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Premium Rate Shock and Coverage Loss Inevitable if Enhanced Financial Assistance Is Not Extended This Year to Affordable Care Act Health Plans

The American Rescue Plan Provided Enhanced Premium Assistance to Make Insurance Coverage More Affordable for Millions

The American Rescue Plan Act of 2021 (ARP) made coverage through health insurance marketplaces created under the Patient Protection and Affordable Care Act dramatically more affordable to millions of people, primarily low- and middle-income Americans who do not receive coverage through their employers, Medicare or Medicaid.

ARP secured greater affordability and coverage by:

1. Increasing the amount of premium assistance for all consumers who receive tax credits under the Affordable Care Act, including free Silver plans for consumers below 150 percent of the federal poverty level.
2. Eliminating the "tax credit cliff" for middle-income consumers at 400 percent of the federal poverty level, ensuring that all consumers can have premiums capped as a percentage of income.
3. Providing automatic eligibility for free Silver plans with very low copays and deductibles for any consumer who received unemployment insurance benefits in 2021.

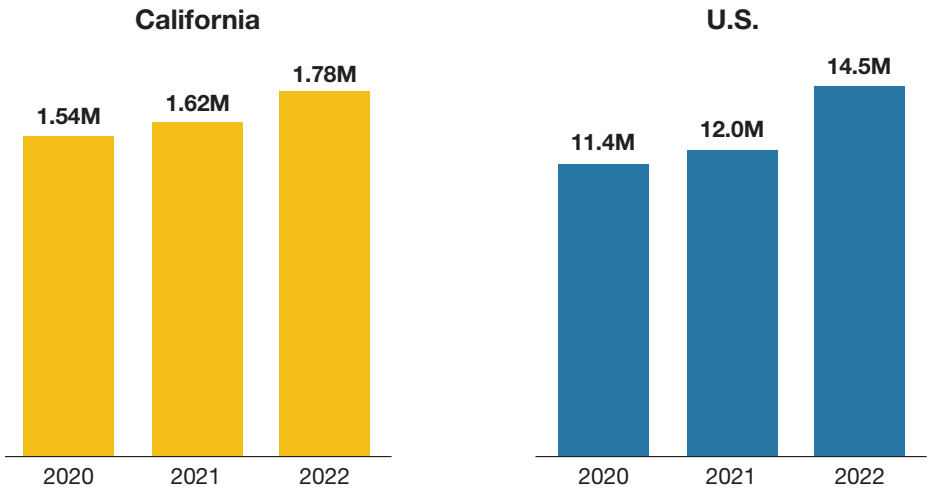
The American Rescue Plan Expanded Access to Comprehensive Coverage and Lowered Health Costs for Millions in California and Across the Country

The ARP had a dramatic impact on making coverage more affordable and helping more Americans who did not previously have insurance get covered through marketplaces across the country.

Record-Breaking Levels of Enrollment

Total enrollment in the recently completed 2022 open-enrollment period was the highest on record. Nationally, 14.5 million Americans signed up for and renewed marketplace coverage for 2022, an increase of 2.5 million over the 12.0 million who enrolled for 2021, and a 21 percent increase in take-up (see Exhibit 1).[1]

Exhibit 1. Marketplace Enrollment as of End of Open Enrollment 2022



This analysis was prepared by Covered California for its ongoing planning and to inform policy making in California and nationally.

Premium Rate Shock and Coverage Loss Inevitable if Financial Assistance Is Not Extended

Like the rest of the nation, California saw its largest enrollment ever, with 1.8 million total consumers in 2022, an increase of 150,000 (9 percent) compared to the same period in 2021.[2] The vast majority of these enrollees (1.64 million, or 92 percent) received tax credits to help reduce the cost of premiums each month, while a small group (134,000, or 8 percent) either did not apply for financial help, or already could purchase a Silver benchmark plan that cost less than 8.5 percent of their income.

American Rescue Plan Resulted in Dramatic Reductions in Premiums

Under the ARP, HealthCare.gov consumers saw average monthly premiums (after tax credits) fall by 23 percent compared the 2021 open-enrollment period (which ended prior to the passage of the American Rescue Plan in March 2021).[3] Similarly, in California, average premiums paid (after tax credits) fell 20 percent compared to 2021.

These reductions in premiums were primarily driven by offering more-generous subsidies that make premium affordable, but also thanks to the risk-mix improvements that come from increased take-up.[4]

Expanded Availability of Far More Affordable Coverage With Very Low Out-of-Pocket Costs for Care

Because of the financial help from the American Rescue Plan, 32 percent of HealthCare.gov consumers selected a plan for $10 or less. Similarly, in California, two-thirds of all consumers were eligible for, and 24 percent enrolled in, a plan for $10 or less. The lower premiums further ensured that more lower-income consumers than ever could access a free high-coverage Silver 94 plan with cost-sharing reduction (CSR) benefits that have member out-of-pocket costs and deductibles better than a Platinum plan, dramatically reducing cost barriers to access care. In California, one-third of all enrollees could access a Silver plan for free in 2022, the vast majority with cost-sharing reductions.

New Enrollment Is Reducing the Uninsured Rate

While further research on coverage churn in 2021 is needed to fully understand the shifts in coverage, all signs point to the national enrollment increase of more than 20 percent being composed primarily of uninsured consumers, or those who would not enroll without the enhanced affordability provided by the American Rescue Plan. This boost took place during a period when fewer consumers likely churned from job-based coverage or Medicaid due to a recovering job market and a hold on Medicaid redeterminations due to the pandemic.[5]

In California, the Biggest Positive Enrollment Impacts Have Been in Communities of Color That COVID Has Hit Particularly Hard

Nationally and in California, many communities of color continue to face higher than average rates of uninsurance, as well as disparate impacts due to the COVID-19 pandemic and health care in general.[6] Compared with the level of enrollment seen at the end of the 2020 open-enrollment period (pre-pandemic), California is showing a surge of enrollment in all communities, with big gains in communities of color for 2022 (see Exhibit 2).

Exhibit 2. Percentage Increase in Enrollment Compared to 2020, by Race/Ethnicity

African-American	33%
Asian American	14%
Latino	18%
White	14%

By helping to improve affordability for all, the American Rescue Plan advanced health equity by expanding access to coverage in communities of color who were hit hardest by the pandemic and economic recession and who are generally disproportionately affected by a lack of access to routine care.

Allowing Increased Subsidies to Expire Would Dramatically Raise Premiums and Increase the Number of Americans Becoming Uninsured

If the ARP premium subsidies are allowed to expire, millions of Americans would be harmed, dropping coverage in the face of higher premiums or struggling to access care. In the exhibits below and in the summaries of potential impacts on California consumers, estimated impacts are based on the "average monthly per-person" change in premiums based on individuals' income levels.

- Roughly 12 million Americans, who currently receive premium support in the marketplaces, would experience dramatic premium increases in their renewal notices beginning in October 2022.
- The lowest-income enrollees — those earning less than 250 percent of the federal poverty level or around $32,000 for a single tax filer and comprising 60 percent of Covered California's subsidized enrollment — will see their paid premiums more than double, on average, with monthly premiums increasing from $65 under ARP to $131 in 2023, an increase of $66 per member, per month of coverage. (See Exhibit 3.)
- Due to the ARP removing the "cliff" that previously prevented middle-income consumers from receiving financial help regardless of how much health coverage cost them relative to their income — in California, 148,000 middle income consumers (9 percent of subsidized enrollment) benefited from lower premiums due to the ARP increases to federal subsidies. For these consumers, if ARP expires, none would receive federal premium support, causing their premiums to increase by an average of $272 per member per month in 2023 — with families getting subsidies facing far higher household premium spikes. (See Exhibit 4.)

Premium Impacts on Real Consumers from Removing ARP Subsidies in California

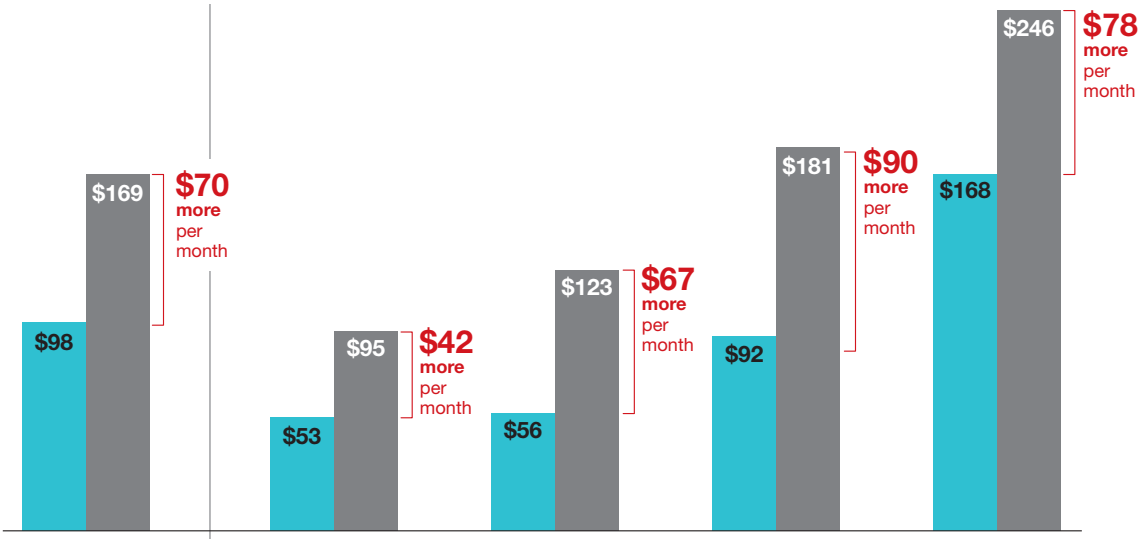
The impacts shown in Exhibits 3 and 4 show large potential consequences, but in many cases they dramatically understate the effect on consumers. The cost of premiums are driven by four independent factors:

- Household size: While the averages are "per person," premiums are based on the number of people covered. Households with more people pay more in premium.
- Consumers' income: Tax credits are adjusted based on consumers' income.
- Consumers' age: Older consumers face far higher health care premiums than do younger people.
- Location: The level of subsidies and health care costs are tied directly to how much health care costs as percentage of income. The lowering of subsidies provided by the American Rescue Plan will have a bigger impact on those living in higher-cost areas.

