 to \$451 (panel a). Eliminating inertia without churn reduces average premiums by 16.8%, compared with 13.2% in the Base setting. The 4.5% reduction in coverage is more than 30% larger than the 3.1% reduction in the Base setting (panel b). Consumers who churn in the Base setting are more premium-sensitive and have weaker preferences for insurance. Annual per-capita social welfare increases by \$965 (panel c), which is slightly larger than the \$902 increase in the Base setting. These simulation results indicate that high consumer churn in the ACA exchanges mitigates some of the impact of inertia.

In our final analysis, we investigate whether consumer attachment to a plan's provider network could be a key mechanism driving the impact of inertia in the ACA exchanges.²³ Attachment to a provider network could be a key driver if there are hassle costs, health costs, or other costs associated with disrupting relationships with providers once established (Drake et al., 2021; Sabety, 2021). Appendix Table A8 indicates that network breadth has only a minimal effect on plan choice, but network inclusivity has a statistically significant and negative impact on plan choice. For example, a standard deviation increase in the network breadth of an enrollee's lagged plan (13.6%) is valued equivalently to a \$0.02 increase in monthly premiums, but a standard deviation increase in the network inclusivity of an enrollee's lagged plan (14.8%) is valued equivalently to a \$8.34 decrease in monthly premiums. Inertia is therefore smaller when a plan's network has more in common with other plan networks and larger when the network contains more exclusive providers. These effects are too small to affect our simulation results. Figure 6 indicates that eliminating inertia except for the part due to network attachment has a similar impact on premiums, enrollment, and welfare as eliminating all inertia in the Base setting. Hence, network preferences do not appear to be a key mechanism driving the welfare impact of inertia.

²²See Appendix Tables A6 and A7 for dollar values.

²³See Appendix Table A9 for dollar values.

Figure 6: Equilibrium Impacts of Inertia's Interactions with Subsidy Design, Consumer Churn, and **Provider Networks**



(c) Change in Consumer Surplus, Profit, Government Spending, and Social Welfare

Notes: Figure reports the impact of inertia on average premiums (panel a), share of eligible consumers enrolled in an exchange plan (panel b), and social welfare (panel c) by simulated setting. The base setting corresponds to the ACA where firms have market power and risk adjustment is in place. Three modifications to the base setting are considered, including: (1) make subsidy exogenous; (2) eliminate churn; and (3) consider the role of provider network inclusivity. The third modified setting compares a reestimated base model with inertia that includes an interaction term between the lagged choice and network inclusivity, with a scenario where inertia is eliminated except for the portion linked to network inclusivity.

4 Conclusion

The provision of health insurance in the U.S. relies heavily on managed competition markets. The goal of managed competition is to encourage private firms to compete and offer high-quality, low-cost benefits to consumers. In this paper, we present new evidence on how consumer choice frictions dampen firm competition in an important environment: the California ACA health insurance exchange. We also illustrate how the fairly intricate policy choices common to managed competition markets can amplify or mitigate these effects.

The choice friction of interest in this paper is inertia, the tendency of consumers not to switch product choices over time even when other products become preferable. We present three novel sets of results regarding inertia in the ACA environment. First, we find high average annual per-capita switching costs of \$2,324, or 44% of average premiums, and we estimate that the elimination of these switching costs would reduce average premiums by 13.2%. These results indicate that inertia is a significant source of firm market power. The premium decreases benefit consumers and the government through reduced subsidy spending, increasing annual per-capita welfare by \$902.

Second, we observe a substantially smaller impact from eliminating inertia on average premiums and social welfare when firm market power and/or risk adjustment are removed. Eliminating inertia in the absence of market power increases consumer surplus by allowing consumers to switch into better plans. However, the net impact on social welfare is smaller than in the ACA setting because government subsidy reductions are small (due to the minimal change in premiums) and firm profit is unaffected (by construction). Removing risk adjustment on its own nearly leads to unraveling of the most generous gold and platinum plan tiers. Eliminating inertia in this setting therefore has a smaller incremental impact on consumer surplus, firm profit, and government spending than in the ACA setting because the market for generous coverage has already largely collapsed.

Third, we analyze several channels through which the effects of inertia are sensitive to policy. Eliminating inertia has a smaller role to play in mitigating market power if premium subsidies are converted to vouchers, but has a larger impact if churn in the exchanges is reduced (e.g., through changes to subsidy eligibility rules or the enactment of a BHP program). The impact of inertia is not sensitive to provider network generosity.

Our study results support the case for reducing choice frictions in the ACA exchanges, particularly in highly-concentrated markets where insurers have considerable market power. However, a primary limitation of our analysis is that we do not identify the economic mechanisms underlying inertia. Thus, we cannot quantify the potentially variable effects of diverse policies intended to reduce inertia. This is currently an active area of research complementary to our own (Brot-Goldberg et al., 2021; Domurat et al., 2021; Drake et al., 2021; Kling et al., 2012). Of particular interest are policies that may reduce switching frictions while encouraging enrollees to remain insured, particularly in light of the ACA's central goal of expanding affordable health insurance coverage to the substantial uninsured population. We find that removing inertia would lead to a small increase in the rate of uninsurance. If one takes our model at face value, this is optimal from a social welfare perspective. However, inertia may not be the only choice friction at work in the ACA or other insurance markets (Abaluck and Gruber, 2011; Handel and Kolstad, 2015). If other frictions exist that lead consumers to place too little weight on the mortality consequences of their insurance choices (Abaluck et al., 2021), then our model parameters may not fully reflect the impact of reductions in insurance on welfare.²⁴

In spite of these limitations, our paper offers novel evidence on the predicted consequences of removing inertia for premiums, government spending, and enrollment in an important new marketplace. Our paper also offers a tractable framework for evaluating those consequences as further evidence develops on the mechanisms underlying inertia, and as new managed competition policies are developed and tested.

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²⁴For recent research on the mortality effects of being insured or being more generously insured, see, e.g., Chandra et al. (2021), Goldin et al. (2021), Miller et al. (2021), and review in Sommers et al. (2017).

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ELECTRONIC APPENDICES – NOT FOR PRINT PUBLICATION

A Constructing the Outside Option

In this study, we use five years of administrative longitudinal data on exchange enrollees. Previous studies of the California exchange treat demand as static and construct the outside option by merging the administrative data with survey data on the uninsured from sources such as the American Community Survey (ACS) or Current Population Survey (CPS) (Tebaldi, 2020; Domurat, 2018; Saltzman, 2019). Our focus is on switching between plans and transitions between exchange plans and other options (i.e., no insurance or exiting the market for another insurance option). Hence, we construct the outside option population using enrollees in our administrative data for years in which they were not enrolled in an exchange plan, subject to remaining eligible for exchange coverage. For example, a consumer that appears in our administrative data in 2016 and 2017 would be deemed uninsured in 2014, 2015, and 2018, subject to remaining eligible for exchange coverage.

In our administrative data, we do not observe whether consumers become uninsured or become ineligible for exchange coverage in years that they do not appear. We impute eligibility for exchange coverage using data from the U.S. Census Bureau's Survey of Income and Program Participation (SIPP) (U.S. Census Bureau, 2019). The SIPP is a panel data set that asks respondents their insurance status during each month. The SIPP also asks respondents why they may have changed coverage status. Potential reasons include obtaining or losing an offer of employer-provided insurance, moving into or out of the state, or becoming eligible for public insurance such as Medicare or Medicaid. To conduct the imputation, we first identify SIPP respondents who transitioned into or out of the individual market. For these respondents, we then construct a transitioned variable indicating whether the respondent became newly eligible or ineligible for the individual market. This variable equals 1 if at least one of the following criteria are met: (1) the respondent is a member of a household that lost or gained an employer-sponsored insurance offer; (2) the respondent moved into or out of California; (3) the respondent experienced a drop in income that made him or her eligible for Medicaid; and (4) the respondent turned 65 and became eligible for Medicare. We estimate a binomial logit model that regresses the transitioned variable on observable demographic characteristics available in both the SIPP and the administrative data, including age, gender, race, income and size of household. We then used the estimated logit to perform an out-of-sample prediction of the probability of exchange eligibility in our administrative data. If this probability exceeded a random draw from the uniform distribution on the interval (0, 1), then the consumer was flagged as exchange eligible. We remove from our outside option population any consumer-year combinations that correspond to years during which the consumer was predicted to be ineligible for exchange coverage. For the example consumer above, the logit prediction would be used to determine if the consumer transitioned into or out of the market and was therefore ineligible for exchange coverage in 2014, 2015, and 2018.

B Mathematical Formulas in the ACA Exchange Model

In this appendix, we write the model variables in terms of three variables: (1) the household choice probabilities $q_{ijt}(\mathbf{p}_t)$; (2) the risk scores $r_{jmt}(\mathbf{p}_t)$; and (3) plan average claims $c_{jmt}(\mathbf{p}_t)$. Marginal revenue $MR_{jmt}(\mathbf{p}_t)$, marginal claims $MC_{jmt}(\mathbf{p}_t)$, marginal transfer $MRA_{jmt}(\mathbf{p}_t)$, and marginal variable administrative cost $MV_{jt}(\mathbf{p}_t)$ can be expressed as

$$MR_{jmt}(\mathbf{p}_{t}) = \left(\frac{\partial q_{jmt}(\mathbf{p}_{t})}{\partial p_{jmt}}\right)^{-1} \sum_{i \in I, k \in J_{fmt}} \sigma_{it} \left(q_{ijt}(\mathbf{p}_{t}) + p_{kmt}\frac{\partial q_{ikt}(\mathbf{p}_{t})}{\partial p_{jmt}}\right)$$

$$MC_{jmt}(\mathbf{p}_{t}) = \left(\frac{\partial q_{jmt}(\mathbf{p}_{t})}{\partial p_{jmt}}\right)^{-1} \sum_{k \in J_{fmt}} \left[c_{kmt}(\mathbf{p}_{t})\frac{\partial q_{kmt}(\mathbf{p}_{t})}{\partial p_{jmt}} + q_{kmt}(\mathbf{p}_{t})\frac{\partial c_{kmt}(\mathbf{p}_{t})}{\partial p_{jmt}}\right] \quad (12)$$

$$MRA_{jmt}(\mathbf{p}_{t}) = \left(\frac{\partial q_{jmt}(\mathbf{p}_{t})}{\partial p_{jmt}}\right)^{-1} \sum_{k \in J_{fmt}} \left[\frac{\partial R_{t}(\mathbf{p}_{t})}{\partial p_{jmt}} \left(rs_{kmt}(\mathbf{p}_{t}) - us_{kmt}(\mathbf{p}_{t})\right) + R_{t}(\mathbf{p}_{t})\left(\frac{\partial rs_{kmt}(\mathbf{p}_{t})}{\partial p_{jmt}} - \frac{\partial us_{kmt}(\mathbf{p}_{t})}{\partial p_{jmt}}\right)\right] \quad (13)$$

$$MV_{jt}(\mathbf{p}_t) = v_{ft} \frac{\partial q_{ft}(\mathbf{p}_t) / \partial p_{jmt}}{\partial q_{jmt}(\mathbf{p}_t) / \partial p_{jmt}}$$
(14)

where v_{ft} is average variable administrative cost and

$$\frac{\partial R_t(\mathbf{p}_t)}{\partial p_{jmt}} = \sum_{l \in J_{mt}} MR_{lmt}(\mathbf{p}_t) \frac{\partial q_{lmt}(\mathbf{p}_t)}{\partial p_{jmt}}$$

$$\frac{\partial us_{kmt}(\mathbf{p}_t)}{\partial p_{jmt}} = \left(\sum_{m \in M, l \in J_{mt}} h_l q_{lmt}(\mathbf{p}_t)\right)^{-1} \left[h_k \frac{\partial q_{kmt}(\mathbf{p}_t)}{\partial p_{jmt}} - \frac{h_k q_{kmt}(\mathbf{p}_t)}{\sum_{m \in M, l \in J_{mt}} h_l q_{lmt}(\mathbf{p}_t)} \sum_{l \in J_{mt}} h_l \frac{\partial q_{lmt}(\mathbf{p}_t)}{\partial p_{jmt}}\right]^{-1} \left[\left(r_{kmt}(\mathbf{p}_t) \frac{\partial q_{kmt}(\mathbf{p}_t)}{\partial p_{jmt}} + q_{kmt}(\mathbf{p}_t) \frac{\partial r_{kmt}(\mathbf{p}_t)}{\partial p_{jmt}}\right) - \frac{r_{jmt}(\mathbf{p}_t)q_{jmt}(\mathbf{p}_t)}{\sum_{m \in M, l \in J_{mt}} r_{lmt}(\mathbf{p}_t)q_{lmt}(\mathbf{p}_t)} \sum_{l \in J_{mt}} \left[r_{lmt}(\mathbf{p}_t) \frac{\partial q_{lmt}(\mathbf{p}_t)}{\partial p_{jmt}} + q_{lmt}(\mathbf{p}_t) \frac{\partial r_{lmt}(\mathbf{p}_t)}{\partial p_{jmt}}\right]\right]$$

Given the nested logit error, the (k, j) element of the Jacobian matrix of the household choice probability is

$$\frac{\partial q_{ikt}(\mathbf{p}_t)}{\partial p_{ijt}} = \begin{cases} \beta_i^p q_{ijt}(\mathbf{p}_t) \left[\frac{1}{\lambda} + \frac{\lambda - 1}{\lambda} q'_{ijt}(\mathbf{p}_t) - q_{ijt}(\mathbf{p}_t)\right] & k = j\\ \beta_i^p q_{ijt}(\mathbf{p}_t) \left[\frac{\lambda - 1}{\lambda} q'_{ijt}(\mathbf{p}_t) - q_{ijt}(\mathbf{p}_t)\right] & k \neq j \end{cases}$$
(15)

where $q'_{ijt}(\mathbf{p}_t)$ is the probability of choosing *j*, conditional on choosing a plan. The (k, j)-element of the Jacobian matrix of the plan risk score equals

$$\frac{\partial r_{kmt}(\mathbf{p}_t)}{\partial p_{jmt}} = \frac{r_{kmt}(\mathbf{p}_t)}{q_{kmt}(\mathbf{p}_t)} \sum_{d \in D} \gamma^d \left[\frac{\partial q_{dkmt}(\mathbf{p}_t)}{\partial p_{jmt}} - s_{dkmt}(\mathbf{p}_t) \frac{\partial q_{kmt}(\mathbf{p}_t)}{\partial p_{jmt}} \right].$$
(16)

The (k, j)-element of the Jacobian matrix of plan average claims equals

•

$$\frac{\partial c_{kmt}(\mathbf{p}_t)}{\partial p_{jmt}} = \theta^r \frac{c_{kmt}(\mathbf{p}_t)}{r_{kmt}(\mathbf{p}_t)} \frac{\partial r_{kmt}(\mathbf{p}_t)}{\partial p_{jmt}}$$
(17)

C Detailed Results

	(1)	(2)	(3)		(1)	(2)	(3)
Monthly Premium (\$100) ×	-0 174***	-0.135***	-0.141***	Previous Choice ×	0 553***	0.231***	0.272***
(\$100) / (\$100) / (\$100)	(0.002)	(0.002)	(0.002)		(0.007)	(0.010)	(0.011)
250% to 400% of FPL	(01002)	0.039***	0.041***	250% to 400% of FPL	(0.007)	0.021***	0.023***
200 % 10 100 % 01 112		(0.001)	(0.001)			(0.003)	(0.003)
> 400% of FPL		0.082***	0.089***	>400% of FPL		0.036***	0.044***
y 100 % 01112		(0.002)	(0.002)	, 100 % 01 11 <u>1</u>		(0.004)	(0.004)
Ages 0 to 17		-0.157^{***}	-0.158***	Age 0 to 17		-0.008	-0.006
		(0.004)	(0.004)	1190 0 10 17		(0.007)	(0.007)
Ages 18 to 34		-0.186***	-0.193***	Age 18 to 34		-0.009***	-0.009***
11ges 10 to 5 1		(0.003)	(0.003)	11ge 10 to 5 1		(0.003)	(0.003)
Ages 35 to 54		-0.087***	-0.092***	Age 35 to 54		-0.013***	-0.014^{***}
11ges 55 to 51		(0.007)	(0.002)	11ge 55 to 51		(0.003)	(0.003)
Black		-0.021***	-0.024***	Black		-0.027***	-0.025***
Diack		(0.003)	(0.003)	Diack		(0.008)	(0.009)
Hispanic		-0.073***	-0.080***	Hispanic		-0.027***	-0.032***
Inspane		(0.002)	(0.002)	Inspanie		(0.003)	(0.003)
Asian		-0.055***	-0.060***	Asian		-0.052***	-0.053***
Asian		-0.055	-0.000	Asiali		-0.032	-0.055
Other read		(0.001)	(0.002)	Other reco		(0.005)	(0.003)
Other face		-0.000	-0.008	Other face		-0.017	-0.019
Mala		(0.002)	(0.002)	Mala		0.026***	0.020***
Wate		-0.021	-0.023	Wate		(0.020	(0.029
Family		(0.001)	(0.001)	Family		0.003)	(0.003)
Panny		-0.001	(0.000	Failing		-0.044	-0.030
AX7	0.501***	(0.001)	(0.001)	Anthom		(0.002)	(0.002)
4V	0.391	0.817	0.838	Allulelli		0.121	0.111
2:1	(0.007)	(0.010)	(0.010)	Dhar Chiald		(0.007)	(0.007)
Sliver	0.122	0.134	0.148	Blue Shleid		0.217	0.208
IN CO.	(0.002)	(0.002)	(0.002)	W :		(0.007)	(0.008)
АМО	-0.014***	-0.034***	-0.0/3***	Kaiser		0.054	0.060***
	(0.001)	(0.001)	(0.002)	TT LL NT		(0.004)	(0.004)
Anthem	0.078***	0.092***	0.305***	Health Net		0.028	0.032
01.11	(0.002)	(0.002)	(0.009)	IIMO		(0.004)	(0.004)
Sive Shield	0.09/***	0.103***	0.222***	HMO		0.145	0.141
	(0.002)	(0.002)	(0.008)	437		(0.000)	(0.007)
Kaiser	0.116***	0.138***	0.057***	AV		0.39/***	0.420***
T 1.1 XT .	(0.002)	(0.002)	(0.005)	0.1		(0.011)	(0.012)
Health Net	0.020***	0.022***	-0.146***	Silver		-0.181***	-0.199***
	(0.001)	(0.001)	(0.010)			(0.003)	(0.004)
Anthem x HMO	-0.170***	-0.179***	-0.130***				
	(0.003)	(0.004)	(0.003)				
Nesting Parameter	0.130***	0.136***	0.148***				
	(0.002)	(0.002)	(0.002)				

Table A1: Estimated Demand Parameters

Notes: Robust standard errors are in parentheses (*** indicates statistical significance at the 1% level, ** at the 5% level, and * at the 10% level). Specification is the same as in Table 4 specification (2).

	Base	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Scenario Definitions									
Inertia	\checkmark			\checkmark		\checkmark		\checkmark	
Oligopoly	\checkmark	N/A	\checkmark	\checkmark	\checkmark				
Risk adjustment	\checkmark	\checkmark	\checkmark			\checkmark	\checkmark		
Endog. Subsidy	\checkmark								
Churn	\checkmark								
Monthly Premiums (U	Insubsidized	Unless Othe	rwise Indica	ted)					
Bronze	\$354	\$361	\$305	\$241	\$222	\$319	\$315	\$240	\$222
Silver	\$471	\$464	\$412	\$454	\$414	\$417	\$413	\$412	\$414
Gold	\$488	\$494	\$455	\$536	\$539	\$451	\$437	\$443	\$458
Platinum	\$540	\$538	\$500	\$1194	\$1171	\$485	\$463	\$514	\$511
Anthem	\$483	\$468	\$405	\$411	\$346	\$432	\$414	\$431	\$437
Blue Shield	\$473	\$466	\$419	\$426	\$386	\$431	\$429	\$441	\$438
Health Net	\$404	\$406	\$347	\$327	\$293	\$353	\$378	\$369	\$345
Kaiser	\$446	\$448	\$391	\$362	\$318	\$389	\$388	\$362	\$370
Other Insurer	\$388	\$396	\$345	\$302	\$288	\$361	\$358	\$336	\$297
HMO	\$422	\$425	\$369	\$348	\$315	\$374	\$378	\$356	\$347
PPO	\$473	\$461	\$406	\$396	\$342	\$429	\$424	\$439	\$420
Average	\$442	\$440	\$384	\$369	\$329	\$397	\$394	\$384	\$373
Subsidized Avg.	\$128	\$126	\$117	\$93	\$80	\$122	\$120	\$90	\$70
Coverage									
Total Coverage	1,756,594	1,697,805	1,702,317	1,768,673	1,716,190	1,771,489	1,712,952	1,805,534	1,761,966
% Enrolled	74.3%	71.9%	72.0%	74.8%	72.6%	75.0%	72.5%	76.4%	74.6%
Bronze	27.1%	27.9%	29.9%	40.1%	44.2%	24.0%	23.7%	29.1%	29.8%
Silver	62.6%	59.9%	61.6%	58.9%	55.3%	65.2%	60.8%	52.7%	44.9%
Gold	6.3%	7.7%	5.7%	1.0%	0.5%	5.7%	8.0%	11.8%	13.8%
Platinum	4.0%	4.5%	2.7%	0.0%	0.0%	5.2%	7.4%	6.4%	11.5%
% Switching	0.0%	25.9%	28.4%	13.3%	34.4%	8.0%	32.1%	20.0%	42.0%
Monthly Claims									
Bronze	\$224	\$250	\$220	\$221	\$218	\$228	\$216	\$250	\$225
Silver	\$393	\$425	\$389	\$395	\$392	\$395	\$388	\$394	\$358
Gold	\$523	\$532	\$515	\$532	\$539	\$520	\$490	\$395	\$450
Platinum	\$751	\$761	\$732	\$1154	\$1114	\$767	\$718	\$552	\$562
Average	\$370	\$399	\$355	\$327	\$316	\$381	\$381	\$362	\$354

Table A2: Simulation Results: Premiums, Coverage, and Claims

Notes: Table reports the impact on premiums, coverage, and claims for each scenario. The Base (or ACA) column reports the observed premiums and coverage. In scenario (1), we eliminate inertia and allow consumers to choose a new plan, but keep premiums the same as in the Base scenario. In scenarios (2) through (8), we simulate combinations of 3 changes: (1) eliminating inertia; (2) repealing risk adjustment; and (3) changing the market structure from oligopoly to perfect competition. The first panel defines each of the scenarios. The second panel summarizes enrollee-weighted average unsubsidized premiums by metal level, insurer, and plan network type. The bottom two rows of the second panel show overall enrollee-weighted average premiums ("Average") and subsidized average premiums ("Subsidized Avg."). The third panel shows total enrollment, the percentage of consumers enrolled in coverage, and market shares by metal level. The final row of the third panel indicates the percentage of consumers who switched plans from the Base scenario. The fourth panel reports average claims by metal tier and on average across all enrollees.

	Base	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Scenario Definitions									
Inertia	\checkmark			\checkmark		\checkmark		\checkmark	
Oligopoly	\checkmark	N/A	\checkmark	\checkmark	\checkmark				
Risk adjustment	\checkmark	\checkmark	\checkmark			\checkmark	\checkmark		
Endog. Subsidy	\checkmark								
Churn	\checkmark								
Welfare Changes									
Cons. Surplus		\$470	\$488	\$101	\$510	\$57	\$529	\$262	\$682
Profit		(\$12)	(\$221)	(\$153)	(\$299)	(\$492)	(\$492)	(\$492)	(\$492)
Gov. Spending									
Prem. Subsidies		(\$100)	(\$500)	(\$333)	(\$639)	(\$549)	(\$607)	(\$227)	(\$74)
CSRs		(\$23)	(\$14)	(\$12)	(\$35)	\$14	(\$12)	(\$37)	(\$81)
Penalties		\$25	\$23	(\$5)	\$18	(\$7)	\$18	(\$21)	(\$3)
Uncomp. Care		\$52	\$49	(\$8)	\$38	(\$13)	\$40	(\$39)	\$0
Social Welfare		\$582	\$902	\$402	\$1060	\$267	\$814	\$136	\$386

Table A3: Simulation Results: Change in Annual Per-Capita Social Welfare

Notes: Table reports the change in annual per-capita social welfare for each scenario relative to the Base (or ACA) scenario. In scenario (1), we eliminate inertia and allow consumers to choose a new plan, but keep premiums for each scenario the same as in the Base scenario. In scenarios (2) through (8), we simulate combinations of 3 changes: (1) eliminating inertia; (2) repealing risk adjustment; and (3) changing the market structure from oligopoly to perfect competition. The first panel defines each of the scenarios. The second panel reports the change in annual per-capita consumer surplus, firm profit, government spending (including premium subsidies, cost sharing reductions, individual mandate penalties, and uncompensated care), and total social welfare relative to the Base scenario.

	Base	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Scenario Definitions									
Inertia	\checkmark			\checkmark		\checkmark		\checkmark	
Oligopoly	\checkmark	N/A	\checkmark	\checkmark	\checkmark				
Risk adjustment	\checkmark	\checkmark	\checkmark			\checkmark	\checkmark		
Endog. Subsidy	\checkmark								
Churn	\checkmark								
Cons. Surplus									
$\tau = 1$		\$470	\$488	\$101	\$510	\$57	\$529	\$262	\$682
$\tau = 0.75$		\$194	\$211	\$72	\$233	\$60	\$253	\$226	\$405
$\tau = 0.50$		(\$83)	(\$65)	\$42	(\$43)	\$62	(\$23)	\$189	\$129
$\tau = 0.25$		(\$359)	(\$341)	\$12	(\$319)	\$65	(\$300)	\$152	(\$147)
$\tau = 0$		(\$635)	(\$618)	(\$17)	(\$596)	\$67	(\$576)	\$116	(\$424)
Social Welfare									
$\tau = 1$		\$582	\$902	\$402	\$1060	\$267	\$814	\$136	\$386
$\tau = 0.75$		\$306	\$625	\$372	\$783	\$269	\$538	\$100	\$110
$\tau = 0.50$		\$30	\$349	\$342	\$507	\$272	\$261	\$63	(\$166)
$\tau = 0.25$		(\$247)	\$73	\$313	\$231	\$274	(\$15)	\$26	(\$443)
$\tau = 0$		(\$523)	(\$204)	\$283	(\$45)	\$276	(\$291)	(\$10)	(\$719)

Table A4: Simulation Results: Sensitivity to Inertia Role in Welfare

Notes: Table reports the sensitivity (as measured by the percentage of inertia τ that is considered to be a choice error) of the change in annual per-capita consumer surplus and social welfare for each scenario relative to the Base (or ACA) scenario. In scenario (1), we eliminate inertia and allow consumers to choose a new plan, but keep premiums for each scenario the same as in the Base scenario. In scenarios (2) through (8), we simulate combinations of 3 changes: (1) eliminating inertia; (2) repealing risk adjustment; and (3) changing the market structure from oligopoly to perfect competition. The first panel defines each of the scenarios. The second and third panels report the change in annual per-capita consumer surplus and social welfare, respectively, relative to the Base scenario.

