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HHS-Operated Risk Adjustment Technical Paper on Possible Model Changes

October 26, 2021

Contents

Overview

The Patient Protection and Affordable Care Act (ACA)[1] established a permanent risk adjustment program to minimize the negative effects of adverse selection and help level the playing field between insurance companies, thereby fostering a stable, vibrant market in which issuers are rewarded for providing high-quality, affordable coverage, not for offering plans designed to attract the lowest-risk enrollees and avoid the highest-risk enrollees. The risk adjustment program is intended to achieve this goal by mitigating the effect of risk selection on premiums by transferring funds from issuers that enroll lower-than-average risk populations to issuers that enroll higher-than-average risk populations.

The Department of Health and Human Services (HHS) has actively sought comment and received feedback on the federal risk adjustment requirements from the beginning of the program's development.[2] This formal and informal feedback has been instrumental in developing program requirements, as well as identifying areas for further study and potential refinements for future benefit years. Most recently, HHS proposed, but did not finalize, several updates to the HHS risk adjustment models in the 2022 Payment Notice.[3] In the 2022 Payment Notice, in response to comments, HHS reiterated its commitment to continue to consider potential changes that could increase the current models' predictive accuracy and acknowledged stakeholders' desire for additional analyses and information on the proposed model specification updates.[4] This paper provides additional detail and analyses on the model updates proposed in the 2022 Payment Notice. It also includes information on HHS' ongoing evaluation of the state payment transfer formula's current cost-sharing reduction induced demand factors (CSR IDFs).

Chapter 1 provides an explanation of how the risk adjustment models currently work, an overview of previous model updates, and an explanation of the current focus on improving the models' predictive accuracy for certain subpopulations. Chapter 2 explores ways to improve the current models' predictive accuracy for the lowest-risk enrollees. Chapter 3 explores ways to improve the predictive accuracy of the enrollment duration factors included in the models. Chapter 4 explores ways to improve the current models' predictive accuracy for the highest-risk

[1] The Patient Protection and Affordable Care Act (Pub. L. 111-148), was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), which amended and revised several provisions of the ACA, was enacted on March 30, 2010. In this paper, we refer to the two statutes collectively as the Affordable Care Act or ACA.

[2] See, e.g., Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act; Request for comments, 75 FR 45584 (August 3, 2010); and the March 2016 Risk Adjustment Methodology White Paper (March 24, 2016), available at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf.

[3] See Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Standards; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations; Proposed Rule, 85 FR 78572 at 78581 – 78586 (December 4, 2020). Also see Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Standards; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations; Final Rule, 86 FR 24140 at 24151 - 24162 (May 5, 2021).

[4] See 86 FR at 24151 – 24162.

enrollees. Chapter 5 provides the predictive ratios and R-squared statistics for all of the model specification changes examined in this paper and discusses the estimated impact of those changes. Additionally, Chapter 5 includes information on how we are planning to simulate the impact of the risk adjustment modeling changes discussed in Chapters 2, 3 and 4 in this paper on plan liability risk scores (PLRS) and transfers under the state payment transfer formula. Finally, Appendix A shares information on the current CSR IDFs in the state payment transfer formula, stakeholder feedback on these factors, and options HHS is evaluating to improve prediction of CSR enrollees' plan liability.[5] We are accepting comments on this paper (including the Appendices) at RARIPAYMENTOPERATIONS@cms.hhs.gov with the subject line of "2021 Model Update Technical Paper" until November 26, 2021.

Chapter 1: Overview and Current Status of Risk Adjustment Models

This chapter provides an introduction to the HHS-operated risk adjustment program and a high-level summary of the state payment transfer formula.[6] The chapter begins by providing background on the history and purpose of the risk adjustment program and the principles that have guided the development of the current HHS risk adjustment models. It also provides details on the calculation of the risk scores and transfer amounts under the state payment transfer formula. Finally, the chapter concludes with a summary of previous changes to the risk adjustment models since the beginning of the HHS risk adjustment program and identifies several areas that could further improve the current models' predictive accuracy for certain subpopulations, which are addressed in more detail in later chapters of this paper.

1.1 Overview of Risk Adjustment

1.1.1 History

Section 1343 of the ACA[7] established a permanent risk adjustment program in which states collect charges from health insurance issuers that enroll lower-than-average risk populations and provide payments to health insurance issuers that enroll higher-than-average-risk populations, such as those with chronic conditions, thereby reducing incentives for issuers to avoid higher-risk enrollees. Consistent with section 1321(c)(1) of the ACA, HHS is responsible for operating the risk adjustment program on behalf of any state that does not elect to do so.[8] Since the 2017 benefit year, HHS has operated the risk adjustment program for all 50 states and

[5] As explained in Appendix A, the data and analyses in Chapters 2 – 5 and the forthcoming transfer simulation will not reflect any changes to the CSR IDFs. Although we did not propose any changes to the CSR IDFs in the 2022 Payment Notice, we wanted to share information with stakeholders about HHS' ongoing evaluation of these factors.
[6] The state payment transfer formula refers to the part of the HHS risk adjustment methodology that calculates payments and charges at the state market risk pool level prior to the calculation of the high-cost risk pool payment and charge terms that apply beginning with the 2018 benefit year. See, e.g., 81 FR at 94080.
[7] 42 U.S.C. § 18063.
[8] 42 U.S.C. § 18041(c).

the District of Columbia.[9] The risk adjustment program applies to risk adjustment covered plans in the individual and small group (including merged) markets, inside and outside the Exchanges.[10] Since the 2014 benefit year, the risk adjustment program has transferred funds from issuers with plans that insure lower-than-average risk enrollees to plans that insure higher-than-average risk enrollees, resulting in billions of dollars being transferred among issuers annually. In 2020 for example, the absolute value of transfers was $11.17 billion, or 7.5 percent of premium, between issuers in all risk pools (excluding the high-cost risk pool).[11]

As described in the 2014 Notice of Benefit and Payment Parameters (2014 Payment Notice) final rule, the risk adjustment methodology developed by HHS is based on the premise that premiums should reflect the differences in plan benefits, quality, and efficiency—not the health status of the enrolled population.[12] The state payment transfer formula that is part of the HHS methodology determines each risk adjustment covered plan's risk score and state transfer payment or charge amount based on the actuarial risk of enrollees, the actuarial value (AV) of coverage, the cost of doing business in local rating areas accounting for care utilization, and the effect of different cost-sharing levels on utilization. Thus, the HHS risk adjustment methodology predicts average group costs to account for risk across plans, in keeping with the Actuarial Standards Board's Actuarial Standards of Practice for risk classification.[13]

Risk adjustment payments and charges under the HHS-operated program are budget neutral, meaning the total amount of risk adjustment charges collected from issuers are equal to the total amount of risk adjustment payments made. These budget-neutral transfers reduce the incentive for issuers to avoid the highest-risk enrollees and reduce the influence of risk selection on the premiums that plans charge.[14]

1.1.2 Purpose and Goals of Risk Adjustment

The purpose of the risk adjustment program is to reduce the influence of risk selection on plan premiums as well as to reduce the incentive for plans to avoid enrolling higher-than-average risk enrollees. Without risk adjustment, plans that enroll a higher proportion of high-than-average-risk enrollees would need to charge a higher average premium (across all of their enrollees) to be financially viable. The intent of risk adjustment is to allow a plan enrolling a higher proportion of high-than-average-risk enrollees to charge the same average premium (other

[9] Massachusetts ran its own risk adjustment program for benefit years 2014-2016. See page 5 of the March 2016 Risk Adjustment Methodology White Paper (March 24, 2016), available at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf.

[10] See 45 CFR 153.20 for definition of risk adjustment covered plans.

[11] See the Summary Report on Permanent Risk Adjustment Transfers for the 2020 Benefit Year at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2020.pdf.

[12] 78 FR 15409 at 15417.

[13] See the Actuarial Standards Board's Actuarial Standards of Practice for risk classification at: http://www.actuarialstandardsboard.org/asops/risk-classification-practice-areas/.

[14] For a further discussion of the budget neutral approach for the HHS-operated risk adjustment program, see the 2020 Payment Notice final rule, 84 FR at 17480 – 17482.

factors being equal) as a plan enrolling a higher proportion of lower-than-average-risk enrollees, shifting the focus of plan competition to plan benefits, quality, efficiency, and value.

1.2 The Current HHS Risk Adjustment Models

1.2.1. Principles of Risk Adjustment

To determine a plan's actuarial risk, the HHS risk adjustment models use an enrollee's demographics and chronic health status information to determine a risk score, which is a relative measure of how costly an individual is anticipated to be to the plan (i.e., a relative measure of the individual's actuarial risk to the plan). Hierarchical condition categories (HCCs) are a critical component of accurate risk prediction as they dictate which diagnostic codes are included in the models, how they are grouped, and how those groupings interact. There are ten principles of risk adjustment which guide the HHS risk adjustment models' diagnostic classification system.[15]

Principle 1: Diagnostic categories should be clinically meaningful.
Principle 2: Diagnostic categories should predict medical (including drug) expenditures.
Principle 3: Diagnostic categories that will affect payments should have adequate sample sizes to permit accurate and stable estimates of expenditures.
Principle 4: In creating an individual's clinical profile, hierarchies should be used to characterize the person's illness level within each disease process, while the effects of unrelated disease processes accumulate.
Principle 5: The diagnostic classification should encourage specific coding.
Principle 6: The diagnostic classification should not reward coding proliferation.
Principle 7: Providers should not be penalized for recording additional diagnoses (monotonicity).
Principle 8: The classification system should be internally consistent (transitive).
Principle 9: The diagnostic classification should assign all ICD-10-CM codes (exhaustive classification).
Principle 10: Discretionary diagnostic categories should be excluded from payment models.

Consistent with these risk adjustment principles, the HHS risk adjustment models exclude diagnoses that are vague or nonspecific (e.g., cough); discretionary in medical treatment or coding (e.g., attention deficit disorder); or not medically significant (e.g., heartburn). The payment models also exclude diagnoses that do not add significantly to costs (e.g., non-melanoma forms of skin cancer). Empirical evidence on frequencies and predictive power; clinical judgment on relatedness, specificity, and severity of diagnoses; and professional judgment on incentives and likely provider responses to the classification system were used to make tradeoffs among principles where they conflicted. Some examples of conflict among

[15] A detailed explanation of the ten principles of risk adjustment can be found in the March 2016 Risk Adjustment Methodology White Paper (March 24,2016), available at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf. Also see Potential Updates to HHS–HCCs for the HHS-operated Risk Adjustment Program (June 17, 2019) paper, available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Potential-Updates-to-HHS-HCCs-HHS-operated-Risk-Adjustment-Program.pdf.

principles include tradeoffs between clinical meaningfulness (principle 1) and adequate sample sizes (principle 3), as well as between encouraging specific coding (principle 5) and predictive accuracy (principle 2).

In addition to the ten principles, the current HHS risk adjustment program has two main process components: (1) a method for measuring risk selection by calculating risk scores,[16] and (2) a method for quantifying financial impacts by calculating risk adjustment transfers at the state market risk pool level.[17] The following sections detail the formulas used to calculate risk scores and transfer amounts under the state payment transfer formula.[18]

1.2.2 Calculation of the Risk Score

To determine the risk score for each risk adjustment covered plan, HHS developed separate models for adults, children, and infants to account for clinical and cost differences in each age group. These HHS risk adjustment models predict plan liability for an average enrollee based on that person's age, sex, and diagnoses (HCCs), producing a risk score.

The risk score for an enrollee is defined as the total predicted relative plan liability expenditures for the enrollee based on the relevant HHS risk adjustment model for the enrollee's age group (adult, child, or infant) and plan metal level. For the metal level of the enrollee's plan, the total predicted relative plan liability expenditures, or individual enrollee risk scores, are calculated based on the following factors: an age factor, a demographic factor, diagnostic (or HCC) factor(s), an enrollment duration factor (adult models only), prescription drug (or RXC) factor(s) (adult models only), and a CSR factor (if applicable). The age model factor assigns risk scores to each of nine age categories which range from 21 to 64 in five-year increments in the adult models and is a significant driver of health risk differences. For a child enrollee, the relative risk assigned to an individual is the sum of the applicable age, demographic, and diagnostic factor(s); and for infants, it is the sum of the appropriate maturity/disease severity category and the male additive term.[19] If applicable, a multiplicative adjustment for induced utilization is made to the risk score for enrollees in individual market CSR plan variations offered through the Exchanges.

Enrollees' model-calculated risk scores are then weighted by enrollment months and aggregated to arrive at a plan-level average risk score for that plan's enrollees within a rating area. As previously stated, the enrollment-weighted average risk score of all enrollees in a particular risk adjustment covered plan (also referred to as the plan liability risk score or PLRS) within a geographic rating area is one of the inputs into the state payment transfer formula, which determines the state transfer payment or charge that an issuer will receive or be required to pay for that plan in a given benefit year for the applicable state market risk pool.

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[16] See The HHS-HCC Risk Adjustment Model for Individual and Small Group Markets under the Affordable Care Act, 2014. Available at: https://www.cms.gov/mmrr/Downloads/MMRR2014_004_03_a03.pdf

[17] See Risk Transfer Formula for Individual and Small Group Markets Under the Affordable Care Act, 2014. Available at: https://www.cms.gov/mmrr/Downloads/MMRR2014_004_03_a04.pdf.

[18] See supra note 6.

[19] In the infant models, there are two additive terms for sex, for age 0 males and age 1 males, which account for higher morbidity and infant mortality in the male infant population (females are the reference group for the mutually-exclusive categories).

The PLRS is a crucial component for calculating risk adjustment transfer payments or charges under the state payment transfer formula. The transfer formula also incorporates several other factors into its calculation of transfers, as described in the next section.

1.2.3 Calculations Under the State Payment Transfer Formula

As explained above, the state payment transfer formula averages all individual risk scores in risk adjustment covered plans in a state market risk pool, and uses the PLRS, combined with other factors, to calculate the payment and charge amounts at the state market risk pool level.

The first step in calculating transfers under the state payment transfer formula is finding the T_{PMPM}, or the transfer amount per billable member per month (PMPM) for plan i, and is described below.

$$T_{PMPM} = \left[\frac{PLRS_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot PLRS_i \cdot IDF_i \cdot GCF_i)} - \frac{AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i}{\sum (s_i \cdot AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i)}\right] \bar{P}_S$$

The transfer formula may be understood to be composed of two key higher-level terms, both enclosed in the square brackets: the risk term ($\frac{PLRS_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot PLRS_i \cdot IDF_i \cdot GCF_i)}$) and the rating term ($\frac{AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i}{\sum (s_i \cdot AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i)}$).

The first of these, the risk term, defines the revenue required by a plan (relative to the statewide market average). It is determined by three component variables:

1. The PLRS, which reflects plan i's AV as well as the plan's enrollee health status risk;[20]
2. An induced demand factor (IDF), which reflects the anticipated induced demand associated with plan i's cost-sharing (metal) level; and
3. A geographic cost factor (GCF), which accounts for differences in premium due to allowable geographic rating variation.

The second term, the rating term, defines the revenue that a plan can be expected to generate given the allowable rating factors (relative to the statewide market average). It is determined by four component variables:

1. AV, which adjusts for relative differences between the plan actuarial value in a market;
2. An Allowable Rating Factor (ARF), which accounts for the impact of allowable rating factors (age or family tier) based on state rating method;
3. An IDF; and
4. A GCF.

The denominators of the risk and rating terms in the transfer equation express statewide average required revenue and allowable premium, respectively. The statewide average required revenue and allowable premium include the same component variables from the numerator multiplied by each plan's share of statewide enrollment, or s_i. Dividing these terms by the

[20] The cost-sharing reduction induced demand factor (CSR IDF) is applied, if applicable, at the enrollee's enrollment-period level prior to calculation of the plan-level $PLRS_i$ and reflects the anticipated induced demand associated with lower cost sharing (see Appendix A for further discussion of CSR IDFs).

respective statewide average expresses the plan's revenue requirement and allowable revenue relative to the average plan offered in the state. Transfers are calculated by converting the applicable factors into dollar amounts by multiplying them by the statewide enrollment-weighted market average plan premium ($\bar{P}_s$ in the transfer formula). The transfer formula assumes a multiplicative relationship among the various cost factors. Other things being equal, a 10 percent increase in the cost of doing business in a rating area increases plan liabilities and premiums by 10 percent, a 10 percent increase in risk increases plan liabilities by 10 percent, etc. If Plan A's actuarial value is 25 percent higher than Plan B's AV, and Plan A's geographic cost factor is 40 percent higher than Plan B's GCF, then Plan A's costs would be expected to be 75 percent greater than Plan B (1.25*1.40 = 1.75).

The final transfer formula is as follows.

$$T_i = T_{PMPM} * \sum_b M_b$$

Structured as shown above, the final transfer formula calculates T_i, plan i's total transfer amount for a rating area. The total transfer amount for each plan for the applicable state market risk pool is calculated by multiplying PMPM transfers (T_{PMPM}), the payment or (if negative) charge to plan i for each member month of enrollment, by the plan's total billable member months ($\sum_b M_b$), where M_b is the number of months during the risk adjustment period the billable enrollee b is enrolled in plan i.

1.3 Previous Risk Adjustment Model and Transfer Formula Updates

HHS has continuously analyzed and refined the HHS risk adjustment models and transfer formula through notice-and-comment rulemaking and has shared detailed analysis in prior white papers. [21] Past updates to the models and transfer formula are described below.

In the 2014 Payment Notice,[22] we established the first set of HHS risk adjustment models that were used for the 2014 and 2015 benefit years. These initial models were developed using the Truven Health Analytics 2010 MarketScan® Commercial Claims and Encounters database (MarketScan® data).

In the 2016 Notice of Benefit and Payment Parameters (2016 Payment Notice),[23] we finalized the recalibration of the HHS risk adjustment models using blended 2011, 2012, and 2013 MarketScan® data to develop final risk adjustment factors for the 2016 benefit year. The goal of this update to the models was to provide risk adjustment factors that reflected more recent treatment patterns and costs while simultaneously providing greater stability within the

[21] See 2011 Risk Adjustment Implementation Issues, September 12, 2011, available at: https://www.cms.gov/CCIIO/Resources/Files/Downloads/riskadjustment_whitepaper_web.pdf and March 2016 Risk Adjustment White Paper, March 24, 2016, available at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf and Potential Updates to HHS-HCCs for the HHS-operated Risk Adjustment Program, June 17, 2019, available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Potential-Updates-to-HHS-HCCs-HHS-operated-Risk-Adjustment-Program.pdf.

[22] 78 FR 15409.

[23] 80 FR 10749.

risk adjustment program and minimizing risk score volatility by blending factors from three years of data.

In the 2017 Notice of Benefit and Payment Parameters (2017 Payment Notice),[24] we finalized the introduction of preventive services into the simulation of plan liability as part of the recalibration of the risk adjustment models beginning with the 2017 benefit year. We also finalized the use of blended 2012, 2013 and 2014 MarketScan® data to recalibrate the risk adjustment model factors for the 2017 benefit year.

In the 2018 Notice of Benefit and Payment Parameters (2018 Payment Notice),[25] we finalized several model updates:

1. Adding enrollment duration factors: We finalized the addition of enrollment duration factors to the adult models starting with the 2017 benefit year. The enrollment duration factors are used in the calculation of adult enrollee risk scores to account for additional risk associated with enrollees with partial-year enrollment. They do so through a set of 11 enrollment duration binary indicatory variables that signify that an enrollee had exactly one to 11 months of enrollment in a given plan. The model-estimated risk value of these indicators decreases monotonically from one to 11 months, reflecting the increased annualized costs associated with fewer months of enrollment.
2. Adding prescription drug factors: We finalized the addition of prescription drugs to the adult models by creating indicators for categories of prescription drugs that interact with HCCs, or RXC-HCC interactions, beginning with the 2018 benefit year. The purpose of including RXCs in the adult risk adjustment models is to improve prediction by identifying health conditions that may otherwise be underreported, as well as to detect diagnoses that may not be present in medical claims data because a patient with a long-term chronic condition has not visited a provider for that condition during their plan enrollment. The presence of a specific drug is used to indicate that the associated diagnosis is possibly present and is captured by the RXC factor, while the RXC-HCC interaction captures differing levels of severity of illness that treatment with a specific drug may indicate. There are currently 10 RXC-HCC interactions used in the adult models.[26]
3. Establishing a high-cost risk pool: We finalized the establishment of a high-cost risk pool beginning with the 2018 benefit year to account for the risk of high-cost enrollees and help ensure that transfers under the state payment transfer formula better reflect typical actuarial risk without the influence of extremely high cost conditions. To account for this high-cost risk pool during recalibration, we exclude a percentage of costs above a certain threshold level (currently the parameters are set at a $1 million threshold and a

[24] 81 FR 12203.
[25] 81 FR 94058.
[26] In the 2018 Payment Notice (81 FR 94058), we finalized the addition of prescription drugs to the adult risk adjustment models by creating indicators for 12 categories of prescription drugs, beginning with the 2018 benefit year. In the 2019 Payment Notice (83 FR 16930), we finalized the removal of the two severity-only RXCs (RXC 11: Ammonia Detoxicants, and RXC 12: Diuretics, Loop and Select Potassium-Sparing).

coinsurance rate of 60 percent[27]) in the calculation of enrollee-level plan liability risk scores. This exclusion ensures that the risk adjustment factors account for risk associated with HCCs and RXCs excluding those extreme costs, because the average risk associated with HCCs and RXCs is better accounted for without inclusion of the high-cost enrollees.

4. Reducing the statewide average premium: We finalized a 14 percent reduction to the statewide average premium in the state payment transfer formula, beginning with the 2018 benefit year, to reflect the portion of administrative costs that does not vary by claims.

In the 2018 Payment Notice, we also finalized the proposal to collect and use enrollee-level External Data Gathering Environment (EDGE) data for recalibration of the risk adjustment models in future benefit years. Because MarketScan® data generally reflects the large group market, the use of enrollee-level EDGE data allows for the annual recalibration of the risk adjustment models to better reflect the populations in the individual and small group (or merged) markets that are subject to risk adjustment. "Enrollee-level EDGE dataset" in this paper refers to the national dataset used for risk adjustment model recalibration. This dataset contains limited information generated by reports HHS receives from issuers' EDGE servers, and excludes plan, state, and other information necessary for calculating risk adjustment transfers. We also finalized the use of blended 2013, 2014 and 2015 MarketScan® data to recalibrate the risk adjustment model factors for the 2018 benefit year.

In the 2019 Notice of Benefit and Payment Parameters (2019 Payment Notice),[28] we finalized the use of equally blended factors from 2014 MarketScan®, 2015 MarketScan®, and the 2016 enrollee-level EDGE dataset. We also finalized the removal of two severity-only RXCs (RXC 11: Ammonia Detoxicants, and RXC 12: Diuretics, Loop and Select Potassium-Sparing) from the adult models for the 2019 benefit year and beyond.

In the 2020 Notice of Benefit and Payment Parameters (2020 Payment Notice),[29] we finalized a pricing adjustment for the plan liability simulation for the Hepatitis C RXC to more closely reflect the expected average additional plan liability of the Hepatitis C RXC for the 2020 benefit year. We also finalized the use of equally blended factors from separately solved 2015 MarketScan®, 2016 enrollee-level EDGE, and 2017 enrollee-level EDGE datasets to recalibrate the risk adjustment model factors for the 2020 benefit year.

In the 2021 Notice of Benefit and Payment Parameters (2021 Payment Notice),[30] we finalized the proposed updates to the risk adjustment models' HCCs to transition the HHS-HCC clinical classifications to the International Classification of Diseases, 10th Revision (ICD-10) diagnosis codes to reflect more recent diagnosis code information and claims data.[31] To develop

[27] See, e.g., 84 FR at 17466 through 17468 and 86 FR at 24183 through 24186.
[28] 83 FR 16930.
[29] 84 FR 17454.
[30] 85 FR 29164
[31] The initial HHS-HCC clinical classification, in place from the 2014 through the 2020 benefit year, was based on International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes. In June 2019, we released a paper on the potential updates to the HHS-HCC clinical classification to incorporate ICD-10-

the HHS-HCC classification changes, we used 2016 and 2017 benefit years' enrollee-level EDGE claims data, which reflected the first two full years of ICD-10 diagnosis coding on claims. To guide the reclassification process, we used the 10 principles that guided the creation of the original HHS-HCC diagnostic classification system as finalized in the 2014 Payment Notice[32] and enumerated in section 1.2.1 of this paper. In the 2021 Payment Notice,[33] we also finalized the use of 2016, 2017 and 2018 enrollee-level EDGE datasets to recalibrate the risk adjustment model factors for the 2021 benefit year and adopted a similar recalibration approach (to use the three most recent years of enrollee-level EDGE datasets available) for future benefit year recalibrations, unless changed in rulemaking. Additionally, we continued to make a pricing adjustment for the plan liability simulation for the Hepatitis C RXC.

In the 2022 Notice of Benefit and Payment Parameters (2022 Payment Notice),[34] we finalized the use of 2016, 2017 and 2018 enrollee-level EDGE datasets to recalibrate the risk adjustment model factors for the 2022 benefit year (the same years used to recalibrate the 2021 models), and finalized a policy for the 2022 benefit year and beyond to publish final risk adjustment coefficients using the three most recent years of EDGE data that are available when we publish the proposed Payment Notice for the applicable benefit year. We also continued to make a pricing adjustment for the plan liability simulation for the Hepatitis C RXC.

In the 2022 Payment Notice, we did not finalize several proposed model specification updates that were intended to improve the models' predictive accuracy for certain subpopulations, including incorporation of a two-stage weighted specification in the adult and child models, revisions to the adult models' enrollment duration factors, and the addition of new severity and transplant indicators interacted with HCC count factors in the adult and child models.[35] We discuss these 2022 Payment Notice proposals in greater detail in Chapters 2-5 of this document.

1.4 Predictive Accuracy of the Current HHS Risk Adjustment Models

The predictive accuracy of a risk adjustment model is typically evaluated using predictive ratios (PRs), calculated as the ratio of predicted to actual weighted mean plan liability expenditures. The predictive ratio represents how well the model has done on average at predicting plan liability for that subpopulation. If prediction is perfect, mean predicted expenditures will equal mean actual expenditures, and the PR will be 1.00. Throughout this

CM diagnosis codes. See Potential Updates to HHS-HCCs for the HHS-operated Risk Adjustment Program, June 17, 2019. Available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Potential-Updates-to-HHS-HCCs-HHS-operated-Risk-Adjustment-Program.pdf.

[32] 78 FR 15409.

[33] 85 FR 29164.

[34] 86 FR 24140.

[35] On July 16, 2021 CMS released "Updated 2022 Benefit Year Final HHS Risk Adjustment Model Coefficients". In part 2 of the HHS Notice of Benefit and Payment Parameters for 2022 final rule (2022 Payment Notice), we finalized the risk adjustment models for the 2022 benefit year, but the 2022 benefit year coefficients included in this final rule contained a few errors that impacted certain factors for the adult models. Therefore, consistent with 45 C.F.R. § 153.320(b)(1)(i), we announced the final 2022 benefit year final risk adjustment adult model coefficients that included some minor revisions: https://www.cms.gov/files/document/updated-2022-benefit-year-final-hhs-risk-adjustment-model-coefficients-clean-version-508.pdf.

paper, we present and discuss PRs from our risk score models. The predicted plan liability for an enrollee is their sum of model factors (i.e., risk score). We calculate separate risk scores for each metal level, reflecting differences in actuarial value.[36]

Predictive accuracy is also measured by the R-squared statistic. This statistic reflects the predictive accuracy of the model for variations in individual expenditures, whereas PRs are used to test the performance of the models among subgroups (for example, enrollees in certain age or expenditure categories, and enrollees with and without HCCs). HHS uses both PRs and R-squared statistics to evaluate the HHS risk adjustment models.

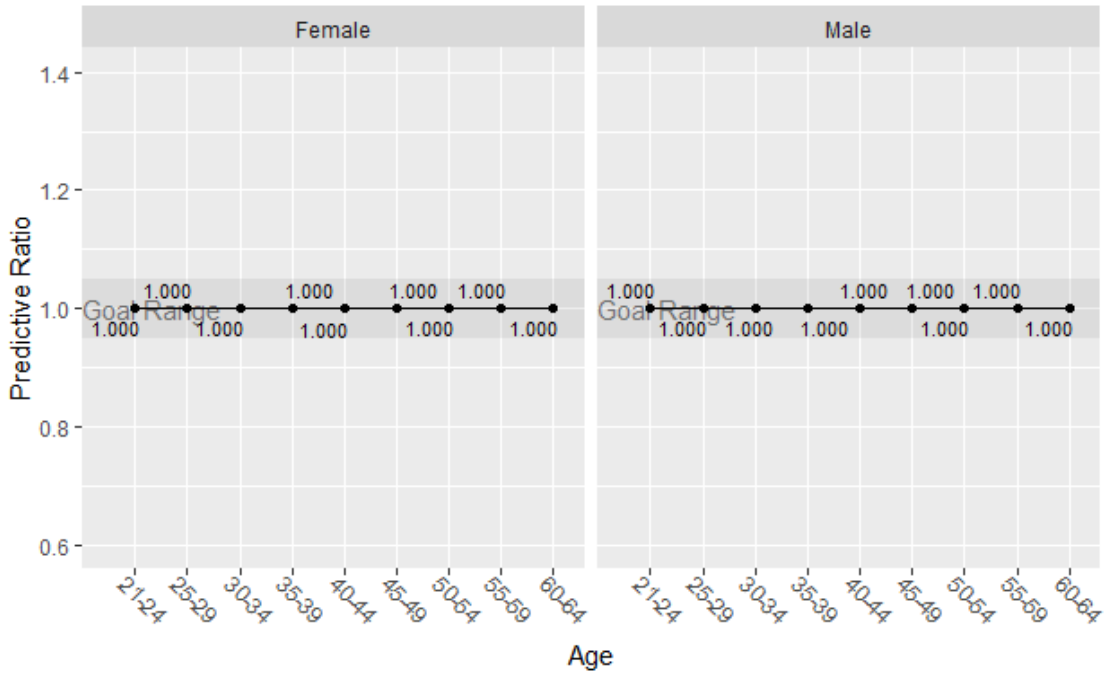
One of the benefits of the current HHS risk adjustment models is that they perfectly predicted mean plan liability expenditure by age-sex factor, HCC or HCC group, RXC, and enrollment duration factor (PRs for all factors included in the model equal exactly 1.00 in the enrollee-level EDGE datasets used for model recalibration).[37,38] The PRs of 1.00 result from a regression that estimates the models to accurately predict mean expenditures for all factors in the regression (i.e., the mean prediction for all variables in the model will equal the actual mean). This perfect prediction can be seen in Figure 1.1.

[36] In Appendix A, we explore PRs that explicitly address differences in induced demand and other factors by metal and CSR, which are included in the risk term of the state payment transfer formula. In particular, some of the PRs in Appendix A include the metal and CSR IDFs. We refer to these as "risk term PRs," since they evaluate the full risk term of the transfer formula.

[37] PRs are also 1 or very close to 1 in validation samples. The PRs calculated in this paper are calculated using the same samples on which the models were calibrated. However, as is common practice in evaluating model fit, we also tested splitting the sample for calibration and validation purposes and the results were unchanged. Further, for purposes of the analysis in this paper, we calculated PRs for at least three data years. The results always appear the same, so we generally only report results in this paper from the 2018 data year, which was the most recently available dataset at the time that we ran these analyses in preparation for announcing the proposals in the proposed 2022 Payment Notice.

[38] There are two exceptions involving RXC variables where the coefficients are constrained such that the PRs are less than 1.0.

Figure 1.1: Adult Silver Plan Model Predictive Ratios by Age-Sex, 2018 Enrollee-Level EDGE Dataset



Despite the predictive accuracy for mean plan liability expenditure in the national calibration sample, some stakeholders have expressed concern that the current risk adjustment models underpredict plan liability for the subpopulation of the lowest-risk enrollees. These stakeholders recommended that CMS address this potential underprediction to prevent a misalignment of incentives that would discourage enrollment of lower risk enrollees relative to higher risk ones and negatively impact the overall health of the risk pool. CMS has continued to consider whether improvements could be made to the predictive accuracy of the risk adjustment models for certain subgroups.[39]

Figure 1.2 shows the predictive ratios for the current adult[40] silver model by decile of mean predicted plan liability expenditure (or "predicted risk") using the 2018 enrollee-level EDGE dataset. We use the silver models in tables and figures throughout this paper, as the silver models apply to the most enrollees, and we generally see similar patterns in the models for the other metal levels. We also focus on the adult models in tables and figures through this paper because the adult models apply to the vast majority of enrollees. Decile 1 represents the lowest decile of predicted risk, 0-10 percent, and decile 10 represents the highest decile of predicted

[39] See, e.g., the 2021 Payment Notice proposed rule, 85 FR at 7101 - 7104 and the 2022 Payment Notice proposed rule, 85 FR at 78582 – 78586.

[40] "Adult enrollees" refers to all adults in the enrollee-level EDGE dataset used to recalibrate the risk adjustment models, which includes adults ages 21-64 without any capitated claims. Adults with capitated claims are excluded from the dataset, as the risk adjustment models are used to evaluate enrollees' expenditures, and capitated claims do not provide meaningful and comparable cost (allowed charges) data in comparison to non-capitated claims for recalibration purposes. We also were concerned that methods for computing and reporting derived amounts from capitated claims could be inconsistent across issuers and would not result in reliable data for recalibration or the analyses in this paper.

risk, 90-100 percent, which we have further segmented into the top 5 percent, 1 percent, and 0.1 percent of predicted expenditures. As seen in Figure 1.2, the current adult models underpredicted plan liability for the lowest-risk enrollees (deciles 1 through 6), overpredicted plan liability for some medium-risk enrollees (decile 8), and underpredicted risk for the highest-risk enrollees (the top 0.1 percent).

Figure 1.2: Adult Silver Plan Model Predictive Ratios by Decile, 2018 Enrollee-Level EDGE Dataset

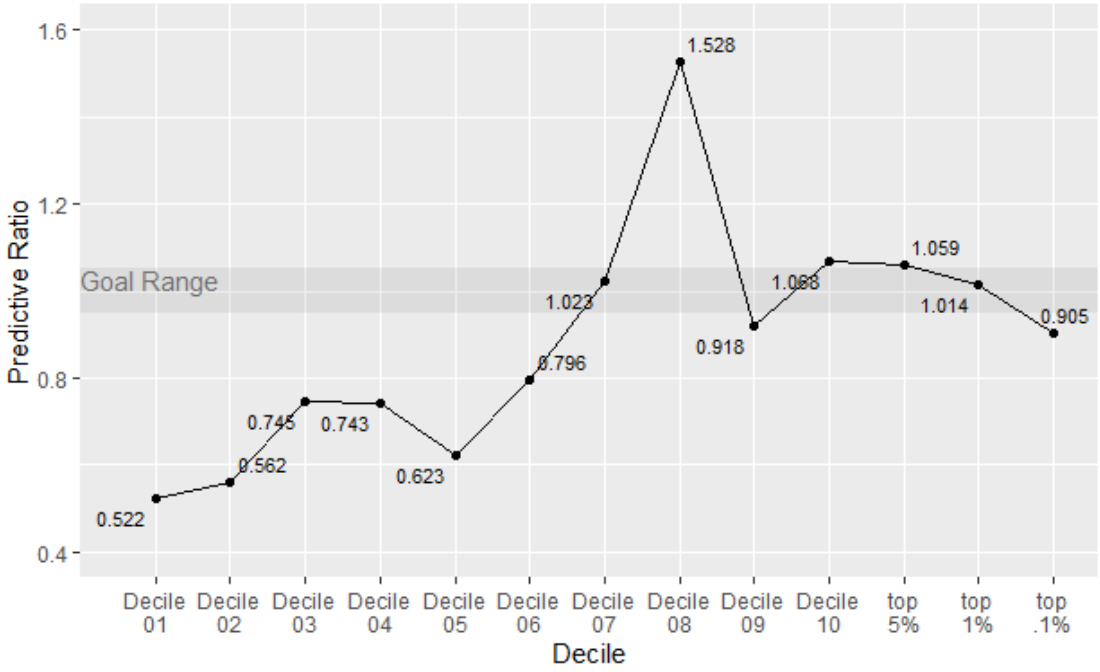


Figure 1.3 shows the risk for enrollees without HCCs in the current adult models was underpredicted, the risk for enrollees with 1 to 5 HCCs tended to be overpredicted, and the risk for enrollees with 7 or more HCCs was underpredicted.

Figure 1.3: Adult Silver Plan Model Predictive Ratios by Number of HCCs, 2018 Enrollee-Level EDGE Dataset

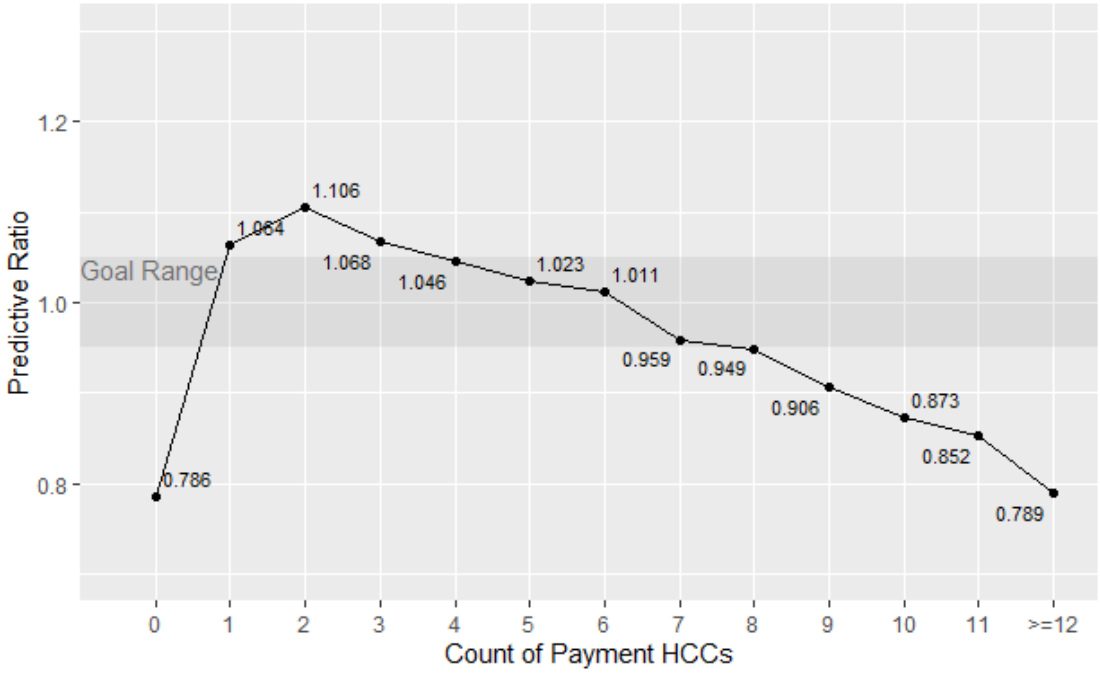
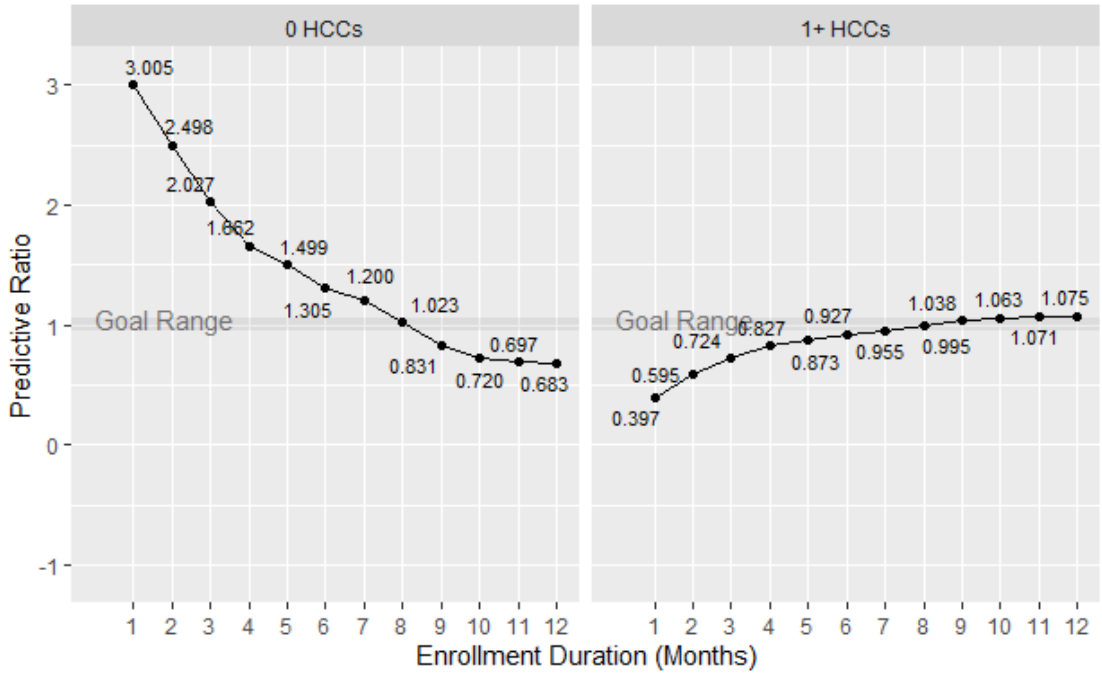


Figure 1.4 shows that the models overpredicted silver plan liability for adult enrollees without HCCs with 1 to 7 months of enrollment and underpredicted silver plan liability for adult enrollees with HCCs with 1 to 6 months of enrollment in the 2018 enrollee-level EDGE dataset. The underprediction among adults without HCCs with 9-12 months of enrollment duration, shown in figure 1.4, is consistent with the broader underprediction of full year enrollees without HCCs, which we discuss in greater detail in Chapter 2.[41]

Figure 1.4 Adult Silver Plan Model Predictive Ratios by Enrollment Duration and Number of HCCs, 2018 Enrollee-Level EDGE Dataset



Although the current models perfectly predicted mean plan liability expenditure in the enrollee-level EDGE data used for model recalibration, continued study and analysis has identified three subpopulations for which the predictive accuracy of the current HHS risk adjustment models could be improved:

1. *Lowest-Risk Enrollees*. The current models underpredicted plan liability for the lowest-risk enrollees (that is, enrollees in low-risk deciles and enrollees without HCCs). The underprediction of the lowest-risk enrollees can be seen in the PRs in the HHS risk adjustment adult models by decile of predicted costs (Figure 1.2) and by number of payment HCCs that the enrollee has (Figure 1.3), using the 2018 enrollee-level EDGE dataset at the silver metal level. As seen in Figure 1.2, the adult models underpredicted the lowest-risk enrollees (risk decile 1) by over 50 percent. The prediction improved mostly monotonically with enrollee risk, with the exception of a substantial

[41] Although 8 months of enrollment is overpredicted, it falls within the goal range of +/- 5 percent (e.g., .95 to 1.05), with a PR of 1.023. Similarly, although 7 and 8 months of enrollment are underpredicted, they fall within the goal range with PRs of .955 and .995 respectively.

overprediction in risk decile 8. As seen in Figure 1.3, the enrollees without HCCs in the adult models were underpredicted, enrollees with 1 to 5 HCCs tended to be slightly overpredicted, whereas enrollees with 7 or more HCCs tended to be somewhat underpredicted. This trend can be seen across all metal levels to varying degrees. Since approximately 80 percent of enrollees in the individual and small group (or merged) markets do not have HCCs, this underprediction applies to a large portion of the risk adjustment population.[42] We did further analysis and found the same patterns, including the underprediction of the enrollees without HCCs, in the child models. [43] Although the model underprediction of lowest-risk enrollees may appear large in percentage terms, it is not large in dollar terms because the lowest-risk enrollees are not costly.

2. *Partial-Year Adult Enrollees.* The current models overpredicted plan liability for partial-year adult enrollees without HCCs and underpredicted plan liability for partial-year (1 to 6 months of enrollment) adult enrollees with HCCs. As described in the proposed 2021 Payment Notice[44] and the proposed 2022 Payment Notice,[45] our analysis of the 2017 and 2018 enrollee-level EDGE datasets found that the current enrollment duration factors are driven by enrollees with HCCs. That is, partial-year enrollees with HCCs had higher PMPM expenditures on average compared to full-year enrollees with HCCs. On the other hand, partial-year enrollees without HCCs did not have substantively different PMPM expenditures compared to full-year enrollees without HCCs. [46]

   We also found that the current factors masked the much stronger relationship between enrollment duration and costs that exists for the small fraction of partial-year enrollees with HCCs. To further illustrate this relationship, Table 1.1 shows the PMPM allowed charges by enrollment duration and by presence of HCCs for adult enrollees, using the 2018 enrollee-level EDGE dataset. Among adults with HCCs, we found that average monthly costs were approximately 3.5 times *higher* (a difference of $3,877 monthly) for adults enrolled for 1 month compared to adults enrolled for 12 months. Among adults

[42] See the Summary Report on Permanent Risk Adjustment Transfer for the 2019 Benefit Year (Figure 3) at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2019.pdf.

[43] The infant models utilize a categorical approach in which infants are assigned a birth maturity (by length of gestation and birth weight) or age 1 category, and a disease severity category (based on HCCs other than birth maturity). There are four Age 0 birth maturity categories--Extremely Immature; Immature; Premature/Multiples; Term--and an Age 1 maturity category. Age 0 infants are assigned to one of the four birth maturity categories and age 1 infants are assigned to the Age 1 maturity category. Our analysis found that the infant models more accurately predicted costs for the lowest-risk infants. The underprediction trends for the lowest-risk adults and children were not observed for infants.

[44] 85 FR 29164 at 29189.

[45] 85 FR 78572 at 78585-78586.

[46] We also explained in the proposed 2021 Payment Notice that we found partial year enrollees in the child models did not have the same risk differences as partial year enrollees in the adult models and they tended to have similar risk to their full year counterparts. See 85 FR at 7103 and 7104. In the infant models, we found that partial year enrollees had higher expenditures on average compared to full-year enrollees; however, the incorporation of enrollment duration factors created interaction issues with the current severity and maturity factors in the infant models and did not have a meaningful impact on the general predictive accuracy of the infant models. Ibid.

without HCCs, however, we found that average monthly costs were 26 percent *lower* (a difference of $46 monthly) for adults enrolled for 1 month compared to adults enrolled for 12 months. Monthly allowed charges generally decreased monotonically with enrollment duration among adult enrollees with HCCs and increased monotonically with enrollment duration among adult enrollees without HCCs. The differences were much more pronounced for shorter enrollment durations (e.g., 1-2 months) than longer enrollment durations (e.g., 11-12 months). Similar relationships held for adults with other partial-year enrollment durations.

Table 1.1: PMPM Allowed Charges by Enrollment Duration and Presence of HCCs (Adult Enrollees), 2018 Enrollee-Level EDGE Dataset

	Adults with HCCs		Adults without HCCs	
Enrollment Duration	**Number of Enrollees (% of all)**	**PMPM Allowed Charges**	**Number of Enrollees**	**PMPM Allowed Charges**
1 month	41,877 (4%)	$5,452	1,051,103	$129
2 months	66,665 (7%)	$3,452	892,311	$132
3 months	86,321 (10%)	$2,753	780,634	$146
4 months	106,445 (12%)	$2,287	764,035	$145
5 months	102,282 (14%)	$2,146	628,808	$152
6 months	106,744 (16%)	$1,994	577,431	$151
7 months	102,756 (17%)	$1,950	501,700	$152
8 months	108,911 (18%)	$1,838	489,152	$154
9 months	104,911 (19%)	$1,760	440,063	$155
10 months	114,432 (20%)	$1,687	453,519	$155
11 months	148,023 (21%)	$1,610	559,719	$159
12 months	2,551,057 (23%)	$1,575	8,583,428	$175

Note: The percentages of number of adult enrollees are row percentages. For example, 4 percent of all enrollees with 1 month of enrollment had an HCC.

As seen in Table 1.1 above, the fraction of partial-year enrollees who had HCCs is small, compared to the approximately 20 percent of the overall population who had HCCs. As compared to the 23 percent of full-year enrollees who had HCCs, only 10 percent of the approximately 5.2 million adults in the 2018 enrollee-level EDGE dataset enrolled for 1 to 6 months had HCCs. However, enrollees with 1 to 6-month enrollment duration factors that had HCCs had PMPM costs that were much higher than full-year enrollees with HCCs. The difference in PMPM costs between enrollees with 1 to 6-month enrollment duration factors who had HCCs and their counterparts without HCCs was even more pronounced. The result is that the current enrollment duration factors, which are estimated using data for partial-year enrollees as a whole, with and without HCCs, reflect an inverse relationship between enrollment duration and costs, resulting in factors fairly close to zero. We further discuss the prediction issues for partial year enrollees, and our consideration of options to improve prediction for this subpopulation, in Chapter 3.

3. *Very Highest-Risk Enrollees.* The current models also underpredicted plan liability for the very highest-risk enrollees (that is, those in the top 0.1 percent risk percentile and those enrollees with the most HCCs). As seen in Figure 1.2 above, the current models underpredicted adult silver plan enrollees' plan liability in the top 0.1 risk percentile by 9 percent. Additionally, as shown in Figure 1.3, enrollees with more than 6 HCCs were underpredicted in the current adult models and, in particular, enrollees with 10 or more HCCs were underpredicted by approximately 17 percent. As discussed above, the models' underprediction of lowest-risk enrollees is not large in dollar terms, because the lowest-risk enrollees are not costly. However, this is not the case for enrollees in the highest deciles of risk. Enrollees in risk decile 10 represent roughly 74.29 percent of actual plan liability, compared to only 1.36 percent for enrollees in risk decile 1. The most expensive enrollees tended to have severe acute illness HCCs. These enrollees were often hospitalized, received ICU care, and were frequently among individuals exceeding the $1 million high-cost risk pool claim threshold.[47] For example, we found that 50 percent of enrollees reaching the $1 million claims threshold have HCC 2 (Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock). These enrollees also tended to have a large number of HCCs that have a non-linear effect on costs, meaning that the actual cost for these enrollees was higher than simply adding the incremental effects of each HCC together. We further discuss the underprediction for the very highest-risk enrollees, and our consideration of options to improve prediction for this subpopulation, in Chapter 4.

1.4.1 Purpose of this Paper

Following our study and consideration of these issues and ways to improve the current models' predictive accuracy for the subpopulations described above, we proposed several model specification changes in the proposed 2022 Payment Notice.[48] We proposed updating the HHS risk adjustment models by adding a two-stage weighted model specification to the adult and child models to weight lower-risk enrollees more heavily, modifying the enrollment duration factors in the adult models to better capture the increased costs of partial-year adult enrollees with HCCs, and adding severity and transplant indicators interacted with HCC counts factors to the adult and child models to better predict costs of the very highest-risk enrollees. After consideration of comments, we did not finalize these proposed model specification updates. However, we reiterated our commitment to continue to consider potential changes to increase the current models' predictive accuracy for these subpopulations and acknowledged stakeholders' desire for additional analyses and information on the proposed model specification updates.[49] In

[47] In the 2018 Payment Notice, we incorporated a high-cost risk pool into the HHS risk adjustment methodology. To account for this high-cost risk pool during recalibration, we exclude a percentage of costs above a certain threshold level (as of the 2022 benefit year, the parameters are set at a $1 million threshold and a coinsurance rate of 60 percent) in the calculation of enrollee-level plan liability risk scores. This ensures that the risk adjustment factors account for risk associated with HCCs and RXCs excluding those extreme costs, because the average risk associated with HCCs and RXCs is better accounted for without inclusion of the high-cost enrollees.

[48] 85 FR 78572 at 78583-86.

[49] 86 FR at 24151 – 24162.

this paper, we describe our detailed analyses of the changes proposed but not finalized in the 2022 Payment Notice.[50]

For the vast majority of the analysis in this paper, we used the 2018 benefit year enrollee-level EDGE dataset to test the model specification changes as this dataset was the most recently available dataset at the time that we ran these analyses in preparation for announcing the proposals in the proposed 2022 Payment Notice. In certain cases, we also used the 2016 and 2017 benefit year enrollee-level EDGE datasets when we were testing model specification changes across data years. Additionally, in limited cases, we used the 2019 benefit year enrollee-level EDGE dataset to run analysis in this paper, such as some testing of the enrollment duration factors, as this dataset has recently become available. Throughout this paper, we prioritized using recent data that would allow us to avoid repeatedly re-running analyses as new datasets became available.

We believe that the information in this paper will assist stakeholders in better understanding these changes as our intention is to re-propose these changes in future rulemaking. Finally, we also share information in Appendix A on the current CSR IDFs in the state payment transfer formula, stakeholder feedback over the years on these factors, and options HHS is evaluating to improve prediction of CSR enrollees' plan liability.[51]

[50] 85 FR 78572 at 78583-86.

[51] As explained in Appendix A, the data and analyses in Chapters 2 – 5 and the forthcoming transfer simulation will not reflect any changes to the CSR IDFs. While we did not propose any changes to the CSR IDFs in the 2022 Payment Notice, we wanted to share information with stakeholders about HHS' ongoing evaluation of these factors. We may propose changes to these factors for future benefit years and would seek stakeholder feedback on any such changes in a future rulemaking.

Chapter 2: Improving the Models' Predictive Accuracy for Lowest-Risk Enrollees – Two-Stage Weighted Approach

This chapter focuses on the underprediction of risk for the lowest-risk enrollee subpopulations – enrollees without HCCs[52] and low-cost enrollees[53] – in the current HHS risk adjustment models. This chapter also discusses our consideration of options to improve the models' predictive accuracy for these subpopulations. Specifically, this chapter explores our considerations that informed the proposed two-stage weighted approach in the proposed 2022 Payment Notice, and provides analyses on the impact of the two-stage weighted approach.

2.1 Current Models' Prediction of Costs for Lowest-Risk Enrollees

As described in Chapter 1, risk adjustment uses models to predict costs based on certain identifying characteristics of a population. In the HHS risk adjustment models, enrollee risk scores are determined by age, sex, health conditions (as indicated by certain diagnoses and, for adult enrollees, prescription drugs), and enrollment duration (for adult enrollees), and are used to predict health expenditures for each metal level. This modeling process works well for an average person within each level of each risk adjustment model factor cell. To the degree a risk adjustment factor's population costs widely vary within the same factor, and plan enrollee costs deviate significantly from the population average, the factor may not precisely predict the health risk across all plan enrollees.

Risk scores for enrollees without HCCs are mainly influenced by the applicable age, sex and enrollment duration factors in the current HHS risk adjustment models.[54] These age, sex and enrollment duration (if applicable) factors serve two functions:

(1) They represent the prediction of plan liability for the approximately 80 percent of enrollees without HCCs ("lowest-risk"); and

(2) They represent a portion of the prediction of plan liability for the approximately 20 percent of enrollees with HCCs ("highest-risk"), with the remaining portion consisting of the liability associated with health conditions.

For all coefficients, we use least squares estimates of the HHS risk adjustment models that balance the fit in these two populations. This constraint affects the age, sex and enrollment duration (if applicable) factors. In particular, looking at enrollees without HCCs separately, the least squares estimates of the age-sex factors would mean that these factors would almost entirely predict plan liability for these enrollees. Considering the highest-risk enrollees separately, the least squares estimates would jointly optimize the age-sex factors and the highest-risk enrollees' HCC coefficients to achieve the best fit. For the highest-risk enrollees, this results

[52] When we refer to the enrollees without HCCs, we are referring to enrollees without payment HCCs throughout this paper.

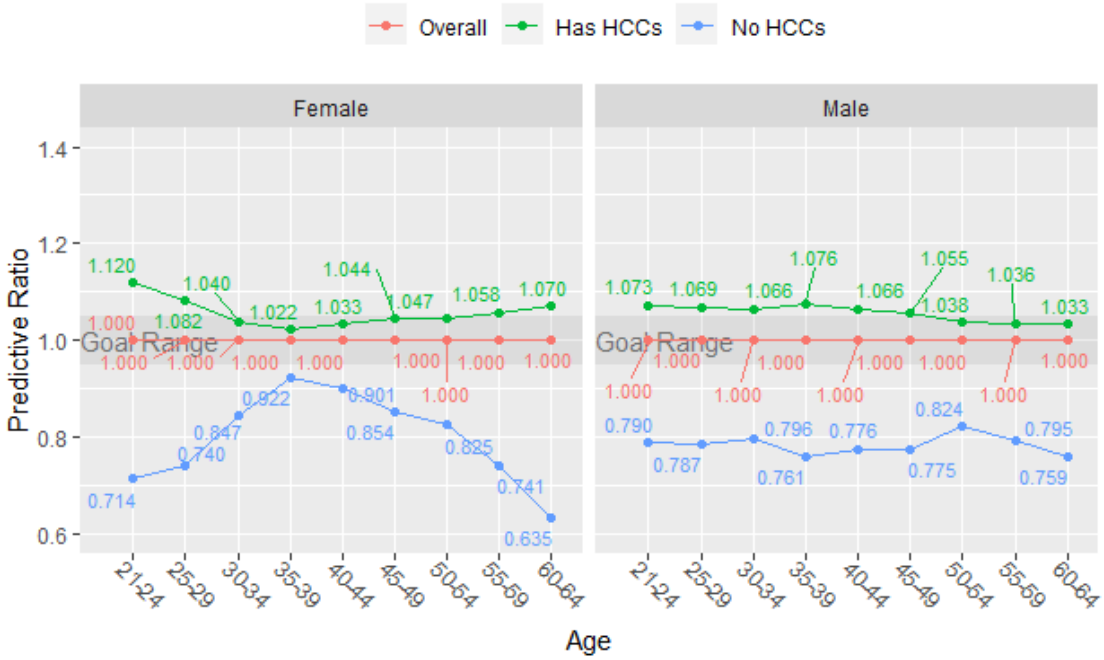
[53] We define low-cost enrollees based on enrollees in the lower deciles of predicted plan liability, which is different than considering enrollees based on HCCs. Assessing the impact of model specification changes based on payment HCCs would yield a different result than assessing the impact of model specification changes based on prediction deciles because of the presence of outliers in prediction deciles.

[54] Adult enrollees without HCCs can have RXC factors, but this is uncommon. Outside of the regression model, adult, child and infant enrollees may also have a CSR adjustment factor.

in age-sex factor estimates that are very small and are less than mean plan liability by age-sex (and may even be negative). The age-sex factor estimates the average of the higher plan liability estimates for the lowest-risk enrollees with the lower plan liability estimates for the highest-risk enrollees, resulting in a combined estimate for the entire population. Therefore, because plan liability for the lowest-risk enrollees (e.g. enrollees without HCCs and low-cost enrollees) is almost entirely comprised of age-sex factors that are averaged across a population that includes the highest-risk enrollees, the average plan liability of the lowest-risk enrollees is underpredicted by the HHS risk adjustment models.

To illustrate how model predictions of plan liability by age-sex factor work, we calculated three sets of PRs for the age-sex factors. First, we calculated PRs for each age-sex factor for all enrollees; second, we calculated PRs for each age-sex factor for enrollees without HCCs; third, we calculated PRs for each age-sex factor for enrollees with HCCs. Figure 2.1 shows that the current adult models underpredict the risk by age-sex category for enrollees without HCCs, overpredicts the risk by age-sex category for enrollees with HCCs (1+ HCCs), but accurately predicts average risk overall by age-sex category when combining both enrollees with and without HCCs.

Figure 2.1: Adult Silver Plan Model Predictive Ratios by Age-Sex, 2018 Enrollee-Level EDGE Dataset



By addressing the underprediction of costs associated with lowest-risk enrollees (enrollees without HCCs and low-cost enrollees) in the risk adjustment models, we expect to encourage retention and entry into the individual and small group (including merged) markets by plans that enroll a higher proportion of this subpopulation of enrollees. These plans are at greater risk of exiting the market if risk adjustment payments or charges undercompensate for the true plan liability of the lowest-risk enrollees. By taking steps to improve the models' ability to predict the true costs for these enrollees, we hope to improve incentives for issuers to create

plans that encourage these individuals to enroll in coverage and improve the individual and small group (including merged) market risk pools. Therefore, in the proposed 2022 Payment Notice, we proposed to update the adult and child models by adding a two-stage weighted model specification to weight lowest-risk enrollees more heavily. The discussion that follows in Section 2.2 outlines options we considered to improve the current models' predictive accuracy for the lowest-risk enrollees. Section 2.3 provides analyses on the impact of the two-stage weighted approach.

2.2 Improving Prediction for Lowest-Risk Enrollees – Two-Stage Weighted Model Specification

Since 2016, we considered a variety of different options to address the underprediction of plan liability for lowest-risk enrollees in various Payment Notices[55] and shared our concerns about the limitations of many of these options. For example, in the 2018 Payment Notice, we explored the creation of two separate age-sex factors in the adult models for enrollees with and without HCCs to address the models' underprediction of costs for the lowest-risk enrollees.[56] However, upon further analysis, we found that since the estimated "high-risk" age-sex factors (meaning the age-sex factors for enrollees with HCCs) contribute substantially less to the overall risk coefficient than do the estimated "low-risk" age-sex factors (meaning the age-sex factors for enrollees without HCCs), the sum of the "high-risk" age-sex factor and the HCC factor(s) for a "high-risk" enrollee could be less than if that enrollee had instead been given just the "low-risk" age-sex factor. In other words, the predicted cost for a high-risk enrollee could be lower than the predicted cost for a low-risk enrollee of the same age and sex. Or, put another way, predicted cost could fall for a low-risk no-HCC enrollee when the enrollee acquires an HCC diagnosis. This lacks face validity and violates the principles of risk adjustment by penalizing issuers for reporting additional conditions.

We also considered adding a non-linear term to the adult and child models to allow greater flexibility in our model specification and improve the fit of our model to non-linear data.[57] While the non-linear approach appeared to at least partially address the underprediction of the lowest-risk enrollee subpopulations, it would result in very different model factor estimates and involved somewhat complex transformations of coefficients to obtain estimates of the marginal effects of the HCC on costs. In addition, the need to explain and justify a fundamentally different model structure is a significant disadvantage, especially when compared to the simplicity of the standard linear regression framework used for the current model framework, which is widely understood and accepted, making it easier for issuers to use in rate setting. Further, the non-linear modeling approach faced operational challenges in achieving consistent convergence of iterative estimates.

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[55] See 81 FR 94058 at 94082-94084, 85 FR 7088 at 7101-7104, and 85 FR 29164 at 29188-29190.
[56] 81 FR 94058 at 94083.
[57] 85 FR 29164 at 29188- 29190. We also discussed using a non-linear and full counts model in the Potential Updates to HHS-HCCs for the HHS-operated Risk Adjustment Program paper, available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Potential-Updates-to-HHS-HCCs-HHS-operated-Risk-Adjustment-Program.pdf.

In addition to the non-linear approach, we investigated an HCC counts approach similar to that implemented in the Medicare Advantage risk adjustment models beginning with Calendar Year 2020.[58] While adoption of a full HCC counts approach for the HHS risk adjustment models for the individual and small group (including merged) markets would improve prediction for the very highest-risk enrollees, it raised concerns of gaming wherein issuers may be incentivized to code additional HCCs to increase the enrollee's HCC count and thus increase their risk adjustment payment (or reduce their charge). Also, similar to the non-linear approach, we found that the full HCC counts approach would result in very large model coefficient changes. These concerns led us to not prefer the full HCC count approach in the policy context of the HHS risk adjustment models.[59]

After consideration of the aforementioned approaches, we wanted to consider an alternative that would limit the number of changes to the current models to promote stability, mitigate gaming concerns, and minimize issuer burden with regard to rate setting. As a result, we focused on weighting the calibration sample observations in model estimation to prioritize improved accuracy of predictions for the lowest-risk enrollee subpopulations. The process that we considered consisted of two stages. The first stage involved estimating the current models to predict plan liability, then using those predicted values to create a set of weights calculated as the inverse of predicted plan liability, such that observations with lower predicted plan liability had higher weights. These weights were then used in a second stage regression to weight each observation to re-estimate predicted values of plan liability, outputting the coefficients for the final HHS risk adjustment models. We refer to this process as the "two-stage weighted approach."[60]

The conceptual reasoning for the two-stage weighted approach is to retain the simple, linear, additive structure of the current models while forcing the models to better predict costs for lowest-risk enrollees. The two-stage weighted approach would address the HHS risk adjustment models' underprediction for this subpopulation and thereby improve model calibration across deciles of predicted expenditures. Recognizing that the reciprocal weighting by predicted expenditures is not a usual or standard procedure in risk adjustment,[61] we are supplementing the explanation of the two-stage weighted approach in the proposed 2022 Payment Notice with this Technical Paper to explain our analysis of the two-stage weighted approach and its impact on the risk adjustment models and transfers calculated under the state payment transfer formula. As detailed in the proposed 2022 Payment Notice and outlined further below, our analysis found the gains in model performance outweigh the potential drawbacks.

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[58] See pages 22-26 of the Report to Congress: Risk Adjustment in Medicare Advantage (December, 2018) available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/RTC-Dec2018.pdf. Also see: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2020Part1.pdf.

[59] As we discuss in Chapter 4, we found that an interacted HCC counts model specification mitigates these gaming concerns and improves prediction compared to the current model, including for the lowest-risk enrollees (enrollees without HCCs and low-cost enrollees).

[60] Although there are two stages in the proposed model, the two-stage weighted model should not be confused with two-stage least squares (2SLS) techniques used to analyze structural equations.

[61] For example, Medicare Advantage does not use a two-stage weighting in its model recalibration.

To develop this approach, we considered a variety of weights for the HHS risk adjustment model estimation. Because all of our risk markers (regressors) are binary variables, but a weight variable needs to be continuous, it was natural to consider functions of the aggregation of the risk markers into predicted cost as regression weights. Since we want to reweight the higher risk individuals with higher predicted cost, we considered the reciprocal of functions of predicted cost as weights. We also considered the reciprocal of predicted cost raised to powers ranging from zero (equal weighting) to 2, in increments of 0.5. This series included the reciprocal of the square root of predicted cost (exponent = 0.5), the reciprocal of predicted cost (exponent = 1.0), the reciprocal of the predicted cost times the reciprocal of the square root of predicted cost (exponent = 1.5), and the reciprocal of the square of predicted cost (exponent = 2.0). We also considered the reciprocal of the natural logarithm of predicted cost.

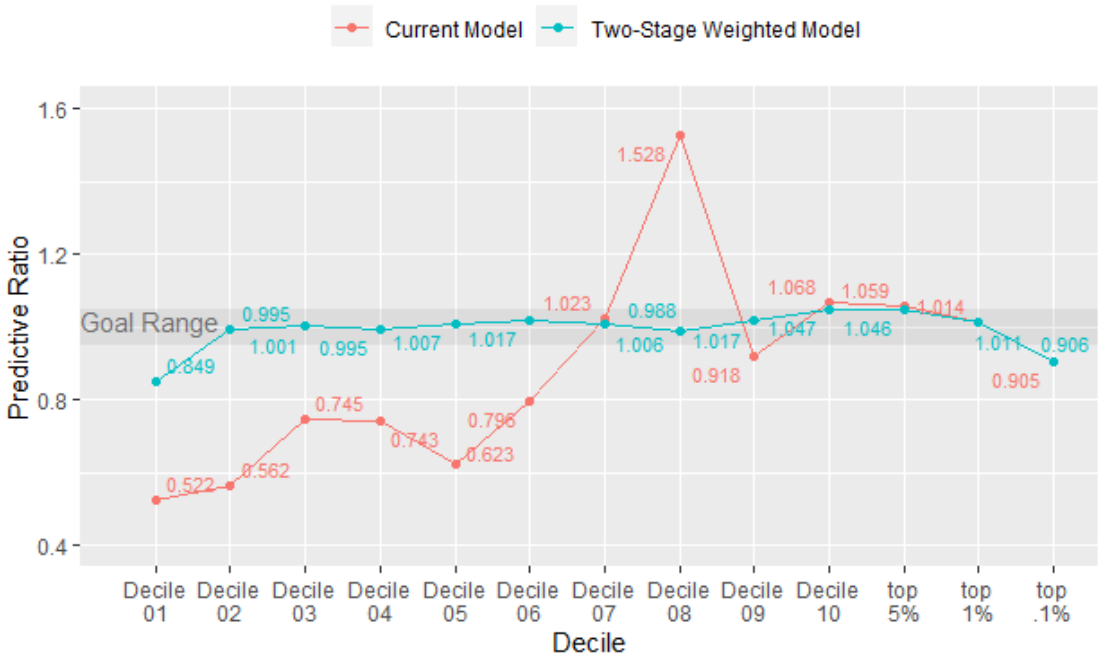
We created weighted least squares estimates of the HHS risk adjustment adult and child models using each of the series of weights, and computed PRs for each estimated model. We evaluated the models based on their PRs, particularly examining lower predicted expenditure deciles. We found that weighting factors by the reciprocal of predicted cost best achieved the objective of improving the prediction for the lowest-risk enrollee subpopulations. Further, we found that capping predicted cost at its 2.5th and 97.5th percentiles in the adult model and the 2.5th and 99.5th percentiles in the child models avoided excessively large or small weights for any observations, and improved the model fit. We multiplicatively combined this new weighting factor with the existing enrollment duration fraction weight[62] to form our final regression weight. Using this final structure for the two-stage weighted approach, we further considered the impacts of the two-stage weighted model specification.

[62] The eligibility fraction is person-specific weight where the number of months enrolled is divided by 12.

2.3 Impact of the Two-Stage Weighted Approach

As part of our consideration of the two-stage weighted approach, we considered its impact on a variety of different subpopulations and other trade-offs. The main purpose of the two-stage weighted approach is to improve prediction of the current models among lower-risk enrollees, which the two-stage weighted approach achieves. As seen in Figure 2.2, using the 2018 enrollee-level EDGE dataset, the two-stage weighted approach improves the PRs of the lower deciles compared to the current models. Similar results can be also seen when using the 2016 and 2017 EDGE data. Figure 2.2 also shows that the two-stage weighted approach eliminates the overprediction observed in risk decile 8 and slightly reduces the overprediction observed in risk decile 10.

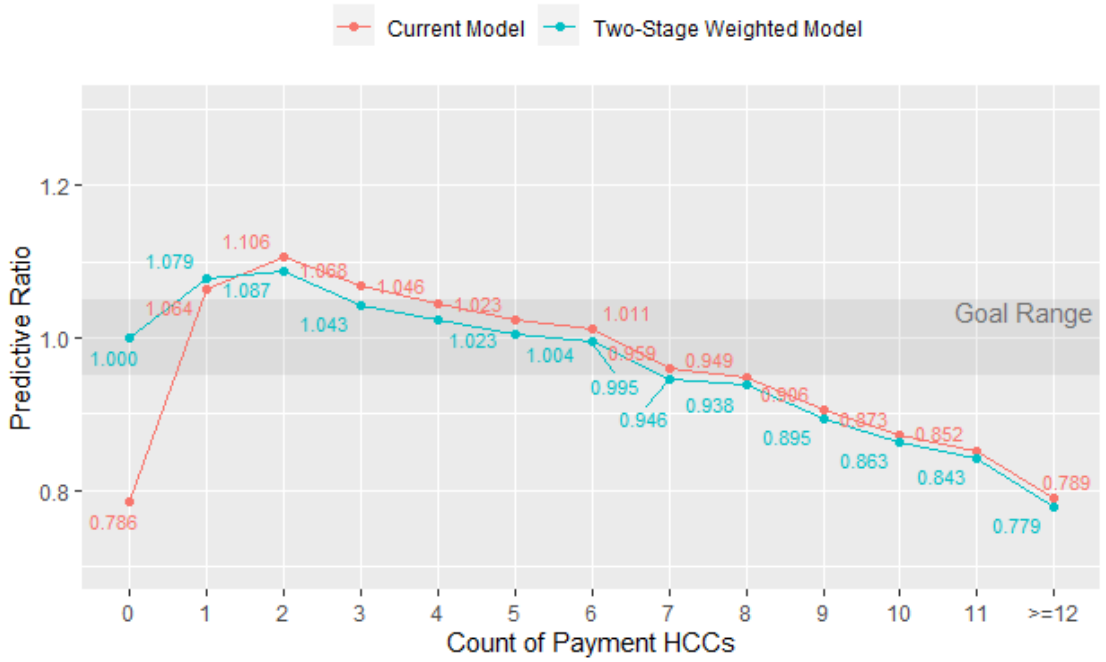
Figure 2.2 Adult Silver Plan Model Predictive Ratios by Decile, 2018 Enrollee-Level EDGE Dataset[63]



[63] In isolation from other model changes, the two-stage weighted approach overpredicts plan liability across the entire sample by 3.6 percent and, when combined with the other model specification changes outlined in Chapters 3 and 4, overpredicts the entire sample by 1.16 percent. Due to this limited impact and for simplicity in understanding the results and analyses shared in this paper, the risk scores and PRs for the two-stage weighted approach and the combined approach discussed in Chapter 5 are not normalized to be 1.00.

We also found that the two-stage weighted approach improves the PRs for enrollees without HCCs, as seen in Figure 2.3. The PRs for enrollees with 1, 2, or any other number of HCCs are only slightly affected by the two-stage weighting approach.

Figure 2.3: Adult Silver Plan Model Predictive Ratios by Number of HCCs, 2018 Enrollee-Level EDGE Dataset



After considering these gains in improved prediction for the lowest-risk enrollees (enrollees with no HCCs and low-cost enrollees), we also considered whether the two-stage weighted approach worsens the fit of the model along other dimensions. We identified three key areas where the two-stage weighted approach worsens the fit of the applicable model for certain subpopulations. First, as seen in Figure 2.4, the two-stage weighted approach predicts plan liability by age-sex factor less accurately than the current model, especially for younger and older women. Overall, we considered this to be an acceptable trade-off because across all age and sex factors, most PRs were within a tolerable threshold of +/– 5 percent (e.g., 0.95 to 1.05) and as seen Figure 2.5, the two-stage weighted approach had the major benefit of more accurately predicting the age-sex factors for the enrollees without HCCs, which is a much larger population than the enrollees with HCCs.

Figure 2.4: Adult Silver Plan Model Predictive Ratios by Age-Sex Factor, 2018 Enrollee-Level EDGE Dataset

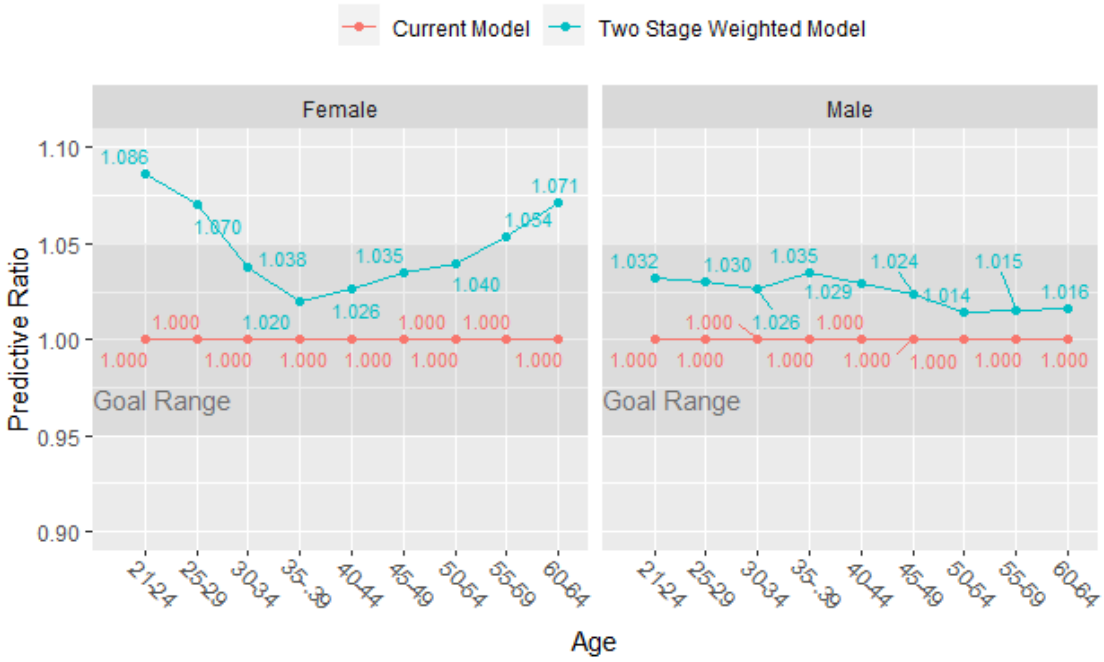
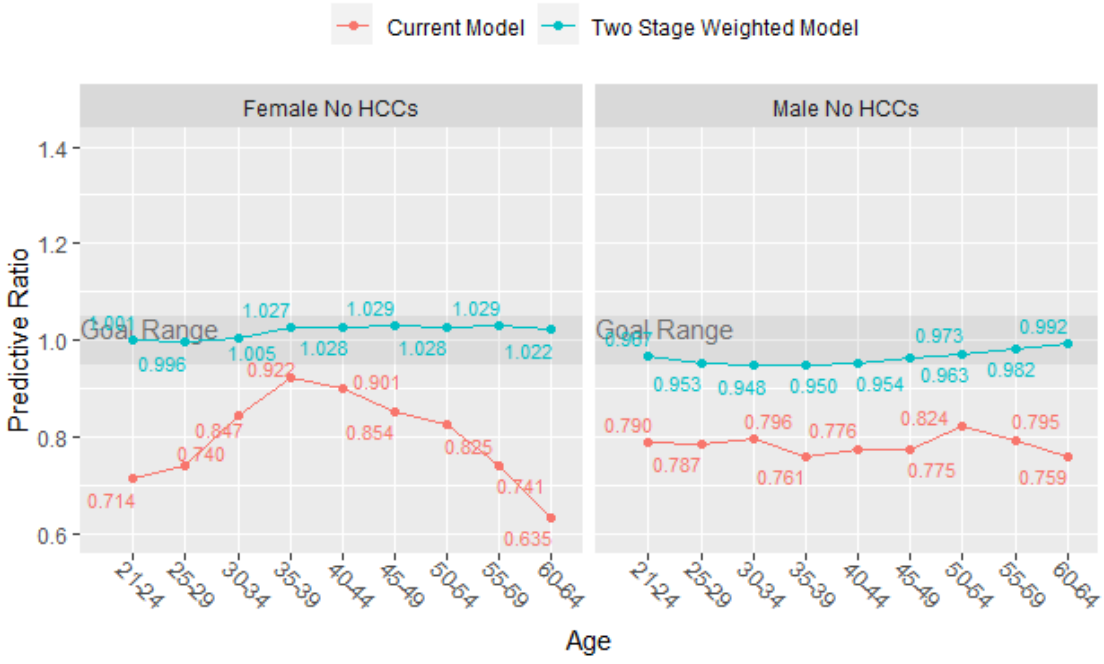


Figure 2.5: Adult Silver Plan Model Predictive Ratios by Age-Sex Factor for Enrollees without HCCs, 2018 Enrollee-Level EDGE Dataset



Second, the two-stage weighted approach is less accurate at predicting costs for certain HCCs, as seen in Table 2.1. The two-stage weighting worsened the adult model PRs by at least

5 percent in 14 (out of 91) ungrouped HCCs and 3 (out of 18) HCC groups.[64] Again, we considered this reduced accuracy to be an acceptable trade-off because most of the PRs for the two-stage weighted approach remained within a tolerable threshold of +/– 5 percent (e.g., 0.95 to 1.05), most enrollees do not have HCCs, and the two-stage weighted approach predicts plan liability better for those enrollees.

Table 2.1 HCCs and HCC Groups Whose PR in the Silver Metal Level Adult Models Worsens by at least 5 Percentage Points (pp) Under the Two-Stage Weighted Approach, 2018 Enrollee-Level EDGE Dataset

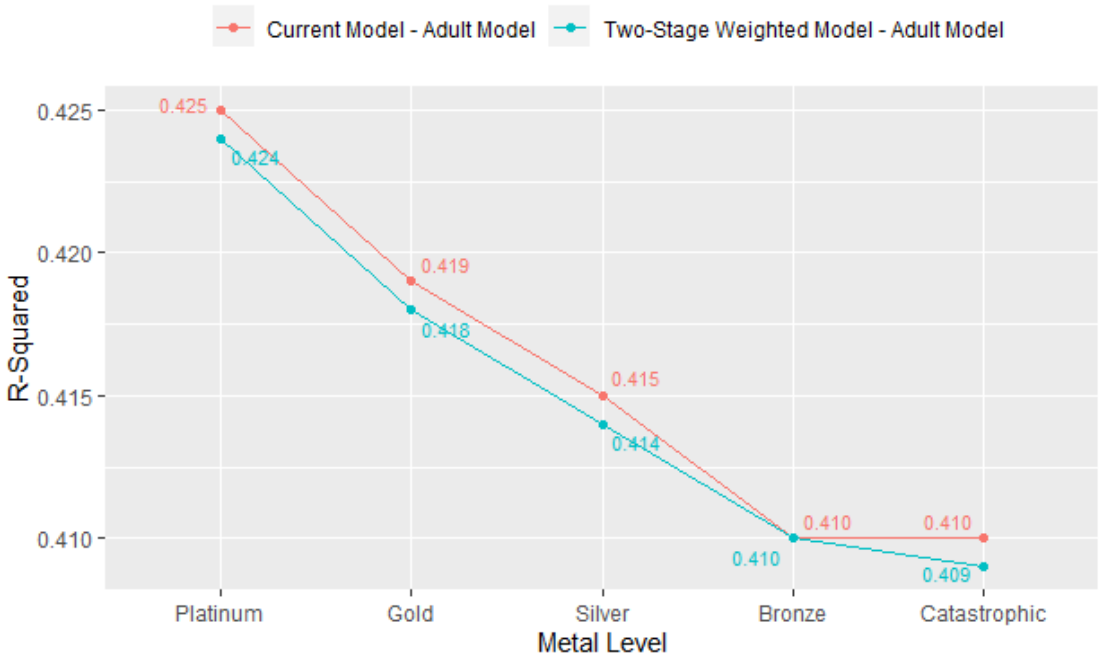
Category	*Label*	*PR*	*pp Difference*
HCC 30	Adrenal, Pituitary, and Other Significant Endocrine Disorders	0.948	5.2
HCC 63	Cleft Lip/Cleft Palate	0.944	5.6
HCC 75	Coagulation Defects and Other Specified Hematological Disorders	0.936	6.4
HCC 87_2	Delusional and Other Specified Psychotic Disorders, Unspecified Psychosis	0.943	5.7
HCC 94	Anorexia/Bulimia Nervosa	0.938	6.2
HCC 97	Down Syndrome, Fragile X, Other Chromosomal Anomalies, and Congenital Malformation Syndromes	0.907	9.3
HCC 102	Autistic Disorder	0.889	11.1
HCC 112	Quadriplegic Cerebral Palsy	1.145	14.5
HCC 142	Specified Heart Arrhythmias	0.942	5.8
HCC 151	Monoplegia, Other Paralytic Syndromes	0.949	5.1
HCC 210	(Ongoing) Pregnancy without Delivery with Major Complications	1.059	5.9
HCC 211	(Ongoing) Pregnancy without Delivery with Complications	1.074	7.4
HCC 212	(Ongoing) Pregnancy without Delivery with No or Minor Complications	1.105	10.5
HCC 219	Major Skin Burn or Condition	0.925	7.5
G07A	Sickle Cell Anemia/Beta Thalassemia	0.926	7.4
G17A	Miscarriage	1.089	8.9
G21	Congenital Heart/Circulatory Disorders	0.896	10.4

Third, the two-stage weighted approach had slightly lower R-squared values compared to the current models. As seen in Figure 2.6, there is a minor decrease in the R-squared using the two-stage weighted approach compared to the current models. The decrease in R-squared is at most 0.1 percentage points for all metals. Similar to the worsening of the age-sex cell and the HCC PRs, we were not concerned about the lower R-squared as the reduction in fit was minor at

[64] For the vast majority of HCCs, the impact is very small and most affected HCCs or HCC groups have very small sample sizes. For example, only one HCC or HCC group in Table 2.1 was present in greater than 1 percent of the enrollees in the 2018 enrollee-level EDGE dataset (HCC 142 *Specified Heart Arrhythmias*). All other HCCs in the table had recalibration dataset frequencies of less than 0.5 percent of enrollees.

all metal levels and the two-stage weighted approach better predicts plan liability for enrollees with no HCCs, which is the majority of enrollees.

Figure 2.6 Comparison of the R-squared Statistic in the Current Adult Model vs. the Two-Stage Weighted Approach, 2018 Enrollee-Level EDGE Dataset



After considering this analysis and the impact on model performance, including the impact on the models' PRs and R-squared statistics, we determined that the two-stage weighted approach does not have material unintended consequences in model performance along other dimensions.

As previously discussed, one of the key benefits of the two-stage weighted approach, which is conducted during recalibration, is that it does not require changes to the number and type of factors in the HHS risk adjustment models and does not add additional complexity to the models. We also found that the two-stage weighted approach did not meaningfully change the coefficients for most HCCs, unlike the non-linear and full HCC counts approaches. For these reasons, we found that the trade-offs in model improvement for the lowest-risk enrollee subpopulations were worth slightly worsening the model fit in other areas. As described in later chapters of this paper, we are also considering other changes to improve model fit for other subpopulations, which would offset the reduction in R-squared and many of the worsened PRs from the two-stage weighted approach.

The two-stage weighted approach effectively eliminates underprediction for the lowest-risk enrollees.[65] The two-stage weighted approach also effectively eliminated overprediction for

[65] As we discuss in Chapter 4, we are considering a separate approach to improve the models' predictive accuracy for the very highest-risk enrollees.

partial-year adult enrollees without HCCs (e.g., enrollees in risk decile 8 as seen in Figure 2.2). It does so because it turns the estimates of the current enrollment duration factors to all be (slightly) negative, reducing their overprediction. This is not a particularly desirable solution, however, because it does not address, and even exacerbates, the underprediction for partial-year adult enrollees with HCCs. For example, the underprediction for adult silver enrollees with HCCs and with 1 to 3 months of enrollment increases from 37 percent to 40 percent.[66] Chapter 3 addresses prediction issues with the current enrollment duration factors, including options to improve predictive accuracy for partial-year adult enrollees.

2.4 Conclusion

In conclusion, we have considered a variety of different options to improve the models' predictive accuracy for the lowest-risk enrollees (that is, enrollees without HCCs and low-cost enrollees), including creation of separate age-sex factors for enrollees with and without HCCs, a non-linear approach, a full HCC counts approach, and the two-stage weighted approach. We determined that the two-stage weighted approach can improve prediction for the lowest-risk enrollees with limited trade-offs in other parts of the models' performance.

[66] As we discuss in Chapter 3, we are considering a separate approach to improve the models' predictive accuracy for partial-year adult enrollees.

Chapter 3: Improving the Models' Predictive Accuracy for Partial Year Enrollees – Enrollment Duration Factors

This chapter describes the current enrollment duration factors in the adult models and discusses potential future changes to these factors, including the proposed 2022 Payment Notice updates to the enrollment duration factors. We also review our testing of other options for the enrollment duration factors.

3.1 Background on the Enrollment Duration Factors[67]

Partial-year enrollment has been common in both the individual and small group (including merged) markets since at least the establishment of the Exchanges, if not earlier. As seen in the comparison of several years of enrollee-level EDGE datasets in Table 3.1 below, for the 2016 benefit year, 50 percent of adult enrollees had fewer than 12 months of enrollment.[68] This percentage has been decreasing over time; for the 2019 benefit year, 41 percent of all adult enrollees had fewer than 12 months of enrollment.

Table 3.1: Adult Enrollment Duration, 2016–2019 Enrollee-Level EDGE Datasets

	2016 EDGE		2017 EDGE		2018 EDGE		2019 EDGE	
1 month	1,491,672	7%	1,307,825	6%	1,092,995	6%	1,054,267	6%
2 months	1,138,150	5%	1,073,182	5%	958,999	5%	875,051	5%
3 months	1,054,764	5%	990,728	5%	866,983	4%	817,502	4%
4 months	960,115	5%	907,115	4%	870,519	4%	793,369	4%
5 months	825,593	4%	787,706	4%	731,123	4%	704,162	4%
6 months	769,669	4%	726,128	4%	684,214	4%	653,851	3%
7 months	707,122	3%	658,367	3%	604,500	3%	576,350	3%
8 months	666,268	3%	626,809	3%	598,107	3%	555,080	3%
9 months	664,113	3%	586,373	3%	545,014	3%	510,879	3%
10 months	1,037,162	5%	857,849	4%	567,996	3%	491,573	3%
11 months	1,215,181	6%	1,052,204	5%	707,796	4%	628,111	3%
12 months	10,507,809	50%	11,161,412	54%	11,135,210	58%	11,059,922	59%

To develop the current enrollment duration factors for the adult models, as we discussed in the 2016 Risk Adjustment White Paper,[69] we reviewed the annualized predicted expenditures, actual expenditures, and PRs by enrollment duration groups (for each: 1 month, 2 months, and so

[67] See supra note 46 for a summary of our analysis with respect to use of enrollment duration factors in the child and infant models. Also see 85 FR at 7103 and 7104. Our current focus is similarly on the adult models and improving prediction of risk for partial-year adult enrollees.

[68] If an enrollee is enrolled in non-calendar year small group coverage, as long as they remain with the same issuer throughout the benefit year, they will be considered a full-year enrollee. This is true even if they switch plans, as long as they remain with the same issuer. However, if they switch to a plan with a different issuer, they will be considered a partial-year enrollee due to data limitations that prevent HHS from knowing that they are the same enrollee with full coverage throughout the benefit year who just switched issuers between plan years.

[69] See pages 35-39 of the March 2016 Risk Adjustment Methodology White Paper (March 24, 2016), available at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf.

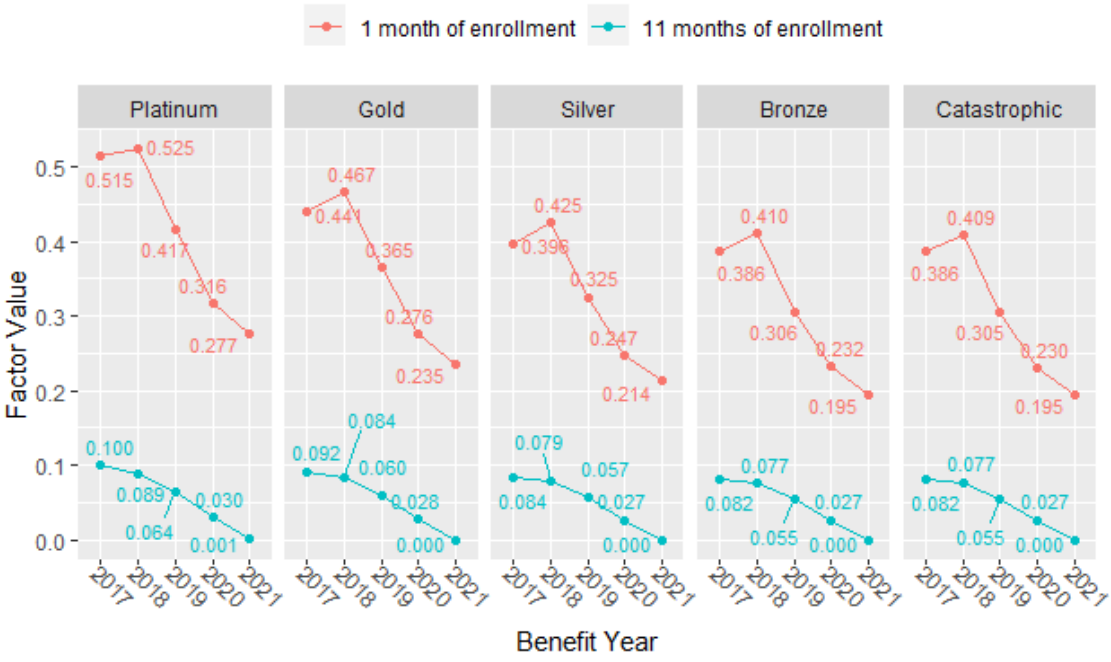
on up to 12 months) for our risk adjustment concurrent modeling sample, which was made up of adults in the 2014 MarketScan® data. We found that actuarial risk for adult enrollees with short enrollment periods tended to be underpredicted in our methodology, and actuarial risk for adult enrollees with full enrollment periods (12 months) tended to be overpredicted.

Many commenters to the 2016 White Paper expressed a preference for adding enrollment duration binary indicator variables (indicating enrollment duration of: 1 month, 2 months, and so on up to 11 months[70]) as additional risk factors, as opposed to creating separate models based on enrollment duration. After reviewing this feedback, we proposed and finalized in the 2018 Payment Notice that, beginning for the 2017 benefit year, the adult models would include enrollment duration factors that apply to all adults with partial-year enrollment.[71] Although the value for the factors change from year to year due to the annual model recalibration, we have not made changes to the structure of the enrollment duration factors since they were first adopted.

The values for the enrollment duration factors have generally decreased since they were first introduced to the HHS-operated risk adjustment adult models for the 2017 benefit year, reflecting a reduced impact of enrollment duration on risk scores of partial year enrollees. After a slight increase between 2017 and 2018, the factors have decreased significantly from 2018 to 2021, and in some cases (the 10- and 11-month factors) the factors are now 0.000, relative to a 12-month enrollment baseline.[72] Figures 3.1 and 3.2 below show the change in the values of the 1-month and 11-month enrollment duration factors over time. The values of the 2- through 10-month enrollment duration factors show a similar decrease over the same timeframe.

[70] Twelve months is the reference group and therefore is not included.
[71] 81 FR 94058 at 94071 – 94074.
[72] In unconstrained models, these factors are negative; therefore, we constrained them to zero because we do not believe negative enrollment duration factors are appropriate, as this would create inappropriate incentives.

Figure 3.1: 1- and 11-Month Enrollment Duration Factors, 2017–2021



The decline in the value of the enrollment duration factors occurred while HHS transitioned from using MarketScan® data to using enrollee-level EDGE data for the annual recalibration of the risk adjustment models, a transition which began for the 2019 and 2020 benefit year recalibrations, and was completed for the 2021 benefit year recalibration. The availability of enrollee-level EDGE data enabled HHS to further analyze this decline and begin to consider potential changes to how we account for partial-year enrollment in the adult risk adjustment models.

As described in section 1.4, the current enrollment duration factors, which are estimated on all partial-year enrollees (with and without HCCs), have factors fairly close to zero. The largest value for the enrollment duration factors in the 2021 benefit year models are around 0.200. These coefficients reflect a weak relationship between enrollment duration and costs when estimating the relationship using enrollees with and without HCCs and controlling for all other variables in the 2021 models. The weak relationship masks the different relationships between enrollment duration and costs that exist for partial-year enrollees with HCCs and partial-year enrollees without HCCs. In particular, there is a strong negative relationship between enrollment duration and costs[73] for enrollees with HCCs which is offset by a weak positive relationship between enrollment duration and costs for enrollees without HCCs.

While we are not certain why enrollment duration is only inversely related to monthly costs among adults with HCCs, the most plausible hypothesis is that medical treatment for many

[73] In the risk adjustment models, costs (or expenditures) are annualized, meaning that an enrollee who incurs $5,000 of costs in 5 months would have annualized costs of (12/5)*$5,000 = $12,000. The negative relationship between enrollment duration and costs discussed in this section is predicated on this annualization.

HCC diagnoses likely has a "fixed cost" element that does not vary with the number of months of enrollment. This fixed cost gets spread over a larger number of months as enrollment duration increases, decreasing average monthly expenditures. This is particularly true for acute or time-limited HCCs (e.g., HCC 212 (Ongoing) Pregnancy without Delivery with No or Minor Complications), including HCCs implying definitive surgical treatment. For example, a 1-month enrollee with an HCC likely had active treatment for, or influenced by, that HCC in their 1 month of enrollment. Conversely, a 12-month enrollee with an HCC may only have had active treatment for, or influenced by, that HCC in 1 of their 12 enrollment months. These two enrollees might have the same total costs for active treatment of the HCC, but the per-month costs for the 1-month enrollee would be 12 times higher than the per-month costs for the 12-month enrollee. However, the cause remains uncertain as this explanation is unlikely to fully account for the inverse relationship between enrollment duration and monthly costs among adults with HCCs.

As described in section 1.4, we have been exploring ways to improve prediction of costs for partial-year adult enrollees with HCCs and partial-year adult enrollees without HCCs under the current enrollment duration factors. We describe some potential changes to the enrollment duration factors to improve the prediction of partial-year enrollees in the following section.

3.2 Potential Changes to the Enrollment Duration Factors

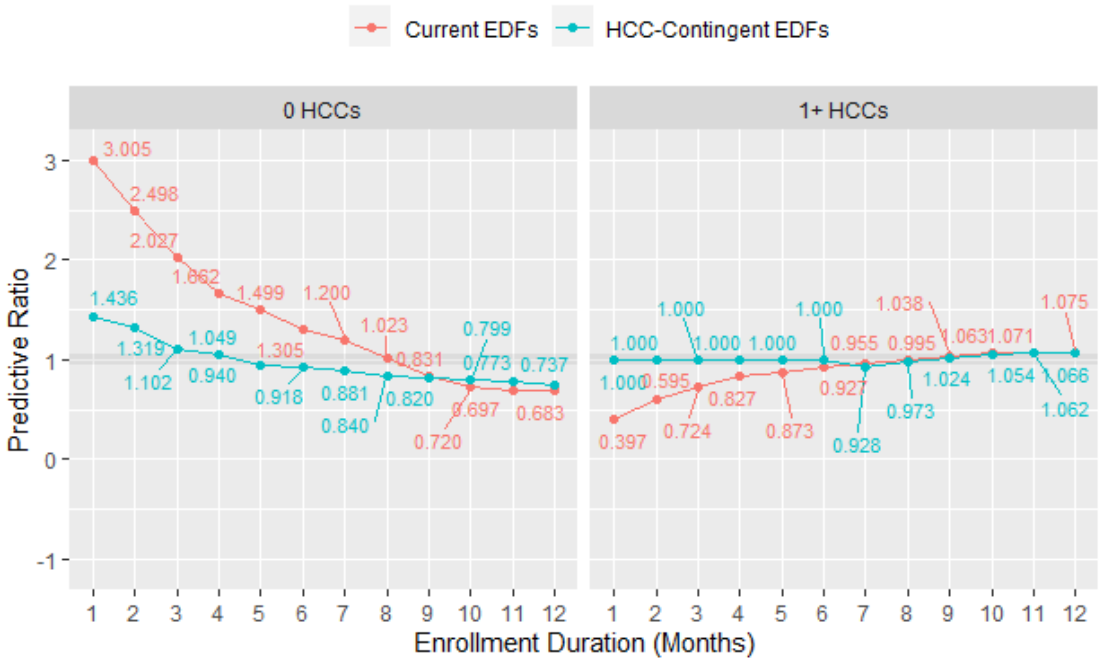
HHS considered a variety of options to improve the prediction of partial-year adult enrollees through modifying the enrollment duration factors. We found that enrollment duration factors that were contingent on whether an enrollee had one or more payment HCCs were the best predictor of a meaningful cost distinction and best reflected the relationship between enrollment duration, HCCs, and cost. The HCC-contingent enrollment duration factors that were proposed in the 2022 Payment Notice,[74] but not finalized, are six binary variables that flag enrollment durations up to six months only among enrollees with at least one HCC.

In this chapter, we report on analysis of the estimated impact of the HCC-contingent enrollment duration factors that were proposed in the proposed 2022 Payment Notice, in isolation (that is, without the two-stage weighting approach described in Chapter 2 or the interacted HCC counts model specification described in Chapter 4). The PRs associated with the HCC-contingent enrollment duration factors show a significant improvement over the current factors' PRs for partial-year adult enrollees with and without HCCs, as shown in Figure 3.2 below. The HCC-contingent enrollment duration factors address the underprediction of plan liability for adults with short enrollment duration and at least one payment HCC, as well as the overprediction of plan liability for adults with short enrollment duration and no payment HCCs. Using the 2018 enrollee-level EDGE dataset to analyze the adult silver model, the HCC-contingent enrollment duration factors eliminate the underprediction among adults with HCCs and 1-6 months of enrollment.[75] Using the HCC-contingent enrollment duration factors, the

[74] 85 FR 78572 at 78585 – 78586.
[75] When the HCC-contingent enrollment duration factors are combined with the two-stage weighted model specification (see Chapter 5), these underpredictions are reduced rather than eliminated.

overprediction among adult silver plan enrollees without HCCs with 1-4 months of enrollment duration is substantially reduced on average and eliminated by 5 months of enrollment duration.

Figure 3.2: Adult Silver Plan Model Predictive Ratios by Enrollment Length Using Current and HCC-Contingent Enrollment Duration Factors, 2018 Enrollee-Level EDGE Dataset



The HCC-contingent enrollment duration factors stop at six months, because the monthly average cost variation by number of months enrolled is substantially reduced after six months, which we observed consistently across data years. The underprediction among adults without HCCs with 7-12 months of enrollment duration is consistent with the broader underprediction of full year enrollees without HCCs discussed in Chapter 2.[76] We also tested adding new enrollment duration factors up to nine months, but did not observe any significant changes when compared to the proposed factors for 1-6 months, and the factors for the 7-9 months were close to zero and sometimes negative. We also did not observe any material improvement to PRs by adding 7-9 month enrollment duration factors. For these reasons, we determined the best option to improve prediction for partial-year adult enrollees is by using the HCC-contingent enrollment duration factors of 1-6 months as proposed in the proposed 2022 Payment Notice.

3.3 Testing Other Options for the Enrollment Duration Factors

Based on suggestions from commenters to past rules and our own continuing analysis, we also tested several other options to restructure the current enrollment duration factors. We considered varying the enrollment duration factors by type of partial-year enrollment (enrolling after open enrollment through a special enrollment period versus enrolling during open

[76] The two-stage weighted approach, discussed in detail in sections 2.2 and 2.3, helps mitigate the underprediction of full year enrollees without HCCs.

enrollment and dropping enrollment partway through the year); by market (individual versus small group market); and by specific HCC (as well as by type of HCC – acute versus chronic). While we are not considering these types of changes to the enrollment duration factors at this time, our analyses of these options are described in this section.

3.3.1 Partial-Year Enrollment Type

Some commenters have expressed concerns that special enrollment period (SEP) enrollees, especially in the individual market, are underpredicted in the current risk adjustment models.[77] In the 2021 Payment Notice,[78] we explained that our preliminary analysis of the 2017 enrollee-level EDGE dataset found that, in comparison to the effect of the presence of HCCs on enrollment duration factors, enrollment timing (e.g., enrollment at the beginning of the year compared to enrollment after open enrollment period, or drop in enrollment before the end of the year) did not appear to affect PMPM expenditures on average. Nonetheless, we tested adding variables to the model for SEP enrollment (first enrollment after January of the applicable benefit year) and drop in enrollment (last enrollment before December of the applicable benefit year) by market.[79] Under this simulation, these variables were added to an adult enrollee's enrollment duration factor as an additional component of their risk score. We repeated this analysis using the 2019 enrollee-level EDGE dataset and found similar results. The estimates for these variables using the 2017 and 2019 enrollee-level EDGE datasets are shown in Table 3.2 below.

Table 3.2: Partial-Year Enrollment Type Factors

	2017 EDGE Data		2019 EDGE Data	
Label	**Individual Market**	**Small Group Market**	**Individual Market**	**Small Group Market**
SEP	0.0685	-0.1099	0.0643	-0.0810
DROP	-0.0484	0.0902	-0.0452	0.0667

Note: SEP is an additional effect for enrollees with first enrollment after March (for 2017 EDGE data) or January (for 2019 EDGE data);[80] DROP is an additional effect for enrollees with last enrollment before December. The SEP and DROP variables were estimated in separate models.

As seen in the table, the additive factors for partial-year enrollment type would be very close to zero and in some cases negative. The additional findings from the analysis of the 2019 enrollee-level EDGE dataset were consistent with our prior findings that enrollment timing does

[77] Some researchers have also found that special enrollment period enrollees have higher costs than open enrollment enrollees. See Garabedian et al., Costs Are Higher For Marketplace Members Who Enroll During Special Enrollment Periods Compared With Open Enrollment, Health Affairs, August 2020, available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01155.

[78] 85 FR 29164 at 29189.

[79] For purposes of this testing, we used the current enrollment duration factors.

[80] Open enrollment for the 2017 benefit year extended through January 31, 2017, so our analysis of the 2017 enrollee-level EDGE dataset includes enrollees with first enrollment after March in the SEP variable. Open enrollment for the 2019 benefit year extended through December 15, 2018, so our analysis of the 2019 enrollee-level EDGE dataset includes enrollees with first enrollment after January in the SEP variable.

not appear to affect PMPM expenditures on average. Therefore, we have not pursued proposals to vary the enrollment duration factors by partial-year enrollment type.

3.3.2 Market

HHS has also received comments requesting consideration of market-specific enrollment duration factors to account for perceived variance in risk of partial-year enrollees by market.[81] We agreed that this was an area that should be explored further, as there may be differences in partial-year enrollment patterns between the individual and small group (including merged) markets. Our preliminary analysis of the 2017 enrollee-level EDGE dataset found that separate enrollment duration factors by market in the adult models may be warranted, given the differences in risk profiles of partial-year enrollees in the individual and small group markets.[82] However, we were unable to develop and propose separate enrollment duration factors by market at that time due to limitations in the available enrollee-level EDGE data.[83] Nonetheless, we have continued to consider these issues.

As we stated in the proposed 2022 Payment Notice,[84] as part of our updated analysis on partial-year enrollment using the 2018 enrollee-level EDGE dataset, we considered adoption of enrollment duration factors by market. However, we did not find a meaningful distinction in relative costs between markets on average once we implemented the proposed HCC-contingent enrollment duration factors in the proposed 2022 Payment Notice. Therefore, we determined it would not be necessary to introduce market-specific factors if HCC-contingent enrollment duration factors were implemented. Even though reasons for and patterns of partial-year enrollment differ by market, we concluded that the patterns most relevant for predicting cost (e.g., how enrollment duration relates to cost conditional on the presence of HCCs) were the same for both markets. Table 3.3 shows potential HCC-contingent enrollment duration factors by market for adult silver plan enrollees using the 2017, 2018 and 2019 enrollee-level EDGE datasets. As seen in Table 3.3, if the HCC-contingent factors were to vary by market, the factors for both markets would generally be very similar, which would add little value to the models while adding additional complexity.

[81] See 86 FR 24140 at 24162 and 85 FR 29164 at 29190.
[82] In the enrollee-level EDGE dataset, merged market enrollees are assigned to the individual or small group market indicator based on their plan.
[83] See 85 FR at 7103-7104.
[84] 85 FR 78572 at 78585.

Table 3.3: Enrollment Duration Factors for Adult Silver Plan Enrollees by Market

	2017 EDGE		2018 EDGE		2019 EDGE	
Label	**Individual Market**	**Small Group Market**	**Individual Market**	**Small Group Market**	**Individual Market**	**Small Group Market**
Enrolled for 1 month, at least one payment HCC	6.766	6.453	6.396	7.823	6.026	6.134
Enrolled for 2 months, at least one payment HCC	2.066	2.794	1.853	2.608	1.755	2.053
Enrolled for 3 months, at least one payment HCC	1.213	1.331	0.874	1.280	1.953	1.385
Enrolled for 4 months, at least one payment HCC	0.510	0.747	0.303	0.615	0.511	0.764
Enrolled for 5 months, at least one payment HCC	0.244	0.419	0.186	0.505	1.315	0.330
Enrolled for 6 months, at least one payment HCC	0.132	0.335	-0.063	0.336	-0.061	0.345

3.3.3 Specific HCCs

HHS also received comments suggesting that certain HCCs may be more common among partial-year enrollees than others and may be contributing more heavily to partial-year enrollee costs. As part of our consideration of these comments, we analyzed the prevalence of HCCs among enrollees with one month of enrollment duration.[85] Some commenters asked HHS to consider whether enrollment duration factors should be tied to certain HCCs, believing that not all HCCs contribute equally to the coefficient for enrollees with the 1-month enrollment duration factor. These stakeholders requested that we constrain the enrollment duration factor to a subset of HCCs driving the high 1-month enrollment duration factor value in the proposed 2022 Payment Notice. One commenter recommended HCC-specific enrollment duration factors for maternity HCCs be finalized for the 2022 benefit year.

As part of our analysis of the proposed HCC-contingent enrollment duration factors in the proposed 2022 Payment Notice, we reviewed the most common HCCs in the 2018 enrollee-level EDGE dataset for 1-month enrollees to determine whether the HCC profile of partial-year enrollees with these common HCCs might differ substantially from full-year enrollees (that is, whether partial-year enrollees tend to have different HCCs than full-year enrollees). As seen in columns 1 and 2 of Table 3.4, our analysis showed that the HCCs that tend to be the most common among 1-month adult enrollees also tend to be the most common HCCs among all adult enrollees with a few exceptions. Additionally, as seen in column 3 of Table 3.4, we also assessed whether there were HCCs that tended to be more common among 1-month adult enrollees compared to all adults and identified those HCCs. As shown in Table 3.4 below, the only

[85] We focused the analysis on enrollees with one month of enrollment because some commenters to the proposed 2022 Payment Notice noted the large proposed 1-month enrollment duration factor under the proposed new HCC-contingent enrollment duration factors and expressed concerns that not all HCCs would equally contribute to that factor.

condition that is both most common among 1-month adult enrollees and more common among 1-month enrollees as compared to all adult enrollees, is HCC 212 (Ongoing) Pregnancy without Delivery with No or Minor Complications. This implies that HCC profiles are more similar than different between partial-year enrollees and full-year enrollees.

Table 3.4: Common HCCs Among 1-Month Enrollees, 2018 Enrollee-Level EDGE Dataset

Most common among 1-month adult enrollees	Most common among all adult enrollees	More common among 1-month adult enrollees compared to all adult enrollees
HCC 20 Diabetes with Chronic Complications	HCC 20 Diabetes with Chronic Complications	HCC 9 Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia
HCC 21 Diabetes without Complication	HCC 21 Diabetes without Complications	HCC 127 Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes
HCC 88 Major Depressive Disorder, Severe, and Bipolar Disorders	HCC 88 Major Depressive Disorder, Severe, and Bipolar Disorders	HCC 184 End-Stage Renal Disease
HCC 161_2 Asthma, Except Severe	HCC 160 Chronic Obstructive Pulmonary Disease, Including Bronchiectasis	HCC 211 (Ongoing) Pregnancy without Delivery with Complications
HCC 212 (Ongoing) Pregnancy without Delivery with No or Minor Complications	HCC 161_2 Asthma, Except Severe	HCC 212 (Ongoing) Pregnancy without Delivery with No or Minor Complications

We also categorized HCCs into acute versus chronic HCCs and tested how enrollment duration patterns varied for those two groups, as we understood commenters' concern that the pattern of PMPM costs by enrollment duration could vary by HCC. As part of this analysis, we considered whether adults with any acute HCCs included a significantly higher fraction of enrollees with short enrollment duration or had significantly higher costs than adults with only chronic HCCs. As seen in Table 3.5, in the 2017 enrollee-level EDGE dataset, the distribution of enrollment duration and PMPM allowed charges by enrollment duration is similar for adults with any acute HCCs versus adults with only chronic HCCs. In other words, the general pattern of decreasing PMPM costs with higher enrollment duration held true, regardless of whether HCCs were acute or chronic.

Table 3.5: PMPM Allowed Charges by Enrollment Duration and Presence of Acute versus Chronic HCCs, 2017 Enrollee-Level EDGE Dataset

	Adults with Any Acute HCCs		Adults with Chronic HCCs Only	
Enrollment Duration	**Number of Enrollees**	**PMPM Allowed Charges**	**Number of Enrollees**	**PMPM Allowed Charges**
1 month	7,567	$16,402	41,449	$16,474
2 months	11,448	$10,604	62,141	$11,268
3 months	16,044	$8,343	81,809	$8,815
4 months	17,918	$6,673	91,817	$7,807
5 months	19,360	$6,014	91,997	$6,688
6 months	21,154	$5,116	94,907	$6,164
7 months	21,593	$4,635	92,226	$5,468
8 months	22,917	$4,162	93,351	$4,991
9 months	23,663	$3,995	94,012	$4,698
10 months	34,520	$3,599	144,179	$4,761
11 months	45,505	$3,332	195,130	$4,781
12 months	468,931	$3,087	2,252,102	$5,706

Note: The list of HCCs we considered to be acute for the purposes of this analysis may be found in Appendix B.

We, therefore, determined that it would add unnecessary complexity to the adult models to introduce one set of enrollment duration factors for adults with any acute HCCs and a separate set for adults with only chronic HCCs. As explained in the 2022 Payment Notice,[86] our primary concern with tying the enrollment duration factors to specific HCCs, such as the maternity HCCs, is that several new factors would have to be added to the models to create these HCC-specific enrollment duration factors, adding an additional level of complexity and potential instability to the model that may not be offset by any gains in predictive accuracy. We continue to believe that the most important factor in predicting costs for partial-year enrollees is the presence of any HCC, rather than the presence of specific types of HCCs.

3.4 Obtaining Diagnosis Codes for Partial-Year Enrollees

Some commenters to the proposed 2022 Payment Notice expressed concerns that issuers, particularly small group market issuers, small issuers, or Medicaid issuers, may have partial-year enrollees with HCCs that are not coded. These commenters expressed concerns that these issuers may have difficulty obtaining diagnoses for partial-year enrollees, creating cases where the issuer may pay claims, and incur costs, for services associated with a condition for the partial-year enrollee, but the issuer's limited time with the partial-year enrollee may not be adequate to capture the diagnosis code associated with the HCC.

[86] 86 FR 24140 at 24162.

Note that this issue differs from the case where issuers may not have a complete diagnostic profile for a partial year enrollee because the services received were not related to the diagnoses that were not captured. For example, if an enrollee received services due to a condition while enrolled with a different issuer, then the current issuer may not have all diagnosis codes for a partial year enrollee. However, such cases do not have cost implications for the current issuer since the partial year enrollee received no services associated with that diagnosis.

While there are likely some cases where an enrollee only receives risk adjustment ineligible services, our analysis found no evidence that it is associated with underpayment. As noted earlier in this chapter, the current models overpredicted for partial-year enrollees with no HCCs. Consistent with this finding, adding enrollment duration factors for partial-year enrollees without HCCs results in negative coefficients for these factors, as seen in Table 3.6. In other words, on average, costs are sufficiently low for partial-year enrollees with no HCCs that even a risk score based only on demographic factors would overpredict plan liability.

Table 3.6: Enrollment Duration Factors for Adult Silver Plan Enrollees without HCCs by Market

Factor	2017 EDGE Data		2018 EDGE Data		2019 EDGE Data	
	IND	SG	IND	SG	IND	SG
Enrolled for 1 month, zero payment HCCs	-0.079	-0.015	-0.073	-0.028	-0.054	-0.046
Enrolled for 2 months, zero payment HCCs	-0.060	-0.018	-0.058	-0.028	-0.036	-0.051
Enrolled for 3 months, zero payment HCCs	-0.037	-0.037	-0.033	-0.036	-0.024	-0.042
Enrolled for 4 months, zero payment HCCs	-0.035	-0.021	-0.025	-0.036	-0.029	-0.034
Enrolled for 5 months, zero payment HCCs	-0.036	-0.017	-0.024	-0.025	-0.025	-0.029
Enrolled for 6 months, zero payment HCCs	-0.028	-0.007	-0.030	-0.016	-0.024	-0.029

Note: IND denotes the individual market; SG denotes the small group market.

The pattern of negative factors for enrollees with short enrollment duration (1-6 months) and no HCCs is consistent with the descriptive statistics in Table 1.1 in section 1.4, which showed that short-term (1-6 month) enrollees without HCCs have lower PMPM allowed charges than short-term enrollees with HCCs or full-year enrollees without HCCs. Further, the similarity of results by market in Table 3.6 is consistent with the similarity of results by market in Table 3.3. In summary, these results support our determination that we have not found any evidence that issuers are unable to capture cost-meaningful HCCs for partial-year enrollees in the individual or small group (including merged) market.

3.5 Conclusion

In conclusion, our analyses and evaluation of the current enrollment duration factors in the adult models identified areas for improving the prediction of costs for partial-year adult enrollees with HCCs and partial-year adult enrollees without HCCs. HHS considered several possible changes to the enrollment duration factors, including varying them by partial-year enrollment type, by market, and by specific HCC or type of HCC. However, we found that the most effective change would be to make the enrollment duration factors contingent on the presence of one or more payment HCCs. HCC-contingent enrollment duration factors described in this chapter would improve the current model's predictive accuracy for these enrollee subpopulations and reduce the number of factors in the adult risk adjustment models.[87]

[87] As detailed in the proposed 2022 Payment Notice, these new factors would only apply to partial-year enrollees with up to 6 months of enrollment and at least one payment HCC. See 85 FR 78572 at 78586.

Chapter 4: Improving the Predictive Accuracy for the Very Highest-Risk Enrollees – Interacted HCC Counts

This chapter explores the prediction of risk for the very highest-risk enrollees in the current adult and child risk adjustment models. While the number of very highest-risk enrollees is small in both the adult and child models, the associated plan costs can be high and make up a significant amount of overall expenditures. In this chapter, we discuss ways to improve prediction for these enrollees through the "interacted HCC counts approach," which was discussed in the proposed 2022 Payment Notice. In addition, we provide analysis to show how the interacted HCC counts approach works and how it can improve prediction for the very highest-risk enrollees in the adult and child models.

4.1 Current Models' Prediction of Costs for the Very Highest-Risk Enrollees

As described in Chapter 1.4, the current risk adjustment models underpredicted costs for enrollees with the highest HCC counts and enrollees in the top 0.1 percent decile. This underprediction matters due to the impact the very highest-risk enrollees have on overall plan liability. While the vast majority (around 80 percent) of enrollees do not have HCCs, those with HCCs make up a significant amount of overall expenditures. For example, as seen in Tables 4.1 and 4.2 below, enrollees in the highest two risk deciles account for approximately 83 percent of total adult silver plan liability, while the top 1 percent of enrollees by predicted risk account for more than 31 percent of adult silver plan liability. While enrollees with 7 or more HCCs account for only 0.2 percent of adult enrollees, they make up more than 8 percent of adult silver plan liability.

Table 4.1: Percent of Total Adult Silver Plan Liability by Decile/Percentile, 2018 Enrollee-Level EDGE Dataset

Decile/Percentile	% Total Adult Silver Plan Liability	Cumulative % Adult Silver Plan Liability
1 (lowest)	1.36%	1.36%
2	1.95%	3.31%
3	2.11%	5.42%
4	2.62%	8.04%
5	3.99%	12.03%
6	2.85%	14.88%
7	1.40%	16.28%
8	0.82%	17.09%
9	8.62%	25.71%
10 (highest)	74.29%	100.0%
Top 5%	62.21%	-
Top 1%	31.36%	-
Top 0.1%	7.39%	-

Table 4.2: Percent of Total Adult Silver Plan Liability by HCC Count, 2018 Enrollee-Level EDGE Dataset

Number of Payment HCCs	% Total Adult Silver Plan Liability	Cumulative % Adult Silver Plan Liability
0	19.17%	19.17%
1	30.70%	49.87%
2	17.85%	67.72%
3	10.28%	78.00%
4	6.32%	84.32%
5	4.21%	88.53%
6	2.98%	91.51%
7	2.21%	93.72%
8	1.64%	95.36%
9	1.31%	96.67%
10+	3.33%	100.00%

As discussed in Chapter 1, the most expensive enrollees tend to have severe acute illness HCCs. In addition, the highest-cost enrollees are also characterized by high numbers (counts) of HCCs. As shown in Table 4.3, for enrollees with a high HCC count, there is an increasing, non-linear effect that leads to higher costs than are predicted by adding up the incremental effects of each HCC. The average PMPM actual cost for enrollees with 1 HCC is 8.4 times the average actual cost for enrollees with 0 HCCs. This ratio increases to 142.5 times for enrollees with 7 HCCs and to 313 times for enrollees with 10 or more HCCs.

Table 4.3: Ratio of Actual Plan Liability compared with Plan Liability at Zero HCCs

Number of HCCs	Ratio: Actual PL / Actual PL at 0 HCCs
1	8.355
2	18.341
3	34.354
4	55.309
5	80.489
6	108.078
7	142.520
8	171.668
9	213.788
10+	313.122

4.2 Improving Prediction for the Very Highest Risk Enrollees – Interacted HCC Counts Approach

To account for the very highest-risk enrollees, the current HHS risk adjustment adult models incorporate a severe illness adjustment that accounts for the interactions or combinations of selected HCCs. When a severity indicator is present,[88] the adult models will look for interactions with a few other HCCs or HCC groups and apply a binary indicator variable in the regression model that indicates whether the enrollee has at least one disease interaction in the category. If a disease interaction category is present, the adult enrollee receives the factors associated with the HCCs that the enrollee has, plus a severity indicator adjustment that would impact their predicted cost.[89] In the current risk adjustment adult models, the total count of an

[88] Prior to the 2021 benefit year, the HHS risk adjustment adult models included two types of severe illness HCC interactions that estimated the additional incremental costs of combinations of high severity HCCs, medium and high. In the V06 HHS-HCC classification update, the medium interaction was removed, as its parameter estimate is usually very low. For example, in the 2017 enrollee-level EDGE dataset, the medium cost severe illness interaction term's estimate was negative and constrained to $0. See Centers for Medicare & Medicaid Services, Potential Updates to HHS-HCCs for the HHS-operated Risk Adjustment Program (June 17, 2019), available at: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/Potential%20HHS-HCC%20Updates%20for%20Risk%20Adjustment%20Program.pdf. The medium severity indicator was removed from the HHS risk adjustment adult models in the 2021 Payment Notice, see 85 FR 29164.

[89] For example, if an enrollee has HCC 2 (Sepsis), which is one of the eight severity indicators in the current adult models, which is paired with HCC 6 (opportunistic infections), which is one of the selected HCC interactions that

enrollee's HCCs does not independently affect their risk score. While this severity adjustment helps the current adult models predict costs accurately among all enrollees with qualifying severe illnesses, it still does not fully address the underprediction for the very highest-risk enrollees.

As discussed in the proposed 2022 Payment Notice,[90] we investigated alternative approaches to improve the current risk adjustment models by incorporating an HCC counts model which we believed could improve prediction for the very highest-risk enrollees while minimizing gaming concerns and disruption of current model factors. The goals for this approach were to:

1. Address the non-linearity in costs between enrollees without HCCs or with very low costs and enrollees with multiple HCCs or with high costs;
2. Empirically incorporate the cost impact of multiple complex diseases; and
3. Reduce incentives for coding proliferation to mitigate the gaming concerns with HCC counts models.

We tested different types of indicators interacted with HCC counts with the goal of improving prediction for the very highest-risk enrollees and multiple HCCs. For this approach, we assessed the HCCs for enrollees with extremely high costs. We found that many of these enrollees had HCCs among the severe illness indicators, transplant HCCs, and other HCCs related to severity of disease. In addition to these indicators, we also found that the very highest-risk enrollees were characterized by high counts of HCCs. This suggests that the count of HCCs as a measure of total disease burden *combined* with the presence of one or more severe illness HCCs holds promise as a means to improve prediction for the very highest-risk enrollees. While the current adult models' severity illness factors are intended to account for some of these severe illness interactions, our analysis found that it still underpredicts costs for the very highest-risk enrollees. As a result, in the proposed 2022 Payment Notice we proposed dropping the current severity illness indicators in the adult models and replacing them with severity and transplant indicators interacted with HCC counts factors in the adult and child models.[91]

Based on our empirical investigation of acute disease severity, including consultation with clinicians, we added 19 HCCs to our list of severe illness HCCs, and removed one of the original eight, for an expanded total of 26 severe illness HCCs, as seen in Appendix C, under the

would trigger a severity adjustment, the enrollee would receive the risk scores for HCC 2 and HCC 6 plus an incremental severity adjustment based on the interaction between a severe illness HCC (e.g. Sepsis) and HCC 6.

[90] 85 FR 78572.

[91] While the current risk adjustment models only apply the severity illness indicators to the adult models because the interaction terms were empirically unimportant in the child models, many of the prediction issues that we observed in the adult models were also observed in the child models. Additionally, we found that the interacted HCC counts approach improved prediction in both the adult and child models. As a result, we proposed in the proposed 2022 Payment Notice to apply the interacted HCC counts specification to both the child and adult models. We did not, however, propose to change the infant model severity illness indicators because the infant models do not categorize infant enrollees the same way as in the adult and child models, rather infant risk scores are determined by inclusion in one of 25 mutually exclusive groups, based on the infant's maturity and the severity of diagnoses, as a result a counts approach would not be applicable.

interacted HCC counts model specification proposal.[92] We experimented with interacting HCC counts separately for each of the severe illness HCCs, but we found this approach to be too complex and prone to overfitting due to estimation of a large number of parameters. We also found that we could simplify the models by interacting any of the selected severe illness HCCs with a count of payment HCCs, with little loss of predictive accuracy. As a result, we decided to use a single interaction variable to indicate "severe" illness, defined as the presence of at least one severe illness HCC for an enrollee, with binary variables for the adult enrollee's total number of payment HCCs = 1, 2, 3, ..., 10+. The proposed interacted HCC counts approach applies slightly differently in the child models, where the severe illness HCC count factors apply from 1, 2, 3, ..., to 8+ payment HCCs.

We also considered including 8 organ transplant status HCCs (heart, lung, liver, etc. transplants) among our severe illness HCCs. We added a set of variables for transplant status interacted with total HCC count to boost predicted expenditures even further for organ transplant enrollees with a large number of HCCs. After some experimentation, we determined that interacting transplant status with number of payment HCCs = 4, 5, 6, 7, 8+ in the adult models produced good predictive accuracy and had sufficient sample sizes for reasonably stable factor estimates. We found that organ transplant adult enrollees with fewer than 4 payment HCCs were very rare, and that including those interactions did not improve predictive accuracy for the highest-risk enrollees. For the child models, having one variable for 4+ payment HCCs provided more stable estimates given the smaller sample sizes for children than for adults. Table 4.4 provides an overview on the proposed interacted HCC count factors for both the child and adult models.

Table 4.4 Structure of the Interacted HCC Count Factors by Risk Adjustment Model Type

	Severity HCC Counts	Transplant HCC Counts
Adult Model Factors	1, 2, 3, 4, 5, 6, 7, 8, 9, 10+	4, 5, 6, 7, 8+
Child Model Factors	1, 2, 3, 4, 5, 6, 7, 8+	4+

When we were investigating the various HCC count approaches, incorporating safeguards to protect against the potential for gaming was a major consideration. We note that given individual HCCs are already in the risk adjustment model, the incentive to code for more HCCs already exists. However, we were specifically concerned that the presence of counts across all HCCs may further incentivize issuers to code for more HCCs, thus increasing their payment or reducing their charge under the state payment transfer formula. This would be inconsistent with the risk adjustment principle not to encourage coding proliferation.[93] However,

[92] HCC 18 (Pancreas Transplant) was not included in the list of HCCs selected for the Proposed Interacted HCC Counts Variables for the Adult and Child Models in the proposed 2022 Payment Notice. *See* Table 3 in the proposed 2022 Payment Notice, 85 FR at 78593. This was due to the fact that HCC 18 has a much lower coefficient than the other transplant HCCs in the adult models and was not underpredicted by the models. We include it in the analysis in this paper to be consistent with the other transplant HCCs for purposes of the further evaluation of this model specification change.

[93] See Section 1.1.2 for information on the principles that guide the HHS risk adjustment models' diagnostic classification system and, in particular, Principle 6: The diagnostic classification should not reward coding proliferation.

we believe that using the proposed interacted HCC count approach, which restricts the incremental risk score adjustment to enrollees with at least one severe illness HCC, lessens the concerns that issuers may attempt to inflate HCC counts to influence their transfers under the state payment transfer formula. Our analysis of the 2016, 2017, and 2018 enrollee-level EDGE datasets revealed that severe illness HCCs are relatively uncommon; less than 2 percent of the adult enrollee-level EDGE data population across these three benefit years had at least one severe illness HCC, as opposed to about 20 percent of adult enrollees with any payment HCC. Therefore, the scope for potentially inflating HCC coding frequency would be limited to a small fraction of total enrollees.

4.3 How the Interacted HCC Counts Approach Works

Based on our above analyses, we proposed in the proposed 2022 Payment Notice[94] to drop the single severity indicator factors in the HHS risk adjustment adult models and replace them with two sets of "interacted HCC counts" variables in the adult and child models, a set of 10 factors triggered by the presence of at least one of an expanded list of severe illness HCCs, and 5 parameters triggered by the presence of at least one transplant HCC, and differentiated by the enrollee's total count of HCCs. Appendix C lists the severe illness and transplant HCCs that were proposed as part of the interacted HCC counts approach in the proposed 2022 Payment Notice.[95] While adding the interacted HCC counts approach to the risk adjustment adult and child models introduces some additional complexity, this is offset by a reduction in complexity due to the removal of the existing severity indicator factors in the adult models. In addition, this change would improve the prediction of the very highest-risk enrollees.

Under the interacted HCC counts approach, when an enrollee has a severe illness HCC, the enrollee's risk score adjustment includes the applicable severe illness HCC counts variable factor, in addition to the applicable HCC factor. The proposed interacted HCC counts factors are based on the counts of all payment HCCs for an enrollee with at least one HCC that is classified as a severe illness or transplant HCC. For example, if an enrollee has diabetes, sepsis, heart failure, and asthma (with sepsis being a severe illness HCC), the enrollee would get credit for all the HCCs listed, plus an additional amount determined based on the total count of all payment HCCs for the enrollee, which in this case would be 4.

Tables 4.5.1 and 4.5.2 show the interacted HCC counts factors for severe illness and transplant status that were proposed in the proposed 2022 Payment Notice based on the number of payment HCC counts for enrollees in the adult silver model. When looking at the interacted HCC counts factors, it is important to consider them in tandem with the enrollee's underlying HCC factors. Even though most of the proposed severe illness HCC count factors are negative, adding a severe illness HCC always increases the enrollee's risk score, because the sum of the severe illness HCC and the interacted HCC count factors is always positive. For example, under this approach, the proposed adult silver model factor in the proposed 2022 Payment Notice for Viral or Unspecified Meningitis (HCC 4), which was proposed as a severe illness HCC, is 8.323; when combined with the smallest severe illness factor for one HCC of -6.181, this diagnosis

[94] 85 FR 78583.
[95] See supra note 92 on HCC selection.

would increase the enrollee's risk score by 2.142. Moreover, an increase in the count of HCCs leads to a monotonic increase in the enrollee risk score, because the severe illness factors are less negative (and sometimes positive) with a larger number of HCCs.

Table 4.5.1 Adult Silver Plan Model Severe Illness Count Factors Proposed in the Proposed 2022 Payment Notice

Severe Illness Factor	
Severe illness, 1 payment HCC	-6.181
Severe illness, 2 payment HCCs	-5.824
Severe illness, 3 payment HCCs	-4.526
Severe illness, 4 payment HCCs	-3.415
Severe illness, 5 payment HCCs	-2.554
Severe illness, 6 payment HCCs	-2.103
Severe illness, 7 payment HCCs	-0.987
Severe illness, 8 payment HCCs	-0.328
Severe illness, 9 payment HCCs	1.458
Severe illness, 10+ payment HCCs	10.431

Table 4.5.2 Adult Silver Plan Model Transplant Count Factors Proposed in the Proposed 2022 Payment Notice

Transplant Status Factor	
Transplant, 4 payment HCCs	3.483
Transplant, 5 payment HCCs	7.353
Transplant, 6 payment HCCs	12.622
Transplant, 7 payment HCCs	18.688
Transplant, 8+ payment HCCs	33.829

To illustrate an example of the potential interacted HCC counts approach, Table 4.6.1 shows a hypothetical 63-year-old male, enrolled for a full 12 months in a silver plan, with diabetes without complication (HCC 21), which is not a severe illness HCC, and no other risk markers. Under the interacted HCC counts approach, his predicted cost is 0.605 (based on the adult model silver plan factors published in the proposed 2022 Payment Notice). Predicted costs are relative to expected costs for the average enrollee; therefore, an enrollee with a predicted cost of 0.605 is expected to be roughly 60 percent as costly as the average enrollee.

Table 4.6.1 Sample Risk Score Calculation: 1 Payment HCC (No Severe Illness HCC)

Age-Sex	HCC	Severe Illness		Predicted Cost
63-year-old male	21	No		
0.343	0.262		=	0.605

If this enrollee develops sepsis, he would also get the factor for HCC 2 (Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock), which is a severe illness HCC, and the associated interacted HCC counts factor for two HCCs, which results in his predicted cost increasing to 4.175, as shown in Table 4.6.2. As previously stated, it is important to view the severe illness HCC count factor together with the enrollee's underlying HCCs. Even though the severe illness HCC count factor for two HCCs is negative (-5.824), when combined with the factor for the severe illness HCC sepsis (9.394), the result is an increase in the enrollee's predicted cost.

Table 4.6.2 Sample Risk Score Calculation: 2 Payment HCCs (With Severe Illness HCC)

Age-Sex	HCC	HCC	Severe Illness	Severe Illness Count Factor		Predicted Cost
63-year-old male	21	2	Yes	2		
0.343	0.262	9.394		-5.824	=	4.175

If this enrollee also develops heart failure, which is not a severe illness HCC, along with the two previously discussed HCCs, he would also get the factor for HCC 130 (Heart Failure) and the enrollee's predicted cost would rise to 7.347, as shown in Table 4.6.3.

Table 4.6.3 Sample Risk Score Calculation: 3 Payment HCCs (With Severe Illness HCC)

Age-Sex	HCC	HCC	HCC	Severe Illness	Severe Illness Count Factor		Predicted Cost
63-year-old male	21	2	130	Yes	3		
0.343	0.262	9.394	1.874		-4.526	=	7.347

The purpose of adding severity and transplant indicators interacted with HCC counts factors is to account for the fact that costs of certain HCCs rise significantly when they occur with multiple other HCCs. Although often negative, the values of the proposed severe illness

factors rise with the enrollee's total number of HCCs, increasing the enrollee's total predicted cost as the number of HCCs increases. As seen in the tables above, when the enrollee with a severe illness HCC (sepsis) in addition to diabetes acquires the heart failure HCC, the total count of payment HCCs increases from 2 to 3. As a result, this illustrative enrollee's predicted cost without heart failure (4.175) rises by 3.172, which is equal to the incremental cost estimated for heart failure (1.874) *plus* the increase in the severe illness HCC count from 2 HCCs to 3 HCCs (-4.526 – (-5.824) = 1.298). This approach aligns with risk adjustment principles that the diagnostic classification should encourage specific coding and that providers and issuers should not be penalized for coding additional conditions.[96]

The proposed interacted HCC counts approach also makes an adjustment for the costs of enrollees with a transplant status who have 4 or more payment HCCs. If our above hypothetical 63-year-old male enrollee with sepsis, diabetes, and heart failure also had kidney transplant status (HCC 183), in addition to his other conditions and the interacted HCC count factors for severe illness, he would also get an interacted HCC counts factor for his transplant, resulting in his predicted cost increasing from 7.347 to 20.444 as shown in Table 4.6.4.

Table 4.6.4 Sample Risk Score Calculation: 4 Payment HCCs (With Severe Illness HCC, Transplant HCC)

Age-Sex	HCC	HCC	HCC	HCC	Severe Illness	Transplant	Severe Illness Count Factor	Transplant Count Factor		Predicted Cost
63-year-old	21	2	130	183	Yes	Yes	4	4		
0.343	0.262	9.394	1.874	8.503			-3.415	3.4383	=	20.444

For an enrollee with a transplant HCC, the incremental transplant HCC add-on factor applies if the total number of payment HCCs is greater than or equal to 4. Under the proposed interacted HCC counts approach, transplant HCCs are a subset of severe illness HCCs. Therefore, an enrollee with a transplant HCC and at least 4 HCCs will have both the severe illness HCC add-on and the transplant add-on included as part of the enrollee's risk score calculation. If the enrollee's total number of payment HCCs was less than 4, they would not receive any incremental transplant add-on, but they would receive the incremental severe illness add-on.

