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May 9, 2021



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News Release

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FOR IMMEDIATE RELEASE

May 20, 2021

Covered California's Enrollment Surges as People Sign Up to Benefit From the New Financial Help and Lower Premiums Now Available Through the American Rescue Plan

- *More than 76,000 people signed up for health insurance during Covered California's special-enrollment period between April 12 and May 15.*
- *The surge is more than 2.5 times higher than a traditional special-enrollment period, reflecting an increase of more than 46,000 people, compared to the same time period in 2019.*
- *Covered California launched a special-enrollment period to allow the uninsured and those enrolled directly through a health insurance carrier to enroll and benefit from lower premiums due to the American Rescue Plan.*
- *More than half of the Covered California households which are benefiting from the new and expanded financial help provided by the American Rescue Plan are getting high-quality coverage for \$1 per month.*
- *In order to start saving, Californians need to enroll by May 31 so they can begin benefiting from the new law on June 1.*

SACRAMENTO, Calif. — New data from Covered California shows a surge in enrollment as tens of thousands of consumers signed up for health care coverage to benefit from the lower premiums now available through the American Rescue Plan. More than 76,000 people have signed up for coverage since Covered California launched a special-enrollment period, which is more than 2.5 times as many as those that enrolled during the same time period in 2019.

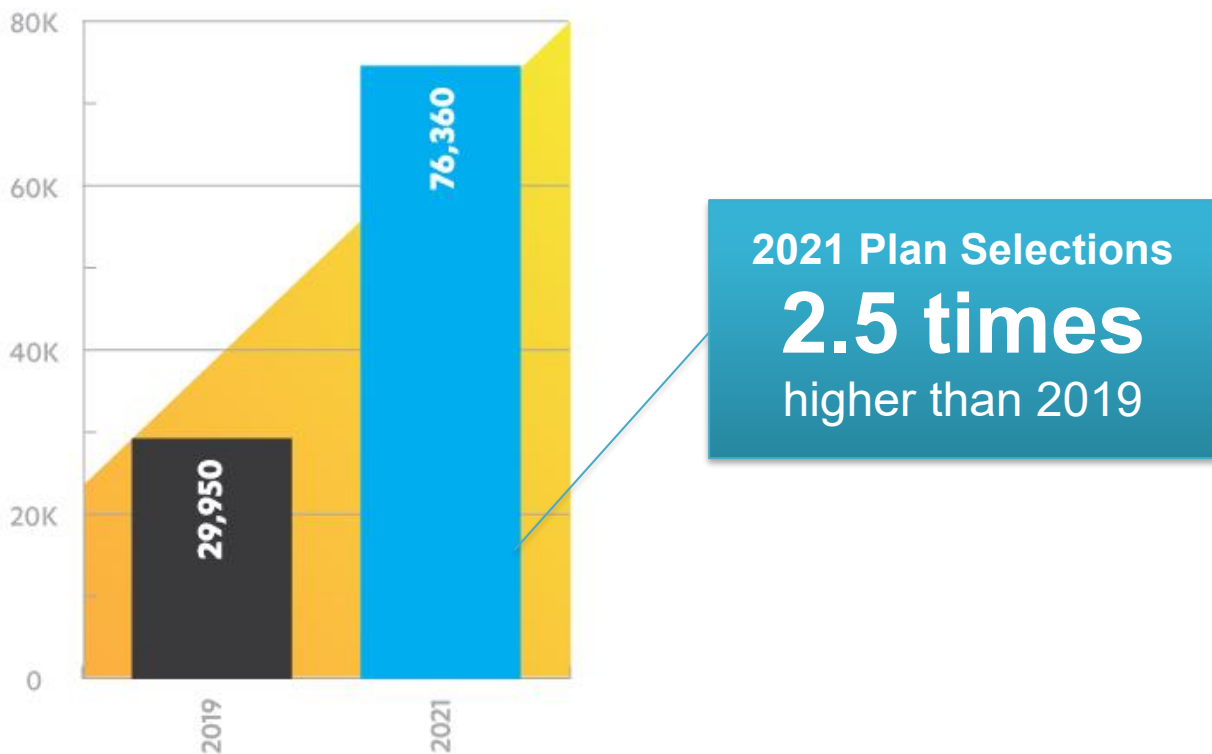
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“The new and expanded financial help provided by the American Rescue Plan is lowering premiums for thousands of Californians, making it easier for them to get covered and stay covered,” said Peter V. Lee, executive director of Covered California. “The good news is that Californians still have time to sign up, but they need to act quickly, because every month that goes by is a month without coverage and money lost.”

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 ensures that everyone eligible will pay no more than 8.5 percent of their household income on their health care premiums. Covered California launched a special-enrollment period on April 12 to allow Californians to sign up for coverage, or switch their coverage to the exchange, in order to begin benefiting from the new law.

The data shows that a total of 76,360 people signed up between April 12 and May 15, which is 46,000 more — or 2.5 times higher — than the same time period in 2019, when a traditional special-enrollment period was last held.¹ (See Table 1: Consumer Plan Selections During Special Enrollment.)

Table 1: Consumer Plan Selections During Special Enrollment (April 12 – May 15)



¹ In 2020, Covered California had 64,430 plan selections during the same period. The increase was due to a special-enrollment period established to respond to the COVID-19 pandemic and recession, which was supported by a major outreach campaign. Today’s announcement is almost 20 percent higher than the results of 2020.

“Quality health care coverage through Covered California is more affordable than ever, and the sooner people sign up, the sooner they can start saving and be covered,” Lee said. “We have seen consumers save hundreds of dollars a month by switching to Covered California, while others are able to get covered for \$1 a month.

In addition to providing lower costs to those who are uninsured or currently purchase coverage directly, the American Rescue Plan reduced the costs for 1.3 million of Covered California’s 1.55 million consumers. Prior to the American Rescue Plan, only 11 percent of those households, which had their eligibility redetermined to benefit from the new law, were able to get a quality plan for \$1 a month. The new data shows that more than four times as many households, or 51 percent of the redetermined group, are now covered for \$1 per month through the new and expanded financial help of the American Rescue Plan.

“For less than the price of a bus ride, or a soda, many Californians are able to get high-quality coverage from some of the best doctors and hospitals in the country,” Lee said. “Do not miss out on this historic opportunity, you owe it to yourself to check it out and see what this new financial help can mean for you and your family.”

Overall, about 680,000 of Covered California’s 1.55 million enrollees are now enrolled in plans that cost \$1 per month. Of those, nearly 400,000 people signed up for enhanced Silver plans that include cost-sharing benefits such as lower co-pays, lower deductibles and lower out-of-pocket expenses which make it easier for them to access the health care they need.

“Lowering the cost of coverage and care helps people stay covered and it allows them to put that money back into our economy, which helps their communities,” Lee said.

Which Californians Need to Act Now to Benefit From the American Rescue Plan?

The new financial assistance can directly help Californians by lowering their monthly premium to levels never seen before. However, in order to maximize their savings, the following groups of people need to act now by May 31 in order to have coverage that starts on June 1:

- **Uninsured Californians:** New data shows that an estimated 810,000 Californians in the state are uninsured and eligible for health insurance through Covered California, with an additional 1 million people eligible for no-cost Medi-Cal. Under the American Rescue Plan, most of those eligible for Covered California would be able to get a high-quality health plan from one of 11 trusted name-brand companies for as little as \$1 per month, or a plan that offers richer benefits for less than \$100 per month (see Figure 1: Premiums Are Lower Than Ever for the Uninsured).

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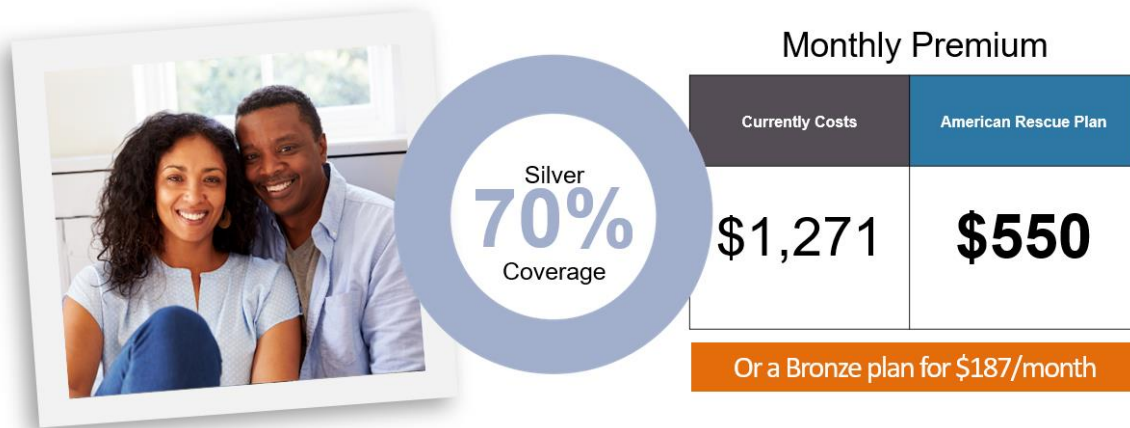
Figure 1: Premiums Are Lower Than Ever for the Uninsured



Sofia in Los Angeles | Age: 21 | Income: \$25,520/year

- Californians insured directly through a health insurance company:** Nearly 270,000 Californians are insured directly through a health insurance company in what is referred to as “off-exchange coverage” and do not receive any financial help. The new and expanded subsidies mean that many consumers will be able save hundreds of dollars per month if they switch and get their insurance through Covered California (see Figure 2: Off-Exchange Consumers Save by Switching to Covered California).

Figure 2: Off-Exchange Consumers Save by Switching to Covered California



Vanessa and Mike in Oakland | Ages: 45 | Income: \$77,580/year

Covered California’s special-enrollment period will run through the end of the year, but Lee encouraged consumers to act now in order to start saving.

(more)

“Do not miss out on this opportunity,” Lee said. “We don’t want any eligible person to be uninsured or leave money on the table.”

Consumers Can Find Out in Minutes How Much They Can Save

Covered California is encouraging people to check if they are eligible for lower premiums due to the American Rescue Plan. Consumers can easily see exactly how they can benefit from the new law at CoveredCA.com by entering their ZIP code, household income and the ages of the people in the household to see how low their premiums can be and the health insurance options in their area.

Those interested in learning more about their coverage options can also:

- Visit www.CoveredCA.com.
- 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 www.CoveredCA.com.

###



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

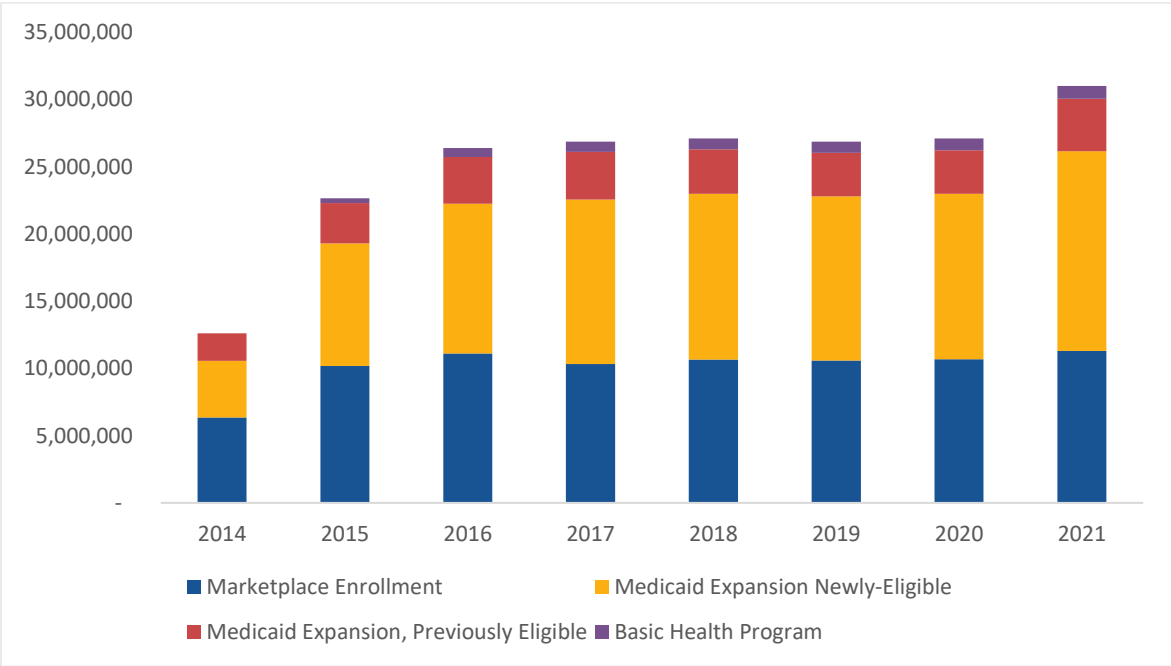
Figure 1 and Table 1 present national ACA-related enrollment for 2014-2021. As of February 2021, 11.3 million consumers had enrolled and effectuated health insurance coverage through the Marketplaces. This estimate does not include individuals who have signed up for coverage during the COVID Special 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.

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

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

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-Products/Effectuated_Quarterly_Snapshots. 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 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

State	Marketplace Effectuated Enrollment, February 2021*	Medicaid Expansion, Newly Eligible, December 2020#	Uninsured Rate (%)†	
			2013	2019
Alabama	159,136	N/A	13.6	9.7
Alaska	16,780	63,539	18.5	12.2
Arizona	143,964	164,269	17.1	11.3
Arkansas	60,258	306,497	16.0	9.1
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	2,018,631	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
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
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
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
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	14.3
Oregon	129,436	490,690	14.7	7.2
Pennsylvania	315,334	913,888	9.7	5.8
Rhode Island	30,670	82,223	11.6	4.1
South Carolina	217,292	N/A	15.8	10.8
South Dakota	29,974	N/A	11.3	10.2
Tennessee	196,626	N/A	13.9	10.1
Texas	1,210,431	N/A	22.1	18.4
Utah	198,037	78,637	14.0	9.7
Vermont	23,700	0	7.2	4.5
Virginia	243,598	494,240	12.3	7.9
Washington	202,546	662,676	14.0	6.6
West Virginia	17,217	193,341	14.0	6.7
Wisconsin	180,328	N/A	9.1	5.7
Wyoming	25,319	N/A	13.4	12.3
Total	11,290,546	14,849,998	14.5	9.2

Notes:

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

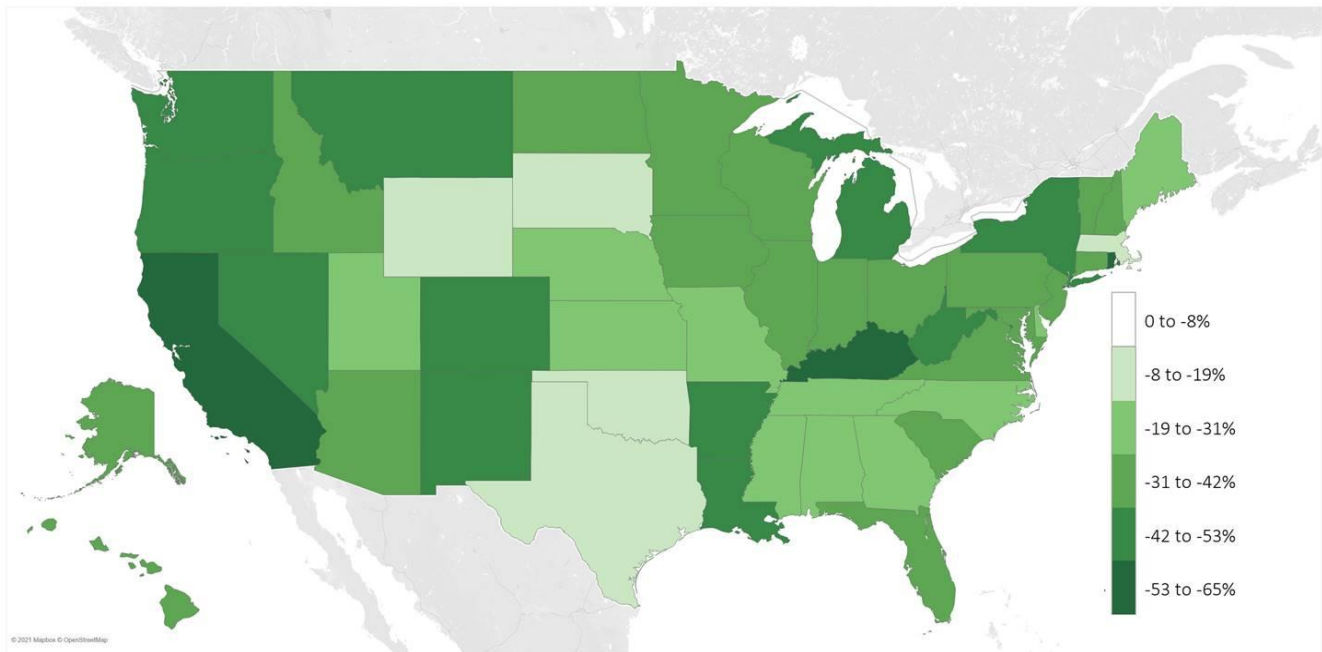
2 - New York has also created a BHP under the ACA, which had 898,891 enrollees as of April-May 2021.

* 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: <https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.2013.html>
<https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.2019.html>

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. <https://aspe.hhs.gov/system/files/pdf/265041/trends-in-the-us-uninsured.pdf>

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

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] <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>

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: <https://aspe.hhs.gov/system/files/pdf/187551/ACA2010-2016.pdf>.

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Health Insurance Coverage Changes Since Implementation of the Affordable Care Act: Asian Americans and Pacific Islanders

Asian Americans and Pacific Islanders (AAPIs) experienced larger relative gains in health insurance coverage than any other racial group in the United States since the Affordable Care Act was fully implemented in 2014.

KEY POINTS

- Gains in health insurance coverage since 2014 have essentially erased the coverage disparity AAPIs experienced compared to non-Hispanic Whites prior to the implementation of the Affordable Care Act.
- The uninsured rate for the AAPI population decreased from 14.7 percent in 2013 to 6.8 percent in 2019. This 54 percent reduction in the uninsured rate was the largest improvement among any racial or ethnic group during this time period.
- Uninsured rates vary greatly among AAPI subgroups, ranging from 2.8 percent for Japanese Americans to 10.0 percent for Korean Americans and 12.3 percent for Native Hawaiians and Pacific Islanders in 2019.
- AAPIs enroll in Marketplace health insurance coverage at rates much higher than their share of the overall population.
- Under the American Rescue Plan, more than 150,000 uninsured AAPIs now have access to zero-dollar premium health plans on HealthCare.gov and 197,000 uninsured AAPIs have become newly eligible for premium savings.

INTRODUCTION

Asian Americans and Pacific Islanders (AAPIs) comprised 5.9 percent of the total U.S. population in 2019 and are the fastest growing racial group in the United States.¹ The AAPI population grew from 16.5 million to 19.2 million between 2013 and 2019, an increase of 16.5 percent, compared to 3.8 percent population growth for the nation as a whole.ⁱ The largest AAPI subgroups in 2019 were Chinese (4.4 million), Asian Indian (4.2 million), Filipino (3.0 million), Vietnamese (1.9 million), Korean (1.5 million), Japanese (0.8 million), and Native

ⁱ Population estimates combines the total number of Asians alone without another race and the total number of Native Hawaiian and Other Pacific Islanders alone. Throughout the brief, we use the term “Asian Americans and Pacific Islanders” for estimates encompassing both groups, and “Asian Americans” and “Native Hawaiians and Other Pacific Islanders,” respectively, for estimates for each of those groups separately. Some data sources refer to Asian Americans as “Asians,” and some data sources refer to Native Hawaiians and other Pacific islanders as “Pacific Islanders.” Some data sources that report data for Asian Americans do not report data for Native Hawaiians and Other Pacific Islanders due to small sample sizes and/or high standard errors for the latter population.

Hawaiian and Other Pacific Islanders (NHPI, 0.6 million). Almost one third (31.4 percent) of the U.S.'s 44.9 million immigrants were AAPI in 2019 and the number of AAPI immigrants increased by 80 percent between 2000 and 2019.²

This Issue Brief analyzes changes in coverage from 2013-2019 among AAPIs and AAPI subgroups, using a combination of data from the American Community Survey (ACS) and Marketplace data, including estimated impacts of the 2021 American Rescue Plan. This Issue Brief is the first in a series of reports examining the change in coverage rates from 2013 to 2019 among select racial and ethnic populations.

METHODS

The American Community Survey (ACS) conducted by the Census Bureau is the largest national survey of households. The Census Bureau surveys almost 300,000 households each month for the ACS and collects health insurance and racial/ethnicity demographic data, along with other types of information.

Our population estimates combine the total number of Asians alone without another race and the total number of Native Hawaiian and Other Pacific Islanders (NHPIs) alone. Throughout the brief, we use the term “Asian Americans and Pacific Islanders” for estimates encompassing both groups, and “Asian Americans” and “Native Hawaiians and Other Pacific Islanders,” respectively, for estimates for each of those groups separately. It is important to note that some data sources that report data for Asian Americans do not report data for NHPIs due to small sample sizes for the latter population.

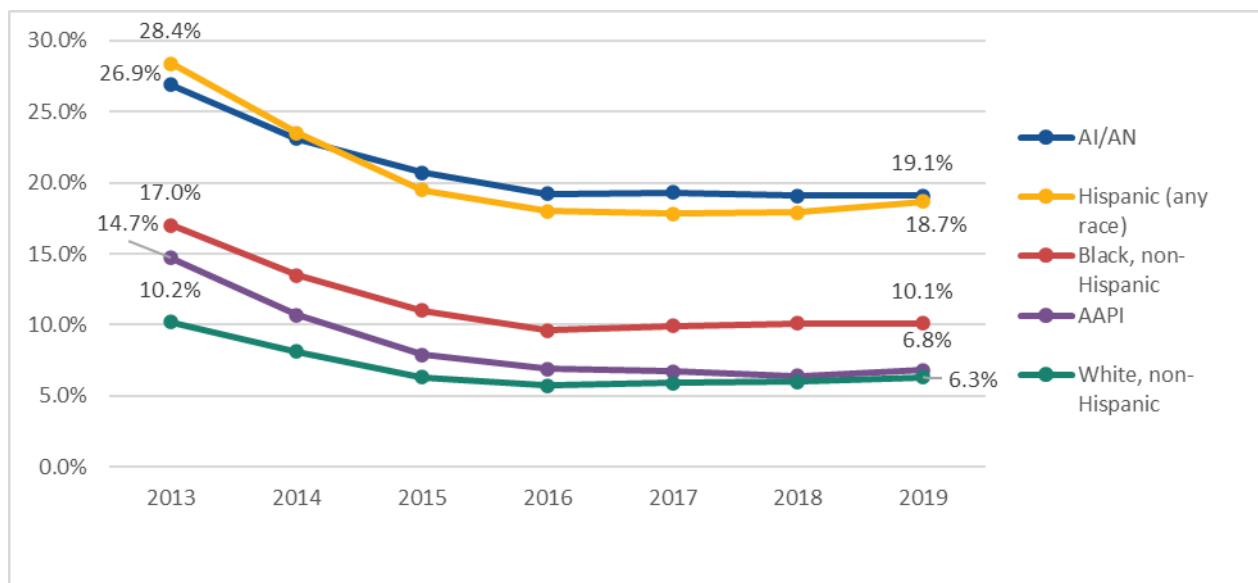
RESULTS

Health Coverage

The uninsured rate among the nation's AAPI population decreased from 14.7 percent in 2013 before the full implementation of ACA provisions to 6.8 percent in 2019, a drop of more than half (53.7 percent). This was the largest relative decreaseⁱⁱ in the uninsured rate from 2013 to 2019 among racial and ethnic demographic groups, followed by non-Hispanic Blacks (40.6 percent), non-Hispanic Whites (38.2 percent), Hispanics (34.2 percent), and American Indians and Alaskan Natives (AI/AN, 29.0 percent). An estimated 6.8 percent of AAPIs were uninsured in 2019, compared with 9.2 percent of the U.S. total, 6.3 percent of non-Hispanic Whites, 10.1 percent of non-Hispanic Blacks, 18.7 percent of Hispanics (all races), and 19.1 percent of AI/ANs for as shown in Figure 1.³ Nearly all of the coverage disparity between AAPIs and non-Hispanic Whites was eliminated between 2013 and 2019.

ⁱⁱ These percentage decreases show relative declines from 2013. In absolute percentage point reductions in uninsured rates, Hispanic and AI/AN populations, which had the highest uninsured rates in 2013, experienced the largest gains in coverage.

Figure 1. Uninsured Rates for Total US Population and by Race and Ethnicity, 2013-2019

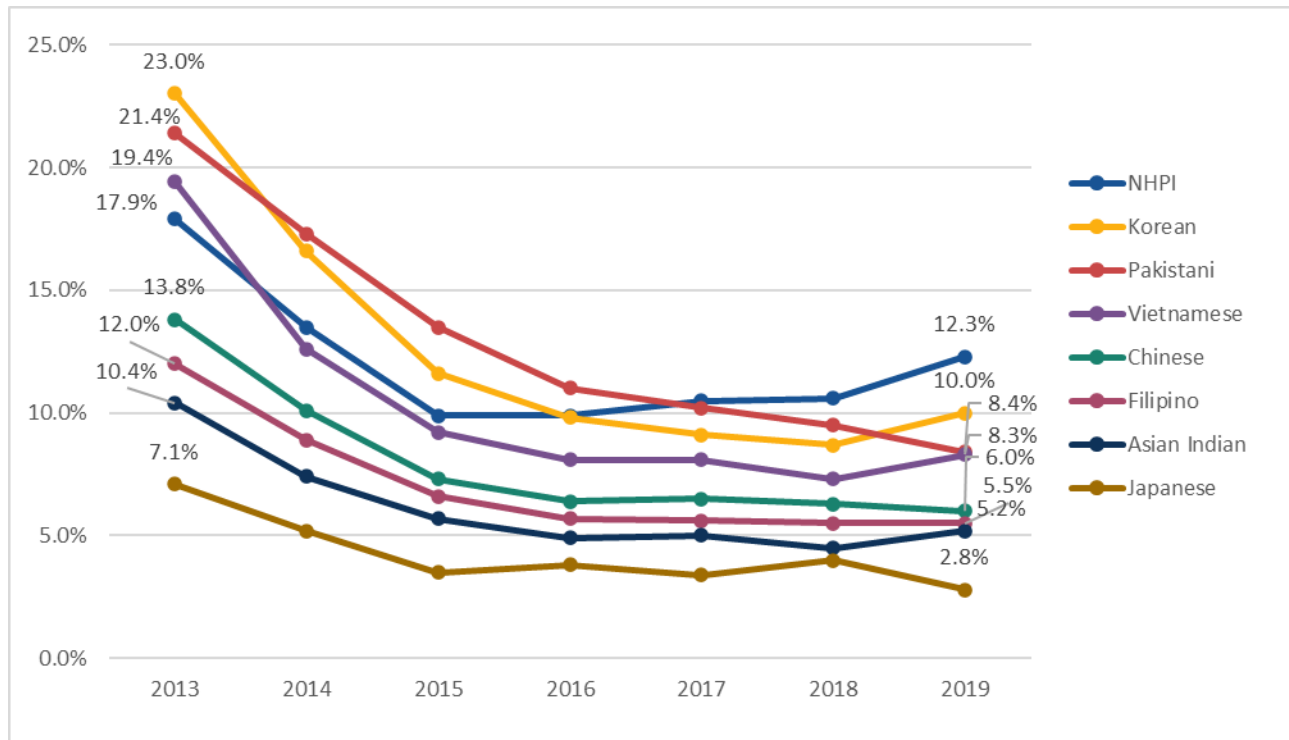


Source: 2013-2019 American Community Survey.

Note: AI/AN = American Indian/Alaskan Native and AAPI = Asian American and Pacific Islander.

Coverage rates vary considerably by AAPI subgroup, with uninsured rates of 2.8 percent for Japanese Americans, 5.2 percent for Indian Americans, 5.5 percent for Filipino Americans, 6.0 percent for Chinese Americans, 8.3 percent for Vietnamese Americans, 10.0 percent for Korean Americans, and 12.3 percent for Native Hawaiian and Other Pacific Islander Americans (NHPIs) in 2019.⁴ Differences among AAPI subgroups can be explained at least in part by variation in employment, employer size, and income.⁵ For example, Korean and Vietnamese Americans are more likely to be self-employed – 9.5 percent for Korean Americans and 8.3 percent for Vietnamese Americans, compared to 5.2 percent for Asian Americans, 3.7 percent for NHPIs, and 6.4 percent for non-Hispanic Whites.⁶ Currently, only Korean Americans and NHPIs have double-digit uninsured rates (10.0 percent and 12.3 percent respectively). This is a substantial change from pre-ACA data. In an earlier ASPE Issue Brief examining uninsured rates of AAPIs in 2010, all subgroups except for Japanese Americans had uninsured rates of at least 10 percent.⁷ All AAPI subgroups reduced their uninsured rates substantially between 2013 (e.g. before the implementation of the ACA Marketplace and Medicaid expansion) and 2019, as shown in Figure 2.

Figure 2. Uninsured Rates by AAPI Subgroup, 2013-2019



Source: 2013-2019 American Community Survey.
 Note: NHPI = Native Hawaiian and Other Pacific Islander.

Marketplace Coverage

AAPIs are enrolled in health plans through the Marketplace at rates far higher than their share of the U.S. population. In the 39 states using HealthCare.gov in 2019, AAPIs represented 4 percent of the total population but accounted for 11 percent of Marketplace health plan selections among those responding to questions on race in their applications.^{8,9iii}

AAPIs are similarly represented at high levels among Marketplace enrollees in several large states with state-based Marketplaces, among those who provided information on their race^{iv}:

- In California (home to more than 30 percent of the total U.S. AAPI population), AAPIs comprised 24 percent of the state Marketplace enrollees compared to 15 percent of the state population.¹⁰
- In New York (home to 9 percent of the total U.S. AAPI population), AAPIs comprised 12 percent of the state Marketplace enrollees compared to 8 percent of the state population.¹¹
- In Washington State (home to 4 percent of the total U.S. AAPI population), AAPIs comprised 15 percent of the Marketplace enrollees compared to 10 percent of the state population.¹²

Together the 39 states using the HealthCare.gov platform in 2019 plus California, New York, and Washington State comprised 92 percent of the total U.S. AAPI population. In these 42 states, an estimated 13 percent of Marketplace enrollees who provided information on race reported that they were AAPI, more than double the AAPI share of the population (6 percent) in those states.¹³

ⁱⁱⁱ The non-response rate for race was 30 percent in 2019 for the Healthcare.gov states.

^{iv} Non-response rates for race in these three states ranged from 19 to 21 percent.

The high enrollment rates of AAPIs in Marketplace health plans may be attributed in part to the efforts of AAPI nonprofit organizations and AAPI insurance agents that offer enrollment assistance in Asian languages.¹⁴ Almost three quarters of AAPIs speak a language other than English at home and 31 percent report speaking English as less than “very well.”¹⁵ For example, the Action for Health Justice, a network of national and local community-based organizations and Federally Qualified Health Centers, was established in July 2013 to reach and educate AAPIs about health insurance options under the ACA.¹⁶ The Action for Health Justice conducted outreach, education and enrollment assistance in 41 Asian languages and 1,255 media outlets. In California, AAPIs were the racial and ethnic group most likely to enroll through an insurance agent (54 percent in 2014 and 35 percent in 2019).¹⁷

Starting April 2021, the American Rescue Plan Act (ARP) offers more opportunity for premium savings through enhanced and expanded eligibility for Marketplace premium tax credits. Under these ARP provisions, an estimated 156,000 uninsured AAPIs have access to zero-premium plans, and 197,000 uninsured AAPIs have become newly eligible for premium savings for Marketplace plans.^{18,19}

Medicaid Coverage

Medicaid provides coverage to low income individuals including children, pregnant women, parents and caretaker relatives, adults, people with disabilities, the blind, and those age 65 and over. The ACA allowed states to expand Medicaid coverage to adults with incomes up to 138% of the Federal Poverty Level (FPL), which has decreased uninsured rates significantly. The average monthly number of Medicaid adult expansion enrollees was 15.9 million in 2019.²⁰ A study of low-income AAPIs showed that their Medicaid coverage gains in states that expanded Medicaid to adults were largely offset by their private coverage gains (mostly in Marketplace) in non-expansion states, and AAPIs had overall lower coverage gains associated with Medicaid expansion than Whites, Hispanics and Blacks.²¹

The vast majority (80 percent) of the nation’s AAPIs lived in the 34 Medicaid expansion states, as of 2019. In California, the state with almost one third (31.9 percent) of the total U.S. AAPI population in 2016, 19.9 percent of the 2016 Medicaid expansion adult population was AAPI, significantly higher than their 14.5 percent share of the state population.²²

Effective December 27, 2020, the Consolidated Appropriations Act, 2021 requires states and the District of Columbia to provide full Medicaid coverage to the citizens of the Freely Associated States living in the United States under the Compacts of Free Association (COFA) provided they otherwise meet Medicaid eligibility requirements. COFA is an agreement between the United States and the three Pacific Island sovereign states of Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau – known as Freely Associated States. Election of this coverage is optional for the U.S. territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands). The extension of full Medicaid benefits to COFA migrants will further increase access to healthcare coverage for this population. In 2018, an estimated 94,000 COFA individuals lived in the U.S. and its territories.²³

Community Health Centers

The ACA provided additional funding for community health centers, which serve patients with private health insurance and public health insurance such as Medicaid or Medicare, as well as patients without health insurance. The number of AAPI patients seen in community health centers increased from 1.08 million in 2013 to 1.28 million in 2018, an increase of 18.7 percent, compared to an increase of 13.5 percent for all patients.²⁴ The ARP awarded community health centers more than \$6 billion to expand health centers’ operational capacity during the pandemic and beyond.²⁵

Disparities in Health Outcomes

AAPIs have the lowest adjusted death rates, the lowest overall cancer incidence rates, and the lowest or second lowest rate of risk factors for heart disease of any racial group in the U.S.^{26,27,28} However, health disparities remain. While AAPIs had the lowest overall cancer incidence rate, research shows that they have high rates of liver cancer and stomach cancer.²⁹ AAPIs also have the highest hepatitis B-related mortality rate and incidence of tuberculosis (16.7 cases per 100,000 compared to 0.5 cases per 100,000 for non-Hispanic Whites, as of 2019).^{30,31}

Data on disease prevalence rates for specific AAPI subgroups are limited, but certain select studies demonstrate large health disparities among the subgroups. The rate of diagnosed diabetes was 9.2 percent for Asian Americans, compared to 7.6 percent for non-Hispanic Whites in 2017-18, but as high as 12.2 percent for Asian Indians and 10.4 percent for Filipinos and as low as 5.6 percent for Chinese.³² The rate of undiagnosed diabetes was 4.6 percent for Asian Americans, compared to 2.5 percent for non-Hispanic Whites in 2013-2016.³³ Cervical cancer incidence rates were 7 to 10 times higher for Vietnamese, Samoans, and Laotians, compared to non-Hispanic Whites in 1998-2002.³⁴

The Affordable Care Act (ACA) has helped address health disparities by expanding health coverage and requiring essential benefits. The ACA essential benefits make preventive services more affordable and accessible, requiring many health insurance plans to cover recommended prevention and wellness benefits with no cost-sharing.

CONCLUSION

Prior to the Affordable Care Act (ACA), AAPIs experienced significantly higher uninsured rates than Non-Hispanic Whites (14.7 percent uninsured rate for AAPIs compared to 10.2 percent for non-Hispanic Whites). Since the implementation of the ACA in 2014, overall coverage disparities for AAPIs compared to Whites have been eliminated due to coverage gains under Medicaid, the individual insurance market (both on and off the Marketplace), and employer-sponsored insurance.³⁵ Among AAPI adults, those with incomes between 138 percent and 400 percent of the FPL and who lived in Medicaid expansion states experienced the largest gains in coverage. More than one million AAPIs gained health insurance coverage in 2016 associated with the implementation of ACA.³⁶

Multi-lingual and culturally-competent outreach, in addition to policies that support pathways to coverage for immigrant communities, are essential in further expanding coverage and access to care in the AAPI population. However, more studies are needed to determine best practices for outreach, education and enrollment activities and how strategies could be improved for AAPIs and other groups. Additional research is also needed to assess the impact of Marketplace coverage and Medicaid expansion on utilization of health services and health outcomes among AAPIs. The passage of the ARP and other policies to bolster coverage may further improve health care access among AAPIs.

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CONTRACTOR PROJECT REPORT

Developing Health Equity Measures

Prepared for
the Office of the Assistant Secretary for Planning and Evaluation (ASPE)
at the U.S. Department of Health & Human Services

by
RAND Health Care

May 2021

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ASPE Executive Summary

In 2014, under the Improving Medicare Post-Acute Care (IMPACT) Act, Congress asked that ASPE study the relationship between social risk factors¹ and Medicare's value-based purchasing (VBP) programs. ASPE wrote two Reports to Congress, making recommendations based on the studies' findings. This included the recommendations that the Centers for Medicare and Medicaid Services (CMS) include measures of health equity in public reporting and VBP programs. Moreover, in the ASPE commissioned report, *Systems Practices for the Care of Socially At-Risk Populations*, the National Academies of Sciences, Engineering, and Medicine calls out a commitment to health equity as one of six promising practices to improve care for socially at-risk populations.²

However, as Medicare's VBP programs do not currently include health equity measures, appropriate measures need to be developed and/or identified before they can be incorporated into these programs. In response to this challenge, ASPE asked the RAND Corporation to develop a proposed definition of health equity as a starting place and to identify existing health equity measurement approaches that may be suitable for inclusion in Medicare's VBP programs, quality reporting efforts, and confidential reports. RAND identified 10 existing approaches to health equity measurement and convened a technical expert panel (TEP) to:

- (1) provide feedback on the project team's proposed definition of a health equity measure and identification of features of health equity measurement approaches;
- (2) develop a set of criteria for evaluating health equity measurement approaches for potential inclusion in Medicare's VBP programs, quality reporting efforts, and confidential reports; and
- (3) evaluate the set of health equity measurement approaches identified by the team according to these criteria.

Based on input from RAND, ASPE, and the TEP, in this report RAND defines a **health equity measurement approach** as *"an approach to illustrating or summarizing the extent to which the quality of health care provided by an organization contributes to reducing disparities in health and health care at the population level for those patients with greater social risk factor burden by improving the care and health of those patients."* We note that this definition focuses on health care quality, as that was the charge from Congress under the IMPACT Act, but measurement approaches could be considered more broadly in other contexts.

The purpose of including health equity measurement approaches in VBP programs and quality reporting efforts is to motivate a focus on improving health for all by reducing disparities and to help providers prioritize particular areas for quality improvement. It could also encourage providers to improve health equity through service enhancements, patient engagement activities, and adoption of best practices.

Of the 10 health equity measurement approaches evaluated by the TEP (which are described in detail in the report itself), the CMS Office of Minority Health's (OMH) Health Equity Summary Score (HESS) received the highest ratings from the TEP overall. This approach first identified those patient

¹ The term "social risk factors" was suggested by the National Academies of Sciences, Engineering, and Medicine as discussed below.

² National Academies of Sciences, Engineering, and Medicine. 2016. *Systems practices for the care of socially at-risk populations*. Washington, DC: The National Academies Press.

experience and clinical care measures that are most suitable for health equity comparisons. Then, the HESS assessed the extent to which care provided through Medicare Advantage contracts was equitable based on race, ethnicity, and dual/low-income subsidy (LIS) eligibility status. The HESS combines data across multiple performance measures, multiple social risk factors, and multiple types of comparisons to create a summary index of health equity.

The Biden-Harris Administration has emphasized the importance of equity across the government, and health equity in particular. This report directly responds to Executive Order 13985, *Advancing Racial Equity and Support for Underserved Communities Through the Federal Government*, which asks all federal agencies to “identify the best methods, consistent with applicable law, to assist agencies in assessing equity with respect to race, ethnicity, religion, income, geography, gender identity, sexual orientation, and disability.”³ Although this report focuses on the Medicare program, much of the findings are applicable more broadly, including the definition of a health equity measurement approach, the criteria that were developed for evaluating health equity measures, and the TEP’s discussion of the measures identified.

Going forward, the health equity measures identified and evaluated in this report can contribute to HHS implementation of Executive Order 13985 and the recommendations in the Report to Congress on the Role of Social Risk in Medicare’s Value-Based Purchasing Programs.⁴

A Note on Social Risk Factors, Race, and Ethnicity

Although the IMPACT Act required that ASPE study “the effect of individuals’ socioeconomic status on quality measures,” ASPE commissioned a series of reports from the National Academies of Science, Engineering, and Medicine who suggested that the term “social risk factors” was more appropriate and provided a conceptual model that listed the specific domains and risk factors.⁵ ASPE’s Reports to Congress and follow-on work, including this report, have used the term social risk factors and the specific factors identified.⁴ In more recent years, there has been further discussion on appropriate terminology, including understanding the distinctions between social determinants of health, social risk factors, and social needs.^{6,7} This continuing discussion shows the interconnectedness of these concepts, while also recognizing that not all characteristics and needs can or should be addressed in the same way.

The social risk factors identified by the National Academies of Science, Engineering, and Medicine include the domains of socioeconomic position; race, ethnicity, and cultural context; gender; social relationships; and residential and community context. These domains and the individual factors within them were identified based on existing evidence of the association between the factor and worse health outcomes. We note that the factors identified include both modifiable social determinants of health, and also additional, non-modifiable factors such as race and ethnicity, which

³ See <https://www.federalregister.gov/documents/2021/01/25/2021-01753/advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government>

⁴ See all of ASPE’s work on this topic at <https://aspe.hhs.gov/social-risk-factors-and-medicares-value-based-purchasing-programs>

⁵ National Academies of Sciences, Engineering, and Medicine. 2016. *Accounting for social risk factors in Medicare payment: Identifying social risk factors*. Washington, DC: The National Academies Press.

⁶ Alderwick, H. and Gottlieb, L.M., 2019. Meanings and misunderstandings: a social determinants of health lexicon for health care systems. *The Milbank Quarterly*, 97(2), p.407.

⁷ Green, K. and Zook M., 2019. When Talking About Social Determinants, Precision Matters. *Health Affairs Blog*, October 29. Available at <https://www.healthaffairs.org/doi/10.1377/hblog20191025.776011/full/>.

are themselves not causal factors for disparities but are subject to structural inequities that produce adverse health outcomes.

The Biden-Harris Administration's emphasis on health equity brings an additional perspective to this issue. In addressing health equity, we in the federal government include many of the same factors that the National Academies of Science, Engineering, and Medicine identified as social risk factors. We take a slightly different perspective than presented by National Academies of Science, Engineering, and Medicine and consider non-modifiable factors such as race, ethnicity, and rural location as associated with health disparities, but not risk factors themselves or drivers of those disparities. We are interested in identifying non-modifiable factors, such as race and ethnicity, to assess differential health outcomes. We also focus on modifiable factors, such as structural racism, that are the drivers of the outcome differences. Addressing health equity issues requires implementing interventions to address the drivers of outcome differences and monitoring outcomes to determine whether equity improved. Such monitoring is built on the health equity measurement approaches evaluated in this report.

Developing Health Equity Measures

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RAND Health Care

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Preface

Socially at-risk individuals receive lower-quality health care and experience worse health outcomes than more advantaged individuals. One way to address this in the Medicare population is to use Medicare’s value-based purchasing (VBP) programs, quality reporting efforts, and confidential reports as tools to drive improvements in quality. In particular, including health equity measurement approaches in VBP programs and quality reporting could motivate providers to focus on reducing disparities and to prioritize particular areas for quality improvement. It could also encourage providers to improve health equity through service enhancements, patient engagement activities, and adoption of best practices.

In this project, RAND Corporation researchers identified existing health equity measurement approaches that might fit with Medicare’s VBP programs, quality reporting efforts, and confidential reports. The project had two objectives: (1) identify health equity measurement approaches, and (2) decide which of these approaches merit consideration for inclusion in Medicare’s VBP programs, quality reporting efforts, and confidential reports. This report describes the methods and findings of the project and delineates potential first steps for the U.S. Department of Health and Human Services to consider as it continues to evaluate the prospect of incorporating health equity measures and domains in Medicare’s VBP and reporting programs.

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Abbreviations

AAC	average annual change
AHRQ	Agency for Healthcare Research and Quality
ASPE	Assistant Secretary for Planning and Evaluation
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CLAS	Culturally and Linguistically Appropriate Services
CMS	Centers for Medicare & Medicaid Services
FFS	fee-for-service
HEDIS	Healthcare Effectiveness Data and Information Set
HESS	Health Equity Summary Score
HHS	U.S. Department of Health and Human Services
LIS	Low-Income Subsidy
MA	Medicare Advantage
MeSH	Medical Subject Headings
MMD	Mapping Medicare Disparities
NQF	National Quality Forum
OMH	Office of Minority Health
PDP	prescription drug plan
RSRR	risk-standardized readmission rate
TEP	technical expert panel
VBP	value-based purchasing

Summary

There is growing recognition that social risk factors⁸—such as income, education, race and ethnicity, and community resources—play a major role in health.⁹ Despite ongoing efforts to address inequities, evidence suggests that socially at-risk individuals receive lower-quality health care and experience worse health outcomes than more-advantaged individuals. Medicare’s value-based purchasing (VBP) programs, quality reporting efforts, and confidential reports to providers of their performance on quality measures could be powerful tools to drive improvements in the quality of care provided to socially at-risk individuals. In particular, including health equity measurement approaches in VBP programs and quality reporting efforts could motivate a focus on reducing disparities and help providers prioritize particular areas for quality improvement. It could also encourage providers to improve health equity through service enhancements, patient engagement activities, and adoption of best practices.

Toward that end, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) asked the RAND Corporation to identify existing health equity measurement approaches that may be suitable for inclusion in Medicare’s VBP programs, quality reporting efforts, and confidential reports. This project had two objectives: (1) identify health equity measurement approaches, and (2) decide which of these approaches merit consideration for inclusion in Medicare’s VBP programs, quality reporting efforts, and confidential reports. To meet these objectives, the project team conducted a literature review to identify health equity measurement approaches developed or used for the purpose of systematic performance assessment and convened a technical expert panel (TEP) to consider the use of these health equity measurement approaches in VBP programs, quality reporting efforts, and confidential reports. The project team synthesized feedback from the TEP to identify the most promising health equity measurement approaches and inform the U.S. Department of Health and Human Services (HHS) about which approaches could be incorporated in Medicare’s VBP programs, quality reporting efforts, and confidential reports.

A formal **definition of a health equity measurement approach** was developed to define the scope of the literature search and help specify the TEP’s evaluation of the identified approaches. The definition, which was first developed iteratively by RAND and ASPE and then further shaped by the TEP, is as follows: an approach to illustrating or summarizing the extent to which the quality of health care provided by an organization contributes to reducing disparities in

⁸ Though many people use the term *social risk factor* to refer to mechanisms that foster inequities in health or health care—e.g., food insecurity or language barriers—we use the term here to refer to groups that tend to bear a disproportionate share of social risk factor burden, e.g., racial and ethnic minorities. In that sense, we are conceptualizing group membership as a proxy for social risk factors. By using the term *social risk factor* to refer to membership in certain groups, we do not mean to imply that risk or disadvantage is inherent in people, homogeneous within groupings (e.g., a particular race) or across geography, or immutable over time. Rather, it is the result of past and present inequities in our society.

⁹ National Academies of Science, Engineering, and Medicine, *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors*, Washington, D.C.: National Academies Press, 2016; United States Department of Health and Human Services, “Healthy People 2020: Social Determinants of Health,” webpage, 2014. As of May 11, 2020: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

health and health care at the population level for those patients with greater social risk factor burden by improving the care and health of those patients.

Ten such approaches were identified. These ten approaches fit within **three broad categories of approaches**: (1) approaches focused on determining which existing quality measures are suitable for health equity comparisons (i.e., permit reliable and valid comparisons among social risk factor groups) or for measuring organizational structures, systems, and processes hypothesized to promote the delivery of high-quality care for all; (2) approaches that engaged in particular kinds of comparisons of measures (not necessarily statistical comparisons), on a measure-by-measure basis, between groups of patients with greater versus lesser social risk factor burden; and (3) approaches that developed a system for combining different dimensions of health equity into a single summary index. Table S.1 lists these ten approaches and provides summary information about them, including whether the approach focused on measure identification (Category 1), measure-by-measure comparisons (Category 2), or creating a summary index (Category 3).

This project also identified a set of guidelines for health equity measurement. A health equity measurement approach should, ideally,

- be based on measures on which disparities in care are known to exist for certain populations or that address health care disparities and culturally appropriate care
- reflect available evidence on the relationship between a social risk factor and health or health care outcome
- be designed to incentivize achievement or improvement for at-risk beneficiaries, including having a valid and appropriate benchmark and/or reference group if comparisons to benchmarks and/or reference groups are made
- include design features that guard against unintended consequences of worsening quality or access or disincentivizing resources for any beneficiaries, including the at-risk beneficiaries who are the focus of health equity measurement
- establish measurability requirements that ensure the ability to make reliable distinctions between health care providers in their performance in the domain of health equity
- capture information about small subgroups where possible while limiting the influence of imprecise estimates of provider performance.

In the case of a summary index, the measure should additionally

- summarize information in a way that is psychometrically sound
- allow for disaggregation of information to permit easy identification of quality improvement targets.

Two of the identified approaches—the Measurement Framework for Evaluating Organizational Compliance with Standards for National Culturally and Linguistically Appropriate Services (CLAS) and the National Quality Forum’s (NQF) Disparities-Sensitive Measure Assessment—determined whether existing quality measures were suitable for health equity comparisons or for measuring organizational structures, systems, and processes hypothesized to promote delivery of high-quality care for all (Category 1).

Two approaches—the Agency for Healthcare Research and Quality’s (AHRQ) National Healthcare Quality and Disparities Report and the Mapping Medicare Disparities (MMD) Tool developed by the Centers for Medicare & Medicaid Services Office of Minority Health (CMS OMH)—focused on performance comparisons by social risk-factor groups either nationally or at a smaller geographical unit. Each of these two approaches included a broad array of measures,

treating each measure separately (the hallmark of Category 2), though only the AHRQ approach involved statistical comparisons.

Two approaches—the CMS OMH stratified reporting of Medicare Advantage (MA), prescription drug plan (PDP), and Medicare Fee-for-Service (FFS) performance data by beneficiary race and ethnicity and the Minnesota Healthcare Disparities Report—involved stratified reporting of data on patient experience and/or clinical care by social risk factors with statistical comparisons to benchmarks. The CMS Office of Minority Health’s approach involved reporting performance at the level of MA contracts, PDP contracts, and states (for Medicare FFS), and the Minnesota Healthcare Disparities Report involved reporting performance both statewide and at the level of individual medical groups. Under these approaches, comparison of performance by contract, state, or medical group was done on a measure-by-measure basis (Category 2).

The CMS Assessment of Hospital Disparities for Dual-Eligible Patients involved two complementary methods for assessing hospital performance in the realm of health equity. The Within-Hospital Disparity Method was used to measure the difference in a health outcome between patients who are dually eligible for Medicare and Medicaid (referred to as dual-eligible patients)¹⁰ and patients who are not dually eligible within a hospital. The Dual Eligible Outcome Method was used to compare performance for dual-eligible patients across hospitals. In each case, the outcome measure of interest was 30-day all-cause unplanned readmission following hospitalization for pneumonia. Because this approach involved only one social risk factor and one outcome measure and the two types of comparisons were kept separate, it fits within Category 2.

Two approaches were identified within Category 3. The CMS OMH’s Health Equity Summary Score (HESS) approach identified patient experience and clinical care measures specifically suitable for health equity comparisons and used data on those measures to assess the extent to which care provided through MA contracts was equitable based on race and ethnicity as well as dual/low-income subsidy (LIS) eligibility status. The HESS combined data across multiple performance measures, multiple social risk factors, and multiple types of comparisons, i.e., both within- and between-provider comparisons and comparisons focused on both cross-sectional performance and improvement in performance to create a summary index of health equity (Category 3).

Zimmerman’s Health-Related Quality of Life Approach to Measuring Health Equity synthesized information across multiple measures (Category 3). Zimmerman’s measure is oriented toward assessing the total deviation from a defined privileged group and allows disaggregation from the national level to the level of states and smaller geographic areas. Zimmerman and Anderson developed a related approach that generates trend information to characterize disparities in self-rated health and healthy days in the past month as either decreasing, increasing, or not changing (this approach involved both Category 2 and Category 3 assessments).

Of approaches focused on measure identification (Category 1), the **NQF Disparities-Sensitive Measure Assessment** was viewed most favorably by the TEP. Using a set of carefully established criteria and an easy-to-understand point system, this approach identified 76

¹⁰ The demonstration of this approach focused on full dual-eligible beneficiaries aged 65 and older.

existing NQF-endorsed measures as disparities-sensitive.¹¹ Although considerable work would be needed to determine whether and how these measures could be linked to social risk data and whether and how valid comparisons could be made, this approach was viewed as a valuable initial step toward measuring health equity and disparities in health care quality. It is potentially applicable to any Medicare VBP or quality reporting program that collects one or more of the disparities-sensitive measures.

Of approaches focused on measure-by-measure comparisons (Category 2), **the approach underlying the Minnesota Healthcare Disparities Report** was judged most favorably by the TEP. The perceived advantages of this approach include its thoughtfully chosen group of measures, incorporation of multiple important social risk factors (i.e., race, ethnicity, preferred language, and country of origin), ability to reliably distinguish performance among providers, clear focus on incentivizing achievement for at-risk beneficiaries, and choice to anchor disparities to the overall state average rather than the performance of a predetermined group. Although some additional work would be needed to transfer this approach to a broader setting, including making careful considerations about sample sizes required for accurate comparisons and determining the availability of data on social risk factors, the method itself is readily applicable to all Medicare VBP and quality reporting programs.

Of approaches focused on summary indices (Category 3), the **CMS OMH HESS** was judged most favorably by the TEP. The perceived advantages of this approach include its joint consideration of cross-sectional performance and improvement in performance, focus on patient experience and clinical quality, careful attention to reliability and the sample size required to achieve it, direct applicability to certain VBP and quality reporting programs, and transferability to other programs. CMS is currently developing a dashboard to provide confidential HESS data to MA contracts in the near future. Scores on this metric could potentially be incorporated into the Medicare Plan Finder and the MA Quality Star Ratings Program. This approach could easily be extended to other social risk factors and measures, and there are plans to test the feasibility of extending this approach to settings beyond MA.

Of the ten approaches evaluated, the HESS received the highest ratings from the TEP overall. Given the high ratings it received, the HESS may be closest to meeting the full scope of goals outlined by ASPE for incorporating a measure of health equity into a Medicare VBP or quality reporting program. If HHS were to move forward with this approach, it could consider possible refinements to the approach based on the practices established by the NQF Disparities-Sensitive Measure Assessment and the Minnesota Healthcare Disparities Report and the guidelines for health equity measurement outlined by the TEP. Several of the measures that are included in the HESS are among the 76 measures identified as disparities-sensitive by NQF. It might be possible to include in the HESS additional measures from the set identified by NQF, provided that the measures are collected for MA plans and meet the reliability and sample size requirements established for the HESS. The analyses that underlie the Minnesota Disparities Report are similar to the analyses that underlie the cross-sectional component of the HESS. In the Minnesota Healthcare Disparities Report, plan performance by patients' preferred language and country of origin are considered in addition to race and ethnicity. Information on country of origin is not available for MA beneficiaries, but information about Spanish preference is

¹¹ *Disparities-sensitive measures* were defined as measures of conditions that are prevalent among at-risk groups, measures assessing a *high-impact* aspect of health care (i.e., conditions affecting large numbers of people, leading causes of morbidity and mortality, conditions leading to high resource use, and severe illnesses), measures on which a substantial disparity has been identified, and measures that map to an NQF-endorsed communication-sensitive practice for care coordination or cultural competency.

available. Thus, Spanish preference could be considered as a possible third social risk factor for the HESS.

Table S.1. Ten Identified Approaches to Health Equity Measurement

Measurement Approach	Setting/Population	Social Risk Factor(s)	Focus
1. Measurement Framework for Evaluating How Well an Organization Meets National Standards for Culturally and Linguistically Appropriate Services (HHS OMH)	Health care organizations	Race/ethnicity; limited English proficiency; low literacy	Measure identification
2. NQF Disparities-Sensitive Measure Assessment	Cross-cutting	Race/ethnicity	Measure identification
3. AHRQ National Healthcare Quality and Disparities Report	Overall U.S. population	Age; sex, race/ethnicity	Measure-by-measure comparisons
4. CMS OMH Mapping Medicare Disparities Tool	Medicare FFS	Race/ethnicity; dual eligibility; sex; age	Measure-by-measure comparisons
5. CMS OMH Reporting of CAHPS and HEDIS Data by Race/Ethnicity for Medicare Beneficiaries	MA and prescription drug plans, Medicare FFS	Race/ethnicity	Measure-by-measure comparisons
6. Minnesota Healthcare Disparities Report	Minnesota health plan enrollees	Race, ethnicity, preferred language, country of origin	Measure-by-measure comparisons
7. CMS Assessment of Hospital Disparities for Dual-Eligible Patients	Hospitals	Dual eligibility	Measure-by-measure comparisons
8. CMS OMH Health Equity Summary Score	Medicare Advantage plans	Race/ethnicity; dual eligibility	Summary index
9. Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity	General adult U.S. population	Race/ethnicity; sex; income	Summary index
10. Zimmerman and Anderson Approach to Evaluating Trends over Time in Health Equity	General adult U.S. population	Race/ethnicity; sex; income	Measure-by-measure comparisons; summary index

NOTE: CAHPS = Consumer Assessment of Healthcare Providers and Systems; CMS = Centers for Medicare & Medicaid Services; HHS = U.S. Department of Health and Human Services; FFS = fee-for-service; HEDIS = Healthcare Effectiveness Data and Information Set; MA = Medicare Advantage; NQF = National Quality Forum; OMH = Office of Minority Health

1. Background and Purpose

Background

There is growing recognition that social risk factors¹²—such as income, education, race and ethnicity, and community resources—play a major role in health.¹³ Despite ongoing efforts to address inequities, evidence suggests that socially at-risk individuals receive lower-quality health care and experience worse health outcomes than more-advantaged individuals.¹⁴

Medicare’s value-based purchasing (VBP) programs, which link reimbursement to the quality and efficiency of health care delivered, could be a powerful tool to drive improvements in the quality of care provided to patients with social risk factors, which could potentially improve health outcomes among patients with social risk factors and reduce health disparities. Medicare’s VBP programs include pay-for-performance programs in each health care setting that reward providers on quality and cost, as well as Alternative Payment Models, such as Accountable Care Organizations, or state population-based models in which providers are at financial risk for lowering costs and improving quality of care. The scope of this report is focused mainly on pay-for-performance programs. Quality reporting efforts and confidential reports to providers may have similar incentivizing effects. The National Academy of Medicine identified the following social risk factors as likely to be important to health outcomes for Medicare beneficiaries: socioeconomic position; race, ethnicity, and cultural context; gender; social relationships; and residential and community context.¹⁵ Including health equity measurement approaches in VBP and quality reporting programs could motivate a focus on reducing disparities and help providers prioritize particular areas for quality improvement activities. It could also encourage providers to address health equity through service enhancements, patient engagement activities, and adoption of best practices to improve performance in the health equity domain. The use of health equity measurement approaches as

¹² Though many people use the term *social risk factor* to refer to mechanisms that foster inequities in health or health care—e.g., food insecurity or language barriers—we use the term here to refer to groups that tend to bear a disproportionate share of social risk factor burden, e.g., racial and ethnic minorities. In that sense, we are conceptualizing group membership as a proxy for social risk factors. By using the term social risk factor to refer to membership in certain groups, we do not mean to imply that risk or disadvantage is inherent in people, homogeneous within groupings (e.g., a particular race) or across geography, or immutable over time. Rather, it is the result of past and present inequities in our society.

¹³ National Academies of Science, Engineering, and Medicine, *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors*, Washington, D.C.: The National Academies Press, 2016; U.S. Department of Health and Human Services (HHS), “Healthy People 2020: Social Determinants of Health,” webpage, 2014. As of May 11, 2020: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>

¹⁴ Institute of Medicine, *How Far Have We Come in Reducing Health Disparities? Progress Since 2000: Workshop Summary*, Washington, D.C.: National Academies Press. 2012.

¹⁵ Assistant Secretary for Planning and Evaluation, *Social Risk Factors and Performance Under Medicare’s Value-Based Purchasing Programs*, Washington, D.C.: HHS, 2016; National Academies of Science, Engineering, and Medicine, *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors*, Washington, D.C.: National Academies Press, 2016.

part of VBP and quality reporting sends a strong signal that health equity is an important component of delivery system transformation.

However, if beneficiaries with social risk factors have worse outcomes because of elements beyond the control of health care providers, the inclusion of health equity measurement approaches in VBP and quality reporting programs could make providers reluctant to care for beneficiaries with social risk factors, out of fear of incurring penalties, not achieving bonuses, or having their reputations damaged due to factors they have limited ability to influence.

In 2014, under the Improving Medicare Post-Acute Care Act,¹⁶ Congress asked that the Assistant Secretary for Planning and Evaluation (ASPE) study the relationship between social risk factors and Medicare's VBP programs. ASPE wrote two Reports to Congress (referred to as *Study A* and *Study B*), making recommendations based on the study's findings. These reports outline multiple strategies for accounting for social risk factors in Medicare's VBP programs.¹⁷ Although the reports recommend including health equity measures in Medicare's VBP programs, they do so cautiously, outlining several considerations that need to be addressed first. For example, the reports stress that the design of any such measurement approach needs to be informed by careful consideration of the linkage between social risk factors and the outcome or outcomes measured. They also highlight the need to consider whether score adjustments are needed to account for factors outside the control of providers. Steps such as these ensure that health equity measurement approaches can be used in VBP programs to incentivize improvements for beneficiaries with social risk factors while guarding against any real or perceived disincentives to care for these beneficiaries.

Project Objectives

ASPE asked the RAND Corporation to identify existing health equity measurement approaches that may be suitable for inclusion in Medicare's VBP programs, quality reporting efforts, and confidential reports. This project had two objectives:

1. Identify and describe health equity measurement approaches.
2. Decide which of these merit consideration for inclusion in Medicare's VBP programs, quality reporting efforts, and confidential reports.

In August 2020, the project team conducted a literature review to identify health equity measurement approaches developed or used for the purpose of systematic performance assessment. In September 2020, the project team convened a technical expert panel (TEP) with experts on social risk factors, health disparities, health equity, quality measurement, and Medicare's VBP programs and quality reporting efforts to consider the use of these health equity measurement approaches in VBP programs, quality reporting efforts, and confidential reports.

¹⁶ 113th Congress of the United States, "H.R.4994 - IMPACT Act of 2014," webpage, 2014. As of January 11, 2021: <https://www.congress.gov/bill/113th-congress/house-bill/4994>

¹⁷ ASPE, *Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs*, Washington, D.C.: HHS, 2016; ASPE, *Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs*, Washington, D.C.: HHS, 2020.

The objectives of the TEP were to (1) provide feedback on the project team’s proposed definition of a health equity measure and identification of features of health equity measurement approaches; (2) reach consensus on a set of criteria for evaluating health equity measurement approaches for potential inclusion in Medicare’s VBP programs, quality reporting efforts, and confidential reports; and (3) evaluate the set of health equity measurement approaches identified by the team according to these criteria.

The project team synthesized feedback from the TEP to identify the most promising health equity measurement approaches in development and inform potential next steps toward incorporating health equity measures and domains in Medicare’s VBP programs, quality reporting efforts, and confidential reports.

The rest of this report is organized as follows. Chapter 2 describes the literature review methods and results. Chapter 3 provides detailed information on each of the identified health equity measurement approaches, and Chapter 4 provides an integrative summary of these approaches. Chapter 5 provides information about how the TEP was convened and conducted. Chapter 6 describes the input provided by the TEP on the project framing and approach. Chapter 7 describes TEP members’ assessment of and commentary on each of the identified health equity measurement approaches. Chapter 8 provides a summary of the findings of this project and key takeaways for the U.S. Department of Health and Human Services (HHS).

2. Literature Review Methods and Results

The project team conducted a review of articles and reports on health equity measurement approaches developed or intended for use in systematic performance assessment.

Definition of a Health Equity Measurement Approach to Assess Organizational Contributions

We developed a formal definition of a *health equity measure* to guide our search. The definition, which emphasizes performance assessment, is as follows: an approach to illustrating or summarizing the extent to which the quality of health care provided by an organization contributes to reducing disparities in health and health care at the population level for those patients with greater social risk factor burden by improving the care and health of those patients.¹⁸ Though such an approach is not centered on performance assessment per se, we agreed that an approach focused on structural measures—measures of the extent to which structures, systems, or processes hypothesized to promote the delivery of equitable care are in place within a health care organization—was in scope, given that such measures capture potentially important mechanisms for aligning care and resources with physical, mental, and social needs to optimize health outcomes for all.

Search Strategy

Our search strategy included three approaches. First, we used a structured database search on Ovid MEDLINE and Cumulative Index to Nursing and Allied Health Literature (CINAHL) to identify English-language, peer-reviewed articles published from January 2010 to August 2020. We identified articles using Medical Subject Headings (MeSH) and keywords with at least (1) one health equity or social risk keyword and (2) one performance measurement keyword. Table 2.1 lists the search terms by category. Second, we used a purposive “snowball” approach to identify potentially relevant documents by reference-mining seminal reports (see List 2.1). These are reports that were identified or suggested by health equity measurement experts within the project team and at ASPE. Third, we conducted a gray literature search to identify relevant documents from websites of federal agencies (Centers for Medicare & Medicaid Services [CMS] and ASPE), the National Academy of Medicine, the National Quality Forum (NQF) Quality Positioning System, and the National Quality Measures Clearinghouse. After removing duplicates, our search yielded 783 records, including both published peer-reviewed journal articles and gray literature reports (Figure 2.1).

¹⁸ The National Academy of Medicine (2016) identified five social risk factors that are conceptually likely to be of importance to health outcomes of Medicare beneficiaries: socioeconomic position; race, ethnicity, and cultural context; gender; social relationships; and residential and community context.

Eligibility Criteria

Because our aim was to identify health equity measurement approaches, we sought to exclude articles and reports if they (1) did not describe a specific health equity measurement approach developed or used for the purpose of systematic performance assessment; or (2) were focused on risk adjustment. These exclusions were applied during the article/report screening process described next.

Article/Report Screening

Figure 2.1 illustrates the article/report screening process. We first reviewed titles and abstracts of the 783 documents we identified. To ensure consistent application of our eligibility criteria, three reviewers first independently coded 60 articles across three separate rounds (i.e., 20 articles in each round). Between rounds, reviewers met to discuss independent review outcomes and discrepancies and their application of the criteria, as well as to further refine the definition of each criterion. Disagreements were resolved through discussion or by involving the principal investigator until consensus was reached. Subsequent titles/abstracts were divided, and each was reviewed by one of the three reviewers. Any uncertainties were discussed by the project team together, and all abstracts marked for inclusion were also reviewed by the project team before proceeding to full-text review. We excluded 647 documents at the title/abstract stage that did not meet eligibility criteria.

We then undertook a full text review of 136 documents to identify measurement approaches that would allow health plans or providers to identify areas in which they are performing well or poorly at providing high-quality care to patients with greater social risk factor burden.

Upon full text review, we applied additional exclusions, with the aim of excluding documents that did not articulate a specific health equity measurement approach. Specifically, we excluded (a) documents that described theoretical approaches or frameworks to health equity measurement not currently in development or in use; (b) documents that proposed adjustments to scores or adjustments to payment allocations within an incentive scheme; (c) documents that simply detailed the existence of disparities without the use of a specific measure of disparity; and (d) documents that described the effect of an incentive scheme on disparities. At this stage, we excluded an additional 114 documents that did not meet the eligibility criteria.

Of the 22 documents that met our eligibility criteria, eight fit the fifth category of measurement approaches described above (i.e., measures of the extent to which structures, systems, or processes hypothesized to promote the delivery of equitable care are in place within a health care organization). Because these eight documents all described similar approaches, we opted to include only the most comprehensive of them in our final results. The document that was kept describes a measurement framework for evaluating how well health care organizations comply with national standards for providing culturally and linguistically appropriate services. This document was authored by Davis et al.¹⁹ and describes the results of research commissioned by HHS's Office of

¹⁹ L. M. Davis, L. T. Martin, A. Fremont, R. Weech-Maldonado, M. V. Williams, and A. Kim, *Development of a Long-Term Evaluation Framework for the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*, Santa Monica, Calif.: RAND Corporation, EP-68215, 2018.

Minority Health (HHS OMH). The seven documents that we did not include in our final results are in List 2.2. Similarly, four of the 22 documents that met our eligibility criteria were reports of national disparities on patient experience, clinical process and outcome, and patient safety measures. Because these four reports all describe similar approaches to the analysis of disparities, we opted to include just one in our final results. The report that was included is the Agency for Healthcare Research and Quality (AHRQ) *National Healthcare Quality and Disparities Report*.²⁰ The three documents that we did not include in our final results are also in List 2.2. Thus, a total of 11 articles/reports were selected for inclusion in our final results. One of the 11 articles/reports selected for inclusion²¹ describes the analytic foundation underlying another of the reports.²² Thus, although 11 articles/reports were identified, they pertain to only ten total approaches (see Table 2.4 for a summary).

In the following chapters, we describe in detail the ten approaches to health equity measurement described in each of these 11 articles/reports. The description includes information about the approach, the setting and population in which the approach was initially evaluated (if applicable), the social risk factors encompassed by the approach, the outcome measures that factor into the approach, and any available psychometric information reported in the article/report. The description also indicates the features of the approach (see *Features of Health Equity Measurement Approaches* above) and whether the approach has been endorsed by a measure endorsement body or is currently in use in a Medicare VBP or quality reporting program.

²⁰ AHRQ, *2018 National Healthcare Quality and Disparities Report*, Rockville, Md., 2019. As of January 4, 2021: <https://www.ahrq.gov/research/findings/nhqrd/nhqdr18/index.html>

²¹ S. C. Martino, R. M. Weinick, D. E. Kanouse, J. A. Brown, A. M. Haviland, E. Goldstein, J. L. Adams, K. Hambarsoomian, D. J. Klein, and M. N. Elliott, "Reporting CAHPS and HEDIS Data by Race/Ethnicity for Medicare Beneficiaries," *Health Services Research* Vol. 48, No. 2 Pt 1, 2013, pp. 417–434.

²² OMH, "Part C and D Performance Data Stratified by Race, Ethnicity, and Gender," database, Centers for Medicare and Medicaid Services, 2020. As of January 4, 2020: <https://www.cms.gov/About-CMS/Agency-Information/OMH/research-and-data/statistics-and-data/stratified-reporting.html>

Table 2.1. Database Search Strategy

Concept	MeSH	Search Terms
Health equity	Health equity; healthcare disparities	Equity; disparit*
Social risk	Social determinants of health; socioeconomic factors; safety-net providers	Social determinants; social risk; safety net; race; ethnicity
Performance measurement	Value-based purchasing; incentive reimbursement	Performance measure; quality measure; value-based purchasing; pay for performance; quality reporting; public reporting; CAHPS; HEDIS

NOTE: The search syntax was as follows:

1. "health equity".sh,kf.
2. "healthcare disparities".sh.
3. "equity".ti,ab.
4. "disparit*".ti,ab.
5. "social determinants of health".sh.
6. "social determinants".ti,ab.
7. "social risk".ti,ab.
8. "socioeconomic factors".sh.
9. "safety-net providers".sh.
10. "safety net".ti,ab.
11. "race".ti,ab.
12. "ethnicity".ti,ab.
13. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12
14. "value-based purchasing".ti,ab,sh.
15. "reimbursement, incentive".sh.
16. "performance measure".ti,ab,kf.
17. "quality measure".ti,ab,kf.
18. "pay for performance".ti,ab.
19. "quality reporting".ti,ab.
20. "public reporting".ti,ab.
21. "CAHPS".ti,ab.
22. "HEDIS".ti,ab.
23. 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22
24. 13 and 23
25. limit 24 to English language
26. limit 25 to yr="2010-Current"

List 2.1. Seminal Reports Mined as Part of Our Purposive Snowball Approach

Anderson, A. C., E. O'Rourke, M. H. Chin, N. A. Ponce, S. M. Bernheim, and H. Burstin, "Promoting Health Equity and Eliminating Disparities Through Performance Measurement and Payment," *Health Affairs*, Vol. 37, No. 3, 2018, pp. 371–377.

ASPE Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs (Study A), 2016.

ASPE Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs (Study B), 2020.

Damberg, C. L., M. N. Elliott, and B. A. Ewing, "Pay-for-Performance Schemes That Use Patient and Provider Categories Would Reduce Payment Disparities," *Health Affairs*, Vol. 34, No. 1, 2015, pp. 134–142.

Hughes, D., J. Levi, J. Heinrich, and H. Mittmann, *Developing a Framework to Measure the Health Equity Impact of Accountable Communities for Health*, Washington, D.C.: Funders Forum on Accountable Health, 2020.

National Academies of Science, Engineering, and Medicine, *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors*, Washington, D.C.: National Academies Press and HHS, 2016.

List 2.2. Articles and Reports That Met Eligibility Criteria but Were Not Included in the Final Results

Articles and reports describing measures of structures, systems, and processes within a health care organization that promote delivery of equitable care

- Hughes, D., J. Levi, J. Heinrich, and H. Mittmann, *Developing a Framework to Measure the Health Equity Impact of Accountable Communities for Health*, Washington, D.C.: Funders Forum on Accountable Health, 2020.
- *Cultural Competency 2010 Measures and Implementation Strategies*, Washington, D.C.: NQF, 2011.
- *Healthcare Disparities and Cultural Competency Consensus Standards Technical Report*, Washington D.C.: NQF, 2012.
- Ng, J. H., M. A. Tirodkar, J. B. French, H. E. Spalt, L. M. Ward, S. C. Haffer, N. Hewitt, D. Rey, and S. H. Scholle, "Health Quality Measures Addressing Disparities in Culturally and Linguistically Appropriate Services: What are Current Gaps?" *Journal of Health Care for the Poor and Underserved*, Vol. 28, No. 3, 2017, pp. 1012–1029.
- Weech-Maldonado, R., A. Carle, B. Weidmer, M. Hurtado, Q. Ngo-Metzger, and R. D. Hays, "The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Cultural Competence (CC) Item Set," *Medical Care*, Vol. 50, No. 9, Suppl 2, 2012, pp. S22–S31.
- Weech-Maldonado, R., J. Drechslein, J. Brown, R. Pradhan, K. L. Rubin, C. Schiller, and R. D. Hays, "Cultural Competency Assessment Tool for Hospitals (CCATH): Evaluating Hospitals' Adherence to the CLAS Standards," *Health Care Management Review*, Vol. 37, No. 1, 2012, pp. 54–66.
- Weech-Maldonado, R., M. N. Elliott, J. L. Adams, A. M. Haviland, D. J. Klein, K. Hambarsoomian, C. Edwards, J. W. Dembosky, and S. Gaillot, "Do Racial/Ethnic Disparities in Quality and Patient Experience Within Medicare Plans Generalize Across Measures and Racial/Ethnic Groups?" *Health Services Research*, Vol. 50, No. 6, 2015, pp. 1829–1849.
- Weech-Maldonado, R., M. Elliott, et al. "Can Hospital Cultural Competency Reduce Disparities in Patient Experiences with Care?" *Medical Care*, Vol. 50, 2012, pp. S48–S55.

Reports of national disparities in health care

- *The National Impact Assessment of CMS Quality Measures Reports*, Baltimore, Md.: CMS, February 2020.
 - Martino, S. C., M. N. Elliott, J. W. Dembosky, K. Hambarsoomian, Q. Burkhart, D. J. Klein, J. Gildner, and A. M. Haviland, *Racial, Ethnic, and Gender Disparities in Health Care in Medicare Advantage*, Baltimore, Md: CMS OMH, 2020.
 - Martino, S. C., M. N. Elliott, J. W. Dembosky, K. Hambarsoomian, Q. Burkhart, D. J. Klein, J. Gildner, and A. M. Haviland, *Rural-Urban Disparities in Health Care in Medicare*, Baltimore, Md.: CMS OMH, 2019.
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Figure 2.1. Literature Review Flow Diagram

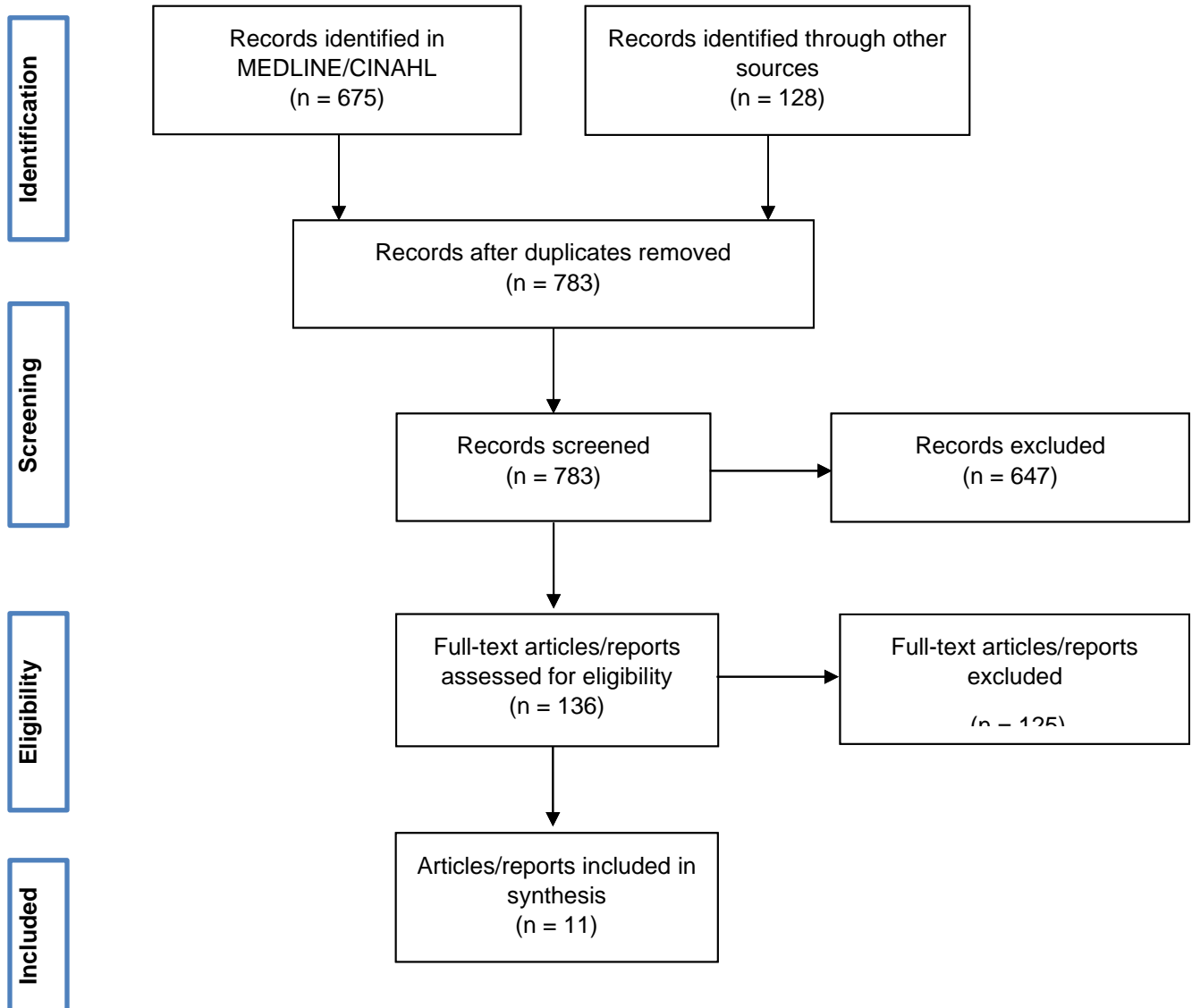


Table 2.2. Summary of the Health Equity Measurement Approaches Identified by the Literature Review

Measurement Approach	Setting/Population	Social Risk Factor(s)
1. Measurement Framework for Evaluating How Well an Organization Meets National Standards for Culturally and Linguistically Appropriate Services (HHS OMH)	Health care organizations	Race/ethnicity; limited English proficiency; low literacy
2. NQF Disparities-Sensitive Measure Assessment	Cross-cutting	Race/ethnicity
3. AHRQ <i>National Healthcare Quality and Disparities Report</i>	Overall U.S. population	Age; sex, race/ethnicity
4. CMS OMH Mapping Medicare Disparities Tool	Medicare FFS	Race/ethnicity; dual eligibility; sex; age
5. CMS OMH Reporting of CAHPS and HEDIS Data by Race/Ethnicity for Medicare Beneficiaries	MA and prescription drug plans, Medicare FFS	Race/ethnicity
6. <i>Minnesota Healthcare Disparities Report</i>	Minnesota health plan enrollees	Race, ethnicity, preferred language, country of origin
7. CMS Assessment of Hospital Disparities for Dual-Eligible Patients	Hospitals	Dual eligibility
8. CMS OMH Health Equity Summary Score	Medicare Advantage plans	Race/ethnicity; dual eligibility
9. Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity	General adult U.S. population	Race/ethnicity; sex; income
10. Zimmerman and Anderson Approach to Evaluating Trends over Time in Health Equity	General adult U.S. population	Race/ethnicity; sex; income

NOTE: CAHPS = Consumer Assessment of Healthcare Providers and Systems; CMS = Centers for Medicare & Medicaid Services; DHHS = U.S. Department of Health and Human Services; FFS = fee-for-service; HEDIS = Healthcare Effectiveness Data and Information Set; MA = Medicare Advantage; NQF = National Quality Forum; OMH = Office of Minority Health

3. Detailed Information on Identified Approaches

In this chapter, we describe in detail the health equity measurement approaches that were identified by the literature described in the preceding chapter. A summary of these measurement approaches appears in the following chapter, which also introduces a categorization scheme by which the measurement approaches are ordered here and elsewhere.

Measurement Framework for Evaluating How Well an Organization Meets National CLAS Standards (HHS OMH)

Overview. This report—which was commissioned by HHS OMH— describes a framework for measuring whether structures, systems, or processes hypothesized to promote health equity are in place within a health care organization or system.²³

Background. The National CLAS Standards are a set of 15 standards intended to advance health equity and help eliminate health care disparities by providing a blueprint for health care organizations to implement culturally and linguistically appropriate services. The essential goal of the standards is framed in the *Principal Standard*: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. The other 14 standards address domains of governance, leadership, and workforce; communication and language assistance; and engagement, continuous improvement, and accountability.

Design and methods. The goal of this approach is to identify a set of well-constructed and validated health equity process and impact measures that could be applied to four settings of care— ambulatory care, hospitals, behavioral health, and public health—to evaluate how well a health care organization meets the National CLAS Standards. Specific criteria were used by the authors of this framework to identify salient measures to consider, including whether the measure (a) assesses cultural competency; (b) captures language needs or preferences and/or is linked to other CLAS-related issues; (c) documents disparities; (d) is validated and/or psychometrically tested; (e) is widely used or suitable for use by a range of health care organizations; (f) has been previously endorsed in commissioned projects or reports for evaluating disparities; and (g) cuts across conditions and/or settings. Measures were categorized as cross-cutting (i.e., applicable across multiple settings) or setting-specific. Based on the criteria, the authors identified six cross-cutting measures (see Table 3.1), six ambulatory-specific measures, nine hospital-specific measures, five behavioral health-specific measures, and six public health-specific measures. Appendix A shows measures that fit the latter four categories.

²³ L. M. Davis, L. T. Martin, A. Fremont, R. Weech-Maldonado, M. V. Williams, and A. Kim, *Development of a Long-Term Evaluation Framework for the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*, Santa Monica, Calif.: RAND Corporation, EP-68215, 2018.

Table 3.1. Cross-Cutting Measures to Evaluate How Well an Organization Meets National CLAS Standards

Measure	Description
Clinician/group's cultural competence based on the CAHPS Cultural Competence Item Set	Domains from CAHPS Cultural Competence Item Set: patient-provider communication; complementary and alternative medicine; experiences of discrimination due to race/ethnicity, insurance, or language; experiences leading to trust or distrust, including level of trust, caring, and confidence in the truthfulness of a provider; and linguistic competency (access to language services)
Clinician/group's health literacy practices based on the CAHPS Item Set for Addressing Health Literacy	Domains from CAHPS Item Set for Addressing Health Literacy: communication with provider, disease self-management, communication about medicines, communication about test results, and communication about forms.
Patients receiving language services supported by qualified language services providers	Percentage of patients with limited English proficiency receiving both initial assessment and discharge instructions supported by assessed and trained interpreters or from bilingual providers and bilingual workers/employees assessed for language proficiency
Screening for preferred spoken language for health care	Percentage of patient visits and admissions in which the preferred spoken language for health care is screened and recorded.
Cultural Competency Implementation Measure	Survey of degree to which health care organizations are providing culturally competent care and addressing the needs of diverse populations, as well as their adherence to 12 of the 45 NQF-endorsed cultural competency practices.
Communication Climate Assessment Toolkit	360-degree organizational assessment using coordinated patient, staff, and leadership surveys, as well as an organizational workbook that collects important information on the organization's policies and practices.

NQF Disparities-Sensitive Measure Assessment

Overview. This report presents a protocol to systematically screen and identify NQF-endorsed measures as disparities-sensitive.²⁴ The set of measures identified by this approach was developed for use across health care settings.