	Base	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Scenario Definitions									
Inertia	\checkmark			\checkmark		\checkmark		\checkmark	
Oligopoly	\checkmark	N/A	\checkmark	\checkmark	\checkmark				
Risk adjustment	\checkmark	\checkmark	\checkmark			\checkmark	\checkmark		
No Sorting									
Bronze	\$354	\$354	\$300	\$245	\$219	\$324	\$318	\$249	\$229
Silver	\$471	\$471	\$420	\$460	\$425	\$420	\$426	\$498	\$520
Gold	\$488	\$488	\$467	\$766	\$755	\$471	\$460	\$460	\$454
Platinum	\$540	\$540	\$544	\$1505	\$1257	\$486	\$488	\$525	\$520
Average	\$442	\$442	\$394	\$460	\$421	\$399	\$400	\$427	\$435
Sorting within metal									
Bronze	\$354	\$358	\$303	\$249	\$230	\$319	\$314	\$250	\$239
Silver	\$471	\$468	\$416	\$450	\$410	\$418	\$418	\$443	\$421
Gold	\$488	\$483	\$452	\$654	\$613	\$457	\$435	\$420	\$415
Platinum	\$540	\$532	\$512	\$1156	\$1154	\$479	\$450	\$492	\$446
Average	\$442	\$441	\$391	\$434	\$402	\$395	\$391	\$389	\$371
Sorting within exchange									
Bronze	\$354	\$362	\$306	\$241	\$222	\$319	\$316	\$241	\$223
Silver	\$471	\$464	\$413	\$455	\$416	\$417	\$414	\$445	\$416
Gold	\$488	\$495	\$456	\$536	\$541	\$451	\$438	\$413	\$459
Platinum	\$540	\$539	\$501	\$1194	\$1177	\$485	\$465	\$515	\$513
Average	\$442	\$440	\$385	\$370	\$330	\$397	\$395	\$386	\$375
Full Sorting									
Bronze	\$354	\$361	\$305	\$241	\$222	\$319	\$315	\$240	\$222
Silver	\$471	\$464	\$412	\$454	\$414	\$417	\$413	\$443	\$414
Gold	\$488	\$494	\$455	\$536	\$539	\$451	\$437	\$412	\$458
Platinum	\$540	\$538	\$500	\$1194	\$1171	\$485	\$463	\$514	\$511
Average	\$442	\$440	\$384	\$369	\$329	\$397	\$394	\$384	\$373

Table A5: Effect of Consumer Sorting on Average Premiums

Notes: Table summarizes weighted average premiums using four different sets of markets shares: (1) market shares under the base case/ACA (panel 1); (2) market shares that allow consumers to choose a new plan in the same metal tier as they chose in the base case; (3) market shares that allow consumers to choose any new plan, but not forgo insurance; and (4) market shares that allow consumers to choose a new plan or forgo insurance (panel 4). The premiums in the bottom panel are the same as the premiums in Table A2.

	Base	(2)	(9)	(10)	(11)	(12)
Scenario Definitions						
Inertia	\checkmark		\checkmark		\checkmark	
Oligopoly	\checkmark	\checkmark	\checkmark	\checkmark	\checkmark	\checkmark
Risk adjustment	\checkmark	\checkmark	\checkmark	\checkmark	\checkmark	\checkmark
Endog. Subsidy	\checkmark	\checkmark			\checkmark	\checkmark
Churn	\checkmark	\checkmark	\checkmark	\checkmark		
Monthly Premiums (Unsubsidized	Unless Othe	rwise Indica	ted)		
Bronze	\$354	\$305	\$355	\$311	\$365	\$298
Silver	\$471	\$412	\$467	\$422	\$480	\$404
Gold	\$488	\$455	\$488	\$464	\$491	\$445
Platinum	\$540	\$500	\$541	\$508	\$542	\$490
Anthem	\$483	\$405	\$482	\$433	\$489	\$395
Blue Shield	\$473	\$419	\$470	\$430	\$480	\$412
Health Net	\$404	\$347	\$399	\$362	\$413	\$339
Kaiser	\$446	\$391	\$445	\$413	\$457	\$381
Other Insurer	\$388	\$345	\$387	\$360	\$398	\$337
HMO	\$422	\$369	\$420	\$387	\$432	\$361
PPO	\$473	\$406	\$471	\$424	\$479	\$397
Average	\$442	\$384	\$440	\$402	\$451	\$375
Subsidized Avg.	\$128	\$117	\$127	\$94	\$131	\$119
Coverage						
Total Coverage	1,756,594	1,702,317	1,757,423	1,734,081	2,509,559	2,397,142
% Enrolled	74.3%	72.0%	74.4%	73.4%	75.4%	72.0%
Bronze	27.1%	29.9%	26.7%	23.0%	27.7%	30.5%
Silver	62.6%	61.6%	63.2%	67.0%	61.0%	61.2%
Gold	6.3%	5.7%	6.2%	6.9%	7.0%	5.6%
Platinum	4.0%	2.7%	3.9%	3.1%	4.3%	2.7%
% Switching	0.0%	28.4%	0.9%	29.8%	2.4%	38.7%
Monthly Claims						
Bronze	\$224	\$220	\$225	\$221	\$329	\$302
Silver	\$393	\$389	\$392	\$391	\$397	\$377
Gold	\$523	\$515	\$524	\$510	\$476	\$445
Platinum	\$751	\$732	\$753	\$720	\$579	\$533
Average	\$370	\$355	\$369	\$371	\$392	\$362

Table A6: Impact of Subsidy Design and Churn: Premiums, Coverage, and Claims

Notes: Table reports the impact on premiums, coverage, and claims for each scenario. Scenarios Base and (2) are the same as in Table A2. In scenarios (9) and (10), we simulate eliminating inertia and converting the ACA's endogenous subsidy to an exogenous subsidy. In scenarios (11) and (12), we simulate eliminating inertia and churn. The first panel defines each of the scenarios. The second panel summarizes enrollee-weighted average unsubsidized premiums by metal level, insurer, and plan network type. The bottom two rows of the second panel show overall enrollee-weighted average premiums ("Average") and subsidized average premiums ("Subsidized Avg."). The third panel shows total enrollment, the percentage of consumers enrolled in coverage, and market shares by metal level. The final row of the third panel indicates the percentage of consumers who switched plans from the Base scenario. The fourth panel reports average claims by metal tier and on average across all enrollees.

	Base	(2)	(9)	(10)	(11)	(12)
Scenario Definitions						
Inertia	\checkmark		\checkmark		\checkmark	
Oligopoly	\checkmark	\checkmark	\checkmark	\checkmark	\checkmark	\checkmark
Risk adjustment	\checkmark	\checkmark	\checkmark	\checkmark	\checkmark	\checkmark
Endog. Subsidy	\checkmark	\checkmark			\checkmark	\checkmark
Churn	\checkmark	\checkmark	\checkmark	\checkmark		
Welfare Changes						
Cons. Surplus		\$488	\$4	\$674	(\$105)	\$325
Profit		(\$221)	(\$10)	(\$222)	\$71	(\$235)
Gov. Spending						
Prem. Subsidies		(\$500)	(\$8)	(\$95)	\$83	(\$589)
CSRs		(\$14)	\$2	\$12	(\$10)	(\$22)
Penalties		\$23	(\$0)	\$10	(\$9)	\$24
Uncomp. Care		\$49	(\$1)	\$22	(\$21)	\$48
Social Welfare		\$902	\$3	\$544	(\$113)	\$853

Table A7: Impact of Subsidy Design and Churn: Change in Annual Per-Capita Social Welfare

Notes: Table reports the change in annual per-capita social welfare for each scenario relative to the Base (or ACA) scenario. Scenarios Base and (2) are the same as in Table A2. In scenarios (9) and (10), we simulate eliminating inertia and converting the ACA's endogenous subsidy to an exogenous subsidy. In scenarios (11) and (12), we simulate eliminating inertia and churn. The first panel defines each of the scenarios. The second panel reports the change in monthly per-capita consumer surplus, firm profit, government spending (including premium subsidies, cost sharing reductions, individual mandate penalties, and uncompensated care), and total social welfare relative to the Base scenario.

	(1)	(2)	(3)	(4)
Monthly Premium (\$100)	-0.134***	-0.135***	-0.134***	-0.135***
•	(0.002)	(0.002)	(0.002)	(0.002)
AV	0.813***	0.814***	0.813***	0.813***
	(0.010)	(0.010)	(0.010)	(0.010)
Silver	0.131***	0.131***	0.131***	0.131***
	(0.002)	(0.002)	(0.002)	(0.002)
НМО	-0.036***	-0.036***	-0.036***	-0.036***
	(0.001)	(0.001)	(0.001)	(0.001)
Previous Choice	0.226***	0.219***	0.243***	0.237***
	(0.010)	(0.010)	(0.010)	(0.010)
Network Breadth		0.000***		0.000***
		(0.000)		(0.000)
Network Inclusivity			-0.076^{***}	-0.076***
			(0.009)	(0.009)

Table A8: Sensitivity to Provider Networks: Demand Parameters

Notes: Robust standard errors are in parentheses (*** indicates statistical significance at the 1% level, ** at the 5% level, and * at the 10% level). Table shows how interacting the previous choice variable with network breadth and network inclusivity affects the demand parameter estimates. Network breadth and network inclusivity are missing for approximately 20% of household-plan combinations.

			Eliminate Inertia
	Base*	Eliminate Inertia	Except Network
			Attachment
Monthly Premiums			
Bronze	\$355	\$305	\$305
Silver	\$451	\$398	\$398
Gold	\$475	\$449	\$449
Platinum	\$525	\$499	\$499
Anthem	\$449	\$370	\$369
Blue Shield	\$466	\$413	\$413
Health Net	\$394	\$335	\$335
Kaiser	\$436	\$383	\$383
Other Insurer	\$367	\$339	\$339
НМО	\$407	\$361	\$362
PPO	\$464	\$395	\$394
Average	\$430	\$375	\$375
Subsidized Avg.	\$135	\$123	\$123
Coverage			
Total Coverage	1,712,503	1,659,073	1,658,788
% Enrolled	74.4%	72.1%	72.1%
Bronze	26.3%	29.2%	29.3%
Silver	64.0%	64.0%	63.8%
Gold	5.8%	4.7%	4.7%
Platinum	3.9%	2.2%	2.2%
% Switching	0.0%	24.8%	25.2%
Monthly Average Claims			
Bronze	\$232	\$225	\$225
Silver	\$391	\$391	\$391
Gold	\$522	\$525	\$525
Platinum	\$737	\$762	\$761
Average	\$371	\$357	\$356
Annual Welfare Changes			
Cons. Surplus		\$510	\$510
Profit		(\$213)	(\$213)
Gov. Spending			
Prem. Subsidies		(\$456)	(\$457)
CSRs		(\$9)	(\$10)
Penalties		\$24	\$24
Uncomp. Care		\$49	\$50
Social Welfare		\$868	\$871

Table A9: Sensitivity to Provider Networks: Simulation Results

Notes: Table reports the impact of inertia and provider networks on monthly premiums, coverage, monthly average claims, and annual per-capita welfare. These simulations were run on a subset of the data because provider network data are missing for some plans. Scenario Base* reports the observed data for the non-missing plans. The first counterfactual scenario reports the complete elimination of inertia, based on demand estimation with network inclusivity. The second counterfactual scenario reports the elimination of inertia except the portion linked to network inclusivity.

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State Benchmarking Models Promising Practices to Understand and Address Health Care Cost Growth

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Executive Summary

As states grow increasingly concerned with rising health care costs, establishing health care cost growth benchmarking programs can provide a structure and process for increasing health system transparency and developing strategies for containing costs. At least eight states have adopted benchmarking programs that bring stakeholders together to set cost growth targets for health care spending, collect data from payers to measure progress, and identify where policy or program action may be required.

Health care cost growth benchmarking programs can provide a structure and process for increasing health system transparency and developing strategies for containing costs.

This white paper explores the evolution of cost growth benchmarking programs across a growing list of states. In Section I, we summarize the history of benchmarking programs, starting with the Massachusetts program that was enacted in 2012 and remains the nation's most expansive program, with an annual reporting and hearing process that engages stakeholders across the state's health care system to inform and shape potential policy interventions. The next two states were Delaware and Rhode Island, which adopted streamlined programs by executive orders in 2018 and 2019. These three pioneering states were followed by five states that have initiated benchmarking programs since 2019 with support from Peterson-Milbank Program for Sustainable Health Care Costs—Oregon in 2019, Connecticut and Washington in 2020, and Nevada and New Jersey in 2021.

In Section II, we discuss the five common features of cost growth benchmarking programs, as well as some features, such as accountability, that are works in progress. The five common features are:

- · Authority to collect and use data to monitor health system spending trends
- · Growth target against which to measure spending trends
- Spending measurement to collect and track healthcare expenditures
- · Data and analytic capacity to support data analysis, reporting and use cases
- · Data use strategy to advance state use cases

An essential ingredient in how the features fit together in each state's overall program is the state's strategy for engaging stakeholders in program development and goal-setting. Holding payers and providers accountable for not exceeding the benchmark is a state concern as well, with Oregon recently adopting legislation to impose financial penalties when performance improvement plans do not achieve compliance.

In Section III, we highlight some leading use cases states are pursuing. States have tailored their benchmarking programs to pursue a broad range of use cases that reflect local priorities for expanding transparency, addressing cost drivers and various contributors of health An essential ingredient in how the features fit together in each state's overall program is the state's strategy for engaging stakeholders in program development and goal-setting. care cost growth, and ensuring that health care spending is being directed to the most beneficial and costeffective services. States may use cost growth benchmarking programs to support and reinforce existing cost-containment and transparency initiatives, providing a new mechanism to collect data and convene stakeholders around common goals. Four leading use cases are:

- Improving health care cost transparency
- Investing in primary care
- Identifying trends in patient cost sharing
- · Advancing alternative payment models

States also are broadening and deepening their benchmarking programs by linking their programs to a wide range of cost-related initiatives, including addressing provider consolidation, accounting for geographic variation, advancing health equity, and ensuring workforce stability.

In Section IV, we discuss how standardization could support the continued growth and utility of benchmarking programs. Increased standardization would allow for more consistent data collection and effective data use across states, including the potential for cross-state comparisons; would reduce cost barriers to establishing programs; and would reduce payer burdens as benchmarking programs spread to more states. Potential areas for advancing standardization include:

- Model language for legislation and executive orders
- Step-by-step guide to setting a cost growth target
- Standard methodology for benchmark data collection
- Strategies for ensuring data accuracy and completeness
- Case studies on state data use cases
- Interstate working group to shape practices and understanding of emerging issue

In the Conclusion, we look forward and anticipate the complex questions that benchmarking programs may help answer as they become the centerpiece of state efforts to understand healthcare cost growth trends and what can be done to contain costs and direct spending toward efficient and equitable investments.

This paper was informed by primary research and 16 interviews with state officials, experts from national organizations, and other key stakeholders (see Appendix: Interview Table); supported with a generous grant from the Robert Wood Johnson Foundation; and developed in close coordination with the Peterson-Milbank Program for Sustainable Health Care Costs.

I. Introduction to Health Care Cost Growth Benchmarking

As states grow increasingly concerned with rising health care costs, establishing health care cost growth benchmarking programs can provide a structure and process for increasing health system transparency and developing strategies for containing costs. At least eight states have adopted health care cost growth benchmarking programs—five in the past two years—that bring stakeholders together to set cost growth targets for health care spending, collect data from payers to measure progress, and identify where policy or program action may be required. Recent program momentum indicates growing state interest in understanding, monitoring and responding to health system performance. This paper will briefly discuss the history of cost growth benchmarking programs, their common features and tailored use cases, before highlighting several opportunities for standardization as more states adopt similar models.

History of State Cost Growth Benchmarking Programs

In 2012, Massachusetts became the first state to enact a cost growth benchmarking program, passing legislation that created a statewide infrastructure, including two new agencies—the Center for Health Information and Analysis (CHIA) and the Health Policy Commission (HPC)—to monitor and respond to health care cost drivers. The Massachusetts program remains the nation's most expansive cost growth benchmarking program, with an annual reporting and hearing process that engages stakeholders across the state's health care system to inform and shape potential policy interventions.

The next two states to adopt cost growth benchmarking programs were Delaware and Rhode Island, which adopted streamlined programs by executive orders (EOs) in 2018 and 2019, respectively. Delaware's program is run by a subcommittee of the Delaware Economic and Financial Advisory Council (DEFAC) and was the first to establish health care quality-specific benchmarks within its program.¹ Rhode Island's program is jointly operated by the state's Office of the Health Insurance Commissioner (OHIC) and Executive Office of Health and Human Services (EOHHS) and expects to pair high-level benchmarking findings with targeted analyses using the state's all-payer claims database (APCD) to derive actionable insights. These programs offer a model for smaller states with limited resources.²

In 2019, Oregon, which had previously extended its long-standing Medicaid cost growth target to cover state employees and teachers, enacted SB 889 to create a cost growth benchmarking program to cover all state health care spending. The state hopes to leverage the program as the centerpiece of its strategy for improving health care transparency and cost containment, adopting many of the robust features of the Massachusetts model and expanding on specific use cases to address state-specific priorities.

In 2020 and 2021, four more states—Connecticut (2020), Washington (2020), New Jersey (2021) and Nevadaⁱ (2021)—joined Oregon, taking initial steps to establish state cost growth benchmarking programs with support from the Peterson-Milbank Program for Sustainable Health Care Costs.³ While these five state

ⁱ Nevada actually passed authorizing legislation in 2019 but the program was not operative until Governor Sisolek used his broad authority under the bill to start a benchmarking program in 2021.

programs are at varying stages of implementation, all have committed to an inclusive stakeholder process for providers, insurers, employers and consumer interests to set a cost growth target and allocate the resources necessary to address cost growth drivers and make health care costs more affordable and sustainable. (See Exhibit 1 below.)



Exhibit 1. States Implementing/Considering a Benchmarking Program, March 2021

* Five states that have been selected to be part of the Peterson-Milbank Program for Sustainable Health Care Costs. Selected states must demonstrate their leadership commitment (through EO or legislation) to establish the target-setting process, the resources to support it and the appointment of a multistakeholder commission to oversee the work.

California is among the next wave of states considering a cost growth benchmarking program. Governor Newsom's 2021 budget summarizes the aspirations California has for using its program to reinforce and amplify other health care transparency and transformation activities:

The Office of Health Care Affordability will be charged with "increasing transparency on cost and quality, developing cost targets for the health care industry, enforcing compliance through financial penalties, and filling gaps in market oversight of transactions that may adversely impact market competition, prices, quality, access, and the total cost of care. In addition to lowering costs, the Office will promote health care workforce stability and training needs, report quality performance and equity metrics on the entire health care system, advance payment models that reward high-quality, cost-efficient care, and promote investments in primary care and behavioral health."⁴

	State	Benchmark Development	Governing State Agency			
ed	Massachusetts⁵	НРС	НРС			
tablish nchma	Delaware ⁶	DEFAC Health Care Spending Subcommittee	Delaware Health Care Commission (DHCC)			
Be	Rhode Island ⁷	OHIC and EOHHS	OHIC and EOHHS			
	Connecticut ⁸	Cost Growth Benchmark Technical Team Stakeholder Advisory Board	Office of Health Strategy (OHS)			
pment	Oregon ⁹	Sustainable Health Care Cost Growth Target Implementation Committee	Oregon Health Authority (OHA), Department of Consumer and Business Services (DCBS), Oregon Health Policy Board (OHPB) ¹⁰			
Develo	Washington ¹¹	Health Care Cost Transparency Board	Washington Health Care Authority (HCA)			
Under	New Jersey ¹²	Interagency Health Care Affordability Workgroup, Health Care Affordability Advisory Board	Office of Health Care Affordability and Transparency, Department of Banking and Insurance (DOBI)			
	Nevada ¹³	Patient Protection Commission (PPC)	Department of Health and Human Services (DHHS)			

Exhibit 2. Benchmarking Program Governance by State

While all eight cost growth benchmarking states have modeled their programs on Massachusetts' initial design, each has tailored elements of their approach and methods to address their state's unique needs. For

example, some states are aiming to use their benchmarking programs not only to measure and contain overall health care system costs, but to monitor how spending is distributed among high-priority preventive care services, such as primary care and behavioral health; states also are combining their core benchmarking programs with broader cost-containment efforts, such as tracking and promoting alternative payment model (APM) adoption, and collecting information on provider consolidation and other market trends that impact health care costs.

Each state has tailored elements of their approach and methods to address their state's unique needs.

Benchmarking programs are being established alongside other cost-containment initiatives in areas such as drug and hospital pricing and antitrust enforcement, providing an opportunity to leverage their emphasis on broad stakeholder involvement in understanding spending trends and offer a valuable platform for gathering information and addressing a wide range of cost-related challenges. In the past year, California's Governor Newsom and Pennsylvania's Governor Wolf have proposed benchmarking programs with expansive mandates to coordinate state efforts across multiple cost-containment priorities.

II. Common Features of Benchmarking Programs

State cost growth benchmarking programs share several common features, including: (1) authority and governance, (2) growth targets, (3) spending measurement, (4) data quality and analytics and (5) data use strategy, all of which are supported by and critical to meaningful stakeholder engagement.



Authority and Governance

States may establish benchmarking programs by EO or legislation,¹⁴ depending on their objectives, level of stakeholder buy-in and prior history with cost containment. Four states have established cost growth benchmarking programs by EO. EOs allow states to:

- Move quickly to advance cost-containment goals and address specific policy priorities;
- Define programmatic goals without the compromises often inherent in a legislative process; and/or
- Immediately engage stakeholders around practical program design questions to inform future legislation.

However, establishing a program by EO may also limit a benchmarking program's scope and sustainability. For example, EOs may not provide the broad authority needed to collect all the data required to fully measure health care system spending against a benchmark or generate the level of public attention and system buy-in required for meaningful accountability. Further, EOs established by one governor may not be supported, or consistently implemented, by the next; without legislative support, long-term staffing and funding are also more exposed to shifting priorities. Establishing a program by EO can allow the process to move quickly, but it could also weaken buy-in from key stakeholders, such as providers and insurers, whose participation is critical for the program's long-term success.

Some states have established benchmarking programs by EO with the intent of pursuing more comprehensive legislative action. In New Jersey, for instance, Governor Murphy's 2021 EO explicitly defines a set of steps designed to build stakeholder support for legislation in 2022.¹⁵

Four states established their cost growth benchmarking programs through legislation. This approach allows for:

- · Setting broad new authority to collect and use health care data
- Generating critical stakeholder and political buy-in around the program's goals and objectives
- Clarifying specific program roles and responsibilities related to other programs/agencies
- Establishing a long-term funding plan to support the program's implementation and management

Legislation can, however, take a long time to develop. Oregon engaged in a multiyear process and considered multiple cost-containment approaches before settling on cost growth legislation. Legislatively enacted programs will generally reflect broader stakeholder input and be less vulnerable to changing political priorities, but legislation typically involves compromises, often related to the scope of data collection and enforcement authority. For example, the 2019 Oregon legislation included performance improvement plans (PIPs), but the Legislature deferred action on how they would be enforced;¹⁶ the Oregon Legislature recently updated the law to mandate a multistep enforcement process.¹⁷



Exhibit 3. States Having Established a Benchmark via Executive Order or Legislation

In 2019, Nevada established the PPC to analyze and make recommendations on health care affordability issues.
 On March 8, 2021, Governor Sisolek directed the PPC to 1) develop a statewide health care cost growth benchmark,
 calculate and analyze statewide health care cost growth, and 3) analyze drivers of health care cost growth and serve

Once created, a benchmarking program must have a governance structure to oversee it—and effective leadership willing to build diverse coalitions in order to realize program goals. In Massachusetts, program governance rests with the HPC, an agency created by the benchmarking law; in every other state, governance rests with preexisting state agencies. However, stakeholder advisory committees often play a key role in early program implementation, charged with making specific decisions during programs' early days, such as Oregon's Sustainable Health Care Cost Growth Target Implementation Committee.

Growth Targets

Five states have established cost growth targets for their benchmarking programs as of May 2021 (Exhibit 4). All five targets considered potential gross state product (PGSP), a measurement of expected state economic growth, in setting their growth targets, though other indicators—median household income and several consumer price indices (CPIs)—were frequently considered in initial deliberations. States have tied targets to PGSP to indicate that, at

Five states have established cost growth targets for their benchmarking programs as of May 2021.

a minimum, state health care cost growth should not exceed the long-run average growth rate of the state's economy. PGSP accounts for a number of economic factors, including the expected growth in national labor force productivity, state civilian labor force, national inflation and state population growth.ⁱⁱⁱ State targets are presently set to range from 2.9% to 3.5% per-capita annual growth.

All five states that have established their targets have also instituted processes for adjusting these targets over time. As illustrated in Exhibit 4, the trend has been to reduce the target over time, with variations as to the baseline year(s) and other state-specific factors impacting the timing and magnitude of changes.

Massachusetts, for example, set its target through legislation to be equal to the growth rate of PGSP for 2013–2017 (3.6%), then directed the HPC to set its 2018–2022 target to be PGSP minus 0.5 percentage points. During this time, the HPC has limited authority to modify the target back up to PGSP if it determines that such an adjustment is "reasonably warranted."^{iv}

Delaware set its benchmark through EO to be 3.8% for 2019, with preset annual reductions down to 3.0% in 2022.¹⁸ Rhode Island set its benchmark through EO to equal the state's PGSP (3.2%) for 2019–2022, with the state planning to reassess its targets for 2023 and beyond.^{19,20}

as the focal point for the Peterson-Milbank program, Governor Sisolak Letter to the PPC. March 8, 2021. Available here: https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2021/2021-03-08_GovernorSisolakLtrToPPC.pdf.

^{III} In Massachusetts, the Secretary of Administration and Finance and the House and Senate Ways and Means committees met to develop an estimate of PGSP growth with input from outside economists; the estimate is established as part of the state's existing consensus tax revenue forecast process.

^{iv} Requires a public hearing prior to making any modification and a two-thirds vote from the board for approval.

	Statewide Cost Growth Targets by Year					
State	2021	2022	2023	2024	2025	2026
MA ²¹	3.1%	3.1%	TBD	TBD	TBD	TBD
DE ²²	3.5%	3.25%	3.0%	TBD	TBD	TBD
RI ²³	3.2%	3.2%	TBD	TBD	TBD	TBD
CT ²⁴	3.4%	3.2%	2.9%	2.9%	2.9%	TBD
OR ²⁵	3.4%	3.4%	3.4%	3.4%	3.4%	3.0%

Exhibit 4. Statewide Cost Growth Targets by Year

Oregon's benchmark was determined by the state's Sustainable Health Care Cost Growth Target Implementation Committee,²⁶ which considered PGSP as well as measures of wage and personal income growth before recommending the state set its cost growth target at 3.4% for 2021–2025,^v which is the current cost growth target for the Oregon Health Plan (Medicaid) and for public employee plans, with a reduction to 3.0% for 2026–2030.^{vi} The committee's decision to use 2020 as the baseline year was significant in that it was done with the recognition that 2020 was a lower-than-average spending year with increased COVID-19 costs more than matched by decreased costs due to deferred care.