The proposed severe illness adjustment in the interacted HCC counts approach proposed in the 2022 Payment Notice increases with an enrollee's total disease burden as measured by number of HCCs for enrollees with a severe illness or transplant HCC. Therefore, the proposed interacted HCC counts approach in the proposed 2022 Payment Notice allows predicted costs to

[96] See Section 1.1.2 for information on the principles that guide the HHS risk adjustment models' diagnostic classification system and, in particular, Principle 5: The diagnostic classification should encourage specific coding and Principle 7: Providers should not be penalized for recording additional diagnoses (monotonicity).

increase for the highest-risk, most expensive enrollees, who tend to have one or more severe illness HCCs plus a large number of other payment HCCs. The current adult models' severe illness adjustment, by contrast, is a single fixed increment that applies to fewer enrollees, both because fewer HCCs are classified as "severe illness" under the models, and because the adjustment is only made when other selected HCCs are present in addition to the severe illness HCC. Based on our review and analysis of the 2018 enrollee-level EDGE dataset, the current models' adjustment applied to 45,931 enrollees, or 0.24 percent of adult enrollees, while the proposed 2022 Payment Notice approach would apply to 258,755 enrollees, or 1.34 percent of adult enrollees.

Figure 4.1 shows risk score changes for selected severe illness HCCs based on the number of HCCs accounting for all the proposed model specification changes in the proposed 2022 Payment Notice (i.e., two-stage weighting, interacted HCC counts, and HCC-contingent enrollment duration factors). As Figure 4.1 demonstrates, there is a consistent quantitative pattern for all of the selected severe illness HCCs where the risk score contribution increases as the counts of payment HCCs increase. This effect is largely due to the interacted HCC counts approach where an enrollee's severe illness adjustment increases as an enrollee's total number of payment HCCs increases.

Figures 4.1: Proposed 2022 Payment Notice Model Specification Updates Impacts on Selected HCCs[97]

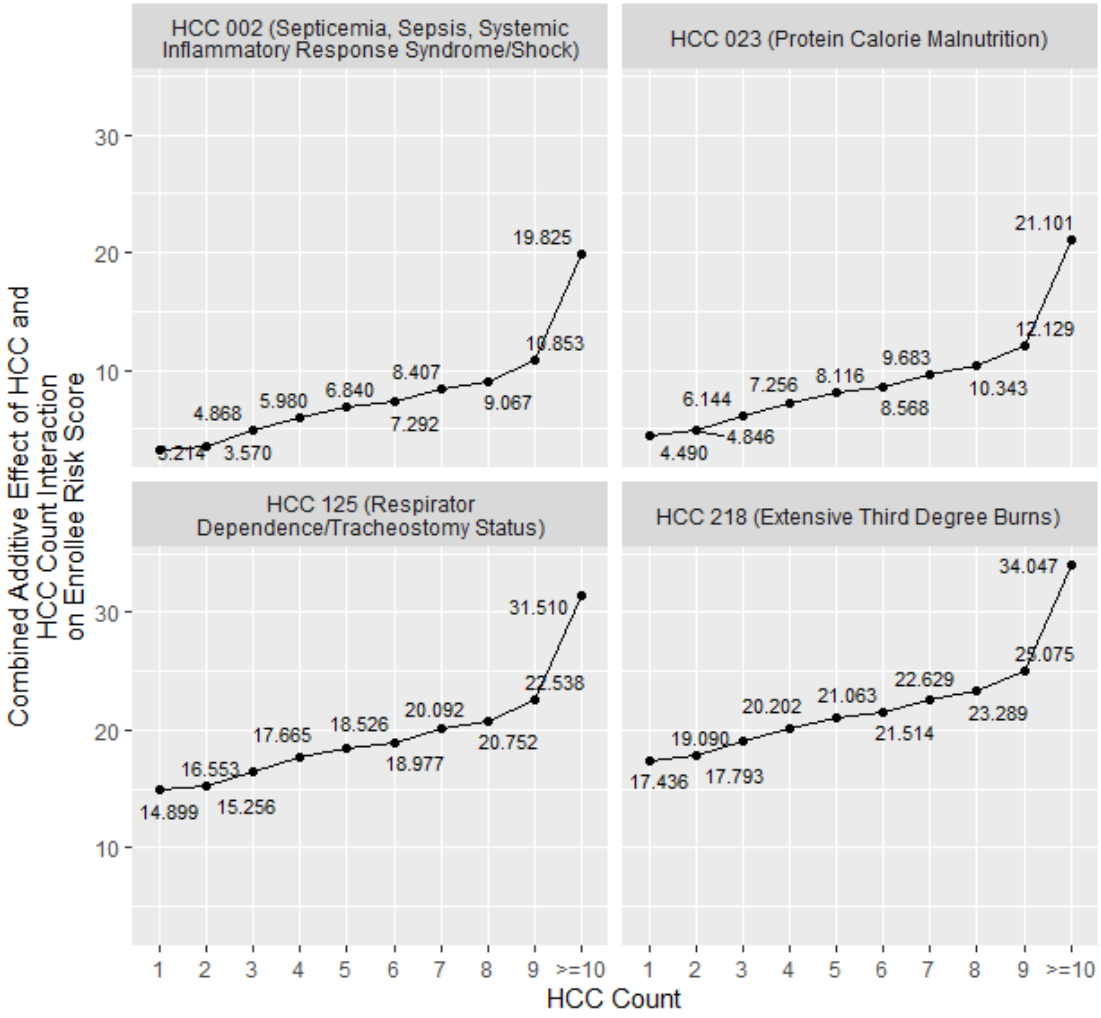


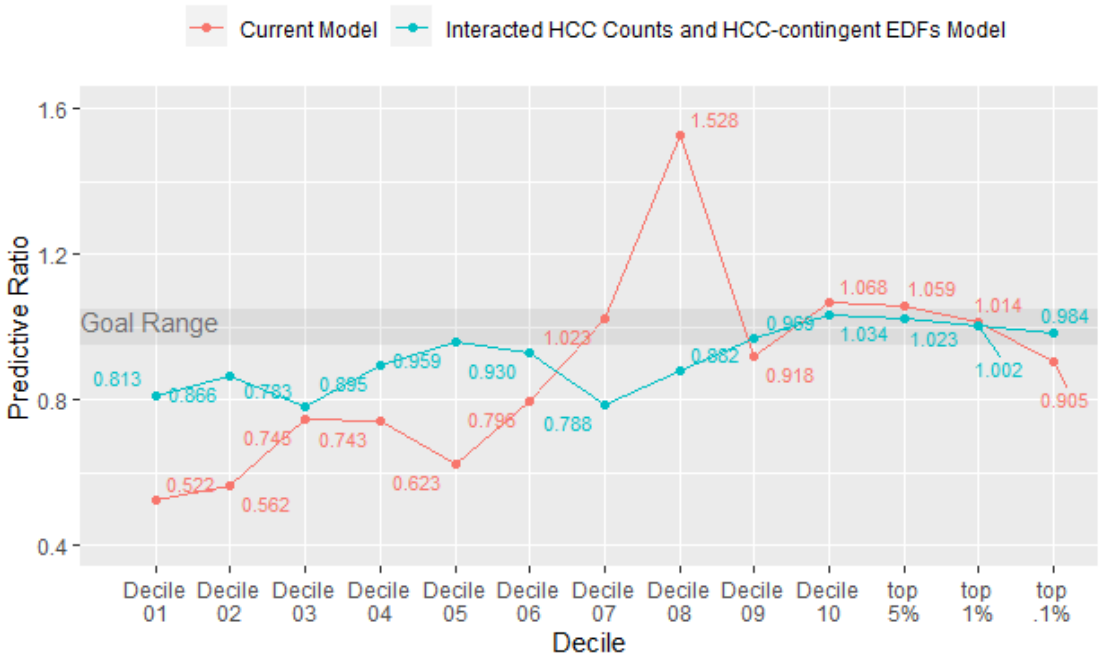
Figure 4.1 does not represent full risk score calculations, instead it reflects only the factors relevant for the selected severe illness HCCs. For example, the risk score contribution for sepsis at 4 HCCs shown in the first panel of Figure 4.1 includes the factor for sepsis plus the interacted HCC count add-on factor for 4 payment HCCs, but does not include the individual factors for the 3 other HCCs that the enrollee would have, or other factors such as age, sex, or RXCs. As Figure 4.1 shows, the inclusion of each additional HCC to the count increases the interacted HCC count add-on factor and results in an increase to the add-on factor's contribution to the risk score.

[97] The data used in Figure 4.1 uses blended factors (i.e. averages across multiple data years, 2016, 2017, and 2018). The rest of Chapter 4 focuses on model factors (and, more often, PRs) associated with a single year of factors.

4.4 Interacted HCC Counts Approach Change Impact

The purpose of this section is to describe the impact of the potential introduction of interacted HCC counts factors into the current adult and child models. One of the benefits of the proposed interacted HCC counts approach is that it improves prediction for both the lowest- and highest-risk enrollees compared to the current models. Figure 4.2 shows the PRs by decile of predicted plan liability in the adult silver plan model using the 2018 enrollee-level EDGE dataset. The proposed interacted HCC counts approach (combined with the HCC-contingent enrollment duration factors, discussed in Chapter 3)[98] allows for the risk adjustment models to better account for the higher costs of enrollees with certain high-cost HCCs (i.e. severe illness and transplants). At the same time, differentiating better between low- and high-cost enrollees enables the models to predict costs more accurately for lower-risk enrollees. This results in improved prediction for both the lowest-risk and very highest-risk enrollees compared with the current adult models, even without accounting for the proposed two-staged weighted approach discussed in Chapter 2. For example, our review of the 2018 enrollee-level EDGE dataset found the proposed interacted HCC counts approach combined with the proposed HCC-contingent enrollment duration factors improves the PR for adult enrollees in risk decile 1 from 0.52 to 0.81 and the PR for adult enrollees without HCCs from 0.79 to 0.90.

Figure 4.2: Adult Silver Plan Model Predictive Ratios by Decile, 2018 Enrollee-Level EDGE Dataset

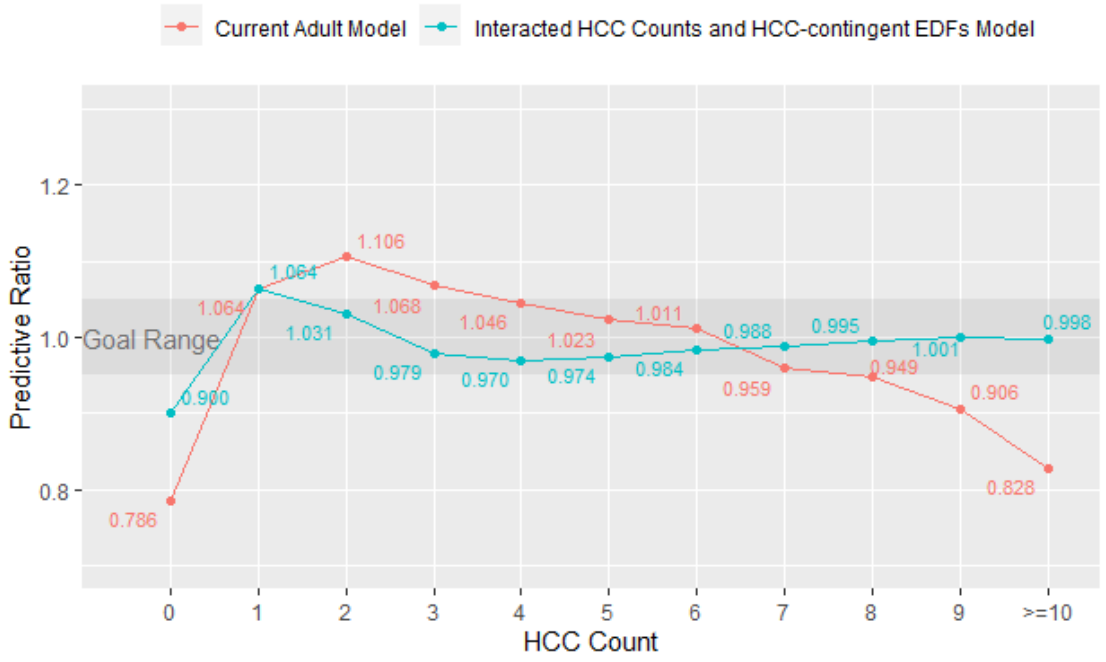


[98] During testing of the different model approaches, we combined the proposed 2022 Payment Notice enrollment duration factor change into our model testing of the interacted HCC counts factors to reduce the number of model types that we were testing at once and to ensure that the results of the interacted HCC count factors would already take into account the reduced overprediction of enrollee costs at decile 8.

In particular, we found that the adoption of the proposed interacted HCC counts and proposed HCC-contingent enrollment duration factors approach in the adult models would improve prediction for enrollees at the highest percentiles of plan liability, particularly in the 10th decile, 5%, 1%, and especially 0.1%. For example, using the adult silver plan model in the 2018 enrollee-level EDGE dataset, the adoption of the proposed interacted HCC counts and proposed HCC-contingent enrollment duration factors improves the PR for the top 0.1 percent of adult silver plan enrollees from 0.91 to 0.98 and the PR for enrollees with 10 or more HCCs from 0.83 to 1.00. We saw similar improvements in the adult models using the 2016 and 2017 enrollee-level EDGE datasets. The adoption of the proposed interacted HCC counts approach[99] also shows improvements in the child models using the 2016, 2017, and 2018 enrollee-level EDGE datasets.

Figure 4.3 shows the PRs by number of HCCs in the adult silver plan model using the 2018 enrollee-level EDGE dataset. As with the PRs by decile in Figure 4.2, the proposed interacted HCC counts approach combined with the proposed HCC-contingent enrollment duration factors significantly improves prediction for adult enrollees across most HCC counts. This is particularly the case for adult enrollees with high numbers of HCCs (greater than 6). We saw similar results for the adult models using the 2016 and 2017 enrollee-level EDGE datasets, as well as when analyzing the impact of the proposed interacted HCC counts approach on the child models.[100]

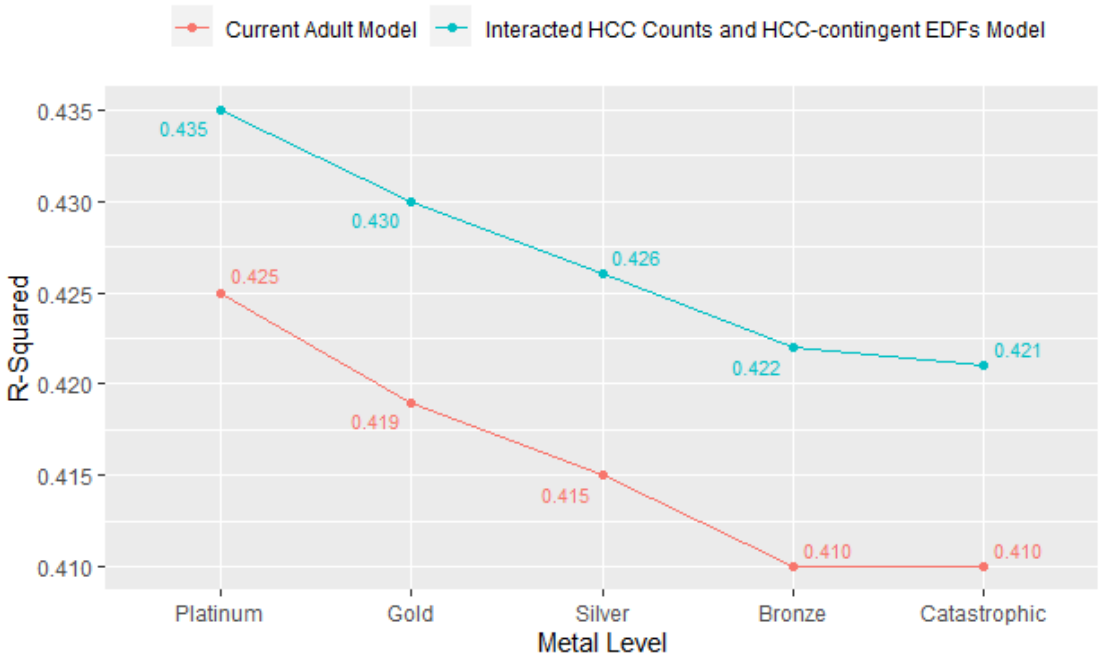
Figure 4.3: Adult Silver Plan Model Predictive Ratios by Number of HCCs, 2018 Enrollee-Level EDGE Dataset



[99] As discussed above, the current child models do not include enrollment duration factors and the proposed HCC contingent enrollment duration factors would only apply to the adult models. Our analysis of the child models therefore focused on the impact of the proposed interacted HCC counts approach.
[100] Ibid.

The proposed interacted HCC counts and proposed HCC-contingent enrollment duration factors approach also demonstrated improved R-squared statistics. Figure 4.4 shows a comparison for the 2018 benefit year of the R-squared statistics for the current adult models and the proposed interacted HCC counts approach combined with the HCC-contingent enrollment duration factors for the adult models. As seen in Figure 4.4, the combination of these proposals improves the R-squared statistics across all metal levels in the adult models. Our analysis showed similar improvements in the child models when the proposed interacted HCC counts approach is applied.[101]

Figure 4.4: R-Squared Statistics for the Adult Models, 2018 Enrollee-Level EDGE Dataset



One benefit of the proposed interacted HCC count approach is that it would not overhaul the existing risk adjustment factors and would build upon the current models. As discussed in Chapter 2, while other approaches we previously considered (such as the non-linear and full HCC counts approaches) would result in factors that would be substantially different than under the current models, under the proposed interacted HCC count approach, the factors would remain fairly stable compared to the current factors and models. In addition, the proposed interacted HCC counts approach can be used in combination with other refinements, such as the proposed two-stage weighted approach and the proposed HCC-contingent enrollment duration factors, and can be easily modified, adjusted, expanded, or constrained in the future to include additional HCCs or to remove HCCs. As previously mentioned, another advantage the proposed interacted HCC counts approach has over the other approaches we considered is that it uses relatively uncommon HCCs, which we believe will mitigate concerns about potentially gaming through reporting of more HCCs. More specifically, by limiting the proposed interacted HCC counts factors to certain severe illness and transplant HCCs, we believe that the proposed interacted

[101] See supra note 990.

HCC counts factors would restrict the scope for coding proliferation and effectively mitigate the potential for gaming.

One potential concern is that the interacted HCC counts coefficients might be based on small sample sizes. To address these concerns, we considered sample sizes of the various interacted HCC counts factors when developing the factors proposed in the proposed 2022 Payment Notice. To that end, we analyzed multiple years of enrollee-level EDGE datasets and chose the model specifications that grouped the HCC counts interacted with individual severity and transplant HCCs into two sets of aggregated factors to maximize sample size, reduce concerns of overfitting the model, and reduce the number of factors being added to the models. The resulting sample sizes for the proposed interacted HCC counts approach in the proposed 2022 Payment Notice were consistent with the sample sizes for individual HCCs in the current adult and child risk adjustment models.

4.5 Conclusion

In summary, the proposed interacted HCC counts approach significantly improves predictions across most deciles and HCC counts for the very highest-risk enrollees, as well as lowest-risk enrollees without HCCs. As discussed previously, we tested the impact of the interacted HCC counts model approach with the HCC-contingent enrollment duration factors to limit the number of model options that we were comparing in our analysis and to ensure that the impact of the reduced overprediction of enrollee costs at decile 8 (due to the HCC-contingent enrollment duration factors) was accounted for when considering the impact of the proposed interacted HCC counts approach. Our analysis of the combined refinements did not worsen model performance for any of the subpopulations examined, and the overall model R-squared rises. However, while the combined refinements showed improvement for lowest-risk enrollees, such improvement is greatly increased when the combined with the two-stage weighted approach discussed in Chapter 2. The proposed interacted HCC counts, HCC-contingent enrollment duration factors, and the two-stage weighting, when combined, can optimize model performance across the risk spectrum (i.e., for lowest-risk, medium risk and very highest-risk enrollees), as demonstrated in Chapter 5.

Chapter 5: Results and Estimated Impact of Model Specification Changes Under Consideration

In response to comments received during the 2022 Payment Notice rulemaking process on the proposed model specification changes described in Chapters 2-4 of this paper, HHS plans to separately release transfer estimates from a simulation conducted using data on issuers' EDGE servers, described in section 5.2, towards the end of 2021. The purpose of providing the information in this chapter and simulated transfer estimates at a later date is to give issuers a further opportunity to assess how these proposed risk adjustment model specification changes may affect risk scores and transfers under the state payment transfer formula.[102]

For this chapter, we first describe model performance metrics of the combined proposed model specification changes using the 2018 enrollee-level EDGE dataset. Then, we outline the methodology behind the transfer simulation that is being conducted using data on issuers' EDGE servers to provide simulated issuer-specific results. This simulation is applying the proposed 2022 model specification changes to 2020 benefit year data from issuers' EDGE servers to estimate what 2020 benefit year transfers would have been if the proposed 2022 model specification changes were applied. We selected 2020 benefit year data for this exercise because it was the most recently available data at the time of conducting the analysis.

5.1 Combined Impact of Model Specification Changes

We presented the estimated impact of the two-stage weighted approach on model performance in Chapter 2, and the estimated impact of the HCC-contingent enrollment duration factors and the interacted HCC counts on model performance in Chapters 3 and 4, respectively. These impacts illustrate two ways in which the model specification changes proposed in the proposed 2022 Payment Notice could be partially implemented. In the proposed 2022 Payment Notice, we considered the potential trade-offs of using the proposed model specifications changes (i.e., two-stage weighted approach, HCC-contingent enrollment duration factors, and interacted HCC counts approach) over the current model specifications. We also explored how to balance the goals of improving the models' prediction with mitigating modeling complexity and gaming concerns, along with promoting market stability.

HHS continues to believe the best way to comprehensively improve the predictive accuracy of the models across the risk spectrum is to implement all three model specification changes together. This section focuses on the combined impact of all the model specification changes described in Chapters 2–4 on model performance, as compared to the current models.

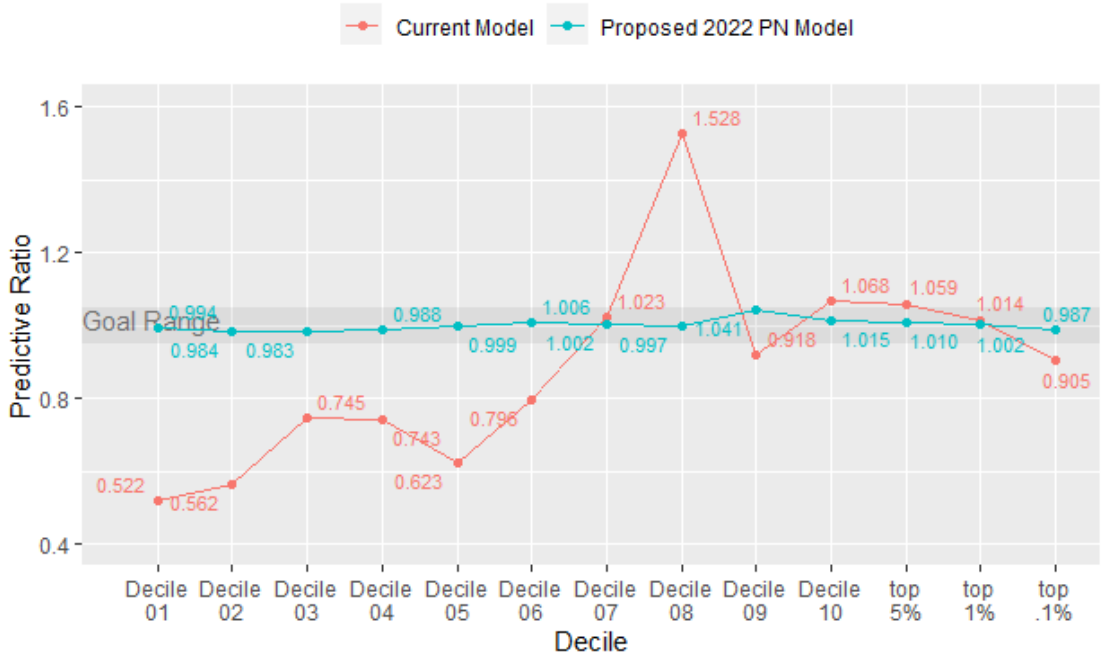
The following figures compare model performance between the current adult models and the combined proposed model specification changes as described in Chapters 2–4 of this paper, as applied to the 2018 enrollee-level EDGE dataset for adult enrollees that include:

[102] If an issuer wishes to use the simulation results to assist in assessing the impact of the model specification changes on future benefit year transfer amounts, it should do so with caution and in combination with other significant data. In particular, smaller issuers may experience a wider degree of variation, given the impact that larger issuers have on transfers within a state market risk pool.

1) The two-stage weighted approach that reweights lowest-risk enrollees more heavily,
2) Monthly enrollment duration factors of up to 6 months for only partial-year enrollees with HCCs, and
3) The interacted HCC counts approach to account for additional incremental risk for enrollees with multiple conditions.

We found that, together, these changes improved PRs in comparison to the current models in each decile of predicted plan liability. Figure 5.1 shows PRs by decile of predicted plan liability for the adult silver plan model using the 2018 enrollee-level EDGE dataset. Additionally, unlike the current adult models (see Figure 2.1), the PRs by age-sex factor for silver plan adult enrollees with and without HCCs are mostly within an acceptable range close to 1.0 when these combined proposed model specification changes are applied, as seen in Figure 5.2. We found similar patterns for PRs by decile of predicted plan liability and age-sex factor across all metal levels for the adult models.

Figure 5.1 Adult Silver Plan Model Predictive Ratios by Decile of Predicted Plan Liability, 2018 Enrollee-Level EDGE Dataset[103]



[103] As previously mentioned, "Enrollee-Level EDGE Dataset" in this paper refers to the national dataset used for risk adjustment model recalibration. This dataset contains limited information generated by reports HHS receives from issuers' EDGE servers, and excludes plan, state, and other information necessary for calculating risk adjustment transfers.

Figure 5.2 Distribution of Proposed 2022 Payment Notice Adult Silver Plan Model Predictive Ratios by Age-Sex Factor, 2018 Enrollee-Level EDGE Dataset

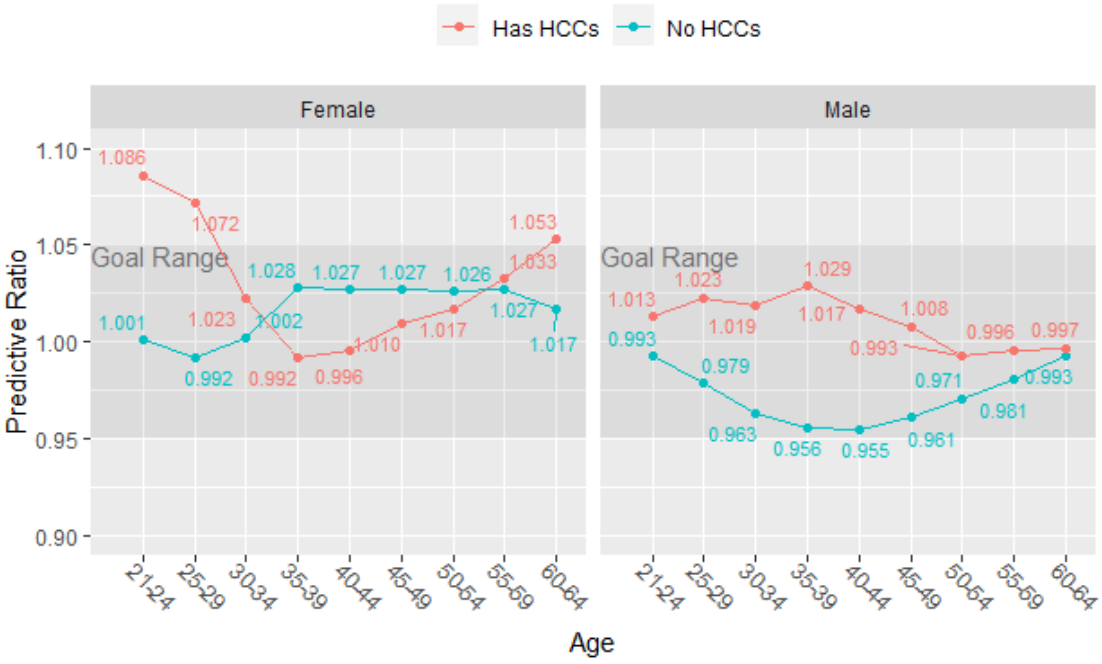


Figure 5.3 shows the adult silver plan model PRs by enrollment length for the current adult models and the proposed 2022 Payment Notice models. When compared to the current model with HCC-contingent EDFs only, adding the two-stage weighting approach and interacted HCC counts model specification weakens the impact of the HCC-contingent enrollment duration factors. The PRs for the models with only HCC-contingent EDFs are slightly closer to 1.0 because the variables for number of HCCs and enrollment duration are explicitly included in the model with HCC-contingent EDFs only. Re-weighting enrollees with lower predicted plan liability during two-stage weighting can cause the PRs for factors in the model to deviate more from 1.0. While some underprediction still remains for enrollees with HCCs and shorter enrollment lengths when the proposed model specification changes are combined, as seen in Figure 5.3, the underprediction is substantially reduced compared to the current models. Similarly, for enrollees without HCCs and shorter enrollment lengths, predictive accuracy improves under the combined proposed model specification changes compared to the current models.

Figure 5.3 Adult Silver Plan Model Predictive Ratios by Enrollment Length for Current Model, Current Model with HCC-Contingent EDFs, and Proposed 2022 Payment Notice Model, 2018 Enrollee-Level EDGE Dataset

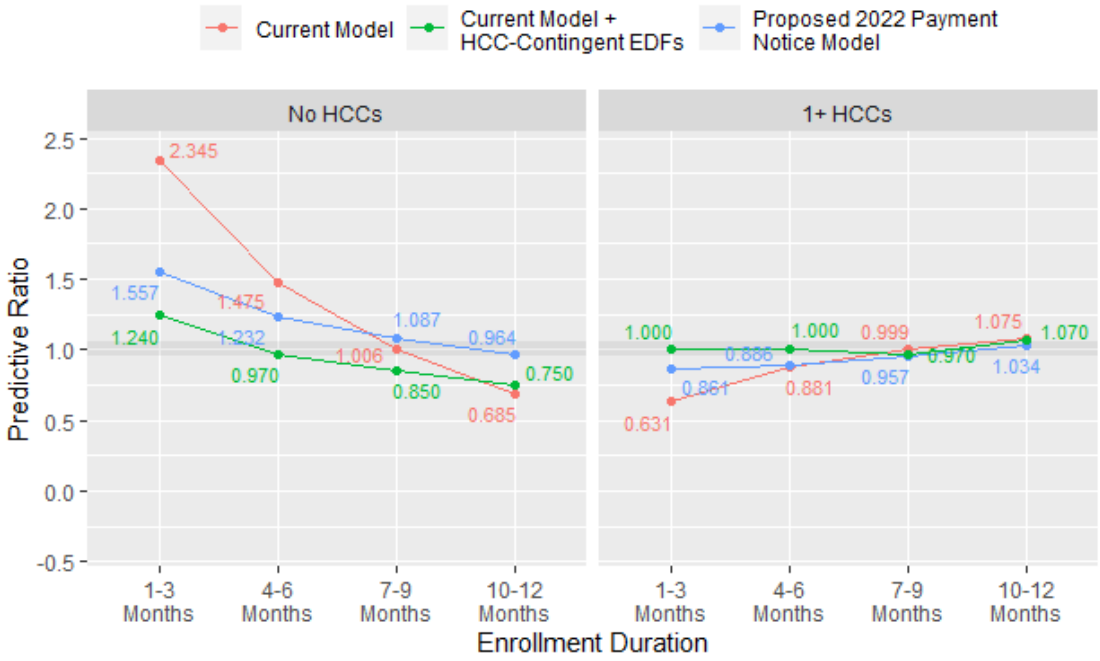
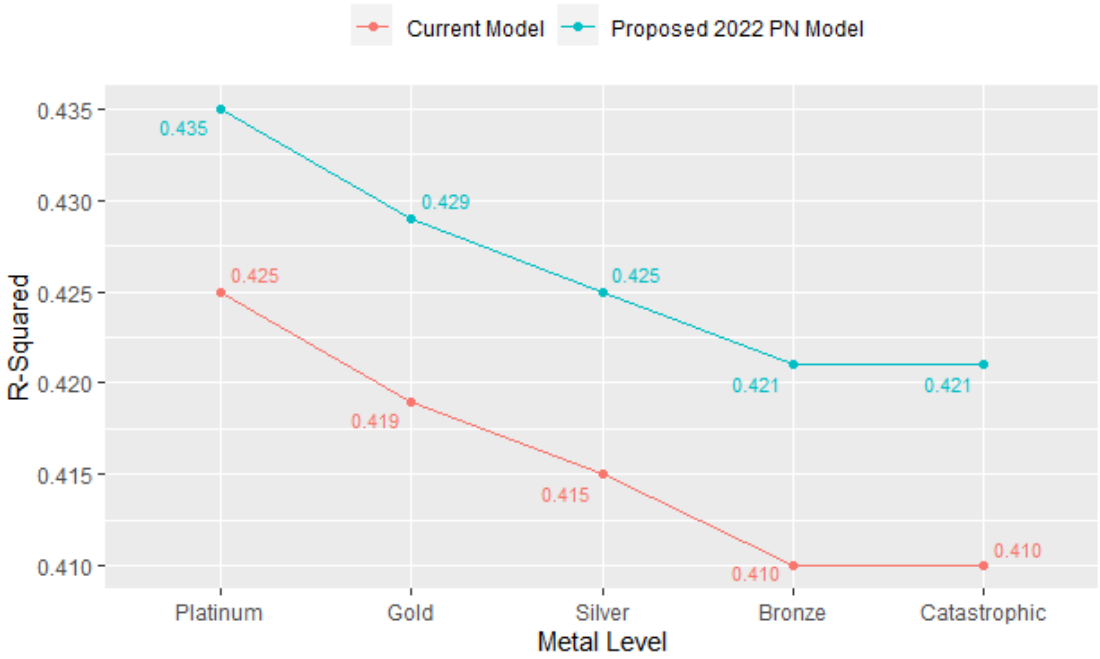


Figure 5.4 shows the R-squared statistics for the current adult models compared to the proposed 2022 Payment Notice models, using the 2018 enrollee-level EDGE dataset. The proposed 2022 Payment Notice adult models have higher R-squared statistics than the current models, indicating a better individual-level fit.

Figure 5.4 Adult Model R-Squared Statistics, 2018 Enrollee-Level EDGE Dataset[104]



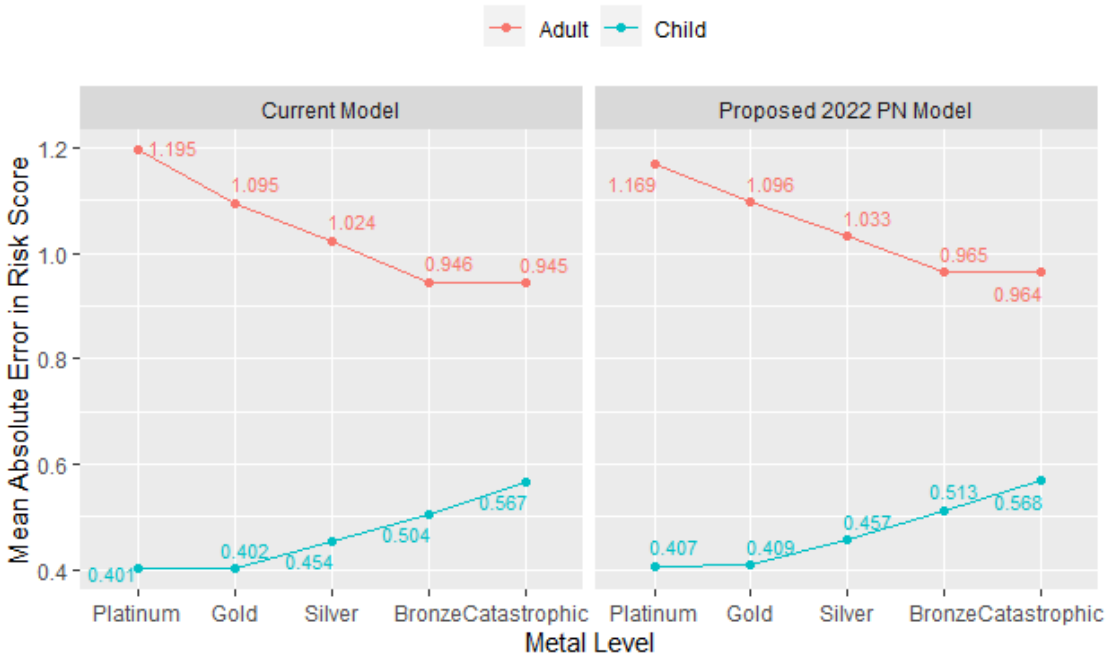
Though we considered PRs and, to a lesser extent, R-squared statistics to be our primary performance metrics, we also considered mean absolute error (MAE) as an alternative metric to evaluate the impact of the model specification changes described in Chapters 2–4. MAEs measure the closeness of the prediction to the eventual outcomes and, unlike R-squared, which measures the proportion of the variance in predicted values explained by the model factors, depend on the absolute magnitude of the data itself. For example, compared to the adult model MAEs, the child model MAEs are lower overall because mean costs are lower and there is less cost variation among children. A low MAE indicates small prediction errors, so all else equal, lower values are more desirable.

We found that the MAEs did not materially differ between the current adult and child models and the proposed 2022 Payment Notice models, which incorporated the combined proposed model specification changes. Figure 5.5 shows the MAEs for the current adult and child models versus the proposed 2022 Payment Notice models. Compared to the current adult models, the proposed 2022 Payment Notice adult models have very slightly higher MAEs for all metal levels except for platinum. This is driven by the two-stage weighted approach, which introduces more variability by weighting observations with lower predicted plan liability higher

[104] For each of the HHS risk adjustment current and proposed models, the R-squared statistic is in the range of published estimates for concurrent risk adjustment models. See Hileman, Geof and Spenser Steele. "Accuracy of Claims-Based Risk Scoring Models." Society of Actuaries. October 2016.

instead of predicting overall plan liability for all enrollees. We found negligible differences between the current and proposed 2022 Payment Notice child models. Overall, the improvements in predictive ratios and R-squared between the current child models and the proposed child models (reflecting the two-stage weighted approach and the interacted HCC counts approach) are not associated with any meaningful increase in MAE.

Figure 5.5 Adult and Child Models' Mean Absolute Errors, 2018 Enrollee-Level EDGE Dataset



After evaluating model performance metrics of the combined proposed model specification changes, we found that, together, these changes are expected to improve model performance in comparison to the current models. Our analysis found general improvement in PRs for the models with the combined proposed model specification changes across each decile of predicted plan liability, by age-sex factor for adult enrollees with and without HCCs, and by enrollment length. We also observed higher R-squared squared statistics across metal levels and similar MAEs compared to the current models. These observations support our belief that the best way to comprehensively improve the predictive accuracy of the models across the risk spectrum is to implement all three model specification changes described in Chapters 2-4 together.

5.2 EDGE Server Transfer Simulation

To give issuers additional information they can use to assess the impact of the combined proposed model specification changes described in Chapters 2–4 on transfer results under the state payment transfer formula, HHS is conducting a transfer simulation on 2020 benefit year plan-level data extracted from issuers' EDGE servers and providing issuer-specific risk score and

transfer estimates.[105] This section provides an overview of the methodology and operational process for running this transfer simulation and explains what issuers can expect from this transfer simulation. We intend to release the transfer simulation results using 2020 plan-level EDGE data towards the end of 2021.

Given the availability of 2020 benefit year data on issuers' EDGE servers, we are using it to conduct this transfer simulation and provide comparative transfer simulation results later this year. Since the purpose of this transfer simulation is to estimate the change in transfers due to model specification changes, the underlying benefit year of data used for the simulation should not matter.

To estimate the impact of the proposed model specification changes, HHS is simulating the process used to calculate transfers for the applicable (un-simulated) benefit year. HHS will first calculate what transfers would be under the current models that do not reflect the combined proposed model specification changes described in Chapters 2 – 4. To provide this benchmark, HHS will use the 2020 plan-level EDGE data to simulate what transfers would be under the most current risk adjustment model factors, the final 2022 risk adjustment model factors.[106] HHS will then use the 2020 plan-level EDGE data to simulate transfers under the risk adjustment model factors as they were proposed in the proposed 2022 Payment Notice, which reflected the adoption of the combined proposed model specifications changes described in Chapters 2 – 4.[107] Stakeholders will be able to compare the results of these two simulations to further analyze the potential impact of the proposed model specification changes.

For the simulation to run successfully, issuers need to run multiple EDGE Ad Hoc commands on their respective EDGE servers.[108] To support this, HHS therefore needs to:

Step 1: Send EDGE server commands to have issuers copy final 2020 benefit year risk adjustment data, so that it can be used separately for this transfer simulation exercise;

Step 2: Send EDGE server commands to apply the final 2022 model factors to the copied 2020 data on issuers' EDGE servers;

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[105] If an issuer wishes to use the simulation results to assist in assessing the impact of the model specification changes on future benefit year transfer amounts, it should do so with caution and in combination with other significant data.

[106] See Updated 2022 Benefit Year Final HHS Risk Adjustment Model Coefficients at: https://www.cms.gov/files/document/updated-2022-benefit-year-final-hhs-risk-adjustment-model-coefficients-clean-version-508.pdf.

[107] See 85 FR at 78586 – 78596.

[108] Issuers are critical partners for running this simulation and need to participate by running the commands provided by CMS within the designated timeframes in order to receive the issuer-level simulation reports. If a credible issuer within a state does not participate, HHS would also not be able to provide simulation results for that state market risk pool. Issuers are considered credible if they have at least 0.5 percent market share in a state. Information on the commands and accompanying timeframes can be found on REGTAP at: https://www.regtap.info/reg_library.php?libfilter_topic=3&libfilter_keyword=xtestyz.

Step 3: Use plan-level EDGE data extracted from issuers' EDGE servers from Step 2 to estimate transfer amounts under the final 2022 models that do not reflect the combined proposed model specification changes;

Step 4: Send EDGE server commands to apply the model factors as they were proposed in the proposed 2022 Payment Notice to the copied 2020 data on issuers' EDGE servers;

Step 5: Use plan-level EDGE data extracted from issuers' EDGE servers from Step 4 to estimate transfer amounts under the proposed 2022 Payment Notice models that reflect the proposed model specification changes; and

Step 6: Compare the transfer simulation results from Steps 3 and 5 to provide further analysis of the impact of the proposed model specification changes.

Table 5.5 below shows the timeline of EDGE server simulation (SIM) zone command iterations. There are four iterations of the SIM zone command where issuers must execute commands as soon as HHS deploys them. Iterations begin on the following dates only for issuers that have successfully completed earlier iterations. For each iteration, separate commands are being released on various dates to:

1. Create simulation zone schema
2. Run the Enrollee Claims Summary (ECS), Frequency (FREQ), Risk Adjustment (RA), High Cost Risk Pool (HCRP), and Ad Hoc commands
3. Archive simulation zone schema

Following the schedule below, issuers have already begun running SIM zone commands on their EDGE servers to support this simulation. We intend to release the transfer simulation results towards the end of 2021, once issuers finish running SIM zone commands, plan-level EDGE data is extracted from issuers' EDGE servers to calculate transfers under the state payment transfer formula, and CMS analyzes the results.

Table 5.5 EDGE Server Simulation (SIM) Zone Commands

Iteration	Tentative Start Date	Description
1	07/16/21	• Data: Final BY20 Data and BY20 Reference Data (RDV42) • CMS deploys commands including Create SIM, ECS, FREQ, RA, HCRP, Ad Hoc, and Archive SIM commands • Issuer and HHS receive reports for remote commands • Note: Issuers who have already copied their BY20 production (PROD) data to the SIM zone for discrepancy analysis and/or beta testing will not receive the 'Iteration 1' Copy PROD to SIM command.
2	07/31/21	• Data: Final BY20 Data and BY21 DIY Table 9 Data • CMS deploys commands including Create SIM, ECS, FREQ, RA, HCRP, Ad Hoc, and Archive SIM commands • Issuer and HHS receive reports

3	08/21/21	• Data: Final BY20 Data and Final BY22 DIY Table 9 Data • CMS deploys commands including Create SIM, ECS, FREQ, RA, HCRP, Ad Hoc, and Archive SIM commands • Issuer and HHS receive reports
4	09/11/21	• Data: Final BY20 Data, Proposed BY22 DIY Table 9 Data, and updated transplant, severity, and enrollment duration logic • CMS deploys commands including Create SIM, ECS, FREQ, RA, HCRP, Ad Hoc, and Archive SIM commands • Issuer and HHS receive reports

Similar to the EDGE server reports issuers receive for the applicable (un-simulated) benefit year of risk adjustment, this simulation exercise will also provide issuers with detailed individual-level data and outbound data files for the simulated results,[109] while HHS will only receive summary-level plan data. HHS intends to publish summary information of this transfer simulation exercise, including information on the change in risk score and change in the transfer as a percent of premium at the state market risk pool level.[110] If an issuer wishes to use the simulation results to assist in assessing the impact of the model specification changes on future benefit year transfer amounts, it should do so with caution and in combination with other significant data. In particular, smaller issuers may experience a wider degree of variation, given the impact that larger issuers have on transfers within a state market risk pool.

5.3 Conclusion

CMS constantly considers ways to refine the risk adjustment models and program requirements, including a variety of different options to address prediction concerns for certain subpopulations. This technical paper focuses on ways to improve the current models' predictive accuracy for the lowest-risk enrollees, certain partial-year adult enrollees, and the very highest-risk enrollees. This paper provides additional data and analysis on proposed model specification changes proposed in the proposed 2022 Payment Notice: two-stage weighting, HCC-contingent enrollment duration factors, and interacted HCC counts.

As discussed above, to further assist stakeholders in understanding the impact of these proposed model specification changes, we intend to release the results from the transfer simulation towards the end of 2021 to provide issuers with illustrative information of what transfers would have been with and without the model specification changes discussed in Chapters 2 - 4.

We are accepting comments on this paper (including the Appendices) at RARIPAYMENTOPERATIONS@cms.hhs.gov with the subject line of "2021 Model Update Technical Paper" until November 26, 2021. We also intend to hold a webinar through REGTAP in November 2021 to review this paper.

[109] Issuers need to participate by running the commands provided by CMS within the designated timeframes in order to receive the issuer-level simulation reports.
[110] Note that the transfer estimates from this simulation will not account for transfer impacts due to 2020 benefit year discrepancies.

Appendix A: Cost-Sharing Reduction Induced Demand Factors

This appendix describes the cost-sharing reduction induced demand factors (CSR IDFs)[111] that are currently used in the state payment transfer formula in the HHS risk adjustment methodology, stakeholder feedback regarding the current CSR IDFs, and potential options—that likely would be implemented no earlier than the 2024 benefit year—to improve prediction of CSR enrollees' plan liability in the state payment transfer formula.

Given that no changes to the CSR IDFs were proposed in the 2022 Payment Notice and the changes proposed in that rule are the primary focus of this paper, none of the data or analyses in Sections 1 – 5 of this paper or in the forthcoming EDGE data transfer simulation will reflect any changes to the CSR IDFs. However, we wanted to share information with stakeholders about our ongoing study and consideration of the current CSR IDFs, including potential options we are exploring to update the CSR IDFs. We continue to consider these options and would propose any changes for future benefit years through notice-and-comment rulemaking, likely no earlier than the 2024 benefit year.

A.1 Background on the CSR Induced Demand Factors

Under the ACA, health insurance plans offered in the individual and small group (including merged) markets are generally grouped into metal levels defined by the plans' AV, meaning the generosity of plan benefits, —bronze (60 percent AV), silver (70 percent AV), gold (80 percent AV), and platinum (90 percent AV). Individuals with household income below 250 percent of the federal poverty level (FPL) and enrolled through the Exchanges in silver plan variants are eligible to receive CSR subsidies,[112] which increase their plan's AV beyond 70 percent by providing the enrollee with more generous cost sharing (maximum out of pocket costs, deductibles, copays, etc.) than the standard silver plan. Until October 2017, issuers received payments from the federal government to compensate for the CSRs issuers provided between the standard silver plan AV (70 percent AV) and the CSR plan variant AVs, which are 73 percent AV for enrollees with household incomes above 200 percent and no more than 250 percent FPL, 87 percent AV for enrollees with household incomes above 150 percent and no more than 200 percent FPL, and 94 percent AV for enrollees with household incomes at or above 100 percent and no more than 150 percent FPL. Starting in October 2017, the federal

[111] These values are commonly referred to as the CSR induced demand factors, the CSR induced utilization factors, the CSR adjustment factors, and the CSR multipliers. We will use the phrase "CSR induced demand factors" or "CSR IDFs" throughout this appendix.

[112] American Indians and Alaska Natives enrolled in any metal level also receive CSRs through zero cost sharing and limited cost sharing plan variants, as do Premium Assistance Medicaid Alternative Plan enrollees in 94 percent AV and zero cost sharing silver plan variants.

government ceased payments of CSRs to issuers.[113] Many issuers started raising premiums to cover CSR costs starting in 2018.

When we developed the state payment transfer formula in the 2014 Payment Notice,[114] we determined that we should account for induced demand associated with two separate sources: (1) the plan generosity differences between metal levels and (2) enrollee receipt of CSRs, which result in greater generosity of CSR plan variations relative to standard plans. Both the higher AVs provided by more generous metal levels and the enhanced cost sharing reductions provided by CSR plan variations allow consumers enrolled in these plans to experience lower cost sharing than less generous metal levels or the standard plan with which the CSR plan variations are associated. As such, based on research findings showing that individuals with lower cost sharing consume more medical care and have higher expenditures than individuals with higher cost sharing,[115] we added metal and CSR IDFs to the state payment transfer formula to account for anticipated increased demand associated with enrollees' selection of higher plan metal levels and enrollee receipt of CSRs. We have maintained the same metal and CSR IDFs since the beginning of the program.[116] The state payment transfer formula appears below.[117]

$$T_i = \left[\frac{PLRS_i \cdot metalIDF_i \cdot GCF_i}{\sum_i (s_i \cdot PLRS_i \cdot metalIDF_i \cdot GCF_i)} - \frac{AV_i \cdot ARF_i \cdot metalIDF_i \cdot GCF_i}{\sum_i (s_i \cdot AV_i \cdot ARF_i \cdot metalIDF_i \cdot GCF_i)}\right] \overline{P_s}$$

And:

$$PLRS_i = \frac{\sum_e (RS_e * csrIDF_e * EMM_e)}{\sum_e BMM_e}$$

Where:

T_i= plan i's per PMPM transfer amount;

$PLRS_i$ = plan i's plan liability risk score;

RS_e = the model calculated risk score for an enrollee's enrollment period e within plan i;

[113] On October 12, 2017, the Attorney General issued a legal opinion that HHS did not have a Congressional appropriation with which to make CSR payments. The Attorney General's opinion regarding CSR payments (2017) is available at: https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

[114] 78 FR 15409 at 15421.

[115] See, for example, the RAND Health Insurance Experiment, available at: https://www.rand.org/health-care/projects/hie.html.

[116] This appendix focuses on the CSR IDFs, as HHS has not noted any significant prediction concerns with the metal IDFs and stakeholders' comments have not focused on the metal IDFs.

[117] Previously published versions of the state payment transfer formula, and the version that appears in section 1.2.3 earlier in this paper, do not show separate IDFs for metal level and CSRs. As this appendix focuses specifically on the CSR IDFs to further illustrate the issues under consideration, we have made explicit in this appendix that the IDF term in the previously published formula refers to metal IDFs, and that CSR IDFs are present in the PLRS term. The different display does not modify or otherwise represent a change to the state payment transfer formula as finalized through the Payment Notice rulemaking process.

$csrIDF_e$ = the CSR induced demand factor for an enrollee's enrollment period e within plan i;[118]

EMM_e = the total enrollment months for an enrollee's enrollment period e within plan i;

BMM_e = the billable months[119] for an enrollee's enrollment period e within plan i;

$metalIDF_i$ = plan i's metal induced demand factor;

GCF_i = plan i's geographic cost factor;

s_i = plan i's share of state enrollment;

AV_i = plan i's metal level AV;

ARF_i = allowable rating factor; and

$\bar{P}_S$ = statewide average premium.

As discussed in Section 1.2.3, the first half of the state payment transfer formula ($\frac{PLRS_i \cdot metalIDF_i \cdot GCF_i}{\sum_i (s_i \cdot PLRS_i \cdot metalIDF_i \cdot GCF_i)}$) is referred to as the risk term and includes IDFs that account for both metal and CSR induced demand (CSR IDFs are included in the calculation of the PLRS), so that the risk scores for CSR enrollees are adjusted by both IDFs. For example, a silver CSR enrollee in an 87 or 94 percent AV plan variant would have a 1.03 metal IDF and a 1.12 CSR IDF, as seen in Tables A.1 and A.2 below. Due to the multiplicative nature of the variables in the risk term, the effects of these IDFs combine in the risk term to roughly equal the effect of the 1.15 metal IDF for platinum plans.

The second half of the state payment transfer formula ($\frac{AV_i \cdot ARF_i \cdot metalIDF_i \cdot GCF_i}{\sum_i (s_i \cdot AV_i \cdot ARF_i \cdot metalIDF_i \cdot GCF_i)}$), referred to as the rating term, is an estimate of what an issuer's premium would need to be in the absence of risk selection[120] and therefore only includes plan-level values, including an IDF variable that only accounts for metal induced demand (i.e., the metal IDFs). Note that the rating term does not include a plan's risk score, because rating on health status risk is not allowable under the ACA for individual and small group non-grandfathered health insurance coverage.[121]

[118] CSR plan variants are denoted at the 16-digit plan ID level and are subsequently aggregated to the 14-digit plan ID level in the $PLRS_i$ calculation step. Transfers are then calculated using the state payment transfer formula at the 14-digit plan ID level.

[119] When the plan average PLRS is calculated, all plan enrollees are counted in the numerator, but only billable plan enrollees (parents and up to the three oldest children) are counted in the denominator. This creates a weighted average plan PLRS that takes into account the fact that families with non-billable children impose more risk per billable member-month than families in which every member-month is billable, all else being equal. See https://www.cms.gov/mmrr/Downloads/MMRR2014_004_03_a03.pdf and https://www.cms.gov/mmrr/downloads/mmrr2014_004_03_a04.pdf.

[120] See https://www.cms.gov/mmrr/downloads/mmrr2014_004_03_a04.pdf

[121] See section 2701 of the Public Health Service Act and 45 CFR 147.102.

Because the CSR IDFs are only represented as a component of the plan's risk score, there is no representation of CSR IDFs in the rating term.

Table A.1 shows the CSR IDFs currently used in the state payment transfer formula. Table A.2 shows the metal IDFs currently used in the state payment transfer formula.

Table A.1: CSR Induced Demand Factors

Household Income	Plan AV	Induced Demand Factor
Silver Plan Variant Recipients		
100-150% of FPL	Plan Variation 94%	1.12
150-200% of FPL	Plan Variation 87%	1.12
200-250% of FPL	Plan Variation 73%	1.00
>250% of FPL	Standard Plan 70%	1.00
Zero Cost Sharing Recipients		
<300% of FPL	Platinum (90%)	1.00
<300% of FPL	Gold (80%)	1.07
<300% of FPL	Silver (70%)	1.12
<300% of FPL	Bronze (60%)	1.15
Limited Cost Sharing Recipients		
>300% of FPL	Platinum (90%)	1.00
>300% of FPL	Gold (80%)	1.07
>300% of FPL	Silver (70%)	1.12
>300% of FPL	Bronze (60%)	1.15

Table A.2 Metal Induced Demand Factors

Metal Level	Induced Demand Factor
Catastrophic	1.00
Bronze	1.00
Silver	1.03
Gold	1.08
Platinum	1.15

A.2 Stakeholder Feedback on CSR Induced Demand Factors

HHS received comments to the proposed 2022 Payment Notice and past Payment Notices asking HHS to review the CSR IDFs in the risk adjustment models. Some of these stakeholders shared anecdotal reports from issuers that suggest the CSR IDFs in the risk term may overcompensate silver plans and undercompensate plans at other metal levels, suggesting this occurs because CSR enrollees tend to be more price sensitive due to their lower incomes and are

not in fact using more services despite having more generous coverage.[122] These commenters argued that issuers are setting the silver plan premiums low to attract these CSR enrollees due to a perceived overcompensation in the risk term in the state payment transfer formula that may occur for some issuers. They stated that these silver premiums, which they explained are lower than the commenters' expectations, ultimately reduced the cost of the second lowest cost silver plan that forms the basis of the premium tax credit (PTC) calculation, thereby reducing the amount of PTC that consumers were eligible to receive. The commenters suggested that HHS should take action to address this misalignment, which they contend would reduce premiums costs for 97 percent of Exchange enrollees. Other commenters generally requested that we reevaluate the CSR IDFs to confirm the current values are accurate or to update them based on more recent data, as we have not recalibrated the IDF factors since the inception of the HHS-operated risk adjustment program in the 2014 benefit year.[123] Although we have not updated the CSR IDFs, we have continued to analyze induced demand and CSR plan liability in both the risk term and the rating term of the state payment transfer formula, which we discuss in detail below.

A.2.1 Risk Term Analysis

To consider the impact of the CSR IDFs on the risk term, we tested for induced demand of CSR enrollees using more recently available data. Using the 2016 and 2017 enrollee-level EDGE datasets,[124] we estimated the mean expenditure differentials associated with enrollment in various metal levels and CSR variants to approximate the effect of health insurance coverage on utilization and expenditures. We included the full set of applicable risk adjustment model factors, including demographic factors, HCCs, RXCs (adult models only), and enrollment duration factors (adult models only), in this analysis, to control for those factors that could independently influence enrollee risk and utilization. The results of this analysis using the 2017 individual market enrollee-level EDGE dataset appear in Tables A.3 and A.4 below. In Table A.3, which assesses CSR IDFs, positive values indicate higher expenditures for CSR enrollees compared to non-CSR silver enrollees, while negative values indicate lower expenditures for CSR enrollees. Accordingly, our analysis shows that all CSR silver enrollees except the American Indian/Alaska Native CSR plan variant enrollees demonstrate lower expenditures than non-CSR silver enrollees.[125] This implies a lack of evidence of higher induced demand associated with receipt of CSRs for most CSR enrollees.[126]

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[122] See Lissenden et al, A Comparison of Health Risk and Costs Across Private Insurance Markets, Med Care 58(2), February 2020, available at: https://pubmed.ncbi.nlm.nih.gov/31688571/. https://pubmed.ncbi.nlm.nih.gov/31688571/.

[123] See 78 FR 15410 at 15421-2.

[124] Preliminary results using the 2018 and 2019 enrollee-level EDGE datasets suggest consistent results with those presented here.

[125] In addition to the 73 percent, 87 percent, 94 percent, zero cost sharing, and limited cost sharing CSR plan variants, we also tested induced demand for the Premium Assistance Medicaid Alternative Plans (94 percent AV and zero cost sharing variants) and again did not find any evidence of induced demand associated with those enrollees.

[126] We also assessed metal IDFs and found that expenditure differentials indicated that the current metal IDFs are reasonable.

Table A.3: Mean Expenditure Differentials by CSR Plan Variant as Compared to Standard Silver Plan, 2017 EDGE Individual Market Enrollee-Level EDGE Dataset

Household Income	Plan Variant	% Difference in Expenditures
>250% of FPL	On-Exchange Silver Standard Plan (70% AV)	(point of comparison)
<300% of FPL	American Indian/Alaska Native Plan (Zero Cost Sharing)	7.53%
>300% of FPL	American Indian/Alaska Native Plan (Limited Cost Sharing)	3.72%
200-250% of FPL	73% AV Plan Variant	-1.38%
150-200% of FPL	87% AV Plan Variant	-0.74%
100-150% of FPL	94% AV Plan Variant	-1.81%

After testing for induced demand, we tested whether CSR plan variants were being overcompensated by the CSR IDFs as some stakeholders had suggested. However, for this analysis, we had concerns about the limitations of assessing the accuracy of model predictions for CSR enrollees using only simulated silver plan liability. As mentioned earlier in this paper, we calculate PRs as the ratio of predicted to actual weighted mean plan liability expenditures. For most of our analyses, we calculate predicted mean plan liability expenditures (the numerator of the PR) using only the model coefficients to which enrollees are subject. As such, predicted mean plan liability expenditures in this context excludes adjustments for CSR IDFs, metal IDFs, and GCFs for each rating area. On the other hand, we generally simulate actual weighted mean plan liability expenditures (the denominator of the PR) based on standardized benefit designs for each metal, cost trends (e.g., medical inflation) from the years used to calibrate the model to the payment year for which the model is effective, and adjustments to account for the high-cost risk pool. These PRs are an excellent tool for investigating how well the risk adjustment models themselves predict expenditures for various subgroup, but in the state payment transfer formula, predicted plan liability represented by the risk term reflects more than just the risk score from the risk adjustment models. As such, we created an additional type of PR that can be used to evaluate the performance of the relative risk measure (i.e., the risk term) in the state payment transfer formula. We termed this type of PR the "nationally-approximated risk term PR."

Rather than reflecting risk score as derived from the model coefficients exclusively, these PRs are a more complete reflection of the risk term in the state payment transfer formula (i.e. they take into account metal-level IDFs and CSR IDFs, but due to data limitations, do not account for the geographic components of the risk term—specifically, GCF and state-level standardization—because all geographic identifiers were excluded from the 2019 Enrollee-level

EDGE dataset for the individual market).[127] The national weighted average of this more complete reflection of the risk term serves as the numerator in the PR calculation, with the national weighted average of standardized paid claims in the denominator (rather than simulated plan liability expenditures).

The results of the analysis on nationally-approximated risk term PRs, seen in Table A.4, indicate that the most common high CSR variants are predicting actual plan liability relatively accurately on average. Although the 73 percent AV Silver CSR variant is overpredicted by about 14 percent, we note that this CSR variant reflects less than half of the enrollment in the 87 percent and 94 percent AV CSR variants, which demonstrate a fair degree of accuracy as indicated by their PRs.

Table A.4: Nationally-Approximated Risk Term Predictive Ratios by Metal-CSR Level, 2019 Enrollee-level EDGE Individual Market Data and 2019 EDGE Plan-Level Data

Metal-CSR Level	Predictive Ratio	Enrollment Months in Plan Level Data
On-Exchange Silver, no CSR	1.03	10,053,099
Silver CSR, 73% AV	1.14	8,044,442
Silver CSR, 87% AV	1.05	18,752,341
Silver CSR, 94% AV	0.98	30,801,803
American Indian/Alaska Native, Zero Cost Sharing	0.71	478,753
American Indian/Alaska Native, Limited Cost Sharing	0.97	72,995

Although we did not specifically identify any evidence of induced demand associated with CSR enrollees, Table A.4 above shows that the risk term PRs[128] associated with CSR enrollees are mostly adequate (PRs within +/– 5 percent are considered reasonable), at least for the most common high CSR variants, although they could be improved. This suggests that, even if silver plan risk scores from the risk adjustment models are overpredicted relative to the 70 percent AV of the standard silver plan, issuers are also paying more than the expected silver plan liability for CSR enrollees in terms of actual paid claims under these plans. As such, this analysis

[127] Testing the accuracy of predictions by CSR level using full risk term PRs (including the geographic components) would require using 2019 EDGE plan-level data (which can only reflect risk scores from the final 2019 risk adjustment models), rather than 2019 Enrollee-level EDGE dataset for the individual market (which can reflect risk scores resulting from the risk adjustment model changes discussed throughout the paper). Although we conducted analysis on the 2019 risk adjustment model full risk term PRs derived from plan-level data, we have not discussed these results in detail here because they are less relevant in the context of the potential model changes presented in this paper. However, we note that the results were extremely similar to the results in Table A.4.

[128] Risk term PRs, which measure the accuracy of the risk term at *predicting actual paid claims*, are better than risk score PRs for this analysis, since CSR plan variants owe more than 70 percent of allowed charges for their CSR enrollees. As stated in section 1.4, risk score PRs evaluate the accuracy of the PLRS at predicting *simulated PMPM plan liability* based on the silver model factors, which account for 70 percent cost sharing.

suggests the risk term is predicting what plans are actually paying for CSR enrollees reasonably well.

As a result of this analysis, we conclude that, in aggregate, the current CSR IDFs in the risk term are not resulting in meaningful overcompensation of CSR plan variants or under-compensation of plans at other metal levels, contrary to concerns of some stakeholders. Nevertheless, we believe that the current CSR IDFs should be re-evaluated because of: (1) a potential lack of alignment between the original intent of the CSR IDFs (accounting for anticipated induced demand due to lower cost sharing) and their current function; and (2) the desire to refine the CSR IDFs in the risk term using more recent data. See A.3.1 for details on current risk term update options under consideration.

A.2.2 Rating Term Analysis

As previously mentioned, the rating term does not include any adjustment for CSR plan variants because CSR IDFs are assessed as a part of plan liability (the risk term), whereas the rating term reflects the premium that the plan would be allowed to collect from enrollees who are of average risk (taking into account their age, geographic location, the stated AV of their metal level, and the applicable metal IDF). However, the value of the AV in the state payment transfer formula for all silver plans, regardless of whether they are CSR plan variants, is the standard silver plan AV of 70 percent. It therefore does not reflect the higher AV ranges of the CSR silver plan variants, which some issuers are reflecting in higher rates. This AV, which is lower than the liability plans incur for the higher-AV CSR variants, could result in silver plans receiving larger risk adjustment payments or owing smaller charges than they would if the rating term were adjusted for CSR liability applicable to the higher AV CSR plan variants. This lack of a CSR adjustment in the rating term could increase compensation for silver plans and decrease compensation for plans at other metal levels relative to what these plans' transfers would have been in the absence of the higher than 70 percent AV among CSR silver plan variations. Therefore, we intend to consider options to address the current treatment of the CSRs in the rating term along with the re-evaluation of the CSR IDFs in the risk term of the state payment transfer formula. See section A.3.2 for details on current rating term update options under consideration.

A.3 Potential Future Changes to CSR Induced Demand Factors

We have identified several potential options to update the risk term and one option to update the rating term to more precisely account for CSR plan liability in the state payment transfer formula. These options could be done in combination to update both the risk term and rating term together, although these options have varying potential impacts on risk adjustment transfers and the state market risk pools. These options are targeted refinements that reflect the current lack of an appropriation for HHS to make CSR payments to issuers, so several of these options would likely not be appropriate if an appropriation to make CSR payments were to be enacted in the future. As noted above, we continue to consider these options and would propose any changes for future benefit years through notice-and-comment rulemaking, likely no earlier than the 2024 benefit year.

A.3.1 Risk Term Update Options

The following three options would revise the CSR IDFs in the risk term[129] to more precisely account for CSR plan liability.

1. Reframe and Recalibrate the CSR IDFs: Under this option, we would reframe and recalibrate the current CSR IDFs to shift their focus from accounting for anticipated induced demand to accounting for the higher AV of CSR plan variants. This change would also update the CSR IDFs using enrollee-level EDGE data for the first time, as they were developed and calibrated using MarketScan® large group market data and have not been updated since 2015. Specifically, under this option, we would refer to the CSR IDFs as "CSR adjustment factors" and refine their values by recalibrating them for all CSR plan variants such that the risk term PRs shown in Table A.4 are as close as possible to 1.00 (accurate prediction) for all CSR plan variants.[130] We believe that this option is consistent with our recent analysis suggesting that the anticipated induced demand does not exist for these enrollees and that this option would address stakeholder requests to evaluate the current CSR IDFs. This option would also preserve flexibility to update the risk term for CSR enrollees in the future. However, as the potential new recalibrated CSR Adjustment Factors could be higher than the current CSR IDFs, this option might not have the impact on transfers that some stakeholders have argued is needed. A potential set of recalibrated CSR adjustment factors appears in Table A.5 below.[131]

[129] These options do not include any changes to the metal IDFs as our analysis found the current metal IDFs in the risk term are reasonable.

[130] Under this option, we would calculate the CSR adjustment factors using multiple years of enrollee-level EDGE data to ensure consistency but would not recalibrate their values each year.

[131] The potential set of recalibrated CSR adjustment factors were recalibrated using only 2019 EDGE plan-level data and are being provided for illustrative purposes. As part of our further consideration of this option, HHS intends to analyze additional years of EDGE plan-level data to ensure consistency of factors across data years.

Table A.5: Potential Recalibrated CSR Adjustment Factors

Household Income	Plan AV	Adjustment Factor
Silver Plan Variant Recipients		
100-150% of Federal Poverty Line (FPL)	Plan Variation 94%	1.20
150-200% of FPL	Plan Variation 87%	1.10
200-250% of FPL	Plan Variation 73%	1.00
>250% of FPL	Standard Plan 70%	1.00
Zero Cost Sharing Recipients		
<300% of FPL	Platinum (90%)	1.15
<300% of FPL	Gold (80%)	1.35
<300% of FPL	Silver (70%)	1.45
<300% of FPL	Bronze (60%)	1.55
Limited Cost Sharing Recipients		
>300% of FPL	Platinum (90%)	1.00
>300% of FPL	Gold (80%)	1.05
>300% of FPL	Silver (70%)	1.15
>300% of FPL	Bronze (60%)	1.25

2. Use Platinum Risk Adjustment Model Factors: The second option would eliminate the CSR IDFs from the PLRS component of the risk term and use the platinum risk adjustment model factors to calculate risk scores for CSR enrollees in the 87 percent, 94 percent, zero cost sharing, and limited cost sharing plan variants. Although we would be calculating PLRS for these enrollees based on the platinum model factors, the metal IDFs would remain unchanged and continue to reflect the metal level of the CSR enrollees (i.e. the silver metal IDFs for the 87 percent and 94 percent AV CSR variants). This option would better capture plan liability for those enrollees since the platinum AV (90 percent) is much closer to the true AV of those plan variants. Under this option, we would continue to use the silver risk adjustment model factors to calculate risk scores for CSR enrollees in the 73 percent AV plan variants. Some stakeholders have requested this option, and we have considered it in the past.[132] However, it is less flexible than the previous option in terms of capturing differences among CSR plan variant enrollees (for example, this would not account for differences between 87 percent and 94 percent CSR plan variant enrollees, or between those enrollees and the zero-cost sharing and limited cost sharing CSR plan variant enrollees).
3. Create Separate Risk Adjustment Models for CSR Plan Variants: The third option would eliminate the CSR IDFs from the PLRS component of the risk term and create separate risk adjustment models for the 87 percent, 94 percent, zero cost sharing, and limited cost sharing CSR plan variants. These additional risk adjustment models

[132] See the August 10, 2017 FAQ titled Information on Risk Adjustment Methodology and Rate Filing Deadlines, available at: https://www.regtap.info/uploads/library/QHP_FAQ_5CR_081117.pdf.

would account for the difference in plan liability between enrollees in these CSR plan variants and the standard silver plan and 73 percent CSR plan variant enrollees, and it would result in risk scores that are more aligned with actual plan liability for CSR enrollees. Some stakeholders have also requested this approach in the past. However, it would complicate risk adjustment by adding several new models to the HHS-operated methodology. Moreover, the HHS risk adjustment models are calibrated using the same standard population across all models. This standard population is drawn from enrollee-level EDGE data (including data from the small group market) and varies by model only in the set of standard payment parameters used to simulate plan liability by metal level. However, it is difficult to justify either (1) using the standard population inclusive of small group market data to calibrate CSR plans because CSR plans are only offered on the individual market, or (2) using a CSR- or individual-market-specific population when all other models are based on the standard population. We would also have to determine if we should have new models for each age group (adult, child, and infant) for each of the 87 percent, 94 percent, zero cost sharing, and limited cost sharing CSR plan variants, or if we should consolidate these models (and if so, how) to increase model factor stability. Furthermore, these higher-AV CSR plan variants have overlapping *de minimis* AV ranges with platinum plans, so the new model factors would be very similar to the existing platinum model factors. Therefore, we believe it would be simpler to adopt one of the other risk term update options described in the previous paragraphs.

A.3.2 Rating Term Update Options

To more precisely reflect CSR plan variants in the second half of the state payment transfer formula, we could use the average silver plan AV of an issuer's silver plan, including CSR plan variant AVs, weighted by the proportion of the issuer's plan enrollment that falls under each CSR plan variant, in the rating term rather than use the standard silver AV (70 percent), as is currently the case. To determine a single rating term AV for a silver plan, we could calculate an enrollment-weighted average AV across the five main silver plan variants.[133] However, if the weighted average were dependent on plan enrollment for each variant and varied at the 14-digit plan ID level, the plan's rating term AV (and thus expected premium) would vary based on plan selection by CSR enrollees, which is contrary to the purpose of risk adjustment. Therefore, to avoid this concern, we could calculate the weighted average rating term AV across all plans at the national level, thereby ensuring the AV will be the same amount for all silver plans nationally. An approach that reflects the higher AV for the CSR plan variants in both terms

[133] The AVs of the five main silver plan variants are the 70 percent AV for the off-Exchange silver plan, the 70 percent AV for the on-Exchange standard silver plan, 73 percent AV for the CSR plan variant for individuals with household income 200-250 percent FPL, 87 percent AV for the CSR plan variant for individuals with household income 150-200 percent FPL, and 94 percent AV for the CSR plan variant for individuals with household income 100-150 percent FPL.

would be in keeping with the intent of the AV factor in the state payment transfer formula to reflect differences in plan generosity rather than selection.

A.4 Next Steps

Our intention with this appendix is to familiarize stakeholders with our considerations regarding the current CSR and metal IDFs and potential options we are considering to more precisely predict plan liability for CSR enrollees. As noted above, we did not propose changes to the CSR or metal IDFs in the 2022 Payment Notice and these options will not be reflected in the EDGE server transfer simulation HHS intends to provide later this year. We continue to conduct analyses of these options and will propose any changes in future notice-and-comment rulemaking, likely no earlier than the 2024 benefit year. As noted above, we are also accepting comments on this paper (including the Appendices) at RARIPAYMENTOPERATIONS@cms.hhs.gov with the subject line of "2021 Model Update Technical Paper" until November 26, 2021.

Appendix B: List of Acute HCCs Used in Enrollment Duration Factors Analysis

The below list includes the HCCs we considered to be acute for the purposes of the analysis of enrollment duration factors by presence of acute vs. chronic HCCs found in section 3.3.3.[134]

(1) HCC 2: Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
(2) HCC 3: Central Nervous System Infections, Except Viral Meningitis
(3) HCC 4: Viral or Unspecified Meningitis
(4) HCC 23: Protein-Calorie Malnutrition
(5) HCC 38: Acute Liver Failure/Disease, Including Neonatal Hepatitis
(6) HCC 42: Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis
(7) HCC 45: Intestinal Obstruction
(8) HCC 47: Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption
(9) HCC 54: Necrotizing Fasciitis
(10) HCC 55: Bone/Joint/Muscle Infections/Necrosis
(11) HCC 63: Cleft Lip/Cleft Palate
(12) HCC 126: Respiratory Arrest
(13) HCC 127: Cardio-Respiratory Failure and Shock, Incl. Respiratory Distress Syndromes
(14) HCC 135: Heart Infection/Inflammation, Except Rheumatic
(15) HCC 154: Vascular Disease with Complications
(16) HCC 156: Pulmonary Embolism and Deep Vein Thrombosis
(17) HCC 163: Aspiration, Specified Bacterial Pneumonias and Other Severe Lung Infections
(18) HCC 203: Ectopic and Molar Pregnancy, Except with Renal Failure, Shock, or Embolism
(19) HCC 204: Miscarriage with Complications
(20) HCC 205: Miscarriage with No or Minor Complications
(21) HCC 207: Completed Pregnancy With Major Complications
(22) HCC 208: Completed Pregnancy With Complications
(23) HCC 209: Completed Pregnancy with No or Minor Complications
(24) HCC 226: Hip Fractures and Pathological Vertebral or Humerus Fractures
(25) HCC 227: Pathological Fractures, Except of Vertebrae, Hip, or Humerus

[134] As this analysis was conducted using the 2017 enrollee-level EDGE dataset, this list of HCCs comes from the V05 classification model and does not represent the current (2021 benefit year) list of payment HCCs in the V07 classification model.

Appendix C: HCCs in the 2021 Adult Model Severity Illness Indicator Variable and HCCs Selected for HCC Interacted Counts Variables for the Adult and Child Models

Payment HCC		2021 Model Severity Illness Indicator	New Severe Illness Indicator	New Transplant Indicator
HCC 2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	X	X	
HCC 3	Central Nervous System Infections, Except Viral Meningitis		X	
HCC 4	Viral or Unspecified Meningitis		X	
HCC 6	Opportunistic Infections		X	
HCC 18	Pancreas Transplant Status[135]		X	X
HCC 23	Protein-Calorie Malnutrition		X	
HCC 34	Liver Transplant Status/Complications		X	X
HCC 41	Intestine Transplant Status/Complications		X	X
HCC 42	Peritonitis/Gastrointestinal Perforation/Necrotizing Enterocolitis	X	X	
HCC 96	Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes		X	
HCC 120	Seizure Disorders and Convulsions	X		
HCC 121	Hydrocephalus		X	
HCC 122	Coma, Brain Compression/Anoxic Damage	X	X	
HCC 125	Respirator Dependence/Tracheostomy Status	X	X	
HCC 126	Respiratory Arrest	X		

[135] HCC 18 (Pancreas Transplant) was not included in this list in the proposed 2022 Payment Notice. HCC 18 has a much lower coefficient than any of the other transplant HCCs in the adult models and was not underpredicted by the models. In the proposed 2022 Payment Notice, we proposed to exclude it from the list in and solicited comments on the proposed treatment of HCC 18. We did not receive any comments on including or excluding HCC 18 in the severity and transplant indicators. We included it in the analysis in this paper to be consistent with all the other transplant HCCs.

Payment HCC	2021 Model Severity Illness Indicator	New Severe Illness Indicator	New Transplant Indicator	Payment HCC
HCC 127	Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes	X		
HCC 135	Heart Infection/Inflammation, Except Rheumatic		X	
HCC 145	Intracranial Hemorrhage		X	
HCC 156	Pulmonary Embolism and Deep Vein Thrombosis	X	X	
HCC 158	Lung Transplant Status/Complications		X	X
HCC 163	Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections		X	
HCC 183	Kidney Transplant Status/Complications		X	X
HCC 218	Extensive Third Degree Burns		X	
HCC 223	Severe Head Injury		X	
HCC 251	Stem Cell, Including Bone Marrow, Transplant Status/Complications		X	X
G13	(Includes HCC 126 Respiratory Arrest and HCC 127 Cardio-Respiratory Failure and Shock, Including Respiratory Distress Syndromes)		X	
G14	(Includes HCC 128 Heart Assistive Device/Artificial Heart and HCC 129 Heart Transplant Status/ Complications)		X	X

CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Phillip L. Swagel, Director

October 19, 2021

Honorable Jason Smith
Ranking Member
Committee on the Budget
U.S. House of Representatives
Washington, DC 20515

Re: Provisions in Reconciliation Legislation That Would Affect Health Insurance Coverage of People Under Age 65

Dear Congressman:

This letter responds to your request for information about the Congressional Budget Office's cost estimates for specified health care provisions contained in the reconciliation legislation being considered by the House of Representatives. The relevant sections would extend eligibility for and increase the amount of premium tax credits and cost-sharing reductions available for health insurance through the marketplaces established under the Affordable Care Act (ACA). They also would establish a federal Medicaid program for states that have not expanded Medicaid under the ACA.

The reconciliation process stems from S. Con. Res. 14, the Concurrent Resolution on the Budget for Fiscal Year 2022, which instructed 13 committees to recommend legislative changes that would affect deficits over the 2022-2031 period.[1] As part of that process, the House Committee on Ways and Means and the House Committee on Energy and Commerce approved legislation on September 15, 2021. On September 27, 2021,

1. Section 2002 of S. Con. Res. 14 instructed 12 committees in the House of Representatives to recommend legislation that would increase the deficit by up to $1.975 trillion and instructed the Committee on Ways and Means to recommend legislation that would decrease the deficit by at least $1 billion. For more information, see Megan S. Lynch, *S.Con.Res. 14: The Budget Resolution for FY2022,* Report R46893, version 2 (Congressional Research Service, September 1, 2021), https://go.usa.gov/xMF57.

the House Committee on the Budget combined the recommendations of the committees and reported H.R. 5376, a bill to provide for reconciliation pursuant to title II of S. Con. Res. 14.

CBO has not yet completed a cost estimate of H.R. 5376 as a whole. This letter provides estimates for the provisions in that bill for which you have requested additional information.

Estimated Federal Costs and Changes in Health Insurance Coverage

You asked how the reconciliation legislation would affect health insurance coverage for people under age 65. CBO and the staff of the Joint Committee on Taxation (JCT) have analyzed the following provisions:

- Section 137501—Improve Affordability and Reduce Premium Costs of Health Insurance for Consumers;
- Sections 137504, 137505, and 30701: provisions affecting coverage for people with low income, particularly those whose income is below 138 percent of the federal poverty level (FPL)—Temporary Expansion of Health Insurance Premium Tax Credits for Certain Low-Income Populations, Ensuring Affordability of Coverage for Certain Low-Income Populations, and Closing the Medicaid Coverage Gap;
- Section 137507—Special Rule for Individuals Receiving Unemployment Compensation; and
- Section 137502—Modification of Employer-Sponsored Coverage Affordability Test in Health Insurance Premium Tax Credit.

CBO and JCT estimate that enacting those provisions would increase deficits by $553.2 billion over the 2022-2031 period (see Table 1). Estimates for all provisions account for interactions with section 137501.

Over the 2022-2031 period, CBO and JCT estimate, enacting the provisions discussed here would result in a net decline of about 3.9 million people without health insurance. The components of that change (which do not sum to the total because of rounding) would be as follows:

- 4.0 million increase in Medicaid enrollment;
- 3.6 million increase in subsidized nongroup enrollment;

- 1.0 million decrease in unsubsidized nongroup enrollment; and
- 2.8 million decrease in enrollment in employment-based coverage.

CBO and JCT estimate that under the legislation, in 2031, 23.6 million people under the age of 65 would be uninsured—a reduction from the current-law total of 27.7 million people.

CBO and JCT classified people who do not have health insurance into mutually exclusive groups on the basis of the most heavily subsidized option available to them.

Of those who would be uninsured under the bill's provisions, CBO and JCT estimate, 24 percent would be eligible for Medicaid or the Children's Health Insurance Program (CHIP), 18 percent would be eligible for a premium tax credit with a dollar value greater than zero through the marketplaces, 30 percent would have access to employment-based coverage, and the remaining 28 percent would be ineligible for subsidized coverage.

Background

Since the ACA was enacted, 38 states and the District of Columbia have expanded Medicaid eligibility to all adults under the age of 65 whose income is up to 138 percent of the FPL. People generally are not eligible for subsidies through the health insurance marketplaces under current law if their income is below 100 percent of the FPL ($12,880 for a single person or $26,500 for a family of four in 2021).

Under current law, people with a modified adjusted gross income between 100 percent and 400 percent of the FPL who are lawfully present in the United States are eligible for premium tax credits if they are not eligible for public coverage (through Medicaid or CHIP, for example) and if they do not have an affordable offer of employment-based coverage. For 2021 and 2022, however, the American Rescue Plan Act of 2021—enacted in March 2021—expanded eligibility for the tax credits to include people whose income is above 400 percent of the FPL.

Under current law, people can use those credits to lower their monthly out-of-pocket costs for premiums. The amount is calculated as the difference between the benchmark premium for health insurance (that is, the premium for the second-lowest-cost silver plan available in the region)

and a specified maximum contribution, expressed as a percentage of income.

For most people, a silver plan pays about 70 percent of the total cost of covered benefits. (That "actuarial value" of the plan would require enrollees to pay out-of-pocket costs of about 30 percent, on average). Cost-sharing reductions (CSRs) effectively increase the actuarial value of silver plans for people whose income is between 100 and 250 percent of the FPL, as follows:

- Between 100 percent and 150 percent of the FPL, the actuarial value increases to 94 percent;
- Between 150 percent and 200 percent of the FPL, the actuarial value increases to 87 percent; and
- Between 200 percent and 250 percent of the FPL, the actuarial value increases to 73 percent.

Because there is no appropriation under current law to pay for CSRs, most insurers use "silver loading"—they charge higher premiums for silver plans offered through the marketplaces.

Basis of Estimate

The provisions considered in this estimate would cause a net increase in the deficit, as follows:

- $209.5 billion under section 137501, Improve Affordability and Reduce Premium Costs of Health Insurance for Consumers;
- $323.1 billion under sections 137504, 137505, and 30701, which concern coverage for people with low income;
- $10.6 billion under section 137507, Special Rule for Individuals Receiving Unemployment Compensation; and
- $10.8 billion under section 137502, Modification of Employer-Sponsored Coverage Affordability Test in Health Insurance Premium Tax Credit.

Improve Affordability and Reduce Premium Costs of Health Insurance for Consumers. Section 137501 would extend the enhanced premium tax credits provided by the American Rescue Plan Act. For 2023 and beyond, the legislation would increase subsidies for people whose income is below

400 percent of the FPL and extend eligibility to people whose income is above that level (see Table 2).

CBO and JCT estimate that section 137501 would increase federal deficits by $209.5 billion over the 2022-2031 period as the result of increased direct spending of $119.7 billion and revenue reductions of $89.8 billion. Those net effects primarily reflect a $259.0 billion increase in premium tax credits for health insurance obtained through the marketplaces partially offset by higher revenues. Those revenues would increase because taxable wages would increase as employment-based coverage declines. CBO and JCT estimate that about 10 percent of the estimated increase in premium tax credits would stem from the enrollment of people whose income is above 700 percent of the FPL.

CBO and JCT expect that section 137501 would have a twofold effect on health insurance coverage obtained through the marketplaces. First, most enrollees who have subsidies under current law would be eligible for enhanced subsidies that would lower their out-of-pocket costs for premiums. Second, subsidies would be extended to include some people who will lose eligibility after 2022 under current law. CBO and JCT anticipate that, in addition to reducing current enrollees' out-of-pocket premium costs, the enhanced subsidies would attract more enrollees to the marketplaces. CBO and JCT estimate that those additional enrollees would account for $167.2 billion of the increase in premium tax credits and that current-law enrollees would account for the remaining $91.8 billion.

CBO and JCT estimate that enacting section 137501 would increase the number of people who have coverage through the marketplaces by 3.4 million, on average, over the 2022-2031 period. The agencies also estimate that the income of 65 percent of those who would not have enrolled without that provision would be above 400 percent of the FPL. For people whose income is more than 600 percent and 700 percent of the FPL, those estimates are 20 percent and 10 percent, respectively.

The estimated increase in marketplace enrollment consists of 1.4 million fewer uninsured people, 600,000 fewer people with nongroup coverage purchased outside of the marketplaces, and 1.6 million fewer people with employment-based coverage. The estimated reduction in employment-based coverage is primarily driven by a reduction in offers as a response to the increased subsidies for coverage through the marketplaces. CBO and JCT estimate that 200,000 people would enroll in coverage through

Medicaid and CHIP as a result of that reduction in offers of employment-based coverage.

Provisions Affecting Coverage for People With Low Income. Beginning in 2022, the bill would extend subsidized coverage to people whose income is below 100 percent of the FPL who otherwise meet eligibility requirements.

For each year from 2022 to 2024, sections 137504 and 137505 would:

- Expand access to subsidized coverage through the marketplaces by extending eligibility for premium tax credits and CSRs to people whose income is below 100 percent of the FPL;
- Expand eligibility for premium tax credits and CSRs to people whose income is below 138 percent of the FPL who have access to an offer of employment-based coverage that is considered affordable under the ACA;
- Modify the subsidy recapture and tax-filing requirements for people whose income is below 138 percent of the FPL; and
- Appropriate funds for outreach and education.

For 2023 and 2024, section 137505 also would increase CSRs for eligible enrollees whose income is below 138 percent of the FPL from the current-law actuarial value of 94 percent to 99 percent. Because funding for CSRs has not been appropriated under current law, most insurers use silver loading to cover those costs. Under section 137505, the federal government would directly reimburse insurers for a portion of the cost of CSRs for eligible people whose income was below 138 percent of the FPL in 2023 and 2024. CBO and JCT expect that most insurers would continue to use silver loading to finance the remaining costs.

For 2024 only, section 137505 would provide marketplace enrollees whose income was under 138 percent of the FPL with additional benefits, such as subsidies for transportation to medical appointments, that currently are covered by state Medicaid programs but not required for marketplace plans.

Starting in 2025, section 30701 would establish a federal Medicaid program to provide coverage to adults whose income is up to 138 percent of the FPL and who reside in a state that has not expanded its program. The Secretary of the Department of Health and Human Services would be required to

administer the program through third-party entities and under contracts with Medicaid managed care organizations. The federal program would be required to provide health care services and enrollee protections that are consistent with the services and protections provided to adults residing in states with programs as expanded under the ACA.

In addition, the section would require states to maintain their Medicaid expansions or pay the federal government an amount approximately equal to the expenditures associated with maintaining expansions. That requirement would apply to states that had expanded their Medicaid programs as of January 1, 2022, but subsequently terminate those expansions. CBO expects that such a requirement would cause most states to maintain their expansion programs rather than have the new federal program cover their adult residents. As a result, CBO estimates that over the 2025-2031 period, states that continued their expansion programs would spend $86.6 billion to operate those programs; states that terminated their expansion programs would pay the federal government $3.6 billion.

After accounting for the effects of section 137501, CBO and JCT estimate that enacting sections 137504, 137505, and 30701 would increase federal deficits by $323.1 billion over the 2022-2031 period: An increase in direct spending of $335.6 billion would be partially offset by an increase in revenues of $12.5 billion. Those effects reflect a $390.0 billion net increase in Medicaid outlays and $27.2 billion in administrative costs, partially offset by a $75.6 million net decrease in subsidies for health insurance obtained through the marketplaces along with other smaller effects.

CBO and JCT estimate that enacting sections 137504, 137505, and 30701 would increase the number of adults who enroll in Medicaid, on average, by 3.8 million annually over the 2022-2031 period. That increase would result, on average, in 2.3 million fewer uninsured people per year, 700,000 fewer people with nongroup coverage, and 900,000 fewer people with employment-based coverage. The estimated effect on the number of people with employment-based coverage is primarily driven by fewer people taking up an offer of health insurance coverage.

CBO and JCT estimate that over the 2022-2024 period, during which eligibility for marketplace subsidies would be extended to people whose income was below 100 percent of the FPL, enrollment in nongroup coverage would increase by 2.3 million people annually, on average. The

estimated increase consists of 1.7 million fewer uninsured people, 300,000 fewer people with employment-based coverage, and 200,000 fewer people enrolled in Medicaid.

After establishment of the federal Medicaid program, Medicaid enrollment would increase by 5.6 million, on average over the 2025-2031 period, CBO and JCT estimate. That projected increase consists of an estimated 6.4 million people enrolling in the federal Medicaid program established by section 30701, partially offset by a decrease of 800,000 people enrolled in state-expanded Medicaid programs. The estimated reduction is associated with CBO's expectation that states that would have expanded after 2021 (according to the agency's baseline projections) would not do so and that few states that already have expanded would terminate their expansions once the federal program was implemented. CBO and JCT expect that people in those states would instead enroll in the federal Medicaid program. According to CBO and JCT's estimates, the net increase in Medicaid enrollment would result in 2.5 million fewer people being uninsured, 1.9 million fewer people having nongroup coverage, and 1.1 million fewer people with employment-based coverage.

Special Rule for Individuals Receiving Unemployment Compensation. Under current law, eligible people may receive a premium tax credit for health insurance through the marketplaces that equals the difference between the benchmark premium and a maximum contribution specified as a percentage of household income. (CBO and JCT estimated the effects of section 137507 relative to section 137501; for the maximum income contribution percentages for 2031 under section 137501, see Table 2 at the end of this estimate.)

Section 137507 would increase the amount of the premium tax credit for people who receive unemployment benefits for any length of time in a year between 2022 and 2025. Under that provision, people whose household income was above 100 percent of the FPL after excluding unemployment benefits, and who are otherwise eligible for premium tax credits, would receive the same credit available to them if their income was 150 percent of the FPL in the year they receive unemployment benefits.

After accounting for the effects of section 137501, CBO and JCT estimate that section 137507 would increase federal deficits by $10.6 billion over the 2022-2031 period as a result of an increase in outlays of $4.9 billion and a

decrease in revenues of $5.7 billion. Those effects would stem primarily from the increase in premium tax credits for health insurance obtained through the marketplaces.

CBO and JCT estimate that 2.0 million people receiving unemployment compensation would be eligible for enhanced premium tax credits under section 137507 if they meet other eligibility requirements. The agencies estimate that, on average in each year from 2022 to 2025, roughly 500,000 people who already would be expected to enroll in marketplace coverage under section 137501 would receive an increased subsidy under section 137507. CBO and JCT estimate that, on average, about 500,000 people would newly enroll and receive a premium tax credit if section 137507 was enacted. The agencies estimate that most of those people would have otherwise been uninsured.

Modification of Employer-Sponsored Coverage Affordability Test. Section 137502 would modify the criteria used to determine an affordable offer of employer-sponsored health insurance for purposes of premium tax credit eligibility. Under current law, unaffordable offers are those that require employees to contribute more than 9.5 percent of their income (indexed annually for inflation) for self-only coverage. Section 137502 would modify that affordability threshold from an indexed 9.5 percent to a nonindexed 8.5 percent of income. If an employee's contribution exceeded 8.5 percent of household income, they and their dependents would be able to purchase subsidized coverage through the marketplaces.

After accounting for the effects of section 137501, CBO and JCT estimate that enacting section 137502 would increase federal deficits by $10.8 billion over the 2022-2031 period as a result of an increase in outlays of $12.1 billion and an increase in revenues of $1.2 billion. Those effects would stem primarily from an increase in premium tax credits for health insurance obtained through the marketplaces, partially offset by higher revenues stemming from higher taxable wages that would result from a reduction in employment-based coverage.

CBO and JCT estimate that, on average over the 2022-2031 period, 300,000 more people would enroll in nongroup coverage under the section. That increase consists of estimated reductions of fewer than 100,000 people without insurance and fewer than 300,000 people with employment-based coverage. The estimate of the reduction in employment-based coverage is

driven primarily by the expectation that fewer people would take up an employment-based offer. Those choosing to take up nongroup coverage instead would do so because the premium tax credits for plans available through the marketplaces would make those plans less expensive than employment-based plans.

I hope this information is useful to you.

Sincerely,

Phillip L. Swagel
Director

cc: Honorable John Yarmuth
Chairman
Committee on the Budget

Identical letters sent to the Honorable Kevin Brady, Ranking Member, Committee on Ways and Means, the Honorable Cathy McMorris Rodgers, Ranking Member, Committee on Energy and Commerce, and the Honorable Virginia Foxx, Ranking Member, Committee on Education and Labor.

Table 1.
Estimated Budgetary Effects of Provisions in Reconciliation Legislation That Would Affect Health Insurance Coverage for People Under Age 65

	By Fiscal Year, Millions of Dollars											
	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2022-2026	2022-2031
Increases or Decreases (-) in Direct Spending												
Sec. 137501 - Improve Affordability and Reduce Premium Costs of Health Insurance for Consumers												
Budget Authority	1,463	19,949	12,519	11,521	11,110	10,867	11,347	12,199	13,815	14,939	56,562	119,729
Estimated Outlays	1,463	19,949	12,519	11,521	11,110	10,867	11,347	12,199	13,815	14,939	56,562	119,729
Sec. 137504, 137505, and 30701 - Provisions Affecting Coverage for People With Low Income												
Budget Authority	8,330	16,942	17,055	27,433	36,562	39,003	44,334	47,456	48,488	50,034	106,322	335,637
Estimated Outlays	8,330	16,942	17,055	27,433	36,562	39,003	44,334	47,456	48,488	50,034	106,322	335,637
Sec. 137507 - Special Rule for Individuals Receiving Unemployment Compensation												
Budget Authority	1,309	1,821	1,419	1,139	-778	0	0	0	0	0	4,910	4,910
Estimated Outlays	1,309	1,821	1,419	1,139	-778	0	0	0	0	0	4,910	4,910
Sec. 137502 - Modification of Employer-Sponsored Coverage Affordability Test in Health Insurance Premium Tax Credit												
Budget Authority	671	1,824	1,493	1,264	982	1,060	950	1,276	867	1,672	6,234	12,059
Estimated Outlays	671	1,824	1,493	1,264	982	1,060	950	1,276	867	1,672	6,234	12,059
Interactions[a]												
Budget Authority	-131	-176	-95	-53	40	0	0	0	0	0	-415	-415
Estimated Outlays	-131	-176	-95	-53	40	0	0	0	0	0	-415	-415
Total Changes in Direct Spending												
Budget Authority	11,642	40,360	32,391	41,304	47,916	50,930	56,631	60,931	63,170	66,645	173,613	471,920
Estimated Outlays	11,642	40,360	32,391	41,304	47,916	50,930	56,631	60,931	63,170	66,645	173,613	471,920
Increases or Decreases (-) in Revenues												
Sec. 137501 - Improve Affordability and Reduce Premium Costs of Health Insurance for Consumers												
Total Revenues	499	197	-9,761	-9,518	-9,068	-10,529	-11,408	-12,367	-13,259	-14,592	-27,651	-89,806
On-budget Revenues	332	-275	-10,640	-10,790	-10,464	-12,018	-12,991	-14,080	-15,101	-16,517	-31,837	-102,544
Off-budget Revenues	167	472	879	1,272	1,396	1,489	1,583	1,713	1,842	1,925	4,186	12,738
Sec. 137504, 137505, and 30701 - Provisions Affecting Coverage for People With Low Income												
Total Revenues	53	-1,586	-3,560	-1,908	3,105	3,211	3,224	3,243	3,315	3,399	-3,896	12,496
On-budget Revenues	-28	-1,819	-3,824	-2,753	2,037	2,143	2,152	2,160	2,211	2,277	-6,387	4,556
Off-budget Revenues	81	233	264	845	1,068	1,068	1,072	1,083	1,104	1,122	2,491	7,940
Sec. 137507 - Special Rule for Individuals Receiving Unemployment Compensation												
Total Revenues	21	-916	-1,645	-1,566	-1,577	2	2	0	0	0	-5,683	-5,679
On-budget Revenues	10	-944	-1,683	-1,615	-1,592	2	2	0	0	0	-5,824	-5,820
Off-budget Revenues	11	28	38	49	15	0	0	0	0	0	141	141
Sec. 137502 - Modification of Employer-Sponsored Coverage Affordability Test in Health Insurance Premium Tax Credit												
Total Revenues	106	159	-170	-120	83	174	137	241	128	474	58	1,212
On-budget Revenues	52	-71	-457	-390	-178	-80	-126	-56	-206	59	-1,044	-1,453
Off-budget Revenues	54	230	287	270	261	254	263	297	334	415	1,102	2,665
Interactions[a]												
Total Revenues	-4	119	152	103	103	0	0	0	0	0	473	473
On-budget Revenues	-2	123	156	106	104	0	0	0	0	0	487	487
Off-budget Revenues	-2	-4	-4	-3	-1	0	0	0	0	0	-14	-14
Total Changes in Revenues	675	-2,027	-14,984	-13,009	-7,354	-7,142	-8,045	-8,883	-9,816	-10,719	-36,699	-81,304
On-budget Revenues	364	-2,986	-16,448	-15,442	-10,093	-9,953	-10,963	-11,976	-13,096	-14,181	-44,605	-104,774
Off-budget Revenues	311	959	1,464	2,433	2,739	2,811	2,918	3,093	3,280	3,462	7,906	23,470

continued

Table 1.
Estimated Budgetary Effects of Provisions in Reconciliation Legislation That Would Affect Health Insurance Coverage for People Under Age 65

	By Fiscal Year, Millions of Dollars											
	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2022-2026	2022-2031
Net Increases or Decreases (-) in the Deficit												
Sec. 137501 - Improve Affordability and Reduce Premium Costs of Health Insurance for Consumers												
Effect on the Deficit	964	19,752	22,280	21,039	20,178	21,396	22,755	24,566	27,074	29,531	84,213	209,535
On-budget Deficit	1,131	20,224	23,159	22,311	21,574	22,885	24,338	26,279	28,916	31,456	88,399	222,273
Off-budget Deficit	-167	-472	-879	-1,272	-1,396	-1,489	-1,583	-1,713	-1,842	-1,925	-4,186	-12,738
Sec. 137504, 137505, and 30701 - Provisions Affecting Coverage for People With Low Income												
Effect on the Deficit	8,277	18,528	20,615	29,341	33,457	35,792	41,110	44,213	45,173	46,635	110,218	323,141
On-budget Deficit	8,358	18,761	20,879	30,186	34,525	36,860	42,182	45,296	46,277	47,757	112,709	331,081
Off-budget Deficit	-81	-233	-264	-845	-1,068	-1,068	-1,072	-1,083	-1,104	-1,122	-2,491	-7,940
Sec. 137507 - Special Rule for Individuals Receiving Unemployment Compensation												
Effect on the Deficit	1,288	2,737	3,064	2,705	799	-2	-2	0	0	0	10,593	10,589
On-budget Deficit	1,299	2,765	3,102	2,754	814	-2	-2	0	0	0	10,734	10,730
Off-budget Deficit	-11	-28	-38	-49	-15	0	0	0	0	0	-141	-141
Sec. 137502 - Modification of Employer-Sponsored Coverage Affordability Test in Health Insurance Premium Tax Credit												
Effect on the Deficit	565	1,665	1,663	1,384	899	886	813	1,035	739	1,198	6,176	10,847
On-budget Deficit	619	1,895	1,950	1,654	1,160	1,140	1,076	1,332	1,073	1,613	7,278	13,512
Off-budget Deficit	-54	-230	-287	-270	-261	-254	-263	-297	-334	-415	-1,102	-2,665
Interactions[a]												
Effect on the Deficit	-127	-295	-247	-156	-63	0	0	0	0	0	-888	-888
On-budget Deficit	-129	-299	-251	-159	-64	0	0	0	0	0	-902	-902
Off-budget Deficit	2	4	4	3	1	0	0	0	0	0	14	14
Total Effect on the Deficit	10,967	42,387	47,375	54,313	55,270	58,072	64,676	69,814	72,986	77,364	210,312	553,224
On-budget Deficit	11,278	43,346	48,839	56,746	58,009	60,883	67,594	72,907	76,266	80,826	218,218	576,694
Off-budget Deficit	-311	-959	-1,464	-2,433	-2,739	-2,811	-2,918	-3,093	-3,280	-3,462	-7,906	-23,470

Data sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

a: Estimates for all provisions account for interactions with Sec. 137501; the estimated interaction effects between other provisions are shown in this line.

Table 2.

Comparison of Maximum Household Contributions for Premium Tax Credits in 2031

	Percentage of Income	
Percent of Federal Poverty Limit	**Under Current Law[a]**	**Under Section 137501**
100-133	2.1	0
133-150	3.1 to 4.2	0
150-200	4.2 to 6.6	0 to 2.0
200-250	6.6 to 8.5	2.0 to 4.0
250-300	8.5 to 10.0	4.0 to 6.0
300-400	10.0	6.0 to 8.5
400+	n.a.	8.5

Data source: Congressional Budget Office.
n.a. = not applicable.

a. Reflects CBO's current-law estimate of the maximum income contributions in 2031.

FOR IMMEDIATE RELEASE
October 12, 2021

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Biden-Harris Administration Greenlights Coverage of LGBTQ+ Care as an Essential Health Benefit in Colorado

New health plan benchmarks expand access to care for transgender patients

For the first time, the Centers for Medicare & Medicaid Services (CMS) approved a request to provide gender-affirming care in the individual and small group health insurance markets as part of Colorado's Essential Health Benefit (EHB) benchmark. Today's landmark step is aligned with the Biden-Harris Administration's efforts to address health care disparities by removing longstanding barriers and expanding access to care for transgender persons.

Colorado's new EHB-benchmark plan will enhance access to coverage for gender-affirming care that meets individual needs and discourages the use of a "one-size-fits-all" framework for transgender persons seeking medical care. Changes to the EHB-benchmark plan will allow access to a wider range of services for transgender individuals in addition to benefits already covered. Such treatments will include eye and lid modifications, face tightening, facial bone remodeling for facial feminization, breast/chest construction and reductions, and laser hair removal. The state is also adding EHBs in the benchmark plan to include mental wellness exams and expanded coverage for 14 prescription drug classes. These changes will take effect beginning on January 1, 2023.

"Health care should be in reach for everyone; by guaranteeing transgender individuals can access recommended care, we're one step closer to making this a reality," said HHS Secretary Xavier Becerra. "I am proud to stand with Colorado to remove barriers that have historically made it difficult for transgender people to access health coverage and medical care."

"Health care should be accessible, affordable and delivered equitably to all, regardless of your sexual orientation. To truly break down barriers to care, we must expand access to the full scope of health care, including gender-affirming surgery and other treatments, for people who rely on coverage through

Medicare, Medicaid & CHIP and the Marketplaces," said CMS Administrator Chiquita Brooks-LaSure. "Colorado's expansion of their essential health benefits to include gender-affirming surgery and other treatments is a model for other states to follow and we invite other states to follow suit."

Gender-affirming care is considered a standard level of care by the American Medical Association, the American Academy of Family Physicians, and the American Psychiatric Association. Transgender patients often face discriminatory hurdles in accessing medically necessary health care services that affirm gender identity.

The Affordable Care Act (ACA) requires non-grandfathered health plans in the individual and small group markets to provide coverage in 10 categories of EHBs, including preventive and wellness services, chronic disease management, maternity and newborn care, hospitalization, prescription drugs, mental health and substance use disorder services, behavioral health treatment, and lab services. CMS regulations allow states the flexibility to develop state-specific "benchmark" plans that detail the specific services covered among these broad categories based on a typical employer plan offered in the state.

CMS recognizes that expanded, gender-affirming coverage vastly improves health care outcomes for the LGBTQ+ community, reduces high rates of depression, anxiety, and suicide attempts as well as decreases substance use, improves HIV medication adherence, and reduces rates of harmful self-prescribed hormone use.

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Note: All HHS press releases, fact sheets and other news materials are available at https://www.hhs.gov/news (/news) .

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ASPE | OFFICE OF HEALTH POLICY
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

ISSUE BRIEF
October 8, 2021

HP-2021-22

Health Insurance Coverage and Access to Care Among Latinos: Recent Trends and Key Challenges

KEY POINTS

- Uninsured rates in the Latino* population have fallen since the passage of the Affordable Care Act (ACA), from 30 percent in 2013 to a low of 19 percent in 2017.
- However, the uninsured rate among Latinos is still more than double that among non-Latino Whites (20 vs. 8 percent in 2019). Even though Latinos are more likely to be in the workforce than non-Latinos, they are less likely to receive health insurance through their employment and more likely to enroll in Medicaid coverage.
- The uninsured rate among Latinos increased slightly between 2017 and 2020, which coincided with substantial reductions in funding for Marketplace outreach and enrollment assistance. Lack of awareness and understanding regarding eligibility for Medicaid and Marketplaces remains a barrier to obtaining health coverage.
- Access to care also improved for Latinos between 2013 and 2016 after passage of the Affordable Care Act.
- However, Latinos are less likely to have a usual source of care, are more likely to be concerned about medical bills, and are more likely to have delayed care in 2020 due to the COVID-19 pandemic compared to non-Latinos.
- Language barriers contribute to disparities in access to care. Latinos who primarily speak Spanish are more likely to lack a usual source of care, have fewer outpatient visits, and receive fewer prescription medications than Latinos who are English proficient.
- The American Rescue Plan's enhanced Marketplace subsidies, combined with increased spending on Navigators and enrollment outreach in 2021, will increase the range of affordable coverage options for Latinos and can help improve health equity in this population.

BACKGROUND

Latinos are the largest racial or ethnic minority group in the United States and are projected to grow to 25% of the population by 2045. The U.S. Office of Management and Budget defines "Hispanic or Latino" as any person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.[1] According to data from the 2020 Decennial Census, there are more than 62 million Latinos living in the U.S.[2] In 2019, among Latino subgroups, Mexicans ranked as the largest at 61.4 percent, followed by Puerto Ricans (9.6 percent), Central Americans (9.8 percent), South Americans (6.4 percent), and Cubans (3.9 percent). States with the largest Latino populations were California, Texas, Florida, New York, Arizona, Illinois, New Jersey, Colorado, Georgia, and New Mexico, and in a growing number of U.S. cities, Latinos are now the

* This brief uses the term "Latino" to refer to all individuals of Hispanic and Latino origin.

majority.[3] Latinos are also the youngest demographic group in the U.S. In 2019 approximately 31 percent of Latino Americans were under the age of 18 compared to 19 percent of non-Latino Whites.

Health outcomes among Latinos are affected by factors such as lack of health insurance, language and cultural barriers, and lack of access to care. The Centers for Disease Control and Prevention (CDC) reports that the leading causes of illness and death among Latinos include heart disease, cancer, unintentional injuries, stroke, and diabetes. Some other health conditions and risk factors that significantly affect Latinos are asthma, chronic obstructive pulmonary disease, HIV/AIDS, obesity, suicide, and liver disease.[4]

Latinos have consistently been overrepresented in the uninsured population. Prior to the implementation of the Affordable Care Act (ACA), Latinos had the second highest nonelderly uninsurance rate among ethnic and racial populations with more than 30 percent uninsured. As described in more detail below, the Latino uninsured rate fell dramatically after the ACA, but as of 2019, Latinos were 20 percent of the total non-elderly population but accounted for 37 percent of the nonelderly uninsured population. Studies show that people without health insurance coverage are less likely to receive necessary preventive care and screening services, have less access to care, and experience worse health outcomes than those with health insurance coverage.[5,6,7] Latinos are more likely to delay care, less likely to have a usual source of care, and more likely to be concerned about medical bills than their non-Latino counterparts. The cost of services is also a significant barrier to care for many in the Latino community.

This issue brief analyzes changes in health insurance coverage and examines disparities in health status and access to care between Latinos and non-Latino Whites using data from 2013-2020. This Issue Brief is part of a series of ASPE Issue Briefs examining the change in coverage rates after implementation of the ACA among select racial and ethnic populations.

DATA SOURCES AND METHODS

This issue brief presents data from several federal data sources. We present coverage estimates from the American Community Survey (ACS), conducted by the Census Bureau. The ACS is the largest national survey of households. The Census Bureau surveys almost 300,000 households each month for the ACS and collects health insurance and demographic information, including race and ethnicity, along with other types of information. This brief used ACS data from 2013 and 2019 for population, health insurance coverage and demographic estimates. Individuals were defined as uninsured if they did not report having any private health insurance, Medicare, Medicaid, CHIP, state-sponsored or other government-sponsored health plan, or military plan at the time of interview; respondents were also defined as uninsured if they had only Indian Health Service coverage.

We present results by Public Use Microdata Areas (PUMAs), the most granular level of geography available in the ACS public use file. PUMAs are geographic areas within each state that contain no fewer than 100,000 people; they can consist of part of a single densely populated county or can combine parts or all of multiple counties that are less densely populated.[†]

We also analyzed the National Health Interview Survey (NHIS) to assess differences in health care access for Latinos and non-Latinos in the U.S. from 2013-2020. All analyses were weighted to reflect the noninstitutionalized population and to adjust for complex survey design. The health care access measures included not having a usual source of care, delaying medical care due to cost, worrying about medical bills, delaying prescription refills to save money, problems paying medical bills.

[†] Detailed maps of PUMAs for each state are available at: https://www.census.gov/geographies/reference-maps/2010/geo/2010-pumas.html.

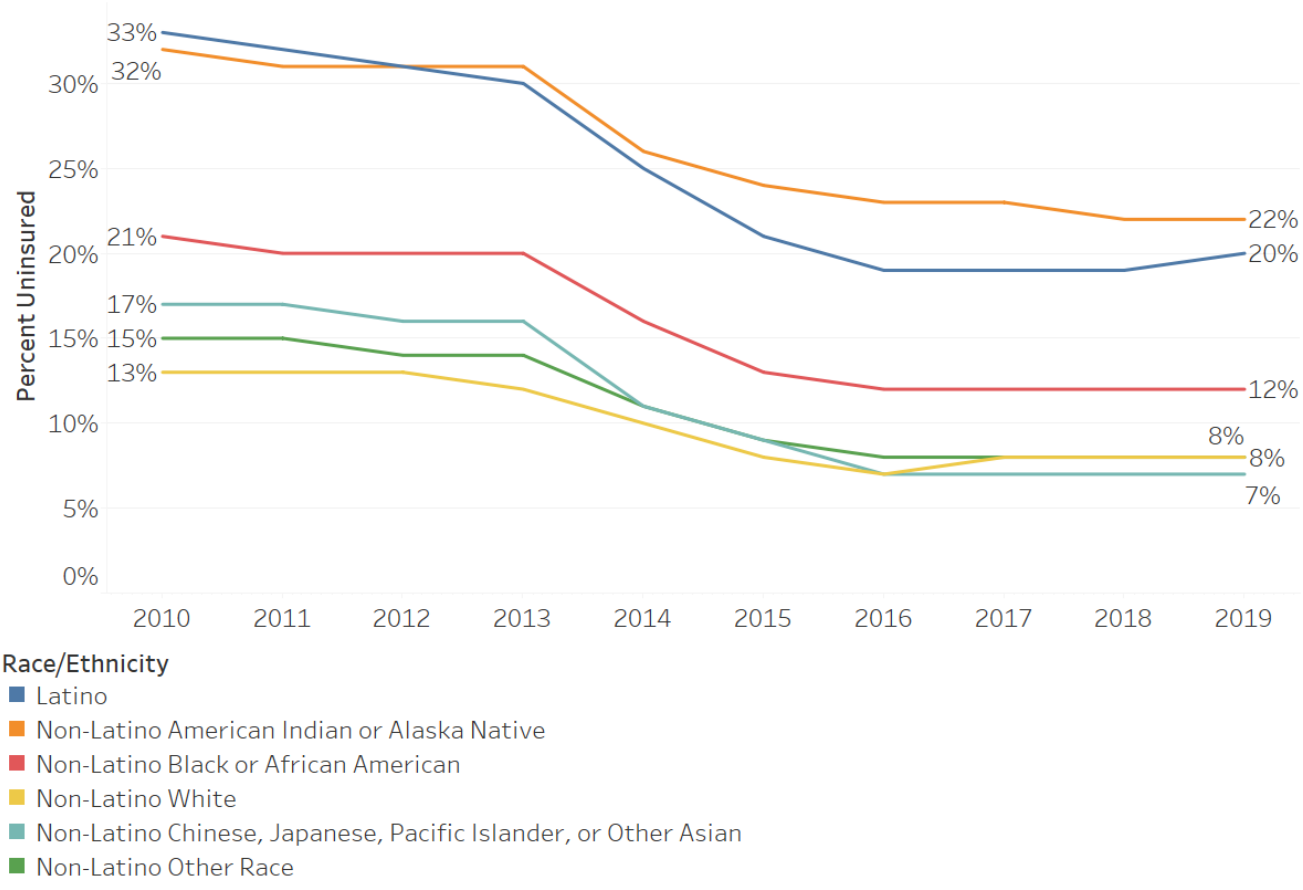
In federal survey data, ethnicity (i.e., Hispanic or Latino origin) and race are two distinct categories. Origin is defined by the Census Bureau as ancestry, lineage, heritage, nationality group, or country of birth. Hispanic or Latino origin includes persons of Mexican, Puerto Rican, Cuban, Central American, South American, or Spanish origin.

HEALTH COVERAGE

The ACA expanded access to health coverage for millions of Americans through the Marketplace and Medicaid expansion to low-income adults. Compared to other ethnic and racial groups, Latinos experienced the largest percentage point decline in their uninsured rate in the ACS data. Figure 1 demonstrates the decline in the uninsured rate among Latinos compared to other groups in the period after implementation of the ACA's coverage expansions, from 30 percent in 2013 to a low of 19 percent in 2017, before increasing slightly back to 20 percent in 2019.

While progress has been made over the past decade, the Latino uninsured rate remained more than double the uninsured rate of non-Latino individuals in the most recent ACS data (20 percent v. 9 percent).[8] The 2020 National Health Interview Survey (NHIS) found among nonelderly respondents, Latino adults (30 percent) were more likely than Black non-Latino (14 percent), White non-Latino (9 percent), and Asian non-Latino (9 percent) adults to be uninsured.[9]

Figure 1: Uninsured Rate for Nonelderly U.S. Population by Race and Ethnicity, 2010-2019



Source: Results are survey-weighted estimates using ACS Public Use Microdata Sample, 2010-2019.

The largest single year increase in the Latino uninsured rate during the time period studied occurred from 2018 to 2019, when the rate increased from 19.2 percent to 20.2 percent. In comparison, the total U.S. uninsured rate increased from 10.7 percent to 11.1 percent from 2018 to 2019. Thus, the pattern of increasing uninsured rates among Latino individuals from 2018-2019 is similar to national trends for other groups, but somewhat more pronounced.

Latino children were particularly affected by the recent coverage losses. While the overall uninsured rate among all U.S. children started increasing between 2016 and 2019, the increase among Latino children was twice as large as the increase among non-Latino children – a 1.6 percent-point increase compared to a 0.7 percent-point increase. This has reversed previous progress towards narrowing coverage disparities between Latino children and their non-Latino peers.[10] This increase in uninsured rates occurred during a period of reduced funding for Marketplace outreach and enrollment assistance, and other changes including immigration policies that may have reduced both Medicaid and ACA-related enrollment.[11]

Though the Latino uninsured rate has decreased substantially since the implementation of the ACA, high uninsurance rates persist in particularly states including Texas, Georgia, and Florida, states that have not adopted Medicaid expansion for adults.[12] These non-expansion states with large Latino populations disproportionately impact the uninsured rate. For Latinos, Medicaid serves an important role for health coverage; while Latinos are more likely to participate in the workforce than non-Latinos,[13] they are less likely to have employer-sponsored insurance.[14] According to a recent ASPE analysis, if the remaining non-expansion states were to expand Medicaid eligibility for adults to 138% of the Federal Poverty Level (FPL), the number of uninsured Latino adults (age 18-64) eligible for Medicaid would increase sixfold from 226,000 to 1,361,000.[15]

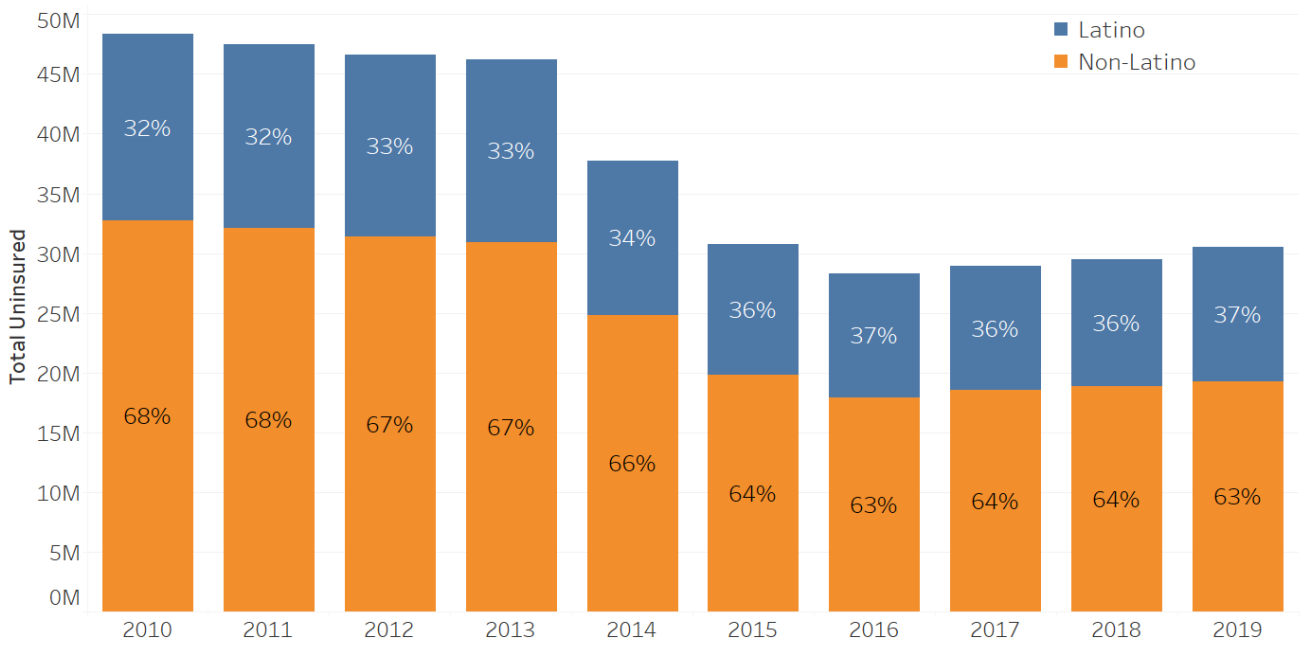
Coverage patterns for Latinos reflect more limited access to employer-sponsored coverage among Latino adults, due to higher rates of employment in low-wage jobs that are less likely to offer health coverage, as well as more limited access to and barriers to enrolling in public coverage options. According to recent survey data, the share of Latino adults who report receiving employer-sponsored coverage is half that of non-Latino Whites, 27 v. 53 percent.[16] The ACA aimed to address these inequities and reduce the financial burden on many households by providing free coverage through Medicaid expansion and significantly limiting costs for low-income families through the Marketplace.

The American Rescue Plan (ARP) builds on the ACA by extending and enhancing Marketplace subsidies, which enables many Americans to access more affordable coverage.[17] Individuals with family incomes above 400 percent of the FPL ($51,520 for a one-person household, $106,000 for a family of four in 2021) now qualify for premium subsidies in 2021. Many others who already qualified for Premium Tax Credits are able to receive larger subsidies. A recent ASPE analysis estimated that among uninsured Latino adults, approximately 69 percent now have access to a zero-premium plan on Healthcare.gov, and 80 percent can find a plan for $50 premiums or less per month due to the ARP subsidy provisions.[18]

Characteristics of Uninsured Latinos

As shown in Figure 2, the total number of uninsured persons in the US declined considerably after implementation of the ACA, from 48 million in 2010 to just over 30 million in 2019. However, over this same period of time, Latinos have represented a growing share of the uninsured population, accounting for 37 percent of the total uninsured in 2019.

Figure 2: Latino and Non-Latino Populations Share of Total Uninsured Population, 2010-2019



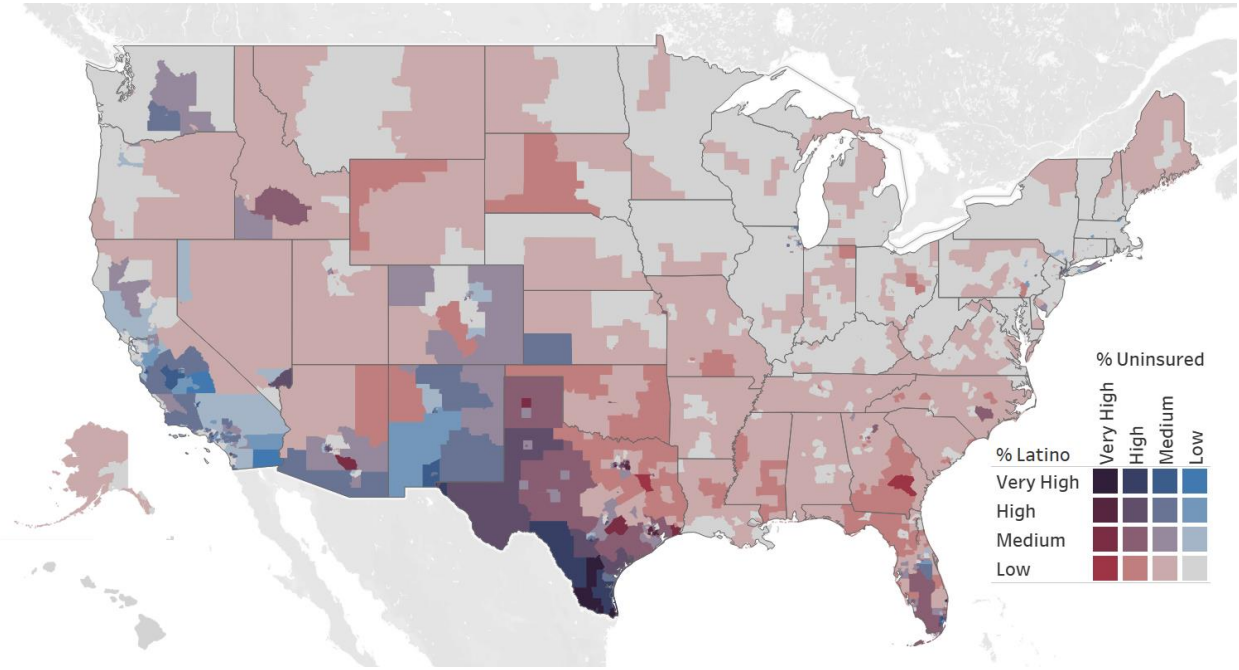
Source: Results are survey-weighted estimates using ACS Public Use Microdata Sample, 2010-2019

The map in Figure 3 displays the nonelderly uninsured rate and percent of persons under the age of 65 who identify as Latino in 2019, by PUMA (local areas defined on page 3 of this report). In the top 10 PUMAs ranked in order of percent uninsured, Latino individuals are an average of 90 percent of the uninsured and 91 percent of Marketplace subsidy-eligible uninsured.[19] As shown in Figure 3, several states with large numbers of Latino individuals have low uninsured rates – indicated in blue on the map – including California, Arizona, New Mexico, and Washington, all states that have expanded Medicaid. States with large Latino populations and high uninsured rates – indicated on the map in purple – include Florida and Texas, which have not expanded Medicaid.

It is important to note that in all of the figures presented, PUMAs in densely populated urban areas do not cover large enough geographic areas to show up clearly in national maps. For example, Figure 3 does not indicate some of the small densely populated PUMAs with high shares of Latino individuals, including those in Central Los Angeles County (where up to 99 percent of the uninsured population is Latino, depending on the PUMA) and in Las Vegas (where up to 65 percent of uninsured are Latino). More granular data are available from ASPE for these and other geographic areas.[‡]

[‡] State and Local Estimates of the Uninsured Population in the U.S. Using the Census Bureau's 2019 American Community Survey available at https://aspe.hhs.gov/pdf-report/estimates-of-the-qhp-eligible-uninsured.

Figure 3: Uninsured Rate and Percent of Persons Who Identify as Latino in 2019, by PUMA



Source: Results are survey-weighted estimates using ACS Public Use Microdata Sample, 2019.
Note: % Latino: Very High (>75%), High (50-75%), Medium (25-50%), Low (0-25%). % Uninsured: Very High (>30%), High (20-30%), Medium (10-20%), Low (0-10%).

Table 1 shows the change in uninsurance for Latinos from 2013 to 2019, by income. All income groups have experienced a reduction in uninsurance since 2013, with the 100-200% FPL group experiencing the largest reduction of 12 percentage points (38 percent vs. 26 percent) – largely due to the implementation of the ACA's Medicaid expansion and Marketplace subsidies in this income range.

Table 1: Estimates of Uninsured Latinos by Household Income, 2013-2019

	Percent Uninsured						
Percentage of Federal Poverty Level	2013	2014	2015	2016	2017	2018	2019
0-100	35%	31%	26%	25%	25%	24%	26%
101-200	38%	32%	26%	25%	24%	25%	26%
201-400	28%	22%	19%	18%	18%	19%	20%
400+	13%	10%	9%	8%	9%	9%	10%

Souce: ASPE analysis of the ACS

Latino individuals for whom English is not their primary language are disproportionately uninsured. Our analysis shows that among the total U.S. nonelderly uninsured population, approximately 4.7 percent do not speak English, but among uninsured Latinos, the share of individuals who do not speak English is more than twice as high at 11.5 percent. Table 2 shows the nonelderly uninsured rates for persons who self-reported not speaking English at all, speaking English very well, or not speaking English well in the ACS. In 2019, the majority of Latinos who do not speak English were uninsured. As Table 2 shows, the uninsured rate for non-Latino individuals who do not speak English was significantly lower than that of their Latino counterparts (27 percent v. 56 percent).

Table 2: Estimates of Nonelderly Uninsured Rates by English Proficiency and Ethnicity, 2013-2019

Ethnicity	Speaks English	Percent Uninsured						
		2013	2014	2015	2016	2017	2018	2019
Latino	Does not speak English	68%	61%	55%	52%	53%	53%	56%
	Yes, but not well	58%	51%	45%	43%	42%	42%	44%
	Yes, speaks well	27%	21%	17%	16%	16%	16%	17%
Non-Latino	Does not speak English	42%	34%	28%	24%	26%	25%	27%
	Yes, but not well	32%	25%	20%	18%	18%	18%	18%
	Yes, speaks well	14%	12%	9%	8%	9%	9%	9%

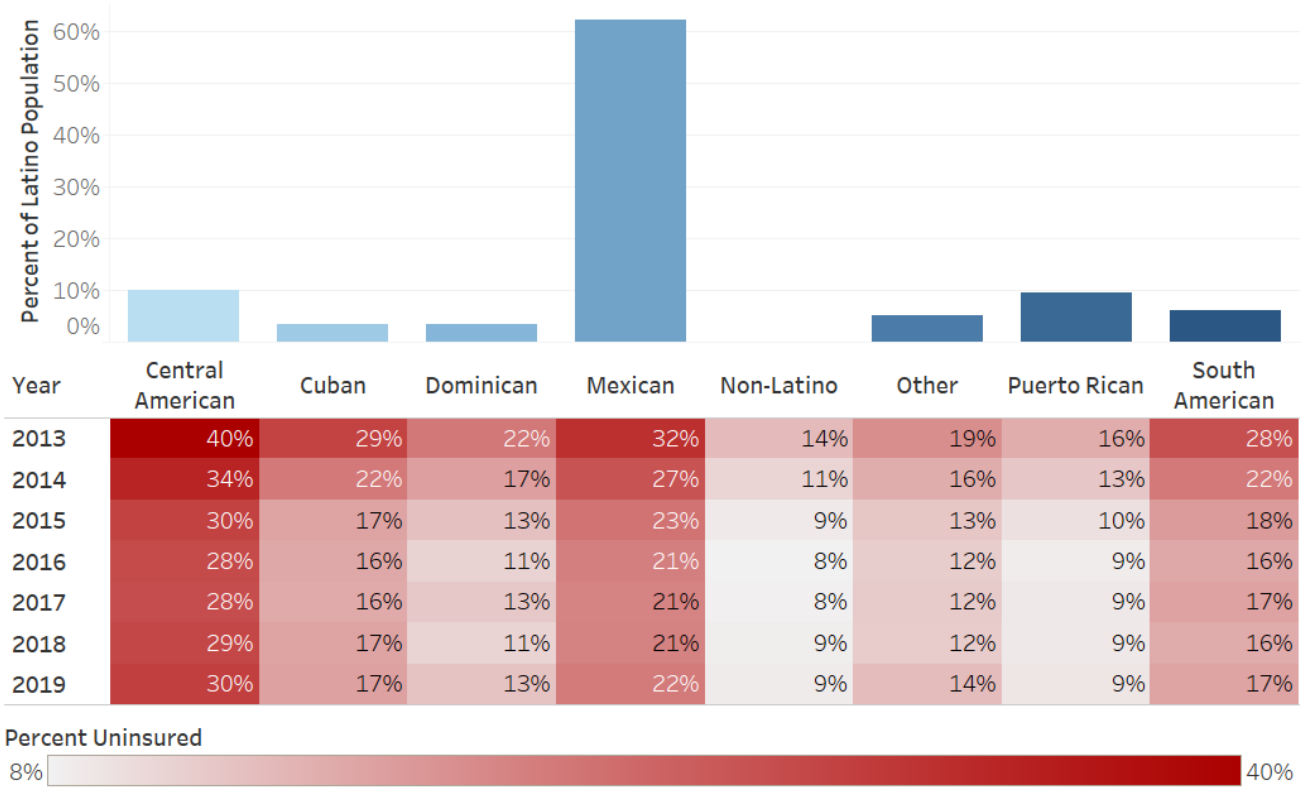
Source: ASPE analysis of ACS

Figure 4 presents uninsured rates for Latino subpopulations by origin, and also shows the share of the Latino population in each subgroup. Latinos of Mexican descent represent by far the largest group, more than 60 percent of the Latino population. In terms of coverage, two results are striking: the uninsured rate fell from 2013 to 2019 for all Latino subgroups, and the underlying variation in uninsured rates across these groups is extremely wide, with rates more than 3 times as high among Central Americans than Puerto Ricans in 2019 (30 percent vs. 9 percent).

Citizenship and immigration status play an important role in these differences across groups. Puerto Ricans are U.S. citizens, meaning they are unencumbered by some of the coverage barriers that immigrants in other Latino subgroups may face. Legal immigrants can purchase coverage through the ACA Marketplace and may receive subsidies for this coverage, including those who are not eligible for Medicaid or CHIP because they have not yet been permanent residents for 5 years, as required by law for Medicaid eligibility. Although they are eligible for coverage, these immigrant groups may face a range of potential barriers to enrollment, including confusion about eligibility policies, difficulty navigating the enrollment process, and language and literacy challenges.

The decline in coverage among Latinos in 2018-2019 may, in part, reflect changes to policies affecting immigrants under the Trump administration, which contributed to growing fears among immigrant families (both Latino and non-Latino) about participating in public programs including health coverage.[20] Research shows immigration policies have had a chilling effect on enrollment for many families, beyond those directly affected by the policies, and can further exacerbate disparities in insurance rates between Latinos and non-Latinos.[21]

Figure 4: Uninsured Rates Among Latino Subgroups, 2013-2019



Year	Central American	Cuban	Dominican	Mexican	Non-Latino	Other	Puerto Rican	South American
2013	40%	29%	22%	32%	14%	19%	16%	28%
2014	34%	22%	17%	27%	11%	16%	13%	22%
2015	30%	17%	13%	23%	9%	13%	10%	18%
2016	28%	16%	11%	21%	8%	12%	9%	16%
2017	28%	16%	13%	21%	8%	12%	9%	17%
2018	29%	17%	11%	21%	9%	12%	9%	16%
2019	30%	17%	13%	22%	9%	14%	9%	17%

Percent Uninsured
8% 40%

Source: ASPE Analysis of ACS

ACCESS TO CARE

Access to affordable, high quality, and timely health care may prevent onset of disease and help patients to avoid experiencing health complications of chronic conditions.[22] While health insurance coverage status is a critical facilitator of access to care, there are other important factors affecting health care access as well. For instance, having a usual source of care is associated with receipt of preventive health care and management of chronic diseases[23] and has been well documented to prevent emergency department visits and reduce unmet health needs.[24,25,26,27,28,29] Even among those with health insurance, cost barriers can lead to delays in health care access associated with poorer health status.[30,31,32] This section explores differences in 2013-2020 trends in access to care between Latinos and non-Latinos.

As shown in Table 4, access to care for Latinos improved considerably for most measures after the implementation of the ACA in 2013. From 2013 to 2019, the share of Latinos without a usual source of care or with delays filling prescriptions due to cost both fell by more than one-third, and the share worried about medical bills fell by one quarter. Notably, rates remained higher among Latinos than non-Latinos throughout the study period for lacking a usual source of care and worried about medical bills measures in Table 4. The last column in Table 4 corresponds to a survey item that was only asked of respondents who reported that they did experience problems paying or were unable to pay for medical bills.

Table 4. Access to Care Trends for Nonelderly Latinos and non-Latinos, 2013-2019.

	No usual source of care		Delayed care due to cost		Worried about medical bills		Delayed refilling prescription medications to save money		Problems paying or unable to pay medical bills		Unable to pay medical bills†	
Year	Latino	Non-Latino	Latino	Non-Latino	Latino	Non-Latino	Latino	Non-Latino	Latino	Non-Latino	Latino	Non-Latino
2013	21%**	12%	10%	10%	36%**	18%	15%**	12%	22%**	19%	56%	54%
2014	19%**	11%	8%	10%	32%**	16%	11%	11%	20%**	17%	54%	55%
2015	18%**	12%	8%	8%	30%**	14%	10%	9%	19%**	16%	55%	55%
2016	17%**	11%	7%*	8%	28%**	13%	10%	9%	17%*	15%	52%	53%
2017	18%**	11%	8%	9%	26%**	14%	10%	10%	17%**	15%	52%	53%
2018	18%**	12%	9%**	10%	28%**	14%	9%	9%	16%	15%	55%	53%
2019	13%**	9%	10%**	8%	27%**	13%	9%	8%	16%	15%	65%	62%

** p < 0.05 for Latino vs. non-Latino*
*** p < 0.01 for Latino vs. non-Latino*

Source: ASPE Analysis of NHIS
† only available for respondents who indicated that they did experience problems paying or were unable to pay medical bills

We also looked at access to care among Latinos by language—specifically, which language the NHIS interview was conducted. Information on the interview language was only available up until 2018, and thus we relied on pooled 2013-2018 NHIS data. Findings presented in Table 5 below show Latinos who were interviewed in Spanish or in a combination of English and Spanish were more likely to lack a usual source of care and worry about medical bills compared to Latinos who were interviewed in English only. This is consistent with a recent study which found health care spending among Latino adults with limited English proficiency was 35 percent lower than for similar Latino adults who were English proficient. Latino adults with limited English proficiency also made fewer outpatient and emergency department visits, had fewer inpatient days, and received fewer prescription medications than Latino adults who were English proficient.[33]

Table 5. Access to care for Nonelderly (<65) Latinos by NHIS Interview Language, 2013-2018.