Premium Rate Shock and Coverage Loss Inevitable if Financial Assistance Is Not Extended

Exhibit 3. Potential Monthly Net Premium Increases After Any Federal Tax Credits for Subsidized Covered California Enrollees Less Than 400 Percent of the Federal Poverty Level — Taking Effect in 2023[7]

For the lowest-income consumers below 250% FPL, the expiration of the ARP would cause average net premiums to double from $65 to $131 per month.



	Less than 400% FPL Total	Less than 150% FPL	150-200% FPL	200-250% FPL	250-400% FPL
Income for single tax filer at bottom of range	–	~$18,000/yr	~$19,000/yr	~$26,000/yr	~$32,000/yr
Count of subsidized enrollees	1,494,000	280,000	451,000	275,000	487,000
Share of subsidized enrollees	91%	17%	28%	17%	30%

Today in 2022 | If no ARP Extension

The following examples of potential premium impacts are modeled after consumers who benefited from the ARP subsidies in 2021. The examples show what would happen to them and their families if the ARP subsidies are allowed to end.

- **Lower-income consumer would see premium go from $0 to $74 per month:** James is 39 years old and lives in Los Angeles. He earns about $19,000 a year, which is less than 150 percent of the federal poverty level. The increased financial help from the American Rescue Plan allows James to currently get comprehensive coverage at no cost, but without the expanded financial help, his cost would jump to $74 per month in 2023.
- **Father of three would see premiums increase by $199 per month — a five-fold spike:** Paul is 40 years old father, and lives in San Diego with his wife and three children. They have a household income of less than $25,000, which is under 200 percent of the federal poverty level. While his wife has insurance coverage through her employer, and the children are enrolled in Medi-Cal, Paul's premiums would go from $50 per month to $249 per month.
- **Family of four would see their premium jump $240 per month — taking a big bite out of their budget:** Mario is 45 years old and lives in Los Angeles with his wife and two children. They earn about $35,000 a year, which is less than 300 percent of the federal poverty level. The expiration of the ARP subsidies would cause the premium to insure their family of four to rise $240, from $717 per month to $958 per month.

Premium Rate Shock and Coverage Loss Inevitable if Financial Assistance Is Not Extended

- **Middle-income couple in early retirement would lose all help and pay $1,720 more each month:** Isabella is 63 years old and lives in Sacramento with her spouse. They earn about $86,000 per year, which is just less than 500 percent of the federal poverty level for a two-person household. Rolling back the ARP subsidies would mean they are no longer eligible for financial help, and their premium would increase by $1,720 per month, from $609 to $2,329. For this couple, to keep their insurance they would need to spend almost a third of their income (32.5 percent) just to cover the cost of their insurance premium.

Exhibit 4. Potential Monthly Net Premium Increases After Any Federal Tax Credits for Subsidized Covered California Enrollees Earning More Than 400 Percent of the Federal Poverty Level — Taking Effect in 2023[8]

By removing ARP support, these middle income Californians would receive no assistance in paying for their health coverage.

	More than 400% FPL Total	400-500% FPL	500-600% FPL	600%+ FPL
Income for single tax filer at bottom of range	—	~$52,000/yr	~$64,000/yr	~$77,000/yr
Count of subsidized enrollees	148,000	78,000	34,000	35,000
Share of subsidized enrollees	9%	5%	2%	2%

Today in 2022 | If no ARP Extension

Many Californians and Americans Across the Nation Would Be Priced Out of Coverage

The Congressional Budget Office (CBO) has estimated that if the American Rescue Plan expires, enrollment would drop back to pre-ARP levels by 2024 because of the higher cost of coverage. This would mean that nationally, an estimated 1.7 million Americans enrolled in the marketplace would drop coverage because of the increased premium.[9]

Premium Rate Shock and Coverage Loss Inevitable if Financial Assistance Is Not Extended

In California, more than 150,000 enrollees who signed up in 2021 and 2022 could drop coverage due to higher premium costs they would need to shoulder.

New Burdens of Out-of-Pocket Costs

For the majority of consumers currently enrolled in a Silver plan (or higher) level of coverage, one consumer strategy to respond to rate hikes and avoid becoming uninsured entirely may be to switch to lower-cost Bronze coverage with lower premiums. This choice comes with major tradeoffs and exposure to substantial out-of-pocket costs that could delay or prevent consumers from accessing care. People choosing to enroll in Bronze plans would be forced to shoulder a higher out-of-pocket cost burden when they seek care, with a median deductible of $6,935 for Bronze plans nationally.[10] By contrast, all California enrollees and many in HealthCare.gov who choose Silver plans can access virtually all outpatient care without being subject to any deductible.[11]

Extending Premium Subsidies This Year Would Avoid Rate Hikes and Coverage Drops

If the premium subsidies enacted by the American Rescue Plan are left to expire, we could observe the following effects.

- Millions of consumers would begin to face higher premiums in October 2022. In addition to the premium increases from expiring premium subsidies, many consumers would face a second blow of higher premiums due to the eroded risk mix within the marketplace likely leading to premium increases not reflected in the figures detailed in this analysis. These premium increases would have the biggest impact on those earning over 400 percent of the federal poverty level ($52,000 for an individual) who would have no premium support to shield them from rising costs.[12]
- Almost 2 million consumers nationally could drop coverage in the face of these price increases.
- People who decide to stay covered would pay dramatically more money and may opt for less comprehensive, high-deductible coverage, potentially making cost a barrier when they need to get care.

The American Rescue Plan has had a dramatic impact on coverage affordability across the country and in California, providing unprecedented affordability and helping millions of uninsured get covered. In the absence of federal action to extend these policies this year, Americans' access to health coverage and care will be dramatically reduced.

About Covered California

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

Endnotes

[1] Centers for Medicare & Medicaid Services (2022). 2022 Open Enrollment Period Report: Final National Snapshot (Jan. 27, 2022). Available at: https://www.cms.gov/newsroom/fact-sheets/marketplace-2022-open-enrollment-period-report-final-national-snapshot.

[2]The somewhat lower rate of growth in California is due to the fact that Covered California had large enrollment growth in 2020 in response to the creation of new, state-funded financial help similar to the subsequent federal ARP subsidy increase, as well as implementing a state penalty for non-coverage and conducting major outreach to promote enrollment. These polices and that state's implementing a major special enrollment outreach effort during the first year of the COVID pandemic resulted in Covered California's having almost 1.6 million enrollees as of 2021 — the largest enrollment before the increases associated with the ARP policies.

[3] Centers for Medicare & Medicaid Services (2022). Biden-Harris Administration Announces 14.5 Million Americans Signed Up for Affordable Health Care During Historic Open Enrollment Period (Jan. 27, 2022). Available at: https://www.cms.gov/newsroom/press-releases/biden-harris-administration-announces-145-million-americans-signed-affordable-health-care-during.

[4] Because the ARP was signed in March 2021, qualified health plan issuers could rely on ARP subsidies when setting rates for 2022 (which occurs in the late spring and early summer). In California, premiums (before tax credits) increased by less than 2 percent for 2022: These rates were lower than widely reported rates for employer-sponsored coverage nationally, and these increases could also be averted in part by members switching to lower-priced plans in their same tier. Covered California (2021). Covered California Announces 2022 Plans: Full Year of American Rescue Plan Benefits, More Consumer Choice and Low Rate Change (July 28, 2021). Available at: 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/; Mercer (2021). Employers expect a 4.7% increase in health benefit costs for 2022 as they focus on improving employee benefits rather than cost-cutting, Mercer survey finds (October 6, 2021). Available at: https://www.mercer.com/newsroom/employers-expect-an-increase-in-health-benefit-costs-for-2022-as-they-focus-on-improving-employee-benefits-rather-than-cost-cutting.html ; PwC Health Research Institute (2021). Medicalcost trend: Behind the numbers 2022. Available at: https://www.pwc.com/us/en/industries/health-industries/library/assets/pwc-hri-behind-the-numbers-2022.pdf.

[5] In the year between the 2021's and 2022's open-enrollment periods, key indicators of changes to coverage that result in churn into marketplace eligibility would have predicted a reduction in sign-ups: rising employment (the unemployment rate dropped from 6.9 percent in October 2020 to 4.6 percent in October 2021) and reduced inflows from Medicaid thanks to the Maintenance of Effort (MOE) for coverage required under the Public Health Emergency. Given the observed enrollment increase relative to 2021, the increased affordability of the ARP stands out clearly as the most likely driver.

[6]Tan, Sean (2021). California Reached Health Coverage Milestone With 94 Percent of People Insured in 2020, but Access to Care Remains a Challenge During the COVID-19 Pandemic. UCLA Center for Health Policy Research (Sept. 2021). Available at: https://healthpolicy.ucla.edu/publications/Documents/PDF/2021/access-to-care-policybrief-sep2021.pdf; Chamie, Gabriel et al. SARS-CoV-2 Community Transmission During Shelter-in-Place in San Francisco. MedRxiv (pre-print) (June 2020). Available at: https://www.medrxiv.org/content/10.1101/2020.06.15.20132233v1. See also American Community Survey. Table S2701 – Selected Characteristics of Health Insurance Coverage In the United States: 2019. Available at: https://data.census.gov/cedsci/table?q=Health%20Insurance&g=0100000US&tid=ACSST1Y2019.S2701&tp=false.

[7] Net premium amounts shown are per member per month, after any federal tax credits, among Covered California enrollees who were receiving subsidies under ARP at the end of the 2022 open enrollment period, approximately 150,000 individuals. Share of total enrollees is out of all enrollees receiving subsidies across all income ranges (1.64 million). Excluded are approximately 127,000 enrollees who did not receive subsidies either because the benchmark plan available to them was considered affordable relative to their income which was over 400% of FPL, or because they asked not to receive financial assistance (and hence no income known). Numbers shown may not sum due to rounding.

[8] Net premium amounts shown are per member per month, after any federal tax credits, among Covered California enrollees who were receiving subsidies under ARP at the end of the 2022 open enrollment period with incomes below 400% of FPL (1.494 million). Share of total enrollees is out of all enrollees receiving subsidies across all income ranges (1.64 million). Excluded are approximately 7,000 enrollees who did not receive subsidies because the benchmark plan available to them was considered affordable relative to their income, despite it being below 400% of FPL. Numbers shown may not sum due to rounding.