Connecticut's OHS²⁷ based its 3.4% cost growth benchmark on a predetermined blend of the growth in percapita PGSP and the forecasted growth in median income of Connecticut residents, with a recommended reduction to 3.2% for 2022 and 2.9% for 2023–2025.

Spending Measurement

States collect total health care spending data from payers for measurement against established target(s).^{vii} A state's total health care spending is referred to as total health care expenditures (THCE). Massachusetts uses a comprehensive THCE measure that includes medical expenses paid to providers by private and public payers, including commercial insurance, Medicare, Medicaid and any non-claims-related payments; all patient cost-sharing amounts, such as deductibles and copays; and the net cost of private health insurance,

^v The target of 3.4% is slightly below the state's projected PGSP for 2025–2029 (3.9%) and projected income for 2025–2029 (3.5%). The implementation committee noted it received stakeholder encouragement to set an aggressive target that would reduce the level of health care spending relative to the rest of the economy and not merely maintain spending at its current level.

^{vi} The committee also recommended that, in 2024, the successor committee should review 20-year historic values of Oregon's per-capita gross state product trend and median wage trend to determine whether the annual 2026–2030 target is appropriately set and whether it should be adjusted on those findings to be higher or lower than 3.0%.

^{vii} All states measure THCE at the statewide aggregate level and per-capita level (to account for changes in population over time); some states additionally measure health care cost growth by geographic region, provider system, health care entity, payer and/or market segment.
which includes administrative expenses and operating margins for commercial payers.²⁸ Delaware, Rhode Island and Oregon have largely adopted the Massachusetts model for their respective state THCE measurements with relatively minor modifications. (See Exhibit 5.)

Payer Spending	MA ²⁹	DE ³⁰	RI ³¹	CT ^{32,33}	OR ^{34,35}
Private Commercial	\checkmark	\checkmark	\checkmark	\checkmark	\checkmark
Medicare Advantage (MA)	\checkmark	\checkmark	\checkmark	\checkmark	\checkmark
Medicare Fee-for-Service (FFS)	\checkmark	\checkmark	\checkmark	\checkmark	\checkmark
Medicaid Managed Care Organization (MCO)	\checkmark	\checkmark	\checkmark	\checkmark	\checkmark
Medicaid FFS	\checkmark	\checkmark	\checkmark	\checkmark	\checkmark
Veterans Affairs ^{viii}	\checkmark	\checkmark	×	\checkmark	\checkmark
Indian Health Service	×	×	×	×	\checkmark
State Correctional Facilities	×	×	×	\checkmark	\checkmark
Insurer Net Cost of Private Health Insurance	\checkmark	\checkmark	\checkmark	\checkmark	\checkmark

Exhibit 5. Data Collected for Spending Measurement by State

Oregon's implementation committee recommended the state's THCE include spending by the Indian Health Service for Oregon residents and by state correctional facilities on those incarcerated in the state to the extent the data is "accessible, comparable, and the collection of data can be replicated over time."

Data Quality and Analytics

States must have the capacity to collect, assess the quality of and analyze the health care spending data they receive to inform the state's specific data use goals. These processes require trained staff to manage activities from data specification development and data collection to quality assurance and reporting. Massachusetts established a robust annual process for collecting and analyzing data, and while Oregon has indicated that it will follow a similar process, it is unclear whether additional states will follow that resource-intensive model.

Massachusetts has two agencies with designated staff responsible for supporting the state's benchmarking program: CHIA, which annually assigns a team of analysts to work with a hired actuarial contractor to support the data collection and analytic process, and the HPC, which provides extensive staff support for the state's subsequent public hearings on results and to translate data findings into recommendations for stakeholder consideration and implementation.^{ix}

viii Data varies by state. In Massachusetts, Delaware and Connecticut, VA data is included. In Oregon, TRICARE is included in implementation committee recommendations. Rhode Island does not include either VA or TRICARE data.

^{ix} CHIA and the HPC support numerous data and oversight activities that extend beyond the management of the benchmarking program.

Delaware and Rhode Island have more streamlined programs with more limited government staffing for data collection (sometimes with only one or two staff partially assigned) and a heavier reliance on outside partnerships for actuarial assurances and analytics.

While most cost growth benchmarking programs are still developing, many will likely rely on a mix of public employees and private contractors to support their programs, similar to the models established for state APCD management.

Data Use Strategy

Effective state benchmarking programs are driven by core questions about the performance of a state's health care system and its cost drivers. The methods of answering those questions, including how a state may leverage its other data resources to contextualize and reinforce findings, define a state's data use strategy. For public transparency—a common use case across benchmarking programs—states develop reporting specific to their audiences, and often collect and use additional data in their presentations.

Data collected through benchmarking programs may be supplemented with other companion requests (supplemental reporting) or with data from other data assets the state may For public transparency—a common use case across benchmarking programs states develop reporting specific to their audiences, and often collect and use additional data in their presentations.

already have access to (e.g., APCD data, hospital discharge data, payer expenditure reports, provider financial reports, surveys of employers and households). Massachusetts, for example, established a robust supplemental data reporting process to support its benchmarking program's numerous use cases, including data on:

- APM adoption
- Consumer premium, cost-sharing and plan type (e.g., high deductible health plan, tiered network plan)
- Prescription drug costs^x
- Provider-relative price data (i.e., how prices for similar services and patients vary by hospital)

Massachusetts uses this data to answer specific questions about health system performance and provide greater context for overall changes in health care cost growth.

Rhode Island, meanwhile, plans to pair use of its APCD with its benchmarking data to support richer and more contextualized analyses around specific areas of interest. For example, the Rhode Island Cost Trends Project Steering Committee has already analyzed the state's APCD data (HealthFactsRI) to examine the state's pharmaceutical cost drivers, identifying drugs administered in the retail and medical pharmacy settings as an important driver of total pharmacy costs. APCD data also demonstrated that prices for medical pharmacy, rather than rates of medical pharmacy utilization, were key drivers for overall pharmaceutical

^x Includes pharmacy benefit manager reporting.

cost growth trends. The committee ultimately recommended the need for additional interventions to control pharmaceutical prices in the state as well as additional monitoring of medical pharmacy trends moving forward.³⁶

Exhibit 6. Benchmarking Data vs. APCD Data Examples



Accountability: The Next Frontier

Although questions about accountability are integral to benchmarking programs, discussions about how to measure compliance with the cost growth target and address noncompliance remain a work in progress. While there is general agreement on the need for accountability mechanisms, accountability is best characterized as unfinished business rather than as a key feature of benchmarking programs.

The 2012 Massachusetts legislation provided PIPs for payers and providers who exceeded spending targets, but PIPs have not been made public. Oregon adopted PIPs in 2019, and 2021 legislation has built on that foundation with a multistep approach to accountability designed to be a collaborative, transparent and supportive process between the state, payers and providers, with the overall goal of collectively achieving the cost growth target. PIPs have been recommended as the first line of accountability when an organization's spending has exceeded the cost growth target "with statistical certainty and without a reasonable basis for doing so." HB 2081, which was signed in May 2021, also directed the OHA to adopt rule criteria for imposing financial penalties on entities that either fail to report cost growth data or repeatedly exceed the benchmark without reasonable cause for three out of five calendar years (CYs), as recommended by Oregon's implementation committee.^{xi} Oregon plans to continue the development of potential accountability measures as appropriate for the benchmark program's implementation.^{37,38}

^{xi} The bill language does note that the criteria used to impose a financial penalty must be based on the degree to which the entity exceeded the target, in addition to the consideration of other factors.

III. Emerging Use Cases in Benchmarking Programs

States have tailored their benchmarking programs to pursue a broad range of use cases that reflect local priorities for expanding transparency, addressing cost drivers and ensuring that health care spending is directed to the most beneficial and cost-effective services. States may use cost growth benchmarking programs to support and reinforce existing cost-containment and transparency initiatives, providing a new mechanism to collect data and convene stakeholders around common goals.

In this section, we look at four leading use cases and some emerging trends in other areas. The four leading use cases are:

- Improving health care cost transparency
- Investing in primary care
- · Identifying trends in patient cost-sharing
- Advancing APMs

Improving Health Care Cost Transparency

The Issue: Health care spending for an average American was six times greater in 2019 than it was in 1970.³⁹ Health care spending growth has consistently outpaced gross domestic product (GDP) growth, with CMS projecting expenditures to reach \$6.0 trillion and comprise nearly 20% of our GDP by 2027.⁴⁰ Health care spending is consistently one of the biggest budgetary items for states and for families, with health care spending by families who have large-employer health plans increasing twice as fast as workers' wages over the past decade.⁴¹

Understanding the contributors to health care cost growth is essential to developing comprehensive and cohesive strategies to contain it. Data on health care cost drivers—across payers, providers and services—provides policymakers and regulators with new insights into market performance failures to develop more targeted policies and program responses, and provides purchasers with additional information to negotiate more rigorous and innovative contracts with their plan and provider partners.

How a Benchmark Helps: Cost growth benchmarking programs allow states to collect comprehensive data about the performance of their health care systems, providing stakeholders with crucial information about their market's health care cost centers and cost drivers. Benchmarking programs also provide recurring opportunities—as health care cost growth assessments are released—to convene stakeholders around results in order to provide additional context and to begin developing actionable policy and program interventions. Improving health care cost transparency is a primary and universal function of state benchmarking programs, though the extent of data collected and released, stakeholder engagement around results and stakeholder accountability for results vary considerably by state.

What States Have Done: Massachusetts supports an annual cycle of data reporting and public hearings in which payers, providers and hospital leaders discuss performance, key trends, identified cost drivers and strategies to improve system performance. The annual process starts each spring with the confirmation of the cost growth target by the HPC and the release of the annual payer data request from CHIA. It is followed by CHIA's collection and analysis of the data through the summer, and reporting of its findings in the fall. The HPC, CHIA and the Attorney General's Office (AGO) then host formal hearings about the results, inviting key stakeholders—leadership from the Legislature, payers, providers, pharmacy benefit managers and consumer groups, among others—to testify, sharing context for results and offering potential future cost mitigation strategies for state consideration. The following winter and spring, the HPC documents its assessment of the results in an annual policy report that outlines actionable recommendations for stakeholders.⁴² Through this process, in addition to the release of summary findings and policy recommendations, CHIA releases a significant amount of data about payer and provider cost trends and cost drivers through a series of organized "databooks" for use by policymakers, regulators, purchasers, advocates and researchers in their ongoing work, creating a more transparent health care system.

Exhibit 7. HPC Annual Timeline⁴³



Investing in Primary Care

The Issue: States are increasingly seeking to ensure health system spending is being invested in services and activities that support long-term health, including primary care. Higher investments in primary care are linked to improved patient health, including decreases in emergency department visits, fewer patient hospitalizations and long-term cost reductions.⁴⁴ In 2017, U.S. health care spending allocated to primary care was less than half of that allocated to prescription drugs.^{45,46} Data to understand the proportion of primary care spending by population is essential to developing policies and programs that promote redistribution of spending and to promoting the long-term health of state residents.

How Benchmarking Helps: Benchmarking programs provide states with a mechanism to measure and monitor primary care spending against total system spend, and use this information to influence market redistribution of funds to increase these important, preventive investments. Benchmarking data on primary care spending will allow policymakers to compare spending patterns by payer, provider and population, and the results will guide further analysis on where primary care initiatives are having the greatest impact on patient health and total health care spending. As benchmarking programs get better at cost attribution, payers and providers will gain better insights into which payment models are most effective in increasing high-value care and decreasing low-value care.

What States Have Done: In 2020, Connecticut's Governor Lamont issued EO No. 5, which charged the OHS with developing and recommending a primary care spending target for the state beginning in 2021 in order to reach a primary care spending target as a percentage of THCE of 10% by 2025. The OHS estimated the current statewide primary care spending to be approximately 4.8% of total health care expenditures and recommended a statewide distribution target of 5.0% in the state's first year of pursuing a primary care spending target.xii The OHS is collecting primary care and overall baseline spending data for 2018, 2019 and 2020 during this calendar year. OHS will collect primary care spending data from payers within their cost growth benchmark data submissions in late 2022. The OHS intends to convene a primary care-focused work group to make further recommendations for annual primary care spending targets for the state in 2022-2024 and other initiatives, including care delivery and payment models, to improve investments in primary care that improve access, guality and the patient and provider experience.

"Setting a primary care spending target can help the State not only increase the percentage of total healthcare spending allocated toward primary care, but also provide valuable data on this foundational component of Connecticut's healthcare system." –CT Office of Health Strategy

xⁱⁱ The OHS calculated a statewide weighted average of current primary care spending by total health care expenditures. Commercial and Medicare data was from the University of Connecticut and Medicaid data was from Freedman HealthCare and the Department of Social Services. While the OHS' best estimate of statewide primary care spending is 4.8%, Freedman HealthCare's data suggests that Medicaid primary care spending alone is 9.0%. This tracks with trends observed in other states, where Medicaid tends to lead in primary care spending compared to commercial insurance, self-insured insurance and Medicare.

Behavioral Health Spending Targets: Similar to primary care, states may wish to assess health system investments in other core health care services, such as behavioral health, where upfront spending could lead to long-term health improvement and cost reductions. Expanding behavioral health treatment is closely linked to expanding primary care since primary care providers (PCPs) are often well positioned to identify patients with behavioral health needs or substance use disorders and help coordinate their care.

Benchmarking programs can provide states with an opportunity to better understand local behavioral health spending and promote stakeholder investments in these preventive activities. In 2019, **Massachusetts'** Governor Baker called for statewide "aggregate primary care and behavioral health expenditure target[s]" and set a goal of increasing spending on these services by 30% between 2019 and 2022.⁴⁷ CHIA has since leveraged its data collection authority to begin collecting behavioral health data as part of its regular benchmark data collection process for reporting commencing in 2021. **Pennsylvania** is similarly exploring whether to establish and support data collection against a behavioral health spending target in its nascent benchmarking program as it pursues broader delivery system reforms.

Identifying Trends in Patient Cost-Sharing

The Issue: Consumers are increasingly bearing the burden of health care system cost growth with rising premium contributions and out-of-pocket expenses. Nationally, from 2008 to 2018, the average premiums

for families with employer health coverage increased by 55% and average out-of-pocket spending increased 70%, as health plans frequently cost more to cover less. Health care spending continues to consume a greater share of employee wages, which have only grown by 12% over the same period.⁴⁸ Data to understand not only how health care costs are changing over time but who is bearing the burden of those costs is critical information for understanding the direct impact of health system performance on households.

Consumers are increasingly bearing the burden of health care system cost growth with rising premium contributions and out-of-pocket expenses.

How Benchmarks Help: States can build on their benchmarking programs' data collection processes to collect "supplemental" data on consumer premiums, cost-sharing and plan design to better understand how consumer spending and spending liability for health care services are changing over time. States may collect average annual premium and cost-sharing data by line-of-business and member characteristics—such as employer size, resident geography and plan type (e.g., HMO, PPO)—as well as benefit type (e.g., high deductible health plans, tiered network plans). Data can be received with and reconciled against other benchmarking reporting, providing states with a more comprehensive picture of cost trends and burdens.

What States Have Done: Massachusetts collects supplemental data on changes in consumer premiums, cost-sharing and plan types as part of its annual reporting process. This data provides critical context to the state's overall benchmarking findings. The state's 2021 Annual Report⁴⁹ found that consumer premiums and cost-sharing continued to increase at a faster rate than worker wages and salaries 2017–2019. (See Exhibit 8.⁵⁰)

In response to the growing cost burden on consumers and the threat it poses to health care coverage and service access in Massachusetts, in 2021, a bill was filed with the Massachusetts Legislature (S.782) that proposed the development of a consumer cost growth benchmark for reporting beginning in CY 2023.^{xiii,51,52} The bill further proposes that payers identified as exceeding the benchmark would be subject to a confidential referral by CHIA to the HPC and may be subject to a PIP requirement; the HPC would also have the discretion to conduct a public hearing for carriers identified as exceeding the consumer benchmark if the PIP submitted by that carrier is considered unacceptable or incomplete.^{53,54}



Exhibit 8. Private Commercial Insurance Affordability in Massachusetts, 2017–2019

Source: CHIA 2021 Annual Report.

Alternative Payment Methods (APMs)

The Issue: The health care industry is increasingly moving away from traditional FFS payments, which encourage more services rather than high-value and well-coordinated services. Both public and commercial payers are experimenting with multiple APMs, which encourage plans and providers to align and share accountability—through various forms of risk-sharing—for achieving the Triple Aim (access, quality and cost of care) for a defined or attributed population.

How Benchmarking Helps: A cost growth benchmarking program can collect information on the number of lives covered under APMs, including definitions of how each model shares risk between payers and providers for both up- and downside risk. As APMs evolve from relatively narrow performance incentives to broad

xiii The consumer cost benchmark would be set equal to the overall cost growth benchmark for CY 2023 and 2024, but may be adjusted by the HPC as necessary for CY 2025 and beyond.

capitation payments, benchmarking programs can help facilitate common understanding between payers and providers on how progress will be measured and what reasonable goals are. By bringing consumers, workers, state officials and other stakeholders to the table, benchmarking programs can also ensure broader buy-in to payer-provider risk-sharing arrangements.

What States Have Done: **Oregon** has made a major commitment to expanding APMs and intends to use its benchmarking program to track progress and facilitate collaboration between payers and providers necessary to achieve its ambitious goals. The state has invested heavily in expanding APMs or value-based purchasing (VBP) within its Medicaid program since 2012, and views that work as central to the state having saved \$6.5 billion over ten years (2012–2022).⁵⁵ The state intends to double down on further expanding VBP through its community care organizations (CCOs)^{xiv} and is committed to replicating the savings it has achieved in Medicaid spending with a larger group of providers and payers in the commercial market through the benchmarking program.

In its January 2021 final report, Oregon's implementation committee identified three benefits for providers in replacing FFS with APMs: financial stability against unforeseen factors that may reduce patient volume, such as COVID-19; financial flexibility to address patients' most critical health needs rather than be limited to providing reimbursable treatments; and the ability to invest in a population with "holistic patient-centered care."⁵⁶

The committee report detailed a two-step strategy for payers to have 70% of all their payments in "advanced VBP models" by 2024, as tracked by benchmark data. First, the committee developed 16 principles for aligning VBP models across payers, including the use of common performance measures, technical assistance to small and safety net providers, and mitigation of adverse impacts on health equity. Second, the committee developed a draft VBP compact charter that has recently been embraced by a broad group of Oregon's leading payers and providers.⁵⁷

The Oregon committee developed 16 principles for aligning VBP models across payers, including the use of common performance measures, technical assistance to small and safety net providers, and mitigation of adverse impacts on health equity.

Oregon's VBP goals are ambitious—70% of all payments under advanced VBP models tied to national standards for risk-sharing by 2024—and provide a model for how states can leverage a benchmarking program, not just to measure VBP, but also to use the stakeholder process to forge agreements on goals and timetables.^{xv,xvi}

x^{iv} Coordinated Care Organizations (CCOs) are the managed care entities that deliver Medicaid care in Oregon. The targets for CCOs under the "CCO 2.0" program are as follows: For 2021: > 35% CMS Learning Action Network (LAN) 2C+; for 2022: > 50% LAN 2C+; for 2023: > 60% LAN 2C+ and > 20% LAN 3B+; for 2024: > 70% LAN 2C+ and > 25% LAN 3B+. ** Oregon's VBP Principle #7: Payers should have the following percentage of all their payments under advanced VBP models (3A and higher) in the following time periods: 35% by 2021, 50% by 2022, 60% by 2023 and 70% by 2024. ** Oregon's VBP Principle #8: Payers should have the following percentage of their payments to primary care practices and general acute care hospitals made under advanced VBP models (3B and higher) in the following time periods: 25% by 2022, 50% by 2023 and 70% by 2024.





Source here: https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf.

Broadening and Deepening the Focus of Benchmarking Programs

As states consider the broad range of factors that impact cost growth trends, benchmarking programs will similarly evolve to address new use cases and view old use cases in new ways. In many states, efforts to restrain hospital costs and prescription drug prices predate benchmarking programs, and states may decide to more closely link these initiatives to benchmarking programs as benchmarking evolves. In the meantime, policymakers already are linking benchmarking programs to a wide range of cost-related initiatives.

Provider Consolidation. Provider consolidation, especially vertical integration into health systems, has increased in recent years,⁵⁸ driving states' interest in understanding the effects of these changes on their health care systems and consumers. Benchmarking programs can provide important information to inform provider consolidation discussions and may be enhanced to include supplemental reporting requirements such as advance notice of proposed large provider mergers, acquisitions and changes in ownership. **Massachusetts**, for example, has tracked provider changes in ownership since the inception of its benchmarking program, requesting that providers "file cost reports with the Center within 60 days after a change of ownership"⁵⁹ as a means of tracking consolidation activities. The HPC played a key role in helping forge a compromise solution with respect to one high-profile merger that was ultimately approved with a set of cost control requirements.⁶⁰ Recently, in the 2021 state legislative session, Massachusetts also considered a bill that seeks to improve transparency of high-cost hospitals by requiring CHIA to report on how much acute care hospitals are contributing to total medical expense (TME) and growth in TME over time.

Oregon has similarly considered provider consolidation issues in its benchmarking program design, while **Pennsylvania** officials have recommended that its proposed Health Value Commission take a more active role in monitoring, reviewing and publishing information on provider consolidation activities in its state once it is established.⁶¹ Additional states with high levels of provider consolidation may incorporate opportunities for provider consolidation review and/or establish future supplemental reporting requirements as part of their benchmarking efforts if trends continue.

Accounting for Geographic Variation. As larger, more geographically diverse states establish cost growth benchmarking programs—such as Oregon, Pennsylvania and California—there Benchmarking programs can provide important information to inform provider consolidation discussions and may be enhanced to include supplemental reporting requirements such as advance notice of proposed large provider mergers, acquisitions and changes in ownership.

will be a greater need to consider regional differences in populations and markets in assessing cost growth trends. The OHA, for example, intends to assess geographic approaches for measuring provider cost growth in future years and when analyzing cost trends.⁶² **California's** proposed program, codified in AB 1130, would similarly require the director of the Office of Health Care Affordability to establish a regional health care cost target for THCE in addition to a statewide target.⁶³

Advancing Health Equity. States are increasingly exploring how benchmarking programs may be used to advance health equity priorities, including assessing how health care spending may be inequitably distributed by community and population type and whether consumer cost and cost liability may present a disproportionate barrier for some populations more than others. **Oregon** has recommended advancing equity efforts by focusing cost analyses on variations in utilization and cost across populations and publishing that information as part of its data use strategy in order to inform future policy conversations around mechanisms to reduce inequities related to health care costs.

Ensuring Workforce Stability. One concern about state benchmarking programs is that providers, in an effort to reduce costs, will cut necessary and critical members of their workforces responsible for delivering highquality care. **Oregon** recognized this concern and is planning to monitor the market for unintended workforce consequences of the benchmark. **California's** benchmarking bill similarly includes protective language: AB 1130 would make the state's new Office of Health Care Affordability responsible for collecting and analyzing data that would allow it to "track spending, set cost targets, approve corrective action plans, monitor impacts on health care workforce stability, and carry out all other functions of the office," and "advance standards for health care workforce stability and training, as these relate to costs." The office would also be responsible for reporting on any impacts to workforce stability as part of its annual report beginning in 2025.

IV. How Standardization Could Benefit Benchmarking Programs

States are the "laboratories of democracy" in our federal system and there are good reasons to encourage states to continue experimenting with different approaches to cost growth benchmarking. At the same time, however, state programs can benefit from coordination and even standardization in certain circumstances. Two trends suggest now is the time to consider how standardization could support the continued growth and utility of state benchmarking programs:

- **Program proliferation**: Massachusetts established the first benchmarking program in 2012 and it continues to serve as the model for new states' programs, though replication was slow to occur. Although states have long experimented with more targeted cost growth programs, such as primary care benchmarking in Rhode Island and Medicaid spending in Oregon, no state had followed Massachusetts in establishing a benchmarking program until Rhode Island (2018) and Delaware (2019) did so by EO. Since then, however, progress has been rapid, with five states establishing benchmarking programs in the past three years.
- **Common features**: All eight states that have state benchmarking programs share a common set of key features, as discussed in Section II of this paper. The Peterson-Milbank Program for Sustainable Health Care Costs has organically facilitated a level of standardization through the procurement of one vendor to support the establishment of the five newest state programs, with the vendor working with the states to tailor the baseline Massachusetts model to address local needs and priorities.

NAIC Annual Statement Offers Standardization Model

The National Association of Insurance Commissioners (NAIC) has a long history of developing standardized approaches for regulatory issues shared by state departments of insurance (DOIs), with the financial accreditation program exemplifying how effective standardization can be in supporting state goals. The crown jewel of the financial accreditation program is an annual financial statement with thousands of data points that is used by all DOIs and their stakeholders as the leading data resource on insurers' financial status. The annual statement is updated every year by the NAIC's Blanks Committee, which follows a rigorous process for developing and annually revising the annual statement and associated exhibits (the blank), including checklists and other materials to facilitate use of the blank.

Increased standardization of benchmarking program designs would allow for more consistent data collection and effective data use across states, including the potential for cross-state comparisons, would reduce cost barriers to establishing programs and would reduce payer burden as benchmarking programs continue to expand nationally. These benefits of standardization must be weighed against their costs, acknowledging that a standard approach for establishing a program or measuring health care spending may not always align with local market dynamics or state reporting priorities, and could stifle innovation. For example,

Benchmarking standardization should comprise both process and form, while allowing state customization and experimentation around a common core of processes and activities.

state benchmarking stakeholders may reach consensus around different methods for provider-patient attribution, whether and how provider price variation should be considered in results, and whether and how data for other use cases (Section III) may be added to the benchmarking process.