	No usual source of care	Delayed care due to cost	Worried about medical bills	Delayed refilling prescription medications to save money	Problems paying or unable to pay medical bills	Unable to pay medical bills†
Language						
English only	15%**	6%**	21%**	10%	18%**	55%
Spanish	22%	8%	46%	10%	18%	54%
English and Spanish	22%	8%	36%	9%	21%	53%

** p < 0.05 for Spanish (or English and Spanish) vs. English only*
*** p < 0.01 for Spanish (or English and Spanish) vs. English only*

Source: ASPE Analysis of NHIS
† only available for respondents who indicated that they did experience problems paying or were unable to pay medical bills

Beginning in July of 2020, NHIS added several questions in response to the COVID-19 pandemic, and Table 6 presents changes in access to care during the pandemic.[34] Latino adults were more likely to have delayed care due to the pandemic compared to non-Latinos. Rates of not getting medical care due to the pandemic were similar among Latinos and non-Latinos, though higher for adults in both groups than for children.

Table 6. Access to Care During the COVID-19 Pandemic (2020) for Latinos and non-Latinos, By Age

	Delayed care due to COVID-19		Did not get medical care due to COVID-19		Visits done virtually due to COVID-19 (telemedicine)	
Year & Age Group	Latino	Non-Latino	Latino	Non-Latino	Latino	Non-Latino
2020: Adults (Ages 18-64)	24%**	19%	15%	16%	82%	85%
2020: Children (Ages 0-17)	12%	14%	8%	8%	74%	83%

** p < 0.05 for Latino vs. non-Latino*
*** p < 0.01 for Latino vs. non-Latino*

Source: ASPE Analysis of NHIS

COVID-19 PANDEMIC ECONOMIC AND HEALTH EFFECTS

The COVID-19 pandemic created unprecedented health and economic crises, with impacts disproportionately affecting low-wage workers, people of color, and women. In many Latino communities, the COVID-19 pandemic exacerbated financial vulnerabilities and health challenges. Job losses during the pandemic left many people without employer-sponsored health insurance (ESI). A recent analysis of Census Bureau data indicated that of the 3.3 million non-elderly adults in the U.S. lost ESI during the summer of 2020, and nearly half of them (1.6 million) were Latino adults.[35] However, studies have shown that these ESI coverage losses appear to have largely been offset by Medicaid and Marketplace enrollment increases.[36]

Latino communities suffered a disproportionately high number of deaths from COVID-19. In part, this may reflect the larger share of Latinos who are essential workers, including food services, health care, and construction. [37] Relative to past years, the number of deaths for Latinos increased 53.6 percent, the largest percentage increase of all racial and ethnic groups.[38] A recent ASPE analysis found that the provisional COVID-19 age-adjusted death rate per 100,000 persons for Latinos was more than double the rate for non-Latino Whites (288 v. 124).[39] In addition, the vaccination rate for Latinos lagged behind that of non-Latino Whites earlier in the vaccination effort; in May 2021, only 57 percent of Latino adults had received at least one vaccine dose, compared to 65 percent of non-Latino Whites. More recently, however, vaccinations for Latinos have surged and have eliminated this disparity. Between July and September, Latino adults experienced the largest increase in vaccine uptake of all racial and ethnic groups, and a September 2021 report indicated that 73 percent of Latino adults report having received at least one dose, compared to 71 percent of non-Latino Whites.[40] Another ASPE report found that COVID-19 vaccination has played a key role in protecting Medicare beneficiaries against hospitalization and deaths from COVID-19, including 5,000 fewer deaths among Latino beneficiaries between January and May 2021.[41]

DISCUSSION

Under ACA coverage expansions, the uninsurance rate among Latinos declined substantially. Despite considerable progress, Latino communities continue to face significant disparities in coverage compared to non-Latinos. Funding for ACA Marketplace outreach and enrollment assistance was drastically reduced in 2017-2018, in addition to changes in policies affecting immigrants that may have dissuaded some from enrolling in health insurance.[42] Evidence suggests that outreach and enrollment assistance are particularly important to Latino communities;[43] out of the 11 million U.S. residents who are uninsured but likely qualify for subsidies in the ACA Marketplace (based on pre-ARP standards), 30 percent are Latino and 9 percent reside in homes where English is not the predominant language.[44] Studies have shown that Marketplace enrollment increases in association with greater levels of advertising.[45,46] Further, studies have found that there are differences in messaging between Spanish and English ads, with Spanish-language ads more likely to mention

enrollment assistance compared to English-language ads.[47] Culturally-tailored outreach and marketing for the ACA Marketplaces are important in closing the gaps in coverage among Latinos, particularly among Latinos who reside in predominantly Spanish-speaking households and who are eligible for subsidies. More personal approaches to enrollment assistance are known to be beneficial in enrolling Latinos, particularly those who predominantly speak Spanish, into coverage. Studies suggest that Latinos are more likely than other groups to receive in-person enrollment assistance and that those who did were more likely to enroll in coverage.[48] Spanish-speakers are also more likely than English-speakers to prefer and seek telephone or in-person assistance (versus online assistance).[49] Spanish-language ads for ACA Marketplace were significantly more likely to be sponsored by state Marketplaces, suggesting a relative lack of federal Marketplace advertising in recent years may have hindered enrollment among Spanish-speaking individuals.[50]

With respect to access to care, we find that Latinos experienced improvements after implementation of the ACA, though they were consistently more likely to report access to care barriers compared to non-Latinos even after the ACA. Latinos were also more negatively affected by the COVID-19 pandemic than non-Latinos, including adverse effects on access to care and higher COVID-19 outcomes including infections and deaths. Increased vaccination rates in recent months among Latinos are a promising change.

Implementation of the ARP offers opportunities to make insurance coverage and health care more affordable for all enrollees, including Latinos. The ARP increased tax credits for millions of people in order to reduce premiums and to provide access to affordable health coverage. Under the ARP, approximately 2.6 million Latinos who are uninsured may be eligible for zero-dollar health care plans, and 3 million may be eligible for plans that are less than $50 per month.[51,52] Increased funding from the Centers for Medicare and Medicaid Services – approximately $80 million total, up from the $10 million in annual funding from 2017 to 2019 – will support navigators' outreach and educational activities, including those with a focus on culturally-responsive interventions.[53] Already, enrollment among Latinos has been increasing: during the 2021 Special Enrollment Period, the percentage of consumers who self-reported as Latino increased to 19 percent, up from 16 percent in 2019-2020.[§54]

Importantly, Latinos are very diverse in their coverage rates, economic conditions, citizenship and immigration status, family origin, and many other factors.[55] Efforts to improve coverage and health equity among Latinos must take these differences into account as they address the health and socioeconomic needs within this population.

CONCLUSION

Though many Latinos have gained coverage under the ACA, there is a significant and persistent disparity in uninsured rates between Latinos and non-Latinos. This disparity is particularly pronounced in states that have not adopted the ACA Medicaid expansion to extend coverage to adults with incomes up to 138% FPL. Implementation of the ARP builds on this progress and makes insurance coverage more affordable for all enrollees, including Latinos. Increased funding for enrollment outreach, Navigator assistance, and education about coverage options can further improve coverage and access to care among Latinos. In turn, coverage and access to care can lead to better health for Latinos, a critical step in improving health equity in the US.

§ Among those enrollees reporting any race/ethnicity.

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ISSUE BRIEF
October 1, 2021

HP-2021-21

Reaching the Remaining Uninsured: An Evidence Review on Outreach & Enrollment

KEY POINTS

- In 2020, approximately 30 million U.S. residents lacked health insurance, and the majority were already eligible for some form of federally-subsidized coverage, primarily Medicaid or Marketplace private insurance. Participation rates and outreach are therefore key considerations in policies designed to expand coverage.
- The most common reason cited among uninsured populations for not enrolling in health coverage is cost: In 2020, 7 in 10 uninsured individuals reported that they could not afford monthly premiums above $75. In addition, nearly two in three uninsured individuals had heard "a little" or "nothing" about financial assistance for Marketplace coverage.
- Due to the American Rescue Plan's expanded eligibility and enhanced Marketplace premium tax credits, it is estimated that 73 percent of uninsured individuals can now access a plan for $50 or less per month, and 62 percent of uninsured individuals can access a plan for free.
- Broad public educational campaigns can increase consumer awareness, but evidence suggests that individual assistance and community outreach are necessary supplements to boosting enrollment, particularly among individuals who are uninsured, individuals with limited English proficiency, and people with limited internet access – who are more likely to be older, low-income and living in rural areas.
- For plan year 2022, CMS announced $80 million in grants awarded to Navigators in Federal Marketplaces, the largest funding allocation for Navigator grants to date, which will enable the training and certification of more than 1,500 Navigators.
- Navigators and private health insurance brokers can help consumers to understand basic insurance concepts; however, they serve very different populations. Research indicates that assisters (including Navigators) are 5 times more likely to serve a predominantly uninsured population than are private health insurance brokers.
- Studies also show that some private health insurance brokers frequently offer consumers policies that do not comply with the ACA consumer protections, including short-term limited duration health insurance, in part due to higher commissions from those plans. These findings raise concerns that brokers and outreach by health plan representatives disproportionately lead individuals to enroll in less comprehensive coverage.

Introduction

"The Affordable Care Act (ACA) extended health insurance coverage to millions of Americans - 31 million enrolled as of early 2021[1] - and reduced the uninsured rate among non-elderly individuals from 18.2 percent in 2010 to an all-time low of 10.4 percent in 2016 (roughly 20 million people).[2] However, between 2017 and 2020, the uninsured rate increased. By 2020, two million more Americans were uninsured compared to 2016, leaving 11.1 percent of the U.S. population without health insurance, many of whom have a pathway to subsidized coverage but remain uninsured.[3] Outreach and enrollment assistance play a crucial role in increasing enrollment and retention of consumers seeking health insurance.

This report reviews evidence on factors affecting enrollment in health coverage among uninsured populations, including take-up of Medicaid and subsidized Marketplace plans among eligible individuals. In addition, the report discusses barriers faced by individuals trying to enroll in health coverage and evidence on the impacts of various outreach strategies and consumer assistance on helping uninsured people gain coverage.

The Remaining Uninsured

A 2021 analysis (using 2019 survey data) estimated that of the 30 million remaining uninsured, one-fourth (25 percent) are Medicaid eligible and over one-third (38 percent) are eligible for subsidized coverage purchased through the Marketplace.[4*] ASPE estimates that before the COVID-19 pandemic, 11 million nonelderly Americans were uninsured despite being potentially eligible for free or reduced cost coverage through the Marketplace.[5] In addition, an estimated 3.6 million uninsured individuals are *newly-eligible* for subsidies because of the American Rescue Plan's (ARP) enhanced premium tax credits (See Appendix Table 1).[6]

Uninsured rates vary widely by race, ethnicity, language, education, and other factors, with substantial disparities in coverage. While Hispanic (19 percent) and Black (13 percent) populations represent a smaller share of the total U.S. population, they disproportionately account for 29 percent and 16 percent of the uninsured population, respectively.[7] In some parts of the U.S., large portions of the uninsured population (up to 69 percent) reside in households in which the adults have limited English proficiency (See Appendix Table 2). Of the 11 million uninsured who are eligible for subsidized Marketplace coverage, 30 percent are Hispanic, 86 percent have a high school education or less, and 9 percent do not predominately speak English at home.[8]

Uninsured populations are also disproportionately more likely to be young adults (38 percent aged 19-34), have low incomes (33 percent under 100 percent of the federal poverty level (FPL)) (See Appendix Table 2),[9] or live in a state that hasn't expanded Medicaid to low-income adults (9.1 percent of adults uninsured vs. 17.1 percent of adults uninsured) (See Appendix Figure 1).[10] In 2019, adults aged 19-64[†] were more than twice as likely as children to be uninsured (11.7 percent vs. 5.2 percent)[11] and, although low-income individuals were more likely to be uninsured than those with higher incomes, around 14 percent of the uninsured had incomes of 400 percent FPL or higher.[12] Over half (52 percent) of the uninsured population lived in families of two or more people, and a majority (82 percent) of the remaining uninsured live in families with at least one full time worker. The Congressional Budget Office (CBO) estimated that at any given point in time in 2019, 11 percent of uninsured individuals lacked coverage for less than six months and 80 percent were without coverage for over a year. Children and members of families with higher incomes (above 400 percent FPL) tended to remain

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[*] The remaining uninsured ineligible for Medicaid or Marketplace financial assistance (37 percent of total uninsured) include 4 percent whose income exceed 400 percent of the federal poverty level (FPL), 12 percent who have an offer of employer coverage, and 13 percent who are ineligible due to their citizenship status. Eight percent of the remaining uninsured live in states which haven't adopted the ACA Medicaid expansion and fall in what is often referred to as the "coverage gap," with incomes above the state's Medicaid eligibility level but below 100 percent FPL, the income level qualifying individuals for Marketplace premium tax credits.

[†] Not including undocumented immigrants.

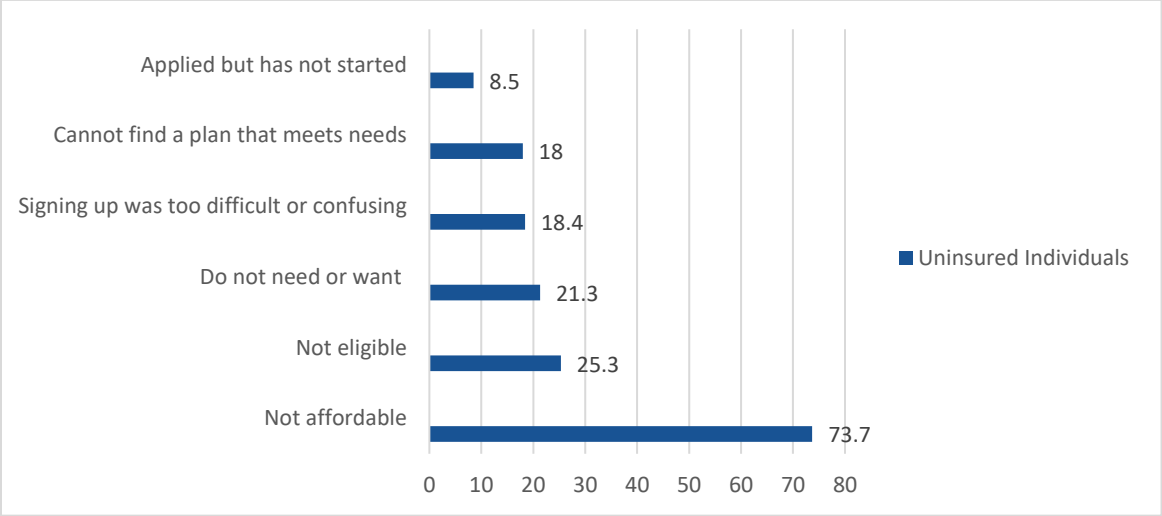
uninsured for shorter periods of time, resulting in "churning," or coverage disruptions and coverage loss.[13] Research has shown that "churning" often leads to periods of uninsurance, delayed care, and less preventive care utilization, as well as higher administrative costs and monthly health care costs.[14]

Various surveys have examined the reasons why people who are uninsured do not have health coverage. By far, the most common answer is cost. A 2020 national survey found that in the past 3 years, 42 percent of uninsured adults looked for individual coverage and did not buy a health insurance plan on their own; most of those individuals said the plan was too expensive (71 percent). Smaller numbers said they found out they were ineligible (6 percent), gained insurance through another source (4 percent), or deductibles or copayments were too high (3 percent).[15] Citing affordability as the main barrier to coverage increased with age, from 67 percent among those 18-29 years of age to 81 percent among those 50-64 years of age. Among uninsured populations, one-fourth (25 percent) reported that they did not think they were eligible for coverage, and Hispanic adults were more likely than their white counterparts to indicate ineligibility as the reason for not being covered (30 percent and 22 percent, respectively).

Lack of information and complexity in the application process are also cited barriers to enrolling in coverage. Thirty-eight percent of uninsured adults who had visited the Marketplaces but did not enroll in a Marketplace plan or Medicaid reported finding the process difficult or confusing.[16] Moreover, many uninsured individuals lack the health literacy to determine their coverage eligibility and navigate the enrollment system, compare their plans options, and use their coverage to access care.[17] For example, one 2021 survey found that more than half of respondents were confused by health insurance and only 20 percent correctly identified all qualified life events, the circumstances that would allow someone to enroll in a new health care plan outside of open enrollment.[18] Factors related to informational barriers are further discussed in this Brief.

As shown in Figure 1, in the 2019 National Health Interview Survey, over one-fifth of the uninsured (21.3 percent) reported they did not need nor want coverage. Reporting that coverage was not wanted or needed was more likely among men (26.8 percent) than women (14.6 percent) and decreased with age. Additional reasons for not having coverage included that "signing up was too difficult or confusing" (18.4 percent), that the consumer "couldn't find a plan that met their needs" (18 percent), or that they had applied but coverage hadn't started (8.5 percent).[19] Note that respondents were able to select more than one reason for not having insurance.

Figure 1. Reasons for Remaining Uninsured Among Non-Elderly Adults



Source: Data from the 2019 National Health Interview Survey

Evidence on Health Coverage Take-Up

Policy Factors

In 2021, ACA-related enrollment reached an all-time high – with over 31 million people enrolled in Marketplace or Medicaid expansion coverage.[20] All states and the District of Columbia have experienced reductions in the uninsured rate since the ACA's implementation in 2013. However, expanding Medicaid in the remaining non-expansion states[‡] would greatly reduce uninsurance rates, with large projected gains in coverage among Black and Hispanic adults.[21] If the remaining states were to expand Medicaid eligibility to adults with incomes up to 138 percent FPL, an estimated four million uninsured non-elderly adults would be newly eligible for Medicaid.

Research shows that states that have developed state-based Marketplaces have experienced increased gains in coverage and lower premium growth compared to states relying on the Federally Facilitated Marketplace (FFM). This is likely due to increased support for coverage, outreach efforts, and state policies that ensure a stable and competitive Marketplace. Between 2012 and 2015, states with state-based Marketplaces saw nearly double the coverage gains compared to FFM states.[22] During the COVID-19 pandemic, all but one state-based Marketplace created a special enrollment period and many have worked to broadcast enrollment opportunities to uninsured populations. For example, many states are collaborating with state labor or employment security departments to provide health insurance enrollment information to individuals filing for unemployment insurance.[23] Moreover, research has found state-based Marketplaces are more likely to engage in targeted outreach to individuals who are more likely to be uninsured, such as Spanish speaking individuals.[24]

Given that cost is the most reported barrier to coverage, it is not surprising that financial assistance plays an important role in increasing coverage among the remaining uninsured. In 2020, 7 in 10 uninsured individuals reported that they could not afford monthly health insurance premiums above $75.[25] States that have both expanded Medicaid and offer additional financial assistance in their Marketplaces generally have lower uninsured rates. For example, Massachusetts has the lowest overall non-elderly uninsured rate in the nation and offers additional subsidies for Marketplace enrollees with incomes below 300 percent FPL.[26] Research has shown that as subsidies decline, insurance take-up falls rapidly, dropping about 25 percent for each $40 increase in monthly enrollee premiums.[27] Studies of Medicaid and the Children's Health Insurance Program (CHIP) have similarly shown that premiums and higher cost-sharing dissuade potential enrollees, while more generous coverage and better provider access lead to higher participation rates.[28,29] However, who is eligible and for what kind of coverage are not the only key policy factors that affect coverage rates. Outreach efforts, enrollment assistance, and other strategies also play important roles, as discussed below.

The American Rescue Plan

Signed into law on March 11, 2021, the ARP expanded eligibility for premium tax credits to households with incomes above 400 percent FPL, and enhanced Marketplace premium tax credits for consumers already eligible for these subsidies. Following passage of the ARP, ASPE estimated that three in four uninsured individuals (73 percent) can now access a plan for $50 or less per month, and 62 percent can access a plan for free.[30] If the ARP enhanced subsidies become permanent, extending beyond 2022, consumer behavior may change. One analysis estimated that subsidized Marketplace enrollment would increase by 5.1 million and the

[‡] The 12 states that have not expanded Medicaid are: Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming. While Missouri voters expanded Medicaid on August 10, 2021 through a ballot measure, the expansion has not been implemented as the measure lacked a revenue source. The Missouri Supreme Court later ruled that the legislature's budget appropriation authorizes the state to fund expansion coverage.

uninsured population would decline by 4.2 million in 2022, if consumers knew at the time of enrollment that the ARP enhanced subsidies were permanent.[31]

The ARP substantially reduced enrollee premiums during the 2021 COVID-19 Special Enrollment Period (February 15 to August 15), with almost half of HealthCare.gov consumers selecting a new plan having a monthly premium of $10 or less, compared to 25 percent during the same period in 2020. Across HealthCare.gov states, 2.1 million Americans signed up for new health insurance coverage during this time period (See Appendix Table 3).[32]

Demographic Factors

There are a variety of demographic factors that are associated with enrollment in both public health insurance programs like Medicaid and CHIP and private health insurance through the Marketplace. Research findings show that enrollment in public programs such as Medicaid and CHIP is generally higher among children than among adults.[33] Childless adults without disabilities have historically lower Medicaid take-up rates than parents and those with disabilities.[34] Medicaid take-up has been found to be higher among women, Black individuals, unemployed adults, people with less education, and those with worse self-reported health.[35] Among privately insured young adults, predictors of enrollment include having higher socioeconomic status, White race, and attitudinal factors such as perceived need, perceived health, and perceived value.[36]

One survey has found among uninsured adults who had heard only a little or nothing about Marketplace plans or subsidies, more than half were younger than 35 and nearly half were not working. More than a quarter were bilingual or Spanish speaking, more than one in five lacked a high school degree, and more than one in seven lacked home internet access.[37] Some uninsured people are aware of their eligibility for subsidies but may not view health care coverage as worth the cost.[38] Additional evidence suggests that higher financial and health insurance literacy are associated with a greater probability of being insured.[39] Moreover, compared with people who enrolled in a Marketplace or Medicaid plan, those who did not ultimately enroll had much greater difficulty comparing plans based on premium costs, potential out-of-pocket costs, provider network, and benefits covered.[40] Many factors influence Marketplace enrollment, including race, ethnicity, and English proficiency. For instance, studies show that Latino adults, who are significantly more likely than other racial and ethnic groups to be uninsured, have lower awareness of critical provisions of the ACA than other groups.[41] For example, one survey found more than half of all Latinos were unaware of the Marketplace.[42] Research has also highlighted additional barriers related to language, with a California study finding that Spanish speakers were twice as likely to report not knowing how to apply as the main reason for not enrolling in Marketplace coverage.[43]

Challenges & Barriers to Take-up

A majority (60 percent) of Marketplace enrollees reported they faced difficulty applying for coverage in 2020.[44] Consumers have different levels of awareness of their health coverage options and the resources available to assist them in obtaining coverage, which is a key challenge to enrolling eligible populations. A 2020 study found that 29 percent of uninsured adults tried to obtain Medicaid/CHIP coverage[§] and 55 percent looked for information on Marketplace health plans. However, 71 percent did not try to obtain coverage through Medicaid/CHIP, 40 percent of whom did not try because they did not think they would be eligible.[45] Moreover, 45 percent did not look for information on Marketplace plans, and of those, 42 percent did not do so because they believed the cost would be too high. Another 2020 survey of the uninsured found that 65 percent of uninsured adults had little or no knowledge about financial assistance for Marketplace coverage.[46] Moreover,

[§] As indicated by response to the question, "Have you tried to obtain coverage through Medicaid, Medical Assistance (MA), the Children's Health Insurance Program (CHIP), or any kind of state or government-sponsored assistance plan based on income or a disability?"

a recent poll found that less than one in five respondents were aware of when the upcoming deadline was to sign up for 2021 coverage through the Marketplace.[47]

While consumers report not looking to enroll in Marketplace plans because they believed cost would be prohibitive, consumers also have little awareness of the financial assistance available to them. Two in three uninsured individuals (65 percent) had heard "nothing" or "a little" about financial assistance for Marketplace coverage and only 11.4 percent of uninsured individuals reported knowing "a lot" about Marketplace financial assistance.[48]

The existing literature highlights the complex nature of health insurance take-up and the shared but also unique needs of various communities in navigating the enrollment process.** Beyond the actual and perceived costs of health insurance, a significant challenge to take-up is health insurance literacy and its correlates. One 2016 study of Asian Americans and Pacific Islanders in California found that new enrollees struggled with informational barriers to accessing care, and that immigrants with limited English proficiency disproportionately experienced challenges with the enrollment process.[49] A study of Latino adults seeking urgent care at a public hospital in California, researchers found that participants experienced challenges with gaining awareness of health insurance benefits and completing the enrollment process; language and fear of authorities also were cited as barriers to take-up.[50] Relatedly, a 2018 cross-sectional study examining underserved Hispanic communities in Texas found that low ACA knowledge was associated with low levels of health insurance literacy and low levels of confidence in choosing and comparing health insurance plans.[51] Other studies in states including Connecticut, Kentucky, and Maryland have found that health insurance terminology was especially confusing to Black and Hispanic enrollees,[52] that difficulty understanding health insurance concepts and mistrust in the health care system are common barriers to enrollment,[53] and that Navigators and In-Person Assisters can help boost enrollment by gaining the trust of patients.[54]

Strategies to Increase Enrollment

Under the ACA, the Centers for Medicare & Medicaid Services (CMS) is responsible for outreach and marketing to consumers enrolling in the federal Marketplace through HealthCare.gov. Research has identified three key enrollment strategies that are effective in helping people enroll in coverage under the ACA: public information campaigns, individual/consumer assistance, and community outreach.[55] Among remaining uninsured Medicaid- or Marketplace- eligible populations, a combination of strategies is likely necessary. Evidence from low-income Medicaid- and CHIP-eligible families shows that consumers have different preferences on where and how they would like to receive information. While broad education and promotion can increase consumer awareness, individual assistance and community outreach are necessary supplements to enroll people who are medically underserved.[56] Recent policy changes regarding Marketplace enrollment, individual assistance, and outreach take this evidence into account, to extend access to coverage for the uninsured and improve health equity. For instance, the CMS payment notice for Plan Year (PY) 2022 lengthens the annual Open Enrollment Period (OEP) by an additional 30 days and creates a new special enrollment period opportunity for certain low-income consumers, providing the opportunity to utilize the ARP's expanded subsidies to access a zero- or low-premium Marketplace plan.[57]

Public Information Campaigns

Public information and advertising campaigns, including health education and promotion efforts, can disseminate materials about health insurance choices and the enrollment process. This strategy may be used

** In addition to the communities highlighted here, ASPE has published briefs on the unique needs and challenges in accessing care faced by LGBTQ+ (https://www.aspe.hhs.gov/sites/default/files/2021-07/lgbt-health-ib.pdf) and rural communities (https://aspe.hhs.gov/sites/default/files/2021-07/rural-health-rr.pdf).

by various entities, including private organizations, media, and government agencies. States can also use specially allocated ACA funding for such local outreach and enrollment supports.[58]

These campaigns can be effective at increasing enrollment among a large population.[59] For example, in 2016 CMS determined that of the 9.6 million enrolled in coverage, 1.8 million had enrolled due to advertising. By 2017, advertising drove 37 percent of enrollments.[60] At the state-level, California, which operates its own Marketplace, has found outreach to result in a more than three-to-one return on investment by increasing enrollment and retention of healthy individuals. Covered California asserts their marketing and outreach expenses in 2015 and 2016 likely lowered premiums by 6 to 8 percent by enrolling healthier consumers, with an estimated combined savings to consumers and the federal government between "$853 million to a high of $1.3 billion" in 2015 and 2016.[61] In Kentucky, researchers concluded that almost 40 percent of unique visitors and web-based applications to the Kentucky Health Benefit Exchange were associated with state-sponsored television advertising.[62] Another study estimates that, between 2013 and 2016, one-fifth of the decline in the uninsured rate in individuals above 400 percent FPL was due to outreach and advertising efforts.[63] Advertisements are one approach to health education, and research has found that the volume and source of advertisements under the ACA were associated with increased coverage. Specifically, government-sponsored advertisements were associated with insurance gains, whereas privately-sponsored advertisements were not similarly associated with increases in coverage.[64]

Public information campaigns can be particularly impactful among certain subpopulations, such as for uninsured individuals, who may need multiple points of contact and exposure to information about health plans and enrollment deadlines before they will enroll.[65] As found in a 2018 GAO study, some stakeholders emphasized how outreach and advertising are particularly important for increasing new enrollment, especially among younger, healthier individuals. Research shows that a higher percentage of adults with low literacy receive their information about health issues from radio and television than through written sources, the internet, or social contacts.[66] Alternatively, research has found that individuals seeking information and online help when making a health insurance plan decision may more likely be higher income.[67] The economic recession has shown that affected families have turned first to community-based organizations for help with linking them to public assistance programs.[68]

Other outreach efforts can include direct-to-consumer materials such as emails, letters, postcards, or automated telephone calls. Such "nudging" efforts are relatively low-cost and can help overcome inertia in coverage take-up. For example, Oregon found that postcards, mailings, and automated telephone outreach increased enrollment among Medicaid-eligible populations.[69] Similarly, Oregon found that generic reminders sent through mail and e-mail increased Marketplace plan shopping by 23 percent.[70] For Marketplace-eligible populations, California experimentally varied enrollment deadline reminders mailed to households with typically low take-up. The effort cost $0.69 per letter but raised enrollment by 1.3 percentage points and increased the average consumer's willingness to pay for insurance by at least $25 per month.[71] A second study in California found that personalized phone calls to individuals who had applied but not selected a Marketplace plan increased enrollment by nearly 3 percentage points and was particularly effective for low-income and elderly individuals, Spanish-speaking individuals, and enrollees transitioning from Medicaid.[72] Researchers in Massachusetts examining the impact of personalized letters found that letters that included a simplified enrollment option ("check-the-box") increased enrollment by 11 percent overall and by 23 percent for individuals below 150 percent FPL.[73] These efforts have also shown to be effective in reducing plan choice errors, which occur when a low-income household enrolls in a gold or platinum plan despite being eligible for cost-sharing reduction (CSR) silver plans with lower premiums and higher actuarial values. Consumers who received a postal message and email increased switching to CSR plans by 11 percent, which saved an average of $84 in premiums and $56 in out-of-pocket expenses per month.[74]

At the federal level, in 2017, the Internal Revenue Service mailed informational letters to 3.9 million households who paid the tax penalty for lacking health insurance, comparing them to a randomized comparison group that did not receive those notices. The uninsured individuals who received letters were 1.1 percentage points more likely to enroll in coverage in the following two years than those in the control group, with the increase in coverage being driven primarily by Marketplace enrollment. Researchers concluded the initiative increased coverage and reduced short-term mortality among the population over the subsequent two years.[75] These results suggest that outreach efforts not only increase coverage but lead to substantial health benefits among those targeted.

Individual/Consumer Assistance

Consumer assistance is effective at helping uninsured individuals make informed decisions during the health coverage selection process, including helping such individuals understand their coverage options and apply for financial assistance. Individual assistance involves educating consumers about their coverage options, helping to screen for eligibility, and supporting them throughout the application process. In this section, we review the following types of individual and consumer assistance: Navigators, Certified Application Counselors (CACs), Community Health Workers (CHWs), and enrollment workers.[76]

Federal rules require Marketplaces to develop and operate Navigator programs funded by federal grants overseen by the CMS.[77] Navigators are required to provide free and unbiased services to consumers, small businesses, and employees as they look for health insurance coverage on the Marketplace.[78] The ACA defines Navigator duties to include the following tasks: performing public education activities to raise awareness of the availability of qualified health plans (QHPs), distributing fair and impartial information regarding enrollment in QHPs and the availability of federal financial assistance, facilitating enrollment in QHPs, providing referrals to appropriate agencies for grievances or complaints, and providing all information in a manner that is linguistically and culturally appropriate for the consumer.[79] Navigators contract directly with the state-based Marketplace or FFM, and a variety of organizations may serve as Navigators. As part of HHS' funding agreement with Navigator organizations in the FFMs, Navigators are tasked with providing impartial information about health insurance options to traditionally underserved populations, including assisting those with limited English proficiency or complex enrollment and financial circumstances.[80] In addition, CACs, who serve a similar function and role as Navigators, operate in the FFMs.[81] However, unlike Navigators, CACs operating in the FFMs are not federally funded. In 2021, CMS awarded 60 organizations Navigator Cooperative Agreement awards for PY 2022 in 30 states with an FFM. These Navigator grants include United Way of Anchorage, the Arizona Alliance for Community Health Centers, and the Illinois Primary Health Care Association.[82] In addition to federal funding, community based training in health insurance, health care resources, and outreach supported at the state- or community-level has also been effective in increasing competencies among a diverse set of Navigators.[83] Of note, CACs and Navigators are not allowed to receive any payment or other consideration directly or indirectly from health insurance issuers in connection with the enrollment of any consumer in a QHP or non-QHP.[84] CMS is also expanding services provided by FFM Navigators and is re-launching a partnership program with local organizations that are active in providing outreach and education about the Marketplace and how consumers can enroll in coverage through HealthCare.gov, Medicaid, or CHIP.

Studies show that consumer assistance can be highly effective in enrolling people in coverage. Nearly 20 percent of consumers[††] who looked for coverage or actively renewed their coverage received consumer assistance in the past year. Forty percent of those who used assistance think it is unlikely they would have the same coverage if not for the help they received.[85] A 2015 study found that in-person assistance increased

[††] Answering "Yes" to the following question, "At any time in the past 12 months, did you get help with shopping, applying, or renewing health insurance or Medicaid from anyone other than a family or friend?" Source: Kaiser Family Foundation Consumer Assistance Survey (March 28 – April 14, 2020)

successful enrollment among lower income populations from 84.9 percent to 93.1 percent.[86] Among those who didn't receive assistance, two-thirds (66 percent) said they would seek consumer assistance if it were available.[87] Consumers cited several reasons for using assistance: they didn't understand their health coverage options (62 percent), the process was too complicated to complete on their own (52 percent), they did not have internet at home (18 percent), they had technical problems with the website (18 percent), or they needed help in another language (15 percent). In a nationally representative survey of assisters, the majority identified similar problems that they work to help consumers address: understanding important financial and nonfinancial considerations beyond premiums, assistance for consumers unable or unwilling to afford plan options, and overcoming limitations for consumers who lack sufficient insurance literacy.[88] Additionally, research has found that recent immigrants or predominantly Spanish speaking individuals, who are among the most likely to be uninsured, tend to prefer to interact directly with a person (e.g., a Navigator) for health information or when enrolling in programs.[89]

Minnesota's state-based Marketplace, MNSure, trained Navigators and CACs and utilized those assisters to conduct additional community outreach, holding regular assistance hours at community centers and places of worship, and also used paper and social media campaigns. In a follow-up evaluation, researchers found that 76 percent of uninsured individuals exposed to the state's outreach activities sought more information about health insurance, and those who gained coverage were almost 7 times more likely to have received in-person assistance during the enrollment process.[90]

From its inception until 2017, the Navigator program had received federal funding in the amount of at least $60 million annually to cover enrollment, outreach, and public education activities in FFM states.[91] Between 2017 and 2020, however, funding for outreach and Navigators was reduced significantly.[92] In 2017, CMS awarded $36.2 million for Navigator grants for PY 2018, which was further reduced to $10 million in the 2019 and 2020 PYs. During this time period, funding for outreach outside of the Navigator programs also decreased by 90 percent.[93] This amounted to $1 spent on advertising per enrollee in 2018, compared to about $11 for 2017 and $5 for 2016.[94] The dramatically reduced investment in federal outreach and enrollment strategies coincided with drops in enrollment. In 2020, 11.4 million people enrolled in Marketplace coverage, a decrease of 1.27 million people from 2016, the year before federal funding cuts.[95] However, this downward trend in outreach spending has been reversed this year, and for the 2022 PY, CMS has made $80 million in grant funding available in grants to Navigators in FFMs.[96] Through the grant awards, 60 Navigator awardee organizations will be able to train and certify more than 1,500 Navigators, quadrupling the number of Navigators in the states using an FFM.[97] In the previously mentioned 2018 GAO study, stakeholders cited Navigator organizations as a factor affecting enrollment and pointed out that the HHS funding reductions in 2018 limited the availability of some Navigator organizations to conduct outreach and assist with enrollment, particularly in rural areas and for consumers with complex circumstances.[98]

Some states have imposed restrictions on Navigators which limit their ability to help certain consumers. For Americans living in states with an FFM, where consumer outreach efforts have been modest to begin with, this chilling effect only makes it harder to learn about the health law and enroll in coverage. For example, 12 states restrict the advice Navigators can offer consumers. Four states bar them from giving advice about the benefits, terms, and features of a particular health plan, despite the fact that federal rules require Navigators to clarify distinctions among plans and assist people in making informed decisions about what coverage to choose. In some instances, state restrictions have led Navigator organizations to withdraw from the program.[99]

Community Outreach

Outreach at the community level includes individual/consumer-level assistance but also focuses on using trusted messengers with a localized message. Partnerships are formed among community organizations, federally qualified health centers, local health centers, hospitals and social workers, faith-based places, and

other trusted local resources who can organize community events.[100] Community Action Agencies' (CAAs) are private and public nonprofit organizations that receive federal funding with roots in their communities and access to vulnerable populations that can help them effectively find and serve the uninsured. CAAs can leverage diverse public and private funding sources to extend outreach and enrollment efforts, providing a holistic approach that combines human services programs with health insurance enrollment.[101]

Community outreach is effective in engaging specific segments of the population with lower rates of coverage. This strategy uses local agencies' existing connections and credibility in the community (including with clients already receiving other public services) to increase access to quality health coverage among populations with low take-up.[102] In a study on different outreach approaches for public health insurance in California between 2001 and 2007, non-technology-based approaches, including media campaigns, provider in-reach, and school-linked approaches such as using school nurses and counselors, yielded a 12 percent increase in new enrollment.[103] More recent research on California has demonstrated the importance of community outreach for diverse populations. A statewide network of Community-Based Outreach, Enrollment, Utilization and Retention in California supports individuals and families in navigating the health insurance system. Organizations in this network often work with low-income populations, mixed status families, and communities of color to support the access, utilization, and maintenance of health coverage. Additionally, enrollers assist individuals with troubleshooting errors and post-application follow-up activities. Enrollers often come from the communities they serve and may be employed as a CAA, Certified Enrollment Counselor (CEC), Navigator, and CAC, at a community-based organization, clinic, or hospital. They also can linguistically support the communities they serve by using Spanish, English, and a number of Asian languages, as Latinos and Asians represent substantial shares of California's Medicaid-eligible and subsidy-eligible population.[104]

Direct Enrollment

Another strategy for Marketplace enrollment in HealthCare.gov states is the Direct Enrollment (DE) program, which allows QHP issuers and web-brokers to enroll consumers in individual health insurance coverage offered through the Marketplace, directly from the QHP issuer or web-broker website.[105] There are two pathways in the DE Program, Classic DE and Enhanced Direct Enrollment (EDE). In Classic DE, consumers start on the QHP issuer or web-broker website and are redirected to HealthCare.gov to complete the application. In EDE, consumers complete the entire enrollment process on the QHP issuer or web-broker website. During the 2021 OEP, the Center for Consumer Information and Insurance Oversight (CCIIO) reported that 37 percent of all plan selections in HealthCare.gov states were made through Classic DE or EDE.[106]

While Classic DE has been an option since the initial 2014 OEP, EDE has only been available since late 2018 when CCIIO began approving entities to use the EDE pathway, which allows QHP issuers and web-brokers to handle the entire Marketplace application process on their respective websites. EDE is intended to provide a comprehensive consumer experience, in which the enrollment is fully completed on the EDE website, using secure data transfers to the federal Marketplace for determinations of a consumer's eligibility for the Marketplace and Medicaid/CHIP, including the calculation of subsidies (if otherwise eligible).[107]

As of August of 2021, CMS lists 43 approved EDE entities, 9 of which are hosting an EDE platform.[108] In the 2021 OEP, 20 percent of plan selections in HealthCare.gov states used the Classic DE pathway, and 17 percent used the EDE pathway. Among new consumers, plan selections in HealthCare.gov states through non-DE channels dropped by about 21 percent during the 2021 OEP, and enrollment through the DE program represented 46 percent of new consumer enrollments on the FFM. [109]

DE is intended to increase ease of enrollment. However, several concerns exist around the ability of the program to protect consumers. While some entities, including one of the largest EDEs, only enroll people in Marketplace plans,[110] other DE entities may expose consumers to additional risks by directing them towards

health plans not subject to the ACA consumer protections. These alternative coverage options that DE entities may offer can impose lifetime and annual benefit limits, require cost-sharing of any amount, leave out ACA essential health benefits, and reject applicants or charge higher premiums based on age, gender, and pre-existing conditions.[111] For example, short-term limited duration insurance (STLDI) plans may charge lower premiums, but are not required to cover pre-existing health conditions, meet minimum medical loss ratios requirements, or cover essential health benefits, and they are not prohibited from discriminating in rating based on gender and health.[112] DE entities may also provide secondary products like vision or accident coverage.[113] Additionally, some DE entities often display products differently than HealthCare.gov and some web-brokers have not displayed premiums and certain other plan details historically. While web-brokers are required to display all plans, they have been permitted to exclude the display of premiums and deductibles and instead can post a standardized disclaimer directing consumers to HealthCare.gov for more information.[114] This practice will no longer be permissible beginning with the PY 2022 OEP; web-broker websites will be required to display QHP comparative information aligned with the information displayed on HealthCare.gov. In addition, QHP issuers are only required to display QHPs they offer in the consumer's area.

By allowing consumers to navigate a single centralized website to view all plans eligible for financial assistance and access tools to compare and enroll in all available plans, HealthCare.gov simplifies the complex application process for Marketplace, Medicaid, and CHIP coverage, as well as assist with Marketplace plan selection. Though some have argued that a decentralized platform and increased choice of enrollment pathways could benefit the consumer, research does not support this assertion.[115] For instance, a study of Medicare Part D plans found that while having fewer than 15 options raised enrollment, having 15 to 30 options did not, and more than 30 options resulted in decreased enrollment.[116] HealthCare.gov also more reliably ensures that those consumers eligible for Medicaid are informed of that fact and directed appropriately. During the 2021 Special Enrollment Period, HealthCare.gov identified nearly 400,000 applicants who were found to be eligible for Medicaid.[117] In contrast to HealthCare.gov, DE entities typically begin the user experience on their websites with a pre-application screening process. Not all DE websites consider and communicate possible Medicaid eligibility. As a result, some consumers eligible for Medicaid that use DE websites may not proceed to completing the eligibility application and therefore may not become aware of their Medicaid eligibility. Most enrollments from DE channels also do not come from consumers visiting websites/web-brokers themselves but come from those assisted by agents and brokers.

Insurance Agents & Brokers

Health insurance agents and brokers are professionals licensed by their state to sell private health insurance to individuals and businesses.[118] According to a CCIIO report, nearly half (approximately 4 million) of all Marketplace enrollees using HealthCare.gov for PY 2020 were assisted by an agent or broker, an increase of 3 percent from PY 2019 and continuing a steady increase from PY 2017.[119] Brokers, similar to assisters or Navigators, can help answer individuals' questions about the Marketplace and financial assistance. Both brokers (53 percent) and assister programs (37 percent) said most clients had questions that were not answered by information on HealthCare.gov.[120]

While both Navigators and brokers can help consumers understand basic insurance concepts, in practice, they have different incentives and often serve different populations. In 2016, 42 percent of assister programs[‡‡] reported most or nearly all clients were uninsured, compared to 8 percent of brokers. Fifty-six percent of assister programs say that most or nearly all clients had income low enough to qualify for Medicaid compared to 30 percent of brokers, and 89 percent of assister programs reported helping individuals eligible for

[‡‡] Assister Programs included: Navigators (those identified by Marketplace officials contracted with and received grant funding directly from the Marketplace), Federal Enrollment Assistance Program (contractors that operate in certain FFM states and that otherwise act as Navigators), Federally Qualified Health Centers (those that received grant funding from HRSA to provide enrollment assistance), and CACs (all other Assister Programs certified to provide assistance in Marketplaces)

Medicaid/CHIP compared to 47 percent of brokers.[121] In addition, only 40 percent of brokers engage in outreach and public education activities compared to 76 percent of assister programs.[122] Brokers were also significantly less likely than Navigators to help individuals who were uninsured, had limited English proficiency, or who lacked internet at home.[123] A quarter of Marketplace assisters with most or all of their clients lacking internet access report that the average individual takes two or more hours to assist and usually require multiple contacts.[124]

Unlike Navigators, brokers are not supported by federal funding. Instead, they earn a commission through private insurance companies for each plan initial enrollment and renewal. Some brokers may only be able to sell plans from specific health insurers. Unlike individual assisters, brokers are not required to remain unbiased and may make a specific plan recommendation to a client, including but not limited to QHPs, such as plans not subject to the ACA consumer protections such as STLDIs and fixed indemnity plans.[125] Per HHS guidance, the standards of conduct for agents, brokers, and web-brokers assisting consumers in HealthCare.gov states include providing consumers with correct information, without omission of material fact, regarding the Marketplace, QHPs, and insurance affordability programs. These standards also include requirements that the agent, broker, or web-broker refrain from misleading, coercive, or discriminatory conduct; provide the Marketplace with correct information; and obtain consumer consent prior to offering assistance.[126]

Brokers earn commissions that differ by plan type and plan premium, and they may be financially incentivized to steer consumers towards specific plans. Brokers have no monetary incentive to redirect eligible consumers to Medicaid/CHIP (which does not pay a commission), and commissions in the Marketplace have declined among QHPs, while health plans not subject to the ACA consumer protections continue to pay a higher commission.[127] In a 2020 report, brokers reported earning a commission of 15 to 20 percent on STLDI plans compared to a 3 to 5 percent commission on ACA plans.[128] In 2020, roughly 1 in 5 Marketplace enrollees who were helped by a broker or commercial health plan representative were offered an alternative health plan not subject to the ACA consumer protections, and one-quarter were offered other policies to buy as a supplement to Marketplace coverage.[129] Moreover, covert testing has highlighted deceptive practices at times used by brokers, such as incorrectly claiming a pre-existing condition or a specific treatment was covered by a STLDI plan.[130,131]

Finally, in contrast to the evidence reviewed earlier on the effectiveness of assisters in boosting coverage rates among eligible populations, the overall impact of private brokers on coverage rates is unclear in terms of the current literature, particularly given that they are less likely to serve people who are medically underserved. However, brokers and agents vary widely in their practices, and these general patterns do not necessarily apply to all of these entities.

Conclusion

Many uninsured individuals are not aware of their coverage options and cite cost and difficulty with the enrollment process as barriers to enroll in coverage. The evidence demonstrates that enrollment strategies such as public information campaigns, individual assistance, and community outreach efforts can be effective at reaching targeted populations, improving consumers' understanding of plans, and increasing enrollment. Research shows that Navigators and consumer assisters can effectively boost enrollment among high need consumers such as low-income individuals, those with limited English proficiency, and individuals lacking internet access. Evidence is weaker on the effectiveness of decentralized approaches, such as the Classic DE and EDE pathways and the use of private brokers, and current financial incentives for these entities may lead consumers to less generous plans that are not subject to the ACA consumer protections. Expanding support for enrollment strategies proven to increase access and take-up of comprehensive coverage can help inform individuals' health insurance choices and reduce the nation's uninsured rate.

APPENDIX

Appendix Table 1. 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

State	Study Population	$0 Available – Any Metal, %			$50 or Less Per Month Available – Any Metal, %		
		Pre-APR, %	Post-ARP*, %	Percentage Point Difference**	Pre-ARP, %	Post-ARP*, %	Percentage Point Difference**
All HealthCare.gov States	**11,103,000**	**42.5%**	**61.7%**	**+19.2%**	**56.8%**	**73.3%**	**+16.5%**
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%**
Iowa	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: ASPE analysis of American Community Survey, 2019; Marketplace Plan Files for Coverage in 2021
https://www.aspe.hhs.gov/reports/access-marketplace-plans-low-premiums-uninsured-american-rescue-plan

Notes: Catastrophic plans excluded from all analyses; *Rounded to the nearest thousand, and "study population" refers to uninsured QHP-eligible nonelderly adults in HealthCare.gov states; **Rounding may result in slight deviation in listed percentage point difference and the difference in pre-ARP and April 2021 ISSUE BRIEF 8 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.

Appendix Table 2. Total Uninsured Population in the United States, Excluding Undocumented Immigrants (2019): Select Demographics and Totals

	U.S. Total
Uninsured (% of population)	26,086,500 (10%)
Age	
Age 0-18	4,032,700 (15%)
Age 19-34	9,946,200 (38%)
Age 35-49	6,904,800 (26%)
Age 50-64	5,202,900 (20%
Income	
<100% FPL	8,684,000 (33%)
100-138% FPL	2,482,800 (10%)
139-249% FPL	6,786,800 (26%)
250-400% FPL	4,492,100 (17%)
400%+ FPL	3,640,100 (14%)
Race/Ethnicity	
Spanish / Hispanic / Latino Origin	7,461,000 (29%)
White Non-Latino	12,291,100 (47%)
Black Non-Latino	4,220,400 (16%)
Asian / Native-Hawaiian / Pacific Islander	986,200 (4%)
American Indian / Alaska Native	434,700 (2%)
Multi-racial or Other	693,100 (3%)
Language in Household (HH)	
No English Speaking Adults	2,242,300 (9%)
English Spoken in HH	22,816,000 (87%)
Spanish Spoken in HH	2,445,600 (9%)
Chinese Spoken in HH	111,900 (0%)
Korean Spoken in HH	51,900 (0%)
Vietnamese Spoken in HH	59,900 (0%)
Tagalog Spoken in HH	20,000 (0%)
Russian Spoken in HH	28,800 (0%)
Other Language Spoken in HH	552,300 (2%)

Source: ASPE analysis of the ACS, https://aspe.hhs.gov/reports/state-county-local-estimates-uninsured-population-prevalence-key-demographic-features

NOTES: Household language columns do not add to 100% because ACS asks respondents whether English was spoken at home and whether a non-English language was spoken at home. Income categorization is done based on the 'health insurance unit" (HIU), which includes adults, their spouses and their dependent children (ages 0-18, plus full-time students under the age of 23.) Estimates are nonelderly population excluding undocumented individuals. Foreign languages in HH (Spanish, Chinese, Korean, Vietnamese, Tagalog, Russian, Other) only apply to people who don't have an English proficient HH member.

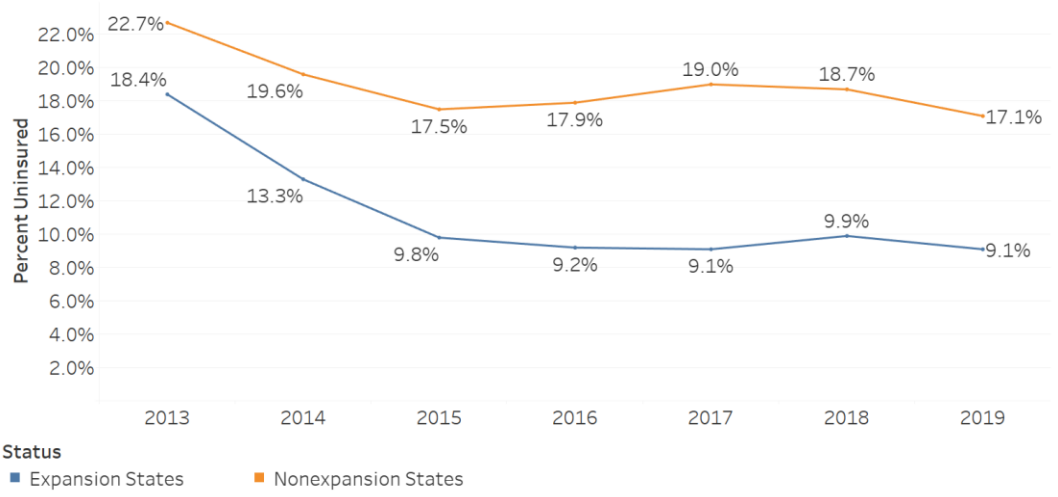
Source: *ASPE analysis of ACS*.

Appendix Table 3. New SEP Plan Selections by HealthCare.gov State, February 15 – August 15

State	2021	2020	2019
All HealthCare.gov States	2,069,596	751,835	554,385
Alaska	4,069	1,460	1,421
Alabama	42,094	13,084	9,243
Arkansas	19,390	6,175	6,107
Arizona	40,827	13,678	13,060
Delaware	5,882	2,583	2,036
Florida	542,067	222,588	152,295
Georgia	147,463	41,138	25,656
Hawaii	4,130	3,014	1,949
Iowa	15,246	6,644	5,875
Illinois	54,432	25,272	22,958
Indiana	27,984	11,810	11,375
Kansas	21,220	7,693	6,124

Source: CMS (2021, Sept.) *2021 Final Marketplace Special Enrollment Period Report.* Accessed at: https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf

Appendix Figure 1. Percentage of adults aged 18–64 who were uninsured at the time of interview, by year and state Medicaid expansion status, 2013–2019



Sources: 2010-2019: Cohen RA, Terlizzi EP, Martinez ME. Health insurance coverage: Early release of estimates from the National Health Interview Survey, 2018. National Center for Health Statistics. May 2019. Available from: https://www.cdc.gov/nchs/nhis/releases.htm.
Notes: For 2013 and 2014, there were 26 Medicaid expansion states including District of Columbia. For 2015, there were 29 Medicaid expansion states. For 2016–2018, there were 32 Medicaid expansion states.

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Fact sheet

Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond Final Rule

Sep 17, 2021 Affordable Care Act

In the Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond final rule, the Centers for Medicare & Medicaid Services (CMS) finalizes standards for issuers, Marketplaces, and Navigators. This rule is a continuation of the recent rulemaking process, as seen in parts 1 and 2 of the Notice of Benefit and Payment Parameters for 2022 final rule, published on January 19 and May 5, 2021, respectively.

Overall, the rule expands access to health insurance coverage through the Marketplaces by lengthening the annual Open Enrollment Period, restoring and expanding Navigator duties, and minimizing burden and confusion for consumers. These changes further the Biden-Harris Administration's goals of providing greater access to coverage, improving affordability for consumers, and reducing burden for issuers and consumers.

Improving Access to Coverage

Navigator Duties

The Federally-facilitated Marketplace (FFM) Navigator Program reaches vulnerable and underserved populations. This program is important to increase awareness of coverage options available through the Marketplaces, help consumers find affordable coverage that meets their needs, and narrow health disparities. Through this final rule, CMS reinstates the requirement that FFM Navigators provide consumers with information and assistance on

certain post-enrollment topics, such as the Marketplace eligibility appeals process, the

Marketplace-related components of the premium tax credit reconciliation process, and the basic concepts and rights of health coverage and how to use it. In addition, the rule expands the interpretation of what activities are encompassed in the duty to provide consumers with information and assistance related to the basic concepts and rights of health coverage and how to use it.

FFM and State-based Marketplace on the Federal Platform (SBM-FP) User Fees

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

2022 Open Enrollment

The rule extends the annual individual market Open Enrollment Period for 2022 and future benefit years to allow consumers more time to review plan choices, seek in-person assistance, and enroll in a plan that best meets their needs. The annual Open Enrollment Period for all individual-market Marketplaces using the federal eligibility and enrollment platform and off-Marketplace individual market plans in states with such Marketplaces for 2022 and future benefit years will be November 1 of the prior year through January 15 of the benefit year. State Marketplaces not using the federal eligibility and enrollment platform maintain flexibilities regarding effective date rules and Open Enrollment end dates, provided the Marketplace's Open Enrollment end date is no earlier than December 15 of the calendar year preceding the relevant benefit year.

Monthly Special Enrollment Period (SEP) for Advance Payments of Premium Tax Credits (APTC)-Eligible Consumers with Household Income up to 150% of the Federal Poverty Level (FPL) whose Applicable Taxpayer has an Applicable Percentage of Zero

To provide more opportunities for certain low-income consumers to access coverage with low or no premiums after APTC, such as under the American Rescue Plan (ARP), Marketplaces will now have the option to provide a monthly SEP for APTC-eligible consumers with a projected annual household income no greater than 150% of the FPL. The rule will permit Marketplaces to provide a SEP for periods of time during which premium tax credits are available without the applicable taxpayer having to contribute toward their applicable portion of premiums before premium tax credits become available, such as those currently available under section 9661 of the ARP. Marketplaces on the federal platform will implement this SEP by providing eligible consumers with a pathway

federal platform will implement this SEP by providing eligible consumers with a pathway through the HealthCare.gov application during such periods of time.

Ensuring Affordability

SEP Clarification

To ensure consistent application of SEPs based on APTC eligibility across the Marketplaces, the final rule clarifies that, for purposes of the § 155.420 SEPs, references to ineligibility for APTC refer to being ineligible for such payments, or being eligible for such payments but for a maximum of $0 per month. That is, an enrollee with a maximum APTC amount of $0 is not considered APTC-eligible, and an enrollee is not considered newly APTC-eligible when they become eligible for $0 APTC after having previously been APTC-ineligible for another reason, such as having other minimum essential coverage. This clarification will mitigate the potential risk of inconsistent interpretation of this eligibility requirement across different Marketplaces. This clarification also ensures that SEP rules clearly reflect that enrollees who qualify for a maximum APTC amount of $0 are eligible for an SEP based on a change that makes them newly eligible for an APTC amount greater than $0 (based on a decrease in their household income, for example). This clarification is especially important in light of the removal of the upper APTC eligibility limit on household income at 400% of the FPL for taxable years 2021 and 2022 under the ARP. While the ARP policy is in place, this clarification will ensure that Marketplaces appropriately find households eligible for an SEP if they newly gain or lose access to APTC, because their maximum APTC amount changed from $0 to more than $0, or vice versa.

Separate Billing

The rule repeals the separate billing regulation that required individual market qualified health plan (QHP) issuers to send a separate bill for that portion of a policyholder's premium attributable to coverage for abortion services for which federal funding is prohibited. Specifically, we codify in its place the policy from the 2016 Payment Notice under which QHP issuers offering coverage of abortion services for which federal funding is prohibited have flexibility in selecting a method to comply with the separate payment requirement under section 1303 of the Affordable Care Act (ACA). We believe the changes offer issuers options for meaningful compliance with section 1303 of the ACA without imposing the operational and administrative burdens of the separate billing policy, and without causing additional consumer confusion and unintended losses of coverage. Reduced administrative burden and costs for issuers are also expected to result in lower premiums for consumers.

State Options

Exchange Direct Enrollment Option Repeal

The rule repeals the Exchange Direct Enrollment option. This option permitted a state Marketplace, SBM-FP, or an FFM state to facilitate enrollment of qualified individuals into individual market QHPs primarily through private-sector direct enrollment entities, including QHP issuers, web brokers, agents, and brokers, rather than the Marketplace's centralized website. Repeal of the Exchange Direct Enrollment option ensures that all available resources can be dedicated to support implementation of the health care provisions of the ARP and other new federal health care legislation, such as the consumer protections in the No Surprises Act, and aligns with recent executive actions designed to strengthen the ACA, increase enrollment in comprehensive coverage, and advance equity. The repeal also addresses concerns that the Exchange Direct Enrollment Option would lead to consumer confusion about coverage options and the availability of financial assistance, resulting in fewer consumers enrolled in comprehensive coverage and disruptions to coordination with other insurance programs.

Section 1332 Waiver Policies

The Department of Health & Human Services (HHS) and the Department of the Treasury (collectively, the Departments) finalize modifications to regulations implementing section 1332 of the ACA governing waivers for state innovation (referred to as section 1332 waivers), including changes to many of the policies and interpretations of the statutory guardrails codified in part 1 of the 2022 Payment Notice final rule. The policies and interpretations in this rule supersede and replace those outlined in the October 2018 "State Relief and Empowerment Waivers" guidance (the 2018 guidance). This rule also repeals and replaces the previous codification of the 2018 guidance guardrail interpretations in part 1 of the 2022 Payment Notice final rule. The Departments also modify regulations to set forth flexibilities in the public notice requirements and post-award public participation requirements for section 1332 waivers under future emergent circumstances, if certain criteria are met. The rule also provides new information regarding the processes and procedures for amendments and extensions of approved section 1332 waivers.

The Departments are of the view that rescinding the 2018 guidance, repealing the codification of its statutory guardrail interpretations in part 1 of the 2022 Payment Notice, and finalizing new policies and interpretations align with the Biden-Harris Administration's goals to strengthen the ACA and increase enrollment in comprehensive coverage. These policies further advance the Biden-Harris Administration's goal to expand coverage by empowering states to develop innovative health coverage options that best fit a state's individual needs, expand coverage to its residents, and lower costs. Assessing the effects of waiver proposals across different groups of state residents aligns with the Biden-Harris

Administration's commitment to ensuring that systemic barriers to opportunities for people of color and other underserved groups are not perpetuated, as well as its commitment to protect and expand access to comprehensive, affordable health care. In addition, these policies further support the Biden-Harris Administration's efforts to build on the ACA to meet the health care needs created by the COVID-19 public health emergency, reduce individuals' health care costs, and make our health care system less complex to navigate.

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Legal Sidebar

Affordable Care Act Litigation Still on the Docket After *California v. Texas*

September 14, 2021

Referred to as "the most challenged statute in American history" by some commentators, the Patient Protection and Affordable Care Act (ACA) has been the subject of numerous lawsuits since its enactment in 2010—more than 2,000 by one estimate. In June 2021, the Supreme Court dismissed the latest challenge that threatened the entire law's existence in *California v. Texas*, leaving the law intact. The dismissal also preserves other suits challenging particular ACA provisions or the Act's implementation, and these cases may have implications for health insurers, health care providers, employers, patients, and others. This Legal Sidebar provides relevant background on private health insurance requirements in Title I of the ACA, discusses several notable past or pending ACA cases, and concludes with select legal considerations for Congress.

ACA Private Health Insurance Requirements: Background

As the Supreme Court has recognized, Congress enacted the ACA to increase the number of individuals covered by health insurance and decrease health care costs. Among the ACA's key features, Title I adopts several private health insurance market reforms designed to promote access to health coverage and protect consumers against discriminatory insurance practices. These reforms include limitations on preexisting condition exclusions; a bar on lifetime and annual benefit limits; coverage of certain essential health benefits; a prohibition on health insurance rescissions (except under limited circumstances); and coverage of preventive health services without cost sharing. To facilitate health insurance enrollment, the ACA required the creation of an insurance marketplace—or Exchange—in each state. The law also imposes various requirements on plans sold on the Exchange to help ensure their quality and affordability. Additionally, to assist individuals in purchasing health insurance on an Exchange, the ACA provides that certain lower- and moderate-income taxpayers may receive federal subsidies to help offset the cost of coverage. Some of the most prominent ACA litigation has been over Title I of the Act, including the cases discussed below.

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Preventive Health Services: Contraceptive Mandate Lawsuits Continue and Litigation Takes a New Turn

The ACA generally requires most employment-based health plans and health insurers to cover certain preventive health services with no out-of-pocket costs—known as cost sharing—to participants. While the ACA does not specify each service that must be covered, the Act requires plans and insurers to cover, among other things, evidence-based items or services with a rating of "A" or "B" in the current U.S. Preventive Services Task Force (USPSTF) recommendations, vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), and women's services as specified in guidelines issued by the Health Resources and Services Administration (HRSA), an agency of the Department of Health and Human Services (HHS). Currently, there are more than 60 types of covered services, ranging from those related to diabetes, lung cancer, and depression screenings, to breastfeeding support and counseling.

Regulations implementing HRSA's guidelines on women's services—and in particular, those relating to contraceptive coverage requirements—have been the subject of voluminous litigation. The 2012 guidelines called for health plans and insurers to cover all Food and Drug Administration-approved contraceptive methods. These guidelines sparked a clash between the Obama Administration, which viewed women's contraceptive coverage access as an important public health objective, and certain employers and other groups, who argued that the mandatory provision of this coverage through their health plans violated their constitutionally and statutorily protected religious beliefs.

To strike a balance between these interests, beginning in 2012, federal regulations have exempted specified types of religious entities (e.g., churches) from the contraceptive coverage requirements. Later versions of the regulations—including those issued in response to Supreme Court decisions—also allowed other organizations (e.g., religiously affiliated universities and religious, closely-held for-profit entities) to opt-out of providing this coverage by self-certifying their religious objections. This latter approach, which the regulations refer to as an "accommodation," shifted the responsibility of providing contraceptive coverage to an insurance company that services an employer's health plan, and itself became the subject of several legal challenges.

In 2017, while challenges to the accommodation process were pending, the Trump Administration issued interim final rules, which were finalized and went into effect in 2019. The final rules made the accommodation process optional and substantially broadened the existing automatic religious exemption, allowing exemptions for any non-governmental employer that opposes providing coverage of required contraceptives based on sincerely held religious beliefs or moral objections. In 2020, in *Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, the Supreme Court upheld the amended regulations, concluding, among other things, that the ACA authorized the Administration to issue religious exemptions from the contraceptive mandate. However, the Court's majority opinion in *Little Sisters* left some issues unresolved, including whether the Administration engaged in "reasoned decisionmaking" when crafting the new exemptions as required by the Administrative Procedure Act. As the contraceptive coverage litigation continues, the Biden Administration has indicated its intent to initiate rulemaking and amend the regulations in the coming months. Any future changes to the regulations may alter the posture of current litigation or provoke new legal action.

Aside from the contraceptive mandate litigation, another lawsuit that has captured court watchers' attention is *Kelley v. Azar*. Unlike other cases involving the contraceptive coverage requirements, the plaintiffs in *Kelley* challenge the ACA's preventive service requirements as a whole, alleging the provision violates certain separation-of-powers principles inherent in the Constitution. Among their claims, plaintiffs in *Kelley* assert that the provision violates the Constitution's Appointments Clause because the provision authorizes members of USPSTF, ACIP, and HRSA to make binding determinations as to which preventive services must be covered by health plans and insurers. According to plaintiffs, this constitutes "significant authority" that can only be exercised by properly appointed "Officers of the

United States," and the officials do not meet those requirements. Additionally, plaintiffs insist that the preventive service requirements run afoul of the nondelegation doctrine, which restricts Congress's ability to transfer legislative power to other entities. Although the Supreme Court has previously upheld broad delegation of authority to governmental entities, plaintiffs in *Kelley* argue that the preventive service requirements are an unconstitutional delegation of legislative authority because the ACA provides no "intelligible principle" to guide USPSTF, ACIP, and HRSA on the selection of preventive services to recommend for coverage.

In February 2021, the U.S. District Court for the Northern District of Texas denied a motion to dismiss these claims, concluding that the plaintiffs successfully demonstrated plausible constitutional violations. The parties are expected to file their merits briefs beginning in late 2021. Any forthcoming decision in *Kelley* may be appealed to the U.S. Court of Appeals for the Fifth Circuit. Should the preventive service requirements ultimately be invalidated, it is possible that health plans may be able to impose cost-sharing amounts on enrollees with respect to these services, or may not be required to offer certain preventive services (although some of the ACA's essential health benefits requirements may compel the provision of at least some services for applicable plans).

Suits Remain over Agency Action That Discontinued Cost-Sharing Reduction Payments

To make plans more affordable for low-income enrollees, the ACA created two subsidies—paid by the federal government to insurers—to help reduce two types of costs that an insured individual typically bears under most insurance plans: (1) monthly premiums to maintain coverage, and (2) additional out-of-pocket costs incurred when receiving medical services. The government's payment or non-payment of the second type of subsidy—known as cost-sharing reductions (CSR) payments—has been the subject of numerous lawsuits, in large part due to differences in the two subsidy provisions' statutory text.

The premium subsidy provision under ACA Section 1401 provides a premium tax credit to certain income-qualified individuals enrolled in an Exchange plan of any level to help offset part of the monthly premiums. Plans offered on the Exchange are designated as one of four levels (bronze, silver, gold, or platinum) depending on the percent of the plan benefits the insurer pays. The CSR subsidy provision of Section 1402 requires insurers to reduce the cost-sharing payments of eligible insureds enrolled in silver-level plans offered on the Exchange. The provision, in turn, directs the HHS Secretary to "make periodic and timely payments to the [insurer] equal to the value of the [CSR]." Unlike Section 1401, however, Section 1402 does not refer to the permanent appropriation in 31 U.S.C. § 1324 for tax refund appropriation.

Before these provisions went into effect in January 2014, HHS requested but failed to obtain annual appropriations from Congress to make CSR payments. Between January 2014 and October 2017, the Treasury Department instead made advance payments of both premium tax credits *and* CSR payments to insurers from the tax refund appropriation based on the HHS and Treasury Secretaries' interpretation at the time that this permanent appropriation, as amended by the ACA, was "available to fund all components of the Act's integrated system of subsidies for the purchase of health insurance." In October 2017, however, following the change from the Obama to the Trump Administration, HHS ceased making CSR payments after the Attorney General issued a legal opinion that the tax refund appropriation cannot be used to make such payments.

The agencies' decision to make CSR payments before October 2017 and the payment cessation thereafter raised several legal questions. Foremost among these is whether CSR payments must be funded by annual appropriations, and if so, whether and to what extent insurers are entitled to damages from the federal government if Congress fails to make such appropriations.

As to the first question, two district courts—one in a decision on the merits in *U.S. House of Representatives v. Burwell*, and the other at the preliminary injunction stage in *California v. Trump*—held that the tax refund appropriation did *not* authorize CSR payments, which are subject to annual appropriations. Neither case, however, proceeded beyond these decisions. *Burwell*, filed by the U.S. House of Representatives to challenge HHS's CSR payments before October 2017, resolved by settlement after HHS reversed its position. *California*, filed by several states and the District of Columbia to challenge the payment cessation, was dismissed without prejudice at the plaintiffs' request after states began implementing a workaround strategy known as "silver-loading." Under this strategy, most state regulators allow insurers to price the value of CSRs into silver plan premiums because CSRs are available only with silver plans. Because ACA's premium tax credit amounts are calculated by subtracting each consumer's income-based premium share from the cost of the silver plan offered to the consumer, higher silver premiums—"loaded" with the value of the CSR—mean higher premium tax credit amounts paid by the federal government for not only those who purchased silver plans, but for those who purchase other plans as well. The higher premium tax credit amounts, in turn, enabled many consumers to purchase zero-premium bronze or gold plans at a cost little more than that of silver plans.

As to the second question, the U.S. Court of Appeals for the Federal Circuit (Federal Circuit), in *Sanford Health v. United States*, held that ACA Section 1402 imposed an unambiguous obligation on the federal government to pay the CSR subsidies, and that this obligation is enforceable through a damages action in the Court of Federal Claims under the Tucker Act. In a companion case, *Community Health Choice, Inc. v. United States*, the Federal Circuit also held that the federal government must pay the full amount of unpaid 2017 CSR payments. However, the court continued, to the extent insurers began implementing silver-loading in 2018 and received additional payments from the government in the form of premium tax credits, the damages awarded to insurers must be offset by those additional payments. The Supreme Court, on June 21, 2021, denied the insurers' petition to review the Federal Circuit's decision. The cases have been remanded back to the Court of Federal Claims to determine the damages amount.

"Alternative" Coverage Arrangements: Expanded Time Frame for Short-Term Coverage Available (at Least for Now) and Association Health Plan Litigation on Hold

While the ACA greatly expanded the scope of federal regulation over private health insurance coverage, the Act's insurance market reforms do not apply uniformly to all types of health coverage. For instance, some types of coverage must only comply with a subset of ACA requirements (e.g., large group plans and insurers are not subject to the essential health benefits package requirement or restrictions on charging higher premiums based on an individual's health status), while some less common types of coverage arrangements are exempt from ACA's reforms or other federal standards. To promote coverage subject to fewer ACA private health insurance requirements (or none at all), the Trump Administration issued regulations that extended the maximum period of short-term, limited-duration insurance and encouraged the adoption of association health plans. While some Members of Congress and stakeholders applauded these efforts to expand alternative, lower cost insurance options, critics raised concerns that these initiatives support coverage that lacks important consumer protections and leads to adverse selection problems in other segments of the insurance market. Litigation ensued over these regulatory actions.

Short-term, limited duration insurance (STLDI) is health coverage designed to bridge coverage gaps when an individual moves from one health insurance arrangement to another (e.g., when a worker is in-between jobs). Given the transitional nature of this coverage, STLDI is generally exempt from federal regulation, including ACA's insurance market reforms. However, federal law does not define how long STLDI coverage can last. To restrict STLDI from being used as primary coverage, an Obama-era regulation specified that STDLI policies could have a maximum duration of three months. In 2018, to boost access to this coverage, the Trump Administration amended the rule to extend STLDI coverage to periods of less than twelve months (and renewable for up to thirty-six months). Following the rule's issuance, a health

plan trade association and other parties sued the federal government, claiming the regulation ran contrary to the ACA and other federal requirements. In *Ass'n for Community Affiliated Plans v. U.S. Department of Treasury*, the U.S. Court of Appeals for the D.C. Circuit disagreed with the plaintiffs and upheld the regulation. Following this decision, the future of STLDI remains in the spotlight, as HHS Secretary Xavier Becerra has indicated that the Department is considering future amendments to the regulations.

Association Health Plans (AHPs) are a type of insurance arrangement that allows groups of individuals or small employers to join together to purchase health coverage. While AHP advocates assert that these health plans allow small groups and individuals to pool resources and purchase coverage at better rates than they would be able to do on their own, others note numerous instances where AHPs failed to pay claims because of fraud or mismanagement. In the past, AHP coverage was generally considered subject to the ACA and other federal requirements applicable to individual and small group coverage. However, in 2018, the Trump Administration through the Labor Department issued regulations that greatly expanded the conditions under which AHPs could offer coverage to small employers and individuals, but comply with less comprehensive, large group standards. The regulations generally established broader criteria in which an AHP sponsor (e.g., a trade association or chamber of commerce) could be considered a single, large "employer" under the Employee Retirement Income Security Act (ERISA) for purposes of offering health coverage subject to the ACA and other large group requirements.

A group of eleven states and the District of Columbia sued the Labor Department, claiming the regulation contravenes the text and purpose of ERISA and the ACA, and a district court sided with the states and largely vacated the rule. The Labor Department appealed the case to the D.C. Circuit, but before the appeals court could issue a decision, it granted the Biden Administration's motion to hold the appeal in abeyance. The case now remains on pause as the Department considers further agency action.

Litigation Regarding Scope of Section 1332 Waivers

ACA Section 1332 allows states to apply for an "innovation waiver" in order to implement customized strategies to provide their residents with access to health insurance while retaining the ACA's basic protections. Through a Section 1332 waiver, states can alter key ACA requirements in the individual and small group insurance markets, subject to certain guardrails. Specifically, the HHS Secretary may grant a waiver request only if the state plan: (1) will provide the insureds with coverage that is at least as comprehensive in covered benefits and at least as affordable; (2) will cover at least a comparable number of state residents; and (3) will not increase the federal deficit. To date, most states have sought Section 1332 waivers to implement reinsurance programs to lower premiums for plans sold in the individual insurance market.

In November 2020, the Centers for Medicare and Medicaid Services (CMS) approved the broadest Section 1332 waiver to date to Georgia. Under part of this waiver known as the Georgia Access Model—the state will eliminate the use of HealthCare.gov, the federally-facilitated Exchange, in the individual market and transition to a decentralized, private-entity-based enrollment system beginning with the 2023 plan year. The state believes a decentralized system would better reach uninsured residents because the private entities, now with a larger market, will have greater incentive to engage in marketing and outreach in order to retain existing enrollees and attract new consumers to the individual market.

On January 21, 2021, two health care providers filed suit to challenge CMS's approval of Georgia's waiver. Among its claims, the lawsuits assert that the approval violates ACA Section 1332 and the Administrative Procedure Act because the second part of the waiver fails to meet Section 1332's guardrails. The plaintiffs allege, for instance, that the Georgia Access Model will not provide coverage to a comparable number of state residents and will not provide insureds with coverage that is at least as comprehensive or affordable to state residents. The lawsuit is currently stayed at HHS's request.

Following the transition to the Biden Administration, HHS requested an updated analysis from the state in order to evaluate whether the Georgia Access Model will satisfy Section 1332's statutory guardrails in light of relevant changes to federal law and policy, including the passage of the American Rescue Plan Act of 2021, that alter the uninsured consumers' incentives to seek coverage.

ACA's Antidiscrimination Provision and Sex Discrimination After *Bostock v. Clayton County*

ACA Section 1557 prohibits various forms of discrimination in federally funded or administered health programs or activities. The provision incorporates four preexisting civil rights statutes and the forms of discrimination they prohibit: (1) Title VI of the Civil Rights Act of 1964 (discrimination based on race, color, or national origin); (2) Title IX of the Education Amendments of 1972 (sex discrimination); (3) the Age Discrimination Act of 1975 (age discrimination); and (4) the Rehabilitation Act of 1973 (disability discrimination). Section 1557(c) grants HHS Secretary authority to promulgate regulations to implement this section.

Among other Section 1557 regulations, HHS's regulations implementing Section 1557's prohibition of sex discrimination have been subject to several legal challenges. In its 2016 final rule, the Agency, under the Obama Administration, defined discrimination "on the basis of sex" to include discrimination "on the basis of . . . termination of pregnancy, . . . sex stereotyping, or gender identity." In 2020, under the Trump Administration, HHS finalized a new rule that, among other changes, repealed the 2016 definition and stated that sex discrimination under Title IX "encompasses neither sexual orientation nor gender identity." HHS also incorporated Title IX's religious and abortion-neutrality exemptions. Both the 2016 and 2020 rules drew challenges that raised several legal questions, including whether Title IX's prohibition of sex discrimination encompasses sex stereotyping or gender identity, and whether Section 1557 incorporates Title IX's exemptions.

Related to the first question, the Supreme Court—three days after HHS finalized the 2020 rule—decided *Bostock v. Clayton County*. In *Bostock*, assessing Title VII of the Civil Rights Act's prohibition against sex discrimination in employment, the Supreme Court held that firing an employee for being homosexual or transgender is unlawful discrimination. In the Court's view, such a decision "necessarily and intentionally discriminates against that individual in part because of sex." Since *Bostock*, at least one circuit court has concluded that Title IX's prohibition on sex discrimination must be read similarly.

In the wake of *Bostock*, several plaintiffs—including some health care providers, several transgender women, and 23 states—filed suits seeking to extend *Bostock* to the Section 1557 context to prevent the enforcement of the 2020 rule and to revive aspects of the 2016 rule. As of August 2021, two district courts—in *Walker v. Azar* and *Whitman-Walker Clinic, Inc. v. HHS*—issued overlapping nationwide preliminary injunction orders that block some provisions of the 2020 rule. Both orders prevent the federal government from implementing the 2020 rule to the extent it excludes sex stereotyping from the definition of sex discrimination. The *Walker* order also barred the government from excluding "gender identity" from the sex discrimination definition, reinstating the 2016 requirement that prohibits providers from denying or limiting certain health services because of an individual's transgender status. In *Whitman-Walker*, the district court also enjoined the federal government from enforcing its incorporation of Title IX's religious exemption, concluding that HHS failed to provide sufficient justification for this change in position in the 2020 rule.

In May 2021, HHS, under the Biden Administration, issued a notification of interpretation and enforcement, clarifying that the Agency will interpret and enforce Section 1557's prohibition on sex discrimination to include discrimination on the basis of (1) sexual orientation and (2) gender identity. The Agency noted that in enforcing Section 1557, it will comply with the Religious Freedom Restoration Act (RFRA), which imposes a heightened standard of review for government actions that "substantially

burden" a person's religious exercise, and provides a private right of action to seek appropriate relief against the government.

As of August 2021, at least two district courts have ruled in favor of certain religious health care providers' RFRA claims and enjoined the federal government from enforcing Section 1557 in a manner that would require those plaintiffs to perform or provide coverage for gender-transition procedures. In one of those cases, the injunction also applies to abortion services. In a May 2021 status report filed in one of the pending cases, HHS stated it intends to initiate a rulemaking proceeding on Section 1557 that "will provide for the reconsideration of many or all of the changes" to the 2020 rules.

Price Transparency Litigation: Hospital Price Disclosure Rule Upheld and Insurer Rule Lawsuit Halted

The ACA also includes provisions that require hospitals and insurers to publicly disclose certain information to consumers. HHS, under the Trump Administration, invoked these provisions to issue a pair of transparency rules that require hospitals and insurers to disclose certain health care price information. Each of these rules has been subject to legal challenge.

With respect to the hospital price transparency rule, CMS issued the rule pursuant to ACA Section 2718(e), which requires that every hospital in the United States publicly disclose a list of its "standard charges for items and services" it provides. Under the rule, CMS interpreted "standard charges" to include not only a hospital's list prices for its items and services, but also—among other information—the negotiated rates that hospitals charge insurers and the standardized discounted cash prices that hospitals charge self-pay patients who do not have or opt not to use insurance. Hospitals may be subject to a civil monetary penalty of up to $300 per day for noncompliance.

In December 2020 in *American Hospital Ass'n v. Azar*, the D.C. Circuit upheld the rule against a challenge by hospitals and their trade groups. The court held that Section 2718(e) permits the HHS Secretary to adopt a rule that defines "standard charges" to encompass regular rates set in advance for identifiable groups of patients, including payer-specific negotiated charges and standardized discounted cash prices. The court further rejected the plaintiffs' argument that the rule violates the First Amendment, concluding the rule's price disclosure provision is a commercial disclosure requirement permitted under the Supreme Court's decision in *Zauderer v. Office of Disciplinary Counsel of the Supreme Court of Ohio*.

Following the D.C. Circuit's decision in *American Hospital Ass'n*, the hospital price transparency rule went into effect on January 1, 2021 as planned. After CMS identified a trend towards a high rate of hospital noncompliance through samples and review during the initial months of 2021, the Agency, in July 2021, issued a proposed rule to increase the civil monetary penalty amounts using hospital bed counts as a scaling factor. If finalized as proposed, the new penalty amounts would go into effect on January 1, 2022.

With respect to the insurer transparency in coverage rule, which was initially scheduled to go into effect on January 1, 2022, CMS invoked an ACA provision requiring insurers to comply with ACA Section 1311(e)(3), which imposes certain reporting and disclosure requirements for health plans sold on the Exchange. Among the required disclosures, insurers must make publicly available, in plain language, data on enrollment, disenrollment, and number of denied claims; information on cost-sharing and payments with respect to any out-of-network coverage; and "[o]ther information as determined appropriate by the Secretary." Relying on this last clause under Section 1311(e)(3)(A)(ix), the transparency in coverage rule requires insurers to disclose, among other information: (1) in-network provider negotiated rates; (2) historical out-of-network allowed amounts; and (3) drug price information including negotiated rates and historical net prices—i.e., prices paid by insurers to drug manufacturers after deducting drug manufacturer price concessions—for prescription drugs. The disclosures must be made through three machine-readable files posted on a website.

In mid-August 2021, the U.S. Chamber of Commerce and the Pharmaceutical Care Management Association (the national trade association representing pharmacy benefit managers) separately sued to challenge the transparency in coverage rule. The plaintiffs assert, among other arguments: (1) the requirement to disclose information in machine-readable files is inconsistent with Section 1311(e)(3)'s "plaintiff language" requirement; and (2) the requirement to disclose historical net prices for prescription drugs exceeds the HHS Secretary's statutory authority to require certain consumer-facing, coverage-related disclosures under Section 1311(e)(3)(A)(ix).

On August 20, 2021, implementing agencies announced, in light of other statutory requirements enacted following the issuance of the transparency in coverage rule, the agencies will defer enforcement of the machine-readable file requirements until July 1, 2022. The agencies also state they will initiate rulemaking proceedings to determine whether the prescription drug machine-readable file requirement in particular remains appropriate in light of the later statutory enactment that imposed certain prescription drug reporting requirements. Following this announcement, the U.S. Chamber of Commerce voluntarily dismissed its suit on August 25, 2021.

Considerations for Congress

Litigation over the ACA highlights areas in which the law grants or potentially grants federal agencies with authority to implement a range of policy choices within the statutory parameters, as well as areas of statutory ambiguity. To the extent Congress determines that the relevant range of policy choices should be limited or expanded, or that the law should be otherwise clarified, Congress may amend the ACA to alter its scope or method of implementation. Congress could, for instance, further clarify: the application of ACA requirements to AHPs and certain other health insurance arrangements; the funding stream for CSR payments; the method for determining compliance with Section 1332's guardrails; the scope of Section 1557's incorporation of Title IX; and the scope of required price disclosure by hospitals and insurers.

Over the years, various bills have been introduced to address some of these issues. For instance, the Marketplace Certainty Act (S. 964) introduced in the 116th Congress would have expanded eligibility for additional CSR payments for certain enrollees, while providing permanent appropriation for CSR payments generally. Some Members of Congress have also introduced legislation that would impact accessibility to STLDI coverage, including the No Junk Plans Act (S. 942), which would restrict the current STLDI rule's implementation and enforcement, and the Health Coverage Choice Act (H.R. 31), which would codify the current STLDI rule.

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Disclaimer

Health Insurance Coverage in the United States: 2020

Current Population Reports

By Katherine Keisler-Starkey and Lisa N. Bunch

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Health Insurance Coverage in the United States: 2020

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Health Insurance Coverage in the United States: 2020

INTRODUCTION

Health insurance is a means for financing a person's health care expenses. While the majority of people have private health insurance, primarily through an employer, many others obtain coverage through programs offered by state and federal governments. Other individuals do not have health insurance coverage at all (The "What Is Health Insurance Coverage?" text box contains more information).

Year to year, the rate of health insurance coverage and the distribution of coverage types may change due to economic trends, shifts in the demographic composition of the population, and policy changes that affect access to care.

This report presents estimates of health insurance coverage in the United States in 2020, a year in which the nation experienced an economic recession related to the COVID-19 global pandemic. The statistics in this report are based on information collected in the Current Population Survey Annual Social and Economic Supplement (CPS ASEC).[1]

The CPS is the longest-running household survey conducted by the Census Bureau. The key purpose of the CPS ASEC is to provide timely and detailed estimates of economic well-being, of which health insurance coverage is an important component. The Census Bureau has integrated improvements to the CPS ASEC as the needs of data users and the health insurance environment have changed.

[1] The U.S. Census Bureau reviewed this data product for unauthorized disclosure of confidential information and approved the disclosure avoidance practices applied to this release: CBDRB-FY21-POP001-0193.

What Is Health Insurance Coverage?

Health insurance coverage in the Current Population Survey Annual Social and Economic Supplement (CPS ASEC) refers to comprehensive coverage at any time during the calendar year for the civilian, noninstitutionalized population of the United States.* For reporting purposes, the U.S. Census Bureau broadly classifies health insurance coverage as private insurance or public insurance.

Private Coverage

- ***Employment-based***: Plan provided through an employer or union.
- ***Direct-purchase***: Coverage purchased directly from an insurance company, or through a federal or state Marketplace (e.g., healthcare.gov).
- ***TRICARE***: Coverage through TRICARE, formerly known as Civilian Health and Medical Program of the Uniformed Services.

Public Coverage

- ***Medicare***: Federal program that helps to pay health care costs for people aged 65 and older and for certain people under age 65 with long-term disabilities.
- ***Medicaid***: This report uses the term Medicaid to include the specific Medicaid government program and other programs for low-income individuals administered by the states such as Children's Health Insurance Program (CHIP) and Basic Health Programs.
- ***CHAMPVA or VA***: Civilian Health and Medical Program of the Department of Veterans Affairs, as well as care provided by the Department of Veterans Affairs and the military.

Additionally, people are considered uninsured if they only had coverage through the Indian Health Service (IHS), as IHS coverage is not considered comprehensive.

* Comprehensive health insurance covers basic health care needs. This definition excludes single service plans such as accident, disability, dental, vision, or prescription medicine plans.

The 2020 estimates highlighted in this report were collected from February 2021 to April 2021. Respondents were asked to report any health insurance coverage they had during the previous calendar year (2020). People are only considered uninsured if they had no coverage at any time during the year. As a result, people who lost coverage during 2020 are not included in the uninsured rate.[2]

[2] The CPS ASEC also includes a measure of health insurance coverage held at the time of the interview. Although this measure of coverage cannot predict coverage in a given calendar year, it offers a snapshot of health insurance coverage early in the year when CPS ASEC data are collected. More information is available in Appendix B: Estimates of Health Insurance Coverage 2013–2020, Figure B-5.

The Impact of the Coronavirus (COVID-19) Pandemic on the Current Population Survey Annual Social and Economic Supplement (CPS ASEC)

The U.S. Census Bureau administers the CPS ASEC each year between February and April by telephone and in-person interviews, with the majority of data collected in March. In 2020, data collection faced extraordinary circumstances due to the onset of the COVID-19 pandemic as the Census Bureau suspended in-person interviews and closed both telephone contact centers. The response rate for the CPS basic household survey was 73 percent in March 2020, about 10 percentage points lower than preceding months and the same period in 2019, which were regularly above 80 percent.

During collection of the 2021 CPS ASEC, for the safety of both interviewers and respondents, in-person interviews were only conducted when telephone interviews could not be done. In March 2021, the response rate for the CPS basic household survey improved to about 76 percent, though not quite returning to the prepandemic trend. While the response rate improved, it is important to examine how respondents differ from nonrespondents, as this difference could affect income and poverty estimates. Using administrative data, Census Bureau researchers have documented that the nonrespondents in both 2020 and 2021 are less similar to respondents than in earlier years. Of particular interest, for the estimates in this report, are the differences in median income and educational attainment, indicating that respondents in 2020 and 2021 had relatively higher incomes and were more educated than nonrespondents. For more details on how these sample differences and the associated nonresponse bias impact income and official poverty estimates, refer to <www.census.gov/newsroom/blogs/research-matters/2021/08/how-did-the-pandemic-affect-survey-response.html>.

Estimates of health insurance coverage for 2019 were collected between February and April of 2020, during the first months of the COVID-19 pandemic. In the middle of the collection period, the Census Bureau suspended in-person interviews and closed telephone contact centers to protect the health and safety of staff and respondents. Last year's report included an explanation of the impact of the coronavirus pandemic on the CPS ASEC.[3] In addition, the Census Bureau produced several working papers exploring how changes in CPS ASEC data collection in 2020 may have affected 2019 estimates.[4] "The Impact of the Coronavirus (COVID-19) Pandemic on the Current Population Survey Annual Social and Economic Supplement (CPS ASEC)" text box provides more information. The Census Bureau recommends that users consider the effect of the pandemic on CPS ASEC data collection in interpreting changes in health insurance coverage between 2019 and other years using the CPS ASEC.

Estimates for 2018 were collected in 2019, prior to the pandemic. In order to make the most consistent comparisons, the majority of the estimates in this report focus on changes in health insurance coverage between 2018, prior to the pandemic, and 2020. More information presenting the 2020 coverage estimates in the context of a longer time frame is available in Appendix B: Estimates of Health Insurance Coverage 2013–2020.

HEALTH INSURANCE COVERAGE BY TYPE AND SELECTED CHARACTERISTICS

Highlights

- In 2020, 8.6 percent of people, or 28.0 million, did not have health insurance at any point during the year (Table 1 and Figure 1).

[3] More information is available in the "The Impact of the Coronavirus (COVID-19) Pandemic on the CPS ASEC" text box in the report "Health Insurance Coverage in the United States: 2019," <www.census.gov/content/dam/Census/library/publications/2020/demo/p60-271.pdf>.

[4] For additional information related to the impact of COVID-19 on the 2020 CPS ASEC, refer to Edward R. Berchick, Laryssa Mykyta, and Sharon M. Stern, "The Influence of COVID-19-Related Data Collection Changes on Measuring Health Insurance Coverage in the 2020 CPS ASEC," <www.census.gov/library/working-papers/2020/demo/SEHSD-WP2020-13.html>, and Jonathan Rothbaum and C. Adam Bee, "Coronavirus Infects Surveys, Too: Nonresponse Bias During the Pandemic in the CPS ASEC," <www.census.gov/library/working-papers/2020/demo/SEHSD-WP2020-10.html>.

- The percentage of people with health insurance coverage for all or part of 2020 was 91.4 (Table 1).
- In 2020, private health insurance coverage continued to be more prevalent than public coverage at 66.5 percent and 34.8 percent, respectively.[5] Of the subtypes of health insurance coverage, employment-based insurance was the most common, covering 54.4 percent of the population for some or all of the calendar year, followed by Medicare (18.4 percent), Medicaid (17.8 percent), direct-purchase coverage (10.5 percent), TRICARE (2.8 percent), and Department of Veterans Affairs (VA) or Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) coverage (0.9 percent) (Table 1 and Figure 1).[6]
- Between 2018 and 2020, the rate of private health insurance coverage decreased by 0.8 percentage points to 66.5 percent, driven by a 0.7 percentage-point decline in employment-based coverage to 54.4 percent (Table 1 and Figure 1).[7]
- Between 2018 and 2020, the rate of public health insurance coverage increased by 0.4 percentage points to 34.8 percent (Table 1 and Figure 1).[8, 9]
- In 2020, 87.0 percent of full-time, year-round workers had private insurance coverage, up from 85.1 percent in 2018. In contrast, those who worked less than full-time, year-round were less likely to be covered by private insurance in 2020 than in 2018 (68.5 percent in 2018 and 66.7 percent in 2020) (Figure 3).[10]
- More children under the age of 19 in poverty were uninsured in 2020 than in 2018. Uninsured rates for children under the age of 19 in poverty rose 1.6 percentage points to 9.3 percent (Figure 6).

This report classifies health insurance coverage into three different groups: overall coverage, private coverage, and public coverage (The "What Is Health Insurance?" text box contains more information). In the CPS ASEC, people are considered to be insured if they were covered by any type of health insurance for part or all of the previous calendar year. People are considered uninsured if, for the entire year, they were not covered by any type of insurance.[11]

In 2020, most people (91.4 percent) had health insurance coverage at some point during the calendar year (Table 1 and Figure 1). More people had private health insurance (66.5 percent) than public coverage (34.8 percent).

Employment-based insurance was the most common subtype of health insurance (54.4 percent), followed by Medicare (18.4 percent), Medicaid (17.8 percent), direct-purchase insurance (10.5 percent), TRICARE (2.8 percent), and VA/CHAMPVA health care (0.9 percent) (Table 1 and Figure 1).

The percentage of people covered by any type of health insurance in 2020 was not significantly different than the percentage in 2018. Although this result seems counter to reports of coverage loss during the COVID-19 pandemic, the CPS ASEC measures coverage in calendar year 2020 based on whether an individual had coverage for all or part of the year during 2020. For example, a person who held coverage in January 2020, but became uninsured later in the year during the COVID-19 pandemic, would still be considered insured in 2020 using the CPS ASEC. Further, individuals losing one type of coverage may also purchase or be eligible for another type of health coverage. People who lose employment-based coverage through job loss might access coverage through the Marketplace, purchase it directly, or they may be eligible for medical assistance through federal and state programs such as Medicaid.

[5] Some people may have more than one coverage type during the calendar year.

[6] The final category includes CHAMPVA coverage and care provided by the VA and the military.

[7] All comparative statements in this report have undergone statistical testing, and unless otherwise noted, all comparisons are statistically significant at the 90 percent confidence level. Standard errors used in statistical testing and margins of errors presented in tables reflect the use of replicate weights to account for the complex sampling design of the CPS ASEC.

[8] This increase was due to growth in the number of people aged 65 and older. The proportion of the population 65 years and older with Medicare coverage decreased between 2018 and 2020, from 93.9 percent to 93.5 percent. However, the percentage of the U.S. population 65 years and older increased between 2018 and 2020.

[9] Throughout this report, details may not sum to totals because of rounding.

[10] In this report, a full-time, year-round worker is a person who worked 35 or more hours per week (full-time) and 50 or more weeks during the previous calendar year (year-round). For school personnel, summer vacation is counted as weeks worked if they are scheduled to return to their job in the fall.

[11] Infants born after the calendar-year reference period are excluded from estimates in this report, with the exception of estimates of coverage at the time of interview (Appendix B, Figure B-5).

Table 1.

Number and Percentage of People by Health Insurance Coverage Status and Type: 2018 to 2020

(Numbers in thousands. Margins of error in thousands or percentage points as appropriate. Population as of March of the following year. Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>)

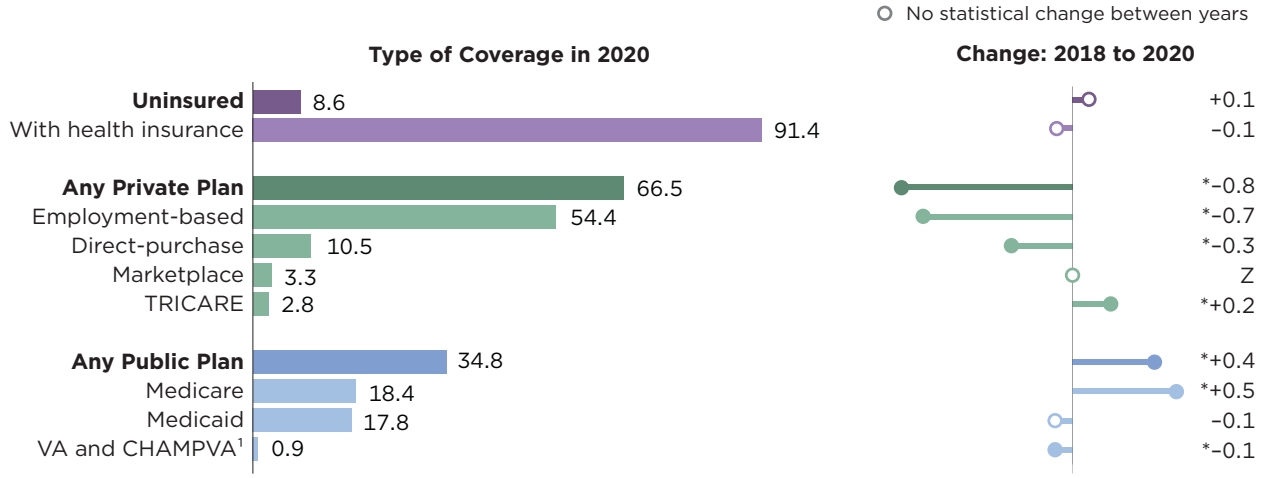
Coverage type	2018				2019				2020				Change (2020 less 2019)	Change (2020 less 2018)
	Number	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Number	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Number	Margin of error[1] (±)	Percent	Margin of error[1] (±)		
Total	**323,668**	**133**	**X**	**X**	**324,550**	**132**	**X**	**X**	**325,638**	**153**	**X**	**X**	**X**	**X**
Any health plan	**296,206**	**641**	**91.5**	**0.2**	**298,438**	**688**	**92.0**	**0.2**	**297,680**	**638**	**91.4**	**0.2**	***–0.5**	**–0.1**
Any private plan[2, 3]	217,780	1,222	67.3	0.4	220,848	1,121	68.0	0.3	216,532	1,166	66.5	0.4	*–1.6	*–0.8
Employment-based[2]	178,350	1,283	55.1	0.4	183,005	1,142	56.4	0.4	177,175	1,070	54.4	0.3	*–2.0	*–0.7
Direct-purchase[2]	34,846	647	10.8	0.2	33,170	776	10.2	0.2	34,041	653	10.5	0.2	0.2	*–0.3
Marketplace coverage[2]	10,743	428	3.3	0.1	9,716	417	3.0	0.1	10,804	439	3.3	0.1	*0.3	Z
TRICARE[2]	8,537	508	2.6	0.2	8,534	522	2.6	0.2	9,183	579	2.8	0.2	*0.2	*0.2
Any public plan[2, 4]	111,330	962	34.4	0.3	110,687	967	34.1	0.3	113,337	923	34.8	0.3	*0.7	*0.4
Medicare[2]	57,720	401	17.8	0.1	58,779	409	18.1	0.1	59,844	393	18.4	0.1	*0.3	*0.5
Medicaid[2]	57,819	891	17.9	0.3	55,851	927	17.2	0.3	57,921	893	17.8	0.3	*0.6	–0.1
VA or CHAMPVA[2, 5]	3,217	182	1.0	0.1	3,221	188	1.0	0.1	2,979	175	0.9	0.1	*–0.1	*–0.1
Uninsured[6]	**27,462**	**630**	**8.5**	**0.2**	**26,111**	**657**	**8.0**	**0.2**	**27,957**	**612**	**8.6**	**0.2**	***0.5**	**0.1**

* Changes between the estimates are statistically different from zero at the 90 percent confidence level.
X Not applicable.
Z Rounds to zero.
[1] A margin of error (MOE) is a measure of an estimate's variability. The larger the MOE in relation to the size of the estimate, the less reliable the estimate. This number, when added to and subtracted from the estimate, forms the 90 percent confidence interval. MOEs shown in this table are based on standard errors calculated using replicate weights.
[2] The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.
[3] Private health insurance includes coverage provided through an employer or union, coverage purchased directly, or TRICARE.
[4] Public health insurance coverage includes Medicaid, Medicare, CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), and care provided by the Department of Veterans Affairs and the military.
[5] Includes CHAMPVA, as well as care provided by the Department of Veterans Affairs and the military.
[6] In the CPS ASEC, individuals are considered to be uninsured if they do not have health insurance coverage for the entire calendar year.
Source: U.S. Census Bureau, Current Population Survey, 2019 to 2021 Annual Social and Economic Supplement (CPS ASEC).

Figure 1.

Percentage of People by Type of Health Insurance Coverage and Change From 2018 to 2020

(Population as of March of the following year)



* Denotes a statistically signficant change between 2018 and 2020 at the 90 percent confidence level.

Z Rounds to zero.

[1] Includes CHAMPVA (Civilian Health Medical Program of the Department of Veterans Affairs), as well as care provided by the Department of Veterans Affairs (VA) and the military.

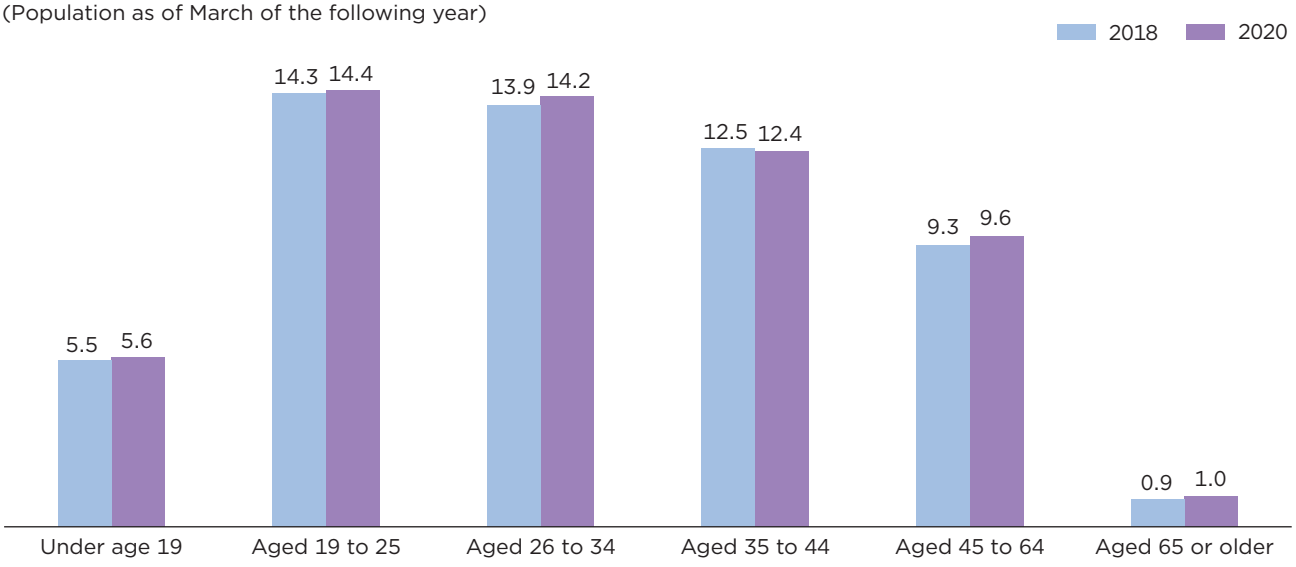
Note: The estimates by type of coverage are not mutually exclusive: people can be covered by more than one type of health insurance during the year. Information on confidentiality protection, sampling error, nonsampling error, and definitions in the Current Population Survey is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>.

Source: U.S. Census Bureau, Current Population Survey, 2019 and 2021 Annual Social and Economic Supplement (CPS ASEC).

Figure 2.

Percentage of People Uninsured by Age Group: 2018 and 2020

(Population as of March of the following year)



Note: There were no significant changes between 2018 and 2020 at the 90 percent confidence level. Information on confidentiality protection, sampling error, nonsampling error, and definitions in the Current Population Survey is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>.

Source: U.S. Census Bureau, Current Population Survey, 2019 and 2021 Annual Social and Economic Supplement (CPS ASEC).

Between 2018 and 2020, of the subtypes of private health insurance, employment-based coverage and direct-purchase insurance decreased, while TRICARE increased. The percentage of people covered by employment-based insurance and direct-purchase insurance decreased by 0.7 percentage points to 54.4 percent and by 0.3 percentage points to 10.5 percent, respectively, in 2020. TRICARE coverage increased by 0.2 percentage points to 2.8 percent in 2020 (Table 1 and Figure 1).

Additionally, the percentage of people covered by a public health insurance plan increased between 2018 and 2020 to 34.8 percent (Table 1 and Figure 1). Of the three subtypes of public health insurance, only the Medicare rate increased between 2018 and 2020. The percentage of people covered by Medicare increased by 0.5 percentage points to 18.4 percent in 2020. This increase in coverage was partly due to growth in the number of people aged 65 and older. The Medicaid rate in 2020 was 17.8 percent, which was not statistically different from 2018.

Age is associated with the likelihood that a person has health insurance coverage. Older adults (those over the age of 65) and children (those under the age of 19) are more likely to have health insurance coverage than those aged 19 to 64, in part because their age makes them eligible for certain public health insurance programs. Medicare provides health coverage benefits for most adults aged 65 and older. Children under the age of 19 may qualify for coverage through Medicaid or the Children's Health Insurance Program (CHIP), and young adults may receive coverage through a parent or guardian's plan until the age of 26.[12]

In 2020, 1.0 percent of adults aged 65 and older were uninsured for the entire calendar year, while 5.6 percent of children under the age of 19 were uninsured in the same period. Among working-age adults, the age group with the largest percentage uninsured for the entirety of calendar year 2020 was those aged 19 to 25 (14.4 percent), followed by those aged 26 to 34 (14.2 percent), adults aged 35 to 44 (12.4 percent), and those aged 45 to 64 (9.6 percent) (Figure 2).[13] Between 2018 and 2020, there were no significant changes in the uninsured rate by age groups.

Selected Social Characteristics

The CPS ASEC can also be used to look at the prevalence and type of health insurance coverage across certain social and economic characteristics, as well as changes in coverage across race and Hispanic origin groups.

Overall, Hispanics had the highest uninsured rate (18.3 percent) in 2020, followed by Blacks (10.4 percent), Asians (5.9 percent), and non-Hispanic Whites (5.4 percent) (Table A-1).[14, 15, 16]

In 2020, Blacks had the highest rate of public coverage (41.4 percent) followed by Hispanics (35.9 percent), non-Hispanic Whites (33.8 percent), and Asians (27.0 percent). In the same year, non-Hispanic Whites had the highest rate of private coverage (73.9 percent), followed by Asians (72.4 percent), Blacks (54.6 percent), and Hispanics (49.9 percent) (Figure 3).

[12] CHIP is a public program that provides health insurance to children in families with income too high to qualify for Medicaid, but who are likely unable to afford private health insurance.

[13] In 2020, the uninsured rate of individuals aged 19 to 25 was not statistically different from the uninsured rate of individuals aged 26 to 34.

[14] Federal surveys give respondents the option of reporting more than one race. Therefore, two basic ways of defining a race group are possible. A group, such as Asian, may be defined as those who reported Asian and no other race (the race-alone or single-race concept) or as those who reported Asian, regardless of whether they also reported another race (the race-alone-or-in-combination concept). The body of this report (text, figures, and tables) shows data using the first approach (race alone). Use of the single-race population does not imply that it is the preferred method of presenting or analyzing data. The Census Bureau uses a variety of approaches. Data for American Indians and Alaska Natives, Native Hawaiians and Other Pacific Islanders, and those reporting two or more races are not shown separately.

In this report, the term "non-Hispanic White" refers to people who are not Hispanic and who reported White and no other race. The Census Bureau uses non-Hispanic Whites as the comparison group for other race groups and Hispanics.

Because Hispanic people may be any race, data in this report for Hispanic people overlap with data for racial groups. Of those who reported only one race, 16.0 percent of White householders, 5.3 percent of Black householders, and 2.7 percent of Asian householders also reported being Hispanic.

Data users should exercise caution when interpreting aggregate results for the Hispanic population and for race groups because these populations consist of many distinct groups that differ in socioeconomic characteristics, culture, and recency of immigration. Data were first collected for Hispanic people in 1972.

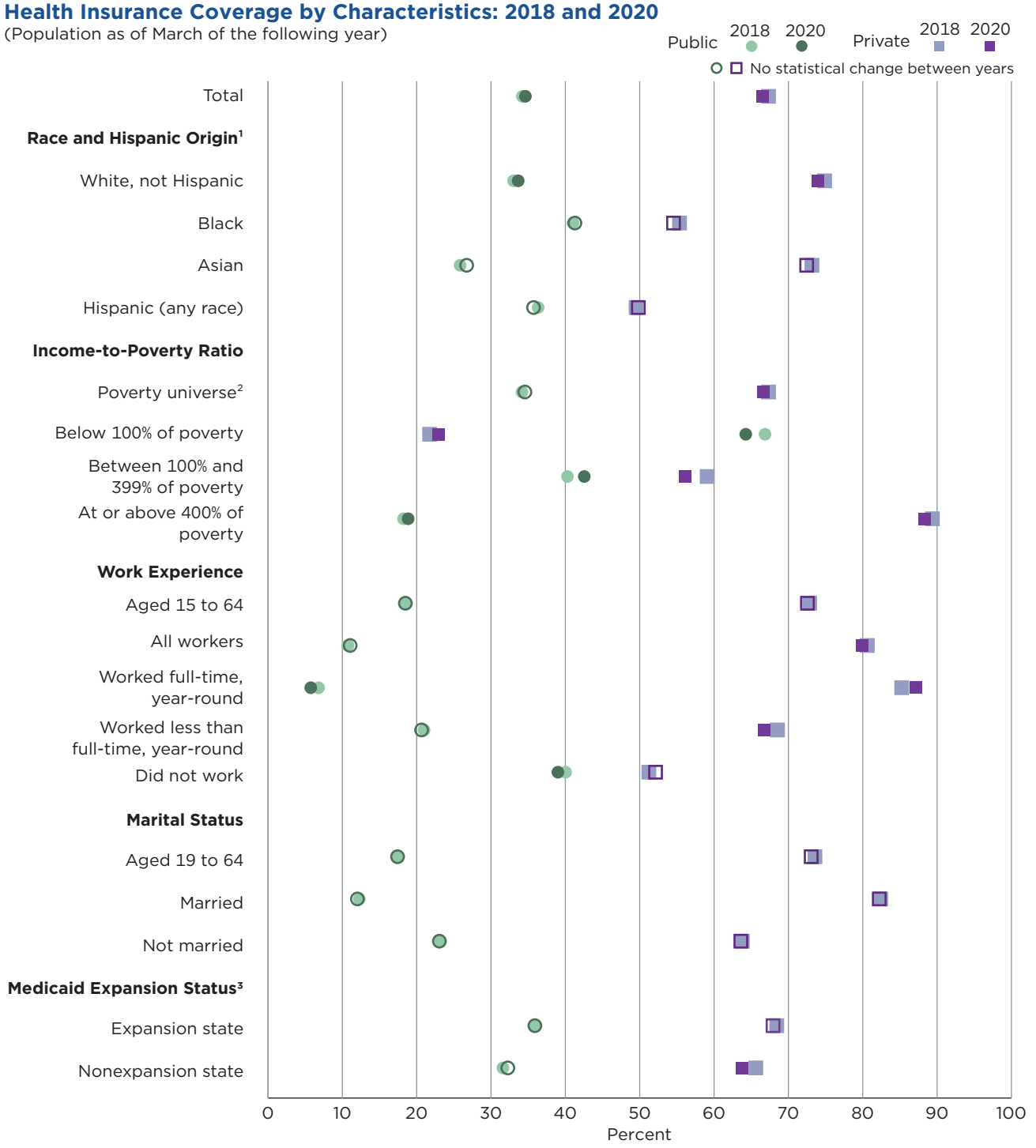
[15] The small sample size of the Asian population and the fact that the CPS ASEC does not use separate population controls for weighting the Asian sample to national totals contributes to the large variances surrounding estimates for this group. As a result, the CPS ASEC may be unable to detect statistically significant differences between some estimates for the Asian population.

[16] In 2020, the uninsured rate of non-Hispanic Whites was not statistically different from the uninsured rate of Asians.

Figure 3.

Health Insurance Coverage by Characteristics: 2018 and 2020

(Population as of March of the following year)



[1] Federal surveys give respondents the option of reporting more than one race. This figure shows data using the race-alone concept. For example, "Asian" refers to people who reported Asian and no other race.

[2] The poverty universe excludes unrelated individuals under the age of 15 such as foster children.

[3] Medicaid expansion status as of January 1, 2020, for 2020 data. Medicaid expansion status as of January 1, 2018, for 2018 data. Expansion states on or before January 1, 2018, include AK, AR, AZ, CA, CO, CT, DC, DE, HI, IA, IL, IN, KY, LA, MA, MD, MI, MN, MT, ND, NH, NJ, NM, NV, NY, OH, OR, PA, RI, VT, WA, and WV. After January 1, 2018, and on or before January 1, 2020, ID, ME, UT, and VA expanded Medicaid. More information is available at <www.medicaid.gov/state-overviews/index.html>.

Note: The estimates by type of coverage are not mutually exclusive: people can be covered by more than one type of health insurance during the year. Information on confidentiality protection, sampling error, nonsampling error, and definitions in the Current Population Survey is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>.

Source: U.S. Census Bureau, Current Population Survey, 2019 and 2021 Annual Social and Economic Supplement (CPS ASEC).

Non-Hispanic Whites experienced changes in health insurance status between 2018 and 2020. Specifically, private coverage decreased by 0.9 percentage points to 73.9 percent, and public coverage increased by 0.6 percentage points to 33.8 percent in 2020. In contrast, there was no significant change in either private or public coverage between 2018 and 2020 for Hispanics of any race, Blacks, or Asians.

Selected Economic Characteristics

For many adults aged 15 to 64, health insurance coverage is related to work status such as working full-time, year-round, working less than full-time, year-round, or not working at all during the calendar year. Workers were more likely than nonworkers to be covered by private health insurance. In 2020, 87.0 percent of full-time, year-round workers were covered through a private insurance plan, compared with 66.7 percent of those working less than full-time, year-round. Those who did not work were the least likely to have private health insurance coverage, at 52.2 percent (Figure 3 and Table A-2).

Overall, between 2018 and 2020, workers' private coverage declined by approximately 0.7 percentage points. However, this decrease was not equal across all types of workers. For example, the percentage of full-time, year-round workers with private coverage increased by 1.9 percentage points, while private insurance coverage rates for those who worked less than full-time, year-round decreased by 1.9 percentage points. There was no statistical change in private coverage for nonworkers between 2018 and 2020.

Rates of public coverage followed a different pattern. Nonworkers were more likely than those working less than full-time, year-round to have public coverage (39.1 percent of nonworkers versus 20.9 percent of less than full-time, year-round workers). Full-time, year-round workers were the least likely to have public coverage, at 6.1 percent. In 2020, public insurance coverage rates decreased by 1.0 percentage point for full-time, year-round workers and 1.0 percentage point for nonworkers compared to 2018.

Many adults obtain health insurance coverage through their spouses, and, therefore, health insurance coverage is related to marital status. Adults aged 19 to 64 who were not married were less likely to have private health insurance than married adults (63.6 percent and 82.1 percent, respectively). There were no changes in private or public health insurance rates between 2018 and 2020 for either married or unmarried people (Figure 3 and Table A-2).[17]

Health insurance coverage and type is also associated with family income-to-poverty ratio, which provides a measure of a family's economic resources.[18] Family resources may determine the ability to afford private health insurance, and families below certain income-to-poverty thresholds may qualify for public health insurance options. Figure 4 shows the public coverage rate, private coverage rate, and uninsured rate for individuals based on their family's income-to-poverty ratio in 2020.

For private insurance, those living in poverty are the least likely to have private insurance (23.2 percent), and each group with a higher income-to-poverty ratio has a higher rate of private insurance. Those living at or above 400 percent of the poverty line are the most likely to have private health insurance (88.2 percent) (Figure 4).

In contrast, those living in poverty are the most likely to have public insurance (64.3 percent), while those living at or above 400 percent of the poverty line are the least likely to have public health insurance (19.1 percent). The percentage of people with public insurance decreases as the income-to-poverty ratio increases.

As the income-to-poverty ratio increases, the percentage of uninsured declines. Those in poverty have the highest rate of people uninsured for the full calendar year (17.2 percent), while those living at or above 400 percent of the poverty line have the lowest rate of people uninsured for all of 2020 (3.4 percent). Other income-to-poverty groups fall between these rates, and those with higher income-to-poverty ratios are less likely to be uninsured.

Changes in health insurance coverage by type were not distributed equally across income-to-poverty ratio groups. For example, people with an income-to-poverty ratio between 100 and 399 percent and those at or above 400 percent of poverty increased their rates of public insurance use between 2018 and 2020 (by 2.2 percentage points and 0.6 percentage points, respectively) (Figure 3).

In contrast, between 2018 and 2020, rates of private insurance decreased for people with an income-to-poverty ratio between 100 and 399 percent

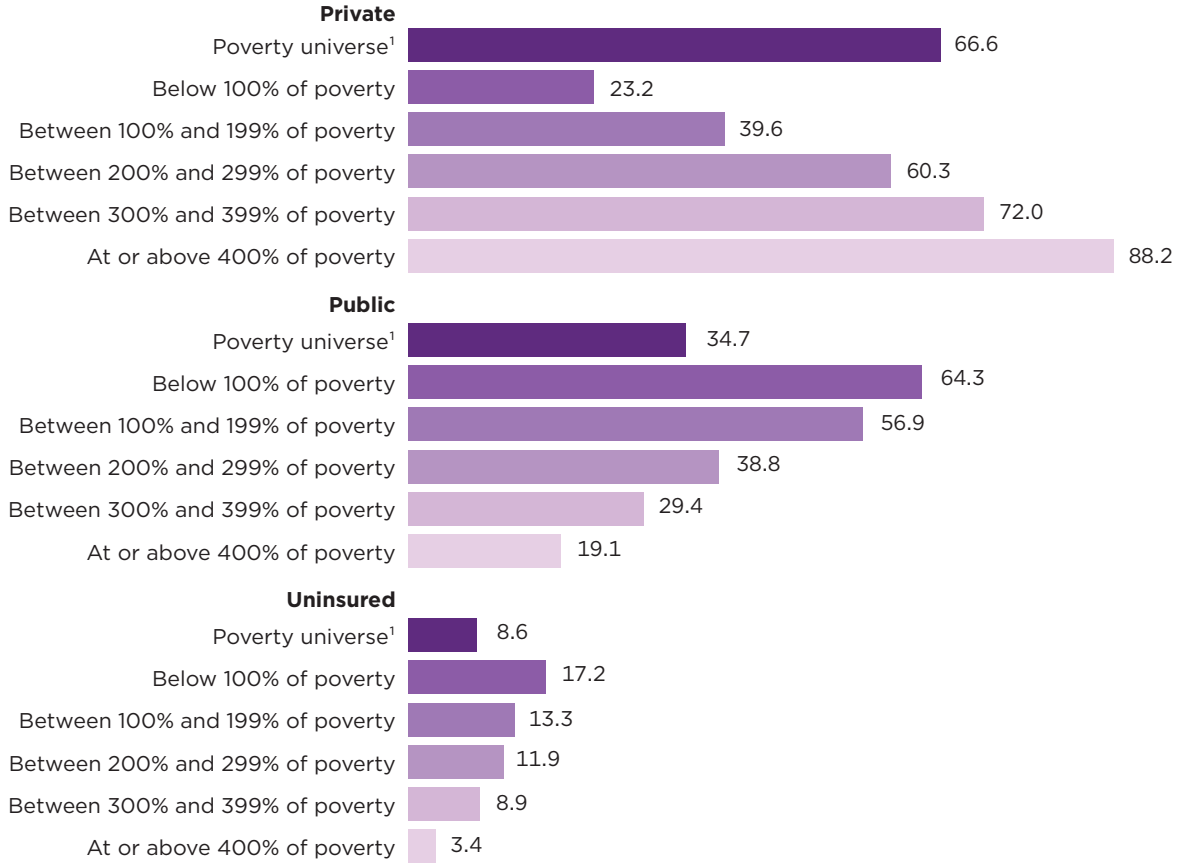
[17] Unmarried people include those who were never married, as well as those who are widowed, divorced, or separated. For estimates of health coverage for each of these groups, refer to Appendix Table A-2.

[18] The Office of Management and Budget (OMB) determined the official definition of poverty in Statistical Policy Directive 14. Appendix B of the report, "Income and Poverty in the United States: 2020," provides a more detailed description of how the Census Bureau calculates poverty. More information is available at <www.census.gov/content/dam/Census/library/publications/2021/demo/p60-273.pdf>.

Figure 4.

Health Insurance Coverage and Type by Income-to-Poverty Ratio: 2020

(Population as of March of the following year)



[1] The poverty universe excludes unrelated individuals under the age of 15 such as foster children.
Note: The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year. Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>.
Source: U.S. Census Bureau, Current Population Survey, 2021 Annual Social and Economic Supplement (CPS ASEC).

of poverty and those at or above 400 percent of poverty (by 2.9 percentage points and 1.0 percentage point, respectively). However, those in poverty saw an increase in private health coverage by 1.3 percentage points (Figure 3).

Income-to-Poverty Ratio and Medicaid Expansion Status

The Patient Protection and Affordable Care Act provided the option for states to expand Medicaid eligibility to adults whose income-to-poverty ratio fell under 138 percent of the poverty line.[19] As of January 1, 2020, 35 states and the District of Columbia had expanded Medicaid eligibility ("expansion states"); 15 states had not expanded Medicaid eligibility ("non-expansion states").[20] The uninsured rate in 2020 varied by state Medicaid expansion status. In 2020, among adults aged 19 to 64, those in expansion states had lower

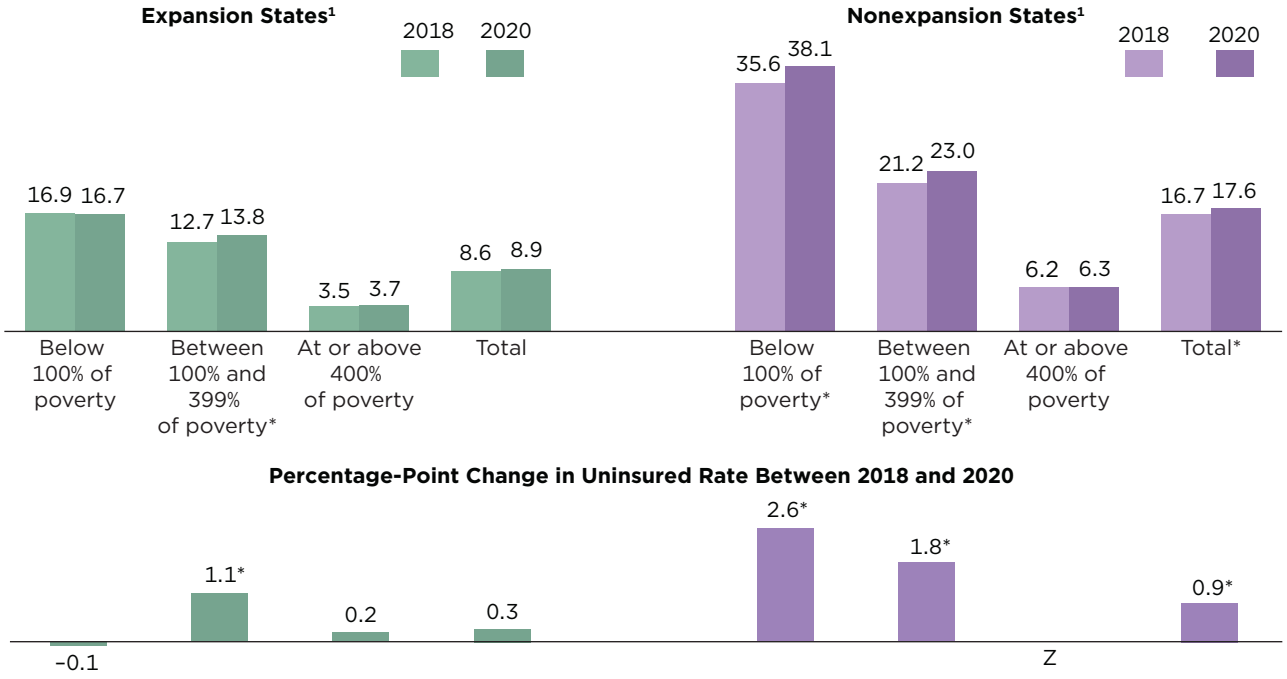
[19] In 2020, the Medicaid income eligibility threshold for adults under the age of 65 in the District of Columbia was 221 percent of the poverty line. More information is available in "Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings From a 50-state Survey," <https://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility,-Enrollment-and-Cost-Sharing-Policies-as-of-January-2020.pdf>.

[20] The 35 states and the District of Columbia that expanded Medicaid eligibility on or before January 1, 2020, include AK, AR, AZ, CA, CO, CT, DC, DE, HI, IA, ID, IL, IN, KY, LA, MA, MD, ME, MI, MN, MT, ND, NH, NJ, NM, NV, NY, OH, OR, PA, RI, UT, VA, VT, WA, and WV. More information is available at <www.medicaid.gov/state-overviews/index.html>.

Figure 5.

Uninsured Rate by Poverty Status and Medicaid Expansion of State for Adults Aged 19 to 64: 2018 and 2020

(Population as of March of the following year, adults aged 19 to 64)



* Denotes a statistically significant change between 2018 and 2020 at the 90 percent confidence level.

Z Rounds to zero.

[1] Medicaid expansion status as of January 1, 2020, for 2020 data. Medicaid expansion status as of January 1, 2018, for 2018 data. Expansion states on or before January 1, 2018, include AK, AR, AZ, CA, CO, CT, DC, DE, HI, IA, IL, IN, KY, LA, MA, MD, MI, MN, MT, ND, NH, NJ, NM, NV, NY, OH, OR, PA, RI, VT, WA, and WV. After January 1, 2018, and on or before January 1, 2020, ID, ME, UT, and VA expanded Medicaid. More information is available at <www.medicaid.gov/state-overviews/index.html>.

Note: Information on confidentiality protection, sampling error, nonsampling error, and definitions, is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>.

Source: U.S. Census Bureau, Current Population Survey, 2019 and 2021 Annual Social and Economic Supplement (CPS ASEC).

uninsured rates (8.9 percent) than those in nonexpansion states (17.6 percent) (Figure 5).

Further, the relationship between poverty status, health insurance coverage in 2020, and the change in coverage between 2018 and 2020 may be related to an individual's state of residence and whether that state expanded Medicaid eligibility (Figure 5).

Uninsured rates were lower for all income-to-poverty groups in expansion states than in nonexpansion states. For people in families living in poverty in nonexpansion states, there was a 2.6 percentage-point increase in the uninsured rate, to 38.1 percent between 2018 and 2020, while there was no statistically significant change in the uninsured rate for those in poverty in expansion states.[21] Among people with family income between 100 and 399 percent of poverty, 23.0 percent of people in nonexpansion states did not have health insurance for the full year, representing a 1.8 percentage-point increase in the percentage of uninsured from 2018. For the same group in expansion states, there was a 1.1 percentage-point increase in the percentage of uninsured to 13.8 percent. For all other income-to-poverty groups, there was no significant change in the uninsured rate between 2018 and 2020.

[21] Between 2018 and 2020, the change in the uninsured rate of people in poverty living in expansion states was not statistically different from the change in the uninsured rate of people in poverty living in nonexpansion states.

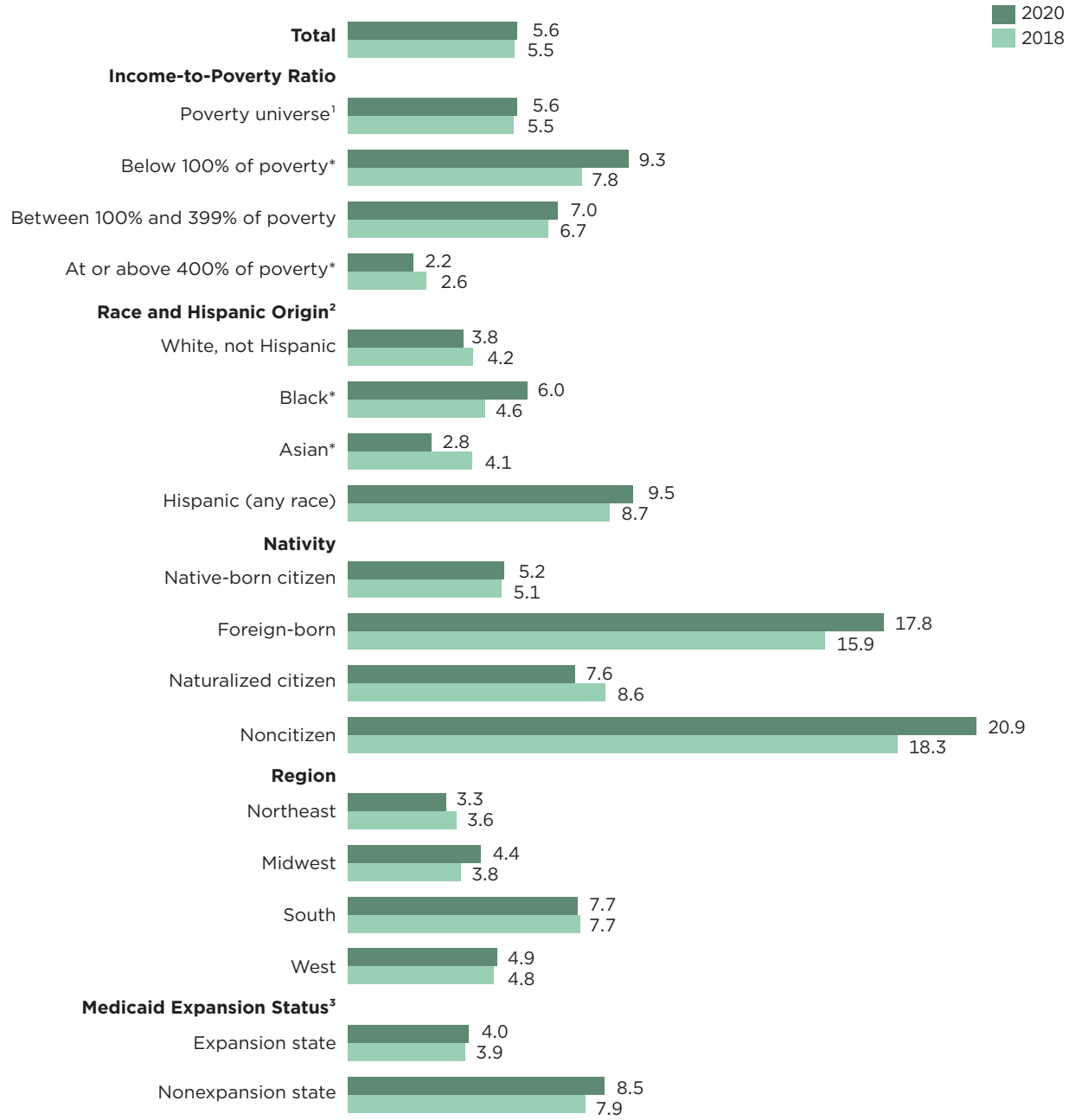
Health Insurance Coverage by Age and Selected Characteristics

In 2020, 5.6 percent of children under the age of 19 did not have health insurance coverage, which was not statistically different from 2018 (Figure 6). Examining coverage by children's characteristics reveals that changes in health insurance coverage between 2018 and 2020 did not occur equally across groups.

Figure 6.

Percentage of Children Under the Age of 19 Without Health Insurance Coverage by Selected Characteristics: 2018 and 2020

(Population as of March of the following year, children under age 19)



* Denotes a statistically significant change between 2018 and 2020 at the 90 percent confidence level.

[1] The poverty universe excludes unrelated individuals under the age of 15 such as foster children.

[2] Federal surveys give respondents the option of reporting more than one race. This figure shows data using the race-alone concept. For example, "Asian" refers to people who reported Asian and no other race.

[3] Medicaid expansion status as of January 1, 2020, for 2020 data. Medicaid expansion status as of January 1, 2018, for 2018 data. Expansion states on or before January 1, 2018, include AK, AR, AZ, CA, CO, CT, DC, DE, HI, IA, IL, IN, KY, LA, MA, MD, MI, MN, MT, ND, NH, NJ, NM, NV, NY, OH, OR, PA, RI, VT, WA, and WV. After January 1, 2018, and on or before January 1, 2020, ID, ME, UT, and VA expanded Medicaid. More information is available at <www.medicaid.gov/state-overviews/index.html>.

Note: Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>.

Source: U.S. Census Bureau, Current Population Survey, 2019 and 2021 Annual Social and Economic Supplement (CPS ASEC).

Among children living in poverty, 9.3 percent did not have health insurance at any time in 2020, representing an increase of 1.6 percentage points since 2018. For children in families at or above 400 percent of poverty, the uninsured rate decreased by 0.4 percentage points, to 2.2 percent. In 2020, 7.0 percent of children between 100 and 399 percent of poverty did not have health insurance, which is not statistically different from 2018. In both years, the percentage of children without health insurance coverage decreased as the income-to-poverty ratio increased.

The percentage of non-Hispanic White children without health insurance coverage was not statistically different in 2020 compared with 2018. However, the uninsured rate decreased for Asian children (by 1.4 percentage points) and increased for Black children (by 1.4 percentage points), to 2.8 percent and 6.0 percent, respectively. In 2020, 9.5 percent of Hispanic children were uninsured, which is not statistically different from 2018.

In 2020, 5.2 percent of children born in the United States were uninsured. However, among foreign-born children, 17.8 percent were uninsured, including 7.6 percent of children who were naturalized citizens and 20.9 percent of children who were not citizens.[22]

Health insurance rates for children varied by region as well.[23] For example, 7.7 percent of children living in the South were uninsured, while the uninsured rates for children in the Northeast (3.3 percent), Midwest (4.4 percent), and West (4.9 percent) were lower.[24]

Health insurance rates varied for children who lived in expansion states compared to those who lived in nonexpansion states (4.0 percent and 8.5 percent, respectively).

Health insurance outcomes for working-age adults aged 19 to 64 may differ from those in other age groups because they do not qualify for certain programs, such as CHIP, and only qualify for Medicare under limited circumstances. In 2020, 11.9 percent of working-age adults (aged 19 to 64) did not have health insurance coverage, which was not statistically different from 2018 (Figure 7).

The uninsured rate for noncitizen adults aged 19 to 64 increased 2.2 percentage points between 2018 and 2020. In 2020, 33.8 percent of working-age noncitizens did not have health insurance, which is higher than foreign-born adults (22.9 percent), naturalized citizen adults (10.7 percent), and native-born adults (9.6 percent).

The uninsured rate decreased by 1.1 percentage points for working-age adults who worked full-time, year-round, from 9.5 percent in 2018 to 8.4 percent in 2020. However, the uninsured rate increased by 1.8 percentage points for working-age adults who worked less than full-time, year-round to 16.4 percent.