Endnotes

[9] Congressional Budget Office (2021). Reconciliation Recommendations of the House Committee on Ways & Means (revised Feb. 17, 2021). Available at: https://www.cbo.gov/system/files/2021-02/hwaysandmeansreconciliation.pdf.

[10] Keith, Katie. Premiums Will Drop, ARPA Savings Continue As 2022 Open Enrollment Period Draws Near. Health Affairs (blog) (Oct. 28, 2021). Available at: https://www.healthaffairs.org/do/10.1377/forefront.20211028.68637.

[11] Gunja, Munira Z., Collins, Sara R., Beutal, Sophie. How Deductible Exclusions in Marketplace Plans Improve Access to Many Health Care Services. The Commonwealth Fund (March 17, 2016). Available at: https://www.commonwealthfund.org/publications/issue-briefs/2016/mar/how-deductible-exclusions-marketplace-plans-improve-access-many. In the proposed 2023 Notice of Benefit and Payment Parameters, CMS proposed to introduce standardized benefit designs to the HealthCare.gov states, which would cover many services and prescription drug benefits before the deductible. See Chu, RC et al. Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces. Assistant Secretary for Planning and Evaluation (December 28, 2021). Available at: https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf.

[12] An estimate by the Urban Institute projected that premiums could be as much as 15 percent lower with ARP subsidies due to the increased enrollment from otherwise uninsured individuals who have a lower risk mix. This is based on the assumption of ARP subsidies being made permanent, and a total of 5 million new enrollments nationally. The loss of almost two million enrollees who did enroll under ARP will still have impacts on the risk mx, raising costs on both unsubsidized enrollees who buy off-exchange, and raising cots to the U.S. Treasury on a per member basis for existing coverage subsidies. See Banthin J, Buettgens M, Simpson M, Wang R. What if the American Rescue Plan's Enhanced Marketplace Subsidies Were Made Permanent? Estimates for 2022. The Urban Institute (April 2021). Available at: 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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BLOG / MARCH 31, 2022

California's Marketplace Tries New Tactics to Reduce the Number of Uninsured and Underinsured

▲ Kim Dimaunahan, Telemetry Oncology R.N., right, brings medication to COVID-19-positive patient Eustacio Garcia, 54, left, inside Little Company of Mary Medical Center on Friday, July 30, 2021, in Torrance, Calif. California recently adopted strategies for its state-run marketplace to decrease friction in the enrollment process and help current marketplace enrollees move into plans with lower cost sharing. Photo: Francine Orr/Los Angeles Times via Getty Images

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TOPLINES

States looking to improve plan enrollment in their health insurance marketplaces and ensure people can get more comprehensive coverage may want to look to California for ideas

California will soon partially automate marketplace enrollment for people losing Medicaid coverage by placing those who are eligible into the lowest-cost silver plan available

Millions of people in the United States lack comprehensive health insurance. Although many are eligible for marketplace subsidies under the Affordable Care Act (ACA), costs associated with health insurance, lack of awareness, and administrative enrollment barriers have hindered coverage take-up. Additionally, some consumers who sign up for marketplace coverage wind up in plans with high out-of-pocket costs, leaving them underinsured with limited access to care.

Reducing barriers that lead to people being uninsured and underinsured requires innovative policies to simplify enrollment and help consumers access more generous plans that fit their budget. California recently adopted strategies for its state-run marketplace to decrease friction in the enrollment process and help current marketplace enrollees move into plans with lower cost sharing.

Reducing the Number of Uninsured

Preventing coverage gaps when people transition from Medicaid to the marketplace

When the COVID-19 public health emergency expires, estimates suggest that nearly 15 million people could lose Medicaid eligibility, creating a risk of disruption in coverage and care. With the American Rescue Plan's (ARP) temporary subsidy expansion in place, one-third of the adults in this group are expected to have access to subsidized marketplace plans, but many are unaware of their eligibility or face enrollment barriers. States can help consumers avoid gaps in coverage by conducting extensive outreach and adopting policies that reduce the burden of "churning" between coverage programs.

To this end, California's marketplace will partially automate marketplace enrollment for people losing Medicaid. The new process, scheduled to take effect later this year, will enroll those eligible for marketplace subsidies into the lowest-cost silver plan (i.e., moderate costs and premiums) available. Consumers qualifying for a plan that requires them to make any premium payment will be automatically enrolled and can accept coverage through their initial premium payment or opt out of coverage by cancelling the plan or declining to make this payment. Consumers qualifying for a $0 premium plan after subsidies (a reality thanks to state-funded premium assistance) will have to consent to their marketplace plan in lieu of making a payment to effectuate coverage, or

may decline by taking no action or actively cancelling their plan. An estimated 25 percent to 30 percent of Californians losing Medicaid eligibility will qualify for marketplace enrollment through the new process.

Reducing enrollment hurdles by removing the burden of nominal premiums

California is alleviating premium charges that are low in absolute terms but impose a barrier to enrolling in health insurance. Although the ARP significantly improved marketplace premium affordability by temporarily expanding federal premium subsidies, allowing many to enroll in $0 premium plans, federal law prohibits the subsidies from paying for the portion of an enrollee's premium that's attributable to certain abortion services. Consequently, consumers in states (like California) that require marketplace plans to cover these services can't get free coverage; they get a bill. While this bill is small, research shows that even nominal premiums significantly reduce coverage take-up. Accordingly, California recently appropriated funds to cover this portion of premiums, allowing eligible consumers to enroll in plans without any monthly premium payment. The ARP's subsidy expansion increased the number of individuals who qualify for $0 premiums under this new state policy, but even before the ARP this change was expected to improve enrollment among low-income individuals.

Reducing the Number of Underinsured

Reenrolling eligible consumers in more generous coverage at no additional cost

The ARP's subsidy expansion increased access to marketplace coverage with lower cost sharing. While it remains in effect, many enrollees with bronze-level plans (i.e., products with the highest cost sharing) who previously would have had to pay higher premiums to get a silver plan with subsidized cost sharing can now enroll in such plans for a $0 premium. In California, this upgrade from a bronze plan to a silver plan with maximum cost-sharing assistance, made easier by the ARP's subsidy enhancements, has the effect of lowering individual medical deductibles from $6,300 to $75. Yet because many marketplace enrollees do not actively shop each year, instead passively "autorenewing" their insurance, consumers may forgo plans with significantly lower cost sharing. California's marketplace identified thousands of enrollees who qualify for more generous coverage from the same insurer at no extra cost.

But after direct outreach to encourage renewing enrollees to switch to more generous plans with lower premiums had a modest impact, the marketplace implemented a new autorenewal policy. Bronze enrollees eligible for the highest level of cost-sharing subsidies are autorenewed in a silver plan — allowing them to access cost-sharing assistance — with the same insurer and provider network for a $0 premium, if available. California's marketplace board of directors has discussed expanding the program to other enrollees who qualify for more generous coverage at the same or a lower premium if the ARP's subsidy expansion is made permanent. Of note, the Biden administration requested stakeholder feedback on a similar proposal for the federal marketplace to take factors like plan generosity and net premiums into account at autorenewal.

Looking Ahead

The uninsured and underinsured face various roadblocks to enrolling in and using coverage. The ARP alleviated some of the cost burden of marketplace plans, presenting the opportunity to broadcast availability of cheaper coverage and implement policies that simplify the sign-up process. While not a panacea, California's policies provide a playbook of approaches to improve take-up of coverage and lower cost barriers to care. These policies can help inform similar efforts in the federal marketplace.

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AREA OF FOCUS

Achieving Universal Coverage

TOPICS

Marketplace Enrollment, Uninsured, Underinsured

2022 Open Enrollment Report

HEALTH INSURANCE MARKETPLACES 2022 OPEN ENROLLMENT REPORT

The Health Insurance Marketplaces 2022 Open Enrollment Report summarizes health plan selections through the individual Marketplaces during the 2022 Open Enrollment Period (2022 OEP). This report includes OEP data for the 33 states with Marketplaces that use the HealthCare.gov eligibility and enrollment platform for the 2022 plan year (HealthCare.gov states), as well as for the 18 State-based Marketplaces (SBMs) that use their own eligibility and enrollment platforms.[1]

Key findings from this report include:

Total Marketplace Plan Selections: Over 14.5 million consumers selected or were automatically re-enrolled in health insurance coverage through HealthCare.gov and State-based Marketplaces during the 2022 OEP. Over 2.5 million more consumers signed up for coverage during the 2022 OEP compared to the 2021 OEP, a 21 percent increase.