Ongoing Challenges With Standardizing APCDs

Determining the right time for standardization is challenging, since it is always harder to change an established state practice than to forge commonality before broad program development. For example, after slightly different APCD data collection models proliferated across the country, a compelling need for states to use a common data layout (CDL) emerged after the Supreme Court ruled that self-insured employers cannot be required to participate in APCD reporting. Harmonizing data collection since has been challenging, requiring states to make structural changes to longestablished data collection and analytic processes. While progress has been made—California is using the CDL as its baseline and Virginia has adopted certain aspects of the CDL—it has been slow and piecemeal, only adding to calls to federalize standardized data collection.⁶⁴ The recently established State All-Payer Claims Database Advisory Committee, overseen by the U.S. Department of Labor, is expected to strengthen standardization—at least for the voluntary reporting of data for group health plans (i.e., self-insured plans).⁶⁵ These developments may be sufficient to bring more standardization to APCDs, but prospects remain uncertain and standardization is definitely more challenging with substantial and long-standing variations across states. Benchmarking standardization should comprise both process and form, while allowing state customization and experimentation around a common core of processes and activities. Potential options for standardization are offered for consideration in the following table:

Program Design Feature	Standardization Opportunities		
Authority and governance. States will pursue cost growth benchmarking programs through the authority of EOs or legislation. ^{xvii}	 Model EO and legislative text that includes program: definitions; purpose and scope; governance structure and representation; target, spending measure and data collection parameters; reporting expectations and time frames; accountability measures; and supplemental use cases. 		
Growth targets. States will need to assess measures of economic, workforce or health care cost growth when setting initial cost growth targets.	 Step-by-step guide to setting a cost growth target including potential federal- and state-calculated benchmarks and benchmark considerations.^{xviii} 		
Spending measurement . States will need to determine whether and how to customize data collection methods and templates to account for local data needs.	 Baseline benchmark data collection methodology comprising: common definitions and data specifications; model processes for collection; templates for payer data collection; data requestor and submitter instructions (including how to engage the CMS in data collection); and options for how states may customize data collection without compromising benchmarking results. 		
Data quality and analytics. States will use similar processes—and access similar data—to ensure submitted data is accurate and complete, and to contextualize findings.	 Guide to federal and local data sources states may use to check data accuracy and completeness (e.g., federal/Center for Consumer Information and Insurance Oversight and state medical loss ratio reporting, NAIC Supplemental Health Care Exhibit). 		
	 Step-by-step guide for aggregating and analyzing quality-checked benchmarking data, including an inventory of other federal statistical resources (e.g., Medical Expenditure Panel Survey—Insurance Component and local data resources (e.g., APCDs, discharge data) that may be leverage to provide context for results. 		
Data use strategy. States will pursue use cases in alignment with their local needs, building and learning from other state examples, when available.	 Model reporting products, product formats, engagement strategies (e.g., hearings) and timelines for benchmark results. 		
	 Case studies on state use cases, with detailed examples of how data needs are identified, translated into data collection and reporting, and then used to inform practice. 		
	 Interstate working group to shape practices and understanding of emerging issues (e.g., non-claims-based payment reporting, provider-specific cost drivers, interstate provider spending, barriers to obtaining self-insured data). 		

Next Steps on Standardization

States, among other benchmarking stakeholders, will increasingly benefit from standardization as state programs proliferate. Leading states, foundations, health data associations and payers may consider establishing a cross-stakeholder workgroup to outline the parameters of benchmarking standardization while so many programs are in their infancy, while also looking to other best practices and lessons learned from similar data collection processes.

^{xvii} May also be pursued through regulatory action or more informal, voluntary coalition building, not discussed here. ^{xviii} Bailit Health's recent "Rhode Island's Cost Trends Project: A Case Study on State Cost Growth Targets" includes a good model. Available here: https://www.milbank.org/wp-content/uploads/2021/01/Fund_Peterson_RI_case_study_ v8.pdf.

V. Conclusion

With eight states on board and others looking closely at cost growth benchmarking, these programs are destined to become a critical data resource for states seeking to understand healthcare cost growth trends and what can be done to contain costs and direct spending toward efficient and equitable investments. As these programs evolve, the questions will become more complex and require robust stakeholder engagement and cooperation to address quandaries such as:

- How do we control total health care costs in a fragmented system?
- Who is bearing the burden of health care cost growth?
- Are health care dollars being spent on the "right" types of services that can improve long-term health and well-being?
- How can benchmarking be leveraged to understand and address issues of health equity

Benchmarking programs are certainly not a panacea; the hard work of controlling costs in a healthcare system that has grown faster than inflation for decades will require states to overcome entrenched interests and make difficult choices. What benchmarking can do is help states identify cost drivers and make datadriven decisions with the full spectrum of stakeholders at the table.

Appendix: Interview Table

Organization	Name	Role	Interview Date	
Washington State Office of the Insurance Commissioner	Jane Beyer	Senior Policy Advisor	August 19, 2020	
National APCD Council	Josephine Porter	Co-Chair of the APCD Council	September 1, 2020	
Rhode Island Office of Health Insurance Commissioner	Cory King	Director of Policy	September 14, 2020	
Massachusetts Center for Health	Ray Campbell	Executive Director	September 18, 2020	
Information and Analysis	Deb Schiel	Deputy Director of Analytics & Chief Analytics Officer		
	Kathy Hines	State Director of Partner Operations and Data Compliance		
	Michael Cocchi	Chief Data Officer, CIO & Deputy Executive Director		
	Gregory Wheeler	Financial Policy Development Manager		
	Amina Khan	Analytic Development Specialist		
Colorado Division of Insurance	Michael Conway	Insurance Commissioner	September 23, 2020	
National Association of Health Data Organizations (NAHDO)	Norm Thurston	Executive Director	October 6, 2020	
Connecticut State, Office of	Victoria Veltri	Executive Director	October 14, 2020	
Health Strategy	Olga Armah	Research Associate		
Pennsylvania Department of Human Services	Doug Jacobs	Chief Innovation Officer	October 19, 2020	
Pennsylvania Insurance Department (PID)	Jessica Altman	Insurance Commissioner	November 13, 2020	
Oregon Health Authority	Jeremy Vandehey	Health Policy and Analytics Director	November 13, 2020	
	Sarah Bartelmann	Policy Lead		
	Amy Clary	APCD Specialist		
Rhode Island Office of Insurance Commissioner	Marie Ganim	Health Insurance Commissioner	November 16, 2020	
Delaware Health Care Commission (DHCC)	Steven Costantino	State Senator	November 19, 2020	
	Ayanna Harrison	Public Health Administrator I		
Washington State Health Care Authority	Mich'l Needham	Chief Policy Officer	December 14, 2020	
National Association of Insurance Commissioners (NAIC)	Mary Caswell	Staff to NAIC Blanks Working Group	January 12, 2021	
National Association of Insurance Commissioners (NAIC)	Scott White, VA Insurance Commissioner	Virginia Insurance Commissioner and Chair of NAIC Financial Condition Committee	January 27, 2021	
New Jersey Department of Banking and Insurance	Justin Zimmerman	Chief of Staff	April 12, 2021	

¹ "Delaware Health Care Spending and Quality Benchmarks Implementation Manual Version 1.0," Delaware Health Care Commission, Mercer. January 31, 2019. Available here: https://dhss.delaware.gov/dhss/files/benchmarksummary013119.pdf.

² "Implementing a Statewide Healthcare Cost Benchmark: How Oregon and Other States Can Build on the Massachusetts Model," Manatt Health. December 2019. Available here: https://www.manatt.com/Manatt/media/Documents/Articles/RWJ-Phase-5-Report-Cost-Benchmarking-Paper-December-2019_FOR-WEB.PDF.

³ "Five States Join the Peterson-Milbank Program for Sustainable Health Care Costs," Milbank Memorial Fund. March 9, 2021. Available here: https://www.milbank.org/news/five-states-join-the-peterson-milbank-program-for-sustainable-health-care-costs/.

⁴ Governor's Budget Summary–2021–22, Health and Human Services. January 1, 2021. Available here: http://www.ebudget. ca.gov/2021-22/pdf/BudgetSummary/HealthandHumanServices.pdf.

⁵ https://www.mass.gov/orgs/massachusetts-health-policy-commission.

⁶ "Minutes of the Delaware Economic & Financial Advisory Council Health Care Spending Benchmark Subcommittee." October 10, 2020. Available here: https://dhss.delaware.gov/dhcc/files/hcsbqltysbcomins_101020.pdf.

⁷ "Rhode Island Health Care Cost Growth Target: Implementation Manual." July 31, 2019. Available here: http://www.ohic.ri.gov/ documents/July%202019/Cost%20Trends/RI%20Implementation%20Manual%202019%207-31.pdf.

⁸ "Preliminary Recommendations of the Healthcare Cost Growth Benchmark Technical Team," Connecticut Office of Health Strategy, Victoria Veltri, Executive Director. September 2020. Available here: https://portal.ct.gov/-/media/OHS/Cost-Growth-Benchmark/CGB-TT-Information/CGB--TT-Meetings-2020/September-24-2020/CT-OHS-Technical-Team-Recommendations-Report---September-2020_finaldraft.pdf.

⁹ "Sustainable Health Care Cost Growth Target: Implementation Committee Recommendations, Final Report to the Oregon Legislature," Oregon Health Authority. January 2021. Available here: https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Cost%20 Growth%20Target%20Committee%20Recommendations%20Report%20FINAL%2001.25.21.pdf.

¹⁰ "Sustainable Health Care Cost Growth Target," Oregon Health Authority. Available here: https://www.oregon.gov/oha/HPA/HP/ Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx.

¹¹ Health Care Cost Transparency Board. Available here: https://www.hca.wa.gov/about-hca/health-care-cost-transparency-board.

¹² "Governor Murphy Signs Executive Order Advancing Health Care Affordability Efforts," Press Release. January 28, 2021. Available here: https://www.nj.gov/governor/news/news/562021/20210128b.shtml.

¹³ Governor Sisolak Letter to the Patient Protection Commission (PPC). March 8, 2021. Available here: https://ppc.nv.gov/uploadedFiles/ ppcnvgov/content/Meetings/2021/2021-03-08_GovernorSisolakLtrToPPC.pdf.

¹⁴ States may also establish new regulations and/or voluntary compacts as intermediary steps toward creating a benchmarking program.

¹⁵ Executive Order No. 217, Office of Governor Phil Murphy, State of New Jersey. January 28, 2021. Available here: https://nj.gov/ infobank/eo/056murphy/pdf/EO-217.pdf.

¹⁶ Enrolled Senate Bill 889, 80th Oregon Legislative Assembly, 2019 Regular Session. Available here: https://olis.leg.state.or.us/ liz/2019R1/Downloads/MeasureDocument/SB889/Enrolled.

¹⁷ Enrolled House Bill 2081, 81st Oregon Legislative Assembly, 2021 Regular Session. Available here: https://olis.oregonlegislature.gov/ liz/2021R1/Downloads/MeasureDocument/HB2081/Enrolled.

¹⁸ "Delaware Health Care Affordability Standards: An Integrated Approach to Improve Access, Quality and Value," Insurance Commissioner of the State of Delaware. December 2020. Available here: https://insurance.delaware.gov/wp-content/uploads/ sites/15/2020/12/Delaware-Health-Care-Affordability-Standards-Report-12182020.pdf. ¹⁹ "Rhode Island Health Care Cost Trends Collaborative Project, Report to the Legislature," Office of the Health Insurance Commissioner and the Executive Office of Health and Human Services. December 2020. Available here: http://www.ohic.ri.gov/documents/2021/ January/Annual%20Cost%20Trends%20Report%20202.pdf.

²⁰ "Rhode Island's Cost Trends Project: A Case Study on State Cost Growth Targets," Peterson-Milbank Program for Sustainable Health Care Costs. January 2021. Available here: https://www.milbank.org/wp-content/uploads/2021/01/Fund_Peterson_RI_case_study_ v8.pdf.

²¹ https://www.mass.gov/info-details/health-care-cost-growth-benchmark.

²² Executive Order 25, Governor John Carney. November 20, 2018. Available here: https://governor.delaware.gov/executive-orders/ eo25/.

²³ "Rhode Island Health Care Cost Growth Target: Implementation Manual." July 31, 2019. Available here: http://www.ohic.ri.gov/ documents/July%202019/Cost%20Trends/RI%20Implementation%20Manual%202019%207-31.pdf.

²⁴ "Preliminary Recommendations of the Healthcare Cost Growth Benchmark Technical Team," Connecticut Office of Health Strategy, Victoria Veltri, Executive Director. September 2020. Available here: https://portal.ct.gov/-/media/OHS/Cost-Growth-Benchmark/CGB-TT-Information/CGB--TT-Meetings-2020/September-24-2020/CT-OHS-Technical-Team-Recommendations-Report---September-2020_finaldraft.pdf.

²⁵ "Sustainable Health Care Cost Growth Target: Implementation Committee Recommendations, Final Report to the Oregon Legislature," Oregon Health Authority. January 2021. Available here: https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Cost%20 Growth%20Target%20Committee%20Recommendations%20Report%20FINAL%2001.25.21.pdf.

²⁶ "Sustainable Health Care Cost Growth Target: Implementation Committee Recommendations, Final Report to the Oregon Legislature," Oregon Health Authority. January 2021. Available here: https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Cost%20 Growth%20Target%20Committee%20Recommendations%20Report%20FINAL%2001.25.21.pdf.

²⁷ "Healthcare Cost Growth Benchmark and Primary Care Target Parameters Adopted by the Office of Health Strategy," Connecticut Office of Health Strategy. November 2020. Available here: https://portal.ct.gov/-/media/OHS/Cost-Growth-Benchmark/CGB-SAB-Information/CGB-SAB-Meetings-2020/SAB-November-17-2020/CT-OHS-Healthcare-Benchmark-Initiative-November-2020-Report_final. pdf.

²⁸ "Benchmark Overview," Massachusetts Health Policy Commission. Available here: https://www.mass.gov/info-details/health-carecost-growth-benchmark.

²⁹ https://www.chiamass.gov/assets/2018-annual-report/2018-Annual-Report-THCE-TME-APM-Technical-Appendix.pdf.

³⁰ https://dhss.delaware.gov/dhss/files/benchmarkmanual06252020.pdf.

³¹ "Rhode Island Health Care Cost Growth Target: Implementation Manual." July 31, 2019. Available here: http://www.ohic.ri.gov/ documents/July%202019/Cost%20Trends/RI%20Implementation%20Manual%202019%207-31.pdf.

³²Includes Connecticut's recommended categories of data collection for spending measurement; the state will begin collecting 2021 performance data in summer/fall of 2022.

³³ "Preliminary Recommendations of the Healthcare Cost Growth Benchmark Technical Team," Connecticut Office of Health Strategy, Victoria Veltri, Executive Director. September 2020. Available here: https://portal.ct.gov/-/media/OHS/Cost-Growth-Benchmark/CGB-TT-Information/CGB--TT-Meetings-2020/September-24-2020/CT-OHS-Technical-Team-Recommendations-Report---September-2020_finaldraft.pdf.

³⁴ Includes Oregon's recommended categories of data collection for spending measurement; the state is not yet collecting all categories of data for statewide spending measurement and is still implementing its benchmark.

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³⁶ "Rhode Island Health Care Cost Trends: Trends in Health Care Cost Growth Pre-COVID-19, Experience with Care Delivery During COVID-19, and How to Address Pharmacy Costs." October 23, 2020. Available here: http://www.ohic.ri.gov/documents/2020/November/16/RI%20Cost%20Trends%20Public%20Meeting%20Slides%202020-10-23.pptx.

³⁷ "Sustainable Health Care Cost Growth Target: Implementation Committee Recommendations, Final Report to the Oregon Legislature," Oregon Health Authority. January 2021. Available here: https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Cost%20 Growth%20Target%20Committee%20Recommendations%20Report%20FINAL%2001.25.21.pdf.

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³⁹ https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-usspendingovertime_3.

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⁴⁵ "Standardizing the Measurement of Commercial Health Plan Primary Care Spending," Milbank Memorial Fund. July 2017. Available here: https://www.milbank.org/wp-content/uploads/2017/07/MMF-Primary-Care-Spending-Report.pdf.

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How Auto-Enrollment Can Achieve Near-Universal Coverage: Policy and Implementation Issues

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TOPLINES

Automatic health insurance enrollment could help achieve near-universal coverage, especially if paired with a public plan option

A comprehensive automatic enrollment strategy for health insurance would reduce the number of uninsured in the U.S. by 24.6 million, at a cost to the federal government of about \$140 billion in 2022



ABSTRACT

Issue: Automatic enrollment is receiving increased policy attention as a means of achieving universal coverage. Auto-enrollment also could have eliminated insurance gaps that occurred during the COVID-19 pandemic. However, it could face resistance from some Americans who would newly be expected to pay premiums. The approach also raises difficult design and implementation issues.

Goal: Explore how two auto-enrollment strategies, one affecting all legal residents and another affecting a narrower low-income population, might work.

Methods: Based on lessons learned from the Affordable Care Act and understanding of subsidized insurance programs, we explore design and implementation issues, such as how to deem enrollment, how to collect premiums, and which exemptions to permit. We also use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to estimate coverage and cost implications of each approach.

Key Findings and Conclusions: Both the comprehensive and limited approach to auto-enrollment would require the development of new administrative systems and enhanced marketplace subsidies to improve coverage affordability. Each approach would operate more simply if accompanied by a public insurance option. We conclude that the administrative and financing challenges related to auto-enrollment can be addressed and that a balance between public costs and sufficient political support could be identified.

INTRODUCTION

The idea of using an administrative mechanism to automatically enroll people who do not actively enroll themselves in a private health insurance plan or a public coverage program is receiving increased attention recently as a way of covering Americans who remain uninsured. Depending on the design, an auto-enrollment policy can target either a narrow segment or a broad swath of the population. During the COVID-19 pandemic, when millions of people lost their jobs and their employerbased insurance, auto-enrollment strategies might have eliminated many coverage gaps.

Absent a single-payer health insurance system, a comprehensive version of auto-enrollment that is mandatory for most people who would otherwise be uninsured may be one of the most likely paths to nearuniversal coverage. But comprehensive auto-enrollment raises significant administrative and political challenges because it generally requires the payment of insurance premiums by at least some of the people who are autoenrolled.¹ Given that, policymakers might also consider a narrower version of auto-enrollment, such as one limited to people who are eligible to enroll without paying a premium.

This paper explores how these two auto-enrollment variants might work and estimates their impacts on coverage and federal government costs. The first option we present is a more comprehensive approach that would lead to universal coverage for legally present U.S. residents. The second option, a less comprehensive approach, would focus on auto-enrolling the country's lowest-income residents who are eligible for comprehensive coverage without a premium contribution.

OPTION 1. MANDATORY AUTO-ENROLLMENT WITH RETROSPECTIVE INCOME-RELATED PREMIUM PAYMENTS

Policy Overview

This option would treat virtually all legal residents of the U.S. as insured 12 months per year, regardless of whether they have actively enrolled in an insurance policy. Incomerelated premiums would be collected at the end of the year from people who did not actively enroll in and maintain insurance coverage. Depending on their income, enrollees would be covered by either Medicaid or an insurance plan offered through the nongroup marketplaces for any months for which they do not otherwise have public or private insurance coverage. Any premiums owed would be collected through the tax system when they filed their tax returns for the year.

To make this auto-enrollment option work, a number of other policies are required:

- The Medicaid eligibility gap must be filled in the 14 states² that have not expanded eligibility to all those with incomes up to 138 percent of the federal poverty level (FPL). This would provide a default coverage option for a large share of the people uninsured under current law. Auto-enrolling these individuals would provide them with adequate, affordable insurance coverage.
- 2. Income-related marketplace subsidies for premiums and out-of-pocket costs must be more generous permanently. Without greater financial assistance, many people will still feel that the coverage available to them is unaffordable. This could make the autoenrollment approach politically unpalatable and unsuccessful in removing financial barriers to necessary medical care.
- 3. Implementation of this auto-enrollment approach would be greatly facilitated if a public insurance option became available on the marketplaces nationwide. This public plan could likely charge premiums below those of many commercial insurers if the government pays providers lower rates than most insurers. Such a plan would act as the default plan in which auto-enrollees ineligible for Medicaid are enrolled. Using a default public option for autoenrollees could address concerns related to plan assignment, plan capacity, provider networks, and reimbursement of claims.
- 4. The approach also requires eliminating the so-called employer-sponsored insurance firewall that prohibits people from receiving marketplace subsidies if they or one of their family members have offers of workplace insurance deemed affordable under current law. Without doing so, many people who are auto-enrolled

into marketplace coverage under this approach would find themselves ineligible for premium and costsharing subsidies, meaning they could be enrolled in coverage and charged premiums that they could not afford.³

5. An ongoing, well-funded education and enrollment assistance campaign is required as well. The objective is to create awareness that all Americans would be effectively insured, and those not actively choosing a plan themselves will be auto-enrolled in either Medicaid or the public insurance option. The campaign would directly explain that, depending on income, those not actively enrolling may owe premiums that will be collected through the tax system, if necessary. The idea is to aggressively encourage active enrollment in coverage over the course of each plan year, minimizing payments due at the end of the year.

Further discussion of each of the first three companion policies is provided in a later section. We first turn to a more detailed explanation of the pathways for enrollment and then to a description of how the health care services received during the year would be reimbursed by the plan under auto-enrollment.

Paths to Health Insurance Coverage

Individuals would enroll in coverage through three pathways: active enrollment during an annual open enrollment period, midyear active enrollment, and year-end auto-enrollment. Auto-enrollment would act as a fallback and affect only the minority of people who neglect to actively enroll in an insurance option for some or all of the calendar year.

Open enrollment period. Annual open enrollment periods for private insurance would continue in the presence of this auto-enrollment option. Active enrollment in employer-sponsored coverage and private nongroup coverage during applicable open enrollment periods would be strongly encouraged, as well as supported by widely available enrollment assistance provided by trained individuals. Individuals enrolling in the nongroup market could choose from all available insurance options and pay monthly premiums related to their income, as under current policy. Open enrollment would provide consumers with the broadest choice of insurance plan options, allowing them to enroll in the plan they anticipate will be the best fit for their needs. Over time, increased awareness of the program would lead more and more people to actively enroll.

People seeking coverage outside the open enrollment period. Active enrollment in nongroup insurance coverage would be permitted at any time, subject to some limitations. Individuals eligible for Medicaid or the Children's Health Insurance Program (CHIP) could enroll in those programs year-round, as under current rules. Midyear enrollees would remain in these programs subject to the state's eligibility redetermination processes.⁴ People covered by employer-based insurance or Medicaid for part of the year and then transitioning into nongroup insurance (due, for example, to a job loss or an increase in income) would qualify for special enrollment periods that would permit them to choose among all of available nongroup plans, as is the case today. For individuals not qualifying for a special enrollment period, midyear enrollment in nongroup insurance would be limited to the public option, as discussed below.

Those enrolling midyear in the public insurance option would be charged income-related monthly premiums for this coverage under the same terms as those who enroll during the open enrollment period. At the end of the year, they may also owe income-related premiums for any prior months in the year during which they were not actively enrolled in insurance, as described in the next section.

Auto-enrollment determined at end of a calendar year.

Some people would end the calendar year with all or some months during which they were not actively enrolled in insurance coverage. Regardless, they would be considered to have been insured for those months, either through Medicaid⁵ or the public option, depending on their income and the specific eligibility rules in their state. Depending on their incomes, they would be responsible for full, partial, or \$0 premium payments for the auto-enrolled months. Cost-sharing responsibilities (e.g., deductibles, copayments, coinsurance) would also vary by income. Any unpaid premiums owed would be collected through the income tax system. As under existing rules, eligibility for financial assistance would be based on annual income because monthly income is not reported on tax returns.⁶ If the auto-enrolled person incurred medical costs during these months, they could file claims for reimbursement with the appropriate plan, as discussed further in the next section.

Use of Services When Not Actively Enrolled in Coverage

People may seek medical care during months of the year even when they have not actively enrolled in coverage. If the need for care is urgent, the provider would be required to deliver the necessary care to the patient and accept the public option's payment rates, without balance billing.

If the need for care is not urgent, the provider would be required to inform the patient whether they are currently participating providers in Medicaid or the public option. Providers must then connect any prospective patients who are not actively enrolled to an insurance support hotline that would help them to actively enroll in Medicaid or the public option.

Providers that deliver care to a patient who has not actively enrolled would be required to submit the bill and patient contact information to the insurance support entity, which will pursue active enrollment of the patient in either Medicaid or the public option, as appropriate.

As noted above, the number of people not actively enrolling in insurance coverage should decrease appreciably over the first few years of the reform. Personal experience, educational campaigns, and knowledge disseminated via news outlets and social contacts will teach people the advantages of early active enrollment as well as the fact that income-related premiums must be paid either way. As a result, this issue should become a smaller one over time.

Exemptions from Auto-Enrollment

To maximize insurance coverage, approximating universal levels, exemptions from the auto-enrollment fallback must be kept to a minimum. The Affordable Care Act's (ACA's) original individual responsibility provision offered several exemptions that released uninsured people in particular circumstances from the coverage mandate and its associated penalties. Both the Obama and Trump administrations used administrative actions to expand these exemptions before the penalties were eliminated entirely beginning with the 2019 plan year.⁷ Together, these actions significantly weakened the mandate. In 2017, about 4.6 million tax returns showed a penalty and nearly 12.9 million claimed exemptions.⁸ The broad availability of exemptions likely resulted in a larger number of people remaining uninsured.

Exemptions of such breadth are not appropriate under the auto-enrollment option described here. Some exemptions may be necessary, but we believe that many of the ACA's exemptions from the mandate penalties should be eliminated and that few people would qualify for those that remained.

This is, first and foremost, because any end-of-year payments required under this approach are premium contributions, not penalties as under the ACA's individual mandate. In addition, several ACA exemptions are unnecessary under this auto-enrollment approach because the conditions they addressed would no longer exist. For example, the ACA provided an exemption for those without access to affordable coverage. Increasing the generosity of subsidies and, thereby, making coverage affordable to all legal residents eliminates the need for an affordability exemption. Similarly, the exemption for individuals ineligible for Medicaid coverage because of their state not expanding Medicaid eligibility is no longer necessary with that gap filled. The ACA exemption for those with income below the required tax filing requirement threshold is not necessary given that these individuals are exempt from any premium contribution under this design. And the ACA exemption for people uninsured for no more than three consecutive months is eliminated as the auto-enrollment strategy treats people as insured for the full year, consistent with the desire to all but eliminate uninsurance.

With that in mind, exemptions would be permitted only in the following circumstances:

• individuals ineligible for subsidized coverage (e.g., undocumented immigrants, citizens living abroad, and incarcerated individuals)

- individuals with a strongly held religious objection to receiving health care or insurance coverage (e.g., Christian Scientists and the Amish)
- members of Indian tribes (who would continue to be eligible for the Indian Health Service, for Medicaid, or for marketplace coverage under generous terms)
- in rare cases, individuals suffering hardships.⁹

Other ACA exemptions would not be adopted.

To avoid adverse selection, individuals who could enroll in Medicaid and the public option would generally need to receive an exemption in advance. For example, if the religious conscience exemption could be claimed after the fact, people could go uninsured and plan to claim the exemption but accept coverage if they get sick. On the other hand, individuals who are ineligible for subsidized coverage (e.g., undocumented individuals) could claim the exemption on the tax return, as they did under the ACA's individual mandate.¹⁰ Hardship exemptions could also be received after the fact.

Reporting of Coverage

Year-end auto-enrollment (and income-related premium collection) requires reporting to verify who lacked coverage for one or more months. The ACA's coverage reporting requirement, which was included primarily to support compliance with the individual mandate and the premium tax credit, is still in effect and should work for this purpose. The provision, in section 6055 of the Internal Revenue Code, requires providers of coverage health insurance issuers, self-insuring employers, and government health programs — to report on the people they cover and for which months they cover them. For marketplace coverage, the reporting responsibility is satisfied by the marketplace itself. Currently this reporting is done using Form 1095-A (for most marketplace coverage), Form 1095-C (for employers that are subject to the employer mandate and self-insure), and Form 1095-B (for all other coverage).¹¹ The law requires this information to be submitted to the Internal Revenue Service (IRS), with a copy sent to covered individuals.¹² This gives the IRS a comprehensive database of which taxpayers were covered

for the year. This is precisely the information required to implement auto-enrollment with retroactive premium collection.

