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# News Release

Media line: (916) 206-7777 @CoveredCANews

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#### FOR IMMEDIATE RELEASE

May 5, 2021

## Covered California Study Shows How Outreach Helps Consumers Get Improved Coverage and Pay Lower Premiums by Making Better Plan Choices

- The study focused on Covered California consumers who selected a Goldor Platinum-level plan, even though they were eligible for a lower-premium Silver plan that provides richer benefits.
- Covered California intervened in these cases to encourage consumers to switch to the better plan level, and those who did saved an average of \$140 per month in premiums and out-of-pocket expenses.
- The study shows how similar outreach could be used across the country to help more Americans save money on their health insurance by maximizing their benefits under the Affordable Care Act.
- Covered California is holding 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.

SACRAMENTO, Calif. — A Covered California study shows how efficient and low-cost outreach can help low-income consumers save on their health insurance. The study focused on Covered California consumers who had selected a Gold or Platinum plan but who were eligible for lower-cost coverage that provided richer benefits.

"The Affordable Care Act made a lot of progress in helping people navigate and understand health insurance, but it can still be confusing to many people, especially for those who have not been insured regularly," said Peter V. Lee, executive director of Covered California. "Covered California tested how best we could inform consumers that they could have better options as part of our mission to help people make better choices and save money. We will use this information to improve our services, and we hope it is useful for other marketplaces across the nation."

The study, "<u>Using Email and Letters to Reduce Choice Errors Among ACA Marketplace Enrollees</u>," was published by Health Affairs, a prominent outlet devoted to health policy and issues affecting health and health care.

The study looked at low-income consumers, particularly those who earn less than 200 percent of the federal poverty level, which is currently equal to \$25,520 per year for an individual and \$52,400 for a family of four. Under the Affordable Care Act, consumers in this income bracket are eligible for Enhanced Silver plans, which feature cost-sharing reductions that have lower premiums and lower out-of-pocket expenses.

A Covered California analysis found that nearly 20,000 Covered California consumers had selected more costly Gold and Platinum plans for the 2019 coverage year, despite being eligible for an Enhanced Silver plan with richer benefits. For example, instead of obtaining a plan with an actuarial value of 94, a Silver 94-eligible consumer chose a plan with an actuarial value of 90 (Platinum) or 80 (Gold) with a higher monthly premium. Similarly, a Silver 87-eligible consumer may have chosen a Gold plan instead of selecting a less-expensive option with more generous coverage.

To encourage those consumers to switch to Enhanced Silver plans, Covered California sent additional emails and letters to consumers that described the average premium and out-of-pocket savings they could see while keeping the same carrier and providers.

The results were significant. At the end of the open-enrollment period for the 2019 coverage year, 19.7 percent of the group that received additional emails switched to Enhanced Silver plans, while 21.6 percent of those that received additional emails and letters made the change. This compares to 17.7 percent of the study's control group, which received traditional renewal reminders that did not specifically call out the potential savings possible by switching.

Consumers who switched to a better plan saved an average of \$84 per month in lower premiums and \$56 per month in reduced out-of-pocket expenses, totaling an average savings of \$1,680 per year.

"Putting money back in the pockets of consumers, while helping them better understand their health plan, is the right thing to do," Lee said. "We are looking to expand our efforts, because lowering the cost of coverage helps people stay covered and it allows them to put that money back into our economy, which helps their communities."

#### The American Rescue Plan Provides New Lower Premiums for Californians

The study comes during the early days of Covered California's new special-enrollment period that allows Californians to benefit from lower health insurance premiums available through the American Rescue Plan. The new law can help an estimated 2.5 million Californians, including the uninsured and those who enrolled directly through a health insurance carrier, by providing additional financial help to lower the cost of their coverage.

#### **Consumers Can Find Out in Minutes How Much They Can Save**

Covered California is encouraging Californians 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 on <a href="CoveredCA.com">CoveredCA.com</a> by entering their ZIP code, household income and the ages of the people in the household. They will see how low their premiums can be and the health insurance options in their area.

"Time is of the essence, because every month that goes by is a month that someone could be covered or could be saving hundreds of dollars on their health insurance," Lee said. "Do not miss out. The sooner you sign up, the sooner you can start saving."

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.

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Media line: (916) 206-7777 Twitter: @CoveredCANews Email: media@covered.ca.gov

FOR IMMEDIATE RELEASE April 28, 2021

### Millions of Californians Could Continue to Pay Lower Premiums Due to the American Families Plan

SACRAMENTO, Calif. — Covered California's executive director, Peter V. Lee, is issuing this statement following tonight's joint session of Congress, during which President Joe Biden introduced the <u>American Families Plan</u>. The proposal outlines the next step to the president's vision for economic recovery and would make permanent the new and expanded financial help from the American Rescue Plan, which is currently lowering health insurance premiums for millions of Americans.

The American Rescue Plan ensures that everyone eligible will pay no more than 8.5 percent of their household income on their health care premiums if they enroll through an Affordable Care Act marketplace like Covered California. However, the law is currently set to expire at the end of 2022.

"The American Families Plan would ensure lower premiums for millions of Americans for the long-term. The proposal would make permanent the new and expanded subsidies that are available right now, which stand to improve the lives of 2.5 million Californians and 25 million Americans.

"Thanks to the leadership of President Biden and Congress, consumers are currently experiencing significant premium savings that will ease their financial burdens and allow them put money back into our economy. We have heard from a retired firefighter and his wife who will save \$1,000 a month, a small business owner who will be able to expand his operations, and a family who says their savings mean they can put their children into a junior lifeguard program this summer.

"Making these savings permanent will help more Californians, and more Americans, get covered and stay covered during this pandemic and recession and beyond.

"While the American Families Plan will need to work its way through Congress, it's important to note that Californians can get these savings now. Covered California is in the early days of a special-enrollment period, and this Friday marks the first deadline for consumers to sign up for coverage and begin saving.

"Many people will be able to get high-quality coverage for as little as \$1 per month, while others will be able to save hundreds of dollars off what they are paying now. Do not miss out — the sooner you sign up, the sooner you can start saving and be covered. We don't want any Californians to be uninsured or leave money on the table."

<u>Covered California is currently holding a special-enrollment period</u> to allow the uninsured, and those insured directly through a health insurance carrier, to sign up for coverage and begin benefiting from the lower premiums. While the special-enrollment period runs through the end of the year, consumers need to enroll by April 30 if they want to maximize their savings and have coverage that starts on May 1.

Consumers who are currently enrolled in Covered California will not need to take any action in order to receive the new benefits.

#### **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.

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# News Release

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**Department of Health Care Services Media Line:** (916) 440-7660 @DHCS\_CA

FOR IMMEDIATE RELEASE April 21, 2021

# California's Largest Public Health Care Purchasers Unite to Address Gaps in Childhood Immunizations and Colorectal Cancer Screenings Due to the COVID-19 Pandemic

- Covered California, the Department of Health Care Services and CalPERS are joining together to require their health insurance companies to address significant drops in preventive care due to the COVID-19 pandemic, which has exacerbated racial and ethnic health disparities across the state.
- Together these three purchasers represent about 40 percent of California's overall population.
- Covered California added performance goals for health plans, requiring them to return to pre-pandemic levels of childhood vaccinations and colorectal cancer screenings by the end of 2021.

SACRAMENTO, Calif. — Covered California, the Department of Health Care Services (DHCS) and CalPERS are taking the lead in addressing gaps in preventive care created by COVID-19 and will pay specific attention to racial and ethnic disparities that have been exacerbated by the pandemic. Covered California, DHCS — which operates the state's Medi-Cal program — and CalPERS announced complementary efforts to ensure that everyone covered by the programs gets vaccines to prevent COVID-19 as they become available while addressing preventive care gaps caused by patients not getting needed services.

"As we focus on the immediate health and economic impacts of COVID-19, we must be proactive to address downstream effects the pandemic can have on the health of Californians and our communities," said Peter V. Lee, executive director of Covered California. "Taking action now, on childhood immunizations and colorectal cancer

screenings, is an investment in future good health, and these policies are intended to help avoid a surge of bad health outcomes in the future."

Covered California will require its 11 health insurance companies to reach prepandemic levels of childhood immunizations and colorectal cancer screenings by the end of 2021 and to exceed those numbers by the end of 2022.

Dr. Alice Hm Chen, Covered California's chief medical officer, said the motivation to act was data showing that COVID-19 has led to a sharp drop-off in primary and preventive care. At the same time, the pandemic has had a strikingly disproportionate impact on people of color.

"Coverage is a means to getting better care and ideally better outcomes," Dr. Chen said. "We wanted not only our health plans, but all health plans and providers in the state, to address the impact of COVID-19 on preventive care. Our hope is that by working collectively, we can make up critical ground that was lost over the past year."

Data from California's Department of Public Health shows that vaccination rates in the state have fallen. As of November 2020, 12 percent fewer children had received their first dose of the MMR (measles-mumps-rubella) vaccine compared to the year before, and 20 percent fewer adolescents received their Tdap (tetanus) shot. Dr. Chen said Covered California and its fellow public purchasers, DHCS and CalPERS, felt a sense of shared urgency to act.

"DHCS shares this focus on equity and childhood wellness, and we are finalizing a roadmap to reduce health inequities in Medi-Cal with measures to recognize health disparities among beneficiaries," said DHCS Director Will Lightbourne. "Early in the pandemic, we identified growing gaps in well-child visits and immunizations. We are committed to closing those gaps and others, in part through our ongoing requirement that Medi-Cal managed care plans conduct performance-improvement efforts on youth preventive health care."

"As the largest purchaser of public employee benefits in California, CalPERS is committed to providing high-quality, equitable care to our members. Our data shows that the use of preventive care, including cancer screenings and immunizations, has declined during the COVID-19 pandemic," said Don Moulds, CalPERS chief health director. "Together, with Covered California and DHCS, we are taking action to close gaps in care created by the pandemic, and are working with our health plans to ensure our members have access to much needed chronic care and preventive care services."

Dr. Chen said colorectal cancer is a leading cause of cancer death and a source of significant racial and ethnic disparities. Data from the Epic Health Research Network found that at the onset of the pandemic, colorectal cancer screenings had declined by nearly two-thirds compared to the historical average. Dr. Chen said those trends need to be reversed immediately.

"As a cancer that is amenable to prevention rather than just early detection, it's critical we get people between the ages of 50 and 75 screened, and it's a process that can be started without an in-person visit," Dr. Chen said. "Treatment for colorectal cancer in its earliest stage can lead to a 90 percent survival rate after five years."

Lee said these provisions chart a path for future collaboration for a bolder shared agenda in support of quality, equity and delivery system transformation.

"Covered California is proud to be joining with both other major purchasers and the health plans. We put a spotlight on core issues of health care equity and quality that matters, and they stepped up for the communities they serve," Lee said.

#### **American Rescue Plan Special-Enrollment Period**

The announcement comes during <u>Covered California's special-enrollment period in support of the American Rescue Plan</u>. The new and expanded financial help that is now available will allow the uninsured to sign up for coverage at dramatically lower premiums, with many being eligible for high-quality plans that cost as little as \$1 per month. Californians who are insured directly through a health insurance carrier can also switch to Covered California, often with the same carrier and coverage level, and save hundreds of dollars a month.

Californians are encouraged to check their health care options, even if they have checked in recent months or years, to see how affordable coverage can be. On <a href="CoveredCA.com">CoveredCA.com</a>, consumers can easily see exactly how they can benefit from the new law. Consumers just need to enter their ZIP code, household income and the ages of people in their household to see their monthly cost and the health insurance options in their area.

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

- Visit www.CoveredCA.com.
- Find local insurance agents or individuals in Navigator organizations who provide free and confidential assistance over the phone or in person, in a variety of languages.
- Get a call from certified enroller. Covered California will have someone reach out to the consumer to help them for free.
- Call Covered California at (800) 300-1506.

#### **About Covered California**

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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.

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#### **About the Department of Health Care Services**

The California Department of Health Care Services (DHCS) is the backbone of California's health care safety net. It provides access to affordable, integrated, highquality health care, including medical, dental, mental health, substance use treatment services and long-term care. DHCS funds health care services for about 13 million Medi-Cal beneficiaries and is the largest health care purchaser in California. It collaborates with the federal government and other state agencies, counties, and partners to invest more than \$100 billion for the care of low-income families, children, pregnant women, seniors, and persons with disabilities. For more information about DHCS, please visit www.dhcs.ca.gov.

#### **About CalPERS**

For more than eight decades, CalPERS has built retirement and health security for state, school, and public agency members who invest their life work in public service. Its pension fund serves more than 2 million members in the CalPERS retirement system and administers benefits for more than 1.5 million members and their families through its health program. It is the largest defined-benefit public pension in the U.S. CalPERS' total fund market value currently stands at approximately \$446 billion. For more information, visit www.calpers.ca.gov.

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DOI: 10.1377/ hlthaff.2020.02099 HEALTH AFFAIRS 40, NO. 5 (2021): 812-819 ©2021 Project HOPE— The People-to-People Health Foundation, Inc. By Andrew Feher and Isaac Menashe

# Using Email And Letters To Reduce Choice Errors Among ACA Marketplace Enrollees

Andrew Feher (andrew.feher@covered.ca.gov) is a senior researcher at Covered California, in Sacramento, California.

**Isaac Menashe** is the deputy director for Evaluation and Research at Covered California.

ABSTRACT During the 2019 open enrollment period in California's Affordable Care Act (ACA) Marketplace, we used a randomized intervention to examine the effects of email and postal messages on choice errors, where low-income households enroll in gold or platinum plans although they are eligible for cost-sharing reduction (CSR) silver plans with lower premiums and higher actuarial values. Relative to the control group, assignment to the email-only treatment increased plan switching to CSR silver plans by 2 percentage points (an 11 percent increase), and assignment to the mail-plus-email treatment increased plan switching to CSR silver plans by 3.9 percentage points (a 22 percent increase). The mail-plus-email treatment significantly increased plan switching across all subpopulations in which choice errors were made. Consumers who switched out of a plan chosen in error saved an average of \$84 per month in premiums and \$56 per month in reduced out-ofpocket expenses. Our results indicate that low-cost nudges can help lowincome enrollees obtain more generous coverage at a lower price and that the combination of email and postal messages is more effective at increasing plan switching than email alone to rectify choice errors.

vidence abounds across different forms of health insurance coverage, including Medicare Part D, employer-sponsored insurance, and the Affordable Care Act (ACA) Marketplaces, that consumers make errors in choosing the appropriate health plan for their circumstances. 1-3 The ACA Marketplaces are a particularly fruitful setting in which to study choice errors because consumers have dozens of plan options to choose from.4 Marketplaces feature five broad coverage options, known as metal tiers, with the following actuarial values (percentage of medical expenses covered by the plan, on average): catastrophic (less than 60 percent), bronze (60 percent), silver (70 percent), gold (80 percent), and platinum (90 percent).

People with incomes of 100–250 percent of the federal poverty level are eligible for cost-sharing

reduction (CSR) plans—also known in California as enhanced silver plans—which increase the actuarial value (by reducing deductibles, copayments, and coinsurance and lowering consumers' out-of-pocket maximums) of the base silver plan from 70 percent to 73, 87 or 94 percent, depending on one's income (200–250 percent of poverty enrolled in the enhanced silver tier yields 73 percent actuarial value, 150–200 percent of poverty enrolled in that tier yields 87 percent, and 100–150 percent of poverty enrolled in that tier yields 94 percent).

Although the ACA requires that insurers make available this important form of financial assistance for low-income enrollees, the Marketplaces do not automatically assign CSR-eligible consumers into enhanced silver tier plans. As a result, they may select suboptimal plans with higher premiums and lower actuarial values than

enhanced silver plans. In this study we focused on two types of choice errors among CSR-eligible consumers: silver-94-eligible consumers who enroll in either gold or platinum plans and silver-87-eligible consumers who enroll in gold plans. These decisions constitute choice errors because instead of obtaining a plan with an actuarial value of 94, a silver-94-eligible consumer chose a plan with an actuarial value of 90 (platinum) or 80 (gold) and a monthly premium higher than that of the silver-94 plan. Similarly, a silver-87eligible consumer who chooses a gold plan would be forgoing a cheaper option with more generous coverage. Choice of a bronze plan by a person eligible for an enhanced silver plan is not necessarily suboptimal because although these plans have a much lower actuarial value than silver-87 or silver-94 plans, they also have lower premiums. If a person eligible for an enhanced silver plan has little or no health care use, enrolling in a bronze plan can be a reasonable financial decision.

The premium consequences of choice errors are substantial. In 2019 among silver-87-eligible enrollees in California's ACA Marketplace, Covered California, those in enhanced silver plans paid an average of \$40 less per month than those in gold plans, and among silver-94-eligible Covered California enrollees, those in enhanced silver plans paid an average of \$40 less per month than those in gold plans and \$95 less per month than those in platinum plans.<sup>5</sup>

In addition to paying excess premiums, when CSR-eligible consumers forgo enhanced silver plans, they miss out on reduced out-of-pocket expenses when using care, as well as much greater financial protection if an adverse health event should occur. For example, based on Covered California's 2019 benefit design, an enrollee in a silver-94 plan pays \$5 for a doctor's visit, whereas those in a platinum or gold plan pay \$15 and \$30, respectively. In 2019 a silver-94 plan had a \$1,000 out-of-pocket maximum compared with \$3,350 for a platinum plan and \$7,200 for a gold plan. And a silver-87 plan had a \$2,600 out-of-pocket maximum compared with a \$7,200 maximum in a gold plan.<sup>6</sup>

Given that CSR plans provide more affordable health insurance premiums, lower cost sharing, and better risk protection, it is a puzzle why consumers would instead choose gold or platinum plans. Previous research points to a lack of awareness, plan complexity, and choice overload as possible explanations.<sup>7,8</sup> To the extent that these barriers play a role in explaining choice errors among CSR silver–eligible consumers, messages that explain the benefits of enhanced silver plans and simplify the plan choice process with a recommendation may be able to increase

CSR silver plan take-up.

In this study we used a randomized intervention in California's ACA Marketplace to examine whether low-cost nudges in the form of messages sent by email, postal mail, or both could induce plan switching among renewing households who were eligible for enhanced silver plans but enrolled in gold or platinum plans in 2018. The messages were tailored to three specific choice error subpopulations: silver-87-eligible enrollees in gold plans, silver-94-eligible enrollees in gold plans, and silver-94-eligible enrollees in platinum plans. Messages described the average premium and out-of-pocket savings consumers could reap if they kept the same issuers and plan networks but switched to the enhanced silver tier. This allowed us to test whether such messages increased plan switching and whether the mode through which the messages were delivered differentially affected plan switching.

#### **Study Data And Methods**

CALIFORNIA'S ACA MARKETPLACE As noted above, our intervention took place in California's state-based ACA Marketplace, Covered California. In addition to being the largest state-based Marketplace, with more than 1.5 million enrollees, Covered California requires qualified health plans to offer standardized benefit designs in which all plans sold on the individual market in the same metal tier have the same cost-sharing and deductible profiles.9 This standardization makes it easy for consumers to shop for plans based on price, network, and quality ratings. And as part of its website's choice architecture, Covered California displays plans in order from lowest to highest estimated total costs (that is, premium plus out-of-pocket expenses), so a silver-87 or silver-94 plan would appear before a gold or platinum plan.

INTERVENTION, STUDY POPULATION, AND DATA Insurers participating in the ACA Marketplaces are required by law to provide CSR subsidies to consumers with incomes of 100-250 percent of poverty, and from 2014 to 2017 the federal government directly reimbursed insurers for doing so. In October 2017, however, shortly before the start of the 2018 open enrollment period, the federal government defunded CSR subsidies. In response, many states-including Californiadirected insurers to make up for the lost reimbursements by raising silver plan premiums, thereby increasing the price of the benchmark plan for federal premium subsidies. When silver plan premiums increased, so too did the subsidies. This strategy, known as silver loading, shielded all subsidized consumers, including those eligible for CSR silver plans, from premium increases and had the effect of lowering net (after-subsidy) premiums for bronze, gold, and platinum plans.

One consequence of this policy change was a large increase in gold plan enrollment across the ACA Marketplaces. Among the thirty-nine states that use the HealthCare.gov platform, gold enrollment increased from 303,989 in 2017 (or 3 percent of total enrollment) to 528,087 in 2018 (or 6 percent of total enrollment). Approximately 73,900 consumers enrolled in gold plans in 2018 had incomes of 100–200 percent of poverty and thus were eligible for enhanced silver plans. 10,11 Covered California experienced an increase in the share of enrollees in gold plans as well. Notably, the overall incidence of choice errors is relatively low, with more than 90 percent of silver-87- and silver-94-eligible enrollees avoiding choice errors by choosing either enhanced silver plans or bronze plans. Among silver-87-eligible enrollees, the share in gold plans increased from 1.7 percent in 2017 to 5.1 percent in 2018, and among silver-94-eligible enrollees, the share in gold or platinum plans increased from 1.6 percent in 2017 to 3.6 percent in 2018.

Enrollment in gold plans in California among silver-87-eligible consumers was further accelerated when two insurers in the Marketplace priced their gold plans lower than their silver plans. Because the gold plans offered by these two insurers were cheaper than their silver plans for the 2018 coverage year, it would not have been a choice error for silver-87-eligible consumers to select these plans, as they would not be paying a higher monthly premium for a plan with lower actuarial value.

For the 2019 enrollment year, this unusual pricing dynamic was addressed as insurers scaled back the extent to which they increased premiums through silver loading and the premiums for gold plans became more expensive than those for silver plans. But many consumers enrolled in gold plans in 2018 might not have been aware that by switching to a silver-87 or silver-94 plan in 2019, they would pay less in premiums and have lower out-of-pocket spending than if they remained in the gold tier. To test alternative approaches to encourage plan switching among 2018 enrollees in gold and platinum plans who were eligible for enhanced silver plans, we designed a three-group block randomized intervention during the open enrollment period for 2019. Our study was not preregistered in a trial registry, nor was our preanalysis plan posted publicly.

Before the start of the 2019 coverage year, in September 2018, we queried the Covered California database and identified 19,159 households enrolled in CSR choice error plans. This

# Our intervention points to a low-cost approach for states that could yield reductions in choice errors.

data set indicated each household's 2018 eligibility for CSR silver plans and their 2018 metal tier selection, as well as demographic information for the primary contact in the household. We then used Stata to randomly assign households to one of three groups (see the online appendix for additional details). 12 These were a control group that received no CSR silver-specific messaging, an email-only group, and a mail-plusemail group. Households in the control group did not receive any messages in October 2018, but from November 2018 to January 2019 they received the standard messages that Covered California sends to renewing consumers during open enrollment, which encourage members to shop and compare plans but do not make explicit metal tier recommendations. Households in the email-only group were assigned to receive a CSR silver-specific email in early October 2018 and a reminder email at the end of October. Thereafter they received the standard messages Covered California sends to renewing consumers during open enrollment. And households in the mailplus-email group were assigned to receive a CSR silver-specific letter by US Postal Service mail in early October and a reminder email at the end of October. Thereafter they received the standard messages that Covered California sends to renewing consumers during open enrollment. For each choice error subpopulation, the email and postal messages described the average premium and out-of-pocket savings consumers could reap by switching metal tiers from gold or platinum to silver while retaining the same issuers and plan networks (see the appendix for sample material).12 Households that previously had indicated a written language preference of Spanish received outreach in Spanish; all others received outreach in English. For those assigned to the treatment groups, the average cost of outreach was \$0.30 per household.<sup>13</sup>

At the end of the open enrollment period in January 2019, we once again queried the Covered

California database to create a data set that indicated each household's 2019 Marketplace enrollment status, CSR silver plan eligibility, and metal tier selection. We then joined this January 2019 data set with the September 2018 data set to create our primary outcome of interest—an indicator for whether the household enrolled in an enhanced silver plan for the 2019 coverage year. In appendix exhibit A2 we report the effect of the intervention on a secondary outcome: calls to the agency's service center.<sup>12</sup>

Because households were randomly assigned to treatment groups, we could obtain unbiased estimates of the intent-to-treat effect by comparing the average outcome across treatment groups. We used linear regression to estimate the effect of treatment assignment on the enhanced silver enrollment rate. To explore heterogeneous treatment effects, we also estimated models that interacted pretreatment covariates with the two treatment indicators.

**LIMITATIONS** Because our research design was based on random assignment, we were able to recover causal effects with minimal assumptions.14 But our design was not without limitations. We implemented this intervention in California's ACA Marketplace, and it might not necessarily generalize to other health insurance settings, such as Medicaid or TRICARE, in which consumers do not have the option of making choice errors (that is, selecting plans with higher premiums but lower actuarial values than those of the available alternatives). But because choice errors have been widely documented and because our intervention was designed to address commonly cited reasons for them, including plan complexity and lack of awareness, we believe that our results can inform efforts in other ACA Marketplaces seeking to reduce these errors.

Second, one-sided noncompliance occurred because not all households had an email address, so a portion of households assigned to the treatment groups could not be treated. To address noncompliance, we estimated the effect of treatment receipt using two-stage least squares regression under different operationalizations of compliance (see appendix exhibits A11 and A12).<sup>12</sup>

Another limitation centers on attrition in our experimental sample. Eight percent of households did not remain enrolled for the 2019 coverage year, reducing our statistical power to detect differences in enhanced silver take-up rates. Between September 2018 and January 2019, consumers may have been terminated by their insurers for nonpayment, gained employer-sponsored coverage, transitioned to Medicaid, moved out of California, or died. Given the randomiza-

tion, attrition rates are comparable across treatment groups. Nevertheless, we tested for differential attrition and then addressed attrition by using partial identification, <sup>15</sup> estimating bounds under the assumption that households whose 2019 enrollment we did not observe would have exhibited systematically high or low CSR take-up (see appendix exhibits A13 and A16). <sup>12</sup>

An additional form of attrition involves income changes that moved consumers out of silver-87 or silver-94 eligibility. Between September 2018 and January 2019, this happened to 18 percent of households. We tested for differential eligibility changes and then reestimated our main analyses among households that maintained the same eligibility across enrollment years (see appendix exhibits A14 and A15).<sup>12</sup>

Finally, the ACA's individual insurance markets are marked by high levels of churning as consumers experience income changes or transition to other sources of coverage. <sup>16</sup> Describing empirical approaches to address the challenges created by churning may offer practical guidance to other states that seek to administer randomized interventions in settings where not all consumers can be treated and that span across coverage years.

#### **Study Results**

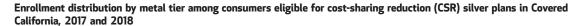
Exhibit 1 shows enrollment distribution in Covered California by metal tier in 2017 and 2018 across the three cost-sharing reduction silver plan eligibility levels.

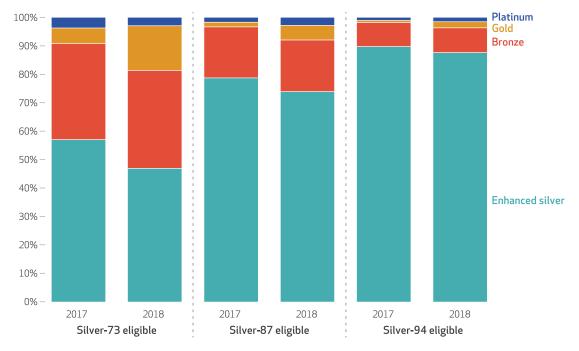
Under random assignment, all pretreatment characteristics were similar on average across treatment groups. Exhibit 2, which presents demographic information for our study population, shows that the treatment and control groups were balanced across a dozen pretreatment characteristics.

Our main question of interest was whether households randomly assigned to the treatment groups switched into enhanced silver plans at higher rates than the control group. Exhibit 3 shows both the pooled and block-level treatment effects. Appendix exhibit A1 includes the regression results.<sup>12</sup>

At the end of the open enrollment period, 17.7 percent of the control group had switched to enhanced silver plans (exhibit 3). This baseline rate of switching is an important reminder of inertia in health insurance markets, where most consumers do not change plans during renewal, even when doing so would lead to substantial cost savings without any change in insurers or provider networks.<sup>17</sup> Relative to the control group, assignment to the email-only treatment group increased the enhanced silver enrollment

#### EXHIBIT 1





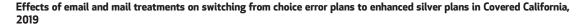
**SOURCE** Authors' analysis of 2017 and 2018 Covered California administrative data. **NOTES** CSR subsidies are available to eligible consumers with household income below 250 percent of the federal poverty level. The three CSR silver plans are defined in the text. Catastrophic plans, which make up 0.1% of total enrollment, are excluded for visual clarity.

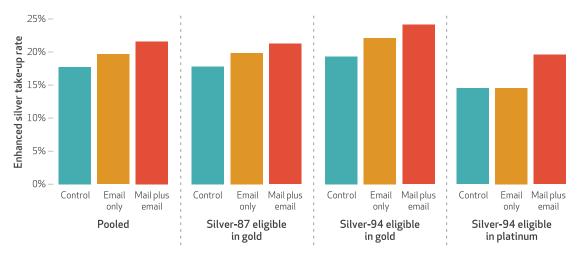
#### **EXHIBIT 2**

#### Summary statistics of the study sample of enrollees in Covered California, 2018 and 2019

Covariates	Control $(n = 5,748)$	Email only $(n = 6,705)$	Mail plus email $(n = 6,706)$
Choice error block (number enrolled) CSR silver-87 eligible in gold CSR silver-94 eligible in gold CSR silver-94 eligible in platinum	4,110 1,019 619	4,796 1,188 721	4,795 1,189 722
Age (years)	42	43	43
Female (%)	52	53	52
Non-Hispanic Black (%) Hispanic (%)	3 24	3 24	3 24
No email <sup>a</sup> (%)	20	20	20
Household income as percent of federal poverty level (%)	166	166	166
English speaker (%) Spanish speaker (%)	88 9	88 9	88 9
Not enrolled in 2019 <sup>b</sup> (%)	8	8	8
Autorenewed into 2018 plan <sup>c</sup> (%)	28	27	27
Gold plan cheaper than silver in 2018d (%)	42	41	40
No. of enrollees per household	1.30	1.31	1.31

**SOURCE** Authors' analysis of 2018 and 2019 Covered California administrative data. **NOTES** The first three rows report enrollment counts by choice error block. The remaining rows report the mean values of pretreatment covariates for the primary contact in the household listed on the Covered California application. There were no statistically significant differences across treatment groups; all p values were well above 0.05, indicating that the groups were balanced. CSR is cost-sharing reduction subsidies. \*Share of enrollees who did not have email addresses in 2018 and 2019. \*Share of 2018 enrollees who did not retain coverage in 2019. \*Share of enrollees who had been automatically renewed into their 2018 plan. \*Share of enrollees who enrolled with an issuer whose gold plan was cheaper than its silver plan in 2018.





**SOURCE** Authors' analysis of 2019 Covered California administrative data. **NOTES** The figure shows enhanced silver plan take-up rates in 2019 by treatment group and by choice error block among renewing enrollees who were in a choice error plan in 2018. The three choice error blocks are explained in the text. All estimates are statistically significant (p < 0.05 or p < 0.01) except for the email-only groups for silver-94-eligible patients in gold and platinum plans.

rate by 2.0 percentage points (p < 0.01), which represents an 11 percent increase in plan switching relative to the control group. In addition, assignment to the mail-plus-email treatment group increased the enhanced silver enrollment rate by 3.9 percentage points (p < 0.01), which represents a 22 percent increase in plan switching relative to the control group. On the basis of our testing for equality of coefficients, we can reject the null hypothesis that the email-only and mail-plus-email treatments are equal (p < 0.01).

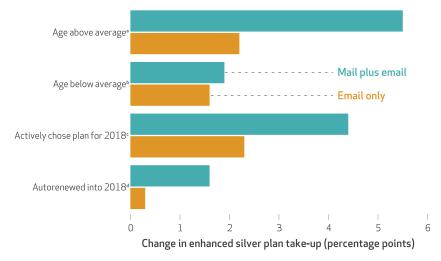
The block-level treatment effects (by type of choice error) were generally similar to the pooled results, but among silver-94-eligible households in platinum plans, the email-only group had no statistical or substantive effect on enhanced silver enrollment. Among silver-94-eligible households enrolled in gold plans, although the point estimate on the email-only group is a substantively large 2.7 percentage points, because of the small size of the block, it is not statistically significant (exhibit 3).

We also estimated the effect of the treatments across various subpopulations (the full set of results is in appendix exhibits A3–A10).<sup>12</sup> As shown in exhibit 4, when the sample was stratified by age (that is, above or below the mean age of 42.5 years) and enrollment pathway (that is, whether a consumer had been autorenewed into their 2018 plans or had actively chosen 2018 plans), we found statistically significant differences in the effects of the interventions.

Among enrollees older than age 42.5, the mail-

#### **EXHIBIT 4**

Effects of email and mail treatments on switching from choice error plans to enhanced silver plans in Covered California: differences by age and enrollment pathway, 2019



**SOURCE** Authors' analysis of 2019 Covered California administrative data. **NOTES** For the two treatment groups, the figure shows the percentage-point change in enhanced silver plan take-up rates in 2019 among renewing enrollees who were in choice error plans in 2018. Choice error plans are explained in the text. The mail-plus-email treatment was significantly more effective among enrollees with ages above average (p < 0.05), whereas the difference in response to the email-only treatment by enrollees younger and older than the mean age was not statistically significant. Both treatments were significantly more effective among enrollees who had actively chosen their 2018 plans (p < 0.10). "Defined as being older than age 42.5. "Defined as being younger than age 42.5. "Consumers who had actively selected choice error plans in 2018. "Consumers who had been autorenewed into their 2018 plans.

plus-email treatment increased plan switching by 5.5 percentage points compared with 1.9 percentage points among younger enrollees (p < 0.05). The difference in response to the email-only treatment by enrollees younger and older than the mean age (a 1.6-percentage-point increase in plan switching versus a 2.2-percentage-point increase) was not statistically significant (exhibit 4).

In examining treatment effects by enrollment pathway, we found that both treatments were significantly more effective among consumers who had actively chosen their 2018 plans (that is, active choosers). The email-only treatment caused a 2.3-percentage-point increase in enhanced silver plan enrollment among active choosers, whereas enhanced silver plan enrollment among those who had been autorenewed into 2018 plans (that is, autorenewers) increased by just 0.3 percentage points after receiving the email-only treatment (p < 0.1). The mailplus-email group caused a 4.4-percentage-point increase in enhanced silver plan enrollment among active choosers compared with a 1.6percentage-point increase among autorenewers (p < 0.05).

The premium and out-of-pocket savings for consumers who took up enhanced silver plans for the 2019 enrollment year were substantial. On average, consumers saved \$84 per month, or more than \$1,000 annually, on their health insurance premiums relative to what they would have paid if they had remained in a choice error plan. Consumers who switched from choice error plans to enhanced silver plans benefited from an estimated average savings of \$56 per month, or more than \$670 on an annualized basis, in reduced out-of-pocket expenses. In contrast, forgone savings for consumers who remained in choice error plans for 2019 averaged \$75 per month, or \$900 on an annualized basis, relative to what they could have paid if they had switched to enhanced silver plans with the same issuer and network (data not shown).

#### **Discussion**

The ACA Marketplaces provide a multitude of plan options, and although policy makers would like to see consumers enroll in the best available plan to maximize take-up of available subsidies, the complexity of health insurance results in choice errors. Every year tens of thousands of CSR-eligible consumers forgo enhanced silver plans for more expensive and less generous coverage—a problem that intensified after the termination of CSR subsidies in October 2017. During the 2019 open enrollment period we tested whether email and postal mail nudges could

increase switching from choice error plans into CSR silver plans in California's ACA Market-place. Our findings indicate that both the email-only and the mail-plus-email treatments had statistically significant effects on CSR silver plan take-up, and, overall, the combination of mail and email was more effective in increasing plan switching than email alone. Only the mail-plus-email treatment had significant effects across all choice error subpopulations.

Importantly, however, although the intervention induced several hundred consumers to take up CSR plans, more than 13,000 remained in choice error plans for the 2019 coverage year. Requiring low-income consumers to navigate a complex decision environment to access financial support for which they are eligible may limit the overall effectiveness of government programs. To encourage more complete take-up of CSR silver plans, ACA Marketplaces could explore approaches that go beyond low-touch nudges. For example, Marketplaces could rebrand metal tiers to more clearly convey the superiority of enhanced silver plans vis-à-vis gold and platinum plans (by calling them "enhanced gold" and "enhanced platinum" rather than "enhanced silver"). Even better, and following a growing literature on the importance of defaults in choice environments, Marketplaces may wish to simplify the enrollment process by eliminating choice error plans from the shopping experience altogether. 18,19

Our results differ from those of an earlier randomized intervention in Colorado's ACA Market-place during the 2016 open enrollment period, in which email and postal messages had no effect on plan switching. <sup>20</sup> Notable differences between the two interventions include the call to action and each state's approach to benefit design. Whereas the Colorado intervention encouraged consumers to switch to the lowest-cost plan within their metal tier, which likely would have involved changing insurers, we informed consumers enrolled in gold or platinum plans that they could save money and get a higher-value plan by switching metal tiers to enhanced silver while keeping the same insurer and provider network.

Covered California's standardized benefit designs allow consumers to compare plans based on the price, network, and quality ratings of the qualified health plans without the added complication of having to understand and compare varying deductibles or copays across plans within the same metal tier. In contrast, as Keith Ericson and colleagues have noted, because Colorado does not have standardized benefit designs, consumers in that state's ACA Marketplace had to assess myriad plan attributes while shopping, which may have contributed to

inertia. Colorado consumers who valued their current provider network and benefit design may have been unwilling to change plans, even if it resulted in premium savings.<sup>20</sup>

#### Conclusion

Our results showed that email and postal nudges can increase switching into CSR silver plans, thereby reducing choice errors and resulting in sizable premium and out-of-pocket savings for low-income consumers. As such, they carry implications for other ACA Marketplaces seeking to assist consumers with metal tier selection. Given that gold enrollment increased not just in California but nationwide after the termination of CSR subsidies, other states are likely grappling with how to guide low-income consumers to the best available plan for which they are eligible. Our intervention points to a low-cost approach for states that could yield reductions in choice errors.

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- **12** To access the appendix, click on the Details tab of the article online.
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#### The Role of Behavioral Frictions in Health Insurance Marketplace Enrollment and Risk: Evidence from a Field Experiment<sup>†</sup>

By RICHARD DOMURAT, ISAAC MENASHE, AND WESLEY YIN\*

We experimentally varied information mailed to 87,000 households in California's health insurance marketplace to study the role of frictions in insurance take-up. Reminders about the enrollment deadline raised enrollment by 1.3 pp (16 percent) in this typically low take-up population. Heterogeneous effects of personalized subsidy information indicate misperceptions about program benefits. Consistent with an adverse selection model with frictional enrollment costs, the intervention lowered average spending risk by 5.1 percent, implying that marginal respondents were 37 percent less costly than inframarginal consumers. We observe the largest positive selection among low income consumers, who exhibit the largest frictions in enrollment. Finally, we estimate the implied value of the letter intervention to be \$25 to \$53 per month in subsidy dollars. These results suggest that frictions may partially explain low take-up for marketplace insurance, and that interventions reducing them can improve enrollment and market risk in exchanges. (JEL C93, G22, G52, H75, I13)

At any one time, approximately 10 million people have health coverage through an exchange created by the Patient Protection and Affordable Care Act (ACA) (CMS 2019), and approximately 30 million people have obtained ACA exchange coverage

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<sup>&</sup>lt;sup>†</sup>Go to https://doi.org/10.1257/aer.20190823 to visit the article page for additional materials and author disclosure statements.

at some point since their creation in 2014.<sup>1</sup> As a fraction of eligible enrollees, however, take-up is surprisingly low. Nearly 60 percent of individuals who are eligible for a federal premium subsidy, and 40 percent of lower-income individuals eligible for progressive premium and cost-sharing subsidies, forgo the subsidy and remain uninsured (Kaiser Family Foundation 2020).<sup>2</sup> That so many subsidy-eligible people fail to take up marketplace insurance is consistent with an extensive literature documenting incomplete participation in benefits programs available to economically disadvantaged individuals (Currie 2006).

One explanation for low take-up is that consumers do not sufficiently value marketplace coverage. In the individual marketplace in Massachusetts, Finkelstein, Hendren, and Shepard (2019) find that the take-up rates and price elasticities imply a willingness-to-pay (WTP) of marginal enrollees for coverage that is far below consumers' marginal health care costs. Finkelstein, Hendren, and Shepard (2019) explore a number of potential explanations, ultimately pointing to the availability of uncompensated care as a primary factor for why consumers' marginal health care costs exceeds their measured WTP.

Evidence from a growing literature on plan choice suggest another potential explanation for the surprisingly low measured WTP: behavioral frictions, such as informational search costs and psychological frictions. Consumers' lack of awareness of plan attributes, choice complexity, choice overload, and inertia can impact both shopping behavior among current enrollees (Ericson et al. 2017) and plan choice (Abaluck and Gruber 2011, Ketcham et al. 2012, Kling et al. 2012, Handel 2013, Handel and Kolstad 2015). Such frictions can result in higher equilibrium pricing (Ericson 2014) and adverse selection welfare loss (Handel 2013; Polyakova 2016; Handel, Kolstad, and Spinnewijn 2019).

These studies suggest that behavioral frictions may also impact *take-up* decisions.<sup>3</sup> Indeed, Wright et al. (2017) finds a positive and persistent effect of randomized nudges on take-up in Oregon's state Medicaid. The potential presence of economically significant behavioral frictions in enrollment decisions would imply different policy responses to encourage coverage take-up than if under-enrollment were due only to the presence of uncompensated care or other explanations.

Frictions in marketplace enrollment decisions potentially have large implications for market risk, with theoretically ambiguous effects. If marginal respondents to an intervention that reduces frictions are sicker, due to severe baseline lack of information about coverage benefits, or more difficulty making take-up decisions due to

<sup>&</sup>lt;sup>1</sup>Estimates based on data on churn from Covered California, which represents about one-eighth of US exchange enrollment. Covered California currently covers 1.3 million enrollees and has covered over 4 million individuals since 2014.

<sup>&</sup>lt;sup>2</sup>For individuals below 250 percent of the federal poverty level (FPL), roughly 70 percent of the market, the interquartile range for net-of-subsidy premiums of a Bronze plan in California in 2020 was \$1 to \$10 per member per month, reflecting an average subsidy of \$371 per month. The most affordable "enhanced" Silver plan (in which cost-sharing is substantially subsidized) typically costs these consumers \$30 to \$128 per month (or less than 30 percent of average insurer-paid claims), reflecting an average subsidy of nearly \$455 per month, including cost-sharing benefits.

<sup>&</sup>lt;sup>3</sup> Finkelstein, Hendren, and Shepard (2019) raise behavioral frictions as a possible factor for the low WTP they measure, but do not study their importance. Evidence from means-tested public programs outside of health care point to behavioral frictions as a potentially important factor in participation decisions, including: retirement saving programs and the earned income tax credit (EITC) (Smeeding, Phillips, and O'Connor 2000; Chetty and Saez 2013; Chetty, Friedman, and Saez 2013; Bhargava and Manoli 2015); employer-matched retirement savings (Madrian and Shea 2001); and antipoverty programs (Bertrand, Mullainathan, and Shafir 2006).

illness, <sup>4</sup> average market risk may increase, leading to higher equilibrium premiums and welfare loss. On the other hand, if marginal respondents are healthier, as would be the case if frictions dissuaded healthy consumers from purchasing insurance, average risk may fall, lowering community-rated premiums, and bolstering market stability. The welfare impact of any intervention depends on the correlation between underlying frictions and the health risk of marginal enrollees. The sign of this correlation is particularly important in ACA markets, where adverse selection on the extensive margin may result in more severe welfare loss than selection across plans (Chandra, Gruber, and McKnight 2011; Hackmann, Kolstad, and Kowalski 2015; Jaffe and Shepard 2018; Finkelstein, Hendren, and Shepard 2019), potentially destabilizing markets (Handel, Hendel, and Whinston 2015). Moreover, the impact of any enrollment intervention on risk selection *into* the market can also have important secondary effects on adverse selection *within* the market, due to equilibrium distribution of risks across plans (Geruso et al. 2019).

In this study, we conduct a field experiment to test how reducing behavioral frictions impacts enrollment decisions and market risk. We randomly assigned 87,394 California households to receive one of five letter interventions, designed to lower informational and psychological frictions that could hinder take-up in Covered California, the state's health benefits exchange. We examine how these interventions impact enrollment and average market risk due to selection of marginal respondents to treatment.

This study makes several contributions, building on recent research on the interaction between behavioral frictions and adverse selection in plan choice (Handel 2013; Polyakova 2016; Handel, Kolstad, and Spinnewijn 2019). First, the implications of reducing behavioral frictions in these recent studies are based on counterfactual simulations, where frictions are hypothetically removed in order to assess equilibrium consequences of improved choice. In contrast, this study exploits experimental variation in the reduction of consumer frictions using tools available to policymakers. Second, we combine our randomized intervention with administrative data on health risk to test how reductions in frictions impact *enrollment* and average market risk. To our knowledge, this study is the first to combine a policy-relevant intervention targeting behavioral frictions with health risk data to identify potential adverse selection implications of frictions in take-up decisions. Finally, we use our randomized assignment to estimate the subsidy dollar-value equivalent of reductions in the behavioral frictions targeted by the letter intervention.

We find that a basic letter reminding consumers of the enrollment deadline raised enrollment by 1.3 pp (or 16 percent) in this low-uptake population. This evidence is consistent with inattention having an important role in take-up. Among low-income consumers, letters making personalized subsidy and plan comparison information

<sup>&</sup>lt;sup>4</sup>A large literature has documented the impact of chronic diseases on distress and emotional change (Jokela et al. 2015) and the link between emotions and decision-making (see Lerner et al. 2015 for a review). Research has also identified direct links between chronic conditions (Bayliss et al. 2003) and anxiety and depression (Miu, Heilman, and Houser 2008; Paulus and Yu 2012) to impaired decision-making, cognitive processes, and care management.

<sup>&</sup>lt;sup>5</sup>By focusing on frictions in enrollment decision, as opposed to plan choice, we are able to study friction on the extensive margin. The potential for extensive margin adverse selection welfare loss in the ACA markets, which are subject to community rating and guaranteed issue, is thought to dominate welfare losses associated with adverse selection in plan choice (Chandra, Gruber, and McKnight 2011; Hackmann, Kolstad, and Kowalski 2015; Jaffe and Shepard 2018; Finkelstein, Hendren, and Shepard 2019).

more salient raise enrollment slightly, indicating that some consumers are not fully aware of the magnitude of subsidy benefits. As subsidies fall with income, the relative benefit of providing subsidy information also falls, further indicating that consumers misperceive their subsidies.

We also find that the letter interventions on average induced healthier consumers into the market. We employ two measures of health risk, expected expenditures based on prior health care encounters, and a second measure based on claims incurred during the covered year following the intervention. We find consistent effects across the two measures. Conservative results suggest that the letter interventions lowered average spending risk by 5.1 percent, implying that marginal respondents to the letters were 37 percent less costly to insure than inframarginal enrollees. Part of the positive selection is driven by the entry of younger consumers, but most is driven by take-up by lower risk consumers conditional on age and region. Age and region are the only factors that plans can use to vary premiums, implying that the positive selection resulted in greater risk pooling and potentially reduced adverse selection in equilibrium.

Finally, we estimate a simple consumer choice model to quantify the subsidy dollar-value equivalent of the letter interventions. We estimate that the information provided by the letters was equivalent to \$25 to \$53 per month in additional premium subsidy. This is remarkable given that the intervention was a mailed letter, costing only \$0.69. The "low touch" nature of the intervention, along with its large implied value, indicates that residual behavioral frictions pose an economically meaningful barrier to take-up, and contribute to explaining why measured WTP for marketplace coverage is so low.

These results highlight the importance of behavioral frictions such as enrollment hassle costs and information search costs in determining enrollment and average market risk. The effects of the relatively low cost and "low touch" interventions studied here motivate policies that further target these frictions, including expanded or more intensive outreach, simpler enrollment processes, and the use of defaults or auto-enrollment. Indeed, back-of-the-envelope calculations suggest that expanding even the low touch intervention from this study to broader populations of marketplace-eligible consumers would lower total market risk by a meaningful amount. Similarly, disinvestment in consumer awareness and enrollment campaigns (Corlette and Schwab 2018) could reduce take-up, and worsen market health risk of the insured.

The rest of the paper proceeds as follows. Section I describes the ACA marketplace from the consumer's vantage point. Section II describes the field experiment, letter interventions, the study sample, and data. In Section III, we outline our empirical strategy for identifying treatment effects on enrollment and average market risk. In Section IV, we present estimated treatment effects on enrollment and market risk, and estimates the implied subsidy-value equivalent of our letter interventions.

<sup>&</sup>lt;sup>6</sup>See Shepard (2019) for recent research in the enrollment and risk effects of easing enrollment through auto-enrollment mechanisms. Additionally, legislation recently enacted in California will require auto-enrollment into Covered California for a large segment of the population studied here (the "County Referred" group) (Senate Bill 260, 2019–2020 first Session, chapter 845, Statutes of 2019).

Section V concludes with a discussion of policy implications and potential generalizability of our findings to broader populations of marketplace-eligible consumers.

#### I. Background on the ACA Marketplaces and Enrollment Frictions

A major provision of the ACA was the establishment of regulated insurance marketplaces, or "Exchanges," for the non-group and small group markets made up of individuals without health insurance coverage through a large employer or another public program. Through regulations on plan characteristics and premium rate-setting, the imposition of a requirement to buy coverage (the "mandate"), and new income-based subsidies to make coverage more affordable, the ACA sought to improve affordability, competition, and stability in a market previously characterized by denials of coverage, complicated products, and low rates of enrollment.

To make premiums more affordable to consumers with higher expected health care costs, insurers under the ACA can only vary plan premiums by age (and smoking, in some states other than California), but the ratio of premiums for the oldest to the youngest consumers cannot exceed 3:1. Insurers also cannot deny coverage to any eligible consumer, a policy known as "guaranteed issue." In addition to premium setting regulations, there are also standardizing rules on the plan benefit designs, to minimize "cream-skimming" and to simplify consumer decision-making by minimizing search frictions and choice complexity. For example, all plans must conform to one of five metal tiers corresponding to actuarial value.

Numerous complexities remain in the ACA's active choice environment. To help households afford coverage, the law also provides progressive premium and cost-sharing assistance. Generally, individuals in households with an income between 100 and 400 percent of the federal poverty level (FPL), and who do not have access to other affordable insurance options (such as employer-sponsored care or Medicaid) are eligible for an Advanced Premium Tax Credit (APTC) for plans sold on the Exchange. The APTC uses a complex formula, based on projected income and the distribution of premiums offered in a market, which means consumers generally need to use an online calculator or complete an insurance application to browse plans and compare their net-of-subsidy prices, a process that requires time and effort.<sup>9</sup>

Surveys conducted by Covered California suggest that frictions may be large. Despite California's multifaceted approach to outreach and marketing (Lee et al. 2017), many uninsured Californians do not understand what their subsidy is for

<sup>&</sup>lt;sup>7</sup>Given the evolution of risk over the life cycle, these types of pricing rules can increase consumer surplus (Handel, Hendel, and Whinston 2015); however, without other mitigating policies they can also lead to adverse selection and instability in the market (Geruso and Layton 2017). To limit adverse selection, the law mandated that individuals be insured. The Tax Cut and Jobs Act of 2017 zeroed out the mandate penalty starting in 2019.

<sup>&</sup>lt;sup>8</sup>Plans sold in the California non-group marketplace must adhere to standardized product designs, beyond actuarial value, including standardized cost-sharing and deductible profiles within metal tier. The impacts of informational interventions reported in this study should therefore be interpreted in the context of heightened standardization, designed to foster plan comparison and competition.

<sup>&</sup>lt;sup>9</sup>Premium credits are reconciled at the end of the year once annual income has been realized. This means that even the complex prices determined during the year may change upon filing taxes (which occurs after all health insurance has already been purchased and consumed).

coverage on the Exchange (Greenberg 2017). And some remain unaware of their eligibility for Exchange coverage and premium subsidies, particularly consumers transitioning between the state Medicaid program and the exchange (Greenberg 2017). These issues reflect a host of frictions related to awareness (of plans, benefits, eligibility, or own risks), informational search costs, choice complexity, inattention, and other psychological frictions. The potential for these nonmonetary behavioral frictions to impede enrollment motivates efforts to raise awareness and to reduce the hassle cost of enrollment.

Efforts to increase enrollment may also have implications for market risk. On one hand, policymakers recognize the potential risk pooling benefits of increasing enrollment among healthier consumers for whom the cost, both financial and transactional, may exceed their demand for insurance. On the other hand, there is concern that easing enrollment among special enrollment populations may raise risk and destabilize premiums (Eyles and Handelman 2016; Federal Register 2017a, b).

#### **II. Study Sample and Interventions**

A. Study Sample: The Covered California "Funnel"

The sampling population for the study is the "Funnel" into Covered California from December 2015 to January 2016, during the open enrollment period for 2016 coverage. This population is comprised of consumers that had an active determination of eligibility for Covered California 2016 coverage, but had not yet selected a plan. Consumers in this study entered the Funnel through two pathways.

The first group of consumers in the Funnel were households that applied directly to Covered California, were determined eligible to enroll (and, if applicable, eligible for subsidies), but never selected a plan. These consumers, who we henceforth refer to as "open enrollment applicants" were self-selected based on interest in market-place coverage by virtue of their applying to Covered California. After initiating the enrollment process, a household may not have chosen a plan for a variety of reasons, including having since received coverage through another source, deciding the costs exceeded the benefits from coverage, but also due to frictions such as difficulty choosing between plan options, confusion about subsidy amounts, or simply forgetting to do so by the deadline. But based on having applied for coverage, open enrollment applicants were aware of Covered California, and likely to have previously seen information about enrollment deadlines, plan options, and potential availability of subsidy benefits.

The second group of consumers in the Funnel were prior enrollees from the state Medicaid program who experienced a change in their eligibility (for example, loss of eligibility due to an increase in income). These changes could have been initiated by the consumer reporting a change in circumstances (e.g., income) to the County, but could also have been initiated by a County performing periodic redetermination.

<sup>&</sup>lt;sup>10</sup>These consumers applied either directly at www.CoveredCA.com or by asking for help from Covered California Certified Enrollers, including call center employees, licensed insurance agents, and navigators to submit applications on a consumer's behalf.

Henceforth, we refer to this population as "county referrals." Any household that entered the Funnel by county referral was sent a formal notice (letter) from their county informing them of their changed Medicaid eligibility and new eligibility to enroll in a plan through Covered California. Depending on their incomes and other eligibility conditions, these consumers may also have been eligible for subsidies through Covered California. Compared to open enrollment applicants, county referral households were typically at an earlier stage in their engagement with the marketplace, and likely to have had less exposure to information about plan options, subsidy benefits, and subsidy determination.

Because information may serve different roles for these two populations, we conduct pooled and separate analyses for open enrollment and county referral samples, allowing us to better understand the mechanisms that drive the results. The total point-in-time size of the Funnel prior to open enrollment was 153,146 households, of which 64 percent were county referrals, and 36 percent open enrollment applicants.

#### B. Sample Selection for the Randomized Control Trial

The prior section describes the full set of households in the Funnel who were deemed eligible for the study at the time of treatment assignment. For budgetary reasons, we reduced the total sample to 126,182 randomly selected households from the full Funnel to be in the study. These households were then randomized into the five study arms using the method described in Section IID. Since the time of the treatment randomization, we became aware that some households were not eligible to enroll in Covered California, or did not have valid addresses, ages, or other eligibility attributes, leading us to exclude these and other households to create the final study sample. The final sample size after applying these exclusions is 87,394 households. Although these exclusions were made after the initial randomization, their impact on each study arm is the same in expectation. These exclusions and their impact on the sample size are discussed in online Appendix Section A1.1 and reported in online Appendix Table 1. Balance tests within the final sample are reported in Section IID.

Comparisons to the uninsured population in California, and to the Covered California enrolled population, are shown in Table 1 Along key dimensions, including age, household income, and race, the study sample closely resembles the uninsured population in California. This suggests that study results may have a reasonable degree of external validity for the remaining uninsured population, at least when considering further efforts to expand coverage on the margin. See online Appendix Section A1.2 for a more detailed comparison of these populations, and Section V for a discussion of how study results may generalize to various broader populations of potential marketplace-eligible consumers.

#### C. Experimental Letter Interventions

Subjects in the study were randomized into one of five arms: a control arm (arm 1) or one of four intervention arms, as preregistered in Yin (2017). Individuals in the control arm received no direct communication beyond the generic outreach and state-wide marketing activities used by Covered California for all consumers,

	Study sample	Covered California 2015	California uninsured 2015
	(1)	(2)	(3)
HH Age (mean)	37.65	43.94	37.28
SD of HH Age	14.64	13.30	13.26
FPL (FPL < 400)	212.25	203.63	216.55
SD of FPL	62.68	63.28	80.03
FPL > 400 (share)	0.14	0.09	0.22
White (share)	0.26	0.34	0.26
Latino (share)	0.43	0.20	0.33
Asian (share)	0.12	0.17	0.11
Black (share)	0.05	0.02	0.05
Observations (Households)	87,394	800,778	1,354,572
Observations (Individuals)	121,828	1,206,920	2,180,528

TABLE 1—DEMOGRAPHICS OF EACH POPULATION

*Notes:* Table 1 reports household-level income and demographic characteristics of the RCT study sample; enrollees in California's health insurance marketplace (Covered California) in December 2015, when the RCT sample was drawn; and the uninsured population in California in 2015 (based on the American Community Survey).

representing status quo interaction with Funnel consumers. <sup>11</sup> The intervention arms received the following letters: <sup>12</sup>

- Basic Letter (Arm 2): Reported the open enrollment deadline, general benefits of insurance, and the Covered California website and telephone number where they could shop for plans.
- Subsidy and Penalty (Arm 3): Reported Basic Letter information (Arm 2) plus the household's estimated monthly subsidy and tax penalty, based on their reported income and household size.
- **Price Compare** (**Arm 4**): Reported the content of Arms 2 and 3, plus a table listing the Silver and Bronze plans offered in their market, with their net-of-subsidy premium.<sup>13</sup>
- Price and Quality Compare (Arm 5): Reported the content of Arm 4, but the table also included plans' quality rating under the ACA's five-star quality rating system (QRS).

Each of the four letter interventions was designed to reduce one or several behavioral frictions that potentially impede take-up. <sup>14</sup>

<sup>&</sup>lt;sup>11</sup>Consumers in all arms, including the control arm, could still have received information through general advertising, such as Covered California sponsored newspaper, radio, and television advertisements, or outreach conducted by third parties.
<sup>12</sup>Letters in all treatment arms were double-sided, accordion-style letters. When opened, the large postcard-sized

<sup>&</sup>lt;sup>12</sup>Letters in all treatment arms were double-sided, accordion-style letters. When opened, the large postcard-sized mailer would unfurl into a four-postcard-length letter. One side of the letter was uniform across all four letter interventions, and reminded the study subject in simple bold typeface about how to enroll, and the January 31, 2016 enrollment deadline. The opposite side of the unfurled letter varied according to assigned treatment, each targeting a specific mechanism, below. Households that indicated Spanish as their primary language when applying to Covered California received the letters in Spanish. Templates of each letter are included in online Appendix Section A2.

<sup>&</sup>lt;sup>13</sup> For low-income consumers eligible for the "enhanced" Silver plan with cost-sharing reductions, the table in the letter reported only Silver plans.

<sup>&</sup>lt;sup>14</sup>While the letters were explicitly designed to target frictions in plan choice and enrollment, they could have also implicitly affected numerous other frictions, including consumer perceptions about the value of insurance, the implied health risks of going without coverage, the private nature of available plans, or norms about enrollment.

Inattention and Psychological Cost of Remembering.—Open enrollment applicants had just a few weeks earlier submitted income information and received an eligibility determination, and were aware of existence of Covered California and its enrollment process. For these consumers, the Basic Letter (Arm 2) provided a reminder that targeted inattention, or the psychological cost of remembering to enroll (as opposed to providing fundamentally new information).<sup>15</sup>

Lack of Awareness about Covered California.—Consumers who enter the Covered California Funnel through county referrals (primarily from Medicaid disenrollment) were likely at an earlier stage of engagement with Covered California for insurance coverage. In many cases, they may not have taken any direct action personally, and may have been less informed about the products and prices available to them in Covered California. For this subpopulation, the Basic Letter targeted both program awareness and inattention. <sup>16</sup>

Lack of Awareness of Subsidy and Penalties.—Conceptually, we view lack of awareness of subsidies as rooted in search costs. As mentioned in Section I, subsidy eligibility, as well as subsidy and penalty levels, are based on a complex formula and not easily determined. To reduce the cost of acquiring this information, the subsidy-reporting letters (Arms 3–5) reported total estimated annual subsidies and penalty for all policy members reported on their initial application.<sup>17</sup>

Lack of Awareness of Plan Attributes.—Previous studies have shown that making plan attributes more salient leads consumers to switch to lower cost plans (Abaluck and Gruber 2011, Kling et al. 2012) or to higher value plans (Ericson and Starc 2016). The salience reduces the cost of acquiring plan attributes and making plans easier to compare, and suggests that assisting consumers in acquiring this information may also improve take-up. The price and quality compare letter (Arms 4 and 5) lower the cost of learning about plan availability, their personalized net-of-subsidy costs, and their quality rating. Moreover, evidence suggests that some consumers demand higher value, not just lower cost (Blumberg and Buettgens 2013, Ericson and Starc 2016).

#### D. Randomization

We assigned each household in the study sample to one of the five study arms, using stratified randomization. This method ensured that we had balanced the sample on observable characteristics, and reduced variation across treatment groups due to randomness. The observable characteristics we used for stratification were

<sup>&</sup>lt;sup>15</sup> Simple reminders with no personalized information have been shown to improve adherence in other settings, such as paying parking tickets (Heffetz, O'Donoghue, and Schneider 2016). Moreover, peak enrollment typically occurs just prior to enrollment deadlines, indicating that procrastination may allow inattention to further impact enrollment. See Ericson (2017) for a discussion about the interactions between inattention and procrastination.

<sup>&</sup>lt;sup>16</sup>While the Basic Letter was designed to be a reminder, it also noted general benefits of insurance and typical claims costs. It is possible that the Basic Letter also raises awareness about health spending risks, and the cost of medical visits, and potentially impacts enrollment through persuasive language.

<sup>&</sup>lt;sup>17</sup> Subsidy and penalty amounts reported in the letter were based on income and family size on the household application and used for the determination of eligibility by Covered California.

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	Treatment Arm							
	Control (1)	Reminder only (2)	Subsidy (3)	Subsidy + price (4)	Subsidy + price + qual (5)	Total (6)	p-value all arms (7)	p-value arm 1 (8)
Letter FPL	212.40	211.98	212.45	211.89	212.52	212.25	0.86	0.74
Actual FPL	207.04	206.71	206.49	206.39	206.98	206.72	0.89	0.51
White	0.259	0.258	0.261	0.260	0.254	0.258	0.62	0.77
Latino	0.426	0.427	0.432	0.425	0.430	0.428	0.62	0.58
Asian	0.122	0.124	0.121	0.125	0.123	0.123	0.79	0.64
Black	0.046	0.047	0.042	0.046	0.046	0.045	0.33	0.52
Spanish language	0.167	0.169	0.167	0.167	0.170	0.168	0.89	0.60
HH size	1.396	1.391	1.396	1.395	1.393	1.394	0.96	0.76
Married	0.488	0.480	0.480	0.480	0.481	0.482	0.52	0.08
HH Age (mean)	37.69	37.90	37.59	37.60	37.46	37.65	0.06	0.65
CDPS risk score	0.412	0.414	0.417	0.412	0.405	0.412	0.85	0.96
HH risk ratio	1.99	2.01	1.99	1.99	1.98	1.99	0.57	0.97
Sample size	17,378	17,431	17,521	17,509	17,555	87,394		

*Notes:* Table 2 reports income and demographic characteristics reported in the administrative data for the final study sample, by treatment arm. Column 7 reports the *p*-value on the null that the mean across all arms are equal. Column 8 reports the *p*-value on the null that the control group mean is equal to the rest of the sample.

income category (<150, 150–200, 200–250, 250–400, >400 percent of FPL, or missing), race category (Latino or Black versus all other), Spanish language preference, email eligible, and whether the household used an enrollment delegate. The unit of stratification was the intersection of each of the five characteristics above, creating 80 stratification units. Households within each of the 80 strata were then randomly assigned to one of the five study arms.

As described in Section IIB, we imposed several exclusion restrictions after the randomization. Randomization ensured that the study arms in the final sample are balanced in expectation. Table 2 reports how observable characteristics of the final study vary by treatment arms. For all characteristics, a joint F-test of equality across arms cannot be rejected at the 0.05 level. The p-value for age is marginally significant (at  $\alpha=0.1$ ), but as seen in the last column, we cannot reject that average age in the control arm is the same as in all treatment arms combined. This is evidence that treatment assignment is unlikely to be correlated with unobservable characteristics that impact enrollment.

#### E. Data

We used three administrative data sources for this study. First, administrative data on applications and enrollment from Covered California permitted us to track plan selection, payment, and cancellations throughout 2016. Households were considered to have taken up insurance if they paid premiums for a plan selected before the

<sup>&</sup>lt;sup>18</sup> In practice, the differences are economically small. The largest differences in age is the 0.23-year difference between Arms 1 and 5. Given estimated marginal effects of age on take-up, this difference implies treatment effects that would be 0.00017 pp larger than our unadjusted estimates, if age were balanced (or only 1.3 percent of our treatment effect). For risk, treatment effect would be only 3.8 percent larger than our unadjusted estimates.

open enrollment deadline. This administrative data also included the demographic and income data reported in Table 2.<sup>19</sup>

We also used two sources of data on health spending risk: risk scores from Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data and Emergency Department Data, derived using the Chronic Illness and Disability Payment System (CDPS), and Verisk risk scores reported by IBM Watson Health (formerly Truven). CDPS risk scores are based on 2015 hospital and emergency department encounter data, and provide a measure of *prospective* health spending risk for the 2016 covered year. CDPS risk scores were available for all study participants, irrespective of take-up in study year 2016. IBM Watson Health's Verisk risk scores are based on diagnoses inferred from complete medical and prescription drug claims experienced during the 2016 enrollment year, following the intervention. As such, they reflect *concurrent* expected health spending based on claims incurred during the study year, and are only available for consumers who took up coverage in 2016.

#### **III. Estimation Strategy**

#### A. Experimental Impacts on Take-Up

Our main outcome of interest is take-up of Covered California insurance. We exploit the random assignment to treatment arm to identify the causal impact of the four letter-based interventions on average take-up rate. We estimate

(1) 
$$Takeup_{i} = \beta_{0} + \beta_{1}Basic_{i} + \beta_{2}SubPen_{i} + \beta_{3}PriceCompare_{i} + \beta_{4}PriceQualCompare_{i} + x'_{i}\Gamma + \epsilon_{i}.$$

Note,  $\beta_j$  captures the experimental treatment effect of assignment to one of the letter intervention arms, compared to take-up in the control group. In some specifications, we collapse the three arms that report subsidies to differentiate between the Basic Letter from letters that report personalized subsidy information. Where meaningful, to estimate the average effect of all letter interventions, we report results when all four interventions arms are combined into a single indicator variable.

We report both unadjusted treatment effects, as well as regression-adjusted estimates using a vector of household-level characteristics,  $x_i$ , including family size, number of kids, age, race, language preferences, marital status, the ACA's age-based community-rating premium ratio, and household income (as percent of the FPL), as well as the full set of interactions with treatment assignment.<sup>21</sup>

<sup>&</sup>lt;sup>19</sup>The data repository is openicpsr-125801 (Domurat, Menashe, and Yin 2021).

<sup>&</sup>lt;sup>20</sup> For a description of the CDPS, see Kronick et al. (2000). Confidential CDPS and Verisk risk scores were obtained from Covered California (Covered California 2017 and 2018).

<sup>&</sup>lt;sup>21</sup> Following Lin (2013), we include the full set of covariate × treatment assignment interactions to address potential issues with asymptotic precision of the regression-adjusted model (Freedman 2008). Given our large sample and balanced randomization, including the full set of interactions does not meaningfully alter precision or point estimates compared to unadjusted models or specifications controlling for only uninteracted covariates.

We also examine heterogeneity by income, which may be related to willingness-to-pay for insurance, and determines subsidies. Additionally, lower-income individuals may face greater choice frictions such as barriers to acquiring information, comparing plans, or following through on purchase, due to language barriers, lower education, or stress-related cognitive overload (Mani et al. 2013; Mullainathan and Shafir 2014; Bhargava, Loewenstein, and Sydnor 2017). On the other hand, higher-wage consumers may face larger opportunity costs for time spent deciding on coverage than lower-wage consumers (assuming total time required to choose is equivalent).<sup>22</sup> To test for heterogeneous treatment effects, we estimate equation (1) including interactions between treatment indicators and baseline household income. And to the extent that these information acquisition costs cause consumers to form incorrect beliefs about their subsidies in ways related to income (particularly given its steep progressivity), then the subsidy-reporting letters may have differential effects on take-up by income.<sup>23</sup>

#### B. Experimental Impacts on Market Risk

To estimate explicitly the impact of the letter interventions on average risk of the study sample, we regress consumers' health risk on treatment assignment, *conditional* on take-up, as in

(2) 
$$RiskScore_i = \beta_0 + \beta_1 Basic_i + \beta_2 SubPen_i + \beta_3 PriceCompare_i + \beta_4 PriceQualCompare_i + x_i'\Gamma + \epsilon_i.$$

The coefficients on the treatment arms in equation (2) capture the impact of the interventions on average risk of the study sample, compared to the control group. Along with the estimated treatment effect on take-up, the impact on average risk can be used to estimate the average risk across respondents to the treatment.<sup>24</sup> Given the smaller sample sizes in risk analyses conditional on take-up, we will report specifications where we combine the three subsidy-reporting letter arms into a single group, *SubsidyArms<sub>i</sub>*.

For the treatment effects in (2) to capture changes in average risk of the study sample experienced by plans, we weight the households by the number of months they are enrolled. In this way, reported treatment effects reflect differences in risk over the plan year, the actuarially relevant time period for premium rating. In practice, the small and insignificant treatment effect on enrollment duration (reported in online Appendix Table 4) results in economically small differences due to weighting.

<sup>&</sup>lt;sup>22</sup>Because the reported subsidy differs by income, it is possible that the differential effects do not reflect different levels of misperception, but rather a uniform misperception and differential responses to those reported values.

<sup>&</sup>lt;sup>23</sup>We also estimated equation (1) including interactions with log baseline CDPS risk. Because the impact on market risk is more evident in equation (2), we report heterogeneous effects by risk in online Appendix Tables 5 and 6.

<sup>&</sup>lt;sup>24</sup>If the interventions also caused some consumers to decrease take-up, then this average risk would correspond to the average of all marginal respondents, including households persuaded and dissuaded by the letters to enroll.

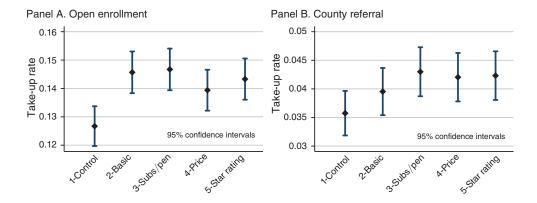


FIGURE 1. TAKE-UP RATES, BY TREATMENT ARM

*Notes:* This figure displays the take-up rates by treatment arm. Panel A restricts the sample to the open enrollment sample. Panel B restricts the sample to the county referral sample. Differences in take-up rates relative to the control correspond to treatment effect estimates reported in Table 3.

#### IV. Results of Letter Interventions on Take-Up and Risk

#### A. Average Treatment Effects on Take-Up

Panels A and B of Figure 1 display the main treatment effects by arm, separately for the open enrollment and county referral samples. Corresponding unadjusted regression results are reported in Table 3. For the open enrollment sample, the letters led to a 1.7 pp increase in take-up, roughly a 13 percent increase over the control group take-up of 12.7 pp. For the county referral sample, the intervention led to a 0.6 pp increase, or an 18 percent increase over a much lower control group take-up rate of 3.6 pp. Combined, the 1.3 pp increase in take-up is equivalent to a 16 percent over the overall control group mean of 8.1 pp. Regression-adjusted estimates, controlling for a full set of covariate-treatment arm interactions described in Section IIIA, are largely unchanged, and reported in online Appendix Table 2.

Using either unadjusted or regression-adjusted models, we find no differences in overall take-up across the letter interventions, a result we revisit in subgroup analyses. For the open enrollment sample, we interpret the Basic Letter as mainly addressing inattention to the deadline, given that the information provided in the letter duplicated information consumers had already been exposed to during their initial active registration. The Basic Letter increased enrollment by roughly 13 percent (logit coefficient for Arm 2 in column 8). The impact of letters that report subsidy and plan characteristics are slightly larger but not significantly different than for the Basic Letter.

Comparing constants, we find that baseline open enrollment take-up is 3.5 times higher than for county referrals. County referrals differed in several key ways, including having 10 percent lower income (conditional on subsidy-eligibility), 19 pp higher

<sup>&</sup>lt;sup>25</sup>Note that these take-up rates correspond to the enrollment rate of the open enrollment and county referral applicants in the study sample control group, which are lower than the overall program take-up rate in the marketplace-eligible population as whole.

TABLE 3—AVERAGE TREATMENT EFFECTS ON TAKE-UP

Model:	OLS					Lo	git	
Funnel sample:	All		Open enrollment		County referral		All	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Arm2345: all letters	0.013 (0.002)		0.017 (0.004)		0.006 (0.002)		0.153 (0.036)	
Arm2: basic letter		0.012 (0.003)		0.019 (0.005)		0.004 (0.003)		0.133 (0.045)
Arm3: subsidy-penalty		0.015 (0.003)		0.020 (0.005)		0.007 (0.003)		0.181 (0.045)
Arm4: price compare		0.010 (0.003)		0.013 (0.005)		0.006 (0.003)		0.139 (0.045)
Arm5: price-quality compare		0.013 (0.003)		0.017 (0.005)		0.007 (0.003)		0.159 (0.045)
County referral							-1.364 (0.066)	-1.364 (0.066)
Arm2345 $\times$ county referral							0.015 (0.073)	
Arm2 × county referral								-0.057 $(0.091)$
$Arm3 \times county referral$								0.022 (0.090)
Arm4 × county referral								0.059 (0.090)
Arm5 $\times$ county referral								0.033 (0.090)
Constant	0.081 (0.002)	0.081 (0.002)	0.127 (0.004)	0.127 (0.004)	0.036 (0.002)	0.036 (0.002)	-1.930 (0.032)	-1.930 (0.032)
Controls Observations $R^2$	N 87,394 0.000	N 87,394 0.000	N 44,248 0.000	N 44,248 0.000	N 43,146 0.000	N 43,146 0.000	N 87,394	N 87,394

*Notes:* Tables 3 reports OLS treatment effects of letter interventions on take-up of 2016 open enrollment coverage, with no controls for household characteristics. Columns 1 and 2 are estimated on the full study sample. Columns 3 and 4 and 5 and 6 restrict the sample to the *Open enrollment* and *County referral* samples, respectively. Columns 7 and 8 report logit specifications on the full sample, including interactions between treatment and an indicator for county referral. Standard errors in parentheses.

fraction who are Latino, and 18 pp lower fraction primary English speaking. As described in Section IIA, county referrals also differed in their baseline awareness of plans, prices, and subsidies available to them through Covered California. Because lower incomes (higher subsidies) tend to raise take-up, the lower county referral take-up rate suggests a number of factors, including differences in demand, prior market engagement, awareness, and language, may influence enrollment. Wright et al. (2017) similarly found lower baseline take-up rates, and smaller (level) effects on (Medicaid) enrollment of a low touch nudge for passive applicants compared to

<sup>&</sup>lt;sup>26</sup>County referral households likely included a mix of consumers at different stages of engagement with Covered California: some may have experienced a change in Medicaid eligibility and been counseled about Covered California options by a county eligibility worker; others may have received a formal notice of changed Medicaid eligibility for the first time, and may not yet have realized Covered California was an option; others may not have been seeking marketplace coverage (e.g., due to having since received job-based coverage); while others may have resembled open enrollment households in that they may have previously applied through CoveredCA.com.

#### Open enrollment sample

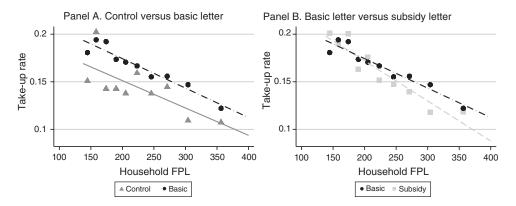


FIGURE 2. TAKE-UP RATES, BY INCOME

*Notes*: Figure 2 displays scatter plots of mean take-up rates within income bins, by treatment arm. *Basic* refers to the Basic Letter arm. *Subsidy* refers to the three subsidy reporting arms. Panel A is restricted to the open enrollment sample. Panel B is restricted to the Country Referral Sample. Regression lines are fitted through the individual household-level data.

those who expressed an interest in coverage, differences the authors attribute to lower awareness or demand for insurance.

For the County referral sample, we find that providing additional subsidy and plan information (Arms 3–5) beyond the Basic Letter (Arm 2) leads to higher take-up (column 6, and in column 8, where the percent impact of a given treatment arm on county referrals is obtained by adding the coefficients on its uninteracted and county referral-interacted terms). While the differences across the Basic Letter and subsidy-reporting arms are not statistically different, the patterns are consistent with a hypothesis that providing more information beyond the uniform reminder, about personalized premium subsidies and plan options, further reduces information frictions for a population with low baseline awareness.

#### B. Heterogeneous Treatment Effects by Income

Figure 2 illustrates how take-up rates vary by income in the open enrollment sample. For visual clarity, panel A displays bin scatter plot for the control and Basic Letter arms, while panel B compares the same Basic Letter arm to the three subsidy-reporting arms. Panel A shows that the Basic Letter led to a level shift in take-up across all incomes. However, providing personalized information about subsidies, which decline by income, reveals heterogeneous effects. Take-up rates for the subsidy-reporting arm appears to fall more steeply as incomes rise than for the Basic Letter arm (likewise, it falls more steeply than the control arm). At low incomes, take-up is slightly higher for the subsidy-reporting arms than the Basic Letter arm. But as incomes rise, take-up rates for the subsidy-reporting arms fall below take-up in the Basic Letter arm, despite the fact that consumers in the Basic Letter arm who enroll do eventually observe the same subsidy information provided in subsidy-reporting letters prior to finalizing their enrollment.

Model:	Logit	OLS	OLS
Sample:	All (1)	Open enrollment (2)	County referral (3)
Arm2: basic letter	0.105 (0.159)	0.025 (0.023)	-0.004 (0.011)
Arm345: subsidy arms	0.279 (0.132)	0.049 (0.019)	0.001 (0.009)
$FPL~(\times~100)$	-0.340 (0.052)	-0.036 (0.007)	-0.013 (0.003)
$Arm2 \times FPL~(\times~100)$	0.033 (0.071)	-0.004 $(0.010)$	0.005 (0.005)
Arm345 $\times$ FPL ( $\times$ 100)	-0.045 $(0.059)$	-0.015 (0.008)	0.004 (0.004)
Constant	-1.544 (0.232)	0.178 (0.035)	0.057 (0.017)
Covariate $\times$ treatment interactions Observations $\mathbb{R}^2$	Y 75,495	Y 32,698 0.041	Y 42,797 0.019

TABLE 4—HETEROGENEOUS TREATMENT EFFECTS, BY INCOME

*Notes:* Table 4 reports heterogeneous treatment effects by income. Models include an interaction between treatment assignment and household income, as measured by percent of FPL  $(\times 100)$ . All regressions control for a full set of household level characteristics  $\times$  treatment interactions. Robust standard errors in parentheses. See online Appendix Table 3 for a nonparametric income specification of income, to test explicitly for differences in treatment effects at difference points in the income distribution.

Table 4 formalizes this by estimating the effect on take-up of income separately interacted with the Basic Letter arm and subsidy-reporting arms. In the open enrollment sample, we observe a larger negative coefficient on the income × subsidy-reporting (*Arm345*) interaction, indicating that take-up falls more steeply when receiving subsidy information than the Basic Letter. Higher income consumers who receive personalized (smaller) subsidy information were less likely to re-initiate the enrollment process than otherwise similar consumers sent the Basic Letter. Hence, the timing of the information appears to matter: in addition to having misperceptions about their subsidies, consumers appear to exhibit a fixed time or hassle cost of re-initiating the enrollment process. These costs, along with the financial cost of plans, add to the total cost of uptake, as evident in other contexts (Currie 2006).

## C. Impact on Health Spending Risk

Panel A of Table 5 reports treatment effects on average prospective CDPS risk scores (equation (2)). Regressions are weighted by the number of months each

 $<sup>^{27}</sup>$  The difference in the coefficient estimates on Arm2  $\times$  FPL  $(\times\,100)$  and Arm345  $\times$  FPL  $(\times\,100)$  is only significant at the 0.169 level for the full sample, and 0.158 level for the open enrollment sample. The differences are more evident when income is specified nonparametrically (online Appendix Table 3). The difference in the relative drop-off in take-up for the lowest to highest income bracket, comparing the subsidy-reporting the Basic Letter arms, is significant at the 0.046 level for the full sample, and 0.096 for the open enrollment sample.

T	A D F G
TABLE 5—TREATMENT EFFECT ON THE	AVERAGE RISK OF ENROLLED CONSUMERS

Funnel sample:	A	<b>1</b> 11	C	pen enrollme	ent	(	County referra	1
Income sample:			<180FPL	180 < FPL < 250	>250FPL	<180FPL	180 < FPL < 250	>250FPL
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Panel A. Dependent varie Arm2345: all letters	able = ln(0.051) $(0.017)$	CDPS Risk	Score)					
Arm2: basic letter		-0.044 $(0.021)$	-0.106 $(0.046)$	-0.025 $(0.040)$	-0.042 (0.034)	0.042 (0.070)	0.004 (0.075)	-0.171 (0.142)
Arm345: subsidy arms		-0.053 $(0.018)$	-0.116 $(0.040)$	-0.033 (0.033)	-0.049 (0.030)	-0.006 $(0.053)$	-0.016 $(0.059)$	-0.086 $(0.132)$
Observations $R^2$	7,945 0.002	7,945 0.002	1,810 0.008	1,933 0.001	2,458 0.002	851 0.001	655 0.000	238 0.009
Panel B. Dependent varie Arm2345: all letters	able = ln( $-0.063$ $(0.036)$	Concurrent	Risk Score)					
Arm2: reminder		-0.035 $(0.045)$	-0.164 (0.101)	-0.025 (0.094)	-0.058 $(0.078)$	0.086 (0.132)	0.068 (0.151)	0.055 (0.209)
Arm345: subsidy arms		-0.072 (0.037)	-0.248 (0.084)	-0.158 (0.078)	-0.013 (0.065)	0.149 (0.107)	0.012 (0.135)	-0.068 $(0.174)$
Constant	3.211 (0.033)	3.211 (0.033)	3.325 (0.075)	3.205 (0.070)	3.160 (0.058)	3.128 (0.093)	3.250 (0.120)	3.347 (0.153)
Observations $R^2$	11,472 0.000	11,472 0.000	2,445 0.004	2,565 0.002	3,655 0.000	1,264 0.002	969 0.000	548 0.001

*Notes:* Table 5 reports treatment effects on average risk of enrolled individuals. The dependent variable in panel A is the log of the CDPS prospective risk score, based on 2015 diagnoses from hospital and emergency room encounters. The dependent variable in panel B is the log of the concurrent risk score, based on realized 2016 claims data. Regressions do not control for age factors or region. Robust standard errors in parentheses.

household held coverage, to reflect average risk experienced by plans.<sup>28</sup> Overall, the letter interventions led to a 5.1 percent decrease in average risk (column 1). This implies that the average risk of the marginal respondent to the letter interventions was 37 percent lower than the average risk of inframarginal enrollees in the study sample.<sup>29</sup> This finding is consistent with larger treatment effects of letters on take-up among those with lower baseline CDPS risk, reported in online Appendix Tables 5 and 6.

The effect of the letter intervention on risk is driven by the open enrollment sample. This can be seen more clearly in Figure 3, which displays the mean log risk for the control and treatment arms, for the open enrollment and county referral samples. Most of the positive selection is driven by enrollment of healthier risks among lower income consumers, evident when comparing across columns 3–5 of Table 5. Moreover, the reduction in average risk in the open enrollment sample appears throughout the distribution of risk. (The cumulative distribution function

 $^{29}$  A 5.1 percent decrease in average risk, given a 16 percent enrollment increase, implies that average risk among marginal responders is  $0.630 = (((1-0.051) \times 116 - 100)/16)$  of the average risk of inframarginal consumers.

<sup>&</sup>lt;sup>28</sup>We explicitly test for differences in coverage duration, by treatment arm. We find that enrollees in the letter intervention arms are covered for a negligible and statistically insignificant 3.9 fewer days, compared to a control mean of 8.4 months. Open enrollment (county referral) enrollees in intervention arms are covered 1.6 (10.2) days fewer, compared to a control mean average of 8.4 (8.5) months. Results are reported in online Appendix Table 4.

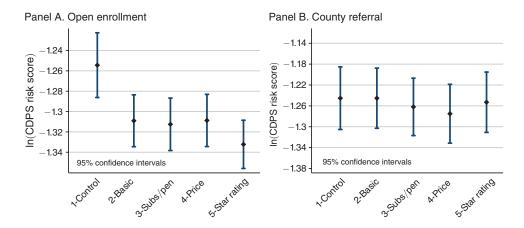


FIGURE 3. LOG CDPS RISK SCORE, BY TREATMENT ARM

*Notes:* Figure 3 depicts average log CDPS risk scores, by treatment arm. Panel A restricts the sample to the open enrollment sample. Panel B restricts the sample to the county referral sample.

for treatment and control arms are plotted in Figure 4.) This suggests that the risk effects are less likely to be driven by, say, only younger consumers responding to treatment (which would appear as a shift primarily in the lower segment of the risk distribution), and more likely by healthier consumers throughout the distribution, conditional on demographic characteristics. We test this explicitly by controlling for the age rating and indicators for rating region, the two factors along which plans are permitted to vary premiums. Controlling for age factors and regions mutes the unconditional treatment effect by about 15 percent, implying that 85 percent of treatment effect on average risk cannot be priced in. (Risk regressions controlling for age and region are reported in online Appendix Table 7.)

CDPS risk scores are a measure of prospective risk, and are based on complete in-patient hospital and emergency department claims observed in any health facility in the state of California from the previous calendar year, irrespective of insurance status. The measure does not capture out-patient encounters. The absence of out-patient encounters may exacerbate a common concern of many risk scores, that they may not adequately account for differences in coverage status when predicting insured spending risk. On the one hand, marginal respondents to treatment (who were uninsured in 2015 and only *appear* healthy) may have pent up demand for care, leading to overstating the positive selection effects on realized spending. On the other hand, these same marginal respondents may consume less hospital and emergency department care once enrolled in a plan that manages care, potentially leading to understating positive selection effects on realized spending. Given random treatment assignment, these issues will not bias our estimated treatment effects on average CDPS risk, but they may influence the interpretation of our estimated treatment effects.

To address this potential issue with the CDPS score, we estimate equation (2) using a second measure of risk based on complete realized claims of consumers enrolled in Covered California during the study year. Results are reported in panel B of Table 5.<sup>30</sup>

<sup>&</sup>lt;sup>30</sup>Concurrent risk scores were reported to us by IBM Watson at the individual level, not household level as with the individual-weighted CDPS scores. Regressions using the concurrent scores were thus run at the individual level.

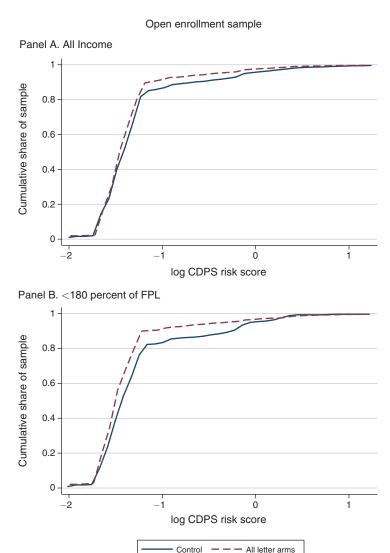


FIGURE 4. CDF of LOG CDPS RISK

*Notes:* Figure 4 depicts the cumulative distribution function of log CDPS risk scores among enrolled consumers, by control and treatment assignment. Panel A is restricted to the open enrollment sample. Panel B is restricted to households with income < 180 percent of FPL within the open enrollment sample.

We find remarkably consistent effects across the two measures of risk. Overall, the letters led to a 6.3 percent decrease in average risk, implying that the average risk of marginal respondents to the interventions was 46 percent lower than average risk of inframarginal enrollees.<sup>31</sup> As with the CDPS risk score, the improved concurrent risk is primarily driven by healthier risk selection in the open enrollment sample.

 $<sup>^{31}</sup>$ A 6.3 percent decrease in average risk, given a 16 percent enrollment increase, implies that average risk among marginal responders is  $0.543 = (((1-0.063)\times 116-100)/16))$  of the average risk of inframarginal consumers.

The concurrent risk scores also show larger positive risk effects of the subsidy reporting letters as compared to the Basic Letter, as was observed with the CDPS risk score. This suggests that marginal respondents to Basic Letter were healthier than enrollees in the control group; and that providing additional information on generous subsidies induced even healthier consumers into the market, consistent with an adverse selection model with behavioral frictions in enrollment.

For the county referral sample, the letter interventions led to statistically insignificant effects on average risk, using either measure of risk. Evidently, the letter interventions induced healthy and sick risks, equally, to take-up. This pattern is consistent with frictions being higher for the sicker consumers in the county referral sample. Reduced take-up among this group would offset any adverse selection at baseline. It could also be that county referral applicants all face similar frictions, but the baseline population exhibits some positive preference selection (e.g., risk aversion is correlated with healthiness), which would also offset any adverse selection. Either way, the baseline correlation between risk and frictions is muted, such that lowering frictions causes both healthy and unhealthy people to take-up.

## D. The Value of the Intervention in the Presence of Behavioral Frictions

In this final subsection we turn to discussing the effects of the intervention in subsidy dollar-equivalent units. This measurement is significant for two reasons. First, as the ACA is a public program aimed at increasing overall coverage through premium subsidies, this number demonstrates the relative economic efficiency of the intervention for increasing take-up, i.e., what subsidy would be needed to generate the same take-up effect as these low-cost letters. Second, this metric can be benchmarked to measurements of willingness-to-pay (WTP) for insurance, and as we will discuss, suggest that those measurements could be impacted by the presence of behavioral frictions targeted in this study.<sup>32</sup>

To measure the value of the letters in dollars, we use two approaches: (i) a choice model approach estimated with data from this study, and (ii) a calibration approach based on external price elasticity estimates. First, consider the choice model approach using estimates from this study alone. To get the subsidy-equivalent value of the letters, we estimate the following reduced-form binary choice (logit) model at the household level:<sup>33</sup>

(3) 
$$u_i = \gamma \times GotLetter_i + \alpha \times MonthlyAPTC_i + x_i'\beta + \varepsilon_i$$

where household i enrolls in a plan if  $u_i > 0$ . The variable  $\gamma$  represents the impact of getting any intervention letter,  $\alpha$  represents the impact of the monthly per-member subsidy level, and  $x_i$  is a set of control variables including region, income, age-based risk. Notice that  $\gamma/\alpha$  roughly represents the value of getting the

<sup>&</sup>lt;sup>32</sup>Throughout this section, we pool the effects of all letters for both samples. As such, it is roughly the population average of the effects of each arm, all of which contain at a minimum the effect of reporting the information in the Basic Letter. However, as noted in Section IVA, the effects for each arm are generally similar.

<sup>&</sup>lt;sup>33</sup>We motivate this model and provide more discussion in online Appendix Section A5. The simplified version of the model presented here takes a reduced-form representation.

letter in subsidy-equivalent units, and hence is our object of interest. For reference, estimates from equation (3) are reported in online Appendix Table 8. We estimate the impact of the letters  $(\gamma/\alpha)$  to be equal to a \$53.39 [95 percent CI: \$30.52, \$76.26] increase in the monthly per-person subsidy.

It is important to note that this estimate relies on unbiased estimates of  $\gamma$  and  $\alpha$ . While  $\gamma$  is well identified from experimental variation, identification of  $\alpha$  is more complicated since it is determined by the subsidy (i.e., age and income), which may be correlated with the preference for insurance. Despite controlling for these factors and their interaction, <sup>35</sup> if the residual subsidy variation (due to variation in household size) is correlated with the unobserved preference for insurance, then our estimates of  $\alpha$  will be biased. The implied semi-elasticities from our estimates of  $\alpha$  are consistent with other correlative estimates in the literature such as Tebaldi (2017), as well market-wide elasticity estimates identified off of exogenous discontinuities found in Ericson and Starc (2015), but smaller than recent estimates that exploit exogenous variation in subsidies, as reported in Shepard (2019); Jaffe and Shepard (2018); and Finkelstein, Hendren, and Shepard (2019).

To address any potential downward bias in  $\alpha$  (and upward bias in  $\gamma/\alpha$ ), we employ a second approach and convert the take-up effects reported from our letters into dollar-equivalent units using an externally estimated semi-elasticity reported in Finkelstein, Hendren, and Shepard (2019)—henceforth, FHS. For this approach, we divide our estimated treatment effects (in percent) by the semi-elasticity from FHS. While that study examines a different state, the discontinuities in marketplace subsidies studied in FHS provide a rigorous source of variation that does not exist in ACA markets. At the bottom of online Appendix Table 8 we report the dollar-equivalent effect of the letters using this second approach. This method implies that the letters are equivalent to \$24.85 in monthly subsidies, roughly one-half of the magnitude from the first estimation method. Combining the above, we estimate the effect of the intervention on enrollment to be equivalent to getting between \$25 and \$53 in additional monthly subsidies.

These estimates also have important implications on measuring the WTP for insurance. Quantifying the WTP for health insurance has important policy implications on subsidy design and optimal coverage. We show in online Appendix Section A5 that in the presence of frictions, techniques often used to measure WTP for goods could lead to biased estimates in either direction.<sup>37</sup> Based

 $<sup>^{34}</sup>$ Notice this interpretation of  $\alpha$  is based on *perceptions* of prices. Hence, the interpretation of  $\gamma/\alpha$  is specifically the subsidy equivalent value for *the sample in this study* at current price perceptions. To the extent that consumers are not fully aware of subsidies, it can affect the measurement of  $\alpha$ , and hence the interpretation of  $\gamma/\alpha$ . We do not attempt to estimate the treatment effect on  $\alpha$ , but provide additional discussion on this topic in online Appendix Section A5.

Appendix Section A5.

Appendix Section A5.

The remaining variation in subsidy level is largely driven by nonlinearities in how family size impacts the federal poverty line, similar to the strategy used by Tebaldi (2017).

 $<sup>^{36}</sup>$ Ericson and Starc (2015) use discontinuities in age-based pricing in the Massachusetts exchange, and report a semi-elasticity of -0.35 for a \$100 premium increase for the full sample, similar to our implied semi-elasticity of -0.4. Finkelstein, Hendren, and Shepard (2019) exploit discontinuities in the subsidy design in Massachusetts, and estimate a larger semi-elasticity of -0.25 for a \$40 premium increase. Robustness in our implied subsidy-dollar equivalents, and their similarity to those estimated for Massachusetts, suggest that our model is not greatly impacted by this bias. Nevertheless, lacking exogenous variation in price, we rely on estimates from Finkelstein, Hendren, and Shepard (2019) to bound our estimates.

<sup>&</sup>lt;sup>37</sup> As a simple example, if some consumers are completely unaware (or forget about) plans offered on the Exchange, then even at low prices they will not enroll and will be presumed to have low valuations for insurance.

on revealed preferences, where the way purchase decisions vary with prices are used to infer some valuation distribution, these techniques assume consumers are fully aware of the availability of the products and prices, and do not face frictions in enrollment. The impact of our intervention letters, equal to \$25 to \$53 per month in subsidies, indicates the presence of economically meaningful frictions. Moreover, the RCT achieved equivalent enrollment gains by reducing these frictions with a passive \$0.69 intervention.

Their presence also offers additional interpretation to recent estimates of WTP for Exchange coverage. For example, the aforementioned FHS study reports the distribution of WTP for coverage in the Massachusetts health benefits exchange. Their approach, similar to that described above, identifies how enrollment varies with exogenous changes in premiums. They find a median overall WTP for insurance among marketplace eligible consumers of around \$100, compared to an average monthly cost of coverage of \$420. Whether using the calibrated estimate of \$25 per month, or internally estimated \$53 per month, the dollar values associated with reduced frictions generated by a passive letter intervention represents a significant portion of the gap between measured WTP and costs. This indicates that behavioral frictions may play an important role in low estimates of the WTP for insurance.

#### V. Discussion

This study documents the existence of economically significant behavioral frictions in health care enrollment. We find evidence that both inattention and information search costs reduce take-up rates in ACA markets, and that relatively inexpensive "low touch" informational interventions can improve take-up. Moreover, the marginal enrollee induced to enroll by the intervention is lower risk than inframarginal enrollees, contributing to 5.1 to 6.3 percent lower average risk. Overall, the letters raised enrollment by 1.3 pp, or 16 percent, which is equivalent to offering this sample an additional \$25 to \$53 per month in subsidies. These results don't imply that low-cost information interventions are a substitute for premiums subsidies. By lowering the available plan cost, subsidies provide a direct financial benefit that reminder letters cannot. These findings suggest that the full value of those subsidies is realized only when behavioral frictions are also addressed.

The interventions from this study could conceivably be scaled up to a broader population of uninsured marketplace-eligible consumers, with implications for market-wide enrollment, average risk, and public subsidy spending. Extrapolating RCT treatment effects to other lower income populations is speculative, however using a conservative back-of-the-envelope calculation, we find modest but economically meaningful impacts. While there are a number of potential populations that could be targeted (the largest being the state's marketplace-eligible uninsured population), we consider only consumers who enter the Funnel throughout the year, but who haven't enrolled after 10 days.<sup>38</sup> The similarity of consumers in the "10-day"

As we illustrate in online Appendix Section A5, the effects of imperfect information on prices is ambiguous and could bias up or bias down measurements of WTP, depending on how actual price variation compares to perceived price variation.

<sup>&</sup>lt;sup>38</sup>The full-year Funnel population includes people who initiated marketplace eligibility determination, or were referred to Covered California, but who don't immediately enroll. They enter the Funnel during the open enrollment

Funnel and our RCT sample along key characteristics (including demographics, income, fraction Country Referrals, and eventual insurance take-up rates) makes generalizing the treatment effects to this population more reliable. Given the restrictive size of this population, we view projections to this group as producing conservative lower bounds on market-wide impacts.

About 4 percent of Covered California's annual covered member-months originate from that year's "10-day" Funnel. In steady state, and factoring in the likely share of renewals each year that had *originally* enrolled after being in the Funnel, we estimate that about 15 percent of annual covered member-months originated from the "10-day" Funnel. Applying the RCT treatment effects on take-up and average risk, we project that an expanded intervention would lead to a 0.6 percent increase in total enrollment, and a 0.2 to 0.3 percent reduction in market-wide risk in the first year; and in steady state, the intervention would lead to a 2.4 percent increase in total enrollment, and a 0.7 to 1.1 percent reduction in market-wide risk, with the upper end of each range reflecting an optimized passive mailing using letters that generated the largest impacts on risk (see online Appendix Section A6 for a detailed description of these projections). Findings from Section IVC suggest that the vast majority of the average risk reduction would not arise from just positive selection in age or membership in less costly regions, but on healthier risks conditional on those factors. If translated to lower premiums, the modest reduction in market-wide risk would lead to meaningful decreases in subsidy and consumer spending, <sup>39</sup> as well as additional coverage increases beyond the direct effect of the intervention. 40 These effects likely represent lower bounds, as the number of people passing through the year-long 10-day Funnel is less than one-half of the size of the point-in-time number of market-place eligible uninsured. Expanding the intervention, or carrying-out more intensive interventions that reduce frictions, may generate larger enrollment increases and reductions in risk. Indeed, ongoing research by Shepard (2020) finds large positive selection effects of auto-enrollment in Massachusetts.

Note that our estimates imply that the letters have the same effect *on enrollment* as increasing the monthly subsidy by \$25 to \$53. As described in Section IVD, measuring the enrollment impact this way provides a useful metric to characterize the behavioral frictions targeted by the letters. However, an increase in subsidies by \$25–\$53 may *not* have the same impact as the letter intervention on average risk. The relative effect depends on how marginal respondents to a letter compares to marginal respondents to an increase in the subsidy. The effect of any enrollment initiative on market risk will depend on the correlation between risk and the financial or behavioral barrier being targeted. If the marginal consumer still facing the

period, or at any time during the year after having gained eligibility due to a qualifying-event (e.g., divorce, change in immigration status, loss of previous coverage, etc.). As in the RCT Funnel sample, entry into the year-long Funnel could have been initiated actively by shoppers, or passively when referred by the counties. The "10-day" Funnel is comprised of people in the year-long Funnel who haven't enrolled in a plan after 10 days.

<sup>&</sup>lt;sup>39</sup>By comparison, the full effect of the subsidies, mandate, and rollout of Massachusetts' individual exchange was a decrease in average costs by 12 percent (Hackmann, Kolstad, and Kowalski 2015); and microsimulations of the repeal of the ACA mandate estimated a steady-state increase in silver plan gross premiums by as much as 6.5 percent (Eibner and Nowak 2018), and an overall gross premium increase of 10 percent (CBO 2017).

<sup>&</sup>lt;sup>40</sup>Enrollment will increase as a direct effect of the letter, and also in response to lower premiums, particularly for unsubsidized consumers. General equilibrium effects of reduced costs on premiums, associated increases in (price-linked) subsidies, and enrollment are beyond the scope of this study.

targeted frictions is healthier, then interventions targeting those frictions would raise enrollment and lower risk. On the other hand, if severe frictions also caused sicker consumers to remain uninsured, then this correlation between health and the friction targeted by an intervention could be muted, or even negative, in which case the intervention could increase risk.<sup>41</sup>

Insurance marketplaces under the Affordable Care Act like Covered California are part of recent movements in publicly financed insurance (such as Medicare Advantage and Part D) in which choice is devolved to individuals, fostering competition among private insurers and providers. The evidence documented in this study provides an important reminder that these consumer-focused models depend on how well individuals make coverage decisions. The experience from California further suggests that targeted policies designed to improve consumer decision-making in health care can alter the well-being of consumers seeking health insurance coverage, and the stability of the market in which they seek it.

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<sup>&</sup>lt;sup>41</sup>The null risk score effects we find for the relatively less-informed Medicaid-transitioning Country Referral population allay concerns that easing enrollment among special enrollment populations may raise risk and destabilize premiums (AHIP 2016; Federal Register 2017a, b).

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# The Role of Behavioral Frictions in Health Insurance Marketplace Enrollment and Risk: Evidence from a Field Experiment

# Richard Domurat, Isaac Menashe and Wesley Yin

## **Online Appendix**

A1. Sample Exclusions and Comparison of Study Sample to Uninsured and Covered California Enrolled Populations

This section summarizes sample exclusions and presents descriptive statistics on the final study sample, and as a comparison, the 2015 Covered California-enrolled and uninsured populations in California.<sup>1</sup>

### A1.1 Sample Exclusions:

As noted in Section 3, the total size of the Funnel prior to open enrollment was 153,146 households of which 64 percent were County Referrals, and 36 percent Open Enrollment Applicants. For budgetary reasons, we reduced the total sample to 126,182 randomly selected households from the full Funnel to be in the study.<sup>2</sup> These households were then randomized into the 5 study arms using the method described in Section 3.4. Since the time of the treatment randomization, we became aware that some households were not eligible to enroll in Covered California, or did not have valid addresses. We excluded these households to create the final study sample. Because treatment assignment was random, these *ex post* exclusions have an identical effect on all study arms in expectation. We report balance tests within this final sample in Section 3.4.

First, we excluded households for whom administrative data reported invalid ages for any member, as invalid ages would have led to incorrect or missing premiums reported in subsidy-reporting letters.<sup>3</sup>

Next, we excluded households who had incomes below 100 percent of FPL. These households were generally ineligible for subsidies in ACA exchanges, and hence were unlikely to enroll in an exchange

<sup>&</sup>lt;sup>1</sup> Data on the uninsured come from the IPUMS (Ruggles, *et al*, 2017) version of the American Community Survey (ACS). We restrict the full ACS to those that are flagged uninsured at the time of interview, not institutionalized, and have incomes above 100 percent FPL.

<sup>&</sup>lt;sup>2</sup> The 126,182 households were randomly selected in two phases. To guarantee sufficient time to compute subsidies and print personalized letters for a sufficient sample by the deadline, we randomly selected 100,000 households from the Funnel sample as of one month before the enrollment deadline. From the households who entered the Funnel over the following two weeks, we randomly sampled (26,182) additional households until we exhausted our budget. Note, because later entrants to the Funnel had higher baseline enrollment, take-up rates for the "Initial Budgetary Exclusion" group are slightly higher than that of the initial Funnel sample ("All"), reported in Appendix Table 1.

<sup>&</sup>lt;sup>3</sup> Enrollee ages are based on year of birth. Specifically, we excluded 0.5% of households with any member that was 100 years or older, or in very rare instances had a negative reported age.

plan. We also dropped households that the postal service reported as having moved before the experiment, and for whom we did not have a current mailing address. Finally, we excluded County Referral households who were deemed ineligible for subsidies.<sup>4</sup>

The final sample size after applying these exclusions is 87,394 households. These exclusions and their impact on the sample size are reported in Appendix Table 1. Although these exclusions were made after the initial randomization, their impact on each study arm is the same in expectation.<sup>5</sup>

# A1.2 Comparison of Study Sample to Other Populations

Table 1 displays demographic summaries for the RCT study population, the Covered California population, and the population of uninsured individuals in California. The average age in the RCT study sample is 37.7 years old, younger than the Covered California population (43.9) but similar to the uninsured (37.3). Appendix Figure 1 displays the full age distributions, and suggests that the age profile of the study sample is more similar to the uninsured than to the Covered California population.

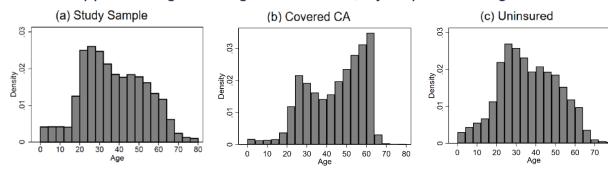
The average income in the study sample is 212 percent of FPL.<sup>6</sup> This is slightly higher than incomes of Covered California (204 percent) enrollees and lower than the uninsured (217 percent). The distribution of race in the study sample also resembles that of the uninsured population. Overall, these statistics suggest that the Funnel population resembles the uninsured, but given their expressed interest in the marketplace, may be slightly more likely to take up insurance than the overall uninsured population in subsequent years. Below, in Appendix Section A6, we provide a more detailed comparison of the RCT sample to other populations for the purpose of assessing generalizability of the RCT results.

<sup>&</sup>lt;sup>4</sup> After implementing the original intervention, it was determined in consultation with state program administrators that many of these consumers were simultaneously being evaluated for other Medicaid coverage options that existed prior to the ACA. For those who qualified—which would have resulted in the consumers being found ineligible for marketplace subsidies—these programs were more financially beneficial than purchasing unsubsidized plans through Covered California.

<sup>&</sup>lt;sup>5</sup> We also replicate all analyses using the full post-randomization pre-exclusion sample of 126,182. As expected, we find that control group take-up is slightly lower in this sample than in the final study sample, given the inclusion of households who are unlikely to take-up; but estimated treatment effects and patterns of heterogeneity are nearly identical to those observed for the final study sample. Results are available upon request.

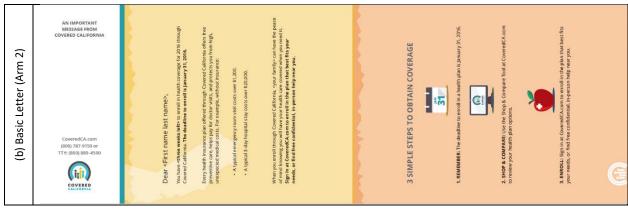
<sup>&</sup>lt;sup>6</sup> FPL information is missing for some households with incomes above 400 percent of FPL, so we restrict estimates of average incomes, here, to households with reported income less than 400 percent of FPL. Households with incomes above 400 percent of FPL are ineligible for subsidies, and did not need to provide their income on the application, resulting in missing incomes for some of these households.

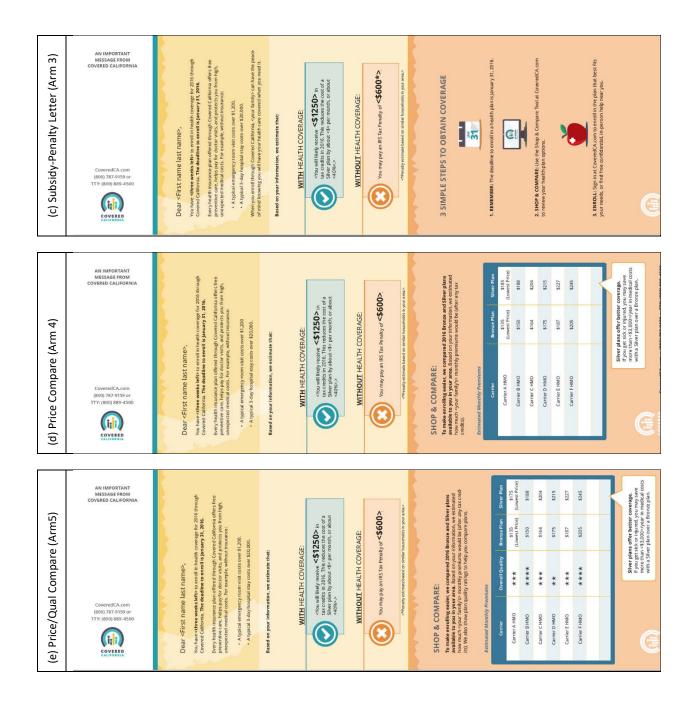
# Appendix Figure 1. Age Distribution, By Populaton Segment



# A2. Intervention Letter Templates







# A3. Heterogeneous Treatment Effects by Health Spending Risk

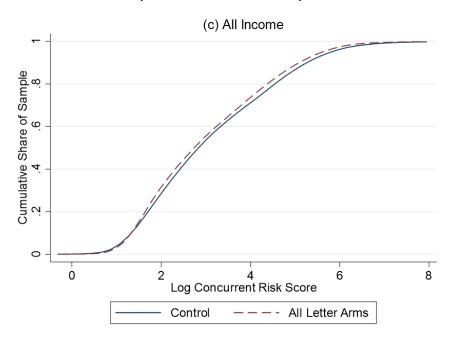
To estimate the differential take-up by health risk, we estimate equation (1) including interactions between treatment assignment and log health spending risk. Results are reported in Appendix Table 5. All specifications control for region and interactions between treatment arms and the consumer age rating factor used for age-based premium pricing. Thus, any heterogeneous take-up risk will represent selection on spending risk that plans are unable to price in.

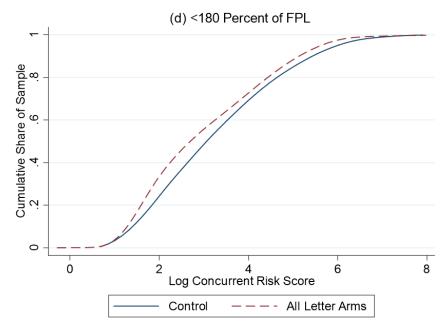
Four patterns are evident. First, the treatment effects are markedly stronger for healthier consumers. Second, the differential treatment effect among healthier consumers is concentrated in the Open Enrollment sample, who are generally aware of the existence of health plan and premium subsidies on the Exchange. Consistent with a simple adverse selection model with behavioral frictions, sicker Open Enrollment applicants with higher demand for coverage may have already incurred the frictional costs associated with shopping and enrolling; and by lowering these frictions, the letters may have disproportionately induced marginally healthier consumers into the market. By contrast, if the County Referral applicants were typically less aware of marketplace options and had a lower overall baseline take-up rate, the intervention may have induced both healthy and sick consumers into the market.

Third, the positive health selection effects of the letter intervention are concentrated among lower income Open Enrollment consumers. This suggests that lower income individuals may face greater hassle cost and frictions associated with remembering to enroll, choosing a plan, and enrolling by the deadline. If so, letters that reduce these frictions would magnify the overall enrollment effects among healthier consumers.

Finally, we examine whether the differential treatment effect by health risk is explained by heterogeneous treatment effects along observable dimensions that plans are permitted to price in—namely, age factors and region. If, for example, the treatment selection effects are embodied in differential treatment effects by age, then much of the healthier risk response would be reflected in the lower premiums received by plans for younger enrollees. To examine this, we repeat the regression specifications of Appendix Table 5, but do not include the interactions between treatment arm and the consumer age rating factors used for age-based premium pricing. Results are reported in Appendix Table 6. Dropping the age rating factor controls leaves the estimated coefficients on the interaction terms between treatment and baseline risk largely unchanged, implying that the vast majority of the positive risk selection induced by the interventions is not explained by differential take-up by age, but rather by unpriced health risk conditional on age.

# Appendix Figure 2. CDF Log Concurrent Risk Open Enrollment Sample





Appendix Figure 2 depicts the cumulative distribution function of log concurrent risk scores among enrolled consumers, by control and treatment assignment. Panel (a) is restricted to the Open Enrollment sample. Panel (b) is restricted to households with income <180 percent of FPL within the Open Enrollment sample.

# A5: A Simple Model of Frictions and Imperfect Information in Insurance Demand

In this section, we discuss a simple model that supplements the intuition outlined in Section 5.4 of the main paper. The goal of the model here is to introduce a framework to think about the value of the letters and how different frictions can bias measurements of WTP. We do not attempt to estimate this model, but rather use it to motivate the estimated model in Section 5.4. The model is an augmented discrete choice model to consider the effect of enrollment frictions (namely remembrance costs), as well as incomplete information. To handle incomplete information and learning, we adopt a framework similar to that of Bayesian learning models—e.g. as in Chernew, Gowriskankaran, and Scanlon (2008).

Consider household i with the option of enrolling in a representative insurance plan. If the household enrolls, they must face some enrollment costs. As an illustration, we focus only on the mental costs associated with remembering to enroll as examined in this paper (call this  $c_i^{Remember}$ ), but it could just as well be other frictions more directly tied to the enrollment process itself (e.g. collecting and entering information for the application, assessing plan options, etc.); and moreover, assume that the household is perfectly informed about all plan characteristics and prices, but not the subsidy level for which they are eligible. We denote the value of the plan (relative to being uninsured and the value of uncompensated care, etc.) as  $\delta_i$ . The disutility of premiums is  $U_i^{premium}$ . The Information set for the household is denoted by  $I_i$  and the perceived monthly subsidy (ATPC) given that information is  $E(\tau_i|I_i)$ . We use this notation to highlight that perceived subsidies can change with new information, such as that included in our letter interventions. Combining the above, the expected indirect utility  $u_i$  of enrolling in the plan relative to remaining uninsured is:

(A) 
$$u_i = \delta_i - U_i^{premium} - c_i^{Remember} + \alpha_i E(\tau_i | I_i) + \varepsilon_i$$

<sup>&</sup>lt;sup>7</sup> For the purpose of this exposition, having one plan is sufficient to demonstrate key mechanisms. In reality, each household is given a menu of plans from which to choose. This model could be augmented to include more plans, but it would complicate notation with little added value to communicating the main mechanisms of interest. This paper focuses on take-up effects, so our primary margin of interest is whether or not to enroll in any plan.

<sup>8</sup> One could add learning about plan characteristics (e.g. as targeted by our treatment arms 4 and 5), using the

<sup>&</sup>lt;sup>8</sup> One could add learning about plan characteristics (e.g. as targeted by our treatment arms 4 and 5), using the same approach as we use for subsidies.

<sup>&</sup>lt;sup>9</sup> As noted in the above footnote, we could have considered take-up of any of a set of plans offered—more realistic to our setting. In this case,  $\delta_i$  more accurately can be thought of as expected value of the "most preferred" of all plans—analogous to the "inclusive value" derived from a plan choice framework ( $E[\max\{u_{ik}\}]$ , where  $u_{ik}$  is the utility of each individual plan). This is how we think about this value when going to the reduced-form version of this model presented in the paper. Note with this interpretation, we assume additive separability in the utility of plans and plan premiums, which is a reduced-form representation of the true indirect utility of the bundled choice set.

 $<sup>^{10}</sup>$  If subsidies and premiums had an identical impact on choice, this would be  $lpha_i*premium_i$ 

 $\varepsilon_i$  is the idiosyncratic utility of having insurance and is centered at 0. The household takes up insurance if the indirect utility  $u_i$  exceeds 0.

Equation (A) departs from a canonical specification of indirect utility in two primary ways: first, we include  $c_i^{Remember}$  to reflect the mental cost of remembering to enroll, which is required by all households choosing to enroll (but can differ). This friction is targeted explicitly by the Basic Reminder letter, the content of which is included in all intervention letters. The second difference is that  $E(\tau_i|I_i)$  captures perceived subsidies, not actual subsidies  $\tau_i$ . In principle, other frictions could affect take-up—e.g. the hassle cost of enrolling in a plan—but are not explicitly modeled here. <sup>11</sup>

The true value in utils of insurance in this model is the term  $\delta_i$ . Since  $\alpha_i$  is the value of perceived subsidy dollars in utils, the dollar valuation for insurance, or "willingness-to-pay" (WTP), could be calculated as  $\delta_i/\alpha_i$ , using unbiased estimates of  $\delta_i$  and  $\alpha_i$ . Using a revealed preference approach, one could try to estimate this object from the observable data. However, there are two reasons that measurement of the WTP using common revealed preference methods might be biased due to the frictions explored in this study. First, to the extent that  $c_i^{Remember}$  must be paid to enroll, standard estimation techniques will include  $c_i^{Remember}$  as part of  $\delta_i$ , since it is generally not observable and not separately identified. Hence, the WTP will generally be calculated as  $(\delta_i-c_i^{Remember})/\alpha_i$ . If this cost  $c_i^{Remember}$  is nonzero, WTP calculations with this approach will be biased downward from the true value of insurance. In short, the measured value of insurance will generally be net of costs of enrolling, such as mental costs of remembering. If enrollment costs are high, consistent with evidence from this study, then value of insurance will likely be measured to be too low.

The second reason that common estimation methods could lead to biased measurement of WTP is in the estimation of  $\alpha_i$ . If changes in perceived subsidies  $E(\tau_i|I_i)$  are not equal to the actual changes (or whatever is observable in the data and used in estimation), then  $\alpha_i$  will not be a correct conversion of utils to dollars. At the extreme, if price changes are not perceived at all, then consumers are not at all responsive to prices, and the WTP for insurance will approach infinity—i.e. upward biased from the actual WTP. On the other end, if consumers overestimate price changes (e.g. if they think subsidy

<sup>&</sup>lt;sup>11</sup> Consumers may face additional frictions and search costs. For example, consumers may face high hassle costs of enrolling in a plan, apart from remembering to enroll and to compare plans and obtaining true prices. As our interventions do not specifically target the ease of enrolling, we do not explicitly model that here, but this framework could be adapted to include enrollment hassle costs. For this reason, the estimated value of our letters can also be thought of as a lower bound on the dollar denominated cost of various frictions associated with the enrollment process.

gradient is steeper than in reality), then the estimation will yield a high value of  $\alpha_i$  and hence a low value for  $\delta_i/\alpha_i$ . In this case, WTP will be downward biased. In summary, misperceptions about prices and subsidies can have an ambiguous effect on the empirical estimation (and bias) of WTP.

Without accounting for behavioral frictions, an econometrician using demand estimation to measure WTP for available plans would confound underlying WTP for insurance with the effects of these behavioral frictions. Distinguishing between an environment where WTP is low and one where WTP is higher but made artificially lower due to the presence of frictions leads to different policy implications.

Finally, a major object of interest in the paper is the "value" of the letters. In the paper, we use an approximation of value which is "the subsidy equivalent effect." However, this model presented here—if estimated—could be used to calculate a more formalized "value" in welfare equivalent units, for example, as done in Chernew, Gowriskankaran, and Scanlon (2008).

# A6. Projecting RCT Treatment Effects to Broader Populations

We consider a hypothetical expansion of the intervention to several populations that a marketplace could conceivably target: a) all uninsured consumers (say, through a potential collaboration with a tax authority charged with administering a state mandate); b) any consumer who enters the year-long Funnel, during open enrollment or any time during the year after becoming enrollment-eligible due to a qualifying-event (e.g. divorce, change in immigration status, loss of previous coverage, etc.), whether by active shopping or county referral; c) the subset of this year-long Funnel who do not enroll in a plan after a number of days, as defined by policy-makers.

Appendix Table 9 reports summary demographic statistics for the RCT Funnel sample, Covered California's enrollee population, sample estimates of California's uninsured population, and two subsets of the year-long Funnel population. Consumers in the "3-day" Funnel enter the Funnel but have not enrolled in a plan after three days. The "10-day" Funnel is analogously defined. Naturally, the selection of consumers in a Funnel defined by the shorter period will have higher take-up, potentially indicating the inclusion of consumers with higher unobserved demand for insurance, awareness of the market, or lower frictions. For purposes of generalizability, our target population would ideally have a similar take-up rate as the control arm of the RCT sample. As discussed below, we calibrated the definition of the Funnel such that the resulting marketplace take-up rate equals the take-up rate in our RCT control

sample. In this way, we define a population to whom our RCT results may generalize more reliably. Doing so, we arrived at the 10-day Funnel. 12

Along age, race, and income, the RCT sample appears similar to the uninsured and the 3- and 10-day Funnel populations. The two Funnel populations also have roughly similar share of County Referral consumers as the RCT control sample. However, the two Funnel populations differ in their eventual marketplace take-up rates, a potential indicator of unobserved demand for insurance and awareness of marketplace coverage. Defined using a shorter period, the 3-day Funnel has a marketplace take-up rate of 11 percent, higher than the 8.1 percent in the RCT control sample, raising doubts as to the generalizability of the RCT results to this population. As discussed above, the 10-day Funnel was arrived at by calibrating the definition of the Funnel to obtain take-up rates matching the 8.1 percent take-up observed in the RCT control arm. We therefore use the 10-day Funnel as the basis of projecting a hypothetical expanded informational letter intervention. We also considered using the uninsured population for purposes of the projection, given its similarity to the RCT sample along income and demographic characteristics. But lacking information on eventual take-up rates, we felt that such an exercise would be too speculative.

Back-of-the-envelope projections for the post-intervention market-wide average health spending risk is calculated as a weighted average across:

(B) 
$$Average \ Risk^{Post} = \frac{s_F(\beta_e) \cdot R_M R_F + s_F \cdot R_F + (1 - s_F) \cdot 1}{1 + s_F(\beta_e)}$$

where  $s_F$  is the pre-intervention share of the Covered California insured market originating from the 10-day Funnel,  $\beta_e$  is RCT treatment effect on enrollment,  $R_M$  is the average risk of marginal enrollees who enroll in response the intervention (relative to the average risk of enrollees originating from the 10-day Funnel targeted by the intervention),  $R_F$  is the relative risk of enrolled consumers originating from the 10-day Funnel (relative to the average risk of enrollees in the rest of the marketplace). Average risk of the market is the post-intervention enrollment share-weighted average risk across marginal respondents from the 10-day Funnel, inframarginal enrollees originating from the 10-day Funnel, and

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<sup>&</sup>lt;sup>12</sup> From our conversations with Covered California, we also think it could be operationally difficult for an exchange to implement a paper mail intervention in fewer than 10 days.

the rest of the enrollees in the market. The risk of marginal enrollees,  $R_M$ , can be determined from parameters identified in the RCT.<sup>13</sup>

The average market-wide risk absent an intervention is given by  $Average\ Risk^{Pre} = s_F \cdot R_F + (1 - s_F)$ . Comparing  $Average\ Risk^{Post}$  to  $Average\ Risk^{Pre}$  identifies the impact of the intervention on market-wide average risk.

Administrative data shows that about 4 percent of Covered California's covered member-months in any year originate from the 10-day Funnel (in any one year,  $s_F=0.04$ ). But among the 96 percent that do not originate from any one year's Funnel, a large fraction are renewals who originated a previous year's Funnel. Under the assumption that renewal and attrition rates among enrollees who do and do not originate from the Funnel are similar, then the steady-state share of Covered California's membermonths of coverage is the share of *new* enrollees in any given year originating from the 10-day Funnel, which for the 10-day Funnel definition is 14 percent (in steady state,  $s_F=0.14$ ). <sup>14</sup>

Our RCT suggests that  $\beta_{Take-up}=0.16$ , and  $\beta_{Risk}=0.051$  to 0.072—that a similar information intervention would generate a 16 percent increase in enrollment, and cause average risk of enrollees from the 10-day Funnel to fall 5.1 percent, or 7.2 percent if mailings were optimized using the intervention (i.e. the subsidy + plan comparison letter) that generated the largest risk impacts, especially for lower income recipients. This implies marginal enrollees that are 37 to 52 percent healthier than inframarginal enrollees in the treated Funnel. Analysis using full administrative data from Covered California show that expected health risk among enrollees originating from the year-long Funnel is 7.8 percent *higher* than the rest of the marketplace. However, the prospective nature of the CDPS risk score, and comparing across two populations with different pre-period insurance and cost-sharing, suggests these differences may not reflect well differences in realized health spending. Nevertheless, we conservatively assume  $R_F = 1.078$ .

 $<sup>^{13}</sup>$   $R_M=\frac{(1-\beta_T)(1+\beta_e)-1}{\beta_e}$  captures the risk of marginal enrollees to the letter intervention, relative to the RCT control group (in this context, the consumers in the 10-day Funnel), where  $\beta_T$  is the reported experimental treatment effect on the average risk of marginal and inframarginal enrollees in the treated population, reported in Table 5.  $^{14}$  The share of new enrollees each year is about 28.5 percent. To apply the steady state share to equation (B) requires making an additional assumption that the RCT treatment effects are independent of renewal and attrition decisions. Unfortunately, administrative data for the study years were not structured to test this. In principle, administrative data on Funnel status could be linked across years to renewal behavior to model explicitly steady state share of enrollees originating from the Funnel.

<sup>&</sup>lt;sup>15</sup> Enrollees originating from the Funnel show higher risk despite having lower average age than the rest of the enrollees. This is primarily driven by a much higher fraction of Funnel consumers (and eventual enrollees from the Funnel) having at least one outpatient OSHPD encounters (relative to all other enrollees in Covered California,

Applying the RCT treatment effects on take-up and average risk, we project that an expanded intervention would lead to a 0.6 percent increase in total enrollment, and a 0.2 to 0.3 percent reduction in market-wide risk in the first year; and in steady state, the intervention would lead to a 2.4 percent increase in total enrollment, and a 0.7 to 1.1 percent reduction in market-wide risk, with the upper end of each range reflecting an optimized mailing using letters that generated the largest impacts on risk.