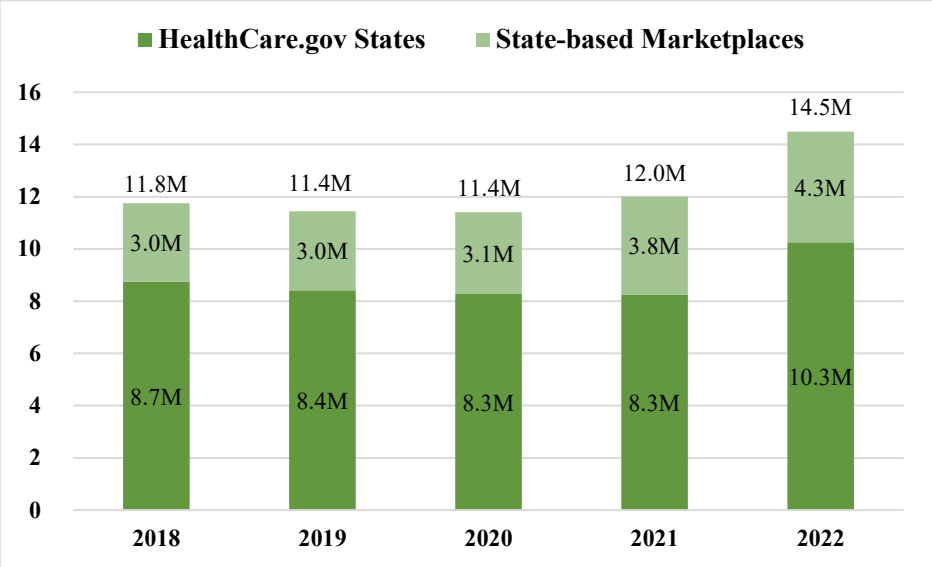
- ***HealthCare.gov Plan Selections:*** In HealthCare.gov states, 10.3 million consumers enrolled in health coverage during the 2022 OEP between November 1, 2021 and January 15, 2022.
- ***State-based Marketplace Plan Selections:*** Across the 18 SBMs, 4.3 million enrollees signed up for health coverage during the 2022 OEP from November 1, 2021 through the end of their respective reporting periods.
- ***New Consumers:*** Nationwide, the number of new consumers signing up for Marketplace coverage during the 2022 OEP increased by 20 percent, to 3.1 million, from 2.5 million in the 2021 OEP.
- ***Demographic Trends:*** Among consumers who attested to a race or ethnicity, 19 percent identified as Hispanic/Latino in the 2022 OEP, compared to 18 percent in the 2021 OEP, and the percent of consumers with a known race or ethnicity who identified as Black increased to 9 percent in the 2022 OEP, from 8 percent in the 2021 OEP.
- ***Premiums and Financial Assistance:*** Nationwide, 2.8 million more consumers are receiving APTC in 2022 compared to 2021. Additionally, 1.1 million consumers reported household incomes over 400% FPL during the 2022 OEP, who would not have been eligible for APTC without the American Rescue Plan (ARP). The average monthly premium after APTC fell by 19 percent, from $164 in 2021 to $133 in 2022, and 28 percent of consumers selected a plan for $10 or less per month after APTC during the 2022 OEP.
- ***Cost-Sharing:*** The percentage of all Marketplace consumers who received cost-sharing reductions (CSRs) increased slightly from the 2021 OEP to the 2022 OEP, from 47 percent to 49 percent, respectively.
- ***Consumer Savings due to ARP:*** The average monthly 2022 premium for HealthCare.gov enrollees was $111. If consumers had not received the additional APTC provided by the ARP, the average monthly premium after APTC for HealthCare.gov consumers would have been 53 percent higher, or $170.

[1] Plan selections and other data by Marketplace platform for each OEP reflects the status of the state's platform at the time of that OEP. Data for SBMs that use their own eligibility and enrollment platforms are retrieved from the respective states' information systems and have not been validated by CMS; thus, metric calculations for these states may vary. The 18 SBMs that use their own eligibility and enrollment platforms in 2022 are California, Colorado, Connecticut, the District of Columbia, Idaho, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, Vermont, and Washington. New Jersey and Pennsylvania transitioned to SBMs for the 2021 plan year. Kentucky, Maine, and New Mexico transitioned to SBMs for the 2022 plan year.

CONSUMERS SELECTING PLANS THROUGH THE MARKETPLACES: 50 STATES, PLUS DC

Over 14.5 million consumers selected or were automatically re-enrolled[2] in a Marketplace plan during the 2022 OEP. This includes 10.3 million consumers in states using the HealthCare.gov platform and 4.3 million consumers in SBMs using their own platforms (see Figure 1).

Figure 1: Plan Selections during 2018 – 2022 Open Enrollment Periods[3]



Nationwide, the number of plan selections during the 2022 OEP increased by 21 percent in comparison to the 2021 OEP (see Table 1). In HealthCare.gov states, plan selections increased by 24 percent, to 10.3 million from 8.3 million during the 2021 OEP, while SBM plan selections increased by 13 percent from 3.8 million in 2021 to 4.3 million in 2022. The HealthCare.gov data reported reflects the HealthCare.gov platform's 2022 OEP from November 1, 2021 through January 15, 2022. For the SBMs, the number of plan selections included in this report reflects the timeframe of each SBM's active 2022 OEP, which varies by state.

At the state level, more than half of states saw increases in plan selections of 10 percent or more. Generally, Medicaid non-expansion states, which comprised over half of total 2022 OEP enrollment, saw higher enrollment increases than expansion states. The states with the greatest increases in plan selections included Texas (42%), Georgia (36%), Arkansas (33%), South Dakota (32%), and North Dakota (32%). In contrast, the states with the lowest increases in plan

[2] As in prior years, consumers with coverage at the end of 2021 who did not make an active selection were generally automatically re-enrolled for 2022. When consumers had 2022 Marketplace plans available to them from their 2021 issuer, they were automatically re-enrolled into the same plan as 2021 or a different plan from the same issuer. Depending on the Marketplace, they could also be automatically re-enrolled into a suggested alternate plan from a different issuer, if no plan from their current issuer was available to them.

[3] For HealthCare.gov states: the 2018 OEP was from 11/1/2017 to 12/15/2017 with data reported through 12/23/2017; the 2019 OEP was from 11/1/2018 to 12/15/2018 with data reported through 12/22/2018 (this includes the additional time provided to consumers who were unable to enroll by the original deadline); the 2020 OEP was from 11/1/2019 to 12/15/2019 with data reported from 11/1/2019 to 12/21/2019 (this includes the additional time provided to consumers who were unable to enroll by the original deadline); the 2021 OEP was from 11/1/2020 to 12/15/2020 with data reported through 12/21/2020 (this includes the additional time provided to consumers who were unable to enroll by the original deadline); the 2022 OEP was from 11/1/2021 to 1/15/2022 with data reported through 1/15/2022. Dates through which data are reported vary for SBMs; see the PUF FAQs for detailed information.

selections included Idaho (7%), New Mexico (6%), Oregon and Rhode Island (4%), and New York (3%).

Table 1: OEP Plan Selections by State

State	Platform	2022	2021	% Change
Total	HealthCare.gov & SBM	14,511,077	12,004,365	21%
Alabama	HealthCare.gov	219,314	169,119	30%
Alaska	HealthCare.gov	22,786	18,184	25%
Arizona	HealthCare.gov	199,706	154,504	29%
Arkansas	HealthCare.gov	88,226	66,094	33%
California	SBM	1,777,442	1,625,546	9%
Colorado	SBM	198,412	179,607	10%
Connecticut	SBM	112,633	104,946	7%
Delaware	HealthCare.gov	32,113	25,320	27%
District of Columbia	SBM	15,989	16,947	-6%
Florida	HealthCare.gov	2,723,094	2,120,350	28%
Georgia	HealthCare.gov	701,135	517,113	36%
Hawaii	HealthCare.gov	22,327	22,903	-3%
Idaho	SBM	73,359	68,832	7%
Illinois	HealthCare.gov	323,427	291,215	11%
Indiana	HealthCare.gov	156,926	136,593	15%
Iowa	HealthCare.gov	72,240	59,228	22%
Kansas	HealthCare.gov	107,784	88,627	22%
Kentucky	SBM	73,935	77,821	-5%
Louisiana	HealthCare.gov	99,626	83,159	20%
Maine	SBM	66,095	59,738	11%
Maryland	SBM	181,603	166,038	9%
Massachusetts	SBM	268,023	294,097	-9%
Michigan	HealthCare.gov	303,550	267,070	14%
Minnesota	SBM	121,322	112,804	8%
Mississippi	HealthCare.gov	143,014	110,966	29%
Missouri	HealthCare.gov	250,341	215,311	16%
Montana	HealthCare.gov	51,134	44,711	14%
Nebraska	HealthCare.gov	99,011	88,688	12%
Nevada	SBM	101,411	81,903	24%
New Hampshire	HealthCare.gov	52,497	46,670	12%
New Jersey	SBM	324,266	269,560	20%
New Mexico	SBM	45,664	42,984	6%
New York	SBM	221,895	215,889	3%
North Carolina	HealthCare.gov	670,223	535,803	25%
North Dakota	HealthCare.gov	29,873	22,709	32%
Ohio	HealthCare.gov	259,999	201,069	29%
Oklahoma	HealthCare.gov	189,444	171,551	10%
Oregon	HealthCare.gov	146,602	141,089	4%
Pennsylvania	SBM	374,776	337,722	11%
Rhode Island	SBM	32,345	31,174	4%
South Carolina	HealthCare.gov	300,392	230,050	31%
South Dakota	HealthCare.gov	41,339	31,375	32%

State	Platform	2022	2021	% Change
Tennessee	HealthCare.gov	273,680	212,052	29%
Texas	HealthCare.gov	1,840,947	1,291,972	42%
Utah	HealthCare.gov	256,932	207,911	24%
Vermont	SBM	26,705	24,866	7%
Virginia	HealthCare.gov	307,946	261,943	18%
Washington	SBM	239,566	222,731	8%
West Virginia	HealthCare.gov	23,037	19,381	19%
Wisconsin	HealthCare.gov	212,209	191,702	11%
Wyoming	HealthCare.gov	34,762	26,728	30%

Table 2 shows enrollment for states that have implemented Basic Health Programs (BHP). In New York and Minnesota, consumers with household incomes at or below 200 percent of the FPL who are not eligible for Medicaid or the Children's Health Insurance Program (CHIP) who apply for coverage are enrolled in the applicable state Basic Health Program instead of a Qualified Health Plan (QHP). Year over year, total BHP enrollment increased 8 percent from approximately 975,000 enrollees in the 2021 OEP to approximately 1.1 million enrollees during the 2022 OEP. Minnesota's BHP enrollment increased by 7 percent and New York's increased by 8 percent from 2021 to 2022.

Table 2: Basic Health Program (BHP) Enrollment[4]

State	2022	2021
Total	1,054,603	975,337
Minnesota	98,581	91,886
New York	956,022	883,451

Figure 2 compares new and returning consumer plan selections nationwide during OEPs from 2018-2022. During the 2022 OEP, new consumer plan selections through all Marketplaces exceeded 3 million for the first time since 2018, and increased 20 percent from the 2021 OEP, despite the 2.8 million new plan selections under the 2021 Special Enrollment Period that was made available from February 15 to August 15, 2021 on HealthCare.gov, and through varying dates for SBMs. As demonstrated below, 11.4 million enrollees returned to the Marketplaces actively or through auto re-enrollment, a 21 percent increase from 9.5 million in 2021.

[4] New York's BHP is known as the Essential Plan and Minnesota's BHP is known as MinnesotaCare.