Collection and Enforcement

As noted above, premium payments for auto-enrolled coverage would generally be collected through the income tax system, much like individual mandate payments were collected prior to the penalties being eliminated. One concern about this approach is that it could lead to taxpayers owing unaffordable amounts at tax time. After a suitable initial period (for example, two years), deferred payments would be subject to interest under normal IRS rules to avoid a disincentive to actively enroll.

If taxpayers fail to pay their premiums at tax filing, unpaid amounts would be collected using the same methods the IRS applies to other tax debts. Individuals facing financial hardship could apply to the IRS for a payment plan to spread out the payments or to have the amounts owed reduced (in addition to the hardship exemptions discussed above). The generous contribution schedules presented above should make such cases rare, particularly over time as the number of people not actively enrolling in coverage falls with greater awareness and experience with the system.

To further incentivize active enrollment and reduce the likelihood of large year-end tax bills, a withholding mechanism could also be adopted. Employers could be required to withhold a percentage of employees' income (for example, five percent) above a certain threshold (for example, \$30,000) unless 1) the employee is enrolled in the employer's coverage, or 2) the employee attests to having other coverage. Employees who inaccurately attest to having coverage could face both interest and moderate penalties, similar to the penalties that currently apply for underwithholding and making insufficient quarterly estimated tax payments. To be sure, such an approach would imperfectly capture the ultimate premium amount given employers' incomplete information about employees' total income and family structure. But it could be better than nothing given the risks of large year-end tax debts.

Companion Policies Required for Implementation of Comprehensive Auto-Enrollment

Medicaid gap considerations. As of May 2021, 14 states have not expanded Medicaid to all those with incomes up to 138 percent of the FPL, as provided by the ACA. The drafters of the ACA had anticipated all states expanding, and the law was written to limit premium tax credit eligibility to those with incomes between 100 percent and 400 percent of poverty. As a result of this language, combined with the Supreme Court decision that expansion was voluntary for states, millions of adults experiencing poverty are ineligible for any financial assistance for health coverage. This eligibility gap makes comprehensive auto-enrollment (and universal coverage) impossible.

We and others have suggested several federal policy approaches to filling in this gap.¹³ For purposes of Option 1, we assume elimination of the 100 percent of poverty threshold for marketplace subsidy eligibility (thereby covering everyone in the Medicaid gap), while simultaneously eliminating the 10 percent state financing share of Medicaid expansion costs for states that have expanded eligibility under the ACA.¹⁴ *Affordability/household financial burdens.* Under current law, marketplace subsidies decline on a sliding scale as income rises. Specifically, the long-run structure of the premium subsidy schedule put in place for 2021 (i.e., prior to the temporary two-year enhancements introduced in the American Rescue Plan Act) was set so individuals with incomes at 100 percent of FPL would have an expected contribution of 2.07 percent of income to purchase a benchmark silver plan, rising to 9.83 percent of income for those with incomes between 300 percent and 400 percent of FPL.

Separately, cost-sharing subsidies increase the actuarial value of a silver plan (normally 70 percent) to 94 percent at incomes below 150 percent of FPL. These cost-sharing subsidies decrease as income rises and phase out for incomes above 250 percent of FPL.

In previous work done by two of us and our Urban Institute colleagues,¹⁵ we provided two possible alternate subsidy schedules, both more generous than current law and the second more generous than the first. Recently introduced legislation, the "Improving Health Insurance Affordability Act of 2021," includes a schedule that falls between the two we analyzed and is presented in Exhibit 1.¹⁶

	Premium tax ci household premium as	redit schedule: percentage of income	Cost-sharing reduction schedule: actuarial value of plan provided to eligible enrollees (%)		
Income (% of FPL)	2021 pre-ARPA schedule: pegged to silver (70% AV) premium, indexed	Alternative schedule: pegged to gold (80% AV) premium, not indexed	2021 pre-ARPA schedule: coverage provided for silver plan enrollee	Alternative schedule: coverage provided for gold plan enrollee	
100–138	2.07	0.0	94	95	
138–150	3.10-4.14	0.0	94	95	
150–200	4.14-6.52	0.0–2.0	87	95	
200–250	6.52-8.33	2.0-4.0	73	90	
250-300	8.33-9.83	4.0-6.0	70	90	
300-400	9.83	6.0-8.5	70	85	
400-500	NA	8.5	70	80	
500-600	NA	8.5	70	80	
600+	NA	8.5	70	80	

Exhibit 1. Enhanced Premium Tax Credit and Cost-Sharing Reduction Schedules

Notes: AV = actuarial value; ARPA is the American Rescue Plan Act; FPL = federal poverty level; NA = not applicable. The Pre-American Rescue Plan Act schedule reflects the long-run policy under current law, as opposed to the temporary increase in premium tax credit generosity provided by the Rescue Plan.

Since most people have insurance coverage already and, thus, would not be auto-enrolled in coverage, those affected by the auto-enrollment policy are primarily those who would otherwise be uninsured.¹⁷ According to our calculations, the alternative subsidy schedule could provide zero-premium coverage in benchmark plans for 42 percent of the currently uninsured. Another 15 percent of the currently uninsured would have an expected premium contribution of no more than 4 percent of income, which is a large discount off the full premium price, yet still a potential source of resistance from some who would prefer to be uninsured.

This schedule would also improve affordability for millions of Americans already enrolled in marketplace coverage or employer-based insurance requiring large household premium contributions relative to income. In general, making financial assistance more generous would increase the cost to the federal government while reducing the costs to households along with the expected resistance to auto-enrollment.

Public option considerations. Option 1 assumes a nationwide public option, allowing all auto-enrollment to be directed into either Medicaid or the public option. The public option would be a plan administered by the federal government or a federal government contractor. The plan would provide benefits consistent with the requirements of a marketplace qualified health plan, and it would be included in the risk-adjustment system. The public option would be available in the marketplace and would be eligible for the premium tax credit and cost-sharing reductions under rules similar to those for other marketplace plans.

A public option is an important component of Option 1 for several reasons:

A public option would eliminate the need for the marketplace to assign enrollees to a particular plan. It is frequently not clear which plan is "best" for a given enrollee. Any assignment algorithm — lowest-cost plans, random assignment, etc. — would create winners and losers among both enrollees and plans. A public option accepting all non-Medicaid auto-enrollment would avoid these issues. This also highlights the importance that auto-enrollees be fully

risk-adjusted with the rest of the nongroup insurance market.

- A public option would simplify provider network questions that are likely to arise. When initiating or considering medical services, both patients and providers want to know as quickly as feasible which providers are included in the patient's insurance network. This would be challenging if a patient might later be auto-enrolled into any number of insurance plans. A public option would avoid this pitfall by making clear which plan applies to people seeking care who are not already actively enrolled in coverage.¹⁸
- Since many midyear auto-enrollees would be identified when they use medical services, private insurers might resist a system of auto-enrolling people in private coverage because of concerns that the auto-enrollees are likely to incur above-average health care costs.¹⁹
- A public option would avert complications related to plan capacity. Currently marketplace plans are permitted to cap their enrollment based on network capacity. The public option could be designed to provide flexible capacity as with existing public programs.

Making auto-enrolled coverage affordable requires subsidies sufficient to make the public option premium affordable. The alternative (higher-generosity) premium tax credit schedule is tied to the second lowest-priced gold plan premium available to the enrollee (the benchmark premium) and would eliminate the indexing of the percentage of income caps that occurs under current law. In some circumstances, the public option would be the benchmark plan or priced even lower; this is particularly likely in noncompetitive markets with high commercial insurance premiums. However, the public option premium could exceed the benchmark premium in some areas, particularly in markets that are already highly competitive.²⁰ In that case we assume the premium tax credit for public option enrollees (actively enrolled or auto-enrolled) would be tied to the public option instead of the second lowest premium plan.

OPTION 2. AUTO-ENROLLMENT FOR INDIVIDUALS IDENTIFIED AS ELIGIBLE FOR FREE COVERAGE

While Option 1 would likely achieve near-universal coverage, one of its central planks may be controversial: It requires individuals to pay for coverage whether they want insurance or not. Although premiums, not penalties would be collected from people otherwise uninsured, some people would compare these premium payments to an individual mandate penalty. At some income levels, the premium contributions would exceed the ACA's original individual mandate penalties. Option 2 would avoid these concerns by auto-enrolling only a segment of low-income people for whom coverage would be free.

Policy Overview

This auto-enrollment system would apply to a narrow segment of the population: low-income people who are eligible for comprehensive \$0 premium coverage and who can be identified through their participation in other public assistance programs, such as Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). By focusing on those people enrolled in TANF and/or SNAP, autoenrollment could take place during the annual open enrollment period and when people enroll in one of these programs midyear.

As with Option 1, a number of complementary policies would be implemented in conjunction with Option 2 to make it workable, fair, and effective:

- The employer-sponsored insurance firewall would be eliminated because auto-enrollees cannot fairly be penalized for the government acting unilaterally to enroll them in coverage.
- 2. Reconciliation of the premium tax credit would be eliminated for people enrolled in SNAP or TANF, including those auto-enrolled under this option. This ensures that auto-enrolled people receiving upfront premium subsidies are not at risk of having to pay them back at the end of the year.
- 3. The Medicaid eligibility gap would be filled in states that have not expanded eligibility to all those with incomes up to 138 percent of poverty. Without doing

so, auto-enrollment would largely be limited to Medicaid expansion states.²¹

4. Income-related marketplace subsidies would be made more generous to increase the number of low-income people eligible for comprehensive \$0 premium coverage beyond those eligible for Medicaid.

Given that auto-enrollment Option 2 would affect a much smaller number of people than would Option 1, and since most of those affected would be auto-enrolled into Medicaid, development of a public option is probably not necessary, although it would be helpful. It is likely feasible for people auto-enrolled into marketplace coverage to be enrolled in the two lowest premium gold marketplace plans in their residential areas.

Implementation Issues

This more limited approach to auto-enrollment could be implemented in several different contexts:

- a component of Option 1 to strengthen its impact
- a stand-alone policy to increase coverage beyond current law but not reach universal coverage
- a first step or phase-in policy to which Option 1 would be added at a later date.

Under any of these contexts, the marketplace or a similar entity would obtain data, including income information, on active SNAP and TANF enrollees from state government agencies. People who are not already enrolled in Medicaid or marketplace coverage and who are eligible for no-premium coverage would be prospectively auto-enrolled into Medicaid or marketplace coverage, depending on their eligibility. Auto-enrollees would be notified of their coverage and given a time window for declining the coverage or opting for a different plan. This opt-out opportunity, combined with limiting auto-enrollment to free coverage, obviates the need for a formal system of exemptions.²²

Comparison to Current Law

Under current law, many states' Medicaid and CHIP programs reimburse providers (or enrollees, if they paid directly) for the costs of care provided to patients during a short period preceding enrollment in these programs. Eligible people may generally enroll in these programs during or just after an episode of care (for example, when admitted to a hospital) and be covered for that care. Consequently, some analysts and policymakers consider people eligible for Medicaid but not enrolled as being effectively insured. Under that assumption, autoenrollment for people already eligible for Medicaid but not enrolled, as proposed here, would have little to no effect on the new enrollees. If that were true, the primary effect of Option 2 would be to auto-enroll people in nonexpansion states into marketplace coverage with enhanced subsidies.

However, there is good reason *not* to consider people who are eligible for but not enrolled in Medicaid as having coverage. Research indicates that people in this circumstance do not use medical care at the levels they would if they were actively insured. For example, Davidoff et al. found that Medicaid-eligible but uninsured adults are significantly less likely to have a usual source of care; more likely to have unmet medical, dental, and prescription drug needs; more likely to delay care because of cost; and less likely to have a healthcare provider visit in the past year.²³ These findings control for an array of individual characteristics, including health status.

Consequently, notifying low-income people identified through their participation in SNAP or TANF at the beginning of the year that they have been auto-enrolled in Medicaid can be expected to have a significant effect on their use of medical care and well-being. These autoenrollees will tend to use more medical care and be significantly less likely to delay their use of necessary care. Consequently, the benefits of Option 2 should accrue to people in both expansion and nonexpansion states.

ESTIMATED COVERAGE EFFECTS OF TWO AUTO-ENROLLMENT OPTIONS

We used the Health Insurance Policy Simulation Model (HIPSM)²⁴ to provide estimates of the impact of the two auto-enrollment approaches presented on the number of people uninsured and on federal government spending for the year 2022 (Exhibit 2). To measure the specific implications of each auto-enrollment strategy, we assumed that the following four reforms had been fully implemented whether Option 1 or Option 2 were enacted:

- Significantly more generous subsidies would be offered on the marketplaces than provided in the long-run ACA schedule. We assume that the alternative subsidy schedule (Exhibit 1) is in place. A less generous subsidy schedule could also be used at lower federal cost, while a more generous schedule could be used to help overcome political resistance to the more aggressive Option 1 approach. Consistent with current law, the subsidies provided under the reforms are assumed to be limited to people legally present in the U.S.
- A public option would be made available.
- The employer-sponsored insurance firewall would be eliminated.
- Eligibility for marketplace subsidies would be expanded to people in the Medicaid coverage gap.

We also looked at the effect of adopting these four reforms under current law prior to the American Rescue Plan Act *without* enacting any type of auto-enrollment.

	Number of uninsured (millions)		Federal spendi			
	Pre-ARPA law	Reform	Difference	Pre-ARPA law	Reform	Difference
Reforms without auto-enrollment	30.8	21.9	-8.8	467.1	546.7	79.6
Reforms with limited auto-enrollment (Option 2)	30.8	18.3	-12.5	467.1	580.5	113.4
Reforms with strong auto-enrollment (Option 1)	30.8	6.2	-24.6	467.1	606.6	139.5

Exhibit 2. Estimated Impact of Auto-Enrollment Options, 2022

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

Notes: ARPA = the American Rescue Plan Act. To produce estimates akin to steady-state effects, we do not include temporary reforms to health insurance premium subsidies enacted as part of the American Rescue Plan Act.

Compared to current law (prior to the American Rescue Plan Act), the set of complementary reforms described above (enhanced subsidies and extension to Medicaid gap population, public option, elimination of the firewall) without any auto-enrollment strategies would reduce the number of uninsured Americans by 8.8 million people at a cost to the federal government of \$79.6 billion in 2022.

Adding the limited auto-enrollment features under Option 2 would reduce the uninsured by 12.5 million people compared to current law at a cost to the federal government of \$113.4 billion in 2022.

Finally, our comprehensive auto-enrollment strategy, or Option 1, would reduce the number of uninsured by 24.6 million people compared to current law prior to the American Rescue Act, leaving only 6.2 million people residing in the U.S. without legal documentation as uninsured. The additional cost to the federal government of Option 1 combined with the other reforms would be \$139.5 billion in 2022. Importantly, our estimates show that the stronger the auto-enrollment approach, the lower the government cost associated with each additional covered life, since stronger auto-enrollment brings in healthier enrollees on average.

CONCLUSION

Even with very generous subsidies available, a purely voluntary system will never reach universal coverage. To the extent that insuring the entire population or almost the entire population is an objective, some type of automatic enrollment will be necessary, whether into a single-payer system or built onto our current multifaced health insurance system. Here, we present two possible approaches to auto-enrollment built on our current system: One has the potential to approximate universal coverage for the legally present U.S. population, and the other would expand coverage among those eligible for fully subsidized (free) coverage significantly beyond voluntary measures. Both would require the development of new administrative systems as well as improving coverage affordability for many Americans. Ideally, each approach would also include implementation of a public insurance option.

Expanded coverage would, therefore, come with additional public costs and may also come with some political resistance from households required to contribute to the costs of their insurance who would prefer to remain uninsured. However, we believe that the administrative and financing challenges are feasible to address, and that a balance between public costs and sufficient political support can be identified.

NOTES

- 1. Any program that aims to achieve universal coverage, including single-payer, would require some people to make payments into a system (either via premiums or taxes) that they would prefer not to make, leading to some significant political resistance.
- 2. Oklahoma is set to begin enrolling people eligible under their new expansion on June 1, 2021, with coverage beginning on July 1, 2021, but we continue to count it as a nonexpansion state until the expansion is actually in place. At the same time as Oklahoma, Missouri passed a ballot initiative to expand eligibility, but there continues to be uncertainty around Missouri's plans to implement its expansion.
- 3. Relatedly, the employer mandate would be eliminated since its operation is tied to the employee firewall (and it is currently expected to collect very little revenue). To encourage active enrollment and reduce the likelihood of large year-end payments, this approach could be combined with some sort of income withholding for employees not enrolled in the employer's coverage and not attesting to other coverage.
- 4. As under current Medicaid rules in many states, coverage would be retroactively effective for a short period (perhaps one to three months) to provide immediate reimbursement for ongoing episodes of care.
- 5. When auto-enrollment in Medicaid is determined at year end or tax time, enrollment would be done through the state's fee-for-service system to avoid complexities around retrospectively assigning people to managed care plans. Importantly, this approach avoids the necessity of making per capita payments to Medicaid managed care plans on behalf of autoenrollees who never use medical care during the year.
- 6. Under current law, Medicaid eligibility is typically determined using monthly income at the time of enrollment. However, using income information provided at the time of tax filing requires eligibility for Medicaid for auto-enrollment purposes to be determined using annual income. Under this approach, people could still actively enroll in Medicaid based on monthly income through traditional enrollment systems.

- 7. See, for example, Timothy S. Jost, "Implementing Health Reform: Exemptions from The Individual Mandate," *Health Affairs Blog*, June 27, 2013; and Katie Keith, "New Guidance on Exemptions from Individual Mandate," *Health Affairs Blog*, Apr. 10, 2018.
- 8. Internal Revenue Service, *Statistics of Income* 2017 *Individual Income Tax Returns Line Item Estimates* (IRS, 2017). For both counts, each return may represent more than one uninsured person. Also, the exemption figure is an undercount since it leaves out tax units that are exempt because of income below the filing threshold.
- 9. The individual mandate allowed hardship exemptions for those who experienced a hardship that interfered with their ability to maintain coverage. Regulations from the Centers for Medicare and Medicaid Services designated specific personal and financial circumstances that qualified as a hardship, including homelessness; eviction from a home; having a utility shut off; medical debt; unexpected increases in expenses for caring for an ill, disabled, or aging relatives; experiencing a natural disaster that resulted in significant property damage; experiencing domestic violence; or experiencing the death of a close family member. Given the additional generosity of subsidies, most individuals facing the designated circumstance are likely to be able to afford coverage, many with no premium contribution required. Thus, we assume that hardship exemptions would be relatively rare and would be available only by applying to the marketplace on a case-by-case basis.
- 10. To avoid the need for undocumented individuals to assert that status on the tax return, the individual mandate exemption form (IRS Form 8965) allowed individuals to use a single code to indicate either being undocumented or other grounds for an exemption. A similar approach would be adopted here.
- 11. Employers that are subject to the employer mandate (generally those with 50 or more full-timeequivalent employees) and that self-insure report using Form 1095-C because that form also includes the information needed to enforce the employer mandate. Specifically, in addition to coverage reporting under Code section 6055, the ACA added Code section 6056, which requires employers subject

to the employer mandate to report on their full-time employees and the coverage that is offered to them (whether or not they enroll). If the employer mandate and employee firewall were repealed, there would be a strong case to repeal section 6056, which is used primarily to enforce those two provisions. In that case, the IRS could straightforwardly shift these employers to doing their coverage reporting on Form 1095-B, which is a shorter and simpler form.

- Following the repeal of the individual mandate penalty, the IRS released guidance permitting issuers to refrain from sending Forms 1095-B for 2019 and 2020 to covered individuals unless they request it. This relief does not apply to 2021 and later years.
- 13. Timothy S. Jost and Harold Pollack, *Key Proposals to Strengthen the Affordable Care Act* (Century Foundation, Nov. 23, 2015); and Linda J. Blumberg et al., *The Healthy America Program, An Update and Additional Options* (Robert Wood Johnson Foundation and Urban Institute, Sept. 2019).
- 14. This approach was described in Linda J. Blumberg et al., *From Incremental to Comprehensive Health Insurance Reform: How Various Reform Options Compare on Coverage and Costs* (Urban Institute and Commonwealth Fund, Oct. 2019). We assume that the federal government would take over the 10 percent contribution that states currently make toward the costs of their Medicaid expansion populations in order to not financially disadvantage expansion states compared to nonexpansion states. A financially equivalent strategy could be used that would increase the federal Medicaid match rates in each expansion state to a level that would approximate 10 percent of costs associated with their expansion populations.
- 15. Blumberg, From Incremental to Comprehensive, 2019.
- 16. The proposed premium tax credit schedule shown in Exhibit1 is also used in the American Rescue Plan Act, which provides enhanced marketplace premium subsidies for 2021 and 2022. However, in addition to being temporary, the American Rescue Plan Act continues to tie premium subsidies to silver-level premiums (consistent with current law) and does not increase cost-sharing subsidies beyond those in current law. In contrast, the Improving Health Insurance Affordability Act of 2021 ties premium tax

credits to gold-level premiums and enhances costsharing subsidies further for those with incomes up to 400 percent of FPL.

- Linda J. Blumberg et al., *Characteristics of the Remaining Uninsured: An Update* (Robert Wood Johnson Foundation and Urban Institute, July 2018). According to this report, 57 percent of the uninsured had incomes below 200 percent of FPL, 26 percent had incomes between 200 percent and 400 percent FPL, and 17 percent had incomes above 400 percent of FPL in 2017.
- 18. There is a trade-off between the level of provider payment rates and voluntary participation of providers in the public option's network. The higher provider payment rates are set, the higher voluntary provider participation. However, higher provider payments also mean higher premiums associated with the public option and higher federal government subsidy costs. The federal government also could consider requiring provider participation as a condition of participation in the Medicare and Medicaid programs as a way to increase the breadth of the public option's provider network, if necessary.
- 19. A counterpoint to this perspective is that, without a public option, private issuers would not only receive auto-enrollees seeking health care midyear but would also be assigned people who have never actively enrolled in coverage and have used few or no health care services. A strong risk-adjustment system could mitigate at least some of the remaining concerns about the distribution of risk of auto-enrollees. In any case, private issuers' objections to a public option might swamp any such concerns about risk.
- 20. Since premiums are strongly associated with the level of payments a plan agrees to pay health care providers, the full premium for a public option will be correlated with the payment rates it uses. Paying providers something like Medicare rates would lead to lower premiums than paying them at the levels typical of commercial insurers. Consequently, the policy decision of which provider payment rates will be used by the public option will have important implications for whether its premium is at or below the benchmark.

- 21. Without filling the Medicaid eligibility gap, some people in nonexpansion states who are eligible by traditional Medicaid rules would be auto-enrolled. However, the impact on the number of people uninsured would be far smaller in these states. One also could envision auto-enrolling people eligible for \$0 premium marketplace bronze coverage where available; however, we oppose such a policy. The large out-of-pocket cost requirements for these plans would make coverage in them of little value to this low-income population, although the full premium cost paid by the federal government on behalf of all of the auto-enrollees would be significant.
- 22. Others have suggested a different approach to prospective auto-enrollment of those eligible for free coverage: identifying eligible people through income tax returns. See Christen Linke Young and Sobin Lee, How Well Could Tax-Based Auto-Enrollment Work? (Brookings Institution, Apr. 2020). While the impact of this option would be limited by the lack of a filing requirement at very low incomes, many people with incomes below the filing threshold choose to file a return — often either to claim tax benefits like the earned income tax credit or to receive a refund of excess income tax withholding. This approach would require larger accompanying changes, such a shifting the marketplace plan year and more broadly eliminating reconciliation. Such an approach could be combined with ours or implemented separately. However, combining the two could be complex given that our approach relies on current-year income while this other approach relies on past-year income.
- 23. Amy Davidoff, Bowen Garrett, and Alshadye Yemane, Medicaid-Eligible Adults Who Are Not Enrolled: Who Are They and Do They Get the Care They Need? (Urban Institute, Oct. 2001).
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The mission of the Commonwealth Fund is to promote a high-performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, and people of color. Support for this research was provided by the Commonwealth Fund. The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.
Racial and Ethnic Inequities in Health Care Coverage and Access, 2013–2019

Jesse C. Baumgartner Sara R. Collins David C. Radley

INTRODUCTION

The Affordable Care Act (ACA) helped to significantly reduce U.S. racial and ethnic disparities in health insurance coverage and to improve access to care, especially in states that expanded eligibility for their Medicaid programs.¹ But, after 2016, coverage gains stalled and slightly eroded. Combined with job and income losses stemming from COVID-19, this interruption in progress has left many people vulnerable to the health and economic risk of lacking comprehensive and affordable insurance during a public health crisis, particularly lower-income residents of the 14 states that have not expanded Medicaid.²

However, the American Rescue Plan Act (ARP) provides nonexpansion states with even greater incentives to expand their Medicaid programs to include all low-income adults. States that pursue expansion will receive a temporary increase in the federal matching rate for their existing Medicaid population and will still pay only 10 percent of the cost for the new enrollees.³ In addition, the ARP temporarily enhances premium subsidies for plans purchased through the marketplaces, including \$0 premium plans for individuals with incomes up to \$19,140 and for families of four earning up to \$39,300. President Biden's American Families Plan proposes to make these subsidies permanent.

In this brief, we update our 2020 report on coverage and access inequities using 2013–2019 data from the American Community Survey Public Use Microdata Sample (ACS PUMS) and the Behavioral Risk Factor Surveillance System (BRFSS).⁴ We examine trends in Black and Latinx/ Hispanic disparities across the following measures, with a particular focus on the effects of Medicaid expansion on equity at the state level:

- adults ages 19 to 64 who are uninsured
- adults ages 18 to 64 who went without care in the past 12 months because of cost
- adults ages 18 to 64 who report having a usual health care provider.



HIGHLIGHTS

- Adult uninsured rates and racial and ethnic coverage inequities declined in almost every state from 2013 to 2019, leading to both increased and more equitable health care access. But progress stalled nationally after 2016, and all groups have reported recent drops in coverage or access.
- The coverage gap between Black and white adults dropped by 4.6 percentage points between 2013 and 2019 to 5.3 points, with the gains largely concentrated between 2013 and 2016. The difference between the Latinx/Hispanic and white uninsured rates fell by 9 percentage points to 16.7 points between 2013 and 2019, reaching a low of 16.3 points in 2018. But the uninsured rates among Black and Latinx/Hispanic adults remain significantly higher than that of white adults.
- Adults in Medicaid expansion states reported better coverage and access rates, narrower disparities between groups, and greater improvements across nearly every measure between 2013 and 2019.
- After Louisiana and Virginia expanded Medicaid in 2016 and 2019, respectively, their uninsured rates for lower-income Black adults dropped significantly in comparison to Georgia and North Carolina, which have not yet expanded.
- Medicaid expansion is associated with increased coverage equity, but adults with income below 138 percent of the federal poverty level (FPL) in the remaining nonexpansion states are disproportionately Black and Latinx/Hispanic.

Health insurance inequities between white, Black, and Latinx/Hispanic adults declined significantly after 2013, but progress stalled after 2016.



Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2013-2019.