Background. To establish a platform for addressing health care disparities and cultural competency in measurement, NQF sought to identify measures from within its existing portfolio of endorsed measures that might be disparities-sensitive (see below). In particular, NQF sought to identify measures sensitive to health care disparities and cultural competency for racial and ethnic minority populations. They established criteria to evaluate measures for how sensitive they were to disparities, assigned points to each measure based on these criteria, and set point thresholds and other rules to identify disparities-sensitive measures.

Design and methods. To evaluate existing measures for disparities sensitivity, two tiers of criteria were established that placed emphasis on prevalence and impact of the condition, quality gap, and impact of the quality process.²⁵ The first-tier criteria—applied to condition-specific measures and measures of health care access and quality—included the prevalence of the condition among minority groups, the size of the gap in the quality of care between disadvantaged and advantaged groups, and the impact the condition has financially or societally. The second-tier criteria—applied to process measures that could be used to improve performance in health equity—included communication-sensitive practices; specifically, whether the measure mapped to either the NQF-endorsed competency framework domain or the care coordination framework domain.

Based on these criteria, a simple scoring system was applied to evaluate over 500 measures in the existing NQF portfolio. For condition-specific measures, 3 points were given for specific conditions such as cancer, diabetes, and heart disease and 2 points for measures on a list of top 20 conditions among Medicare beneficiaries, such as substance abuse or obesity. Cross-cutting areas, such as patient safety, functional status, or pain management, were given 3 points. All other condition-specific measures were given 1 point. Similarly, the greater the size of the quality gap between disadvantaged and advantaged groups, the more points were assigned; e.g., a 0-percent to 2-percent quality gap was assigned 1 point, while a quality gap greater than 14 percent was given 4 points. To reflect impact, 1 point was assigned for each National Quality Strategy priority area or goal addressed, and 1 point each for whether a condition was a leading cause of morbidity/mortality overall, was associated with high resource use, had high severity of illness, or

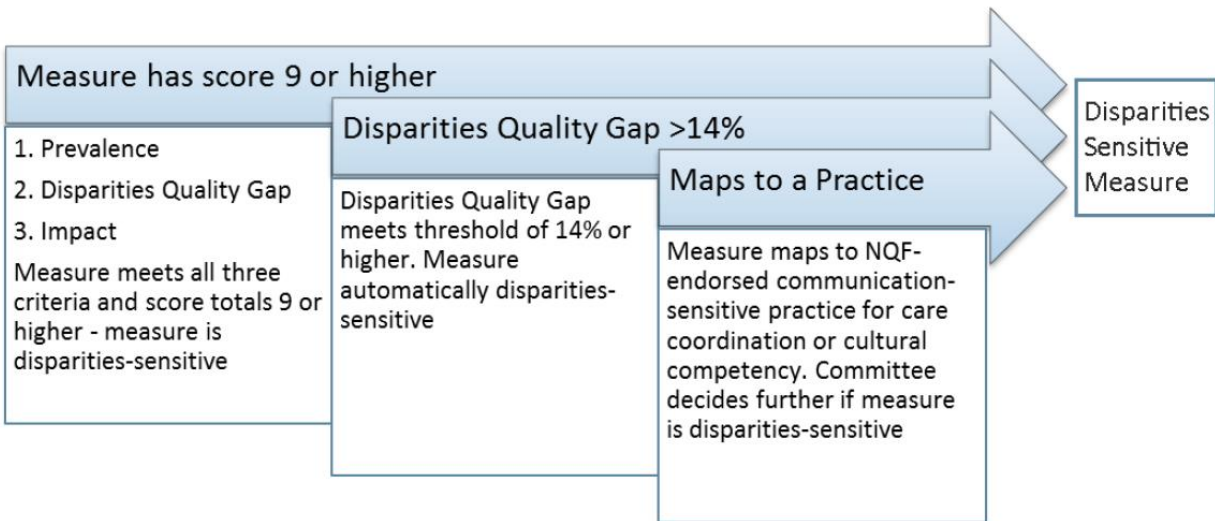
²⁴ *Healthcare Disparities and Cultural Competency Consensus Standards: Disparities Sensitive Measure Assessment*, NQF Technical Report, Washington, D.C., 2012. As of January 4, 2021: https://www.qualityforum.org/Publications/2012/11/Healthcare_Disparities_and_Cultural_Competency_Consensus_Standards_Disparities-Sensitive_Measure_Assessment.aspx. Also see NQF, *A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity*, Washington, D.C., 2017. As of January 4, 2021: http://www.qualityforum.org/Publications/2017/09/A_Roadmap_for_Promoting_Health_Equity_and_Eliminating_Disparities_The_Four_I_s_for_Health_Equity.aspx

²⁵ Measures addressing the National Quality Strategy priority areas or goals were judged to fit this criterion, as were measures assessing a high-impact aspect of health care (e.g., conditions affecting large numbers, leading causes of morbidity and mortality, conditions leading to high resource use, and severe illnesses).

was one for which poor quality would be consequential. Finally, 2 points were given to any measures that mapped to the two NQF-endorsed framework domains.

To select measures, NQF emphasized prevalence, the threshold of the quality gap, impact, and whether a measure could be mapped to an NQF-endorsed framework domain addressing care coordination or cultural competency (Figure 3.1). If the measure scored 9 or higher on the first-tier criteria, the measure was considered disparities-sensitive. Further, if the quality gap was 14 percent or higher, the measure was also automatically considered disparities-sensitive. The NQF analysis found that measures that fit within the highest quality-gap quartile also had the highest first-tier score, which identified an initial set of 62 measures deemed disparities-sensitive. Additional analysis of whether a measure mapped to an NQF-endorsed framework domain identified another 14 measures, for a total of 76 disparities-sensitive measures. These measures are listed in Appendix B.

Figure 3.1. NQF Disparities-Sensitive Measure Identification



AHRQ *National Healthcare Quality and Disparities Report*

Overview. This report describes approaches to measuring and reporting providers' performance for patients with social risk factors versus without them, and also measures health disparities specifically using methods for formally comparing performance between patients with social risk factors versus without them.²⁶ The approaches are applied to the overall U.S. population. Data come from a large number of national surveys and databases maintained by several federal agencies, including AHRQ, CMS, the Centers for Disease Control and Prevention, the Indian Health Service, the National Institutes of Health, the Substance Abuse and Mental Health Services Administration, and the Health Resources and Services Administration.²⁷

Background. The AHRQ *National Healthcare Quality and Disparities Report* is an annual report mandated by Congress to provide a comprehensive overview of the quality of health care received by the general U.S. population and disparities in care experienced by different racial and socioeconomic groups. It includes information on disparities in access to care and quality of care in the most recent data year, as well as changes in disparities over time. The report also includes information on federal initiatives to reduce disparities. The social risk factors addressed include age, sex, and race and ethnicity. In this report, comparisons are made between a reference group²⁸ and a *priority population* group based on a population characteristic, such as sex (i.e., women versus men) or minority racial and ethnic groups versus Whites. The report includes more than 250 structure, process, and outcome measures covering a broad array of health care services and settings. For example, the report provides data on access to health care, patient experience, patient safety, maternal and child health, functional status preservation and rehabilitation, supportive and palliative care, health promotion, clinical preventive services, use of effective treatments, care coordination, care affordability, morbidity, and mortality.

Design and methods. All measures are scored as percentages. Two criteria are applied to identify meaningful differences in measure performance between two groups in the single current, or most recent, data year. First, the absolute difference in measure performance between the priority population group and the reference group must be statistically significant with $p < 0.05$ on a two-tailed test. Second, the relative difference between the two groups must be at least 10 percent when framed positively or negatively (i.e., in either direction). For example, performance on the measure could be 10 percent higher in the reference group than the priority group, and that would be characterized as a *meaningful difference*, or *disparity*.

To evaluate changes in disparities over time, the average annual change (AAC) in measure performance for each group is first calculated as the coefficient in an unweighted regression analysis that estimates performance in at least four time points between 2000 and the most recent data year for both the priority and the reference groups. Then, the AAC of the reference group is

²⁶ AHRQ, *2018 National Healthcare Quality and Disparities Report*, Rockville, Md., 2019. As of January 4, 2021: <https://www.ahrq.gov/research/findings/nhqdr/nhqdr18/index.html>

²⁷ More information about data sources can be found in the *2018 National Healthcare Quality and Disparities Report Data Sources*, Rockville, Md.: AHRQ, October 2019. As of January 4, 2021: <https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqdr/2018qdr-datasources.pdf>

²⁸ Use of the term *reference group* here mirrors that found in the AHRQ report.

subtracted from the AAC for the priority group, and the difference is tested for statistical significance. The disparity is characterized as *improving* over time if the difference between the AAC of the priority population and reference group was less than -1 percentage point (i.e., in a favorable direction), and the test of the difference had a p-value < 0.10. The disparity is characterized as *worsening* if the difference in the AAC between the groups was more than 1 percentage point and the test of the difference had a p-value < 0.10. Finally, the disparity is characterized as *not changing* if the absolute value of the AAC difference was less than 1 percentage point or the absolute value of the difference in the AAC was greater than 1 percentage point and the p-value of the test of the difference was ≥ 0.10 .

CMS OMH Mapping Medicare Disparities Tool

Overview. This tool was developed to measure and report providers' performance for Medicare FFS beneficiaries with social risk factors versus without them. Social risk factors addressed include race, ethnicity, dual eligibility, sex, and age. The Mapping Medicare Disparities (MMD) Tool is published on the CMS OMH website.²⁹

Background. The CMS OMH MMD Tool is an online interactive map that illustrates comparisons of disparities between groups of Medicare beneficiaries (e.g., racial and ethnic groups) in health outcomes, utilization, and spending. The tool offers two types of comparisons: The *Hospital View* visually compares hospital performance on a range of metrics and performance scores categorized by geography (e.g., county, state, and national), hospital type (e.g., acute care and critical access), hospital ownership (e.g., government, physician, proprietary, tribal, and voluntary), and/or hospital size (i.e., number of beds). This view does not allow comparisons of hospital performance specifically for different social risk factor groups; it allows comparisons only of hospital performance overall. However, pertinent to the current effort, the *Population View* compares groups according to social risk factors (such as race and ethnicity, age, sex) on their condition prevalence and on health care utilization, quality, and spending.

Design and methods. The MMD Tool draws on data from CMS administrative enrollment and claims data for Medicare beneficiaries enrolled in Medicare FFS and includes hundreds of measures over three dozen conditions.³⁰ The Population View provides descriptive statistics by social risk factor group on indicators such as Medicare spending, hospital and emergency department utilization, preventable hospitalizations, readmission rates, risk-standardized 30-day all-cause mortality rates for acute myocardial infarction and heart failure, and discharge destinations for a range of conditions. In this Population View, measures can be examined at both state and county levels, or by urban versus rural locations. Comparisons can be made against the national, state, or county average for a given measure. However, no statistical comparisons are made.

²⁹ Office of Minority Health, "Mapping Medicare Disparities," online tool, Centers for Medicare and Medicaid Services, 2020. As of January 4, 2021: <https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH-Mapping-Medicare-Disparities>

³⁰ Detail on these measures can be found in NORC at the University of Chicago, "The Mapping Medical Disparities Tool: Technical Documentation," Version 8.0, HHS OMH, July 30, 2020. As of January 4, 2021: <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Mapping-Technical-Documentation.pdf>

CMS OMH Reporting of CAHPS and HEDIS Data Stratified by Race and Ethnicity for Medicare Beneficiaries

Overview. This is an approach to measuring and reporting care provided to Medicare beneficiaries with social risk factors versus without them. This approach is currently used to report Medicare Part C and D performance data at contract and state levels stratified by race and ethnicity on the CMS OMH website.³¹ This stratified reporting will be extended to include rural and urban comparisons in 2021.

Background. The CMS OMH has reported Medicare FFS, Part C, and Part D performance data, stratified by race and ethnicity (specifically, Asian or Pacific Islander, Black, Hispanic, and White) annually since 2015. The purpose of stratified reporting in this context is to provide information for targeting quality improvement activities and resources, to monitor MA and prescription drug plan (PDP) performance, and to advance the development of culturally and linguistically appropriate quality improvement strategies. Stratified estimates of performance by social risk factor are provided for individual MA contracts, individual PDP contracts, and states (FFS). Statistical comparisons of contract scores are made to the national average for a particular racial or ethnic group.

Design and methods. Under this stratified reporting approach, patient experience (from the CAHPS survey) and clinical quality (from HEDIS) measures are evaluated for inclusion in reporting according to two criteria: *reliability*, which is the extent to which a given measure is able to distinguish true differences among plans for a given racial or ethnic group, and *informativeness*, which reflects the amount of information about minority group scores that are not contained in scores for Whites.³² This latter criterion assesses whether stratification of data by racial and ethnic groups provides enough new information about plan performance to justify the loss in precision that comes from basing estimates on fewer observations (i.e., a smaller sample). The approach imposes certain minimum sample requirements for reporting a measure; specifically, at least 100 measure completes for MA contracts and 200 measure completes for individual PDP contracts for a given racial or ethnic group. Two years of data are combined in each report to increase sample sizes. Scores that do not meet the minimum sample size threshold or for which reliability is < 0.60 are not reported; scores that meet the sample size requirement and for which reliability is between 0.60 and 0.70 are reported but flagged as having low reliability.

³¹ OMH, “Part C and D Performance Data Stratified by Race, Ethnicity, and Gender,” database, CMS, 2020. As of January 4, 2021: <https://www.cms.gov/About-CMS/Agency-Information/OMH/research-and-data/statistics-and-data/stratified-reporting.html>

³² S. C. Martino, R. M. Weinick, D. E. Kanouse, J. A. Brown, A. M. Haviland, E. Goldstein, J. L. Adams, K. Hambarsoomian, D. J. Klein, and M. N. Elliott, “Reporting CAHPS and HEDIS Data By Race/Ethnicity For Medicare Beneficiaries, *Health Services Research*, Vol. 48, No. 2 Pt 1, 2013, pp. 417–434.

Minnesota Healthcare Disparities Report

Overview. This measurement approach pertains to Minnesota health plan enrollees and is used to measure, formally compare, and report providers' performance for plan members with social risk factors versus without them. Key social risk factors addressed include race and ethnicity, preferred language, and country of origin. The report is authored by MN Community Measurement—an independent collaborative organization that collects, analyzes, and reports regional data on health care quality and cost—and is published on this organization's website.³³

Background. MN Community Measurement publicly reports comparative data on health care performance for Minnesota patients enrolled in state and federally funded public programs and private or Medicare-managed programs.³⁴ Their *Minnesota Healthcare Disparities Report* describes medical group performance on health care process and outcomes using 12 HEDIS measures, stratified by race, Hispanic ethnicity, preferred language, and country of origin. These measures include

- optimal diabetes care (HEDIS composite measure)
- optimal vascular care (HEDIS composite measure)
- optimal asthma control, adults
- optimal asthma control, children
- colorectal cancer screening
- adolescent mental health and/or depression screening
- adult depression: follow-up at six and 12 months; response at six and 12 months; remission at six and 12 months.

Composites comprise multiple standard HEDIS measures. For example, optimal diabetes care is defined as achieving or meeting all of the following: (a) HbA1c less than 8.0 mg/dL; (b) blood pressure less than 140/90 mm Hg; (c) on a statin medication, unless allowed contraindications or exceptions are present; (d) non-tobacco user; and (e) patient with ischemic vascular disease on daily aspirin or antiplatelets, unless allowed contraindications or exceptions are present.

Design and methods. In this approach, data are reported at two levels. At the state level, social risk factor groups are compared with each other (e.g., White females versus White males, non-English-speaking Black patients versus English-speaking Black patients) and with the overall state average and state average for the social risk factor group for each measure. At the medical group level, social risk factor groups are compared with the overall state average and state average for the social risk factor group. Minimum sample sizes are required to permit reporting; for standard HEDIS measures, a minimum threshold of 30 patients per medical group is required for public recording. For composite measures, the minimum threshold for reporting is 60 patients per medical group.

³³ MN Community Measurement, *Minnesota Health Care Disparities by Race, Hispanic Ethnicity, Language and Country of Origin: 2019 Report*, Minneapolis, Minn., May 2020. As of January 4, 2021: <https://mncmsecure.org/website/Reports/Community%20Reports/Disparities%20by%20RELC/2019%20Disparities%20by%20RELC%20Chartbook%20-%20FINAL.pdf>

³⁴ A. M. Snowden, V. Kunerth, A. M. Carlson, J. A. McRae, and E. Vetta, "Addressing Health Care Disparities Using Public Reporting," *American Journal of Medical Quality*, November 19, 2011.

Race, ethnicity, language, and country of origin data are submitted by medical groups and clinics directly to Minnesota Community Measurement for analysis and reporting, utilizing an extensive extraction and validation process to ensure that medical groups collect these data elements from patients using best practices. The best practices include that

- patients self-report their race and Hispanic ethnicity
- patients have the option to select one or more categories for race (i.e., medical groups/clinics do not collect data using a multiracial category).

Medical groups and clinics must adhere to all of the above best practices for collecting these social risk factor data to be included in the rate calculation.

CMS Assessment of Hospital Disparities for Dual-Eligible Patients

Overview. This approach³⁵ compares outcomes of care for dual-eligible Medicare beneficiaries across hospitals and quantifies disparities between dual-eligible and non-dual-eligible beneficiaries within the same hospital. It focuses on one specific social risk indicator, dual eligibility status, and one outcome measure, unplanned readmission following hospitalization for pneumonia.

Background. This approach is used in confidential reporting to hospitals and focuses on reporting disparities in performance to inform quality improvement efforts. The outcome measure is specified as the number of unplanned readmissions within 30 days of discharge for Medicare beneficiaries 65 years and older who were hospitalized at short-term acute care hospitals following an index admission for pneumonia. The pneumonia measure cohort includes patients aged 65 years or older enrolled in Medicare FFS in the prior year with a principal discharge diagnosis of pneumonia or sepsis with secondary discharge diagnosis of pneumonia coded present on admission. The measure is constructed using Medicare administrative claims and enrollment data.

Design and methods. Hospital performance on this measure is calculated using two complementary approaches: The Within-Hospital Disparity Method measures the difference in outcomes between patients who are dually eligible³⁶ and patients who are not dually eligible within a hospital; the Dual Eligible Outcome Method compares performance on the outcome for dually eligible patients across hospitals. For both approaches, the outcome is adjusted for patient age and medical conditions at the time of admission and 12 months prior. Results are reported for hospitals with at least 25 patients overall and 12 patients per group (dual-eligible and non-dual-eligible patients).

The Within-Hospital Disparity Method calculates, for each hospital, an absolute rate difference in the outcomes between patients who are dual-eligible versus those who are not, within that hospital. As an absolute value, this method does not consider the direction of the disparity. Under this method, levels of hospital performance are characterized in two ways: (1) the distribution of the absolute value of the absolute rate difference is divided into ten equal categories; hospitals falling in higher deciles have larger within-hospital disparity; and (2) a statistical test of the difference of the disparity from zero.

The Dual Eligible Outcome Method measures and compares hospital performance for the subgroup of patients who are dual-eligible by calculating a risk-standardized readmission rate (RSRR) for dual-eligible patients for each hospital. This method also characterizes performance levels in two ways: (1) the distribution of the dual-eligible specific RSRRs is divided into ten equal categories; hospitals falling in higher deciles have high dual-specific RSRRs; and (2) a statistical test of the difference of the RSRR from the national readmission rate of dual-eligible patients, such that performance is worse, no different, or better than the national rate for dual-eligible patients.

³⁵ Yale New Haven Health Services Corporation/Center for Outcomes Research and Evaluation, *Assessing Hospital Disparities for Dual Eligible Patients: Thirty-Day All-Cause Unplanned Readmission Following Pneumonia Hospitalization*, New Haven, Conn., 2018. Disparity methods confidential reporting overview, as of January 5, 2021: <https://www.qualitynet.org/inpatient/measures/disparity-methods>; disparity methods confidential reporting methodology, as of January 5, 2021: [qualitynet.org/inpatient/measures/disparity-methods/methodology](https://www.qualitynet.org/inpatient/measures/disparity-methods/methodology)

³⁶ The demonstration of this approach was focused on full dual eligible beneficiaries.

CMS OMH Health Equity Summary Score

Overview. The Health Equity Summary Score (HESS)³⁷ is a summary health equity metric that is designed to promote and incentivize excellent care for racial and ethnic minorities and dual- and Low-Income-Subsidy (LIS)–eligible MA beneficiaries. The HESS can be used to compare performance for patients with social risk factors across providers or assess improvement in performance for providers' socially at-risk populations over time, both within contracts and between contracts.

Background. The HESS is designed to measure both current (cross-sectional) quality of care and quality improvement and to incentivize good care to both racial and ethnic minorities and beneficiaries who are dually eligible for Medicare and Medicaid or eligible for a LIS under Medicare Part D (referred to as *DE/LIS eligible*). The HESS summarizes performance across two types of data: (1) patient experience, as measured by CAHPS: doctor communication, ease of getting needed care, getting care quickly, ease of getting needed prescription drugs, customer service, care coordination, and flu immunization; and (2) clinical care, as measured by HEDIS: breast cancer screening, colorectal cancer screening, diabetes care (both nephropathy and retinal exam), and adult body mass index assessment. Both types of data are linkable to social risk factors at the level of the individual Medicare beneficiary, and the measures that are included in the HESS are continually evaluated for their suitability for inclusion.

Design and methods. The cross-sectional component of the HESS combines the two most recent years of data, while the improvement (i.e., performance over time) score compares performance in the two most recent years with performance in the two years prior. To assure accurate measurement, a plan's HESS is based only on the combination of social risk factor groups and measures for which there is sufficient sample size of 100 and reliability greater than or equal to 0.7. For improvement measures, this must hold at both baseline and follow-up. For each measurable MA contract, the HESS is based on however many social risk factor groups can be reliably measured, and information is combined to give equal weight to each social risk factor group. To be eligible to receive a HESS score, an MA contract must have a minimum of 500 enrollees and publicly reported quality scores, including a Medicare Part C summary rating and at least one CAHPS or HEDIS Medicare Star rating.

The process for calculating the HESS is visually depicted in Figure 4.2. Cross-sectional performance for each measurable racial and ethnic minority group and for DE/LIS-eligible beneficiaries is estimated using linear models, yielding one score for each social risk factor group for each measure. All measures are rescaled to a 0–100 scale and modeled separately, and estimates are standardized to put them on a common scale across measures and groups. The standardized estimates are then combined across measures and social risk factor groups to yield a single cross-sectional performance score for each MA contract. Performance scores are converted to a five-star scale

³⁷ D. Agniel, S. C. Martino, Q. Burkhart, K. Hambarsoomian, N. Orr, M. K. Beckett, C. James, S. H. Scholle, S. Wilson-Frederick, J. Ng, and M. N. Elliott, "Incentivizing Excellent Care to At-Risk Groups with a Health Equity Summary Score," *Journal of General Internal Medicine*, November 2019.

using the Medicare Part C clustering algorithm.³⁸ Improvement scores combine both a within-plan component and a between-plan, or benchmarked, component. The within-plan component measures the narrowing or widening of within-plan disparities (between the two-year baseline period and the two-year performance period) and compares—measure by measure—performance for all lagging groups to performance for the leading group (i.e., the group with the highest baseline score on a measure) of each contract. The between-plan or nationally benchmarked component measures the improvement of each social risk factor group compared with that group’s national average improvement. As with the cross-sectional score, this procedure is undertaken for each measurable racial and ethnic minority group and for DE/LIS beneficiaries. Cross-sectional and improvement scores are blended according to the scheme in Figure 4.3. As the figure shows, low improvement scores cannot result in a blended score lower than a plan’s cross-sectional score, which prevents high-performing plans from being penalized for what may be necessarily limited improvement. By design, improvement counts more toward a contract’s HESS when cross-sectional performance is lower, to encourage and reward improvement for low-performing plans. For example, as can be seen in Figure 4.3, a contract that scores one star on the cross-sectional component of the HESS can earn an additional blended star if it achieves four stars for improvement, and it can earn two additional blended stars if it achieves five stars for improvement. Finally, a contract’s HESS is computed by averaging its blended score for race and ethnicity and its blended score for DE/LIS to produce a final composite score. Composite HESS scores are generated separately for clinical care and patient experience.

³⁸ CMS, “Medicare 2020 Part C & D Star Ratings Technical Notes,” October 2019. As of January 5, 2021: <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Star-Ratings-Technical-Notes-Oct-10-2019.pdf>

Figure 4.2. Components of the HESS

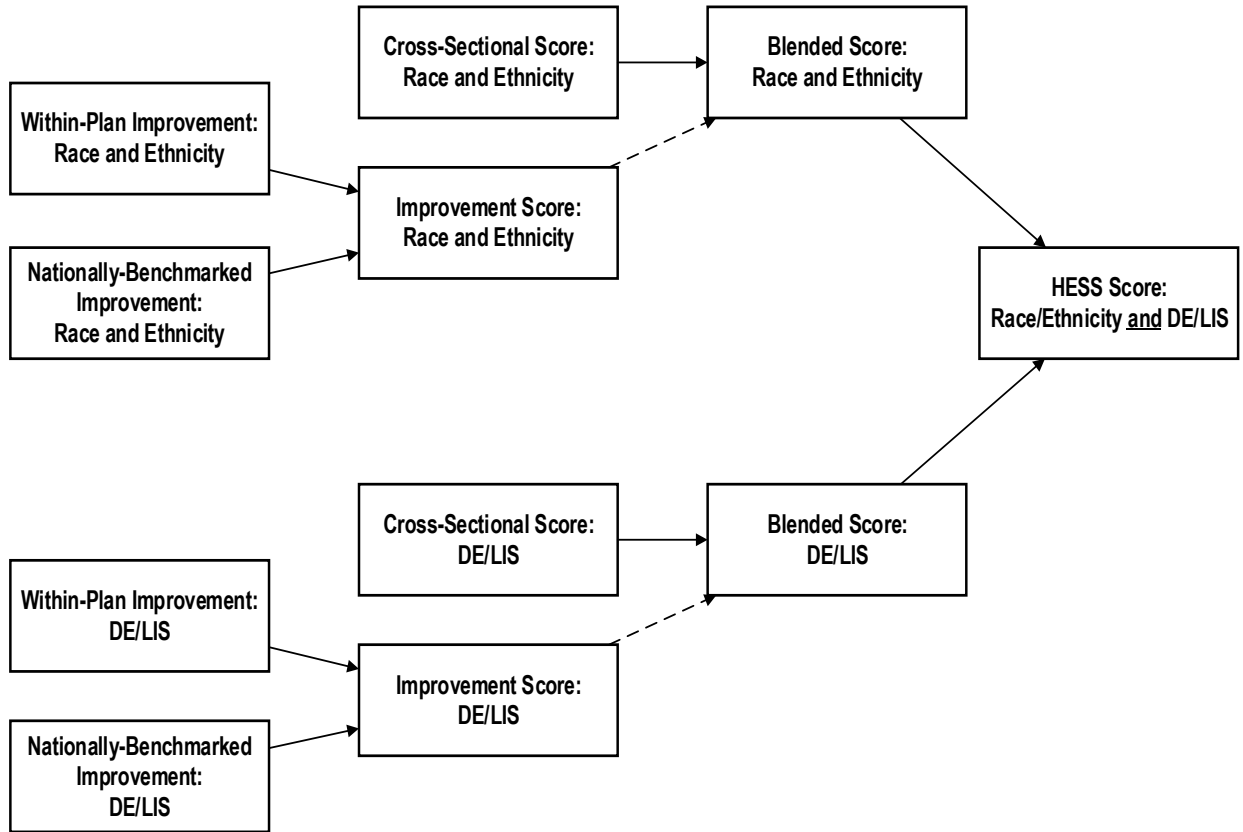


Figure 4.3. HESS: Blending Scheme

Improvement stars

		missing	1	2	3	4	5
Cross-sectional stars	1	1	1	1	1	2	3
	2	2	2	2	2	3	3
	3	3	3	3	3	3	4
	4	4	4	4	4	4	5
	5	5	5	5	5	5	5

Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity

Overview. Like the HESS, this approach by Zimmerman³⁹ synthesizes information across multiple measures, in this case using a health-related quality of life criterion. The approach is oriented toward quantifying the total deviation of a population from a defined privileged group and allows disaggregation, e.g., to the level of states.

Background. This health equity measure compares the average health-related quality of life of individuals within numerous social categories (race, ethnicity, sex, and income) to the average quality of life of individuals from a privileged social category: specifically, high-income White men. The assumption undergirding this measure is that wealthy White men hold the highest social privilege in the United States, and therefore it is their experience that is the relevant comparison standard. Moreover, while the identities of socially marginalized groups have changed over time, as have the ways in which marginalization translates into health outcomes, the privileged status of upper-income White men has been stable for decades. In using wealthy White men as the comparator, the measure implicitly treats gender, race, and income as the social risk factors of interest. The health experiences of all those who do not belong to the privileged group are included in the computation of the measure, though scores for specific subgroups (e.g., low-income Black women) can be derived.

Design and methods. The proposed measure conceptually defines *health disutility* as the “distastefulness” associated with one’s health falling short of the optimal achievable health. To build this approach, 2017 Behavioral Risk Factor Surveillance System data were used from adults aged 18 to 64 years from all 50 states and the District of Columbia. The key outcome is a measure of *healthy days* derived from the Centers for Disease Control and Prevention’s health-related quality of life scale. This scale was constructed by summing the answers to two questions about how many days in the previous 30 days the respondent felt that their mental or physical health was not good, rescaled such that higher scores equal more healthy days and age-adjusted. To calculate the measure, for each state, a health deficit was defined for each individual in the group as the amount by which their health falls below the average health in the most privileged group. The metric can be summed over the total state population to get the mean value of distastefulness for the state or can be summed over specific social groups, for example, to show how the health of low-income Black women compares with the health of the privileged group within that state.

³⁹ F. J. Zimmerman, “A Robust Health Equity Metric,” *Public Health*, Vol. 175, 2019, pp. 68–78.

Zimmerman and Anderson Approach to Evaluating Trends over Time in Health Equity

Overview. This approach by Zimmerman and Anderson⁴⁰ focuses on changes in patterns of health disparities and health equity over a 25-year period at different geographic levels and summarizes that information using a health-related quality of life criterion. In many ways, this is a longitudinal counterpart to the approach described on the previous page. Here, too, the social risk factors encompassed by the method are race and ethnicity, sex, and income.

Background. Health equity is defined across multiple dimensions, including health disparities, or differences in health outcomes among groups; health inequality, or the overall variation in health across individuals without regard to social group; and health justice, or the correlation of health outcomes with social attributes, e.g., economic status.

Design and methods. To build the approach, 25 years of Behavioral Risk Factor Surveillance System data from adults aged 18 to 64 years were used to assess two key outcomes: self-reported general health on a 5-point scale (excellent, very good, good, fair, poor) and *healthy days*, which is the mean number of self-reported healthy days for physical and mental health during the past 30 days. For each of these two outcomes, four different measures of health equity are assessed: (1) *Black-White disparity*: mean difference in the health outcome between White and Black individuals; (2) *income disparity*: mean difference in the health outcome between top, middle, and bottom income categories; (3) *health justice*: variation in health outcome that is not explained by sex, income, or race/ethnicity; and (4) a summary health equity measure that is the mean weighted departure of individual health from best achievable health. The summary health equity measure is the only one of the three that combines information across the self-reported–health and healthy days outcomes. This summary measure is weighted such that larger departures from the best achievable health are weighted more heavily than smaller departures, and best achievable health is defined as the average outcome of the most privileged identifiable group (White men in top income category). Each measure is calculated for the nation overall, as well as for each state and year combination for which data were available. This approach provides information about trends in health equity (across the four dimensions) over time.

⁴⁰ F. J. Zimmerman and N. W. Anderson, “Trends in Health Equity in the United States by Race/Ethnicity, Sex, and Income, 1993–2017,” *JAMA Network Open*, Vol. 2, No. 6, 2019, pp. e196386.

4. Summary of Identified Health Equity Measurement Approaches

Table 4.1 summarizes the ten approaches that were identified. Some of the identified approaches focused primarily on determining which existing quality measures are suitable for health equity comparisons (i.e., permit reliable and valid comparisons among social risk factor groups) or for measuring organizational structures, systems, and processes hypothesized to promote the delivery of high-quality care for all. Other approaches focused primarily on making measure-by-measure comparisons, either making comparisons between providers in how they stack up against a higher-level standard or making comparisons within a provider or other reporting unit. Finally, some of the identified approaches focused on developing a system for combining different dimensions of health equity into a single summary index. Table 4.1 identifies the primary focus of each measure and further characterizes measures within those three primary categories.

The Measurement Framework for Evaluating How Well an Organization Meets National CLAS Standards (HHS OMH) and the NQF Disparities-Sensitive Measure Assessment both identified existing measures of processes for improving health equity, including organizational structures, systems, and processes that are hypothesized to promote the delivery of equitable care. The underlying assumption of these approaches is that such measures provide an assessment of how committed health care organizations are to the goal of providing equitable care and how equipped they are to meet the needs of a culturally and demographically diverse mix of patients. As mentioned above, our literature review identified several other articles and reports that similarly described such measures. Because there was a large degree of overlap among the specific measures identified in these articles and reports, we decided to bring only these two reports to the TEP for their evaluation, in the interest of expediency. The HHS OMH approach was the most recent and comprehensive of the articles and reports that we identified, and the NQF Disparities-Sensitive Measure Assessment identified additional categories of quality measures (e.g., preventive care, processes of care, and health outcome measures) above and beyond what fit under the CLAS rubric (and thus was of additional value).

Two approaches—the AHRQ National Healthcare Quality and Disparities Report and the CMS OMH MMD Tool—focused on making performance comparisons by social risk factor groups within a reporting unit on a measure-by-measure basis. In the case of the AHRQ National Disparities Report, the reporting unit is the nation, and the broad array of measures included access to care, processes of care, outcomes of care, and patient experiences of care (CAHPS). The AHRQ report focuses both on current cross-sectional performance and improvement in performance over time, using both statistical significance and magnitude criteria to identify meaningful differences in care across social risk factor groups. The CMS OMH MMD Tool focuses, one-by-one, on an even broader array of measures, all of which are derived from Medicare claims data and thus pertain to Medicare FFS only. The measures include chronic disease prevalence, health care utilization and spending, mortality rates, and patient safety measures but do not involve tests of statistical significance or magnitude criteria for identifying meaningful differences. The CMS OMH MMD Tool does, however, allow users to view disparities data at more granular levels of geography, including state and county levels.

CMS OMH reports scores from the CAHPS and HEDIS, stratified by race, ethnicity, and gender, and also provides two separate views of this information. One view facilitates comparisons of performance of MA and PDP contracts and states in the quality of care they provide to a particular racial or ethnic group or to rural or urban residents. The other view facilitates comparisons of performance within MA and PDP contracts and states in the quality of care provided to different racial and ethnic groups and in urban versus rural areas. In each case, the focus is on cross-sectional performance, comparisons are made measure-by-measure, and statistical comparisons to the national average for each social risk factor group are provided.

The *Minnesota Healthcare Disparities Report*, issued annually by Minnesota Community Measurement, presents data on a set of clinical process of care measures (HEDIS) stratified by race, ethnicity, preferred language, and country of origin. Stratified data are presented at the state level and at the medical group level. This approach, too, focuses on measure-by-measure comparisons. At the state level, scores for social risk factor groups are compared with each other and to overall statewide averages on each measure. The state-level reporting is similar to one of the options provided by the CMS OMH MMD Tool and to the CMS OMH stratified reporting of Medicare FFS data at the state level. At the medical group level, scores for social risk factor groups are compared with overall statewide averages and state averages specific to the social risk factor group. The medical group-level reporting is similar to the CMS OMH stratified reporting of MA and PDP performance data at the contract level, in that both present between- and within-provider comparisons. However, the data presented by the CMS OMH span the nation, whereas the data presented in the *Minnesota Healthcare Disparities Report* is limited to the state of Minnesota. Like the CMS OMH MMD Tool and the CMS OMH stratified reporting approach, the *Minnesota Healthcare Disparities Report* focuses on cross-sectional performance.

The CMS Assessment of Hospital Disparities for Dual-Eligible Patients focuses on a single social risk indicator, dual-eligibility status, and a single outcome measure, 30-day all-cause unplanned readmission following hospitalization for pneumonia, but the principles of this approach could be applied more broadly. Performance for dual-eligible patients is compared across hospitals using criteria of statistical significance and magnitude of differences. Performance is also compared within hospitals for dual-eligible and non-dual-eligible beneficiaries, again using criteria of statistical significance and magnitude of differences. This approach is one of only three identified approaches that include a magnitude criterion for distinguishing ten levels of performance. The other two approaches that use such a criterion are the *AHRQ National Disparities Report* and the CMS OMH HESS.

The CMS OMH HESS approach identified CAHPS and HEDIS measures suitable for health equity comparisons (based on criteria of reliability and reportability) and uses data on those measures to assess the extent to which care provided through MA contracts was equitable according to race and ethnicity and dual/LIS-eligibility status. This approach compares both cross-sectional performance and improvement in performance for racial and ethnic minority groups and for dual/LIS-eligible beneficiaries across contracts relative to national averages for each group. This approach also compares performance for different racial and ethnic groups and for dual/LIS eligible and noneligible beneficiaries within contracts. The HESS is one of three identified approaches that developed a system for combining different dimensions of health equity into a single equity measure (the other two being the approaches by Zimmerman and by Zimmerman and Anderson, described next). In particular, the HESS combines data across multiple measures, multiple social

risk factors, and across multiple types of comparisons, i.e., both within- and between-provider comparisons and comparisons focused on both cross-sectional performance and improvement in performance. Performance is summarized on a 1-to-5-star scale. A dashboard for presenting HESS data to MA contracts confidentially is under development. On that dashboard, contracts can drill down to see data for each measure and group to pinpoint their areas of strength and weakness.

Like the CMS OMH HESS, the Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity synthesizes information across more than one measure rather than examining the measures individually, as is done, e.g., in the AHRQ and CMS OMH stratified reporting approaches. Zimmerman's approach is oriented toward assessing the total deviation from a defined privileged group (high-income White males) and allows disaggregation from the national level to the level of states and smaller geographic areas. Although this approach—which focuses on cross-sectional performance only—implicitly describes being female, low-income, and non-White as risk factors, it does not allow for making distinctions among these groups, i.e., it treats them collectively as a singular disadvantaged group.

In part, the Zimmerman and Anderson Approach to Evaluating Trends over Time in Health Equity is comparable to the approach taken in the *AHRQ National Disparities Report* to look at trends over time. It uses 25 years of Behavioral Risk Factor Surveillance System data to examine trends in health disparities by race (Black versus White individuals) and income and uses statistical tests of trend information to characterize disparities in self-rated health and healthy days in the past month as either decreasing, increasing, or not changing (no trend identified). The Zimmerman and Anderson approach is also similar to the Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity and the CMS OMH HESS, in that it combines information on multiple measures and summarizes information on equity across social risk factors (race and ethnicity, sex, and income).

Table 4.1. Summary of Identified Approaches to Health Equity Measurement

	Approach (see key below)									
	1	2	3	4	5	6	7	8	9	10
Approach focused primarily on measure identification	x	x								
Identified existing measures of processes for improving health equity	x	x								
Assessed suitability of existing quality measures for health equity comparisons		x			x					
Approach focused primarily on measure-by-measure comparisons			x	x	x	x	x			x
Made between-provider (or other reporting unit) comparisons					x	x	x	x	x	
Made within-provider (or other reporting unit) comparisons			x	x	x	x	x	x		x
Examined cross-sectional (point-in-time) performance			x	x	x	x	x	x	x	
Examined on improvement in performance			x					x		x
Included use of statistical tests of differences			x		x	x	x	x		
Included consideration of magnitude of differences			x				x	x		
Summary indices of health equity								x	x	x
Combined information on multiple measures								x	x	x
Combined information on multiple social risk factors								x	x	x
Combined information on multiple types of comparisons ^a								x		

^a For example, between- and within-unit comparisons or comparisons focused on cross-sectional performance and improvement in performance.

NOTES: **Approach 1** = Measurement Framework for Evaluating How Well an Organization Meets National CLAS Standards (HHS OMH); **Approach 2** = NQF Disparities-Sensitive Measure Assessment; **Approach 3** = AHRQ National Healthcare Quality and Disparities Report; **Approach 4** = CMS OMH Mapping Medicare Disparities Tool; **Approach 5** = CMS OMH Reporting of CAHPS and HEDIS Data by Race/Ethnicity for Medicare Beneficiaries; **Approach 6** = *Minnesota Healthcare Disparities Report*; **Approach 7** = CMS Assessment of Hospital Disparities for Dual-Eligible Patients; **Approach 8** = CMS OMH Health Equity Summary Score; **Approach 9** = Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity; **Approach 10** = Zimmerman and Anderson Approach to Evaluating Trends Over Time in Health Equity.

5. Technical Expert Panel Process and Members

The project team convened a TEP via videoconference to discuss the measurement of health disparities and health equity and incorporation of health equity measures or domains in Medicare VBP and quality reporting programs. RAND researchers constructed an initial list of potential panelists with expertise in social risk factors, health disparities, health equity, risk adjustment, value-based and alternative payment models, and Medicare's VBP programs. This initial list was founded on the team's knowledge of the field and a preliminary review of recent literature on the topics of health disparities and health equity measurement. A final list was constructed in consultation with ASPE. The final list consisted of eight first-choice experts and eight alternates. All eight first-choice experts agreed to participate on the panel. Biographical information about each of the expert panelists is provided in Appendix C.

The project team developed a TEP notebook, which was shared with panelists five days prior to the first of two meetings held eight days apart. The notebook consisted of a TEP charter; biographies of the participating panelists; project background, objectives, and methods used to identify health equity measures and approaches; descriptions of each of the ten approaches to health equity measurement that were identified via the literature review; and preliminary criteria for evaluating those approaches. The team also distributed rating sheets to facilitate the assessment of each approach according to the rating criteria and to solicit additional commentary from the panelists.

During the initial meeting, the TEP was asked to provide feedback on the team's proposed definition of a health equity measure and categorization of features of health equity measures. At that initial meeting, the panel was also tasked with coming to a consensus on a final set of criteria for evaluating the identified approaches to health equity measurement and to begin discussing the identified approaches. Approaches that were not discussed at the initial meeting were discussed at the second meeting. To facilitate the discussion, the team presented an overview of each approach and invited the TEP members to engage in a focused discussion following each overview. Each meeting lasted two hours. A project team member took notes during the discussion, and the meetings were audio recorded for additional notetaking afterward.

The team updated the rating criteria in response to the feedback given during the initial meeting and distributed the revised rating sheet directly following the first meeting. TEP members submitted their ratings for all ten approaches to health equity measurement using the updated rating criteria within ten days of the second meeting. The team drew on the input provided by the TEP via the rating sheets, verbal comments made during the meetings, comments submitted using the teleconferencing platform's chat function, and email messages sent after the meetings to provide the following assessment.

6. TEP Input on Project Framing and Approach

Input on Definition of a Health Equity Measurement Approach

TEP members pointed out that membership in defined “at-risk” groups is often not a direct mechanism for risk of receiving poor quality care but a proxy for more direct risk factors, such as food insecurity and homelessness. The group acknowledged, however, that researchers tend to rely on group membership as a proxy for direct mechanisms when constructing equity measures or assessing disparities because data on direct mechanisms is often unavailable. Moreover, members of some “at-risk” groups—e.g., racial and ethnic minorities—are especially likely to experience discrimination and other inequities based on group membership; in such instances, group membership on its own is a direct mechanism of interest. Nevertheless, the TEP emphasized the importance of encouraging organizations to collect additional data about risk factors rather than relying solely on data about group membership to assess equity and identify targets for improvement.

Relatedly, the TEP counseled that a measure of health equity should not be limited to comparing quality of care provided to groups predetermined to be disadvantaged, e.g., racial and ethnic minority patients to a reference group that is predetermined to be advantaged, e.g., White patients. Keeping with the racial/ethnic example, one issue is that White patients may not be the group for which performance is highest on a measure. Even if White patients are the group for which performance is highest on a measure, they may still be getting suboptimal care. In either case, using care received by White patients as the benchmark for racial and ethnic minority patients would not encourage the highest-quality care possible for racial and ethnic minority patients. Moreover, the practice of defining and comparing to a *reference* group may imply a standard for *nonreference* groups, suggest that those groups are nonnormative, and promote a need for assimilation and acculturation.

Rather than using the quality of care provided to one prespecified group as the benchmark for other groups, the TEP advocated adopting a framework for equity that focuses on making sure that all groups and people are provided with the care and resources they need to achieve optimal health. In practice, this could mean comparing all other groups with the highest-performing group, regardless of whether the highest-performing group is nominally “at risk,” comparing all groups to an overall state or national average, or adopting an approach that focuses on improvement rather than on point-in-time performance for a group. The TEP also emphasized that achieving high-quality care for all groups requires aligning care and resources with patient needs and preferences to optimize their health rather than defining outcomes based on a predetermined reference group that has certain advantages along one or more dimensions. Furthermore, the TEP encouraged adopting a framework for equity that sets a universal target of excellent care for all groups and all people but that recognizes that the best care for a given group or person may require tailoring and customization of care.

This view of health equity as maximizing opportunities for all to be healthy is reflected in the philosophy of the Robert Wood Johnson Foundation’s Health Opportunity and Equity (HOPE)

Initiative.⁴¹ The HOPE Initiative tracks social and economic factors, community and safety factors, physical environment factors, access to health care, and a limited set of health outcomes (infant mortality, low birthweight, premature mortality, and self-rated health) by race and ethnicity and socioeconomic status for tracking progress toward health equity at the state and national level. Although this framework does not fit with the definition of a health equity measurement approach developed for this project, it is one that merits future consideration for its applicability to the assessment of health care organizations.

Input on Premise of the Project

TEP members also felt it was important for the research team to acknowledge that there is currently little empirical evidence that pay-for-performance and quality reporting strategies translate into reduction of disparities. Thus, if CMS were to incorporate one or more of the health equity measurement approaches identified by this project in a VBP or reporting program, it would be important to evaluate the impact on health equity so that this evidence base can be established. TEP members also advised that careful consideration should be given to the way payment is tied to performance on health equity measures. Consistent with our definition of a health equity measurement approach, TEP members felt that payment on the equitable delivery of care should be reserved for the purpose of improving care for at-risk populations and that the number of high-risk patients that an organization serves should be considered as part of any payment scheme, as this partly determines the magnitude of an organization's contribution to health equity nationally.

Input on Evaluation Criteria

The research team developed a preliminary set of criteria for evaluating the health equity measurement approaches identified by the literature review. The TEP provided input on those criteria during the first TEP meeting. The revised set of criteria, which incorporates the TEP's feedback, is shown in Table 6.1.

The criterion that social risk factor groups be measured at the most granular level possible did not appear in the preliminary set developed by the research team. This criterion was discussed in the context of race and ethnicity, with TEP members emphasizing the importance of characterizing the needs of smaller groups when possible and distinguishing the needs of subgroups who are sometimes combined to boost sample sizes, e.g., Asians and Pacific Islanders. TEP members acknowledged that most organizations are unlikely to have the sample sizes required for stable, meaningful measurement of small groups but that developers of health equity measurement approaches should at least attempt measurement of care for small groups (perhaps by pooling data across years or reporting units) and report on any trade-offs involved in doing so. The TEP also emphasized the importance of having accurate data on patient race and ethnicity. Self-report is the gold standard for collecting data on race and ethnicity,⁴² but the process for eliciting information

⁴¹ Robert Wood Johnson Foundation, "Measures to Advance Health and Opportunity," HOPE Initiative homepage, undated. As of January 7, 2021: <https://www.hopeinitiative.org/>

⁴² D. J. Klein, M. N. Elliott, A. M. Haviland, P. A. Morrison, N. Orr, S. Gaillot, and R. Weech-Maldonado, "A Comparison of Methods for Classifying and Modeling Respondents Who Endorse Multiple Racial/Ethnic Categories," *Medical Care*, Vol. 57, 2019, pp. e34–e41.

about race and ethnicity in a way that best captures how Medicare beneficiaries identify themselves has evolved over time and will require continued attention to keep pace with demographic and cultural trends in the United States.⁴³ Another criterion that did not appear in the preliminary set is the one pertaining to the likely impact of adopting an approach into a Medicare VBP or reporting program on how equitably organizations provide care to their patients. The TEP felt that it was important to add such an overall evaluation of whether implementing an approach in its currently specified form would help achieve the goal of health equity.

⁴³ U.S. Census Bureau, “Research to Improve Data on Race and Ethnicity,” webpage, U.S. Department of Commerce, 2017. As of January 7, 2021: <https://www.census.gov/about/our-research/race-ethnicity.html>

List 6.1. Revised Criteria for Evaluating Health Equity Measurement Approaches

Evidence-based

Is the approach based on available evidence of the relationship between the social risk factor and outcome?

Usability

Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?

Does the approach guard against unintended consequences of worsening quality or access or disincentivizing resources for any beneficiaries?

Measurement Equivalence

Is the approach appropriate for use with all social risk factor groups, or is it applicable only to certain groups?

Breadth of Applicability

Is the approach suitable only to a specific VBP or quality reporting program, or can it be more to multiple providers and settings?

Reliability

Is the approach able to distinguish performance between providers/programs?

Does the approach capture granular subgroups where possible while limiting the influence of imprecise estimates?

Impact

How likely is it that incorporating this measure or approach in a VBP or quality reporting program would result in a noticeable improvement in health equity?

7. Detailed Assessment of Identified Approaches

Measurement Framework for Evaluating How Well an Organization Meets National CLAS Standards

TEP members' ratings of this approach are shown in Table 7.1. A majority of members (five) fully agreed that this approach is evidence-based, and all either fully or partially agreed that the approach is designed to incentivize achievement or improvement for at-risk beneficiaries. Members were divided in their assessment of whether the approach guards against unintended consequences of worsening access or resources for at-risk beneficiaries and whether the approach is able to reliably distinguish performance among providers; in each case, four members said that the approach either fully or partially meets the criterion, three said that there is not enough information to tell, and one member said that the approach does not meet the criterion. Most members (five) said that the approach is applicable to particular groups, several specifically highlighting applicability to people with limited English proficiency and racial and ethnic minority groups. Four of seven members⁴⁴ said that the approach is applicable to multiple VBP or reporting programs. A majority of members (five) felt that incorporation of the approach in a VBP or reporting program would somewhat or very likely result in a noticeable improvement in health equity.

In discussing this approach, TEP members pointed out that much is still unknown about the structures, processes, and systems that are necessary to foster health equity. One member referenced a study by Blustein and colleagues⁴⁵ that demonstrated that a hospital could perform well on structural measures thought to facilitate high-quality care for racial and ethnic minority patients but not make a significant contribution to reducing racial and ethnic disparities in hospital care. Given such findings, TEP members felt that further evidence of the direct impact of constructs included in the National CLAS Standards on health equity would be needed before they could confidently say that incorporation of this approach into a VBP or reporting program would have the desired impact on health equity.

TEP members felt that some of the cross-cutting measures identified by Davis and colleagues would be more likely to foster health equity than others if tied to an incentive scheme. For example, one member mentioned that the CAHPS Cultural Competence Item Set, the CAHPS Item Set for Addressing Health Literacy, and a measure of the percentage of patients with limited English proficiency who get appropriate linguistic support are valuable in that they measure the desired outcome—provision of culturally and linguistically appropriate services—directly. On the contrary, some members felt that process measures, such as screening for and recording cultural and language issues, are less useful in that the absence of such documentation does not mean that

⁴⁴ One member did not complete this rating for this measurement approach. Two members did not complete the rating of whether this approach captures granular subgroups where possible. Otherwise, all eight members completed every rating for every approach.

⁴⁵ J. Blustein, J. S. Weissman, A. M. Ryan, T. Doran, and R. Hasnain-Wynia, "Performance in Medicaid Can Efficiently Reduce Racial and Ethnic Disparities," *Health Affairs*, Vol. 30, No. 6, 2011, pp. 1165–1175.

services were not provided, and the presence of such documentation does not necessarily mean that patients got more appropriate care. This is not to say that these measures are not valuable, just that they should not be used as proxies for the quality of care that is delivered.

Another disadvantage of this approach identified by one TEP member is that it does not recognize or reward the ability of an organization to address patient needs by financial situation or, more generally, by social class. Finally, one member felt that collection of the data needed for this approach would be “exceedingly burdensome” for organizations, particularly given that the impact of assessing adherence to CLAS standards is still largely unknown.

Table 7.1. TEP Ratings of Measurement Framework for Evaluating How Well an Organization Meets National CLAS Standards

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	5	2		1
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	3	5		
Does the approach guard against unintended consequences for at-risk beneficiaries?	2	2	1	4
Is the approach able to reliably distinguish performance between providers?	2	2	1	3
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine
Is the approach appropriate for use with all social risk factor groups?		5	2	1
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine
Is the approach applicable only to a specific VBP or reporting program, or can it be applied more broadly?		4		3
		Yes	No	Not Enough Information to Determine
Does the approach capture granular subgroups where possible?			1	5
	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?	1	4	1	2

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

NQF Disparities-Sensitive Measure Assessment

TEP members' ratings of this approach are shown in Table 7.2. Nearly all members (seven) fully agreed that this approach is evidence-based, and nearly all (seven) either fully or partially agreed that the approach is designed to incentivize achievement or improvement for at-risk beneficiaries. Members were divided in their assessment of whether the approach guards against unintended consequences of worsening access or resources for at-risk beneficiaries, with four members saying that there is not enough information to tell, and four saying that the approach either fully or partially fulfills this criterion. A majority of members (five) fully or partially agreed that the approach is able to reliably distinguish performance among providers. A majority (five) also said the approach is applicable to particular groups, sometimes noting a particular focus on racial and ethnic minority groups, and that the approach is applicable to multiple VBP or reporting programs. Nearly all members (seven) felt that incorporation of the approach in a VBP or reporting program would somewhat or very likely result in a noticeable improvement in health equity.

In commenting on this approach, most TEP members felt that its principal advantage is in the way that it formally and rigorously vetted a large group of measures for possible inclusion in a stratified reporting scheme or other approach to health equity measurement. Many also emphasized the advantage of the measures being NQF-endorsed, and several highlighted that some of the measures are based on claims data, which alleviates data collection burden. Most members commented that the usability, applicability, and reliability of the approach would depend on how the disparities-sensitive measures were used in a health equity metric or reporting program. Even so, nearly all felt that incorporating measures determined to be disparities-sensitive into a more complete approach to health equity measurement could have a noticeable impact on health equity, particularly if rewards are focused on improvements for at-risk populations toward feasible and desired benchmarks.

Table 7.2. TEP Ratings of NQF Disparities-Sensitive Measure Assessment

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	7	1		
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	4	3		1
Does the approach guard against unintended consequences for at-risk beneficiaries?	2	2		4
Is the approach able to reliably distinguish performance between providers?	4	1	1	1
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine
Is the approach appropriate for use with all social risk factor groups?		5	3	
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine
Is the approach applicable only to a specific VBP or reporting program, or can it be applied more broadly?		5		3
		Yes	No	Not Enough Information to Determine
Does the approach capture granular subgroups where possible?		4	1	1
	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?	1	6	1	

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

AHRQ National Healthcare Quality and Disparities Report

TEP members' ratings of this approach are shown in Table 7.3. Nearly all members (seven) fully agreed that this approach is evidence-based, but there was considerable uncertainty about whether the approach is designed to incentivize achievement or improvement for at-risk beneficiaries. There was also considerable uncertainty about whether the approach guards against unintended consequences of worsening access or resources for at-risk beneficiaries, with five members saying that there is not enough information to tell and two saying that the approach does not meet this criterion. Only two members fully or partially agreed that the approach is able to reliably distinguish performance among providers—one member commented that there is likely too little data to make this approach feasible at the level of individual providers—but a majority (five) said the approach is applicable to all social risk factor groups. Six members said that the applicability to VBP or reporting programs is uncertain. Members were divided about whether incorporation of the approach in a VBP or reporting program would result in a noticeable improvement in health equity; five said that such an outcome would be somewhat likely, one said that it would be somewhat unlikely, and two said that it would be very unlikely.

Some TEP members commented that the major limitation of this approach is the heterogeneity of the measures included and their selection based on availability in federal data sets. It was noted that some of the measures are relevant only at the population level but that many are applicable to hospitals, plans, and other health care organizations, and thus are potentially useful for one or more Medicare VBP and quality reporting programs. However, the majority opinion was that additional work would be needed to determine exactly how this approach could be operationalized at these finer levels of analysis. One member commented that although the analytic methods are robust, the approach does not appear applicable to the task of comparing provider performance or showing providers their performance relative to peers or benchmarks. Several members questioned the appropriateness of comparing groups of patients to predefined reference groups and pointed out that catching disadvantaged patients up to a predefined reference group is only a small part of achieving health equity. One member expressed a strong preference for an approach that rewards any meaningful improvement for a high-risk group, stating that, absent such a criterion, providers could be rewarded for providing substandard care to all groups equally or worsening care for leading groups. Some also expressed concerns about the degree of risk adjustment involved in this approach, with a couple commenting that some measures used in this approach could be heavily influenced by social factors for which adjustments are not currently being made.

Table 7.3. TEP Ratings of AHRQ National Healthcare Quality and Disparities Report

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	7	1		
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	2	2	2	2
Does the approach guard against unintended consequences for at-risk beneficiaries?	1		2	5
Is the approach able to reliably distinguish performance between providers?	1	1	3	3
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine
Is the approach appropriate for use with all social risk factor groups?		2	5	1
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine
Is the approach applicable only to a specific VBP or reporting program, or can it be applied more broadly?		2		6
		Yes	No	Not Enough Information to Determine
Does the approach capture granular subgroups where possible?		5	1	2
	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?		5	1	2

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

CMS OMH Mapping Medicare Disparities Tool

TEP members' ratings of this approach are shown in Table 7.4. A majority of members (five) fully agreed that this approach is evidence-based, but there was considerable uncertainty about whether the approach is designed to incentivize achievement or improvement for at-risk beneficiaries, with three members saying that the approach does not meet this criterion. There was also considerable uncertainty about whether the approach guards against unintended consequences of worsening access or resources for at-risk beneficiaries, with three saying that the approach does not meet this criterion, two saying that it partially meets this criterion, and three saying that there is not enough information to tell. A majority of members (five) said that the approach is unable to reliably distinguish performance among providers. Most members (five) saw the approach as being applicable to particular social risk factor groups, but some (three members) saw it as more broadly applicable. Members were divided in their opinion of the applicability to VBP or reporting programs, with three saying that it is applicable to multiple programs, three saying that there is not enough information to decide, and two saying that it is applicable to one program only (without specifying which program). Six members said that this approach would be either somewhat or very unlikely to result in a noticeable improvement in health equity if incorporated into a VBP or reporting program.

Several TEP members commented that this approach is not likely to incentivize achievement or improvement for at-risk beneficiaries as it is currently designed, citing both its descriptive purpose (i.e., lack of statistical comparisons) and focus on comparing performance across geographic areas rather than providers. The majority opinion was that significant work would need to be done to convert the approach into an equity quality metric and that issues of risk adjustment (beyond age), sample size, and ability to reliably discriminate performance across providers would need to be addressed. One member commented that exclusion of the MA population, due to lack of necessary data, is a significant limitation of the tool. During the discussion, it was noted that CMS is considering incorporating other programs' data sources into the MMD Tool, which would increase the scope but not address the main limitations of the tool as seen by the TEP.

Table 7.4. TEP Ratings of CMS OMH Mapping Medicare Disparities Tool

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	5	2		1
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	1	3	3	1
Does the approach guard against unintended consequences for at-risk beneficiaries?		2	3	3
Is the approach able to reliably distinguish performance between providers?	1	1	5	1
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine
Is the approach appropriate for use with all social risk factor groups?		5	3	
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine
Is the approach applicable only to a specific VBP or reporting program or can it be applied more broadly?		3	2	3
		Yes	No	Not Enough Information to Determine
Does the approach capture granular subgroups where possible?		2	3	3
	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?		2	3	3

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

CMS OMH Reporting of CAHPS and HEDIS Data, Stratified by Race and Ethnicity, for Medicare Beneficiaries

TEP members' ratings of this approach are shown in Table 7.5. Six members fully agreed that this approach is evidence-based, while two said that it partially meets this criterion. Nearly all (seven) either fully or partially agreed that the approach is designed to incentivize achievement or improvement for at-risk beneficiaries. There was, however, considerable uncertainty about whether the approach guards against unintended consequences of worsening access or resources for at-risk beneficiaries, with four members saying that there is not enough information to decide and two saying that the approach does not meet this criterion. Six members either fully or partially agreed that the approach is able to reliably distinguish performance among providers. Four members said the approach is applicable to all social risk factor groups, and half said it is applicable to particular groups. Six members said that the approach is applicable to multiple VBP or reporting programs, while two said that there is not enough information to decide. A majority of members (five) said that this approach would be either somewhat or very likely to result in a noticeable improvement in health equity if incorporated into a VBP or reporting program, but two members said that it would be very unlikely to have such an effect.

One TEP member commented that this was among the stronger approaches in the set identified, and another said that this was the most robust approach in attending to adequacy of sample size and reliability of scores for making between-provider comparisons. One member commented that, in its current form, this approach is best suited for incentivizing improvement via public reporting (its current use) and that additional risk adjustment might be needed before payment could be fairly tied to performance. A couple of members pointed out that some of the measures used in this approach are collected via survey and mentioned that there are limitations to this mode of data collection, e.g., low response rates and sample sizes and the possibility of recall bias. Relatedly, a couple of members suggested that this approach could be improved by incorporating outcome measures, e.g., by supplementing the current set of measures with encounter data. Several members observed that many MA and PDP contracts are unmeasurable for at least some racial and ethnic minority groups and measures. One member suggested that more years of data could be pooled to gain insight into performance for smaller populations, such as American Indians and Alaska Natives and Asian and Latino subgroups.

Table 7.5. TEP Ratings of CMS OMH Reporting of CAHPS and HEDIS Data Stratified by Race and Ethnicity for Medicare Beneficiaries

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	6	2		
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	4	3		1
Does the approach guard against unintended consequences for at-risk beneficiaries?		2	2	4
Is the approach able to reliably distinguish performance between providers?	4	2	1	1
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine
Is the approach appropriate for use with all social risk factor groups?		4	4	
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine
Is the approach applicable only to a specific VBP or reporting program, or can it be applied more broadly?		6		2
		Yes	No	Not Enough Information to Determine
Does the approach capture granular subgroups where possible?		3	3	2
	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?	1	4	1	2

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

Minnesota Healthcare Disparities Report

TEP members' ratings of this approach are shown in Table 7.6. Six members fully agreed that this approach is evidence-based, while two said that it partially meets this criterion. Nearly all (seven) fully agreed that the approach is designed to incentivize achievement or improvement for at-risk beneficiaries. A majority (five) felt that there was not enough information to determine whether the approach guards against unintended consequences of worsening access or resources for at-risk beneficiaries, though three members said that the approach either fully or partially meets this criterion. Six members either fully or partially agreed that the approach is able to reliably distinguish performance among providers. A majority of members (five) said the approach is applicable to particular social risk factor groups, and the remainder said it is applicable to all groups. Nearly all (seven) said that the approach is applicable to multiple VBP or reporting programs. All members said that this approach would be either somewhat or very likely to result in a noticeable improvement in health equity if incorporated into a VBP or reporting program.

Several members commented that this approach uses a thoughtfully chosen group of measures focused on processes and outcomes of care for specific, common conditions. One member highlighted the focus on disparities by language and country of origin as a particularly strong feature. Two members commented that some of the measures could be strongly influenced by social determinants of health and that there should be further consideration given to risk adjustment; although this concern was raised in the context of this approach, it may be applicable to other approaches involving similar measures. Three members expressed concern that insufficient attention had been given to the sample size required for reliable provider-based measurement and that each measure should have undergone testing to determine the sample size needed for reliability of 0.70 or higher. Most members, though, felt that this approach was a strong building block for a more broadly applicable approach, with one member commenting specifically about the benefit of anchoring disparities to the overall state average rather than the performance of a predetermined group.

Table 7.6. TEP Ratings of Minnesota Healthcare Disparities Report

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	6	2		
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	7	1		
Does the approach guard against unintended consequences for at-risk beneficiaries?	1	2		5
Is the approach able to reliably distinguish performance between providers?	1	5	1	1
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine
Is the approach appropriate for use with all social risk factor groups?		5	3	
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine
Is the approach applicable only to a specific VBP or reporting program, or can it be applied more broadly?		7		1
		Yes	No	Not Enough Information to Determine
Does the approach capture granular subgroups where possible?		3	1	4
	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?	1	7		

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

CMS Assessment of Hospital Disparities for Dual-Eligible Patients

TEP members' ratings of this approach are shown in Table 7.7. All members either fully or partially agreed that this approach is evidence-based and that it is designed to incentivize achievement or improvement for at-risk beneficiaries. Members were divided about whether the approach guards against unintended consequences of worsening access or resources for at-risk beneficiaries, with four saying that it fully or partially meets this criterion, two saying that it does not meet this criterion, and two saying that there is not enough information to judge. Nearly all (seven) either fully or partially agreed that the approach is able to reliably distinguish performance among providers. Four members said the approach is applicable to all social risk factor groups, while three said it is applicable to particular groups (citing dual-eligible beneficiaries as the applicable group). Four members felt that the approach is applicable to multiple VBP or reporting programs, while three members felt that it was applicable to one program only. Members were divided in their judgment of the likelihood that this approach would result in a noticeable improvement in health equity if incorporated into a VBP or reporting program: One member said that such a result is very likely, four said somewhat likely, and three said somewhat unlikely.

A couple of TEP members commented about the narrowness of this assessment, but both conceded that the approach seems broadly applicable to social risk factor groups and measures and so could be extended in those ways to increase impact. It was also noted that the within-hospital component of this approach does not distinguish the direction of differences. This could create a scenario in which worsening care for dual-eligible patients (or other at-risk patients if this approach were to be extended to other groups) results in a higher score on the measure (and an incentive if the approach were linked to an incentive scheme). A couple of TEP members also commented that there is insufficient evidence that having just 12 patients in each group for a within-plan comparison can result in a meaningfully informative estimate. One member commented that with such small samples, even large inequities are likely to lead to a null finding, which is potentially misleading. Finally, almost all TEP members preferred an approach in which additional casemix adjustment for contextual factors such as housing and food instability were incorporated.

Table 7.7. TEP Ratings of CMS Assessment of Hospital Disparities for Dual-Eligible Patients

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine	
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	6	2			
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	5	3			
Does the approach guard against unintended consequences for at-risk beneficiaries?	3	1	2	2	
Is the approach able to reliably distinguish performance between providers?	1	6		1	
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine	
Is the approach appropriate for use with all social risk factor groups?		3	4	1	
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine	
Is the approach applicable only to a specific VBP or reporting program, or can it be applied more broadly?		4	3	1	
		Yes	No	Not Enough Information to Determine	
Does the approach capture granular subgroups where possible?		1	3	4	
		Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?	1	4	3		

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

CMS OMH Health Equity Summary Score

TEP members' ratings of this approach are shown in Table 7.8. Nearly all members (seven) fully agreed that this approach is evidence-based and that it is designed to incentivize achievement or improvement for at-risk beneficiaries. Nearly all (seven) either fully or partially agreed that the approach guards against unintended consequences of worsening access or resources for at-risk beneficiaries, with one member specifically commenting that the HESS is built to incentivize rather than penalize providers. Again, nearly all members (seven) fully agreed that the approach is able to reliably distinguish performance among providers. Four members said the approach is applicable to particular social risk factor groups, and four said it is applicable to all groups, with one member commenting that the HESS was explicitly designed to be able to add other social risk factors as more information about their relationship to quality becomes available. Nearly all members (seven) said that the approach is applicable to multiple VBP or reporting programs. All members said that this approach would be either somewhat or very likely to result in a noticeable improvement in health equity if incorporated into a VBP or reporting program.

Two members commented that, unlike other measures, the HESS is precisely suited for inclusion in VBP programs, increasing the likelihood that it would have an impact on equity. Three members specifically commented that it is among the better approaches identified, particularly given its joint consideration of cross-sectional performance and improvement in performance. One member highlighted its focus on patient experience and clinical quality measures as a positive feature, another highlighted its careful attention to reliability and the sample size required to achieve it (though one member commented that the strict reliability standards might not allow for including small subgroups in reporting), and yet another commented that data collection burden is not an issue because this is a secondary use of the data summarized by the metric. The consensus opinion was that this is a sound summary measure of health equity that produces information that is actionable and important.

Table 7.8. TEP Ratings of CMS OMH Health Equity Summary Score

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine	
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	7	1			
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	7	1			
Does the approach guard against unintended consequences for at-risk beneficiaries?	3	4		1	
Is the approach able to reliably distinguish performance between providers?	7	1			
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine	
Is the approach appropriate for use with all social risk factor groups?		4	4		
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine	
Is the approach applicable only to a specific VBP or reporting program, or can it be applied more broadly?		7		1	
		Yes	No	Not enough information to determine	
Does the approach capture granular subgroups where possible?		3	2	3	
		Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?	2	6			

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity

TEP members' ratings of this approach are shown in Table 7.9. All members either fully or partially agreed that this approach is evidence-based. Members were divided about whether the approach is designed to incentivize achievement or improvement for at-risk beneficiaries, with four saying that it fully or partially meets this criterion, two saying that it does not meet this criterion, and two saying that there is not enough information to judge. Four members said that this approach does not guard against unintended consequences of worsening access or resources for at-risk beneficiaries, and three said that there is not enough information to make this determination. Four members said that the approach is not able to reliably distinguish performance among providers, and two said that there is not enough information to make this determination. A majority of members (five) said the approach is applicable to all social risk factor groups, while two said it is applicable to particular groups. Though two members said that the approach is applicable to multiple VBP or reporting programs, six said there was not enough information to make this determination. A majority of members (five) said that it was somewhat or very unlikely that this approach would result in a noticeable improvement in health equity if incorporated into a VBP or reporting program.

The consensus opinion was that this is an interesting approach for describing full population equity issues, but a lot of work would be required to adapt this approach for incorporation into a VBP or quality reporting program, and there are potential barriers to making such an adaptation. Several members raised concerns about the measures that are summarized by this approach, citing evidence that different racial and ethnic groups use the self-rated health scale differently and that some minority groups have lower expectations about overall health. Members also raised concerns about the use of White men as the reference group. Although White men are a standard for privilege, they do not represent optimal health on many measures. Using White men as the reference group for calculating this measure thus sets a low bar for assessing equity. A couple of TEP members pointed out that the approach depends on collecting or having available the Behavioral Risk Factor Surveillance Survey measures on which the measure is based and that there would be significant logistical challenges to ensuring consistent data quality and completeness if one were to collect these data from patients or plan members. A couple of members also commented that the required sample size for making accurate comparisons using this approach is unknown, as is the time frame in which one might expect meaningful changes in this score as a result of organizational changes. Finally, one member pointed out that there is a potentially serious patient-mix issue to address, in that an organization could score well on this metric simply by serving a large proportion of patients who are counted among the disadvantaged but for whom disparities relative to high-income White males are small.

Table 7.9. TEP Ratings of Zimmerman Health-Related Quality of Life Approach to Assessing Health Equity

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	6	2		
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	2	2	2	2
Does the approach guard against unintended consequences for at-risk beneficiaries?	1		4	3
Is the approach able to reliably distinguish performance between providers?	2		4	2
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine
Is the approach appropriate for use with all social risk factor groups?		2	5	1
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine
Is the approach applicable only to a specific VBP or reporting program, or can it be applied more broadly?		2		6
		Yes	No	Not Enough Information to Determine
Does the approach capture granular subgroups where possible?		3	2	3
	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?	1	2	3	2

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

Zimmerman and Anderson Approach to Evaluating Trends over Time in Health Equity

TEP members' ratings of this approach are shown in Table 7.10. All members either fully or partially agreed that this approach is evidence-based. Members were divided about whether the approach is designed to incentivize achievement or improvement for at-risk beneficiaries, with four saying that it fully or partially meets this criterion, two saying that it does not meet this criterion, and two saying that there is not enough information to judge. Four members said that there was not enough information to determine whether this approach guards against unintended consequences of worsening access or resources for at-risk beneficiaries, and two said that the approach does not satisfy this criterion. The majority of members (five) said either that the approach is unable to distinguish performance among providers or that there is not enough information to tell. Members were divided about the applicability of this approach to different social risk factor groups, with two saying that it is appropriate for particular groups, three saying that it is appropriate to all groups, and three saying that there is not enough information to tell. Though two members said that the approach is applicable to multiple VBP or reporting programs, six said there was not enough information to make this determination. A majority of members (five) said that it was somewhat or very unlikely that this approach would result in a noticeable improvement in health equity if incorporated into a VBP or reporting program.

All of the same critiques that were applied to the Zimmerman (2019) approach were raised about this approach. One member commented that the focus on change over time is advantageous in that it provides potential to reward an organization for improving the health of a currently disadvantaged group. One member commented that the distinction made between health disparities, inequality, and justice is unusual and unhelpful, while another commented that a measure that simply compares care for Black and White patients is limited in that it pegs the care of Black patients to that of White patients.

Table 7.10. TEP Ratings of Zimmerman and Anderson Approach to Evaluating Trends over Time in Health Equity

Criterion	Meets Criterion	Partially Meets Criterion	Does Not Meet Criterion	Not Enough Information to Determine
Is the approach based on available evidence of the relationship between the social risk factor and outcome?	5	3		
Is the approach designed to incentivize achievement or improvement for at-risk beneficiaries?	2	2	2	2
Does the approach guard against unintended consequences for at-risk beneficiaries?	1	1	2	4
Is the approach able to reliably distinguish performance between providers?	1	1	3	3
		Appropriate for Particular Groups	Appropriate for All Groups	Not Enough Information to Determine
Is the approach appropriate for use with all social risk factor groups?		2	3	3
		Applicable to Multiple Programs	Applicable to One Program Only	Not Enough Information to Determine
Is the approach applicable only to a specific VBP or reporting program, or can it be applied more broadly?		2		6
		Yes	No	Not Enough Information to Determine
Does the approach capture granular subgroups where possible?		1	3	4
	Very Likely	Somewhat Likely	Somewhat Unlikely	Very Unlikely
How likely is it that incorporating this approach into a VBP or reporting program would result in a noticeable improvement in health equity?	1	2	2	3

NOTE: Values are the number of experts who gave a particular rating. Model response is shown in bold.

8. Summary and Key Takeaways

Summary

The objectives of this project were to search for existing health equity measurement approaches and consider their suitability for inclusion in Medicare's VBP programs, quality reporting efforts, and confidential reports as a way to incentivize health equity. A formal **definition of a health equity measurement approach** was developed to guide the search: an approach to illustrating or summarizing the extent to which the quality of health care provided by an organization contributes to reducing disparities in health and health care at the population level for those patients with greater social risk factor burden by improving the care and health of those patients.

Ten such approaches were identified and evaluated by a panel of experts on social risk factors, health disparities, health equity, risk adjustment, value-based and alternative payment models, and Medicare's VBP programs. These ten approaches, which generated varying levels of enthusiasm among the panel, fit within **three broad categories of approaches**: (1) approaches focused on determining which existing quality measures are suitable for health equity comparisons (i.e., permit reliable and valid comparisons among social risk factor groups) or for measuring organizational structures, systems, and processes hypothesized to promote the delivery of high-quality care for all; (2) approaches that engaged in particular kinds of comparisons of measures (not necessarily statistical comparisons), on a measure-by-measure basis, between groups of patients with greater versus lesser social risk factor burden; and (3) approaches that developed a system for combining different dimensions of health equity into a single summary index.

This project also identified a set of guidelines for health equity measurement. A health equity measurement approach should, ideally,

- be based on measures on which disparities in care are known to exist for certain populations or that address health care disparities and culturally appropriate care
- reflect available evidence bearing on the relationship between a social risk factor and health or health care outcome
- be designed to incentivize achievement or improvement for at-risk beneficiaries, including having a valid and appropriate benchmark and/or reference group if comparisons to benchmarks and/or reference groups are made
- include design features that guard against unintended consequences of worsening quality or access or disincentivizing resources for any beneficiaries, including the at-risk beneficiaries who are the focus of health equity measurement
- establish measurability requirements that ensure the ability to make reliable distinctions between health care providers in their performance in the domain of health equity
- capture information about small subgroups, where possible, while limiting the influence of imprecise estimates of provider performance.

In the case of a summary index, the measure should also

- summarize information in a way that is psychometrically sound
- allow for disaggregation of information to permit easy identification of quality improvement targets.

Key Takeaways

The ten approaches that the TEP evaluated were judged to meet these requirements to widely varying degrees. Of approaches focused on measure identification (Category 1), the **NQF Disparities-Sensitive Measure Assessment** was viewed most favorably by the TEP. Using a set of carefully established criteria and an easy-to-understand point system, this approach identified 32 NQF-endorsed measures as disparities-sensitive. Although considerable work would be needed to determine whether and how these measures could be linked to social risk data and whether and how valid comparisons could be made, this approach was viewed as a valuable initial step toward measuring health equity and disparities in health care quality. It is potentially applicable to any Medicare VBP or quality reporting program that collects one or more of the 32 disparities-sensitive measures. Furthermore, there may be the potential to enhance the favored approaches to be described next by incorporating one or more of the disparities-sensitive measures identified by this NQF approach.

Of approaches focused on measure-by-measure comparisons (Category 2), **the approach underlying the *Minnesota Healthcare Disparities Report*** was judged most favorably by the TEP. The perceived advantages of this approach include its thoughtfully chosen group of measures, incorporation of multiple important social risk factors, ability to reliably distinguish performance among providers, clear focus on incentivizing achievement for at-risk beneficiaries, and choice to anchor disparities to the overall state average rather than the performance of a predetermined group. Although some additional work would be needed to transfer this approach to a broader setting, including making careful considerations about sample sizes required for accurate comparisons and determining the availability of data on social risk factors, the method itself is readily applicable to all Medicare VBP and quality reporting programs.

Of approaches focused on summary indices (Category 3), the **CMS OMH HESS** was judged most favorably by the TEP. The perceived advantages of this approach include its joint consideration of cross-sectional performance and improvement in performance, focus on patient experience and clinical quality, careful attention to reliability and the sample size required to achieve it, direct applicability to certain VBP and quality reporting programs, and transferability to other programs. CMS OMH has designed a dashboard to provide confidential HESS data to MA contracts, though that dashboard has not yet been fully implemented. Scores on this metric could easily be incorporated into the Medicare Plan Finder and the MA Quality Star Ratings Program if doing so aligned with CMS's strategic priorities. This approach also could easily be extended to other social risk factors and measures, and there are plans to test the feasibility of extending this approach to settings beyond MA.

Of the ten approaches evaluated, the HESS received the highest ratings from the TEP overall. Given the high ratings it received, the HESS may be closest to meeting the full scope of goals outlined by ASPE for incorporating a measure of health equity into a Medicare VBP or quality reporting program. If HHS were to move forward with this approach, it could consider possible refinements to the approach based on the practices established by the NQF Disparities-Sensitive Measure Assessment and the *Minnesota Healthcare Disparities Report* and the guidelines for health equity measurement outlined by the TEP. Several of the measures that are included in the HESS are among the 76 measures identified as disparities-sensitive by NQF. It might be possible to include in the HESS additional measures from the set identified by NQF, provided that the measures are collected for MA plans and meet the reliability and sample size requirements established for the HESS. The

analyses that underlie the *Minnesota Disparities Report* are similar to the analyses that underlie the cross-sectional component of the HESS. In the Minnesota Healthcare Disparities Report, plan performance by patients' preferred language and country of origin are considered in addition to race and ethnicity. Information on country of origin is not available for Medicare Advantage beneficiaries, but information about Spanish preference is available. Thus, Spanish preference could be considered as a possible third social risk factor for the HESS.

Appendix A. Ambulatory, Hospital, Behavioral Health, and Public Health Measures Identified as Part of the Measurement Framework for Evaluating How Well an Organization Meets National CLAS Standards (HHS OMH)

Ambulatory Care Measures

CAHPS Cultural Competence Item Set

CAHPS Clinician/Group Survey

Disparities-Sensitive or CLAS-Salient Measures

Controlling High Blood Pressure

Hemoglobin A1c Poor Control

Uncontrolled Diabetes Admission Rate

Diabetes Short-Term Complications Admission Rate

Hospital Measures

Hospital CAHPS Survey

Hospital CAHPS Survey Health Literacy Item Set

Cultural Competency Assessment Tool for Hospitals

Joint Commission Standards for Hospital Accreditation and Elements of Performance

Joint Commission 2016 Measure List for Accreditation Chart-Abstracted Process Measures

Disparities-Sensitive or CLAS-Salient Measures

30-Day, All-Cause, Risk-Standardized Readmission Rate Following Pneumonia Hospitalization

Median Time to ECG for Acute Myocardial Infarction or Chest Pain Patients

30-Day, All-Cause, Risk-Standardized Readmission Rate Following Coronary Artery Bypass Graft Surgery

Risk-Adjusted Deep Sternal Wound Infection

Behavioral Health Measures

Experience of Care and Health Outcomes (ECHO) Survey

Disparities-Sensitive or CLAS-Salient Measures

Alcohol Screening and Follow-Up for People With Serious Mental Illness

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Antidepressant Medication Management

30-Day All-cause Unplanned Readmission Following Psychiatric Hospitalization In An Inpatient Psychiatric Facility

Public Health Measures

Developing a Self-Assessment Tool for CLAS in Local Public Health Agencies

CAHPS Clinician/Group Survey

Disparities-Sensitive or CLAS-Salient Measures

Flu Vaccinations for Adults Ages 18 and Older

Asthma Emergency Department Visits

Depression Screening, Adolescents 18 Years of Age

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Appendix B. Measures Identified as Disparities-Sensitive According to the NQF Disparities-Sensitive Measure Assessment

Measures Identified Through First-Tier Review

Perinatal Care

Exclusive Breast Milk Feeding

Cesarean Section

Pediatric Care

Developmental Screening by 2 Years of Age

Children Who Received Preventive Dental Care

Children Who Receive Family-Centered Care

Children Who Receive Effective Care Coordination of Healthcare Services When Needed

Children With Special Health Care Needs Who Receive Services Needed for Transition to Adult Care

Children With Inconsistent Health Insurance Coverage in the Past 12 Months

Children Who Have Inadequate Insurance Coverage for Optimal Health

Children Who Attend Schools Perceived as Safe

Children Who Live in Communities Perceived as Safe

Utilization/Appropriateness of Use

Relative Resource Use for People with Asthma

Relative Resource Use for People with COPD

Relative Resource Use for People with Diabetes

Relative Resource Use for People with Cardiovascular Conditions

Asthma Emergency Department Visits

Prostate Cancer: Avoidance of Overuse Measure—Bone Scan for Staging Low-Risk Patients

Screening and Prevention

Cervical Cancer Screening

Preventive Care and Screening: Body Mass Index Screening and Follow-Up

Depression Screening by 13 Years of Age

Depression Screening by 18 Years of Age

Pneumonia Vaccination Status for Older Adults

Pneumococcal Immunization (PPV 23)

High Risk for Pneumococcal Disease—Pneumococcal Vaccination

Pneumococcal Vaccination of Nursing Home/Skilled Nursing Facility Residents
Pneumococcal Polysaccharide Vaccine Ever Received (Home Health)
Influenza Immunization: Outpatient
Influenza Immunization: Inpatient
Flu Shots for Adults Ages 50 and Over
Influenza Vaccination of Nursing Home/Skilled Nursing Facility Residents
Percentage of LTC Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine

Diabetes Care

Hemoglobin A1c Testing
Hemoglobin A1c Control (<8.0%)
Hemoglobin A1c Poor Control (>9.0%)
Diabetes and Elevated HbA1C—Use of Diabetes Medications
Adults Taking Insulin with Evidence of Self-Monitoring Blood Glucose Testing
Patients Who Had a Serum Creatinine in Past 12 Reported Months
Diabetic Foot and Ankle Care, Peripheral Neuropathy—Neurological Evaluation
Diabetic Foot Care and Patient Education Implemented
Diabetes Mellitus and Medication Possession Ratio for Chronic Medications

Cardiovascular Care

Controlling High Blood Pressure
Coronary Artery Disease and Medication Possession Ratio for Statin Therapy
Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
Median Time to ECG for Acute Myocardial Infarction (AMI) or Chest Pain Patients
Heart Failure: ACE Inhibitor or ARB Therapy for Left Ventricular Systolic Dysfunction
30-Day, All-Cause, Risk-Standardized Mortality Rate Following AMI Hospitalization for Adult Patients
Survival Predictor for Abdominal Aortic Aneurysm
Atrial Fibrillation—Warfarin Therapy
Deep Vein Thrombosis Anticoagulation \geq 3 Months
Adherence to Statin Treatment for Hyperlipidemia
Proportion of Patients with Hypercalcemia

Cancer Care

Oncology: Cancer Stage Documented
Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients

Risk-Adjusted Morbidity and Mortality for Esophagectomy for Cancer

Multiple Myeloma—Treatment with Bisphosphonates

Hospice and Palliative Care

Proportion of Patients Who Died from Cancer Not Admitted to Hospice

Hospice and Palliative Care—Treatment Preferences

Hospice and Palliative Care—Pain Screening

Hospice and Palliative Care—Pain Assessment

Rehabilitation/Restorative Care

Physical Therapy or Rehabilitation/Restorative Care for Long-Stay Patients with New Balance Problem

Measures Identified Through Second-Tier Review (Communication/Care Coordination)

Clinician/Group Health Literacy Practices Based on CAHPS Item Set for Addressing Health Literacy

Clinician/Group's Cultural Competence Based on the CAHPS Cultural Competence Item Set

Patients Receiving Language Services Supported by Qualified Language Services Providers

Screening for Preferred Spoken Language for Health Care

Experience of Care and Health Outcomes (ECHO) Survey

Advance Care Plan

Reconciled Medication List Received by Discharged Patients

Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)

Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)

Proportion of Cancer Patients Admitted to the ICU in the Last 30 Days of Life

Percentage of Hospice Patients with Documentation of a Discussion of Spiritual/Religious Concerns or Documentation That the Patient/Caregiver Did Not Want to Discuss

Diabetes Short-Term Complications Admission Rate (PQI 1)

Diabetes Long-Term Complications Admission Rate (PQI 3)

Uncontrolled Diabetes Admission Rate (PQI 14)

Rate of Lower-Extremity Amputation Among Patients with Diabetes (PQI 16)

Appendix C. Biographical Information on Expert Panelists

Arlene Ash, Ph.D., is Professor and Division Chief of Biostatistics and Health Services Research in the Department of Population and Quantitative Health Sciences at the University of Massachusetts Medical School. She is an elected fellow of the American Statistical Association, the American Association for the Advancement of Science, and the International Statistical Institute. Dr. Ash pioneered tools for using administrative data to monitor and manage health care delivery systems, including those now widely used by the Medicare program and the Department of Health and Human Services. In 1996, she cofounded DxCG (now part of Cotiviti, Inc.) to promote “fair and efficient health care” through predictive software. In 2008, Dr. Ash’s risk-based predictive modeling work was honored by AcademyHealth with its Health Services Research Impact Award. Since 2014, she has worked with MassHealth (Massachusetts’ Medicaid and Children’s Health Insurance Program) to develop risk models that account for both medical and social risk factors when predicting health care utilization and costs. Her more than 200 research publications reflect long-standing interests in women’s health; gender, age and racial disparities; and quality, equity and efficiency in health care financing and delivery. She has also used her statistical expertise to advance gender equity in pay and to improve the integrity of U.S. elections.