Among working-age adults in 2020, those who were separated (20.2 percent), never married (16.0 percent), divorced (13.2 percent), or widowed (12.1 percent) were more likely to be uninsured than those who were married (8.5 percent).[25]

Health insurance rates for working-age adults also varied by region. For example, 11.3 percent of adults living in the West in 2020 were uninsured, a 0.8 percentage-point increase from 2018. There was no significant change in uninsured rates for working-age adults in other regions.

ADDITIONAL INFORMATION ABOUT HEALTH INSURANCE COVERAGE

State and Local Estimates of Health Insurance Coverage

Since the CPS ASEC produces thorough and timely estimates of income, poverty, and health insurance, the Census Bureau recommends that people use it as the data source for national estimates. However, the Census Bureau also publishes annual estimates of health insurance coverage by state and other smaller geographic units based on data collected in the American Community Survey (ACS). Single-year estimates are available for geographic units with populations of 65,000 or more. Five-year estimates are available for all geographic units, including census tracts and block groups.

Due to the impact of the pandemic on data collection, the standard 1-year estimates from the 2020 ACS will not be released. However, the Census Bureau plans to release experimental estimates developed from the 2020 ACS 1-year data later this year in the form of a limited number of data tables for limited geographies.

[22] In 2020, the uninsured rate of native-born children under the age of 19 was not statistically different from the uninsured rate of naturalized citizen children.

[23] For information about how the Census Bureau classifies regions, refer to <https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf>.

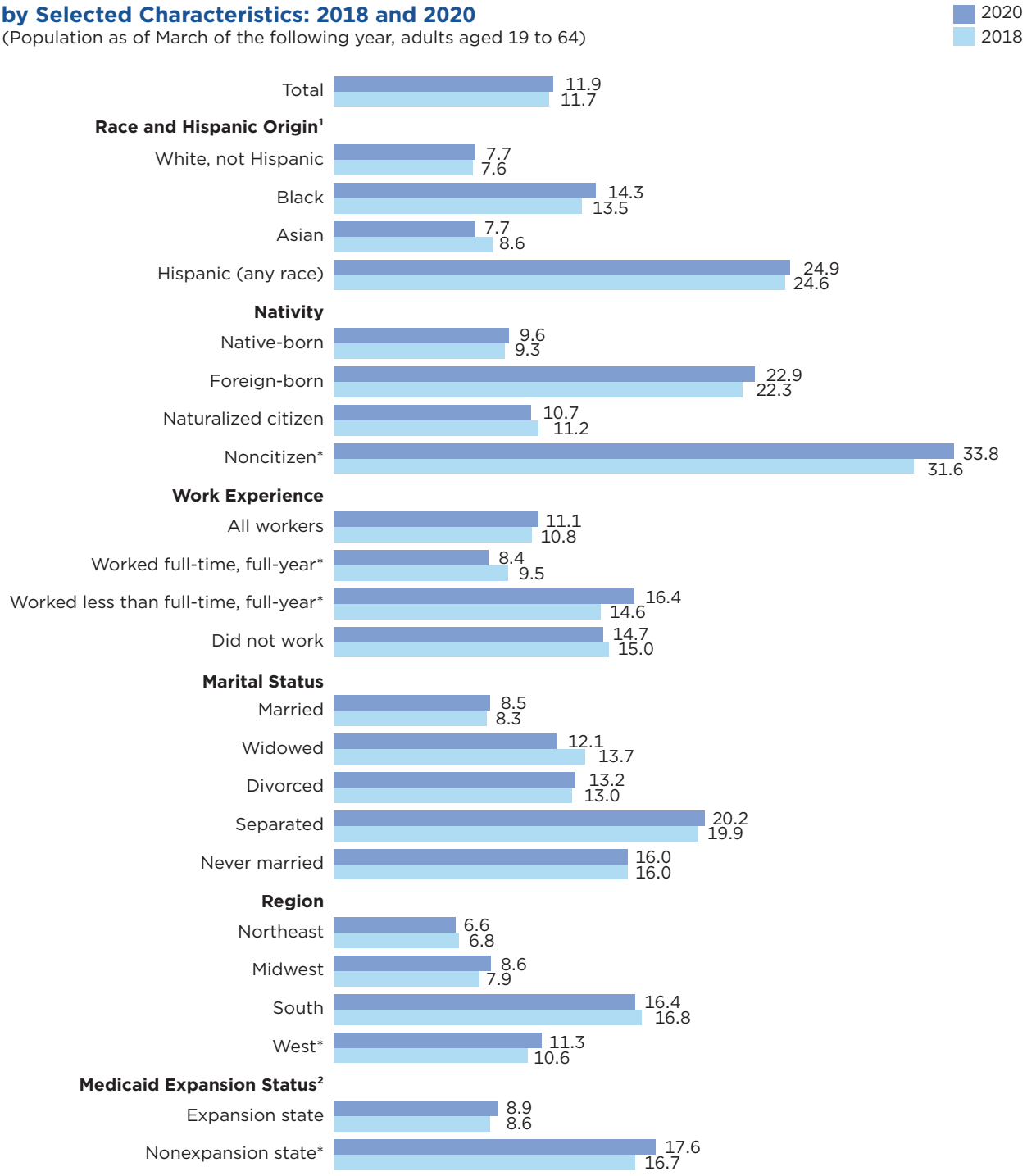
[24] In 2020, the uninsured rate of children living in the West was not statistically different from the uninsured rate of children living in the Midwest.

[25] In 2020, the uninsured rate of divorced adults aged 19 to 64 was not statistically different from the uninsured rate of widowed adults aged 19 to 64.

Figure 7.

Percentage of Working-Age Adults Without Health Insurance Coverage by Selected Characteristics: 2018 and 2020

(Population as of March of the following year, adults aged 19 to 64)



* Denotes a statistically significant change between 2018 and 2020 at the 90 percent confidence level.

[1] Federal surveys give respondents the option of reporting more than one race. This figure shows data using the race-alone concept. For example, "Asian" refers to people who reported Asian and no other race.

[2] Medicaid expansion status as of January 1, 2020, for 2020 data. Medicaid expansion status as of January 1, 2018, for 2018 data. Expansion states on or before January 1, 2018, include AK, AR, AZ, CA, CO, CT, DC, DE, HI, IA, IL, IN, KY, LA, MA, MD, MI, MN, MT, ND, NH, NJ, NM, NV, NY, OH, OR, PA, RI, VT, WA, and WV. After January 1, 2018, and on or before January 1, 2020, ID, ME, UT, and VA expanded Medicaid. More information is available at <www.medicaid.gov/state-overviews/index.html>.

Note: Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>.

Source: U.S. Census Bureau, Current Population Survey, 2019 and 2021 Annual Social and Economic Supplement (CPS ASEC).

The Census Bureau's Small Area Health Insurance Estimates (SAHIE) program also produces single-year estimates of health insurance for all states and all counties. These estimates are based on statistical models using data from a variety of sources, including current surveys, administrative records, and annual population estimates. In general, SAHIE estimates have lower variances than ACS estimates but are released later because they incorporate these additional data into their models.

Small Area Health Insurance Estimates are available at <www.census.gov/programs-surveys/sahie.html>. The most recent estimates are for 2019.

Additional Data

The CPS ASEC is used to produce additional health insurance coverage tables. These tables are available on the Census Bureau's Health Insurance Web site. The Web site may be accessed through the Census Bureau's home page at <www.census.gov> or directly at <www.census.gov/data/tables/2021/demo/health-insurance/p60-274.html>.

For assistance with health insurance data, contact the Census Bureau Customer Services Center at 1-800-923-8282 (toll-free), or search your topic of interest using the Census Bureau's "Question and Answer Center" found at <https://ask.census.gov>.

Data.census.gov

Data.census.gov is the new platform to access data and digital content from the Census Bureau. It is the official source of data for the Census Bureau's most popular surveys and programs such as the ACS, Decennial Census, Economic Census, and more. Through the centralized experience on data.census.gov, data users of all skill levels can search premade tables or create custom statistics from Public Use Microdata files.

The Census Bureau created easy ways to visualize, customize, and download data through a single platform on data.census.gov in response to user feedback. To learn more about data.census.gov, check out the release notes at <https://www2.census.gov/data/api-documentation/data-census-gov-release-notes.pdf>.

In addition to the pretabulated detailed and historical tables available online, data users of all skill levels can create custom statistics from Public Use Microdata files using the Microdata Access Tool (MDAT) available at <https://data.census.gov/mdat>. The MDAT provides data users the ability to create customized tables using public-use data from the CPS ASEC.

Public-Use Microdata

Microdata for the CPS ASEC are available online at <www.census.gov/data/datasets/time-series/demo/cps/cps-asec.html>. Technical methods have been applied to CPS microdata to avoid disclosing the identities of individuals from whom data were collected.

Census Data API

The Census Data Application Programming Interface (API) gives the public access to pretabulated data from various Census Bureau data programs. It is an efficient way to query data directly from Census Bureau servers with many advantages, including the ability to easily download target variables and geographies and immediately access the most current data. Users can find which datasets are currently available via API online at <www.census.gov/data/developers/data-sets.html>.

SOURCE AND ACCURACY OF THE ESTIMATES

The estimates in this report are from the CPS ASEC. The CPS is the longest-running survey conducted by the Census Bureau. The CPS is a household survey primarily used to collect employment data. The sample universe for the basic CPS consists of the resident civilian, noninstitutionalized population of the United States. People in institutions, such as prisons, long-term care hospitals, and nursing homes, are not eligible to be interviewed in the CPS. Students living in dormitories are included in the estimates only if information about them is reported in an interview at their parents' home. Since the CPS is a household survey, people who are homeless and not living in shelters are not included in the sample.

The CPS ASEC collects data in February, March, and April each year, asking detailed questions categorizing income into over 50 sources. The key purpose of the CPS ASEC is to provide timely and comprehensive estimates of income, poverty, and health insurance and to measure change in these national-level estimates. The CPS ASEC is the official source of national poverty estimates calculated in accordance with the Office of Management and Budget's Statistical Policy Directive 14.[26]

The CPS ASEC collects data in the 50 states and the District of Columbia; these data do not represent residents of Puerto Rico or U.S. Island Areas.[27] The 2021 CPS ASEC sample consists of about 90,800 addresses. The CPS ASEC includes military personnel who live in a household with at least one other civilian adult, regardless of whether they live off post or on post. All other armed forces personnel are excluded. The estimates in

[26] The OMB determined the official definition of poverty in Statistical Policy Directive 14. Appendix B of the report, "Income and Poverty in the United States: 2020," provides a more detailed description of how the Census Bureau calculates poverty. More information is available at <www.census.gov/content/dam/Census/library/publications/2021/demo/p60-273.pdf>.

[27] U.S. Island Areas include American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, and the Virgin Islands of the United States.

this report are controlled to March 2021 independent national population estimates by age, sex, race, and Hispanic origin. Beginning with 2010, population estimates are based on 2010 Census population counts and are updated annually taking into account births, deaths, emigration, and immigration.

The estimates in this report (which may be shown in text, figures, and tables) are based on responses from a sample of the population and may differ from actual values because of sampling variability or other factors. As a result, apparent differences between the estimates for two or more groups may not be statistically significant. All comparative statements have undergone statistical testing and are statistically significant at the 90 percent confidence level unless otherwise noted. In this report, the variances of estimates were calculated using the Successive Difference Replication (SDR) method.

Beginning with the 2011 CPS ASEC report, the standard errors and confidence intervals displayed in tables were calculated using the SDR method, unless otherwise noted. In previous years, the standard errors of CPS ASEC estimates were calculated using the generalized variance function (GVF) approach. Under this approach, generalized variance parameters were used in formulas provided in the source and accuracy statement to estimate standard errors. Further information on replicate weights, standard errors, income top-coding and data swapping on the public-use file, and changes to the CPS ASEC data file is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>.

Comments

The Census Bureau welcomes the comments and advice of data and report users. If you have suggestions or comments on the health insurance coverage report, please write to:

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APPENDIX A.

Table A-1.

Percentage of People by Health Insurance Coverage Status and Type by Selected Characteristics: 2018, 2019, and 2020—Con.

(Numbers in thousands. Population as of March of the following year. Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>)

Characteristic	Total								
		Any health insurance						Uninsured[4]	
				Private health insurance[2]		Public health insurance[3]			
	Number	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)
2020 Total	**325,638**	**91.4**	**0.2**	**66.5**	**0.4**	**34.8**	**0.3**	**8.6**	**0.2**
Race[5] and Hispanic Origin									
White	247,763	91.7	0.2	68.6	0.4	34.3	0.3	8.3	0.2
White, not Hispanic	194,230	94.6	0.2	73.9	0.4	33.8	0.4	5.4	0.2
Black	43,427	89.6	0.6	54.6	1.0	41.4	0.8	10.4	0.6
Asian	20,125	94.1	0.6	72.4	1.2	27.0	1.1	5.9	0.6
Hispanic (any race)	61,160	81.7	0.7	49.9	0.9	35.9	0.7	18.3	0.7
Age									
Under age 65	269,802	89.8	0.2	70.0	0.4	22.6	0.3	10.2	0.2
Under age 19[6]	76,156	94.4	0.3	62.2	0.6	35.1	0.6	5.6	0.3
Aged 19 to 64	193,646	88.1	0.3	73.0	0.4	17.7	0.3	11.9	0.3
Aged 19 to 25[7]	29,269	85.6	0.6	69.4	0.9	18.2	0.8	14.4	0.6
Aged 26 to 34	40,916	85.8	0.6	70.4	0.8	18.2	0.6	14.2	0.6
Aged 35 to 44	42,004	87.6	0.5	73.7	0.7	16.3	0.6	12.4	0.5
Aged 45 to 64	81,457	90.4	0.3	75.3	0.5	18.0	0.4	9.6	0.3
Aged 65 and older	55,836	99.0	0.1	49.6	0.8	93.6	0.3	1.0	0.1
Nativity									
Native-born	280,839	93.1	0.2	68.2	0.4	35.4	0.3	6.9	0.2
Foreign-born	44,799	80.7	0.7	55.8	0.9	30.9	0.7	19.3	0.7
Naturalized citizen	22,667	91.7	0.5	63.8	1.0	36.8	0.9	8.3	0.5
Not a citizen	22,132	69.4	1.2	47.5	1.3	24.9	1.0	30.6	1.2
Region									
Northeast	54,771	95.2	0.4	69.1	0.9	37.8	0.9	4.8	0.4
Midwest	67,436	93.8	0.4	71.7	0.8	33.5	0.7	6.2	0.4
South	125,396	88.2	0.4	63.4	0.6	33.6	0.5	11.8	0.4
West	78,035	91.8	0.3	65.0	0.7	35.7	0.6	8.2	0.3
State Medicaid Expansion Status[8]									
Lived in Medicaid expansion state	211,948	93.6	0.2	67.9	0.5	36.1	0.4	6.4	0.2
Did not live in Medicaid expansion state	113,690	87.4	0.4	63.8	0.6	32.5	0.5	12.6	0.4

Footnotes provided at end of table.

Table A-1.

Percentage of People by Health Insurance Coverage Status and Type by Selected Characteristics: 2018, 2019, and 2020—Con.

(Numbers in thousands. Population as of March of the following year. Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>)

Characteristic	Total								
		Any health insurance						Uninsured[4]	
				Private health insurance[2]		Public health insurance[3]			
	Number	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)
2019 Total	**324,550**	**92.0**	**0.2**	**68.0**	**0.3**	**34.1**	**0.3**	**8.0**	**0.2**
Race[5] and Hispanic Origin									
White	247,869	92.2	0.2	70.1	0.4	33.5	0.3	7.8	0.2
White, not Hispanic	194,518	94.8	0.2	75.2	0.4	33.0	0.4	5.2	0.2
Black	42,991	90.4	0.5	55.2	0.9	41.8	0.9	9.6	0.5
Asian	19,905	93.8	0.7	74.4	1.1	25.2	0.9	6.2	0.7
Hispanic (any race)	60,517	83.3	0.7	51.6	0.9	35.8	0.8	16.7	0.7
Age									
Under age 65	269,908	90.5	0.2	71.4	0.4	22.0	0.3	9.5	0.2
Under age 19[6]	76,636	94.8	0.3	63.6	0.7	34.3	0.7	5.2	0.3
Aged 19 to 64	193,272	88.9	0.3	74.4	0.4	17.2	0.3	11.1	0.3
Aged 19 to 25[7]	29,605	85.8	0.7	70.8	0.8	17.2	0.7	14.2	0.7
Aged 26 to 34	40,511	86.7	0.5	71.5	0.7	17.8	0.6	13.3	0.5
Aged 35 to 44	41,412	88.6	0.5	75.6	0.7	15.6	0.6	11.4	0.5
Aged 45 to 64	81,744	91.2	0.3	76.7	0.5	17.6	0.5	8.8	0.3
Aged 65 and older	54,642	98.9	0.1	51.6	0.7	93.8	0.3	1.1	0.1
Nativity									
Native-born	279,653	93.5	0.2	69.7	0.4	34.6	0.3	6.5	0.2
Foreign-born	44,897	82.2	0.7	57.7	0.8	30.8	0.7	17.8	0.7
Naturalized citizen	22,750	91.3	0.6	64.0	1.1	36.6	1.0	8.7	0.6
Not a citizen	22,147	72.9	1.1	51.3	1.2	24.9	1.0	27.1	1.1
Region									
Northeast	55,080	95.3	0.4	70.8	0.9	35.9	0.9	4.7	0.4
Midwest	67,486	94.3	0.4	73.2	0.7	33.5	0.8	5.7	0.4
South	124,084	89.0	0.4	65.0	0.6	32.8	0.5	11.0	0.4
West	77,900	92.4	0.4	66.5	0.8	35.4	0.7	7.6	0.4
State Medicaid Expansion Status[8]									
Lived in Medicaid expansion state	205,888	94.0	0.2	69.3	0.4	35.6	0.4	6.0	0.2
Did not live in Medicaid expansion state	118,661	88.4	0.4	65.9	0.6	31.6	0.5	11.6	0.4

Footnotes provided at end of table.

Table A-1.

Percentage of People by Health Insurance Coverage Status and Type by Selected Characteristics: 2018, 2019, and 2020—Con.

(Numbers in thousands. Population as of March of the following year. Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>)

Characteristic	Total								
		Any health insurance						Uninsured[4]	
				Private health insurance[2]		Public health insurance[3]			
	Number	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)
2018 Total	**323,668**	**91.5**	**0.2**	**67.3**	**0.4**	**34.4**	**0.3**	**8.5**	**0.2**
Race[5] and Hispanic Origin									
White	247,472	91.8	0.2	69.3	0.4	33.8	0.3	8.2	0.2
White, not Hispanic	194,679	94.6	0.2	74.8	0.4	33.2	0.3	5.4	0.2
Black	42,758	90.3	0.5	55.4	1.1	41.2	0.9	9.7	0.5
Asian	19,770	93.2	0.6	73.1	1.3	26.1	1.1	6.8	0.6
Hispanic (any race)	59,925	82.2	0.6	49.6	1.0	36.5	0.8	17.8	0.6
Age									
Under age 65	270,881	90.0	0.2	70.2	0.4	22.8	0.3	10.0	0.2
Under age 19[6]	77,333	94.5	0.3	61.8	0.7	35.7	0.7	5.5	0.3
Aged 19 to 64	193,548	88.3	0.3	73.5	0.4	17.6	0.3	11.7	0.3
Aged 19 to 25[7]	29,297	85.7	0.6	69.9	0.9	18.3	0.7	14.3	0.6
Aged 26 to 34	40,768	86.1	0.5	71.3	0.8	17.5	0.6	13.9	0.5
Aged 35 to 44	41,027	87.5	0.5	73.7	0.6	16.2	0.5	12.5	0.5
Aged 45 to 64	82,455	90.7	0.3	75.8	0.5	18.1	0.4	9.3	0.3
Aged 65 and older	52,788	99.1	0.1	52.4	0.7	94.1	0.3	0.9	0.1
Nativity									
Native-born	277,848	93.2	0.2	69.1	0.4	34.9	0.3	6.8	0.2
Foreign-born	45,820	81.1	0.6	56.0	0.9	31.2	0.7	18.9	0.6
Naturalized citizen	22,296	91.2	0.6	64.0	1.0	36.4	1.0	8.8	0.6
Not a citizen	23,524	71.4	1.0	48.4	1.1	26.2	1.0	28.6	1.0
Region									
Northeast	55,266	94.9	0.5	69.4	0.9	36.9	0.8	5.1	0.5
Midwest	67,458	94.3	0.4	72.8	0.8	33.3	0.7	5.7	0.4
South	123,391	87.9	0.4	64.2	0.6	33.1	0.4	12.1	0.4
West	77,553	92.3	0.4	65.9	0.8	35.6	0.7	7.7	0.4
State Medicaid Expansion Status[8]									
Lived in Medicaid expansion state	197,396	93.8	0.2	68.4	0.5	36.1	0.4	6.2	0.2
Did not live in Medicaid expansion state	126,273	88.0	0.4	65.6	0.6	31.8	0.4	12.0	0.4

[1] A margin of error (MOE) is a measure of an estimate's variability. The larger the MOE in relation to the size of the estimate, the less reliable the estimate. This number, when added to and subtracted from the estimate, forms the 90 percent confidence interval. MOEs shown in this table are based on standard errors calculated using replicate weights.

[2] Private health insurance includes coverage provided through an employer or union, coverage purchased directly, or TRICARE.

[3] Public health insurance coverage includes Medicaid, Medicare, CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), and care provided by the Department of Veterans Affairs and the military.

[4] Individuals are considered to be uninsured if they do not have health insurance coverage for the entire calendar year.

[5] Federal surveys give respondents the option of reporting more than one race. Therefore, two basic ways of defining a race group are possible. A group, such as Asian, may be defined as those who reported Asian and no other race (the race-alone or single-race concept) or as those who reported Asian regardless of whether they also reported another race (the race-alone-or-in-combination concept). This table shows data using the first approach (race alone). The use of the single-race population does not imply that it is the preferred method of presenting or analyzing data. The Census Bureau uses a variety of approaches. Data for American Indians and Alaska Natives, Native Hawaiians and Other Pacific Islanders, and those reporting two or more races are not shown separately.

[6] Children under the age of 19 are eligible for Medicaid/CHIP.

[7] This age group is of special interest because of the Affordable Care Act's dependent coverage provision. Individuals aged 19 to 25 may be eligible to be a dependent on a parent's health insurance plan.

[8] Medicaid expansion status as of January 1, 2020, 2019, and 2018, respectively. Expansion states on or before January 1, 2018, include AK, AR, AZ, CA, CO, CT, DC, DE, HI, IA, IL, IN, KY, LA, MA, MD, MI, MN, MT, ND, NH, NJ, NM, NV, NY, OH, OR, PA, RI, VT, WA, and WV. After Jan 1, 2018, and on or before January 1, 2019, VA expanded Medicaid. After January 1, 2019, and on or before January 1, 2020, ID, ME, and UT expanded Medicaid. For more information, refer to <www.medicaid.gov/state-overviews/index.html>.

Note: The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.
Source: U.S. Census Bureau, Current Population Survey, 2019, 2020, and 2021 Annual Social and Economic Supplement (CPS ASEC).

Table A-2.

Health Insurance Coverage Status and Type by Age and Selected Characteristics: 2018, 2019, and 2020—Con.

(Numbers in thousands. Population as of March of the following year. Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>)

Characteristic	Total								
		Any health insurance						Uninsured[4]	
				Private health insurance[2]		Public health insurance[3]			
	Number	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)
2020									
Total, 15 to 64 years old	**210,421**	**88.5**	**0.3**	**72.5**	**0.4**	**18.8**	**0.3**	**11.5**	**0.3**
Disability Status[5]									
With disability	15,134	91.0	0.7	45.5	1.2	52.9	1.2	9.0	0.7
With no disability	194,199	88.2	0.3	74.4	0.4	16.2	0.3	11.8	0.3
Work Experience									
All workers	154,502	89.0	0.3	79.8	0.4	11.4	0.3	11.0	0.3
Worked full-time, year-round	99,588	91.6	0.3	87.0	0.3	6.1	0.2	8.4	0.3
Worked less than full-time, year-round	54,913	84.3	0.5	66.7	0.7	20.9	0.5	15.7	0.5
Did not work at least one week	55,920	87.1	0.4	52.2	0.7	39.1	0.7	12.9	0.4
Total, 19 to 64 years old	**193,646**	**88.1**	**0.3**	**73.0**	**0.4**	**17.7**	**0.3**	**11.9**	**0.3**
Marital Status									
Married[6]	98,821	91.5	0.3	82.1	0.4	12.3	0.4	8.5	0.3
Widowed	3,304	87.9	1.5	60.1	2.4	32.6	2.4	12.1	1.5
Divorced	18,486	86.8	0.7	65.0	1.0	24.9	0.9	13.2	0.7
Separated	3,738	79.8	1.9	53.0	2.3	29.7	2.0	20.2	1.9
Never married	69,297	84.0	0.5	63.9	0.6	22.1	0.5	16.0	0.5
Total, 26 to 64 years old	**164,377**	**88.5**	**0.3**	**73.7**	**0.4**	**17.6**	**0.3**	**11.5**	**0.3**
Educational Attainment									
No high school diploma	13,758	68.1	1.4	35.4	1.2	35.4	1.3	31.9	1.4
High school graduate (includes equivalency)	43,850	83.9	0.6	61.5	0.7	25.8	0.7	16.1	0.6
Some college, no degree	23,885	89.3	0.6	72.6	0.8	20.4	0.8	10.7	0.6
Associate degree	17,799	91.0	0.6	77.7	0.9	16.5	0.8	9.0	0.6
Bachelor's degree	41,047	94.1	0.4	87.5	0.5	8.8	0.4	5.9	0.4
Graduate or professional degree	24,039	96.5	0.4	92.3	0.5	5.8	0.5	3.5	0.4

Footnotes provided at end of table.

Table A-2.

Health Insurance Coverage Status and Type by Age and Selected Characteristics: 2018, 2019, and 2020—Con.

(Numbers in thousands. Population as of March of the following year. Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>)

Characteristic	Total								
		Any health insurance						Uninsured[4]	
				Private health insurance[2]		Public health insurance[3]			
	Number	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)
2019									
Total, 15 to 64 years old	**210,228**	**89.3**	**0.3**	**73.9**	**0.4**	**18.2**	**0.3**	**10.7**	**0.3**
Disability Status[5]									
With disability	15,056	91.6	0.6	47.3	1.3	52.4	1.3	8.4	0.6
With no disability	194,194	89.1	0.3	75.8	0.4	15.6	0.3	10.9	0.3
Work Experience									
All workers	157,181	89.8	0.3	80.8	0.3	11.2	0.3	10.2	0.3
Worked full-time, year-round	112,803	91.1	0.3	85.8	0.3	7.0	0.2	8.9	0.3
Worked less than full-time, year-round	44,379	86.6	0.5	68.2	0.7	21.6	0.6	13.4	0.5
Did not work at least one week	53,047	87.8	0.5	53.2	0.7	39.1	0.7	12.2	0.5
Total, 19 to 64 years old	**193,272**	**88.9**	**0.3**	**74.4**	**0.4**	**17.2**	**0.3**	**11.1**	**0.3**
Marital Status									
Married[6]	100,795	92.4	0.3	83.4	0.4	12.2	0.4	7.6	0.3
Widowed	3,319	86.5	1.7	56.5	2.5	33.5	2.3	13.5	1.7
Divorced	18,290	88.0	0.7	67.4	1.0	23.6	0.9	12.0	0.7
Separated	3,802	81.0	1.8	51.8	2.2	31.4	1.9	19.0	1.8
Never married	67,065	84.3	0.5	65.1	0.6	21.3	0.5	15.7	0.5
Total, 26 to 64 years old	**163,666**	**89.4**	**0.3**	**75.1**	**0.4**	**17.2**	**0.3**	**10.6**	**0.3**
Educational Attainment									
No high school diploma	13,733	71.5	1.3	38.9	1.3	35.9	1.4	28.5	1.3
High school graduate (includes equivalency)	43,630	85.1	0.5	64.2	0.7	24.2	0.7	14.9	0.5
Some college, no degree	24,315	89.8	0.6	73.7	0.8	19.7	0.8	10.2	0.6
Associate degree	17,998	91.6	0.7	79.3	0.9	15.8	0.8	8.4	0.7
Bachelor's degree	40,563	94.7	0.4	87.6	0.6	9.1	0.4	5.3	0.4
Graduate or professional degree	23,428	96.8	0.4	93.2	0.5	5.4	0.4	3.2	0.4

Footnotes provided at end of table.

Table A-2.

Health Insurance Coverage Status and Type by Age and Selected Characteristics: 2018, 2019, and 2020—Con.

(Numbers in thousands. Population as of March of the following year. Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>)

Characteristic	Total								
		Any health insurance						Uninsured[4]	
				Private health insurance[2]		Public health insurance[3]			
	Number	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)
2018									
Total, 15 to 64 years old	**210,794**	**88.7**	**0.3**	**72.8**	**0.4**	**18.8**	**0.3**	**11.3**	**0.3**
Disability Status[5]									
With disability	15,438	90.4	0.7	44.7	1.2	53.9	1.1	9.6	0.7
With no disability	194,434	88.5	0.3	74.9	0.4	16.0	0.3	11.5	0.3
Work Experience									
All workers	155,221	89.3	0.3	80.5	0.4	11.1	0.2	10.7	0.3
Worked full-time, year-round	111,950	90.5	0.3	85.1	0.4	7.2	0.2	9.5	0.3
Worked less than full-time, year-round	43,271	86.2	0.5	68.5	0.7	21.3	0.6	13.8	0.5
Did not work at least one week	55,573	86.9	0.4	51.3	0.8	40.2	0.7	13.1	0.4
Total, 19 to 64 years old	**193,548**	**88.3**	**0.3**	**73.5**	**0.4**	**17.6**	**0.3**	**11.7**	**0.3**
Marital Status									
Married[6]	101,805	91.7	0.3	82.3	0.4	12.6	0.3	8.3	0.3
Widowed	3,385	86.3	1.6	55.6	2.2	34.9	2.2	13.7	1.6
Divorced	18,683	87.0	0.7	64.7	1.0	25.3	1.0	13.0	0.7
Separated	4,200	80.1	2.0	52.4	2.3	29.7	1.8	19.9	2.0
Never married	65,475	84.0	0.5	64.7	0.6	21.6	0.5	16.0	0.5
Total, 26 to 64 years old	**164,250**	**88.7**	**0.3**	**74.2**	**0.4**	**17.5**	**0.3**	**11.3**	**0.3**
Educational Attainment									
No high school diploma	15,197	71.0	1.2	37.0	1.2	36.9	1.3	29.0	1.2
High school graduate (includes equivalency)	44,573	85.1	0.5	64.3	0.7	24.4	0.6	14.9	0.5
Some college, no degree	24,977	89.3	0.6	73.8	0.8	19.3	0.7	10.7	0.6
Associate degree	17,735	91.0	0.6	78.7	0.8	15.8	0.7	9.0	0.6
Bachelor's degree	39,255	93.8	0.3	87.2	0.5	8.5	0.4	6.2	0.3
Graduate or professional degree	22,514	96.6	0.4	92.9	0.5	5.7	0.4	3.4	0.4

[1] A margin of error (MOE) is a measure of an estimate's variability. The larger the MOE in relation to the size of the estimate, the less reliable the estimate. This number, when added to and subtracted from the estimate, forms the 90 percent confidence interval. MOEs shown in this table are based on standard errors calculated using replicate weights.

[2] Private health insurance includes coverage provided through an employer or union, coverage purchased directly, or TRICARE.

[3] Public health insurance coverage includes Medicaid, Medicare, CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), and care provided by the Department of Veterans Affairs and the military.

[4] Individuals are considered to be uninsured if they do not have health insurance coverage for the entire calendar year.

[5] The sum of those with and without a disability does not equal the total because disability status is not defined for individuals in the U.S. armed forces.

[6] The combined category "married" includes three individual categories: "married, civilian spouse present," "married, U.S. armed forces spouse present," and "married, spouse absent."

Note: The estimates by type of coverage are *not* mutually exclusive; people can be covered by more than one type of health insurance during the year.

Source: U.S. Census Bureau, Current Population Survey, 2019, 2020, and 2021 Annual Social and Economic Supplement (CPS ASEC).

Table A-3.

Health Insurance Coverage Status and Type by Family Type and Family Income-to-Poverty Ratio: 2018, 2019, and 2020—Con.

(Numbers in thousands. Population as of March of the following year. Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>)

Characteristic	Total								
		Any health insurance						Uninsured[4]	
				Private health insurance[2]		Public health insurance[3]			
	Number	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)
2020 Total	**325,638**	**91.4**	**0.2**	**66.5**	**0.4**	**34.8**	**0.3**	**8.6**	**0.2**
Household Relationship									
Married couple family	193,596	93.6	0.2	74.8	0.4	29.4	0.4	6.4	0.2
With children under 18 years	106,005	92.6	0.3	75.5	0.6	20.4	0.6	7.4	0.3
Unmarried male reference person	42,018	86.9	0.6	58.9	0.9	36.6	0.8	13.1	0.6
With children under 18 years	10,891	86.2	1.4	54.7	1.9	35.4	1.8	13.8	1.4
Unmarried female reference person	72,338	90.3	0.4	50.2	0.7	50.3	0.6	9.7	0.4
With children under 18 years	31,937	89.3	0.7	41.7	1.1	52.2	1.1	10.7	0.7
Unrelated subfamilies	1,017	86.5	3.8	51.3	6.0	38.3	5.2	13.5	3.8
Secondary individuals	16,670	82.8	0.9	61.3	1.3	25.7	1.0	17.2	0.9
Income-to-Poverty Ratio									
Total, poverty universe	325,156	91.4	0.2	66.6	0.4	34.7	0.3	8.6	0.2
Below 100 percent of poverty	37,156	82.8	0.8	23.2	0.9	64.3	1.0	17.2	0.8
Below 138 percent of poverty	56,337	83.9	0.6	25.3	0.7	64.6	0.8	16.1	0.6
Between 100 and 199 percent of poverty	52,336	86.7	0.6	39.6	0.9	56.9	0.8	13.3	0.6
Between 200 and 299 percent of poverty	50,389	88.1	0.5	60.3	0.9	38.8	0.8	11.9	0.5
Between 300 and 399 percent of poverty	41,655	91.1	0.6	72.0	0.9	29.4	0.8	8.9	0.6
At or above 400 percent of poverty	143,620	96.6	0.2	88.2	0.3	19.1	0.3	3.4	0.2

Footnotes provided at end of table.

Table A-3.

Health Insurance Coverage Status and Type by Family Type and Family Income-to-Poverty Ratio: 2018, 2019, and 2020—Con.

(Numbers in thousands. Population as of March of the following year. Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>)

Characteristic	Total								
		Any health insurance						Uninsured[4]	
				Private health insurance[2]		Public health insurance[3]			
	Number	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)
2019 Total	**324,550**	**92.0**	**0.2**	**68.0**	**0.3**	**34.1**	**0.3**	**8.0**	**0.2**
Household Relationship									
Married couple family	197,994	93.9	0.2	75.8	0.4	28.9	0.4	6.1	0.2
With children under 18 years	109,323	93.0	0.4	76.4	0.7	19.7	0.6	7.0	0.4
Unmarried male reference person	40,246	88.0	0.6	61.2	0.8	35.7	0.8	12.0	0.6
With children under 18 years	10,244	86.8	1.3	55.2	1.9	36.0	1.8	13.2	1.3
Unmarried female reference person	69,641	91.1	0.4	51.4	0.7	50.4	0.7	8.9	0.4
With children under 18 years	30,494	91.2	0.7	42.9	1.2	53.2	1.2	8.8	0.7
Unrelated subfamilies	941	90.6	3.6	58.5	6.0	38.2	6.2	9.4	3.6
Secondary individuals	15,728	81.4	1.0	62.1	1.2	23.4	1.1	18.6	1.0
Income-to-Poverty Ratio									
Total, poverty universe	324,048	92.0	0.2	68.1	0.3	34.0	0.3	8.0	0.2
Below 100 percent of poverty	33,879	84.1	0.8	22.9	0.9	66.6	1.0	15.9	0.8
Below 138 percent of poverty	52,816	84.6	0.6	25.2	0.8	65.9	0.8	15.4	0.6
Between 100 and 199 percent of poverty	51,349	85.9	0.6	39.9	1.0	55.5	1.0	14.1	0.6
Between 200 and 299 percent of poverty	48,924	89.0	0.5	63.0	0.9	37.3	0.9	11.0	0.5
Between 300 and 399 percent of poverty	43,078	91.7	0.5	72.6	0.8	29.5	0.8	8.3	0.5
At or above 400 percent of poverty	146,818	97.0	0.2	88.8	0.3	19.2	0.3	3.0	0.2

Footnotes provided at end of table.

Table A-3.

Health Insurance Coverage Status and Type by Family Type and Family Income-to-Poverty Ratio: 2018, 2019, and 2020—Con.

(Numbers in thousands. Population as of March of the following year. Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>)

Characteristic	Total								
		Any health insurance						Uninsured[4]	
				Private health insurance[2]		Public health insurance[3]			
	Number	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)	Percent	Margin of error[1] (±)
2018 Total	**323,668**	**91.5**	**0.2**	**67.3**	**0.4**	**34.4**	**0.3**	**8.5**	**0.2**
Household Relationship									
Married couple family	195,914	93.6	0.2	75.3	0.4	29.1	0.4	6.4	0.2
With children under 18 years	109,341	92.6	0.4	75.1	0.7	20.9	0.6	7.4	0.4
Unmarried male reference person	40,495	87.2	0.6	59.0	0.8	36.9	0.7	12.8	0.6
With children under 18 years	10,398	87.2	1.1	53.0	1.8	38.2	1.6	12.8	1.1
Unmarried female reference person	70,093	90.6	0.4	51.3	0.7	50.1	0.7	9.4	0.4
With children under 18 years	31,462	90.2	0.6	43.3	1.1	51.4	1.2	9.8	0.6
Unrelated subfamilies	1,069	86.9	3.4	50.0	5.1	42.4	4.6	13.1	3.4
Secondary individuals	16,097	81.5	1.0	61.6	1.2	23.8	1.0	18.5	1.0
Income-to-Poverty Ratio									
Total, poverty universe	323,172	91.5	0.2	67.3	0.4	34.3	0.3	8.5	0.2
Below 100 percent of poverty	38,056	83.7	0.6	22.0	0.8	66.8	0.9	16.3	0.6
Below 138 percent of poverty	58,204	84.4	0.6	24.7	0.7	65.8	0.7	15.6	0.6
Between 100 and 199 percent of poverty	55,302	86.4	0.6	41.6	0.9	54.4	0.8	13.6	0.6
Between 200 and 299 percent of poverty	50,632	89.2	0.5	64.4	0.8	36.2	0.8	10.8	0.5
Between 300 and 399 percent of poverty	43,624	91.9	0.4	75.1	0.8	27.7	0.7	8.1	0.4
At or above 400 percent of poverty	135,559	96.6	0.2	89.2	0.3	18.5	0.3	3.4	0.2

[1] A margin of error (MOE) is a measure of an estimate's variability. The larger the MOE in relation to the size of the estimate, the less reliable the estimate. This number, when added to and subtracted from the estimate, forms the 90 percent confidence interval. MOEs shown in this table are based on standard errors calculated using replicate weights.

[2] Private health insurance includes coverage provided through an employer or union, coverage purchased directly, or TRICARE.

[3] Public health insurance coverage includes Medicaid, Medicare, CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), and care provided by the Department of Veterans Affairs and the military.

[4] Individuals are considered to be uninsured if they do not have health insurance coverage for the entire calendar year.

Note: The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.

Source: U.S. Census Bureau, Current Population Survey, 2019, 2020, and 2021 Annual Social and Economic Supplement (CPS ASEC).

APPENDIX B.
ESTIMATES OF HEALTH INSURANCE COVERAGE: 2013 TO 2020

The Current Population Survey Annual Social and Economic Supplement (CPS ASEC) is used to produce official estimates of income and poverty, and it serves as the most widely-cited source of estimates on health insurance coverage and the uninsured.

SURVEY REDESIGN

The Census Bureau has consistently sought to improve measurement of health insurance coverage. The CPS ASEC underwent a two-stage redesign in recent years, including changes to the questionnaire incorporated over the period of 2014 to 2016, followed by changes to post-survey collection processing methods in 2019.[1] Evidence suggests that the redesign effectively addressed known limitations to CPS ASEC health coverage and improved health insurance coverage measurement.[2]

In consideration of these and previous changes in survey design, researchers should use caution when comparing results over time. Due to the differences in measurement, health insurance estimates for calendar year 2013 through 2017 are not directly comparable to previous years. Estimates for calendar years 2018 and beyond may be compared with each other and with 2017 estimates from the 2018 CPS ASEC Bridge File or 2016 estimates from the 2017 CPS ASEC Research File. Although it is not appropriate to directly compare 2018 estimates with earlier years processed with the legacy system, it is helpful to examine the estimates in this report in the context of a longer time period to better understand the changes that occurred in health coverage in 2020.

RECENT CHANGES IN THE HEALTH INSURANCE LANDSCAPE

Changes in health coverage over time reflect economic trends, demographic shifts, and changes in federal and state policy. Several such policy changes are related to the Patient Protection and Affordable Care Act (ACA).

Many of the provisions of the ACA went into effect in 2014, including the establishment of health insurance marketplaces (e.g., healthcare.gov) and the optional expansion of Medicaid eligibility. Over the following years, some states took the opportunity to expand Medicaid eligibility. The first year, 24 states and the District of Columbia expanded eligibility. By 2020, all but 15 states had expanded Medicaid eligibility.

As a result, many people, particularly adults aged 19 to 64, may have become eligible for coverage options under the ACA. Based on family income, some people may have qualified for subsidies or tax credits to help pay for premiums associated with health insurance plans. In addition, people with lower income may have become eligible for Medicaid coverage if they resided in one of the states (or the District of Columbia) that expanded Medicaid eligibility.

Notably, some provisions of the ACA no longer apply. For example, as of 2019 the individual mandate penalty requiring individuals to be covered by health insurance or pay a tax penalty was cancelled at the federal level, although several states and the District of Columbia have state health insurance coverage mandates.

The economic shock related to the COVID-19 global pandemic also may have affected health insurance coverage in the United States in 2020. The Families First Coronavirus Response Act required states, as a condition of receiving increased Medicaid funding, to provide continuous coverage for those enrolled in Medicaid. A recent Centers for Medicare & Medicaid Services report showed that Medicaid enrollment increased dramatically in 2020, after declines in enrollment from 2017 to 2019. Specifically, annual Medicaid enrollment during the period February 2020 through January 2021 increased from 34.0 million to 40.2 million among adults aged 19 and older; Medicaid and the

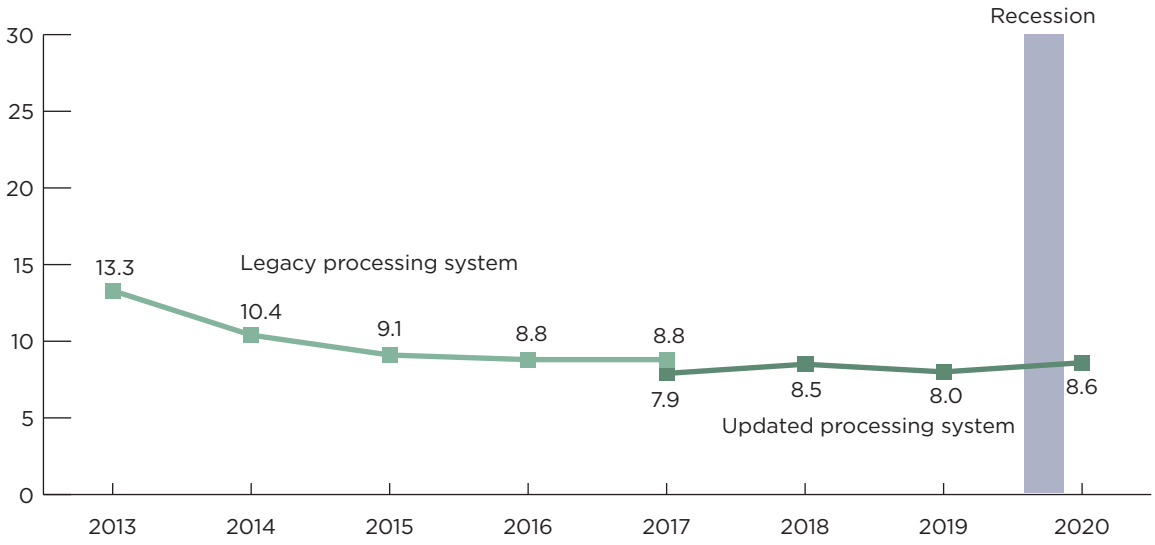
[1] For more information on the survey redesign, refer to Appendix A in Edward R. Berchick, Jessica C. Barnett, and Rachel D. Upton, "Health Insurance Coverage in the United States: 2018," *Current Population Reports*, P60-267, U.S. Census Bureau, Washington, DC, 2019.

[2] Heide Jackson and Edward R. Berchick, "Improvements in Uninsurance Estimates for Fully Imputed Cases in the Current Population Survey Annual Social and Economic Supplement," Inquiry: *The Journal of Health Care Organization, Provision, and Financing*, 2020, and E. R. Berchick and H. M. Jackson, "Health Insurance Coverage in the 2017 CPS ASEC Research File," <www.census.gov/library/working-papers/2019/demo/SEHSD-WP2019-01.html>.

Figure B-1.

Percentage of People Without Health Insurance Coverage: 2013 to 2020

(Numbers in percent. Population as of March of the following year)



Note: Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>.

Source: U.S. Census Bureau, Current Population Survey, 2018 Annual Social and Economic Supplement Bridge File and 2014 to 2021 Annual Social and Economic Supplement (CPS ASEC).

Children's Health Insurance Program enrollment increased from 35.0 million to 38.3 million for children under the age of 19.[3, 4]

The coronavirus pandemic and the related stay-at-home orders during the spring of 2020 also affected how the Census Bureau collected data for the CPS ASEC. The edition of this report released in September 2020 provides an overview of the issues.[5] In addition, the Census Bureau produced several working papers exploring how changes in CPS ASEC data collection in 2020 may have affected 2019 estimates. These analyses revealed that the 2020 CPS ASEC sample differed from the previous year with respect to a number of characteristics that are correlated with health insurance coverage. For example, the 2020 CPS ASEC sample was older, more educated, and more likely to have a disability than the 2019 sample.[6] Researchers should consider the effect of the pandemic on CPS ASEC data collection in interpreting changes in health insurance coverage between 2019 and other years using the CPS ASEC. As a result, no comparisons between calendar year coverage in 2019 (collected in 2020) and other survey years are reported in this Appendix.

Estimates of health insurance coverage: 2013 to 2020

Uninsured Rates

Figure B-1 shows the percentage of people without health insurance coverage from 2013 to 2017, under the legacy processing system, and from 2017 to 2020, using the updated processing system. The uninsured rate declined from 2013 to 2014, when many provisions of the ACA went into effect and continued to decline

[3] Appendices A and B of the December 2020 and January 2021 Medicaid and CHIP Enrollment Trends Snapshot are available at <www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/december-2020-january-2021-medicaid-chip-enrollment-trend-snapshot.pdf>.

[4] Throughout this appendix, details may not sum to totals because of rounding.

[5] "The Impact of the Coronavirus (COVID-19) Pandemic on the CPS ASEC" text box in the "Health Insurance Coverage in the United States: 2019," report is available at <www.census.gov/content/dam/Census/library/publications/2020/demo/p60-271.pdf>.

[6] Additional information related to the impact of COVID-19 on the 2020 CPS ASEC is available in Edward R. Berchick, Laryssa Mykyta, and Sharon M. Stern, "The Influence of COVID-19-Related Data Collection Changes on Measuring Health Insurance Coverage in the 2020 CPS ASEC," <www.census.gov/library/working-papers/2020/demo/SEHSD-WP2020-13.html>, and Jonathan Rothbaum and C. Adam Bee, "Coronavirus Infects Surveys, Too: Nonresponse Bias During the Pandemic in the CPS ASEC," <www.census.gov/library/working-papers/2020/demo/SEHSD-WP2020-10.html>.

through 2016.[7] The uninsured rate for 2017 was lower under the updated processing system than under the legacy system. However, the percentage of uninsured increased between 2017 and 2018 by 0.5 percentage points to 8.5 percent.

In 2020, the uninsured rate was 8.6 percent, 0.6 percentage points higher than the uninsured rate in 2017, but not significantly different from the rate in 2018. The CPS ASEC only includes people who had no coverage at all during calendar year 2020 as uninsured. Therefore, people losing health insurance coverage in 2020 are not considered uninsured in 2020.

Private health insurance coverage

The percentage of people with private health insurance coverage from 2013 to 2020 is presented in Figure B-2.[8] As shown, there was an increase in private coverage rates between 2013 and 2015, coincident with the implementation of the ACA, followed by a leveling of private coverage between 2015 and 2017.

Using the updated processing system, there was no statistically significant change in the private coverage rate between 2017 and 2018. However, between 2018 and 2020, the percentage of people with private health insurance coverage at any point during the year declined 0.8 percentage points to 66.5 percent.

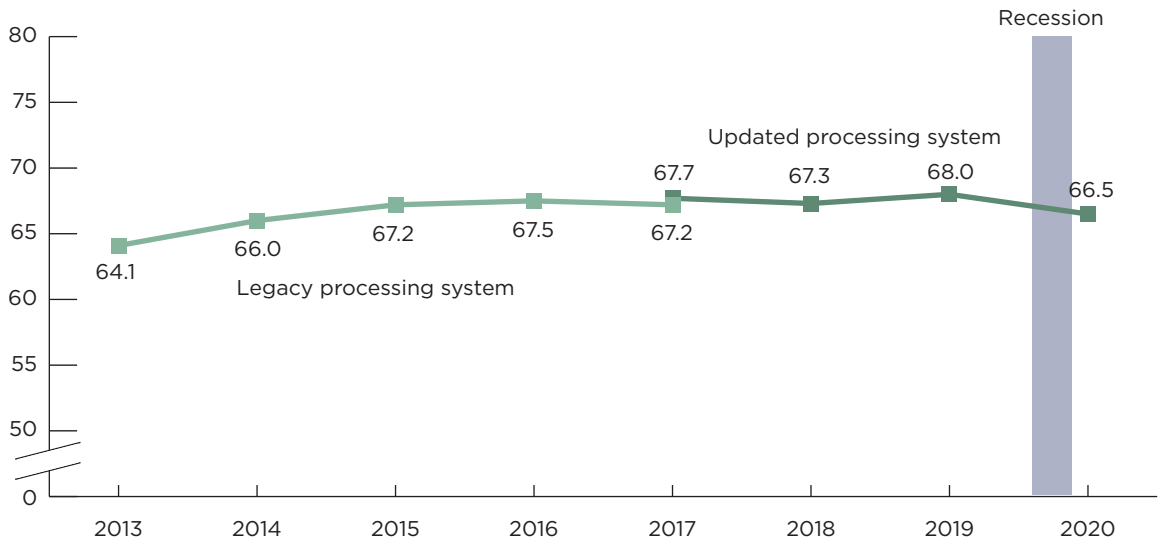
Public coverage

Figure B-3 shows the percentage of people with public coverage and Medicaid coverage in the CPS ASEC from 2013 to 2020. Using the legacy

[7] There was no significant change in the uninsured rate between 2016 and 2017 using the legacy processing system.

[8] Private coverage includes employer-sponsored insurance, insurance purchased directly by an individual, through a broker or the Marketplace (such as healthcare.gov). The updated processing system further includes TRICARE as private coverage.

Figure B-2.
Percentage of People With Private Health Insurance Coverage: 2013 to 2020
(Numbers in percent. Population as of March of the following year)



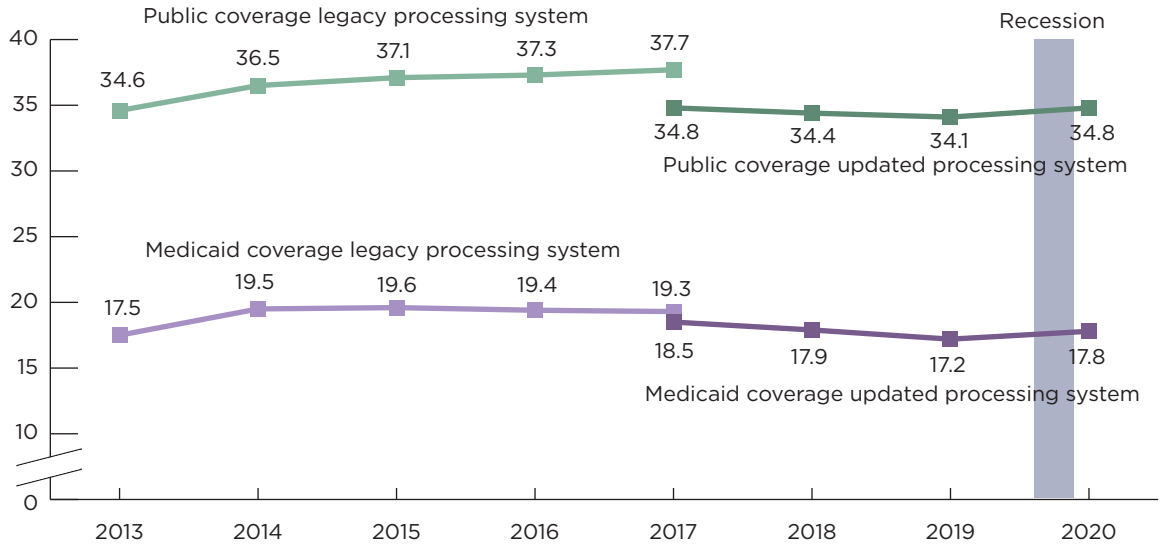
Note: Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>.

Source: U.S. Census Bureau, Current Population Survey, 2018 Annual Social and Economic Supplement Bridge File and 2014 to 2021 Annual Social and Economic Supplement (CPS ASEC).

Figure B-3.

Percentage of People With Public Coverage and Medicaid Coverage: 2013 to 2020

(Numbers in percent. Population as of March of the following year)



Note: Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>.

Source: U.S. Census Bureau, Current Population Survey, 2018 Annual Social and Economic Supplement Bridge File and 2014 to 2021 Annual Social and Economic Supplement (CPS ASEC).

processing system, public coverage increased from 2013 to 2017.[9] Public coverage rates were lower in 2017 using the updated processing system compared to the legacy processing system. However, TRICARE is defined as private coverage in the updated processing system and not as public coverage as in the legacy system.

Although public coverage rates declined between 2017 to 2018 using the updated processing system, the percentage of people holding public coverage increased by 0.4 percentage points to 34.8 percent between 2018 and 2020.

As with public coverage, the percentage of people with Medicaid coverage declined between 2017 and 2018 by 0.7 percentage points to 17.9 percent under the updated processing system. Although there was no significant difference in Medicaid coverage rates reported in the CPS ASEC between 2018 and 2020, the lack of change masks a 0.4 percentage-point increase in the percentage of working-age adults aged 19 to 64 covered by Medicaid during this same time. Working-age adults may have been more vulnerable to losing coverage during the COVID-19 pandemic than other age groups (Figure B-4).[10]

Current Coverage, or Coverage at Time of the CPS ASEC Interview

The redesigned CPS ASEC also includes a measure of current coverage, health insurance coverage

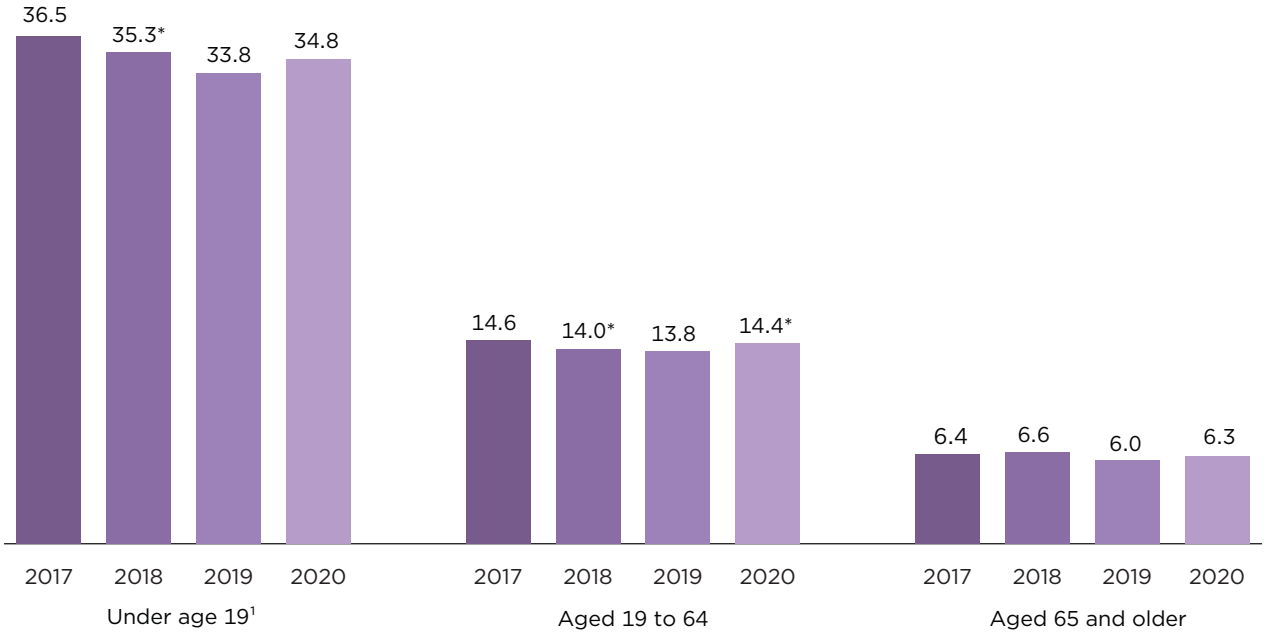
[9] Under the legacy processing system, public coverage increased annually, except for 2015 to 2016, which was not a significant change.

[10] There was no significant change in the Medicaid coverage rate for children under the age of 19 or for percentage of adults aged 65 and older between 2018 and 2020.

Figure B-4.

Percentage of People With Medicaid Coverage by Age Group: 2017 to 2020

(Numbers in percent. Population as of March of the following year)



* Denotes a statistically significant change from between 2017 and 2018, or 2018 and 2020. Users should consider the effect of the pandemic on 2020 CPS ASEC data collection in interpreting changes in health insurance coverage between 2019 and other years using the CPS ASEC. As a result, no comparisons between calendar year coverage in 2019 (collected in 2020) and other survey years are reported here.

[1] The percentage of children under 19 with Medicaid coverage in 2020 is statistically different from the percentage of children under 19 with Medicaid coverage in 2017.

Note: Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>.

Source: U.S. Census Bureau, Current Population Survey 2018 Annual Social and Economic Supplement Bridge File and 2019 to 2021 Annual Social and Economic Supplement (CPS ASEC).

held at the time of the CPS ASEC interview. Although this measure of coverage cannot predict coverage in a given calendar year, it offers a snapshot of health insurance coverage early in the year, when CPS ASEC data are collected. A discussion of differences between the primary measure of health insurance coverage (calendar year coverage) and current coverage measured at the time of the interview in the CPS ASEC were discussed in the Research Matters blog, "Current Coverage, Calendar-Year Coverage: Two Measures, Two Concepts," published in 2019.[11]

Figure B-5 illustrates the change in current coverage at the time of the 2019 CPS ASEC interview in early 2019, before the pandemic and pandemic-related changes to data collection, and at the time of the CPS ASEC interview in early 2021.

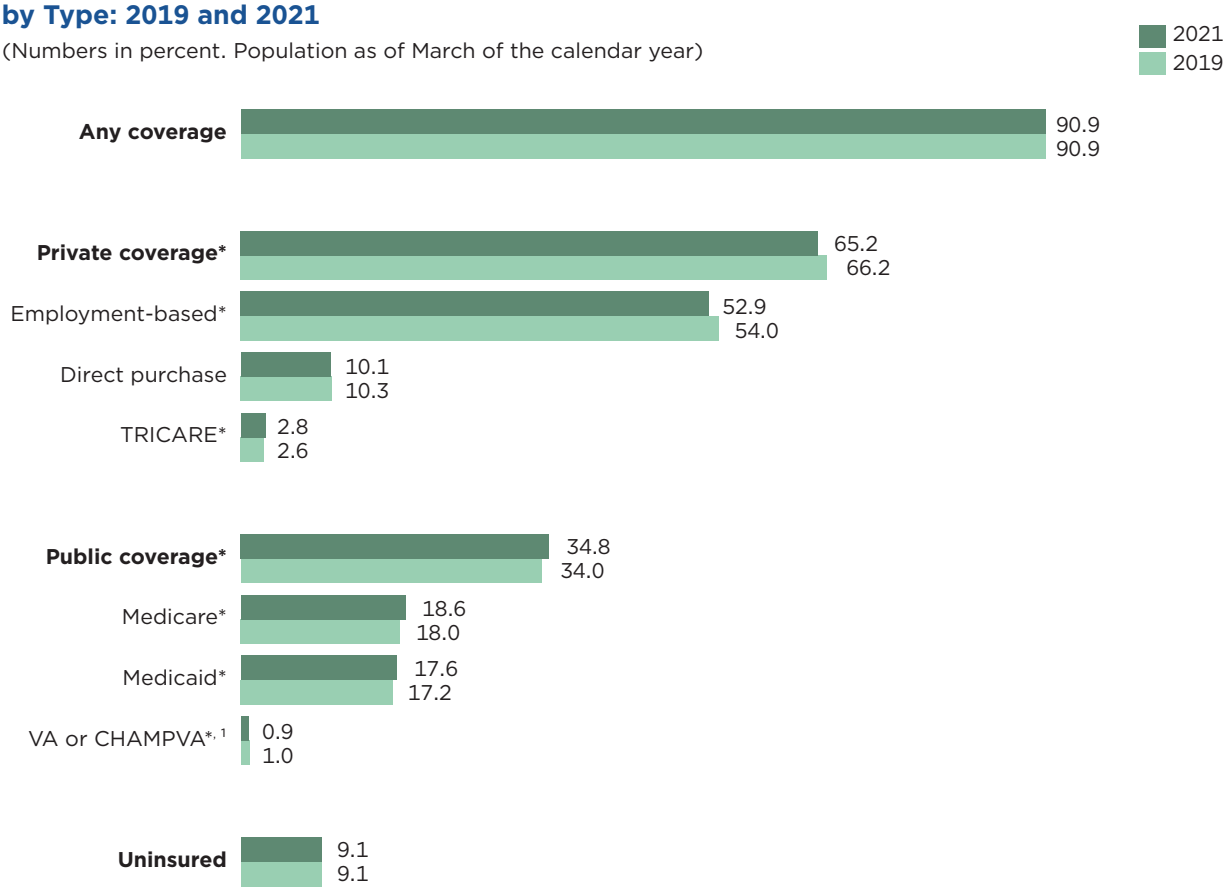
As shown in Figure B-5, a decline in private coverage over the period was partly offset by an increase in the percentage of people covered by public insurance programs. As a result, the percentage of uninsured in early 2021 (9.1 percent), when the CPS ASEC was collected, was not statistically different from the uninsured rate in early 2019.

[11] Sharon Stern, "Current Coverage, Calendar-Year Coverage: Two Measures, Two Concepts," <www.census.gov/newsroom/blogs/research-matters/2019/09/current-coverage.html>.

Figure B-5.

Percentage of People With Health Insurance Coverage at Time of CPS ASEC Interview by Type: 2019 and 2021

(Numbers in percent. Population as of March of the calendar year)



* Denotes a statistically significant change between 2019 and 2021 at the 90 percent confidence level.

[1] Includes CHAMPVA (Civilian Health Medical Program of the Department of Veterans Affairs), as well as care provided by the Department of Veterans Affairs (VA) and the military.

Note: The estimates by type of coverage are not mutually exclusive: people can be covered by more than one type of health insurance during the year. Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf>.

Source: U.S. Census Bureau, Current Population Survey, 2019 and 2021 Annual Social and Economic Supplement (CPS ASEC).

Consistent with calendar year coverage, private coverage in early 2021 declined 1.0 percentage point to 65.2 percent, from early 2019 before the COVID-19 pandemic. This decrease in private coverage was partly driven by a 1.1 percentage-point drop in coverage through employer-sponsored insurance to 52.9 percent, as many individuals may have lost their jobs and their coverage during the pandemic.[12, 13]

In contrast, by early 2021, 34.8 percent of people were covered through public insurance programs, representing an increase of 0.9 percentage points. Between early 2019 and early 2021, Medicaid coverage increased by 0.4 percentage points to 17.6 percent, consistent with reports of increased enrollment. In early 2021, 18.6 percent of people were covered under Medicare, representing an increase of 0.6 percentage points since 2019.[14]

[12] There was no statistical difference between the percent change in private coverage and the percent change in employment-based coverage between early 2019 and early 2021.

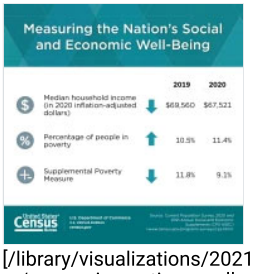
[13] For more information regarding job losses during the COVID-19 pandemic, refer to Ryan Ansell and John P. Mullins, "COVID-19 Ends Longest Employment Recovery and Expansion in CES History, Causing Unprecedented Job Losses in 2020," *Monthly Labor Review*, U.S. Bureau of Labor Statistics, June 2021, <https://doi.org/10.21916/mlr.2021.13>.

[14] Between 2019 and 2021, there was no statistical difference between the percent change in public coverage and Medicaid; public coverage and Medicare; or Medicaid and Medicare.

Income, Poverty and Health Insurance Coverage in the United States: 2020

FOR IMMEDIATE RELEASE: TUESDAY, SEPTEMBER 14, 2021

SEPTEMBER 14, 2021
RELEASE NUMBER CB21-151



[/library/visualizations/2021/comm/measuring-nations-well-being.html]

SEPT. 14, 2021 — The U.S. Census Bureau announced today that median household income in 2020 decreased 2.9% between 2019 and 2020, and the official poverty rate increased 1.0 percentage point. Meanwhile the percentage of people with health insurance coverage for all or part of 2020 was 91.4%. An estimated 8.6% of people, or 28.0 million, did not have health insurance at any point during 2020, according to the 2021 Current Population Survey Annual Social and Economic Supplement (CPS ASEC).

Median household income was $67,521 in 2020, a decrease of 2.9% from the 2019 median of $69,560. This is the first statistically significant decline in median household income since 2011.

Between 2019 and 2020, the real median earnings of all workers decreased by 1.2%, while the real median earnings of full-time, year-round workers increased 6.9%. The total number of people with earnings decreased by about 3.0 million, while the number of full-time, year-round workers decreased by approximately 13.7 million.

The official poverty rate in 2020 was 11.4%, up 1.0 percentage point from 2019. This is the first increase in poverty after five consecutive annual declines. In 2020, there were 37.2 million people in poverty, approximately 3.3 million more than in 2019.

Private health insurance coverage continued to be more prevalent than public coverage, at 66.5% and 34.8%, respectively. Some people may have more than one coverage type during the calendar year. Of the subtypes of health insurance, employment-based insurance was the most common subtype of health insurance, covering 54.4% of the population for some or all of the calendar year.

These findings are contained in two Census Bureau reports: Income and Poverty in the United States: 2020 [https://www.census.gov/library/publications/2021/demo/p60-273.html] and Health Insurance Coverage in the United States: 2020 [https://www.census.gov/library/publications/2021/demo/p60-274.html] . For consistency with past reports, the income and poverty estimates in the Income and Poverty in the United States: 2020 report are based on the concept of money income, which is pretax and does not include stimulus payments and tax credits. An appendix to the income and poverty report provides post-tax estimates of median household income and income inequality metrics that do reflect the stimulus payments.

Another Census Bureau report, The Supplemental Poverty Measure: 2020 [https://www.census.gov/library/publications/2021/demo/p60-275.html] , was also released today. The Supplemental Poverty Measure (SPM) rate in 2020 was 9.1%. This was 2.6 percentage points lower than the 2019 SPM rate. The SPM estimates reflect post-tax income that include stimulus payments. The SPM provides an alternative way of measuring poverty in the United States and serves as an additional indicator of economic well-being. The Census Bureau has published poverty estimates using the SPM annually since 2011 in collaboration with the U.S. Bureau of Labor Statistics (BLS).

All three reports are based on data from the CPS ASEC. The Current Population Survey [https://www.census.gov/programs-surveys/cps.html] (CPS), sponsored jointly by the Census Bureau [https://census.gov/] and BLS [https://www.bls.gov/] , is conducted every month and is the primary source of labor force statistics for the U.S. population. It is used to calculate monthly unemployment

rate estimates. Supplements are added in most months. The CPS ASEC – conducted in February, March and April – is designed to give annual, national estimates of income, poverty and health insurance numbers and rates. It collects information about income and health insurance coverage during the prior calendar year.

The Impact of the Coronavirus (COVID-19) Pandemic on the CPS ASEC

The Census Bureau administers the CPS ASEC each year between February and April by telephone and in-person interviews, with the majority of data collected in March. In 2020, data collection faced extraordinary circumstances due to the onset of the COVID-19 pandemic as the Census Bureau suspended in-person interviews and closed both telephone contact centers. The response rate for the CPS basic household survey was 73% in March 2020, about 10 percentage points lower than preceding months and the same period in 2019, which were regularly above 80%.

During collection of the 2021 CPS ASEC, for the safety of both interviewers and respondents, in-person interviews were only conducted when telephone interviews could not be done. In March 2021, the response rate for the CPS basic household survey improved to about 76%, though not quite returning to the prepandemic trend. While the response rate improved, it is important to examine how respondents differ from nonrespondents, as this difference could affect income and poverty estimates. Using administrative data, Census Bureau researchers have documented that the nonrespondents in both 2020 and 2021 are less similar to respondents than in earlier years. Of particular interest, for the estimates in this report, are the differences in median income and educational attainment, indicating that respondents in 2020 and 2021 had relatively higher income and were more educated than nonrespondents. For more details on how these sample differences and the associated nonresponse bias impact income and official poverty estimates, refer to our Research Matters blog. [https://www.census.gov/newsroom/blogs/research-matters/2021/08/how-did-the-pandemic-affect-survey-response.html]

Income

- Median household income was $67,521 in 2020, a decrease of 2.9% from the 2019 median of $69,560.
- The 2020 real median income of family households and nonfamily households decreased 3.2% and 3.1% from their respective 2019 estimates. The difference between the 2019 to 2020 percent changes in median income for family and nonfamily households was not statistically significant.
- Real median household incomes decreased 3.2% in the Midwest and 2.3% in the South and the West from their 2019 medians. The change for the Northeast was not statistically significant. The differences between the 2019 to 2020 percent changes in median household income among all regions were not statistically significant.
- The Gini index is a statistical measure of income inequality ranging from 0.0 to 1.0. It measures the amount that any two incomes differ, on average, relative to mean income. It is an indicator of how far apart or “spread out” incomes are from one another. A value of 0.0 represents perfect equality, and a value of 1.0 indicates total inequality. The money income Gini index was 0.489 in 2020, not statistically different from 2019.

Post-tax Income and Inequality Estimates

In response to the COVID-19 pandemic, Congress passed legislation to aid individuals and families. This legislation included the Coronavirus Aid, Relief, and Economic Security Act (CARES Act); the Coronavirus Response and Relief Supplemental Appropriations Act (CRRSA Act); and the Families First Coronavirus Response Act (FFCRA). The CARES and CRRSA Acts provided households with additional income in the form of stimulus payments and tax credits. Given the large scale of the stimulus payments, the income and poverty report includes an appendix which compares household median income and inequality measures based on post-tax income.

- Post-tax, real median household income increased 4.0% between 2019 and 2020.
- The Gini index based on post-tax income fell 3.1% from .442 in 2019 to .428 in 2020.

Race and Hispanic Origin

Race data refer to people reporting a single race only. Hispanics can be of any race.

- The 2020 real median incomes of non-Hispanic White, Asian and Hispanic households decreased from their 2019 medians, while the change for Black households was not statistically different. Between 2019 and 2020, median incomes declined 2.7% for non-Hispanic White, 4.5% for Asian, and 2.6% for Hispanic households. However, the differences between the 2019 to 2020 percent changes in median household income among the race groups were not statistically significant.

Earnings

- In 2020, real median earnings of those who worked full-time, year-round increased 6.9% from their 2019 estimate. Median earnings of men ($61,417) and women ($50,982) who worked full-time, year-round increased by 5.6% and 6.5%, respectively. The differences between the 2019 to 2020 percent changes in median earnings among all full-time, year-round workers; male full-time, year-round workers; and female full-time, year-round workers were not statistically significant.
- The real median earnings of all workers age 15 and over with earnings decreased 1.2% between 2019 and 2020, from $42,065 to $41,535.
- The total number of those who worked full-time, year-round declined by 13.7 million between 2019 and 2020. This was the largest year-to-year decline in the number of full-time, year-round workers since 1967, the first year for which there is comparable data. The number of female full-time, year-round workers decreased by about 6.2 million, while the decrease for their male counterparts was approximately 7.5 million.

Poverty

- As defined by the Office of Management and Budget (OMB) and updated for inflation using the Consumer Price Index, the weighted average poverty threshold for a family of four in 2020 was $26,496. (Refer to <www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html [https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html] > for the complete set of dollar value thresholds that vary by family size and composition.) (OMB determined the official definition of poverty in Statistical Policy Directive 14).
- The official poverty rate in 2020 was 11.4%, up 1.0 percentage point from 2019 This is the first increase in poverty after five consecutive annual declines.
- In 2020, there were 37.2 million people in poverty, approximately 3.3 million more than in 2019.
- Between 2019 and 2020, poverty rates increased for married-couple families and families with a female householder. (In the income and poverty report, families with a female householder with no spouse present are referred to as families with a female householder. Families with a male householder with no spouse present are referred to as families with a male householder.)
- The poverty rate for married-couple families increased from 4.0% in 2019 to 4.7% in 2020.
- For families with a female householder, the poverty rate increased from 22.2% to 23.4%. The poverty rate for families with a male householder was 11.4% in 2020, not statistically different from 2019.

Race and Hispanic Origin

Race data refer to people reporting a single race only. Hispanics can be of any race.

- Between 2019 and 2020, the poverty rate increased for the non-Hispanic White and Hispanic populations.
- Among the non-Hispanic White population, 8.2% were in poverty in 2020, while the Hispanic population had a poverty rate of 17.0%. Among the major racial groups examined in this report, the Black population had the highest poverty rate (19.5%), but did not experience a significant change from 2019. The poverty rate for the Asian population (8.1%) in 2020 was not statistically different from 2019. The 2020 poverty rates for the Asian and non-Hispanic White populations were not statistically different.

Age

- Poverty rates for people under the age of 18 increased from 14.4% in 2019 to 16.1% in 2020. Poverty rates also increased for people ages 18 to 64 from 9.4% in 2019 to 10.4% in 2020. The poverty rate for people ages 65 and older was 9.0% in 2020, not statistically different from 2019.

Supplemental Poverty Measure

The SPM extends the official poverty measure by taking into account many of the government programs designed to assist low-income families and individuals that are not included in the current official poverty measure, such as the stimulus payments enacted as part of economic relief legislation related to the COVID-19 pandemic.

Additionally, the SPM deducts necessary expenses for critical goods and services from income. Deducted expenses include taxes, childcare, commuting expenses, contributions toward the cost of medical care and health insurance premiums, and child support paid to another household. The SPM permits the examination of the effects of government transfers on poverty estimates. The SPM does not replace the official poverty measure and is not used to determine eligibility for government programs.

While the official poverty measure includes only pretax money income, the SPM adds the value of in-kind benefits, such as the Supplemental Nutrition Assistance Program (SNAP), school lunches, housing assistance, stimulus payments and refundable tax credits.

- The SPM released today shows that in 2020, the overall SPM rate was 9.1%. This was 2.6 percentage points lower than the 2019 SPM rate.
- The SPM rate for 2020 was 2.3 percentage points lower than the official poverty rate of 11.4%. This is the first time in the history of the SPM where poverty is lower using the SPM than the official poverty rate.
- The 2020 SPM rate of 9.1% was the lowest rate since estimates were initially published for 2009.
- Social Security continued to be the most important antipoverty program, moving 26.5 million individuals out of poverty.
- Unemployment insurance benefits, also expanded during 2020, prevented 5.5 million people from falling into poverty.
- Stimulus payments, enacted as part of economic relief legislation related to the COVID-19 pandemic, moved 11.7 million persons out of poverty. For example, not including stimulus payments in resources, the poverty rate for all people would have been 12.7% rather than 9.1%.
- There were 11 states plus the District of Columbia for which SPM rates were higher than official poverty rates, 30 states with lower rates, and 9 states for which the differences were not statistically significant.

Age

- SPM rates were down for all major age categories: children under age 18, adults ages 18 to 64, and adults age 65 and older between 2019 and 2020.

Health Insurance

In previous years, the Census Bureau released estimates of health insurance from two surveys. The CPS ASEC asks people about coverage during the previous calendar year. The American Community Survey (ACS) asks people to report their health insurance coverage at the time of interview. However, this year's report relies solely on data from the CPS ASEC because of impacts of the COVID-19 pandemic on the 2020 ACS [https://www.census.gov/newsroom/press-releases/2021/changes-2020-acs-1-year.html] .

- In 2020, 8.6% of people, or 28.0 million, did not have health insurance at any point during the year. The percentage of people with health insurance coverage for all or part of 2020 was 91.4%.
- In 2020, private health insurance coverage continued to be more prevalent than public coverage at 66.5% and 34.8%, respectively. (Some people may have more than one coverage type during the calendar year.). Of the subtypes of health insurance, employment-based insurance was the most common subtype, covering 54.4% of the population for some or all of the calendar year.
- Between 2018 and 2020, the rate of private health insurance coverage decreased by 0.8 percentage points to 66.5%, driven by a 0.7 percentage-point decline in employment-based coverage to 54.4%.

- Between 2018 and 2020, the rate of public health insurance coverage increased by 0.4 percentage points to 34.8%. In that time, there was a 0.5 percentage-point increase in Medicare coverage. This increase was due to growth in the number of people age 65 and over. The proportion of the population 65 years and older with Medicare coverage decreased between 2018 and 2020 from 93.9% to 93.5%. However, the percentage of the U.S. population 65 years and older increased between 2018 and 2020.
- In 2020, 87.0% of full-time, year-round workers had private insurance coverage, up from 85.1% in 2018. In contrast, those who worked less than full-time, year-round were less likely to be covered by private insurance in 2020 than in 2018 (68.5% in 2018 and 66.7% in 2020).
- More children under the age of 19 in poverty were uninsured in 2020 than in 2018. Uninsured rates for children under the age of 19 in poverty rose 1.6 percentage points to 9.3%.

Regional estimates are available for income, poverty, SPM and health insurance in each respective report. There is also a table showing state-level poverty rates using the supplemental poverty measure.

The CPS ASEC is subject to sampling and nonsampling errors. All comparisons made here and in each respective report have been tested and found to be statistically significant at the 90% confidence level, unless otherwise noted.

Additional information on the source of the data and accuracy of the income, poverty and health insurance estimates is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf [https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar21.pdf] >.

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California expands health insurance mandates, modifies leave laws

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In this article

California has completed its regular 2021 session with a variety of health insurance and related legislation. Along with expanding required coverage for large groups, new laws require coverage of COVID-19 testing and vaccines without cost sharing, add dependent coverage for parents, and mandate screening children for adverse physical or emotional experiences. Lawmakers also postponed changes to the state's paid family and disability leave programs and broadened unpaid leave protections for caregivers. Gov. Gavin Newsom vetoed a pharmacy benefit manager (PBM) anti-steering law.

Expanded large-group coverage

Large-group health insurance policies issued or renewed in California on or after July 1, 2022, must cover medically necessary "basic health care services," under legislation (Ch. 636, SB 280) enacted in October. These services include:

- Physician services
- Hospital inpatient and ambulatory care services
- Diagnostic laboratory services
- Diagnostic and therapeutic radiologic services
- Home healthcare
- Preventive healthcare

- Emergency healthcare, including ambulance and ambulance transport services
- Hospice care

Plans also must provide out-of-area coverage for “urgently needed services” for an unforeseen illness or injury requiring immediate treatment.

California is one of only four states that define large-group plans as policies for more than 100 employees. Similar coverage requirements already apply to individual and small-group plans through the federal Affordable Care Act’s mandated essential health benefits. California’s basic healthcare mandate doesn’t apply to self-funded ERISA plans or stand-alone dental or vision policies. However, no exemption applies for grandfathered health insurance plans.

The new law also prohibits large-group insurers (including officials, employees, agents and representatives) from marketing practices or benefit designs that discourage enrollment by individuals with significant health needs. In addition, large-group insurers are barred from discriminating based on race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

The new law imposes a $2,500 fine for a first-time violation. The fine increases to $15,000–$100,000 per violation if the discrimination is a general practice or a knowing violation. The penalty does not apply to grandfathered large-group insured plans or dental or vision policies.

COVID-19 testing and vaccine coverage

Insured California health plans must cover COVID-19 diagnostic and screening tests, immunizations and related healthcare services with no patient cost sharing. No prior authorization or any other utilization management requirements may apply under recently signed legation (Ch. 729, SB 510).

Insured plans also must cover without cost sharing any items, services or immunizations — whether provided in or out of network — to prevent or mitigate COVID-19, if they meet certain criteria. These provisions apply retroactively to March 4, 2020, when the governor declared a COVID-19 state of emergency. The out-of-network cost-sharing ban applies only during the federal public health emergency, which the US Department of Health and Human Services has regularly renewed every 90 days.

“Screening testing” under the law means tests to identify people with asymptomatic COVID-19 infections who do not have known, suspected or reported exposure to the virus. Screening tests help to identify unknown cases so measures can be taken to prevent further transmission. People undergoing these screenings may include all of the following:

- Employees in a workplace setting
- Students, faculty and staff in a school setting
- Individuals returning from or preparing for travel

- Someone at home who does not have COVID-19 symptoms or a known exposure to someone with COVID-19

This differs from federal guidance (see Q&A-5), which exempts group health plans from covering COVID-19 tests without cost sharing if the tests are conducted for surveillance or employment-related purposes. These provisions also will apply to any future disease for which the California governor declares a public health emergency.

Dependent coverage

Individual health plans issued or renewed on or after Jan. 1, 2023, that provide dependent coverage must make it available to a parent or stepparent of the enrollee or insured. To be eligible, a dependent must meet the definition of a qualifying relative under Section 152(d) of the federal tax code and must reside within the plan's service area. The coverage mandate (Ch. 468, AB 570) does not apply to group health plans.

Childhood mental health coverage

Insured health plans that cover pediatric services and preventive care must also cover screenings for "adverse childhood experiences" (ACEs). The new law (Ch. 641, SB 428) defines an ACE as an event, a series of events or a set of circumstances that a child experiences as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

The act doesn't address what screening tool to use or specify follow-up care. Future regulations may clarify this coverage requirement. Cost sharing may apply. The mandate applies to insured health plans issued or renewed on or after Jan. 1, 2022.

Paid disability and family leave

California's current calculation rates for state disability insurance (SDI) and paid family leave (PFL) benefits will continue for another year until Jan. 1, 2023, under recent legislation (Ch. 78, AB 138). The current rates were due to sunset at the end of this year under a 2016 law (Ch. 5, AB 908), but the new law averts a lapse to the lower pre-2018 levels. Benefits for 2022 will continue at 60%–70% of an employee's highest quarterly earnings in a base period divided by 13, capped at the annually adjusted weekly maximum benefit ($1,357 for 2021).

Other legislation (AB 123) would have raised the weekly benefit to 65%–70% of an employee's weekly wage for PFL and the first 12 weeks of SDI benefits for claims beginning on or after Jan. 1, 2023, and then to 70%–90% in 2025. However, the governor vetoed that measure, citing budgetary concerns.

Unpaid caregiver leave

Legislation (Ch. 327, AB 1033) expands an employee's right under the California Family Rights Act (CFRA) to take unpaid leave to care for a "designated person" with a serious health condition. The CFRA, much like the federal Family and Medical Leave Act (FMLA), provides up to 12 weeks of unpaid leave for qualified employees to bond with a new child or care for their own serious health condition (other than pregnancy) or a seriously ill family member — including grandparents, grandchildren and registered domestic partners.

The new category of "designated person" means anyone identified by the employee at the time of the CFRA leave request. An employer may limit an employee to one designated person per 12-month leave period.

PBM anti-steering

California legislation (SB 524) would have barred health plans that provide prescription drug coverage from requiring patients to use a particular pharmacy or pharmacies if other network pharmacies can provide the services or medication. The measure initially raised concerns because it would have applied to self-funded ERISA plans as well as insured plans. Under a revised version, only California-regulated health insurers and health care service plans would have had to comply.

However, Gov. Gavin Newsom vetoed the bill, saying it remains "unclear what business relationships between health plans, insurers, and their agents are intended to be affected."

Related resources

Non-Mercer resources

- Ch. 729, SB 510 (California Legislature, Oct. 8, 2021)
- SB 524 (California Legislature, Oct. 8, 2021)
- Veto message on SB 524 (Governor's Office, Oct. 8, 2021)
- Ch. 636, SB 280 (California Legislature, Oct. 7, 2021)
- Ch. 641, SB 428 (California Legislature, Oct. 7, 2021)
- Ch. 468, AB 570 (California Legislature, Oct. 5, 2021)
- Ch. 327, AB 1033 (California Legislature, Sept. 27, 2021)
- Ch. 78, AB 138 (California Legislature, July 13, 2021)

- FAQS about Families First Coronavirus Response Act and Coronavirus Aid, Relief, And Economic Security Act Implementation Part 43 (US Department of Labor, June 23, 2020)
- California's declared COVID-19 state of emergency (Governor's Office, March 4, 2020)

Mercer Law & Policy resources

- States, cities tackle COVID-19 paid leave (updated regularly)
- Roundup of selected state health developments, third-quarter 2021 (Oct. 22, 2021)
- Changes to California's paid leave programs coming in 2023 (Oct. 8, 2021)

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Increasing Insurance Choices In The Affordable Care Act Marketplaces, 2018–21

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ABSTRACT The Affordable Care Act (ACA) relies on insurers to offer health plans in the individual health insurance Marketplaces. Since the ACA's implementation, levels of Marketplace competition have varied, reaching a nadir in 2018. We examined the characteristics of counties that experienced changes in insurers' participation in the ACA Marketplaces from 2016 to 2021. Using data from the Kaiser Family Foundation and other sources, we found that 1,968 counties (accounting for 66 percent of the US population younger than age sixty-five) have more insurers in 2021 than in 2018, whereas only twelve counties (comprising 0.4 percent of the US nonelderly population) have fewer insurers. The number of counties with monopolist Marketplace insurers declined from 1,616 in 2018 to 294 in 2021. Recent Marketplace insurer gains were more likely in counties that lost insurers from 2016 to 2018 or had a monopolist insurer in 2018. Increased competition may lead to lower gross premiums in the ACA Marketplaces. Given the Biden administration's support for the ACA Marketplaces, it appears likely that the ACA individual health insurance market will be stable and profitable for the next several years.

The Affordable Care Act's (ACA's) individual health insurance Marketplaces rely on the willingness of private insurers to sell regulated insurance products across the entire country.[1] Insurers' decisions to participate have two parts: They must first decide whether they will participate at all, and then they must decide in which geographic areas they will offer plans. These choices have varied substantially over time, and overall Marketplace insurer participation reached a nadir in 2018.[2] Uncertainty during the 2017 and 2018 rate-setting cycles over the ACA's future and federal policy changes were both implicated in insurer exits.

Insurers' Marketplace participation has been an ongoing concern since the passage of the ACA, and previous research concluded that counties with limited insurer participation experienced faster gross premium increases from 2014 to 2018.[3] Insurer exits also have been associated with subsequent reductions in Marketplace enrollment at the county level.[4,5] Insurers returned to some counties served by the federal Marketplace in 2020 and 2021.[6] However, little is known about the characteristics of the counties that gained insurers after the 2018 plan year. In this article we assess the extent to which counties gained Marketplace insurers during 2018–21, the characteristics of these counties, and the types of insurers that entered new service areas or expanded their Marketplace offerings. This information may help guide state and federal policy on issues such as reinsurance and state-based public options.

Study Data And Methods

We obtained annual county-level data on insurers' Marketplace participation from the Kaiser

Family Foundation's Insurer Participation on the ACA Marketplaces database for 2016–21,[2] which is based on insurers' state rate filings and a review of information on HealthCare.gov. We merged county-level data with data on community-level characteristics from the Health Resources and Services Administration's Area Health Resources Files,[7] data on the partisan composition of state legislatures and governors' offices from the National Conference of State Legislatures,[8] data on average medical loss ratios for all individual insurance plans by state from the Centers for Medicare and Medicaid Services' Medical Loss Ratio Data and System Resources,[9] and Kaiser Family Foundation data on state Medicaid expansion[10] and the creation of state-based Marketplaces.[11] As a supplementary analysis, we also extracted data on insurer and plan characteristics for 2018 and 2021 from the Robert Wood Johnson Foundation's Health Insurance Exchange (HIX) Compare database.[12] HIX Compare contains information on nearly every ACA Marketplace plan and insurer in all fifty states plus Washington, D.C. Our final data set included 25,080 annual observations from 3,135 counties.

ANALYSIS Our analysis proceeded in five steps. First, we counted the number of US counties and the percentage of the population younger than age sixty-five with one, two, or three or more insurers by year. Second, we examined mean changes in insurer participation from 2018 to 2021, stratified by the number of insurers that sold on-Marketplace products in each county that had either one or two insurers in 2018. Third, we created maps to show how changes in the number of participating Marketplace insurers varied by geography.

Fourth, we estimated linear probability models to explore the characteristics of counties that either had limited insurer participation in 2021 (defined as two or fewer insurers) or gained Marketplace insurers from 2018 to 2021. We included several covariates that may relate to insurers' participation on the ACA Marketplaces.[13] These included rurality and population demographics that have been previously associated with the likelihood of insurer entry, such as the percentage of residents who are Black, Hispanic, or ages 45–64;[14] per capita death rates (which may be a proxy for underlying population health);[15] each state's average medical loss ratios for all individual insurance plans (a general measure of insurer profitability);[16] whether the state expanded Medicaid (as Medicaid expansion been shown to transfer a cohort of people with higher-than-average health care costs out of the ACA Marketplaces and thus reduce Marketplace premiums);[17,18] party control of state legislatures and governors' offices; and whether the state operated its own Marketplace (an indicator of state-specific political and financial support for ACA Marketplace operations).[13,17,19,20] Rurality was determined using Rural-Urban Continuum Codes from the Department of Agriculture (metropolitan, codes 1–3; nonmetropolitan, codes 4–7; and rural, codes 8–9).[21] State partisan control took on values of Republican, Democrat, or divided, depending on whether a single party controlled both chambers of the state legislature and the governor's office. We used 2018 values for all characteristics, with the exception of our reinsurance waiver variable, which took on a value of 1 if a state implemented a Section 1332 waiver to implement a reinsurance program with an effective date from 2018 to 2021 and a value of 0 otherwise. Because the scales for these covariates vary widely, continuous variables were Z-scored to aid in interpretability. We also tested whether either having limited insurer participation in 2021 or gaining Marketplace insurers from 2018 to 2021 was related to having a monopoly insurer in 2018 or declining Marketplace participation between 2016 and 2018. Monopoly insurer status was not included in adjusted models because of its high correlation with several other variables. Standard errors were clustered at the state level, and all models were weighted by total county population younger than age sixty-five to produce nationally representative estimates.[13]

Last, we described the characteristics of new insurers that entered into the Marketplaces in policy years 2019–21, existing insurers that expanded their Marketplace offerings into new geographic areas, and existing insurers that did not expand those offerings.

LIMITATIONS This study had several limitations. Our analysis was cross-sectional in nature, and thus our results should be interpreted as associations. State policy and partisanship variables are highly correlated, which complicates differentiation of their independent associations with the outcomes. We were unable to observe enrollment in individual plans or insurers, nor did we observe net premiums paid. The HIX Compare database is presented at the rating area level, which does not map to county boundaries in some states. We were unable to see which plans were offered in specific counties or to observe changes in consumer welfare (the benefits that individuals derive from insurance coverage) or behavior in response to changes in Marketplace offerings and insurer participation. The Area Health Resources Files do include mortality information for specific age groups, but these are often suppressed because of low cell counts (fewer than twenty-five deaths) for sparsely populat-

ed counties or younger age groups. We relied on the overall crude death rate instead.

Study Results

Overall, insurers' participation in the ACA Marketplaces increased from 2018 to 2021, partially reversing the trend in insurer exits from 2016 to 2018 (exhibit 1). In 2021, 1,451 counties (which comprise 75.2 percent of the US population younger than age sixty-five) have access to three or more Marketplace insurers, whereas 1,390 counties (with 21.4 percent of the US nonelderly population) are served by two insurers, and 294 counties (with 3.4 percent of the US nonelderly population) have a single insurer.

These gains were nonrandom and disproportionately accrued in counties with limited insurer participation. From 2018 to 2021 counties gained a mean of 1.22 insurers (95% confidence interval: 1.17, 1.26) if they only had one insurer in 2018, compared to a mean gain of 0.68 insurers (95% CI: 0.62, 0.74) in counties with two insurers in 2018 and a mean gain of 0.51 insurers (95% CI: 0.38, 0.64) in counties with three or more insurers in 2018 (exhibit 2).

County-level changes in the number of insurers participating in the Marketplaces in 2018–21 are shown visually in exhibit 3. We found that 1,968 counties (which account for 66 percent of US nonelderly population) had more insurers in 2021 than in 2018. The South Atlantic, Midwest, and Pacific Northwest regions observed the largest gains in insurers during this period. Insurer gains were also made in several states that had insurer monopolies in 2018; Alabama remains the only state with a majority of its land area served by one insurer in 2021. Only twelve counties had fewer insurers in 2021 compared with 2018, comprising approximately 0.4 percent of the US nonelderly population. The number of counties with monopolist Marketplace insurers declined from 1,616 (26 percent of the US nonelderly population) in 2018 to 294 (3 percent of the US nonelderly population) in 2021.

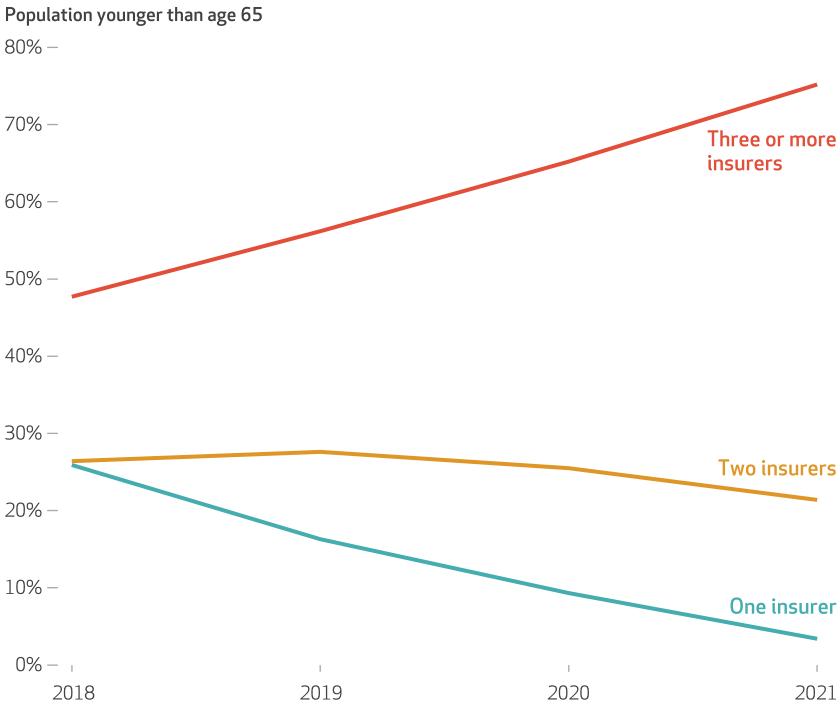
Compared to counties with three or more Marketplace insurers in 2021, counties with limited insurer participation in 2021 were more likely to also have had limited insurer participation in 2018 (100.0 percent versus 36.6 percent) and to have Republican-controlled (50.4 percent versus 46.9 percent) or divided (37.1 percent versus 30.6 percent) state governments, and they were less likely to be in states with state-run Marketplaces (14.8 percent versus 35.8 percent) (exhibit 4). These findings comport with previous research.[13]

Compared to counties that did not gain Marketplace insurers from 2018 to 2021, counties that gained insurers were more likely to have limited insurer participation in 2018 (58.9 percent versus 39.2 percent), a monopoly Marketplace insurer in 2018 (34.0 percent versus 9.8 percent), or loss of insurers from 2016 to 2018 (88.6 percent versus 80.7 percent) or to be in states with Republican-controlled state governments (56.0 percent versus 31.5 percent), and they were less likely to be in states that had a state-run Marketplace (23.9 percent versus 43.8 percent), expanded Medicaid (54.9 percent versus 87.0 percent), or implemented reinsurance waivers (14.6 percent versus 20.2 percent). Additional results for demographic and rurality variables, as well as p values, are in online appendix exhibit A1.[22]

We also examined characteristics of plans offered by three types of ACA Marketplace insurers: insurers that did not participate in ACA Marketplaces in 2018 and entered Marketplaces for the first time in 2019–21, insurers that participated in ACA Marketplaces in 2018 and expanded into new service areas in 2019–21, and insurers that participated in ACA Marketplaces in 2018 and did not expand into new service areas during 2019–21. Subsidiaries of the same parent company were counted as a single insurer. A total

EXHIBIT 1

Percent of US population younger than age 65, by number of insurers on the Affordable Care Act Marketplace at the county level, 2018–21

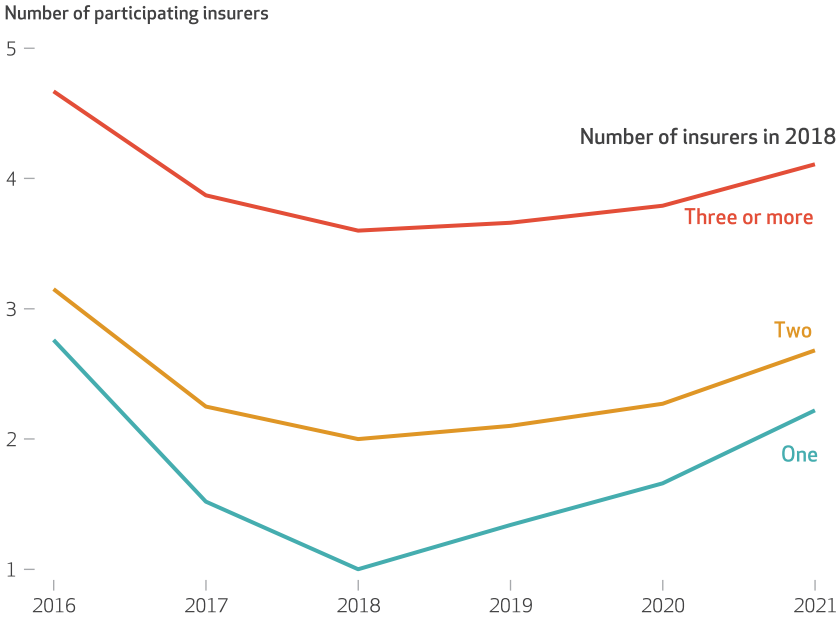


SOURCE Authors' analysis of annual county-level data on insurers' Marketplace participation from the Kaiser Family Foundation and population data from the Area Health Resources Files, 2018–21.

of 121 unique insurers participated in any Marketplace in 2021; ten of these were new entrants (offering 1,629 plans), thirty-eight were existing insurers (offering 35,851 plans) that had expanded into additional service areas since 2018, and seventy-three were existing insurers (offering 16,606 plans) that did not expand into new areas. A breakdown of new and existing ACA Marketplace insurers' 2021 product offerings, including metal levels and plan type, is in appendix exhibit A2.[22] Compared with existing Marketplace insurers that did not expand into new areas, existing Marketplace insurers that expanded into new areas were less likely to be Blue Cross Blue Shield Association members (7.9 percent versus 37.0 percent), were more likely to offer silver plans (78.0 percent versus 67.2 percent), and were consequently more likely to offer cost-sharing reduction plans (58.5 percent versus 50.1 percent). Compared with insurers that did not expand into new areas, insurers that expanded into new areas were more likely to offer health maintenance organization (49.7 percent versus 43.4 percent) and exclusive provider organization (44.1 percent versus 37.1 percent) plans. Compared with all existing insurers, new Marketplace entrants were more likely to be Blue Cross Blue Shield Association members (40.0 percent versus 27.0 percent) and to offer plans that were health maintenance organizations (63.2 percent versus 47.7 percent), multitier (36.2 percent versus 8.3 percent), or child only (4.7 percent versus 0.6 percent), and they were less likely to actively market those plans (86.5 percent versus 95.2 percent) (appendix exhibit A2). [22] The top ten insurance carriers in terms of total unique insurance plans offered on the Marketplaces are in appendix exhibit A3.[22]

EXHIBIT 2

Mean number of Affordable Care Act Marketplace insurers per county, 2016–21, by insurer participation in 2018



SOURCE Authors' analysis of annual county-level data on insurers' Marketplace participation from the Kaiser Family Foundation, 2016–21. **NOTE** The exhibit displays the mean number of unique corporate parent companies of insurers (which may have multiple Health Insurance Oversight System identification numbers for different licenses for products such as health maintenance organizations and preferred provider organizations available on the Affordable Care Act Marketplaces) in 2016, 2017, 2019, and 2021, stratified by the number of Marketplace insurers that were available in 2018.

Discussion

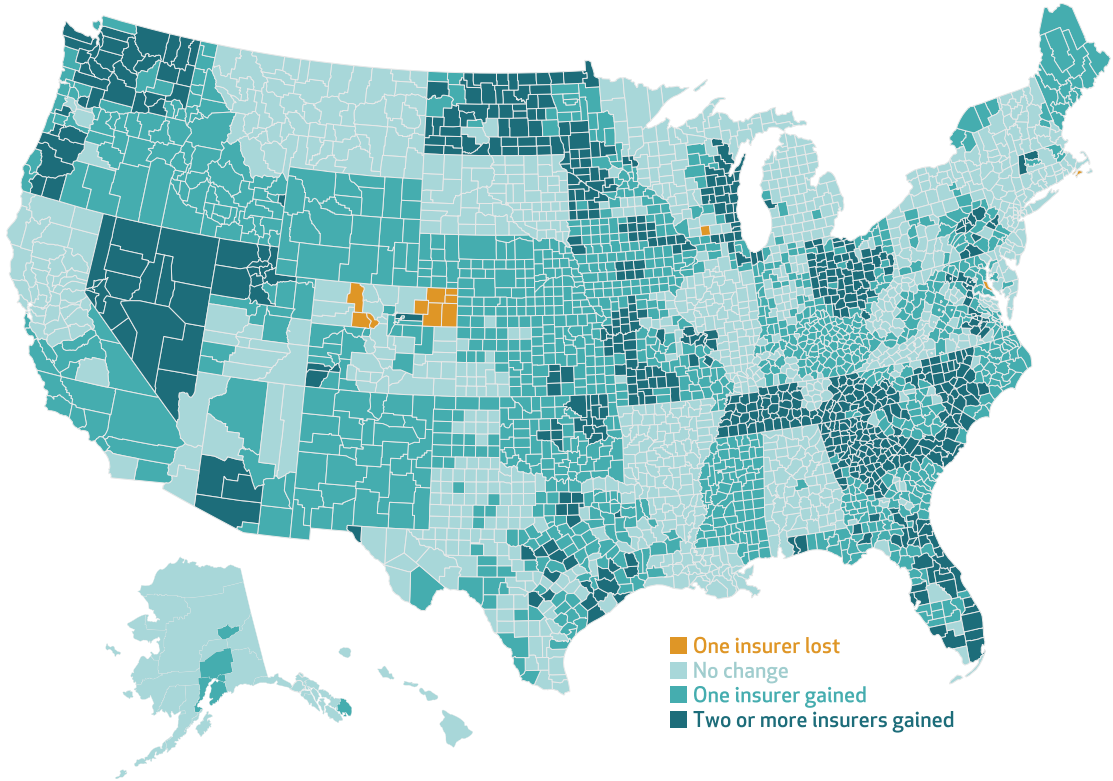
Our results demonstrate that the percentage of people who reside in US counties with only one or two insurers on the ACA Marketplaces has decreased markedly since 2018. Increased insurer participation in 2019, 2020, and 2021 was associated with both a loss of insurer participation from 2016 to 2018 and insurer monopolies in 2018.

Many factors may have led to insurers' Marketplace exits between 2016 and 2018, including insurers facing insolvency and liquidating because of insufficient risk adjustment or risk corridor payments,[23,24] as well as losses resulting from high claims costs relative to premium revenue.[25] In 2017, as insurers were deciding whether and where to offer plans on the Marketplace for 2018, they faced substantial political and policy uncertainty. Insurers had experienced several years of significant losses on the Marketplaces with only hints of financial improvement, political uncertainty as a new administration with a unified government had promised to repeal and replace the Affordable Care Act, and policy uncertainty as direct payments for cost-sharing reduction subsidies were in litigation.[13,26–29] As a result, the percentage of people who lived in US counties with only one or two Marketplace insurers spiked in 2018.

However, insurers' practice of silver loading to compensate for the loss of federal government reimbursement for cost-sharing reduction benefits and the failure of any attempt to legislatively repeal or replace the ACA removed some of this financial and policy unpredictability. Silver loading and the lack of Marketplace competition led to insurers having very low average medical loss ratios and high gross per member per month margins for 2018.[30] High levels of profitability resulting from high average gross premiums and concurrent low net premiums (due to increased subsidies) may have led insurers to enter new markets or reenter markets that they had previously exited.

EXHIBIT 3

Change in the number of insurers offering Affordable Care Act Marketplace insurance policies, by county, 2018–21



SOURCE Authors' analysis of annual county-level data on insurers' Marketplace participation from the Kaiser Family Foundation, 2018–21. **NOTE** The exhibit displays the net change in the number of unique corporate parent companies of insurers (which may have multiple Health Insurance Oversight System identification numbers for different licenses for products such as health maintenance organizations and preferred provider organizations) offering Marketplace plans between 2018 and 2021.

EXHIBIT 4

Characteristics of counties with limited versus increased participation in Affordable Care Act Marketplaces, 2018–21

	Had limited insurer participation in 2021		Gained insurers, 2018–21	
Characteristics	**Yes**	**No**	**Yes**	**No**
COUNTY LEVEL				
Limited insurer participation in 2018 (%)	100.0	36.6**	58.9	39.2**
Monopoly insurer in 2018 (%)	59.9	14.7**	34.0	9.8**
Reduced insurer participation in 2016–18 (%)	86.2	85.8	88.6	80.7**
STATE LEVEL				
Mean medical loss ratio	0.93	0.94**	0.93	0.95**
State-run Marketplace (%)	14.8	35.8**	23.9	43.8**
Medicaid expansion (%)	63.5	66.5	54.9	87.0**
Reinsurance waiver (%)	17.9	16.0	14.6	20.2**
State party control (%)				
Democrat	12.5	22.5**	15.6	28.7**
Republican	50.4	46.9**	56.0	31.5**
Divided	37.1	30.6**	28.4	39.8**

SOURCE Authors' analysis of annual county-level data on insurers' Marketplace participation and state Medicaid expansion status from the Kaiser Family Foundation, state partisan control from the National Conference of State Legislatures, medical loss ratios from the Centers for Medicare and Medicaid Services, and demographics from the Area Health Resources Files, 2018–21. **NOTES** The exhibit shows mean characteristics of counties with and without limited insurer participation (defined as two or fewer participating Marketplace insurers) in 2021 and counties that did and did not have increases in Marketplace insurer participation from 2018 to 2021. Observations from 3,148 counties were weighted by county nonelderly population. $^{**}p < 0.05$

Policy Implications

The ACA Marketplaces still have substantially lower insurer participation in 2021 than during their peak in 2015.[2] Gross premiums have been declining since 2018, partially as a result of increased insurer competition.[6] Increased competition is an unalloyed positive for people who do not receive premium subsidies.[31] However, the ACA's price-linked subsidy system produces a counterintuitive result: Lower gross premiums may result in concomitant reductions in premium spreads between low-cost and benchmark plans on the Marketplace. This could increase the out-of-pocket expenses paid by some subsidized buyers (those with household incomes of 100–400 percent of the federal poverty level), as these spreads determine the magnitude of the federal premium tax credit subsidy.[32] Provisions in the American Rescue Plan Act of 2021 that increased ACA individual-market insurance subsidies may counteract this trend.

Increased insurer participation in ACA Marketplaces may reduce potential cost savings that subsidized consumers could achieve under state public option programs. Lower gross premium levels resulting from increased insurer participation could keep net premiums flat for subsidized Marketplace enrollees or could lead net premiums to increase.[33] Washington State's public option program offered medical providers rates that were similar to commercial rates, at 160 percent of the Medicare fee schedule.[34] The public option has not significantly reduced gross or net premiums for the plans sold on the ACA Marketplaces where there is competition, as private insurer premiums converged to a common level before implementation of the public option.[35]

The American Rescue Plan Act's enhanced subsidies for people with incomes of 100–400 percent of the federal poverty level and the new availability of subsidies for people with incomes greater than 400 percent of poverty will increase the number of ACA individual-market health insurance buyers who are insensitive to gross premium level. These changes may also lead to increases in average enrollment duration and decreases in morbidity in the individual market as the enhanced subsidies increase affordability, and they could lead healthier people to enroll in coverage.[36] Given the Biden administration's support for the ACA Marketplaces, it appears likely that the ACA individual health insurance market will be both stable and profitable for the next several years.[37]

Conclusion

Recent trends of increased ACA Marketplace insurer participation in counties with declining participation from 2016 to 2018 could be interpreted as a response to reduced political, policy, and financial risk. "Repeal and replace" was foreclosed by its political defeat. The ACA's financial structure of price-linked subsidies builds resilience into the program, as this subsidy system guarantees a large customer base that is minimally exposed to changes in premium levels.[38,39] In the next several years political and policy predictability as well as expanded subsidies and increased federally funded advertising and political support in profitable markets could be an attractive environment for insurers to enter new markets and expand their service areas, thus leading to enhanced competition. ■

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NOTES

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BACKGROUNDER
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DOMESTIC POLICY STUDIES

Premiums, Choices, Deductibles, Care Access, and Government Dependence Under the Affordable Care Act: 2021 State-by-State Review

Edmund F. Haislmaier and Abigail Slagle

KEY TAKEAWAYS

Americans deserve more health care options. Obamacare did not help. It increased premiums and deductibles while limiting plans and restricting physician networks.

Not only has Obamacare made insurance more expensive, but it also provides fewer coverage choices and pushed more Americans into government-run health programs.

Some states have reduced premiums through deregulatory actions; Congress should enact further reforms that build on that success.

This year marks 11 years since the passage of the Affordable Care Act (ACA)—also known as Obamacare—and seven years since its key elements took effect. In that time, health insurance premiums spiked, coverage options fell, and more Americans became dependent on government-run health care. This *Backgrounder* examines the changes in these three areas—premiums, choice, and government-run care—and outlines ways that Congress can reverse this trend. (For a summary of changes in all three metrics, see Appendix Table 1.)

Rising Health Insurance Premiums in the Individual Market

Comparing premium changes in the individual market before and after the ACA is a key measure of the law's financial effect on consumers. In 2013, the

national average premium paid in the individual (non-group) market was $244 (per member, per month).[1] In 2019, the national average premium paid in the individual market was $558 (per member, per month). This is a 129 percent increase from 2013 to 2019.[2] Over the same period in the large-employer market, national average premiums paid per member per month grew by only 29 percent (from $363 to $558).[3] This means premiums for individual market coverage under the ACA effectively doubled between 2013 and 2019.

Premium changes varied by state. (See Appendix Table 2.) In nearly every state, consumers on average paid higher premiums under the ACA. In 40 states, the average monthly premium for individual-market coverage more than doubled by 2019—and it more than tripled in five of them (Alabama +244 percent, Nebraska +212 percent, Missouri +202 percent, West Virginia +243 percent, and Wyoming +201 percent). States with the smallest premium increases over this period—New Jersey (+20 percent), New York (+24 percent), Rhode Island (+40 percent), and Vermont (+44 percent)—were ones that had imposed costly regulations on their individual markets before the ACA and consequently already had high average premiums in 2013. Only one state, Massachusetts, saw a decline (–5 percent) in average premiums paid over this period. That was because almost all the ACA's new mandates and regulations, along with a similar set of income-related subsidies, were already in place in the Massachusetts individual market before the ACA took effect. Massachusetts was the state with the highest average monthly premium pre-ACA ($422 in 2013).

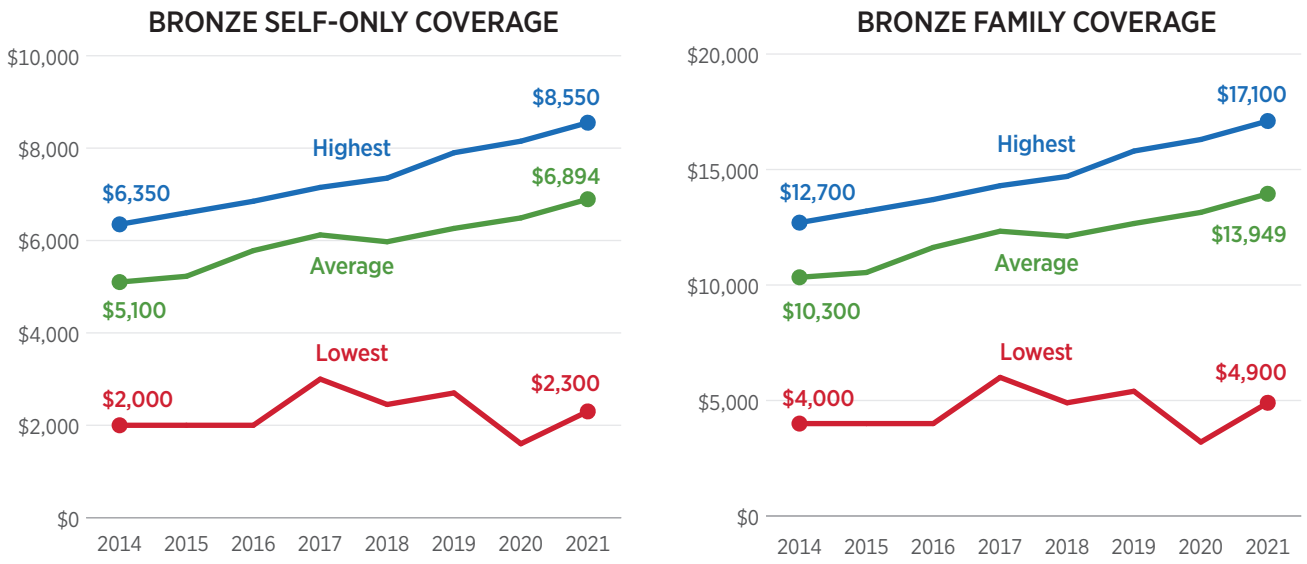
Higher Deductibles

At the same time that premiums more than doubled in the individual market, deductibles for ACA-compliant coverage also significantly increased.[4] Deductibles for bronze-level plans sold on the federal exchange

1. "Average premium paid" is calculated as total premium revenues divided by total member months for a given market or market segment. This measure reflects what consumers actually paid for insurance, as opposed to list prices, which vary by the type of plan, location, and age of the enrollee.
2. Authors' calculations using data from medical loss ratio filings with the Centers for Medicare and Medicaid Services (CMS), "Medical Loss Ratio Data and System Resources," https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html (accessed October 14, 2021). For a more extensive analysis, see Edmund F. Haislmaier and Abigail Slagle, "Obamacare Has Doubled the Cost of Individual Health Insurance," Heritage Foundation *Issue Brief* No. 6068, March 21, 2021, https://www.heritage.org/health-care-reform/report/obamacare-has-doubled-the-cost-individual-health-insurance.
3. Ibid. Because the regulation of large-employer plans was little affected by the ACA, changes in average premiums paid for large-employer, fully insured coverage can be presumed to reflect primarily changes in plan design and medical trend.
4. This *Backgrounder* uses bronze plans, rather than silver plans, as the basis for measuring changes in deductibles. Most subsidized consumers purchase silver plans, which are subject to cost-sharing reductions. Thus, most enrollees in silver plans have real deductibles that are lower than their plans' stated deductibles. Furthermore, few consumers purchase gold or platinum plans. Thus, for measuring changes over time in deductibles, the most relevant level is bronze plans, which are the choice of most of the customers who do not qualify for cost-sharing reductions. They are the plans purchased by the most price-sensitive consumers: those who must pay any additional cost out of their own pockets.

CHART 1

Obamacare Increased Average Deductibles by 35%



NOTES: Data are for bronze plans offered on the exchange in the 36 states that have consistently used the federal exchange platform, healthcare.gov. Bronze plans are the most relevant for measuring changes in deductibles as they are not subject to the cost-sharing reductions that result in most silver plan enrollees having a real deductible that is lower than their plan's stated deductible.
SOURCE: HealthCare.gov, "FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers," https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/ (accessed October 27, 2021).

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increased by more than one-third (35 percent) under the ACA. For self-only coverage, deductibles rose from an average of $5,100 in 2014 to $6,894 in 2021, while the average deductible for family coverage increased from $10,333 in 2014 to $13,949 in 2021.[5] (See Chart 1.)

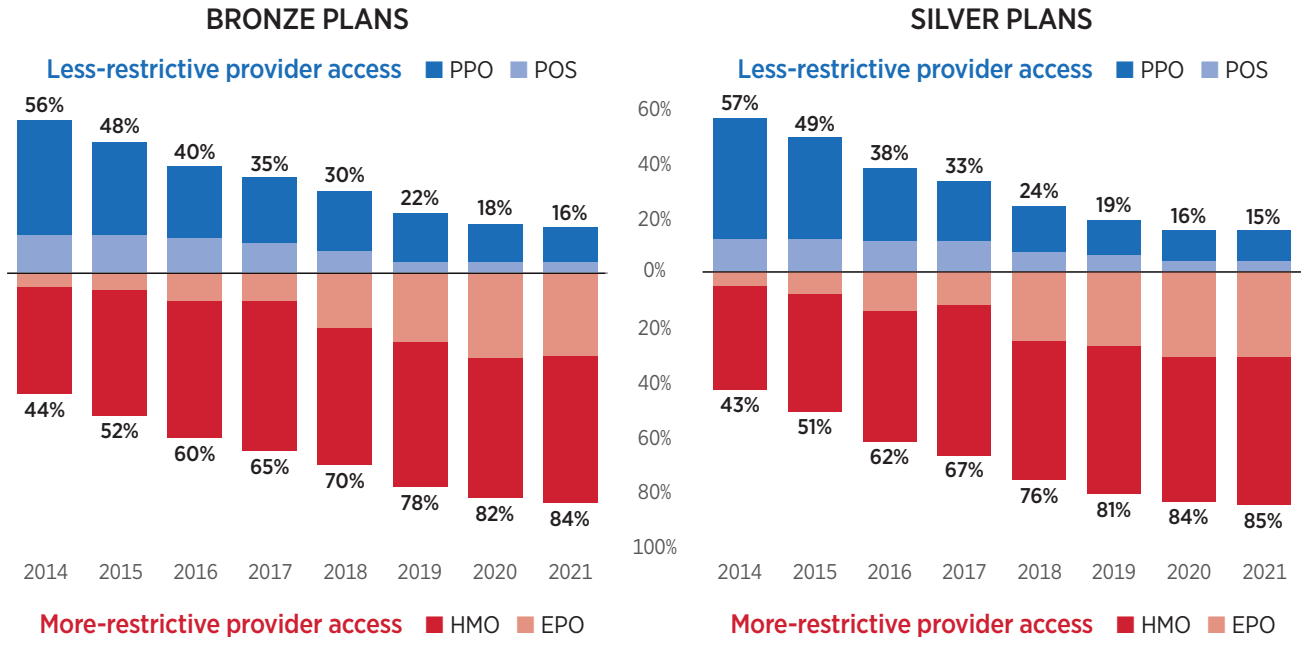
Narrower Networks

While Obamacare enrollees have been paying more in premiums and out-of-pocket costs, their access to medical providers has also been shrinking. During the 2014 plan year, 44 percent of bronze plan offerings had more

5. Authors' calculations based on medical deductibles data for bronze plans offered on the exchange in the 36 states that have consistently used a federally facilitated exchange (healthcare.gov) since 2014. In recent years some carriers have offered bronze plan designs that impose a high deductible for prescription drugs but no medical deductible. We excluded those plan designs from our analysis.

CHART 2

Obamacare Plans Reduced Access to Medical Providers



PPO—Preferred Provider Organization EPO—Exclusive Provider Organization POS—Point of Service HMO—Health Maintenance Organization
NOTES: Authors' calculations from plan design data for plans offered on the exchange in the 36 states that have consistently used the federal exchange platform, healthcare.gov. Ninety percent of exchange enrollments are in either bronze (35%) or silver (55%) plans.
SOURCE: HealthCare.gov, "FFM QHP Landscape Files: Health and Dental Datasets for Researchers and Issuers," https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/ (accessed October 25, 2021).

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restrictive provider networks,[6] but by 2021 that figure has increased to 84 percent. Silver plans experienced the same effect, moving from just 43 percent of the plans having more restrictive networks in 2014 to 85 percent of plan designs in 2021.[7] (See Chart 2.)

6. Provider access varies by plan network designs. The four basic plan designs, ordered from least to most restrictive are Preferred Provider Organization (PPO), Point of Service (POS), Exclusive Provider Organization (EPO), and Health Maintenance Organization (HMO). Under a PPO plan, you pay less if you use providers in the plan's network. For an additional cost you can use a non-network provider and can do so without needing a referral approved by the plan. POS plans are like PPO plans with the exception that for the plan to reimburse treatment by a specialist, you must first get a referral from your primary care doctor. An EPO is a managed care plan that (except in an emergency) reimburses only for the services of those providers in the plan's network. Like an EPO, an HMO is a managed care plan that pays only for treatment by providers who work for or contract with the plan and requires you to get referrals from your primary care doctor for specialists and (non-emergency) hospitalization. Typically, to be eligible for coverage through an HMO, you must also either live or work within its geographic service area.
7. Authors' calculations based on data on plan networks for plans offered on the exchange in the 36 states that have consistently used a federally facilitated exchange (healthcare.gov) since 2014.

Insurers have essentially responded to the higher claims costs resulting from Obamacare's regulations by increasing premiums and enrollee cost sharing while narrowing the networks of providers that their plans will reimburse.

The result: enrollees with Obamacare coverage have been paying more while getting less access to doctors and hospitals.

This is anomalous to both employer-group health insurance plans and the pre-ACA individual market. Prior to Obamacare, insurers generally offered—and customers generally expected—a rough trade-off in plan design to provide customers value for their purchase. Typically, plans with higher out-of-pocket costs offered a broader choice of providers, while plans with limited provider choice offered lower out-of-pocket costs. However, Obamacare has managed to force insurers into offering plans characterized by both limited provider choice and high out-of-pocket costs.

Fewer Choices and Less Competition in the ACA Exchanges

As consumers paid higher premiums and experienced narrower networks, fewer insurers offered plans on the ACA exchanges. Individual insurance markets are about one-third less competitive than they were before the ACA took effect.[8] In 2013, there were 395 insurers offering coverage in the individual market at the state level. By 2018, insurer competition had fallen by more than half (54 percent), with only 181 insurers offering coverage on the Obamacare exchanges, and there were eight states in which only one insurer offered exchange coverage that year. Over the past three years, insurer competition has partially rebounded in response to steps the Trump Administration took to stabilize the market. In 2021, there are 253 insurers offering exchange coverage, though this is still 36 percent fewer than before the implementation of Obamacare.

Appendix Table 3 displays the percentage change in insurer competition in the 2013 individual market and the 2021 ACA exchanges, by state. In 2013, there was no state that had fewer than two insurers offering coverage, and two states (Florida and Texas) had 18 insurers offering coverage. Despite insurers reentering the exchanges in recent years, for 2021 Delaware still has only one insurer offering exchange coverage, and 12 states and the

8. Heritage Foundation calculations based on federal and state information on exchange participation and National Association of Insurance Commissioners data for pre-ACA market participation (accessed through Mark Farrah Associates subscription service). Insurer offerings are counted based on parent companies. Data for 2013 includes only insurers with 1,000 or more covered lives in the applicable state. Figures for 2014 and subsequent years do not include insurers selling exclusively off the exchanges.

District of Columbia still have only two insurers offering exchange coverage. Only five states have more insurers participating in their exchange in 2021 than they had offering coverage in their individual market in 2013.[9]

Greater Dependence on Government Coverage

Not only did the ACA increase the cost of private coverage and reduce its availability; it also significantly expanded government-run coverage through Medicaid. Historically, Medicaid provided health care coverage to the vulnerable poor: children, pregnant women, the elderly, and people with disabilities. The ACA, however, expanded the scope of eligibility to include lower-income able-bodied adults, predominantly those without dependent children. Furthermore, the ACA offered states a much higher level of federal financing for this new population (100 percent in the first three years, eventually declining to 90 percent over subsequent years) than for their existing Medicaid populations.[10]

Between 2013—the last year before the ACA took full effect—and 2019, enrollment in Medicaid and the Children's Health Insurance Program (CHIP) increased by 10 million individuals.[11] Enrollment in those programs jumped by a further 9 million individuals in 2020.

The 2020 sharp increase was largely due to effects of the COVID-19 pandemic. When governments responded to COVID-19 by imposing restrictions on businesses and the public, the resulting adverse economic impacts fell disproportionately on industries that employ more low-wage workers, such as hospitality, personal services, and retail. Consequently, lower-income workers were more likely to suffer economic dislocation and seek assistance from safety-net programs. Also, in March 2020 Congress enacted a temporary increase in federal funding for state Medicaid programs conditioned on states continuing to cover, for the duration of

9. For a more extensive analysis, see Edmund F. Haislmaier and Abigail Slagle, "Obamacare's Health Insurance Exchanges in 2021: Increased Options, but Still Less Than Pre-ACA," Heritage Foundation *Issue Brief* No. 6066, March 16, 2021, https://www.heritage.org/health-care-reform/report/obamacares-health-insurance-exchanges-2021-increased-options-still-less.

10. Originally, the ACA would have compelled states to offer Medicaid to the expansion eligibility group or lose their Medicaid funding. However, after litigation, expansion is optional. See Nina Owcharenko Schaefer, "The Supreme Court's Medicaid Decision: The ACA Mess Just Got Messier," Heritage Foundation *Issue Brief* No. 3663, July 11, 2012, https://www.heritage.org/health-care-reform/report/the-supreme-courts-medicaid-decision-the-obamacare-mess-just-got-messier.

11. Centers for Medicare and Medicaid Services, "Monthly Medicaid and CHIP Application, Eligibility Determination, and Enrollment Reports and Data," https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/index.html (accessed October 14, 2021). For 2013 data, see Laura Snyder et al., "Medicaid Enrollment: December 2013 Data Snapshot," Kaiser Commission on Medicaid and the Uninsured, June 2014, Table A-1, http://files.kff.org/attachment/medicaid-enrollment-snapshot-december-2013-issue-brief-download (accessed October 14, 2021).

the health emergency, all individuals who were already on Medicaid. In December 2013, national Medicaid and CHIP enrollment was 61.1 million. By December 2020, 80.2 million people were enrolled in Medicaid and CHIP—an increase of 31.1 percent from 2013 and of 12 percent from the end of March 2020 (the start of the widespread national COVID-19 response).[12]

Due to the effects of the COVID-19 response, all states and the District of Columbia experienced increased Medicaid enrollment in 2020. (See Appendix Table 4.) While the increases varied by state, Medicaid enrollment surged in both expansion and non-expansion states. For instance, while both California and New York adopted the ACA Medicaid expansion, neither Texas nor Florida have done so. In 2020 Medicaid enrollment jumped in all four states, growing by 903,000 individuals in California; 689,000 in New York; 630,000 in Texas; and 492,000 in Florida.

Health Care Choices: A Plan to Lower Premiums, Increase Choice, and Protect the Vulnerable

The ACA led to higher premiums, fewer choices, and greater government dependence. To reverse these consequences, policymakers need to provide relief from the ACA mandates that contributed to the problem. As a start, the Trump Administration provided new flexibilities to mitigate some of these issues. A critical step included changes to regulations implementing the law's Section 1332 waivers, which allow states to seek waivers from certain federal ACA requirements.[13] The results, thus far, are encouraging.[14]

Seven states had 1332 waivers in effect by 2019, and five additional states were approved to implement waivers in 2020.[15] In the initial seven states,

12. Ibid. For a more extensive discussion see Edmund F. Haislmaier, "COVID-19: Effects of the Response on Health Insurance Coverage in 2020," Heritage Foundation *Issue Brief* No. 6079, May 14, 2021, https://www.heritage.org/public-health/report/covid-19-effects-the-response-health-insurance-coverage-2020.
13. Additionally, the Trump Administration has offered greater flexibility on coverage arrangements including short-term limited-duration plans, association health plans, and health-reimbursement arrangements. Each of these promotes greater choice for consumers. However, some states do not currently allow consumers in the state to benefit from the full range of the new flexibility. For more information, see Doug Badger and Whitney Jones, "Five Steps Policymakers Can Take to Permit the Sale and Renewal of Affordable Alternative to Obamacare Policies," Heritage Foundation *Backgrounder* No. 3310, April 26, 2018, https://www.heritage.org/health-care-reform/report/five-steps-policymakers-can-take-permit-the-sale-and-renewal-affordable; Robert E. Moffit, "Trump's Expansion of Health Reimbursement Accounts Improves Health Care Choices," The Daily Signal, June 14, 2019, https://www.dailysignal.com/2019/06/14/trumps-expansion-of-health-reimbursement-accounts-improves-health-care-choices/; and Robert E. Moffit, "Trump's New Health Initiative Will Spell Relief for Americans," The Daily Signal, June 19, 2018, https://www.dailysignal.com/2018/06/19/trumps-new-health-initiative-will-spell-relief-for-americans/.
14. Doug Badger, "How Health Care Premiums Are Declining in States That Seek Relief from the ACA's Mandates," Heritage Foundation *Issue Brief* No. 4990, August 13, 2019, https://www.heritage.org/health-care-reform/report/how-health-care-premiums-are-declining-states-seek-relief-obamacares.
15. Center for Consumer Information and Insurance Oversight, "Section 1332: State Innovation Waivers," https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers-.html#Section%201332%20State%20Application%20Waiver%20Applications (accessed October 14, 2021).

first-year premium reductions (relative to projected rates) ranged from 6 percent (Oregon) to 43.4 percent (Maryland), with an average reduction of 19.9 percent across the seven states.[16] All five states with waivers taking effect in 2020 projected similar premium reductions.[17]

Given the proven relief that waivers provide from high premiums, policymakers in other states should consider similar waivers.

However, more needs to be done. Congress should build on the Trump Administration's regulatory changes and provide additional relief from the ACA's burdensome and costly regulations.

One such approach, the Health Care Choices Proposal,[18] would do just that. Under the proposal, Congress would eliminate key regulations that led to increased costs and reduced the ability of private companies to offer products people want to buy. It would also change another key aspect of Obamacare that led to higher costs and reduced choices: the current ACA subsidy structure that gives taxpayer dollars to insurance companies and increases those subsidies as insurance companies raise premiums.[19] Instead, states would receive that funding in the form of grants to help the low-income and those with pre-existing conditions access coverage. Finally, unlike Obamacare (which put most subsidized individuals on Medicaid), subsidized individuals would be able to apply their subsidy dollars toward private coverage of their choice.

The Center for Health and Economy estimated that the Health Care Choices Proposal would lower premiums by as much as 24 percent and result in nearly 4 million more people purchasing insurance by 2030, with more people enrolling in private coverage versus public insurance over the same period.[20]

16. Alaska, 2017: –34.7 percent; Minnesota, 2018: –20 percent; Oregon, 2018: –6 percent; Maine, 2019: –9.4 percent; Maryland, 2019: –43.4 percent; New Jersey, 2019: –15.1; and Wisconsin, 2019: –10.6 percent. See Chris Sloan, Neil Rosacker, and Elizabeth Carpenter, "State-Run Reinsurance Programs Reduce ACA Premiums by 19.9% on Average," Avalere, March 13, 2019, https://avalere.com/press-releases/state-run-reinsurance-programs-reduce-aca-premiums-by-19-9-on-average (accessed October 14, 2021).
17. Colorado projected a 16 percent premium reduction, Delaware a 13.7 percent reduction, Montana an 8 percent reduction, North Dakota a 19.8 percent reduction, and Rhode Island a 5.9 percent reduction. See Center for Consumer Information and Insurance Oversight, "Section 1332: State Innovation Waivers." Data on the effects of these waivers on 2020 premium payments will not be available until November or December 2021.
18. For more information, see Health Policy Consensus Group, "Health Care Choices 2020: A Vision for the Future," November 2020, https://www.healthcarechoices2020.org/wp-content/uploads/2020/10/HEALTH-CARE-CHOICES-2020_A-Vision-for-the-Future_FINAL-002-1.pdf (accessed October 14, 2021).
19. Ibid.
20. Center for Health and Economy, "The Health Care Choices Proposal," October 22, 2020, https://www.healthcarechoices2020.org/wp-content/uploads/2020/10/The-Health-Care-Choices-Proposal-Score.pdf (accessed October 14, 2021).

Conclusion

Since taking effect, the ACA more than doubled premiums in the individual market while cutting the number of participating insurers by one-third. It also led insurers to raise plan deductibles and narrow their provider networks while at the same time significantly increasing the number of people dependent on government-run health care. To reverse those trends, Congress should build on promising improvements made possible by the Trump Administration's deregulatory agenda and consider the Health Care Choices Proposal, which would lower costs, increase choices, and protect the vulnerable.

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APPENDIX TABLE 1

Changes in Premiums, Choice, and Government-Run Care Since ACA (Page 1 of 2)

State	Individual Market: Average Monthly Premium Paid 2013–2019	Individual Market: Number of Insurers 2013–2021	Medicaid and CHIP: Enrollment 2013–2020
Alabama	244%	-50%	6%
Alaska	116%	-50%	103%
Arizona	150%	-55%	52%
Arkansas	136%	-57%	42%
California	106%	-8%	30%
Colorado	147%	-43%	72%
Connecticut	117%	-71%	47%
Delaware	198%	-75%	17%
D.C.	78%	-50%	19%
Florida	143%	-56%	14%
Georgia	183%	-45%	21%
Hawaii	104%	0%	26%
Idaho	137%	0%	45%
Illinois	147%	-33%	10%
Indiana	101%	-73%	66%
Iowa	153%	-40%	43%
Kansas	159%	-33%	6%
Kentucky	132%	-67%	80%
Louisiana	125%	-63%	46%
Maine	95%	-25%	12%
Maryland	146%	-63%	37%
Massachusetts	-5%	0%	23%
Michigan	120%	-43%	37%
Minnesota	84%	-17%	34%
Mississippi	149%	-60%	-2%
Missouri	202%	-33%	21%
Montana	157%	50%	88%
Nebraska	212%	-50%	31%
Nevada	137%	0%	112%
New Hampshire	76%	50%	45%
New Jersey	20%	0%	69%
New Mexico	161%	67%	61%
New York	24%	20%	19%
North Carolina	183%	-50%	18%
North Dakota	78%	0%	55%
Ohio	125%	-25%	33%
Oklahoma	198%	-25%	15%
Oregon	144%	-50%	81%
Pennsylvania	151%	-50%	40%

APPENDIX TABLE 1

Changes in Premiums, Choice, and Government-Run Care Since ACA (Page 2 of 2)

State	Individual Market: Average Monthly Premium Paid 2013–2019	Individual Market: Number of Insurers 2013–2021	Medicaid and CHIP: Enrollment 2013–2020
Rhode Island	40%	0%	71%
South Carolina	167%	-56%	34%
South Dakota	123%	-50%	8%
Tennessee	173%	-40%	16%
Texas	136%	-44%	13%
Utah	171%	-44%	22%
Vermont	44%	-33%	19%
Virginia	186%	-20%	71%
Washington	98%	29%	64%
West Virginia	243%	-50%	49%
Wisconsin	151%	-13%	18%
Wyoming	201%	-60%	-10%
U.S.	**129%**	**-36%**	**31%**

SOURCES:

- **Premium data:** Centers for Medicare and Medicaid Services, "Medical Loss Ratio Data and System Resources," https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html (accessed October 22, 2021).
- **Insurer participation data:** Heritage Foundation calculations based on federal and state information on exchange participation, and National Association of Insurance Commissioners data for 2013 market participation, accessed through Mark Farrah Associates, http://www.markfarrah.com (accessed October 22, 2021).
- **Medicaid and CHIP enrollment data:** Centers for Medicare and Medicaid Services, "Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data," https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/index.html (accessed October 22, 2021). Data for 2013 are from Laura Snyder, Robin Rodwitz, Eileen Ellis, and Dennis Roberts, "Medicaid Enrollment: December 2013 Data Snapshot," Kaiser Commission on Medicaid and the Uninsured *Issue Brief*, June 2014, Table A-1, https://www.kff.org/report-section/medicaid-enrollment-snapshot-decem- ber-2013-tables/ (accessed October 22, 2021).