Figure 2: New and Returning Consumer Plan Selections during 2018 – 2022 Open Enrollment Periods

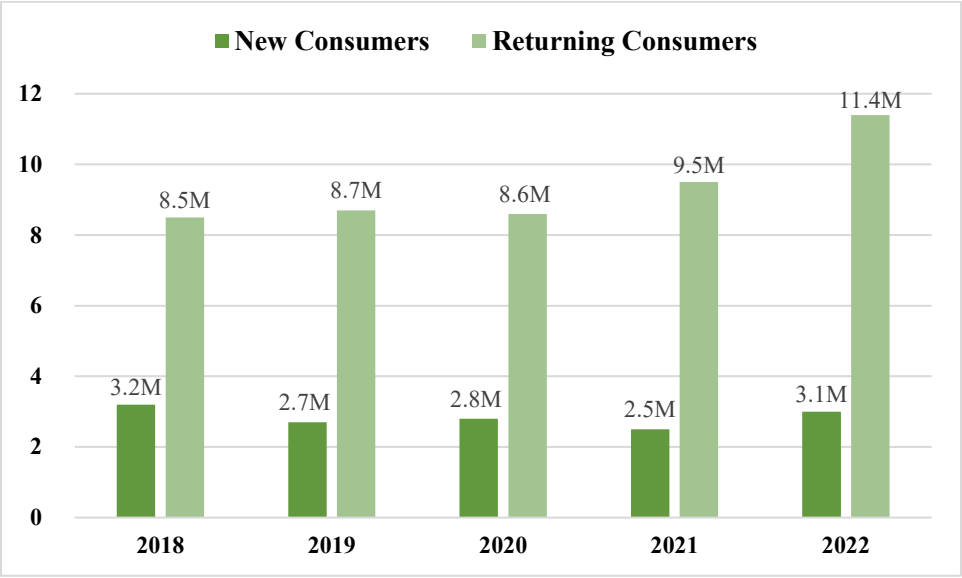


Table 3 summarizes consumers who selected plans during the 2022 OEP by enrollment type. Nationally, new and actively returning consumers' plan selections as a percentage of total plan selections remained steady from the 2021 OEP to the 2022 OEP at 21 percent and 46 percent respectively. Similar to 2021, in HealthCare.gov states, 23 percent of enrollees represented new consumers while 55 percent were consumers who actively returned to the HealthCare.gov platform. For states using SBM platforms, 16 percent of plan selections were new consumers and 25 percent were actively returning. Additional plan selection and demographic data for all 50 states plus DC are provided in the accompanying PUFs.

Table 3: Summary of OEP Plan Selections by Enrollment Type

	Count 2022	Count 2021	% of Total 2022	% of Total 2021
New Consumers: All States	3,066,360	2,545,559	21	21
Returning Consumers Re-enrolling in Coverage: All States	11,444,717	9,458,806	79	79
Active Re-enrollees: All States	6,742,948	5,513,796	46	46
Automatic Re-enrollees: All States	4,701,769	3,945,010	32	33
HealthCare.gov States				
New Consumers: HC.gov States	2,380,835	1,884,174	23	23
Returning Consumers Re-enrolling in Coverage: HC.gov States	7,874,801	6,367,529	77	77
Active Re-enrollees: HC.gov States	5,680,878	4,648,617	55	56
Automatic Re-enrollees: HC.gov States	2,193,923	1,718,912	21	21
State-based Marketplaces				
New Consumers: SBMs	685,525	661,385	16	18
Returning Consumers Re-enrolling in Coverage: SBMs	3,569,916	3,091,277	84	82
Active Re-enrollees: SBMs	1,062,070	865,179	25	23
Automatic Re-enrollees: SBMs	2,507,846	2,226,098	59	59
Total Plan Selections: All States	14,511,077	12,004,365	100	100
Total Plan Selections: HC.gov States	10,255,636	8,251,703	100	100
Total Plan Selections: SBMs	4,255,441	3,752,662	100	100

CONSUMERS APPLYING FOR AND SELECTING PLANS: DETAILS

Reported below are statistics on the individuals who requested coverage on submitted applications for the 2022 and 2021 OEPs. During the 2022 OEP, 68 percent of applicants requesting coverage through the Marketplaces were determined eligible to make a Marketplace plan selection, compared to 66 percent during the 2021 OEP. On the HealthCare.gov platform, 94 percent of applicants were determined eligible to make a Marketplace plan selection, and 44 percent of applicants using the SBMs were determined eligible to make a plan selection. The percentage of consumers who applied for coverage through HealthCare.gov and were preliminarily determined eligible for their state's Medicaid or Children's Health Insurance Program (CHIP) fell by 2 percentage points to 6 percent in comparison to 2021.

Table 4: Marketplaces Application Activity and Eligibility for 2022 and 2021

	Count 2022	Count 2021	% of Total 2022	% of Total 2021
Consumers Requesting Coverage on Applications Submitted – All States	25,830,064	22,186,055	100	100
Marketplace Eligible – All States	17,485,459	14,696,181	68	66
HealthCare.gov States				
Consumers Requesting Coverage on Applications Submitted – HC.gov States[5]	12,194,577	9,932,394	100	100
Marketplace Eligible – HC.gov States[5]	11,486,135	9,249,680	94	93
Medicaid/CHIP Eligible – HC.gov States	743,544	762,533	6	8
State-based Marketplaces[6]				
Consumers Requesting Coverage on Applications Submitted – SBMs	13,635,487	12,253,661	100	100
Marketplace Eligible - SBMs	5,999,324	5,446,501	44	44

Table 5 shows demographic and plan characteristics among consumers who selected or were automatically re-enrolled in a plan during the 2022 and 2021 OEPs. Some of the changes in the 2022 OEP demographic composition and plan choices of consumers can be attributed to the impacts of the ARP. For example, the percent of consumers with a household income over 400% FPL increased by 4 percentage-points for HealthCare.gov states and SBMs, from 2 percent and 6 percent in 2021 to 6 percent and 10 percent in 2022 respectively. Nationally, during the 2022 OEP, 89 percent of consumers had their premiums reduced by APTC compared to 85 percent in the 2021 OEP. 92 percent of HealthCare.gov consumers had plan selections with APTC compared to 88 percent in 2021 while 83 percent of SBM consumers had plan selections with APTC compared to 78 percent in 2021. The percentage of all Marketplace consumers who received cost-sharing reductions (CSRs) increased slightly from 47 percent during the 2021 OEP

[5] The Consumers Requesting Coverage on Applications Submitted and Consumers Determined Eligible for QHP metrics have an updated methodology this year that consistently excludes auto re-enrollment applications associated with only cancelled policies. Such applications are considered operational artifacts, rather than true application submissions. To allow for cross-year comparison, the 2021 values for these metrics were recalculated using the updated methodology and differ from what was published in last year's Open Enrollment snapshots and final report.

[6] Most State-based Marketplaces have integrated eligibility systems with their State Medicaid. In those states, Consumers Requesting Coverage on Applications Submitted includes applications received for MAGI Medicaid renewals, in addition to QHP renewal applications and new applications. Some SBMs do not report on consumers determined eligible for Medicaid/CHIP and thus a total number is not provided here. See the PUF definitions for further information.

to 49 percent during the 2022 OEP. Over 30 percent of 2022 OEP HealthCare.gov enrollees selected plans that cover 94 percent of their expected health care costs (94% AV).

Table 5: Demographic and Plan Characteristics of Consumers with OEP Plan Selections (HealthCare.gov States and SBMs, Unless Otherwise Noted)

	% of Total[7] 2022	% of Total[7] 2021
Age		
< 18	9	9
18 - 34	25	25
35 - 54	36	36
55+	29	30
Gender		
Female	54	54
Male	46	46
Location: HealthCare.gov States		
Rural	18	18
Non-rural	82	82
Household Income: HealthCare.gov States		
< 100%	1	2
≥ 100% and ≤ 150%	40	41
≥ 100% and ≤ 138%	31	32
> 150% and ≤ 250%	31	32
> 250% and ≤ 400%	18	17
> 400% FPL	6	2
Other Household Income[8]	3	6
Household Income: SBMs[9]		
< 100%	2	3
≥ 100% and ≤ 150%	12	13
≥ 100% and ≤ 138%	3	NA
> 150% and ≤ 250%	36	39
> 250% and ≤ 400%	27	26
> 400% FPL	10	6
Other Household Income[8]	14	14
Financial Assistance		
With APTC: All States	89	85
HealthCare.gov States	92	88
SBMs	83	78
With CSR: All States[9]	49	47
HealthCare.gov States	53	51
73% AV	5	4
87% AV	13	12
94% AV	35	34
American Indian/Alaskan Native	1	1
SBMs[9]	37	39

[7] Totals may not sum to 100% due to rounding.
[8] Other household income includes plan selections for which consumers were not requesting financial assistance and unknown household income. Please see PUFs for more information.
[9] Idaho has been excluded from SBM household income metrics as Idaho's household income data was not available for both years at the time of this report. Nevada has been excluded from SBM CSR metrics as Nevada's CSR data was not available for both years at the time of this report.

	% of Total[7] 2022	% of Total[7] 2021
Metal Level		
Catastrophic	1	1
Bronze	32	35
Silver	56	55
Gold	10	8
Platinum	1	1

Table 6 provides race and ethnicity demographics for all consumers who enrolled in plans during the 2022 OEP. Overall, among consumers who attested to a race or ethnicity, 19 percent identified as Hispanic/Latino in the 2022 OEP, compared to 18 percent in the 2021 OEP. The percentage of consumers who self-reported as Black, Non-Hispanic increased to 9 percent from 8 percent in 2021. Similarly, 20 percent of HealthCare.gov consumers attested to being Hispanic/Latino, an increase from 19 percent in 2021, and 11 percent of enrollees self-reported as Black compared to 9 percent in 2021. SBM consumers who identified as Hispanic/Latino increased from 17 percent to 18 percent from 2021 to 2022, and those who attested to being Black remained steady at 5 percent for 2022 and 2021.

Table 6: Race and Ethnicity Demographics of Consumers with OEP Plan Selections

	% of Total[10] 2022	% of Total[10] 2021
Race/Ethnicity: All States		
Race/Ethnicity Known	67	69
Hispanic/Latino	19	18
White, Non-Hispanic	55	57
Black, Non-Hispanic	9	8
Asian, Non-Hispanic	12	13
Native Hawaiian/Pacific Islander, Non-Hispanic	<1	<1
American Indian/Alaska Native, Non-Hispanic	1	1
Other, Non-Hispanic	2	NA
Multi-Racial, Non-Hispanic	2	2
Race/Ethnicity Unknown, Non-Hispanic	33	31
Race/Ethnicity: HealthCare.gov States		
Race/Ethnicity Known	62	66
Hispanic/Latino	20	19
White, Non-Hispanic	56	59
Black, Non-Hispanic	11	9
Asian, Non-Hispanic	9	9
Native Hawaiian/Pacific Islander, Non-Hispanic	<1	<1
American Indian/Alaska Native, Non-Hispanic	1	1
Other, Non-Hispanic	1	1
Multi-Racial, Non-Hispanic	2	2
Race/Ethnicity Unknown, Non-Hispanic	38	34

[10] Totals may not sum to 100% due to rounding.