Findings from Section 5.2 suggest that the vast majority of the average risk reduction—or about 85 percent—is not explained just by positive selection in age or membership in less costly regions, but on healthier risks conditional on those factors. A reduction in market-wide risk of about 1.0 percent, if translated to lower premiums, would lead to meaningful decreases in public subsidy and consumer spending. It would also lead to additional increases in enrollment beyond the direct letter effect, in response to premium reductions, particularly among unsubsidized consumers. The most reliable price elasticities are based on discontinuities in Massachusetts' subsidy design, which imply that a decrease in premiums by \$40 results in a 25 percent enrollment increase (Finkelstein, Hendren and Shepard 2019). As context, a 1 percent decrease in monthly premiums (\$5) would roughly imply a 3 percent increase in enrollment for the low-income unsubsidized consumers, and perhaps 1-2 percent for the above 400 percent of FPL segment of the unsubsidized market. Naturally, lower costs will tend to lower both premiums and (price-linked) subsidies, which will tend to raise net-of-subsidy premiums for other metal tiers, leading to plan switches, changes in risk sorting, and some changes in subsidized take-up. Accounting for these equilibrium dynamics would require a structural model of premium setting and plan choice by risk. As the purpose of the projection is to provide bounds for the actuarial risk impacts of an expanded intervention, we stop short of structurally modeling these equilibrium effects.

These estimates are likely lower bounds on the enrollment and risk effects, given the restrictive definition of the treated population. As a reference, there are roughly 2.2 million uninsured Californians

comprised primarily of renewing marketplace consumers), making their predictive risk higher than predicted risk for people without encounters (based only on age and sex). As noted in Section 5.3, lower cost sharing among Medicaid and uninsured (uncompensated) care may result in greater OSPHD encounters than consumers in higher cost sharing or managed care Covered California plans. Hence, when comparing populations with different preperiod coverage and cost-sharing, differences in OSHPD-based prospective risk may not capture differences in underlying health or realized claims under the same cost-sharing and coverage. (Importantly, this issue does *not* bias our estimates of  $\beta_r$  using the CDPS score, as  $\beta_r$  was identified by randomizing treatment across a common population.) The much lower age of the Funnel population, as well as anecdotal information from plans, suggests that the enrollees from the year-long Funnel are similar, or even healthier, than other enrollees. In principle, we could estimate  $R_F$  directly using concurrent 2016 claims based risk measures detailed in Section 3.5 and 5.3. Unfortunately, currently the claims data sources available to Covered California do not allow us to obtain the concurrent risk measures linked to Funnel status.

at any point in time, of which about 1.4 million are estimated to be marketplace-eligible. If targeted to the entire uninsured marketplace-eligible population, even a smaller risk effect could generate a larger reduction in total market risk than our lower bound estimates.

Appendix Table 1. Sample Exclusions

	Number of Households	Take-up
Universe of Households	153,146	7%
Initial Budgetary Exclusion	26,964	9%
Funnel Sample Size for Budget	126,182	7%
Reason for Sample Exclusion		
Any member with invalid age	50	0%
FPL<100	3,463	1%
Invalid Mailing Address	4,167	3%
SAWS and Deemed Subsidy Ineligible	35,283	1%
Final Study Sample Size	87,394	9%

Appendix Table 1 reports the number of households associated with sample exclusions imposed on the Funnel poulation, and the take-up rate for that exclusion. The December 2015 Funnel included 153,146 households who were initially considered eligible for the study. The initial exclusion dropped a randomly selected 26,964 households, due to study budget constraints. The resulting 126,182 households were then randomization into five study arms, according to the stratified methodology described in Section 3.4. As described in Section 3.2, after randomization, additional exclusions were imposed based on information about household program eligibility and address availibility. Exclusion counts in the table are unconditional on the other exclusions, so households may appear in more than one row. The final study sample size was 87,394.

Appendix Table 2. Average Treatment Effects on Take-up

Model			0	LS			Lo	git
Funnel Sample	Δ	All	Open En	rollment	County	Referral	Α	All .
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Arm2345: All Letters	0.012***		0.016***		0.009***		0.168***	
	(0.002)		(0.005)		(0.003)		(0.039)	
Arm2: Basic Letter		0.012***		0.016***		0.007**		0.134***
		(0.003)		(0.006)		(0.004)		(0.049)
Arm3: Subsidy-Penalty		0.014***		0.023***		0.012***		0.191***
		(0.003)		(0.006)		(0.004)		(0.048)
Arm4: Price Compare		0.010***		0.011*		0.010***		0.143***
		(0.003)		(0.006)		(0.004)		(0.048)
Arm5: Price-Quality Compare		0.012***		0.015**		0.008**		0.170***
		(0.003)		(0.006)		(0.004)		(0.048)
County Referral							-1.507***	-1.507***
							(0.075)	(0.075)
Arm2345*County Referral							0.051	
							(0.083)	
Arm2*County Referral								-0.011
								(0.104)
Arm3*County Referral								0.036
								(0.104)
Arm4*County Referral								0.106
								(0.104)
Arm5*County Referral								0.073
								(0.103)
Constant	0.071***	0.071***	0.143***	0.143***	0.057***	0.057***	-1.786***	-1.786***
	(0.016)	(0.016)	(0.027)	(0.027)	(0.017)	(0.017)	(0.213)	(0.213)
Control: Covariates x Treatment Arms	Υ	Υ	Υ	Υ	Υ	Υ	Υ	Υ
Observations	87,394	87,394	44,248	44,248	43,146	43,146	87,394	87,394
R-squared	0.028	0.029	0.036	0.038	0.019	0.022	,	•

Appendix Tables 2 reports OLS treatment effects of letter interventions on take-up of 2016 open enrollment coverage, with a full set of interactions between treatment arms and all control, following Lin (2013). Columns (1)-(2) are estimated on the full study sample. Columns (3)-(4) and (5)-(6) restrict the sample to the Open Enrollment and County Referral samples, respectively. Columns (7)-(8) reports logit specifications on the full sample, including interactions between treatment assignment and an indicator for County Referral. Covariates include household level controls, including family size, number of kids, age, race, language preferences, marital status, Covered California's age-based community-rating premium ratio, and household income (as percent of the FPL). Robust standard errors in parentheses. \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

Appendix Table 3. Heterogeneous Treatment Effects, by Income (Non-Parametric)

Mode	·l	OLS			Logit	
Sample	e All	OE	County Ref	All	OE	County Ref
	(1)	(2)	(3)	(4)	(5)	(6)
Arm2: Basic Letter	0.006	0.023*	-0.002	0.092	0.174**	-0.055
	(0.005)	(0.012)	(0.005)	(0.070)	(0.088)	(0.117)
Arm345: Subsidy Arms	0.013***	0.033***	0.003	0.186***	0.240***	0.088
	(0.004)	(0.010)	(0.004)	(0.057)	(0.073)	(0.093)
FPL in [180, 250]	-0.002	-0.000	-0.005	-0.031	0.012	-0.113
	(0.005)	(0.012)	(0.005)	(0.078)	(0.094)	(0.140)
FPL in [250, 400]	-0.011	-0.008	-0.010	-0.124	-0.062	-0.291
	(800.0)	(0.015)	(0.008)	(0.114)	(0.131)	(0.253)
Arm2 x FPL in [180, 250]	0.008	-0.004	0.013*	0.093	-0.027	0.336*
	(0.007)	(0.016)	(0.007)	(0.098)	(0.119)	(0.174)
Arm345 x FPL in [180, 250]	-0.003	-0.020	0.005	-0.046	-0.133	0.141
	(0.006)	(0.013)	(0.005)	(0.081)	(0.099)	(0.144)
Arm2 x FPL in [250, 400]	0.009	0.000	0.007	0.115	0.036	0.224
A 245 FDL :- [250, 400]	(0.008)	(0.016)	(0.007)	(0.110)	(0.127)	(0.257)
Arm345 x FPL in [250, 400]	-0.004	-0.025**	0.007	-0.056	-0.163	0.289
Constant	(0.007) 0.167***	(0.013) 0.155***	(0.006) 0.035***	(0.092) -1.797***	(0.106) -1.715***	(0.207) -3.443***
Constant	(0.010)	(0.019)	(0.009)	(0.133)	(0.159)	(0.244)
	(0.010)	(0.019)	(0.003)	(0.133)	(0.133)	(0.244)
$\Delta_1 = \beta_{Arm345} - \beta_{Arm2}$	0.007*	0.010	0.006	0.094*	0.067	0.143
P-val: $(\Delta_1)$	0.090	0.307	0.121	0.086	0.329	0.132
$\Delta_2 = \beta_{Arm345 \times FPL[180,250]} - \beta_{Arm2 \times FPL[180,250]}$	0] -0.011*	-0.015	-0.008	-0.139*	-0.107	-0.196
P-val: $(\Delta_2)$	0.077	0.241	0.149	0.072	0.257	0.156
$\Delta_3 = \beta_{Arm345 \times FPL[250,400]} - \beta_{Arm2 \times FPL[250,400]}$	0.013*	-0.026**	0.001	-0.171**	-0.200**	0.065
P-val: $(\Delta_3)$	0.057	0.049	0.925	0.048	0.046	0.746
$\Delta_2$ - $\Delta_1$	-0.018*	-0.025	-0.014	-0.233*	-0.173	-0.339
P-val: $(\Delta_2 - \Delta_1)$	0.060	0.238	0.105	0.057	0.252	0.115
$\Delta_3$ - $\Delta_1$	-0.020**	-0.036*	-0.005	-0.265**	-0.267*	-0.078
P-val: $(\Delta_3 - \Delta_1)$	0.044	0.097	0.559	0.039	0.086	0.762
Controls	Υ	Υ	Y	Υ	Υ	Y
Observations	75,495	32,698	42,797	75,495	32,698	42,797
R-squared	0.065	0.039	0.018	-,	- ,	,

Appendix Table 3 reports heterogeneous treatment effects by income brackets.  $\Delta_1$  reports the additional treatment effect of the Subsidy Reporting arms over the Basic Reminder for the <180 FPL segment.  $\Delta_3$  reports the same effect for the 250-400 FPL bracket. ( $\Delta_3$  -  $\Delta_1$ ) reports the difference in the relative effects. All regressions control for a full set of household level characteristics, described in Section 4.1. Robust standard errors in parentheses. \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

Appendix Table 4. Treatment Effects on Coverage Duration, Among Enrolled Consumers

	Dependent Variable: Enrollment Length (months)											
Entry Sample	Δ	.II		Ор	en Enrollm	ent		County Referral				
Income Sample	Α	.II	All	All	≤180 FPL	180-250	>250 FPL	All	All	≤180 FPL	180-250	>250 FPL
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Arm2345: All Letters	-0.131		-0.053					-0.343*				
	(0.095)		(0.109)					(0.190)				
Arm2: Basic Letter		-0.121		0.017	0.042	-0.068	0.101		-0.558**	-0.177	-0.923**	-1.594**
		(0.118)		(0.134)	(0.248)	(0.246)	(0.209)		(0.250)	(0.354)	(0.404)	(0.731)
Arm345: Subsidy Arms		-0.134		-0.077	0.085	-0.160	-0.119		-0.276	-0.002	-0.633**	-1.275**
		(0.098)		(0.112)	(0.206)	(0.206)	(0.178)		(0.196)	(0.279)	(0.318)	(0.633)
Control Group Mean (month)	8.44	8.44	8.43	8.43	8.64	8.26	8.42	8.47	8.47	8.66	8.40	8.00
Observations	7,962	7,962	6,214	6,214	1,817	1,934	2,463	1,748	1,748	852	657	239
R-squared	0.031	0.031	0.030	0.030	0.035	0.050	0.034	0.048	0.049	0.073	0.062	0.182

Appendix Table 4 reports treatment effects of letter interventions on duration of coverage, conditional on take-up. Enrollment duration is measured as the average number of months of paid coverage among household policy holders on policies opened during open enrollment. Column headers note sample specifications. Robust standard errors in parentheses. \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

Appendix Table 5. Heterogeneous Treatment Effects, by Baseline Risk (Not Controlling for Age Factors or Regions)

Funnel Sample	Д	All .		Ор	en Enrollm	ent			Co	ounty Refer	ral	
Income Sample	Д	All .	All	All	≤180 FPL	180-250	>250 FPL	All	All	≤180 FPL	180-250	>250 FPL
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Arm2345: All Letters	0.000		-0.012					0.007				
	(0.005)		(0.010)					(0.004)				
Arm2: Basic Letter		0.001		-0.007	-0.016	-0.007	0.001		0.005	0.005	0.009	-0.003
		(0.006)		(0.013)	(0.027)	(0.024)	(0.018)		(0.005)	(0.008)	(0.010)	(0.009)
Arm345: Subsidy Arms		-0.000		-0.013	-0.013	-0.014	-0.009		0.007*	0.006	0.008	0.008
		(0.005)		(0.010)	(0.022)	(0.020)	(0.014)		(0.004)	(0.006)	(0.008)	(0.009)
In(CDPS Score)	-0.001	-0.001	0.005	0.005	0.005	0.002	0.007	-0.001	-0.001	-0.003	0.001	-0.000
	(0.003)	(0.003)	(0.006)	(0.006)	(0.013)	(0.012)	(0.009)	(0.002)	(0.002)	(0.003)	(0.004)	(0.006)
Arm2345 x In(CDPS Risk)	-0.010***		-0.022***					0.001				
	(0.003)		(0.007)					(0.003)				
Arm2 x In(CDPS Risk)		-0.009**		-0.020**	-0.032*	-0.020	-0.011		0.001	0.006	-0.002	-0.006
		(0.004)		(0.009)	(0.019)	(0.017)	(0.013)		(0.004)	(0.005)	(0.006)	(0.007)
Arm345 x ln(CDPS Risk)		-0.010***		-0.023***	-0.035**	-0.021	-0.014		0.000	0.002	-0.001	-0.001
		(0.004)		(0.007)	(0.015)	(0.014)	(0.010)		(0.003)	(0.004)	(0.005)	(0.006)
Constant	0.080***	0.080***	0.133***	0.133***	0.166***	0.148***	0.111***	0.034***	0.034***	0.040***	0.036***	0.022***
	(0.004)	(0.004)	(0.009)	(0.009)	(0.019)	(0.017)	(0.012)	(0.004)	(0.004)	(0.005)	(0.007)	(0.008)
Control: Age and Region	N	N	N	N	N	N	N	N	N	N	N	N
Observations	86,876	86,876	44,029	44,029	9,783	12,169	22,077	42,847	42,847	18,977	15,756	8,114
R-squared	0.001	0.001	0.001	0.001	0.003	0.001	0.000	0.000	0.000	0.000	0.000	0.001

Appendix Table 5 reports heterogenous treatment effects on take-up, by baseline health spending risk. Risk is measured using the CDPS prospective risk score, based on diagnoses from 2015 hospitalizations and emergency room encounters. Column headers note sample specifications. Appendix Table 6 reports estimates from analogous specifications controlling for the age-based premium ratios. Robust standard errors in parentheses. \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

Appendix Table 6. Heterogeneous Treatment Effects, by Baseline Risk (Controling for Age Factors and Regions)

Funnel Sample	A	All .		Ор	en Enrollm	ent			Co	ounty Refer	ral	
Income Sample	A	All	All	All	≤180 FPL	180-250	>250 FPL	All	All	≤180 FPL	180-250	>250 FPL
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Arm2345: All Letters	0.008		0.002					0.010				
	(0.008)		(0.015)					(0.007)				
Arm2: Basic Letter		0.013		0.008	0.025	0.030	-0.003		0.017*	0.030**	0.010	-0.006
		(0.010)		(0.019)	(0.044)	(0.040)	(0.025)		(0.009)	(0.014)	(0.017)	(0.015)
Arm345: Subsidy Arms		0.007		0.000	0.018	-0.006	-0.003		0.008	0.021*	0.001	-0.011
		(0.008)		(0.015)	(0.035)	(0.033)	(0.020)		(0.007)	(0.011)	(0.014)	(0.012)
Age Rating	0.017***	0.017***	0.012**	0.012**	0.041***	0.032**	0.000	0.019***	0.019***	0.021***	0.022***	0.006
	(0.003)	(0.003)	(0.006)	(0.006)	(0.015)	(0.014)	(0.007)	(0.003)	(0.003)	(0.005)	(0.006)	(0.005)
In(CDPS Score)	-0.005*	-0.005*	0.003	0.003	-0.003	-0.004	0.008	-0.005**	-0.005**	-0.008**	-0.004	-0.000
	(0.003)	(0.003)	(0.006)	(0.006)	(0.013)	(0.012)	(0.009)	(0.003)	(0.003)	(0.004)	(0.005)	(0.006)
Arm2345 x In(CDPS Risk)	-0.009**		-0.021***					0.001				
	(0.003)		(0.007)					(0.003)				
Arm2 x In(CDPS Risk)		-0.008*		-0.018**	-0.027	-0.017	-0.012		0.003	0.010*	-0.001	-0.008
		(0.004)		(0.009)	(0.020)	(0.017)	(0.013)		(0.004)	(0.006)	(0.007)	(0.007)
Arm345 x In(CDPS Risk)		-0.009**		-0.021***		-0.021	-0.014		0.000	0.004	-0.002	-0.004
		(0.004)		(0.007)	(0.015)	(0.014)	(0.010)		(0.003)	(0.005)	(0.006)	(0.006)
Arm2345 x Age Rating	-0.005		-0.008					-0.002				
	(0.004)		(0.006)					(0.004)				
Arm2 x Age Rating		-0.007		-0.008	-0.024	-0.022	0.002		-0.007	-0.013**	-0.001	0.001
		(0.005)		(0.008)	(0.021)	(0.019)	(0.010)		(0.004)	(0.006)	(0.009)	(0.008)
Arm345 x Age Rating		-0.004		-0.007	-0.019	-0.006	-0.003		-0.001	-0.008	0.004	0.011*
		(0.004)		(0.007)	(0.017)	(0.016)	(0.008)		(0.004)	(0.006)	(0.007)	(0.006)
Constant	0.053***	0.053***	0.117***	0.116***	0.116***	0.082**	0.120***	0.008	0.008	0.008	-0.005	0.034**
	(0.009)	(0.009)	(0.016)	(0.016)	(0.037)	(0.034)	(0.021)	(0.008)	(0.008)	(0.013)	(0.014)	(0.017)
Control: Age and Region	Υ	Υ	Υ	Υ	Υ	Υ	Υ	Υ	Υ	Υ	Υ	Υ
Observations	86,876	86,876	44,029	44,029	9,783	12,169	22,077	42,847	42,847	18,977	15,756	8,114
R-squared	0.004	0.004	0.003	0.003	0.009	0.007	0.002	0.008	0.008	0.006	0.010	0.018

Appendix Table 6 reports heterogenous treatment effects on take-up, by baseline health spending risk. Risk is measured using the CDPS prospective risk score, based on 2015 hospitalizations and emergency room encounters. Column headers note sample specifications. All regressions control for ACA age-based community-rating premium ratios and region. Appendix Table 5 reports estimates from analogous specifications without controls. Robust standard errors in parentheses. \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

Appendix Table 7. Treatment Effect on the Average Risk of Enrolled Consumers (Controlling for Age Factors and Region)

		Panel A: D	<u>ependent</u> Va	riable = In(CDPS	Risk Score)			
Funnel Sample	Д	All .	(	Open Enrollmen	t		County Referral	
Income Sample			<180FPL	180 <fpl<250< th=""><th>&gt;250FPL</th><th>&lt;180FPL</th><th>180<fpl<250< th=""><th>&gt;250FPL</th></fpl<250<></th></fpl<250<>	>250FPL	<180FPL	180 <fpl<250< th=""><th>&gt;250FPL</th></fpl<250<>	>250FPL
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Arm2345: All Letters	-0.043**							
	(0.017)							
Arm2: Basic Letter		-0.037*	-0.086*	-0.017	-0.041	0.089	-0.014	-0.257**
		(0.020)	(0.045)	(0.039)	(0.033)	(0.067)	(0.072)	(0.120)
Arm345: Subsidy Arms		-0.045**	-0.101**	-0.019	-0.049	0.045	-0.029	-0.126
		(0.017)	(0.039)	(0.032)	(0.030)	(0.052)	(0.057)	(0.109)
Constant	-1.521***	-1.521***	-1.449***	-1.626***	-1.467***	-1.512***	-1.696***	-1.744***
	(0.043)	(0.043)	(0.103)	(0.072)	(0.063)	(0.172)	(0.116)	(0.188)
Observations	7,945	7,945	1,810	1,933	2,458	851	655	238
R-squared	0.065	0.065	0.086	0.085	0.052	0.109	0.114	0.187
		Panel B: Depe	endent Varial	ole = In(Concurr	ent Risk Scor	e)		
Funnel Sample	Α	All .	(	Open Enrollmen	t		County Referral	
Income Sample			<180FPL	180 <fpl<250< td=""><td>&gt;250FPL</td><td>&lt;180FPL</td><td>180<fpl<250< td=""><td>&gt;250FPL</td></fpl<250<></td></fpl<250<>	>250FPL	<180FPL	180 <fpl<250< td=""><td>&gt;250FPL</td></fpl<250<>	>250FPL
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Arm2345: All Letters	-0.023							
	(0.034)							
Arm2: Basic Letter		0.008	-0.085	-0.021	-0.011	0.164	0.059	-0.047
		(0.043)	(0.097)	(0.090)	(0.074)	(0.132)	(0.150)	(0.206)
Arm345: Subsidy Arms		-0.034	-0.189**	-0.122	0.008	0.272***	0.023	-0.242
•		(0.035)	(0.080)	(0.075)	(0.061)	(0.104)	(0.135)	(0.179)
		. ,		`		, ,	• • • • • • • • • • • • • • • • • • • •	

Appendix Table 7 reports treatment effects on average risk of enrolled individuals, controlling for age factors and region. Table 5 reports analogous specifications controlling for age and region. The dependent variable in Panel A is the log of the CDPS prospective risk score, based on 2015 hospital and emergency room encounters. The dependent variable in Panel B is the log concurrent risk score, based on realized 2016 claims data. Robust standard errors in parentheses. \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

2.052\*\*\*

(0.170)

2,565

0.111

2.020\*\*\*

(0.144)

3,655

0.120

2.137\*\*\*

(0.236)

1,264

0.107

2.258\*\*\*

(0.180)

2,445

0.128

Constant

Observations

R-squared

2.087\*\*\*

(0.081)

11,472

0.111

2.088\*\*\*

(0.081)

11,472

0.111

2.159\*\*\*

(0.325)

548

0.168

2.090\*\*\*

(0.318)

969

0.111

Appendix Table 8. Indirect Utility Model Logit Regressions and Implied Valuations

Entry Sample		All
Income Sample		All
	(1)	(2)
γ	0.148***	0.147***
	(0.032)	(0.031)
$\alpha$	0.276***	
	(0.013)	
Constant	-0.925***	-1.575***
	(0.116)	(0.115)
Controls	Υ	Υ
Observations	87,394	87,394
Implied Value: Letter (\$/m)	53.388***	
	(11.671)	
Calibration using FHS (2019)		
Takeup Effect (%)	:	15.533
Implied Value: Letter (\$/m)		24.85

Appendix Table 8 reports estimates from the indirect utility model (equation 3).  $\alpha$  represents the effect of the subsidy on indirect utility.  $\gamma$  represents the effect of receiving any treatment letter on indirect utility. The implied value of the letter in subsidy-dollar equivalence is calculated as  $\gamma/\alpha$ . The bottom portion reports implied letter values where  $\alpha$  is calibrated to elasticities reported in Finkelstein, Hendren and Shepard (2019). \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

Appendix Table 9. Demographics of Comparison Populations

		Covered California	California	Full-Year "3-Day"	Full-Year "10-Day"
	RCT Sample	2015	Uninsured 2015	Funnel	Funnel
	(1)	(2)	(3)	(4)	(5)
HH Age (mean)	37.65	43.94	37.28	37.16	37.10
SD of HH Age	14.64	13.30	13.26	13.93	13.94
FPL (FPL<400)	212.25	203.63	216.55	210.45	210.48
SD of FPL	62.68	63.28	80.03	64.02	64.03
FPL > 400 (share)	0.14	0.09	0.22	0.10	0.10
White (share)	0.26	0.34	0.26	0.26	0.26
Latino (share)	0.43	0.20	0.33	0.43	0.43
Asian (share)	0.12	0.17	0.11	0.12	0.12
Black (share)	0.05	0.02	0.05	0.05	0.05
County Referred	0.49	0.02	N/A	0.45	0.46
Marketplace Take-up	0.081	1.000	N/A	0.110	0.082
N (Households)	87,394	800,778	1,354,572	644,586	624,166
N (Individuals)	121,828	1,206,920	2,180,528	947,597	916,697

Appendix Table 9 reports household-level income and demographic characteristics of the RCT study sample; enrollees in California's health insurance marketplace (Covered California) in December 2015, when the RCT sample was drawn; the uninsured population in California in 2015 (based on the American Community Survey); and the two definitions of the "full-year" Funnel population in 2016, corresponding to the study's 2016 coverage year. The 3-day (10-day) Funnel is comprised of consumers who initiated the eligibility process for coverage in Covered California at anytime during 2016, including the open enrollment period at the end of 2015, but did not enroll after 3 (10) days. Statistics for the 3- and 10-day Funnel populations do not include individuals in the RCT treatment arms, but individuals in the RCT control arm by five, to reflect the full Funnel population in the absence of the RCT. The marketplace take-up rate in column 1 is retricted to the control arm of the RCT study sample, only.



# **HEALTH**

# Paying too much for health insurance? New subsidies announced



BY ANA B. IBARRA, APRIL 12, 2021 UPDATED APRIL 14, 2021



Covered California, the state's insurance marketplace, today opened a special enrollment period that allows people to sign up and make use of federal COVID-19 relief dollars designated for health coverage aid. Image via iStock

#### **IN SUMMARY**

Covered California has \$3 billion in federal aid for people who enroll this year or already are signed up. The savings could be hundreds of dollars per month.

# Lea este artículo en español.

Californians enrolled in health coverage this year will qualify for substantial savings as \$3 billion in federal aid kicks in, including for people who are currently getting no subsidies.

Covered California, the state's insurance marketplace, today opened a special enrollment period that allows people to sign up and make use of federal COVID-19 relief dollars designated for health coverage aid. This money is on top of subsidies already provided to some low-income and middle-income Californians through the Affordable Care Act.

Households that already receive some aid could get a couple hundred dollars more in savings in their monthly premiums. Also, people who are currently paying full price for insurance could get about \$700 in savings a month, said Covered California Executive Director Peter V. Lee.

Experts expect this boost in aid to translate into a significant drop in the number of Californians living without health insurance, especially once the word spreads.

"This is a huge deal for middle class Californians paying mammoth checks to insurance companies," Lee told CalMatters. Affordability, he said, is the number one reason people go without health coverage.

The new aid, part of the American Rescue Plan, makes subsidies available to many more Californians. Covered California estimates about 2.5 million people will benefit from new and expanded help. That includes about 810,000 currently uninsured people.

# "This is a huge deal for middle class Californians paying mammoth checks to insurance companies."

- PETER V. LEE, COVERED CALIFORNIA EXECUTIVE DIRECTOR

For people looking to sign up, their coverage can go into effect as soon as May 1 if they enroll before the end of April. People will be able to sign up for the remainder of the year. This enhanced federal aid, however, does have an expiration date: It will run through the end of 2022.

For people already enrolled in a health plan through Covered California, their out-of-pocket share will be automatically adjusted; they should see savings as early as next month.

The federal law expands eligibility for federal assistance and sets a maximum for how much of their own money families and individuals can spend on health coverage – 8.5% of their income.

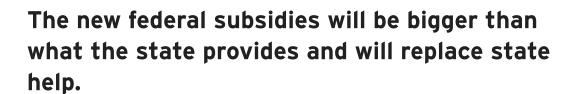
For instance, for a household with \$70,000 of annual income, the cost of its health insurance would be capped at \$5,950 per year. A household earning \$200,000 per year wouldn't have to pay more than \$17,000 per year for health insurance.

"The American Rescue Plan does limit the subsidy to amounts in excess of 8.5% of household income, so for a millionaire that would be premiums in excess of \$85,000 (a year) and American health care is expensive but it's not that expensive," Joseph Newhouse, a professor of health policy and management at Harvard University, said during a press call with Covered California.

Previously, households with incomes above 400% federal poverty level – about \$51,040 for an individual or \$104,800 for a family of four - were not eligible for federal assistance. Those families and individuals often buy their health coverage directly from insurers, but now those same people may be able to pocket some of their premium cost if they go through the state exchange.

Last year, California became the first state in the nation to offer aid to middle-income residents who made too much to benefit from federal subsidies. The state raised the threshold for aid to incomes at 600% of the poverty level. Lee said about 50,000 more Californians signed up for coverage through the state marketplace when that assistance came online.

The new federal subsidies will be bigger than what the state provides and will replace state help. Now "California doesn't have to write the check," Lee said.



According to the state Department of Finance, it may be another month or so before the state knows exactly how this will be reflected in the state's budget.

California has **embraced the ACA** wholeheartedly and has passed several pieces of legislation to enhance the health law. Besides creating its own bucket of subsidies, it also created its own tax penalty when the previous administration eliminated the federal one. Surveys and polls have shown that mandating people to have health insurance through a penalty is

unpopular, but Lee and other insurance market experts say it does nudge people to sign up.

L.A. Care Health Plan, which serves Los Angeles County, has about 100,000 people enrolled through Covered California. Lower income individuals who are just above the threshold to qualify for Medi-Cal could see their portion of the premium reduced to almost zero, said John Baackes, the CEO of L.A. Care Health Plan.

The vast majority of L.A. Care enrollees "were getting a subsidy of some sort, but none had a \$0 payment," Baackes said.

During 2020, as many people lost their jobs during the pandemic and with it their employer-sponsored health insurance, more people fled to Covered California and Medi-Cal, the state health insurance program for low-income people.

Historically, people drop off Covered California because they gain coverage through a job or become newly eligible for Medi-Cal. Usually, about 10% of those who drop off become uninsured, Lee said. Last year, that number grew - about 25% of those who left Covered California lost coverage completely.

## Ana B. Ibarra



Ana is a Sacramento-based health reporter. She joined CalMatters in 2020 after four years at Kaiser Health News, where she covered California health care and policy. She started her reporting career at... More by Ana B. Ibarra

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Press release

## CMS to Adopt Rules to Lower Health Care Costs in 2022 Federal Health Insurance Marketplace Plans

Apr 30, 2021 Affordable Care Act

The Centers for Medicare & Medicaid Services (CMS) today adopted new provisions to lower maximum out-of-pocket costs to consumers by \$400, while increasing competition and improving the consumer experience for millions of Americans who will rely on the Federal Health Insurance Marketplaces in plan year 2022. These actions demonstrate a strong commitment by the Biden-Harris Administration to protect and build on the Affordable Care Act (ACA), reduce health care costs, and make our health care system easier to navigate and more equitable.

The second 2022 Notice of Benefit and Payment Parameters final rule (also known as the "2022 payment notice") includes several provisions to help consumers more easily distinguish between plan options and increase opportunities to qualify for future special enrollment periods (SEPs), when consumers are eligible to enroll in marketplace plans outside annual open enrollment. These SEP policies will offer greater flexibility for those who need coverage—particularly those communities hardest hit by COVID-19. Already, an additional 800,000 Americans have enrolled in the ACA under the SEP enacted by the Administration.

"Families deserve to have access to health care coverage that doesn't break the bank. That's why today we're acting to lower consumers' maximum out-of-pocket costs by \$400 and why President Biden has a plan to reduce families' health care costs for the long run," said U.S. Department of Health and Human Services (HHS) Secretary Xavier Becerra. "Health care access is personal to me as it is for families across the country. The Department of Health and Human Services is committed to building on the ACA to make sure our health care system is more accessible for every American."

"The ACA and the American Rescue Plan offer a lifeline to coverage for millions who might otherwise be uninsured," said Jeff Wu, CMS acting principal deputy administrator and the

deputy director for policy in the CMS Center for Consumer Information & Insurance

Oversight. "Those groundbreaking legislative actions are lowering health insurance premiums for millions of Americans, and the regulatory steps we're taking today build upon those actions. They will ensure that next year, Americans will continue to find affordable, quality coverage through the marketplaces. Consumers and insurers alike will benefit from improvements in the 2022 payment notice."

The annual payment notice makes regulatory changes in the individual and small-group health insurance markets, and outlines parameters and requirements issuers need to design plans and set rates for the upcoming plan year. The notice also includes regulatory standards to help states, the marketplaces, and insurance issuers in the individual and small-group markets better serve consumer needs.

This year, CMS is finalizing the payment notice in multiple phases. The first 2022 payment notice final rule was released in January 2021, as outlined in a fact sheet available at: <a href="https://www.cms.gov/newsroom/fact-sheets/notice-benefit-and-payment-parameters-2022-final-rule-fact-sheet">https://www.cms.gov/newsroom/fact-sheets/notice-benefit-and-payment-parameters-2022-final-rule-fact-sheet</a>. The second 2022 payment notice final rule, released today, continues CMS's trend toward stabilizing the insurance market, promoting program integrity, and reducing regulatory burden.

For consumers, the second phase of the 2022 payment notice expands options for accessing coverage. It also breaks down barriers—like high costs—that too often have put health care out of reach, particularly in underserved communities. The rule finalizes a maximum annual limitation on cost-sharing that is \$400 below what CMS proposed in November 2020.

The new SEP policies, for example, will expand the opportunities consumers have to sign-up for health coverage outside the annual open enrollment period. This includes offering consumers an SEP when they have not received timely notice (and were reasonably unaware) of events that would allow them to qualify, and when they no longer receive employer contributions or government subsidies (such as those provided under the American Rescue Plan Act of 2021) for continued employer health coverage under the Consolidated Omnibus Budget Reconciliation Act (or "COBRA").

Additionally, revised measures establishing parameters for determining insurance affordability and cost sharing will allow consumers to purchase lower-priced plans. These allow those age 30 and over to apply for catastrophic coverage (coverage that generally offers lower-priced plans to protect someone from high medical costs). The calculations will slow the growth rate for cost-sharing, which might otherwise place an undue burden on sicker and lower-income enrollees, and when adopted by the Internal Revenue Service, will also expand eligibility for tax credits to reduce the cost of health insurance premiums for

lower-income enrollees.

A number of other provisions will make it easier for consumers to comparison shop for plans, as well as improve support for the Federal Health Insurance Marketplaces, health insurance issuers, and other stakeholders who facilitate access to coverage. For further information on provisions in the second 2022 payment notice final rule, consult the fact sheet available at: <a href="https://www.cms.gov/newsroom/fact-sheets/notice-benefit-and-payment-parameters-2022-final-rule-part-two-fact-sheet">https://www.cms.gov/newsroom/fact-sheets/notice-benefit-and-payment-parameters-2022-final-rule-part-two-fact-sheet</a>

To view the final rule in its entirety, please visit: <a href="https://www.federalregister.gov/public-inspection/2021-09102/patient-protection-and-affordable-care-act-notice-of-benefit-and-payment-parameters-for-2022-and">https://www.federalregister.gov/public-inspection/2021-09102/patient-protection-and-affordable-care-act-notice-of-benefit-and-payment-parameters-for-2022-and</a>

CMS anticipates additional rulemaking for the 2022 payment notice later this year.

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**Fact sheet** 

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

Apr 30, 2021 Affordable Care Act

The Notice of Benefit and Payment Parameters for 2022 final rule part two finalizes some of the standards included in the proposed rule for states, exchanges, non-federal governmental plans, issuers in the individual and small-group markets (including those that participate in the federally facilitated exchange direct enrollment program), and web brokers. These changes further the Administration's efforts on health equity by lowering maximum consumer out-of-pocket costs by \$400, improving competition and stability, elevating the consumer experience, expanding transparency, ensuring state flexibility, and promoting program integrity. The Centers for Medicare & Medicaid Services (CMS) anticipates additional rulemaking for the 2022 payment notice later this year.

## Lowering Consumers' Maximum Out-of-Pocket Costs by \$400

Premium Adjustment Percentage Index (PAPI) and Cost-sharing Parameters

Considering the overwhelming comments received, the Department of Health and Human Services (HHS) is not finalizing the proposed PAPI, maximum annual limitation on cost sharing, or the required contribution percentage, which were calculated using National Health Expenditure Accounts (NHEA) projections and estimates of private health insurance premiums (excluding Medigap and the medical portion of property and casualty insurance). Instead, we are finalizing calculation of the PAPI and the cost-sharing parameters using the NHEA projections of average per-enrollee\_employer-sponsored insurance (ESI) premium, which was the measure used for benefit years 2015 through 2019. Based on the NHEA ESI premium data, the final premium adjustment percentage index for 2022 is 1.3760126457, the final required contribution percentage for 2022 is 8.09%. and the final maximum annual

limitation on cost sharing for 2022 is \$8,700 for self-only coverage and \$17,400 for other-than-self-only coverage. The final 2022 reduced annual limitation on cost sharing for eligible enrollees with incomes between 100% and 200% of the federal poverty level (FPL) is \$2,900 for self-only coverage and \$5,800 for other-than-self-only coverage. The 2022 reduced annual limitation on cost sharing for eligible enrollees with incomes above 200% and through 250% FPL is \$6,950 for self-only coverage and \$13,900 for other-than-self-only coverage. The rule finalizes a maximum annual limitation on cost sharing that is \$400 below what CMS proposed in November 2020.

## Increasing Competition & Stability

## Risk Adjustment (RA) Model Specifications

HHS is not finalizing many of the proposed updates to the RA model specifications that we proposed in the 2022 payment notice proposed rule. Specifically, we proposed changes to the RA models to include a two-stage specification in the adult and child models, to replace the existing severity illness indicators in the adult models with new severity and transplant indicators with hierarchical condition category (HCC) counts factors in the adult and child models, and modify the enrollment duration factors in the adult models. We are not finalizing these changes at this time, and instead intend to release a technical paper in the future with more data and analysis on the impact of the proposed model specification changes on transfers. However, we are finalizing the continuation of the pricing adjustment for hepatitis C drugs that has been in place since the 2020 benefit year.

## • RA Reporting and Policies Related to Temporary Premium Credits

We are also finalizing RA reporting requirements for issuers of risk adjustment covered plans who choose to provide temporary premium credits, if permitted by HHS during a future public health emergency. As finalized, these issuers would be required to report to their EDGE servers the lower, adjusted plan premiums that reflect actual premiums billed to enrollees. We also finalize the clarification regarding calculation of HHS risk adjustment payment and charges in light of these premium credits by specifying that, for states where issuers of risk adjustment covered plans provide temporary premium credits when permitted by HHS, the plan average premium and statewide average premium used in the state payment transfer formula would be calculated using issuers' adjusted premium amounts.

Updates to Data Used for RA Model Recalibration
 HHS is finalizing the policy to use the three most recent consecutive years of enrollee-level EDGE data that are available in time for incorporating into the coefficients in the proposed rule and to not update the coefficients for additional years of data between the proposed and final rules if an additional year of enrollee-level EDGE data becomes available. Adoption of this policy results in the use of enrollee-level EDGE data from the

2016, 2017 and 2018 benefit years for the 2022 model recalibration, the same data years used for the 2021 model recalibration.

## Alabama's 2022 State Flexibility Request

HHS is approving the 2022 benefit year requests submitted by the state of Alabama to reduce RA state transfers by 50% for both the individual market (including both the catastrophic and non-catastrophic risk pools) and the small-group market. HHS reviewed the data submitted by Alabama as part of its requests, in addition to other data and information available to HHS, along with timely submitted public comments, and determined that the requests meet the *de minimis* standard in both markets as set forth in 45 CFR § 153.320(d). As such, HHS will reduce individual and small group market RA state transfers for Alabama issuers by 50% for the 2022 benefit year.

# Collection and Payment of HHS Risk Adjustment Data Validation (HHS-RADV) Adjustments

HHS is finalizing the policy to revert to the previous schedule for the collection of HHS-RADV charges and disbursement of payments in the calendar year in which HHS-RADV results are released (for example, collection and disbursement of 2021 benefit year HHS-RADV adjustments would begin in summer or fall of 2023).

## Elevating the Consumer Experience

## Special Enrollment Period (SEP) Verification

HHS is not finalizing the provision to require all exchanges to conduct SEP verification for at least 75% of new enrollments for consumers not already enrolled in coverage through the relevant exchange. HHS agreed with commenters' concerns around imposing additional administrative burden on consumers, and administrative and financial burden on states at this time.

#### SEPs

We are finalizing a policy to permit exchange enrollees who qualify for an SEP because they lose advance payment of premium tax credit (APTC) eligibility to change to a new plan at any metal level, and a policy to allow an individual who did not receive timely notice of an SEP triggering event, and was otherwise reasonably unaware that a triggering event occurred, to select a new qualified health plan (QHP) within 60 days of the date that he or she knew, or reasonably should have known, of the occurrence of the triggering event. Also, we are finalizing a policy to codify that individuals with COBRA coverage may qualify for an SEP to enroll in individual health insurance coverage on- or off-exchange based on the cessation of employer contributions or government subsidies (such as those provided for under the American Rescue Plan Act of 2021) to COBRA continuation coverage. Finally, we are finalizing a minor clarifying amendment related to the market-wide application of the SEP that is triggered upon an error of an exchange.

## Web Broker Display Requirements

HHS is not finalizing the proposal to create an exception to existing requirements related to the QHP comparative information that web broker non-exchange websites are required to display. We agreed with commenters that the display of more QHP comparative information on web broker non-exchange websites is in the best interest of consumers to aid them in comparing QHP options without having to potentially navigate to multiple websites. Instead, we communicated our intention to clarify these display requirements in future rulemaking and limit our current use of enforcement discretion that permits web brokers to only display issuer marketing name, plan marketing name, plan type, and metal level for all available QHPs so that web broker non-exchange websites will be required to display all QHP information consistent with § 155.205(b)(1) and (c), with the exception of medical loss ratio information and transparency of coverage measures under § 155.205(b) (1)(vi) and (vii), for all available QHPs beginning with the start of the 2022 open enrollment period. We explained that this interim enforcement approach applicable beginning with the start of the plan year 2022 open enrollment period does not establish new requirements and instead represents a change in the exercise of enforcement discretion, and that the effect of this approach is that web broker non-exchange websites will be required to display QHP comparative information consistent with existing rules (which will align the QHP information displayed on web broker websites with the QHP information displayed on HealthCare.gov). We believe this approach is reasonable, given that QHP information has been more readily accessible for some time, both through public use files and the marketplace application programming interface.

## Direct Enrollment (DE) Entity Plan Display Requirements

HHS is finalizing the policy to update website display requirements for DE entities. Specifically, DE entity websites will be required to display and market the following three categories of plans or products across at least three distinct website pages, with certain narrow exceptions: QHPs offered through the exchange, individual health insurance coverage subject to Affordable Care Act (ACA) market-wide rules offered outside the exchange (including QHPs and non-QHPs other than excepted benefits), and all other products, such as excepted benefits not subject to ACA market-wide rules. The first exception to these requirements allows plans from the first two categories (all of which are subject to ACA market-wide rules) to be displayed on the same website page when a consumer has received an offer of an individual coverage health reimbursement arrangement (HRA), subject to certain conditions. The second exception to these requirements allows DE entities to display and market stand-alone dental plans certified by an exchange but offered outside the exchange and non-certified stand-alone dental plans on the same off-exchange dental plan shopping website pages.

## • QHP Enrollee Experience Survey Results and Quality Rating System (QRS) Framework

HHS is finalizing the proposal to post an annual QHP enrollee experience survey public use file (PUF) to further support transparency of QHP quality data and provide consumers, states, issuers, and researchers with valuable enrollee experience data. In addition, we are finalizing the removal of the composite and domain levels of the QRS hierarchy to simplify the QRS framework, to align with other CMS quality reporting programs, and to help improve balancing the influence of individual measures on the overall quality score.

## • Employer-sponsored Coverage (ESC) Verification

We will not take enforcement action against exchanges that do not perform random sampling as required by 45 CFR 155.320(d)(4) for plan years 2020 and 2021, and extend this to plan year 2022. HHS will exercise such discretion in anticipation of finalizing its evaluation of the results of the employer verification study to (1) determine the unique characteristics of the population with offers of employer-sponsored coverage that meets minimum value and affordability standards, (2) compare premium and out-of-pocket costs for consumers enrolled in affordable employer-sponsored coverage to exchange coverage.

and (3) identify the incentives, if any, that drive consumers to enroll in exchange coverage rather than coverage offered through their current employer.

## Expanding Transparency

Pharmacy Benefit Management (PBM) Transparency

HHS is finalizing a rule to provide for collecting prescription drug data directly from PBMs. The data will be used to enhance our understanding of the true cost of prescription drugs provided in exchange plans, and shed light on the role that PBMs play in their cost. The data collected is required to be kept confidential and may only be disclosed for limited purposes outlined in statute.

## Ensuring State Flexibility

• States' Essential Health Benefit (EHB) Benchmark Plan Options

HHS is finalizing May 6, 2022 as the deadline for states submitting EHB benchmark plan selections for the 2024 plan year and for states reporting whether they will permit between-category substitution for the 2024 plan year.

## Promoting Program Integrity

• HHS Audits, Compliance Reviews, and Civil Money Penalties (CMPs) Authority
HHS is finalizing the proposals related to its audit and compliance review authority to
further protect the integrity of federal funds. Specifically, HHS finalizes several
amendments to provide more clarity on HHS's audit procedures regarding the APTC,
cost-sharing reduction (CSR), and user fee programs. We also finalize regulations to
provide HHS authority to conduct compliance review to ensure compliance with federal
APTC, CSR, and user fee requirements. Additionally, we finalize the extension of these
authorities to QHP issuers in state-based exchanges using the federal platform to align
with our existing authority over issuers in federally facilitated exchange and stateexchange states. HHS also finalizes the proposals to codify similar audit processes and
compliance review authority for the transitional reinsurance program operated by HHS
from 2014-2016 benefit years, as well as the HHS-operated risk adjustment program

(including high-cost risk pool audits). In addition, HHS finalizes the amendments to clarity

that HHS has the ability to impose CMPs when it is enforcing the applicable federal APTC, CSR, and user-fee requirements in any exchange, regardless of whether the exchange is established and operated by HHS or a state. Additionally, HHS is finalizing minor procedural changes to the requirements for administrative appeals of CMPs by health insurance issuers and non-federal governmental plans to align with current practices for the Departmental Appeals Board.

## Annual Reporting of State-required Benefits

HHS is finalizing July 1, 2022 as the deadline for states to submit to HHS their annual reports for 2022 on state-required benefits pursuant to 45 CFR 156.111(d) and (f). However, we are also announcing that we intend to exercise enforcement discretion with regard to the first annual reporting submission deadline of July 1, 2021 under current regulation. Pursuant to this enforcement posture, we will not take enforcement action against states that do not submit an annual report in 2021. As such, states are required to notify HHS of their state-required benefits in the manner specified at § 156.111(d) and (f) by July 1, 2022.

To view the press release on the second 2022 Notice of Benefit and Payment Parameters final rule (also known as the "2022 payment notice", please visit: <a href="https://www.cms.gov/newsroom/press-releases/cms-adopt-rules-lower-health-care-costs-2022-federal-health-insurance-marketplace-plans">https://www.cms.gov/newsroom/press-releases/cms-adopt-rules-lower-health-care-costs-2022-federal-health-insurance-marketplace-plans</a>

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#### **BRIEFING ROOM**

## Fact Sheet: The American Families Plan

**APRIL 28, 2021 • STATEMENTS AND RELEASES** 

Today, President Biden announced the American Families Plan, an investment in our kids, our families, and our economic future.

In March, the President signed into law the American Rescue Plan, which continues to provide immediate relief to American families and communities. Approximately 161 million payments of up to \$1,400 per person have gone out to households, schools are reopening, and 100 percent of Americans ages 16 and older are now eligible for a COVID-19 vaccine. The Rescue Plan is projected to lift more than five million children out of poverty this year, cutting child poverty by more than half. While too many Americans are still out of work, we are seeing encouraging signs in the labor market, as businesses begin to rehire and some of the hardest hit sectors begin to reopen.

But the President knows that we need to do more. It is not enough to restore where we were prior to the pandemic. We need to build a stronger economy that does not leave anyone behind – we need to build back better. President Biden knows a strong middle class is the backbone of America. He knows it should be easier for American families to break into the middle class, and easier to stay in the middle class. He knows that we need to continue to enable those who dropped out of the workforce – particularly the approximately two million women who left due to COVID – to rejoin and stay in the workforce. And, he knows that, unlike in past decades, policies to make life easier for American families must focus on bringing everyone along: inclusive of gender, race, or place of residence – urban, suburban, or rural.

The American Jobs Plan and the American Families Plan are once-in-a-generation investments in our nation's future. The American Jobs Plan will create millions of good jobs, rebuild our country's physical infrastructure and workforce, and spark innovation and manufacturing here at home. The American Families Plan is an investment in our children and our families—helping families cover the basic expenses that so many struggle with now, lowering health insurance premiums, and continuing the American Rescue Plan's historic reductions in child poverty. Together, these plans reinvest in the future of the American economy and American workers, and will help us out-compete China and other countries around the world.

To grow the middle class, expand the benefits of economic growth to all Americans, and leave the United States more competitive, President Biden's American Families Plan will:

- Add at least four years of free education. Investing in education is a down payment on the future of America. As access to high school became more widely available at the turn of the 20th Century, it made us the best-educated and best-prepared nation in the world. But everyone knows that 13 years is not enough today. The American Families Plan will make transformational investments from early childhood to postsecondary education so that all children and young people are able to grow, learn, and gain the skills they need to succeed. It will provide universal, high quality preschool to all three- and four- year-olds. It will provide Americans two years of free community college. It will invest in making college more affordable for low- and middle-income students, including students at Historically Black Colleges and Universities (HBCUs), Tribal Colleges and Universities (TCUs), and institutions such as Hispanic-serving institutions, Asian American and Native American Pacific Islander-serving institutions, and other minority-serving institutions (MSIs). And, it will invest in our teachers as well as our students, improving teacher training and support so that our schools become engines of growth at every level.
- Provide direct support to children and families. Our nation is strongest when everyone has the opportunity to join the workforce and contribute to the economy. But many workers struggle to both hold a full-time job and care for themselves and their families. The American Families Plan will provide direct support to families to ensure that low- and middle-income families spend no more than seven percent of their income on child care, and that the child care they access is of high-quality. It will also provide direct support to workers and families by creating a national comprehensive paid family and medical leave program that will bring America in line with competitor nations that offer paid leave programs. The program will allow people to manage their health and the health of their families. And, it will provide critical nutrition assistance to families who need it most and expand access to healthy meals to our nation's students dramatically reducing childhood hunger.
- Extend tax cuts for families with children and American workers. While the American Rescue Plan provided meaningful relief for hundreds of millions of Americans, too many families and workers feel the squeeze of too-low wages and the high costs of meeting their basic needs and their aspirations. At the same time, the wealthiest Americans continue to get further and further ahead. The American Families Plan will extend key tax cuts in the American Rescue Plan that benefit lower- and middle-income workers and families.

including the Child Tax Credit, the Earned Income Tax Credit, and the Child and Dependent Care Tax Credit. In addition to making it easier for families to make ends meet, tax credits for working families have been shown to boost child academic and economic performance over time. The American Families Plan will also extend the expanded health insurance tax credits in the American Rescue Plan. These credits are providing premium relief that is lowering health insurance costs by an average of \$50 per person per month for nine million people, and will enable four million uninsured people to gain coverage.

Leading economic research has shown that the investments proposed in the American Families Plan will yield significant economic returns – boosting productivity and economic growth, producing a larger, more productive, and healthier workforce on a sustained basis, and generating savings to states and the federal government. Evidence shows that a dollar invested in high-quality early childhood programs for low-income children will result in up to \$7.30 in benefits, including increased wages, improved health, and reduced crime. Parental paid leave has been shown to keep mothers in the workforce, increasing labor force participation and boosting economic growth. And, sustained tax credits for families with children have been found to yield a lifetime of benefits, ranging from higher educational attainment to higher lifetime earnings

In all, the American Families Plan includes \$1.8 trillion in investments and tax credits for American families and children over ten years. It consists of about \$1 trillion in investments and \$800 billion in tax cuts for American families and workers. Alongside the American Families Plan, the President will be proposing a set of measures to make sure that the wealthiest Americans pay their share in taxes, while ensuring that no one making \$400,000 per year or less will see their taxes go up. When combined with President Biden's American Jobs Plan, this legislation will be fully paid for over 15 years, and will reduce deficits over the long term.

# ADD AT LEAST FOUR YEARS OF FREE PUBLIC EDUCATION, CLOSE EQUITY GAPS, AND MAKE COLLEGE MORE AFFORDABLE

Early in the 20th century, the expansion of access to free public high school in the United States set a new global standard. Direct public investment in our children's future propelled U.S. economic growth and enhanced our global competitiveness. Now, mounting evidence suggests that 13 years of school is no longer sufficient to prepare our students for success in today's economy. Research tells us that we must invest early to support our children's development and readiness for academic success; our transforming economy requires that we provide every student the opportunity to obtain a postsecondary degree or certificate.

That is why the American Families Plan calls for an additional four years of free, public education for our nation's children. Specifically, President Biden is calling for \$200 billion for free universal pre-school for all three- and four-year-olds and \$109 billion for two years of free community college so that every student has the ability to obtain a degree or certificate. In addition, he is calling for an approximately \$85 billion investment in Pell Grants, which would help students seeking a certificate or a two- or four-year degree. Recognizing that access to postsecondary education is not enough, the American Families Plan includes \$62 billion to invest in evidence-based strategies to strengthen completion and retention rates at community colleges and institutions that serve students from our most disadvantaged communities. This is alongside a \$46 billion investment in HBCUs, TCUs, and MSIs. President Biden is also calling for \$9 billion to train, equip and diversify American teachers in order to ensure that our high school graduates are ready for success. These investments, combined with those laid out in the President's American Jobs Plan, will boost earnings, expand employment opportunities, and enable the U.S. to win the  $21^{\text{st}}$  century.

## UNIVERSAL PRE-SCHOOL FOR ALL THREE- AND FOUR-YEAR-OLDS

Preschool is critical to ensuring that children start kindergarten with the skills and supports that set them up for success in school. In fact, research shows / that kids who attend universal pre-K are more likely to take honors classes and less likely to repeat a grade, and another study finds low-income children who attend universal programs do better in math and reading as late as eighth grade. Unfortunately, many children, but especially children of color and low-income children, do not have access to / the full range of high-quality pre-school programs available to their more affluent peers. In addition to providing critical benefits for children, preschool has also been shown to increase labor force participation / among parents - especially women — boosting family earnings and driving economic growth. By some estimates, the benefits of a universal pre-K system to U.S. GDP are more than three times greater than the investment / needed to provide this service.

• President Biden is calling for a national partnership with states to offer free, high-quality, accessible, and inclusive preschool to all three-and four-year-olds, benefitting five million children and saving the average family \$13,000, when fully implemented. This historic \$200 billion investment in America's future will first prioritize high-need areas and enable communities and families to choose the settings that work best for them. The President's plan will also ensure that all publicly-funded preschool is high-quality, with low student-to-teacher ratios, high-quality and developmentally appropriate curriculum, and supportive classroom environments that are inclusive for all students. The President's plan will leverage investments in tuition-free community college and teacher scholarships to support those who wish to earn a bachelor's degree or another credential

that supports their work as an educator, or to become an early childhood educator. And, educators will receive job-embedded coaching, professional development, and wages that reflect the importance of their work. All employees in participating pre-K programs and Head Start will earn at least \$15 per hour, and those with comparable qualifications will receive compensation commensurate with that of kindergarten teachers. These investments will give American children a head start and pave the way for the best-educated generation in U.S. history.

# FREE COMMUNITY COLLEGE AND OTHER POSTSECONDARY EDUCATION INVESTMENTS

For much of the 20<sup>th</sup> century, graduating from high school was a gateway to a stable job and a living wage. But over the last 40 years, we have seen the most growth in jobs requiring higher levels of job preparation , including education and training. Today, 70 percent of jobs are held by people with more than a high school degree. American workers need and deserve additional support to build their skills, increase their earnings, remain competitive, and share in the benefits of the new economy. President Biden's plan will expand access to affordable postsecondary education, laying the groundwork for innovation and inclusive economic growth for all Americans. Specifically, President Biden's plan will:

- Offer two years of free community college to all Americans, including DREAMers. The current crisis has led to a steep college enrollment decline , particularly for low-income students and students of color. As of Fall 2020, high-minority and high-poverty high schools saw a 9.4 percent and 11.4 percent decline in college enrollment, respectively. But even before the pandemic, cost remained a barrier to attending and graduating from community college for many Americans. President Biden's \$109 billion plan will ensure that first-time students and workers wanting to reskill can enroll in a community college to earn a degree or credential for free. Students can use the benefit over three years and, if circumstances warrant, up to four years, recognizing that many students' lives and other responsibilities can make full-time enrollment difficult. If all states, territories, and Tribes participate, about 5.5 million students would pay \$0 in tuition and fees.
- Provide up to approximately \$1,400 in additional assistance to low-income students by increasing the Pell Grant award. While nearly 7 million students depend on Pell Grants, the grant has not kept up with the rising cost of college. Over the last 50 years dependence, the value of Pell Grants has plummeted. The maximum grant went from covering nearly 80 percent of the cost of a four-year college degree to under 30 percent leading millions of low-income students to take out debt to finance their education. One in three community college students receive Pell Grants to pay for their education. Among students of color, nearly 60 percent of Black, half of American Indian or Alaska Native, almost half of Latino,

and over one-third of Native Hawaiian or Pacific Islander students rely on Pell Grants to pay for college. The American Families Plan will increase the maximum Pell Grant award by approximately \$1,400, a down payment on President Biden's commitment to double the maximum award. The plan also allows DREAMers to access Pell Grants.

- Increase college retention and completion rates. An education beyond high school ↗ can lead to higher pay, financial stability, social mobility, and better health outcomes. It also has public benefits such as a reduction in crime rates ↗ and higher civic engagement. However, far too many students enter college but do not graduate. Research ↗ shows that only approximately three out of five students finish any type of degree or certificate program within six years. To complete, students need additional support. The President is proposing a bold \$62 billion grant program to invest in completion and retention activities at colleges and universities that serve high numbers of low-income students, particularly community colleges. States, territories, and Tribes will receive grants to provide funding to colleges that adopt innovative, proven solutions for student success, including wraparound services ranging from child care and mental health services to faculty and peer mentoring; emergency basic needs grants; practices that recruit and retain diverse faculty; transfer agreements between colleges; and evidence-based remediation programs.
- Provide two years of subsidized tuition and expand programs in high-demand fields at **HBCUs, TCUs, and MSIs.** Research *¬* has found that HBCUs, TCUs, and MSIs are vital to helping underrepresented students move to the top of the income ladder. For example, while HBCUs are only three percent of four-year universities 7, their graduates make up approximately 80 percent of Black judges, half of Black lawyers and doctors, and 25 percent of Black undergraduates earning STEM degrees. Yet, these institutions have significantly less 7 resources than other top colleges and universities, undermining their ability to grow and support more students. President Biden is calling on Congress to make a historic investment in HBCU, TCU, and MSI affordability. Specifically, he is calling for a new \$39 billion program that provides two years of subsidized tuition for students from families earning less than \$125,000 enrolled in a four-year HBCU, TCU, or MSI. The President is also calling for \$5 billion to expand existing institutional aid grants to HBCUs, TCUs, and MSIs, which can be used by these institutions to strengthen their academic, administrative, and fiscal capabilities, including by creating or expanding educational programs in high-demand fields (e.g., STEM, computer sciences, nursing, and allied health), with an additional \$2 billion directed towards building a pipeline of skilled health care workers with graduate degrees. These investments, combined with the \$45 billion proposed in the American Jobs Plan targeted to these institutions, will enable America's

HBCUs, TCUs, and MSIs to tackle longstanding inequities in postsecondary education and make the U.S. more competitive on the global stage.

## **EDUCATION AND PREPARATION FOR TEACHERS**

Few people can have a bigger impact on a child's life than a great teacher. Unfortunately, the U.S. faces a large and growing teacher shortage. Before the pandemic, schools across the nation needed an estimated additional 100,000 certified teachers 7, resulting in key positions going unfilled. Shortages of certified teachers disproportionately impact schools with higher percentages of students of color, which have a higher proportion of teachers that are uncertified and in their first or second year 7, exacerbating educational disparities. At the same time, while teachers of color can have a particularly strong impact on students of color 7, around one in five teachers 7 are people of color, compared to more than half of K-12 7 public school students. President Biden is calling on Congress to invest \$9 billion in American teachers, addressing shortages, improving training and supports for teachers, and boosting teacher diversity.

These investments will improve the quality of new teachers entering the profession, increase retention rates and increase the number of teachers of color, all of which will improve student outcomes like academic achievement ¬ and high school graduation rates ¬, resulting in higher long-term earnings, job creation and a boost to the economy ¬. In addition, as more teachers stay in the profession, a virtuous cycle is created, wherein districts save money on recruiting and training new teachers ¬ and can invest those funds back into programs that directly impact students.

Specifically, President Biden's plan will:

- Address teacher shortages, improve teacher preparation, and strengthen pipelines for teachers of color. President Biden is calling on Congress to double scholarships for future teachers from \$4,000 to \$8,000 per year while earning their degree, strengthening the program, and expanding it to early childhood educators. The President's plan also invests \$2.8 billion in Grow Your Own programs and year-long, paid teacher residency programs, which have a greater impact on student outcomes, teacher retention, and are more likely to enroll teacher candidates of color. His plan targets \$400 million for teacher preparation at HBCUs, TCUs, and MSIs and \$900 million for the development of special education teachers.
- **Help current teachers earn in-demand credentials.** Many teachers are eager to answer the call to get certified in areas their schools need, like special education, but are deterred

due to the high cost of professional programs. President Biden is calling on Congress to invest \$1.6 billion to provide educators with opportunities to obtain additional certifications in high-demand areas like special education, bilingual education, and certifications that improve teacher performance. This funding will support over 100,000 educators, with priority for public school teachers with at least two years of experience at schools with a significant portion of low-income students or significant teacher shortages. All funds will be available immediately, flowing through the states, and available until expended.

• Invest in educator leadership. Millions of teachers – and the students they educate – would stand to benefit from greater mentorship and leadership opportunities. President Biden is calling on Congress to invest \$2 billion to support programs that leverage teachers as leaders, such as high-quality mentorship programs for new teachers and teachers of color. These programs are proven tools to improve both student outcomes and teacher retention by providing new teachers with the support they need. The President's plan will also leverage teachers as leaders of other key priorities within their school buildings, and compensate teachers for this work, recognizing the incredible expertise of our veteran educators, and their value in supporting the next generation of great teachers.

## PROVIDE DIRECT SUPPORT TO CHILDREN AND FAMILIES

The hope of a middle-class life has gotten further and further out of reach for too many

American families, as the costs of raising children – from child care to taking paid leave time to
care for a new child or when a child is ill – have grown. Middle-class families and those trying
to break into the middle class increasingly feel the strain of these rising costs, while wage
growth has failed to keep up. These rising costs impact our economy as a whole as well. In part

due to the lack of family friendly policies, the United States has fallen behind its
competitors in female labor force participation. One study found that a lack of child care
options costs the United States economy \$57 billion per year in lost earnings, productivity,
and revenue. Another study found that lack of paid leave options cost workers \$22.5 billion
each year in lost wages.

#### **CHILD CARE**

The high cost of child care continues to make it hard for parents − especially women − to work outside the home and provide for their families. Difficulty in finding high-quality, affordable child care leads some parents ⊅ to drop out of the labor force entirely, some to reduce their

work hours, and others to turn down a promotion. When a parent drops out of the workforce, reduces hours, or takes a lower-paying job early in their careers—even temporarily—there are lifetime consequences on earnings, savings, and retirement. These costs are especially significant for mothers and people of color, exacerbating inequality and harming the economic security of their families, as 91 percent of the income gains experienced by middle-class families over the last forty years were driven by women's earnings.

High-quality early care and education lay a strong foundation so that children can take full advantage of education and training opportunities later in life. The evidence is clear: for early years, quality care is education. This especially important for children from low-income families, who too often start school without access to high-quality educational opportunities. A study by Nobel Laureate James Heckman found that every dollar invested in a high-quality, birth to five program for the most economically disadvantaged children resulted in \$7.30 in benefits as children grew up healthier, were more likely to graduate high school and college, and earned more as adults.

Building on the American Jobs Plan's investments in school and child care infrastructure and workforce training, President Biden's American Families Plan will ensure low and middle-income families pay no more than 7 percent of their income on high-quality child care for children under 5 years-old, saving the average family \$14,800 per year on child care expenses, while also generating lifetime benefits for three million children, supporting hundreds of thousands of child care providers and workers, allowing roughly one million parents, primarily mothers, to enter the labor force, and significantly bolstering inclusive and equitable economic growth. Specifically, President Biden's plan will invest \$225 billion to:

- Make child care affordable. Families will pay only a portion of their income based on a sliding scale. For the most hard-pressed working families, child care costs for their young children would be fully covered and families earning 1.5 times their state median income will pay no more than 7 percent of their income for all children under age five. The plan will also provide families with a range of inclusive and accessible options to choose from for their child, from child care centers to family child care providers to Early Head Start.
- **Invest in high-quality child care.** Child care providers will receive funding to cover the true cost of quality early childhood care and education–including a developmentally appropriate curriculum, small class sizes, and culturally and linguistically responsive environments that are inclusive of children with disabilities. These investments support positive interactions that promote children's social-emotional and cognitive development.

• Invest in the child care workforce. More investment is needed to support early childhood care providers and educators, more than nine in ten ↗ of whom are women and more than four in ten ↗ of whom are women of color. They are among the most underpaid ↗ workers in the country and nearly half ↗ receive public income support programs. The typical child care worker earned \$12.24 ↗ per hour in 2020—while receiving few, if any, benefits, leading to high turnover and lower quality of care. This investment will mean a \$15 minimum wage for early childhood staff and ensure that those with similar qualifications as kindergarten teachers receive comparable compensation and benefits. And, it will ensure child care workers receive job-embedded coaching and professional development, along with additional training opportunities funded by the American Jobs Plan and American Families Plan. These investments will lead to better quality care, while also enabling these workers to care for their own families, reducing government spending on income support programs and increasing tax revenues.

## **PAID LEAVE**

The United States has fallen behind our economic competitors in the number of women participating in the labor force. The pandemic has exacerbated this problem, pushing millions of people—especially women—out of the workforce, eroding more than 30 years of progress in women's labor force participation and resulting in a \$64 billion loss in wages and economic activity per year. A lack of family-friendly policies, such as paid family and medical leave for when a worker need time to care for a new child, a seriously ill family member, or recover from their own serious illness, has been identified as a key reason for the U.S. decline in competitiveness. The United States is one of the only countries in the world that doesn't guarantee paid leave. Nearly one in four mothers return to work within two weeks of giving birth and one in five retirees left or were forced to leave the workforce earlier than planned to care for an ill family member. Further, today nearly four of five private sector workers have no access to paid leave. 95 percent of the lowest wage workers nostly women and workers of color lack any access to paid family leave.

Paid family and medical leave supports workers and families and is a critical investment in the strength and equity of our economy. President Biden's American Families Plan will:

• Create a national comprehensive paid family and medical leave program. The program will ensure workers receive partial wage replacement to take time to bond with a new child, care for a seriously ill loved one, deal with a loved one's military deployment, find safety from sexual assault, stalking, or domestic violence, heal from their own serious illness, or take time to deal with the death of a loved one. It will guarantee twelve weeks of paid parental, family, and personal illness/safe leave by year 10 of the program, and also

ensure workers get three days of bereavement leave per year starting in year one. The program will provide workers up to \$4,000 a month, with a minimum of two-thirds of average weekly wages replaced, rising to 80 percent for the lowest wage workers. We estimate this program will cost \$225 billion over a decade.

President Biden's paid leave plan has broad benefits for working families and the economy as a whole. Studies have shown that, under state paid leave laws, new mothers are 18 percentage points more likely to be working a year after the birth of their child. In addition, paid leave can reduce racial disparities in wage loss between workers of color and white workers, improve child health and well-being, support employers by improving employee retention and reducing turnover costs, and increase women's labor force participation. Over 30 million workers, including 67 percent of low-wage workers, do not have access to a single paid sick day. Low-wage and part-time workers, a majority of whom are women not paid sick days.

The COVID pandemic has highlighted the need for a national paid sick leave policy, to help workers and their loved ones quickly recover from short-term illness and prevent the spread of disease. Therefore, the President calls upon Congress to pass the Healthy Families Act which will require employers to allow workers to accrue seven days paid sick leave per year to seek preventative care for them or their family—such as getting a flu shot, recovering from short-term illness, or caring for a sick child or family member or a family member with disability-related needs.

#### **NUTRITION**

The pandemic has added urgency to the issue of nutrition insecurity, which disproportionately affects low-income families and families of color. No one should have to worry about whether they can provide nutritious food for themselves or their children. A poor diet jeopardizes a child's ability to learn and succeed in school. Nutrition insecurity can also have long-lasting negative impact on overall health and put children at higher risk for diseases such as diabetes, heart disease, and high blood pressure. Today, one-fifth of American children are obese 7, and research shows 7 that childhood obesity increases the likelihood of obesity in adulthood. In addition to the incredible financial burden on the health care system, diet-related diseases carry significant economic and national security implications by decreasing work productivity, increasing job absenteeism, and threatening military readiness. A recent study 7 found that U.S. children are getting their healthiest meals at school, demonstrating that school meals are one of the federal government's most powerful tools for delivering nutrition security to children. To ensure the nutritional needs of families are met, President Biden's plan will invest \$45 billion to:

- Expand summer EBT to all eligible children nationwide. The Summer EBT Demonstrations helps low-income families with children eligible for free and reduced-price meals during the school year purchase food during the summer. Research shows that this program decreases food insecurity among children and has led to positive changes in nutritional outcomes. The American Families Plan builds on the American Rescue Plan's support for Summer Pandemic-EBT by investing more than \$25 billion to make the successful program permanent and available to all 29 million children receiving free and reduced-price meals.
- **Expand healthy school meals.** The Community Eligibility Provision (CEP) allows highpoverty schools to provide meals free of charge to all of their students. It is currently available to individual schools, groups of schools within a district, or an entire district with at least 40 percent of students participating in the Supplemental Nutrition Assistance Program (SNAP) or other means tested programs. The program is particularly important because some families whose children would be eligible for free meals may not apply for them due to stigma or not fully understanding the application process. In addition, other families in high-poverty schools may still be facing food insecurity but make just enough to not qualify for free school meals. However, only 70 percent of eligible schools have adopted CEP, because some schools would receive reimbursement below the free meal rate. The President's plan will fund \$17 billion to expand free meals for children in the highest poverty districts by reimbursing a higher percentage of meals at the free reimbursement rate through CEP. Additionally, the plan will lower the threshold for CEP eligibility for elementary schools to 25 percent of students participating in SNAP. Targeting elementary students will drive better long-term health outcomes by ensuring low-income children are receiving nutritious meals at an early age. The plan will also expand direct certification to automatically enroll more students for school meals based on Medicaid and Supplemental Security Income data. This proposal will provide free meals to an additional 9.3 million children, with about 70 percent in elementary schools.
- Launch a healthy foods incentive demonstration. To build on progress made during the Obama Administration to improve the nutrition standards of school meals, this new \$1 billion demonstration will support schools that are further expanding healthy food offerings. For example, schools adopting specified measures that exceed current school meal standards will receive an enhanced reimbursement as an incentive.
- Facilitate re-entry for formerly incarcerated individuals through SNAP
   eligibility. Individuals convicted of a drug-related felony are currently ineligible to receive

SNAP benefits unless a state has taken the option to eliminate or modify this restriction. Denying these individuals—many of whom are parents of young children—SNAP benefits jeopardizes nutrition security and poses a barrier to re-entry into the community in a population that already faces significant hurdles to obtaining employment and stability. SNAP is a critical safety net for many individuals as they search for employment to support themselves and their families. This restriction disproportionately impacts African Americans, who are convicted of drug offenses at much higher rates than white Americans.

#### **UNEMPLOYMENT INSURANCE REFORM**

The unemployment insurance (UI) system is a critical lifeline to workers at the hardest times. During the pandemic, it saved millions from poverty and helped people put food on the table. But, the system is in desperate need of reform and strengthening. Too often Americans found themselves waiting weeks to get the benefits they deserved. Too often the benefits Americans would automatically receive would've been too low and would not have gone long enough absent Congress stepping in. Too often the safeguards to prevent fraud in the system have been insufficient. And it has been unemployed people of color who have borne the brunt of the UI system's weaknesses. President Biden is committed to strengthening and reforming the system for the long term. That's why he won \$2 billion in the American Rescue Plan to put toward UI system modernization, equitable access, and fraud prevention. And, that's why he wants to work with Congress to automatically adjust the length and amount of UI benefits unemployed workers receive depending on economic conditions. This will ensure future legislative delay doesn't undermine economic recovery and it will enable permanent reform of the system to provide the safety net that workers deserve in the hardest times.

#### TAX CUTS FOR AMERICA'S FAMILIES AND WORKERS

While the American Rescue Plan provided meaningful relief for hundreds of millions of Americans, that is just a first step. Now is the time to build back better, to help families and workers who for too long have felt the squeeze of stagnating wages and an ever-increasing cost-of-living. Direct assistance to families in the form of tax credits paid on a regular basis lifts children and families out of poverty, makes it easier for families to make ends meet, and boosts the academic and economic performance of children over time. But if Congress does not act, millions of American families and workers will see their taxes go up at the end of the year.

President Biden believes we must extend the American Rescue Plan's expanded tax credits that lifted millions of children out of poverty, made it easier for families to afford child care, and ensured that low-income workers without children would not continue to be taxed into

poverty.

Specifically, President Biden's plan will:

- Extend expanded ACA premiums tax credits in the American Rescue Plan. Health care should be a right, not a privilege, and Americans facing illness should never have to worry about how they are going to pay for their treatment. No one should face a choice between buying life-saving medications or putting food on the table. President Biden has a plan to build on the Affordable Care Act and lower prescription drug costs for everyone by letting Medicare negotiate prices, reducing health insurance premiums and deductibles for those who buy coverage on their own, creating a public option and the option for people to enroll in Medicare at age 60, and closing the Medicaid coverage gap to help millions of Americans gain health insurance. The American Families Plan will build on the American Rescue Plan and continue our work to make health care more affordable. The American Rescue Plan included a historic investment in reducing Americans' health care costs. The biggest improvement in health care affordability since the Affordable Care Act, the American Rescue Plan provided two years of lower health insurance premiums for those who buy coverage on their own, saving families an average of \$50 per person per month  $\mathbb{Z}$ . The American Families Plan will make those premium reductions permanent, a \$200 billion investment. As a result, nine million  $\nearrow$  people will save hundreds of dollars per year on their premiums, and four million **z** uninsured people will gain coverage. The Families Plan will also invest in maternal health and support the families of veterans receiving health care services.
- Extend the Child Tax Credit increases in the American Rescue Plan through 2025 and make the Child Tax Credit permanently fully refundable. The President is calling for the Child Tax Credit expansion, first enacted in the American Rescue Plan, to be extended. This legislation expands the Child Tax Credit from \$2,000 per child to \$3,000 per child for six-years old and above, and \$3,600 per child for children under six. It also makes 17-year-olds eligible for the first time and makes the credit fully refundable on a permanent basis, so that low-income families—the families that need the credit the most—can benefit from the full tax credit. The expanded Child Tax Credit in the American Rescue Plan benefited nearly 66 million children, and it was the single largest contributor to the plan's historic reductions in child poverty.

For a family with two parents earning a combined \$100,000 per year and two children under six, the Child Tax Credit expansion means an additional \$3,200 per year in tax relief. For a family with two parents earning a combined \$24,000 per year and two children

under six, the expansion means even more, with a credit increase of than \$4,400 because the full credit was not previously fully available to them.

The credit would also be delivered regularly. This means that families will not need to wait until tax season to receive a refund. Instead, they will receive regular payments that allow them to cover household expenses as they arise.

The American Families Plan will make permanent the full refundability of the Child Tax Credit, while extending the other expansions to the Child Tax Credit through 2025—when the 2017 law's individual provisions expire. The President is committed to working with Congress to achieve his ultimate goal of making permanent the Child Tax Credit as well as all of the expansions he signed into law in the American Rescue Plan.

• Permanently increase tax credits to support families with child care needs. To help families afford child care, President Biden is calling on Congress to make permanent the temporary Child and Dependent Care Tax Credit (CDCTC) expansion enacted in the American Rescue Plan. Families will receive a tax credit for as much as half of their spending on qualified child care for children under age 13, up to a total of \$4,000 for one child or \$8,000 for two or more children. A 50 percent reimbursement will be available to families making less than \$125,000 a year, while families making between \$125,000 and \$400,000 will receive a partial credit with benefits at least as generous as those they receive today. The credit can be used for expenses ranging from full-time care to after school care to summer care.

This is a dramatic expansion of support to low- and middle-income families. In 2019, a family claiming a CDCTC for the previous year got less than \$600 \( \neq \) on average towards the cost of care, and many low-income families got nothing. If Congress fails to extend the CDCTC expansion, more than 6 million families could see their taxes go up at the end of the year – many by thousands of dollars – making obtaining affordable child care more difficult. Importantly, this tax credit works in tandem with the American Families Plan's direct investments in childcare affordability for families with young children.

• Make the Earned Income Tax Credit Expansion for childless workers permanent.

Before this year, the federal tax code taxed low-wage childless workers into poverty or deeper into poverty — the only group of workers it treated this way. The American Rescue Plan addressed this problem by roughly tripling the EITC for childless workers, benefitting 17 million → low-wage workers, many of whom are essential workers including cashiers, cooks, delivery drivers, food preparation workers, and childcare providers. For

example, a childless worker who works 30 hours per week at \$9 per hour earns income that, after taxes, leaves them below the federal poverty line. By increasing her EITC to more than \$1,100, this EITC expansion helps pull such workers out of poverty.

The President is calling on Congress to make this expansion permanent. President Biden believes our tax code should reward work and not wealth. And that means rewarding workers who work hard every day at modest wages to provide their communities with essential services.

• **Give IRS the authority to regulate paid tax preparers**. Tax returns prepared by certain types of preparers have high error rates. These preparers charge taxpayers large fees while exposing them to costly audits. As preparers play a crucial role in tax administration, and will be key to helping many taxpayers claim the newly-expanded credits, IRS oversight of tax preparers is needed. The President is calling on Congress to pass bipartisan legislation that will give the IRS that authority.

## TAX REFORM THAT REWARDS WORK - NOT WEALTH

The President's tax agenda will not only reverse the biggest 2017 tax law giveaways, but reform the tax code so that the wealthy have to play by the same rules as everyone else. It will ensure that high-income Americans pay the tax they owe under the law—ending the unfair system of enforcement that collects almost all taxes due on wages, while regularly collecting a smaller share of business and capital income. The plan will also eliminate long-standing loopholes, including lower taxes on capital gains and dividends for the wealthy, that reward wealth over work. Importantly, these reforms will also rein in the ways that the tax code widens racial disparities in income and wealth.

President Biden's plan uses the resulting revenue to rebuild the middle class, investing in education and boosting wages. It will also give tax relief to middle-class families, dramatically reducing child poverty and cutting the cost of child care in half for many families. The result of the President's individual tax reforms will be a tax code with fewer loopholes for the wealthy and more opportunity for low- and middle-income Americans.

Altogether, these tax reforms focused on the highest income Americans would raise about \$1.5 trillion across the decade. In combination with the American Jobs Plan, which produces long-term deficit reduction through corporate tax reform, all of the investments would be fully paid for over the next 15 years.

## President Biden's plan will:

• Revitalize enforcement to make the wealthy pay what they owe. We have a two-tiered system of tax administration in this country: regular workers pay the taxes they owe on wages and salaries while some wealthy taxpayers aggressively plan to avoid the tax laws. Those with the highest incomes generate income in opaque categories where misreporting rates can reach 55 percent . A recent study found that the top one percent failed to report 20 percent of their income . and failed to pay over \$175 billion in taxes that they owed. But today, the IRS does not even have the resources to fully investigate this evasion. As a result of budget cuts, audit rates on those making over \$1 million per year fell by . 80 percent . between 2011-2018.

The President's proposal would change the game—by making sure the wealthiest Americans play by the same set of rules as all other Americans.It would require financial institutions to report information on account flows so that earnings from investments and business activity are subject to reporting more like wages already are.It would also increase investment in the IRS, while ensuring that the additional resources go toward enforcement against those with the highest incomes, rather than Americans with actual income less than \$400,000. Additional resources would focus on large corporations, businesses, and estates, and higher-income individuals. Altogether, this plan would raise \$700 billion over 10 years.

- Increase the top tax rate on the wealthiest Americans to 39.6 percent. One of the 2017 tax cut's clearest giveaways to the wealthy was cutting the top income tax rate from 39.6 percent to 37 percent, exclusively benefitting the wealthiest households—those in the top one percent. This rate cut alone pives a couple with \$2 million in taxable an annual tax cut of more than \$36,400. The President's plan restores the top tax bracket to what it was before the 2017 law, returning the rate to 39.6 percent, applying only to those within the top one percent.
- End capital income tax breaks and other loopholes for the very top. The President's tax reform will end one of the most unfair aspects of our tax system: that the tax rate the wealthy pay on capital gains and dividends is less than the tax rate that many middle-class families pay on their wages. Households making over \$1 million—the top 0.3 percent of all households—will pay the same 39.6 percent rate on all their income, equalizing the rate paid on investment returns and wages. Moreover, the President would eliminate the loophole that allows the wealthiest Americans to entirely escape tax on their wealth by

passing it down to heirs. Today, our tax laws allow these accumulated gains to be passed down across generations untaxed, exacerbating inequality. The President's plan will close this loophole, ending the practice of "stepping-up" the basis for gains in excess of \$1 million (\$2.5 million per couple when combined with existing real estate exemptions) and making sure the gains are taxed if the property is not donated to charity. The reform will be designed with protections so that family-owned businesses and farms will not have to pay taxes when given to heirs who continue to run the business. Without these changes, billions in capital income would continue to escape taxation entirely.

The President is also calling on Congress to close the carried interest loophole so that hedge fund partners will pay ordinary income rates on their income just like every other worker. While equalizing tax rates on wages and capital gains will address this disparity, permanently eliminating carried interest is an important structural change that is necessary to ensure that we have a tax code that treats all workers fairly. The President would also end the special real estate tax break—that allows real estate investors to defer taxation when they exchange property—for gains greater than \$500,000, and the President would also permanently extend the current limitation in place that restricts large, excess business losses, 80 percent of which benefits those making over \$1 million.

Finally, high-income workers and investors generally pay a 3.8 percent Medicare tax on their earnings, but the application is inconsistent across taxpayers due to holes in the law. The President's tax reform would apply the taxes consistently to those making over \$400,000, ensuring that all high-income Americans pay the same Medicare taxes.

*To view this fact sheet in your browser, click here ↗*.

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# **Health Insurance Premium Tax Credit and Cost-Sharing Reductions**

Updated April 26, 2021

Congressional Research Service https://crsreports.congress.gov R44425

## **Summary**

Certain individuals without access to subsidized health insurance coverage may be eligible for the premium tax credit (PTC) established under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) and amended under the American Rescue Plan Act of 2021 (ARPA, P.L. 117-2) to include several temporary provisions. The dollar amount of the PTC varies from individual to individual, based on a formula specified in statute. Individuals who are eligible for the PTC may be required to contribute some amount toward the purchase of health insurance.

In order to be eligible to receive the premium tax credit in 2021, individuals must have annual household income at or above 100% of the federal poverty level; not be eligible for certain types of health insurance coverage, with exceptions; file federal income tax returns; and enroll in a plan through an individual exchange. Exchanges (or marketplaces) are not insurance companies; rather, exchanges serve as marketplaces for the purchase of health insurance. They operate in every state and the District of Columbia.

The PTC is refundable, so individuals may claim the full credit amount when filing their taxes, even if they have little or no federal income tax liability. The credit also is advanceable, so individuals may choose to receive advanced payments of the credit (or APTC). APTCs are provided on a monthly basis to coincide with the payment of insurance premiums, automatically reducing consumer costs associated with purchasing insurance. The credit is financed through permanent appropriations authorized under the federal tax code.

Individuals who receive premium credit payments also may be eligible for subsidies that reduce cost-sharing expenses. The ACA established two types of cost-sharing reductions (CSRs). One type of subsidy reduces annual cost-sharing limits; the other directly reduces cost-sharing requirements (e.g., lowers a deductible). Individuals who are eligible for CSRs may receive both types. Although applicable health plans must provide these CSRs, such plans no longer receive direct payments to reimburse them for the cost of providing the subsidies to eligible consumers.

The ARPA makes temporary changes to the PTC and to CSRs. Its provisions amend statute to

- expand eligibility for and the amount of the PTC applicable to certain exchange plans for tax years 2021 and 2022;
- suspend the requirement, for tax year 2020, that individuals pay back PTC amounts that were provided in excess; and
- expand eligibility for and the calculation of both the PTC and CSRs for individuals who receive unemployment compensation during calendar year 2021.

This report describes current law (including the ARPA's temporary changes) and applicable regulations and guidance, specifically how the PTC and CSR requirements apply in 2021.

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#### American Rescue Plan Act of 2021

This report reflects provisions enacted under the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) that make temporary changes to the premium tax credit (PTC) and cost-sharing reductions (CSRs). The ARPA's provisions amend statute to

- expand eligibility for and the amount of the PTC applicable to certain exchange plans for tax years 2021 and 2022;
- suspend the requirement, for tax year 2020, that individuals pay back PTC amounts that were provided in excess; and
- expand eligibility for and the calculation of both the PTC and CSRs for individuals who receive unemployment compensation during calendar year 2021.

This report describes current law and applicable regulations and guidance, specifically how the PTC and CSR requirements apply in 2021. As of the date of publication of this report, the Internal Revenue Service (IRS) had posted minimal guidance with respect to implementation of the ARPA's PTC provisions. On March 23, 2021, the Centers for Medicare & Medicaid Services (CMS) posted general questions and answers about accessing the enhanced PTC benefits through the exchanges; this document did not address the enhanced CSRs. Implementation guidance is discussed in relevant sections of this report.

Sources: IRS, "The Premium Tax Credit - The Basics," at https://www.irs.gov/affordable-care-act/ individuals-and-families/the-premium-tax-credit-the-basics; and CMS, "Extended Access Opportunity to Enroll in More Affordable Coverage Through HealthCare.gov," at https://www.cms.gov/newsroom/ factsheets/extended-access-opportunity-enroll-more-affordable-coverage-through-healthcaregov.

Notes: Following ARPA enactment, the IRS indicated on its PTC webpage that the agency is reviewing the ARPA's tax provisions and will "provide more details soon." Since enactment, the IRS has issued ARPA guidance about the provision suspending repayment of excess credit for tax year 2020 only and the provision affecting eligibility and amount of the PTC.

## **Background**

Certain individuals and families without access to subsidized health insurance coverage may be eligible for a premium tax credit (PTC). This credit, authorized under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) and amended under the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2), applies toward the cost of purchasing specific types of health plans offered by private health insurance companies. Individuals who receive PTC payments also may be eligible for subsidies that reduce cost-sharing expenses.<sup>2</sup>

To be eligible for the PTC and cost-sharing reductions (CSRs), individuals and families must enroll in health plans offered through health insurance exchanges and meet other criteria. Exchanges operate in every state and the District of Columbia (DC). <sup>3</sup> Exchanges are not insurance companies; rather, they are marketplaces that offer private health plans to qualified individuals and small businesses. The ACA specifically requires exchanges to offer insurance options to individuals and to small businesses, so exchanges are structured to assist these two different types of customers. Consequently, each state has one exchange to serve individuals and families (an individual exchange) and another to serve small businesses (a Small Business Health Options Program, or SHOP, exchange).

<sup>1 §1401</sup> of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended); new §36B of the Internal Revenue Code of 1986 (IRC); and §§9661-9663 of the American Rescue Plan Act of 2021 (ARPA, P.L. 117-2).

<sup>&</sup>lt;sup>2</sup> ACA §1402; and new §18071 of the Public Health Service Act (PHSA).

<sup>&</sup>lt;sup>3</sup> For additional background about the exchanges, see CRS Report R44065, Overview of Health Insurance Exchanges.

Health insurance companies that participate in the individual and SHOP exchanges must comply with numerous federal and state requirements. Among such requirements are restrictions related to the determination of premiums for exchange plans (rating restrictions). Insurance companies are prohibited from using health factors in determining premiums. However, they are allowed to vary premiums by age (within specified limits), geography, number of individuals enrolling in a plan, and smoking status (within specified limits).4

#### Premium Tax Credit

The dollar amount of the PTC is based on a statutory formula and varies from individual to individual. Individuals who are eligible for the premium credit generally are required to contribute some amount toward the purchase of their health insurance.

The PTC is refundable, so individuals may claim the full credit amount when filing their taxes even if they have little or no federal income tax liability. The credit also is advanceable, so individuals may choose to receive the credit in advance of filing taxes on a monthly basis to coincide with the payment of insurance premiums (technically, advance payments go directly to insurers). Advance payments (or APTC) automatically reduce monthly premiums by the credit amount. Therefore, the direct cost of insurance to an individual or family APTCs generally will be lower than the advertised cost for a given exchange plan.

#### Eligibility

In order to be eligible to receive the PTC, individuals must meet the following criteria:

- file federal income tax returns;
- enroll in a plan through an individual exchange;
- have annual household income at or above 100% of the federal poverty level (FPL)<sup>5</sup> for tax year 2021;<sup>6</sup> and
- not be eligible for minimum essential coverage (see the "Not Eligible for Minimum Essential Coverage" section in this report), with exceptions.

These eligibility criteria are discussed in greater detail below.

#### File Federal Income Tax Returns

Because premium assistance is provided in the form of a tax credit, such assistance is administered by the Internal Revenue Service (IRS) through the federal tax system. The premium

<sup>&</sup>lt;sup>4</sup> For additional discussion regarding these rating restrictions, see CRS Report R45146, Federal Requirements on Private Health Insurance Plans.

<sup>&</sup>lt;sup>5</sup> The guidelines that designate the federal poverty level (FPL) are used in various federal programs for eligibility purposes. The poverty guidelines vary by family size and by whether the individual resides in the 48 contiguous states and the District of Columbia, Alaska, or Hawaii. See Office of the Assistant Secretary for Planning and Evaluation, "Frequently Asked Questions Related to the Poverty Guidelines and Poverty," at https://aspe.hhs.gov/frequently-askedquestions-related-poverty-guidelines-and-poverty#programs.

<sup>&</sup>lt;sup>6</sup> ARPA §9661 expands eligibility for the premium tax credit (PTC) by temporarily eliminating the phaseout for households with annual incomes above 400% FPL. Elimination of the phaseout applies to tax years 2021 and 2022. The phaseout would resume beginning in 2023.

credit process requires qualifying individuals to file federal income tax returns, even if their incomes are at levels that normally do not necessitate the filing of such returns.

Married couples are required to file joint tax returns to claim the premium credit, with some exceptions. The calculation and allocation of credit amounts may differ in the event of a change in tax-filing status during a given year (e.g., individuals who marry or divorce).<sup>7</sup>

#### Enroll in a Plan Through an Individual Exchange

Premium credits are available only to individuals and families enrolled in plans offered through individual exchanges; premium credits are not available through SHOP exchanges. Individuals may enroll in exchange plans if they (1) reside in a state in which an exchange was established; (2) are not incarcerated, except individuals in custody pending the disposition of charges; and (3) are citizens or have other lawful status.<sup>8</sup>

Undocumented individuals (individuals without proper documentation for legal residence) are prohibited from purchasing coverage through an exchange, even if they

#### **Actuarial Value and Metal Plans**

Most health plans sold through exchanges established under the ACA are required to meet actuarial value (AV) standards, among other requirements. AV is a summary measure of a plan's generosity, expressed as the percentage of medical expenses estimated to be paid by the insurer for a standard population and set of allowed charges. In other words, the higher the percentage, the lower the cost sharing, on average, for the population. AV is not a measure of plan generosity for an enrolled individual or family, nor is it a measure of premiums or benefits packages.

An exchange plan that is subject to the AV standards is given a precious metal designation: platinum (AV of 90%), gold (80%), silver (70%), or bronze (60%).

could pay the entire premium. Because the ACA prohibits undocumented individuals from obtaining exchange coverage, these individuals are not eligible for the PTC. Although certain individuals are not eligible to enroll in exchanges due to incarceration or legal status, their family members may still receive the PTC as long as those family members meet all eligibility criteria.

SEP. The SEP would allow such individuals to enroll in exchange plans and possibly receive the PTC. For additional information about this COBRA-related SEP, see DOL, "FAQs About COBRA Premium Assistance Under the American

Rescue Plan Act of 2021," April 7, 2021, at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-

(OEP). The OEP for exchanges occurs near the end of a given calendar year for enrollment into health plans that begin

activities/resource-center/faqs/cobra-premium-assistance-under-arp.pdf.

<sup>&</sup>lt;sup>7</sup> See IRS, "Health Insurance Premium Tax Credit: Final Regulations," 77 *Federal Register* 30377, May 23, 2012. <sup>8</sup> Generally, enrollment through individual exchanges is restricted to a certain time period: an open enrollment period

the following year. Under certain circumstances, individuals may enroll in exchange plans outside of the OEP. For individuals who experience a "triggering event" during the plan year, exchanges are required to provide a "special enrollment period" (SEP) to allow such individuals the option of enrolling into an exchange for that plan year. SEP rules are specified at 45 C.F.R. 155.40, at https://www.govinfo.gov/content/pkg/CFR-2013-title45-vol1/xml/CFR-2013-title45-vol1-sec155-420.xml. The Biden Administration announced an extended SEP for individuals to enroll in health plans through federally operated exchanges. Consumers have until August 15, 2021, to enroll in applicable exchanges under the extended SEP; see CMS, "2021 Special Enrollment Period Access Extended to August 15 on HealthCare.gov for Marketplace Coverage," March 23, 2021, at https://www.cms.gov/newsroom/press-releases/2021- special-enrollment-period-access-extended-august-15-healthcaregov-marketplace-coverage. On a related topic, the Department of Labor (DOL) announced that individuals who lose access to the temporary subsidy authorized under the ARPA, which pays the premiums for coverage established under the Consolidated Omnibus Budget Reconciliation Act (COBRA), may qualify for a separate

# Have Annual Household Income at or Above 100% of the Federal Poverty Level

Individuals generally must have household income (based on FPL) that meets a minimum level to be eligible for the PTC in 2021, as specified under the ARPA. <sup>9</sup> Household income is measured according to the definition for modified adjusted gross income (MAGI). <sup>10</sup> An individual whose MAGI is at or above 100% FPL may be eligible to receive the PTC for tax year 2021. <sup>11</sup>

**Table 1** displays the income levels that correspond to the eligibility criteria for the PTC in 2021 (using poverty guidelines updated by the Department of Health and Human Services [HHS] for 2020).<sup>12</sup>

Table 1. Income Levels Applicable to Eligibility for the Premium Tax Credit for 2021, by Selected Family Sizes

(based on 2020 HHS poverty guidelines)

Number of	Income	FPL	
Persons in Family	48 Contiguous States and DC	Alaska	Hawaii
l	\$12,760	\$15,950	\$14,680
2	\$17,240	\$21,550	\$19,830
3	\$21,720	\$27,150	\$24,980
4	\$26,200	\$32,750	\$30,130

**Source:** Congressional Research Service (CRS) computations based on Department of Health and Human Services (HHS), "Annual Update of the HHS Poverty Guidelines," 85 Federal Register 3060, January 17, 2020, at https://www.govinfo.gov/content/pkg/FR-2020-01-17/pdf/2020-00858.pdf.

**Notes:** For 2021, the income levels used to calculate premium credit eligibility and amounts are based on 2020 HHS poverty guidelines. The poverty guidelines are updated annually for inflation. FPL = Federal Poverty Level. DC = District of Columbia.

<sup>&</sup>lt;sup>9</sup> There are exceptions to the lower bound income threshold at 100% FPL. One exception relates to the state option under the ACA to expand Medicaid for individuals with income up to 138% FPL. If a state chooses to undertake the ACA Medicaid expansion (or has already expanded Medicaid above 100% FPL), eligibility for premium credits would begin above the income level at which Medicaid eligibility ends in such a state. (Note that in states that do not expand Medicaid to at least 100% FPL, some low-income residents in those states are *ineligible* for both premium credits and Medicaid.) Another exception is for lawfully present aliens with incomes below 100% FPL, who are *not* eligible for Medicaid for the first five years that they are lawfully present. The ACA established §36B(c)(1)(B) of the IRC to allow such lawfully present aliens to be eligible for premium credits. Lastly, the final regulation on premium credits provided a special rule for credit recipients whose incomes at the end of a given tax year end up being less than 100% FPL. Such individuals will continue to be considered eligible for the PTC for that tax year.

<sup>&</sup>lt;sup>10</sup> See CRS Report R43861, *The Use of Modified Adjusted Gross Income (MAGI) in Federal Health Programs*, for background information about the use of MAGI in determining eligibility for premium tax credits.

<sup>&</sup>lt;sup>11</sup> ARPA §9661 expands eligibility for the PTC by temporarily eliminating the phaseout for households with annual incomes above 400% FPL. Elimination of the phaseout applies to tax years 2021 and 2022. The phaseout would resume beginning in 2023.

<sup>&</sup>lt;sup>12</sup> The poverty guidelines are updated annually, at the beginning of the year. However, premium credit calculations are based on the prior year's guidelines to provide individuals with timely information as they compare and enroll in exchange plans during the OEP (which occurs prior to the beginning of the plan year).

In addition to individuals who meet the applicable income levels listed in **Table 1**, the ARPA provides special access to individuals who receive unemployment compensation (UC).<sup>13</sup> It deems individuals who receive UC for any week in calendar year 2021 to have met the PTC income eligibility criteria for tax year 2021. For these individuals, the ARPA also temporarily adjusts the calculation of the PTC amount (see the discussion about this calculation in the "Determination of Required Premium Contributions and Premium Tax Credit Amounts" section of this report).

#### Not Eligible for Minimum Essential Coverage

To be eligible for a premium credit, an individual may *not* be eligible for *minimum essential coverage* (MEC), with exceptions (described below). The ACAbroadly defines MEC to include Medicare Part A; Medicare Advantage; Medicaid (with exceptions); the State Children's Health Insurance Program (CHIP); Tricare; Tricare for Life, a health care program administered by the Department of Veterans Affairs; the Peace Corps program; any government plan (local, state, federal), including the Federal Employees Health Benefits Program (FEHBP); any plan offered in the individual health insurance market; any employer-sponsored plan (including group plans regulated by a foreign government); any grandfathered health plan; any qualified health plan offered inside or outside of exchanges; and any other coverage (such as a state high-risk pool) recognized by the HHS Secretary.<sup>14</sup>

However, the ACA provides certain exceptions regarding eligibility for MEC and PTC. An individual may be eligible for premium credits even if he or she is eligible for any of the following sources of MEC:

- the individual (non-group) health insurance market;<sup>15</sup>
- an employer-sponsored health plan that is either unaffordable or inadequate; <sup>16</sup> or
- limited benefits under the Medicaid program.<sup>17</sup>

#### Medicaid Expansion

Under the ACA, states have the option to expand Medicaid eligibility to include all non-elderly, nonpregnant individuals with incomes up to 138% FPL.<sup>18</sup> If an individual who applied for premium credits through an exchange is determined to be eligible for Medicaid, the exchange must have that individual enrolled in Medicaid instead of an exchange plan. Therefore, in states that implemented the optional Medicaid expansion to include individuals with incomes at or above 100% FPL (or any state that decided to expand eligibility to individuals irrespective of the

<sup>&</sup>lt;sup>13</sup> See ARPA §9663. With respect to this provision, unemployment compensation (UC) references a long-standing definition in the federal tax code: "any amount received under a law of the United States or of a State which is in the nature of unemployment compensation" (26 U.S.C. §85(b)). For a discussion of various UC benefits, see CRS Report R46687, Current Status of Unemployment Insurance (UI) Benefits: Permanent-Law Programs and COVID-19 Pandemic Response.

<sup>&</sup>lt;sup>14</sup> See CRS Report R44438, The Individual Mandate for Health Insurance Coverage: In Brief.

<sup>&</sup>lt;sup>15</sup> The private health insurance market continues to exist outside of the ACA exchanges. Moreover, almost all exchange plans may be offered in the market outside of exchanges.

<sup>&</sup>lt;sup>16</sup> For 2021, if the employee's premium contribution toward the employer's self-only plan exceeds 9.83% of household income, such a plan is considered *unaffordable* for premium credit eligibility purposes. For additional information, see IRS, Revenue Procedure 2021-23, at https://www.irs.gov/pub/irs-drop/rp-21-23.pdf. If a plan's actuarial value is less than 60%, the plan is considered *inadequate* for premium credit eligibility purposes.

<sup>&</sup>lt;sup>17</sup> Limited benefits under Medicaid include the pregnancy-related benefits package, treatment of emergency medical conditions only, and other limited benefits.

<sup>&</sup>lt;sup>18</sup> See CRS In Focus IF10399, Overview of the ACA Medicaid Expansion.

ACA's Medicaid expansion provisions), premium credit eligibility begins at the income level at which Medicaid eligibility ends.

# Determination of Required Premium Contributions and Premium Tax Credit Amounts

#### **Required Premium Contribution Examples**

The amount of the PTC varies from individual to individual. Calculation of the credit is based on the annual household income (i.e., MAGI) of the individual (and tax dependents), the premium for the exchange plan in which the individual (and any dependents) is enrolled, and other factors. For simplicity's sake, the following formula illustrates the calculation of the credit:

#### Standard Plan Premium - Required Premium Contribution = Premium Tax Credit Amount

Premiums are allowed to vary based on a few characteristics of the person (or family) seeking health insurance. *Standard Plan* refers to the second-lowest-cost silver plan (see text box in the "Eligibility" section of this report) in the person's (or family's) local area. *Required Premium Contribution* refers to the amount that a premium credit-eligible individual (or family) may pay toward the exchange premium. The required premium contribution is capped according to household income, with such income measured relative to FPL (see **Table 1**). The cap requires lower-income individuals to contribute a smaller share of income toward the monthly premium for the standard plan, compared with the requirement for higher-income individuals. The required premium contribution caps typically are updated through IRS guidance on an annual basis. However, the ARPA temporarily replaces those caps. <sup>19</sup> The ARPA caps that apply in 2021 are lower than the percentages that applied just prior to enactment of the law (see **Figure 1**). <sup>20</sup>

The amount of the credit for a given individual is calculated as the difference between the premium of the plan in which the individual enrolls and his or her required contribution. Given that the premium and required contribution vary from person to person, the premium credit amount likewise varies. An extreme example is when the premium for the standard plan is very low, the tax credit may cover the entire premium and the individual may pay nothing toward the premium. The opposite extreme scenario, for some higher-income individuals, is when the required contribution exceeds the premium amount, leading to a credit of zero dollars, meaning the PTC-eligible individual (or family) would pay the entire premium amount.

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hypothetical examples included in this section of this report.

 $<sup>^{19}</sup>$  See ARPA §9661. The new percentages apply to the PTC for tax years 2021 and 2022. Beginning in 2023, the annual update to these percentages would revert back to pre-ARPA statute and applicable IRS guidance.

<sup>&</sup>lt;sup>20</sup> By reducing these caps, the ARPA increases the potential premium credit amounts for eligible individuals. While these lower caps apply across eligible income groups, the benefit is most significant for those with incomes up to 150% FPL; such individuals may now receive full subsidies to cover standard plan premiums, as illustrated in the

10% Max. % of household income 8.5% 8.5% 8% Federal poverty level 6% continues 6% 4% 4% 2% 2% 0% 0% 0% 100 150 200 250 300 350 400 450+ Federal Poverty Level (%)

Figure 1. Cap on Required Premium Contributions for Individuals Who Are Eligible for the Premium Tax Credit in 2021

(cap varies by income, as measured relative to the federal poverty level)

**Source:** Internal Revenue Service (IRS), Revenue Procedure 2021 -23, at https://www.irs.gov/pub/irs-drop/rp-21-23.pdf.

**Notes:** The cap assumes that the individual enrolls in the standard plan (second-lowest-cost silver plan) used to calculate premium credit amounts. If the individual enrolls in an exchange plan that is more expensive than the standard plan, the individual would be responsible for paying any premium amount that exceeds the calculated credit amount.

Section 9661 of the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) applies these percentages to tax years 2021 and 2022. Prior to ARPA enactment, the percentages for 2021 ranged from 2.07% to 9.83%, as indicated in Revenue Procedure 2020-36. By reducing the percentages to the current range of 0.0% to 8.5%, the ARPA reduced the required premium contributions for credit-eligible individuals. In effect, these reduced percentages result in larger credit amounts compared with what they would have been prior to ARPA enactment.

To illustrate the premium credit calculation for 2021, consider a premium credit eligible individual living in Lebanon, KS—the geographic center of the continental United States—with household income of \$19,140 (150% FPL, according to applicable regulations). For 2021, such an individual would be required to contribute 0.0% of that income toward the premium for the standard plan in his or her local area (see **Figure 1**). In other words, the individual would have a zero dollar premium if he or she enrolled in the standard plan. In contrast, an individual residing in the same area with income of \$31,900 (250% FPL) would be required to contribute 4.0% of his or her income toward the premium for the same plan. The maximum amount this individual would pay for the standard plan would be \$1,276 (that is, \$31,900 x 4.0%) for the year, or approximately \$106 per month.<sup>21</sup>

A similar calculation is used to determine the required premium contribution for a family. For instance, consider a couple and one child residing in Lebanon, KS, who are eligible for the PTC with household income of \$32,580 in 2021. For a family of this size, this income is equivalent to 150% FPL for premium credit purposes. Just as in the example above of the individual with

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<sup>&</sup>lt;sup>21</sup> For estimates of premium credit amounts based on factors for which insurance companies are allowed to vary premiums (as described in the "Background" section of this report), see Kaiser Family Foundation, "Health Insurance Marketplace Calculator," at http://kff.org/interactive/subsidy-calculator/.

income at 150% FPL, this family would be required to contribute 0.0% of its annual income toward the premium for the standard plan in its local area.

In addition to calculating a given individual's credit amount according to the formula discussed above, the ARPA includes a special rule specifically for UC beneficiaries. As discussed in the "Eligibility" section of this report, ARPA deems individuals who receive UC for any week in calendar year 2021 to have met the PTC income eligibility criteria for tax year 2021. The law also disregards household income (i.e., MAGI as applicable to the PTC) that exceeds 133% FPL. Income at or below that level qualifies for a zero-dollar premium for the standard plan (see **Figure 1**), similar to the preceding calculations for the hypothetical individual and family with incomes at 150% FPL.

Generally, the arithmetic difference between the premium and the individual's (or family's) required contribution is the tax credit amount provided to the individual (or family). Therefore, factors that affect either the premium or the required contribution (or both) will change the premium credit amount; such factors include age, family size, and choice of metal plan.

#### Reconciliation of Advance Premium Tax Credit Payments

As mentioned previously, an eligible individual (or family) may receive advance payments of the premium credit to coincide with when insurance premiums are due. For such an individual, the advance premium tax credit (APTC) is provided on a monthly basis and the amount is calculated using an *estimate* of income. When an individual files his or her tax return for a given year, the total amount of APTC he or she received in that tax year is reconciled with the amount he or she should have received, based on *actual* income, as determined on the tax return.

If an individual's income *decreased* during the year and he or she should have received a larger tax credit, the additional credit amount will be included in the individual's tax refund for the year or used to reduce the amount of taxes owed.

If an individual's income *increased* during the year and he or she received too much in APTC payments, the excess amount generally will be repaid in the form of a tax payment, with a temporary exception. The ARPAsuspends the requirement to repay excess APTC for the 2020 tax year.<sup>22</sup> On April 9, 2021, the IRS provided guidance regarding implementation of this provision. Individuals who would have had to pay back an excess amount and have not yet filed their 2020 tax returns are not required to file an excess amount on their returns or to file Tax Form 8962. (Form 8962 is the form used by a tax filer to claim the PTC. Using the form, the tax filer calculates the PTC amount based on the actual income level from the tax return and reconciles the PTC amount with the total APTC amount already received, which was calculated using an income estimate.) Individuals who would have had to pay back an excess amount and already filed their 2020 tax returns are not required to file an amended return. The IRS will directly amend the returns that have already been filed to reimburse those individuals for any excess APTC repaid for the 2020 tax year, without any additional action required by the relevant tax filers.<sup>23</sup>

For individuals with incomes below 400% FPL(other than tax year 2020), any repayment amount is capped, with greater tax relief provided to individuals with lower incomes (see **Table 2**).

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<sup>&</sup>lt;sup>22</sup> See ARPA §9662.

<sup>&</sup>lt;sup>23</sup> IRS, "IRS Suspends Requirement to Repay Excess Advance Payments of the 2020 Premium Tax Credit; Those Claiming Net Premium Tax Credit Must File Form 8962," April 9, 2021, at https://www.irs.gov/newsroom/irs-suspends-requirement-to-repay-excess-advance-payments-of-the-2020-premium-tax-credit-those-claiming-net-premium-tax-creditmust-file-form-8962.

Table 2. Annual Limits on Repayment of Excess Premium Tax Credits, 2021

Household Income (Expressed as a Percentage of the Federal Poverty Level)	Applicable Dollar Limit for Unmarried Individuals <sup>a</sup>
Less Than 200%	\$325
At Least 200% But Less Than 300%	\$800
At Least 300% But Less Than 400%	\$1,350

Source: IRS, Internal Revenue Bulletin 2020-46, at https://www.irs.gov/irb/2020-46 IRB.

Notes: The applicable dollar limit for all other tax filers is twice the limit for unmarried individuals.

a. Does not include surviving spouses or heads of households.

#### **Preliminary Tax Credit Data**

The IRS has published preliminary data about the PTC in its annual "Statistics of Income" (SOI) reports. The most recently published SOI report is for tax year 2018.<sup>24</sup> The following data provide summary statistics about two overlapping populations: tax households that received APTC, and households that claimed the credit on their individual income tax returns.<sup>25</sup>

#### Tax Year 2018

For tax year 2018, around 6 million tax returns indicated receipt of advance payments of the tax credit, totaling to almost \$46.1 billion. Of those 6 million returns, nearly 2.3 million tax households received advance payments that were less than what they were eligible for, and approximately 3.2 million tax households received advance payments that were more than what they were eligible for.<sup>26</sup> The remaining difference represents households that received the correct amount in APTC.

The SOI data indicate that approximately 5.4 million tax returns for the 2018 tax year claimed a total of nearly \$41.8 billion of tax credit. The 5.4 million returns represent the number of tax households that were actually eligible for the credit, based on the information provided in the 2018 tax returns.<sup>27</sup> These eligible households represent those who received advance payments of the credit and those who claimed the credit after the end of the tax year.<sup>28</sup> The IRS also has published limited tax credit data by state, county, and zip code.<sup>29</sup>

<sup>&</sup>lt;sup>24</sup> The data represent tax return information at the time of filing; therefore, the data do not incorporate corrections or amendments made to the tax returns at a later time. IRS, "Affordable Care Act Items," Table 2.7, at <a href="https://www.irs.gov/statistics/soi-tax-stats-individual-income-tax-returns-publication-1304-complete-report">https://www.irs.gov/statistics/soi-tax-stats-individual-income-tax-returns-publication-1304-complete-report</a>.

<sup>&</sup>lt;sup>25</sup> The SOI report does not include all estimates of tax credit recipients and claimants necessary to fully describe the overlap of these two taxpayer populations.

<sup>&</sup>lt;sup>26</sup> The 3.2 million taxpayers who received excess advanced payments paid back a total of approximately \$4.4 billion.

<sup>&</sup>lt;sup>27</sup> The number of taxpayers who received advance payments exceeded the number who were eligible for the credits, indicating that some taxpayers received unauthorized credits. The IRS did not include, in the SOI report, an estimate of the number of taxpayers who received unauthorized credits.

<sup>&</sup>lt;sup>28</sup> The IRS did not include, in the SOI report, separate estimates of the number of eligible taxpayers who received advance payments and the number who did not.

<sup>&</sup>lt;sup>29</sup> See IRS, "ACA Data from Individuals," at https://www.irs.gov/statistics/soi-tax-stats-affordable-care-act-aca-statistics-individual-income-tax-items.

#### **Enrollment Data**

HHS regularly publishes data on persons selecting and enrolling in exchange plans, including individuals who were determined eligible for the PTC. For plan year 2020, HHS made reports and public-use files available with national enrollment data, as well as limited data by state, county, and zip code.<sup>30</sup> During the 2020 open enrollment period, approximately 87% of all exchange enrollees were eligible for the tax credit.<sup>31</sup> As of the publication date of this report, HHS had not yet published comparable data for plan year 2021.

## **Cost-Sharing Reductions**

An individual who qualifies for the PTC, is enrolled in a silver plan (see text box above, "Actuarial Value and Metal Plans"), *and* has annual household income no greater than 250% FPL (a temporary exception is provided for individuals who receive UC; see below) is eligible for cost-sharing reductions (CSRs).<sup>32</sup> The purpose of these CSR subsidies is to reduce an individual's (or family's) expenses related to cost-sharing requirements under the silver plan; such requirements may include deductibles, co-payments, coinsurance, and annual cost-sharing limits.<sup>33</sup> There are two types of CSRs, and the level of assistance for each varies by income band (see descriptions below). Individuals who are eligible for cost-sharing assistance may receive both types of subsidies, as long as they meet the applicable eligibility requirements.

In addition to individuals who meet the CSR eligibility requirements described below, the ARPA provides special access to individuals who receive UC. It deems individuals who receive UC for any week in calendar year 2021 to have met the CSR income eligibility criteria for plan year 2021.<sup>34</sup> The ARPA also disregards any household income above 133% FPL in 2021, which provides UC beneficiaries with the greatest level of cost-sharing assistance (see description of CSRs by income band below).

The ACA requires the HHS Secretary to provide full reimbursements to insurers that provide CSRs. Federal outlays for such reimbursements totaled the following amounts:

• FY2014: \$2.111 billion

• FY2015: \$5.382 billion

FY2016: \$5.652 billion

• FY2017: \$7.317 billion

• FY2018-FY2020: \$0<sup>35</sup>

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<sup>&</sup>lt;sup>30</sup> CMS, "2020 Marketplace Open Enrollment Period Public Use Files," at https://www.cms.gov/index.php/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2020-Marketplace-Open-Enrollment-Period-Public-Use-Files.

<sup>&</sup>lt;sup>31</sup> See CMS, "Health Insurance Exchanges 2020 Open Enrollment Report," April 1, 2020, at https://www.cms.gov/files/document/4120-health-insurance-exchanges-2020-open-enrollment-report-final.pdf.

<sup>&</sup>lt;sup>32</sup> ACA §1402.

<sup>&</sup>lt;sup>33</sup> A *deductible* is the amount an insured consumer pays for covered health care services before the applicable insurer begins to pay for such services (with exceptions). *Coinsurance* is a share of costs, expressed as a percentage, an insured consumer pays for a covered health service. A *co-payment* is a fixed dollar amount an insured consumer pays for a covered health service. An *annual cost-sharing limit* is the total dollar amount an insured consumer would be required to pay out of pocket for use of covered services in a plan year. Once an insured consumer's out-of-pocket spending meets this limit, the insurer generally will pay 100% of covered costs for the remainder of the plan year.

<sup>&</sup>lt;sup>34</sup> ARPA §2305.

<sup>&</sup>lt;sup>35</sup> Data provided to CRS by the IRS Budget Office.

Although the ACA authorized the cost-sharing subsidies and payments to reimburse insurers, it did not address the financing for such payments. The Obama Administration provided CSR payments to insurers using an existing appropriation that finances the PTC (among other tax benefits). The House of Representatives filed suit in 2014, claiming the payments violated the appropriations clause of the U.S. Constitution. After holding that the House has standing to sue the Obama Administration, the U.S. District Court for the District of Columbia concluded that payments for CSRs were unconstitutional for lack of a valid appropriation enacted by Congress. The court barred the Obama Administration from making the payments but stayed its decision pending appeal of the case. Following the November 2016 election, the court delayed the case to allow for nonjudicial resolution, including possible legislative action. Congress did not provide appropriations, and on October 13, 2017, the Trump Administration filed a notice announcing it would terminate payments for these subsidies beginning with the payment that was scheduled for October 18 of that year. In response, attorneys general of 18 states and DC filed suit in the U.S. District Court for the Northern District of California challenging HHS's decision to terminate CSR payments.<sup>36</sup>

Despite the administrative decision to terminate CSR payments, such decision provides no relief to insurers that continue to be required under federal law to provide CSRs to eligible individuals. In response, health insurers increased premiums to offset this loss in reimbursements (if permitted by state insurance regulators); this practice is referred colloquially as *silver loading*.<sup>37</sup>

As part of the legal challenges related to CSR payments, the Federal Circuit Court of Appeals concluded that insurers were "entitled to recover unpaid cost-sharing reduction (CSR) payments that the Trump Administration withheld, but only to the extent insurers had not recouped their losses through higher premiums." The practice of silver loading is protected under federal law through plan year 2021.<sup>39</sup>

#### Reduction in Annual Cost-Sharing Limits

Each metal plan limits the total dollar amount an insured consumer will be required to pay out of pocket for use of covered services in a plan year (referred to as an *annual cost-sharing limit* in this report). In other words, the amount an individual spends in a given year on health care services covered under his or her plan is capped.<sup>40</sup> For 2021, the annual cost-sharing limit for self-only coverage is \$8,550; the corresponding limit for family coverage is \$17,100.<sup>41</sup> One type of cost-sharing assistance reduces such limits (see **Table 3**). This CSR reduces the annual limit faced by premium credit recipients with incomes up to and including 250% FPL; greater subsidy amounts are provided to those with lower incomes. In general, this cost-sharing assistance targets

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<sup>&</sup>lt;sup>36</sup> For a discussion of legal considerations related to the termination of CSR payments, see CRS Legal Sidebar LSB10018, *Department of Health and Human Services Halts Cost-Sharing Reduction (CSR) Payments*.

<sup>&</sup>lt;sup>37</sup> For background on silver loading, see Bipartisan Policy Center, "Stabilizing the Individual Insurance Market: What Happened and What Next?," March 2018, at https://bipartisanpolicy.org/wp-content/uploads/2019/03/BPC-Health-Stabilizing-The-Individual-Health-Insurance-Market.pdf.

<sup>&</sup>lt;sup>38</sup> Aviva Aron-Dine and Christen Linke Young, "Silver-Loading Likely to Continue Following Federal Circuit Decision on CSRs," *Health Affairs*, October 13, 2020, at https://www.healthaffairs.org/do/10.1377/hblog20201009.845192/full/.

<sup>&</sup>lt;sup>39</sup> §609 of the Further Consolidated Appropriations Act, 2020, P.L. 116-94.

 $<sup>^{40}</sup>$  The annual cost-sharing limit applies only to health services that are covered under the health plan and are received within the provider network, if applicable.

<sup>&</sup>lt;sup>41</sup> See "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans," 85 *Federal Register* 29164, May 14, 2020, at https://www.govinfo.gov/content/pkg/FR-2020-05-14/pdf/2020-10045.pdf.

individuals and families that use a great deal of health care in a year and, therefore, have high cost-sharing expenses. Enrollees who use very little health care may not generate enough cost-sharing expenses to reach the annual limit.

Table 3.ACA Cost-Sharing Reductions: Reduced Annual Cost-Sharing Limits, 2021

	Annual Cost-Sharing Limits			
Household Income Tier, by Federal Poverty Level	Self-Only Coverage	Family Coverage		
100% to 150%	\$2,850	\$5,700		
Greater Than 150% to 200%	\$2,850	\$5,700		
Greater Than 200% to 250%	\$6,800	\$13,600		

**Source:** Department of Health and Human Services (HHS), "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans," 85 Federal Register 29164, July 13, 2020, at https://www.govinfo.gov/content/pkg/FR-2020-05-14/pdf/2020-10045.pdf.

Note: ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended).

For example, consider the hypothetical individual who resides in Lebanon, KS and has household income at 150% FPL(as discussed in the "Required Premium Contribution Examples" section of this report). Aperson eligible to receive CSRs at that income level would face an annual cost-sharing limit of \$2,850, compared to an annual limit of \$8,550 for someone also enrolled in a silver plan but does not receive this subsidy. The practical effect of this reduction would occur when this individual spent up to the reduced amount. For additional covered services received by the individual, the insurance company would pay the entire cost. Therefore, by reducing the annual cost-sharing limit, eligible individuals are required to spend less before benefitting from this financial assistance.

#### **Reduction in Cost-Sharing Requirements**

The second type of CSR also applies to premium credit recipients with incomes up to and including 250% FPL. For eligible individuals, the cost-sharing requirements (for the plans in which they have enrolled) are reduced to ensure that the plans cover a certain percentage of allowed health care expenses, on average. The practical effect of this CSR is to increase the actuarial value (AV) of the exchange plan in which the person is enrolled (**Table 4**). In other words, enrollees face lower cost-sharing requirements than they would have without this assistance. Given that this type of CSR directly affects cost-sharing requirements (e.g., lowers a deductible), both enrollees who use minimal health care and those who use a great deal of services may benefit from this assistance.

Table 4. ACA Cost-Sharing Reductions: Increased Actuarial Values

Household Income Tier, by Federal Poverty Level	New Actuarial Values for Cost- Sharing Subsidy Recipients		
100% to150%	94%		
Greater Than 150% to 200%	87%		
Greater Than 200% to 250%	73%		

Source: 45 C.F.R. §156.420.

Note: ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended).

To be eligible for cost-sharing subsidies, an individual must be enrolled in a silver plan, which already has an AV of 70% (see text box above, "Actuarial Value and Metal Plans"). For an individual who receives the CSR referred to in **Table 4**, the health plan will impose different cost-sharing requirements so that the silver plan will meet the applicable increased AV. The ACA does not specify how a plan should reduce cost-sharing requirements to increase the AV from 70% to one of the higher AVs. Through regulations, HHS requires each insurance company that offers a plan subject to this CSR to develop variations of its silver plan; these silver plan variations must comply with the higher levels of actuarial value (73%, 87%, and 94%).<sup>42</sup> When an individual is determined by an exchange to be eligible for CSRs, the person is enrolled in the silver plan variation that corresponds with his or her income.

Consider the same hypothetical individual discussed in the previous section. Since this person's income is at 150% FPL, if he or she receives this type of subsidy, the silver plan in which he or she is enrolled will have an AV of 94% (as indicated in **Table 4**), instead of the usual 70% AV for silver plans.

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<sup>&</sup>lt;sup>42</sup> See 45 C.F.R. §156.420.





HP-2021-09

# Access to Marketplace Plans with Low Premiums on the Federal Platform

# Part III: Availability Among Current HealthCare.gov Enrollees Under the American Rescue Plan

Under the American Rescue Plan of 2021 (ARP), we estimate more than 3 in 4 (79 percent) of the nearly 8 million current HealthCare.gov enrollees likely can access a zero-premium plan, while more than 4 in 5 (87 percent) likely can access a plan for \$50 or less per month.

D. Keith Branham, Ann B. Conmy, Thomas DeLeire, Josie Musen, Xiao Xiao, Rose C. Chu, Christie Peters, and Benjamin D. Sommers

#### **KEY POINTS**

- The American Rescue Plan (ARP) enhances and expands eligibility for advance payments of premium tax credits (APTCs) to purchase Marketplace insurance coverage under the Affordable Care Act (ACA). This Issue Brief estimates the changes in the availability of health plans with no premiums ("zero-premium plans") or premiums for \$50 or less per month ("low-premium plans") after APTCs among current HealthCare.gov enrollees under the ARP.<sup>1</sup>
- The ARP has substantially increased the availability of low-premium silver and gold plans; most low-premium plans before the ARP were in the bronze tier.
- Under the ARP, we estimate that the availability of zero-premium plans has increased by 41 percentage points in the silver metal tier, with nearly half (48 percent) of current enrollees now able to enroll in a silver plan at no premium cost to them. Similarly, we estimate that the availability of low-premium plans has increased by 25 percentage points in the silver metal tier, with 7 in 10 (70 percent) of current enrollees now able to find a low-premium silver plan.
- Availability of zero-premium gold plans also increased under the ARP, from 6 percent to 15 percent.
   Availability of low-premium gold plans increased from 22 to 44 percent, presenting additional
   opportunities for some current enrollees not eligible for high AV silver plans (i.e. those with income
   above 200 percent FPL) to switch to plans with zero or low premiums and higher actuarial value (AV).
- The ARP reduced the expected individual contribution of household income toward benchmark plan premiums to zero percent for applicable taxpayers with income between 100 and 150 percent of the Federal Poverty Level (FPL). Combined with cost-sharing reductions, this means that nearly all (99 percent) of current Health Care.gov enrollees in this income range can find a zero-premium plan with an actuarial value (AV) of 94 percent.

<sup>&</sup>lt;sup>1</sup> All references to premiums in this Issue Brief refer to premiums after application of APTCs, for those eligible to receive them. All results referring to "currently enrolled" in this brief are based on current plan selections in HealthCare.gov states for coverage in 2021 as of March 1, 2021, excluding those with catastrophic coverage.

#### **INTRODUCTION**

This is the third ASPE Issue Brief in a series on the availability of zero- and low-premium plans in the HealthCare.gov Marketplace. In the first Issue Brief, published on March 29, 2021, we noted there are approximately 8 million individuals currently enrolled in Marketplace health plans in HealthCare.gov states as of March 1, 2021.¹ Prior to the passage of the American Rescue Plan Act of 2021, Marketplace advanced premium tax credit (APTC) payments for many individuals in HealthCare.gov states - particularly low-income individuals - were large enough to substantially reduce premiums for many consumers, and in some cases to zero dollars, depending on the plan selections they might make. With the passage of the American Rescue Plan (ARP) and its enhanced and expanded Marketplace premium tax credit provisions, current HealthCare.gov enrollees' access to zero- and low-premium health plans has increased.

The ARP builds on the ACA by increasing access to health coverage through financial incentives to states to expand Medicaid and enhanced Marketplace premium tax credit eligibility. Under the ARP, ACA Marketplace premium tax credits temporarily become more generous in two ways: 1) for most consumers with household income between 100-400 percent FPL in Medicaid non-expansion states and between 138-400 percent FPL in Medicaid expansion states, the expected household income contribution toward premiums for the benchmark plan is lowered, including a reduction to 0% for those between 100-150 percent FPL; and 2) for consumers above the previous household income limit (400 percent FPL) for premium tax credit eligibility, the eligibility income limit is removed. The ARP changes to Marketplace premium tax credits apply for coverage beginning January 2021 and last for two years (2021 and 2022). APTCs under the new provisions became available through the HealthCare.gov Marketplace starting April 1, 2021. Reduced premium tax credits are available for all of 2021, and consumers can claim the increased credits for January–April 2021 at tax filing.

The Centers for Medicare & Medicaid Services (CMS) determined that the COVID-19 emergency presents exceptional circumstances for consumers in accessing health insurance and provided access to a Special Enrollment Period (SEP) for individuals and families to apply and enroll in the coverage they need. This SEP will be available to eligible consumers in the 36 states served by the federal Marketplace on the HealthCare.gov platform.<sup>2,ii,iii</sup> Consumer access to the 2021 COVID-19 SEP on HealthCare.gov began on February 15, 2021 and will run through August 15, 2021.<sup>3,4,iv</sup> Most of the fifteen states (including the District of Columbia) that run a State-Based Marketplace (SBM) have also made available a COVID-19 SEP with a similar timeframe.<sup>5,v</sup>

The ARP's enhanced Marketplace premium tax credit eligibility and the current COVID-19 SEP together provide new opportunities for current HealthCare.gov enrollees to find more affordable health coverage and higher quality plans at lower premiums when shopping on HealthCare.gov.<sup>6</sup>

This Issue Brief examines the impact of the ARP on the availability of zero-premium and low-premium health plans among current HealthCare.gov enrollees (referred to subsequently as "currently enrolled" or "the study population"). The brief compares access to such plans before and after the ARP's implementation and

HealthCare.gov states examined include: Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

iii States operating their own State-Based Marketplace (SBM) that do not use the HealthCare.gov platform are not included in the analysis: California, Colorado, Connecticut, District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and Washington.

iv The SEP also allows individuals currently enrolled in a plan through HealthCare.gov to switch plans.