Kevin Fiscella, MD, MPH, is Dean’s Professor of Family Medicine at the University of Rochester Medical Center. He has worked part-time in federally qualified health centers for more than 37 years as a family physician, addiction medicine physician, and Human Immunovirus physician. He is also a health services researcher with more than 250 peer-reviewed publications largely related to socioeconomic status, race, health, health care, and equity. Over the past decade, his research has focused on implementation research to identify pragmatic strategies for promoting health equity through randomized trials. Examples include community health workers for navigation of patients with cancer, practice-based outreach strategies to reduce disparities in cancer screening, use of electronic health record data for interventions and for primary outcomes assessment, peer-led patient activation trainings for low-income and minority people living with HIV, and use of academic detailing of clinicians and patient-centered peer coaching to promote uptake of atherosclerotic cardiovascular disease prevention among low-income and minority patients. Dr. Fiscella also has two decades of national committee experience related to measuring and reporting on health disparities and promotion of health, including two Institutes of Medicine committees, co-chairing two NQF advisory committees—measures for disparities/cultural and linguistic competency and SES-risk adjustment of quality measures. He currently represents the American Society of Addiction Medicine on the Board of the National Commission on Correctional Health Care (that accredits correctional health care), where he chairs the policy and research committee. He is a current member of the Disparities Monitoring Committee for NQF and a former member of the technical Advisory Panel on SES and Blood Pressure for the National Committee for Quality Assurance and former associate medical director for the local provider performance system for the New York State Delivery System Reform Incentive Program.

Darrell J. Gaskin, Ph.D., MS, is the William C. and Nancy F. Richardson Professor in Health Policy and Director of the Hopkins Center for Health Disparities Solutions at the Johns Hopkins Bloomberg School of Public Health in the Department of Health Policy and Management. Dr. Gaskin is a health

services researcher and health economist. He is an internationally recognized expert in health and health care disparities. He seeks to identify and understand place-based barriers to care for low-income, minority, and other vulnerable populations; to develop and promote policies and practices that address the social determinants of health to improve access to care, quality of care, and health care outcomes; and to promote equity in well-being, health, and health care by race, ethnicity, socioeconomic status, and geography. He serves on the Board of Scientific Counselors of the National Center for Health Statistics of the Centers for Disease Control and Prevention. He chairs the National Advisory Committee of the Robert Wood Johnson Foundation's System for Action program. Also, he serves on the Board of Directors of AcademyHealth and the American Society of Health Economists. He is a 2019 recipient of the Presidential Early Career Award for Scientists and Engineers. Dr. Gaskin has a Ph.D. in public health economics from the Johns Hopkins University. He holds an MS degree in economics from the Massachusetts Institute of Technology, and a BA degree in economics from Brandeis University.

Romana Hasnain-Wynia, MS, Ph.D., is the Chief Research Officer at Denver Health, where she oversees Denver Health's research and sponsored programs through the Office of Research and represents research interests as a member of the Executive Leadership Team. She also actively mentors junior investigators at Denver Health and the University of Colorado, Anschutz Medical Campus. Prior to joining Denver Health, Dr. Hasnain-Wynia served as the director of the Addressing Disparities program at the Patient Centered Outcomes Research Institute (PCORI), where she was responsible for providing strategic oversight and leadership for the program's funding priorities. Prior to PCORI, she was the director of the Center for Health Care Equity and Associate Professor at Northwestern University Feinberg School of Medicine. She spent a decade at the American Hospital Association's Health Research and Educational Trust, where she was Vice President of Research. She has been the principal investigator for a number of national studies focusing on advancing equity in health care with an emphasis on developing and integrating equity measurement in health systems. She uses mixed methods approaches in her research and has expertise in designing pragmatic trials in "real world settings." She is a member of NQF's Disparities Standing Committee and serves as the Chair of the Board for the Colorado Health Institute and is a member of the editorial boards of the journals *Health Affairs* and *Health Services Research*.

Sinsi Hernández-Cancio, JD, is a vice president at the National Partnership for Women and Families, where she leads the Health Justice team. She is a national health and health care equity policy and advocacy thought leader with 25 years of experience advancing equal opportunity for women and families of color, and almost 20 years advocating for increased health care access and improved quality of care for underserved communities. Sinsi is deeply committed to transforming our health care system to meet the needs of our rapidly evolving nation so we can all thrive together. She believes that our future prosperity depends on ensuring that our health care system routinely provides excellent, comprehensive, culturally centered, and affordable care for every single person, family, and community, and that this requires the dismantling of structural inequities including racism, sexism, ableism, homophobia, transphobia, xenophobia, and religious bigotry. Sinsi is a recognized leader in the national health equity movement, a sought-after strategic advisor, and a dynamic, inspiring speaker. She has presented at national events across the country and served on numerous advisory committees for organizations including the National Academy of Medicine, the National Committee for Quality Assurance, the Patient Centered Outcomes Research Institute, the Robert Wood Johnson Foundation, the National Center for Complex Health and Social Needs, and the American Association of Pediatrics. She has published extensively and has appeared

in national- and state-level English and Spanish television, radio, and print media. Her extensive experience in health and health equity policy and advocacy spans the state government, labor, and nonprofit arenas. Prior to joining the National Partnership's staff, she was the founding director of Families USA's Center on Health Equity Action for System Transformation, where she led efforts to advance health equity and reduce disparities in health outcomes and health care access and quality by leveraging health care and delivery system transformation to reduce persistent racial, ethnic, and geographic health inequities with an intersectional lens. Prior to that, she advised and represented two governors of Puerto Rico on federal health and human services policies, and she worked for the Service Employees International Union as a senior health policy analyst and national campaign coordinator for their Healthcare Equality Project campaign to enact the Affordable Care Act. She earned an AB from Princeton University's Woodrow Wilson School of Public and International Affairs and a JD from New York University School of Law, where she was an Arthur Garfield Hays Civil Liberties Fellow, and won the Georgetown Women's Law and Public Policy Fellowship.

Cara James, Ph.D., is President and CEO at Grantmakers In Health (GIH). Prior to joining GIH, she served as Director of the Office of Minority Health at CMS, where she provided leadership, vision, and direction to advance the HHS and CMS goals related to reducing disparities and achieving health equity for vulnerable populations, including racial and ethnic populations, persons with disabilities, sexual and gender minorities, and persons living in rural communities. Under her guidance, CMS developed its first CMS Equity Plan to Improve Quality in Medicare and its first Rural Health Strategy, created an ongoing initiative to help individuals understand their coverage and connect to care, increased the collection and reporting of demographic data, and developed numerous resources to help stakeholders in their efforts to reduce disparities. Before joining CMS, Dr. James served as Director of the Disparities Policy Project and Director of the Barbara Jordan Health Policy Scholars Program at the Henry J. Kaiser Family Foundation, where she was responsible for addressing a broad array of health and access to care issues for people of color and other underserved populations, including the potential impact of the Affordable Care Act, analyses of state-level disparities in health and access to care, and disparities in access to care among individuals living in health professional shortage areas. Prior to joining the foundation, she worked at Harvard University and the Picker Institute. Dr. James is a past member of the National Academies of Sciences, Engineering and Medicine's (NASEM) Health and Medicine Roundtable on the Promotion of Health Equity and has served on several NASEM committees. She has published a number of peer-reviewed articles. Dr. James holds her doctorate in health policy and her bachelor's degree in psychology from Harvard University.

Ninez Ponce, MPP, Ph.D. (BS University of California Berkeley; MPP Harvard; Ph.D. University of California Los Angeles [UCLA]), is Professor in the UCLA Fielding School of Public Health and Director of its Center for Health Policy Research. She leads the California Health Interview Survey (CHIS), the nation's largest state health survey, recognized as a national model for data collection on race/ethnicity, sexual orientation and gender identity, and immigrant health. She is a health services researcher most interested in reducing transaction costs levied on consumers and providers that produce racial/ethnic disparities. Her research on health disparities focuses on developing multicultural survey measures, implementing population-based health surveys in diverse populations, and examining the intersection of social factors and health policy. In 2019, Dr. Ponce and the CHIS team received the AcademyHealth Impact award for her contributions to population health measurement to inform public policies.

Dana Gelb Safran, Sc.D., was most recently Head of Measurement for Haven, the health care venture formed by Amazon, Berkshire Hathaway, and JPMorgan Chase (ABJ) to improve health care experiences and costs through transforming health care delivery and financing. In that role, Dr. Safran was a member of the executive leadership team and responsible for the company's data strategy, for guiding the development of a robust analytics infrastructure, and for applying data, analytics, and measurement to optimize the venture's success. Prior to her position at Haven, Dr. Safran was Chief Performance Measurement and Improvement Officer at Blue Cross Blue Shield of Massachusetts (BCBSMA). As an architect of the BCBSMA Alternative Quality Contract (AQC) and the leader responsible for its unique use of behavioral economics and payer-provider collaboration to reduce cost while improving quality, Dr. Safran is widely recognized as having contributed to the national push toward value-based payment. Prior to joining BCBSMA, she led a research institute at Tufts University School of Medicine dedicated to developing patient-reported measures of health and health care quality. She remains on the faculty at Tufts and serves on a number of state and national advisory bodies related to health care quality and affordability. Since 2017, Dr. Safran has served as a Commissioner on the Medicare Payment Advisory Commission (MedPAC). She earned her Master and Doctor of Science degrees from the Harvard School of Public Health.

Inequities in Health and Health Care in Black and Latinx/Hispanic Communities: 23 Charts

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INTRODUCTION

COVID-19 has devastated Black and Latinx/Hispanic communities in the United States during the past year, erasing recent life expectancy gains and reinforcing racism as a potent, structural driver of health and human inequity.¹

The health disparities contributing to this burden are long-standing. They reach well beyond the pandemic and have left many communities of color with historically worse outcomes. This chartbook details inequities between white, Black, and Latinx/Hispanic communities across a range of health indicators in four main areas:

- insurance coverage and access to care
- receipt of health services
- health status
- mortality.

To say that these communities are at higher risk of poor health means recognizing the reasons why. During the pandemic, socioeconomic factors — where people live and work, how much they are paid, and what kind of access they have to healthy living environments and high-quality health care — have all influenced who is exposed to COVID-19 and, ultimately, who has died.² Across almost all U.S. age groups, that has disproportionately been Black and Latinx/Hispanic people.³

These associations should invoke moral outrage, but they should not surprise us. They stem from a history of structural racism that is entrenched in U.S. policies.⁴ It is a legacy where, in some U.S. cities, people born a few miles apart might have a 20-year difference in life expectancy.⁵

It is therefore important to assess the performance of U.S. health care through a racial equity lens. And, in our efforts to reform that system, we must acknowledge that health inequities cannot be separated from “the policies and institutions that undergird the U.S. racial hierarchy.”⁶

For example, we cannot talk about health without understanding the impact of racial segregation.⁷ By refusing to underwrite mortgages in neighborhoods of color, intercede against racial housing covenants and discriminatory zoning, and, later in the 20th century, regulate predatory lending, the federal government cut Black and other nonwhite Americans out of government-subsidized wealth-building programs and helped create separate and unequal living conditions.⁸

The health effects of these policies are vast⁹:

- In many areas, residents of heavily Black neighborhoods have less access to primary care providers than those living in neighborhoods with fewer Black residents.¹⁰
- Air pollution emissions are higher where people of color live, temperatures are hotter, and green spaces scarcer.¹¹
- In historically redlined neighborhoods, poor health outcomes such as elevated preterm birth risk, asthma-related emergency visits, later cancer-stage diagnoses, and a wide range of chronic health conditions remain prevalent decades later.¹²

Past policies like these also have helped create wide economic inequities, which can influence who is more likely to be covered

by health insurance and have timely access to care, who has the financial assets to recover from medical financial shocks, whose insurance plans pay providers more, and which health facilities accept someone as a patient.¹³

At the same time, the effects of structural and interpersonal racism also manifest within health systems:

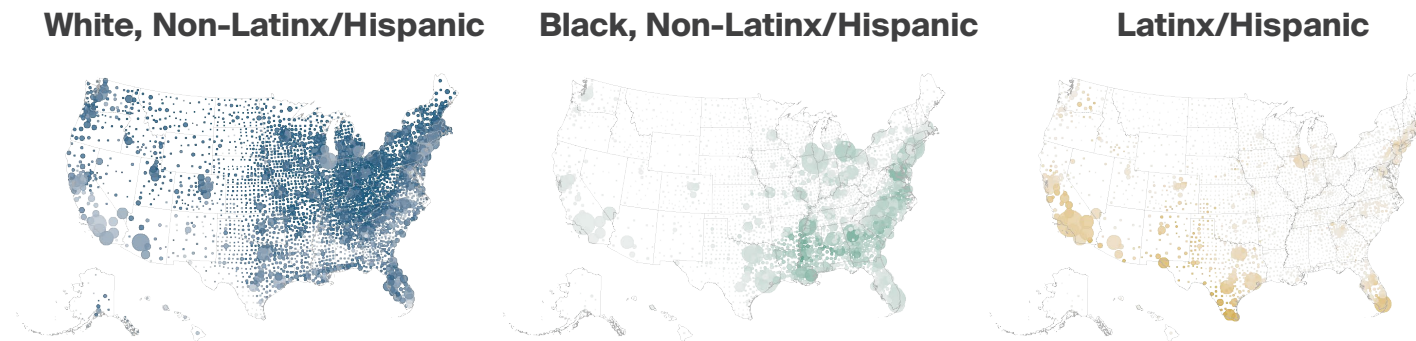
- Many Black and Latinx/Hispanic patients receive inadequate care once they are in the doctor’s office, following on generations of unequal treatment and medical racism.¹⁴ Commonly they are mistreated and disregarded by providers, encounter significant language and cultural communication barriers, are prescribed lower-value or suboptimal care, or suffer the effects of racial bias within hospital treatment algorithms.¹⁵
- Even within the same hospitals, Black and Latinx/Hispanic patients are more likely than white patients to experience severe complications related to birth, regardless of insurance status.¹⁶

Achieving antiracism in the health care delivery system will require policies that account for, and confront, the underlying structures that have brought us to this point. In the following charts, we depict current inequities in the way that Black and Latinx/Hispanic people experience health and health care in the U.S.¹⁷ and highlight policies associated with improvement. And, along the way, we reference national and state-level barriers standing in the way of further progress.¹⁸

SOCIOECONOMIC INEQUITIES

Where communities are located can have large health implications.

U.S. racial and ethnic demographics map



White people make up a significant but slowly declining majority of the U.S. population (60% vs. 12% African American and 19% Latinx/Hispanic).¹⁹ There are large differences in where racial and ethnic communities are concentrated. For example, nearly 60 percent of Black people live in southern states, which have among the poorest health outcomes, lowest access to health care, and weakest social safety nets in the country.²⁰ The Latinx/Hispanic population, which is more spread out regionally, also comprises many distinct communities and nationalities that include a wide range of socioeconomic levels.

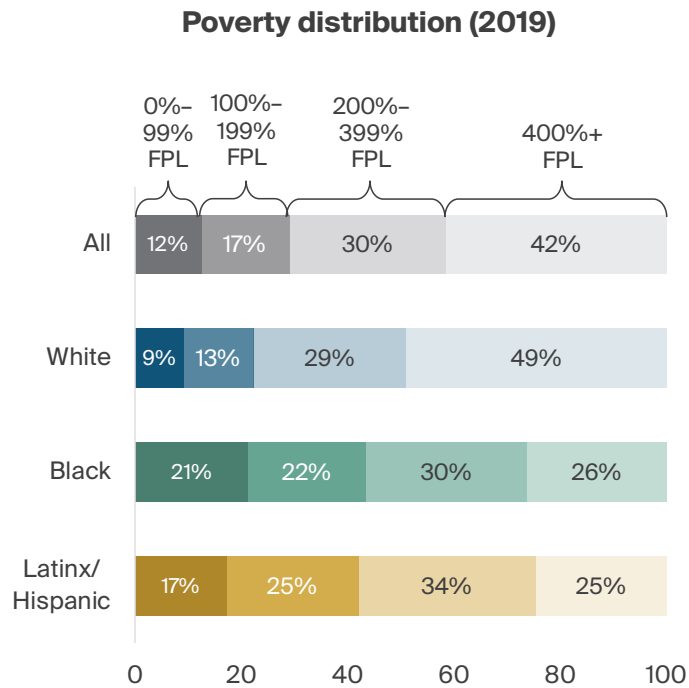
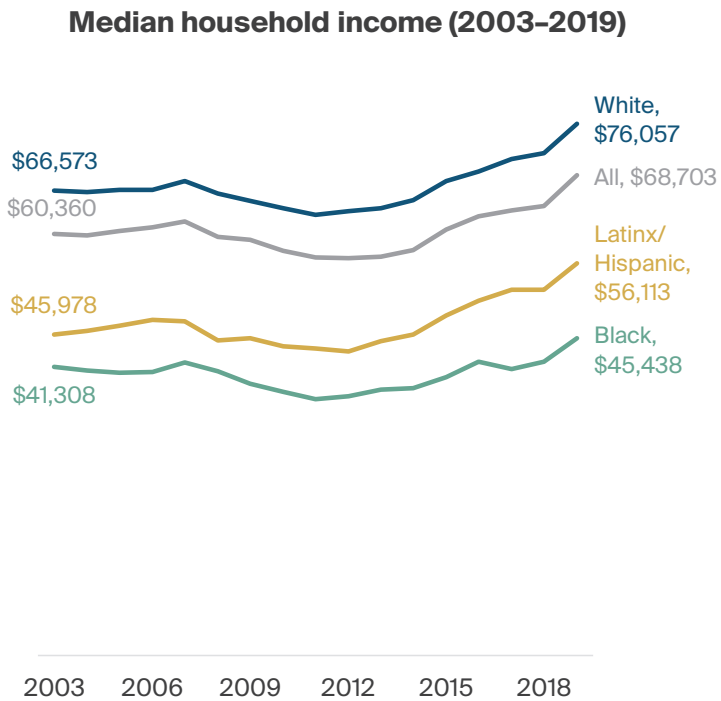
Significant variation in state policies and the way states implement federally funded programs, such as the Affordable Care Act (ACA), can disproportionately affect communities of color.²¹

Note: Bubbles are sized relative to the county population count for each race/ethnicity group; color density is based on the share of the county population in each race/ethnicity group.

Data: National Center for Health Statistics. Vintage 2019 postcensal estimates of the resident population of the United States (April 1, 2010, July 1, 2010–July 1, 2019), by year, county, single-year of age (0, 1, 2, . . . 85 years and older), bridged race, Latinx/Hispanic origin, and sex. Prepared under a collaborative arrangement with the U.S. Census Bureau. Available from: https://www.cdc.gov/nchs/nvss/bridged_race/data_documentation.htm as of July 9, 2020, following release by the U.S. Census Bureau of the unbridged Vintage 2019 postcensal estimates by five-year age group on June 25, 2020.

SOCIOECONOMIC INEQUITIES

Income inequities, which impact health and access to care, persisted over the past 15 years. Black and Latinx/Hispanic households live below the poverty level at around twice the rate of white households.



The United States has a long history of government-aided residential segregation, unequal access to education, discriminatory financial institutions and assistance programs, disproportionate incarceration, disparate employment hiring practices and pay, and discrimination within the workplace.²² These policies and practices, marked by entrenched structural racism, have contributed to significant gaps within education, economic opportunity, and income, factors that are themselves associated with health access and outcomes.²³ Income disparities have persisted in the U.S. during the past 15 years as wealth inequality has increased.

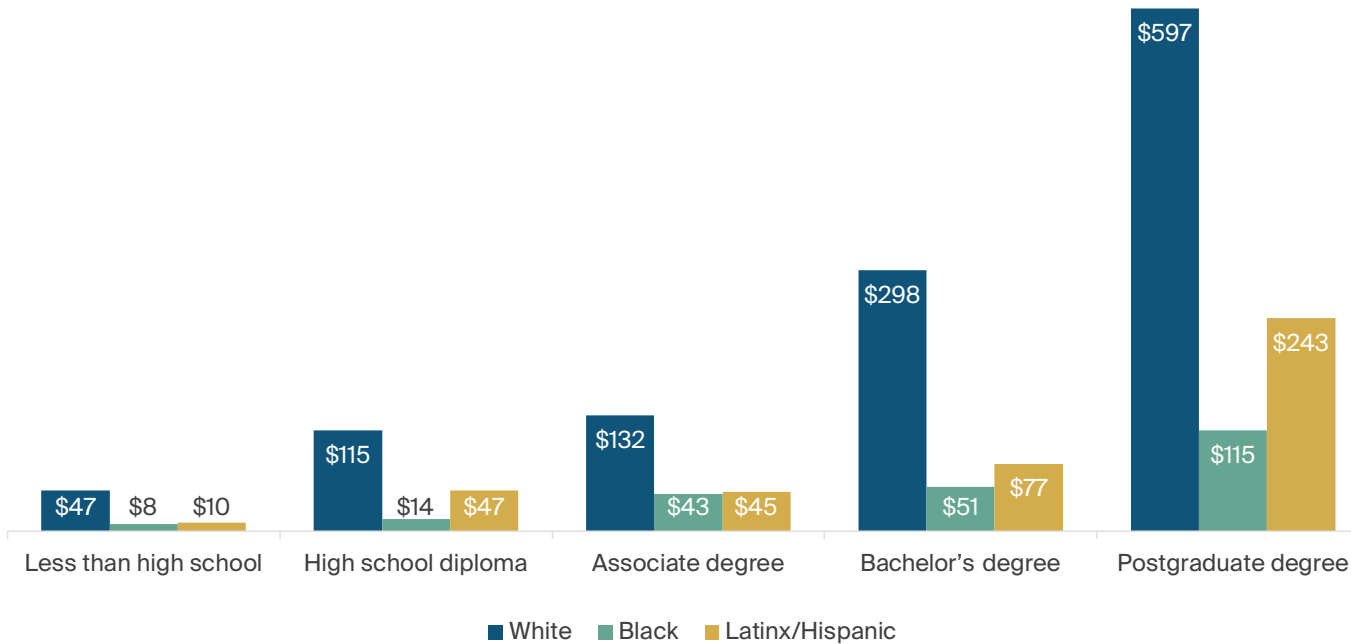
Note: 100% of the federal poverty level (FPL) in 2019 was \$12,490 for an individual and \$25,750 for a family of four.

Data: Median household income – [Current Population Survey](#), 2003–2019 Annual Social and Economic Supplements (2019 dollars); Poverty distribution – [American Community Survey](#), Public Use Microdata Sample (ACS PUMS), 2019.

SOCIOECONOMIC INEQUITIES

Reflecting the impact of racism on social and economic policies, Black and Latinx/Hispanic household wealth is significantly lower than white household wealth across all education levels.

Median household wealth (in \$ thousands), 2019



Inequities often persist regardless of education or income. This is particularly true of household wealth, defined as the net value of a family’s assets — such as bank accounts, stock holding, and home equity — against debt. Wealth has now become a frequent prerequisite for accessing care as health costs have grown, and patients pay more out of their own pocket.

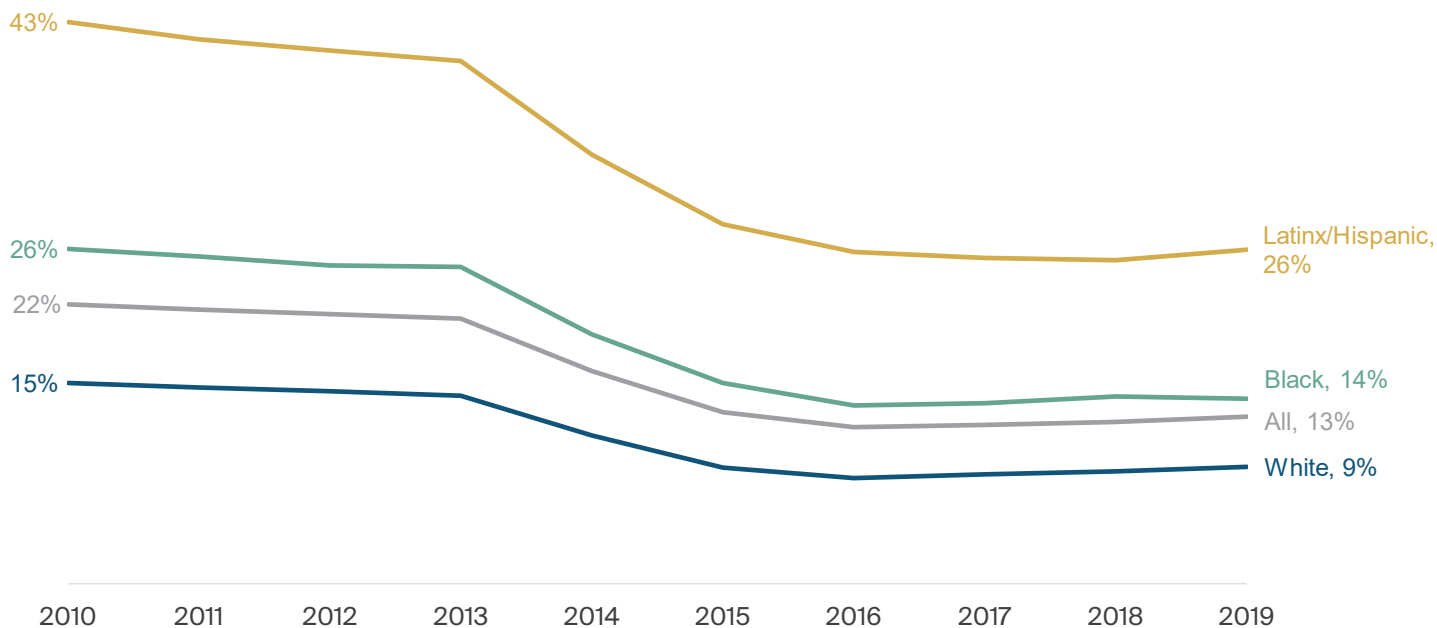
White wealth is substantially higher than Black and Latinx/Hispanic wealth. Research shows that to be true at every income and education level, and that white people with a high school degree have the same median household wealth as Black people with a postgraduate degree. The disparities reflect the impact of discriminatory policies like federal home-lending programs that excluded nonwhite Americans from participating in the wide expansion of home ownership during the 20th century.²⁴

Data: Federal Reserve Board’s 2019 Survey of Consumer Finances; Chart reproduced from Ana Hernández Kent and Lowell R. Ricketts, “Wealth Gaps Between White, Black and Hispanic Families in 2019,” Federal Reserve Bank of St. Louis, Jan. 5, 2021.

INSURANCE COVERAGE AND ACCESS TO CARE

Coverage inequities significantly declined after key ACA provisions went into effect, but gains have stalled and disparities persist.

Percent of adults ages 19–64 who are uninsured, 2010–2019



Data: American Community Survey, Public Use Microdata Sample (ACS PUMS), 2010–2019.

Insurance coverage disparities are long-standing and are associated with lower health care access and poorer health.²⁵ These gaps have become even more perilous during the COVID-19 pandemic.²⁶

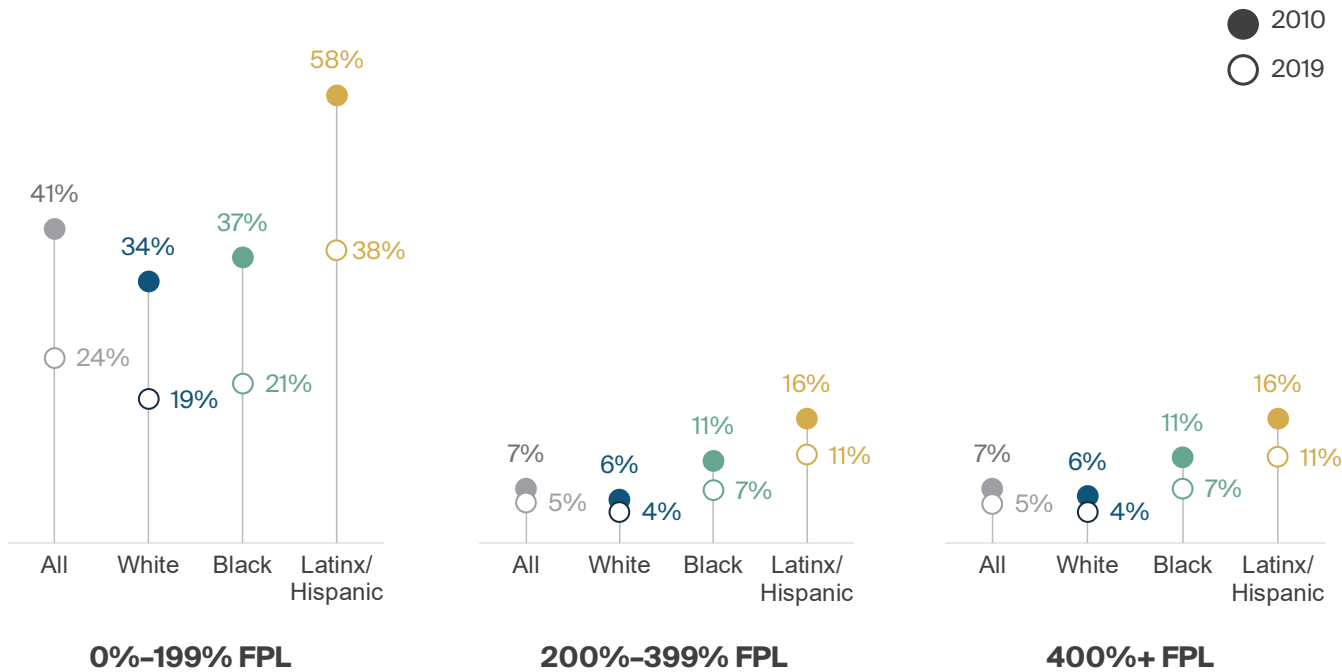
Insurance for U.S. adults has historically been tied to employment, which reflects racial and ethnic economic inequality. Black and Latinx/Hispanic adults are much less likely to receive coverage through their employer.²⁷ The ACA aimed to address these inequities through the expansion of Medicaid and the availability of subsidized individual plans. Thus far, the law has increased coverage and significantly reduced racial and ethnic differences.²⁸

But disparities persist, particularly for Latinx/Hispanic communities, and national progress has stalled since 2016. The uninsured are also more likely to have medical debt, which can lead to long-term financial problems.²⁹

INSURANCE COVERAGE AND ACCESS TO CARE

Black and Latinx/Hispanic nonelderly adults are still uninsured at higher rates than white adults across all income levels, underscoring the need for additional reforms.

Percent of adults ages 19–64 who are uninsured, by income, 2010–2019



The ACA increased coverage the most for lower-income adults, who are disproportionately Black and Latinx/Hispanic. By providing virtually no-cost insurance through Medicaid expansion and significantly limiting costs for low-income families through the marketplaces, it has reduced financial burden and preserved wealth and income for many households.⁵⁰

Though racial and ethnic coverage differences across all income groups have decreased since 2010, Black and Latinx/Hispanic adults within each category are still more likely than whites to be uninsured. Those remaining disparities could be addressed through additional targeted reforms like filling the Medicaid expansion gap and enhancing marketplace subsidies (as the American Rescue Plan does temporarily for the next two years).

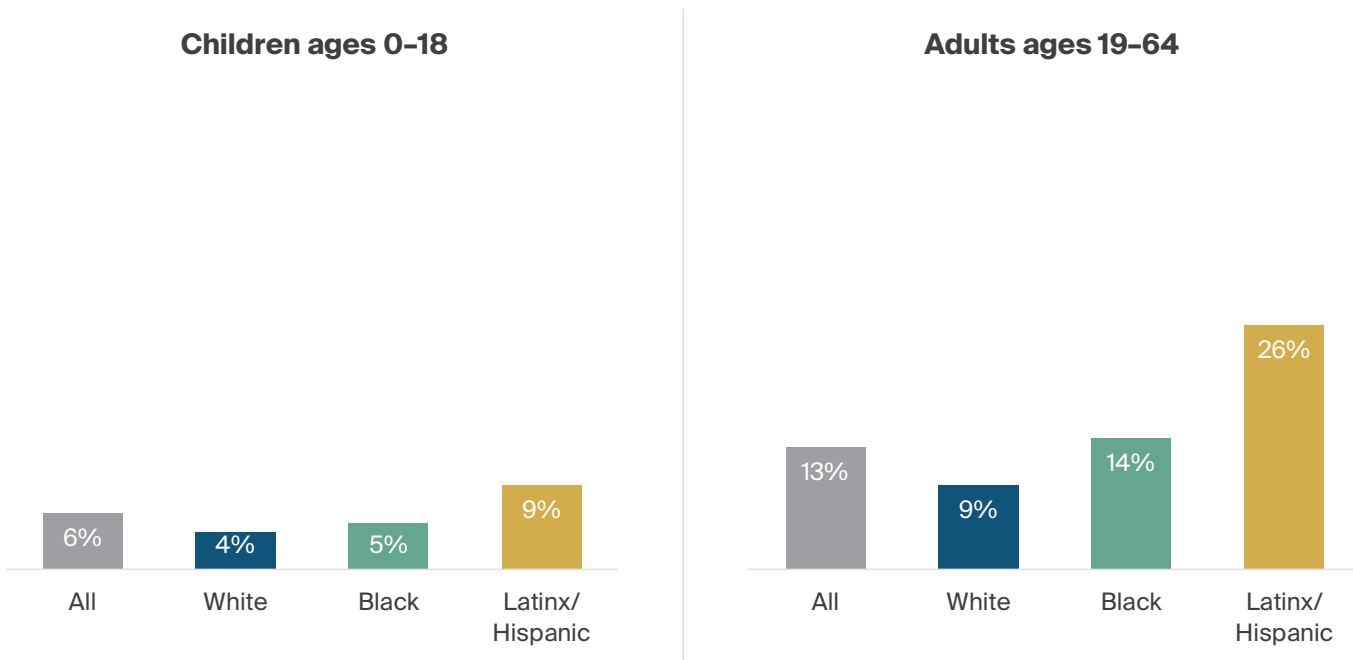
Note: FPL = federal poverty level.

Data: American Community Survey, Public Use Microdata Sample (ACS PUMS), 2010–2019.

INSURANCE COVERAGE AND ACCESS TO CARE

Reflecting federal and state policies, children across all groups are more likely to be insured than adults, but Latinx/Hispanic children are still uninsured at twice the rate of white and Black children.

Percent of children and nonelderly adults who are uninsured, 2019



Uninsured rates and disparities among children are significantly lower than among adults. This is linked to the implementation of the Children’s Health Insurance Program (CHIP) in 1997 and federal and state Medicaid expansions for children.³¹ However, some 4.4 million children still lack insurance, and the number has increased by at least 200,000 each year since 2016.³²

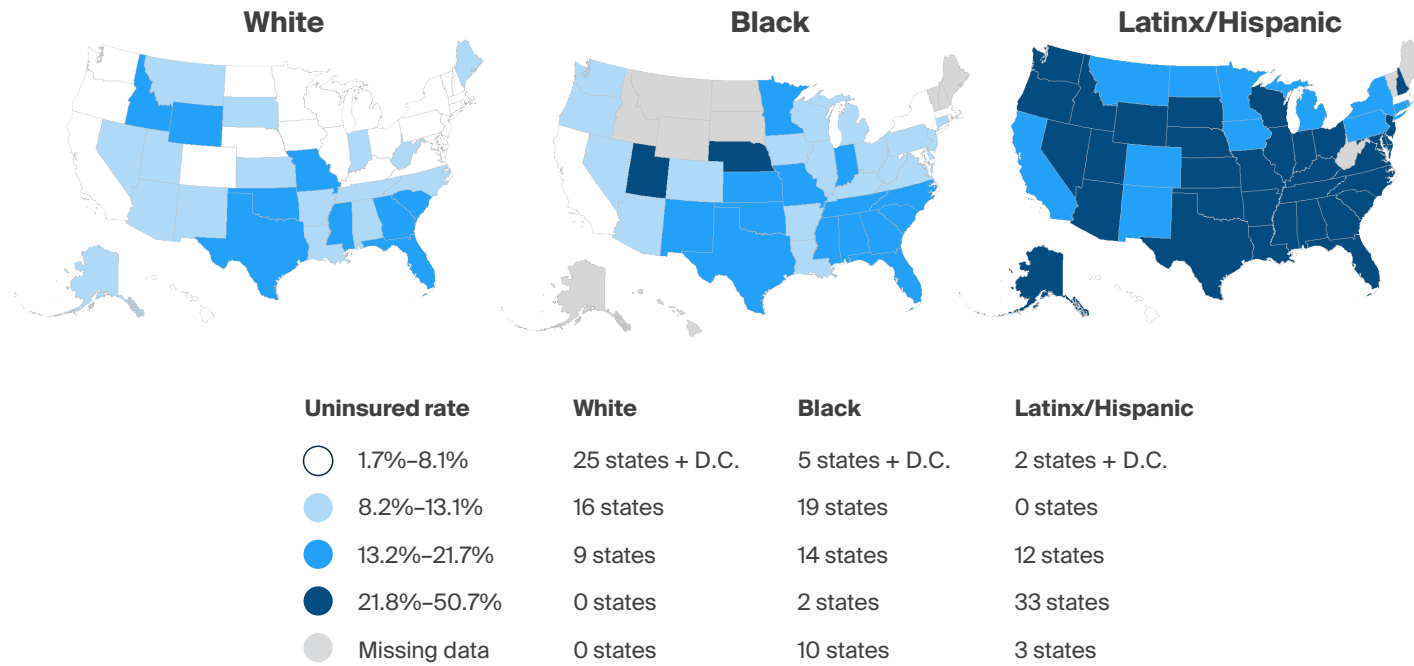
The uninsured rate for Latinx/Hispanic children is higher, largely because undocumented children are typically ineligible for Medicaid or CHIP. The Trump administration’s immigration policies also may have deterred eligible families.³³ While the Biden administration is seeking to end many of these, longer-term impacts are uncertain.³⁴ Some states also enforce more frequent Medicaid and CHIP eligibility checks, which can disproportionately affect Black and Latinx/Hispanic children.³⁵

Data: American Community Survey, Public Use Microdata Sample (ACS PUMS), 2019.

INSURANCE COVERAGE AND ACCESS TO CARE

State-level coverage rates by race and ethnicity exhibit significant regional variation that is often tied to state policy decisions.

Percent of adults ages 19–64 who are uninsured, by state, 2019



Coverage rates and disparities exhibit significant regional variation, in part because of the 2012 Supreme Court decision that allowed states to choose whether they expanded Medicaid to all adults with low income.

Research indicates that expansion is associated with large increases in coverage equity.⁵⁶ Eight of the 14 remaining nonexpansion states are in the South, and Black adults are significantly concentrated in these states.

Because undocumented immigrants are ineligible for coverage through the marketplaces and Medicaid, Latinx/Hispanic people still have the highest uninsured rate in almost every state. They are also more likely to live in certain nonexpansion states, like Texas and Florida.

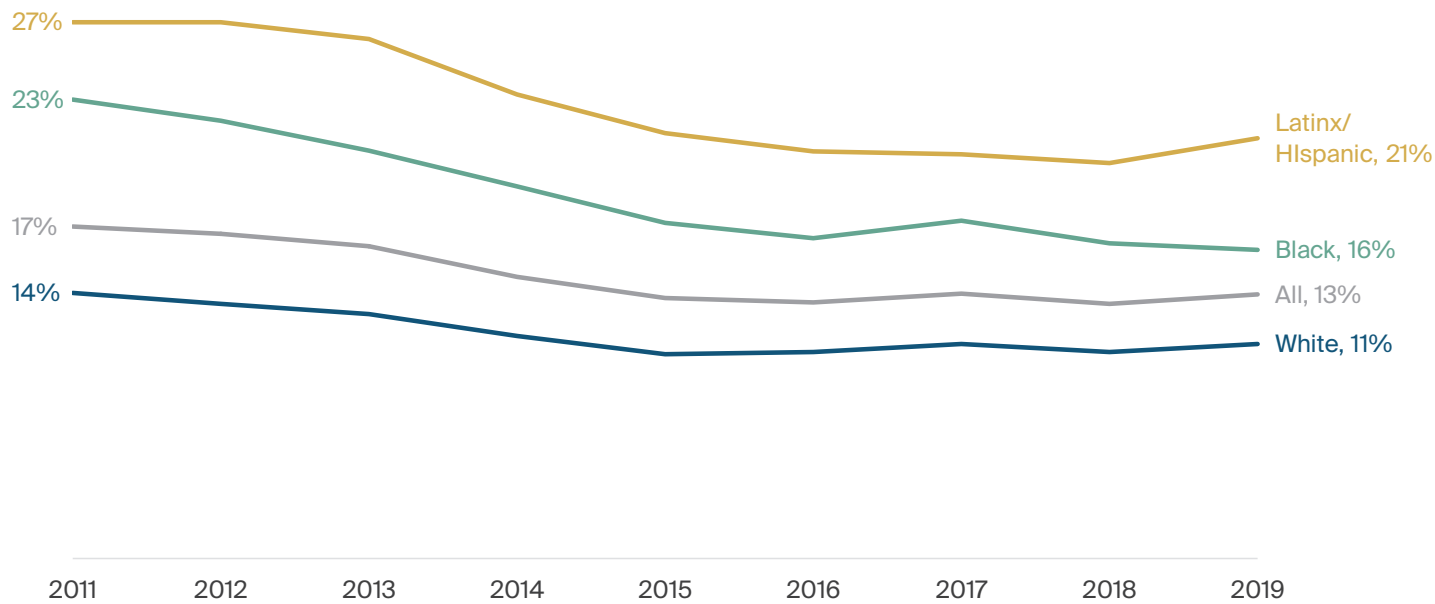
Note: Map groupings are calculated by taking the 25th, 50th, and 75th percentiles across the full distribution of state uninsured rates for all three racial/ethnic groups.

Data: American Community Survey, Public Use Microdata Sample (ACS PUMS), 2019.

INSURANCE COVERAGE AND ACCESS TO CARE

All groups experienced fewer financial barriers after the ACA coverage expansions, but Black and especially Latinx/Hispanic adults are still more likely than white adults to forgo needed care because of cost.

Percent of adults age 18 and older who went without care because of cost in the past year, 2011–2019



Insurance coverage is the most important determinant of access to care, and people with no coverage or inadequate insurance are more likely to avoid care because of cost.³⁷ The ACA's coverage expansions made large improvements in both areas, but Black and Latinx/Hispanic adults still report cost-related barriers at higher rates.

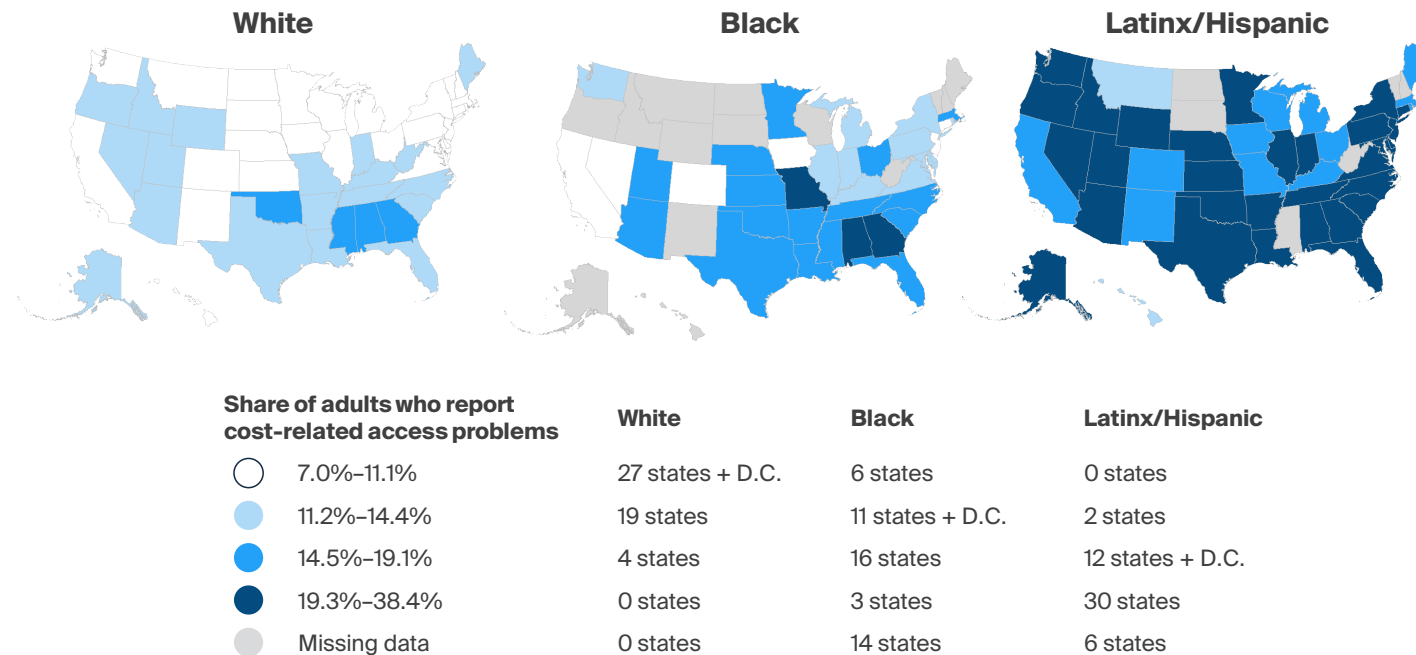
Disparities in cost-related barriers reflect differences in uninsured rates and “underinsurance” or high cost-sharing responsibilities in private plans.³⁸ Data show that Black and Latinx/Hispanic people in employer-coverage households are more likely to have high out-of-pocket costs relative to income.³⁹

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2011–2019.

INSURANCE COVERAGE AND ACCESS TO CARE

Financial barriers to health care vary widely across states but are particularly high for Black and Latinx/Hispanic adults in states that have not expanded Medicaid.

Percent of adults age 18 and older who went without care because of cost in the past year, by state, 2019



Cost-related access problems across the U.S. follow a similar pattern to the geographic variation that exists within insurance coverage.

Cost barriers are higher in states that have not expanded Medicaid, particularly for Black and Latinx/Hispanic adults. Research indicates that expansion is associated with larger declines in cost-related access problems and increased equity.⁴⁰ However, cost-related access problems exist for lower- and middle-income people who are privately insured, too.⁴¹

Latinx/Hispanic adults also face larger cost-related access problems in most states, likely reflecting insurance barriers related to current immigration policies.

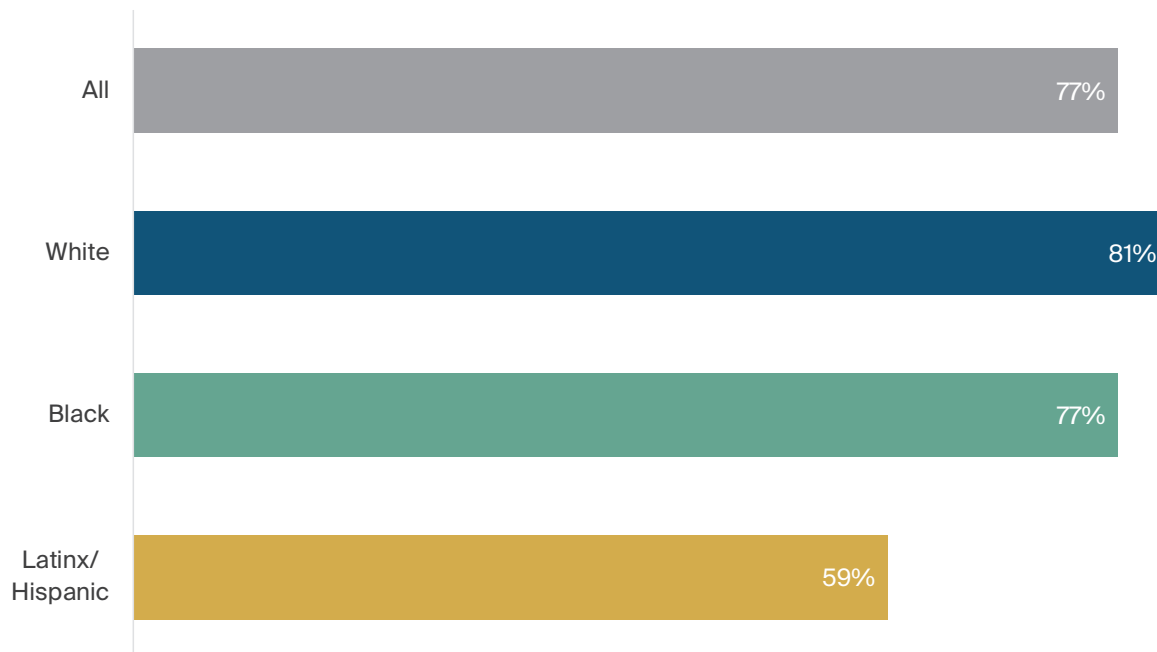
Note: Map groupings are calculated by taking the 25th, 50th, and 75th percentiles across the full distribution of state rates for all three racial/ethnic groups.

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2019.

INSURANCE COVERAGE AND ACCESS TO CARE

Black and Latinx/Hispanic adults are less likely to have a usual care provider, driven in part by coverage disparities and structural access barriers.

Percent of adults age 18 and older with a usual source of care, 2019



Data: Behavioral Risk Factor Surveillance System (BRFSS), 2019.

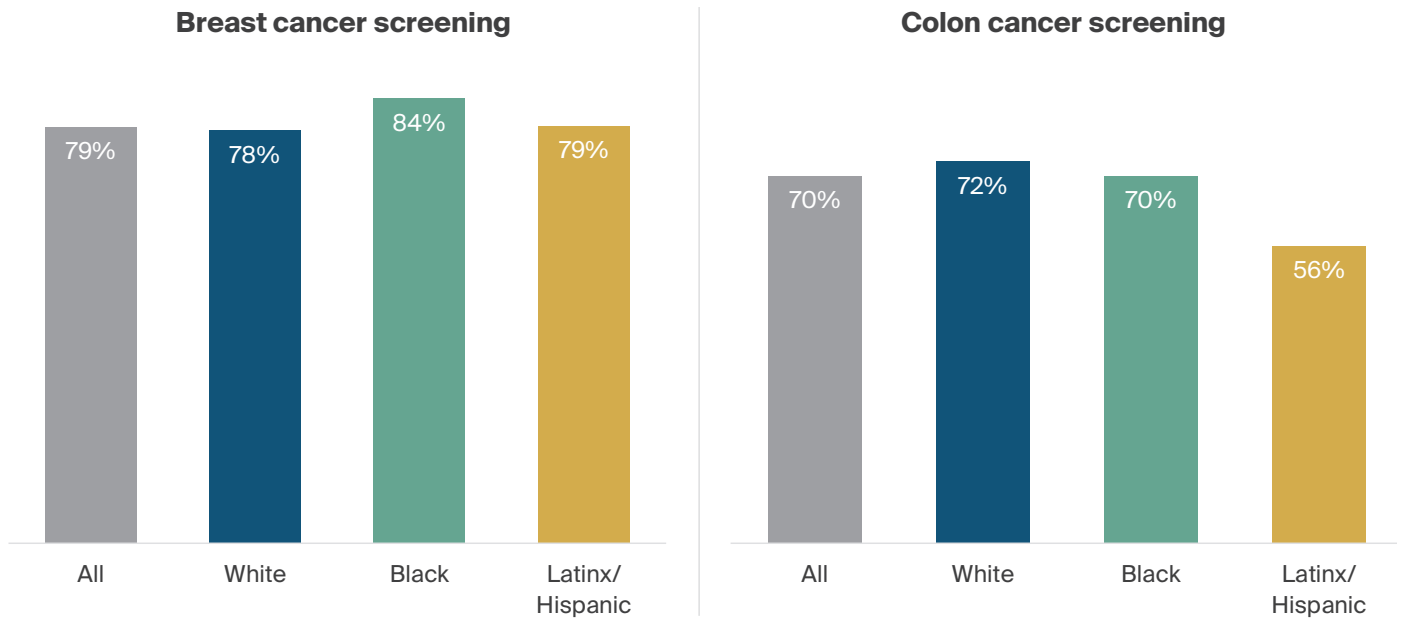
Studies have pointed to coverage as a key component of disparities in usual source of care, finding that those without insurance are more likely to report not having a regular provider and skipping preventive services.⁴²

An additional barrier is the distance to and supply of providers in an area, which often reflects historical racial segregation.⁴³ Researchers have found that, in some cities, neighborhoods with more Black and Latinx/Hispanic adults have access to fewer primary care providers in close proximity.⁴⁴ Other studies have shown racial inequities within facility admissions,⁴⁵ as well as insurance-type segregation⁴⁶ that can limit choices. In addition, Black and Latinx/Hispanic communities may have difficulty finding providers that can deliver care with cultural humility.⁴⁷

RECEIPT OF HEALTH SERVICES

Breast cancer screening rates are high for all groups, but Black and Latinx/Hispanic adults are often diagnosed at more advanced stages.

Percent of adults age 18 and older with up-to-date cancer screenings, 2018



Age-appropriate screening can identify cancers early and improve treatment success rates. Access to screening is mediated by insurance coverage,⁴⁸ as well as cost-sharing barriers⁴⁹ and access to a usual care provider.⁵⁰ The ACA narrowed coverage disparities and required all insurers and employers to cover recommended preventive care without cost sharing.⁵¹

While screening rates have increased, and the current variation within breast cancer exams is modest, Latinx/Hispanic adults have much lower rates of colon cancer screening. Research also indicates that breast cancer screening rates may be overestimated for Black and Latinx/Hispanic women.⁵²

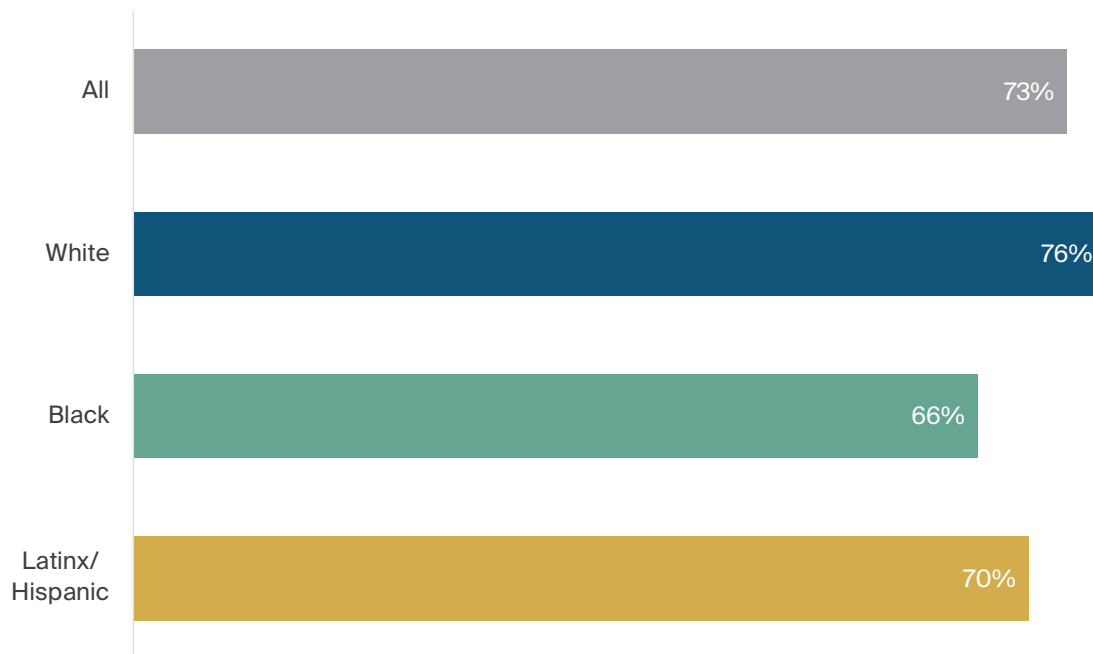
Black adults continue to die from cancer at higher rates than white adults and are often diagnosed at later stages,⁵³ a trend that also occurs among Latinx/Hispanic adults for breast cancer.⁵⁴ (See page 23 for breast and colon cancer mortality data.) This could relate to remaining disparities in care quality, timing differences for screening exams, and broader health system access barriers to high-quality care.

Note: Breast cancer screening is women ages 50 to 75 who received a mammogram in the past two years; colon cancer screening is adults ages 50 to 75 with a recent colon cancer screening test.
 Data: Behavioral Risk Factor Surveillance System (BRFSS), 2018.

RECEIPT OF HEALTH SERVICES

Higher child vaccination rates reflect public policy, though rates are still lower for both Black and Latinx/Hispanic children.

Percent of children ages 19–35 months who received all recommended doses of seven key vaccines, 2019



Note: Recommended vaccines are the 4:3:1:3:3:1:4 series, which includes ≥ 4 doses of DTaP/DT/DTP, ≥ 3 doses of poliovirus vaccine, ≥ 1 doses of measles-containing vaccine, full series of Hib (3 or 4 doses, depending on product type), ≥ 3 doses of HepB, ≥ 1 dose of varicella vaccine, and ≥ 4 doses of PCV.

Data: National Immunization Survey, 2019.

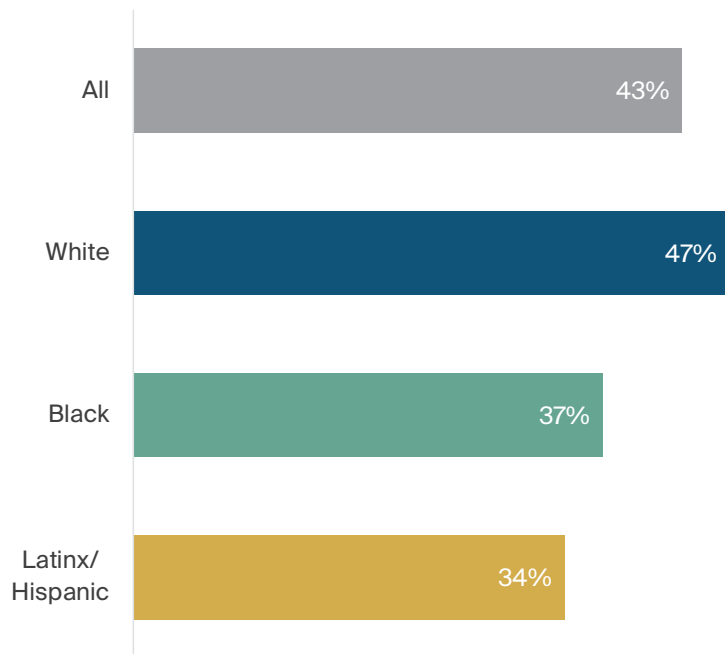
Higher child vaccination rates for all groups can be explained in large part by direct federal and state policies implemented during the past 30 years. These include the Vaccines for Children (VFC) program⁵⁵ run by the CDC, as well as the Children's Health Insurance Program (CHIP) and Medicaid expansions for children.

By greatly decreasing the number of uninsured children and providing free or low-cost vaccines to lower-income families, those policies have removed financial barriers and helped decrease vaccination disparities between the different communities.⁵⁶ Still, notable differences remain between white and Black and Latinx/Hispanic children. These programs will be particularly critical during the next several years, as COVID-19 vaccines are distributed to the general population.

RECEIPT OF HEALTH SERVICES

Adult flu vaccination rates are below the target for all groups, but especially among Black and Latinx/Hispanic adults who face more access barriers.

Percent of adults age 18 and older with a seasonal flu shot in the past year, 2019



Data: Behavioral Risk Factor Surveillance System (BRFSS), 2019.

Adult flu vaccination rates for all groups are well under the national goal of 70 percent,⁵⁷ and rates for Black and Latinx/Hispanic adults are much lower than for whites.

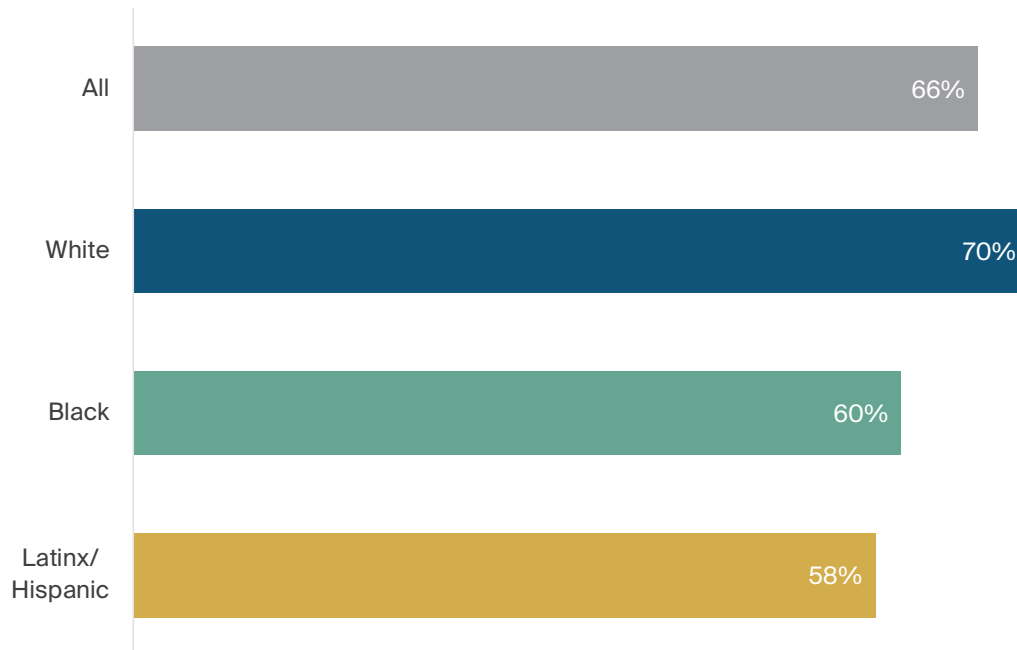
This inequity is particularly troubling in the context of COVID-19. Black and Latinx/Hispanic communities have been disproportionately burdened by the pandemic but have lower access to COVID-19 vaccines,⁵⁸ a racial vaccination disparity also appeared during the H1N1 pandemic in 2009–2010.⁵⁹

Vaccination is strongly linked to access measures including insurance coverage and having a usual care provider.⁶⁰ Data presented earlier show that those access disparities remain significant for Black and Latinx/Hispanic adults but are much lower for children.

RECEIPT OF HEALTH SERVICES

Black and Latinx/Hispanic adults are less likely to receive dental care services, which insurance plans often do not cover.

Percent of adults age 18 and older with a dental visit in the past year, 2018



Data: Behavioral Risk Factor Surveillance System (BRFSS), 2018.

Differences in dental care access reflect both economic inequity and insurance coverage inadequacies.

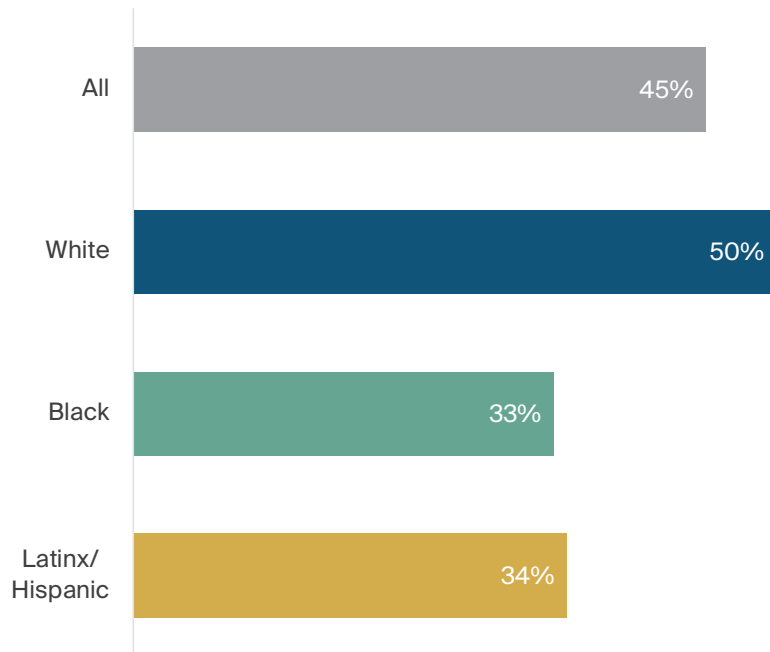
Black and Latinx/Hispanic families are more likely to be uninsured or insured by public health insurance programs. Traditional Medicare does not cover most dental services and state Medicaid programs have discretion over whether to offer it. Only 18 states and the District of Columbia provide comprehensive Medicaid coverage for dental care; the majority of states provide restricted or emergency-only coverage.⁶¹ In addition, many dentists still do not accept Medicaid.⁶²

Private insurance plan coverage of adult dental services is also limited, although less so. Dental benefits are not included in the ACA's essential benefit package for marketplace plans, and only 60 percent of employers who provide health benefits offer dental coverage.⁶³

RECEIPT OF HEALTH SERVICES

Black and Latinx/Hispanic adults with a mental health illness are less likely to receive mental health care.

Percent of adults age 18 and older with any mental illness who received mental health services in the past year, 2019



While recent federal legislation has improved access to mental health services overall,⁶⁴ Black and Latinx/Hispanic adults are less likely than white adults to receive needed mental health services. The pandemic has likely exacerbated this, as Black and Latinx/Hispanic adults have been more likely to experience mental health concerns related to COVID-19.⁶⁵

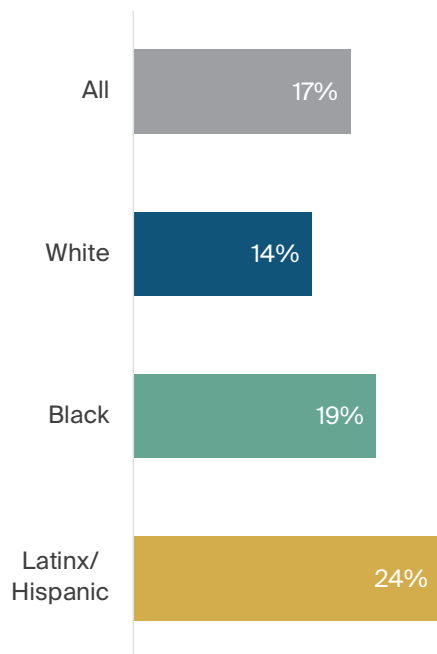
These differences partly reflect disparities in coverage and access. Language and cultural factors also can influence utilization, and experiences with racism have eroded trust in medical providers and institutions.⁶⁶ In addition, the criminal justice system, which targets Black and Latinx/Hispanic people disproportionately, fails to provide adequate support for individuals with mental health issues.⁶⁷

Data: Chart reproduced from National Institute of Mental Health, “Mental Illness,” NIMH, last updated Jan. 2021. See “Figure 2. Mental Health Services Received in Past Year Among U.S. Adults with Any Mental Illness (2019).” Data from SAMHSA, National Survey on Drug Use and Health (NSDUH), 2019.

HEALTH STATUS

Latinx/Hispanic and Black working-age adults are more likely to report being in fair or poor health.

Percent of adults ages 18–64 who report being in fair or poor health, 2019



Data: Behavioral Risk Factor Surveillance System (BRFSS), 2019.

Poor health outcomes are often a manifestation of racism's cumulative impact, through long-term discrimination, socioeconomic inequity, unequal access to health care, and differential treatment within care delivery systems.⁶⁸

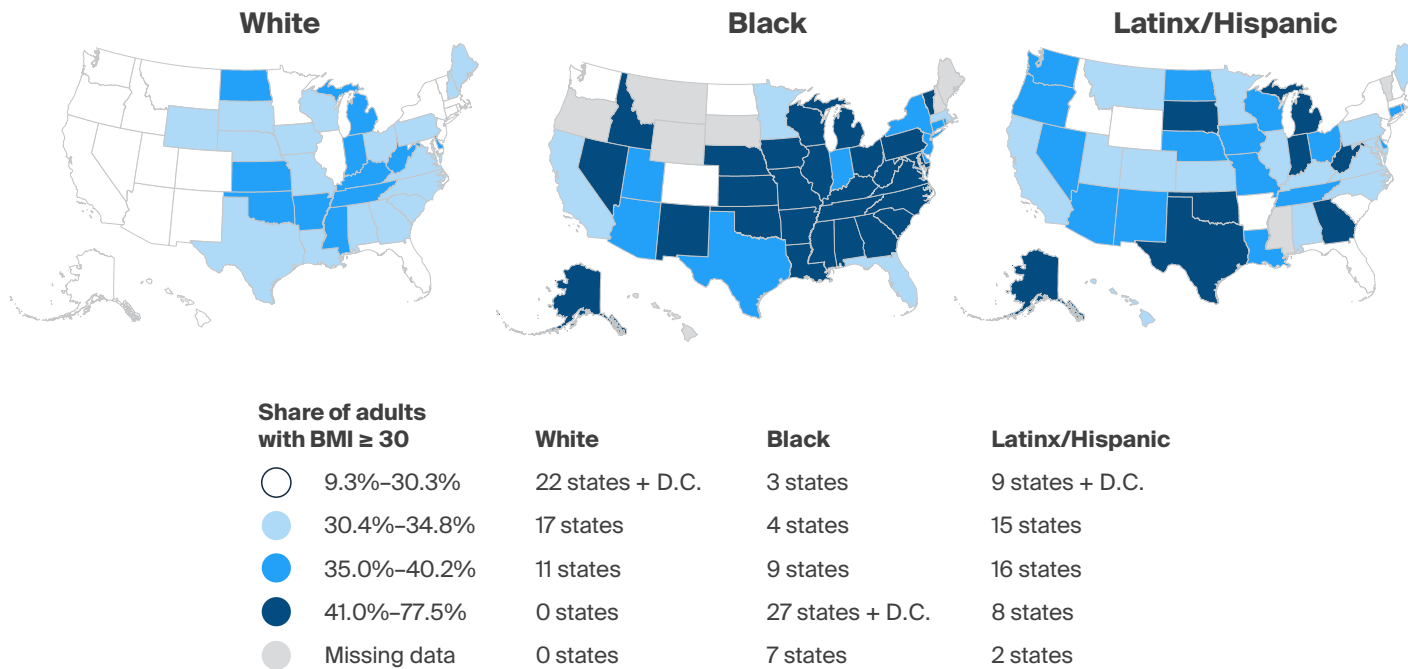
Federal surveys have consistently tracked self-reported health to assess the population's quality of life and the potential burden of chronic health conditions. Though health status can be interpreted differently, past research has linked poor self-reported health with elevated mortality risk.⁶⁹

Over the past 10 years, there have been consistent and significant differences between white, Black, and Latinx/Hispanic adults with respect to self-reported health.

HEALTH STATUS

All groups report elevated obesity. Black and Latinx/Hispanic adults, whose living environments can be impacted by policies like residential segregation, report higher rates in most states.

Percent of adults ages 18–64 who are obese, by state, 2019



The U.S. has a much higher rate of obesity than other wealthy countries.⁷⁰ Working-age adults in all three racial and ethnic groups currently report rates above 30 percent.⁷¹ However, in most states, rates for Black and Latinx/Hispanic adults are higher than they are for white adults. Obesity rates are particularly high in southern states, where Black, Latinx/Hispanic, and white residents all tend to have poorer health outcomes and access to health care.

Researchers find a connection between obesity and both residential segregation (stemming from structural racism) and the socioeconomic environment of different communities. These barriers can affect access to resources associated with healthy lives, such as green spaces and healthy food.⁷²

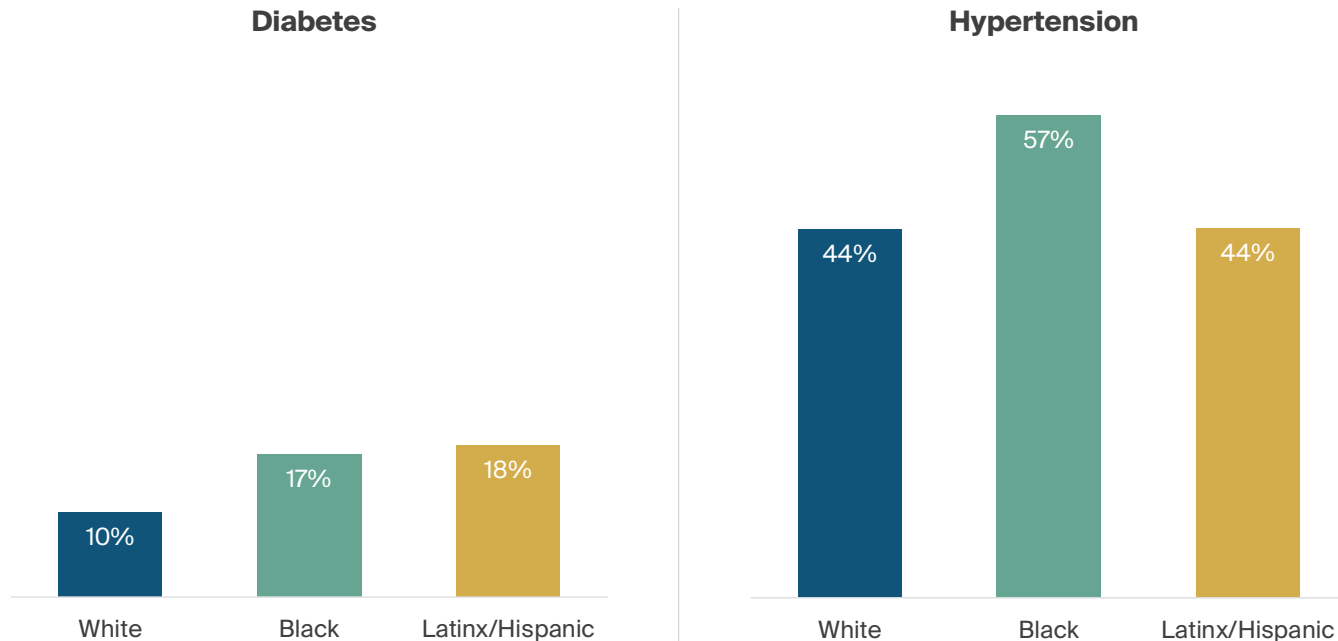
Notes: Obesity is measured by adults with BMI ≥ 30. Map groupings are calculated by taking the 25th, 50th, and 75th percentiles across the full distribution of state rates for all three racial/ethnic groups.

Data: Behavioral Risk Factor Surveillance System (BRFSS), 2019.

HEALTH STATUS

Obesity is associated with additional health risks. Black and Latinx/Hispanic adults experience higher rates of diabetes than whites, and Black adults also report higher hypertension rates.

Age-adjusted prevalence of hypertension and diabetes among adults age 18 and older



Obesity can lead to significant chronic health conditions such as diabetes and hypertension, which disproportionately burden Black adults and can lead to additional health complications — including those resulting from COVID-19.

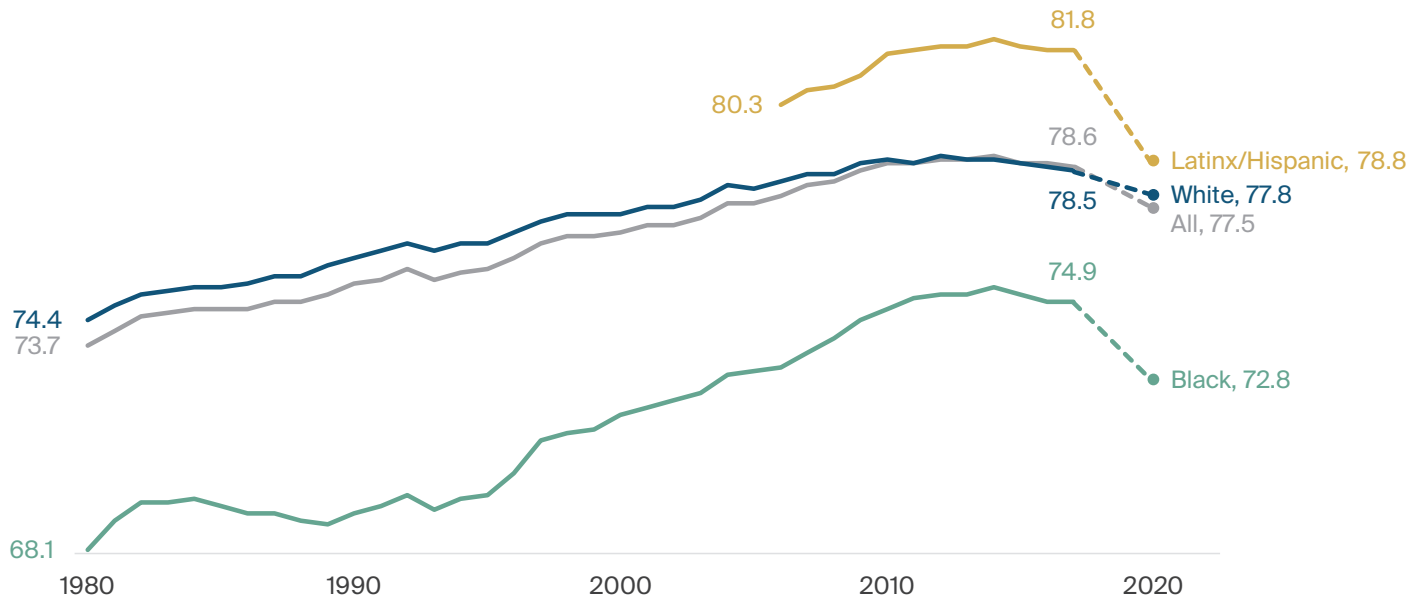
Many chronic conditions are associated with an array of upstream inequities beyond health care, but Black and Latinx/Hispanic communities also deal with an unequal health system in trying to manage their illness. For example, people with diabetes who are uninsured and have lower income are much more likely to encounter problems paying for their medications.⁷³ Diabetes treatment rates are also lower for Black and Latinx/Hispanic people, and research has shown that even with insurance, Black Americans with the condition are less likely than others to receive newer medications.⁷⁴ Diabetes-related amputation rates are also much higher among Black Medicare beneficiaries compared to white beneficiaries, who are more likely to be offered limb-saving procedures or to receive early-intervention services.⁷⁵

Data: Diabetes — 2013–16 National Health and Nutrition Examination Survey (NHANES), as reported in *2020 National Diabetes Statistics Report* (Centers for Disease Control and Prevention, Aug. 2020); Hypertension — 2017–18 NHANES, reproduced from Yechiam Ostchega et al., *Hypertension Prevalence Among Adults Aged 18 and Over: United States, 2017–2018* (NCHS, Apr. 2020).

MORTALITY

The gap in average life expectancy between Black and white adults has existed for generations, and COVID-19 erased recent progress.

Average life expectancy at birth (years), 1980–2020



Notes: 1980–2017 data come from: [United States Life Tables](#), *National Vital Statistics Reports* 68, no. 7 (June 24, 2019). Black and white data points before 2006 include Latinx/Hispanic people; starting in 2006, they represent non-Latinx/Hispanic Black and non-Latinx/Hispanic white. 2020 projections (dashed lines) appear in Andrasfay and Goldman (see below), reflecting the Institute for Health Metrics and Evaluation (IHME) current/medium projection (Oct. 2020).

Chart reproduced from: Theresa Andrasfay and Noreen Goldman, “Reductions in 2020 U.S. Life Expectancy Due to COVID-19 and the Disproportionate Impact on the Black and Latino Populations,” *PNAS* 118, no. 5 (Feb. 2021): e2014746118.

One of the most powerful health indicators is the number of years one expects to live. Mirroring other racial inequities, this number has always been markedly different for Black and white people in the U.S.

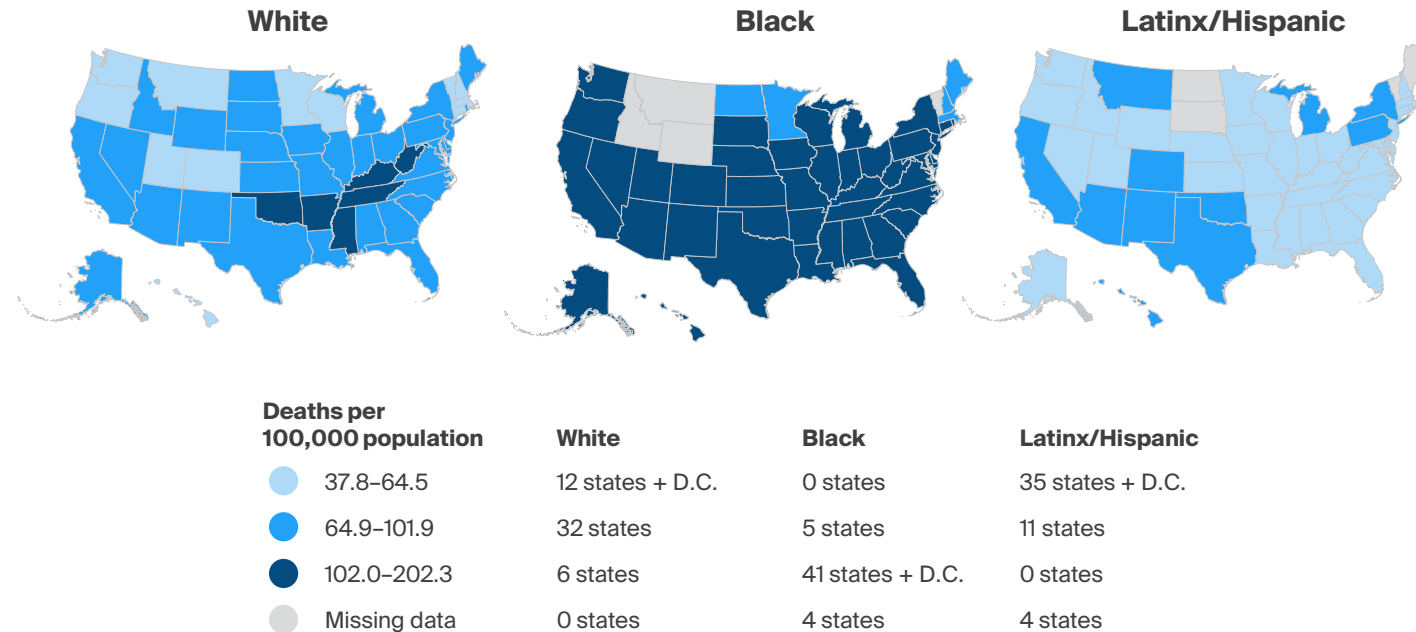
Latinx/Hispanic people, who comprise a range of nationalities, have historically lived longer — a paradox of sorts when considering the broad socioeconomic disadvantages many of these communities have faced.⁷⁶

White, Black, and Latinx/Hispanic adults were experiencing modest declines in life expectancy by 2014. But COVID-19, through its disproportionate impact on communities and neighborhoods shaped by structural racism, has dramatically changed those trajectories.⁷⁷ Early data indicate that Latinx/Hispanic and Black communities, who have been much more likely to die at younger ages during the pandemic, have lost between two and three years of life expectancy; whites have lost less than one year.⁷⁸

MORTALITY

Black adults across the U.S. die from treatable conditions at significantly higher rates than white and Latinx/Hispanic adults.

Mortality amenable to health care (deaths per 100,000 population), 2016 and 2017



The Commonwealth Fund tracks deaths before age 75 from medical conditions that, with proper health care, are usually manageable and treatable. Nationally, Black people die from these causes (such as diabetes) at a rate of 154.9 deaths per 100,000, double the rate for whites.⁷⁹ Disparities exist across all states, and Black adults are concentrated within regions that do worse overall.