	% of Total[10] 2022	% of Total[10] 2021
Race/Ethnicity: SBMs[11]		
Race/Ethnicity Known	79	74
Hispanic/Latino	18	17
White, Non-Hispanic	53	55
Black, Non-Hispanic	5	5
Asian, Non-Hispanic	17	19
Native Hawaiian/Pacific Islander, Non-Hispanic	<1	<1
American Indian/Alaska Native, Non-Hispanic	<1	<1
Other, Non-Hispanic	5	NA
Multi-Racial, Non-Hispanic	2	2
Race/Ethnicity Unknown, Non-Hispanic	21	26

CONSUMER PREMIUMS AND FINANCIAL ASSISTANCE

Table 7 shows the average premiums for consumers who made plan selections in the Marketplaces during the 2022 OEP. Nationally, the average monthly premium after APTC decreased by 19 percent from $164 in 2021 to $133 in 2022 and 28 percent of consumers selected a plan for $10 or less per month after APTC. Likewise, the average monthly APTC for all consumers increased by 4 percent from $485 in 2021 to $505 in 2022.

The average monthly premium after APTC for all HealthCare.gov consumers fell 22 percent, from $143 in 2021 to $111 in 2022. The expansion in financial assistance for consumers resulted in a 3 percent increase of the average monthly APTC amount for HealthCare.gov enrollees, from $509 in 2021 to $524 in 2022. As shown in table 7, 32 percent of all HealthCare.gov consumers had a plan selection with a premium of $10 or less per month after APTC, a 14 percentage-point increase from 18 percent in 2021. Similarly, 38 percent of new HealthCare.gov enrollees and 30 percent of returning enrollees benefited from a plan selection with a premium of $10 or less after APTC in 2022.

In the SBMs, the average monthly premium after APTC decreased by 10 percent to $188 in 2022 from $210 in 2021. Of all SBM consumers who enrolled in plans through the 2022 OEP, 19 percent selected plans that were $10 or less per month.

[11] SBM race/ethnicity breakouts for the 2022 OEP do not add up to total plan selections as WA reported consumers choosing more than one race in multiple categories. SBM race/ethnicity breakouts for the 2021 OEP do not add up to total plan selections as NY, VT, and WA reported consumers choosing more than one race in multiple categories. Some SBM applications do not include Other or Multi-Racial as an option. Colorado did not report race or ethnicity metrics for the 2021 OEP so is excluded from the metrics for both years.

Table 7: Average Monthly Premium before and after APTC

	% of Plan Selections with ≤$10 Premium after APTC	Average Monthly Premium after APTC	Average Monthly Premium before APTC	Average Monthly APTC Amount for Consumers Receiving APTC
All States				
2022: All Consumers[12]	28%	$133	$585	$505
2021: All Consumers[12]	NA	$164	$579	$485
HealthCare.gov States				
2022: All Consumers	32%	$111	$594	$524
2022: New Consumers	38%	$106	$538	$473
2022: Returning Consumers	30%	$112	$611	$540
Actively Re-enrolled	32%	$99	$615	$545
Auto Re-enrolled	24%	$148	$601	$526
2021: All Consumers	18%	$143	$590	$509
2021: New Consumers	23%	$119	$533	$468
2021: Returning Consumers	16%	$151	$607	$521
Actively Re-enrolled	17%	$129	$611	$529
Auto Re-enrolled	13%	$210	$596	$496
State-based Marketplaces				
2022: All Consumers[12]	19%	$188	$563	$452
2021: All Consumers[12]	NA	$210	$553	$426

Figure 3 illustrates the distributions of monthly premiums after APTC for HealthCare.gov consumers during the 2021 and 2022 Open Enrollment Periods. Despite the increase in consumers with higher incomes, which would drive average net premiums up, 2022 coverage was made more affordable for consumers in comparison to the 2021 OEP due to the expanded APTC provided by the ARP. During the 2022 OEP, 22 percent of consumers selected plans with a $0 monthly premium after APTC, versus 14 percent during the 2021 OEP, and over half of 2022 OEP consumers had premiums of $50 or less after APTC, an increase of 13 percentage points from 2021.

[12] Nevada has been excluded from average APTC and average premium metrics as this data was not available at the time of this report.

Figure 3: 2021 and 2022 OEP Premium Distribution in HealthCare.gov States[13]

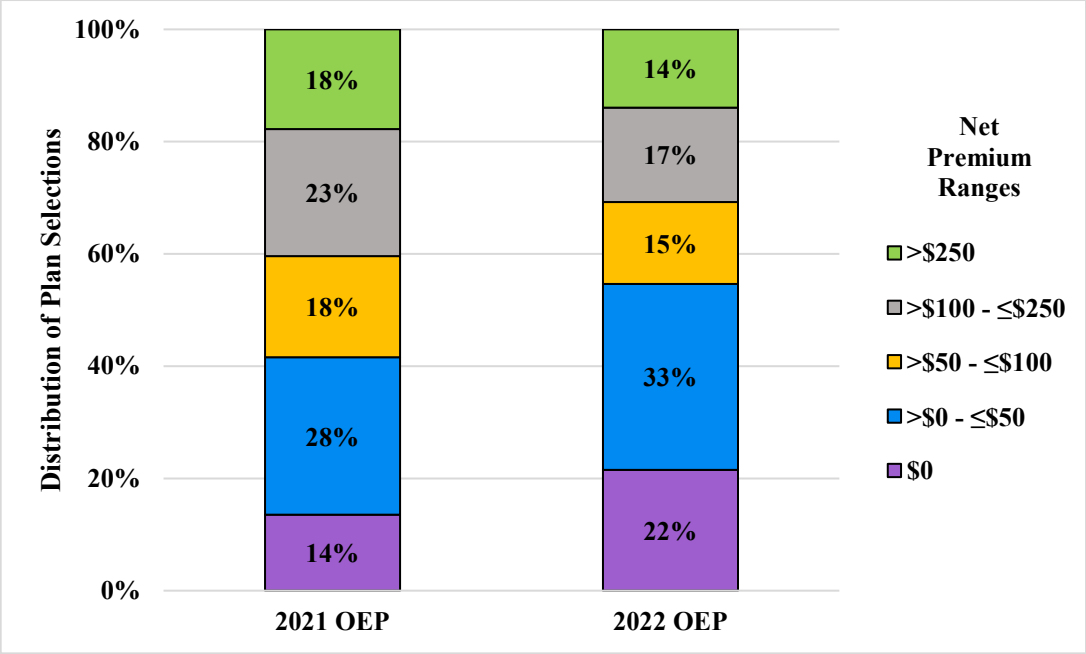


Table 8 details average 2022 monthly premiums for consumers in HealthCare.gov states due to the APTC expansion made available through the ARP. The table also simulates what the average monthly premium would be, for each HealthCare.gov state, without the ARP APTC expansion, assuming the same level and demographic composition of enrollment and plan choices. The average monthly premium for 2022 would have been $170, 53 percent higher than the average premium enrollees will actually pay in 2022 under ARP. In 23 states, monthly premiums would rise by at least 50 percent, on average, without the ARP expansion. In 30 of the 33 HealthCare.gov states, the difference in the actual average monthly 2022 premium with APTC and the average monthly 2022 premium without ARP expansion was at least $50, which would equate to a $2,500 increase in premiums annually.

[13] The 2021 OEP distribution of monthly premiums after APTC has been adjusted to exclude states that transitioned to SBMs for the 2022 coverage year (Kentucky, Maine, and New Mexico), therefore, these numbers may not match what was previously published.

Table 8: HealthCare.gov Consumer Savings due to ARP[14]

State	Actual Average Monthly 2022 Premium with ARP APTC Expansion	Average Monthly 2022 Premium without ARP APTC Expansion	$ Premium Increase without ARP ATPC Expansion	% Premium Increase without ARP APTC Expansion
Total	**$111**	**$170**	**$59**	**53%**
Alaska	$158	$255	$97	62%
Alabama	$96	$158	$62	65%
Arkansas	$134	$207	$73	54%
Arizona	$180	$250	$69	38%
Delaware	$169	$270	$101	60%
Florida	$80	$129	$49	61%
Georgia	$105	$155	$50	47%
Hawaii	$164	$235	$71	43%
Iowa	$135	$233	$97	72%
Illinois	$204	$281	$78	38%
Indiana	$193	$266	$73	38%
Kansas	$149	$214	$65	44%
Louisiana	$157	$242	$85	54%
Michigan	$170	$236	$66	39%
Missouri	$137	$205	$68	50%
Mississippi	$72	$120	$48	67%
Montana	$142	$225	$83	58%
North Carolina	$96	$159	$63	66%
North Dakota	$100	$180	$80	80%
Nebraska	$121	$219	$98	81%
New Hampshire	$212	$272	$60	28%
Ohio	$230	$298	$68	29%
Oklahoma	$93	$153	$60	65%
Oregon	$201	$284	$82	41%
South Carolina	$107	$167	$60	56%
South Dakota	$91	$178	$87	95%
Tennessee	$128	$188	$60	47%
Texas	$86	$133	$47	55%
Utah	$62	$115	$53	86%
Virginia	$126	$197	$71	56%
Wisconsin	$161	$251	$90	56%
West Virginia	$204	$332	$128	63%
Wyoming	$88	$203	$116	132%

[14] The Average Monthly 2022 Premium without ARP Expansion metric calculates APTC assuming a consumers' income, family composition, and OE 2022 plan selection remain the same. However, in the absence of the expanded APTC available from the ARP, some consumers would choose not to enroll at all and others would select less generous plans with lower premiums. APTC is calculated with the applicable percentages that would be in effect without the ARP. For coverage year 2022, the applicable percentages at 26 CFR 1.36B-3(g)(2) would be multiplied by 1.0113319445, the excess of the rate of premium growth over the rate of income growth for 2013 to 2021 (Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Final Rule, 86 FR 24140 at 24228).