APPENDIX TABLE 2

Average Premiums Paid in the Individual Market, by State (Page 1 of 2)

Dollar figures shown are average premiums paid per member, per month.

State	2013	2014	2015	2016	2017	2018	2019	CHANGE 2013–2019
Alabama	$178	$320	$350	$402	$531	$618	$613	244%
Alaska	$342	$584	$769	$840	$956	$796	$737	116%
Arizona	$214	$299	$289	$318	$517	$549	$534	150%
Arkansas	$185	$311	$336	$354	$363	$424	$437	136%
California	$271	$388	$401	$406	$428	$511	$557	106%
Colorado	$237	$345	$338	$388	$420	$560	$586	147%
Connecticut	$291	$421	$464	$457	$524	$670	$631	117%
Delaware	$272	$404	$439	$486	$554	$744	$811	198%
D.C.	$268	$319	$350	$333	$352	$419	$474	78%
Florida	$237	$351	$386	$391	$429	$554	$577	143%
Georgia	$209	$332	$365	$394	$426	$600	$591	183%
Hawaii	$265	$334	$324	$365	$435	$525	$541	104%
Idaho	$199	$274	$318	$341	$381	$457	$471	137%
Illinois	$247	$356	$357	$386	$492	$601	$609	147%
Indiana	$241	$375	$434	$405	$408	$477	$484	101%
Iowa	$251	$316	$324	$368	$419	$612	$635	153%
Kansas	$234	$311	$312	$350	$434	$564	$606	159%
Kentucky	$231	$345	$337	$351	$370	$493	$537	132%
Louisiana	$250	$358	$388	$436	$514	$599	$562	125%
Maine	$334	$446	$454	$427	$503	$693	$650	95%
Maryland	$209	$273	$318	$336	$396	$559	$514	146%
Massachusetts	$442	$525	$419	$387	$365	$414	$420	-5%
Michigan	$212	$309	$359	$370	$385	$464	$467	120%
Minnesota	$235	$335	$382	$428	$525	$501	$433	84%
Mississippi	$214	$318	$360	$362	$401	$535	$532	149%
Missouri	$197	$300	$332	$377	$431	$579	$595	202%
Montana	$251	$408	$374	$417	$543	$618	$645	157%
Nebraska	$238	$355	$371	$388	$502	$709	$743	212%
Nevada	$205	$297	$357	$367	$369	$489	$485	137%
New Hampshire	$300	$391	$374	$392	$460	$593	$529	76%
New Jersey	$419	$464	$500	$500	$476	$558	$502	20%
New Mexico	$190	$327	$346	$319	$368	$507	$496	161%
New York	$377	$412	$412	$395	$407	$448	$466	24%
North Carolina	$240	$362	$394	$456	$592	$706	$680	183%
North Dakota	$276	$354	$396	$414	$405	$465	$492	78%
Ohio	$222	$324	$358	$380	$385	$461	$500	125%

APPENDIX TABLE 2

Average Premiums Paid in the Individual Market, by State (Page 2 of 2)

State	2013	2014	2015	2016	2017	2018	2019	CHANGE 2013–2019
Oklahoma	$210	$306	$316	$365	$558	$638	$626	198%
Oregon	$220	$395	$366	$366	$437	$504	$537	144%
Pennsylvania	$241	$362	$376	$387	$512	$653	$604	151%
Rhode Island	$325	$406	$376	$381	$371	$433	$456	40%
South Carolina	$232	$341	$367	$399	$483	$599	$620	167%
South Dakota	$246	$324	$335	$369	$437	$521	$548	123%
Tennessee	$213	$288	$307	$361	$493	$684	$581	173%
Texas	$221	$348	$359	$350	$403	$517	$521	136%
Utah	$159	$248	$245	$266	$314	$445	$431	171%
Vermont	$406	$478	$517	$514	$502	$529	$585	44%
Virginia	$229	$310	$333	$370	$395	$623	$655	186%
Washington	$279	$403	$404	$389	$399	$493	$553	98%
West Virginia	$261	$418	$464	$519	$642	$820	$894	243%
Wisconsin	$268	$433	$505	$452	$489	$695	$673	151%
Wyoming	$301	$487	$596	$571	$590	$899	$906	201%
U.S.	**$244**	**$353**	**$374**	**$389**	**$440**	**$550**	**$558**	**129%**

NOTE: Averages are calculated using premium and enrollment data for all individual market plans, which include both ACA-compliant plans and "grandfathered" (pre-ACA) plans.
SOURCE: Centers for Medicare and Medicaid Services, "Medical Loss Ratio Data and System Resources," https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html (accessed October 22, 2021).

APPENDIX TABLE 3

Health Insurers Participating in the Pre-ACA Individual Market vs. the ACA Exchanges (Page 1 of 2)

Shown below are the number of insurer options at the state level.

	PRE-ACA	ACA EXCHANGE								CHANGE
State	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2013–2021**
Alabama	4	2	3	3	1	2	2	2	2	–50%
Alaska	4	2	2	1	1	1	1	2	2	–50%
Arizona	11	8	11	8	2	2	5	5	5	–55%
Arkansas	7	3	3	4	3	3	3	3	3	–57%
California	12	11	10	12	11	11	11	11	11	–8%
Colorado	14	10	10	8	7	7	7	8	8	–43%
Connecticut	7	3	4	4	2	2	2	2	2	–71%
Delaware	4	2	2	2	2	1	1	1	1	–75%
D.C.	4	3	3	2	2	2	2	2	2	–50%
Florida	18	8	10	7	5	4	5	7	8	–56%
Georgia	11	5	9	8	5	4	4	6	6	–45%
Hawaii	2	2	2	2	2	2	2	2	2	0%
Idaho	5	4	5	5	5	4	4	4	5	0%
Illinois	12	5	8	7	5	4	5	5	8	–33%
Indiana	11	4	9	8	4	2	2	2	3	–73%
Iowa	5	4	3	4	4	1	2	2	3	–40%
Kansas	9	3	3	3	3	3	3	3	6	–33%
Kentucky	6	3	5	7	3	2	2	2	2	–67%
Louisiana	8	4	5	4	3	2	2	3	3	–63%
Maine	4	2	3	3	3	2	3	3	3	–25%
Maryland	8	4	5	5	3	2	2	2	3	–63%
Massachusetts	8	9	10	10	9	7	8	8	8	0%
Michigan	14	9	13	11	9	7	8	8	8	–43%
Minnesota	6	5	4	4	4	4	4	4	5	–17%
Mississippi	5	2	3	3	2	1	1	2	2	–60%
Missouri	12	3	6	6	4	3	4	7	8	–33%
Montana	2	3	4	3	3	3	3	3	3	50%
Nebraska	4	4	3	4	2	1	1	2	2	–50%
Nevada	5	4	5	3	3	2	2	3	5	0%
New Hampshire	2	1	5	5	4	3	3	3	3	50%
New Jersey	3	3	5	5	2	3	3	3	3	0%
New Mexico	3	5	5	4	4	4	4	4	5	67%
New York	10	16	16	15	14	12	12	12	12	20%
North Carolina	12	2	3	3	2	2	3	4	6	–50%
North Dakota	3	3	3	3	3	2	3	3	3	0%
Ohio	12	11	15	14	10	8	9	9	9	–25%

APPENDIX TABLE 3

Health Insurers Participating in the Pre-ACA Individual Market vs. the ACA Exchanges (Page 2 of 2)

	PRE-ACA	ACA EXCHANGE								CHANGE
State	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2013–2021**
Oklahoma	8	4	4	2	1	1	2	3	6	–25%
Oregon	10	11	10	9	6	5	5	5	5	–50%
Pennsylvania	14	7	9	7	5	5	6	7	7	–50%
Rhode Island	2	2	3	3	2	2	2	2	2	0%
South Carolina	9	3	4	3	1	1	2	4	4	–56%
South Dakota	4	3	3	2	2	2	2	2	2	–50%
Tennessee	10	4	5	4	3	3	5	5	6	–40%
Texas	18	11	14	16	10	8	8	8	10	–44%
Utah	9	6	6	4	3	2	3	5	5	–44%
Vermont	3	2	2	2	2	2	2	2	2	–33%
Virginia	10	5	6	7	8	6	7	8	8	–20%
Washington	7	7	9	10	7	5	5	7	9	29%
West Virginia	4	1	1	2	2	2	2	2	2	–50%
Wisconsin	15	13	15	16	14	11	12	12	13	–13%
Wyoming	5	2	2	1	1	1	1	1	2	–60%
U.S.	**395**	**253**	**308**	**288**	**218**	**181**	**202**	**225**	**253**	**–36%**

NOTES: Insurer participation is counted at the parent company level. Figures for 2013 are for insurers with 1,000 or more covered lives in the applicable state. Figures for 2014 through 2021 are for exchange-participating insurers and do not include any insurers selling policies exclusively on the exchanges.
SOURCES: Heritage Foundation calculations based on federal and state information on exchange participation, and National Association of Insurance Com-missioners data for 2013 market participation, accessed through Mark Farrah Associates, http://www.markfarrah.com (accessed October 22, 2021).

APPENDIX TABLE 4

December Medicaid and CHIP Enrollment by State (Page 1 of 2)

State	2013	2014	2015	2016	2017	2018	2019	2020	CHANGE in 2020	CHANGE 2013–2020
Alabama	941,815	876,485	888,024	892,753	899,576	911,983	921,100	1,001,444	8.7%	6.3%
Alaska	117,933	127,888	137,868	176,799	200,369	211,912	223,065	239,981	7.6%	103.5%
Arizona	1,288,495	1,496,616	1,681,587	1,739,041	1,716,236	1,700,470	1,708,073	1,963,007	14.9%	52.3%
Arkansas	630,196	824,682	839,277	948,181	913,552	850,695	811,360	892,423	10.0%	41.6%
California	9,590,645	11,919,314	12,166,109	12,405,352	12,220,546	11,927,676	11,588,323	12,491,149	7.8%	30.2%
Colorado	862,549	1,183,251	1,324,115	1,387,165	1,357,645	1,305,951	1,286,739	1,484,080	15.3%	72.1%
Connecticut	631,274	760,584	746,047	761,310	836,906	855,943	850,657	927,770	9.1%	47.0%
Delaware	217,801	235,047	241,704	241,664	247,948	248,964	230,983	254,739	10.3%	17.0%
D.C.	220,556	256,282	263,296	264,849	264,016	259,243	253,546	262,327	3.5%	18.9%
Florida	3,603,561	3,373,853	3,576,023	4,337,514	4,297,880	3,703,423	3,613,005	4,104,699	13.6%	13.9%
Georgia	1,736,905	1,749,519	1,782,498	1,755,450	1,812,561	1,821,852	1,816,358	2,093,853	15.3%	20.6%
Hawaii	306,542	308,567	339,044	345,975	346,747	331,075	326,337	385,887	18.2%	25.9%
Idaho	258,950	287,585	282,440	299,841	297,688	280,570	267,602	376,688	40.8%	45.5%
Illinois	2,934,163	3,126,814	3,134,109	3,065,331	3,062,268	2,860,188	2,812,371	3,238,003	15.1%	10.4%
Indiana	1,073,116	1,216,683	1,437,538	1,508,219	1,478,130	1,450,933	1,485,826	1,779,627	19.8%	65.8%
Iowa	525,340	572,104	608,837	622,071	668,047	691,918	679,651	750,018	10.4%	42.8%
Kansas	405,965	400,885	407,388	408,885	389,441	389,535	376,289	429,274	14.1%	5.7%
Kentucky	847,848	1,073,384	1,179,314	1,230,475	1,272,976	1,222,239	1,288,288	1,529,906	18.8%	80.4%
Louisiana	1,176,564	1,044,151	1,077,109	1,415,385	1,455,541	1,577,428	1,468,338	1,718,400	17.0%	46.1%
Maine	279,318	287,807	279,000	269,428	263,741	256,900	264,424	312,227	18.1%	11.8%
Maryland	1,063,575	1,143,810	1,162,313	1,281,890	1,323,306	1,316,115	1,328,704	1,461,878	10.0%	37.4%
Massachusetts	1,396,037	1,586,233	1,676,400	1,655,529	1,683,846	1,598,878	1,567,780	1,720,365	9.7%	23.2%
Michigan	1,939,665	2,253,958	2,311,459	2,330,154	2,366,223	2,333,409	2,320,304	2,650,886	14.2%	36.7%
Minnesota	874,883	1,213,607	1,070,731	1,049,566	1,082,484	1,069,346	1,044,160	1,173,856	12.4%	34.2%
Mississippi	695,324	714,084	693,365	684,094	674,933	620,567	616,093	680,078	10.4%	–2.2%
Missouri	845,600	855,487	948,576	976,256	957,642	888,597	847,982	1,022,258	20.6%	20.9%
Montana	148,107	167,328	185,716	245,360	274,234	279,675	260,710	279,013	7.0%	88.4%
Nebraska	233,321	240,058	237,979	243,657	245,863	247,510	247,737	304,573	22.9%	30.5%
Nevada	352,589	548,377	596,516	623,574	638,420	636,208	626,078	749,040	19.6%	112.4%
New Hampshire	147,932	167,330	189,687	191,363	189,811	184,476	181,753	213,815	17.6%	44.5%
New Jersey	1,129,849	1,672,822	1,737,333	1,795,251	1,780,672	1,738,183	1,706,298	1,905,205	11.7%	68.6%
New Mexico	508,825	687,942	738,231	775,020	743,780	728,327	743,312	818,279	10.1%	60.8%
New York	5,626,023	6,300,006	6,620,649	6,420,227	6,477,870	6,523,404	5,997,950	6,686,686	11.5%	18.9%
North Carolina	1,699,903	1,821,459	2,000,804	2,083,547	2,101,517	1,763,338	1,772,156	2,012,555	13.6%	18.4%
North Dakota	69,365	86,120	89,240	94,681	93,983	91,072	89,370	107,199	19.9%	54.5%
Ohio	2,227,864	2,900,815	2,932,001	2,910,351	2,845,785	2,651,092	2,609,614	2,955,796	13.3%	32.7%

APPENDIX TABLE 4

December Medicaid and CHIP Enrollment by State (Page 2 of 2)

State	2013	2014	2015	2016	2017	2018	2019	2020	CHANGE in 2020	CHANGE 2013–2020
Oklahoma	753,233	799,478	781,927	804,355	780,488	728,153	713,247	863,285	21.0%	14.6%
Oregon	635,112	1,036,190	1,044,686	986,111	976,182	979,447	996,363	1,150,385	15.5%	81.1%
Pennsylvania	2,322,189	2,403,656	2,769,810	2,918,260	2,986,599	2,949,567	2,938,411	3,261,323	11.0%	40.4%
Rhode Island	189,977	263,426	280,350	298,148	312,705	311,254	292,050	325,713	11.5%	71.4%
South Carolina	844,564	995,296	936,141	996,551	1,009,409	1,044,270	1,044,183	1,129,165	8.1%	33.7%
South Dakota	113,463	116,878	118,295	119,956	118,085	110,749	108,795	122,896	13.0%	8.3%
Tennessee	1,356,284	1,425,497	1,564,417	1,636,770	1,548,572	1,396,302	1,452,381	1,575,722	8.5%	16.2%
Texas	4,256,160	4,704,853	4,727,969	4,799,893	4,474,461	4,308,644	4,180,368	4,810,748	15.1%	13.0%
Utah	318,885	298,773	311,057	311,117	302,585	288,403	309,812	390,385	26.0%	22.4%
Vermont	145,219	177,819	191,415	169,092	163,649	160,114	151,190	172,171	13.9%	18.6%
Virginia	957,110	958,583	955,868	993,220	1,028,297	1,053,309	1,414,239	1,639,534	15.9%	71.3%
Washington	1,164,459	1,644,648	1,779,640	1,818,225	1,782,832	1,739,111	1,728,648	1,908,464	10.4%	63.9%
West Virginia	375,057	522,491	548,380	567,064	549,678	520,656	507,398	560,146	10.4%	49.3%
Wisconsin	1,037,425	1,034,899	1,044,478	1,037,863	1,034,480	1,020,034	1,046,309	1,219,693	16.6%	17.6%
Wyoming	71,977	71,535	64,508	61,925	60,042	58,118	55,974	64,559	15.3%	–10.3%
U.S.	**61,149,512**	**69,934,959**	**72,701,268**	**74,954,758**	**74,610,247**	**72,197,226**	**71,171,704**	**80,171,173**	**12.6%**	**31.1%**

NOTES: Figures are counts of the unduplicated number of individuals enrolled in Medicaid or CHIP as of the last day of the reporting period, including those with retroactive, conditional, or presumptive eligibility. For 2014 and subsequent years, figures are for only those individuals eligible for comprehensive benefits.

SOURCES: Centers for Medicare and Medicaid Services, "Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data," https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/index.html (accessed October 22, 2021). Data for 2013 are from Laura Snyder, Robin Rodwitz, Eileen Ellis, and Dennis Roberts, "Medicaid Enrollment: December 2013 Data Snapshot," Kaiser Commission on Medicaid and the Uninsured *Issue Brief*, June 2014, Table A-1, https://www.kff.org/report-section/medicaid-enrollment-snapshot-december-2013-tables/ (accessed October 22, 2021).

By Paul D. Jacobs and Steven C. Hill

ACA Marketplaces Became Less Affordable Over Time For Many Middle-Class Families, Especially The Near-Elderly

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ABSTRACT **The Affordable Care Act provides tax credits for Marketplace insurance, but before 2021, families with incomes above four times the federal poverty level did not qualify for tax credits and could face substantial financial burdens when purchasing coverage. As a measure of affordability, we calculated potential Marketplace premiums as a percentage of family income among families with incomes of 401–600 percent of poverty. In 2015 half of this middle-class population would have paid at least 7.7 percent of their income for the lowest-cost bronze plan; in 2019 they would have paid at least 11.3 percent of their income. By 2019 half of the near-elderly ages 55–64 would have paid at least 18.9 percent of their income for the lowest-cost bronze plan in their area. The American Rescue Plan Act temporarily expanded tax credit eligibility for 2021 and 2022, but our results suggest that families with incomes of 401–600 percent of poverty will again face substantial financial burdens after the temporary subsidies expire.**

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Individual private insurance purchased outside of employer or group plans has been at the center of market-based efforts to increase insurance coverage in the US, and the affordability of these plans is key to the success of those strategies. The high and rising cost of health care relative to slower growth in income poses a critical obstacle for families attempting to purchase private coverage. In 2019, 73.7 percent of nonelderly uninsured adults reported that at least part of the reason they were uninsured was because coverage was not affordable.[1] To address this issue, the Affordable Care Act (ACA) sought to increase coverage by providing tax credits to purchase individual coverage through regulated Marketplaces.

Before implementation of the American Rescue Plan Act of 2021, those with incomes greater than four times the federal poverty level did not qualify for tax credits and could face substantial financial burdens when purchasing coverage. The American Rescue Plan Act temporarily eliminated this eligibility restriction for 2021 and 2022 and, for families with incomes above 400 percent of poverty, established tax credits that cap the premium of the second-lowest-cost silver plan in an area at 8.5 percent of a family's income. Starting in 2023, however, families with incomes above 400 percent of poverty will again lack access to tax credits. In this article we estimate measures of affordability that illustrate the burdens that families with incomes above 400 percent of poverty would face after the expiration of the American Rescue Plan Act tax credits.

Middle-class families are among those affected by lack of subsidies before 2021 and after 2022. Families with incomes just above the threshold for obtaining subsidies are more likely to find coverage unaffordable, so we focus on those with incomes of 401–600 percent of poverty who either had nongroup coverage or were uninsured. In 2019 this group contained 4.4 million people, roughly half of whom were uninsured (see online

appendix exhibit 2).[2] Although our sample included only about 7 percent of the total uninsured population in the US in 2019,[3] this population constituted 88 percent of the people likely to benefit from eliminating the cap on income for premium tax credits.[4] Families of four with annual incomes of $106,000–$159,000 in 2021 were in this group, as were two-person families with incomes of $69,680–$104,520 and single adults with incomes of $51,520–$77,280.[5] These families are part of the middle class,[6] which faced many challenges even before the COVID-19 pandemic.[7]

The median family income of our middle-class study population rose 3.5 percent from 2015 to 2019, whereas the median premiums of the lowest-cost Marketplace plans rose between 49.7 percent and 59.3 percent, depending on the metal tier level, during the same period (appendix exhibit 3).[2] The slower growth of income compared with premiums suggests that affordability worsened during those years. Marketplace premiums increased for a variety of reasons. First, the number of issuers offering plans decreased from 2015 to 2018,[8] and the reduced competition was associated with rising premiums.[9,10] Second, any underbidding of premiums in the earlier years may have been replaced with premiums being set to yield a short-term profit, subject to the applicable limits of the medical loss ratio regulations.[11] Third, the federal reinsurance and risk corridor programs, which reduced issuers' risk, ended. Fourth, when the federal government ceased subsidizing cost-sharing reductions for lower-income families with silver plans, plan issuers built those costs into their premiums. This resulted in greater premium affordability for families eligible for tax credits[10,12] and adversely affected those with higher incomes.[4,13]

Our study is novel in several ways. First, we assessed affordability by comparing premiums with family income,[14,15] whereas most other studies have reported rising premiums.[8,10,13,16] Second, we provide nationally representative estimates of affordability across families in all states. We used plan data for both federally facilitated and state-based Marketplaces. Other studies have been limited to the federally facilitated Marketplace[8,14,16] or the federally facilitated Marketplace and California.[10] Third, we accounted for detailed geographic differences in plan offerings, including differences in plan service areas at the five-digit ZIP code level, and we linked these data to data from the federal household survey with the largest sample size to improve the precision of our estimates for the sample population. Fourth, across 2015–19 we focused on middle-class families that were previously ineligible for tax credits. Fifth, unlike some earlier work in this area,[10,13,14] we present a measure of affordability that highlights the potential impact of medical cost sharing on family finances.

Study Data And Methods

DATA To obtain a nationally representative sample of families, we used data from the American Community Survey (ACS), conducted by the Census Bureau for the period 2015–19. Modified adjusted gross income was simulated using detailed information about family structure, amounts and sources of income, and the final regulations from the Internal Revenue Service.[17] Therefore, our analysis focused on family units comprising taxpayers and their dependents, as defined under the tax code.

Premium and deductible amounts came from Centers for Medicare and Medicaid Services (CMS) data files. Additional details on the source of CMS data for each year are in appendix part 1.[2] Marketplace plan data were matched to ACS families, using a crosswalk between the geographic identifiers available in the ACS and the areas within each state where plan availability and Marketplace premiums varied (appendix part 2).[2] After linking, plan premiums were assigned on the basis of the appropriate premium for the age of the ACS sample member in the forty-eight states and Washington, D.C., that allowed premiums to vary by age. Family premiums then were calculated among eligible members of each tax filing unit in the ACS using federal or state Marketplace rules for setting family premiums. (Below we use the term *family premium* for all tax filing units regardless of size, including those with only one eligible member.) Because the ACS does not collect information about tobacco use, we calculated premiums as if no adults in the family used tobacco.

SAMPLE We studied nonelderly people in the market for private, nongroup insurance, including both those with nongroup insurance and those without any insurance, in families with incomes exceeding 400 percent of the federal poverty level. We focused on families with incomes of 401–600 percent of poverty, who are typically considered part of the middle class.[3,18] Because self-employed people could deduct nongroup premiums from their income before the introduction of the American Rescue Plan Act tax credits, we excluded people (and their dependents) who reported that they were self-employed and whose annual self-employed earnings were more than $3,000. In 2019 our final sample represented 4.4 million people, or 8.4 percent of the total population with incomes of 401–600 percent of poverty (appendix exhibit 2).[2] The sam-

The pronounced increases in burdens from 2015 to 2019 were a result of premium growth exceeding income growth.

ple sizes for people with incomes of 401–600 percent of poverty ranged from 39,086 to 41,424 per year. The sample sizes for people with incomes above 600 percent of poverty ranged from 37,172 to 39,888 per year.

AFFORDABILITY To assess the impact of potential premiums on each family, we computed family premiums as a percentage of family income. We computed these measures for bronze, silver, and gold levels of coverage. We focused primarily on burdens for bronze plans because they have the lowest premiums. In most states silver plan premiums were affected when the federal government ceased subsidizing cost-sharing reductions. To save money, people ineligible for ACA premium credits may have chosen to purchase off-Marketplace silver plans that did not include these costs, but data on off-Marketplace plans were not consistently available.

We present median percentages as the key measure of financial burden. In a sensitivity analysis that accounted for potential skewness in the distributions of income and premiums, we defined high financial burdens using three different thresholds for the premiums for the lowest-cost plan as a percentage of family income: 8.5, 10, and 20 percent. The American Rescue Plan Act sets tax credits for families with incomes above 400 percent of poverty so that they would pay 8.5 percent of income for out-of-pocket premiums for the second-lowest-cost silver plan in their area. The previous literature used 10 percent and 20 percent thresholds,[15,19–21] representing spending that is likely to be financially burdensome.

In a second sensitivity analysis, we added the deductible and premium to find the lowest-cost plan. Deductibles are a critical component of the perceived and actual financial burdens that people face when obtaining care. Our measure illustrates some of the risk for potential out-of-pocket spending for health care goods and services, although we did not measure families' actual out-of-pocket expenses.

In a third sensitivity analysis, we examined the affordability of the twenty-fifth-percentile plan, to highlight the affordability of alternative choices.

To provide additional context, we retrieved average spending in 2019 for other, nonhealth categories of goods and services among families with incomes of roughly 401–600 percent of poverty from Bureau of Labor Statistics data.[22] We calculated comparable estimates by dividing average spending for each category by average pretax income within each income group.

STATISTICAL METHODS Estimates were population weighted. Statistical tests accounted for the complex design of the ACS but not variation associated with the methods used to calculate financial burdens. Tests comparing medians used balanced repeated replication methods.

LIMITATIONS There were several limitations to this study. First, we did not use off-Marketplace plans in the analysis because available data on these plans, especially their service areas, are incomplete. In 2018, among silver plans, the lowest-cost off-Marketplace plans tended to have somewhat lower premiums than the lowest-cost on-Marketplace plans.[23]

Second, our measures of financial burden did not account for the higher premiums that tobacco users would face. Accounting for tobacco use surcharges would increase estimates of the population facing high burdens.[14,21]

Third, we did not have confidential ACS data with exact geographic location. Instead, the financial burden for each family was estimated as a weighted average across the Marketplace service or rating areas within the family's Public Use Microdata Area, using population totals for each area as the weights.

Fourth, ACS respondents reported insurance status and types of insurance with error.[24,25] However, the ACS appears to measure nongroup coverage more accurately than the widely used Current Population Survey.[24] Moreover, our higher-income study population is unlikely to misreport public plans with premiums as nongroup coverage.[25]

Fifth, the ACS collected insurance status at a point in time and income over the past year, and we assumed that each family's insurance status and income would be constant throughout the year.

Study Results

MEDIAN BURDENS OF LOWEST-COST PLANS The financial burden of the lowest-cost plans for peo-

ple who had family incomes of 401–600 percent of poverty and who had nongroup coverage or were uninsured during the period 2015–19 differed considerably by plan metal level and over time (exhibit 1). In 2019 the median financial burden of the lowest-cost bronze plan was 11.3 percent of income compared with 14.9 percent for the lowest-cost silver plan (a difference of 3.6 percentage points; $p < 0.001$) and 17.4 percent for the lowest-cost gold plan ($p < 0.001$). Financial burdens increased significantly ($p < 0.001$) from 2015 to 2019 for each metal level. For example, the median financial burden of the lowest-cost bronze plan increased from 7.7 percent in 2015 to 11.3 percent in 2019 ($p < 0.001$). In some instances, the relative financial burden of plans with different metal levels also changed over time. For example, the difference between the median financial burden of the lowest-cost bronze plan compared with the lowest-cost silver plan increased from 2.0 percentage points in 2017 to 3.9 percentage points in 2018 ($p < 0.001$).

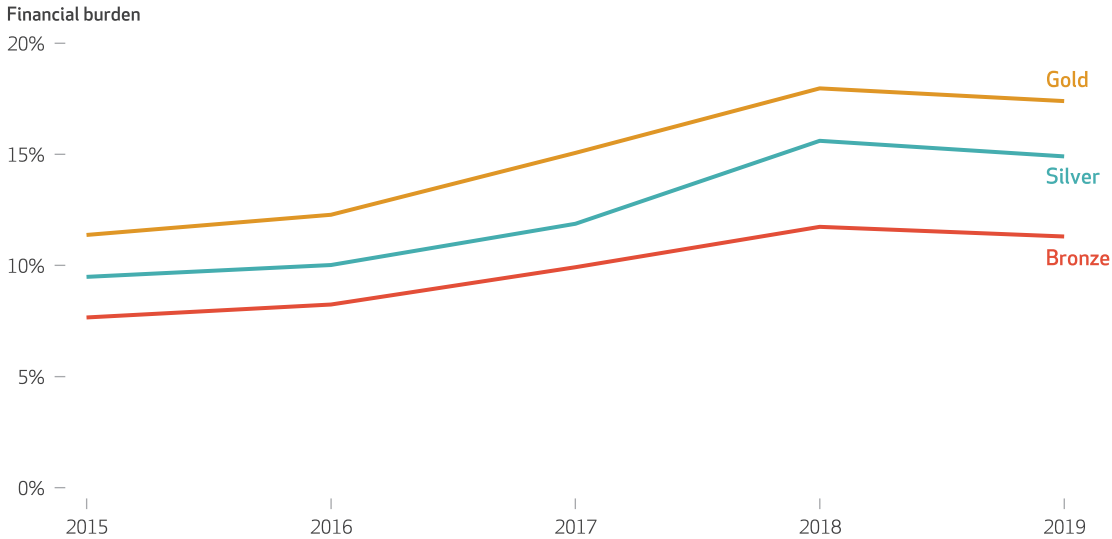
The increases in financial burden were primarily attributable to increases in premiums that outpaced increases in income (appendix exhibit 3).[2] Although median family income for those with incomes of 401–600 percent of poverty increased only 3.5 percent from 2015 to 2019, the lowest available premiums increased between 49.7 percent and 59.3 percent, depending on the metal level. Furthermore, there were no meaningful changes in the age or family composition of our study population during this period.

Because financial burdens are defined as premiums as a proportion of family income, financial burdens differed considerably by the family's income relative to the poverty level (exhibit 2). The median financial burden of the lowest-cost bronze plan was 12.0 percent in 2019 for families with incomes of 401–500 percent of poverty. That median burden was higher than for families with incomes of 501–600 percent of poverty (10.3 percent; $p < 0.001$) and for families with incomes above 600 percent of poverty (6.0 percent; $p < 0.001$).

Exhibit 3 shows how potential financial burdens differed by age and geography. In 2019 the median financial burden of the lowest-cost bronze family plan was 10.4 percent of income for people up to age 20, 8.8 percent for people ages 21–44, 13.3 percent for people ages 45–54, and 18.9 percent for near-elderly people ages 55–64. Because insurers in forty-eight states and Washington, D.C., are allowed, within limits, to vary their premiums by age, median financial burdens tended to increase with age. The higher median financial burden for people up to age 20

EXHIBIT 1

Financial burdens of the Marketplace plan with the lowest premium among people in families with incomes of 401–600 percent of the federal poverty level, by plan metal level, 2015–19



SOURCE Authors' analysis of data for 2015–19 from the American Community Survey and plan data for 2015–19 from the Centers for Medicare and Medicaid Services. **NOTES** Financial burden is defined as the median percentage of family income needed to purchase the Marketplace plan with the lowest family premium for people who do not use tobacco. The sample comprised people age 64 or younger with nongroup coverage or without any coverage, excluding people and the dependents of people who reported that they were self-employed and whose annual self-employed earnings were more than $3,000. $p < 0.001$ for the burden in 2019 compared to 2015 within each metal level, for the burden of the bronze compared to the other metal levels, and for the difference in burden between the lowest-cost silver plan and the lowest-cost bronze plan in 2018 compared to the same difference in 2017.

than for those ages 21–44 reflected the burden of family premiums, which include both eligible adults and children. Although adults may have lived without children or by themselves, people up to age 20 nearly always had at least one adult parent or caretaker in the family unit. The median financial burden of the lowest-cost bronze plan in 2019 was higher for people in nonmetropolitan areas (14.0 percent) compared with people in metropolitan areas (11.0 percent; $p < 0.001$) (exhibit 3).

FINANCIAL BURDENS OF OTHER PLANS Exhibit 4 provides several alternative ways of understanding the financial burden of Marketplace plans. Specifically, instead of choosing the lowest-cost plan in an area, people might wish to purchase higher-cost plans because these plans have more generous benefits or wider provider networks. Although the lowest-cost bronze plan's premium was 11.3 percent of income at the median in 2019, purchasing the bronze plan with a premium at the twenty-fifth percentile would have cost 12.4 percent of income at the median in 2019. Because out-of-pocket spending for the purchase of medical goods and services may also represent considerable shares of family income not captured in the financial burdens of premiums, exhibit 4 shows financial burdens defined by the plan with the lowest combined premium plus deductible. Whereas the premium of the lowest-cost bronze plan would have cost 11.3 percent of family income at the median in 2019, the plan with the lowest premium and deductible would have a combined cost, including both the premium and the deductible, of 26.6 percent of family income at the median.

HIGH FINANCIAL BURDENS Exhibit 4 shows the percentages of people who had nongroup coverage or were uninsured and who had incomes of 401–600 percent of poverty with financial burdens exceeding various thresholds. The premium of the lowest-cost bronze plan in 2019 would have been at least 8.5 percent of income for 68.1 percent of families. Likewise, the premium of the lowest-cost silver plan would have been at least that threshold for 82.0 percent of families, and the lowest-cost gold plan would have been at least that threshold for 85.8 percent of families. The lowest-cost bronze plan would have imposed a burden of at least 10 percent of income for 58.1 percent of our middle-class population sample and a burden of at least 20 percent of income for 14.9 percent of that sample.

The extent of high financial burdens for Marketplace premiums also increased substantially over time. Whereas 41.9 percent of families in our sample faced a burden of at least 8.5 percent of income for the lowest-cost bronze plan in 2015, by 2019, 68.1 percent would have faced such a burden. Likewise, in 2015 only 2.7 percent of families would have paid at least 20 percent of their income for the lowest-cost bronze plan, but by 2019 this had increased to 14.9 percent.

EXHIBIT 2

Financial burdens of the Marketplace plan with the lowest premium among people in families with incomes above 400 percent of the federal poverty level, by income group and plan metal level, 2015–19

	Median percent of family income				
Income groups and metal levels	**2015**	**2016**	**2017**	**2018**	**2019**
401%–500% of poverty					
Bronze	8.2	9.0	10.6	12.5	12.0
Silver	10.2	10.9	12.7	16.6	15.8
Gold	12.2	13.3	16.1	19.1	18.4
501%–600% of poverty					
Bronze	6.8	7.3	8.7	10.4	10.3
Silver	8.5	8.8	10.6	13.9	13.6
Gold	10.2	10.8	13.3	16.0	15.8
>600% of poverty					
Bronze	4.3	4.5	5.4	6.3	6.0
Silver	5.3	5.5	6.5	8.4	8.0
Gold	6.4	6.8	8.2	9.7	9.3

SOURCE Authors' analysis of data for 2015–19 from the American Community Survey and plan data for 2015–19 from the Centers for Medicare and Medicaid Services. **NOTES** Financial burden and sample descriptions are in the notes to exhibit 1. $p < 0.001$ for burden of the lowest income group (401%–500% of poverty) relative to the other income levels in each year and for each metal level, and for 2019 versus 2015 for each income group and each metal level.

COMPARISON WITH OTHER TYPES OF SPENDING To provide additional context for our estimates of Marketplace burdens, we compared median potential spending on health insurance to the percentages of income that households spend, on average, for other types of goods and services. Bureau of Labor Statistics[22] data from 2019 show that households with incomes roughly equivalent to our sample with incomes of 401–600 percent of poverty spent an average of 21.5–30.8 percent of income on housing, 12.4–17.5 percent on transportation, and 8.8–12.4 percent on food (appendix exhibit 1).[2] By comparison, we estimated that the median burden of the lowest-cost bronze plan would be 11.3 percent of income, that of the lowest-cost silver plan would be 14.9 percent of income, and that of the lowest-cost gold plan would be 17.4 percent of income. Thus, our estimates of the median potential financial burdens of bronze plans for 2019 suggest that families could expect to pay more for their Marketplace coverage than for each category of household spending except housing and transportation, and an amount roughly comparable to the average percentage spent on food.

Discussion

Our estimates show a striking pattern of increased premiums relative to income since

EXHIBIT 3

Financial burdens of the Marketplace plan with the lowest premium among people in families with incomes of 401–600 percent of the federal poverty level, by plan metal level, age, and metropolitan area, 2015–19

Characteristics and metal levels	Median percent of family income				
	2015	2016	2017	2018	2019
AGE, YEARS					
Bronze					
0–20	6.9	7.4	8.8	11.0	10.4
21–44	6.0	6.5	7.8	9.0	8.8
45–54	9.0	9.6	11.5	13.8	13.3
55–64	12.2	13.3	16.2	19.1	18.9
Silver					
0–20	8.5	8.9	10.6	14.6	13.6
21–44	7.5	7.9	9.3	11.9	11.6
45–54	11.2	11.6	13.8	18.4	17.7
55–64	15.2	16.1	19.3	25.8	25.0
Gold					
0–20	10.2	10.9	13.1	16.7	16.1
21–44	8.9	9.7	11.7	13.7	13.4
45–54	13.4	14.2	17.5	21.0	20.5
55–64	18.2	19.8	24.8	29.4	28.6
METROPOLITAN AREA STATUS					
Bronze					
Nonmetropolitan area	8.6	9.9	12.7	15.1	14.0
Metropolitan area	7.5	8.0	9.6	11.3	11.0
Silver					
Nonmetropolitan area	10.7	12.1	15.2	20.1	18.6
Metropolitan area	9.3	9.8	11.5	15.0	14.5
Gold					
Nonmetropolitan area	12.9	14.8	18.7	22.6	20.7
Metropolitan area	11.2	12.0	14.7	17.4	17.0

SOURCE Authors' analysis of data for 2015–19 from the American Community Survey (ACS) and plan data for 2015–19 from the Centers for Medicare and Medicaid Services. **NOTES** Financial burden and sample descriptions are in the notes to exhibit 1. ACS sample members were defined as living in a metropolitan area if the majority of the resident population living in the Public Use Microdata Area was living in a metropolitan area. $p < 0.001$ for the following comparisons: burden for people ages 55–64 relative to each of the other age groups in each year and for each metal level, people residing in metropolitan areas relative to people in nonmetropolitan areas in each year and for each metal level, and 2019 relative to 2015 within each metal level for each characteristic and metal level.

2015. Even when we considered the cheapest available plan (the lowest-cost bronze plan), the median premium for families with incomes of 401–600 percent of poverty increased from 7.7 percent of income in 2015 to 11.3 percent in 2019. Our nationally representative estimates of increased potential burdens during the 2015–19 period broadens understanding of the trend previously documented for adults with incomes of 401 percent of poverty[14] by covering a wider range of incomes; by including the full cost of family premiums for eligible family members; by accounting for family variation in income; and by excluding the self-employed, who can receive an alternative subsidy through the tax code.

For near-elderly people ages 55–64 with incomes of 401–600 percent of poverty, our estimates suggested that by 2019 half would have paid at least 18.9 percent of their incomes for the lowest-cost bronze plan in their area. A policy simulation from 2017 projected that adults ages 50–64 would constitute 96 percent of those newly receiving tax credits if those credits were extended to families above 400 percent of poverty.[4]

Based on our calculations of the share of people who would have faced high burdens, an increasing number of middle-class families with incomes of 401–600 percent of poverty likely perceive these amounts to be unaffordable or unsustainable. Whereas 41.9 percent of these families faced a burden of at least 8.5 percent of income for the lowest-cost bronze plan in 2015, by 2019 the percentage facing such a burden was 68.1 percent. Likewise, in 2015 only 2.7 percent of families would have paid at least 20 percent of their income for the lowest-cost bronze plan, and this had increased to 14.9 percent by 2019. In 2019 the median percentage of income that families with incomes of 401–600 percent of poverty would pay for health insurance premiums was comparable to the average percentage of income spent on food for families with similar incomes but less than their expenditures on housing and transportation. These estimates of the relative burden of health spending compared with spending for other consumer goods would be even higher if they included the out-of-pocket expenses that families incur for medical goods and services. As an illustration, when we combined both premiums and deductibles in a burden measure, costs for bronze coverage in 2019 were more than a quarter of income for half of families with incomes of 401–600 percent of poverty.

The pronounced increases in burdens from 2015 to 2019 were very clearly a result of premium growth exceeding income growth among our study population, rather than changes in demographics or family composition. Premium growth during this period may have contributed to declines in nongroup enrollment for people with incomes above 400 percent of poverty.[9] Premium increases have been linked to declining competition among issuers[9,10] and to federal policies—including the end of reinsurance and risk corridor programs[11]—and state and issuer responses to the end of federal cost-sharing subsidies in 2018.[4,10,12–14]

Since 2018 premiums have declined as issuers' participation in the Marketplaces has risen.[8] From 2018 to 2021 the average premium of the lowest-cost silver plan in the federally facilitated Marketplaces fell 9 percent.[8] The percentage of federally facilitated Marketplace enrollees who could choose plans from three or more issuers rose from 44 percent to 78 percent during this period.[8] Nonetheless, recent declines only partially mitigate the upward trend since 2014,[8]

EXHIBIT 4

Alternative measures of the financial burden of Marketplace plans among people in families with incomes of 401–600 percent of the federal poverty level, 2015–19

	Median percent of income				
Metal level and cost measure	**2015**	**2016**	**2017**	**2018**	**2019**
Bronze					
Lowest premium	7.7	8.2	9.9	11.7	11.3
25th percentile premium	8.5	9.2	10.9	12.5	12.4
Lowest combined premium plus deductible	18.3	20.9	24.5	26.0	26.6
Silver					
Lowest premium	9.5	10.0	11.9	15.6	14.9
25th percentile premium	10.6	11.1	12.9	16.6	16.2
Lowest combined premium plus deductible	14.6	16.1	18.9	23.5	23.4
Gold					
Lowest premium	11.4	12.3	15.1	18.0	17.4
25th percentile premium	12.5	13.5	16.2	18.8	18.5
Lowest combined premium plus deductible	14.5	14.3	18.1	21.0	20.4
	Share with premiums ≥8.5% of family income				
Bronze, lowest premium	41.9	48.0	60.3	70.1	68.1
Silver, lowest premium	58.4	61.9	71.1	83.9	82.0
Gold, lowest premium	70.4	74.3	81.7	88.2	85.8
	Share with premiums ≥10% of family income				
Bronze, lowest premium	30.3	36.4	49.4	60.2	58.1
Silver, lowest premium	46.2	50.1	61.4	76.5	74.4
Gold, lowest premium	59.7	64.5	73.9	82.8	80.6
	Share with premiums ≥20% of family income				
Bronze, lowest premium	2.7	3.9	9.5	16.4	14.9
Silver, lowest premium	7.3	8.8	16.8	33.3	30.6
Gold, lowest premium	13.2	17.1	31.2	42.4	40.1

SOURCE Authors' analysis of data for 2015–19 from the American Community Survey and plan data for 2015–19 from the Centers for Medicare and Medicaid Services. **NOTES** Financial burden and sample descriptions are in the notes to exhibit 1. $p < 0.001$ for the following comparisons: 2019 relative to 2015 for each measure of burden within each metal level, burdens of silver plans relative to other metal levels for each year and each measure of burden, and lowest combined premium and deductible relative to both other measures of burden within each year and each metal level; $p < 0.01$ for 25th percentile premium relative to both other measures of burden within each year and metal level.

and long-term growth in health care spending has outpaced growth in workers' wages, making it increasingly expensive for even middle-class families to finance health care.

Although previous research has often focused on the affordability of coverage for lower-income families,[15] continued growth in health care costs emphasizes the importance of studying families that are more traditionally considered part of the middle class. Our results highlight the impact of increasing health care costs on a population that is not enrolled in public or employer-based coverage and for whom advanceable tax credits have not previously been available. The full impact of rising health care costs is seldom seen by people with employer-based insurance, and Medicare and Medicaid shield beneficiaries from most of the growth in health spending by not charging premiums (for the Medicare hospital benefit and for most Medicaid beneficiaries) or by generously subsidizing coverage (for Medicare's outpatient coverage). As costs rise, however, people deciding whether to purchase Marketplace coverage will generally face higher premiums, higher copayments, or both. For example, from 2018 to 2021 median deductibles for bronze plans in the federally facilitated Marketplaces rose 12 percent, and those for silver plans rose 16 percent.[8] Increasing premiums and cost sharing directly affected middle-class families, which, as we found, experienced sizable financial burdens when shopping for plans on the Marketplaces. These costs likely compel some families to go without coverage[1] or to inhibit spending on other nonhealth goods when they purchase Marketplace coverage. The increasing potential burden of deductibles in bronze and silver plans may also limit access to and encourage stinting on health care.

The estimates in this article were based on a comprehensive set of Marketplace premium data linked by age and detailed geographic levels to nationally representative survey data on people who had nongroup coverage or were uninsured.

Although we believe that these estimates are the best available evidence for understanding premium burdens for families with higher incomes, our estimates are nonetheless simulations of the actual burden that families would face. We calculated burdens using lowest-cost Marketplace plans, which may have limited provider networks or other restrictions on the use of care. People desiring access to specific physicians or other types of providers may need to purchase higher-cost plans and thus would experience higher burdens. Families might be able to save money by enrolling in a qualified health plan outside the Marketplaces, but available data sets with these plans lack complete information on plans or service areas. Families with tobacco users would pay more than we estimated. Some of the families we studied could have liquid financial assets that could be used to help purchase health coverage, potentially ameliorating the burden of Marketplace premiums.[26] However, data on assets are not available in the ACS, and spending down assets could be unsustainable for younger people, who would spend down for many years before they become eligible for Medicare.

Policy Implications

On March 11, 2021, President Biden signed the American Rescue Plan Act into law. This law broadens eligibility for the ACA's premium tax credits to families with incomes above 400 percent of the poverty level for two years. For families above 400 percent of poverty, the new Marketplace tax credits cap the premium of the second-lowest-cost silver plan in the area at 8.5 percent of the family's income. We found a median premium burden for lowest-cost silver plans of 14.9 percent of income for families with incomes of 401–600 percent of the poverty level in 2019. Had the American Rescue Plan Act been in effect in 2019, this implies that premium tax credits would have amounted to roughly 6.4 percent of income for the median family in this group, or $5,632, and would have reduced the burden of lower-cost silver plans by 44 percent. We also found that half of the study population ages 45–54 would have paid at least 17.7 percent of their income to purchase the lowest-cost silver plan in 2019, which suggests somewhat broader potential benefits across age groups of extending the tax credits than was found in an earlier simulation of less generous credits.[4]

The increasing potential burden of deductibles in bronze and silver plans may limit access to and encourage stinting on health care.

Conclusion

For 2021 and 2022 the American Rescue Plan Act extends premium tax credits for Marketplace plans to families with incomes above 400 percent of the poverty level. By pegging tax credits to limit the cost of the second-lowest-cost silver plan to 8.5 percent of income, this extension will greatly reduce premium burdens for middle-class families. Subsidizing premiums for this group may expand their coverage, but should these credits expire in 2023 as intended, these middle-class families would again face the entire cost of premiums and less affordable coverage, adding to the challenges such families face. ■

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Growth In ACA-Compliant Marketplace Enrollment And Spending Risk Changes During The COVID-19 Pandemic

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ABSTRACT **In 2020 the COVID-19 pandemic caused millions to lose their jobs and, consequently, their employer-sponsored health insurance. Enacted in 2010, the Affordable Care Act (ACA) created safeguards for such events by expanding Medicaid coverage and establishing Marketplaces through which people could purchase health insurance. Using a novel national data set with information on ACA-compliant individual insurance plans, we found large increases in Marketplace enrollment in 2020 compared with 2019 but with varying percentage increases and spending risk implications across states. States that did not expand Medicaid had enrollment and spending risk increases. States that expanded Medicaid but did not relax 2020 Marketplace enrollment criteria also had spending risk increases. In contrast, states that expanded Medicaid and relaxed 2020 enrollment criteria experienced enrollment increases without spending risk changes. The findings are reassuring with respect to the ability of Marketplaces to buffer employment shocks, but they also provide cautionary signals that risks and premiums could begin to rise either in the absence of Medicaid expansion or when Marketplace enrollment is constrained.**

A basic objective of health insurance is to protect people from the financial costs of care made necessary by catastrophic medical events.[1] The COVID-19 pandemic has increased the risk for such events, with millions infected, hundreds of thousands dead, and unknown longer-term sequelae for survivors. Unfortunately, before the pandemic millions of Americans lacked health insurance, and millions more lost both their jobs and their employer-sponsored health insurance during the pandemic. The American Rescue Plan Act of 2021 and recent executive orders have attempted to address these issues by supporting enrollment in individual insurance Marketplaces and increasing premium subsidies for Marketplace plans.

Before the pandemic the Affordable Care Act (ACA) had expanded health insurance coverage and provided insurance options for people who otherwise might have lost employer-sponsored insurance if laid off. Although the drafters of the ACA envisioned that all low-income people would be eligible for Medicaid, the Supreme Court ruled in 2012 that states could opt out of the ACA's expansion of the Medicaid program to working-age adults with no dependents. People not eligible for Medicaid could purchase individual insurance in the ACA's Marketplaces. States had the option of managing their own state-based Marketplaces or relying on the federal government to manage their Marketplaces, either entirely (in federally facilitated Marketplaces) or partially (in state-based Marketplaces us-

ing the federal platform). For simplicity we refer to both of the latter two arrangements as federally facilitated Marketplaces.[2–4]

The state-based and federally facilitated Marketplaces differed in their policy responses to the pandemic. Twelve of the thirteen state-based Marketplaces implemented expanded special enrollment periods in 2020 for people affected by the pandemic; none of the federally facilitated Marketplaces did so. These twelve state-based Marketplaces allowed people to purchase health insurance during special enrollment periods even if they did not meet the ACA's original special enrollment period eligibility criteria, which were designed to prevent people from purchasing insurance only when they had acute medical needs.[5]

The expanded enrollment criteria are identical in principle to those of a January 2021 executive order creating a special enrollment period for federally facilitated Marketplaces from February 15 through May 15, 2021,[6,7] which state-based Marketplaces similarly followed.[8,9] In March 2021 Congress passed the American Rescue Plan Act, increasing premium subsidies for Marketplace plan enrollees for two years as well as providing cost-sharing protection for people seeking testing, prevention, or treatment for COVID-19. These changes could dramatically increase people's health insurance coverage and affordability. They will also increase the size of the federal debt.[10–12]

At this time, there is limited information on how the pandemic and subsequent changes in Marketplace enrollment criteria affected individual-market enrollment in 2020, including during special enrollment periods. There also is little information on how similar policies enacted in 2021 could affect the numbers or composition of enrollees. To address these questions, we examined enrollment changes and changes in health care needs, as measured by medical spending risk, among ACA-compliant individual-market plan enrollees from 2019 to 2020. We used a novel data set, the Wakely National Risk Adjustment Reporting project database, comprising data from insurance companies operating in twenty-nine states and containing approximately 77 percent of the total ACA-compliant individual-market enrollment nationally in 2019 (see online appendix exhibit A1 for member-month coverage by state market group).[13]

Study Data And Methods

POPULATION DATA Under the ACA, people can purchase health insurance plans that meet the ACA's coverage standards either from Marketplaces directly or through insurance companies, brokers, or agents. Plans purchased through these latter channels are known as off-Marketplace plans. To increase the stability of premiums and distribute spending risk within this overall individual market, the ACA created a risk-adjustment program. Under this program, health insurance companies submit information on diagnoses and demographic data that enable estimates of spending risk (expressed as a risk score) for each ACA-compliant individual-market plan. Data for this study are derived from this database.

The risk score predicts individual-level spending in the current year, using diagnoses and demographic data from the same year. At the end of each calendar year, the Centers for Medicare and Medicaid Services (CMS) calculates the relative level of medical spending risk for enrollees in each company's plans by comparing risk scores, which are a function of age, sex, diagnosis, months of enrollment, and use of certain prescription drugs.[14] Companies with higher scores compared with their market average receive additional dollars at the end of the year, whereas those with lower scores compared with their market average pay additional dollars. The end-of-year transfers of dollars attempt to equalize the risk-adjusted premiums across insurance companies offering ACA-compliant individual insurance plans, thus balancing the spending risk associated with the specific draw of enrollees that each company received relative to those of other companies operating within the same market in the same state.

The data collection process contains several protections against the loss of patient and insurer confidentiality. For example, companies use an external data gathering environment server to which they submit encrypted information about their enrollment numbers and the demographic and diagnosis information for their enrollees; CMS then releases programs that run on each server (that is, a decentralized analytic design). An unfortunate adverse effect of this process has been the slow release of data for external research evaluation; at present, it is unclear when data from the pandemic period will be available for researchers outside of the individual insurance companies participating in the Marketplaces.

Therefore, we used data from the Wakely Consulting Group. Through the Wakely National Risk Adjustment Reporting project, Wakely receives summarized data from health insurance companies that administer ACA-compliant individual-market plans, including Marketplace plans. Most plans participating in the risk-adjustment program are sold through Market-

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places, but the program and our sample also include ACA-compliant off-Marketplace individual insurance plans. Reporting of data to Wakely is voluntary, and not all eligible plans do so. However, companies have an incentive to submit accurate data to Wakely to obtain advance information about potential premium transfers, which they use in their financial reporting. The Wakely National Risk Adjustment Reporting project provides insurance companies with the only such advance estimates across multiple states.

The sample of companies and states used in this study remained relatively constant from 2019 to 2020, although some small insurance companies entered or exited certain markets. Although it is possible that these data are not representative of all ACA-compliant plans in the US, and our data use agreement precludes disclosure of details that could identify specific companies in the sample, the data contain 77 percent of all national Marketplace enrollment and an even higher enrollment percentage among the included states.

We used two sets of data summaries from the Wakely National Risk Adjustment Reporting data set that spanned January 2019–December 2020. The first contained monthly membership information, from which we determined the number of unique individuals enrolled in each plan in each year as well as their first month of enrollment for each plan year. The second contained summaries of estimated Health and Human Services–Hierarchical Condition Categories risk scores for each insurance company in each market, as derived from the company's inpatient and outpatient claims diagnosis codes. In past years the average risk score difference between estimates from the Wakely National Risk Adjustment Reporting program and the final CMS risk adjustment program has been less than 0.5 percent.

To estimate relative spending risk, we calculated the risk score for each member, using the silver plan risk score coefficient without the cost-sharing reduction adjustment in the Health and Human Services–Hierarchical Condition Categories risk-adjustment model.[15] Then we compared the resulting risk scores to estimate the relative difference in spending risk from 2019 to 2020. We did not include any adjustments for medical and pharmacy cost trends in our estimates.

CLASSIFICATION OF STATES States varied in their implementation of coverage expansion options under the ACA. Therefore, we classified states and Washington, D.C., with respect to several characteristics as of January 2020, immediately before the COVID-19 pandemic's onset in much of the US: Medicaid expansion; whether the state used the federally facilitated Marketplace and so did not relax special enrollment period eligibility criteria in 2020; and the use of coverage expansion options beyond those required by the ACA, including additional premium subsidies or state mandates.

The country is enmeshed in an unfortunate natural experiment on the value of health insurance during a medical crisis.

We defined four mutually exclusive groups: states that did not expand Medicaid to working-age adults, all of which used the federally facilitated Marketplace (54.0 million 2020 member-months in the Wakely data set); states that did expand Medicaid but relied on the federally facilitated Marketplace (29.0 million member-months in the data set); states that operated their own Marketplace platform and policies, or state-based Marketplaces (14.5 million member-months in the data set); and California, which not only operated its own Marketplace platform but also expanded 2020 premium subsidies beyond those of the original ACA program to include people at or below 600 percent of the federal poverty level and introduced a state health insurance mandate in 2020 (25.0 million member-months in the data set). The Wakely data include information on all four groups, although the specific states within each group other than California remain masked to protect insurance company confidentiality (see appendix exhibit A1 for member-month coverage by state grouping and appendix exhibit A2 for grouping characteristics of all states and Washington, D.C.).[13]

EXPOSURE TO MONTHS WITH INCREASED UNEMPLOYMENT RATES During the pandemic, states experienced varying trends in unemployment rates, partly because SARS-CoV-2 infection spread across the country unevenly and partly because states differed in their efforts to mitigate the consequences of the pandemic—for example, they adopted different measures with respect to

The state-based Marketplace states experienced favorable selection into the Marketplaces.

closures of nonessential businesses or other social isolation measures. As a result of these factors, the duration and severity of elevated unemployment periods varied across states, with a median month-to-month unemployment rate absolute change of 3.2 percentage points between January and October 2020 across all states. We obtained monthly state unemployment rate data from Bureau of Labor Statistics local area unemployment statistics estimates (as of January 21, 2021).[16]

Based on their exposure to the number of months with increased unemployment, we classified states into one of two mutually exclusive groups: slow recovery and fast recovery. This analysis was limited to federally facilitated Marketplace states because of limitations imposed by the Wakely National Risk Adjustment Reporting data use agreement as well as lack of variation among state-based Marketplaces in unemployment recovery status.

We then divided the calendar year into three periods based on data availability: early (January–March), mid (April–July), and late (August–October). We defined the change in the unemployment rate for a given state in month t as the absolute difference between the unemployment rate in month t and the unemployment rate in December 2019. We then took the average of the three monthly changes for each state across the three periods. If a state in a given period had a monthly average change greater than or equal to the median absolute change in unemployment rate from January through October across all states, we classified the state for that period as having "high" unemployment changes, and conversely for "low" unemployment changes. All states had low early-year unemployment compared with December 2019, and all states except Nebraska experienced high midyear unemployment. States differed, however, in whether they had elevated late-year unemployment. We classified states whose periods of high unemployment persisted into the late-year period as slow-recovery states, and those that had returned to low unemployment by the late-year period as fast-recovery states (we included Nebraska as a fast-recovery state as our data use agreement precluded reporting Nebraska-specific results; see appendix exhibit A2 for more information).[13]

ANALYSIS For each of the four groups of states, we compared their total number of unique enrollees in 2019 with the total number in 2020 and then compared the predicted relative spending risk (using the Health and Human Services–Hierarchical Condition Categories risk score estimates) among enrollees in 2019 with that of enrollees in 2020. In other words, we estimated the change in total enrollment and change in expected spending per capita among each of the four groups of states. These estimates of within-group change are analogous to estimates of excess mortality from the pandemic that compare all-cause mortality before and after the pandemic's onset.

Next, to differentiate between people who purchased plans during the open enrollment versus special enrollment periods, we examined enrollment changes from 2019 to 2020 for the four groups of states, based on the initial month of enrollment. For most states, open enrollment started in the late fall or early winter during the preceding year and continued through December for federally facilitated Marketplace states or longer for state-based Marketplace states—for example, the end of January; for people entering during the open enrollment period, the first enrollment month had to be January or February.

After the end of open enrollment, people could purchase a Marketplace plan if they met the ACA's special enrollment period eligibility criteria—for example, they experienced a recent job loss or other qualifying event. These rules, however, applied only to the subset of ACA-compliant individual insurance plans sold through the Marketplaces. In addition, twelve of the thirteen state-based Marketplaces relaxed special enrollment period eligibility criteria during the pandemic, but, as noted above, states using the federally facilitated Marketplace did not. In all states special enrollment period enrollees would have had a first enrollment month between March and December. We were unable to examine relative spending risk based on the initial month of enrollment because the Wakely risk score data set did not include this level of detail.

Finally, because of the potential importance of Medicaid expansion in buffering insurance losses during the pandemic and the absence of detailed monthly Medicaid enrollment information, we examined outcomes among states that had shorter versus longer periods of high unemployment (that is, fast-recovery states versus

slow-recovery states), stratified by whether the state did or did not expand Medicaid. To estimate the effect of Medicaid expansion, we focused only on states that used the federally facilitated Marketplace because only those states varied with respect to Medicaid expansion, whereas all states with state-based Marketplaces expanded Medicaid. Among the federally facilitated Marketplace states that did not expand Medicaid, we examined changes in enrollment and relative spending risk among enrollees from 2019 to 2020 for states with fast versus slow unemployment recovery. We then repeated these analyses among federally facilitated Marketplace states that expanded Medicaid.

To create 95 percent confidence intervals for the results shown in our exhibits, we assumed that the states' relative changes from 2019 to 2020 were independently and identically distributed according to a t-distribution. We weighted the mean and standard deviation used to calculate the confidence intervals based on the number of member-months in each state. For the fourth group consisting of a single state, California, we were unable to assess the variance because our data use agreement precluded analyses at the substate (insurance company) level.

LIMITATIONS This study had several limitations. First, we lacked complete, individual-level data on all types of health insurance coverage in the US, and thus were unable to track individuals as they lost employer-sponsored insurance and either gained Medicaid or ACA-compliant individual-market insurance or became uninsured. This type of comprehensive data set does not exist, even in states with all-payer claims data sets. Because of the absence of this comprehensive information or even individual-level data on Medicaid and Marketplace enrollment, our analyses relied on the Wakely National Risk Adjustment Reporting data set.[17] It is possible that some missing data could materially influence the results.

The base Wakely National Risk Adjustment Reporting project data used for this study included only state-level summaries, not individual-level monthly data. However, the base data were blinded and aggregated into state groupings, as defined above, to protect the confidentiality of the participants' results by state (other than California, for which we obtained special permission) and the insurance companies contributing data. Wakely reviewed the data for reasonableness but did not audit or verify the data provided by participating insurance companies. It is uncertain the extent to which the participating insurance company population differs materially from the national commercial average in terms of demographics, health status, or location (see appendix exhibit A1 for member-month coverage by state market group).[13] Any differences from the data collected and market averages may result in material differences in risk estimates.

These findings provide reassurance about the prospects of recent policy changes to expand insurance coverage through the Marketplaces.

Although our analysis did not use a 100 percent sample of claims, it had the advantage of including not only Marketplace plans but also ACA-compliant non-Marketplace plans—that is, the entire sample of plans within the risk adjustment program. In contrast, prior CMS reports have focused on Marketplace-only plans because of data access barriers.

Because changes in medical coding practices can change risk scores, we assumed that coding practices were stable between 2019 and 2020. We adjusted risk scores to approximate change in spending risk by standardizing for differences due to metal level and cost-sharing reduction status but did not account for other factors such as geographical cost factors, other socioeconomic factors, or differences in state health policies.

Because we lacked information on the individual-level characteristics of enrollees, we were unable to examine differences by age, sex, race and ethnicity, or job type. We only had the net change in employment information at the state level and so were unable to disaggregate employment shifts by number of jobs lost and gained in each month. We also did not have information on the duration of individual employment losses, changes in employer-sponsored insurance, or uptake of insurance through the COBRA insurance program. Historically, Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) continuation insurance uptake has been low because of the relatively high costs of unsubsidized group commercial insurance.[18] The American Rescue Plan Act, however, provided 100 percent subsidies for COBRA insurance from April 2021 to September 2021.

Study Results

Exhibit 1 displays the changes from 2019 to 2020 in ACA-compliant individual-market enrollment and relative spending risk among the enrolled for our four main categories of states. Among states that did not expand Medicaid and had federally facilitated Marketplaces, there was a substantial increase in enrollment (10.3 percent; 95% CI: 7.1, 13.4) from 2019 to 2020, with the 2020 enrollees having 3.8 percent higher (95% CI: 2.5, 5.1) average relative risk compared with 2019 enrollees. In federally facilitated Marketplace states that expanded Medicaid, 2020 enrollment was 0.7 percent higher (95% CI: –2.0, 3.5) than in 2019, and average relative risk was 2.0 percent higher (95% CI: 1.1, 3.0). Among state-based Marketplace states that expanded Medicaid, enrollment in 2020 was 2.9 percent higher (95% CI: –3.0, 8.7), and average relative risk was 0.5 percent lower (95% CI: –1.3, 0.4) compared with 2019. Finally, in California, a state-based Marketplace that expanded Medicaid and introduced state-financed premium subsidies in 2020, 2020 enrollment was 8.9 percent higher, and average relative risk was 0.8 percent lower compared with 2019.

Exhibit 2 displays changes in enrollment from 2019 to 2020 by month of enrollment. There were relatively modest enrollment changes from 2019 to 2020 during the open enrollment period among all four groups of states. After open enrollment (that is, during the traditional special enrollment periods), however, there were larger percentage enrollment changes from 2019 to 2020 for all four groups of states. Not surprisingly, the largest percentage increases in enrollment were in California and other state-based Marketplace states that expanded Medicaid and that relaxed the special enrollment period eligibility rules in 2020.

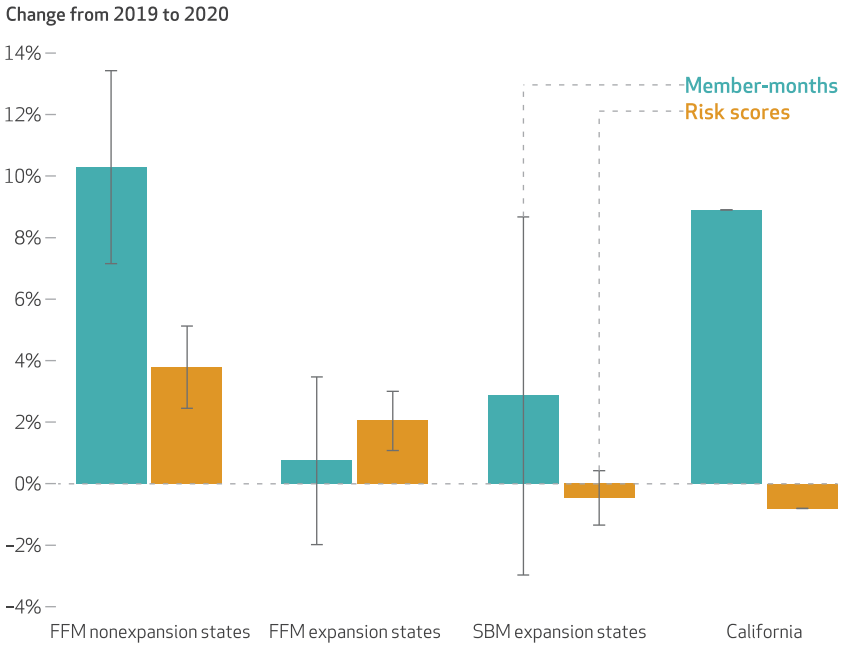
Exhibit 3 displays changes from 2019 to 2020 in Marketplace enrollment and relative spending risk of enrollees among federally facilitated Marketplace states that had fast versus slow recovery from the unemployment shock, stratified by Medicaid expansion status. Among federally facilitated Marketplace states that did not expand Medicaid, there were both enrollment and relative risk increases among the enrolled from 2019 to 2020; slow-recovery states had larger percentage enrollment increases in 2020 compared with fast-recovery states (11.7 percent versus 6.8 percent). Among federally facilitated Marketplace states that expanded Medicaid, however, enrollment did not measurably change in 2020, but relative risk increased, particularly in slow-recovery states.

Discussion

As the ACA coverage expansion efforts approach their first decade and the US endures a pandemic, the country is enmeshed in an unfortunate natural experiment on the value of health insurance during a medical crisis. Not surprisingly, there was greater individual-market enrollment in 2020 compared with 2019, but the magnitude of the percentage change was notably larger in states that did not expand Medicaid and in California, which increased subsidies and introduced a mandate. The impact of the enrollment changes on the risk pool varied across the state groupings, with increases in relative spending risk among enrollees within both groups of federally facilitated Marketplace states and decreases in relative spending risk in state-based Marketplace states, including California. In other words, the state-based Marketplace states experienced favorable selection into the Marketplaces.

EXHIBIT 1

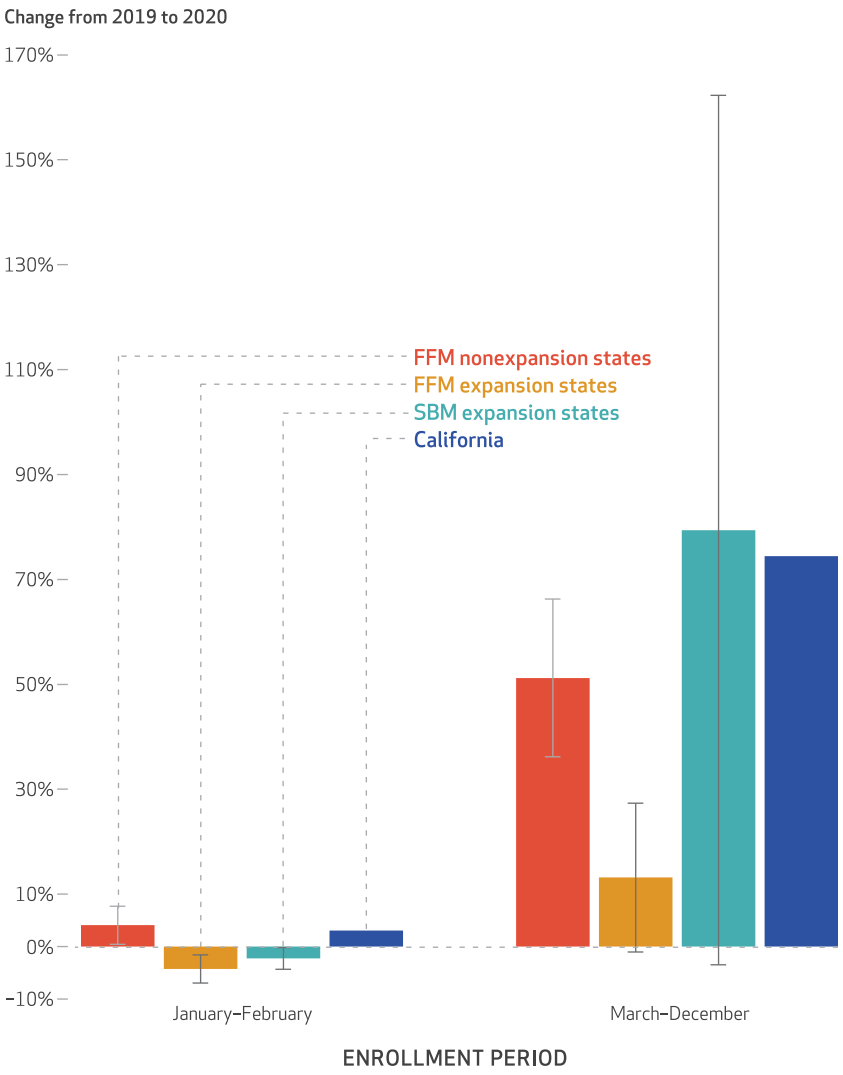
Change from 2019 to 2020 in Affordable Care Act (ACA)–compliant individual-market plan enrollment and relative spending risk, by state groupings



SOURCE Authors' analyses of data from 2019 and 2020 Wakely National Risk Adjustment Reporting project data. **NOTES** Percent changes for member-months and risk scores from 2019 to 2020 are shown for California and state groupings as defined in appendix exhibit A2 (see note 14 in text). All 2019 and 2020 risk scores were calculated using the 2020 Health and Human Services–Hierarchical Condition Categories (HHS-HCC) risk adjustment model. Member risk was measured using silver plan risk score coefficients and did not include any cost-sharing reduction risk score adjustments to compare morbidity. Error bars denote 95% confidence intervals. Confidence intervals should be used for comparison across state groupings for member-months only or risk scores only—that is, member-months should not be compared with risk scores. Confidence intervals were suppressed for California because of the low numbers of insurance companies in a single state and confidentiality concerns. The data are from individual ACA plans only and exclude any catastrophic plans. "Risk scores" refers to 2020 HHS-HCC risk adjustment model risk scores (relative spending risk). FFM is federally facilitated Marketplace. SBM is state-based Marketplace.

EXHIBIT 2

Change from 2019 to 2020 in Affordable Care Act (ACA)–compliant individual-market plan enrollment among early versus later enrollees, by state grouping



SOURCE Authors' analyses of data from 2019 and 2020 Wakely National Risk Adjustment Reporting project data. **NOTES** Percent changes in ACA-compliant individual-market plan enrollment during periods of months from 2019 to 2020 are shown for California and state groupings as defined in appendix exhibit A2 (see note 14 in text). Error bars denote 95% confidence intervals. Confidence intervals were suppressed for California because of the low numbers of insurance companies in a single state and confidentiality concerns. The data are from individual ACA plans and exclude any catastrophic plans. FFM is federally facilitated Marketplace. SBM is state-based Marketplace.

Most of the enrollment growth in 2020 compared with 2019 occurred during the special enrollment period months rather than the open enrollment period, which also coincided with the timing of large, pandemic-related employment changes. Finally, among federally facilitated Marketplace states, Marketplace enrollment was higher where Medicaid was not an option, particularly among states with more prolonged periods of unemployment (that is, slow-recovery states).

Importantly, the findings do not indicate that the state groupings led to the changes—that is, this was not a causal analysis. As the US experiences the second year of the COVID-19 pandemic, however, both jobs and health remain under threat; in the midst of such threats, descriptive information can be valuable in illustrating relevant associations and refining hypotheses about the recently enacted policies.

Specifically with respect to the American Rescue Plan Act, the findings suggest a few possibilities. First, Marketplace enrollment could increase substantially from the expansions of the premium subsidy, conditional on effective implementation of the subsidies—for example, having high levels of awareness, sufficient outreach, and facilitated enrollment. In particular, only Marketplace plans are eligible for the now-higher subsidies, but millions of Americans have been enrolled in subsidy-ineligible plans: ACA-compliant plans sold off the Marketplace, plans that were grandfathered under the ACA, or plans that are ACA-noncompliant such as association plans. It will be especially important that such people receive accurate information about how to access newly expanded subsidies. Furthermore, continued shifts in employment with associated gains and losses of employer-sponsored insurance will also affect the number of people insured through Marketplace plans.

Second, the impact of this enrollment growth on the risk pool could be minimal or even favorable in states that have expanded Medicaid and that simplified the enrollment process.[19,20] Conversely, the enrollment growth might adversely affect the risk pool in states that never expanded Medicaid or that have large enrollment barriers. The absence of Medicaid expansion to working-age adults eliminates an important insurance option for many lower-income Americans. For those without employment-based insurance or Medicare, Marketplace enrollment becomes their primary insurance option. This group of Medicaid expansion–eligible adults could have higher spending levels than suggested by their risk scores for a multitude of reasons—for example, poor diagnostic documentation because of historical barriers to obtaining care or greater prevalence of poorly measured social factors that adversely affect spending and health.[21] Any risk score increase across a given state's Marketplace will likely affect premiums adversely, as the risk-adjustment program focuses on spreading risks within the market and does not address changes in the overall levels of risks across the market.

The above hypothesis with respect to Medicaid expansion assumes that state Medicaid expansion status influences the extent to which people losing employer-sponsored insurance enter Marketplace plans versus Medicaid. In fact, in

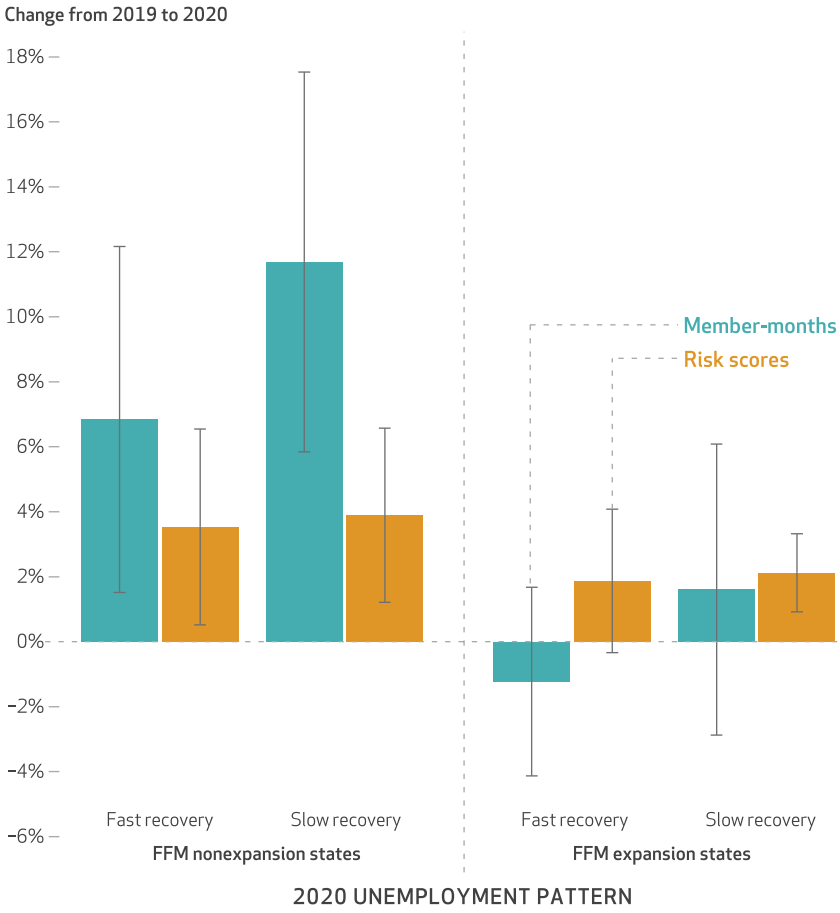
past years millions of Marketplace applicants had been eligible for Medicaid, provided that they lived in a state that expanded Medicaid.[22] Moreover, among states that did expand Medicaid, Medicaid enrollment had increased 9 percent by September 2020 compared with February 2020.[23] Enrollment in Marketplace plans in federally facilitated Marketplace states that did not expand Medicaid experienced a markedly larger increase in 2020 compared with Marketplace enrollment in federally facilitated Marketplace states that did expand Medicaid, consistent with the unavailability of Medicaid as an option.[24,25]

Although the American Rescue Plan Act provides additional federal support for states that have not expanded Medicaid to do so, these incentives might not lead such states to alter their course. Enrolling in a Marketplace plan requires some effort on the part of the consumer, which could limit the cost-lowering effects of the subsidies. Furthermore, consumers with higher expected medical needs are likely more motivated to enroll than those with lesser needs, which increases the average spending risk.

Overall, these findings provide reassurance about the prospects of recent policy changes to expand insurance coverage through the Marketplaces, especially the provisions of the American Rescue Plan Act. Among states that continue to opt out of Medicaid expansion, however, there could be unfavorable effects on the risk pool and higher future premiums. In sum, the ability of new policies to augment coverage and improve plan affordability may depend on the extent to which states followed the ACA's original design of both expanding Medicaid and supporting an individual insurance Marketplace. ■

EXHIBIT 3

Change from 2019 to 2020 in Affordable Care Act (ACA)–compliant individual-market plan enrollment and relative spending risk among federally facilitated Marketplace (FFM) states, by unemployment pattern and Medicaid expansion status



SOURCE Authors' analyses of data from 2019 and 2020 Wakely National Risk Adjustment Reporting project data. **NOTES** Percent changes for member-months and risk scores from 2019 to 2020 are shown for state groupings as defined in appendix exhibit A2 (see note 14 in text). The FFM nonexpansion and FFM expansion state percent changes shown are disaggregated by 2020 unemployment patterns as defined in appendix exhibit A2 (see note 14 in text). All 2019 and 2020 risk scores were calculated using the 2020 Health and Human Services–Hierarchical Condition Categories (HHS-HCC) risk adjustment model. Member risk was measured using silver plan risk score coefficients and did not include any cost-sharing reduction risk score adjustments to compare morbidity. Risk scores refers to 2020 HHS-HCC risk-adjustment model risk scores (relative spending risk). Error bars denote 95% confidence intervals. Confidence intervals should be used for comparison across state groupings for member-months only or risk scores only—that is, member-months should not be compared with risk scores. The data are from individual ACA plans and exclude any catastrophic plans.

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Build Back Better Increases Health Coverage and Makes It More Affordable

By Judith Solomon and Tara Straw

The new House Build Back Better legislation would make meaningful progress in covering millions of people who lack health coverage by closing the Medicaid coverage gap and reducing premiums for people buying coverage through the Affordable Care Act (ACA) marketplaces. While these provisions are temporary, both would last through 2025 and would provide a strong foundation to further expand coverage, address racial and ethnic health inequities, and improve people's health and economic well-being.

Under the proposal, more than 2 million uninsured adults with incomes below the poverty line would be able to enroll in ACA marketplace plans beginning in January 2022 without paying any premiums. By quickly making coverage available to this group — 60 percent of whom are people of color and none of whom currently have a path to coverage because they live in states that have refused to adopt the ACA's Medicaid expansion — Build Back Better would achieve a top priority of civil rights and health equity leaders, who have emphasized its importance in reducing persistent racial inequities in health care and health outcomes.[1] Closing the coverage gap is a key component of efforts to reduce high and increasing rates of deaths and severe health complications among Black people who give birth.[2] And it will deliver coverage to large numbers of older adults and people who have disabilities and chronic health conditions.

The continuation of increased premium tax credits would allow more people who previously couldn't afford marketplace coverage to enroll and would reduce premium costs for many others. The Build Back Better legislation would extend through 2025 temporary premium tax credit enhancements that were enacted in the American Rescue Plan for 2021 and 2022. These enhancements were likely a major reason for this year's record marketplace enrollment; over 2.8

[1] Letter from leaders and members of the Congressional Black Caucus and the Congressional Hispanic Caucus to Majority Leader Charles S. Schumer and Speaker Nancy Pelosi, September 5, 2021, https://drive.google.com/file/d/140TY2wr0rBUGY7S9jNeKDxTDlyKhtiXY/view; Letter from Southerners for Medicaid Expansion to Democratic Senators, September 17, 2021, https://southerners4medex.org/racial-health-equity-leaders-call-on-u-s-senate-to-close-medicaid-gap-for-good/.

[2] Judith Solomon, "Closing the Coverage Gap Would Improve Black Maternal Health," Center on Budget and Policy Priorities, July 26, 2021, https://www.cbpp.org/research/health/closing-the-coverage-gap-would-improve-black-maternal-health.

million people signed up during special enrollment periods in the federal and state-based marketplaces. Extending the Rescue Plan enhancements would help sustain these gains and reach additional uninsured people.

Legislation Would Open Marketplace Plans to Cover People in the Coverage Gap

People with incomes below the poverty line generally aren't eligible for premium tax credits under current law. People with incomes between 100 and 138 percent of the poverty line (or about $13,000 to $18,000 in yearly income for a single adult and about $22,000 to $30,000 for a family of three) who would be eligible for Medicaid if their states adopted the expansion can receive premium tax credits and enroll in marketplace plans, and many do. But the combination of states' refusal to expand Medicaid and the federal floor on premium tax credit eligibility set at 100 percent of the poverty line creates a coverage gap for adults with incomes below the poverty line who aren't eligible under other Medicaid categories, such as categories that provide coverage to very low-income parents and people with health conditions that meet a narrow definition of "disability."

Under the Build Back Better legislation, people with incomes below the poverty line who are not eligible for Medicaid under their state's rules would become eligible for premium tax credits, giving them a new pathway to affordable coverage in the marketplace. Enhancements would be made to marketplace plans to ensure that people with very low incomes who would be eligible for Medicaid if their state adopted the expansion have access to affordable health care. All people who would be eligible for Medicaid if their states had expanded, including those with incomes between 100 and 138 percent of the poverty line, would be eligible to enroll in the enhanced plans. With the enhancements:

- **People wouldn't pay a premium** because premium tax credits would be enough to cover the full cost. This would begin in 2022.
- **The plans would have very low deductibles and other cost-sharing charges** to make sure that people can get the health care they need without unaffordable out-of-pocket costs. The actuarial value of the plans — the percentage of total average costs of covered benefits that the plan pays — would be set at 99 percent beginning in 2023, which translates to minimal cost sharing. In 2022, people with incomes below the poverty line would receive plans with a 94 percent actuarial value, the same as marketplace plans now available to people with incomes between 100 and 150 percent of the poverty line.
- **Low-paid workers would be eligible for financial assistance even if they have an offer of employer coverage.** Beginning in 2022, the legislation would ensure that people who would be eligible for Medicaid if their state adopted the expansion can enroll in marketplace coverage even if they have an employer offer of coverage. This mirrors how state Medicaid programs work — someone with an offer of employer coverage can choose to enroll in Medicaid, which has much lower costs than even heavily subsidized employer plans, which is particularly important for very low-income people. Eliminating any barrier to coverage based on an offer of employer coverage for people with the lowest incomes is critical because the general marketplace eligibility rules mean that many people who have an offer of employer

coverage are barred from receiving premium tax credits for marketplace coverage even though the employer coverage isn't truly affordable for them or their families.[3]

- **People could enroll at any time during the year.** As with Medicaid, people would not be restricted to enrolling during designated marketplace enrollment periods, starting in 2022.
- **The plans would add benefits to more closely align with Medicaid.** Beginning in 2024, the plans would cover the costs of **transportation to medical appointments** for people who couldn't otherwise get the care they need. This would be in addition to emergency medical transportation, which marketplace plans already cover. Beginning in 2024, the plans also would cover **family planning services and supplies,** and people would have free choice of participating family planning providers regardless of whether the providers are in their managed care network.

These enhancements are critical to ensuring that people with incomes below or near the poverty line, whose financial resources for premiums, deductibles, and co-payments as well as transportation are extremely limited, have access to coverage that meets their needs.

Closing the coverage gap is an important step in undoing the effects of structural racism. A large body of evidence suggests that coverage will improve outcomes for conditions that have a greater impact on communities of color and bring increased financial security and protection from medical debt, which affects people of color at a higher rate. Most of the states that have refused to adopt the Medicaid expansion are located in the South and have above-average shares of Black and brown residents.[4] (See Appendix Table 1.)

Bill Would Strengthen Case for State Adoption of the Medicaid Expansion

While Build Back Better would provide a federal path to coverage for people who lack it — which is critically important — a state-administered Medicaid program that integrates the expansion population with other enrollees will continue to hold many advantages.

First, states that adopt the Medicaid expansion reduce the number of people who have to shift between the state Medicaid program and the marketplace. For example, in a state that has adopted the Medicaid expansion, when a child receiving Medicaid turns 19, they can remain in Medicaid. But in a non-expansion state, where low-income adults get their coverage in the marketplace rather than through Medicaid, that 19-year-old would have to shift to the marketplace even if their income remains very low. Similarly, a parent whose income falls from 120 percent of the poverty line to 25 percent of the poverty line due to a job loss can remain in Medicaid in an expansion state but would have to shift from marketplace to Medicaid coverage in a non-expansion state. In addition, parents and children are more likely to be in the same plan in expansion states because they are both eligible

[3] Tara Straw, "Trapped by the Firewall: Policy Changes Are Needed to Improve Health Coverage for Low-Income Workers," Center on Budget and Policy Priorities, December 3, 2019, https://www.cbpp.org/research/health/trapped-by-the-firewall-policy-changes-are-needed-to-improve-health-coverage-for.

[4] Laura Harker, "Closing the Coverage Gap a Critical Step for Advancing Health and Economic Justice," Center on Budget and Policy Priorities, October 4, 2021, https://www.cbpp.org/research/health/closing-the-coverage-gap-a-critical-step-for-advancing-health-and-economic-justice.

for Medicaid, while in non-expansion states, many parents of children in Medicaid will be in marketplace coverage if the coverage gap proposal is enacted.

State-administered Medicaid coverage also lets states develop approaches that connect health care to housing and other community-based services, which is especially important for people with mental illness or substance use disorders and people experiencing homelessness. Moreover, expansion has produced savings in several areas of state budgets by reducing costs for uncompensated care and providing federal matching funds for behavioral health and other services previously funded with state dollars, among other things. Because Medicaid coverage is broader in some areas than marketplace coverage, some of these benefits will remain larger for expansion states.[5]

In most expansion states, the benefits from expansion will outweigh any possible financial benefit they would get from dropping expansion, and the Build Back Better bill would make expansion even more valuable. States that have expanded would receive a 3 percentage point increase in the amount the federal government pays toward a state's expenditures (known as the "federal medical assistance percentage" or FMAP) for expansion in 2023 through 2025, bringing the federal share to 93 percent.

To further encourage expansion, non-expansion states would still qualify for the financial incentive enacted in the American Rescue Plan if they expand. For the first two years of expansion, they would receive a two-year, 5 percentage point increase in the state's FMAP for all groups other than those eligible through expansion, amounting to a large financial benefit.

Finally, the bill would reduce the federal funding going to non-expansion states that helps pay for uncompensated care provided to uninsured people. Medicaid expansion has been shown to significantly reduce uncompensated care. Hospital uncompensated care decreased sharply immediately after ACA coverage provisions took effect, with declines from 2013 to 2015 that were several times larger in expansion states than non-expansion states.[6] In Louisiana, which expanded Medicaid in 2016, expansion was associated with a 33 percent reduction in uncompensated care costs as a share of total operating expenses, with an even greater reduction of 55 percent for rural hospitals.[7] Reducing federal funds for uncompensated care avoids having the federal government provide funding intended for uncompensated care that is no longer actually uncompensated.

Expanding Premium Tax Credits Would Increase Private Coverage

The Build Back Better legislation would extend the Rescue Plan's premium tax credit enhancements through 2025, instead of letting them expire after 2022. The enhancements eliminate or reduce premiums for millions of marketplace enrollees to ensure that people don't spend more than 8.5 percent of their income on premiums, with lower income people paying far less.

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[5] Inna Rubin, Jesse Cross-Call, and Gideon Lukens, "Medicaid Expansion: Frequently Asked Questions," Center on Budget and Policy Priorities, June 16, 2021, https://www.cbpp.org/research/health/medicaid-expansion-frequently-asked-questions.

[6] Gideon Lukens, "Medicaid Expansion Cuts Hospitals' Uncompensated Care Costs," Center on Budget and Policy Priorities, April 20, 2021, https://www.cbpp.org/blog/medicaid-expansion-cuts-hospitals-uncompensated-care-costs.

[7] Kevin Callison *et al.,* "Medicaid Expansion Reduced Uncompensated care Costs At Louisiana Hospitals; May Be A Model For Other States," *Health Affairs*, March 2021, https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01677.

Under the Rescue Plan, people with income between 100 and 150 percent of the poverty line (about $13,000 to $19,000 for a single person and $26,500 to nearly $40,000 for a family of four in the 2022 coverage year) pay no premiums for a benchmark plan, after accounting for premium tax credits, and other families pay a capped share of income toward health coverage.[8] These improvements to premium tax credits help almost everyone enrolled in marketplace coverage, except for higher-income people whose premiums are already less than 8.5 percent of their incomes.

The ACA made insurance more affordable for many people, yet as of 2019 the uninsured rate for lower-income people eligible for the most generous subsidies remained high: 14.1 percent of people with incomes between 138 and 250 percent of the poverty line were uninsured, compared to 3.1 percent for people with incomes above 500 percent of the poverty line.[9] Uninsured people at all income levels cite cost as the greatest barrier to coverage. In states that have improved financial assistance beyond the federal subsidies available, uninsured rates are low and access to care has improved.[10]

The Rescue Plan premium tax credit improvements have proven helpful in encouraging people, particularly low-income people, to access marketplace coverage. During this year's six-month special enrollment period at HealthCare.gov (the federal marketplace), 45 percent of the people who newly selected a plan had incomes at or below 150 percent of the poverty line and 74 percent had incomes at or below 250 percent of poverty (about $32,000 for a single person).[11] The federal marketplace has increased support for health enrollment navigators, who provide one-on-one help with applying and enrolling, from $10 million to $91.5 million for the 2022 coverage year. These navigators focus outreach to people with lower incomes and other disproportionately underserved populations.[12]

Enhanced premium tax credits could also help improve racial equity in private health coverage enrollment.[13] Before the Rescue Plan was enacted, an estimated 11.2 million people were eligible for

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[8] Some states' marketplace plans include state-mandated benefits and or extra benefits (like vision) that are not part of the essential health benefits (EHB) that plans must cover. The premium tax credit is calculated based on the EHB, so enrollees in those states may still pay a small additional premium.

[9] CBPP analysis of Census American Community Survey 2019.

[10] Aviva Aron-Dine and Matt Broaddus, "Improving ACA Subsidies for Low- and Moderate-Income Consumers Is Key to Increasing Coverage," Center on Budget and Policy Priorities, March 21, 2019, https://www.cbpp.org/research/health/improving-aca-subsidies-for-low-and-moderate-income-consumers-is-key-to-increasing. 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, https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_sep_collins_2017_aca_tracking_survey_ib_v2.pdf.

[11] Department of Health and Human Services (HHS), "2021 Final Marketplace Special Enrollment Period Report," October 20, 2021, https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf.

[12] Tara Straw, "Marketplaces Poised for Further Gains as Open Enrollment Begins," Center on Budget and Policy Priorities, October 29, 2021, https://www.cbpp.org/research/health/marketplaces-poised-for-further-gains-as-open-enrollment-begins.

[13] Danilo Trisi *et al.*, "House Build Back Better Legislation Advances Racial Equity," Center on Budget and Policy Priorities, September 27, 2021, https://www.cbpp.org/research/poverty-and-inequality/house-build-back-better-legislation-advances-racial-equity.

a premium tax credit but uninsured, according to federal estimates. About half of this group were people of color, including 30 percent who were Latino; 14 percent who were Black; 3 percent who were Asian, Native Hawaiian, or Pacific Islander; 1 percent who were American Indian/Alaska Native; and 2 percent who were multiracial or "some other race."[14] All racial and ethnic groups would likely see large declines in the number of uninsured non-elderly adults; Black adults would see the largest gains, with more than 1 in 3 uninsured Black people gaining coverage, the Urban Institute estimates.[15]

The Build Back Better legislation would extend the Rescue Plan's reduced premiums for marketplace enrollees, making coverage markedly more affordable through 2025. With the Rescue Plan's changes, in 2021:[16]

- A single individual making $18,000 pays zero net premium rather than $54 per month (3.6 percent of income) and qualifies for the most generous subsidies for deductibles and other cost-sharing amounts.
- A single individual making $30,000 pays $85 rather than $195 per month in premiums (3.4 instead of 7.8 percent of income) and qualifies for a plan with reduced deductibles and other cost-sharing amounts. (See Figure 1.)
- A family of four making $50,000 pays $67 rather than $252 per month in premiums for benchmark coverage (1.6 instead of 6.0 percent of their income) and qualifies for generous cost-sharing reductions.[17]
- A family of four making $75,000 pays $340 rather than $588 per month in premiums for benchmark coverage (5.4 instead of 9.4 percent of their income).

[14] HHS, Office of the Assistant Secretary for Planning and Evaluation, "State, County, and Local Estimates of the Uninsured Population: Prevalence and Key Demographic Features," March 11, 2021, https://aspe.hhs.gov/reports/state-county-local-estimates-uninsured-population-prevalence-key-demographic-features. These estimates exclude those lacking legal documentation. They do not account for whether uninsured individuals have an affordable offer of employer coverage, which also affects eligibility for marketplace enrollment. Latino category may include any race. All other categories are non-Latino. Categories are combined because of data limitations and do not necessarily represent how individuals would like to be categorized.

[15] Estimates based on permanent premium tax credit improvements. Jessica S. Banthin, Michael Simpson, and Andrew Green, "Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress," Commonwealth Fund issue brief, September 9, 2021, https://www.commonwealthfund.org/publications/issue-briefs/2021/sep/coverage-cost-effects-key-health-insurance-reforms-congress.

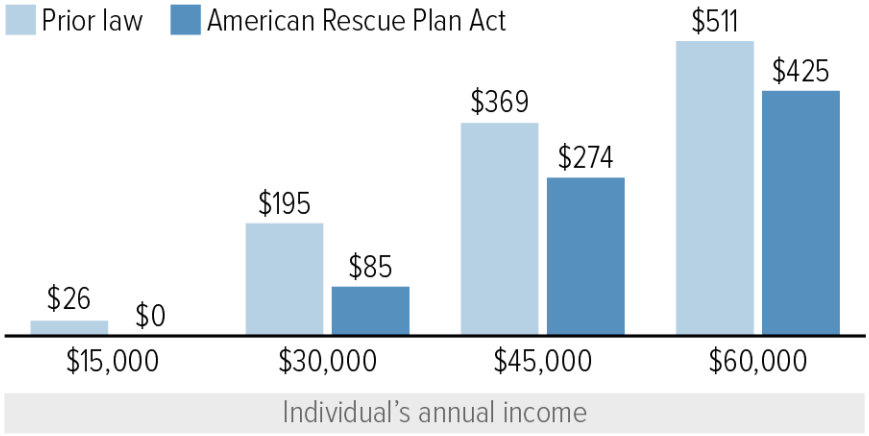
[16] Examples are calculated using the 2020 federal poverty line, which is used to determine the 2021 "applicable percentage," the percentage of income people pay for coverage. Under the Build Back Better legislation, the applicable percentages would remain the same across years, though income and the poverty line may change.

[17] CBPP calculations. Examples assume consumers face the national average marketplace benchmark premium for 2021. 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.

FIGURE 1

Build Back Better Would Extend Rescue Plan Affordability Provision

Monthly premium for benchmark marketplace coverage for a 45-year-old, based on national average premium, 2021



Note: These premiums are applicable in all states except for those with different poverty level standards than the national standard (Alaska and Hawai'i) and those states that subsidize marketplace premiums beyond the federal subsidy (California, Massachusetts, New York, and Vermont).

Source: CBPP calculations based on American Rescue Plan Act

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Extending Premium Tax Credits Helps Older People and Those Living in High-Cost Areas

The ACA's health insurance marketplaces have been a critical source of coverage for older people, who rely on the individual market more than other age groups.[18] That's because many older adults who don't have access to coverage through their job want health insurance — 84 percent of people aged 55 to 64 have a pre-existing condition[19] — but find it unaffordable without the ACA's help. Older people account for nearly 29 percent of marketplace enrollees, even though they are only roughly 13 percent of the total population. And adults 55 and older accounted for 22 percent of new HealthCare.gov enrollees in the six-month special enrollment period that ended August 15.[20]

Because of the Rescue Plan's expanded premium tax credits, 2 million current enrollees and 1.3 million uninsured people who are aged 55 to 64 and live in the 36 states that use HealthCare.gov are eligible for a marketplace plan with a monthly net premium of $50 or less or, for more than half of

[18] Jane Sung *et al.*, "Affordability Challenges for Older Adults in the Nongroup Market," AARP Public Policy Institute, March 2021, https://www.aarp.org/content/dam/aarp/ppi/2021/03/affordability-challenges-older-adults-nongroup-market.doi.10.26419-2Fppi.00099.008.pdf.

[19] HHS, Office of the Assistant Secretary for Planning and Evaluation, "Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act," January 5, 2017, https://aspe.hhs.gov/sites/default/files/private/pdf/255396/Pre-ExistingConditions.pdf.

[20] HHS, 2021 Final Marketplace Special Enrollment Period Report.

them, a $0 premium.[21] Any eligible marketplace enrollee making $25,000 now pays $38 rather than the previous $132 per month in premiums (1.84 instead of 6.33 percent of income) for a benchmark silver plan.

In addition to increasing the premium tax credit amounts, the Rescue Plan also expands who is eligible for a premium tax credit in a way that significantly benefits older people, by allowing people with incomes above 400 percent of the poverty line ($52,000 for a single person) to receive a premium tax credit if their premiums exceed 8.5 percent of their income. Before the Rescue Plan, people with income above that threshold weren't eligible for financial help and had to pay the full premium, even if they faced excessive premium burdens.

This "cliff" particularly affected older people, whose premiums are much higher as a share of income than younger people because the ACA allows insurers to charge older people higher "sticker price" premiums. In 2021, the average unsubsidized premium for marketplace coverage ranged from $787 to $1,058 per month for 55- to 64-year-olds, versus $353 to $428 for 21- to 34-year-olds.[22]

Extending the Rescue Plan's 8.5 percent income cap on premiums is also important to middle-income people who live in areas with high premiums.[23] The cap targets the most assistance to people with high premium burdens. For example, marketplace benchmark coverage for a 40-year-old in Charleston, West Virginia earning $55,000 a year (431 percent of the poverty line for a single person) costs about $731 per month, more than 1.5 times the national average. Prior to the Rescue Plan, this person wasn't eligible for any help paying their premium. With the premium tax credit provided under the Rescue Plan, this person gets a monthly premium discount of $341, bringing their premium down to $390 per month.[24] In lower-cost states, a person of the same age with the same income doesn't receive a premium tax credit because their premium is already below 8.5 percent of their income. And the premium tax credit enhancement automatically phases out at higher income levels because premiums are generally less than 8.5 percent of income for high-income people.

Providing premium tax credits to limit premium liability to no more than 8.5 percent of income for middle-income households helps other people who might otherwise have trouble affording coverage. For example, in 2021:

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[21] HHS, Office of the Assistant Secretary for Planning and Evaluation, "Access to Marketplace Plans with Low Premiums on the Federal Platform, Part III: Availability Among Current HealthCare.gov Enrollees Under the American Rescue Plan," April 13, 2021, https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/199886/low-premium-plans-ib-part-iii.pdf and HHS, Office of the Assistant Secretary for Planning and Evaluation, "Access to Marketplace Plans with Low Premiums on the Federal Platform, Part II: Availability Among Uninsured Non-Elderly Adults Under the American Rescue Plan," April 1, 2021, https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/199741/ASPE%20ACA%20Low%20Premium%20Plans%20Issue%20Brief%20II.pdf.

[22] Kaiser Family Foundation, "2021 Health Insurance Marketplace Calculator," https://www.kff.org/interactive/subsidy-calculator-2021/.

[23] Aviva Aron-Dine, "Making Health Insurance More Affordable for Middle-Income Individual Market Consumers," Center on Budget and Policy Priorities, March 21, 2019, https://www.cbpp.org/research/health/making-health-insurance-more-affordable-for-middle-income-individual-market.

[24] Kaiser Family Foundation, "2021 Calculator – Before COVID-19 Relief," https://www.kff.org/interactive/subsidy-calculator-2021-before-covid-relief/ and Kaiser Family Foundation, "2021 Health Insurance Marketplace Calculator," https://www.kff.org/interactive/subsidy-calculator-2021/.

- A typical 60-year-old making $60,000 has seen their premiums cut by more than half, or $535 per month. Instead of paying $960 per month in premiums for benchmark coverage, or 19 percent of income, the consumer pays $425, or 8.5 percent of their income.
- A typical family of four with income of $110,000 has seen their premiums cut almost in half, by $666 per month. Instead of paying $1,445 per month in premiums for benchmark coverage, or nearly 16 percent of their income, the family pays $779, or 8.5 percent of their income, with the premium tax credit making up the difference.

Conclusion

By closing the coverage gap, the Build Back Better legislation would quickly provide coverage to people who have been shut out because their states have refused to expand Medicaid. It would enhance that coverage to better align with Medicaid and recognize the financial realities of very low-income households and provide incentives to encourage more states to adopt the Medicaid expansions. The proposal's extension of improved premium tax credits would make marketplace coverage more accessible and affordable for millions of people.

The Build Back Better coverage expansions and improvements would last through 2025 and Congress will need to extend them to maintain these coverage gains.

Appendix

APPENDIX TABLE 1

Uninsured Adults in the Coverage Gap, by Race/Ethnicity, 2019

State	Total	Asian	Black	Latino	Other	White
Total, non-expansion states	2,211,000	29,000	617,000	613,000	60,000	893,000
Alabama	137,000	*	53,000	*	*	75,000
Florida	425,000	6,000	109,000	118,000	12,000	179,000
Georgia	275,000	*	130,000	24,000	*	114,000
Kansas	44,000	*	*	8,000	4,000	26,000
Mississippi	110,000	*	59,000	*	*	44,000
North Carolina	207,000	*	68,000	19,000	12,000	106,000
South Carolina	105,000	*	42,000	*	*	55,000
South Dakota	16,000	*	*	*	6,000	9,000
Tennessee	119,000	*	31,000	5,000	*	79,000
Texas	766,000	14,000	118,000	422,000	12,000	200,000
Wyoming	7,000	*	*	*	*	5,000

* Reliable estimates are not available due to small sample size.

Note: Totals may not sum due to rounding. Estimates are for non-elderly adults aged 19 to 64. Income eligibility for Medicaid and ACA marketplace coverage is determined by grouping individuals into health insurance units for each program and applying state eligibility rules to modified adjusted gross income. Excludes estimated population lacking legal documentation. Latino category may include any race. All other categories are non-Latino. Other includes those who identify as multiple races.

Source: CBPP estimates based on the 2019 American Community Survey

Explaining Health Care Reform: Questions About Health Insurance Subsidies

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Health insurance is expensive and can be hard to afford for people with lower or moderate income, particularly if they are not offered health benefits at work. In response, the Affordable Care Act (ACA) provides for sliding-scale subsidies to lower premiums and out-of-pocket (OOP) costs for eligible individuals.

This brief provides an overview of the financial assistance provided under the ACA for people purchasing coverage on their own through health insurance Marketplaces (also called exchanges).

Health Insurance Marketplace Subsidies

There are two types of subsidies available to marketplace enrollees. The first type, called the premium tax credit, works to reduce enrollees' monthly payments for insurance coverage. The second type of financial assistance, the cost sharing subsidy, is designed to minimize enrollees' out-of-pocket costs when they go to the doctor or have a hospital stay. In order to receive either type of financial assistance, qualifying individuals and families must enroll in a plan offered through a health insurance Marketplace (https://www.healthcare.gov/health-plan-information/).

PREMIUM TAX CREDIT

The premium tax credit reduces enrollees' monthly payments for insurance plans purchased through the Marketplace. Marketplace plans are offered in four "metal" levels of coverage: bronze, silver, gold, and platinum. Bronze plans tend to have the lowest premiums but have the highest deductibles (https://www.kff.org/slideshow/cost-sharing-for-plans-offered-in-the-federal-marketplace/) and other cost sharing, leaving the enrollee to pay more out-of-pocket when they receive covered health care services, while platinum plans have the highest premiums but very low out-of-pocket costs. The premium tax credit can be applied to plans in any of these metal levels. Also offered on the Marketplace are Catastrophic health plans (https://www.healthcare.gov/choose-a-plan/plans-categories/#catastrophic) with even lower premiums and higher cost sharing compared to bronze plans. Catastrophic plans are generally only available to individuals younger than 30, and premium tax credits cannot be applied to these plans.

Who is eligible for the premium tax credit?

In order to receive the premium tax credit for coverage starting in 2022, a marketplace enrollee must meet the following criteria:

- Have a household income at least equal to the Federal Poverty Level (FPL), which for the 2022 benefit year will be determined based on 2021 poverty guidelines: (Table 1)
- Not have access to affordable coverage through an employer (including a family member's employer)
- Not be eligible for coverage through Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or other forms of public assistance
- Have U.S. citizenship or proof of legal residency (Lawfully present immigrants whose household income is below 100% FPL can also be eligible for tax subsidies through the Marketplace if they meet all other eligibility requirements.)
- If married, must file taxes jointly in order to qualify

For the purposes of the premium tax credit, household income is defined as the Modified Adjusted Gross Income (MAGI) of the taxpayer, spouse, and dependents. The MAGI calculation (https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/what-income-is-counted-in-determining-my-eligibility-for-premium-tax-credits/) includes income sources such as wages, salary, foreign income, interest, dividends, and Social Security.

Table 1: Federal Poverty Guidelines for 2022 Coverage Year

Number in Household	100% FPL	138% FPL	150% FPL	200% FPL	250% FPL	300% FPL	400% FPL
1	$12,880	$17,774	$19,320	$25,760	$32,200	$38,640	$51,520
2	$17,420	$24,039	$26,130	$34,840	$43,550	$52,260	$69,680
3	$21,960	$30,304	$32,940	$43,920	$54,900	$65,880	$87,840
4	$26,500	$36,570	$39,750	$53,000	$66,250	$79,500	$106,000
5	$31,040	$42,835	$46,560	$62,080	$77,600	$93,120	$124,160

NOTE: Tax credit eligibility for the 2022 coverage year is based on 2021 federal poverty guidelines. For households with more than 5 people, add $4,540 for each additional person. Somewhat higher guidelines are established for Alaska and Hawaii.
SOURCE: For more information see ASPE's "Poverty Guidelines" webpage (https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines).

Employer coverage is considered affordable if the employee's contribution – for self-only coverage, not including the cost of adding family members – is less than 9.61 percent (https://www.irs.gov/irb/2021-35_IRB) of household income. Under this rule, if an employer covers 100% of the cost of self-only coverage for its workers but nothing toward the cost of family coverage, the offer of employer coverage would still be considered affordable, meaning that family members would nonetheless be ineligible for marketplace subsidies. This anomaly is sometimes referred to as the "family glitch."

The employer's coverage must also meet the minimum value (https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/im-offered-health-benefits-at-work-but-theyre-not-very-good-im-applying-for-better-coverage-and-subsidies-in-the-marketplace-the-application-asks-whether-im-offe/) standard, meaning that the plan has an actuarial value of at least 60 percent (equivalent to a bronze plan), with an annual OOP limit on cost sharing of no more than $8,700/$17,400 in 2021. Minimum value plans must also provide substantial coverage for hospitalization and physician care. People who are offered employer-sponsored coverage that fails to meet one or both of these requirements can qualify for Marketplace subsidies if they meet the other criteria listed above.

In states that have expanded Medicaid under the ACA, adults with income up to 138% FPL are generally eligible for Medicaid and so ineligible for Marketplace subsidies. In the 12 states that have not adopted the Medicaid expansion, adults with income as low as 100% FPL can qualify for Marketplace subsidies, but those with lower incomes are not eligible for tax credits and generally not eligible for Medicaid unless they meet other state eligibility criteria (https://www.kff.org/state-category/medicaid-chip/medicaidchip-eligibility-limits/). KFF estimates that 2.2 million (https://www.kff.org/policy-watch/taking-a-closer-look-at-characteristics-of-people-in-the-coverage-gap/) Americans living in non-expansion states fall into this coverage gap.

An exception to the rule restricting tax credit eligibility for adults with income below the poverty level is made for certain lawfully present immigrants. Other federal rules restrict Medicaid eligibility for lawfully present immigrants, other than pregnant women, until they have resided in the U.S. for at least five years. Immigrants who would otherwise be eligible for Medicaid but have not yet completed their five-year waiting period may instead qualify for tax credits through the Marketplace. If an individual in this circumstance has an income below 100 percent of poverty, for the purposes of tax credit eligibility, his or her income will be treated as though it is equal to the poverty level. Immigrants who are not lawfully present are ineligible to enroll in health insurance through the marketplace, receive tax credits through the marketplaces, or enroll in non-emergency Medicaid and CHIP.

What amount of premium tax credit is available to people?

The premium tax credit works by limiting the amount an individual must contribute toward the premium for the "benchmark" plan – or the second-lowest cost silver plan available to the individual in their Marketplace. This "required individual contribution" is set on a sliding income scale. In 2022, for individuals with income up to 150% FPL, the required contribution is zero, while at an income of 400% FPL or above, the required contribution is 8.5% of household income (Table 2).

These amounts were set by the American Rescue Plan Act (https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-will-improve-affordability-of-private-health-coverage/) (ARPA) and they are in effect temporarily, just for the 2021 and 2022

coverage years. Prior to ARPA, the required contribution percentages for the 2020 plan year ranged from 2.06% of household income for people with income between 100% and 133% FPL to 9.78% of income for people with income from 300% to 400% FPL. In addition, prior to ARPA, people with income above 400% FPL were not eligible for premium tax credits. Congress is debating extension of the ARPA subsidy changes for future years.

Table 2: Required Individual Contribution to Benchmark Plan Premium

Household Income Range (expressed as % of FPL)	Required % of household income at start of range	Required % of household income at top of range
Up to 150%	0	0
150% up to 200%	0	2
200% up to 250%	2	4
250% up to 300%	4	6
300% up to 400%	6	8.5
400% and higher	8.5	8.5

SOURCE: Internal Revenue Service (https://www.irs.gov/irb/2021-35_IRB#REV-PROC-2021-36)

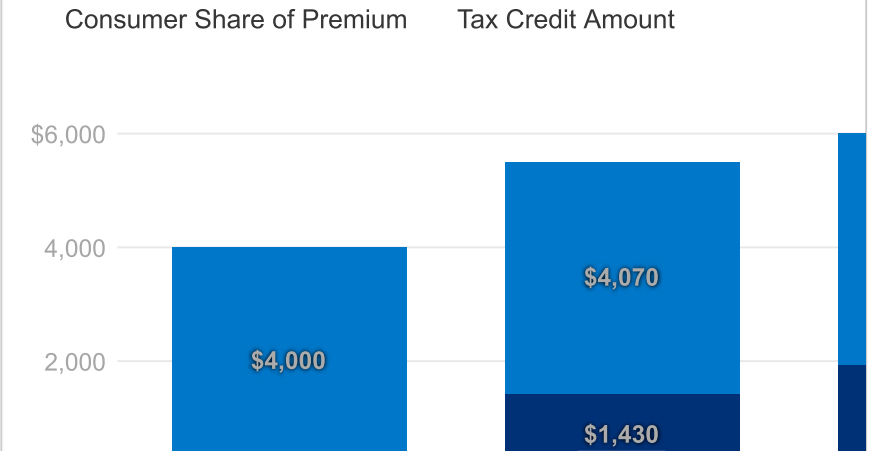
The amount of tax credit is calculated by subtracting the individual's required contribution from the actual cost of the "benchmark" plan. So, for example, if the benchmark plan costs $6,000 annually, the required contribution for someone with an income of 150% FPL is zero, resulting in a premium tax credit of $6,000; if that same person's income equals 250% FPL, the individual contribution is 4% of $32,200, or $1,030, resulting in a premium tax credit of $4,070.

The premium tax credit can then be applied toward any other plan sold through the Marketplace (with the exception of catastrophic coverage). The amount of the tax credit remains the same, so a person who chooses to purchase a plan that is more expensive than the benchmark plan will have to pay the difference in cost. Conversely, if a person chooses a less expensive plan, such as the lowest-cost silver plan or a bronze plan, the tax credit will cover a greater share of that plan's premium, and possibly even cover the entire cost, leaving the consumer with a zero-premium plan. (When the tax credit exceeds the cost of a plan, it lowers the premium to zero and any remaining tax credit amount is unused.) Figure 1 shows an example of how premium tax credits would work for a 45-year-old individual with a 2022 income equal to 250% of FPL. The example assumes the unsubsidized benchmark plan premium for someone this age would be $6,000 annually, while unsubsidized premiums for the lowest cost bronze, lowest cost silver, and lowest cost gold plans for this person would be $4,500, $5,500, and $6,800, respectively.

Figure 1

How Premium Tax Credit Reduces a Consumer's Share of Premium for Different Plans for a Single person at 250% FPL in 2022

For a consumer with an income of $25,760 (250% FPL), premium tax credit = cost of benchmark plan minus required individual contribution (4% of household income), or $4,070. Unsubsidized premium for each plan is illustrative.



For certain components of a marketplace plan premium, the premium tax credit will not apply. First, the tax credit cannot be applied to the portion of a person's premium attributable to covered benefits that are not essential health benefits (https://www.healthcare.gov/glossary/essential-health-benefits/) (EHB). For example, a plan may offer adult dental benefits, which are not included in the definition of EHB. In that case, the person would have to pay the portion of the premium attributable to adult dental benefits without financial assistance. In addition, the ACA requires that premium tax credits may not be applied to the portion of premium attributable to "non-Hyde" abortion (https://www.healthaffairs.org/do/10.1377/hblog20210919.154415/full/) benefits. Marketplace plans that cover abortion are required to charge a separate $1 monthly premium to cover the cost of this benefit; although insurers can itemize the $1 charge on a single monthly bill and collect what enrollees owe monthly, including for the $1 charge, in a single transaction. Finally, if the person smokes cigarettes and is charged a higher premium for smoking, the premium tax credit is not applied to the portion of the premium that is the tobacco surcharge.

How will premium tax credit be provided?

To receive the premium tax credit, people must apply for coverage through the Marketplace and in their application, provide information about their age, address, household size, citizenship status, and estimated income for the coming year. Immediately after submitting the application, people will receive a determination

letting them know the amount of premium tax credit for which they qualify. The consumer then has the option to have the tax credit paid in advance, claim it later when they file their tax return, or some combination of the two options.

The advanced premium tax credit (APTC) option allows consumers to have 1/12 of their tax credit paid directly to their marketplace plan insurer each month, reducing the monthly amount the consumer owes. However, because the APTC eligibility determination is based on estimated income, the enrollee is required to reconcile their APTC at tax time the following year, once they know what their actual income was. (For people receiving an advanced payment of the premium tax credit in 2021, the reconciliation would occur when they file their 2021 tax return in 2022). If the consumer overestimated their income when they applied, they can receive the unclaimed premium tax credit for which they were eligible as a refundable tax credit when they file. If the consumer underestimated their income at the time of application and excess APTC was paid on their behalf during the year, they would have to repay some or all of the excess tax credit when they file. There are maximum repayment limits which vary depending on income, shown in Table 3.

Table 3: Repayment Limits for Advanced Premium Tax Credits, 2021 Tax year

Income (% Federal Poverty Level)	Maximum repayment amount for a single taxpayer	Maximum repayment amount for other taxpayers
Less than 200% FPL	$325	$650
200% – less than 300% FPL	$800	$1,600
300% – less than 400% FPL	$1,350	$2,700
400% FPL or greater	No limit, full amount of excess credit must be repaid	No limit, full amount of excess credit must be repaid

SOURCE: Internal Revenue Service (https://www.irs.gov/pub/irs-drop/rp-20-45.pdf)

Alternatively, people can opt to pay their entire premium costs each month and wait to receive their tax credit until they file their annual income tax return the following year, although most marketplace participants cannot afford this option. The premium tax credit is refundable, meaning it is available to qualifying enrollees regardless of whether they have federal income tax liability. Everyone who receives APTC in a tax year is required to file a tax return for that year in order to continue receiving financial assistance in the future.

Cost Sharing Subsidies

The second form of financial assistance available to Marketplace enrollees is a cost sharing subsidy. Cost sharing subsidies reduce enrollees' out-of-pocket cost due to deductibles, copayments, and coinsurance when they use covered health care services.

Who is eligible for the cost sharing subsidy?

People who are eligible to receive a premium tax credit and have household incomes from 100% to 250% of poverty are eligible for cost sharing subsidies.

How are cost sharing subsidies provided?

Unlike the premium tax credit (which can be applied toward any metal level of coverage), cost sharing subsidies are only offered through silver plans. For eligible individuals, cost sharing reductions (CSR) are applied to a silver plan, essentially making deductibles and other cost sharing under that plan more similar to that under a gold or platinum plan. Individuals with income between 100% and 250% FPL can continue to apply their premium tax credit to any metal level plan, but they can only receive the cost sharing subsidies if they pick a silver-level plan.

What amount of cost sharing subsidies are available to people?

Cost sharing subsidies are determined on a sliding scale based on income. The most generous cost sharing subsidies are available for people with income up to 150% FPL. For them silver plans that would otherwise have an actuarial value of 70% (meaning the plan would have very high deductibles) are modified to have an actuarial value of 94%. This level of cost sharing reduction plan (sometimes called CSR 94 plans) is similar to a platinum plan, and otherwise, applicable silver plan deductibles, copays, and other cost sharing are substantially reduced. Somewhat less generous cost sharing subsidies are available for people with income of 151% FPL up to 200% FPL that increase the silver plan actuarial value to 87% (CSR 87 plans), with cost sharing more similar to that under a gold plan. And for people with income of 200% up to 250% FPL, modest cost sharing reductions are available to increase the silver plan actuarial value to 73% (CSR 73 plans) and to reduce deductibles and other cost sharing below levels otherwise applicable under a normal silver plan.

Insurers have flexibility in how they set deductibles and copays to achieve the actuarial value under marketplace plans, including CSR plans. On average (https://www.kff.org/slideshow/cost-sharing-for-plans-offered-in-the-federal-marketplace/), in 2021 federal marketplace plans, annual deductibles in CSR94 plans were $177, compared to $4,816 in a normal Silver plan, while average annual deductible in CSR87 and CSR73 plans were $800 and $3,835, respectively.

The ACA also requires maximum annual out-of-pocket spending limits on cost sharing under marketplace plans, with reduced limits for CSR plans. In 2023, the maximum OOP limit will be $8,700 ($17,400 family) for all QHPs; with lower maximum OOP amounts permitted under cost sharing reduction plans. (Table 4)

Table 4: Maximum Annual Limitation on Cost Sharing, 2022

Plan type	Income Level	OOP Maximum on Cost Sharing	
		Individual	Family
All plans	All income levels	$8,700	$17,400
CSR 73 Silver Plan	201% – 250% FPL	$6,950	$13,900
CSR 87 Silver Plan	151% – 200% FPL	$2,900	$5,800
CSR 94 Silver Plan	100% – 150% FPL	$2,900	$5,800

SOURCE: HHS Notice of Benefit and Payment Parameters for 2022 (https://www.federalregister.gov/documents/2021/05/05/2021-09102/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2022-and)

Discussion

Subsidies to make insurance more affordable and increase insurance coverage are a key element of the Affordable Care Act. Premium and cost sharing subsidies of varying levels are available to individuals and families with low to moderate incomes, to make coverage and care more affordable.

Beginning in 2021, the ARPA temporarily increased marketplace premium tax credit amounts and extended eligibility for premium tax credits. As a result of these changes, marketplace participants with the lowest incomes (up to 150% FPL) are now eligible for zero-premium silver plans with cost sharing subsidies that also reduce their out-of-pocket cost for covered benefits. The ARPA subsidies first became available to consumers during a pandemic-related special enrollment opportunity (https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf) in 2021, and more than 2.8 million individuals signed up for new health insurance coverage during that time. Even so, KFF estimates millions more uninsured individuals (https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/) are eligible for marketplace financial assistance but not enrolled. As the public learns more about more affordable coverage options in the marketplace, it is possible that even greater numbers can enroll in plans with both monthly premiums and deductibles that they find affordable.

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Ten Changes to Watch in Open Enrollment 2022

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Even as the ninth annual Open Enrollment period gets underway, the Affordable Care Act (ACA) Marketplaces continue to evolve and important changes are expected. Keep an eye on:

1. Open enrollment dates are changing

In most states, the Open Enrollment period will be longer this time. In recent years, in the HealthCare.gov states, it has lasted only 6 weeks; but now it will run from November 1, 2021 through January 15, 2022. That said, people should still sign up by December 15 if they want coverage to take effect on January 1. Signing up later generally means coverage will start February 1. State-run marketplaces have flexibility to hold even longer OE periods and some will do so (https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/when-can-i-enroll-in-private-health-plan-coverage-through-the-marketplace/).

2. Plan choices and premiums will change in 2022

As happens every year, premiums for marketplace plans will change somewhat in 2022. In HealthCare.gov states, the average benchmark plan premium will be about 3% lower (https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2022QHPPremiumsChoiceReport.pdf) than in 2021, while in some state-based marketplaces, qualified health plan premiums will increase modestly, on average.

In addition, the number of insurers participating in the marketplace will increase in 2022. In HealthCare.gov states, 32 additional insurers will offer marketplace coverage, bringing the total to 213. Competition by insurers can sometimes change the so-called benchmark plan (the second-lowest cost silver plan, on which marketplace subsidies are based) if a new silver plan earns this designation in 2022. On average, consumers in HealthCare.gov states will have a choice of nearly 83 qualified health plans in 2022, compared to an average of 46 plans in 2021.

3. Improved marketplace subsidies continue and will reduce net premiums for most consumers

Expanded marketplace premium subsidies, enacted under the American Rescue Plan Act (https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-will-improve-affordability-of-private-health-coverage/) (ARPA), took effect in 2021 and remain in effect for 2022. The dollar amount of premium tax credits increased and now fully cover the cost of enrolling in the benchmark silver plan for consumers with income up to 150% FPL. Before, consumers at 150% FPL had to pay more than 4% of household income for the benchmark plan. For people up to 150% FPL, cost sharing subsidies also substantially reduce deductibles and copays under zero-premium silver plans, making them similar to platinum plans.

ARPA also extended eligibility for premium tax credits to reach people with income over 400% FPL ($51,520 for a single person in 2022, $87,840 for family of 3). Now these consumers must contribute no more than 8.5% of income toward the benchmark silver plan. Before, for older consumers, the age-rated premium for benchmark plans could easily cost more than 20% of household income. ARPA premium tax credit changes are temporary, ending after 2022, although legislation (https://www.kff.org/policy-watch/how-marketplace-costs-premiums-will-change-if-rescue-plan-subsidies-expire/) to make them permanent is pending in Congress.

The KFF subsidy calculator (https://www.kff.org/interactive/subsidy-calculator/) helps people estimate the amount of financial assistance based on their age, income, family size, and zip code.

4. Active renewing is strongly recommended

In most states, if enrollees have not updated their application and plan selection for 2022, the marketplace may auto-re-enroll them in their current plan or a similar plan for the coming year. Over the last three Open Enrollment periods, about 40% (https://www.cms.gov/research-statistics-data-systems/marketplace-products/2021-marketplace-open-enrollment-period-public-use-files) of returning marketplace participants were auto-re-enrolled. However, passively renewing can sometimes put consumers at a disadvantage. For example, if the benchmark plan changes from one year to the next (e.g., due to entrance of new insurers), the dollar value of tax credits, which are tied to the cost of the benchmark plan, can also change. That means someone now enrolled in the 2021 benchmark plan who is passively renewed could see unexpected monthly premium cost increases if another plan gains benchmark status in 2022 and costs less.

Enrollees who did not take advantage of new ARPA subsidies when those subsidies came online this year could also miss out if they don't actively renew. While the marketplace automatically adjusted subsidies for many current enrollees at the end of the COVID-SEP, it could not apply more help to people already in zero-premium bronze plans. More than 800,000 (https://aspe.hhs.gov/sites/default/files/private/pdf/265291/low-premium-plans-issue-brief.pdf) HealthCare.gov enrollees were in zero-premium bronze plans at the end of Open Enrollment for 2021, and many of them would be better off in silver plans with the new ARPA subsidies. All marketplace enrollees are encouraged to update their

application during Open Enrollment, even if personal circumstances have not changed, so they can see all current plan and financial assistance options. Otherwise, the extended Open Enrollment will leave a short window (until January 15) when consumers can still make changes.

5. People with very low income will have added time to enroll

Starting in 2022, HealthCare.gov will allow enrollment throughout the year for people with income up to 150% of the federal poverty level (or FPL, which is $19,320 per year for a single person in 2022, $32,940 for family of 3). A new special enrollment opportunity will be offered each month, and as noted above, plan choices will include zero-premium plans with vastly reduced deductibles. To sign up during the year, people can attest to having 2022 income at or below 150% FPL, then continue with their application. The marketplace will conduct real-time income verification, as it does for all applicants, and might ask for additional documentation to be submitted within 90 days. This year, HealthCare.gov will ask for documentation when consumers estimate their 2022 income will be substantially lower (by 50% or $12,000, whichever is greater) than the amount reported on their most recent federal income tax return.

Extended enrollment could benefit millions of people. At the end of the last Open Enrollment, roughly 1/3 (https://www.kff.org/health-reform/state-indicator/marketplace-plan-selections-by-household-income-2/?dataView=0&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) of marketplace participants had income at or below the 150% FPL threshold; and during the recent COVID enrollment opportunity in 2021, 45% (https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf) of people signing up in HealthCare.gov states (22% in state marketplaces) had incomes at or below this threshold. Open Enrollment remains the best time to sign up for year-long coverage, but the added enrollment opportunities will make it easier for people to sign up for premium-free plans with low cost-sharing throughout the year.

6. More enrollment help will be available

In HealthCare.gov states, funding for Navigators (https://www.kff.org/private-insurance/issue-brief/navigator-funding-restored-in-federal-marketplace-states-for-2022/) has been restored following years of substantial funding cuts averaging 84%. Navigators are trained enrollment experts, certified by the marketplace, who provide free help to individuals shopping for marketplace coverage and subsidies, or help signing up for Medicaid and CHIP. Twice as many programs will be available in 2022, with more resources to serve consumers, including extended hours, remote assistance, and language translation services. The "Find Local Help" (https://localhelp.healthcare.gov/#/) link on HealthCare.gov provides contact information and hours of operation for the nearest programs.

7. Three new state-run marketplaces will open

This fall 3 states – Kentucky (https://kynect.ky.gov/healthcoverage/s/?language=en_US), Maine (https://www.coverme.gov/home), and New Mexico (https://www.bewellnm.com/) – are launching state-based marketplaces. Some 173,000 residents of these states already enrolled in plans through HealthCare.gov will have their data transferred to the new state marketplace and receive instructions for accessing their accounts and enrolling in 2022 coverage.

8. New surprise medical bills protection will take effect

Most marketplace plans are HMOs or EPOs with closed provider networks, meaning they generally will not cover non-emergency care from an out-of-network provider; and even when plans do cover out-of-network claims, consumers can face "balance billing" charges in excess of what their plan will pay. That will change next year when a new federal law starts protecting consumers from surprise medical bills (https://www.kff.org/private-insurance/fact-sheet/surprise-medical-bills-new-protections-for-consumers-take-effect-in-2022/). Beginning January 1, all insurance plans, including marketplace plans, must cover emergency services (other than ground ambulance) at the in-network rate, and out-of-network emergency room facilities and doctors will not be allowed to bill patients more than the in-network cost sharing amount under their plan. These protections will also apply for non-emergency care received by patients while at in-network hospitals, ambulatory surgery centers, or other facilities.

9. Some recent changes have changed back

This year, it will again be important for consumers to carefully estimate their 2022 income when they apply for marketplace subsidies. Thanks to a temporary repayment holiday (https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/i-had-a-marketplace-plan-with-premium-tax-credits-in-2020-but-my-income-changed-a-lot-during-the-year-and-im-worried-i-might-have-to-repay-the-irs-when-i-file-my-2020-return-this-year-what/) enacted as part of pandemic relief legislation, people who filed their 2020 tax return this spring did not have to repay any excess 2020 premium tax credit; but the repayment requirement is now back in force. Marketplace consumers who under-estimate their 2022 income risk owing more taxes (https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/whats-the-most-i-would-have-to-repay-the-irs/) if they claim excess premium tax credits during the year. If people do experience a significant change in their 2022 income after they've signed up, they should update their marketplace account as soon as possible to avoid receiving excess subsidies.

Another key change this year reversed Trump Administration revisions to the "public charge (https://www.kff.org/report-section/estimated-impacts-of-final-public-charge-inadmissibility-rule-on-immigrants-and-medicaid-coverage-key-findings/)" rule that would have made it harder for immigrants to enter or stay in the U.S. if they needed public assistance to obtain health coverage. That action deterred (https://www.kff.org/report-section/estimated-impacts-of-final-public-charge-inadmissibility-rule-on-immigrants-and-medicaid-coverage-key-findings/) many people from applying for or remaining enrolled in health coverage for fear this could impact their immigration status. This year the Biden

Administration rescinded the Trump Administration changes to the public charge rule. Now, under current rules, immigration officials will not consider (https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/i-thought-people-who-earn-more-than-4-times-the-federal-poverty-level-are-not-eligible-for-marketplace-subsidies-has-that-changed/) enrollment in Marketplace, CHIP, or Medicaid coverage as part of a public charge test when people apply for a green card.

10. Will New Enrollment Records Be Set?

Marketplace enrollment reached a record high of 12.2 million people as the special COVID enrollment period ended in most states in August 2021. Affordability gains due to expanded subsidies, as well as outreach and enrollment assistance, likely contributed to this result. Even so, an October 2021 KFF poll found that only 1 in 4 people (https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-october-2021/) who are uninsured or who buy their own health insurance checked to see if they qualified for more help once the ARPA subsidy improvements became available. Shortly after ARPA's enactment, KFF estimated nearly 11 million uninsured Americans (https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/) were eligible for but not enrolled in subsidized marketplace plans, including 1.4 million who became newly eligible for marketplace subsidies. These uninsured individuals, including those eligible for zero-premium plans, disproportionately (https://www.kff.org/private-insurance/issue-brief/a-closer-look-at-the-uninsured-marketplace-eligible-population-following-the-american-rescue-plan-act/) have a high school education or less, are Hispanic, young adults, live in rural areas, or lack Internet access at home. It remains to be seen during this next Open Enrollment whether additional time and enrollment help, and expanded financial help yields even more signups.

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The American Rescue Plan Act's Marketplace Provisions

Early Implementation Experiences and Lessons Learned from Three State-Based Marketplaces

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Included in the wide-ranging American Rescue Plan Act of 2021 (ARPA) are several provisions that expand the Affordable Care Act's (ACA's) premium tax credits (PTCs) for families and individuals who have coverage through the health insurance Marketplaces. These provisions call for one of the most significant changes to the ACA since its passage 11 years ago. Designed to help people affected by the COVID-19 public health emergency (PHE) and to address the affordability of health insurance for people with low and moderate incomes, a long-standing policy problem,[1] the ARPA boosts the amount of the subsidies provided to those already eligible for Marketplace PTCs. For the first time, the ARPA also offers subsidies to people with incomes above 400 percent of the federal poverty level (FPL).

Importantly, these ARPA provisions are temporary and last through 2022, unless Congress makes them permanent, as called for in the American Families Plan. That the provisions are temporary underscores the need for quick action on the parts of state-based Marketplaces (SBMs) and the federally facilitated Marketplace (FFM) to ensure people take advantage of this new financial help. If made permanent, the ARPA PTC enhancements are estimated to reduce the number of people uninsured by 4.4 million, to add 5.1 million Marketplace enrollees, and to reduce Marketplace premiums by 15 percent by 2022 (Banthin et al. 2021).

To provide some insight into early lessons learned by SBMs implementing the ARPA Marketplace provisions, we interviewed state Marketplace officials, representatives from navigator organizations, and Marketplace health insurers in California, New York, and Washington State. In the interviews, we

asked how these states implemented the ARPA Marketplace provisions, how implementation was going, and what future steps they might take. We chose these study states because each has long been a leader among SBMs. Thus, their experiences implementing the ARPA provisions offer lessons that could be helpful to state and federal policymakers as the 2022 open enrollment period approaches and could inform future Marketplace improvements. We conducted semistructured interviews between May and August 2021. To conduct this work, we relied on federal and state documents and reports and other grey literature.

Summary of Study Findings

State officials in the three study states were eager to take advantage of the ARPA Marketplace provisions. Further, knowing that the enhanced subsidies were available for a short time, states acted quickly to mount robust marketing and consumer outreach campaigns. Sometimes this involved using strategies states had not previously employed, such as coordinating with other state agencies to promote the Marketplace and the enhanced subsidies. We find that how states adjusted their Marketplaces to accommodate the ARPA provisions varied along several dimensions, including in the length of ARPA-related special enrollment periods, implementation schedules, and the extent to which the Marketplace system changes adopted were automated for consumers. In some instances, how study states implemented the ARPA Marketplace provisions aligned with federal action taken on the FFM. Consistent with the FFM, early data released by the study states indicate the ARPA provisions have been promising: Marketplace enrollment is up, the share of enrollees receiving premium subsidies has increased, and consumers are, on average, paying lower premiums.

Even while implementing the ARPA provisions, the study states continued to try to improve their Marketplaces and anticipate upcoming needs. As one important example, the study state Marketplaces are partnering with their state Medicaid agencies to prepare for when the PHE ends; now that Marketplace coverage has become more affordable, Marketplace officials think an opportunity exists to enroll people as they are disenrolled from Medicaid. Officials noted that previous take-up of Marketplace insurance by terminating Medicaid enrollees was limited because Marketplace coverage was too costly.