Differences within this health care measure reflect an unequal health system as well as underlying structural racism that produces different living environments. Rates of premature death are linked to factors such as poverty, insurance status, and hospital quality.⁸⁰ Premature deaths also lead to loss of economic productivity in racially and ethnically diverse communities.⁸¹

Mortality rates are much lower among Latinx/Hispanic adults, with researchers pointing to potential immigration-related factors and health behaviors like smoking as reasons.⁸² But Latinx/Hispanic obesity and diabetes rates are on the rise, and pre-COVID mortality data showed increasing Latinx/Hispanic midlife mortality from several related causes.⁸³

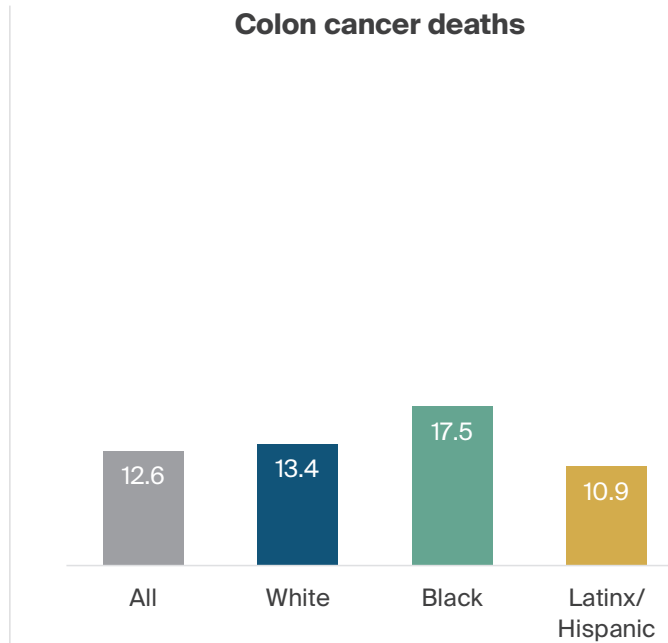
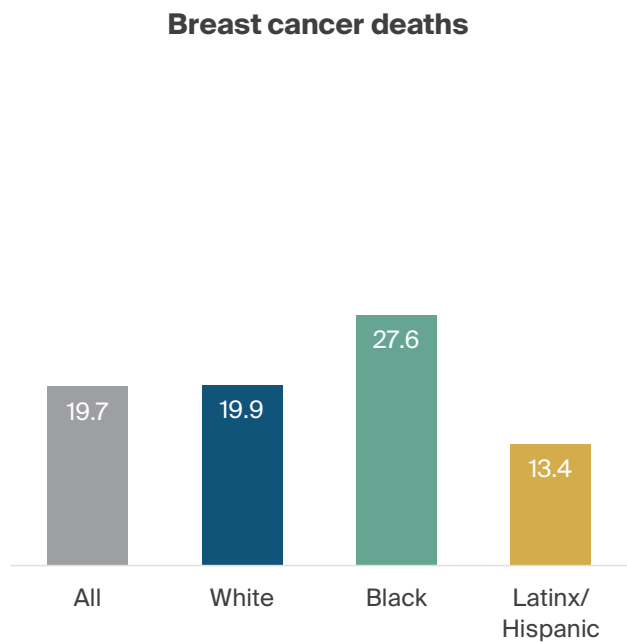
Note: Measure includes deaths before age 75 from one of 33 preventable or treatable health conditions. Map groupings are calculated by taking the 33rd and 66th percentiles across the full distribution of state rates for all three racial/ethnic groups.

Data: National Vital Statistics System (NVSS) Mortality All-County Micro Data Files, 2016 and 2017.

MORTALITY

Black individuals are more likely to die from breast and colon cancer, reflecting both later-stage diagnoses and differential treatment.

Age-adjusted breast and colorectal cancer deaths per 100,000 population, 2018



Black individuals are more likely than white people to be diagnosed later and die of both breast and colon cancer. Disparities in mortality persist even when controlling for factors such as age and stage of cancer.

It appears that hospital attributes, such as quality, have significant effects on these outcomes.⁸⁴ Even when a diagnosis is made, Black breast cancer patients are more likely to experience subpar treatment that departs from standard clinical guidelines. Such treatment disparities are seen with other types of cancer as well.⁸⁵

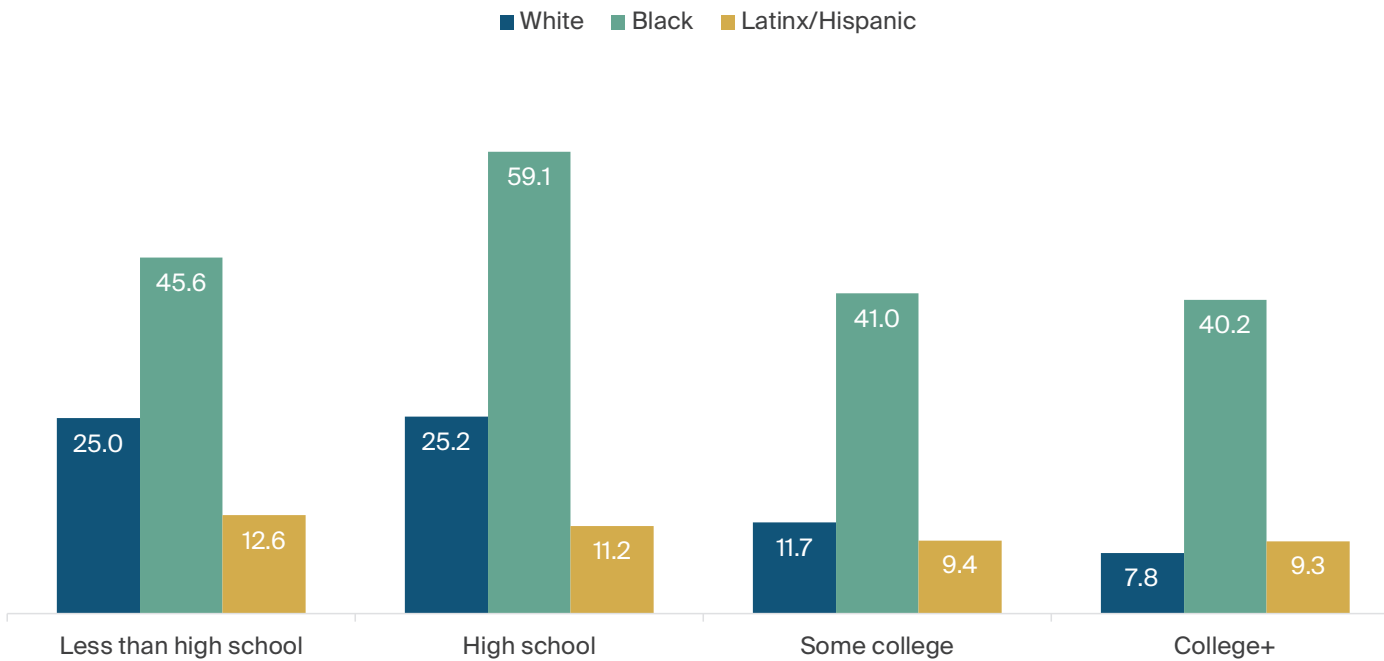
Latinx/Hispanic individuals are less likely to die from cancer overall, though risk is higher for certain cancers related to infection. Averages also mask significant differences for certain Latinx/Hispanic communities, such as rates for prostate cancer among Puerto Ricans.⁸⁶

Note: Breast cancer deaths are among female population; colon cancer deaths are among full population.
 Data: National Vital Statistics System (NVSS) Mortality Data Files, 2018.

MORTALITY

Across all education levels, Black people suffer pregnancy-related deaths at two to four times the rate of white and Latinx/Hispanic people.

Pregnancy-related deaths per 100,000 live births in the U.S., by education level, 2007–2016



Black and Latinx/Hispanic people are more likely than white people to experience severe complications related to birth, irrespective of insurance status.⁸⁷

Disparities in pregnancy-related deaths between Black and white populations are long-standing and persist regardless of economic status or education.⁸⁸ These inequities have been documented between different hospitals and even within the same hospital.⁸⁹ Latinx/Hispanic maternal mortality rates are lower than white rates, despite the well-documented disadvantages many members of Latinx/Hispanic communities face.⁹⁰

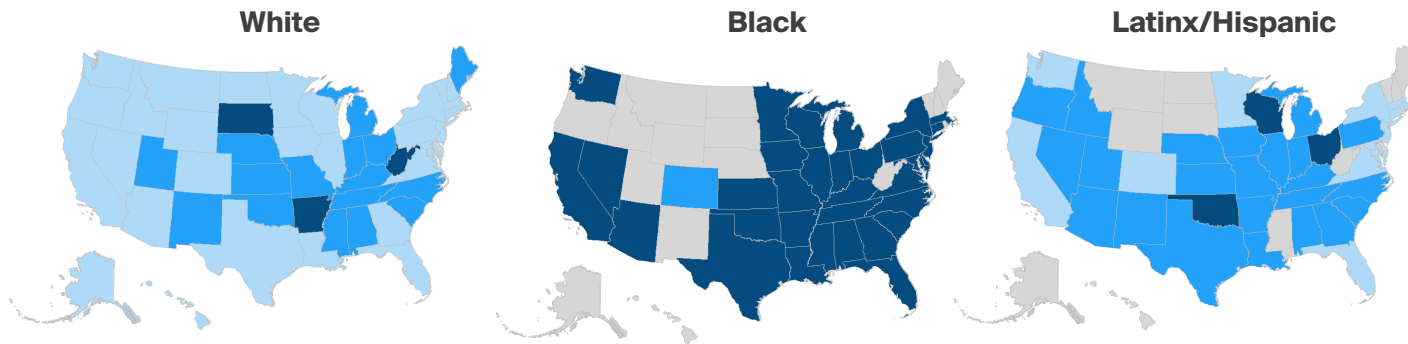
Where people give birth in the U.S. is important: three-fourths of Black babies are delivered in one-fourth of hospitals, which tend to be of lower quality and perform worse on delivery-related indicators than hospitals where white babies are delivered.⁹¹ Providers are also more likely to disregard Black people’s pregnancy requests.⁹²

Data: Emily E. Petersen et al., “Racial/Ethnic Disparities in Pregnancy-Related Deaths – United States, 2007–2016,” *Morbidity and Mortality Weekly Report (MMWR)* 68, no. 35 (Sept. 6, 2019): 762–65.

MORTALITY

Infant mortality disparities exist in nearly every state; rates are particularly high in Black communities.

Deaths in the first year of life per 1,000 live births, by state, 2017



Deaths in the first year of life per 1,000 live births	White	Black	Latinx/Hispanic
2.7–4.9	30 states	0 states	11 states
5.0–6.8	16 states	1 state	23 states
6.9–15.9	3 states	33 states + D.C.	3 states
Missing data	1 state + D.C.	16 states	13 states + D.C.

The national Black infant mortality rate is more than two times that for whites,⁹⁵ with inequities in every state. While there is not a large national difference between Latinx/Hispanic and white infant mortality rates, the maps show disparities in many individual states.⁹⁴ Certain Latinx/Hispanic communities, including Puerto Ricans, experience larger disparities.⁹⁵

Socioeconomic factors such as employment and education are closely tied to structurally racist policies and are associated with infant mortality;⁹⁶ yet they cannot fully explain the differences.⁹⁷ Hospital quality and differential treatment, as well as doctors’ race, play a significant role in deaths.⁹⁸

Insurance coverage also matters. Infant mortality rates have declined since the ACA became law, with Black mortality dropping the most. Rates also decreased by greater amounts in states that have expanded Medicaid eligibility.⁹⁹

Note: Map groupings are calculated by taking the 33rd and 66th percentiles across the full distribution of state rates for all three racial/ethnic groups.

Data: National Vital Statistics System (NVSS) Linked Birth and Infant Death Data, 2017.

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The Commonwealth Fund

Affordable, quality health care. For everyone.

About the Commonwealth Fund

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.

Health Insurance Trends

May 2021

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Introduction

Hundreds of millions of Americans have felt the impact of the COVID-19 pandemic, not only in their personal lives but also in how they interact with health care. As the pandemic winds down, the health care market approaches a turning point in its digital transformation and is entering a promising new era: health care delivery is expanding online, new technologies are unleashing innovation, and there is a fresh vitality in the Medicare and Affordable Care Act (ACA) markets that could lead to significant expansions.

This report, eHealth's inaugural edition of its new biannual signature research series, presents an analysis of survey responses and first-hand interviews collected from more than 4,700 consumers and more than two dozen insurer representatives across three megatrends that dominate the health care market today: COVID-19, Technology and Innovation, and Public Policy Reforms.

- **COVID-19 and other major issues today** – How will life be different after the pandemic? How do consumers feel about vaccination requirements? What kind of action should be taken on drug costs? How many experience surprise medical bills, and what's behind the surprise?
- **Technology and Innovation** – Where do consumers look for innovation when it comes to health care? Are they willing to share personal medical information to optimize their coverage and care? How do insurance companies expect the use of digital medical services to shape the future of coverage?
- **Public Policy Reforms** – After more than a year of the pandemic, how do people feel about proposals to expand access to Medicare or strengthen the Affordable Care Act?

For more information, refer to the Methodology section at the end of this report.

Highlights

ON COVID, VACCINES AND SURPRISE BILLS

- **Most (54%) say COVID vaccination should not be required by law**, but a similar figure (53%) say proof of vaccination should be required for all air travel, domestic and international.
- **69% say they've had a surprise medical bill**, but among these 67% say the bill was a surprise because they didn't understand how their coverage worked. Among Medicare beneficiaries, fewer (54%) report having a surprise medical bill in the past.
- **After the pandemic is over, half (51%) are less likely to go on a cruise**, while about a third are less likely to attend a concert (36%), go to a movie theater (35%), travel by plane (34%) or eat at a restaurant (33%).

ON THE INTERSECTION OF TECHNOLOGY AND HEALTH CARE

- **54% say they would opt to share their personal medical claims history with a licensed agent** if it helped them find a better health plan for their personal needs and budget; 59% of Medicare beneficiaries feel the same.
- **49% say private enterprise does a better job than government when it comes to health care innovation**, while 20% say government is better; those figures are 53% and 14%, respectively, among Medicare beneficiaries.

ON PUBLIC POLICY ISSUES

- **60% favor expanding access to Medicare in some form**, whether that means making Medicare available to all Americans (28%), lowering the eligibility age to 60 (18%), or allowing adults age 50+ to buy in early (14%).
- **49% say Medicare should continue to be run through public/private cooperation** between government and insurers; only 16% feel government alone should run the Medicare program.
- **74% say the federal government should directly negotiate with drug makers to lower costs**; among Medicare beneficiaries, 86% feel the same.

INSIGHTS FROM INSURERS

- **52% of insurers say they do not anticipate raising rates due to the COVID pandemic**; 39% do anticipate raising rates, but no more than 5%.
- **33% are likely to make changes to plan benefits** as a result of the pandemic, with 86% of those saying changes are likely to their telehealth and mental health benefits.
- **55% report a 50% or greater increase in utilization of telehealth benefits** over the period before the pandemic; many report an increase in use of mental health benefits as well.

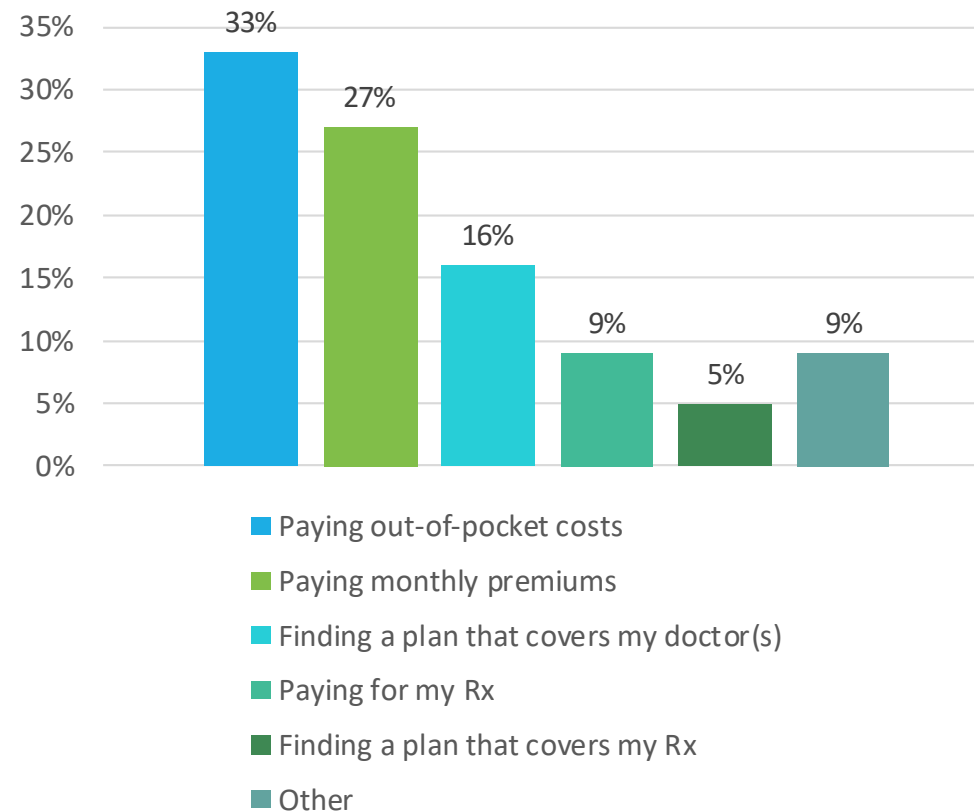
Findings from General Population and Medicare Beneficiary Audiences

Health Insurance Consumers' Biggest Concerns

More health insurance consumers worry about out-of-pocket costs than about monthly premiums

- A third of general population respondents (33%) say their top concern is paying their portion of the bill when they get medical care.
- A quarter (27%) say their top concern is paying monthly premiums to keep coverage in effect.
- 16% say their top concern is finding a plan that covers their preferred doctor.

What's your biggest concern about your health coverage?



Coverage type and age play a big role in shaping top concerns

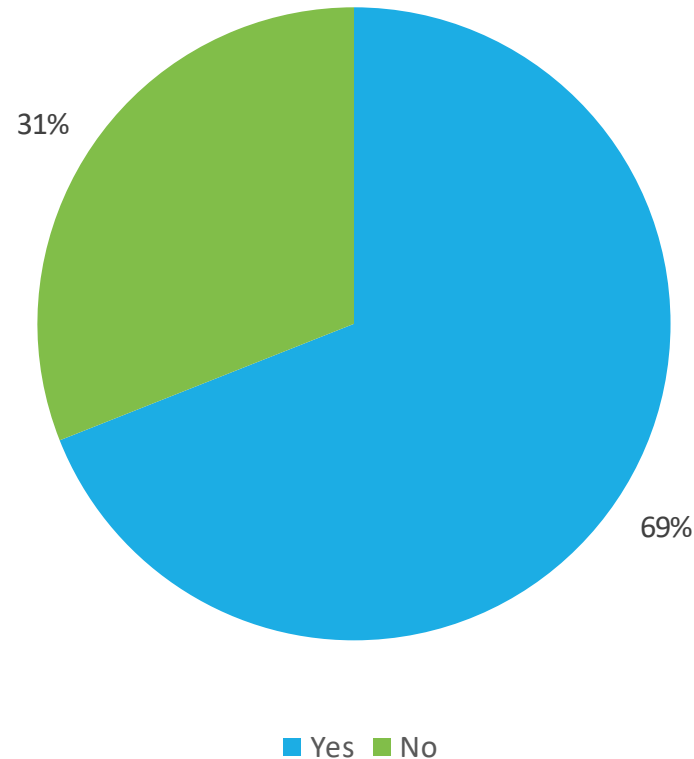
- 37% of those with ACA coverage cite premiums as their top concern, compared to 28% of those with employer-based coverage and 14% of those on Medicare.
- 42% of those age 18 to 24 cite concern about out-of-pocket costs for medical care, compared to 25% of those age 55 to 64.
- 13% of those age 65+ say paying for prescription drugs is their top concern, versus 7% of those age 18 to 24.

Surprise Medical Bills

Most report having had a surprise medical bill, but follow-up questions highlight the need for better consumer education about coverage

- Nearly seven in ten (69%) among general population respondents say they've had a surprise medical bill in the past.
- Of these, about two thirds (67%) say that, in the end, the bill was a "surprise" because they hadn't understood how their coverage worked; an additional 27% say the medical claim resulting in the surprise bill had been incorrectly processed by their insurer.

Have you ever had a surprise medical bill?



Medicare beneficiaries are less likely to have had a surprise medical bill, while the middle-aged are the most likely to report one

- Among respondents from our Medicare beneficiary audience, 54% say they had a surprise bill in the past, compared to 69% of our general population audience.
- General population respondents age 45 to 54 are those most likely to say they had a surprise medical bill (77%).

Snapshot: Medicare Consumer Perspective

"I'm on Medicare but I have good supplemental insurance, so I felt that I was sufficiently covered during the worst of the COVID months. I'm grateful for that. It did make me think about the ability to see a doctor during a pandemic. I had to put a lot of appointments on hold. This concerned me, but I felt if I had a true emergency I would be given good care.

"I really think the COVID crisis was handled fairly well here in New Jersey. My local hospital was at the epicenter of the pandemic. Luckily, I didn't need any treatment during this time but I did have a friend who had to go to the hospital and the facilities for non-COVID patients were very thorough.

"I thought that information released to the public was fair. That said, I did not think that they did a good job of handling people in long term care facilities. As the pandemic progressed, I did feel that more appropriate measures were taken.

"I think everyone should have access to health care. I also feel that the idea of co-pays for services should be eliminated. I do not think that someone should be able dictate where you go for treatment or which doctor you can see. Additionally, in my opinion, there should not be a wait time for procedures, or pre-approvals required."

~ Theresa K., age 72, New Jersey

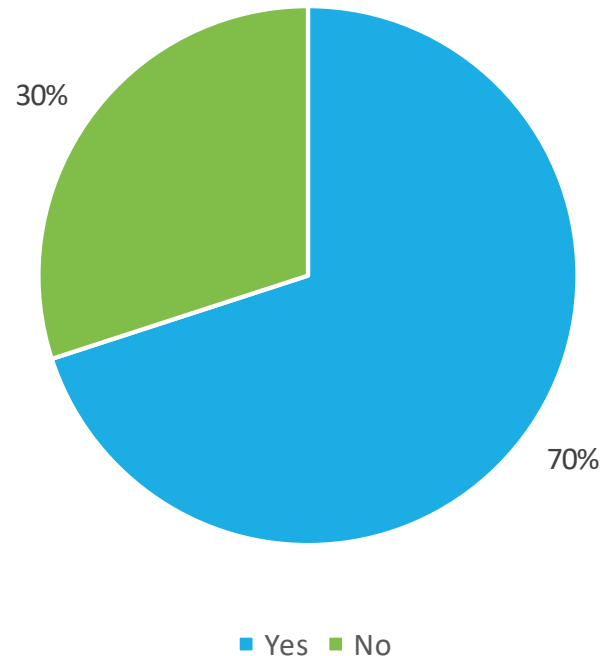
The opinions and thoughts expressed above are the interviewee's own and do not necessarily represent those of eHealth.

COVID Vaccination Choices

Seven in ten respondents have received at least one COVID vaccination – many are open to annual boosters

- 70% of general population respondents report receiving at least one COVID vaccination.
- 30% say they have not yet been vaccinated.
- 60% of general population respondents say they would get an annual COVID booster if it were recommended, as would 75% of Medicare beneficiaries.

Have you received at least one COVID vaccination?



Medicare beneficiaries were especially likely to have received a COVID vaccine

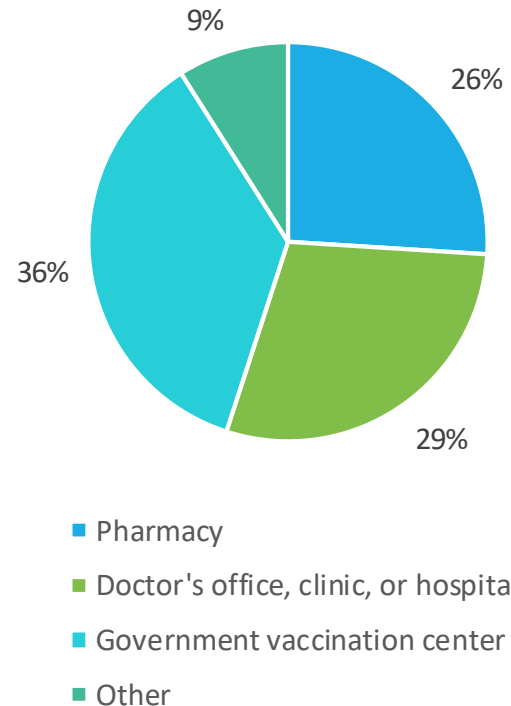
- Among Medicare beneficiaries, more than eight in ten (82%) report they have received at least one COVID vaccine shot.
- Respondents age 18 to 24 are the least likely to have received at least one COVID vaccination (61%).

COVID Vaccination Choices (cont.)

Most got their COVID shots elsewhere than at government vaccination facilities

- More than a third (36%) of vaccinated respondents say they got their shot at a government facility.
- 29% say they got their shot at a doctor's office, clinic, or hospital.
- 26% say they got their shot at a pharmacy.
- 9% got their vaccine at some other location.

Where did you get your COVID vaccination?



Older adults are more likely than young adults to receive their vaccinations at a government facility

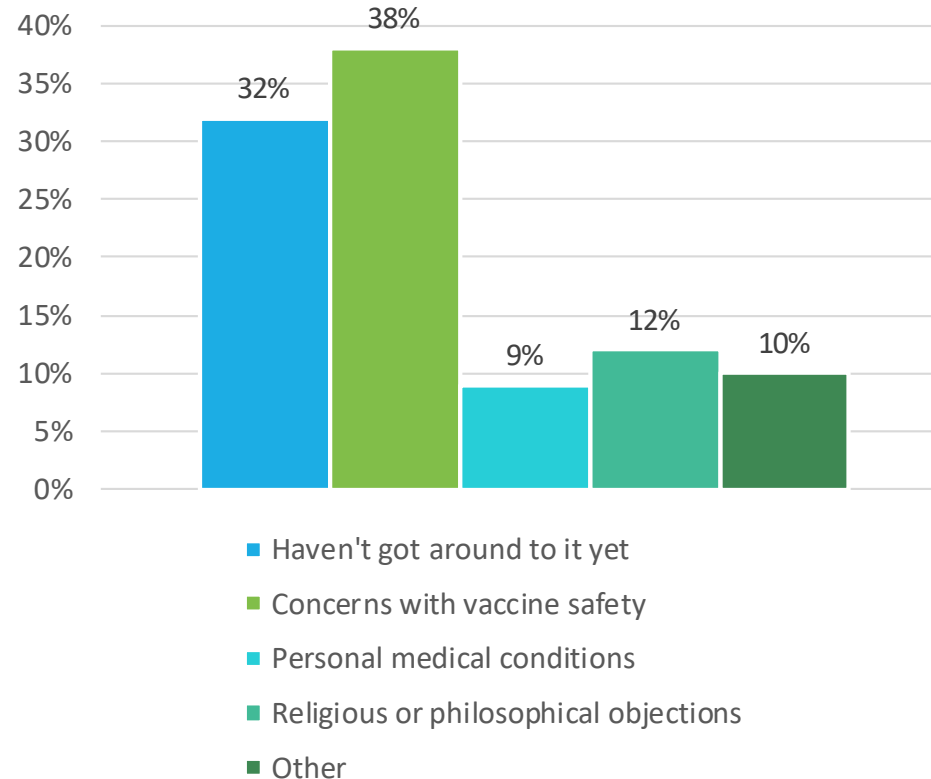
- 30% of respondents under age 35 were vaccinated at a pharmacy, compared to only 18% of respondents age 65 and older.
- 43% of respondents age 65 and older say they got their shot at a government facility, compared to 32% of those age 25 to 34.

COVID Vaccination Choices (cont.)

Concerns with vaccine safety are a big factor for the unvaccinated

- 32% of the unvaccinated say they still intend to be vaccinated.
- 38% do not intend to be vaccinated due to concerns about vaccine safety.
- 12% cite religious or philosophical objections to vaccination.
- 9% say they have a medical condition which prevents them from being vaccinated.

Why haven't you been vaccinated?



Political differences and age illustrate divide over vaccination

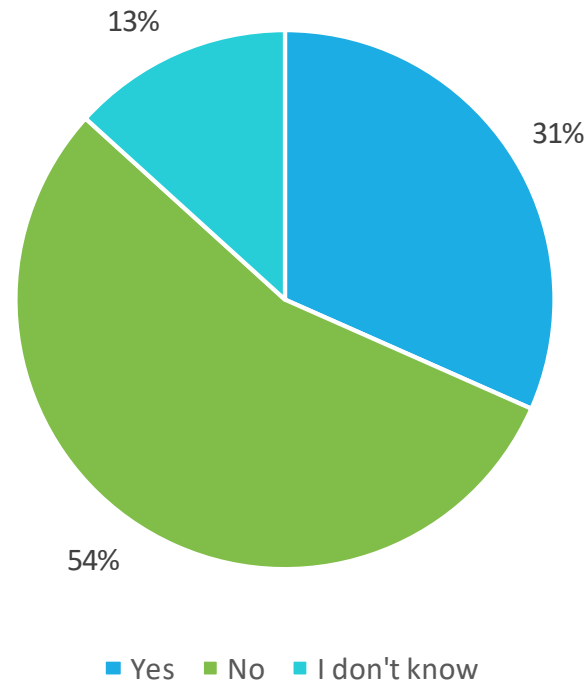
- 53% of Democratic voters who have not yet been vaccinated still intend to get the shot, compared to 19% of Republican voters.
- Unvaccinated people age 45 to 54 are most likely to cite religious or philosophical objections (17%), while people age 65 and older were least likely (7%).

COVID Vaccination Choices (cont.)

Democrats and Medicare-age adults are most likely to support legal requirements for vaccination

- 54% of general population respondents say the government should not require vaccination.
- Nearly half (49%) of Democratic voters support mandatory vaccination, compared to 16% of Republicans and 20% of Independents.
- 38% of Medicare beneficiaries support mandatory vaccination, compared to just 26% of those age 45 to 54.

Should COVID vaccination be required by law?



Most respondents support vaccination requirements for air travelers

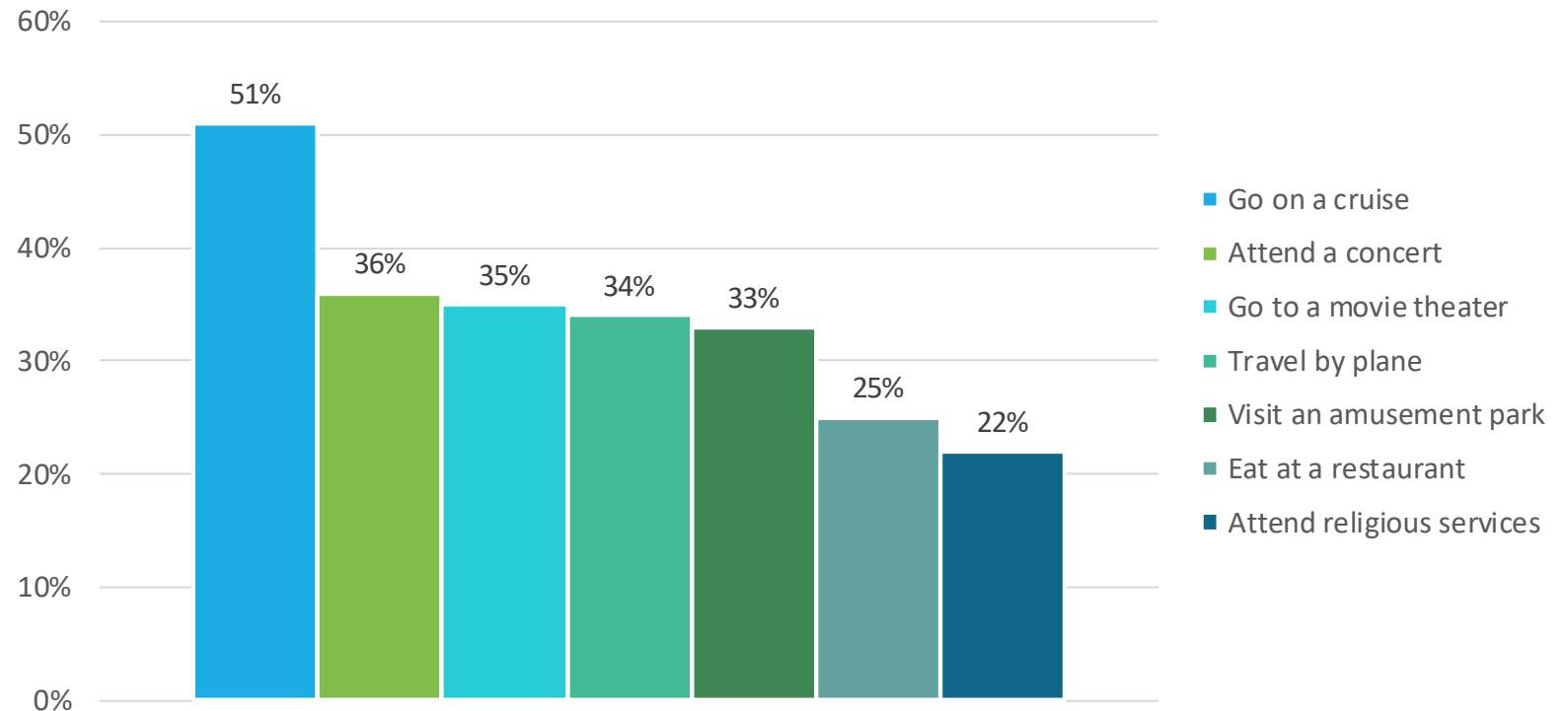
- 53% of general population respondents say proof of vaccination should be required for both domestic and international air travelers. About two thirds (67%) of Medicare beneficiaries agree.
- 16% of general population respondents say proof of vaccination should only apply to international air travelers.
- 31% say no proof of vaccination should be required for any air travel.

Expectations for Life After COVID

Many are likely to make lifestyle changes even after the pandemic is over

- 51% of general population respondents say they will be less likely to go on a cruise (among Medicare enrollees, that figure is 58%).
- About a third will be less likely to attend a music concert (36%), go to the movies (35%), travel by plane (34%) or visit an amusement park (33%).
- More than two in ten say they would be less likely to eat out (25%) or attend religious services (22%).

Which activities are you less likely to engage in after the pandemic is over?



Snapshot: Public Policy Perspective

“Our nation must accelerate progress on improving quality of care while reducing non-value-added costs. Most of the levers are in the hands of individuals, providers, and employers, but legislators and policy makers have a key role to play as well. They should use what we have learned in managing COVID-19 in the past 16 months to create new incentives to mitigate the negative effects of the social determinants of health; for example, by increasing access to synchronous and asynchronous web-based services, and utilizing the infrastructure created to deliver COVID testing and vaccination for other important health care services.

“In our lifetimes both the public and the private sectors will remain indispensable in the delivery of health care services. Instead of an agenda to eliminate one or the other, the focus should be on collaboration and cooperation in achieving the best outcomes, delivered as efficiently and compassionately as possible.

“My advice for the Biden Administration as they tackle the nation’s health care challenges is: Do not let the ‘perfect’ become the enemy of the good. There is a lot of ‘low-hanging fruit’ achievable today – especially with the increased application of information technologies and web-based strategies. And we must increase the incentives to rapidly raise the number of health care providers in preparation for the ‘Silver Tsunami’ (the aging of the Baby Boomers), which is already in progress. Let’s do that by training more Americans rather than by luring talented men and women from other countries where they are vitally needed.”

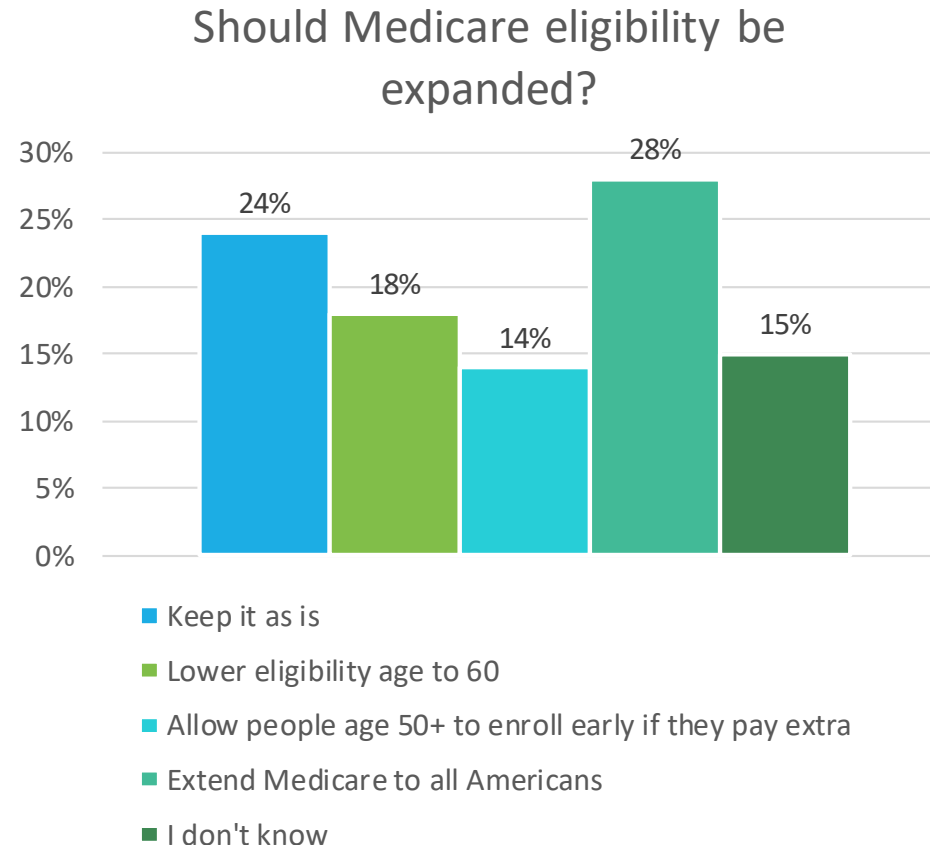
~ **Woodrow A. Myers Jr, M.D., former health commissioner for Indiana and New York City**

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The Future of the Medicare Program

Six in ten (60%) favor expanding Medicare in some form

- 28% of general population respondents favor expanding Medicare to cover all Americans.
- 18% favor lowering the standard Medicare eligibility age from 65 to 60.
- 14% say people age 50 and older should be able to enroll in Medicare early if they pay extra.



Current Medicare beneficiaries have a different take

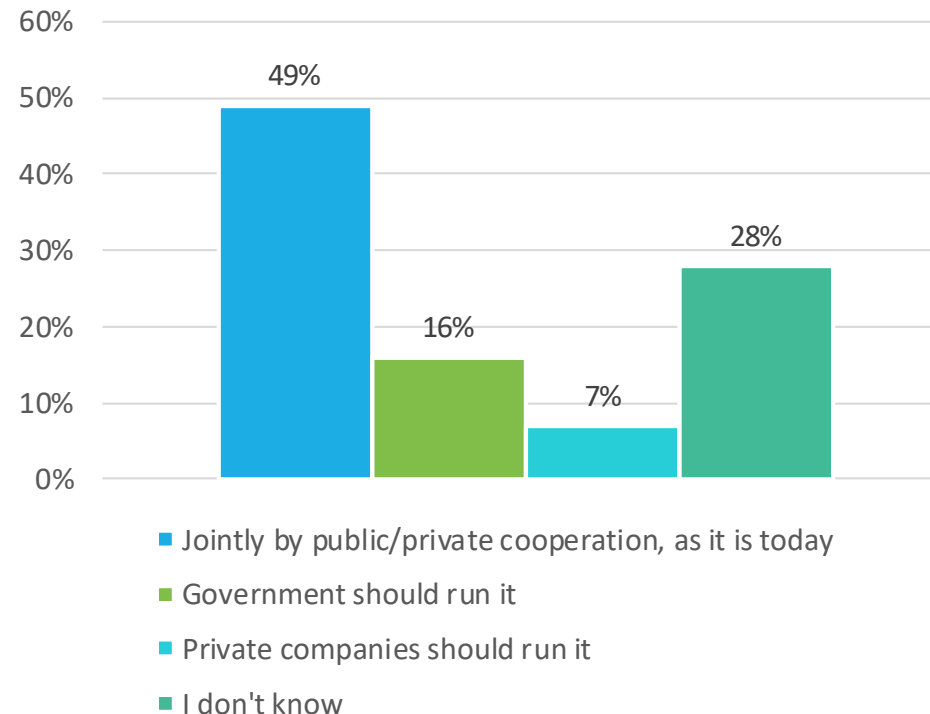
- 47% of current Medicare enrollees say the program should stay as-is, primarily for people age 65 and older. Only 24% of respondents from the general population audience feel the same.
- 21% of Medicare beneficiaries say Medicare should be expanded to cover all Americans.
- 13% favor lowering the eligibility age to 60; 10% would allow people age 50+ to pay to enroll early.

The Future of the Medicare Program (cont.)

Current beneficiaries favor a strong role for private enterprise in Medicare

- About half (49%) of Medicare beneficiary respondents say Medicare should continue to be run by public/private cooperation.
- 16% say it should be run by government alone.
- 7% say it should be run entirely by private sector companies.
- 28% are unsure.

Who should run the Medicare program?*



Political differences correspond to different opinions on the future of Medicare

- Among general population survey respondents, 38% of Democrats favor allowing the government to run the Medicare program with no private sector cooperation, compared to only 13% of Republicans.
- 22% of Republicans favor allowing the private sector to run the Medicare program on its own, compared to only 4% of Democrats.

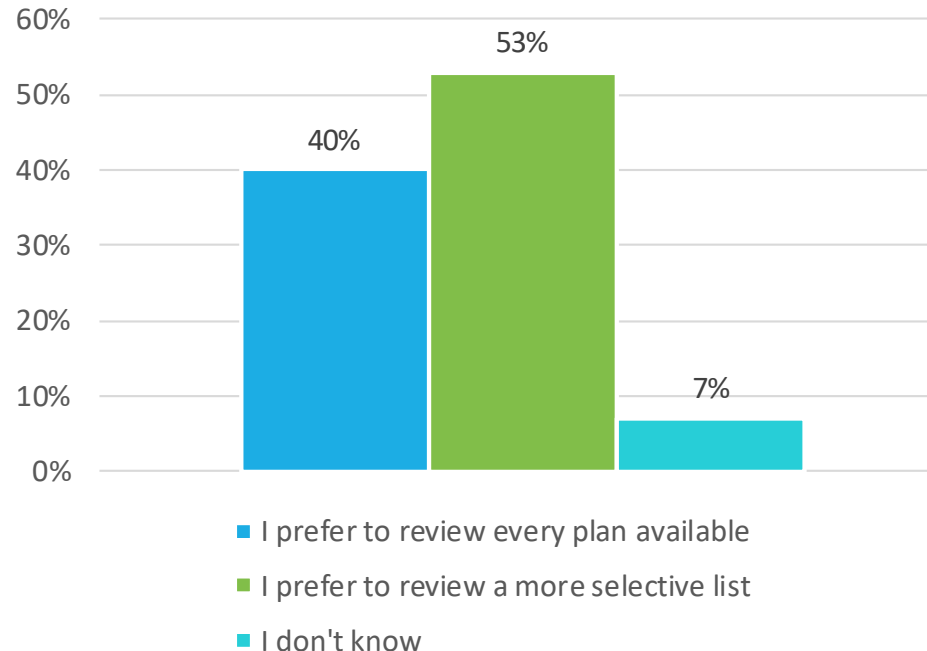
*This chart depicts responses from Medicare beneficiary respondents only.

Shopping for Medicare

Most Medicare beneficiaries want to select a plan from among a curated list of choices

- More than half (53%) say that when shopping for Medicare coverage they prefer to review choices from among a selective list of plan options.
- 40% say they prefer to review each and every Medicare plan option available to them in their area.
- 7% are uncertain.

Would you rather choose from among all available Medicare plans or a more selective set of options?*



Most Medicare beneficiaries are not dissuaded from working with a licensed agent, despite agents earning commissions

- 65% of Medicare beneficiary respondents say they are not bothered by the fact that a licensed agent or broker may earn a commission on sales.
- Licensed agents can provide personal help and advice to health insurance shoppers at no extra cost, since commission are already integrated into premiums.

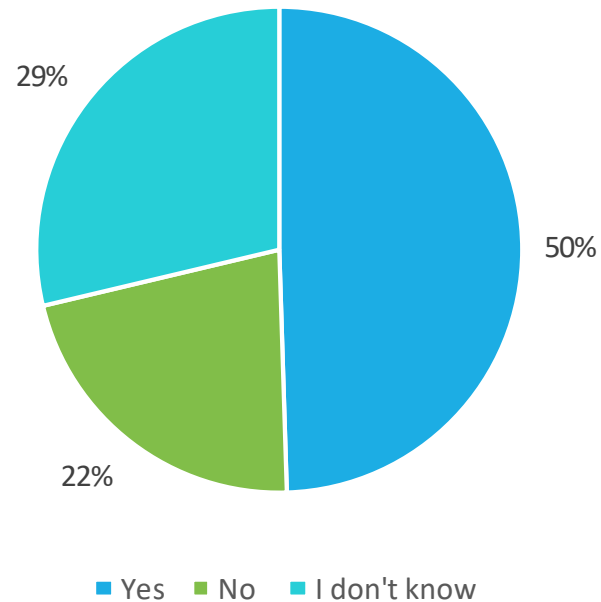
*This chart depicts responses from Medicare beneficiary respondents only.

The Future of the Affordable Care Act (ACA)

Half of Americans approve of more subsidy support for ACA plan enrollees

- Half (50%) of general population respondents say the temporary expansion of government-funded health insurance subsidies to lower the cost of coverage under the ACA should be made permanent.
- 22% feel the expansion of subsidies should not be made permanent; 29% are uncertain.

Should the Biden Administration's expansion of subsidies under the ACA be made permanent?



Proposal for automatic enrollment in ACA coverage gets lackluster support

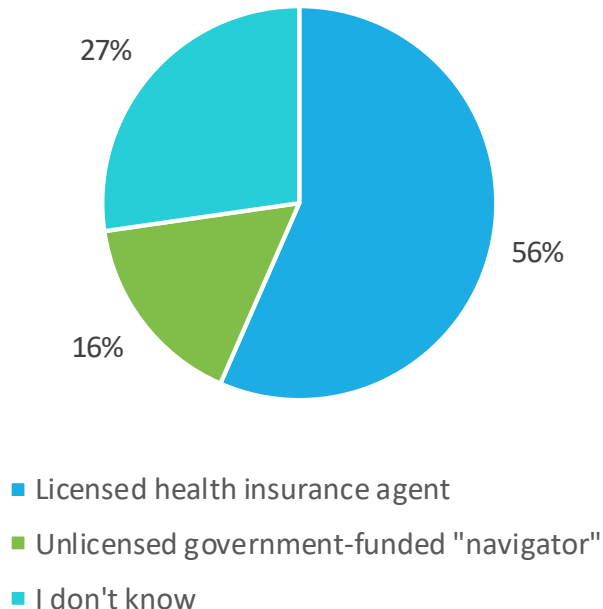
- Only 33% of general population respondents support proposals that would automatically enroll the uninsured into ACA health insurance plans.
- 44% say they would not support auto-enrollment in ACA coverage.
- 24% say they are unsure.

The Future of the Affordable Care Act (cont.)

Most express a higher level of trust in licensed agents than government navigators

- 56% of general population respondents say they would prefer to work with a licensed agent than an unlicensed navigator when enrolling in a health insurance plan.
- 16% say they would rather work with an unlicensed navigator.
- 27% are uncertain.

Who would you rather get assistance from if you were purchasing health insurance?



Republicans and people who buy their own health coverage are more likely to prefer working with a licensed agent

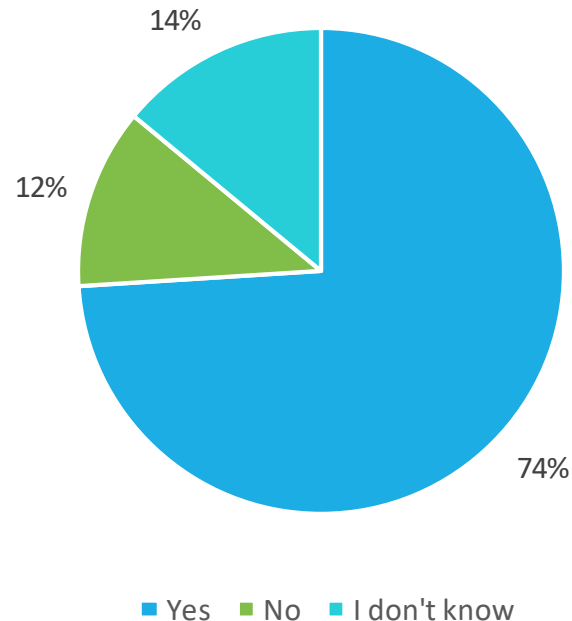
- 71% of Republican voters would rather work with a licensed agent, compared to 50% of Democratic voters.
- Two thirds (66%) of respondents who purchase their own health insurance say they would prefer working with a licensed agent than an unlicensed navigator.

Prescription Drug Costs

Most Americans support direct government action to reduce the cost of prescription drugs

- 74% of general population respondents feel the federal government should directly negotiate with pharmaceutical companies to reduce the cost of prescription drugs.
- 12% would not support the federal government negotiating with drug companies to reduce costs.
- 14% are uncertain.

Should the Biden Administration directly negotiate with drug companies to reduce costs?



Medicare beneficiaries and Democrats are most likely to support government action on drug costs

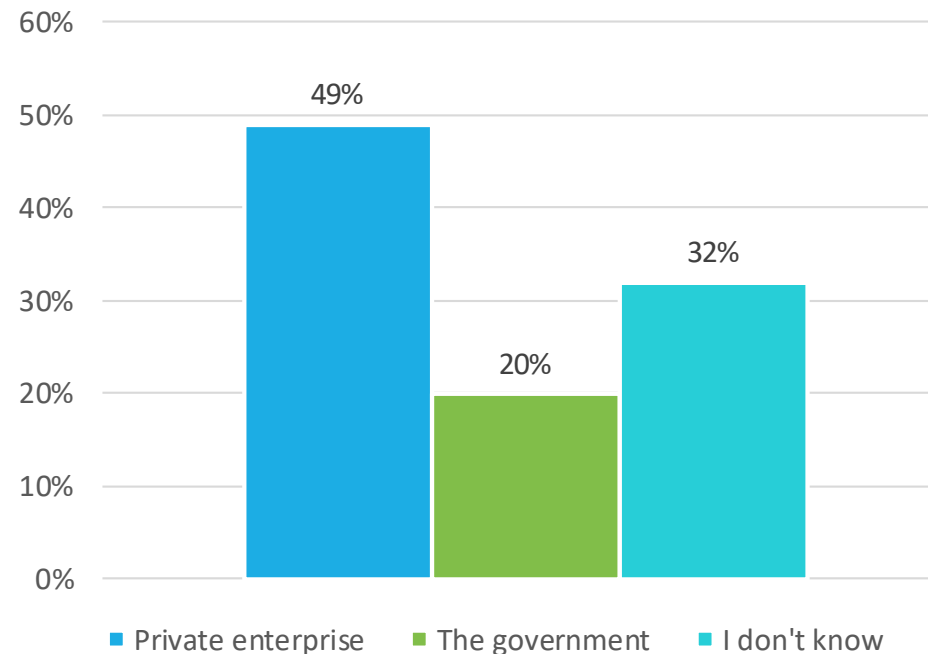
- 86% of Medicare beneficiaries support the federal government negotiating with drug companies to reduce prescription drug costs.
- 84% of Democratic voters support the federal government directly negotiating on costs with pharmaceutical companies, compared to 64% of Republicans.

Innovation in Health Care

Most consumers look to private enterprise for the best in technology and innovation

- About half (49%) of general population respondents say private enterprise does a better job when it comes to technology and innovation in health care. (Among Medicare beneficiaries, that figure is 53%.)
- 20% feel that the government does a better job than private enterprise. (Among Medicare beneficiaries that figure is 14%.)
- 32% are uncertain.

When it comes to technology and innovation in health care today, who does a better job?



Republicans and Independents are more likely than Democrats to look to private enterprise for innovation in health care

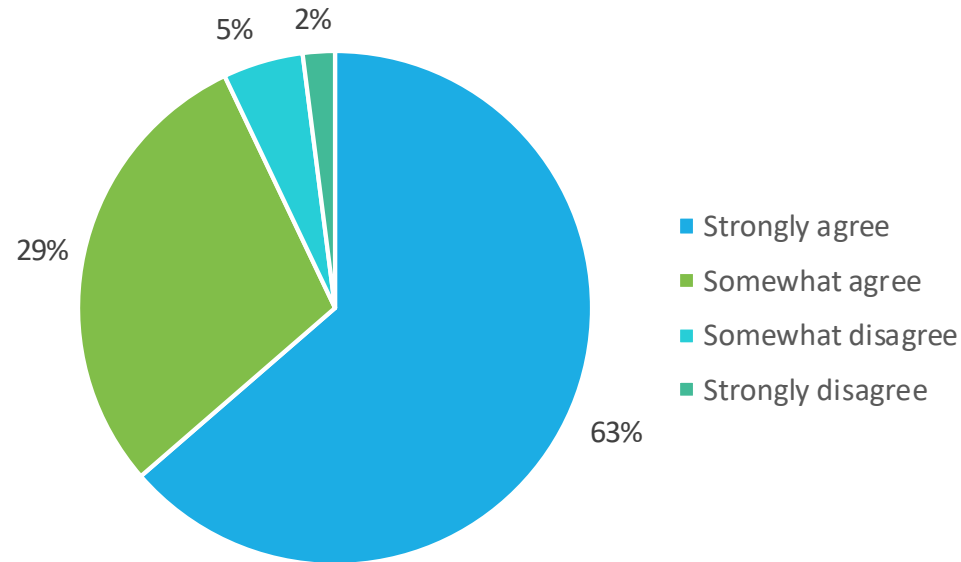
- Majorities of both Republicans (70%) and Independents (52%) say private enterprise does a better job with technology and innovation in health care.
- By contrast, only 37% of Democratic voters felt the same way; 29% of Democratic voters say government does a better job with health care technology and innovation.

Leveraging Medical Claims for Customized Care

Most consumers feel strongly that their medical claims history belongs to them

- Nearly two thirds (63%) of general population respondents strongly agree that they should be able to share their claims history with the individuals and institutions of their choice. (81% of Medicare beneficiaries feel the same.)
- An additional 29% say they “somewhat agree” with that statement.
- Only 7% express disagreement.

“My medical claims history belongs to me and I should be able to share it with whomever I want.”



Most consumers would opt to share their claims history with an agent if it helped them get better plan recommendations

- More than half (54%) of general population respondents say they would share their claims history with a licensed agent if it helped them find a more optimal plan for their personal needs and budget. (59% of Medicare beneficiaries felt the same.)
- 20% say they would not opt to share their claims history with an agent; 26% are uncertain.

Findings from Our Survey of Health Insurance Companies

Snapshot: Insurer Perspective

“COVID had an enormous impact on how Americans view the current health care landscape, and the public’s appetite for new solutions.

“The massive spike in unemployment caused many consumers to see what a difficult position they were in when they lost their group insurance through their employer and had to find other options on their own. Many jumped at the opportunity to obtain ACA-compliant coverage (especially those that were above the old subsidy lines but fall beneath the new ones). I think the pandemic will go down in history as possibly the single largest factor leading to the resurgence of the ACA market.

“It’s also led to an explosion in telehealth benefit utilization as suddenly the option to receive health care services from home became tangible for individuals that wanted to do everything in their power to avoid exposure to the virus. I think that this will continue to be a growing segment as many consumers who never would have considered utilizing it in the past now see the benefits. As technological advancements continue to improve the consumer experience, this option will become even more attractive.

“Finally, between the fallout from the pandemic and the current political leadership there appears to be a very good chance that the Medicare eligibility age is reduced. If/when that happens, it will have a big impact on the market as an entirely new demographic of individuals will be aging in at the same time.”

~ **Michael J. Zundel, National Director of Recruiting at UnitedHealthOne**

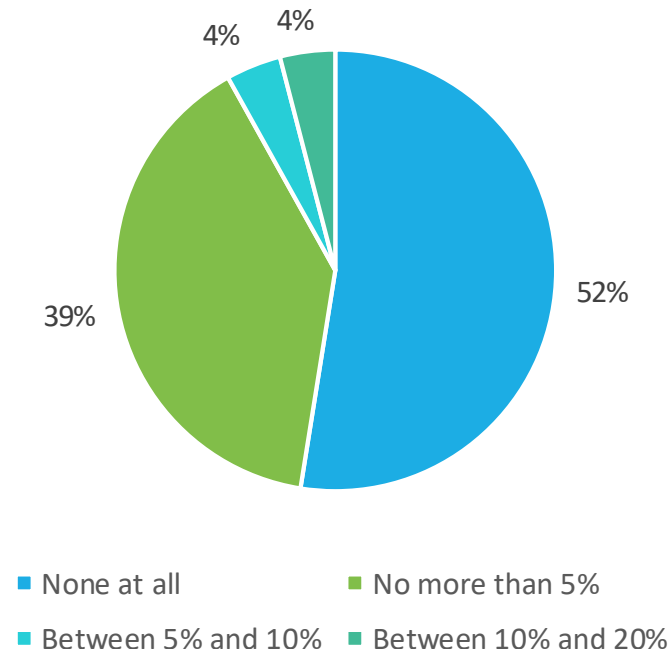
The opinions and thoughts expressed above are the interviewee’s own and do not necessarily represent those of eHealth or UnitedHealthOne.

The Pandemic's Impact on Premiums

Most insurers do not anticipate raising rates significantly as a result of the COVID pandemic

- About half (52%) say they do not anticipate raising rates at all as a result of the pandemic.
- 39% say they do expect to raise rates as a result of the pandemic, but no more than 5%.
- 4% anticipate raising rates 5-10%; another 4% anticipate raising rates 10-20%.

How much, if any, do you anticipate raising premiums as a direct result of the COVID pandemic?



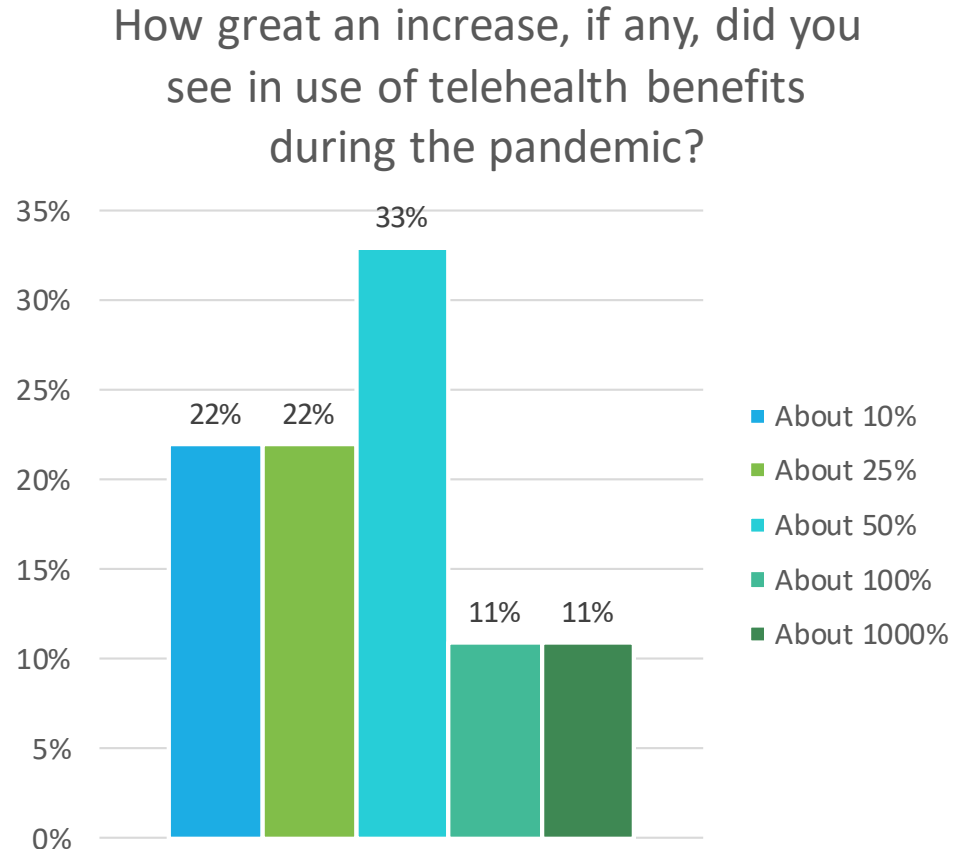
Some insurers plan to make changes to plan benefits as a result of the pandemic

- A third of insurers say they are either very likely (4%) or somewhat likely (29%) to make changes to plan benefits due to the COVID pandemic.
- Among these, 86% say any changes are likely to occur in their telehealth and mental health benefits; 43% say they may make changes to substance abuse benefits.

Utilization of Telehealth & Mental Health Benefits

All insurance company respondents reported an increase in member utilization of telehealth benefits

- 22% report an increase in telehealth utilization of about 10%; another 22% report an increase of about 25%.
- 33% report an increase in telehealth utilization of 50%.
- 22% report an increase in telehealth utilization of about 100% or greater.



Most insurers report an increase in utilization of mental health benefits as well

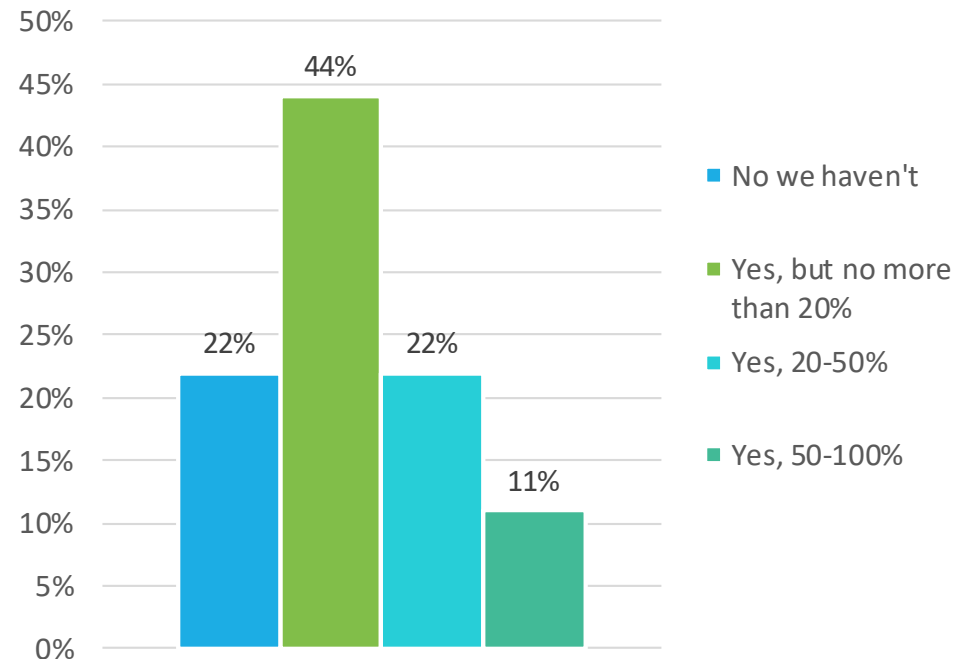
- 44% report an increase in use of mental health benefits of about 10%.
- 22% report an increase in use of mental health benefits of 25%.
- 11% report an increase in use of mental health benefits of about 100%.
- 22% report no increase in use of mental health benefits.

Delayed Care & Future Underwriting Risks

Most insurers report an increase in non-COVID care among members

- 44% of respondents say they've seen an increase in non-COVID care of 20% or less.
- 22% report an increase in non-COVID care of 20-50%.
- 11% report an increase in non-COVID care of 50-100%.
- 22% say they have seen no increase in non-COVID care among members.

Have you seen an increase in non-COVID care since the low point of the pandemic?



Many insurers are concerned about future underwriting risks resulting from the shut-down

- 50% of insurance company respondents express concern about the potential long-term underwriting risks associated with the economic shut-down, social distancing, and other restrictions on social life since the COVID pandemic began.

Methodology

Findings presented in this report are based on voluntary surveys conducted by eHealth of consumers age 18+ and health insurance company representatives. The surveys were conducted between May 1 and May 13, 2021 and more than 4,700 responses were collected. These include the collection of 2,231 responses from a general population audience sample obtained through a third-party vendor at eHealth's direction; the collection of 2,575 responses from Medicare beneficiaries who purchased a Medicare insurance plan through eHealth; and the collection of 26 responses from insurance industry representatives working for health insurance companies with whom eHealth has a relationship. Unless otherwise indicated, findings presented are taken from among respondents in the general population audience. Findings illustrating sentiments expressed by Medicare beneficiaries are taken from respondents from the Medicare beneficiary audience rather than from a subset of the general population audience. Insurers invited to participate in eHealth's survey provide health insurance coverage for more than 100 million Americans, by eHealth's estimate. Party affiliation is based on respondents voluntarily identifying themselves as more likely to vote for candidates from either the Democratic or Republican parties; those reporting themselves as equally likely to vote for candidates of either major party are classified for the purposes of this report as Independents. Within this report, percentages have been rounded to the nearest full percentage point and may add to slightly more or less than 100% due to rounding.

About eHealth

eHealth, Inc. (NASDAQ: EHTH) operates a leading health insurance marketplace at eHealth.com and eHealthMedicare.com with technology that provides consumers with health insurance enrollment solutions. Since 1997, we have connected more than 8 million members with quality, affordable health insurance, Medicare options, and ancillary plans. Our proprietary marketplace offers Medicare Advantage, Medicare Supplement, Medicare Part D prescription drug, individual, family, small business and other plans from over 180 health insurance carriers across fifty states and the District of Columbia.



Listening to Californians with Low Incomes: How They Experience the Health Care System and What It Means for the Future

The COVID-19 pandemic has upended the lives of most Californians, and caused significant impacts to the physical, emotional, and financial well-being of all residents, especially those with low incomes. To better understand how the pandemic impacted the health and health care experiences of Californians with low incomes, the California Health Care Foundation and NORC at the University of Chicago, a national research organization, conducted a statewide survey of California residents who had received care since March 2019, with an oversampling of residents with low incomes (defined as below 200% of the federal poverty level).¹⁻³

The survey, conducted in the summer of 2020, asked respondents about their health care concerns, experiences, and access before and during the COVID-19 pandemic. Survey findings were supplemented with qualitative findings from interviews conducted with 37 survey respondents with low incomes and with 10 health care experts.

“Inequality is growing. We know that as a result of the pandemic, economic, health, and inequality otherwise, the gap has only widened. The pandemic served as this great magnifier of what was already there. I talk about it as a crisis within a crisis. . . . We should have known it was going to happen because it’s building upon decades, generations of inequities and injustices.”

— Kiran Savage-Sangwan
California Pan-Ethnic Health Network (CPEHN)

KEY FINDINGS:

Understanding the Impact of the COVID-19 Pandemic

The study found that the pandemic exposed and exacerbated inequities in health, mental health, and health care access for Californians with low incomes, particularly for Californians of color. In addition, the pandemic heightened and increased economic and employment inequalities, placing additional stress on people most likely to experience inequities. Specific findings from the research are presented below.

Deteriorating mental health for many. The pandemic exerted a significant impact on the mental and emotional health of many Californians with low incomes, especially those who already considered their mental health to be “fair or poor.” More than half of respondents with low incomes (53%) who rated their prepandemic mental health as “fair or poor” reported worse mental health since the start of the pandemic.

Strong interest in care for mental health problems. More than two-thirds of respondents with low incomes (68%) who wanted to see a provider during the pandemic wanted care for a mental health problem. This finding reveals both the extent of the pandemic’s negative impact on people’s mental health and indicates that the long-entrenched stigma associated with acknowledging and seeking care for mental health problems may be decreasing.

Pent-up demand for health care. Many Californians with low incomes have not received needed care or have delayed care since the start of the pandemic. This survey was limited to Californians who had received care since

March 2019. However, only 24% reported a problem that they wanted to see a provider for since the start of the pandemic, suggesting many may have been delaying care. Furthermore, among those who wanted to see a provider, many did not receive care for their health problem.

Telehealth a critical source of care. Two-thirds of respondents with low incomes (65%) and three-quarters of respondents of color (76%) who received care during the pandemic received care via telehealth (either phone or video). Among those who received care via telehealth, satisfaction was high, with 70% of respondents with low incomes and 82% of respondents of color with low incomes saying they would likely choose a phone or video visit over an in-person visit in the future.

Experience of stress prevalent and debilitating. Californians with low incomes were more likely to experience pandemic-related stressors than those with higher incomes.⁴ Ninety-six percent of respondents with low incomes experienced at least one pandemic-related stress. Stress was associated with worsening mental health during the pandemic.

LOOKING FORWARD:

Implications for the Future

Interviews with leading health care experts revealed six key themes for how California's health care system should respond to the lessons learned during the pandemic.

Restructuring payment systems to address health care inequities. Experts recognized that addressing inequities in health and health care access will require changes to policy and to health care payment models. One expert stressed the importance of moving away from fee-for-service payment models toward value-based and place-based contracting to incentivize health care systems to proactively engage high-risk patients in their communities, and to coordinate care and services that address their physical, behavioral, and social needs.

Expanding access to mental health care and promoting emotional well-being. The significant mental health concerns experienced by respondents highlights the

urgency to increase access to care for mental health issues. Experts emphasized that mental health services should be integrated into primary care settings and be redesigned to reach people where they are (instead of waiting for them to engage with the system) and to promote mental well-being and prevention. In addition, the mental health workforce needs to be expanded and diversified to better meet the needs of people from different cultural backgrounds. Experts offered solutions including leveraging a community-based workforce to provide outreach to people experiencing mental health issues and expanding the use of nontraditional mental health services such as technology-based supports.

Redefining access to health care. The research revealed the need to bring Californians with low incomes back into the health care system as soon as possible. Experts recommended leveraging primary care providers, the mass COVID-19 vaccination effort, and community health workers and *promotores de salud* to reengage patients in accessing care not only to address existing health issues but also for critical prevention, such as screenings for adults and children, and vaccinations for children. Experts also recommended that these measures should continue beyond the immediate term and serve as a starting point for reconsidering how California's health care system ensures convenient and comprehensive access to care, especially for those with low incomes and for people of color.

"We need to make sure that there are incentives for more place-based, equity-driven coordination of care and services to address the medical, behavioral, and social needs of low-income, high-need patients. Right now, the current model of care, especially fee-for-service, drives structural inequity, and helps perpetuate structural racism and economic inequality."

— Dr. Rishi Manchanda, HealthBegins

Ensuring equitable access to telehealth. The pandemic connected many more Californians to telehealth, and experts agreed that telehealth will continue to play a critical role in the health care system moving forward. However, they also noted that investment is needed to ensure that Californians with low incomes have sufficient technology, connectivity, and privacy for effective telehealth visits. While telehealth offers significant benefits, such as requiring less time and hassle to get care and expanding access to linguistically and racially/ethnically diverse providers, they emphasized that all patients should be able to choose whether they receive care in person or via telehealth.

Breaking down data silos in health and social services. The research demonstrated that many Californians with low incomes have needs for health care, mental health care, social services, and economic support. Patient needs can be more easily and safely addressed by establishing data systems and structures that enable health care providers to share health information about patients, both between health care delivery systems and between health systems and other types of providers such as jails and prisons or homeless service providers.

Addressing social determinants of health. The study emphasized the importance of social determinants of health, and their impact on the stress and deteriorating health experienced by many Californians with low incomes during the pandemic. Experts universally agreed that addressing these social determinants of health, including housing, food security, and employment, will be critical to reducing inequities in health but cautioned that there are no easy solutions. Many experts recommended expanding investment in housing and economic opportunities in communities disproportionately affected by inequities.

About the Authors

This report was written by Jen Joynt, independent health care consultant; Lucy Rabinowitz, MPH, principal research analyst at NORC; and Rebecca Catterson, MPH, senior research director at NORC. **NORC** at the University of Chicago is an objective nonpartisan research institution that delivers reliable data and rigorous analysis to guide critical programmatic, business, and policy decisions.

About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

1. The survey was limited to Californian residents age 18 to 64 who had received health care between March 2019 and the time of the survey, which was conducted June 24 to August 21, 2020.
2. In 2020 the FPL was \$12,760 for a single person and \$26,200 for a family of four.
3. Sixty-eight percent of the sample were residents with low incomes.
4. Respondents were asked if they experienced any of the following COVID-19-related stresses: Concern about the health or well-being of a loved one; affording basic needs, such as food, rent, and utilities; children out of school or childcare unavailable; stress in your relationship or marriage; death of a loved one; other stress.



Viewpoint

Making the Affordable Care Act Marketplace More Affordable

Zirui Song, MD, PhD

As the Biden administration aims to expand health insurance coverage, making insurance plans in the US Affordable Care Act (ACA) Marketplace more affordable is a key priority.

Debate over the ACA Marketplace has focused more on competition among insurers—often measured by the number of insurers offering Marketplace plans in a state—and less on the declining competition between health care delivery organizations. Yet hospital and physician concentration, which raises prices of health care services for Marketplace enrollees and their insurers, directly contributes to higher Marketplace premiums¹—costing taxpayers through ACA premium subsidies and exacerbating insurer exit from the ACA Marketplace.

There are only 2 ways to lower prices—competition and regulation. Although encouraging hospital and physician competition is often invoked, it is difficult to achieve in practice. Hospital and physician consolidation has not slowed. States often lack resources to evaluate mergers and acquisitions, and the Federal Trade Commission is similarly constrained to challenge most deals. Separating large delivery systems into competitive entities is exceedingly difficult. As a result, policy makers are left with price regulation as the more realistic lever.

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

Rationale for Capping Prices in the ACA Marketplace

Although containing prices in the commercial insurance market writ large (which enrolls half of the country) would be challenging, a legislative window of opportunity exists to do so in the ACA Marketplace—a federally subsidized program that enrolls 3% of the population. Doing so would follow precedent for patients across federal health programs, decrease cost sharing for current ACA Marketplace enrollees, and save taxpayer dollars to help finance insurance expansion.

The federal government pays traditional Medicare prices, or less, in nearly all federal health programs. When Medicare Advantage enrollees are seen by an out of network clinician, the clinician must accept traditional Medicare prices as payment in full. Without this provision, enacted by a Republican Congress and administration in 2003, Medicare Advantage plans would face higher prices and likely compete less effectively against traditional Medicare. By foreclosing the opportunity to charge higher prices out of network, it additionally encourages hospitals and physicians to join Medicare Advantage plans' networks.

Similarly, in the 3 federal health systems—Veterans Health Administration, Military Health System, and Indian Health Service—many services are purchased from community hospitals and physicians, who are also paid roughly Medicare prices.²⁻⁴ A generation ago, the Department of Defense was concerned that health care spending crowded out resources for force readiness, so it lowered its prices to Medicare levels as well.

In the ACA Marketplace, by contrast, government spending through subsidies reflects commercial prices, which are consistently higher than Medicare prices. Commercial prices nationwide are double Medicare prices for hospitalizations and 43% higher for physicians.⁵ Although these gaps may be smaller in the ACA Marketplace due to narrower networks, prices likely remain substantially above Medicare levels.

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Options for Capping Prices in the ACA Marketplace

An incremental policy could prevent further escalation of prices. Lawmakers could cap all prices on the ACA Marketplace (both in network and out of network) around current average levels, such as 200% of Medicare for hospitals, to minimize revenue losses.

Alternatively, lawmakers could approach the precedent of other federal programs by capping all ACA Marketplace prices closer to Medicare levels. Based on current commercial-to-Medicare price differences and spending on hospitals and physicians, a cap at Medicare levels would lower insurer expenses by about 30%. If insurers passed these savings onto enrollees and the government (ie, taxpayers) entirely through lower ACA premiums, premiums would decline by the same amount (insurers cannot keep all savings as profit under the ACA requirement that at least 80% to 85% of premiums are spent on care).

Based on 2020 ACA Marketplace enrollment and subsidy rules, if the premiums savings were used entirely to lower government subsidies, the government would save 38% on its subsidies. The government, however, could also share those savings with enrollees, such as by reducing the maximum percentage of income that enrollees could pay in ACA Marketplace premiums. If this “limit on out-of-pocket premiums” were proportionally reduced by 30%—eg, from 10% to 7% of income for a family of 4 at 300% to 400% of the federal poverty level—the family’s maximum premium would fall from roughly \$9000 to \$6000 per year, and government savings on subsidies would decrease from 38% to 30%. Concretely, 30% of the \$577 billion in ACA Marketplace subsidies over the next 10 years still yields over \$170 billion in federal savings.⁶

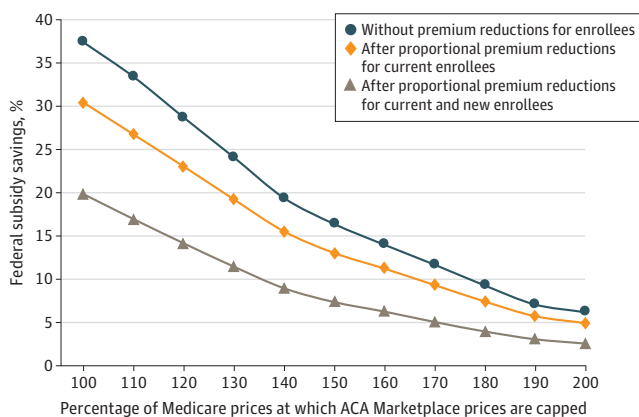
Lower ACA premiums and cost-sharing would also stimulate ACA Marketplace enrollment. Assuming that every 1 percentage-point drop in premiums and cost-sharing increases enrollment by 0.5%, ACA enrollment would increase by 15% (about 1.5 million). The government would spend some of its subsidy savings on new subsidies for these enrollees—estimated to consume roughly one-third of the savings—but its remaining savings, summed across all enrollees, would remain a substantial 20%. This could finance other needs, including helping states pay for new Medicaid enrollees.

The **Figure** illustrates projected federal savings at levels of the ACA Marketplace price cap. The closer the cap approaches Medicare prices, the larger the federal savings and ACA Marketplace enrollment, but the more hospitals and physicians are affected.

Implications and Extensions

The American Rescue Plan Act of 2021 increased ACA Marketplace subsidies through 2022 by an estimated \$35 billion, though it did not directly address the underlying prices of care. Incorporating a price cap would create much-needed revenue to finance these subsidies and other priorities.

Figure. Level of ACA Marketplace Price Cap and Federal Savings^a



ACA indicates the Affordable Care Act.

^a Federal subsidy savings from capping ACA Marketplace prices at 100% through 200% of Medicare prices are shown as a percent of current law subsidies. The calculations used average commercial and Medicare prices, distribution of spending across inpatient and outpatient care, and current enrollment and subsidy rules. A 1 percentage-point drop in out-of-pocket costs on the ACA Marketplace is assumed to increase enrollment by 0.5%, consistent with assumptions used by the Congressional Budget Office.

Without additional federal spending, lawmakers could extend a price cap to protect the uninsured, whose billed charges usually exceed even commercial prices. Lawmakers could also extend a price cap to the few million people in ACA-compliant plans outside the ACA Marketplace to unify the rules between potentially similar populations.

A price cap would likely trigger opposition and concerns regarding diminished patient access. Although hospital and practice revenue is especially salient during the pandemic, clinicians have long accepted Medicare prices for treating other federal populations—from the children of military families to the elderly enrolled in Medicare Advantage—suggesting they are likely to continue accepting ACA Marketplace enrollees. Hospitals and physicians might respond to a price cap by increasing utilization or raising prices in other settings.⁷ The magnitudes of these responses deserve monitoring. Even with increased enrollment, ACA Marketplace enrollees would remain a small share of most hospital and physician and patient panels, for whom a price cap is less consequential to clinical revenue compared with broader price reductions.

ARTICLE INFORMATION

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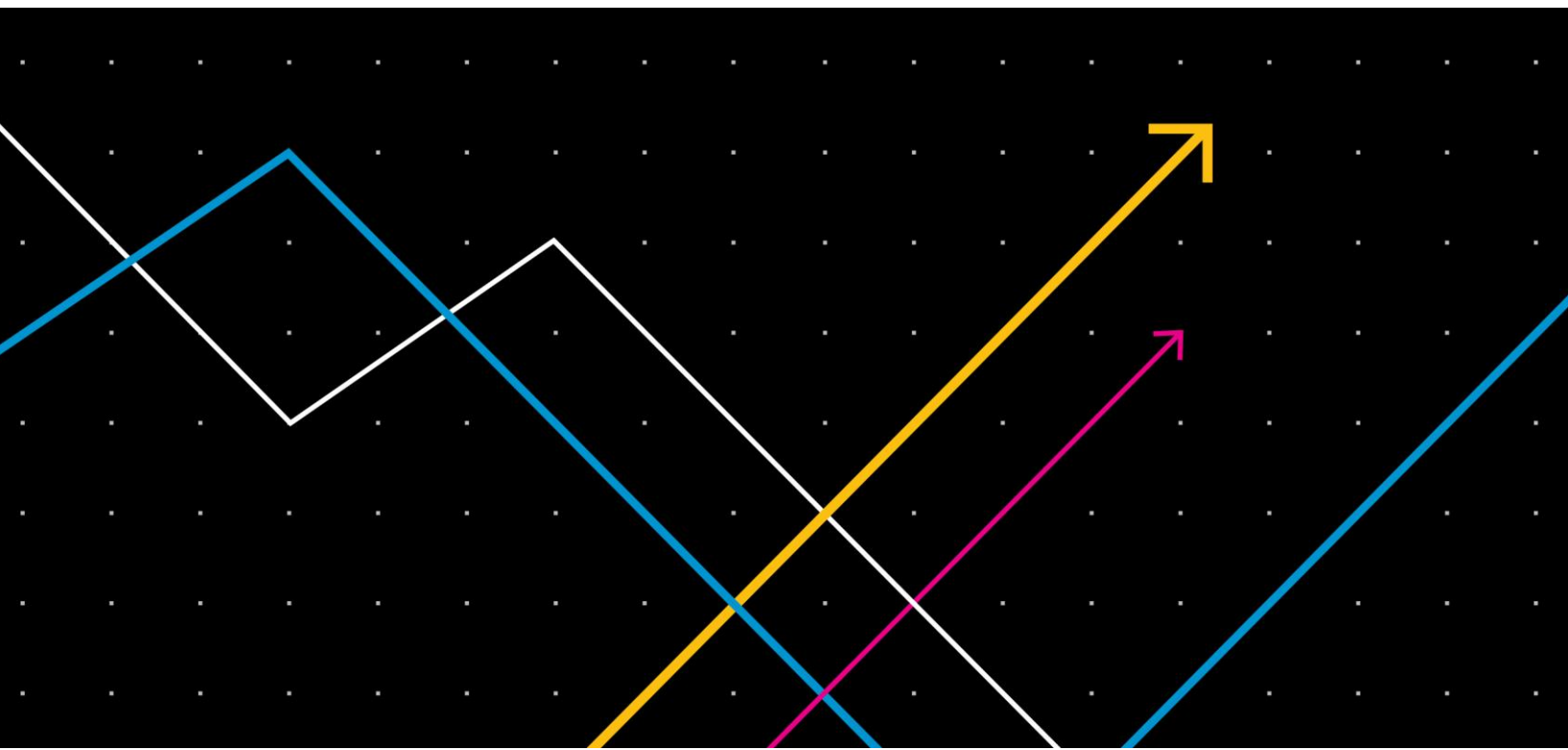
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RESEARCH REPORT

Marketplace Premiums and Participation in 2021

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May 2021

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ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is a leading research organization dedicated to developing evidence-based insights that improve people's lives and strengthen communities. For 50 years, Urban has been the trusted source for rigorous analysis of complex social and economic issues; strategic advice to policymakers, philanthropists, and practitioners; and new, promising ideas that expand opportunities for all. Our work inspires effective decisions that advance fairness and enhance the well-being of people and places.

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Marketplace Premiums and Participation in 2021

In 2021, the Affordable Care Act (ACA) Marketplaces entered their eighth year of operation and appears to be approaching a steady path, as reflected by premium growth. Predictions that the federal and state Marketplaces would shrink over time or fail in some areas of the country have not come to pass, and insurer participation is increasing. A large premium increase in 2018 did not disrupt the market as much as projected, because the premium tax credits are designed to shield subsidized enrollees from such changes. Since then, premiums appear to have stabilized. Recent data show that the national average benchmark premium fell again in 2021, following decreases in both 2019 and 2020. This decline is remarkable because it contrasts with premium increases in the employer-sponsored insurance market over the same period. However, this nationwide average belies the variation in premiums both across and within states.

In this paper, we explore premiums at the state and rating region levels, focusing on the changes between 2020 and 2021. Though the Marketplace as a whole is approaching a steady path, the wide range of premiums at the state and rating region levels suggest various economic and policy factors influence these premium differences. Insurer participation is key to setting premium levels and influencing growth over time. State policymakers may adopt policies that directly and indirectly affect premiums and premium growth rates. We present regression results that examine the relationship between 2021 Marketplace benchmark premiums by rating region and factors such as the number of insurers participating in a rating region, the type of insurers participating, measures of hospital concentration, and the adoption of several state policies. We conclude by analyzing specific insurers' increased participation and its effects on a sample of markets in select states.

Background

In 2018, benchmark premiums increased dramatically after the Trump administration announced in late summer 2017 that the federal government would no longer reimburse insurers for cost-sharing reductions.¹ Under current law, insurers are still required to provide reductions in cost sharing for low-income people; thus, in response to the announcement, insurers built the expected costs of funding the cost-sharing reductions into their premiums. States took various approaches when providing

guidance to participating insurers, but most states required that insurers load the additional costs into silver-tier Marketplace premiums.² Insurer uncertainty regarding enforcement of the individual mandate may also have contributed to premium increases in 2018 (Holahan et al. 2019). In addition, insurers were concerned that enrollment would be affected by the sustained legislative effort to repeal the Affordable Care Act in spring and summer 2017. The result was substantial increases in silver Marketplace premiums; in 2018, the national average benchmark premium climbed more than 30 percent (table 1).