Appendix A:

Public Use Files

Public Use Files Contents: More information on applications and plan selections is available in a suite of accompanying public use files (PUFs). The PUFs contain information on applications submitted and the number of medical and stand-alone dental plan selections by state, county and ZIP code. The 2022 OEP State-Level PUF includes other plan and demographic information including the metal level of selected plans, premium and financial assistance information, age, gender, rural location, self-reported race and ethnicity, and household income as a percentage of the FPL. Within the 2022 OEP State, Metal Level, and Enrollment Status PUF, data are stratified by new, returning, and automatically re-enrolled consumers and by plan metal level. The methodology for this report and detailed metric definitions are included in the materials for the PUFs. The state-level PUFs can be found at: https://www.cms.gov/research-statistics-data-systems/marketplace-products/2022-marketplace-open-enrollment-period-public-use-files

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

DATA POINT
March 23, 2022

HP-2022-10

Projected Coverage and Subsidy Impacts If the American Rescue Plan's Marketplace Provisions Sunset in 2023

An estimated 3 million people currently insured in the individual market would lose coverage and become uninsured if the American Rescue Plan's premium tax credit provisions are not extended beyond 2022.

D. Keith Branham, Christine Eibner, Federico Girosi, Jodi Liu, Kenneth Finegold, Christie Peters, and Benjamin D. Sommers

KEY POINTS

- The American Rescue Plan (ARP) included two key provisions that improve affordability for consumers obtaining coverage through the Marketplace: 1) lowering the percentage of income consumers are expected to contribute toward premiums for those between 100 and 400 percent of the federal poverty level (FPL); and 2) extending premium tax credits to households above 400 percent FPL.
- Currently, the ARP premium tax credit provisions are only available through coverage year 2022 and legislation is required to extend them beyond this time frame.
- Of the 19.6 million people estimated to be insured in the individual market, a projected 3.0 million (15 percent) would become uninsured if the premium tax credit provisions provided by the American Rescue Plan (ARP) were to expire in 2023.
- If these provisions expire, our projections estimate that 8.9 million people remaining in Marketplace would see reductions in their Marketplace premium subsidies for individual market coverage (averaging $406 per person, annually) and approximately 1.5 million would lose subsidies entirely (averaging $3,277 per person, annually) but remain insured.
- The states with the largest projected numbers of people losing coverage or experiencing subsidy reductions include California, Florida, Georgia, North Carolina, Pennsylvania, and Texas; with more than 7.7 million people projected to be affected in these six states alone.

BACKGROUND

The American Rescue Plan (ARP) reduces the amount of income individuals and families are expected to contribute toward premiums for individual market coverage through the Marketplace exchanges and extends premium tax credits to households with income above 400 percent of the federal poverty level (FPL). Previous ASPE analyses have shown the impacts of the ARP in lowering Marketplace premiums and improving plan affordability through increased access to zero- and low-premium plans on the HealthCare.gov platform.[1,2,3,4] The ARP increased access to zero-premium plans on the HealthCare.gov platform from 43 percent to 62 percent of uninsured non-elderly adults, and access to low-cost plans (less than $50 per month in premium) increased from slightly more than half of consumers (57 percent) to nearly three quarters (73 percent). With these changes in effect, Marketplace enrollment hit an all-time high of 14.5 million people by the end of the 2022 Open Enrollment Period (OEP).[5] The ARP tax-credit provisions only apply to Marketplace coverage through 2022; under current law, these provisions will expire for coverage year 2023.* This, in turn, will raise out-of-pocket premiums for millions of Americans.

If the ARP premium tax credit provisions are extended, millions of people will continue to benefit from the enhanced and expanded premium subsidies. If the ARP premium tax credit provisions are allowed to sunset, these consumer benefits will be eliminated, likely leading to increases in the number of uninsured and higher out-of-pocket costs for individuals and families purchasing insurance through the Marketplace.

This report projects the potential impacts if the ARP premium tax credits expire in 2023, with both national and state level estimates developed using the Comprehensive Assessment of Reform Efforts (COMPARE) microsimulation model.

METHODS

The projected estimates in this data point primarily come from an analysis by ASPE and RAND using the COMPARE model.[6] The model uses data from multiple nationally representative, publicly available sources to estimate changes in health insurance enrollment and health care spending in response to policy changes, based on economic theory.[7,8,9,10] Primary data sources include the Current Population Survey (CPS),[11] Medical Expenditure Panel Survey (MEPS),[12] the Centers for Medicare & Medicaid Services (CMS) National Health Expenditure Accounts (NHEA),[13] and the Kaiser Family Foundation (KFF) Employer Health Benefits Survey.[14]

COMPARE creates a representation of the U.S. population by assigning individuals in the CPS a spending amount, using the spending of a similar individual from the MEPS. These spending amounts are adjusted to account for people with extremely high health expenditures, and to align with NHEA estimates, according to a procedure developed by researchers from the Agency for Healthcare Research and Quality.[15,16] CPS respondents who report that they are employed are matched to firms in the KFF data.

The model assesses choices that would be made by individuals and families in the sample by weighing the costs and benefits of available insurance options. In doing so, the model considers premiums, out-of-pocket spending, the value of health care consumption, and financial risk. Premiums are estimated based on the expenditures of individuals in the insurance pool, generosity of the plan, and administrative costs.

The model generates estimates for coverage changes at the national level. To produce state-level results in this report, we then allocated the national estimates for coverage changes based on each state's share of

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* The ARP also included a special provision to further lower premium and out-of-pocket costs for individuals receiving unemployment compensation; however, this provision only applied to 2021 coverage and is not examined in this report. See the ASPE report here for more information: https://aspe.hhs.gov/reports/arp-unemployed-ib.

subsidized and unsubsidized Marketplace enrollment during the 2022 Open Enrollment Period. Current Marketplace enrollment totals are from the CMS Marketplace 2022 Open Enrollment Period Public Use Files;[5] these figures are not rounded as they represent actual total plan selections made during the 2022 OEP.[†] In contrast, our projected estimates using the COMPARE model are rounded to the nearest thousand.

We used CMS 2022 OEP data for on-Marketplace subsidized coverage enrollment to calibrate COMPARE's projected estimates at both the national and state level. We used this approach to ensure that the model reproduced observed subsidized enrollment, and to mitigate potential bias due to inertia in decision-making that may have occurred after ARP implementation and that is not reflected in COMPARE's methodology. We assumed that the COMPARE estimates of the unsubsidized population were accurate and allocated the national-level total unsubsidized enrollment as estimated by COMPARE to states based on the proportion of unsubsidized Marketplace enrollees in each state. Because there is no off-Marketplace enrollment in DC,[17] unsubsidized Marketplace enrollment in DC reflects total unsubsidized individual market enrollment. For DC, we therefore derived total unsubsidized individual market enrollment directly from CMS data.

LIMITATIONS

COMPARE is designed to produce national-level policy estimates. The state-specific results presented in this analysis do not account for state-specific factors that may impact the effects of ending ARP premium tax credit provisions; instead, we developed national estimates and then allocated those changes to states based on enrollment totals. Factors we did not incorporate in our approach include state-specific policy responses, such as state-funded subsidy enhancements, and state-specific economic factors, such as trends in employment and wage growth. For example, our methodology would not capture the possibility that a state experiencing high wage growth might realize a less-than-proportional loss in insurance if the ARP were to be eliminated.

When allocating enrollment among the subsidized population, we assumed the proportion losing coverage and having subsidies reduced is equivalent across states. This approach does not account for differences in the income distribution of subsidy-eligible people within each state, an omission that could be important if the probability of losing coverage varies based on income. For example, lower income people may be particularly sensitive to out-of-pocket (OOP) premium costs and may be more likely to disenroll if subsidies fall (and hence OOP contributions rise). Alternatively, higher income people could be at high risk of losing coverage because the elimination of the ARP would end subsidies entirely for people with incomes over 400 percent of the federal poverty level.

For the unsubsidized population, our allocation methodology is based only on Marketplace unsubsidized enrollment, but we use it to assess changes in total individual market unsubsidized enrollment. This approach requires an assumption that changes in off-Marketplace enrollment among unsubsidized individuals mirror changes in on-Marketplace enrollment within state.

COMPARE's projections of subsidized individuals may not be directly comparable to actual plan selections from CMS administrative data for several reasons, including but not limited to: 1) COMPARE is a simulation model using survey data, which leads to margins of error in the estimates produced; 2) survey data are from years preceding 2022 and projected forward, resulting in additional potential for lower accuracy in the projected estimates; and 3) COMPARE models the individual market as a whole and may count some people qualifying for subsidies, but actually enrolled off-Marketplace (unsubsidized), as subsidized Marketplace enrollees.

[†] These estimates include all states and DC as of the end of their open enrollment periods, including any run-out periods. This includes State-based Marketplaces with open enrollment periods extending beyond January 15, 2022, in addition to states using the HealthCare.gov platform whose 2022 open enrollment period ended January 15, 2022.

FINDINGS

Table 1 summarizes our key projections for coverage changes in the individual insurance market if ARP subsidies expire. We also calculated national totals for premium changes, which are not included in Table 1, and we do not have state-level estimates for premium outcomes.

Of the 19.6 million people insured in the individual market, 3.0 million[‡] (15.0 percent) are projected to become uninsured if the ARP's premium tax credit provisions expire in 2023. A projected 8.9 million people remain enrolled in Marketplace coverage but would experience reductions in their Marketplace premium subsidies (with an average reduction of $406 per person per year). An additional 1.5 million are projected to lose subsidies entirely (averaging $3,277 per person per year) but remain insured through some source of coverage.[§] In total, this would amount to 13.3 million[**] individual market enrollees projected to be impacted.[††]

The states with the largest projected numbers of people losing coverage or experiencing subsidy reductions include California, Florida, Georgia, North Carolina, Pennsylvania, and Texas, with more than 7.7 million people projected to be affected in these six states alone. An additional 22 states are projected to have more than 100,000 people impacted each. Half of these states are projected to have impacted numbers of 200,000 or more.