<sup>&</sup>lt;sup>v</sup> See state profiles here: <a href="https://www.healthinsurance.org/states/">https://www.healthinsurance.org/states/</a>.

highlights the changes in availability. We examine the availability of zero- and low-premium plans before and after the ARP by metal tier, select demographic characteristics, and state-level estimates.

#### **METHODOLOGY**

The study methodology for this analysis of the currently enrolled is the same as in ASPE's prior analyses, *Access to Marketplace Plans with Low Premiums on the Federal Platform - Part I: Availability Among Uninsured Non-Elderly Adults and HealthCare.gov Enrollees Prior to the American Rescue Plan.* See Methodology and Appendix of that Issue Brief for further detail of the study methodology. For the ARP impacts we analyzed two APTC provisions: lowering the household income contribution toward premiums for the benchmark plan for those with household incomes between 100 and 400 percent FPL, and removing the ACA upper income limit for eligibility above 400 percent FPL. The ARP's unemployment compensation provisions, which affect countable income for determining Marketplace premium tax credits, are not included in this analysis. Vi

This analysis has several limitations. Data for State-Based Marketplaces are not readily available for 2021 and our estimates therefore do not represent the full United States. Additionally, race and ethnicity data for HealthCare.gov enrollees were frequently missing (42 percent of enrollees) and therefore unusable for estimating descriptive statistics for this group.

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vi Note: We assume enrollees with income above 400 percent FPL are now APTC eligible, but some may not be if they are enrolled in or have access to other affordable minimum essential coverage under ACA rules.

#### ZERO- AND LOW-PREMIUM PLAN AVAILABILITY BY METAL TIER

Table 1 shows the availability of zero- and low-premium plans by plan metal tier in the study population, before and after the ARP.

Table 1. Zero- and Low-Premium Plan Availability for Current HealthCare.gov Enrollees by Metal Tier, Pre- and Post-American Rescue Plan of 2021

Current HealthCare.gov Enrollees – Plan Availability	Pre-ARP	Post-ARP#	Percentage Point Difference**		
Total Population*	7,968,000				
\$0 Premium Plan, %					
Any Metal Tier	65.9%	78.7%	+12.7%		
Bronze	65.9%	78.7%	+12.7%		
Silver	7.1%	48.3%	+41.1%		
Gold	6.2%	14.7%	+8.5%		
\$50 or Less Per Month Premium Plan, %					
Any Metal Tier	78.1%	87.0%	+8.9%		
Bronze	78.1%	87.0%	+8.9%		
Silver	44.7%	70.1%	+25.3%		
Gold	21.8%	44.1%	+22.3%		

Data Sources: HealthCare.gov Marketplace Plan Files for Coverage in 2021; CMS/CCIIO MIDAS Plan Selections as of March 1, 2021

Notes: Catastrophic plans excluded from the analyses; \*Rounded to the nearest thousand; \*\*Rounding may result in slight deviation in listed percentage point difference and the difference in pre-ARP and post-ARP values calculated from the rounded values in the table; # "Post-ARP" only refers to the two subsidy provisions from the ARP examined in this analysis: lowering of maximum applicable percent of household income toward benchmark premiums and extension of APTC to applicable taxpayers with household incomes above 400 percent FPL.

We estimate that access to zero- and low-premium plan availability increased an additional 12.7 percentage points and 8.9 percentage points, respectively, under ARP. Overall, more than 3 in 4 (78.7 percent) adults in this population may be able to access a zero-premium plan in the Marketplace and nearly 7 in 8 (87.0 percent) may be able to find a plan for \$50 or less per month.

#### **Silver Plans**

Under the ARP, silver zero- and low-premium plans have become substantially more available. We estimate availability of zero-premium plans to increase by 41.1 percentage points in the silver metal tier, with nearly half (48.3 percent) of the currently enrolled now able to enroll in a silver plan at no premium cost to them. Similarly, we estimate availability of low-premium plans to increase by 25.3 percentage points in the silver metal tier, with 7 in 10 (70.1 percent) of the currently enrolled now able to find a silver plan for \$50 or less per month premium cost.

Because income based cost-sharing reductions (CSRs) are only available for silver plans and for eligible consumers with household income between 100 and 250 percent FPL, it these findings indicate for CSR-eligible consumers there may be new opportunities for low-premium plans with more generous coverage (i.e. higher Actuarial Value [AV] in and lower out-of-pocket costs, e.g. reduced deductibles, copays, etc.).

vii With the exception of American Indians and Alaskan Natives, whose incomes can be higher, and who can utilize CSRs towards plans at any metal level.

viii The actuarial value (AV) of a health plan is the average percentage of total costs of in-network essential health benefits (EHB) covered by the health plan. The AV available ranges from 60% for bronze plans, 70% for silver plans, 80% for gold plans, and 90% for platinum plans. For certain eligible individuals (generally those with household incomes between 100%-250% FPL) silver cost-sharing reduction (CSR) plans are available, which enhance AV from 70% to 73%, 87%, or 94% depending on income. Catastrophic plans are excluded from all analyses.

Additionally, the ARP reduced the expected contribution of household income toward benchmark plan (second-lowest cost silver) premiums to zero percent for those with household incomes between 100 and 150 percent FPL, meaning that nearly all of the currently enrolled eligible consumers in this income range can find a zero-premium plan with an AV of 94 percent (i.e. on average, consumers enrolled in these plans only have to pay out-of-pocket for 6 percent of total in-network health care costs), with the exception of those living in a state or rating area in which all silver plans cover benefits beyond the ACA's Essential Health Benefits (EHBs).

#### **Gold Plans**

Availability of zero-premium gold plans also increased under the ARP, from 6.2 to 14.7 percent, among those currently enrolled in HealthCare.gov states. The same was true for availability of low-premium gold plans, increasing from 21.8 to 44.1 percent, presenting additional opportunities for some currently enrolled consumers to switch to plans with zero- or low-premium cost with higher AV than standard silver plans.

#### ZERO- AND LOW-PREMIUM PLAN AVAILABILITY BY DEMOGRAPHIC CHARACTERISTICS

Table 2 shows availability of zero- and low-premium plans by demographics in the study population, before and after the ARP.

Table 2. Zero- and Low-Premium Plan Availability for Current HealthCare.gov Enrollees by Demographics, Pre- and Post-American Rescue Plan of 2021

Current HealthCare.gov	Takal	\$0 Available - Any Metal			\$50 or Less Per Month Available - Any Metal		
Enrollees – Plan Availability	Total Population*	Pre- ARP, %	Post- ARP#, %	Percentage Point Difference**	Pre- ARP, %	Post- ARP#, %	Percentage Point Difference**
Total Population*	7,968,000	65.9%	78.7%	+12.7%	78.1%	87.0%	+8.9%
Rural Status <sup>‡</sup>							
Rural	1,193,000	65.2%	78.7%	+13.5%	78.8%	88.4%	+9.6%
Urban	6,774,000	66.0%	78.7%	+12.6%	78.0%	86.7%	+8.7%
Age							
0-17	758,000	52.8%	70.4%	+17.6%	74.1%	83.0%	+8.9%
18-24	704,000	73.4%	85.6%	+12.2%	86.6%	92.6%	+6.0%
25-34	1,257,000	58.4%	75.7%	+17.3%	72.1%	84.3%	+12.2%
35-44	1,302,000	61.8%	77.0%	+15.2%	74.0%	84.9%	+10.9%
45-54	1,593,000	69.5%	80.5%	+11.0%	79.6%	87.8%	+8.3%
55-64	2,239,000	70.9%	80.0%	+9.1%	80.6%	88.2%	+7.6%
65+	115,000	88.7%	90.8%	+2.1%	94.3%	95.7%	+1.4%
Income/FPL							
<100%	104,000	43.4%	43.4%	0.0%	53.9%	53.9%	0.0%
100-138%	2,663,000	98.4%	98.6%	+0.2%	99.5%	99.5%	0.0%
>138-150%	702,000	88.7%	91.5%	+2.8%	98.9%	99.2%	+0.3%
>150-200%	1,520,000	74.9%	91.3%	+16.3%	94.3%	98.9%	+4.6%
>200-250%	1,036,000	51.8%	86.4%	+34.6%	77.4%	97.8%	+20.3%
>250-300%	637,000	28.5%	67.4%	+38.9%	55.6%	89.5%	+33.9%
>300-350%	415,000	16.6%	40.9%	+24.3%	36.3%	70.6%	+34.3%
>350-400%	287,000	13.4%	24.5%	+11.1%	28.4%	48.4%	+20.0%
>400%	115,000	0.0%	2.6%	+2.6%	0.0%	7.6%	+7.6%
Unknown†	489,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Data Sources: HealthCare.gov Marketplace Plan Files for Coverage in 2021; CMS/CCIIO MIDAS Plan Selections as of March 1, 2021

Notes: Catastrophic plans excluded from all analyses; \*Rounded to the nearest thousand; \*\*Rounding may result in slight deviation in listed percentage point difference and the difference in pre-ARP and post-ARP values calculated from the rounded values in the table; # "Post-ARP" only refers to the two

<sup>&</sup>lt;sup>‡</sup>Rural vs urban defined at the county level in the Marketplace files.

<sup>&</sup>lt;sup>†</sup>Consumers who do not request financial assistance when applying for coverage do not enter their household income information. A small number of consumers that do request financial assistance have missing household incomes due to a tax filing status that makes them APTC-ineligible or data anomalies. Lawfully present individuals with a household income less than 100% FPL who were denied Medicaid due to their immigration status can be APTC eligible (26 CFR 1.36B-2(b)(5)).

subsidy provisions from the ARP examined in this analysis: lowering of the maximum applicable percent of income toward benchmark premiums and extension of APTCs to those above 400 percent FPL. Race and ethnicity estimates included in the other issue briefs in the series are not included in this brief due to high missingness in the plan selection files (42%) used for the analysis.

#### **Rural Status**

Under the ARP, zero- and low-premium health plans are now available to 78.7 percent and 88.4 percent, respectively, of current HealthCare.gov enrollees in rural counties. In urban counties zero- and low-premium health plans are available to 78.7 percent and 86.7 percent, respectively, of the study population.

#### Income

Among current HealthCare.gov enrollees, the greatest increase in availability of zero-premium plans was among those with incomes between 200 and 300 percent FPL, with increases of greater than 30 percentage points. The greatest increase in availability of low-premium plans was among those with incomes between 250 and 350 percent FPL, with increases also greater than 30 percentage points.

#### **ZERO- AND LOW-PREMIUM PLAN AVAILABILITY BY STATE**

Table 3 shows zero- and low-premium plan availability by HealthCare.gov state for the study population, before and after the ARP.

Table 3. Zero- and Low-Premium Plan Availability for Current HealthCare.gov Enrollees by State, Pre- and Post-American Rescue Plan of 2021

State	Total Population*	\$0 Available - Any Metal, %			\$50 or Less Per Month Available - Any Metal, %		
		Pre-ARP, %	Post-ARP#, %	Percentage Point Difference**	Pre-ARP, %	Post-ARP#, %	Percentage Point Difference**
All							
HealthCare.gov	7,968,000	65.9%	78.7%	+12.7%	78.1%	87.0%	+8.9%
States							
Alabama	163,000	84.2%	92.4%	+8.2%	89.4%	94.2%	+4.9%
Alaska	18,000	0.0%	0.0%	0.0%	70.1%	79.4%	+9.3%
Arizona	149,000	37.7%	63.3%	+25.6%	55.4%	72.2%	+16.7%
Arkansas	63,000	34.1%	68.8%	+34.7%	56.4%	79.3%	+22.9%
Delaware	25,000	50.6%	71.7%	+21.1%	64.7%	78.6%	+13.9%
Florida	2,086,000	82.4%	91.7%	+9.3%	89.0%	93.9%	+5.0%
Georgia	508,000	71.0%	83.6%	+12.6%	80.0%	87.7%	+7.6%
Hawaii	21,000	0.0%	0.0%	0.0%	72.3%	81.6%	+9.4%
Illinois	273,000	0.0%	0.0%	0.0%	55.4%	73.8%	+18.4%
Indiana	130,000	25.2%	49.3%	+24.2%	39.7%	60.9%	+21.2%
lowa	55,000	69.2%	82.4%	+13.3%	76.9%	85.7%	+8.9%
Kansas	84,000	56.7%	77.2%	+20.4%	70.1%	83.6%	+13.6%
Kentucky	72,000	49.6%	71.1%	+21.6%	63.7%	77.4%	+13.7%
Louisiana	78,000	59.3%	79.1%	+19.7%	72.6%	85.6%	+13.0%
Maine	55,000	0.0%	0.0%	0.0%	52.1%	73.0%	+20.9%
Michigan	253,000	41.1%	68.1%	+27.0%	59.7%	77.5%	+17.7%
Mississippi	109,000	68.0%	89.0%	+21.0%	82.8%	93.2%	+10.4%
Missouri	205,000	67.7%	80.9%	+13.3%	76.0%	84.6%	+8.6%
Montana	42,000	47.5%	70.9%	+23.4%	62.8%	78.3%	+15.5%
Nebraska	84,000	84.7%	92.6%	+7.9%	90.2%	94.4%	+4.1%
New Hampshire	44,000	26.2%	47.7%	+21.5%	38.2%	57.5%	+19.3%
New Mexico	41,000	42.4%	63.0%	+20.6%	55.0%	69.9%	+14.9%
North Carolina	510,000	77.0%	88.4%	+11.3%	84.9%	91.4%	+6.5%
North Dakota	22,000	77.1%	86.4%	+9.4%	83.9%	88.9%	+5.0%
Ohio	191,000	32.2%	59.8%	+27.7%	50.6%	69.1%	+18.4%
Oklahoma	166,000	81.0%	91.2%	+10.2%	88.1%	93.4%	+5.2%
Oregon	132,000	0.0%	0.0%	0.0%	47.9%	65.2%	+17.3%
South Carolina	222,000	72.6%	86.5%	+13.8%	82.1%	90.1%	+8.0%
South Dakota	30,000	67.7%	85.8%	+18.1%	80.4%	90.7%	+10.3%
Tennessee	203,000	63.2%	79.5%	+16.3%	73.4%	84.6%	+11.2%
Texas	1,262,000	78.4%	88.1%	+9.7%	85.4%	90.7%	+5.3%
Utah	200,000	75.9%	87.8%	+11.9%	86.2%	91.5%	+5.3%
Virginia	246,000	55.7%	76.1%	+20.5%	70.1%	82.4%	+12.3%
West Virginia	18,000	14.9%	49.4%	+34.5%	35.6%	63.9%	+28.3%
Wisconsin	181,000	48.7%	69.2%	+20.5%	62.1%	78.3%	+16.2%
Wyoming	26,000	86.1%	92.3%	+6.2%	89.7%	93.3%	+3.6%

Data Sources: HealthCare.gov Marketplace Plan Files for Coverage in 2021; CMS/CCIIO MIDAS Plan Selections as of March 1, 2021.

Notes: Catastrophic plans excluded from all analyses; \*Rounded to the nearest thousand, and "study population" refers to current HealthCare.gov plan selections in *HealthCare.gov* states; \*\*Rounding may result in slight deviation in listed percentage point difference and the difference in pre-ARP and post-ARP values calculated from the rounded values in the table; # "Post-ARP" only refers to the two subsidy provisions from the ARP examined in this analysis: lowering of max applicable percent of income toward benchmark premiums and extension of APTC to those above 400 percent FPL.

#### **State Level Availability**

Under the ARP, HealthCare.gov states continue to vary widely in the availability of zero-premium plans; some states (Alaska, Hawaii, Illinois, Maine, and Oregon) did not have any zero-premium plans available, while in other states half or more of the currently enrolled HealthCare.gov population may have them available. There was also variability by state for low-premium plans and in most states more than 3 in 4 can find a low-premium plan.

Some states may not have zero-premium plans available to anyone; for example, if all plans in the state cover some services that are not ACA essential health benefits (EHBs), then premiums in that state cannot be reduced by APTCs to zero dollars. APTCs cannot be applied to non-EHB portions of the premium and therefore these plans will always have some amount of premium cost to the consumer.\* However, due to the comprehensiveness of the ACA EHBs, non-ACA EHB portions of premiums are typically relatively small.

#### CONCLUSION

The American Rescue Plan Act of 2021 enhances Marketplace premium tax credits for consumers in HealthCare.gov states and expands eligibility for premium tax credits to applicable taxpayers with household incomes of 400 percent FPL and greater. We find that zero-premium and low-premium plans have become much more widely available based on these new tax credit provisions. These changes have improved the coverage options for millions of HealthCare.gov enrollees.

ix In places where plans cover services not included in the ACA's Essential Health Benefits (EHB), consumers in this income range will still pay some premium. The plans in these states all cover some non-Essential Health Benefits in their QHPs, which are not eligible for APTCs. See discussion of this in the Part I Issue Brief in this series.

<sup>\*</sup> Non-essential health benefits are services beyond the ACA's ten categories of essential services, due to certain state mandates (for example, adult vision and adult dental coverage). For more details about specific state coverage requirements see: https://www.cms.gov/cciio/resources/data-resources/ehb#ehb.

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# More details about changes for taxpayers who received advance payments of the 2020 Premium Tax Credit

FS-2021-08, April 2021

WASHINGTON — The American Rescue Plan Act of 2021 suspends the requirement that taxpayers increase their tax liability by all or a portion of their excess advance payments of the Premium Tax Credit (excess APTC) for tax year 2020. A taxpayer's excess APTC is the amount by which the taxpayer's advance payments of the Premium Tax Credit (APTC) exceed his or her Premium Tax Credit (PTC).

The IRS recently announced that, for tax year 2020, taxpayers with excess APTC for 2020 are not required to file Form 8962, Premium Tax Credit, to reconcile their APTC with the amount of PTC they may claim for 2020. They should not report an excess advance Premium Tax Credit repayment on 2020 Form 1040 or Form 1040-SR, Schedule 2, Line 2, or file Form 8962.

Eligible taxpayers claiming a net Premium Tax Credit (net PTC) must file Form 8962 when they file their 2020 tax return. If the taxpayer's PTC computed on the return is more than the APTC paid on the taxpayer's behalf during the year, the difference is a net PTC. See the Form 8962, and its instructions for more information.

Understanding how recent legislative changes for the PTC affect individuals and families and their 2020 tax return is important. The IRS developed this fact sheet to explain what taxpayers need to know about claiming a net PTC and what to do if they have excess APTC for tax year 2020.

#### What is the Premium Tax Credit?

The Premium Tax Credit helps pay for health insurance coverage bought from the Health Insurance Marketplace. When a taxpayer or a family member of the taxpayer applies for coverage, the Marketplace estimates the amount of the PTC the taxpayer may be able to claim for the year of coverage. This estimate is based on information the taxpayer provides about family size and projected household income.

Eligible taxpayers then choose to have all, some, or none of the estimated credit paid in advance directly to their insurance company on their behalf. These payments – which are called advance payments of the Premium Tax Credit, advance credit payments, or APTC – lower what taxpayers pay out-of-pocket for their monthly premiums.

Alternatively, taxpayers can choose not to get APTC, pay the full amount of their monthly premium, and claim all of the benefit of the PTC that they are allowed when they file their tax return. This will increase their refund or lower the amount of tax they owe.

Taxpayers use Form 8962, Premium Tax Credit, to figure the amount of their PTC and reconcile it with their APTC.

## How do taxpayers know that APTC was paid for their coverage?

Taxpayers who enrolled, or enrolled a family member, in health insurance coverage for 2020 through the Marketplace should have received Form 1095-A, Health Insurance Marketplace Statement from the Marketplace. This form shows the months of coverage and any APTC paid to the taxpayer's insurance company for the coverage.

The Marketplace also notifies the IRS annually that APTC was paid for the coverage of a taxpayer or a member of the taxpayer's family. Prior to the legislative change, the IRS mailed letters to taxpayers for whom APTC was paid but who did not file Form 8962 when they filed their tax return. The letter asks the taxpayer to respond so that the IRS can continue processing the taxpayer's tax return.

## What about those who already filed their 2020 tax return?

Taxpayers who have already filed their 2020 tax return and who have excess APTC do not need to file an amended tax return or contact the IRS. Instead, taxpayers should follow the below procedures:

If a taxpayer has excess APTC, filed their return with Form 8962 and it's still being processed: The IRS will reduce the excess advance Premium Tax Credit repayment amount the taxpayer reported on their 2020 Form 1040 or Form 1040-SR, Schedule 2, Line 2, and Line 29 of Form 8962 to zero and process their return. There is no need to contact the IRS. If a taxpayer receives a IRS letter about excess APTC for tax year 2020, they should disregard the letter.

If a taxpayer has excess APTC and filed their return without Form 8962: The individual might have received a letter from the IRS. If they have excess APTC for 2020, they should disregard the IRS letter asking for a missing Form 8962. The IRS will continue processing the 2020 return without Form 8962. If the taxpayer didn't get a letter about a missing Form 8962, the IRS will process the 2020 without Form 8962. If they didn't file a Form 8962 but still reported an excess advance Premium Tax Credit repayment amount on their return, the IRS will reduce it to zero and process the return. There is no need to contact the IRS.

If a taxpayer paid an excess APTC repayment amount when they filed their return with Form 8962: Individuals in this situation should not file an amended tax return to get a refund of this amount. The IRS is taking steps to reimburse taxpayers who filed Form 8962, reported, and paid an excess advance Premium Tax Credit repayment amount with their 2020 tax return before the recent changes made by the American Rescue Plan Act of 2021. Individuals in this situation should not file an amended return solely to get a refund of this

If a taxpayer is claiming net PTC and filed their return without Form 8962: They will receive a letter from the IRS asking for a completed Form 8962. Taxpayers claiming a net PTC must file Form 8962 when they file their 2020 tax return. If they filed a 2020 tax return and claimed a net PTC but did not file Form 8962 with their return, they should respond to the IRS notice they received or will soon receive. The IRS may need more information to process their 2020 return if there's an amount claimed on Form 1040 or 1040-SR, Schedule 3, Line 8. Individuals

amount. The IRS will provide more details soon.

are eligible for net PTC for 2020 if their PTC for 2020 is more than the APTC paid for health insurance coverage and the coverage of their family members for 2020, or if they are allowed a PTC for 2020 and were not eligible for APTC, or chose not to receive the benefit of APTC, at enrollment in their health plan for 2020.

If individuals have net PTC for 2020, they should review and respond to the IRS notice so that the IRS can finish processing their 2020 tax return and, if applicable, issue any refund due.

#### Who should file Form 8962 with their 2020 tax return?

If taxpayers have excess APTC for 2020: They should not file Form 8962 when they file their 2020 tax return and they should not include an amount on Form 1040 or Form 1040-SR. Schedule 2, Line 2. The IRS will process that tax return without Form 8962 and will not add any excess advance Premium Tax Credit repayment amount to the 2020 tax liability. The taxpayer should disregard notices from the IRS asking for a missing Form 8962 if they have excess APTC for tax year 2020.

If individuals are claiming net PTC on Form 1040 or 1040-SR, Schedule 3, Line 8: They must file Form 8962 with their return and report net PTC on Line 26. Taxpayers are eligible to claim net PTC if:

- They are allowed a PTC for 2020 but were not eligible for, or chose not to receive the benefit of, APTC at enrollment in Marketplace coverage for 2020, or
- They received the benefit of APTC for 2020 but their PTC allowed for 2020 is more than the APTC paid on their behalf for 2020.

The IRS needs the information on Form 8962 to process the tax return for taxpayers claiming a net PTC. If they have net PTC and receive a letter asking for more information, they should respond to the notice so that the IRS can finish processing their 2020 tax return and, if applicable, issue any refund due.

#### How is the net PTC claimed on the tax return?

Eligible taxpayers may claim a PTC for health insurance coverage in a qualified health plan purchased through a Health Insurance Marketplace. Taxpayers use Form 8962 to figure the amount of their PTC and reconcile it with their APTC. This computation lets the taxpayer know whether they have excess APTC or may claim net PTC.

Only taxpayers who enrolled themselves, their spouse if filing a joint return, or a person whom they claim as a dependent, in a qualified health plan through the Marketplace are allowed a PTC. Taxpayers claim the PTC on their federal income tax return. Taxpayers who chose not to get APTC in 2020 and paid the full monthly premium get all of the benefit of the PTC when they claim it on their 2020 tax return.

A taxpayer claiming a PTC for 2020 must reduce their PTC by the amount of APTC paid on their behalf for 2020. This reconciliation is done on Form 8962. If the taxpayer's PTC computed on the return is more than the APTC paid on the taxpayer's behalf during the year, the difference is a net PTC.

Claiming a net PTC will increase the taxpayer's refund or lower the amount of tax he or she owes. Net PTC is reported on Form 1040, Schedule 3, Line 8. Taxpayers claiming a net PTC must file Form 8962 and report an amount on Line 26 of the form when filing their 2020 tax return.

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# A Public Option for Health Insurance in the Nongroup Marketplaces: Key Design Considerations and Implications



## At a Glance

Some Members of Congress have proposed introducing a federally administered health insurance plan, or "public option," to compete with private plans in the nongroup marketplaces established by the Affordable Care Act. In this report, the Congressional Budget Office describes the key design considerations of such a public option and some of their major implications.

**Key Design Considerations.** Among the key considerations that policymakers designing a public option would face are the following:

- Would the public option conform with state insurance regulations?
- Would it be offered in multiple metal tiers and available outside the marketplaces?
- How would payment rates for providers and prices for prescription drugs be determined?
- Would certain providers be required to participate?
- What administrative activities would the plan take on, and what administrative costs would it incur?
- Would the public option participate in risk-adjustment transfers?
- How would it be funded?
- Would it be offered everywhere or only in geographic markets with low insurer participation or high premiums?

**Implications of Design Choices.** Policymakers' choices about design features of the public option would have implications for federal outlays and revenues, health insurance premiums, and health insurance coverage.

- Federal Outlays and Revenues. The budgetary impact of implementing a public option would depend largely on how the option affected the premium of the benchmark plan, which is used to determine marketplace subsidies. A public option with a premium similar to or higher than those of private plans would have little impact, whereas a public option with a relatively low premium would lower the benchmark premium and subsidies.
- Premiums. The public option's premiums could be higher or lower than those of private nongroup plans, depending mostly on the characteristics of the option: how provider payment rates were determined, the health care utilization of enrollees in the public option compared with that of enrollees in private plans, whether the public option participated in risk-adjustment transfers, and whether the plan's administrative expenses were more similar to those of Medicare or private insurers.
- Health Insurance Coverage. A public option would affect the total number of people in the United States with health insurance and their sources of coverage by attracting people currently enrolled in the nongroup market, the uninsured population, and people with employment-based coverage. The decrease in the uninsured rate would most likely be largest among those whose income is too high to receive marketplace subsidies. The net effect of implementing a public option on the number of people enrolled in subsidized marketplace coverage would probably be relatively small.

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## **Notes**

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

# **Summary**

Some Members of Congress have introduced legislative proposals that would make a federally administered health insurance plan—often referred to as a public option—available for purchase with or without federal subsidies in the nongroup marketplaces established under the Affordable Care Act. The insurance risk of the public option would be borne by the federal government—that is, the federal government would bear financial responsibility for medical claims covered by the plan.

In this report, the Congressional Budget Office discusses some of the key design considerations associated with such a program (see Figure S-1). The agency then explains how those design choices would affect the public option's premiums, private insurers' premiums and participation in the marketplaces, health insurance coverage in the United States, and federal outlays and revenues. Certain design choices could, for example, result in a public option that used the federal government's ability to set administered prices and its purchasing power to offer marketplace enrollees a lower-premium plan with a broad provider network; such a plan would most likely encourage a significant number of people to enroll in the public option. Other design choices could be made to establish a public option that was similar to private plans in terms of premiums and provider networks; although such a plan would provide stability to markets in which few private insurers currently participate, it would probably encourage fewer people to enroll in the public option.

This report does not consider policy changes—such as increases in marketplace subsidies—that are often proposed alongside a public option but that are not essential components of such a program.

# How Would a Public Option Affect Federal Outlays and Revenues?

Introducing a public option in the nongroup marketplaces could affect the federal budget through three main pathways. First, federal subsidies for insurance purchased through the marketplaces could be reduced. (Those subsidies are determined by the premiums of a benchmark plan—currently, the second-lowest-cost silver plan.)<sup>1</sup> Second, the number of people enrolling in market-place coverage and claiming a subsidy in the form of a premium tax credit could change. Third, the Congress could appropriate funding to cover start-up or ongoing administrative costs.

The budgetary implications of the public option would therefore depend on how the public option affected the benchmark premium and the number of people who signed up for subsidized coverage. Each of those factors, in turn, would depend on private insurers' participation in the marketplace and on the premiums of private plans and the public option.

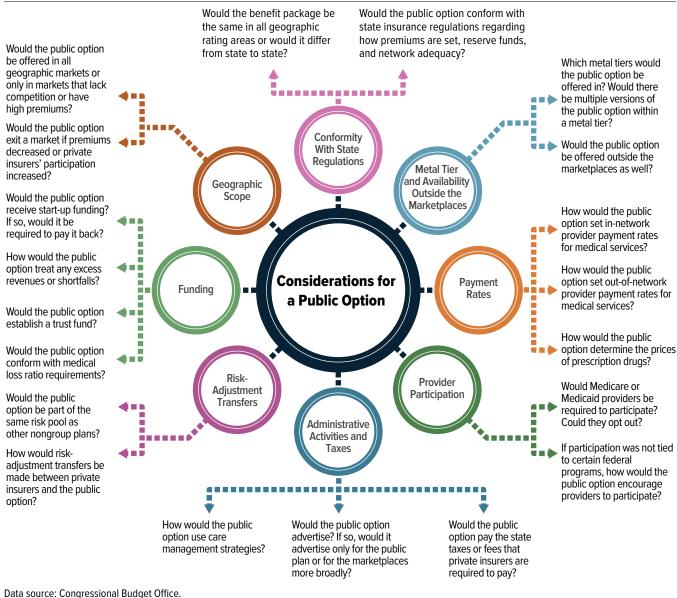
# How Would a Public Option Affect Premiums?

Depending on the combination of design choices policymakers made, the public option's premiums could be similar to those of private plans, in which case, the benchmark premium and the total number of people with subsidized marketplace coverage (including enrollees in private plans and enrollees in the public option) would remain about the same. The public option's premiums would be similar to or higher than private insurers' premiums if, for example, the plan had the following characteristics: provider payment rates were similar to or higher than rates paid by private plans, prescription drug price negotiation was contracted to a pharmacy benefit

<sup>1.</sup> Plans in the nongroup marketplaces are classified according to their actuarial value (that is, the percentage of the total costs of covered benefits that the plan will pay for, on average) into bronze, silver, gold, and platinum tiers; bronze plans have the lowest actuarial value and platinum plans the highest. For example, a typical silver plan has an actuarial value of 70 percent, whereas a typical gold plan has an actuarial value of 80 percent. The Affordable Care Act caps the premium contribution as a share of income for enrollees eligible for subsidized coverage. The difference between this premium contribution and the premium of the benchmark plan is subsidized through a premium tax credit, which is typically paid directly to the insurance company on the basis of the enrollee's estimated income. Although subsidies under the premium tax credit are calculated using the benchmark plan, they can be applied to any plan in the nongroup marketplace.

Figure S-1.

#### **Design Considerations for a Federally Administered Public Option**



manager, and the plan incurred administrative costs similar to those of private plans. In that case, the effects on federal outlays and revenues would be small. The main effect of such a public option would be to add another coverage choice to the private plans in the marketplaces, which could make marketplace coverage more attractive, particularly in markets with few insurers.

Alternatively, the public option's premiums could be substantially lower than those of private plans. That would be the case if, for example, the plan had the

following features: provider payment rates were administered and set at or around Medicare rates, prescription drug prices were set by statute below commercial prices, and the public option was exempt from certain taxes or fees paid by private insurers. Such a public option would enter many markets as the lowest- or second-lowest-cost plan, reducing the benchmark premium and the average federal subsidy. In some markets, the public option could increase the ability of private insurers to negotiate lower rates with providers; those insurers might, in turn, lower their premiums to maintain their market share, which

could further reduce the benchmark premium. Such a public option would be more disruptive to nongroup marketplaces than other forms of an option would be. It would probably reduce health care providers' and prescription drug manufacturers' revenues. It would probably also cause some private insurers to exit the market entirely, thereby reducing coverage options.

SUMMARY

# How Would a Public Option Affect Health Insurance Coverage?

A low-premium public option would have the largest effect on the uninsured rate of people who are ineligible for marketplace subsidies because their income is above 400 percent of the federal poverty guidelines (commonly referred to as the federal poverty level).<sup>2</sup> Because they must pay the full premium, they are more responsive

2. The American Rescue Plan Act of 2021 (Public Law 117-2) extended eligibility for marketplace subsidies to people with income above 400 percent of the federal poverty level (FPL) in 2021 and 2022. (In most states, the FPL in 2021 is \$12,880 for a single person and increases by \$4,540 for each additional person in a household. Thus, for a single person, 400 percent of the FPL is \$51,520 in 2021.) Given the temporary nature of those changes, this report focuses on the marketplace subsidy structure that was in effect before enactment of the American Rescue Plan Act of 2021 and that will be in effect again under current law starting in 2023.

than people in the subsidy-eligible income range to changes in premiums.

The net effect that a public option would have on the total number of people who received subsidies to purchase coverage through the marketplaces is ambiguous and would probably be small. Decreases in the benchmark premium and subsidy could result in higher net premiums (that is, premiums minus subsidies) for private plans, which might cause some enrollees in those plans to forgo coverage or switch to the public option or to a lower-tier plan. If the public option's care management was limited and the plan had a broad provider network, it might attract some people who currently forgo marketplace subsidies and purchase a plan outside the marketplace.

A low-premium public option would also attract some people who currently have employment-based coverage: Some of those people would forgo their employer's offer of insurance, and some employers would choose to no longer offer health insurance. That effect would be small, relative to the total number of people with employment-based coverage, because employers' and most employees' premium contributions are excluded from taxable compensation and because people with affordable offers of employment-based coverage are ineligible for marketplace subsidies under current law.

# **Chapter 1: Background**

Recently, several proposals to establish a public option—the details of which have varied significantly—have been put forth. This report provides a general framework for evaluating the key design choices in such proposals; it does not analyze any specific bill or proposal.

To establish that general framework, the Congressional Budget Office first defined the scope of the report by identifying characteristics of a public option common to many proposals. The agency then considered several characteristics of the current nongroup health insurance market that have led policymakers to put forth such proposals.<sup>1</sup>

#### Scope of the Report

Although various proposals have defined the specifics of a public option differently, CBO focused on a program with the following key characteristics:

- The public option would be offered by the federal government in the health insurance marketplaces established under the Affordable Care Act (ACA) and would, at a minimum, be offered in the metal tier used to determine the federal subsidy.<sup>2</sup>
- The federal government would bear the insurance risk, but it could contract out claims processing and related administrative functions.<sup>3</sup>
- The nongroup health insurance market is the private market in which individuals and families purchase health insurance directly from an insurer, rather than obtaining it through an employer.
- Under current law, the second-lowest-cost silver plan is the benchmark plan that determines the amount of premium tax credits in a marketplace. A public option offered in the silver tier would be considered in the determination of the benchmark plan and the premium tax credit.
- 3. Several legislative proposals, including the Keeping Health Insurance Affordable Act of 2019 (S. 3, 116th Cong.), the CHOICE Act (H.R. 2085 and S. 1033, 116th Cong.), and the Public Option Deficit Reduction Act (H.R. 1419, 116th Cong.), specify that the public option would not transfer insurance risk to private insurers. The Medicare-X Choice Act (H.R. 2000 and S. 981, 116th Cong.) specifies that the public option would not transfer insurance risk, except under alternative payment models. Those proposals also would allow the public option to

- The plan would adopt the ACA's geographic rating areas, and premiums could vary only on the basis of metal tier, rating area, family size, age (by no more than a specified ratio), and tobacco use.<sup>4</sup>
- The plan would be subject to the same federal eligibility, benefit, and network-adequacy requirements that private nongroup plans are subject to under the ACA.<sup>5</sup> In addition, enrollees in the plan would be eligible for income-based premium tax credits and, in the case of plans offered in the silver tier, cost-sharing reductions available under the ACA.
- The premiums for the plan would be set to cover the expected medical expenses of enrollees plus the costs of administration.

Several types of proposals are not considered in this report. For example, proposals to establish a public option often include changes that would substantially increase marketplace subsidies by switching the benchmark plan from silver to gold.<sup>6</sup> Although increasing

- contract out administrative functions. Contractors could play a role similar to that of the administrative contractors for Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) authorized under section 1874A of the Social Security Act (codified at 42 U.S.C. §1395kk-1 (2018)).
- 4. See Centers for Medicare & Medicaid Services, "Market Rating Reforms" (updated June 2, 2017), https://go.usa.gov/x74Ft.
- 5. Under the ACA, plans in the marketplace must, among other things, cover 10 essential health benefits, have no annual or lifetime caps on such benefits, be made available to people with preexisting conditions, and offer specified actuarial values. For more information, see Annie L. Mach and Namrata K. Uberoi, Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA), Report R43854, version 9 (Congressional Research Service, April 5, 2016), https://go.usa.gov/x72xu.
- 6. For example, the Choose Medicare Act (H.R. 2463 and S. 1261, 116th Cong.) would change the benchmark plan from silver to gold (that is, from a plan with an actuarial value of 70 percent to one with a value of 80 percent). Both the Choose Medicare Act and the Keeping Health Insurance Affordable Act of 2019 (S. 3, 116th Cong.) would extend eligibility for premium tax credits to people with income of up to 600 percent of the federal poverty level.

#### Box 1-1.

# Effects of the American Rescue Plan Act of 2021 on Marketplace Subsidies and a Public Option

The American Rescue Plan Act of 2021 (Public Law 117-2), which was enacted in March 2021, includes provisions that temporarily expand subsidies for health insurance obtained through the marketplaces established under the Affordable Care Act. Those provisions are scheduled to be in effect in 2021 and 2022.1 The enacted legislation increases subsidies for those with income between 100 percent and 400 percent of the federal poverty quidelines (commonly referred to as the federal poverty level, or FPL).2 Those with income up to 150 percent of the FPL pay a zero net premium for the benchmark plan, and those with income between 150 percent and 400 percent of the FPL experience reductions in the share of income they are expected to pay for a benchmark plan. The enacted legislation also extends subsidy eligibility to those with income at or above 400 percent of the FPL so that they do not pay more than 8.5 percent of their income for a benchmark plan. Given the temporary nature of these changes, this report focuses on the marketplace subsidy structure that was in effect before enactment of the American Rescue Plan Act of 2021 and that will be in effect again under current law starting in 2023.

- For more information on how the Congressional Budget Office estimated the effect of these provisions, see Congressional Budget Office, Reconciliation Recommendations of the House Committee on Ways and Means (revised February 17, 2021), www.cbo.gov/publication/57005.
- In most states, the federal poverty level in 2021 is \$12,880 for a single person and increases by \$4,540 for each additional person in a household. Thus, for a single person, 400 percent of the FPL is \$51,520 in 2021.

The temporary increases to the marketplace subsidies and expanded eligibility for those subsidies would not significantly change the effect of the public option on federal outlays and revenues, health insurance premiums, or health insurance coverage after those provisions expired. However, in periods when the enhanced subsidies and a public option were both in effect, the impact of the public option on those outcomes would differ in two major ways:

- First, if the entry of the public option into a marketplace lowered the benchmark premium, the federal savings stemming from lower average premium tax credits would be higher because there would be more people enrolled in subsidized coverage as a result of the American Rescue Plan Act of 2021.
- Second, the American Rescue Plan Act of 2021 could lessen the effect of a public option on coverage rates. That is because the expanded eligibility for a marketplace subsidy would prompt people with income above 400 percent of the FPL who would otherwise have been uninsured to enroll in the marketplace plans. A public option would have the largest effect on subsidy-ineligible, uninsured people, and expanding eligibility to those with income above 400 percent of the FPL would decrease the overall size of that group.

marketplace subsidies or benefits could substantially increase coverage and federal subsidies, neither change is an essential component of a public option; they are therefore outside the scope of this report. (For a brief discussion of the temporary increases to marketplace subsidies enacted in the American Rescue Plan Act of 2021, see Box 1-1.)

Lawmakers have recently proposed legislation that would allow certain people who would not otherwise be eligible for Medicare or Medicaid to purchase coverage through—or "buy in" to—those programs. Such proposals would introduce design considerations and implications that differ from those raised by the type of public option considered in this report.<sup>8</sup>

For example, the Patient Protection and Affordable Care Enhancement Act (H.R. 1425, 116th Cong.) would increase marketplace subsidies without introducing a public option. See Congressional Budget Office, cost estimate for Rules Committee Print 116-56, Patient Protection and Affordable Care Enhancement Act (June 24, 2020), www.cbo.gov/publication/56434.

<sup>8.</sup> For more information, see Kaiser Family Foundation, "Compare Medicare-for-All and Public Plan Proposals" (May 15, 2019), https://tinyurl.com/rweag65. For examples of Medicare buy-in legislation, see the Expanding Health Care Options for Early Retirees Act (H.R. 4527 and S. 2552, 116th Cong.), the Medicare Buy-In and Health Care Stabilization Act of 2019 (H.R. 1346, 116th Cong.), and the Medicare at 50 Act (S. 470, 116th Cong.). For an example of Medicaid buy-in legislation, see the State Public Option Act (H.R. 1277 and S. 489, 116th Cong.).

In addition, this report does not consider any proposals that would establish a public option at the state level. Some of those proposals more closely resemble regulation of the rates that private insurers pay providers than they do a public option as defined here. Nor does this report consider proposals that would have the federal government contract with private insurers to bear the insurance risk.

Also outside the scope of this report, which focuses on the nongroup market, is a public option that employers could offer their employees. A public option available in the large-group or small-group markets would introduce its own set of design considerations and implementation challenges and would have significantly different budgetary consequences. (For a brief overview of those issues, see Box 1-2.)

#### Characteristics of the Current Nongroup Health Insurance Market

Several characteristics of the nongroup health insurance market have led policymakers to consider establishing a nongroup public option. Those characteristics include volatility in insurers' participation, a lack of competition, narrow provider networks, and provider payment rates and administrative costs that are often higher than those of publicly administered programs such as Medicare and Medicaid. A public option might mitigate those concerns to some extent, depending on how it was designed.

#### Volatility in Insurers' Participation and Lack of Competition

The number of insurers in the nongroup marketplaces has fluctuated over time as various insurers have entered and exited. In 2021, an average of 5.0 insurers are participating in at least one of the marketplaces in each state, up from 3.5 in 2018 but down from 6.0 in 2015. Volatility in insurers' participation in the marketplaces or in their plan offerings may force enrollees to involuntarily switch plans, which is one form of a phenomenon called insurance churning. That volatility undermines

the attractiveness of marketplace plans and may dissuade some people from signing up for coverage.<sup>11</sup>

In addition to that volatility, the marketplaces in some geographic areas have only a few insurers participating in them. Although participation by insurers has increased in recent years, 22 percent of enrollees live in a county with only one or two insurers in 2021 (see Figure 1-1 on page 10). Low insurer participation in the marketplaces limits enrollees' choice of a plan and lessens competition among insurers, thereby contributing to higher premiums. CBO found a negative association between the number of insurers in a marketplace and the premiums for the second-lowest-cost silver plan in a marketplace, which is consistent with academic research (see Figure 1-2 on page 11).12 In markets with four or more insurers, the average monthly premium for the second-lowest-cost silver plan is about \$330 in 2021, whereas in markets with only one insurer, the average monthly premium is about \$480.

#### **Narrow Provider Networks**

In 2017, 21 percent of plans in the marketplaces had physician networks that included less than a quarter of eligible physicians in the plan's area, and 41 percent of plans' networks included less than 40 percent of

For instance, Washington State introduced a version of a public option administered by private insurers for the 2021 plan year that caps aggregate payment rates at a specified multiplier of Medicare fee-for-service payment rates. For more information, see James C. Capretta, "Washington State's Quasi-Public Option," *The Milbank Quarterly*, vol. 98 (March 2020), https://tinyurl.com/y4omu2uo.

See Daniel McDermott and Cynthia Cox, *Insurer Participation* on the ACA Marketplaces, 2014–2021 (Kaiser Family Foundation, November 23, 2020), https://tinyurl.com/ydc6wlpb.

<sup>11.</sup> Churning, even when it does not result in gaps in coverage, has been associated with worsening quality of care in self-report surveys. For more information, see Benjamin D. Sommers and others, "Insurance Churning Rates for Low-Income Adults Under Health Reform: Lower Than Expected but Still Harmful for Many," *Health Affairs*, vol. 35, no. 10 (October 2016), pp. 1816–1824, http://doi.org/10.1377/hlthaff.2016.0455.

<sup>12.</sup> Researchers have estimated that the population-weighted average premium for the second-lowest-cost silver plan would have been reduced by 5.4 percent in 2014 if United Healthcare had entered all federally facilitated marketplaces and enrolled an average of 16 percent of enrollees in each market. The average benchmark premium would have been 11.1 percent lower if all insurers that sold individual coverage in a state had also sold nongroup marketplace coverage in each of that state's rating areas. For more information, see Leemore Dafny, Jonathan Gruber, and Christopher Ody, "More Insurers Lower Premiums: Evidence From Initial Pricing in the Health Insurance Marketplaces," American Journal of Health Economics, vol. 1, no. 1 (Winter 2015). pp.53-81, http://doi.org/10.1162/ajhe\_a\_00003. For further evidence on the relationship between premiums and insurers' participation in the marketplaces, see Linda J. Blumberg and others, Is There Potential for Public Plans to Reduce Premiums of Competing Insurers? (Urban Institute, October 2019), https://tinyurl.com/yyhk55og.

#### Box 1-2.

#### Creating a Public Option That Could Be Offered by Employers

In addition to establishing a federally administered public health insurance plan that would be offered in the nongroup market—often referred to as a public option—policymakers could make such a plan available to employers so that they could offer it to their employees.¹ Most people obtain health insurance coverage through their or a family member's employer, so a public option that employers could offer their employees could have a much greater impact on sources of coverage and federal subsidies for health insurance than one limited to the nongroup market.

Implementing a public option that could be offered by employers would be more complex than implementing one that was available only in the nongroup market. Specifically, allowing the public option to be offered through employers would change the set of design choices, the nature of the implementation challenges, and the magnitude of the effects on federal costs and on health insurance coverage. A detailed analysis of those questions is outside the scope of this report.

In general, an employment-based public option could be made available in any of the following forms:

- A fully insured plan in the small-group market. Small employers could offer the plan, and the federal government would bear the insurance risk. In most states, employers with
- 1. The nongroup market refers to the private market in which individuals and families purchase health insurance directly from an insurer, rather than obtaining it through an employer. Several legislative proposals would create a public option that would be available to employers. For example, the Choose Medicare Act (H.R. 2463 and S. 1261, 116th Cong.) and the Medicare-X Choice Act (H.R. 2000 and S. 981, 116th Cong.) would create a federal public option that would be offered to small employers through the Small Business Health Options Program marketplaces established by the Affordable Care Act. The Medicare-X Choice Act specifies that the public option would be made available in the small-group market only after it was offered in the nongroup market. The Choose Medicare Act would make a federal public option available in the large-group market and would allow the Centers for Medicare & Medicaid Services to act as a third-party administrator for self-insured employers.

50 or fewer employees qualify as small under the Affordable Care Act and are thus eligible to purchase small-group coverage.<sup>2</sup>

- A fully insured plan in the large-group market. Large employers could offer the plan, and the federal government would bear the insurance risk.
- A self-insured plan. Employers who offered the plan would bear the insurance risk, and the federal government would provide administrative services, such as forming provider networks and setting or negotiating payment rates. Under the Employee Retirement Income Security Act, self-insured plans are not subject to state regulations, and many of the federal regulations that apply to fully insured plans in the large-group market do not apply to self-insured plans.

#### **Design Considerations and Implementation Challenges**

Under current law, the small-group and nongroup markets are subject to many of the same regulations, which would make offering the public option in the small-group market simpler than offering it in the large-group market. In most cases, small-group premiums can vary only by rating area, family size, age (by no more than a specified ratio), and tobacco use; most private insurers in the small-group market participate in a single risk pool and make risk-adjustment transfers; and small-group insurers are subject to the same essential health benefit requirements as nongroup insurers.

Policymakers could decide to vary the public option's premiums by market segment (small group or nongroup). If both the public option and private insurers participated in the risk-adjustment system—which transfers funds among insurers on the basis of the relative health of their enrollees—it would be more challenging to set the same premiums in both the small-group and nongroup

Continued

eligible physicians.<sup>13</sup> Narrow hospital networks were also prevalent—29 percent of individuals eligible for marketplace plans had access only to a plan whose network

13. See Daniel Polsky, Janet Weiner, and Yuehan Zhang, Exploring the Decline of Narrow Networks on the ACA Marketplaces in 2017, LDI Issue Brief, vol. 21, no. 9 (Leonard Davis Institute of Health Economics, November 2017), https://tinyurl.com/y5gjgwqm.

included less than 70 percent of eligible hospitals.<sup>14</sup> Only 5 percent of firms offering health benefits to their

See Centers for Medicare & Medicaid Services, "Market Rating Reforms" (updated June 2, 2017), https://go.usa.gov/x74Ft.

<sup>14.</sup> See Erica Hutchins Coe, Jessica Lamb, and Suzanne Rivera, Hospital Networks: Perspective From Four Years of the Individual Market Exchanges (McKinsey Center for U.S. Health System Reform, May 2017), https://tinyurl.com/y3u3gjr6. If a network was tiered, the authors included only the hospitals in the lowest cost-sharing tier in their analysis.

Box 1-2. Continued

#### Creating a Public Option That Could Be Offered by Employers

markets because the premiums would need to account for anticipated risk-adjustment transfers in two separate markets.

Under current law, premiums for fully insured large-group plans can be experience rated, and large-group insurers do not participate in a federal risk-adjustment program.<sup>3</sup> If the public option was available in the large-group market and its premiums were experience rated, a premium-setting mechanism would have to be developed. If, instead, the public option's premiums were set using the nongroup market's rating rules, large firms with healthier employees would tend to prefer to self-insure or offer experience-rated private plans, and firms with sicker employees would tend to prefer the public option. If low administrative costs, provider payment rates, and prescription drug prices kept its premiums low, a public option might still attract firms with healthier employees.

Most employees in large firms have health coverage that is self-insured by their employer through an administrative services only (ASO) arrangement—that is, the employer pays for their enrollees' medical claims and contracts with a third party to form provider networks, negotiate payment rates, and process claims. If the public option was available as an ASO, the government would provide administrative services but would not need a premium-setting mechanism.

#### Implications for Enrollment and Federal Spending

A public option that was available in the nongroup market and through employers could have much higher enrollment than a

- 3. Experience rating refers to a method of setting premiums that predicts a group's future health care costs on the basis of its past experience, such as the actual cost of providing health care coverage to the group during a given period of time. For an overview of which Affordable Care Act provisions apply to fully insured large group plans, see Annie L. Mach and Bernadette Fernandez, Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA), Report R42069 (Congressional Research Service, February 2016).
- See Kaiser Family Foundation, 2018 Employer Health Benefits Survey (October 2018), https://tinyurl.com/ybqx9xnl.

nongroup-only public option for several reasons. The number of workers and dependents enrolled in employment-based plans is roughly 10 times the size of the population in the nongroup market.<sup>5</sup> Additionally, employers and employees might be more responsive to the lower premiums that a public option might offer than people in the nongroup market, who are insulated from premiums by the structure of subsidies. The availability of a public option could have a pronounced effect in the small-group market, because the decision of small employers to offer health insurance is more sensitive to premiums than that of large employers.<sup>6</sup>

The Congressional Budget Office expects that if the public option was offered by employers in the group market at premiums below current private premiums, employers would increase wages, which would increase taxable compensation and, in turn, federal tax revenues. Any costs of administering the program that were not covered by premium collections would, as long as appropriated funds were available, increase federal outlays.

If employers offered the public option and it paid providers lower rates than private insurers paid, the public option's impact on health care providers' revenues would also be greater than if the public option was available only in the nongroup market. Consequently, providers would be more likely to opt out of Medicaid and Medicare if participation in the public option was tied to those programs. The potential for spillover effects on the rates that private insurers negotiated with providers and the broader impact on private insurers would also be larger.

employees reported that they offered one or more plans that they considered to have a narrow network.<sup>15</sup>

After controlling for other factors, some researchers have found evidence to suggest that marketplace plans with narrow provider networks tend to have lower premiums. 16 Several possible explanations for that finding exist.

In CBO's baseline projections, 151 million people have employment-based coverage in 2021, and 14 million people have nongroup coverage. For more information, see Congressional Budget Office, Federal Subsidies for Health Insurance Coverage for People Under 65: 2020 to 2030 (September 2020), www.cbo.gov/publication/56571.

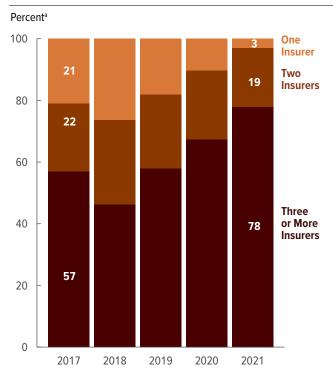
See Jonathan Gruber and Michael Lettau, "How Elastic Is the Firm's Demand for Health Insurance?" *Journal of Public Economics*, vol. 88, nos. 7–8 (July 2004), pp. 1273–1293, https://doi.org/10.1016/S0047-2727(02)00191-3.

<sup>15.</sup> See Kaiser Family Foundation, 2019 Employer Health Benefits Survey (September 25, 2019), Section 14, https://tinyurl.com/y47uagba.

<sup>16.</sup> See Leemore S. Dafny and others, "Narrow Networks on the Health Insurance Marketplaces: Prevalence, Pricing, and the Cost of Network Breadth," *Health Affairs*, vol. 36, no. 9 (September 2017), pp. 1606–1614, https://doi.org/10.1377/hlthaff.2016.1669.

Figure 1-1.

# Number of Insurers That People Enrolling in Coverage Through the Marketplaces Were Able to Choose From



Some of the nongroup health insurance marketplaces established by the Affordable Care Act are more competitive than others. The number of insurers participating in each of the more than 500 geographic rating areas across the country has ranged from 1 to 10 or more since 2017.

Data source: Congressional Budget Office, using data from Daniel McDermott and Cynthia Cox, *Insurer Participation on the ACA Marketplaces, 2014–2021* (Kaiser Family Foundation, November 2020), https://tinyurl.com/y37ugsc8. See www.cbo.gov/publication/57020#data.

a. Percentage of all people enrolled in a marketplace plan in a given year. For 2021, values are based on the number of people who signed up for a plan for the year in 2020. CBO modified the rounded percentages reported in the Kaiser Family Foundation report so that they would sum to 100 percent.

Plans with narrow networks may achieve savings by excluding high-priced or inefficient providers. Another possibility is that plans with narrow networks may be able to negotiate lower prices with providers in exchange for bringing a greater number of patients to those providers. In addition, the threat of exclusion from the network could induce providers to become more efficient and decrease unnecessary spending. Also, longer travel

times to receive care and greater difficulty scheduling appointments might dissuade enrollees in plans with a limited set of in-network providers from seeking some care.

Although narrow networks may result in lower premiums, they may also limit enrollees' access to care, especially in areas with a limited number of geographically accessible providers. One study of marketplace enrollees in California found that plans with narrow networks exacerbated the problem of limited access to providers for enrollees in rural areas. Moreover, plans with narrow networks often have limited coverage of out-of-network care, which can leave patients exposed to high medical bills. 18

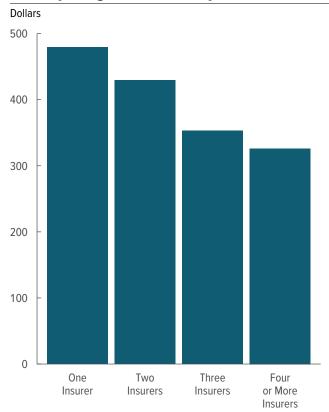
# Higher Provider Payment Rates Than Those Paid by Public Programs

CBO estimates that in 2020, the rates paid to providers by insurers in the broader commercial market (which includes employment-based plans and nongroup plans) were roughly twice as high as Medicare's rates for hospitals and 25 percent higher than the program's rates for physicians. <sup>19</sup> The net prices paid by commercial insurers for prescription drugs are, the agency estimates, somewhat higher than the net prices paid in

- 17. See Simon F. Haeder, David Weimer, and Dana B. Mukamel, "A Consumer-Centric Approach to Network Adequacy: Access to Four Specialties in California's Marketplace," *Health Affairs*, vol. 38, no. 11 (November 2019), pp. 1918–1926, https://doi.org/10.1377/hlthaff.2019.00116.
- 18. See Kathy Hempstead, "Marketplace Pulse: Percent of Plans With Out-of-Network Benefits" (Robert Wood Johnson Foundation, October 4, 2018), https://tinyurl.com/y5ryko74.
- 19. For more information, see CBO's Single-Payer Health Care Systems Team, How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program, Working Paper 2020-08 (Congressional Budget Office, December 2020), Section 4, www.cbo.gov/ publication/56811; Daria M. Pelech, "Prices for Physicians' Services in Medicare Advantage and Commercial Plans," Medical Care Research and Review, vol. 77, no. 3 (June 2020), pp. 236-248, https://doi.org/10.1177/1077558718780604; Eric Lopez and others, How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature (Kaiser Family Foundation, April 2020), https://tinyurl.com/y6yyb83z; and Jared Lane K. Maeda and Lyle Nelson, "How Do the Hospital Prices Paid by Medicare Advantage Plans and Commercial Plans Compare With Medicare Fee-for-Service Prices?" INQUIRY: The Journal of Health Care Organization, Provision, and Financing, vol. 55 (June 2018), pp. 1-8, https://doi.org/10.1177/0046958018779654.

Figure 1-2.

# Average Monthly Premiums of Benchmark Plans in 2021, by the Number of Insurers Participating in the Marketplace



The benchmark plan's premiums tend to be lower in geographic areas with more insurers, which accords with academic research suggesting that greater competition among insurers contributes to lower premiums.

Data source: Congressional Budget Office, using data from the Robert Wood Johnson Foundation's HIX Compare database. See www.cbo.gov/publication/57020#data.

Plans in the nongroup health insurance marketplaces established by the Affordable Care Act are classified according to their level of cost sharing into tiers named after precious metals. Under current law, the benchmark plan for a marketplace is the second-lowest-cost silver plan in that marketplace.

Medicare Part D.<sup>20</sup> Moreover, CBO projects that provider payment rates in the commercial market will grow faster than Medicare's rates over the next decade, which would further widen the gap between commercial and Medicare rates over time.<sup>21</sup>

CBO does not know of research estimating provider payment rates in the nongroup market for a broad range of services, but the agency expects that they fall between Medicare's rates and broader commercial rates, on average.<sup>22</sup> Two factors suggest that payment rates in the nongroup market are lower than the rates in the broader commercial market and that they could be lower than Medicare's rates in some markets: Nongroup plans generally have narrower provider networks than employment-based plans; and a significant number of

- 20. Net prices are the total prices paid at pharmacies minus rebates from manufacturers and other discounts. The net prices that Medicare Part D pays for outpatient prescription drugs are closer to the prices paid by commercial plans than are the program's prices for hospital and physicians' services because Medicare uses tools similar to those used by commercial plans to determine prices for outpatient prescription drugs. CBO expects that Medicare's net prices for outpatient prescription drugs are somewhat lower than those paid by private plans: Manufacturers are required to offer the highest rebate that they offer to any payer, excluding certain government programs, such as Medicare Part D; manufacturers may therefore be less willing to offer steep discounts to commercial plans than to Medicare Part D plans. For more information, see Congressional Budget Office, A Comparison of Brand-Name Drug Prices Among Selected Federal Programs (February 2021), www.cbo.gov/publication/56978.
- 21. In CBO's projections for 2020 to 2030, Medicare's payment rates grow by 2.3 percent per year for hospitals and by 0.3 percent per year for physicians, while commercial payment rates increase by 4.2 percent per year for hospitals and by 2.9 percent per year for physicians. For more information, see CBO's Single-Payer Health Care Systems Team, How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program, Working Paper 2020-08 (Congressional Budget Office, December 2020), Section 4, www.cbo.gov/publication/56811.
- 22. Recent studies have compared rates paid by nongroup plans with rates paid by employment-based plans and public programs, but they have done so only for a narrow set of physicians' services or by using data from the first years of the marketplaces. See Adam I. Biener and Thomas M. Selden, "Public and Private Payments for Physician Office Visits," *Health Affairs*, vol. 36, no. 12 (December 2017), pp. 2160–2164, https://doi.org/10.1377/hlthaff.2017.0749; and Heidi Allen and others, "Comparison of Utilization, Costs, and Quality of Medicaid vs Subsidized Private Health Insurance for Low-Income Adults," *JAMA Network Open*, vol. 4, no. 1 (January 2021), e2032669, https://doi.org/10.1001/jamanetworkopen.2020.32669.

Medicaid managed care organizations, which typically have narrow provider networks, participate in the nongroup marketplaces. Payment rates are lower, on average, in narrow network plans. <sup>23</sup> Likewise, insurers participating in Medicaid managed care tend to pay providers lower rates than employment-based plans, and they may pay lower rates than other marketplace plans, too. <sup>24</sup> One study reports that average spending is lower in the nongroup market than in the employment-based group market even though enrollees in the nongroup market have higher risk scores, on average. <sup>25</sup> That discrepancy suggests that provider payment rates of plans in the nongroup market may be lower than those of

- 24. See Erik Wengle and others, Effects of Medicaid Health Plan Dominance in Health Insurance Marketplaces (Urban Institute, June 2020), https://tinyurl.com/yy6wzthy; and Katherine Hempstead, "Marketplace Pulse: Medicaid Managed Care Organizations in the Individual Market" (Robert Wood Johnson Foundation, May 20, 2019), https://tinyurl.com/yxsnz5ty.
- 25. See Brett Lissenden and others, "A Comparison of Health Risk and Costs Across Private Insurance Markets," *Medical Care*, vol. 58, no. 2 (February 2020), pp. 146–153, https://doi.org/10.1097/MLR.0000000000001239.

employment-based group plans, though nongroup plans' more stringent care management and the fact that they generally require enrollees to pay a larger share of costs than employment-based plans may also contribute to the difference in average spending.

# **Higher Administrative Costs Than Those of Other Payers**

Administrative costs in the nongroup market accounted for an average of 17 percent of total premiums from 2015 to 2018.26 That administrative cost share is higher than in most other market segments, partly because, on average, nongroup insurers have fewer enrollees—and thus less revenue from premiums—yet many administrative costs are fixed (that is, they do not vary with the number of enrollees). By comparison, CBO estimates that in 2020, administrative costs accounted for 8 percent of total spending for Medicaid, 2 percent of Medicare's fee-for-service (FFS) program spending, 7 percent of all spending for Medicare (including spending for FFS, Medicare Advantage, and Part D), and 12 percent of private plans' spending, on average. Such expenses include the cost of claims processing and appeals, quality improvement, advertising, fraud reduction programs, educational activities for beneficiaries, certification of providers, general information technology, accounting costs, taxes, salaries and broker compensation, and (for private insurers) profits and losses.

<sup>23.</sup> See John A. Graves and others, "Breadth and Exclusivity of Hospital and Physician Networks in U.S. Insurance Markets," *JAMA Network Open*, vol. 3, no.12 (December 2020), e2029419, http://doi.org/10.1001/jamanetworkopen.2020.29419; Leemore S. Dafny and others, "Narrow Networks on the Health Insurance Marketplaces: Prevalence, Pricing, and the Cost of Network Breadth," *Health Affairs*, vol. 36, no. 9 (September 2017), pp. 1606–1614, https://doi.org/10.1377/hlthaff.2016.1669; and Jonathan Gruber and Robin McKnight, "Controlling Health Care Costs Through Limited Network Insurance Plans: Evidence From Massachusetts State Employees," *American Economic Journal: Economic Policy*, vol. 8, no. 2 (May 2016), pp. 219–250, https://doi.org/10.1257/pol.20140335.

<sup>26.</sup> See CBO's Single-Payer Health Care Systems Team, How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program, Working Paper 2020-08 (Congressional Budget Office, December 2020), Box 14-1, www.cbo.gov/publication/56811.

# **Chapter 2: Key Design Considerations**

This report focuses on the following key design considerations that policymakers will face as they develop proposals that would create a public option:

- Would the public option conform with state insurance regulations pertaining to benefit packages, how premiums are set, reserve funds, and network adequacy?
- Would the public option be offered in multiple metal tiers, and would it be available outside the marketplaces?
- How would provider payment rates for medical services and the prices of prescription drugs be determined?
- Would Medicare or Medicaid providers be required to participate in the public option?
- How would the public option's administrative activities and administrative costs compare with those of private insurers?
- Would the public option participate in the riskadjustment system, which transfers funds among insurers on the basis of the relative health of their enrollees?
- How would the public option be funded? How would excess premiums or shortfalls be handled?
- Would the public option be offered everywhere or only in geographic areas with low insurer participation or high premiums?

#### **Conformity With State Regulations**

An important question for policymakers is whether, or to what extent, the public option would conform with state insurance regulations. Because it would be administered by a federal entity, the public option would not necessarily be subject to those regulations, but the Congress could nevertheless specify that the public option conform with them. For example, each state sets its own requirements for coverage of specific services for nongroup insurers in the marketplaces, resulting in variation among states in the services that insurers must

cover.¹ The public option could offer a single national benefit package that covered all services that were mandated by any state. In that case, the public option's benefit package would be more generous than private plans in some states. If, instead, the public option was designed to provide a single national benefit package that did not conform with all state regulations, it could be less generous than private plans in some states. A third option would be to design a public option benefit package that matched each state's set of required benefits. Such a plan would align more closely with existing private plans, but it would be more complex to administer.

In addition to benefit-package requirements, private insurers are subject to other state regulations and to a review of their premiums. Some states allow less variation in premiums by age than the federal government permits.<sup>2</sup> If the public option's premiums were set using the Affordable Care Act's broader age requirements and did not conform with state requirements, the public option in such states would be more attractive to younger enrollees, who are healthier, on average. Also, determining the benchmark plan and premium tax credit would pose significant implementation challenges if the public option did not adhere to state premium-setting rules. Policymakers would also need to decide whether the public option would voluntarily conform with rules, which vary from state to state, regarding the amount of reserve funds that private insurers are required to hold to prevent insolvency. Furthermore, states use a variety of qualitative and quantitative standards to measure network adequacy. Policymakers could decide whether

<sup>1.</sup> The Affordable Care Act mandates that health insurance plans cover 10 categories of essential health benefits (EHB), and states have their own benefit requirements and develop their own EHB benchmark. For example, in 2014 and 2015, 10 percent of states included weight-loss services in the EHB benchmark, 37 percent included infertility treatments, and 88 percent included chiropractic care. See Janet Weiner and Christopher Colameco, Essential Health Benefits: 50-State Variations on a Theme (Leonard Davis Institute of Health Economics and Robert Wood Johnson Foundation, October 2014), https://tinyurl.com/y6o34zxy.

See Centers for Medicare & Medicaid Services, "Market Rating Reforms" (updated June 2, 2017), https://go.usa.gov/x74Ft.

state regulators would need to approve the network adequacy of the public option or if the public option would have its own standards. If the public option had its own standards, private insurers could be subject to stricter standards than the public option in some states and looser standards in others.

# Metal Tiers and Availability Outside the Marketplaces

The public option could be offered in all the metal tiers of marketplace insurance plans (bronze, silver, gold, and platinum) or in only a subset; for this analysis, the Congressional Budget Office assumed that the public option would always be offered in the metal tier of the benchmark plan.<sup>3</sup> Moreover, multiple public plans could be offered within a metal tier or just a single plan. If multiple plans were offered in a tier, they might have varying combinations of cost sharing and deductibles and provide different benefits, such as coverage of dental and vision care.

Additionally, the public option could be offered exclusively in the marketplaces, or it could also be available for purchase outside the marketplaces, which would require a separate enrollment platform. An off-marketplace nongroup public option could be more attractive to certain segments of the population than one offered in the marketplaces. For example, premiums of off-marketplace silver plans are often lower than those of marketplace silver plans because in many cases private insurers cover the costs of cost-sharing reductions—that is, discounts that reduce the out-of-pocket expenses of qualifying individuals—by increasing premiums for silver plans offered through the marketplaces. If the

costs of cost-sharing reductions for the public option were also covered through the premium of the market-place silver plan, the premium of a silver plan outside the marketplace could be lower than that of a marketplace silver plan, making the off-marketplace public option more attractive to unsubsidized enrollees. Additionally, an off-marketplace public option would be more attractive to employees with an individual coverage health reimbursement arrangement—a tax-advantaged account that employers can offer to employees for the purchase of a nongroup plan. Employees can use their contributions to such an account, which reduce their taxable income, to purchase off-marketplace coverage; that tax benefit is not available for the purchase of marketplace coverage.<sup>6</sup>

# In-Network Provider Payment Rates for Medical Services

One key factor influencing a health plan's premiums is the payment rates paid to providers for covered services. There are two broad approaches to determining in-network provider payment rates that the federal government could consider—administering rates or negotiating them.

#### **Administered Rates**

The federal government could specify formula-driven payment rates in law or regulation. It could use the Medicare fee-for-service rates, a multiplier of Medicare rates, or a new fee schedule. A multiplier could be an across-the-board increase to Medicare rates—120 percent or 150 percent of the Medicare FFS rate schedule, for example—or policymakers could make targeted increases to Medicare rates. Medicare already has payment pol-

<sup>3.</sup> For example, the Public Option Deficit Reduction Act (H.R. 1419, 116th Cong.) and the Keeping Health Insurance Affordable Act of 2019 (S. 3, 116th Cong.) would require that a bronze, silver, and gold plan be offered. The CHOICE Act (H.R. 2085 and S. 1033, 116th Cong.) and Medicare-X Choice Act (H.R. 2000 and S. 981, 116th Cong.) would require that silver and gold plans be offered. The Choose Medicare Act (H.R. 2463 and S. 1261, 116th Cong.) would require that a gold plan be offered and would increase the metal tier of the benchmark plan from silver to gold.

For example, the CHOICE Act (H.R. 2085 and S. 1033, 116th Cong.), the Keeping Health Insurance Affordable Act of 2019 (S. 3, 116th Cong.), and the Public Option Deficit Reduction Act (H.R. 1419, 116th Cong.) would make the public option available only in the marketplaces.

The federal government stopped funding cost-sharing reductions in late 2017. Judicial decisions have since required the federal government to fund those reductions—but only to the extent

that insurers do not otherwise recoup the costs of the reductions by embedding them in the premiums of their marketplace plans. For more information, see *Sanford Health Plan v. United States*, 969 F.3d 1370 (Fed. Cir. 2020) and *Community Health Choice*, *Inc. v. United States*, 970 F.3d 1364 (Fed. Cir. 2020).

<sup>6.</sup> For more information, see HealthCare.gov, "Individual Coverage Health Reimbursement Arrangements (HRAs)" (accessed February 5, 2020), https://go.usa.gov/xAc9S.

<sup>7.</sup> For example, the Keeping Health Insurance Affordable Act of 2019 (S. 3, 116th Cong.) and the Public Option Deficit Reduction Act (H.R. 1419, 116th Cong.) specify that the public option would use Medicare FFS rates for the first three years. After that, new rates could be developed, but average medical costs could not exceed what they would be under the Medicare FFS rates.

<sup>8.</sup> For example, the Medicare-X Choice Act (H.R. 2000 and S. 981, 116th Cong.) gives the Secretary of Health and Human Services the authority to increase reimbursement rates in rural areas by up to 25 percent.

icies in place to preserve access to rural health care, but the public option could apply further increases—say, 125 percent of the Medicare FFS rate schedule—in rural areas.9 Basing payment rates on Medicare rates would leverage the existing infrastructure for setting Medicare payments and thereby decrease administrative costs for the public option. That approach would also incorporate geographic variation in payment rates, though the geographic variation in commercial prices is much greater than the variation in Medicare payment rates. 10 If the federal government developed a new fee schedule, it could be based on average or median commercial rates. Such an approach would be more administratively complex than using the existing Medicare FFS rate schedule because it would require the development of a system for collecting and processing commercial claims data.

#### **Negotiated Rates**

The federal government could negotiate with health care providers to determine payment rates, as commercial insurers currently do. In general, the outcomes of negotiations over payment rates reflect the negotiating leverage of insurers and providers. Insurers with larger market shares are typically able to negotiate lower payment rates, and hospitals and physician groups with large market shares are typically able to negotiate higher payment rates. Providers might also accept lower rates to participate in a narrower network. The federal government would need to develop an approach to conducting those negotiations; it could either negotiate directly with

thousands of health care providers or contract with an outside party to conduct negotiations.

Although negotiated payment rates would not be set in statute, policymakers could impose certain constraints on the negotiations, such as upper or lower limits on the rates. Such limits on the public option's negotiated rates could be based on Medicare rates or on commercial rates. Those limits could be specified for particular procedures or services, or they could be based on an aggregate measure and apply to all services. A provider who did not accept the public option's final payment rate offer would be out of the public option's network. Regardless of the specific approach chosen, negotiating rates would be more administratively complex than adopting a formula-driven approach to rate setting and would involve additional expenses.

#### **Implementation Challenges**

If the public option's payment rates were negotiated, the negotiations would be administratively complex and difficult to implement. The federal government could choose to negotiate directly with thousands of health care providers, but policymakers would need to develop a new infrastructure and system for conducting the negotiations. Alternatively, the federal government could choose to contract with one or more third parties to negotiate with providers; but without transferring insurance risk, aligning contractors' incentives to negotiate lower rates with the government's incentives could be difficult. In addition, the government would incur significant expenses to hire contractors for such purposes. Moreover, priorities could shift from one Administration to the next—a situation that would lead to greater uncertainty in payment rates over time. For example, one Administration might prioritize negotiating low payment rates, whereas another might prioritize attracting providers and thus agree to higher rates.

If the public option's payment rates, whether administered or negotiated, were tied to commercial rates, several implementation challenges would arise. First, using commercial rates to determine the public option's rates would create additional administrative complexities and costs, and policymakers would have to determine which commercial rates to include, which sources of data to use,

<sup>9.</sup> For more information on Medicare's efforts to preserve access to care in rural areas, see Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System* (June 2016), Chapter 7, https://go.usa.gov/x79rn (PDF, 278 KB).

See Bill Johnson and others, Comparing Commercial and Medicare Professional Service Prices (Health Care Cost Institute, August 2020), https://tinyurl.com/y3dzsss2.

<sup>11.</sup> See Eric T. Roberts, Michael E. Chernew, and J. Michael McWilliams, "Market Share Matters: Evidence of Insurer and Provider Bargaining Over Prices," *Health Affairs*, vol. 36, no. 1 (January 2017), pp. 141–148, https://doi.org/10.1377/hlthaff.2016.0479; Martin Gaynor, Kate Ho, and Robert J. Town, "The Industrial Organization of Health-Care Markets," *Journal of Economic Literature*, vol. 53, no. 2 (June 2015), https://doi.org/10.1257/jel.53.2.235; and Glenn A. Melnick, Yu-Chu Shen, and Vivian Yaling Wu, "The Increased Concentration of Health Plan Markets Can Benefit Consumers Through Lower Hospital Prices," *Health Affairs*, vol. 30, no. 9 (September 2011), pp. 1728–1733, https://doi.org/10.1377/hlthaff.2010.0406.

<sup>12.</sup> For example, the Choose Medicare Act (H.R. 2463 and S. 1261, 116th Cong.) specifies that, "in the aggregate," prices should be no higher than those paid by nongroup insurers in the marketplace and no lower than those paid by Medicare.

and how frequently to update the data. Tying the public option's payment rates to those in the fully insured group market and self-insured market would most likely result in higher rates than tying them only to the nongroup market's rates.

Similarly, policymakers would need to decide whether the relevant commercial price was an average among all geographic areas or specific to each rating area. If the commercial price of all markets was averaged and that average price was the upper bound in rate negotiations, the government would face difficult coordination challenges when negotiating with multiple hospital and provider systems in multiple markets. If, instead, the commercial price was measured in each rating area separately, some of those implementation challenges would be mitigated, but more-detailed data on private payment rates would be required.

Finally, basing the public option's payment rates on commercial rates could affect providers' negotiations with private insurers. In some cases, providers might be less willing to give price concessions to private insurers because those concessions would not only lower private payments but also decrease the price used to determine public option rates.

Paying providers at or around Medicare rates for enrollees in the public option could negatively affect the revenues of some providers. However, because the nongroup market accounts for a relatively small share of total enrollment in the broader commercial market, the effect on providers' revenues would be limited.

#### Out-of-Network Benefits and Payment Rates for Out-of-Network Providers

Another important design consideration for the public option is whether out-of-network care would be covered and, if so, under what circumstances. At one extreme, the public option could operate like a health maintenance organization (HMO) and not cover any out-of-network care beyond emergency services, which are required to be covered without prior authorization under the Affordable Care Act and the Consolidated Appropriations Act, 2021 (Public Law 116-260).<sup>13</sup> An

HMO-style benefit would reduce the public option's claims costs but would require enrollees to pay for most or all of their care if they elected to receive nonemergency out-of-network services, particularly if the provider network was narrow. At the other extreme, the public option could cover all out-of-network care with no additional cost sharing for patients. That approach would provide more comprehensive protection for enrollees, but it would also increase the public option's claims costs and limit the plan's ability to steer enrollees toward higher quality or more cost-effective providers. Another approach would be for the public option to cover out-ofnetwork care but require enrollees to pay a larger share of the cost for that care. In many plans currently offered in the marketplaces, enrollees face very high cost sharing for out-of-network care.14 If out-of-network care was covered under the public option, it would also be important to determine whether providers would be allowed to bill patients for amounts beyond their required copayments and coinsurance.15

How the out-of-network payment standard would influence in-network payment rates for the public option would depend on several factors: the extent to which the public option covered out-of-network care, patients' share of the cost for such care (including whether patients were required to pay any costs in addition to their required copayments and coinsurance), and providers' ability to turn away out-of-network patients. Those factors would affect the attractiveness to providers of staying out of network versus accepting in-network payment rates. However, the specific effects of out-of-network standards on in-network rates would depend on how payment rates were set and the degree of leverage providers had in securing higher in-network rates.

<sup>13.</sup> The ACA required all marketplace plans to cover emergency services even if they were out of network, but it did not prohibit health care providers from billing patients for any expenses beyond what the health plan paid them. Starting in 2022, the No Surprises Act, a provision of the Consolidated Appropriations

Act, 2021, requires health insurers to cover out-of-network care in cases of emergencies or when such care is provided by an ancillary provider at an in-network facility. In such situations, providers are prohibited from billing patients beyond what they are required by their plan to pay in coinsurance and copayments.

<sup>14.</sup> See Kathy Hempstead, "Marketplace Pulse: Percent of Plans With Out-of-Network Benefits" (Robert Wood Johnson Foundation, October 4, 2018), https://tinyurl.com/y5ryko74.

<sup>15.</sup> For example, the Choose Medicare Act (H.R. 2463 and S. 1261, 116th Cong.) and the Keeping Health Insurance Affordable Act of 2019 (S. 3, 116th Cong.) specify that the public option would use Medicare rules that limit how much providers can charge patients for out-of-network services. The allowed amount is the maximum amount—including amounts paid by the plan and the patient—that a health plan will pay a provider for a covered service.

#### **Pricing of Prescription Drugs**

In addition to deciding how the prices of medical services would be set, policymakers would need to specify an approach to determining prices for prescription drugs under the public option. The prices paid for prescription drugs vary widely among health plans and federal programs, and they depend, in part, on the approach policymakers adopt. <sup>16</sup> Policymakers could consider several different strategies, including authorizing the Secretary of Health and Human Services (HHS) to negotiate drug prices with manufacturers, contracting with a private pharmacy benefit manager (PBM) to negotiate prices, or setting prices in law or regulation. <sup>17</sup>

# Authorize the Secretary of Health and Human Services to Negotiate Prices

The effectiveness of authorizing the HHS Secretary to negotiate drug prices, as several recent legislative proposals would do, would depend on the degree of leverage granted to the Secretary, which could vary substantially, and on the extent to which the Secretary exercised that leverage. <sup>18</sup> The Secretary's bargaining position could be

- 16. The prices for brand-name prescription drugs in Medicare Part D are determined through negotiations between plan sponsors or PBMs and manufacturers under market conditions similar to those affecting commercial insurers. By contrast, the prices of prescription drugs in Medicaid are heavily influenced by manufacturer rebates that are specified in federal statute. For more information, see Congressional Budget Office, A Comparison of Brand-Name Drug Prices Among Selected Federal Programs (February 2021),www.cbo.gov/publication/56978.
- 17. Most recent proposals for a public option have authorized the HHS Secretary to negotiate drug prices. For example, see the Keeping Health Insurance Affordable Act of 2019 (S. 3, 116th Cong.), the Medicare-X Choice Act (H.R. 2000 and S. 981, 116th Cong.), the CHOICE Act (H.R. 2085 and S. 1033, 116th Cong.), and the Choose Medicare Act (H.R. 2463 and S. 1261, 116th Cong.). Another option would be to contract pharmaceutical coverage to a private insurer, as is done for Medicare Part D.
- 18. In the context of Medicare Part D, CBO has determined that negotiation is likely to be effective only if it is accompanied by some source of pressure on drug manufacturers to agree to price concessions. For CBO's analysis of price negotiations in Medicare Part D, see Congressional Budget Office, letter to the Honorable Chuck Grassley regarding negotiation over drug prices in Medicare (May 17, 2019), www.cbo.gov/publication/55270. In its recent analysis of the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3, 116th Cong.), CBO determined that imposing limits on the negotiated price and subjecting drug manufacturers that did not participate in negotiations or agree to a negotiated price to an excise tax would result in lower negotiated prices. The authority to impose a tax on a manufacturer that did not agree to the Secretary's price would

enhanced by using tools such as a tiered formulary (a list with drugs divided into different tiers that require beneficiaries to pay varying amounts) and the ability to exclude one or more drugs in a therapeutic class (a group of drugs that treat a common condition) or to require preauthorization for their use. The ability to require preauthorization for drugs that do not have therapeutic competition would add additional leverage.

Conversely, other policies, such as requiring certain drugs to be covered, could weaken the Secretary's bargaining position. An illustration of such a policy is provided by the requirement, which does not apply to commercial insurers, that Medicare Part D plans cover certain drugs—specifically, all drugs in six "protected" therapeutic classes. That requirement improves beneficiaries' access to those drugs, but it also diminishes the leverage of plans to obtain lower net prices for them. Without the ability to exclude a drug from a formulary, the authority to negotiate would, on its own, be unlikely to yield prices below those paid by commercial plans and could result in prices that were higher than the prices paid by those plans.

Authorizing the HHS Secretary to negotiate prescription drug prices would be a new approach, so resolving implementation challenges would probably take more time. Moreover, if the Secretary was granted discretion in the negotiation of drug prices, the Secretary's willingness to limit access to certain high-priced drugs to secure lower average prices could change with Administrations.

#### **Contract With a Private Entity**

Contracting with a pharmacy benefit manager and granting it the authority to negotiate with drug manufacturers on behalf of the public option would be most similar to the approach taken by private insurers and self-insured employers. In that scenario, a PBM would negotiate prices with drug manufacturers under market conditions similar to those that private insurers face and thus would most likely reach agreement on similar prices. Many of the same bargaining tools that would be available to an HHS Secretary who was authorized to negotiate drug prices would also be available to a PBM, and any

have the same effect as excluding a drug from the public option's formulary if the tax was high enough to cause the manufacturer to lose money on sales of the drug in the United States. For more information, see Congressional Budget Office, letter to the Honorable Frank Pallone Jr. regarding the budgetary effects of H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act (December 10, 2019), www.cbo.gov/publication/55936.

requirements placed on the public option's formularies—such as a minimum number of drugs within a therapeutic class that it must cover—could weaken the PBM's leverage, just as they would the Secretary's leverage.

The net prices paid for prescription drugs under the public option would be greatly affected by the rebates that the PBM received from drug manufacturers. PBMs can secure rebates by including a manufacturer's drug on a plan's formulary or by placing the drug in a tier that requires beneficiaries to pay a smaller amount, making it more attractive to beneficiaries than competing drugs. Thus, the prices paid by the public option would depend on the leverage available to the PBM to negotiate rebates, which would, in turn, depend on whether the public option managed beneficiaries' use of prescription drugs through tiered formularies and similar approaches. <sup>20</sup>

#### **Set Prices in Law or Regulation**

If prices were set by statute, the administered prices could vary widely on the basis of how those prices were determined. For example, if prices were set around the average prices paid in Medicare Part D, they would be substantially higher than if they were based on prices paid in Medicaid. (The Medicaid Drug Rebate Program, which specifies the rebates that drug manufacturers must pay to state Medicaid agencies, keeps prices in the program relatively low.) Policymakers could also grant the public option the authority to use prices in the federal supply schedule for pharmaceuticals, which establishes prices for all federal purchasers that buy drugs directly from wholesalers or manufacturers and provide their own dispensing services. Those prices, which are determined by statutory rebates and negotiation between the Department of Veterans Affairs and drug manufacturers, fall between Medicaid prices and Medicare Part D prices. The simplest approach, administratively, would be for the statute to require that prices be based on an existing fee schedule.

Tying drug prices in the public option to prices in private markets or in another federal program could

have spillover effects on other payers. In Medicaid, for example, manufacturers currently owe a rebate that is based in part on the lowest price paid by any buyer, excluding certain government programs. That rebate makes it more costly for manufacturers to offer large discounts to those buyers because doing so increases the rebate under Medicaid; consequently, they charge higher prices in the private market than they would otherwise for brand-name drugs. That spillover effect is greater for drugs with a larger Medicaid market share.<sup>21</sup> If the public option paid lower prices for drugs, that could also hinder pharmaceutical innovation, especially if it had a sizable effect on manufacturers' revenue streams from different pharmaceutical products. However, any such effect would probably be negligible because the nongroup public option's market share is expected to be relatively small.

# Provider Participation and Ties to Participation in Medicare and Medicaid

To construct a provider network for the public option, policymakers could tie participation in the public option to participation in other public programs. They could, for example, make participation in the public option a condition of participating in Medicare. <sup>22</sup> Tying participation in the public option to participation in other public programs could result in a broader provider network and thus increase the attractiveness of the public option. Survey data suggest that according to some measures—such as patients' having a usual source of care and providers' acceptance rates for new patients—Medicare beneficiaries' access to care is comparable to or better than that of people with private health insurance. <sup>23</sup>

- 21. See Mark Duggan and Fiona M. Scott Morton, "The Distortionary Effects of Government Procurement: Evidence From Medicaid Prescription Drug Purchasing," *The Quarterly Journal of Economics*, vol. 121, no. 1 (February 2006), pp. 1–30, https://doi.org/10.1093/qje/121.1.1.
- 22. The Medicare-X Choice Act (H.R. 2000 and S. 981, 116th Cong.) specifies that a provider who opted out of the public plan would not be allowed to participate in Medicare.
- 23. See Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy (March 2020), Chapter 4, pp. 107–140, https://go.usa.gov/xAPRt (PDF, 368 KB); Kayla Holgash and Martha Heberlein, "Physician Acceptance of New Medicaid Patients: What Matters and What Doesn't," Health Affairs Blog (April 10, 2019), https://tinyurl.com/y4k6ubre; and Juliette Cubanski and others, A Primer on Medicare: Key Facts About the Medicare Program and the People It Covers (Kaiser Family Foundation, March 2015), https://tinyurl.com/y222ehfg.

<sup>19.</sup> Different tiers usually have varying cost-sharing requirements. Generic drugs typically require beneficiaries to pay the smallest amount, followed by preferred brand-name drugs (drugs for which the plan has negotiated a rebate in exchange for preferred status) and then nonpreferred brand-name drugs.

<sup>20.</sup> For more information, see Commonwealth Fund, *Pharmacy Benefit Managers and Their Role in Drug Spending* (April 2019), https://doi.org/10.26099/njmh-en20.

For many types of care, the Medicare provider network would probably provide sufficient coverage for public option enrollees. However, some types of providers, including pediatricians, are currently underrepresented in Medicare, so limiting required participation to Medicarecertified providers might not result in an adequate provider network for a nongroup public option. If provider payment rates were determined through negotiation, requiring Medicare providers to participate in the public option would give the public option more negotiating leverage and could support lower payment rates. CBO does not expect that requiring Medicare providers to participate in the public option would cause a substantial number of providers to opt out of Medicare because the number of people enrolled in marketplace plans is much smaller than the number enrolled in Medicare. However, for the specialties that are underrepresented in Medicare, the public option's negotiating leverage associated with participation requirements would be substantially weaker.

Policymakers could extend the participation requirement to providers who participate in Medicaid. Doing so would increase patient access and add to the number of providers in specialties such as pediatrics in the public option's network, though Medicaid patients' access to physicians tends to be more limited than that of privately insured or Medicare patients. The limited access to care in Medicaid is driven by several factors, including that the program has lower payment rates and higher rates of denied claims than private insurance and Medicare. However, the public option might not have those issues: It would have different plan characteristics from Medicaid, so, even without a statutory requirement, Medicaid providers might find participating in the public option attractive.

Requiring providers who participate in Medicare or Medicaid to also participate in the public option would not, in itself, guarantee access to care for public option enrollees. For instance, providers might limit the availability of appointments for public option enrollees or see enrollees only at certain clinics. In addition to tying participation in the public option to participation in other public programs, policymakers could specify access standards. For example, they could ensure that a minimum

percentage of contracted providers were accepting new patients, or they could establish maximum wait times for appointments with providers.<sup>25</sup> The Centers for Medicare & Medicaid Services and state Medicaid agencies might have difficulty enforcing those standards.

Alternatively, policymakers could choose not to require Medicare or Medicaid providers to participate in the public option. In that case, provider payment rates would be one important factor in a provider's decision to participate in the program. Another factor that could affect provider participation would be whether the program was structured to require certain providers to opt in or out. If, for example, Medicare providers had to opt out—that is, if those providers participated in the public option by default—participation would probably be greater than if providers had to opt in. Policymakers could also use a number of other strategies to encourage participation, such as forgiving qualifying providers' medical school loans.

#### **Administrative Activities and Taxes**

The costs of administering the public option would depend on the design choices made by policymakers. A nationally standardized public option—for example, one that used administered rates based on Medicare, the Medicare provider network, and a single benefit package—would have larger economies of scale and lower administrative costs than a public option with negotiated payment rates, a tailored provider network, and benefit packages that varied by state.

One important determinant of administrative costs is the care management strategies that are used, such as

<sup>24.</sup> See Abe Dunn and others, *The Costs of Payment Uncertainty in Healthcare Markets*, Working Paper 2020-13 (Federal Reserve Bank of San Francisco, April 2020), https://doi.org/10.24148/wp2020-13.

<sup>25.</sup> The ACA required marketplace health plans to provide their enrollees with access to covered services "without unreasonable delay." Recently, the federal network-adequacy requirements became looser, and more responsibility for ensuring network adequacy was delegated to state regulators. Those regulators use a variety of qualitative and quantitative standards, so network-adequacy requirements vary considerably from state to state. See Jane B. Wishner and Jeremy Marks, Ensuring Compliance With Network Adequacy Standards: Lessons From Four States (Urban Institute, March 2017), https://tinyurl.com/y2d2rgzm.

<sup>26.</sup> Several recent legislative proposals—including the Keeping Health Insurance Affordable Act of 2019 (S. 3, 116th Cong.), the Public Option Deficit Reduction Act (H.R. 1419, 116th Cong.), and the CHOICE Act (H.R. 2085 and S. 1033, 116th Cong.)—would not require Medicare or Medicaid providers to participate in the public option. But unless they opted out, those providers would become participating providers in the public option by default.

requiring prior authorization for medical services and referrals for specialty care. Such strategies increase the administrative costs of operating the plan but decrease the quantity of health care services utilized and thus lower the overall costs of the plan. Medicare fee-forservice employs fewer care management tools than Medicare Advantage or commercial insurers, on average. For example, the program does not require prior authorization (except under limited circumstances), it does not require patients to obtain a referral before their initial visit to many types of specialists, and it does not impose direct limits on the number of appointments with physicians that it will cover each year.<sup>27</sup> If the public option used care management strategies that were more intensive than those used by Medicare FFS, it would have to define those protocols. CBO expects that the reductions in utilization and claims costs associated with care management strategies could offset the increased administrative costs of using them, but the offsetting effects are generally uncertain.<sup>28</sup>

Policymakers could choose whether the public option would advertise and, if so, whether the advertising campaign would be specifically for the public plan or for marketplace coverage more broadly.<sup>29</sup> Similarly, policymakers

27. See Centers for Medicare & Medicaid Services, "How Original Medicare Works" (accessed October 16, 2020), https://go.usa.gov/x75CX; Vilsa Curto and others, "Health Care Spending and Utilization in Public and Private Medicare," American Economic Journal: Applied Economics, vol. 11, no. 2 (April 2019), pp. 302–332, http://dx.doi.org/10.1257/app.20170295; and Gretchen Jacobson and Tricia Neuman, "Prior Authorization in Medicare Advantage Plans: How Often Is It Used?" (Kaiser Family Foundation, October 24, 2018), https://tinyurl.com/yyv6jdqo.

- 28. For more information on how CBO views the relationship between the administrative costs of care management and the associated reductions in utilization, see CBO's Single-Payer Health Care Systems Team, How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program, Working Paper 2020-08 (Congressional Budget Office, December 2020), Sections 9 and 12, www.cbo.gov/publication/56811.
- 29. Research suggests that private insurers use advertising strategically to attract healthier enrollees. That practice would have larger implications if the public option had its own separate risk pool. See Naoki Aizawa and You Suk Kim, "Advertising and Risk Selection in Health Insurance Markets," *American Economic Review*, vol. 108, no. 3 (March 2018), pp. 828–867, https://doi.org/10.1257/aer.20151485. Research also suggests that government spending on advertising for the marketplaces increases enrollment. See Naoki Aizawa and You Suk Kim, *Government Advertising in Market-Based Public Programs: Evidence From the Health Insurance Marketplace*,

could choose whether to pay brokers to help people enroll in the public option, as private insurers often do.<sup>30</sup>

The public option's administrative costs could include several types of taxes and fees that private insurers are required to pay, or the public option could be exempted from those taxes and fees.<sup>31</sup> For example, private insurers must pay a user fee to offer plans through the online health insurance marketplace platform operated by the federal government; the public option could be exempted from that fee.<sup>32</sup> States generally do not have the authority to impose taxes on federal programs, such as Medicare Advantage, Medicare Part D, and Federal Employees Health Benefits plans.<sup>33</sup> The Congress could, however, require the public option to make payments to states instead of paying taxes on premiums. Additionally, it could specify that the public option would pay states that operated their own marketplace platform a fee to use the platform.

#### **Risk-Adjustment Transfers**

Enrollees in the nongroup plans available in the marketplaces are part of a single risk pool, and the private insurers offering those plans participate in a risk-adjustment system that spreads the risk among themselves.<sup>34</sup> Insurers with healthier enrollees make payments to insurers with less healthy enrollees within a state to limit the financial incentive that insurers have to seek out healthier

- 30. As indicated by the fees they collect, brokers play a smaller role in the nongroup market than they do in the small-group market. In 2018, brokers' fees per member per month averaged \$9.32 in the nongroup market and \$21.40 in the small-group market. See Kaiser Family Foundation, "Broker Compensation by Health Insurance Market" (accessed November 8, 2020), https://tinyurl.com/y5jjsud6.
- For example, the CHOICE Act (H.R. 2085 and S. 1033, 116th Cong.) explicitly exempts the public option from state premium taxes.
- 32. In 2021, that user fee is set to equal 3 percent of the premiums that the private insurer collects. See Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans, 85 Fed. Reg. 7088 (proposed February 6, 2020), https://go.usa.gov/x75rw.
- 33. See Jason Levitis, John-Pierre Cardenas, and Steven Costantino, Considerations for a State Health Insurer Fee Following Repeal of the Federal 9010 Fee (State Health & Value Strategies, January 2020), https://tinyurl.com/y2ehhe2m.
- 34. See Section 1343 of the Patient Protection and Affordable Care Act, Public Law 111–148 (codified at 42 U.S.C. §18063).

Working Paper 27695 (National Bureau of Economic Research, August 2020), www.nber.org/papers/w27695.

enrollees and avoid sicker ones. The total value of funds in the risk-adjustment pool depends in part on a state's average premium.

Policymakers would need to decide whether the public option would share a risk pool with private insurers in the nongroup market. If private insurers and the public option were part of a single risk pool, risk-adjustment transfers would be made among private insurers and the public option on the basis of the relative health of the plans' enrollees. If the public option attracted disproportionately sicker enrollees, private insurers would make transfer payments to the public option. However, risk adjustment does not perfectly capture differences in individual health risk, so those transfers would not fully reflect the underlying health risk of enrollees. Moreover, evidence from other markets suggests that insurers might behave strategically to increase the risk score that they report for their enrollees.<sup>35</sup> If private insurers engaged in that behavior more than the public option did, risk-adjustment transfers would favor private insurers, and the public option's premiums would be higher as a result.

If people enrolled in the public option made up their own separate risk pool, differences between the public option's premiums and those of private plans would reflect differences in enrollees' health status. Private insurers' incentive to use strategies to attract healthier enrollees would be stronger than it is under the current system. Healthier enrollees who would otherwise have enrolled in the public option might instead purchase coverage from those private insurers, worsening the public option's risk pool. Furthermore, if the public option's risk pool was separate from that of private insurers, the premium of the benchmark plan could reflect enrollees with substantially different health risks from those enrolled in the public option.

# Funding and Treatment of Excess Revenues and Shortfalls

The public option could be funded through premium payments (including premium tax credit payments as well as enrollees' premium contributions) and separate appropriations from the Congress. Those appropriations could be made annually, or policymakers could provide only start-up funding. CBO anticipates that the start-up costs for a public option could be substantial. Such costs would include those associated with establishing payment rates, enrolling providers, advertising, addressing unforeseen implementation problems, and providing sufficient reserve funds to cover initial claims costs. Policymakers could require the public option to use its premium revenues to pay back the start-up costs over a specified period of time.<sup>36</sup> In general, the public option's premiums would be lower if it was not required to repay any start-up funding it received through the appropriation process.

Lawmakers could appropriate funding that not only supported the public option but also benefited private insurers. For example, the Congress could provide an annual appropriation to cover the costs of funding cost-sharing reductions for the public option and private insurers. (Under current law, private insurers cover those costs through premiums.) Additionally, the federal government could appropriate funds for a risk-corridor program that would limit plans' losses and gains beyond an allowable range or for a reinsurance program that would provide payments to plans that enrolled higher-cost individuals. Those programs would limit premium volatility in the face of the uncertainty introduced by the public option's entering a market, and they might allow private insurers and the public option to offer a lower premium.37

<sup>35.</sup> For example, see Michael Geruso and Timothy Layton, "Upcoding: Evidence From Medicare on Squishy Risk Adjustment," *Journal of Political Economy*, vol. 128, no. 3 (March 2020), pp. 984–1026, https://doi.org/10.1086/704756; Tamara Beth Hayford and Alice Levy Burns, "Medicare Advantage Enrollment and Beneficiary Risk Scores: Difference-in-Differences Analyses Show Increases for All Enrollees on Account of Market-Wide Changes," *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, vol. 55 (January 2018), pp. 1–11, https://doi.org/10.1177/0046958018788640.

<sup>36.</sup> For instance, the Keeping Health Insurance Affordable Act of 2019 (S. 3, 116th Cong.) and the Public Option Deficit Reduction Act (H.R. 1419, 116th Cong.) would provide \$2 billion in start-up funds that the public option would be required to repay over 10 years. The CHOICE Act (H.R. 2085 and S. 1033, 116th Cong.), which does not specify the amount of funding for start-up, would also require the funding to be repaid in full over 10 years. The Choose Medicare Act (H.R. 2463 and S. 1261, 116th Cong.), which would provide \$2 billion in start-up funding, does not include a repayment clause.

<sup>37.</sup> See Matthew Fiedler and others, "Health Care Price Regulation and Public Options: Assessing Approaches to Increasing the Public Role" (webinar, Brookings Institution, September 23, 2020), https://tinyurl.com/y3j9slgo.

Another design consideration is how the federal government would treat excess premium revenues or shortfalls. Although the public option's premiums would be set to cover *anticipated* medical and administrative costs, premium collections would exceed or fall short of actual expenses. Policymakers could require the public option to hold funds in reserve to cover unexpectedly high spending and decrease the likelihood of shortfalls. Alternatively, they could specify that excess revenues or shortfalls be incorporated in the calculations of the public option's premiums for the next year by subtracting excess revenues or adding any shortfall to that year's expected expenses. (Typically, regulators do not allow private insurers to account for prior excesses or shortfalls when setting premiums.) Such an approach could be implemented through the creation of a trust fund for the public option into which premiums and tax credits would be deposited and from which claims costs and administrative costs would be paid. One likely effect of incorporating the previous year's excess revenues or shortfalls into the following year's premiums is that the public option's premiums would become more volatile. Another option would be to return any excess revenues to the Treasury and to draw funds to cover any shortfall from the Treasury. Alternatively, excess revenues could be returned to enrollees through a rebate.

In addition to holding reserves, health insurance plans often embed a contingency margin to account for the possibility of unexpectedly high spending when setting premiums.<sup>38</sup> Policymakers would need to decide the amount, if any, that would be included in the public option's premiums to account for such contingencies.<sup>39</sup> The likelihood of excess premium revenues would be greater if a contingency margin was included in the public option's premiums, and that likelihood would increase with the size of that margin. Shortfalls would be more likely if policymakers took steps to limit the growth of premiums without also taking steps to reduce claims costs or administrative costs.

A related consideration is whether the public option would conform with medical loss ratio (MLR) rules, which require nongroup insurers to pay rebates to consumers if their medical spending and quality improvement expenses fall below 80 percent of their premium collections. 40 If some administrative activities were contracted to a private entity and others were handled by a federal agency, it might be difficult to track administrative costs that were dedicated to quality improvement, which would, in turn, make it difficult to correctly calculate the percentage of premiums spent on those expenses for MLR purposes.

An important implementation question policymakers would need to consider is how premiums would be determined in the public option's early years, before the plan accumulated any of the data on claims that would eventually be used to calculate expected medical expenses. In the first years of the marketplaces, insurers underpriced premiums, illustrating the difficulty of projecting the health care costs of a new population.<sup>41</sup> Any concern that the public option's premiums might be similarly underpriced in its early years would be lessened if its entry into the nongroup market was not expected to significantly change the overall risk profile of that market. When setting premiums, policymakers could consider an approach that based the public option's premiums on the premiums of private plans in a given rating area, perhaps using the premium of the benchmark plan as a starting point. Such an approach could make the introduction of the public option less disruptive to the marketplaces. If the public option's premiums were based on private plans' premiums rather than the expected costs of the public option, choices about how excess revenues or shortfalls would be treated and whether the public option would conform with MLR requirements would have particular relevance.

#### **Geographic Scope**

Policymakers could decide to offer a public option in all geographic markets. Alternatively, they could choose to make the public option available only in those rating areas that have high premiums or that lack sufficient numbers of private insurers. In either case, policymakers

<sup>38.</sup> A contingency margin is an amount set aside to cover variation between actual and projected costs in a given year. For more information, see Patricia A. Davis, *Medicare Part B: Enrollment and Premiums*, Report R40082, version 47 (Congressional Research Service, May 6, 2020), https://go.usa.gov/x75rT.

<sup>39.</sup> For example, the CHOICE Act (H.R. 2085 and S. 1033, 116th Cong.) and the Public Option Deficit Reduction Act (H.R. 1419, 116th Cong.) require a contingency margin.

<sup>40.</sup> See Centers for Medicare & Medicaid Services, "Medical Loss Ratio" (accessed November 8, 2020), https://go.usa.gov/x75r7.

<sup>41.</sup> See Matthew Fiedler, *Taking Stock of Insurer Financial*Performance in the Individual Health Insurance Market Through
2017 (USC-Brookings Schaeffer Initiative for Health Policy,
October 2017), https://tinyurl.com/y54czhdj.

would need to specify metrics for triggering the entry of the public option into different rating areas.<sup>42</sup> Policymakers would also need to decide if the trigger mechanism would work in both directions: Would the public option exit a market if premiums moderated or additional private insurers entered the market? Or would the public option remain in a market indefinitely once it entered?

Implementing a trigger mechanism, especially a twoway trigger mechanism, would introduce significant challenges. Insurers decide whether to participate in the nongroup marketplaces and set their premiums only months before open enrollment. Using the current year's market conditions to determine whether the public option would enter a market would be administratively simpler than using the conditions anticipated in the upcoming year; but under that approach, the public option would not be as well matched to the plan offerings with which it would actually compete. To reduce the volatility associated with a two-way trigger mechanism, policymakers could base the public option's exit on insurer participation or premiums over multiple years rather than in a single year; they could also make the metric for exiting more stringent than the metric for entering. Similarly, policymakers could specify a

minimum number of years that the public option would remain in a market after entering. The degree of administrative complexity associated with a trigger mechanism would depend, in part, on design choices related to other features of the public option. For example, if the public option negotiated provider payment rates and formed provider networks, significant lead time would be necessary for the public option to enter a marketplace.

If a trigger mechanism was used to determine which geographic markets to enter, private insurers might adjust their plan offerings and premiums to prevent the public option from entering a given rating area. The possibility that a public option might enter an area could affect private insurers' negotiations with health care providers by giving the insurers leverage to negotiate lower payment rates—which would allow them to lower premiums—especially if there was a one-way trigger.

If a two-way mechanism was implemented and the public option was not expected to remain in a given rating area, concerns about plan cancellations could discourage enrollment. Enrollees whose public plan was canceled could be automatically enrolled in another plan, or they could be required to make a new plan selection, which would lower the likelihood of their remaining covered.<sup>43</sup>

<sup>42.</sup> Proposals could include a phase-in period, during which the public option would first be offered in rating areas with few or no insurers before being extended to all rating areas within a few years. See, for example, the Medicare-X Choice Act (H.R. 2000 and S. 981, 116th Cong.). This report focuses on the design considerations associated with a fully phased-in program.

<sup>43.</sup> Currently, enrollees in nongroup marketplace plans that are canceled are automatically enrolled in a plan with similar coverage and premiums. See Centers for Medicare & Medicaid Services, "Federal Health Insurance Exchange 2021 Open Enrollment" (October 26, 2020), https://go.usa.gov/xsQaM.

# Chapter 3: Implications of Key Design Features for Premiums, Coverage, and Federal Outlays and Revenues

The choices that policymakers made about the design of the public option would affect the public option's premiums, private insurers' premiums and their participation in the marketplaces, and health insurance coverage in the United States. Those factors would, in turn, affect federal outlays and revenues.

#### **The Public Option's Premiums**

Provider payment rates and prescription drug prices are key determinants of the public option's premiums. The scope of covered benefits, the use of care management strategies, network breadth and access to care, and constraints on providers' billing practices are also important drivers of premiums through their impact on health care utilization. Other major factors affecting the public option's premiums are the health risk of enrollees, the risk-adjustment system, and the administrative costs of operating the plan.

# **Provider Payment Rates and Prescription Drug Pricing**

The federal government could implement the public option in ways that would result in a relatively low premium or in ways that would result in a relatively high premium.

The public option could have relatively low premiums if providers were paid using the Medicare fee-for-service rate schedule and if pharmaceutical prices were set low by statute. Likewise, if the Secretary of Health and Human Services was granted considerable bargaining leverage—the authority to create tiered drug formularies and exclude higher-cost providers from the public option's network, for example—and used it effectively, the public option could negotiate relatively low provider payment rates and prescription drug prices. Tying provider participation to Medicare or Medicaid would increase the ability of the public option to offer

relatively low payment rates while maintaining high levels of provider participation. 1 If payment rates were negotiated, setting an upper limit on them would make the possibility of the HHS Secretary's walking away from negotiations more credible and could increase the Secretary's leverage. The negotiated payment rates—and thus the public option's premiums—would probably be lower if the upper limit on negotiated payment rates was lower, because prices might ultimately converge around that limit. Even if the HHS Secretary had significant leverage, the outcome of negotiations would still be highly uncertain, because as priorities changed from one Administration to the next, HHS Secretaries might not exercise that leverage to the same degree. By contrast, the public option's premiums would be relatively high if the HHS Secretary negotiated provider payment rates without a source of bargaining leverage and if a pharmacy benefit manager was unable to use restricted formularies and negotiated prescription drug prices under market conditions similar to those facing private insurers.

If, as a new entrant into the marketplaces, the public option had a small market share compared with those of private insurers and the HHS Secretary had no other source of leverage, negotiated rates could be higher than those of the private plans in that marketplace. If provider participation was not tied to Medicare or Medicaid, the public option's ability to form an adequate network would depend on the relative attractiveness of its provider payment rates, and its bargaining position in rate negotiations would thus be undermined. Attracting

See Jeffrey Clemens and Joshua D. Gottlieb, "In the Shadow of a Giant: Medicare's Influence on Private Physician Patients," *Journal of Political Economy*, vol. 125, no. 1 (February 2017), pp. 1–39, https://doi.org/10.1086/689772.

providers in certain specialties or in rural areas with few providers could be especially difficult.<sup>2</sup>

Specifications regarding coverage and payment rates for out-of-network care would also affect the HHS Secretary's leverage in negotiations with providers. The exact effect of out-of-network coverage and payment rates on negotiations would depend on the relative market shares of the public option and negotiating provider and on how much volume the provider could expect to attract when out of network. For example, if the public option included expansive out-of-network coverage and limited patients' out-of-pocket costs for such care, providers could remain out of network and still bill at high rates. Because providers would have little incentive to accept low in-network rates, the Secretary's negotiating leverage would be diminished.

#### **Health Care Utilization**

Health care utilization depends on the scope of covered benefits, the use of care management tools, network breadth and access to care, and constraints on providers' billing practices.<sup>3</sup> If the benefit package of the public option covered a broader set of services or pharmaceuticals than competing private plans, the public option's utilization rate would be higher than that of private plans. Similarly, more generous coverage of and cost sharing for out-of-network care could increase health care utilization, which would tend to increase the public option's premiums. If the public option used fewer care management tools, the volume and intensity of care that patients would demand and that providers would recommend would be higher. If the public option imposed fewer constraints on pharmaceutical utilization, utilization of all drugs—particularly more expensive drugs—would be greater. Likewise, if the public option had a broader

provider network and better access to care than private nongroup plans, health care utilization could increase, which would, in turn, push up premiums. Finally, if the public option imposed fewer constraints on providers' billing practices than private nongroup plans, providers might bill for more expensive care or indicate that the services they provide are more complex or intensive than they would if more constraints were in place, resulting in larger payments to providers.

#### Health Risk and the Risk-Adjustment System

The public option's premiums would depend on the health risk of enrollees, on whether the public option participated in the same risk pool as private insurers in the nongroup market, and on how well the risk-adjustment system controlled for risk selection. The health risk of enrollees would depend on how current nongroup market enrollees sorted themselves between private plans and the public option as well as on the health status of any new enrollees that the public option attracted to the nongroup market. If the public option's premiums were significantly lower than private plans' premiums, the public option could attract healthier people who currently forgo coverage into the nongroup market, causing the aggregate risk score in the market to decrease. If the public option's premiums were somewhat lower than private plans' premiums, the public option would attract relatively healthy people from other plans. In that case, the option's attractiveness to sicker and higher-cost people would depend on how other characteristics of the plan—including its network breadth, benefit package, and care management—compared with those of private plans. If the public option's premiums were higher than private plans' premiums but some of its other features were more attractive than those of other plans, such features would tend to encourage sicker and higher-cost people to enroll.

If the public option shared a risk pool with private insurers and participated in risk-adjustment transfers, the impact of favorable or adverse risk selection on premiums would be lessened but not eliminated, because risk adjustment is imperfect. The link between the health risk of enrollees and the public option's premiums would be significantly stronger if the public option did not share a risk pool with private insurers or participate in risk-adjustment transfers. In that case, if the public option attracted sicker enrollees, its premiums would be higher, and private insurers' premiums lower, than they would be otherwise. Conversely, if the public option

<sup>2.</sup> Providers' decisions about whether to accept the public option would depend on the mix of their other patients and on the payment rates of private insurers in the market. For instance, providers who saw a large number of Medicaid or Medicare enrollees might accept lower payment rates than providers who saw mostly patients with private insurance. Providers in geographic areas or specialties with low commercial rates might also be more likely to accept low payment rates from the public option.

For more information, see CBO's Single-Payer Health Care Systems Team, How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program, Working Paper 2020-08 (Congressional Budget Office, December 2020), Section 6, www.cbo.gov/ publication/56811.

attracted healthier enrollees and did not participate in risk adjustment, the public option's premiums would be lower, and private insurers' premiums higher, than they would be without such selection.

#### **Administrative Costs**

Depending on the design choices, the public option's administrative costs could be similar to those of private nongroup plans, or they could be substantially lower. If the public option used a single national benefit package and leveraged existing federal administrative activities for example, by basing payment rates and provider participation on Medicare FFS—administrative costs would be relatively low. (As a share of total spending, administrative costs in the public option would be higher than administrative costs for Medicare FFS, mainly because the economies of scale of the public option would be smaller.) The lack of profit would also push down administrative costs in the public option. If the public option negotiated payment rates, set up provider networks, applied care management techniques, advertised, and paid state insurance taxes and marketplace user fees, its administrative costs could be similar to those of private nongroup plans.

# Private Insurers' Premiums and Participation in the Marketplaces

The public option's effects on health insurance coverage and the federal budget would also depend on private insurers' response to the public option's entry into the market, including whether they changed their premiums and whether they continued to participate in the marketplaces or exited them. The effect that introducing a public option would have on the private insurers in a nongroup marketplace would depend on how the public option's premiums and plan characteristics compared with those of private insurers, the amount of competition in the marketplace before the public option's entry, the extent to which the public option affected private insurers' provider payment rates, and the health risk of the people selecting private plans.

Private insurers' decisions to exit or remain in each market would vary depending on the structure of the marketplace and on any competitive advantages the public option might have. Private insurers would remain in a given marketplace if they anticipated that the profits they would earn would justify the costs of remaining. If the public option offered particularly low premiums or other attractive features, some private insurers might

exit the nongroup market. The larger the public option's competitive advantages, the more difficult it would be for private insurers to remain profitable. For example, if the public option was not required to conform with state benefit mandates or rating requirements and if it paid providers Medicare rates and required providers participating in other federal programs to join its network, private insurers would have difficulties retaining sufficient market share while keeping their premiums high enough to justify their participating in the marketplaces. Private insurers who remained in the marketplaces might respond to the public option's entry into the market by lowering their premiums or otherwise improving the quality of their plans, though some insurers might face constraints that limited their ability to compete in terms of premiums or quality. The entry of the public option might have a smaller effect on insurers in marketplaces that already have several private insurers competing on premiums and plan quality.

A key driver of how private insurers responded to the entry of the public option would be how the entry of the public option affected private insurers' negotiating dynamics with providers. A public option with innetwork and out-of-network rates that were substantially lower than private insurers' in-network rates could put downward pressure on private insurers' negotiated rates. One reason providers might be more willing to agree to lower in-network rates with a private insurer after a public option entered a market is that if they did not, the public option's premiums might be lower than the private plan's, and some of the insurers' enrollees might switch from the private plan to the public option. The provider would then receive the public option's lower payment rate for those enrollees, whereas before the entry of the public option, the enrollees might have switched to another private insurer that also paid rates higher than the public option's rates. That possibility would reduce the provider's leverage in the negotiation, thus decreasing the rate that the provider could command from the private insurer.

Providers might also be willing to agree to lower innetwork rates because if the private insurer needed to substantially reduce premiums to attract enough enrollees to remain in the market, it could use that necessity as additional leverage in its negotiations with providers to obtain reduced payment rates. Providers might accept lower rates from the private insurer if they concluded that doing so would be preferable to the insurer's leaving the market entirely. Providers are most likely to accept lower rates to prevent private insurers from exiting the market in markets with dominant hospital and physician systems, because an insurer's profitability in such markets can depend on the outcome of negotiations with a single health system. The entry of the public option could, however, have an offsetting effect. The loss of market share to the public option that private insurers would experience could decrease their bargaining power, so some private insurers' provider payment rates and premiums could increase.

Whether the public option attracted sicker enrollees—and the impact that any such health selection had on the private insurers' risk pool—would also affect the premiums of private plans. If the public option did not participate in risk-adjustment transfers and had plan characteristics that attracted sicker enrollees from private plans, the medical costs of private plans would tend to fall as the people in their risk pool became healthier; as a result, private insurers would probably lower their premiums. In addition, if the public option attracted sicker enrollees, in turn lowering private plans' medical costs, the entry of the public option could increase private insurers' profits per enrollee and encourage additional private insurers to enter the marketplace.

If, instead, the public option participated in risk-adjustment transfers, the effect of any health selection on private insurers' premiums would be significantly smaller because private insurers would make risk-adjustment transfers to the public option. If the public option participated in risk-adjustment transfers and it increased the nongroup market's average risk by drawing sicker enrollees into the market, private premiums would increase.

# Premium Tax Credits and Net Premiums

Individuals and families who are eligible for a subsidy to purchase health insurance coverage through the market-places receive that subsidy in the form of a premium tax credit equal to the difference between the cap on their premium contribution—that is, the maximum amount (calculated as a share of their income) that they are required to pay to purchase the benchmark plan—and the premium of the benchmark plan. Together, the premiums of the public option and of the private plans remaining in a marketplace would determine the benchmark plan, which, in turn, would determine the premium tax credit and net premiums.

The effect that establishing a public option would have on premium tax credits would depend on how the public option's premiums compared with those of private plans as well as on how private insurers responded to the public option's entry into a given marketplace. If the public option entered a marketplace in the silver tier and offered the lowest or second-lowest premiums in that tier, the benchmark premium and subsidy would fall (see Figure 3-1). If the public option entered a marketplace with premiums that were higher than those of the second-lowest-cost silver plan, the subsidy would not change unless competition from the public option or the change in the mix of enrollees' health status caused the lower-premium private insurers to reduce their premiums.

Regardless of whether the public option's premiums were higher or lower than the private plans' premiums in a given marketplace, the net premium of the benchmark plan would remain unchanged for all subsidized individuals except those for whom the benchmark premium was below the cap on their premium contribution. However, if the benchmark premium and subsidy fell but the premiums of private plans did not fall by a corresponding amount, the net premium for plans other than the benchmark plan would increase.

In marketplaces with fewer insurers, where premiums tend to be higher, the public option would be more likely to enter with premiums that were lower than the private plans' premiums, and the benchmark premium would be more likely to fall. Conversely, in marketplaces with more robust competition, the public option would be less likely to enter with the lowest or second-lowest premiums, and even when it did enter with the lowest or

<sup>4.</sup> Medicare Advantage plans pay rates similar to those paid by Medicare fee-for-service. In interviews, many executives of hospitals and health plans cited competitive pressure from Medicare FFS as one reason for the similar rates, but an important factor in that dynamic is the limits on out-of-network billing in the Medicare program. Without similar restrictions, the public option would not exert as much downward pressure on prices as Medicare FFS. See Robert A. Berenson and others, "Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices," *Health Affairs*, vol. 34, no. 8 (August 2015), pp. 1289–1295, https://doi.org/10.1377/hlthaff.2014.1427.

Figure 3-1.

# Federal Subsidies and Net Premiums for Health Insurance Purchased in the Nongroup Marketplaces Under Four Different Scenarios for a Public Option

### No Public Option

Under current law, the benchmark plan is the secondlowest-cost silver plan. That plan's premium is used to determine the value of federal subsidies.

### High-Premium Public Option

If the public option entered the market with a premium that was higher than that of the second-lowest-cost silver plan, the benchmark premium, and thus federal subsidies, would not change.

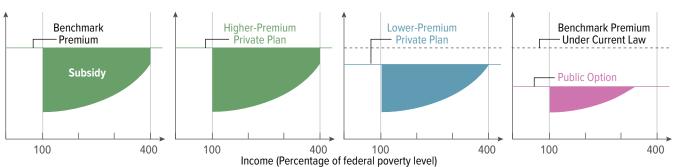
### Low-Premium Public Option

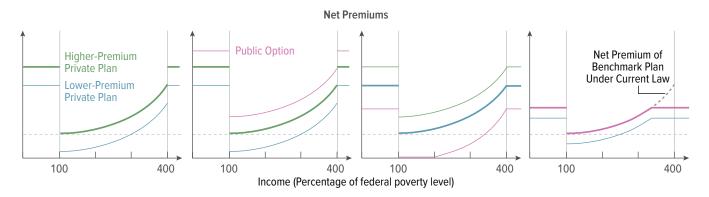
If the public option entered the market as the lowest-cost or second-lowest-cost plan, the benchmark premium and subsidies would decrease, thereby increasing net premiums for people enrolled in private plans.

### Low-Premium Public Option With Competition and Market Exit

If private plans exited the market or lowered premiums in response to the public option's entry, the benchmark premium and subsidies could further decrease.







Data source: Congressional Budget Office.

In the graphs showing net premiums, the bold line in each scenario indicates the benchmark plan.

Net premiums for people enrolled in the benchmark plan who have income between 100 percent and 400 percent of the federal poverty guidelines (commonly referred to as the federal poverty level) would be the same in all scenarios until the net premium reaches the plan's premium. (In most states, the federal poverty level in 2021 is \$12,880 for a single person and increases by \$4,540 for each additional person in a household. Thus, for a single person, 400 percent of the federal poverty level is \$51,520 in 2021.) The gray dashed line represents the net premium for the benchmark plan at 100 percent of the federal poverty level. It is included as a visual reference.

The amount of the subsidy that an individual or family would receive is equal to the difference between the benchmark plan's premium and the individual's or family's premium cap.

The curve representing the premium cap is a simplification of the actual premium cap structure.

second-lowest premiums, the effect on the benchmark premium and subsidy would be smaller.

People with income above 400 percent of the FPL are ineligible for subsidies. Consequently, their net premiums do not depend on the benchmark premium; rather, those net premiums equal the premiums of the plan in which they are enrolled. Introducing the public option with premiums below those of private insurers would give people who are ineligible for subsidies access to a lower-cost plan.

#### **Health Insurance Coverage**

The effect of the public option on the number of people with health insurance coverage and their sources of coverage would depend on the geographic areas in which the plan was offered, the plan's premiums, its effects on the benchmark premium and tax credits, and how attractive it was compared with private plans. A plan's attractiveness is based on a number of factors, including the plan's net premium, the breadth of its provider network, the degree to which it employs care management tools, and other characteristics. If the public option was offered only in the nongroup market, enrollment in the plan would draw from the existing nongroup market, the uninsured, and those with employment-based insurance, the Congressional Budget Office anticipates. The effect on the total number of people without health insurance would be relatively small.

#### **Effect on the Currently Uninsured Population**

Among the currently uninsured population, the greatest potential for coverage gains would be among people who have income above the subsidy eligibility threshold of 400 percent of the FPL and who do not have access to employment-based coverage. In 2019, that group accounted for an estimated 9 percent of the uninsured population, or 2.6 million individuals. CBO expects that if the premiums of the public option were significantly lower than those of private plans in a geographic area, some of that group would enroll in the public option. The decision to purchase health insurance depends on the net premium, and because unsubsidized people are not shielded from any portion of premiums, they are especially sensitive to premium changes in the

nongroup market.<sup>6</sup> As nongroup market premiums have increased over time, the number of unsubsidized people enrolled has fallen, and the number of subsidized people enrolled has remained fairly steady.<sup>7</sup> The magnitude of the public option's effect on coverage among that population would depend heavily on the plan's premiums. If the cost of cost-sharing reductions was embedded in the premiums of the public option offered in the marketplaces' silver tier rather than funded through a Congressional appropriation, unsubsidized enrollment would be higher if the public option was also offered outside the marketplaces with a lower premium.

Even if the public option offered lower premiums than private plans, its entry into the nongroup market would have only a limited effect on the coverage rate of people with income less than 400 percent of the FPL who are currently uninsured but eligible for subsidies. In 2019, that group accounted for an estimated 19 percent of the total uninsured population, or 5.5 million individuals.8 The structure of premium tax credits limits the share of income that a person or family must pay in net premiums for the benchmark plan and thus shields the subsidy-eligible population from high premiums (see Figure 3-1 on page 29).9 As a result of the subsidy structure, subsidized marketplace enrollment has remained steady, even as premiums have increased over time. Some of the currently uninsured subsidy-eligible population would enroll in the nongroup marketplaces if the net premiums of the plan were substantially lower than those of private plans currently in the marketplaces

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

See Amy Finkelstein, Nathaniel Hendren, and Mark Shepard, "Subsidizing Health Insurance for Low-Income Adults: Evidence From Massachusetts," *American Economic Review*, vol. 9, no. 4 (April 2019), pp. 1530–1567, https://doi.org/10.1257/ aer.20171455.

See Centers for Medicare & Medicaid Services, Trends in Subsidized and Unsubsidized Enrollment (October 2020), https://go.usa.gov/x75fz (PDF, 274 KB); and Rachel Fehr, Cynthia Cox, and Larry Levitt, Data Note: Changes in Enrollment in the Individual Health Insurance Market Through Early 2019 (Kaiser Family Foundation, August 21, 2019), https://tinyurl.com/stmr8vd.

<sup>8.</sup> For an analysis of the uninsured population, see Congressional Budget Office, *Who Went Without Health Insurance in 2019, and Why?* (September 2020), www.cbo.gov/publication/56504.

<sup>9.</sup> For more information on the structure of premium tax credits, see Kaiser Family Foundation, "Explaining Health Care Reform: Questions About Health Insurance Subsidies" (October 30, 2020), https://tinyurl.com/4xdo5zqt.

or if other features of the public option were more attractive than those of private plans.

Among other groups of uninsured people, the entry of a public option into the nongroup marketplaces would have only a small effect on coverage. In 2019, 11 percent of the uninsured population, or 3.2 million people, had income that was too low to qualify for marketplace subsidies and lived in states where Medicaid had not been expanded under the Affordable Care Act. In general, without a change in the eligibility criteria for subsidies, that group would find the public option unaffordable regardless of the plan's design choices. 10 About half of the uninsured population in 2019 was eligible for Medicaid or had access to affordable employment-based coverage that made them ineligible for marketplace subsidies. (For a brief discussion of the effects of extending subsidy eligibility to those with offers of affordable employment-based coverage, see Box 3-1.) People who are not lawfully present in the United States—in 2019, an estimated 13 percent of the uninsured population, or 4.0 million individuals—are ineligible for marketplace coverage but could be eligible for nongroup coverage available outside the marketplaces.

If the public option was offered in limited geographic areas and a trigger mechanism was used to determine when it would enter a particular area, the public option's effect on overall coverage would be smaller. Although the public option could have a larger effect on coverage in marketplaces with high premiums or limited competition, the overall impact would be smaller because of the program's narrower scope.