TABLE 1
State Average Benchmark Premium for a 40-Year-Old Nonsmoker and Percent Change, 2017–21

	Benchmark Premium (\$)					Percent Change			
	2017	2018	2019	2020	2021	2017–18	2018–19	2019–20	2020–21
US average	357	472	466	451	443	31.9	-1.2	-3.2	-1.7
Alabama	468	556	544	551	550	18.7	-2.1	1.2	-0.2
Alaska	927	727	714	721	674	-21.6	-1.8	0.9	-6.5
Arizona	539	517	464	438	411	-4.1	-10.3	-5.6	-6.2
Arkansas	302	364	380	365	387	20.6	4.2	-3.8	5.8
California	335	424	446	426	397	26.7	5.0	-4.3	-6.8
Colorado	340	438	496	374	351	28.7	13.3	-24.6	-6.2
Connecticut	436	541	472	565	519	24.1	-12.8	19.7	-8.1
DC	298	324	393	414	384	8.7	21.4	5.2	-7.1
Delaware	423	591	685	548	522	39.5	15.9	-20.0	-4.7
Florida	336	476	485	472	449	41.8	1.7	-2.7	-4.9
Georgia	320	489	457	438	442	52.8	-6.5	-4.2	1.1
Hawaii	347	456	503	471	467	31.6	10.2	-6.4	-0.8
Idaho	355	479	486	521	494	35.1	1.4	7.4	-5.3
Illinois	356	488	474	425	413	36.9	-2.9	-10.2	-3.0
Indiana	275	344	338	392	398	25.0	-1.9	16.1	1.3
Iowa	332	756	731	689	474	127.7	-3.2	-5.7	-31.3
Kansas	362	485	528	486	469	33.9	8.7	-7.8	-3.6
Kentucky	266	401	433	460	444	50.6	7.8	6.4	-3.6
Louisiana	413	487	461	497	492	17.7	-5.3	7.9	-1.1
Maine	378	575	531	499	430	52.4	-7.7	-6.0	-13.9
Maryland	309	456	419	397	339	47.6	-8.2	-5.3	-14.5
Massachusetts	252	315	330	354	355	25.4	4.6	7.3	0.3
Michigan	265	368	373	351	335	38.7	1.3	-5.9	-4.5
Minnesota	442	380	333	312	292	-14.1	-12.2	-6.3	-6.4
Mississippi	332	520	521	484	457	56.3	0.4	-7.2	-5.5
Missouri	369	520	491	479	462	41.2	-5.6	-2.4	-3.6
Montana	450	522	553	472	434	16.0	5.9	-14.7	-8.1
Nebraska	474	757	747	676	579	59.6	-1.3	-9.5	-14.4
Nevada	303	431	412	379	387	42.3	-4.4	-8.0	2.0
New Hampshire	267	475	402	405	325	77.8	-15.2	0.5	-19.7
New Jersey	339	411	348	389	367	21.3	-15.3	11.8	-5.6
New Mexico	255	424	366	346	329	66.5	-13.8	-5.4	-5.1
New York	454	498	566	591	575	9.7	13.7	4.4	-2.7
North Carolina	540	618	611	543	489	14.6	-1.2	-11.1	-10.0

	Benchmark Premium (\$)					Percent Change			
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21
North Dakota	334	309	396	333	410	-7.4	27.9	-15.8	23.0
Ohio	263	364	367	360	358	38.7	0.6	-1.8	-0.4
Oklahoma	503	658	661	546	485	30.9	0.4	-17.5	-11.1
Oregon	321	395	433	439	418	23.1	9.4	1.6	-4.9
Pennsylvania	369	526	457	440	440	42.5	-13.0	-3.7	-0.1
Rhode Island	261	311	336	332	328	19.0	8.0	-1.2	-1.2
South Carolina	390	524	557	509	471	34.3	6.2	-8.5	-7.4
South Dakota	457	495	526	562	575	8.4	6.2	6.9	2.3
Tennessee	471	741	546	509	451	57.4	-26.3	-6.7	-11.3
Texas	287	404	419	415	410	40.9	3.7	-1.1	-1.2
Utah	311	550	539	481	463	77.1	-1.9	-10.8	-3.8
Vermont	492	505	517	662	574	2.8	2.3	27.9	-13.2
Virginia	318	524	558	517	470	64.7	6.4	-7.2	-9.1
Washington	247	336	388	389	374	35.6	15.7	0.2	-3.9
West Virginia	462	532	585	622	641	15.3	9.9	6.4	3.0
Wisconsin	359	524	519	478	432	45.8	-0.9	-7.9	-9.7
Wyoming	501	861	860	877	782	71.7	-0.1	2.0	-10.9

Source: Urban Institute analysis of data from Healthcare.gov and relevant state-based Marketplace websites.

Note: State average is average of second-lowest silver premium offered in each rating region.

A key feature of the Marketplace has enabled it to withstand these upheavals in premiums without substantial enrollment losses: premium tax credits are designed to protect subsidized enrollees from increases in premiums. Marketplace enrollment did not fall as much as some feared in the wake of the large premium increases of 2018 because of the structure of the premium tax credits. On the one hand, the policy change regarding cost-sharing reductions that caused large premium increases in 2018 had an unanticipated side effect of increasing premium subsidies, thus reducing premium costs for subsidized enrollees. On the other, enrollment declined for unsubsidized enrollees, who must pay the full cost of premium increases.

As we have shown in prior work, however, national averages can mask key differences at the state level (Holahan et al. 2017; Holahan, Wengle, and Elmendorf 2020). Our analysis of premium variation at the rating region and state levels is important to informing policymakers of how the market is evolving over time. Another feature of the Marketplace relevant to our analysis is how the benchmark is defined as the second-lowest premium in each region. The benchmark premium determines the amount of the subsidy available in each rating area. This encourages participating insurers to price low to gain market share. Policies that encourage insurer participation may result in more stable premiums over time.

Data and Methods

Our analysis relies on premium and insurer participation data for all states and the District of Columbia; we use data from Healthcare.gov for 36 states³ and data from 15 state-based Marketplace websites. We collected data at the rating region level for 502 rating regions. To more closely examine how premiums vary within and across states, we present substate data on insurer participation and the lowest-cost silver premium those insurers offer. We present these data for five years, 2017 through 2021, in selected rating regions in 20 states, representing 32 percent of the population. We selected these regions for geographic variety, a mix of states with state-based and federally facilitated Marketplaces, a combination of rural and urban regions within each state, and high- and low-competition markets.

We calculate state average benchmark premiums and growth rates from 2017 to 2021 at the rating region level and weight them by rating region population using estimates from the US Census Bureau's 2019 American Community Survey. The benchmark premium is defined as the second-lowest premium in the rating region. We focus on this premium in most of our analyses because it is used to define the federal premium tax credit.

To understand how insurer participation and state policies are associated with premium levels, we estimate a linear regression model whereby the rating region is the unit of observation and the dependent variable equals the benchmark monthly premium for a 40-year-old nonsmoker in 2021. We define several market-level factors expected to influence premiums, including the number of participating insurers and the type of participating insurers (such as Blue Cross Blue Shield carriers, co-op plans, and previous Medicaid insurers). In addition, we include a variable that measures the market concentration of hospitals in the rating region, because premiums may be higher when hospitals have greater market power and insurers have less power to negotiate lower payment rates. This variable is calculated using data from the 2018 American Hospital Association annual survey.

We also control for several state-level policies likely to influence premiums: state-specific community-rating laws, Medicaid expansion to childless adults with incomes up to 138 percent of the federal poverty level, state reinsurance programs, and state-based Marketplaces. Finally, we also include regional controls, an average wage index, and each rating area's population. We include more details on the variables in the regression model in appendix A.

Findings

Marketplace Premiums Have Declined for the Third Year in a Row

The national average benchmark premium has remained stable for the past three years, declining slightly each year. In 2021, the average benchmark premium fell 1.7 percent (table 1). This followed small declines of 1.2 and 3.2 percent in 2019 and 2020. These declines contrast with patterns for premiums for employer-sponsored insurance, which rose 4 percent in both 2019 and 2020 (data not yet available for 2021; KFF 2019, 2020). The stability of Marketplace premiums in recent years likely owes to both market-level factors and state policy decisions.

Increasing insurer competition is an important factor in dampening premium growth, as we will examine in more detail. In 2020 and 2021, insurers increased their participation in Marketplaces (averages of 3.9 and 4.3 insurers participating per rating region in 2020 and 2021), expanding to new states and to new rating areas within states.⁴ New entrants included national and regional insurers, Medicaid insurers, and small start-up insurers. Medicaid insurers are those who operated exclusively in the Medicaid managed-care market before 2014; they have increased their participation in the Marketplaces over time. Medicaid insurers are experienced in establishing narrow, low-cost provider networks that allow them to offer lower premiums than other insurers.

State policy decisions also play a major role in reducing premium growth. As of 2021, 12 states have implemented reinsurance programs explicitly designed to lower premiums in the first year or two of implementation and to contain growth over time.⁵ Five states implemented reinsurance programs before 2019 (Alaska, Maryland, Minnesota, New Jersey, and Oregon). Five states implemented reinsurance programs in 2019 and 2020 (Colorado, Delaware, Montana, North Dakota, and Rhode Island). Three states implemented reinsurance in 2021 (Georgia, New Hampshire, and Pennsylvania). This market expansion contributed to premium declines or smaller premium increases in 2021 than would have occurred otherwise. Expansion of Medicaid has also been shown to reduce premium growth in the years immediately following its implementation (Peng 2017). Premium growth likely declines because some very low-income people with high health care needs tend to switch out of the Marketplace and into Medicaid. Maine and Virginia expanded Medicaid in 2019. Idaho, Nebraska, and Utah expanded Medicaid in 2020, and Missouri and Oklahoma plan to expand in 2021.

It is unclear exactly how the COVID-19 pandemic and resulting recession have affected the Marketplace. Data do not reveal a substantial increase in Marketplace enrollment. The pandemic may have contributed toward the decline in premiums for 2021. Early national data for all health care

providers show that though spending on COVID-19-related testing and illness increased in 2020, spending on other health care fell substantially, leaving insurers with surpluses.⁶ So, it is not surprising that average benchmark premiums decreased or only increased slightly for 2021.

The decline in the average national benchmark premium, however, masks some variation across states. The majority of states saw declines ranging from 0 to 10 percent (34 states) or small increases of less than 6 percent (7 states). Yet, 10 states saw double-digit declines in the benchmark premium, ranging from 10 percent to 31 percent: Iowa (-31.3 percent), New Hampshire (-19.7 percent), Maryland (-14.5 percent), Nebraska (-14.4 percent), Maine (-13.9 percent), Vermont (-13.2 percent), Tennessee (-11.3 percent), Oklahoma (-11.1 percent), Wyoming (-10.9 percent), and North Carolina (-10.0 percent). At the other end of the spectrum, only one state saw a large increase in benchmark premiums in 2021: North Dakota with 23 percent.

Premium Levels Vary by Market Competitiveness and State Policy Decisions

The national average benchmark premium in 2021 is \$443 per month for a 40-year-old nonsmoker (table 1). This is the full premium before any premium tax credit. State variation in premium levels is much greater than the state variation in premium growth rates. Average state benchmark premiums range from a low of \$292 in Minnesota to a high of \$782 in Wyoming. This means that someone who has to pay the full premium would face costs more than twice as high in Wyoming as in Minnesota. Sixteen states have monthly premiums below \$400 and 10 have premiums above \$500. In addition to Minnesota, other low-premium states include New Hampshire (\$325), Rhode Island (\$328), New Mexico (\$329), and Michigan (\$335). In addition to Wyoming, other high-premium states include Alabama (\$550), Nebraska (\$579), West Virginia (\$641), and Alaska (\$674). Premiums in New York and Vermont cannot be compared with those in other states because of community-rating policies that prescribe the same premium for all ages.

As with premium growth rates, premiums vary by state because of both economic and policy factors. To better understand some of this variation, we estimated a multivariate linear regression to identify factors associated with higher or lower benchmark premiums. We estimated the regression using benchmark premiums at the rating region level (table 2). We control for both the number and the type of insurers participating in each rating region. Previously, we have shown that premiums are lower in rating regions with a higher number of competing insurers (Jacobs, Banthin, and Trachtman 2015). The type of insurer participating in the market also makes a difference. When Medicaid insurers (that have previously served the Medicaid managed-care market) participate, a market is

associated with lower premiums. Another factor that influences premiums is the degree of hospital consolidation. It is more difficult for insurers to negotiate lower prices with hospitals that have local market power. To control for costs, we include a wage index measure.

TABLE 2
Regression Coefficients Associated with Benchmark Premium Costs in 2021

	Coefficient
Dependent variable	
Benchmark premium	
Independent variables	
Blue Cross Blue Shield insurer participating in 2021?	24.60**
Medicaid insurer participating in 2021?	-49.62***
Co-op insurer participating in 2021?	64.32***
One insurer participating in region in 2021	148.02***
Two insurers participating in region in 2021	113.55***
Three insurers participating in region in 2021	46.42***
Four insurers participating in region in 2021	43.39***
Hospital system Herfindahl-Hirschman Index	-0.0022*
Area wage index	5.53
Medicaid expansion status	-41.98***
Community rated	158.98***
Reinsurance	-34.45***
State-based Marketplace?	-51.93***
Census region South	9.38
Census region Northeast	48.71***
Census region West	62.85***
Constant	445.64***
N	502
R²	0.48

Source: Urban Institute analysis of data from Healthcare.gov and relevant state-based Marketplace websites.

Notes: The benchmark premium is taken from each rating region in 2021.

* $p < 0.10$; ** $p < 0.05$; *** $p < 0.01$.

To control for state policy decisions, we include an indicator for states with community-rated premiums, a Medicaid expansion to people with incomes up to 138 percent of the federal poverty level, and a reinsurance program, because these programs are all associated with lower premiums. We also include an indicator for a state-based Marketplace, to reflect possible enhanced communications between insurers and state officials.

We find that the number of insurers participating in a region was strongly associated with premium levels. A rating area with just one insurer was associated with a benchmark premium (for a 40-year-old nonsmoker) \$148 per month higher than the benchmark premium in rating regions with five or more insurers. A rating area with two participating insurers was associated with a benchmark premium \$114 per month higher than those in markets with five or more insurers. Rating areas with

three or four insurers were associated with benchmark premiums around \$45 per month higher than those in regions with five or more insurers.

Our regression shows that the type of insurer also matters. The presence of a Medicaid insurer was associated with a benchmark premium \$50 per month lower for a 40-year-old nonsmoker relative to those in regions without a Medicaid insurer. Medicaid insurers may be either fostering lower premiums through their own aggressive pricing and business models or choosing to enter markets with already lower benchmark premiums; the former seems more plausible.

Our measure of hospital concentration, the Herfindahl-Hirschman Index (HHI), is small, negative, and statistically significant, implying that greater degrees of hospital concentration are associated with lower Marketplace premiums, the opposite of what we would expect. We tested for the correlation between HHI and insurer concentration and found a high correlation. A simple regression of hospital HHI against the number of insurers showed that HHI is 3,313 points higher in markets with one insurer and 1,631 points higher in markets with two insurers than HHIs in markets with five or more insurers (appendix A). Such a high correlation is probably responsible for the small effect of the hospital concentration measure on premiums. In other words, markets with few insurers are also likely to have high hospital market concentration, and determining the independent effects is difficult.

State policies are also strongly associated with premium levels. States that have expanded Medicaid, adopted reinsurance, and run their own state-based Marketplaces have average monthly benchmark premiums for a 40-year-old nonsmoker lower than states that have not implemented those programs by \$42, \$35, and \$48 per month.

Insurer Participation Has Increased for the Past Three Years, 2019–21

Table 3 shows the changes in insurer participation between 2017 and 2021 in 52 regions in 20 states in our study sample. The 52 Marketplaces include most of the largest cities in the United States. Blue Cross Blue Shield plans are the most frequent participant in the Marketplaces we examined. Their participation increased from 35 regions in 2017 to 40 in 2021. Anthem's participation declined after 2017 but gradually increased after 2018, and it participates in 13 of our 52 rating regions in 2021. Although Anthem is a member of the Blue Cross Blue Shield Association, we classify it as a separate entity because Anthem is a publicly traded company and tends to make different participation decisions than most other Blue Cross Blue Shield Association members. UnitedHealthcare and Cigna left several markets before and after 2017 but expanded participation by 2021. Humana and Aetna

left all 52 markets in 2017 and did not return. Bright and Oscar, newer insurers, significantly increased participation in 2021, participating in 9 and 21 regions, respectively.

TABLE 3

Insurer Participation in Rating Regions among Select Study Regions, by Insurer, 2017–21

	2017	2018	2019	2020	2021
Blue Cross Blue Shield ^a	35	34	34	36	40
Anthem	16	8	10	11	13
UnitedHealthcare	4	2	2	2	11
Cigna	5	3	4	4	8
Humana	3	0	0	0	0
Aetna	3	0	0	0	0
Bright Health	0	1	2	7	9
Oscar	3	6	10	17	21
Centene	21	23	28	29	34
Molina	12	12	12	13	13
CareSource	6	6	6	7	7
Kaiser Permanente	13	13	13	13	13
Other	45	41	44	44	55
Total number of participating insurers	166	149	165	183	224

Source: Urban Institute analysis of data from Healthcare.gov and relevant state-based Marketplace websites.

Note: ^a This excludes Anthem.

Centene, a major participant in Medicaid managed care, greatly expanded participation, having a presence in 34 regions by 2021. Centene not only entered new markets but also purchased existing plans, such as Fidelis in New York and Health Net in Arizona and California. Molina and CareSource were also important but grew little, having expanded their participation before the study window (Holahan, Wengle, and Elmendorf 2020). Kaiser participated in 13 markets throughout the period. Several other insurers, both local/regional and provider-sponsored insurers, gradually increased their footprints.

More detail on these insurers follows, drawing on the state-specific tables included in appendix B.

Blue Cross Blue Shield. Blue Cross Blue Shield (hereafter “Blue Cross”) plans generally participate in all markets in all the states we examined and have participated for all years 2017 through 2021. For the most part, Blue Cross plans stay in markets where they have participated over our entire study period. There are exceptions, however. Blue Cross plans did not enter the Phoenix, Arizona, Marketplace until 2020 and the Arkansas and Oregon Marketplaces until 2021. Regence Blue Cross entered the Washington Marketplace in 2021 after leaving in 2018. Frequently, Blue Cross insurers have relatively low premiums and are competitive even with area Medicaid plans. This is true in the markets we studied in California, Florida, Minnesota, Pennsylvania, Rhode Island, and Texas.

Blue Cross silver premiums are relatively high where there is little competition. This would include Alabama and North Carolina, though Blue Cross insurers recently faced increasing competition in North Carolina with the entrance of several national insurers and Ambetter. Oklahoma premiums are also high, once again likely owing to the lack of competition. Several Blue Cross insurers (BridgeSpan, LifeWise, and Regence) participated in the Seattle market. All insurers in Seattle had silver premiums somewhat higher than the market average, despite competition from several other insurers.

Anthem. Anthem's pricing and participation decisions have been less consistent than those of traditional Blue Cross insurers. Anthem left the California Marketplaces of Los Angeles, San Diego, and San Francisco in 2018. It reentered only the Los Angeles Marketplace in 2020. It left the Indiana Marketplace in 2018 and has not yet returned. Anthem participates in all markets we studied in Georgia. Anthem's lowest silver premiums are lower in the competitive Atlanta market in 2021 but higher elsewhere in the state. Anthem left the Columbus and Cleveland markets in 2018 but reentered in 2021 with high silver premiums. In Virginia, Anthem offers an HMO product that has fairly low premiums, and it has participated in all markets we studied throughout the state. The Empire Blue Cross (Anthem) premiums in New York are higher than those of other insurers participating in our study markets. Anthem's premiums and pricing position tend to vary by state, as seen by high silver premiums in Ohio and New York but low prices in many other participating states.

National plans. Several large national commercial insurers left the Marketplaces before our study period, but some of the largest insurers exited during this period. For example, UnitedHealthcare (hereafter "United") left Richmond and the DC suburbs of Virginia in 2018. Aetna left Richmond and Virginia Beach in 2018. Humana left Atlanta in 2018. But, as noted, these three insurers left many other markets before 2017. Anthem and Humana have not reentered any of the markets in this study.

United, however, has entered several markets. In 2021, it entered Tulsa and Oklahoma City, Raleigh-Durham, Baltimore and the DC suburbs in Maryland, and Seattle. It participated in all of our study markets in New York, though with high premiums, because it never left New York as it did other states. United premiums have historically been high in most Marketplaces, but new entrants had premiums much more in line with the competition. United now only offers either HMOs or exclusive provider organizations on the federal Marketplace, whereas before it exited the Marketplaces in 2017, it offered point-of-service products in some markets. These broad network products were not price competitive and tended to attract adverse risk, hence United leaving several markets. More recently, United seems to have limited its offerings to in-network coverage and may have tightened networks to offer more competitive products. Additionally, though United was often a higher-priced insurer

when it left in 2016 and 2017 (Holahan, Blumberg, and Wengle 2016), its premiums have increased substantially in the intervening years, so other insurers may have caught up with United.

Cigna participated in all five years of the study in the Raleigh-Durham market but only entered the rural market in North Carolina in 2021. It also participated in all five years in Richmond and the DC suburbs of Virginia. It left the Maryland market in 2018 but entered the Phoenix market in 2019. Despite all these entrances and exits, Cigna is often competitive where it participates, offering the lowest silver plan in three of the four states where it participates in 2021.

Bright Health is a new insurer that has entered several of our study markets. It entered Birmingham in 2018, Phoenix in 2019, and Oklahoma City, Charlotte, and Tampa, and Orlando in 2020. It entered Miami, Raleigh-Durham, and the rural market in North Carolina in 2021. Bright's silver premiums are generally competitive where it participates.

Oscar has become a major player in Marketplaces around the country, particularly in large urban areas. It participated in all five years in San Francisco, New York City, and Long Island and entered the Los Angeles, Austin, Phoenix, and Cleveland markets in 2018. Oscar entered the Orlando, Columbus, and El Paso Marketplaces in 2019. In 2020, Oscar entered the markets in Philadelphia, Dallas-Fort Worth, Houston, Atlanta, Miami, Tampa, and Richmond. Finally, it entered the Oklahoma City and Tulsa markets, the North Carolina rural market, and the Tallahassee market in 2021.

Medicaid plans. Ambetter, the brand name of most Centene Corporation Marketplace products, became a major insurer in the Marketplaces in the past few years, expanding on its Medicaid presence in several states while entering states where it had not participated in Medicaid previously. Ambetter generally offers one of the lowest-priced silver plans in all markets in which it participates. It was present for all five study years in Seattle (as Coordinatedcare), Little Rock, Dallas-Fort Worth, Austin, El Paso, Atlanta, Indianapolis, and rural Indiana. It was in the Cleveland market in all years and entered the Columbus market in 2018. Ambetter was in the Miami and Tampa Marketplaces in all years but only entered Orlando in 2018 and Tallahassee in 2021. It was in the Atlanta market in all five years but only entered Augusta in 2020. Ambetter entered the Houston market in 2018 and the Raleigh-Durham market in 2019 and entered the Phoenix and rural Arizona markets in 2021. Centene purchased Fidelis in 2018 and is one of the lowest-cost plans in New York City and Long Island.

Health Net, an important insurer in the western United States, is now owned by Centene. For all five years, it participated in the Phoenix market and several California markets, including Los Angeles, San Diego, Sacramento, and San Francisco. It left the rural market in Northern California in 2018.

Health Net appeared to be high-priced in the Northern California markets but competitive in the Southern California markets.

CareSource participated for all study years in Indiana, Ohio, and West Virginia. CareSource is a Midwest Medicaid insurer that has expanded into several midwestern and border-state Marketplaces. It entered the Atlanta Marketplace in 2020, despite not participating in Medicaid in Georgia.

Molina is a Medicaid insurer that has a substantial presence in the Marketplace. It participated in all study years in Ohio, Los Angeles, San Diego, Miami, Tampa, Jacksonville, Orlando, Houston, Dallas-Fort Worth, and Seattle.

Provider-sponsored plans. Several provider-sponsored plans have participated in local markets. The most prominent provider sponsor has been Kaiser, though Kaiser did not enter any new markets from 2017 to 2021. Its premiums have been competitive in the DC suburbs of Virginia and Maryland, Richmond, Seattle, Atlanta, and Baltimore. Kaiser has been prominent in all California markets in this study, including Los Angeles, San Diego, San Francisco, Sacramento, and the rural northern region; its premiums are low in the northern part of the state but costlier in Los Angeles and San Diego. Kaiser also participates in Portland and rural Oregon.

Geisinger participated in the Pennsylvania markets of Scranton/Wilkes-Barre and Harrisburg. The University of Pittsburgh Medical Center plan has participated in the Pittsburgh, Scranton/Wilkes-Barre, and Harrisburg markets. The Providence plan participated in Portland. Innovation, part of the Inova hospital system, participated only in 2017. Optima, the insurance product of Virginia Beach's Sentara hospital system, continues to offer coverage in the Richmond and Virginia Beach markets.

Discussion

The average national benchmark premium declined for the third year in a row in 2021, underscoring the Marketplace's fundamental stability. Average premiums fell in 43 states and only 1 saw an increase higher than 6 percent. Many factors drove benchmark premium changes, including increased insurer entry into markets and state policies (e.g., reinsurance and Medicaid expansion) that dampened premium growth. It is unclear what effect the pandemic and ensuing economic disruption have had on the Marketplace, but neither enrollment nor premiums have increased significantly as a result.

Premium levels continue to vary substantially by rating region and state in 2021 because of several economic and policy factors we identified. Markets with more insurers have lower premiums

than markets with just one or two insurers. When Medicaid insurers participate in markets, they tend to offer lower premiums, presumably because of their narrower networks of lower-cost providers. For 2021, we have also found a significant premium effect associated with Marketplace type; state-based Marketplaces are associated with lower benchmark premiums, presumably because they more aggressively manage insurer participation. Markets in states that have expanded Medicaid and implemented reinsurance also have lower premiums than rating areas in states without such policies.

This year, several new insurers entered local Marketplaces. Some insurers, such as Anthem, reentered markets they had previously left. (And Aetna is rumored to be reentering several Marketplaces in 2022.)⁷ United, Anthem, Bright, and Oscar greatly expanded their participation in 2021, moving into new states and new regions within states where they had previously operated. Ambetter (Centene), a major national insurer, has continued to expand into several markets in 2021.

Several provisions in the American Rescue Plan Act will bolster the Marketplace in 2021 and 2022. Expanded premium tax credits that make enrolling in coverage less expensive and expanded eligibility for subsidized insurance to people with incomes above 400 percent of the federal poverty level should increase enrollment and encourage greater participation by insurers. The Congressional Budget Office has projected Marketplace enrollment will increase by 1.7 million in 2022 (CBO 2021).

Broader reform proposals by the Biden administration may further strengthen the Marketplace. The administration has indicated intent to reverse several Trump administration decisions regarding outreach and advertising expenditures. Even returning these expenditures to their 2016 levels could increase enrollment, given that awareness of financial assistance and the Marketplace overall remains low (Haley and Wengle 2021). The expanded premium subsidies proposed in the American Rescue Plan are currently temporary, but making them permanent would improve affordability for many individuals and families with low to moderate incomes. If the enhanced premium subsidies were made permanent, Marketplace enrollment would increase by more than 5 million people in 2022 and nongroup premiums would be 15 percent lower because of the healthier risk pool (Banthin et al. 2021).

The Marketplace was designed to shield subsidized enrollees from premium increases and has successfully done so. Even when premiums jumped substantially for the 2018 plan year, after the elimination of payments for cost-sharing reductions, enrollment stayed steady.⁸ The Affordable Care Act set the benchmark by the second-lowest premium bid to encourage competition among participating insurers, and this feature seems to work when insurer participation is high. Increased insurer participation in 2021 indicates insurers believe the market will continue to grow.

Appendix A. Data

In this appendix, we provide more detailed information regarding the variables included in the regression model and the year in which the data are measured.

Variables That Measure Market Competition

1. **The number of insurers as of 2021.** We use dummy variables for the number of insurers participating in a region, with 5+ as the omitted category. This variable ranges from 1 to 10, with a median value of 3.
2. **Insurer type as of 2021.** We use dummy variables to indicate whether at least one insurer in the rating region is one of three types. We define Blue Cross insurers as members of the Blue Cross Blue Shield Association. Co-ops, established under the Affordable Care Act, are listed on the National Alliance of State Health Co-Ops website. In 2021, three co-ops were present in five states. Medicaid insurers are those that offered Medicaid managed-care plans before the creation of the Marketplaces in 2014.
3. **Hospital concentration as of 2018.** We use a continuous variable to control for hospital concentration by computing HHI at the rating region level. This HHI is computed using annual survey data from the American Hospital Association. Higher market concentration results in greater difficulty for insurers in negotiating lower provider payment rates, implying greater concentration should result in higher premiums, all else being equal. This variable ranges from 0 to 10,000, with a median value of 2,628.

Variables That Characterize State Policies and Additional Controls

1. **Pure community rating.** This is a binary variable equal to one in New York and Vermont, states with pure community rating (no age variation) in their private nongroup insurance markets.
2. **States that expanded Medicaid by 2020.** This dummy variable equals one if the insurer (or rating region, depending on the regression) is located in a state that expanded Medicaid eligibility under the Affordable Care Act by 2020 for all residents with incomes up to 138 percent of the federal poverty level. As of the 2021 plan year, 37 states had expanded Medicaid.
3. **Reinsurance.** This dummy variable equals one if the state is 1 of 15 states that has implemented a reinsurance program as of 2021.
4. **State-based Marketplace.** This dummy variable equals one if the state is 1 of 16 states that runs its own Marketplace as of 2021.
5. **Census region.** We use these dummy variables to control for geographic variation. The Midwest is the omitted category.

6. **Area wage index.** We control for area wages because areas with higher labor costs are expected to have higher premiums, given that medical care is a labor-intensive good. We calculate this index at the rating region level for 2016. The index ranges from 0.0059 to 1.74, and the median value is 0.81
7. **Rating region population as of 2019.** This is taken from the US Census Bureau's 2019 American Community Survey, using county-level populations and aggregating them to the rating region level.

TABLE A.1

Regression Coefficient of Hospital Herfindahl-Hirschman Index, 2018

	Coefficient
Dependent variable	
Benchmark premium in 2021	
Independent variables	
Hospital Herfindahl-Hirschman Index	0.0048148***
Constant	461.06***
R²	0.022

Source: Urban Institute analysis of data from Healthcare.gov and relevant state-based Marketplace websites.

Note: * $p < 0.10$; ** $p < 0.05$; *** $p < 0.01$.

TABLE A.2

Regression Coefficient of Number of Participating Insurers, 2021

	Coefficient
Dependent variable	
Hospital Herfindahl-Hirschman Index in 2018	
Independent variables	
One insurer participating in region in 2021	3,313.72***
Two insurers participating in region in 2021	1,631.66***
Three insurers participating in region in 2021	1,284.93***
Four insurers participating in region in 2021	308.62
Constant	2,513.74
R²	0.0768

Source: Urban Institute analysis of data from Healthcare.gov and relevant state-based Marketplace websites.

Note: * $p < 0.10$; ** $p < 0.05$; *** $p < 0.01$.

Appendix B. State Tables

TABLE B.1

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected Alabama Markets

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				Average Annual Change, 2017-21
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	
Birmingham										
Insurer										
Blue Cross and Blue Shield of Alabama	457	542	525	539	565	18.5	-3.0	2.7	4.8	5.7
Bright Health	n/a	546	499	525	623	n/a	-8.6	5.4	18.7	5.1
Percent change in lowest option available						15.6	-8.0	5.4	7.6	5.2
Selected rural region										
Insurer										
Blue Cross and Blue Shield of Alabama	416	493	494	507	537	18.5	0.2	2.7	5.9	6.8
Percent change in lowest option available						18.5	0.2	2.7	5.9	6.8
State average (all regions)	435	515	504	521	550	18.5	-2.3	3.3	5.6	6.3

Source: "FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers," Healthcare.gov, <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/>.

Note: n/a = not applicable (insurer was not participating in the Marketplace).

TABLE B.2

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected Arizona Markets

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	Average Annual Change, 2017-21
Phoenix										
Insurer										
Ambetter from Arizona					391	n/a	n/a	n/a	n/a	n/a
Complete Health	n/a	n/a	n/a	n/a	391	n/a	n/a	n/a	n/a	n/a
Blue Cross Blue Shield of Arizona	n/a	n/a	n/a	423	410	n/a	n/a	n/a	-3.1	n/a
Bright Health	n/a	n/a	427	394	430	n/a	n/a	-7.5	8.9	0.7
Cigna	n/a	n/a	426	423	429	n/a	n/a	-0.8	1.4	0.3
Health Net	475	471	415	411	381	-0.9	-11.8	-1.1	-7.2	-5.2
Oscar	n/a	n/a	479	426	463	n/a	n/a	-10.9	8.5	-1.2
UnitedHealthcare	n/a	n/a	n/a	n/a	463	n/a	n/a	n/a	n/a	n/a
Percent change in region's lowest premium option						-0.9	-11.8	-5.0	-3.4	-5.3
Selected rural region										
Insurer										
Ambetter from Arizona					573	n/a	n/a	n/a	n/a	n/a
Complete Health	n/a	n/a	n/a	n/a	573	n/a	n/a	n/a	n/a	n/a
Blue Cross Blue Shield of Arizona	638	618	648	656	624	-3.1	4.9	1.1	-4.8	-4.8
Percent change in region's lowest premium option						-3.1	4.9	1.1	-12.6	-4.8
State average (all regions)	497	487	448	431	411	-2.0	-8.0	-3.8	-4.6	-37.3

Source: "FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers," Healthcare.gov, <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/>.

Note: n/a = not applicable (insurer was not participating in the Marketplace).

TABLE B.3

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected Arkansas Markets

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				Average Annual Change, 2017-21
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	
Little Rock										
Insurer										
Ambetter	292	353	363	358	387	21.0	2.7	-1.4	n/a	7.4
Arkansas Blue Cross and Blue Shield	n/a	n/a	n/a	n/a	399	n/a	n/a	n/a	n/a	n/a
Health Advantage	359	429	423	414	416	19.4	-1.4	-2.1	n/a	5.3
QualChoice Health Insurance (also Ambetter) ^a	330	392	381	390	417	19.0	-2.9	2.3	7.0	6.4
Percent change in lowest option available						21.0	2.7	-1.4	8.1	7.6
Selected rural region										
Insurer										
Ambetter	295	356	378	358	387	21.0	6.0	-5.3	8.1	7.4
Arkansas Blue Cross and Blue Shield	n/a	n/a	n/a	n/a	399	n/a	n/a	n/a	n/a	n/a
Health Advantage	379	476	447	414	416	25.4	-6.1	-7.3	0.4	3.1
QualChoice Health Insurance (also Ambetter)	323	384	381	390	417	18.7	-0.8	2.3	7.0	6.8
Percent change in lowest option available						21.0	6.0	-5.3	8.1	7.4
State average (all regions)	281	341	362	358	387	21.2	6.2	-1.1	8.1	8.6

Source: "FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers," Healthcare.gov, <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/>.

Note: n/a = not applicable (insurer was not participating in the Marketplace).

TABLE B.4

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected California Markets

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				Average Annual Change, 2017-21
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	
Rating region 15: East Los Angeles										
Insurer										
Anthem	287	n/a	n/a	380	355	n/a	n/a	n/a	-6.6	-6.6
Blue Shield of California	284	325	346	352	327	14.6	6.3	1.7	-7.1	3.9
Health Net	269	325	337	327	343	20.8	3.7	-3.0	4.9	6.6
Kaiser Permanente	320	391	404	390	362	22.1	3.4	-3.6	-7.2	3.7
L.A. Care Health Plan	258	316	338	342	325	22.5	6.8	1.3	-5.2	6.4
Molina Healthcare	251	406	391	377	357	62.1	-3.7	-3.6	-5.3	12.4
Oscar	n/a	408	443	357	365	n/a	8.5	-19.4	2.4	-2.9
Percent change in lowest option available						26.2	6.5	-3.0	-0.7	7.3
San Diego										
Insurer										
Anthem	444	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Blue Shield of California	406	394	419	427	408	-2.9	6.3	1.7	-4.4	0.2
Health Net	307	392	395	359	367	27.6	0.8	-9.0	2.3	5.4
Kaiser Permanente	354	432	447	431	418	22.1	3.4	-3.6	-3.0	4.7
Molina Healthcare	297	418	391	370	343	41.1	-6.4	-5.5	-7.2	5.5
Sharp Health Plan	356	479	457	385	374	34.8	-4.7	-15.6	-2.9	2.9
Percent change in lowest option available						32.1	-0.1	-8.2	-4.4	4.8
Sacramento										
Insurer										
Blue Shield of California	479	446	474	482	461	-6.9	6.3	1.7	-4.4	-0.8
Health Net	501	584	620	648	703	16.5	6.1	4.5	8.5	8.9
Kaiser Permanente	402	478	494	468	485	19.1	3.4	-5.4	3.7	5.2
Western Health Advantage	426	557	596	573	516	30.7	7.0	-3.8	-10.0	6.0
Percent change in lowest option available						11.0	6.3	-1.3	-1.4	3.6
San Francisco										
Insurer										
Anthem	543	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Blue Shield of California	484	578	615	625	607	19.5	6.3	1.7	-2.9	6.2
Chinese Community	407	502	532	607	601	23.4	6.0	14.0	-0.9	10.6
Health Net	543	702	799	825	959	29.2	13.8	3.3	16.1	15.6
Kaiser	444	529	546	517	536	19.1	3.4	-5.4	3.7	5.2
Oscar	483	606	657	574	571	25.5	8.5	-12.7	-0.6	5.2
Percent change in lowest option available						23.4	6.0	-2.9	3.7	7.6
Northern counties, rural										
Insurer										
Anthem	408	602	623	542	557	47.5	3.6	-13.1	2.8	10.2
Blue Shield of California	450	578	644	633	617	28.4	11.3	-1.7	-2.4	8.9
Health Net	519	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Kaiser Permanente	402	478	494	468	485	19.1	3.4	-5.4	3.7	5.2
Percent change in lowest option available						19.1	3.4	-5.4	3.7	5.2
State average (all regions)	318	394	413	396	397	24.1	4.9	-4.2	0.4	6.3

Source: Covered California, <https://www.coveredca.com/>.

Notes: n/a = not applicable (insurer was not participating in the Marketplace). Insurers instructed to load the cost of cost-sharing reductions into silver Marketplace premiums only.

TABLE B.5

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Delaware

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				Average Annual Change, 2017-21
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	
Entire state										
Insurer										
Highmark Blue Cross Blue Shield Delaware	480	573	660	521	522	19.4	15.2	-21.0	0.1	3.4
Aetna	414	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
State average change in lowest option available	414	573	660	521	522	38.3	15.2	-21.0	0.1	8.2

Source: "FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers," Healthcare.gov, <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/>.

Notes: n/a = not applicable (insurer was not participating in the Marketplace). Insurers instructed to load the cost of cost-sharing reductions into silver Marketplace premiums only.

TABLE B.6

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected Florida Markets

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				Average Annual Change, 2017-21
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	
Miami										
Insurer										
Ambetter	296	435	440	452	461	46.7	1.2	2.7	2.2	13.2
AvMed	n/a	n/a	n/a	n/a	459	n/a	n/a	n/a	n/a	n/a
Bright Health	n/a	n/a	n/a	n/a	445	n/a	n/a	n/a	n/a	n/a
Florida Blue (Blue Cross and Blue Shield of Florida)	422	583	543	524	449	37.9	-6.9	-3.4	-14.4	3.3
Health Options	318	442	458	450	n/a	39.0	3.5	-1.6	13.6	13.6
Humana	477	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Molina Healthcare	320	567	568	551	523	77.5	0.1	-2.9	-5.2	17.4
Oscar	n/a	n/a	n/a	445	458	n/a	n/a	n/a	2.9	2.9
Percent change in lowest option available						46.7	1.2	1.1	0.0	12.3
Tampa										
Insurer										
Ambetter	305	428	467	437	454	40.3	9.2	-6.4	3.9	11.8
Florida Blue (Blue Cross and Blue Shield of Florida)	341	496	489	475	438	45.5	-1.4	-2.7	-7.9	8.4
Bright Health	n/a	n/a	n/a	432	439	n/a	n/a	n/a	1.5	1.5
Health Options	325	481	491	446	n/a	48.1	2.1	-9.2	13.7	13.7
Humana	428	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Molina Healthcare	339	567	585	552	542	67.3	3.1	-5.6	-1.8	15.7
Oscar	n/a	n/a	n/a	447	448	n/a	n/a	n/a	0.4	0.4
Percent change in lowest option available						40.3	9.2	-7.5	1.2	10.8
Jacksonville										
Insurer										
Ambetter	233	314	462	452	442	35.0	47.1	-2.1	-2.3	19.4
AvMed	n/a	n/a	n/a	n/a	\$521	n/a	n/a	n/a	n/a	n/a
Florida Blue (Blue Cross and Blue Shield of Florida)	345	494	469	453	440	43.2	-5.1	-3.5	-2.7	8.0
Bright Health	n/a	n/a	n/a	440	459	n/a	n/a	n/a	4.3	4.3
Health Options	327	485	515	487	n/a	48.0	6.3	-5.4	n/a	16.3

Molina Healthcare	307	527	512	500	467	72.0	-2.9	-2.3	-6.6	15.0
Oscar	n/a	n/a	n/a	n/a	520	n/a	n/a	n/a	n/a	n/a
Percent change in lowest option available						35.0	47.1	-4.7	0.0	19.4
Orlando										
Insurer										
Ambetter	n/a	469	490	481	477	n/a	4.6	-2.0	-0.8	0.6
AvMed	n/a	n/a	n/a	n/a	466	n/a	n/a	n/a	n/a	n/a
Cigna	n/a	n/a	n/a	n/a	504	n/a	n/a	n/a	n/a	n/a
Florida Blue (Blue Cross and Blue Shield of Florida)	386	546	509	533	464	41.4	-6.8	4.6	-12.9	6.6
Bright Health	n/a	n/a	n/a	465	483	n/a	n/a	n/a	n/a	n/a
Health Options	341	469	483	470	n/a	37.4	3.1	-2.7	n/a	12.6
Molina Healthcare	n/a	n/a	n/a	521	525	n/a	n/a	n/a	0.7	0.7
Oscar	n/a	n/a	467	474	468	n/a	n/a	1.4	-1.4	0.0
Percent change in lowest option available						37.4	-0.2	-0.5	-0.2	9.1
Tallahassee										
Insurer										
Ambetter	n/a	n/a	n/a	n/a	473	n/a	n/a	n/a	n/a	n/a
Cigna	n/a	n/a	n/a	n/a	652	n/a	n/a	n/a	n/a	n/a
Florida Blue (Blue Cross and Blue Shield of Florida)	430	692	662	634	466	61.0	-4.3	-4.2	-26.6	6.5
Oscar	n/a	n/a	n/a	n/a	487	n/a	n/a	n/a	n/a	n/a
Percent change in lowest option available						61.0	-4.3	-4.2	-26.6	6.5
State average (all regions)	322	457	467	458	449	41.8	2.2	-2.1	-2.0	10.0

Source: "FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers," Healthcare.gov, <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/>.

Notes: n/a = not applicable (insurer was not participating in the Marketplace). Insurers instructed to load the cost of cost-sharing reductions into silver Marketplace premiums only.

TABLE B.7

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected Georgia Markets

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				Average Annual Change, 2017-21
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	
Atlanta										
Insurer										
Alliant Health Plans	n/a	n/a	n/a	n/a	510	n/a	n/a	n/a	n/a	n/a
Ambetter	264	417	440	419	448	57.8	5.4	-4.8	7.1	16.4
Anthem (Blue Cross Blue Shield of Georgia)	324	581	438	440	437	79.2	-24.5	0.4	-0.6	13.6
CareSource	n/a	n/a	n/a	473	499	n/a	n/a	n/a	5.3	5.3
Humana	538	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Kaiser Permanente	372	421	529	545	445	13.3	25.5	3.1	-18.2	5.9
Oscar	n/a	n/a	n/a	557	534	n/a	n/a	n/a	-4.2	-4.2
Percent change in lowest option available						57.8	5.1	-4.5	4.5	15.7
Augusta										
Insurer										
Alliant Health Plans	n/a	n/a	n/a	n/a	452	n/a	n/a	n/a	n/a	n/a
Ambetter	n/a	n/a	n/a	401	448	n/a	n/a	n/a	11.6	11.6
Anthem (Blue Cross Blue Shield of Georgia)	322	464	490	473	506	44.3	5.5	-3.5	7.1	13.4
Percent change in lowest option available						44.3	5.5	-18.2	11.6	10.8
Selected rural region										
Insurer										
Alliant Health Plans	n/a	n/a	n/a	n/a	448	n/a	n/a	n/a	n/a	n/a
Ambetter	n/a	n/a	324	367	456	n/a	n/a	13.3	24.3	18.8
Anthem (Blue Cross Blue Shield of Georgia)	430	629	666	684	646	46.1	6.0	2.7	-5.6	12.3
Percent change in lowest option available						46.1	-48.5	13.3	22.1	8.3
State average (all regions)	307	475	434	419	442	55.1	-8.8	-3.5	5.7	12.1

Source: "FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers," Healthcare.gov, <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/>.

Notes: n/a = not applicable (insurer was not participating in the Marketplace). Insurers instructed to load the cost of cost-sharing reductions into all silver plans, both on Marketplace and off.

TABLE B.8

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected Indiana Markets

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				Average Annual Change, 2017-21
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	
Indianapolis										
Insurer										
Ambetter	284	364	372	441	462	28.2	2.0	18.6	4.8	13.4
Anthem	414	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
CareSource	286	366	396	421	433	28.1	7.9	6.5	2.7	11.3
Mdwise	317	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Percent change in lowest option available						28.2	2.0	13.3	2.7	11.6
Selected rural region										
Insurer										
Ambetter	201	268	257	330	398	33.1	-4.0	28.4	20.7	19.5
CareSource	258	295	312	332	341	14.2	5.9	6.5	2.8	7.3
Percent change in lowest option available						33.1	-4.0	28.4	3.5	15.2
State average (all regions)	264	332	333	379	398	26.1	0.1	13.8	5.0	11.3

Source: “FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers,” Healthcare.gov, <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/>.

Notes: n/a = not applicable (insurer was not participating in the Marketplace). Insurers instructed to load the cost of cost-sharing reductions into all Marketplace metal tiers.

TABLE B.9

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected Maryland-Area Markets

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				Average annual change, 2017-21
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	
Rating Region 1: Baltimore										
Insurer										
CareFirst	355	559	489	401	371	57.5	-12.5	-18.0	-7.5	4.9
Cigna	415	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Kaiser Permanente	309	436	404	388	339	41.1	-7.4	-3.9	-12.6	4.3
UnitedHealthcare	n/a	n/a	n/a	n/a	344	n/a	n/a	n/a	n/a	n/a
Percent change in lowest option available						41.1	-7.4	-3.9	-12.6	4.3
Rating Region 3: Washington, DC, suburbs										
Insurer										
CareFirst	355	559	489	401	371	57.5	-12.5	-18.0	-7.5	4.9
Cigna	409	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Kaiser Permanente	309	436	404	388	339	41.1	-7.4	-3.9	-12.6	4.3
UnitedHealthcare	n/a	n/a	n/a	n/a	355	n/a	n/a	n/a	n/a	n/a
Percent change in lowest option available						41.1	-7.4	-3.9	-12.6	4.3
State average (all regions)	296	436	404	388	339	47.3	-7.4	-3.9	-12.6	5.8

Source: Maryland Health Connection.

Notes: n/a = not applicable (insurer was not participating in the Marketplace). Insurers instructed to load the cost of cost-sharing reductions into silver Marketplace premiums only.

TABLE B.10

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected Minnesota Market

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				Average Annual Change, 2017-21
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	
Minneapolis										
Insurer										
Blue Plus	419	425	309	294	309	1.7	-27.5	-4.7	4.9	-6.4
HealthPartners	363	327	304	295	290	-9.9	-7.1	-2.9	-1.8	-5.4
Medica	395	352	300	306	284	-10.9	-14.7	2.1	-7.3	-7.7
UCare	366	315	282	261	265	-13.8	-10.4	-7.6	1.5	-7.6
Percent change in lowest option available						-13.2	-10.4	-7.6	1.5	-7.4
State average (all regions)	429	362	313	298	292	-15.5	-13.6	-5.0	-1.8	-9.0

Sources: 2017 data taken from the Robert Wood Johnson Foundation's HIX Compare dataset. 2018 - 2021 data from MNsure. Insurers instructed to load the cost of cost-sharing reductions into silver Marketplace premiums only, although the impact is minimal due to the Basic Health plan.

TABLE B.11

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected New York Markets

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				Average Annual Change, 2017-21
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	
New York City										
Insurer										
Affinity Health Plan	483	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
EmblemHealth	518	652	791	898	934	25.7	21.4	13.5	4.0	16.1
Empire Blue Cross Blue Shield (Anthem)	575	883	905	874	883	53.5	2.6	-3.5	1.0	13.4
Fidelis Care	456	510	598	622	644	11.7	17.2	4.0	3.6	9.1
Healthfirst	454	531	581	623	611	17.1	9.5	7.1	-1.9	8.0
MetroPlus	468	504	591	619	649	7.7	17.2	4.8	4.7	8.6
NorthShore LIJ	487	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Oscar	483	538	590	657	694	11.3	9.7	11.3	5.6	9.5
UnitedHealthcare	714	825	803	888	940	15.5	-2.7	10.5	5.9	7.3

Percent change in lowest option available						11.2	15.3	6.5	-1.3	7.9					
Long Island															
Insurer															
Affinity Health Plan	494	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a					
EmblemHealth	590	741	900	1,021	1,062	25.7	21.4	13.5	4.0	16.1					
Empire Blue Cross Blue Shield (Anthem)	510	783	725	769	777	53.4	-7.5	6.1	1.0	13.3					
Fidelis Care	446	480	562	585	599	7.5	17.2	4.0	2.3	7.8					
Healthfirst	454	564	617	642	611	24.4	9.5	3.9	-4.8	8.3					
NorthShore LIJ	487	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a					
Oscar	483	538	590	646	678	11.3	9.7	9.5	4.9	8.9					
UnitedHealthcare	714	825	803	888	940	15.5	-2.7	10.5	5.9	7.3					
Percent change in lowest option available						7.5	17.2	4.0	2.3	7.8					
State average (all regions)						439	487	559	589	583	10.9	14.9	5.2	-0.9	7.5

Source: New York State of Health.

Note: n/a = not applicable (insurer was not participating in the Marketplace). Insurers instructed to load the cost of cost-sharing reductions into silver Marketplace premiums only, although the impact is minimal due to the Basic Health plan

TABLE B.12

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected North Carolina Markets

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				Average annual change, 2017-21
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	
Charlotte										
Insurer										
Blue Cross Blue Shield of North Carolina	565	659	503	428	470	16.7	-23.7	-15.0	9.9	-3.0
Bright Health	n/a	n/a	n/a	405	423	n/a	n/a	n/a	4.2	4.2
Percent change in lowest option available						16.7	-23.7	-19.4	4.2	-5.5
Raleigh-Durham										
Insurer										
Ambetter	n/a	n/a	470	410	449	n/a	n/a	-12.6	9.4	-1.6
Blue Cross Blue Shield of North Carolina	489	571	452	437	458	16.7	-20.9	-3.2	4.8	-0.7
Bright Health	n/a	n/a	n/a	n/a	426	n/a	n/a	n/a	n/a	n/a
Cigna	447	541	541	522	425	20.8	0.0	-3.5	-18.6	-0.3
UnitedHealthcare	n/a	n/a	n/a	n/a	525	n/a	n/a	n/a	n/a	n/a
Percent change in lowest option available						20.8	-16.5	-9.1	3.5	-0.3
Selected rural region										
Insurer										
Blue Cross Blue Shield of North Carolina	537	610	664	661	419	13.5	9.0	-0.5	-36.6	-3.6
Bright Health	n/a	n/a	n/a	n/a	441	n/a	n/a	n/a	n/a	n/a
Cigna	n/a	n/a	n/a	n/a	553	n/a	n/a	n/a	n/a	n/a
Oscar Health Plan of North Carolina Inc.	n/a	n/a	n/a	n/a	479	n/a	n/a	n/a	n/a	n/a
UnitedHealthcare	n/a	n/a	n/a	n/a	460	n/a	n/a	n/a	n/a	n/a
Percent change in lowest option available						13.5	9.0	-0.5	-36.6	-3.6
State average (all regions)	516	601	563	507	489	16.4	-6.2	-10.1	-3.5	-0.9

Source: "FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers," Healthcare.gov, <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/>.

Notes: n/a = not applicable (insurer was not participating in the Marketplace). Insurers instructed to load the cost of cost-sharing reductions into silver Marketplace premiums only.

TABLE B.13

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected Ohio Markets

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				Average Annual Change, 2017-21
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	
Columbus										
Insurer										
Ambetter from Buckeye Health Plan	n/a	417	401	366	375	n/a	-3.7	-8.8	2.4	-3.4
Anthem	342	n/a	n/a	n/a	431	n/a	n/a	n/a	n/a	n/a
CareSource	284	385	474	460	488	35.4	23.3	-3.0	6.2	15.5
Medical Mutual of Ohio	326	423	437	493	501	29.9	3.4	12.7	1.6	11.9
Molina Healthcare	301	461	444	391	398	53.5	-3.7	-12.1	1.9	9.9
Oscar	n/a	n/a	382	407	398	n/a	n/a	6.7	-2.3	2.2
Percent change in lowest option available						35.4	-0.8	-4.1	2.4	8.2
Cleveland										
Insurer										
Ambetter from Buckeye Health Plan	224	307	323	322	319	36.8	5.1	-0.1	-1.0	10.2
Anthem	363	n/a	n/a	n/a	481	n/a	n/a	n/a	n/a	n/a
CareSource	253	319	371	360	382	26.2	16.1	-2.9	6.3	11.4
Medical Mutual of Ohio	376	364	360	407	403	-3.1	-1.2	13.2	-1.0	2.0
Molina Healthcare	252	346	366	330	330	37.2	5.7	-9.8	0.1	8.3
Oscar	n/a	434	466	453	480	n/a	7.4	-2.6	5.9	3.6
Percent change in lowest option available						36.8	5.1	-0.1	-1.0	10.2
Selected rural region										
Insurer										
Anthem	413	n/a	555	619	610	n/a	n/a	11.7	-1.6	5.1
CareSource	347	579	708	618	492	66.8	22.2	-12.7	-20.4	14.0
Medical Mutual of Ohio	n/a	n/a	n/a	579	508	n/a	n/a	n/a	-12.3	-12.3
Molina Healthcare	290	415	469	386	383	43.2	12.8	-17.6	-0.7	9.4
Percent change in lowest option available						43.2	12.8	-17.6	-0.7	9.4
State average (all regions)	252	348	359	353	358	38.2	3.2	-1.4	1.4	10.3

Source: "FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers," Healthcare.gov, <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/>.

Notes: n/a = not applicable (insurer was not participating in the Marketplace). Insurers instructed to load the cost of cost-sharing reductions into silver Marketplace premiums only.

TABLE B.14

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected Oklahoma Markets

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				Average Annual Change, 2017-21
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	
Tulsa										
Insurer										
Blue Cross and Blue Shield of Oklahoma	507	532	543	542	546	4.8	2.2	-0.2	0.8	1.9
CommunityCare	n/a	n/a	n/a	n/a	493	n/a	n/a	n/a	n/a	n/a
Medica	n/a	n/a	635	528	478	n/a	n/a	-16.9	-9.3	-13.1
UnitedHealthcare	n/a	n/a	n/a	n/a	552	n/a	n/a	n/a	n/a	n/a
Percent change in lowest option available						4.8	2.2	-2.9	-9.3	-1.3
Oklahoma City										
Insurer										
Blue Cross and Blue Shield of Oklahoma	485	507	485	500	506	4.5	-4.5	3.1	1.4	1.1
Bright Health	n/a	n/a	n/a	492	476	n/a	n/a	n/a	-3.3	n/a
Medica	n/a	n/a	686	613	489	n/a	n/a	-10.7	-20.3	-15.5
Oscar	n/a	n/a	n/a	n/a	495	n/a	n/a	n/a	n/a	n/a
UnitedHealthcare	n/a	n/a	n/a	n/a	502	n/a	n/a	n/a	n/a	n/a
Percent change in lowest option available						4.5	-4.5	1.5	-3.3	-0.4
Selected rural region										
Insurer										
Blue Cross and Blue Shield of Oklahoma	493	524	520	530	530	6.2	-0.7	1.8	0.1	1.9
CommunityCare	n/a	n/a	n/a	n/a	493	n/a	n/a	n/a	n/a	n/a
Medica	n/a	n/a	654	585	538	n/a	n/a	n/a	-8.0	-8.0
Percent change in lowest option available						6.2	-0.7	1.8	-6.9	0.1
State average (all regions)	495	520	514	515	485	5.1	-1.2	0.3	-5.9	-0.4

Source: “FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers,” Healthcare.gov, <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/>.

Notes: n/a = not applicable (insurer was not participating in the Marketplace). Insurers instructed to load the cost of cost-sharing reductions into silver Marketplace premiums only.

TABLE B.15

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected Oregon Markets

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				Average Annual Change, 2017–21
	2017	2018	2019	2020	2021	2017–18	2018–19	2019–20	2020–21	
Portland										
Insurer										
BridgeSpan Health Company	361	391	420	421	522	8.2	7.3	0.3	24.0	10.0
Kaiser Permanente	302	375	408	438	426	24.2	8.8	7.4	-2.7	9.4
Moda Health	386	405	433	414	468	4.9	6.9	-4.4	13.0	5.1
PacificSource Health Plans	442	484	425	436	491	9.5	-12.2	2.6	12.6	3.1
Providence Health Plan	326	380	414	397	472	16.6	8.9	-4.1	18.9	10.1
Regence BlueCross BlueShield of Oregon	n/a	n/a	n/a	n/a	464	n/a	n/a	n/a	n/a	n/a
Percent change in lowest option available						24.2	8.8	1.5	2.9	9.3
Selected rural region										
Insurer										
BridgeSpan Health Company	n/a	n/a	n/a	n/a	580	n/a	n/a	n/a	n/a	n/a
Kaiser Permanente	302	375	408	438	406	24.2	8.8	7.4	-7.3	8.3
Moda Health	397	436	478	455	460	9.8	9.6	-4.8	1.1	3.9
PacificSource Health Plans	446	488	445	455	479	9.4	-8.8	2.2	5.3	2.0
Providence Health Plan	490	456	517	496	502	-6.9	13.4	-4.1	1.2	0.9
Regence BlueCross BlueShield of Oregon	n/a	n/a	n/a	n/a	516	n/a	n/a	n/a	n/a	n/a
Percent change in lowest option available						24.2	8.8	7.4	-7.3	8.3
State average (all regions)	311	388	424	424	418	24.8	9.1	0.1	-1.4	8.1

Source: “FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers,” Healthcare.gov, <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/>.

Notes: n/a = not applicable (insurer was not participating in the Marketplace). Insurers instructed to load the cost of cost-sharing reductions into silver plans, both on and off Marketplace.

TABLE B.16

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected Pennsylvania Markets

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				Average Annual Change, 2017-21
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	
Philadelphia										
Insurer										
Ambetter	n/a	n/a	465	461	449	n/a	n/a	-0.9	-2.4	-1.7
Independence Blue Cross	374	466	464	464	447	24.5	-0.3	0.0	-3.7	n/a
Oscar	n/a	n/a	n/a	461	479	n/a	n/a	n/a	3.9	3.9
Percent change in lowest option available						24.5	-0.3	-0.8	-2.9	5.1
Pittsburgh										
Insurer										
Highmark	313	483	481	329	343	54.2	-0.4	-31.7	4.4	6.6
UPMC Health Plan	232	350	328	334	350	50.8	-6.2	1.9	4.7	12.8
Percent change in lowest option available						50.8	-6.2	0.2	4.4	12.3
Scranton/Wilkes-Barre										
Insurer										
Ambetter	n/a	n/a	n/a	n/a	404	n/a	n/a	n/a	n/a	n/a
First Priority Health	397	581	474	n/a	n/a	46.1	-18.4	n/a	n/a	13.9
Geisinger	396	506	481	498	502	27.8	-4.8	3.4	0.9	6.8
Highmark	n/a	n/a	n/a	434	436	n/a	n/a	n/a	0.5	0.5
UPMC Health Plan	n/a	442	414	422	637	n/a	-6.3	1.9	50.9	15.5
Percent change in lowest option available						11.6	-6.3	1.9	-4.2	0.8
Harrisburg										
Insurer										
Capital (Blue Cross Blue Shield)	497	853	635	583	506	71.7	-25.6	-8.2	-13.2	6.2
Geisinger	441	627	567	605	611	42.2	-9.6	6.7	0.9	10.0
Highmark	522	693	601	498	524	32.9	-13.3	-17.1	5.4	1.9
UPMC Health Plan	n/a	n/a	523	527	603	n/a	n/a	0.7	14.5	7.6
Percent change in lowest option available						42.2	-16.5	-4.9	1.6	5.6
State average (all regions)	348	455	446	432	440	30.6	-2.0	-3.0	1.8	6.8

Source: "FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers," Healthcare.gov, <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/>.

Notes: n/a = not applicable (insurer was not participating in the Marketplace). Insurers instructed to load the cost of cost-sharing reductions into silver Marketplace premiums only.

TABLE B.17

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Rhode Island

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				Average Annual Change, 2017-21
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	
Entire state										
Insurer										
Blue Cross Blue Shield of Rhode Island	265	385	381	372	401	45.2	-1.0	-2.4	7.8	12.4
Neighborhood Health Plan of Rhode Island	243	287	315	316	328	18.3	9.8	0.3	3.8	8.1
State average change in lowest option available	243	287	315	316	328	18.3	9.8	0.3	3.8	8.1

Source: Healthsource RI.

Notes: n/a = not applicable (insurer was not participating in the Marketplace). Insurers instructed to load the cost of cost-sharing reductions into silver Marketplace premiums only.

TABLE B.18

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected Texas Markets

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	Average Annual Change, 2017-21
Dallas-Fort Worth										
Insurer										
Ambetter	322	415	410	410	447	29.0	-1.1	-0.2	9.1	9.2
Blue Cross and Blue Shield of Texas	449	570	555	428	399	27.0	-2.6	-23.0	-6.6	-1.3
Friday Health Plans	n/a	n/a	n/a	n/a	417	n/a	n/a	n/a	n/a	n/a
Molina Healthcare	277	411	431	408	420	48.4	4.7	-5.3	3.0	12.7
Oscar	n/a	n/a	n/a	411	457	n/a	n/a	n/a	11.2	11.2
Scott and White Health Plan	n/a	n/a	n/a	n/a	465	n/a	n/a	n/a	n/a	n/a
Percent change in lowest option available						48.4	-0.2	-0.7	-2.1	11.4
Houston										
Insurer										
Ambetter	n/a	390	385	381	413	n/a	-1.1	-1.1	8.3	2.0
Blue Cross and Blue Shield of Texas	431	545	508	422	381	26.5	-6.8	-16.9	-9.6	-1.7
Community Health Choice	311	460	464	464	492	48.0	1.0	0.0	5.9	13.7
Friday Health Plans	n/a	n/a	n/a	n/a	391	n/a	n/a	n/a	n/a	n/a
Molina Healthcare	283	399	418	395	407	41.3	4.6	-5.4	3.0	10.9
Oscar	n/a	n/a	n/a	416	458	n/a	n/a	n/a	10.2	10.2
Percent change in lowest option available						37.9	-1.1	-1.1	0.0	8.9
Austin										
Insurer										
Ambetter	273	383	429	446	487	40.7	11.9	3.9	9.2	16.5
Blue Cross and Blue Shield of Texas	454	583	545	532	559	28.5	-6.6	-2.4	5.2	6.2
Friday Health Plans	n/a	n/a	n/a	n/a	450	n/a	n/a	n/a	n/a	n/a
Oscar	n/a	404	476	461	490	n/a	17.9	-3.1	6.3	7.0
Scott and White Health Plan	n/a	n/a	n/a	n/a	441	n/a	n/a	n/a	n/a	n/a
Sendero Health Plans, local nonprofit	290	455	537	517	549	56.5	18.1	-3.6	6.1	19.3

Percent change in lowest option available						40.7	11.9	3.9	-1.1	13.9					
						El Paso									
Insurer															
Ambetter from Superior HealthPlan	274	396	373	395	435	44.5	-6.0	5.9	10.2	13.7					
Blue Cross and Blue Shield of Texas	393	495	483	488	502	25.7	-2.3	1.0	2.8	6.8					
Friday Health Plans	n/a	n/a	n/a	n/a	397	n/a	n/a	n/a	n/a	n/a					
Molina Healthcare	285	395	431	412	424	38.6	9.0	-4.4	3.0	n/a					
Oscar	n/a	n/a	396	398	433	n/a	n/a	0.6	8.8	4.7					
Percent change in lowest option available						44.1	-5.8	5.9	7.5	13.0					
State average (all regions)						279	394	403	406	410	41.3	2.4	0.6	0.9	11.3

Source: “FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers,” Healthcare.gov, <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/>.

Notes: n/a = not applicable (insurer was not participating in the Marketplace). Insurers instructed to load the cost of cost-sharing reductions into silver Marketplace premiums only.

TABLE B.19

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected Virginia Markets

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				Average Annual Change, 2017-21
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	
Richmond										
Insurer										
Aetna	289	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Anthem HealthKeepers	303	497	531	489	448	64.2	6.7	-8.0	-8.4	13.6
Cigna	296	439	490	502	441	48.0	11.7	2.5	-12.1	12.5
Kaiser Permanente	329	447	638	592	528	36.0	42.7	-7.3	-10.8	15.1
Optima Health	n/a	900	801	528	528	n/a	-11.0	-34.1	0.1	-15.0
Oscar	n/a	n/a	n/a	520	535	n/a	n/a	n/a	2.7	2.7
Piedmont Community Health Plan	357	572	674	n/a	n/a	60.0	17.9	n/a	n/a	39.0
UnitedHealthcare	333	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Virginia Premier Health Plan	n/a	n/a	504	514	n/a	n/a	n/a	2.1	n/a	n/a
Percent change in lowest option available						51.6	11.7	-0.3	-9.6	13.4
Virginia Beach/Norfolk										
Insurer										
Aetna	336	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Anthem HealthKeepers	338	n/a	542	515	472	n/a	n/a	-5.0	-8.4	-6.7
Optima Health	376	641	602	478	516	70.5	-6.1	-20.6	8.1	13.0
Percent change in lowest option available						90.8	-15.4	-11.9	-1.2	15.6
Washington, DC, suburbs										
Insurer										
Anthem HealthKeepers	336	511	552	514	471	52.3	8.0	-6.9	-8.4	11.2
CareFirst BlueChoice	432	720	802	671	598	66.7	11.3	-16.3	-10.9	12.7
Cigna	313	458	508	527	470	46.1	11.0	3.8	-10.7	12.5
Innovation Health	296	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Kaiser Permanente	329	447	638	592	528	36.0	42.7	-7.3	-10.8	15.1
UnitedHealthcare	319	n/a	n/a	n/a	515	n/a	n/a	n/a	n/a	n/a
Percent change in lowest option available						51.4	13.5	1.2	-8.5	14.4
State average (all regions)	309	506	526	504	470	63.9	4.1	-4.2	-6.7	14.3

Source: “FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers,” Healthcare.gov, <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/>.

Notes: n/a = not applicable (insurer was not participating in the Marketplace). Insurers instructed to load the cost of cost-sharing reductions into silver Marketplace premiums only.

TABLE B.20

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected Washington Market

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				Average Annual Change, 2017–21
	2017	2018	2019	2020	2021	2017–18	2018–19	2019–20	2020–21	
Seattle										
Insurer										
BridgeSpan Health Company	315	n/a	n/a	447	466	n/a	n/a	n/a	4.4	4.4
Coordinated Care	235	328	368	380	381	39.6	12.3	3.2	0.2	13.8
Group Health (Kaiser Permanente)	280	404	439	405	358	44.2	8.7	-7.7	-11.5	8.4
LifeWise	324	n/a	n/a	419	409	n/a	n/a	n/a	-2.5	-2.5
Molina Healthcare	257	385	412	379	373	49.7	6.9	-8.1	-1.5	11.8
Premera Blue Cross	404	517	520	515	473	27.9	0.7	-0.9	-8.2	4.9
Regence	326	n/a	n/a	n/a	458	n/a	n/a	n/a	n/a	n/a
UnitedHealthcare	n/a	n/a	n/a	n/a	463	n/a	n/a	n/a	n/a	n/a
Percent change in lowest option available						39.6	12.3	2.9	-5.4	12.4
State average (all regions)	238	326	368	379	368	37.0	13.1	3.0	-2.9	-2.9

Source: Washington Healthplan Finder.

Notes: n/a = not applicable (insurer was not participating in the Marketplace). Insurers instructed to load the cost of cost-sharing reductions into silver Marketplace premiums only. Group Health is now owned by and marketed as Kaiser Permanente but was marketed as Group Health during this period.

TABLE B.21

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected West Virginia Markets

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	Average Annual Change, 2017-21
Charleston										
Insurer										
CareSource	505	555	611	653	717	9.8	10.2	6.8	9.9	9.2
Highmark Blue Cross Blue Shield	541	653	713	747	788	20.7	9.1	4.8	5.5	10.0
Percent change in lowest option available						9.8	10.2	6.8	9.9	9.2
Selected rural region										
Insurer										
CareSource	485	555	614	656	692	14.5	10.7	6.8	5.6	9.4
Highmark Blue Cross Blue Shield	493	595	649	680	717	20.7	9.1	4.8	5.5	10.0
Percent change in lowest option available						14.5	10.7	6.8	5.6	9.4
State average (all regions)	441	514	562	601	641	16.7	9.3	6.9	6.7	9.9

Source: "FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers," Healthcare.gov, <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/>.

Notes: Insurers instructed to load the cost of cost-sharing reductions into all metal tiers, both on Marketplace and off.

TABLE B.22

Lowest Silver Monthly Premiums for a 40-Year-Old and Percent Change from 2017 to 2021, by Insurer, in Selected Wyoming Markets

	LOWEST SILVER PREMIUM (\$)					PERCENT CHANGE				
	2017	2018	2019	2020	2021	2017-18	2018-19	2019-20	2020-21	Average Annual Change, 2017-21
Cheyenne										
Insurer										
Blue Cross Blue Shield of Wyoming	457	795	790	806	728	74.0	-0.7	2.0	-9.7	16.4
Mountain Health CO-OP	n/a	n/a	n/a	n/a	828	n/a	n/a	n/a	n/a	n/a
Percent change in lowest option available						74.0	-0.7	2.0	-9.7	16.4
Selected rural region										
Insurer										
Blue Cross Blue Shield of Wyoming	502	873	867	884	799	74.0	-0.7	2.0	-9.7	16.4
Mountain Health CO-OP	n/a	n/a	n/a	n/a	793	n/a	n/a	n/a	n/a	n/a
Percent change in lowest option available						74.0	-0.7	2.0	-10.4	16.3
State average (all regions)	494	860	854	871	782	16.7	9.3	6.9	6.7	9.9

Source: "FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers," Healthcare.gov, <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/>.

Notes: n/a = not applicable (insurer was not participating in the Marketplace). Insurers instructed to load the cost of cost-sharing reductions into all metal tiers, both on Marketplace and off.

Notes

- ¹ Eric Hargan (acting Secretary, US Department of Health and Human Services), memo to Seema Verma (administrator, Centers for Medicare & Medicaid Services), regarding payments to insurers for cost-sharing reductions, October 12, 2017, <https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf>; and Dan Mangan, “Obamacare Bombshell: Trump Kills Key Payments to Health Insurers,” CNBC, October 13, 2017, <https://www.cnbc.com/2017/10/12/obamacare-bombshell-trump-kills-key-payments-to-health-insurers.html>.
- ² Sabrina Corlette, Kevin Lucia, and Maanasa Kona, “States Step Up to Protect Consumers in Wake of Cuts to ACA Cost-Sharing Reduction Payments,” *To the Point* (blog), Commonwealth Fund, October 27, 2017, <https://www.commonwealthfund.org/blog/2017/states-step-protect-consumers-wake-cuts-aca-cost-sharing-reduction-payments>.
- ³ Kentucky’s health insurance Marketplace, kynect, was relaunched in October 2020 but still uses Healthcare.gov for now; a full relaunch is planned for 2022. Steve Rogers, “State Relaunching Improved ‘kynect’ System for Benefits,” WTVQ, October 5, 2020, <https://www.wtvq.com/2020/10/05/state-relaunching-improved-kynect-system-for-benefits/>.
- ⁴ Authors’ calculations based upon Marketplace participation data from Healthcare.gov and state-based Marketplace websites. The data are weighted by rating region population from the Census Bureau.
- ⁵ Reinsurance programs are designed to encourage insurers to reduce premiums in exchange for back-end payments from the state to cover exceptionally high-cost enrollees whose spending exceeds a threshold.
- ⁶ “COVID-19 and the Individual Market,” Robert Wood Johnson Foundation, April 17, 2020, <https://www.rwjf.org/en/library/research/2020/04/covid-19-and-the-individual-market.html>.
- ⁷ Bruce Japsen, “CVS Health Will Return Aetna to Obamacare Market,” *Forbes*, February 16, 2021, <https://www.forbes.com/sites/brucejapsen/2021/02/16/cvs-will-return-aetna-to-obamacare-market>.
- ⁸ The premium increase had the unanticipated side effect of increasing subsidies and making insurance more affordable for those eligible for subsidies. Unsubsidized enrollment fell off, however, because of the premium increases.

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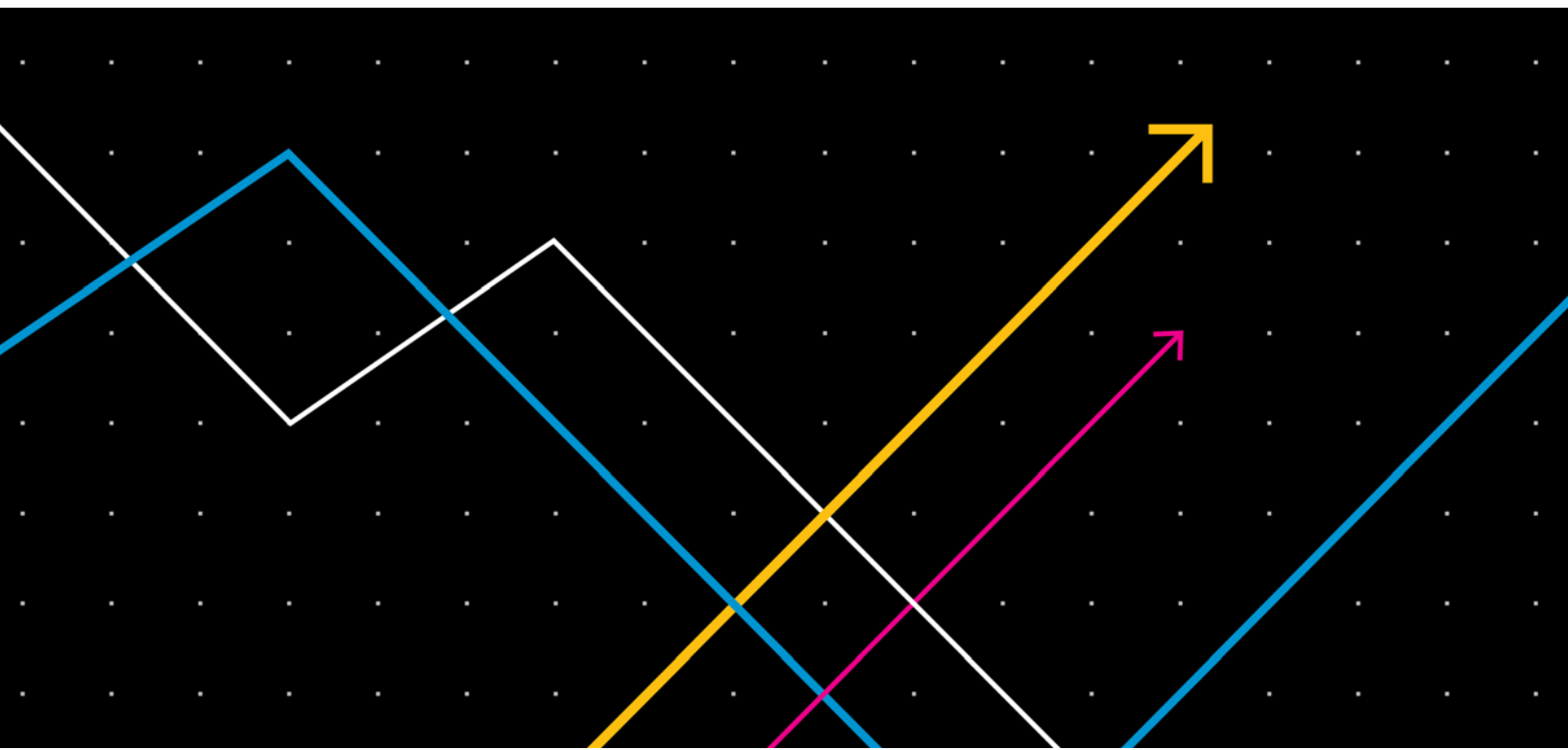
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RESEARCH REPORT

Distributional Effects of Alternative Health Reform Proposals

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May 2021

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The
Commonwealth
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Distributional Effects of Alternative Health Reform Proposals

In this report, we examine the distributional effects of two health reform policies that are each financed with two alternative tax strategies. We determine the net beneficiaries, for whom new government spending exceeds new taxes, and the net contributors, who pay more in new taxes than they receive in new benefits. Health reform poses difficult choices for policymakers. It is important to know what effects health reform proposals will have on coverage and affordability and which income and demographic groups will most benefit, as well as what a reform policy will cost and who will bear the financing burden.

The first policy we examine is an incremental reform that would expand coverage considerably compared with current law, mainly in the nongroup market through enhanced premium and cost-sharing subsidies and the introduction of a public option. The second policy is a more comprehensive reform that both further improves subsidies and introduces an auto-enrollment feature resulting in universal coverage of people legally present in the United States. Each option is financed through two alternative approaches—an increase in payroll taxes that falls on both employers and employees or a proportional increase in income tax rates. We show the distribution of new spending and new taxes by income, race/ethnicity, age, and region, as well as by what coverage a person would have had without reform.

Our main findings are as follows:

- The incremental reform extends coverage to 14.8 million people, and with auto-enrollment that leads to full coverage of all legally present people; the comprehensive reform covers 27.2 million more people than without reform. The annual federal cost of the incremental reform, modeled as fully phased in in 2022, is \$103.6 billion and the comprehensive reform is \$168.7 billion. Both improve affordability for large numbers of people, particularly the comprehensive reform.
- Financing reform with an income tax increase is considerably more progressive than financing with a payroll tax increase. Tax units with incomes less than \$200,000 pay more under a payroll tax than with income tax financing. For those with incomes higher than \$200,000, tax payments are considerably higher with income tax financing.
- Both reforms are redistributive toward populations with low incomes, although more so with income tax financing. The lowest-income groups see coverage and affordability gains and pay

relatively little in new taxes. Those with incomes more than 600 percent of the federal poverty level (FPL) have relatively few new benefits and substantially more in new tax payments.

- Largely because of income differences, Black non-Hispanic,¹ Hispanic, and American Indian and Alaska Native people are net beneficiaries, while white non-Hispanic, Asian American and Pacific Islander, and other (more than one race) people are net contributors.
- There is considerable redistribution by region. People in the South are net beneficiaries in part because of the new and improved subsidies for people with low incomes in states that have not expanded Medicaid (most are in the South). On average, the other three regions are net contributors.
- The uninsured are clear net beneficiaries. They benefit from gaining coverage and improved affordability of care and, because their income is generally low, pay relatively little in new taxes. But only about 30 percent of new federal spending is on the uninsured. The remaining 70 percent of new spending improves affordability for large numbers of people who already have coverage.

Incremental and Comprehensive Reform

The two reform policies are described in table 1. The incremental policy builds on the Affordable Care Act (ACA) but does not provide universal coverage. It substantially improves premium and cost-sharing subsidies. As shown in table 2, the amounts individuals would be expected to pay in premiums are sharply reduced from the current law baseline at each income level. Further, subsidies are extended above 400 percent of the federal poverty level (FPL) with no one paying more than 8.5 percent of income for nongroup coverage. This limit is the same as under the American Rescue Plan Act (ARPA), but the subsidies modeled here are permanent, and the reforms are presented compared with a baseline with pre-ARPA subsidies. Cost-sharing subsidies are also improved relative to current law; they would be tied to gold plans and are never below 80 percent actuarial value. The reform would offer ACA essential benefits for all insurance. The policy would restore the ACA individual mandate penalties and eliminate access to short-term limited duration policies. The policy would have a public option in the nongroup market that would set provider payment rates equal to those in highly competitive markets. In states that have not expanded Medicaid, the federal government would make available marketplace coverage for those between current Medicaid eligibility levels, which are typically very low, and 100 percent of FPL. Because the federal government would pay for this coverage, the policy would also increase the Medicaid matching rate for the expansion population to 100 percent in expansion states. The reform would eliminate the employer coverage firewall, which excludes those

with household employer-sponsored insurance (ESI) offers that are deemed affordable under the ACA from federal subsidies, and there would be no penalty for employers not providing insurance.

TABLE 1
Provisions of Health Reforms Simulated

	Baseline (before ARPA)	Incremental reform	Comprehensive reform
Household premiums	Premium percent of income caps range from 2.07 to 9.83 percent of incomes (marketplaces); no premium subsidies for those with incomes above 400% FPL	Lower percent of income caps than ACA plus extension to higher incomes (marketplaces): ranging from 0 percent to 8.5 percent of income for those with incomes 400% FPL or higher	Lower percent of income caps than ACA plus extension to higher incomes (marketplaces): ranging from 0 percent to 8 percent of income for those with incomes 600% FPL or higher
Cost-sharing	Premium percent of income caps tied to 70% AV plan; additional subsidies to lower cost sharing further for those with incomes up to 250% FPL	Premium percent of income caps tied to 80% AV plan. Additional subsidies to lower cost sharing further for those with incomes up to 400% FPL	Premium percent of income caps tied to 80% AV plan. Additional subsidies to lower cost sharing for those with incomes up to 500% FPL
Covered benefits	ACA essential health benefits	ACA essential health benefits	ACA essential health benefits
Reinsurance	Reinsurance only in states with waiver	Permanent program; \$10 billion per year funded by general revenues; grows by percent growth	Permanent program; \$10 billion per year funded by general revenues; grows by percent growth
Automatic enrollment	No	Yes; limited to zero-premium households with SNAP or TANF receipt	Yes; all legally present residents enrolled through Continuous Auto-Enrollment with Retrospective Reimbursement (CARE)
Are there penalties for remaining uninsured?	No	Yes; restores ACA penalties	No; all legally present are insured
Is there expanded access to short-term limited duration policies?	Yes	No; returns to 2016 rules	No; all enrolled in compliant coverage
Are there limits on provider payment rates?	No	Yes, in nongroup market: public plan pays at levels equivalent to highly competitive market rates and private nongroup plans capped at same rates in and out of network; this reform requires a public option	Yes, in nongroup market: public plan pays at levels equivalent to highly competitive market rates and private nongroup plans capped at same rates in and out of network; this reform requires a public option
Does it eliminate the Medicaid eligibility gap?	No; no federal subsidies available below 100% FPL and very limited Medicaid eligibility in states that have not expanded Medicaid	Yes; federal government pays 100% of Medicaid expansion population costs in expansion states and lowers marketplace subsidy income threshold to just above Medicaid eligibility in nonexpansion states	Yes; federal government pays 100% of Medicaid expansion population costs in expansion states and lowers marketplace subsidy income threshold to just above Medicaid eligibility in nonexpansion states

	Baseline (before ARPA)	Incremental reform	Comprehensive reform
Are those with ESI offers in the household excluded from federal subsidies?	Yes; the “firewall” prevents people with an affordable offer of insurance from receiving premium subsidies	No	No
Does the program lead to universal coverage?	No	No	For legally present residents but not for undocumented immigrants
Do employers face a penalty for not insuring workers?	Yes	No	No

Source: Urban Institute.

Notes: ARPA = American Rescue Plan Act; ACA = Affordable Care Act; AV = actuarial value, which is the average percentage of covered benefits that a plan will pay; FPL = federal poverty level; SNAP = Supplemental Nutrition Assistance Program; TANF = Temporary Assistance for Needy Families.

* Nongroup public option coverage is set to approximate Medicare rates by estimating premiums in each rating area as if there were at least five competing insurers and modestly competitive provider markets. See the appendix for additional detail.

TABLE 2

Enhanced Premium Tax Credit and Cost-Sharing Reduction Schedule

Income (% of FPL)	Household Premium as a % of Income			Cost-Sharing Reduction Schedule AV of Plan Provided to Eligible Enrollees (%)		
	Before ARPA	Incremental reform	Comprehensive reform	Before ARPA	Incremental reform	Comprehensive reform
100–138	2.07	0.0–1.0	0	94	95	100
138–150	3.10–4.14	1.0–2.0	0	94	95	100
150–200	4.14–6.52	2.0–4.0	0	87	95	100
200–250	6.52–8.33	4.0–6.0	0.0–1.0	73	90	95
250–300	8.33–9.83	6.0–7.0	1.0–2.0	70	90	95
300–400	9.83	7.0–8.5	2.0–4.0	70	85	90
400–500	NA	8.5	4.0–6.0	70	80	85
500–600	NA	8.5	6.0–8.0	70	80	80
More than 600	NA	8.5	8	70	80	80

Sources: Internal Revenue Service (26 CFR 601.105, “Examination of Returns and Claims for Refund, Credit, or Abatement; Determination of Correct Tax Liability,” 2020, <https://www.irs.gov/pub/irs-drop/rp-20-36.pdf>), Health and Human Services Department (“Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Governmental Plans,” 85 Fed. Reg. 29164, May 14, 2020, <https://www.federalregister.gov/documents/2020/05/14/2020-10045/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2021>), and Urban Institute.