Chief among the lessons learned from California's, New York's, and Washington's implementations of the ARPA Marketplace provisions that could be useful to other SBMs and the FFM are the following:

- Centering how the ARPA's new and expanded financial help makes insurance more affordable for more people is essential for ARPA messaging. However, messages need to be customized for different groups. To help overcome long-standing beliefs that health insurance is unaffordable, ARPA messaging could focus on how the enhanced subsidies are new and make health insurance more affordable than ever. For uninsured people, messaging could also highlight the importance of having health insurance during the pandemic. For people insured outside of the Marketplace (hereafter "off-Marketplace" consumers), messages could focus on themes related to saving more with Marketplace coverage. Finally, messaging to current

Marketplace enrollees could encourage consumers to review their health plan selections to ensure they have picked the best option.

- To raise awareness about the ARPA's enhanced subsidies, marketing and consumer outreach can be conducted via communication strategies including direct mail or print or digital campaigns. Like messaging, strategies should be tailored for different groups. An effective communication strategy reaches people multiple times through different communication channels.
- Establishing partnerships with other state agencies (e.g., state unemployment agencies, state health insurance regulators, and state Medicaid agencies) is crucial to helping promote the Marketplace generally and raising awareness among potential enrollees about the availability of new financial help for purchasing coverage.
- Engaging Marketplace partners (e.g., health plans, brokers, and navigators) helps with conducting direct outreach and education to current and potential enrollees about the financial assistance the ARPA offers.

Major ARPA Marketplace Provisions

The ARPA has many provisions,[2] including an increase in the amount of and expanded eligibility for the ACA premium subsidies for people who get health insurance through SBMs or the FFM. In addition, it calls for extra subsidies for people who receive unemployment insurance benefits during 2021. We discuss these in detail below.

Enhanced premium tax credits. The ARPA increases the value of PTCs available to Marketplace enrollees by reducing the share of income people are expected to pay toward their premiums (table 1). For example, before the ARPA, people with incomes below 138 percent of FPL in states that have not expanded Medicaid contributed 2.07 percent of their household income to enroll in a benchmark silver plan. Under the ARPA, people with incomes below 150 percent of FPL can select a benchmark silver plan with no premium payment. The law also extends PTCs for the first time to people with incomes over 400 percent of FPL, capping the percentage of income these people contribute toward premiums for a Marketplace plan at 8.5 percent. The ARPA subsidies substantially reduce premium payments for many eligible people. For example, a 64-year-old earning just above 400 percent of FPL would pay $4,394 per year in Marketplace premiums under the ARPA, down from $12,698 per year before the ARPA provisions took effect (Pollitz 2021). As mentioned, these are temporary enhancements available only through 2022, unless Congress acts to extend them.

TABLE 1

Advanced Premium Tax Credit Schedules under the Affordable Care Act and American Rescue Plan Act, 2021

Income range (% of the federal poverty level)	Range of applicable percentage-of-income caps under the ACA	Range of applicable percentage-of-income caps under the ARPA
<138	2.07	0
138–150	3.10–4.14	0
150–200	4.14–6.52	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
500–600	n/a	8.5
600+	n/a	8.5

Sources: Internal Revenue Service, US Department of Health and Human Services, and the American Rescue Plan Act of 2021, Pub. L. No. 117-2.
Notes: ACA = Affordable Care Act. ARPA = American Rescue Plan Act. n/a is not applicable.

Three major groups could benefit from these ARPA Marketplace provisions: uninsured people; people with nongroup health insurance purchased directly from an insurer, rather than the ACA Marketplace, known as the off-Marketplace population; and people already enrolled in a Marketplace plan before the ARPA.

The estimated ARPA-induced Marketplace enrollment increase is substantial. Nationally, Marketplace enrollment is expected to increase by 30 percent, from 14.9 to 19.5 million, by 2022 (table 2). For the study states, Washington's enrollment is expected to increase the most (43.4 percent), followed by California (19.6 percent) and New York (15.0 percent). The estimated decline in the number of people uninsured is also considerable, ranging from 11.4 percent in California to 18.0 percent in Washington. Nationwide, the number of people uninsured is expected to drop by 13.6 percent.

TABLE 2

Estimated Marketplace Enrollment and Number of Uninsured People in the Study States and the US, with and without the ARPA, 2022 Plan Year

	Estimated Marketplace Enrollment			Estimated Uninsurance		
	Without ARPA (1,000s of people)	With ARPA (1,000s of people)	Percent change	Without ARPA (1,000s of people)	With ARPA (1,000s of people)	Percent change
California	2,145	2,567	19.7	3,682	3,262	-11.4
New York	1,079	1,241	15.0	1,106	944	-14.6
Washington	276	396	43.5	597	489	-18.1
US	**14,960**	**19,574**	**30.8**	**30,766**	**26,579**	**-13.6**

Source: Jessica Banthin, Matthew Buettgens, Michael Simpson, and Robin Wang, "What If the American Rescue Plan Act's Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022" (Washington, DC: Urban Institute, 2021).
Notes: ARPA = American Rescue Plan Act. ACA = Affordable Care Act. "Without ARPA" is under the pre-ARPA Affordable Care Act subsidy schedule, and "with ARPA" is under the enhanced subsidies outlined in the ARPA.

Extra subsidies for unemployed people. Another important ARPA provision is extra subsidies for people who receive unemployment insurance benefits in 2021. Specifically, people who receive unemployment for at least one week in 2021 are eligible for zero-dollar premiums and cost-sharing reductions. Unlike the enhanced subsidies available through 2022, these unemployment subsidies extend through 2021 only.

Key Features of the Marketplaces in Three Study States

As some of the first states with SBMs, the study states launched their Marketplaces in 2014, the same year the FFM became available. These SBMS, Covered California, NY State of Health, and Healthplanfinder, share many common features but have important differences, largely reflecting the various innovations the states have implemented to improve their Marketplaces (table 3). Some of these programmatic attributes shaped the study states' experiences with the ARPA.

TABLE 3

Key Features of Study State-Based Marketplaces and the Federally Facilitated Marketplace before American Rescue Plan Act Implementation

	California	New York	Washington	FFM
First year of SBM implementation (plan year)	2014	2014	2014	2014
Marketplace enrollment (end of 2021 open enrollment period)	1,625,546	215,889	222,731	8,251,703
Standard open enrollment period	November 1–January 31	November 1–February 7	November 1–January 15	November 1–December 15
ACA Medicaid expansion?	Yes	Yes	Yes	n/a
Standardized plans?	Yes	Yes	No	No
Community rated?	No	Yes	No	No
Public option health plan available on Marketplace?	No	No	Yes	No
Basic health plan?	No	Yes	No	No
State additional premium subsidy?	Yes	No	No[a]	n/a
Coverage mandate tax penalty?	Yes	No	No	No

Sources: Open enrollment data for 2021 are from "2021 Marketplace Open Enrollment Period Public Use Files," Centers for Medicare & Medicaid Services, last modified April 21, 2021. Study states' open enrollment periods are from Covered California, "Amid a Surge in Enrollment Last Week, Covered California Extends Deadline for Jan. 1 Coverage through Friday," news release, December 16, 2019; NY State of Health, *2020 Open Enrollment Report* (New York: NY State of Health, 2021); and Ryan Blethen, "Open Enrollment for Washington Health Benefit Exchange Begins Friday; Here's What You Need to Know," *Seattle Times*, October 30, 2019. The 2020 open enrollment period for the FFM is from "Key 2020 Open Enrollment Dates," Healthcare.gov, accessed October 18, 2021. State Medicaid expansion decisions are from "Status of State Action on the Medicaid Expansion

Decision," Kaiser Family Foundation, accessed October 18, 2021. Information on standardized plans, community rating, public option health plan availability on the Marketplace, basic health plans, state additional premium subsidies, and coverage mandate tax penalties are from Justin Giovannelli, Kevin Lucia, and Sabrina Corlette, "What Is Your State Doing to Affect Access to Adequate Health Insurance?," Commonwealth Fund, September 23, 2021.
Notes: FFM = federally facilitated Marketplace. SBM = state-based Marketplace.
[a] Washington has created an additional state subsidy program that will take effect in 2023.

Shared characteristics include adoption of the ACA Medicaid expansion and longer-than-usual open enrollment periods compared with that of the FFM. Among the innovative features the study states' Marketplaces have implemented is requiring Marketplace insurers' participation to create plans and standardize cost-sharing and benefit designs to make it easier for consumers to compare plans (California and New York). In addition, New York has instituted plan community ratings, and Washington offers a Marketplace public option plan. New York is also one of two states (the other being Minnesota) that operates a basic health plan.[3] In contrast, the FFM has not adopted any of these innovations. Finally, California is the only study state that has an individual mandate that imposes a state tax penalty on people lacking health insurance. It was also the only state that provided some Marketplace enrollees with premium subsidies to help address affordability issues before the ARPA; beginning in January 2020, California made available state-financed Marketplace subsidies for people with incomes up to 600 percent of FPL.[4] Under the ARPA, California suspended its state premium subsidies.

Study Findings

Though each study state took a robust, multifaceted approach to implementing the ARPA Marketplace provisions, the strategies they adopted differed. The states' implementation plans fell into three broad and interrelated categories:

- programmatic designs and ARPA implementation timelines
- ARPA messaging
- ARPA marketing campaigns and consumer outreach

Programmatic Designs and ARPA Implementation Timelines

States had to quickly make multiple programmatic and system decisions pertaining to implementing the ARPA provisions. These included whether to establish an ARPA special enrollment period (SEP), when to roll out the various provisions and the extent to which the provisions would be automated, and whether enrollees would be allowed to switch plans or insurers during the SEP.

TABLE 4

Differences in American Rescue Plan Act Implementation Decisions between Study States and the Federally Facilitated Marketplace

	California	New York	Washington	FFM
End of ARPA SEP	**12/31/2021**	**12/31/2021**	**8/15/2021**	**8/15/2021**
Timeline of ARPA enhanced subsidies				
Date available for people with incomes < 400% of FPL	4/1/2021	4/1/2021	4/1/2021	4/1/2021
Date automated	5/1/2021	6/5/2021	5/6/2021	9/1/2021
Date available for people with incomes < 400% of FPL	4/1/2021	4/1/2021	4/1/2021	4/1/2021
Date automated	5/1/2021	6/5/2021	5/6/2021	9/1/2021
Timeline and automation of ARPA unemployment benefit				
Date unemployment benefit implemented	7/1/2021	First week of June 2021	Second week of May 2021	7/1/2021
Automated?	Yes, when implemented; eligibility redetermined June 21–26, with a July 1 effective date	No	Yes, when implemented	No
Plan switching decisions				
Allow consumers to change plans during SEP?	Yes	Yes	Yes	Yes
Transfer out-of-pocket spending within insurer?	Yes	Yes	Left up to individual insurers	Left up to individual insurers
Allow consumers to change carriers during SEP?	Yes	Yes	Yes	Yes

Sources: Timelines for study states' enhanced subsidies and automation of the ARPA unemployment benefit are from Peter V. Lee, "Executive Director's Report," Covered California board presentation given August 19, 2021; "Health Insurance Changes for Unemployed New Yorkers in 2021," NY State of Health, accessed October 18, 2021; and Washing Health Benefit Exchange, "Public Health Emergency Special Enrollment and American Rescue Plan Act Implementation," presentation given August 13, 2021. Timelines for the FFM's ARPA enhanced subsidies and automation of the employment benefit and the FFM's plan switching decisions are from "New, Lower Costs on Marketplace Coverage," Centers for Medicare & Medicaid Services, accessed October 18, 2021; and US Department of Health and Human Services, "2021 Special Enrollment Period Access Extended to August 15 on HealthCare.gov for Marketplace Coverage," news release, March 23, 2021. Study states' plan switching decisions are from Covered California, "Covered California Policy and Action Items," board presentation given March 18, 2021; "Health Insurance Changes for Unemployed New Yorkers in 2021," NY State of Health; and Joan Altman and Mary McHale, "Part I – American Rescue Plan Act: Exchange Impacts," presentation given virtually April 12, 2021.

Notes: ARPA = American Rescue Plan Act. FFM = federally facilitated Marketplace. SEP = special enrollment period. FPL = federal poverty level.

ESTABLISHING AN ARPA SPECIAL ENROLLMENT PERIOD

Recognizing that the pandemic has affected millions of people and that access to health care was needed, the US Department of Health and Human Services (HHS), under executive order from President Biden, announced an SEP to allow people to enroll in the FFM from February 15 to May 15,

2021.[5] HHS later extended the FFM SEP end date to August 15, 2021. New York and California both had had continuously running PHE-related SEPs since 2020. With the passage of the ARPA, both states decided to extend their SEPs through December 2021. One Covered California official explained the state's reasoning behind keeping the SEP open through 2021: "They knew it was going to be difficult to bring consumers' attention to the ARPA Marketplace provisions, particularly in the middle of the year, and they wanted consumers to be able to take full advantage of the ARPA subsidies regardless of when they became aware of them." New York Marketplace officials expressed similar sentiments.

Washington adopted a different approach. Though Washington, too, had an SEP during 2020 because of the PHE, the state closed it on January 15, 2021, following the state's standard open enrollment period (table 3). However, once the FFM opened an SEP for the PHE in February 2021, Washington followed suit. Washington also decided to align with the FFM by closing its SEP on August 15, 2021. Washington officials offered several reasons for closing the state's ARPA SEP on that date rather than extending it until the end of 2021. First, state officials wanted the SBM to be aligned with the FFM. They also recognized that between the state's PHE SEP and the ARPA SEP, the state "had been in open enrollment for a long time," as one official said. Another consideration was to allow Marketplace staff to focus on the process and technical improvements they wanted to introduce for the 2022 open enrollment period, which starts November 1, 2021.

THE TIMING AND EXTENT OF AUTOMATION OF THE ARPA PROVISIONS

Officials in each study state highlighted the considerable efforts and resources it took to upgrade their systems to accommodate ARPA provisions, especially because each state operates an integrated enrollment system for its public health programs. As one California official observed, it was a "Herculean task to make the changes to the [Covered California] website and make changes to the enrollment system" to maximize the time state residents could take advantage of the enhanced subsidies. At the same time, states were motivated to implement the provisions to help people harmed by the pandemic and, more generally, to help make insurance more affordable. Toward that end, each state implemented the ARPA provisions in different ways using different timelines, which also differed from the FFM's approach.

The FFM launched ARPA provisions in phases, beginning with enhanced subsidies becoming available to new and existing qualified individuals on April 1, 2021. Enhanced subsidies for unemployed individuals, however, were not made available until July 1. In addition, the FFM did not initially automate any of the provisions; instead, it required all current enrollees to log into Healthcare.gov to get the ARPA enhanced savings.[6] However, the FFM began to automatically apply enhanced subsidies for some current Marketplace enrollees in August, and they took effect September 1.[7]

Study states used different implementation timelines than the FFM, and they automatically applied the enhanced subsides to eligible enrollees from the start. Washington had the most aggressive approach, rolling out all the new ARPA provisions simultaneously, including the unemployment benefit. Washington officials acknowledged considerable internal debate about how to push out ARPA benefits. Ultimately, they decided it would be too confusing to consumers to say, "You get a benefit now, but you have to come back in August," as one official said. In April 2021, Washington notified current enrollees

of the upcoming changes, and by mid-May existing qualifying enrollees' accounts had been automatically updated with enhanced subsidies for their June premiums. Most enrollees did not need to act to receive these enhanced subsidies, according to officials.[8]

In contrast, California and New York followed the FFM's approach more closely and implemented ARPA provisions in several steps. According to one New York official, the state's decision to "bite it [the ARPA provisions] in pieces" was "purely driven by [Marketplace] system complexity." Further, though they wanted to get benefits out to people as fast as possible, New York also wanted to automate as much as possible. New York launched enhanced ARPA subsidies for current Marketplace enrollees already receiving PTCs first. At the beginning of April, the enhanced subsidies were made available to these enrollees, but enrollees had to actively make changes to their accounts to receive the subsidies. About 20 percent did so, according to New York officials. By June 1, though, the enhanced subsidies were automatically applied to this group. Extending advanced premium tax credits to enrollees with incomes above 400 percent of FPL and to people eligible for the unemployment-related subsidies came later, because these changes involved more system testing and processing, according to New York Marketplace officials. These provisions were both launched the first week of June 2021. Though the advanced premium tax credits for those with incomes above 400 percent of FPL were automated, New York did not automatically apply the unemployment-related subsidies to qualified current enrollees; instead, the state sent notices informing enrollees of the new benefit.

California also implemented the ARPA provisions in phases, though its approach was somewhat more automated than New York's. For current enrollees, enhanced PTCs were available to all income groups starting April 5, 2021, but enrollees had to actively make changes to their accounts to receive them. Then, starting May 1, Covered California automatically applied ARPA subsidies for all eligible current enrollees, including those with incomes over 400 percent of FPL. Eligibility was redetermined for 900,000 households, according to state officials. Like New York, the unemployment-related subsidy was implemented later, but it was automatically applied to qualifying individuals in July 2021.

SWITCHING PLANS AND INSURERS DURING THE ARPA SPECIAL ENROLLMENT PERIOD

During the ARPA SEP, the FFM allowed Marketplace enrollees to switch health plans within the same insurer, but insurers decided whether enrollees could carry over any 2021 out-of-pocket spending to the new plan (CMS 2021). The FFM also allowed enrollees to change insurers, but any out-of-pocket spending did not transfer to the new insurer.

All three study states followed the FFM's policy and did not allow enrollees to carry over any out-of-pocket spending if they changed insurers. But the states' approaches to carrying over spending for people who switched plans but stayed with the same insurer varied. Washington followed the FFM, leaving it up to an insurer's discretion whether consumers could transfer out-of-pocket spending if they switched plans within an insurer. In contrast, New York and California allowed enrollees to change plans within an insurer and to transfer any 2021 out-of-pocket spending to the new plan.

Developing Consumer Messaging about ARPA Provisions

Developing messaging for the ARPA that resonated with different populations was a challenge, which state officials and other stakeholders readily acknowledged. They knew they were up against long-standing consumer behavior and thinking regarding health insurance. For example, some uninsured people feel they cannot afford insurance or do not see the value in having coverage. People with off-Marketplace coverage commonly think they would never qualify for financial assistance purchasing coverage or do not want it. More fundamentally, several interviewees commented that the ACA and the Marketplace have been on shaky policy ground for the past several years, which posed yet another challenge to engaging possibly wary consumers. As one insurer said, "Everything from mandate repeal to the price shock…This market [has been] subject to a much higher degree of fundamental policy change. We're just coming out of the fourth or fifth case, not knowing if the ACA would survive."

MAJOR ARPA MESSAGING STRATEGIES

Affordability was at the heart of each state's efforts to engage both uninsured people and the off-Marketplace population via messaging about the ARPA provisions. Still, customized messages for target groups were needed. For example, a major obstacle state officials and other interviewees noted was that many uninsured people want insurance but think they cannot afford it. In various ways, states and their partners tried to get the word out that the ARPA brings something new and different to the Marketplace, and that consumers should revisit Marketplace coverage see how cheap it is now. They also let consumers know coverage was available because of new federal pandemic-related relief. Another messaging strategy used for the uninsured population was highlighting the importance of having insurance, particularly during the pandemic.

Though affordability was also at the center of messaging for the off-Marketplace group, their messaging had to be tweaked. As one official commented, it does not make sense to communicate "you need insurance" to this group, like it does for uninsured people; instead the message was that people "can save more" if they switch to a Marketplace plan.

THE TEMPORARY NATURE OF ARPA SUBSIDIES

Almost universally, interviewees did not think the subsidies' temporary nature was a barrier. Indeed, several interviewees suggested people operate one year at a time when it comes to health insurance. Even so, study states addressed the limited availability of the enhanced subsidies in different ways. On the one hand, California highlighted the subsidies' impermanence to encourage people to take advantage of the subsidies as quickly as possible. As one official said, "We made brand new ads…explaining that there is $3 billion in the state of California to pay for the subsidy [from the ARPA], and this is your chance!" In contrast, New York and Washington let people know that the subsidies are temporary but, as one official said, "We are not leading with it."

Marketing Campaigns and Consumer Outreach

Each study state adopted a robust marketing and consumer outreach campaign to communicate about the ARPA subsidies. Unlike the FFM, which received $50 million in funding to advertise the 2021 ARPA

SEP,[9] study states used existing Marketplace funds to finance their campaigns; no new state resources were provided. Instead, state officials said they took stock of their operations and moved current resources around to prioritize marketing the new enhanced subsidies.

States employed various strategies to conduct their ARPA campaigns and reach consumers, from running TV ads to working with health plans. States also tapped a wide range of agencies to help them reach consumers, including state insurance regulators, state tax boards, and state labor departments. Some of their strategies sought to raise general awareness about ARPA benefits, whereas others were targeted at particular groups (i.e., the uninsured, the off-Marketplace population, and current Marketplace enrollees).

RAISING AWARENESS ABOUT THE ARPA SUBSIDIES

To raise general awareness about the ARPA, each study state employed paid campaigns that included TV, radio, and print advertising starting in April 2021. They also launched digital campaigns including social searches and streaming videos. Study states also updated their Marketplace websites with information about the ARPA, including a section with frequently asked questions that states modified as provisions were implemented. California and Washington put "quick calculators" on their websites to allow consumers to easily view the benefits of the ARPA subsidies. States also added staff to their Marketplace call centers and expanded the centers' hours. In different ways, navigators were also brought into to help promote the ARPA. California offered grants to selected navigators to help fund local ARPA ad campaigns, and Washington amended contracts with navigators to allow them to spend their marketing resources outside of the regular open enrollment period to support implementation of the enhanced subsidies.

In addition, study states provided partners with webinar trainings about the ARPA, toolkits, informational flyers and posters, and talking points. New York coordinated with state parks to give people ARPA flyers with their parking tags when they entered a park.

Insurers, too, launched marketing efforts, including putting ARPA information in plan advertising via social media and direct mail flyers. Some have also called members to tell them about the new subsidies available. Still others have embarked on community-level outreach efforts, such as setting up enrollment and information booths at farmer's markets, food pantries, and the like.

MARKETING AND OUTREACH TO TARGET GROUPS

Apart from a general ARPA marketing campaign, states also targeted particular populations to encourage them to take advantage of the enhanced subsidies. Market circumstances partly dictated the extent to which states targeted different groups for outreach. For example, Washington has a fairly limited off-Marketplace group, whereas California has a sizable off-Marketplace population.

Uninsured people. States used various strategies to engage uninsured people. One was contacting people who had taken an action on their websites (e.g., requested information, provided an email, or submitted an application without enrolling) and sent information to them about the ARPA, the value of health insurance, and how to find help with enrolling in coverage. States used email, direct mail, and text

messaging for this effort. In addition, states relied on their navigators to get the word out. Washington sent information about people who did not complete Marketplace enrollment to navigators and had them contact these people with information about the ARPA. Both New York and California launched similar efforts with their navigators.

Another important strategy the study states used to reach uninsured people was coordinating with state unemployment offices. In April and June, the New York unemployment office sent emails to more than 5 million people who had received unemployment benefits to make them aware of the new ARPA benefits. California and Washington similarly partnered with their states' unemployment agencies to provide people receiving unemployment benefits with information about ARPA benefits they might be eligible for.

Marketplace officials also said they targeted particular segments of the uninsured population in their campaigns. Washington used social media (e.g., placing ads on TikTok, Spotify, and Hulu) to engage young adults because this group accounts for a big share of the state's uninsured population. New York pushed hard to reach uninsured people with incomes above 400 percent of FPL by doing outreach to organizations, associations, and other groups that they had not necessarily targeted in the past, including freelancers, restauranteurs, and actor's guilds. New York also worked with companies like Uber and Lyft to send in-app messages to drivers. California officials noted targeting people in low-income areas, communities of color, and people hardest hit by the pandemic.

California also employed strategies that were unique to the state. The first was partnering with its state tax board. As mentioned, California imposes a state tax penalty for people who do not have health insurance (table 3). Covered California worked with the state tax board and sent Marketplace information to tax filers who had paid the penalty. California also obtained lists from all insurers that provided information for consumers who recently terminated their health insurance; this is a new requirement provided through recent state legislation (S.B. 260). In June 2021, Covered California received the first set of lists and started contacting people to see if they may need Marketplace services.

The off-Marketplace population. Both Marketplace representatives and insurers highlighted the off-Marketplace group as particularly tough to engage. A central challenge interviewees identified is that many in this group think they will never qualify for financial help in the Marketplace or do not think they need such help. Several interviewees also commented that the timing of the ARPA provisions was difficult for the off-Marketplace group because it is "off season"; that is, the off-Marketplace group has been "trained," as one insurer put it, to shop for insurance in the fall. Across the board, interviewees were hopeful that more of the off-Marketplace population would move to the Marketplace near the end of the year.

That said, a principal strategy states used to reach off-Marketplace individuals was engaging with health plans and encouraging them to notify their members about the ARPA. However, the efforts states dedicated to this strategy varied. In Washington, this was not a big focus because of the limited size of the off-Marketplace population, which the state estimates is only about 30,000 individuals (Altman and McHale 2021). Even so, Washington worked with insurers to get them to let their

nongroup customers know they may be eligible for the ARPA subsidies in the Marketplace. As one official said, plans have been "surprisingly responsive" to this ask, even though Washington insurers were said to like the off-Marketplace business because such enrollees tend to be more affluent.

New York officials estimated 70,000 people with off-Marketplace coverage would transition to the Marketplace because of the ARPA provisions. To help move these people, Marketplace officials asked that health plans notify their off-Marketplace enrollees about the enhanced subsidies. Plans agreed to do so, but, as one state official commented, "We didn't exactly get the reception [from the health plans] that we'd thought we'd get." In part, plans' responses seemed driven by their level of off-Marketplace enrollment. One interviewee commented that the insurer they represent had not been involved much with the ARPA because it did not view the potential gain as worth the additional marketing effort, particularly in the middle of the year. New York Marketplace staff also worked with the state health insurance regulator, the Department of Financial Services, to require health plans to provide information about the ARPA subsidies in their 2022 premium notices to customers.

Among the study states, California probably had the most developed approach to engaging health plans to reach the off-Marketplace population. Potential Marketplace enrollment is large in California for this group; the state estimates about 790,000 Californians were enrolled in nongroup health coverage, and 270,000 of them could receive ARPA subsidies (Covered California 2021). The state coordinated with health plans and employed several strategies with the aim of "garnering QHP [qualified health plan] participation to help convert their enrollees…but minimize the risk that the consumer may just go to another plan," as one Marketplace official said. Toward that end, California launched temporary "microsites" that enable insurer-specific enrollment through the Covered California website in June 2021.[10] Consumers can also access an insurer's cobranded Covered California microsite via a link on the insurer's website. For off-Marketplace consumers who switch to a Marketplace plan within the same insurer, insurers must transfer any out-of-pocket spending accrued to the new plan.

Apart from engaging insurers, California and New York also reached out to insurance brokers to help re-enroll off-Marketplace consumers. The New York Department of Financial Services, the state's insurance regulator, sent out 130,000 emails to health insurance brokers about the availability of the enhanced subsidies under the ARPA. Covered California encouraged (though did not require) insurers to offer incentive bonuses to agents for moving off-Marketplace enrollees to Marketplace coverage. California officials said some insurers are doing this. One plan representative we spoke with said their plan established a bonus program for the ARPA that pays top brokers $100 per individual transferred.

Marketplace enrollees. As discussed above, the study states automated many of the ARPA provisions for current Marketplace enrollees, so marketing and outreach to this group was more limited. Even so, some people needed to take an action to take up benefits. For example, people who did not report their income or people who had experienced changes (e.g., began receiving unemployment benefits) but had not reported them needed to notify the Marketplace to receive the benefits. To reach these enrollees, each study state conducted an email or direct mail campaign to tell current enrollees about the ARPA, see if it applies to them, and encourage them to report any changes that may affect their eligibility. As

one state official put it, "We're constantly trying to make sure that they [current enrollees] are at the most advantageous position." Another part of this outreach effort was educating all enrollees to consider getting more comprehensive coverage, especially for those with incomes below 250 percent of FPL.

In addition, states engaged partners to contact current enrollees about the ARPA. New York sent lists to facilitated enrollers of their clients who could potentially benefit from enhanced subsidies. (Unique to New York, facilitated enrollers are health plan employees certified by the state to enroll people in health insurance, including Marketplace products. Marketplace officials said facilitated enrollers account for the bulk of Marketplace enrollment, about 60 to 70 percent.) California and Washington launched similar efforts with their navigator networks.

Early Effects of the ARPA Marketplace Provisions in Study States

Consistent with reports from the FFM, early data from the study states suggest the response to the ARPA Marketplace provisions has been strong. Since implementing the ARPA provisions in mid-August 2021,[11] the number of new plan selections made in California's Marketplace, though lower than that in the FFM, was 2.6 times higher than during the same period in 2019 (257,350 versus 97,430). The increase in new plan selections was comparable in Washington's Marketplace.

TABLE 5

Changes in Plan Selections, Premiums, and the Share of People Receiving Subsidies in the Study States and Federally Facilitated Marketplace, 2019 and 2021

	California	New York	Washington	FFM
Plan selections during 2019 comparison period[a]	97,430	n/a	10,763	383,026
Plan selections during 2021 comparison period[a]	257,350	47,116	28,027	1,541,591
Percent change, 2019–21[b]	164.1	n/a	160.4	302.5
Percent reduction in average monthly premium under ARPA APTCs (%)[b]	49	48	47	50
Average 2021 Marketplace premium before ARPA APTCs ($)[b]	571	656	505	590
Average monthly premium savings due to ARPA APTCs ($)	90	155	86	67
Share with subsidies, 2019 (%)	80.3	58.0	65.0	88.0
Share with subsidies, 2021 (%)	86.3	64.0	78.0	93.0
Percentage-point change in people receiving subsidies, 2019–21[b]	6.0	6.0	13.0	5.0

Sources: Plan selections in California and the share of California residents with subsidies in 2019 and 2021 are from Peter V. Lee, "Executive Director's Report," Covered California board presentation given August 19, 2021. Plan selections in New York and in the FFM for the 2021 SEP were calculated using US Department of Health and Human Services, *2021 Final Marketplace Special Enrollment Period Report* (Washington, DC: US Department of Health and Human Services, 2021); and US Department of Health and Human Services, *2021 Marketplace Special Enrollment Period Report 1* (Washington, DC: US Department of Health and Human Services, 2021). Washington's 2019 and 2021 SEP plan selections are from Washington Health Benefit Exchange, "Public Health Emergency Special Enrollment and American Rescue Plan Act Implementation," presentation given August 13, 2021. The share of New York residents with subsidies in 2019 is from NY State of Health, *2019 Open Enrollment Report* (New York: NY State of

Health, 2019); the authors calculated the share of New Yorkers with subsidies in 2021 using NY State of Health, "Health Insurance Coverage Update September 2021" (New York: NY State of Health, 2021). The shares of Washington residents with subsidies in 2019 and 2021 are from Washington Health Benefit Exchange, *Health Coverage Enrollment Report Spring 2019* (Olympia, WA: Washington Health Benefit Exchange, 2019); and Washington Health Benefit Exchange, "Public Health Emergency Special Enrollment and American Rescue Plan Act Implementation." Shares of people with FFM coverage receiving subsidies in 2019 and 2021 are from Centers for Medicare & Medicaid Services, *Health Insurance Exchanges 2019 Open Enrollment Report* (Baltimore: Centers for Medicare & Medicaid Services, 2019); and US Department of Health and Human Services, *2021 Final Marketplace Special Enrollment Period Report*.

Notes: ARPA = American Rescue Plan Act. FFM = federally facilitated Marketplace. SEP = special enrollment period. APTCs = advanced premium tax credits. n/a = not available.

[a] For each state the 2021 comparison periods are after the passage of the ARPA. Importantly, they are not a perfect comparison with the 2019 comparison periods: The 2019 comparison periods were true SEPs, meaning a person had to have a qualifying life event to enroll in Marketplace coverage. In contrast, the 2021 comparison periods have functioned like open enrollment, meaning people did not need to have a qualifying life event to enroll in coverage. The goal of the comparison is to assess the effect of the ARPA enhanced subsidies on enrollment by comparing 2021 enrollment with a similar period in the recent past (2019) when the enhanced subsidies were not available. Finally, the dates used to calculate the percent change between the 2019 and 2021 comparisons periods were bound by what the states have reported and are not the same. The 2019 and 2021 comparison periods are as follows: April 10–October 10 for California, February 15 to August 15 for New York, May 6–August 15 for Washington, and May 6–August 15 for the FFM. Data were not available for the 2019 comparison period for New York.

[b] Data in these rows are authors' calculations.

With the launch of the ARPA provisions, average monthly premiums decreased by almost half in each study state, consistent with the FFM experience. However, the average premium savings were higher in the study states than in the FFM and varied, ranging from a high of $155 per month in New York to a low of $86 in Washington. This variation in savings owes to the variation in state premiums, which reflect some contextual factors (e.g., underlying state demographic differences, such as age and income), Marketplace program characteristics, and other influences. For example, the higher average premium savings in New York reflect the state's higher average monthly premium ($656) due to its use of community rating (table 3). Finally, the share of Marketplace enrollees who receive subsidies to help pay their premiums has increased relative to 2019 since the ARPA provisions took effect.

State officials also reported observing other changes since the ARPA provisions' implementation, including changes in enrollee plan selections. Washington officials reported that since it launched the ARPA provisions in August 2021, 82 percent of Marketplace enrollees who switched plans changed from a bronze plan (data not shown; Washington Health Benefit Exchange 2021). Similarly, New York reported that the share of enrollees choosing silver plans has increased while the share in bronze plans has declined since the ARPA subsidies became available (NY State of Health 2021b).

More broadly, California officials reported that the enrollment increase brought about by the ARPA has contributed to the state's ability to negotiate a low rate change with health plans for 2022. Further, Covered California will expand the regions in which current Marketplace insurers operate and add a new insurer in 2022, which will help increase competition and consumer choice, according to state officials.[12] In contrast, the number of insurers approved to participate in Washington's Marketplace declined by one for 2022, and the state approved an average 4.17 percent rate increase for Marketplace plans in the coming year, despite rate decreases of more than 3 percent in the past two consecutive years.[13]

Lessons Learned

The study states' early experiences implementing the ARPA Marketplace provisions offer the following lessons that can be useful for other SBMs and the FFM as the 2022 open enrollment period approaches and for informing future Marketplace efforts:

- Modifying Marketplace systems and programmatic features can help state officials effectively and efficiently implement the new ARPA provisions. To the extent possible, policymakers can make Marketplace system upgrades that, after notifying enrollees in advance, will automatically apply enhanced subsidies so consumers do not need to act to receive them. This is a comparatively low-cost strategy that makes enhanced subsidies available quickly without requiring consumer action. Though modifications to premiums and cost-sharing reductions have to be implemented every open enrollment period, the ARPA experience has illustrated the importance of being able to make system and program changes midyear.
- Policymakers should also consider lengthening the ARPA SEP. Doing this will allow consumers to take full advantage of the financial help the ARPA offers.
- It is important that ARPA messaging emphasize how the new and expanded financial help makes insurance more affordable for more people. However, different groups require different messages. To help overcome long-standing beliefs that health insurance is unaffordable, ARPA messaging can underscore that enhanced subsidies are new and make health insurance more affordable than ever and can encourage consumers to revisit Marketplace coverage. For uninsured people, messaging can also highlight the importance of having health insurance during the pandemic. For off-Marketplace consumers, central messages can focus on saving more with the enhanced Marketplace subsidies. Finally, messaging to current Marketplace enrollees can encourage such enrollees to review their health plan selections to ensure they have picked the best option.
- To raise awareness about the ARPA enhanced subsidies, marketing and consumer outreach can be conducted via communication strategies ranging from direct mail to print and digital campaigns. Like messaging, however, it is integral that communication and outreach strategies be tailored for different groups (e.g., placing ads on social media platforms to reach young adults but relying on radio ads and billboards in rural areas where people tend to be older and to drive more). An effective communication strategy should also reach people multiple times using different communication channels.
- Establishing partnerships with other state agencies (e.g., state unemployment agencies, state health insurance regulators, and state Medicaid agencies) is essential to promoting the Marketplace generally and raising potential enrollees' awareness about the availability of enhanced subsidies. Working with state agencies allows the Marketplace to reach new populations who could be greatly helped by the ARPA provisions. These alliances will become especially important when the PHE ends.

- Engaging Marketplace partners (e.g., health plans, brokers, and navigators) is integral for conducting direct outreach and education to current and potential enrollees about the financial help the ARPA offers. These entities can be important messengers providing hands-on help with enrolling in Marketplace coverage or switching to a different plan that offers better benefits at a lower price. Marketplace partners can be engaged in several ways, including urging plans to allow consumers to switch plans and transfer any accrued out-of-pocket spending or encouraging plans to offer incentives to brokers. Finally, allowing carrier-specific shopping experiences in the Marketplace could help promote the ARPA provisions among plans and brokers.

Going Forward

Even while implementing the ARPA provisions, the study states continued to look for ways to improve their Marketplaces and anticipate upcoming needs. Regarding the latter, study state Marketplaces are partnering with their state Medicaid agencies to prepare for when the PHE ends. Now that Marketplace coverage has become more affordable, Marketplace officials think an opportunity exists to enroll people in the Marketplace as they are disenrolled from Medicaid; officials noted that the take-up of Marketplace insurance by terminating Medicaid enrollees was previously limited because such coverage was too costly. Indeed, California is working on operationalizing autoenrollment, through which people no longer eligible for Medicaid will automatically move to Covered California. This was included in recent legislation (S.B. 260), and expected implementation is June 2022.

In addition, Washington passed a state subsidy in spring of 2021 that is slated to be implemented at the end of 2022, just as ARPA subsidies terminate if Congress does not make them permanent. One Washington official acknowledged, however, that the state subsidy would not be "nearly the same kind of money" available through the ARPA, and it would need to be targeted to people with very low incomes.

Across the board, stakeholders hoped the ARPA enhancements will be made permanent, which is called for in the August version of the federal budget reconciliation package (JEC Democrats 2021). Apart from helping with affordability, many interviewees felt making the subsidies permanent would help stabilize the Marketplaces, which could help raise consumers', brokers', and insurers' confidence in and reliance on the Marketplaces for coverage. Making enhanced subsidies permanent would also allow states to shift their attention to implementing other improvements to their Marketplaces, such as reducing out-of-pocket costs beyond premiums or extending open enrollment periods (Levitis 2021). Moving forward, many important issues pertaining to the Marketplaces need monitoring, including the impact of the end of the ARPA unemployment-related enhanced subsidies in December and what happens when the PHE ends.

Notes

[1] Centers for Medicare & Medicaid Services, "2021 Special Enrollment Period for Marketplace Coverage Starts on HealthCare.gov Monday, February 15," news release, February 12, 2021, https://www.cms.gov/newsroom/press-releases/2021-special-enrollment-period-Marketplace-coverage-starts-healthcaregov-monday-february-15.

[2] Other important ARPA insurance provisions not addressed in this brief include subsidies for COBRA payments and 2020 premium tax credit reconciliation relief.

[3] A basic health plan is an option under the ACA that allows states to establish a program in which people with incomes between 138 and 200 percent of FPL enroll in health plans with low to no premiums and very limited cost sharing. Nearly 800,000 New Yorkers were enrolled in the state's basic health plan as of February 2020; see New York State of Health (2021a).

[4] As discussed later, in 2021 Washington adopted a state subsidy slated to be implemented in 2023.

[5] CMS, "2021 Special Enrollment Period for Marketplace Coverage Starts on HealthCare.gov Monday, February 15," news release.

[6] Importantly, consumers who do not act will receive the enhanced premium tax credits when they file their 2021 federal tax returns.

[7] "New, Lower Costs on Marketplace Coverage," Healthcare.gov, accessed October 15, 2021, https://www.healthcare.gov/more-savings/.

[8] However, those who had not previously reported their incomes or had not reported that they received unemployment in 2021 had to act to receive the enhanced subsidies. Likewise, people who did not take the maximum amount of premium tax credits in advance or had not given permission to the Marketplace to update their accounts had to update their accounts to receive subsidies.

[9] Centers for Medicare & Medicaid Services, "HHS Secretary Becerra Announces Reduced Costs and Expanded Access Available for Marketplace Health Coverage under the American Rescue Plan," news release, April 1, 2021, https://www.cms.gov/newsroom/press-releases/hhs-secretary-becerra-announces-reduced-costs-and-expanded-access-available-Marketplace-health.

[10] Though microsites were designed for the off-Marketplace group, other potential and current enrollees can use them. In addition, the microsites allow users to shop for all Marketplace insurers.

[11] Dates for plans' special enrollment periods vary somewhat because of data availability and differences in when states implemented ARPA changes.

[12] Covered California, "Covered California Announces 2022 Plans: Full Year of American Rescue Plan Benefits, More Consumer Choice and Low Rate Change," news release, July 28, 2021, https://www.coveredca.com/newsroom/news-releases/2021/07/28/covered-california-announces-2022-plans-full-year-of-american-rescue-plan-benefits-more-consumer-choice-and-low-rate-change/.

[13] Washington State Office of the Insurance Commissioner, "Average 4.17% Rate Change Approved for 2022 Exchange Health Insurance Market," news release, September 20, 2021, https://www.insurance.wa.gov/news/average-417-rate-change-approved-2022-exchange-health-insurance-market; and Washington State Office of the Insurance Commissioner, "Kreidler Approves Average Rate Decrease of 3.2 Percent for Washington's 2021 Exchange Health Insurers," September 4, 2020, https://www.insurance.wa.gov/news/kreidler-approves-average-rate-decrease-32-washingtons-2021-exchange-health-insurers.

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Resource:
Health Insurance Benefit Mandates in California State and Federal Law

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ABOUT THIS RESOURCE

The California Health Benefits Review Program (CHBRP) responds to requests from the California Legislature to provide independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals (and other health-insurance related legislation).[1,2] This document has been prepared by CHBRP to inform interested parties of existing state and federal health insurance benefit mandate laws that may relate to the subject or purpose of a proposed state health insurance benefit mandate or repeal bill.

This document includes the following:

- Table 1. California Health Insurance Benefit Mandates (by Topic)
- Table 2. California Mandates with Sunset or Contingency Language
- Table 3. Federal Health Insurance Benefit Mandates
- Appendix A. Explanation of Table Terms and Categories
- Appendix B. Discussion of Basic Health Care Services

Benefit Mandate Categories

CHBRP defines health insurance benefit mandates through the lens of its authorizing statute.[3] Therefore, the mandates listed in Tables 1 and 2 fall into one or more of the following categories: (a) offer or provide coverage for the screening, diagnosis, or treatment of specific diseases or conditions; (b) offer or provide coverage for types of health care treatments or services, including coverage of medical equipment, supplies, or drugs used in a treatment or service; (c) offer or provide coverage permitting treatment or services from a specific type of health care provider; and/or (d) specify terms (limits, timeframes, copayments, deductibles, coinsurance, etc.) for any of the other categories. Table 1 includes California's state health insurance benefit mandate laws, and Table 3 includes federal health insurance benefit mandate laws.

Information Included for Listed Mandates

Table 1 identifies relevant California statutes. The table specifies when the law mandates *an offer* of coverage for the benefit. The table also identifies which health insurance markets (group and/or individual, explicitly includes Medi-Cal, Medi-Cal exempt, Medi-Cal excluded) are subject to the mandate. Explanations of these terms are provided in Appendix A.

Table 2 lists California benefit mandate statutes that contain either a sunset clause or contingency language. Sunset clauses specify that the law will no longer be in effect after the listed date. Contingency language specifies that the state law is in effect only so long as a federal law is in effect, or only if federal rulings do not indicate that some or all of the state law would exceed essential health benefits (EHBs).

Table 3 identifies relevant federal statutes, both those in existence prior to passage of the Affordable Care Act (ACA)[4] as well as federal benefit mandates contained in the ACA. Like Table 1, Table 3 identifies the health insurance markets subject to the mandate. Because none of the federal mandates are mandates to *offer* coverage, this information is not included in Table 3.

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[1] Additional information about CHBRP is available at: www.chbrp.org.
[2] Completed CHBRP analyses are available at: www.chbrp.org/completed_analyses/index.php.
[3] Available at: http://chbrp.com/about_chbrp/faqs/index.php.
[4] The federal "Patient Protection and Affordable Care Act" (P.L.111-148) and the "Health Care and Education Reconciliation Act" (P.L 111-152) were enacted in March 2010. Together, these laws are referred to as the Affordable Care Act (ACA).

Key Facts

- **Applicability of mandate laws:** Not all health insurance is subject to state health insurance benefit mandate laws. CHBRP annually posts estimates of Californians' sources of health insurance, including figures for the numbers of Californians with health insurance subject to state benefit mandates.[5]

- **California insurance regulation:** California has a bifurcated legal and regulatory system for health insurance products. The Department of Managed Health Care (DMHC) regulates health care service plan contracts, which are subject to the Health and Safety Code. The California Department of Insurance (CDI) regulates health insurance policies, which are subject to the California Insurance Code. DMHC-regulated plan contracts and CDI-regulated policies may be subject to state benefit mandate laws, depending upon the exact wording of the law.

- **Federal benefit mandates:** Federal benefit mandates can apply more broadly than state benefit mandates. For example, federal benefit mandates, unlike state mandates, may apply to Medicare or to self-insured plans. Table 3 only lists federal benefit mandate laws that are applicable to DMHC-regulated plans and CDI-regulated policies, which are also under the purview of state law.

- **Federal-state mandate overlap:** DMHC-regulated plans and CDI-regulated policies may be subject to both state and federal benefit mandate laws. Federal benefit mandates may interact or overlap with state benefit mandates, as in the case of mammography benefits. In addition, state laws that duplicate federal laws allow state-level regulators explicit authority to implement them, as in the case of Essential Health Benefits (EHBs). Some known interactions are noted in the footnotes for Table 1.

- **DMHC rules:** DMHC-regulated health plans are subject to "minimum benefit" laws and regulations, also known as "Basic Health Care Services," that may interact or overlap with state benefit mandate laws. The Basic Health Care Services requirement for DMHC-regulated health plans is noted in Table 1 and further explained in Appendix B.

[5] Available at: www.chbrp.org/other_publications/index.php.

Table 1. California Health Insurance Benefit Mandates[6] (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer?[7]	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
DMHC-Regulated Health Care Service Plan "Basic Health Care Services" (BHCS)- Mix of law and regulation (see Appendix B)						
0	All health plans regulated by the Department of Managed Health Care (DMHC) are required to cover medically necessary basic health care services, including: (1) Physician services; (2) Hospital inpatient services and ambulatory care services; (3) Diagnostic laboratory and diagnostic and therapeutic radiologic services; (4) Home health services; (5) Preventive health services; (6) Emergency health care services, including ambulance and ambulance transport services, out-of-area coverage, and ambulance transport services provided through the 911 emergency response system; (7) Hospice care. See Appendix B for further details. Large group health policies regulated by the California Department of Insurance (CDI) have similar requirements.	Multiple Sections - See Appendix B	10112.281		See Appendix B	Not a distinct mandate
Essential Health Benefits						
1	A federal mandate that requires some plans and policies to cover essential health benefits (EHBs) and places limits on cost sharing. The state statutes listed in this row define EHBs and cost sharing for California.[8,9] (also see Table 3)	1367.005 1367.006	10112.27 10112.28		Small Group and Individual[10] as well as Large Group if sold via Covered California[11] (Medi-Cal excluded)[12]	a, b, d
Cancer Benefit Mandates – also see row 37 under "Outpatient Prescription Drug Benefit Mandates"						
2	Breast cancer screening, diagnosis, and treatment	1367.6	10123.8		Not Specified	a
3	Cancer screening tests, with further requirements for biomarker tests	1367.665	10123.20		Not Specified (for biomarkers, explicitly includes Medi-Cal)	b, d
4	Cervical cancer screening	1367.66	10123.18		Group and Individual (Medi-Cal excluded)	a
5	Clinical trials	1370.6	10145.4		Group and Individual (Medi-Cal excluded)	b, d
6	Colorectal cancer screening, prohibits cost sharing	1367.668	10123.207			a, b, d

[6] Defined per CHBRP's authorizing statute, available at: http://chbrp.com/about_chbrp/faqs/index.php

[7] "Mandate to offer" indicates that all health care service plans and health insurers selling health insurance subject to the benefit mandate are required to *offer* coverage for the benefit. The health plan or insurer may comply (1) by including coverage for the benefit as standard in its health insurance products or (2) by offering coverage for the benefit separately and at an additional cost (e.g., a rider). See Appendix A.

[8] Affordable Care Act (ACA), Section 1301, 1302, and Section 1201 modifying Section 2707 of the Public Health Service Act (PHSA). See Table 3 below.

[9] Review report: *California's State Benefits Mandates and the Affordable Care Act's "Essential Health Benefits*, available at: www.chbrp.org/other_publications/index.php.

[10] The EHB coverage requirement applies to non-grandfathered plans and policies sold outside of the exchange as well as to qualified health plans (QHPs, see ACA Section 1301) certified by and sold via a health insurance exchange.

[11] Effective 2017, states may allow large-group market qualified health plans (QHPs, see ACA Section 1301) to be certified by and sold via an exchange [ACA Section 1312(f)(2)(B)]. Large-group QHPs would be subject the EHB coverage requirement.

[12] See Appendix A for explicitly includes Medi-Cal, Medi-Cal excluded, and Medi-Cal exempt language.

Table 1. California Health Insurance Benefit Mandates[6] (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer?[7]	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
7	Mammography	1367.65 (a)	10123.81		Not Specified (DMHC) Group and Individual (CDI)	a, c
8	Mastectomy and lymph node dissection (length of stay, complications, prostheses, reconstructive surgery)	1367.635	10123.86		Not Specified	b, d
9	Prostate cancer screening	1367.64	10123.835		Group and Individual (Medi-Cal excluded)	a
Chronic Conditions Benefit Mandates – also see rows under "Outpatient Prescription Drug Benefit Mandates," which are often relevant to chronic condition treatment						
10	Diabetes education	N/A	10176.6	Offer	Not Specified (CDI)	a
11	Diabetes education, management, and treatment	1367.51	10176.61		Not Specified	a, b, d
12	HIV/AIDS, AIDS vaccine	1367.45	10145.2		Group and Individual (DMHC), Not Specified (CDI) (Medi-Cal excluded)	a
13	HIV/AIDS, HIV Testing	1367.46	10123.91		Group and Individual (Medi-Cal excluded)	a
14	HIV/AIDS, Transplantation services for persons with HIV	1374.17	10123.21		Group and individual (CDI) Not Specified (DMHC)	d
15	Osteoporosis	1367.67	10123.185		Not Specified	a
16	Phenylketonuria	1374.56	10123.89		Not Specified	a
Hospice & Home Health Care Benefit Mandates						
17	Dementing illness exclusion prohibition	1373.14	10123.16		Group and Individual (Medi-Cal excluded)	a, d
18	Home health care	1374.10 (non-HMOs only)	10123.10	Offer	Group (Medi-Cal excluded)	b, d
19	Hospice care	1368.2	N/A[13]		Group (DMHC) (Medi-Cal excluded)	b
Mental Health Benefit Mandates						
20	Alcohol and drug exclusion prohibition	N/A	10369.12		Group (CDI) – not specified	d
21	Alcoholism treatment	1367.2(a)	10123.6	Offer	Group (Medi-Cal excluded)	a
22	Behavioral health treatment for autism and related disorders (also see Table 2)	1374.73	10144.51 10144.52		Not Specified	b
23	Care provided by a psychiatric health facility	1373(h)(1)	N/A		Not Specified (DMHC)	b, d

[13] N/A indicates that the benefit mandate does not apply to products governed under the specified code.

Table 1. California Health Insurance Benefit Mandates[6] (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer?[7]	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
24	Coverage and premiums for persons with physical or mental impairment	1367.8	10144		Group and Individual (Medi-Cal excluded)	a, d
25	Coverage for mental and nervous disorders, including care provided by a psychiatric health facility	N/A	10125	Offer	Group (CDI)	a
26	Coverage for persons with physical handicap	N/A	10122.1	Offer	Group (CDI)	a, d
27	Coverage for mental illnesses and substance use disorders (in parity with coverage for other medical conditions)	1374.72	10144.5 10123.15		Not Specified (Medi-Cal exempt)	a, b, d
28	Coverage for mental health and substance use disorder in compliance with federal law. [14]	1374.76	10144.4		Large Group and Individual (Medi-Cal excluded)	a, b, d
29	Nicotine or chemical dependency treatment in licensed alcoholism or chemical dependency facilities	1367.2(b)	10123.6	Offer	Group (Medi-Cal excluded)	b, d
30	Prohibition of lifetime waiver for mental health services	1374.5	10176(f)		Individual (Medi-Cal excluded)	a, d
31	Prohibition on determining reimbursement eligibility from inpatient admission status	1374.51	10144.6		Not Specified	d
32	Medical necessity determination and utilization review of benefits related to mental health and substance use disorders (see also Table 3)	1374.72 1374.721	10144.5 10144.52		Not Specified (Medi-Cal excluded)	a, b, c, d
Orthotics & Prosthetics Benefit Mandates						
33	Orthotic and prosthetic devices and services	1367.18	10123.7	Offer	Group (Medi-Cal excluded)	b
34	Prosthetic devices for laryngectomy	1367.61	10123.82		Not Specified	b
35	Special footwear for persons suffering from foot disfigurement	1367.19	10123.141	Offer	Group (Medi-Cal excluded)	b
Outpatient Prescription Drug Benefit Mandates						
36	Authorization for nonformulary prescription drugs	1367.24	N/A		Not Specified (DMHC) (Medi-Cal exempt)	d
37	HIV/AIDS, pre-exposure and post-exposure prophylaxis: prohibition of step therapy or prior authorization	1342.74	10123.1933		Not specified	d
38	Oral anticancer medication cost-sharing limits (also see Table 2)	1367.656	10123.206		Group and Individual (Medi-Cal excluded)	d
39	Prescription Medications (also see Table 2) – addresses cost sharing, formularies, and utilization management protocols related to HIV/AIDS medications	1342.72 1342.73 1367.205 1367.41 1367.42 1367.47	10123.192 10123.193 10123.1931 10123.1932 10123.201 10123.65		Varied: some Not Specified (some Medi-Cal exempt) and some Small Group and Individual (Medi-Cal excluded)	b, d

[14] ACA Section 1311(j) and Section 1563(c)(4) modifying Section 2726 of the Public Health Services Act (PHSA). See Table 3 below.

Table 1. California Health Insurance Benefit Mandates[6] (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer?[7]	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
40	Prescription drugs: coverage for previously prescribed drugs	1367.22	N/A		Not Specified (DMHC)	d
41	Prescription drugs: coverage of "off-label" use	1367.21	10123.195		Not Specified (DMHC), Group and Individual (CDI)	d
42	Prescription drugs: prorating cost sharing for partial fill for Schedule II controlled substance	1367.43	10123.203		Not specified	d
43	Prior authorization requests for prescription drugs	1367.241	10123.191		Not Specified (Medi-Cal exempt)	d
44	At home tests for sexually transmitted diseases (STDs), in network only	1367.34	10123.208		Not Specified (Medi-Cal exempt)	a, b
45	Step Therapy	1367.244 1367.206	10123.197 1367.241		Not Specified (Medi-Cal exempt)	d
Pain Management Benefit Mandates						
46	Acupuncture	1373.10 (non-HMOs only)	10127.3	Offer	Group (Medi-Cal excluded)	c, d
47	General anesthesia for dental procedures	1367.71	10119.9		Not Specified	b
48	Pain management medication for terminally ill	1367.215	N/A		Not Specified (DMHC)	b
Pediatric Care Benefit Mandates						
49	Asthma management	1367.06	N/A		Not Specified (DMHC)	a
50	Comprehensive preventive care for children aged 16 years or younger	1367.35	10123.5		Group (Medi-Cal excluded)	b
51	Comprehensive preventive care for children aged 17 or 18 years	1367.3	10123.55	Offer	Group (Medi-Cal excluded)	b
52	Coverage for the effects of diethylstilbestrol	1367.9	10119.7		Not Specified (DMHC) Group and Individual (CDI)	a
53	Screening children at risk for lead poisoning for blood lead levels	1367.3(b)(2)(D)	10123.5 10123.55		Group (DMHC), Group (CDI) (Medi-Cal excluded)	b
54	Screening children (and adults) for adverse childhood experiences (ACEs)	1367.34	10123.51		Not Specified	a, b
55	Screening children for blood lead levels	N/A	10119.8	Offer	Individual or Group (CDI)	b
Provider Reimbursement Mandates						
56	Emergency 911 transportation[15]	1371.5	10126.6		Not Specified	d
57	Licensed or certified providers	1367(b)	N/A		Not Specified	c, d

[15] The ACA (Section 1001 modifying Section 2719A of the PHSA) imposes a related requirement regarding coverage and cost-sharing for emergency services. Grandfathered health plans (ACA Section 1251) are not subject to this requirement. See Table 3 below.

Table 1. California Health Insurance Benefit Mandates[6] (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer?[7]	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
58	Medical transportation services – direct reimbursement	1367.11	10126.6		Not Specified	d
59	OB-GYNs as primary care providers[16]	1367.69 1367.695	10123.83 10123.84		Not Specified	c, d
60	Pharmacists – compensation for services within their scope of practice	1368.5	10125.1	Offer	Not Specified (DMHC) Group (CDI)	c, d
61	Telehealth	1374.13 1374.14	10123.85 10123.855		Not Specified (explicitly includes Medi-Cal)	c, d
Reproductive Benefit Mandates						
62	Contraceptive devices (including devices requiring a prescription) and sterilization, and contraceptive education and counseling	1367.25	10123.196		Group and Individual (explicitly includes Medi-Cal)	b
63	Fertility preservation services	1374.551	N/A		Not specified (Medi-Cal exempt)	a, b
64	Infertility treatments	1374.55	10119.6	Offer	Group (Medi-Cal excluded)	a, b, d
65	Maternity services	N/A	10123.865 10123.866		Group and Individual (CDI)	b
66	Maternity – amount of copayment or deductible for inpatient services	1373.4	10119.5		Not Specified (Medi-Cal excluded)	d
67	Maternity – minimum length of stay[17]	1367.62	10123.87		Not Specified (DMHC) Group and Individual (CDI)	d
68	Maternal mental health	1367.625	10123.867		Not Specified	a
69	Participation in the statewide prenatal testing Expanded Alpha-fetoprotein (AFP)[18] program	1367.54	10123.184		Group and Individual (Medi-Cal excluded)	b
70	Prenatal diagnosis of genetic disorders	1367.7	10123.9	Offer	Group (Medi-Cal excluded)	b
71	Annual supply of self-administered hormonal contraceptives	1367.25	10123.196		Group and Individual (Medi-Cal excluded)	d
72	Reproductive health care services	1367.31	10123.202		Not Specified (Medi-Cal exempt)	d
Sterilization						

[16] The ACA (Section 1001 modifying Section 2719A of the PHSA) imposes a similar requirement prohibiting prior authorization for access to OB-GYNs. Grandfathered health plans (ACA Section 1251) are not subject to this requirement. See Table 3 below.
[17] The federal Newborns' and Mothers' Health Protection Act of 1996 requires coverage for a minimum length of stay in a hospital after delivery *if* the plan covers maternity services. See Table 3 below.

Table 1. California Health Insurance Benefit Mandates[6] (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer?[7]	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
73	Sterilization rationale exclusion prohibition	1373(b)	10120		Not Specified	d
Surgery Benefit Mandates						
74	Jawbone or associated bone joints	1367.68	10123.21		Not Specified (DMHC) Group and Individual (CDI)	a
75	Reconstructive surgery[19]	1367.63	10123.88		Not Specified (Medi-Cal exempt)	b
Other Benefit Mandates						
76	Blindness or partial blindness exclusion prohibition	1367.4	10145		Group and Individual (Medi-Cal excluded)	a, d
77	COVID-19 diagnostic and screening testing	1342.2	10110.7		Not Specified	a, b, d
78	Cost sharing limits - for essential health benefits (EHBs), prohibits lifetime and annual dollar coverage limits (also see Table 3)	1367.001	10112.1		Group and Individual (Medi-Cal excluded)	b, d
79	Cost sharing limits - family cost sharing limits (also see Table 3)	1367.006 1367.007	10112.28 10112.29		Varied: Large Group, Small Group, Individual (Medi-Cal excluded)	d
80	Cost sharing limits - preventive services without cost sharing (in compliance with federal laws and regulations)[20] (also see Table 3)	1367.002	10112.2		Group and Individual (Medi-Cal excluded)	b, d
81	Public health emergency (CA governor declared) disease prevention/mitigation services	1342.3	10110.75		Not Specified	a, b, d
82	Second opinions	N/A	10123.68		Not Specified (CDI)	c

[19] The federal Women's Health and Cancer Rights Act of 1998 requires coverage for post mastectomy reconstructive surgery. See Table 3 below.
[20] ACA, Section 1001 modifying Section 2713 of the PHSA. See Table 3 below.

Table 2. California Mandates with a Sunset or Contingency Clause in Existing Code (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Disabling Clause (Type and Language)
Cancer Benefit Mandates				
1	Oral anticancer medication cost-sharing limits	1367.656	10123.206	SUNSET – 1367.656(b) and 10123.206(b): "This section shall remain in effect only until January 1, 2024, and as of that date is repealed."
Chronic Conditions Benefit Mandates				
2	HIV/AIDS, antiretroviral drug treatments	1342.72	10123.1931	SUNSET – 1342.72(c) and 10123.1931(b): "This section shall remain in effect only until January 1, 2023, and as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2023, deletes or extends that date."
Mental Health Benefit Mandates				
3	Behavioral health treatment for autism and related disorders	1374.73	10144.51 10144.52	CONTINGENCY – 1374.73(a)(2) and 10144.51(a)(2): "[This] section does not require any benefits to be provided that exceed the essential health benefits that all health insurers will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act."
Outpatient Drug Benefit Mandates				
4	Prescription cost sharing	1342.71 1342.73 1367.205 1367.41 1367.42	10123.192 10123.193 10123.1932 10123.201	SUNSET – 1342.73(d) and 10123.1932(c): "This section shall remain in effect only until January 1, 2024, and as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2024, deletes or extends that date."
Other Benefit Mandates				
5	Family cost sharing limits	1367.006 1367.007	10112.28 10112.29	CONTINGENCY – 1367.006(c)(2) and 10112.28(c)(2): "The [annual out-of-pocket] limit shall result in a total maximum out-of-pocket limit for all covered essential health benefits equal to the dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the dollar amounts adjusted as specified in Section 1302(c)(1)(B) of PPACA." CONTINGENCY – 1367.007(a)(2) and 10112.29(a)(2): "The dollar amounts [of the small employer deductible] shall be indexed consistent with Section 1302(c)(4) of PPACA and any federal rules or guidance pursuant to that section."
6	Preventive services without cost sharing (in compliance with federal laws and regulations)[21]	1367.002	10112.2	CONTINGENCY - 1367.002 and 10112.2: "To the extent required by federal law, a group or individual [health plan shall] comply with Section 2713 of the federal Public Health Service Act [as added by] Section 1001 of the federal Patient Protection and Affordable Care Act."

[21] ACA, Section 1001 modifying Section 2713 of the PHSA.

Table 3. Federal Health Insurance Benefit Mandates[22]

#	Federal Law	Topic Addressed by Benefit Coverage Mandate[23]	Markets Subject to the Mandate[24]	Mandate Category
Federal Mandates in Existence Prior to the Passage of the Affordable Care Act of 2010 (ACA)				
1	Pregnancy Discrimination Act of 1978 amending Title VII of the federal Civil Rights Act	Requires coverage for pregnancy and requires the coverage be in parity with other benefit coverage.	Group (15 or more)	d
2	Newborns' and Mothers' Health Protection Act of 1996	If maternity is covered, requires that coverage include at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section).	Group	d
3	Women's Health and Cancer Rights Act of 1998	If mastectomy is covered, requires coverage for certain reconstructive surgery and other post-mastectomy treatments and services.	Group	b
4	Mental Health Parity and Addiction Equity Act of 2008, modified by the Affordable Care Act of 2010 [ACA Section 1311(j) and Section 1563(c)(4) modifying Section 2726 of the Public Health Services Act (PHSA)]	If mental health or substance use disorder (MH/SUD) services are covered, requires that cost-sharing terms and treatment limits be no more restrictive than the predominant terms or limits applied to medical/surgical benefits.[25]	Group and Individual	d
Federal Mandates in the Affordable Care Act of 2010 (ACA)				
5	Section 1001 modifying Section 2711 of the PHSA	Prohibits lifetime and annual limits on the dollar value of benefits. [26]	Group and Individual	d
6	Section 1001 modifying Section 2713 of the PHSA	Preventive services without cost sharing.[27,28] As soon as 12 months after a recommendation appears in any of three sources, benefit coverage is required. The four sources are: • 'A' and 'B' rated recommendations of the United States Preventive Services Task Force (USPSTF)[29]; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC)[30]; • For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA)[31]; and • For women, preventive care and screenings provided for in comprehensive guidelines supported by HRSA.[32]	Group and Individual	a, d
7	Section 1001 modifying Section 2719A(b) of the PHSA	If emergency services are covered, requires coverage for these services regardless of whether the participating provider is in or out of network, with the same cost-sharing levels out of network as would be required in network, and without the need for prior authorization.	Group and Individual	d
8	Section 1001 modifying Section 2719A(d) of the PHSA	Prohibits requiring prior authorization or referral before covering services from a participating health care professional who specializes in obstetrics or gynecology.	Group and Individual	d
9	Section 1201 modifying Section 2704 of the PHSA	Prohibits "preexisting condition" benefit coverage denials.	Group and Individual[33]	d

10	Section 1301, 1302, and Section 1201 modifying Section 2707 of the PHSA	Requires coverage of essential health benefits (EHBs), and, for plans and policies that provide coverage for EHBs, and places limits on cost sharing. The 10 EHB categories are: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.[34]	Small Group and Individual[35] In 2017, Large Group sold via Covered California[36]	a, b, d

[22] CHBRP defines health insurance benefit mandates as per its authorizing statute, available at: http://chbrp.com/about_chbrp/faqs/index.php.
[23] All listed federal health insurance benefit mandates are benefit coverage mandates. CHBRP is aware of no federal "mandates to offer."
[24] Unless otherwise noted, the federal mandates in the ACA do not apply to grandfathered health plans (Section 1251).
[25] California law requires compliance with this mandate. See Table 1 above (categorized with "Mental Health Benefit Mandates").
[26] Annual limits and lifetime limits apply to grandfathered plans, with the exception that grandfathered individual market plans are not subject to the prohibitions on annual limits [ACA Section 1251(a)(4)].
[27] California law requires compliance with this mandate. See Table 1 above (categorized with "Other Benefit Mandates").
[28] For more information on the preventive services coverage requirement, see CHBRP's resource, *Federal Preventive Services Benefit Mandate and the California Benefit Mandates*, available at: www.chbrp.org/other_publications/index.php.
[29] Available at: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.
[30] Available at: www.cdc.gov/vaccines/hcp/acip-recs/index.html.
[31] Regulations published in the Federal Register (Vol. 75, No 137, July 19, 2010) clarified which HRSA guidelines were applicable. The guidelines appear in two charts: Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, available at: http://brightfutures.aap.org/clinical_practice.html; and Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, available at: http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/index.html.
[32] Available at: https://www.hrsa.gov/womens-guidelines/index.html
[33] Applies to grandfathered group market health plans and grandfathered individual market plans [ACA Section 1251(a)(4)].
[34] California has laws in place to define EHBs for the state. See Table 1 above (categorized with "Essential Health Benefits").
[35] The EHB coverage requirement will apply to nongrandfathered plans and policies sold outside of the exchange as well as to qualified health plans (QHPs, see ACA Section 1301) certified by and sold via a health insurance exchange.
[36] Effective 2017, states may allow large-group market qualified health plans (QHPs, see ACA Section 1301) to be certified by and sold via a health insurance exchange [ACA Section 1312(f)(2)(B)]. Large group QHPs would be subject to the EHB coverage requirement.

APPENDIX A EXPLANATION OF TABLE TERMS AND CATEGORIES

Code: A health insurance benefit mandate is a law requiring health insurance products (plans and policies) to provide, or in some cases simply to offer coverage for specified benefits or services. Because California has a bifurcated regulatory system for health insurance products, a benefit mandate law may appear in either of two codes, or in both:

- Health & Safety Code: The California Department of Managed Health Care (DMHC) regulates and licenses health care services plans as per the California Health and Safety Code.[37] In addition to commercial enrollees,[38] a majority of Medi-Cal beneficiaries are enrolled in DMHC-regulated plans.[39]
- Insurance Code: The California Department of Insurance (CDI) licenses disability insurance carriers and regulates disability insurance, which includes health insurance policies, per the California Insurance Code.[40]

Mandated Benefit Coverage or Mandated Offer of Benefit Coverage: In the language of either code section, the law may mandate coverage of benefits or may mandate that coverage for the benefits be offered.

- "Mandate to cover" means that all health insurance subject to the law must cover the benefit.
- "Mandate to offer" means all health care service plans and health insurers selling health insurance subject to the mandate are required to offer coverage for the benefit for purchase. The health plan or insurer may comply with the mandate either (1) by including the benefit as standard in its health insurance products, or (2) by offering coverage for the benefit separately at an additional cost (e.g., a rider).

Markets Subject to the Mandate: In the language of either code, the law may (or may not) specify which market(s) are subject to the mandate.

- The individual market includes health insurance products issued to an individual to provide coverage for a person and/or their dependents.
- The group markets include health insurance products issued to employers (or other entities) to provide coverage for employees (or other persons) and/or their dependents. The large group market includes plans or policies with 101 or more enrollees. The small group market includes plans and policies with 100 or fewer (at least 1) enrollees.
- Technically not in a "market," the majority of Medi-Cal beneficiaries are enrolled in a DMHC-regulated plan. These beneficiaries are not considered to be in "group" market plans. These beneficiaries' plans may or may not be subject to the mandates listed in this document. Where possible, notes have been added to Table 1 indicating whether or not these beneficiaries' plans are or are not subject to the listed benefit mandate. The added notes are:
  - Explicitly includes Medi-Cal: the law explicitly requires compliance from health insurance products enrolling Medi-Cal beneficiaries.

[37] Available at: http://leginfo.legislature.ca.gov/faces/home.xhtml
[38] This group includes enrollees in DMHC-regulated plans associated with the California Public Employees' Retirement System (CalPERS) but not persons enrolled in CalPERS' self-insured plan (which is subject only to federal law).
[39] See CHBRP's *Estimates of Sources of Health Insurance*, a resource available at https://chbrp.org/other_publications/index.php
[40] Available at: http://leginfo.legislature.ca.gov/faces/home.xhtml

- Medi-Cal exempt: the law explicitly exempts from compliance health insurance products enrolling Medi-Cal beneficiaries.
- Medi-Cal excluded: the law specifies that it is applicable to group and/or individual market health insurance products – as Medi-Cal beneficiaries are enrolled in neither ,[41] CHBRP assumes that health insurance products enrolling Medi-Cal beneficiaries are not required to comply.

Mandate Category: As per CHBRP's authorizing statute, the listed mandates fall into one or more types. A particular mandate law can require that subject health insurance do one or more of the following:

a. Offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition. An example would be a mandate that requires coverage for all health care services related to the screening and treatment of breast cancer.

b. Offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service. An example would be a mandate to cover reconstructive surgery.

c. Offer or provide coverage for services from a specified type of health provider that fall within the provider's scope of practice. An example would be a mandate that requires coverage for services provided by a licensed acupuncturist.

d. Offer or provide any of the forms of coverage listed above per specific terms and conditions. For example, the mental health parity law requires coverage for serious mental health conditions to be *on par* with other medical conditions, so that mental health benefits and other benefits are subject to the same copayments, limits, etc.

[41] DMHC and healthcare.gov specify that individual health plans are plans that you buy on your own, for yourself, or for your family and group health plans are obtained through your job, union, or as a retiree for employees/retirees and their families (see https://www.dmhc.ca.gov/HealthCareinCalifornia/TypesofCoverage.aspx and https://www.healthcare.gov/glossary/group-health-plan/). Enrollment of Medi-Cal beneficiaries in DMHC-regulated plans seems to fit neither definition.

APPENDIX B DISCUSSION OF BASIC HEALTH CARE SERVICES[42]

The California Department of Managed Health Care (DMHC) regulates health care service plans, which are subject to the Knox-Keene Health Care Service Plan Act of 1975, as amended, which was codified in the Health and Safety Code.[43] The Knox-Keene Act requires all health care service plans, except specialized health care service plans, to provide coverage for all medically necessary basic health care services.

This requirement is based on several sections of the Knox-Keene Act rather than one straightforward provision, and so is not technically a health insurance benefit mandate as defined by CHBRP's authorizing statute. Specifically, subdivision (b) of Section 1345 defines the term "basic health care services" to mean all of the following: (1) Physician services, including consultation and referral; (2) Hospital inpatient services and ambulatory care services; (3) Diagnostic laboratory and diagnostic and therapeutic radiologic services; (4) Home health services; (5) Preventive health services; (6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage and ambulance transport services provided through the 911 emergency response system; (7) Hospice care pursuant to Section 1368.2. "Basic health care services" are also further defined in Section 1300.67 of Title 28 of the California Code of Regulations.

In addition, subdivision (i) of Section 1367 of the Health and Safety Code provides the following: A health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service that health care service plans are required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

Although the Act does not explicitly state that "basic health care services" means all "medically necessary" basic health care services, there are numerous provisions within the Knox-Keene Act that reference "medical necessity" and that place requirements on plans in terms of what they must do when denying, delaying, or modifying coverage based on a decision for medical necessity (Section 1367.01). In addition, Section 1300.67 of Title 28 of the California Code of Regulations, which further defines "basic health care services," does further clarify that "the basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any co-payment, deductible, or limitation of which the Director may approve…"

The entire Knox-Keene Act and the applicable regulations can be accessed online on the DMHC's website at www.dmhc.ca.gov.

[42] The text in this appendix was adapted from a document prepared by the Department of Managed Health Care.
[43] Health and Safety Code Section 1340 et seq.

ABOUT CHBRP

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.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report. Detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications are available at http://www.chbrp.org/

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Supporting Health Equity and Affordable Health Coverage for Immigrant Populations: State-Funded Affordable Coverage Programs for Immigrants

Prepared by Manatt Health

STATE Health & Value STRATEGIES | *Driving Innovation Across States*

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Introduction

The crisis in immigrant health coverage has been both highlighted and exacerbated by the recent pandemic. COVID-19 has taken a heavy toll on immigrants, who are disproportionately frontline/service workers, making them particularly vulnerable to the virus.[1] Indeed, approximately 70 percent of all immigrants in the United States (U.S.) workforce are employed as essential workers.[2] Research affirms that foreign-born individuals are at higher risk of COVID-19 mortality, with one recent study establishing Latino(a) immigrants of working age as more than 11 times as likely to die from COVID-19 than U.S.-born non-Latino(a) individuals.[3] High rates of uninsurance among the nation's immigrant population are compounding COVID-19's impact. While the Patient Protection and Affordable Care Act (ACA) led to significant gains in health coverage by insuring more than 20 million people, nearly 30 million individuals remained uninsured as of 2019.[4,5] Immigrants (including "lawfully present" and undocumented individuals) make up 23 percent of the uninsured nationally.[6] The uninsured immigrant population, which includes those who are ineligible for government sponsored coverage due to citizenship status, has few viable options for affordable health coverage, except for emergency care.

Access to affordable health coverage and healthcare for immigrant populations in the U.S. is critical to advancing health equity and reducing health disparities. In recent months, many states and localities have focused on covering the remaining uninsured and providing access to healthcare as COVID-19 continues to surge. To cover low-income residents who are ineligible for subsidized health insurance under the ACA or through Medicaid/the Children's Health Insurance Program (CHIP), states are pursuing legislative or administrative actions to extend affordable healthcare coverage to all residents, regardless of immigration status, using state-only funds ("state-funded affordable coverage programs"). While this approach has gained traction in recent months, many states and localities had already established these types of programs prior to the pandemic as an effective public health strategy to address longstanding social, economic, and health inequities.

This issue brief—the first in a series "Supporting Health Equity and Affordable Health Coverage for Immigrant Populations"—provides an overview of the national immigrant health coverage landscape and offers considerations for policymakers related to state-funded affordable coverage programs for low-income individuals who do not qualify for subsidized health insurance under the ACA or other public programs due to immigration status.

Potential Eligibility for Federally Funded Coverage Programs Based on Immigrations Status

An individual must be lawfully present (authorized to live in the U.S.) in order to be potentially eligible for federally funded health coverage programs. In general, lawfully present immigrants can purchase coverage through the Marketplace and access federal subsidies to offset the cost of that coverage. Only lawfully present immigrants with a "qualified" status can be eligible for Medicaid/CHIP, and some qualified immigrant populations must wait five years after obtaining lawful status before they can enroll in Medicaid/CHIP coverage, while others, such as refugees and victims of trafficking, are exempt from this "five-year bar." States also have the option under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to expand Medicaid coverage to lawfully present children and pregnant individuals, regardless of whether they are qualified.[7] In contrast, individuals who are undocumented and those with Deferred Action for Childhood Arrivals (DACA) status ("Dreamers"), among others, are ineligible for health insurance under the ACA (and are prohibited from purchasing Marketplace coverage even without subsidies), with the exception of temporary, limited scope coverage for emergency services ("emergency Medicaid").[8] The uninsured immigrant population in the U.S. includes people who are eligible for health insurance under the ACA or other public programs but are not enrolled, as well as those

who are ineligible for government sponsored coverage due to citizenship status. Even when immigrants are eligible for coverage, in recent years they haved faced barriers to enrollment including the "chilling effect" from Public Charge[i] and other exclusionary immigration policies that have adversely impacted the take up of health coverage.

Table 1: Potential Eligibility for Federally Funded Coverage Programs Based on Immigration Status

Immigration Status	Marketplace Eligible[9]	Medicaid/CHIP Eligible[10]
Lawfully Present and Eligible for Federally Funded Coverage Programs		
Valid non-immigrant visa holders (e.g., student visas, worker visas)	✔	✘
Humanitarian statuses or circumstances (including Temporary Protected Status, Special Juvenile Status, asylum applicants, Convention Against Torture, victims of trafficking)	✔	✘
Legal status conferred by other laws (temporary resident status, Legal Immigration Family Equity Act, Family Unity individuals)	✔	✘
Qualified non-citizens • Lawful Permanent Residents [(LPR)/Green Card Holder)]* • Paroled into the U.S. for at least one year* • Battered non-citizens, spouses, children, or parents* • People fleeing persecution (e.g., asylees, refugees) • Granted withholding of deportation • Cuban/Haitian entrants • Certain Amerasian immigrants • Members of a federally recognized Indian tribe or American Indian born in Canada • Veterans or active duty military and their family members • Victims of trafficking and their family members • Citizens of the Marshall Islands, Micronesia, and Palau who are living in one of the U.S. states or territories ["Compact of Free Association (COFA) migrants"][ii] • Granted Iraqi or Afghan special immigrant status • Children receiving foster care or adoption assistance • Conditional entrant granted before 1980	✔	✔

[i] Public charge determinations apply when immigrants enter the country or apply for a green card, and individuals can be deemed inadmissible if they are found likely to become "primarily dependent on the government for subsistence." Under longstanding Public Charge guidance, which was updated during the Trump administration but reinstated this year, using Medicaid (other than long-term care), CHIP, and Marketplace are not considered in Public Charge determinations.

[ii] Section 208 of the Consolidated Appropriations Act, 2021 eliminated the five-year bar for COFA migrants, restoring access to Medicaid after a drafting error in the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) excluded this population from coverage.

Table 1: Potential Eligibility for Federally Funded Coverage Programs Based on Immigration Status		
Immigration Status	**Marketplace Eligible[9]**	**Medicaid/CHIP Eligible[10]**
Ineligible for Federally Funded Coverage Programs Due to Immigration Status		
Undocumented immigrants • Individuals who entered the country without authorization • Individuals who entered the country lawfully and stayed after their visa or status expired	✗	✗[iii]
DACA: Temporary status allowing individuals who came to the country as children to remain in the U.S.	✗	✗
Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA): Temporary status allowing parents of citizens or LPRs to remain in the country	✗	✗

**Subject to the five-year bar (i.e. requirement to reside in the U.S. for five years or more before becoming eligible for Medicaid/CHIP). Note that there is no five-year bar for accessing subsidized Marketplace coverage.*

State-Funded Affordable Coverage Programs for Immigrants: National Landscape

States are relying on two predominant models to offer access to affordable coverage for immigrant populations that are ineligible for federally funded health coverage: (1) establishing state Medicaid/CHIP equivalent or comparable programs; and (2) creating state premium or cost-sharing subsidies to enable individuals to purchase Marketplace coverage.

State coverage solutions for immigrants are being advanced primarily by leveraging state Medicaid/CHIP programs to provide access to coverage for children and adults. As of September 2021, six states (California, Illinois, Massachusetts, New York, Oregon, Washington) and the District of Columbia (D.C.) are implementing affordable Medicaid/CHIP equivalent or comparable coverage programs subsidized through state funds for low-income children and adults who do not qualify for subsidized health insurance under the ACA or through other public programs like Medicaid/CHIP, including because of their immigration status. The following table summarizes state-funded coverage programs that are currently in effect and build on states' Medicaid/CHIP programs to provide affordable healthcare for immigrant populations.

[iii] The federal government matches state costs for emergency Medicaid services.

Table 2: Implemented State-Funded Affordable Coverage Programs for Immigrants[iv]				
State	**Program**	**Eligibility**	**Benefits**	**Cost-Sharing**
Immigrant Children and Adolescents				
CA	Health4All Kids	Age 18 and younger with income < 266% of the federal poverty level (FPL)	Full scope Medicaid equivalent benefits	Copayments: None Premiums: For enrollees with incomes > 160% and < 266% of the FPL; premiums amount to $13 per month per child ($39 family max)
D.C.[v]	Immigrant Children's Program	Age 20 and younger with income ≤ 200% of the FPL	Full scope Medicaid equivalent benefits	Copayments: None Premiums: None
IL	All Kids	Age 18 and younger with income < 318% of the FPL	Full scope Medicaid equivalent benefits	Copayments: Tiered copayment structure for enrollees with incomes > 147% FPL and < 318% FPL; copayments range from $100 per year per family for all services to $500 per year per child for hospital services Premiums: Tiered copayment structure for enrollees with incomes > 157% and < 318% FPL; premiums range from $15 per month per child ($40 family max) to $40 per child per month ($80 family max)
MA	Children's Medical Security Plan	Age 18 and younger with income at any level	Limited scope medical benefits (see additional information)	Copayments: Tiered copayment structure for all enrollees; copayments range from $2 to $8 per service per member based on income Premiums: Tiered premium structure for enrollees with incomes ≥ 200% to ≥ 400.1% FPL; premiums range from $7.80 per child per month to $64 per child per month
NY	Child Health Plus	Age 18 and younger with income at any level	Comprehensive medical benefits (see additional information)	Copayments: None Premiums: Tiered premium structure for enrollees with incomes ≥ 160% to ≥ 400% FPL; premiums range from $9 per month per child ($27 family max) to $231 per month per child (no max)

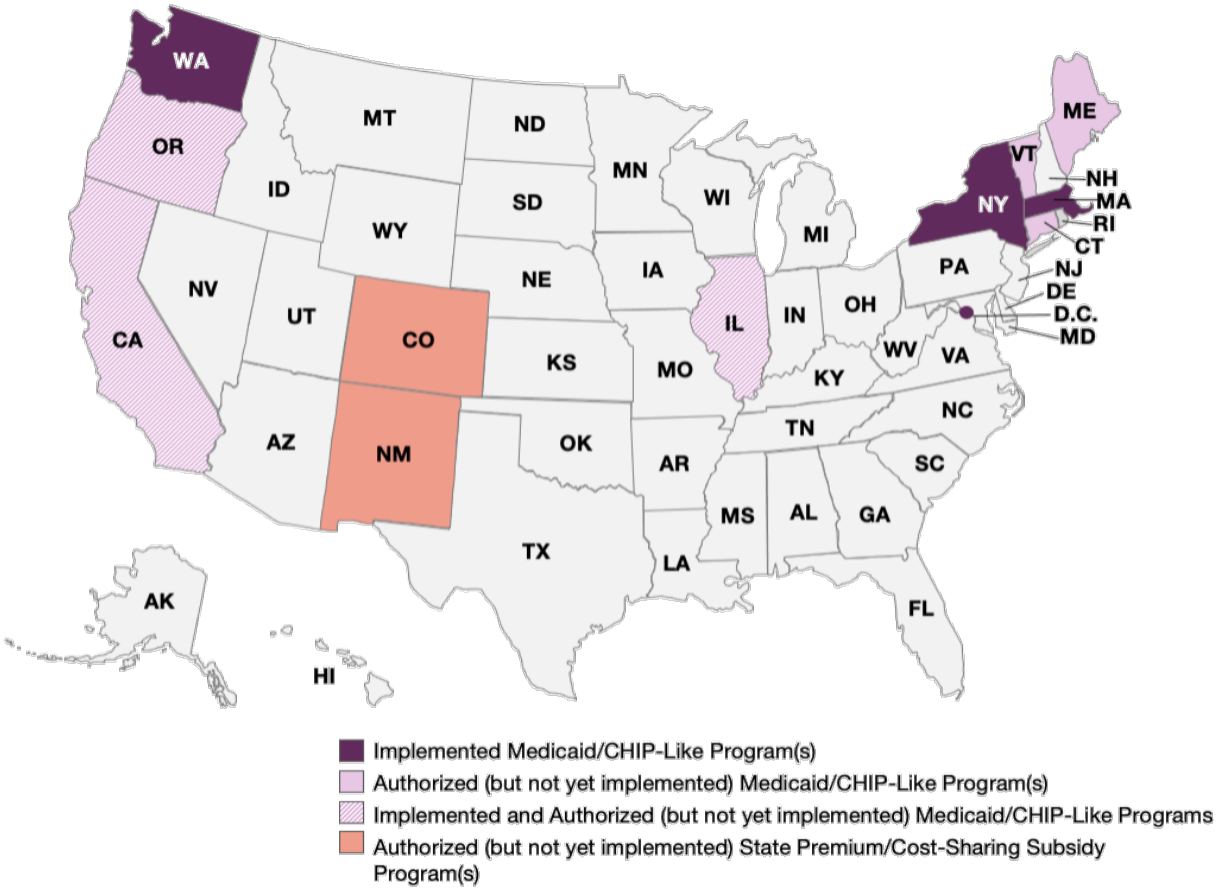
[iv] Table 2 does not include state-sponsored efforts to provide coverage to pregnant/postpartum individuals, nor does it reflect state efforts to establish state-based premium subsidies to purchase individual market coverage for people who are not eligible for ACA, Medicaid, or CHIP coverage.

[v] Both D.C. programs represented in Table 2 are financed with District-only funds.

Table 2: Implemented State-Funded Affordable Coverage Programs for Immigrants[iv]				
State	**Program**	**Eligibility**	**Benefits**	**Cost-Sharing**
OR	Cover All Kids	Age 18 and younger with income < 305% of the FPL	Full scope Medicaid equivalent benefits	Copayments: None Premiums: None
WA	Apple Health for Kids	Age 18 and younger with income ≤ 312% FPL	Full scope Medicaid equivalent benefits	Copayments: None Premiums: Tiered premium structure for enrollees with incomes > 210% and ≤ 312% FPL; premiums range from $20 per month per child ($40 family max) to $30 per month per child ($60 family max)
Immigrant Adults				
CA	Young Adult Expansion	Ages 19 to 25 with income ≤ 138% of the FPL	Full scope Medicaid equivalent benefits	Copayments: None Premiums: None
D.C.	DC Health Care Alliance	Age 21 and older with income ≤ 215% of the FPL; includes an asset test	Limited scope medical benefits (see additional information)	Copayments: None Premiums: None
IL	Health Benefits for Immigrant Seniors	Age 65 and older with income ≤ 100% FPL; includes an asset test	Comprehensive medical benefits (see additional information)	Copayments: None Premiums: None

Other states have established programs at the local level (e.g., Harris County, Texas) to achieve the same aim.[11] Momentum appears to be growing, as a number of other states (e.g., Connecticut,[12] New Jersey,[13] Vermont[14]) have recently enacted state budgets or passed legislation authorizing similar programs (see Figure 1) expected to take effect in 2022 or later. The list of states with recently enacted legislation includes Colorado, which is planning to provide state-based premium subsidies for people who are ineligible for ACA subsidies and Medicaid/CHIP to purchase individual market coverage. Colorado has established through state statute the Health Insurance Affordability Enterprise, which will be funded through a new state health insurance premium tax that replaces the federal health insurance tax in 2021.[15] Part of that funding will be used to create a state-based premium subsidy program that will be available in 2023 to people with incomes up to 300 percent FPL who are ineligible for ACA subsidies, regardless of immigration status. More specifically, the program will be available to qualified individuals (primarily including undocumented individuals and those in the ACA's "family glitch") and designed to meet federal Qualified Health Plan (QHP) requirements.[16]

Figure 1. State Efforts Related to State-Funded Affordable Coverage Programs for Individuals, Regardless of Immigration Status[17]



Notes: Figure 1 reflects comprehensive, affordable coverage programs for individuals, regardless of immigration status.

Generally, state and local policymakers are seeking to advance coverage solutions for immigrants in an effort to cover their remaining uninsured residents, who are disproportionately undocumented people.[18] The benefits of affordable health coverage are undeniable, including improved access to primary and preventive healthcare services, better health outcomes, and higher rates of school and work attendance. Higher health insurance rates in states strengthens the healthcare system by increasing revenue to providers, decreasing uncompensated care costs, and enhancing provider capacity to deliver care.[19] While opponents of state-funded coverage programs cite state spending as a concern, research indicates that health coverage expansions for immigrant populations are ultimately less expensive than providing emergency-only services.[20]

State-Funded Affordable Coverage Programs for Immigrants: Considerations for Policymakers

The design and features of state-funded affordable coverage programs for people who do not qualify for subsidized Marketplace coverage under the ACA or other public programs due to their immigration status vary depending on the makeup of the state's uninsured population, policy objectives, and available resources, among other factors. As noted above, two predominant models that states are relying on to offer access to affordable coverage for immigrant populations that are ineligible for federally funded health coverage are: (1) establishing

state Medicaid/CHIP equivalent or comparable programs (see Table 2); and (2) creating state premium or cost-sharing subsidies to enable individuals to purchase Marketplace coverage. There are a variety of considerations related to opting for one model over the other, including availability of state funding, political and cultural considerations in the state, desire to align coverage to either Medicaid/CHIP or Marketplace coverage, and bandwidth of the state agency (Medicaid program, Department of Insurance, or Marketplace) to implement the program.

We outline below other key program design considerations related to state-funded affordable coverage program development.

Program Costs. Projected program expenditures differ depending on program eligibility (i.e., age and income level), take-up, and, in the case of state programs that mirror Medicaid/CHIP-like benefits, generosity of benefits. California's Health4All Kids, which provides full scope Medicaid equivalent benefits to individuals age 18 and younger, cost about $300 million annually as of 2017.[21] In contrast, Massachusetts's state budget appropriated $15.4 million for the Children's Medical Security Plan that provides healthcare services limited in scope for uninsured children under age 18.[22] As of August 2021, Colorado had budgeted $40 million for its Health Insurance Affordability Enterprise subsidies available to qualified individuals, and estimated that take-up of coverage among undocumented populations would be 25 to 30 percent of the state's total undocumented and uninsured population.[23]

Eligibility and Enrollment. All states implementing state-funded affordable coverage programs for immigrants without access to subsidized health insurance coverage under the ACA or other public programs offer services for children and adolescents. California, Colorado, D.C., Illinois and New Mexico have or are developing initiatives that cover adults. Most states set income eligibility standards for their programs, sometimes paired with asset tests. New York's Child Health Plus program is an exception, providing subsidized health insurance to children under the age of 19 at any income level, regardless of immigration status. To control program costs, some states utilize enrollment caps and waitlists based on available state funding.[24] Colorado is evaluating different eligibility parameters (e.g., first-come first-serve basis, lottery system), and will prioritize certain populations based on eligibility factors in an effort to reduce disparities.[25] Other states have not used these types of levers because enrollment numbers have fallen well short of estimates. For example, Oregon anticipated that 15,000 immigrants age 18 and younger would be eligible for the Cover All Kids program that launched in January 2018. By June 2019, just under 6,000 children were enrolled.[26] To promote the uptake of coverage and prevent disenrollment, states employ various strategies, including automatically transitioning individuals from emergency Medicaid into state-funded coverage (Oregon Cover All Kids approach),[27] automatically enrolling individuals into Medicaid managed care (D.C. Immigrant Children's Program approach),[28] and extending 12 months continuous coverage (Illinois All Kids approach).[29]

Communication and Outreach. Through their efforts to extend coverage to individuals ineligible for federally funded health insurance programs, regardless of immigration status, states have learned that addressing systemic barriers to enrollment requires targeted, community-based outreach paired with investment. Oregon provides a multi-pronged, culturally and linguistically responsive approach to encourage immigrant youth to enroll in Cover All Kids.[30] Efforts included establishing a stakeholder workgroup of diverse community partners that launched a statewide outreach campaign, and investing nearly $2.5 million in funding for community-based organizations (CBOs) to provide outreach, enrollment, and system navigation services. Washington employs community-based enrollment specialists at hospitals, clinical health departments, and community outreach centers,[31] and Illinois refers adult enrollees to Protecting Immigrant Families and Immigrant Family Resources to answer enrollment questions.[32] Efforts such as these are particularly important in light of enrollment barriers and reluctance to engage with the state for fear about the potential impact on immigration status.

Cost-Sharing. Among the states with Medicaid/CHIP equivalent or comparable state-funded affordable coverage programs that impose copayments and/or premiums, most use a tiered structure based on household income and family size. New York's program has premiums that range from $9 per month per child for those with incomes between 160 and 221 percent of the FPL, to $231 per child per month for those with incomes 400 percent of the FPL or greater.[33] For administrative simplicity, California has aligned its Health4AllKids premium structure with that

of its Medicaid program.[34] A few states do not require cost-sharing in their programs at all. Colorado is evaluating the subsidy structure for its program, considering subsidizing monthly premiums costs to incentivize enrollment (premium wrap) or reducing out-of-pocket costs [Cost Sharing Reduction (CSR)]. Per state legislation, the lowest income individuals will have no premiums and be provided benefits actuarially equivalent to 90 percent of the full actuarial value of benefits provided under the program.[35] While cost-sharing creates hurdles to equitable health coverage for low-income individuals, imposing copayments and premiums on higher income enrollees may be appropriate (e.g., for people with incomes above 400 percent of the FPL in states that do not have income limits). Notably, states are unlikely to offset program costs through cost-sharing requirements on low-income populations. Research indicates that potential revenue gains are offset by enrollment churn, increased utilization of costly services, and administrative expenses.[36]

Benefits. In an effort to ensure access to comprehensive health coverage for all, several states align benefits in state-funded affordable coverage programs for immigrants to their Medicaid state plan benefits. Other states limit the scope of benefits in these programs (e.g., to primary care, preventive services) and/or impose service limits (e.g., dental care up to $1,000 per year, up to 20 behavioral health outpatient visits per year). In the case of states pursuing state premium subsidy programs, individuals will likely have access to individual market coverage that provides access to Essential Health Benefits (EHBs), though states can opt to provide less robust (and therefore less costly) coverage that does not meet ACA QHP standards.[vi] In other words, state-subsidized health coverage is not required to cover ACA-mandated EHBs or be certified as a QHP.

Financing. The influx of federal stimulus dollars, and American Rescue Plan Act (ARP) funding in particular, has provided substantial relief to state budgets, likely contributing to lawmakers' ability to finance and garner support for state-funded affordable coverage programs. States standing up coverage for their residents without access to subsidized coverage due to their immigration status, are financing these programs using state general funds, including funds generated through health insurance premium taxes (Colorado and New Mexico), other provider taxes, tobacco taxes and disease management program savings.[37] States such as Massachusetts have elected to carve emergency services out of their Medicaid/CHIP-based state-funded benefit packages to ensure they maximize federal matching funds for emergency Medicaid.[38] In practice, enrollees retain coverage for emergency services, and the state-funded program serves as a supplemental or wrap-around benefit. California has undertaken a creative approach and is planning to provide full scope Medicaid equivalent benefits (including emergency services) in its Young Adult Expansion, but will seek to recoup from the Centers for Medicare & Medicaid Services (CMS) federal funds that would have otherwise been provided for emergency Medicaid.[39]

Conclusion

Extending state-funded coverage to low-income children and adults who do not qualify for subsidized health insurance under the ACA or through Medicaid/CHIP due to their immigration status has long been a strategy available to states, and the significant burden that COVID-19 has placed on immigrant populations has catalyzed further action. As the immigrant population grows at a rapid pace, states have an imperative to address persisting structural racism that impacts the health of immigrants by closing the gap in coverage and better integrating immigrant families into the healthcare system. Absent new federal statutory or policy options for covering immigrant populations, this momentum is likely to continue as states take it upon themselves to implement state-funded affordable coverage programs for their remaining uninsured residents, regardless of their immigration status.

[vi] EHBs are a set of 10 categories of services that Marketplace plans are required to cover under the ACA. EHBs are minimum requirements, so plans may offer additional benefits, such as dental and vision on top of the required services.

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THE HEALTH INSURANCE COVERAGE LANDSCAPE IN THE LATE COVID-19 PERIOD

Statement of
Linda J. Blumberg*
Institute Fellow, Urban Institute

before the
Finance Committee
United States Senate

HEALTH INSURANCE COVERAGE IN AMERICA: CURRENT AND FUTURE ROLE OF FEDERAL PROGRAMS

October 20, 2021

* The views expressed are my own and should not be attributed to the Urban Institute, its trustees, or its funders.

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Chairman Wyden, Ranking Member Crapo, and distinguished members of the committee:

Thank you for inviting me to address current issues related to health insurance in the US. While I am an employee of the Urban Institute, the views expressed in this testimony are my own and should not be attributed to the Urban Institute, its trustees, or its funders.

Research has demonstrated that the Affordable Care Act has increased health insurance coverage in the US among the nonelderly by more than 20 million people.[1] The enhancements of premium tax credits provided by the American Rescue Plan Act (ARPA) have increased coverage further, albeit temporarily, given the limited duration of the enhanced credit period. These reforms also have improved affordability of insurance coverage and increased access to care for millions of Americans.

As a result, the US health insurance system provided a stronger safety net during the pandemic-induced economic downturn than in prior recessions. According to the Urban Institute's Health Reform Monitoring Survey, the number of nonelderly adults with employer-based insurance fell by approximately 5.5 million between March 2019 and April 2021.[2] Yet unlike prior recessions, the number with Medicaid increased even more. As a consequence, the number of uninsured held steady instead of increasing nationwide. However, while nationwide data is encouraging, the number of uninsured rose in nonexpansion states because smaller shares of people who lost employer coverage were eligible for Medicaid.

Still, nationwide, the private nongroup insurance Marketplaces are, by all indications, fundamentally stable. In 2021, the national average benchmark premium fell for the third year in a row, with average decreases in 43 states and only 1 state with an increase of more than 6 percent, following very large premium increases in 2018.[3] In addition, insurer participation in the Marketplaces has increased since 2017 in many population centers. However, in areas with lower insurer participation and/or consolidation among health providers, premiums and premium growth tend to be higher.

Even recognizing the successes, significant gaps remain in the health insurance system. First, more than 3 million people living below the poverty line and 1.2 million near-poor people are uninsured and ineligible for any financial assistance because they live in states that have not expanded Medicaid eligibility.[4] In addition, absent the temporarily increased ARPA Marketplace subsidies, my Urban Institute colleagues estimate that the number of uninsured nationally would reach 30 million in 2022.[5] Conversely, they estimate that making the ARPA subsidies permanent and extending them to lower-

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[1] Linda J. Blumberg, Michael Simpson, Matthew Buettgens, Jessica Banthin, and John Holahan, "The Potential Effects of a Supreme Court Decision to Overturn the Affordable Care Act: Updated Estimates" (Washington, DC: Urban Institute, 2020).

[2] Michael Karpman and Stephen Zuckerman, "The Uninsurance Rate Held Steady during the Pandemic as Public Coverage Increased: Trends in Health Insurance Coverage between March 2019 and April 2021" (Washington, DC: Urban Institute, 2021).

[3] John Holahan, Jessica Banthin, and Erik Wengle, *Marketplace Premiums and Participation in 2021* (Washington, DC: Urban Institute, 2021).

[4] Michael Simpson, Jessica Banthin, and Matthew Buettgens, "Most Uninsured People Gaining Medicaid Eligibility under Potential Expansion Would Have Incomes below the Federal Poverty Level" (Washington, DC: Urban Institute, 2021).

[5] Jessica Banthin, Michael Simpson, and Andrew Green, "The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress" (New York: Commonwealth Fund, 2021).

income people in nonexpansion states would decrease the uninsured by another 7 million people at a net federal cost of $27.7 billion in 2022, or $333 billion over 10 years. In addition, these estimates indicate that such policies would increase Marketplace enrollment while decreasing Marketplace premiums by 18 percent, on average, because of the relatively better average health of the new enrollees.[6] Taking lower premiums and out-of-pocket costs into account, the average per enrollee health care costs for those insured through the Marketplaces would be over $1,100 lower per year.[7]

While such opportunities exist to expand coverage, further action also must be considered, because the pending end of the national public health emergency (PHE) will also end the requirement that states keep people enrolled in Medicaid, and this transition poses future challenges for coverage. Urban Institute estimates indicate that Medicaid enrollment could decrease by as many as 15 million people during 2022 once the PHE-related maintenance-of-effort requirement ends, including 8.7 million adults and 5.9 million children. These numbers are partly offset by the projection that one-third of those adults would qualify for subsidized private health coverage in the Marketplaces. About two-thirds of the children would be eligible for assistance, much of it through CHIP. However, others have highlighted that the number losing Medicaid coverage at the end of the PHE could exceed 15 million people, given the difficulty of contacting still-eligible people to reverify and renew enrollment when they have not been in contact with state Medicaid systems for up to two years.[8]

Thus, the risk of a significant increase in the number of people uninsured following the end of the PHE is substantial, and such risk merits legislative and administrative consideration. As I have outlined, permanent, enhanced premium tax credits should encourage more people to move from Medicaid to the Marketplace once they lose Medicaid eligibility. Further, aggressive outreach and enrollment efforts at the state and federal levels, in addition to streamlining Medicaid redetermination and enrollment processes, are among viable options available to address the potential for a near-term increase in the number of uninsured Americans.

Thank you for the opportunity to share information with you on these important issues. I'd be happy to answer any of your questions.

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[6] Jessica Banthin, Matthew Buettgens, Michael Simpson, and Robin Wang, "What If the American Rescue Plan's Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022" (Washington, DC: Urban Institute, 2021).

[7] Banthin, Buettgens, Simpson, and Wang, "What If the American Rescue Plan's Marketplace Subsidies Were Made Permanent?"

[8] Kinda Serafi, Cindy Mann, and Nina V. Punukollu, "The Risk of Coverage Loss for Medicaid Beneficiaries as the COVID-19 Public Health Emergency Ends," *To the Point* (blog), Commonwealth Fund, September 23, 2021, https://www.commonwealthfund.org/blog/2021/risk-coverage-loss-medicaid-beneficiaries-covid-19.

Note

This testimony was submitted to the committee with the following publications appended:

- Jessica Banthin, Michael Simpson, and Andrew Green, "The Coverage and Cost Effects of Key Health Insurance Reforms Being Considered by Congress" (New York: Commonwealth Fund, 2021).
- Linda J. Blumberg, "Design of Public Option and Capped Provider Price Reforms: Important Interactions between Provider Prices and Other Program Features" (Washington, DC: Urban Institute, 2021).
- Michael Karpman and Stephen Zuckerman, "The Uninsurance Rate Held Steady as Public Coverage Increased: Trends in Health Insurance Coverage between March 2019 and April 2021" (Washington, DC: Urban Institute, 2021).
- Stacey McMorrow, Jessica Banthin, Matthew Buettgens, Michael Simpson, Genevieve M. Kenney, and Clare Wang Pan, "Extending the American Rescue Plan Act's Enhanced Marketplace Affordability Provisions Could Benefit Nearly One Million Uninsured Children and Parents" (Washington, DC: Urban Institute, 2021).

NASHP

State-Based Marketplaces Report Savings and Growth for Older Adult and Moderate-Income Populations

October 20, 2021 / by Christina Cousart

The American Rescue Plan Act (ARPA) had a significant impact on the ability of Americans to access and afford health insurance through the federally facilitated marketplace and state-based exchanges across the country. ARPA's dual policies of enhancing existing tax credits used to purchase coverage and providing first time tax credits for moderate income households (those above 400% of the federal poverty level (FPL)) enabled millions to access coverage through marketplace plans since the law's enactment in March of 2021.

The National Academy for State Health Policy (NASHP) recently analyzed how ARPA has impacted enrollees in state-based health insurance marketplaces (SBMs) across different age and income groups. Specifically, NASHP examined households with individuals over 55 years of age for whom health insurance is often cost-prohibitive because of higher charges associated with age (known as age rating) and individuals with income over 400% FPL who newly qualify for subsidies.

To conduct this analysis, NASHP collected data from 15 SBMs operating in CA, CO, CT, DC, ID, MD, MA, MN, NV, NJ, NY, PA, RI, VT, and WA. This analysis was conducted as part of NASHP's work with the State Based Exchange Leadership

Network—a consortium of state leaders and staff operating the SBMs. Data are current as of September 2021, except where otherwise indicated.

Increased Enrollment and Affordability for Pre-Retirees in SBM Plans

Over one million (1,040,015) 55+ year-olds are currently enrolled in plans through the 15 SBMs reporting data, with the majority of SBMs (**CA, CO, CT, DC, ID, MD, MA, MN, NV, NJ, NY, PA, RI, VT, WA**)[1] reporting increased enrollment of this population when compared to this time last year. For example, **Colorado** reported an increase in enrollment of 11 percent and two states, **Idaho** and **Maryland**, reported a significant increase in enrollment of 63 and 55 percent, respectively.

Enrollment increases may be a result of lower out-of-pocket premium costs resulting from ARPA's premium tax credit enhancements. Thirteen SBMs report lower average premiums paid by 55+ year-olds after the enactment of APRA. Average premiums for 55+ year-olds fell by over 20 percent in nine states (CA, CT, DC, MD, NV, NJ, PA, RI, WA), with seven of those states reporting decreases in premiums of over $100 per month (or $1,200 per year) (CT, DC, NV, NJ, PA, WA).[2]

Increased affordability may also be driving this population to seek higher value coverage in the form of silver and gold level plans available through the marketplaces. Growth was especially notable in gold-level enrollments, as SBMs saw a 13% increase compared with last year.[3] Overall 66% of 55+ enrollees elected either a silver or gold plan across the 15 SBMs.

Affordability and Enrollment Gains for Moderate-Income Enrollees in SBM Plans

Under ARPA, for the first time, households earning at or above 400% FPL ($104,800 for a family of four in 2021), could qualify for premium tax credits available through the marketplaces. This help is capped at 8.5% of household income ensuring support for enrollees in areas with high healthcare costs and high cost of living. The availability of tax credits has led to significant savings, with nine states (**CA**, **CO, DC, ID, MA, MD, NV, NY, VT**) reporting that the average out-of-pocket premiums have fallen by greater than $100 per month (or $1,200 per year) since ARPA's enactment. The **District of Columbia** and **Idaho** report that average premiums have fallen over $300 per month (or $3,600 per year), while **California** and **Colorado** report savings of over $400 per month (or $4,800 per year).[4]

The increased affordability of SBM plans for those with income at or above 400% FPL may have triggered more of these moderate income households to enroll in coverage through SBMs. Since the enactment of ARPA, the U.S. Department of Health and Human Services reports that an estimated 88,600 individuals from households with income above 400% FPL have enrolled in coverage through the SBMs.[5]

Looking ahead, SBMs are preparing for the next open enrollment season, launching on November 1, and working to ensure that customers, new and old, continue to leverage their resources to access the best value coverage. NASHP will continue to monitor emerging SBM trends.

Customer Testimonials on ARPA and Marketplace Coverage

Since enactment of ARPA, customers of the Washington Health Benefit Exchange report greater ability to afford and

use coverage through the marketplace. As shared by one 57-year old customer "My bill [is] $242 less than I presently pay. . . . If this continues, I could afford to get better insurance or pay out of pocket for occupational therapy that my insurance and the third party employer tell me I can't have." Another consumer reported that the additional subsidies enabled them to move from bronze to silver-level coverage which, in-turn, enabled them to afford prescription medicines the individual had previously been unable to purchase.

Notes

[1] 2020 data not available for NJ and PA during which they operated on the Federally Facilitated Marketplace (FFM). Data unavailable at the time of reporting from NV.

[2] Analysis is based on premium data reported as of April 1, 2021. Data not available for MA and NY which do not allow for age-based rating of premiums.

[3] 2020 data not available for NJ and PA during which they operated on the Federally Facilitated Marketplace (FFM). Data unavailable at the time of reporting from NV.

[4] Based on households electing to receive financial assistance in the form of advanced premium tax credits. Data not available for CT, MN, NJ.

[5] U.S. Department of Health and Human Services, "2021 Final Marketplace Special Enrollment Period Report." Report, September 15, Accessed at: https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf.

Infographic: ARPA Encourages Coverage Uptake for Older, Moderate Income Americans in State-Based

Marketplaces

Download the infographic (PDF)

ARPA Yields Significant Savings for Some Pre-Retirees

Subsidy enhancements have enabled single digit coverage for the first time for older adults. For example, a 60-year-old in Connecticut making $19,000 a year can now access a silver-level plan through the SBM for as low as $3/month or $36 per year (a 95 percent savings from pre-ARPA rates).

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ISSUE BRIEFS / OCTOBER 19, 2021

Expanding Consumer Health Insurance Options by Easing the Boundaries Between Individual and Small-Group Markets

TOPLINES

Interest is growing in ways to ease boundaries between the individual and small-group insurance markets

Consumers would likely have more coverage options if they could cross the individual/small-market boundary in either direction

AUTHORS

Mark A. Hall, Michael J. McCue

Abstract

- **Issue:** Prior to the Affordable Care Act (ACA), policymakers typically aimed to keep the small-group and individual health insurance markets separate, because of their distinct market and regulatory conditions. The ACA, however, brought similar regulatory reforms to both market segments. Therefore, prior assumptions about "border crossing" merit reexamination.
- **Goals:** Determine whether selective forms of crossing the border between individual and small-group markets might enhance consumer options without undermining regulatory goals.
- **Methods:** Comparison of premiums between the individual and small-group markets, and public policy analysis of two options for crossing this market boundary.
- **Key Findings and Conclusions:** Whereas initially under the ACA, unsubsidized premiums in the individual market were much lower than in the small-group market, now premium levels are much more similar. But because market conditions can vary substantially by location, consumer options could be enhanced by providing select opportunities to cross this market border in either direction. Self-employed individuals might find better unsubsidized prices as a "group of one" in the small-group market. Or small firms might be able to provide lower-cost coverage by subsidizing workers' purchase of individual insurance. Policies that ease these market boundaries without substantially harming market conditions may be valuable.

Introduction

Now that the Supreme Court has rejected the third attempt to strike down the Affordable Care Act (ACA), the law's basic structure appears to be secure, yet deficits remain. Efforts at more fundamental enhancements, such as a public option, so far have stalled. Therefore, policymakers are currently considering more incremental measures to expand coverage and improve the affordability of private health insurance.[1] Among these are policy changes that lower the boundaries between the three segments within the commercial health insurance market:

- Individual
- Small group: employers with up to 50 workers (up to 100 in California, Colorado, and New York)

- Large group: employers with more than 50 workers (more than 100 in California, Colorado, and New York).

Distinctive regulatory rules have evolved for each segment, as policymakers have aimed to maintain "borders" between the markets (Exhibit 1).[2]

EXHIBIT 1

Characteristics of Health Insurance Market Segments

Market segment	Pre-ACA market conditions and rules	Post-ACA market conditions and rules
Individual	Unsubsidized Some mandated benefits Experience rated* Preexisting conditions excluded No open enrollment 60%–75% medical loss ratio typical	Partially subsidized Comprehensive benefits mandate Community rated* Preexisting conditions covered Annual open enrollment ≥80% medical loss ratio required
Small group (2 to 50, or 2 to 100)	Employer-sponsored Some mandated benefits Modified community rating* Preexisting conditions limited** Year-round open enrollment 75%–85% medical loss ratio typical	Employer-sponsored Comprehensive benefits mandate Community rated* Preexisting conditions covered Year-round open enrollment ≥80% medical loss ratio required
Large group (>50, or >100)	Employer-sponsored Few mandated benefits Experience rated* Preexisting conditions limited** Year-round open enrollment 85%–95% medical loss ratio typical	Employer-sponsored Few mandated benefits Experience rated* Preexisting conditions covered Year-round open enrollment ≥85% medical loss ratio required

Download data

* Experience rating bases premiums on each group's previous claims experience. Modified community rating includes some, but a limited, element of experience rating. Community rating bases premiums on marketwide averages, adjusted for age and tobacco use.

** Prior to the ACA, group plans could exclude preexisting conditions, but only for one year.

Data: Authors' analysis of state and federal market regulations.

Source: Mark A. Hall and Michael J. McCue, *Expanding Consumer Health Insurance Options by Easing the Boundaries Between Individual and Small-Group Markets* (Commonwealth Fund, Oct. 2021). https://doi.org/10.26099/e50v-eb64

Until recently, many policymakers thought it was important to keep these market borders distinct to prevent opportunistic "border crossings" that exploit regulatory gaps and loopholes. To avoid consumer protections thought to impose excess cost, some individuals have tried banding together to purchase as a group, but that has exposed

them to financial mismanagement or fraud.[3] Or, in the past, employers have tried to lessen the cost of group coverage by carving out individual workers with costly health conditions and offering them skimpier coverage designed for the nonemployment market.[4] Accordingly, regulators have had to prohibit and police such border-crossing strategies.[5]

Under the ACA, however, the individual versus small-group distinction is now much less important than previously. Prior to the ACA, individual coverage was entirely unsubsidized. Coverage was kept more affordable by restricting coverage for people with preexisting conditions and offering others more limited benefits. To remedy the resulting inadequacy in coverage, the ACA imposes on the individual market, and strengthens for the small-group market, the same basic set of rules that most states had previously created for the small-group market: no one can be turned down, coverage must be fairly comprehensive, and rates must be based on community averages. Further, to make individual coverage more affordable, the ACA created sliding-scale premium subsidies.

Certainly, important differences remain between the individual and small-group markets. For instance, the small-group market has continuous open enrollment whereas enrollment in the individual market is limited to designated periods, usually just once a year.[6] Also, small-group insurance is often based on broader provider networks than in the individual market.

These differences aside, it is no longer the case that an employee would receive inferior coverage if relegated to the individual market. Nor would an individual encounter a substantially different set of market rules and conditions by moving to the small-group market. The major difference remaining is simply the price of insurance. To better understand these price differences, we conducted an analysis of insurers' financial reports and rate filings with the federal government. Specifically, we analyzed unsubsidized premium rates in 2021 for identical levels of coverage that insurers offered in both the individual and small-group markets to understand how prices might compare in certain market settings.

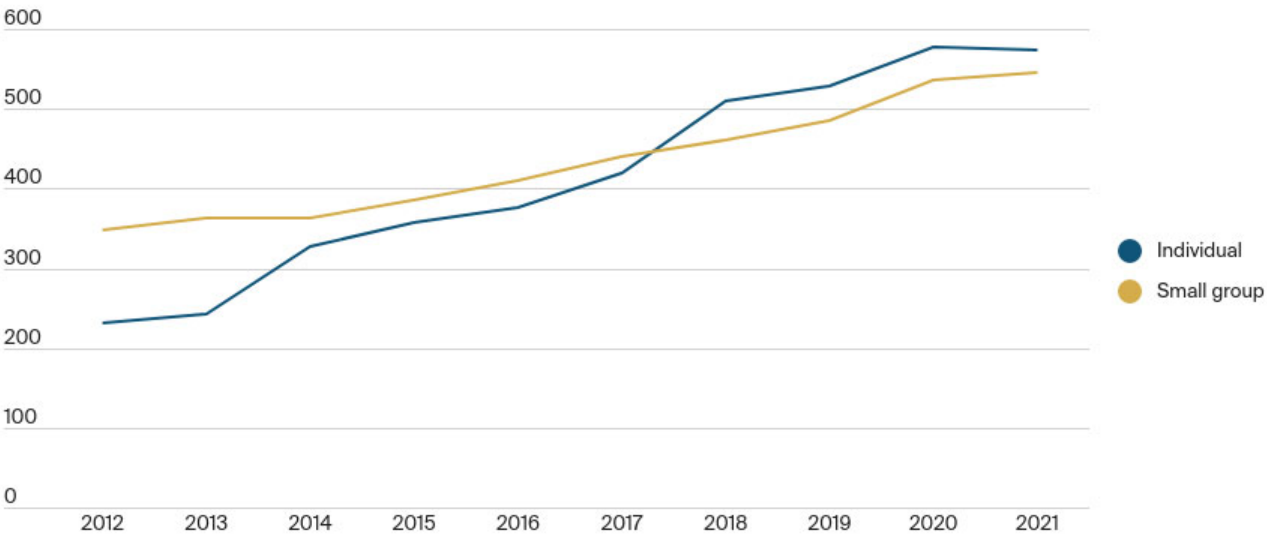
Key Findings

Initially following Affordable Care Act implementation, strong competition resulted in individual coverage premiums being surprisingly low — often substantially lower than premiums for equivalent coverage in the small-group market. Because insurers had underestimated the medical needs of new enrollees, they then had to substantially increase rates to levels higher than small-group rates, which had increased more moderately. Most recently, however, individual insurers realized they had overcorrected and so premiums have leveled off.[7] With small-group premiums continuing to increase

in pace with medical costs, the prices in the two market segments now resemble each other much more than in the past (Exhibit 2).[8]

EXHIBIT 2

Average Monthly Premiums in the Individual and Small-Group Markets, 2012–2021



Note: Data and methodology through 2019 are described in Mark A. Hall and Michael J. McCue, "The Individual Health Insurance Market Is Looking More Like the Group Market Under the Affordable Care Act," *To the Point* (blog), Commonwealth Fund, Aug. 26, 2019. Premiums for 2020 and 2021 are projected, based on insurers' rate filings with the federal government.

Data: Authors' analysis of insurers' financial reports to the Centers for Medicare and Medicaid Services.

Source: Mark A. Hall and Michael J. McCue, *Expanding Consumer Health Insurance Options by Easing the Boundaries Between Individual and Small-Group Markets* (Commonwealth Fund, Oct. 2021). https://doi.org/10.26099/e50v-eb64

To better understand how prices might compare in particular market settings, we conducted an apples-to-apples analysis of unsubsidized premium rates in 2021 for identical levels of coverage that insurers offered in both the individual and small-group markets. Based on the availability of data — and to ensure that the compared plans were virtually identical — we limited this analysis to eight states with small-group exchanges operated under the ACA (known as SHOP exchanges, for the Small Business Health Options Program).[9] Accordingly, these results should be viewed more as a convenience

sample that illustrates a range of possible conditions in other states rather than as a reliable representation of nationwide averages or typical conditions.

Using silver-plan rates from the largest county in each state with available rate data, we calculated the enrollment-weighted averages (Exhibit 3). This example is for a single 30-year-old. Amounts for other ages or family compositions will vary, but because demographic adjustments are uniform across these markets, proportionate differences remain the same regardless of age or family composition.

EXHIBIT 3

Silver-Plan Premiums for a Single 30-Year-Old

State	Individual market	Small group	Difference	% difference
Alabama	$508.55	$303.72	$204.83	67%
Wyoming	$704.09	$493.45	$210.64	43%
Virginia	$495.33	$336.58	$158.75	47%
Wisconsin	$525.36	$446.42	$78.94	18%
Montana	$433.01	$392.61	$40.40	10%
Georgia	$407.83	$394.74	$13.09	3%
Maine	$379.52	$370.70	$8.82	2%
New Hampshire	$328.63	$385.77	–$57.14	–15%
Average	**$472.79**	**$390.50**	**$82.29**	**21%**

Download data

Data: Authors' analysis of Qualified Health Plan Landscape Medical Market Data.

Source: Mark A. Hall and Michael J. McCue, *Expanding Consumer Health Insurance Options by Easing the Boundaries Between Individual and Small-Group Markets* (Commonwealth Fund, Oct. 2021). https://doi.org/10.26099/e50v-eb64

This rate comparison varies based on idiosyncrasies across these sampled states. In half, individual premium rates are substantially higher (18%–67%) than small-group rates, but in half, individual rates are either lower (–15%) or fairly similar (2%–10% more). Moreover, such comparisons are likely to change from year to year.[10] And, even when one market does not have a clear price advantage over another, people able to shop in both markets have more choice of plans. Accordingly, consumers' options would likely be maximized if they could cross the individual/small-market boundary in either direction — so long as that would not harm the integrity of market rules.

Increasing Consumer Options Without Harming Market Conditions

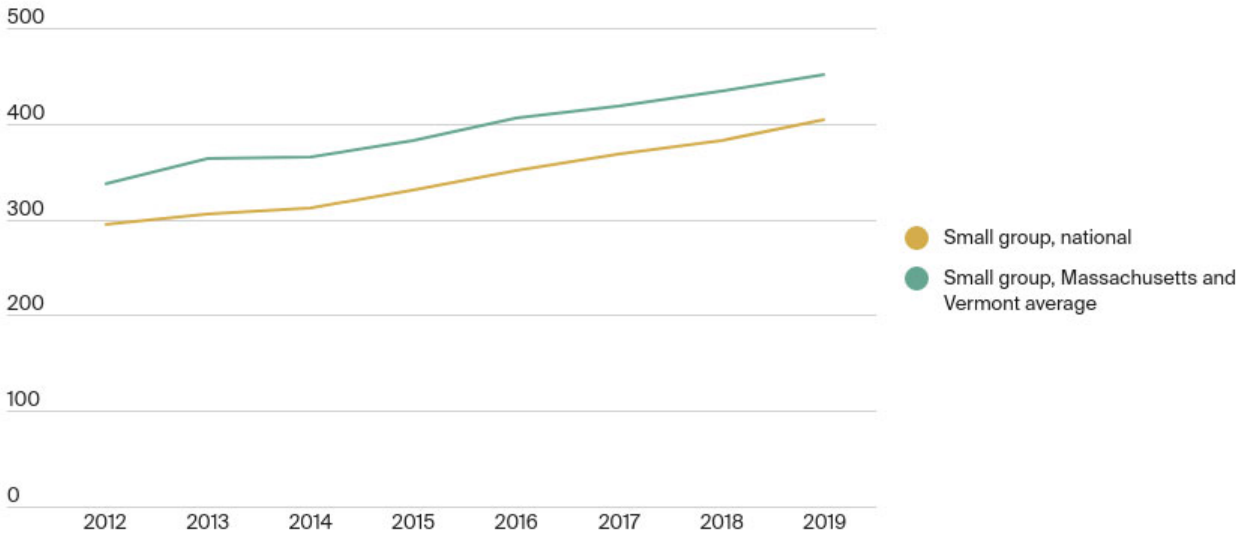
The previous two sections illustrate how market rules and market conditions between the small-group and individual segments have become more closely aligned. We next examine policy options that could permit more "border crossing" between the two segments as a possible means to increase consumer options.

One option is to allow people who are eligible for employer coverage to purchase individual coverage instead through the subsidized exchanges.[11] Other options also could help people who do not qualify for ACA subsidies, based on their income levels or citizenship status. Should employers be allowed, for instance, to subsidize workers' purchase of individual insurance with pretax compensation? Or should self-employed individuals be allowed to purchase group coverage as a "group of one?" Under either option, subscribers would not be allowed to combine both the tax benefits of employer sponsorship and the ACA's sliding-scale premium subsidy. But for those who are not eligible for substantial ACA subsidies, it might make good sense to allow them to compare options between the two market segments.

The primary objection to border crossing is adverse selection. Depending on market conditions, subscribers in either market segment might be concerned if large numbers of those in the other segment with greater medical needs were to cross over, driving up community-rated prices. However, one high-level indication that lowering the individual/small-market boundary is not fundamentally harmful is that two states (Massachusetts and Vermont) have chosen to merge their individual and small-group markets, and two others (Maine and North Dakota) are either considering this or planning to do so.[12] Data from the two merged-market states indicate that despite entering the market reform era with somewhat higher rates, the combining of each state's risk pools has not resulted in small-group claims increasing at a noticeably different rate than the national average (Exhibit 4).

EXHIBIT 4

Average Small-Group Claims, National Compared with Merged Market States, 2012–2019 (dollars per person, per month)



Data: Authors' analysis of insurers' financial reports to the Centers for Medicare and Medicaid Services.

Source: Mark A. Hall and Michael J. McCue, *Expanding Consumer Health Insurance Options by Easing the Boundaries Between Individual and Small-Group Markets* (Commonwealth Fund, Oct. 2021). https://doi.org/10.26099/e50v-eb64

Selective border crossing raises different concerns than a wholesale market merger. If selective crossing is done strategically to take advantage of different market rules, the results could weaken or undermine those rules. Two particular measures, however, appear to lower fences without risking significant adverse selection. The first is allowing self-employed individuals to purchase small-group coverage as a "group of one." The second is to allow small employers to subsidize workers' purchase of individual insurance through health reimbursement arrangements (HRAs). We discuss each in turn.

Group-of-one rule. Prior to the ACA, 16 states allowed self-employed individuals to purchase group coverage through their sole proprietorships, denominating these as "groups of one."[13] The ACA, however, defined groups as having at least two independent members (e.g., owner plus an unrelated employee). Most or all of these states changed their small-group rules to conform with the federal definition, but Virginia expanded

small-group coverage to include the self-employed as a way to provide more affordable options.[14] Also, a few states (e.g., Iowa, Texas, and Utah) loosened the ACA's owner-plus-employee requirement for group status to include so-called mom-and-pop businesses, in which the only employees are the owners themselves.[15] Some brokers report that this flexibility is helping self-employed people find "more affordable [or] generous coverage." In addition to price, another potential advantage of small-group coverage is that it often offers broader provider networks, such as preferred provider organizations (PPOs), rather than only health maintenance organizations (HMOs).

The only concern that has been raised about returning to, or adopting, a group-of-one rule for the small-group market is that doing so conflicts with the ACA and thus might be beyond state authority.[16] One solution to that problem is for Congress to amend the ACA. Pending that, however, the Virginia Bureau of Insurance ruled that its group-of-one rule does not contravene the ACA because it expands rather than contracts small-group options, and so far federal authorities have not objected.[17] Thus, this option appears to be readily available to states.

Health reimbursement arrangements. HRAs are tax-sheltered accounts through which employers can subsidize workers' health-related expenses without those subsidies counting toward workers' taxable income. If employers earmarked HRA funds for health insurance premiums, then workers could purchase individual coverage with pretax rather than after-tax funds, producing a substantial discount equivalent to each worker's federal and state tax bracket, plus payroll taxes. Initially, however, federal agencies prohibited this arrangement, out of concern that employers who previously were offering health insurance would dump their workers onto the subsidized individual exchanges. Congress adopted a solution to that problem, though, with a 2016 enactment that allowed qualified small employer HRAs (QSEHRAs) under limited conditions.[18] QSEHRAs cannot be offered selectively to only some employees, and the employer's contribution reduces pro rata any premium subsidy a worker might be eligible for through the ACA exchange.

So far, QSEHRAs have received only limited uptake. One reason is their complexity.[19] QSEHRAs differ from conventional HRAs, which themselves differ from flexible spending accounts (FSAs, also known as cafeteria plans) and health savings accounts (HSAs). Understanding, navigating, and administering all of these different employee benefit arrangements can be daunting, especially in view of the additional requirements imposed by the Employee Retirement Income Security Act (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and the Health Insurance Portability and Accountability Act (HIPAA).

Moreover, QSEHRAs were followed by a similar but distinctive HRA version known as individual-coverage HRAs (ICHRAs), created by a 2019 regulation.[20] ICHRAs accomplish

the same basic goal of QSEHRAs but are available to employers of any size. Because ICHRAs were created by regulation rather than statute, however, they are subject to a somewhat different set of constraints. And, because ICHRAs reduce market boundaries between the large-group and individual markets, they raise different public policy concerns than QSEHRAs.[21] For instance, because larger groups are not subject to the same community rating rules that govern the individual market, allowing larger employers to fund individual insurance through HRAs could lead to some degree of adverse selection.

Conclusion

Interest is growing in policy options to ease boundaries between the individual and small-group markets. Self-employed individuals who do not qualify for subsidized insurance could benefit from being able to purchase group insurance as a group of one. Or small firms with workers who might qualify for federal subsidies could provide more affordable coverage choices by helping workers to purchase individual coverage. Moreover, bringing more employer-subsidized purchasers into the individual market could stimulate more innovation and competition between insurers.

For small businesses to take full advantage of these opportunities, however, tax and regulatory rules need streamlining and simplification. The time may be right to rethink and redesign these policies in a way that avoids regulatory strictures designed to address problems that no longer exist.

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20 Individual Coverage HRA (ICHRA), PeopleKeep, n.d.

21 Peter Newell, *Trump Administration Health Reimbursement Arrangements Put ACA Subsidies at Risk for Low-Income Workers* (United Hospital Fund, Oct. 2020); JoAnn Volk and Kevin Lucia, "Federal Rule Creating New Health Coverage Option for Employers Could Destabilize the Individual Market," *To the Point* (blog), Commonwealth Fund, July 24, 2019; and Christen Linke Young, Jason Levitis, and Matthew Fiedler, *Evaluating the Administration's Health Reimbursement Arrangement Proposal* (Brookings Institution, Dec. 2018). Similar concerns exist for the aspect of the Trump administration's rule on association health plans that would allow self-employed individuals to join the large-group market. See Keith, "Association Health Plan Proposed;" Lucia et al., "In the Wake of New Association;" and Norris, "Problem with Association."

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AREA OF FOCUS

Achieving Universal Coverage

TOPICS

Health Insurance Marketplace

VIEWPOINT

The Affordable Care Act Resurrected
Curtailing the Ranks of the Uninsured

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On June 17, 2021, in *California v Texas*, a majority of the US Supreme Court rejected the latest challenge to the constitutionality of the Affordable Care Act (ACA) on the grounds that the plaintiffs lacked standing to bring their claims.[1] This ruling marks the third time that the US Supreme Court rejected a challenge to the constitutionality of the ACA.[1] The new lease on life for the ACA creates a window of opportunity for curtailing the ranks of the uninsured. Living up to this imperative will require the executive and legislative branches of the federal government to make the most of the policy options available to them. This Viewpoint reviews the national coverage gap and its potential redress by enhancing federal outreach to the uninsured, rendering permanent the health insurance benefits of the American Rescue Plan Act (ARPA), and establishing a federal health insurance program for low-income adults in states that did not expand their Medicaid programs.

The 2019 American Community Survey of the US Census Bureau revealed that an estimated 29.6 million individuals lacked health insurance.[2] Comparable estimates were reported by the National Health Interview Survey of the US Centers for Disease Control and Prevention, which estimated that for January through June 2020, 11.1% of US residents (an estimated 30 million younger than 65 years) were uninsured.[3] Both surveys noted that the proportion of individuals without health insurance in states that did not expand their Medicaid program (14 states) was nearly twice that of those in states that did expand Medicaid (17.1% vs 9.1%).[4] Low-income Black, Latino, and Native American adults were disproportionately affected, with self-reported rates of 12%, 22%, and 28%, respectively.[4] The most common reason given by eligible adults for their lack of health insurance was that the requisite coverage was unaffordable, reported by 73.7%.[4] Frequent reference (reported by 18.4% of respondents) was also made to the view that signing up with a health insurance plan was difficult and confusing.[4] Among the survey respondents, 25.3% deemed themselves ineligible for health insurance coverage.[4] A similar proportion (21.3%) concluded that they neither needed nor wanted health insurance.[4] A recent survey by the Urban Institute of 9032 uninsured adults revealed limited familiarity with the health insurance marketplaces and the subsidies thereof.[5] Awareness of the existence of state-based exchange call centers and of in-person assistance on HealthCare.gov proved equally limited.[5]

> The prospect of curtailing the ranks of the uninsured hinges on the continued viability of the [Affordable Care Act].

One course of action toward improving the national state of uninsurance is to markedly bolster federal marketing, outreach, and enrollment assistance. Continued sustained efforts along these lines remain all but indispensable if the national state of uninsurance is to be rendered a thing of the past. Examples of such mobilization drives by the executive branch abound. The latest such effort unfolded in the wake of an executive order on strengthening Medicaid and the ACA issued by President Joe Biden on January 28, 2021.[6] In observance of the president's directive, the US Department of Health and Human Services (HHS) established a special enrollment period (February 15-May 15, 2021) with the federally facilitated marketplaces (HealthCare.gov). A total of $50 million was committed to this effort. Subsequent extension of the special enrollment period through August 15, 2021, sought to introduce consumers to the savings afforded by the ARPA. Looking ahead, the Centers for Medicare & Medicaid Services has recently proposed to extend the 2022 annual open enrollment period by 30 days. Enhanced assistance by government navigators was to expand and improve counseling to consumers.

A parallel strategy for reducing the ranks of the uninsured is to render permanent the temporary marketplace insurance benefits instituted by the ARPA. As noted by President Biden, it is his goal to render permanent the temporary premium subsidies, deductibles, and tax credits enabled by the ARPA as part of the American Families Plan.[7] A component of the president's budget for fiscal year (FY) 2022, a $200 billion investment in ARPA benefits, is to "enable millions of uninsured people to gain coverage."[8] It is all but certain that the extension of the ARPA benefits will be embodied in the yet-to-be enacted FY2022 Omnibus Appropriations Bill, the framework agreement of which was passed by the Senate on August 10, 2021.[9] The final financial parameters of the House version of the FY2022 Omnibus Appropriations Bill remain to be determined. All indications are that the 2022 spending package will rely on the budget reconciliation process with an eye toward bypassing the prospect of a Senate filibuster. Alternative legislative vehicles for rendering permanent the ARPA health insurance benefits could be afforded by the Improving the Health Insurance Affordability Act of 2021 (S 499, 117th Cong, 1st Sess [2021]) or the Health Care Affordability Act of 2021 (HR 369, 117th Cong [2021]), which are sponsored by Sen Jeanne Shaheen (D, New Hampshire) and Rep Lauren Underwood (D, Illinois), respectively.

Yet another critical element in the effort to drive down the national rate of uninsurance is the introduction of health exchange options to states that have not as yet expanded their Medicaid programs. Doing so will all but eliminate the coverage gap by providing health care insurance to an estimated 2 million to 5 million presently uninsured individuals. Absent such intervention, the Medicaid-eligible individuals in question are likely to remain uninsured for years to come. The notion of "ACA expansion extension and filling the Medicaid Coverage Gap" is presently slated for passage via the yet-to-be enacted FY2022 Omnibus Appropriations Bill.[9] Consideration could also be given to the Medicaid Saves Lives Act, the Senate (S 2315, 117th Cong, 1st Sess [2021]) and House (HR 4595, 117th Cong [2021]) versions of which were sponsored by Sen Raphael Warnock (D, Georgia) and Rep Carolyn Bourdeaux (D, Georgia), respectively. Both bills call on the secretary of the Department of Health and Human Services to "establish a program to provide health care coverage to low-income adults in states that have not expanded Medicaid." This plan is advantaged by the reality that the federal government already operates successful marketplaces in all nonexpansion states.

The prospect of curtailing the ranks of the uninsured hinges on the continued viability of the ACA. While the decision in *California v Texas* proved essential in ensuring the future of the ACA, it did not signify the end to future challenges to the law.[10] One such challenge is already being adjudicated by Judge Reed C. O'Connor in the US District Court for the Northern District of Texas, the same trial court from which *California v Texas* sprung. The case in question, *Kelley v Becerra*, challenges the constitutionality of the zero cost-sharing coverage of preventive services (eg, vaccines) mandated by Section 2713 of the ACA. Two challenges are of particular note. One challenge pertains to the so-called nondelegation doctrine according to which Congress was vague in delegating to others the determination of what preventive services fall within Section 2713.