#### **Effect on the Currently Insured**

The public option might have a larger effect on sources of coverage for the currently insured than the currently uninsured. If the benchmark premium fell but private premiums did not, subsidized enrollees who remained in their current plan would face a reduction in premium subsidies and an increase in net premiums. Some people would lose their eligibility for a subsidy altogether if the benchmark premium fell below their required premium contribution—an outcome that is more likely to occur among younger enrollees, whose premiums are lower. In that case, the second-lowest-cost silver plan would have a lower net premium, but those enrollees would

no longer qualify for a premium tax credit that could be used to purchase other plans, such as a bronze plan or the lowest-cost silver plan. As a consequence, some enrollees might switch to a lower-tier plan, and some enrollees might choose to forgo coverage entirely. If the public option was also introduced in the bronze tier with premiums that were below those of private plans, enrollees who would otherwise forgo coverage might be more likely to remain enrolled. Although such a change is outside the scope of this report, several of the proposals for a public option that have been introduced would increase subsidies, which would offset that dynamic and increase federal spending.

A public option with a broader network and fewer care management tools in place than competing private plans in the nongroup marketplaces could draw enrollees from those plans. Many enrollees in the nongroup market might value plan attributes related to the provider network and care management enough that they would switch to a public option, even if the premium was similar or slightly higher than those of private plans. A plan with a broader provider network and fewer care management tools restricting utilization might also lead some people who currently have nongroup insurance offered outside the marketplaces (and who thus forgo premium tax credits) to enroll in the subsidized public option.<sup>11</sup>

Some employees, particularly those who pay relatively high premiums for employment-based insurance, might forgo coverage through their employer and enroll in the public option. The magnitude of that effect would depend on how attractive the public option was to employees compared with the health insurance plan their employer offered. Additionally, if the public option was seen as attractive, some employers might forgo offering coverage entirely, thereby further decreasing enrollment in employment-based coverage. That effect might be concentrated among small firms, which have lower offer rates, on average. <sup>12</sup> If the public option was available outside the marketplaces, some employers might offer

<sup>10.</sup> Some public option proposals would extend eligibility for subsidies to people who are ineligible for Medicaid only because they live in a state where Medicaid had not been expanded.

<sup>11.</sup> See Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, About 2.5 Million People Who Currently Buy Coverage Off-Marketplace May Be Eligible for ACA Subsidies, ASPE Data Point (October 4, 2016), https://go.usa.gov/xAaac.

<sup>12.</sup> See Agency for Healthcare Research and Quality, *Medical Expenditure Panel Survey Insurance Component 2019 Chartbook*, AHRQ Publication 20(21)-0052 (October 2020), https://go.usa.gov/x75GR.

Box 3-1.

#### Extending Access to a Subsidized Nongroup Public Option to People With Employer Offers

A provision of the Affordable Care Act (ACA), which is commonly referred to as the employer firewall, does not allow people with offers of affordable health insurance through their employer to access the federal subsidies that are available for plans purchased in the nongroup marketplaces established by the ACA.¹ If policymakers wanted to establish a federally administered public health insurance plan (or public option) in the nongroup market and extend access to the marketplace subsidies to those with employment-based coverage, they could remove that firewall.

Alternatively, policymakers could consider making changes to the firewall rather than removing it altogether. For example, the calculation used under current law to determine whether the plan being offered by an employer is affordable is based on the cost of an employee-only plan rather than a family plan.<sup>2</sup> That leaves some families ineligible for premium subsidies because the employee's contribution for an employee-only plan does not exceed the affordability standard even though the employee's contribution for a family plan would exceed it. Policymakers could consider various approaches to addressing that issue, including basing the affordability calculation on the contribution for a family plan or extending marketplace subsidies to dependents of people with an offer of employee-only coverage that was affordable but an offer of family coverage that was not.<sup>3</sup>

- The ACA established marketplaces through which people could purchase subsidized insurance in the nongroup market. The nongroup market is the private market in which individuals and families purchase health insurance directly from an insurer, rather than obtaining it through an employer.
- See HealthCare.gov, "Affordable Coverage" (accessed February 19, 2021), www.healthcare.gov/glossary/affordable-coverage/.
- 3. For example, the Patient Protection and Affordable Care Enhancement Act (H.R. 1425, 116th Cong.) proposes addressing this issue—often referred to as

In the Congressional Budget Office's assessment, removing the affordability firewall would lead to an increase in the number of people enrolled in subsidized marketplace plans, thereby driving up the costs of premium tax credits, which in turn would increase costs to the federal government. Even without a public option, removing the firewall would significantly increase the number of people eligible for nongroup subsidies. CBO estimated that about one-quarter of the 151 million people projected to have employment-based coverage in 2021 would become eligible for nongroup subsidies if the firewall was removed.<sup>4</sup> Moreover, in 2019, 31 percent of uninsured people were eligible for subsidized employment-based coverage, and most of those people had employer offers that were affordable according to current standards. If the firewall was removed, some of the people who were made eligible for subsidized marketplace coverage would choose such coverage over employment-based coverage or going uninsured. The number of people who made that choice would depend on several factors, including the subsidized plan's cost sharing, scope of benefits, provider networks, and ease of enrollment. Maintaining the firewall but changing the affordability standard for family plans would result in a much smaller change in eligibility for subsidies in the nongroup market.

the family glitch—by basing the affordability calculation on the contribution for a family plan.

- 4. CBO based this estimate on subsidy eligibility rules in existence before enactment of the American Rescue Plan Act of 2021 (Public Law 117-2). For more information, see Congressional Budget Office, Answers to Questions for the Record Following a Hearing Conducted by the Senate Committee on the Budget on CBO's Budget Projections (December 2020), pp. 3–5, www.cbo.gov/publication/56908.
- See Congressional Budget Office, Who Went Without Health Insurance in 2019, and Why? (September 2020), www.cbo.gov/publication/56504.

individual coverage health reimbursement arrangements to their employees rather than offering group health insurance or forgoing an offer of coverage altogether.

#### **Federal Outlays and Revenues**

The effect that the establishment of a nongroup public option would have on federal spending and revenues would depend primarily on how it affected the premiums of the benchmark plan and on the number of people who were eligible for subsidies who ultimately

purchased insurance through the marketplaces. If the entry of the public option into a marketplace lowered the benchmark premium, the average size of the premium tax credit would decrease, resulting in federal savings for existing enrollees. The effect on the number of subsidized enrollees is ambiguous but most likely would be small. The public option could increase federal costs by increasing enrollment among three main groups of people who would be eligible for subsidies:

People who would otherwise have been uninsured,

- People who became eligible for subsidies because their employer dropped their offer of coverage after the public option entered the market, and
- People who would have enrolled in a nongroup plan outside the marketplaces despite being eligible for subsidized coverage.

That increase in subsidized enrollment would be offset by decreases in subsidized enrollment among people who became uninsured because the net premium for the private plan they were enrolled in increased and among people who became ineligible for subsidies because the premium of the benchmark plan fell below their required premium contribution.

In addition, the public option might slightly increase federal tax revenues collected from people whose employers stopped offering coverage. Premiums paid by employers and most employees are excluded from taxable compensation, and employers that dropped health insurance offers are expected to shift the savings associated

with not offering health insurance into taxable wages and other benefits.<sup>13</sup>

If it offered a public option, the federal government would incur many start-up and administrative costs associated with operating the program. The budgetary effect of those expenses would depend on what portion of ongoing administrative costs was covered by premiums and what portion was funded through annual appropriations. It would also depend on whether those costs were to be repaid over time.

The budgetary effects of establishing a public option would depend on other design choices as well. If the public option was offered only in certain less-competitive markets rather than nationwide, the total effect on federal outlays and revenues would be smaller.

<sup>13.</sup> For more information, see Congressional Budget Office, Federal Subsidies for Health Insurance Coverage for People Under 65: 2020 to 2030 (September 2020), www.cbo.gov/publication/56571.

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### **About This Document**

The Congressional Budget Office prepared this report at the request of the Chairman of the House Budget Committee. In keeping with CBO's mandate to provide objective, impartial analysis, the report makes no recommendations.

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

Phillip L. Swagel

Director April 2021

#### FAQS ABOUT COBRA PREMIUM ASSISTANCE UNDER THE AMERICAN RESCUE PLAN ACT OF 2021

#### **April 07, 2021**

Set out below are Frequently Asked Questions (FAQs) regarding implementation of certain provisions of the American Rescue Plan Act of 2021 (ARP), as it applies to the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly called COBRA. These FAQs have been prepared by the Department of Labor (DOL). Like previously issued FAQs (available at <a href="https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs">https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs</a>), these FAQs answer questions from stakeholders to help individuals understand the law and benefit from it, as intended. The Department of the Treasury and the Internal Revenue Service (IRS) have reviewed these FAQs, and, concur in the application of the laws under their jurisdiction as set forth in these FAQs.

#### **COBRA Continuation Coverage**

COBRA continuation coverage provides certain group health plan continuation coverage rights for participants and beneficiaries covered by a group health plan. In general, under COBRA, an individual who was covered by a group health plan on the day before the occurrence of a qualifying event (such as a termination of employment or a reduction in hours that causes loss of coverage under the plan) may be able to elect COBRA continuation coverage upon that qualifying event. Individuals with such a right are referred to as qualified beneficiaries. Under COBRA, group health plans must provide covered employees and their families with certain notices explaining their COBRA rights.

#### **ARP COBRA Premium Assistance**

Section 9501 of the ARP provides for COBRA premium assistance to help Assistance Eligible Individuals (as defined below in Q3) continue their health benefits. The premium assistance is also available for continuation coverage under certain State laws. Assistance Eligible Individuals are not required to pay their COBRA continuation coverage premiums. The premium assistance applies to periods of health coverage on or after April 1, 2021 through September 30, 2021. An employer or plan to whom COBRA premiums are payable is entitled to a tax credit for the amount of the premium assistance.

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<sup>&</sup>lt;sup>1</sup> For more information on COBRA continuation coverage requirements applicable to private-sector employment-based group health plans, see "An Employer's Guide to Group Health Continuation Coverage Under COBRA," available at <a href="https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/an-employers-guide-to-group-health-continuation-coverage-under-cobra.pdf">https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/an-employers-guide-to-group-health-continuation-coverage-under-cobra.pdf</a>.

#### **General Information**

# Q1: I have heard that the ARP included temporary COBRA premium assistance to pay for health coverage. I would like more information.

The ARP provides temporary premium assistance for COBRA continuation coverage for Assistance Eligible Individuals (see Q3 to determine if you are eligible). COBRA allows certain people to extend employment-based group health plan coverage, if they would otherwise lose the coverage due to certain life events such as loss of a job.

Individuals may be eligible for premium assistance if they are eligible for and elect COBRA continuation coverage because of their own or a family member's reduction in hours or an involuntary termination from employment. This premium assistance is available for periods of coverage from April 1, 2021 through September 30, 2021. This premium assistance is generally available for continuation coverage under the Federal COBRA provisions, as well as for group health insurance coverage under comparable state continuation coverage ("mini-COBRA") laws.

If you were offered Federal COBRA continuation coverage as a result of a reduction in hours or an involuntary termination of employment, and you declined to take COBRA continuation coverage at that time, or you elected Federal COBRA continuation coverage and later discontinued it, you may have another opportunity to elect COBRA continuation coverage and receive the premium assistance, if the maximum period you would have been eligible for COBRA continuation coverage has not yet expired (if COBRA continuation coverage had been elected or not discontinued).

#### Q2: Which plans does the premium assistance apply to?

The COBRA premium assistance provisions apply to all group health plans sponsored by private-sector employers or employee organizations (unions) subject to the COBRA rules under the Employee Retirement Income Security Act of 1974 (ERISA). They also apply to plans sponsored by State or local governments subject to the continuation provisions under the Public Health Service Act. The premium assistance is also available for group health insurance required under state mini-COBRA laws.

#### Q3: How can I tell if I am eligible to receive the COBRA premium assistance?

The ARP makes the premium assistance available for "Assistance Eligible Individuals." An Assistance Eligible Individual is a COBRA qualified beneficiary who meets the following requirements during the period from April 1, 2021 through September 30, 2021:

- Is eligible for COBRA continuation coverage by reason of a qualifying event that is a reduction in hours (such as reduced hours due to change in a business's hours of operations, a change from full-time to part-time status, taking of a temporary leave of absence, or an individual's participation in a lawful labor strike, as long as the individual remains an employee at the time that hours are reduced) or an involuntary termination of employment (not including a voluntary termination); and
- Elects COBRA continuation coverage.

However, you are not eligible for the premium assistance if you are eligible for other group health coverage, such as through a new employer's plan or a spouse's plan (not including excepted benefits, a qualified small employer health reimbursement arrangement (QSEHRA), or a health flexible spending arrangement (FSA)), or if you are eligible for Medicare. Note that if you have individual health insurance coverage, like a plan through the Health Insurance Marketplace®², or if you have Medicaid, you may be eligible for ARP premium assistance. However, if you elect to enroll in COBRA continuation coverage with premium assistance, you will no longer be eligible for a premium tax credit, advance payments of the premium tax credit, or the health insurance tax credit for your health coverage during that period.

Note: If the employee's termination of employment was for gross misconduct, the employee and any dependents would not qualify for COBRA continuation coverage or the premium assistance.

#### Q4: If I am eligible for the premium assistance, how long will it last?

Your premium assistance can last from April 1, 2021 through September 30, 2021. However, it will end earlier if:

- You become eligible for another group health plan, such as a plan sponsored by a new employer or a spouse's employer (not including excepted benefits, a QSEHRA, or a health FSA), or you become eligible for Medicare\*\*, or
- You reach the end of your maximum COBRA continuation coverage period.

If you continue your COBRA continuation coverage after the premium assistance period, you may have to pay the full amount of the premium otherwise due. Failure to do so may result in your loss of COBRA continuation coverage. Contact your plan administrator, employer sponsoring the plan, or health insurance issuer for more information.

When your COBRA premium assistance ends, you may be eligible for Medicaid or a special enrollment period to enroll in coverage through the Health Insurance Marketplace® or to enroll in individual market health insurance coverage outside of the Marketplace. A special enrollment period is also available when you reach the end of your maximum COBRA coverage period. You may apply for and, if eligible, enroll in Medicaid coverage at any time. For more information, go to: <a href="https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/">https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/</a>.

\*\*Individuals receiving the COBRA premium assistance must notify their plans if they become eligible for coverage under another group health plan (not including excepted benefits, a QSEHRA, or a health FSA), or for Medicare. Failure to do so can result in a tax penalty.

# Q5: Who is eligible for an additional election opportunity for COBRA continuation coverage?

A qualified beneficiary whose qualifying event was a reduction in hours or an involuntary termination of employment prior to April 1, 2021 and who did not elect COBRA continuation coverage when it was first offered prior to that date or who elected COBRA continuation coverage but is no longer enrolled (for example, an individual who dropped COBRA

<sup>&</sup>lt;sup>2</sup> Health Insurance Marketplace® is a registered service mark of the U.S. Department of Health & Human Services.

continuation coverage because he or she was unable to continue paying the premium) may have an additional election opportunity at this time. Individuals eligible for this additional COBRA election period must receive a notice of extended COBRA election period informing them of this opportunity. This notice must be provided within 60 days of the first day of the first month beginning after the date of the enactment of the ARP (so, by May 31, 2021) and individuals have 60 days after the notice is provided to elect COBRA. However, this additional election period does not extend the period of COBRA continuation coverage beyond the original maximum period (generally 18 months from the employee's reduction in hours or involuntary termination). COBRA continuation coverage with premium assistance elected in this additional election period begins with the first period of coverage beginning on or after April 1, 2021. Individuals can begin their coverage prospectively from the date of their election, or, if an individual has a qualifying event on or before April 1st, choose to start their coverage as of April 1st, even if the individual receives an election notice and makes such election at a later date. In either case, please note that the premium assistance is only available for periods of coverage from April 1, 2021 through September 30,2021.

Due to the COVID-19 National Emergency, the DOL, the Department of the Treasury, and the IRS issued a Notice of Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak ("Joint Notice"). This notice provided relief for certain actions related to employee benefit plans required or permitted under Title I of ERISA and the Code, including the 60-day initial election period for COBRA continuation coverage. The DOL's Employee Benefits Security Administration (EBSA) provided further guidance on this relief in EBSA Disaster Relief Notice 2021-01. This extended deadline relief provided in the Joint Notice and Notice 2021-01 does not apply, however, to the 60-day notice or election periods related to COBRA premium assistance under the ARP.

# Q6: Does the ARP change any State program requirements or time periods for election of continuation coverage?

No. The ARP does not change any requirement of a State continuation coverage program. The ARP only allows Assistance Eligible Individuals who elect continuation coverage under State insurance law to receive premium assistance from April 1, 2021 through September 30, 2021. It also allows Assistance Eligible Individuals to switch to other coverage offered to similarly situated active employees if the plan allows it, provided that the new coverage is no more expensive than the prior coverage. See Q15 and Q17 for more information.

#### **Premiums**

#### Q7: How do I apply for the premium assistance?

If you were covered by an employment-based group health plan on the last day of your employment or a family member's employment (or the last day before your or your family member's reduction in hours causing a loss of coverage), the plan or issuer should provide you and your beneficiaries with a notice of your eligibility to elect COBRA continuation coverage

<sup>&</sup>lt;sup>3</sup> 85 FR 26351 (May 4, 2020).

<sup>&</sup>lt;sup>4</sup> Available at <a href="https://www.dol.gov/sites/dolgov/files/ebsa/employers-and-advisers/plan-administration-and-compliance/disaster-relief/ebsa-disaster-relief-notice-2021-01.pdf">https://www.dol.gov/sites/dolgov/files/ebsa/employers-and-advisers/plan-administration-and-compliance/disaster-relief/ebsa-disaster-relief-notice-2021-01.pdf</a>.

and to receive the premium assistance. The notice should include any forms necessary for enrollment, including forms to indicate that you are an Assistance Eligible Individual and that you are not eligible for another group health plan (this does not include excepted benefits, a QSEHRA, or a health FSA), or eligible for Medicare.

If you believe you are (or may be, upon a COBRA election) an Assistance Eligible Individual and have not received a notice from your employer, you may notify your employer of your request for treatment as an Assistance Eligible Individual (for example, using the "Request for Treatment as an Assistance Eligible Individual Form" that is attached to the Summary of COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021) for periods of coverage starting April 1, 2021. If you are an Assistance Eligible Individual, the ARP provides that you must be treated, for purposes of COBRA, as having paid in full the amount of such premium from April 1, 2021 through September 30, 2021. Accordingly, plans and issuers should not collect premium payments from Assistance Eligible Individuals and subsequently require them to seek reimbursement of the premiums for periods of coverage beginning on or after April 1, 2021, and preceding the date on which an employer sends an election notice, if an individual has made an appropriate request for such treatment. You should contact your plan or issuer directly to ask about taking advantage of the premium assistance.

#### Q8: How will the premium assistance be provided to me?

You will not receive a payment of the premium assistance. Instead, Assistance Eligible Individuals do not have to pay any of the COBRA premium for the period of coverage from April 1, 2021 through September 30, 2021. The premium is reimbursed directly to the employer, plan administrator, or insurance company through a COBRA premium assistance credit.

#### Q9: Am I required to pay any administrative fees?

If you are an Assistance Eligible Individual, you will not need to pay any part of what you would otherwise pay for your COBRA continuation coverage, including any administration fee that would otherwise be charged.

#### **Notices**

#### Q10: Does the ARP impose any new notice requirements?

Yes, plans and issuers are required to notify qualified beneficiaries regarding the premium assistance and other information about their rights under the ARP, as follows:

- A general notice to all qualified beneficiaries who have a qualifying event that is a reduction in hours or an involuntary termination of employment from April 1, 2021 through September 30, 2021. This notice may be provided separately or with the COBRA election notice following a COBRA qualifying event.
- A notice of the extended COBRA election period to any Assistance Eligible Individual (or any individual who would be an Assistance Eligible Individual if a COBRA continuation coverage election were in effect) who had a qualifying event

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<sup>&</sup>lt;sup>5</sup> ARP section 9501(a)(1)(A).

before April 1, 2021. This requirement does not include those individuals whose maximum COBRA continuation coverage period, if COBRA had been elected or not discontinued, would have ended before April 1, 2021 (generally, those with applicable qualifying events before October 1, 2019). This notice must be provided within 60 days following April 1, 2021 (that is, by May 31, 2021).

The ARP also requires that plans and issuers provide individuals with a notice of expiration of periods of premium assistance explaining that the premium assistance for the individual will expire soon, the date of the expiration, and that the individual may be eligible for coverage without any premium assistance through COBRA continuation coverage or coverage under a group health plan. Coverage may also be available through Medicaid or the Health Insurance Marketplace®. This notice must be provided 15 - 45 days before the individual's premium assistance expires.

Unless specifically modified by the ARP, the existing requirements for the manner and timing of COBRA notices continue to apply. Due to the COVID-19 National Emergency, DOL, the Department of the Treasury, and the IRS issued guidance extending timeframes for certain actions related to health coverage under private-sector employment-based group health plans. The extensions under the Joint Notice and EBSA Disaster Relief Notice 2021-01 do not apply, however, to the notices or the election periods related to COBRA premium assitance available under the ARP. Therefore, plans and issuers must provide the notices according to the timeframes specified in the ARP (outlined above).

DOL is committed to ensuring that individuals receive the benefits to which they are entitled under the ARP. Employers or multiemployer plans may also be subject to an excise tax under the Internal Revenue Code for failing to satisfy the COBRA continuation coverage requirements. This tax could be as much as \$100 per qualified beneficiary, but not more than \$200 per family, for each day that the taxpayer is in violation of the COBRA rules.

#### Q11: What information must the notices include?

The notices must include the following information:

- The forms necessary for establishing eligibility for the premium assistance;
- Contact information for the plan administrator or other person maintaining relevant information in connection with the premium assistance;
- A description of the additional election period (if applicable to the individual);
- A description of the requirement that the Assistance Eligible Individual notify the plan when he/she becomes eligible for coverage under another group health plan (not including excepted benefits, a QSEHRA, or a health FSA), or eligible for Medicare and the penalty for failing to do so;

<sup>6</sup> Notice of Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID–19 Outbreak (Joint Notice). 85 FR 26351 (May 4, 2020); EBSA Disaster Relief Notice 2021-01 (Feb. 26, 2021), available at https://www.dol.gov/sites/dolgov/files/ebsa/employers-and-advisers/plan-administration-and-compliance/disaster-relief/ebsa-disaster-relief-notice-2021-01.pdf. Note that the Departments of Labor and the Treasury share jurisdiction for enforcement of the COBRA continuation provisions.

- A description of the right to receive the premium assistance and the conditions for entitlement; and
- If offered by the employer, a description of the option to enroll in a different coverage option available under the plan.

#### Q12: Will there be model notices?

Yes. DOL has developed model notices that are available at https://www.dol.gov/cobra-subsidy.

#### **Individual Questions For Employees And Their Families**

#### Q13: How much time do I have to enroll in COBRA continuation coverage?

In general, individuals who are eligible for COBRA continuation coverage have 60 days after the date that they initially receive their COBRA election notice to elect COBRA continuation coverage. Due to the COVID-19 National Emergency, DOL, the Department of the Treasury, and the IRS issued guidance extending timeframes for certain actions related to health coverage under private-sector employment-based group health plans. The extensions under the He Joint Notice and EBSA Disaster Relief Notice 2021-01 do not apply, however, to the notices or elections related to COBRA premium assistance available under the ARP. Potential Assistance Eligible Individuals therefore must elect COBRA continuation coverage within 60 days of receipt of the relevant notice or forfeit their right to elect COBRA continuation coverage with premium assistance. Similiarly, plans and issuers must provide the notices required under the ARP within the timeframe required by the ARP.

Assistance Eligible Individuals do not need to send any payments for the COBRA continuation coverage during the premium assistance period. For additional information about this guidance visit: <a href="https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/disaster-relief">https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/disaster-relief</a>.

# Q14: I am an Assistance Eligible Individual who has been enrolled in COBRA continuation coverage since December 2020. Will I receive a refund of the premiums that I have already paid?

No. The COBRA premium assistance provisions in the ARP apply only to premiums for coverage periods from April 1, 2021 through September 30, 2021. If you were eligible for premium assistance, but paid in full for periods of COBRA continuation coverage beginning on or after April 1, 2021 through September 30, 2021, you should contact the plan administrator or

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<sup>&</sup>lt;sup>7</sup> Note, however, that a potential Assistance Eligible Individual has the choice of electing COBRA continuation coverage beginning April 1, 2021 or after (or beginning prospectively from the date of your qualifying event if your qualifying event is after April 1, 2021), or electing COBRA continuation coverage commencing from an earlier qualifying event if the individual is eligible to make that election, including under the extended time frames provided under the Joint Notice and EBSA Notice 2021-01. The election period for COBRA continuation coverage with premium assistance does not cut off the individual's preexisting right to elect COBRA continuation coverage, including under the extended time frames provided under the Joint Notice and EBSA Notice 2021-01. Note, that the premium assistance is only available for periods from April 1, 2021 through September 30,2021.

employer sponsoring the plan to discuss a credit against future payments (or a refund in certain circumstances).

# Q15: I am currently enrolled in COBRA continuation coverage, but I would like to switch to a different coverage option offered by the same employer. Can I do this?

Group health plans can choose to allow qualified beneficiaries to enroll in coverage that is different from the coverage they had at the time of the COBRA qualifying event. The ARP provides that changing coverage will not cause an individual to be ineligible for the COBRA premium assistance, provided that:

- The COBRA premium charged for the different coverage is the same or lower than for the coverage the individual had at the time of the qualifying event;
- The different coverage is also offered to similarly situated active employees; and
- The different coverage is not limited to only excepted benefits, a QSEHRA, or a health FSA.

If the plan permits individuals to change coverage options, the plan must provide the individuals with a notice of their opportunity to do so. Individuals have 90 days to elect to change their coverage after the notice is provided.

# Q16: Only part of my family elected COBRA continuation coverage but all of us were eligible. Can I enroll the others and take advantage of the premium assistance?

Each COBRA qualified beneficiary may independently elect COBRA continuation coverage. If a family member did not elect COBRA continuation coverage when first eligible and that individual would be an Assistance Eligible Individual, that individual has an additional opportunity to enroll and qualify for the premium assistance. However, this extended election period does not extend the maximum period of COBRA continuation coverage had COBRA continuation coverage been originally elected. See Q3 and Q5 above for more information.

# Q17: I received my COBRA election notice. Can I change my coverage option from the one I had previously?

In general, COBRA continuation coverage provides the same coverage that the individual had at the time of the qualifying event. However, under the ARP, a plan may offer Assistance Eligible Individuals the option of choosing other coverage that is also offered to similarly situated active employees and that does not have higher premiums than the coverage the individual had at the time of the qualifying event. See Q15 for more information.

# Q18: I am currently enrolled in individual market health insurance coverage, but I am potentially an Assistance Eligible Individual. Can I switch to COBRA continuation coverage with premium assistance?

Yes, Potential Assistance Eligible Individuals can use the election period to change from individual market health insurance coverage (that they got either through a Health Insurance Marketplace®, such as through HealthCare.gov, or outside of the Marketplace) to COBRA continuation coverage with premium assistance. Additionally, you may apply for and, if eligible

enroll in Medicaid at any time. If you elect to enroll in COBRA continuation coverage with premium assistance, you will no longer be eligible for a premium tax credit, or advance payments of the premium tax credit, for Marketplace coverage you otherwise would qualify for during this premium assistance period. You must contact the Marketplace to let them know that you've enrolled in other minimum essential coverage or you may have to repay some or all of the advance payments of the premium tax credit made on your behalf during the period you were enrolled in both COBRA continuation coverage and Marketplace coverage. This repayment would be required when filingyour income tax return for 2021 (see additional information about contacting the Marketplace below).

### Q19: Can I end my individual health insurance coverage retroactively if I can qualify for COBRA with premium assistance starting on April 1?

Enrollees generally are not permitted to terminate coverage purchased through a Marketplace retroactively. You must do so prospectively. If you want to end coverage that you got from a Health Insurance Marketplace®, such as on HealthCare.gov, because you want to change to COBRA continuation coverage with premium assistance, you must update your Marketplace application or call the Marketplace to do so. If you enrolled in coverage through HealthCare.gov, you can call 1-800-318-2596 (TTY: 1-855-889-4325). If your state has its own Marketplace platform, find contact information for your State Marketplace here: <a href="https://www.healthcare.gov/marketplace-in-your-state/">https://www.healthcare.gov/marketplace-in-your-state/</a>.

If you want to end individual health insurance coverage that you got outside of a Marketplace, such as directly from an insurance company, you must contact the insurance company to do so.

## Q20: What should I consider when making a decision whether to continue with individual market health insurance coverage or change to COBRA continuation coverage with premium assistance?

You should consider the factors you normally would when deciding on which health insurance coverage is right for you and your family. For example, in addition to premium cost, you may want to compare cost-sharing requirements such as plan deductibles and copays. You may also want to consider how much progress you have made toward your deductible and other plan accumulators, and compare different plans' and coverage options' provider networks and prescription drug formularies based on your family's medical care needs. Note, however, that if you are currently employed by the employer offering the COBRA continuation coverage with premium assistance, you may enroll in Marketplace coverage but are ineligible for a subsidy or a premium tax credit for the Marketplace coverage for the period you are offered the COBRA continuation coverage with premium assistance.

# Q21: Can I qualify for a special enrollment period (SEP) to enroll in individual market health insurance coverage, such as through a Health Insurance Marketplace®, when my COBRA premium assistance ends on September 30? What about if my COBRA continuation coverage ends sooner than that?

When your COBRA premium assistance ends, you may be eligible for a SEP to enroll in coverage through a Health Insurance Marketplace®, or to enroll in individual health insurance

coverage outside of the Marketplace. You may also qualify for a SEP when you reach the end of your maximum COBRA coverage period. For more information about this SEP, see: https://www.healthcare.gov/unemployed/cobra-coverage/.

For more information about enrolling in Marketplace coverage, see: HealthCare.gov, or you can call 1-800-318-2596 (TTY: 1-855-889-4325). If your state has its own Marketplace platform, find contact information for your State Marketplace here: https://www.healthcare.gov/marketplace-in-your-state/.

You may apply for and, if eligible, enroll in Medicaid coverage at any time. For more information, go to: <a href="https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/">https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/</a>.

#### **More Information**

Q21: How can I get more information on my eligibility for COBRA continuation coverage or the premium assistance, including help if my employer has denied my request for the premium assistance?

For group health plans sponsored by private-sector employers, guidance and other information is available on the DOL web site at <a href="https://www.dol.gov/cobra-subsidy">https://www.dol.gov/cobra-subsidy</a>. You can also contact one of EBSA's Benefits Advisors at askebsa.dol.gov or 1.866.444.3272.

EBSA's Benefits Advisors may also be able to assist if you feel that your plan or employer has improperly denied your request for treatment as an Assistance Eligible Individual. Employers and plans may be subject to an excise tax under the Internal Revenue Code for failing to satisfy the COBRA continuation coverage requirements. This tax could be as much as \$100 per qualified beneficiary, but not more than \$200 per family, for each day that the plan or employer is in violation of the COBRA rules. If you feel you may have been improperly denied premium assistance, contact EBSA at askebsa.dol.gov or 1.866.444.3272.

If you work for a state or local government employer and have questions regarding the premium assistance, please contact the Centers for Medicare & Medicaid Services via email at <a href="mailto:phig@cms.hhs.gov">phig@cms.hhs.gov</a> or call 410-786-1565.





HP-2021-08

## Access to Marketplace Plans with Low Premiums on the Federal Platform

### Part II: Availability Among Uninsured Non-Elderly Adults Under the American Rescue Plan

Under the American Rescue Plan of 2021 (ARP), we estimate that approximately 3 in 5 (62 percent) of the 11 million uninsured non-elderly adults eligible for Marketplace coverage in HealthCare.gov states likely can access zero-premium plans, while nearly 3 in 4 (73 percent) likely can access a plan for \$50 or less per month.

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#### **KEY POINTS**

- The American Rescue Plan (ARP) enhances and expands eligibility for advance payments of premium tax credits (APTCs) to purchase Marketplace insurance coverage under the Affordable Care Act (ACA). This Issue Brief estimates the changes in the availability of health plans with no premiums ("zero-premium plans") or premiums for \$50 or less per month ("low-premium plans") after APTCs among uninsured non-elderly adults potentially eligible for Marketplace plans in HealthCare.gov states under the ARP.
- Under the ARP, we estimate that the availability of zero-premium plans has increased by 19 percentage points in this population, and low-premium plans by 16 percentage points.
- Whereas most low-premium plans before the ARP were in the bronze tier, the ARP has substantially increased the availability of low-premium silver and gold plans. Availability of silver tier plans for zero-premium has increased by 22 percentage points, with approximately a quarter (25 percent) of this population now able to access such a plan. Availability of low-premium plans for this population increased by 28 percentage points, with approximately half (50 percent) now potentially able to find a low-premium silver plan. Zero-premium gold plan availability also increased for this population substantially, from 3 to 11 percent, and for low-premium gold plan availability from 13 to 30 percent.
- The ARP reduced the expected individual contribution of household income toward benchmark plan premiums to zero percent for applicable taxpayers with income between 100 and 150 percent of the Federal Poverty Level (FPL). Combined with cost-sharing reductions, this means that nearly all eligible uninsured adults in this income range can find a zero-premium plan with an actuarial value (AV) of 94 percent.

<sup>&</sup>lt;sup>1</sup> All references to premiums in this Issue Brief refer to premiums after application of APTCs, for those eligible to receive them. The uninsured examined in this analysis are non-elderly adults (ages 18-64) in *HealthCare.gov* states who are likely eligible for Marketplace plans based on their incomes being above 138 percent of the Federal Poverty Level (FPL) in Medicaid expansion states, and above 100 percent FPL in non-expansion states. For brevity, we refer to this as the "uninsured population" in the Issue Brief. We do not examine those below 100 percent FPL in this analysis, though some individuals in this income range may be QHP-eligible.

- Under the ARP, approximately 66 percent of Black non-Latino uninsured adults now may have access to a zero-premium plan and 76 percent can find a low-premium plan. Among Hispanic and Latino uninsured adults, 69 now may have access to a zero-premium plan and 80 percent may now be able find a low-premium plan.
- We estimate there are approximately 2 million uninsured adults with incomes of 400 percent FPL or greater in Healthcare.gov states who may be newly eligible for coverage with Marketplace premium tax credits under the ARP.

#### **INTRODUCTION**

This is the second ASPE Issue Brief in a series on the availability of zero- and low-premium plans in the HealthCare.gov Marketplace. In the first Issue Brief, published on March 29, 2021, we estimated there are approximately 11.1 million non-elderly, uninsured Americans in HealthCare.gov states potentially eligible to enroll in a Qualified Health Plan (QHP) in the Marketplace. Prior to the passage of the American Rescue Plan Act of 2021, Marketplace advanced premium tax credit (APTC) payments for many individuals in HealthCare.gov states - particularly low-income individuals - were large enough to substantially reduce premiums for many consumers, and in some cases to zero dollars, depending on the plan selections they might make. With the passage of the American Rescue Plan (ARP) and its enhanced and expanded Marketplace premium tax credit provisions, the uninsured population's access to zero- and low-premiums health plans has increased.

The ARP builds on the ACA by increasing access to health coverage through financial incentives to states to expand Medicaid and enhanced Marketplace premium tax credit eligibility. Under the ARP, ACA Marketplace premium tax credits temporarily become more generous in two ways: 1) for most consumers with household income between 100-400 percent FPL in Medicaid non-expansion states and between 138-400 percent FPL in Medicaid expansion states, the expected household income contribution toward premiums for the benchmark plan is lowered, including a reduction to 0 percent for those between 100-150 percent FPL; and 2) for consumers above the previous household income limit (400 percent FPL) for premium tax credit eligibility, the eligibility income limit is removed. The ARP changes to Marketplace premium tax credits apply for coverage beginning January 2021 and last for two years (2021 and 2022). APTCs under the new provisions will be available through the HealthCare.gov Marketplace starting April 1, 2021. Reduced premium tax credits are available for all of 2021, and consumers can claim the increased credits for January–April 2021 at tax filing.

The Centers for Medicare & Medicaid Services (CMS) determined that the COVID-19 emergency presents exceptional circumstances for consumers in accessing health insurance and provided access to a Special Enrollment Period (SEP) for individuals and families to apply and enroll in the coverage they need. This SEP will be available to eligible consumers in the 36 states served by the federal Marketplace on the HealthCare.gov platform.<sup>3, ii, iii</sup> Consumer access to the 2021 COVID-19 SEP on HealthCare.gov began on February 15, 2021 and will run through August 15, 2021.<sup>4,5, iv</sup> Most of the fifteen states (including the District of Columbia) that run a State-Based Marketplace (SBM) have also made available a COVID-19 SEP with a similar timeframe.<sup>6, v</sup>

ii HealthCare.gov states examined include: Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

iii States operating their own State-Based Marketplace (SBM) that do not use the HealthCare.gov platform are not included in the analysis: California, Colorado, Connecticut, District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and Washington.

<sup>&</sup>lt;sup>iv</sup> The SEP also allows individuals currently enrolled in a plan through HealthCare.gov to switch plans.

<sup>&</sup>lt;sup>v</sup> See state profiles here: <a href="https://www.healthinsurance.org/states/">https://www.healthinsurance.org/states/</a>.

The ARP's enhanced Marketplace premium tax credit eligibility and the current COVID-19 SEP together provide new opportunities for eligible uninsured and underinsured individuals to find affordable health coverage and higher quality plans at lower premiums when shopping on HealthCare.gov.<sup>7</sup>

This Issue Brief examines the impact of the ARP on the availability of zero-premium and low-premium health plans in HealthCare.gov states among uninsured non-elderly adults potentially eligible for Marketplace coverage (referred to subsequently as "the uninsured" or "the study population"). VI The brief compares access to such plans before and after the ARP's implementation and highlights the changes in availability. We examine the availability of zero- and low-premium plans before and after the ARP by metal tier, select demographic characteristics, and state-level estimates.

#### **METHODOLOGY**

The study methodology for this analysis of the uninsured is the same as in ASPE's prior analysis, *Access to Marketplace Plans with Low Premiums on the Federal Platform - Part I: Availability Among Uninsured Non-Elderly Adults and HealthCare.gov Enrollees Prior to the American Rescue Plan.* See Methodology and Appendix of that Issue Brief for further detail of the study methodology. For the ARP impacts we analyzed two APTC provisions: lowering the household income contribution toward premiums for the benchmark plan for those with household incomes between 100 and 400 percent FPL, and removing the ACA upper income limit for eligibility above 400 percent FPL. The ARP's unemployment compensation provisions, which affect countable income for determining Marketplace premium tax credits, are not included in this analysis.

This analysis has several limitations. Data for State-Based Marketplaces are not readily available for 2021 and our estimates therefore do not represent the full United States. This analysis of the uninsured does not account for immigration status or the availability of an employer offer of coverage, which both affect eligibility for Marketplace subsidies.

vi Analysis of the effect of the American Rescue Plan on availability of zero- and low-premium plans among 2021 HealthCare.gov enrollees is currently in progress. All results referring to "uninsured adults" in this brief are uninsured non-elderly adults who are potentially QHP-eligible in HealthCare.gov states.

#### ZERO- AND LOW-PREMIUM PLAN AVAILABILITY BY METAL TIER

Table 1 shows the availability of zero- and low-premium plans by plan metal tier in the study population, before and after the ARP.

Table 1. Zero- and Low-Premium Plan Availability for Uninsured QHP-Eligible Non-Elderly Adults in HealthCare.gov States by Metal Tier, Pre- and Post-American Rescue Plan of 2021

Uninsured Non-Elderly Adults – Plan Availability	Pre-ARP	Post-ARP#	Percentage Point Difference**
Total Population*			
\$0 Premium Plan, %			
Any Metal Tier	42.5%	61.7%	+19.2%
Bronze	42.5%	61.7%	+19.2%
Silver	3.4%	24.9%	+21.5%
Gold	3.4%	11.2%	+7.7%
\$50 or Less Per Month Premium Plan, %			
Any Metal Tier	56.8%	73.3%	+16.5%
Bronze	56.8%	73.3%	+16.5%
Silver	21.9%	49.8%	+27.9%
Gold	12.6%	30.0%	+17.4%

Data Sources: American Community Survey, 2019, Marketplace Plan Files for Coverage in 2021

Notes: Catastrophic plans excluded from the analyses; \*Rounded to the nearest thousand; \*\*Rounding may result in slight deviation in listed percentage point difference and the difference in pre-ARP and post-ARP values calculated from the rounded values in the table; # "Post-ARP" only refers to the two subsidy provisions from the ARP examined in this analysis: lowering of maximum applicable percent of household income toward benchmark premiums and extension of APTC to applicable taxpayers with household incomes above 400 percent FPL.

We estimate that access to zero- and low-premium plan availability increased an additional 19.2 percentage points and 16.5 percentage points, respectively, under ARP. Overall, approximately 3 in 5 (61.7 percent) adults in this population may be able to access a zero-premium plan in the Marketplace and nearly 3 in 4 (73.3 percent) may be able to find a plan for \$50 or less per month.

#### **Silver Plans**

Under the ARP, silver zero- and low-premium plans have become substantially more available. We estimate availability of zero-premium plans to increase by 21.5 percentage points in the silver metal tier, with nearly a quarter (24.9 percent) of the uninsured now able to find a silver plan at no premium cost to them. Similarly, we estimate availability of low-premium plans to increase by 27.9 percentage points in the silver metal tier, with nearly half (49.8 percent) of the uninsured now able to find a silver plan for \$50 or less per month premium cost.

Because income based cost-sharing reductions (CSRs) are only available for silver plans and for eligible consumers with household income between 100 and 250 percent FPL, vii these findings indicate for CSR-eligible consumers there may be new opportunities for low-premium plans with more generous coverage (i.e. higher Actuarial Value [AV] viii and lower out-of-pocket costs, e.g. reduced deductibles, copays, etc.).

vii With the exception of American Indians and Alaskan Natives, whose incomes can be higher, and who can utilize CSRs towards plans at any metal level.

viii The actuarial value (AV) of a health plan is the average percentage of total costs of in-network essential health benefits (EHB) covered by the health plan. The AV available to all QHP eligible individuals ranges from 60% for bronze plans, 70% for silver plans, 80% for gold plans, and 90% for platinum plans. For certain eligible individuals (generally those with household incomes between 100%-250% FPL) silver cost-sharing reduction (CSR) plans are available, which enhance AV from 70% to 73%, 87%, or 94% depending on income. Catastrophic plans are excluded from all analyses.

Additionally, the ARP reduced the expected contribution of household income toward benchmark plan (second-lowest cost silver) premiums to zero percent for those with household incomes between 100 and 150 percent FPL, meaning that 100 percent of the eligible consumers in this income range can find a zero-premium plan with an AV of 94 percent (i.e. on average, consumers enrolled in these plans only have to pay out-of-pocket for 6 percent of total in-network health care costs).

#### **Gold Plans**

Availability of zero-premium gold plans also increased under the ARP, from 3.4 percent to 11.2 percent. The same was true for low-premium gold plans, increasing from 12.6 to 30.0 percent, presenting additional opportunities for the uninsured to find plans for zero- or low-premium cost with higher AV than standard silver plans.

#### ZERO- AND LOW-PREMIUM PLAN AVAILABILITY BY DEMOGRAPHIC CHARACTERISTICS

Table 2 shows availability of zero- and low-premiums plans by demographics in the study population, before and after the ARP.

Table 2. Zero- and Low-Premium Plan Availability for Uninsured QHP-Eligible Non-Elderly Adults in HealthCare.gov States by Demographics, Pre- and Post-American Rescue Plan of 2021

Uninsured Non-Elderly Adults	Total	\$0 Available - Any Metal				\$50 or Less Per Month Available - Any Metal		
– Plan Availability	Population*	Pre- ARP, %	Post- ARP#, %	Percentage Point Difference**	Pre- ARP, %	Post- ARP#, %	Percentage Point Difference**	
Total Population*	11,103,000	42.5%	61.7%	+19.2%	56.8%	73.3%	+16.5%	
Rural Status <sup>‡</sup>								
Rural	1,921,000	46.7%	65.1%	+18.4%	60.6%	76.8%	+16.2%	
Urban	9,182,000	41.6%	60.9%	+19.4%	56.0%	72.5%	+16.5%	
Age								
0-17	Excluded	N/A	N/A	N/A	N/A	N/A	N/A	
18-24	1,333,000	44.2%	69.1%	+24.9%	62.2%	82.1%	+19.9%	
25-34	3,058,000	36.7%	60.0%	+23.3%	53.4%	72.6%	+19.2%	
35-44	2,721,000	41.6%	60.2%	+18.6%	55.8%	71.5%	+15.7%	
45-54	2,290,000	42.8%	58.7%	+15.9%	55.7%	69.6%	+13.9%	
55-64	1,701,000	52.3%	65.1%	+12.8%	62.0%	75.4%	+13.4%	
65+	Excluded	N/A	N/A	N/A	N/A	N/A	N/A	
Income/FPL								
<100% <sup>†</sup>	Excluded	N/A	N/A	N/A	N/A	N/A	N/A	
100-138%	1,290,000	99.9%	100.0%	+0.1%	100.0%	100.0%	0.0%	
>138-150%	611,000	90.1%	93.3%	+3.2%	100.0%	100.0%	0.0%	
>150-200%	2,370,000	75.2%	93.2%	+18.0%	97.7%	100.0%	+2.3%	
>200-250%	1,990,000	36.9%	84.6%	+47.7%	66.8%	99.7%	+32.9%	
>250-300%	1,269,000	18.2%	54.7%	+36.4%	39.3%	84.5%	+45.1%	
>300-350%	901,000	9.5%	26.6%	+17.1%	19.5%	51.4%	+31.8%	
>350-400%	617,000	6.9%	13.7%	+6.8%	14.1%	30.2%	+16.1%	
>400% <sup>†</sup>	2,055,000	0.0%	3.8%	+3.8%	0.0%	7.7%	+7.7%	
Unknown <sup>†</sup>	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Race/Ethnicity <sup>§</sup>								
Hispanic and Latino	3,788,000	50.2%	68.7%	+18.5%	64.5%	79.9%	+15.4%	
White Non-Latino	5,157,000	36.3%	55.9%	+19.5%	50.7%	68.1%	+17.4%	
Black Non-Latino	1,504,000	45.1%	65.5%	+20.4%	59.3%	75.5%	+16.2%	
Asian/Native-Hawaiian/Pac. Isl.	296,000	35.3%	52.8%	+17.4%	51.1%	66.3%	+15.2%	
American Indian / Alaska Native	150,000	45.3%	62.8%	+17.5%	59.2%	75.6%	+16.4%	
Multi-racial or Other	208,000	42.7%	61.3%	+18.6%	58.1%	73.4%	+15.4%	

Data Sources: American Community Survey, 2019; Marketplace Plan Files for Coverage in 2021

†Included for consistency with tables in Part I of the Issue Brief series, but not applicable to the uninsured component of the analysis

†Rural vs urban defined at the county level in the Marketplace files; §Race and ethnicity based on American Community Survey categories

Notes: Catastrophic plans excluded from all analyses; \*Rounded to the nearest thousand; \*\*Rounding may result in slight deviation in listed percentage point difference and the difference in pre-ARP and post-ARP values calculated from the rounded values in the table; # "Post-ARP" only refers to the two subsidy provisions from the ARP examined in this analysis: lowering of the maximum applicable percent of income toward benchmark premiums and extension of APTCs to those above 400 percent FPL.

#### **Rural Status**

Under the ARP, zero- and low-premium health plans are now available to 65.1 percent and 76.8 percent, respectively, of the study population in rural counties. In urban counties they are available to 60.9 percent and 72.5 percent, respectively, of the study population.

#### Income

We estimate approximately 2 million non-elderly uninsured individuals with incomes of 400 percent FPL or greater in HealthCare.gov states may be eligible for APTC under the ARP. Those with incomes between 200 percent and 300 percent FPL saw the greatest increase in availability of zero- and low-premium plans, with more than a 30-percentage point increase for both.

#### **Race and Ethnicity**

Under the ARP, approximately 65.5 percent of Black non-Latino adults in our study population now can access a zero-premium plan and 75.5 percent can find a plan for \$50 or less per month. Among Hispanic and Latino adults, approximately 68.7 percent now have access to a zero-premium plan and 79.9 percent can now find a plan for \$50 or less per month.

#### **ZERO- AND LOW-PREMIUM PLAN AVAILABILITY BY STATE**

Table 3 shows zero- and low-premium plan availability by HealthCare.gov state for the study population, before and after the ARP.

Table 3. Zero- and Low-Premium Plan Availability for Uninsured QHP-Eligible Non-Elderly Adults by HealthCare.gov State, Pre- and Post-American Rescue Plan of 2021

<b>.</b> .	6	ŞU AV	ailable - Any Met	al, %	\$50 or Less Per Month Available - Any Metal, %		
State			_	Pre-ARP, %	Post-ARP#, %	Percentage Point Difference**	
All							
HealthCare.gov	11,103,000	42.5%	61.7%	+19.2%	56.8%	73.3%	+16.5%
States							
Alabama	229,000	67.7%	79.7%	+12.0%	74.3%	84.8%	+10.6%
Alaska	37,000	0.0%	0.0%	0.0%	60.4%	77.4%	+17.0%
Arizona	389,000	24.7%	53.3%	+28.6%	42.1%	65.1%	+23.0%
Arkansas	124,000	22.9%	58.0%	+35.1%	46.1%	69.7%	+23.6%
Delaware	33,000	43.2%	61.4%	+18.2%	53.7%	68.8%	+15.1%
Florida	1,560,000	46.1%	66.2%	+20.1%	58.0%	74.1%	+16.1%
Georgia	737,000	46.0%	66.8%	+20.9%	59.5%	75.9%	+16.4%
Hawaii	22,000	0.0%	0.0%	0.0%	42.1%	56.7%	+14.6%
Illinois	463,000	0.0%	0.0%	0.0%	37.5%	59.5%	+22.1%
Indiana	267,000	16.0%	48.6%	+32.6%	36.4%	61.5%	+25.1%
lowa	80,000	55.8%	73.5%	+17.7%	61.8%	80.8%	+19.0%
Kansas	144,000	49.7%	68.5%	+18.8%	60.3%	76.2%	+15.9%
Kentucky	137,000	39.8%	65.0%	+25.1%	55.7%	73.6%	+17.9%
Louisiana	193,000	39.6%	60.3%	+20.7%	51.2%	69.4%	+18.2%
Maine	58,000	0.0%	0.0%	0.0%	34.6%	58.7%	+24.1%
Michigan	286,000	25.0%	54.1%	+29.1%	42.7%	64.4%	+21.7%
Mississippi	172,000	28.1%	58.5%	+30.4%	48.0%	69.4%	+21.4%
Missouri	254,000	45.9%	65.5%	+19.5%	58.5%	74.2%	+15.6%
Montana	50,000	40.5%	55.8%	+15.3%	49.5%	64.3%	+14.8%
Nebraska	66,000	64.4%	83.6%	+19.1%	73.2%	90.5%	+17.3%
New Hampshire	54,000	16.3%	39.1%	+22.8%	29.1%	52.8%	+23.7%
New Mexico	95,000	33.6%	57.1%	+23.5%	48.4%	66.6%	+18.3%
North Carolina	643,000	59.1%	76.4%	+17.3%	69.0%	81.9%	+12.9%
North Dakota	24,000	53.0%	67.0%	+14.0%	55.5%	82.2%	+26.7%
Ohio	384,000	23.2%	52.7%	+29.5%	41.3%	65.3%	+24.1%
Oklahoma	238,000	55.7%	73.0%	+17.4%	64.7%	78.9%	+14.3%
Oregon	166,000	0.0%	0.0%	0.0%	43.8%	63.1%	+19.3%
South Carolina	285,000	53.7%	71.4%	+17.6%	65.5%	77.1%	+11.6%
South Dakota	45,000	63.8%	76.9%	+13.1%	73.0%	84.6%	+11.6%
Tennessee	369,000	50.7%	69.4%	+18.7%	62.2%	76.7%	+14.5%
Texas	2,730,000	52.8%	69.7%	+17.0%	63.1%	76.3%	+13.2%
Utah	135,000	52.9%	72.2%	+19.3%	66.5%	79.1%	+12.6%
Virginia	322,000	36.9%	63.1%	+26.2%	54.0%	70.6%	+16.6%
West Virginia	56,000	5.7%	34.7%	+29.0%	27.3%	56.4%	+29.1%
Wisconsin	212,000	40.5%	60.6%	+20.2%	52.5%	69.0%	+16.5%
Wyoming	42,000	67.4%	81.7%	+14.3%	70.0%	86.7%	+16.8%

Data Sources: American Community Survey, 2019; Marketplace Plan Files for Coverage in 2021

Notes: Catastrophic plans excluded from all analyses; \*Rounded to the nearest thousand, and "study population" refers to uninsured QHP-eligible non-elderly adults in *HealthCare.gov* states; \*Rounding may result in slight deviation in listed percentage point difference and the difference in pre-ARP and

post-ARP values calculated from the rounded values in the table; # "Post-ARP" only refers to the two subsidy provisions from the ARP examined in this analysis: lowering of max applicable percent of income toward benchmark premiums and extension of APTC to those above 400 percent FPL.

#### **State Level Availability**

Under the ARP, HealthCare.gov states continue to vary widely in the availability of zero-premium plans; some states (Alaska, Hawaii, Illinois, Maine, and Oregon) did not have any zero-premium plans available, ix while in other states more than three-quarters of the uninsured population may have them available. There was also variability by state for low-premium plans; however, now more than 50 percent of the study population in every state can find a low premium plan.

Some states may not have zero-premium plans available to anyone; for example, if all plans in the state cover some services that are not ACA essential health benefits (EHBs), then premiums in that state cannot be reduced by APTCs to zero-premium. APTCs cannot be applied to non-EHB portions of the premium and therefore these plans will always have some amount of premium cost to the consumer.\* However, due to the comprehensiveness of EHBs, non-EHB portions of premiums are typically relatively small.

#### **CONCLUSION**

The American Rescue Plan Act of 2021 enhances Marketplace premium tax credits for consumers in HealthCare.gov states and expands eligibility for premium tax credits to applicable taxpayers with household incomes of 400 percent FPL and greater. We find that zero-premium and low-premium plans have become much more widely available based on these new tax credit provisions. These changes have improved the coverage options for millions of uninsured Americans and can help reduce racial and ethnic disparities in access to affordable health care coverage.

ix In places where plans cover services not included in the ACA's Essential Health Benefits (EHB), consumers in this income range will still pay some premium. The plans in these states all cover some non-Essential Health Benefits in their QHPs, which are not eligible for APTCs. See discussion of this in the Part I Issue Brief in this series.

<sup>\*</sup> Non-essential health benefits are services beyond the ACA's ten categories of essential services, due to certain state mandates (for example, adult vision and adult dental coverage). For more details about specific state coverage requirements see: <a href="https://www.cms.gov/cciio/resources/data-resources/ehb#ehb">https://www.cms.gov/cciio/resources/data-resources/ehb#ehb</a>.

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#### SUGGESTED CITATION

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FOR IMMEDIATE RELEASE **April 1, 2021** 

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**Contact: HHS Press Office** 

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### HHS Secretary Becerra Announces Reduced Costs and Expanded Access Available for Marketplace Health Coverage Under the American Rescue Plan

An average of three out of five eligible uninsured Americans can access \$0 plans after advance payments of tax credits and an average of four out of five current HealthCare.gov consumers will be able to find a plan for \$10 or less per month after advance payments of tax credits

Department also announces \$50 Million Boost to Special Enrollment Period Outreach Campaign

Today, U.S. Department of Health and Human Services (HHS) Secretary Xavier Becerra announced that additional savings and lower health care costs are available for consumers on HealthCare.gov. The American Rescue Plan (ARP) has increased tax credits available to consumers, helping to reduce premiums and giving consumers access to affordable health care coverage.

The Department also announced an additional \$50 million in advertising to bolster the Special Enrollment Period outreach campaign. The campaign will run through August 15, 2021.

"We're delivering lower health care costs to more Americans because everyone deserves access to quality, affordable health care. Today help is here and millions of Americans can start saving money on their health insurance premiums thanks to the American Rescue Plan," said HHS Secretary Xavier Becerra. "The Biden Administration is committed to bringing down health care costs for families. Consumers can save money by visiting HealthCare.gov and choosing a plan that works for them and their budget. HHS will be reaching out to encourage Americans to use the Special Enrollment Period to sign up for quality, affordable coverage through HealthCare.gov."

Premium tax credit calculations for the Marketplaces on HealthCare.gov are now adjusted so that most consumers qualify for more substantial advance payments of premium tax credits. Many Americans on the Marketplaces will see their premiums decrease, on average, by \$50 per person per month and \$85 per

policy per month. An average of four out of five consumers currently enrolled in a plan through HealthCare.gov will be able to find a plan for \$10 or less per month with the newly expanded financial assistance under the American Rescue Plan. Additionally, after advance payments of the premium tax credits, an average of three out of five uninsured adults eligible for coverage on HealthCare.gov may be able to access a zero-premium plan and nearly three out of four may find a plan for \$50 or less per month on HealthCare.gov.

Current enrollees should review their application, make any changes needed to their current information, submit their application and select a plan, or reselect their current plan, to receive the increased advance payments of premium tax credits for 2021 Marketplace coverage. Consumers who take action in April and confirm updated savings on the plan of their choice will start receiving the savings and lower costs starting with their May 1 premiums.

Consumers who want to enroll in coverage and see if they qualify for more affordable premiums can visit HealthCare.gov or CuidadoDeSalud.gov to view 2021 plans and prices and, if eligible, enroll in a plan that best meets their needs. Additionally, consumers can call the Marketplace Call Center at 1-800-318-2596, which provides assistance in over 150 languages. TTY users should call 1-855-889-4325. Consumers can also find a local assister or agent/broker in their area: https://localhelp.healthcare.gov. Eligible consumers can apply through HealthCare.gov through August 15, 2021, to gain access to the Special Enrollment Period to change or update their plan choices.

Consumers who live in a state that operates its own Marketplace platform should visit their state Marketplace website or call center for more information about when these additional savings will be available through their State-based Marketplace.

The Centers for Medicare & Medicaid Services (CMS) launched an educational campaign that focuses on raising awareness among the uninsured about the new savings and the availability of assistance to pay for premiums for those who qualify during the Special Enrollment Period. CMS is also communicating with current enrollees to let them know they can also use this opportunity to update their enrollment information and access the expanded financial assistance. The outreach campaign includes broadcast and digital advertising and educates enrollees with email and text messages.

To see how the American Rescue Plan will bring down health care costs and expand on the Affordable Care Act, visit: https://www.hhs.gov/about/news/2021/03/12/fact-sheet-american-rescue-plan-reduceshealth-care-costs-expands-access-insurance-coverage.html.

To learn more about the premiums for uninsured individuals and families for the Marketplaces that use HealthCare.gov, visit: https://aspe.hhs.gov/pdf-report/access-to-low-premiums-issue-brief-part-II.

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5/12/2021	HHS Secretary Becerra Announces	Reduced Costs and Expanded Access Available fo	r Marketplace Health Co	overage Under the Americ.
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Last revised: April 1, 2021

#### **HHS Headquarters**

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HP-2021-07

## Access to Marketplace Plans with Low Premiums on the Federal Platform

### Part I: Availability Among Uninsured Non-Elderly Adults and HealthCare.gov Enrollees Prior to the American Rescue Plan

Among the estimated 11 million uninsured non-elderly adults potentially eligible for Marketplace plans in HealthCare.gov states, 2 in 5 (42 percent) likely could find a plan for \$0 and more than half (57 percent) a plan for \$50 or less per month, after application of advance premium tax credits (APTC).

These numbers will increase beginning in April 2021 due to the American Rescue Plan.

D. Keith Branham, Ann B. Conmy, Thomas DeLeire, Josie Musen, Xiao Xiao, Rose C. Chu, Christie Peters, and Benjamin D. Sommers

#### **KEY POINTS**

- Many uninsured and underinsured individuals can access plans with no premiums ("zero-premium plans") or premiums for \$50 or less per month ("low-premium plans") after application of advance payments of premium tax credits (APTCs). These individuals may enroll in coverage under the Special Enrollment Period currently being made available on HealthCare.gov due to the COVID-19 pandemic.
- Among non-elderly uninsured adults potentially eligible for Marketplace plans in HealthCare.gov states, zero- and low-premium plans are most commonly available to lower-income individuals. For example, approximately 90 percent or more of eligible uninsured individuals with incomes between 100 and 150 percent of the federal poverty level (FPL) can currently find a plan for \$0, and all such individuals may find a plan for \$50 or less per month.
- By age group, more than half (52 percent) of eligible individuals ages 55-64 can find a zero-premium plan, and 62 percent could find a low-premium plan. Many eligible young uninsured adults (ages 18-24) can also find a zero-premium (44 percent) or low-premium (62 percent) plan.
- Half (50 percent) of eligible uninsured Hispanic / Latino adults can find a zero-premium plan and 64.5 percent can find a low-premium plan. Among eligible Black uninsured adults, 45 percent likely have available a zero-premium plan and 59 percent can find a low-premium plan.
- Among the nearly 8 million individuals *currently* enrolled in plans on the federal Marketplace, 15 percent are enrolled in a zero-premium plan after application of APTC (66 percent have access to a zero-premium plan), and 43 percent are enrolled in a low-premium (78 percent have access to such plans).
- Access to zero-premium and low-premium plans will increase when the subsidies newly enacted in the American Rescue Plan become available on April 1. ASPE will be providing updated analyses in the future.

i All references to premiums in this Issue Brief refer to premiums after application of APTCs, for those eligible to receive them.

#### **INTRODUCTION**

Approximately 30 million Americans remain uninsured, meaning that they do not have financial protection from the costs of obtaining health services and treatment, and many are eligible for Medicaid or Marketplace coverage.¹ Black, Latino, and Native American persons are more likely to be uninsured, and communities of color have been especially hard hit by both the COVID-19 pandemic and the economic downturn.² The Centers for Medicare & Medicaid Services (CMS) determined that the COVID-19 emergency presents exceptional circumstances for consumers in accessing health insurance and provided access to a Special Enrollment Period (SEP) for individuals and families to apply and enroll in the coverage they need. This SEP will be available to consumers in the 36 states served by the federal Marketplace on the HealthCare.gov platform.³,ii,iii Consumer access to the 2021 COVID-19 SEP on HealthCare.gov began on February 15, 2021 and will run through August 15, 2021.⁴.⁵ This SEP is an opportunity for uninsured and underinsured individuals living in the 36 states using Healthcare.gov to enroll in affordable coverage.⁶ Some of these individuals may have lost health insurance coverage or income during the COVID-19 pandemic. The SEP also allows individuals currently enrolled in a plan through HealthCare.gov to switch plans. Most of the fifteen states (including the District of Columbia) that run a State-Based Marketplace (SBM) have also made available a COVID-19 SEP with a similar timeframe.<sup>7,8</sup>

Marketplace financial assistance, including advanced premium tax credit (APTC) payments, is essential to making health insurance available to individuals with no alternative for affordable coverage. APTCs are generally available to eligible individuals and families with household incomes between 100 and 400 percent of the federal poverty level (FPL) in states that have not expanded Medicaid under the ACA and between 138 and 400 percent FPL in states that have expanded Medicaid. For many individuals, particularly low-income individuals, APTCs on HealthCare.gov are large enough to substantially reduce premiums for consumers, in some cases to zero dollars. These credits are based on the premium of the benchmark plan (the second-lowest cost silver (SLCS) plan) available through HealthCare.gov in a person's area of residence. These zero-dollar and low-premium plans are more affordable so more people can enroll in health insurance. These plans can provide access to health care coverage and financial protection for millions of Americans who otherwise may be left uninsured and potentially liable for the full costs of their health care utilization.

Previous literature has identified affordability and unawareness of subsidy eligibility as common reasons individuals remain uninsured. <sup>12,13,14</sup> Zero- and low-premium plans help to directly address this challenge, but many uninsured individuals may not realize they may be eligible to enroll in zero- or low-premium HealthCare.gov plans. Lower costs may also attract more younger and healthier individuals to enroll in Marketplace plans, which in turn can improve the risk pool and lower overall average costs for the broader Marketplace population. <sup>15,16,17</sup>

This Issue Brief examines the availability of zero- and low-premium plans in states served by the federal Marketplace, Healthcare.gov, based on the premium subsidies available as of March 1, 2021, which does not yet include the enhanced subsidies created by the American Rescue Plan. Those subsidies will become available on Healthcare.gov on April 1, 2021, taking effect for covered enrollees as early as May 1, and are discussed in more detail later in this Issue Brief.

Tables in the brief show zero- and low-premium plan availability for HealthCare.gov states overall, subset by demographic and other characteristics, and by state. The purpose of this Issue Brief is to expand understanding and awareness of the availability of low premium health plans, where they may be available, and to whom.

HealthCare.gov states examined include: Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.

Estates operating their own State-Based Marketplace (SBM) that do not use the HealthCare.gov platform are not included in the analysis: California, Colorado, Connecticut, District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and Washington.

#### **METHODOLOGY**

We used the U.S. Census Bureau 1-Year 2019 American Community Survey Public Use Microsample File (ACS PUMS) to identify non-elderly adults (ages 18 to 64) uninsured at the time of the survey. For each uninsured non-elderly adult, we calculated whether a 2021 HealthCare.gov plan, after application of APTCs, could have been purchased for \$0 ("zero-premium plan") or for \$50 or less per month ("low-premium plans," which by definition include plans with zero premiums). The analysis uses HealthCare.gov Qualified Health Plan (QHP) premium and service area data from the Centers for Medicare & Medicaid Services (CMS) for 2021 coverage. 18,19

The sample excludes individuals with household income (based on ACS health insurance unit, or HIU) less than 100% of the Federal Poverty Level (FPL) in Medicaid non-expansion states and less than 138% FPL in Medicaid expansion states, as they are generally not eligible for APTCs. There are some exceptions to this not accounted for in the analysis. For example, certain legal immigrants with incomes below these thresholds may be eligible for APTCs if they are not eligible for Medicaid. Additionally, we did not account for whether a person had an affordable offer of employer coverage, which also affects QHP subsidy eligibility.

We estimated the counts of uninsured non-elderly adults and the percentage of these individuals with access to zero-premium and low-premium plans. We used the Census person-level weights to account for the assignment of respondents to multiple counties (see the Appendix for more detail). These counts and percentages were calculated for HealthCare.gov states, by demographic and other characteristics, and at the national (HealthCare.gov states only) and state level.

In addition to examining the uninsured population, we also identified availability of the zero-premium and low-premium plans among the currently enrolled HealthCare.gov population as of March 1, 2021, which covers the first two weeks of the 2021 SEP (which started on February 15, 2021). This analysis used HealthCare.gov QHP data along with 2021 HealthCare.gov plan selection data from the CMS Multidimensional Insurance Data Analytics System (MIDAS), which includes plan selection premiums, APTC calculations, and household modified adjusted gross income (MAGI).<sup>20</sup> It is important to note that all enrollees for the current HealthCare.gov population are included in the analysis—including ages 0-17 and 65+ and those with unknown or <100 percent FPL income, who were excluded from the uninsured component of the analysis.

See the APPENDIX: DETAILED METHODOLOGY for further details of the study methodology, which was adapted from a prior ASPE analysis.<sup>21</sup> We round all population counts to the nearest thousand for both the uninsured and HealthCare.gov enrollee analyses.

This analysis has several limitations. State-Based Marketplace data are not readily available for 2021 and our estimates therefore do not represent the full United States. Additionally, race and ethnicity data for HealthCare.gov enrollees were frequently missing (42 percent of enrollees) and therefore unusable for estimating descriptive statistics for this group. Lastly, the analysis of the uninsured does not account for immigration status or eligibility for most other forms of minimum essential coverage, which both affect eligibility for Marketplace subsidies.

iv The uninsured estimates for this analysis may differ from those released by ASPE on March 12, 2021 and found here: <a href="https://aspe.hhs.gov/pdf-report/estimates-of-the-qhp-eligible-uninsured">https://aspe.hhs.gov/pdf-report/estimates-of-the-qhp-eligible-uninsured</a>. The methodologies differ in several ways. For example, the uninsured component of this analysis does not account for undocumented immigration status, is restrict to uninsured ages 18-64, and excludes uninsured <=100% FPL.

#### ZERO- AND LOW-PREMIUM PLAN AVAILABILITY BY PLAN METAL TIER

Table 1 shows the availability of zero- and low-premium plans among Marketplace-eligible uninsured non-elderly adults and the 2021 HealthCare.gov enrollee population by plan metal tier.

Table 1. Zero- and Low-Premium Plan Availability and Selection in HealthCare.gov States by Metal Tier, 2021

	Uninsured QHP Eligible Non-Elderly Adults –	2021 HealthCare.gov QHP Enrollees <sup>b,c</sup>		
	Plan Availability <sup>a,b</sup>	Availability	Selected Plans	
Total Population*	11,103,000	7,968	3,000	
\$0 Premium Plan, %				
Any Metal Tier	42.5%	65.9%	14.5%	
Bronze	42.5%	65.9%	10.5%	
Silver	3.4%	7.1%	3.7%	
Gold	3.4%	6.2%	0.3%	
\$50 or Less Per Month Premium Plan, %				
Any Metal Tier	56.8%	78.1%	43.4%	
Bronze	56.8%	78.1%	17.7%	
Silver	21.9%	44.7%	25.1%	
Gold	12.6%	21.8%	0.7%	

a. Data Source: American Community Survey, 2019

Note: Catastrophic plans and plan selections excluded from the analyses.

#### **Uninsured QHP Eligible Non-Elderly Adults**

The analysis included 11.1 million uninsured non-elderly adults in HealthCare.gov states potentially eligible for Marketplace coverage (with or without APTCs) based on their income. Among this population, approximately 2 in 5 (42.5 percent) may be able to access a zero-premium plan in the Marketplace during the SEP and more than half (56.8 percent) can find a plan for \$50 or less per month. Most of these plans are in the bronze metal tier. Low-premium plans of \$50 or less per month (which include plans with zero-dollar premiums) are more common than zero-premium plans in all three tiers. Low-premium silver and gold plans, available to 21.9 percent and 12.6 percent of uninsured non-elderly adults respectively, are substantially more available than zero-dollar premium silver and gold plans, each of which are available to only 3.4 percent of the uninsured.

#### 2021 HealthCare.gov Enrollees

A majority of current 2021 HealthCare.gov enrollees have access to zero-premium and low-premium plans: 65.9 percent have access to a zero-premium plan and 78.1 percent have access to a low-premium plan. While less than 10 percent of enrollees have access to a zero-premium silver plan (7.1 percent) or a zero-premium gold plan (6.2 percent), 44.7 percent have access to a low-premium silver plan and 21.8 percent have access to a low-premium gold plan. Among current 2021 HealthCare.gov enrollees, 14.5 percent are enrolled in a zero-premium plan and 43.4 percent in a low-premium plan. More HealthCare.gov participants are enrolled in a zero-premium bronze plan (10.5 percent) than a zero-premium silver plan (3.7 percent) or a zero-premium gold plan (0.3 percent). More consumers enrolled in low-premium silver plans (25.1 percent) than low-premium bronze (17.7 percent) or gold (0.7 percent) plans, in part likely due to greater AV for silver than bronze plans and cost-sharing reductions (CSRs) often resulting in higher AV in silver than gold plans.

b. Data Source: HealthCare.gov Marketplace Plan Files for Coverage in 2021

c. Data Source: CMS/CCIIO MIDAS Plan Selections as of March 1, 2021

<sup>\*</sup>Rounded to the nearest thousand

All results referring to "uninsured adults" in this brief are uninsured, non-elderly adults who are QHP-Eligible in HealthCare.gov states.

vi The actuarial value (AV) of a health plan is the average percentage of total costs of in-network essential health benefits (EHB) covered by the health plan. The AV available to all QHP eligible individuals ranges from 60% for bronze plans, 70% for silver, 80% for gold, and 90% for platinum. For certain-

#### ZERO- AND LOW-PREMIUM PLAN AVAILABILITY BY DEMOGRAPHIC CHARACTERISTICS

Table 2 shows zero- and low-premium plan availability among the uninsured non-elderly adult population and current enrollees in the HealthCare.gov states by demographic characteristics.

Table 2. Zero- and Low-Premium Plan Availability in HealthCare.gov States by Demographics, 2021

	Uninsured QHP Eligible Non-			2021 HealthCare.gov QHP			
	Elderly Adul	ts – Plan A	Availability <sup>a,b</sup>	Enrollees <sup>b,c</sup>			
	-	\$0	\$50 or Less		\$0	\$50 or Less	
	Total	Available	Per Month	Total	Available	Per Month	
	Population*	- Any	Available -	Population*	- Any	Available -	
		Metal, %	Any Metal, %		Metal, %	Any Metal, %	
Total Population*	11,103,000	42.5%	56.8%	7,968,000	65.9%	78.1%	
Rural Status <sup>‡</sup>							
Rural	1,921,000	46.7%	60.6%	1,193,000	65.2%	78.8%	
Urban	9,182,000	41.6%	56.0%	6,774,000	66.0%	78.0%	
Age							
0-17	Excluded	N/A	N/A	758,000	52.8%	74.1%	
18-24	1,333,000	44.2%	62.2%	704,000	73.4%	86.6%	
25-34	3,058,000	36.7%	53.4%	1,257,000	58.4%	72.1%	
35-44	2,721,000	41.6%	55.8%	1,302,000	61.8%	74.0%	
45-54	2,290,000	42.8%	55.7%	1,593,000	69.5%	79.6%	
55-64	1,701,000	52.3%	62.0%	2,239,000	70.9%	80.6%	
65+	Excluded	N/A	N/A	115,000	88.7%	94.3%	
Income/FPL							
<100% <sup>†</sup>	Excluded	N/A	N/A	104,000	43.4%	53.9%	
100-138%	1,290,000	99.9%	100.0%	2,663,000	98.4%	99.5%	
>138-150%	611,000	90.1%	100.0%	702,000	88.7%	98.9%	
>150-200%	2,370,000	75.2%	97.7%	1,520,000	74.9%	94.3%	
>200-250%	1,990,000	36.9%	66.8%	1,036,000	51.8%	77.4%	
>250-300%	1,269,000	18.2%	39.3%	637,000	28.5%	55.6%	
>300-350%	901,000	9.5%	19.5%	415,000	16.6%	36.3%	
>350-400%	617,000	6.9%	14.1%	287,000	13.4%	28.4%	
>400% <sup>†</sup>	2,055,000	0.0%	0.0%	115,000	0.0%	0.0%	
Unknown <sup>†</sup>	N/A	N/A	N/A	489,000	0.0%	0.0%	
Race/Ethnicity§							
Hispanic and Latino	3,788,000	50.2%	64.5%	#	#	#	
White Non-Latino	5,157,000	36.3%	50.7%	#	#	#	
Black Non-Latino	1,504,000	45.1%	59.3%	#	#	#	
Asian/Native-Hawaiian/Pacific Isl.	296,000	35.3%	51.1%	#	#	#	
American Indian / Alaska Native	150,000	45.3%	59.2%	#	#	#	
Multi-racial or Other	208,000	42.7%	58.1%	#	#	#	

a. Data Source: American Community Survey, 2019

eligible individuals (generally household income 100%-250% FPL) silver cost-sharing reduction (CSR) plans are available which enhance AV from 70% to 73%, 87%, or 94% depending on income. AV is allowed to vary within a de minimis range by -4/+2 percentage points and expanded bronze plans that pay for at least one major service other than preventive services before the deductible or meet the requirements of high deductible health plans can vary by -4/+5 percentage points (45 CFR 156.140(c)). Catastrophic plans are excluded from all analyses.

b. Data Source: HealthCare.gov Marketplace Plan Files for Coverage in 2021

c. Data Source: CMS/CCIIO MIDAS Plan Selections as of March 1, 2021

Note: Catastrophic plans and plan selections excluded from the analyses

<sup>\*</sup>Rounded to the nearest thousand

<sup>&</sup>lt;sup>‡</sup>Rural vs urban defined at the county level in the Marketplace files

<sup>§</sup>Race and ethnicity based on American Community Survey categories

<sup>#</sup>Excluded because of high % missing/unknown in HealthCare.gov data (42%)

<sup>†</sup>Consumers who do not request financial assistance when applying for coverage do not enter their household income information. A small number of consumers that do request financial assistance have missing household incomes due to a tax filing status that makes them APTC-ineligible or data anomalies. Lawfully present individuals with a household income less than 100% FPL who were denied Medicaid due to their immigration status can be APTC eligible (26 CFR 1.36B-2(b)(5)).

#### **Uninsured QHP Eligible Non-Elderly Adults**

Zero- and low-premium plans availability was slightly higher for uninsured non-elderly adults in rural counties (46.7 percent and 60.6 percent, respectively) compared to those in urban counties (41.6 percent and 56.0 percent, respectively). These plans were most commonly available to people with lower incomes; for example, approximately 90.1 percent of those with incomes between 138 and 150 percent of FPL could find a plan for zero premium, and all could find a plan for \$50 or less per month.

Older (but non-elderly) uninsured adults were more likely to be able to find a low-cost plan, with approximately 1 in 2 (52.3 percent) of those ages 55-64 likely having a zero-premium plan available and more than 3 in 5 (62.0 percent) a plan for \$50 or less per month, which is partially a factor of the "age curves" used to calculate benchmark and other Marketplace premiums. Unsubsidized premiums increase with age but APTCs remain fixed as a percentage of income; therefore, older adults typically qualify for larger subsidies, which they can then use to buy lower-premium or even zero-premium plans.

Half (50.2 percent) of Hispanic or Latino uninsured adults have a zero-premium option and 64.5 percent could find a plan for \$50 or less per month. Among Black Non-Latino uninsured adults, 45.1 percent have a zero-premium plan available and 59.3 percent have a plan available for \$50 or less per. Finally, over 2 million uninsured non-elderly adults residing in HealthCare.gov states were above 400 percent of FPL and were not eligible for subsidies, though people in this income range are now potentially eligible for APTCs with the recent enactment of the American Rescue Plan.

#### 2021 HealthCare.gov Enrollees

Access to zero-premium plans for those currently enrolled in HealthCare.gov states does not differ much between rural (65.2 percent) and urban areas (66.0 percent), and access to low-premium plans is also similar in rural areas (78.8 percent) and urban areas (78.0 percent).

Access to zero- and low-premium plans among current enrollees is highest for adults ages 18-24 (73.4 percent and 86.6 percent, respectively) and ages 55-64 (70.9 percent and 80.6 percent, respectively). This pattern for older adults relates to the higher amounts of APTC available to older adults, and the high rates for the youngest adults corresponds to their generally lower incomes qualifying each of these groups for higher amounts of APTC.

Current HealthCare.gov enrollees with the lowest incomes where APTCs are applicable (100-200 percent of FPL) had the greatest access to zero-premium plans (approximately 75 percent or higher) and the greatest access to low-premium plans (94 percent or higher).

Availability of zero-premium plans generally decreased at higher incomes, going from 98.4 percent among those with incomes between 100 and 138 percent FPL to 13.4 percent for those with incomes between 350 and 400 percent FPL (the exception being enrollees with income less than 100 percent FPL, who are often not eligible for APTCs and among whom only 43.4 percent have access to a zero-premium plan). Vii Availability of low-premium plans followed a similar pattern by income.

vii Per the ACA, most individuals with incomes under 100 percent FPL are not eligible for premium tax credits. Medicaid expansion was made optional for states by Supreme Court case *Sebelius v. National Federation of Independent Business*. The exception is for individuals that are not eligible for Medicaid because of immigration status; these individuals can have incomes less than 100 percent FPL or less than 138 percent FPL (non-expansion vs. expansion) and qualify for APTC (premium subsidies).

#### **ZERO- AND LOW-PREMIUM PLAN AVAILABILITY BY STATE**

Table 3 presents state-level zero- and low-premium plan availability in HealthCare.gov states.

Table 3. Zero- and Low-Premium Plan Availability in HealthCare.gov States, 2021

		d QHP Eligible s – Plan Avai	e Non-Elderly lability <sup>a,b</sup>	2021 HealthCare.gov QHP Enrollees <sup>b,c</sup>			
State	Total Population*	\$0 Available - Any Metal, %	\$50 or Less Per Month Available - Any Metal, %	Total Population*	\$0 Available - Any Metal, %	\$50 or Less Per Month Available - Any Metal, %	
HealthCare.gov States	11,103,000	42.5%	56.8%	7,968,000	65.9%	78.1%	
Alabama	229,000	67.7%	74.3%	163,000	84.2%	89.4%	
Alaska	37,000	0.0%	60.4%	18,000	0.0%	70.1%	
Arizona	389,000	24.7%	42.1%	149,000	37.7%	55.4%	
Arkansas	124,000	22.9%	46.1%	63,000	34.1%	56.4%	
Delaware	33,000	43.2%	53.7%	25,000	50.6%	64.7%	
Florida	1,560,000	46.1%	58.0%	2,086,000	82.4%	89.0%	
Georgia	737,000	46.0%	59.5%	508,000	71.0%	80.0%	
Hawaii	22,000	0.0%	42.1%	21,000	0.0%	72.3%	
Illinois	463,000	0.0%	37.5%	273,000	0.0%	55.4%	
Indiana	267,000	16.0%	36.4%	130,000	25.2%	39.7%	
lowa	80,000	55.8%	61.8%	55,000	69.2%	76.9%	
Kansas	144,000	49.7%	60.3%	84,000	56.7%	70.1%	
Kentucky	137,000	39.8%	55.7%	72,000	49.6%	63.7%	
Louisiana	193,000	39.6%	51.2%	78,000	59.3%	72.6%	
Maine	58,000	0.0%	34.6%	55,000	0.0%	52.1%	
Michigan	286,000	25.0%	42.7%	253,000	41.1%	59.7%	
Mississippi	172,000	28.1%	48.0%	109,000	68.0%	82.8%	
Missouri	254,000	45.9%	58.5%	205,000	67.7%	76.0%	
Montana	50,000	40.5%	49.5%	42,000	47.5%	62.8%	
Nebraska	66,000	64.4%	73.2%	84,000	84.7%	90.2%	
New Hampshire	54,000	16.3%	29.1%	44,000	26.2%	38.2%	
New Mexico	95,000	33.6%	48.4%	41,000	42.4%	55.0%	
North Carolina	643,000	59.1%	69.0%	510,000	77.0%	84.9%	
North Dakota	24,000	53.0%	55.5%	22,000	77.1%	83.9%	
Ohio	384,000	23.2%	41.3%	191,000	32.2%	50.6%	
Oklahoma	238,000	55.7%	64.7%	166,000	81.0%	88.1%	
Oregon	166,000	0.0%	43.8%	132,000	0.0%	47.9%	
South Carolina	285,000	53.7%	65.5%	222,000	72.6%	82.1%	
South Dakota	45,000	63.8%	73.0%	30,000	67.7%	80.4%	
Tennessee	369,000	50.7%	62.2%	203,000	63.2%	73.4%	
Texas	2,730,000	52.8%	63.1%	1,262,000	78.4%	85.4%	
Utah	135,000	52.9%	66.5%	200,000	75.9%	86.2%	
Virginia	322,000	36.9%	54.0%	246,000	55.7%	70.1%	
West Virginia	56,000	5.7%	27.3%	18,000	14.9%	35.6%	
Wisconsin	212,000	40.5%	52.5%	181,000	48.7%	62.1%	
Wyoming	42,000	67.4%	70.0%	26,000	86.1%	89.7%	

a. Data Source: American Community Survey, 2019

Note: Catastrophic plans and plan selections excluded from all analyses

b. Data Source: HealthCare.gov Marketplace Plan Files for Coverage in 2021

c. Data Source: CMS/CCIIO MIDAS Plan Selections as of March 1, 2021

<sup>\*</sup>Rounded to the nearest thousand

#### **Uninsured QHP Eligible Non-Elderly Adults**

HealthCare.gov states varied widely in the availability of zero-premium plans to uninsured adults; in some states (Alaska, Hawaii, Illinois, Maine, and Oregon) they were non-existent, while such plans may be available to up to two-thirds of the uninsured in other states examined in the analysis. Similar variability was found for low-premium plans with state-level ranges from 27.3 percent to 74.3 percent. Some states may not have zero-premium plans available to anyone; for example, if all plans in the state cover some services not considered essential health benefits (EHBs), then premiums in that state cannot be reduced by APTCs to zero dollars. APTCs cannot be applied to non-EHB portions of the premium and therefore these plans will always have some amount of premium cost to the consumer. However, due to the comprehensiveness of EHBs, non-EHB portions of premiums are typically relatively small.

Some of the state-to-state variability is due to the composition of the enrolled and uninsured population, especially the income distribution in each state. Part of this variability is also due to whether a state has expanded Medicaid; in states that have not expanded, a larger percentage of the HealthCare.gov enrolled and uninsured populations are likely to have incomes below 138 percent FPL.

#### **2021** HealthCare.gov Enrollees

Access to zero- and low-premium plans varies considerably by state for HealthCare.gov enrollees, ranging from 0 to 86.1 percent for zero-premium plans and 35.6 to 90.2 percent for low-premium plans. Five states have no access to zero-premium plans (Alaska, Hawaii, Illinois, Maine and Oregon), the same states where the uninsured don't have access to zero-premium plans.

viii Non-essential health benefits are services beyond the ACA's ten categories of essential services. For example, Hawaii requires coverage of infertility services. For more details see: <a href="https://www.cms.gov/cciio/resources/data-resources/ehb#ehb">https://www.cms.gov/cciio/resources/data-resources/ehb#ehb</a>

#### **DISCUSSION**

#### **Access to Low-Cost Marketplace Coverage Among the Uninsured Population**

During the first half of 2020, 30 million Americans were uninsured according to the National Health Interview Survey, and we estimate at least 11 million may be eligible for Marketplace coverage in HealthCare.gov states. While the ACA coverage provisions led to a decrease in the number of uninsured non-elderly adults by 20 million between 2010 and 2016, the number of uninsured since 2016 has increased by approximately 2 million by the first half of 2020. The majority of the uninsured are currently eligible for coverage through Medicaid or the Marketplace with financial assistance. The Kaiser Family Foundation found 66 percent of uninsured nonelderly adults were eligible for Medicaid (including expansion), premium tax credits in the Marketplace, or other public insurance programs in 2019. One of the most common reasons why the number of uninsured individuals remains high is their concern about the cost of health insurance coverage.

This Issue Brief analysis finds that more than half (56.8 percent) of uninsured non-elderly adults could find a zero- or low-premium plan through HealthCare.gov. Specifically, 42.5 percent may have access to a zero-premium plan and 56.8 percent may have access to a low-premium plan for \$50 or less per month. This suggests that many uninsured individuals be able to find affordable options for coverage but may be unaware they are eligible for coverage and/or financial assistance, may not know how to enroll in coverage, or may struggle with the complexity of insurance and/or the enrollment process.<sup>24</sup>

The purpose of this Issue Brief is to bring awareness about the availability of zero- and low- premium plans to both the uninsured and underinsured populations as well as current Marketplace enrollees. However, it is important for consumers to understand that premiums are only one component of health coverage costs. While premiums represent the monthly cost to maintain coverage, there are other out of pocket cost-sharing expenses (i.e., deductibles, copays, and coinsurance) when receiving care. Some zero- or low-premium plans have higher consumer cost-sharing than higher premium plans, so consumers need to balance plan features when they select a plan.

Many of the zero- or low-premium plans are bronze plans with high deductibles (i.e., amount consumers need to spend out-of-pocket before the plan covers costs) and consumers need to be aware of out-of-pocket costs associated with different plan options. The median QHP deductibles – without cost-sharing reductions – for individuals in HealthCare.gov states by metal tier in 2021 are approximately \$6,992 for bronze, \$4,879 for silver, and \$1,533 for gold. For those eligible for cost-sharing reductions (people with incomes between 100 and 250 percent FPL), these deductibles are typically substantially lower for silver plans. For example in 2021, comparable median deductibles for silver plans with cost-sharing reductions were \$3,318 for 73 percent AV silver plans (available to those with income of 200 and 250 percent FPL), \$620 for 87 percent AV (available to those with income between 150 and 200 percent FPL), and \$74 for 94 percent AV (available to those with income between 100 and 150 percent FPL).

#### **Equity Impacts**

This analysis finds access to zero- and low-premium plans varies across demographic groups. Historically, policies, laws, and practices served to limit health insurance coverage options for communities of color. The uninsured population disproportionately includes Black and Latino individuals, younger adults, individuals living in rural areas, and individuals with incomes between 100-400 percent of FPL. The uninsured population is also more likely to defer or forgo needed health care, resulting in higher potential for poor health outcomes. <sup>29,30</sup>

ix Certain preventive services, such as an annual check-up and diagnostic screenings, are typically available before the deductible is met and with no cost-sharing, i.e. these services are accessible to a person before they have to pay toward their deductible.

Our analysis indicates that zero- and low-premium plans are available to approximately 40 percent or more of Black, Latino, and Native American adults who lack insurance and could qualify for APTCs, higher than some other racial and ethnic groups. Our findings suggest the ACA and access to coverage through the Marketplace can help address disparities in health insurance coverage in these populations.

Among the currently uninsured population in HealthCare.gov states examined in this analysis, access to both zero- and low-premium plans is slightly higher in rural areas, compared to urban areas. One factor in this pattern may be average income in rural areas being lower than urban areas and more individuals therefore qualify for larger subsidies.

#### The American Rescue Plan

The American Rescue Plan (ARP), signed into law on March 11, 2021, increases and expands eligibility for the ACA Marketplace premium subsidies for people enrolling in Marketplace health plans. Under the ARP, premium tax credits become more generous in several ways. For instance, among those with incomes less than 400 percent FPL who already are eligible for APTCs, the expected percentage of household income contribution toward benchmark premiums is lowered, including a reduction to 0 percent for those with household incomes between 100-150 percent of FPL. Those with incomes above 400 percent of FPL are now generally eligible for APTCs that cap their premium contribution at no more than 8.5 percent of their household income.

Advanced payments of premium tax credits under these ARP changes will be available on HealthCare.gov beginning April 1, 2021. The analysis in this Issue Brief does not account for the ARP changes to the Marketplace premium tax credit structure and therefore reflects the pre-ARP eligibility structure. The ARP will increase the availability of zero- and low-premium plans in the Marketplace for many consumers and uninsured individuals, and ASPE will publish additional analyses soon after this one examining the availability of these plans under the ARP.

There are also unemployment provisions in the ARP allowing individuals who received unemployment compensation during any week of 2021 to be deemed to have an income not in excess of 133 percent FPL for the purpose of calculating eligibility for APTCs and cost-sharing reductions. The provision will not be implemented until summer. We do not address the provision in this brief; however, it is important to note the provision will further increase availability of zero- and low-premium plans.

#### **CONCLUSION**

There is evidence that zero-premium and low-premium plan availability encourages uninsured people to enroll in the Marketplace.<sup>31,32</sup> Increasing consumer awareness of such plans is an important part of the strategy to increase health insurance coverage. The availability of the SEPs though HealthCare.gov during the COVID pandemic is another: during the first two weeks of the availability of the 2021 COVID-19 SEP through HealthCare.gov, 385,864 new consumers requested coverage on an application submitted on or after February 15.<sup>33,34</sup>

The ARP includes provisions that build upon the ACA, including enhancing and expanding Marketplace subsidies. These changes will further improve the affordability of coverage for uninsured individuals as well as those already enrolled in Marketplace health plans, likely leading to more individuals enrolling in health insurance coverage in the coming months.

#### APPENDIX: DETAILED METHODOLOGY

#### A. Factors Applicable to Both the Uninsured and HealthCare.gov Enrollee Analyses

#### **Qualified Health Plans**

QHPs must offer a comprehensive package of items and services, known as Essential Health Benefits (EHBs). QHPs can also offer benefits beyond EHBs, and QHPs report the premium percentage attributable to EHB. Most QHPs have an EHB percentage of 100%; however, plans that cover benefits beyond EHB have EHB percentages smaller than 100%, reflecting the fact that some premium pays for benefits beyond EHB. Premium tax credits cannot be applied to premium costs affiliated with non-EHB benefits.

#### Marketplace Health Insurance Premiums

We used plan year 2021 QHP premium and service area data similar to what is found in the HealthCare.gov state QHP landscape files.\* The data include plan premiums and the EHB percent of premium at the county-level. We assume plans cover all zip codes in a county. Alaska uses zip codes, rather than counties to define rating areas, and we assign each county to a single rating area based on the rating area that covers the most population using Census data.

#### B. Availability of Zero-Premium and Low-Premium Plans Among Currently Uninsured QHP Eligible

We used data from the 2019 American Community Survey (ACS) from IPUMS USA. IPUMS USA (originally, the "Integrated Public Use Microdata Series") is a website and database providing access to integrated, high-precision samples of the American population drawn from U.S. Census Bureau public use data, including the ACS.xi

#### Number of QHP Eligible Uninsured Non-Elderly Adults

Using the ACS, we identified non-elderly adults (ages 18 to 64) who lack health insurance at the time of the survey and are likely QHP eligible, defined for the purpose of this analysis based on having an income at or above 100% Federal Poverty Level (FPL) in non-expansion states or above 138% FPL in Medicaid expansion states. For each uninsured adult, we calculated whether a 2021 Marketplace health insurance plan, net of APTC, could have been purchased for zero dollars or for \$50 or less per month. Note that the QHP eligible population includes both those eligible for APTCs, and those whose incomes are too high to qualify pre-ARP but are still eligible to enroll in a QHP without a subsidy.

The ACS queries respondents about whether they were covered by the following types of health insurance: (1) Insurance through a current or former employer or union, (2) Insurance purchased directly from an insurance company, (3) Medicare, (4) Medicaid, (5) TRICARE or other military health care, and/or (6) VA health care. Consistent with how the U.S. Census Bureau calculates the official rate of individuals without any source of health insurance coverage, we define individuals who were not covered by any of these six sources of coverage as uninsured.

We used the ACS to identify Health Insurance Units (HIUs). HIUs differ from households or families, as defined by the U.S. Census Bureau, in that they group together individuals who would likely be considered a "family

<sup>\*</sup> https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/

xi https://usa.ipums.org/usa/

unit" in determining eligibility for either private or public coverage. HIUs are comprised of individuals living in the same household. Hereafter, we refer to HIUs as "families" or "family income" interchangeably. Family income is the sum of income of all family members.

We constructed income as a percentage of the FPL in order to identify QHP eligible individuals. FPL varies by family size. The 48 contiguous states and DC use the same FPL while Alaska and Hawaii each have their own FPL. Individuals in families with income as a percentage of FPL that is less than 100% in Medicaid non-expansion states and that is less than 138% in Medicaid expansion states are considered not to be QHP eligible for the purposes of this analysis and are excluded. We defined states as having expanded Medicaid if they did so by January 2021. Note, some uninsured individuals below these thresholds may be QHP eligible under certain circumstances but due to the complexity of information on immigration status needed to identify this in the ACS, we do not account for them in this analysis. We also did not model whether a person had an affordable offer of employer coverage, which also affects QHP subsidy eligibility.

We restricted the uninsured portion of the analysis to non-elderly adults (ages 18 to 64), with household incomes at or above 100% FPL, who are both uninsured and potentially QHP eligible.

#### Assigning Counties to ACS PUMS Respondents

As the smallest geographic unit available in the ACS is a Public Use Microdata Area (PUMA), and since PUMAs can be made up of multiple counties, there is not a one-to-one correspondence between counties-level premiums and the geography of respondents. We use the Missouri Census Data Center's Geographic Correspondence Engine to map PUMAs to counties. Respondents living in PUMAs for which there is only one county are assigned to that county. Respondents living in PUMAs which are comprised of multiple counties are assigned to each of those counties but are weighted according to the county's relative population in the 2010 Census. County-level Marketplace premiums are then assigned to each ACS respondent based on their assigned county.

#### Calculation of Maximum Premium Tax Credits

The percent of household income that each respondent must pay to purchase a 2021 benchmark plan is determined by that respondent's income as a percentage of the FPL. The expected family contribution (EFC) towards premiums is that percentage multiplied by family income. We allocate the EFC among each uninsured person (age less than 65) in the family using the relevant age curve used for their state.<sup>35-36</sup>

#### Calculation of the Premium Tax Credit

We calculated the premium tax credit (PTC) for each respondent by subtracting the EFC from the EHB premium of the benchmark plan in that respondent's county. If this difference is less than zero, the PTC is set to zero. We also set the PTC to zero for respondents with income as a percentage of poverty that is greater than 400% or less than 138% (100% in states that did not expand Medicaid as of January 2021).

#### Calculation of the Lowest Cost Premium Net of APTC

For each metal level and county, we found two lowest cost plans based on the age 21 total premium: 1) the lowest cost plan among all plans, and 2) the lowest cost plan with an EHB percent of premium equal to 100%. For each respondent and metal level, we then adjusted the age 21 premiums according to the respondent's age and the relevant age factor for the respondent's state. We then found net premiums for each respondent by taking the difference between each plan's EHB premium and the respondent's PTC. If the PTC was greater than the relevant plan's EHB premium, we set the difference equal to \$0 and set the final net premium equal

to the non-EHB portion of the plan's premium (which is \$0 for plans with an EHB percent of premium equal to 100%). The final net lowest cost premium for each respondent and metal level was equal to the lesser of the two net premiums for the metal level.

Availability of Zero-Premium Plans and Low-Premium Plans

A respondent is determined to have a zero-premium plan available if the net lowest cost premium is \$0. A respondent is determined to have a low-premium plan available if the net lowest cost premium is \$50 or less per month. Catastrophic plans were excluded from the analysis.

#### **Estimation of Counts**

We estimate counts of uninsured non-elderly adults, percentages of uninsured non-elderly adults with access to a zero-premium plan, and percentages of non-elderly adults with access to a low-premium plan using the Census person-level weights to account for assignment of respondents to multiple counties. The counts and percentages were calculated for HealthCare.gov states in aggregate, by demographic characteristics, and at the state level.

#### C. Availability of Zero Premium and Low Premium Plans Among QHP Enrollees in HealthCare.gov States

We used data on 2021 Marketplace selections in HealthCare.gov states using active plan selections as of March 1, 2021. An active plan selection is one that is non-cancelled with an end date of December 31, 2021. After excluding catastrophic plan selections, we have a total of 7,968,000 consumers with plan selections. From these data, we use attested household income, county and state of residence, age, the individual- and policy-level gross premium, policy-level premium net of applied APTC (net premium), and maximum amount of APTC available to the household.

Note: For the HealthCare.gov enrollee analysis we include all plan selections, including all ages and income; this includes individuals excluded from the uninsured portion of the analysis described in section A of the appendix (i.e. individuals ages 0-17, ages 65+, and household income below 100% FPL are all excluded from the uninsured analysis, but are included in the HealthCare.gov enrollee analysis described here).

Calculation of the Lowest Cost Premium Net of Premium Tax Credits

We used the calculated maximum APTC amount for a given household to determine the final premiums after applying APTC. For each plan available to a household, we calculated the net premium as the difference between the plan's EHB premium for all household members and household's maximum available APTC. If the maximum APTC was greater than the relevant plan's EHB premium, we set the difference equal to \$0 and set the final net premium equal to the non-EHB portion of the plan's premium for all household members (which is \$0 for plans with an EHB percent of premium equal to 100%). We then found the lowest net premium for each household and metal level.

We distributed the net premium amount among household members based on each member's individual gross premium amount, which aligns with the relevant age curve except in cases of tobacco rating. When a policy included more than 3 children such that some children are not rated, we distributed the total child rate among all children younger than 21 years-old (e.g., if the policy included 4 children, each with a rate of \$100, the policy-level premium would be \$300 and each child's premium would be \$75). We included tobacco users and calculated plan premiums using tobacco rates when they exist.

We assume that families with multiple enrollment groups or policies maintain their selected grouping arrangement regardless of the selected plan. We also assume that all family members select the same plan and require that the plan be available to all household enrollment groups.

Calculation of Current Plan Selection Premiums Net of Premium Tax Credits

We took the calculated policy-level premium net of APTC and distributed it to policy members based on each member's individual gross premium amount, as described above. Consumers have the option to use less than their maximum available APTC; consumers may opt to do so if they expect their income to rise during the year and want to avoid paying back PTC when filing taxes. For current plan selection premiums, we used the consumer elected APTC amounts, rather than the maximum amount available.

aspe.hhs.gov/reports

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#### U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Part III - Administrative, Procedural, and Miscellaneous

RELIEF FOR FORM 1040 FILERS AFFECTED BY ONGOING CORONAVIRUS
DISEASE 2019 PANDEMIC

Notice 2021-21

#### I. PURPOSE

On March 13, 2020, the President of the United States issued an emergency declaration under the Robert T. Stafford Disaster Relief and Emergency Assistance Act in response to the ongoing Coronavirus Disease 2019 (COVID-19) pandemic (Emergency Declaration). The Emergency Declaration instructed the Secretary of the Treasury "to provide relief from tax deadlines to Americans who have been adversely affected by the COVID-19 emergency, as appropriate, pursuant to 26 U.S.C. 7508A(a)." Pursuant to the Emergency Declaration, this notice provides relief under section 7508A of the Internal Revenue Code (Code) for the persons described in section III.A of this notice that the Secretary of the Treasury has determined to be affected by the COVID-19 emergency.

#### II. BACKGROUND

Section 7508A provides the Secretary of the Treasury or her delegate (Secretary) with authority to postpone the time for performing certain acts under the internal revenue laws for a taxpayer determined by the Secretary to be affected by a Federally declared disaster as defined in section 165(i)(5)(A) of the Code. Pursuant to

section 7508A(a), a period of up to one year may be disregarded in determining whether the performance of certain acts is timely under the internal revenue laws.

#### A. Taxpayers Affected by COVID-19 Emergency

The Secretary has determined that any person with a Federal income tax return filed on Form 1040, Form 1040-SR, Form 1040-NR, Form 1040-PR, Form 1040-SS, or Form 1040(SP) (Form 1040 series), or a Federal income tax payment reported on one of these forms, that absent this notice would be due April 15, 2021, is affected by the COVID-19 emergency for purposes of the relief described in this section III (Affected Taxpayer). In addition, persons who are required to file and furnish Form 5498, IRA Contribution Information, Form 5498-ESA, Coverdell ESA Contribution Information, and Form 5498-SA, HSA, Archer MSA, or Medicare Advantage MSA Information (Form 5498 series) that absent this notice would generally be due June 1, 2021, are Affected Taxpayers.

The Secretary has also determined that any individual with a period of limitations to file a claim for credit or refund of Federal income tax that absent this notice would expire on or after April 15, 2021, and before May 17, 2021 (for example, certain individual taxpayers with claims for credit or refund in respect of their 2017 taxable years), is an Affected Taxpayer.

## B. Postponement of Due Dates with Respect to Certain Federal Tax Returns and Federal Tax Payments

For an Affected Taxpayer, the due date for filing Federal income tax returns in the Form 1040 series and making Federal income tax payments in connection with one

of these forms having an original due date of April 15, 2021, is automatically postponed to May 17, 2021. Affected Taxpayers do not have to file any form, including Form 4868, Application for Automatic Extension of Time to File U.S. Individual Income Tax Return, to obtain this relief. This relief includes the filing of all schedules, returns, and other forms that are filed as attachments to the Form 1040 series or are required to be filed by the due date of the Form 1040 series, including, for example, Schedule H and Schedule SE, as well as Forms 965-A, 3520, 5329, 5471, 8621, 8858, 8865, 8915-E, and 8938. Finally, elections that are made or required to be made on a timely filed Form 1040 series (or attachment to such form) will be timely made if filed on such form or attachment, as appropriate, on or before May 17, 2021.

As a result of the postponement of the due date for Affected Taxpayers to file Federal income tax returns and make Federal income tax payments from April 15, 2021, to May 17, 2021, the period beginning on April 15, 2021, and ending on May 17, 2021, will be disregarded in the calculation of any interest, penalty, or addition to tax for failure to file the Federal income tax returns or to pay the Federal income taxes postponed by this notice. Interest, penalties, and additions to tax with respect to such postponed Federal income tax filings and payments will begin to accrue on May 18, 2021.

The postponement of the due date for filing these Federal income tax returns to May 17, 2021, also automatically postpones to the same date the time for Affected Taxpayers to make 2020 contributions to their individual retirement arrangements (IRAs and Roth IRAs), health savings accounts (HSAs), Archer Medical Savings Accounts (Archer MSAs), and Coverdell education savings accounts (Coverdell ESAs). This postponement also automatically postpones to May 17, 2021, the time for reporting and

payment of the 10-percent additional tax on amounts includible in gross income from 2020 distributions from IRAs or workplace-based retirement plans.

Forms in the Form 5498 series must be filed with the IRS and furnished to participants and beneficiaries by the due date specified in General Instructions for Certain Information Returns (Forms 1096, 1097, 1098, 1099, 3921, 3922, 5498, and W-2G). Because filers of Form 5498 series are Affected Taxpayers, the due date for filing and furnishing the Form 5498 series is postponed to June 30, 2021. The period beginning on the original due date of those forms and ending on June 30, 2021, will be disregarded in the calculation of any penalty for failure to file those forms. Penalties with respect to such a postponed filing will begin to accrue on July 1, 2021.

The relief provided in this section III.B for filing Federal income tax returns and paying Federal income taxes is available solely with respect to the Form 1040 series returns having an original due date of April 15, 2021, in respect of an Affected Taxpayer's 2020 taxable year, and the Form 5498 series returns that are due as described above. Businesses and any other type of taxpayer who file Federal income tax returns on forms outside of the Form 1040 series are not Affected Taxpayers for purposes of the relief described in this section III.B.

No extension is provided in this notice for the payment or deposit of any other type of Federal tax, including Federal estimated income tax payments, or for the filing of any Federal return other than the Form 1040 series and the Form 5498 series for the 2020 taxable year.

#### C. Relief with Respect to Certain Claims for Refund

Individuals with a period of limitations to file a claim for credit or refund of Federal income tax expiring on or after April 15, 2021, and before May 17, 2021, have until May 17, 2021, to file those claims for credit or refund. This postponement is limited to claims for credit or refund properly filed on the Form 1040 series or on a Form 1040-X.

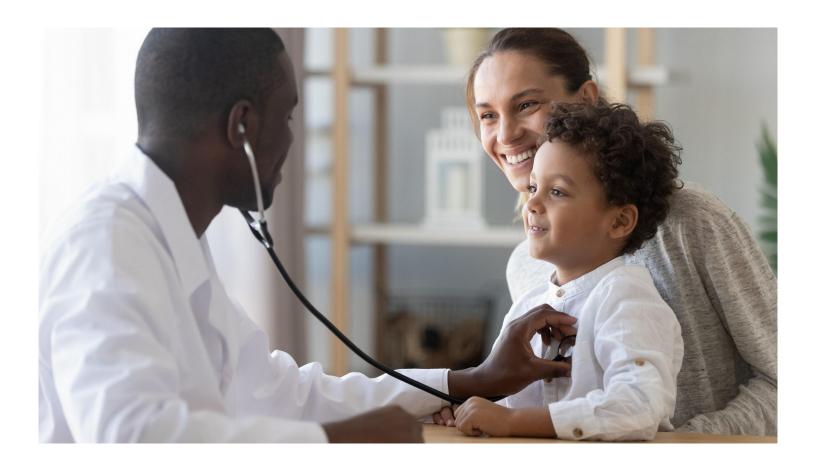
As a result of the postponement of the time for individuals to file claims for credit or refund of Federal income tax where the period to file that claim expires on or after April 15, 2021, and before May 17, 2021, the period beginning on April 15, 2021, and ending on May 17, 2021, will be disregarded in determining whether the filing of those claims is timely.

# IV. EXTENSION OF TIME TO PARTICIPATE IN THE ANNUAL FILING SEASON PROGRAM

Revenue Procedure 2014-42, 2014-29 IRB 192, created a voluntary Annual Filing Season Program to encourage tax return preparers who do not have credentials as practitioners under Treasury Department Circular No. 230 (*Regulations Governing Practice before the Internal Revenue Service*) to complete continuing education courses for the purpose of increasing their knowledge of the law relevant to Federal tax returns. Tax return preparers who complete the requirements in Rev. Proc. 2014-42 receive an annual Record of Completion. Under Rev. Proc. 2014-42, applications to participate in the Annual Filing Season Program for the 2021 calendar year must be received by April 15, 2021. In light of the relief granted in section III of this notice, the 2021 calendar year application deadline is postponed to May 17, 2021.

#### V. CONTACT INFORMATION

The principal author of this notice is Jennifer Auchterlonie of the Office of Associate Chief Counsel, Procedure and Administration. For further information regarding this notice, you may call (202) 317-5436 (not a toll-free call).



Matthew Fiedler



## **BROOKINGS**

#### MAY 5, 2021

**Editor's Note:** This analysis is part of the <u>USC-Brookings Schaeffer Initiative for Health Policy</u>, which is a partnership between Economic Studies at Brookings and the University of Southern California Schaeffer Center for Health Policy & Economics. The Initiative aims to inform the national health care debate with rigorous, evidence-based analysis leading to practical recommendations using the collaborative strengths of USC and Brookings. USC-Brookings Schaeffer Initiative research on the prices of health care services is supported by Arnold Ventures.

n the coming months, Congress may consider policy changes aimed at expanding coverage and reducing overall health care spending, perhaps as part of a broader reconciliation bill.

That debate may include discussion of proposals to create a public option, a publicly operated health insurance plan that people who buy coverage on the individual market can purchase in lieu of a private plan.[1]

A common rationale for creating a public option is that a public option could pay health care providers less than existing private plans, just as the Medicare program pays providers less than commercial insurance plans. Paying lower prices would, in turn, allow a public option to set lower premiums or impose less enrollee cost-sharing, which would directly reduce consumers' costs and reduce the federal government's cost of subsidizing premiums and cost-sharing (in some combination).

This analysis considers how a public option would need to be designed to replicate Medicare's ability to pay providers substantially less than private plans while still eliciting provider participation. In brief, I argue that a public option would likely need two key features. First, it would need to set prices administratively (as the Medicare program does) rather than through negotiations with providers (as private insurers do). Second, it would need to be impossible for a provider to serve patients covered by the public option's private competitors without also serving patients covered by the public option.

The analysis then considers whether there is still a rationale for creating a public option if policymakers are unwilling to adopt these design features—or simply do not wish to reduce provider prices. I conclude that, without paying providers less, a public option likely could not set lower premiums than typical existing plans; its lower administrative costs and lack of a profit margin would likely be more than offset by disadvantages in utilization management, risk selection, and diagnosis coding. It might be able to offer lower premiums than existing plans that have broad networks and looser utilization controls, but at best only slightly lower. Thus, for this type of public option to create significant value, it would need to offer better coverage than existing plans (and convince consumers of that fact). A public option's lack of a profit motive offers a reason it might offer better coverage, but far from a guarantee. In sum, while it is hard to envision this type of public option doing much harm, it also might not do much good.

## **Proof of Concept: Traditional Medicare**

Experience from Medicare offers "proof of concept" that an insurance plan can pay providers much less than commercial insurers do and still elicit provider participation. Indeed, a broad literature, which is summarized in Figure 1, finds that commercial plans pay around twice what Medicare pays for inpatient hospital services. Commercial plans appear to pay even more in relation to Medicare for outpatient facility services. Differentials are smaller for physician services, but still substantial.

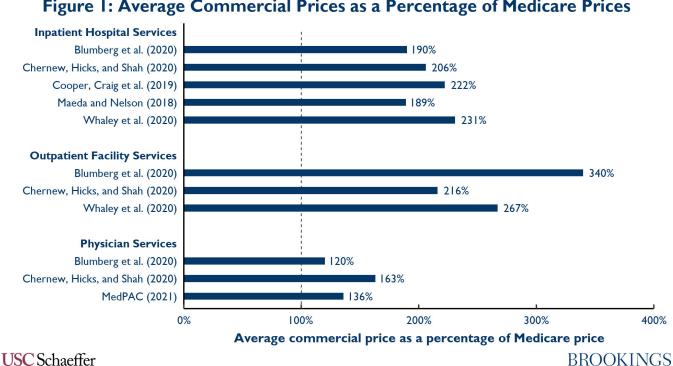


Figure 1: Average Commercial Prices as a Percentage of Medicare Prices

Despite the fact that Medicare pays much lower prices than commercial plans, Medicare beneficiaries have robust access to providers. Hospital and physician participation in Medicare is virtually universal, and surveys of Medicare beneficiaries find that they generally do not have difficulty finding a physician when

they need one (and experience levels of access similar to people with commercial plans). This likely reflects the fact that Medicare's prices, while far below commercial prices, still exceed providers' marginal cost of delivering care, which ensures that serving Medicare beneficiaries is profitable for health care providers. Indeed, the Medicare Payment Advisory Commission estimates that Medicare's prices exceeded hospitals' marginal cost by 8% on average in 2019.

## Designing a Public Option that Could Pay Lower Prices

The example of traditional Medicare suggests that it would be feasible for a public option to pay less than existing private plans while still attracting participation from providers. However, whether that occurred in practice would depend on how a public option was designed. I turn now to those design questions.

I begin by discussing a public option that would determine provider prices administratively, as Medicare does. I argue that this type of public option could pay less than existing private plans and still attract providers; however, this would only be true if providers that wanted to serve patients covered by the public option's private competitors also had to serve the public option's patients. I then turn to a public option that would negotiate prices with providers, like private plans; I argue that this type of public option would likely struggle to pay lower prices than existing private plans.

#### Public option with administered prices

Many public option proposals envision setting prices administratively, meaning that the public option would establish formulas that specify what it would pay for each service, often with adjustments for certain provider characteristics (e.g., the provider's geographic location or teaching status). In practice, these types of public option proposals generally link the public option's prices to Medicare's prices.

The challenge for this type of public option would be attracting providers. In particular, providers who were paid more by existing private plans than by the public option would likely be reluctant to participate in the public option unless the public option had other tools to encourage participation. (A corollary is that a public option that lacked other tools for encouraging participation would primarily attract providers who it paid more than existing plans and, thus, pay providers more, on average, than existing plans with comparable networks.) While this conclusion is intuitive, it is worth being precise about why this would be true, as doing so can offer insight into how to solve the participation problem.

The core issue is that a provider's decision to participate in the public option would reduce consumers' demand for private plans—and particularly private plans that included that provider.[3] That, in turn, would reduce the premiums private plans could charge for plans that included the provider, thereby reducing private insurers' eagerness to reach agreement with the provider and weakening the provider's bargaining position. Of course, the provider would need to weigh these

costs of participating in the public option against the profits it could earn by serving public option patients. But this tradeoff between gaining volume under the public option and weakening its bargaining position with other plans is fundamentally similar to the tradeoff providers face when negotiating with private plans today, so it follows that a provider would be unlikely to participate at prices well below what it received from existing plans.[4]

Policymakers would have a couple of options for solving this problem. One approach would be to require a provider to serve the public option's patients if it wanted to serve patients covered by the public option's private competitors (perhaps with exceptions for emergency care and certain other defined circumstances).[5] For example, a provider that refused to participate in an individual market public option might be barred from participating in private Marketplace plans.[6] This approach would eliminate the main benefit provider obtains by opting out of the public option: the ability to extract higher prices from private plans. Thus, it would then be in the provider's interest to serve the public option's patients as long as the public option's prices exceeded the provider's marginal cost.

Notably, the Medicare program includes rules like this. Institutional providers are required to accept Medicare patients on the same terms as they treat other patients, which would generally prevent providers from turning away traditional Medicare patients while treating Medicare Advantage patients.[8] These rules may be an important reason that provider participation in traditional Medicare is so broad, despite the presence of private Medicare Advantage plans. (The fact that Medicare beneficiaries are enrolled in traditional Medicare program by default and that traditional Medicare has a large legacy market share may also play a role in allowing traditional Medicare to elicit broad provider participation.)

An alternative approach would be to directly require providers to participate in the public option. This type of requirement could be enforced by making participation in the public option a condition of participation in other federal coverage programs, such as Medicare and Medicaid, an approach that has been taken by at least one prominent public option proposal.[9] Alternatively, it could be enforced by freestanding fines on providers that declined to participate in the public option.

#### Public option with negotiated prices

I now turn to a public option that would determine prices through negotiations with providers, similar to how prices are determined in private insurance plans. The public option proposal passed by the

nouse or kepresentatives during the 2009 health care reform depate took this basic approach, and some recent public option proposals would also determine prices through negotiations.[10]

However, there is little reason to expect that a public option could negotiate lower prices than private plans. Ultimately, an insurer's only source of leverage in price negotiations is the threat to exclude a provider from its network if the provider refuses to agree to an acceptable rate. There is no clear reason to expect a public option to be better at wielding that threat than private plans and some reason to believe it would be worse since it might face political pressure to maintain a broad network.

A public option might be able to negotiate better prices if it had a source of leverage that private insurers lack. For example, if a provider that failed to reach agreement with the public option was also barred from serving patients covered by the public option's private competitors, as suggested above, that could allow the public option to negotiate much lower prices. But for that leverage to be useful to the public option, the public option would need to be willing to use it. And there is reason to believe that it would be reluctant to do so in practice. In particular, the same political pressures that would tend to make a public option leery of excluding a provider from its own network would likely make the public option even more leery of excluding a provider from the individual market entirely. [11]

Negotiating prices with providers would also be administratively complex. There are about 6,000 hospitals in the United States and hundreds of thousands of physician practices.[12] Managing negotiations with all of those providers would be difficult and would cause the public option to incur meaningful administrative costs, forfeiting at least part of the administrative cost advantages a public option might otherwise hold (as discussed further below). In practice, the agency responsible for administering a public option could (and likely would) delegate that responsibility to a contractor, but it would then need to compensate the contractor. Creating appropriate incentives for a contractor could also be difficult.

## Effects of a public option on prices negotiated by private plans

As an aside, I note that if a public option was successful in paying providers less than existing private plans while attracting broad provider participation, the public option's private competitors would likely also become able to negotiate lower prices with providers. (A corollary is that private plans would likely be viable competitors for a public option that paid providers less than existing

5/7/2021 pians.)

In detail, faced with competition from the public option, private plans would recognize that they could not set premiums too far above the public option's premium and still expect to attract enrollees. That, in turn, would make it unprofitable for insurers to pay providers prices too far above the public option's prices, making insurers willing to walk away from negotiations with providers rather than pay prices that high. Providers, for their part, would recognize that if they failed to reach agreement with private plans, then their patients would enroll in the public option instead and they would be paid the public option's prices, making it in their interest to agree to prices close to the public option's prices.

Exactly where the prices paid by private plans landed would depend on how much competitive pressure the public option created, which would depend in turn on non-price determinants of the public option's costs.[13] As I discuss in greater detail below, research comparing traditional Medicare to private Medicare Advantage plans suggests that a public option might manage utilization less aggressively, attract sicker enrollees, and be less aggressive in coding diagnoses under the individual market's risk adjustment program (although it might also have somewhat lower administrative costs). Those factors would tend to raise the public option's premium, reducing how much competitive pressure it placed on private plans and thereby allowing providers to negotiate prices somewhat above the public option's prices.

The notion that the presence of a public plan could constrain the prices that private plans paid providers is not just theoretical. A striking feature of the Medicare program is that private Medicare Advantage plans pay physicians and hospitals prices that closely mirror traditional Medicare's prices. There is some debate over whether this primarily reflects the effects of competitive pressure from traditional Medicare or the fact that the amounts providers can collect for out-of-network care delivered to Medicare Advantage enrollees are capped at traditional Medicare's prices. However, I have argued elsewhere that unless providers are compelled to accept an insurer's patients (which they generally are not outside of emergency situations), the scope for an out-of-network cap to reduce *negotiated* prices is likely relatively limited. If that is true, then it suggests that competition from traditional Medicare plays the lead role in explaining why Medicare Advantage plans negotiate prices so close to traditional Medicare's.

Finally, I note that the introduction of a public option that reduced provider prices could also change what types of plans consumers held. When the overall level of provider prices is lower, private plans are likely to have less scope to use narrow networks to negotiate lower prices. Similarly, when unit prices are lower, plan efforts to reduce utilization will tend to generate smaller reductions in claims spending. This suggests that introducing a public option that paid providers less would tend to reduce the premium advantage held by narrow network and tightly managed plans, which would likely cause consumers to migrate toward broader network, less tightly managed plans (whether they be private or public).

## Rationales for Creating a Public Option Other than Reducing Provider Prices

In practice, policymakers might not be willing to design a public option in a way that would make it effective in reducing prices—or might not even have the goal of reducing prices in the first place. In that case, a natural question is whether there is still a rationale for creating a public option.

This section considers two potential alternative rationales. First, a public option might offer consumers lower premiums by virtue of incurring lower administrative costs or eschewing profits. Second, because a public option would lack a profit motive, it might offer better coverage. I discuss each rationale in turn and conclude that neither is compelling, although neither can be completely dismissed.

Before proceeding, I note that creating a public option that paid providers prices similar to the prices paid by existing private plans would be easier said than done. As described above, if a public option negotiated prices with providers, it might well end up paying providers *more* than existing private plans.

Setting prices administratively would be challenging too. The entity administering the public option would need comprehensive, granular data on the prices paid by private plans, which do not currently exist. Additionally, the prices paid by the public option would likely need to vary across providers in ways that mirrored how prices vary in private plans, which could be difficult to achieve; if a public option failed to do so, it would disproportionately attract providers that it paid more than private plans and potentially pay higher average prices than private plans with comparable provider networks. Another complication is that providers might recognize that agreeing to a lower price with a private insurer could reduce what they were paid by the public option, leading providers to demand higher prices from private plans than they do today.[14] I do not discuss these issues further, but policymakers interested in implementing a public option that paid prices similar to existing private

plans would need to grapple with them.

## Lower premiums

A common argument in favor of a public option is that it could set lower premiums by virtue of incurring lower administrative costs or eschewing profits. I consider each potential source of savings in turn:

Underwriting margin (% of premiums) 10 5 Plausible range of individual market margins for 2021 Individual 0 -5 -10 2011 2012 2013 2014 202 I 2015 2016 2017 2018 2019 2020

Figure 2: Insurer Underwriting Margins by Market Segment

Source: CMS Medical Loss Ratio public use file; author's calculations.

Note: The underwriting margin equals the difference between premium revenue and contemporaneous expenses. Payments from the ACA's transitional reinsurnace program are treated as premium revenue. Calculations exclude payments and charges under the ACA's risk corridor program. See text for methods underlying the projections of individual market margins for 2021.

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• **Profit margins:** Public option proposals generally envision that a public option would set premiums that covered its costs but did not incorporate a profit margin. The importance of this difference from private plans depends on the size of the margins earned by private plans.

To provide insight on that question, Figure 2 plots insurers' underwriting margins for 2011 through 2019, as estimated in the MLR data. [15] A clear challenge in forecasting future individual market margins is that they have been highly volatile in recent years, likely because of the <u>rapidly changing policy environment</u>. Insurers incurred losses in the years before implementation of the ACA's main reforms in 2014, but those losses deepened dramatically thereafter, likely primarily because insurers misjudged the post-ACA risk pool. Insurers returned to profitability in 2017 following large premium increases. Margins then surged in 2018 and 2019 as insurers reacted to (and, as it turned out, overreacted to) various Trump administration policy changes.

By contrast, margins in the small and large group markets—where policy has been relatively stable—have fluctuated in a narrow range over this period, centered on an average of 2.9% in the case of the small group market and an average of 2.4% in the case of the large group market.

Additionally, individual market margins appear to be on track to return to the low-to-mid single-digits in 2021.[16] The average Marketplace premium has fallen by 2.2% from 2019 through 2021, likely driven at least in part by insurer entry.[17] Gauging how insurers' expenses evolved from 2019 to 2021 (and, more to the point, how insurers expected them to evolve when setting 2021 premiums) is harder given the uncertainty caused by the COVID-19 pandemic. Thus, Figure 2 presents a range of plausible margins corresponding to a range of assumptions about expenses.

The top of the range corresponds to a scenario in which insurers' nominal per enrollee expenses in 2021 equal their 2019 level, which may be roughly where expenses stood when insurers finalized their rates in mid-to-late 2020.[18] This scenario is one in which the COVID-19 pandemic continues to place substantial downward pressure on health care utilization throughout 2021, as it did during much of 2020; it yields a margin of 6.1% of premiums. The bottom of the range corresponds to a scenario in which nominal per enrollee expenses in 2021 are 5% higher than in 2019, which is roughly what would happen if expenses returned gradually to their pre-COVID trend during 2021; this scenario yields a projected margin of 1.4% of premiums.

Taken together, the recent history of margins in the small and large group markets and the fact that individual market margins appear on track to return to the low-to-mid single-digits this year suggests that it is reasonable to expect individual market margins to settle in the low single-digits over the medium run. However, the outlook may become clearer with more years of data.

If lower administrative costs and the lack of a profit margin were the only differences between a public option and private plans, then the preceding discussion suggests that a public option that paid providers prices comparable to existing plans would likely charge lower premiums than existing plans, perhaps by mid-to-high single-digit percentages. However, research that has compared traditional Medicare (the model for most public option proposals) to private Medicare Advantage plans suggests that a public option would have *higher* costs than private plans along several other dimensions:

• **Utilization:** Holding enrollees characteristics fixed, enrollees appear to use more health care when

enrolled in traditional Medicare than when enrolled in Medicare Advantage, presumably because Medicare Advantage plans manage utilization more aggressively. For example, <u>Curto and colleagues</u> estimate that a person enrolled in traditional Medicare uses 9% more services than an otherwise identical person enrolled in a Medicare Advantage plan.

- **Risk selection:** Traditional Medicare also seems to be preferred by enrollees who have greater <u>health care needs</u>. Estimates of the extent of selection vary, but Curto and colleagues' estimates imply that traditional Medicare enrollees' claims risk was about 6% higher than the Medicare population as a whole, even after adjusting for characteristics included in risk adjustment.[19].
  - Diagnosis coding: A <u>wealth of evidence</u> demonstrates that Medicare Advantage plans are more aggressive in coding enrollees' diagnoses. Using a particularly compelling methodology, Geruso and Layton estimate that Medicare Advantage plans' more aggressive diagnosis coding makes enrollees look 6% sicker than identical traditional Medicare enrollees. In Medicare Advantage, a portion of private plans' aggressive coding is offset by a "coding intensity adjustment" that reduces private plans' risk scores. In principle, policymakers could do something similar for an individual market public option, although existing public option proposals generally do not.

Taken together, utilization, risk selection, and diagnosis coding differences like these would be more than enough to offset the public option's lower administrative costs and lack of a profit margin. And it is conceivable that the utilization and risk selection differences between an individual market public option and its private competitors could be larger than the differences between traditional Medicare and Medicare Advantage plans since many existing individual market plans have narrow networks and tight utilization controls. Thus, a public option that paid providers prices similar to existing plans would likely charge *higher* premiums—and perhaps much higher premiums—than typical existing plans.

This type of public option might be able to offer lower premiums than existing plans that have broad networks or looser utilization controls. A public option would likely have smaller disadvantages in utilization and risk selection relative to these plans, although it might also have smaller administrative cost advantages. Thus, relative to these plans, a public option's lower administrative costs and lack of a profit margin might outweigh its cost disadvantages, particularly if policymakers created a coding intensity adjustment that offset part of private plans' diagnosis coding disadvantages. However, it seems likely that any premium advantage a public option did hold

As a final note, if the public option's premiums were close enough to private plans' premiums that the public option did attract non-trivial enrollment, it could modestly reduce the premiums of private plans. First, it might place some competitive pressure on those plans, causing them to set premiums that incorporated lower profit margins. Second, the public option's coding disadvantages could cause it to make risk adjustment payments to private plans, which might reduce private plans' premiums. Third, advantageous selection might also reduce private plans' premiums, although this is less clear; while selection would clearly make the average private plan enrollee healthier, it might not make the *marginal* enrollee healthier, and it is the marginal enrollee that governs private plans'

#### Better coverage

premium-setting incentives.