Note: ARPA = American Rescue Plan Act; AV = actuarial value, which is the average percentage of covered benefits that a plan will pay; FPL = federal poverty level; baseline premiums are pegged to benchmark silver (70% AV) premium; reforms are pegged to gold (80% AV) premium.

The comprehensive policy model would also build on the ACA. It would result in universal coverage of legally present people because all Americans would be automatically enrolled in coverage even if they did not take active steps to sign up. They would be required to pay income-related premiums, either during or at the end of the year.² Premium and cost-sharing subsidies would still be tied to the gold metal tier but would be even more generous than in the incremental reform. As shown in table 2, for example, the amount that households would have to pay at any income level would not exceed 8 percent. The policy would have the same permanent reinsurance program, and short-term limited-duration policies would be eliminated. The option also would have a nongroup public option with provider payment rates based on highly competitive markets. The policy would eliminate the Medicaid gap, as in the incremental reform, by extending marketplace coverage to people with incomes below 100 percent of FPL, with the federal government paying all costs. The Medicaid matching rate would also be increased in current expansion states. Employers would not have a penalty for not insuring workers, and the employer coverage firewall policy would be eliminated.

The cost and coverage estimates of both reform options, as well as the distributional effects, are produced using the Urban Institute's Health Policy Simulation Model (HIPSM). We made estimates as if the reforms were fully implemented in 2022. Costs and coverage are compared with a baseline for 2022 modeled before passage (and not including the effects) of the American Rescue Plan Act (ARPA). We use this and the Urban Brookings Tax Policy Center (TPC) tax model to develop tax scenarios that will raise enough money to finance both expansions. Methods are explained in greater detail in the appendix.

Coverage and Spending Effects of the Two Reforms

In this section, we show the changes in coverage and spending for each option. Table 3 shows the changes in coverage and spending for the incremental reform, while table 4 provides the same estimates for the comprehensive reform.

Incremental reform coverage. In this reform, the number of newly insured people is 14.8 million (table 3).³ Employer coverage falls by 16.7 million. Because of the elimination of the firewall and the enhancement of subsidies, individuals prefer to obtain coverage in either the marketplace or Medicaid. Private nongroup coverage increases by 24.3 million; almost all of this is because of marketplace coverage expansion. Many factors are responsible for this sizable expansion, including the improved subsidies, expansion of coverage in states that have not expanded Medicaid, dropping of employer coverage following elimination of the firewall, and reintroduction of the individual mandate. Medicaid coverage expands by 7.2 million largely because TANF and SNAP recipients are auto-enrolled, but the

elimination of the firewall and individual mandate reintroduction also contribute. The expansion of nongroup and Medicaid coverage together more than offset the decline in employer coverage, resulting in fewer people without minimum essential coverage (14.8 million), including 2.6 million who leave noncompliant nongroup coverage. The previously underinsured and uninsured primarily enroll in more affordable marketplace plans, but a small number enroll in employer coverage or Medicaid. This reform reduces the number without minimum essential coverage from 33.3 million to 18.5 million.

TABLE 3

Coverage of and Spending for the Nonelderly before ARPA and under Incremental Reform, 2022

(thousands of people)	Health Insurance Coverage			
	Before ARPA	Incremental reform	Change from current law	Percent change from current law (%)
Insured (minimum essential coverage)	244.1	258.9	14.8	6.1
Employer	149.3	132.6	-16.7	-11.2
Private nongroup	15.0	39.2	24.3	162.3
<i>Basic health program</i>	0.9	0.9	*	1.5
<i>Marketplace with subsidy</i>	8.5	32.8	24.3	286.9
<i>Other ACA compliant nongroup</i>	5.6	5.5	-0.1	-1.8
Medicaid/CHIP	71.2	78.4	7.2	10.2
<i>Disabled</i>	9.4	10.0	0.6	5.8
<i>Medicaid expansion</i>	14.8	17.7	2.8	19.1
<i>Traditional nondisabled adult</i>	12.7	14.4	1.7	13.5
<i>Nondisabled Medicaid/CHIP child</i>	34.2	36.3	2.1	6.3
<i>State-funded program</i>	*	*	*	1.9
Other public	8.7	8.7	0.0	0.0
Uninsured (No MEC)	33.3	18.5	-14.8	-44.4
Uninsured	30.8	18.5	-12.2	-39.7
Noncompliant nongroup	2.6	0.0	-2.6	-100.0
Total	277.4	277.4	0.0	0.0

(millions of dollars)	Spending			
	Before ARPA	Incremental reform	Change from current law	Percent change from current law (%)
Household	587.9	557.6	-30.2	-5.1
Premiums	300.3	271.2	-29.1	-9.7
Other health care spending	287.6	286.4	-1.2	-0.4
Federal government	467.1	570.7	103.6	22.2
Medicaid	376.1	427.6	51.5	13.7
Marketplace PTC	58.3	108.4	50.1	86.0
Marketplace CSR	0.0	7.3	7.3	nc
Reinsurance	1.3	10.0	8.7	661.0
Uncompensated care	31.4	17.4	-14.0	-44.5
State government	220.4	213.8	-6.6	-3.0
Medicaid	199.9	202.9	3.0	1.5
Marketplace PTC	0.4	0.0	-0.4	-100.0
Marketplace CSR	0.0	0.0	0.0	nc
Reinsurance	0.4	0.0	-0.4	-100.0

(millions of dollars)	Spending			
	Before ARPA	Incremental reform	Change from current law	Percent change from current law (%)
Uncompensated care	19.6	10.9	-8.7	-44.5
Employers	800.1	705.0	-95.1	-11.9
Providers	27.5	15.2	-12.2	-44.5
Total, all payers	2,102.9	2,062.3	-40.6	-1.9

Source: Health Insurance Policy Simulation Model (HIPSM), 2021. Reform simulated in 2022.

Notes: * = less than \$500 million; PTC = ACA premium tax credits; CSR = cost-sharing reductions; nc = not calculated.

Incremental reform spending. Federal government spending on the incremental reform increases by \$103.6 billion, after accounting for savings from the public option’s reduced payment rates. Medicaid expenditures increase by \$51.5 million as coverage expands. Marketplace premiums and cost-sharing subsidies, including amounts needed to fill in the Medicaid gap, increase by \$57.4 billion, and spending on reinsurance increases by \$8.7 billion. Uncompensated care funded by the federal government would fall by \$14.0 billion. States would see savings of \$6.6 billion primarily because the reduction in spending on uncompensated care (\$8.7 billion) offsets the increase in Medicaid spending (\$3.0 billion). Employers spend \$95.1 billion less; this is a significant amount but accounts for only 12 percent of employer spending, largely because of fewer employees staying with employer coverage. We assume this is passed on to workers in the higher wages (i.e., employers do not reap savings in the end). Households save \$30.2 billion because of expanded coverage and more generous subsidies. Providers incur \$12.2 billion less in uncompensated care costs. National health spending under this reform would fall by \$40.6 billion (1.9 percent) because of savings from the public option, decreases in the demand for uncompensated care, and the shift from employer coverage to the less expensive marketplace plans, and Medicaid more than offsets the cost of additional coverage and subsidies.

Comprehensive reform coverage. The more comprehensive option analyzed in this report, as shown in table 4, would reduce the number of uninsured by 27.2 million. This leaves 6.2 million uninsured, all of whom are ineligible for subsidies because they are not legally present in the United States. Employer coverage would fall by 18.3 million because of the elimination of the firewall and much more generous subsidies available in the marketplace. Nongroup coverage would expand by 32.9 million because of the further improvement in subsidies, the elimination of the firewall, and the auto-enrollment policy. Another 12.5 million would be newly enrolled in Medicaid; this results from the elimination of the firewall, the individual mandate reintroduction, and comprehensive auto-enrollment. Employer coverage falls by 18.3 million because of the elimination of the firewall. The expansion of private nongroup coverage and Medicaid more than offsets the decline in employer coverage. As a result, the number of uninsured falls by 27.2 million; 2.6 million of which had noncompliant nongroup coverage.

TABLE 4

Coverage of and Spending for the Nonelderly before ARPA and under Comprehensive Reform, 2022

(thousands of people)	Health Insurance Coverage			
	Before ARPA	Comprehensive reform	Change from current law	Percent change from current law
Insured (minimum essential coverage)	244.1	271.3	27.2	11.1%
Employer	149.3	131.1	-18.3	-12.2%
Private nongroup	15.0	47.8	32.9	219.8%
<i>Basic health program</i>	0.9	0.9	0.1	6.5%
<i>Marketplace with subsidy</i>	8.5	41.4	32.9	388.2%
<i>Other ACA compliant nongroup</i>	5.6	5.5	-0.1	-1.8%
Medicaid/CHIP	71.2	83.7	12.5	17.6%
<i>Disabled</i>	9.4	10.4	0.9	9.9%
<i>Medicaid expansion</i>	14.8	19.6	4.8	32.3%
<i>Traditional nondisabled adult</i>	12.7	15.0	2.3	18.3%
<i>Nondisabled Medicaid/CHIP child</i>	34.2	38.6	4.5	13.1%
<i>State-funded program</i>	*	*	*	2.2%
Other public	8.7	8.7	0.0	0.0%
Uninsured (no MEC)	33.3	6.2	-27.2	-81.5%
Uninsured	30.8	6.2	-24.6	-79.9%
Noncompliant nongroup	2.6	0.0	-2.6	-100.0%
Total	277.4	277.4	0.0	0.0%
(millions of dollars)	Spending			
	Before ARPA	Comprehensive reform	Change from current law	Percent change from current law
Household	587.9	537.2	-50.7	-8.6%
<i>Premiums</i>	300.3	255.3	-45.0	-15.0%
<i>Other health care spending</i>	287.6	281.9	-5.7	-2.0%
Federal government	467.1	635.8	168.7	36.1%
<i>Medicaid</i>	376.1	456.4	80.3	21.3%
<i>Marketplace PTC</i>	58.3	155.7	97.4	167.2%
<i>Marketplace CSR</i>	0.0	11.1	11.1	nc
<i>Reinsurance</i>	1.3	10.0	8.7	661.0%
<i>Uncompensated care</i>	31.4	2.6	-28.8	-91.8%
State government	220.4	213.0	-7.4	-3.3%
<i>Medicaid</i>	199.9	211.4	11.4	5.7%
<i>Marketplace PTC</i>	0.4	0.0	-0.4	-100.0%
<i>Marketplace CSR</i>	0.0	0.0	0.0	nc
<i>Reinsurance</i>	0.4	0.0	-0.4	-100.0%
<i>Uncompensated care</i>	19.6	1.6	-18.0	-91.8%
Employers	800.1	704.2	-95.9	-12.0%
Providers	27.5	2.3	-25.2	-91.8%
Total, all payers	2,102.9	2,092.4	-10.5	-0.5%

Source: Health Insurance Policy Simulation Model (HIPSM), 2021. Reform simulated in 2022.

Note: * = less than \$500 million; MEC = ACA minimum essential coverage; PTC = ACA premium tax credits; CSR = cost-sharing reductions; nc = not calculated.

Comprehensive reform spending. Federal government spending would increase by \$168.7 billion because of coverage expansion (again, net of the savings from the public option). Of this, \$80.3 billion would be for Medicaid. Marketplace premium tax credits and cost-sharing reductions would amount to \$108.5 billion; reinsurance payments would increase by \$8.7 billion. Offsetting this to some degree would be a reduction in payments for uncompensated care of \$28.8 billion. States would save \$7.4 billion, almost completely because of \$18 billion less in uncompensated care costs, but they would have \$11.4 billion in net new spending on Medicaid. Employers would spend \$95.9 billion less on health insurance; again, slightly more than 12 percent of current spending. Households would save \$50.7 billion because of expanded coverage and much more generous subsidies. Providers would see a reduction of \$25.2 billion in spending on uncompensated care. Thus, this reform would achieve universal coverage, leaving no legally present residents without insurance. It would result in \$168.7 billion in new federal spending but significantly reduce household, employer, and state spending. Overall, the comprehensive reform package would reduce national health spending by \$10.5 billion (0.5 percent). The improved subsidies and additional coverage still do not fully offset savings from the public option, reduction in demand for uncompensated care for the uninsured, and the movement of people from employer to less expensive marketplace or Medicaid coverage.

Tax Financing

We use two approaches to raise the funds necessary to pay for the federal costs of each health reform option—\$103.6 billion for the incremental reform and \$168.7 billion for the comprehensive reform. The first is a proportional increase in income tax rates; the second is an increase in payroll taxes that would be split evenly between employers and employees. The first is a relatively progressive financing approach—higher-income groups pay a higher percent of income than do lower-income groups. The latter is more regressive—the payroll tax increase applies the same rate at all income levels.

We use the Urban-Brookings Tax Policy Center (TPC) tax model to develop tax scenarios that raise enough revenue for each reform scenario. TPC solves for a proportional increase in income tax rates (the more progressive option) and new payroll tax (the less progressive option) that raised the needed amount of revenue. The revenue estimates include the impact of increased taxable income, as reduced ESI coverage translates into higher-wage income under both coverage scenarios. We assume that the employers cannot reduce worker compensation as they compete for labor; thus, when people leave ESI, payments for health benefits are replaced by higher wages.

Table 5 shows income tax rates under current law and for scenarios raising \$103.6 billion and \$168.7 billion, respectively. For the incremental reform, the income tax scenario increases tax rates by 4.7 percent (e.g., increases the top rate from 37.0 percent to 38.7 percent). The payroll tax scenario imposes a new payroll tax of 0.9 percent split evenly between employers and employees. For the comprehensive scenario, the income tax scenario increases tax rates by 8.8 percent (e.g., increases the top rate from 37.0 percent to 40.3 percent). The payroll tax scenario imposes a new payroll tax of 1.7 percent, split evenly between employers and employees.

TABLE 5

Tax Rates Needed to Finance Reforms with Income Tax Increases

Taxable income brackets (dollars)				Marginal tax rates (%)		
Single filers		Married filing jointly		Current law	Incremental reform	Comprehensive reform
More than	But not more than	More than	But not more than			
--	\$10,075	--	\$20,150	10.0	10.5	10.9
\$10,075	\$40,950	\$20,150	\$81,900	12.0	12.6	13.1
\$40,950	\$87,325	\$81,900	\$174,650	22.0	23.0	23.9
\$87,325	\$166,725	\$174,650	\$333,450	24.0	25.1	26.1
\$166,725	\$211,725	\$333,450	\$423,450	32.0	33.5	34.8
\$211,725	\$529,300	\$423,450	\$635,150	35.0	36.6	38.1
\$529,300	--	\$635,150	--	37.0	38.7	40.3

Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0920-2).

Note: Income brackets simulated for 2022.

Table 6 shows the average tax change by income group under each scenario. Under both reform scenarios, tax units with incomes below \$200,000 see larger tax increases under the payroll tax option, while tax units with incomes above \$200,000 see larger tax increases under the income tax option. The difference between the income tax and payroll tax options is largest at the highest-income levels. For example, tax units with incomes of more than \$1,000,000 would see tax increases of \$26,350 under the incremental reform and \$50,140 under the comprehensive reform under the income tax scenario versus only \$8,270 and \$15,370, respectively, under the payroll tax scenario.

TABLE 6

Change in Tax Burden by Income Group under Reforms Raising \$104 Billion and \$169 Billion, 2022

Expanded cash income level (2019 dollars) ^a	Average Federal Tax Change (\$)			
	Incremental reform (\$104 billion)		Comprehensive reform (\$169 billion)	
	Increase in income tax rates	Employer and employee payroll tax	Increase in income tax rates	Employer and employee payroll tax
Less than 10,000	10	40	10	60
10,000–20,000	80	140	80	190
20,000–30,000	100	190	110	280
30,000–40,000	190	290	230	420
40,000–50,000	330	430	390	590
50,000–75,000	490	600	620	820
75,000–100,000	640	720	880	1,040
100,000–200,000	810	830	1,310	1,370
200,000–500,000	1,720	1,330	3,210	2,470
500,000–1,000,000	5,560	2,840	10,560	5,380
More than 1,000,000	26,350	8,270	50,140	15,730
All	670	590	1,110	950

Source: Urban-Brookings Tax Policy Center Microsimulation Model (version 0319-2).

Notes: Data are from calendar year 2022. Estimates include the impact of increased taxable income as reduced ESI coverage translates into higher wages. Baseline is the law currently in place as of March 17, 2020.

^a Includes both filing and nonfiling units but excludes those that are dependents of other tax units. Tax units with negative adjusted gross income are excluded from their respective income class but included in the totals. For a description of expanded cash income, see “Income Measure Used in Distributional Analyses by the Tax Policy Center,” Tax Policy Center, accessed May 3, 2021, <http://www.taxpolicycenter.org/TaxModel/income.cfm>.

The total changes in tax burden implied by these distributional estimates are assigned to families in HIPSM for the analysis below that compares benefits with taxes for individuals with various characteristics. The increases in total tax burdens distributed under these two reforms exceed the revenue increases for the income tax scenarios because of TPC conventions for distributional and revenue analyses. Revenue estimates include tax units' behavioral responses while distributional estimates do not. Under these reforms, this results in the increase in tax burdens for distributional purposes exceeding the revenue gains because the revenue estimates include the effect of tax filers sheltering income in response to higher income tax rates while the distributional estimates keep taxable income fixed.⁴ In addition, differences in treatment of income used for contributions to pretax retirement accounts further widen the gap between TPC revenue and distributional estimates for changes in income tax rates.⁵

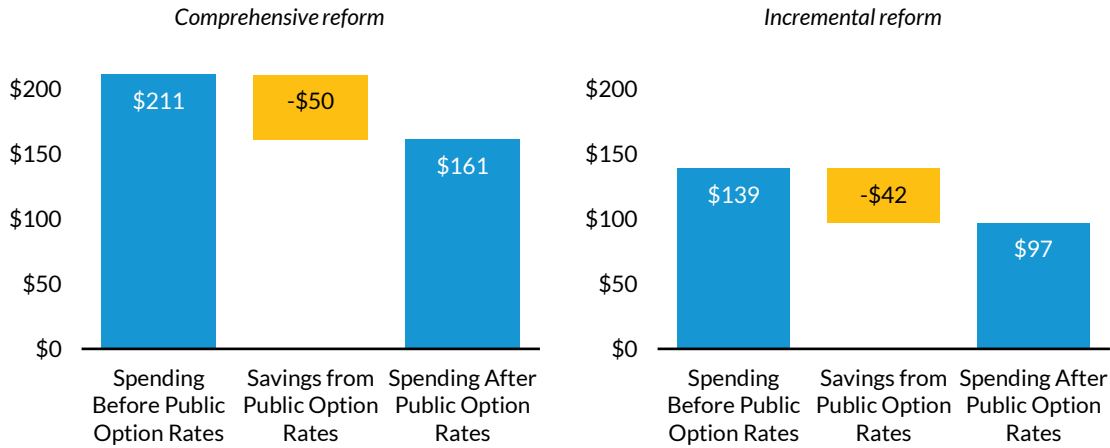
Distributional Analysis

In this section, we show the changes in government spending (federal and state) and changes in federal taxes under the incremental and comprehensive reforms. Tables 7 and 8 show spending and taxes in billions of dollars for both reforms; per capita versions of those tables are available in the appendix. We show spending, tax payments, and net spending (spending minus taxes) by income, race/ethnicity, age, prereform insurance status, and region.

Both reforms examined include a public option that pays reduced rates to providers in the nongroup market and pays lower prices for prescription drugs. Because these rates lower government spending on nongroup enrollees but are not assumed to lower the amount of care provided, figure 1 presents an estimate of changes in benefits equal to the spending that would occur at current law prices for these beneficiaries. Figure 1 shows the change in spending without the public option rate reductions, which represents the increase in health services provided under each option. The figure then shows the savings from the public option's reduced payment rates and, finally, spending after accounting for the public option savings. We use the latter concept in the rest of the report because it shows actual spending and the amount of new revenue that must be raised. We mention this because by focusing on spending after the public option effects, we are understating benefits that some people will receive—payment rates are lower, but we assume no change in services received.⁶ These will have the greatest effects on groups most likely to have marketplace coverage (e.g., those with incomes between 100 percent and 400 percent of FPL). Those residing in the South have benefits understated further because newly subsidized people with incomes below 100 percent of FPL in nonexpansion states are enrolled in marketplace coverage. Figures comparing per capita changes in net health services provided (benefits) and net spending are in the appendix.

FIGURE 1

Effects of the Public Option Provider Rate Reduction on Spending under Incremental and Comprehensive Reform



Source: Health Insurance Policy Simulation Model (HIPSM), 2021. Reform simulated in 2022

Note: Dollars are in billions.

Table 7 shows the incremental reform’s federal costs would be \$103.6 billion; \$6.6 billion of this would be savings to states. Thus, the increase in government spending is \$97.0 billion; this amount, distributed to people and offset by the new taxes they pay, is represented in figures 2 and 3. The table also shows that the tax burden needed to raise tax revenues to finance incremental reform under the income tax scenario would be \$119.2 billion, which is greater than the increased spending for reasons explained above. Table 8 shows that for the comprehensive reform, federal costs would be \$168.7 billion, with states saving \$7.4 billion for an increase in all government spending of \$161.3 billion. The income tax burden to raise the needed funds would be greater, at \$196.2 billion. The figures below consistently show more in net contributors than in net benefits for two reasons. First, new federal spending exceeds new government spending because some of it provides savings to states. Second, the new federal taxes exceed the cost of new federal spending for reasons explained earlier.

Incremental Reform

Income. In the first panel of table 7, as well as in figure 2, we show results by income. Those with incomes below 100 percent of FPL receive a considerable amount of new government spending, mostly coming from the new coverage of individuals below FPL in nonexpansion states. Individuals at this income level pay little in either federal income or payroll taxes. Thus, they have the greatest increase in net new spending under this health reform (\$35.7 billion with income tax financing and \$32.8 billion in payroll tax financing; \$519 and \$477, respectively, on a per capita basis).

TABLE 7

Spending under Current Law and the Two Reforms (Nonelderly Population), 2022

(billions of dollars)	Number of people (millions)	Change in Spending for Acute Health Care			Change in Tax Burden		Net Change: New Benefits Minus New Taxes	
		All gov't	Federal gov't	State gov't	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes
by income								
Less than 100% of FPL	69	36.5	40.1	-3.6	0.8	3.6	35.7	32.8
Between 100% and 200% of FPL	67	12.0	14.4	-2.4	6.8	10.2	5.2	1.8
Between 200% and 400% of FPL	93	36.9	38.5	-1.6	33.2	39.0	3.8	-2.1
Between 400% and 600% of FPL	52	6.4	6.2	0.2	12.6	13.8	-6.3	-7.4
More than 600% of FPL	55	5.2	4.4	0.8	65.7	37.0	-60.5	-31.8
by race/ethnicity								
American Indian and Alaskan native	5	1.9	2.1	-0.2	1.2	1.3	0.7	0.6
Asian and Pacific islander	18	4.1	4.5	-0.3	7.6	6.0	-3.4	-1.9
Black, non-Hispanic	39	15.6	16.3	-0.7	9.3	10.2	6.3	5.4
Hispanic	55	17.6	18.6	-1.0	9.9	10.9	7.8	6.7
White, non-Hispanic	213	56.5	60.9	-4.4	88.9	73.2	-32.3	-16.7
Other	6	1.3	1.2	0.0	2.3	1.9	-1.1	-0.6
by age								
Birth to age 18	79	9.4	6.3	3.1	24.4	22.0	-15.0	-12.6
Ages 19–34	71	21.9	25.7	-3.8	15.9	18.3	6.0	3.6
Ages 35–54	88	42.0	43.6	-1.6	39.6	34.7	2.4	7.3
Ages 55–64	39	23.7	28.0	-4.3	25.2	21.6	-1.5	2.1
Ages 65 and older	59	0.0	0.0	0.0	14.1	7.0	-14.1	-7.0
by coverage type before reform								
Employer sponsored	150	69.3	62.7	6.6	89.9	78.6	-20.6	-9.2
Medicaid	71	0.0	9.8	-9.8	4.8	7.8	-4.8	-7.8
Other public	65	0.0	0.0	0.0	14.2	8.0	-14.2	-8.0
Nongroup	15	-7.6	-7.1	-0.5	4.9	3.8	-12.5	-11.4
Uninsured or STLD	35	35.3	38.2	-2.9	5.3	5.4	30.0	29.9
by region								
Northeast	57	10.3	12.1	-1.8	22.9	17.2	-12.5	-6.9
Midwest	69	20.4	21.1	-0.7	22.9	21.7	-2.5	-1.3

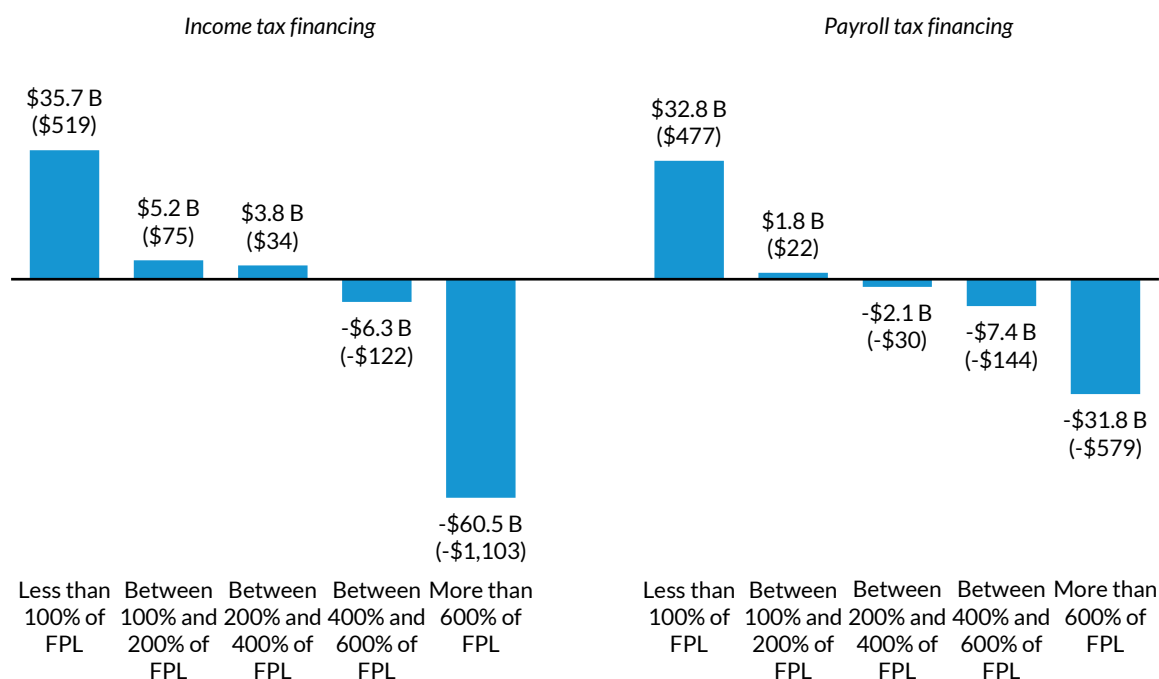
(billions of dollars)	Change in Spending for Acute Health Care				Change in Tax Burden		Net Change: New Benefits Minus New Taxes	
	Number of people (millions)	All gov't	Federal gov't	State gov't	Scenario 1:	Scenario 2:	Scenario 1:	Scenario 2:
					fund with increased income taxes	fund with increased payroll taxes	fund with increased income taxes	fund with increased payroll taxes
by income								
South	129	45.8	45.9	-0.1	43.3	39.9	2.5	5.9
West	81	20.5	24.5	-4.0	30.2	24.8	-9.6	-4.3
Overall	336	97.0	103.6	-6.6	119.2	103.6	-22.1	-6.6

Source: Health Insurance Policy Simulation Model (HIPSM), 2021; Urban-Brookings Tax Policy Center Microsimulation Model (version 0920-2); reform simulated in 2022.

Notes: Federal spending includes the federal share of Medicaid and federal spending for ACA premium tax credits (PTCs), cost-sharing reductions (CSRs), reinsurance, and uncompensated care for the uninsured. State spending includes the state share of Medicaid and state spending for PTCs, CSRs, reinsurance, and uncompensated care for the uninsured. Government spending is the total of federal and state spending. Income tax funding is a percent increase over current marginal tax rates, so higher earners in higher-rate brackets face a larger increase than those in lower-rate brackets. Payroll tax funding is a new flat-rate tax on all wages, salaries, and self-employment income. The statistical matching process importing tax changes into HIPSM did not control for race, region, or health insurance status. The tax estimates presented here for those classifications reflect differences in income and demographics across those groups in HIPSM. STLD = short-term or limited-duration plan that does not provide ACA minimum essential coverage.

Those with incomes between 100 and 200 percent of FPL also receive substantial assistance because of the more generous subsidy schedule. They also pay relatively little in federal taxes; thus, they are also net beneficiaries from reform. Those with incomes between 200 and 400 percent of FPL also receive significant new spending from the improved subsidy schedule. Both two-income groups include many who have left employer coverage because of the elimination of the firewall. However, individuals with incomes between 200 and 400 percent of FPL begin to pay more in taxes; as a result, the net spending is positive but relatively small if the reform is financed by income taxes. In the scenario with increased payroll taxes, new tax payments slightly exceed new spending.

FIGURE 2
Effects on Governmental Spending of Incremental Reform, by Income Level



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Source: Health Insurance Policy Simulation Model (HIPSM), 2021. Reform simulated in 2022.

Note: Numbers in parentheses are per capita contributions.

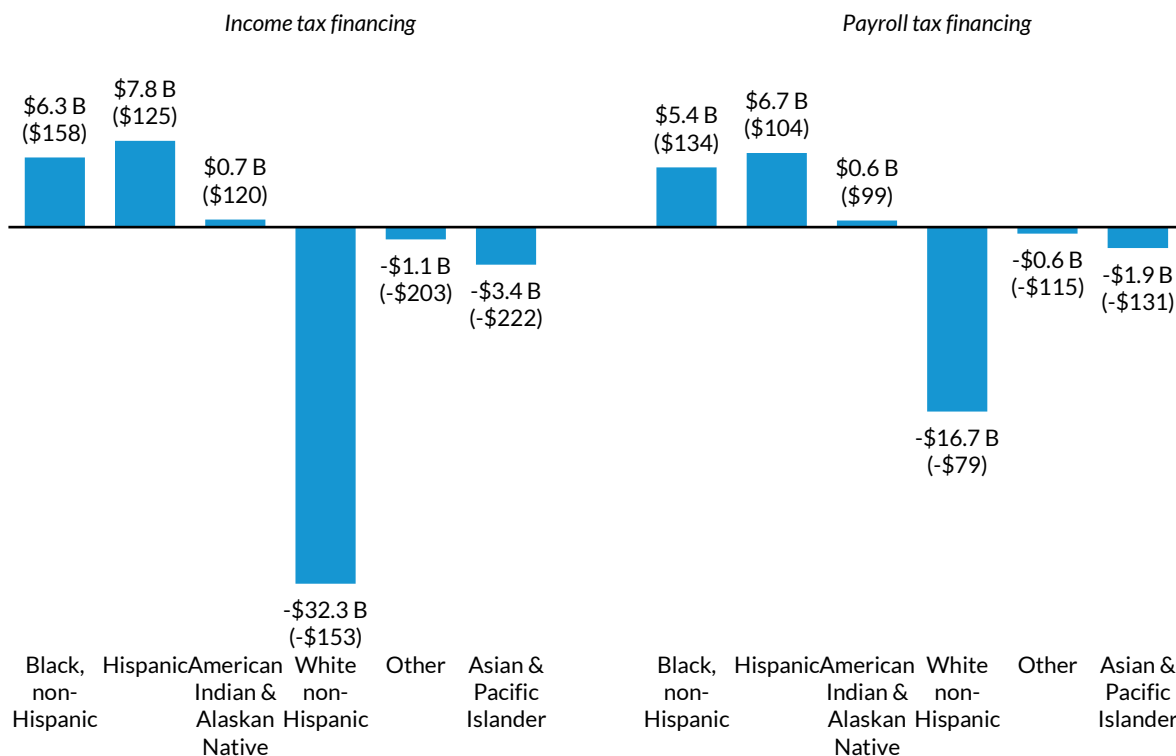
Those with incomes between 400 and 600 percent of FPL benefit from the elimination of the cap on marketplace tax credits, but at these income levels individuals pay more in taxes; thus, they are relatively small net contributors, more so with payroll than with income tax financing—\$122 and \$144, respectively, on a per capita basis.

Those with incomes above 600 percent of FPL have little in these reforms that benefit them other than the cap on nongroup premiums, which affects relatively few people. They pay substantial amounts in additional taxes, particularly with the income tax increase. They have a net contribution of \$60.5 billion under the income tax scenario and \$31.8 billion in the payroll tax scenario. On a per capita basis, these are \$1,103 and \$579, respectively. Thus, the incremental reform is fairly redistributive, particularly when financed with income taxes.

Race/ethnicity. The next panel shows results by race and ethnicity. Results are also shown in figure 3. American Indian and Alaska native, Black non-Hispanic, and Hispanic people are all net beneficiaries because the benefits they receive from new coverage and expanded subsidies exceed the new tax payments they are required to make. These groups tend to have lower incomes, which affects both benefits and tax payments. In contrast, white non-Hispanic and Asian and Pacific Islander people, as well as people of other races (those reporting two or more races in survey data) all pay more in new taxes than they receive in new health spending. Each group receives positive new spending, but new tax payments are greater. These groups have higher levels of insurance coverage as well as higher incomes, so there is less to gain from reform, and they have more resources with which to pay. Net spending is particularly negative for white non-Hispanic people, who pay \$32.3 billion more in taxes than they receive in spending under the income tax scenario and \$16.7 billion more in the payroll tax scenario. Much of this large total reflects the white non-Hispanic group's large size; total change in net spending depends on both the change in net spending per person and on group size. On a per capita basis, they are net contributors by \$153 and \$78, respectively, under income and payroll tax financing. Overall, the gains to groups that are net beneficiaries are greater under income tax financing, and the net contributions are greater for groups who are net contributors, relative to payroll tax financing. Changes in new spending per person range from an increase of \$158 for Black non-Hispanic people to a decrease of \$222 for Asian and Pacific Islander people, both under income tax financing.

FIGURE 3

Effects on Governmental Spending of Incremental Reform, by Race/Ethnicity



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Source: Health Insurance Policy Simulation Model (HIPSM), 2021. Reform simulated in 2022.

Note: Numbers in parentheses are per capita contributions.

Age. The third panel of table 7 examines distributional effects by age. Younger adults, both ages 19 to 34 and 35 to 54, receive more in new spending than they pay in taxes. This changes for those ages 55 to 64. Under the income tax scenario, they are slight net contributors, while under payroll tax financing they have a small increase in net spending. The first two columns show that those ages 55 to 64 received substantial new spending, but they are also at an age when incomes are typically highest, thus resulting in higher tax payments.

Adults ages 65 and older and children ages 18 and younger are net contributors in both income tax and payroll tax scenarios. People ages 65 and older are assumed all to be covered by Medicare, so they receive no new net spending from these reforms, but they do contribute to the program’s financing with both income taxes and payroll taxes. Children are also net contributors. They receive a small amount of new spending, because broad coverage for children already exists; uninsurance among children (5.4

percent nationally among those ages 18 and younger) is rare compared with adults (16.1 percent for those ages 19 to 64). However, we attribute tax burdens to all family members; children do not personally pay either income or payroll taxes, but their share of the family's increased tax is assigned to them. The allocation of tax burdens across all family members reflects the fact that children are affected by changes in taxes; that is, by making tax payments, the family has less disposable income, which will affect their ability to spend on children. Considering new net benefits provided, children ages 18 and younger and adults ages 65 and older pay more in new taxes than they receive in new spending (because coverage for these groups is already very high), while adults ages 19 to 64 are all better off.

Prereform insurance status. The fourth panel shows changes in benefits by insurance status in the absence of reform. With the elimination of the employer coverage firewall, those with ESI can leave that coverage and enroll in marketplace coverage even if they had affordable coverage. A relatively small share of those with ESI shifts to marketplace or Medicaid coverage, but because individuals with ESI before reform is a very large group, the total spending for those leaving ESI and receiving new marketplace subsidies or Medicaid is substantial. (There is no change in spending for those who keep their employer coverage.) Because those with ESI tend to have relatively high incomes, tax payments exceed spending for this group, particularly with income tax financing.

Coverage does not change for those on Medicaid, but all costs for the expansion population under the reform shift from states to the federal government. Medicaid recipients do pay small amounts in taxes; thus, they appear as net contributors in both the income and payroll tax scenarios. The other public group consists primarily of Medicare, but also includes some other forms of coverage (e.g., Tricare). They receive no new benefits but do pay both income and payroll taxes.

Those with nongroup coverage have a reduction in spending (\$7.6 billion). They contribute both income and payroll taxes and are thus net financial contributors. The drop in spending is, however, not actually a reduction in services provided as such, but rather a reduction in subsidy costs because the public option's introduction lowers benchmark premiums. This saves the federal government by lowering subsidy costs. It shows up as a reduction in spending on these groups, but it is not a loss in health benefits (an issue addressed in figure 1).

The uninsured are clear net beneficiaries. They see a substantial increase in spending. Because they predominantly have low incomes, their tax payments are low. Thus, they are fairly large net gainers regardless of whether reform is financed through income or payroll taxes—\$30.0 billion in net new spending with income tax financing and \$29.9 billion with payroll taxes. In addition, as many people gain coverage under the reform, the demand for uncompensated care on their behalf decreases. This

suggests that because total new federal spending exceeds new spending on the uninsured by a considerable amount, health reform does more than help the uninsured; it also makes insurance more affordable for people who had coverage prereform.

Region. The final panel of table 7 shows that in the incremental reform the Northeast, Midwest, and West all are net contributors and the South net beneficiaries. The Northeast, in particular, receives far less new government spending than they pay in new taxes—\$10.3 billion in spending versus \$22.8 million in tax payments with income tax financing and \$17.3 billion with payroll tax financing—so they are large net contributors. The South has the largest amount of new spending, about 47 percent of the total increase. The South also makes substantial tax payments, but these account for only 36 percent of new income tax revenue and 39 percent of new payroll tax revenue. New spending exceeds these tax payments, so they are net beneficiaries. The Midwest and, more so, the West have less in new spending than they see in new tax payments, but, except for the West under income taxes, they have more new benefits than taxes.

Comprehensive Reform

Comprehensive reform's distributional effects, as shown in table 8, are largely similar to the effects of incremental reform across different groups but significantly larger in magnitude. Both new government spending and the tax payments needed to finance the reform are greater than under incremental reform. Below we present only the main differences between incremental and comprehensive reform.

TABLE 8

Distribution of Changes in Government Spending for Acute Health Care and in Federal Taxes under Comprehensive Reform

(billions of dollars)	Number of people (millions)	Change in Spending for Acute Health Care			Change in Tax Burden		Net Change: New Benefits Minus New Taxes	
		All gov't	Federal gov't	State gov't	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes
by income								
Less than 100% of FPL	69	51.5	53.1	-1.6	0.9	6.3	50.6	45.2
Between 100% and 200% of FPL	67	30.1	32.0	-1.9	7.8	14.5	22.3	15.6
Between 200% and 400% of FPL	93	70.6	72.5	-1.9	40.2	51.7	30.4	18.9
Between 400% and 600% of FPL	52	7.3	8.5	-1.2	23.0	25.6	-15.7	-18.3
More than 600% of FPL	55	1.8	2.5	-0.7	124.3	70.7	-122.5	-68.9
by race/ethnicity								
American Indian and Alaskan native	5	3.1	3.4	-0.3	1.8	2.1	1.3	1.0
Asian and Pacific islander	18	7.5	7.9	-0.4	13.0	10.3	-5.5	-2.7
Black, non-Hispanic	39	23.9	24.3	-0.3	13.5	15.4	10.4	8.5
Hispanic	55	29.6	29.8	-0.2	14.9	17.2	14.6	12.4
White, non-Hispanic	213	95.1	101.3	-6.3	149.0	120.7	-53.9	-25.6
Other	6	2.1	2.0	0.1	3.9	3.1	-1.8	-1.0
by age								
Birth to age 18	79	19.0	12.9	6.1	38.6	34.5	-19.6	-15.5
Ages 19–34	71	38.1	42.7	-4.6	26.0	31.1	12.1	7.0
Ages 35–54	88	67.8	70.8	-3.0	66.4	57.7	1.4	10.1
Ages 55–64	39	36.4	42.3	-5.9	39.7	33.2	-3.3	3.2
Ages 65 and older	59	0.0	0.0	0.0	25.5	12.2	-25.5	-12.2
by coverage type before reform								
Employer sponsored	150	89.0	80.1	8.9	144.8	124.7	-55.8	-35.7
Medicaid	71	0.0	9.8	-9.8	6.5	12.4	-6.5	-12.4
Other public	65	0.0	0.0	0.0	25.6	14.0	-25.6	-14.0
Nongroup	15	2.7	3.2	-0.5	9.4	7.4	-6.7	-4.7
Uninsured or STLD	35	69.6	75.6	-6.0	9.9	10.2	59.7	59.4
by region								
Northeast	57	19.8	21.3	-1.4	40.1	29.7	-20.2	-9.9

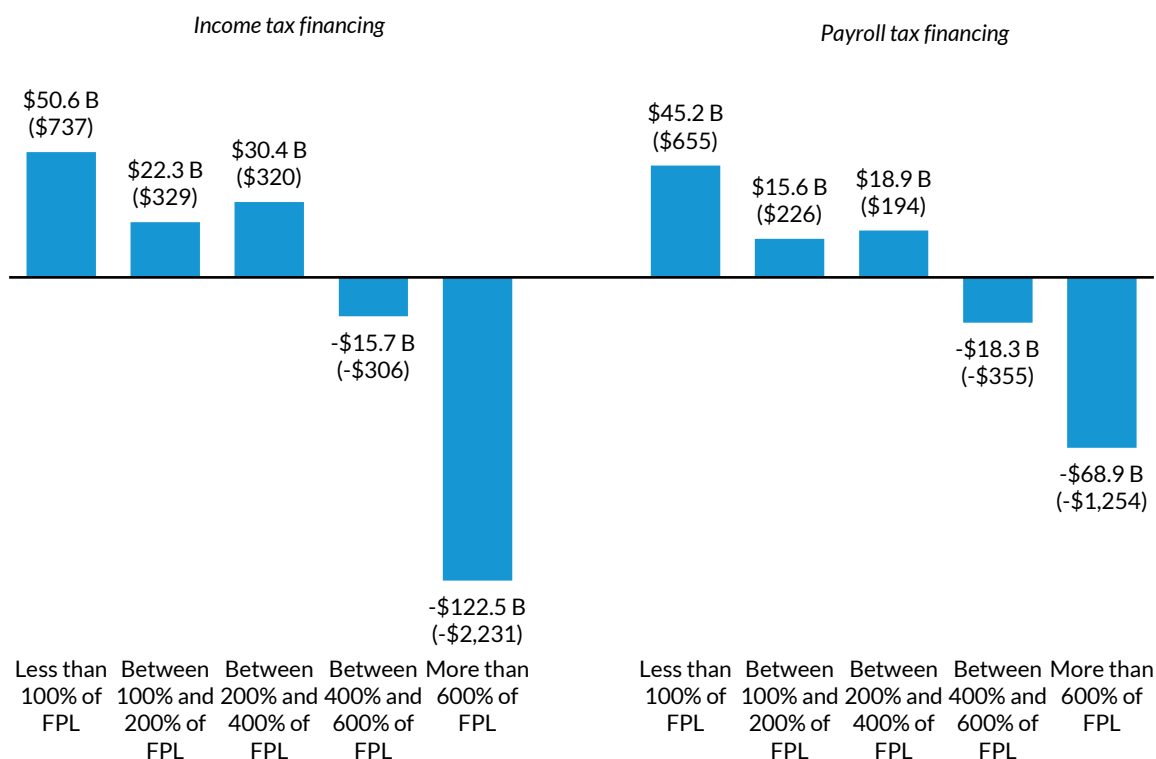
(billions of dollars)	Change in Spending for Acute Health Care			Change in Tax Burden		Net Change: New Benefits Minus New Taxes		
	Number of people (millions)	All gov't	Federal gov't	State gov't	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes
Midwest	69	33.7	34.6	-0.9	36.1	34.3	-2.4	-0.6
South	129	70.9	71.2	-0.3	69.0	63.3	1.9	7.6
West	81	36.8	41.6	-4.8	51.0	41.4	-14.1	-4.5
Overall	336	161.3	168.7	-7.4	196.2	168.7	-34.9	-7.4

Sources: Urban Institute Health Insurance Policy Simulation Model, 2021; Urban-Brookings Tax Policy Center Microsimulation Model (version 0920-2); reform simulated in 2022.

Notes: Federal spending includes the federal share of Medicaid and federal spending for ACA premium tax credits (PTCs), cost-sharing reductions (CSRs), reinsurance, and uncompensated care for the uninsured. State spending includes the state share of Medicaid and state spending for PTCs, CSRs, reinsurance, and uncompensated care for the uninsured. Government spending is the total of federal and state spending. Income tax funding is a percent increase over current marginal tax rates, so higher earners in higher-rate brackets face a larger increase than those in lower-rate brackets. Payroll tax funding is a new flat-rate tax on all wages, salaries, and self-employment income. The statistical matching process importing tax changes into HIPSIM did not control for race, region, or health insurance status. The tax estimates presented here for those classifications reflect differences in income and demographics across those groups in HIPSIM. STLD = short-term or limited-duration plan that does not provide ACA minimum essential coverage.

Income. The first panels of table 8 and figure 4 show the changes by income. Compared with incremental reform, spending and benefits are larger for each group under comprehensive reform, except the highest-income group.⁷ This reflects the fact that subsidies are more generous at each income level. Tax payments are also larger to finance the greater spending. Tax payments increase dramatically at higher incomes under the income tax scenario, but they are larger under comprehensive reform at each income level for either type of financing.

FIGURE 4
Effect on Governmental Spending of Comprehensive Reform, by Income Level



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Source: Urban Institute Health Insurance Policy Simulation Model, 2021; reforms simulated in 2022.

Note: Numbers in parentheses are per capita contributions.

The lowest-income group has large increases in spending relative to the incremental approach. Tax payments are only slightly higher. The result is net spending is dramatically higher for the lowest-income group, \$50.6 billion with income tax financing and \$45.2 billion with a payroll tax increase—\$737 and \$655 per capita, respectively, under income and payroll tax financing.

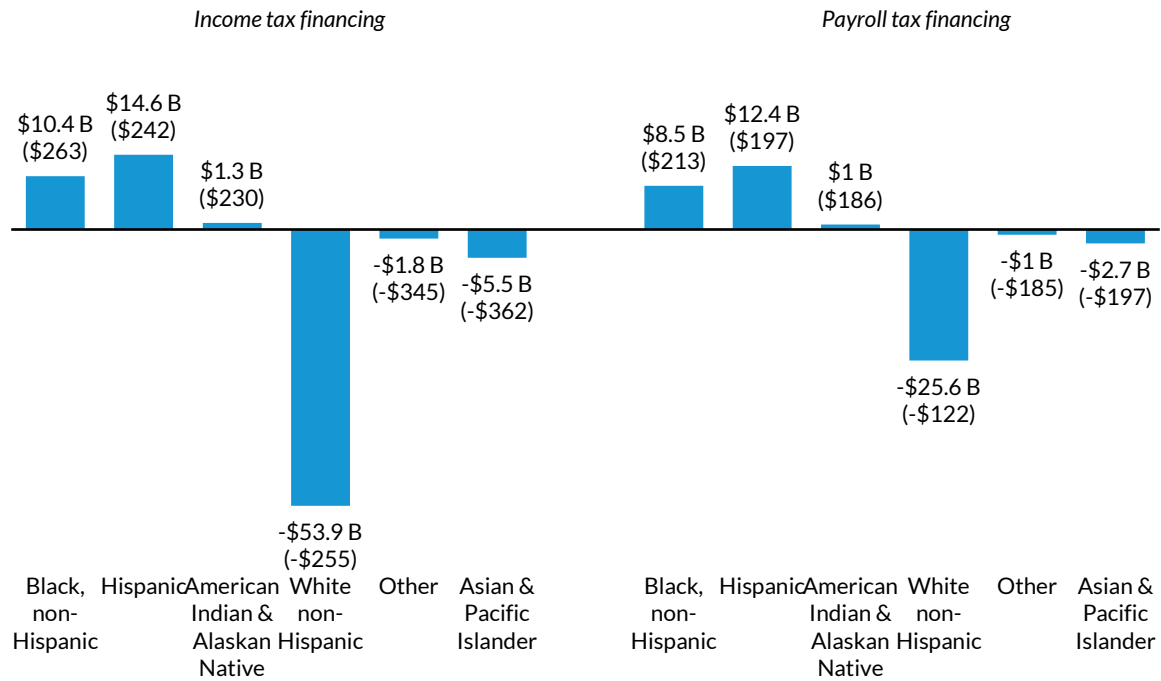
At the other end, those with incomes above 600 percent of FPL see relatively low new spending, but tax payments are substantially higher under either the income tax or payroll tax scenarios; thus, the net contributions are higher for those with incomes above 600 percent of FPL: \$122.5 billion under the income tax scenario and \$68.9 billion under the payroll tax scenario.

The amount the highest-income group pays in new taxes is substantially greater under comprehensive reform than under incremental reform. This is true particularly true for income taxes, but also for payroll taxes. Thus, the highest-income group members are substantial net contributors: \$122.5 billion under the income tax scenario and \$68.9 billion under the payroll tax scenario compared with \$60.5 billion and \$31.8 billion, respectively, under the incremental reform.

Race/ethnicity. Each race and ethnicity group sees higher spending under the comprehensive reform than under current law or the incremental reform, reflecting the filled Medicaid gap, more generous subsidies, and auto-enrollment of all otherwise-uninsured people into coverage. With the program's higher cost, each group pays substantially more in income or payroll taxes. This is particularly true for white non-Hispanic people, Asian and Pacific Islander people, and people of other races. As shown in figure 5, the net new spending is greater for Black non-Hispanic, Hispanic, and American Indian and Alaskan native people because gains in coverage and affordability exceed new tax payments, while the net contributions are larger for white non-Hispanic people, Asian and Pacific Islander people, and people of other races. This for the most part reflects prereform insurance coverage and income differences, as well as the relative size of each group. Changes in net new spending per person range from an increase of \$263 for Black non-Hispanic people to a decrease of \$362 for Asian and Pacific Islander people, both under income tax financing.

FIGURE 5

Effect on Governmental Spending of Comprehensive Reform, by Race/Ethnicity



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Source: Urban Institute Health Insurance Policy Simulation Model, 2021; reforms simulated in 2022.

Note: Numbers in parentheses are per capita contributions.

Age. Results by age show a similar pattern. Per capita new spending is higher as age increases, except for those ages 65 and older where there are no new net benefits because the reforms do not change Medicare coverage. Tax payments for each age group are also higher than under incremental reform for both the income and payroll tax scenarios. Income tax payments rise more with increasing age because younger workers have, on average, lower incomes. The age gradient is smaller with the payroll tax scenario.

Prereform insurance coverage. Net spending for those with ESI is greater under the comprehensive reform than under the incremental reform because subsidies are greater, making it more attractive for people to leave their employer coverage once the firewall is eliminated. Overall, 18.3 million people leave ESI under comprehensive reform, versus 16.7 million people under incremental reform. Those with ESI tend to have higher incomes; they therefore pay more in both income and payroll taxes (particularly income taxes, as marginal rates increase with income) and are significant net contributors.

The uninsured receive substantial new benefits, roughly twice that seen in the incremental reform. They pay somewhat more in new taxes, particularly with payroll tax financing. Because new spending for the previously uninsured is substantially greater than new tax payments, the previously uninsured are large net beneficiaries. The gains are about the same if the reform is financed with income or payroll tax increases (\$59.7 and \$59.4 billion, respectively, in new spending).

Region. The final panel of table 8 shows that in this reform people in the Northeast, Midwest, and West are net contributors and in the South are net beneficiaries. The Northeast and West contribute considerably more in tax payments than they receive in new spending. Both prereform coverage levels and incomes are higher in the Northeast than elsewhere. The difference between spending and tax payments is particularly large with income tax financing. The South again has substantial new spending because of large gains in coverage and new subsidies. About 44 percent of new spending under comprehensive reform goes to the South. But because of lower per capita incomes, the region contributes 35 percent of new income tax revenues and 38 percent of new payroll tax revenues. The Midwest is a small net contributor under either form of financing. The West is a substantial net contributor with income tax financing and a smaller net contributor with payroll tax financing.

Conclusion

In this report, we examined two health care reform options—incremental and comprehensive. The incremental reform reduces the number of people without minimum essential coverage by 14.8 million. The comprehensive reform would reduce the number without minimum essential coverage by 27.2 million. Under these options, the number with employer coverage would fall by 16.7 million and 18.3 million, respectively. Marketplace coverage would increase by more than 24 million in the incremental reform and 32.9 million in the comprehensive reform. Medicaid enrollment would increase by 7.2 million and 12.2 million, respectively.

Spending in the incremental reform by the federal government would increase by \$103.6 billion. In the comprehensive reform, spending by the federal government would increase by \$168.7 billion. Net new government spending (federal spending minus savings to states) increases by \$97.0 billion with incremental reform and \$161.3 billion with comprehensive reform. In the incremental reform, Medicaid spending would increase by \$51.5 billion and marketplace premium and cost-sharing subsidies by \$57.4 billion. In the comprehensive plan, Medicaid spending would increase by \$80.3 billion while marketplace premium tax credits and cost-sharing reductions would increase by \$117.1 billion

(including reinsurance payments). Thus, the incremental and comprehensive reforms differ substantially in scope and cost.

In the distributional analysis, we show considerable redistribution by income. Those with incomes below 200 percent of FPL benefit considerably, while those with incomes above 600 percent of FPL are substantial net contributors, more so with income tax financing. Important redistribution by race/ethnicity also exists. Black non-Hispanic, Hispanic, and American Indian people tend to be net gainers. White non-Hispanic people, Asian American and Pacific Islander people, and people of other races are net contributors. Regions also have considerable redistribution—people in the South are net gainers and other regions net contributors.

Finally, we show more redistribution with income tax financing than with payroll tax financing; the former reduces the amount paid by people with low incomes and increases the amount paid by the highest-income group. In the incremental reform, net benefits per capita are \$519 with income tax financing and \$477 with payroll tax financing for those with incomes below 100 percent of FPL. For those with incomes above 600 percent of FPL, net contributions per capita are \$1,103 with income tax financing and \$579 with payroll tax financing. In the comprehensive reform, net benefits per capita for those with incomes below 100 percent of FPL are \$737 with income tax financing and \$655 with payroll tax financing. For those with incomes above 600 percent of FPL, net contributions are \$2,231 with income tax financing and \$1,254 with payroll tax financing.

The uninsured benefit considerably with substantial new benefits and relatively little in new tax payments. But only about 30 percent of new federal spending goes to the uninsured. The remainder goes to making insurance substantially more affordable for individuals who already had employer or nongroup coverage.

Methods

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

offerings and strategies for increasing affordability to state-specific proposals—and can describe the effects of a policy option over several years.

HIPSM is based on two years of the American Community Survey, which provides a representative sample of families large enough for us to produce estimates for individual states and smaller regions, such as cities. The model is designed to incorporate timely, real-world data to the extent they are available. In particular, we regularly update the model to reflect published Medicaid and Marketplace enrollment and costs in each state.

Given uncertain economic conditions in 2020, owing to the COVID-19 pandemic and consequent recession and its rapid evolution, we use a 2022 current-law baseline, a year when conditions should be more stable. In doing so, we assume, consistent with Congressional Budget Office projections, that the economy will have partly recovered from the pandemic recession by that time.⁸ We assume the characteristics of people who remain unemployed at that time are largely consistent with the distribution identified in US Department of Labor data from August 2020, which showed that higher-wage jobs had recovered to a much greater extent than lower-wage jobs.

The simulations account for relevant state regulations, such as banning short-term, limited-duration plans. Our current-law estimates account for the federal individual mandate penalties set to \$0 beginning in plan year 2019, as well as the fact that California, the District of Columbia, Massachusetts, and New Jersey have their own individual mandate penalties. We treat Missouri and Oklahoma, where the ACA Medicaid expansion has been approved by ballot initiative but not yet implemented, as nonexpansion states. We do this because the political environments surrounding expansion, even once ballot initiatives are passed, remain uncertain, and the timing and implementation of these expansions are therefore still uncertain.

The current version of HIPSM is calibrated to state-specific targets for marketplace enrollment following the 2020 open enrollment period, 2020 marketplace premiums, and late 2019 Medicaid enrollment from the Centers for Medicare and Medicaid Services monthly enrollment snapshots. Aging our projections to 2022 involved several steps. First, we aged the 2020 population to 2022 using projections from the Urban Institute's Mapping America's Futures program. We then inflated incomes and health costs to 2022. Because the pandemic has reduced use of expensive care, we assume costs for private nongroup health insurance and Medicaid are flat in 2021 but return to default inflation assumptions in 2022. Under our default assumptions, we estimate Medicaid will grow at 5 percent, and out-of-pocket spending and uncompensated care will grow at 3 percent.

We use the Urban-Brookings Tax Policy Center (TPC) tax model to develop tax scenarios raising enough revenue to finance the coverage scenarios in 2022.⁹ For each coverage scenario, we solve for a proportional increase in income tax rates (more progressive option) and a rate for a new payroll tax (less progressive option) that raises the needed amount of revenue. The revenue estimates include the impact of increased taxable compensation because of reduced ESI coverage under both coverage scenarios.¹⁰ For the combined distributional analysis of health benefits and taxes, we export increases in tax burden from tax units in the tax model to families in HIPSM using a statistical matching process.¹¹

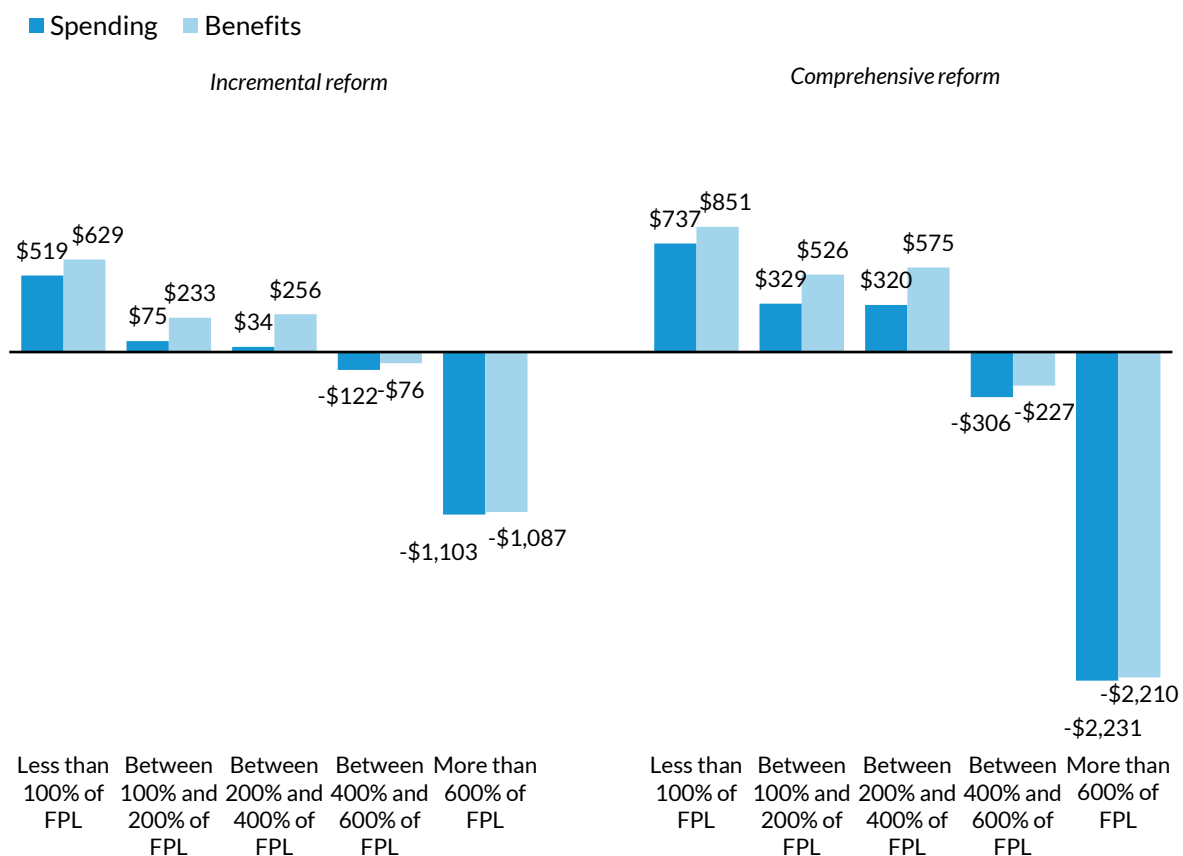
The estimates presented in this report were completed before the American Rescue Plan (ARP) Act was enacted in early March 2021. Some aspects of that plan, such as enhanced subsidies for ACA marketplace insurance, are similar to the plans presented here; however some provisions of the reforms modeled (e.g., auto-enrollment, public option in the nongroup market, full federal funding of Medicaid expansion) are not in the ARP, while some aspects of the ARP (Consolidated Omnibus Budget Reconciliation Act subsidies, assignment of maximum subsidies to those who have received unemployment benefits) are not in the modeled plans. In addition, the reforms presented here are assumed permanent while the ARP provisions are temporary.

For this analysis, we assume the Medicaid enhanced federal medical assistance percentage and maintenance-of-effort provisions in the Families First Coronavirus Response Act would have expired before 2022. However, in a letter to governors sent in late January 2021, the acting secretary of the US Department of Health and Human Services indicated the public health emergency declaration will be extended through calendar year 2021.¹² This means the maintenance-of-effort requirement, which prohibits states from disenrolling Medicaid enrollees unless they request it, will last through January 2022, and the enhanced federal medical assistance percentage will be available through March 2022. Consequently, Medicaid enrollment will be notably higher in early 2022 than indicated in our estimates. However, it will decline to the levels we show later in the year. Also, the federal government will pay a higher share of Medicaid costs in the first quarter of 2022 than we indicate.

Appendix. New Services Provided Compared with New Spending

The following three figures show the differences between net spending and net new services provided (labeled benefits) on a per capita basis for the incremental reform and comprehensive reforms. Differences between net spending and new services provided do not vary with financing, so the results with payroll tax financing are similar (not shown). Results are shown by income level, race/ethnicity, and region.

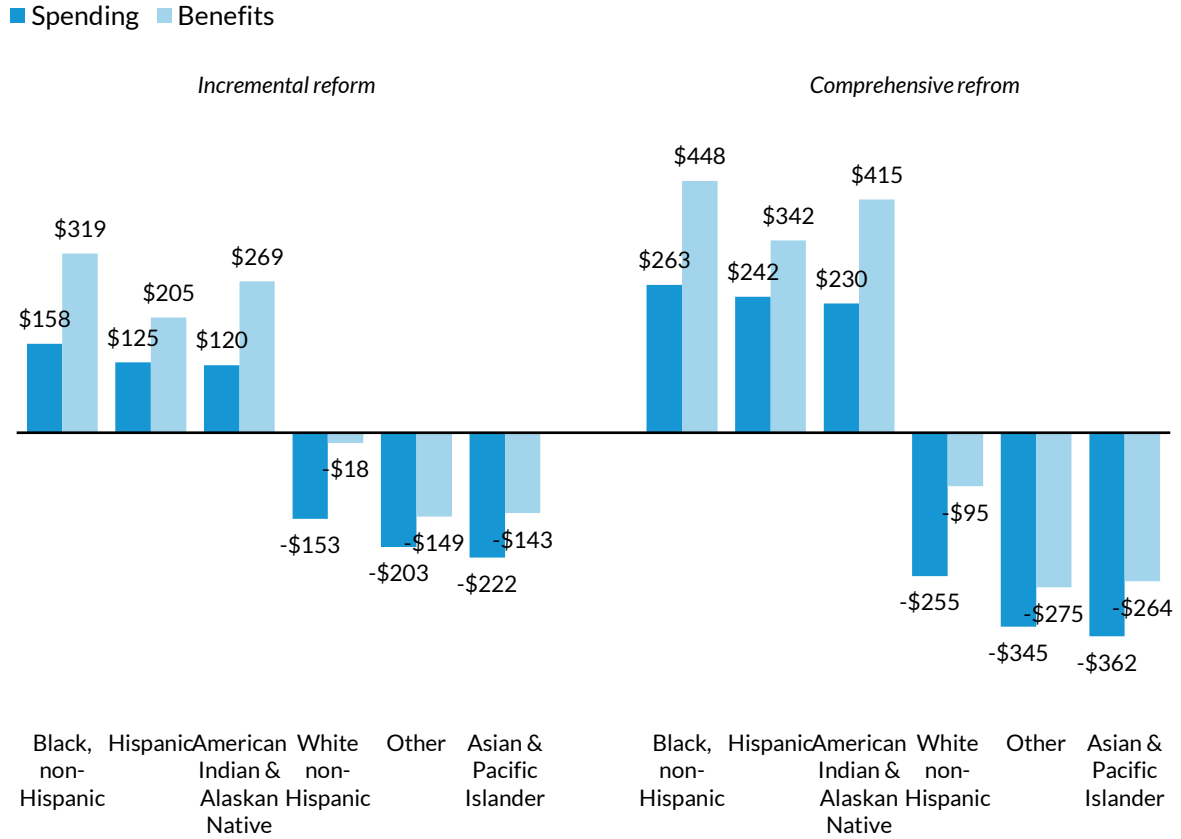
FIGURE A.1
Effects on Net Spending and Net Benefits with Income Tax Financing, by Income Level (dollars per person)



Source: Urban Institute Health Insurance Policy Simulation Model, 2021; reform simulated in 2022.

FIGURE A.2

Effects on Net Spending and Net Benefits with Income Tax Financing, by Race/Ethnicity (dollars per person)

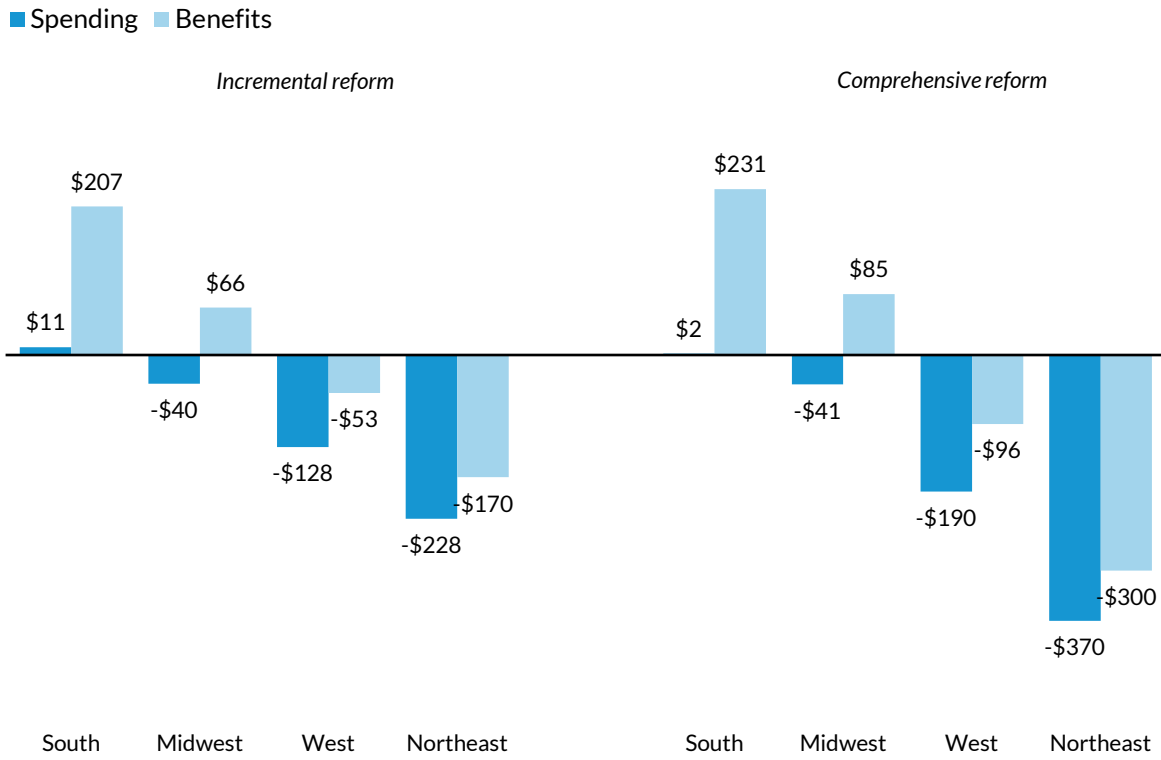


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Source: Urban Institute Health Insurance Policy Simulation Model, 2021; reform simulated in 2022.

FIGURE A.3

Effects on Net Spending and Net Benefits with Income Tax Financing, by Region (dollars per person)



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Source: Urban Institute Health Insurance Policy Simulation Model, 2021; reform simulated in 2022.

TABLE A.1

Distribution of Changes in Government Spending for Acute Health Care and in Federal Taxes under Incremental Reform

Dollars per Person	Average Change in Spending for Acute Health Care			Average Change in Tax Burden		Net Change: Average New Benefits Minus Average New Taxes	
	All gov't	Federal gov't	State gov't	Scenario 1:	Scenario 2:	Scenario 1:	Scenario 2:
				fund with increased income taxes	fund with increased payroll taxes		
by income							
Less than 100% of FPL	531	584	-53	12	55	519	477
Between 100% and 200% of FPL	179	215	-36	104	157	75	22
Between 200% and 400% of FPL	398	415	-17	364	428	34	-30
Between 400% and 600% of FPL	122	118	4	244	266	-122	-144
More than 600% of FPL	94	79	15	1,197	673	-1,103	-579
by race/ethnicity							
American Indian and Alaskan native	348	381	-33	228	249	120	99
Asian and Pacific islander	229	248	-19	451	360	-222	-131
Black, non-Hispanic	398	416	-18	240	264	158	134
Hispanic	321	339	-18	196	217	125	104
White, non-Hispanic	265	286	-20	418	344	-153	-79
Other	226	221	5	429	341	-203	-115
by age							
Birth to age 18	119	79	40	310	280	-192	-161
Ages 19-34	309	363	-54	235	271	74	38
Ages 35-54	476	495	-18	463	405	14	72
Ages 55-64	604	713	-109	648	555	-44	49
Ages 65 and older	0	0	0	240	120	-240	-120
by coverage type before reform							
Employer sponsored	463	419	44	609	532	-146	-69
Medicaid	0	138	-138	67	110	-67	-110
Other public	0	0	0	218	123	-218	-123
Nongroup	-508	-473	-36	336	261	-844	-770
Uninsured or STLD	1,004	1,085	-82	172	175	831	828
by region							
Northeast	181	212	-31	410	309	-228	-127
Midwest	296	307	-10	336	319	-40	-22

Dollars per Person	Average Change in Spending for Acute Health Care			Average Change in Tax Burden		Net Change: Average New Benefits Minus Average New Taxes	
	All gov't	Federal gov't	State gov't	Scenario 1:	Scenario 2:	Scenario 1:	Scenario 2:
				fund with increased income taxes	fund with increased payroll taxes		
South	354	355	-1	342	315	11	38
West	253	302	-49	381	314	-128	-61
Overall	288	308	-20	362	315	-73	-26

Sources: Urban Institute Health Insurance Policy Simulation Model, 2021; Urban-Brookings Tax Policy Center Microsimulation Model (version 0920-2); reform simulated in 2022.

Notes: Federal spending includes the federal share of Medicaid and federal spending for ACA premium tax credits (PTCs), cost-sharing reductions (CSRs), reinsurance, and uncompensated care for the uninsured. State spending includes the state share of Medicaid and state spending for PTCs, CSRs, reinsurance, and uncompensated care for the uninsured. Government spending is the total of federal and state spending. Income tax funding is a percent increase over current marginal tax rates, so higher earners in higher-rate brackets face a larger increase than those in lower-rate brackets. Payroll tax funding is a new flat-rate tax on all wages, salaries, and self-employment income. The statistical matching process importing tax changes into HIPSM did not control for race, region, or health insurance status. The tax estimates presented here for those classifications reflect differences in income and demographics across those groups in HIPSM. STLD = short-term or limited-duration plan that does not provide ACA minimum essential coverage.

TABLE A.2

Distribution of Changes in Government Spending for Acute Health Care and in Federal Taxes under Comprehensive Reform

Dollars per Person	Average Change in Spending for Acute Health Care			Average Change in Tax Burden		Net Change: Average New Benefits Minus Average New Taxes	
	All gov't	Federal gov't	State gov't	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes
by income							
Less than 100% of FPL	750	774	-24	13	95	737	655
Between 100% and 200% of FPL	449	477	-28	120	222	329	226
Between 200% and 400% of FPL	760	781	-21	440	566	320	194
Between 400% and 600% of FPL	139	163	-24	445	494	-306	-355
More than 600% of FPL	33	45	-12	2,263	1,286	-2,231	-1,254
by race/ethnicity							
American Indian and Alaskan native	574	622	-48	344	387	230	186
Asian and Pacific islander	417	437	-20	779	614	-362	-197
Black, non-Hispanic	611	620	-9	348	399	263	213
Hispanic	539	542	-4	296	341	242	197
White, non-Hispanic	446	475	-29	700	567	-255	-122
Other	376	365	11	721	561	-345	-185
by age							
Birth to age 18	240	163	77	492	440	-252	-200
Ages 19–34	537	601	-64	384	459	153	78
Ages 35–54	769	803	-34	775	674	-6	95
Ages 55–64	927	1,079	-151	1,020	853	-93	75
Ages 65 and older	0	0	0	435	208	-435	-208
by coverage type before reform							
Employer sponsored	595	535	60	981	845	-386	-250
Medicaid	0	138	-138	91	174	-91	-174
Other public	0	0	0	393	215	-393	-215
Nongroup	181	214	-33	639	506	-458	-325
Uninsured or STLD	1,979	2,150	-171	321	332	1,658	1,646
by region							
Northeast	348	374	-25	718	533	-370	-184

Dollars per Person	Average Change in Spending for Acute Health Care			Average Change in Tax Burden		Net Change: Average New Benefits Minus Average New Taxes	
				Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes	Scenario 1: fund with increased income taxes	Scenario 2: fund with increased payroll taxes
	All gov't	Federal gov't	State gov't				
Midwest	490	503	-12	531	504	-41	-14
South	548	550	-2	546	501	2	47
West	454	513	-59	644	523	-190	-69
Overall	480	501	-22	596	512	-116	-33

Sources: Urban Institute Health Insurance Policy Simulation Model, 2021; Urban-Brookings Tax Policy Center Microsimulation Model (version 0920-2); reform simulated in 2022.

Notes: Federal spending includes the federal share of Medicaid and federal spending for ACA premium tax credits (PTCs), cost-sharing reductions (CSRs), reinsurance, and uncompensated care for the uninsured. State spending includes the state share of Medicaid and state spending for PTCs, CSRs, reinsurance, and uncompensated care for the uninsured. Government spending is the total of federal and state spending. Income tax funding is a percent increase over current marginal tax rates, so higher earners in higher-rate brackets face a larger increase than those in lower-rate brackets. Payroll tax funding is a new flat-rate tax on all wages, salaries, and self-employment income. The statistical matching process importing tax changes into HIPSM did not control for race, region, or health insurance status. The tax estimates presented here for those classifications reflect differences in income and demographics across those groups in HIPSM. STLD = short-term or limited-duration plan that does not provide ACA minimum essential coverage.

Notes

- ¹ This report uses terms for race/ethnicity that match, or are collapsed from, those used in the American Community Survey, on which the HIPSM model is based. The authors acknowledge these may not be the preferred identifiers, and we remain committed to using inclusive language wherever possible.
- ² For more information on auto-enrollment options, see Blumberg, Holahan, and Levitis (forthcoming).
- ³ Throughout the report, “uninsured” includes everyone without minimal essential coverage, including both people with no insurance and with short-term limited-duration plans.
- ⁴ TPC excludes microdynamic responses from distributional analysis to better capture the impact of tax changes on well-being. For example, an increase in the capital gains rate can result in reduced revenues because of reduced realizations. But the households paying less tax because of reduced realizations are not better off because they face increased tax rates. For that reason, TPC holds realization fixed when analyzing the distributional impact of changes in capital gains rates.
- ⁵ For distributional analysis, to equate the measure of tax subsidies for contributions to traditional and Roth retirement accounts, TPC books tax increases on income used for pretax contributions to retirement accounts in the year the income is earned as opposed to in the future year when the income is withdrawn. For more information see Toder and Khitatrakun (2020).
- ⁶ There will also be an offsetting effect of lower value than presented for people who would choose not to have coverage but who will be automatically enrolled under the comprehensive plan.
- ⁷ In this case, a small increase in spending is slightly more than offset by a small decrease in demand for uncompensated care that accompanies universal coverage of the legally present.
- ⁸ “Interim Economic Projections for 2020 and 2021,” Congressional Budget Office, accessed June 25, 2020, <https://www.cbo.gov/system/files/2020-05/56351-CBO-interim-projections.pdf>.
- ⁹ For more information on the TPC tax model, see “Brief Description of the Tax Model,” Tax Policy Center, updated August 23, 2018, <https://www.taxpolicycenter.org/resources/brief-description-tax-model>.
- ¹⁰ We assume that employers hold total compensation fixed so reductions in nontaxable ESI benefits result in increased taxable wages. Before considering changes in tax policy, both coverage scenarios increase tax revenues in 2022 by \$34 billion. We used a statistical matching process to import changes in ESI coverage from HIPSM into the tax model. For a description of the matching process, see Mermin and Buettgens (2020).
- ¹¹ The process is similar to the one described in Mermin and Buettgens (2020), except that the tax model, as opposed to HIPSM, is the donor database.
- ¹² Alex M. Azar, “Renewal of Determination that a Public Health Emergency Exists,” Department of Health and Human Services, January 7, 2021, <https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-07Jan2021.aspx>.

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GRIST

2022 ACA cost-sharing caps and other changes set; ESR penalties projected

By Kaye Pestaina, Jennifer Wiseman and Margaret Berger
May 18, 2021

In this article

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The US Department of Health and Human Services (HHS) has released Part 2 of the [Notice of Benefit and Payment Parameters for 2022](#). The annual notice primarily addresses Affordable Care Act (ACA) standards for the small-group and individual insurance markets, but also has some items that affect employer-sponsored plans. The notice provides the adjustment factor used to update the ACA's cost-sharing limits (also called the out-of-pocket (OOP) maximums), employer shared-responsibility (ESR) assessments and the maximum employee contribution percentage for "affordable" employer coverage. The latest notice also creates a special-enrollment period so COBRA beneficiaries can enroll in individual market coverage after losing government- or employer-paid COBRA subsidies. Other items in the notice focus on implementation and enforcement of existing standards and increased transparency for prescription drug information in the individual and small-group insurance markets. This GRIST describes the provisions that most directly affect large employer-sponsored plans.

Calculation of adjustment factor reverts to old method

HHS determines the annual adjustment to the ACA's in-network OOP maximums and ESR assessments using the "premium adjustment percentage." This figure reflects the average per capita growth in private health insurance premiums since 2013. Although the method of determining the premium growth rate for 2020 and 2021 included individual market data, HHS has reverted to the method used from 2015 to 2019, which includes only employer-sponsored insurance plan data. This method sets the 2022 premium adjustment percentage at 1.3760126457.

2022 ACA in-network OOP maximums

Using the final premium adjustment percentage, the 2022 ACA in-network OOP maximums for essential health benefits (EHBs) under nongrandfathered group health plans are:

- **Self-only coverage:** \$8,700
 - This amount is also the embedded individual in-network OOP maximum for family coverage. Self-insured and large-group insured nongrandfathered health plans must embed an individual in-network OOP

maximum in any coverage tier that is broader than self-only and has a family OOP limit greater than the ACA-required self-only OOP limit.

- **Coverage other than self-only:** \$17,400

These figures represent an approximately 1.8% increase above the 2021 OOP maximums of \$8,550 for self-only coverage and \$17,100 for all other coverage tiers.

High-deductible health plans (HDHPs) qualifying to work with health savings accounts (HSAs) have different limits. The 2022 HDHP OOP maximums for HDHPs are \$7,050 for self-only coverage and \$14,100 for other coverage tiers, up from \$7,000 and \$14,000 in 2021.

2022 ESR assessments projected

The premium adjustment percentage is also used to adjust the ESR assessment. Although IRS has not yet announced the 2022 adjusted amounts, Mercer has projected the 2022 ESR assessments by applying the final premium adjustment percentage:

- **Employers not offering coverage:** \$2,750 per full-time employee (a 1.9% increase from \$2,700 for 2021)
- **Employers offering coverage that is unaffordable or lacks minimum value:** \$4,120 per full-time employee who receives subsidized coverage through a public exchange (a 1.5% increase from \$4,060 for 2021)

IRS is expected to announce the 2022 assessments in regularly updated ESR Q&As ([#55](#)) posted on the agency's website.

Projected 2022 ESR required contribution percentage

The premium growth rate used to update the premium adjustment percentage is also part of the IRS formula for calculating the "required contribution percentage." This percentage determines whether an employee's contribution for employer coverage is affordable for ESR purposes. In the [past](#), IRS has adjusted this percentage using HHS's method for determining the premium growth rate. Using that method, Mercer has projected the 2022 affordability figures for employer coverage:

- **Projected 2022 required contribution percentage.** The required contribution percentage for 2022 should decrease to 9.61%, down from 9.83% for 2021.
- **Projected federal poverty level (FPL) safe harbor amount.** For employers that use the FPL safe harbor, the monthly employee contribution limit for the lowest-cost, self-only option should decrease to \$103.15, down from \$104.53 for 2021.

Impact on premium tax credits

IRS will likely use the revised HHS methodology in future years to adjust the premium tax credit that eligible individuals can receive for public exchange coverage. HHS states that the new methodology will increase premium tax credits starting in 2023. For 2021 and 2022, the American Rescue Plan Act of 2021 (ARPA) temporarily increases public exchange subsidies in lieu of annual indexing.

New special-enrollment events created

Individuals seeking public exchange coverage generally must enroll during an annual enrollment period, unless they experience certain events triggering eligibility for a special-enrollment period (SEP). The final notice adds two new events that trigger a SEP for individuals losing subsidized COBRA coverage. Both SEPs apply across the entire individual insurance market — public exchanges in all states (whether run by the state or federal government), as well as the off-exchange private individual insurance market.

Complete cessation of government contributions to COBRA

If the government is paying all or part of an individual's COBRA premium, the complete cessation of this subsidy triggers a special-enrollment opportunity for individual market coverage. The government subsidy includes, but is not limited to, the COBRA subsidy under ARPA. Only complete, not partial, cessation of the subsidy triggers the SEP.

The date of the triggering event for the SEP is the last day of the period when the government subsidized all or part of the coverage. Individuals have 60 days before or after that date to enroll in coverage.

Example. Maria gets laid off on June 1 and enrolls in fully subsidized COBRA coverage due to the ARPA. The ARPA COBRA subsidy will expire on Sept. 30, so Maria will become responsible for the full COBRA premium on Oct. 1. If she decides to end her COBRA coverage when the ARPA subsidy expires, she will have 60 days before (from Aug. 2 through Sept. 30) or after (Oct. 1 through Nov. 29) the last date of subsidized COBRA coverage to enroll in individual insurance coverage.

Complete cessation of employer contributions to COBRA

Complete cessation of employer contributions for COBRA coverage likewise will trigger a SEP. A reduction in an employer's COBRA contribution does not trigger a SEP — the employer must cease its contributions entirely. Employer contributions include complete or partial payment of an individual's COBRA premium. In the preamble to the notice, HHS states that an employer's payment of a 2% administrative fee for COBRA coverage doesn't qualify as an employer contribution, since employers do not have to charge this fee.

According to the notice, this is not a change for the federal Healthcare.gov exchange, which currently allows a SEP when employer contributions to COBRA cease. However, state exchanges and off-exchange individual market insurers now must offer the same SEP.

The date of the triggering event for the SEP is the last day of the period when the employer either completely or partially subsidized COBRA coverage. Individuals have 60 days before or after that date to enroll in coverage.

Example. Michael is laid off on June 1, 2022. He enrolls in COBRA. His former employer pays 50% of the COBRA premium. Later that year, the employer informs Michael that it is completely terminating its COBRA contributions after Sept. 30, 2022. Beginning Oct. 1, 2022, Michael will be responsible for 100% of the COBRA premium. If Michael decides to end COBRA coverage effective Oct. 1, he will have 60 days before or after Sept. 30 to enroll in an individual market plan.

Other changes

Every year, the notice addresses a myriad of operational and enforcement standards for the individual and small-group insurance market, including some specific to the qualified health plans (QHPs) on public exchanges. However, the 2022 notice has a few items of potential interest to employers sponsoring group health plans.

Medical loss ratio. Medical loss ratio (MLR) requirements apply to health insurers, including those providing large-group insurance coverage. The latest notice allows insurers more flexibility to pay out an MLR rebate early. The notice also makes some technical changes to MLR rules, such as adding a definition of “prescription drug rebates and other price concessions” to calculate the MLR.