The more worrisome challenge is the second one, which touches on the way the individuals making the decision are appointed, that is, officers of the Health Resources and Services Administration, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the US Preventive Services Task Force of the Agency for Healthcare Research and Quality. As the US Supreme Court understood it, the appointments clause of the US Constitution requires that "principal" but not "inferior" officers be nominated by the president with the advice and consent of the Senate. The argument made by the plaintiffs is that the "principal" officers were not correctly appointed and that their exercise of power is problematic. While *Kelley v Becerra*, unlike its 3 predecessors, does not seek to completely upend the ACA, its effect on coverage of key preventive services could be significant. Congress could, in theory, step in to specify directly what should be covered in a zero-cost way. However, given the current political gridlock, these issues might not be resolved in the very near future.

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The Inequity of the Medicaid Coverage Gap and Why It Is Hard to Fix It

Larry Levitt, MPP

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The Affordable Care Act (ACA) envisioned a seamless system of health coverage. All people who are poor and near poor would be covered by Medicaid, and those with incomes above that who do not have access to employer-provided health benefits could buy private insurance in the ACA marketplace with subsidies to help make it more affordable.

The Supreme Court had other ideas.

In the 2012 decision that upheld the constitutionality of the requirement to get insured or pay a tax penalty—which has since been repealed—the court threw a curveball (or, maybe more aptly, a knuckleball) on Medicaid. It ruled that states could not be required to expand Medicaid to everyone with incomes up to 138% of the poverty level (currently about $17 800 for a single person and $30 000 for a family of 3).

The federal government still makes it extremely enticing for states to expand Medicaid eligibility. It covers 90% of the cost. And, in the American Rescue Plan passed earlier this year, there is now an additional fiscal incentive provided to states for 2 years if they start the expansion process. The net effect of this incentive is that states would literally make money for 2 years if they expand Medicaid.[1] They would still have to cover their 10% share of the cost after the temporary incentive expires.

Thirty-eight states plus the District of Columbia have opted to expand Medicaid, seeing this as a good opportunity to expand access to health coverage with primarily federal funding. In some cases—Idaho, Maine, Missouri, Nebraska, Oklahoma, and Utah—voters passed ballot measures to expand the program over the opposition of state political leaders. However, 12 states, largely in the South, have chosen not to expand Medicaid, wanting to avoid the additional budgetary expense and the appearance of supporting "Obamacare" (as the ACA is still often called).

The result is what has come to be known as the "Medicaid coverage gap." People with incomes below the poverty level are not eligible for premium help in the ACA marketplace. In the original ACA vision, before the Supreme Court decision, there was no need for ACA marketplace eligibility below that level because all poor people were expected to be eligible for Medicaid.

In states that have not expanded Medicaid, adults who are not elderly or disabled and who are without children are not eligible, no matter how low their income. Parents are eligible in all the nonexpansion states, but generally with very low income thresholds—the median income limit is 40% of the poverty level.[2] In Texas, for example, which has the largest number of uninsured adults of any state, a parent with 2 children making more than $3733 per year (17% of the poverty level) would be ineligible for Medicaid and caught in the coverage gap.

An estimated 2.2 million uninsured adults fall in the coverage gap,[3] with income too high to qualify for traditional Medicaid but too low to qualify for subsidized ACA marketplace coverage. Over three-quarters of people in the coverage gap live in just 4 southern states: Florida, Georgia, North Carolina, and Texas.

Black and Hispanic people are more likely to be uninsured than White people,[4] and one reason is that 59% of those in the Medicaid coverage gap are racial and ethnic minority groups.

President Biden vowed during the campaign to close the Medicaid coverage gap, and it is part of the social spending package Democrats in Congress are currently debating, called the Build Back Better Act. An issue of health and racial equity that plugs a big hole in the ACA would seem like a no-brainer for Democrats, but major challenges must be overcome.

One big challenge is money. If the 12 holdout states chose to expand Medicaid, the federal government would automatically cover its 90% share of the cost as an entitlement. However, if Congress votes to fill the Medicaid gap, it will count as new spending and will be competing against other priorities. Democrats in Congress passed a budget resolution authorizing up to $3.5 trillion in spending over 10 years for the Build Back Better plan, but there is pressure from some centrists within the party to scale back that spending.

When tallying costs of new programs, Congress generally operates on a 10-year time horizon. One way of reducing the budgetary expense of filling the Medicaid gap would be to allow it to "sunset"—expire after a specific date—and hope that a future Congress extends it or that the holdout states decide to continue the expansion themselves.

The cost could be affected as well by what happens in the 38 states (plus the District of Columbia) that already have expanded Medicaid. Some of these states might choose to drop the expansion if the federal government steps in and covers the entire cost, leading to more people in the gap and a higher federal cost. These states—which are covering 10% of the cost of expanded eligibility—may also be resentful that states that have not expanded Medicaid would in effect be let off the hook while their poor residents still get coverage. A maintenance-of-effort requirement would serve as a stick to discourage current expansion states from dropping Medicaid expansion, but may intensify the resentment. Providing additional fiscal carrots to states to maintain Medicaid expansion would also discourage such a policy decision, but cost more money.

There are political headwinds, too. Even though Democrats in Congress overwhelmingly support the ACA and health coverage for poor people, the people in the coverage gap live largely in Republican states. Just 3 Democratic senators represent states that have not expanded Medicaid. Nonetheless, filling the Medicaid gap does have some politically powerful advocates. Democratic Senator Raphael Warnock of Georgia (a nonexpansion state) campaigned heavily on expanding Medicaid and is up for reelection next year. Democratic Representative James Clyburn of South Carolina (also a nonexpansion state), who is the House majority whip, has framed filling the Medicaid gap as an issue of racial equity.

In fact, no health proposal currently being debated would likely do more to expand health coverage and promote racial equity than filling the Medicaid gap. But to become a reality, this proposal will have to overcome political obstacles, fiscal constraints, and competing priorities.

ARTICLE INFORMATION

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ACA Marketplaces Well-Positioned for Strong 2022 Open Enrollment Season

Joel Ario and Amy Zhan, Manatt Health

With the Patient Protection and Affordable Care Act's (ACA's) ninth open enrollment period (OEP) set to launch in less than a month, the ACA Marketplaces are seeing record enrollment numbers with more generous subsidies, new carrier competition, and a relatively stable rating environment.[i] At the same time, there is uncertainty with the trajectory of the COVID-19 pandemic and medical costs trending upward as the economy recovers, albeit at an uneven pace.

These trends have made for a challenging rate review process in the 47 states plus the District of Columbia (D.C.) that conduct their own ACA rate reviews of carrier-proposed rates using federal review standards.[ii] The process this year has not generated as much attention as prior years, partly because there were no big surprises this year, such as the termination of cost sharing reduction (CSR) payments in 2017 and the volatility of COVID-19 last year, and because the Biden Administration has made a series of changes—expanding subsidies through the American Rescue Plan Act of 2021 (ARP) and increasing funding for consumer outreach—that have helped to stabilize and strengthen the ACA Marketplaces.

State announcements of 2022 rates have trickled out at a slower pace than in prior years, and it is likely that many states will not publish their approved rates until the beginning of open enrollment. As always, state rate results vary widely and, even within states, there often are substantial variations among carriers and across different regions in geographically diverse states. With these caveats, this expert perspective highlights some observations about the factors that are impacting rate changes this year and the kind of variations that exist among states.

ARP Subsidies and Enrollment Gains Drive Carrier Expansions

With ARP subsidies dramatically expanding premium subsidies and drawing 2.8 million new customers to the ACA Marketplaces during special enrollment periods (SEPs) this year, carriers have expanded their footprints for 2022 in many states. Although carrier expansions for 2022 are still subjects to final adjustments, announced expansions to date include the following:

- UnitedHealthcare has nearly doubled its footprint from 11 to 18 states, including expansions into Alabama, Florida, Georgia, Illinois, Louisiana, Michigan, and Texas.
- After fully exiting the ACA Marketplaces in 2018, Aetna/CVS is reentering eight states for 2022: Arizona, Florida, Georgia, Missouri, Nevada, North Carolina, Texas, and Virginia.
- Cigna has expanded from 10 states into three new states for 2022: Georgia, Mississippi, and Pennsylvania.
- Oscar is continuing to grow its footprint for 2022, adding three new states: Arkansas, Illinois, and Nebraska—while also expanding its existing footprints in eight other states.

Carrier participation in the ACA Marketplaces has been increasing since 2018, and it has produced two positive results for consumers. First, it increases consumer choices. For example, the percentage of enrollees with a choice of three or more insurers increased from 58 percent in 2019 to 78 percent in 2021.[iii] Second, more competition generally correlates with lower premiums. For example, a comprehensive state by state study of insurer competition and premium rates for 2018 and 2019 found that "states with lower silver premiums generally have robust competition among several insurers."[iv]

Recent Financial Trends and Pandemic-Related Uncertainties Cloud the Rate Environment

While carrier expansions bring new competition, it is noteworthy that second quarter financial results (the most recent available) were down on a year over year basis for many of the largest carriers. National for-profit carriers reporting decreases in net income for the second quarter included United (35 percent),[v] Anthem (22 percent),[vi] and Cigna (16 percent).[vii] Aetna reported decreased earnings as well, and Centene, originally a Medicaid company that has become the largest carrier in the ACA Marketplaces with more than two million members, reported a net loss for the second quarter.[viii]

Carriers generally attributed their reduced income to higher medical loss ratios (MLRs)—the percentage of premiums that are paid out in claims costs—due to patients returning for deferred care in the spring and early summer. Combined with an economy that is picking up steam, this helps explain why some states report higher medical trends in 2022 rate filings than previous years. New Jersey, for instance, is reporting an average trend of 9.4 percent.[ix]

While recent financial results merit consideration, most insurers remain profitable. This is particularly true in the individual market, where many carriers are benefiting from MLRs that decreased from 103 percent on average in 2015 to 70 percent in 2018 and have continued to generate high profits into 2021. Under the ACA, carriers are required to pay rebates when their MLR dips below 80 percent in the individual market, and carriers have been paying record-high rebates—from less than $200 million in 2017 to more than $2 billion last year.[x] Because rebates are calculated on a three-year rolling average, many carriers face an ongoing cycle of substantial rebates if their rates remain too high.

In addition, careful study of the pandemic's impact on rates indicates that pandemic-related trends have tended to net out over time. This was the key finding in a recent brief by the American Academy of Actuaries.[xi] The Academy found that deferred care and COVID-19 treatment costs tend to be inversely related, meaning that other medical costs increase when the virus is waning as it was this spring, while a waxing virus tends to squeeze out other costs as will likely be the case for the third quarter.[xii]

State Results Vary More for 2022 Than in Recent Years

Given this complex mix of competing factors, it should not be surprising that the emerging picture for 2022 is more rate variation and more upward pressure on rates, though nothing like the increases that occurred in 2018, when rates increased by 28 percent on average in response to the termination of CSR payments. On average, rates went up 2 to 3 percent in 2019, decreased less than 1 percent in 2020, and increased less than 1 percent in 2021.[xiii] There were variations among the states, but rates were remarkably stable across more states with few states reporting average rate increases or decreases of 5 percent or more.

This year the variations in proposed and approved average individual market rates have been more significant in the early reporting states:

State	Rate Adjustments
California	**1.8 percent increase** in approved rates, with three or more carrier choices for 94 percent of enrollees[xiv]
Florida	**6.6 percent increase** in approved rates, with four new carriers[xv]
Georgia	**0.7 percent increase** in proposed rates, with five new carriers including United, Aetna, and Cigna[xvi]
Maryland	**2.1 percent increase** in approved rates, reduced from 3.5 percent increase in proposed rates[xvii]
Massachusetts	**6.9 percent increase** in proposed rates for merged individual and small group Market[xviii]
Minnesota	**10.1 percent increase** in proposed rates
Mississippi	**3.1 percent increase** in proposed rates, with one new carrier, Cigna[xix]
Missouri	**2.3 percent increase** in proposed rates, with Blue Cross and Blue Shield (BCBS) of Kansas City proposing 15.4 percent increase[xx]
Montana	**0.5 percent increase** in proposed rates, with Co-Op proposing 4.5 percent increase and two commercial carriers proposing rate decreases[xxi]
Nebraska	**8.6 percent increase** in proposed rates, with one new carrier, Oscar[xxii]
New Jersey	**7.9 percent increase** in approved rates, with one new carrier, Centene/Ambetter[xxiii]
New York	**3.7 percent increase** in approved rates, ranging from a 9.7 percent increase for HealthPlus to a 4.4 percent decrease for Independent Health, reduced from 11.2 percent average increase in proposed rates[xxiv]

State	Rate Adjustments
Oregon	**1.5 percent increase** in approved rates ranging from a 4.9 percent increase for Regence to a .9 percent decrease for Providence, reduced from 1.8 percent average increase in proposed rates[xxv]
Rhode Island	**2.1 percent increase** in approved rates for two carriers in individual market, reduced from 6.3 percent average increase in proposed rates[xxvi]
Virginia	**1.4 percent increase** in approved rates ranging from a 7.6 percent increase for Care First to a 13 percent decrease for Kaiser, reduced from 5.1 percent average increase in proposed rates[xxvii]

Conclusion

The Marketplaces will enter the 2022 OEP with record enrollment, more affordable benefit plans due to ARP subsidies, and expanded carrier competition in many states. The challenges this year—ongoing COVID-19-related expenses, the return of pent-up demand, and increasing medical inflation—pose varying risks across local markets, which will result in rate increases that vary by state and carrier. Even still, the overall result for the ACA Marketplaces will be a third straight year of relatively stable rates, partly as a result of ACA standards for "effective rate review" that have improved the rate review process in the 47 states that have adopted those standards.

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[ii] An effective rate review system must: receive sufficient data and documentation concerning rate increases to conduct an examination of the reasonableness of the proposed increases; consider several factors, including medical cost trend changes, changes in service utilization, cost-sharing changes, changes in benefits, and more; make a determination of the reasonableness of the rate increase under a standard set forth in State statute or regulation; post either rate filing under review or rate filing justifications on the state website or post a link to the rate filing justification information that appears on the CMS website; provide a mechanisms for receiving public comments; and report results of rate reviews to CMS for rate increases subject to review. HHS conducts rate review for three states: Oklahoma, Texas and Wyoming. More information is available here: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet (https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet)

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ACA Changes Considered; Coverage Held Steady

The Affordable Care Act served as a pandemic safety net. Congress and the White House aim to further expand the law.

BY KATIE KEITH

The Affordable Care Act (ACA) served as a safety net during the pandemic, and Marketplace enrollment peaked in light of the broad COVID-19 special enrollment period (SEP) and enhanced premium tax credits under the American Rescue Plan Act (ARPA). Congress is considering how to build upon these developments in the Build Back Better Act. Meanwhile, the Biden administration finalized its first full rule on Marketplace coverage, continued to implement the No Surprises Act, and awarded new funding for navigators and states.

Uninsurance Rates, Marketplace Enrollment

New data from the Census Bureau, the Centers for Disease Control and Prevention, and the Urban Institute showed that the uninsurance rate remained stable in 2020 despite pandemic-related economic upheaval and job loss. The Census Bureau found that 8.6 percent of people were uninsured in 2020, which was not significantly different from the rate of 8.5 percent in 2018. The other analyses also showed a steady, albeit higher, uninsurance rate for 2020.

The new data suggest that the ACA served as a coverage safety net during the pandemic. In contrast to prior recessions, many would-be uninsured people had new options under the ACA to enroll in individual-market coverage or Medicaid. Coverage losses were likely mitigated by a Medicaid maintenance-of-effort requirement put in place by Congress in the Families First Coronavirus Response Act in 2020. This requirement incentivized states to ensure continuous enrollment in Medicaid during the declared public health emergency.

Separate data underscore the importance of Marketplace coverage. In September 2021 the Department of Health and Human Services (HHS) issued data showing that a record-high 12.2 million people were actively enrolled in Marketplace coverage as of August 2021. Midyear enrollment peaked thanks to the more than 2.8 million people who enrolled during the broad six-month COVID-19 SEP. Of these, 2.1 million people enrolled through the thirty-six states that use HealthCare.gov, while an additional 738,000 people enrolled through the fifteen state-based Marketplaces.

Enrollment was bolstered by the enhanced subsidies. More than 90 percent of new enrollees qualified for subsidies, and 48 percent of new HealthCare.gov consumers paid premiums of $10 per month or less. Existing HealthCare.gov consumers also saw savings: On average, premiums were $53 less per month. Enrollment was also higher among higher-income consumers who did not qualify for Marketplace subsidies before ARPA.

The already record-high effectuated enrollment—referring to those who enroll and pay premiums to activate their policies—combined with continued ARPA subsidies is likely to result in much higher enrollment during the upcoming open enrollment period for 2022.

Congress Considers Broader Coverage Reforms

Congress may soon build on these coverage gains through the Build Back Better Act, a budget reconciliation package that reflects many Biden administration health care priorities. The US House of Representatives released a proposal in September, but the scope and cost of the package remain under debate.

The House proposal would adopt permanent enhanced ARPA subsidies; further improve Marketplace affordability; close the Medicaid coverage gap (the income range above the Medicaid eligibility cap but below the federal poverty level, which is the minimum threshold for Marketplace subsidies); permanently extend the Children's Health Insurance Program (CHIP); require Medicaid and CHIP to provide twelve months of continuous eligibility for children; require Medicaid and CHIP to offer full benefits for pregnant and postpartum women through one year after pregnancy; authorize Medicare to negotiate prescription drug prices; and enhance Medicare benefits by adding coverage for vision, hearing, and dental services.

The full House has not yet considered this proposal, and the legislation is expected to change over time. The timeline for action, and the bill's fate in the Senate, is unclear.

Administration Finalizes First Marketplace Rule

The Biden administration adopted its first full rule on the ACA. Although federal officials had finalized rules or parts of rules proposed by the Trump administration, the Biden administration had not yet issued its own proposed and final rule to reflect its new Marketplace priorities.

That changed in September 2021, when HHS (joined in part by the Department of the Treasury) finalized a new rule that reversed several Trump-era regulatory changes and adopted a new SEP for low-income consumers. The new rule rescinded or revised the subset of policies that the Trump administration finalized shortly before Inauguration Day. These had included adopting a controversial interpretation of Section 1332, allowing states to transition away from HealthCare.gov, and implement-

ing a lower user fee. HHS and Treasury replaced the Trump-era interpretations of Section 1332 with an approach that generally tracks the Obama-era guidance from 2015. The agencies also established new processes for states to request extensions of or amendments to approved waivers.

HHS extended the length of the annual open enrollment period from forty-five days to seventy-five days. Beginning with the 2022 plan year, the open enrollment period will run from November 1 to January 15 for the federal Marketplace. State-based Marketplaces can set a shorter period so long as it extends through at least December 15. A longer period will help those who need additional assistance or time to enroll, such as those who are auto-reenrolled, lack internet access, or have limited English proficiency. Separately, HHS reinstated the requirement that federal navigators provide information and assist consumers with certain postenrollment issues (such as filing an appeal).

The final rule eliminated the Trump-era "double billing" requirement that insurers send (and consumers pay) one bill for the coverage of certain abortion services and a separate bill for all other services. This rule had never gone into effect after being challenged in court and then delayed during the pandemic. The Biden administration repealed this requirement and reverted to a prior policy that gives insurers flexibility in complying with this ACA requirement.

The most significant new policy in the Biden administration rule is a monthly SEP for people and their dependents who are eligible for Marketplace subsidies and whose household income is under 150 percent of the federal poverty level. This change will make it easier for low-income people to enroll in Marketplace coverage throughout the year; it could be especially critical to helping those who will lose Medicaid coverage when the COVID-19 public health emergency ends successfully transition to Marketplace coverage. This low-income SEP is permanent but will be in effect only when this population qualifies for maximal subsidies—that is, when Congress sets the taxpayer's premium contribution to 0 percent, as is the case for 2021 and 2022 under ARPA.

While the final rule did not adopt new standardized plans or federal network adequacy requirements, HHS intends to do so for 2023 and has discussed its likely approach. For instance, HHS expects to adopt quantitative time and distance standards for network adequacy and will evaluate networks to help ensure access to providers where there have been complaints about network adequacy in the past (for instance, behavioral health).

No Surprises Act Implementation

Federal officials continued to issue new rules to implement the No Surprises Act, which goes into effect in 2022. This new law will protect patients from out-of-network surprise medical bills for emergency services (including by air ambulances) at in- and out-of-network facilities and for nonemergency services at in-network facilities (unless a patient consents to treatment by an out-of-network provider). Patients will be responsible for only the same amount of cost sharing that they would have paid if the service had been provided by an in-network provider. Providers and facilities cannot send "balance" bills to patients to collect a higher amount.

The Biden administration has now issued two interim final rules to implement the No Surprises Act. The first rule focused on patient protections, disclosure requirements, and communication between insurers and providers, among other requirements. The second rule focused on the independent dispute resolution process that will be used to resolve payment disputes between insurers and providers. Separately, federal officials issued a proposed rule on the collection of air ambulance data, enforcement, and insurer disclosure of compensation to agents and brokers for short-term plans and individual-market coverage.

New Guidance And Funding

HHS issued a significant amount of funding to navigators and states. A total of sixty organizations will receive $80 million to serve as navigator entities in the thirty states that use the federal Marketplace. Twenty-one state-based Marketplaces will receive a total of $20 million to modernize their systems and implement ARPA. And twenty-nine state insurance departments will receive $19.6 million to bolster implementation of certain ACA requirements.

HHS and Treasury have also been busy with Section 1332. Federal officials revised the amount of federal pass-through funding that states will receive for 2021. These amounts were adjusted in light of higher enrollment from ARPA and the broad SEP. Overall, thirteen states will receive an additional $452 million in federal pass-through funding. Colorado received approval for a five-year extension of its waiver for a state-based reinsurance program; additional states have asked for similar waiver extensions. HHS posted a new data brief on the effect of state-based reinsurance programs in 2021 and issued user-fee data for 2020.

Georgia rejected HHS's request for an updated analysis of part of its Section 1332 waiver—the Georgia Access Model, which would eliminate HealthCare.gov and make Georgia the only state without a single one-stop-shop Marketplace for consumers in need of private coverage. HHS wanted an updated analysis in light of increased Marketplace enrollment and the impact of ARPA. From here, HHS and Treasury may assess whether Georgia remains in compliance with its waiver.

Separately, HHS delayed enforcement of Trump-era transparency requirements. Insurers and plans will no longer have to publicly release data on drug pricing, and reporting of data on negotiated rates and out-of-network amounts is delayed through July 1, 2022. Businesses and pharmacy benefit managers had sued over these requirements before the new enforcement delays. HHS also issued the quality rating information bulletin for 2022, approved new direct enrollment entities, and posted final risk-adjustment model coefficients. ■

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Extending the American Rescue Plan Act's Enhanced Marketplace Affordability Provisions Could Benefit Nearly 1 Million Uninsured Children and Parents

Stacey McMorrow, Jessica Banthin, Matthew Buettgens, Michael Simpson, Genevieve M. Kenney, and Clare Wang Pan

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Signed into law in March 2021, the American Rescue Plan Act (ARPA) contained numerous provisions aimed at supporting recovery from the COVID-19 pandemic and associated recession.[1] Among these provisions are changes to the subsidy schedule governing access to financial assistance to purchase health insurance coverage in the Affordable Care Act (ACA) Marketplaces. These changes give Americans access to greater financial assistance purchasing coverage through 2022 and have the potential to reduce uninsurance and make coverage more affordable for those already purchasing nongroup coverage. Making these provisions permanent is a topline priority in Senate Democrats' fiscal year 2022 budget resolution.[2]

Though children were not the primary target of the ACA coverage expansions or subsequent efforts to strengthen the ACA, recent increases in children's uninsurance rates and the critical need to address unmet health needs and catch up on forgone care during the pandemic suggest that removing barriers to health care for children could be particularly important in the coming years (Alker and Corcoran 2020; McMorrow et al. 2020; Gonzalez, Karpman, and Haley 2021). These risks for children are also exacerbated by parents' rising uninsurance rates and pandemic-related unmet health needs (Gonzalez et al. 2020; Haley, Kenney, Wang Pan, et al. 2021).

Children may benefit from extending the ARPA's enhanced subsidies if they gain coverage or their parents gain coverage or experience premium or OOP cost savings (Wright Burak 2019). In this brief, we consider the impacts of extending the enhanced subsidies on all children and their parents and

children under age 6 and their parents. Using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), we find the following:

- Nearly 1 million uninsured children and parents, including approximately 300,000 uninsured children, would gain insurance coverage if ARPA subsidy enhancements were made permanent.
- About 67,000 uninsured children who would gain coverage through these provisions would be under age 6, and approximately 267,000 uninsured parents who would gain coverage would have a child under age 6. This suggests even more young children could benefit when their parents gain coverage.
- Nearly two-thirds of the coverage gains for families would be concentrated among children and parents with incomes between 200 and 400 percent of the federal poverty level (FPL).
- If ARPA subsidy enhancements were made permanent, we project that about 3.3 million children and 6.3 million parents would remain uninsured in 2022, unless additional policy changes are introduced. Most remaining uninsured children would be eligible for Medicaid or the Children's Health Insurance Program, or CHIP (57.2 percent), or tax credits (13.6 percent). But about 41.2 percent of parents would be ineligible for subsidized coverage because of their immigration status or residence in a state that has not expanded Medicaid under the ACA; this represents approximately 2.6 million parents, including 636,000 uninsured parents who would become eligible for Medicaid if their state were to expand Medicaid under the ACA.
- Approximately 4.5 million children and parents who had nongroup coverage before the ARPA would experience household premium reductions of 28 percent per person, on average; those with incomes below 200 percent of FPL would save even more, 41 percent per person. Total household spending on premiums and OOP costs would fall by averages of 18 percent per person overall and 25 percent per person in families with income below 200 percent of FPL.

Background

The ACA expanded coverage options for millions of Americans, and though such options focused largely on childless adults, children's and parents' uninsurance also declined (Karpman et al. 2016). From 2013 to 2016, uninsurance fell from 7.0 to 4.3 percent among children and from 17.6 to 11.0 percent among parents (Haley, Kenney, Wang Pan, et al. 2021). In recent years, however, declines in children's and parents' uninsurance have stalled (Haley et al. 2019, 2020), and uninsurance increased for both groups in 2019 (Haley, Kenney, Wang Pan, et al. 2021). From 2018 to 2019, uninsurance increased from 4.8 to 5.2 percent among children and from 11.2 to 11.7 percent among parents.

Thus, many families with children faced precarious health care access and affordability as the COVID-19 pandemic and resulting recession took hold in 2020, and numerous families experienced additional economic and health challenges in the ensuing months. Many families with children lost jobs and incomes during the recession, but parents who kept working through the pandemic also faced

challenges related to child care safety and availability (Karpman, Gonzalez, and Kenney 2020). Both children and parents have reportedly faced significant mental health challenges during the pandemic (Hamel et al. 2020; Panchal et al. 2021), as well as forgone and delayed care (Gonzalez et al. 2020, 2021). As of now, no definitive estimates of the number of children and parents who lost health insurance coverage during the pandemic exist,[3] but several protections have likely prevented catastrophic coverage losses. Under the Families First Coronavirus Response Act, for example, states became eligible for an increase in federal Medicaid funding throughout the public health emergency, so long as they maintain eligibility for those enrolled on or after March 18, 2020. As the recovery continues and some of these protections expire, it will be critical for families to be able to access affordable coverage and care, especially given the urgent need for children and parents to catch up on care they missed during the pandemic. Moreover, both physical and mental health care needs for children and families may have increased because of the pandemic and the associated stressors of remote learning and social isolation.

The ARPA included numerous provisions with the potential to benefit families and children, including a child tax credit and efforts to make insurance coverage more widely available and affordable (Acs and Werner 2021; Wheaton, Giannarelli, and Dehry 2021). The changes to the Marketplace subsidy schedule were particularly important for children and parents, especially those whose families may have lost jobs and access to employer-sponsored insurance during the pandemic. Specifically, premium contributions for those with incomes below 150 percent of FPL were reduced to zero; required premium contributions were significantly reduced for those with incomes between 150 and 400 percent of FPL; and premium contributions were capped at 8.5 percent of income for people with incomes above 400 percent of FPL, who were previously ineligible for any subsidies (table 1). As under current law, people not meeting immigration requirements and those with access to an employer-sponsored plan deemed affordable under the ACA (i.e., with employee premiums at or below 9.8 percent of household income) would remain ineligible for subsidies under extended ARPA subsidies.

TABLE 1

Subsidy Schedules under Current Law and the American Rescue Plan Act, 2022

Premium contribution percentage-of-income limits for benchmark coverage

Income (% of FPL)	Before ARPA	Under ARPA
< 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

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. ARPA is American Rescue Plan Act. n/a is not applicable; people with incomes above 400 percent of FPL are ineligible for subsidies under current law. Percentage-of-income caps applied in 2022; current-law caps are for 2021 and indexed each year. Annual adjustments to caps have been modest and are not made until close to the end-of-year open enrollment period.

Children and their parents may benefit from these enhanced affordability provisions in at least three ways. First, uninsured children may gain coverage if subsidy enhancements allow families to newly purchase coverage for children. Second, uninsured parents may gain coverage with newly affordable options, and their already insured children may benefit from the associated health and financial improvements for their family (Wright Burak 2017). Finally, household spending on premiums would decline for families who already had nongroup coverage before the subsidy enhancements, which frees up resources for other needs. Understanding these effects will provide policymakers with insights for strengthening the health and financial well-being of children and families and identify remaining gaps in coverage affordability and accessibility.

Methods

We used the Urban Institute's Health Insurance Policy Simulation Model to produce the estimates in this brief. HIPSM is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options. The model simulates household and employer decisions and models the way changes in one insurance market interact with changes in other markets. Results from HIPSM simulations have been shown to be consistent with actual policy outcomes and other respected microsimulation models (Glied, Arora, and Solís-Román 2015).

An earlier report modeled the effects of the ARPA's enhanced subsidies on coverage for the entire nonelderly population in 2022 (Banthin et al. 2021). That simulation assumed the ARPA's changes to the subsidy schedule were permanent and the changes were fully phased in by 2022. In other words, consumers, employers, and insurers in the model had fully adapted their decision making to the new schedule. Additional details on the 2022 HIPSM baseline estimates, including assumptions about the pandemic's economic effects, can be found in the earlier report.

In this brief, we present estimates from the same simulation for children and parents overall and young children and their parents. We describe changes in the coverage distribution for children and parents under the enhanced subsidy schedule, and we consider changes in premiums and OOP spending for families who had nongroup coverage before the ARPA. Children are those ages 18 and younger and parents are nonelderly adults (ages 19 to 64) with a child in their tax unit. We produce estimates for young children ages 5 and younger and their parents because of the importance of early childhood to future health and well-being.

This analysis has some limitations. First, assumptions about population, income, and health cost growth are always somewhat uncertain, but the additional uncertainty associated with the current economic recovery and frequently changing pandemic-related policies exacerbate the issue. For example, the current projections assume the Medicaid maintenance-of-effort provisions will expire in

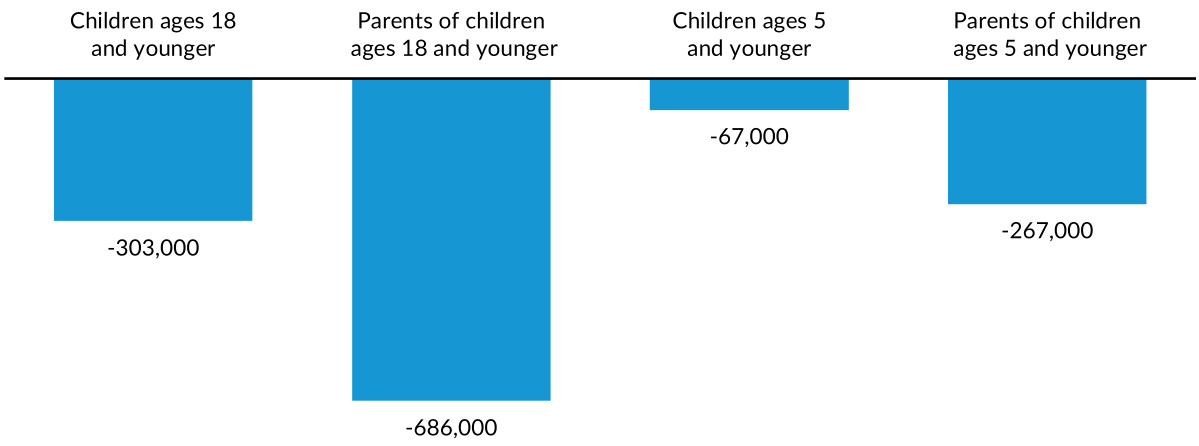
early 2022, and states have up to 12 months to complete the redetermination process.[4] It is impossible to predict how quickly individual states will work through verifications, redeterminations, and renewals, however, so Medicaid enrollment may be higher in 2022 than these estimates indicate. In addition, our definition of parents excludes noncustodial parents and some unmarried parents living together with their children but assigned to different tax units.

Results

If the ARPA's enhanced subsidies were made permanent, we find that the number of uninsured children would fall by approximately 303,000, and the number of uninsured parents would fall by about 686,000 (figure 1). The number of uninsured young children would fall by about 67,000, and about 267,000 parents of young children would gain coverage.

FIGURE 1

Change in the Numbers of Uninsured Children and Parents under a Permanent ARPA Marketplace Premium Subsidy Schedule, 2022



URBAN INSTITUTE

Source: Urban Institute Health Insurance Policy Simulation Model, 2021.
Note: ARPA is American Rescue Plan Act.

Uninsurance rates would drop from 4.6 to 4.2 percent for children and from 10.8 to 9.8 percent for parents (table 2). The increases in private nongroup coverage, of 0.5 and 1.2 percentage points for children and parents, are the key drivers of the projected decline in uninsurance. Young children have somewhat lower uninsurance rates than children overall, whereas their parents have somewhat higher uninsurance rates than parents overall both before and under the permanent ARPA subsidy schedule. But, the projected effects of the subsidies on young children and their parents are similar to those for parents and children overall; for both groups, reductions in uninsurance under the ARPA would be largely offset by gains in private nongroup coverage.

TABLE 2

Coverage Distribution of Children and Parents before and under a Permanent ARPA Marketplace Premium Subsidy Schedule, 2022

	Children ages 18 and younger			Parents of children ages 18 and younger		
	Before ARPA (%)	Under ARPA (%)	Percentage-point change	Before ARPA (%)	Under ARPA (%)	Percentage-point change
Employer	46.0	45.9	-0.1	60.2	60.0	-0.2
Private nongroup	1.7	2.2	0.5	4.8	6.0	1.2
Medicaid/CHIP	45.1	45.1	0.1	21.4	21.5	0.1
Other public	1.8	1.8	0.0	2.2	2.2	0.0
Noncompliant nongroup	0.8	0.7	-0.1	0.6	0.5	-0.1
Uninsured	4.6	4.2	-0.4	10.8	9.8	-1.1
	Children ages 5 and younger			**Parents of children ages 5 and younger**		
	Before ARPA (%)	**Under ARPA (%)**	**Percentage-point change**	**Before ARPA (%)**	**Under ARPA (%)**	**Percentage-point change**
Employer	42.1	42.1	0.0	55.9	55.7	-0.2
Private nongroup	1.3	1.7	0.4	4.1	5.2	1.1
Medicaid/CHIP	50.3	50.3	0.0	25.3	25.4	0.1
Other public	2.1	2.1	0.0	2.1	2.1	0.0
Noncompliant nongroup	0.7	0.7	-0.1	0.6	0.5	-0.1
Uninsured	3.4	3.1	-0.3	12.0	11.0	-0.9

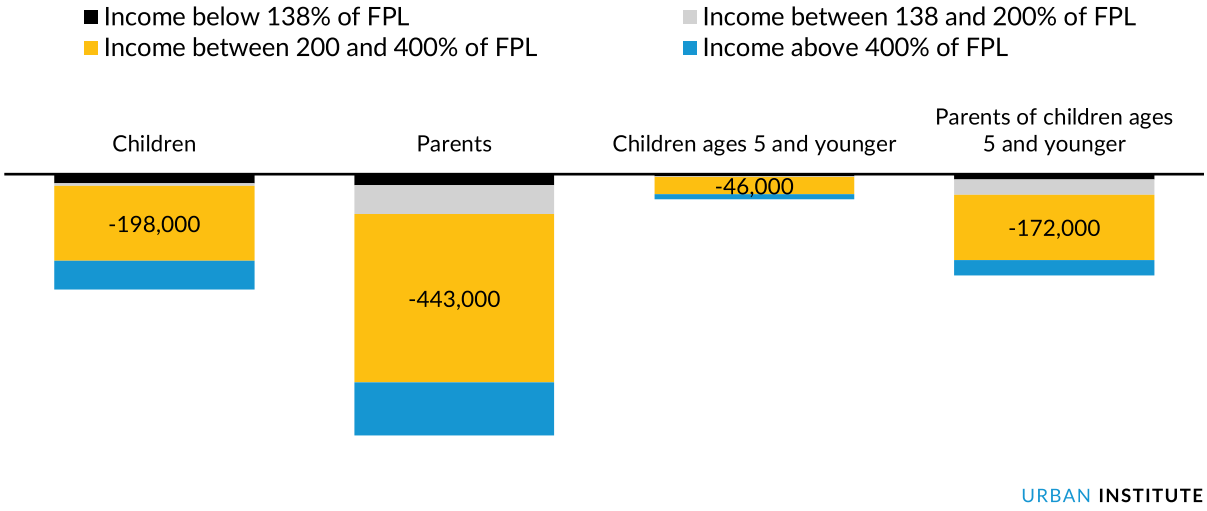
Source: Urban Institute Health Insurance Policy Simulation Model, 2021.

Notes: ARPA is American Rescue Plan Act. CHIP is Children's Health Insurance Program. Estimates may not add to 100 percent because of rounding.

If the ARPA subsidies were made permanent, the declines in uninsurance would be concentrated among children and families with incomes between 200 and 400 percent of FPL (figure 2). Of the approximately 303,000 children who would gain coverage, about 198,000 would live in families with moderate incomes. About 443,000 of the 686,000 parents expected to gain coverage would have incomes in this range. An additional 75,000 children and 139,000 parents expected to gain coverage would have incomes above 400 percent of FPL. These patterns are similar for young children and their parents. However, compared with all parents, a slightly larger share of parents of young children gaining coverage would have incomes between 138 and 200 percent of FPL.

FIGURE 2

Change in the Numbers of Uninsured Children and Parents under a Permanent ARPA Marketplace Premium Subsidy Schedule, by Income Group, 2022



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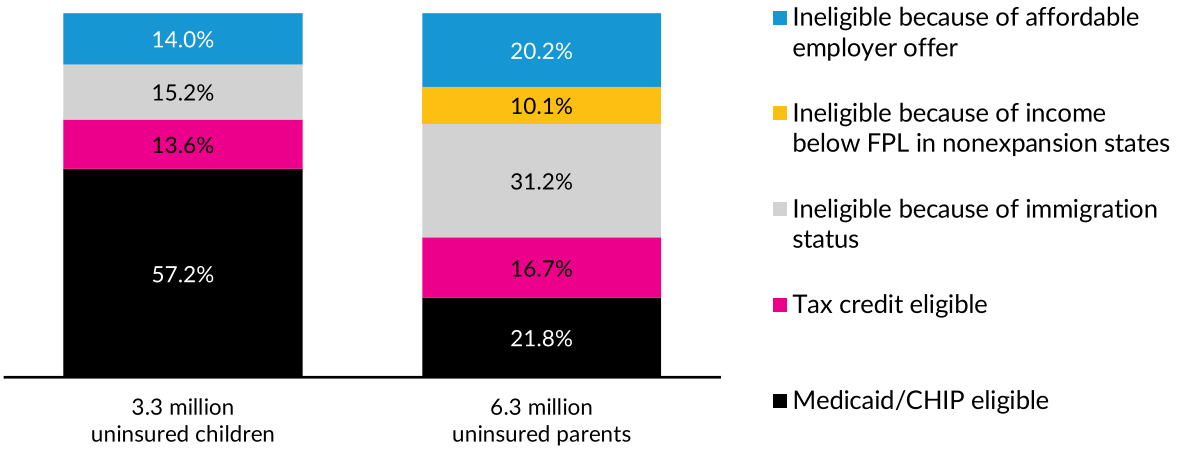
Source: Urban Institute Health Insurance Policy Simulation Model, 2021.

Notes: FPL is federal poverty level. ARPA is American Rescue Plan Act. Income groups are based on calculations for Medicaid eligibility.

If the ARPA subsidy schedule were made permanent and no other coverage changes were enacted, we project 3.3 million children and 6.3 million parents would remain uninsured in 2022 (figure 3). Among the remaining uninsured children, we estimate about 57.2 percent would be eligible for Medicaid or CHIP coverage and another 13.6 percent would be eligible for Marketplace subsidies. About 29.2 percent of uninsured children would be ineligible for publicly subsidized coverage, including 15.2 percent ineligible because of their immigration status and 14.0 percent ineligible because they have access to an affordable employer offer of coverage.

FIGURE 3

Eligibility for Publicly Subsidized Coverage among Uninsured Children and Parents under a Permanent ARPA Marketplace Premium Subsidy Schedule, 2022



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Source: Urban Institute Health Insurance Policy Simulation Model, 2021.
Notes: ARPA is American Rescue Plan Act. FPL is federal poverty level. CHIP is Children's Health Insurance Program. Income groups are based on calculations for Medicaid eligibility.

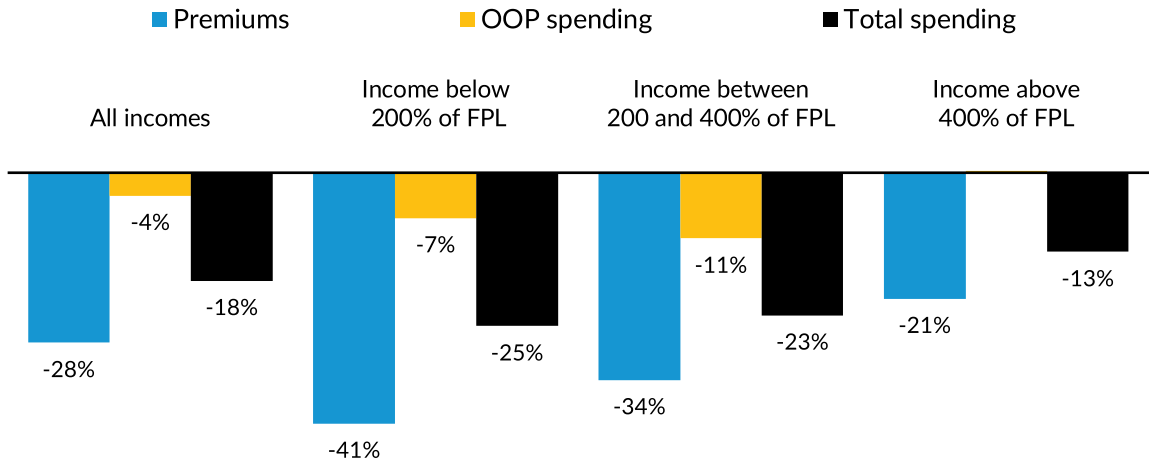
This distribution differs markedly for uninsured parents. Compared with more than 70 percent of uninsured children, only 38.5 percent of uninsured parents would be eligible for Medicaid/CHIP (21.8 percent) or Marketplace subsidies (16.7 percent). Nearly one-third of uninsured parents would be ineligible for publicly subsidized coverage because of their immigration status, and another 10.1 percent (or about 636,000 parents) would be ineligible for having income below the FPL in a state that did not expand Medicaid under the ACA. Finally, 20.2 percent of uninsured parents would be ineligible because they have access to an affordable employer offer. These patterns are quite similar to those for young children and their parents, except young children are far less likely to be ineligible because of their immigration status (data not shown).

Approximately 4.5 million children and parents who had nongroup coverage before the ARPA could also benefit from the enhanced subsidies through reductions in household premiums and OOP spending. Across all income groups, these families would experience an average reduction in premium spending of about 28 percent per person and an average reduction in OOP spending of 4 percent per person; the overall reduction in household spending would be 18 percent per person (figure 4). These cost savings would be larger for families with incomes below 400 percent of FPL. On average, families with incomes below 200 percent of FPL would experience a 41 percent reduction in premiums per person and a 7 percent reduction in OOP spending per person. Those with incomes between 200 and 400 percent of FPL would experience an average premium reduction of about 34 percent per person and an average OOP spending reduction of about 11 percent per person. Total household spending on premiums and OOP costs would decline by an average of 25 percent per person for those with

incomes below 200 percent of FPL and by 23 percent per person for those with incomes between 200 and 400 percent of FPL.

FIGURE 4

Change in Households' per Person Health Care Spending under a Permanent ARPA Marketplace Premium Subsidy Schedule among Families Who Had Nongroup Coverage before the ARPA, by Income Group, 2022



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Source: Urban Institute Health Insurance Policy Simulation Model, 2021.
Notes: ARPA is American Rescue Plan Act. OOP is out-of-pocket. FPL is federal poverty level. Sample includes families in which at least one parent or child had nongroup coverage before the ARPA. Income groups are based on calculations for Medicaid eligibility. There is a small (0.3 percent) increase in OOP spending for families with incomes above 400 percent of FPL.

Discussion

This analysis finds that almost 1 million children and parents could gain coverage under extension of the ARPA Marketplace subsidy enhancements. These coverage gains would be concentrated among families with incomes between 200 and 400 percent of FPL and would likely improve access to needed care for children and parents in lower- and moderate-income families. In addition to those directly gaining coverage through the enhanced subsidies, many already insured children will likely benefit if their uninsured parents gain coverage. Evidence strongly suggests that parents having health insurance coverage has both health and economic benefits for children and families (Wright Burak 2017). Further, more than 4 million children and parents who had nongroup coverage before the ARPA could experience significant household premium and OOP cost savings, especially those with incomes below 400 percent of FPL.

Both children's and parents' uninsurance rates were increasing leading up to the pandemic (Haley, Kenney, Wang Pan, et al. 2021), and many families with children were struggling to meet health care and other basic needs (Karpman et al. 2018; Karpman, Kenney, and Gonzalez 2018). Since early 2020, pandemic-related job losses, fears of coronavirus exposure, and associated concerns have contributed

to continued problems accessing needed health care and affording food, housing, and other basic needs (Gonzalez et al. 2020, 2021; Gonzalez, Karpman, and Haley 2021; Karpman et al. 2020; Karpman, Gonzalez, and Kenney 2020). Though some of these concerns may ease as the pandemic recedes and the economy recovers, new complications will likely arise as pandemic protections run out and prepandemic inequities remain unchanged. Thus, making the enhanced ARPA subsidies permanent will provide much needed relief for many families struggling to afford health insurance and health care, and the additional cost savings may free up resources for other family needs.

Still, we project that more than 3 million children and 6 million parents would remain uninsured in 2022 even if the ARPA subsides were made permanent. Congress and the Biden administration are tackling several of the remaining barriers to coverage identified in this analysis. First, a federal program targeting people in the Medicaid coverage gap has been identified as a priority in Senate Democrats' fiscal year 2022 budget resolution.[5] Urban Institute estimates indicate that in combination with the extension of the ARPA subsidies, filling the Medicaid coverage gap would reduce the number of nonelderly uninsured people by 7.0 million, or about 2.8 million more than extending the ARPA subsidies alone (Banthin, Simpson, and Green 2021). Our analysis suggests an estimated 636,000 uninsured parents with incomes below the FPL in the 12 states that have not yet expanded Medicaid under the ACA would become eligible for subsidized coverage under the Democrats' proposed reforms.

Second, the Biden administration is committed to improving outreach and enrollment efforts to ensure people are aware of their eligibility for assistance and have the support needed to enroll.[6] In addition to the 2021 COVID-19 special enrollment period, which has resulted in at least 2.5 million new Marketplace enrollees,[7] the administration intends to expand the 2022 open enrollment period by 30 days and to invest $80 million in the navigator program. The latter will provide outreach and enrollment assistance targeted to people of color; rural communities; immigrant communities; people facing language, transportation, or internet access barriers; and other underserved populations. The administration has also proposed creating a special enrollment period for certain consumers with low incomes who may be eligible for the most generous Marketplace subsidies.[8] Taken together, these outreach and enrollment efforts could have meaningful impacts for the 70 percent of uninsured children and nearly 40 percent of uninsured parents who are already eligible for Medicaid or Marketplace tax credits.

Changing the employer affordability provision, which restricts otherwise eligible people from accessing Marketplace subsidies if they have access to an employer plan that costs the employee less than 9.8 percent of their household income, could affect about 20 percent of uninsured parents. One modest policy change would be eliminating the "family glitch," which restricts eligibility for subsidized coverage for the whole family even when the only affordable employer offer is for a single employee plan. Analyses of such a proposal have not found large effects on uninsurance, but they have found potential for household cost savings (Buettgens and Banthin 2021). To further reduce uninsurance for people affected by the employer affordability provision, however, lowering or eliminating the affordability threshold may be necessary.

Addressing immigration restrictions on receiving Medicaid and Marketplace subsidies will also be critical to closing coverage gaps, because almost one-third of uninsured parents are ineligible for publicly subsidized coverage because of their immigration status. Though the Biden administration reversed the Trump administration's changes to the public charge rule that made many immigrant families afraid to use public benefits for which they were eligible (Haley, Kenney, Bernstein, et al. 2021), further efforts to expand eligibility for affordable coverage to undocumented or otherwise ineligible immigrants will be needed to achieve universal coverage. Finally, children and families need far more than health insurance to thrive, so ongoing attention to paid leave, child care, and educational and income supports will also be critical to ensure all children and their families have the opportunity for healthy, stable futures.

Notes

1 American Rescue Plan Act, Pub. L. No. 117-2 (2021).

2 "FY2022 Budget Resolution Toplines," US Senate Democratic Leadership, August 9, 2021, https://www.democrats.senate.gov/imo/media/doc/Topline%20Summary%20of%20FY2022%20Budget%20Resolution.pdf.

3 Joan Alker, "Q: How Many Children Were Uninsured in 2020?" *Say Ahhh!* (blog), Georgetown University Health Policy Institute, Center for Children and Families, August 10, 2021, https://ccf.georgetown.edu/2021/08/10/how-many-children-were-uninsured-in-2020/.

4 Daniel Tsai (deputy administrator and director, Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services), letter to state health officials, regarding "Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations upon Conclusion of the COVID-19 Public Health Emergency," August 13, 2021, https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf.

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6 Katie Keith, "ACA Round-Up: Navigator Grantees, GAO Investigation, Contraceptive Mandate, and More," *Health Affairs Blog*, September 1, 2021, https://www.healthaffairs.org/do/10.1377/hblog20210901.961047/full.

7 Katie Keith, "Marketplace Special Enrollment Reaches 2.5 Million; Administration Announces Health Care Reconciliation Priorities," *Health Affairs Blog*, August 10, 2021, https://www.healthaffairs.org/do/10.1377/hblog20210810.821428/full.

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How Does Uninsurance Vary among Asian American/Pacific Islander Parents?

Jennifer M. Haley, Genevieve M. Kenney, Clare Wang Pan, and Elizabeth Grazevich

Since 2014, Asian Americans/Pacific Islanders (AAPIs) have experienced declines in uninsurance under implementation of key provisions of the Affordable Care Act (ACA), which included expanded subsidized coverage options for adults.[1] By 2019, AAPI parents were less likely to be uninsured than parents in any other racial or ethnic group.[2] But despite AAPIs' fast population growth between 2000 and 2019,[3] the relatively small size of this population means data are seldom disaggregated by national origin.[4] AAPI parents' low overall uninsurance rate masks variation in uninsurance across AAPI national-origin groups, limiting understanding about the diversity of AAPI communities and the AAPI communities facing greater challenges accessing needed health care. Here we use 2018–19 American Community Survey data to examine uninsurance rates among non-Hispanic parents who are AAPI or AAPI and another race by national origin.

Findings

An estimated 5.8 percent of AAPI parents (294,000 parents) were uninsured in 2018–19 (figure 1),[5] compared with 11.5 percent of parents overall (data not shown). But AAPI parents' uninsurance varied dramatically by national origin, ranging from 3.2 and 3.4 percent for Japanese and Indian parents to 14.3 and 16.9 percent for Nepalese and Burmese parents. In addition, 13.8 percent of AAPI parents, and 20.6 percent of Korean parents, with family incomes below 200 percent of the federal poverty level were uninsured.

Uninsurance was twice as high among noncitizen AAPI parents as among their citizen counterparts (8.8 versus 4.3 percent), and 50.1 percent of uninsured AAPI parents were noncitizens (data not shown). Immigration-related restrictions could limit their eligibility for publicly subsidized coverage and contribute to uninsurance. Moreover, AAPI parents who reported not speaking English well had much higher uninsurance rates than parents who speak English well (14.8 versus 4.7 percent); that 28.7 percent of uninsured AAPI parents reported not speaking English well (data not shown) suggests language may also be a barrier to accessing culturally competent health care.

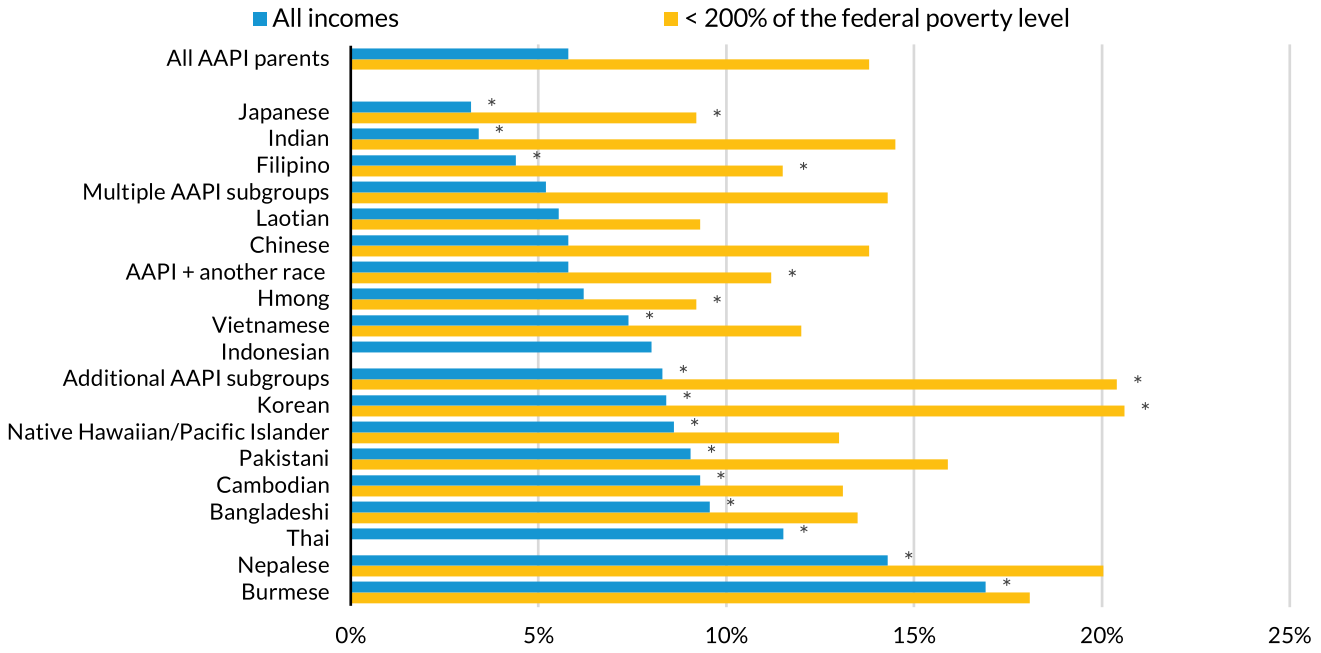
Conclusions

AAPI parents' uninsurance rate, like that for children,[6] hides large disparities by national origin. These disparities are partly associated with differences in citizenship status, work status, and other structural factors,[7] and they highlight the need to disaggregate data to reveal differences in access to needed care across subgroups of parents.

Targeting outreach and enrollment assistance to uninsured AAPI parents in languages beyond English and Spanish could help reach and enroll those who speak other languages who qualify for subsidized health insurance coverage such as Medicaid. Forging tighter connections between safety net providers, AAPI community-based organizations, and stakeholders working to advance equity could also help better meet the health needs of AAPI parents ineligible for subsidized coverage because of their immigration status or income.[8] Rising unemployment and the alarming increase in anti-Asian racist violence during the pandemic and associated trauma and stress add urgency to ensuring AAPI families have the access to needed care and security that health insurance can provide.

FIGURE 1

Uninsurance Rates among Non-Hispanic Asian American/Pacific Islander Parents Ages 19 to 64, by National Origin and Family Income, 2018–19



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Source: Urban Institute analysis of 2018–19 American Community Survey (ACS) data from the Integrated Public Use Microdata Series reflecting an adjustment for potential misreporting of coverage.
Notes: AAPI = Asian American/Pacific Islander. An estimated 294,000 AAPI parents were uninsured in 2018–19, including those identified as AAPI and another race. National origin refers to category selections or write-in responses to the ACS question about race. "Additional AAPI subgroups" refers to those with unspecified AAPI national origin or in categories with sample sizes too small (< 250) for separate analysis. We do not present the rate for Thai and Indonesian parents with family incomes below 200 percent of the federal poverty level because of small sample size.
* The subgroup's rate is significantly different from the overall AAPI rate at the 0.05 level. Estimates and standard errors available upon request.

[1] Rose C. Chu and Benjamin D. Sommers, "Health Insurance Coverage Changes since Implementation of the Affordable Care Act: Asian Americans and Pacific Islanders" (Washington, DC: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2021).
[2] Jennifer M. Haley, Genevieve M. Kenney, Clare Wang Pan, Robin Wang, Victoria Lynch, and Matthew Buettgens. "Uninsurance Rose among Children and Parents in 2019: National and State Patterns" (Washington, DC: Urban Institute, 2021).
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[5] Total includes parents who are AAPI and another race. Excluding such parents, AAPI parents' uninsurance rate would be 5.8 percent (14.2 percent among those with incomes below 200 percent of the federal poverty level), representing 263,000 adults.
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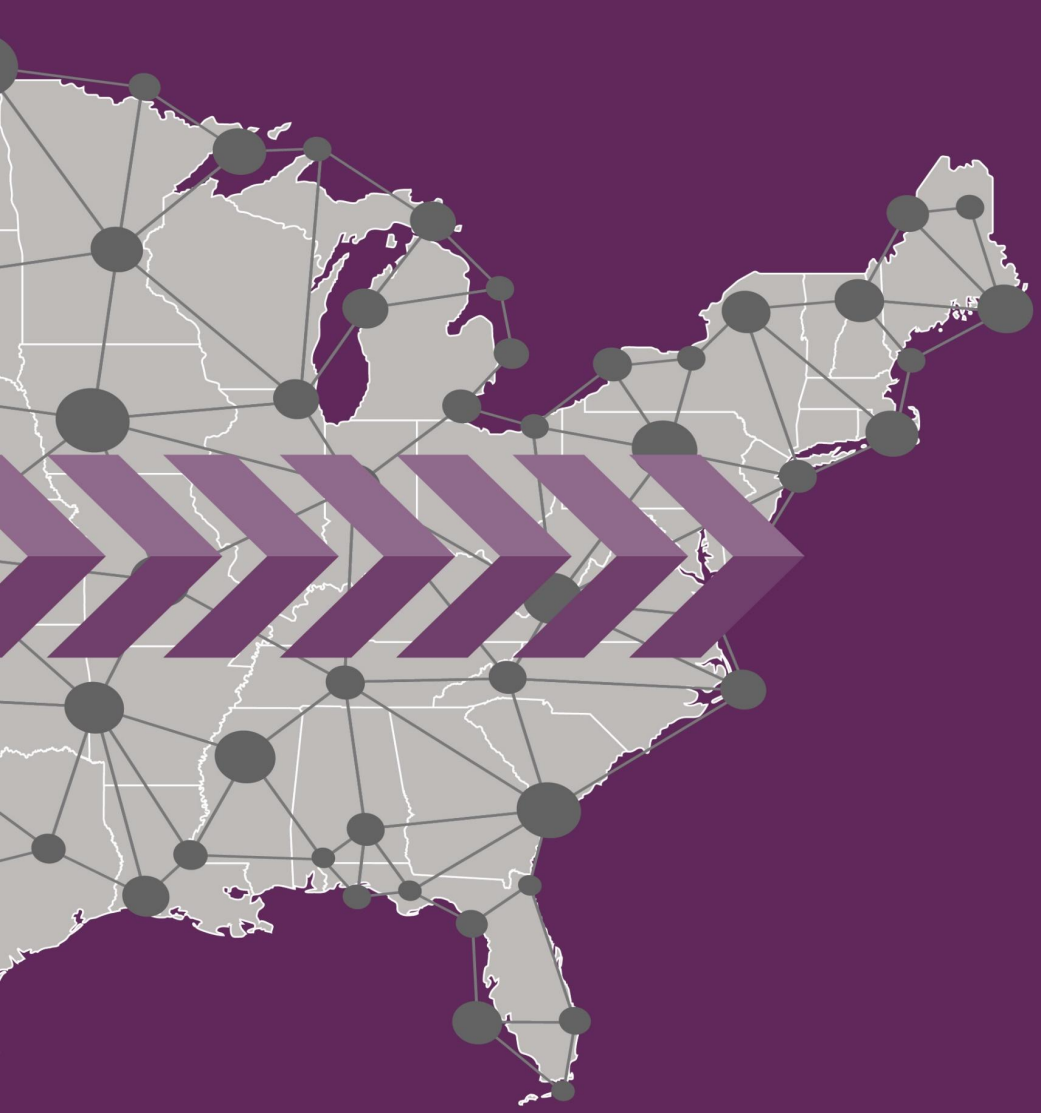

State Strategies to Support Afghan Evacuees in Accessing Health Coverage

Manatt Health

Revised: October 8, 2021

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Agenda

- **Level-Setting: Overview of Afghan Evacuee Crisis and New Centers for Medicare & Medicaid Services (CMS) Factsheet**
- **Potential Immigration Statuses and Health Coverage Options for Afghan Evacuees**
- **State Strategies for Enrolling Evacuees into Health Coverage**
- **Discussion**

Level-Setting

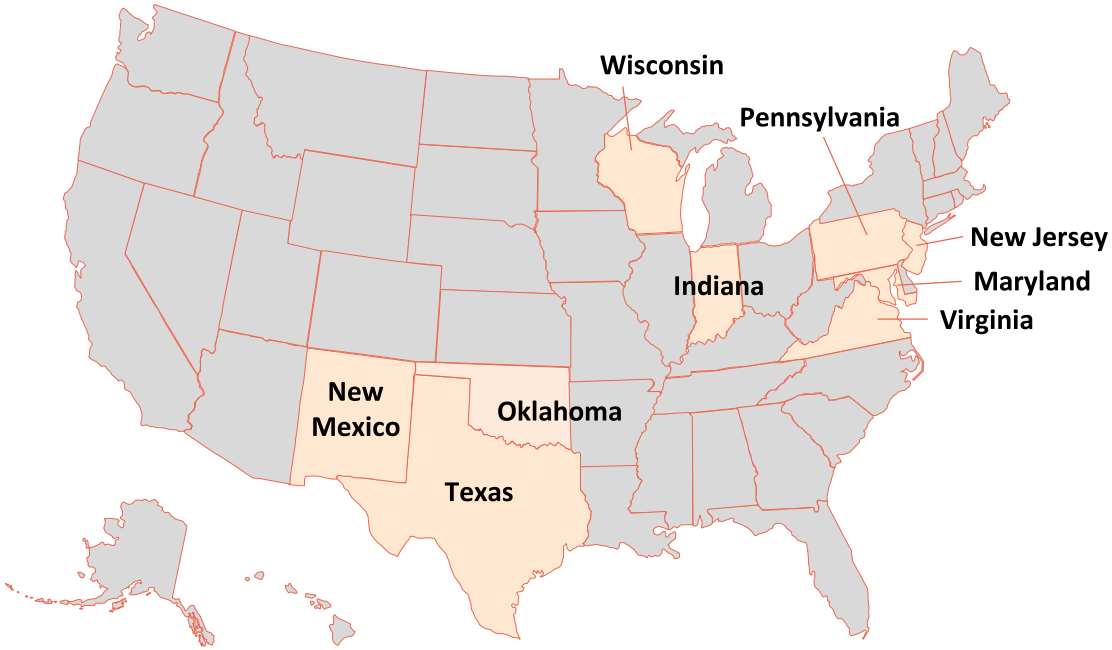
Overview of the Afghan Evacuation Process

The United States (U.S.) is in the process of resettling over 120,000 Afghan nationals. Many of these evacuees are from areas with limited access to healthcare and vaccinations and are in critical need of healthcare services.

- Among the thousands of people who have already arrived in the U.S., many are currently living on military bases or alternate accommodations (e.g., hotels).
- 9 states are currently processing-evacuees (see map).
- These individuals will eventually resettle in states all over the country.

States Processing Afghan Evacuees

(as of September 2021)



Need for Access to Healthcare & Social Services

Evacuees are in need of healthcare services, as measles and other infections spread and newcomers grapple with the trauma associated with leaving their country.

Pressing Healthcare Needs:

- **Infectious diseases are spreading** among evacuees living in close quarters, including reported cases of:
  - Vaccine-preventable diseases, such as COVID-19, measles, mumps, chickenpox, and hepatitis A.
  - Other diseases, including tuberculosis, malaria, and leishmaniasis.
- High rates of **depression, anxiety, and post-traumatic stress disorder** (experienced among 33% of asylum seekers and evacuees).

States Have Reported Evacuees Experiencing:

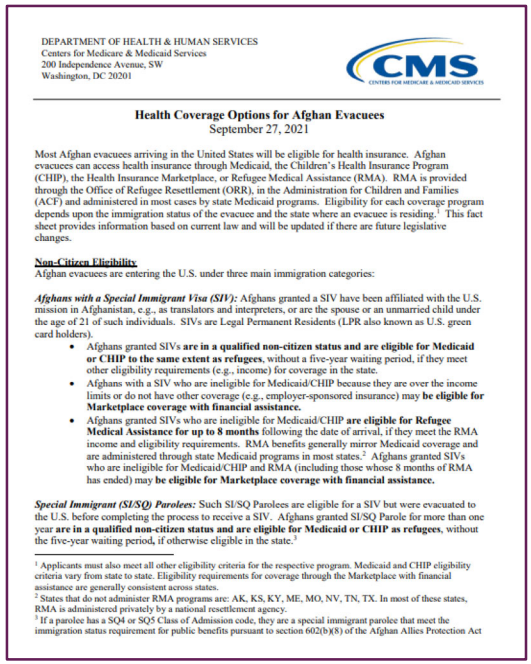
- **Challenges enrolling** in health coverage.
- **Barriers to accessing critical healthcare services**.
- **Urgent need for resources**, including food, clothing, and interpreters.
- **Challenges accessing affordable housing**

Under the Biden Administration's Operation Allies Welcome (OAW) program, all Afghan evacuees are being tested for COVID-19 upon arrival into the country. Evacuees will be offered (or, depending on their immigration status, required to receive) a tuberculosis screening and several vaccines free of charge, including: COVID-19; Measles, Mumps, Rubella (MMR); polio; and other age-appropriate vaccinations.

Source: C.D.C. Requires Quarantine After Measles Vaccination for Afghan Evacuees; Common Mental Disorders in Asylum Seekers and Refugees; and OAW.

CMS Factsheet on the Afghan Evacuee Crisis

On September 27, 2021, CMS released a factsheet intended to help states and advocacy organizations understand the healthcare options available to Afghan evacuees.



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Health Coverage Options for Afghan Evacuees
September 27, 2021

Most Afghan evacuees arriving in the United States will be eligible for health insurance. Afghan evacuees can access health insurance through Medicaid, the Children's Health Insurance Program (CHIP), the Health Insurance Marketplace, or Refugee Medical Assistance (RMA). RMA is provided through the Office of Refugee Resettlement (ORR), in the Administration for Children and Families (ACF) and administered in most cases by state Medicaid programs. Eligibility for each coverage program depends upon the immigration status of the evacuee and the state where an evacuee is residing.[1] This fact sheet provides information based on current law and will be updated if there are future legislative changes.

Non-Citizen Eligibility
Afghan evacuees are entering the U.S. under three main immigration categories:

Afghans with a Special Immigrant Visa (SIV): Afghans granted a SIV have been affiliated with the U.S. mission in Afghanistan, e.g., as translators and interpreters, or are the spouse or an unmarried child under the age of 21 of such individuals. SIVs are Legal Permanent Residents (LPR also known as U.S. green card holders).

- Afghans granted SIVs **are in a qualified non-citizen status and are eligible for Medicaid or CHIP to the same extent as refugees**, without a five-year waiting period, if they meet other eligibility requirements (e.g., income) for coverage in the state.
- Afghans with a SIV who are ineligible for Medicaid/CHIP because they are over the income limits or do not have other coverage (e.g., employer-sponsored insurance) may **be eligible for Marketplace coverage with financial assistance.**
- Afghans granted SIVs who are ineligible for Medicaid/CHIP **are eligible for Refugee Medical Assistance for up to 8 months** following the date of arrival, if they meet the RMA income and eligibility requirements. RMA benefits generally mirror Medicaid coverage and are administered through state Medicaid programs in most states.[2] Afghans granted SIVs who are ineligible for Medicaid/CHIP and RMA (including those whose 8 months of RMA has ended) may **be eligible for Marketplace coverage with financial assistance.**

Special Immigrant (SI/SQ) Parolees: Such SI/SQ Parolees are eligible for a SIV but were evacuated to the U.S. before completing the process to receive a SIV. Afghans granted SI/SQ Parole for more than one year **are in a qualified non-citizen status and are eligible for Medicaid or CHIP as refugees**, without the five-year waiting period, if otherwise eligible in the state.[3]

[1] Applicants must also meet all other eligibility criteria for the respective program. Medicaid and CHIP eligibility criteria vary from state to state. Eligibility requirements for coverage through the Marketplace with financial assistance are generally consistent across states.
[2] States that do not administer RMA programs are: AK, KS, KY, ME, MO, NV, TN, TX. In most of these states, RMA is administered privately by a national resettlement agency.
[3] If a parolee has a SQ4 or SQ5 Class of Admission code, they are a special immigrant parolee that meet the immigration status requirement for public benefits pursuant to section 602(b)(8) of the Afghan Allies Protection Act

Included in the Factsheet

- **Coverage Options for 3 Types of Afghan Evacuees:**
  - Special Immigrant Visa (SIV) Holders
  - Special Immigrant (SI/SQ) Parolees
  - Humanitarian (Non-SI/SQ) Parolees*
- **Enrollment and Coverage Strategies/Considerations:**
  - Application Assistors and Out-Stationing
  - Presumptive Eligibility
  - State Residency and Applications for Individuals Moving to Another State
  - Reasonable Opportunity Period
- **Information about a special enrollment period (SEP) to enroll in Marketplace coverage available to Afghan evacuees**

*After CMS released the factsheet, Congress enacted additional protections for Afghan evacuees in its September 30, 2021 Continuing Resolution. This presentation accounts for those additional legislative provisions. CMS may similarly issue an updated factsheet to reflect these legislative changes.

Source: Health Coverage Options for Afghan Evacuees.

Potential Immigration Statuses and Health Coverage Options for Afghan Evacuees

Afghan Evacuees Immigration Statuses

Most Afghan evacuees will receive one of the following "lawfully present" immigration statuses:

Immigration Status	Eligible Individuals
Special Immigrant Visa (SIV) Holders	Individuals **affiliated with the U.S. mission in Afghanistan** (e.g., translators), their **spouses**, and their unmarried **children** under the age of 21. *Note: SIV holders receive Lawful Permanent Resident (green card) status.*
Special Immigrant (SI/SQ) Parolees	Individuals who are **eligible for a SIV, but who were evacuated** to the U.S. before completing the SIV application process.
Humanitarian (Non-SI/SQ) Parolees	Individuals who are **not eligible for a SIV**, but were nonetheless evacuated for humanitarian reasons and paroled into the U.S. They may apply for asylum, work authorization, and other immigration benefits.

"Parole" means that an individual has received temporary permission to enter the United States without a visa or other formal immigration status.

- Afghan parolees (SI/SQ and humanitarian) will generally receive a parole period of 2 years.
- The Afghanistan Supplemental Appropriations Act, passed as part of the Sept. 30, 2021 Continuing Resolution, enhanced protections for humanitarian parolees by:
  - Expanding health coverage options.
  - Requiring expedited processing of asylum applications (decision within 150 days).
  - Making Afghan parolees eligible for REAL ID-compliant driver's licenses and state ID cards.

Source: Special Immigrant Visas for Afghans - Who Were Employed by/on Behalf of the U.S. Government; and OAW.

Overview: Afghan Evacuee Eligibility for Coverage

- **CMS anticipates that "most Afghan evacuees … will be eligible for health insurance,"** whether under:
  - Medicaid or the Children's Health Insurance Program (CHIP)
  - Refugee Medical Assistance (RMA), which provides short-term medical assistance to newly arriving Afghans who are not eligible for Medicaid.
  - The Marketplace (potentially including premium tax credits)
- **For each evacuee, eligibility for coverage will depend on:**
  - Holding a qualifying immigration status
  - Satisfying all program-specific eligibility criteria, such as income and residency requirements.

Medicaid & CHIP

Most Afghan evacuees may enroll in Medicaid/CHIP if they meet program eligibility criteria in their state of intended residence.

- **Background: The 5-year bar on Medicaid/CHIP coverage**
  - Federal law generally limits Medicaid/CHIP eligibility to "qualified non-citizens" who have resided in the U.S. for at least 5 years (the so-called "5-year bar").[1]
  - Certain groups are exempt from the 5-year bar, including refugees and asylees. They may enroll in Medicaid/CHIP at any time if they meet program eligibility criteria.

- **Congress exempted most Afghan evacuees from the 5-year bar.** The following groups are eligible for "entitlement programs and other benefits" on the same terms as refugees:
  - All SIV holders and SI/SQ parolees.
  - Humanitarian parolees who arrive in the U.S. between July 31, 2021 and Sept. 30, 2022 *(as well as the qualifying family members of these parolees, even if they are admitted after September 30, 2022).*

Humanitarian parolees who arrived in the U.S. *before* July 31, 2021 are subject to the 5-year bar on Medicaid/CHIP coverage, with certain exceptions:

- Under CHIPRA 214, states may waive the 5-year bar for lawfully present ***children and pregnant people*** who meet all Medicaid/CHIP eligibility requirements.[1]
- States must cover ***treatment for emergency medical conditions*** for any individual who would be eligible for Medicaid but for their immigration status.

Note: (1) The 5-year bar was imposed under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). Under section 214 of the CHIP Reauthorization Act of 2009 (CHIPRA), states have the ability to waive this 5-year bar for lawfully residing children and pregnant women.

Source: Afghan Allies Protection Act of 2009, as amended; Extending Government Funding and Delivering Emergency Assistance Act, Section 2502.

Refugee Medical Assistance (RMA)

RMA is potentially available to any newly arriving Afghan evacuees who do not qualify for Medicaid/CHIP.

- **Background on Refugee Medical Assistance**
  - RMA provides up to 8 months of health coverage to immigrants who are not eligible for Medicaid/CHIP, and who meet other requirements (e.g., income thresholds).
  - RMA benefits generally mirror Medicaid coverage.
  - RMA is typically administered through state Medicaid programs (but paid for with federal dollars).[1]
- **RMA is potentially available to all newly arriving Afghan evacuees* who do not qualify for Medicaid/CHIP** (e.g., because they exceed income thresholds, which may be particularly likely in non-expansion states). While enrolled in RMA coverage, these individuals may:
  - Apply for an immigration status that would qualify them for Medicaid/CHIP without the 5-year bar (e.g., asylum)
  - Apply for Marketplace coverage (potentially with subsidies).

**RMA is not available to Humanitarian parolees who arrived in the U.S. before July 31, 2021*

The HHS Office of Refugee Resettlement maintains a list of key state contacts regarding RMA and other refugee resettlement programming.

Note: (1) The following states do not administer an RMA program: AK, KS, KY, ME, MO, NV, TN, TX. In most of these states, RMA is administered privately by a national resettlement agency.

CORRECTED CONTENT

Commercial Insurance in the Marketplace

Afghan evacuees who do not qualify for Medicaid/CHIP are eligible to purchase coverage on the Marketplace, potentially with subsidies in certain cases.

Afghan evacuees with income < 100% of the federal poverty level (FPL) likely will not qualify for premium tax credits.[1] They must pay full price for Marketplace coverage.

- In states that have not expanded Medicaid under the Affordable Care Act, RMA may be the only form of comprehensive, federally supported health coverage for low-income adult evacuees.
- These adults may, however, qualify for limited Medicaid coverage of emergency services.

Afghan evacuees with income > 100% FPL may qualify for premium tax credits if they do not qualify for Medicaid, CHIP, or any other form of "minimum essential coverage."

Note: For plan years 2021 and 2022, the American Rescue Plan Act of 2021 (ARP) temporarily increased existing premium tax credits, including by making these subsidies available to those with incomes > 400% FPL. Congressional Democrats are considering legislation to make these changes permanent.

Afghan evacuees can use HealthCare.gov to apply for and enroll in Marketplace coverage.

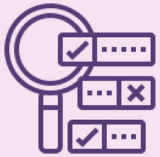
If a state has its own Marketplace platform, contact information can be found here: www.HealthCare.gov/marketplace-in-your-state/.

Note: (1) A previous version of this deck erroneously stated that premium tax credits are available to lawfully present immigrants below 100% FPL. This policy applies only to lawfully present immigrants would be eligible for Medicaid/CHIP but for the 5-year bar on coverage. This exception does not apply to Afghan evacuees, however, because they are not subject to the 5-year bar.

SEP for Marketplace Coverage

The CMS factsheet on the Afghan Evacuee Crisis includes information on a SEP through the Marketplace available to Afghan evacuees, including individuals:

Who move to, or gain lawful presence in, the U.S.



Who initially qualify for Medicaid, CHIP, or RMA coverage, but later lose such coverage.

Who receive a determination of ineligibility for Medicaid or CHIP after the end of an enrollment period.

- Individuals have 60 days to enroll in Marketplace coverage.
- Coverage generally starts the first of the month after an individual applies and selects a plan.
- Evacuees who know ahead of time that their RMA coverage will end may apply and select a plan up to 60 days before the end of their coverage, allowing Marketplace coverage to start on the first of the month.

Source: Health Coverage Options for Afghan Evacuees.

State Strategies for Enrolling Evacuees into Health Coverage

Application Assisters & Out-Stationing

Before evacuees are resettled, states can conduct in-reach activities into military bases and leverage their existing network of application assisters, community-based organizations (CBOs), and navigators to help individuals complete single streamlined applications for, and enroll in, health coverage.

State Strategies

- **Provide or fund specialized training for assisters and navigators** on Afghan evacuees' unique enrollment issues (e.g., potential change in residency, need for interpreters).
- **Rely on the existing application assister workforce** to help evacuees complete and submit applications for health coverage.
- Leverage **locally anchored organizations** to assist individuals and families with connecting to critical social supports (e.g., food pantries) and provide assistance with navigating the healthcare system.
- **Out-station workers** including: (1) Medicaid agency eligibility workers to help facilitate enrollment and, if authorized, determine eligibility; and (2) provider/contractor employees or trained volunteers to assist evacuees with completing applications.
  - ✓ States may receive **50% Federal Medical Assistance Percentages (FMAP)** for out-stationed eligibility functions.
  - ✓ States may **claim salaries for out-stationed workers, travel, training, space, and related expenditures** so long as they are directly attributable to the out-stationing activities, as defined by 42 C.F.R. 435.904.

Out-station locations can include hospitals that receive Disproportionate Share Hospital (DSH) funding, Federally Qualified Health Centers (FQHCs), and any "alternate location" that the state demonstrates is an equal or more effective location (alternate locations must be approved by CMS).

Source: 42 C.F.R. 435.904; and State Medicaid Director Leter (SMDL) #01-008.

Presumptive Eligibility

States can implement new or enhanced presumptive eligibility processes to quickly enroll eligible evacuees into coverage.

Program Feature	Description	Sample Policy Changes[1]
Eligible Populations	▪ States can use presumptive eligibility for children, pregnant women, parents, expansion adults, former foster care children, certain individuals with income above 133% FPL, among others.	✓ Extend regular presumptive eligibility to all eligible populations. ✓ Update SPAs to adopt regular presumptive eligibility for eligibility groups based on age or disability status.
Qualified Entities	▪ A qualified entity is an entity determined by the state to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements.	✓ Designate the military bases, medical hotels where evacuees are being housed, the Medicaid agency, or other entities as qualified entities, and provide them with training to make presumptive eligibility determinations. ✓ Establish state and local government agencies as qualified entities.
Application	▪ States are not required to use a written application for PE. ▪ States may use either gross income or a reasonable estimate of MAGI.	✓ Develop guidance clarifying that qualified entities may administer presumptive eligibility applications verbally or through an online portal. ✓ Simplify presumptive eligibility income determination process by switching to a "gross income" approach.

<u>Reminder</u>: Presumptive eligibility enables healthcare providers and other qualified entities to provide children and certain groups access to Medicaid or CHIP services without having to wait for their application to be fully processed.

Note: (1) Changes can be made on an expedited basis using a Medicaid Disaster Relief SPA.

Hospital Presumptive Eligibility

States can leverage their current hospital presumptive eligibility policies and operational approaches to support enrollment of Afghan evacuees.

Program Feature	Description	Sample Policy Changes
Eligible Populations and Qualified Entities	▪ Qualified hospitals must determine eligibility presumptively for most populations, other than those eligible on the basis of age or disability. ▪ Hospitals can make presumptive eligibility determinations for individuals who are not patients.	✓ Implement State Plan Amendments (SPAs) to adopt hospital presumptive eligibility for eligibility groups based on age or disability status. ✓ Allow and encourage hospitals to make presumptive eligibility determinations for individuals outside of the "4 walls" of the hospital – including for individuals who are not patients of the hospital.
Eligibility Period	▪ States must adopt reasonable standards regarding the number of periods of presumptive eligibility that will be authorized in a given timeframe.	✓ Allow one period of presumptive eligibility per calendar year.
Application	▪ States are not required to use a written application for PE. ▪ Hospitals and other qualified entities must accept self-attested information regarding income, immigration status, and state residency.	✓ Develop guidance clarifying that qualified hospitals may administer presumptive eligibility applications verbally or through an online portal. ✓ Simplify the presumptive eligibility income determination process by switching to a "gross income" approach.

Source: COVID-19 FAQs for State Medicaid and CHIP Agencies.

Medicaid State Residency & Applications for Individuals Moving to Another State

States can proactively enroll evacuees who are still being processed at military bases (including those that are out-of-state) based on the individual's "intent to reside" or by covering the person as a "non-state resident."

- **States can enroll Afghan evacuees based on "intent to reside":**
  - Residency is defined as the place where the individual is living and intends to reside (42 C.F.R. 435.403).
  - States have flexibility to define the term "intent to reside," including accepting attestation that an individual is a state resident without requiring further documentation.
  - States may not deny Medicaid eligibility because the individual has not resided in the state for a minimum, specified period of time or does not have a fixed address.

- **Alternatively, states can extend Medicaid eligibility to "non-residents."**

- **Application process considerations for evacuees moving to another state:**
  - Evacuees may apply for Medicaid in the state in which they intend to reside.
  - When applying, evacuees should use the address where they intend to live, if known, or provide another address where the Medicaid agency can reach them (e.g., the address of a community organization).
  - Effective date of eligibility would be the date the individual arrives in their new state of residence.
  - Individuals can designate an authorized representative (e.g., case manager from a refugee resettlement organization) to:
    - Communicate with the state Medicaid agency on the person's behalf.
    - Report changes in circumstances.
    - Receive copies of notices and other information.

Source: Health Coverage Options for Afghan Evacuees.

Reasonable Opportunity Period

Verifying immigration status for evacuees may present challenges to facilitating enrollment into coverage. The CMS factsheet reminds states of their obligation to give applicants a Reasonable Opportunity Period to provide supporting documentation if their immigration status cannot be verified via data matching sources.

- If (1) a state is unable to promptly verify an Afghan evacuee's immigration status, and (2) the individual has attested to eligible immigration status and is found otherwise eligible for Medicaid, then **the state is required to furnish benefits**:
  - ✓ During the **90-day Reasonable Opportunity Period**; or
  - ✓ A **longer period provided by the state for non-citizens making a good faith effort** to obtain documentation or where the agency needs more time to verify the individual's immigration status.
- Before discontinuing Reasonable Opportunity Period coverage, states must provide individuals **at least 10 days advance notice**.
- **Notices must be accessible** to individuals with limited English proficiency or living with disabilities.

Source: Section 1137(d) of the Social Security Act; 42 C.F.R. § 435.956(b); 42 C.F.R. § 435.956(b)(2)(ii)(B); 42 C.F.R § 431.211; 42 C.F.R. §435.905(b); and 42 C.F.R. 431.206(e).

Maintaining Contact with Afghan Evacuees

States should consider a multi-prong approach for maintaining accurate mailing addresses, which supports sending notices, benefit cards, managed care plan information, and renewal packets to Afghan evacuees as they are processed and begin to resettle.

Create specialized notices in Pashto and Dari that inform individuals about how to update their contact information when they move, and the importance of doing so.

Partner with resettlement organizations or other community organizations to remind individuals enrolled in Medicaid or Marketplace coverage to update their contact information.

Encourage applicants to use a stable mailing address so that they know where to go to check for updated mail (e.g., a local social service agency office or CBO).

State Reactor: Virginia

Discussion

The slides and a recording of the webinar will be available at www.shvs.org after the webinar

Thank You

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Appendix

Immigration Statuses & Eligibility for Coverage

Immigration Status[1]	Medicaid/CHIP	Marketplace
Certain protected classes of "qualified non-citizens," including: ▪ People who have been granted asylum or refugee status ▪ ***Afghans with a Special Immigrant Visa (SIV)[2]*** ▪ ***Special Immigrant (SI/SQ) Parolees[2]*** ▪ ***Humanitarian (Non-SI/SQ) Parolees[3]***	**Same coverage as U.S. citizens** *(no 5-year bar)*	**Yes**
Other classes of qualified non-citizens, including: ▪ Lawful Permanent Residents (LPRs) (aka "Green Card" holders) ▪ People who have been granted "parole" into the U.S. for a period of at least 1 year	*Children & Pregnant People:* **Same coverage as U.S. citizens if state has elected CHIPRA 214 option**	**Yes**
	All Others: **Same coverage as U.S. citizens after meeting 5-year bar.** During 5-year bar, no coverage except for Emergency Medicaid.	
Lawfully present people who are not "qualified non-citizens," including: ▪ Asylum applicants and people with certain other humanitarian statuses ▪ People with "non-immigrant" visa status (e.g., time-limited visas for work or study) ▪ People who have been granted parole for less than 1 year ▪ People with legal status conferred by certain other laws (e.g., the Legal Immigration Family Equity Act)	*Children & Pregnant People:* **Same coverage as U.S. citizens if state has elected CHIPRA 214 option**	**Yes**
	All Others: **No coverage**, except for Emergency Medicaid.	
Undocumented people, including those eligible for Deferred Action for Childhood Arrivals (DACA)	**No coverage**, except for Emergency Medicaid.	**No**

Notes: (1) This table does not present a comprehensive list of immigration statuses eligible for federally funded coverage programs. (2) Per CMS guidance, SIV holders and SI/SQ parolees will share the same Medicaid/CHIP, Marketplace, and RMA eligibility rules as refugees. (3) Per the Afghanistan Supplemental Appropriations Act (enacted Sept. 30, 2021), humanitarian (non-SI/SQ) parole recipients are similarly eligible for these programs on the same terms as refugees.

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October 4, 2021

Closing the Coverage Gap a Critical Step for Advancing Health and Economic Justice

By Laura Harker

One of the most important steps Congress can take to advance health equity in recovery legislation under consideration is to close the Medicaid "coverage gap." More than 2 million adults, majorities of whom live in the South and are people of color, are uninsured and in the coverage gap, meaning they have incomes below the federal poverty line but no pathway to affordable coverage because their state is one of 12 that has refused to adopt the Affordable Care Act's (ACA) Medicaid expansion. Budget reconciliation legislation passed by the House Energy and Commerce Committee would permanently close the Medicaid coverage gap, and Congress should ensure this solution remains permanent and comprehensive in the final recovery package.

People of color make up about 60 percent of those in the coverage gap, higher than their 41 percent share of the adult, non-elderly population in non-expansion states. This reflects economic, educational, and housing injustices that lead to higher rates of poverty for people of color and over-representation in low-paid jobs that don't offer employer coverage. Moreover, many of the states that have refused to adopt the expansion have a long history of policy decisions, based on racist views of who deserves to get health services, that restricted access to coverage in the past and continue to do so today.

Closing the coverage gap is an important step in undoing the effects of structural racism that continue to affect people's health and well-being. A large body of evidence suggests that closing the gap would:

- **Help the people in the coverage gap afford and access health care**. States that expanded Medicaid eligibility to more low-income adults showed a greater reduction in racial disparities in coverage and access to care, narrowing gaps in uninsurance rates between Black and Latino people and white people and decreasing racial disparities in screening rates for certain conditions and ability to afford care.
- **Improve outcomes for key conditions that have a greater impact on communities of color**. Expanding Medicaid helped reduce disparities in certain chronic illnesses, improve maternal health outcomes for Black mothers, and remove barriers people of color face in accessing behavioral health care.

- **Bring increased financial security and protection from medical debt, which affects people of color at a higher rate.** Medicaid expansion states had smaller differences between communities of color and white communities in the share of medical debt than non-expansion states.
- **Improve stability of health systems that people of color rely on, including rural hospitals, safety net hospitals, and community health centers, which would see a reduction in uncompensated care.** Rural hospitals that have closed in several non-expansion states like Georgia, Florida, and South Carolina were more likely to be located in counties with shares of Black residents above the statewide average.

Closing the coverage gap is only one step toward health equity, where everyone has a fair opportunity to achieve the best health possible. Additional work is needed to address critical health equity challenges, such as improving the cultural competency and diversity among the health care workforce, reducing bias among health providers, and responding to social factors such as food insecurity and housing instability that disproportionately affect marginalized racial and ethnic groups because of historic and ongoing racism and discrimination. But closing the coverage gap is an important component to achieving health equity. It would provide more than 2 million people health coverage so they can access needed health care services and receive critical care coordination services that can be vital to managing illnesses.[1]

Many Non-Expansion States Have Long History of Restricting Access to Health Coverage

Most of the states that have refused to adopt the Medicaid expansion — despite strong financial incentives for the states and clear health and economic benefits for individuals — are located in the South and have above-average shares of Black and brown residents. (See Figure 1.) Many of the same states choosing not to expand Medicaid coverage to low-income adults also have a long history of restricting access to health care to low-income people in their states.

Before Medicaid's enactment in 1965, states could opt into federal programs to pay for health care for low-income people. But many states in the South with larger Black populations opted not to participate; only 3.3 percent of program participants in 1963 came from Southern states.[2]

Once Medicaid was established, states continued to have flexibility to make certain decisions related to the breadth of the program and these states often made choices that restricted access. For example, Medicaid eligibility for children and parents was originally linked to eligibility for cash assistance through the Aid to Families with Dependent Children (AFDC) program. States in the South typically had very limited AFDC programs and historically denied Black and brown people

[1] Judith Solomon, "Build Back Better Legislation Would Close the Medicaid Coverage Gap," Center on Budget and Policy Priorities, updated September 13, 2021, https://www.cbpp.org/research/health/build-back-better-legislation-would-close-the-medicaid-coverage-gap.

[2] Southern states in this study included ten states in the Deep South and neighboring states.
LaShyra T. Nolen, Adam L. Beckman, and Emma Sandoe, "How Foundational Moments In Medicaid's History Reinforced Rather Than Eliminated Racial Health Disparities," *Health Affairs,* September 1, 2020, https://www.healthaffairs.org/do/10.1377/hblog20200828.661111/full/.

access to aid through very restrictive eligibility rules and other discriminatory practices.[3] Prior to the mid-1980s, the only way most parents and children could receive Medicaid was to receive assistance through AFDC; these restrictive policies meant that access to health coverage was also very limited. After Medicaid eligibility expanded for children starting in the mid-1980s, the eligibility restrictions in AFDC had less impact on children but continued to sharply limit Medicaid access for parents.

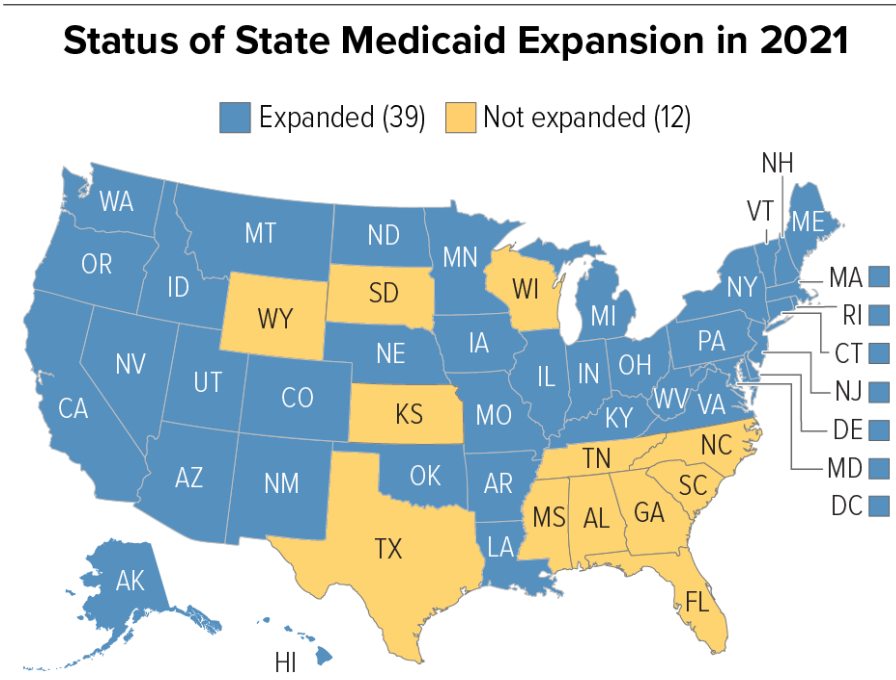
In 1996, when the Temporary Assistance for Needy Families (TANF) program replaced AFDC, Medicaid eligibility was delinked from eligibility for cash assistance. In response to this "delinking," some states chose to *expand* Medicaid eligibility to cover more parents (child eligibility was already being expanded through other mechanisms), but others, including many states that later refused to expand Medicaid, maintained low eligibility levels for parents that dated back to their old AFDC programs.

The ACA called for expanding Medicaid to *all* non-elderly adults, parents and non-parents alike, with incomes below 138 percent of the federal poverty line. In states that refuse to adopt the expansion, adults without minor children at home continue to have no pathway to coverage if their incomes are below the poverty line (above that, they can purchase subsidized coverage in the marketplace). And, while states can increase the eligibility limits for parents, many non-expansion states continue to have very low eligibility limits for them — often only a fraction of the poverty line. In a typical non-expansion state, parents must have earnings of below about $9,000 a year (for a family of three) to qualify for Medicaid,[4] compared to earnings below $30,300 (138 percent of the poverty line) in most expansion states. (Expansion states may also set their thresholds higher, as Connecticut and the District of Columbia do.)

[3] Ife Floyd *et al.*, "TANF Policies Reflect Racist Legacy of Cash Assistance: Reimagined Program Should Center Black Mothers," Center on Budget and Policy Priorities, August 4, 2021, https://www.cbpp.org/research/family-income-support/tanf-policies-reflect-racist-legacy-of-cash-assistance.

[4] Center on Budget and Policy Priorities, "Policy Basics: Introduction to Medicaid," updated April 14, 2020, https://www.cbpp.org/research/health/introduction-to-medicaid.

FIGURE 1



Note: Wisconsin extends Medicaid eligibility to adults up to 100 percent of the poverty line through a waiver. Therefore, Wisconsin has no coverage gap population and is not included in estimates.

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Medicaid Expansion Has Reduced Racial Disparities in Health Coverage and Access to Care

Racial health disparities are driven by many factors rooted in structural racism, such as discrimination and bias in the health care system; lack of investment in communities of color, which limits access to resources such as nutritious food and clean air; and educational disparities and employment discrimination, which result in a higher representation of people of color in jobs that don't offer health coverage.

Medicaid expansion and subsidized private coverage through the Affordable Care Act reduced racial disparities in coverage. Between 2013 and 2019, the ACA helped reduce the uninsured rate for Black adults by 10 percentage points and the uninsured rate for Latino adults by 14.5 percentage points nationally.[5] But gaps persist: the uninsured rate for non-elderly white adults in the United States in 2019 was 9 percent, compared to 14 percent for Black adults, 26 percent for Latino adults, 25 percent for American Indian and Alaska Native adults, and 14 percent for Native Hawaiian or

[5] Jesse C. Baumgartner, Sara R. Collins, and David C. Radley, "Racial and Ethnic Inequities in Health Care Coverage and Access, 2013-2019," Commonwealth Fund, June 9, 2021, https://www.commonwealthfund.org/publications/issue-briefs/2021/jun/racial-ethnic-inequities-health-care-coverage-access-2013-2019.

other Pacific Islander adults.[6] Asian adults had a slightly lower uninsured rate (8 percent) than white adults, an improvement compared to before the ACA, when Asian adults were more likely to be uninsured. But uninsured rates vary among different groups of people of Asian descent, reflecting varying degrees of poverty, immigration-related barriers to coverage, language access barriers, and other factors.[7] For example, between 2017 and 2018, people who are Korean or Vietnamese were significantly more likely to be uninsured than Indian, Chinese, or Filipino adults.[8]

States that have adopted the Medicaid expansion have narrowed the gap in uninsured rates between Black and Latino people and white people more so than states that haven't expanded.[9] Between 2013 and 2019, the gap between white and Black adults shrank by 5.1 percentage points in expansion states versus 4.6 percentage points in non-expansion states, while the gap between white and Latino adults shrank by 10.1 percentage points in expansion states versus 7.5 percentage points in non-expansion states.[10]

Medicaid expansion has also helped lower non-elderly (aged 0 to 64) uninsured rates among American Indians and Alaska Natives, from 31 percent in 2013 to 20 percent in 2019 in expansion states, with a significantly smaller decline — from 29 percent to 25 percent — during the same period in non-expansion states.[11]

Most people in the coverage gap in 2019 lived in Southern states; these states varied in the racial and ethnic make-up of people in the coverage gap.[12] In Texas, people of color made up 74 percent of those in the coverage gap, with Latino adults alone comprising 55 percent. In Mississippi most of the coverage gap population was Black, and in both Georgia and South Carolina it was more than 40 percent Black. Over 70 percent of Asian adults and 88 percent of Latino adults in the coverage gap lived in Texas and Florida.[13] (See Figure 2 and Appendix Table 1.)

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[6] Samantha Artiga *et al.,* "Health Coverage by Race and Ethnicity, 2010-2019," Kaiser Family Foundation, July 16, 2021, https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/. Due to the COVID-19 pandemic's impact on data collection, Census did not release its usual American Community Survey (ACS) estimates for 2020. Current Population Survey (CPS) health insurance data are not used here because multiple survey changes and data collection challenges over the past several years limit comparability over time.

[7] Asian & Pacific Islander Forum, "Health Care Access," https://www.apiahf.org/focus/health-care-access/.

[8] Munira Z. Gunja *et al.*, "Gap Closed: The Affordable Care Act's Impact on Asian Americans' Health Coverage," Commonwealth Fund, July 2020, https://www.commonwealthfund.org/sites/default/files/2020-07/Gunja_gap_closed_ACA_impact_asian_americans_coverage_db.pdf.

[9] Baumgartner, Collins, and Radley, *op. cit.*

[10] *Ibid.*

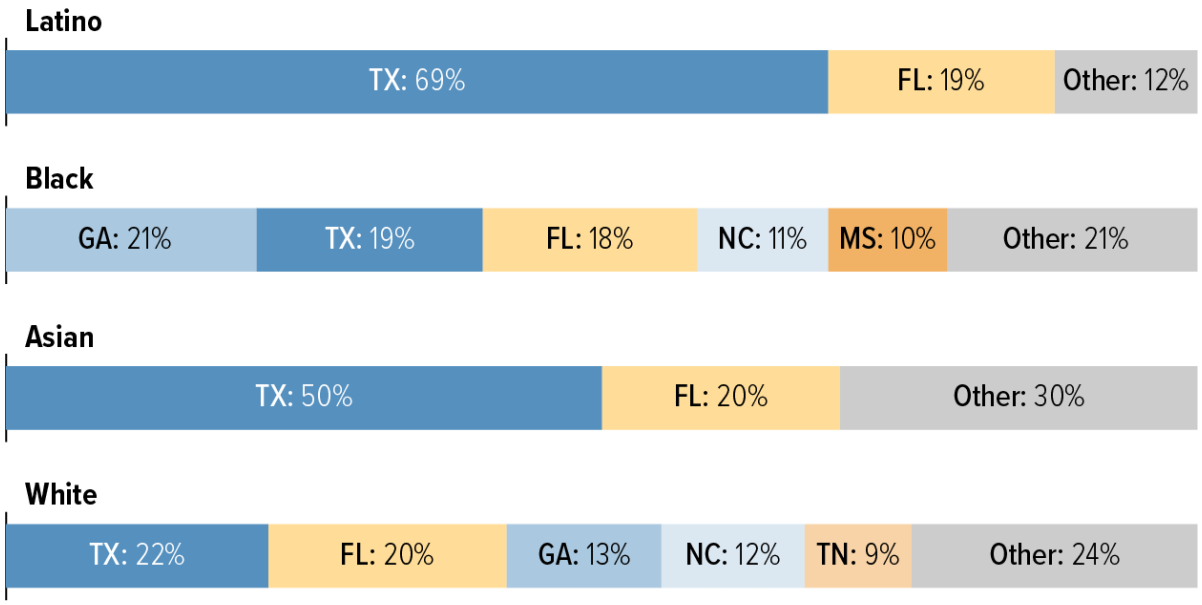
[11] 2013 data from Kaiser Family Foundation, "Health and Health Care for American Indians and Alaska Natives (AIANs) in the United States," May 10, 2019, https://www.kff.org/infographic/health-and-health-care-for-american-indians-and-alaska-natives-aians/. 2019 data from Artiga *et al.*

[12] Includes uninsured adults aged 19-64, excluding the population lacking legal documentation. Due to the COVID-19 pandemic's impact on data collection, Census did not release its usual ACS estimates for 2020, and evidence shows that CPS data for 2020 suffered from non-response bias. In addition, the smaller sample size of the CPS relative to the ACS would constrain the reliability of these state-level estimates.

[13] Gideon Lukens and Breanna Sharer, "Closing Medicaid Coverage Gap Would Help Diverse Group and Narrow Racial Disparities," Center on Budget and Policy Priorities, June 14, 2021, https://www.cbpp.org/research/health/closing-medicaid-coverage-gap-would-help-diverse-group-and-narrow-racial.

FIGURE 2

Where People Falling in the Coverage Gap Live, by Race and Ethnicity



Note: Latino category may include any race; all other categories are non-Latino.
Source: CBPP analysis of 2019 American Community Survey

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Disparities in access to care — measured, for example, by whether people have a usual source of care or forgo care due to cost — between white and Black non-elderly adults and between white and Latino non-elderly adults narrowed across the country after the major coverage provisions of the ACA took effect. There is also evidence that states that took the Medicaid expansion saw larger reductions in disparities. For example, disparities between white and Black adults and white and Latino adults in the share of people who avoided care due to cost narrowed more in Medicaid expansion states than in non-expansion states. And expansion states nearly eliminated disparities between the share of white and Black adults with a usual source of care, but disparities remained in non-expansion states.[14] While not all studies found that Medicaid expansion resulted in a reduction in disparities among racial and ethnic groups in particular care utilization, some showed smaller racial differences in access to certain health services after expansion, such as high-risk cancer surgery and HIV testing.[15]

[14] Baumgartner, Collins, and Radley, *op. cit.*

[15] Madeline Guth, Samantha Artiga, and Olivia Pham, "Effects of the ACA Medicaid Expansion on Racial Disparities in Health and Health Care," Kaiser Family Foundation, September 30, 2020, https://www.kff.org/report-section/effects-of-the-aca-medicaid-expansion-on-racial-disparities-in-health-and-health-care-issue-brief/.

Closing the coverage gap would also help narrow racial disparities in coverage among children. One in three people in the gap are parents with children at home. Extending coverage to parents increases enrollment among eligible children, research shows, so closing the coverage gap for adults would likely lead to coverage gains for children as well.[16] Latino children in non-expansion states are 2.5 times less likely to be insured than Latino children in expansion states and the gap between coverage rates for Latino and white children is growing faster in states without Medicaid expansion.[17]

Closing Coverage Gap Would Help Address Health Crises Affecting Communities of Color

Black and Latino adults are more likely than white adults to be diagnosed with a chronic disease.[18] This is influenced by factors such as racial inequities in health care access, unequal treatment people of color face in the health care system, and chronic stress from experiencing race-based discrimination. Medicaid expansion is associated with improved outcomes such as early diagnosis or treatment and fewer deaths related to chronic diseases, with people of color experiencing the greatest improvements. For example, expansion is associated with a reduction in mortality among people with end-stage renal disease, especially among Black people, and a reduction of disparities in timely treatment between Black and white people with advanced cancer diagnoses.[19]

Some of the strongest evidence of the role of Medicaid expansion in reducing racial disparities in health outcomes comes from research on health outcomes for people who give birth. A recent study of maternal mortality from 2006 to 2017 found that while the overall maternal mortality ratio (deaths per 100,000 live births) worsened over the period, the increase was much less in expansion versus non-expansion states. The difference was significant for Hispanic mothers and was greatest among Black mothers. That makes closing the coverage gap key to addressing the United States' Black maternal health crisis, in which Black mothers are three times more likely to die from pregnancy-related complications than white mothers.[20]

The nation is also experiencing a behavioral health crisis, marked by rising deaths from overdose, sustained high levels of suicide, and a nationally declared public health emergency due to opioid misuse. The COVID-19 pandemic has exacerbated this crisis, especially for people of color. Black

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[16] Julie L. Hudson and Asako S. Moriya, "Medicaid Expansion For Adults Had Measurable 'Welcome Mat' Effects On Their Children," *Health Affairs,* September 2017, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0347?journalCode=hlthaff.

[17] Kelly Whitener, Matthew Snider, and Alexandra Corcoran, "Expanding Medicaid Would Help Close Coverage Gap for Latino Children and Parents," Georgetown University Center for Children and Families and UnidosUS, June 29, 2021, https://ccf.georgetown.edu/wp-content/uploads/2021/06/Expanding-Medicaid-Would-Help-Close-Coverage-Gap-for-Latino-Children-and-Parents.pdf.

[18] Michelle Odlum *et al.*, "Trends in Poor Health Indicators Among Black and Hispanic Middle-aged and Older Adults in the United States, 1999-2018," *JAMA Network Open,* November 11, 2020, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772802.

[19] Blythe J.S. Adamson *et al.*, "ACA Medicaid Expansion Association With Racial Disparity Reductions in Timely Cancer Treatment," *American Journal of Managed Care*, July 19, 2021, https://www.ajmc.com/view/aca-medicaid-expansion-association-with-racial-disparity-reductions-in-timely-cancer-treatment.

[20] Erica L. Eliason, "Adoption of Medicaid Expansion Is Associated with Lower Maternal Mortality," *Women's Health Issues*, February 25, 2020, https://www.whijournal.com/article/S1049-3867(20)30005-0/fulltext.

and Hispanic people have been more likely to report symptoms of anxiety and depression during the pandemic compared to non-Hispanic Asian and white people.[21] Black people in the U.S. with an opioid use disorder have less access to the full range of treatment options compared to white people.[22]

Medicaid expansion is associated with improved self-reported mental health and greater access to mental health and substance use disorder treatment.[23] Expanding coverage can remove affordability barriers for people of color and work alongside efforts to increase provider capacity and diversity and reduce cultural stigma surrounding mental health care.

Closing the Coverage Gap Can Reduce Medical Debt, Expand Economic Opportunity

Closing the Medicaid coverage gap also has economic benefits both to individuals who receive coverage and to the broader community. Extending health coverage to people in the gap can protect more people from medical debt and provide more flexibility for people to pursue opportunities for economic mobility, such as participating in training programs and starting or building businesses.

Medical debt is the top cause of bankruptcy in the United States and people of color are more likely to report trouble paying medical bills.[24] In 2018, about 28 percent of households with a Black family member and 22 percent with a Latino family member had medical debt, compared to 17 percent of households with a white family member and 10 percent with an Asian family member.[25]

A CBPP analysis of medical debt by ZIP code shows that there are racial disparities in medical debt in both expansion and non-expansion states, but the share of medical debt is significantly more prevalent overall in non-expansion states. The data analyzed provides the share of people with medical debt in majority-white communities (defined as ZIP codes where at least 60 percent of the population is white) and majority communities of color (where at least 60 percent of the population is non-white). In expansion states, 18 percent of people in communities that are majority people of color had medical debt in collections, versus 11 percent of majority-white communities. In non-expansion states the rates of medical debt and the racial gap in rates were higher: 28 percent of

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[21] Nirmita Panchal *et al.*, "The Implications of COVID-19 for Mental Health and Substance Use," Kaiser Family Foundation, February 10, 2021, https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use.

[22] Substance Abuse and Mental Health Services Administration, "The Opioid Crisis and the Black/African American Population: An Urgent Issue," April 2020, https://store.samhsa.gov/product/The-Opioid-Crisis-and-the-Black-African-American-Population-An-Urgent-Issue/PEP20-05-02-001.

[23] Jennifer Sullivan, Miriam Pearsall, and Anna Bailey, "To Improve Behavioral Health, Start by Closing the Medicaid Coverage Gap," Center on Budget and Policy Priorities, September 9, 2021, https://www.cbpp.org/research/health/to-improve-behavioral-health-start-by-closing-the-medicaid-coverage-gap.

[24] Brianna Wells, "Solving the Medical Debt Crisis," Greenlining Institute, March 2021, https://greenlining.org/wp-content/uploads/2021/03/Greenlining-Medical-Debt-Crisis-Report-2021.pdf.

[25] Neil Bennett *et al.*, "Who Had Medical Debt in the United States?" U.S. Census Bureau, April 7, 2021, https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html.

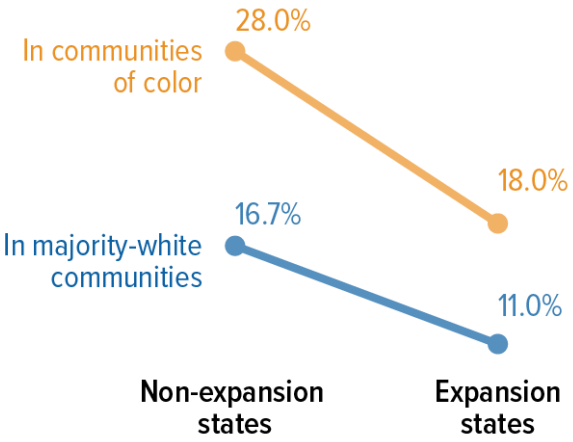
people in majority communities of color had medical debt compared to 16.7 percent of people in white communities.[26] (See Figure 3.)

Further reducing disparities in medical debt by closing the coverage gap will help address the racial wealth gap and keep more money in the pockets of people of color to pay for other needs and boost their financial security. Furthermore, closing the coverage gap can reduce the geographic differences in medical debt. Among regions in the United States, the average amount of medical debt in collections was highest in the South — where many of the states haven't adopted the Medicaid expansion. Also, the drop in new medical debt from 2013 to 2020 was 34 percentage points greater in expansion than in non-expansion states, indicating the gains that closing the coverage gap may have.[27]

FIGURE 3

States Without Medicaid Expansion Have Larger Gap in Medical Debt by Race and Ethnicity

Share of people with medical debt in collections



Note: Majority-white and communities of color are ZIP codes where at least 60 percent of the population is white or non-white, respectively. Five expansion states excluded due to insufficient data.

Source: CBPP analysis of Urban Institute "Debt in America" data

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Closing the Coverage Gap Will Strengthen Health Care Systems That Serve People of Color

Expanding health coverage also plays a role in reducing disparities in the availability of health care providers that serve larger numbers of people of color. Most of the funds for closing the coverage gap go to payments for health care services, allowing more rural hospitals, safety net hospitals, and community health centers — many of which disproportionately serve people with low incomes and people of color — to stay open and even to provide more services in their communities.

Of the ten states with the most rural hospital closures since 2010, all but two are non-expansion states — and the two that have expanded Medicaid, Oklahoma and Missouri, only began the expansion in 2021.[28] In some of the non-expansion states, closed rural hospitals were more likely to be in counties with a higher share of Black residents. (See Figure 4.) For example, six out of the nine rural hospitals that closed in Georgia since 2005 were in counties with higher shares of people of color compared to the statewide average: five had a higher share of Black residents and one a higher share of Latino residents. Five out of eight shuttered rural hospitals in Florida were in counties with shares of Black residents above the state average, as were all four shuttered rural hospitals in South

[26] CBPP analysis of data downloaded from the Urban Institute, "Debt in America: An Interactive Map," updated March 31, 2021, https://apps.urban.org/features/debt-interactive-map/?type=overall&variable=pct_debt_collections.

[27] Raymond Kluender *et al.*, "Medical Debt in the US, 2009-2020," *JAMA*, July 20, 2021, https://jamanetwork.com/journals/jama/article-abstract/2782187.

[28] The top ten are Texas, Tennessee, Georgia, Kansas, Missouri, North Carolina, Oklahoma, Alabama, Florida, and Mississippi.

Carolina (though that state's closures were not in the top ten).[29] While not all non-expansion states saw this kind of disparity, these examples show the importance of greater inclusion of communities of color in conversations about people's access to health care in rural areas.

Community health centers are also important sources of health services for people of color, who comprise 62 percent of community health center patients but 40 percent of the overall U.S. population.[30] In a 2018 survey, community health centers in Medicaid expansion states were more likely to report financial stability improvements since 2010 and coordination of care with community social service providers, compared to centers in non-expansion states.[31] Medicaid expansion was also associated with an increased share in community health center patients receiving screenings and treatment for conditions like asthma and hypertension, the latter condition seeing the greatest improvements for Hispanic patients in rural community health centers.[32]

Medicaid expansion also helped bring new federal funding for services provided through Indian Health Services, tribal health programs, and urban Indian health facilities or facilities contracted to provide services for American Indians. With new revenue from Medicaid expansion, Indian Health Services in Montana was able to increase the amount of care they provide and to allow more people to receive critical preventive care.[33] Medicaid is an important source of coverage for American Indians and Alaska Natives (AIAN); about 55,000 non-elderly AIAN adults would gain coverage if the remaining states expanded their Medicaid programs.[34]

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[29] CBPP analysis using data on rural hospital closures from the Cecil G. Sheps Center for Health Services Research and county population information from American Community Survey 2019 5-year estimates. https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.

[30] National Association of Community Health Centers, "Community Health Center Chartbook," January 2021, https://www.nachc.org/research-and-data/research-fact-sheets-and-infographics/2021-community-health-center-chartbook/.

[31] Corinne Lewis *et al.*, "The Role of Medicaid Expansion in Care Delivery at Community Health Centers," Commonwealth Fund, April 4, 2019, https://www.commonwealthfund.org/publications/issue-briefs/2019/apr/role-medicaid-expansion-care-delivery-FQHCs.

[32] Megan B. Cole *et al.*, "Medicaid Expansion and Community Health Centers: Care Quality And Service Use Increased For Rural Patients," *Health Affairs,* June 2018, https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1542.

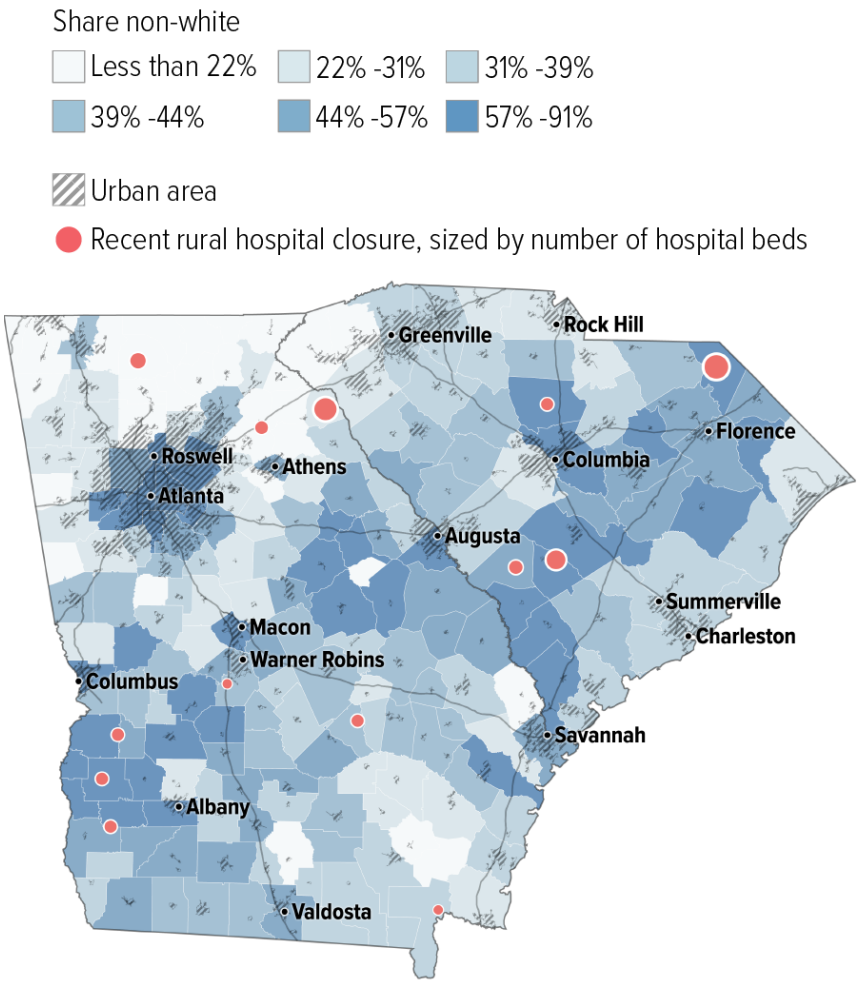
[33] Montana Budget and Policy Center, "Medicaid Expansion in Indian Country: Improving the Health of Individuals and Communities," November 2018, https://montanabudget.org/report/medicaid-expansion-in-indian-country-improving-the-health-of-individuals-and-communities.

[34] D. Keith Branham, Christie Peters, and Benjamin D. Sommers, "Estimates of Uninsured Adults Newly Eligible for Medicaid If Remaining Non-Expansion States Expand," Data Point No. HP-2021-12, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, May 27, 2021, https://aspe.hhs.gov/reports/estimates-medicaid-eligibility-non-expansion-states.

FIGURE 4

Rural Hospital Closures Affecting Communities of Color

Share of non-white population by county and sites of recent rural hospital closures



Notes: Most of the states with a high number of rural hospital closures, like Ga. and S.C., are Medicaid non-expansion states.

The median number of rural hospital beds is 25, according to UNC Sheps Center data from 2015, the latest available.

Source: CBPP analysis using data on rural hospital closures from the Cecil G. Sheps Center for Health Services Research (https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures), and county population information from American Community Survey 2019 5-year estimates

APPENDIX TABLE 1

Uninsured Adults in the Coverage Gap, by Race/Ethnicity, 2019

State	Total	Asian	Black	Latino	Other	White
Total, non-expansion states	2,211,000	29,000	617,000	613,000	60,000	893,000
Alabama	137,000	*	53,000	*	*	75,000
Florida	425,000	6,000	109,000	118,000	12,000	179,000
Georgia	275,000	*	130,000	24,000	*	114,000
Kansas	44,000	*	*	8,000	4,000	26,000
Mississippi	110,000	*	59,000	*	*	44,000
North Carolina	207,000	*	68,000	19,000	12,000	106,000
South Carolina	105,000	*	42,000	*	*	55,000
South Dakota	16,000	*	*	*	6,000	9,000
Tennessee	119,000	*	31,000	5,000	*	79,000
Texas	766,000	14,000	118,000	422,000	12,000	200,000
Wyoming	7,000	*	*	*	*	5,000

* Reliable estimates are not available due to small sample size.
Note: Totals may not sum due to rounding. Estimates are for non-elderly adults aged 19 to 64. Income eligibility for Medicaid and ACA marketplace coverage is determined by grouping individuals into health insurance units for each program and applying state eligibility rules to modified adjusted gross income. Excludes estimated population lacking legal documentation. Latino category may include any race. All other categories are non-Latino. Other includes those who identify as multiple races. See Appendix II for more details.
Source: CBPP estimates based on the 2019 American Community Survey

OCT, 01, 2021

How State-Based Marketplaces Can Maximize Consumer Outreach during Open Enrollment

Julie Bataille, GMMB

As state-based marketplaces (SBMs) get ready for the next annual open enrollment period for health insurance, for many it represents a renewed opportunity to build on the hard work and lessons learned that took place over the year to enroll individuals in quality and affordable health coverage. The extension of special enrollment periods for much of the last year and availability of subsidies from the American Rescue Plan Act (ARP) now mean that nationally 12.2 million Americans (https://www.cms.gov/newsroom/press-releases/biden-harris-administration-announces-record-breaking-122-million-people-are-enrolled-coverage) have health coverage through federally facilitated or state-based marketplaces. Of those 12.2 million, 2.8 million (https://www.hhs.gov/sites/default/files/2021-sep-enrollment-savings.pdf) of them are newly enrolled in coverage.

As open enrollment approaches, the challenge for SBMs is getting all consumers to check out their options for the coming year and find the health coverage that best meets their needs now. In addition, for those new to the marketplace, SBMs will need to help these individuals navigate a process that may be unfamiliar.

Many SBMs are making concerted efforts to connect residents with public and private health coverage options and are continuing to communicate the new financial help available through ARP. Millions have filed for unemployment since the beginning of the pandemic – many losing their employer-sponsored health coverage or experiencing financial instability along the way. The ongoing COVID-19 pandemic continues to bring uncertainty for consumers and a need for marketplaces to continue to respond to that reality. It is more important than ever to conduct outreach, provide enrollment assistance, and clearly communicate with consumers what health coverage options are available for them in 2022.

Messaging and Marketing to Meet the Moment

Research shows that affordability remains the primary barrier to coverage. The subsidies now available are driving premiums down significantly, with consumers saving $40/month (https://www.cms.gov/newsroom/fact-sheets/2021-marketplace-special-enrollment-period-state-state-premium-savings-returning-consumers-american) on average in premiums during the special enrollment period.

Building off the outreach strategies implemented during special enrollment periods earlier this year, SBMs are continuing to employ messaging and communication strategies to reach their audiences. Marketplaces are using messaging (https://www.shvs.org/wp-content/uploads/2021/09/2021-OEP-Messages-for-Marketplaces.pdf) that reinforces the availability of lower premiums to convey the large numbers of consumers who have qualified for them during the year, and states should continue messaging that specifies the benefits and services covered to address consumer questions and get them enrolled.

Additionally, messaging and outreach that makes a concerted effort to help consumers review their plan choices is especially important given that some still do not know about the increased subsidies – and for those above 400 percent of the federal poverty level, they are not used to shopping on the marketplace.

In addition, marketplaces remain focused on making sure the right messages reach consumers. For example, many SBMs are using data to target and maximize marketing dollars to key audiences and are coming up with creative ways to do just that.

Mindful that audiences continue to consume more information online and that individuals and communities are at varying comfort levels for in-person events due to ongoing COVID-19 health and safety concerns, leveraging a combination of digital, mass media and on the ground outreach to reach consumers where they are continues to be important.

Direct to Consumer Contact

Developing targeted outreach strategies and messaging for consumers that may be less familiar with the open enrollment and the marketplace process will be especially important this year. This includes consumers that qualified for a free marketplace plan because they received unemployment insurance or received free COBRA premiums through September and th
that are first-time consumers in the marketplace. To reach these consumers, SBMs have
opportunity to recognize their unique circumstances and tailor messages to them throu

direct communication including text and email. SBMs can leverage their own data to reach out to consumers with specific steps they can take based on their circumstances and where they are in the enrollment process – reminding them what they need to do to choose coverage for next year and where to get help with questions if needed.

For example, since 2018, HealthSource RI (HSRI) has been using a texting program as a targeting tool to reach specific populations that need special assistance. Most recently, they implemented text campaigns for consumer groups who qualified for additional financial assistance, due to the American Rescue Plan Act (ARP), and now could benefit from switching to a plan with lower deductible and out-of-pocket costs. This includes bronze enrollees who had leftover tax credits after the new ARP subsidies became available and were good candidates to find a less expensive plan option and individuals who paid monthly premiums late. Additionally, as part of their retention strategy, HSRI began surveying customers, via text message, who had lost coverage due to non-payment. The responses from these text messages were tracked and provided to the Operations team, so that the team could conduct live outbound calling to determine what options are available for the customers, including helping them enroll in no-cost coverage via Medicaid.

Outreach and Education

Outreach to consumers continues to take a hybrid approach with many states recognizing the need to hold both in-person and virtual opportunities to educate and enroll consumers in coverage options. Additional federal support for navigators in federally facilitated marketplaces is a welcome change and something many SBMs are continuing to support as well. Marketplaces are also making concerted efforts to reach directly into communities with remaining numbers of uninsured to provide information about coverage options from trusted on the ground partners.

For example, as part of Maryland Health Connection's commitment to health equity, the SBM continues to organize virtual events to engage with community leaders representing Black and Hispanic/Latino Marylanders and reach the people they serve. Typically, the SBM would leverage paid media dollars to secure added value, such as radio remotes from enrollment events. In 2020, when in-person events were not an option, the state organized Facebook Live events, hosted by Black radio stations with extensive reach. They hosted "Barbershop Conversations" in partnership with Live Chair Health (https://www.livechair.co/), an organization that brings instant access to health care resources – including the marketplace – to barbershops in Maryland. The Facebook Live was moderated by a radio station DJ and featured a barber and local navigator discussing their community, health, and coverage.

In addition, to develop deeper community relationships, Pennsylvania conducted the Pennie Health Equity Tour (https://ymcaharrisburg.org/locations/ymca-center-healthy-living/programs/the-health-equity-tour/) in partnership with the YMCA. The 2021 Health Equity Tour is a 12-month series of events taking place throughout the 67 counties in Pennsylvania to raise awareness about access to health coverage and health resources. During the tour, [illegible] staff educate attendees on how to obtain insurance through the state-based marketplac

Applying Lessons Learned

A commitment to help consumers know about and make informed choices about their coverage options and a focus on improving equity will continue to shape the outreach and education efforts for marketplaces again this year. As open enrollment begins with the continued backdrop of the COVID-19 pandemic, marketplaces are applying lessons learned from the past year to continue to make sure as many residents as possible access quality and affordable health insurance.

UCLA CENTER FOR HEALTH POLICY RESEARCH

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Health Policy Brief

September 2021

California Reached Health Coverage Milestone With 94% of People Insured in 2020, but Access to Care Remains a Challenge During the COVID-19 Pandemic

Sean Tan, MPP

"Federal and state policies enacted in response to the pandemic may have played a key role in mitigating the negative effects of COVID-19 on health care access."

SUMMARY: Ninety-four percent of Californians were currently insured in 2020, a record high for the state since the California Health Interview Survey (CHIS) began surveying respondents about health care coverage in 2001. However, barriers to health care utilization and the COVID-19 pandemic presented challenges to achieving equitable access to care. About 11% of Black or African American Californians reported not having a usual place to go when sick or needing health advice in 2020, a 36% increase from 2019, and despite 88.2% being insured. Among Californians who had delayed care, more than half had forgone or had not eventually received the necessary medical care in 2020, and 1 in 5 who had delayed care cited COVID-19 concerns as a reason. While COVID-19 was a rising concern, the high cost of medical care or lack of insurance remained pivotal reasons for going without care in 2020.

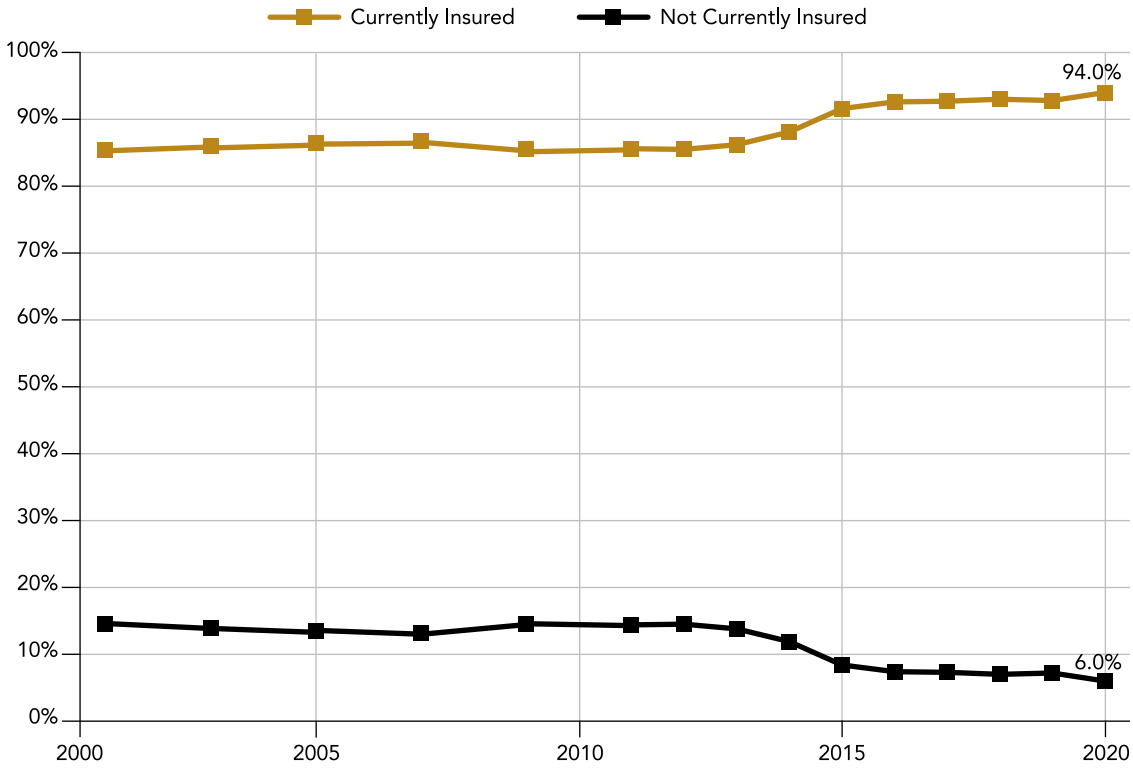
Using newly released 2019 and 2020 CHIS data, this brief examines changes in access to care in 2020 amid the COVID-19 pandemic. Indicators for access to care used in this brief are health care insurance status, usual place to go when sick or needing health advice, delays in medical care and forgoing care, and time of last dental visit. These indicators are typically used to assess access to care, while dental visits provide an expansive view of what is considered to be health care. This brief also looks into differences in health care access through various determinants of health.

Having health insurance is a key aspect of access to health care, and lack of insurance is one of the greatest barriers to accessing care.[1] However, this may be changing in California. According to data from the 2020 California Health Interview Survey (CHIS), 94% of all Californians were insured in 2020—the highest rate of coverage among all Californians since CHIS began surveying respondents about their coverage in 2001 (Exhibit 1).

Given the major disruptions caused by the COVID-19 pandemic, health care coverage in California was anticipated to decrease rather than increase. However, federal and state policies enacted in response to the pandemic may have played a key role in mitigating the negative effects of COVID-19 on health care access. For example, at the onset of the pandemic, the California Department of Insurance directed all insurance companies to provide a grace period of at least 60 days for payment of premiums by policyholders.[2]

Exhibit 1

Percentage of Total California Population Currently Insured vs. Not Currently Insured in California, 2001–2020

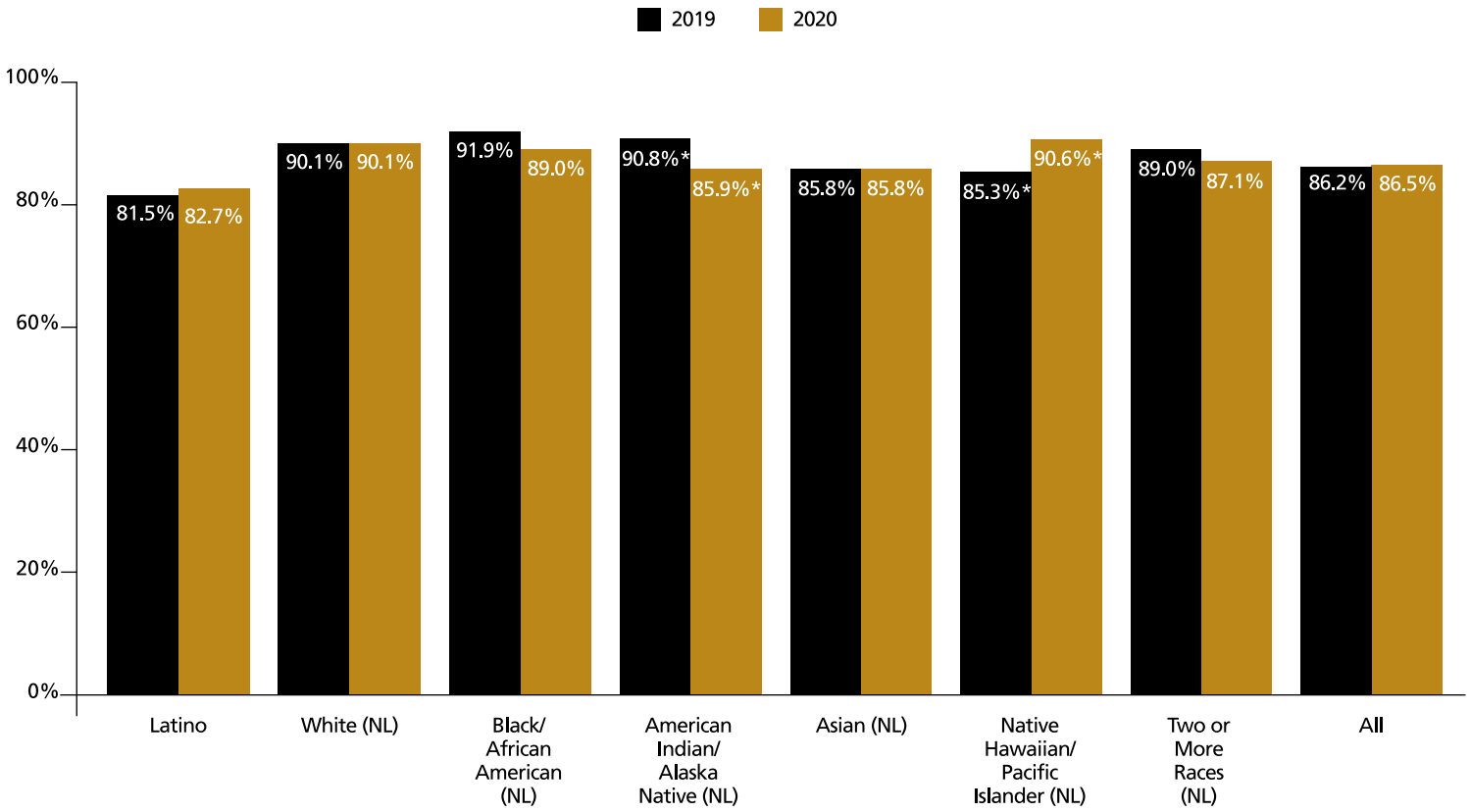


Source: 2001 to 2020 California Health Interview Surveys (2001–2011; collected every other year)

"Nonetheless, health care utilization patterns in California were still drastically and negatively affected by the COVID-19 pandemic."

Also, flexibilities were created in the Medi-Cal program that retained enrollees and allowed for greater ease of access to health care; these included placing a moratorium on redetermining current enrollees' eligibility and waiving requirements such as pre-authorizations and utilization controls.[3] Nonetheless, health care utilization patterns in California were still drastically and negatively affected by the COVID-19 pandemic.