A different rationale for creating a public option is that it would offer better coverage. By virtue of lacking a profit motive, a public option might be less motivated to reduce its claims spending and thus might eschew cost-sharing, network, or utilization management practices that discourage receipt of appropriate care or expose enrollees to excessive financial risk. Of course, private insurers face competitive pressure to avoid these practices. But this is true only to the extent that consumers can observe these practices, which not always be the case, particularly given the complexity of health insurance products.

There is some empirical evidence consistent with the view that a public option would better serve its enrollees' interests. Indeed, some of the additional utilization that occurs in traditional Medicare relative to private Medicare Advantage plans appears to be high-value care. However, this evidence is far from definitive. Tighter utilization controls might unavoidably discourage some mix of low- and high-value care, and enrollees might be willing to accept that tradeoff in exchange for lower premiums or other benefits, so this pattern could arise even if Medicare Advantage plans were acting in accord with enrollees' wishes.

Even if a public option did offer better coverage, consumers would only benefit if the public option attracted substantial enrollment. A public option that paid providers prices similar to existing plans might struggle to do so. As described in the last section, this type of public option would likely set higher premiums than most existing plans. While it might set slightly lower premiums than existing plans with broad networks and looser utilization controls, those types of plans currently play a

willing to pay the higher premiums those plans charge. Thus, for this type of public option to attract meaningful enrollment, consumers would likely need to be willing to pay much more for a public option than for private plans.

It is certainly conceivable that consumers would be willing to pay more for a public option. In particular, a public option's differing incentives and governance might allow it to elicit greater trust from consumers. That might make consumers more confident that a public option would provide good coverage and, thus, willing to pay higher premiums. As an empirical matter, the fact that traditional Medicare retains a majority of Medicare beneficiaries even though Medicare Advantage plans offer lower premiums and supplemental benefits is consistent with the view that consumers look more favorably on public plans. But there are other factors that could also account for traditional Medicare's market share (e.g., Medicare Advantage plans' narrower networks and the fact that traditional Medicare is the default enrollment choice), and it is far from clear that individual market consumers would have similar attitudes.

As a final note, while a public option might offer better coverage in some respects, it could offer worse coverage in others. Most importantly, a public option might be less nimble than private plans and take longer to cover new types of care, particularly if doing so required a statutory change. Indeed, the fact that prescription drug coverage had become essentially universal in employersponsored insurance plans by the time Medicare added a prescription drug benefit offers a cautionary tale.

### Conclusion

This piece has argued that a public option could pay providers less than existing private plans while still attracting providers as long as it had two features: (1) the public option set prices administratively; and (2) providers could not serve patients covered by the public option's private competitors without also serving the public option's patients. A public option that had these features would likely also create competitive pressure that would substantially reduce the prices paid by private plans.

If policymakers are not willing to adopt these design features (or are simply not interested in reducing provider prices), then the rationale for creating a public option is less clear. A public option that paid prices comparable to existing plans would likely set higher premiums than most existing

public option would at best offer slightly lower premiums. Thus, a public option's only real way to add value would be to offer better coverage (and convince consumers of that fact). This is possible, but by no means certain.

piano. Even relative to existing piano with broad networks and looser atmization controls, this type of

In closing, I note that this piece does not address the question of whether policymakers *should* seek to implement a public option that paid lower prices. Reductions in providers' revenues could make some providers unable to cover their fixed costs, forcing them to cut costs or exit the market, either of which could have negative consequences for patient care. Providers might also have weaker incentives to invest in improving quality since attracting additional patients would now be less lucrative and since higher quality would be less likely to be rewarded with higher prices when prices are set administratively. Lower prices would also, naturally, tend to result in lower incomes for health care providers.

Those potential downsides would need to weighed against the savings generated by a public option —and what those savings could finance. Policymakers might reasonably be willing to tolerate some risk of negatively affecting care delivery if implementing a public option saved money for consumers, facilitated expanding insurance coverage, or had some other beneficial effect.

Additionally, to the extent that the savings from a public option were used to finance expanded insurance coverage, that would tend to offset some of the financial pressure a public option placed on providers, thereby reducing the risk that a public option would have ill effects on care delivery in the first place.

#### About the Author



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#### Footnotes:

- [1] Some proposals also allow employers to purchase coverage through the public option on behalf of their workers. Those proposals are not the focus of this piece, although many of the main considerations are similar.
- [2] I discuss the design and effects of a public option, as well as other tools for reducing provider prices, at greater length in another recent paper.
- [3] A provider might also decline to participate in the public option if the public option paid prices below the provider's marginal cost. However, the broad provider access enjoyed by Medicare beneficiaries suggests that such providers would be relatively rare as long as the public option paid providers at least as much as Medicare does, which essentially all prominent public option proposals do.
- [4] There is a caveat. Unlike when a provider negotiates with a private insurer, a provider could not hope to "hold out" to get a better price from a public option that sets prices administratively. In essence, the public option would be able to make a "take-it-or-leave-it" offer to providers. That might allow the public option to attract providers at modestly lower prices than existing private plans, but likely not dramatically lower prices.
- [5] Note that merely requiring providers to "participate" in the public option would not be good enough. Providers would need to be required to give public option patients meaningful access to their services. My earlier paper discusses how those types of requirements could be structured in greater detail.
- [6] In principle, this could be structured as a requirement on *insurers* rather than providers. That is, *insurers* could be barred from covering services delivered by providers that did not serve public option patients.
- [7] On the other hand, this could lead some providers with marginal cost above the public option's

prices to stop serving the individual market altogether since they would have little hope of negotiating higher prices with private plans without being able to offer private plans preferential access to their services. In any case, the example of Medicare suggests the number of providers in this category would likely be small, at least as long as the public option paid providers prices at least as high as Medicare's.

- [8] See 42 CFR § 489.53(a)(2).
- [9] A potential concern with the latter approach is that providers might opt out of Medicare and Medicaid rather than comply with the requirement to participate in the public option. That is likely not a substantial risk in the case of an individual market public option since forgoing all Medicare and Medicaid volume would be too high a price to pay to protect their margins in the relatively small individual market.
- [10] Some proposals place bounds on the prices the public option is permitted to negotiate. In practice, proposals like these might end up resembling a public option that set administered prices equal to the upper bound.
- [11] A public option could likely also do better than private plans if providers were literally required to participate in the public option since the public option could then set prices by fiat. But a public option could do better in this setting precisely because prices would, in effect, be administered, not negotiated.
- [12] There are approximately 1 million licensed physicians in the United States. The American Medical Association's 2018 Benchmark Survey found that about 15% were in solo practice (suggesting there are around 150,000 solo practices), and another 20% are in practices with 2-4 physicians (contributing at least another 50,000 practices).
- [13] My earlier paper provides quantitative simulations of how these factors would affect outcomes.
- [14] A similar problem may arise under the Medicaid drug rebate program, which generally requires drug manufacturers to offer state Medicaid programs the best price it offers any payer. One solution to this problem would be to determine what the public option paid providers based on what private plans paid before the public option was created. A problem with this solution is that these prices might get "stale" over time.

[15] I note that the estimates in Figure 2 are estimates of contemporaneous *accounting* profits that omit the costs of capital investments made in prior years, so true economic profits could be smaller. Indeed, in a competitive market with free entry, economic profits would be expected to be zero. In practice, however, private insurers appear to wield some market power, so it is likely that at least a portion of observed margins represent economic profits. Additionally, insurers do have incentives to understate their premium revenue and overstate their claims costs in these data to avoid paying MLR rebates, which could cause these data to understate profit margins.

[16] On the other hand, 2020 will likely be another year of high margins, primarily because the COVID-19 pandemic led to large reductions in utilization of non-urgent care, which substantially depressed claims spending.

[17] This estimate was calculated using the Marketplace open enrollment public use files and holds the distribution of enrollment by state and metal level fixed from 2019 to 2021. The calculation only includes states that used the HealthCare.gov enrollment platform in both years.

[18] Data from the Bureau of Economic Analysis indicate that nominal health care spending per capita was about 0.5% below its 2019 average level as of September 2020.

[19] In detail, Curto and colleagues. report that average per member per month spending in traditional Medicare is \$855 (in the geographic areas they examine), after adjusting for individual characteristics accounted for in risk adjustment. In analyses that attempt to adjust for a broader set of health status characteristics, that estimate falls to \$706 per member per month. In other work, I have estimated that Medicare Advantage plans accounted for 30% of total Medicare enrollment in the states and year the authors examined. This suggests that the claims risk of traditional Medicare enrollees was about 6% (=1/[0.7+0.3\*706/855]-1) higher than the Medicare population as a whole. There have likely been improvements in risk adjustment since the years the authors examine (2010), so differences could be smaller today, although plans could also have gotten better at risk selection over time.

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## Key Elements of the Biden Administration's Proposed Title X Regulation

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**ISSUE BRIEF** 

#### Introduction

On April 15, 2021, the Department of Health and Human Services (HHS) published a notice of proposed rulemaking (NPRM) in the Federal Register entitled "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services (https://www.federalregister.gov/documents/2021/04/15/2021-07762/ensuring-access-to-equitableaffordable-client-centered-quality-family-planning-services)", which proposed to replace the Trump Administration rules published on March 4, 2019. The Trump regulations made many programmatic changes to the Title X family planning program, notably adding restrictions to federal funding for abortion counseling and referral, as well as bans on federally-funded Title X sites from being co-located with abortion services. The Biden HHS is proposing to revise the Trump Administration rules by essentially re-instating prior regulations that are very similar to those that were in effect from 1993-2019 with several revisions that focus on "ensuring access to equitable, affordable, clientcentered, quality family planning services" for all clients, especially for low-income clients. This brief provides an overview of the key elements of the Biden Administrations proposed regulations for the federal Title X family planning program.

#### **Impact of the Trump Administration Title X Regulations**

In the proposed rules, HHS outlines the substantial impact the Trump Administration regulations have had on the network over the time that the regulations have been in effect. The number of clients served by the program dropped from 3,939,749 clients in 2018 to 3,095,666 clients in 2019 (a 21% decrease), and then further decreased to

1,536,744 clients in 2020 which is a 60% decrease in clients served from 2018 (Figure 1). This dramatic drop is likely due to a combination of the impact of the pandemic with fewer people seeking care and the significant reduction in Title X sites serving clients due to the Trump Administration regulations.

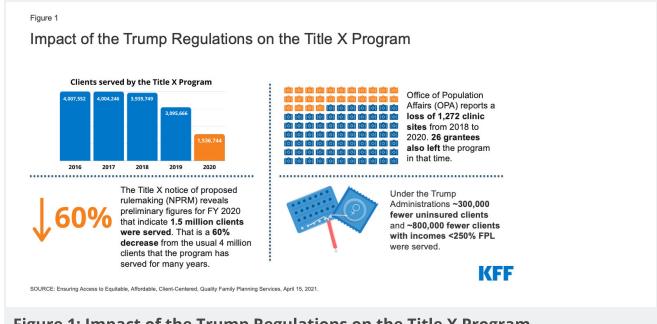


Figure 1: Impact of the Trump Regulations on the Title X Program

From 2018 to 2020, HHS reports a loss of 26 grantees (26%) who receive Title X funding and then distribute funds to the Title X clinic sites within their networks, as well as a loss of 1,272 clinic sites. There are currently six states (https://www.kff.org/womens-healthpolicy/issue-brief/current-status-of-the-title-x-network-and-the-path-forward/) without any Title Xfunded services (HI, ME, OR, UT, VT, WA) and Office of Population Affairs (OPA) has been unable to find new grantees to fill most of the gaps that the Trump Administration rule created. There are an additional eight states (https://www.kff.org/womens-health-policy/issue-brief/current-status-of-the-title-x-network-and-thepath-forward/) that lost over half of their Title X network (AK, CT, IL, MA, MD, MN, NY, NH).

The Trump Administration regulations have had a substantial impact on low-income and uninsured clients that have relied on these services. Compared to 2018, there was a decrease in over 800,000 low-income clients (incomes < 250% of the Federal Poverty Level (FPL)) and over 300,000 uninsured clients. There has also been a substantial decrease in the number of sexual and reproductive health services provided from 2018 to 2019. There was a decrease of close to 400,000 women who received contraception through the Title X program from 2018 to 2019, about 300,000 fewer cancer screenings, and over one million fewer sexual transmitted infection (STI) tests.

#### **Impact of the Trump Administration Title X Regulations**

#### Title X Clinics Will Be Able to Refer for Abortion Services and Have Co-located **Abortion Services**

The Biden HHS proposed Title X regulations are similar to the regulations that were in place from 1993 to 2019. They again allow Title X funded sites and providers to discuss and refer clients to abortion services when they wish to terminate a pregnancy and permit family planning services to be co-located with abortion services, but maintain the longstanding prohibition on the use of Title X funds to pay for abortions. The proposed regulations once again require, "upon request of the client, nondirective counseling and referral, regarding any option requested: (1) prenatal care and delivery; (2) infant care, foster care, or adoption; and (3) pregnancy termination."

#### 2. Quality Family Planning Guidelines Will Be Used as a Standard of Care

The proposed regulations will again base the standards of care for the Title X program on Providing Quality Family Planning Services (QFP) guidelines (https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm?s cid=rr6304a1 w). They also incorporate several of the QFP's recommendations into the regulations, including providing a range of Food and Drug Administration (FDA)- approved contraceptive methods onsite or a referral if necessary, using a client-centered approach to care provision and delivering high-quality care to all clients equitably. First published in 2014 by the Office of Population Affairs and the Centers for Disease Control (CDC), QFP recommendations are based on rigorous systematic reviews of the scientific evidence and reference other clinical guidelines from federal agencies and professional medical associations.

#### 3. Contraceptive Services Include FDA-approved Contraceptives and Natural **Family Planning**

The proposed regulations revert to the previous definition of family planning services, which includes FDA-approved contraceptive services, and natural family planning services. The Trump Administration had dropped the requirement for "FDA-approved" and required a broad range of "acceptable and effective" family planning methods (including contraceptives, natural family planning or other fertility awareness-based methods)." This opened the path for organizations to qualify for federal Title X support even though they only offered a single method such as fertility awareness-based approaches or one, like abstinence, which is not an FDA-approved method. Ensuring that women have access to a broad range of FDA-approved contraceptive methods is significant because on average, women use 3.4 methods through their lifetime and women's contraceptive preferences change across their reproductive years (**Table 1**).

Table 1: The types of contraception that women use change over the course of their reproductive years

	All Women		Age Group	
Type of contraception used in past 12 months	18-49	18-25	26-35	36-49
Oral contraceptives	37%	50%*	37%	28%
Injectables	4%	5%	5%	2%
Patch	2%	4%*	2%	0%
Ring	3%	3%	4%	2%
IUD	23%	13%	24%	28%*
Implants	7%	11%*	7%	2%
Male condoms	39%	47%*	36%	35%
Fertility awareness- based methods	8%	6%	11%*	7%
Emergency contraception	9%	15%*	11%	2%
Other	4%	6%	4%	3%

NOTE: \*Estimate is statistically different from estimate for all women ages 18-49 (p < 0.05). Table is among

#### 4. Clinic Sites That Do Not Provide a Broad Range of Contraceptive Methods Must Provide Referrals to a Provider That Does

If a clinic does not provide a broad range of contraceptive methods or the method that a client seeks, referrals can assure access to their preferred method of contraception. In the proposed regulations, clinic sites that do not provide a broad range of contraceptive methods on-site must be able to provide clients with a referral to a provider who does offer the client's method of choice. The regulations specify that the referral provided must not unduly limit access to the client's method of choice, such as excessive distance or travel time to the referral location or referral to services that are cost-prohibitive for the client. Other Title X clinics and U.S. Health Resources & Services Administration (HRSA) Section 330-funded Federally Qualified Health Centers could both provide services on a sliding fee scale, but services at non-federally funded clinics or other sites may not be affordable without insurance or offered on a sliding scale. However, it is unclear in the proposed regulations whether this referral has to be another Title X-funded site, or if it can be outside of the Title X network, and if so, how the client will be able to afford that service or method.

The KFF Women's Health Survey found (https://www.kff.org/womens-health-policy/issuebrief/womens-sexual-and-reproductive-health-services-key-findings-from-the-2020-kff-womens-healthsurvey/) that one in five women is not using their preferred method of contraception and this share is higher among uninsured (27%) and low-income women (25%) and women of color compared to white women (Figure 2). Among women who say they are not using their preferred method of contraception, a quarter of women say it is because they cannot afford it (Figure 3). Women using their preferred contraceptive method (https://pubmed.ncbi.nlm.nih.gov/33607120/) are more likely to consistently use their method and intend to continue using it compared to women not using their preferred method and Title X clinics can make contraception more affordable.

#### Figure 2

## One in four uninsured women and low-income women are not using their preferred method of birth control

If you could use any type of birth control method available, would you want to use a different method than you're currently using, or not?

**Overall Contraceptive Users 18-49** 

**Insurance Type** 

27% Uninsured\*

20% Medicaid

Private Insurance (Ref) 16%

Income

<200% FPL\* 25%

16% ≥200% FPL (Ref)

Race/ethnicity

Black 18%

22% Hispanic

White (Ref) 17%

Urbanicity

19% Rural

Urban (Ref) 18%

NOTE: \*Estimate is statistically different than estimate for reference (Ref) within group (p < 0.05).

SOURCE: KFF Women's Health Survey 2020 • PNG

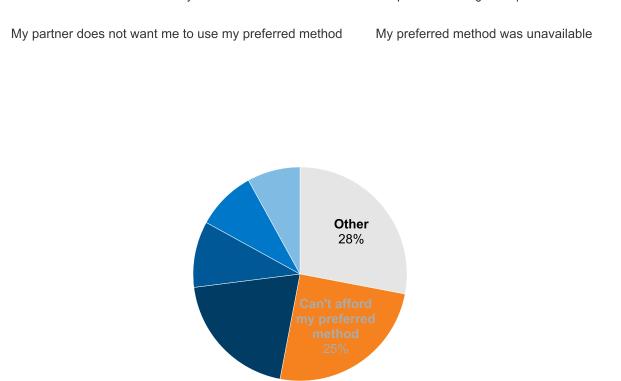


#### Figure 3

## One in four women report not using their preferred contraceptive method because they cannot afford it

Among women not using their preferred method of birth control, the primary reason they are not using their preferred method of birth control:

Can't afford my preferred method Provider recommended a different method I have medical conditions making me ineligible for my preferred method



NOTE: Among women who answered "Yes" to "If you could use any type of birth control method available, would you want to use a different method than you're currently using, or not?"





#### 5. Clinic Sites Will Be Required to Assess Clients' Family Income Before **Determining Payment**

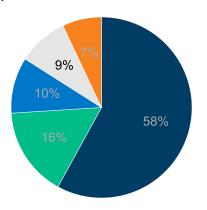
One of the goals of the Title X program is to ensure cost is not a barrier to family planning services. The Title X program uses a sliding fee scale that bases the amount a client has to pay on their income. Clients with incomes at or below 100% of the Federal Poverty Level are not to be charged for their services, while clients with incomes between 101% and 250% FPL receive discounted services based on their ability to pay. Recognizing that a client's income cannot always be verified, the proposed regulations state that charges can be based on the client's self-reported income if verification is too burdensome. Clinics are still required to make efforts to bill third party payors for clients with coverage, regardless of their income.

A new addition to the proposed regulations specifically addresses insured clients whose family income is at or below 250% FPL and requires that they do not pay more (in copayments or additional fees) than what they would otherwise pay without insurance when the sliding fee scale is applied. This ensures that clients with insurance are not paying more than what they would pay without insurance for their family planning services. There is a sizable share of low-income women with insurance that still rely on these public programs (16%) to pay for their contraceptive care (**Figure 4**).

Figure 4

## When private insurance did not cover the full cost of contraception, public programs picked up the cost for 1 in 6 low-income women

How did you pay for your most recent birth control care?



My insurance covered the full cost I used Medicaid or some other public program

I did not have any coverage for birth control and paid for it myself

My insurance covered part of the cost and I paid the rest

NOTE: Among privately-insured women age 18-49 with income < 200% FPL.

SOURCE: KFF Women's Health Survey 2020 • PNG



#### 6. Advancing Health Equity as a Criterion for Awarding Grant Funds

Family planning care has a long history of inequitable care (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2835625/) with people of color and low-income people disproportionately receiving coercive and non-client centered care. When asked to rate their contraceptive care provider on four items of client-centered contraceptive <u>counseling (https://pcccmeasure.ucsf.edu/)</u> — respecting me as a person, letting me say what mattered to me about my birth control, taking my preferences about my birth control seriously, and gave me enough information to make the best decision about my birth control — less than half of women and even smaller shares of Black and Hispanic women, low-income women, and uninsured women rated their contraceptive counseling as excellent on all four items (Figure 5).

#### Figure 5

Black and Hispanic women, low-income women, and uninsured women are less likely to say they received excellent care across a 4-item measure of personcentered contraceptive counseling

Overall contraceptive users ages	18-	44%
49		44 /0

#### Race/ethnicity

Black*	36%
Hispanic*	38%
White (Ref)	49%

#### Income

<200% FPL*	35%
≥200% FPL (Ref)	47%

#### **Insurance Type**

Uninsured*	28%
Medicaid	39%
Private insurance (Ref)	47%

NOTE: \*Estimate is statistically different from reference estimate within group. The percentage reported is the percentage of women ages 18--49 who rate their more recent contraceptive care provider as excellent for respecting you as a person, letting you say what mattered to you about your birth control, taking your preferences about your birth control seriously, and giving you enough information to make the best decision about your birth control method. †Includes Planned Parenthood; other family planning clinic; a school or school-based clinic or college health center; walk-in clinic, such as an urgent care center or clinic inside a store; community health



In their 2011 report (https://www.nap.edu/catalog/13181/clinical-preventive-services-for-womenclosing-the-gaps), the Institute of Medicine (now the National Academy of Medicine), defines quality health care as health care that is provided using a client-centered approach and is equitable, among other attributes. These attributes of quality care are added to the new proposed regulation with a specific focus on services that are clientcentered, culturally and linguistically appropriate, inclusive, trauma-informed, and ensure equitable and quality service delivery. HHS is proposing to add the ability to advance health equity as a new criterion for awarding grant funds. These additions would help to ensure care is more equitable, particularly by incorporating the evidence-based **Quality Family Planning Guidelines** 

(https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6304a1.htm?s cid=rr6304a1 w). However, it is unclear how all of these additions to the program will be actualized in the provision of care by clinics across grantee networks. There are few evidence-based tools for clinics to use to assess whether their provision of family planning services is culturally and

linguistically appropriate, inclusive, trauma-informed, and equitable. However, this is one area where OPA could provide more guidance to clinics through program guidelines or through the development and dissemination of tools for assessing and implementing these attributes in family planning.

#### **Rebuilding the Title X Network**

The Biden HHS regulations were published on April 15, 2021, with a 30-day public comment period and <u>public comments</u>

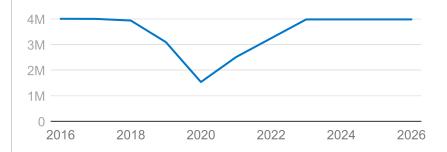
(https://www.federalregister.gov/documents/2021/04/15/2021-07762/ensuring-access-to-equitableaffordable-client-centered-quality-family-planning-services#open-comment) are due Monday, May 17, 2021. HHS will then address the public comments and issue a final regulation. Regulations usually become effective 60 days after publication of the Final Regulations, but the agency could make them effective sooner if it has good cause. Currently funded grantees could begin bringing clinic sites who have left the program back into their networks immediately after the effective date, but in order to receive new funds for services, grantees that left the Title X program will have to wait to apply to the program when the Funding Opportunity Announcement is released, which is anticipated in December 2021.

HHS estimates that it will likely take at least two years for program participation and clients served to reach previous numbers. This assumes that most of the service sites that withdrew from the Title X program have remained open and would be able to rejoin under the proposed rule. The pandemic plus the regulations resulted in significantly lower numbers of clients served in 2020 (~1.5 million clients). HHS anticipates that the number of clients would increase to about 3.2 million by 2022 and then by 2023 be back to the ~4 million clients the program has historically served (Figure 6). While the reduction in Title X funded sites and clients has been well documented, there is less known about whether clinics have had to close, reduce hours, or lay off staff. The pandemic has also significantly reshaped many elements of the health care delivery system from telemedicine to workforce that has also likely impacted the family planning network in the US. One aspect of the regulation that could make it easier for sites to expand their workforce (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5585132/) is a change that acknowledges that consultation for medical services related to family planning can be provided by

healthcare providers beyond physicians. Historically, the Title X regulations have required that all clients must have access to a consultation overseen by a physician. The proposed regulations expand the types of providers who can provide consultations for medical services related to family planning to include physician assistants and nurse practitioners, which could help with staffing and restructuring.



Number of clients served by the Title X Family Planning Program



SOURCE: Family Planning Annual Report 2019 National Summary and Proposed 2021 Regulation "Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services" PNG



#### **Grantees and Individuals with Conscience Objections**

The preamble to the proposed regulations states that "individuals and grantees with conscience objections will not be required to follow the proposed rule's requirements regarding abortion counseling and referral." Although, this exemption predates the Trump regulations, the Trump Administration was the first to actively encourage faithbased organizations to apply to become grantees even if they included sites that limited their family planning offerings to abstinence and fertility awareness methods. However, the regulation does not specify how the Biden Administration will address this allowance to ensure that Title X clients receive all the family planning counseling and referrals they seek, especially when it comes to abortion care counseling and referrals. How will OPA ensure that clients who seek services from grantees with objections to abortion and certain methods of contraception have a choice to go to a provider that offers a full range of counseling and referrals? The regulation is also unclear regarding the responsibility of the grantees with conscience objections to providing some contraceptive methods to refer clients to another provider who offers these methods.

#### **Looking Forward**

HHS is accepting <u>public comments</u>

(https://www.federalregister.gov/documents/2021/04/15/2021-07762/ensuring-access-to-equitable-<u>affordable-client-centered-quality-family-planning-services#open-comment</u>) on the proposed Title X regulations until May 17, 2021. Current and former Title X grantees and clinic sites and other interested parties can comment on how any of these changes will impact the

provision of services to family planning clients. There are elements of the regulations that are ambiguous and inconsistent, and commenters are encouraged to ask for more clarification. HHS estimates that these new regulations will bring many of the previous grantees back into the Title X program that left due to restrictions on abortion referrals and the ban on co-location of abortion services. It is unknown, however, how many will return, and if so, how long it will take to restore the network. While the Biden Administration's regulations will allow the program to operate largely under the same rules that it had been operating since 1993, unless Congress specifies otherwise, a future administration could again revise the regulations and reinstate the types of policies that triggered the dramatic reduction in the Title X network of providers and the sizable drop of federally funded family planning services across the nation.

APPENDIX (HTTPS://WWW.KFF.ORG/REPORT-SECTION/KEY-ELEMENTS-OF-THE-BIDEN-ADMINISTRATIONS-PROPOSED-TITLE-X-REGULATION-APPENDIX/)



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| May 5, 2021

## **Revisiting the Basic Health Program**

Patricia Boozang, Kyla Ellis, and Amy Zhan, Manatt Health

State policymakers are focused on increasing access to and affordability of health care coverage—especially in light of the COVID-19 pandemic and the priorities of the new Biden-Harris administration. Recently, state interest has turned to introducing new state-sponsored coverage and adopting the Affordable Care Act (ACA) Basic Health Program (BHP) option.

The BHP is an option, established under <u>Section 1331 of the ACA</u> (https://www.law.cornell.edu/uscode/text/42/18051), that allows states to establish a coverage program for individuals with household income under 200 percent of the federal poverty level (FPL) with federal financial support. To date, BHPs have been established in New York and Minnesota. Both states have seen significant BHP enrollment, due in large part to low consumer premiums and cost-sharing compared with the Marketplace, leading other states to look to the program as a possible strategy to meet their affordability goals.

States—both those with existing BHPs and those interested in implementing a BHP—are also interested in expanding eligibility beyond the current 138 percent to 200 percent FPL population. This could be accomplished through statutory reforms to Section 1331 of the through a Section 1332 waiver, and/or by establishing a buy-in program to allow residen purchase low-cost BHP coverage.

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This issue brief provides a refresher on the BHP structure as outlined in the ACA, lessons learned from the two states that have implemented the program to date, and considerations for further evolution of the program under legislative or executive action.

(https://www.shvs.org/wp-content/uploads/2021/05/Manatt-SHVS-Brief\_-Revisiting-the-Basic-Health-Program.pdf)





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MAY, 04, 2021

# The Final 2022 Notice of Benefit & Payment Parameters: Implications for States

#### Sabrina Corlette, Georgetown University Center on Health Insurance Reforms

On April 30, 2021, the U.S. Departments of Health & Human Services (HHS) and Treasury released the final 2022 Notice of Benefit & Payment Parameters (https://public-inspection.federalregister.gov/2021-09102.pdf) (NBPP), the annual rule governing core provisions of the Affordable Care Act (ACA), including the operation of the marketplaces, standards for insurers, and the risk adjustment program. This rule finalizes the majority of provisions included in a proposed rule (https://www.shvs.org/the-draft-2022-notice-of-benefit-payment-parameters-implications-for-states/) published on November 25, 2020, although several proposals were finalized in a rule (https://www.govinfo.gov/content/pkg/FR-2021-01-19/pdf/2021-01175.pdf) published on January 19, 2021. A detailed summary of the final 2022 NBPP can be found via the *Health Affairs* blog, here

(https://www.healthaffairs.org/do/10.1377/hblog20210501.979745/full/). This post reviews provisions of the final rule of particular import to the state-based marketplaces (SBMs) and state insurance regulators.

## Future Rulemaking: Provisions of January 19 Final Rule \*be Revisited

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The NBPP rule issued on January 19, 2021 finalized proposals to (1) allow states to establish a "Direct Enrollment" exchange in lieu of a government-run eligibility and enrollment platform; (2) significantly lower the user fees collected to operate the marketplace; and (3) codify guidance issued in 2018 that relaxes the standards for approving state Section 1332 waivers. In its April 30 rulemaking, HHS announced that, "due to a change in Administration priorities," it would issue a rule later this spring to increase the marketplace user fees from 2.25 to 2.75 percent of premiums for insurers in the federally facilitated marketplaces (FFM) and from 1.75 to 2.25 percent of premiums for insurers in the SBMs that use the federal platform. HHS also indicated that it will revisit the Direct Enrollment option for SBMs and the changes to the regulations governing 1332 waivers. For more information on the January 19 final rule and the proposed rule, see this SHVS expert perspective (https://www.shvs.org/the-draft-2022-noticeof-benefit-payment-parameters-implications-for-states/).

#### Improvements to Affordability: Adjusting Premium Contribution and Maximum Out-of-Pocket Cost Methodology

In its 2020 NBPP, the administration changed the methodology used to calculate annual changes in the percentage of income that subsidized marketplace enrollees must contribute to premiums, as well as the maximum out-of-pocket amount. Because a majority of commenters have expressed concern that this methodology increased the rate of growth of the premium contribution percentage and maximum out-of-pocket cap, the administration will revert to the methodology it adopted in 2015. In the short term, this will not affect premium contributions because the American Rescue Plan capped them for plan years 2021 and 2022. However, the final rule reduces the maximum annual limitation on cost sharing in 2022 to \$8,700 for selfonly coverage and \$17,400 for family coverage, \$400 less than what it would have been under the proposed rule. In addition, to ensure that marketplaces and insurers have information in a timely fashion, HHS announced that, beginning in January of 2022, they will publish the premium adjustment percentage, required contribution percentage, and maximum out-ofpocket cap via sub-regulatory guidance instead of notice and comment rulemaking.

#### **Expanding Access to Coverage via Special Enrollment Periods**

The final rule includes three changes to policy on special enrollment periods (SEPs). In particular, individuals enrolled in a Consolidated Omnibus Budget Reconciliation Act (COBRA) plan, who receive subsidies via the American Rescue Plan (https://www.shvs.org/cobraassistance-in-the-american-rescue-plan-act-a-guide-for-states/) will qualify for a SEP when those subsidies expire on September 30, 2021. HHS also codified a SEP for individuals whose employer subsidies for COBRA benefits cease.

HHS has also added new flexibility for marketplace enrollees and their dependents to switch to a plan at a different metal level (i.e., from Gold to Silver or Bronze), if they become newly ineligible for premium tax credit. The SBMs will be required to implement this change by later than January 1, 2024. Privacy - Terms

The rule further allows individuals to qualify for a SEP if they did not receive timely notice of a triggering event, and provides 60 days from the date that the individual becomes aware of the triggering event to enroll or change plans. Those who qualify for this SEP will be allowed to choose the earliest effective date that would have been available if he or she had received timely notice of the triggering event. This and the COBRA SEP are effective within 60 days of the publication of the final rule.

#### **Easing Some Program Integrity Requirements**

Federal rules require the SBMs to conduct audits to ensure that individuals who have an affordable offer of employer-sponsored insurance are not improperly receiving premium tax credits. However, this verification process is administratively burdensome for the SBMs and employers' response rates have been low. In this final rule HHS announced that it will refrain from taking enforcement action against any SBMs that do not perform the random sample audits required.

HHS has also chosen not to finalize a proposal to require all the SBMs to conduct verification of eligibility for SEPs. Most commenters opposed this requirement due to the administrative burdens for both the SBMs and consumers. Additionally, HHS noted that there are currently only four SBMs that have a more limited program of SEP verification than the federal marketplace, all of which report that there is no evidence to suggest any misuse of SEPs.

The final rule also codifies a proposal for HHS to step in and conduct audits of insurers regarding premium tax credits, cost-sharing reduction payments, and user fees in situations where a state "fails to substantially enforce" ACA standards. HHS notes that it will follow a process that mirrors the determination of whether a state is substantially enforcing standards under the Public Health Service Act.

#### **Essential Health Benefits: Updates and Reporting** Requirements

In the 2021 NBPP, HHS announced that it would require states to submit an annual report on any state benefit mandates that are in addition to those covered by the essential health benefit (EHB) benchmark plan, thus triggering a potential requirement that the state defray any additional premium costs. The first such annual report was due July 1, 2021. In this final rule, HHS announced that it will exercise "enforcement discretion" and refrain from penalizing any state that does not submit the report this year. However, HHS indicates that it will begin enforcing this requirement in 2022. It further clarifies that it will not impose the defrayal requirement retroactively. The final rule also clarifies that states must submit updates to their EHB benchmark plans by May 6, 2022 to apply for the 2024 plan year.

#### **State Flexibility on Risk Adjustment**

As in past years, no state has requested authority to operate a risk adjustment program, ^^ HHS will continue to operate it in every state and the District of Columbia. In its proposed HHS had floated allowing states to request changes to the risk adjustment transfers for the privacy - Terms

three years. This was not finalized, but states may continue to submit annual requests to change the transfer formula for both the individual and small-group markets. Alabama is the only state to have done so, and in this rule HHS approved its request for plan year 2022.

#### **Displays of Quality Rating Information**

In response to requests for greater state flexibility over the display of marketplace plans' star ratings, HHS clarifies that the SBMs may customize the display for quality rating information to "best reflect local priorities."

## City of Columbus v. Trump: Federal Court Ruling on Network Adequacy, Plan Standardization, and Other Provisions

In March 2021, a federal court ruled that several provisions of the 2019 NBPP must be vacated. Of particular note, the court found that HHS could no longer defer to states in the conduct of network adequacy reviews, and that it must reinstate the standardized plan options that had previously been offered on HealthCare.gov. In this final rule, HHS notes that it will take some time to come into compliance with the court's order, but that it intends to do so in time for plan year 2023.

## Shifting Federal Policy on Web-brokers and Enhanced Direct Enrollment

HHS has declined to finalize three proposals affecting web brokers and enhanced direct enrollment (EDE) providers. First, HHS had proposed giving EDE providers an additional 12 months to provide translations of their website content for limited English proficient consumers. The "vast majority" of comments opposed this proposal, and therefore HHS will not be granting EDE providers any extra time to come into compliance.

Second, HHS had proposed allowing Navigators and certified application counselors (CACs) to use web-broker websites and EDE providers as they assist consumers with marketplace eligibility and enrollment. A majority of comments opposed this proposal, and HHS decided not to finalize it, meaning that Navigators and CACs in states using HealthCare.gov may not use web-broker websites to facilitate enrollment.

Third, HHS had proposed granting web-brokers greater flexibility regarding the amount and type of information they must display about marketplace plans with whom they do not support enrollment. Because "almost all" commenters urged HHS to require web-brokers to display sufficient information about plans for consumers to make informed comparisons, HHS decided not to finalize this proposal. Thus, beginning with the open enrollment period starting November 1, 2021, web-brokers must display all plan information that they receive from the marketplace or directly from marketplace insurers.

HHS is finalizing a proposal requiring EDE providers that sell off-marketplace or non-ACA compliant policies to display these plans on separate web pages.

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## Declines in Uncompensated Care Costs for The Uninsured under the ACA and Implications of Recent Growth in the Uninsured Rate

Michael Karpman, Teresa A. Coughlin, and Rachel Garfield

#### **Summary**

The increase in the uninsured rate in recent years, as well as loss of coverage during the pandemic, has led to attention on the consequences of being uninsured. The need for medical care to test, treat, or prevent COVID-19 has also highlighted the potential consequences of <u>uncompensated care for uninsured people</u>. Uncompensated care costs occur because, although people who are uninsured use less care than people with coverage, most who are uninsured have limited income or resources and cannot afford the high cost of medical care, if and when they do need or use health care.

To understand the potential implications of coverage shifts for uncompensated care, this analysis uses the Medical Expenditure Panel Survey (MEPS) to examine how uncompensated care costs for the uninsured changed following implementation of the ACA's coverage provisions in 2014. We define uncompensated care as costs not covered by the individual's health insurance (if they had insurance at some point in the year) or out-of-pocket payments. We consider uncompensated care across a wide range of services and settings and compare average annual costs over two time periods, 2011-2013 and 2015-2017, to assess the effect of the ACA's major coverage expansion. We also examine changes in sources of payment for uncompensated care costs between the two periods. Key findings include:

- Reflecting a significant decline in the share and number of people who were uninsured at any point in
  the year, the average annual share of nonelderly individuals who had any uncompensated care costs
  fell by more than a third following ACA implementation, going from 7.3 percent in 2011-2013 down to
  4.8 percent in 2015-2017. This change represents a decline in the number of people with
  uncompensated care costs from 20.2 million to 13.1 million.
- Correspondingly, the aggregate annual cost of uncompensated care provided to uninsured individuals dropped by a third following implementation of the ACA's coverage provisions, from an average of \$62.8 billion per year in 2011-2013 to \$42.4 billion in 2015-2017. The cost of implicitly subsidized uncompensated care—or care that had no payment source, including a non-health insurance source—dropped from \$21.6 billion to \$15.1 billion per year on average before and after the ACA, respectively.
- Despite declines in total amounts, the distribution of total aggregate spending for the uninsured (including amounts paid out-of-pocket and expenses uncompensated) was similar across the two



- periods, with the majority (approximately 70%) uncompensated and about 20% paid out of pocket by uninsured people both before and after the ACA.
- Uncompensated care costs declined across most provider and service types, and the distribution of
  costs of uncompensated care by service type was similar both before and after the ACA, with
  hospitals continuing to be the site of care for approximately 60% of uncompensated care.

While this analysis finds significant declines in uncompensated care across providers and services following the ACA coverage expansions, the nation still faces sizable uncompensated care costs. As detailed elsewhere, while providers incur significant costs in caring for the uninsured, the bulk of their costs are compensated through a web of complex funding streams that are financed largely with public dollars. However, these approaches may be inefficient, may not target funds to providers with the most uncompensated care, or may still leave uninsured people with bad debt, credit issues, or even bankruptcy. Provider charity covers some of the remaining uncompensated care costs, and a very small share, estimated to account for less than one percent of private insurance payments, is potentially covered through cost-shifting to those with private insurance. Even before the pandemic, the uninsured rate in the United States had ticked up in recent years; potential losses of coverage due to pandemic-related job loss could exacerbate these losses and reverse to some extent the significant coverage gains seen since the full implementation of the ACA in 2014. At the same time, recent efforts – including reopening of ACA enrollment by the Biden Administration and enhanced premium subsidies and new incentives for states to expand Medicaid under the American Rescue Plan – could increase the number of people covered.

#### Introduction

The economic downturn caused by the COVID-19 pandemic could <u>potentially</u> lead to more people in the United States being <u>uninsured</u>. In addition to posing challenges to these individuals' ability to access needed health care and be protected from medical debt, rising uninsured rates could exacerbate issues with uncompensated care costs associated with providing health care to the uninsured. Though uninsured people use less care than their insured counterparts, when they do use care and cannot pay for it themselves, the cost of that care is uncompensated. Providers may absorb these costs as bad debt or tap into other funding sources to cover some of the costs. However, these approaches may be inefficient, may not target funds to providers with the most uncompensated care, or may still leave uninsured people with bad debt, credit issues, or even bankruptcy.

Over the years, the federal government, states, and localities have devoted considerable resources to pay providers for care they provide to uninsured patients through several program efforts (e.g., community health centers, Veterans Health Administration, and indigent care programs) and also through direct financial support (e.g., Medicaid Disproportionate Share Hospital (DSH) payments, and uncompensated care pools). However, the policy that has had the largest impact on reducing uncompensated care costs is arguably the enactment of the Affordable Care Act, which expanded health insurance coverage and helped shrink the nation's uninsured rate to the <u>lowest level</u> in recorded history. Other <u>research</u> has documented <u>declines</u> in uncompensated care for specific types of providers, but to

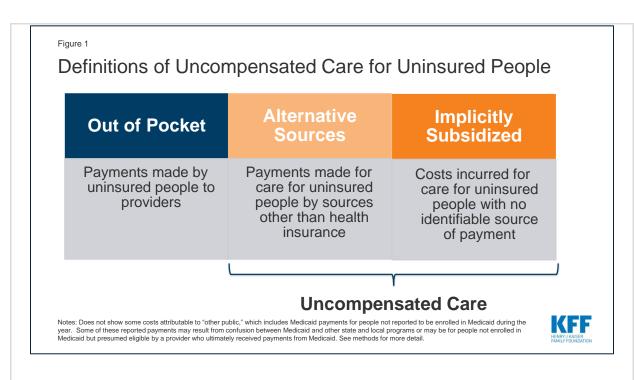
date there is no assessment of system-wide changes in uncompensated care for the uninsured after the ACA.

In this brief, we look at how uncompensated care costs for the uninsured changed following implementation of the ACA's major coverage provisions in 2014. Specifically, <u>building</u> on <u>previous analyses</u>, we use Medical Expenditure Panel Survey (MEPS) data to examine health care costs associated with care provided to uninsured people ages 0-64 before and after the ACA coverage provisions took effect. We also examine sources of payment for uncompensated care costs and the allocation of these costs across types of providers and services. Additional details on the methods underlying the analysis are in the Methods Overview below and in the technical appendix at the end of the brief.

#### **Methods Overview**

We use 2011-2017 data from the Medical Expenditure Panel Survey Household Component (MEPS-HC), a nationally representative survey of the civilian noninstitutionalized population conducted by the Agency for Healthcare Research and Quality that collects detailed information on monthly health insurance coverage and health care utilization and spending. We focus on uncompensated care costs among people ages 0-64 who were uninsured for part or all of a given year during the study period, since nearly all adults ages 65 and older are covered by Medicare. We estimate average annual per capita and total uncompensated care costs for nonelderly people before and after ACA implementation, pooling years of data for pre- and post-ACA implementation time periods (e.g., 2011-2013 and 2015-2017) to increase the precision of our estimates.<sup>1</sup>

We define uncompensated care as costs not covered by health insurance or out-of-pocket payments (see Figure 1). Our definition of uncompensated care includes two components. The first is *alternative sources of payment,* which include payments made on behalf of an uninsured person from sources other than comprehensive health insurance plans and out-of-pocket payments. These include payments from publicly run or regulated sources, such as VA and CHAMPVA, other federal sources (such as the Indian Health Service), other state and local sources (such as state and local health departments), and non-health insurance programs such as workers compensation. Alternative sources of payment also include payments from other private sources and unclassified sources (see appendix for details on these sources).



The second component of our definition of uncompensated care is *implicitly subsidized care*, which represents care received by the uninsured not covered by a directly identifiable source of payment linked to an individual patient. For example, when providers receive lower payments for treating an uninsured patient than they would have otherwise received if the patient was privately insured, we consider that implicitly subsidized care. Implicitly subsidized care <a href="may reflect">may reflect</a> charity care, private grant programs, medical debt, Medicaid DSH payments, state and local support for public hospitals, and other government spending. Our estimates of implicitly subsidized care are based on a provider's expected private payments for care if an uninsured patient had been privately insured minus any actual payments the providers received from the patient in out-of-pocket payments or payment from other private or unclassified sources. More detail on the process for estimating these costs, including adjustments to reconcile differences between the MEPS-HC and the National Health Expenditure Accounts and to account for medical inflation and population growth, can be found in the technical appendix, along with specifics on the analysis and its limitations.

## **Changes in the Number and Share of People with Uncompensated Care Costs**

Like prior research, we find that the uninsured rate among nonelderly individuals dropped significantly following implementation of the ACA's coverage provisions. Based on analysis of MEPS, the average annual share of the nonelderly who were ever uninsured during the year in 2015-2017 was 19.6 percent, down from 25.5 percent in 2011-2013. This represents a decline in the number of people who were uninsured at some point during the year from 70.7 million to 53.3 million over the period. We also found a similar decrease in the share of individuals uninsured for the full year (Table 1).

Consistent with the decline in uninsured rates, we find that the average annual share of nonelderly individuals who had any uncompensated care costs significantly fell by more than a third following ACA implementation, going from 7.3 percent in 2011-2013 down to 4.8 percent in 2015-2017. This change represents a decline in the number of people with uncompensated care costs from 20.2 million to 13.1 million (Table 1).

Table 1: Uninsurance and Uncomposition 201	ensated Care 1-2013 and 2		ieriy Peop	ile Ages U to 64	,
	20	2011-2013		2015-2017	
	%	#	%	#	
ninsured in any month of the year1	25.5%	70.700.000	19.6%	53.300.000	***

2011-2013		2015-2017		
%	#	%	#	
25.5%	70,700,000	19.6%	53,300,000	***
14.7%	40,600,000	8.7%	23,700,000	***
10.9%	30,100,000	10.9%	29,700,000	
7.3%	20,200,000	4.8%	13,100,000	***
	% 25.5% 14.7% 10.9%	% # 25.5% 70,700,000 14.7% 40,600,000 10.9% 30,100,000	%     #     %       25.5%     70,700,000     19.6%       14.7%     40,600,000     8.7%       10.9%     30,100,000     10.9%	%     #     %     #       25.5%     70,700,000     19.6%     53,300,000       14.7%     40,600,000     8.7%     23,700,000       10.9%     30,100,000     10.9%     29,700,000

<sup>&</sup>lt;sup>1</sup> Estimates for numbers uninsured or with any uncompensated care costs are rounded to the nearest 100,000. All estimates are annual averages for each three-year period.

Source: Medical Expenditure Panel Survey-Household Component, 2011-2013 and 2015-2017

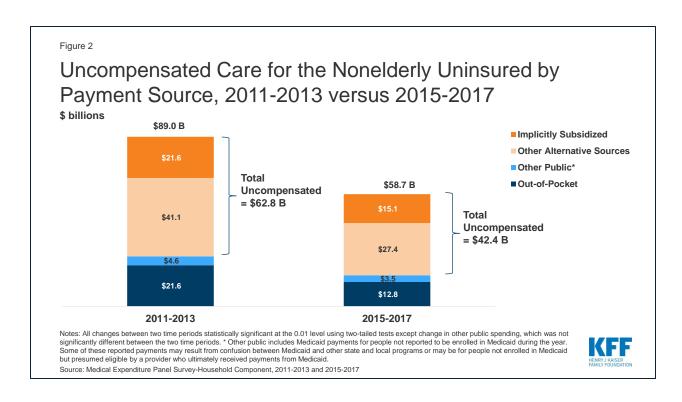
#### Changes in Uncompensated Care Costs for Uninsured **People**

Reflecting the decline in the uninsured rate, we find aggregate uncompensated care costs for the uninsured decreased by a third following implementation of the ACA's coverage provisions.

Uncompensated care costs include expenditures not covered directly by the individual's health insurance (if they had any at some point in the year) or out-of-pocket spending. In 2015-2017, we estimate average annual aggregate uncompensated care costs for all uninsured (including full-year uninsured and for the periods when part-year uninsured lacked coverage) totaled \$42.4 billion, down from \$62.8 billion in 2011-2013 (Figure 2). In both 2011-2013 and 2015-2017, about one-third of uncompensated care costs were implicitly subsidized, or not linked to a specific funding source; the balance was paid by alternative (nonhealth insurance) sources, which included payments from federal programs (e.g., Indian Health Service), state and local governments, and other sources.

<sup>&</sup>lt;sup>2</sup> For MEPS participants who were not in scope for all 12 months of the year, measures of uninsurance during the year are based on the months when they were eligible for the survey.

<sup>\*/\*\*/\*\*\*</sup> Estimate is significantly different from estimate for 2011-2013 at the 0.10/0.05/0.01 level, using two-tailed



Despite declines in total amounts, the majority of aggregate expenses incurred by uninsured people were uncompensated in both 2011-2013 and 2015-2017. The distribution of aggregate spending for the uninsured was similar across the two periods. Uncompensated care costs accounted for about 70 percent of total average annual medical expenditures for the uninsured estimated at \$89.0 billion and \$58.7 billion, respectively, before and after ACA implementation. These totals reflect aggregate spending for the full-year uninsured and part-year uninsured for the periods when they lacked coverage. Through out-of-pocket payments, the uninsured themselves paid 21.8 percent (\$12.8 billion) of the population's annual average aggregate expenditures in 2015-2017. Remaining direct expenditures (\$3.5 billion, or 6.0 percent) in 2015-2017 was composed of other public spending.<sup>2</sup>

#### **Changes in Uncompensated Care Costs by Setting**

Uncompensated care costs fell by an equal percentage in hospital and community settings following the ACA, but hospitals continue to shoulder the majority of these costs (Table 2).

Between 2011-2013 and 2015-2017, annual average uncompensated care costs dropped by about a third in both hospital settings (from \$36.9 billion to \$25.1 billion, a 32% decline) and community settings (from \$19.7 billion to \$13.4 billion, also a 32% decline). Hospitals, however, continued to bear the bulk of uncompensated care costs, likely reflecting both the high cost of hospital care and laws requiring hospitals to treat and stabilize all patients, regardless of insurance status. In 2015-2017, hospital uncompensated care costs totaled \$25.1 billion, about 60 percent of overall uncompensated care costs. The balance of costs was incurred for community-based providers (\$13.4 billion) and prescription drugs (\$3.9 billion). Among community-based providers, office-based visits to physicians, nurses, and physician assistants accounted for the largest share of uncompensated care costs, at about \$7.1 billion.

Table 2: Uncompensated Care Costs for the Nonelderly (Age 0-64) Uninsured by Place and Type of Service, 2011-2013 and 2015-2017			
	2011-2013	2015-2017	
	\$ Billions	\$ Billions	
Total uncompensated care costs	\$62.8	\$42.4	***
Hospital settings	\$36.9	\$25.1	***
Community settings	\$19.7	\$13.4	***
Office-based visits	\$17.0	\$10.8	***
Physician, nurses, physician assistants	\$12.0	\$7.1	***
Other providers	\$5.0	\$3.6	*
Home health	\$0.3	\$0.3	
Dental	\$1.9	\$1.2	***
Other medical <sup>1</sup>	\$0.4	\$1.2	**
Prescription Drugs	\$6.2	\$3.9	**

<sup>&</sup>lt;sup>1</sup> Other medical includes glasses and contact lenses, ambulance services, disposable supplies, and durable medical equipment. \*/\*\*/\*\*\* Estimate is significantly different from estimate for 2011-2013 at the 0.10/0.05/0.01 level, using two-tailed tests.

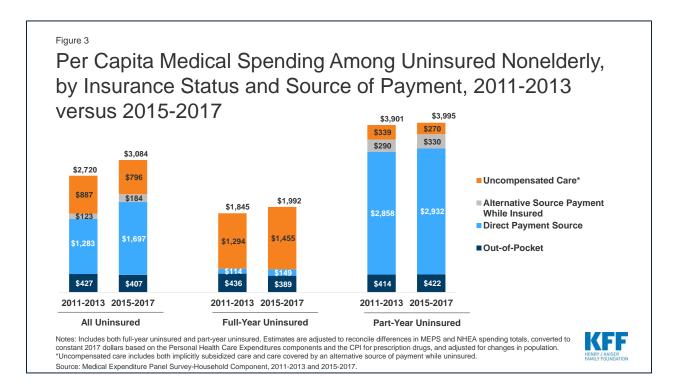
Source: Medical Expenditure Panel Survey-Household Component, 2011-2013 and 2015-2017

## **Changes in Uncompensated Care Per Capita Among the Nonelderly Uninsured**

Though aggregate uncompensated care has declined in the wake of the ACA, the share of health care spending that ends up uncompensated for those who remain uninsured did not decline following the ACA. On an average per capita basis, total spending among people who were uninsured at some point during the year (including spending while insured or uninsured) went from \$2,720 in 2011-2013 to \$3,084 in 2015-2017 (Figure 3), with uncompensated care costs accounting for a third (\$887) of average per capita costs before the ACA and about a quarter (\$796) after the ACA. The distribution of spending that was out-of-pocket, covered by insurance or alternative sources while insured, and uncompensated shifted slightly after the ACA, largely due to the part-year uninsured (who have some payment through insurance in the months when they are insured) accounting for a larger share of the uninsured. When looking at average per capita costs among the full-year uninsured, nearly three quarters of their average per capita spending was uncompensated care in both periods, with out-of-pocket spending constituting the majority of their remaining expenditures both before and after the ACA (Figure 3).

As in the past, people who are uninsured for the full year have much lower health care spending from all sources than those with coverage for some or all of the year. As shown in Table 1 (above), most people who are uninsured at some point during the year do not have any uncompensated care when they are uninsured. Many delay or avoid using care, even when needed, and others may use care but pay out of pocket for that care. In addition, on an average per capita basis, uninsured people had significantly lower per capita spending than the full-year insured, which was estimated to be an average of \$5,591 in 2015-2017 (data not shown). Among the uninsured, per capita spending was twice as high for those who were uninsured for only part of the year compared to those who were uninsured all year

both before and after the ACA (Figure 3). The higher spending of the part-year uninsured is due to their spending while insured, which accounted for the majority of their expenditures.



#### **Looking Ahead**

The ACA brought about a significant decline in provider uncompensated care costs in caring for the uninsured. This result was <u>anticipated</u> given the major coverage expansion afforded by the ACA. However, the ACA did not offer universal health insurance coverage and <u>not all states</u> adopted the Medicaid expansion. As a consequence, while uncompensated care costs declined by nearly a third following implementation of the ACA's major coverage provisions in 2014, these costs continue to be considerable. We estimate uncompensated care costs totaled \$42.4 billion in 2015-2017, with \$15.1 billion of those costs implicitly subsidized, or not tied to any payment source such as non-health insurance sources of payment.

Importantly, <u>multiple programs</u> sponsored by federal, state, and local governments help health care providers offset a sizable share of these costs. However, these approaches may be inefficient, may not target funds to providers with the most uncompensated care, or may still leave uninsured people with bad debt, credit issues, or even bankruptcy. Provider charity covers some of the remaining uncompensated care costs, and a very small share, <u>estimated</u> to account for less than one percent of private insurance payments, is potentially covered through cost-shifting to those with private insurance. <u>Research</u> examining trends in private hospital payments and changes in the uninsured, as well as research examining private insurance payment rates and market power among large hospitals with high uninsured

patient mix, has not found a consistent, close link between the uninsured and increase private payment rates to offset uncompensated care costs.

Uncompensated care costs may be on the rise. Since 2017, the last year of our study period, the uninsured rate increased both in 2018 and 2019, growing by a million and a half people during that two-year period, which likely brought about an uptick in uncompensated care costs. Further, the widespread job losses resulting from the COVID-19 pandemic in 2020 threaten to put health insurance coverage at risk for millions of workers and their families. As of February 2021, the unemployment rate stood at 6.2 percent, nearly double the pre-pandemic level, and many workers have left the labor force. While many who lose employer coverage could become eligible for Medicaid or ACA marketplace subsidies, some may not enroll, and others may continue to be ineligible for coverage. The need for medical care to test, treat, or prevent COVID-19 has also highlighted the potential consequences of uncompensated care for uninsured people.

A rise in uncompensated care costs is always a concern but particularly so now given that the expected increase in these costs occurs at a time when state and local governments face <u>declining revenues</u> because of the pandemic-induced recession. A drop in revenues could jeopardize funding for existing programs that help offset uncompensated care costs, just as some providers have incurred significant financial losses from COVID-19. While the federal government has made <u>provider relief funds</u> available to reimburse providers for treating patients with COVID-19, there is no guaranteed allotment of funds for uninsured patients, and limited funds have been paid out to offset costs for uninsured patients to date.

Given the heightened need for health care among many due to the pandemic, additional coverage loss at a time of shrinking resources to cover health care expenses could further challenge the ability of the health care system to meet needs. At the same time, recent efforts – including reopening of ACA enrollment by the Biden Administration and enhanced premium subsidies and new incentives for states to expand Medicaid under the American Rescue Plan – could increase the number of people covered and put reduced pressure on providers and government sources of financing for uncompensated care.

#### **Technical Appendix**

In this appendix, we provide a more detailed description of our study data, methods, and limitations, including our approach for estimating uncompensated care costs.

#### **Data**

We use 2011-2017 data from the Medical Expenditure Panel Survey Household Component (MEPS-HC), a nationally representative survey of the civilian noninstitutionalized population conducted by the Agency for Healthcare Research and Quality. The MEPS-HC collects <u>detailed information</u> on monthly health insurance coverage and health care utilization and spending. Expenditure data reported by MEPS-HC participants are validated using information collected through the MEPS Medical Provider Component

(MPC), which follows up with a sample of respondents' health care providers and pharmacies to collect information on charges and payments. MPC data are used to edit and impute spending in the MEPS-HC.

#### **Definition of Uncompensated Care Costs**

We identify uninsured patients' spending that reflects uncompensated care costs, which include payments made on behalf of an uninsured person from sources other than comprehensive health insurance plans and out-of-pocket payments. Our definition of uncompensated care costs includes two components: 1) alternative sources of payment for care and 2) implicitly subsidized care. Below we describe how we identify spending while uninsured; define uninsured spending from alternative sources; calculate implicitly subsidized care; and apply adjustments to the data to reconcile differences in estimated expenditures between the MEPS-HC with the National Health Expenditure Accounts (NHEA) and to account for inflation and population growth.

#### **IDENTIFYING SPENDING WHILE UNINSURED**

We consider spending for medical events (e.g., provider visits, prescription fills) to be uninsured if the person was not insured in the month when the event occurred and the spending was not covered by private insurance (including TRICARE), Medicare, or Medicaid/CHIP. We merge monthly insurance status data from the MEPS-HC full-year consolidated file to each medical event file to determine whether individuals were uninsured when the event occurred. We calculate spending while uninsured for the following medical events:<sup>3</sup>

- Prescription drugs
- Hospital inpatient stays
- Hospital emergency room visits
- Hospital outpatient visits
- Office-based physician visits, including visits to physician-supervised health care professionals such as nurse practitioners and physician assistants
- Office-based non-physician provider visits
- Home health visits
- Dental visits
- Other medical expenses, which includes spending on durable medical equipment, disposable medical supplies, ambulance services, and vision care

For most types of medical events, we use the event month to determine coverage status at the time of care. For hospital inpatient stays, we use coverage status based on the month of the beginning of the stay. For prescription medicines, we link the prescription fills to other medical events (if applicable) and base coverage status on the month of those events. For prescribed medicines that cannot be linked to other events and for "other" medical expenses in which event month is unavailable, we randomly assign the drug fill or expense to a month within the survey round and year in which the fill or expense occurred.

This approach allows us to assess total uninsured and insured spending by service and payer for people who were uninsured for part or all of the year.

#### DEFINING UNINSURED SPENDING FROM ALTERNATIVE SOURCES

Alternative sources of payment include the following payments made for care while uninsured:

- VA or CHAMPVA
- Other federal sources, including Indian Health Service, military treatment facilities, and other care provided by federal government
- Other state and local sources, including community clinics, state and local health departments, and state programs other than Medicaid
- Workers compensation
- Other private sources, including private insurance payments reported for people without comprehensive private health insurance coverage during the year
- Other unclassified sources, including auto, homeowners, and liability insurance and other unknown sources

Private insurance coverage in the MEPS-HC is defined as having a major medical plan covering hospital and physician services. Some payments classified as "other private" may be from single-service plans.

Our definition of alternative sources excludes "other public" spending reported in the MEPS, which represents Medicaid payments for people not reported to be enrolled in Medicaid during the year. Some of these reported payments may result from confusion between Medicaid and other state and local programs or <a href="may be">may be</a> for people not enrolled in Medicaid but presumed eligible by a provider who ultimately received payments from Medicaid.

We assume that payment from alternative sources are negotiated between payers and providers such that any difference between charges and payments represent a contractual discount accepted by the provider. Therefore, there is no implicit subsidy for care covered by these sources.

#### CALCULATING IMPLICITLY SUBSIDIZED CARE

As noted in the brief, our estimates of implicitly subsidized care are based on the expected private payments for care if an uninsured person was privately insured minus their actual payments made out-of-pocket and from other private or unclassified sources.

We first sum the total charges and payments for each service, excluding prescription medicines, among full-year privately insured nonelderly people with no reported public coverage or public spending during the year. We then take the ratio of average total payments to average total charges for each service. This payment-to-charge ratio represents the average share of charges for each service that we would expect to be covered by private insurance. We do not calculate a payment-to-charge ratio or implicitly subsidized care for prescription drugs because the MEPS-HC does not provide data on charges.

Next, we identify uninsured spending for each service that is eligible for implicitly subsidized care among people who were uninsured for part or all of the year. Eligible charges and payments are based on whether the service was only paid for out-of-pocket and/or covered by other private or unidentified sources. Charges and payments while uninsured are considered ineligible if fully or partially covered by Medicare, Medicaid, private insurance, other public sources, or other indirect sources.

For each service, we multiply the total eligible charges while uninsured by the privately insured payment-to-charge ratio to calculate the expected payment for the service if the uninsured person was privately insured. We then subtract actual out-of-pocket or private payments from expected privately insured payments for each service; this difference represents implicitly subsidized care.

#### APPLYING NHEA, INFLATION, AND POPULATION ADJUSTMENTS

The MEPS-HC captures less aggregate medical spending than the National Health Expenditure Accounts (NHEA) data, even after accounting for difference in populations and medical expenditure categories across sources. We adjust expenditures by payer and service type to more closely reflect NHEA aggregate expenditure totals based on adjustment factors developed by Bernard et al. for reconciling MEPS and NHEA expenditures in 2012. Adjustment factors are available for the following payers: private insurance, Medicare, Medicaid, defense, VA, and workers' compensation; no adjustment is made for other public payers and other sources. We also do not adjust out-of-pocket expenditures, which is not measured directly in the NHEA but is instead a residual category of expenditures. We instead assume out-of-pocket expenditures reported in the MEPS-HC are more accurate. Consistent with this approach, NHEA adjustments for implicitly subsidized care are calculated only for the share of eligible uninsured spending paid by other private insurance because there is no adjustment for out-of-pocket spending or spending from other unclassified sources. For each payer, NHEA adjustments are made for the following service categories: hospital, physician, non-physician providers, dental care, home health care, prescription drugs, and other medical equipment.

We use the Personal Health Care Expenditure components of the NHEA for hospital care, physician/clinical services, other professional services, dental care, home health care, and durable medical equipment. We adjust prescription drug spending for inflation using the Consumer Price Index for prescription drugs. After these adjustments are made, we sum implicitly subsidized care and indirect uninsured spending across payment sources and service types to calculate uncompensated care costs overall, by payer, and by service type. We apply the same NHEA and inflation adjustments to insured spending. Finally, we adjust all estimates to account for population growth based on Census Bureau population projections for 2017 so that estimated changes over time in medical expenditures are not driven by changes in population.

#### **Analysis and Limitations**

We compare average annual per capita and total uncompensated care costs for nonelderly people ages 0 to 64 between 2011-2013 and 2015-2017, the periods just before and just after implementation of the

ACA's major coverage provisions in 2014. We pool three years of data in each period to increase the precision of our estimates. All analyses use survey weights and survey design variables to calculate standard errors that reflect the complex design of the MEPS.

Though approximately one-third of self-reported expenditures in the MEPS-HC are validated based on the MPC, there is still potential for measurement error in estimated expenditures and the MPC does not collect spending data from dental providers, non-physician providers, or medical equipment. <a href="Studies">Studies</a> have also found measurement error in self-reported health insurance coverage in the MEPS, which may affect our estimates of spending among the uninsured and, consequently, uncompensated care costs.

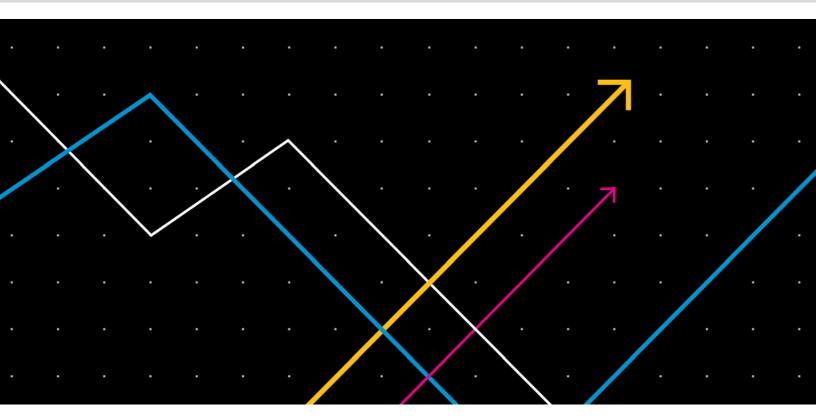
Michael Karpman and Teresa A. Coughlin are with the Urban Institute. Rachel Garfield is with KFF.

#### **Endnotes**

<sup>1</sup> We exclude 2014 from our analysis of uncompensated care costs in the pre- and post-ACA periods because it is a transition year when the ACA's major coverage provisions were implemented.

<sup>&</sup>lt;sup>2</sup> MEPS identifies these expenditures as Medicaid payments that were made for individuals not reported to be enrolled in the program at any time during the year. Some of these reported payments may result from confusion between Medicaid and other state and local programs or may be for people not enrolled in Medicaid but presumed eligible by a provider who ultimately received payments from Medicaid. Agency for Healthcare Research and Quality, *MEPS HC-201: 2017 Full-Year Consolidated Data File* (Rockville, MD: Agency for Healthcare Research and Quality, August 2019), https://meps.ahrg.gov/data\_stats/download\_data\_files\_detail.isp?cboPufNumber=HC-201.

<sup>&</sup>lt;sup>3</sup> Because the MEPS is a survey of the civilian noninstitutionalized population, it does not collect expenditure data for some services, such as long-term care provided in institutional settings and residential treatment for mental health and substance use disorders.



#### RESEARCH REPORT

How Might State Medicaid and Other Health Programs Be Affected in the Pandemic's Aftermath?

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**April 2021** 







#### 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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iv ACKNOWLEDGMENTS

# How Might State Medicaid and Other Health Programs Be Affected in the Pandemic's Aftermath?

Shortly after the novel coronavirus appeared in the United States in January 2020, policymakers began forecasting what dire consequences would ripple through society. The number of deaths from COVID-19 was expected to be large, but few could have imagined more than half a million lives would be lost one year after the pandemic started. Experts more accurately predicted the pandemic's immediate toll on the economy, understanding that social distancing would require shutting down large sectors of the economy for extended periods and would therefore lead to significant job losses.<sup>2</sup> Many believed these job losses would lead to similarly large losses of job-related health coverage and cause spikes in either uninsurance rates or Medicaid enrollment (Gangopadhyaya and Garrett 2020). Health systems would be significantly strained by the need to treat the hundreds of thousands of people stricken by the virus while also experiencing steep declines in utilization (and by extension revenue) of most health services, as consumers avoided interactions that might expose them to the virus (Cox, Kamal, and McDermott 2021). Similarly, public health systems would be forced to redeploy human and financial resources to support COVID-19 outreach, education, testing, and contact tracing (Krisberg 2020). From a fiscal standpoint, many assumed that state and federal revenues would plummet as tax collections shrank because of the pandemic, straining budgets for public services just as demands on the health and human services safety net skyrocketed (Dadyan 2020; McNichol and Leachman 2020).

Though many of these predictions have come true, a much more nuanced and variable picture of the pandemic's effects is emerging. COVID-19 infection and death rates have been devastating but have varied by state, owing, in part, to states' inconsistent efforts to enforce risk-mitigation rules surrounding public gatherings and mask wearing (Guy et al. 2021; Zhang and Warner 2020). In April 2020, unemployment spiked by 10.3 percentage points to 14.7 percent, the highest rate and largest over-the-month increase in the history of US Bureau of Labor Statistics data (available back to January 1948). But some sectors and workers have been hit much harder than others; those in the food and

beverage, entertainment, and hotel and travel sectors have suffered the most job losses, whereas many higher-income workers have been able to nearly seamlessly shift to remote work and remain employed. This latter effect has translated into more robust than expected income tax collections for the federal government and states with income taxes, meaning stress on state budgets varies considerably more than most predicted. Further, uninsurance rates appear not to have grown significantly in the past year, because employer-sponsored coverage losses have been largely offset by increases in Medicaid and Affordable Care Act (ACA) Marketplace enrollment. This is more true in states that expanded Medicaid under the ACA, successfully providing more Americans with coverage during the pandemic than states that opted not to expand Medicaid (Buettgens 2021).

Federal financial relief has played a massive role in mitigating harm, infusing roughly \$5.5 trillion into the economy over the past 12 months<sup>6</sup>—in the form of individual payments, payments to businesses, enhanced unemployment benefits, support for a range of health programs and activities, and direct aid to state, local, and tribal governments—which has certainly helped many individuals, businesses, and public-sector agencies weather the economic downturn (box 1).

In this paper, we examine the effects of the pandemic on Medicaid and other health care programs and those programs' future outlooks based on information gathered through interviews with health care stakeholders and comprehensive reviews of the literature. Our key findings are as follows:

- A year ago, many predicted the pandemic's economic effects would be devastating, but many of these predictions have not materialized. The economy has recovered better than many expected, state revenues have been higher than most expected, and huge infusions of federal assistance have bolstered individuals, businesses, and state and local governments.
- States' economic conditions vary considerably, however. State economies that depend on tourism, travel, and energy and that lack income taxes are in worse shape than those not dependent on such sectors and those with income taxes. Effects have varied dramatically across population groups as well; workers with low incomes, service industry workers, and communities of color have experienced higher unemployment, morbidity, and mortality rates during the pandemic.
- Enhanced federal matching funds and the public health emergency's maintenance-of-effort (MOE) rules initially protected state Medicaid programs and beneficiaries. Other behavioral health, public health, and maternal and child health programs also received supplemental federal funds critical to their pandemic responses. Consequently, Medicaid and other health programs did not experience significant budget cuts in 2020. Some states reduced staff and

initiated furloughs to manage costs, and non-Medicaid health programs not protected by federal legislation faced real or proposed cuts, many of which were not implemented or have been reversed.

- The pandemic has had far-reaching effects on how beneficiaries seek and how providers deliver health care services. Most Medicaid programs increased financial support and direct payments to providers experiencing steep revenue declines. And social distancing necessitated a shift to virtual operations and remote work for state program administrative staff, a transition described as smooth overall.
- Experts interviewed in early 2021 predicted continuation of the pandemic-era status quo, at least for the year ahead. Their biggest concern at the time was whether additional federal assistance would be available for states and localities. With the passage of the American Rescue Plan Act and its \$350 billion in state, local, and tribal government relief, that concern has been addressed, at least for now.
- Experts seemed to think, or hope, expansions of health insurance coverage availability and improvements to the safety net could occur as policymakers use the experience of the pandemic to reimagine safety net programs to be nimbler, more equitable, more focused on prevention, and more holistic. Whether such advances occur will be important to monitor.

In the following sections, we explore how Medicaid and other behavioral and public health programs responded to the pandemic and how the pandemic affected health care utilization and delivery systems. We then examine states' budget responses, how those responses varied in 2020, and what stakeholders predict may unfold in the coming year as governors and state legislatures work to plan and balance their budgets for fiscal year 2022. We conclude with predictions of how, as vaccine rollout continues and the economy recovers, programs may evolve to be better prepared for another public health emergency.

#### Research Methods

Between December 2020 and February 2021, we conducted 14 individual and small-group interviews with 31 health program stakeholders to identify and examine key concerns about the implications of state budgets for health programs during the pandemic-prompted economic downturn. The stakeholders represented governors' offices, state legislatures, and Medicaid, public health, behavioral health, maternal and child health, and long-term services and supports programs; and staff from policy

research organizations. Interview questions focused on the influence of the COVID-19 emergency on policy and practice for Medicaid and other health programs, as well as the budget-related risks and opportunities for health programs in and beyond 2021. We also conducted and periodically updated a comprehensive scan of publicly available information on state budgets during the pandemic from sources such as national policy and research organizations, professional organizations, and national and local news outlets. Our findings primarily reflect insights into and responses to the pandemic that emerged between March 2020 and March 2021.

#### BOX 1

#### COVID-19 Fiscal Relief Bills and Health Provisions Enacted during the Pandemic

The Coronavirus Preparedness and Response Supplemental Appropriations Act, passed March 6, 2020, provided \$8.3 billion in emergency discretionary funding primarily to the Centers for Disease Control and Prevention (CDC) for COVID-19 vaccine research. It also provided states with grants and cooperative agreements.<sup>a</sup>

The Families First Coronavirus Response Act, passed on March 18, 2020, provided small and midsize employers refundable tax credits that reimbursed them for providing paid sick and family leave wages to their employees. It also gave states \$1 billion for emergency transfers to pay for unemployment benefits.

Regarding health policy provisions, the law also authorized a 6.2 percentage-point increase to Medicaid's federal medical assistance percentage for states that agreed to maintenance-of-effort rules prohibiting disenrollment of beneficiaries who were in the program when the federal public health emergency was declared.<sup>b</sup> It also provided \$1.2 billion to cover the costs of COVID-19 testing and required all commercial insurers, Medicaid, and the Children's Health Insurance Program to cover testing and diagnosis for COVID-19 without patient cost-sharing.<sup>c</sup>

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, passed March 27, 2020, provided an estimated \$2 trillion stimulus package to battle the pandemic's harmful effects. It included a \$150 billion Coronavirus Relief Fund for state, local, and tribal governments (allocated by population shares) for expenditures incurred because of COVID-19. It also expanded unemployment insurance from three to four months and provided a temporary supplemental \$600 in unemployment compensation a week; established a \$500 billion lending fund for businesses, cities, and states; and provided a \$1,200 direct payment to many Americans and \$500 for each dependent child, among many other provisions. The CARES Act also established the Paycheck Protection Program to provide loans to small businesses as an incentive to keep workers on payroll.

The CARES Act also included the following health provisions: \$127 billion for a Public Health and Social Services Emergency Fund, which provided grants to hospitals, public entities, nonprofit entities, and Medicare- and Medicaid-enrolled providers; \$16 billion for the Strategic

National Stockpile, which supports procurement of personal protective equipment, ventilators, and other medical supplies; \$11 billion for vaccines, diagnostics, and other medical needs; \$4.3 billion for the CDC and its public health preparedness and response efforts; \$425 million to the Substance Abuse and Mental Health Services Administration to address mental health and substance use disorder needs growing from the pandemic; \$50 million for suicide prevention; \$100 million in flexible funding to address mental health, substance use disorders, youth needs, and homelessness; and \$200 million to the Centers for Medicare & Medicaid Services.<sup>e</sup>

The Paycheck Protection Program and Health Care Enhancement Act, passed in April 2020, provided an additional \$310 billion to the Paycheck Protection Program, \$75 billion in aid to (mostly) hospitals and other health care providers, \$25 billion for COVID-19 testing capacity, and \$60 billion in small business disaster loans.<sup>f</sup>

 The act's health care provisions included \$75 billion to support hospital and other providers via a new Provider Relief Fund and \$25 billion to enhance states' capabilities to conduct COVID-19 testing and contact tracing.

The Consolidated Appropriations Act, 2021, passed at the end of 2020, included \$900 billion in COVID-19 relief and for direct payments to individuals, an extension of the Paycheck Protection Program, education funding, and restoration of earlier enhancements to unemployment insurance payments.

The bill's health care provisions included a one-time, one-year 3.75 percent increase in the Medicare physician fee schedule and funding for a national campaign to increase awareness and knowledge of the safety and effectiveness of vaccines for the prevention and control of diseases, including COVID-19.

The American Rescue Plan, passed March 11, 2021, provided an additional \$1.9 trillion, including money for direct payments to individuals; \$350 billion in direct aid to state, local, and tribal governments to cover increased expenditures, replenish lost revenue, and mitigate economic harm from the pandemic; extensions of unemployment benefits; expansions of tax credits (child tax credit, earned income tax credit, and child and dependent care tax credit); and additional support for K-12 schools and higher education institutions.<sup>g</sup>

- The bill's health care provisions included \$8.5 billion to the CDC for vaccine activities; \$47.8 billion for COVID-19 testing and tracing; \$7.7 billion for state, local, and territorial public health departments to establish, expand, and sustain their public health workforce; \$7.6 billion for community health centers; \$3 billion for block grant programs under the Substance Abuse and Mental Health Services Administration; \$6.1 billion to the Indian Health Service; \$200 million to support COVID-19 infection control in skilled nursing facilities; and \$250 million for "strike teams" to assist skilled nursing facilities.<sup>h</sup>
- One of the bill's key Medicaid provision is a new, temporary fiscal incentive to encourage Medicaid expansion in the 12 states that have not yet adopted expansion under the ACA as of this writing. On top of the regular 90 percent federal matching rate for the Medicaid expansion

population, states that expand now can also receive a 5 percentage-point increase in their federal matching rate for two years after the expansion takes effect. The American Rescue Plan also gives states a new option to extend Medicaid coverage for postpartum women from the current 60 days following birth to a full year. States can also receive a 10 percentage-point increase in federal matching funds for Medicaid home- and community-based services from April 1, 2021, through March 30, 2022. Beginning April 1, 2021, the law provides 100 percent federal matching funds for two years for services received through Urban Indian Health Programs and the Native Hawaiian Health Care Systems Program. Finally, the new law provides \$8.5 billion in fiscal year 2021 for provider relief fund payments to rural Medicaid, CHIP, and Medicare providers (Musumeci 2021).

https://www.nytimes.com/2021/03/01/business/covid-state-tax-revenue.html?referringSource=articleShare.

<sup>&</sup>lt;sup>a</sup> Erlinda A. Doherty, "Phases of Federal Financial Response to Coronavirus for States," National Conference of State Legislatures (NCSL) blog, April 30, 2020, https://www.ncsl.org/blog/2020/04/30/phases-of-federal-financial-response-to-coronavirus-for-states.aspx.

<sup>&</sup>lt;sup>b</sup> Doherty, "Phases of Federal Financial Response to Coronavirus for States"; and "COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies," Medicaid.gov, last updated January 6, 2021, https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf.

<sup>&</sup>lt;sup>c</sup> NCSL, "Summary of HR 6201—Families First Coronavirus Response Act" (Washington, DC: NCSL, n.d.).

<sup>&</sup>lt;sup>d</sup> NCSL, "Summary of HR 6201-Families First Coronavirus Response Act."

e "COVID-19 Stimulus Bill: What It Means for States," NCSL, April 2, 2020, https://www.ncsl.org/ncsl-in-dc/publications-and-resources/coronavirus-stimulus-bill-states.aspx; "Unemployment Insurance Relief during COVID-19 Outbreak," US Department of Labor, accessed April 15, 2021, https://www.dol.gov/coronavirus/unemployment-insurance; and Mary Williams Walsh, "Virus Did Not Bring Financial Rout That Many States Feared," *New York Times*, March 1, 2021,

f "COVID-19 Stimulus Bill: What It Means for States," NCSL; and Teresa A. Coughlin, Christal Ramos, and Haley Samuel-Jakubos, "Safety Net Hospitals in the COVID-19 Crisis: How Five Hospitals Have Fared Financially" (Washington, DC: Urban Institute, 2020)

<sup>&</sup>lt;sup>g</sup> "Paycheck Protection Program," US Small Business Administration, accessed April 15, 2021, https://www.sba.gov/funding-programs/loans/covid-19-relief-options/paycheck-protection-program; and Doherty, "Phases of Federal Financial Response to Coronavirus for States."

<sup>&</sup>lt;sup>h</sup> "American Rescue Plan Act of 2021," NCSL, March 9, 2021, https://www.ncsl.org/ncsl-in-dc/publications-and-resources/american-rescue-plan-act-of-2021.aspx.

i "American Rescue Plan Act of 2021," NCSL.

<sup>&</sup>lt;sup>1</sup> "Status of State Medicaid Expansion Decisions: Interactive Map," Kaiser Family Foundation, April 13, 2021, https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

#### How State Medicaid and Other Health Programs Responded to the Pandemic

State Medicaid and other health programs, including those focused on public health, mental health, substance use treatment, and maternal and child health, received considerable assistance through various provisions in the six federal relief bills passed since the pandemic began (box 1). Highlights of this federal support include a 6.2 percentage-point increase in federal Medicaid matching funds in return for a maintenance-of-effort (MOE) requirement forbidding states from disenrolling beneficiaries during the public health emergency; billions of dollars in grants and direct payments to providers; large investments in public health capacity to provide COVID-19 testing, contact tracing, and vaccine distribution; billions of dollars in expansions of the Substance Abuse and Mental Health Block Grant; and new financial incentives for states to expand Medicaid coverage to single adults and postpartum women.

States also benefited from additional flexibility granted to them by the federal agencies that set policies and help administer their programs. According to our key informants, the US Department of Health and Human Services acted quickly at the outset of the pandemic to issue guidance for states that allowed health programs to respond more nimbly and effectively to the crisis. For instance, guidance for Medicaid took the form of numerous letters to state Medicaid directors and other health officials. These ranged from a March 2020 letter introducing a new waiver authority available to help states adjust their programs to pandemic conditions<sup>7</sup> to, more recently, guidance issued in late December 2020 on planning for the eventual return to regular operations at the conclusion of the public health emergency (table 1).<sup>8</sup> Near the start of the pandemic, the Department of Health and Human Services and the Office of Civil Rights also implemented several good faith HIPAA waivers meant to advance data sharing and telehealth while limiting provider burdens. These waivers allow HIPAA-covered providers to use audio or video communication platforms without being penalized for noncompliance with certain HIPAA rules, such as lacking a business associate agreement with the vendors running such platforms.

TABLE 1
Medicaid and CHIP Waivers and Amendments for the Pandemic Response

Waiver type	COVID-19 response	State actions as of March 2021
Medicaid disaster relief State Plan Amendments (SPAs)	CMS developed a template for Medicaid disaster relief SPAs <sup>a</sup> to aid states' pandemic responses. States used SPAs to make temporary changes to their Medicaid state plans to bolster access to Medicaid and covered services during the pandemic. States also used traditional SPAs to respond to the pandemic.	16 states expanded coverage for testing and related services to uninsured individuals. 18 states eliminated, waived, or suspended enrollment fees, premiums, or similar charges in Medicaid.
Section 1115 waivers	CMS also developed a template for Medicaid Section 1115 demonstration waivers during the pandemic. <sup>b</sup> These waivers could be retroactive to March 1, 2020, and will expire 60 days after the public health emergency has ended. These waivers have predominantly been used to extend HCBS flexibilities to beneficiaries receiving LTSS.	7 states received approval for waiver provisions to make retainer payments to certain habilitation and personal care providers to maintain capacity during the emergency.  4 states received approval for waiver provisions to provide LTSS for affected individuals, even if services are not included in the care plan or are delivered in alternative settings.
Section 1135 waivers	During declared emergencies and disasters, the secretary of the Department of Health and Human Services can use Section 1135 authority to meet Medicaid enrollees' needs. Specifically, certain Medicare, Medicaid, and CHIP requirements may be waived or modified. CMS issued blanket Section 1135 waivers <sup>c</sup> for many Medicare provisions in March 2020, and states have submitted additional waivers for Medicaid programs.	All 50 states and DC have waivers allowing out-of-state providers with equivalent licensing to practice in their states.  44 states have waivers to allow service provision in alternative settings, like unlicensed facilities.  43 states suspended FFS prior authorizations.
1915(c) waiver Appendix K	Section 1915(c) waivers facilitate provision of states' Medicaid HCBS generally and can be used to respond to emergencies. As with the other emergency authority strategies, CMS provided guidance for Appendix K in pandemic-related waiver amendment requests. <sup>d</sup> Through Appendix K, states can modify or expand HCBS eligibility and services, modify or suspend certain planning and delivery regulations, and support service providers. In December 2020, CMS announced emergency authorities granted through Appendix K could be maintained up to six months after the public health emergency ends.	 41 states have temporarily modified processes for level-of-care evaluations. 50 states (including DC but not AK) are permitting virtual evaluations, assessments, and person-centered planning meetings. 49 states have temporarily expanded settings where services can be provided. 39 states have temporarily increased provider payment rates.

**Source:** "Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19," Kaiser Family Foundation, April 12, 2021, https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/.

**Notes:** CMS = Centers for Medicare & Medicaid Services. HCBS = home- and community-based services. LTSS = long-term services and supports. CHIP = Children's Health Insurance Program. FFS = fee-for-service.

<sup>&</sup>lt;sup>a</sup> The template for Medicaid disaster relief State Plan Amendments is available at https://www.medicaid.gov/state-resource-center/downloads/medicaid-disaster-relief-spa-template.docx.

Taken together, federal legislative changes and administrative flexibility set the stage for how Medicaid and other state health programs responded to the pandemic. In the sections below, we examine these health programs' responses to the pandemic and experiences related to changes in health care delivery, benefits coverage, support for providers, program operations, and the extent to which health equity has become a more prominent focus.

#### Changes in How Health Care Is Sought and Delivered

The pandemic has prompted dramatic changes in how health care is sought and delivered, as social distancing and fears of contracting the virus caused greater discontinuities in care, limited in-person visits, and increased reliance on telehealth (Gonzalez et al. 2020, 2021b; Hill and Burroughs 2020; Smith and Blavin 2021). Consistent with other data sources (Gonzalez et al. 2021a, 2021b), our study's key informants reported that people have avoided routine, preventive, and nonurgent care throughout the pandemic, citing decreases in childhood vaccine rates, dental visits, and follow-up care for newborn screenings. They also described how the pandemic has exacerbated health needs, particularly related to mental health and substance use disorders. In 2020, 4 in 10 adults in the US reported symptoms of anxiety or depressive disorders, up from 1 in 10 in 2019, and such rates were even higher among young adults, parents, communities of color, and essential workers (Panchal et al. 2021). The CDC also reported accelerated substance use and overdose deaths during the pandemic (Czeisler et al. 2020). §

When patients have sought care, they have opted for virtual care at much higher rates than were common before the pandemic. Telehealth now accounts for 6 percent of all outpatient visits, compared with 1 percent of visits before the crisis, and one in three adults used telehealth between March and September 2020 (Mehrotra et al. 2020; Smith and Blavin 2021). Key informants reported that virtual care likely mitigated preexisting barriers to care, such as lack of transportation and child care, leading to better attendance for certain types of health care visits, including prenatal and postpartum care appointments and group therapy sessions for substance use treatment. Interviewees also mentioned that preexisting provider shortages may be ameliorated by telehealth, citing implications for the

<sup>&</sup>lt;sup>b</sup> Calder Lynch (deputy administrator and director of the Center for Medicaid and CHIP Services), letter to state Medicaid directors, "COVID-19 Public Health Emergency Section 1115(a) Opportunity for States," March 22, 2020, https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20002-1115template.docx.

<sup>&</sup>lt;sup>c</sup> "COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers," Centers for Medicare & Medicaid Services, March 30, 2020, https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf.

d "Emergency Preparedness and Response for Home and Community Based (HCBS) 1915(c) Waivers," Medicaid.gov, accessed April 18, 2021, https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/home-community-based-services-public-health-emergencies/emergency-preparedness-and-response-for-home-and-community-based-hcbs-1915c-waivers/index.html.

behavioral health workforce in particular. According to one stakeholder, "There are long-standing provider shortages in behavioral health. Telehealth has somewhat been able to alleviate that...[because now] they can provide services across state lines, and they are able to reach consumers that might not [otherwise] have the resources."

Health care systems, payers, and policymakers have made many policy adjustments to accommodate the shift to telehealth. These have included expanding rules related to the site of care, such that providers can connect with patients via telephone calls and virtual platforms like Zoom, Skype, and FaceTime (Hill and Burroughs 2020). Before the pandemic, only 19 state Medicaid programs paid for telehealth services delivered to patients in their homes, and not all reimbursed these services at the same rate as in-person care. But within the last year, all 50 states and the District of Columbia have expanded telehealth for Medicaid populations. Similarly, many major private insurers have also modified telehealth policies; whether voluntarily or by state law, these insurers have waived cost-sharing for select services, expanded virtual mental health and/or substance use services, and instituted parity requirements stipulating that payers reimburse in-person and virtual care at the same level.

Though many key informants were optimistic about telehealth's potential for improving access to care, they were also concerned about the efficacy and sustainability of telehealth-related policy changes. Some interviewees supported making permanent policies such as payment parity, whereas others disagreed and worried about the quality of virtual care. Several informants suggested that though audio-only care can reach patients unable to connect via video applications, it presents challenges because providers cannot monitor important indicators, such as a patient's physical condition, affect, or expressions. Some key informants described the potential for increased costs related to overuse of virtual care in fee-for-service environments and noted the lack of sufficient data to determine whether telehealth access and outcomes are equitable across populations (Hill and Burroughs 2020). Key informants unanimously agreed, however, that expanded telehealth services would continue in some capacity; they expressed doubt that the US would revert to prepandemic low levels of utilization and rigid policies. One interviewee remarked, "Telehealth is here to stay."

Though the pandemic has affected all aspects of the health care delivery system, key informants suggested some of the most notable shifts have been to long-term care services and supports (LTSS). For decades before the pandemic, Medicaid programs worked to increase the share of LTSS delivery and spending in home and community settings relative to institutional settings (O'Malley Watts, Musumeci, and Chidambaram 2020). This shift accelerated in response to the pandemic, as long-term care facilities experienced dramatically high death rates; though populations living in these facilities account for 1 percent of the US population, they accounted for 35 percent of all COVID-19 deaths in

the US. <sup>10</sup> Providers worked to avoid these settings in favor of approaches that allow seniors and people with disabilities to remain at home and limit their exposure to the coronavirus. Indeed, key informants reported that consumer interest in home- and community-based sevices (HCBS) and family caregiving has increased, and hospitals are making more referrals to home health providers and fewer referrals to nursing facilities. <sup>11</sup>

Policymakers have bolstered HCBS during the public health emergency, incorporating flexibilities and expanding reimbursement for these services. Medicaid altered federal rules to allow family caregivers to deliver and receive reimbursement for this care, including home health services for older adults and children and youth with special health care needs (Randi, Girmash, and Honsberger 2021). <sup>12</sup> As described above, most states have taken advantage of these flexibilities through Appendix K waivers, enabling temporary changes to their Medicaid programs during the public health emergency. Further, the Biden administration has proposed new supports, such as tax credits, for family caregivers providing care across the life-span. <sup>13</sup>

#### **Benefit Protections and Cuts**

Lawmakers commonly cut health program benefits to address budget shortfalls (Snyder and Rudowitz 2016). For example, the number of states reporting at least one benefit restriction in their Medicaid programs increased during the Great Recession. Medicaid accounts for a large portion of state budgets and, therefore, can be particularly vulnerable to cost-saving measures. However, cuts to Medicaid bring with them losses of federal matching funds. Medicaid includes mandatory benefits, but other benefits are considered optional and are therefore susceptible to being cut.

However, informants generally described cutting health benefits as counterproductive during an economic downturn that is concurrent with a pandemic. Underscoring the importance of facilitating access to services as needs increase, key informants reported that policymakers have largely protected health benefits in Medicaid. In fact, the MOE requirement enacted at the start of the pandemic initially prohibited cuts to services for Medicaid beneficiaries. Further, many states extended access to benefits by relaxing certain prior authorization, documentation, and referral requirements for services such as long-term care and HCBS (Gifford et al. 2020).

Interviewees were concerned, however, that not all benefits were protected and some programs would still be susceptible to cuts as states address budget pressures in the coming year. Adding to these fears, the Trump administration released an interim final rule in October 2020 that permitted states to cut optional benefits previously protected under the MOE requirement. <sup>14</sup> For example, the rule allowed

states to reduce coverage of certain substance use treatment and adult oral health services. <sup>15</sup> The National Health Law Program reported that several states were planning to implement benefit cuts in response to the rule change and submitted a letter to the Biden administration in April 2021, cosigned by 161 other organizations, requesting that it rescind the interim final rule. <sup>16</sup> States have also made or proposed cuts to non-Medicaid health programs that are not legislatively protected; Colorado, Georgia, and Utah cut state funding for mental health and substance use disorder services in 2020 (Aron-Dine, Hayes, and Broaddus 2020). However, as some states' financial outlooks have improved, legislators may be able to restore these funds. Colorado's Governor Polis, for instance, reversed some of last year's cuts in his proposed 2021 budget. <sup>17</sup> Federal aid from the American Rescue Plan may also help policymakers mitigate benefit cuts by relieving budget pressures.

#### **Supporting Health Care Providers through Uncertain Times**

The pandemic has had far-reaching effects on all segments of the health care industry, and supporting health care providers has been a major piece of the pandemic response for Medicaid and other safety net health care programs. Unexpected and significant shifts in health care utilization have resulted in uncertainty and strained many providers' resources. For instance, hospitals have faced significant COVID-19 testing and treatment needs, while demand for routine and preventive care provided by pediatric and family practitioners has steeply declined. And in the first few months of the pandemic, providers struggled to obtain the supplies they needed to treat patients safely, including personal protective equipment and COVID-19 tests.

Key informants suggested that early in the public health emergency, providers who no longer had the volume of patients needed to maintain solvency were particularly vulnerable, such as primary care practices, behavioral health providers, substance use treatment providers, pediatricians, dentists, adult day health centers, and other congregate community services. These providers faced threats of closure and, according to key informants, commonly looked to Medicaid for assistance. As one interviewee expressed, "I would include a third crisis on top of the public health emergency and fiscal crisis—a provider sustainability crisis."

The CARES Act included a \$175 billion Provider Relief Fund (distributed directly to providers, not through state Medicaid agencies). However, Medicaid providers often had trouble accessing these dollars, especially at first, because of how they were allocated.

Many Medicaid programs acted swiftly to maintain their provider networks and protect beneficiaries' access to care both now and after the pandemic, when demand increases. States used

State Plan Amendments (SPAs) and Social Security Act Section 1115, 1135, or 1915(c), Appendix K, waivers to modify their Medicaid programs in ways that increased financial support for providers. For instance, most states used disaster relief SPAs to temporarily increase provider payment rates. A majority have also used Section 1135 emergency waivers to ensure providers are reimbursed even if they cannot comply with certain requirements because of the pandemic. States' 1135 waivers, for example, allow billing by out-of-state providers, increase scope of practice for some providers, and waive requirements for quality-measure reporting so providers are not penalized for experiencing lower-than-anticipated volume. States have also employed mechanisms like interim or retainer payments to help providers stay afloat. Interim payments are made to providers in advance (addressing immediate cashflow issues) and ultimately reconciled against actual services provided, whereas retainer payments help habilitation and personal care providers (e.g., adult day health centers) maintain capacity when circumstances such as social distancing or self-quarantining prevent beneficiaries from actually receiving services.

SPAs and waivers require approval from the Centers for Medicare & Medicaid Services (CMS), and key informants suggested that CMS provided timely and useful guidance to state Medicaid agencies and worked quickly to process requests. One interviewee was disappointed CMS did not approve a state's request to extend retainer payments to providers other than those offering HCBS, noting behavioral health providers could benefit from this policy option. However, most praised the federal agency's responsiveness.

Many of the state actions described above involved direct payments from Medicaid to providers, but some Medicaid programs worked through their managed-care organizations (MCOs) to channel funds to providers. More than two-thirds of Medicaid beneficiaries are enrolled in risk-based comprehensive MCOs, <sup>19</sup> and states pay a fixed monthly capitation rate to MCOs to provide care to these beneficiaries, regardless of utilization. Those funds may not be reaching providers facing decreased utilization, so some states have directed MCOs to bolster payments to providers in their networks; for example, they might direct MCOs to temporarily increase their provider rates or fee schedules or to make retainer payments, and MCOs may apply these directions widely or target them to specific providers (McMorrow et al. 2020). For instance, New Hampshire was one of the first states to receive approval from CMS (in April 2020) to require Medicaid MCOs to distribute a share of their capitation payments between September 2019 and June 2020 to six essential provider types: critical access hospitals, residential substance use disorder providers, home health care providers, private duty nursing providers, personal care providers, and federally qualified health centers/rural health centers (Guyer and Boozang 2020). Key informants described some situations where health plans elected to

route overpayment capitation dollars to their provider network without a state mandate, such as in California, where Medicaid behavioral health plans made supplemental payments to behavioral health care providers.

Even with state Medicaid program efforts to extend financial support to providers facing revenue declines, key informants emphasized that many providers are still struggling, and some have gone out of business or significantly reduced their capacities. This raises concerns about supply after the pandemic, when demand will presumably increase. This is especially concerning for mental health and substance use treatment providers, who key informants described as operating on very thin margins even before the pandemic and who especially needed federal fiscal relief in 2020. Interviewees reported that smaller, community-based behavioral health care facilities were most likely to have temporarily closed while they established processes for virtual care and obtained enough personal protective equipment to function. Some have since restored their capacities, but others have remained closed, possibly permanently. One interview explained, "[Behavioral health providers] are very much at risk despite the obvious imperative to expand, rather than contract, mental health care during a pandemic that leaves people isolated and has shot up overdose rates already."

Finally, some key informants felt the public health emergency had placed a spotlight on the fundamental weaknesses of a volume-based health care delivery system. Some observed that providers in value-based systems (e.g., accountable care organizations) have been able to respond more nimbly to pandemic-related volume losses and to pivot more smoothly to virtual health care. Before the pandemic, state Medicaid programs were already moving toward value-based care, though programs' progress varied considerably. Further, key informants acknowledged that efforts to launch or strengthen Medicaid value-based care programs had generally been paused, as Medicaid agencies, MCOs, and providers responded to the crisis. Still, several informants emphasized that one lesson learned from the pandemic was that states need to shift their Medicaid delivery systems to what one informant described as "more secure" payment models.

#### **Adapting Program Operations to Pandemic Conditions**

While officials from Medicaid and other state-funded health programs grappled with how to facilitate beneficiaries' access to care and providers' sustainability during the pandemic, they simultaneously transitioned programs' administrative functions to a remote work environment and, to the extent possible, began administering benefits virtually. Most key informants felt the transition to virtual program operations had been smooth overall, though success varied by state. Some states had already

invested in the necessary technology before the pandemic. Others, however, were "completely unprepared," according to one key informant, and were working without the appropriate technology for months (e.g., agencies that lacked laptops with cameras and microphones).

For state Medicaid agencies, several factors facilitated the shift to virtual benefits administration. The ACA had long ago prompted states to embrace modern technology in their Medicaid programs, for instance, by requiring an online application option. Key informants described these technology investments, including call centers, online beneficiary accounts, and streamlined eligibility verification, as very advantageous to Medicaid program operations during the crisis. As indicated above, Medicaid programs also used SPAs and waiver authority to adopt new policies to limit in-person interactions for applying for benefits during the pandemic. One key informant noted fewer in-person application requirements made Medicaid more like commercial coverage, which could lead to long-term changes in how the program is perceived—as health coverage rather than social welfare—if these policies are sustained after the public health emergency. Finally, the MOE requirement was helpful because it temporarily allowed states to stop processing eligibility redeterminations. Several key informants suggested states were relieved to provide continuous coverage without needing to process renewals, considering the workload associated with the pandemic.

Though they emphasized the adaptability and resilience of state health programs during the pandemic, key informants also underscored the immense pressure public health and other health program staff faced in 2020 as they, like the rest of the world, adapted to new working conditions and faced challenges related to child care or family members contracting COVID-19, all while keeping essential programs running. One interviewee emphasized the burden on state-run psychiatric facility staff, who faced mandatory overtime amid COVID-19-related staffing shortages, noting, "[We have] a lot of concern about the unmet mental health needs of our mental health workforce."

Another interviewee focused on the highly politicized nature of the country's pandemic response, which placed significant pressure on public health leaders, some of whom resigned or retired early. And in public health departments, staff have been transferred from their regular positions into roles related to COVID-19 (e.g., testing, contract tracing, and vaccine administration), limiting the resources available for typical public health programs and activities.

In some states, budget-related funding reductions, such as furloughs and hiring or pay freezes, compounded pressures on state health program staff. However, key informants suggested these measures were not as common as they had been in previous economic recessions. Some pointed to states that instead trimmed their Medicaid budgets by suspending contractor work (e.g., contracts with

IT companies). Several interviewees noted that states such as Washington and Wyoming implemented furloughs across all state agencies, affecting health program staff. As revenue projections improved during 2020, however, states lifted these measures.

#### **Increased Recognition of Health Inequities**

Inequities in health outcomes for communities of color, a long-standing and shameful aspect of US history, have been thrust into the spotlight over the past year. Communities of color are at greater risk of contracting and dying from COVID-19 (Dubay et al. 2020), <sup>20</sup> and Black and Hispanic people consistently receive smaller shares of COVID-19 vaccinations relative to their shares of COVID-19 cases and deaths and their shares of the total population (Ndugga et al. 2021). However, one silver lining of the pandemic is that political support for addressing racism and structural health inequities through policy change has grown. For instance, many state and local legislatures declared racism a public health crisis in 2020.<sup>21</sup>

Acknowledging racism as a public health crisis has prompted state legislators and governors to form working groups, task forces, and advisory councils to delineate actionable steps for addressing structural inequities. For example, as of August 2020, 18 states had created task forces to address the pandemic's disproportionate toll on communities of color. <sup>22</sup> Several of these state task forces, such as those in California, Michigan, and New Jersey, have specifically focused on improving collection and analysis of data disaggregated by race and ethnicity. <sup>23</sup> By closely tracking these data, states intend to improve detection of racial disparities, increase transparency in reporting, and design targeted interventions.

Moreover, state task forces have reportedly emphasized the need for states to directly engage with communities and integrate their input in all policies and strategies, both within the context of the pandemic and more broadly. <sup>24</sup> Because myriad policies and programs shape structural and social determinants of health, key informants highlighted that state programs must use a coordinated approach to address health and social needs through a community-driven equity lens. Accordingly, a handful of states have launched strategies to incorporate community feedback in long-term policy decisions. For example, Michigan Governor Gretchen Whitmer established the Black Leadership Advisory Council, tasked with developing, reviewing, and recommending policies and state actions to address racial inequities.

Key informants also highlighted increasing interest in police reform and the intersection between public and behavioral health systems. For instance, the American Public Health Association

recommends taking a "public health approach" to combatting law enforcement violence by shifting funds to community-led health, employment, affordable housing, and violence-reduction initiatives, as well as more closely involving social workers and mental health professionals in public safety matters (Barna 2020). Interviewees underscored the importance of involving mental health professionals in emergency response procedures, as 25 percent of all fatal police shootings involve people with untreated severe mental illness. <sup>25</sup> One key informant mentioned the forthcoming 988 crisis line, a new hotline that will connect callers with mental health professionals, <sup>26</sup> as a tool for more appropriately responding to mental health emergencies, instead of relying on law enforcement.

# States' Fiscal Outlooks for 2021

Though many predicted the fiscal crisis would be deep and uniform across states, it has not been. The pandemic-created economic downturn differed significantly from recent recessions in that the economic pain was heavily concentrated in accommodation and service sectors and among lower-income workers. As such, the pandemic's effects on revenues have been felt much worse in some states than in others.

Initially, some predicted states would collectively experience a revenue shortfall of more than \$1 trillion. <sup>27</sup> However, according to the Urban Institute's State and Local Finance Initiative, total state tax revenues declined by 1.8 percent from April to December 2020 compared with the same period in 2019—a significant decline but not an unprecedented fiscal crisis. But, this rate masks wide variation among states. On one hand, 22 states have seen revenues increase in 2020 relative to 2019, including those that have progressive state income taxes and recently enacted tax rate increases. On the other hand, 28 states reported declines in overall state tax collections during this period, with 7 reporting double-digit declines. The hardest-hit states were those that heavily rely on fossil fuel production (e.g., Alaska and Louisiana), those relying on services and tourism (e.g., Hawaii and Nevada), and those that do not have an income tax and depend more on sales taxes (e.g., Florida and Texas). <sup>28</sup> Local governments appear to have been hurt far more than state governments because of their reliance on revenue sources, such as property taxes, including for commercial property, and taxes or fees on hotel stays and restaurant meals, which have declined sharply during the pandemic.

During our interviews in early 2021, key informants consistently said the largest unknown that would affect state and local finances in the coming year was whether federal relief might include more funds for state and local governments, and if so, how much. By early March 2021, this picture became clearer. The nearly \$1.9 trillion American Rescue Plan, described above, included \$350 billion in funds

for state and local governments. Under the law, state governments receive roughly \$195 billion, local governments receive \$130 billion, and territories and tribes get \$24.5 billion. State funds include \$25.5 billion divided equally across states and the District of Columbia and \$169 billion distributed based on states' unemployment rates at the end of 2020. Some key informants argued distributing aid based on unemployment made sense, citing recent data estimating that for every 1 percentage-point increase in unemployment, state revenues decrease by 3.7 percentage points. <sup>29</sup> With regard to local relief funds, half will be distributed based on population size and the other half based on a modified Community Development Block Grant formula. Though unemployment and local grant formulas may not be the best proxy for need, they recognize economic conditions are an important driver of fiscal need. <sup>30</sup>

Several key informants remarked that the pandemic's timing was fortuitous, given that it took hold near the end of states' fiscal years. Many state legislatures had finished their planning for fiscal year 2021 by then and only needed to endure a couple of months of stress at the end of state fiscal year 2020. However, many states were forced to significantly rewrite recently enacted budgets, and 26 states convened special legislative sessions to adjust their plans in light of the pandemic, which, as described above, sometimes involved cutting budgets and putting initiatives on hold. The most significant tension facing states last year, according to key informants we spoke with, was their inabilities to react to growing budget and fiscal stress by cutting Medicaid or other health programs during a public health emergency. One interviewee explained, "Reductions in reimbursement rates and other cuts to providers...[have] been the go-to place in Medicaid in recessions. But we haven't had a recession with a pandemic before."

#### The Outlook for Medicaid in 2021

Medicaid has long been the largest or second-largest component of state budgets (alongside education), so the program is a logical target for cuts during recessions. At the same time, the generous federal matching dollars the program provides states mean Medicaid is not always the most attractive target for cuts. Smaller programs, less likely to be funded by the federal government, often suffer larger cuts.

Traditionally, budgeters focus on three Medicaid policy areas when considering cuts: program eligibility, covered benefits, and provider reimbursement. For 2021, however, eligibility cuts are prohibited during the public health emergency, because MOE rules dictate states must maintain the eligibility thresholds in place at the start of the pandemic and provide continuous coverage to those enrolled at that time to receive enhanced federal matching funds. Cuts to provider reimbursement do not seem well-advised either, according to key informants, because many providers—already operating

on thin margins because Medicaid is the lowest per capita payer in the system—suffered large revenue losses during 2020 amidst dramatic decreases in health care utilization. According to one stakeholder, some cuts to provider rates and optional Medicaid benefits for adults, such as dental care, may still be considered for 2021, depending on the state and its degree of fiscal stress.

Even as many providers experienced steep revenue declines during the crisis, Medicaid MCOs did not, because their contracts with states—which provide fixed per member per month capitation rates regardless of whether enrollees use services—were typically negotiated before the pandemic. Key informants told us that low utilization during the year upended health plans' medical loss ratios (the proportion of dollars received that goes toward paying for services, rather than administrative costs, which CMS requires to be at least 85 percent) and resulted in large, unspent reserves. Some states worked to claw back what state policymakers considered overpayments last year, whereas others worked with health plans to negotiate direct payments from plans to providers to help providers weather the storm. Key informants told us that health plan arrangements and contracts may be key areas of focus in 2021, as states work to meet residents' needs while balancing their budgets. As one official said, "No one wants to see Medicaid MCO dollars just sitting there, unused." Another informant noted that 2020 MCO overpayments underscored the need to ensure accountability and transparency in Medicaid managed care and suggested states should make medical loss ratios publicly available.

Medicaid continues to be the largest payer, by far, of LTSS (CMS 2021). LTSS also constitute the largest share of Medicaid spending, accounting for 32 percent of total Medicaid expenditures in fiscal year 2019 (CMS 2020). As such, LTSS are often a target when policymakers consider Medicaid cuts and, according to key informants, they are even more vulnerable during the pandemic. Nursing facility residents suffered disproportionate COVID-19 mortality, raising numerous questions about their quality of care. More LTSS have been delivered through HCBS waivers in recent decades, and policymakers will likely consider accelerating that trend this year, as society questions the logic of continuing to care for the elderly primarily through institutions rather than in community-based settings. As part of this trend, policymakers will likely also consider more ways to reimburse family caregivers.

One large, looming question identified by stakeholders holds significant implications for state budgets: What will happen to Medicaid eligibility once the public health emergency's MOE requirement is lifted? States could face a large backlog of eligibility redeterminations, and advocates have expressed concern over how state systems will cope with this demand, especially in states that implemented staff cuts and furloughs to balance their budgets. Medicaid enrollment may decline significantly, depending on the state of the economy when the public health emergency declaration is lifted. And if state systems are overwhelmed by the need to redetermine eligibility for their entire enrollee population in a

condensed period, stakeholders worried that the quality and accuracy of those redeterminations may suffer, leading to unintended outcomes.

Overall, stakeholders were reluctant to predict how Medicaid will fare this year and largely suggested maintenance of the status quo. That is, given the large infusion of federal support, the continuance of the public health emergency and its enhanced federal match, and a lack of policy bandwidth for dealing with much beyond the pandemic, stakeholders did not expect to see significant cuts or new initiatives. They predicted that prepandemic efforts to bring down prescription drug prices and invest in value-based payment strategies, among other priorities, will likely be paused this year.

Interestingly, however, some stakeholders were guardedly optimistic about possible program expansions this year, rather than cuts. Specifically, they hoped governors and state legislatures that have been ideologically opposed to expanding Medicaid under ACA authority might finally be persuaded that expanded coverage, facilitated by enhanced federal matching funds, is a wise way to bolster the health care safety net before the next emergency. Others mentioned more limited expansions of Medicaid postpartum coverage as another way to enhance coverage while also addressing profound racial inequities in maternal health. Informants shared these opinions even before passage of the American Rescue Plan, which, as noted, includes provisions to encourage states to adopt both expansions.

#### The Outlook for Behavioral and Other Health Programs in 2021

During a typical recession, non-Medicaid health programs, including those related to public health, mental health and substance use disorder treatment, and maternal and child health, can be more vulnerable to budget cuts, because they do not receive the same amount of federal matching funds as Medicaid. That is, cuts to these programs, unlike cuts to Medicaid, do not garner such large losses in federal funding while reducing state spending. But as mentioned above, key informants did not anticipate policymakers aggressively targeting these programs for cuts during the current recession. Public health programs are vitally needed to support ongoing COVID-19 testing, contact tracing, and vaccine rollout. They are also critical to supporting community and population health needs after the pandemic. Behavioral health programs are playing—and will continue to play—a crucial role in supporting people who have suffered from mental health and substance use disorders amidst pandemic-related personal and financial losses. And maternal and child health programs, which largely support preventive and primary maternal and pediatric care infrastructures, will be required to support mothers and children disproportionately vulnerable to COVID-19 and its effects.

Federal policymakers have provided new funding to safeguard these programs. As described above, the CARES Act doubled the size of the Substance Abuse and Mental Health Block Grant and included an additional 5 percent set-aside for crisis intervention (Moss et al. 2020). The Title V Maternal and Child Health Services Block Grant program also increased by \$32 million last year (March of Dimes 2020). And most recently, the American Rescue Plan builds on these investments by providing \$7.7 billion to bolster the public health workforce, \$1.5 billion for block grants for community mental health services, and \$1.5 billion for block grants for substance use disorder prevention and treatment. Still, states facing dire budget shortfalls may need to make cuts in these areas despite infusions of new federal dollars.

## **Longer-Term Effects and Opportunities**

Perhaps what is most certain at this time is that the US faces great uncertainty in 2021 and beyond. Even as the vaccine rollout continues, some states' COVID-19 infection rates persist at levels seen during some of the worst months of 2020. Meanwhile, though the economy has restored more than half the jobs it lost during the pandemic, nearly 10 million fewer jobs exist now than before the pandemic. Thus, economic pain and its spillover effects on population health will continue. Indeed, leading economists predict it could take until early 2024 for the economy to fully regain the 22 million jobs lost in March and April 2020. April 2020.

Many of the key informants we interviewed worried that, as the country emerges from the pandemic, a secondary pandemic may be on the horizon. That is, as Americans were locked down and avoided routine preventive and primary care over the past year, they may now experience a resurgence of traditional health problems, including chronic illnesses like obesity and diabetes. Data already show childhood vaccination rates have dropped precipitously in the past year, potentially portending higher rates of avoidable childhood illnesses like measles, mumps, and rubella.<sup>35</sup>

The pandemic's long-term impacts on the population's mental health and substance use are also of great concern. Millions of Americans have lost jobs, suffered through the deaths of family members, and attempted to cope with the stress and anxiety of social isolation, caring for sick family members, juggling work and children's remote learning, food insecurity, and homelessness. Rates of depression and suicidal ideation have increased during the pandemic (Czeisler et al. 2020), and stakeholders were concerned about increased intimate partner violence, homelessness, and opioid and other substance use (Czeisler et al. 2020; Evans, Lindauer, and Farrell 2020). According to behavioral health experts, working at a job is a critical component of recovery from mental health and substance use disorder. But

in an economy that has lost millions of low-wage jobs (Kinder and Ross 2020), this aspect of recovery may not be accessible.

As noted, the pandemic laid bare stark racial inequities in the US and, by extension, in health systems. Black and Indigenous people have died of COVID-19 at 1.4 times the rate of white people, and Latinx people have died at a rate more than 1.2 times greater than that of white people.<sup>37</sup> With the vaccine rollout, these inequities have persisted. According to the CDC, as of March 1, 2021, race or ethnicity was known for just over half (54 percent) of people who had received at least one dose of the vaccine; among this group, nearly two-thirds were white (65 percent), 9 percent were Hispanic, 7 percent were Black, 5 percent were Asian, 2 percent were American Indian or Alaska Native, and 14 percent identified as multiple races or another race (Ndugga et al. 2021). These data build on myriad other well-known social inequities faced by people of color, including disproportionate rates of poverty, food insecurity, and unemployment; unequal access to health care and coverage; and adverse health outcomes, such as obesity, diabetes, and maternal morbidity and mortality (Artiga, Orgera, and Damico 2020; NASEM 2017; Odoms-Young and Marino 2018). 38 States are increasingly crafting policies to address health inequities, and key informants were optimistic this focus would continue, claiming such problems could no longer be ignored. As one interviewee said, "States have created new infrastructure around integrating equity into their [COVID-19] response that may be retained for future emergency responses."

One stakeholder observed a take-away from the past year is that Medicaid is "a first responder for the nation," citing the program's critical role in any disaster, including the current crisis. Over the past year, Medicaid has protected millions of Americans' health coverage, provided a safety net for people losing employer-sponsored coverage, and bolstered health systems inundated with COVID-19-related demand or struggling because of declines in routine health care utilization. Federal officials quickly issued waivers and guidance for how states could maximize the flexibility of their programs, and Congress swiftly enhanced federal financial support for Medicaid and protected beneficiaries from disenrollment during the public health emergency. Further enhancements in the American Rescue Plan, like increased financial incentives to expand Medicaid to single adults in states that have not done so, promise to further ensconce Medicaid's role as a crucial component of the safety net.

Finally, several stakeholders were optimistic that the nation's experience with COVID-19 could be a catalyst for reforming many aspects of the health care safety net. By analyzing both how and where US systems fell short in caring for the population and how and where they successfully adapted, stakeholders hoped that an improved US health care system would emerge. They envisioned a system that places greater emphasis on prevention and preparedness, racial and ethnic equity, social determinants

of health, value- and outcomes-based (rather than volume-based) reimbursement for health services, and safer community-based systems of long-term care. Stakeholders also hoped that this transformed health care system might more nimbly respond to health crises as they arise. Applying lessons learned during the pandemic will be important for repeating avoidable future mistakes. Key questions to monitor whether this advancement happens include the following:

- Will financial incentives included in the American Rescue Plan spur states that have not already expanded Medicaid under the ACA to do so?
- Will states maintain or reduce Medicaid eligibility when the MOE requirement is lifted?
- Will Medicaid programs, health plans, and providers point resources toward addressing gaps and inequities in care that occurred during the pandemic?
- Will states build on their COVID-19-inspired equity and data collection efforts to create more effective and comprehensive monitoring systems?
- Will states redouble their attention and investments on behavioral health systems in anticipation of increased needs for mental health and substance use treatment services after the pandemic?
- How will community-based long-term care services and investments evolve after the pandemic?
- What additional federal rule changes will occur and are needed for states to achieve more proactive, preventive, holistic, and equitable health care systems?

The questions above illustrate an initial policy framework for monitoring the country's longer-term responses to the pandemic and its fiscal aftermath.

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#### STATEMENT OF INDEPENDENCE

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# Abbreviated Analysis

# California Assembly Bill 1400: Guaranteed Health Care for All

Summary to the 2021–2022 California State Legislature April 22, 2021

Prepared by
California Health Benefits Review Program
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#### **SUMMARY**

The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP) conduct a limited analysis of Assembly Bill 1400 (Kalra) Guaranteed Health Care for All. AB 1400, introduced on February 14, 2021, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system. This limited analysis is intended to support the Legislature in assessing the potential impacts of AB 1400. It draws primarily from existing research, policy analyses, and simulations developed in recent years to assess related proposals at both the state and national levels. CHBRP found significant evidence that provides some broadly applicable cost estimates and policy implications/uncertainties resulting from AB 1400.

#### **Bill Scope**

Assembly Bill (AB) 1400 (Guaranteed Health Care for All Act), introduced on February 14, 2021, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system. CalCare would be charged with providing high-quality health care and long-term care to all California residents, including those who are presently either uninsured or underinsured. It is intended to create a state-run "single payer" health system in California.

#### **Background**

On March 3, 2021, the California Assembly Committee on Health requested that CHBRP complete a limited analysis of Assembly Bill 1400 (Kalra) Guaranteed Health Care for All. This limited analysis synthesizes various robust studies and research to support consideration of the fiscal and policy implications of AB 1400 for California.

#### **Approach: Leveraging Existing Evidence**

CHBRP relies on available studies and simulation modeling released by researchers, government entities, and policy analysts to synthesize the range of impacts that single-payer health care systems might have on the existing health care system in California, as well as long-term care implications. Common findings from these simulations of proposed redesigns of health care at the state and/or federal levels give policymakers much to consider. Where possible, CHBRP attempts to extrapolate the impacts on California.

CHBRP highlights some of the potential costs and benefits related to AB 1400 based on existing evidence<sup>1</sup>, and provides a limited analysis related to how health care utilization might change as a result of AB 1400.

Finally, CHBRP was asked by the Legislature to provide an estimate of the initial fiscal reserves that would be needed to implement AB 1400 (in the short term). CHBRP attempts to provide an estimate based upon the existing literature, the California Legislative Analyst Office's work from 2008, and current health care spending in the state by government and private payers. CHBRP also provides an estimate of total California health expenditures for 2021.

#### **Benefit Coverage**

AB 1400 would provide for and cover a wide range of medical benefits and other services. These would incorporate the health care benefits and standards of other existing federal and state provisions, including the federal Children's Health Insurance Program, Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program.

Approximately 100,000 Californians received long-term care services through Certified Nursing Facilities in 2019 (Kaiser Family Foundation, 2019a). The majority of residents were Medi-Cal enrollees (62%), whereas 15% had Medicare coverage, and 23% had private or other coverage (including self-pay). Medicare limits reimbursement for long-term care for rehabilitation services after a hospital stay, such

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<sup>&</sup>lt;sup>1</sup> Studies include the LAO analysis, studies from RAND, Urban Institute, PERI, and the CBO.

that the burden of custodial long-term care falls upon Medi-Cal, private long-term care insurance, and out-of-pocket spending by families.

AB 1400 would greatly enhance the coverage for long-term care services throughout the state, but it would not only cover the costs from existing payers, it would likely subsidize families providing or financing caregiving on their own who do not benefit from one of the existing coverage programs.

#### **Policy Context**

The current U.S. health care system is a multipayer model with significant involvement and financial risk borne by employers, insurance companies, individuals obtaining health care and purchasing insurance, and taxpayers in the form of Medicare, Medicaid, Children's Health Insurance Program (CHIP), Tricare, Veteran's Health Administration, Indian Health Services, and local safety net programs.

Generally, single-payer systems are relatively less costly than multipayer privatized systems and are responsible for a slightly smaller share of the gross domestic product. In the United States, administrative and overhead costs for health care exceed other countries by at least 15%.

In the years between 2010 to 2019, twenty states proposed 59 different single-payer bills. Most, but not all, of the single-payer proposals come from states that expanded Medicaid under the Affordable Care Act (ACA), leaving only a small portion of the population uninsured. Many state single-payer bills share many common elements: they all make residents universally eligible for health insurance coverage, and include low or no cost sharing for patients, comprehensive benefits, limits on health insurers offering duplicate coverage, and set criteria for provide participation and reimbursement.

However, although single-payer models such as AB 1400 have been introduced at the state and federal level, none have ever been fully enacted and implemented in the United States.

The COVID-19 pandemic has exposed gaps in care delivery and in public health. In the present system, persistent disparities exist based on

income, region, and race and ethnicity. Prior to the COVID-19 pandemic, the United States ranked last in life expectancy and highest in suicide rates among 11 over industrialized countries. The U.S. also reported high numbers of preventable hospitalizations and avoidable deaths. Some advocates believe that these deficiencies may be improved by legislation such as AB 1400.

#### **Key Considerations and Unknowns**

CHBRP's analysis is not intended to make recommendations. However, in reviewing the studies, analyses, and evidence from numerous studies, CHBRP offers these key considerations and the remaining unknown impacts or implementation pieces for consideration.

#### **Fiscal Uncertainties**

AB 1400 would rely on the state collecting revenues sufficient to fund a new single-payer health system and centrally control costs. Additionally, California would need to combine funds that currently fund health care within California via a variety of sources into a single budget managed by the state. Unlike the federal government, California must balance its budget each year. The state would need to ensure revenues collected for health care services would meet changing needs and health care cost trends. Any external or environmental issues that suppress revenue collection in a given year, or create unpredictability in revenues or spending would harm program sustainability.

#### **Integration Considerations**

Eliminating cost sharing in AB 1400 may improve access to care and consumer affordability, but could increase costs due to greater use of services and ultimately compromise long-term sustainability.

Provider Impact and Hospitals. Although a single-payer system allows for private providers to continue operating as private entities, the payment sources would be limited to the new CalCare single-payer program. Consolidating all Californians under one single-payer system would require price setting that takes the previous multipayer rates into consideration, adjusts them downward to address new administrative efficiencies, and pays hospitals

and providers a new, blended payment rate for services rendered or people cared for.

#### **Administrative and Legal Questions**

Federal revenues currently support Medicare, Medicaid, and Covered California's individual market tax credits and cost sharing reductions. In addition, the federal government allows for the deduction or exemption of employee benefit spending from payroll and income taxation. To obtain the necessary revenue to support AB 1400, CHBRP assumes that the state will negotiate separate waivers with the federal government to ensure federal funds from several sources flow into CalCare.

AB 1400 does not establish a revenue model for financing its provisions. CHBRP is also aware of two existing provisions in the State's Constitution (Proposition 4 of 1979 and Proposition 98 of 1988) that affect California's ability to raise and spend revenues necessary to successfully implement AB 1400.

#### **Other Impacts**

The scale and challenge of the implementation of AB 1400 may result in negative or unanticipated impacts to insurers, health care providers, hospitals, health care technology companies, and large segments of the health care workforce.

#### **High Level Meta-Analysis**

A high-level meta-analysis published in 2020 identified 22 modeled predictions (over the past 30 years) of the cost of single-payer health care in the United States. Financing or revenue plans were not considered, just cost estimates. It found that 19 of the 22 studies (86%) predicted net savings during the first year of operation, with a range of 7% higher net costs to 15% lower net costs. The range of cost increases due to insurance coverage improvements resulting in higher use of services ranged between 2% and 19%. Simplification of payment administration, reduced prescription drug costs, and other components resulted in net savings of 3% to 27%. Overall, the authors estimated that net savings averaged 1.4% per year.

#### **Consensus Cost and Reserve Estimates**

CHBRP projects current California health care spending from all sources to total \$330.7 billion in 2021. Adjusted for inflation, previous analyses of single-payer bills in California (SB 840, SB 562) suggest that California could result in between \$314 billion and \$391 billion in total health care spending in 2021. These estimates include approximately \$33 billion in additional spending due to reduced cost sharing and deductibles.

CHBRP estimates that 50% of the current estimated health care spending plus the additional spending due to the implementation of AB 1400 should be placed in a reserve fund to ensure benefits can be offered to California residents. That amounts to \$158.5 billion to \$195.5 billion in reserves.

#### Conclusion

In the literature, there is a general consensus that single-payer health care would increase efficiency, initially decrease net costs, and result in long-term net savings over time. The uncertainty around immediate benefits, however, creates significant challenges for state implementation, in particular. The evidence illustrates that maximizing performance and savings will require a very complex and intensive undertaking.

AB 1400, if enacted successfully, would establish affordable coverage for the approximately 3.24 million who remain uninsured in California. AB 1400 would promote greater equity and reduce the financial burden that millions of Californians experience, even those with health insurance.

Considerable research and analysis has highlighted some of the requirements, potential benefits, pitfalls, and uncertainties for states considering single-payer proposals. Some of the key barriers and uncertainties facing policymakers if AB 1400 were enacted, include:

The ability to integrate all or many financing sources and populations is one key to reap some of the intended benefits of a single-payer system. CalCare would need to consolidate federal funds from Medicare, Medicaid, and the ACA exchanges into the state single-payer plan using waiver provisions in those federal programs. Proposed state single-payer plans generally

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lack "fallback" plans for capturing federal funds should the federal government deny the waivers.

Single-payer design notions that eliminate or reduce premiums and cost sharing would need to secure offsets.

Disruption to the state's health care workforce, health care providers, insurers, and residents may be high. Uncertainty in finance may impact innovation, technology adoption, and public health during an extended period of uncertainty.

Additionally, state constitutional prohibitions on deficit spending, constrain state plans

when tax revenues fall during economic recession.

The scale of the uncertainties in fiscal projections and the risks managing hundreds of billions of dollars in health care spending provide a live experiment with opportunity but also unanticipated potential risks and costs.

Regarding long-term care, CHBRP found it difficult to project the fiscal impact of expanding long-term care coverage beyond what Medicare and Medicaid currently provide due to lack of measurable data, availability of long-term care supply, and how informal caregivers would respond to AB 1400.