EHB benchmark plans. Many self-insured employer health plans select a state EHB benchmark plan to determine which benefits are subject to certain ACA mandates. Last year’s notice required states to annually report certain information about their benchmark plans, starting July 1, 2021. This year’s notice states that HHS will not enforce the reporting requirement in 2021 and will not publish any 2021 reports on its website.

ACA pharmacy benefit manager (PBM) transparency. For the first time, this year’s notice implements the ACA’s PBM transparency requirements. Under the ACA’s amendments to the [Social Security Act](#), health benefit plans or other entities providing PBM services to QHPs or Medicare Part D plans must disclose certain information to HHS. The notice places the reporting obligation directly on PBMs and any QHP issuers that do not contract with a PBM. These disclosures are to HHS only, not to the public. HHS last year set out some specifics on the [form and manner](#) of this data collection.

Upcoming pharmacy transparency rules for employer plans. Employers await more details on implementation of the Consolidated Appropriations Act of 2021 (CAA), which requires group health plans to disclose certain prescription drug and other information to relevant agencies. Large employer plan sponsors may want to review the notice’s prescription drug transparency-reporting requirements for exchange and off-exchange QHPs and their contracted PBMs. The required disclosures for group health plans and QHPs don’t directly overlap, but both do require disclosing information about prescription drug rebates, fees and other remuneration provided by drug manufacturers to the plan or its PBM. The notice says that HHS, along with Treasury and the Department of Labor (DOL), may issue future guidance explaining any interaction between the QHP and future CAA pharmacy data collections.

Transparency-in-coverage regulation. Another set of transparency rules, the 2020 final [transparency-in-coverage regulation](#), will require large employer-sponsored plans and insurance issuers to publicly disclose extensive price and cost-sharing information beginning in 2022. Among other details, the disclosure must provide certain prescription drug pricing information, including a prescription drug’s net price after manufacturer rebates, discounts, chargebacks and other reductions. HHS has released some information on the [form and manner](#) of this public disclosure in data collection notices published last year. Those templates set out the data elements for disclosures by HHS-regulated insurers. Whether DOL will create different templates for ERISA plans is unclear.

Drug coupons and OOP maximums. Unlike past notices in recent years, the current one makes no changes to how large employer-sponsored plans can treat drug manufacturer coupons when tracking individuals’ costs toward the OOP maximum.

Employer issues

The main takeaways from the notice for large employers include the following:

- **Assess impact of revised indexing rules.** If IRS adopts HHS's revised methodology for determining the premium growth rate, the employee contribution limit under the FPL affordability safe harbor will decrease for the first time. Employers should take this change into account during 2022 plan design and budget planning. For example, an employer that set the 2021 employee contribution for the lowest-cost, self-only coverage at the FPL safe harbor amount will need to lower the monthly contribution for 2022 to stay within that safe harbor. This change is also likely to increase premium tax credits and cost-sharing reduction subsidies available to full-time employees seeking public exchange coverage because they were not offered affordable employer coverage. The change, along with ARPA's temporary increase in the amount and availability of premium tax credits, may prompt employers to revisit which employees are offered affordable coverage. Such employers should evaluate their risk for ESR assessments and consider affordable coverage alternatives for employees (especially lower-wage employees).
- **Note special-enrollment change.** The notice clarifies that former employees may enroll in individual insurance coverage after their COBRA subsidies end. Employers will want to keep this in mind as they implement the ARPA COBRA subsidy and communicate with former employees about coverage options. The SEP related to employer COBRA contributions may affect employer decisions about whether to contribute to COBRA coverage going forward.
- **Look out for prescription drug reporting rules for ERISA plans.** QHPs and other HHS-regulated entities have received specific formats and attestations for their drug transparency reports. Look for DOL to do the same for drug reporting by ERISA plans.
- **Expect additional HHS regulations for the individual market.** The latest notice is Part 2 of the annual notice initially finalized by the Trump administration in January 2021. Look for the Biden administration to issue separate rules undoing some of the earlier changes to standards for state innovation waivers and states' ability to create alternatives to public exchanges.

Related resources

Non-Mercer resources

- [Rev. Proc. 2021-25](#) (IRS, May 10, 2021)
- [Final Notice of Benefit and Payment Parameters for 2022, Part 2](#) (HHS, May 5, 2021)
- [Press release for Part 2](#) (HHS, April 30, 2021)
- [Fact sheet for Part 2](#) (HHS, April 30, 2021)
- [Final Notice of Benefit and Payment Parameters for 2022, Part 1](#) (Jan. 19, 2021)
- [Proposed Notice of Benefit and Payment Parameters for 2022](#) (Dec. 4, 2020)
- [Final transparency-in-coverage rule](#) (Federal Register, Nov. 12, 2020)

- [Rev. Proc. 2019-29](#) (IRS, July 22, 2019)

Mercer Law & Policy resources

- [2022 HSA, HDHP and excepted-benefit HRA figures set](#) (May 11, 2021)
- [COBRA help, dependent care items in COVID-19 bill near enactment](#) (March 10, 2021)
- [Healthcare cost transparency rules and MLR changes finalized](#) (Dec. 2, 2020)
- [2021 ACA out-of-pocket maximums, ESR penalties, other changes ahead](#) (June 3, 2020)
- [Agencies ease ACA rule on drug coupons and out-of-pocket costs](#) (Sept. 3, 2019)
- [New push for ACA innovation waivers aims to rekindle state interest](#) (May 21, 2019)
- [2020 ACA cost-sharing caps set, play-or-pay penalties projected](#) (May 8, 2019)

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AREA OF FOCUS

Achieving Universal Coverage →

ISSUE BRIEFS / MAY 17, 2021

The Affordable Care Act in the Biden Era: Identifying Federal Priorities for Administrative Action



▲ President Joe Biden, with Vice President Kamala Harris (left), signs executive orders on health care, including reopening enrollment in the Affordable Care Act. The Biden administration has pledged to expand coverage and help improve affordability under the ACA. Photo by Mandel Ngan/AFP via Getty Images

TOPLINES

Health care stakeholders support policy changes to improve access to affordable coverage and promote health equity

Reversing Trump-era health care policies and fixing the family glitch is a priority for many stakeholders

AUTHORS

Katie Keith

Abstract

- **Issue:** Federal officials have significant flexibility in implementing the Affordable Care Act and can adopt different positions based on an administration's preferred policy goals. The Biden administration has pledged to use its executive authority to strengthen and expand access to marketplace coverage and Medicaid.
- **Goals:** Identify high-priority federal administrative policy changes related to the Affordable Care Act and Medicaid.
- **Methods:** Analysis of nine key publicly available recommendations to the Biden–Harris presidential transition team made by patient and consumer advocates, health insurers, hospitals, physicians, state marketplace officials, and state insurance commissioners.
- **Key Findings and Conclusions:** Health care stakeholders have offered broad support for a range of federal administrative policy changes to increase access to affordable, comprehensive health insurance and promote health equity. Top recommendations included increasing funds for outreach and enrollment, fixing the family glitch, limiting short-term plans and association health plans, and revisiting policies on state innovation waivers. Stakeholders also emphasized the need for policies that streamline enrollment and eligibility processes and help people gain and maintain coverage. These recommendations offer a framework for the Biden administration to adopt policies consistent with its goal of increasing access to coverage.

INTRODUCTION

Since the Affordable Care Act (ACA) became law, more than 20 million people have gained health insurance coverage, with the U.S. uninsured rate reaching a record low by 2016.¹ This expansion in coverage has improved access to care and narrowed racial and ethnic coverage disparities.²

As with any complex legislation, however, the ACA's success has been shaped by how federal officials have interpreted and implemented the law's various requirements and programs. New administrations, each with its own policy preferences, can reach starkly different conclusions on what federal law allows or requires.³ Federal officials generally have flexibility in implementing and administering the ACA so long as they comply with the Administrative Procedure Act.

Understanding the Administrative Procedure Act

The Administrative Procedure Act, adopted in 1946, governs the process that federal agencies must use when developing and issuing new rules. The law helps ensure that agencies use a fair process for decision-making and rely on a sound administrative record.

In general, when issuing a new rule, an agency must first publish a notice of proposed rulemaking in the *Federal Register* and provide an opportunity for the public to comment on the notice. The agency then publishes a final rule in the *Federal Register* that considers and responds to the public comments that were received. (There are some exceptions to this process that allow an agency to avoid having to provide advance notice or solicit public comment, such as when issuing nonbinding guidance or interim final rules in response to an emergency.)

The Administrative Procedure Act also establishes standards for courts to use when reviewing agency action. There is a substantial amount of case law regarding agency rulemaking and procedures under the Administrative Procedure Act. In general, the Supreme Court has held that an agency's decision is arbitrary and capricious if the agency relied on factors that Congress did not intend for it to consider, failed to consider an important aspect of the problem, offered an explanation that runs counter to the evidence, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise. This same standard applies to other types of agency action, such as the approval of state waiver requests.

Many Obama- and Trump-era rules and other actions were challenged on these grounds (in addition to constitutional grounds or under other statutes, such as the Religious Freedom Restoration Act). Past administrations have won about 70 percent of challenges brought under the Administrative Procedure Act. The Trump administration — which faced criticism for stretching the bounds of executive authority and not always heeding “the rules about the rules” — only won about 23 percent of these challenges.

Sources: 5 U.S.C. § 551 et seq.; Todd Garvey, *A Brief Overview of Rulemaking and Judicial Review* (Congressional Research Service, Mar. 27, 2017); Institute for Policy Integrity, “[Roundup: Trump-Era Agency Policy in the Courts](#),” New York University School of Law, Feb. 2021; Bethany A. Davis Noll and Christine Pries, “[The Administration’s Record in the Courts](#),” *The Hill*, Nov. 3, 2020; and Margot Sanger-Katz, “[For Trump Administration, It Has Been Hard to Follow the Rules on Rules](#),” *New York Times*, Jan. 22, 2019.

In light of this flexibility, health care stakeholders offered a range of recommendations to the incoming Biden administration on ways to enhance the ACA and the Medicaid

program. This analysis reflects a review of nine publicly available recommendations to the Biden–Harris presidential transition team from a diverse group of health care stakeholders. The stakeholders include a coalition of 33 patient advocacy organizations, Families USA, the Center on Budget and Policy Priorities, the Association for Community Affiliated Plans, the Federation of American Hospitals, the Catholic Health Association of the United States, the American College of Physicians, the State Health Exchange Leadership Network of the National Academy for State Health Policy (on behalf of 17 state marketplaces), and 11 state insurance commissioners.⁴

These recommendations were identified based on a scan of publicly available organizational comments to the incoming Biden–Harris administration and selected to represent diverse stakeholder interests that span the health care industry. Not all sets of recommendations mention all issues, and silence should not be taken as a sign that the issue is not a priority.⁵

KEY FINDINGS

Using its executive authority, the Biden administration has significant opportunities to shape the administration and evolution of the ACA and the Medicaid program using its executive authority. There is broad support among a diverse group of health care stakeholders for federal administrative policy changes to increase access to affordable, comprehensive health insurance and promote health equity. The priorities listed below were cited in a majority of the stakeholder recommendations (Exhibit 1). Those garnering the most support were: limiting the duration of short-term plans, reversing the Trump administration’s public charge rule, and rescinding Section 1332 guidance on “innovation waivers.”

EXHIBIT 1

High-Priority Recommendations for the Biden–Harris Transition Team

Recommendations Supported by a Majority of Stakeholders

* The Biden administration has already taken action consistent with this recommendation, either in part or in whole, as of May 12, 2021.

Source: Katie Keith, *The Affordable Care Act in the Biden Era: Identifying Federal Priorities for Administrative Action* (Commonwealth Fund, May 2021). <https://doi.org/10.26099/mddc-vt49>

All but one of the recommendations call for reversing Trump-era policies. The Biden administration has already heeded some of these calls, particularly in making operational changes that do not require new rulemaking. Other changes will require federal officials to release new guidance or issue new regulations that comply with the Administrative Procedure Act.

Recommendations were made before enactment of the American Rescue Plan Act, which makes significant enhancements to both the ACA and Medicaid but does not

address the high-priority recommendations that stakeholders most frequently cited.

Improving Access to Coverage

Marketing, Outreach, and Enrollment Assistance

Nearly all stakeholders recommended greater federal investment in marketing, outreach, and enrollment assistance; a COVID-19 emergency enrollment period; and reverses to funding cuts and regulatory changes to the navigator program. The Biden administration has already implemented such policies. In response to an executive order, federal officials authorized a six-month COVID-19 special enrollment period where qualifying individuals can newly enroll in coverage or change their plan through HealthCare.gov.⁶ Federal officials also authorized \$100 million for marketing and will award \$80 million for navigator grantees for 2022.⁷

Oversight of Direct-Enrollment Entities

Most stakeholders also called for increased oversight of direct enrollment (DE) entities. DE was launched in fall 2013 in response to the challenging HealthCare.gov rollout and then expanded by the Trump administration, which created an “enhanced” DE pathway. Under this pathway, the entire marketplace enrollment process is completed on a third party’s website (meaning a consumer never visits or creates an account with HealthCare.gov).

Stakeholders echoed concerns that have long been raised about DE entities and the enhanced DE pathway.⁸ The state insurance commissioners noted that expanded DE could undermine core goals of the ACA by providing incomplete information about coverage options to consumers and failing to coordinate with state Medicaid programs. The Federation of American Hospitals more simply urged the Biden administration to “strengthen standards for web brokers and brokers selling marketplace plans.”

Medicaid Work and Community-Engagement Requirements

Finally, stakeholders urged the Biden administration to rescind guidance and waivers that allow states to impose work or community-engagement requirements on Medicaid beneficiaries. These waiver approvals were successfully challenged in court, and the Supreme Court may rule on their legality even though the Biden administration rescinded prior guidance and revoked approved waivers.⁹ Some stakeholders also highlighted the need to reverse other Medicaid waivers related to block grants, premiums, and lockouts.

Other Recommendations for Improving Access to Coverage

Stakeholders made many other recommendations regarding access to coverage. These are not listed in Exhibit 1 because they were not included in the majority of recommendations. However, the Biden administration also was encouraged to:

- Extend the annual open enrollment period beyond 45 days.
- Extend and simplify special enrollment periods (including new special enrollment periods for low-income consumers and those who lose their jobs).
- Improve facilitated and simplified enrollment for the uninsured and automate enrollment, eligibility determinations, and renewal.
- Improve data infrastructure and modernize state and federal eligibility and enrollment processes.
- Resume Internal Revenue Service outreach about the availability of marketplace coverage.
- Reinstate guaranteed issue protections for those who lose coverage because of nonpayment of premiums.
- Authorize waivers for continuous, 12-month Medicaid coverage.
- Extend postpartum Medicaid coverage for 12 months.

Improving Affordability of Coverage

Stakeholders urged the Biden administration to fix the “family glitch” and reverse the methodology for calculating the premium adjustment percentage. Legislation has been introduced, but not enacted, to address these issues, but the Biden administration could rectify these affordability challenges on its own.

Family Glitch

The “family glitch” stems from an Obama-era interpretation of whether an offer of job-based coverage is “affordable” or not.¹⁰ Currently, the definition of “affordable” for both an individual employee and their family is based on the cost of individual-only coverage. When an employee has access to an offer of “affordable” job-based coverage, the employee *and* their family are ineligible for premium tax credits through the

marketplace. This is true even when the cost of family or spousal coverage is very high, meaning that the family members of low-income workers are ineligible for marketplace subsidies and cannot afford the family coverage being offered. This interpretation has been criticized for unfairly penalizing families and for being inconsistent with the goals of the ACA.¹¹

In the absence of a congressional fix, stakeholders urged the Biden administration to redefine “affordable” using the cost of family coverage. Doing so could extend marketplace subsidies to an estimated 5.1 million low-income people — more than half of whom are children — who do not currently qualify for financial help (and will not see relief under the American Rescue Plan).¹²

Premium Adjustment Percentage

The premium adjustment percentage is a measure of premium growth that helps determine how much individuals must contribute to premiums and out-of-pocket costs. The Trump administration altered this methodology in a way that increased premiums and out-of-pocket costs for millions of consumers.¹³ Stakeholders urged the Biden administration to revert to a prior methodology that is less inflationary. The Biden administration did so in a spring 2021 rule; this methodological change will reduce the maximum limit on out-of-pocket costs for 2022 plans by \$400 relative to the Trump-era methodology.¹⁴

Other Recommendations for Improving Affordability of Coverage

Stakeholders made many other recommendations regarding affordability. These are not listed in Exhibit 1 because they were not included in the majority of recommendations. However, the Biden administration also was encouraged to:

- Maintain state flexibility for silver-loading, so states can continue to direct insurers to increase silver-plan premiums to compensate for the nonpayment of cost-sharing reductions.
- Realign metal level premiums based on the generosity of coverage by ensuring that premiums, especially for silver plans, are priced appropriately based on actuarial value and utilization.
- Allow income-based third-party payment programs so that hospital systems and independent nonprofits can pay premiums for low-income consumers.¹⁵
- Limit wellness program incentives.

Improving Adequacy of Coverage

Stakeholders offered significant support for reversing Trump-era rules on short-term health plans and association health plans. Many stakeholders also urged the Biden administration to address other insurance products that are exempt from ACA protections.

Not Just Short-Term Plans: Concerns About Other Noncomprehensive Products

Much attention has been paid to short-term health plans and association health plans following the Trump administration's rules to expand access to those products. But these are not the only types of noncomprehensive insurance products currently on the market that are exempt (or largely exempt) from the ACA's protections.

Stakeholders also raised concerns about fixed-indemnity products, farm bureau plans, health care sharing ministries, and direct primary care arrangements. Their concerns include inadequate benefits, deceptive marketing practices, consumer confusion, lack of state and federal oversight, and limited avenues for legal recourse. Some also highlighted emerging arrangements that seek to be regulated only under federal law and not state laws, as is the case with the Data Marketing Partnership, an arrangement that is under litigation in Texas.

Most stakeholders made fewer explicit recommendations as to how the Biden administration should address these other products. Stakeholders, such as the Association for Community Affiliated Plans, urged the Biden administration to institute robust data collection and reporting efforts for all types of noncompliant plans. And the state insurance commissioners urged the Biden administration to modernize the Department of Labor's approach to oversight of federally regulated health plans.

Even without more explicit recommendations, stakeholders underscored the need for federal officials to explore policies to limit — or, at a minimum, monitor — a broader array of non-ACA products beyond short-term plans and association health plans. Doing so is critical to protecting consumers from these products, which often fail to offer comprehensive coverage and are increasingly marketed in aggressive, misleading ways.

Short-term plans do not have to meet the ACA's requirements and include significant

benefit gaps that make these policies less expensive and thus more attractive for younger and healthier people.¹⁶ The Obama administration limited the sale of short-term plans to those that cover only three months. The Trump administration revised that rule to allow short-term plans to provide coverage for up to one year and be renewed for up to three years. The Trump-era rule was challenged, but ultimately upheld, in court.¹⁷ Congress, the court noted, gave the government “wide latitude” to define short-term plans and made clear that a future administration could narrow this definition and further revise the rule on short-term plans.¹⁸

The association health plan rule enabled sole proprietors and small businesses to enroll in large-group coverage that is not subject to the same protections that apply in the individual and small-group health insurance markets (such as rating limits based on age or gender). Most of the rule’s provisions were invalidated by a district court judge.¹⁹ That decision was appealed, but a decision has not yet been issued, and the Biden administration asked for a delay in the litigation to consider its options.

Stakeholders generally urged the Biden administration to reinstate Obama-era restrictions on short-term plans and to reverse the association health plan rule, with some encouraging additional restrictions on short-term plans. These include a ban on the purchase of consecutive short-term plan policies (known as stacking) and a ban on sales during the annual marketplace open enrollment period.

Other Recommendations for Improving Adequacy of Coverage

Stakeholders made many other recommendations regarding coverage adequacy. These are not listed in Exhibit 1 because they were not included in the majority of recommendations. However, the Biden administration also was encouraged to:

- Reevaluate the actuarial value calculator to help reduce cost-sharing amounts.
- Adopt standardized plan options or meaningful-difference standards to better inform consumers about differences among marketplace plans.
- Reverse all or some changes to the process for selecting essential health benefits.
- Require meaningful federal oversight of provider network adequacy.
- Reverse the rule on health reimbursement arrangements for excepted benefits; these allowed employers to pay premiums for employees to enroll in noncomprehensive excepted benefits and short-term plans.

Promoting Health Equity

Stakeholders strongly urged the Biden administration to reverse the “public charge” rule which discouraged immigrants from enrolling in certain public programs, such as Medicaid, even when eligible.²⁰ The Supreme Court was scheduled to hear some of the challenges to the public charge rule, but the Biden administration settled the lawsuits, leading to dismissal. The U.S. Department of Homeland Security then formally rescinded the rule.²¹

Stakeholders also recommended reversing changes made by the Trump administration to implement Section 1557 of the ACA, the law’s primary nondiscrimination provision. The Trump-era rule eliminated certain language-access requirements (such as a requirement to include translated taglines on consumer notices and allowing audio, instead of video, interpretation services) and explicit protections for LGBT patients, among many other changes.²² The Biden administration announced in guidance that it would enforce Section 1557’s protections on behalf of LGBT people,²³ but new rulemaking and additional changes are expected. Implementation of Section 1557 has long been litigated, and challenges over both Obama- and Trump-era interpretations remain pending.

Other Recommendations for Promoting Health Equity

Stakeholders made many other recommendations regarding health equity. These are not listed in Exhibit 1 because they were not included in the majority of recommendations. However, the Biden administration also was encouraged to:

- Reverse the double-billing rule, which requires insurers to send, and consumers to pay, separate bills for premiums for abortion-related coverage and all other covered health care services.
- Revise the contraceptive mandate rules.
- Classify Deferred Action for Childhood Arrivals (DACA) recipients as eligible for marketplace coverage and certain Medicaid/Children’s Health Insurance Program (CHIP) coverage.

Allowing Greater State Flexibility

Many stakeholders urged the Biden administration to rescind the current approach to state innovation waivers under Section 1332 of the ACA. The Trump administration

replaced Obama-era guidance with its own interpretation of Section 1332 that was criticized as legally unsound.²⁴ That interpretation was ultimately adopted in regulations.²⁵

Beyond reverting to Obama-era policy on Section 1332, several stakeholders asked for additional flexibility in the use of Section 1332 waivers. The State Health Exchange Leadership Network, the state insurance commissioners, the American College of Physicians, and Families USA identified ways that Section 1332 could better enable state experimentation to advance progressive policy goals. Some of these stakeholders explicitly noted the use of Section 1332 waivers for state public health insurance options.

Other Recommendations for Allowing Greater State Flexibility

Stakeholders made many other recommendations regarding state flexibility. These are not listed in Exhibit 1 because they were not included in the majority of recommendations. However, the Biden administration also was encouraged to:

- Clarify that state-funded and -administered subsidies are not counted as income for marketplace income calculations or federal tax filings.
- Rescind reporting requirements regarding state-mandated benefits.

POLICY IMPLICATIONS

The Biden administration has flexibility to change its positions on ACA and Medicaid policies. The recommendations discussed in this brief offer a framework for policy changes that are supported by diverse health care stakeholders and are consistent with President Biden's goals of protecting and strengthening the Affordable Care Act and Medicaid. These policies also complement the changes made under the American Rescue Plan and the Biden administration's stated commitment to advance health equity.

Stakeholder consensus was greatest on the need to reverse Trump-era changes. This is likely because those policy changes are well-known and understood.²⁶ Apart from fixing the family glitch, there was less consensus for affirmative policies that go beyond reversing Trump-era changes. Stakeholders were supportive of new affirmative policies but included fewer specific recommendations. This suggests that additional policy development will be helpful to further build consensus as the Biden administration turns to new rulemaking.

Stakeholders also emphasized the need for policies that help people enroll in and stay enrolled in coverage, including the millions of people who are already eligible for, but not enrolled in, subsidized marketplace coverage or Medicaid. To make this vision a reality, stakeholders urged the elimination of bureaucratic eligibility hurdles; auto-enrollment based on, say, the receipt of Supplemental Nutrition Assistance Program (SNAP) benefits; continuous Medicaid eligibility for adults; and consumer-friendly plan design policies (such as facilitated plan selection, standardized plans, and meaningful difference standards). These changes would likely reduce enrollment barriers and make it easier for families to select a plan and keep their coverage.

In making changes, federal officials are required to comply with the Administrative Procedure Act and fully justify all policy changes.²⁷ Failure to do so will make it harder to defend legal challenges before a much more conservative federal judiciary.²⁸ Litigation could inhibit, or at least delay, progress on these stakeholder priorities.

The Biden administration can use executive action to increase access to affordable, comprehensive health insurance and promote health equity in the areas of private health insurance and Medicaid. Doing so is supported by a range of diverse health care stakeholders.

Acknowledgments

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5. Recommendations from Families USA, for instance, focused primarily on “affirmative” steps that the Biden administration could take and only generally note the need to

steps that the Biden administration could take and only generally note the need to “revers[e] harmful Trump administration policies.” See Dorn and Isasi, *supra* note 4. In acknowledging the need to “go beyond reversing harmful Trump administration policies,” Families USA linked to a piece that encouraged federal administrative action consistent with those recommended by others here. These actions included authorizing a COVID-19 emergency enrollment period for HealthCare.gov; increasing marketing, outreach, and enrollment assistance; fixing the family glitch; and reversing the public charge rule. See Katie Keith, “CMS Could Do More in Light of the Coronavirus Crisis,” *Health Affairs Blog*, Mar. 25, 2020.

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20. Sara Rosenbaum, “[The New ‘Public Charge’ Rule Affecting Immigrants Has Major Implications for Medicaid and Entire Communities](#),” *To the Point* (blog), Commonwealth Fund, Aug. 15, 2019.

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25. Katie Keith, “[The 2022 Final Payment Notice \(Sorta\)](#),” *Health Affairs Blog*, Jan. 15, 2021.

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27. Federal agencies will need to acknowledge a change in the policy, explain why the

agency believes the new policy is better, identify factual or policy arguments for why it is changing its position, and address the interests of those who may have relied on the prior interpretation.

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PUBLICATION DETAILS

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AREA OF FOCUS

Achieving Universal Coverage

TOPICS

**Affordable Care Act,
Medicaid,
Medicaid Waivers,
Health Disparities,
Government Programs & Policies**

COVID-19: Effects of the Response on Health Insurance Coverage in 2020

Edmund F. Haislmaier

KEY TAKEAWAYS

The latest data show that the economic disruptions from the COVID-19 pandemic was not as bad for U.S. health coverage as initially feared.

Going forward, lawmakers can improve health care for all Americans by lowering health costs through greater choice and competition.

Rather than expanding eligibility and insurance subsidies, lawmakers can help the chronically uninsured by helping those eligible access available coverage.

The economic dislocation caused by government responses to the COVID-19 pandemic last year had less of an adverse effect on health insurance coverage than was initially feared, according to data. Because most working Americans and their dependents have health insurance through employer-sponsored plans, analysts and policymakers had raised concerns last spring that millions of Americans could lose their health insurance coverage as a result of the sudden employment dislocation due to the COVID-19 shutdowns. Indeed, some analysts had projected substantial coverage losses.¹

Insurance Enrollment Changes in 2020

While enrollment in private employment-based coverage did decline somewhat in 2020, that reduction

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TABLE 1

Changes in Health Insurance Enrollment in 2020

Insurance Market Segment	Dec. 2019	Dec. 2020	CHANGE	
			Number	Percent
Individual (non-group)	13,655,230	14,260,664	605,434	4.4%
Fully-Insured Employer Group	50,000,848	47,760,093	-2,240,755	-4.5%
Self-Insured Employer Group	110,326,464	109,941,976	-384,488	-0.3%
Subtotal Employer	160,327,312	157,702,069	-2,625,243	-1.6%
Medicaid	64,572,069	72,204,587	7,632,518	11.8%
CHIP	6,560,184	6,695,834	135,650	2.1%
Subtotal Medicaid and CHIP	71,132,253	78,900,421	7,768,168	10.9%
Total	245,114,795	250,863,154	5,748,359	2.3%

NOTE: Data for Medicaid and CHIP are through November 2020.

SOURCES: Private market data are from NAIC and Mark Farrah Associates. Medicaid and CHIP data from Centers for Medicare and Medicaid Services. For more information, see footnote 2.

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was more than offset by increases in private individual-market coverage and public program coverage through the Children’s Health Insurance Program (CHIP).² (See Table 1.)

Some observations:

- The bulk of the coverage losses occurred in the fully insured employer-group market, where enrollment dropped by 2.2 million individuals, or 4.5 percent, from 50 million individuals at the end of 2019 to 47.8 million at the end of 2020.
- In the self-insured employer-group market, which is more than twice the size of the fully insured market, enrollment decreased by only 384,000 individuals (or 0.3 percent) from 110.3 million in 2019 to 109.9 million in 2020.

- In contrast, enrollment in individual market plans increased by 605,000 individuals (or 4.4 percent) from 13.7 million individuals at the end of 2019 to 14.3 million at the end of 2020.
- By far, the biggest change in 2020 was the substantial increase in enrollment in public programs. Enrollment in Medicaid and CHIP increased by 7.8 million individuals (or 10.9 percent) from 71.1 million in 2019 to 78.9 million in 2020. As Table 1 shows, almost all (98 percent) of that increase was in Medicaid, with CHIP enrollment increasing by only 135,000 individuals, or 2 percent.

In sum, the overall effect was that in 2020 net enrollment in private coverage (group and non-group) decreased by 2 million individuals, or 1.2 percent, while enrollment in public coverage (Medicaid and CHIP) increased by 7.8 million individuals, or 10.9 percent.

Likely Effects of Government Response to COVID-19

In the employer-group market, fully insured plans are purchased primarily by small and medium-size firms, while larger businesses tend to self-insure their health plans. Prior to 2020, enrollment in fully insured plans was gradually declining by 1 percent to 2 percent per year, while enrollment in self-insured plans was increasing at about the same pace.

Thus, at least half of the 2020 enrollment decline in fully insured employer plans was likely due to the effects of government responses to COVID-19, as smaller businesses generally suffered more from the lockdowns than did larger firms.

The substantial increase in enrollment in Medicaid and CHIP reflects not only COVID-19-related economic dislocation but also two temporary program changes that Congress enacted in response to COVID-19. The Families First Coronavirus Response Act (enacted March 18, 2020) temporarily increased federal funding for state Medicaid programs but conditioned the extra funding on states continuing to cover, for the duration of the health emergency, individuals who were already on Medicaid. The CARES Act (enacted March 27, 2020) temporarily increased unemployment compensation payments and specified that the additional payments were not to be counted as income for purposes of determining Medicaid or CHIP eligibility.³

Thus, much of the net increase in Medicaid enrollment likely reflects the temporary retention or addition of individuals who would not have qualified

for coverage under normal eligibility criteria. Also, some individuals may have become newly eligible due to COVID-19-related reductions in income, and some who were already eligible, but not enrolled, may have sought coverage in response to COVID-19.⁴

Policy Implications

In general, private health insurance coverage remained fairly stable in the face of COVID-19-related economic dislocations. That may have been partly the result of employers maintaining furloughed workers on their current coverage. It was also likely due to the fact that those who do lose job-based coverage have alternatives, including COBRA continuation coverage, replacement individual-market coverage, or (if they are low-income) public program coverage through Medicaid or CHIP.

The experience of 2020 indicates that there do not appear to be any significant systemic gaps or barriers to people maintaining or switching health insurance coverage in response to changing economic circumstances. Consequently, Congress increasing taxpayer subsidies for health insurance coverage is not likely to have much effect on enrollment. For instance, in the last COVID-19 bill, Congress temporarily (for 2021 and 2022) expanded eligibility and increased subsidies for those purchasing individual-market exchange coverage and also created new temporary subsidies for continuation coverage for those losing employment-based coverage.⁵ Yet those continuation coverage subsidies were largely unnecessary, as under Obamacare individuals eligible for unsubsidized continuation coverage already had the option of enrolling in subsidized exchange coverage instead.

Furthermore, economic research finds that many low-income uninsured individuals do not enroll in even heavily subsidized coverage unless they incur a medical condition that entails paying more than they normally do for medical care.⁶ In part, that is due to the widespread availability of “charity care” provided by hospitals and clinics at low or no cost to low-income individuals. Also, some public policies—such as retroactive eligibility for Medicaid coverage and the creation of numerous exceptions allowing for enrollment in subsidized exchange coverage outside of the annual open season—reinforce the tendency among low-income uninsured individuals without significant and immediate medical needs to not enroll in coverage unless and until they have to do so to avoid incurring more than nominal out-of-pocket costs for treatment.

That is consistent with what researchers have long observed about Medicaid—namely, that at any given time, a significant portion of the population eligible for Medicaid is not enrolled in the program.⁷

In sum, policies that simply expand the availability of free or nearly free coverage as a strategy for covering the remaining low-income uninsured population are unlikely to have much, if any, measurable effect.

A more productive approach would include Congress reforming existing programs—which currently provided tens of billions of dollars per year to hospitals and clinics to offset their costs for treating low-income uninsured patients⁸—and allowing patients to apply subsidies from other programs (such as CHIP, Medicaid, and Obamacare) to any private coverage of their choice. Such an approach would allow needy patients to receive subsidy dollars and apply them toward the public or private coverage for which they are already eligible.

Conclusion

The data show that health insurance enrollment remained relatively stable in 2020 despite widespread economic dislocation caused by government responses to the COVID-19 pandemic.

That suggests that Congress’s health reform agenda going forward should focus on reducing costs by expanding choice and competition.

In addition, rather than simply expanding eligibility and subsidies, the better approach for addressing the residual uninsured population is through reforms that enroll them in coverage for which most are already eligible. Today, those individuals are essentially “functionally insured”—meaning that they seek and receive free medical care when and as needed—but are not “formally insured.” The main benefit of identifying and enrolling those individuals in formal coverage, particularly through private managed care plans, is that they will be more likely to get care sooner and in more appropriate settings.

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Endnotes

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3. See Public Law No. 116-127 § 6008(b)(3), and Public Law No. 116-136 § 2104(h).
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5. See American Rescue Plan Act of 2021, Public Law No. 117-2, § 9501 and § 9661, enacted March 11, 2021.
6. See Amy Finkelstein, Nathaniel Hendren, and Mark Shepard, “Subsidizing Health Insurance for Low-Income Adults: Evidence from Massachusetts,” *American Economic Review*, Vol. 109, No. 4 (April 2019), <https://economics.mit.edu/files/15852> (accessed April 26, 2021).
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THE PUBLIC'S PERSPECTIVE ON THE UNITED STATES PUBLIC HEALTH SYSTEM

May 2021

Robert Wood Johnson Foundation



HARVARD
T.H. CHAN
SCHOOL OF PUBLIC HEALTH

REPORT SUMMARY

Survey Background

Public health is a broad field, encompassing the protection and promotion of the public's health domestically and globally. In the United States, over the past several decades, the field of public health has moved away from focusing on infectious disease control and now encompasses a much wider range of issues such as the environment and climate change, injury prevention, racism, healthy housing, and reducing drug and alcohol abuse. However, the emergence of the Covid-19 pandemic in 2020 has once again brought infectious diseases back into the forefront of the American consciousness.

The Robert Wood Johnson Foundation and Harvard T.H. Chan School of Public Health conducted this poll in February and March of 2021 to inform leaders about public views on the public health system in the United States during the Covid-19 era. This survey focuses on public views about the nation's public health system at the federal, state, and local levels. It examines trust in key groups in health and healthcare, ratings of the job performance of public health agencies, trust in information from public health departments, understanding of different health and social issues that fall within the purview of public health, and public views on the biggest health problems facing the nation.

This report uses data from an original survey conducted February 11 – March 15, 2021, among a nationally representative, probability-based sample of 1,305 adults ages 18 or older. It also includes summaries of related polling data from other organizations, where comparisons and trends are relevant.

Report Highlights

As the U.S. government has led a large-scale response to the Covid-19 pandemic, it has brought infectious disease control back to the forefront of the American consciousness. Most Americans are now familiar with the term *public health* and assign public health agencies broad responsibility over many issues, including chronic and infectious disease prevention, mental health, health care, and drug abuse.

This survey finds that the public broadly believes the activities of public health agencies are important to the health of the United States and supports substantial increases in spending on public health programs, but has serious concerns about how the system functions now. The public lacks the high level of trust in key public health institutions necessary to address today's and future challenges.

Despite a broad awareness and recognition for the important role public health agencies play in protecting and promoting the health of the general public and vulnerable groups, this survey also shows the American public has higher trust in healthcare professionals than public health institutions and agencies, people give mixed ratings on the job performance of public health agencies, and a substantial minority of the public does not trust health information shared by their state and local public health departments.

These findings raise notable concerns for leaders working to shape the future of the United States public health system in the post-Covid-19 era of the 21st century. If this important field is to move ahead, it has to address the concerns of lack of trust and inadequate performance ratings for major public health institutions and agencies.

Key Findings

- There is broad public support for substantially increasing federal spending on public health. About seven in ten adults (71%) favor substantially increasing federal spending on improving the nation's public health programs, while 27% are opposed.
- A large majority of the public (72%) believes the activities of public health agencies are extremely or very important to the health of the nation.
- The public's rating of the nation's public health system and medical system have changed over time, with positive ratings of the public health system declining from 43% to 34% from 2009 to 2021, and positive ratings of the medical system increasing from 36% to 51% from 2009 to 2020.
- In terms of overall trust in the recommendations made to improve health, in the middle of the Covid-19 pandemic, the public currently trusts nurses, healthcare workers, and doctors more than public health institutions and agencies.
- In both 2009 and 2021, the public rated the job performance of the Centers for Disease Control and Prevention (CDC) higher than the nation's public health system overall. In 2021, 54% of the public gave the CDC positive job performance ratings (excellent or good), while 59% did in 2009.

Additional Findings

- When it comes to rating the job performance of public health agencies in the federal government, the public is divided over positive ratings of the CDC (54%), the Food and Drug Administration (FDA) (48%), and the National Institutes of Health (NIH) (47%).
- When rating the job performance of their own state and local health departments, the public is also divided, where a slight majority of adults (53%) rate their local health department as doing an excellent or good job and about half of adults (49%) rate their state health department as doing an excellent or good job at protecting the public from health threats and preventing illness, including responding to the Covid-19 outbreak.
- When it comes to the reliability of information at the state level, about two-thirds of adults (65%) say that on balance, they think the information provided by their state health department about the health of people in their state is reliable, leaving about one-third of adults (32%) who say they think the information is unreliable.
- When it comes to the reliability of information at the local level, about three-quarters of adults (74%) say that on balance, they think the information provided by their local health department about the health of people in their local community is reliable, leaving more than one in five adults (23%) who say they think the information is unreliable.
- When asked an open-ended question about the top two biggest health problems facing the nation, the most-cited health problems are Covid-19 (59%), cancer (19%), obesity (19%), health care access (15%), and mental illness (10%). In addition, heart disease (9%), diabetes (8%), health care costs (7%), and drug addiction/abuse (7%) are mentioned among the biggest health problems facing the nation.
- In addition, public views of the issues that fall under the responsibility of public health agencies are more limited than views of public health experts. Importantly, unlike public health experts, a majority of the public does not currently identify three major problems facing society — climate change, gun violence, and racism — as main responsibilities for public health agencies to handle.

INTRODUCTION

This report, *The Public’s Perspective on the United States Public Health System*, summarizes the results of a 2021 poll conducted for the Robert Wood Johnson Foundation and the Harvard T.H. Chan School of Public Health. It examines ratings of the job performance of public health agencies, familiarity with the public health system, trust in public health leadership groups and information from public health departments, understanding of different health and social issues that fall within the purview of public health, and views on the biggest health problems facing the nation.

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This report uses data from an original survey conducted February 11 – March 15, 2021, among a nationally representative, probability-based sample of 1,305 adults ages 18 or older living in the U.S. Race/ethnicity is categorized as non-Hispanic white, non-Hispanic Black, and Hispanic/Latino (self-reported). The margin of error at the 95% confidence interval is ± 3.6 percentage points. This report also includes summaries of related polling data from other organizations, where comparisons and trends are relevant. Other polling data includes Harris 1996 (n=1004), HSPH/RWJF 2009 (n=1109), Gallup 2009 (n=1011), Gallup 2019 (n=1015), HSPH/RWJF/NPR 2020 (n=1885), and Gallup 2020 (n=1226).

I. Trust in Key Groups

Nurses, healthcare workers, and doctors are the most-trusted groups for recommendations made to improve health

When it comes to public trust in the recommendations made by different groups to improve health, in the middle of the Covid-19 pandemic, the public currently trusts nurses, healthcare workers, and doctors more than the nation’s public health institutions and agencies (see Table 1). At least two-thirds of the public report trusting nurses (71%), healthcare workers they know (70%), and doctors (67%) a great deal or quite a lot when it comes to recommendations made to improve health.

Table 1. Public Trust in Key Groups in Health and Healthcare (in Percent)

Q5. In terms of recommendations made to improve health, how much do you trust the recommendations of each of the following groups? Do you trust them a great deal, quite a lot, somewhat, not very much, or not at all for recommendations they make to improve health?

	Great deal/Quite a lot	Somewhat	Not very much/Not at all	DK/Ref
Nurses	71	22	5	2
Healthcare workers you know	70	24	5	1
Doctors	67	24	7	2
The American Cancer Society	56	31	11	2
The CDC	52	25	20	3
The American Red Cross	48	30	16	6
Your local health department	44	36	18	2
Your state health department	41	36	21	2
The Surgeon General	40	37	19	4
Your friends or family	40	37	20	3
The NIH	37	29	19	15
The FDA	37	38	24	1
The National Academy of Medicine	34	35	16	15
The federal Department of Health and Human Services	33	37	28	2

Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health, *The Public’s Perspective on the United States Public Health System*, 2/11/21 – 3/15/21. Q5. Questions asked of randomized half-samples of adults ages 18+ (n=655 and n=650). DK/Ref = don’t know or refused response. CDC = Centers for Disease Control and Prevention. NIH = National Institutes of Health; FDA = Food and Drug Administration.

A slight majority of the public also reports having a great deal or quite a lot of trust in the American Cancer Society (56%) and the Centers for Disease Control and Prevention (CDC) (52%). At least four in ten adults report having high trust in the American Red Cross (48%), their local health department (44%), their state health department (41%), the Surgeon General (40%), and their friends or family (40%).

Notably, less than half the public has high trust (“a great deal” or “quite a lot”) in the nation’s public health institutions and agencies, with the exception of the CDC. Fewer than four in ten adults report having a great deal or quite a lot of trust in the National Institutes of Health (37%), the Food and Drug Administration (37%), the National Academy of Medicine (34%), and the federal Department of Health and Human Services (33%), when it comes to recommendations made to improve health.

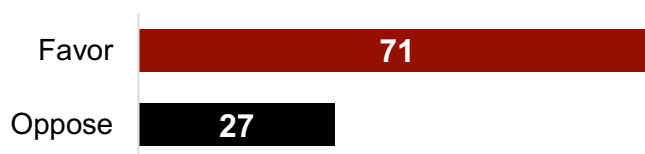
II. Views on the U.S. Public Health System

Majority of adults favor substantially increasing federal spending to improve the nation's public health programs

There is broad public support for increasing federal spending on public health in the U.S. (see Figure 1). About seven in ten adults (71%) favor substantially increasing federal spending on improving the nation's public health programs, while 27% are opposed.

Figure 1. Public Support for Substantially Increasing Federal Spending on Improving U.S. Public Health Programs (in Percent)

Q11. Do you favor or oppose substantially increasing federal spending on improving the nation's public health programs?



Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health, *The Public's Perspective on the United States Public Health System*, 2/11/21 – 3/15/21. Q11. Asked of a randomized half-sample of n=650 adults ages 18+. 2% of adults provided don't know responses or refused to answer the question.

Majority of adults believe the activities of public health agencies are extremely or very important to the health of the nation

In addition, when it comes to rating the importance of public health agencies, a large majority of the public (72%) believes the activities of public health agencies in the United States are extremely or very important to the health of the United States (40% “extremely,” 32% “very”). One in five adults (20%) say the activities of public health agencies are somewhat important to the health of the United States, while 4% say they are not too important, and an additional 4% say they are not important at all.

During the Covid-19 pandemic, the public rates the nation’s medical system higher than the public health system

Despite the recognized importance of public health agencies and broad public support for increased funding, a larger share of the public gives positive ratings to the nation’s medical system (51% express a great deal or quite a lot of confidence) than it does to the nation’s public health system (34% give excellent or good ratings) during the Covid-19 pandemic (see Table 2). Public confidence in the nation’s medical system has increased during the Covid-19 pandemic (see *Gallup 2020*), with about half of adults (51%) giving it a positive rating in 2020 compared with pre-pandemic measures in both 2009 (36%) and 2019 (36%).¹

By contrast, only about one-third of adults (34%) adults give positive ratings to the nation’s system for protecting the public from health threats and preventing illness, with nearly two-thirds of adults (65%) rating the nation’s public health system as fair or poor. These ratings are lower than roughly a decade ago, when this question was previously asked in 2009 and 43% of the public rated the nation’s public health system as excellent or good.

Table 2. Public Ratings of the Nation’s Public Health vs. Medical Systems, 2009 and 2020/2021

	Positive Rating (%)	
	2009	2020-2021
Nation’s medical system ^a	36	51*
Nation’s public health system ^b	43	34*

^a Gallup 6/14-6/17/09 (n=1011) and Gallup 6/8-7/24/20 (n=1226), Q: Please tell me how much confidence you, yourself, have in each one – a great deal, quite a lot, some or very little? The medical system. A great deal/quite a lot reported as positive ratings. ^b 2009 data from the HSPH/RWJF *Health Priorities Survey*, 6/24-6/28/09 (n=556 adults). Q: How would you rate the nation’s system for protecting the public from health threats and preventing illness? Excellent/good reported as positive ratings. 2021 data from HSPH/RWJF, *The Public’s Perspective on the United States Public Health System*, 2/11/21 – 3/15/21 (n=1,305 adults ages 18+). *Statistically significant difference from 2009 to 2020/2021 at p<0.05.

¹ See [Gallup](#) 2009 Jun 14-17 (n=1011 adults); 2019 Jun 3-16 (n=1015 adults); 2020 Jun 8-Jul 24 (n=1226 adults).

Public divisions on the job performance rating of the CDC, FDA, and NIH

When it comes to rating the job performance of public health agencies in the federal government, the public is split in its ratings of the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and the National Institutes of Health (NIH) (see Table 3). A slight majority of adults (54%) rate the CDC as doing an excellent or good job, while 45% rate it as doing a fair or poor job. Nearly half of adults (48%) rate the FDA as doing an excellent or good job, while 51% rate it as doing a fair or poor job. The public is also split on the performance of the NIH, as 47% rate it as doing an excellent or good job, while 44% rate it as doing a fair or poor job.

Of note, the CDC is rated higher than the nation’s public health system overall in both 2009 (59% positive ratings) and 2021 (54% positive ratings). Ratings of state health departments, the FDA, and the NIH remained relatively steady over this time period.

Table 3. Public Ratings of Public Health Departments and Agencies, 2009 and 2021

	Excellent/Good Rating (%)	
	2009	2021
The CDC	59	54
Local health department	N/A	53
State health department	52	49
The FDA	44	48
The NIH	42	47
Nation’s public health system	43	34*

Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health, *The Public’s Perspective on the United States Public Health System*, 2/11/21 – 3/15/21. Q8/Q9/Q15/Q16/Q21/Q22. Federal questions asked of n=1,305 adults ages 18+. State (n=650) and local (n=655) health department questions were asked of randomized half-samples of adults. 2021 state/local health department ratings are composites of Q15-16 (state) and Q21-22 (local). CDC = Centers for Disease Control and Prevention. NIH = National Institutes of Health; FDA = Food and Drug Administration. Local health departments were not rated in 2009. *indicates statistically significant difference from 2009 to 2021 at p<0.05. 2009 data come from the HSPH/RWJF *Health Priorities Survey*, 6/24-6/28/09 (n=1,109 adults, some questions asked of half-samples).

Public divisions on rating the job performance of their state and local health departments

When it comes to rating the job performance of their own state and local health departments, the public is also divided. About half of adults (49%) say their state health department is doing an excellent or good job at protecting the public from health threats and preventing illness, including responding to the Covid-19 outbreak, while 51% say it is doing a fair or poor job. Similarly, a slight majority of adults (53%) say their local health department is doing an excellent or good job at protecting the public from health threats and preventing illness, including responding to the Covid-19 outbreak, while 46% say it is doing a fair or poor job.

III. Familiarity and Reliability of Public Health Information

Three-quarters of adults are familiar with the work of their state health department

When it comes to their state health department, three-quarters of adults (75%) say they are familiar with the activities of their state health department, including 20% who are very familiar and 55% who are somewhat familiar. One-quarter of adults (25%) report being unfamiliar with the activities of their state health department, including 18% who are not too familiar and 7% who are not at all familiar.

Two-thirds of adults are familiar with the work of their local health department

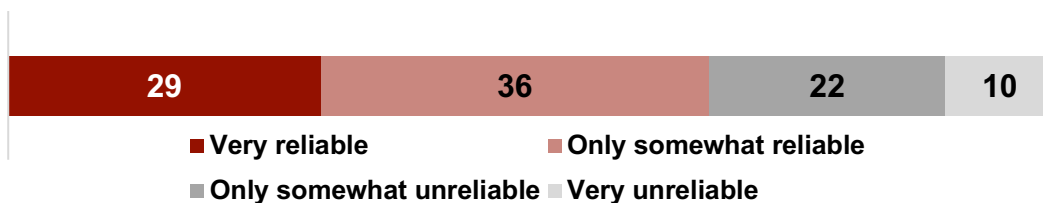
When it comes to their local health department, about two-thirds of adults (66%) say they are familiar with the activities of their local health department, including 17% who are very familiar and 49% who are somewhat familiar. One-third of adults (33%) report being unfamiliar with the activities of their local health department, including 23% who are not too familiar and 10% who are not at all familiar.

About two-thirds of adults believe the information provided by their state health department is reliable, while about one-third do not

About two-thirds of adults (65%) say that on balance, they think the information provided by their state health department about the health of people in their state is reliable, leaving about one-third of adults (32%) who say they think the information is unreliable. See Figure 2 below for details.

Figure 2. Views on the Reliability of Information Provided by Your State Health Department (in Percent)

Q17-18. On balance, do you think the information provided by your state health department about the health of people in your state is reliable, or not? And would you say it is very or only somewhat [reliable/unreliable]?



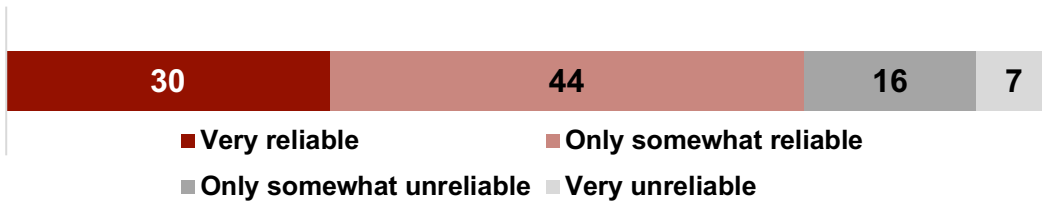
Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health, *The Public's Perspective on the United States Public Health System*, 2/11/21 – 3/15/21. Q17-18. Questions were asked of a randomized half-sample of n=650 adults ages 18+. 3% of adults provided don't know responses or refused to answer the question.

About three-quarters of adults believe the information provided by their local health department is reliable, while more than one in five do not

About three-quarters of adults (74%) say that on balance, they think the information provided by their local health department about the health of people in their local community is reliable, leaving more than one in five adults (23%) who say they think the information is unreliable. See Figure 3 below for details.

Figure 3. Views on the Reliability of Information Provided by Your Local Health Department (in Percent)

Q23-24. On balance, do you think the information provided by your local health department about the health of people in your local community is reliable, or not? And would you say it is very or only somewhat [reliable/unreliable]?



Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health, *The Public's Perspective on the United States Public Health System*, 2/11/21 – 3/15/21. Q23-24. Questions were asked of a randomized half-sample of n=655 adults ages 18+. 3% of adults provided don't know responses or refused to answer the question.

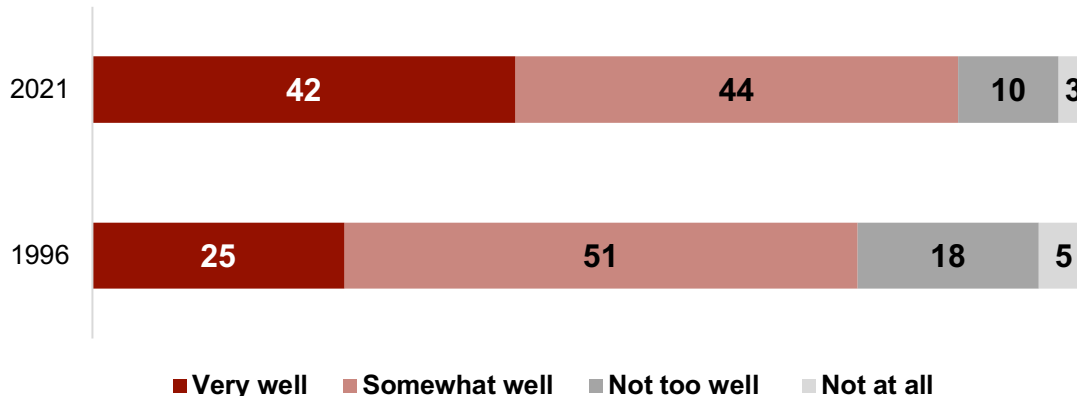
IV. Understanding of Public Health Issues

Most of the public believes they have a general understanding of what is meant by “public health”

When it comes to understanding public health, about four in ten adults (42%) say they understand what is meant by the words “public health” very well, while 44% say they understand it somewhat well (Figure 4). Public understanding of the term “public health” has increased since it was measured in 1996 by Harris,² when 25% of the public said they understand the term very well and 51% said they understood it somewhat well.

Figure 4. Growing Public Understanding of “Public Health” (in Percent)

Q6. If you read or hear somebody talking about public health, how well do you feel that you understand what they mean by those two words “public health”?



Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health, *The Public’s Perspective on the United States Public Health System*, 2/11/21 – 3/15/21. Q6. N=1,305 adults ages 18+. Harris Poll, 12/12-12/16/1996 (n=1004).

Public views of what issues are included in public health are more limited than the issues considered by public health experts

When given a list of 33 issues that are widely considered by public health experts to be within the domain of public health, there are different levels of public understanding over which issues are the main responsibilities for public health agencies to handle. At least half of the public cited 28 issues as being what they consider main responsibilities for public health agencies (see Table 4).

² See the [Harris Poll](#), conducted 12/12/1996-12/16/1996 (n=1004 adults).

Table 4. Issues Considered by the Public to be Main Responsibilities for Public Health Agencies

Q26-29. When you think of the following issues, would you consider each of the following to be one of the main responsibilities for public health agencies, or not? You can select multiple issues as being main responsibilities for public health agencies. How about ____?

	%
Providing vaccines to prevent the spread of COVID-19	92
Controlling the spread of new infectious diseases like Ebola, Zika, or COVID-19	91
Providing vaccines to prevent illnesses like the yearly flu, measles, and mumps	90
Enforcing standards for safe drinking water	90
Reducing causes of food poisoning, such as salmonella or E. coli	88
Preventing and treating mental illness	87
Reducing infant mortality and preterm birth	80
Preventing chronic diseases like heart disease, cancer, and diabetes	80
Preventing the spread of HIV/AIDS	79
Reducing shortages of health professionals, hospitals, and community health centers	76
Reducing health care costs	75
Reducing prescription painkiller abuse and addiction	75
Preparing the public in advance to handle health problems or injuries resulting from emergency events, such as bombings or terrorist attacks	74
Improving air and water quality	72
Reducing illegal drug abuse and addiction	70
Reducing the gaps in health and health care between whites and minorities	67
Providing health insurance for those who don't have it	67
Responding to natural disasters, like wildfires, major hurricanes or floods	67
Providing family planning services	66
Safely disposing of garbage	66
Reducing the gaps in health care between men and women	65
Reducing alcohol abuse	61
Cleaning up the environment	60
Improving diet and physical activity	60
Reducing smoking and tobacco use	59
Reducing sexual violence	58
Reducing domestic violence	56
Increasing the availability of healthy, affordable housing	50
Reducing eviction and homelessness	49
Reducing racism	43
Preventing violence and deaths from guns	40
Preventing injuries caused by motor vehicle crashes	39
Reducing climate change	33

Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health, *The Public's Perspective on the United States Public Health System*, 2/11/21–3/15/21. Q26-29. Questions were asked of randomized half-samples of n=655 and n=650 adults ages 18+.

At the top of the list, most adults say that infectious disease issues fall within the domain of public health, as well as mental illness, chronic diseases, and maintaining safe air and water. This includes 92% of the public who say providing vaccines to prevent the spread of Covid-19 is one of the main responsibilities for public health agencies, as is controlling the spread of new infectious diseases like Ebola, Zika, or Covid-19 (91%), providing vaccines to prevent illnesses like the yearly flu, measles, and mumps (90%), enforcing safe standards for drinking water (90%), reducing causes of food poisoning such as salmonella or E. coli (88%), and preventing and treating mental illness (87%).

Between seven and eight in ten adults say the following issues are main responsibilities of public health agencies: reducing infant mortality and preterm birth (80%), preventing chronic diseases like heart disease, cancer, and diabetes (80%), preventing the spread of HIV/AIDS (79%), reducing shortages of health professionals, hospitals, and community health centers (76%), reducing health care costs (75%), reducing prescription painkiller abuse and addiction (75%), preparing the public in advance to handle health problems or injuries resulting from emergency events, such as bombings or terrorist attacks (74%), improving air and water quality (72%), and reducing illegal drug abuse and addiction (70%).

Between half and two-thirds of adults say the following issues are main responsibilities of public health agencies: reducing the gaps in health and healthcare between whites and minorities (67%), providing health insurance for those who don't have it (67%), responding to natural disasters, like wildfires, major hurricanes, or floods (67%), providing family planning services (66%), safely disposing of garbage (66%), reducing the gaps in health care between men and women (65%), reducing alcohol abuse (61%), cleaning up the environment (60%), improving diet and physical activity (60%), reducing smoking and tobacco use (59%), reducing sexual violence (58%), reducing domestic violence (56%), and increasing the availability of healthy, affordable housing (50%).

Fewer than half of adults say the following issues are main responsibilities of public health agencies: reducing eviction and homelessness (49%), reducing racism (43%), preventing violence and death from guns (40%), preventing injuries caused by motor vehicle crashes (39%), and reducing climate change (33%).

Of note, responses to this question do not necessarily indicate lack of public concern about these issues. For example, the public has shown wide concern about racism, gun violence, and climate change recently in other polling.³ In addition, this question was asked after the American Medical Association (AMA) declared racism to be a public health threat in November 2020,⁴ but before the Centers for Disease Control and Prevention (CDC) declared racism to be a serious public health threat in April 2021.⁵ Other issues, including climate change⁶ and gun violence,⁷ have also been prominently discussed as public health issues by national and international experts in recent years.

Responses to this question indicate that while many issues are of wide public concern, the public does not see these issues as falling within the field of public health, and they do not believe they are main responsibilities for public health agencies to tackle. This is intended to be used for public health agencies and leadership organizations, to understand which top issues are “owned” by the field in the public consciousness.

Notably, when examining the differences in views between adults who say they understand what the term “public health” means very well compared to those who do not, there were few differences in views on the main responsibilities of public health agencies.

³ See [Pew Research Center 2020](#); [Kaiser Family Foundation/Washington Post 2019](#); [Pew Research Center 2019](#).

⁴ See [AMA: Racism is a threat to public health](#), November 16, 2020. ⁵ See [CDC media statement on racism and health](#), April 8, 2021. ⁶ Watts N et al. Health and climate change: policy responses to protect public health. *Lancet*. 2015;386(10006):1861–1914. ⁷ Institute of Medicine and National Research Council. 2013. *Priorities for Research to Reduce the Threat of Firearm-Related Violence*. Washington, DC: The National Academies Press.

V. Views on the Biggest Local and National Health Problems

Covid-19, cancer, obesity, and healthcare access cited as biggest national health problems

When asked an open-ended question about the top two biggest health problems facing the nation, the most-cited health problems are Covid-19 (59%), cancer (19%), obesity (19%), health care access (15%), and mental illness (10%) (see Table 5). In addition, heart disease (9%), diabetes (8%), health care costs (7%), and drug addiction/abuse (7%) are mentioned among the biggest health problems facing the nation.

When asked an open-ended question about the top two biggest health problems facing their own local communities, adults' views are similar to concerns nationally (see Table 5). The most-cited health problems are Covid-19 (57%), obesity (12%), and drug addiction/abuse (10%), along with cancer (9%), health care access (9%), mental illness (9%), heart disease (9%), and diabetes (9%).

Table 5. Top 2 Biggest National and Community Health Problems (in Percent)

Q1-4. What would you say is the biggest health problem facing [the United States / your local community]? And beyond the biggest health problem, what would you say is the second biggest health problem facing [the United States / your local community]? [Open-ended]

	United States (National)	Local Community
Coronavirus/COVID-19	59	57
Cancer	19	9
Obesity	19	12
Health care access	15	9
Mental illness	10	9
Heart disease	9	9
Diabetes	8	9
Health care costs	7	4
Drug addiction/abuse	7	10

Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health, *The Public's Perspective on the United States Public Health System*, 2/11/21 – 3/15/21. Q1-4. Questions were asked of randomized half-samples of n=650 (national) and n=655 (local community) adults ages 18+. Categories ranked by overall highest % among all respondents for national problems. No other problems were mentioned by more than 5% of adults.

Before the Covid-19 pandemic, when prior polling asked adults about the biggest health problem in their local communities in 2019, the top five answers given were drug and opioid addiction or abuse (19%), access to healthcare (11%), obesity (9%), cancer (8%), and healthcare costs (6%).⁸

⁸ See [Life Experiences and Income Inequality in the United States](#), NPR/Harvard/Robert Wood Johnson Foundation, conducted 7/17/19-8/18/19, Q21 (n=1885).

VI. Differences by Race/Ethnicity

Latino/Hispanic adults (who comprise approximately 16% of the U.S. adult population) and African American/Black adults (who comprise approximately 12% of the U.S. adult population) often have distinct perspectives compared with non-Hispanic whites. Below, key findings from this report are highlighted, by race/ethnicity.

- Latino adults have distinct views compared to non-Hispanic white adults when it comes to having a great deal or quite a lot of trust in recommendations made to improve health by several key groups in health and healthcare (see Table 6). In particular, Latino adults have higher levels of trust in their local health departments (57% to 38%), the FDA (51% to 35%), their friends and family (49% to 39%), and the National Academy of Medicine (47% to 29%) when it comes to recommendations made to improve health.
- There are not statistically significant differences between Black adults and non-Hispanic white adults when it comes to reporting a great deal or quite a lot of trust in recommendations made to improve health by these groups (see Table 6).

Table 6. Public Trust in Key Groups in Health and Healthcare, By Race/Ethnicity

Q5. In terms of recommendations made to improve health, how much do you trust the recommendations of each of the following groups? Do you trust them a great deal, quite a lot, somewhat, not very much, or not at all for recommendations they make to improve health?

	A Great Deal/Quite a Lot of Trust (%)		
	White	Latino	Black
Nurses	75	66	67
Healthcare workers you know	73	71	66
Doctors	68	63	67
The American Cancer Society	55	64	51
The CDC	51	49	60
The American Red Cross	47	54	50
Your local health department	38	57*	44
Your state health department	39	48	44
The Surgeon General	40	44	39
Your friends or family	39	49*	39
The NIH	36	33	43
The FDA	35	51*	34
The National Academy of Medicine	29	47*	30
The federal Department of Health and Human services	32	39	29

Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health, *The Public's Perspective on the United States Public Health System*, 2/11/21 – 3/15/21. Q5. Questions asked of randomized half-samples of adults ages 18+ (n=655 and n=650). CDC = Centers for Disease Control and Prevention. NIH = National Institutes of Health; FDA = Food and Drug Administration. *indicates statistically significant difference between Latino and NH white at p<0.05. Items rank-ordered by highest % overall.

- When it comes to rating the job performance of public health departments and agencies, a larger share of Latino adults give positive ratings at all levels compared to non-Hispanic white adults (see Table 7). In addition, a higher share of Black adults give the CDC, FDA, NIH, and their state health departments positive job performance ratings compared to non-Hispanic white adults (see Table 7).

Table 7. Public Ratings of Public Health Departments and Agencies (2021), By Race/Ethnicity

	Excellent/Good Rating (%)		
	White	Latino	Black
The CDC	52	60*	63*
Local health department	52	60*	58
State health department	45	61*	56*
The FDA	45	56*	57*
The NIH	44	58*	54*
Nation's public health system	33	45*	39

Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health, *The Public's Perspective on the United States Public Health System*, 2/11/21 – 3/15/21. Q8/Q9/Q15/Q16/Q21/Q22. N=1,305 adults ages 18+. Some questions asked of randomized half-samples of adults. State/local health department responses are composites of Q15-16 (state) and Q21-22 (local). CDC = Centers for Disease Control and Prevention. NIH = National Institutes of Health; FDA = Food and Drug Administration. *indicates statistically significant difference between Black v. non-Hispanic white or Latino v. non-Hispanic white at $p < 0.05$. Items rank-ordered by highest % overall.

- When given a list of 33 issues that are widely considered by public health experts to be within the domain of public health, majorities of all three racial/ethnic groups identified 27 issues as being what they consider main responsibilities for public health agencies.
- On the six remaining issues, public opinion differs substantially by racial/ethnic identity (see Table 8). On these issues, half or more Black adults identified each as main responsibilities for public health agencies to handle, while a majority of Latino adults identified four out of the six issues as main responsibilities for public health agencies. On all six issues, the majority of whites do not see these as main responsibilities for public health agencies to handle.

Table 8. Issues Considered by the Public to be Main Responsibilities for Public Health Agencies, by Race/Ethnicity (in Percent)

Q26-29. When you think of the following issues, would you consider each of the following to be one of the main responsibilities for public health agencies, or not? You can select multiple issues as being main responsibilities for public health agencies. How about ____?

	White	Black	Latino
Increasing the availability of healthy, affordable housing	41	63*	72*
Reducing eviction and homelessness	42	74*	56*
Reducing racism	36	61*	58*
Preventing violence and deaths from guns	35	59*	54*
Preventing injuries caused by motor vehicle crashes	35	50*	41
Reducing climate change	29	50*	40*

Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health, *The Public's Perspective on the United States Public Health System*, 2/11/21–3/15/21. Q26-29. Questions asked of randomized half-samples of adults ages 18+ (n=655 and n=650). *indicates statistically significant difference between Black v. non-Hispanic white or Latino v. non-Hispanic white at $p < 0.05$.

VII. Differences by Geographic Location

This poll also examined potential differences in views across urban, suburban, and rural geographies of the United States. Public ratings of the nation’s public health system, as well as state and local health departments, are shown below.

- When it comes to rating the job performance of the nation’s public health system and state and local health departments, there are few differences in adults’ views by geographic location (Table 9). Ratings of the nation’s public health system and state health departments show consistent ratings across geographies, while a higher share of suburban adults (59%) give positive job performance ratings to their local health departments compared to urban adults (46%).

Table 9. Public Ratings of The Public Health System and Health Departments (2021), By Geographic Location

	Excellent/Good Rating (%)		
	Urban	Suburban	Rural
State health department	51	48	47
Local health department	46	59*	51
Nation’s public health system	33	37	31

Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health, *The Public’s Perspective on the United States Public Health System*, 2/11/21 – 3/15/21. Q8/Q9/Q15/Q16/Q21/Q22. N=1,305 adults ages 18+. State and local health department questions were asked of randomized half-samples of adults and are composites of Q15-16 (state) and Q21-22 (local). *indicates statistically significant difference between suburban and urban adults at $p < 0.05$. Items rank-ordered by highest % reported among urban adults.

VIII. Differences by Political Party Affiliation

Many views held by the public differ substantially by political party affiliation. Highlights of major differences in views between adults in the general public who identify themselves as Democrats and Republicans are included below.

- When it comes to trusting the recommendations of different groups to improve health, there are major differences in views between Democrats and Republicans (see Table 10).

Table 10. Public Trust in Key Groups in Health and Healthcare, By Political Party Affiliation

Q5. In terms of recommendations made to improve health, how much do you trust the recommendations of each of the following groups? Do you trust them a great deal, quite a lot, somewhat, not very much, or not at all for recommendations they make to improve health?

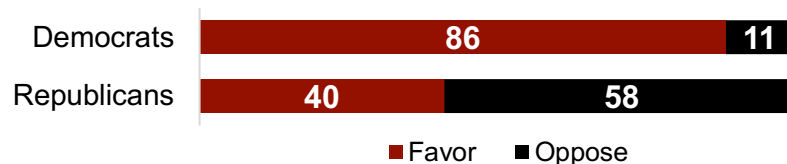
	A Great Deal/Quite a Lot of Trust (%)	
	Democrats	Republicans
Doctors	80*	52
Healthcare workers you know	78	70
The CDC	76*	27
Nurses	75	68
The American Cancer Society	61	50
The NIH	61*	21
The American Red Cross	60*	40
Your state health department	59*	22
Your local health department	53*	38
The Surgeon General	50*	24
The FDA	47*	26
The National Academy of Medicine	47*	17
The federal Department of Health and Human services	43*	22
Your friends or family	35	46

Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health, *The Public's Perspective on the United States Public Health System*, 2/11/21 – 3/15/21. Q5. Questions asked of randomized half-samples of adults ages 18+ (n=655 and n=650). CDC = Centers for Disease Control and Prevention. NIH = National Institutes of Health; FDA = Food and Drug Administration. *indicates statistically significant difference between Democrats and Republicans at p<0.05. Items rank-ordered by highest % reported among Democrats.

- In addition, most Democrats (86%) favor substantially increasing federal spending on improving the nation's public health programs, compared to four in ten Republicans (40%) (see Figure 5).

Figure 5. Public Support for Substantially Increasing Federal Spending on Improving U.S. Public Health Programs, by Political Party Affiliation (in Percent)

Q11. Do you favor or oppose substantially increasing federal spending on improving the nation's public health programs?



Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health, *The Public's Perspective on the United States Public Health System*, 2/11/21 – 3/15/21. Q11. Asked of a randomized half-sample of n=650 adults ages 18+.

- When it comes to rating the job performance of public health departments and agencies, a substantially higher share of Democrats adults give positive job performance ratings to public health departments and agencies compared to Republicans (see Table 11).

Table 11. Public Ratings of Public Health Departments and Agencies (2021), By Political Party Affiliation

	Excellent/Good Rating (%)	
	Democrats	Republicans
The CDC	74*	32
The NIH	66*	28
Local health department	64*	40
The FDA	58*	34
State health department	56*	39
Nation's public health system	40*	30

Robert Wood Johnson Foundation/Harvard T.H. Chan School of Public Health, *The Public's Perspective on the United States Public Health System*, 2/11/21 – 3/15/21. Q8/Q9/Q15/Q16/Q21/Q22. N=1,305 adults ages 18. Some questions asked of randomized half-samples of adults. State/local health department responses are composites of Q15-16 (state) and Q21-22 (local). CDC = Centers for Disease Control and Prevention. NIH = National Institutes of Health; FDA = Food and Drug Administration. *indicates statistically significant difference between Democrats and Republicans at p<0.05. Items rank-ordered by highest % reported among Democrats.

- When it comes to the reliability of information at the state level, Republicans are more likely than Democrats (47% to 19%) to say that on balance, they think the information provided by their state health department about the health of people in their state is unreliable. At the local level, Republicans are also more likely than Democrats (34% to 11%) to say that on balance, they think the information provided by their local health department about the health of people in their local community is unreliable.
- When it comes to understanding the main responsibilities of public health agencies, Republican have a more limited view of public health issues than Democrats on 28 out of 33 issues examined. Of note, there are six issues where Republicans and Democrats are more than 30 percentage points different in their views: providing health insurance for those who don't have it (48% to 84%); providing family planning services (44% to 87%); reducing racism (24% to 58%); preventing violence and deaths from guns (20% to 57%); reducing the gaps in health care between men and women (46% to 78%); and reducing the gaps in health and healthcare between whites and minorities (43% to 90%).
- The items least likely to be seen by Democrats as main responsibilities of public health agencies are preventing injuries caused by motor vehicle crashes (47%) and reducing climate change (47%).
- The items least likely to be seen by Republicans as main responsibilities of public health agencies are preventing violence and death from guns (20%) and reducing climate change (19%).

IX. Methodology

This poll is part of an on-going series of surveys developed by researchers at the Harvard Opinion Research Program (HORP) at Harvard T.H. Chan School of Public Health in partnership with the Robert Wood Johnson Foundation. The research team consists of the following members at each institution.

Harvard T.H. Chan School of Public Health: Robert J. Blendon, Professor of Health Policy and Political Analysis, Emeritus, and Executive Director of HORP; John M. Benson, Senior Research Scientist and Managing Director of HORP; Mary G. Findling, Assistant Director of HORP; Chelsea Whitton Pearsall, Research Coordinator.

Robert Wood Johnson Foundation: Carolyn Miller, Senior Program Officer, Research-Evaluation-Learning; Jordan Reese, Director of Media Relations; Martina Todaro, Research Associate, Research-Evaluation-Learning.

Interviews were conducted by SSRS of Glen Mills (PA) via telephone (including both landline and cell phone) using random-digit dialing, February 11 – March 15, 2021, among a nationally representative probability-based sample of 1,305 U.S. adults age 18 or older. Interviews were conducted in English and Spanish. The margin of error for total respondents is +/-3.6 percentage points, at the 95% confidence level.

Possible sources of non-sampling error include non-response bias, as well as question wording and ordering effects. Non-response in telephone surveys produces some known biases in survey-derived estimates because participation tends to vary for different subgroups of the population. To compensate for these known biases and for variations in probability of selection within and across households, sample data are weighted by cell phone/landline use and demographics (sex, age, race/ethnicity, education, and Census region), as well as party identification, to reflect the true population. Other techniques, including random-digit dialing, replicate subsamples, and systematic respondent selection within households, are used to ensure that the sample is representative.

Characteristics of Population Subgroups

	Group's weighted % of total sample	Number of interviews (unweighted)		Margin of error at the 95% confidence level (percentage points)	
		Total sample	Half samples*	Total sample	Half samples
Total adults	100	1305	653	+/-3.6	+/-5.1
By race/ethnicity					
White (non-Latino)	62	580	290	+/-5.0	+/-7.0
Black (non-Latino)	12	301	151	+/-7.6	+/-10.7
Latino	16	326	163	+/-6.9	+/-9.7
By geography/metro status					
Urban	40	547	274	+/-5.6	+/-7.9
Suburban	46	602	301	+/-5.4	+/-7.6
Rural	14	156	78	+/-9.9	+/-14.0
By party identification**					
Republican	25	230	115	+/-7.9	+/-11.2
Democrat	31	517	259	+/-6.0	+/-8.4

Note: *Half-samples vary slightly in size. Average number per half-sample. **Because Black and Latino adults were oversampled, the unweighted sample sizes for party identification contain more interviews with those two racial/ethnic groups, which identify more as Democrats and less as Republicans than the overall adult population does. However, the weighted percentages (25% R, 31% D) reflect the actual distribution of Democrats and Republicans in the U.S. adult population, so the overall results are representative of the total U.S. adult population.

**ROBERT WOOD JOHNSON FOUNDATION
HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH**

**THE PUBLIC'S PERSPECTIVE ON
THE UNITED STATES PUBLIC HEALTH SYSTEM**

This survey was conducted for the Robert Wood Johnson Foundation and Harvard T.H. Chan School of Public Health, via telephone (landline and cell phone) by SSRS, an independent research company. Interviews were conducted in English and Spanish, **February 11– March 15, 2021**, among a nationally representative, probability-based sample of 1,305 adults age 18 or older living in the U.S. The margin of error for total respondents is +/-3.6 percentage points, at the 95% confidence level.

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I. Public Health Priorities and Views on Leadership

(Asked of half-sample A; n=655)

Q1. What would you say is the biggest HEALTH PROBLEM facing your LOCAL COMMUNITY?

First choice	%
Coronavirus/COVID-19	52
Obesity	5
Mental illness	4
Access to care	4
Diabetes	4
Drug addiction/abuse (NET)	4
<i>Opioid addiction/abuse (painkillers, Rx painkillers, OxyContin, Vicodin, Percocet, or fentanyl)</i>	1
<i>Other drug addiction/abuse</i>	3
Vaccinations	2
Cancer	2
Cost	2
Heart disease/heart attack/heart failure	2
Flu/influenza	1
High blood pressure	1
Environmental factors	1
Poor diet/Nutrition	1
Poverty/economy/unemployment	1
Other	6
None/No health problems facing your local community	3
Don't know/Refused	5

(Asked of half-sample A; n=655)

Q1. What would you say is the biggest HEALTH PROBLEM facing your LOCAL COMMUNITY?

(If mentioned a health problem facing their local community)

Q2. And beyond the biggest health problem, what would you say is the SECOND biggest health problem facing your LOCAL COMMUNITY?

Q1/Q2 Combo Table - Top Two Biggest Health Problems Facing Your Local Community

Base: Half-sample A respondents; n=655

Combined first and second choices	%
Coronavirus/COVID-19	57
Obesity	12
Drug addiction/abuse (NET)	10
<i>Opioid addiction/abuse (painkillers, Rx painkillers, OxyContin, Vicodin, Percocet, or fentanyl)</i>	2
<i>Other drug addiction/abuse</i>	8
Access to care	9
Cancer	9
Mental illness	9
Heart disease/heart attack/heart failure	9
Diabetes	9
Diseases (Alzheimer's, STDs, other disease mentions)	4
Environmental factors	4
Cost	4
Flu/influenza	3
High blood pressure	3
Poor diet/Nutrition	3
Vaccinations	3
Homelessness	2
Poor health choices/Not living healthy lifestyle	2
Poverty/economy/unemployment	2
Alcohol abuse	1
Smoking	1
Aging population/the elderly (care/services)	1
Government/politics/politicians	1
Discrimination/health disparity	1
Other	8
None/No health problems facing your local community	3
Don't know/Refused	5

(Asked of half-sample B; n=650)

Q3. What would you say is the biggest HEALTH PROBLEM facing THE UNITED STATES?

First choice	%
Coronavirus/COVID-19	53
Access to care	8
Obesity	7
Cancer	5
Mental illness	4
Cost	3
Heart disease/heart attack/heart failure	3
Drug addiction/abuse (NET)	3
<i>Opioid addiction/abuse (painkillers, Rx painkillers, OxyContin, Vicodin, Percocet, or fentanyl)</i>	1
<i>Other drug addiction/abuse</i>	2
Poor diet/Nutrition	2
Diabetes	1
Government interference	1
Poor health choices/Not living healthy lifestyle	1
Diseases (Alzheimer's, STDs, other disease mentions)	1
Government/politics/politicians	1
Discrimination/health disparity	1
Other	3
None/No health problems facing the United States	1
Don't know/Refused	2

(Asked of half-sample B; n=650)

Q3. What would you say is the biggest HEALTH PROBLEM facing THE UNITED STATES?

(If mentioned a health problem facing the United States)

Q4. And beyond the biggest health problem, what would you say is the SECOND biggest health problem facing THE UNITED STATES?

Q3/Q4 Combo Table – Top Two Biggest Health Problems Facing the United States

Base: Half-sample B respondents; n=650

Combined first and second choices	%
Coronavirus/COVID-19	59
Cancer	19
Obesity	19
Access to care	15
Mental illness	10
Heart disease/heart attack/heart failure	9
Diabetes	8
Cost	7
Drug addiction/abuse (NET)	7
<i>Opioid addiction/abuse (painkillers, Rx painkillers, OxyContin, Vicodin, Percocet, or fentanyl)</i>	4
<i>Other drug addiction/abuse</i>	3
Poor diet/Nutrition	4
Poor health choices/Not living healthy lifestyle	3
Flu/influenza	3
Government interference	2
Diseases (Alzheimer's, STDs, other disease mentions)	2
Government/politics/politicians	2
Discrimination/health disparity	2
High blood pressure	1
HIV/AIDS	1
Environmental factors	1
Smoking	1
Vaccinations	1
Poverty/economy/unemployment	1
Other	7
None/No health problems facing the United States	1
Don't know/Refused	2

Q5. In terms of recommendations made to improve health, how much do you trust the recommendations of each of the following groups? What about (INSERT ITEM)? Do you trust them a great deal, quite a lot, somewhat, not very much, or not at all for recommendations they make to improve health?

(Asked of half-sample C; n=655)

a. The CDC, or Centers for Disease Control and Prevention

	%
A great deal	26
Quite a lot	26
Somewhat	25
Not very much	8
Not at all	12
Don't know/Refused	3

(Asked of half-sample C; n=655)

b. Your state health department

	%
A great deal	19
Quite a lot	22
Somewhat	36
Not very much	11
Not at all	10
Don't know/Refused	2

(Asked of half-sample C; n=655)

c. Nurses

	%
A great deal	36
Quite a lot	35
Somewhat	22
Not very much	3
Not at all	2
Don't know/Refused	2

(Asked of half-sample C; n=655)

d. The NIH, or National Institutes of Health

	%
A great deal	19
Quite a lot	18
Somewhat	29
Not very much	8
Not at all	11
Don't know/Refused	15

(Asked of half-sample C; n=655)

e. Doctors

	%
A great deal	37
Quite a lot	30
Somewhat	24
Not very much	5
Not at all	2
Don't know/Refused	2

(Asked of half-sample C; n=655)

f. Your friends or family

	%
A great deal	20
Quite a lot	20
Somewhat	37
Not very much	13
Not at all	7
Don't know/Refused	3

(Asked of half-sample C; n=655)

g. The American Red Cross

	%
A great deal	22
Quite a lot	26
Somewhat	30
Not very much	9
Not at all	7
Don't know/Refused	6

(Asked of half-sample D; n=650)

h. The FDA, or Food and Drug Administration

	%
A great deal	13
Quite a lot	24
Somewhat	38
Not very much	14
Not at all	10
Don't know/Refused	1

(Asked of half-sample D; n=650)

i. Your local health department

	%
A great deal	18
Quite a lot	26
Somewhat	36
Not very much	11
Not at all	7
Don't know/Refused	2

(Asked of half-sample D; n=650)

j. The federal Department of Health and Human Services

	%
A great deal	13
Quite a lot	20
Somewhat	37
Not very much	15
Not at all	13
Don't know/Refused	2

(Asked of half-sample D; n=650)

k. The Surgeon General

	%
A great deal	18
Quite a lot	22
Somewhat	37
Not very much	11
Not at all	8
Don't know/Refused	4

(Asked of half-sample D; n=650)

l. Healthcare workers you know

	%
A great deal	34
Quite a lot	36
Somewhat	24
Not very much	4
Not at all	1
Don't know any healthcare workers (vol)	1
Don't know/Refused	*

(Asked of half-sample D; n=650)

m. The National Academy of Medicine

	%
A great deal	16
Quite a lot	18
Somewhat	35
Not very much	8
Not at all	8
Don't know/Refused	15

(Asked of half-sample D; n=650)

n. The American Cancer Society

	%
A great deal	26
Quite a lot	30
Somewhat	31
Not very much	7
Not at all	4
Don't know/Refused	2

Q5 Summary Table

	Great deal/ Quite a lot	Somewhat	Not very much/ Not at all	Don't know/ Refused
Nurses ^c	71	22	5	2
Healthcare workers you know ^d	70	24	5	1
Doctors ^c	67	24	7	2
The American Cancer Society ^d	56	31	11	2
The CDC, or Centers for Disease Control and Prevention ^c	52	25	20	3
The American Red Cross ^c	48	30	16	6
Your local health department ^d	44	36	18	2
Your state health department ^c	41	36	21	2
The Surgeon General ^d	40	37	19	4
Your friends or family ^c	40	37	20	3
The NIH, or National Institutes of Health ^c	37	29	19	15
The FDA, or Food and Drug Administration ^c	37	38	24	1
The National Academy of Medicine ^d	34	35	16	15
The federal Department of Health and Human Services ^d	33	37	28	2

^c Asked of half-sample C; n=655.

^d Asked of half-sample D; n=650.

Q6. If you read or hear somebody talking about public health, how well do you feel that you understand what they mean by those two words “public health”?

	%
Very well	42
Somewhat well	44
Not too well	10
Not at all	3
Don't know/Refused	1

Q7. How important do you think the activities of public health agencies are to the health of the United States?

	%
Extremely important	40
Very important	32
Somewhat important	20
Not too important	4
Not at all	4
Don't know/Refused	*

II. Views on the Nation's Public Health System

Q8. How would you rate the **nation's system for protecting the public from health threats and preventing illness**? Would you rate it as:

	%
Excellent	6
Good	28
Fair	36
Poor	29
Don't know/Refused	1

Q9. Now I'm going to read you a list of agencies in the **FEDERAL** government. For each one, please tell me how good a job you think it is doing. How about (INSERT ITEM)? Do you think it is doing an excellent, good, fair, or poor job?

a. The CDC, or Centers for Disease Control and Prevention

	%
Excellent	17
Good	37
Fair	27
Poor	18
Don't know/Refused	1

b. The FDA, or Food and Drug Administration

	%
Excellent	12
Good	36
Fair	35
Poor	16
Don't know/Refused	1

c. The NIH, or National Institutes of Health

	%
Excellent	11
Good	36
Fair	31
Poor	13
Don't know/Refused	9

(Asked of half-sample C; n=655)

Q10. Do you favor or oppose substantially increasing federal spending on preventing the spread of infectious diseases like COVID-19?

	%
Favor	71
Oppose	28
Don't know/Refused	1

(Asked of half-sample D; n=650)

Q11. Do you favor or oppose substantially increasing federal spending on improving the nation's public health programs?

	%
Favor	71
Oppose	27
Don't know/Refused	2

Q12. Do you generally approve or disapprove of the decisions that have been made by the federal Department of Health and Human Services about COVID-19 since the start of the outbreak?