Black and Latinx/Hispanic adults have historically reported much higher uninsured rates than white adults. This disparity reflects economic inequities, for these communities are less likely than white adults to receive coverage through their jobs,⁵ as well as immigration policies that can constrain coverage options for Latinx/Hispanic families in particular.⁶

The ACA promised to increase coverage equity by funding 100 percent of state Medicaid expansions in the first three years, phasing down to 90 percent over time, and by subsidizing individual marketplace plans.

Uninsured rates for all three groups fell after coverage expansions went into effect in 2014, and Black and Latinx/ Hispanic adults made the largest gains. The Black adult uninsured rate dropped from 24.4 percent in 2013 to a low of 13.7 percent in 2016, before rising slightly to 14.2 percent in 2019. The Latinx/Hispanic uninsured rate decreased from 40.2 percent in 2013 to a low of 24.9 percent in 2018 but has since edged upward to 25.7 percent in 2019 (Table 1). These trends reduced coverage disparities in relation to white adults by 4.6 percentage points for Black adults and 9 points for Latinx/Hispanic adults (Table 6).

But progress stalled under the Trump administration, and coverage has eroded for all groups since 2016. The Latinx/ Hispanic uninsured rate rose by nearly 1 percentage point between 2018 and 2019. This increase may reflect immigration policies initiated by the Trump administration that have led to reduced enrollment in public programs.

Black adult uninsured rates and coverage disparities declined in most states

after 2013, with lower rates and larger improvements in states that expanded Medicaid.

Percentage of uninsured adults ages 19-64 in each state, by race and Medicaid expansion status



Notes: Expansion states are those that expanded Medicaid by January 1, 2019. As of that date, there were 17 states that had not yet expanded Medicaid. Idaho, Nebraska, and Utah implemented Medicaid expansion in 2020, which is not captured by 2019 ACS data. States are separated by Medicaid expansion status and ordered by 2019 Black adult uninsured rate. Alaska, Hawaii, Idaho, Maine, Montana, New Hampshire, North Dakota, South Dakota, Vermont, and Wyoming do not have sufficient sample size to estimate Black adult uninsured rates.

Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2013, 2019.

Between 2013 and 2019, Black adult uninsured rates dropped by at least 7 percentage points in 33 states,⁷ and the disparity in relation to white adults decreased by at least 4 points in 23 states (Table 2). Similar to the national trend, this progress occurred largely between 2013 and 2016.

The ACA allowed states to expand eligibility for Medicaid to everyone below 138 percent of FPL (\$17,608 for an individual and \$36,156 for a family of four), funded exclusively by the federal government in the first three years. Expanded Medicaid provided a comprehensive coverage option, at little or no cost, to eligible low-income people, who are disproportionately Black and Latinx/Hispanic.

States that had expanded Medicaid under the ACA by 2019 (left side of exhibit) typically reported lower uninsured rates among Black and white adults, larger improvements since 2013, and smaller disparities. Nonexpansion states like Georgia and Mississippi, home to large Black communities, reported some of the highest uninsured rates for both Black and white adults.

Latinx/Hispanic adult uninsured rates are lower in Medicaid expansion states, and disparities with white adults are less.

Percentage of uninsured adults ages 19–64 in each state, by race/ethnicity and Medicaid expansion status



Notes: Expansion states are those that expanded Medicaid by January 1, 2019. As of that date, there were 17 states that had not yet expanded Medicaid. Idaho, Nebraska, and Utah implemented Medicaid expansion in 2020, which is not captured by 2019 ACS data. States are separated by Medicaid expansion status and ordered by 2019 Latinx/Hispanic adult uninsured rate. Maine, North Dakota, Vermont, and West Virginia do not have sufficient sample size to estimate Latinx/Hispanic adult uninsured rates.

Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2013, 2019.

Latinx/Hispanic adults continue to face significant coverage barriers. These include ACA limits that do not allow undocumented immigrants to access Medicaid or the marketplaces, as well as other U.S. immigration policies.

Latinx/Hispanic uninsured rates in 2019 were at least 10 percentage points below 2013 rates in 33 states,⁸ and disparities with white adults were at least 7 percentage points smaller in 25 states (Table 2). States that had expanded Medicaid by 2019 (left side of exhibit) typically reported lower uninsured rates for Latinx/Hispanic and white adults and smaller disparities between the two. Nonexpansion states typically reported higher uninsured rates for Latinx/Hispanic and white adults; these included Texas and Florida, which are home to around 30 percent of the U.S. Latinx/Hispanic population.

But progress has largely stalled since 2016 likely, at least in part, because of Trump administration actions that may have discouraged eligible Latinx/Hispanic families from seeking coverage. Those included the public-charge rule that allows the government to deny citizenship based on past Medicaid use,⁹ which the Biden administration has already stopped enforcing.¹⁰

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Despite starting from a higher baseline, adults living in Medicaid expansion states reported greater coverage gains and disparity improvements from 2013 to 2019.



Percentage-point change in uninsured rate for U.S. adults ages 19-64, 2013 to 2019

Notes: Reported values for expansion/nonexpansion categories are averages among survey respondents, not averages of state rates. Expansion states are those that expanded Medicaid by January 1, 2019. As of that date, there were 17 states that had not yet expanded Medicaid. Idaho, Nebraska, and Utah implemented Medicaid expansion in 2020 and are considered nonexpansion for this analysis.

Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2019.

We also analyzed pooled uninsured rates for individuals across two categories of states — the 33 states and the District of Columbia that had expanded their Medicaid program under the ACA as of January 1, 2019, and the 17 that had not.¹¹

Despite lower pre-ACA uninsured rates, Black, Latinx/Hispanic, and white adults living in expansion states all reported larger coverage gains between 2013 and 2019 than those in nonexpansion states. The uninsured rate among Black adults living in expansion states dropped 11.3 percentage points, while the uninsured rate for Latinx/Hispanic adults dropped by 16.3 points (Table 1). Those gains largely occurred between 2013 and 2016.

Coverage disparities between Black and Latinx/Hispanic and white adults also narrowed more in Medicaid expansion states (Table 6) — declining by 5.1 points for Black adults and 10.1 points for Latinx/Hispanic adults.

After Louisiana and Virginia expanded Medicaid, uninsured rates for lower-income Black adults dropped significantly compared to Georgia and North Carolina.

Percentage of Black uninsured adults ages 19-64 living at 0-199% FPL



Note: FPL = federal poverty level.

Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2019.

To further examine the effects of Medicaid expansion on coverage inequities, we look more closely at four states. Georgia, Louisiana, North Carolina, and Virginia did not expand their Medicaid programs immediately in 2014, when the ACA's coverage expansions took effect. Louisiana and Virginia eventually expanded in 2016 and 2019, but Georgia and North Carolina have not.

The uninsured rate for Black adults with incomes below 200 percent of FPL (\$25,760 for an individual and \$53,000 for a family of four in 2021) dropped in all four states, but progress stalled after 2016 in Georgia and North Carolina (Table 3).

In contrast, in Louisiana the uninsured rate among low-income Black adults dropped by an additional 14.7 percentage points after expansion. Virginia expanded Medicaid in 2019 and reported a 6.2-point coverage improvement for the same group. Expansion in these two states also further narrowed the coverage gap between Black and white adults (Table 3).

Low-income Black and Latinx/Hispanic adults are more likely than white adults to live in the 14 states that have not expanded Medicaid.

Percentage of low-income U.S. adults (<138% FPL) ages 19–64 who live in Medicaid nonexpansion states, by race/ethnicity



The ACA's coverage expansions have been a key tool for increasing coverage and improving racial and ethnic health care equity.

But even though Black and Latinx/ Hispanic adults are disproportionately lower-income and more likely to be eligible for coverage under the law's Medicaid expansion, they are also more likely to live in states that have chosen not to expand Medicaid eligibility.

Among those with income less than 138 percent of poverty, 46 percent of Black adults, 38 percent of Latinx/ Hispanic adults, and 34 percent of white adults live in the 14 states that have not yet expanded Medicaid.

Notes: Calculation based on whether states have expanded Medicaid; currently, 14 states have not yet expanded. FPL = federal poverty level. Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2019.

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Black–white differences in cost-related access problems were cut in half between 2013 and 2019. Gains for white and Latinx/Hispanic adults have eroded slightly since 2016.

Percentage of U.S. adults ages 18-64 who avoided care because of cost in the past 12 months, by race/ethnicity



Data: Behavioral Risk Factor Surveillance System (BRFSS), 2013-2019.

By expanding coverage options and reducing out-of-pocket cost exposure for lower-income people, the Affordable Care Act lowered financial barriers that can deter patients from getting timely health care.¹²

Black and Latinx/Hispanic adults were much more likely to be uninsured prior to the ACA's coverage expansions and have seen the largest improvements since then. Greater coverage has been associated with improvements in access to health care.

The proportion of Black adults reporting they had avoided care because of cost dropped from 23.2 percent in 2013 to a low of 17.3 percent in 2019, with most of the gains concentrated between 2013 and 2016. Latinx/Hispanic adults reported a similar improvement trend: those with cost-related access problems fell from 27.8 percent in 2013 to a low of 21.2 percent in 2018, but rose to 22.8 percent in 2019 (Table 4). Gains for white adults also eroded slightly after 2016.

These improvements in access to care narrowed the disparity between Black and white adults by more than half, from 8.1 percentage points in 2013 to 3.8 points in 2019. The gap between Latinx/Hispanic and white adults fell from 12.7 points to a low of 8.3 points in 2018, but it has since increased (Table 6). Latinx/Hispanic adults reported an increase in cost-related access problems in 2019 that coincided with an uptick in their uninsured rate.¹³

Cost-related access problems for Black adults declined between 2013 and 2019. Disparities are less in Medicaid expansion states.

Percentage of adults ages 18–64 in each state who avoided care because of cost in the past 12 months, by race and Medicaid expansion status



Notes: Expansion states are those that expanded Medicaid by January 1, 2019. As of that date, there were 17 states that had not yet expanded Medicaid. Idaho, Nebraska, and Utah implemented Medicaid expansion in 2020, which is not captured by 2019 BRFSS data. States are separated by Medicaid expansion status and ordered by 2019 Black adult rate. Alaska, Arizona, Hawaii, Idaho, Iowa, Maine, Montana, New Hampshire, New Mexico, North Dakota, Oregon, South Dakota, Utah, Vermont, West Virginia, Wisconsin, and Wyoming do not have sufficient sample size to estimate Black adult rates. New Jersey did not report BRFSS measures for 2019 because of a reporting error.

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2013, 2019.

Cost-related access problems declined for Black and Latinx/Hispanic adults in most states between 2013 and 2019 (see also exhibit on next page), though changes were not statistically significant for all states (see Table 5).

Mirroring coverage, states that had expanded Medicaid by 2019 (left side of exhibit here and on next page) typically reported lower rates of cost-related access problems for all three groups and larger improvements since 2013 — particularly among Black and Latinx/Hispanic adults.

Latinx/Hispanic adults in Medicaid expansion states experienced fewer costrelated access problems and greater improvements between 2013 and 2019.

Percentage of adults ages 18–64 in each state who avoided care because of cost in the past 12 months, by race/ethnicity and Medicaid expansion status



In our pooled analysis, people living in expansion states also reported smaller disparities than those in nonexpansion states, and Black adults in expansion states had narrowed the gap with white adults to just 2.3 percentage points by the end of 2019 (Table 6).

Notes: Expansion states are those that expanded Medicaid by January 1, 2019. As of that date, there were 17 states that had not yet expanded Medicaid. Idaho, Nebraska, and Utah implemented Medicaid expansion in 2020, which is not captured by 2019 BRFSS data. States are separated by Medicaid expansion status and ordered by 2019 Latinx/Hispanic adult rate. Alabama, Maine, Mississippi, New Hampshire, North Dakota, South Dakota, Tennessee, Vermont, and West Virginia do not have sufficient sample size to estimate Latinx/Hispanic adult rates. New Jersey did not report BRFSS measures for 2019 because of a reporting error.

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2013, 2019.

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Black adults reported the largest improvement in having a usual care provider between 2013 and 2019. Access has eroded since 2016 for both Latinx/Hispanic and white adults.



Percentage of U.S. adults ages 18-64 who reported a usual source of care, by race/ethnicity

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2013–2019.

Having a usual source of care — a personal doctor or other provider — is generally seen as a strong indicator of health care access.¹⁴

White adults were the most likely to have a usual source of care in 2013, at 77.6 percent, but after 2016 they reported a decline, down to 76.5 percent in 2019. Around 71 percent of Black adults reported a usual care provider in 2013. That improved to a high of 74.7 percent in 2016, though gains stalled after that point. This more than halved the disparity with white adults to 2.4 percentage points (Tables 4 and 6).

Only around 55 percent of Latinx/Hispanic adults had a usual source of care in 2013. After improving to a high of 59.1 percent in 2015, this rate declined to 56.2 percent in 2019.¹⁵

People living in Medicaid expansion states are much more likely to have a usual source of care, and Black adults in those states are as likely as white adults to report a usual care provider (Table 4).

POLICY IMPLICATIONS

New policies to expand health insurance coverage, and to help those who are eligible to enroll, will be necessary to cover more U.S. adults and further narrow racial and ethnic disparities.¹⁶ Since taking office, the Biden administration has taken several steps to improve coverage, through executive actions and legislative proposals. These include opening the ACA marketplaces for a special open enrollment period ending in August; funding new outreach and advertising efforts to increase Americans' awareness of coverage options available to them; and issuing executive orders to reverse Trump administration rules that undermined insurance markets and make other improvements, such as fixing the "family glitch."¹⁷ Biden also has issued executive orders on immigration policy and ended enforcement of the publiccharge rule that has dissuaded even legal immigrants from seeking coverage for themselves and their children.¹⁸ And he has begun to unwind state efforts to impose work requirements in Medicaid and undermine insurance markets.¹⁹

On the legislative front, the American Rescue Plan includes a significant, though temporary, enhancement of marketplace premium subsidies.²⁰ It also provides temporary premium subsidies for people who sign up for COBRA coverage following job loss, as well as temporary access to zero-premium marketplace plans for people who file for unemployment this year. And the law incentivizes the 14 Medicaid nonexpansion states to move forward with a substantial, though temporary, increase in the federal Medicaid matching rate for their full Medicaid populations.

President Biden's American Families Plan proposes to make the ARP subsidies permanent.²¹ The Urban Institute estimates this change would reduce the number of uninsured by 4.2 million in 2022 and lower household health care costs for people enrolled in the marketplaces and the individual market by nearly one-quarter.²² Recent estimates also indicate that the infusion of federal spending if all 14 states expanded could create more than 1 million new jobs nationwide.²³

The fraught politics over Medicaid expansion in states like Florida and Texas will continue to stall forward movement on expansion, despite the new incentives in the ARP. In the meantime, 2 million people in the Medicaid coverage gap — too poor to qualify for marketplace subsidies and ineligible for their state Medicaid programs — will ride out the pandemic and beyond without access to affordable health insurance.²⁴ This group, among the poorest in the country, is disproportionately Black and Latinx/Hispanic. Allowing eligible people in these states to enroll in a plan offered through the marketplaces at \$0 premium and \$0 deductible and Medicaid equivalent benefits would provide health and economic security.²⁵

In the longer term, Congress may pursue additional reforms that build on these changes, such as adding a public insurance plan choice for everyone in the marketplaces²⁶ and creating a mechanism for automatically enrolling people in coverage.²⁷ Research shows that reforms like these could place the nation on a path toward universal, and more equitable, coverage and access to care.²⁸

HOW WE CONDUCTED THIS STUDY

Indicators and Data Sources

- *Percentage of uninsured adults ages 19–64:* U.S. Census Bureau, American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2019.
- Percentage of adults ages 18–64 who went without care because of cost during the past year and Percentage of adults ages 18–64 who had a usual source of care: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System (BRFSS), 2013–2019.

The ACS PUMS and BRFSS are large federal surveys used to track demographic and health characteristics of the U.S. population. The ACS samples approximately 3.5 million individuals each year, with annual response rates typically above 90 percent. The Census Bureau makes a portion of the ACS response records available to researchers in the Public Use Microdata Sample. The Centers for Disease Control and Prevention conducts the BRFSS each year in partnership with implementing agencies in each state. The 2019 BRFSS had a response rate just below 50 percent, with approximately 418,000 completed responses; similar response rates were seen in previous years.

Analytical Approach

We stratified survey respondents by their self-reported race and ethnicity: white (non-Latinx/Hispanic), Black (non-Latinx/Hispanic), or Latinx/ Hispanic (any race). We calculated national and certain state annual averages from 2013 to 2019 for each of the indicators listed above, stratified by race/ethnicity. We also calculated the average annual rate for white, Black, and Latinx/Hispanic adults from 2013 to 2019 across two categories of states: the Medicaid expansion group, which included the 33 states that, along with the District of Columbia, had expanded their Medicaid programs under the ACA as of January 1, 2019; and the nonexpansion group, which comprised the 17 states that had not expanded Medicaid as of that time (Idaho, Nebraska, and Utah are considered nonexpansion states in this analysis because they implemented their Medicaid expansions in 2020). Oklahoma and Missouri have passed ballot initiatives to expand Medicaid, but these have not yet been implemented. Reported values for expansion/nonexpansion categories are averages among survey respondents, not averages of state rates.

Subpopulation rates based on small samples were suppressed. Estimates derived from ACS PUMS and BRFSS were suppressed if the measures' relative standard error (standard error divided by the estimate) was less than 30 percent.

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TABLE 1. U.S. UNINSURED RATES BY DEMOGRAPHICS, 2013-2019 (ADULTS AGES 19-64)

	United States						Expansion states					Nonexpansion states			
	2013	2016	2018	2019	Net change (% points)	2013	2016	2018	2019	Net change (% points)	2013	2016	2018	2019	Net change (% points)
TOTAL	20.4	12.1	12.4	12.9	-7.6	18.3	9.3	9.4	9.8	-8.5	24.5	17.2	18.0	18.4	-6.0
Race/Ethnicity															
White	14.5	8.2	8.6	9.0	-5.5	13.1	6.3	6.5	6.9	-6.2	17.3	11.8	12.6	13.0	-4.3
Black	24.4	13.7	14.4	14.2	-10.1	21.5	10.1	10.4	10.2	-11.3	27.8	17.9	19.1	18.9	-8.8
Latinx/Hispanic	40.2	25.5	24.9	25.7	-14.5	36.4	20.3	19.4	20.1	-16.3	47.0	34.7	34.4	35.2	-11.8
Income															
0–199% FPL	37.9	23.1	23.2	23.9	-14.0	34.7	17.5	17.1	17.5	-17.2	43.2	32.1	32.7	33.8	-9.4
200%-399% FPL	20.0	12.9	13.9	15.0	-5.0	18.9	10.9	11.4	12.6	-6.3	22.0	16.1	18.0	18.9	-3.1
400%+ FPL	6.7	4.1	4.8	5.2	-1.6	6.2	3.4	3.9	4.2	-2.0	7.9	5.6	6.8	7.1	-0.8
Race/Ethnicity, by income															
0–199% FPL															
White	31.2	17.5	18.0	18.6	-12.6	28.7	13.0	13.0	13.4	-15.3	35.4	25.2	26.2	27.0	-8.4
Black	34.4	20.3	20.8	20.6	-13.9	30.6	14.3	14.3	13.5	-17.1	38.6	26.9	27.9	28.1	-10.5
Latinx/Hispanic	54.0	36.7	36.0	37.8	-16.2	48.8	28.6	27.4	28.6	-20.2	62.9	50.0	49.4	51.5	-11.3
200%-399% FPL															
White	15.3	9.6	10.6	11.4	-3.9	14.5	8.1	8.7	9.6	-4.9	16.7	12.1	13.7	14.4	-2.2
Black	20.5	11.9	13.3	13.9	-6.6	19.2	10.2	10.6	11.0	-8.3	21.9	13.8	16.1	16.8	-5.1
Latinx/Hispanic	35.5	23.2	23.7	25.3	-10.3	32.9	19.4	19.4	21.2	-11.7	40.3	29.8	31.0	32.1	-8.2
400%+ FPL															
White	5.2	3.1	3.7	4.0	-1.3	4.8	2.6	3.0	3.2	-1.6	6.2	4.3	5.1	5.6	-0.6
Black	10.2	5.6	7.1	6.8	-3.5	9.7	4.7	5.7	5.9	-3.8	11.1	7.1	9.1	8.0	-3.0
Latinx/Hispanic	15.0	9.5	10.7	11.3	-3.7	13.9	8.1	8.8	9.3	-4.6	17.1	12.2	14.3	15.3	-1.8

Notes: Expansion states are those that expanded Medicaid by January 1, 2019. As of that date, there were 17 states that had not yet expanded Medicaid. Idaho, Nebraska, and Utah implemented Medicaid expansion in 2020 and are considered nonexpansion for this analysis.

Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2019.

TABLE 2. STATE UNINSURED RATES AND DISPARITIES, 2013-2019 (ADULTS AGES 19-64)

				2013						2019	2019					
		White	Black	Black-white	Latinx/Hispanic	Latinx/Hispanic-		White	Black	Black-white	Latinx/Hispanic	Latinx/Hispanic-				
State	All	rate	rate	disparity	rate	white disparity	All	rate	rate	disparity	rate	white disparity				
United States	20.4	14.5	24.4	9.9 b	40.2	25.7 b	12.9 a	9.0 a	14.2 a	5.3 b	25.7 a	16.7 b				
Alabama	20.4	16.7	24.4	7.7 b	59.2	42.4 b	14.9 a	12.6 a	16.7 a	4.0 b	39.0 a	26.4 b				
Alaska*	23.9	18.3	29.1	10.7	23.6	5.2	15.3 a	10.0 a	_	_	29.3	19.4 b				
Arizona*	23.7	16.0	22.8	6.8 b	38.2	22.2 b	15.4 a	9.6 a	13.0 a	3.3 b	24.7 a	15.1 b				
Arkansas*	24.2	21.2	27.6	6.4 b	50.6	29.4 b	13.1 a	11.0 a	11.8 a	0.9	33.3 a	22.3 b				
California*	24.0	14.1	20.9	6.8 b	377	23.6 b	11 O a	5.8 a	77 a	19 b	18.3 a	12.5 b				
Colorado*	18.5	14.2	20.0	6.3 b	351	20.0 ±	10.4 a	76 a	9.5 a	1.0 -	20.0 a	12.0 ±				
Connecticut*	13.3	94	18.4	90 b	28.7	19.3 b	8.2 a	5.3 a	8.2 a	2.9 b	19.3 a	14.0 b				
Delaware*	14.2	11 7	14.0	2.3	317	19.9 b	9.6 a	70 a	10.8	3.8	25.0	18.0 b				
District of Columbia*	8.3	37	10.9	71 b	14.5	10.8 b	4.4 a	17 a	67 a	5.0 b	67	50 b				
Florida	28.9	21.6	32.9	11.3 b	43.0	21.4 b	19.4 a	15.3 a	21.5 a	61 b	25.9 a	10.6 b				
Georgia	26.0	191	28.4	9.3 b	601	410 b	18.9 a	14.7 a	18.8 a	40 b	46 0 a	31.3 b				
Hawaii*	10.2	11.0	20.4	0.0 0	8.4	-3.6	5 Q a	73 a	10.0 4	0 5	67	_0.6				
Idaho	23.3	20.4			44.0	-3.0 23.6 h	15.0 a	13.8 a			275 a	-0.0 13.7 h				
Illinois*	18.3	11.6	26.0	1/1 / h	301	23.0 b	10.3 a	67 a	12.5 a		21.0 a	15.7 b				
Indiana*	10.3	16.8	26.8	10.0 b	40.5	21.0 b 23.7 h	11.6 a	10.2 a	1/1 3 a	0.0 b	22.0 a	13.5 b				
	19.5	10.0	20.5	0.0 b	40.5	20.7 b	6.0 a	10.2 a	19.4	4.0 b	10.2 a	13.5 b				
Kansas	17.4	12.9	20.5	9.0 b	42.2	19.0 b	12.2 2	0.7 a	12.4	0.9 5	32.4 2	13.0 b				
Kantuala/*	21.0	10.0	24.4	10.0 b	42.2	20.3 0	13.2 a	9.7 a	11.2 .	9.1 b	02.4 a	22.0 D				
	21.0	19.2	20.9	10.7 b	52.5	22 Q h	9.0 a	10.4 a	12.1	0.4 b	20.2 a	20.3 0				
Louisiana Moine*	24.7	10.9	31.5	12.4 0	02.7	10.0	13.0 a	10.4 a	13.1 a	2.7 0	30.0 a	20.4 0				
Mandanda	14.0	10.0	14.0	- 6.0 b	33.7	10.0	11.4 ª	10.6 d	74.0	20 -	- 20.7 •	 25.0 k				
Managahurand"	14.0	8.0	14.8	0.2 D	41.3	32.8 D	8.3 a	4.4 a	7.4 a	3.0 0	29.7 a	25.2 D				
Massachusetts"	5.4	4.1	9.8	5.7 D	12.1	7.9 D	4.3 a	3.5 a	7.1	3.7 D	7.9 a	4.4 D				
Michigan	10.1	13.8	24.2	10.4 0	30.1	10.3 0	8.3 a	7.4 a	8.9 a	1.4 0	18.1 a	IU.0 D				
Minnesota	10.8	8.2	21.3	13.1 D	38.0	30.5 D	0.0 a	4.9 a	13.8	8.9 D	20.6 a	15.7 0				
Mississippi	24.9	20.4	29.6	9.2 0	50.5	30.1 b	19.5 a	10.0 a	21.5 a	4.9 0	43.3	20.0 D				
Mastarat	18.3	16.1	27.0	10.9 b	40.3	24.2 D	14.3 a	13.3 a	17.2 a	3.9 D	29.3 a	16.0 0				
Montana	23.3	20.1	-	-	31.0	10.9	11.7 a	9.8 a	_	-	16.3	6.4				
Nebraska	15.0	11.2	30.0	18.8 0	38.0	26.7 b	11.3 a	7.8 a	22.7	14.9 0	30.2	22.4 0				
Nevada*	27.2	20.4	31.0	10.5 b	41.1	20.7 b	15.7 a	10.8 a	11.3 a	0.5	26.8 a	16.0 b				
New Hampshire*	15.7	14.9	-	-	24.4	9.4 b	8.9 a	8.0 a	-	_	22.4	14.4 b				
New Jersey*	18.9	11.1	22.4	11.3 b	40.8	29.7 b	11.2 a	5.5 a	12.3 a	6.8 b	26.5 a	20.9 b				
New Mexico*	27.9	15.2	30.7	15.6 b	34.6	19.5 b	14.5 a	8.8 a	14.0	5.2	15.9 a	7.0 b				
New York*	15.4	9.7	16.7	7.0 b	29.5	19.7 b	7.5 a	4.5 a	7.9 a	3.4 b	15.1 a	10.6 b				
North Carolina	22.7	16.5	27.0	10.5 b	59.4	42.9 b	16.5 a	12.3 a	17.4 a	5.1 b	45.4 a	33.1 b				
North Dakota*	13.6	11.0				-	8.6 a	6.3 a			18.2	11.9 в				
Ohio*	15.8	14.1	22.0	8.0 b	34.0	20.0 b	9.2 a	8.1 a	11.8 a	3.8 b	22.0 a	13.9 b				
Oklahoma	24.5	19.1	27.4	8.3 b	50.8	31.6 b	21.5 a	16.9 a	21.7	4.8 b	40.6 a	23.7 b				
Oregon*	21.4	18.4	20.0	1.6	42.6	24.1 b	10.1 a	8.0 a	10.1 a	2.1	23.8 a	15.8 b				
Pennsylvania*	13.6	11.0	21.8	10.8 b	28.3	17.2 b	7.8 a	6.5 a	9.2 a	2.7 b	17.9 a	11.4 b				
Rhode Island*	16.6	11.6	21.7	10.1 b	43.0	31.4 b	6.0 a	3.9 a	6.9 a	3.0	13.8 a	9.9 b				
South Carolina	22.8	18.2	26.8	8.5 b	56.5	38.3 b	15.9 a	13.1 a	17.1 a	4.0 b	43.0 a	29.9 b				
South Dakota	17.4	12.5	-	-	49.2	36.7 b	13.6 a	10.0	-	-	27.0	17.0 b				
Tennessee	20.3	17.3	22.7	5.4 b	60.1	42.9 b	14.8 a	12.0 a	15.9 a	3.9 b	50.7 a	38.8 b				
Texas	29.8	17.4	26.9	9.4 b	47.1	29.6 b	24.5 a	14.6 a	20.0 a	5.4 b	38.2 a	23.7 b				
Utah	17.8	13.7	20.2	6.5	41.6	27.9 b	12.1 a	8.6 a	26.8	18.3 b	28.9 a	20.4 b				
Vermont*	9.8	9.7	-	_	-	-	6.7 a	6.0 a	-	_	-	-				
Virginia*	17.3	12.3	22.2	9.9 b	43.7	31.4 b	11.1 a	7.7 a	12.1 a	4.5 b	33.2 a	25.5 b				
Washington*	19.9	15.8	22.7	6.9 b	46.5	30.7 b	9.4 a	6.4 a	11.8 a	5.3 b	27.7 a	21.3 b				
West Virginia*	20.3	20.0	20.5	0.5	54.1	34.1 b	9.9 a	9.7 a	12.8	3.1	-	-				
Wisconsin	12.7	10.2	21.6	11.4 b	34.7	24.5 b	8.1 a	5.7 a	12.5 a	6.8 b	30.3	24.6 b				
Wyoming	17.9	16.3	-	-	27.7	11.4 b	16.8	14.4	-	_	28.9	14.5 b				

Notes: (a) 2019 uninsured rate for group is significantly different from 2013 (p<0.05). (b) Black or Latinx/Hispanic uninsured rate is significantly different from white uninsured rate (p<0.05). * Expanded Medicaid as of January 1, 2019. As of January 1, 2019, there were 17 states that had not yet expanded Medicaid. Idaho, Nebraska, and Utah implemented Medicaid expansion in 2020, which is not captured by 2019 ACS data. Missouri and Oklahoma have passed ballot initiatives to expand Medicaid, but these have not yet been implemented. (–) means there was not sufficient sample size to estimate the rate.

Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2013-2019.

TABLE 3. GEORGIA, LOUISIANA, NORTH CAROLINA, VIRGINIA UNINSURED RATES BY DEMOGRAPHICS, 2013–2019 (ADULTS AGES 19–64)

	Georgia						Louisiana					North Carolina					Virginia				
	2013	2016	2018	2019	Net change (% points)	2013	2016	2018	2019	Net change (% points)	2013	2016	2018	2019	Net change (% points)	2013	2016	2018	2019	Net change (% points)	
TOTAL	26.0	18.1	19.1	18.9	-7.1	24.7	15.4	11.8	13.0	-11.7	22.7	15.3	15.7	16.5	-6.2	17.3	12.2	12.2	11.1	-6.1	
Race/Ethnicity																					
White	19.1	13.9	14.9	14.7	-4.4	18.9	11.8	9.5	10.4	-8.5	16.5	11.1	11.8	12.3	-4.2	12.3	8.9	8.7	7.7	-4.6	
Black	28.4	18.0	19.2	18.8	-9.7	31.3	17.3	11.3	13.1	-18.1	27.0	16.3	16.0	17.4	-9.6	22.2	13.3	14.8	12.1	-10.1	
Latinx/Hispanic	60.1	46.8	45.5	46.0	-14.1	52.7	43.8	39.6	38.8	-13.9	59.4	43.9	43.9	45.4	-14.0	43.7	34.2	32.3	33.2	-10.5	
Income																					
0-199% FPL	46.3	35.0	35.9	36.1	-10.2	41.8	25.9	17.8	19.3	-22.5	42.0	29.3	29.9	31.0	-11.0	38.3	28.7	27.8	23.4	-14.9	
200%-399% FPL	21.9	16.4	18.8	19.7	-2.2	21.3	14.4	11.6	14.9	-6.4	18.9	14.1	15.5	17.0	-1.9	18.4	13.4	14.3	14.6	-3.8	
400%+ FPL	8.1	5.6	7.3	6.7	-1.4	9.7	5.5	5.9	5.7	-4.0	6.0	4.2	5.0	5.8	-0.1	5.7	3.8	4.3	4.4	-1.3	
Race/Ethnicity, by income																					
0-199%FPL																					
White	40.9	32.3	33.1	32.9	-8.0	37.7	24.3	16.5	17.8	-19.9	35.7	24.5	25.3	26.6	-9.1	31.6	24.4	23.2	18.0	-13.5	
Black	41.4	29.4	30.4	30.7	-10.7	42.0	22.8	14.0	15.4	-26.6	38.4	24.2	23.1	25.1	-13.4	37.1	24.4	24.8	18.6	-18.6	
Latinx/Hispanic	75.5	62.6	63.4	64.9	-10.6	70.7	58.5	54.0	54.0	-16.6	73.2	59.8	60.3	60.4	-12.8	67.0	58.0	54.1	52.7	-14.3	
200%-399% FPL																					
White	17.9	13.7	16.4	18.3	0.4	19.0	12.0	10.9	13.5	-5.5	14.9	11.1	13.4	13.8	-1.1	14.2	10.1	10.7	10.9	-3.3	
Black	21.0	14.1	16.4	15.2	-5.8	22.5	14.3	8.7	12.8	-9.7	20.4	13.0	14.0	16.4	-4.0	18.0	12.1	13.7	13.3	-4.8	
Latinx/Hispanic	50.0	40.4	40.7	42.5	-7.4	45.3	38.4	34.8	37.9	-7.4	47.2	35.3	34.3	39.1	-8.1	42.6	34.3	33.8	37.6	-5.0	
400%+ FPL																					
White	5.9	4.5	5.7	5.3	-0.6	7.4	4.5	4.6	4.3	-3.0	4.8	3.5	4.1	4.6	-0.2	4.0	2.9	3.3	3.2	-0.8	
Black	12.4	6.5	9.3	8.8	-3.5	14.6	6.4	7.9	9.5	-5.1	10.0	5.9	8.0	7.6	-2.5	8.8	4.5	6.9	5.8	-3.0	
Latinx/Hispanic	21.3	16.2	18.6	16.3	-5.0	31.4	20.0	20.4	11.8	-19.6	16.3	10.2	13.5	23.0	6.7	16.3	10.8	11.5	13.7	-2.6	

Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2019.

TABLE 4. RATES FOR ADDITIONAL ACCESS INDICATORS BY RACE/ETHNICITY, 2013-2019 (ADULTS AGES 18-64)

	United States					Expansion states					Nonexpansion states				
	2013	2016	2018	2019	Net change (% points)	2013	2016	2018	2019	Net change (% points)	2013	2016	2018	2019	Net change (% points)
Care avoided because of c	ost in pre	vious 12	months												
TOTAL	18.5	15.1	15.1	15.9	-2.7	17.0	13.3	13.2	13.8	-3.2	21.4	18.4	18.4	19.4	-2.0
Race/Ethnicity															
White	15.1	12.7	12.9	13.5	-1.6	14.0	11.3	11.2	11.8	-2.2	17.2	15.3	15.9	16.5	-0.7
Black	23.2	17.9	17.6	17.3	-5.9	20.8	15.1	14.4	14.1	-6.7	26.0	21.2	21.2	20.8	-5.2
Latinx/Hispanic	27.8	21.9	21.2	22.8	-5.0	26.3	19.8	19.6	20.5	-5.8	30.5	25.5	23.8	26.4	-4.1
Usual source of care															
TOTAL	72.0	73.8	72.6	71.9	-0.2	74.0	76.4	75.0	74.2	0.2	68.4	69.2	68.3	67.8	-0.6
Race/Ethnicity															
White	77.6	78.6	77.0	76.5	-1.1	79.0	80.5	79.1	78.5	-0.5	74.8	75.0	73.1	72.9	-1.9
Black	71.1	74.7	74.1	74.1	3.0	73.5	77.8	77.2	78.0	4.6	68.3	71.1	70.7	69.8	1.6
Latinx/Hispanic	55.3	58.2	58.2	56.2	0.9	58.2	62.6	61.2	58.4	0.3	50.0	50.7	53.2	52.6	2.6

Notes: Expansion states are those that expanded Medicaid by January 1, 2019. As of that date, there were 17 states that had not yet expanded Medicaid. Idaho, Nebraska, and Utah implemented Medicaid expansion in 2020 and are considered nonexpansion for this analysis. New Jersey did not report BRFSS measures for 2019 because of a reporting error.

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2013-2019.

TABLE 5. CARE AVOIDED BECAUSE OF COST IN PREVIOUS 12 MONTHS, STATE RATES AND DISPARITIES, 2013-2019 (ADULTS AGES 18-64)

				2013						2019	.019				
		White	Black	Black-white	Latinx/Hispanic	Latinx/Hispanic-		White	Black	Black-white	Latinx/Hispanic	Latinx/Hispanic-			
State	All	rate	rate	disparity	rate	white disparity	All	rate	rate	disparity	rate	white disparity			
United States	18.5	15.1	23.2	8.1 b	27.8	12.7 b	15.9 a	13.5 a	17.3 a	3.8 b	22.8 a	9.3 b			
Alabama	19.0	17.6	23.0	5.4 b	-	-	21.6	20.4	21.4	1.0	32.6	12.2			
Alaska*	15.9	14.1	27.3	13.2	27.3	13.2 b	15.0	14.2	-	_	22.4	8.3			
Arizona*	19.8	16.1	_	_	27.6	11.4 b	16.5	14.9	14.4	-0.5	20.9	6.0 b			
Arkansas*	25.2	22.2	31.8	9.6 b	40.0	17.8 b	18.9 a	17.7	20.6	2.9	23.0	5.3			
California*	17.9	14.2	15.7	1.4	23.5	9.3 b	13.8 a	11.1 a	10.5	-0.6	18.6 a	7.6 b			
Colorado*	17.0	14.3	25.4	11.1 b	24.3	10.1 b	13.8 a	13.1	10.4 a	-2.7	16.9 a	3.7 b			
Connecticut*	14.0	10.6	20.9	10.4 b	25.7	15.1 b	11.6	9.4	8.3 a	-1.1	20.2	10.8 b			
Delaware*	14.2	11.7	19.6	7.8 b	19.9	8.2 b	12.9	11.1	14.1	3.0	19.8	8.7 b			
District of Columbia*	11.8	6.2	16.3	10.1 b	15.2	9.0	11.4	8.7	13.0	4.3	16.0	7.3			
Florida	25.7	19.9	27.8	7.9 b	34.2	14.3 b	20.8 a	19.1	20.0	0.9	25.7 a	6.6 b			
Georgia	22.5	19.5	26.5	7.0 b	32.3	12.8 b	20.6	17.8	22.4	4.6	30.0	12.2 b			
Hawaii*	10.1	9.5	_	_	16.7	7.2 b	9.1	9.3	_	_	12.2	2.8			
Idaho	18.9	17.3	58.9	41.5 b	23.6	6.3	17.3	16.4	_	_	21.9	5.5			
Illinois*	16.1	11.1	24.6	13.4 b	28.8	17.7 b	15.6	12.5	14.6 a	2.2	26.4	13.9 b			
Indiana*	18.1	15.9	25.0	9.1 b	30.6	14.7 b	14.9 a	13.5	15.5	2.0	23.8	10.3 b			
lowa*	11.8	10.9	_	_	26.5	15.7 b	9.9	8.8	10.0	1.3	19.7	10.9 b			
Kansas	15.9	13.6	22.4	8.7 b	25.0	11.3 b	15.9	13.7	22.0	8.3 b	23.4	9.7 b			
Kentucky*	21.6	21.6	20.3	-1.3	23.1	1.5	14.5 a	13.9 a	12.9	-1.1	17.2	3.3			
Louisiana*	23.2	20.1	27.5	7.4 b	32.7	12.7	16.9 a	15.7	17.6 a	1.9	21.6	5.9			
Maine*	12.3	12.0	_	_	-	_	15.4 a	14.8 a	-	_	19.4	4.6			
Marvland*	14.7	10.1	16.8	6.8 b	37.9	27.8 b	12.4 a	9.1	12.4 a	3.3 b	27.4 a	18.3 b			
Massachusetts*	9.7	7.9	10.9	3.0	20.7	12.8 b	9.8	8.1	15.3	7.2 b	16.4	8.3 b			
Michigan*	17.7	15.8	25.1	9.4 b	24.4	8.7 b	13.6 a	12.5 a	15.1 a	2.7	17.3	4.9			
Minnesota*	11.9	10.5	23.2	12.7 b	22.1	11.6 b	11.8	10.5	17.9	7.4 b	24.5	14.0 b			
Mississippi	25.1	20.2	31.7	11.5 b	34.5	14.3	20.0 a	19.2	20.4 a	1.2	-	_			
Missouri	19.1	15.4	25.2	9.8 b	29.1	13.7	17.4	15.7	26.0	10.4 b	15.2	-0.5			
Montana*	16.1	15.4	_	_	24.4	9.0	12.5 a	12.5 a	-	_	14.2	1.7			
Nebraska	15.3	13.1	31.0	17.9 b	24.1	11.0 b	15.0	13.4	19.8	6.4	23.0	9.6 b			
Nevada*	19.8	17.3	26.5	9.3	23.4	6.1	18.1	17.2	12.9	-4.3	21.8	4.7			
New Hampshire*	13.7	12.5	33.7	21.2 b	32.4	19.9 b	13.8	13.2	_	_	_	_			
New Mexico*	21.4	16.3	29.7	13.5	26.9	10.6 b	15.8 a	13.1	_	_	18.2 a	5.2 b			
New York*	17.1	12.5	15.6	3.1	29.7	17.1 b	13.2 a	9.1 a	12.2	3.1	22.8 a	13.8 b			
North Carolina	21.3	18.2	26.1	8.0 b	31.7	13.6 b	18.8	16.7	20.8	4.1	27.3	10.6 b			
North Dakota*	8.3	7.8	-	_	-	-	10.9	9.7	-	_	-	_			
Ohio*	17.3	15.6	23.9	8.3 b	22.7	7.1	14.5 a	13.3	17.2	3.8	19.0	5.6			
Oklahoma	20.4	18.8	25.3	6.5	31.9	13.2 b	19.5	18.1	21.6	3.5	27.7	9.5 b			
Oregon*	21.7	19.2	_	_	33.6	14.3 b	16.2 a	14.6 a	_	_	24.9	10.2 b			
Pennsylvania*	14.3	11.9	20.6	8.7 b	28.2	16.3 b	11.8 a	10.1	15.5	5.4 b	23.5	13.4 b			
Rhode Island*	17.0	13.5	15.7	2.2	32.9	19.3 b	9.8 a	8.4 a	13.4	5.0	15.5 a	7.1 b			
South Carolina	22.6	20.1	24.4	4.3 b	27.7	7.6	18.2 a	15.9 a	20.2	4.3	27.0	11.1 b			
South Dakota	11.4	9.8	-	_	22.6	12.8 b	11.8	10.5	-	_		_			
Tennessee	20.6	20.4	21.3	0.9	-	-	17.8	16.0 a	19.1	3.0	37.5	21.5 b			
Texas	22.0	15.5	24.6	9.2 b	29.6	14.2 b	21.6	16.5	20.2	3.7	26.8	10.3 b			
Utah	17.1	14.8	_	_	27.8	13.1 b	16.3	14.2	19.6	5.4	22.1	7.9 b			
Vermont*	10.7	10.5	-	_	-	_	11.3	11.1	-	_	_	_			
Virginia*	17.6	14.0	20.5	6.5 b	35.0	21.1 b	14.1 a	11.6	14.8	3.2	30.4	18.8 b			
Washington*	17.9	16.3	25.0	8.6	30.6	14.2 b	13.2 a	11.9 a	13.7	1.7	21.2 a	9.3 b			
West Virginia*	22.2	21.8	35.5	13.7 b	-	-	16.2 a	16.0 a	-	_	-	-			
Wisconsin	14.1	11.9	33.1	21.1 b	22.6	10.7	12.5	11.7	-	-	19.0	7.3			
Wyoming	16.6	14.3	-	_	31.7	17.3 b	16.2	14.4	-	-	24.9	10.5 b			

Notes: (a) 2019 rate for group is significantly different from 2013 (p<0.05). (b) Black or Latinx/Hispanic rate is significantly different from white rate (p<0.05). * Expanded Medicaid as of January 1, 2019. As of January 1, 2019, there were 17 states that had not yet expanded Medicaid. Idaho, Nebraska, and Utah implemented Medicaid expansion in 2020, which is not captured by 2019 ACS data. Missouri and Oklahoma have passed ballot initiatives to expand Medicaid, but these have not yet been implemented. New Jersey did not report BRFSS measures for 2019 because of a reporting error. (–) means there was not sufficient sample size to estimate the rate.

Data: Behavioral Risk Factor Surveillance System, 2013-2019.

TABLE 6. TRENDS IN BLACK-WHITE AND LATINX/HISPANIC-WHITE DISPARITIES IN INSURANCE COVERAGE AND ACCESS, 2013-2019

		Black-white disparity (percentage points)						Latinx/Hispanic-white disparity (percentage points)					
	2013	2016	2018	2019	Net change (% points)	2013	2016	2018	2019	Net change (% points)			
Uninsured rates (adults ages 19-64)*													
U.S. average	9.9	5.5	5.8	5.3	-4.6	25.7	17.4	16.3	16.7	-9.0			
Expansion states	8.4	3.9	3.9	3.3	-5.1	23.4	14.1	12.9	13.2	-10.1			
Nonexpansion states	10.5	6.1	6.4	5.9	-4.6	29.8	23.0	21.8	22.3	-7.5			
Care avoided because of cost (adults ages 18-64)**													
U.S. average	8.1	5.2	4.7	3.8	-4.3	12.7	9.3	8.3	9.3	-3.5			
Expansion states	6.8	3.9	3.2	2.3	-4.5	12.3	8.6	8.4	8.7	-3.6			
Nonexpansion states	8.7	5.9	5.3	4.2	-4.5	13.3	10.2	7.9	9.9	-3.4			
Usual source of care (adults ages 18–64)**													
U.S. average	6.5	3.9	2.8	2.4	-4.1	22.4	20.4	18.7	20.3	-2.1			
Expansion states	5.5	2.7	1.9	0.4	-5.1	20.9	17.9	17.9	20.0	-0.8			
Nonexpansion states	6.5	3.9	2.4	3.0	-3.5	24.7	24.4	19.9	20.3	-4.5			

Notes: Expansion states are those that expanded Medicaid by January 1, 2019. As of that date, there were 17 states that had not yet expanded Medicaid. Idaho, Nebraska, and Utah implemented Medicaid expansion in 2020, and are considered nonexpansion for this analysis.

* Data: American Community Survey Public Use Microdata Sample (ACS PUMS), 2013–2019.

** Data: Behavioral Risk Factor Surveillance System (BRFSS), 2013-2019.

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The American Rescue Plan Act of 2021 A Historic if Transitory Expansion of the ACA

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The American Rescue Plan Act of 2021 (ARPA), a \$1.9 trillion economic stimulus bill, was signed into law by President Biden on March 11, 2021.¹ Although the bill largely focused on the devastation related to the COVID-19 pandemic, the ARPA is also poised to effectuate a momentous expansion of the Patient Protection and Affordable Care Act (ACA).² With an eye toward increasing access to health care and bolstering affordability, the ARPA expands health insurance marketplace subsidies, defrays the health insurance costs of the unemployed, and incentivizes nonexpansion states to expand their Medicaid programs to all low-income adults.¹ Projections of the Congressional Budget Office (CBO) suggest that in so doing, the ARPA will extend health care coverage to an estimated 2.5 million uninsured US residents by 2023.³ The CBO further projects that premiums will decline by as much as 100% for as many as 3.4 million low-income enrollees.³ This Viewpoint discusses the ARPA elements that bolster the ACA and describes their potential implications and uncertainties.

In one of its most prominent features, the ARPA markedly expands the ACA marketplace subsidies (premium tax credits) during calendar years 2021 and 2022; this is the first increase in marketplace subsidies and thus in insurance expansion since the passage of the ACA.¹ In so doing, the ARPA seeks to decrease the health insurance premiums of enrollees who earn up to 150% of the federal poverty level (FPL). Before the ARPA, individuals in this income category were required to contribute up to 4.14% of their household income to their health insurance premium.² Under the ARPA, the health insurance premiums of individuals in this income category will be fully subsidized at the second-lowest-priced Marketplace health insurance plan in the Silver category. Some—albeit more limited—premium relief will be extended to enrollees whose earnings places them at 400% of the FPL. Moreover, enrollees whose earnings exceed 400% of the FPL, heretofore excluded from receiving premium support, will be eligible for marketplace subsidies that will decrease their contribution to no more than 8.5% of their annual income. In yet another important revision of the ACA, individuals receiving unemployment benefits will be deemed "applicable taxpayers" and thus eligible for marketplace subsidies even if their earnings place them below 100% of the FPL; under the ACA, this group was not subsidy eligible. According to estimates from the CBO, as many as 1.4 million individuals receiving unemployment benefits may enroll in subsidized marketplace plans.³ 6/11/2021

The American Rescue Plan Act of 2021: A Historic if Transitory Expansion of the ACA | Health Care Reform | JAMA | JAMA Network

Apart and distinct from augmenting marketplace premium subsidies, the ARPA also addresses the needs of unemployed individuals who lose their employer-provided health insurance plan.¹ Equal consideration is being given to individuals whose health plan enrollment eligibility was compromised by involuntary underemployment. With these challenges in mind, the ARPA commits to fully subsidizing the costs of the COBRA (Consolidated Omnibus Budget Reconciliation Act) health insurance premiums of displaced employees from April 1 to September 30, 2021.⁴ Absent extension of this commitment by government action, the COBRA subsidies in question will be discontinued. In yet another provision, employers will be eligible for a refundable payroll tax credit to offset amounts paid under the COBRA subsidy provisions. CBO estimates suggest that 2.2 million additional individuals are likely to enroll in subsidized COBRA health insurance plans.³

The ARPA also aims to enhance the ACA via the 12 states that have yet to expand their Medicaid program to all low-income adults (≤138% of the FPL).¹ With an eye toward incentivizing these remaining nonexpansion states, the ARPA commits to increasing the federal matching fund contribution to the Medicaid programs of the nonexpansion states by 5 percentage points for 2 years. The collective potential net benefit of the increase in funding to the nonexpansion states is estimated at \$10 billion.⁵ The federal incentive program may encourage states such as Wyoming and Kansas, which have previously considered the prospect of expanding their Medicaid program only to reject this possibility. Support for the conversion could also be triggered by the experience of Missouri and Oklahoma, which have resolved through popular vote to expand their Medicaid programs but have yet to do so legislatively.⁶ Further expansion of additional state Medicaid programs is also contingent on the outcome of Medicaid expansion ballot initiatives planned for Florida, Mississippi, and South Dakota in 2022.

However, the ARPA vision of an augmented ACA also faces multiple challenges. Perhaps most important is the obligatory upgrade of the state-based federally facilitated marketplaces that will have to be brought into compliance with the law. Although the ARPA allocates \$20 million to defray the relevant costs required by this modernization effort, the magnitude of the task and the short timeline for achieving it may well prove challenging. Similar challenges are to be anticipated for the federal health insurance exchange website of the Department of Health and Human Services,⁷ which will require similar updates. Much will also be expected of other elements of the federal government, including the Internal Revenue Service, given the implications of the new regulations to tax filings for 2020. Further guidance from the Department of Labor is similarly anticipated.

An additional important consideration is the matter of *California v Texas*, a case the US Supreme Court is expected to decide by June, wherein the feasibility of the ACA is at stake.⁸ The case rests on the argument that the elimination of the "individual mandate" by the Tax Cuts and Jobs Act of 2017 renders some or all of the ACA unconstitutional.⁹ The Biden administration, departing from the position of the Trump administration, has taken the position that ACA remains constitutional. Although reading into the results of oral arguments is hardly an exact science, defenders of the ACA have some reason for optimism. The Supreme Court may uphold the statute through a combination of several different positions (ie, that the plaintiffs lacked standing to sue to invalidate the ACA), that the mandate remained constitutional even with a penalty of zero, and that even if the mandate itself were held unconstitutional, it is severable from the rest of the ACA, which would result in an empty victory for the challengers because it would merely eliminate a mandate Congress had already eliminated de facto. Any of these outcomes would leave the Biden administration free to continue to strengthen the ACA rather than having to address the challenging and uncertain task of implementing a replacement statute.

The first 100 days of the Biden administration have seen the implementation of a significant number of health care policies. Efforts to bolster the ACA, none more important than those embedded in ARPA, led the way. Whether Congress will extend the ARPA-associated ACA upgrades beyond the COVID-19 pandemic remains an unresolved question. Much will also depend on the outcome of *California v Texas*. If the Supreme Court upholds the ACA in large part, as many experts expect, the Biden administration is likely to do its very best to live up to its commitment to further expanding the access to and the affordability of health care.

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Recent and Anticipated Actions to Reverse Trump Administration Section Non-Discrimination Rules

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The Biden Administration has started taking steps to reverse Trump Administration policy and regulations that significantly narrowed the implementation and administrative enforcement or 1557, the Affordable Care Act's nondiscrimination provision, particularly as the regulations ap gender identity and sexual orientation. In addition, several lawsuits challenging the <u>regulation (https://www.kff.org/racial-equity-and-health-policy/issue-brief/the-trump-administrations-final-rule-on-section-discrimination-regulations-under-the-aca-and-current-status/)</u>, which were initially issued by the Obama Administration and later substantially revised by the Trump Administration, are pending. Sect prohibits discrimination based on race, color, national origin, sex, age, and disability in health programs and activities receiving federal financial assistance. The two versions of the regulation, ado conflicting interpretations about the content and scope of prohibited discrimination. This issu provides an update on current developments and identifies issues to watch in the coming wermonths.