Percentage of Californians Who Have a Usual Place to Go When Sick or Needing Health Advice Across All Racial/Ethnic Groups, 2019 and 2020 **Exhibit 2**



*Statistically unstable estimates

Source: 2019 and 2020 California Health Interview Surveys

A greater number of Black or African American Californians did not have a usual place to go to when sick or needing health advice in 2020

While California set a new record in health care coverage overall, the Black or African American population in particular faced greater barriers to accessing care in 2020. Among Black or African American Californians, the proportion reporting that they had a usual place to go to when sick or needing health advice decreased from 91.9% in 2019 to 89% in 2020 (Exhibit 2). In other words, there was a 36% increase from 2019 to 2020 among those in this population who did not have a usual source of care. While the increase was statistically insignificant, the change is still notable given the severity of COVID-19 infections and mortality rates last year among Black or African American individuals.[4]

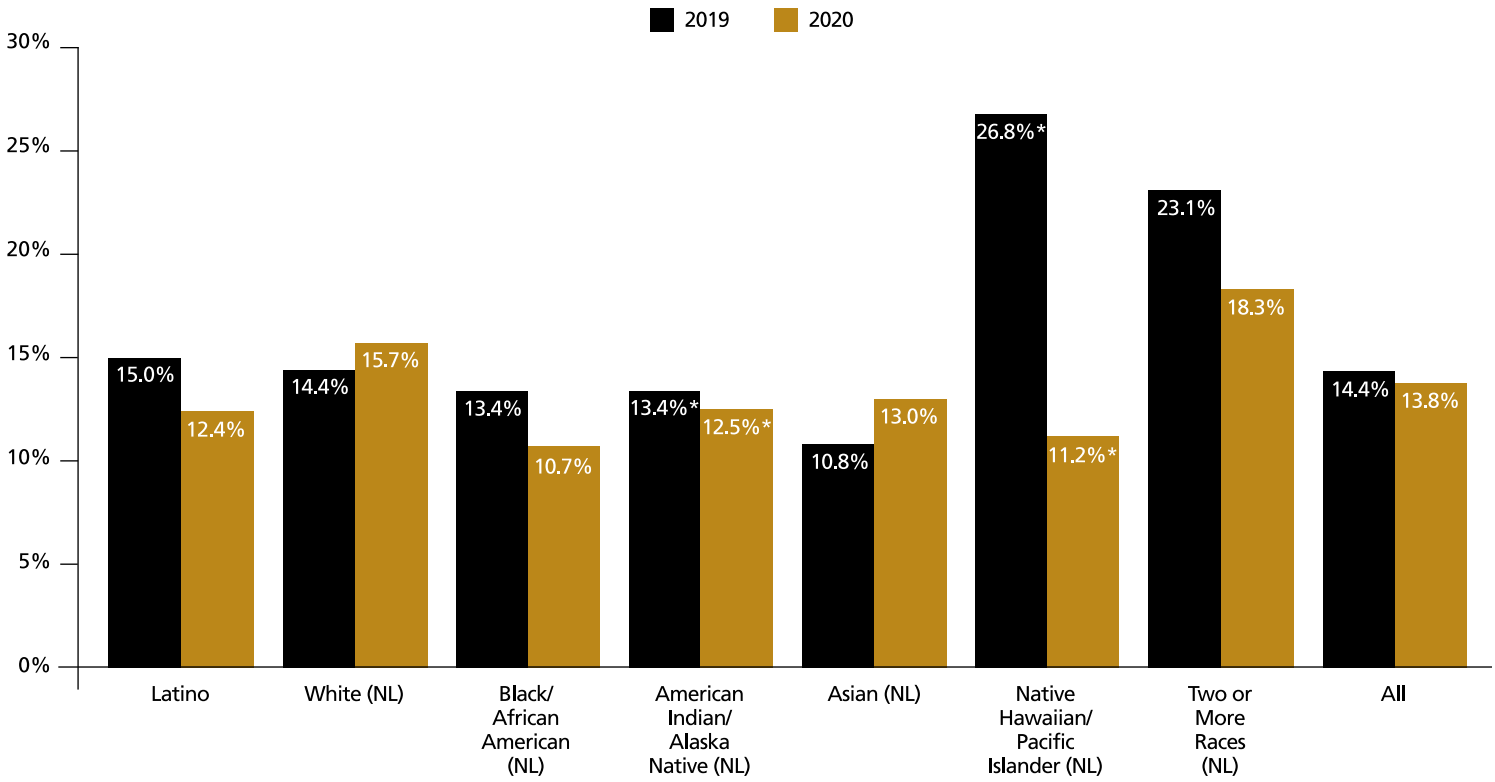
Among Black or African American Californians who did not have a usual source of care in 2020, 27.5% were children (0–17 years old), 68.8% were adults (18–64 years old), and 3.7% were older adults (65 years and older) (See Appendix A1). About 9 out of 10 (91.7%) lived in urban areas, and 88.2% were currently insured (Appendix A2).

While there was an increase in the proportion of Black or African American Californians who reported a doctor's office as their usual source of care from 63.9% in 2019 to 68.5% in 2020, the proportion who used a community/ government-run clinic as the usual source of care decreased, dropping from 24.1% in 2019 to 18.2% in 2020 (Appendix A3).

Among the Latino population in California, 82.7% reported having a usual place to go when they were sick or needed health advice in 2020, compared with 81.5% in the previous

"The Black or African American population in particular faced greater barriers to accessing care in 2020."

Exhibit 3 **Percentage Who Delayed or Did Not Get Care by Race/Ethnicity, 2019 and 2020**



*Statistically unstable estimates
Note: NL = Non-Latino
Sources: 2019 and 2020 California Health Interview Surveys.

"The COVID-19 pandemic negatively affected access to care, with decreases from 2019 to 2020 in the number of doctor visits and preventive visits."

year (Exhibit 2). Among the state's white and Asian American populations, a steady trend was seen from 2019 to 2020, with an estimated 90.1% and 85.8% of these groups, respectively, reporting having a usual source of care in 2020.

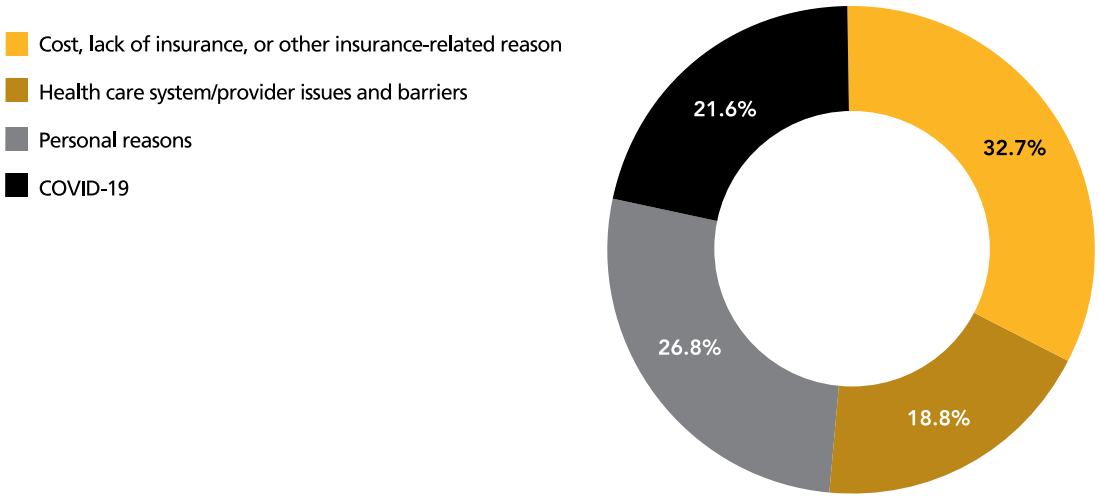
Doctor visits and routine checkups in past 12 months were significantly affected during COVID-19 pandemic

The COVID-19 pandemic negatively affected access to care, with decreases from 2019 to 2020 in the number of doctor visits and preventive visits. When asked about having a preventive visit in the past 12 months, 67.9% of California adults had had one in 2020, a statistically significant decrease from the estimate of 71.1% in 2019, and the lowest estimate since 2013 (Appendix A4). Similarly, a decrease was seen in the number of California adults who had had at least one doctor visit in the past 12 months. In 2020, about 80.3% reported that they had had a doctor visit in the past 12 months, a statistically significant drop from 2019, when the percentage was 82.4% (Appendix A5).

While doctor visits and preventive visits among adults significantly decreased, there was also a nonsignificant decrease from 14.4% in 2019 to 13.8% in 2020 in the proportion of Californians who reported that they had delayed or not gotten the medical care they needed in the past 12 months (Exhibit 3).

Examining racial patterns among those who had delayed or not received needed care in the past 12 months, we found that Latino and Black or African American populations reported having lower proportions of delayed care (Exhibit 3). Among the Latino population, the decrease was from 15% in 2019 to 12.4% in 2020. Among the Black or African American population, the decrease was from 13.4% in 2019 to 10.7% in 2020.

Main Reasons for Delaying or Forgoing Necessary Medical Care in California, 2020 **Exhibit 4**



Sources: 2020 California Health Interview Surveys

On the other hand, the Asian American population reported the greatest increase in percentage across any racial/ethnic group in 2020, with about 13% reporting delaying or not receiving needed care, an increase from 10.8% in 2019. Among the white population, about 15.7% had delayed care or not gotten care in the past 12 months, a slight increase from 14.4% in 2019. While delays in care between 2019 and 2020 decreased from 26.8% to 11.2% among Native Hawaiian or Pacific Islander populations and from 13.4% to 12.5% among American Indian or Alaska Native populations, these estimates were statistically unstable.

Overall, fewer Californians had delayed care in 2020 compared to 2019. However, of those who had delayed care in 2020, more than half (59.5%) had forgone care (not eventually gotten the medical care they felt they needed), which was higher than the estimate in 2019 of 56% (Appendix A6). Within all racial/ethnic groups, more than half had forgone care in 2020, with Latino and white populations reporting the highest percentages (61.6% and 61.5%, respectively) (Appendix A7).

Women accounted for more than half of those who had forgone (not eventually gotten) care in 2020

Women comprised 58.2% of those in California who had forgone care in 2020, an increase from 55.7% in 2019 (Appendix A8). This trend is consistent with declines at the national level in reproductive health care utilization during the initial months of the COVID-19 pandemic.[5] Among women and across racial/ethnic groups, about half to more than half had forgone care in 2020, including 60% of women who identified as Latina, white, or Black or African American (Appendix A9).

About 1 in 5 Californians reported COVID-19 as their reason for delaying or forgoing necessary medical care

Approximately 1 in 5 Californians cited COVID-19 as a reason for delaying or forgoing necessary medical care (Exhibit 4). On a related note, 44.2% of those who had delayed or forgone necessary medical care due to COVID-19 concerns were older adults (Appendix A10). This finding is in line with the higher risks of COVID-19–related hospitalization and death among older adults compared to younger adults (aged 18–29).[6]

"Almost half of those who had delayed or forgone necessary medical care due to COVID-19 concerns were older adults."

Exhibit 5 **Main Reasons for Delaying or Forgoing Necessary Medical Care in California by Race/Ethnicity, 2020**

	Latino	White (NL)	Black or African American (NL)	Asian (NL)	Two or More Races (NL)
Cost, lack of insurance, or other insurance-related reasons	40.0%	28.1%	31.9%	30.0%	28.4%
Health care system/provider issues and barriers	19.4%	16.9%	20.2%	20.0%	30.3%
Personal reasons	27.1%	26.8%	18.3%	28.6%	27.9%
COVID-19	13.5%	28.2%	29.6%	21.5%	13.4%

Note: NL = Non-Latino

Sources: 2020 California Health Interview Surveys.

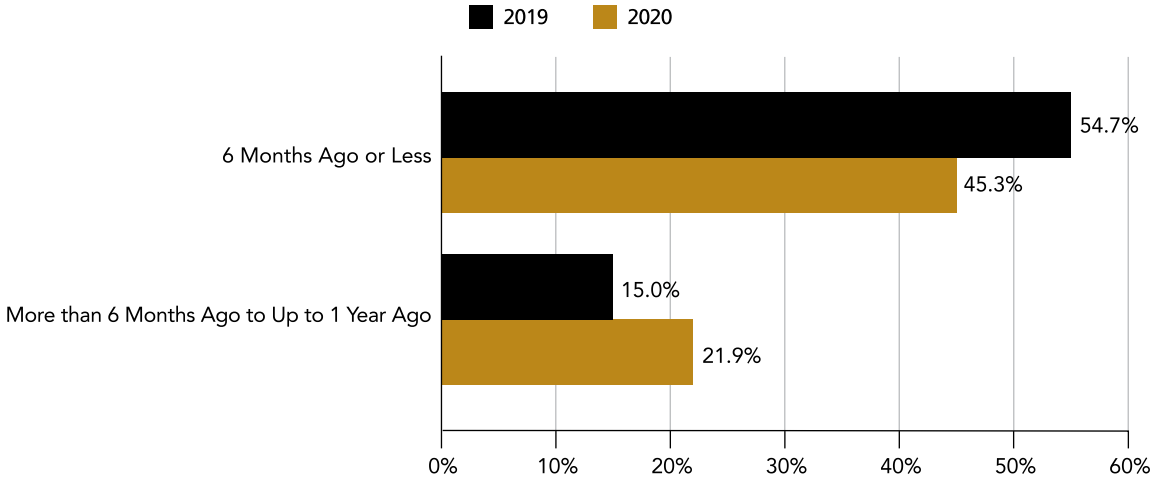
Cost of medical care and lack of insurance were major barriers to accessing care for many Californians amid COVID-19 pandemic and related concerns

Along with concerns about COVID-19, the cost of medical care and lack of insurance were still major obstacles for many Californians to accessing care in 2020 (Exhibit 5). Among those in the Latino population who had delayed or forgone care, 40% cited the cost of medical care or lack of insurance, and about 13.5% cited concerns about COVID-19. The percentages reporting the same two concerns as a reason for delaying or forgoing care were similar among the Black or African American population (31.9% for cost/lack of insurance, and 29.6% for COVID-19 concerns) and the Asian American population (30% and 21.5%, respectively).

Fewer Californians, regardless of age, had visited a dentist as recently as six months ago or less in 2020

Amid the COVID-19 pandemic, decreases in utilization of other types of care, such as dental visits, were also observed. Of all California adults in 2020, 45.3% had seen a dentist six months ago or less—a drastic decrease from 2019, when 54.7% had reported visiting the dentist within that time span (Exhibit 6). In 2020, 21.9% of adults had visited a dental clinic more than six months and up to a year ago, a large increase from 15% of adults in 2019. These changes were also seen among children (ages 3–11 and under 3, with teeth) and adolescents (ages 12–17). The percentage of children who had had their last dental visit six months ago or less dropped from 72.8% in 2019

Exhibit 6 **Time Since Last Dental Visit by Percentage of Adults (18+) in California, 2019 and 2020**



Sources: 2019 and 2020 California Health Interview Surveys

to 59.2% in 2020 (Appendix A11), while the percentage among adolescents decreased from 84% in 2019 to 66.1% in 2020 (Appendix A12). These decreases suggest that Californians, regardless of age, may have responded to the risk of COVID-19 infection or stay-at-home guidelines by delaying other types of care aside from medical care.

Discussion/Policy Implications

With record-high rates of health insurance, California has a window of opportunity to achieve universal health care coverage. However, the path to covering all Californians is not guaranteed without greater attention to those who remain without health insurance. About 2.3 million Californians were not insured in 2020; under current policies, many of these individuals will continue to be ineligible due to their citizenship status.[7] In addition, California faces tough decisions ahead as policies enacted to maintain and stabilize insurance markets and mitigate the negative effects of COVID-19 were conditional on California's being in a state of public health emergency.

The COVID-19 pandemic has worsened already existing disparities in health care access and will likely have negative consequences on health outcomes. At the same time, new policies and strategies were set in motion in response to the pandemic, and these may hold the key to improving and strengthening equity in health care access. One example is the broader use of telehealth in providing care, for which a greater range of questions will be featured in the 2021 CHIS. Moreover, lessons from the rollout of COVID-19 vaccines point to the critical need for equity-based public health interventions and the prioritizing of marginalized communities in order to improve access to care.[8]

Data Sources and Methods

This policy brief presents data from the 2019 and newly released 2020 California Health Interview Survey (CHIS), conducted by the UCLA Center for Health Policy Research.

In this brief, forgoing necessary medical care is defined as delaying care and not getting the necessary medical care eventually. To construct the estimate for forgoing care, the CHIS questionnaire asked respondents who had delayed or not gotten the medical care they felt they needed in the past 12 months whether they had gotten the care eventually. The term "COVID-19 or COVID-19 concerns" was aggregated based on open-ended responses concerning reasons for delaying or forgoing care in 2020. This brief utilizes the Office of Management and Budget (OMB) Department of Finance definitions of race and ethnicity when providing estimates on racial/ethnic groups. Estimates of the last dental visit for children were based on data for children ages 3–11 and children under 3 years who have teeth.

Author Information

Sean Tan, MPP, is a senior public administration analyst at the UCLA Center for Health Policy Research and currently works on the topics of health insurance and access to care with the California Health Interview Survey.

Funder Information

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CHIS california health interview survey

The California Health Interview Survey covers a wide array of health-related topics, including health insurance coverage, health status and behaviors, and access to health care. It is based on interviews conducted continuously throughout the year with respondents from more than 20,000 California households. CHIS interviews were offered in English, Spanish, Chinese (both Mandarin and Cantonese), Vietnamese, Korean, and Tagalog. CHIS is designed with complex survey methods requiring analysts to use complex survey weights in order to provide accurate variance estimates and statistical testing. CHIS is a collaboration of the UCLA Center for Health Policy Research, the California Department of Public Health, the California Department of Health Care Services, and the Public Health Institute. For funders and other information on CHIS, visit ***chis.ucla.edu.***

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Endnotes

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Denise Williams, of Adelanto, California, says the Inland Empire Health Plan, a county-run Medi-Cal managed-care insurer that covers her son, Markeano, does not coordinate effectively with his doctors or with another state agency that provides some of his care. (HEIDI DE MARCO / KHN)

MEDI-CAL MAKEOVER

California’s Reboot of Troubled Medi-Cal Puts Pressure on Health Plans

By Bernard J. Wolfson

Photos by Heidi de Marco

SEPTEMBER 21, 2021

When Denise Williams' baby boy was 2 months old, she became alarmed by a rattling sound in his lungs and took him to the emergency room. While undergoing treatment, he spiraled into a disabling neurological disorder.

Now 2 years old, Markeano is attached to breathing and feeding tubes. He can't walk or move his arms.

"If I want him to sit up, I have to sit him up. If I want him to play with a car, I've got to put his hand on the car and move it back and forth," said Williams, 38, who lives with Markeano, her four other children and her husband, Marcus, in Adelanto, California, a small city in the High Desert region of San Bernardino County.

Markeano is enrolled in the Inland Empire Health Plan, a county-run managed-care insurer that provides coverage under Medi-Cal, California's version of the federal Medicaid program for people with low incomes or disabilities. He also receives care through California Children's Services, which covers kids with serious conditions.

But Williams still finds it difficult to get her son the specialized care he needs. What's worse, neither his insurers nor his doctors take responsibility for managing his care, she said. "No one coordinates the care except for me."

Markeano has a severe neurological condition and is attached to breathing and feeding tubes. (HEIDI DE MARCO / KHN)

Poor care coordination is one of the many shortcomings of Medi-Cal, which covers over a third of the state's population and nearly 40% of children under 18. Advocates, patients and even the state auditor say Medi-Cal has failed to hold accountable the managed-care health plans that cover almost 12 million of its nearly 14 million enrollees.

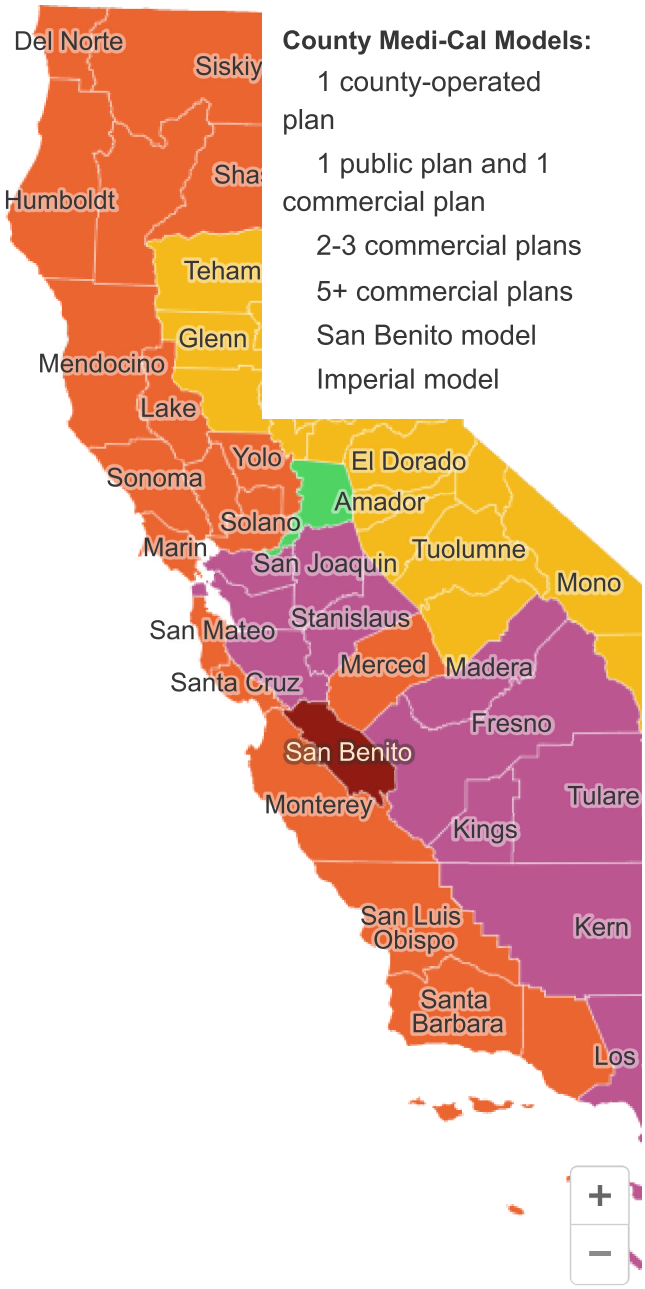
To remedy these failings, the state has begun an ambitious contracting process that aims to commit the health plans to better service. The state's exact strategy is unclear. But it is expected to result in new rules for Medi-Cal managed care. The nine commercial insurers, including giants Health Net, Anthem Blue Cross, and Blue Shield of California, will have to bid for new contracts intended to set more rigorous care standards. While their members account for fewer than one-third of managed-care enrollees, the companies have made nearly $3 billion from Medi-Cal since 2014.

Non-commercial plans like the Inland Empire Health Plan, which are established by county authorities, won’t have to submit bids, but they will be required to sign the new contracts.

“The state has had a lot of difficulty — because of skill and will — in managing and enforcing the terms of its existing contracts,” said Alex Briscoe, head of the California Children’s Trust and former director of Alameda County’s Health Care Services Agency. “This represents an opportunity not only to redesign the contracts but also to reimagine the state’s role in enforcing them.”

Medi-Cal Across the State

The way in which Medi-Cal is delivered to enrollees is complex and differs by county.



NOTE: Data as of July 2021. County models are based on California Department of Health Care Services classifications. (For more information about the models, click here.)

KHN

It's also an opportunity for the state to make a statement in selecting plans.

"Some are doing worse than others, and that should be taken into account in terms of decisions as the plans bid," said Edwin Park, a California-based research professor at the Georgetown University Center for Children and Families.

Jacey Cooper, California's Medicaid director, said the state's focus will be assuring that plans provide access to care and are committed to improving the outcomes of Medi-Cal beneficiaries.

The recontracting process is intertwined with an ambitious $6 billion experiment to move Medi-Cal beyond medicine into the realm of social services.

'Deficient Oversight'

Data shows that Medi-Cal plans are failing enrollees in many ways. Patients often have long waits or travel times for medical appointments, and get fragmented services and poor information about their care. Some communities of color, as well as rural residents, receive lower-quality service than others.

Faulty treatment hits the 4.6 million kids in managed-care Medi-Cal particularly hard because children need a lot of routine care, and many are not getting it. In July, close to 500 advocacy and provider groups sent a letter to the Department of Health Care Services, which runs Medi-Cal, urging it to make the managed-care plans improve pediatric care. "The deficiencies in the Medi-Cal managed care program contribute to health disparities for children across the state that can last a lifetime," they wrote. The new contracts, the letter said, should require health plans to fix the problem.

Federal law provides significant protection for all children in Medi-Cal and other state Medicaid programs. It requires coverage for regular checkups, immunizations, and other preventive and diagnostic care.

But state data shows that Medi-Cal managed-care plans often fail to meet these requirements. Only about one-quarter of infants and toddlers in Medi-Cal get the recommended number of well-child visits and screenings for developmental delays. The plans fall short on immunizations as well.

A 2019 report by the California State Auditor ranked California 40th among state Medicaid programs in use of preventive services by children.

The report blamed the state's poor performance on "deficient oversight of the managed care plans" and an insufficient number of health care providers willing to accept Medi-Cal's low payment rates.

"I don't see how we can have a high-performing Medi-Cal system that doesn't do well on those basic services for kids," said Mike Odeh, health policy director at Children Now, an Oakland-based advocacy group.

To be fair, Medi-Cal has had its share of successes, too, including early and robust expansion of enrollment under the Affordable Care Act, extension of coverage to large numbers of immigrants without legal documents, and pioneering programs that address not only medical and mental health but also the social and environmental circumstances of enrollees.

Nonetheless, Medi-Cal managed-care plans often earn poor to mediocre marks for the quality of their care. Meanwhile, the largest commercial plans have profited handsomely from the program, especially since the expansion of Medicaid in 2014. That helps explain why the rebidding process is such a sensitive matter for them. Health Net, Anthem Blue Cross, Molina Healthcare and Blue Shield of California all declined to discuss their bidding strategies with KHN.

Collectively, the commercial plans have generated $2.9 billion in net profits from Medi-Cal since fiscal year 2014, according to data provided by the state. Health Net, the state's largest commercial Medi-Cal insurer, with around 2 million enrollees, accounted for $2.1 billion of that amount. Anthem Blue Cross, the second-largest commercial Medi-Cal plan, with 1.3 million enrollees, accounted for $873 million.

An Anthem Blue Cross spokesperson noted that Medi-Cal managed-care plans are required by law to spend at least 85 cents of every dollar on medical care or efforts to improve care. That, along with other factors, limits the health plans' profits, he said.

Kaiser Permanente, which is at or near the top of Medi-Cal quality scores, has lost money in the program every year since 2014 — and before that, too.

Health Net and Anthem Blue Cross get poor to mediocre marks on key pediatric services in many counties, according to state data. Health Net Medi-Cal plans in Sacramento, Kern, Stanislaus and San Diego counties, for example, were at or near the bottom of the pack in timeliness of pediatric appointments.

A Health Net spokesperson said the company has improved over the past two years and now outperforms its competitors on state quality indicators in nine of the 13 counties where it operates.

The 2019 state audit, citing earlier concerns about incomplete and inaccurate reporting, noted that the integrity of the state's quality data can be hard to assess.

And non-commercial plans often have low scores, too. "Quality is stubbornly low across all plans in Medi-Cal. Nobody gets a pass here," said Cary Sanders, senior policy director at the California Pan-Ethnic Health Network.

The state rarely holds any of the plans fully to account, advocates and Medi-Cal experts say. The Department of Health Care Services started imposing financial penalties for poor quality only in 2017, and since then it has levied only two such fines: one against Health Net for $335,000 and one against the publicly run Health Plan of San Joaquin for $135,000.

The department does require subpar performers to devise so-called corrective action plans, but critics say they rarely produce significant improvement.

Even if enforcement were effective, the standards for Medi-Cal plans are too low, advocates say. Until 2019, insurers needed to be only in the 25th percentile of Medicaid plans nationally to avoid corrective action. The department raised the bar to the 50th percentile in 2019 but has not enforced it so far because of the covid-19 pandemic.

The department next year will begin penalizing any health plan that "fails to exceed, rather than just meet" the minimum performance level on any measure, said Cooper, the state's Medicaid chief. It will do so every year, rather than target only persistently poor performers, she said.

Williams is saddled with hours of legwork to find care for Markeano, whether speech, swallowing and cognitive therapy or extra oxygen tanks to make sure he doesn't run out during long car trips to see his doctors. (HEIDI DE MARCO / KHN)

Pay for Performance

In June, the Department of Health Care Services released preliminary details on the bidding process, outlining some of the new requirements. It expects to issue more details by year's end but won't announce plan selections until the end of 2022. The new contracts are slated to take effect Jan. 1, 2024.

But will the state lean hard enough on the plans? Based on the documents released so far, this could be a "potential missed opportunity," said Sanders. "There aren't enough teeth here to improve health plan accountability."

Other advocates cite what they say has been a cozy relationship between health plans and the state. "I just think the whole delivery system has historically been filled with a lot of politics, favoritism, good old boys," said

Isabel Becerra, CEO of the Coalition of Orange County Community Health Centers, whose members provide Medi-Cal services in the county.

Some advocates and analysts say the best way for the state to hold the managed-care plans' feet to the fire is to tie the fixed monthly rates it pays them to their performance on a number of measures, including preventive services and health equity.

"If you want to change how they work, you have to change the incentives that drive them," said Briscoe, of the California Children's Trust.

Medicaid chief Cooper said her staff is working to link payment to quality and health equity.

Some advocates say the state should withhold payments from poorly performing plans. The plans, however, would prefer being rewarded for exceeding expectations to being dinged for failing to meet them.

A Communication Breakdown

The rebidding process is expected to reduce the number of insurance companies participating in Medi-Cal — and some experts say that's a good thing.

"The idea of competition is you're supposed to be competing on the basis of quality, but if there are too many choices beneficiaries aren't able to discern the differences," said Georgetown University's Park.

In some regions, the Medi-Cal health plans that contract directly with the state outsource care and administrative tasks to other plans or physician groups. L.A. Care, for example, farms out enrollees to subcontractors such as Kaiser Permanente, Anthem Blue Cross and Blue Shield of California. The Department of Health Care Services says that in evaluating the bids it will look favorably on health plans that commit to keeping closer tabs on their subcontractors.

The state reports quality scores only for plans with which it contracts directly, and their data can be skewed by wide variation in the performance of the subcontractors.

Moreover, the divided responsibility between health plans and their subcontractors can confuse beneficiaries.

"The subcontractor says, 'No, call the plan' — and the plan says, 'Call the subcontractor,' and there's really no accountability," said Abigail Coursolle, a senior attorney at the National Health Law Program in Los Angeles.

The Williamses installed a disinfectant dispenser in the kitchen to help protect Markeano from infections. (HEIDI DE MARCO / KHN)

Denise Williams faces a similar problem. She said the Inland Empire Health Plan does not communicate effectively — or at all — with California Children's Services or Markeano's doctors. As a result, she is saddled with hours of

legwork to find care for her son, whether speech, swallowing and cognitive therapy or extra oxygen tanks to make sure he doesn't run out during long car trips to see his doctors.

"They tell me, 'Your pediatrician or neurologist should be doing this.' Then when I talk to the pediatrician and the neurologist, they say, 'Talk to your insurance,'" Williams said. "So it's like, 'I already talked to you guys. Can't you guys talk to each other — or can we get on a three-way? Because this is draining. I've got a kid that I need to take care of.'"

Inland Empire Health acknowledged the gaps in coordination among managed-care plans, California Children's Services and providers, saying it was "eager to embrace the care coordination improvements" that the state says it will require. The new contracts also will require plans to address some of the nonmedical problems that can compromise health, such as inadequate housing, unclean air and water, and food insecurity.

In addition to being predominantly poor, over two-thirds of Medi-Cal enrollees are from non-white communities that have historically been socially and economically marginalized — which is why the state says it will put a high priority on reducing health care inequities.

Denise Williams, who is Black, wonders if her travails are related to long-standing inequities.

"Sometimes I don't know if it's because of my color or what," she said. "I try to remain calm at all times, so that way it's not a stereotype of an angry Black lady or whatever. But at the same time, I'm my kid's only advocate, so if I never say nothing, my kid would just be lying in the bed all day."

California Healthline correspondent Angela Hart contributed to this report.

This story was produced by KHN, which publishes California Healthline, an editorially independent service of the California Health Care Foundation.

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The End of the COVID Public Health Emergency: Potential Health Equity Implications of Ending Medicaid Continuous Coverage

Patricia Boozang and Adam Striar, Manatt Health

Medicaid enrollment has increased by over 10 million (or 15 percent) from February 2020 through February 2021 across all states since the outbreak of the COVID-19 pandemic.[1] A significant contributor to these gains in coverage is the Families First Coronavirus Response Act (FFCRA) "continuous coverage" requirement, which limits the ability of states to disenroll individuals from Medicaid. Following the end of the federal public health emergency (PHE), states will no longer be subject to this requirement, which could potentially result in widespread disenrollments from Medicaid and jeopardize health care coverage and access for millions of low-income individuals.

States have a clear imperative to center health equity as they plan for the end of the PHE given that Black, Latino/a, and other people of color are most at risk of coverage loss. People of color are overrepresented in the Medicaid program and are more likely to experience volatility and instability in employment and housing as a result of longstanding, structural racism, thus increasing the chances that these individuals could lose coverage for administrative reasons at the end of the PHE. This comes as Black and Latino/a individuals are experiencing the worst impacts of the pandemic–Black and Latino/a individuals are more than twice as likely to have been hospitalized or to have died as a result of complications from COVID-19.[2] Maintaining coverage is critical to ensuring access to care during the ongoing pandemic, including for deferred care for chronic conditions. In order to optimize coverage retention and access to health care at the end of the PHE, state and federal leaders need to be working now to employ a range of strategies that streamline and improve their redetermination processes. This expert perspective highlights the urgency and specific recommendations for states to retain coverage gains for Medicaid-eligible individuals at the end of the PHE, and ensure that coverage retention efforts include an equity focus.

Background

Passed by Congress in March 2020, FFCRA was intended, in part, to shore up state finances by temporarily increasing the federal share of Medicaid funding for states. To protect health coverage during the pandemic, states were prohibited from disenrolling individuals from Medicaid for the duration of the federal PHE as a condition of acces the enhanced funding. This "continuous coverage" requirement extends from March 18, 2020, through the end of

month in which the PHE ends.[3] In January 2021, the Biden administration announced that the PHE will likely remain in place through the entirety of 2021, meaning the continuous coverage requirement will likely remain in effect at least through the end of this year.[4]

In a typical annual redetermination process, some number of enrollees lose Medicaid coverage due to changes in circumstances that impact eligibility (e.g., income increases). More commonly, Medicaid eligible people "churn" at redetermination–or lose coverage as a result of administrative barriers like a lack of online options for renewing coverage, complicated paperwork and documentation processes, and personal circumstances that prevent individuals from responding to a renewal request on time (these challenges are particularly acute for individuals with significant health needs). Evidence suggests that churn–and not external factors like an improving economy driving income ineligibility for Medicaid–have been the primary sources of Medicaid enrollment decreases in recent years.[5] The FFCRA continuous coverage requirement effectively eliminates churn in Medicaid for the duration of the PHE.[6][7]

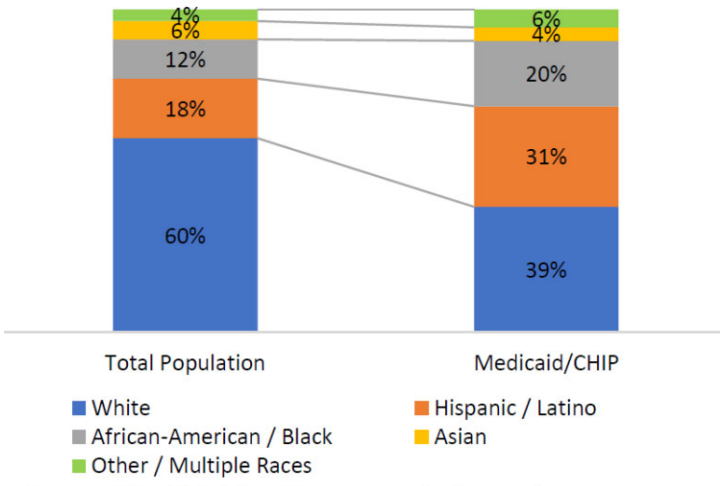
Following the expiration of the PHE, states will resume normal eligibility and enrollment activities and begin to redetermine Medicaid eligibility for all enrollees, some of whom have not had to go through this process in nearly two years (including some who have never had to redetermine their Medicaid eligibility because they enrolled during the pandemic or shortly before it began). The Centers for Medicare & Medicaid Services (CMS) released guidance that describes timelines and obligations for states to restart eligibility and enrollment activities following the end of the PHE. This guidance attempts to help mitigate coverage disruptions by giving states 12 months to complete the "PHE unwinding" process and requiring robust consumer communication, among other strategies.[8] CMS has reiterated that states should pursue eligibility and enrollment strategies that promote continuity of coverage and ensure that enrollees have ample time to respond to requests.

But there is still considerable risk of coverage loss following the end of the PHE due to the coverage churn that is so prevalent in Medicaid, despite the fact that the vast majority of people enrolled in Medicaid at the end of the PHE are likely to remain eligible for Medicaid or be eligible for subsidized ACA Marketplace coverage. Black, Latino/a and other people of color enrolled in the Medicaid program face disproportionate risk of loss of coverage due to churn.

Implications of the End of the PHE for People and Communities of Color

Large scale disruption in health coverage as a result of the expiration of the federal PHE will have disproportionate impact on Black, Latino/a, and other people of color, who are significantly overrepresented in state Medicaid programs. Despite making up less than a third of the total United States population in 2019, more than half of Medicaid and CHIP enrollees were Black or Latino/a. (See Figure 1.) Since Black, Latino/a and other people of color make up the largest share of Medicaid enrollees, they will necessarily bear the most significant impact of any large-scale coverage losses at the end of the PHE.

Figure 1: U.S. Total Population vs. Medicaid/CHIP Enrollees by Race/Ethnicity, 2019



Source: http://statehealthcompare.shadac.org/

(https://www.shvs.org/wp-content/uploads/2021/09/Table-1-1.png)

Longstanding, structurally racist policies and practices in the United States have created an environment where Black, Latino/a and other people of color experience a significantly greater degree of volatility in employment and housing – conditions that will exacerbate the coverage impacts at the end of the PHE. Even before the pandemic, Black and Latino/a individuals were more likely to work in service sector professions and experience a greater degree of month-to-month income volatility.[9] This is largely driven by historical and ongoing discrimination in employment, education, and other social systems.[10] Black and Latino/a individuals are also significantly less likely to own their homes and more likely to face steep rental costs, which has its roots in myriad historical and ongoing racist policies excluding people of color from desirable housing (e.g., "redlining").[11] Black, Latino/a and other people of color have borne the worst economic impacts of the pandemic. While the unemployment rate in 2020 increased by only 1.8 percentage points for white individuals, it increased by 3.2 and 3.5 percentage points for Black and Latino/a individuals, respectively.[12] Additionally, recent Census data suggest that the pandemic has only exacerbated housing instability among people of color.[13]

These economic and housing impacts put Black, Latino/a, and other people of color at disproportionate risk of losing their health coverage at the end of the PHE. Changes in circumstances related to employment, income, and housing heighten the risk of individuals losing coverage as a result of churn. Medicaid agencies will face greater challenges in accessing the necessary income data to automate redetermination of eligibility for individuals with volatile employment situations, and will therefore be more reliant on sending paper notices requesting enrollee income information. Individuals who have experienced changes in employment face greater challenges in verifying their income. Additionally, Medicaid agencies will face challenges in locating enrollees who have moved or are newly experiencing homelessness to make them aware of redetermination requirements and request any necessary eligibility information.

Centering Equity in Planning for the End of the PHE

PHE unwinding and potential implications for coverage losses are a looming health equity issue. Accordingly, it will be critical for state and federal policymakers to take steps to ensure continuity of coverage and minimize disenrollment of Medicaid-eligible individuals following the end of the PHE and to ensure that redetermination efforts include an equity focus. States can deploy a variety of strategies to maximize coverage retention including:

- Launching a robust communications plan to leverage paid media, social media, consumer noticing, and partnership with community-based organizations to spread the word about upcoming Medicaid renewal requirements
- Engaging through a community-based approach with trusted messengers and community-based assisters to do outreach and assistance
- Leveraging managed care plans to engage in outreach and assistance activities through a community-based approach
- Collaborating with and funding navigators and assisters for outreach and renewal assistance
- Updating state IT systems to leverage the widest possible range of data to automate renewals
- Ensuring that paper forms are only used when required, and are simple, and pre-populated
- Employing a broad outreach strategy and opportunities to update address information
- To the extent they are found ineligible for Medicaid, ensuring that individuals are transferred to a state-based marketplace or Healthcare.gov for subsidized Marketplace coverage.

State Health and Value Strategies will be producing a variety of products and programming to support states as they plan for their PHE coverage transition. While the exact end date of the PHE is not currently known, what is known is that robust and immediate planning efforts by state and federal leaders are critical for ensuring that the end of the PHE does not exacerbate already widespread racial and ethnic disparities in the American health care system. At the same time, efforts to improve coverage retention post-PHE can have significant benefit on the broader public health by improving health care coverage and access for the population overall.

[1] https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360 (https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360)

[2] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html (https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html)

[3] FFCRA § 6008

[4] https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf (https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf)

[5] https://familiesusa.org/wp-content/uploads/2019/09/Return_of_Churn_Analysis.pdf (https://familiesusa.org/wp-content/uploads/2019/09/Return_of_Churn_Analysis.pdf)

[6] https://www.cbpp.org/research/health/continuous-coverage-protections-in-families-first-act-prevent-coverage-gaps-by#:~:text=The%20continuous%20coverage%20provision%20does,experience%20fluctuations%20in%20their%20earnings (https://www.cbpp.org/research/health/continuous-coverage-protections-in-families-first-act-prevent-coverage-gaps-by#:~:text=The%20continuous%20coverage%20provision%20does,experience%20fluctuations%20in%20their%20earnings)

[7] https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/ (https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/)

[8] https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf (https://www.medicaid.gov/federal-policy-guidance/downloads/sho-21-002.pdf)

[9] https://home.uchicago.edu/~j1s/RDFO_4_2020.pdf (https://home.uchicago.edu/~j1s/RDFO_4_2020.pdf)

[10] https://www.epi.org/publication/swa-2020-employment-report/ (https://www.epi.org/publication/swa-2020-employment-report/)

[11] https://www.urban.org/urban-wire/new-data-suggest-covid-19-widening-housing-disparities-race-and-income (https://www.urban.org/urban-wire/new-data-suggest-covid-19-widening-housing-disparities-race-and-income)

[12] https://www.epi.org/indicators/state-unemployment-race-ethnicity/ (https://www.epi.org/indicators/state-unemployment-race-ethnicity/)

[13] https://www.urban.org/urban-wire/new-data-suggest-covid-19-widening-housing-disparities-race-and-income (https://www.urban.org/urban-wire/new-data-suggest-covid-19-widening-housing-disparities-race-and-income)

SOA Research Institute

Health Care Cost Trends

“Uninsured Rate” Measurements and Health Policy Considerations

September 2021

“Uninsured Rate” Measurements and Health Policy Considerations

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"Uninsured Rate" Measurements and Health Policy Considerations

Executive Summary

The Patient Protection and Affordable Care Act (ACA) was signed into law March 23, 2010. The transformative health care legislation was multi-faceted, but its primary purpose was to reduce the number of uninsured Americans. Like other federal and state policies proposed in the 21st Century, the ACA's primary devices include government funding, prescriptive rating rules, and insurance mechanisms (e.g. risk adjustment) to mitigate risk and encourage insurer participation. While numerous challenges have been recognized in the law's first decade, the ACA has resulted in more people being enrolled in newly expanded Medicaid markets. The private individual market also has somewhat higher enrollment, but significantly less than original expectations; recent changes in labor economics, market mechanics, and the regulatory environment signal potential renewed growth in this market which may impact health insurance enrollment results.

The individual market has remained at the center of regulatory activity and in the foreground of public discussion due to market challenges and changes in political leadership. Market observers are quick to report on its statistical results and connect outcomes to the success or failure of specific policies and/or administrative program management. Success measurement can take many forms,[1] but the "uninsured rate" is the most common metric cited to measure overall ACA performance; while lacking a reliable population standard and measurement technique, the "uninsured rate" refers to the percentage of Americans who do not have health insurance.

The suboptimal precision of the "uninsured rate" determination stems from various established organizations and survey respondents having different standards of what specifically qualifies as "health insurance coverage". The recent expansion of short-term limited duration plans (generally with more limited benefits) and reductions in enrollment of ACA-compliant coverage is a notable example of potential differentiation in uninsured rate trends. The Census Bureau reports that many individuals have difficultly reporting whether their coverage is "direct purchase" or procured through their employer; distinguishing between qualifying and unqualified types of individual coverage is certainly a more significant and error-prone challenge.[2] Also, time horizon is a distinguishing consideration; a periodic gap between losing group coverage and procuring individual coverage may or may not be reasonably construed as counting toward a population measure of uninsured status. Additionally, changes in the measured uninsured rate may not align with changes in personal risk exposure as some individuals may have access to coverage when needed but are currently uninsured; for example, Medicaid benefits are often retroactively accessible.

[1] Fann, Greg. July 2019. Annual Ranking of The ACA's First Decade. *In the Public Interest*. Annual Ranking Of The ACA's First Decade (soa.org)
[2] State Health Access Data Assistance Center. October 22, 2020. September 23rd Webinar - An Annual Conversation with the U.S. Census Bureau: 2019 Health Insurance Coverage Data from the American Community Survey (ACS) & Current Population Survey (CPS). September 23rd Webinar - An Annual Conversation with the U.S. Census Bureau: 2019 Health Insurance Coverage Data from the American Community Survey (ACS) & Current Population Survey (CPS) | SHADAC

While different measurement techniques are applied, directional changes in uninsured rate calculations are often used as a primary source to gauge the impact of ACA policy, the administrative management of the program, and the impact of subsequent regulations. Consequently, appropriate comprehension of the uninsured rate is an important measure as it shapes the direction of future policy.

Various public and private sources attempt to assess the uninsured rate, usually on an annual reporting cycle. Results between publications vary, but there is consensus agreement that the uninsured rate significantly declined during the ACA implementation and transition period (2014-2016) but has slowly and modestly increased since 2016. It is generally acknowledged that the economic downturn and reductions in employer-sponsored insurance coverage associated with the COVID-19 pandemic have accelerated the increase in the uninsured rate, albeit not as significant as originally anticipated. As reporting is lagged, the precise impact of COVID-19 is not known, but it is evident that enrollment in Medicaid programs has increased while coverage in employer-sponsored insurance has declined. The pandemic has also necessitated logistical changes in survey collection methods, resulting in reduced response rates and potential declines in measurement accuracy.

Looking ahead, 2021 premium subsidy enhancements in the individual market- often the "insurer of last resort"- are expected to commence a return to a declining uninsured rate environment. Transparent parameter changes in the American Rescue Plan Act (APRA)[3] have been widely acknowledged in the public sphere and complement the less-understood and still-developing[4] favorable mechanical market changes[5] which have increased subsidy-determining benchmark plan premiums relative to other benefit plans that consumers purchase in the marketplace. The impact of enhanced subsidies on federal spending and the uninsured rate will be of significant interest to stakeholders in assessing policy impact and will likely serve as a basis for the efficacy of the current framework versus long-promoted public considerations and other private market configurations. Accuracy of reporting estimates and appropriate understanding of results are critical requirements.

In alignment with the SOA's Strategic Plan objective to "inform the public's understanding of key societal issues", this report examines the various publications reporting on the uninsured rate which stakeholders frequently access to measure policy efficacy and inform future policy considerations. A key aim of this research is to highlight the diverse sources and methods used in various reports and guide stakeholders to properly interpret reported results. This research also explores regulatory and market dynamics in recent years and a focus expansion from measurements of the uninsured rate to the rationale of Americans remaining uninsured and likely pathways to broader insurance coverage.

[3] McDermott, Daniel, Cox, Cynthia, and Amin, Krukita. March 15, 2021. Impact of Key Provisions of the American Rescue Plan Act of 2021 COVID-19 Relief on Marketplace Premiums. *KFF Health Reform*. Impact of Key Provisions of the American Rescue Plan Act of 2021 COVID-19 Relief on Marketplace Premiums | KFF

[4] Dorn, Stan, Fann, Greg, and Markus, Hannah. April 12, 2021. Misalignment Between Premiums and Coverage Generosity Imposes Heavy Cost Burdens on Consumers in Health Insurance Exchanges. *Axene Health Partners, LLC and Families USA*. Misalignment Between Premiums and Coverage Generosity Imposes Heavy Cost Burdens on Consumers in Health Insurance Exchanges – Axene Health Partners, LLC (axenehp.com) Misalignment between Premiums and Coverage Generosity Imposes Heavy Cost Burdens on Consumers in Health Insurance Exchanges - Families Usa

[5] Fann, Greg. October 21, 2020. Cheaper by the Dozen: 12 Years of the Affordable Care Act. *LinkedIn Pulse*. (1) Cheaper by the Dozen: 12 Years of the Affordable Care Act | LinkedIn

Section 1: Uninsured Rate Reporting

Throughout each year, various published reports are released which contain estimates of the number of people without health insurance. News articles usually follow and often contain the high-level results of the published reports and a comparison to prior year results; such articles often mention the reported statistics in relation to other recent reports. The summarized stories rarely include the methodology and caveats embedded in the research reports. This can lead to an incomplete understanding of results.

As an understanding of health insurance coverage trends is paramount to policy considerations, an appropriate understanding of the uninsured rate is obligatory. Improper comprehension of the uninsured rate is a real danger which may misinform stakeholders of the implications of current policy and potentially lead to the development of misguided policy. Misinterpretation of results may be due to confirmation bias and selective reporting, recency bias,[6] or time constraints prohibiting a complete review of reporting of the uninsured rate. This section describes the various uninsured reports which may influence health policy considerations.

1.1 CURRENT POPULATION SURVEY ANNUAL SOCIAL AND ECONOMIC SUPPLEMENT (CPS ASEC)

The CPS ASEC is an annual survey report that the U.S. Census Bureau has produced since 1987. It is one of the most widely used sources of U.S. health coverage statistics. The survey questions are rich in detail and cover social and economic characteristics of each person. Detailed income data is collected, enabling the relation of economic status to changes in health insurance coverage.

The CPC ASEC is conducted in February through April each year, with questions asked about health coverage at any time during the previous calendar year. Effectively, a respondent insured for only a few days during the year would be counted as "covered" and not uninsured. Beginning in 2013, the CPS ASEC also asks about coverage at the time of interview.

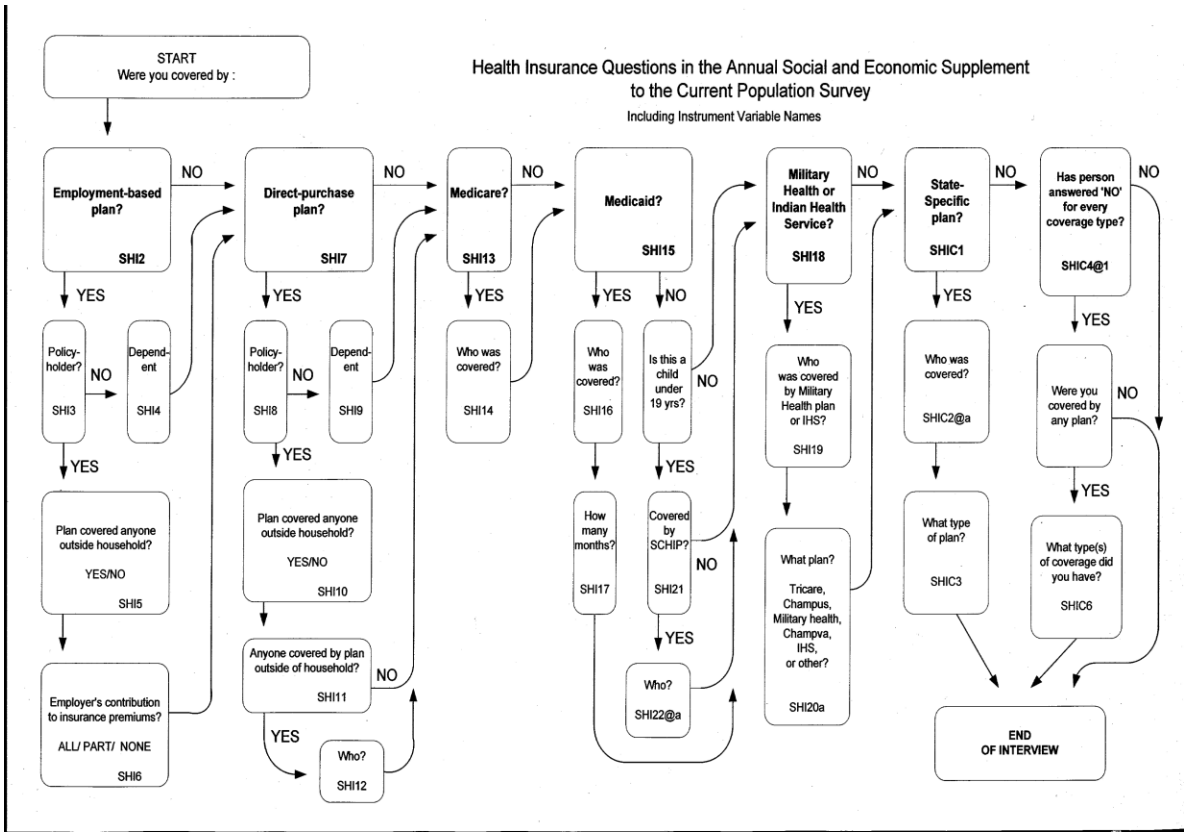
Due to its relatively small sample size of about 60,000, the CPS ASEC is better suited for national measurements rather than analysis of selected local markets or comparisons between states. The CPS ASEC has undergone methodology changes which complicate the analysis of longitudinal studies. In 2014, the questionnaire was redesigned to improve measurements; it 2019, the processing system and underlying algorithms were updated.

Due to the COVID-19 pandemic, data collection methods for the 2019 CPS were modified.[7] For safety reasons, in-person interviews were suspended and shifted to telephone interviews. The response rate declined about 10 percentage points in March and respondents were skewed toward being older, having a higher education level, and more likely to have a disability. Based on limited response mechanisms, respondents are also believed to have higher incomes. Technical adjustments were applied, but the 2019 report (published September 2020) should be utilized with greater caution given the unique circumstances, and data users should bear in mind the context of the pandemic when interpreting these changes.

[6] More recent reports are often regarded in the news cycle as more recent and valuable, regardless of accuracy and measurement period.
[7] Berchick, Edward R., Mykata, Laryssa, and Stern, Sharon M. September 15, 2020. The Influence of COVID-19-related Data Collection Changes on Measuring Health Insurance Coverage in the 2020 CPS ASEC. *United States Census Bureau*. COVID-19 and Measuring Health Insurance Coverage in the 2020 CPS ASEC (census.gov)

The robust survey questionnaire defines "Direct-purchase" as "coverage purchased directly from an insurance company or through a federal or state marketplace".[8] Respondents have personal liberty to determine whether limited coverage benefits (e.g. short-term limited duration plans) qualify as Direct-purchase coverage. Figure 1 displays a flow chart[9] illustrating the series of questions asked to survey respondents.

Figure 1
CPS ASEC QUESTIONAIRE FLOW CHART



1.2 AMERICAN COMMUNITY SURVEY (ACS)

Since 2008, the ACS has served as a second annual health insurance survey from the U.S. Census Bureau. The CPS ASEC and the ACS are released in September and provide prior year results. The ACS has a significantly larger sample size which allows coverage estimates at a regional level; the CPS ASEC is primarily used for national results, and most granularly applied at the state level.[10] This ACS provides a larger sample size than other surveys and is the best source for local level measurements. Consistent ACS reporting allows historical comparisons from 2008 through 2019.

[8]Keisler-Starke, Katherine and Bunch, Lisa N. September 2020. Health Insurance Coverage in the United States: 2019. *United States Census Bureau.* Health Insurance Coverage in the United States: 2019 (census.gov)
[9] Current Population Survey Annual Social and Economic Supplement (CPS-ASEC). September 10, 2019. *United States Census Bureau.* https://www.census.gov/topics/health/health-insurance/guidance/cps-asec.html
[10] Due to sample size, state-level estimates using the CPS ASEC are computed using a three-year average.

ACS survey data is collected throughout the year. Health coverage at the time of interview is assessed; naturally, the ACS reported uninsured rate is higher than the CPS ASEC at any time during the previous calendar year measure. While each CPS ASEC respondent is personally contacted by visitation or telephone, many ACS respondents reply via the Internet or through completion of a paper form. Less detailed information is gathered through the ACS. With a notable exception of the most recent reports, the CPS ASEC and the ACS have generally produced directionally consistent and similar changes in the uninsured rate each year. CPS ASEC showed the uninsured rate declining while the ACS showed an increase in 2019; as mentioned, the recent CPS ASEC results should be interpreted with greater caution because of the data collection interruptions due to COVID-19.

Like the CPS ASEC, the ACS questionnaire defines "Direct-purchase" without coverage specificity as "insurance purchased".[11] Respondents may decide whether non-ACA compliant insurance coverage qualifies. The ACS may underreport Medicaid coverage as other surveys (CPS, NHIS, MEPS) use more familiar state-specific names. Figure 2 displays the health coverage questions asked of survey respondents.

Figure 2
ACS QUESTIONAIRRE

16. Is this person CURRENTLY covered by any of the following types of health insurance or health coverage plans? Mark "Yes" or "No" for EACH type of coverage in items a – h.

a. Insurance through a current or former employer or union (of this person or another family member)

b. Insurance purchased directly from an insurance company (by this person or another family member)

c. Medicare, for people 65 and older, or people with certain disabilities d. Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability

e. TRICARE or other military health care

f. VA (enrolled for VA health care)

g. Indian Health Service

h. Any other type of health insurance or health coverage plan – Specify.

1.3 NATIONAL HEALTH INTERVIEW SURVEY (NHIS)

The NHIS is an annual report developed by the Center for Disease Control's National Center for Health Statistics. The survey is intended to provide estimates on a wide range of health measures for the civilian noninstitutionalized population. The NHIS estimates are national. The NHIS produced partial state-level estimates of the uninsured rates until 2019 but stopped doing so in conjunction with a reduced sample size.

The NHIS questionnaire was redesigned in 2019. Accordingly, data users are cautioned to apply direct comparisons between estimates for 2019 and earlier years. A working paper[12] entitled "Preliminary

[11] The American Community Survey. *United States Census Bureau.* The American Community Survey 2020 Questionnaire (census.gov)
[12] Preliminary Evaluation of the Impact of the 2019 National Health Interview Survey Questionnaire Redesign and Weighting Adjustments on Early Release Program Estimates. May 2020. *National Health Insurance Survey*. Preliminary Evaluation of the Impact of the 2019 National Health Interview Survey Questionnaire Redesign and Weighting Adjustments on Early Release Program Estimates (cdc.gov)

Evaluation of the Impact of the 2019 National Health Interview Survey Questionnaire Redesign and Weighting Adjustments on Early Release Program Estimates" discusses these changes.

Most NHIS reports are branded as "Early Release", signifying the desire to provide timely estimates before the release of final annual microdata files. These reports are published prior to final editing and final weighting to provide timely access to results.

The NHIS Early Release Program also includes quarterly estimates. As most uninsured rate reporting is on an annual cycle, these quarterly reports provide the most frequent updating of changes in the uninsured rate. Data users need to be aware of seasonal changes in the uninsured rate before drawing conclusions.

The common NHIS measure is a point in time estimate, although "uninsured for the Entire Year" information is also collected.

1.4 MEDICAL EXPENDITURE PANEL SURVEY HOUSEHOLD COMPONENT (MEPS-HC)

The MEPS-HC report is produced by the Agency for Healthcare Research and Quality (AHRQ). The AHRQ, like the CDC, is a division of the Department of Health and Human Services. Many stakeholders are familiar with "MEPS" from MEPS-IC, with "IC" referencing "Insurance Component". The MEPS-IC is a report of insurance coverage through private and public-sector employers.

The MEPS-HC includes data from individual and families represented in the prior year's NHIS. The MEPS-HC results are lagged an additional year relative to other reports when published and generally attract less attention.

1.5 HEALTH REFORM MONITORING SURVEY (HRMS)

The HRMS is an Urban Institute research program designed to monitor ACA dynamics before federal government surveys are available. The HRMS utilizes questions from federal government surveys and results are compared to federal data. The Urban Institute highlights that nongovernmental surveys are necessary to supplement federal survey to expedite understanding of emerging results. While recognizing the value of federal surveys, the Urban Institute notes that "the time lag between data collection and release means little information has been available as major provisions of the law have been implemented in 2014 and early 2015, an important window of opportunity to make policy and programmatic changes that could improve the law's effectiveness".[13]

HRMS data is collected quarterly. Unlike the federal surveys, the output is data available to researchers rather than a formal report. Various measures can be gleaned to report on emerging ACA dynamics.[14]

1.6 NATIONAL HEALTH AND WELL-BEING INDEX (GALLUP)

Gallup, Inc. is a private analytics company widely known for public opinion polling. Since 2008, Gallup has produced the National Health and Well-Being Index. The survey "provides an in-depth view of Americans' wellbeing and offers insights into their attitudes and behaviors at the national, state and community

[13] Karpman, Michael, Long, Sharon K., and Michael Huntress. March 2015. Nonfederal Surveys Fill a Gap in Data on ACA. *Urban Institute*. Nonfederal Surveys Fill a Gap in Data on ACA (urban.org)

[14] Long, Sharon K., Bart, Lea, Karpman, Michael, Shartzer, Adele, and Zuckerman, Stephen. September 2017. Sustained Gains In Coverage, Access, And Affordability Under The ACA: A 2017 Update. *Health Affairs*. Sustained Gains In Coverage, Access, And Affordability Under The ACA: A 2017 Update | Health Affairs

levels".[15] Larry Levitt of the Kaiser Family Foundation (KFF), an organization that closely tracks the uninsured rate,[16] characterizes Gallup's survey to the federal surveys as "Gallup generally has the most current data on insurance coverage, and it's a large survey. Government surveys measure insurance coverage more precisely with a long series of questions, but results are lagged."[17] While generally on an annual cycle, Gallup's most recent reporting of the uninsured rate was published in January 2019 and reflected insurance coverage in the fourth quarter of 2018.

1.7 COMMONWEALTH FUND SURVEYS

This Commonwealth Fund ACA Tracking survey tracks ACA implementation. The most recent report was released in May 2018. The Commonwealth Fund Biennial Health Insurance survey assesses the uninsured rate every two years. Additionally, the survey assesses underinsurance, which the Commonwealth Fund believes is a measure of deductibles and out-of-pocket limits relative to income.

1.8 CONGRESSIONAL BUDGET OFFICE (CBO) REPORTS

The CBO is a federal agency that supplies Congress with nonpartisan budget and economic information. The CBO provides independent analyses to support the Congressional budget process and develops reports and cost estimates for proposed legislation, often upon request from Congress. In addition to reporting on the uninsured rate, the CBO projects the future uninsured rate in the process of assessing the implication of various policies. Most CBO reports are ten-year projections with annual results.

In a 2019 report,[18] the CBO explained the agency's view of what constitutes health insurance coverage. The definition of coverage has always been a challenge. Many of the uninsured rate reports ask respondents if they had insurance, sometimes from time periods predating the interview by a year. Survey results are necessarily dependent on respondents' views of what meets the definition of health insurance.

The CBO's definition of private insurance coverage is designed to include what industry stakeholders generally regard as comprehensive major medical coverage. Interestingly and perhaps more challenging for measurements, some short-term, limited-duration policies "are included in CBO's definition of private insur-ance if they provide major medical coverage".[19]

Short-term, limited-duration policies are of particular interest as their popularity grew during the first three years of ACA markets. They were particularly comparatively attractive to relatively healthy individuals who did not qualify for ACA premium subsidies. Aware of their growth, President Obama limited their duration to three months. President Trump later expanded their flexibility. While enrollment reporting of short-term limited-duration policies is very weak unlike ACA markets, it is believed that growth has been significant in recent years. The inclusion or exclusion of short-term limited-duration policies could determine whether the insured rate is increasing or declining.

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[15] How Does the Gallup National Health and Well-Being Index Work?. *Gallup*. How Does the Gallup National Health and Well-Being Index Work?
[16] Uninsured. *KFF*. Uninsured | KFF
[17] Levitt, Larry. January 23, 2019. *Twitter*. https://twitter.com/larry_levitt/status/1088083503604916230?s=20
[18] Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018. April 2019. *Congressional Budget Office*. Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018 (cbo.gov)
[19] Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018. April 2019. *Congressional Budget Office*. Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018 (cbo.gov)

The CBO compiles data from the NHIS, the MEPS-HC; and the CPS to determine the number of people without insurance coverage. The CBO aptly describes the clear challenges with federal survey data:

"The only reliable information about the number of people without health insurance coverage comes from federal surveys, and there is no single, definitive survey for measuring that population. For a variety of reasons, CBO uses data from the NHIS as its primary benchmark for estimates of the number of people who are uninsured. Those data are available more quickly than data from some other surveys, and, because they are generated from a larger sample, they provide more reliable estimates of the uninsured. Also, because the NHIS samples households continuously throughout the year and includes a question about insurance status on the day each household is surveyed, it produces the most accurate measure of the average number of people uninsured over the course of the year. As a result, the data more closely correspond to the concept of average enrollment that underlies CBO's projections.

Although CBO uses the NHIS as its primary benchmark for the uninsured, the agency also compares that benchmark with estimates from the MEPS-HC and the CPS, taking into account the strengths and weaknesses of those surveys, to continually evaluate the accuracy of the NHIS and better understand trends over time in the number of uninsured."[20]

[20] Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018. April 2019. *Congressional Budget Office*. Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018 (cbo.gov)

Section 2: Uninsured Rate Tables

A tabular comparison of the various surveys referenced in Section 1 and longitudinal charts of the uninsured rate measures are presented in this section.

2.1 MEASUREMENT PARAMETERS

The various surveys are listed in Table 1 with general timing, rough sample size, and population measured. As discussed in Section 1, the measurement definition has a differential impact on the uninsured rate calculation. Age is also a determining factor. According to the ACS, the uninsured rate for children under age 19 is 6%. It is higher for adults age 19 to 64 (13%) and lower for adults over age 65 (1%).[21] These results are logical as Medicare covers almost adults over age 65 and government programs are more apt to cover children (e.g. Children's Health Insurance Program) than adults.

Table 1
UNINSURED SURVERY PARAMATERS

	Organization (Department)	Report Title	Timing	Sample Size	Population	Measurement
Government	CDC (HHS)	National Health Interview Survey	May/Sept	40,000	Civilian Non-institutionalized	At time of interview
	AHRQ (HHS)	MEPS-HC	Annually	30,000	Non-institutionalized	Insured any time during year
	Census Bureau (Commerce)	CPS ASEC	Annually	60,000	Non-institutionalized	Insured any time during prior year, detailed information
	Census Bureau (Commerce)	ACS	Annually	2,150,000	Non-institutionalized	At time of interview
Private	Gallup	National Health and Well-Being Index	Annually	28,000	Adults 18-64	At time of interview
	Urban Institute	Health Reform Monitoring Survey	Quarterly	8,000	Adults 18-64	At time of interview
	Commonwealth Fund	ACA Tracking Survey	2 to 4 months early in year	2,403	Adults 19-64	At time of interview
	Commonwealth Fund	Biennial Health Insurance Surveys	August 2019	4,272	Adults 19-64	At time of interview

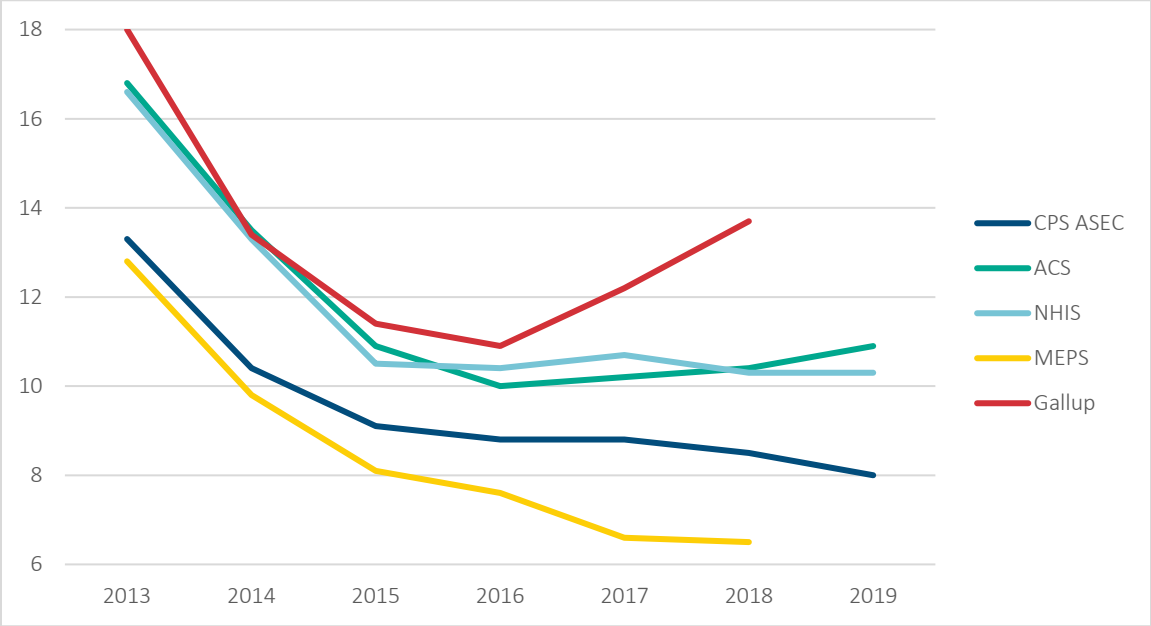
[21] Health Insurance Historical Tables – HHI Series. *United States Census Bureau.* Health Insurance Historical Tables - HHI Series (census.gov)

2.2 MEASUREMENT RESULTS

Figure 3 displays the measured uninsured rate since 2013 of the federal surveys and the private Gallup poll. The ACS and the NHIS results are generally similar. The CPS ASEC, which has a stricter definition of being uninsured for an entire year, has expectedly lower results. The CPS ASEC has also experienced some methodology changes which make longitudinal comparisons a challenge. The MEPS results, which are only available through 2018 and has a similarly strict definition as the CPS ASEC, are a notably low outlier. The Gallup results are a notably high outlier, particularly the most recent data point, and Gallup has not continued its annual measurement cycle. For purposes of analyzing recent trends in the uninsured rate, the ACS and the NHIS provide the most reasonable results. The ACS is more robust and can be analyzed at a geographical level, while the NHIS results are continuously produced and provide earlier indicators of changing results.

Figure 3

UNINSURED RATE OVER TIME FROM SELECTED SURVEYS



Section 3: Uninsured Rate Discrepancies

While various reports assessing the uninsured rate utilize different survey methods and report on different time periods and population groups, results have usually tracked in the same direction or minimally in different directions. Generally, uninsured rate reports complement each other.

Unsurprisingly, there was consensus agreement that the uninsured rate declined significantly in 2014 and 2015 as major ACA programs were being implemented. The initial years of enhanced federal funding for a newly eligible Medicaid population and new individual marketplace subsidies were marked by increased enrollment in both markets. In the third and final year of the ACA's transitional phase,[22] all organizations reported a continued decline in the uninsured rate but a noticeable flattening from the two prior years.[23]

Significant premium increases in the individual market in 2017 resulted in enrollment reductions and the uninsured rate increased for the first time since ACA implementation. Multiple policy changes in 2018 were believed to have an impact on ACA market enrollment and consequently the uninsured rate. The two primary changes had difficult to measure but directionally opposite impact. First, President Trump reduced the funding available for advertising and enrollment assistance. Second, the defunding of Cost-Sharing Reduction (CSR) payments resulted in larger premium subsidies and lower net premiums for consumers.[24] Each of these changes had varying impact at the state level, and the uninsured rate in 2018 was of greater interest than prior years, due to the enhanced level of policy changes.

3.1 2018 NHIS EARLY RELEASE

In November 2018, the CDC released the NHIS results for the first six months of 2018. The report showed a decline in the uninsured rate in states that had not expanded Medicaid after an increase in 2017. Results are displayed in Table 2. Comparatively, the uninsured rate in Expansion states was relatively flat both years. Overall, a logical combination of both state groupings suggested a nationwide reversal in the uninsured rate in 2018 while the NHIS report qualitatively noted that results were "not significantly different from 2017."[25]

[22] Federal reinsurance and risk corridors were a risk mitigators to encourage insurers to participate in new markets with a large degree of uncertainty. Both programs were temporary from 2014 to 2016.
[23] All uninsured rate measures in the table reflect a greater than 1% reduction in 2014 and 2015, and a reduction less than 1% in 2016.
[24] Fann, Greg. August 1, 2017. The Cost-Sharing Reduction Paradox: Defunding Would Help ACA Markets, Not Make Them Implode. *Axene Health Partners, LLC*. The Cost-Sharing Reduction Paradox: Defunding Would Help ACA Markets, Not Make Them Implode – Axene Health Partners, LLC (axenehp.com)
[25] Martinez, Michael E., Zammitti, Emily P., and Cohen, Robin A. November 2018. Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–June 2018. *National Center for Health Statistics, Centers for Disease Control*. Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January – June 2018 (cdc.gov)

Table 2
UNINSURED RATE OVER TIME

Uninsured Rate: Early Release of Estimates from the National Health Interview Survey, January–June 2018		
Year	Expansion States	Non-Expansion States
2010	16.4%	20.3%
2011	15.3%	19.6%
2012	15.0%	19.2%
2013	14.9%	18.4%
2014	10.9%	16.0%
2015	8.2%	14.0%
2016	7.8%	14.7%
2017	7.6%	15.7%
2018 (Jan-June)	7.6%	14.8%

Mathematically, the 2018 distinction between Medicaid expansion states and non-expansion states was directionally logical. CSR defunding reduced non-silver individual market premiums for subsidized enrollees. Because premium subsidies are determined by silver premium levels and removal of CSR funding necessitated higher silver premium levels, premium subsidies rose. The amount of the subsidy increase was dependent on the rise in silver premiums, which varied based on the income composition of enrollees in silver plans. Effectively, silver premiums were based on the average actuarial value[26] of silver enrollees. As actuarial value varies by income and individuals with incomes between 100% of the Federal Poverty Level (FPL) and 138% of the FPL are in Medicaid in Expansion states and in the individual marketplace in Non-Expansion states, Non-Expansion States on average have a higher silver actuarial value and resulting higher premium subsidies and lower premiums. Table 3 displays the applicable actuarial values associated with each income group.

Table 3
SILVER PLAN ACTUARIAL VALUES

Silver Enrollees' Actuarial Value by FPL		
Actuarial Value	Expansion States	Non-Expansion States
94%	138%-150%	100%-150%
87%	150%-200%	150%-200%
73%	200-250%	200-250%
70%	>250%	>250%

At the end of 2018, the reported evidence suggested that the 2017 increase in the uninsured rate had been neutralized, and perhaps reversed due to lower ACA market premiums resulting from CSR defunding, particularly in states that had not expanded Medicaid.

3.2 THE 2018 GALLUP REPORT

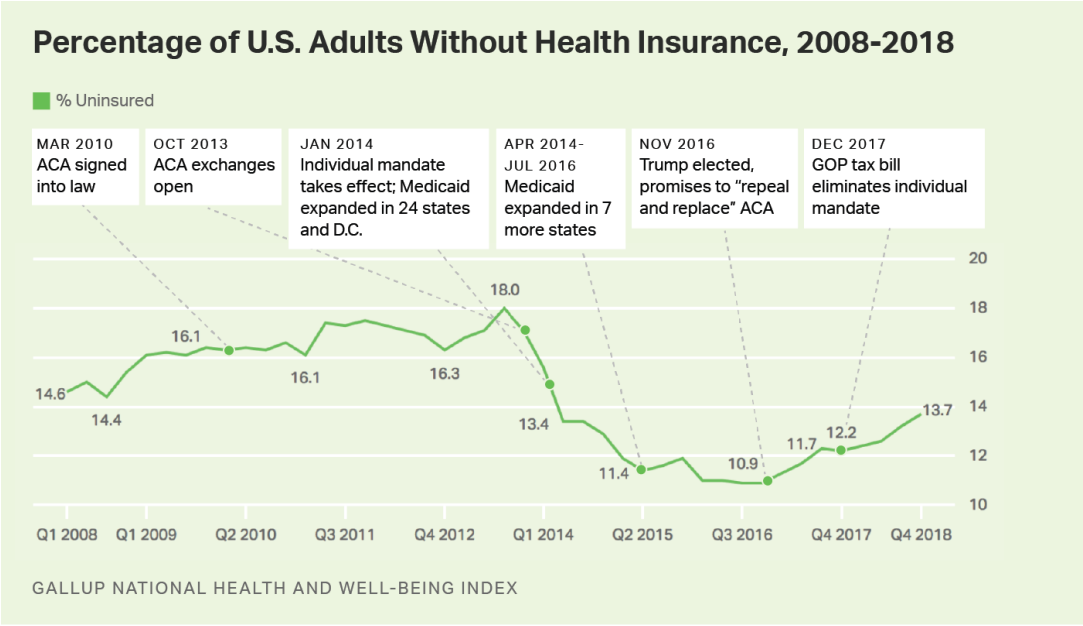
Gallup's National Health and Well-Being Index reporting on the 2018 uninsured rate was released in January 2019 as expected. The magnitude of the change in the uninsured rate was not expected.

[26] Some states and insurers implemented experience rating mechanisms on silver plans rather apply straightforward actuarial value calculations, which generally decreased silver premiums.

Gallup reported that the adult uninsured rate in the fourth quarter of 2018 was 13.7%, a full 1.5% higher than the fourth quarter in 2017. Longitudinal results are displayed in Figure 4.[27] The results created an uproar in the news media and the health policy community, and naturally ignited politically charged responses. "The number of Americans lacking health insurance has increased by 7 million since Donald Trump became president", the Fiscal Times noted while referencing the Gallup report.[28] Newsmax reported, "The American adult uninsured rate rose to its highest level in four years, registering at 13.7 percent in the fourth quarter of 2018".[29] Andy Slavitt, who served as the Centers for Medicare and Medicaid Services (CMS) during the Obama administration, said "7 million Americans have lost insurance under Trump as he has steadily undermined the law & people."[30] These reactions were a mere two months after a government report told the opposite story about 2018. KFF's Larry Levitt decisively noted, "We have a somewhat murky picture of insurance coverage right now."[31] While previous differences in uninsured reports had been mild and not contradictory, there was clearly some differences to resolve before responding with policy action.

Figure 4

GALLUP NATIONAL HEALTH AND WELL-BEING INDEX



[27] Gallup, U.S. Uninsured Rate Rises to Four-Year High, January 23, 2019. https://news.gallup.com/poll/246134/uninsured-rate-rises-four-year-high.aspx. Copyright © 2019 Gallup, Inc. All rights reserved. Reprinted with permission.

[28] Rainey, Michael. January 23, 2019. 7 Million More Uninsured Under Trump *The Fiscal Times*. 7 Million More Uninsured Under Trump | The Fiscal Times

[29] Freeman, Brian. January 23, 2019. Gallup: Uninsured Rate Among Americans Spikes. *Newsmax.* Gallup: Uninsured Rate Among Americans Spikes | Newsmax.com

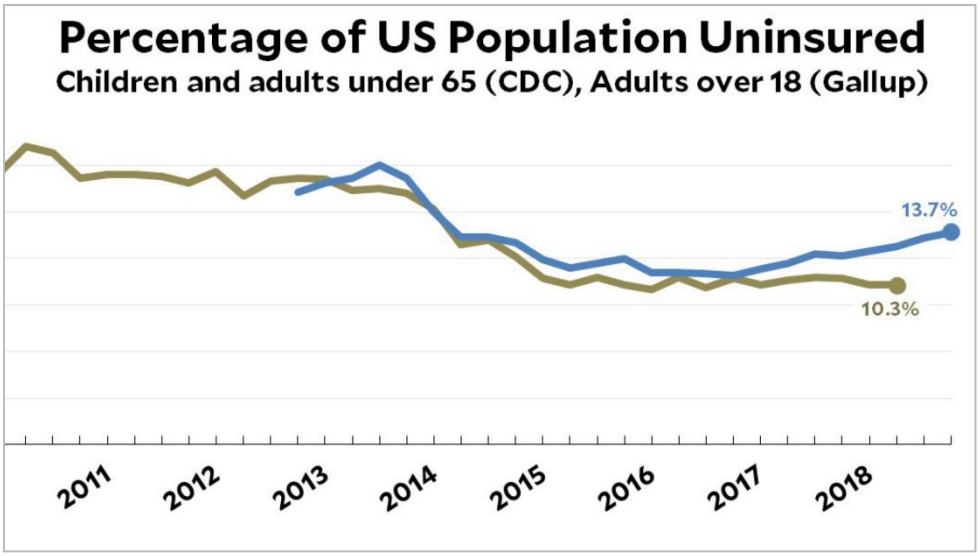
[30] Hayden, Jen. January 24, 2019. 7 million Americans have lost their healthcare insurance under Donald Trump — so far. *Alternet*. 7 million Americans have lost their healthcare insurance under Donald Trump — so far - Alternet.org

[31] Levitt, Larry. January 23, 2019. *Twitter* https://twitter.com/larry_levitt/status/1088083503604916230

It was not long before questions[32] were asked about the accuracy of the Gallup Report. A Slate article was titled "Gallup Says the Uninsured Rate Is Rising. Is It?".[33] Similarly, Factcheck asked "Did the Uninsured Increase by 7 Million?".[34] Politifact judged Senator Maria Cantwell's claim "7 million more Americans are uninsured now than when President Trump was elected" as half-true, noting that she cited "one study of health insurance coverage, the one undertaken by Gallup. However, she ignores two closely watched government studies that showed much smaller changes in uninsured Americans, and in one instance, actually found a modest reduction in the number of people without insurance."[35] Mr. Levitt believed[36] the aggregate policy impacts would cause 2018 ACA enrollment to fall but was skeptical[37] of Gallup's latest uninsured numbers, as he was in 2017[38] and 2018.[39] As full year reporting of 2018 emerged, reports generally suggested mild changes in the uninsured rate. The Commonwealth Fund reported "the adult uninsured rate was 12.4 percent in 2018, statistically unchanged from the last time we fielded the survey in 2016."[40] A longitudinal comparison of Gallup and results from the CDC NHIS is displayed in Figure 5.[41]

Figure 5

COMPARSION OF GALLUP AND CDC RESULTS



The Gallup results were ultimately seen as an outlier and the reported increase was not viewed as representative of a real change in the uninsured rate, but the initial reporting created quite a stir that could

[32] Robertson, Lori. February 12, 2019. Did the Uninsured Increase by 7 Million? *Factcheck.org*. Did the Uninsured Increase by 7 Million? - FactCheck.org

[33] Weissmann, Jordan. January 23, 2019. Gallup Says the Uninsured Rate Is Rising. Is It? *Slate*. New Gallup survey says the unisured rate is spiking under Trump. (slate.com)

[34] Did the Uninsured Increase by 7 Million? - FactCheck.org

[35] Jacobson, Louis. January 25, 2019. Have 7 million Americans become uninsured since 2016? *Politifact*. PolitiFact | Have 7 million Americans become uninsured since 2016?

[36] Alonso-Zaldivar, Ricardo and.Vineys, Kevin S. February 7, 2018. AP Count: Nearly 11.8M enroll for Obama health law in 2018. *AP News. https://apnews.com/article/north-america-wa-state-wire-ri-state-wire-ct-state-wire-tx-state-wire-837a78792b944937b6e0fca69ee55e4e*

[37] Levitt, Larry. January 23, 2019. *Twitter.* https://twitter.com/larry_levitt/status/1088087848719249415?s=20

[38] Levitt, Larry. October 20, 2017. *Twitter. https://twitter.com/larry_levitt/status/921382328592580609?s=20*

[39] Levitt, Larry. January 16, 2018. *Twitter.* https://twitter.com/larry_levitt/status/953283108454809600?s=20

[40] Collins, Sara R., Bhupal, Herman K., and Doty, Michelle M. February 7, 2019. Health Insurance Coverage Eight Years After the ACA. *The Commonwealth Fund*. https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca

[41] Mother Jones, The Uninsured Rate Has Soared Under Trump — Maybe, January 23, 2019. https://www.motherjones.com/kevin-drum/2019/01/the-uninsured-rate-has-soared-under-trump-maybe/. Reprinted with permission.

have been avoided with a better collective synthesis of uninsured rate reporting. Market observers were naturally interested in Gallup's updated report a year later. It was thought that 2018 results may be restated rather than potentially projecting a decline in the uninsured rate in 2019, coinciding with repeal of the individual mandate penalty and further reductions in advertising and outreach funding in individual marketplaces. Two years have gone by and Gallup has not reported uninsured rate statistics for 2019 or 2020. The last Gallup report still indicates a significant increase in the uninsured rate in 2018. Accordingly, federal government reports have played a more exclusive role as reliable sources for assessment of the uninsured rate in recent years.

Section 4: Rationale for Being Uninsured

As the uninsured rate has levelized since 2016 and recent changes are both more difficult to measure and more likely to be viewed as resulting from changes in the pandemic environment rather than from policy implications, some attention has shifted from precise measurements to a more qualitative understanding of the uninsured population. While ACA implementation has resulted in a material impact, the uninsured rate remains higher than desired. Notably, enrollment in the private individual marketplace is significantly lower than expected. The individual market is important as it serves as a last resort and is often the only option available to people who do not qualify for government programs or do not have access to affordable employer-sponsored insurance. After the Supreme Court decision in 2012 that gave states a choice of expanding Medicaid, CBO revised its enrollment forecast[42] to include 31 million people in the individual market in 2021.

After a rapid uninsured rate decline associated with ACA implementation and commencement of a stabilizing level, some research has focused on stakeholders' interests in individuals' rationale for being uninsured. Prior to the ACA, the rationale for being uninsured was purportedly understandable. It was perceived that there were two overwhelming rationales for being uninsured; being unable to afford basic coverage or having chronic medical conditions in a medically underwritten regulatory environment. The ACA's rating rules and subsidy formulas were specifically designed to make insurance more attractive to those with low incomes and pre-existing medical conditions.

With the ACA's implementation, a rationale for being uninsured is seemingly less transparent. Insurance is now more attractive to low-income individuals, and everyone is eligible for ACA coverage regardless of health status. General reasons for being uninsured include premium levels, lack of awareness, and a poor perception of the value of coverage. To support future efforts to improve the uninsured rates, reporting entities have begun collecting survey information to better understand the rationale of being uninsured.

4.1 COMMONWEALTH FUND BIENNIAL SURVEY

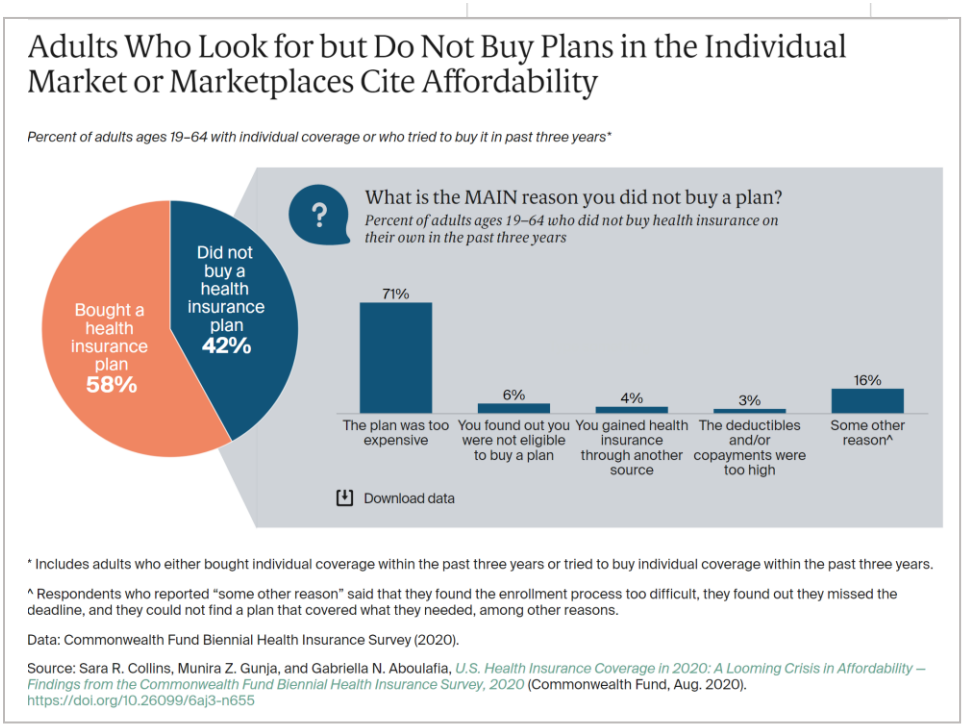
The Commonwealth Fund reports[43] that most uninsured individuals indicate that premiums are too expensive. 71% of those surveyed said that health insurance options are too expensive. Even after the implementation of the ACA, named for intentions of improving affordability, prices are still referenced as the overwhelming reason why people do not personally have health insurance. Figure 6 displays the survey results.

[42] Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision. July 2012. *Congressional Budget Office*. Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision (cbo.gov)

[43] Collins, Sara R., Gunja, Munira Z., and Aboulafia, Gabriella N. August 9, 2020. U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability. *The Commonwealth Fund*. Health Coverage Affordability Crisis 2020 Biennial Survey | Commonwealth Fund

Figure 6

REASONS FOR NOT BUYING MARKETPLACE COVERAGE



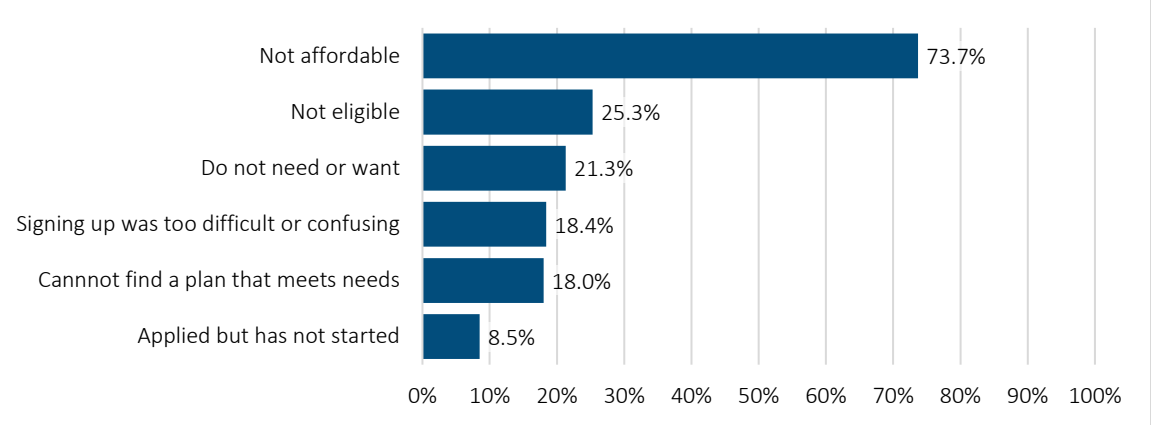
4.2 CDC NHIS

The CDC also reports "affordability" as the primary deterrent to procuring insurance with a similar response rate as the Commonwealth survey. Perhaps surprising to some advocates who understand the risk protection value of health insurance, 21.3% of people indicated they did not want coverage.[44] Figure 7 displays the survey results.

[44] Cha, Amy E. and Cohen, Robin A. September 2020. Percentage of adults aged 18–64 who identified with selected reasons for being currently uninsured: United States, 2019 *National Center for Health Statistics, Centers for Disease Control*. NCHS Data Brief, Number 382, September 2020 (cdc.gov)

Figure 7

REASONS FOR BEING UNINSURED: PERCENTAGE OF ADULTS AGED 18–64 WHO IDENTIFIED WITH SELECTED REASONS FOR BEING CURRENTLY UNINSURED: UNITED STATES, 2019



4.3 AFFORDABILITY CONSIDERATIONS

While survey questions regarding health insurance coverage are susceptible to respondent error, the rationale for not having insurance may be even more inaccurate. It is possible that many respondents who claimed that insurance was "not affordable" had not fully explored coverage options and prices. A recent KFF analysis[45] suggests that 4 million of the 15 million individuals eligible for marketplace coverage have access to free coverage. An additional 5 million people have access to subsidized coverage. Results are displayed in Table 4. Recent legislative changes in the ARPA improve consumer value and provide more Americans with access to more generous premium subsidies. A large contingent of individuals remain uninsured for reasons other than price, but accurate rationales may not be identified in current surveys.

Table 4

UNINSURED POPULATION AND MARKETPLACE SUBSIDY ELIGIBILITY

State	Total Marketplace Eligible Uninsured	Uninsured Eligible for Free Bronze Plan	Uninsured Eligible for Partial Subsidies	Uninsured Ineligible for Subsidies
US Total	14,922,400	4,004,600 (27%)	4,945,300 (33%)	5,972,500 (40%)

[45] McDermott, Daniel, Cox, Cynthia, and Claxton, Gary. January 27, 2021. Marketplace Eligibility Among the Uninsured: Implications for a Broadened Enrollment Period and ACA Outreach. *KFF Private Insurance*. Marketplace Eligibility Among the Uninsured: Implications for a Broadened Enrollment Period and ACA Outreach – Appendix Tables – 9623 | KFF

Section 5: Pathways to Coverage

As we try to better understand the rationale for people being uninsured, we are also seeking how to best understand how more people can become insured. Comprehension of likely reductions in the uninsured rate begins with understanding the likely pathways to coverage. In support of this effort, the CBO has segmented population groups eligible for various types of subsidized coverage and delineated the reasons why other groups were not eligible.[46] Many uninsured individuals eligible for subsidized coverage have access to free or near free coverage, while others, who are also eligible for financial assistance, are still required to pay a substantial premium contribution.

5.1 CBO ASSESSMENT OF UNINSURED POPULATION

In round numbers, there are around 30 million people uninsured in the United States under age 65. Most uninsured individual residents in the United States are eligible for Subsidized Coverage; among those eligible, there is a wide variance of premium contributions from free coverage to beyond pre-ACA levels. Most of this group was eligible for financial assistance prior to the ACA, but the ACA has added to the number of subsidy eligible uninsured Americans. About one-third of Americans are ineligible for financial assistance, most of whom are ineligible due to income not falling within the ACA's range of subsidy eligibility.

The largest segment of the current uninsured population was eligible for Subsidized Coverage prior to the ACA. About a quarter of the uninsured population is newly eligible for Subsidized Coverage as a direct result of the ACA. Ineligibility for Subsidized Coverage is generally the result of income level or legal status. The ACA limits subsidy eligibility from 100% to 400%[47] of the FPL; some ACA enrollees within the income range, younger people in particular, may have premium levels below the maximum enrollee contribution and not be eligible for subsidies. Everyone ineligible for Subsidized Coverage can enroll in the individual market but would be required to pay the full premiums, which are generally financially unattractive. The CBO notes that "about 48 percent of noncitizens who were not lawfully present in this country were uninsured in 2019, compared with 10 percent of citizens and other lawfully present residents".[48]

Table 5 illustrates the subsidy eligibility of various group of uninsured individuals residing in the United States. Access to Subsidized Coverage is a clear pathway to insurance for most of the uninsured population. Policy advocacy of encouraging greater levels of insurance coverage generally falls into three categories; increasing the populations eligible for Subsidized Coverage, formulaic changes in subsidy calculations to improve consumer value propositions for those already eligible, and promotion of greater consumer awareness of Subsidized Coverage availability.

[46] Who Went Without Health Insurance in 2019, and Why? September 2020. *Congressional Budget Office*. Who Went Without Health Insurance in 2019, and Why? (cbo.gov)
[47] The 400% limit was removed by ARPA.
[48] Who Went Without Health Insurance in 2019, and Why? September 2020. *Congressional Budget Office*. Who Went Without Health Insurance in 2019, and Why? (cbo.gov)

Table 5
SUBSIDIZED PATHWAYS TO COVERAGE

Population	Eligibility Reason	Population Split	Group Description
Eligible for Subsidized Coverage	Prior to the ACA	31%	Employer-Sponsored
Eligible for Subsidized Coverage	Prior to the ACA	10%	Traditional Medicaid / CHIP
Eligible for Subsidized Coverage	Result of the ACA	19%	ACA Marketplace
Eligible for Subsidized Coverage	Result of the ACA	7%	ACA Medicaid Expansion
Eligible for Subsidized Coverage	**Total Eligible**	**67%**	**All Eligible Groups**
Not Eligible for Subsidized Coverage	Income Related	11%	Income too low in non-expansion states
Not Eligible for Subsidized Coverage	Income Related	9%	Income too high for marketplace subsidies
Not Eligible for Subsidized Coverage	Not Income Related	13%	Not Lawfully Present
Not Eligible for Subsidized Coverage	**Total Not Eligible**	**33%**	**All Ineligible Groups**

5.2 IMPACT OF RECENT POLICY CHANGES

The Urban Institute's Health Insurance Policy Simulation Model (HIPSM) is "designed to estimate the cost and coverage effects of proposed health care policy options".[49]. The core data in the HIPSM is two years of the ACS. In December, baseline coverage was presented which tallied insurance coverage enrollment by income group. Notably, the HIPSM segments short-term limited duration plans and other non-ACA compliant coverage as a separate line item. This alleviates potential confusion in other surveys as to whether short-term plan enrollees may be counted as being uninsured.

The baseline data in Table 6 provides insightful distribution patterns of variances in type of insured coverage by income level.

Table 6
HEALTH INSURANCE COVERAGE BY INCOME LEVEL

	Income as a % of FPL				
Type of Coverage	<138%	138-200	200-400	400+	All
% of Population	*28.5%*	*11.2%*	*26.7%*	*33.6%*	*100.0%*
Employer-Sponsored	11.6%	38.7%	68.6%	86.0%	54.9%
Public (Medicaid/CHIP)	69.3%	31.9%	13.3%	4.4%	28.3%
Individual ACA-Compliant	3.0%	14.0%	6.4%	4.0%	5.5%
Non-ACA Compliant	0.4%	0.3%	1.3%	1.3%	0.9%
Uninsured	15.7%	15.2%	10.4%	4.3%	10.4%

The ARPA enhances the ACA's subsidy parameters by reducing the maximum premium contributions for the benchmark plan at all income levels. The Urban Institute used the HIPSM to update the baseline data and model the anticipated ARPA impact[50] using similar coverage categories; results are displayed in Table 7. Naturally, enrollment in the individual ACA-compliant market is expected to increase, the uninsured rate is expected to decrease, and little changes are expected in other categories. As net premiums decline, and

[49] Buettgens, Matthew and Banthin, Jessica. The Health Insurance Policy Simulation Model for 2020. December 2020. *Urban Institute*. The Health Insurance Policy Simulation Model for 2020: Current-Law Baseline and Methodology (urban.org)
[50] Banthin, Jessica, Buettgens, Matthew, Simpson, Michael, and Wan, Robin. April 2021. What if the American Rescue Plan's Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022. *Urban Institute*. What if the American Rescue Plan's Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022 (urban.org)

a larger proportion of the population has access to free or near free coverage, more people will be insured but many will likely remain uninsured despite financially attractive options. The focus on reducing the uninsured rate may change from reducing premiums to increasing awareness of available coverage value.

Table 7

ARPA IMPACT ON HEALTH INSURANCE COVERAGE

ARPA Impact		
Insurance Coverage	Before ARPA	After ARPA
Employer-Sponsored	53.8%	53.7%
Public (Medicaid/CHIP)	28.7%	28.9%
Individual ACA-Compliant	5.4%	7.1%
Non-ACA Compliant	0.9%	0.8%
Uninsured	11.1%	9.6%

Section 6: Pandemic Implications

For individuals interested in health insurance policy, there is anxious anticipation in September for the usual releases of uninsured rate reports from the CDC and the Census Bureau. In September 2020, the results of the uninsured rate in the prior year seemed more outdated than usual. The significant economic and health landscape changes due to COVID-19 deflated excitement for what should have been a very interesting year. After all, the individual mandate penalty no longer applied. The penalty was once thought by many stakeholders to be the linchpin holding the ACA market together. As this report is being written, the US Supreme Court is considering the constitutionality of the ACA based on the mandate's essentiality to the functioning of the law. It was thought that market enrollment would plummet without a penalty and the uninsured rate would skyrocket. Additionally, the 2018 policies of reduced advertising and enrollment assistance continued, and insurer response to CSR defunding is a multi-year phenomenon.[51] There was indeed significant interest in 2019 results, but it was all overshadowed by the landscape changes due to COVID-19.

The Census Bureau was transparent in discussing the unplanned data collection challenges. For the CPS ASEC, the Bureau collects information each spring for the prior year. Traditionally, this has included in-person interviews. In March 2020, in-person interviews ceased, and all subsequent interviews were conducted via telephone. Response rates dropped about 10%, and reductions were believed to be unevenly distributed by age, sex, race and income.

Federal agencies' efforts to apply appropriate adjustment were admirable, but they acknowledged the inherent challenges should be acknowledged by interested stakeholders and results should be viewed with more caution than usual. Perhaps more relevant than the reporting accuracy was the current relevance. The COVID-19 pandemic reshuffled the steady population of enrollees in employer-sponsored insurance, with temporary and permanent job layoffs shifting people to the individual market, Medicaid, and the ranks of the uninsured. A more speculative view on the 2019 uninsured rate was received with less fanfare and health policy stakeholders were less focused on issues unrelated to the pandemic.

Coming out of the pandemic, comparisons of the uninsured rate with prior measures may require more discernment. A growth in Medicaid eligibility is expected; as many people are eligible for Medicaid for the first time, there may be some unfamiliarity with the program. Retroactive enrollment may play a larger role; effectively, people may be uninsured until they need medical coverage. Much of the federal response to the pandemic includes temporary financial mechanisms which should reduce the uninsured rates. It remains to be seen whether some of these efforts are temporary or will be permanently extended. As stakeholders digest future updates of the uninsured rate, they will be wise to apply a greater degree of discernment, particularly in connection to understanding policy implications and using the results to inform future policy.

[51] Sprung, Andrew. June 5, 2019. Silver loading is just getting started. *Xpostfactoid Blog*. xpostfactoid: Silver loading is just getting started

Section 7: Summary

Comprehension of the uninsured rate is a necessary requirement in shaping health policy. Rich detailed information is available through multiple public and private reports produced each year. Raw data is also available for researchers interested in conducting their own research.

Multiple entities report on the uninsured rate and measure various populations using various methods. Confusion across surveys can arise without a proper understanding of what is being measured and established consistent processes. Many researchers prefer utilization of the Census Bureau's ACS due to its large sample size and credibility in small, geographic regions. Its drawback is its infrequent annual release, in September for the previous year. In the pandemic environment, the September 2020 report on 2019 seemed to be more outdated than usual. The NHIS produced by the CDC provides timelier national estimates and has tracked closely with the ACS. The Gallup report was a widely cited private source but appeared to produce outlier results in January 2019 which have not been updated.

A reduction in the uninsured rate is a major health policy goal, and applicable measures are often used to assess policy efficacy. Likewise, policy proposals are often promoted by the projected uninsured rate impact that they will purportedly have. Contradicting uninsured rate reports created confusion on the directional changes in 2018, and the interest in connecting the uninsured rate to policy implications was overshadowed by the COVID-19 pandemic as 2019 results became available.

While the uninsured rate is reactive to health policy, it is important to highlight the other determinants of the uninsured rate. Economic trends have historically had an impact on insurance rates, particularly in employer-sponsored markets. The correlation between a strong economy and insurance coverage is likely significantly less in an ACA environment that is more attractive to lower-income individuals. Also, the federal response to the COVID-19 pandemic has changed this equation through ACA subsidy enhancements and other temporary free coverage opportunities, e.g. COBRA subsidies.

Demographic trends are a significant factor, particularly age and citizenship. Noncitizens who are unlawfully present have a much higher chance of being uninsured than citizens and lawfully present noncitizens. Elderly adults are almost universally covered through Medicare, and children are more likely to be covered than non-elderly adults due to government programs designed specifically for children.

As the ACA has impacted the uninsured rate, it has changed the demographic characteristics of the uninsured population. In 2019, The Commonwealth Fund asked, "Who are the Remaining Uninsured?".[52] We now have a good understanding of the demographics of the uninsured and the likely pathways they have towards coverage. The dynamics of improving insurance coverage is different than it was a decade ago. Most of the uninsured population now has access to subsidized coverage, and it is free or near free for many eligible enrollees. The cost problem associated with high gross premiums is an expensive but transparent problem; the recognition that people remain uninsured when there is little financial burden is a different challenge for stakeholders. In aggregate, the current resulting dynamics are that the uninsured population is a growing mix of people who have access to free or attractively priced coverage and a remaining group of people who do not.[53] Namely, the ACA consumer value proposition is still highly

[52] Gunka, Munira Z. and Collins, Sara R. 2020. Who Are the Remaining Uninsured, and Why Do They Lack Coverage? *Commonwealth Fund*. August 28, 2019 Who Are the Remaining Uninsured, and Why Do They Lack Coverage? | Commonwealth Fund
[53] Fann, Greg. Land of the Free. *Axene Health Partners, LLC*. Land of the Free – Axene Health Partners, LLC (axenehp.com)

variable across age and income levels[54] despite recent attention to the ARPA removing the subsidy cliff. Further reduction of the uninsured rate will require systematic improvements, some of which are hard and financial and others which are soft and promotional. Actuaries should play a key role in educating stakeholders on the former but should also understand the dynamics of the latter and command a broader, holistic view. A transparent understanding of the uninsured rate, underlying policy implications, rationale for population groups being uninsured, and likely pathways to coverage should lead us to better clarification of market dynamics and understanding of who is uninsured and why and result in stronger policy efficacy in the future.

[54] Fann, Greg. 2021. Actuarial Clarity for Building on the ACA: Let's 86 the 8.5% Myth and Other False Narratives. *Descant Blog*. Actuarial Clarity for Building on the ACA: Let's 86 the 8.5% Myth and Other False Narratives (descant.info)

Section 8: Acknowledgments

The researchers' deepest gratitude goes to those without whose efforts this project could not have come to fruition: The Project Oversight Group and others for their diligent work overseeing questionnaire development, analyzing and discussing respondent answers, and reviewing and editing this report for accuracy and relevance.

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State-based Marketplace Experiences with the American Rescue Plan Act (ARPA)

September 13, 2021

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About the State Health Exchange Leadership Network

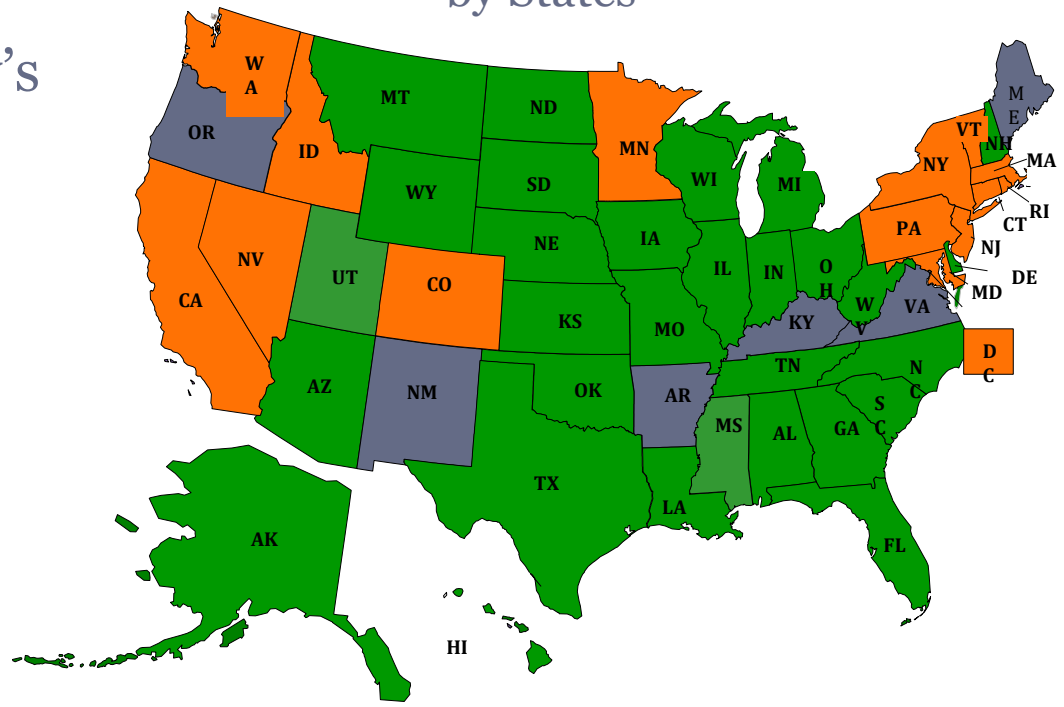
The National Academy for State Health Policy (NASHP) is a nonpartisan forum of state policymakers leading innovative solutions to today's health policy concerns.

NASHP is home to the State Health Exchange Leadership Network, a consortium of state leaders and staff dedicated to operation of the state-based health insurance marketplaces (SBMs).

For additional information, please contact Hemi Tewarson, Executive Director, NASHP, htewarson@nashp.org

[1]SBM data presented in this analysis based on reports from 12 states operating SBMs: California, Connecticut, the District of Columbia, Idaho, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New York, Pennsylvania, Rhode Island, Washington

Health Insurance Marketplace Models by States



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The Health Insurance Marketplaces are an essential piece of the coverage continuum

The pandemic underscored…

- When employment fluctuates, Marketplace coverage is stable – ensuring people have access to coverage
- The importance of the 3 M's – Medicaid, Marketplaces and Medicare – working in tandem to keep uninsured rates low
- Affordable, accessible health coverage and care is critical

Marketplaces rapid response…

- Since March 2021, **over 2.5 M individuals** have enrolled in coverage through the health insurance marketplaces[1]
- SBMs ensure continued access to coverage by:
  - Opening special enrollment periods
  - Increasing outreach investments and efforts
  - Coordinating with sister agencies, like unemployment
  - Negotiating with carriers to encourage greater flexibilities

[1]The Centers for Medicare and Medicaid Services (CMS). **More than 2.5 Million Americans Gain Health Coverage During Special Enrollment Period.** https://www.cms.gov/newsroom/press-releases/more-25-million-americans-gain-health-coverage-during-special-enrollment-period

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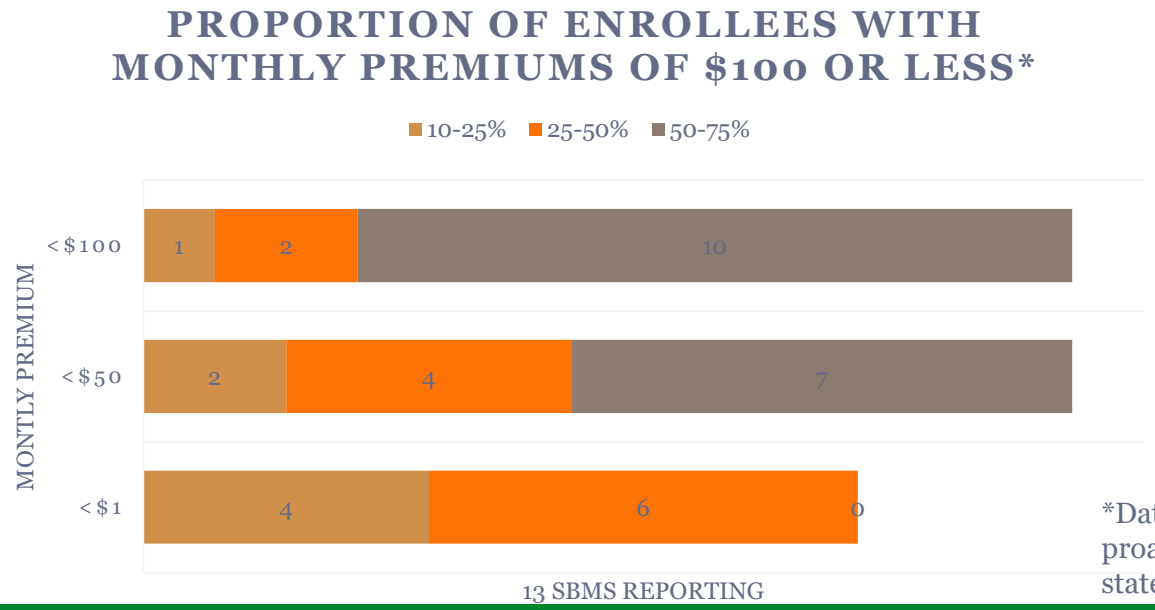
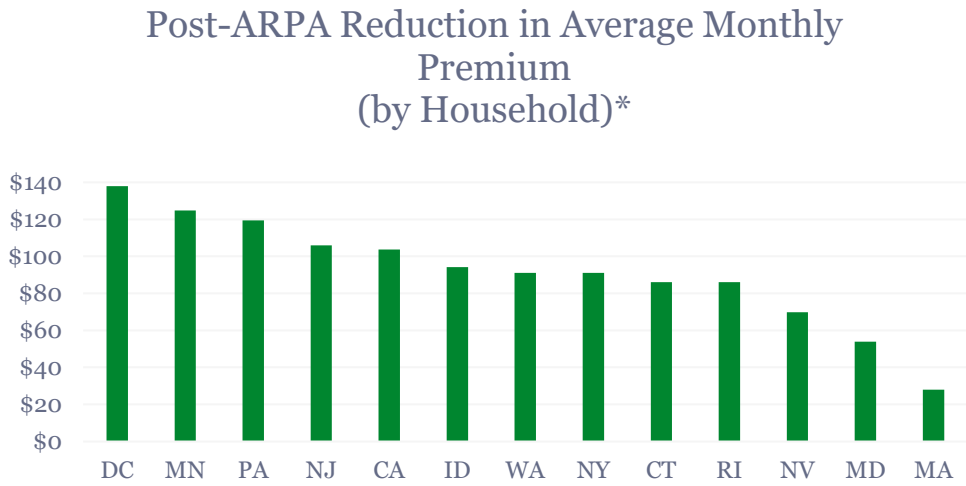
ACA created the coverage infrastructure and the American Rescue Plan Act's (ARPA) APTC enhancements increased affordability for millions of Americans

- Cost is cited as the #1 barrier prohibiting individuals from enrolling in marketplace coverage
- ARPA has resulted in significant savings
  - SBMs report up to 66% in average monthly premium savings for subsidized households





- Since ARPA:
  - 10 SBMs report that over 50% of their enrollees pay less than $100/month for coverage
  - 6 report that over a quarter of enrollees pay $1 or less per month

*Data include unsubsidized households, including those that had not proactively elected into ARPA's APTCs; NJ data represents federal ARPA and state subsidy

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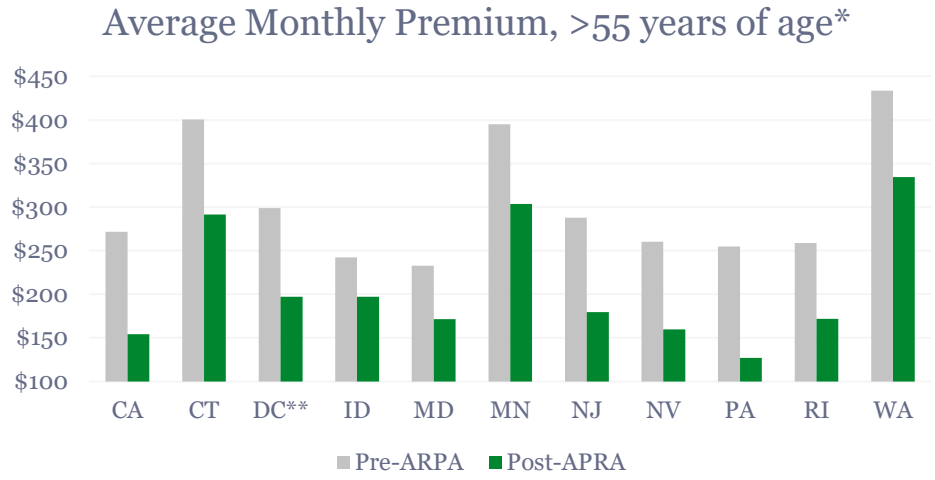
ARPA's subsidy enhancements are improving affordability for key populations

- ARPA has resulted in needed financial support to individuals and families across states and income levels.
- SBMs report notable savings in SBM premiums among >55 year-olds; 9 states report average premium reductions of over $50/ month

	% Reduction in Average Household Premium Post-ARPA*		
	<250% FPL	250-400% FPL	>400% FPL
CA	-50.3%	-38.5%	-29.3%
CT	-42.7%	-33.9%	
DC	-44.1%**	-45.7%**	-22.3%
ID	-45.1%	-26.8%	
MD	-53.6%	-34.1%	-12.0%
MA	-15.2%	-29.2%	-23.5%
MN	-56.0%	-38.8%	-24.5%
NJ	-64.4%	-48.5%	-30.7%
NV	-55.8%	-52.6%	-31.7%
NY	-50.7%	-31.4%	-36.7%
PA	-77.8%	-61.5%	-44.5%
RI	-64.3%	-38.9%	-15.6%
WA	-51.8%	-37.1%	-27.0%

Over 50% premium reduction



*Data include unsubsidized households, including those that had not proactively elected into ARPA's APTCs; NJ data represents federal ARPA and state subsidy
**Includes subsidized households only

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ARPA's enhanced subsidies allow marketplace consumers to buy higher value coverage

- Increased affordability allows consumers choice to purchase plans based on their value, better insulating families from out-of-pocket costs

- 12 SBMs report that at least a quarter of post-ARPA enrollees are electing silver-level qualified health plans
  - 5 SBMs report over 50% of new enrollees have elected a silver plan

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Long term enhanced marketplace premium support provides needed stability for families and insurance markets

- The COVID-19 pandemic is predicted to have reverberating effects on both the U.S. healthcare system and the economy for years to come.
  - Marketplaces will remain an important and reliable coverage source, especially as families navigate a shifting economy.
- Commitment to lowering coverage costs provides financial security individuals & families can count on
- Sustained policies (i.e., permanent extension of APTC enhancements) will promote premium affordability
  - By 2022, a permanent expansion of ARPA's APTC enhancements is estimated to lead to:[1]
    - 4.4 M fewer uninsured
    - 5.1 M additional marketplace enrollees
    - A 15% reduction in marketplace premiums

[1] Banthin, J., Buettgens, M., Simpson, M., et al. (2021) What If the American Rescue Plan's Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022. The Urban Institute. https://www.urban.org/sites/default/files/publication/104072/what-if-the-american-rescue-plans-enhanced-marketplace-subsidies-were-made-permanent-estimates-for-2022_0.pdf

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SEPTEMBER 2021

CHCF Issue Brief

by Katherine Wilson, Wilson Analytics

Unexpected Growth in California Health Insurance During COVID-19 Recession

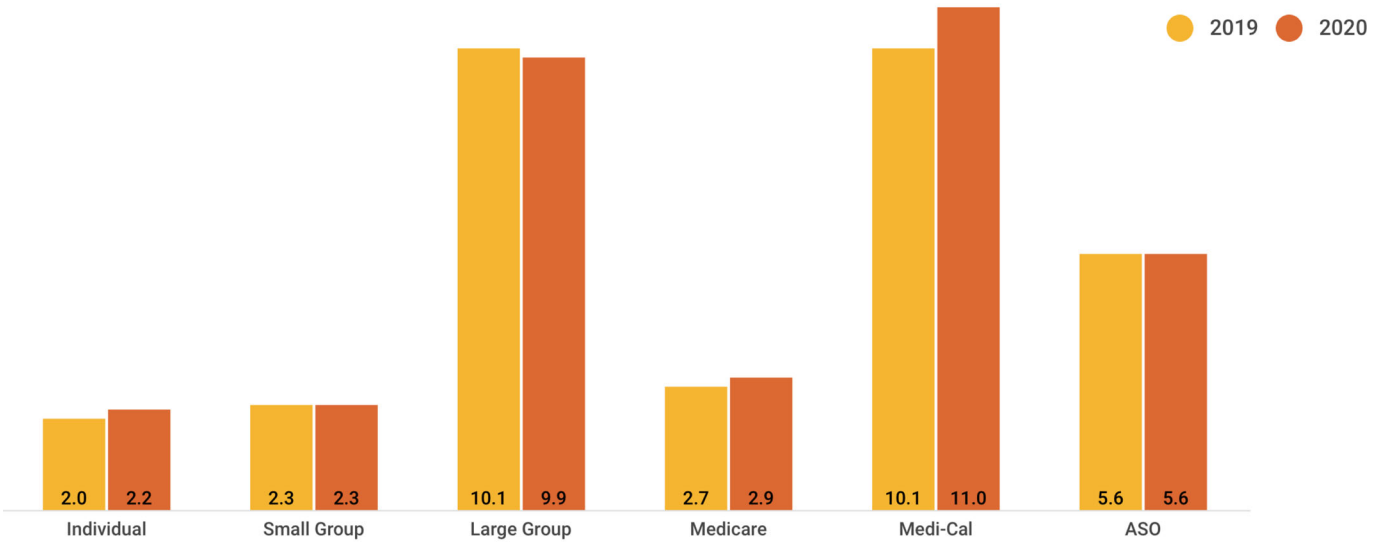
Medi-Cal and Individual Market Growth Led the Way, While Employer-Sponsored Coverage Dipped Only Slightly

New data released by the state's Department of Managed Health Care and the California Department of Insurance show that — despite job losses — total health insurance enrollment in the pandemic year 2020 increased by over one million (3.3%) (see Figure 1).[1] These findings, based on figures through December 2020, confirmed and extended the midyear look at enrollment dynamics in *Hanging On to Coverage?*

The impressive 2020 enrollment gains were driven mainly by growth in Medi-Cal managed care and to a lesser extent by increases in individual coverage and Medicare managed care. State and federal policies designed to help people get and keep coverage during the pandemic were important factors in the growth in both the Medi-Cal and individual markets. Enrollment declines among employer-sponsored insurance were smaller than job losses might have predicted.

Detailed California enrollment resources, including a quick reference guide and a statewide California Health Insurance Enrollment data file, are available on the California Health Insurance Enrollment Almanac page.

Figure 1. California Health Insurance Enrollment, by Market, 2019 vs. 2020 (in millions)



Notes: Medicare and Medi-Cal enrollment reflect managed care only. *ASO* is administrative services only, provided to self-insured employers. Enrollment is as of December.

Sources: *Enrollment Summary Report* (2019–20), Department of Managed Health Care (DMHC); and *Health Insurance Covered Lives Report* (2019–20), California Department of Insurance (CDI).

Medi-Cal Managed Care Enrollment Surges as Feds and State Halt Medicaid Terminations During Public Health Emergency

In contrast to 2018 and 2019 declines, data from state regulators show that Medi-Cal managed care expanded in 2020 by 9.2% (927,300), reaching 11.0 million enrollees (see Figure 2). The Medi-Cal surge was also documented in California Department of Health Care Services (DHCS) reporting,[2] which showed that Medi-Cal's 2020 growth began in April, the first month following the declaration of the COVID-19 public health emergency (PHE) on March 16, 2020.

The steady growth in Medi-Cal was not driven by an increase in new enrollments, as might be expected during an economic downturn. In fact, new Medi-Cal enrollments in 2020 (PDF) were lower than in 2019.[3] Instead, overall Medi-Cal enrollment expanded because federal and state policies halted annual eligibility redeterminations during the PHE to ensure continuous Medicaid coverage.[4] Ordinarily, in nonpandemic times, about 104,000 enrollees per month would lose Medi-Cal coverage during the annual renewal process, according to state budget documents.[5] With this process halted, Medi-Cal enrollment climbed steadily during 2020.

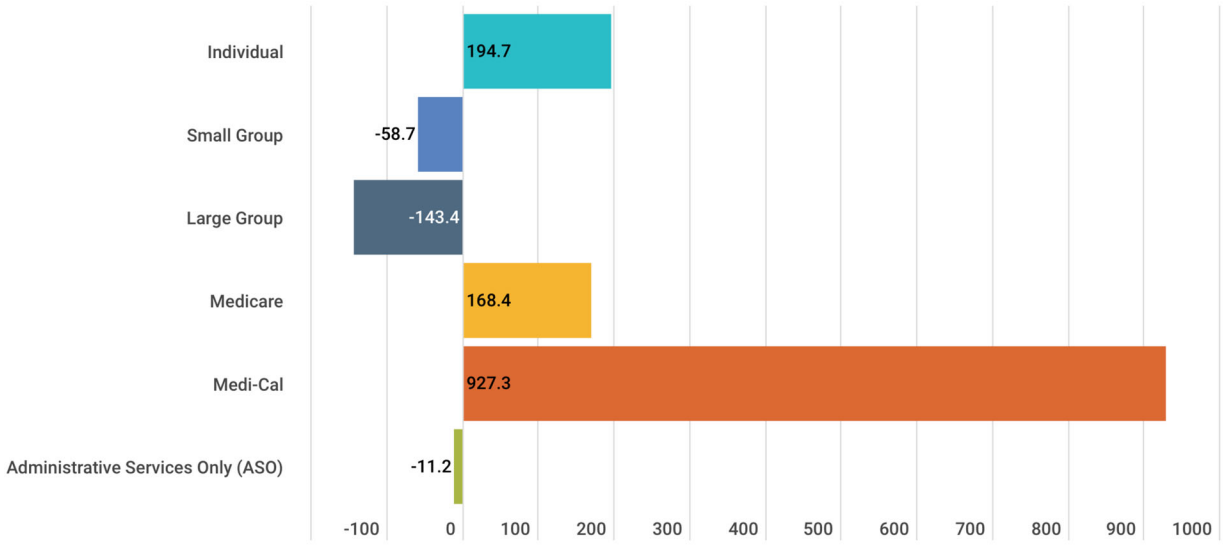
Individual Enrollment Up Nearly 10%, Boosted by State Action on Premium Assistance and Extended Enrollment Periods

Reversing a four-year decline, individual market enrollment increased 9.7% (195,000) in 2020, to end the year with 2.2 million enrollees (see Figure 3, page 3).

The growth in individual coverage was driven by a 19% enrollment increase (238,000) in Covered California, coinciding with three major developments. First, new state-funded premium assistance came online, bringing aid to 45,000 middle-income enrollees (400% to 600% of poverty) for the first time and adding to existing federal assistance for another half-million enrollees.[6] Second, special enrollment periods linked to the pandemic, recession, and wildfires kept sign-ups open much of the year, avoiding attrition during the year. Third, sign-ups by people who had lost job-based insurance increased over prepandemic levels.[7]

Individual enrollment outside Covered California (so-called "off-exchange" enrollment), continued its long decline, decreasing by 5.7% (43,000) in 2020. Covered California now accounts for about two-thirds of the individual market, and most Covered California enrollees (88%) receive a premium subsidy.

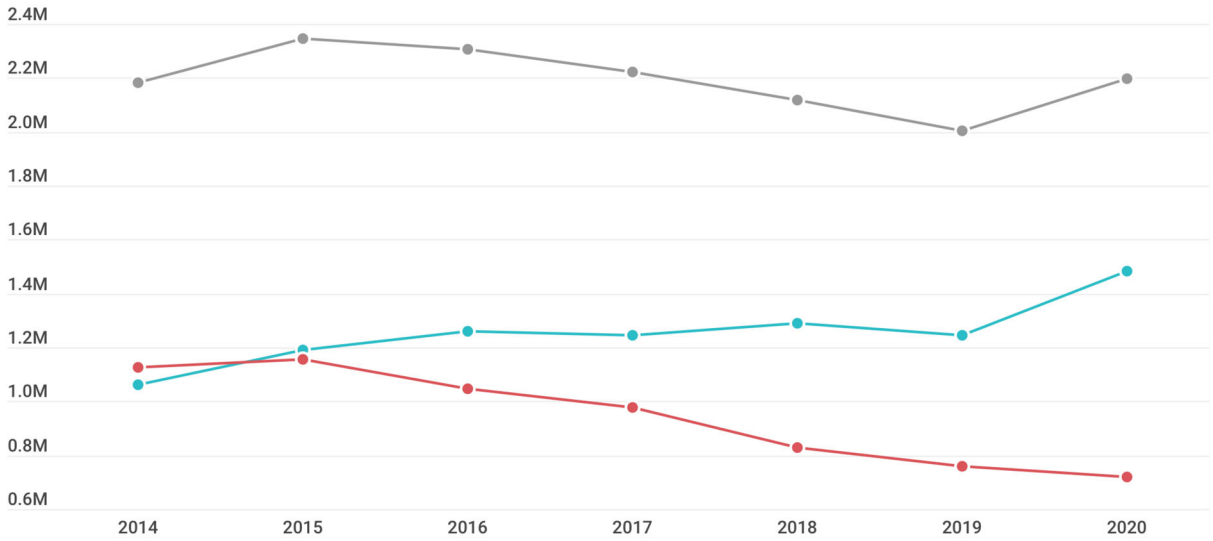
Figure 2. California Health Insurance Enrollment Change, 2019 to 2020 (in thousands)



Notes: Medicare and Medi-Cal enrollment reflect managed care only. *ASO* is administrative services only, provided to self-insured employers. Enrollment is as of December. See interactive chart for percentage changes.

Sources: *Enrollment Summary Report* (2019–20), DMHC; and *Health Insurance Covered Lives Report* (2019–20), CDI.

Figure 3. Individual Market Enrollment, Covered California and Non-Covered California, 2014 to 2020



Notes: *Non–Covered California* individual enrollment is calculated as total individual market (from regulators) minus Covered California individual enrollment (from Covered California). Enrollment is as of December. See interactive chart for number and percentage changes.

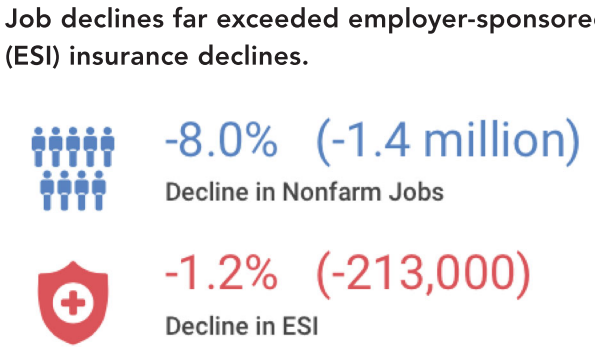
Sources: *Enrollment Summary Report* (2014–20), DMHC; *Health Insurance Covered Lives Report* (2014–20), CDI; and *Active Member Profile* (2014–20), Covered California.

Job-Based Enrollment Declined, but Less Than Job Losses and Expectations

Employer-sponsored insurance (ESI), which consists of small group, large group, and administrative services only (ASO) enrollment, declined 1.2% (213,000) to 17.8 million in 2020. In that same period, nonfarm job losses were far greater, plunging 8.0% (1.4 million jobs) year over year (see Figure 4). Early predictions of massive ESI losses did not materialize, in part due to a tendency for job losses to have occurred among people who did not have health insurance through their job and for some employers to have extended health benefits to furloughed workers. For example, nationwide, among establishments receiving a coronavirus-related loan, 70% paid a portion of health insurance premiums for some or all employees in the summer of 2020. In addition, some losing ESI coverage may have enrolled in COBRA (Consolidated Omnibus Budget Reconciliation Act) or in job-based coverage through another employer.[8]

All components of ESI declined: large group (1.4%), small group (2.5%), and ASO provided to self-insured employers (0.2%). The growth in individual coverage (195,000) nearly offset the declines in ESI.

Figure 4. Jobs vs. Employer-Sponsored Insurance, California, 2020



Sources: California Employment Development Department, press release, January 22, 2021; *Enrollment Summary Report* (2019–20), DMHC; and *Health Insurance Covered Lives Report* (2019–20), CDI.

Medicare Managed Care Enrollment Continued Its Steady Climb

Medicare managed care grew by 6.3% in 2020 to 2.9 million enrollees. Consistent with recent years, it expanded due both to increases in the age 65+ population and faster growth in Medicare Advantage than in fee-for-service Medicare.

In Summary, Enrollment in the 2020 Pandemic Year

The year 2020 finished with 1.1 million more California health insurance enrollees than 2019. Growth in Medi-Cal managed care and individual market enrollment drove the expansion, along with increased enrollment in Medicare managed care. These enrollment gains far outweighed the small declines in group and ASO enrollment.

Growth in insurance enrollment during a recession stands in contrast with historical trends. During the recession in the early 2000s and in the Great Recession, the number of Americans with insurance fell (PDF). These recessions preceded the Affordable Care Act coverage expansions in 2014, which contributed to the net enrollment gains in 2020, in addition to factors that may be unique to this pandemic, such as many employers continuing to offer coverage to furloughed workers.

Looking Ahead: Road Bumps and Opportunities in 2022

The 2020 enrollment dynamics — characterized by policy-driven growth in Medi-Cal and the individual market — could stay in play through the end of 2021. But in 2022, the environment could change, including a plunge in Medi-Cal enrollment.

Impact of PHE's end on Medi-Cal. The national PHE declaration may remain through the entirety of 2021, keeping the Medi-Cal continuous coverage requirement in place. Once the PHE ends, counties must resume renewals and redeterminations, which are expected to take place gradually over the following 12-month period (PDF).[9] These enrollment actions could lead to an unprecedented number of Californians being disenrolled from Medi-Cal. Help transitioning to other sources of coverage will be critical for them.

Impact of policies and new laws on the individual market. The year 2020 showed that longer sign-up periods and additional special enrollment periods lead to steadier enrollment and coverage in the individual market. Given financial premium support and California's coverage mandate, could extended sign-up periods remain available in 2022 without excessive risk to insurers? In 2021, additional federal premium assistance for marketplace purchasers became available through the American Rescue Plan. This has already boosted early 2021 Covered California enrollment, and should also contribute to strong individual market performance in 2022. Extension of the additional federal premium assistance beyond the current expiration date at the end of 2022 will be important for maintaining the enrollment gains.

The economy and employer-sponsored insurance. The extent of the economic recovery will shape the recovery of ESI and its long-term health.

The pandemic year of 2020 provided important lessons on how policy can affect enrollment levels and coverage in the state, and California will need to navigate the coming changes with care.

About the Author

Katherine Wilson is an independent consultant specializing in health insurance markets and health care costs.

About the Foundation

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

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

Endnotes

1. Total enrollment consists of individual, group, Medi-Cal and Medicare managed care, and administrative only services provided to self-insured employers.
2. Department of Health Care Services reporting of Medi-Cal Certified Eligibles Tables, by County from 2010 to Most Recent Reportable Month (April 2021). Figures showed 2020 expansion of 897,000 and 917,000 in Medi-Cal managed care and total Medi-Cal (which includes FFS), respectively.
3. *Stakeholder Advisory Committee Meeting* (PDF), DHCS, February 11, 2021, p. 40. The number of new Medi-Cal enrollees (with no prior enrollment) in the April to December 2020 period was 90,000 fewer than for the same period in 2019. Similarly, total new enrollments (newly enrolled + re-enrollments) were 297,000 lower in the April to December period of 2020 than in the same period in 2019.
4. The federal government, in its Families First Coronavirus Response Act, provided a 6.2 percentage point increase in the federal share of Medicaid spending and tied it to a requirement to maintain eligibility (MOE) through the end of the public health emergency (PHE). Specifically, states must provide continuous eligibility through the end of the month in which the PHE ends for those enrolled as of March 18, 2020, or any time thereafter during the PHE period. To comply, the state, through executive order (PDF) and directives (PDF) to counties, ordered delays in annual eligibility reviews — so-called "redeterminations" or "renewals" — which would otherwise have dropped some beneficiaries.
5. "COVID-19 Caseload Impact: Regular Policy Change Number: 251," in *Medi-Cal May 2020 Local Assistance Estimate for Fiscal Years 2019–20 and 2020–21* (PDF), California Dept. of Health Care Services.
6. Active Member Profiles (Dec. 2020), Covered California.
7. *Coverage When You Need It: Lessons from Insurance Coverage Transitions in California's Individual Marketplace Pre and Post the COVID-19 Pandemic* (PDF), Covered California, September 22, 2020.
8. "As the Pandemic Eases, What Is the State of Health Care Coverage and Affordability in the U.S.?: Findings from the Commonwealth Fund Health Care Coverage and COVID-19 Survey, March–June 2021," Commonwealth Fund, July 16, 2021. Nationally, in the March–June 2021 period, 40% of those who lost employer coverage because of job loss related to the pandemic enrolled in either COBRA or other ESI coverage.
9. Updated Guidance Related to Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency (PDF), Centers for Medicare & Medicaid Services, August 13, 2021.