	%
Approve	49
Disapprove	47
Don't know/Refused	4

III. Views on State Public Health Systems

(Asked of half-sample B; n=650)

Q13. How familiar are you with the activities of your state's health department? Would you say you are not at all familiar, not too familiar, somewhat familiar, or very familiar with the activities of your state's health department?

	%
Very familiar	20
Somewhat familiar	55
Not too familiar	18
Not at all familiar	7
Don't know/Refused	-

(Asked of half-sample B; n=650)

Q14. Do you generally approve or disapprove of the decisions that have been made by YOUR STATE'S HEALTH DEPARTMENT about COVID-19 since the start of the outbreak?

	%
Approve	59
Disapprove	38
Don't know/Refused	3

(Asked of half-sample B; n=650)

Q15. When it comes to the COVID-19 outbreak specifically, do you think YOUR STATE'S HEALTH DEPARTMENT is doing an excellent, good, fair or poor job at responding to the COVID-19 outbreak?

	%
Excellent	16
Good	33
Fair	32
Poor	19
Don't know/Refused	*

(Asked of half-sample B; n=650)

Q16. And more generally beyond COVID-19, do you think YOUR STATE'S HEALTH DEPARTMENT is doing an excellent, good, fair or poor job at protecting the public from health threats and preventing illness?

	%
Excellent	12
Good	36
Fair	37
Poor	14
Don't know/Refused	1

(Asked of half-sample B; n=650)

Q17. On balance, do you think the information provided by YOUR STATE HEALTH DEPARTMENT about the health of people in your state is reliable, or not?

(Asked of half-sample B respondents who said the information provided by their state health department about the health of people in their state is reliable; n=455)

Q18. And would you say it is very reliable, or only somewhat reliable?

(Asked of half-sample B respondents who said the information provided by their state health department about the health of people in their state is unreliable; n=181)

Q18. And would you say it is very unreliable, or only somewhat unreliable?

Q17/Q18 Combo Table

Base: Half-sample B respondents; n=650

	%
Reliable (NET)	65
Very reliable	29
Somewhat reliable	36
Unreliable (NET)	32
Somewhat unreliable	22
Very unreliable	10
Don't know/Refused	3

IV. Views on Local Public Health Systems

(Asked of half-sample A; n=655)

Q19. How familiar are you with the activities of your LOCAL health department? Would you say you are not at all familiar, not too familiar, somewhat familiar, or very familiar with the activities of your LOCAL health department?

	%
Very familiar	17
Somewhat familiar	49
Not too familiar	23
Not at all familiar	10
Don't know/Refused	1

(Asked of half-sample A; n=655)

Q20. Do you generally approve or disapprove of the decisions that have been made by YOUR LOCAL HEALTH DEPARTMENT about COVID-19 since the start of the outbreak?

	%
Approve	66
Disapprove	28
Don't know/Refused	6

(Asked of half-sample A; n=655)

Q21. When it comes to the COVID-19 outbreak specifically, do you think YOUR LOCAL HEALTH DEPARTMENT is doing an excellent, good, fair or poor job at responding to the COVID-19 outbreak?

	%
Excellent	16
Good	35
Fair	33
Poor	15
Don't know/Refused	1

(Asked of half-sample A; n=655)

Q22. And more generally beyond COVID-19, do you think YOUR LOCAL HEALTH DEPARTMENT is doing an excellent, good, fair or poor job at protecting the public from health threats and preventing illness?

	%
Excellent	14
Good	40
Fair	34
Poor	10
Don't know/Refused	2

(Asked of half-sample A; n=655)

Q23. On balance, do you think the information provided by YOUR LOCAL HEALTH DEPARTMENT about the health of people in your local community is reliable, or not?

(Asked of half-sample A respondents who said the information provided by their local health department about the health of people in their local community is reliable; n=493)

Q24. And would you say it is very reliable, or only somewhat reliable?

(Asked of half-sample A respondents who said the information provided by their local health department about the health of people in their local community is unreliable; n=139)

Q24. And would you say it is very unreliable, or only somewhat unreliable?

Q23/Q24 Combo Table

Based on Half-sample A respondents; n=655

	%
Reliable (NET)	74
Very reliable	30
Somewhat reliable	44
Unreliable (NET)	23
Somewhat unreliable	16
Very unreliable	7
Don't know/Refused	3

Q25. How closely do you follow news about health issues in your state?

	%
Very closely	36
Somewhat closely	48
Not too closely	10
Not closely at all	5
Don't know/Refused	1

V. Views on Public Health Issue Domains

(Asked of half-sample C; n=655)

Q26. When you think of the following issues, would you consider each of the following to be one of the **main responsibilities** for **public health agencies**, or not? You can select multiple issues as being main responsibilities for public health agencies. How about (INSERT ITEM)?

- a. Controlling the spread of new infectious diseases like Ebola, Zika, or COVID-19

	%
Yes, one of the main responsibilities	91
No, not one of the main responsibilities	9
Don't know/Refused	*

- b. Responding to natural disasters, like wildfires, major hurricanes or floods

	%
Yes, one of the main responsibilities	67
No, not one of the main responsibilities	32
Don't know/Refused	1

- c. Providing vaccines to prevent illnesses like the yearly flu, measles, and mumps

	%
Yes, one of the main responsibilities	90
No, not one of the main responsibilities	9
Don't know/Refused	1

- d. Preventing the spread of HIV/AIDS

	%
Yes, one of the main responsibilities	79
No, not one of the main responsibilities	19
Don't know/Refused	2

- e. Preventing chronic diseases like heart disease, cancer, and diabetes

	%
Yes, one of the main responsibilities	80
No, not one of the main responsibilities	19
Don't know/Refused	1

- f. Reducing smoking and tobacco use

	%
Yes, one of the main responsibilities	59
No, not one of the main responsibilities	40
Don't know/Refused	1

g. Reducing alcohol abuse

	%
Yes, one of the main responsibilities	61
No, not one of the main responsibilities	38
Don't know/Refused	1

h. Reducing illegal drug abuse and addiction

	%
Yes, one of the main responsibilities	70
No, not one of the main responsibilities	29
Don't know/Refused	1

(Asked of half-sample C; n=655)

Q27. When you think of the following issues, would you consider each of the following to be one of the **main responsibilities** for **public health agencies**, or not? You can select multiple issues as being main responsibilities for public health agencies. How about (INSERT ITEM)?

a. Preventing injuries caused by motor vehicle crashes

	%
Yes, one of the main responsibilities	39
No, not one of the main responsibilities	60
Don't know/Refused	1

b. Preventing violence and deaths from guns

	%
Yes, one of the main responsibilities	40
No, not one of the main responsibilities	59
Don't know/Refused	1

c. Reducing climate change

	%
Yes, one of the main responsibilities	33
No, not one of the main responsibilities	65
Don't know/Refused	2

d. Reducing domestic violence

	%
Yes, one of the main responsibilities	56
No, not one of the main responsibilities	42
Don't know/Refused	2

e. Providing health insurance for those who don't have it

	%
Yes, one of the main responsibilities	67
No, not one of the main responsibilities	31
Don't know/Refused	2

f. Reducing the gaps in health and health care between whites and minorities

	%
Yes, one of the main responsibilities	67
No, not one of the main responsibilities	30
Don't know/Refused	3

g. Providing family planning services

	%
Yes, one of the main responsibilities	66
No, not one of the main responsibilities	32
Don't know/Refused	2

h. Reducing eviction and homelessness

	%
Yes, one of the main responsibilities	49
No, not one of the main responsibilities	51
Don't know/Refused	*

(Asked of half-sample D; n=650)

Q28. When you think of the following issues, would you consider each of the following to be one of the **main responsibilities** for **public health agencies**, or not? You can select multiple issues as being main responsibilities for public health agencies. How about (INSERT ITEM)?

a. Preparing the public in advance to handle health problems or injuries resulting from emergency events, such as bombings or terrorist attacks

	%
Yes, one of the main responsibilities	74
No, not one of the main responsibilities	25
Don't know/Refused	1

b. Improving diet and physical activity

	%
Yes, one of the main responsibilities	60
No, not one of the main responsibilities	39
Don't know/Refused	1

c. Reducing infant mortality and preterm birth

	%
Yes, one of the main responsibilities	80
No, not one of the main responsibilities	17
Don't know/Refused	3

d. Preventing and treating mental illness

	%
Yes, one of the main responsibilities	87
No, not one of the main responsibilities	12
Don't know/Refused	1

e. Reducing health care costs

	%
Yes, one of the main responsibilities	75
No, not one of the main responsibilities	23
Don't know/Refused	2

f. Reducing the gaps in health care between men and women

	%
Yes, one of the main responsibilities	65
No, not one of the main responsibilities	33
Don't know/Refused	2

g. Reducing shortages of health professionals, hospitals, and community health centers

	%
Yes, one of the main responsibilities	76
No, not one of the main responsibilities	22
Don't know/Refused	2

h. Improving air and water quality

	%
Yes, one of the main responsibilities	72
No, not one of the main responsibilities	26
Don't know/Refused	2

(Asked of half-sample D; n=650)

Q29. When you think of the following issues, would you consider each of the following to be one of the **main responsibilities** for **public health agencies**, or not? You can select multiple issues as being main responsibilities for public health agencies. How about (INSERT ITEM)?

a. Cleaning up the environment

	%
Yes, one of the main responsibilities	60
No, not one of the main responsibilities	38
Don't know/Refused	2

b. Enforcing standards for safe drinking water

	%
Yes, one of the main responsibilities	90
No, not one of the main responsibilities	10
Don't know/Refused	*

c. Safely disposing of garbage

	%
Yes, one of the main responsibilities	66
No, not one of the main responsibilities	33
Don't know/Refused	1

d. Reducing causes of food poisoning, such as salmonella or E. coli

	%
Yes, one of the main responsibilities	88
No, not one of the main responsibilities	12
Don't know/Refused	*

e. Increasing the availability of healthy, affordable housing

	%
Yes, one of the main responsibilities	50
No, not one of the main responsibilities	48
Don't know/Refused	2

f. Reducing sexual violence

	%
Yes, one of the main responsibilities	58
No, not one of the main responsibilities	40
Don't know/Refused	2

g. Reducing racism

	%
Yes, one of the main responsibilities	43
No, not one of the main responsibilities	55
Don't know/Refused	2

h. Reducing prescription painkiller abuse and addiction

	%
Yes, one of the main responsibilities	75
No, not one of the main responsibilities	23
Don't know/Refused	2

i. Providing vaccines to prevent the spread of COVID-19

	%
Yes, one of the main responsibilities	92
No, not one of the main responsibilities	8
Don't know/Refused	*

Q26/Q27/Q28/Q29 Yes, one of the main responsibilities Summary

	%
Providing vaccines to prevent the spread of COVID-19 ^d	92
Controlling the spread of new infectious diseases like Ebola, Zika, or COVID-19 ^c	91
Providing vaccines to prevent illnesses like the yearly flu, measles, and mumps ^c	90
Enforcing standards for safe drinking water ^d	90
Reducing causes of food poisoning, such as salmonella or e coli ^d	88
Preventing and treating mental illness ^d	87
Reducing infant mortality and preterm birth ^d	80
Preventing chronic diseases like heart disease, cancer, and diabetes ^c	80
Preventing the spread of HIV/AIDS ^c	79
Reducing shortages of health professionals, hospitals, and community health centers ^d	76
Reducing health care costs ^d	75
Reducing prescription painkiller abuse and addiction ^d	75
Preparing the public in advance to handle health problems or injuries resulting from emergency events, such as bombings or terrorist attacks ^d	74
Improving air and water quality ^d	72
Reducing illegal drug abuse and addiction ^c	70
Reducing the gaps in health and health care between whites and minorities ^c	67
Providing health insurance for those who don't have it ^c	67
Responding to natural disasters, like wildfires, major hurricanes or floods ^c	67
Providing family planning services ^c	66
Safely disposing of garbage ^d	66
Reducing the gaps in health care between men and women ^d	65
Reducing alcohol abuse ^c	61
Cleaning up the environment ^d	60
Improving diet and physical activity ^d	60
Reducing smoking and tobacco use ^c	59
Reducing sexual violence ^d	58
Reducing domestic violence ^c	56
Increasing the availability of healthy, affordable housing ^d	50
Reducing eviction and homelessness ^c	49
Reducing racism ^d	43
Preventing violence and deaths from guns ^c	40
Preventing injuries caused by motor vehicle crashes ^c	39
Reducing climate change ^c	33

^c Asked of half-sample C; n=655.

^d Asked of half-sample D; n=650.

VI. Special Demographics

Q30. Since the start of the COVID-19 outbreak, have you or anyone else in your household lost their job, their business, been furloughed, had their wages or hours reduced, or taken mandatory unpaid leave, or not?

	%
Yes	45
No	55
Don't know/Refused	*

Q31. Does anyone living in your household receive any government assistance from SNAP, the Supplemental Nutrition Assistance Program, or WIC, the Women, Infants, and Children Program, or not?

	%
Yes	15
No	84
Don't know/Refused	1

Q32. Are you, yourself, currently covered by any form of health insurance or health plan, or do you not have health insurance at this time?

(Asked of respondents who are who are covered by health insurance; n=1,106)

Q33. Which of the following is your main source of health insurance coverage?

(Asked of respondents with Medicaid or Medicare; n=479)

Q34. Do you also have coverage from Medicare/Medicaid, or not?

Q32/Q33/Q34 Combo Table

Based on total respondents

	%
Covered by health insurance	86
A plan through your or your spouse's employer or union	39
A plan you purchased yourself	8
Medicare (%)	21
Medicaid (%)	14
Medicare, not Medicaid	16
Medicaid, not Medicare	9
Medicare + Medicaid	5
The VA or Tricare	4
Indian Health Service (IHS)	-
Plan through your parent/mother/father	4
Some other form of insurance	1
Don't know/Refused what type of coverage	1
Not covered by health insurance	14
Don't know/Refused if covered by health insurance	*

D13. In general, how would you describe your own health?

	%
Excellent	19
Very good	29
Good	30
Fair	15
Poor	7
Don't know/Refused	-

Q35. Do you have any disability that keeps you from participating fully in work, school, housework, or other activities?

	%
Yes	21
No	79
Don't know/Refused	*

Q36. Has a doctor or other health care professional ever told you that you have a chronic illness, such as heart disease, lung disease, cancer, diabetes, high blood pressure, asthma or a mental health condition, or hasn't that happened?

	%
Yes	44
No	55
Don't know/Refused	1

Q37. Do you personally know anyone, such as a close friend or family member, who has died due to complications from COVID-19?

	%
Yes	35
No	65
Don't know/Refused	*

VII. Demographics

D1. Are you registered to vote at your present address, or not?

Yes	No	Don't know/ Refused
78	21	1

D2. Just to confirm: What is your current age?

D2a. Could you please tell me if you are...?

18 to 29	30 to 49	50 to 64	65 or older
20	33	25	22

D3. Were you born in the United States, on the island of Puerto Rico, or in another country?

	%
U.S.	83
Puerto Rico	*
Another country	16
Don't know/Refused	1

D4. What is the last grade or class that you completed in school?

	%
High School or less (NET)	39
Less than high school (grades 1-11, grade 12 but no diploma)	9
High school graduate or equivalent (e.g. GED)	30
Some college but no degree (incl. 2 year occupational or vocational programs)	29
College or post-graduate (NET)	32
College graduate (e.g. BA, AB, BS)	20
Postgraduate (e.g. MA, MS, MEng, Med, MSW, MBA, MD, DDs, PhD, JD, LLB, DVM)	12
Don't know/Refused	*

D5. Are you currently married, living with a partner, divorced, separated, widowed or have you never been married?

	%
Married	50
Living with partner	6
Divorced	8
Separated	3
Widowed	7
Never been married	24
Refused	2

PARTY. In politics today, do you consider yourself a (Republican), (Democrat), an Independent, or what?

Republican	Democrat	Independent	Other/None	Don't know/ Refused
25	31	29	11	4

PARTY. In politics today, do you consider yourself a (Republican), (Democrat), an Independent, or what?

(Asked of those who consider themselves independent, other party, Don't know/Refused or refused to say; n=558)

PARTYLEAN. Do you LEAN more towards the (Republican) Party or the (Democratic) Party?

**Party/Partylean Combo Table
Based on total respondents**

	%
Republican/Republican leaners	36
Democrat/Democratic leaners	46
Independent	12
Other party	1
Don't know/refused	5

D6. Last year, that is in 2020, what was your % annual household income from all sources, BEFORE taxes? Just stop me when I get to the right category.

D6a. Could you tell me if your % annual household income is less than 50 thousand, 50 thousand but less than 100 thousand, or over 100 thousand dollars?

D6b. Is that 100 to under 150 thousand, 150 to under 200 thousand, 200 to under 250 thousand, or 250 thousand dollars or more?

	%
Less than \$50,000 (NET)	44
Under \$15,000	11
\$15,000 to under \$20,000	8
\$20,000 to under \$25,000	6
\$25,000 to under \$35,000	9
\$35,000 to under \$50,000	9
Less than \$50,000 unspecified	1
\$50,000 but less than \$100,000 (NET)	25
\$50,000 to under \$75,000	13
\$75,000 to under \$100,000	11
\$50,000 but less than \$100,000 unspecified	1
Over \$100,000 (NET)	24
\$100,000 to under \$150,000	12
\$150,000 to under \$200,000	7
\$200,000 to under \$250,000	2
\$250,000 or more	2
Over \$100,000 unspecified	*
Don't know	3
Refused	4

D10. Are you, yourself, of Latino or Hispanic origin or descent, such as Mexican, Puerto Rican, Cuban, or some other Latin American background?

D11. (And besides being Latino,) What is your race? Are you white, black or African American, Asian, American Indian or Alaska Native, or Native Hawaiian or other Pacific Islander?

(Asked of respondents who are Hispanic and American Indian/Alaskan Native; n=17)

D12. With which do you identify more? Hispanic or Latino, or American Indian or Alaska Native?

Race Table

Based on total respondents

	%
Hispanic	16
Non-Hispanic White	62
Non-Hispanic Black	12
Non-Hispanic Asian	4
American Indian/Alaskan Native	2
Non-Hispanic Else	2
Non-Hispanic Native Hawaiian/Pacific Islander	1
Non-Hispanic No Answer	1

RSEX. Are you male or female?

	%
Male	49
Female	51
Other (vol)	*
Don't know/Refused	-

D7. Do you consider yourself to be...?

LGBQ Identity Table
Based on total respondents

	%
Straight/Heterosexual	88
LGBQ (NET)	6
Gay/Lesbian	2
Bisexual	3
Queer/Other	1
Don't know/Refused	6

D8. Some people describe themselves as transgender when they experience a different gender identity from their sex at birth. For example, a person who was raised male, but who identifies as female. Some people who do not identify as either male or female might also call themselves transgender. Do you consider yourself to be transgender?

Transgender	Genderqueer or gender non-conforming	No	Don't know/Refused
1	*	96	3

LGBTQ Identity Table
Based on total respondents

	%
LGBTQ	7
Cis and Straight	86
Don't know/Refused	7

HH1. How many adults 18 or older live in your household? Please include yourself and all the adults who live with you.

	%
1	22
2	49
3	19
4	7
5	1
6	1
7 or more	1
Don't know/Refused	*

D15. How many children under 18 are currently living in your household?

	%
One or more children <18 (NET)	34
1	15
2	12
3	5
4	2
5 or more	*
No children under 18 living in household	65
Don't know/Refused	1

Health Policy Brief

May 2021

A Snapshot of California's Whole Person Care Pilot Program: Implementation Strategies and Enrollees

Nadereh Pourat, Brenna O'Masta, Leigh Ann Haley, and Emmeline Chuang

“The Whole Person Care Pilot program coordinates medical, behavioral, and social services to improve the health and well-being of Medi-Cal beneficiaries with complex needs.”

SUMMARY: The Whole Person Care (WPC) Pilot program implemented under California's Section 1115 Medicaid Waiver, "Medi-Cal 2020," coordinates medical, behavioral, and social services to improve the health and well-being of Medi-Cal beneficiaries with complex needs. In this policy brief, we analyze data from the interim statewide evaluation of WPC to present a snapshot of the 25 participating pilots,

based on key implementation strategies and enrollee characteristics. The data can be used by organizations that are developing population health management programs for high-need, high-risk Medi-Cal beneficiaries under the California Advancing and Innovating Medi-Cal (CalAIM) initiative, as well as by other programs providing care to low-income patients.

A small proportion of the insured population is responsible for a relatively large proportion of the health services used in the United States.¹ Many of these individuals have complex medical, behavioral health, and social needs that require an integrated approach to care.² In 2016, the California Department of Health Care Services (DHCS) began a demonstration program called Whole Person Care (WPC) to promote the integrated delivery of care for Medi-Cal beneficiaries who use acute and costly services in multiple care areas. Under WPC, eligible beneficiaries receive care coordination and other services not traditionally covered by Medi-Cal to address medical, behavioral health, and social needs, with the aim of improving their health outcomes and overall well-being.

In 2017, 25 WPC pilots in 26 counties began enrolling eligible Medi-Cal beneficiaries. Pilots had flexibility in the specific target

populations served and in how WPC was implemented.³ WPC was originally scheduled to end in December 2020 but was extended for a year due to the COVID-19 pandemic.

Some of the services provided under WPC will be incorporated into CalAIM, a multiyear initiative planned by DHCS that is designed to use WPC approaches to improve beneficiaries' health outcomes. Under CalAIM, Medi-Cal managed care plans are expected to provide Enhanced Care Management (ECM) and In Lieu of Services (ILOS) through contracts with community-based providers, including organizations participating in WPC.⁴ CalAIM is expected to begin implementation in January 2022. This policy brief provides a snapshot of each pilot's implementation strategies and enrollee characteristics to inform CalAIM transition planning. Data are drawn from the statewide evaluation of WPC conducted by the UCLA Center for Health Policy Research.^{5,6}

“The data indicate the importance of tailoring future efforts to the unique needs of various subgroups of Medi-Cal enrollees.”

WPC Program Implementation Strategies

Exhibit 1 provides insight into similarities and differences by county across pilots in the target populations served, strategies used to identify and enroll eligible beneficiaries, care coordination approaches, other WPC services offered, and engagement of social service providers as partners. For example, data show that 16 pilots provided services to more than one target population, and 16 used street- or shelter-based outreach to identify eligible enrollees. Thirteen pilots used a single dedicated care coordinator to follow enrollees across all WPC-participating care settings, and 17 used co-located staff from different service sectors to facilitate access to care. Care coordinators' caseloads varied significantly across pilots (from 10 to 300), reflecting differing levels of enrollee need and intensity of services provided. Highlighting the importance of housing support to enrollees, 12 pilots offered tenancy support, landlord incentives, and funds to support housing placement. Many provided medical respite (18) and sobering centers (14).

WPC Enrollee Characteristics

Exhibit 2 provides insight into the WPC enrollee profile by county, including enrollment information, the demographics and health status of enrollees, and the utilization of services by these individuals prior to WPC enrollment. Pilots differed in multiple elements, such as the number of enrollees served (from fewer than 300 to more than 10,000); average length of enrollment (3–17 months); inclusion of adults 65 years of age or older (1%–22%); individuals experiencing homelessness (4%–100%); those affected by mental health conditions (30%–87%) or substance use disorders (12%–67%); and those ever involved with the justice system during enrollment (0%–100%). Data showed considerable variation across pilots in the average use of services pre-WPC (per enrollee, per year) for outpatient services (7.4–50.4), ED visits (1–5.8), and hospitalization rates (0.3–2.2).

WPC Pilot Profiles

Collectively, these data demonstrate how individual pilots tailored their approaches to address community-specific needs. For example, Los Angeles County's WPC pilot focused on all six target populations and used multiple programs and forms of outreach to identify and enroll eligible beneficiaries. A diverse care coordination team that included peer staff helped link enrollees to a medical home and services such as housing and medical respite. In another example, Riverside County's WPC pilot focused on serving the justice-involved population; co-located WPC enrollment staff with probation staff to enroll individuals in jails and prisons prior to release; and used a single dedicated care coordinator (typically, a registered nurse) to connect enrollees to a medical home and services, including employment assistance.

Implications for Transition to CalAIM

This snapshot is intended to inform efforts to transition the WPC program into ECM and ILOS components of CalAIM. Heterogeneity across pilots in program implementation and enrollee characteristics highlights the importance of tailoring future efforts to the unique needs of various subgroups of Medi-Cal enrollees with high utilization of services. In some counties, a narrower focus on specific target populations or smaller enrollment indicate that additional work is needed to expand enrollment to everyone with high levels of need and service use. The data also reflect the level of effort necessary to establish a specific infrastructure for effectively serving identified target populations.

Exhibit 1 WPC Program Implementation Elements by Pilots as of July 2020

	Alameda	Contra Costa	Kern	Kings	Los Angeles	Marin	Mariposa (SCW/PCC)	Mendocino	Monterey	Napa	Orange	Placer	Riverside
Primary target population													
1. High utilizer	1	1	1		1	1	1		2	2	2	1	
2. Homeless	2		2		2	2				3	2	2	
3. At risk of homelessness			3		3	3						3	
4. Chronic physical conditions				4	4							4	
5. Severe mental illness/substance use disorders (SMI/SUD)				5	5		5	5			5	5	
6. Justice-involved			6	6	6							6	6
Enrollment Strategies													
Identification approach													
1. Street- or shelter-based outreach			1	1	1	1			1		1	1	
2. Health care facility outreach		2	2	2	2	2			2		2	2	
3. Referrals		3	3	3	3	3	3		3		3	3	3
4. Administrative data (e.g., health plan eligibility lists)	4		4			4	4		4			5	
5. Predictive modeling based on program criteria		5											
Enrollment approach													
1. At health care facilities			1	1	1	1	1	1			1	1	1
2. Warm handoff at co-located organization		2	2	2	2	2	2	2			2	2	2
3. On street, at shelter, or other community-based location			3	3	3	3	3	3			3	3	3
4. By telephone			4	4	4	4	4	4			4	4	4
5. Auto-enrollment and opt out	5	5			5								
Care Coordination Approach													
Organization of care coordinators (CC)													
1. Single CC	1	1	1	1			1	1		-		1	1
2. Multiple CCs					2	2			2		2		
Average CC caseload (by tier)	15	(25, 80, 300)	-	(30, 75)	25	(17, 30)	10	19	43	40	35	20	50
Selected types of staff included in care coordination team													
1. CHW or staff with lived experience	1	1		1	1	1	1	1			1	1	1
2. Licensed social worker or psychologist	2	2	2		2	2	2	2	2	-	2	2	2
3. Physician or nurse practitioner	3	3	3		3	3	3	3			3	2	3
Type of co-located staff to facilitate access to services and resources													
1. Medical	1	1	1	1	1	1	1		1		1		1
2. Mental health	2		2	2	2	2	2		2		2		2
3. Housing						3					3		
4. Non-housing social services		4	4	4	4	4	4	4			4	4	
5. Substance abuse			5	5	5	5	5	5			5		5
CCs have real-time access to at least some of the following data:													
1. Medical	1	1	1	1	1	1	No	1	No		1	1	1
2. Behavioral health	2	2	2	2	2	2				-		2	2
3. Social services	3	3	3	3	3	3		3				3	3
Care coordinators can access needs assessment, comprehensive care plan, and referrals in the same system		✓	✓	✓	✓	✓	✓	✓	✓	-	✓		
Selected WPC Services Offered													
Housing-related services													
1. Housing navigation, tenancy support	1	1	1	1	1	1	1	1	1		1	1	1
2. Landlord incentives	2		2		2	2	2	2	2		2	2	2
3. Funds (e.g., security deposit, utilities)	3	3	3		3	3	3	3	3		3	3	3
Selected other services													
1. Employment assistance		1	1	1	1	1	1	1	1		1	1	1
2. Sobering center	2			2	2	2	2	2	2				2
3. Recuperative care (medical respite)	3		3		3	3	3	3	3		3	3	3
Partnership Characteristics													
Total number of organizations participating in WPC pilot	42	12	15	8	50	39	11	8	17	12	34	24	14
Types of partners with highest engagement with WPC administration													
1. Housing	1		1		1	1		None	1	1	1	1	1
2. Justice	2	2	2	2	2	2	2		2	2	2	2	2
3. Other social services	3	3	3	3	3	3	3		3	3	3	3	3

Note: Unavailable data are indicated by a dash (-).

(Exhibit 1 continues on next page)

WPC Program Implementation Elements by Pilots as of July 2020

Exhibit 1

	Sacramento	San Benito (SCWPCC)	San Bernardino	San Diego	San Francisco	San Joaquin	San Mateo	Santa Clara	Santa Cruz	Shasta	Solano	Sonoma	Ventura
Primary target population													
1. High utilizer	1	1	1	1	2	1	1	1		1	1	2	1
2. Homeless	2	2		2		2						3	
3. At risk of homelessness		3		3		3						3	
4. Chronic physical conditions						5			4		5	5	
5. Severe mental illness/substance use disorders (SMI/SUD)									5				
6. Justice-involved													
Enrollment Strategies													
Identification approach													
1. Street- or shelter-based outreach	1	1		1	1	1	1			1		1	1
2. Health care facility outreach	2	2		2	2	2	2	2		2	2		2
3. Referrals	3	3		3	3	3	3	3	3	3	3	3	3
4. Administrative data (e.g., health plan eligibility lists)	4	4	4		4	4	4	4	4		4	4	4
5. Predictive modeling based on program criteria			5		5			5					5
Enrollment approach													
1. At health care facilities	1	1	1	1		1	1	1	1	1	1	1	1
2. Warm handoff at co-located organization	2	2	2	2		2	2	2	2	2	2	2	2
3. On street, at shelter, or other community-based location		3	3	3		3	3	3	3	3	3	3	3
4. By telephone				4			4	4	4			4	4
5. Auto-enrollment and opt out					5								
Care Coordination Approach													
Organization of care coordinators (CC)													
1. Single CC		1				1		1	1		1	-	
2. Multiple CCs	2		2	2	2		2			2			2
Average CC caseload (overall and by tier)	(55, 75)	13	55	(5, 13)	176	75	(6, 31)	30	30	23	35	20	(50, 100)
Selected types of staff included in care coordination team													
1. CHW or staff with lived experience	1	None	1	1	1	1	1	1	1		1	1	1
2. Licensed social worker or psychologist	2			2	2	2	2	2	2	2	2	2	2
3. Physician or nurse practitioner	3			3	3	3	3	3	3			3	3
Type of co-located staff to facilitate access to services and resources													
1. Medical	1		None	None	1		None	1	None	None	None	None	
2. Mental health		2				-							
3. Housing	3	3			3								3
4. Non-housing social services		4			4			4					
5. Substance abuse		5											
CCs have real-time access to at least some of the following data:													
1. Medical	1	1	No	1	No	1	1	No	1	No		-	1
2. Behavioral health	2	2									2		2
3. Social services	3	3		3		3	3				3		3
Care coordinators can access needs assessment, comprehensive care plan, and referrals in the same system	✓	✓	✓	✓	✓	✓					✓	-	✓
Selected WPC Services Offered													
Housing-related services													
1. Housing navigation, tenancy support	1	1	1	1	1	1		1	1	1	1	-	1
2. Landlord incentives	2	2						2					
3. Funds (e.g., security deposit, utilities)	3	3		3	3		3	3	3	3			
Selected other services													
1. Employment assistance	1	1		1				1		1	1	1	1
2. Sobering center		2	2		2	2	2	2		2		2	
3. Recuperative care (medical respite)	3	3	3	3	3	3		3	3	3		3	3
Partnership Characteristics													
Total number of organizations participating in WPC pilot	31	10	9	20	9	25	8	43	18	15	11	16	46
Types of partners with highest engagement with WPC administration													
1. Housing	1	1			1	1	1	1	None	1		1	1
2. Justice	2		2	2		2							2
3. Other social services	3	3	3	3	3			3		3	3	3	3

Note: Unavailable data are indicated by a dash (-).

Exhibit 2 WPC Enrollment Profile by Pilots for the First Two Program Years, 2017–2018

	Alameda	Contra Costa	Kern	Kings	Los Angeles	Marin	Mariposa (SCW/PCC)	Mendocino	Monterey	Napa	Orange	Placer	Riverside
Primary target population													
1. High utilizer	1	1	1		1	1	1		2	2	2	1	
2. Homeless	2		2		2	2				3		2	
3. At risk of homelessness			3		3	3						3	
4. Chronic physical conditions				4	4							4	
5. Severe mental illness/substance use disorders (SMI/SUD)				5	5		5	5			5	5	
6. Justice-involved			6	6	6							6	6
Enrollment Characteristics													
Total enrollment				1			1	1	1	1		1	
1. Up to 300													
2. 301–1,000			2			2							
3. 1,001–10,000	3	4			4						3		3
4. >10,000													
Ever disenrolled (%)	10	56	4	49	66	2	–	15	44	38	57	63	15
Mean length of overall enrollment, in months	7	13	5	7	11	3	5	9	14	9	11	14	6
Enrollee Demographics													
Age 0–20 at enrollment (%)	3	5	2	–	1	–	0	–	0	–	3	0	3
Age 45–64 at enrollment (%)	48	38	41	33	48	53	63	50	62	48	50	63	21
Age 65 years or older at enrollment (%)	6	15	4	–	5	12	–	10	14	5	7	10	1
Male (%)	56	40	53	55	62	63	52	50	48	61	59	58	76
White (%)	22	27	34	37	21	61	85	76	34	69	48	75	33
African American or Black (%)	44	22	13	11	35	16	0	–	–	–	6	–	15
Latinx (%)	12	24	41	43	28	10	–	7	34	19	25	7	43
Ever homeless during enrollment (%)	19	4	31	15	51	64	–	46	95	100	100	97	27
Ever justice-involved during enrollment (%)	–	–	42	30	2	0	–	48	–	0	0	20	100
Enrollee Health Status at Enrollment (Light Orange = Lowest %; Dark Orange = Highest %)													
Any chronic physical health condition (%)	73	59	53	64	69	69	82	85	89	75	61	72	37
Hypertension (%)	24	21	22	15	20	20	41	19	40	21	18	21	5
Diabetes (%)	11	15	12	13	12	8	–	12	30	11	9	12	2
Any chronic mental health condition (%)	65	33	30	54	58	62	67	80	71	70	49	66	33
Any substance use disorder (%)	38	12	15	22	24	37	–	48	52	50	31	44	23
Pre-WPC Utilization per Enrollee per Year (Light Orange = Lowest Quartile; Dark Orange = Highest Quartile)													
Number of outpatient services	22	10	20	15	20	19	20	33	27	16	11	13	7
Number of outpatient mental health services	11	3	3	5	11	6	6	19	8	4	4	4	3
Number of outpatient substance use disorder services	4	1	6	2	3	2	1	2	3	4	2	2	2
Number of emergency department visits	2.3	1.0	1.5	2.0	2.3	2.0	3.6	2.7	5.0	2.2	2.3	2.6	1.3
Number of hospitalizations	1.0	0.5	0.3	0.3	1.0	0.6	0.5	0.3	1.2	0.4	0.6	0.6	0.3

Notes: Unavailable or sparse data are indicated by a dash (–).

(Exhibit 2 continues on next page)

Health status conditions are based on CMS' Chronic Condition Warehouse condition categories.

Utilization is measured during two years pre-WPC enrollment.

Outpatient services include any service not provided in an inpatient setting, at the emergency department, or through long-term care.

WPC Enrollment Profile by Pilots for the First Two Program Years, 2017–2018

Exhibit 2

	Sacramento	San Benito (SCWPCC)	San Bernardino	San Diego	San Francisco	San Joaquin	San Mateo	Santa Clara	Santa Cruz	Shasta	Solano	Sonoma	Ventura
Primary target population													
1. High utilizer	1	1	1	1	2	1	1	1		1	1	2	1
2. Homeless	2	2		2	2	2						3	
3. At risk of homelessness		3		3		3						3	
4. Chronic physical conditions						5			4		5	5	
5. Severe mental illness/substance use disorders (SMI/SUD)									5			5	
6. Justice-involved													
Enrollment Characteristics													
Total enrollment													
1. Up to 300		1		1						1	1		
2. 301–1,000	2		2			2	3	3	2			2	
3. 1,001–10,000					4								3
4. >10,000													
Ever disenrolled (%)	31	53	28	5	43	13	40	17	10	74	43	38	13
Mean length of overall enrollment, in months	8	5	11	5	14	7	16	17	13	12	13	5	11
Enrollee Demographics													
Age 0–20 at enrollment (%)	–	0	8	0	0	0	1	1	–	–	0	4	1
Age 45–64 at enrollment (%)	61	74	44	78	50	50	44	59	49	67	58	42	57
Age 65 years or older at enrollment (%)	8	–	6	–	8	4	22	8	22	–	9	11	3
Male (%)	57	52	45	58	72	52	52	49	60	50	48	50	46
White (%)	38	56	22	50	29	40	34	29	57	77	32	58	42
African American or Black (%)	31	0	18	15	31	18	7	8	–	–	35	5	4
Latinx (%)	9	41	46	11	11	26	27	34	11	5	10	12	38
Ever homeless during enrollment (%)	98	97	4	61	100	47	34	41	54	98	50	–	59
Ever justice-involved during enrollment (%)	0	61	0	9	–	14	0	0	15	0	–	0	0
Enrollee Health Status at Enrollment (Light Orange = Lowest %; Dark Orange = Highest %)													
Any chronic physical health condition (%)	61	82	86	85	64	74	85	81	89	89	91	74	82
Hypertension (%)	24	–	31	39	15	28	38	34	27	29	50	20	31
Diabetes (%)	14	–	21	25	6	14	23	25	14	19	28	12	19
Any chronic mental health condition (%)	49	85	71	70	57	63	62	53	87	80	65	70	67
Any substance use disorder (%)	33	67	24	51	42	38	31	28	35	53	46	41	43
Pre-WPC Utilization per Enrollee per Year (Light Orange = Lowest Quartile; Dark Orange = Highest Quartile)													
Number of outpatient services	19	16	24	31	23	26	26	22	50	24	27	22	26
Number of outpatient mental health services	4	5	10	8	8	9	10	5	29	6	4	9	7
Number of outpatient substance use disorder services	8	3	5	4	10	4	4	2	9	2	2	4	3
Number of emergency department visits	2.9	4.5	2.9	5.8	3.2	5.0	3.6	2.6	2.8	4.0	5.1	2.4	3.3
Number of hospitalizations	0.7	1.0	1.7	1.9	0.8	0.7	2.2	0.9	0.8	0.7	1.5	1.2	0.8

Notes: Unavailable or sparse data are indicated by a dash (–).

Health status conditions are based on CMS' Chronic Condition Warehouse condition categories.

Utilization is measured during two years pre-WPC enrollment.

Outpatient services include any service not provided in an inpatient setting, at the emergency department, or through long-term care.

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Data and Methodology

Data in Exhibit 1 are from a questionnaire administered to all pilots in June–July 2020. Designation of lowest and highest percentages or utilization in Exhibit 2 are identified by examining the distribution of each indicator across pilots and selecting the lowest and highest 25% or quartile.

For more detailed methods, please refer to the UCLA Center for Health Policy Research publication *Interim Evaluation of California's Whole Person Care (WPC) Program* (see Endnote 6).

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Pourat N, O'Masta B, Haley LA, Chuang E. 2021. *A Snapshot of California's Whole Person Care Pilot Program: Implementation Strategies and Enrollees*. Los Angeles, CA: UCLA Center for Health Policy Research.

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Changing the “Family Glitch” Would Make Health Coverage More Affordable for Many Families

Matthew Buettgens and Jessica Banthin

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Under the Affordable Care Act (ACA), families are generally ineligible for Marketplace premium tax credits (PTCs) if a family member is offered worker-only coverage through an employer that is deemed affordable. The cost of covering the entire family, however, is not considered and may be unaffordable. Coverage is considered affordable if employee contributions for worker-only coverage do not exceed 9.83 percent of family income.¹ In this brief, we investigate the impact of a proposed change that some legal experts believe the US Treasury Department and Internal Revenue Service could make through administrative action or that could be made through legislation: If family coverage is unaffordable, all family members except workers with affordable offers of single coverage would be eligible for Marketplace PTCs.

We find that if this change were made,

- 4.8 million people would be made eligible for premium tax credits (90 percent of them are already purchasing health coverage at more than 9.83 percent of their family income);
- not all of those gaining eligibility for PTCs would be better off switching, but 710,000 more people would enroll in Marketplace coverage with PTCs; in addition, just over 90,000 family members—mainly children—would newly enroll in Medicaid or the Children’s Health Insurance Program (CHIP) owing to their parents seeking Marketplace coverage;
- most new Marketplace, Medicaid, and CHIP enrollees would switch from employer-sponsored insurance (ESI), but there would be 190,000 fewer uninsured people;
- families switching from ESI would save about \$400 per person in premiums on average, accounting for the tax advantage of ESI; families with incomes below 200 percent of the federal poverty level (FPL) would save \$580 per person;

- health insurance premiums in the nongroup market would decline nationwide by about 1 percent, on average, because the new enrollees would generally be healthier than existing ones; and
- the change would cost the federal government \$2.6 billion a year, a 0.6 percent increase in federal spending on acute health care for the nonelderly. This includes new federal spending on health care, offset by additional tax revenue, and savings on uncompensated care spending. State government spending would increase by \$121 million, a 0.1 percent increase. This would be partially offset by additional state and local tax revenue, which we are unable to compute.

Introduction

Since 2014, the health insurance Marketplaces established in every state by the ACA have become an important and stable source of health coverage for millions of Americans. Enrollment has been steady through two changes in presidential administration and years of major policy changes and uncertainties. In 2020, Marketplace enrollment reached its highest level since 2016,² and the American Rescue Plan Act is expected to increase enrollment even further in the next two years.

More than four-fifths of Marketplace enrollees receive federal financial assistance (Buettgens and Banthin 2020). Under the ACA, people with incomes between 100 percent and 400 percent of FPL may qualify for PTCs that reduce the cost of purchasing private health coverage in the Marketplaces.³ If their income is below 250 percent of FPL, they may also receive cost-sharing reductions (CSRs) that lower their out-of-pocket health spending. Since the enactment of the ACA, millions of Americans have enrolled in private health coverage with PTCs and CSRs.

But there are important restrictions on eligibility for this assistance other than income. PTC recipients must be lawfully present in the United States. PTCs are not available to those eligible for Medicaid or other types of public coverage. As a result, the lower limit for PTC eligibility is 138 percent of FPL (or higher) in states that have expanded eligibility under the ACA. Finally, to be eligible, a family must generally not have a family member with an affordable offer of employer coverage, as defined by the law. This controversial test is the subject of this brief. Under current rules, employer-sponsored insurance is deemed affordable if the cost of employee-only coverage is no more than 9.83 percent of family income in 2021. All family members are ineligible for PTCs to purchase Marketplace coverage if just one family member has an affordable offer of coverage (and family coverage is available) from an employer. This is the case even if the cost of coverage for the whole family is greater than 9.83 percent of family income. This problem is often called the “family glitch.”

Changing the Family Glitch

Some legal experts believe the Treasury Department has administrative authority to alter the affordability test to consider the cost of family coverage as it affects family members. These experts

argue that because the affordability of employer-sponsored insurance is described in different language in different sections of the ACA, the Treasury Department has discretion to interpret the statutory language either way. Under this scenario, the department would interpret the statute in such a way that a spouse or a child in a family with an affordable offer for the employee but an unaffordable offer of family coverage would be eligible for PTCs to enroll in the Marketplace. The employee would continue to be ineligible for the subsidies. In this brief, we consider the impact of such a change on health insurance coverage and costs. Such a change could be also be made through legislation if a change through administrative action is not possible.

One limitation of the proposed change is that the amount of the PTC would not be adjusted for the cost of employee-only employer coverage. Accordingly, maintaining coverage for the entire family would generally require purchasing employee-only coverage through an employer and contributing to Marketplace coverage for the dependents up to the maximum amount required based on family income. As a result, the family might still need to pay more than 9.83 percent of income for coverage when the cost of coverage for the worker is added to the cost of Marketplace coverage for the other family members. This cost of paying two premiums is sometimes called “premium stacking” and limits the potential savings of the policy change for many families.

Another important factor that limits the potential gain in affordability from changing the family glitch is the exclusion from taxes of employer-provided health insurance benefits. When workers receive health insurance through their jobs, the value of the benefit is not counted as income for tax purposes. The value of the tax exclusion increases with the worker’s income, and for high-income workers, this tax subsidy can add up to as much as 40 percent of the cost of premiums, when accounting for both federal and state taxes (Maag et al. 2012). A family moving from family employer coverage to a combination of single employer and family Marketplace coverage must weigh the difference in premiums after accounting for all tax savings.⁴ Since PTC amounts are larger for families with lower incomes, the combination of these two relationships means that among families with incomes between 100 percent and 400 percent of FPL who gain eligibility for tax credits, those with lower incomes are more likely to benefit from the proposed change than families with higher incomes.

In this study, we used the Urban Institute’s Health Insurance Policy Simulation Model to estimate the number of people who would gain eligibility for tax credits under the proposed change, how health coverage would change as a result, the savings in health care costs among those taking advantage of their new eligibility, and effects on health spending and the federal deficit. The proposed change would be permanent, so we conduct this analysis without including the temporary enhancements to Marketplace subsidies in the American Rescue Plan Act.

Methods

This study updates our 2016 estimates of the effects of changing the family glitch (Buettgens, Dubay, and Kenney 2016). A key difference from that earlier study is that we consider only a change in eligibility for tax credits for the dependents of a worker with an affordable offer of single coverage if

family coverage is too expensive or unavailable. The worker with an affordable offer of single coverage remains ineligible for tax credits, and so the impact on employer decisions to offer coverage is small. Under option 1 in the 2016 paper, which made the entire family eligible for PTCs if family coverage was unaffordable, employer decisions to offer insurance coverage changed to a larger degree than under the policy analyzed here. There have also been five years of premium growth since then. Premiums for employer-sponsored health coverage have increased faster than the affordability threshold, so more people would gain eligibility under the proposed change than in earlier years.⁵ Our current model captures differences in health coverage since 2016, particularly the increase in the number of states that have expanded Medicaid eligibility and regulatory changes that have expanded the coverage of non-ACA-compliant coverage. The federal income tax brackets and rates changed in 2018, so the computation of the tax advantage of employer-sponsored health insurance is somewhat different. Finally, our estimates assume that the COVID-19 pandemic's effects on employment will bleed into 2022, a consideration that did not exist earlier.

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

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

All estimates are for US residents younger than 65, and reforms are presented as if fully implemented in 2022. These estimates include the residual economic impacts of the COVID-19 pandemic on health coverage in that year but do not include the temporary enhancements to Marketplace premiums under the American Rescue Plan Act.⁶

For this analysis, we assume the Medicaid enhanced federal medical assistance percentage and continuous coverage provisions in the Families First Coronavirus Response Act would have expired before 2022. But in a January 2021 letter to governors, the acting secretary of the US Department of Health and Human Services indicated the public health emergency declaration will be extended through calendar year 2021.⁷ This means the continuous coverage requirement, which prohibits states from disenrolling Medicaid enrollees unless they request it, is expected to last through January 2022,

and the enhanced federal medical assistance percentage will be available through March 2022. Consequently, Medicaid enrollment may be higher in early 2022 than indicated in our estimates. But enrollment will decline to the levels we show later in the year. Also, the federal government will pay a higher share of Medicaid costs in the first quarter of 2022 than we indicate.

Results

We begin by estimating the number of people who would gain eligibility under the proposed fix to the family glitch, along with their current health coverage, ages, and family incomes. We then simulate the coverage decisions of families affected by the change and show how the distribution of health coverage would change. We show the amount that those families who switch from employer to Marketplace coverage would save on health insurance premiums, considering the important tax advantage of financing health coverage through an employer. Finally, we show the overall impact of the proposed change on health care spending and the federal deficit. For all these results, we assume that Marketplace PTCs would be at their permanent levels under the ACA, without the temporary enhancements in the American Rescue Plan Act.

Families Affected by the Family Glitch

We estimate that the proposed change would make 4.8 million people eligible for Marketplace PTCs (table 1). These are members of families in which at least one member is offered single coverage deemed affordable under the law, but health coverage for the entire family costs more than 9.83 percent of family income. The workers with affordable offers of single coverage would remain ineligible for Marketplace coverage with tax credits. We estimate there would be 3.6 million workers connected to family members gaining PTC eligibility but who themselves would still be disqualified by offers of single coverage that are deemed affordable (data not shown).

TABLE 1

Characteristics of Those Who Would Gain Eligibility If the Family Glitch Were Eliminated

	Dependents gaining eligibility	
	N (thousands)	Share of total
Current health coverage		
ESI	4,052	84.4%
Nongroup	124	2.6%
Uninsured	462	9.6%
STLDs	161	3.4%
Total	4,799	100.0%
Age		
0-18	2,197	45.8%
19-34	1,133	23.6%
35-54	976	20.3%
55-64	492	10.3%

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

Note: ESI = employer-sponsored insurance; STLDs = short-term, limited-duration policies, or nongroup coverage that is not compliant with the Affordable Care Act.

Most of those gaining access to Marketplace subsidies are in families who currently value health insurance enough to pay roughly 10 percent of their income or more for coverage. About 84 percent are currently enrolled in employer coverage. Just under 10 percent are uninsured, and the remainder have nongroup coverage, whether ACA compliant or not. Similarly, almost 90 percent of the workers disqualified by affordable offers of single coverage already have insurance. Thus, the most common scenario among those affected by the proposed change is a family currently covered through an employer plan who can now choose between that coverage and a combination of single coverage for those with affordable single offers and subsidized Marketplace coverage for other family members.

Nearly 2.2 million children who do not qualify for Medicaid or CHIP would gain eligibility for Marketplace subsidies under the proposed change to the family glitch. This amounts to almost 46 percent of those gaining eligibility. By definition, those gaining eligibility are dependents of workers, so it is not surprising that many would be children. This result occurs despite substantial past expansions of eligibility for children under Medicaid and CHIP. For example, child eligibility thresholds range from close to 200 percent of FPL in many states to 405 percent of FPL in New York.⁸

Changes in Health Coverage

Those gaining eligibility for PTCs would not necessarily be better off taking them. That depends on the amount of PTCs available at their income level, the cost of single coverage for the worker with an affordable offer, the tax advantage of financing the family's health coverage through an employer, and the difference in out-of-pocket health costs for the family. Not all of those who save money would necessarily switch. When our model accounts for these factors, we estimate that 710,000 more people would enroll in nongroup coverage with PTCs if the family glitch were changed (table 2). There would also be a small decrease in full-pay nongroup enrollment, as a few current nongroup enrollees would gain PTC eligibility. We estimate that the new Marketplace enrollees would be healthier than current enrollees, on average, and would lower nongroup premiums slightly. Nationally, the average reduction would be about 1 percent (data not shown). In addition to lowering premiums for those not receiving PTCs, this would reduce federal PTC costs without affecting the costs of those receiving PTCs.

TABLE 2

Health Insurance Coverage Distribution of the Nonelderly Population (Thousands of People)

	ACA before ARPA		Family glitch corrected		Change	Percentage-point change	Percent difference
Insured (MEC)	244,113	88.0%	244,303	88.1%	190	0.1%	0.1%
Employer	149,325	53.8%	148,740	53.6%	-585	-0.2%	-0.4%
Private nongroup	14,960	5.4%	15,643	5.6%	682	0.2%	4.6%
Basic Health Program	864	0.3%	865	0.3%	1	0.0%	0.1%
Marketplace with PTC	8,484	3.1%	9,194	3.3%	710	0.3%	8.4%
Other nongroup	5,613	2.0%	5,584	2.0%	-29	0.0%	-0.5%
Medicaid/CHIP	71,162	25.6%	71,255	25.7%	93	0.0%	0.1%
Disabled	9,436	3.4%	9,438	3.4%	2	0.0%	0.0%
Medicaid expansion	14,845	5.4%	14,851	5.4%	5	0.0%	0.0%
Traditional nondisabled adult	12,680	4.6%	12,683	4.6%	3	0.0%	0.0%
Nondisabled Medicaid/CHIP child	34,161	12.3%	34,243	12.3%	82	0.0%	0.2%
State-funded program	40	0.0%	40	0.0%	0	0.0%	0.0%
Other public	8,665	3.1%	8,665	3.1%	0	0.0%	0.0%
Uninsured (No MEC)	33,333	12.0%	33,144	11.9%	-190	-0.1%	-0.6%
Uninsured	30,766	11.1%	30,577	11.0%	-190	-0.1%	-0.6%
Noncompliant nongroup	2,567	0.9%	2,567	0.9%	0	0.0%	0.0%
Total	277,446	100.0%	277,446	100.0%	0	0.0%	0.0%

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

Notes: ACA = Affordable Care Act; ARPA = American Rescue Plan Act; CHIP = Children's Health Insurance Program; MEC = minimum essential coverage; PTC = premium tax credit. Results are simulated for 2022 without the American Rescue Plan Act's enhanced PTCs.

There would be an increase of 93,000 in Medicaid and CHIP enrollment, including 82,000 more children. Parents and other family members gaining Marketplace subsidy eligibility will be more likely to seek coverage. When they do so, children and other dependents will be screened for Medicaid and CHIP eligibility as well. That is why enrollment increases in these programs, even though eligibility has not changed. The increase is modest mainly because child Medicaid and CHIP participation rates are already high (Haley et al. 2020).

Changing the family glitch would reduce employer coverage by 585,000 people, roughly 0.4 percent of the total number of people covered through employers. Thus, most of the increase in Marketplace, Medicaid, and CHIP enrollment would be from those currently enrolled in employer coverage. These families currently pay more than 9.83 percent of their family incomes on this coverage. The number of people switching from employer coverage is notably lower than the number of people with employer coverage gaining eligibility because of premium stacking and the tax advantage of financing health insurance through an employer that increases with family income. Expanded access to Marketplace subsidies for dependents would not noticeably change employers' decisions to offer coverage because employer coverage would still be the only alternative for workers with affordable offers of single coverage.

There would be 190,000 fewer uninsured people under the proposed change. Around 462,000 uninsured people gain Marketplace subsidy eligibility (table 1), and 42 percent of those would enroll. Under the proposed change, at least one family member (the worker with an affordable offer of coverage) would be left out of subsidy eligibility and must pay for coverage through an employer or pay the full single premium for nongroup coverage, so this is a less attractive option than if the entire family were made eligible.

Premium Savings among New Marketplace PTC Enrollees

Among families who switch from employer coverage to a combination of Marketplace coverage and employer coverage for workers ineligible for PTCs, we estimate they currently spend \$2,481 per person on premiums (table 3). After the proposed change to the family glitch, they would spend \$1,028 less per person on premiums. But they would also lose most of their current tax advantage for employer coverage, about \$625 per person. On net, families switching coverage in response to fixing the family glitch would save \$403 per family member. Not all those who gain eligibility under this policy change would be better off switching, but those who do see substantial savings.

TABLE 3

Annual Premium and ESI Tax Subsidies per Family Member for Families Switching from ESI to Marketplace Coverage with ESI for Ineligible Workers

	Premiums per person	Tax subsidy change per person ^a	Total per person
ACA before ARPA			
Income below 200% of FPL	\$1,763	\$0	\$1,763
Income from 200% to 400% of FPL	\$2,855	\$0	\$2,855
All incomes	\$2,481	\$0	\$2,481
Family glitch corrected			
Income below 200% of FPL	\$743	\$441	\$1,184
Income from 200% to 400% of FPL	\$1,823	\$720	\$2,544
All incomes	\$1,453	\$625	\$2,078
Change			
Income below 200% of FPL	-\$1,021	\$441	-\$580
Income from 200% to 400% of FPL	-\$1,031	\$720	-\$311
All incomes	-\$1,028	\$625	-\$403

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

Notes: ACA = Affordable Care Act; ARPA = American Rescue Plan Act; ESI = employer-sponsored insurance; FPL = federal poverty level. Results are simulated for 2022 without the American Rescue Plan Act's enhanced PTCs.

^a Only changes in tax subsidies (not tax subsidies under the baseline) are computed.

These savings are highest at low income levels because PTCs are more generous at lower incomes and the tax advantage for employer coverage tends to increase with income. Switching families with incomes below 200 percent of FPL save \$580 per person, while those with higher incomes save \$311 per person.

Health Care Spending and Federal Spending

Because of new subsidized enrollment in Marketplace coverage (partially offset by modestly lower Marketplace premiums), the federal government would spend \$3.0 billion more in premium tax credits (table 4). Additional Medicaid enrollment would cost the federal government \$349 million.

TABLE 4

Total Spending on Acute Care for the Nonelderly, Millions of Dollars

	ACA before ARPA	Family glitch corrected	Difference	Percent difference
Household				
Premiums	\$300,270	\$299,019	-\$1,251	-0.4%
Other health care spending	\$287,587	\$287,879	\$292	0.1%
Subtotal, household	\$587,856	\$586,897	-\$959	-0.2%
Federal government				
Medicaid	\$376,113	\$376,463	\$349	0.1%
Marketplace PTC	\$58,277	\$61,304	\$3,027	5.2%
Marketplace CSR	\$0	\$0	\$0	0.0%
Additional	\$1,314	\$1,314	\$0	0.0%
Uncompensated care demand	\$31,400	\$31,208	-\$192	-0.6%
Subtotal, federal government	\$467,105	\$470,289	\$3,184	0.7%
State government				
Medicaid	\$199,944	\$200,100	\$156	0.1%
Marketplace PTC	\$398	\$420	\$22	5.5%
Marketplace CSR	\$46	\$48	\$3	5.9%
Additional	\$357	\$357	\$0	0.0%
Uncompensated care demand	\$19,625	\$19,505	-\$120	-0.6%
Subtotal, state government	\$220,370	\$220,431	\$61	0.0%
Employers				
Premium contributions	\$800,116	\$798,115	-\$2,001	-0.3%
Providers				
Uncompensated care	\$27,475	\$27,307	-\$168	-0.6%
Total, all payers	\$2,102,923	\$2,103,038	\$116	0.0%

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

Notes: ACA = Affordable Care Act; ARPA = American Rescue Plan Act; CSR = cost-sharing reduction; PTC = premium tax credit. Results are simulated for 2022 without the American Rescue Plan Act's enhanced PTCs.

We estimate that the demand for uncompensated care funded by the federal government would decline by \$192 million. But uncompensated care is funded by many federal programs. Medicare Disproportionate Share Hospital is the only one for which we can count on savings being automatically realized when the number of uninsured people declines. Thus, the actual savings will likely be only half the decline in demand, about \$96 million (table 5).

Another offset to new federal spending is that federal tax revenue would increase as fewer workers take up employer coverage. We estimate that there would be about \$714 million in new tax revenue. Thus, the policy would require about \$2.6 billion in new federal spending, a 0.6 percent increase in federal spending on acute health care for the nonelderly.

New Medicaid enrollment would increase state spending by \$156 million (table 4). New nongroup enrollment would increase spending by \$25 million in California, Massachusetts, and Vermont, which have state-funded supplemental subsidy programs. The demand for state-funded uncompensated care would fall by \$120 million. States fund uncompensated care in diverse ways, and it is difficult to

estimate how much states would save. For table 4, we assume that nationwide, half the change in demand would be realized as savings. That results in \$60 million of uncompensated care savings to states. The net change in state spending is thus \$121 million, a 0.1 percent increase in spending on acute health care for the nonelderly. This spending would be at least partially offset by increased tax revenue because of higher wages in response to lower employer coverage. But we cannot compute state and local taxes.

Household spending on health care decreases by about \$1 billion, or 0.2 percent. The health care cost savings of people switching from employer coverage are partially offset by the spending of those previously uninsured who newly enroll in private coverage. They are now paying premiums and consuming more health care.

Employer spending decreases slightly, by about \$2 billion, or 0.3 percent. The number of people switching from employer coverage is only about 0.1 percent of the total covered population, so the change in total spending is negligible.

TABLE 5
Net Federal Deficit Impact, 2022

	Difference (millions)
Federal government	
Medicaid	\$349
Marketplace PTC	\$3,027
Uncompensated care (Medicare DSH)	-\$96
Federal tax change	-\$714
Total	\$2,566

Source: The Urban Institute’s Health Insurance Policy Simulation Mode, 2021.

Notes: DSH = disproportionate share hospital; PTC = premium tax credit. Results are simulated for 2022 without the American Rescue Plan Act’s enhanced PTCs.

Conclusions

We simulate the impact of a proposed change to the ACA that would address the family glitch by extending eligibility for Marketplace subsidies to dependents of workers offered affordable single coverage when the cost of family coverage is more than 9.83 percent of family income.

We find that addressing the family glitch through this change would make 4.8 million people eligible for tax credits, nearly half of whom would be children who are not eligible for Medicaid or CHIP. Nine-tenths of those gaining eligibility already have family health coverage through their employer that would be considered unaffordable using the ACA threshold.

The change would increase Marketplace coverage with PTCs by 710,000 people and Medicaid/CHIP coverage by 93,000 people. Most of these would switch from employer coverage, but

that represents only about 0.4 percent of the total number with employer-sponsored health insurance. We find that the proposed change would reduce the number of uninsured people by about 190,000.

The biggest impact of changing the family glitch would be to make health coverage more affordable for hundreds of thousands of families. Not all the families gaining PTC eligibility would be better off switching, but we estimate that the families who do switch from family employer coverage would save just over \$400 per person in premiums on average, accounting for the tax advantage of financing health coverage through an employer. Switching families with incomes below 200 percent of FPL would save \$580 per person, while switching families at higher incomes would save \$311 per person.

We estimate that changing the family glitch would increase federal government spending by about \$2.6 billion annually, a 0.6 percent increase in spending on acute health care for the nonelderly. State spending would increase by \$121 million, which is only a 0.1 percent increase in state spending on acute health care for the nonelderly. This new spending will be partially offset by additional tax revenue. But HIPSM does not compute state and local taxes.

In summary, changing the family glitch would lower health care premiums for hundreds of thousands of affected families without undermining employer coverage. There would be a modest increase in health coverage, but the biggest effect would be to improve affordability. There would be a small increase in federal government spending and a tiny increase in state spending that would be at least partially offset by additional tax revenue.

Appendix

TABLE A.1

Those Who Would Gain PTC Eligibility If the Family Glitch Were Changed, by State

State	Number gaining PTC eligibility (thousands)	Share of total gaining eligibility	Share of nonelderly population
Alabama	74	1.6%	1.8%
Alaska	14	0.3%	2.0%
Arizona	162	3.4%	2.6%
Arkansas	47	1.0%	1.8%
California	655	13.7%	1.9%
Colorado	64	1.3%	1.3%
Connecticut	22	0.5%	0.7%
Delaware	13	0.3%	1.7%
District of Columbia	2	0.0%	0.3%
Florida	432	9.0%	2.5%
Georgia	203	4.2%	2.1%
Hawaii	11	0.2%	0.9%
Idaho	47	1.0%	3.1%
Illinois	106	2.2%	1.0%
Indiana	94	2.0%	1.7%
Iowa	31	0.7%	1.2%
Kansas	52	1.1%	2.1%

State	Number gaining PTC eligibility (thousands)	Share of total gaining eligibility	Share of nonelderly population
Kentucky	72	1.5%	1.9%
Louisiana	48	1.0%	1.2%
Maine	19	0.4%	1.8%
Maryland	44	0.9%	0.8%
Massachusetts	44	0.9%	0.8%
Michigan	146	3.0%	1.9%
Minnesota	58	1.2%	1.2%
Mississippi	68	1.4%	2.7%
Missouri	95	2.0%	1.8%
Montana	12	0.3%	1.4%
Nebraska	41	0.8%	2.5%
Nevada	51	1.1%	1.8%
New Hampshire	11	0.2%	1.0%
New Jersey	55	1.2%	0.7%
New Mexico	20	0.4%	1.1%
New York	72	1.5%	0.4%
North Carolina	218	4.5%	2.4%
North Dakota	18	0.4%	2.9%
Ohio	196	4.1%	2.1%
Oklahoma	88	1.8%	2.6%
Oregon	42	0.9%	1.2%
Pennsylvania	111	2.3%	1.1%
Rhode Island	11	0.2%	1.3%
South Carolina	104	2.2%	2.5%
South Dakota	21	0.4%	2.9%
Tennessee	125	2.6%	2.2%
Texas	600	12.5%	2.3%
Utah	77	1.6%	2.6%
Vermont	6	0.1%	1.2%
Virginia	126	2.6%	1.7%
Washington	66	1.4%	1.0%
West Virginia	18	0.4%	1.2%
Wisconsin	69	1.4%	1.4%
Wyoming	17	0.4%	3.2%
Total	4,797	100.0%	1.7%

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

Note: PTC = premium tax credit.

Notes

- ¹ The percentage of household income that defines an affordable offer of coverage is updated each year.
- ² "Marketplace Effectuated Enrollment and Financial Assistance," Kaiser Family Foundation, accessed May 4, 2021, <https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/>.
- ³ Legal immigrants who are ineligible for Medicaid solely because of immigration restrictions—most commonly, they have been resident in the US for less than five years—may also qualify for Marketplace subsidies, even if their incomes are less than 100 percent of FPL.
- ⁴ In addition, in accordance with economic theory, we assume that families who decide to decline family coverage will be compensated by their employers with higher wages or additional tax-free benefits. Our model

automatically incorporates these changes to compensation into workers' decisions regarding health insurance enrollment.

- ⁵ See the Medical Expenditure Panel Survey Insurance/Employer Component summary tables, series I.C and I.D at “Summary Data Tables,” Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, last updated October 26, 2020, https://www.meps.ahrq.gov/data_stats/quick_tables.jsp.
- ⁶ See the methodology appendix in Blumberg et al. (2020).
- ⁷ Norris Cochran (acting secretary, US Department of Health and Human Services), letter to governors regarding the public health emergency, January 22, 2021, <https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf>.
- ⁸ “Medicaid and CHIP Income Eligibility Limits for Children as a Percent of the Federal Poverty Level,” Kaiser Family Foundation, accessed May 4, 2021, <https://www.kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

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Matthew Buettgens is a senior fellow in the Health Policy Center at the Urban Institute, where he is the mathematician leading the development of Urban’s Health Insurance Policy Simulation Model (HIPSM). The model is being used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington and to the federal government. Buettgens’s recent work includes research analyzing various aspects of national health insurance reform, both nationally and by state. Research topics include the costs and coverage implications of Medicaid expansion for both federal and state governments; small-firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance coverage and the remaining uninsured; the effect of reform on employers; the affordability of coverage under health insurance exchanges; and the implications of age rating for the affordability of coverage. Buettgens was previously a major developer of the Health Insurance Reform

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In the News

Large Companies Say Expense of Employee Health Care Coverage Will Be “Unsustainable,” Stronger Government Role Needed to Contain Costs

Joan Stephenson, PhD

A substantial majority of top executives at large US companies say that the cost of offering health care coverage to employees will become unsustainable within a decade, and that solutions would require the government to play a larger role in providing coverage and reining in costs, according to a [new survey](#).

The survey, commissioned by the Purchaser Business Group on Health (PBGH) and the Kaiser Family Foundation (KFF), working with the market research firm Beresford Research, examined opinions by key decision makers—chief executive officers, chief financial officers, chief operational officers, chief human resource officers, or people directly reporting to those positions—at 302 large US employers (with at least 5000 employees) that provide health benefits to their workers.

“The COVID pandemic has made even more clear the problems with our current system, including high costs, incomplete coverage, limited access to care, under-investment in public health, and serious racial and ethnic inequities,” the PBGH and KFF researchers noted. “All of this, occurring against a backdrop of ever-rising health care costs, is causing many to re-think their priorities and positions on key health care policy issues.”

The authors noted that alterations in the political landscape resulting from the 2020 election have extended the potential policy options to be considered, including proposals of new coverage choices, such as a Medicare-like public health coverage option or lowering the eligibility age for Medicare. They launched the survey because views of large employers—who, as a primary source of private coverage, are important stakeholders in the anticipated policy debates—are largely unknown.

Respondents answered a panel of questions in December 2020 and January 2021 about how they perceive the costs of health care and health insurance, their views of which policies should be pursued by policy makers, and their opinions about potential government actions to address providing health coverage and reducing costs. The KFF and PBGH researchers analyzed the responses and prepared the report on the survey’s findings.

Overall, 83% of respondents agreed that employer costs for health benefits are excessive. In 2020, according to a [2020 KFF report](#), the average cost of annual family premiums for company-sponsored health insurance was \$21,342, a 55% increase since 2010; the average annual premium for single coverage was \$7,470. Covered workers contribute 27% of the premium for family coverage, on average, and 17% of the premium for single coverage.

Respondents to the new survey did not point to any single factor as the primary cause of excessive costs, but a large proportion agreed that “moderate,” “considerable,” or “very large” contributors to high costs include prescription drug prices, “hospital and health care provider consolidation” and increased market power, volume-based payments, and unhealthy behaviors among large segments of the population.

The survey found that 87% of respondents believe the cost of providing health benefits will become unsustainable within the next 5 to 10 years, and 85% expressed some level of agreement that the government will need to play a larger role in providing coverage and containing costs in that time frame.

In addition, respondents “overwhelmingly believe” that the government playing a larger role in providing coverage and containing costs would be better for their business (83%) and their

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employees (86%). Of those with a positive view of government involvement, more than 40% said they believed it could lower the cost of premiums for employees and costs for employers.

A majority of the executives expressed some level of agreement with policy changes that would create a public option similar to Medicare for their employees (65%) or the general public (70%) or lower the age for Medicare eligibility to 60 years for their employees (60%) or the general public (70%). "Equally interesting, only small shares expressed disagreement with these ideas," the researchers noted.

In answering questions about specific government interventions to contain health costs, the majority of those surveyed expressed support for imposing limits on out-of-network charges (such as in "surprise-billing" situations) and allowing the federal government to negotiate prices for certain costly drugs or to limit increases in drug prices. Nine out of 10 expressed support for pursuing policies that would increase transparency of prices and total cost of care, as well as for measures that would strengthen antitrust enforcement or otherwise address noncompetitive conduct.

In other work, some of these policy options were considered by policy experts at the RAND Corporation in a [research brief](#) summarizing findings of a recent [analysis](#) that explored strategies to reduce hospital costs, 40% of which are borne by private insurers. The researchers analyzed 3 options: regulating prices, improving price transparency, and enhancing price competition by decreasing concentration in hospital markets.

Of these strategies, regulating prices would reduce hospital spending the most, the RAND analysis found. The researchers estimated that setting prices for all commercial health care payers at 100% to 150% of Medicare rates would slash hospital spending by about \$62 billion and \$237 billion annually, which would cut overall national health spending by 1.7% to 6.5%.

Policies to increase transparency in hospital prices would reduce hospital spending to a lesser extent, according to the analysis, potentially saving between \$9 billion and \$27 billion annually, depending on the effectiveness of price transparency initiatives in motivating patients and employers to pursue lower prices. Increasing hospital market competition might reduce annual hospital spending by \$6 billion to \$69 billion.

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Summary of Provisions of HHS' Final 2022 Notice of Benefit and Payment Parameters and Other Key Regulations

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On April 30, 2021, the Department of Health and Human Services (HHS) released the remainder of the final Notice of Benefit and Payment Parameters for 2022.¹ The notice includes important final rules and parameters for the operation of the individual and small group health insurance markets in 2022 and beyond. This paper summarizes key provisions of the final notice and other related information on forthcoming regulations by HHS.

Overview

The following highlights the key changes and information included in the 2022 final Payment Notice

- 1. Maximum Out-of-Pocket:** HHS finalized a different formula for the maximum out-of-pocket (and related) cost-sharing limits. Consequently, the new maximum out-of-pocket in 2022 will be \$8,700 for self-only coverage or \$400 less than in the proposed Payment Notice.
- 2. Risk Adjustment:** HHS did not finalize their proposed policies to add severity and transplant indicators, the two-stage specification adjustment, and their proposed changes to enrollment duration factors. The 2022 risk adjustment model will include the same factors as the 2021 risk adjustment model. HHS finalized other proposed policies, including the data period used to recalibrate the model, the 2022 risk adjustment coefficients, key timelines for the risk adjustment data validation (RADV) program, and the risk adjustment user fee.
- 3. User Fees:** HHS announced that it would release a regulation to increase user fees to 2.75% for issuers in the Federally-facilitated Exchange (FFE) and 2.25% in State-based Exchanges that use the Federal platform (SBE-FPs) for 2022.
- 4. PBM Reporting:** HHS finalized the requirement that Prescription Drug Benefit Managers (PBMs) or issuers without a PBM report key information about prescription drugs, such as prescription drug rebate information.
- 5. MLR Changes:** HHS finalized the definition of prescription drug rebates to include all direct and indirect remuneration received by an issuer, including discounts or charge backs. Issuers will need to deduct these amounts from incurred claims starting for the 2022 Medical Loss

¹ Department of Health and Human Services, "Final Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022", <https://public-inspection.federalregister.gov/2021-09102.pdf>

Ratio (MLR) reporting year. Additionally, HHS eliminated the option to automatically include the 0.8% for quality improvement from MLR reporting and rebate calculations.

- 6. Forthcoming regulation:** HHS intends to propose future regulations on user fees, 1332 waivers, standard plan designs, and other items in either a new regulation released sometime this spring or the 2023 Payment Notice.

The following provides details on the specific changes in the final 2022 Notice of Benefit and Payment Parameters, as well as potential future rule-making from HHS.

Exchange Establishment Standards (Direct Enrollment)

HHS did not finalize the proposed changes to allow greater flexibility in how Direct Enrollment (DE) entities display information on QHPs. The proposal would have allowed DE entities not to list as much information on QHPs that they cannot sell (such as an issuer with which a broker does not have an agreement).

User Fees

Previously, HHS announced it intended to change the 2022 user fee rates. The Trump Administration set user fee rates for issuers in states that utilize Healthcare.Gov in a previous regulation. In particular, the prior Administration set user fee rates at 2.25% for FFE (down from 3.0%) and 1.75% for SBE-FP states (down from 2.5%). However, the Biden Administration announced it intends to set user fee rates for issuers in FFE states at 2.75% and at 2.25% for SBE-FP states for the calendar year 2022 in a forthcoming regulation.

Eligibility

HHS finalized the requirement to allow individuals a special enrollment period if they did not receive timely notice of an event that triggers an enrollment period (i.e., if someone was not reasonably made aware of their eligibility for a SEP, they would maintain access to SEP).

HHS did not finalize the proposal to increase SEP verification for State-Based Exchanges or require all Exchanges to verify at least 75% of all enrollees claiming eligibility for a Special Enrollment Period, which would have been effective in 2024.

Data Collection for Pharmacy Benefit Managers

HHS finalized the requirement that PBMs (or QHP Issuers if they do not use a PBM) must report the following required data to HHS:

- Percent of all prescription drugs dispensed through retail vs. mail-order pharmacies

- Generic dispensing rate
- Aggregate amount and type of rebates, discounts, or price concessions, excluding bona fide service fees (e.g., distribution service fee, inventory management fees, product stocking allowances, and administrative service agreement and patient care program fee)
- Aggregate amount of rebates, discounts, or price concessions that are passed through to the plan sponsor, and the total number of prescriptions dispensed
- Aggregate amount of the difference between the amount the health plan pays the PBM and the amount the PBM pays retail and mail-order pharmacies (spread pricing)

Civil Monetary Penalties will be assessed for non-compliance.

Issuer Requirements

Maximum Out of Pocket Updates

HHS finalized that the maximum out-of-pocket (MOOP) amounts for standard plans² and cost sharing variations for 2022.

- Standard Plans: \$8,700/\$17,400 (single/family)
- 100%-150% FPL: \$2,900/\$5,800 (single/family)
- 150%-200% FPL: \$2,900/\$5,800 (single/family)
- 200%-250% FPL: \$6,950/\$13,900 (single/family)

The new single MOOP is \$400 less than the proposed rule (\$9,100) because of a change in HHS's indexing methodology (the premium adjustment percentage index).

The catastrophic plan's deductible and MOOP will also be set to \$8,700/\$17,40 (single/family). Going forward, HHS announced it would release MOOP and related cost sharing amounts in January via guidance rather than in the Payment Notice unless there is a change in the indexing methodology.

Audit and Compliance

HHS finalized to expand audit and compliance authority for APTC and CSR compliance for FFE and SBE-FP states, which includes reviews of Exchange user fees, coverage effectuation and

² Standard plans include platinum, gold, silver non-cost sharing variation, and bronze metal offerings as well as catastrophic plans.

termination, and premium calculations. HHS may recoup any APTC, CSR, or user fees in the case of audit non-compliance.

HHS also finalized expanding this audit and compliance authority in states whose SBE or SBE-FP are not adequately enforcing the applicable standards. In any such case, the authority to de-certify a QHP would remain solely with the SBE or SBE-FP.

HHS did not finalize the proposal to change the quality rating system and instead asked for further comments if the quality rating system methodology should be changed. HHS did announce the full QHP enrollee satisfaction survey would be made public, beginning with the 2021 results during 2022 OEP (as opposed to the current limited information available).

Payment Disputes

HHS finalized its proposal to extend the window during which issuers may report APTC payment inaccuracies to HHS from the current 90-day window to up to three years after payments are received, as long as they are reported within 15 days of discovery, and a good-faith effort is made to research and identify such inaccuracies.

Risk Adjustment

HHS finalized several updates to the risk adjustment program in the payment notice but did not finalize any proposals specific to structural changes of the HCC model.

Risk Adjustment Model Recalibration

HHS finalized to use the three most recent and available consecutive years of EDGE Server data at the time of the proposed Payment Notice to recalibrate the risk adjustment model annually. In addition, HHS will not update the coefficients for additional years of data between the proposed and final rule if an additional year of enrollee-level EDGE data becomes available.

Risk Adjustment Model Updates

HHS did not finalize their proposal to include a two-stage specification in both the adult and child models. HHS also did not finalize to separately add severity and transplant indicators that would interact with HCC count factors. HHS did not finalize removing current severity illness indicators as well. This means that the 2022 risk adjustment model's HCCs remain the same as 2021.

HHS also did not finalize removing the current 11 enrollment duration factors (EDFs) and replacing them with six EDFs (up to six months) attributable to only those members with one or more payment HCCs. This means that the categories for the 2022 enrollment duration factors remain the same as 2021.

HHS finalized the proposal to adjust the plan liability associated with Hepatitis C drugs to reflect future market pricing of Hepatitis C drugs before solving for the adult model coefficients.

Finally, HHS finalized that risk score adjustments for CSR plans will continue for the 2022 benefit year as finalized in the previous payment notices.

Premium Credits

HHS finalized the requirement that statewide average premiums would be reduced for any premium credits (as a reduction to the applicable benefit year premiums) and therefore reflect actual premiums billed to members. These lower premiums must also be reported to the EDGE Server.

State Flexibility Requests

HHS finalized Alabama's request for a reduction of risk adjustment transfers in 2022³.

HHS did not finalize the proposed policy to allow states to pursue multi-year state flexibility reduction requests.

Audit and Compliance Review of Transitional (Federal) 2014 through 2016 Transitional Reinsurance-eligible Plans

HHS finalized several amendments to clarify and expand its compliance review authority, establishing timeframes for issuers to respond to audit notices, reports, inquiries, and requests for supplemental information, and the process for issuers to request extensions to respond. However, HHS made some slight modifications to certain audit timelines in response to comments received.

Audit and Compliance Review of Risk Adjustment Covered Plans

Consistent with the finalized policies for reinsurance-eligible plans and in addition to the HHS-RADV process, HHS also finalized amendments for reviewing risk adjustment covered plans, with slight modifications to certain audit timelines.

HHS is not finalizing its proposal to disburse high-cost risk pooling payments or charges recovered by HHS during an audit on a pro-rata basis. HHS is continuing to consider options.

³ Alabama requested a 50% reduction in transfers for both the Individual and Small Group markets in 2022. In 2020 and 2021, Alabama only requested this reduction for the Small Group market.

EDGE Discrepancy Materiality Threshold

HHS finalized their proposal to increase the materiality threshold for EDGE server data issues from \$10,000 to \$100,000. This means the amount in dispute must equal or exceed \$100,000 or one percent of the total estimated transfer amount in the applicable state risk pool for reconsideration requests.

Risk Adjustment User Fee

HHS finalized the 2022 risk adjustment user fee to be \$0.25 PMPM, unchanged from 2021.

Risk Adjustment Data Validation (RADV)

RADV Exemptions

HHS finalized the proposal to codify RADV exemptions for issuers with only small group market carryover coverage and sole issuers in a state market risk pool.

RADV Initial Validation Audit (IVA) Demonstrations

HHS finalized the policy that IVA entities must demonstrate they are reasonably free of conflicts. Specifically, the IVA entity must 1) not have or previously have had a role in establishing any relevant internal controls of the issuer's risk adjustment or EDGE server data process for the applicable year, and 2) not have served in any capacity as an advisor regarding the risk adjustment or EDGE server data submission for the applicable year.

Discrepancy and Appeals

HHS clarified that issuers are not permitted to use the discrepancy or administrative appeal process to contest IVA findings. Plans should review and discuss IVA findings with the IVA entity prior to submitting and attesting those results to HHS.

RADV Appeals

HHS clarified that the 30-day window to request an appeal of the second RADV audit begins on the date of release of the report on RADV Adjustments to the Risk Adjustment Transfers for the particular benefit year.

Collections, Disbursements, and MLR Reporting

HHS is finalizing the proposal to revert to the previous schedule for the collection and disbursement of RADV adjustments. This will result in collections and disbursements occurring in

the same calendar year in which HHS-RADV results are released, beginning with the 2019 benefit year RADV.

For example, 2021 RADV results will be released in early summer 2023, and issuers will be instructed to report these amounts in the 2022 MLR reporting year (submitted by July 31st, 2023). Collections and disbursements of RADV charges and allocations for the 2021 RADV results will begin in summer or fall of 2023.

As finalized, RADV results for 2019 and 2020 will be released in 2022, and issuers will include the results in the 2021 MLR reporting (reported by July 31st, 2022).

Table 1: Risk Adjustment and HHS-RADV Benefit Years to Include in MLR Reports for MLR Reporting Years 2020-2025

MLR Reporting Year	RA Benefit Year to Include	RADV Benefit Year(s) to Include
2020 (Filed in 2021)	2020	NA
2021 (Filed in 2022)	2021	2017 2019 & 2020 *
2022 (Filed in 2023)	2022	2018 2021*
2023 (Filed in 2024)	2023	2022
2024 (Filed in 2025)	2024	2023
2025 (Filed in 2026)	2025	2024

* Including multiple years of HHS-RADV due to transition to the policy finalized in this rule to revert to the prior schedule for collection and disbursement of HHS-RADV results beginning with the 2019 benefit year.

Medical Loss Ratio Changes

HHS will require insurers to deduct prescription drug rebates and other price concessions from incurred claims under the MLR rules starting in the 2022 MLR reporting year. HHS defines prescription drug rebates and other price concessions to mean all remuneration received by an issuer and entities providing pharmacy benefit management services to the issuer, related to the provision of a prescription drug covered by the issuer. This excludes any remuneration, coupons, or price concessions that are passed on to the enrollees or bona fide service fees. This deduction applies regardless of the entity from which the issuer receives the remuneration (e.g., pharmaceutical manufacturer, wholesaler, retail pharmacy, or other vendor).

HHS also adopted the public health emergency (PHE) data reporting and rebate requirements developed in the September 2020 interim final rule. Under this rule, issuers must account for temporary premium credits during a declared PHE as a reduction in earned premium for MLR rebate calculations.

HHS finalized the proposal to continue the flexibility of accounting for temporary premium credits through a reduction in earned premiums going forward with the following changes:

- A safe harbor under which an issuer that prepays at least 95% of the total rebate owed to enrollees in the given MLR report will not be subject to a penalty. Members enrolled over multiple years would get the current year's rebate plus the remaining balance after prepayment from the prior year. For members no longer enrolled, the remaining balance after prepayment would be issued.
- Allow premium credits to be applied no later than October following the MLR reporting year.
- As discussed below, issuers will no longer be allowed to report 0.8% of earned premium as quality improvement expenses and must report itemized expenditures beginning with the 2020 MLR reporting year.

Rules Vacated by Columbus v Cochran

The Payment Notice also included a discussion about the implications of the recent ruling in the Columbus v. Cochran cases. On March 4, 2021, the United States District Court for the District of Maryland decided *City of Columbus et al. v. Cochran*.⁴ The plaintiffs challenged nine rules from the 2019 Notice of Benefit and Payment Parameters. The court upheld five of the rules but also ordered that the following four rules be vacated:

- The elimination of federal network adequacy reviews for certain FFEs, where the state performed a sufficient review. Starting in Plan Year 2023, there will be a federal review of network adequacy for all FFM states.
- The elimination of designating some plans as “standardized options” on FFEs. Starting in Plan Year 2023, standardized option designations will resume on FFEs.
- Requirement of additional documentation for those. Going forward, additional documentation will no longer be required under these circumstances.

⁴ Some also refer to this as the “Take Care” case.

- The option to use 0.8% of revenue as Quality Improvement Expenses to satisfy the minimum loss ratio requirements. Going forward, starting with the MLR filing for 2020 (due on July 31, 2021), issuers will have to itemize the Quality Improvement expenses in order to count them in the numerator of the MLR calculation.

Actuarial Value Calculator

HHS also released the final 2022 actuarial value calculator (AVC).⁵ Similar to the 2015 AVC, HHS did not include any trend factor for medical or drug spending for 2021 to 2022 in the AVC.

Future Regulation

HHS announced that it intends to revisit a number of topics that were finalized in the 2022 Payment Notice under the Trump Administration, notably 1332 State Innovation waivers and Exchange Direct Enrollment (DE) options for states in future rule-making.

If you have any questions or to follow up on any of the concepts presented here, please contact any of the following authors:

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⁵ <https://www.cms.gov/ccio/resources/regulations-and-guidance/#plan-management>