Administrative Actions

On May 10, 2021, the Biden Administration <u>announced</u> (https://www.hhs.gov/about/news/2021/C announces-prohibition-sex-discrimination-includes-discrimination-basis-sexual-orientation-gender-identity.html HHS Office for Civil Rights (OCR) will include gender identity and sexual orientation as it interprets and enforces (https://www.federalregister.gov/documents/2021/05/25/2021-10477/notificatior interpretation-and-enforcement-of-section-1557-of-the-affordable-care-act-and-title) Section 1557's prohib against sex discrimination (Figure 1). This announcement followed a federal agency review existing regulations and policy directed by President Biden's <u>executive order on preventing ar</u> combatting discrimination based on gender identity and sexual orientation (https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-preventing-and-cc discrimination-on-basis-of-gender-identity-or-sexual-orientation/), which he issued on his first day in offic May 2021 announcement marks both a reversal of Trump Administration policy and an expar Obama Administration policy. While the <u>Obama Administration regulations (https://www.kff.org/requity-and-health-policy/issue-brief/summary-of-hhss-final-rule-on-nondiscrimination-in-health-programs-and-eerincluded gender identity and sex stereotyping in the definition of sex discrimination, they omis sexual orientation, noting that federal law in this area was still evolving at that time. Subseque Trump Administration <u>eliminated (https://www.govinfo.gov/content/pkg/FR-2020-06-19/pdf/2020-11758.pc</u> gender identity and sex stereotyping from the regulations. However, just after the Trump Administration regulations were published, the Supreme Court, in <u>Bostock v. Clayton County, G</u> (https://www.supremecourt.gov/opinions/19pdf/17-1618 hfci.pdf), ruled that sex discrimination in the employment context does include discrimination based on gender identity or sexual orientati Following the <u>Bostock ruling, two federal district courts issued nationwide preliminary injunctiv</u> (https://www.kff.org/racial-equity-and-health-policy/issue-brief/the-trump-administrations-final-rule-on-section-regulations-under-the-aca-and-current-status/) (Figure 1 and described further below), bl implementation of several provisions of the Trump Administration's regulations related to Sec 1557.</u>



Figure 1: Key Dates in Section 1557 Implementation

HHS recently indicated (https://affordablecareactlitigation.files.wordpress.com/2021/05/dcc-joint-status-re 21.pdf) that it will issue a new notice of proposed rule-making (NPRM) to revise the Section regulations. The Biden Administration states that its "anticipated rulemaking proceeding will for the reconsideration of many or all of the changes to existing Section 1557 regulations (https://affordablecareactlitigation.files.wordpress.com/2021/05/dcc-joint-status-report-5-14-21.pdf)" that are l challenged in current litigation (described below). The timeframe for the new NPRM is uncerta HHS stating that it intends to do so "as expeditiously as reasonably possible" while "account[ir HHS's limited resources (https://affordablecareactlitigation.files.wordpress.com/2021/05/dcc-joint-status-re 21.pdf). . . ." In light of the Biden Administration's May 10 announcement, it is likely that the new will propose not only restoring gender identity but also adding sexual orientation to the reguldefinition of sex discrimination, thereby expanding on the Obama Administration interpretati extent to which the new NPRM proposes restoring or expanding other Section 1557 provision were changed by the Trump Administration unrelated to the definition of sex discrimination, set those related to <u>discrimination in health insurance benefit design</u>; <u>language access</u>; <u>notices</u>, <u>g</u> <u>procedures</u>, <u>and enforcement</u>; <u>and covered entities (https://www.kff.org/racial-equity-and-health-polic</u> <u>brief/the-trump-administrations-final-rule-on-section-1557-non-discrimination-regulations-under-the-aca-and-custatus/</u>), remains to be seen. The new NPRM also could propose <u>restoring provisions prohibitin</u> <u>discrimination based on gender identity and sexual orientation that were eliminated by the Tr</u> <u>Administration (https://www.kff.org/racial-equity-and-health-policy/issue-brief/the-trump-administrations-finissection-1557-non-discrimination-regulations-under-the-aca-and-current-status/</u>) in other federal health car regulations outside of Section 1557 that apply to Medicaid, the ACA Marketplaces, and private insurance issuers.

Court Actions

Three of the five cases challenging the Trump Administration regulations have been put to provide the Biden Administration with additional time to complete its review of exis regulations and policy (Table 1). Courts in two of the cases on hold issued the <u>nationwide</u> preliminary injunction orders (https://www.kff.org/racial-equity-and-health-policy/issue-brief/the-trump-administrations-final-rule-on-section-1557-non-discrimination-regulations-under-the-aca-and-current-status/) th continue to block implementation of some provisions of the Trump Administration regulation orders remain in place, although the federal government appealed both of them. A third case challenging the Trump Administration regulations also has been put on hold, though the parti disagree (https://affordablecareactlitigation.files.wordpress.com/2021/05/merged 94413 -1-1621119514.pdf) how long the delay in that case should last. The cases currently on hold include:

• A DC case, Whitman-Walker Clinic v. HHS

(https://affordablecareactlitigation.files.wordpress.com/2020/06/6611972-0-11462.pdf), brought by health and social service providers who serve LGBTQ people and people with limited English profi (LEP). The district court's <u>nationwide preliminary injunction</u> (<u>https://affordablecareactlitigation.files.wordpress.com/2020/09/6725227-0-26785.pdf)</u> prevents the fede government from implementing provisions of the Trump Administration regulations that (1 sex stereotyping from definition of sex discrimination and (2) incorporate a blanket religiou freedom exemption from claims of sex discrimination. The <u>next status report is due</u> (<u>https://affordablecareactlitigation.files.wordpress.com/2021/05/dcc-continued-stay-order.pdf)</u> to the court August 12, 2021.

A New York case, Asapansa-Johnson Walker v. Azar

(https://affordablecareactlitigation.files.wordpress.com/2020/06/johnson-walker-complaint.pdf), brought b transgender women of color. The district court's <u>nationwide preliminary injunction</u> (https://affordablecareactlitigation.files.wordpress.com/2020/08/ajw-pi.pdf) prevents the federal goverr from implementing provisions of the Trump Administration regulations that exclude gende and sex stereotyping from definition of sex discrimination, <u>require healthcare providers to individuals consistent with their gender identity</u>, and prohibit providers from denying or lim <u>services based on gender identity</u> (https://affordablecareactlitigation.files.wordpress.com/2021/05/2c-joint-status-report-5-14-21.pdf) to the constant of the trump and trum

Another New York case, <u>NY v. HHS</u>

(<u>https://affordablecareactlitigation.files.wordpress.com/2020/07/file0.122871054374752.pdf</u>), brought by a 23 states. Both sides have <u>agreed</u>
 (<u>https://affordablecareactlitigation.files.wordpress.com/2021/05/merged_94413_-1-1621119514.pdf</u>) to put on hold but disagree about when the next status report should be due to the court. The state propose (<u>https://affordablecareactlitigation.files.wordpress.com/2021/05/merged_94413_-1-1621119514.pdf</u>)
 13, 2021, while the federal government proposes (<u>https://affordablecareactlitigation.files.wordpress.com/2021/05/merged_94413_-1-1621119514.pdf</u>) August

(https://affordablecareactlitigation.files.wordpress.com/2021/05/merged_94413_-1-1621119514.pdf) August 2021.

Two other cases challenging the Trump Administration regulations are currently active

1). Decisions in these cases could influence the contents of the Biden Administration's expecter as well as the status of the Trump regulations that remain in effect. The active cases include:

- A Massachusetts case, <u>Boston Alliance of Gay, Lesbian, Bisexual & Transgender Youth v. HHS</u> (<u>https://affordablecareactlitigation.files.wordpress.com/2020/07/bagly-complaint.pdf</u>), brought by a trans man and health care and social service providers who serve LGBTQ people and people with June 3, 2021 hearing is <u>scheduled (https://affordablecareactlitigation.com/aca-enforcement-directly-an</u> on HHS's motion to dismiss the lawsuit.
- Another DC case, <u>Chinatown Service Center v. HHS</u> (https://justiceinaging.org/wpcontent/uploads/2021/02/LEDComplaint.pdf), brought by community-based organizations serving adults with LEP. The <u>complaint (https://justiceinaging.org/wp-content/uploads/2021/02/LEDComplaint.j</u> case was filed recently, and HHS has not yet responded.

Another two cases, which were filed to challenge the Obama Administration regulation are still pending, raise issues about the interaction between Section 1557's nondiscrimi provisions and federal laws that protect religious beliefs. The Supreme Court did not reac issue in *Bostock*, noting that this is a question for future cases to decide. These cases include:

- <u>Religious Sisters of Mercy v. Becerra (https://affordablecareactlitigation.files.wordpress.com/2018/10/10/2510.pdf)</u>, in which the Biden Administration is <u>appealing</u> (<u>https://www.pacermonitor.com/public/case/39934209/The Religious Sisters of Mercy, et al v Xavier Becer North Dakota federal court ruling (https://www.hhs.gov/sites/default/files/document-124-memorandu and-order.pdf)</u> that blocks it from requiring Catholic health care entities to perform or provide insurance coverage for gender transition services under the Obama Administration's Sectic regulations.
- <u>Franciscan Alliance v. Becerra, (https://affordablecareactlitigation.files.wordpress.com/2018/10/complain</u> <u>177110100373.pdf</u>) in which religiously affiliated health care providers claim that the Obama Administration regulations' inclusion of gender identity and termination of pregnancy in the definition of sex discrimination would require them to serve people seeking transgender ca people who have terminated a pregnancy in violation of the providers' religious rights. The Court of Appeals <u>sent the case back to the trial court</u>

(<u>https://affordablecareactlitigation.files.wordpress.com/2021/04/5c-unpublished-decision.pdf</u>) to determin whether the providers' claims are moot in light of the subsequent Trump Administration re as well as the recent Biden Administration actions. Briefing on these issues <u>closes on June</u> (<u>https://affordablecareactlitigation.files.wordpress.com/2021/04/supp-br-order.pdf</u>).

Looking Ahead

The interpretation and enforcement of Section 1557's prohibition against discrimination in fec funded health programs and activities will continue to develop in the coming months. Outside Section 1557 regulations and surrounding litigation, federal courts in other cases have grante individuals alleging discrimination under Section 1557, relying on the text of the statute itself. example, a <u>Wisconsin federal court permanently blocked</u>

(https://affordablecareactlitigation.files.wordpress.com/2019/08/4920644-0-8552.pdf) the state Medicaid procategorical exclusion of gender affirming services from coverage as a violation of the statutor prohibition against sex discrimination. Future court rulings, the forthcoming NPRM, and admi enforcement by OCR under the new Biden Administration policy together will influence Sectio law and policy and could affect the ability to access health coverage and care without discrimi Table 1: Lawsuits Challenging the Trump Administration's Section 1557 R

Case Name/Court	Plaintiffs	
<u>Whitman-Walker Clinic v. HHS</u> (<u>https://affordablecareactlitigation.files.wordpress.com/2020/06/6611972-</u> <u>0-11462.pdf)</u>	Health care and social service providers	Case is on hold, with ne assess next steps. Natic rule remains in place.
(DC district court and DC Circuit Court of Appeals.)	who serve LGBTQ people and people with LEP	 On 9/2/20, the (https://affordable 26785.pdf) preve provisions of th sex stereotypin incorporate a b sex discriminat
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		• On 5/14/21, the (https://affordable report-5-14-21.pd

		 assessment pu Administration proposed rule- revise the regu reconsider mar Administration gender identity discrimination Court's <i>Bostock</i> The next status (<u>https://affordable</u> <u>stay-order.pdf</u>) or are to file motiv after the Biden regulations and
<u>Asapansa-Johnson Walker v. Azar</u> (<u>https://affordablecareactlitigation.files.wordpress.com/2020/06/johnson-</u> walker-complaint.pdf)	2 transgender women of color	Case is on hold, with ne assess next steps. Natic Administration rule rem
(NY district court (eastern district) and 2 nd Circuit Court of Appeals)		 On 8/17/20, the <u>(https://affordable</u> preventing the the Trump Adn and sex stereor
		 On 10/29/20, tł (https://affordable 10-29-20.pdf) exp federal governi Administration healthcare providentity and eli limiting service (https://affordable 10-29-20.pdf) the preliminary inju plaintiffs can es provisions.
		• The Trump Adr (https://affordable appeal.pdf) both (https://affordable appeal.pdf) of the to have them o (https://affordable while the appeal
		• After the Biden (<u>https://affordable</u>
		 order.pdf) to the (https://affordable abeyance-3-15-21 Administration existing regulat based on gend Biden Administ On 5/14/21, the (https://affordable report-5-14-21.pd assessment pu Administration proposed rule- revise the regu reconsider man Administration gender identity discrimination Court's Bostock The next joint s (https://affordable report-5-14-21.pd resolve the cas (https://affordable report-5-14-21.pd appeal of the p government arg (https://affordable report-5-14-21.pd
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<u>NY v. HHS</u> (<u>https://affordablecareactlitigation.files.wordpress.com/2020/06/johnson-walker-complaint.pdf)</u> (NY district court (southern district))	23 states (NY, CA, MA, CO, CT, DE, DC, HI, IL, ME, MD, MI, MN, NV, NJ, NM, NC, OR, PA, RI, VT, VA, WI)	Case is on hold, althoug The states <u>propose</u> (<u>https://affordablecar</u> <u>1621119514.pdf</u>) 6/13 (<u>https://affordablecar</u> <u>1621119514.pdf</u>) 8/12 • The states' <u>motiv</u> (<u>https://affordable</u> <u>110818.pdf</u>) and (<u>https://affordable</u> <u>114477.pdf</u>) the c • However, the c (<u>https://affordable</u> <u>11149.pdf</u>) the fe (<u>https://affordable</u> <u>11149.pdf</u>) the fe (<u>https://affordable</u> <u>1612986613.pdf</u>) 1 oppose) in light

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Boston Alliance of Gay, Lesbian, Bisexual & Transgender Youth v. HHS (https://affordablecareactlitigation.files.wordpress.com/2020/07/bagly- complaint.pdf) (Massachusetts district court)	A transgender man and health care and social service providers who serve LGBTQ people and people with LEP	Case is active. Hearing <u>s</u> <u>enforcement-directly</u> lawsuit. The court <u>denied (hi</u> <u>and-1557/)</u> federal { government had <u>i</u> (<u>https://affordablecar</u> <u>3-21.pdf</u>) for the ca review of regulative executive order d and policy to previdentity and sexual time to review the (<u>https://affordablecar</u> <u>17.pdf</u>) the request
<u>Chinatown Service Center v. HHS (https://justiceinaging.org/wp- content/uploads/2021/02/LEDComplaint.pdf)</u> (DC district court)	Community- based organizations serving older adults with LEP	Case is active. Awaiting (<u>https://justiceinagin</u> ք

SOURCE: KFF analysis of case documents, available at <u>https://affordablecareactlitigation.com/aca-enforcement-directly-and</u> <u>directly-and-1557/)</u>.

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ISSUE BRIEF

REFORMING HEALTH INSURANCE: Competition Across State Lines

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Executive Summary

The U.S. Constitution was designed to promote interstate commerce, but Congress acted in 1945 to artificially fragment insurance markets state by state. As a result, individuals can buy health plans *only* from insurers that are licensed by the state where they live. Without any competition from companies based outside their state, the result is higher premiums on the individual market—and premiums that vary greatly from state to state, with large disparities consistently tracking state borders. This is in sharp contrast with the premiums for employ-er-sponsored plans—which are exempt from state regulation and vary little between states.

In addition to restricting competition, state regulations have long increased the cost of health insurance through benefit mandates and restrictions on cost controls, but many of these regulations have been mandated nation-wide by the Affordable Care Act (ACA). Yet ACA is also responsible for an increase in the variation of individual market premiums between states, as well as a general increase in premiums. It has done so by requiring insurers to price coverage according to the idiosyncratic balance of medical risks of those who happen to be enrolled in the state, rather than in proportion to individuals' own expected medical costs. This means that insurers in states with a relatively sicker pool of enrollees must price ACA plans much higher than plans in states with a relatively healthier pool of individuals.

Reformers have long urged that individuals be allowed to buy health insurance across state lines. Unfortunately, the precarious financing of state individual-market risk pools, as structured by ACA, is inherently incompatible with vigorous interstate competition. However, the large economies of scale associated with many health-care services make competition across state lines essential to the efficient provision of medical care. Such competition will require reestablishing an individual insurance market outside ACA's regulatory framework.

Background

The U.S. Constitution's Commerce Clause (Article 1, Section 8, Clause 3) was designed to prevent states from restricting trade and competition across their borders with protectionist legislation.¹ Over time, a unified national marketplace has, in most industries, allowed American businesses to grow nationwide, to benefit from associated economies of scale, and—through competition—to pass those gains on to consumers.

Yet after the Supreme Court ruled in 1944 (*United States v. South Eastern Underwriters Association*) that the Sherman Antitrust Act applied to insurance, the industry pressured Congress to overturn the ruling.² This led to the McCarran-Ferguson Act of 1945, which put the states in charge of regulating insurance, including the exclusive power to license insurers to operate within their borders; the new law also protected state insurance regulations from preemption by federal regulation.

As the proportion of Americans with private health insurance soared from 23% in 1945 to 83% in 1975, the industry grew up fragmented into 50 different states.³ The inconvenience of this arrangement was, to some extent, checked by the Employee Retirement Income Security Act (ERISA) of 1974, which preempted state regulation of health-care benefits for self-insured employer plans.⁴ (A self-insured plan is one where the employer pays the benefits that it offers from its own funds but typically hires an insurance company to administer the benefits.) Though this provision allows large employers to procure health-care services for their employees nationwide, the millions of Americans who must get health-insurance coverage from small group plans or individual policies remain locked out of health plans from other states.

FIGURE 1.



Monthly Average Benchmark Premiums (ACA Silver Plan) by State, 2021

The Republican Party's 2000 platform pledged to permit small businesses to "band together, across state lines, to purchase insurance through association health plans."⁵ In 2008, 2012, and 2016, this proposal was expanded to allow individuals to purchase health insurance across state lines.⁶ And in 2018, the Trump administration finalized a regulation to facilitate the formation of Association Health Plans for small businesses.⁷

The following year, the U.S. Department of Health and Human Services issued a formal Request for Information with the intent of making it easier for individuals to purchase insurance across state lines but was unable to make any progress in implementing it.⁸ The upshot is that allowing individuals to purchase health insurance from other states would likely require statutory authorization and revisions to the McCarran-Ferguson Act.

Premium Disparities Between States

Premiums for equivalent ACA plans on the individual market vary greatly between states. Average premiums for benchmark silver plans in 2021 range from \$307 per month in Minnesota to \$791 in Wyoming (**Figure 1**). Americans can therefore find themselves paying very different prices for a product that is standardized by federal law.



The variation in individual market premiums does not simply reflect differences in the underlying cost of delivering medical care; it shows state-specific differences in health-insurance markets. This is clear from the fact that, while premiums vary relatively little within states (even across substantial distances), substantial differences in premiums track state boundaries (even between neighboring counties). For instance, in every county in eastern Oklahoma, benchmark premiums range from \$500 to \$699, whereas every

county across the border in western Arkansas has premiums between \$200 and \$399 (Figure 2).

Under ERISA, large employers typically manage the health benefits covered by their self-insured plans across state lines, which frees them from restrictive and potentially costly state regulations. Employer-sponsored health-insurance premiums are not just lower on average than those for equivalent individual market plans but vary much less *between* states (**Figure 3**).

FIGURE 3.



State Regulatory Capture

State governments often operate with limited administrative and technical resources and are highly vulnerable to lobbying by interest groups. Medical providers—physicians and hospitals—are well represented in state capitols, and they frequently push legislatures to mandate that insurers pay for services that they provide, as a way to increase the sales (and prices) of these services.

The typical state had fewer than one benefit mandate in 1970; by 2017, the average was 37. James Bailey of Temple University has estimated that each benefit mandate enacted by states tends to increase health-insurance premiums by 0.4%–1.1% and that new mandates were responsible for 9%–23% of premium increases during 1996–2011. Benefit mandates may have added value to insurance coverage by preventing insurers from leaving gaps in coverage, in order to deter sicker individuals from enrolling.⁹ Still, in a study of the period 1989–94, Frank Sloan and Christopher Conover of Duke University estimated that 20%–25% of Americans without health insurance were deterred from purchasing coverage because of the added costs resulting from benefit mandates.¹⁰

Lobbyists for hospitals and physicians have similarly pushed states to enact laws that increase their pricing power, by making it hard for insurers to exclude them from networks of covered providers. When HMOs began to squeeze hospital costs in the late 1990s, more than 1,000 bills were introduced in state legislatures. Most states enacted laws requiring insurers to reimburse "any willing provider" for treatment according to their standard payment arrangements. A study by Maxim Pinkovskiy of the Federal Reserve Bank of New York found that anti-HMO state laws drove up the incomes of medical providers, increased service use, slowed reduction in hospital lengths of stay, and caused U.S. health-care spending to increase by 2% of GDP—accounting for much of the growth in health-insurance costs in the early 2000s.¹¹

The structure of insurance markets does much to influence the ability of providers to inflate and pass on costs. Blue Cross hospital insurance plans were initially established by the American Hospital Association (AHA) for the sake of bolstering hospital revenues, and AHA in most states secured favorable tax and regulatory policies to protect hospitals from competition.¹² By providing open-ended reimbursements to facilities according to the expenditures they incurred, such insurance plans caused hospital costs to soar.

If individuals were allowed to purchase plans from other states, regulators in each state would be forced to place the interests of these individuals above those of insurers and the rest of the health-care industry. A 2008 study by the Department of Health and Human Services estimated that the reduction in premiums resulting from allowing individuals to shop for insurance across state lines could reduce the number of uninsured Americans by 12 million.¹³

ACA Regulations

Section 1333 of ACA allows states to combine their markets, enabling residents to purchase plans from other states. But ACA also eliminated much of the variation in state-level regulatory arrangements, by requiring all states to adopt many of the costliest benefit mandates and plan design features that had previously existed at the state level.

In fact, much of the present variation in premiums between states is the result of *new* market distortions introduced by ACA, rather than features that preceded it. Indeed, the dispersion of premiums between states has increased greatly since ACA was implemented in 2014 (**Figure 4**).

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FIGURE 4.



Average Benchmark ACA Premiums (Silver Plan) by State and Year

The spike and variation in premiums on the individual market since ACA went into effect are largely the result of the legislation's "community rating" regulation, which requires insurers to cover all enrollees in broad demographic categories at the same premium, regardless of differences in their medical risks. This regulation led plans to prove disproportionately attractive to individuals with the most serious medical assistance needs causing costs to soar and premiums to rise until few unsubsidized healthier enrollees remained.¹⁴

This arrangement created enormous uncertainty—requiring insurers to price plans without knowing the likely costs of covering those who enrolled. As a consequence, some insurers set premiums too low—incurring enormous losses while driving competitors from the market.¹⁵ By 2018, 52% of Americans lived in counties that had only a single insurer offering plans on the individual market.¹⁶ Though competitors have since returned, as the market has stabilized (only 10% of counties had a single insurer for 2021), it has so far done little to narrow disparities in premiums. Wyoming, which has the highest premiums in the nation, had only a single insurer on its individual market until 2021 and does not require regulatory approval of rate increases—leaving its insurer's pricing power largely unconstrained.¹⁷

Nebraska, which has the nation's second-highest premiums, similarly had a single insurer participating in the ACA exchange. It hiked premiums on the individual market to take advantage of an arrangement known as "silver-loading."¹⁸ Silver-loading was a response to the absence of federal appropriations for Cost-Sharing-Reduction subsidies, which expand the proportion of medical costs covered by silver plans from 70% to 73%, 87%, or 94%, depending on enrollees' annual income. States realized that they could help insurers claim additional federal subsidies to make up the shortfall by allowing them to inflate benchmark plan premiums.¹⁹ Yet while silver-loading has clearly artificially inflated silver-plan premiums, it does not explain the expanded variation between states, as the variation in premiums for gold plans (which cover 80% of medical costs) is just as great (Figure 4).

In an attempt to reduce premiums by increasing the proportion of enrollees who need little medical care, five states and the District of Columbia have reinstituted the individual mandate penalty that Congress repealed at the end of 2018.²⁰ Yet the mandate did little to compel individuals to enroll in order to reduce premiums at the federal level because the penalty was small relative to the often exorbitant cost of premiums, and its reestablishment at the state level is unlikely to be more effective.²¹ Reinsurance programs that provide additional subsidies to plans that attract disproportionate numbers of sicker enrollees have been established by 15 states and may prove more successful at reducing premiums.²² But the cost of such programs would soar if an influx of enrollees from other states were permitted.

The structure of the ACA-regulated individual market, which depends on a delicately balanced risk pool, maintained by a combination of state-managed subsidies and regulatory cross-subsidies between plans, is therefore likely to be incompatible with vigorous competition across state lines. Such competition is therefore likely to require the reestablishment of an insurance market where plans may be priced in proportion to individuals' medical risks.

This market already exists, albeit to a limited and restricted degree, with Short-Term Limited Duration Insurance (STLDI). Such plans are available in about half the states, though the maximum duration of enrollment permitted by state law varies (some states allow plans to guarantee renewal for up to three years, while others limit enrollment to three months).²³ STLDI plans are able to offer significantly lower premiums and better benefits to individuals who sign up before they get sick, and they seek to attract enrollees by providing access to broad national networks of medical providers. ACA plans, by contrast, typically cover only the bare minimum number of local providers required by state law.²⁴ *Allowing individuals to purchase STLDI plans from other states would make insurance coverage more affordable while also facilitating the development of competition between national networks of medical providers*.

Congress should protect consumers by establishing national standards for STLDI plans. These standards should require insurers to renew coverage indefinitely, regardless of medical conditions that individuals may develop, and prevent states from forcing individuals to drop coverage that they purchased in other states.

Fundamental Transformation

Competition across state lines is necessary for any fundamental transformation in American health care. While the old model, providing services by local hospitals, made sense 80 years ago, the growing specialization of the medical profession and the capital intensity of surgical procedures make it increasingly inappropriate. Not every county can support cutting-edge neurosurgery, and some states may be unable to do so. Large academic medical centers and specialized facilities typically deliver significantly better-quality clinical outcomes than smaller hospitals, where staff may be poorly equipped and have little experience treating complex cases.²⁵

Given that hospital care involves high fixed costs, economies of scale are substantial. In 2017, the cost of a knee replacement in the U.S. averaged \$30,000, while that for heart bypass surgery was \$78,000—but prices vary enormously between facilities.²⁶ At such levels, disparities in price and quality between facilities dwarf the cost and inconvenience associated with traveling to more efficient providers. Limiting individuals to instate insurance binds them to inefficient and often monopolistic provider markets that are often dominated by single medical systems—subjecting them to inflated pricing power and ever-rising costs of care.

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The fragmentation of insurance markets by states also undermines the portability of health-insurance coverage between jobs. The inability to carry STLDI coverage across state lines prevents individuals from renewing plans. While some states prohibit the purchase of STLDI coverage altogether, moving to even the most pro-STLDI state would force individuals to purchase coverage afresh. This would expose them to the risk of coverage denials and rate increases due to preexisting conditions. A robust, competitive, private insurance market, therefore, requires the underwriting and interstate portability to go hand in hand. For insurance to be compatible with interstate competition, insurers need to be allowed to price it in proportion to an individual's risks, and individuals must be allowed to retain insurance renewability guarantees as they move from state to state.

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- ²⁶ Margot Sanger-Katz, "In the U.S., an Angioplasty Costs \$32,000. Elsewhere? Maybe \$6,400," New York Times, Dec. 27, 2019.