#### BACKGROUND

On March 3, 2021 the California Assembly Committee on Health requested that CHBRP complete a limited analysis of Assembly Bill 1400 (Kalra) Guaranteed Health Care for All. This limited analysis is intended to support the Legislature in assessing the potential impacts of AB 1400. It draws primarily from existing research, policy analyses, and policy simulations developed in recent years to assess related proposals at both the state and national level. This limited analysis synthesizes several rigorous and high-quality studies and a substantial body of research to support consideration of the fiscal and policy implications of AB 1400 for California.

#### **APPROACH**

#### **Leveraging Existing Evidence**

In this limited analysis, CHBRP relies on available studies and simulation modeling released by researchers, government entities, and policy analysts to synthesize the range of impacts that a single-payer health care system might have on the existing health care system in California. Although important details vary among single-payer proposals that have been considered in recent years, common findings from these simulations of proposed redesigns of health care at the state and/or federal levels offer policymakers estimates of spending magnitude and suggest the policy implications to consider prior to enacting a comprehensive single-payer bill. These studies also help identify the challenges of potentially implementing AB 1400 at the state level. Where possible, CHBRP attempts to extrapolate the impacts on California by incorporating demographic adjustments and trending forward spending and utilization of some of these key examples. CHBRP also provides further information on the relative health status of the uninsured versus insured in California.

Finally, CHBRP was asked by the Legislature to provide an estimate of the initial fiscal reserves that would be needed to implement AB 1400 (in the short term). CHBRP attempts to provide an estimate based upon the existing literature, the California Legislative Analyst Office's (LAO's) work from 2008, and current health care spending in the state by government and private payers.

#### INTRODUCTION

This section provides information about the multipayer system of health care currently used in the United States and California, and contrasts it to single-payer options. CHBRP describes the traditional health care insurance and delivery model in the United States, which is used to deliver acute care and subacute care, and also delineates that system of providers and payers from the separate system used to provide long-term care to residents of the United States and California which relies on Medicaid, private long-term care insurance, and significant out-of-pocket spending by families and caregivers.

### **Overview of Multipayer System**

The current U.S. health care system is a multipayer model with significant involvement and financial risk borne by employers, insurance companies, individuals obtaining health care and purchasing insurance, and taxpayers in the form of Medicare, Medicaid, Children's Health Insurance Program (CHIP), Tricare, Veteran's Health Administration, Indian Health Services, and local health programs (Donnelly et al., 2019). At a national level, our multipayer system leads to fragmentation and inequity, such that higher income individuals with tax-deductible or tax-exempt comprehensive employer-sponsored insurance coverage can access state-of-the-art care from highly regarded academic medical centers at little to no out-of-pocket cost, whereas low-income individuals with Medicaid face barriers to accessing care,

including limited provider networks. Today's health care system leads to approximately 8.5% of the California population going without insurance due to lack of affordable options, lack of information about benefits and programs available, perceived need, or explicit exclusions due to immigration status (Commonwealth Fund, 2020). The concept of single payer is sometimes conflated with universal coverage, but the ideas are distinct (Liu and Brook, 2017). Universal coverage can be achieved through a variety of policy options that range from expanding or adding to existing multipayer coverage programs and rules, to establishing a single-payer system. Alternatively, a single-payer system could apply to a subset of the population, as with Medicare for the disabled and people age 65 years and over, or the Veterans Health Administration (VHA) program.

Many proposals propose a universal single-payer approach that applies to everyone within state boundaries irrespective of age, gender, income, health status, employment, and citizenship. The label "single payer" can be misleading, as considerable differences exist among universal health care systems. There are essentially three types of universal health care (Glied et al., 2019). The first is single-payer coverage whereby all residents are covered. These systems are government financed through taxes, pays providers directly for all health care covered, and there are no out-of-pocket costs. The United Kingdom is a prominent example of this system (Glied et al., 2019). The second is based on a regulated compulsory private health care approach. Insurance is required for all residents unless exempted. The Government determines what's covered and there may be some deductible costs. Consumers pay premiums to insurers, and insurers pay providers. The Netherlands is a prominent example of this system (Glied et al., 2019). And third, there is government-financed mixed public-private coverage system, where all residents are covered, a wide variety of services are covered, there is some cost sharing, and there is a private insurance option for the rest. Government finances nonprofit insurers, but supplemental private insurance is also available. France is a prominent example of this model (Glied et al., 2019).

Generally, single-payer systems are relatively less costly than multipayer privatized systems and are responsible for a slightly smaller share of the gross domestic product (GDP) (Glied, 2009). Overall, the differences in system performance among the universal coverage of Organisation for Economic Cooperation and Development (OECD)<sup>2</sup> countries are very small, whereas the difference between the performance of any one of these countries and the United States is enormous and persistent (Glied, 2009). However, these differences in health outcomes could be driven by country or state spending on social programs that are likely to have more meaningful impacts on health outcomes than health spending (Papanicolas et al., 2019). There is even evidence that states with a higher ratio of social spending to health spending achieve better health outcomes within 1 to 2 years of switching (Bradley et al., 2016).

Despite higher levels of health spending in the United States when compared to other industrialized countries, the U.S. population uses fewer services in most categories. Higher spending is linked to higher overall prices paid due to the multipayer nature of the U.S. health care system and the lack of systematic price controls (Anderson et al., 2019). Whereas Medicare fee-for-service (FFS) sets rates for providers each year, private insurers who provide coverage to individuals through the individual market, employer-sponsored insurance, Medicaid Managed Care Plans, and Medicare Advantage plans all negotiate with providers separately to set payment rates. Providers and insurers with negotiating power due to market concentration, reputation, or other reasons are able to negotiate better prices than those without negotiating power (Anderson et al., 2019; Hussey and Anderson, 2003). The administrative burdens of negotiating prices and billing, plus the profit motive in the U.S. health system, results in administrative and overhead costs for health care exceeding other countries by at least 15% (Himmelstein et al., 2020; Woolhandler et al., 2003).

From 2010 through 2019, legislators in 20 states proposed 59 different single-payer bills (Keith, 2019). Most, but not all, of the single-payer proposals came from states that expanded Medicaid under the Affordable Care Act (ACA), leaving only a small fraction of the population uninsured. Thus, it appears that beyond achieving universal coverage, state single-payer bills also seek to control health spending

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<sup>&</sup>lt;sup>2</sup> The Organisation for Economic Co-operation and Development is an intergovernmental economic organization with 37 member countries, founded in 1961.

through expansive rate-setting authority and streamlined administration, as well as to relieve individuals of their growing out-of-pocket expenses. These state single-payer bills share many common elements: They all make residents universally eligible for health insurance coverage, and include low or no cost sharing for patients, comprehensive benefits, limits on health insurers offering duplicate coverage, and set criteria for provide participation and reimbursement. However, although single-payer models such as AB 1400 have been introduced at the state and federal level, none have ever been fully enacted and implemented in the United States (Parnell et al., 2020).

California does not yet offer universal access, despite significant coverage expansion over the past 10 years. In 2022, it is estimated that 3.2 million non-elderly Californians will be uninsured (9.5%), including 1.3 million undocumented Californians (Dietz et al., 2021a). Multipayer financing of health care and a diffuse delivery system, including a "patchwork" of safety net providers serving low-income and uninsured populations, result in inefficiencies and inequities in health care delivery, access to care, and quality for many Californians. Profits and financial incentives for providers and insurers often drive-up spending despite a lack of improvements in clinical quality, disparities, avoidable deaths, or patient experience. The COVID-19 pandemic has exposed gaps in care delivery and in public health. In the present system, persistent disparities exist based on income, region, and race and ethnicity (Healthy California Commission, 2020).

Communities of color experiences with racism, discrimination, socioeconomic deprivation, and environmental stressors were exacerbated during the COVID-19 pandemic (Fortuna et al., 2020). COVID-19 incidence and mortality have continued existing health disparities and created new inequities (Okonkwo et al., 2020). Persistent disparities due to higher rates of COVID-19 incidence and other health conditions exist by income, region, race, and ethnicity. Increasing access to health coverage and reducing out of pocket costs promotes equity, improves access to health care services, and will result in better outcomes (Bernstein et al., 2010). Prior to the COVID-19 pandemic, the United States ranked last in life expectancy and highest in suicide rates among 11 over industrialized countries. The U.S. also reported high numbers of preventable hospitalizations and avoidable deaths. (Choo and Carroll, 2020). Proponents of a universal single-payer system as proposed in AB 1400 believe it will reduce barriers to health care access and treatment, and make health care more affordable for the most vulnerable populations. Although these reforms would not address the racism and poverty that led to these disparities in health outcomes, it would attempt to address the poor health outcomes faced by underrepresented or vulnerable groups.

#### **Long-Term Care**

Although the U.S. focuses on primary and acute health care in policy discussions, long-term care is a very important component of the health care system that gets little attention. Long-term care affects people of all ages and is a major driver of spending in public programs, namely Medicare and Medicaid. People with long-term care needs often go without appropriate or preferred care, and this places burdens on families due to excessive caregiving and financial responsibilities. Twenty percent of adults with long-term care needs who reside in their community are unable to access the care they need (Feder et al., 2000). It is a global challenge, as the combination of disability increases, population aging, and need for LTSS is a concern throughout the world (Thach and Weiner, 2018; de la Maisonneuve and Martins, 2013; European Commission, 2015; World Bank, 2016).

In the United States, long-term services and supports (LTSS) is a blanket term that "encompass a variety of health, health-related, and social services that assist individuals with functional limitations due to physical, cognitive, or mental conditions or disabilities," (Thach and Weiner 2018). LTSS services can provide assistance with activities of daily living (ADL), which include eating, dressing, and bathing. LTSS also provides supports for instrumental activities of daily living (IADLs), which include tasks like housekeeping and financial management. LTSS is designed to help people with disabilities function in their daily lives, and leverages LTSS providers that include informal, unpaid support and formal, paid caregivers. LTSS can be delivered in different settings, such as intermediate care facilities for those with developmental disabilities, nursing homes for custodial care and rehabilitation patients, and community-

based services (e.g., adult day services, assisted living). The financing and delivery systems have historically favored institutional settings, although government policies and advocacy efforts have facilitated a shift toward greater home and community-based services (HCBS) use (Thach and Weiner, 2018).

Medicaid, the federal-state health care and LTSS program for the low-income population, is a critical part of financing for LTSS. By 2040, the United States population is projected to increase from 318.7 million in 2014 to over 380 million people, with the elderly population increasing from 48 million to slightly more than 83 million people (Colby and Ortman, 2015).

The State of California currently administers LTSS, which provides long-term care services delivered through Skilled Nursing Facilities, In-Home Supportive Services, Home and Community-Based Services, Community-Based Adults Services, and a variety of other mechanisms. However, all of the programs listed above are not under the Medi-Cal umbrella; some are controlled and funded by the Department of Aging, Department of Developmental Services, and Department of Social Services. Although the Medi-Cal fee-for-service program spent approximately \$16.2 billion on long-term care in 2018, there were other sources of services and spending for LTSS in the state (CHCF, 2020). In addition, it is estimated that another \$8.4 billion was spent for long-term care in Medicare in 2017 (CHCF, 2017), and an unknown amount was spent by individuals or their private long-term care insurance policy.

Approximately 100,000 Californians received long-term care services through Certified Nursing Facilities in 2019 (KFF, 2019a). The majority of residents were Medi-Cal enrollees (62%), whereas 15% had Medicare coverage and 23% had private or other coverage (including self-pay). Medicare limits reimbursement for long-term care for rehabilitation services after a hospital stay, such that the burden of custodial long-term care falls upon Medi-Cal, private long-term care insurance, and out-of-pocket spending by families.

Given the unknown levels of spending occurring out-of-pocket for individuals and through private long-term care insurance policies, it is difficult to predict the monetary impact of expanding long-term care coverage beyond what Medicare and Medicaid currently provide.

#### **Health Care Administrative Costs**

Administrative and overhead costs in health insurance include activities related to billing, utilization review, marketing, compensation of administrators, and profit.

#### **Medical Loss Ratio**

A percentage of all health care expenditures relate to administration, overhead, and profit. The amount of money spent on medical care by a health insurance carrier or health plan as a percentage of their collected premium revenue is a term called Medical Loss Ratio (MLR). Per the ACA³, Insurers in the large-group commercial insurance market are required to spend at least 85% of their premium revenues on medical care, whereas small-group and individual market insurers must spend at least 80% of the premiums collected on medical care. If the minimum MLR goal is not met in a given year, the insurer must issue refunds to their enrollees to meet the MLR target.<sup>4</sup>

 $<sup>^{3}\ \</sup>underline{\text{https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio}.$ 

<sup>&</sup>lt;sup>4</sup> However, traditional fee-for-service limits the administrative spending in the program by attempting to process claims through fiscal intermediaries (typically commercial insurers operating in the region) and allowing those fiscal intermediaries to charge a small portion (less than 2%) of the claims paid. That results in Medicare having an MLR of 98% or better, because they intentionally limit spending on administrative costs by contracting with fiscal intermediaries. In Medicaid, which is primarily delivered by commercial insurers, the MLR is 85% and is subject to rigorous requirements around reporting and calculation. However, insurers that use subcontractors who use their own employees to deliver services (rather than network providers) are able to capture the entire amount spent by the subcontractor in the medical cost numerator.

Evidence suggests that billing-and-insurance—related costs in our multipayer health system are substantial. Jiwani et al. (2014) estimate that approximately \$375 billion in expenditures are added to the overall costs of our health system due to these multipayer billing-and-insurance—related activities. They estimate that moving to a simplified, single-payer system would result in 15% savings to the system. Woolhandler et al. (2003) published a landmark study on administrative spending in the United States in 2003, and updated it in 2020 using 2017 data (Himmelstein et al., 2020). They found that the United States spent 34.2% of every health care dollar on administration, in comparison to Canada, which spent 17% (Jiwani et al., 2014). Although we should not anticipate administrative costs to be removed entirely under a simplified, multipayer system, there is support for the notion that between 14% and 17% of current health care spending is due to inefficient administrative activities linked to the multipayer system. However, it is unreasonable to expect that a single-payer system could operate on a 2% administrative margin like Medicare.

#### Fraud and Abuse

Fraud and abuse are a problem throughout health care. In 2019, CMS estimated over \$28.91 billion in improper payments (and \$57.36 billion in Medicaid and CHIP Programs across the country) occurring in Medicare fee-for-service (CMS, 2019). It is difficult to assess the impact of fraud and abuse throughout the system, because information is limited to providers and individuals who were engaged in fraud and were caught. Although Medicare fee-for-service operates with a very low administrative overhead rate of less than 2% according to the most recent Medicare Boards of Trustees' report (2020). This level of administrative spending is comparable to a 98% or better medical loss ratio due to the automated review of Medicare claims and low overhead spending. However, the program is also a target for insurance fraud due to the lack of prior authorization, utilization review, and other strategies health insurance carriers often use to limit use of expensive or otherwise avoidable services. In shifting toward a single-payer model as proposed by AB 1400, planners and policymakers should consider that the savings from administrative spending reductions could be limited by the presence of health insurance fraud and abuse depending on the structures and barriers put in place to remove fraud and abuse. For example, Medicare's Center for Program Integrity (CMS, 2021) focuses on reviewing claims using algorithms to identify patterns, individual providers, and limit payments for fraudulent claims. In 2019, \$2.2 billion from the overall administrative spending was allocated to Medicare's health care fraud and abuse control program (Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2020). Medicare Advantage and Part D plans, which are run by private insurers, must adhere to an 85% medical loss ratio (Society of Actuaries, 2019).

#### **POLICY CONTEXT**

#### **Bill Provisions**

Assembly Bill (AB) 1400 (the California Guaranteed Health Care for All Act), introduced on February 14, 2021, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system. CalCare would be charged with providing high-quality health care to all California residents, including those who are presently either uninsured, ineligible for public coverage, or underinsured (unaffordable high deductible plans, etc.). It is intended to create a state-run "single payer" health system in California.

AB 1400 would require coverage of "a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state programs, including the federal Children's Health Insurance Program, Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program, (AB 1400, February 19, 2021 see Appendix A)." The bill seeks to enact a health care cost control mechanism to facilitate new health coverage and health care service delivery for all residents of California, including the undocumented. AB 1400 would prohibit participating providers from billing or

contracting with an individual eligible for CalCare benefits for a covered benefit, but would allow contracting for a health care service that is not a covered benefit if certain criteria were met. "The bill would authorize health care providers to collectively negotiate fee-for-service rates (with CalCare) of payment for health care items and services using a third-party representative, as provided. The bill would require the CalCare Board to annually determine an institutional provider's global budget, to be used to cover operating expenses related to covered health care items and services for that fiscal year, and would authorize payments under the global budget," (AB 1400, see Appendix A).

Existing state and federal programs in California would be affected if the legislation were fully implemented. AB 1400 would require the board of CalCare "to seek all necessary federal waivers, approvals, and agreements to allow various existing federal health care payments to be paid into CalCare, which would then assume responsibility for all benefits and services previously paid for with those funds," (AB 1400, see Appendix A).

This bill states the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for CalCare. The bill would create the CalCare Trust Fund in the State Treasury, as a continuously appropriated fund, consisting of any federal and state moneys received for the purposes of the act.

Finally, AB 1400 would prohibit specified provisions of this act from becoming operative until the Secretary of California Health and Human Services gives written notice to the Secretary of the Senate and the Chief Clerk of the Assembly that the CalCare Trust Fund has the revenues to fund the costs of implementing the act.

#### **Evidence From California**

#### **Healthy California Commission**

The Healthy California for All Commission<sup>5</sup> was established in 2019 to develop a plan for advancing progress toward achieving a health care delivery system for California that provides coverage and access through a unified financing system, including, but not limited to a single-payer financing system. According to the Commission, the concept of "unified financing" describes a state-wide system to arrange and assure health care in which:

- There is a standard package of health care services;
- The standard package of health care services would not be limited by demographic, employment, disability status, or income;
- Benefit distinctions between public programs and private plans would be eliminated within a system of unified financing.

In its first deliverable required by SB 104, the report<sup>6</sup> explores strengths and limitations of California's existing health care system and identifies areas for improvement. A future Commission report will provide key considerations to inform the design of a unified financing system, as proposed by AB 1400. The Commission's Report (originally scheduled for February of 2021), was delayed due to the COVID-19 pandemic.

#### Existing Data on California's Health Insurance Coverage and Financing

Californians receive health insurance from a range of public and private sources, which can change over time. Roughly half of Californians receive job-based coverage in 2020 based on their own employment or

<sup>&</sup>lt;sup>5</sup> Established by Senate Bill 104 (Chapter 67, Statutes of 2019).

<sup>&</sup>lt;sup>6</sup> https://chhs-data-prod.s3.us-west-2.amazonaws.com/uploads/2020/08/24133724/Healthy-California-for-All-Environmental-Analysis-Final-August-24-2020.pdf.

a family members' employee benefits (CHCF 2017). Approximately 5% of Californians purchase insurance through the individual insurance market through Covered California or purchased directly from an insurance carrier. Medicare provides coverage for most elderly (age 65 years or over) residents and those with disabilities under 65. Approximately 17% of Californians are covered by Medicare, VHA, military health care, and Indian health services. Medi-Cal provides coverage to another 23% of Californians who are eligible due to income or disability (CHCF, 2017). Approximately 3.2 million Californians are projected to be uninsured in 2022 (Dietz et al., 2021a), including the share of undocumented Californians who are covered through restricted-scope Medi-Cal and are not eligible for full-scope Medi-Cal coverage. Of the projected 3.2 million Californians who remain uninsured, 1.3 million are undocumented, and the majority of the remainder are eligible for Medi-Cal or Covered California with subsidies. According to the 2019 California Health Interview Survey, 50.4% of the uninsured report very good or excellent health status, whereas 61.2% of the insured report very good or excellent health status. The uninsured report higher levels of fair or poor health status (17.8%), whereas 12.1% of insured Californians report fair or poor health status.

California responded to the ACA by expanding Medi-Cal to low-income childless adults, parents earning 100%–138% federal poverty level (FPL), and by starting a state-based insurance marketplace, Covered California (Garrett and Gangopadhyaya, 2016). Federal policymakers expanded Medi-Cal eligibility to adults with incomes below 138% of the federal poverty level (about \$16,700 for a single adult) and lawful permanent resident immigration status for over 5 years through the ACA, with the federal government covering 95% of total costs for this group in 2020 and beyond. California independently decided to expand its Medi-Cal program using state funds to other populations, including people earning up to 138% FPL who do not meet the 5-year bar for lawful permanent residents, and undocumented immigrants up to age 26 years. Californians earning incomes between 138%–600% of the FPL can purchase health plans through Covered California using premium tax credits. Between 1.2 and 1.4 million enrollees have insurance through Covered California, with about 85% of enrollees receiving federal tax credits or subsidies (McConville, 2018). The recently passed American Rescue Plan Act (2021) provides additional tax credits and subsidies to people earning up to 400% FPL and new tax credits for those earning more than 400% FPL (Dietz et al., 2021b).

California uses available federal, state, and local funds to provide health insurance to some immigrant population groups, such as young unauthorized immigrant children and pregnant women. Some counties, have provided access to outpatient and inpatient care for all low-income residents (Gelatt et al., 2014). Many of California's counties offer basic health care for uninsured residents and undocumented immigrants through public hospitals or private providers. However, the program is not portable and not equivalent to insurance coverage (Rojas and Dietz, 2016; Healthy California For All Commission, 2020).

The health care safety net for low-income residents of California represents a "patchwork of programs and providers." (Newman and Roh, 2019). Many Californians have gained insurance coverage due to the implementation of the Patient Protection and Affordable Care Act (ACA) in 2014. Most lawful permanent residents earning less than 138% of the federal poverty level are now eligible for health care coverage through Medi-Cal, while those earning higher incomes have access to tax credits and subsidies designed to make health insurance more affordable through Covered California, California's health insurance exchange. While the federal government has provided the vast majority of funds for the Medi-Cal expansion, General Fund spending for Medi-Cal has increased by 5% annually, and currently constitutes about 17% of General Fund expenditures (McConville et al., 2017; Tatar and Chapman, 2019).

#### **Overall Estimates of Health Spending in California**

Based on National Health Expenditure (NHE) data, California spent \$295 billion on health care (more than any other state) in 2014.8 Unfortunately, NHE data is not updated at the state level on a yearly basis,

<sup>&</sup>lt;sup>7</sup> This estimate excludes Californians who are only eligible for emergency and pregnancy related services. It also excludes those are "dually eligible" for Medi-Cal and Medicare. It counts them in Medicare and other public.
<sup>8</sup> National Health Expenditures, 2014: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-

National Health Expenditures, 2014: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.

but applying the urban Consumer Price Index (CPI) to inflate the spending level of 2014 into 2021 dollars gives us a conservative sense of the possible magnitude of the state's current health care spending. From 2014 to 2021, CPI would add 11.9% to the \$295 billion spent in 2014, for a predicted total of \$330.7 billion from all sources in 2021. If we apply a historical growth rate from the NHE data (5.7% per year) to the 2014 total, the 2021 projected estimate increases to an upper bound of \$435 billion. Per capita spending in 2021 (based on an estimated 39.51 million residing in California) would be \$8,370 per year using CPI to calculate a lower-bound, or \$11,010 using historical 1991-2014 NHE growth as an upper-bound. National evidence indicates health care spending grew at a lower rate than 5.7% from 2014 to 2018, which suggests that the actual per capita spending on health care in 2021 for California lies between those two numbers (California HealthCare Foundation, 2020).

#### **Existing Data on Impact of Single-Payer Proposals in California**

Several bills have been introduced in California to create a single-payer system, including SB 562 (Lara) in 2017, SB 810 (Leno) in 2011, and SB 840 (Kuehl) in 2007. None of those bills were enacted, but each proposal and cost estimate is helpful for assessing the likely impact of AB 1400. Although there are differences between AB 1400 and the three bills summarized below (Table 1), the cost estimates for each bill provide a useful range of values when estimating the potential costs of implementing AB 1400. The overall health care spending in California is estimated to be \$330.7 billion or more in 2021 dollars (adjusted for inflation using CPI) so that the potential cost impact in 2021 for each bill can be compared to the current spending level and to assess the additional funds needed to implement each bill.

Table 1. Comparison of Previous California Single-Payer Bills

Bill Details	SB 840 (2007)	SB 810 (2011)	SB 562 (2017)
Summary	<ul> <li>Establishes the California         Healthcare System (CHS)         that would be administered         by a new agency under the         control of a new         Commissioner.</li> <li>The CHS would, on a single-         payer basis, negotiate for or         set fees for health care         services provided through         the system and pay claims         for those services.</li> </ul>	<ul> <li>Establishes the California         Healthcare System (CHS)         that would be administered         by a new agency under the         control of a new         Commissioner.</li> <li>The CHS would, on a single-         payer basis, negotiate for or         set fees for health care         services provided through         the system and pay claims         for those services.</li> </ul>	<ul> <li>Establishes the Healthy California (HC) program and would provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state.</li> <li>An appointed HC Board would govern the program.</li> </ul>
Populations Covered	All CA residents	All CA residents	All CA residents, regardless of immigration status
Benefits	<ul> <li>Designs benefit packages to provide a wider array of medical services than provided to many insured Californians under current law.</li> <li>Includes all medical care determined to be medically appropriate for an individual by their health care provider.</li> <li>Includes inpatient, outpatient, imaging, dental, vision, mental health, post-</li> </ul>	<ul> <li>Includes all medical care determined to be medically appropriate for an individual by their health care provider.</li> <li>Includes inpatient, outpatient, imaging, dental, vision, mental health, post-hospitalization nursing home care, prescription drugs, and more.</li> <li>Residents at or below 200% of FPL would be eligible for no-cost Medi-Cal and would</li> </ul>	Would cover a wide range of medical benefits and other services and incorporate the health care benefits and standards of other existing federal and state provisions, including the state's Children's Health Insurance Program (CHIP), Medi-Cal, ancillary health care or social services covered by regional centers for persons with

Bill Details	SB 840 (2007)	SB 810 (2011)	SB 562 (2017)
	hospitalization nursing home care, prescription drugs, and more.  Residents at or below 200% of the Federal Poverty Level (FPL) would be eligible for the type of benefits offered under the Medi-Cal program.	be entitled to not less than the full scope of benefits available under the Medi-Cal program.	developmental disabilities, Knox-Keene, and Medicare.  Includes all medical care determined to be medically appropriate for an individual by their health care provider.  Includes inpatient, outpatient, imaging, emergency services, dental, vision, mental health, nursing home care, prescription drugs, and more.
Copays and Deductibles	Not specified but would allow deductibles and copayments beginning in year 3	Not specified but would allow deductibles and copayments beginning in year 3	Members shall not be required to pay any form of cost sharing for covered benefits
Financing Mechanism	Means-based premiums from sources including employers, individuals, and government <sup>9</sup>	Means-based premiums from sources including employers, individuals, and government <sup>10</sup>	Revenue plan to be determined
Organization and Planning	<ul> <li>The Commissioner would seek all necessary waivers, exemptions, agreements, or legislation to allow various existing federal, state, and local health care payments to be paid to the CHS, which would then assume responsibility for all benefits and services previously paid for with those funds.</li> <li>Prohibits health care service plan contracts or health insurance policies from being issued for services covered by the CHS.</li> <li>A Payments Board would administer the finances of the CHS.</li> <li>A Premium Commission would determine the cost of the CHS and develop a premium structure for the system that complies with specified standards.</li> </ul>	<ul> <li>The Commissioner would seek all necessary waivers, exemptions, agreements, or legislation to allow various existing federal, state, and local health care payments to be paid to the CHS, which would then assume responsibility for all benefits and services previously paid for with those funds.</li> <li>Prohibits health care service plan contracts or health insurance policies from being issued for services covered by the CHS.</li> <li>A Payments Board would administer the finances of the CHS.</li> <li>A Premium Commission would determine the cost of the CHS and develop a premium structure for the system that complies with specified standards.</li> </ul>	<ul> <li>The HC Board would administer the program, including seeking all necessary waivers, approvals, and agreements to allow existing federal health care payments to be paid to the HC program, which would then assume responsibility for all benefits and services previously paid for with those funds; engaging and paying health care providers; authorizing program expenditures; and determining when individuals may start enrolling in the program.</li> <li>Prohibits health care service plans and health insurers from offering health benefits or covering any service for which coverage is offered to individuals under the HC program.</li> </ul>
Potential Cost Impact	\$210 billion (LAO estimate)	Unknown	Approximately \$400 billion (Senate Rules Committee

<sup>&</sup>lt;sup>9</sup> SB 1014: *Taxation: single-payer health care coverage tax* was introduced in February 2007 as a funding mechanism for SB 840 and proposed various taxes including on employers and employees. One of its provisions stated that it created "a health care coverage premium paid through the imposition of taxes on wages."

<sup>10</sup> There was no companion bill introduced in 2011 to create a funding mechanism for SB 810.

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Bill Details	SB 840 (2007)	SB 810 (2011)	SB 562 (2017)
in Year 1, at time of potential enactment	\$282 billion in 2016		estimate) \$331 billion in 2017
Potential Cost Impact in 2021 \$	\$311.4 billion, or \$7,880 per capita	Unknown	\$356.5 billion, or \$9,057 per capita

Source: California Health Benefit Review Program, 2021

#### Differences Between AB 1400 and Previous Single-Payer Attempts in California:

All three proposals above (SB 840 of 2007, SB 810 of 2011, and SB 562 of 2017) included comprehensive benefits, and attempted to achieve universal coverage for all California residents (including the undocumented) by redirecting revenues from individual and employer premiums, federal and state government programs, and taxes into a fund set aside for each proposed single-payer system. In some cases, the actual financing mechanism is vague or unknown, but in all three bills, a health care board would determine benefits and negotiate reimbursement rates for private providers. All three bills would require the state to negotiate waivers in Medicare and Medicaid to allow for the pass through of federal funds to the new single-payer system.

SB 562 did not propose any cost sharing or coinsurance for services received, whereas the other two bills allowed them in the third year of implementation. The financing mechanism for each bill varied, with SB 562 not including a specific financing plan, whereas SB 840 called for additional taxes on payroll, self-employed income, and unearned income. All analyses suggest that cost savings will be incurred due to simplification, administrative savings, and negotiated prices with providers. Although these savings do not fully offset new spending, they do reduce the need for additional revenue.

Revenue sources proposed by SB 840 included certain new taxes <sup>11</sup> and the redirection of funds from existing government programs. State payments for services would be paid directly to the state government system, which then bears responsibility for delivering all benefits, items, and services. Formulas would be established to ensure equitable contributions from all California counties and other local health jurisdictions by a Commissioner.

Under the SB 840, physicians and other individual providers (such as dentists) generally would be compensated for their services by the single-payer system as fee-for-service providers or as providers employed by, or under contract with, health care systems that provide comprehensive coordinated services, such as Kaiser Permanente or potentially other medical practice groups.

SB 840 would establish budgets for hospitals, certain clinics, and medical provider groups, such as independent practice associations or Kaiser Permanente. These budgets would include components for operating expenses and capital expenditures.

The LAO (2008) cost estimate for SB 840 indicated that that the bill would result in a net shortfall of \$42 billion in 2011–2012 (the first full year of operations) and \$46 billion in 2015–2016. These shortfalls resulted largely from a faster rate of growth for health benefits costs relative to the single-payer program revenues.

The University of Massachusetts, Amherst, Political Economy Research Institute (PERI) provided an economic analysis of the proposed measure. The authors (Pollin, et al., 2017) estimated that through

<sup>&</sup>lt;sup>11</sup> SB 840 provides for taxes on payrolls, self-employed income, and unearned income.

implementation of Healthy California (SB 562), overall costs of providing full health care coverage to all Californians could fall by about 18% relative to spending levels under the existing system. There would have been two broad areas of cost saving under Healthy California. The first is a set of structural changes in the areas of: 1) administration; 2) pharmaceutical pricing; and 3) fee structures for service providers. PERI estimated that overall utilization would have risen by 12% under SB 562.

PERI's report suggests that two new taxes could be used to generate the revenue required to offset the loss of private insurance spending: a gross receipts tax of 2.3% and a sales tax of 2.3% (Pollin et al., 2017). However, SB 562 did not explicitly create a funding mechanism.

However, the California Senate Committee on Appropriations estimated that if the bill was financed "through a new payroll tax (with no cap on wages subject to the tax), the additional payroll tax rate would be about 15 percent of earned income." (McCarthy, 2017). Regardless, any analysis of the bill is necessarily speculative and incomplete; the way that California would actually finance its health care system if SB 562 was enacted is entirely ambiguous.

The second assumption on how SB 562 would be financed is through reductions of inefficiency in the current multipayer system. PERI assumed that reductions in unnecessary services, inefficiently delivered services, missed prevention opportunities, and fraud would save roughly 5%.

PERI also estimated the long-term care services that would be covered under AB 1400 in a follow-up study to SB 562. These include, among others, nursing homes, home health care services, rehabilitation, and personal care. Within the CMS Health Consumption Expenditures accounts, spending in these areas are mostly covered within the two categories of nursing home services and home health care. In 2017, spending in these two categories totaled to \$265 billion, that is, nearly 8% of all Health Consumption Expenditures.

Given such uncertainties in coverage within SB 562, Pollin and his co-authors believed it "is prudent to allow, as a high-end approximation, that long-term care spending under Medicare for All will increase by the same 12 percent level that we have applied for other categories of Health Consumption Expenditures (Pollin et al., 2018)."

On the whole, the PERI analysis predicted that although SB 562's single-payer system would be expensive, its cost in taxes would ultimately be cheaper than the costs that Californians currently pay to private insurers. The study did not, however, analyze the effects of SB 562 on employment. Impacts on employment would impact the state's tax base and other revenues (Pollin et al., 2017).

The Senate Committee on Appropriations analysis predicted total annual costs of about \$400 billion per year, including all covered health care services and administrative costs, at full enrollment. PERI, on the other hand, estimated, "The overall annual costs of this single-payer system for California would be \$331 billion as of 2017," and \$356.5 billion in 2021 dollars.

The range of cost estimates varies from \$7,200 to \$9,057 per person in 2021, suggesting that the overall amount spent by AB 1400 is lower than average spending on health care each year throughout the United States from all payers.

The Lewin Group (2002) prepared analyses of multiple health care reform options for the state of California, ranging from Medi-Cal expansion to single payer. Their single payer modeling indicated between \$9.6 billion to \$14.4 billion in new spending would occur due to new utilization of acute and long-term care in 2002. Adjusting for inflation, that is the equivalent of \$14.2 to \$21.3 billion dollars in 2021. The Lewin Group report also calculated cost offsets to finance the three single payer reform proposals, which included tobacco taxes, payroll taxes, income taxes, taxes on unearned income, and administrative efficiencies (Lewin Group, 2002).

#### **Evidence From Other State Single-Payer Proposals**

Nine states currently have single-payer proposals under consideration. Four of the nine states are in New England. Connecticut's 2021 Regular Session proposal 12 would establish a self-insured universal single-payer health care program that operates on a fee-for-service basis with individual providers. It would be funded through taxation in lieu of premiums and would request a waiver from the federal government pursuant to Section 1332 of the ACA. Similarly, Rhode Island's proposal 13 proposed a universal single-payer health care insurance program (Rhode Island Comprehensive Health Insurance Program, RICHIP), modeled as a "Medicare-for-all" type of program. The proposal would be funded through the consolidation of government and private payments to insurance carriers. Massachusetts also has an introduced bill in the 2021–2022 Regular Session, HD 2656/SD 546, which would establish a Medicare for All Program in the state, establishing the Massachusetts Health Care Trust. 14 Vermont's H 276, introduced in the 2021–2022 Regular Session, would implement a publicly financed health program for all residents over time. HB 602, introduced in the 2021 Texas Legislature, would provide comprehensive health care benefits coverage through a publicly funded program called the Healthy Texas Program. Maryland's HB 534, introduced in the 2021 Regular Session would establish a state Program to provide comprehensive universal health coverage for every resident and be funded by certain revenue.

Virginia, Washington, and Hawaii have introduced studies (Virginia HB 2271) or created commissions (Washington State SB 5399) or pilot programs (Hawaii SB 2980/ SB 3128),

#### IMPACT OF AB 1400 BASED ON EXISTING EVIDENCE

#### **High-Level Meta-Analysis**

A high-level meta-analysis <sup>15</sup> (Cai et al., 2020) identified 22 modeled predictions (over the past 30 years) of the cost of single-payer financing in the United States. This analysis focused on the cost estimates of single payer financing proposals, but did not consider financing or revenue plans. Cai et al. found that 19 of the 22 studies (86%) predicted net savings during the first year of operation, with a range of 7% higher net costs to 15% lower net costs. The range of cost increases due to insurance coverage improvements resulting in higher use of services ranged between 2% and 19%. Simplification of payment administration, reduced prescription drug costs, and other components resulted in net savings of 3% to 27%. Overall, the authors estimated that net savings averaged 1.4% per year.

Net financial impacts during the first year of single-payer implementation ranged from a 7.2% increase in costs to a 15.5% decrease (net savings. The study found the median value was 3.5% in net. They also found that 19 of the 22 plans would result in savings. Higher use of health services increased costs by 2.0% to 19.3% (with a median of 9.3%) and offsetting savings due to simplification, lower drug costs, and other cost reductions ranged from 3.3% to 26.5% (with a median of 12.1%) in net savings (Cai et al., 2020). The costs and savings varied by the number of newly insured people, benefit generosity, increase use of services and cost sharing decisions.

All 22 studies predicting savings due to simplified payment administration (ranging from 1.2% to 16.4%, with a median of 8.8%). Other sources of savings were lowered prices for medications and durable medical equipment, reduced fraud and waste, and lowering prices based on Medicare payment rates (Cai et al., 2020).

Current as of April 22, 2021

<sup>&</sup>lt;sup>12</sup> HB 5340 has been introduced in the Connecticut 2021 Regular Session.

<sup>&</sup>lt;sup>13</sup> Senate 233 has been introduced in the Rhode Island 2021 Regular Session.

<sup>&</sup>lt;sup>14</sup> The Trust would establish health care taxes on employers, workers, and residents that will replace spending on insurance premiums and out-of-pocket spending for services covered by the Trust,

<sup>&</sup>lt;sup>15</sup> A meta-analysis is a statistical method combining the results of several scientific studies that focus on the same question.

Over a longer time horizon of ten years, projected net savings increase for all 22 models, even in the three estimates for proposals that had net costs in the first year. (Cai et al., 2020).

Table 2: CBO and Urban Institute Analyses of Similar Single Payer Proposals

Name	Population Expected to Enroll	Estimate of Total Spending	Year of Analysis	Benefits/ Comprehensiveness	LTSS Included	Excluded Groups
CBO Option 5	All US residents	\$6.92 trillion in 2030	2019, 2020	Comprehensive	Yes, SNF and LTSS	None
Urban Institute, Reform 8	All US residents	\$4.22 trillion in 2020	2019	Comprehensive	Yes, LTSS	None

Source: California Health Benefits Review Program, 2021.

Key: CBO, Congressional Budget Office; LTC, long-term care; LTSS, long-term services and support; SNF, skilled nursing facility.

#### LONG TERM CARE

#### AB 1400 and Long Term Care

AB 1400 would greatly enhance the coverage for long-term care services throughout the state, but it would not only cover the costs from existing payers, it is likely to subsidize families providing caregiving on their own who do not benefit from one of the existing coverage programs (Medi-Cal, Medicare, or private long-term care insurance) or social services programs (e.g., In-Home Supportive Services). Because long-term care is not a traditional benefit for employer-based or private individual market plans, the change in service use and spending would be sizable if AB 1400 were implemented.

AB 1400 would have to consolidate the roughly \$25 billion per year spent by Medi-Cal and Medicare, provide additional funding to address self-pay services <sup>16</sup>, private long-term care insurance, and the gaps in services that people cannot easily access. In addition, all of the funding allocations for social services and developmentally disabled programs might need to be consolidated under the health care umbrella for AB 1400 to be efficient. The actual cost of private long-term care insurance premiums and self-payment by long-term care users who are not receiving custodial care through Medi-Cal or rehabilitative care through Medicare is unknown.

If someone is eligible for Medi-Cal due to the cost of skilled nursing care effectively lowering their income, they are considered to have a share of cost. The share of cost is the amount paid by individuals on Medi-Cal for their skilled nursing services, and are not currently borne by the Medi-Cal program itself.

<sup>&</sup>lt;sup>16</sup> Self-pay is another significant source of spending for long-term care services. Families also "spend down" due to expensive long-term care needs, meaning they expend so much of their family income and savings that they become eligible for Medi-Cal for the remainder of their custodial long-term care service needs. Having a comprehensive long-term care benefit may be expensive, but it will drastically improve the ability of families to retain savings and alleviate the economic burden that often falls upon children and spouses of individuals needing long-term care services.

#### **Analyses of Federal Single Payer Options**

Recent analyses of multiple single-payer model approaches by the Congressional Budget Office (CBO) and Urban Institute provide estimates of cost and insurance impacts in the United States. Two of the models selected by CBO and Urban Institute are comparable to AB 1400, and the results from the CBO and Urban Institute models are instructive for those assessing the feasibility and cost of AB 1400.

In December of 2020, CBO modeled five illustrative options for single payer based on a Medicare for All approach. The model results varied due to differences in providers' reimbursement rates, patients' cost sharing, and the coverage of LTSS. CBO estimated how these five approaches could impact the federal budget in 2030 and assessed other outcomes. One of the options produced by the CBO (Reform 5) is quite similar to the underlying direction of AB 1400. Reform 5, as scored by the CBO is a single-payer program with additional benefits and no cost-sharing. It eliminates all cost-sharing requirements, adds adult dental, vision, hearing, and LTSS benefits. It also assumes high payment rates to providers and drug companies. This option covers all U.S. residents, including undocumented immigrants. National spending on health care would grow by approximately \$290 billion in 2020. Based on California's share of national health spending (11.39%) according to the 2014 Health Expenditure data, California's health spending would be projected to increase by \$33 billion in 2020 (or \$33.46 billion in 2021 dollars).

The CBO projected that the percentage of revenues spent on administration by hospitals would decrease by 7 percentage points (from 19% to 12%). Relatedly, physician administrative costs as a share of revenue would decrease from 15% to 9% (a 6% percentage point decrease). In addition, it estimated that physicians would spend 4.8% fewer work hours and nurses would spend 18.4% fewer work hours. These assumptions build on a large evidence base showing high administrative overhead among U.S. health care providers relative to other nations (Bruenig, 2020).

In October of 2019, the Urban Institute estimated the effects of eight varying health care reform options. The analysis uses their Health Insurance Policy Simulation Model (HIPSM)<sup>17</sup> and new Medicare simulation model, MCARE-SIM, and the Dynamic Simulation of Income Model (DYNASIM).

CHBRP's summary focuses on the Urban Institute's analysis of a comprehensive single-payer reform similar to the Medicare for All Act of 2019. This is called Reform 8: "Single-payer with enhanced benefits and no cost-sharing requirements," (Blumberg et al., 2020). This option includes all U.S. residents, eliminates all cost-sharing requirements, and adds adult dental, vision, hearing, and LTSS benefits (Blumberg et. al., 2019). The LTSS benefits modeled were likely less generous than those proposed in AB 1400.

Table 3: Urban Institute's Estimates of "Reform 8 Single Payer with Enhanced Benefits and No Cost Sharing"

	Health Care Spending (Billions)		
Current Law	Federal	State	National
ACA	1,284.3	302.3	3,496.8
Single Payer enhanced with broad benefits and no cost sharing	4,128.9	42.7	4,216.5

Source: Urban Institute, 2019

Current as of April 22, 2021 <a href="https://www.chbrp.org">www.chbrp.org</a> 15

<sup>&</sup>lt;sup>17</sup> HIPSM is a detailed microsimulation model of the U.S. health care system designed to predict the cost and insurance coverage impacts of proposed health care policy reforms.

# **Estimating Changes in Payment for Services Based on Reimbursement Levels and Changes in Utilization**

Over recent decades, numerous studies focused on the U.S. case have shown that people do vary their utilization of health care, at least to some degree, depending on how much they must pay out-of-pocket for their care. Perhaps the most well-known study of this issue is the RAND Health Insurance experiment. This project was conducted between 1974 and 1982. During those years, nearly 6,000 U.S. households were given health insurance, but with different arrangements with respect to cost sharing. The experiment showed that health care use and individual spending tended to fall as the amount of cost sharing increased (Manning, et al., 1988). Following from the results of the RAND study and subsequent relevant literature, we would expect average health spending to increase if cost sharing were reduced, as proposed in the draft legislation for the Healthy California program.

But that then raises the more precise question — that is, *how much* would we expect utilization rates to rise through the CalCare program, relative to current utilization rates, especially among the uninsured and underinsured? The extensive literature that has emerged following from the RAND study is highly informative here. Some of this subsequent literature, building from the RAND study, has utilized additional data and modeling assumptions, to produce a broad finding that, on average, a 10% increase in out-of-pocket costs would be associated with a 2% decrease in health expenditures. Conversely, this result suggests that a 10% decrease in out-of-pocket costs would be associated with a 2% increase in health expenditures.<sup>18</sup>

#### **Impact on Provider Supply and Hospitals**

Total spending on health care would be lower if provider payment rates under a single-payer system were set at Medicare FFS rates rather than at a higher level, such as average commercial health insurance reimbursement rates. However, Medicare rates are higher than Medi-Cal rates. Setting payment rates equal to Medicare FFS rates under a single-payer system would reduce the average payment rates most providers receive. If Medicare rates were not sufficient to cover the actual cost of delivering services for a provider, such a reduction in provider payment rates could result in providers leaving the market (closing practices, relocating to other states, or trying to provide care outside of the single-payer program), reducing services, and reduce the quality of care (Ellis and McGuire, 1986; Rice, 1997). It could also result in providers attempting to bill for more services with a low marginal cost to generate additional revenue. Studies have found that increases in provider payment rates lead to a greater supply of medical care, whereas decreases in payment rates lead to a lower supply. However, those studies are based only on changes in Medicare's payment rates in our existing multipayer system. These results may not be relevant for a single-payer system because of the lack of ability to avoid certain lower-paying patients or payers. Provider responses to payment changes are challenging to predict under a state-based singlepayer system because providers might be able to offset losses in one payer by increasing their rates for other payers or seeing more patients from other payers in a multipayer system. Those opportunities would no longer exist in a single-payer system (CBO, 2019).

#### Legal and Financial Hurdles for State Single-Payer Health Care

To finance these universal and comprehensive benefits, state single-payer bills use several strategies similar to AB 1400 to capture health expenditures from the existing multi-payer system, while navigating a number of financial and legal impediments. The state bills combine federal funds from Medicare, Medicaid, and the ACA marketplace tax credits and cost sharing reductions into the single-payer plan using waivers in those federal programs (Wiley, 2018). The U.S. Department of Health and Human Services (DHHS) has substantial flexibility over approving or negotiating state waivers in Medicaid,

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<sup>&</sup>lt;sup>18</sup> At the same time, several studies have raised significant concerns with respect to relying on a single, static estimate of the relationship between out-of-pocket expenditures and overall health care spending. For instance, it has been shown that the extent to which people will alter their health care utilization rates will be responsive to the specific types of cost-sharing arrangement being used.

Medicare, and Section 1332 of the ACA. However, proposed legislation usually does not have substitute revenue to "fall back" on were the agency to deny the waivers. Instead, the waiver's failure would typically undermine the ability to deliver the single-payer program as proposed. State budget rules often harm a state's ability to maintain spending levels during economic recession or downturn (Bagley, 2017). That means that without a series of federal waivers related to Medicare, Medicaid, and Affordable Care Act requirements and federal funding, the revenues to support AB 1400 will not exist at the state level.

State single-payer proposals also face challenges in redirecting premiums for employer-sponsored health plans due to the Employee Retirement Income Security Act (ERISA) (KFF, 2019b). ERISA pre-empts all state laws that "relate to" employer-sponsored benefits, such that "states cannot simply mandate that employers cease offering health benefits," (Gaffney et al., 2021). States do retain broad power to regulate health care providers and health insurers, but ERISA preempts the application of state insurance regulations to employers' self-funded health plans, which now comprise more than 60% of all employer-sponsored health benefits (KFF, 2019b). ERISA challenges states' abilities to capture employer health spending — a source of funding that would be critical to the viability of a single-payer system.

The labyrinth of ERISA pre-emption has inspired creative drafting of state single-payer bills to do indirectly what ERISA prohibits them from doing directly (Fuse Brown and McCuskey, 2019). State single-payer proposals appear to use three strategies for state bills to capture employer health spending and shift employees into the state single-payer system:

- Payroll taxes on employers;
- Income taxes on employees; and
- Restrict providers from accepting reimbursement from private insurance companies.

Nearly all states' bills include one of these strategies; most include a combination of them.

#### KEY CONSIDERATIONS AND UNKNOWNS

CHBRP's analysis is not intended to make recommendations regarding the appropriateness or feasibility of AB 1400. However, in reviewing the analyses and evidence from numerous studies, CHBRP offers these key considerations and remaining unknown impacts to inform the Legislature.

### **Integration Considerations**

Plan Design in AB 1400 that eliminates premiums and cost sharing will likely need to secure offsets. This could be accomplished via increased tax revenue, lower payments to providers, or some other funding mechanism. Premiums and cost sharing account for a substantial portion of health care expenditures today. Eliminating cost sharing may improve access to care and consumer affordability, but could increase costs due to greater use of services and ultimately compromise long-term sustainability. Findings from the RAND Health Insurance experiment and more recent work on the impact of cost sharing and coinsurance in reducing the use of health care suggest that removing cost barriers through a single-payer system could trigger new use to be paid for by the system. Much of that use may be necessary, but it is not currently occurring or is being delayed due to cost barriers for a segment of the population. In addition, reduced premiums are likely to draw new enrollees into the health care system, so that they have increased access to care in contrast to being uninsured (MACPAC, 2015).

**Provider Impact and Hospitals.** Although a single-payer system allows for private providers to continue operating as private entities, the payment sources will be limited to the new CalCare single-payer program. Currently, hospitals and health care providers negotiate reimbursement rates with private insurance companies (including Medicare Advantage and Medi-Cal managed care plans), receive lower, fee-schedule-based payments from fee-for-service Medicare and Medicaid, and also receive cost sharing

payments from insured patients, and partial or full payment for self-pay services from uninsured or out-of-network patients. Consolidating all Californians under one single-payer system would require price setting that takes the previous multipayer rates into consideration, adjusts them downward to address administrative efficiencies, and pays hospitals and providers a new, blended payment rate for services rendered or people cared for.

A single-payer health care system in California could help the state meet a number of goals — universal health care coverage, comprehensive benefits, increased equity, greater access and quality, improved affordability, lower administrative costs, and slower growth in health care costs (CHCF, 2017).

#### **Fiscal Uncertainties**

The ability to manage costs is predicated on a single government entity budgeting for the health care costs of a single risk pool that has the potential to centrally impose cost controls. If that single risk pool is less than universal, market forces will limit its reach, potentially undermining the ability to address consumer affordability, at least for some consumer segments. It may be difficult to achieve system wide access and quality goals if a substantial portion of the population is excluded from the single-payer program. For example, the Medicare population accounts for 14% of the California population and is responsible for about 20% of total state health care spending — it may be difficult to see system-wide improvements if this population is excluded and program goals are not well aligned.

California's ability to collect sufficient dollars to fund a single-payer system and its ability to aggregate and direct funds currently devoted to health care within the state depends on robust revenues. States, unlike the federal government, cannot operate with a budget deficit. Therefore, the ability to ensure that revenue trends keep pace with health care cost trends is a fundamental concern for a state-based, single-payer program. Any external factor that reduces expected revenues in a given year, or increases unpredictability of revenues or costs, could jeopardize program sustainability.

Health spending (the sum of public and private spending, including personal out-of-pocket spending by consumers) under a single-payer system could increase or decrease, depending on the extent to which:

- Health care benefits improve relative to currently available coverage;
- Utilization of health care services increases due to reduced out-of-pocket costs and additional insured people;
- · Reduced provider reimbursement rates; and
- Administrative costs of health insurance and health care delivery can be reduced.

The productivity of the health care workforce and administrative costs in health care delivery and health insurance impact total expenditures devoted to health care.

#### **Administrative and Legal Questions**

#### Revenues:

CHBRP assumes federal revenues via a waiver agreement.

The bill does not establish the revenue model for financing AB 1400. The Legislature pledges to enact legislation that would develop a revenue plan to fund AB 1400, with considerations for federal revenue available to support CalCare. CHBRP assumes those federal revenues would be obtained through subsequent waivers of Medicaid (Section 1115), Medicare, and ACA (Section 1332) requirements and regulations such that California would rely on federal matching revenue and financing based upon the current federal share of funding for Medicaid, Medicare, and Covered California tax credits and subsidies. In addition, California would need to leverage potential savings from the implementation of AB 1400 such that the federal cost of Medicaid, Medicare, and Covered California plan tax credits would decrease, allowing federal savings to be allocated to California for the purposes of financing the single-payer

system. The federal government would also receive previously foregone tax revenues from individuals and employers who were receiving tax-exempt or tax-deductible employee health benefits. While California would receive a share of tax revenues on newly taxable payroll or income through state taxes, a substantial amount of revenue would be collected by the federal government. The state would benefit from capturing those funds to ensure they flowed into the CalCare program through one of the federal waivers mentioned above. AB 1400 also requires that all state revenues from CalCare would be placed in an account within the CalCare Trust Fund Account. CHBRP is aware of existing provisions in the state's Constitution that affect the California's ability to raise and spend revenues. Two additional legal considerations raise additional uncertainties.

The first legal consideration is regarding Proposition 4 of 1979. Proposition 4 established a constitutional limit on spending known as the "Gann Limit." The Gann Limit was later updated by Prop. 98 of 1988 and Prop. 111 of 1990. According to the state Senate Appropriations Committee analysis of SB 562, "the very large tax revenues that this bill would require…would clearly exceed the Gann Limit." While CHBRP does not provide legal analysis, overcoming this obstacle may require California voters to repeal the Gann Limit or exempt new single-payer-related taxes from the limit, as the Senate Appropriations Analysis of SB 562 suggests. AB 1400 would it seem, offer similar interactions with the Gann Limit as SB 562 did.

The second legal consideration is Proposition 98 of 1988 (which was subsequently modified by Prop. 111 of 1990). Prop. 98 amended the constitution to require a minimum level of funding for K-12 schools and community colleges. The state Senate Appropriations Committee analysis of SB 562 (McCarthy, 2017) stated taxes raised to support the single-payer program would be "considered the proceeds of taxes and would be subject to the requirements of Proposition 98." Prop. 98 would require some of the new tax revenues raised by SB 562 (or the proposed AB 1400) would have to support to K-12 education and community colleges. If voters wanted funds to go directly to the state single-payer program, California voters would have vote to change the funding guarantee in Prop. 98 or explicitly exempt the new taxes from Prop. 98-eligible tax revenues.

#### **Other Uncertainties**

The scale and challenge of the implementation of AB 1400 may result in unanticipated impacts in the following categories:

- Reduced investment in hospital capacity/investment if provider rates are set lower than costs;
- Reduced technology adoption;
- Disruption and upheaval in health care workforce (including IT, insurance...)/ loss of jobs; and
- Reductions in health care workforce pay.
- Changes in provider reimbursement rates in a single-payer system could have long-term effects
  on provider supply. If provider reimbursement rates were significantly lower, people could decide
  not to enter the medical profession or locate in California. Supply of hospitals and health care
  facilities could decline due to closures, or investments in facility improvements or construction
  might be limited. If health care prices decreased, additional Californians gained coverage, and
  cost sharing was eliminated the state could face shortages due to increased demand for services
  and fewer providers.
- Consumer protections: It is unclear whether CalCare would be subject to existing consumer protections, including existing Medicaid due process rights and other Medicaid protections as well as the consumer protections to which seniors and others are entitled under Medicare. It is unclear whether the federal waivers would waive or preserve existing Consumer protections under Medicaid and Medicare. Although the statutes would stay in place, it is unclear whether CalCare would need to abide by the state standards developed over many decades. Although AB 1400 acknowledges that consumers need timely access to care, AB 1400 would need to adapt existing bodies of law to ensure a long list of consumer protections continue.
- Integrated care and salaried providers: As drafted, AB 1400 appears to eliminate integrated care delivery systems and rely exclusively on fee-for-service. It allows a group practice, county

- organized health system (COHS), or local Medi-Cal managed care initiative to be paid on a salaried basis but does not clarify the role of these entities in the new single-payer health system envisioned by AB 1400.
- Other consequences of AB 1400 could include the need to develop new information technology to administer the program. This new information technology could cost billions of dollars according to estimates from the California Senate Committee on Appropriations (See Senate Committee on Appropriations Analysis of SB 562 in 2017 [McCarthy, 2017]).

#### CONCLUSION

CHBRP's synthesis of evidence provides policymakers with some consensus estimates of costs and potential savings, and details many of the implementation questions and uncertainties that all states would experience in implementing legislation as complex as AB 1400. In addition, CHBRP's also highlights some of the unique legal and financial constraints that California would face if it enacted AB 1400.

#### **Implementation Considerations**

The meta review and other studies suggest that single-payer health care would reduce financial burden, increase efficiency, and result in net savings. An initial net cost reduction (3%-4%) is estimated to grow over time, resulting in longer-term savings over 10 or more years. This uncertainty around immediate benefits, however, creates significant challenges for state implementation, in particular. The evidence illustrates that maximizing performance and savings will require a very complex and intensive undertaking.

Further, to achieve the cost reductions identified in the studies CHBRP reviewed of single-payer proposals, payment processes should be simplified, drug prices reduced, and data used to reduce inappropriate or improper care and payment (Cai et al., 2020). All of these are enormously challenging undertakings. The authors of the Cai et al. (2020) meta-analysis note that "the logical next step is real-world experimentation, including evaluation and refinement to minimize transition costs and achieve modeled performance in reality."

Considerable research and analysis has highlighted some of the potential benefits, pitfalls, and uncertainties for states considering single-payer proposals. Some of the key uncertainties facing policymakers in considering AB 1400 include the following:

It may be difficult to achieve system-wide access and quality goals if a substantial portion of the population is excluded from the single-payer program. Similarly, single-payer design notions that eliminate or reduce premiums and cost sharing would need to secure offsets. The ability to manage costs is predicated on a single risk pool that has the potential to centrally impose cost controls.

On the funding side, there is substantial uncertainty about California's ability to collect sufficient dollars to fund a single-payer system and its ability to aggregate and direct funds currently devoted to health care within the state.

Other potential concerns are economic in nature, but also impact current health care delivery. Disruption to the state's health care workforce, safety net providers, integrated health care systems, health care providers, insurers, and residents may be significant. Uncertainties in capital needs and funding may dampen investments in innovation, technology, and public health, during an extended period of uncertainty.

As the body of literature demonstrates, there are legal and financial hurdles for state single-payer legislation, such as AB 1400. Successful implementation of CalCare would require the consolidation of

federal funds from Medicare, Medicaid, and the ACA exchanges into the state single-payer plan using waiver provisions in those federal programs. Proposed state single-payer plans generally lack fallback plans for capturing federal funds should the federal government deny the waivers. In addition, state constitutional prohibitions on deficit spending, constrain state plans when tax revenues fall during economic recession.

The scale and risks of managing hundreds of billions of dollars in health care spending provide a live experiment with opportunity but also unanticipated risks and costs. CHBRP is aware of existing provisions in the state's Constitution that affect the California's ability to raise and spend revenues. The CBO (2020) itself noted that "a high degree of uncertainty surrounds its own estimates. That uncertainty stems from many factors, including estimates of how providers and patients would respond to the single-payer system, administrative costs under the system and under current law, how regulations and other administrative actions following enactment of the legislation creating the system would affect costs, health care spending and economic conditions in the future under current law, spending on certain components of health care today, and after effects of the current coronavirus pandemic.

New health care utilization might be induced by lower copays/deductibles/patient cost (and the removal of utilization management. This would create financial and access challenges. The CBO projected that some offsets may be achieved in hospital costs, as the share of revenues that hospitals spend on administration may fall under a single-payer system. Similarly, physicians' and other health care providers' administrative overhead may fall, and physicians and nurses could spend less time on administrative activities.

#### **Long-Term Care Conclusions**

Although spending information from Medicare and Medicaid on custodial and rehabilitation-related long-term care is available, there is limited information on the informal caregiving, private long-term care insurance premium costs and spending, and out-of-pocket costs for individuals and families. Therefore, it is difficult to predict the monetary impact of expanding long-term care coverage beyond what Medicare and Medicaid currently provide. There is no available evidence to estimate the level of pent-up demand for publicly-funded long-term care services there might be were AB 1400 to be enacted. Therefore, it is challenging to assess the level of long-term care supply that would be needed to quickly respond to pent-up demand and new demand for long-term care services due to the expansion of benefits proposed by AB 1400.

#### **Upfront Reserve Estimate**

Overall health care spending in California is estimated to be between \$284 billion and \$358 billion in 2021 dollars. Spending is likely to increase due to comprehensive of benefits and reduced cost sharing, which means utilization will increase too. Some estimates suggest another \$33 billion in spending due to the removal of cost sharing and demand for services increasing. Given the need to spend state dollars to leverage federal matching funds, and the new spending projected, CHBRP estimates that 50% of the current estimated health care spending plus the additional spending due to the implementation of AB 1400 should be placed in a reserve fund to ensure benefits can be offered to California residents. That amounts to \$158.5 billion to \$195.5 billion in reserves.

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#### APPENDIX A TEXT OF BILL ANALYZED

On March 3, 2021, the California Assembly Committee on Health requested that CHBRP analyze AB 1400. CHBRP has included the bill summary, below. For the full bill language text, you may access it at: <a href="https://chbrp.org/completed">https://chbrp.org/completed</a> analyses/index.php.

Introduced by Assembly Members Kalra, Lee, and Santiago
(Principal coauthors: Assembly Members Chiu and Ting)
(Principal coauthors: Senators Gonzalez, McGuire, and Wiener)
(Coauthors: Assembly Members Friedman, Kamlager, McCarty, Nazarian, Luz Rivas, and Wicks)
(Coauthors: Senators Becker, Cortese, Laird, and Wieckowski)

February 19, 2021

An act to add Title 23 (commencing with Section 100600) to the Government Code, relating to health care coverage, and making an appropriation therefor.

#### LEGISLATIVE COUNSEL'S DIGEST

AB 1400, as introduced, Kalra. Guaranteed Health Care for All.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. PPACA defines a "qualified health plan" as a plan that, among other requirements, provides an essential health benefits package. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

This bill, the California Guaranteed Health Care for All Act, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. The bill, among other things, would provide that CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state provisions, including the federal Children's Health Insurance

Program, Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program. The bill would require the board to seek all necessary waivers, approvals, and agreements to allow various existing federal health care payments to be paid to CalCare, which would then assume responsibility for all benefits and services previously paid for with those funds.

This bill would create the CalCare Board to govern CalCare, made up of 9 voting members with demonstrated and acknowledged expertise in health care, and appointed as provided, plus the Secretary of California Health and Human Services or their designee as a nonvoting, ex officio member. The bill would provide the board with all the powers and duties necessary to establish CalCare, including determining when individuals may start enrolling into CalCare, employing necessary staff, negotiating pricing for covered pharmaceuticals and medical supplies, establishing a prescription drug formulary, and negotiating and entering into necessary contracts. The bill would require the board to convene a CalCare Public Advisory Committee with specified members to advise the board on all matters of policy for CalCare. The bill would establish an 11-member Advisory Commission on Long-Term Services and Supports to advise the board on matters of policy related to long-term services and supports.

This bill would provide for the participation of health care providers in CalCare, including the requirements of a participation agreement between a health care provider and the board, provide for payment for health care items and services, and specify program participation standards. The bill would prohibit a participating provider from discriminating against a person by, among other things, reducing or denying a person's benefits under CalCare because of a specified characteristic, status, or condition of the person.

This bill would prohibit a participating provider from billing or entering into a private contract with an individual eligible for CalCare benefits regarding a covered benefit, but would authorize contracting for a health care item or service that is not a covered benefit if specified criteria are met. The bill would authorize health care providers to collectively negotiate fee-for-service rates of payment for health care items and services using a 3rd-party representative, as provided. The bill would require the board to annually determine an institutional provider's global budget, to be used to cover operating expenses related to covered health care items and services for that fiscal year, and would authorize payments under the global budget.

This bill would state the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for CalCare. The bill would create the CalCare Trust Fund in the State Treasury, as a continuously appropriated fund, consisting of any federal and state moneys received for the purposes of the act. Because the bill would create a continuously appropriated fund, it would make an appropriation.

This bill would prohibit specified provisions of this act from becoming operative until the Secretary of California Health and Human Services gives written notice to the Secretary of the Senate and the Chief Clerk of the Assembly that the CalCare Trust Fund has the revenues to fund the costs of implementing the act. The California Health and Human Services Agency would be required to publish a copy of the notice on its internet website.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

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The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP Faculty Task Force comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are Task Force Contributors to CHBRP from UC that conduct much of the analysis. The CHBRP staff works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, Milliman, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The National Advisory Council provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at www.chbrp.org.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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# Filling the Coverage Gap: Policy Options and Considerations

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As of April 2021, 12 states (https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/) have not adopted the Affordable Care Act (ACA) provision to expand Medicaid to adults with incomes through 138% of poverty. In these states, 2.2 million uninsured people with incomes under poverty fall in the "coverage gap" (https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/) and do not qualify for either Medicaid or premium subsidies in the ACA marketplace (See Appendix Table). An additional 1.8 million uninsured adults in these states are currently eligible for marketplace coverage (because their incomes are between 100% and 138% of poverty level) but would be eligible for Medicaid if their state expanded.

The federal government covers 90% of the cost of Medicaid coverage for adults covered through the ACA expansion, a higher share than it does for other Medicaid enrollees. The American Rescue Plan Act (ARPA) (https://www.kff.org/medicaid/issue-brief/medicaid-provisions-in-the-american-rescue-plan-act/) enacted in March 2021 includes an additional temporary fiscal incentive (https://www.kff.org/medicaid/issue-brief/new-incentive-for-states-to-adopt-the-aca-medicaid-expansion-implications-for-state-spending/) for states to newly implement the ACA Medicaid expansion, and KFF analysis shows that all non-expansion states would actually save money for two years by newly expanding. The incentive would be available for two years following expansion, but there is no time limit for states to take up the option. It is unclear which (https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/) states, if any, may take advantage of the new option, which has prompted discussion about whether further steps could be taken to guarantee coverage to people in the gap in President Biden's forthcoming American Families Plan.

President Biden proposed during the campaign that a public option insurance plan would be broadly available and automatically enroll people in the coverage gap, but such a plan would be difficult to pass in a closely divided Congress. This issue brief

examines some of the other options policymakers may consider to extend coverage to people in the gap, including increased fiscal incentives for states, a narrower public option, and making people with incomes below the poverty level eligible for enhanced ACA premium subsidies.

# What are leading options to provide coverage for people in the coverage gap?

#### Add More Financial Incentives for Medicaid Expansion

Additional incentives for non-expansion states generally include increases to the expansion match rate or other broader fiscal incentives for expansion states. In addition to the APRA, which included a two-year, 5-percentage point increase in the federal matching rate for traditional (non-ACA) enrollees, policies could increase the expansion match rate. For example, the policy could allow new expansion states to receive the three years of 100% federal matching dollars, as was available to states that had implemented in 2014, or could increase the current expansion match rate (e.g., to 95%) more broadly to all expansion states (new and current expansion states). Alternatively, policies could provide additional financial incentives for all expansion states that increase the opportunity cost of not expanding (e.g., an increase in the traditional match rate) or could create financial disincentives to not expanding (e.g., a decrease in the traditional match rate or limits on disproportionate share hospital payments (DSH) or uncompensated pool funds).

Policies to encourage non-expansion states to cover people in the coverage gap build on the existing Medicaid infrastructure in those states. As with other states that have adopted the expansion, expansion builds on existing Medicaid provider networks, health plans, and eligibility systems, as well as existing mechanisms to draw down federal funds for coverage. Coverage offered through Medicaid is designed to be affordable for people with low incomes. Medicaid generally prohibits premiums and deductibles and limits cost-sharing to nominal amounts, which differs from coverage provided in the Marketplace or other coverage. In addition, there is no open enrollment period for Medicaid, so individuals can enroll at any time, and eligibility is based on monthly income (not projected annual income). Individuals are eligible for Medicaid even if they have an offer of employer coverage, and unlike marketplace coverage, there is no reconciliation at the end of the year to align benefits with actual income.

**These options still rely on state action to adopt the expansion.** There are already substantial financial incentives for states to expand Medicaid under the ACA; some states have not acted on them largely due to politics or ideology, so it is unclear if additional incentives will impel them to act. Providing additional funding that would benefit only non-expansion states could also create equity issues in federal funds

flowing to states that already expanded. For some policies, the legal limits of the federal government's ability to leverage Medicaid funds to states as an incentive to adopt the ACA expansion is unclear.

#### **Create a Broad or Narrow Public Option**

Instead of relying on Medicaid, federal policy makers could create a new public option that would be available broadly or more narrowly targeted for the people in the coverage gap. President Biden campaigned on a "public option," a new federal public health insurance option, that would be available to all people eligible for marketplace coverage, people with employer coverage, and people who would otherwise be eligible for Medicaid in non-expansion states. For the last group (the coverage gap population), enrollment would be automatic, fully funded by the federal government, premium-free and provide the full scope of Medicaid benefits. Under the Biden campaign proposal, states that have expanded could move Medicaid expansion enrollees into the public option, with a maintenance-of-effort payment from the states. Instead of a broad public option, a narrower option to provide coverage specifically for people in the coverage gap could be developed.

A public option would not depend on states to expand coverage and could be tailored to people with low incomes, but creating a new federal coverage option presents some political, administrative and implementation challenges. Creating a broad or narrow public option would require an infrastructure to set up and administer a new federal health insurance program. For example, it requires resources to set up the plan, set rates, administer or contract with plans to administer benefits, and establish and conduct eligibility and enrollment processes. Even if the new public option plan were administered in conjunction with an existing federal health program (such as Medicare or the Federal Employees Health Benefits Program), there would be a number of design choices, such as (https://www.cbo.gov/publication/57125) whether and how the public option would conform with state insurance regulations; set payment rates for providers and prices for prescription drugs; and enroll providers or contract with health plans. Different choices would have implications for costs, access, and affordability. A broad public option has the potential to deliver coverage at a lower cost than in private insurance by restraining health care prices, but that would also be strongly opposed by the health care industry.

Setting up a narrow public option plan targeted to cover 2.2 million nationwide would still require many policy design choices and could be administratively complex, especially for a relatively small population nationwide. The guarantee of coverage for people with incomes below poverty at full federal cost would almost certainly mean that none of the current non-expansion states would choose to expand in the future. While a maintenance of effort requirement on current expansion states could theoretically prevent current expansion states from dropping the Medicaid expansion and shifting costs to the federal government, such a requirement could be difficult to sustain politically and could face legal challenges. This inequity across states could

potentially be addressed through fiscal carrots provided to expansion states, but that would also increase federal costs. Given the limited scope of coverage, a narrow public option would likely be less disruptive to the health care industry than a broad public option.

#### **Expand Eligibility for Marketplace Premium Subsidies**

Policy makers could consider an option to extend financial assistance for coverage by extending Marketplace premium subsidies to people in the coverage gap. Under current law, individuals below poverty are generally not eligible for premium subsidies to purchase coverage in the ACA marketplace, with the only exception being authorized immigrants who are ineligible for Medicaid because they have been in the U.S. fewer than five years. One approach to covering people in the coverage gap would be to make them eligible for marketplace premium subsidies. Under the American Rescue Plan – which enhanced ACA premium subsidies for two years – people with incomes below 150% of the poverty level are eligible for a 100% premium subsidy for the second lowest cost silver plan. They are also eligible for costsharing reductions that provide them with coverage that has an actuarial value of 94%. This means that, on average, they are responsible for deductibles and copays equal to 6% of their health spending. The average <u>deductible (https://www.kff.org/slideshow/cost-</u> sharing-for-plans-offered-in-the-federal-marketplace/) in these reduced cost-sharing plans in 2021 is \$149, with an average out-of-pocket limit of \$1,189. A policy to cover people in the coverage gap could reduce cost-sharing further for people with income below poverty, comparable to the nominal cost-sharing in Medicaid. It also would be theoretically possible to provide wrap-around benefits for services like nonemergency medical transportation (NEMT) that are covered by Medicaid but not covered in the Marketplace, but there is currently no mechanism for doing so.

Similar to other options, expansion of marketplace subsidies does not depend on state action, but there a number of design challenges for policy makers to **consider.** A policy to extend marketplace subsidies would expand coverage by building on the existing marketplace structure, which would reduce administrative complexity and could be accomplished relatively quickly and easily. However, there could be some challenges to this structure for people below poverty, depending on how the policy is designed, which would take time to implement.

Unless further cost-sharing reductions and benefit enhancements were included, marketplace plans would have significantly higher cost-sharing and less comprehensive benefits than Medicaid. While provider networks in Medicaid may be more limited than typical employer insurance plans, in some parts of the country the networks in marketplace plans can be even more restrictive. As an entitlement program, Medicaid provides beneficiaries with broader legal protections for accessing care than enrollees in private insurance plans. Unlike Medicaid, eligibility for marketplace premium subsidies is reconciled for the year after the fact based on actual income. Such a reconciliation could be waived for people with incomes below poverty – including the need to file a tax return — but eligibility still requires estimating annual income rather than current income as in Medicaid.

There is some precedent for providing coverage to Medicaid enrollees through the marketplace. For example, in Arkansas, the state buys marketplace coverage for Medicaid expansion enrollees; the state also pays the premium and other cost sharing amounts and provides wrap around coverage. Extending marketplace subsidies to people in the coverage gap raises all of the same potential inequities across states as a public option.

## What are the cost considerations for these options?

All options to expand coverage are likely to increase federal spending and could require offsets through other proposals that produce savings. In addition to the specific structure of the policy, cost considerations include:

**Distribution of state and federal costs:** Cost for Medicaid are shared by states and the federal government, while costs for marketplace subsidies and a public option would be borne entirely by the federal government (and the individual covered, for any premiums or out of pocket costs). Thus, policies that rely on Medicaid may cost less to the federal government, depending on how much of a fiscal incentive might be provided to non-expansion states to encourage them to expand, as well as to current expansion states.

Relative costs of Medicaid versus private coverage: In addition, Medicaid costs per person may be lower than private insurance primarily due to provider payment rates. Coverage costs (for both Medicaid and marketplace coverage) may also vary by state as health care costs and markets vary. For example, premiums in marketplace plans tend to be higher in rural areas with little competition among hospital and plans. The federal government may also face costs if a new option creates an incentive for a current expansion state to drop coverage, leading the federal government to lose the state share of financing. For coverage options that use a new public option, the difference between Medicare rates and private coverage or Medicaid coverage is also a factor.

**Enrollment:** Lastly, government costs depend in large part on take-up and enrollment in the new option. If there are no adjustments for higher out of pocket costs, enrollment in coverage options through the marketplace could be relatively lower than other approaches. Additionally, enrollment likely depends on outreach, if open enrollment periods apply to the group that could be eligible for Medicaid, and how incomes is counted (monthly or over the course of the year).

#### What to watch?

Existing and new research (https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansionunder-the-aca-updated-findings-from-a-literature-review/) continue to show that expanding eligibility for health coverage to people with low incomes reduces the uninsured rate, improves access to and utilization of care, reduces uncompensated care costs, improves affordability of care, and reduces racial and ethnic disparities in coverage (https://www.kff.org/medicaid/issue-brief/effects-of-the-aca-medicaid-expansion-on-racial-disparities-inhealth-and-health-care/). The pandemic has highlighted the importance of access to coverage and challenges with accessing care for uninsured people. President Biden is expected to release the American Families Plan in the near future, which may include proposals to address coverage for people in the coverage gap. Congress may also consider proposals as part of a budget reconciliation bill. In the meantime, some states may move forward with expansion efforts and take advantage of existing incentives under the ARPA, and there are efforts to get expansion on the ballot in Mississippi and South Dakota and other states considering expansion (https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactivemap/) in their legislative sessions. Understanding the tradeoffs that different approaches have for government cost, administrative feasibility, and affordability for low-income people will be helpful in assessing policies as details of specific proposals are released. While alternative approaches to Medicaid expansion could be more expensive for the federal government and offer fewer protections for beneficiaries, they could also guarantee coverage for low-income people now in states that may not choose to expand for many years or at all.

# **Appendix Table**

#### Uninsured Adults in Non-Expansion States Who Would Be Eligible for Medicaid if Their States Expanded, by Current Eligibility for Coverage, 2019 May Be Eligible for Marketplace In the Coverage Gap Coverage State (<100% FPL) (100%-138% FPL\*\*) **All States Not Expanding** 2,188,000 1,800,000 Medicaid Alabama 77,000 127,000 Florida 415,000 375,000 269,000 Georgia 184,000 45,000 Kansas 37,000 102,000 Mississippi 64,000 North Carolina 212,000 161,000 South Carolina 105,000 84,000 South Dakota 16,000 11,000 118,000 Tennessee 108,000 Texas 771,000 662,000 Wisconsin\* 0 30,000 Wyoming 7,000 8,000

NOTES: \* Wisconsin provides Medicaid eligibility to adults up the poverty level under a Medicaid waiver. As a result, there is no one in the coverage gap in Wisconsin. \*\* The "100%-138% FPL" category presented here uses a Marketplace eligibility determination for the lower bound (100% FPL) and a Medicaid eligibility determination for the upper bound (138% FPL) in order to appropriately isolate individuals within the range of

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# Barriers to Price and Quality Transparency in Health Care Markets

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#### **Preface**

Consumers of health care in the United States often lack information on the actual prices of the care they receive and can also lack access to information about the quality of their care. In part, this can be attributed to the complexities of a system in which multiple payers often pay different prices for the same services. In June 2019, President Donald Trump signed an executive order called *Improving Price and Quality Transparency in American Healthcare to Put Patients First* in an effort to give consumers information about the price and quality of health care services to promote informed decisionmaking. To facilitate improvements in price and quality transparency, the administration is interested in informing policymakers and the public of ways in which the government and the private sector can aid or impede price and quality transparency.

This report summarizes the results of an environmental scan designed to gather information on how health care prices are set, price variation in health care markets, barriers to price and quality transparency for consumers, and the extent to which price and quality information is used in marketing efforts. The report should be of interest to federal policymakers and stakeholders as they consider various price transparency initiatives, including recent federal rulemaking related to hospital and insurer price transparency. This work was conducted between October 2019 and December 2019.

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# Summary

In most markets, buyers know the price of goods or services before they purchase them. In the U.S. health care market, prices are generally opaque to consumers and not often known to them before they receive care. This is partially due to the fact that the U.S. health care system is complex, with multiple payers paying different prices for similar services and negotiated rates between commercial insurers and providers that are not publicly disclosed. A further complication is that consumers do not usually pay the full price of their care; instead, they typically pay a flat fee (copay) or a portion of the price (coinsurance), based on their health insurance coverage.

In June 2019, President Donald Trump issued an executive order called *Improving Price and Quality Transparency in American Healthcare to Put Patients First* with the intention of promoting consumer price and quality transparency initiatives in health care to facilitate better-informed consumer decisionmaking. As part of this effort, the administration sought to inform policymakers and the public about how prices are currently set in health care markets, how the government and private payers can aid or limit price and quality transparency, and the extent to which providers can use advertising to promote price and quality information.

To that end, the Office of the Assistant Secretary for Planning and Evaluation asked the RAND Corporation to conduct an environmental scan to synthesize existing knowledge on these topics.

#### How Are Health Care Prices Set?

#### Physicians and Hospitals

Public payers, such as Medicare and Medicaid, typically set prices for physicians and hospitals prospectively; providers have little direct bargaining leverage other than deciding not to serve these patient populations. The majority of care provided to veterans covered by the Veterans Health Administration is provided in Veterans Health Administration facilities, which are federally funded and employ salaried health care providers. Commercial health plans, in contrast, negotiate with physicians and hospitals to determine prices, including prices for their Medicare Advantage or Medicaid managed care plans. Some research has shown substantial variation in negotiated prices, while other research suggests more moderate variation in some markets. Insured consumers rarely pay the full negotiated price of their care, typically paying a smaller copayment or coinsurance amount. Although the government does not directly affect prices paid by commercial health plans, commercial prices tend to be positively correlated with Medicare fee-for-service prices.

#### **Pharmaceuticals**

In the case of pharmaceuticals, Medicaid receives mandated rebates from drug manufacturers for dispensed prescriptions, and the Veterans Health Administration negotiates prices in exchange for including a manufacturer's drug on a limited formulary. Commercial health plans, including those that cover Medicare Part D enrollees, negotiate both the prices paid to pharmacies and any discounts and rebates received directly from drug manufacturers. Self-pay prices faced by consumers in pharmacies (either because of uninsurance or because of full prices on a high-deductible plan) are set by individual pharmacies. Big-box stores (e.g., Walmart, Target) and pharmacy chains (e.g., CVS, Walgreens) can use heavily discounted prices of certain generic drugs to drive traffic to their stores.

#### Medical Devices

Most medical devices are not purchased directly by Medicare, Medicaid, or private insurers. Rather, these items (ranging from latex gloves to expensive imaging equipment) are purchased by providers and considered in the price of bundled or fee-for-service payments. For durable medical equipment, such as crutches or blood sugar monitors that are generally used by patients at home, Medicare uses a competitive bidding process to determine prices.

#### Price and Quality Transparency Initiatives

Recent federal consumer transparency efforts have focused primarily on hospital price transparency. A 2018 federal rule requires that hospitals release their chargemaster data for all items and services in a machine-readable format, and a 2019 final federal rule requires hospitals to disclose payer-specific negotiated rates for all items and services and to disclose payer-specific negotiated rates in a consumer-friendly manner for "shoppable" services, which are those that can be scheduled in advance by a consumer. The government also issued a final rule in 2020 that requires commercial insurers to provide online price transparency tools to their members and to disclose negotiated prices for all covered services. The federal government also promotes quality transparency by providing quality information about physicians and hospitals to consumers via the Care Compare online tool (previously known as Physician Compare and Hospital Compare).

State governments have also pursued various consumer price transparency efforts. In particular, a number of states have established or are in the process of establishing all-payer claims databases (APCDs). These databases form the basis for various price transparency tools intended for consumer use. One standout example is the state of New Hampshire, which has used its APCD data to create an extensive online price transparency tool that provides provider-specific pricing to consumers, taking into account their insurance status.

Most commercial insurers have also rolled out price transparency tools for their members to help estimate the costs of various services. However, these tools could be of limited value, as they can be difficult to navigate and do not always provide accurate pricing.

#### Barriers to Price and Quality Transparency

A key limitation of recent government consumer price transparency initiatives aimed at hospitals is that they have focused on charges and negotiated prices. Charges are the "list" price of care, and they are generally not related in any systematic way to the actual amounts paid by public or private insurers. Negotiated prices, in contrast, are much more relevant and represent the actual price of care paid by the insurer to the hospital. In price transparency efforts aimed at consumers of health care, the out-of-pocket (OOP) price paid by the consumer is probably the most relevant.

There are also some regulatory barriers to price transparency. First, in *Gobeille v. Liberty Mutual Insurance Company*, 2016, the Supreme Court determined that the Employee Retirement Income Security Act of 1974 (ERISA) preempts state APCD reporting requirements for self-insured employers. This undermines many state price transparency initiatives that rely on APCD data. Second, Statement 6 from the Federal Trade Commission and Department of Justice's 1996 Statements of Antitrust Enforcement Policy in Health Care is intended to limit the sharing of price data for anticompetitive reasons, but it could be cited by those opposed to current price transparency initiatives to note that sharing price data could have anticompetitive effects in some markets. Finally, the Health Insurance Portability and Accountability Act protects patients' rights to privacy over their medical information, but it makes the sharing and disclosure of health data (for transparency or other reasons) more cumbersome.

On the part of insurers and providers, a potential barrier to price transparency is contract language that prohibits the disclosure of negotiated prices. However, there are efforts in Congress to pass legislation that would disallow or limit the effect of such clauses in contracts. State and federal governments have also passed legislation to prohibit the use of "gag clauses" that prevent pharmacists from telling patients about lower-cost drug options.

Finally, consumer information on the Centers for Medicare & Medicaid Services (CMS) Care Compare website has some important limitations. Price and quality data are not explicitly linked, so consumers might assume that a higher price means higher quality. Price data on hospitals are very limited and are not included for physicians, and both price and quality data might not include enough variation to enable meaningful comparisons between providers.

# Advertising Price and Quality Information

Our literature search identified only a handful of articles that addressed advertising price and quality information. The available literature suggests that hospitals and physicians do not typically include pricing and quality information in their advertisements. Data on the amount that

hospitals and physicians spend on advertising are lacking, as is information about the substance of advertising. One barrier to advertising price information could be clauses in provider-insurer contracts that prohibit the disclosure of negotiated prices. Furthermore, providers might be concerned that publicizing price data could lead to a "race to the bottom" on prices, in which all insurers demand the lowest prices offered by a provider.

Pharmaceutical companies conduct a substantial amount of direct-to-consumer advertising, but they have historically not advertised price or quality information. However, pharmaceutical advertisements do sometimes offer discounts or coupons, and, more recently, some advertising has directed consumers to pricing information via a web link.

The literature search did not identify any articles that addressed advertising by device manufacturers.

#### Conclusions and Recommendations

In an effort to help consumers make better-informed health care choices, federal policymakers sought to identify potential barriers to price and quality transparency. Findings of this environmental scan show that consumer price transparency is being pursued by federal and state governments, as well as by commercial insurance companies. The findings also highlight potential barriers to meaningful transparency that could be addressed:

- First, policymakers could consider initiatives aimed at OOP price transparency given the focus of federal price transparency initiatives on consumers. For example, policymakers can continue to pursue initiatives such as a 2020 federal rule that requires insurers to provide online price transparency tools to their members that would display OOP prices. Such efforts would also address shortcomings of existing insurer price transparency tools, which are offered by most private plans but do not always offer accurate pricing information.
- Second, existing tools that promote quality transparency, such as Care Compare, could be improved upon to allow meaningful comparisons between providers. In particular, CMS could consider the following:
  - o presenting detailed, provider-specific pricing information for a wide range of services
  - o presenting the full variation in quality scores rather than limiting information to differences from the national mean
  - o explicitly linking detailed quality and price data by presenting both pieces of information together.
- Third, policymakers can continue to pursue legislation that would limit or prohibit clauses in provider-insurer contracts that do not allow for the disclosure of negotiated prices. Such contract language presents a key barrier to price transparency. Similar clauses in contracts between private insurers and pharmacies that prohibited pharmacists from informing patients when paying for a

- drug out of pocket would be less expensive than paying the copay through their insurance are no longer permitted following 2018 legislation.
- Fourth, the federal government could consider regulations that would require drug manufacturers to submit cost effectiveness or comparative effectiveness data on their drugs in order for those drugs to be covered by Medicare, similar to requirements in other countries. This data could be made public to consumers to allow for more informed decisionmaking.
- Fifth, states could work together with federal agencies, such as the Department of Labor (DOL), to address the issue of ERISA preemption undermining state APCDs. The DOL could require the collection of APCD data from self-funded health plans. This would be a significant undertaking, however, as the DOL currently does not collect any data similar to APCDs.
- Finally, states can work to improve price transparency and quality transparency:
  - o States that have not yet established APCDs could do so.
  - States that do have APCDs but do not have online price transparency tools for consumers can create them.
  - States that do have APCDs and online price transparency tools can work to improve the breadth and quality of the data provided.
  - O States can provide consumers with detailed quality information on providers in conjunction with online transparency tools.

The barriers to consumer price and quality transparency identified through this work generally represented limitations of existing tools. Efforts to achieve price and quality transparency have the potential to allow consumers to make better-informed decisions about their health care, particularly if the challenges and barriers outlined in this report are addressed.

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# **Abbreviations**

ACA Affordable Care Act

AMP Average Manufacturer Price

APC Ambulatory Payment Classification

APCD all-payer claims database

ASP average sales price

ASPE Office of the Assistant Secretary for Planning and Evaluation

CalPERS California Public Employees' Retirement System

CBO Congressional Budget Office

CMS Centers for Medicare & Medicaid Services

DME durable medical equipment
DOJ Department of Justice
DOL Department of Labor
DRG diagnosis-related group

ERISA Employee Retirement Income Security Act of 1974

FDA U.S. Food and Drug Administration

FFS fee-for-service

FTC Federal Trade Commission

GAO U.S. Government Accountability Office

GDDP generic drug discount program HCCI Health Care Cost Institute

HMO health maintenance organization

IPPS Inpatient Prospective Payment System

MA Medicare Advantage

MAC Maximum Allowable Cost

OOP out-of-pocket

OPPS Outpatient Prospective Payment System

PhRMA Pharmaceutical Research and Manufacturers of America

RVU relative value unit

VHA Veterans Health Administration
WAC Wholesale Acquisition Cost

# 1. Introduction

In June 2019, President Donald Trump signed an executive order called *Improving Price and Quality Transparency in American Healthcare to Put Patients First*. The purpose of the order was to make consumers aware of price and quality of health care services to help them make more-informed decisions about health care use. To improve price and quality transparency, the administration wanted to inform policymakers and the public of the ways in which the government and the private sector could aid or impede price and quality transparency.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) asked the RAND Corporation to synthesize existing knowledge on how health care prices are set in the United States, how the government affects prices, the level of price variation in health care markets, ways in which the government and commercial insurers can aid or impede price and quality transparency to consumers, and the extent to which health care providers advertise price and quality information to consumers.

In response to ASPE's request, RAND researchers conducted an environmental scan of existing literature to synthesize and summarize existing knowledge related to consumer price transparency and to highlight gaps in the literature. The purpose of the scan was to understand how U.S. prices are set in certain health care market segments, how government impacts prices, how providers market themselves to consumers, and how the government or commercial insurers could serve as barriers to price and quality transparency.

The environmental scan included four health care markets:

- health care professionals
- hospitals and other facilities
- pharmaceuticals
- medical devices.

For each market, we gathered information on three broad topics: how prices are set, the factors that influence the level of consumer price and quality transparency, and the extent to which providers advertise on price and quality.

This report proceeds as follows. In Chapter 2, we briefly describe how we conducted the environmental scan. In Chapters 3–6, we describe the results of the scan for each of the four markets. We begin each chapter by describing how we defined the market, briefly characterizing the size and quality of the relevant literature, and highlighting our key findings for this market. We then describe the results of the scan in more detail, organizing our discussion around the three broad topics mentioned above. In Chapter 7, we summarize our findings and discuss recommendations to policymakers suggested by our findings.

## 2. Methods

RAND researchers conducted an environmental scan of available literature from peerreviewed sources and the gray literature (including consumer advocacy groups, research organizations, and state and federal agencies). The scan included four health care markets:

- health care professionals (physicians and nonphysicians)
- hospitals and other facilities (ambulatory surgical centers, skilled nursing facilities)
- pharmaceuticals (pharmaceutical companies and pharmacies)
- medical devices.

For each market, the scan gathered information on ten key policy issues related to cost and quality transparency. These issues can be grouped into three broad topics:

How are prices set?

- How are Medicare, Medicaid, Veterans Health Administration (VHA), commercial, and self-pay prices set in each market?
- What strategies do health plans use in determining prices they pay providers?
- How does the government impact the prices in each market?

What influences the level of consumer price and quality transparency?

- Government
  - What government actions limit price and quality transparency?
  - What government actions are beneficial for price and quality transparency?
- Commercial payers
  - In what ways do the design of federal health care programs and commercial health insurance produce incentives (or lack thereof) that serve as a barrier to price and quality transparency?
  - What contractual and noncontractual agreements between private actors serve as barriers to price and quality transparency, and how common are they?
  - How can the ethical codes of organizations and trade associations be barriers to price and quality transparency?
- <u>Data availability</u>: How does the availability (or lack thereof) of useful quality measures serve as a barrier to price and quality transparency?

What is the relationship between price, quality, and advertising?

- How do providers use advertising in this market?
- Are there regulatory or other barriers that impede advertising?
- How is price or quality information featured in health care provider advertising?
- What is known about successful advertising strategies in this market?

We summarize the results of the environmental scan in the context of these three categories. Given the nature of the available data and the scope of this work, we conducted a targeted

literature search to identify articles of relevance. We did not restrict the search to specific market segments; we included any articles related to health care and sorted the results by market segment after the fact. The appendix lists the search terms used for this work.

Our search of three databases (PubMed, Business Source Complete, and EconLit) identified 1,095 articles; we identified an additional 56 articles in the gray literature. Research assistants conducted an initial triage to identify articles of potential relevance based on the title and abstract. From the initial set of 1,151 articles, they identified 197 peer-reviewed articles and 56 articles from the gray literature as potentially relevant. The lead author of this report oversaw their work to ensure that their decisions were consistent with the goals of this work. The research team reviewed the initial list and abstracted information for 113 articles relevant to this task.

We supplemented the search with (limited) additions based on cited literature and searches of government webpages. In particular, the initial search turned up very few articles related to advertising of price or quality information by pharmacies, so we conducted additional targeted Google and Google Scholar searches focused on identifying information on pharmacy pricing strategies for self-pay patients. These searches also included specific searches for information on the generic drug discount programs (GDDPs) offered by pharmacies starting in 2006. We found relevant articles and employed a snowball search method to look at articles that cited relevant articles to identify additional relevant information. We also specifically searched for pharmacy advertising efforts, which we defined as efforts by pharmacies to market medication prices and quality directly to consumers.

This report cites 161 total sources based on our initial and supplemental literature searches.

# 3. Health Care Professionals

#### Overview

In this chapter, we summarize the results of our environmental scan of the literature on health care professionals. We defined the market segment "health care professionals" as providers who can bill Medicare directly for services: physicians, nurse practitioners, and clinical psychologists. We included several other categories who can also bill Medicare (clinical nurse specialists, clinical social workers, physical therapists, occupational therapists, and speech language pathologists; Medicare, undated-a). The literature focused primarily on physicians.

Our literature search identified a number of articles on pricing and price variation and a few on price and quality transparency in this market. However, the literature search did not identify any articles related to how physician organizations' ethical codes might affect price or quality transparency.

We identified the following key findings from the environmental scan:

- Medicare fee-for-service (FFS) prices influence market prices for physicians in most fields.
- A number of articles suggest substantial price variation in the private market, although more-recent research suggests more-moderate variation.
- Medicaid prices are set by the state, but they are influenced by prices in the private sector.
- Prices in commercial plans respond directly to changes in Medicare prices.
- Federal regulations around Medicare affect out-of-network prices in Medicare FFS and Medicare Advantage.
- Major barriers to transparency include lack of physician pricing data in existing transparency tools and clauses in provider-insurer contracts that prohibit disclosure of negotiated prices. Physicians themselves lack incentive to disclose prices.
- Most websites that offer price information focus on inpatient care or surgeries.

#### How Are Prices Set?

Throughout this section, we distinguish among four key terms:

- *Prices* are the actual paid amounts received by a provider, typically through a combination of insurer and individual payments.
- Billed amounts are the prices charged by physicians.
- Costs are the amount incurred by the physician for providing a patient's care.
- Out-of-pocket (OOP) prices are the amount paid by the consumer.

Pricing for physician services is opaque and varies from payer to payer. Insurance affects both the total payment for a care episode and also what the patient pays. In both the public and private sectors, there has been a move from FFS to bundled payments. Under a bundled payment model, providers or health care facilities are paid a single payment for all the services performed to treat a patient for a specific episode of care. The bundled price could vary retrospectively based on quality or other metrics, making it difficult to isolate the price of a specific physician service (Garfield, Orgera, and Damico, 2019).

#### Medicare

Medicare's FFS program pays physicians a fixed amount for each service provided, according to the Medicare Physician Fee Schedule. This schedule defines payments for thousands of services, using a system of weights determined by the nature of the work, the cost to the physician of providing it, and the liability associated with each service (Pelech, 2018a). The weight is then adjusted based on a number of additional factors and translated into dollar amounts (Clemens and Gottlieb, 2017; Feldman, Dowd, and Coulam, 2015).

The Medicare Access and CHIP Reauthorization Act of 2015 introduced two ways to reward providers for quality and clinical practice improvement: (1) an incentive payment of 5 percent for those who participate in advanced alternative payment models and (2) a positive or negative payment adjustment for those who do not, via the Merit-Based Incentive Payment System (MedPAC, 2019).

Medicare Advantage (MA) plans are an alternative to Medicare FFS. These plans are administered by private insurance companies and negotiate rates with physicians to provide care. MA plans tend to pay providers at rates at or close to Medicare FFS rates, as do Medicaid managed care plans (Berenson, Ginsburg, et al., 2012). MA plans negotiate lower prices for some of the services for which Medicare FFS has been found to overpay relative to commercial insurers, such as lab tests and medical equipment (Trish et al., 2017).

#### Medicaid

There are two kinds of Medicaid payment structures: FFS, in which the state pays providers directly for each covered service, and managed care, in which the state pays a managed care plan a fee for each person enrolled (MedPAC, undated). Although most Medicaid enrollees are in managed care plans (81 percent as of 2016), the majority of Medicaid spending (just over 50 percent) comes from FFS arrangements (MedPAC, undated).

Under FFS, states set their own reimbursement rates for physician services, based on input from a variety of stakeholders (Lollar, 2016). The prices are then specified in a Medicaid State Plan, which is a contract with the Centers for Medicare & Medicaid Services (CMS) explaining how the state will run its Medicaid program. Any subsequent changes need approval at the federal level, including changes to provider reimbursement (Medicaid, undated).

Even though the prices are set by the state, Medicaid prices are indirectly influenced by the private sector: If reimbursement rates are too low, Medicaid beneficiaries could lose access to providers (Reinhardt, 2013).

## Veterans Health Administration

The VHA, the nation's largest integrated health care system, provides care to U.S. military veterans (U.S. Department of Veterans Affairs, undated-b). The VHA is funded through a congressional appropriation, and most of the health care is provided within the system by health care providers who are salaried employees of the federal government (U.S. Department of Veterans Affairs, undated-a; Nugent and Hendricks, 2003). More recently, VHA policy has expanded access to care from non-VHA facilities under the Veterans Choice Program, which was recently replaced by the MISSION Act (U.S. Department of Veterans Affairs, 2019b). Under the Choice program, providers are required to accept Medicare payment rates (Miller, Cullen, and Lushniak, 2018). In 2018, the VHA spent \$62.9 billion on services provided at VHA facilities and \$14.9 billion on services provided in the community (U.S. Government Accountability Office, 2019).

A study conducted in 1999 compared actual VHA costs at six VHA medical centers with the FFS costs for the same services that would have been paid by Medicare. The study found that the VHA provided care at a lower cost (Nugent et al., 2004). More-recent evidence is mixed; one study of dialysis prices showed higher prices at the VHA (Hynes et al., 2012).

#### Commercial Health Plans

As of 2013, almost 95 percent of private sector insurers still used an FFS model (Zuvekas and Cohen, 2016). Only about 5 percent of physicians are paid by capitation. In fact, although health maintenance organization (HMO) plans themselves are capitated, they still pay physicians primarily on an FFS basis; fewer than 20 percent of patient visits to physicians covered by HMOs are paid by capitation (Zuvekas and Cohen, 2016).

Health care prices for physicians in the private sector are set by negotiation between insurance carriers and providers, in markets with varying degrees of competition (Clemens and Gottlieb, 2017). As a result, prices paid by private insurers "can vary substantially, for ostensibly similar services, across both providers and insurers" (Clemens and Gottlieb, 2017). However, some recent work has found less variation in physician prices (Whaley, 2015).

Commercial plans have been shown to respond directly to changes in Medicare prices: Claims data suggest that for every \$1.00 increase in Medicare prices, commercial plans implement a corresponding \$1.16 fee increase in their prices (Clemens and Gottlieb, 2017).

According to a recent Congressional Budget Office (CBO) working paper, many private health plans use a relative value unit (RVU) system that is similar to Medicare's. RVUs are a measure of value used in Medicare's reimbursement formula for physician services. The plans

then negotiate with physicians about how to translate RVUs into dollars and can develop different conversion factors by practice, hospital, or even specialty (Pelech, 2018a).

Dyckman and Associates, a health care consulting and litigation firm, surveyed commercial health plans for the MedPAC Advisory Commission in 2003 and found that all 33 surveyed health plans used payment methods modeled on the Medicare physician fee schedule, including 20 with minimal modification (Pelech, 2018a; Feldman, Dowd, and Coulam, 2015; Dyckman and Hess, 2003). Similarly, a 2017 study using physician payments from a large private insurer found that three-quarters of services were benchmarked to the Medicare physician fee schedule (Clemens, Gottlieb, and Molnár, 2017).

Federal regulations around Medicare affect out-of-network prices in Medicare FFS and Medicare Advantage. Federal regulations require physicians to accept Medicare FFS rates as payment in full for out-of-network services received by MA enrollees. These policies affect innetwork pricing as well: "limits on out-of-network prices in MA plans limit the prices that insurers can negotiate in network" (Pelech, 2018b; U.S. Department of Veterans Affairs, undated-b).

## Out-of-Pocket Prices for Insured and Self-Pay Patients

Medicare, Medicaid, the VHA, and commercially insured patients typically pay a per-visit copay (a flat charge regardless of the price of the service) or coinsurance (a percentage of the price of the service) for physician care (after having met any applicable deductibles).

"Self-pay" patients, meaning those not using insurance, could be responsible for the full billed amount to receive physician services. Physicians often require that uninsured patients pay up front for services. Patients who cannot afford the full billed amount might be able to negotiate a discounted price or a payment schedule with the provider. They might also pay with credit cards or could be turned away from care (Garfield, Orgera, and Damico, 2019).

#### Variation

There is abundant evidence that physician prices in the private sphere vary widely across providers, insurers, and care settings (Clemens and Gottlieb, 2017; Dunn and Shapiro, 2014; Reschovsky and White, 2014). In one study on negotiated physician prices, the authors found less variation in primary care, where prices ranged from 85 percent to 135 percent of the Medicare rate, while specialist prices exhibited wider variation—more than 100 percentage points in some markets. These differences are not explained by any characteristics that have been measured, such as patient age or gender, physician specialty, place of service, whether the physician was in the insurer's provider network, or type of plan. One study found that the geographic area of the practice explained about one-third of the variation but noted that additional research would be needed to explain the remaining variation (Berenson, Ginsburg, et al., 2012; Baker, Bundorf, and Royalty, 2013). Another study found that increases in physician market power, particularly via market consolidation, led to higher negotiated prices (Sun and

Baker, 2015). Other work found that physician services provided in hospital outpatient departments have prices that are often twice as high as those provided in community settings, even for identical services, such as magnetic resonance imaging of the knee (Reschovsky and White, 2014). Furthermore, there was substantial variation across geographic regions, suggesting that the differences cannot be attributed solely to hospitals' higher operating costs.

A CBO analysis found that the average ratios of commercial prices to Medicare FFS prices in the most expensive metropolitan statistical areas "were at least 70 percent higher for all services than the average price ratios in the least costly areas" (Pelech, 2018a). The average ratios comparing Medicare Advantage to Medicare FFS prices varied much less (Berenson, Ginsburg, et al., 2012).

Researchers at the University of Chicago found that physicians in more-concentrated markets charged higher prices. Their work indicates that consolidation caused a 14 percent average price increase from 2007 to 2013 (Scheffler, Arnold, and Whaley, 2018). The increase was higher for specialists than for primary care physicians (Scheffler, Arnold, and Whaley, 2018). Other work has similar findings (Dunn and Shapiro, 2014; Austin and Baker, 2015; Baker, Bundorf, Royalty, et al., 2014; Gaynor, 2018; Gaynor, Ho, and Town, 2015). When insurance markets are consolidated rather than provider markets, negotiated prices are lower (Scheffler and Arnold, 2017).

# What Influences the Level of Consumer Price and Quality Transparency?

#### Government

Government has an important role in promoting transparency of prices because physicians otherwise have little incentive to make price data publicly available. In October 2020, CMS released a final rule with price transparency requirements that, while aimed at insurers, should result in greater transparency of physician and hospital prices (Keith, 2020; Internal Revenue Service, Employee Benefits Security Administration, and Department of Health and Human Services, 2020). The rule requires commercial insurers to provide cost-sharing estimates to members via online tools, as well as to disclose negotiated prices for in-network providers and allowed amounts for out-of-network providers.

The 2011 U.S. Government Accountability Office (GAO) report *Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care* encouraged the U.S. Department of Health and Human Services to "determine the feasibility of making estimates of complete costs of health care services available to consumers" (Boerner, 2014; U.S. Government Accountability Office, 2011). The issue of transparency attracted media attention, and, as of 2018, 26 states had statewide cost databases. However, in 2017, the advocacy group Catalyst for Payment Reform gave only seven of these states a passing grade on the accessibility and clarity of these price data (de Brantes et al., 2017).

Some researchers have suggested providing better access to health care prices online, which some states have done by mandating that payers and providers make these prices available (Kratka et al., 2018). For example, New Hampshire has an online price transparency tool that provides negotiated prices and OOP prices for a number of health care services (Mehrotra, Brannen, and Sinaiko, 2014). Many states (including New Hampshire) require insurers to submit their claims data to all-payer claims databases (APCDs); these data can be used for price transparency initiatives. However, the Supreme Court's decision in Gobeille v. Liberty Mutual *Insurance Company* stated that the Employee Retirement Income Security Act of 1974 (ERISA) preempts states' authority to require APCD submission from self-insured employers, thereby undermining the completeness and utility of transparency tools that use APCD data (Fuse Brown and King, 2016). Federal legislation that passed in June 2019 would have established a federal APCD, which would not, in theory, be subject to ERISA preemption. However, an update to the legislation in December 2019 moved to use federal dollars to establish a grant program to help create and improve state APCDs (McIntire, 2019). The legislation was ultimately passed by Congress as the No Surprises Act and was signed into law in December 2020. The act establishes one-time federal grants to states to either establish or improve an APCD but does not address ERISA preemption (Hoadley, Keith, and Lucia, 2020; Fuchs and Hoadley, 2021).

Another example of a state initiative is a price transparency tool provided to enrollees by the California Public Employees' Retirement System (CalPERS), which manages health benefits for state employees. The tool allows members to compare prices and OOP spending for in-network providers, including for common outpatient services (Desai et al., 2017). However, the New Hampshire and CalPERS tools are not yet the norm; even when prices are available, it is not always clear what they refer to, as most websites do not specify whether the price quoted is the consumer's OOP cost (Kratka et al., 2018). Where they do exist, current state price transparency laws generally have not applied to outpatient settings (Saloner et al., 2017). There are also costs to laws that require providers to disclose the price of care before a service is provided. The laws could motivate providers to be more forthcoming about their prices; however, they also create new burdens for physician offices (Saloner et al., 2017). There could also be inconsistent compliance with such laws: For example, a report out of Massachusetts suggested poor compliance by the three biggest insurers in the state (Health Care for All, undated).

A recent effort to provide cost and quality information to consumers is Care Compare (previously known as Physician Compare), a CMS website designed for consumers to help them "make informed choices about the health care they receive through Medicare" (Medicare, undated-c). Mandated by the Affordable Care Act (ACA), the website was launched in 2010 and includes performance scores as well as whether the provider accepts Medicare payment rates. Care Compare does not include other price data, such as provider-specific negotiated rates or OOP amounts.

## Commercial Payers

The peer-reviewed literature had limited information about the role of price transparency for commercial payers. A recent survey of commercial health plans found that the vast majority (94 percent) offered some online pricing tool, and 71 percent offered estimates for physician services (Higgins, Brainard, and Veselovskiy, 2016). However, only about 2 percent of plan members used these tools, suggesting that there could be limited knowledge that the tools exist or issues with ease of use (de Brantes et al., 2017). Insurers' online pricing tools might also be of limited use because they typically provide broad ranges of prices, and those prices are not always based on the most recent negotiated rates (Higgins, Brainard, and Veselovskiy, 2016). Although insurers have incentive to steer consumers to lower-cost providers, they might do so in other ways, such as tiered provider networks (Sinaiko, Landrum, and Chernew, 2017). These limitations of insurer-provided transparency tools highlight the need for government price transparency initiatives, such as federal initiatives that require hospitals to disclose negotiated prices and state regulations that require insurers to submit their data to APCDs.

The effectiveness of these tools is still uncertain. One analysis suggests that, in an environment of increasing transparency, finance leaders will have to "identify the practical steps and data analytics tools needed to develop accurate pricing information and to find ways to share that information with patients that are in keeping with organizational interests" (Whitehouse, 2015).

# Data Availability

A major barrier to transparency is lack of information: Transparency cannot be provided when prices are not known. As noted by the Agency for Healthcare Research and Quality in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) *Ambulatory Care Improvement Guide*, "Many providers do not even know the price of the services they offer (since each insurer has its own negotiated rates), and most do not know the prices of the tests and procedures they recommend and order for their patients" (CAHPS, 2016).

The ability to obtain price information can vary substantially. In a secret shopper exercise, trained interviewers posed as nonelderly adults seeking new patient primary care appointments and asked the price of such an appointment (Saloner et al., 2017). The callers presented themselves as holding different kinds of insurance. While 89 percent of uninsured callers received price information, only 62 percent of those with employer-sponsored insurance were quoted a price. The prices quoted varied by insurance status, type of physician office, and county-level uninsurance rate (Saloner et al., 2017).

When websites about prices exist, at least as of 2012, they focused on inpatient care for medical conditions (73 percent) or surgeries (71 percent). In systematic internet searches to identify publicly available, patient-oriented websites for price comparison, researchers found that information about outpatient services was available much less often (diagnostic or screening

procedures were available only at 37 percent of the sites, radiology at 23 percent of the sites, prescription drug costs at 15 percent of the sites, and laboratory tests at 10 percent of the sites; Kullgren, Duey, and Werner, 2013).

# What Is the Relationship Between Price, Quality, and Advertising?

We identified few articles that examined physician advertising. Direct-to-consumer advertising for health care services has been increasing: A review looking at the two decades between 1997 and 2016 found that direct-to-consumer advertising for health services increased from \$542 million to \$2.9 billion. However, the largest increases were from hospitals, dental centers, cancer centers, mental health and addiction clinics, and medical services (Schwartz and Woloshin, 2019).

A lack of advertising on price in the legal industry could provide some parallels with lack of advertising by physicians. The legal blog *Above the Law* suggests several reasons why lawyers may not advertise prices: First, it is difficult to commit to a price in advance without knowing anything about the client; second, the work is unpredictable; and, third, advertising prices can lead to a "race to the bottom," with attorneys trying to undercut one another on price (Chung, 2017). The same broad principles could be applicable to physicians: The type and amount of care can be difficult to predict before seeing a patient, and physicians might be concerned that posting prices could lead to increased competition on prices.

Our literature search did not identify any articles that assessed the extent to which physicians can advertise price or quality information. In addition to the principles noted above, physicians might not advertise on price due to clauses in insurer-provider contracts that limit the disclosure of negotiated pricing information. The literature primarily cited these clauses related to hospital-insurer contracts, but it is likely that they apply to physicians as well (Beck, 2014). Indeed, providers do tend to advertise on procedures that are largely not covered by insurance, such as laser eye surgery, in vitro fertilization, dental crowns, and cosmetic rhinoplasty. However, even in these markets, there is some evidence that there is limited price-shopping by consumers, despite the fact that they face the full price of the procedures (Tu and May, 2007).

# 4. Hospitals

This chapter summarizes the results of our environmental scan of the literature on hospitals and other facilities. We defined the market segment "hospitals and other facilities" to include inpatient and outpatient care provided in hospital settings, ambulatory surgical centers, and care provided in skilled nursing facilities.

Literature on this topic focuses primarily on care provided in an inpatient hospital setting. Our search identified a number of articles describing how hospital prices are set and identifying price transparency initiatives. Very few articles addressed hospital advertising of price and quality.

We identified the following key findings from the environmental scan:

- Public payers set prices prospectively; private payers negotiate prices and discounts with hospitals.
- Medicare FFS indirectly influences rates paid by Medicare Advantage and commercial payers.
- A number of news sources noted recent federal efforts to improve hospital price transparency—specifically, federal rulemaking that requires hospitals to release chargemaster data and negotiated prices. A recent final rule also requires insurers to disclose negotiated prices.
- Limitations of government price transparency efforts include their focus on charges or prices that are not those paid by the consumer.
- Other barriers to price transparency include the extent to which it is feasible or legal for hospitals to release negotiated prices.
- Data on hospital quality are available to consumers primarily via CMS's Care Compare tool (previously known as Hospital Compare) and through quality data from U.S. News. However, there are limitations on the extent to which consumers can make meaningful price and quality comparisons between hospitals.
- There appears to be little to no advertising of pricing information by hospitals; this could be driven by clauses in insurer-hospital contracts that prohibit prices from being disclosed and by hospital concerns that this could drive down prices.

# How Are Hospital Prices Set?

Throughout this section, we distinguish among four key terms:

• *Prices* are the actual paid amounts received by a hospital, typically through a combination of insurer and individual payments.

- *Charges* are the list prices on a hospital's chargemaster, which are generally not related in any systematic way to the actual amounts paid by insurers (Reinhardt, 2006).
- Costs are the amount incurred by the hospital for providing a patient's care.
- *OOP prices* are the amount paid by the consumer.

#### Medicare

Medicare FFS sets rates for inpatient hospital care using the Inpatient Prospective Payment System (IPPS; Centers for Medicare & Medicaid Services, undated-a). Under the IPPS, each case seen by a hospital is categorized into a diagnosis-related group (DRG). Medicare's payment rate for each DRG is set prospectively, based on the average cost of treating patients in that DRG. Payments are adjusted based on the regional wage index, whether the hospital receives an adjustment for treating a disproportionate share of low-income patients, and whether it is a teaching hospital.

Medicare FFS pays for outpatient hospital services in a similar fashion via the Hospital Outpatient Prospective Payment System (OPPS; Reinhardt, 2006; Guidi, 2010). Under the OPPS, cases are categorized into Ambulatory Payment Classifications (APCs), and payments to hospitals are determined for each APC based on the average cost of services for the APC. Payments are adjusted based on the regional wage index. Medicare FFS prospectively sets rates for inpatient and outpatient care.

MA managed care plans are administered by private insurers to provide Medicare Part A, Part B, and sometimes Part D coverage to Medicare beneficiaries (Medicare, undated-c). Insurers and hospitals negotiate prices for hospital services for MA beneficiaries similar to the way in which prices are set for commercial insurance products, described in more detail below (Berenson, Sunshine, et al., 2015; McGuire, Newhouse, and Sinaiko, 2011). A number of recent studies have found that MA hospital rates are very similar to those paid by Medicare FFS, partially due to regulations that require out-of-network hospitals to accept payment at Medicare FFS rates for MA patients. Therefore, hospitals have little leverage to negotiate higher rates (Berenson, Sunshine, et al., 2015; Curto et al., 2019; Maeda and Nelson, 2018; Baker, Bundorf, Devlin, et al., 2016). Furthermore, based on interviews with senior personnel from health plans and hospitals, the authors of one study noted that negotiations between health plans and hospitals often include both commercial insurance products and MA and that negotiators are mindful of the rates negotiated for the other products.

#### Medicaid

Hospital payments by state Medicaid programs are a combination of a base payment and a supplemental payment (Cunningham et al., 2016). The base payment is the rate paid by Medicaid FFS or Medicaid managed care for care provided to Medicaid beneficiaries; supplemental payments are provided by the state and might or might not be directly tied to provided services.

Supplemental payments can include Disproportionate Share Hospital payments to hospitals that treat a disproportionate number of low-income patients, as well as state supplemental payments that are often financed through upper payment limits, intergovernmental transfers, or provider taxes (Cunningham et al., 2016).

Medicaid base payments can be considered the "price" of hospital care to Medicaid beneficiaries and can vary from state to state and between Medicaid FFS and Medicaid managed care. In general, Medicaid FFS programs pay for inpatient hospital services through prospective payments based on DRGs (similar to Medicare FFS) or by prospective per diem payments (Reinhardt, 2006). Outpatient services are largely based on fee schedules imposed by the state or on the APC system used by Medicare. Like MA plans, Medicaid managed care plans negotiate prices with hospitals.

#### Veterans Health Administration

The VHA is the nation's largest health care system. Most of the health care is provided within the system by health care providers who are salaried employees of the federal government (Trivedi et al., 2011). A recent federal rule finalized that the VHA pays non-VHA hospitals, at most, the prospective payment rate set by Medicare (U.S. Department of Veterans Affairs, 2019a).

#### Commercial Health Plans

The way that commercial health plans pay hospitals varies, but prices are generally based on discounted charges, per diem payments, or episodes of care (i.e., DRGs; Reinhardt, 2006). The key feature that determines the prices paid to hospitals by commercial insurers is aggressive negotiation (Berenson, 2015). Regardless of the type of payment, hospitals and insurers enter into annual negotiations to determine the dollar amount per diem, the dollar amount per DRG unit, or the discount on charges (Reinhardt, 2006).

Prices in the hospital market vary substantially (Craig, Ericson, and Starc, 2018; Hsia and Akosa Antwi, 2014; Hsia, Akosa Antwi, and Weber, 2014; Hsia et al., 2014). A 2019 report found that hospital prices paid by commercial health plans ranged from 150 percent to more than 300 percent of Medicare rates across states and from 150 percent to more than 400 percent of Medicare rates across health systems (White and Whaley, 2019). Cooper et al., 2019, found that hospitals in monopoly markets had prices that were 12.5 percent higher than hospitals in more competitive markets. They found substantial variation in prices in competitive and noncompetitive markets even for services that were plausibly identical, such as magnetic resonance imaging.

A 2010 examination of health care costs and drivers by the Massachusetts Attorney General notes that "Price variations are not correlated to (1) quality of care, (2) the sickness of the population served or complexity of the services provided, (3) the extent to which a provider cares for a large portion of patients on Medicare or Medicaid, or (4) whether a provider is an academic

teaching or research facility" (Massachusetts Attorney General, 2010, p. 3; underline in original). Rather, price variations are correlated to "market leverage as measured by the relative market position of the hospital or provider group compared with other hospitals or provider groups within a geographic region or within a group of academic medical centers" (Massachusetts Attorney General, 2010, p. 4). A detailed discussion of existing work in the *Handbook of Health Economics* comes to the same conclusion that variation in prices is unlikely to be fully explained by underlying costs, quality, or demand and is largely linked to market power (Gaynor and Town, 2011).

Other research has found that higher hospital prices tend to be associated with larger hospitals, teaching hospitals, system membership with large market shares, the provision of specialized services, and smaller market share by health plans (White, Reschovsky, and Bond, 2014; Wu, 2009).

The government indirectly influences commercial prices through Medicare pricing. There are two schools of thought about how this influence works. Standard economic theory predicts that when Medicare reduces prices, providers will reduce their volume of Medicare patients and reduce prices to commercial insurers to attract more privately insured patients (Feldman, Dowd, and Coulam, 2015). Cost-shifting theory predicts that when Medicare reduces prices, providers increase prices to commercial insurers to make up the difference. While cost-shifting is commonly cited as the prime influence, a 2011 review of the literature found that the true extent of cost-shifting was limited (Frakt, 2011). Other work found that when Medicare reduced prices, commercial prices fell, supporting standard economic theory (White, 2013). Commercial prices remain substantially higher than Medicare prices in many markets, a finding that could be explained by price discrimination (Reinhardt, 2006). A recent paper found that up to 57 percent of hospital cases covered by private insurers had prices that were directly linked to Medicare's prospective pricing (Cooper et al., 2019).

The government could also indirectly influence commercial prices via regulations such as antitrust policy. As noted above, prices vary substantially by the amount of market power a hospital has, so antitrust policy can influence prices by influencing the level of market concentration.

## Out-of-Pocket Price for Insured and Self-Pay Patients

Medicare, Medicaid, and commercially insured patients typically pay a per-day or per-visit copay or coinsurance for hospital care (after having met any applicable deductibles). Most veterans receiving care at VHA facilities do not pay any OOP expenses for inpatient care.

Uninsured and other self-pay patients are generally billed the amount on the hospital's chargemaster for services provided, even though those charges are generally well above what public and private insurers pay (Garfield, Orgera, and Damico, 2019; Reinhardt, 2006). Hospitals sometimes offer uninsured patients discounted prices based on their chargemasters, and some patients might receive care free of charge on a charitable basis. However, only about one-quarter

of uninsured patients reported receiving discounted or free care in 2015 (Garfield, Orgera, and Damico, 2019).

# State Rate-Setting Models

The state of Maryland sets hospital rates at the state level. Beginning in the late 1970s, and most recently extended for an additional five years in 2019, Maryland has a Medicare waiver that allows it to require that all health care payers pay the same for inpatient and outpatient hospital services. According to Patel et al., 2015, the rate-setting eliminated any cost-shifting among payers and equitably distributed the costs of uncompensated care and medical education. However, it meant that Medicare paid higher rates for hospital services in Maryland than under the national payment program, costing roughly an additional \$500 million (Patel et al., 2015; Pauly and Town, 2012). Vermont has recently implemented a similar system (Centers for Medicare & Medicaid Services, undated-c). Other states have instituted similar models in the past, but they have ended, largely due to deregulatory pressure (Rocco et al., 2017).

# What Influences the Level of Consumer Price and Quality Transparency?

In this section, we highlight the ways in which the government, private payers, and availability of relevant data aid or present barriers to price and quality transparency. However, we note here that in the past several years, hospitals themselves have increasingly made price transparency tools available online for a subset of common services (Cohen, 2019; Meyer, 2018b).

#### Government

Promoting transparency. State and federal governments can promote price transparency by creating or requiring price transparency initiatives. For example, in July 2019, CMS released the executive order Improving Price and Quality Transparency in American Healthcare to Put Patients First. In particular, CMS finalized a rule in November 2019 with consumer-friendly price transparency requirements for hospitals, including making available machine-readable standard charges for all items and services and disclosing the payer-specific negotiated prices for 300 common shoppable services in a consumer-friendly way (Commins, 2019; Wynne, LaRosa, and Cowey, 2019). In addition, CMS released a final rule in October 2020 that includes price transparency requirements aimed at insurers (Keith, 2020; Internal Revenue Service, Employee Benefits Security Administration, and Department of Health and Human Services, 2020). The rule requires commercial insurers to provide cost-sharing estimates to members via online tools, as well as to disclose negotiated prices for in-network providers and allowed amounts for out-of-network providers.

A number of state-based online price transparency initiatives also report prices for inpatient care (Kullgren, Duey, and Werner, 2013). Many states now have APCDs and use them for

consumer price transparency initiatives (Rocco et al., 2017). For example, Colorado uses APCD data to let consumers compare costs of procedures across hospitals, and New Hampshire uses APCD data to provide detailed online price and quality information for common health services. However, research shows that the impact of the New Hampshire tool has largely been due to changes in plan benefit design as a result of highlighting the variation in health care prices rather than directly through consumer price shopping (Tu and Gourevitch, 2014). Only 1 percent of New Hampshire residents accessed New Hampshire's online price transparency tool between 2011 and 2013 (Mehrotra, Brannen, and Sinaiko, 2014).

The key tool through which the federal government supports hospital quality transparency is the Care Compare website. Care Compare allows consumers to compare hospital performance on a number of measures related to patient experience, timely and effective care, complications, readmissions and deaths, use of medical imaging, and payment and value of care (Centers for Medicare & Medicaid Services, undated-b).

Limiting transparency. A key question for recent federal price transparency efforts is whether they actually make the relevant prices transparent. In 2018, CMS released the FY2019 Hospital Inpatient Prospective Payment Systems Final Rule, which included a provision requiring hospitals to release their chargemaster information annually (Centers for Medicare & Medicaid Services, 2018). However, using hospital charge data in price transparency efforts might not provide consumers with the most relevant data. A number of sources note that given the disconnect between hospital charges and prices (Reinhardt, 2006; Meyer, 2018a; Meyer, 2019; Whaley, 2018), chargemaster data do not reflect costs paid by most insurers or patients and, therefore, might not be particularly useful in price transparency initiatives (Reinhardt, 2006). The most recent federal rule on price transparency does require greater transparency of hospitals' negotiated prices, although there is less focus on the OOP prices, which are the prices actually paid by consumers. Similarly, the Care Compare tool also does not provide OOP price information (U.S. Government Accountability Office, 2014; Internal Revenue Service, Employee Benefits Security Administration, and Department of Health and Human Services, 2020).

Another barrier to price transparency is the extent to which it is possible for hospitals to provide useful price information to consumers. For example, California hospitals are required to provide price estimates to uninsured patients. However, based on a study that sent letters of inquiry to hospitals asking for pricing on one of three common procedures (laparoscopic cholecystectomy, a hysterectomy, or routine screening colonoscopy), only 28 percent of hospitals even responded to the letters, and of those, only 10 percent included both physician and facility fees (Farrell et al., 2010). Some hospitals have also argued that it is logistically and financially burdensome to post negotiated prices because a given hospital could have hundreds of contracts (King, 2019a).

An additional consideration is whether price transparency efforts should focus on employers in addition to individual consumers of health care. White et al., 2014, estimated that requiring all

private health plans to provide OOP pricing tools to consumers could save \$18 billion in health care spending over ten years; however, using state-based APCDs to provide hospital price information to employers and physicians could save \$61 billion over the same time period.

A few government decisions or regulations could act as barriers to price transparency. For example, in *Gobeille v. Liberty Mutual Insurance Company*, the Supreme Court determined that ERISA preempts state APCD reporting requirements for self-insured employers (Fuse Brown and King, 2016). This could substantially impact the accuracy of analyses based on APCDs, because 61 percent of individuals enrolled in employer-sponsored health insurance are enrolled in fully or partially self-funded plans (Kaiser Family Foundation and NORC at the University of Chicago, 2019). Federal legislation that passed in June 2019 would have established a federal APCD. A federally mandated APCD would not, in theory, be subject to ERISA preemption. However, the legislation was updated in December 2019 and no longer would establish a national APCD. It would instead use federal dollars to establish a grant program to help create and improve state APCDs (McIntire, 2019). The legislation was ultimately passed by Congress as the *No Surprises Act* and was signed into law in December 2020. The act establishes one-time federal grants to states to help create or improve state APCDs but does not address ERISA preemption (Hoadley, Keith, and Lucia, 2020; Fuchs and Hoadley, 2021).

Another example is the Federal Trade Commission (FTC) and Department of Justice (DOJ) Statements of Antitrust Enforcement Policy in Health Care, issued in 1996. The intention of Statement 6 on provider participation in exchanges of price and cost information was to limit the sharing of price data in cases where it might have anticompetitive effects, but it could limit price transparency as well. For example, the FTC encouraged Minnesota to focus on consumer price transparency initiatives while cautioning against making negotiated rates public in highly concentrated markets (Gudiksen, Chang, and King, 2019). Another (unintended) challenge to price transparency is the need to balance patients' rights to privacy under the Health Insurance Portability and Accountability Act versus making data easily available and shareable for transparency efforts (Institute of Medicine, 2009).

### Commercial Payers

Promoting transparency. A number of commercial payers have recently rolled out online price transparency tools. For example, Blue Cross Blue Shield now provides a tool that supplies pricing information for common elective procedures based on its own claims data ("Price Check," 2011). UnitedHealth offers a tool that allows members to compare both negotiated rates and OOP costs, while Aetna and Anthem provide information on discounted prices to members (Higgins, Brainard, and Veselovskiy, 2016; Beck, 2014; U.S. Government Accountability Office, 2011). As of 2014, most plans (98 percent) provide online price calculator tools that allow plan members to calculate OOP costs, although only about 2 percent of members actually access them (Beck, 2014). These tools have important limitations, however, highlighting the need for government transparency requirements and initiatives. For example, less than half of

tools actually take the plan's current negotiated rates into account when providing price estimates (Higgins, Brainard, and Veselovskiy, 2016), and cases have been reported in the media of actual prices faced by consumers far exceeding the range provided by insurer price estimator tools (Gantz, 2019).

Another recent effort supported by commercial payers is the Health Care Cost Institute (HCCI). When it launched, HCCI partnered with Aetna, Humana, and UnitedHealthcare to develop an online tool for consumers with comprehensive market-level price and quality information (UnitedHealth Group, 2014). There are also other third-party price transparency tools, such as Castlight, but our literature search did not identify the extent to which they are used by commercial insurers.

Limiting transparency. A potential barrier to hospital price transparency is the concern that negotiated rates might not be permitted to be made public under some contracts. One industry news article noted that it will be difficult to comply with requirements to post negotiated rates because some contracts do not allow it. The same concern was noted by news articles, peer-reviewed articles, and government reports (Beck, 2014; Reinhardt, 2006; U.S. Government Accountability Office, 2011). Furthermore, the insurance industry is also pushing back against any policy that would require hospitals to release negotiated prices, noting that this could "hamper competitive negotiations and push healthcare prices higher" (King, 2019b). This concern was also noted by news articles, peer-reviewed articles, and government reports (Beck, 2014; Reinhardt, 2006; U.S. Government Accountability Office, 2011).

However, Congress is considering action on this issue: Bipartisan legislation voted out of the Senate Health Education Labor and Pensions Committee on June 26, 2019 (the Lower Health Care Costs Act of 2019), would outlaw clauses in contract language that forbid parties to price negotiations from revealing those fees (Blumenthal, Gustafsson, and Seervai, 2019). The legislation had not yet been voted on by Congress as of March 2021.

## Data Availability

A critical concern regarding data on hospital quality is that they might not give consumers information with which to make meaningful comparisons between hospitals. For example, Care Compare, the CMS initiative that provides hospital quality information based on care of Medicare beneficiaries, provides only limited information to consumers on hospital performance measures. Care Compare presents scores only as summaries with one of three values: better than, no different from, or worse than the national mean. Dor, Encinosa, and Carey, 2015, noted, "These categories are determined according to the 95 percent confidence interval estimates produced by the underlying risk-adjustment model employed by CMS. The vast majority of hospitals fall within the confidence intervals of the 'no different' category, so there is little variation" (Dor, Encinosa, and Carey, 2015). CMS could consider presenting more-detailed quality score information, rather than simply whether scores differ from the national mean. Quality information based on experiences of non-Medicare beneficiaries is also limited.

The other major source of consumer-friendly hospital quality information is the U.S. News hospital ratings, which are based on four elements: patient outcomes, patient experience, other (hospital-level) care-related indicators, and expert opinion (U.S. News staff, 2019). However, similar to Care Compare, patient outcomes are based on Medicare data alone and might not be representative of other patient populations.

Another concern with Care Compare is the limited extent to which data about quality and pricing are linked. This is particularly important: Research shows that when shopping for health care services, almost one-quarter of consumers might consider high prices to signal high quality (U.S. Government Accountability Office, 2011; Phillips, Schleifer, and Hagelskamp, 2016; Schleifer, Silliman, and Rinehart, 2017). However, the Care Compare tool only provides very broad pricing information, including Medicare spending per beneficiary (displayed as a ratio, relative to the state and national averages) and whether payments for four conditions (heart attack, heart failure, hip or knee replacement, and pneumonia) are higher, lower, or no different from the national average (Centers for Medicare & Medicaid Services, undated-b). It does not include hospital- or insurer-specific pricing information. A 2014 GAO report noted concerns with how information is presented to consumers, citing lack of clarity in language and no option for consumers to customize results (U.S. Government Accountability Office, 2014).

# What Is the Relationship Between Price, Quality, and Advertising?

Our literature search identified only two articles addressing the link between price and quality information and hospital advertising. The first, which investigated how advertising affected quality (as opposed to how quality affected advertising), found that hospital advertising predicted performance on Hospital Consumer Assessment of Healthcare Providers and Systems global measures in competitive markets (Huppertz et al., 2017). This was likely due to improved brand recognition, which is known to positively impact consumer opinions. The second study conducted a structured review of the websites of 10 percent of U.S. hospitals to examine the price and quality information available to consumers (Muhlestein, Wilks, and Richter, 2013). The study found that only 1 percent of hospitals advertised about pricing on their websites, and 6 percent advertised about quality. The authors found that the available information was not sufficient to provide meaningful comparisons between hospitals.

The lack of advertising of price information could also be linked to clauses in some insurer-provider contracts that prohibit negotiated rates from being made public (Beck, 2014; Reinhardt, 2006). Furthermore, hospitals might be concerned that disclosing price information could lead to a "race to the bottom" in which insurers demand the lowest prices offered (Wilde Mathews, 2019). The dearth of relevant articles in this area could be because hospitals tend not to advertise price and quality information, but it might also reflect lack of detailed data on content or spending for hospital advertising.

We identified a handful of lawsuits filed by the DOJ to address practices by hospitals or health systems that limited marketing. In these cases, the hospitals or health systems generally sought to use their market power to limit marketing for anticompetitive reasons. The first case involved a health system in Iowa limiting the types and amount of advertising by each member hospital (United States v. Hospital Association of Greater Des Moines, Inc. ....., 1993). The DOJ alleged that this limited price and quality competition among the hospitals. The case ended in a settlement in which the health system and member hospitals agreed not to enter into any agreements amongst themselves related to the type of advertising or amount of spending on advertising. Another lawsuit involved a health system exercising its market power to limit insurers from encouraging consumers from seeking higher-value care from other providers and from sharing information about the cost and quality of competitors (United States and the State of North Carolina v. the Charlotte-Mecklenburg Hospital Authority, d/b/a Carolinas Healthcare System, 2019). Finally, two other lawsuits involved health systems and hospitals entering into agreements with other health systems or hospitals to limit marketing (United States v. Charleston Area Medical Center, Inc., and St. Mary's Medical Center, Inc., 2016; United States and State of Michigan v. Hillsdale Community Health Center....., 2018). For example, in one case, two large medical centers had agreed to limit marketing to specific geographic areas to maintain market power in those areas (United States v. Charleston Area Medical Center, Inc., and St. Mary's Medical Center, Inc., 2016). Given the anticompetitive nature of the agreements that brought about these cases, all of these lawsuits ended in settlements in which the hospitals or health systems were no longer permitted to limit marketing.

# 5. Pharmaceuticals

## Overview

This chapter summarizes the results of our environmental scan of the literature on pharmaceuticals. We defined the market segment "pharmaceuticals" as all prescription drugs dispensed or administered to patients at outpatient pharmacies (such as CVS, Walgreens, etc.) or in a physician's office.

There is minimal literature focused on the topics of price transparency, quality, and advertising in the pharmaceutical sector. The literature we identified in our search focused largely on pharmaceutical pricing. Only two articles specifically focused on direct-to-consumer advertising, and one focused on quality transparency. Additional searches for information on advertising of drug prices or quality did not generally return results, which can likely be attributed to the fact that pharmacy marketing generally focuses on attracting consumers to the store to purchase products other than medications. One important exception was the marketing efforts associated with the GDDPs, which were designed to ensure that consumers were aware of those benefits and came to the pharmacy specifically to take advantage of those discounts.

We identified the following key findings from our environmental scan:

- The net price, which is the final price paid for a given drug across all payers (including consumers), is generally not disclosed publicly due to agreements between payers and pharmaceutical manufacturers.
- Self-pay prices faced by consumers in pharmacies (either because of uninsurance or because of a high-deductible plan that charges full prices) are set by individual pharmacies.
- Consumer prices for pharmaceuticals are available via different tools, but the extent to which they are used to assist consumers in shopping for prices is uncertain.
- Opportunities exist for the government to encourage increased price and quality transparency for pharmaceuticals, such as emphasizing development of comparative and cost-effectiveness measures.

### How Are Prices Set?

Pharmaceutical pricing, as with many other segments in the health care system, involves a complex set of actors and many different stages. For brand-name prescription drugs, which are usually the first product in either the class or for that particular drug to enter the market, pharmaceutical manufacturers establish a list price, which is the publicly stated price at which they expect to sell the drug. The list price is usually not the price paid by any downstream entities involved in the supply and use of the prescription drug.

Prescription drugs are sold by manufacturers to wholesalers, which are intermediaries that sell the drugs to pharmacies and physician offices (The Health Strategies Consultancy LLC, 2005; Joint Task Force on the Fair Pricing of Prescription Drugs, 2018). Wholesalers pay a price that is lower than the list price. This price is referred to as the Wholesale Acquisition Cost (WAC; The Health Strategies Consultancy LLC, 2005; Ohn and Kaltenboeck, 2019). Wholesalers in turn sell the prescription drugs to pharmacies and other entities that will dispense or administer the medications to patients.

Health care payers, which include health plans (Medicare Part D and commercial enrollees), pharmacy benefit managers (organizations that manage pharmacy benefits on behalf of health plans), the government (Medicaid, Medicare Part B, and the VHA), and sometimes patients themselves (via self-pay), reimburse pharmacies and other suppliers for the drug, plus dispensing fees. Reimbursement rates are based on factors that differ across payer type and across the setting in which the drug is dispensed and administered.

#### Health Plans

Health plans negotiate outpatient prescription drug reimbursement rates for Medicare Part D and commercial plan enrollees with pharmacies that belong to the health plan's network. Reimbursement rates for branded drugs are usually based on a benchmark price established through negotiation or based on the WAC. Generic drugs are reimbursed at the Maximum Allowable Cost (MAC). This is the maximum price at which a given health plan will reimburse pharmacies for dispensing generic drugs. The MAC is established via negotiations between the pharmacy and the health plan (The Health Strategies Consultancy LLC, 2005). If pharmacies are able to purchase the generic drug for less than the MAC, they retain the difference as additional revenue.

Health plans also negotiate with pharmaceutical manufacturers of branded drugs for rebates, which are reimbursements made from manufacturers to health plans in exchange for the health plan placing the drug on a lower cost-sharing tier, which makes the drug less expensive for patients, or for the health plan achieving a previously agreed volume-based milestone of drugs dispensed (The Health Strategies Consultancy LLC, 2005).

The final price for a given drug is the net price paid by the health plan, plus any cost-sharing paid by the patient, for the drug—this price takes into account pharmacy reimbursements and any manufacturer rebates. This net price, inclusive of rebates and other discounts, is generally never disclosed outside of health plans, reflecting a significant lack of price transparency (Kirchhoff, Johnson, and Thaul, 2018). However, health plans offering Medicare Part D coverage are required to pass rebates through to Medicare beneficiaries via lower premiums.

#### Government

A number of government entities have established pharmaceutical reimbursement rates for their respective health care programs. Medicaid programs have access to preferential manufacturer rebates via the Medicaid Drug Rebate Program. As part of this program, Medicaid programs agree to cover all of a given manufacturer's prescription drugs in exchange for receiving rebates that are calculated based on whether the drug is branded or generic. Branded drug rebates are the greater of 23 percent of the Average Manufacturer Price (AMP), which incorporates discounts provided to other purchasers, or the difference between the AMP and the best price (the lowest price the manufacturer sold the drug for in the market; Baghdadi, 2017). Generic drug rebates are 13 percent off of the AMP. Medicaid programs are also able to negotiate supplemental rebates, in addition to the federally mandated rebates, via the creation of Preferred Drug Lists (Ohn and Kaltenboeck, 2019; Congressional Budget Office, 2019).

Medicare Part B, which covers physician services, reimburses providers for administering prescription drugs to patients in their offices or outpatient settings. Part B drugs are reimbursed based on a formula established by the Medicare Program, equal to the average sales price (ASP) at which the manufacturer sells the drug to the provider plus 6 percent (Danzon and Taylor, 2010).

The VHA negotiates prices for prescription drugs dispensed via its in-network hospitals, clinics, and pharmacies. The VHA has a national formulary and establishes contracts with manufacturers stipulating the price for each drug. For drug classes with therapeutic substitutes, the VHA negotiates with manufacturers for preferential inclusion on the formulary in exchange for lower prices and exclusion of other competitor prescription drugs. For some drugs, VHA prices are 35 percent lower than those paid by Medicare Part D beneficiaries (Huetteman, 2019).

Government reimbursement rates for health care programs can have a ripple effect on other payers. The Medicaid "best price" rule creates a floor for prescription drug pricing:

Manufacturers are unwilling to offer lower prices to other payers for fear of triggering the best price clause and being required to offer the same pricing to Medicaid (Baghdadi, 2017).

The VHA is exempt from the Medicaid best price rule. However, the VHA represents a relatively low market share for the entire country, so its negotiated prices are unlikely to affect other payers.

The Medicare Part B ASP + 6 percent reimbursement approach has been generally adopted by other payers (Werble, 2017). In this case, the government led the way with pricing.

### **Pharmacies**

Pharmacies also play an important role in establishing prescription drug prices. There are a number of different types of pharmacies, including independent pharmacies, grocery store pharmacies, big-box pharmacies (e.g., Walmart or Target), and chain pharmacies (e.g., CVS or Walgreens). Each type of pharmacy has different profit-making considerations as part of its business strategy in dispensing pharmaceuticals. For example, big-box and chain pharmacies might offer additional discounts on prescriptions because they expect customers to purchase other items while they are in the store (Choudhry and Shrank, 2010). Independent pharmacies

might focus more on the consumer experience to encourage repeat business for refill prescriptions.

As described above, pharmacies are reimbursed by health plans and government payers for dispensing covered prescription drugs to plan enrollees. Those reimbursement rates are determined via negotiations with the different payers.

Pharmacies also dispense prescription drugs to patients without health insurance or who are enrolled in high-deductible plans and who therefore might need to pay the full price of the prescription out of pocket. Prices paid by patients in these two categories are established by individual pharmacies and are therefore not based on a simple or straightforward formula. Previous studies have found that drug prices vary across pharmacies even within the same ZIP code or geographic area (Arora et al., 2017; Gellad et al., 2009; Hauptman, Goff, and Vidic, 2017; Rodwin, 2019), with one study finding up to \$52 of variation in price for a single drug within the same ZIP code (Arora et al., 2017). Variation in pharmacy prices is likely due to different discount programs or coupons offered or accepted by individual pharmacies.

Starting in 2006, big-box and chain pharmacies, including Walmart, Target, and Walgreens, began offering GDDPs. These programs offered very low prices (often \$4 for a 30-day supply) for a specific set of generic prescription drugs. These programs are offered outside of insurance coverage and are available to any customer who fills a generic prescription at the store, regardless of their insurance status (Choudhry and Shrank, 2010; Zhang et al., 2012). These programs therefore could have substantially reduced costs for patients, as the new price offered by pharmacies was generally substantially lower than the regular self-pay price and often was also much lower than the cost-sharing charged by commercial health plans (Zhang et al., 2012). Pharmacies were able to do this because of their purchasing power for included generic drugs and also because of the low costs of producing generic drugs. In addition, large pharmacies might have leveraged the program to bring customers into the store and sell other products at the same time (Choudhry and Shrank, 2010).

### Out-of-Pocket Price for Insured and Self-Pay Patients

Prices for prescription drugs are also established for patients, both those with insurance and those who pay all costs out of pocket (self-pay). Health plans for both Medicare Part D and commercial insurance generally use a tiered formulary approach, in which patients have lower cost-sharing (often even \$0) for less-expensive generic drugs; higher cost-sharing for preferred-brand drugs (for example, \$42 is the median Part D plan copayment for a 30-day supply); higher cost-sharing still for non-preferred brands (for example, a median coinsurance of 38 percent of the cost of the drug for Part D plans); and 25 percent of the cost for specialty drugs for most Part D plans, which are often biologic products with few close substitutes (Cubanski and Damico, 2019). For specialty drugs, patient cost-sharing can translate into hundreds of dollars per month because of the 25-percent pricing rule.

Medicaid recipients usually have very low or no cost-sharing for prescriptions dispensed and covered by Medicaid. Veterans receiving VHA benefits also often have low or no cost-sharing (McCaughan, 2017). Medicare Part B patients pay 20 percent of the reimbursement rate for the prescription (ASP + 6 percent), but, in practice, more than 80 percent of Medicare Part B enrollees have supplemental coverage that further reduces cost-sharing (Cubanski et al., 2018).

Patients with no insurance, and many who are enrolled in high-deductible plans, pay the full cost of prescription drugs out of pocket. Those in high-deductible plans benefit from their health plan's negotiated pharmacy rate; they pay 100 percent of that rate while within the deductible's limits. Patients with no coverage at all pay the pharmacy's stated price, which varies by pharmacy. Patients who are prescribed expensive medications and do not have insurance could be eligible for pharmacy assistance programs, which are charities that help with OOP costs. Patients might also receive assistance from pharmaceutical manufacturers, which lower the cost of the prescription. Therefore, although the net price determines how much the health system overall paid for a given drug, patient cost-sharing and pharmacy prices are important markers for consumers who may need to fill prescriptions.

# What Influences the Level of Consumer Price and Quality Transparency?

Price and quality transparency for pharmaceuticals rely on different considerations than for other sectors, such as hospitals and physicians. Price transparency for consumers can largely focus on increasing information about the price (cost-sharing or total pharmacy price) that the consumer can expect to pay to obtain the prescription drug. Quality measures for pharmaceuticals focus on comparative effectiveness, which provides information on the relative effectiveness of a given drug compared with another, and cost-effectiveness, which incorporates cost information with comparative effectiveness to establish an overall measure of the value of a given medication. These measures focus on different medications or types of treatment for a specific condition and provide information about the relative effectiveness and value of substitute therapies compared with one another. Information about these measures, as well as lower-cost therapeutic substitutes, might not be readily available to consumers. The government and health plans can both play important roles in price and quality transparency efforts, as discussed in this section.

#### Government

Government can play an important role in price transparency efforts by actively requiring increased transparency and also by targeting negotiated contract terms between different players that can reduce transparency. One example has been efforts to target gag clauses in contracts between health plans and pharmacies (Dabbous et al., 2019; Salazar, 2018; DeBenedette, 2018). Gag clauses prohibited pharmacists from informing patients when they could pay less out of pocket for a drug than what their insurance plan's copay would charge. The Patient Right to

Know Drug Prices Act, signed into federal law in 2018, prohibits such clauses in contracts between insurers or pharmacy benefit managers and pharmacies, and the Know the Lowest Price Act, also signed into law in 2018, does the same for Medicare Advantage and Medicare Part D plans (Coppock, 2018). A regulation implemented in Ohio requires health plans to tell patients the lowest price for a prescription and prohibits health plans from charging more than the cost of the drug when the drug price is lower than the copay (DeBenedette, 2018). Another approach to increasing transparency for pharmacies is to require health plans to regularly update their MAC pricing information, which is the price on which generic drug reimbursement is based; providing pharmacies with the most up-to-date reimbursement numbers available can help pharmacists know in advance what they can expect to be reimbursed for a drug (Salazar, 2018).

The government also increases price transparency through the Medicare Plan Finder tool, which provides Medicare beneficiaries with information on the prices they can expect to pay for covered drugs under each Medicare Part D plan. Beneficiaries can enter the specific drugs they currently take and see how much they can expect to pay if they were to enroll in each Medicare Part D plan available for the year. This tool substantially increases transparency for consumers seeking information about OOP prescription drug prices; however, research has found that the tool could be too complicated and that further simplification of financial information could help Medicare beneficiaries make better plan decisions (McGarry, Maestas, and Grabowski, 2018). For example, displaying simple information on total costs alone, or total costs, premiums, and OOP costs, rather than displaying complicated plan benefit design details, has been shown to result in the selection of lower-cost plans by beneficiaries, without any reductions in plan quality on average in the chosen plans.

One government action that has had mixed effects on the ability of states to establish price transparency standards for pharmaceuticals is ERISA. ERISA is a federal law that governs the offering of employee benefit plans. States that have passed laws designed to require pricing data to be disclosed, as well as laws designed to require health plans to disclose their pricing methodology, have been challenged in the courts based on ERISA preemption. The lawsuits claim that states do not have the authority to establish requirements that apply to ERISA plans, because ERISA plans are subject to federal, and not state, law. Courts in different states have ruled differently; thus, ERISA preemption could limit the ability of states to establish price transparency requirements (Stecker, 2018).

## Commercial Payers

The primary contractual agreement between private actors and insurers that serves as a barrier to price transparency is the fact that pharmaceutical manufacturers sell their products to different payers for different prices (Kirchhoff, Johnson, and Thaul, 2018). Because of negotiated rebates with manufacturers and reimbursement to pharmacies, only the health plan knows the final net price of a drug.

Consumers' ability to determine a given drug's price depends on multiple factors, including the health plan in which they are enrolled and their ability to determine whether a prescribed drug is a generic or preferred brand. Health plan enrollees might only learn the price they must pay for a drug when they fill the prescription. Pricing tools such as GoodRx and Blink Health exist to help consumers find information about anticipated OOP costs for a specific drug for their specific plan; however, evidence suggests that patients do not often use these tools (GoodRx, undated; Blink Health, 2021; Mehrotra et al., 2017). Although most commercial insurers offer pricing tools, 75 percent of nonelderly respondents to a survey noted that they did not price-shop because they lacked knowledge of where to obtain pricing information, so awareness of price transparency tools could be lacking (Mehrotra et al., 2017). Furthermore, consumers might be unwilling to change providers or pharmacies. GoodRx and Blink Health also offer coupons that consumers can use to purchase drugs at a lower cost from their local pharmacies without insurance, and Blink Health allows consumers to purchase drugs through its website; these drugs are then filled by pharmacists in its network. This allows consumers to know the price up front without considering deductibles or other plan benefit details.

### Data Availability

Price and quality measures for pharmaceuticals generally focus on measures of comparative effectiveness (which does not take cost into account) and cost-effectiveness (which does incorporate cost). One study noted that manufacturers provide scant information on these topics for the prescription drugs they are selling (Danzon and Taylor, 2010). There is also some evidence that pharmaceutical prices fluctuate substantially, creating challenges for transparency (Elsevier Clinical Solutions, 2015; Wineinger, Zhang, and Topol, 2019). This dearth of information restricts the ability of health plans and consumers to make decisions based on more-complete information about the drug's effectiveness and costs. Requiring manufacturers to provide cost-effectiveness (as is the case in other countries, such as Canada) or comparative effectiveness information would serve to increase transparency and, by extension, might also provide incentives for manufacturers to establish prices that are in line with the health benefits provided by the specific medication. For example, the federal government could require drug manufacturers to submit cost or comparative effectiveness data in order for the manufacturer's drugs to be covered by Medicare; the government could then make this information publicly available.

# What Is the Relationship Between Price, Quality, and Advertising?

Pharmaceutical manufacturers use direct-to-consumer advertising to increase awareness of their products among patients. The U.S. Food and Drug Administration (FDA) regulates advertising of pharmaceuticals, with specific requirements associated with the type of information that can and cannot be presented, including the risks and benefits of the medication

(Schwartz and Woloshin, 2019). Advertising can include coupons or discounts designed to reduce patients' OOP costs for the drug being marketed; these are often offered for very expensive drugs (e.g., specialty drugs) and for branded drugs for which there are generic competitors. Discounts and coupons raise concerns about patients using medications for which OOP costs are lower but for which alternatives with lower total costs are available (Schwartz and Woloshin, 2019; Dafny, Ody, and Schmitt, 2017).

Pharmaceutical advertising has not generally included information about price and quality; however, the Pharmaceutical Research and Manufacturers of America (PhRMA), which represents large manufacturers, has suggested that manufacturers direct consumers to websites where they can find pricing information (Moore, 2019). PhRMA's recommendation was issued around the same time as the Trump administration proposal requiring manufacturers to include prescription drug list prices as part of every advertisement (Weixel, 2019). However, hours before the rule was set to take effect, a federal judge blocked the administration from implementing it; a hearing on the administration's appeal was held in June 2020, and the prior ruling was upheld ("U.S. Appeals Court Rejects Rule Requiring Drug Prices in TV Ads," 2020).

In response to these proposals, at least one manufacturer set up a website with pricing information; another (Johnson & Johnson) provides list prices in advertisements for its drug Xarelto (a blood thinner; Moore, 2019). One study found that consumers were substantially less interested in an expensive prescription drug if the list price was included in the advertisement; their level of interest did not change for a low-priced drug (Garrett et al., 2019).

Our search for information on advertising by pharmacies did not yield many results. One study published in 2010 noted that seven of the ten largest pharmacy chains advertised GDDPs (Czechowski, Tjia, and Triller, 2010). Another study found that as of 2013, 10 percent of lowincome residents surveyed in the area of Houston, Texas, were aware of GDDPs because of television advertisements (Omojasola et al., 2014). Although we did not identify articles that studied the extent and content of advertising (or lack thereof) in a detailed manner, the lower generic prices offered by different pharmacies starting in 2006 were clearly advertised and much-discussed by policymakers, consumers, and other stakeholders, and, therefore, advertisements likely played an important role in encouraging patient use of those lower-cost programs. It is possible that pharmacies do not advertise self-pay drug prices beyond GDDPs for a number of reasons: Norms of the industry, advertising of other products to attract customers to the store more broadly, hesitance to advertise certain prices when lower prices might be available through coupons or other discounts available through sites such as GoodRx, and the complexity of advertising prices for thousands of drugs (beyond those commonly taken generics often included in GDDPs) could all play a role. Furthermore, until 2018, pharmacies might have been concerned that advertising self-pay prices could violate gag clauses in contracts with commercial insurers. However, the literature largely does not address this question.

### Overview

This chapter summarizes the results of our environmental scan of the literature on medical devices. Although medical devices are a small part of the overall health care market, they are a large market unto themselves. The 2014 Medicare cost report data suggest that hospitals spent about \$10 billion on medical supplies and \$14 billion on implantable devices for Medicare-covered services that year (MedPAC, 2017). The total market was between \$120 and \$172 billion in 2013, or 4 to 6 percent of total U.S. spending on health care, and that percentage has remained stable since then (MedPAC, 2017).

The market segment for commodity items—surgical apparel, wound dressings, etc.—is relatively straightforward and competitive. In contrast, the market for high-technology devices, particularly implantable devices, is very different. The barrier to entry is higher, because of research and development costs, and there is more regulatory oversight. As a result, competition is more limited, and profits can be much higher (MedPAC, 2017). We focus on this segment of the market.

The literature on technologically advanced medical devices is limited. Our search identified three specific articles about price transparency and devices; to this we added a few other articles that were highly relevant. In general, the literature draws on data from claims, including the HCCI database, which contains information on commercial prices of durable medical equipment (DME).

We identified the following key findings from our literature scan:

- As with physician pricing, Medicare coverage decisions and pricing impact private insurance costs for devices.
- For DME, consumers can find out in advance what their cost will be before purchasing the item. However, that does not mean that the actual price paid by insurance is transparent.
- The market dynamics for commodity items versus high technology devices vary greatly. For items like surgical supplies, companies compete heavily on price; the market for high-tech devices like implantable defibrillators is less competitive, meaning that prices are often more opaque and higher (MedPAC, 2017).
- Hospitals could encounter barriers when trying to work with physicians around device prices—for example, confidentiality clauses and physician-manufacturer relationships (U.S. Government Accountability Office, 2012).

### How Are Prices Set?

Medicare pays for most medical devices (other than DME), such as syringes or imaging equipment, indirectly, because they are components of the delivery of care. Therefore, providers are reimbursed for the devices they use in the course of caring for beneficiaries as part of their total bundled price (MedPAC, 2017). As a result, hospitals have an incentive to use lower-cost devices, because their share of the bundled payment will thus be reduced. In contrast, physicians themselves could have less incentive to use lower-priced devices, because they are not generally financially responsible for the cost of the device.

Medicare Part B covers DME prescribed for home use (such as blood sugar monitors or crutches); the patient pays a percentage of the price plus a deductible (Medicare, undated-b). Beneficiaries with supplemental coverage might have additional coverage of DME. CMS used a statutory-based fee schedule for DME until 2011, when it implemented a competitive bidding process. The initial years of the program produced prices comparable to those obtained, on average, by large commercial insurers—sophisticated purchasers that negotiated prices with suppliers of DME and similar items (Newman, Barrette, and McGraves-Lloyd, 2017). On average, the prices after the bidding were 35 percent lower than in 2010, before the program started. There is also evidence that the government's competitive bidding program affected the overall market for DME and similar items, with high-cost suppliers leaving the market or reductions in prices by all suppliers or both (Newman, Barrette, and McGraves-Lloyd, 2017).

According to an analysis of claims data from 2007 to 2012, "for laboratory services and durable medical equipment, where commercial prices are lower than Medicare FFS rates, MA plans take advantage of these lower commercial prices" (Trish et al., 2017). This is somewhat similar to the case for hospital services, for which MA plans pay the same as or slightly less than Medicare FFS does.

# What Influences the Level of Consumer Price and Quality Transparency?

Prices for high-technology devices cut into hospital profits, so hospitals and other parties are interested in lower, or at least stable, device prices and generally favor price disclosure (Pauly and Burns, 2008). The market for medical devices differs from the other market segments discussed in this report, because the purchasers of devices are not only consumers and insurers, but also health care providers.

#### Government

Our literature search did not identify any descriptions of government pushes for price or quality transparency of medical devices. In a 2010–2011 GAO survey about implantable devices, respondents said that "the price information they provided for at least one device did not account for all discounts and rebates obtained" (U.S. Government Accountability Office, 2012). GAO concluded that this lack of transparency could hamper the ability of hospitals to be "prudent"

purchasers" of the devices: "The lack of price transparency for the IMDs [implantable medical devices] we examined makes it difficult to know whether hospitals are achieving the best device prices" (U.S. Government Accountability Office, 2012).

## Commercial Payers

Transparency is sometimes explicitly forbidden in medical device contracts, and sellers often charge some buyers more than they charge others. Some device sellers have designed contracts that include language forbidding buyers from disclosing the final negotiated price to other buyers, or even to patients or insurers (Pauly and Burns, 2008). For example, in 2007, Boston Scientific brought lawsuits against data intermediaries, claiming that the intermediaries used pricing data that were submitted to them by hospitals to compile comparative pricing data (Robinson and Bridy, 2009). The lawsuits were settled out of court but led to legislation (which ultimately did not pass) that would have mandated that medical device manufacturers disclose their pricing information. As such, this type of contract language limits price transparency, although transparency of device prices (other than some DME) might be more directly relevant to providers than consumers.

# Data Availability

There are some limited data on the quality of medical devices using adverse event information maintained by the FDA and device recall information (U.S. Food and Drug Administration, 2011). However, the major limitation of these data is that they are not created for the purpose of making comparisons; thus, in their current format, their utility could be limited.

# What Is the Relationship Between Price, Quality, and Advertising?

From 1997 through 2016, spending on medical marketing of drugs, disease awareness campaigns, health services, and laboratory testing increased from \$17.7 billion to \$29.9 billion (Schwartz and Woloshin, 2019), but specific information about spending on device advertising was not available. The environmental scan did not yield any results regarding advertising and transparency of prices and quality for medical devices.

# 7. Discussion and Conclusions

In the physician and hospital sectors, prices are set in a similar way. Medicare FFS sets the prices it pays to hospitals and physicians, typically on a case or per-diem basis, while commercial insurers negotiate with physicians and hospitals to determine rates. There is substantial variation in prices paid by commercial payers, and prices are generally higher in markets with higher provider concentration.

The government does not directly affect prices paid by commercial payers, but it does have an indirect impact in several ways. First, MA prices are generally very similar to prices in Medicare FFS. In addition, although prices paid by commercial payers are generally substantially higher than Medicare prices, prices paid by commercial payers have been shown to decrease in response to reductions in Medicare reimbursement rates.

Outpatient pharmaceutical prices vary by payer; government payers either receive mandated and supplemental rebates (Medicaid) for dispensed prescriptions or negotiate prices in exchange for inclusion on a limited formulary (VHA). Commercial health plans, which also offer coverage for Medicare Part D enrollees, negotiate prices paid to the pharmacy as well as rebates and other discounts from manufacturers. Medicare negotiates prices for medical devices that are accessed directly by consumers, but costs for many devices are bundled into prices for episodes of care. Pharmacies set prices individually for self-pay patients.

Recent federal efforts toward consumer price transparency have primarily focused on hospital price transparency. A 2018 federal rule included a requirement that hospitals release their chargemaster data and update the information annually. A 2019 federal rule requires hospitals to disclose their standard charges for all services online in a machine-readable format and to disclose the rates that they negotiate with private payers in a consumer-friendly manner for 300 shoppable services. Additionally, a 2020 final federal rule requires insurers to create online pricing tools and to disclose negotiated rates for both in-network and out-of-network providers, as well as prices for prescription drugs (Keith, 2020; Internal Revenue Service, Employee Benefits Security Administration, and Department of Health and Human Services, 2020). There are various state price transparency efforts as well. Perhaps the most high profile is the establishment of state APCDs, which have been used to develop various price transparency tools for consumers. The primary mechanism through which the federal government promotes consumer quality transparency is the Care Compare tool, which allows consumers to view and compare quality measures for hospitals and physicians.

One limitation of many government price transparency initiatives is that they are generally not focused on prices faced by the consumer. For example, pushes for hospital price transparency have focused on charges, which are generally not the prices paid by any insurer or by the consumer, and, more recently, on transparency of negotiated prices. Although negotiated prices

do provide data that allow consumers to make meaningful comparisons between providers, these are still not the prices actually faced by consumers. However, OOP price transparency would be difficult to convey accurately, because any tool would need to know not only negotiated prices between plans and providers but also the specific plan benefit design information of each consumer's insurance plan and where the consumer falls in their benefit (for example, whether the deductible has been met).

The environmental scan did not identify any work related to how ethical codes of provider organizations affect price or quality transparency.

A key limitation of the Care Compare government quality transparency tool is that although it provides quality data in a simple way to consumers (i.e., better than, worse than, or no different from the national mean), there is little variation with which to make meaningful comparisons because the majority of providers fall into the category of being no different from the national mean.

Commercial insurers are also promoting price transparency, largely through online tools provided to their members to estimate costs of service. These tools have varying degrees of utility and accuracy. However, commercial insurance contracts can present a barrier to price transparency efforts because of contract clauses that do not allow disclosure of negotiated prices or, in the case of pharmaceuticals, net prices, and the insurance industry is pushing back against requirements for hospitals to release negotiated prices. The federal government is pursuing legislation that would disallow or limit the effect of such clauses in provider-insurer contracts, and federal legislation has been signed into law that disallows pharmacy "gag clauses" that prevent pharmacists from disclosing lower-cost drug options to patients.

Limited information was available about the extent to which providers, pharmacies, and device manufacturers use pricing and quality information in marketing efforts. It appears that hospitals and physicians do not commonly advertise price or quality information. Although pharmaceutical companies have historically not included price information in advertising, they have offered discounts or coupons as part of advertisements. More recently, efforts have been made to enable consumers to access information about pricing using a link or other information provided in the pharmaceutical advertisement. However, it is not clear whether this practice will be adopted across all pharmaceutical companies.

Policymakers are interested in initiatives that could reduce barriers to price and quality transparency, increase meaningful price and quality transparency for consumers, and improve consumers' knowledge and control of their own health care costs. To that end, the findings of this environmental scan are informative.

• First, policymakers could consider focusing initiatives on OOP price transparency, as federal price transparency initiatives have been aimed at consumers and OOP costs are likely most relevant for consumers. Policymakers could continue to pursue measures such as a 2020 federal rule that requires insurers to provide OOP prices to their members via online price transparency tools. Such efforts would help

- to address the shortcomings of existing insurer price transparency tools, which are currently not required and do not always offer accurate pricing information.
- Second, existing federal quality transparency tools, such as Care Compare, could be improved upon to allow more meaningful comparisons between providers. In particular, CMS could consider the following actions:
  - Present detailed, provider-specific pricing information for a broader range of services.
  - Present the full variation in quality scores rather than limiting information to differences from the national mean.
  - Explicitly link detailed quality and price data by presenting both pieces of information together.
- Third, policymakers could continue to pursue legislation that would limit or prohibit clauses in insurer-provider contracts that do not allow negotiated prices to be disclosed, as they did with similar clauses in contracts between private insurers and pharmacies that prohibited pharmacists from informing patients when paying for a drug out of pocket would be less expensive than paying the copay through their insurance.
- Fourth, the federal government could consider regulations that would require drug manufacturers to submit cost effectiveness or comparative effectiveness data on their drugs in order for those drugs to be covered by Medicare. These data could be made public to allow consumers (and providers) to make better-informed decisions about prescription drugs.
- Fifth, states could work together with federal agencies, such as the Department of Labor (DOL), to require self-funded health plans to submit data to a national APCD. This would address the issue of ERISA preemption undermining state APCDs. This would, however, be a significant undertaking because the DOL currently does not collect any data similar to APCDs.
- Finally, states can work to improve price transparency and quality transparency by taking the following actions:
  - o States that have not yet established APCDs could do so.
  - States that do have APCDs but do not have online price transparency tools for consumers can create them.
  - States that do have APCDs and online price transparency tools can work to improve the breadth and quality of the data provided.
  - States can provide consumers with detailed quality information on providers in conjunction with online transparency tools.

Efforts to achieve price and quality transparency have the potential to allow consumers to make better-informed decisions about their health care, particularly if the challenges and barriers outlined in this report are addressed.

### Appendix: Search Terms for the Targeted Literature Review

### Peer-Reviewed Literature

**PubMed 2015-**

present; English

Pric\*[tiab] OR payment\*[tiab] OR reimburs\*[tiab] OR rate-setting[tiab] OR "rate setting"[tiab] OR "quality care"[tiab]

**AND** 

Health plan\*[tiab] OR healthcare plan\*[tiab] OR health care plan\*[tiab] OR US healthcare[tiab] OR US health care[tiab] OR medicare[tiab] OR Medicaid[tiab] OR "veterans affairs" [tiab] OR "veterans health administration" [tiab] OR health insurance[tiab]

**AND** 

Negotiat\*[tiab] OR bargain\*[tiab] OR transparent[tiab] OR transparency[tiab] OR barrier\*[tiab] OR advertis\*[tiab] OR quality measure\*[tiab]

Results: 687

OR

**PubMed 2009-**

2014; English

Pric\*[tiab] OR payment\*[tiab] OR reimburs\*[tiab] OR rate-setting[tiab] OR "rate setting"[tiab] OR "quality care"[tiab]

**AND** 

Health plan\*[tiab] OR healthcare plan\*[tiab] OR health care plan\*[tiab] OR US healthcare[tiab] OR US health care[tiab] OR medicare[tiab] OR Medicaid[tiab] OR "veterans affairs" [tiab] OR "veterans health administration" [tiab] OR health insurance[tiab]

**AND** 

transparent[tiab] OR transparency[tiab]

**Results: 64** 

**NOT:** (nigeria[ti] OR india[ti] OR kenya[ti] OR kyrgyzstan[ti] OR korea[ti]) OR (china[ti] OR iran[ti] OR australia[ti] or ghana[ti] OR japan[ti])

Results: 649

### **Business Source Complete**

### 2009-present; English

TI(Pric\* OR payment\* OR reimburs\* OR rate-setting OR "rate setting" OR "quality care") OR AB(Pric\* OR payment\* OR reimburs\* OR rate-setting OR "rate setting" OR "quality care")

### **AND**

TI(Health plan\* OR healthcare plan\* OR health care plan\* OR "US healthcare" OR "US health care" OR medicare OR Medicaid OR "veterans affairs" OR "veterans health administration" OR "health insurance") OR AB(Health plan\* OR healthcare plan\* OR health care plan\* OR "US healthcare" OR "US health care" OR medicare OR Medicaid OR "veterans affairs" OR "veterans health administration" OR "health insurance")

### **AND**

TI(Negotiat\* OR bargain\* OR transparent OR transparency OR barrier\* OR advertis\* OR quality measure\*) OR AB(Negotiat\* OR bargain\* OR transparent OR transparency OR barrier\* OR advertis\* OR quality measure\*)

Results: 444 - duplicates and non-U.S. results = 378

### **EconLit**

### 2009-present; English; Academic Papers/Working Papers

TI(Pric\* OR payment\* OR reimburs\* OR rate-setting OR "rate setting" OR "quality care") OR AB(Pric\* OR payment\* OR reimburs\* OR rate-setting OR "rate setting" OR "quality care")

### AND

TI(Health plan\* OR healthcare plan\* OR health care plan\* OR "US healthcare" OR "US health care" OR medicare OR Medicaid OR "veterans affairs" OR "veterans health administration" OR "health insurance") OR AB(Health plan\* OR healthcare plan\* OR health care plan\* OR "US healthcare" OR "US health care" OR medicare OR Medicaid OR "veterans affairs" OR "veterans health administration" OR "health insurance")

### **AND**

TI(Negotiat\* OR bargain\* OR transparent OR transparency OR barrier\* OR advertis\* OR quality measure\*) OR AB(Negotiat\* OR bargain\* OR transparent OR transparency OR barrier\* OR advertis\* OR quality measure\*)

Results: 59 - duplicates and non-U.S. results = 21

Added some citations using the "similar articles" and "cited by" feature in PubMed.

**TOTAL: 1,095** 

### **Gray Literature**

### **Congressional Research Service**

Health care pricing transparency Health care price transparency health payment negotiate health payment barrier health reimburse negotiate

### **Congressional Budget Office (via Advanced Google)**

healthcare pric\* transparency site:cbo.gov health pric\* transparency site:cbo.gov health price\* barrier site:cbo.gov

### **Government Accountability Office (via Advanced Google)**

health price\* site:gao.gov health price\* transparency site:gao.gov

### **Advanced Google**

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## Broadening Marketplace Enrollment Periods Would Boost Access to Health Coverage

By Sarah Lueck<sup>1</sup>

The Biden Administration's decision to open HealthCare.gov to 2021 enrollment through August 15 is an important step to giving people access to comprehensive plans and financial assistance. But beyond the COVID-19 public health emergency, the Administration should make additional, permanent changes to make it easier for more people to enroll in coverage through the Affordable Care Act (ACA) marketplaces. (See Figure 1.)

The Biden Administration, in its executive order on health care, directed relevant agencies to examine "policies or practices that may present unnecessary barriers to individuals and families attempting to access Medicaid or ACA coverage, including for mid-year enrollment..."<sup>2</sup> Federal open and special enrollment rules fit within this directive. The yearly open enrollment period (when anyone can newly enroll or change marketplace plans) is needlessly short, and people's awareness of it remains low, even a decade after the ACA was enacted. After the end of open enrollment, people can access coverage only if they qualify for a special enrollment period (SEP), a process that is overly complex and restrictive. Millions of people experience the events that make them eligible for SEPs each year, yet few use the SEP to sign up for a plan. During the course of each year, more people leave the marketplace than join it — an imbalance that appears to be driving a

FIGURE 1

### **Biden Administration Can Boost** Access to Health Coverage



### Lengthen the open enrollment period.

Reinstate a longer open enrollment period of at least 12 weeks to give people more time to sign up for or change plans.



Create a "financial help" special enrollment period (SEP).

Allow people who are eligible for significant financial help to enroll in a marketplace plan at any time.



Create a "job loss" SEP.

Grant someone who loses their job an SEP, even if they aren't losing job-based health benefits.

Source: CBPP

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seasonal drop in insured rates that did not exist prior to the ACA.

<sup>&</sup>lt;sup>1</sup> Gideon Lukens contributed to the analysis for this report.

<sup>&</sup>lt;sup>2</sup> White House, "Executive Order on Strengthening Medicaid and the Affordable Care Act," January 28, 2021, https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengtheningmedicaid-and-the-affordable-care-act/.

HealthCare.gov is essentially in the middle of a six-month open enrollment period because of the public health emergency. But looking ahead, the Administration should make permanent rule changes to simplify people's pathways to the marketplaces, including by:

- Lengthening the annual open enrollment period. Reinstate a longer open enrollment period of at least 12 weeks, up from the current six weeks, to give people more time to sign up for or change plans each year.
- Create a "financial help" SEP. Allow people who are eligible for significant financial help to enroll in a marketplace plan at any time during the year.
- Create a "job loss" SEP. Grant someone who loses their job an SEP, even if they aren't losing job-based health benefits.

### **Enrollment Rules Present Barriers to Health Coverage**

More than one-third of people who are uninsured are already eligible for Medicaid or for premium tax credits in the marketplace.<sup>3</sup> While cost remains the top concern for many, some may be unaware that affordable coverage is available, or bureaucratic or other hurdles may have kept them from enrolling in or maintaining their coverage.

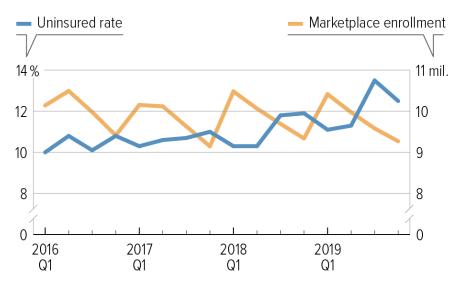
Enrollment deadlines and rules appear to be one of those hurdles. Many people who are eligible for special enrollment periods to enroll outside of the standard annual open enrollment period aren't using them, possibly because they aren't aware of them or because the system is too confusing.<sup>4</sup> Prior to the pandemic, marketplace enrollment consistently fell during the year by more than 1 million people. And the yearly decline in marketplace enrollment appears to have driven a troubling seasonal increase in the uninsured. The number of adults without coverage rose by more than 1 million between the first and fourth quarter of each year from 2016 through 2019, then fell by more than 1 million in the first quarter of the subsequent year (after marketplace open enrollment), National Health Interview Survey data show.<sup>5</sup> (See Figure 2.)

<sup>&</sup>lt;sup>3</sup> Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under 65: 2020-2030," September 29, 2020, <a href="https://www.cbo.gov/publication/56571">https://www.cbo.gov/publication/56571</a>.

<sup>&</sup>lt;sup>4</sup> Matthew Buettgens, Stan Dorn, and Hannah Recht, "More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods," Urban Institute, November 2015, <a href="https://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf">https://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf</a>.

<sup>&</sup>lt;sup>5</sup> Enrollment patterns have been different in the pandemic, with states and the federal government reporting increases in marketplace sign-ups when they have opened marketplace plans to enrollment and as people have lost employer-sponsored plans.

## Uninsured Rate Reflects Seasonal Changes in Marketplace Enrollment



Note: Marketplace enrollment depicted in quarterly averages. Uninsured rate includes persons under age 65.

Source: CBPP analysis using Marketplace effectuated enrollment data from the Centers for Medicare and Medicaid Services, and early release estimates of quarterly uninsured rates from the National Health Interview Survey.

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If the system were working well, marketplace enrollment would be roughly stable during the year, as the number of people enrolling in plans (because they lose job-based benefits or Medicaid, for example) would roughly match the number who leave (because they become eligible for Medicaid or get a job with health coverage). But the system is not working well.

The ACA marketplaces began operating seven years ago, and many people who are uninsured or accustomed to getting coverage from their job or other sources may not be aware of its rules and deadlines. In a 2018 survey, just one-quarter of potential marketplace consumers knew the open enrollment deadline. Recent cutbacks in marketing and outreach under the Trump Administration likely exacerbated the lack of awareness.

Revamping rules for both open and special enrollment periods would help increase access to health coverage and reduce gaps in insurance when people experience changes in their lives. A more accessible enrollment structure would help even more people maintain coverage and avoid periods

<sup>&</sup>lt;sup>6</sup> Ashley Kirzinger, Bryan Wu, and Mollyann Brodie, "KFF Health Tracking Poll-November 2018: Priorities for New Congress and Future of the ACA and Medicaid Expansion," Kaiser Family Foundation, November 28, 2018, <a href="https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-november-2018-priorities-congress-future-aca-medicaid-expansion/">https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-november-2018-priorities-congress-future-aca-medicaid-expansion/</a>.

without insurance, when combined with improvements in marketplace financial assistance, such as the enhanced premium tax credits enacted in the American Rescue Plan.<sup>7</sup>

Nearly three-quarters of marketplace enrollees have annual incomes between 100 percent and 250 percent of the federal poverty line, or about \$13,000 and \$31,000 for an individual. People in this group have incomes that overlap with or are only a little higher than the incomes of people receiving Medicaid, which allows people to enroll in health coverage at any point during the year. And they may have children who are covered through the Children's Health Insurance Program (CHIP), which also has year-round enrollment. Many potential marketplace enrollees may therefore be accustomed to a continuous enrollment cycle and less familiar with the marketplace's more restrictive structure.

Existing enrollment rules may pose challenges for low-income people for another reason. Research has shown that living in "chronic scarcity" (in which people lack money, time, and other basic resources) requires expending enormous mental effort to solve immediate problems, which makes decision-making more difficult and leaves less bandwidth to, for example, remember small details and remember to act. At the same time, people with low incomes are eligible for significant financial help if they manage to enroll in a marketplace plan, making it all the more important to clear the hurdles they face.

### Permanently Extend the Yearly Open Enrollment Period

As noted, awareness of the open enrollment period is low. In addition, it occurs during a period of the year (November 1 through December 15) when research shows people experience higher levels of financial and mental stress, making it possibly "the worst time of the year to require complex health insurance enrollment decisions." Lower-income people are likely to experience especially acute financial pressure between Thanksgiving and New Year's Day, as expenses such as gifts and heating bills strain household budgets.

Many state-based marketplaces regularly provide longer open enrollment periods that stretch well into or through January. <sup>10</sup> The federal marketplace has also, at times, provided a longer annual open enrollment: people had five months to enroll for 2014, the first year the marketplaces began, and three months for several years after that with open enrollment closing at the end of January or in mid-February. Then, for the 2018 plan year, the Trump Administration cut this period in half, to just

<sup>&</sup>lt;sup>7</sup> Sarah Lueck and Tara Straw, "Recovery Legislation Should Build on ACA Successes to Expand Health Coverage, Improve Affordability," CBPP, April 8, 2021, <a href="https://www.cbpp.org/research/health/recovery-legislation-should-build-on-aca-successes-to-expand-health-coverage">https://www.cbpp.org/research/health/recovery-legislation-should-build-on-aca-successes-to-expand-health-coverage</a>.

<sup>&</sup>lt;sup>8</sup> Allison Daminger *et al.*, "Poverty Interrupted: Applying Behavioral Science to the Context of Chronic Scarcity," ideas42, May 2015, <a href="http://www.ideas42.org/wp-content/uploads/2015/05/I42">http://www.ideas42.org/wp-content/uploads/2015/05/I42</a> PovertyWhitePaper Digital FINAL-1.pdf.

<sup>&</sup>lt;sup>9</sup> Katherine Swartz and John A. Graves, "Shifting the Open Enrollment Period for ACA Marketplaces Could Increase Enrollment and Improve Plan Choices," *Health Affairs*, July 2014, <a href="https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.0007">https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2014.0007</a>.

<sup>&</sup>lt;sup>10</sup> CBPP, "State-Based Marketplaces Open Enrollment Periods for 2019 Coverage," <a href="http://www.healthreformbevondthebasics.org/state-based-marketplaces-oe6-dates-2019/">http://www.healthreformbevondthebasics.org/state-based-marketplaces-oe6-dates-2019/</a>.

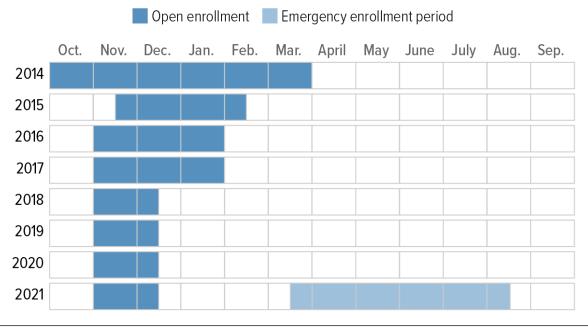
six weeks. (See Figure 3.) It also slashed spending on outreach, marketing, and enrollment assistance, which likely contributed to increased confusion or lack of awareness among the public.<sup>11</sup>

Reinstating a longer period, such as the November 1 through January 31 open enrollment that was in place during 2016 and 2017, would give more people time to enroll and allow for more expansive outreach efforts. It would also push the enrollment period past the stressful end-of-year period and give more people time to consider health coverage enrollment when they have less stress and more bandwidth.

FIGURE 3

# Reviving Longer Open Enrollment Periods Could Enable More to Gain Coverage

Duration of open enrollment periods for federal marketplace coverage through HealthCare.gov



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### **Broaden Events That Trigger Special Enrollment Periods**

For those who need coverage but miss the annual open enrollment period, qualifying for an SEP is the only way to access a marketplace plan. Dozens of different events trigger an SEP, such as having a baby and getting married, losing other health coverage, or moving out of the Medicaid "coverage gap" because their income rises above the poverty line. Usually, when one member of a

<sup>&</sup>lt;sup>11</sup> Shelby Gonzales, "Trump Administration Slashing Funding for Marketplace Enrollment Assistance and Outreach," CBPP, September 1, 2017, <a href="https://www.cbpp.org/blog/trump-administration-slashing-funding-for-marketplace-enrollment-assistance-and-outreach">https://www.cbpp.org/blog/trump-administration-slashing-funding-for-marketplace-enrollment-assistance-and-outreach</a>; CBPP, "Sabotage Watch: Tracking Efforts to Undermine the ACA," updated February 2, 2021, <a href="https://www.cbpp.org/sabotage-watch-tracking-efforts-to-undermine-the-aca/">https://www.cbpp.org/sabotage-watch-tracking-efforts-to-undermine-the-aca/</a>.

family experiences one of these events, anyone eligible to sign up for a plan with that person (typically a spouse or children) is also eligible to enroll through the marketplace.

Two major problems plague SEPs. First, few of the people who could use SEPs are doing so — estimates range from 5 to 15 percent of those eligible. It's easy to see why many people who are eligible for SEPs do not use them to enroll in a marketplace plan. To enroll in coverage using an SEP, people must know they have experienced an event that triggers one and then take action to claim it, usually within 60 days. They are required to complete the marketplace's usual application and enrollment process. And, in the majority of states that rely on HealthCare.gov, people must also submit documentation before they can enroll using an SEP. They have to track down paperwork, such as a letter from an employer or insurer, that shows they experienced the event that triggered the SEP.

Second, some events when a person might otherwise seek coverage do not trigger an SEP. Losing a job, for example, doesn't trigger an SEP unless a person is also losing health coverage through that job. And a drop in income — even one that qualifies someone for significant financial assistance in the marketplace — does not trigger an SEP if the person has been uninsured.

Failing to permit enrollment in a marketplace plan at these key moments, when someone might be more likely to apply and enroll in coverage, means missing opportunities to help them become insured. It also means that many people who are otherwise eligible for marketplace financial assistance have no way to access it when they need it most.

Notably, the emergency special enrollment period now in place at HealthCare.gov, and similar enrollment periods that states running their own marketplaces have made available during the COVID-19 public health emergency, simplify the normal structure in important ways. Uninsured people can access marketplace coverage during this time, while normally most SEPs are triggered when someone loses other health coverage. In addition, the emergency HealthCare.gov enrollment period allows people who might be eligible for another SEP due to loss of health coverage or other reason to more easily enroll in a plan, without having to know or document that they experienced another SEP-triggering life event. By March 31, more than 500,000 people had enrolled in marketplace plans during the emergency SEP that began in February, a substantial increase compared to the same period in prior years.<sup>12</sup>

Before the emergency SEP ends on August 15, it is critical to ensure that permanent policies are in place that emphasize bringing people into coverage rather than keeping them out. Adding two new SEP-triggering events for individuals found eligible for advance premium tax credits or who were uninsured and have become unemployed would improve the system.<sup>13</sup>

<sup>&</sup>lt;sup>12</sup> CMS, "2021 Marketplace Special Enrollment Period Report," April 7, 2021, <a href="https://www.cms.gov/newsroom/fact-sheets/2021-marketplace-special-enrollment-period-report-0">https://www.cms.gov/newsroom/fact-sheets/2021-marketplace-special-enrollment-period-report-0</a>.

<sup>&</sup>lt;sup>13</sup> ACA statute gives the Administration broad authority to make federal rule changes related to enrollment policies, including adding new SEP-triggering events. These could be written to apply across all states, including in those states that operate their own marketplaces rather than relying on HealthCare.gov. Federal rules in this area serve as a minimum standard; states that run their own marketplaces have the authority to add and broaden enrollment opportunities beyond what the federal government does.

### Create a "Financial Help" SEP

The financial assistance available through the ACA marketplaces has made health insurance more affordable for many people, yet the uninsured rate for lower-income people eligible for the most generous subsidies remains high: 14.1 percent of people with incomes between 138 and 250 percent of the poverty line are uninsured, compared to 3.1 percent for people with incomes above 500 percent of the poverty line. At lower income levels, people are also more likely to experience financial problems related to medical bills or to delay medical care because of cost. Such problems are more prevalent among people who experience gaps in their health coverage. <sup>15</sup>

Many people with low incomes are eligible for a marketplace plan that costs nothing, or very little, in monthly premiums because the ACA premium tax credits reduce their costs. Under the recently enacted American Rescue Plan, in 2021 and 2022, people with incomes up to 150 percent of the poverty line (or about \$19,000 a year for an individual) can enroll in a silver plan without paying anything toward the premium, and they are eligible for the most generous reductions in deductibles and other cost-sharing charges. People at slightly higher income levels are also eligible for assistance that cuts their premium costs significantly. Four in five marketplace enrollees can find a plan for \$10 or less per month.

For now, the emergency special enrollment period means that people who are determined to be eligible for financial help can also access a marketplace plan so they can receive it. But once the emergency SEP closes, the Biden Administration should establish a "financial help" SEP to allow people to enroll in a plan when they are determined eligible for advance premium tax credits, without having to experience or prove that some other SEP-triggering event has occurred.

A concern typically raised about year-round enrollment is that it will lead to adverse selection, which occurs when healthy people wait until they get sick to enroll in coverage. But, when people are receiving significant help paying their premiums, such that they can buy a plan for \$0 or a relatively low monthly amount, it is unlikely that they are an adverse selection risk. It is far more likely that they have delayed getting coverage because they were not aware it was an option, did not know that it was affordable for them, or unwittingly missed an earlier enrollment deadline.

Some states already provide year-round enrollment to low-income people without any significant signs of adverse selection. In Massachusetts, people with incomes up to 300 percent of poverty (about \$36,000 for an individual or \$75,000 for a family of four) can generally enroll in marketplace

<sup>&</sup>lt;sup>14</sup> Aviva Aron-Dine and Matt Broaddus, "Improving ACA Subsidies for Low- and Moderate-Income Consumers Is Key to Increasing Coverage," CBPP, March 21, 2019, <a href="https://www.cbpp.org/research/health/improving-aca-subsidies-for-low-and-moderate-income-consumers-is-key-to-increasing.">https://www.cbpp.org/research/health/improving-aca-subsidies-for-low-and-moderate-income-consumers-is-key-to-increasing.</a>

<sup>&</sup>lt;sup>15</sup> Sara R. Collins *et al.*, "U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability," Commonwealth Fund, August 19, 2020, <a href="https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial">https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial</a>.

<sup>&</sup>lt;sup>16</sup> Tara Straw *et al.*, "Health Provisions in American Rescue Plan Act Improve Access to Health Coverage During COVID Crisis," CBPP, March 15, 2021, <a href="https://www.cbpp.org/research/health/health-provisions-in-american-rescue-plan-act-improve-access-to-health-coverage">https://www.cbpp.org/research/health/health-provisions-in-american-rescue-plan-act-improve-access-to-health-coverage</a>.

coverage year-round.<sup>17</sup> New York and Minnesota allow year-round enrollment for people with incomes up to 200 percent of poverty who are eligible for coverage through their Basic Health Programs.<sup>18</sup> In contrast to the federal marketplace, Massachusetts consistently has stable or increasing marketplace enrollment over the course of the year.<sup>19</sup> And, while quarterly data on state uninsured rates are not available, all three of these states have overall uninsured rates among the lowest in the nation. A financial help SEP could be limited to people with incomes up to 300 percent of poverty, as in Massachusetts, to assuage any concerns that it could cause adverse selection.

### Create a "Job Loss" SEP

Many people who lose their jobs qualify for the existing "loss of coverage" SEP because they also lose their employer-sponsored health benefits. But newly unemployed people whose employers didn't offer coverage and who were already uninsured would not be eligible for an SEP under current rules, even though losing their job may make them, and their family members, newly eligible for premium tax credits.

A new SEP tied to job loss (irrespective of loss of coverage) would help more people access the marketplace. Outreach to this group could be simplified by sharing information about the SEP with people who apply for unemployment benefits. Such an SEP would likely lead to limited, if any, additional adverse selection, since most job separations are not related to health status.

### Allowing Enrollment for Financial Help and Job Loss Populations Has Broader Benefits

Creating SEPs for financial help and job loss would make enrollment possible for people who miss the yearly open enrollment period because they are unaware of the deadline or are dealing with other challenges. These SEPs would also open the door to people who already qualify for existing special enrollment periods — in particular, because they are exiting Medicaid or job-based health coverage — but are confused and deterred by the SEP requirements.

These changes would also allow for additional forms of streamlined enrollment and targeted outreach. For example, tax filing season could be used as an opportunity to share health insurance information and offer streamlined enrollment opportunities to uninsured people eligible for zero-premium or low-premium plans. And children's sign-ups for Medicaid or CHIP (which tend to occur outside the marketplace open enrollment period) could be used to reach out to their marketplace-eligible parents, or even to create streamlined enrollment opportunities using Medicaid and CHIP eligibility data.

<sup>&</sup>lt;sup>17</sup> Sarah Lueck, "Proposed Change to ACA Enrollment Policies Would Boost Insured Rate, Improve Continuity of Coverage," CBPP, June 5, 2019, <a href="https://www.cbpp.org/research/health/proposed-change-to-aca-enrollment-policies-would-boost-insured-rate-improve">https://www.cbpp.org/research/health/proposed-change-to-aca-enrollment-policies-would-boost-insured-rate-improve</a>.

<sup>&</sup>lt;sup>18</sup> The ACA created the Basic Health Program, an option for states to offer state-contracted plans outside of the marketplace that are more affordable for enrollees. States receive 95 percent of the financial assistance the federal government would have otherwise provided people up to 200 percent of the poverty level had they enrolled in marketplace plans.

<sup>&</sup>lt;sup>19</sup> Lueck.



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# What if the American Rescue Plan's Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022

Jessica Banthin, Matthew Buettgens, Michael Simpson, and Robin Wang

**APRIL 2021** 

### Introduction

The recently enacted American Rescue Plan Act (ARPA) includes several provisions designed to expand access to affordable health insurance coverage in 2021 and 2022, while the economy continues recovering from the COVID-19 pandemic and recession. One provision is the expansion of Affordable Care Act (ACA) marketplace subsidies over that period, which can improve health insurance affordability for people whose incomes have fallen due to reduced employment opportunities during the pandemic. Expanding these subsidies could substantially reduce household spending on health care, reduce the number of people uninsured, and increase marketplace enrollment, but the new subsidies' effects may be limited by their brief availability.

In this paper, we seek to show the maximum potential impact of the ARPA's enhanced marketplace subsidies on health insurance coverage and set the stage for next steps by policymakers. To do so, we show the enhanced subsidies' effects on coverage as if they were permanent changes (instead of limited to 2021 and 2022), and we assume people, employers, and insurers have fully responded to the new subsidies. Because of our approach, our estimates differ from those by the Congressional Budget Office (CBO). Adhering to their mandate, the CBO estimated the ARPA as written, including the temporary nature of changes to marketplace subsidies. Given that a permanent change in subsidies would be expected to have a larger effect than one that is temporary, our estimate

of the reduction in the number of people uninsured is more than three times as large as the CBO's.

If the ARPA's temporary enhancements to marketplace subsidies were made permanent and consumers, employers, and insurers had fully adjusted to the new coverage options, we find that in 2022:

- 4.2 million fewer people would be uninsured;
- 5.1 million more people would enroll in the subsidized marketplace; and
- Nongroup premiums would be 15 percent lower.

### American Rescue Plan Act Coverage Provisions Effective in 2022

In early 2021, the United States had 10 million fewer jobs than a year earlier, before the pandemic. To ensure people who have lost their jobs can continue to access health insurance coverage during the ongoing crisis, the ARPA includes several provisions to expand eligibility to and reduce the costs of health insurance coverage. Some of these provisions are limited to 2021, but we focus here on the health care provision that remains in place in 2022: enhanced premium tax credits in the ACA marketplace.

The ARPA includes two major changes for people who enroll in coverage through the marketplace (Table 1). It enhances premium tax credits for those previously eligible for subsidies and expands eligibility for subsidies to individuals and families previously ineligible because

their incomes were greater than 400 percent of the federal poverty level (FPL).<sup>3</sup> The new subsidy schedule substantially reduces households' premium payments. Under the ARPA, everyone eligible for tax credits with income below 150 percent of FPL can select a free silver health plan. As another example, the Kaiser Family Foundation (KFF) estimates that an illustrative 64-year-old just above 400 percent of FPL would pay \$12,698 per year before the ARPA and \$4,394 after the ARPA.<sup>4</sup>

The ARPA does not change the marketplace's cost-sharing reduction schedule (Table 1). Under current law, cost-sharing reductions (CSRs) are available to people who have incomes from 100 to 250 percent of FPL and who enroll in a silver plan through the marketplace. A silver plan has an actuarial value of about 70 percent. The subsidies work by increasing the actuarial value of a silver plan to 73 percent, 87 percent, or 94 percent, depending on income, thus lowering out-of-pocket costs for consumers.

The ARPA includes the first major federal expansion of marketplace subsidies since the ACA's enactment in 2010. In the eight years since it first opened for enrollment in late 2013, the marketplace survived several policy changes and continues to serve nearly 11 million people.<sup>5</sup> In 2020, effectuated enrollment was 10.7 million.<sup>6</sup> Projections that the marketplace would shrink or fail in certain areas of the country, especially in the wake of large premium increases in 2018, have not borne out. Yet,

though the national average benchmark premium has fallen for three years in a row, indicating stability, premium levels vary considerably across states. Not all states and rating regions have robust insurer participation. The ARPA's enhanced premium tax credits could have a range of positive impacts on the marketplace by increasing marketplace enrollment that could lead to greater insurer participation, improvements in the overall risk pool, and result in lower premiums.

### **Data and Methods**

We produce our 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 quickturnaround 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. Results from HIPSM simulations have been favorably compared with actual policy outcomes and other respected microsimulation models.7

We model the effects of the ARPA's enhanced marketplace subsidies on coverage in 2022 as if they were permanent changes and as if consumers, employers, and insurers have fully responded to the new subsidy schedule. In other words, our analysis assumes expanded marketplace subsidies are permanent and fully phased in.

We provide additional information on the model and its underlying data in the appendix. There we explain how we calibrated the model to project distributions of coverage in 2022 before ARPA as a baseline against which to measure the effects of the ARPA's enhanced marketplace subsidies. We also explain other key assumptions regarding the pandemic's economic effects.

Table 1. Subsidy Schedules before ARPA and American Rescue Plan, 2022

Income (% of FPL)	Before ARPA	American Rescue Plan				
Premium Tax Credit Percent of Income Limits for Benchmark Coverage						
< 138	2.07	0.0-0.0				
138–150	3.10-4.14	0.0-0.0				
150–200	4.14-6.52	0.0-2.0				
200–250	6.52-8.33	2.0-4.0				
250–300	8.33-9.83	4.0-6.0				
300–400	9.83	6.0-8.5				
400–500	n.a.	8.5-8.5				
500–600	n.a.	8.5-8.5				
600+	n.a.	8.5-8.5				
Benchmark Plan	Silver	Silver				
Cost-Sharing Reductio	ns: Actuarial Value of Plan Provided t	o Eligible Enrollees (%)				
< 138	94	94				
138–150	94	94				
150–200	87	87				
200–250	73	73				
250–300	70	70				
300–400	70	70				
400–500	70	70				
500–600	70	70				
600+	70	70				

SOURCES: Internal Revenue Service, Health and Human Services Department, and American Rescue Plan Act of 2021, Pub. L. No. 117-2.

Notes: FPL is federal poverty level. Percentage-of-income caps applied in 2022; before-ARPA caps are for 2021 and are indexed each year. Annual adjustments to caps have been modest and are not made until close to the end of year open enrollment period.

### **Findings**

## Changes in Coverage and the Number of People Uninsured

We find the number of people uninsured would drop by 4.2 million, or almost 14 percent, in 2022 if the ARPA's enhanced marketplace subsidies were permanent and consumers, employers, and insurers responded to the new subsidy schedule as if it were fully phased in (Table 2). In addition, about 317,000 people with non-ACA-compliant nongroup coverage would switch to ACA-compliant plans. Some enrollees in noncompliant coverage are attracted to such plans by their lower premiums. Under the ARPA, many of these people are newly eligible for premium tax credits that reduce premiums for marketplace plans and would therefore switch to the more comprehensive ACA-compliant plans.

Most of the previously uninsured people would be attracted to the marketplace by the enhanced subsidies. We estimate subsidized marketplace enrollment would increase by 5.1 million people, an increase of 60 percent in 2022, if the ARPA were permanent.

In response to the newly enhanced marketplace subsidies, we estimate 475,000 fewer people would be covered by employer-sponsored insurance (ESI). Most of the people who would leave ESI are those whose firms would still sponsor health insurance but whose offers are not deemed affordable; a very small number are those whose firms would stop offering health coverage. The ARPA does not change the ACA's so-called "firewall." which makes families with workers who have offers of affordable employer coverage ineligible for marketplace subsidies. Of the 475,000 people leaving ESI, nearly all would be attracted to the nongroup market because of newly

Table 2. Coverage Distribution of the Nonelderly before ARPA and with Permanent ARPA Marketplace Premium Subsidy Schedule, 2022

Thousands of people

	Before ARPA		Alternative Subsidies		Change	Change (%)
Insured (Minimum Essential Coverage)	244,113	88.0%	248,617	89.6%	4,504	1.8%
Employer	149,325	53.8%	148,850	53.7%	-475	-0.3%
Private Nongroup	14,960	5.4%	19,574	7.1%	4,613	30.8%
Basic Health Program	864	0.3%	866	0.3%	2	0.2%
Marketplace with PTC	8,458	3.0%	13,535	4.9%	5,076	60.0%
Nongroup Coverage without PTC	5,638	2.0%	5,174	1.9%	-465	-8.2%
Medicaid/CHIP	71,162	25.6%	71,528	25.8%	366	0.5%
Disabled	9,436	3.4%	9,437	3.4%	1	0.0%
Medicaid Expansion	14,845	5.4%	14,986	5.4%	141	0.9%
Traditional Nondisabled Adult	12,680	4.6%	12,855	4.6%	175	1.4%
Nondisabled Medicaid/CHIP Child	34,161	12.3%	34,210	12.3%	49	0.1%
State-funded Program	40	0.0%	40	0.0%	0	0.0%
Other Public	8,665	3.1%	8,665	3.1%	0	0.0%
Uninsured (No MEC)	33,333	12.0%	28,829	10.4%	-4,504	-13.5%
Uninsured	30,766	11.1%	26,579	9.6%	-4,188	-13.6%
Noncompliant Nongroup	2,567	0.9%	2,251	0.8%	-317	-12.3%
Total	277,446	100.0%	277,446	100.0%	0	0.0%

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

Notes: PTC is premium tax credit. CHIP is Children's Health Insurance Program. MEC is minimum essential coverage.

Table 3. Uninsured Nonelderly before ARPA and with Permanent ARPA Marketplace Premium Subsidy Schedule, by Income Group, 2022

Thousands of people

	Before ARPA	Alternative Subsidies	Change	Change (%)
Below 138% of FPL	14,530	14,218	-312	-2.1%
Between 138% and 200% of FPL	4,581	3,942	-639	-13.9%
Between 200% and 400% of FPL	7,712	5,298	-2,414	-31.3%
Above 400% of FPL	3,943	3,120	-823	-20.9%
Total, all incomes	30,766	26,579	-4,188	-13.6%

SOURCE: Urban Institute Health Insurance Policy Simulation Model, 2021. Note: Income groups are based on computations for Medicaid eligibility.

enhanced subsidies and lower premiums. We estimate fewer than 10,000 people would become newly uninsured because of the ARPA (data not shown), nearly all of whom would be eligible for Medicaid or marketplace subsidies but would choose not to enroll coverage.

We project that Medicaid and Children's Health Insurance Program (CHIP) enrollment would increase by about 366,000 people as a result of the ARPA's enhanced subsidies. These increases would result from increased enrollment in the nongroup market by family members and from eligibility determinations that

send some people to Medicaid when they sought coverage after passage of the ARPA.

### Changes in Marketplace Premiums

This substantial increase in marketplace enrollment under the ARPA's enhanced subsidies would also reduce average health risk scores in the entire nongroup market. We estimate that lower health risk scores would reduce premiums by about 15 percent on average in 2022, if the changes were fully phased in immediately (data not shown). The main reason average health risk would fall

under the ARPA's enhanced subsidies is that those with higher health care needs are more likely to have already purchased coverage before ARPA. The enhanced subsides, estimated here, are more likely to attract uninsured people with average or lower health needs, including younger enrollees.

### The Uninsured by Income Group

The ARPA would substantially reduce the number of people uninsured in 2022, and most people gaining coverage would have incomes below 400 percent of FPL. People with modest incomes, between 200 and 400 percent of FPL, would experience the largest reductions in uninsurance under the ARPA, 2.4 million people, a decline of 31 percent (Table 3). The number of uninsured people with incomes between 138 and 200 percent of FPL would drop about 14 percent, or by 639,000. And the number of uninsured people with incomes below 138 percent of FPL would drop 2 percent, or by 312,000. Improvements are smaller in this group because the ARPA does not address the Medicaid gap by extending subsidies to people below 100 percent FPL who live in states that have not expanded Medicaid.

Under the ARPA, people with incomes above 400 percent of FPL, who meet other eligibility criteria, are newly eligible for marketplace subsidies for the first time since its inception in 2014. The number of uninsured people with income in this range would drop by 823,000, or by about 21 percent.

## Changes in Federal and Household Spending

Because of the coverage changes outlined above, we estimate federal spending would increase by \$17.6 billion in 2022 (Table 4). This includes increased spending on marketplace subsidies and Medicaid and CHIP that is offset slightly by reductions in uncompensated care.8

One of the ARPA's largest impacts would be the decrease in household health care spending for people enrolled in the marketplace (Table 5). Average spending on premiums would drop nearly 50 percent among nongroup enrollees with incomes below 200 percent of FPL, declining from \$1,182 to \$624 per person. Average total spending on both premiums and out-of-pocket expenses would drop 32 percent among people in this income group, falling from \$2,496 to \$1,689 per person. Families in other income groups would experience slightly smaller declines in spending. Among all nongroup market enrollees, total spending on both premiums and out-of-pocket expenses would decline 23 percent, from \$4,926 to \$3,788 per person.

### Coverage Effects by State

Table 6 shows changes in the number of people uninsured by state in 2022. All states would see significant reductions in the number of people uninsured, ranging from a 681,000 decline in Texas to a 4,000 decline in Vermont. Other states with the largest decreases in the number people of uninsured are California (419,000), Georgia (193,000), Ohio (190,000), New York (163,000), and Arizona (158,000). The percent declines in the number of people uninsured range from 28 percent in West Virginia to 3 percent in Florida. Other states with large percent decreases in uninsurance are Ohio (26%), New Hampshire (25%), Arkansas (23%), Louisiana (23%), and Indiana (21%).

Table 4. Federal Health Care Spending for the Nonelderly before ARPA and with Permanent ARPA Marketplace Premium Subsidy Schedule, 2022

#### Millions of dollars

	Before ARPA	Alternative Subsidies	Change
Medicaid and CHIP	376,113	378,098	1,985
Marketplace PTC	58,277	76,701	18,424
Reinsurance	1,314	1,314	0
Uncompensated Care	15,700	12,913	-2,787
Total	451,405	469,026	17,622

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

Notes: CHIP is Children's Health Insurance Program. PTC is premium tax credit. Uncompensated care includes federal spending that will shrink in proportion to reductions in the number of uninsured (largely Medicare Disproportionate Share Hospital payments).

Table 5. Household Spending for the Nonelderly with Nongroup Coverage before ARPA and with Permanent ARPA Marketplace Premium Subsidy Schedule, by Income Group, 2022

Dollars

		Spending per Enrollee				
	Before ARPA	Alternative Subsidies	Change	Change (%)		
	Househol	d Spending on Premiums				
Below 200% of FPL	1,182	624	-559	-47.2%		
Between 200% and 400% of FPL	2,619	1,609	-1,009	-38.5%		
Above 400% of FPL	5,864	4,173	-1,691	-28.8%		
All Incomes	2,768	1,850	-919	-33.2%		
	Household	l Out-of-Pocket Spending				
Below 200% of FPL	1,314	1,065	-248	-18.9%		
Between 200% and 400% of FPL	2,691	2,158	-533	-19.8%		
Above 400% of FPL	3,022	2,970	-51	-1.7%		
All Incomes	2,157	1,938	-219	-10.1%		
Total Household Spending						
Below 200% of FPL	2,496	1,689	-807	-32.3%		
Between 200% and 400% of FPL	5,309	3,767	-1,542	-29.0%		
Above 400% of FPL	8,885	7,143	-1,742	-19.6%		
All Incomes	4,926	3,788	-1,138	-23.1%		

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

Note: FPL is federal poverty level.

Table 6. Number of People Uninsured before ARPA and with Permanent ARPA Marketplace Premium Subsidy Schedule, 2022

Thousands of people

State	Before ARPA	Alternative Subsidies	Change	Change (%)
Alabama	486	427	-58	-12.0%
Alaska	95	77	-18	-18.7%
Arizona	755	596	-158	-21.0%
Arkansas	230	177	-53	-23.1%
California	3,682	3,262	-419	-11.4%
Colorado	484	396	-87	-18.1%
Connecticut	203	177	-26	-12.6%
Delaware	67	60	-6	-9.3%
District of Columbia	43	38	-5	-11.9%
Florida	2,641	2,563	-78	-3.0%
Georgia	1,401	1,209	-193	-13.7%
-	114	96	-18	-15.7%
Hawaii				
daho 	161	144	-17	-10.7%
Ilinois	1,073	937	-136	-12.7%
ndiana	499	393	-106	-21.3%
owa	144	115	-29	-20.0%
Kansas	341	298	-43	-12.7%
Kentucky	294	233	-61	-20.8%
ouisiana	381	294	-87	-22.9%
Maine	54	47	-6	-11.6%
Maryland	420	387	-34	-8.0%
Massachusetts	248	228	-19	-7.8%
Michigan	552	457	-95	-17.2%
Minnesota	291	253	-39	-13.2%
Mississippi	371	314	-57	-15.3%
Missouri	676	565	-110	-16.3%
Montana	79	64	-16	-19.9%
Nebraska	135	117	-18	-13.4%
Nevada	397	326	-71	-17.8%
New Hampshire	74	56	-19	-25.0%
New Jersey	731	643	-88	-12.0%
New Mexico	216	174	-42	-19.3%
New York	1,106	944	-163	-14.7%
North Carolina	1,179	1,059	-120	-10.2%
North Dakota	75	61	-14	-18.6%
Ohio	724	534	-190	-26.2%
Oklahoma	597	527	-70	-11.7%
Oregon	346	282	-64	-18.5%
Pennsylvania	693	571	-122	-17.6%
Rhode Island	60	54	-6	-9.7%
South Carolina	572	483	-89	-15.5%
South Dakota	95	77	-18	-18.7%
ennessee	731	588	-143	-19.5%
exas	4,996	4,316	-681	-13.6%
Jtah	299	282	-17	-5.6%
/ermont	44	39	-4	-10.1%
/irginia	755	660	-94	-12.5%
Vashington	597	489	-108	-18.1%
West Virginia	109	78	-31	-28.3%
Visconsin	366	335	-32	-8.7%
Vyoming	85	74	-11	-13.4%
Total	30,766	26,579	-4,188	-13.6%

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

### **Discussion**

If the ARPA's temporary enhancements to marketplace subsidies were made permanent and consumers, employers, and insurers had fully adjusted to the new coverage options, 4.2 million fewer people would be uninsured in 2022. Subsidized marketplace enrollment would increase by 5.1 million people, a 60 percent jump, and household financial burdens among the 13.5 million subsidized marketplace enrollees would fall substantially because of lower premiums.<sup>9</sup>

If the ARPA's expanded marketplace subsidies were permanent, increased enrollment would also reduce health risk scores, leading to premium reductions of 15 percent in the entire nongroup market. Moreover, permanent enhancement of subsidies would likely encourage additional insurer participation in the marketplace as result of higher enrollment. The marketplace is working well in most states and national average benchmark premiums fell for the third consecutive year in 2021. Still, average state benchmark premiums vary by a factor greater than two. Research shows increased insurer participation tends to drive premiums to more competitive levels. In this way the ARPA's enhanced subsidies could ultimately work to improve stability and competitiveness in the entire nongroup market.10

### Employer Responses to Permanently Enhanced Subsidies

Some worry that permanently expanding premium tax credit eligibility to those with incomes above 400 percent of FPL could cause some employers to stop offering ESI to their workers. Small employers, in particular, are potentially the most likely to stop offering insurance, because their workers tend to have lower incomes than those of large employers and they are exempt from the ACA's employer responsibility requirements. Since the ACA was first proposed, some policymakers have worried the subsidies available in the nongroup market would encourage employers to stop offering ESI. However, research shows most employers responded to the ACA by increasing the rates at which

they offer insurance to their employees, and total ESI coverage increased in the years following implementation of the marketplace in 2014. Our analysis of the ARPA's expanded marketplace subsidy schedule is consistent with the latest research on employers, and we estimate very few employers currently offering insurance to their workers would find it advantageous to stop offering coverage. This partially owes to the substantial value of the ESI subsidy under the current tax structure and employee preferences for broad provider networks. 12

### Comparing Our Estimates with CBO's Estimates

Our estimates of the ARPA's coverage effects in 2022 are not directly comparable with such estimates from the CBO because our estimates rely on different assumptions. We aim to estimate the maximum potential impact of the ARPA's enhanced marketplace subsidies to set the stage for policymakers' next steps. We modeled our results as if the ARPA's changes to marketplace subsidies were permanent and consumers, employers, and insurers have fully adjusted their behavior in response.

Adhering to its mandate, on the other hand, the CBO estimated the ARPA's health care provisions as written. 13 Interpreting the provisions as temporary, the CBO likely estimates the effects of the ARPA's enhanced marketplace subsidies to be substantially lessened by several factors such as enrollees' confusion or lack of awareness of the new subsidies. possible difficulties enrolling, inertia, and other barriers. The CBO stated employers would be less likely to change their decisions to offer coverage to their employees if the enhanced subsidies were temporary. In addition, the CBO may consider that limiting the enhanced subsidies to two years could mean insurers are less likely to newly enter or expand their participation in a market, adjust their estimates of their enrollees' average health risk, or develop plans to attract newly eligible enrollees in response to the new law.

The CBO estimated that, as written, the ARPA's temporary enhanced marketplace

subsidy schedule would reduce the number of uninsured people by 1.3 million in 2022, compared to our estimate of 4.2 fewer million uninsured people from a permanent change. The CBO also finds increased marketplace enrollment of 1.7 million people in 2022, much less than our estimate of 5.1 million people with new subsidized marketplace coverage.

Regarding ESI, the CBO estimates that 100,000 people with ESI would switch to the marketplace because of new subsidies, while we estimate 475,000 people with ESI would switch to other sources of coverage, with 335,000 people moving to the subsidized marketplace. As noted, the CBO does not believe employers would change coverage decisions given the ARPA's temporary nature. We estimate that employers would be unlikely to change coverage decisions whether the ARPA's enhanced marketplace subsidies were temporary or permanent, but that employees who face high ESI premium contributions and are offered generous marketplace subsidies would change coverage if the policies were permanent.

Lastly, the CBO estimates the ARPA's enhanced marketplace subsidies would increase federal outlays and reduce revenues, increasing the deficit by \$21.9 billion in 2022. We estimate net federal spending to increase by \$17.6 billion in 2022 under our assumption of a permanent change in law. One likely reason for the difference in costs is that, under our assumptions, we estimate nongroup premiums would fall by 15 percent.

### **Data and Methods Appendix**

We produced our estimates using HIPSM. 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. Our earlier work provides detailed information on the model's design.<sup>14</sup>

The pre-pandemic version of HIPSM was calibrated to state-specific targets for marketplace enrollment following the 2020 open enrollment period, 2020 marketplace premiums, and late 2019 Medicaid enrollment from the Centers for Medicare & Medicaid Services monthly enrollment snapshots. 15 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 2022.16,17 Under our default assumptions, we estimate Medicaid will grow at five percent per year, and out-of-pocket spending and uncompensated care will grow at three percent per year.

Given uncertain economic conditions in 2020, we use a 2022 baseline, a year when conditions should be more stable. We thereby assume, consistent with CBO projections, 18 that the economy will have partly recovered from the pandemic by then. We assume the characteristics of people who remain

unemployed at that time are largely consistent with the distribution identified in U.S. Department of Labor data from August 2020, which showed high-wage jobs had recovered to a much greater extent than low-wage jobs. Our 2022 baseline preceded the enactment of the ARPA. We compare this baseline with an alternative policy that makes the ARPA's enhanced premium tax credits permanent.

HIPSM accounts for relevant state regulations, such as banning short-term, limited-duration plans. 19 Our estimates account for the federal individual mandate penalties being set to \$0 beginning in plan year 2019, as well as the fact that California, the District of Columbia, Massachusetts, and New Jersev 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 Medicaid nonexpansion states. We do this because the political environments surrounding expansion, even once ballot initiatives are passed, remain uncertain, and the timing and implementation of these expansions are therefore still unknown.

For this analysis, we assume the Medicaid enhanced Federal Medical Assistance Percentage (FMAP) 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 U.S. Department of Health and Human Services indicated the public health emergency declaration will be extended through calendar year 2021.20 This means the maintenance-of-effort requirement, which prohibits states from disenrolling Medicaid enrollees unless they request it, is expected to last through January 2022. After that, the increased Medicaid enrollment from prohibiting disenrollment will start to phase out, as states resume normal eligibility determinations and process the backlog from the maintenance-of-effort provision. How fast this will happen is uncertain, so Medicaid enrollment may be higher in early 2022 than our estimates indicate. Also, the enhanced FMAP is expected to be available through March 2022. Thus, the federal government will pay a higher share of Medicaid costs in the first guarter of 2022 than we indicate.

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- <sup>2</sup> One provision subsidizes the cost of COBRA coverage through September 2021, and another provision guarantees the most generous premium tax credits to anyone who has an unemployment insurance claim in 2021.
- 3 To be eligible for marketplace subsidies, a person must be lawfully present, not eligible for public coverage, and not have an affordable offer of coverage in the family.
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- 5 Policy changes include the reduced length of open enrollment; reduced funding for outreach, advertising, and enrollment assistance; elimination of payments for mandatory cost-sharing reductions; and elimination of the penalty associated with the individual mandate among other changes.
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- 8 Savings from uncompensated care are mainly from lower Medicare Disproportionate Share Hospital spending. Federal costs for uncompensated care are also paid by a number of other agencies including HHS, VA, and IHS; we assume their funding will not automatically shrink in proportion to the reduction in the number of uninsured or the resulting change in demand for uncompensated care.
- In a recently published report, we estimated coverage effects of a policy (labeled option 3) with similar marketplace subsidies to those under ARPA described in this report. Option 3 would offer more generous CSR subsidies than ARPA, but slightly smaller premium subsidies for lower income households. Its effects on coverage overall are nearly identical. As expected, in comparing the coverage effects of the two policies, we find that option 3 would result in somewhat smaller reductions in the number of uninsured people below 200 percent FPL than ARPA because of slightly less generous premium subsidies for that group. We also find that option 3 would result in somewhat larger reductions in the number of uninsured people above 200 percent FPL, relative to ARPA, due to more generous CSR subsidies for that group. The impact on coverage of the enhanced CSRs at higher incomes in option 3 is limited because of the so-called firewall. See Blumberg, Linda J, et al. Cost and Coverage Implications of Five Options for Increasing Marketplace Subsidy Generosity. Urban Institute. 2021. https://www.urban.org/sites/default/files/publication/103604/cost-and-coverage-implications-of-five-options-for-increasing-marketplace-subsidy-generosity\_0.pdf. Accessed April 12, 2021.

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The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.

### **ERRATA**

This brief was corrected April 20, 2021. On page 3, the income range in the first row of table 3 is "below 138 percent of FPL"; a previous version stated the range as "100 to 138 percent of FPL." On the same page, the fourth sentence of "The Uninsured by Income Group" section now refers to "people with incomes below 138 percent of FPL."

### **ABOUT THE AUTHORS & ACKNOWLEDGMENTS**

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## A Tool for States to Address Health Care Consolidation: Prohibiting Anticompetitive Health Plan Contracts

By Katherine L. Gudiksen, Erin C. Fuse Brown, and Johanna Butler\*

Rampant consolidation in nearly every state has created dominant health care systems that can use anticompetitive contracting practices to charge supracompetitive prices, especially to commercial insurance plans. With COVID-19 expected to accelerate the consolidation of health care providers, state policymakers are searching for tools to curtail the abuse of market power by dominant health providers. To create a more level playing field for negotiations, the National Academy for State Health Policy has developed a model act, *Prohibiting Anticompetitive*Contract Terms in Health Care Contracts, that bans anticompetitive contract terms using states' consumer protection and antitrust laws. This report describes how the model act can give states essential tools to help them rein in rising health care costs.

### Overview

Rising health care costs from provider consolidation represent a critical financial challenge for states. High health care costs present states with policy tradeoffs – leaving costs unchecked means fewer state resources to invest in other priorities, such as social determinants of health, health equity, and other, non-health areas such as education and infrastructure. Private-sector employers and individuals who purchase insurance reel under increased premiums driven in large part by rising hospital costs. Without effective tools to slow the growth of health care costs, health spending will continue to threaten public and private resources in every other area.

A primary driver of rising health care costs is the wave of health care consolidation that gives consolidated providers market leverage to raise prices unhampered by competitive forces. Nearly all major metropolitan hospital markets are highly concentrated. Nationwide, as of 2018, more than half of all physicians and 72 percent of hospitals were affiliated with a health system. Evidence suggests that provider consolidation leads to higher hospital and physician prices and higher total expenditures – all while having little to no impact on improving quality of care, reducing utilization, or improving efficiency.

Rampant consolidation has created dominant health systems that can use anticompetitive contracting practices to charge supracompetitive prices, especially to commercial insurance plans.<sup>5</sup> As the COVID-19 pandemic will likely accelerate consolidation of health care providers with strained resources,<sup>6</sup> policymakers are searching for ways to limit the impact of increased provider market power on health care costs. In many states, it is not enough to try to prevent consolidation from occurring through premerger review because most state and metropolitan markets are *already* highly concentrated. In these already consolidated markets, states need tools to curtail the abuse of market power by dominant health providers.

Although state attorneys general may be able to prosecute anticompetitive behavior — such as the use of anticompetitive contracting provisions by dominant systems — under current antitrust authority, legislation prohibiting these contract clauses is necessary to improve state enforcement authority and disrupt the distorted bargaining dynamic between health insurers and powerful providers. State officials

have routinely heard that insurers lack proper leverage to negotiate contract terms to reduce hospital and physician costs. To address the harms from anticompetitive contract provisions and create a more level playing field for negotiations, the National Academy for State Health Policy (NASHP) has developed a model act, <u>Prohibiting Anticompetitive Contract Terms in Health Care Contracts</u>. The model act prohibits four common anticompetitive contract terms, making the use of these provisions presumptively unlawful under a state's consumer protection and antitrust laws.

### **Anticompetitive Contracting Practices by Consolidated Entities**

One of the primary ways that dominant providers raise prices is through **anticompetitive health plan contracting**, <sup>7</sup> in which powerful provider groups and health systems exploit their market power to demand terms in their contracts with health insurance plans. When health care markets become consolidated, a dominant health system may control multiple hospitals, multi-specialty physician practices, clinics, and ancillary service providers. Due to network adequacy laws, some services or providers are considered "must-haves," such as a hospital with a neonatal intensive care unit or trauma facility, for a health plan to offer a commercially viable provider network. Health plans must ensure their provider networks are robust enough for their members to have access to essential services.

Insurers typically have two options for containing costs in competitive contracting:

- Exclude high-cost, low-value providers from the network, or
- Give consumers an incentive to choose more cost-effective alternatives.8

Consolidated health systems leverage their market power in negotiations with insurers because the insurer cannot afford to exclude must-have providers from its network. Dominant health systems can use all-ornothing negotiations to raise prices for all of their affiliated providers by threatening to prevent any of their providers from participating in the insurer's network unless the insurer accepts the prices and terms set by the health system. These types of distorted negotiations between providers and insurers directly contribute to higher costs for states, employers, and patients. The four contracting practices that have raised the most concern among antitrust enforcers and lawmakers, and those that are targeted in the NASHP model act, are: (1) all-or-nothing contracting; (2) anti-tiering or anti-steering clauses; (3) most-favored-nation clauses; and (4) gag clauses.

All-or-nothing contracting: Health systems may use all-or-nothing provisions to leverage the status of their must-have providers or facilities in highly concentrated markets to demand higher payment rates for the entire system, including those providers in more competitive locations and specialties. An all-or-nothing provision requires the health plan to contract with all providers in that system or none of them. The insurer then faces a difficult choice – include all of the health systems' facilities and providers in the network (even those of lower value or where there are other competitive choices) or lose all of them, which means the plan will not have a commercially viable provider network anywhere the health system has a must-have provider. By bargaining on behalf of all its affiliates, a powerful health system can thus raise the prices for its less desirable providers by tying them to must-have providers.

Anti-tiering or anti-steering clauses: Tiered networks and steering incentives are cost-saving strategies used by insurers to encourage patients to seek higher value care. When using tiered networks, insurers place providers into tiers based on price and quality and then offer patients financial incentives, typically through lower cost-sharing, to choose providers from a higher-value tier. When health systems use anti-tiering, they require a health plan to place that system's facilities or providers in the most preferred tier, even if the health system's providers do not meet the insurers' cost or quality standards for the highest-value tier. In the case of anti-steering provisions, the health system may forbid the insurer from using cost-sharing incentives to steer patients to other providers, even if they offer better value. Dominant

health systems use anti-tiering or anti-steering provisions to stop health plans from implementing these cost-control measures and thereby avoid competition.

*Gag clauses*: Gag clauses may prevent either party in a contract from disclosing terms of that agreement, including prices, to a third party. While many states have laws requiring insurers to disclose out-of-pocket costs to enrollees, only a few states have laws allowing patients, plan sponsors (such as an employer), or even state regulators to obtain negotiated price or quality information. <sup>10</sup> As a result, patients and employers may be unable to access necessary information to make informed choices between providers, both for individual health care services and network inclusion. The lack of transparency from gag clauses and the mistaken notion that prices are trade secrets: <sup>11</sup>

- Undermine price transparency tools for consumers;
- Decrease plan sponsors' ability to push back on rising prices; and
- Make it more difficult for policymakers to understand how health care markets are operating in their state.

Gag clauses may be especially insidious when used in conjunction with other anticompetitive contract terms. For example, they may be used to hide the magnitude of variation in provider rates and therefore obscure the effects of an anti-steering clause.

Most-favored-nation (MFN) clauses: Unlike the other contract clauses included in the NASHP model, most-favored-nation clauses are typically used by a dominant insurer, sometimes in concert with a dominant health system. MFN clauses, sometimes called "pricing parity" or "price protection" clauses, are contractual agreements in which a provider or health system agrees not to offer lower prices to any other insurer. Dominant insurers thus ensure that they are getting the best prices. At first glance, these terms may appear to be pro-competitive because the health system is agreeing to lower their contracted prices with the insurer if the health system accepts a lower price from one of its competitors. Effectively, however, MFNs ensure that no rival insurer can negotiate with the health system to offer a novel insurance product (e.g., a narrow network) at lower rates. In addition, MFNs may allow insurers and providers to collude to raise prices. Insurers can accept an anticompetitive price increase from a dominant provider without competitive disadvantage because the insurer can pass the increase through to consumers in the form of higher premiums, as long as they know all competitors must also pay the same or higher rates. <sup>12</sup>

### State Antitrust Enforcement: A Resource-Intensive, Insufficient Solution

Recent lawsuits by state and federal antitrust enforcers and private plaintiffs have exposed how dominant health systems use contracting practices to increase prices and limit the ability of payers to control costs. <sup>13</sup> High-profile cases by then-California Attorney General Xavier Becerra against Sutter Health <sup>14</sup> and North Carolina Attorney General Josh Stein against Atrium Health <sup>15</sup> targeted those dominant health systems' use of anticompetitive terms in their health plan contracts, including all-or-nothing bargaining, antitiering, and anti-steering clauses that prevented private health plans from using financial incentives to encourage patients to choose lower-cost providers, and gag clauses that barred health plans from sharing price and quality information with patients.

While state attorneys general can use existing antitrust enforcement authority to address the anticompetitive contracting, bringing a case is resource-intensive, lengthy, and can be difficult to prove. Even if a settlement imposes conduct remedies and monetary penalties against the dominant health system, settlements avoid trial and do not establish legal precedent for future enforcement actions. <sup>16</sup> As Emilio Varanini, deputy attorney general in the antitrust section of the California Department of Justice, has argued, "while litigation can blaze the way for addressing such anticompetitive conduct, ultimately legislation may be a far more effective tool for carrying out competition as a policy goal." <sup>17</sup> Beyond

easing enforcement, in states that have passed legislation curtailing one or more of these contracting practices, one of the key benefits is that it alters the bargaining dynamic between powerful providers and health insurers by strengthening the ability of insurers' to resist providers' anticompetitive terms (and less-powerful providers' ability to resist dominant insurers' most-favored nation terms). NASHP's model act builds on lessons learned from these recent, high-profile legal cases and gives states a tool to prohibit anticompetitive contract clauses through legislation.

### **Prohibiting Anticompetitive Contracting through NASHP's Model Act**

The NASHP model act also prohibits health care providers, health insurers, and plan administrators from demanding, soliciting, or agreeing to any health care contract that contains anticompetitive contract terms. The model specifically prohibits all-or-nothing, anti-steering, or anti-tiering, MFNs, and gag clauses, however it gives a state's insurance commissioner or attorney general the ability to add other clauses through regulation that may result in anticompetitive effects. This flexibility is important as dominant health care entities' contracting strategies may evolve to protect their market share and raise prices in response to these prohibitions. The model renders these prohibited contract clauses null and void and presumptively unlawful.

Although there is growing evidence that these health care contract provisions are used anticompetitively and pose a serious threat to competition, there could be pro-competitive uses of these clauses and, in some specific cases in health care markets, they may be used to lower costs. <sup>18</sup> To allow for potential pro-competitive uses of these contract provisions, the model act does include a waiver process where the attorney general or insurance commissioner could approve the use of these contract terms if the benefits outweigh the harms. The regulating state agency is authorized to promulgate rules on which arrangements may be eligible for waivers, such as accountable care organizations, value-based payment arrangements, or those involving rural or other safety-net providers.

The NASHP model is designed to give enforcement authority to both the attorney general and the insurance commissioner in order to ensure broad enforcement and oversight of health system behavior and health care contracts. The attorney general and the insurance commissioner would have the authority to investigate, audit, and review any documents to ensure compliance with the law and to impose penalties for violations under state Unfair and Deceptive Acts or Practices (UDAP) laws. Importantly, the model also includes a private right of action to allow parties injured by these contract clauses to recover damages.

### **Conclusion**

In highly consolidated markets, dominant health systems use their market power to demand anticompetitive terms in their contracts with health insurers, thus increasing prices and thwarting health insurers' cost-containment efforts. In the post-pandemic world, state policymakers face limited state resources and rising health care consolidation. The NASHP model act provides policymakers with a tool to prevent already consolidated entities from further exploiting their market power to raise prices and restrict competition. A legislative ban will ease antitrust enforcement and eliminate the resource-intensive, fact-specific determination of harm in litigation. Legislation prohibiting anticompetitive contract terms will level the playing field between health insurers and dominant health systems, giving insurers the bargaining leverage to resist price demands of dominant systems and to direct patients to higher-value options. The NASHP model is an important step in state efforts to mitigate the harms that result from the significant consolidation in provider and insurer markets over the past decades, while also preparing states for the expected rise in consolidation after the pandemic.

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### Notes

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APR, 12, 2021

# COBRA Assistance in the American Rescue Plan Act: A Guide for States

Dan Meuse, SHVS

**UPDATED: April 12, 2021** The Department of Labor has updated information (https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra/premiumsubsidy) on the COBRA Assistance program in the American Rescue Plan, including FAQs and model notices.

The American Rescue Plan Act (ARPA) was signed into law on March 11, 2021 as a signature effort to assist in the recovery from the COVID-19 pandemic and the related economic downturn. Included as part of the sweeping legislation is a program to fully subsidize COBRA coverage for six months starting in April of 2021. The COBRA Assistance program will operate alongside a number of other programs designed to improve affordability of insurance coverage, and states will need to review what actions they should take to implement ARPA provisions and assist their consumers. This expert perspective provides a short overview of COBRA and mini-COBRA, the major elements of the ARPA COBRA Assistance program, and considerations for state policymakers related to the program.

## **COBRA Continuation Coverage**

Privacy - Terms

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) included a provision that allowed a person who loses employer-sponsored coverage to remain in that coverage if they elect to pay the full premium amount, plus an administrative fee of two percent. As a result, for many, the cost of continuing their coverage through COBRA is prohibitively expensive. Indeed, the Kaiser Family Foundation estimates that the total annual cost of employer-sponsored health coverage offered by firms of 20 or more employees in 2019 was \$7,012 for single coverage and \$20,599 for family coverage.[i]

A person qualifies for COBRA coverage if their employment is terminated for any reason other than gross misconduct, or if their hours are reduced. Family members of an employee also qualify for COBRA coverage along with the employee or in the event of the death of the employee, divorce, or if the employee gains eligibility for Medicare. The employee must be enrolled in the employer health plan at the time of the qualifying event.

Employees and other beneficiaries must be provided notice of COBRA rights for continuation of coverage and the plan must be notified of a qualifying event to trigger a COBRA election notice. A person generally has 60 days to enroll in COBRA coverage after the qualifying event. Generally, COBRA coverage can be maintained for 18 months, unless the COBRA coverage is due to the employee's qualification for Medicare, which provides a 36-month COBRA window.[ii]

COBRA generally applies to employers with 20 or more employees. Most states[iii] have a state continuation of coverage program for employees that are not protected by COBRA, often called mini-COBRA. While each state structures its mini-COBRA system a little differently, generally, the programs function in the same way as COBRA.

### The American Rescue Plan Act and COBRA Assistance

ARPA creates a new 100 percent subsidy for COBRA coverage premiums from April 1, 2021, through September 30, 2021. Additionally, ARPA opens up the ability to enroll in COBRA coverage even if a person declined coverage earlier or if their enrollment window closed. Finally, ARPA extends the subsidy to continuation coverage under state mini-COBRA requirements.

**Subsidy structure and operation.** The COBRA assistance program is designed to be generally invisible to the enrollee. The language from ARPA reads: "In the case of any premium... for COBRA continuation coverage with respect to any assistance eligible individual described in paragraph (3), such individual shall be treated for purposes of any COBRA continuation provision as having paid in full the amount of such premium."[iv] Enrollees that are eligible are deemed to have paid their premium. The assistance is accessed by plan sponsors or insurance companies as a refundable tax credit against payroll taxes.[v] This allows 501(c)(3) organizations to access the assistance credits. The Department of Labor has published guidance (https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/cobra-premium-assistance-under-arp.pdf) on identifying assistance-eligible individuals.

**New COBRA election opportunity.** ARPA also allows individuals who would have been eligible to enroll in COBRA coverage but did not enroll, as well as those who enrolled in COBRA but th unenrolled, to join (or re-join) COBRA coverage. However, no one can join coverage if their COBRA coverage window (either 18 or 36 months from their qualifying event) has passed. Privacy - Terms

coverage cannot extend beyond the original 18 or 36 month window.[vi] Plan administrators or insurance companies will be required to provide notice to those eligible for the new election opportunity by May 30, 2021.[vii]

**State continuation of coverage programs (mini-COBRA).** The COBRA Assistance program of ARPA is explicitly available for state continuation of coverage programs, also called mini-COBRA.[viii] These programs are generally available to employees of small employers (fewer than 20 employees) or other entities not subject to COBRA. Mini-COBRA programs, however, are not uniform across states, and include different election windows, notice requirements, and coverage eligibility categories.

Limitations. COBRA coverage allows for plan enrollment for anyone whose employment is terminated except for the reason of gross misconduct. The ARPA COBRA Assistance program limits assistance to those eligible for COBRA, unless the eligibility was due to the voluntary termination of employment by the employee.[ix] Also, COBRA is only available if the employer is still offering a health plan. ARPA allows for enrollment in the employer plan if it changed, but if the employer is closed, and no health plan is offered, there is no opportunity for COBRA enrollment. COBRA assistance does not apply to Health Reimbursement Accounts (HRAs) which some employers use to allow their employees to purchase their own coverage.

## State Considerations for the COBRA Assistance Program

There are a number of elements of the COBRA Assistance program that warrant attention by state policymakers–even if COBRA is generally not a state-regulated program.

Limited time for COBRA Assistance. The COBRA Assistance program provides six months (April – September, 2021) of coverage subsidy. On October 1, there could be a bolus of newly uninsured and as it stands now, there is no Special Enrollment Period (SEP) for persons who choose to end COBRA coverage because of unaffordability. It is possible that legislation could be passed to extend the COBRA Assistance program, or that marketplaces could take action to allow a SEP due to loss of government COBRA subsidies.[x] However, persons that move into Marketplace coverage at that point would have to enroll in a new plan with a new deductible and maximum out-of-pocket limit for the final months of 2021.

Increased assistance for Marketplace coverage. ARPA also significantly increases the financial assistance available to consumers on the Marketplace. Not only are there additional subsidies to cap the cost of health insurance at 8.5 percent of income, the amount of income lower-income individuals are expected to pay towards premiums is also lowered.[xi] That means families up to 150 percent of the federal poverty level will have access to \$0 premium plans and other income levels will see significant premium reductions. ARPA also provides \$0 premiums for the so-called "high value silver" plans, with significantly reduced cost-sharing for anyone that is deemed eligible for unemployment compensation in 2021.[xii] These options provide a low or no-cost alternative to COBRA without the assistance cliff in October. As a result, states will need to develop communications support to help consumers navigate the complex decision process for options.

**State mini-COBRA eligibility changes.** The COBRA Assistance availability for state continuation of coverage programs, along with the new eligibility window, may require states to take regulatory or legislative action to allow individuals to re-gain access to mini-COBRA benefits so they can access the assistance. Given that the COBRA assistance begins in April and ends September 30 regardless of when and individual enrolls, states will need to take quick action to allow enrollment in mini-COBRA for eligible individuals.

The COBRA Assistance program creates a short-term, affordable health insurance option for many Americans impacted by the pandemic economic slowdown. As states work through the variety of opportunities to increase coverage through the American Rescue Plan, understanding the value and limitations of the COBRA Assistance program will be key to designing effective state policy and communicating with consumers about the options available to them.

- [i] https://www.kff.org/private-insurance/issue-brief/key-issues-related-to-cobra-subsidies/ (https://www.kff.org/private-insurance/issue-brief/key-issues-related-to-cobra-subsidies/)
- [ii] COBRA is overseen by the Department of Labor. Further information on COBRA can be found at: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/cobra-continuation-health-coverage-consumer.pdf
- [iii] https://www.kff.org/private-insurance/state-indicator/expanded-cobra-continuation-coverage-for-small-firm-employees/?

currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D (https://www.kff.org/private-insurance/state-indicator/expanded-cobra-continuation-coverage-for-small-firm-employees/?

currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)

- [iv] Public Law 117-2. Section 9501(a)(1)(A)
- [v] Public Law 117-2. Section 9501(b)(1)(A)
- [vi] Public Law 117-2. Section 9501(a)(4)
- [vii] Public Law 117-2. Section 9501(a)(5)(C)
- [viii] Public Law 117-2. Section 9501(a)(9)(B)
- [ix] Public Law 117-2. Section 9501(a)(3)(A)
- [x] Note: In 2020, healthcare.gov created a SEP if an *employer* completely ceases to subsidize someone's COBRA premiums.
- [xi] Public Law 117-2. Section 9661
- [xii] Public Law 117-2. Section 9663

By Emily M. Johnston, Stacey McMorrow, Clara Alvarez Caraveo, and Lisa Dubay

# Post-ACA, More Than One-Third Of Women With Prenatal Medicaid Remained Uninsured Before Or After Pregnancy

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ABSTRACT Medicaid has a long history of serving pregnant women, but many women are not eligible for Medicaid before pregnancy or after sixty days postpartum. We used data for new mothers with Medicaid-covered prenatal care in 2015-18 from forty-three states participating in the Pregnancy Risk Assessment Monitoring System (PRAMS) to describe patterns of perinatal uninsurance and health outcomes of women experiencing uninsurance. We found that 26.8 percent of new mothers with Medicaid-covered prenatal care were uninsured before pregnancy, 21.9 percent became uninsured two to six months postpartum, and 34.5 percent were uninsured in either period, with higher perinatal uninsurance rates in nonexpansion states and for Hispanic women who completed the PRAMS survey in Spanish. Together, our findings indicate that despite recent coverage gains, further policy change is needed to help women maintain health insurance coverage before and after pregnancy and to allow them to address ongoing health issues including obesity and depression.

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ince the early 1990s, the Medicaid program has played an important role in providing insurance coverage for pregnant women with low incomes in the United States.<sup>1,2</sup> In 2018 the program covered 43 percent of births nationwide.3 Pregnancy-related Medicaid coverage is available to women with incomes up to 200 percent of the federal poverty level in most states, and several states offer even more generous eligibility. Because pregnancy-related Medicaid eligibility is almost always more generous than eligibility for other adults, many women with low incomes not otherwise eligible for Medicaid gain coverage during their pregnancies but then lose that coverage sixty days after delivery, when their pregnancy-related eligibility expires.2 During 2005-13, for example, 65 percent of women who had their deliveries paid for by Medicaid were uninsured for at least one month during their pregnancy, and more than half were

uninsured at some point in the six months after delivery.<sup>5</sup> For immigrant women, uninsurance before or after pregnancy may also reflect Medicaid eligibility restrictions, which bar noncitizen adults from Medicaid eligibility if they lack documentation or if they have five or fewer years of lawful residence in the US.<sup>6-8</sup>

The Affordable Care Act (ACA) provided new coverage options, starting in 2014, for adults with low incomes, including Medicaid expansion for adults with incomes up to 138 percent of poverty in some states and, for higher-income adults, availability of federally subsidized Marketplace coverage for adults with incomes up to 400 percent of poverty. Numerous studies have tracked changes in Medicaid coverage and uninsurance under the law for women of reproductive age and mothers at various points relative to pregnancy. 9-15 Specifically, the ACA Medicaid expansion has reduced uninsurance among women of reproductive age overall, 10,11 and particular-

ly among new mothers in the year after delivery. <sup>12</sup> Expansion has also increased preconception and postpartum Medicaid coverage. <sup>13-15</sup> Although these studies did not find a significant impact of Medicaid expansion on uninsurance among women with low incomes just before pregnancy, <sup>13,14</sup> Jamie Daw and colleagues found that it was associated with a 28 percent reduction in churning between insurance and uninsurance throughout the perinatal period. <sup>16</sup>

Insurance coverage during the periods before (preconception) and after (postpartum) pregnancy has the potential to improve women's health.<sup>17,18</sup> Preconception coverage can help women prevent unintended pregnancies and may improve management of chronic conditions before women become pregnant, which may ultimately lead to better maternal and infant birth outcomes. 17 Importantly, the expansion of Medicaid eligibility under the ACA not only increased coverage and reduced churn but has also improved other outcomes among women and mothers. For example, the ACA Medicaid expansions improved access to care, increased use of health services, and led to better self-reported health among women of reproductive age, which could help women ensure a healthy start to their pregnancies. 11,14 Rebecca Myerson and colleagues also found improvements in several specific measures of preconception health, including folic acid intake and preconception health counseling, among a sample of new mothers.<sup>14</sup> After delivery, postpartum coverage can also improve chronic condition management and increase access to care needed to recover from birth, potentially preventing late maternal deaths and improving overall health and wellbeing for mothers and their children.<sup>18</sup> Stacey McMorrow and colleagues found increases in postpartum access to care and reduced problems affording care among new mothers after the major ACA coverage provisions, 19 and Erica Eliason further found that the ACA Medicaid expansion was associated with reductions in maternal mortality.20

Despite significant improvements under the ACA, however, churning into and out of coverage and between types of coverage persists, <sup>21</sup> many women remain uninsured before and after their pregnancies, <sup>9,14</sup> and those who are uninsured face significant health problems. For example, a recent analysis documented obesity, cesarean deliveries, gestational diabetes, pregnancy-related hypertension, and depression—all conditions that require ongoing monitoring and care—among women who lost Medicaid coverage and became uninsured in the postpartum period. <sup>22</sup> Moreover, the US continues to have the highest maternal mortality rate among devel-

oped countries, along with large and persistent racial inequities. <sup>23,24</sup>

Several federal and state efforts have targeted the postpartum period, with proposals to extend pregnancy-related Medicaid coverage for up to a year postpartum, as a third of all pregnancyrelated deaths occur within a year after birth.<sup>25</sup> Recent analysis has estimated that such provisions could benefit 123,000 new mothers uninsured during the year after pregnancy annually, who would become newly eligible for Medicaid or Children's Health Insurance Program coverage through a postpartum extension.<sup>26</sup> But given the importance of preconception health and ongoing preconception uninsurance in the post-ACA era, it is important to consider policies that can address coverage gaps throughout the perinatal period.14 Further take-up of ACA Medicaid expansion, for example, could reduce both preconception and postpartum uninsurance, particularly because states that have not yet expanded Medicaid have even lower eligibility thresholds than the pre-ACA thresholds in expansion states.4

To better understand how different Medicaid policies may address the remaining barriers to coverage surrounding pregnancy among women with low incomes, we focus on a sample of women who had their prenatal care covered by Medicaid. In this sample of new mothers, we consider whether women were uninsured just before pregnancy, shortly after pregnancy, in either period alone, or in both periods. We further document the health status of women with prenatal Medicaid coverage who experience uninsurance during the perinatal period to provide insights on the potential benefits of expanding coverage to these women. Although changes in coverage and churn under the ACA have been well documented by other studies, 12-14,16 understanding which women continue to experience uninsurance surrounding pregnancy and when in the perinatal period uninsurance occurs can inform future policies aimed at improving maternal and child health beyond the ACA.

### **Study Data And Methods**

**DATA** We used data from the Pregnancy Risk Assessment Monitoring System (PRAMS) in forty-three states (online appendix table 1).<sup>27</sup> PRAMS is a state-specific surveillance system of pregnancies resulting in a live birth and combines birth certificate data with a survey of new mothers.<sup>28</sup> We included women in twenty-seven expansion states and sixteen nonexpansion states. Because not all states are included in all years, we adjusted the PRAMS survey weights to reflect the number of years a state appears during the survey

period. Nonexpansion states are those that never expanded during the 2015–18 period. We excluded data from years before expansion for Alaska (2015) and Louisiana (2015–16), classifying both as expansion states for the remaining years.

We focused on a sample of women ages twenty and older who gave birth in calendar years 2015-18 and who reported that their prenatal care was covered by Medicaid, representing 36.6 percent of new mothers in the data (appendix table 2).<sup>27</sup> We excluded teenagers from our analysis because they face different coverage options than adults through Medicaid and the Children's Health Insurance Program. We considered the period 2015-18 to focus on patterns of uninsurance after the implementation of the major coverage provisions of the ACA and because pooling multiple years of data allowed us an adequate sample size to investigate differences in perinatal uninsurance rates by women's characteristics.

**METHODS** We described patterns of uninsurance before and after pregnancy for women with Medicaid coverage for their prenatal care, using PRAMS measures of insurance coverage at three points: one month before conception; during prenatal care; and at the time of the postpartum survey, which is typically conducted two to six months after delivery. We refer to these three periods collectively as the perinatal period, and we excluded women who were missing insurance information in any of these periods.<sup>29</sup> Although PRAMS includes a measure of payer at delivery from the birth certificate, we limited our analysis to the three coverage measures collected directly from the PRAMS questionnaire for consistency of measurement.

We next examined how each of three perinatal uninsurance rates (preconception only, postpartum only, and both periods) varied across our sample by women's race and ethnicity, the language of their survey, whether they are first-time mothers or mothers with previous births, and by their family income. We focused on patterns by race and ethnicity because several proposals to extend postpartum Medicaid coverage have been motivated by vast disparities in maternal mortality rates between Black women and their White and Hispanic counterparts. 30,31 We further considered survey language among Hispanic women because it may help identify women likely to face barriers to Medicaid eligibility because of immigration status if women completing the survey in Spanish are more likely than those completing an English-language survey to be recent immigrants. 32 Similarly, we considered differences between women who already have children and first-time mothers because parents have historically had more generous eligibility for Medicaid

outside pregnancy than childless adults, making first-time mothers particularly at risk for preconception uninsurance in nonexpansion states.

Finally, we examined differences in perinatal uninsurance patterns by income because of the importance of income in the variation in Medicaid eligibility between expansion and nonexpansion states and the variation in eligibility for pregnancy-related Medicaid eligibility versus other Medicaid pathways, such as parental Medicaid. We constructed two income categories using the PRAMS dollar-value income categories. Because these categories vary across states and survey years, we chose a threshold of \$20,500 that could be consistently applied across states and years and classified women as having incomes above or below that amount. Throughout all of our analyses, we considered how patterns differed between the twenty-seven ACA Medicaid expansion states and the sixteen nonexpansion states in our sample. We assessed whether differences were statistically significant, using twosided t-tests, and all analyses used PRAMS survey weights adjusted for the number of years the state was in our sample. Sample sizes for all subgroup analyses are in appendix table 2.<sup>27</sup>

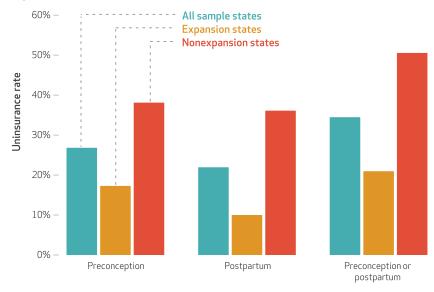
LIMITATIONS Our study had several limitations. First, PRAMS is not nationally representative and does not include the same states in all years. Our sample states represent an estimated 7.5 million births in 2015-18, which is about 48 percent of the approximately 15.6 million births nationally in those years and does not include California.3 Second, PRAMS measures are self-reported and may suffer from recall or other biases. Third, we were unable to measure women's income with more detail than broad categories and were unable to observe women's immigration status or years of US residence, thereby preventing us from accurately assessing likely eligibility for Medicaid coverage under current or proposed policy. Finally, for four states in our sample that expanded Medicaid after January 1, 2014 (New Hampshire, Pennsylvania, Alaska, and Louisiana), expansion status might not apply to the preconception period for women who gave birth in the first year after expansion.<sup>33</sup>

### **Study Results**

Among new mothers who had their prenatal care covered by Medicaid in forty-three states during the period 2015–18, 26.8 percent were uninsured before their pregnancy, and 21.9 percent became uninsured in the two to six months after delivery (exhibit 1). These patterns varied sharply between states that did and did not expand Medicaid under the ACA. In expansion states, 17.3 percent of women with Medicaid-covered

### EXHIBIT 1

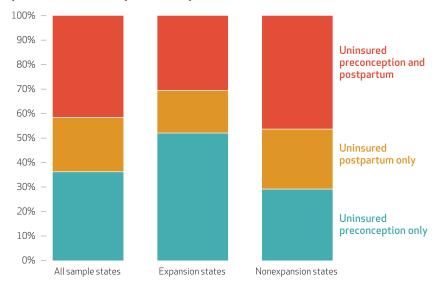
# Perinatal uninsurance rates for new mothers with prenatal Medicaid coverage, by Medicaid expansion status, 2015–18



**SOURCE** Authors' analysis of 2015–18 Pregnancy Risk Assessment Monitoring System (PRAMS) data. **NOTES** The sample includes women ages twenty and older with a live birth in calendar years 2015–18 who reported that their prenatal care was covered by Medicaid in forty-three states with at least one year of PRAMS data during 2015–18. Differences in the rates of uninsurance for preconception, postpartum, and both preconception or postpartum are significantly different between expansion and nonexpansion states (p < 0.05).

### EXHIBIT 2

# Uninsurance timing for new mothers with prenatal Medicaid coverage who experienced perinatal uninsurance, by Medicaid expansion status, 2015-18



**SOURCE** Authors' analysis of 2015–18 Pregnancy Risk Assessment Monitoring System (PRAMS) data. **NOTES** The sample includes women ages twenty and older with a live birth in calendar years 2015–18 who reported that their prenatal care was covered by Medicaid and that they were uninsured in the preconception or postpartum period in forty-three states with at least one year of PRAMS data during 2015–18. Differences in the rates of uninsurance for preconception only, postpartum only, and both preconception and postpartum are significantly different between expansion and nonexpansion states (p < 0.05).

prenatal care were uninsured preconception, compared with 38.1 percent in nonexpansion states, and 10.0 percent of new mothers with prenatal Medicaid coverage became uninsured postpartum in expansion states, compared with 36.1 percent in nonexpansion states. About 34.5 percent of mothers with prenatal Medicaid coverage were uninsured at some point during the perinatal period, with mothers in nonexpansion states much more likely to have been uninsured (50.6 percent) than those in expansion states (21.0 percent).

Among those who were ever uninsured during the perinatal period, about 36.4 percent were uninsured preconception only, 22.2 percent were uninsured postpartum only, and 41.4 percent were uninsured in both periods (exhibit 2). These patterns also differ by expansion status. In nonexpansion states, women who were ever uninsured were much more likely to be uninsured in both periods than women who were ever uninsured in expansion states. On the contrary, those who were ever uninsured in expansion states were much more likely to be uninsured preconception only, compared with women who were ever uninsured in nonexpansion states.

Perinatal uninsurance rates among women with prenatal Medicaid also varied by women's characteristics (exhibit 3). In expansion states, differences by race and ethnicity were relatively modest for each measure of perinatal uninsurance, except for among Hispanic women who completed the survey in Spanish, who had the highest rates across all three uninsurance measures. This was especially pronounced for the share uninsured both preconception and postpartum, at 36.9 percent for Hispanic women who completed a Spanish-language survey compared with less than 7 percent for all other groups, including Hispanic women who completed an English-language survey (6.6 percent). These patterns may, in part, reflect Medicaid eligibility rules that restrict eligibility for women who are not US citizens.8

In nonexpansion states, Black women had the lowest rate of being uninsured in both periods (10.2 percent), and they also had relatively low rates for preconception-only and postpartum-only uninsurance. As in expansion states, Hispanic women in nonexpansion states who completed the survey in Spanish had the highest rate of being uninsured in both periods (54.0 percent), but in these states Hispanic women who completed the survey in English also had much a much higher rate of lacking both preconception and postpartum coverage (38.4 percent) than their White, Black, or other race counterparts. In both expansion and nonexpansion states, disparities in uninsurance between Black and White

Uninsurance rates by perinatal period among new mothers with prenatal Medicaid coverage, by selected characteristics and Medicaid expansion status, 2015-18

Characteristics	Uninsured preconception only	Uninsured postpartum only	Uninsured preconception and postpartum
EXPANSION STATES			
Race/ethnicity (%) White, non-Hispanic (any language) (ref) Black, non-Hispanic (any language) Hispanic (English) Hispanic (Spanish) Other, non-Hispanic (any language) Prior live birth (%) Mothers with multiple children (ref) First-time mothers Income (%)  \$\$20,500 \$\$20,500 (ref)	11.6 8.9** 9.2** 15.4** 9.9 8.1 18.5**	3.1 2.9 4.3*** 6.9*** 4.6*** 3.5 4.0 2.7*** 4.4	3.2 2.1*** 6.6*** 36.9*** 4.8*** 6.4 6.2 5.5 6.2
NONEXPANSION STATES			
Race/ethnicity (%) White, non-Hispanic (ref) Black, non-Hispanic Hispanic (English) Hispanic (Spanish) Other, non-Hispanic Prior live birth (%)	18.0 12.0*** 14.9 8.2*** 13.7***	9.6 11.9 16.6** 19.8** 10.6	18.0 10.2** 38.4** 54.0** 22.9**
Mothers with multiple children (ref) First-time mothers Income (%)	12.0 20.4**	13.2 10.6**	24.7 21.4**
≤\$20,000 >\$20,000 (ref)	16.4** 12.8	12.1 12.1	24.5 22.0

**SOURCE** Authors' analysis of 2015–18 Pregnancy Risk Assessment Monitoring System (PRAMS) data. **NOTES** The sample includes women ages twenty and older with a live birth in calendar years 2015–18 who reported that their prenatal care was covered by Medicaid and that they were uninsured in the preconception or postpartum period in forty-three states with at least one year of PRAMS data during 2015–18. Significance indicators are for tests of difference from the reference category. \*\*p < 0.05

women were relatively modest compared with the gaps between Hispanic women and each of these groups.

First-time mothers were much more likely than their counterparts who were already mothers to be uninsured preconception only. In expansion states, 18.5 percent of first-time mothers were uninsured preconception only compared with 8.1 percent of mothers with other children. In nonexpansion states, both rates were somewhat higher, but the pattern was the same. These patterns emphasize the role of Medicaid in covering parents with low incomes even in the absence of an ACA Medicaid expansion. In addition, higher-income women were slightly more likely to be uninsured across all perinatal uninsurance measures in expansion states, whereas women with lower incomes were slightly more likely to be uninsured preconception only and in both periods in nonexpansion states. These patterns reflect the fact that those who could not qualify for Medicaid outside of pregnancy in expansion states had higher incomes than those in nonexpansion states.

Importantly, women with prenatal Medicaid coverage who experienced uninsurance at any point during the perinatal period were at risk for reduced access to and affordability of health care services outside of pregnancy, and these women reported health problems that could make this reduced access dangerous (exhibit 4). About 6.7 percent had preconception diabetes or hypertension, 12.2 percent had preconception depression, and almost 30 percent had obesity before pregnancy. In addition, about one-third had a cesarean delivery, 8.7 percent reported always or often feeling depressed, and 11.5 percent reported always or often lacking interest in activities in the postpartum period.

### Discussion

Health insurance coverage and access to care before, during, and after pregnancy are impor-

#### EXHIBIT 4

Maternal health outcomes among new mothers with prenatal Medicaid coverage who were ever uninsured during the perinatal period, 2015-18

	All sample states		
Maternal health outcomes (%)	Mean	SE	
PRECONCEPTION			
Preconception diabetes Preconception high blood pressure Preconception diabetes or high blood pressure Preconception depression Preconception obesity	3.0 5.4 6.7 12.2 29.9	0.003 0.004 0.004 0.005 0.009	
PRENATAL			
Prenatal diabetes Prenatal high blood pressure <sup>a</sup> Prenatal diabetes or high blood pressure <sup>a</sup> Prenatal depression <sup>a</sup>	10.5 12.2 19.5 15.1	0.006 0.006 0.008 0.007	
DELIVERY AND POSTPARTUM			
Had a cesarean delivery Received postpartum checkup Experiences postpartum depression: always or often Experiences postpartum depression: sometimes Experiences postpartum lack of interest: always or often Experiences postpartum lack of interest: sometimes	32.9 85.2 8.7 20.3 11.5 21.4	0.009 0.006 0.005 0.007 0.006 0.007	

**SOURCE** Authors' analysis of 2015–18 Pregnancy Risk Assessment Monitoring System (PRAMS) data. **NOTE** The sample includes women ages twenty and older with a live birth in calendar years 2015–18 who reported that their prenatal care was covered by Medicaid and that they were uninsured in the preconception or postpartum period in forty-three states with at least one year of PRAMS data during 2015–18. SE is standard error. \*Estimate is only for 2016–18.

tant in promoting maternal and infant health. 17,18 Despite coverage provisions including Medicaid expansion and subsidized Marketplace coverage, we found that more than one-third of mothers with Medicaid for prenatal care were uninsured either before they became pregnant or in the two to six months postpartum in the years after ACA implementation. Fully half of women with prenatal Medicaid coverage in nonexpansion states experienced perinatal uninsurance. Even in expansion states, one in five women with prenatal Medicaid coverage experienced perinatal uninsurance, primarily in the preconception period. Consistent with prior analysis of racial disparities in uninsurance among new mothers, we observed the highest rates of uninsurance in both periods for Hispanic women, especially for those who completed the survey in Spanish.<sup>34</sup> Differences in uninsurance between Black and White new mothers with prenatal Medicaid coverage were more modest, suggesting that coverage expansions alone are unlikely to address the extreme Black-White disparities in maternal mortality.

The patterns of perinatal uninsurance documented here have important policy implications. Uninsurance only in the preconception period suggests that pregnancy and parenthood often bring women into the Medicaid program,

through either new eligibility or new awareness of existing eligibility, and that once enrolled, these women are able to maintain insurance coverage. Women who are uninsured in the preconception period are least likely to benefit from a postpartum Medicaid extension but would benefit from outreach and enrollment efforts before pregnancy, particularly in expansion states, where more of these women are likely to be Medicaid eligible. In nonexpansion states, women experiencing preconception-only uninsurance could benefit from take-up of the ACA Medicaid expansion. In all states, outreach and enrollment efforts for subsidized Marketplace coverage could help women not eligible for Medicaid identify affordable coverage options.

Women experiencing uninsurance only in the postpartum period may have had access to public or private coverage before their pregnancy but were unable to maintain that coverage after enrolling in Medicaid for their pregnancy. This could reflect loss of employer coverage because of changes in employment after childbirth, issues transitioning between Medicaid eligibility categories such as from pregnancy-related eligibility to parental or expansion eligibility, or changes in income affecting Medicaid or Marketplace eligibility. An extension of postpartum Medicaid eligibility to a full year postpartum

could help such women maintain coverage during the critical "fourth trimester" and provide a longer period to return to work and employer coverage or to manage enrollment paperwork and transition to parental Medicaid or Marketplace coverage.

Women experiencing uninsurance both preconception and postpartum indicates a lack of accessible public and private coverage options outside of pregnancy. These women may temporarily benefit from a postpartum extension but would likely need additional support to maintain coverage after it expires and before any subsequent pregnancy. To the extent that they are eligible for Medicaid or Marketplace subsidies but not enrolled, they may also benefit from increased outreach efforts. However, the high rates of uninsurance in both periods among Hispanic women completing a Spanish-language survey suggests that some of these women might not be eligible for Medicaid coverage outside of pregnancy because of eligibility policies barring noncitizen women from Medicaid for their first five years of US residence. Similarly, immigration restrictions likely bar some of these women from accessing subsidized coverage through the Marketplace. Moreover, recent changes to the public charge rule have created additional concerns for Medicaid-eligible women, resulting in some choosing to forgo this benefit for fear of future immigration consequences for themselves and their families.<sup>35,36</sup>

Finally, women experiencing uninsurance during the perinatal period have health needs that require ongoing medical attention, including depression, diabetes, hypertension, obesity, and recovery from cesarean delivery. Without coverage, women may forgo needed care because of cost, which has implications for their health and, in the case of depression, the healthy development of their children.<sup>22</sup> Policies to increase Medicaid coverage among women before and after pregnancy, including Medicaid expansion, postpartum Medicaid extension, and increased outreach and enrollment, have the potential to improve women's self-reported health and increase the use of needed preconception and postpartum health services. 11,14 By improving women's health outside of pregnancy, these policies can help women maintain good health throughout their lives and improve the health and wellbeing of their children. ■

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# **EYE ON HEALTH REFORM**

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# The American Rescue Plan Expands The ACA

Congress temporarily enhanced the Affordable Care Act and newly incentivized the expansion of state Medicaid programs.

BY KATIE KEITH

resident Joe Biden signed the American Rescue Plan Act (ARPA) into law March 11, 2021. The legislation temporarily expands the Affordable Care Act's (ACA's) premium tax credits and increases federal financial incentives for states that have not vet done so to expand their Medicaid programs to low-income adults. These changes were enacted just ahead of the ACA's eleventh anniversary, as the nation awaits a Supreme Court decision on another global challenge to the law. Enrollment through HealthCare.gov has increased during the broad special enrollment period announced by the Biden administration, and federal officials have issued new guidance on ARPA, COVID-19, and more.

### American Rescue Plan Builds On ACA

Congress passed ARPA using the budget reconciliation process, requiring only a Senate majority rather than the sixty votes normally needed to overcome a filibuster. Among its many provisions, ARPA increases the tax credits available under the ACA and broadens eligibility for them, for the first time since the ACA's passage. Notably, these changes are temporary; they will end after 2022, as will the savings they mean for consumers, unless Congress makes some or all these changes permanent.

For 2021 and 2022 ARPA extends ACA premium tax credits to higher-income people who did not previously qualify because their incomes exceeded 400 percent of the federal poverty level. Individuals and families who newly qualify for

this financial help will not have to contribute more than 8.5 percent of their overall household income toward individual-market premiums. About 3.6 million uninsured people are estimated to be newly eligible for premium tax credits because of this change.

ARPA also increases, for 2021 and 2022, the amount of ACA premium tax credits available to those with incomes of 100-400 percent of the federal poverty level. People in this group will contribute a lower percentage of their income toward premiums than under the original ACA. For instance, those with incomes of 100-150 percent of poverty can enroll in a no-premium silver Marketplace plan; under prior law they contributed about 2-4 percent of their income toward premiums. The level of premium contribution increases as income increases, but ARPA caps the amount at 8.5 percent for all. An estimated nine million current Marketplace enrollees are expected to see savings, and many uninsured people could receive tax credits upon enrolling in Marketplace coverage.

Enhanced premium tax credits—for lower- and middle-income Americans—became available through HealthCare .gov on April 1, less than one month after ARPA was signed into law. State-based Marketplaces have adopted their own timelines to implement these changes; ARPA included \$20 million to help state-based Marketplaces update their systems.

Several additional temporary measures in ARPA are still being implemented. For 2021 only, people who receive or are approved to receive

unemployment benefits qualify for the maximum ACA premium tax credits and cost-sharing reductions, meaning a nopremium silver Marketplace plan and low out-of-pocket expense. ARPA also prevents people from having to repay excess ACA premium tax credits that were received during 2020, and it subsidizes Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage for laid-off workers through September 30, 2021.

These benefits do come at a cost. ARPA's enhanced premium tax credits, for instance, are projected to increase federal deficits by \$34.2 billion over ten years, and the enhanced subsidies for those receiving unemployment benefits will cost an additional \$4.5 billion. Most of these costs will go toward subsidizing current enrollees, but new enrollment is expected. Of the estimated 1.7 million people expected to enroll in coverage through the Marketplace in 2022, 1.3 million are expected to have been previously uninsured.

Finally, ARPA makes many changes to Medicaid, including substantial new incentives for the twelve states that have not yet expanded their Medicaid programs to all adults with incomes up to 138 percent of the federal poverty level to do so. States that opt to expand will receive a temporary increase of 5 percentage points in federal matching funds for non-expansion populations (in addition to 90 percent federal matching funds for the expansion population, as under the ACA). If all twelve states expanded their Medicaid programs, they would collectively receive a total of \$16.4 billion in increased federal funds over two years for their nonexpansion populations at a cost of about \$6.8 billion for their contributions toward the expansion population. It is not yet clear whether states will take advantage of this new incentive, but the ARPA changes have spurred renewed discussion in at least some states.

### HealthCare.gov Enrollment

Enrollment in the thirty-six states that use HealthCare.gov increased in the reg-

ular 2021 open enrollment period as many people lost coverage during the pandemic. This increase occurred even though federal officials declined to allow a broad special enrollment period in 2020, which most state-based Marketplaces allowed.

The Biden administration reversed course and authorized a broad enrollment period through HealthCare.gov to counteract some of the effects of the pandemic. This opportunity was initially available in 2021 from February 15 through May 15 and then extended through August 15. During this time, anyone who qualifies can newly enroll in coverage or change their plan through HealthCare.gov. Enrollment has already increased: More than 528,000 consumers newly selected a plan as of March 31. The Biden administration also committed \$100 million for Marketplace advertising and outreach and an additional \$2.3 million for navigator grantees to raise consumers' awareness of new coverage options and financial help available under ARPA.

# ACA Litigation Largely On Hold

A decision from the Supreme Court is still pending in *California v. Texas*, a global challenge to the ACA that was argued in November 2020. In February 2021 the Department of Justice submitted a letter notifying the Court that it was formally changing its position in *Texas*. The department now asserts that the individual mandate, even with a \$0 penalty, remains constitutional. Even if the Supreme Court finds the mandate to be unconstitutional, the department newly believes that the mandate is severable from the rest of the ACA, meaning that the rest of the law should stand.

It is unusual for the Justice Department to abandon positions taken by a prior administration. But this change was expected given President Biden's long-standing commitment to the ACA, among other factors. The letter is unlikely to have a substantive impact on the outcome in *Texas*, but the Biden administration clearly felt it was important to make its defense of the ACA known to the Supreme Court.

The new administration has also responded to other pending health-related Supreme Court litigation. It sought dis-

missal of litigation over the Trump administration's public charge rule, which made it harder for recipients of certain government benefits such as Medicaid to qualify for residency, and then rescinded the rule itself. It asked for similar dismissal in litigation over a Trump administration rule denying Title X funds to clinics that provide abortion referrals; that request has not yet been granted. And it has taken steps to withdraw approval for Medicaid waivers that authorize work or community engagement requirements in Arkansas and New Hampshire, arguing that there is no need for the Court to rule on related litigation at this time.

Other ACA-related cases could be coming. Insurers asked the Supreme Court to review an appellate decision that insurers were entitled to unpaid costsharing reduction amounts. However, the amount due must be offset by any excess premium tax credits that insurers received as a result of "silver loading"—the increase of premiums on Marketplace silver plans, thus increasing costs for "benchmark" plans and consequently increasing premium tax credits—or other types of premium loading. It is not clear whether the Court will agree to hear these appeals.

Beyond the Supreme Court, the Department of Justice has asked for stays or delays in other ACA-related litigation. This includes pending appeals over Trump administration rules loosening restrictions on association health plans, providing greater protections to providers who object to performing certain services for reasons of conscience, and requiring that insurers bill separately for abortion-related coverage. The department has generally cited the need for time to consult with new agency leadership. Other cases, such as a challenge over the Trump administration's refusal to authorize a broad special enrollment period, have been dismissed in light of Biden administration actions. And Georgia received permission to intervene in a lawsuit challenging federal approval of the state's waiver under Section 1332 of the ACA and Trump-era guidance interpreting Section 1332's consumer protections.

In addition, a federal appellate court heard arguments in a challenge to an Obama-era rule on Section 1557 of the ACA, the law's major antidiscrimination provision. And a federal trial court in Maryland set aside some Trump-era regulatory changes related to network adequacy standards, standardized plans, income verification processes, and medical loss ratios. Those parts of the rule were vacated, and most were remanded to the Department of Health and Human Services (HHS) for further action.

### **New Guidance But Few Rules From The New Administration**

The Biden administration has not yet proposed or finalized new ACA-related rules but has issued coverage-related guidance. HHS provided technical guidance on implementing the broad special enrollment period and the enhanced subsidies under ARPA. The agency informed states with approved Section 1332 waivers of the amount of federal pass-through funding—representing what the federal government would have spent absent the waiver on premium tax credits, cost-sharing reductions, and small employer tax credits in the state-they can expect to receive for 2021; states have asked HHS to recalculate these amounts in light of ARPA. And HHS released guidance for insurers ahead of the 2022 plan year, such as certification and rate submission timelines, as well as a summary report on changes to risk adjustment data following the data validation process.

HHS, joined by the Departments of Labor and the Treasury, issued guidance to further clarify COVID-19 testing and vaccine coverage requirements. The guidance confirms that plans and insurers must cover, without cost sharing, the COVID-19 vaccine, administration costs for the vaccine, and COVID-19 tests (including for asymptomatic people regardless of whether a person was exposed to COVID-19).

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Research Letter | Health Policy

# Trends in Out-of-Pocket Healthcare Expenses Before and After Passage of the Patient Protection and Affordable Care Act

Krishna Vangipuram Suresh, BS; Kevin Wang, BA; Adam Margalit, MD; Amit Jain, MD

### Introduction

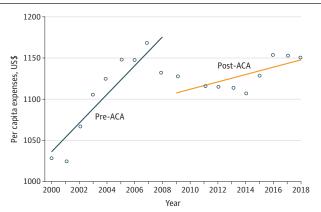
One goal of the 2010 Patient Protection and Affordable Care Act (ACA) was to limit patient out-of-pocket (OOP) health expenses. This cross-sectional study aimed to analyze trends in OOP health expenses in the United States during the last 2 decades and compare the distribution of services that most contribute to OOP spending.

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

### **Methods**

This study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline for cross-sectional studies. Institutional review board approval and informed consent were waived because the data were publicly available. Data from the National Health Expenditures (NHE) Accounts from 2000 to 2018 were analyzed. OOP expenditures represent total payments made in the form of deductibles, coinsurance, and health and flexible

Figure. Changes in Out-of-Pocket Expenses Before and After the Patient Protection and Affordable Care Act (ACA)



Dots represent the mean per capita OOP expenses for total health care expenditures at a given year. Lines of best fit are included to demonstrate overall trends over time.

Table. Summary of OOP Spending Trends in Components of Total Health Care Expenses

	OOP spending,	OOP spending, mean, \$			AAGR, % (SD)	
Expense	2000	2009	2018	2000-2009	2010-2018	P value <sup>a</sup>
Services						
Physician	164.78	173.25	187.00	0.5 (2.1)	0.8 (2.2)	.006
Dental	141.44	163.89	168.00	1.7 (3.4)	0.3 (2.4)	.03
Medications						
Nonprescription	156.03	182.62	196.00	1.7 (2.4)	0.8 (1.8)	<.001
Prescription	173.52	189.64	144.00	1.1 (5.8)	-2.9 (3.5)	<.001
Nonphysician and/or nondental services	56.87	66.73	80.00	1.8 (1.7)	2.0 (1.7)	<.001

 $Abbreviations: AAGR, average \, annual \, growth \, rate; OOP, out-of-pocket. \\$ 

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<sup>&</sup>lt;sup>a</sup> Changes in trends in OOP health expenses before and after the Patient Protection and Affordable Care Act.

### JAMA Network Open | Health Policy

savings accounts and by individuals who are uninsured. Expenditure estimates were converted to per capita estimates, and the Consumer Price Index was used to adjust all values to 2018 US dollars. Significance was determined using linear regression with gamma error distribution and log link. Significant changes in trends between pre-ACA (2000-2009) and post-ACA (2010-2018) OOP health expenses were determined using an interaction term between ACA and calendar year within the regression. Statistical analyses were 2-tailed ( $\alpha$  < .05) and performed using Stata version 15.0 (StataCorp).

### **Results**

From 2000 to 2018, total OOP per capita health expenses increased from \$1028 to \$1148. The average annual growth rate (AAGR) of OOP spending significantly decreased following the ACA (mean [SD], 0.2% [1.1%] vs 1.0% [2.3%]; linear regression P = .001; quadratic P = .001) (**Figure**). Mean (SD) AAGR for OOP spending increased for physician services from pre-ACA to post-ACA periods (0.5% [2.1] to 0.8% [2.2]) but decreased for other components of health care cost (**Table**). Total per capita health expenditures increased from \$6649 to \$10 627 from 2000 to 2018, with a pre-ACA AAGR (SD) of 3.4% (2.2%) and post-ACA AAGR (SD) of 1.9% (1.6%) (P for trend < .001).

### **Discussion**

Compared with the pre-ACA period, OOP spending increased at a slower rate for almost all health care services during the post-ACA period. Tax legislation in 2003 encouraged employers to provide high deductible health plans (HDHPs) to their employees; however, HDHPs do not reduce OOP spending because of the high upfront cost of care. The ACA implemented OOP spending maximums and increased access to preventive care services, which may have counteracted high OOP spending in HDHP plans. However, ACA-mandated price ceilings are still significant—\$7900 in 2019—which may explain why OOP spending is still increasing annually. We speculate that ACA-imposed spending limits for HDHPs account for substantial OOP savings. Furthermore, access to coverage for individuals who were previously uninsured may account for additional OOP savings.

AAGRs for OOP health expenses have increased for physician services since the introduction of the ACA, possibly because of increased use of out-of-network care. Cooper et al<sup>3</sup> demonstrated that at in-network hospitals, some services provided by anesthesiologists, pathologists, or assistant surgeons were billed as out-of-network services, with patients held responsible for additional costs. These costs may come under control with the passage of recent federal legislation to limit surprise billing.

OOP health expenses for prescription medications decreased rapidly from 2010 to 2018. Reasons for these findings include increased prevalence of prescription to nonprescription switches for medications, increased number of clinicians using nonprescription medications as first-line management, loss of patent protection for name-brand drugs, and increased use of prior authorization for prescriptions.<sup>1,4-6</sup>

Although the ACA may provide a partial explanation for OOP spending trends, we cannot definitively attribute these changes to the ACA alone. Coinciding economic events, such as the Great Recession, likely decreased consumer willingness to pay OOP for health-associated costs. In the current study, we were unable to determine whether these decreases were secondary to disproportionately high rates of Baby Boomers becoming eligible for Medicare. Moreover, savings in OOP health spending may be nullified by increased taxpayer spending on Medicaid. Access to coverage for individuals who were previously uninsured through Medicaid expansion may account for the greatest OOP savings.

#### ARTICLE INFORMATION

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# Can Automatic Retention Improve Health Insurance Market Outcomes?<sup>1</sup>

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January 8, 2021

### **Abstract**

There is growing interest in market design using default rules and other "choice architecture" principles to steer consumers toward desirable outcomes. Using data from Massachusetts' health insurance exchange, we study an "automatic retention" policy intended to prevent coverage interruptions among low-income enrollees. Rather than disenroll people who lapse in paying premiums, the policy automatically switches them to an available free plan until they actively cancel or lose eligibility. We find that automatic retention has a sizable impact, switching 14% of consumers annually and differentially retaining healthy, low-cost individuals. The results illustrate the power of defaults to shape insurance coverage outcomes.

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### 1 Introduction

One of the best-established findings in behavioral economics is that people are often passive and that defaults – what happens when individuals fail to act – have a major impact on outcomes. There is growing interest in applying this principle to improve outcomes in policy-relevant settings.

Health insurance offers instructive examples. Programs like the Affordable Care Act's (ACA) exchanges aim to provide affordable coverage via markets that allow for choice and competition. However, these arrangements add complexity, and there is evidence that consumers struggle to choose well (Abaluck and Gruber, 2011; Bhargava et al., 2017) and exhibit inertia in plan switching decisions (Handel, 2013; Ericson, 2014; Ho et al., 2017). Default rules may therefore be quite impactful in these settings.

In this paper, we describe and evaluate a policy that leverages defaults to prevent loss of coverage when consumers lapse on premium payments, an important and under-appreciated challenge in health insurance. Under standard rules, lapsers are disenrolled, leaving them uninsured unless they obtain other coverage. We discuss an alternate policy, which we call "automatic retention," that instead defaults lapsers into a free plan if one is available.

We study auto retention empirically in Massachusetts' pre-ACA health insurance exchange, where the policy was used for several years with little attention. We are not aware of research that has described the policy or studied its effects.

We find that the policy has a major impact, retaining 14% of enrollees per year (weighted by duration enrolled). Auto retention is the primary way consumers switch plans, creating three times more switches than occur actively during open enrollment. The policy differentially retains young, healthy, and low-cost people, implying important consequences for the market's risk pool and extensive margin adverse selection. Using auxiliary data from the state's All-Payer Claims Database, we find little evidence that the policy leads to significant duplication of coverage. We conclude by discussing policy tradeoffs and implications.

### 2 Exchange Background and the Auto Retention Policy

**Exchange Setting** Our setting is Massachusetts' pre-ACA subsidized health insurance exchange, known as Commonwealth Care ("CommCare"). Established under the state's 2006 "Romneycare"

reform, CommCare provided subsidized private plans to low-income adults without access to insurance from an employer or public program. Subsidies were set to make the cheapest plan's premium "affordable," defined as 0-5% of monthly income. Additional background and statistics are discussed in Online Appendix A.

Like the ACA exchanges that followed it, CommCare took a regulated market-based approach. This structure puts policymakers in the position of market designers who set the rules under which insurers compete and consumers choose. Beyond standard "incentives" policies like subsidies and benefit regulation, market designers also devise rules related to what Thaler (2018) calls "choice architecture," which can have a large impact on boundedly rational consumers. Thoughtful choice architecture can "nudge" consumers towards desirable outcomes, while careless design can lead to poor outcomes. In this paper, we describe a nudge policy that affects what happens when consumers lapse on paying monthly premiums.

Challenge of Premium Lapses Most enrollees in health insurance markets owe some balance of monthly after-subsidy premiums. This raises the challenge of ensuring that consumers pay their bills. Premium lapses are common in health insurance exchanges. While we do not directly observe lapses in our CommCare data, 6% of consumers terminate enrollment each month. Data on subsidized enrollees in Massachusetts' post-ACA exchange (where reason for exit is observed) suggest that 30% of terminations are due to premium lapses.

The fundamental issue underlying lapsing is that the exchange has no way to *automatically collect* premiums.<sup>2</sup> Consumers may opt out at any time, but what happens when they simply stop paying? Premium lapses create a dilemma for market designers. Should they disenroll the lapser – which may lead to a spell of uninsurance and associated adverse consequences? Or should they weaken enforcement of premium collection? In practice, policymakers seek a balance, sending multiple notices over a grace period of 2-3 months before disenrolling a lapser. However, more creative approaches may be desirable to improve on this outcome.

<sup>&</sup>lt;sup>2</sup> As such, an alternate approach would be to find a way to *automatically* collect or withhold premiums, possibly via the tax system. This approach is used successfully by both employers (withholding from paychecks) and Medicare (withholding from Social Security benefits). Auto-collection via taxes was not feasible in CommCare due to cross-department legal and administrative barriers. But tax-based collection seems a natural fit for the ACA, whose subsidies are administered by the IRS as income tax credits.

**Automatic Retention Policy** Auto retention was an approach to reduce coverage interruptions for lapsers. Rather than *automatically disenroll* premium lapsers, the policy instead *automatically switched* them to a \$0 premium plan if available. Lapsers carried debt for unpaid premiums but retained coverage unless they actively canceled or lost eligibility. If they paid this debt within 60 days, they could switch back to their old plan.

The key precondition for auto retention is the availability of "backstop" coverage that is free (or more generally, in which up-front premium collection can be waived). In CommCare, this condition held only for the 100-150% of poverty income group, for whom the cheapest plan was free while other plans varied from \$2 to \$34 per month. Auto retention was not used for higher-income groups who did not have access to a \$0 plan.<sup>3</sup> We use the 150-200% of poverty group (for whom the cheapest plan costs \$39-40) as a control group in our analysis.

### 3 Data and Methods

Our main dataset is de-identified CommCare enrollment records linked to insurer claims. Online Appendix A describes the dataset and cleaning process. We limit our analysis to fiscal years 2010-2013, when the auto retention policy was in place.<sup>4</sup>

A limitation of our data is that they do not include an indicator for plan switching due to auto retention. We infer its use from the (much higher) rates of "mid-year" plan switching for the 100-150% of poverty group. We first drop a small number of known cases where mid-year switching is allowed (changes in service area or income group). To proxy for harder-to-observe exceptions, we use mid-year switching rates for the 150-200% "control" group.<sup>5</sup> Our estimate of the rate of auto retention is the *excess mid-year switching rate* for the "treatment" group (100-150% of poverty) relative to the controls.

A second limitation of the CommCare data is that it lacks information on other sources of health insurance. To assess whether auto retention leads to *duplicate coverage*, we draw on

<sup>&</sup>lt;sup>3</sup> Auto retention was unnecessary for below-poverty enrollees who had access to *all plans* for free, making premium lapsing moot.

<sup>&</sup>lt;sup>4</sup> Auto retention appears to have been used inconsistently in 2009, so we exclude it for simplicity. It was not used prior to 2009, since all plans were free for the 100-150% of poverty group.

<sup>&</sup>lt;sup>5</sup> Other exceptions include the dropping of an enrollee's PCP from network and receipt of a special hardship waiver. In practice, these appear to be rare; the control group's mid-year switching rates are less than 0.3% per month.

Massachusetts' All-Payer Claims Database (APCD), which lets us observe enrollment in both CommCare and nearly all other health insurance in the state. Online Appendix A further describes our APCD cleaning methods.

### 4 Results

### 4.1 Auto Retention Estimates

Figure 1 shows the switching patterns underlying our estimates. The panels show monthly plan switching rates during 2010-13 for the treatment and control groups (with 2010-11 pooled because patterns are similar). Open enrollment switches in the first month of the year (shaded in gray) are excluded from our estimates but shown for context.

Two results stand out in Figure 1. First, mid-year switching rates are an order of magnitude higher for the treatment group (averaging 2.2% per month) compared to the control group (0.24% per month). The excess switching rate— our estimate of the impact of auto retention— is 1.9% per month, on average. When summed over all 11 mid-year months, auto retention results in about three times more switches than occurs during formal open enrollment (which averages 6-7% for one month). Automatic retention is the *primary* way consumers switch plans in the treatment group.

To translate these monthly rates into annual estimates, we calculate the share of total enrolleemonths accounted for by mid-year switchers in each year. This share is 15.3% in the treatment group and 1.5% in the control group, implying an excess share of 13.8%. This is our main estimate of the share of consumers affected by auto retention.<sup>6</sup>

The second clear pattern in Figure 1 is a large switching spike in months 3 or 4 of each year except 2012. Excess switching rates average 9.3% during these spikes, versus 1.4% in all other months. This appears to be driven by *changes in which plans are free* at the start of the year. When a plan shifts from free to non-free, its enrollees face a choice to either: (1) actively switch to a different plan that is now free, or (2) stick with their current plan and actively pay a premium. In

<sup>&</sup>lt;sup>6</sup> This estimate of 13.8% is lower than 11 times the monthly excess switching rate (1.9%) because of consumer churn into and out of the sample. See Online Appendix Table B.1 for these statistics.

practice, many enrollees do neither, instead lapsing. This results in an auto-switching spike just after the 2-3-month grace period ends.

Figure 2 shows evidence for this interpretation. It breaks down treatment group switching rates by the origin plan's free/non-free status in the current and prior year.<sup>7</sup> Only plans that shift from being free to non-free (blue series) show a spike. Plans that remain non-free in both years (red series) exhibit steady mid-year switching but no spike. Switching out of free plans (green series) is much lower; this is expected, as one cannot lapse on a \$0 premium. This story also explains why there was no switching spike for 2012 in Figure 1; this was the only year that the prior year's free plan remained free.<sup>8</sup> These patterns suggest that plan transitions from free to non-free are an important trigger for lapsing and may merit attention by policymakers.

### 4.2 Mechanisms: Financial vs. Hassle Costs

Why do so many enrollees lapse on paying premiums? While the reasons are undoubtedly complex, one key question is whether lapsing reflects the *financial cost* (or "affordability") of a higher premium or the *hassle cost* of paying any positive premium (e.g., the time and attention cost of remembering to pay the bill)? These stories have different policy implications so are worth distinguishing.

To do so, we explore the relationship between mid-year switching rates and the premium of the origin plan (see Online Appendix Figure B.3). Our analysis suggests a role for both mechanisms. Hassle costs appear to be key during the month 3-4 switching spike. There is little relationship between origin plan premium and auto-switching rates, and they are high even in cases with very low premiums (<\$5 per month). One example is illustrative: a plan whose premium increased from \$0 to \$3 at the start of 2013. Following this change, 24% of its enrollees auto-switch out in 2013m3, and another 2.5% per month switch out during the rest of the year. It is implausible that \$3 per month is unaffordable; instead, this must reflect some form of hassle cost.

<sup>&</sup>lt;sup>7</sup> Figure 2 pools estimates for 2010-12 and omits 2013 because of the different spike timing in 2013 (month 3 rather 4). CommCare updated regulations at this time, limiting the grace period to 2 months starting in 2013. Online Appendix Figure B.2 shows estimates for each year 2010-13, which are similar to the pooled results.

<sup>&</sup>lt;sup>8</sup> This is true statewide except for one small area in Western Massachusetts where (because of an insurer entry) the free plan in 2011 became non-free in 2012. Consistent with our story, we see a large (19.0%) switching spike in this region only (see Online Appendix Figure B.2). Because the area is small, it is not visible in Figure 1.

We do, however, see evidence for financial costs mattering outside of the month 3-4 spike. For these months, we find that an additional \$10 per month premium obligation raises the mid-year switching rate by 0.5-1.0% points (relative to an average of 1.8%). Although \$10 is a modest amount – just 1% of monthly income even at the poverty line – this analysis shows that even nominal premiums can deter enrollment in low-income groups.

### 4.3 Heterogeneity Analysis

The auto retention policy differentially affects certain groups. Online Appendix Table B.2 compares mid-year switchers (a proxy for auto-retained enrollees) to all other enrollees in the treatment group. Switchers are younger (by 4.1 years), less likely to have a chronic illness (by 3.4% points, or 6%), and have lower medical risk scores (by 0.025, or 2.5% lower predicted spending). Their average medical spending per month enrolled is 8.6% lower. Notably, the larger percentage gap in spending than risk score indicates that switchers are differentially profitable even after risk adjustment. Spending for auto-switchers is particularly low in the six months following the auto-switch, consistent with research showing that enrollees lapse at times when they use less health care (Diamond et al., 2020).

The average switcher stays enrolled in CommCare for 10 months after the switch, which is substantial in a market where typical durations are about a year. Notably, 15% of switchers "reswitch" within three months of their auto-switch. This is non-trivial, but implies that the vast majority (85%) stick with their newly assigned plan, boosting the market share of these lowest-price plans.

### 4.4 Does Auto Retention Lead to Duplicate Coverage?

A key concern with auto retention is that it retains enrollees who may have gained other insurance (e.g., via a new job) and should technically be ineligible for CommCare. Duplicative coverage would not harm enrollees but would result in unneeded public spending on subsidies. Using the

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<sup>&</sup>lt;sup>9</sup> The exchange attempts to avoid duplication via a unified Medicaid-CommCare enrollment system (which should mechanically prevent inappropriate duplication), annual eligibility redetermination, and periodic cross-checks of enrollee lists for commercial insurance. However, these safeguards may still miss some enrollees.

APCD, however, we find that coverage duplication rates for CommCare enrollees are low (3.1%) and not much different for enrollees in the 11 months surrounding a mid-year plan switch (3.6%).

### 5 Discussion

This paper has described a policy we call "automatic retention," which Massachusetts used in its pre-ACA insurance exchange to reduce termination for premium non-payment among low-income health insurance enrollees. Rather than disenrolling lapsers, the policy automatically switched them to a free plan if one is available. Our analysis suggests the policy had a major impact, retaining 14% of consumers per year. Retained enrollees are younger, healthier, and lower-cost, suggesting that the policy improves the market risk pool. We were concerned auto retention would lead to duplicate coverage, but evidence from the APCD suggests duplication is rare and not much different for enrollees around the time of mid-year plan switches.

A limitation of our analysis is that we do not see counterfactual outcomes for the 100-150% of poverty treatment group *without* auto retention in place. Absent auto retention, we expect that lapses would mechanically lead to termination, but we do not know how transient or long-lasting the coverage gap would be. In separate work on the post-ACA Massachusetts exchange (when auto retention was no longer in effect), McIntyre (2020) finds that changes in which plans were free/non-free lead to a large spike in terminations due to non-payment for the same 100-150% of poverty group. The vast majority of terminated consumers do not return within 12 months, suggesting that coverage gaps may be significant.

The finding that defaults matter for *retaining* enrollees in health insurance adds to a broader literature on the power of defaults to shape market outcomes. Most prior work on defaults within health insurance has focused on consumer inertia when given an opportunity to switch plans. In ongoing work on the same Massachusetts market, two of us also find large impacts of an automatic *enrollment* default during the initial sign-up process (Shepard and Wagner, 2021).

Our findings point to a key role for the *hassle cost* of paying a premium in driving lapses, rather than affordability. "Hassles" may reflect a variety of factors, including informational barriers (e.g., lost or unopened mail notices), the time cost of setting up online auto-payment, or the attention cost of remembering to write a check each month. Further research into mechanisms would be useful in guiding policy responses. Finding a way to withhold or collect premiums

automatically – a strategy used successfully by employers and Medicare – would address many of these issues.

There are tradeoffs inherent to auto retention. In reducing terminations, the policy increases subsidized insurance enrollment. On the one hand, reducing uninsurance is a key policy goal. On the other hand, public subsidy spending also rises. Whether that spending is "worth it," given benefits to the newly insured and spillover benefits to society, is a key issue animating current debate about the ACA.

Another tradeoff involves the policy's effect on competitive incentives. The policy boosts market share for the lowest-price plan(s) that receive auto-switched individuals. This should encourage insurers to compete aggressively to be the lowest-price plan. However, this price competition could lead to quality reductions and may be distorted by risk selection incentives. Like other policies, auto retention appears to involve a tradeoff between improving risk selection on the extensive margin while worsening it on the intensive margin (Saltzman 2020; Geruso et. al, 2020).

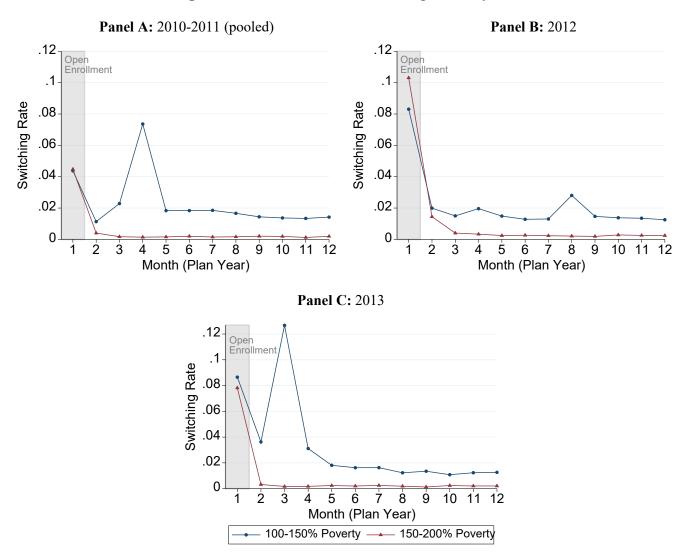
Implementation of auto retention in other settings, like the ACA exchanges, would face similar tradeoffs, in addition to legal and practical challenges. Nonetheless, our evidence suggests that if these challenges could be surmounted, changing default rules can meaningfully improve coverage retention.

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Figure 1: Share of Enrollees Switching Plans, by Month



NOTE: The figure shows the share of sample enrollees who switch plans by month of the year for the treatment group subject to auto retention (100-150% of poverty, in blue) and control group not subject to the policy (150-200% of poverty, in red). Panel A shows 2010-11 (pooled because of similar patterns); panel B shows 2012; and panel C shows 2013. Open enrollment, when switching is typically allowed, is shaded in gray. Higher switching rates in all other ("mid-year") months for the treatment group indicate the impact of the auto retention policy.



Figure 2: Plan Switching Rates, by Origin Plan Free/Non-free Status

NOTE: The figure breaks down switching rates for the treatment group (100-150% of poverty) by the free/non-free status of the origin plan to understand the source of the large switching spike in Figure 1. It shows monthly switching rates out of three types of plans: (1) plans that were free last year but become non-free this year (blue solid line), (2) plans that were non-free (>\$0) both last year and this year (red dashed), and (3) plans that are free this year, regardless of their premium last year. Statistics are pooled across 2010-2012 for simplicity, with 2013 omitted because of its different timing of the spike (month 3 rather than month 4). Results are similar if broken down separately by year (see Appendix Figure B.2). The figure indicates that all of the large switching spike comes from enrollees in plans that change from being free to non-free at the start of the new year.

### **Online Appendix:**

"Can Automatic Retention Improve Health Insurance Market Outcomes?"

By Adrianna McIntyre, Mark Shepard, Myles Wagner

### Appendix A: Data, Sample, and Methods Details

CommCare Dataset Our main dataset is complete (de-identified) administrative enrollment data for the CommCare program, linked to insurer claims. This data was obtained via a data use agreement with the Massachusetts Health Connector, the administrator of CommCare. We thank the Connector for its assistance in providing and interpreting the data. The dataset is structured at the enrollee x month level, with information on individual income group, location, demographics, and plan enrollment during that month. To this, we merge on information on monthly spending and (at an annual level) medical diagnoses and risk scores calculated from the linked claims dataset.

Starting from the full data that spans fiscal years 2007-2014, we limit our sample to the fiscal year 2010-13 period when the auto retention policy was consistently in effect. <sup>10</sup> (CommCare's fiscal year runs from July-June, so this represents in calendar time July 2009 to June 2013.) We next limit the sample to enrollee-month observations in either the 100-150% of poverty "treatment" group (subject to auto retention) or the 150-200% of poverty "control" group (not subject to the policy).

Sample Limitations for Measuring Auto Switching Rate Our goal is to measure the rate of automatic plan switching due to the automatic retention policy. However, a key limitation of the data is that they do not include a direct flag for plan switching due to the policy. Instead, we infer its use from the (much higher) rates of "mid-year" plan switching – outside of the beginning-

<sup>&</sup>lt;sup>10</sup> We make these drops for the following reasons. The auto retention policy was not in effect in 2007 (when the cheapest plan was not free for the treatment group) or 2008 (when all plans were free for the treatment group, making lapsing irrelevant). We exclude 2009 because auto retention appears to have been used inconsistently during the year and because there was an extended open enrollment period (months 1-3) that makes it difficult to separate out automatic from active switching. We exclude fiscal 2014 both because is a short year (July 2013 to December 2013) and because its latter months interact with the implementation of the ACA.

of-year open enrollment period when switching is allowed – for the 100-150% of poverty group versus other groups.

Aside from open enrollment, there are a few exceptions that allow for mid-year switching. We observe and exclude from our sample instances of the two main exceptions: changes in geographic area or income group. These exclusions – which we make whether or not the enrollee actually switched plans – drop 0.4% (geography changes) and 3.2% (income changes) of member-month observations, of which only 1.6% represent switches. Enrollees are also technically allowed to switch plans within two months of initially enrolling in the market. We chose not to drop these cases because they represent a relatively large share of the sample (12%) and switching rates are not much higher in these months, even in the control group. Enrollees are also allowed to "reswitch" plans in the 60 days following an auto-switch; we retain these observations in the sample because this is an outcome of interest.

Table A.1 shows summary statistics for the final sample, separately for the treatment (100-150% of poverty) and control (150-200% of poverty) groups. The two groups face different premiums – e.g., the cheapest plan is \$0 in the treatment group versus \$39-40 in the control group – which leads to differential selection into participation in the market (Finkelstein, Hendren, and Shepard, 2019). This selection can account for some of the age and medical spending differences for the two groups. These differences should not have a major impact on mid-year plan switching rates aside from the auto retention policy. Moreover, the mid-year switching rate is so low for the control group (0.2%), that all of our results would be similar if we simply analyze patterns for the treatment group.

Measuring Switching and Excess Plan Switching Rates The key variable for our analysis is the plan switching rate, defined as the share of individuals continuously enrolled between months t-1 and t who switch plans between those months. We calculate switching rates both for the open enrollment period (month 1) when active switching is allowed for any reason, and for months 2-12 of the year ("mid-year" months) when active switching is typically not allowed.

As described above, we drop observations with known exceptions that allow for mid-year switching (changes in income group or service area). In addition, an individual who has lapsed and been auto-switched may "re-switch" back to their old plan within 3 months if they pay their premium debt. To avoid counting re-switches in our estimates of auto retention (e.g., for Figure

1), we do not count mid-year switches within 3 months of another plan switch for either the treatment or control group. (These observations are retained in the sample but recoded as non-switches for calculating the switching rate.) We instead report re-switching as a separate outcome in Table B.2.

During open enrollment, switching rates are similar for the treatment and control groups (6.5% and 6.9%, respectively). However, "mid-year" switching rates in the other 11 months are an order of magnitude higher for the treatment group (2.2% per month) relative to the control group (0.24%). This is consistent with our understanding of the data generating process. The low control group switching rate reflects a few hard-to-observe exceptions that allow for mid-year switching, while the much higher rate for the treatment group reflects the auto retention policy.

To measure the excess switching rate formally, we run the following OLS regression:

$$1\{SwitchPlans_{it}\} = \alpha_t + \beta \cdot 1\{TreatGrp_{it}\} + \varepsilon_{it}$$
(1)

where  $\alpha_i$  are time fixed effects that capture baseline switching rates in the control group, and  $\beta$  (the coefficient of interest) captures the excess switching rate for the treatment group. In some analyses, we run regression (1) separately for certain subsets of plans (e.g., plans that transition from free to non-free) or subsets of time periods (spike month vs. non-spike months).

Supplementary Dataset: Mass. APCD A key limitation of the CommCare data is that we cannot observe insurance outside of the CommCare market. A question of particular interest is whether the auto retention policy leads to *duplicate* coverage in both CommCare and outside private insurance. To assess this, we draw on information from the Massachusetts All-Payer Claims Database (APCD). The APCD lets us observe coverage in both CommCare and nearly all other health insurance in the state – with the sole important exception being traditional Medicare, which is unlikely to be relevant for the non-elderly, non-disabled population in CommCare. The APCD includes a synthetic ID that follows individuals across insurers, letting us observe duplicate coverage.

Using the APCD's member eligibility file, we construct an enrollment history dataset for people ever enrolled in CommCare that also includes their coverage history in other insurance.

<sup>&</sup>lt;sup>11</sup> We use the APCD version 3.0, which includes calendar years 2009-2013. The APCD, which is not linked to the CommCare data, was obtained under a separate data use agreement with Massachusetts' Center for Health Information and Analysis.

The data construction requires some care. Each record in the ME file describes a member's enrollment spell in a particular health plan, with variables describing the characteristics of the health plan (such as the plan's carrier), and the start- and end-dates of the spell. We use the variables "Insurance Type Code" (ME003) and "Special Coverage" (ME031) as CommCare indicators. Both are categorical variables that indicate a CommCare enrollment; however, since they do not always coincide, we define our sample of CommCare enrollment spells as those for which *either* variable indicates CommCare.

An additional challenge is that many records for BMC enrollments have missing values for the end-date, specifically coded as "12/31/2099" or "12/31/2199." We find that these are often (in about 98% of cases) accompanied by another record with an identical start-date and a non-missing end-date. In these cases, we disregard the record with the missing end-date in the construction of our panel. In the remaining 2% of cases, we truncate the end-date to be 12/31/YYYY, where YYYY is the year of the report ("eligibility year", given by the variable ME004).

We validate the construction of this dataset by comparing it to the true CommCare enrollment data. The numbers line up quite closely. The APCD CommCare subset matches within 3% the member-month counts in the true CommCare data for fiscal years 2009-2013 (10.7 million in the APCD compared to 10.4 million true CommCare member-months). Enrollment across plans and over time also line up quite closely.

With this panel dataset in hand, we turn to non-CommCare enrollment spells in the APCD. We do not have an external dataset to validate the non-CommCare enrollment, so we take the spell descriptors in the APCD at face-value. We define dual enrollment as a month in which a CommCare member is also enrolled in non-CommCare health insurance.

Table A.1: Sample Summary Statistics

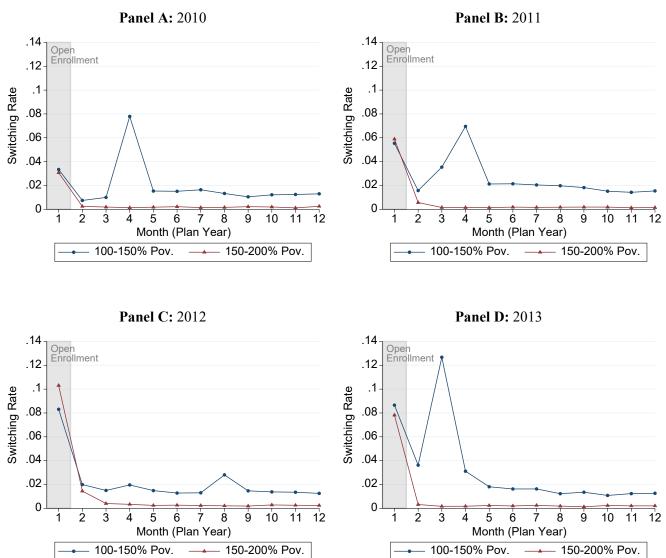
		100-150% Poverty (Treatment Grp.)	150-200% Poverty (Control Grp.)	
		(1)	(2)	
<b>Enrollment and Switching</b>				
Total enrollment per mor	nth	35,108	28,067	
Terminations per month		1,811	1,752	
Duration Enrolled (mont	hs): Median	14.0	13.0	
	Mean	19.7	18.0	
Share Switch Plans:	Open Enr.	6.53%	6.87%	
	Mid-Year	2.17%	0.24%	
Consumer Premiums (\$/m	onth, after su	bsidies)		
Lowest-Premium Plan		\$0.00	\$39.29	
Other Plans:	Average	\$8.03	\$53.85	
	Max	\$34.00	\$91.00	
Consumer Attributes and	Costs			
Age (years)		42.6	44.6	
Share Male		42.1%	40.6%	
Income (% of Poverty L	ine)	127.5	174.5	
Risk Score (HHS-HCC	)	1.037	1.128	
Medical Costs (\$ per m	onth)	\$334.70	\$376.80	

NOTE: The table shows summary statistics for our sample, separately for the treatment group subject to the auto retention policy (100-150% of poverty) and the control group not subject to the policy (150-200% of poverty). Risk score (HHS-HCC) refers to the HHS Hierarchical Condition Category risk adjustment method used in the ACA Marketplaces. We impute this risk score for each enrollee at an annual level based on demographics and diagnoses observed on their claims and normalize mean risk score to 1.0 for the whole market. Medical costs refer to average monthly medical spending (insurer-paid and cost sharing) during the enrollment spell.

### **Appendix B: Additional Figures and Tables**

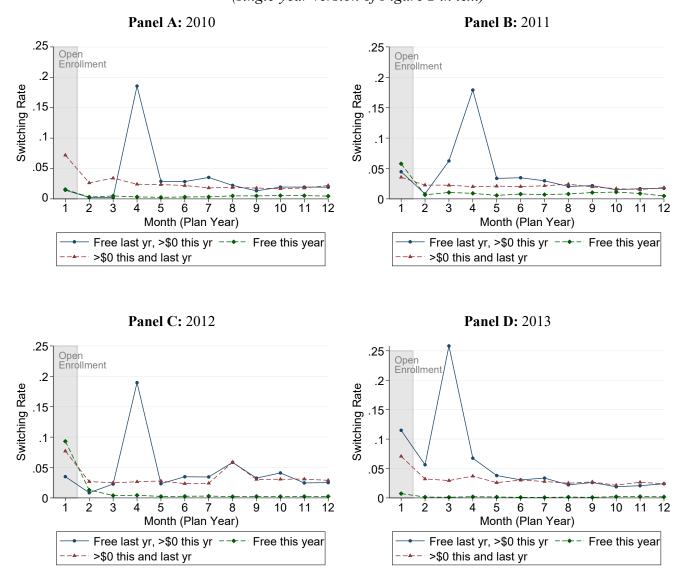
Figure B.1: Share of Enrollees Switching Plans, by Month

(single-year version of Figure 1 in text)



NOTE: The figure shows an annual version of Figure 1 in the body text for each year 2010-13. The figure shows the share of sample enrollees who switch plans by month of the year for the treatment group subject to auto retention (100-150% of poverty, in blue) and control group not subject to the policy (150-200% of poverty, in red). Open enrollment, when switching is typically allowed, is shaded in gray. Higher switching rates in all other ("mid-year") months for the treatment group indicate the impact of the auto retention policy.

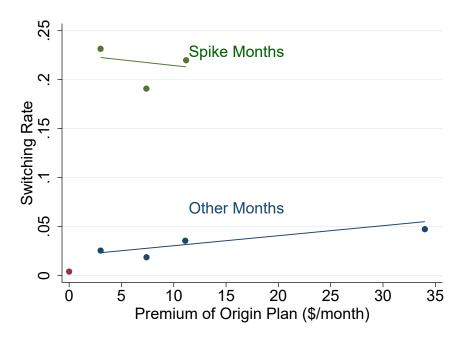
**Figure B.2:** Plan Switching Rates, by Origin Plan Free/Non-free Status (single-year version of Figure 2 in text)



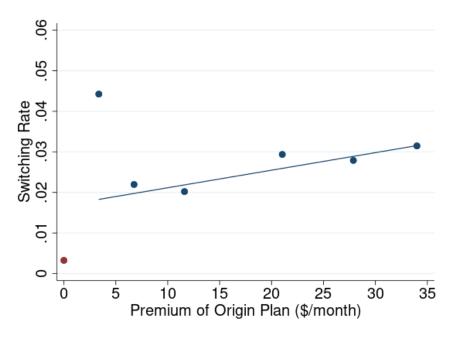
NOTE: The figure shows an annual version of Figure 2 in the body text for each year 2010-13. The figure breaks down switching rates for the treatment group (100-150% of poverty) by the free/non-free status of the origin plan to understand the source of the large switching spike in Figure 1. It shows monthly switching rates out of three types of plans: (1) plans that were free last year but become non-free this year (blue solid line), (2) plans that were non-free (>\$0) both last year and this year (red dashed), and (3) plans that are free this year, regardless of their premium last year. Consistent with the results in Figure 2, these figures indicate that all of the large switching spike in month 3 or 4 comes from enrollees in plans that change from being free to non-free at the start of the new year.

Figure B.3: Mid-Year Switching Rates vs. Origin Plan Premium Amount

### Panel A: Prior-Year Free Plans



Panel B: Prior-Year Non-Free Plans



NOTE: The figure shows binned scatter plots of the relationship between mid-year switching rates and the monthly premium of the origin plan during the current year. In all cases, \$0 current premium is included as a separate category (shown in red). Based on the patterns in Figure 2, the relationship is broken down by plans that were free in the prior year (panel A) versus non-free plans in the prior year (panel B). Panel A is further broken down between the spike months (month 3 or 4, depending on the year) and non-spike months.

**Table B.1:** Prevalence of Mid-Year Switchers, Treatment vs. Control

	100-150% Poverty (Treatment Grp.) (1)	150-200% Poverty (Control Grp.) (2)
Share of member-years w/ mid-year switch	11.96%	1.32%
Share, weighted by months enrolled in yr.	15.27%	1.51%
Avg. Members per Year	66,582	55,643

NOTE: The table shows the share of member-years from the pooled 2010-2013 sample that experience at least one mid-year switch, for the 100-150% of poverty group (column 1) and the 150-200% of poverty group (column 2), both un-weighted and weighted by the number of months observed in each year (excluding months with a change in geographic area or income group).

**Table B.2:** Characteristics of Mid-Year Switchers vs. Other Enrollees

		100-150%	6 Poverty	Enrollees	
	Mid-Year Switchers	All Others	Diff.	(s.e.)	Combined Population
	(1)	(2)		(3)	(4)
<b>Share of Enrollment Months</b>	15.3%	84.7%			100%
<b>Demographics and Risk</b>					
Income (% of Poverty Line)	126.9	127.6	-0.7	(0.1)**	127.5
Age (years)	39.1	43.2	-4.1	(0.1)**	42.6
Share Male	0.429	0.419	+0.009	(0.003)**	0.421
Chronic Illness	0.576	0.609	-0.034	(0.003)**	0.604
Cancer	0.069	0.100	-0.030	(0.002)**	0.095
Risk Score (HHS-HCC)	1.016	1.041	-0.025	(0.017)	1.037
Medical Spending (\$/month)					
Total spending	\$310.0	\$339.2	-\$29.2	(5.6)**	\$334.7
6 months prior to switch	\$325.9	n/a			
6 months after switch	\$298.7	n/a			
<b>Duration and Switching</b>					
Duration enrolled: Prior to auto-switch	11.9	n/a			
After auto-switch	9.9	n/a			
Re-Switch Plans (w/in 3 mon.)	0.153	n/a			

NOTE: The table shows average characteristics in the treatment group (100-150% of poverty) for mid-year switchers (column 1) versus all other enrollees (column 2). Column (3) shows the difference between groups, and column (4) shows the average for the combined population of switchers and all others. Medical status variables (chronic illness and cancer) are based on diagnoses observed on claims for each year. Risk score (HHS-HCC) refers to the HHS Hierarchical Condition Category risk adjustment method used in the ACA Marketplaces. We impute this risk score for each enrollee at an annual level based on demographics and diagnoses observed on their claims. Medical costs refer to average medical spending (insurer-paid and cost sharing) per month enrolled; for switchers, we also show this separately for the (up to) 12 months enrolled prior to and after the mid-year switch. Share re-switch plans refers to the share of mid-year switchers who take the opportunity to switch plans again within three months.





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## Recovery Legislation Should Build on ACA Successes to Expand Health Coverage, Improve Affordability

By Sarah Lueck and Tara Straw

The Affordable Care Act (ACA) expanded health coverage to more than 24 million people, sharply dropping the uninsured rate for people of all ages, of all racial and ethnic backgrounds, and at all education levels. The recently enacted American Rescue Plan — particularly its two-year premium tax credit enhancements for marketplace enrollees and strong financial incentives for states to expand Medicaid — is expected to reach millions of the roughly 30 million people who remain uninsured, a group disproportionately composed of people of color. To address these disparities and make further strides toward universal coverage, an essential priority for recovery legislation, Congress should make broader, permanent improvements to marketplace coverage.

Many people who are uninsured are eligible for financial help to buy a marketplace plan but cite cost as an obstacle. The Rescue Plan took substantial steps to address this gap, primarily by enhancing premium tax credits to make coverage more affordable in 2021 and 2022. Low- and moderate-income people are eligible for significant discounts in the premiums they must pay to enroll in a plan, with some paying nothing. And people with higher incomes but high premium burdens are newly eligible for the premium tax credit under the Rescue Plan. The Congressional Budget Office (CBO) estimates these provisions will increase marketplace enrollment by 1.7 million people in 2022.<sup>2</sup>

Building on these successes to further strengthen marketplace coverage should be a top priority in recovery legislation. Permanently enhancing premium tax credits, reducing people's deductibles and other out-of-pocket costs, and extending marketplace coverage to more families whose employer-sponsored coverage is unaffordable, among other policies, would expand coverage to more people and make health care more accessible and affordable. These changes, when paired with steps to

<sup>1</sup> Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People Under Age 65: CBO and JCT's September 2020 Projections," September 29, 2020, <a href="https://www.cbo.gov/system/files/2020-10/51298-2020-09-healthinsurance.pdf">https://www.cbo.gov/system/files/2020-10/51298-2020-09-healthinsurance.pdf</a>; CBPP, "Chart Book: Accomplishments of Affordable Care Act," March 19, 2019, <a href="https://www.cbpp.org/research/health/chart-book-accomplishments-of-affordable-care-act">https://www.cbpp.org/research/health/chart-book-accomplishments-of-affordable-care-act</a>.

<sup>&</sup>lt;sup>2</sup> Congressional Budget Office, "Reconciliation Recommendations of the House Committee on Ways and Means," February 15, 2021, https://www.cbo.gov/publication/57005.

strengthen and expand Medicaid,<sup>3</sup> would help ensure that the nation's recovery improves low-paid workers' health, well-being, and economic security and help address troubling racial inequities in access to health coverage and care.<sup>4</sup>

## Permanent Premium Tax Credit Enhancements Would Make Coverage More Affordable for Millions

The American Rescue Plan's two-year premium tax credit increases are an important first step in making health insurance more affordable. They will eliminate or reduce premiums for millions of current marketplace enrollees and expand eligibility to millions more, ensuring that no marketplace enrollee spends more than 8.5 percent of their income on premiums. Some 3.6 million people will be newly eligible for financial help, which will likely not just reverse insured rate losses under the Trump Administration but restore the upward trend that ended in 2016.<sup>5</sup>

The Urban Institute estimated that if similar improvements were made permanent, which recovery legislation should do, about 4.5 million people would gain coverage. Policymakers should also enhance the Rescue Plan's credits (and make the enhancements permanent) to provide further help to low-income people.

People's savings from the credits will already be significant. Marketplace enrollees with incomes below 150 percent of the poverty line (about \$19,000 for a single person) will pay no premiums for a benchmark plan, after accounting for premium tax credits, and families with incomes between 150 and 400 percent of the poverty line (about \$51,000 for a single person) will pay a lower share of income toward premiums than they did before. For example, a family of four making \$50,000 will pay \$67 rather than \$252 per month in premiums for benchmark coverage (1.6 instead of 6.0

<sup>&</sup>lt;sup>3</sup> For more on the added financial incentives for states to expand Medicaid, see Jesse Cross-Call, "House Bill Gives States Incentive to Quickly Expand Medicaid, Cover Millions of Uninsured," CBPP, February 25, 2021, <a href="https://www.cbpp.org/research/health/house-bill-gives-states-incentive-to-quickly-expand-medicaid-cover-millions-of.">https://www.cbpp.org/research/health/house-bill-gives-states-incentive-to-quickly-expand-medicaid-cover-millions-of.</a>

<sup>&</sup>lt;sup>4</sup> Sharon Parrott *et al.*, "Building an Equitable Recovery Requires Investing in Children, Supporting Workers, and Expanding Health Coverage," CBPP, March 24, 2021, <a href="https://www.cbpp.org/research/poverty-and-inequality/building-an-equitable-recovery-requires-investing-in-children">https://www.cbpp.org/research/poverty-and-inequality/building-an-equitable-recovery-requires-investing-in-children</a>.

<sup>&</sup>lt;sup>5</sup> Department of Health and Human Services, "Fact Sheet: The American Rescue Plan: Reduces Health Care Costs, Expands Access to Insurance Coverage and Addresses Health Care Disparities," March 12, 2021, <a href="https://www.hhs.gov/about/news/2021/03/12/fact-sheet-american-rescue-plan-reduces-health-care-costs-expands-access-insurance-coverage.html">https://www.hhs.gov/about/news/2021/03/12/fact-sheet-american-rescue-plan-reduces-health-care-costs-expands-access-insurance-coverage.html</a>. Also see Tara Straw, "Lower Premiums, More Time to Enroll Will Boost Marketplace Enrollment," CBPP, April 1, 2021, <a href="https://www.cbpp.org/blog/lower-premiums-more-time-to-enroll-will-boost-marketplace-enrollment">https://www.cbpp.org/blog/health-insurance-coverage-losses-since-2016</a> Widespread; and Matt Broaddus and Aviva Aron-Dine, "Uninsured Rate Rose Again in 2019, Further Eroding Earlier Progress," CBPP, September 15, 2020, <a href="https://www.cbpp.org/research/health/uninsured-rate-rose-again-in-2019-further-eroding-earlier-progress">https://www.cbpp.org/research/health/uninsured-rate-rose-again-in-2019-further-eroding-earlier-progress</a>.

<sup>&</sup>lt;sup>6</sup> Linda J. Blumberg *et al.*, "Cost and Coverage Implications of Five Options for Increasing Marketplace Subsidy Generosity," Urban Institute, February 2021, <a href="https://www.urban.org/sites/default/files/publication/103604/cost-and-coverage-implications-of-five-options-for-increasing-marketplace-subsidy-generosity.pdf">https://www.urban.org/sites/default/files/publication/103604/cost-and-coverage-implications-of-five-options-for-increasing-marketplace-subsidy-generosity.pdf</a>.

percent of their income) — an annual savings of \$2,220.7 Four out of five enrollees can get a plan for \$10 or less per month.

People with income above 400 percent of the poverty line are newly eligible for assistance and, like other marketplace enrollees, will pay no more than 8.5 percent of their income toward premiums. This is especially important to middle-income people, older people, and people who live in areas with high premiums, who bear the highest premium burdens. For example, marketplace benchmark coverage for a 50-year-old in Charleston, West Virginia earning \$55,000 a year (431 percent of the poverty line) costs about \$1,021 per month, about 22 percent of income and more than 1.5 times the national average premium. Under the Rescue Plan this person will get a monthly premium discount of \$632, bringing their premium down to \$390 per month. The premium tax credit enhancement will automatically phase out in lower-cost areas and at higher income levels because premiums are generally less than 8.5 percent of income.

About 8.9 million uninsured people were likely eligible for a premium tax credit under prior law, the Kaiser Family Foundation estimates. More than half of uninsured people eligible for credits are people of color, including 31 percent who are Latino and 15 percent who are Black.<sup>10</sup> About 16.8 percent of people with incomes between 138 and 250 percent of the poverty line are uninsured, compared to 3.7 percent for people with incomes above 500 percent of the poverty line.<sup>11</sup>

Data suggest that low- and moderate-income people still face the greatest challenges affording coverage and care. <sup>12</sup> Making permanent improvements to the premium tax credits would appreciably reduce uninsured rates and improve access to care. <sup>13</sup> And to better help the lowest-income people,

<sup>&</sup>lt;sup>7</sup> CBPP calculations. Examples assume consumers face the national average marketplace benchmark premium. The family of four is composed of two 40-year-old parents, a 5-year-old, and a 10-year-old. The benchmark plan is the second-lowest-cost silver-tier plan offered where the consumer lives.

<sup>&</sup>lt;sup>8</sup> Aviva Aron-Dine, "Making Health Insurance More Affordable for Middle-Income Individual Market Consumers," CBPP, March 21, 2019, <a href="https://www.cbpp.org/research/health/making-health-i.nsurance-more-affordable-for-middle-income-individual-market">https://www.cbpp.org/research/health/making-health-i.nsurance-more-affordable-for-middle-income-individual-market</a>.

<sup>&</sup>lt;sup>9</sup> Kaiser Family Foundation, "2021 Calculator – Before COVID-19 Relief," March 10, 2021, <a href="https://www.kff.org/interactive/subsidy-calculator-2021-before-covid-relief/">https://www.kff.org/interactive/subsidy-calculator-2021-before-covid-relief/</a>, and "Health Insurance Marketplace Calculator," March 10, 2021, <a href="https://www.kff.org/interactive/subsidy-calculator/">https://www.kff.org/interactive/subsidy-calculator/</a>.

<sup>&</sup>lt;sup>10</sup> Daniel McDermott *et al.*, "Marketplace Eligibility Among the Uninsured: Implications for a Broadened Enrollment Period and ACA Outreach," Kaiser Family Foundation, January 27, 2021. <a href="https://www.kff.org/report-section/marketplace-eligibility-among-the-uninsured-implications-for-a-broadened-enrollment-period-and-aca-outreach-appendix-tables/">https://www.kff.org/report-section/marketplace-eligibility-among-the-uninsured-implications-for-a-broadened-enrollment-period-and-aca-outreach-appendix-tables/</a>. This analysis does not include individuals who are over the age of 65, who are eligible for Medicaid, who have incomes below poverty, or whose immigration status makes them ineligible for marketplace coverage.

<sup>&</sup>lt;sup>11</sup> CBPP analysis of Census 2019 American Community Survey data. See also Aviva Aron-Dine and Matt Broaddus, "Improving ACA Subsidies for Low- and Moderate-Income Consumers Is Key to Increasing Coverage," CBPP, March 21, 2019, <a href="https://www.cbpp.org/research/health/improving-aca-subsidies-for-low-and-moderate-income-consumers-is-key-to-increasing">https://www.cbpp.org/research/health/improving-aca-subsidies-for-low-and-moderate-income-consumers-is-key-to-increasing</a>.

<sup>&</sup>lt;sup>12</sup> Ibid.

<sup>&</sup>lt;sup>13</sup> Sara R. Collins, Munira Z. Gunja, and Michelle M. Doty, "Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage?" Commonwealth Fund, September 2017,

Congress could augment the Rescue Plan's improvements by raising the income threshold at which people qualify for zero-premium benchmark plans from 150 percent to 200 percent of the poverty line (roughly \$25,500 for a single person).

### Reducing Out-of-Pocket Costs Would Help People Access Care

Premiums are only one part of making health coverage affordable. Health plans also come with out-of-pocket costs in the form of deductibles, <sup>14</sup> copayments, and coinsurance that people must pay when they get care. <sup>15</sup> If these cost-sharing amounts are high, they can deter people from enrolling in a plan, even if premium help is significant. For people who do enroll, especially those with low incomes, high charges can lead them to delay or avoid getting care they need or can increase financial problems as medical bills go unpaid. <sup>16</sup> And research on cancer survivors suggests that high deductibles may magnify racial disparities in access to health care. While high deductibles are generally linked to cost-related problems for all patients, in one study Black patients in high-deductible plans experienced more barriers to care (such as delaying filling a prescription to save money or being unable to see a specialist because of cost) than their white counterparts. <sup>17</sup>

Under the ACA, people with incomes between the poverty line and 250 percent of the poverty line (about \$13,000 to \$32,000 for an individual and \$26,000 to \$66,000 for a family of four) are eligible for reduced deductibles and other cost sharing if they enroll in a silver marketplace plan. <sup>18</sup> These individuals enroll in a silver plan with reduced out-of-pocket costs compared to the standard silver plan. The law also caps the total cost-sharing charges that people can be required to pay under their plans each year, an amount that also decreases to provide greater financial protection to people with lower incomes.

https://www.commonwealthfund.org/sites/default/files/documents/ media files publications issue brief 2017 s ep collins 2017 aca tracking survey ib v2.pdf.

<sup>&</sup>lt;sup>14</sup> Deductibles are an annual amount that the enrollee must pay before the insurance plan begins to cover many or all covered items and services (e.g., a \$2,000 deductible means that enrollee must pay that amount before the plan would begin paying for a portion of a hospital stay). Many plans cover lower-cost items, such as a certain number of physician visits or generic prescriptions, before the enrollee has paid the deductible, and the ACA requires certain preventive services to be covered at no cost to enrollees.

<sup>&</sup>lt;sup>15</sup> Copayments are flat dollar amounts that plans charge enrollees for an item or service (e.g., \$30 for a doctor visit). Coinsurance charges are a percentage of the cost (e.g., 30 percent of the cost of a prescription drug).

<sup>&</sup>lt;sup>16</sup> Sara R. Collins *et al.*, "U.S. Health Coverage in 2020: A Looming Crisis in Affordability," Commonwealth Fund, August, 19, 2020, <a href="https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial">https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial</a>.

<sup>&</sup>lt;sup>17</sup> Megan B. Cole *et al.*, "Association Between High-Deductible Health Plans and Disparities in Access to Care Among Cancer Survivors," JAMA Network, June 24, 2020, <a href="https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2767589">https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2767589</a>

<sup>&</sup>lt;sup>18</sup> As noted, the ACA establishes metal tiers — bronze, silver, gold, and platinum — to organize plans for consumers and set standards for what deductibles and other charges insurers can include. See CBPP, "Cost-Sharing Charges in Marketplace Plans, Answers to Frequently Asked Questions," updated August 2020, <a href="http://www.healthreformbeyondthebasics.org/cost-sharing-charges-in-marketplace-health-insurance-plans-answers-to-frequently-asked-questions/">http://www.healthreformbeyondthebasics.org/cost-sharing-charges-in-marketplace-health-insurance-plans-answers-to-frequently-asked-questions/</a>.

Cost-sharing assistance is delivered by means of the actuarial value (or AV, which measures the share of costs a plan covers) for silver plans available to people at various income levels. When people eligible for assistance enroll in a silver plan, they automatically receive a version with a higher AV than the standard silver value of 70 percent; depending on a person's income, current law provides silver plans that have AVs of 73 percent, 87 percent, or 94 percent. This significantly reduces deductibles and other cost-sharing charges for millions of people.

But the cost-sharing assistance phases down significantly starting at 200 percent of the poverty line, down to nothing for those at incomes higher than 250 percent. The resulting costs are especially significant for people with incomes between 200 to 300 percent of the poverty line. For example, a person with income of \$26,000 a year (around 200 percent of the poverty line) would be eligible for a silver plan with an enhanced AV of 73 percent. But the average deductible for these plans in 2021 is about \$3,400, or 13 percent of the person's income. Even with a premium tax credit boost that allows them to get a plan for a zero-dollar premium, it would be challenging, and perhaps impossible, for them to pay the out-of-pocket costs associated with a hospital stay or ongoing treatment for a chronic condition.

The recovery package should expand cost-sharing help to more people and reduce out-of-pocket costs for those who are already eligible, along the lines that Senator Jeanne Shaheen of New Hampshire proposed in 2019.<sup>21</sup> Legislation should raise the actuarial values of silver plans for everyone from the poverty line to four times the poverty line. Under this approach, people with incomes at 200 percent of poverty would be able to get the equivalent of a platinum plan with an average deductible in the range of \$0 to \$200. And someone at 300 percent of the poverty line would see plan deductibles drop several thousand dollars a year, from about \$5,000 on average to about \$1,000.<sup>22</sup> When combined with the proposed improvements in premium tax credits described above, everyone with incomes up to 400 percent of poverty could buy a marketplace plan that is at least the equivalent of a gold plan (with an 80 percent AV) for no more than 8.5 percent of their income.

Another way to reduce the burden of out-of-pocket costs, proposed in other legislation and in the plan President Biden released during his campaign, would be to benchmark premium credits to a gold plan instead of the current silver plan. But boosting the silver plan AVs can achieve a similar

<sup>&</sup>lt;sup>19</sup> AVs are a way to compare the generosity of different insurance plans. For example, silver plans, with a 70 percent AV, would be expected to pay 70 percent of the covered medical costs for a typical population, while gold plans, with an 80 percent AV, would cover 80 percent of covered costs of the typical population. Under the ACA, the premium tax credits are calculated based on the cost of the second-lowest-cost silver plan available where a person lives.

<sup>&</sup>lt;sup>20</sup> Kaiser Family Foundation, "Cost-Sharing for Plans Offered in the Federal Marketplace, 2014-2021," January 15, 2021, <a href="https://www.kff.org/slideshow/cost-sharing-for-plans-offered-in-the-federal-marketplace/">https://www.kff.org/slideshow/cost-sharing-for-plans-offered-in-the-federal-marketplace/</a>.

<sup>&</sup>lt;sup>21</sup> Marketplace Certainty Act, S. 964, as introduced April 1, 2019, <a href="https://www.congress.gov/bill/116th-congress/senate-bill/964/text?format=txt">https://www.congress.gov/bill/116th-congress/senate-bill/964/text?format=txt</a>.

<sup>&</sup>lt;sup>22</sup> Deductibles and other cost-sharing charges can vary widely even among plans with the same AV. Under current law, the average deductible for a silver plan (70 percent AV) is near \$5,000 in 2021. A new AV of 85 percent for people at 300 percent of poverty would result in average deductibles of about \$1,000; the average 2021 deductible for plans with a slightly higher AV of 87 percent was \$800. See Kaiser Family Foundation, "Cost-Sharing for Plans Offered in the Federal Marketplace, 2014-2021," op. cit.

result for enrollees — making plans with at least a gold AV available to everyone with income up to four times the poverty level — while also providing more help to those in need.<sup>23</sup>

## **Employer Coverage Improvements Would Help Low-Income Workers and Their Families**

While employer coverage often works reasonably well for middle- and upper-middle-income employees, lower-income workers are frequently offered less robust coverage and required to pay a larger share of premiums out of pocket.24 Among people in families with job-based coverage, those with incomes below 200 percent of poverty spend an average of 14.0 percent of their income on premiums and out-of-pocket costs, compared to 7.9 percent for people with incomes between 200 and 400 percent of poverty, and 4.5 percent for people at or above 400 percent of poverty.25

Meanwhile, approximately 6 million workers and family members with incomes below 400 percent of poverty are uninsured but "firewalled" from accessing subsidized marketplace coverage because they have an offer of employer coverage.26 The ACA firewall prevents people from receiving premium tax credits if anyone in their family has an employer offer of coverage for which the employee-only premium is less than 9.83 percent of family income and for which the actuarial value is at least 60 percent (equivalent to a marketplace bronze plan), even when a premium tax credit would provide lower premiums — sometimes as low as zero — for a plan with a higher actuarial value.

Short of fully repealing the firewall, policymakers could make several modifications to expand coverage and significantly improve affordability for lower-income workers.

### Fix the "Family Glitch"

Policymakers could fix the "family glitch" by determining the affordability of employer-sponsored coverage using the family premium rather than the premium for employee-only coverage. This would allow an employee's family members to access a premium tax credit when family coverage is unaffordable, even if the employee's self-only premium is affordable.<sup>27</sup>

<sup>&</sup>lt;sup>23</sup> If, as recommended, premium tax credits are made permanently available to people at higher income levels (over 400 percent of poverty) who have high premium burdens, then benchmarking the credits to gold instead of silver plans would have the unintended consequence of further boosting assistance to this group.

<sup>&</sup>lt;sup>24</sup> Tara Straw, "Trapped by the Firewall: Policy Changes Are Needed to Improve Health Coverage for Low-Income Workers," CBPP, December 3, 2019, <a href="https://www.cbpp.org/research/health/trapped-by-the-firewall-policy-changes-are-needed-to-improve-health-coverage-for.">https://www.cbpp.org/research/health/trapped-by-the-firewall-policy-changes-are-needed-to-improve-health-coverage-for.</a>

<sup>&</sup>lt;sup>25</sup> Gary Claxton, Bradley Sawyer, and Cynthia Cox, "How Affordability of Health Care Varies by Income Among People With Employer Coverage," Kaiser Family Foundation, April 14, 2019, <a href="https://www.healthsystemtracker.org/brief/how-affordability-of-health-care-varies-by-income-among-people-with-employer-coverage/#item-start">https://www.healthsystemtracker.org/brief/how-affordability-of-health-care-varies-by-income-among-people-with-employer-coverage/#item-start</a>.

<sup>&</sup>lt;sup>26</sup> Matthew Buettgens, Lisa Dubay, and Genevieve M. Kenney, "Marketplace Subsidies: Changing the 'Family Glitch' Reduces Family Health Spending But Increases Government Costs," *Health Affairs*, July 2016, <a href="https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1491">https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1491</a>.

<sup>&</sup>lt;sup>27</sup> A better approach would be to make the employee as well as family members eligible for marketplace coverage if the cost of family coverage exceeds the affordability percentage. Otherwise, the family would have to pay both the employer premium for single coverage and the marketplace premium for other family members, and so the total cost could still exceed the affordability standard. However, this approach could add significantly to cost.

An estimated 5.1 million people, about half of them children, would become eligible for a tax credit under this proposal, according to a Kaiser Family Foundation analysis. <sup>28</sup> A plurality of people gaining eligibility would be those with incomes between 250 and 400 percent of the poverty line.

People with incomes under 138 percent of the poverty line would experience the biggest premium reductions, with the average family premium falling from 20 percent of income in employer-sponsored coverage to 5.5 percent in the marketplace, according to an Urban Institute analysis.<sup>29</sup> People with incomes between 138 and 200 percent of the poverty line would see their premiums cut in half, from 17.6 percent to 8.2 percent of their income. A separate analysis concurred that fixing the family glitch would reduce families' average total health care spending by thousands of dollars and drop their risk of spending at least 20 percent of income on health care by more than two-thirds.<sup>30</sup>

Apart from a legislative solution, the Biden Administration could address the family glitch under its statutory authority to correct the Obama Administration's interpretation that created this gap. While the statute is clear that the employee is barred if they have an offer of affordable employer coverage, the same isn't necessarily true of family members. The Obama Administration's Treasury Department interpreted 26 U.S.C. 5000A to determine the employee's "required contribution" for coverage in one way for the firewall (measuring the affordability of family coverage by the cost of individual coverage) but in a different way for determining whether an individual responsibility payment was owed (measuring the affordability of family coverage by the cost of family coverage). The latter interpretation is more reasonable and could be adopted without a statutory change.

### Lower the Employer Coverage Affordability Threshold

As explained above, employer-sponsored coverage is considered unaffordable if the employee's share of the premium for the lowest-cost plan exceeds roughly 10 percent of household income (9.83 percent in 2021). Reducing this threshold to correspond with the 8.5 percent of income premium cap could prod more employers to make the coverage they offer more affordable, especially given the penalties certain employers would otherwise face, as we explain below. For employers that don't meet the new standard, their workers would be free to seek subsidized marketplace plans. Lowering the affordability threshold would primarily benefit low-income workers, who are more likely to have high premiums relative to income and would be eligible for the most substantial assistance if no longer firewalled.

<sup>&</sup>lt;sup>28</sup> Cynthia Cox *et al.*, "The ACA Family Glitch and Affordability of Employer Coverage," Kaiser Family Foundation, April 7, 2021, <a href="https://www.kff.org/health-reform/issue-brief/the-aca-family-glitch-and-affordability-of-employer-coverage">https://www.kff.org/health-reform/issue-brief/the-aca-family-glitch-and-affordability-of-employer-coverage</a>.

<sup>&</sup>lt;sup>29</sup> Buettgens, Dubay, and Kenney, *op. cit.* Adults with incomes below 138 percent of poverty are eligible for Medicaid in states that expanded Medicaid under the ACA; a person with an offer of employer-sponsored coverage is not barred from Medicaid eligibility. The percentage of income includes the cost of employer-sponsored coverage, after accounting for the tax exclusion, plus the percentage of income the rest of the family would contribute toward marketplace coverage. The percentage of income an enrollee would pay for marketplace premiums is based on calculations under prior law, before enactment of the American Rescue Plan. The difference between enrollee premiums for employer-sponsored coverage compared to those in the marketplace is larger with the Rescue Plan's premium tax credit enhancements.

<sup>&</sup>lt;sup>30</sup> Sarah A. Nowak, Evan Saltzman, and Amado Cordova, "Alternatives to the ACA's Affordability Firewall," RAND Corporation, 2015, <a href="https://www.rand.org/pubs/research\_reports/RR1296.html">https://www.rand.org/pubs/research\_reports/RR1296.html</a>.

Lowering the affordability standard could also increase employer penalty collections and help finance the shift of workers to marketplace coverage with premium tax credits. Currently, a penalty for each full-time worker is triggered if a firm doesn't offer coverage and any employee gets a premium tax credit in the marketplace. If the firm offers coverage but the employee-only premium is unaffordable or the plan doesn't meet a standard known as minimum value, the penalty applies to each full-time worker who receives a credit.

Congress could also de-link the affordability standard for employees' premium tax credit eligibility from the affordability standard for the employer penalty. Under such a policy, failing to offer coverage or offering subpar coverage would trigger the penalty, irrespective of workers' enrollment in marketplace coverage with premium tax credits. This would allow more workers (particularly those with low incomes) to enroll in subsidized marketplace plans without necessarily penalizing more employers.

### Raise the Minimum Value Standard

Another way to improve health care affordability for people with offers of job-based coverage would be to increase the share of anticipated health costs that the plan pays for. A large-employer or self-insured group plan currently meets the minimum value standard if it covers at least 60 percent of the plan's total allowed benefit cost. By contrast, the marketplace benchmark plan covers 70 percent of expected costs, and as noted, people with incomes below 250 percent of the poverty line are eligible for cost-sharing assistance that further lowers consumers' costs by increasing plans' actuarial values.

One option would be to raise the minimum value standard from 60 percent to 70 percent to align with the marketplace benchmark. Raising the minimum value standard wouldn't affect most employers since the average employer plan has an actuarial value of 85 percent.<sup>31</sup> While it could lead some employers to pass on premium increases to employees, the affordability standard would also constrain these increases. Other employers offering low-value plans may drop coverage altogether but, to the extent that employees are eligible for premium tax credits, this might give more workers and their families access to more affordable and comprehensive coverage in the marketplace.

### Other Provisions Would Further Access to Affordable, High-Quality Coverage

Policymakers could implement several other policies to insure more people with comprehensive coverage and, in some cases, reduce costs.

### **Broaden Enrollment Periods for Marketplace Plans**

Marketplace enrollment consistently falls during a typical year. If the system were working well, it would be roughly stable, as the number of people enrolling in plans during the year (because they lose job-based benefits or Medicaid, for example) would roughly match the number who leave

<sup>&</sup>lt;sup>31</sup> Actuarial Research Corporation, "Final Report: Analysis of Actuarial Values and Plan Funding Using Plans from the National Compensation Survey," compiled for Office of Policy Research, Employee Benefits Security Administration, Department of Labor, May 12, 2017, <a href="https://www.dol.gov/sites/default/files/ebsa/researchers/analysis/health-and-welfare/analysis-of-actuarial-values-and-plan-funding-using-plans-from-the-national-compensation-survey.pdf">https://www.dol.gov/sites/default/files/ebsa/researchers/analysis/health-and-welfare/analysis-of-actuarial-values-and-plan-funding-using-plans-from-the-national-compensation-survey.pdf</a>.

(because they become eligible for Medicaid or get a job with health coverage). But the system is not working well.

Many people who are eligible for "special enrollment periods" (SEPs) to enroll during the year aren't using them, possibly because they aren't aware of them or because the system is too confusing. <sup>32</sup> (A person needs an SEP to enroll in a plan after the annual open enrollment period for marketplaces has closed; SEPs are triggered by certain situations, such as losing other coverage and having a baby, but often are not available to people who have been uninsured or had gaps in coverage. <sup>33</sup>) The yearly decline in marketplace enrollment appears to be driving a troubling seasonal increase in those who are uninsured. The number of adults without coverage rose by more than 1 million between the first and fourth quarter of each year from 2016 through 2019, then fell by more than 1 million in the first quarter of the subsequent year (after marketplace open enrollment), National Health Interview Survey data show.

Enrollment periods should be expanded and simplified nationwide. The Biden Administration has temporarily opened HealthCare.gov to enrollment, in response to the COVID-19 public health emergency, and many states that run their own marketplaces have taken similar steps.<sup>34</sup> But beyond August 15, the current deadline for the emergency enrollment period, permanent changes will be needed to ensure that marketplace enrollment policies strike a better balance between the goals of expanding coverage and limiting adverse selection (which occurs when healthy people opt not to enroll, leaving a less healthy and higher-cost population in the insurance pool).

While the Administration has broad authority to modify marketplace enrollment rules, for example to lengthen the yearly enrollment period and add new events that trigger an SEP, Congress could include legislative provisions to set this process in motion. For example, legislation could guarantee people who are eligible for significant financial assistance the ability to enroll in a marketplace plan year-round. This would help more people access the improved financial assistance recommended above. In Massachusetts, a similar policy gives broad access to people who have incomes up to 300 percent of the poverty level; enrollment in the state's marketplace is stable over the course of the year. Massachusetts also consistently has among the lowest marketplace premiums in the country, showing that more open enrollment policies can be compatible with maintaining a broad risk pool. Any changes to enrollment rules (or to financial assistance) should be

<sup>&</sup>lt;sup>32</sup> Matthew Buettgens, Stan Dorn, and Hannah Recht, "More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods," Urban Institute, November 2015, <a href="https://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf">https://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf</a>.

<sup>&</sup>lt;sup>33</sup> CBPP, "Special Enrollment Period Reference Chart," updated October 2020, http://www.healthreformbeyondthebasics.org/wp-content/uploads/2020/10/REFERENCE-CHART\_Special-Enrollment-Periods-10.20.pdf.

<sup>&</sup>lt;sup>34</sup> "HHS Announces Marketplace Special Enrollment Period for Covid-19 Public Health Emergency," Department of Health and Human Services press release, January 28, 2021, <a href="https://www.hhs.gov/about/news/2021/01/28/hhs-announces-marketplace-special-enrollment-period-for-covid-19-public-health-emergency.html">https://www.hhs.gov/about/news/2021/01/28/hhs-announces-marketplace-special-enrollment-period-for-covid-19-public-health-emergency.html</a>.

<sup>&</sup>lt;sup>35</sup> Sarah Lueck, "Proposed Change to ACA Enrollment Policies Would Boost Insured Rate, Improve Continuity of Coverage," CBPP, June 5, 2019, <a href="https://www.cbpp.org/research/health/proposed-change-to-aca-enrollment-policies-would-boost-insured-rate-improve">https://www.cbpp.org/research/health/proposed-change-to-aca-enrollment-policies-would-boost-insured-rate-improve</a>.

accompanied by a robust public outreach and enrollment assistance effort, to ensure that eligible people are aware of what's available and how to sign up.

### Help States Improve Affordability and Access through the Basic Health Program

The ACA established the Basic Health Program (BHP), an optional program available to states to provide more affordable coverage to people with low incomes who are otherwise eligible to purchase subsidized marketplace coverage. States adopting a BHP can use it to cover those with incomes between 138 and 200 percent of poverty, as well as lawfully present immigrants who have an immigration status that doesn't qualify them for Medicaid. The federal government pays the state 95 percent of the amount of premium tax credits and cost-sharing reductions that would have otherwise been provided to eligible individuals to purchase marketplace coverage, and the state is required to provide coverage at least as generous as that provided through the marketplace.

Minnesota and New York — the two states that took up the BHP option — are able to provide coverage with lower premiums and cost sharing, and with fewer access barriers, than otherwise available marketplace coverage.<sup>36</sup> The more generous coverage costs the states less because they use plan procurement processes that result in provider payment rates that fall in between commercial coverage and Medicaid. Both Minnesota and New York have exceptionally low uninsured rates, with their BHPs likely a contributing factor.

To create a new pathway for states to make major coverage expansions and improvements, a recovery package should:

- Allow states to open BHP coverage to people at higher income levels, rather than restricting it
  to people with incomes below 200 percent of poverty. States should continue to receive
  federal funding equal to 95 percent of premium tax credits and cost-sharing assistance
  amounts for people otherwise eligible for subsidized marketplace coverage.
- Broaden options for the delivery of care model, to make BHP more feasible for states that have limited or no use of managed care in Medicaid. For example, statutory language could be added to allow for other models that also promote coordinated care, such as integrated care models like those Minnesota uses (e.g., Hennepin Health), or the use of an administrative service organization, which Connecticut uses in its Medicaid program.
- Provide upfront funding for BHP implementation. The statute prohibits states from using BHP trust funds to finance administrative costs; they can only use them to lower cost-sharing charges or provide additional benefits.

### **Public Option**

Private health insurance plans spend more per enrollee than Medicare or Medicaid does, largely due to higher provider payment rates, and the difference is growing.<sup>37</sup> One approach to bringing

<sup>&</sup>lt;sup>36</sup> Jennifer Tolbert, Larisa Antonisse, and Stan Dorn, "Improving the Affordability of Coverage through the Basic Health Program in Minnesota and New York," Kaiser Family Foundation, <a href="https://www.kff.org/health-reform/issue-brief/improving-the-affordability-of-coverage-through-the-basic-health-program-in-minnesota-and-new-york/">https://www.kff.org/health-reform/issue-brief/improving-the-affordability-of-coverage-through-the-basic-health-program-in-minnesota-and-new-york/</a>.

<sup>&</sup>lt;sup>37</sup> Karyn Schwartz *et al.*, "Limiting Private Insurance Reimbursement to Medicare Rates Would Reduce Health Spending by About \$350 Billion in 2021," Kaiser Family Foundation, March 1, 2021, <a href="https://www.kff.org/report-">https://www.kff.org/report-</a>

down provider rates would be to create a public plan that pays providers rates based on Medicare's, whether equal to Medicare's or to some specified multiple of Medicare rates.

Not only would the public plan itself pay much lower prices for hospital and specialty physician services than commercial plans currently do, it would also increase private insurers' bargaining power with providers. If the provider and the plan did not reach agreement on a price allowing the plan to set premiums competitive with the public option's, the private plan's customers would leave for the public option, and the provider would be stuck with the public option rates. Thus, the public option would exert downward pressure on commercial payment rates as well.<sup>38</sup>

The public plan would also directly compete with insurers, likely forcing them to reduce the profit margin built into premiums in areas of the country with limited insurance market competition. The Urban Institute estimates that a public plan paying Medicare rates that was offered only in the ACA marketplaces could save over \$150 billion over ten years.<sup>39</sup> (It would also significantly reduce the cost of the premium tax credit improvement package above.)

Introducing a public plan could increase coverage, but the impact would be very small unless the affordability and access improvements discussed above were adopted as well. For example, just introducing a public plan in the marketplaces, without other changes, would increase the number of people with health coverage by only about 200,000, according to Urban's estimates. That's because it would lower prices only for the relatively small number of uninsured people not eligible for premium tax credits.

### **Close Subpar Plan Loopholes**

Subpar plans proliferated in recent years amid the Trump Administration's rule changes and anti-ACA rhetoric, as well as aggressive marketing to the public. These plans are not required to meet ACA standards or abide by the ACA's pre-existing condition protections. They expose people to health and financial risks the ACA aimed to address. For example, patients experiencing lymphoma, a heart attack, or a hospitalization for mental health care would face tens of thousands of dollars in out-of-pocket costs if they had a so-called short-term plan rather than an ACA plan. <sup>40</sup> Subpar plans

section/limiting-private-insurance-reimbursement-to-medicare-rates-would-reduce-health-spending-by-about-350-billion-in-2021-issue-brief/. See also Eric Lopez et al., "How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature," Kaiser Family Foundation, April 15, 2020, <a href="https://www.kff.org/report-section/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature-issue-brief/">https://www.kff.org/report-section/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature-issue-brief/</a> and Rabah Kamal, "How has U.S. spending on healthcare changed over time?" Kaiser Family Foundation, December 23, 2020, <a href="https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-usspendingovertime">https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#item-usspendingovertime</a> 10.

<sup>&</sup>lt;sup>38</sup> Matthew Fiedler, "Capping prices or creating a public option: How would they change what we pay for health care?" Brookings Institution, November 19, 2020, <a href="https://www.brookings.edu/research/capping-prices-or-creating-a-public-option-how-would-they-change-what-we-pay-for-health-care/">https://www.brookings.edu/research/capping-prices-or-creating-a-public-option-how-would-they-change-what-we-pay-for-health-care/</a>.

<sup>&</sup>lt;sup>39</sup> Linda J. Blumberg, "Estimating the Impact of a Public Option or Capping Provider Payment Rates," Urban Institute, March 2020, <a href="https://www.urban.org/sites/default/files/2020/03/23/estimating-the-impact-of-a-public-option-or-capping-provider-payment-rates.pdf">https://www.urban.org/sites/default/files/2020/03/23/estimating-the-impact-of-a-public-option-or-capping-provider-payment-rates.pdf</a>.

<sup>&</sup>lt;sup>40</sup> Dane Hansen and Gabriela Dieguez, "The impact of short-term limited-duration policy expansion on patients and the ACA individual market," Milliman Research Report, February 2020, https://www.lls.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf.

also increase premiums for comprehensive coverage because they pull healthier people out of the ACA risk pool, leaving a costlier group of people behind. This increases affordability problems for people who are not eligible for ACA subsidies, especially those with pre-existing health conditions. And intense, sometimes deceptive marketing of subpar plans leads people to think they have decent coverage and then find out, when they get sick, that they don't. 41

Congress should act to comprehensively address subpar plans. Rule changes could redefine short-term plans as those lasting up to three months instead of a year or longer (as under Trump-era changes) and strengthen standards for other forms of subpar coverage. <sup>42</sup> It's especially hard to see the purpose of low-quality products that undermine ACA protections for people with pre-existing conditions if financial assistance is expanded and improved so that people can enroll in affordable, comprehensive health coverage through the marketplaces.

<sup>&</sup>lt;sup>41</sup> Government Accountability Office, "Private Health Coverage: Results of Covert Testing for Selected Offerings," August 24, 2020, <a href="https://www.gao.gov/assets/710/708967.pdf">https://www.gao.gov/assets/710/708967.pdf</a>; and Michelle Andrews, "Think your health care costs are covered? Beware the 'junk' insurance plan," National Public Radio, December 12, 2020, <a href="https://www.npr.org/sections/health-shots/2020/12/03/941620737/think-your-health-care-costs-are-covered-beware-the-junk-insurance-plan">https://www.npr.org/sections/health-shots/2020/12/03/941620737/think-your-health-care-costs-are-covered-beware-the-junk-insurance-plan</a>.

<sup>&</sup>lt;sup>42</sup> Christen Linke Young, "Taking a Broader Look at Junk Insurance," Brookings Institution, July 6, 2020, <a href="https://www.brookings.edu/research/taking-a-broader-view-of-junk-insurance/">https://www.brookings.edu/research/taking-a-broader-view-of-junk-insurance/</a>.

### The ACA Family Glitch and Affordability of Employer Coverage

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#### **ISSUE BRIEF**

Financial assistance to buy health insurance on the Affordable Care Act (ACA) Marketplaces is primarily available for people who cannot get coverage through a public program or their employer. Some exceptions are made, however, including for people whose employer coverage offer is deemed unaffordable or of insufficient value. For example, people can qualify for ACA Marketplace subsidies if their employer requires them to spend more than 9.83% of his household income on the company's health plan premium.

Currently, this affordability threshold of household income is based on the cost of the employee's self-only coverage, not the premium required to cover any dependents. In other words, an employee whose contribution for self-only coverage is less than 9.83% of household income is deemed to have an affordable offer, which means that the employee and his or her family members are ineligible for financial assistance on the Marketplace, even if the cost of adding dependents to the employer-sponsored plan would far exceed 9.83% of the family's income. This definition of "affordable" employer coverage has come to be known as the "family (http://kff.org/health-costs/perspective/measuring-the-affordability-of-employer-health-coverage/) glitch (https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/my-employer-offers-health-benefits-to-me-and-my-family-the-company-pays-the-entire-cost-of-my-coverage-but-contributes-nothing-toward-the-cost-of-covering-my-family-we-cant-afford-to-enroll/)."

While the Obama administration interpreted the ACA as excluding these dependents from subsidy eligibility, <a href="mailto:some">some</a> (<a href="https://www.healthaffairs.org/do/10.1377/hpb20141110.62257/full/">https://www.healthaffairs.org/do/10.1377/hpb20141110.62257/full/</a>) suggested that the IRS interpretation was narrow and that the family glitch can be addressed through administrative action. President <a href="mailto:Biden's">Biden's</a> (<a href="https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-care-act/">https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-care-act/</a>) health care executive order called for federal agencies to review whether administrative policies could improve the affordability of dependent coverage, hinting at a potential administrative fix to the family glitch.

In this brief, we estimate that 5.1 million people fall into the family glitch. A majority of them are children, and among adults, women are more likely to fall into the glitch than men. We explore demographic characteristics of people who fall into the family glitch, present state-level estimates, and discuss how many people may benefit from policies aimed at addressing the family glitch. While estimates of the cost of eliminating the family glitch are beyond the scope of this analysis, the Congressional Budget Office (CBO) has previously projected it would cost the federal government \$45 billion over 10 years. Our estimate includes people with incomes above 400% of poverty, who are temporarily eligible for Marketplace financial assistance under the <u>American Rescue Plan Act (https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums/)</u> of 2021 (ARPA) passed in March 2021.

### Who falls into the family glitch?

Using 2019 data from the Current Population Survey (CPS), we estimate how many people are affected by the family glitch across three groups: dependents with employer coverage, those with individual market coverage, and those without health insurance. In all three groups, we exclude people who are eligible for a public program (Medicare, Medicaid, the Children's Health Insurance Program, or Basic Health Program). Dependents were considered as falling in the family glitch if a worker in the family had an employer offer of affordable self-only coverage but unaffordable family coverage. More details are available in the Methods section.

One limitation of this analysis is the use of 2019 survey data, which – although it is the most recent year of data available – may not accurately represent current household circumstances during the pandemic and resulting economic downturn. In an earlier analysis, we estimated that, on net, about 2-3 million people lost employer-sponsored <a href="COVETAGE">COVETAGE</a> (https://www.kff.org/policy-watch/how-has-the-pandemic-affected-health-coverage-in-the-u-s/) between March and September of 2020. Others may have lost their own employer coverage but transitioned onto a family member's employer plan. It is therefore difficult to know whether or how pandemic-related coverage changes have affected the current number of people falling into the family glitch as more recent data are not yet available.

In total, we find more than 5.1 million people fall in the ACA family glitch. The vast majority of those who fall in the glitch, 4.4 million people (85%), are currently enrolled through employer-sponsored health insurance. These families are likely spending far more for health insurance coverage than individuals with similar incomes eligible for financial assistance on the ACA Marketplaces and could spend less on premiums if they could enroll in Marketplace plans and qualify for subsidies. One study estimated that those who fall into the family glitch are spending on average 15.8% of their incomes (https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1491) on employer-based coverage.

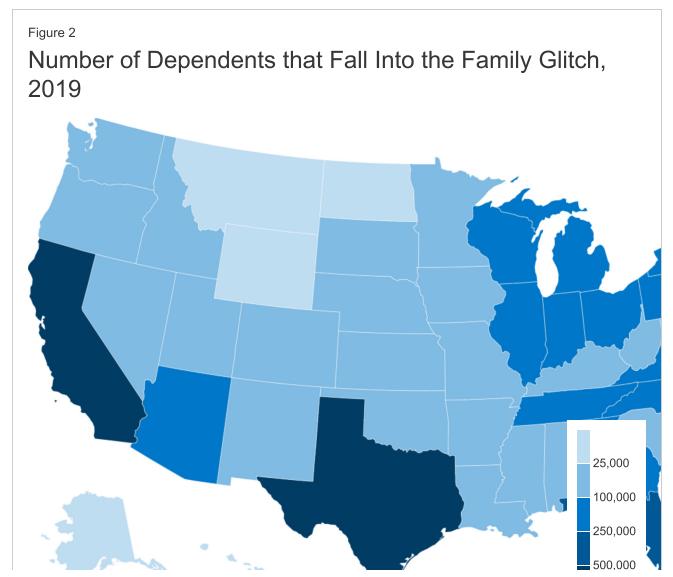
Demographics of Dependents that Fall Into the Family Glitch

Category		Number	— Share —	
Overall		5,141,000	100%	
Insurance Coverage	Dependent on ESI Policy	4,375,000	85%	
	Direct Purhcase	315,000	6%	
	Uninsured	451,000	9%	
Income	100% - 150% FPL	581,000	11%	
	150% - 200%	914,000	18%	
	200% - 250%	852,000	17%	
	250% - 400%	1,679,000	33%	
	400% - 600%	824,000	16%	
	Over 600%	292,000	6%	
Sex	Male	2,393,000	47%	
	Female	2,748,000	53%	
Age	0 - 18	2,761,000	54%	
	18+	2,380,000	46%	

Of the remaining people who fall into the family glitch, 315,000 people (6% of those falling in the family glitch) are currently buying unsubsidized individual market coverage and 451,000 people (9%) do not have any health insurance.

More than half of those who fall in the ACA family glitch (about 2.8 million people) are children under the age of 18. These are children who do not qualify for the Children's Health Insurance Program (CHIP). About 0.5 million people in the family glitch are ages 18-26. The ACA requires employers to offer coverage to dependents up to age 26, but that coverage does not need to meet affordability standards set elsewhere in the ACA.

People who fall in the family glitch are more likely to be female (54%) than male (46%). Among adults falling in the family glitch (those over the age of 18), 59% are women and 41% are men.



The states with the largest number of people falling into the family glitch are Texas (671,000), California (593,000), Florida (269,000), and Georgia (206,000).

### How many might benefit from a fix to the family glitch?

The American Rescue Plan Act (ARPA) <u>recently (https://www.kff.org/health-reform/issue-brief/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums/) passed (https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/) by Congress and signed into law by President Biden in March 2021 does not address the family glitch, but it does include provisions temporarily extending the ACA subsidy eligibility beyond 400% of poverty in 2021 and 2022. The bill also increases the affordability of Marketplace coverage by reducing premium contribution requirements for people already eligible for subsidies. ARPA limits Marketplace premium contributions for</u>

eligible people to 8.5% of income, which is well below the contributions people in the family glitch are expected to pay toward employer-based coverage (above 9.83% of income). These provisions only last through the 2022 plan year, but at least for that period, a policy fix to the family glitch would extend subsidy eligibility to virtually all the 5.1 million people who fall in the glitch.

However, even if the family glitch is addressed, unless Congress extends the ARPA subsidies beyond 2022, the roughly 1.1 million people who fall into the family glitch and have incomes above 400% of poverty would no longer be eligible for subsidies starting in 2023.

Additionally, the availability of Marketplace tax credits may not be enough to substantially improve affordability for some families, particularly if the worker is not made eligible to join the family members on a subsidized Marketplace plan. Even if the family glitch is addressed, many families may have to contribute toward two health plan premiums – an employer plan for the worker and a subsidized Marketplace plan for the dependents – and these two plans would also have separate deductibles and out-of-pocket maximums.

### How might a fix to the family glitch affect insurance markets?

The vast majority (94%) of those who fall into the family glitch are in better health (self-reported as being in good, very good, or excellent health). A similar share of people currently purchasing health coverage directly in the individual market (94%) are in better health. Therefore, the individual market risk pool may remain unchanged or even benefit if these individuals who are currently in employer-sponsored coverage or uninsured were to shift to enrolling through the Marketplaces. The ACA requires that individual market premiums be based on the average cost of insuring consumers in the market and region. If a number of healthy people who currently fall into the family glitch instead were to get insurance through the Marketplaces, the average cost of insuring individual market consumers could decrease, having a downward effect on premiums, all else being equal.

Figure 3

## Insurance and Health Status of Dependents with Unaffordable Employer Coverage

— Insurance —	— Health Status —	Number	— Share —
Overall	Better Health	4,848,000	94%
	Worse Health	293,000	6%
Dependent ESI	Better Health	4,145,000	95%
	Worse Health	229,000	5%
Direct Purchase	Better Health	294,000	93%
	Worse Health	21,000	7%
Uninsured	Better Health	409,000	91%
	Worse Health	42,000	9%

NOTE: Better Health includes people who self-reported their health status as "Excellent," "Very Good," or "Good." Worse Health includes people who self-reported their health status as "Fair" or "Poor." SOURCE: KFE analysis of 2019 Current Population Survey (CPS) • PNG



### **Discussion**

The ACA made insurance coverage more affordable and accessible for millions of people. However, 30 million Americans remain uninsured and millions more underinsured people (https://www.healthsystemtracker.org/indicator/access-affordability/percentinsured/) struggle with the cost of premiums and out-of-pocket expenses. President Biden campaigned on building on the ACA and addressing affordability of coverage more broadly. Although not as ambitious as his campaign pledge to remove the firewall (https://www.kff.org/health-reform/issue-brief/affordability-in-the-aca-marketplace-under-a-proposal-like-joe-bidens-health-plan/) between employer coverage and the Marketplaces altogether, a fix to the family glitch could improve the affordability of health coverage for millions of people.

Our analysis finds 5.1 million people fall into the ACA's family glitch. Most Americans who fall in the family glitch are currently enrolled in employer-based coverage, but some could pay lower premiums if they are allowed to buy subsidized Marketplace coverage. A smaller number of uninsured people may also gain coverage with a fix to the family glitch. The vast majority of those who fall in the family glitch and have individual market coverage would also pay lower premiums with a fix to the family glitch.

The exact number of people who would benefit from a fix to the family glitch will depend in part on how such a policy change is made and other potential changes to the ACA. Since Congress has temporarily expanded ACA subsidies for people with incomes above 400% of poverty and increased the amount of assistance available to nearly all Marketplace shoppers, virtually all of people currently in the family glitch could become eligible for Marketplace subsidies with a fix to the family glitch. However, even if the family glitch is addressed, when the ARPA's temporary subsidies expire, people who fall into the family glitch and have incomes over 400% of poverty would no longer be eligible for financial assistance on the exchange due to their incomes.

For a variety of reasons, some families may prefer to stay on the same employer plan rather than move dependents onto the Marketplace, even if premium subsidies are made available to them. Families will need to consider their total costs of care, including their premium and out-of-pocket costs, and some may benefit from sharing a single employer-sponsored family plan with a shared out-of-pocket limit. This may be the case particularly for families with relatively high health costs and those with higher incomes that would not qualify them for substantial ACA premium subsidies or cost sharing reductions. Provider networks will be another consideration for some families, as they tend to be broader in employer plans relative to the ACA Marketplace plans.

The bulk of people in the family glitch, however, are healthy and relatively low-income. If these low-income family members are allowed to purchase subsidized Marketplace coverage, some would also qualify for financial assistance to bring down their out-of-pocket costs. In contrast to means-tested Marketplace plans, employer plans typically do not reduce premium contributions or cost sharing based on the employee's income, so lower-income families with employer coverage end up paying <a href="mailto:much more">much more</a> (<a href="https://www.healthsystemtracker.org/brief/how-affordability-of-health-care-varies-by-income-among-people-with-employer-coverage/">much more</a> (<a href="https://www.healthsystemtracker.org/brief/how-affordability-of-health-care-varies-by-income-among-people-with-employer-coverage/">https://www.healthsystemtracker.org/brief/how-affordability-of-health-care-varies-by-income-among-people-with-employer-coverage/</a>) of their income toward health costs than their higher-income counterparts, on average.

A fix to the family glitch would increase government spending, with the amount depending how many of those who fall in the glitch choose to enroll through the Marketplaces. A Congressional Budget Office (CBO) score of a bill that passed in the U.S. House of Representatives (https://www.congress.gov/bill/116th-congress/house-bill/1425/text) estimates a fix to the family glitch would increase federal spending (https://www.cbo.gov/publication/56434) by \$45 billion over 10 years. This estimate does not include the temporarily expanded subsidies under ARPA.

METHODS (HTTPS://WWW.KFF.ORG/REPORT-SECTION/THE-ACA-FAMILY-GLITCH-AND-AFFORDABILITY-OF-EMPLOYER-COVERAGE-METHODS/)

>

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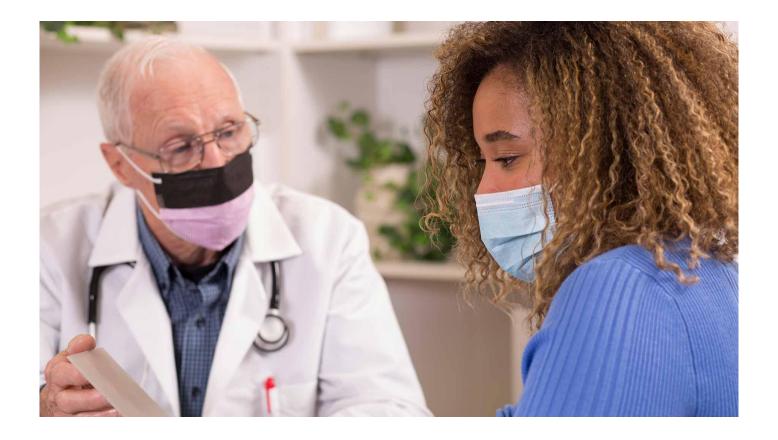
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# GALLUP

MARCH 31, 2021

# In U.S., An Estimated 46 Million Cannot Afford Needed Care

### BY **DAN WITTERS**



### STORY HIGHLIGHTS

- 35% of low-income earners were unable to pay for care in prior 12 months
- One in eight (12%) have cut back on spending on food to pay for care
- Broad support exists for capping out-of-pocket costs in Medicare

Editor's Note: The research below was conducted in partnership between West Health and Gallup.

WASHINGTON, D.C. -- Nearly one-in-five U.S. adults -- 18%, about 46 million people -- report that if they needed access to quality healthcare today, they would be unable to pay for it. These results are based on a new study conducted by <u>West Health</u> and Gallup.

Not	able to afford quality care today
	%
.S. total	18
ACE/ETHNICITY	
lack adults	29
lispanic adults	21
/hite adults	16
ACE BY AGE	
on-White adults 18-49	27
on-White adults 50-64	26
on-White adults 65+	16
/hite adults 18-49	20
/hite adults 50-64	15
/hite adults 65+	8
est Health-Gallup Healthcare Study; Feb. 15-21, 2021 (n=3,753)	

This current measure of healthcare unaffordability runs considerably higher among Black adults (29%) and somewhat higher for Hispanic adults (21%) than for White adults (16%). And while unaffordability of care is lower for people 65 and older than for their younger counterparts, White older adults are half as likely to report such a condition as are non-White older people (8% and 16%, respectively).

This survey was conducted by web from Feb. 15-21, 2021, with 3,753 adults, ages 18+, living in all 50 U.S. states and the District of Columbia via the <u>Gallup Panel</u>, a probability-based panel of about 120,000 adults nationwide.

### Needed Care Was Skipped by 18% of Households in Prior 12 Months

While 18% of survey respondents reported that that they would be unable to pay for quality care if they needed it today, the same percentage also reported that someone in their household skipped care they needed for cost reasons in the prior 12 months. That time period covers roughly the first year of the COVID-19 pandemic.

The chances of any given household suffering from this form of healthcare insecurity are inversely related to annual household income, with 35% of respondents from low-income households -- those earning under \$24,000 per year -- reporting forgoing care in the prior 12 months. That is five times the rate reported by those from high-income households (7%), defined as earning at least \$180,000.

### U.S. Healthcare Insecurity, by Household Annual Income

Has there been a time in the last 12 months when you or a member of your household had a health problem, but you did not seek treatment due to the cost of care?

### Could not afford care in prior 12 months

	%
U.S. total	18
ANNUAL HOUSEHOLD INCOME	
Under \$24,000	35
\$24,000-<\$48,000	27
\$48,000-<\$90,000	19
\$90,000-<\$120,000	11
\$120,000-<\$180,000	10

West Health-Gallup Healthcare Study, Feb. 15-21, 2021

GALLUP PANEL

	Could not afford care in prior 12 months
	%
\$180,000 or more	7
West Health-Gallup Healthcare Study, Feb. 15-21, 2021	
GALLUP PANEL	

## Reduction in Household Spending Due to Cost of Care Spans All Income Groups

With nearly one in five U.S. adults forgoing some healthcare in the prior 12 months due to the cost, many Americans are cutting back on household spending to pay for the care that they currently are receiving. About one in eight adults, for example, say they cut back their spending on food (12%) and over-the-counter drugs (11%) to pay for healthcare or medicine. The proportion doing this rises to about 1/4 of those in households earning less than \$24,000 annually. Additionally, 21% of those from low-income households have had to reduce spending on utilities due to the cost of care, underscoring the disproportionate sacrifices made by lower-income households in the COVID-era.

Over one-third (35%) of respondents, in turn, report that they have reduced spending on recreational or leisure activities in the previous 12 months in order to afford care, including 21% of those in households earning at least \$180,000 per year.

Reductions in Household Spending Due to Cost of Healthcare, by Income

In the last 12 months, has your household reduced spending on any of the following to pay for the healthcare or medicine that you required? (% Yes)

U.S.		\$24K-	\$48K-	\$90K-	\$120K-	
total	<\$24K	<\$48K	<\$90K	<\$120K	<\$180K	\$180K+
%	%	%	%	%	%	%

West Health-Gallup Healthcare Study, Feb. 15-21 2021 (n=3,753)

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	U.S. total	<\$24K	\$24K- <\$48K	\$48K- <\$90K	\$90K- <\$120K	\$120K- <\$180K	\$180K+
	%	%	%	%	%	%	%
Recreational or leisure activities	35	50	45	37	32	27	21
Clothing	26	43	32	29	19	20	13
Food	12	24	19	13	7	6	4
Over-the-counter drugs	11	25	15	11	7	6	3
Utilities	9	21	14	9	5	4	3

West Health-Gallup Healthcare Study, Feb. 15-21 2021 (n=3,753)

**GALLUP PANEL** 

# Majority Support Exists for Cost Containment and Broader Access Policies

As substantial percentages of U.S. adults have had to reduce spending on basic household goods to pay for healthcare, public support runs high for various proposed forms of government action meant to make healthcare more affordable.

For example, over 80% of Americans -- including over 70% of Republicans -- favor setting caps on out-of-pocket costs for both prescription drugs and general healthcare services for those who are insured by Medicare. And lowering the age of Medicare eligibility to 60 is supported by 65% of adults, including 60% of political independents and 42% of Republicans.

Other options are viewed quite differently by the major political party groups. While 60% of all Americans favor "making Medicare available to everyone," support ranges from 93% among Democrats to 19% among Republicans. Similarly, 59% favor "expanding and strengthening" the Affordable Care Act; but the 98% of support among Democrats contrasts with 15% among Republicans. Slight majorities of independents endorse both proposals.

Support for Proposed Government Healthcare Policy, by Political Identity

Do you favor or oppose the federal government enacting policy for each of the following? (% Favor)

	U.S.			
	total	Democrat	Independent	Republican
	%	%	%	%
Setting caps on out-of-pocket costs for prescription drugs in Medicare	88	97	83	81
Setting caps on out-of-pocket costs for general healthcare services in Medicare	85	96	80	74
Lowering the age of Medicare eligibility to 60	65	86	60	42
Making Medicare available to everyone	60	93	54	19
Expanding and strengthening the Affordable Care Act	59	98	51	15

West Health-Gallup Healthcare Study, Feb. 15-21, 2021 (n=3,753)

**GALLUP PANEL** 

### **Implications**

As the U.S. enters its second year of the COVID-19 pandemic, economic recovery, though <u>uneven</u>, has also progressed <u>with 379,000 jobs added in February</u>, considerably exceeding projected forecasts for the month and totaling <u>17 million recovered jobs</u> since April. The passage of the new <u>\$1.9 trillion COVID-19 relief bill</u>, which was debated but not yet passed until after this survey, stands to provide additional relief to large numbers of households and businesses in need.

Despite these reasons for optimism, the cost of healthcare and its potential ramifications <u>continues</u> to serve as a burdensome part of day-to-day life for millions of Americans, illustrating the enduring nature of the issue as the U.S. slowly enters the closing stages of the pandemic. Over a 12-month period that roughly covers the first full year of the COVID-era, 18% of American households had to forgo some degree of needed healthcare because they were not able to afford it due to the cost. And, one year in, 18% of adults report that they would be unable to afford quality care if they needed it today. These realities can spill over into other health issues, such as <u>delays in diagnoses</u> of new cancer and associated treatments that are due to forgoing needed care.

The practical ramifications of widespread reductions in basic household spending to offset the cost of care are considerable and should not come with great surprise given the substantial number of Americans who suffer its effects. Dovetailing with these realities is majority support for a number of public policies currently being considered, underscoring a public that continues to remain open to government action designed to provide relief from healthcare expenses.

Learn more about how the **Gallup Panel** works.

#### SURVEY METHODS



Results are based on a survey conducted by web from Feb. 15-21, 2021, with 3,753 adults, ages 18+, living in all 50 U.S. states and the District of Columbia as a part of the Gallup Panel. For results based on this sample of national adults, the margin of sampling error at the 95% confidence level is  $\pm 2.2$  percentage points for response percentages around 50% and is  $\pm 1.3$  percentage points for response percentages around 10% or 90%, design effect included. For reported sub-groups, the margin of error will be larger, typically ranging from  $\pm 3$  to  $\pm 5$  percentage points.

Samples are weighted to correct for unequal selection probability and non-response. Post-stratification weighting takes into account gender, age, race, Hispanic ethnicity, education, and region. Demographic weighting targets are based on the most recent Current Population Survey figures for the aged 18 and older U.S. population.

RELEASE DATE: March 31, 2021

SOURCE: Gallup https://news.gallup.com/poll/342095/estimated-million-cannot-afford-needed-care.aspx

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APR, 30, 202

## American Rescue Plan Provides a New Opportunity for States to Invest in Equitable, Comprehensive and Integrated Crisis Services

Ashley Traube, Patricia Boozang, Jocelyn Guyer, Manatt Health

### Overview

The American Rescue Plan (ARP) Act enacted on March 11, 2021 establishes a state option to provide community mobile crisis intervention services for a five-year period beginning in April 2022. As an incentive to state adoption, the law provides for an 85 percent enhanced federal matching rate for qualifying services for the first three years of state coverage.[1] To further encourage states, ARP also includes \$15 million in state planning grants to support their efforts to develop a state plan amendment or waiver request (e.g., Section 1115, 1915(b) or 1915(c)) to take up the option. The new mobile

### Box 1: Behavioral Health Needs across

- Drug overdoses have surged to their highest levels. More than 87,000
   Americans died—an annual increase of close to 30%—from drug overdoses from September 2019 to September 2020.1
- Adolescent mental health is worsening. Among adolescents aged 12 to 17, the percentage with a past year major depressive episode increased from 9% in 2004 to 15.7% in 2019.<sup>2</sup>
- However, suicide rates declined for the first time in 20 years. After increasing from 1999 through 2018, the ageadjusted suicide rate in 2019 (13.9 per 100,000) declined significantly from 2018 (14.2).<sup>3</sup>

Sources: 1. Centers for Disease Control and Prevention (CDC). Provisional Drug Overdose Death Counts. April 4, 2021. Available <a href="https://example.com/https://ex

(https://www.shvs.org/wp-content/uploads/2021/04/Box-1.jpg)

crisis provision arrives just as many states and localities are exploring strategies to address the worsening behavioral health—mental health and substance use disorder (SUD)—crisis (Box 1) – as well as preparing for implementation of **998**, the new, national hotline for behavioral health crises. For states and localities reviewing their policing procedures, the new option also could be used to support state efforts to refine the role of law enforcement in responding to behavioral health crisis, offering more resources to the police on such calls or, in some instances, even entirely avoiding the need for law enforcement.

### What Are Community Mobile Crisis Intervention Services?

Community mobile crisis intervention services are a critical part of states' crisis and behavioral health systems of care. The Substance Abuse and Mental Health Services Administration (SAMHSA) National Guidelines for Behavioral Health Crisis Care, distill the elements of a crisis system into three core components with linkages to broader behavioral health continuums of care:

- 1. Regional or statewide crisis call centers coordinating in real time;
- 2. Centrally deployed, 24/7 mobile crisis; and
- 3. 23-hour crisis receiving and stabilization facilities

Using this model, the regional or statewide crisis call center triages a call and dispatches a mobile crisis unit to respond to an individual in crisis. Mobile crisis teams – comprised of qualified professionals that are trained to de-escalate and treat individuals in crisis – work to assess and stabilize individuals experiencing behavioral health emergencies in the least restrictive setting and divert individuals with mental illness from jail and emergency departments to crisis receiving and stabilization facilities and other community based treatment.[2][3] Mobile crisis teams enable states and localities to begin to away from relying heavily on police, many of whom are insufficiently trained in behavioral health crisis, to other, trained first responders.[4]

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Approximately 7-10 percent of police contacts involve individuals with mental illness which are very likely to result in arrest and incarceration, usually for minor offenses.[5] A primary police response to behavioral health crisis can criminalize and stigmatize mental illness and SUD, and make it more likely that the underlying mental illness or SUD remains untreated.

#### Why Are States Expanding Crisis Mobile Intervention Services?

Even prior to the enactment of ARP, a growing number of states and localities were reorienting their crisis response systems to include mobile crisis intervention teams and connect individuals in crisis to follow-up behavioral health treatment and recovery services.[6]<sup>[7]</sup> The mobile crisis state option is one critical tool available beginning in April 2022 to invest in comprehensive and integrated crisis infrastructure that will:

- Stabilize individuals in crisis;
- Connect them to follow up behavioral health services:
- · Reduce the stigma associated with behavioral health crisis; and
- · Lessen the reliance of communities on police as first responders.

Investing in a comprehensive crisis system that prioritizes behavioral health treatment can also help states and localities better support individuals residing in under-resourced communities who are less likely to be diagnosed with a behavioral health condition and connected to treatment.[8] [9] The option can also augment states' efforts to ready their behavioral health crisis systems for the establishment of 988 as the national suicide prevention and mental health crisis hotline in July 2022.[10] Beginning in July 2022, states' must have systems in place to route and address calls that come into 988.

### What are Key State Questions on the New Option?

There are a number of key questions that states will need to consider as they begin to design or evolve their existing community mobile crisis services that align with the ARP Act provision.

### What are Qualifying Community Mobile Crisis Intervention Services under ARP?

ARP defines "qualifying community mobile crisis intervention services" as services that are available continuously, and provided in a timely manner by a multi-disciplinary mobile crisis team that is:

- Comprised of least one behavioral health professional who can conduct an assessment, as well as other professionals or paraprofessionals with appropriate expertise in behavioral or mental health crisis response, including nurses, social workers, peer support specialists and others;
- Trained in trauma-informed care, de-escalation strategies and harm-reduction;
- · Provide screening and assessment, stabilization and de-escalation and coordination with health, social and other supports, as needed; and
- Maintain relationships with relevant community partners, including a range of medical, behavioral and crisis providers.

### What Are Some of the Promising Models for Crisis Mobile Intervention Services?

There are a number of different crisis response models operating across the country that are funded through a combination of Medicaid, state and other funding, and which leverage different professionals based on community need and workforce capacity. These are useful models for states to consider as they seek to develop community mobile crisis intervention services consistent with ARP service definitions.

- Mobile Crisis Teams. A number of states—at least 13 as of September 2019—dispatch Medicaid-funded mobile crisis teams and least six other states and localities dispatch mobile crisis teams funded through non-Medicaid means.[11] Georgia's Department of Behavioral Health and Developmental Disabilities provides mobile crisis services 24/7/365 on a statewide basis using a team of specially trained behavioral health professionals and para-professionals through its Georgia Crisis and Access Line. Mobile crisis teams respond within specified timeframes, depending on the urgency of the call, and provide on-site crisis management through assessment, de-escalation, consultation and referral with post-crisis follow-up to assure linkage with recommended services. [12]
- Community Paramedicine. Community paramedicine programs expand the roles of paramedics and emergency medical technicians (EMTs) to provide preventive, primary care and population health services to support under-resourced communities. An emerging model of community paramedicine, mobile crisis management programs dispatch specialty trained paramedics and EMTs to respond to behavioral health crisis situations. North Carolina worked with its behavioral health managed care entities which manage publicly funded behavioral health services and select counties to pilot a community paramedicine mobile crisis management program. As part of the program, paramedics received advance mental health and substance use disorder training, and were dispatched to behavioral health crisis calls to provide triage, behavioral health crisis assessment, on-site intervention and referral to continuum of crisis intervention services and supports. Depending on the triage and assessment, community paramedics would treat and release or treat and transport to crisis receiving centers.[13]
- Co-responder Programs. Co-responder crisis intervention models pair law enforcement and behavioral health specialists to respond to individuals in behavioral health crises. Colorado's Office of Behavioral Health operates co-responder programs throughout counties in the state using a combination of state and federal grant funds where a behavioral health specialist and police officer respond together at the scene. The co-responder teams provide on-scene crisis response, including crisis de-escalation, behavioral health screening and assessment, as well as call disposition planning. In addition, the teams also provide referrals and linkages to community-based services, outreach and linkage to families (as appropriate), peer support and care coordination.[14]

### Which Populations Are Eligible to Receive Community Mobile Crisis Intervention Services?

States appear to have broad flexibility under ARP to tailor eligibility for community mobile crisis intervention services to any Medicaid eligible individual who is experiencing a mental health or substance use disorder crisis in a non-facility setting.

Most crisis services, including mobile crisis intervention services, are geared toward treating adults ages 18 to 65. This means that crisis supports are often lacking for special populations, including youth, older people, and individuals with co-occurring intellectual and developmental disabilities (וֹרְיִרִירִי) who experience behavioral health crises.

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To address the growing behavioral health crisis needs of children and youth, states can consider designing youth specific models. For example, Massachusetts' Behavioral Partnership provides child-centered and family driven mobile crisis intervention services for youth who are age 20 and younger through its Emergency Services Program provider. Mobile crisis intervention teams – comprised of master's level clinicians with family and youth specific training and bachelor's and paraprofessional staff – meet clients in home or school settings and work with youth and their families to deescalate crisis events to avoid treatment in hospital settings and out-of-home-placements.[15]

Individuals with I/DD are more likely to be diagnosed with a mental disorder than other individuals, yet disability-specific crisis supports are often lacking for this population.[16] A number of states, including Tennessee, cover behavioral health crisis services for Medicaid beneficiaries with I/DD and co-occurring mental health disorders who are receiving long terms services and supports (LTSS) through Medicaid waivers. TennCare MCOs provide behavioral health crisis prevention, intervention and stabilization services for enrollees with I/DD receiving managed LTSS which include person-centered prevention and crisis prevention planning, training to caregivers, development of community linkages and cross-system supports and 24/7 crisis intervention and stabilization response.[17] In addition, states and communities may also incorporate I/DD trainings as part of their crisis trainings for first responders.[18]

Today, there are also significant barriers for accessing culturally competent mobile crisis intervention and other crisis services for Black, Latino and LGBTQ populations.[19] New ARP funding provides states the opportunity to design new or enhance existing community mobile crisis intervention services to be inclusive of the needs of these and other populations of focus. States can cultivate culturally competent mobile crisis intervention services by ensuring that crisis providers have an awareness of historical trauma faced by under-resourced communities, as well as mental health stigma which can act as a barrier to accessing behavioral health care for key populations of focus.[20]

### How Can States Use the New ARP Option and Funding to Support a "Firehouse Model" for Crisis Services?

Currently, funding for state crisis systems is pieced together across a patchwork of funding sources and payers. Funding is also largely inadequate to sustain the crisis system using a "firehouse model" which refers to mobile crisis services providers who are "on-call" and able to be dispatched at all times to anyone in crisis regardless of insurance status – similar to other emergency services like fire departments. Medicaid can reimburse for crisis services delivered to Medicaid covered individuals only. Many private insurers may not cover crisis services. Taken together, these factors force states and localities to subsidize crisis services for insured and uninsured individuals using limited state and local funds which inhibit the access and availability of mobile crisis services across states and localities.

The state option for qualifying community mobile crisis intervention services represents a promising opportunity for states to better leverage federal funds to sustain their crisis systems and crisis providers. States that have expanded Medicaid will be able to claim 90 percent federal matching funds to support mobile crisis intervention services. For all other Medicaid enrollees, states will be able to claim 85 percent enhanced federal match on these services for the first three years of the option. States may consider developing or enhancing crisis provider reimbursement rates to reflect cost of making "on call" mobile crisis services available to Medicaid enrollees. As part of their mobile crisis design work, states may also consider extending emergency Medicaid coverage to individuals in acute behavioral health crises who are eligible for Medicaid but for their immigration status.[21]

By fully optimizing the new, enhanced federal funding for community mobile crisis intervention services, states may well be able to move their crisis systems closer to a firehouse model, and better target limited state funds to other aspects of the crisis system, such as readying the system for the transition to the 988 mental health crisis line. While the enhanced federal funding for community mobile crisis intervention services is temporary, states that have expanded Medicaid will be able to continue to draw down 90 percent federal match for services provided to the Medicaid expansion population.

### Conclusion

The ARP mobile crisis state option and enhanced FMAP provide a critical tool for states to invest in a more equitable, comprehensive and integrated crisis system that connects individuals in behavioral health crisis with specialized and appropriate behavioral health treatment. This option is just one piece of crisis planning that states and localities can undertake to fully transform their behavioral health crisis systems. The enhanced FMAP is temporary and only covers the Medicaid portion of the crisis system. This means that states must consider how to sustain investment in crisis services once the funding elapses and how to financially support a universal, payer blind system. This may include working with commercial payers, employers and other stakeholders to ensure adequate coverage and funding for crisis services beyond Medicaid. Additionally, significant community and stakeholder engagement and training will likely be required to design culturally responsive and equitable systems that individuals in behavioral health crises, their families, police, other first responders and behavioral health providers feel comfortable engaging. The ARP mobile crisis option and funding can jumpstart states' efforts to reform their crisis systems.

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<sup>[1]</sup> Public Law No: 117-2. March 11, 2021. Available here. (https://www.congress.gov/bill/117th-congress/house-bill/1319/text#toc%20H155EAEF98A524898BC6F93FE5BB8CB2A)

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