CONCLUSION

The ARP premium tax credit provisions build on the Affordable Care Act (ACA) and provide substantial financial support to Marketplace consumers to ensure that they have access to affordable, comprehensive health insurance coverage. Recent national survey data indicates that the uninsured rate among those under age 65 fell from 12.3 to 10.7 percent from the end of 2020 to the fall of 2021, concurrent with the implementation of the ARP.[18]

If the ARP premium subsidy provisions are allowed to sunset in 2023, many Marketplace consumers will likely see substantial increases in out-of-pocket premium costs, and the number of uninsured Americans will likely increase significantly. Extension of the ARP's premium tax credit provisions would maintain important gains in health care coverage over the past year and prevent increased financial burdens on Americans who obtain health insurance through the Marketplace.

[‡] Of the projected 3 million losing individual coverage and becoming uninsured if the ARP were to be eliminated, 400,000 are estimated to be unsubsidized with ARP in place (who lose coverage due to rising premiums from changes in the risk pool without ARP in place).

[§] The majority (849,000) of the 1.5 million who lose subsidies entirely but remain insured are projected to remain in unsubsidized individual market coverage (approximately 56 percent); however, approximately 44 percent (680,000) are projected to move to employer-sponsored coverage.

[**] Of the projected 13.3 million experiencing subsidy losses or becoming uninsured if the ARP were to be eliminated, 400,000 are estimated to be unsubsidized (who lose coverage due to rising premiums from changes in the risk pool), and 12.9 million estimated to be subsidized in the COMPARE model.

[††] Out of an estimated 19.6 million people enrolled on the individual market in 2022, we project 13.3 million would experience subsidy losses and/or become uninsured if the ARP were to be eliminated, with the remaining 6.3 million being unsubsidized and remaining insured with and without ARP. Of the remaining 6.3 million people that are unsubsidized individual market enrollees under the ARP who are projected to remain insured if the ARP subsidies are eliminated, most remain unsubsidized insured on the individual market (6.1 million), but a small share (200,000) transition to ESI, under the model parameters.

Table 1. Projected National and State-Level Changes in Coverage and Subsidy Receipt if the American Rescue Plan Premium Tax Credit Provisions Sunset in 2023*

State	With ARP, 2022			Without ARP, 2022[«]		
	Marketplace Enrollment, 2022 OEP[‡] (A)*	Marketplace Enrollment - State Share of National, 2022 OEP[‡] (B)*	Projected Number of People Insured through the Individual Market[§] (C)*	Projected Number Losing Individual Coverage and Becoming Uninsured (D)*	Projected Number with Complete Subsidy Loss but Remaining Insured[^] (E)*	Projected Number Remaining in Marketplace Coverage with Reduced Subsidy (F)*
Total	**14,511,077**	**N/A**	**19,648,000**	**2,954,000**	**1,529,000**	**8,865,000**
Alabama	219,314	1.5%	262,000	44,000	24,000	141,000
Alaska	22,786	0.2%	34,000	5,000	2,000	13,000
Arizona	199,706	1.4%	309,000	41,000	20,000	114,000
Arkansas	88,226	0.6%	119,000	18,000	9,000	54,000
California	1,777,442	12.2%	2,373,000	361,000	189,000	1,094,000
Colorado	198,412	1.4%	368,000	42,000	17,000	101,000
Connecticut	112,633	0.8%	182,000	24,000	11,000	63,000
Delaware	32,113	0.2%	44,000	7,000	3,000	20,000
District of Columbia	15,989	0.1%	16,000	1,000	<1,000	2,000
Florida	2,723,094	18.8%	3,064,000	543,000	309,000	1,793,000
Georgia	701,135	4.8%	897,000	142,000	76,000	440,000
Hawaii	22,327	0.2%	35,000	5,000	2,000	13,000
Idaho	73,359	0.5%	162,000	16,000	6,000	32,000
Illinois	323,427	2.2%	466,000	66,000	33,000	192,000
Indiana	156,926	1.1%	255,000	33,000	15,000	87,000
Iowa	72,240	0.5%	98,000	15,000	8,000	44,000
Kansas	107,784	0.7%	143,000	22,000	12,000	67,000
Kentucky	73,935	0.5%	119,000	15,000	7,000	41,000
Louisiana	99,626	0.7%	124,000	20,000	11,000	63,000
Maine	66,095	0.5%	104,000	14,000	7,000	38,000
Maryland	181,603	1.3%	312,000	38,000	17,000	98,000
Massachusetts	268,023	1.8%	517,000	57,000	23,000	132,000
Michigan	303,550	2.1%	453,000	63,000	31,000	177,000
Minnesota	121,322	0.8%	288,000	27,000	9,000	49,000

Mississippi	143,014	1.0%	160,000	29,000	16,000	94,000
Missouri	250,341	1.7%	332,000	51,000	27,000	155,000
Montana	51,134	0.4%	74,000	10,000	5,000	30,000
Nebraska	99,011	0.7%	114,000	20,000	11,000	65,000
Nevada	101,411	0.7%	135,000	21,000	11,000	63,000
New Hampshire	52,497	0.4%	105,000	11,000	4,000	25,000
New Jersey	324,266	2.2%	472,000	67,000	33,000	192,000
New Mexico	45,664	0.3%	73,000	10,000	4,000	26,000
New York	221,895	1.5%	503,000	49,000	16,000	94,000
North Carolina	670,223	4.6%	818,000	135,000	74,000	428,000
North Dakota	29,873	0.2%	40,000	6,000	3,000	18,000
Ohio	259,999	1.8%	444,000	55,000	24,000	140,000
Oklahoma	189,444	1.3%	221,000	38,000	21,000	123,000
Oregon	146,602	1.0%	251,000	31,000	14,000	79,000
Pennsylvania	374,776	2.6%	506,000	76,000	40,000	230,000
Rhode Island	32,345	0.2%	49,000	7,000	3,000	19,000
South Carolina	300,392	2.1%	365,000	60,000	33,000	192,000
South Dakota	41,339	0.3%	49,000	8,000	5,000	27,000
Tennessee	273,680	1.9%	363,000	56,000	29,000	169,000
Texas	1,840,947	12.7%	2,219,000	370,000	204,000	1,182,000
Utah	256,932	1.8%	311,000	52,000	28,000	165,000
Vermont	26,705	0.2%	39,000	6,000	3,000	16,000
Virginia	307,946	2.1%	421,000	63,000	32,000	188,000
Washington	239,566	1.7%	480,000	52,000	20,000	115,000
West Virginia	23,037	0.2%	28,000	5,000	3,000	15,000
Wisconsin	212,209	1.5%	295,000	43,000	22,000	128,000
Wyoming	34,762	0.2%	41,000	7,000	4,000	23,000

Table Notes:
OEP = Open Enrollment Period. Numbers may not sum exactly due to rounding.
* Columns A and B reflect data on individual plan selections reported in the CMS 2022 Open Enrollment Report; Columns C, D, E, and F contain estimates from the COMPARE model and are rounded to the nearest thousand.
« The remaining 6.3 million people (of the total 19.6 million) are unsubsidized individual market enrollees under the ARP scenario (e.g., incomes too high to qualify for subsidies) who remain insured if the ARP subsidies are eliminated. Most (6.1 million) remain insured on the individual market, but a small share (200,000) transition to ESI under the model parameters.
‡ Estimates represent only on-Marketplace individual coverage. The number and share of Marketplace OEP enrollment represent the cumulative 2022 plan selections obtained from the CMS Open Enrollment Period Public Use Files, available here: https://www.cms.gov/research-statistics-data-systems/marketplace-products/2022-marketplace-open-enrollment-period-public-use-files.
§ Estimates represent both Marketplace and off-Marketplace enrollees; COMPARE's methodology does not distinguish on- from off-Marketplace enrollment for unsubsidized individuals.
^ Includes coverage from any source post-ARP, Marketplace or otherwise.

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ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

ISSUE BRIEF
March 21, 2022

HP-2022-09

Health Coverage for Women Under the Affordable Care Act

Sarah Sugar, Joel Ruhter, Christie Peters, Nancy De Lew, and Benjamin D. Sommers

KEY POINTS

- Coverage expansions under the ACA decreased uninsured rates and improved stability of health coverage for women. Over 10 million adult women (19-64) gained coverage between 2010 and 2019, as did over 7 million women of reproductive age (15-44).
- The ACA's coverage expansions have been associated with improved access to care, increased use of health services, and better self-reported health among women of reproductive age.
- Despite the ACA's coverage gains, approximately 7.9 million women of reproductive age remain uninsured.
- A disproportionate share of uninsured women are Latino (40 percent), and nearly half reside in the 12 states that have not adopted the ACA Medicaid expansion (47 percent).
- Nearly 1.9 million uninsured adult women (19-64) who live in Medicaid non-expansion states would be newly eligible for Medicaid if the remaining 12 states adopted the Medicaid expansion.
- Among women of reproductive age, an estimated 3.8 million have incomes at or below 138% FPL, the ACA Medicaid expansion income eligibility limit. Over half of them – 1.9 million – live in Medicaid non-expansion states and could fall in the coverage gap.
- An estimated 4.1 million uninsured women of reproductive age are eligible for subsidized Marketplace coverage under the tax credit provisions of the American Rescue Plan.

BACKGROUND

The Affordable Care Act (ACA) increased access to comprehensive health care coverage among women. Prior to the ACA, nearly 22 million women under age 65 were uninsured,[1] and one-third of women who tried to buy a health plan were either charged a higher premium, had specific services excluded from their plans, or were turned down for coverage altogether.[2] For example, before the ACA's consumer protections took full effect, only 12 percent of health plans in the individual market offered maternity coverage, and young women were frequently charged higher premiums than their male counterparts .[3,4]

The ACA prohibited plans from charging different premiums to women than men of the same age. In addition, plans were required to cover maternity care and preventive services for women without cost-sharing, such as breast and cervical cancer screenings, well-woman visits, birth control and related counseling, breastfeeding supplies and supports, and sexually transmitted infection services.[5] The elimination of cost-sharing for contraceptives in most private health insurance plans saved women an estimated $483 million to $1.4 billion in out-of-pocket spending in 2013, and studies indicate this policy was associated with increased use of prescription contraception.[6] A recent ASPE report estimated that 58 million women currently benefit from the ACA's coverage of preventive services without cost-sharing in private plans.[7] Research also has found that early detection of breast cancer improved post-ACA and the ACA's dependent coverage provision was associated with higher early detection of cervical cancer in women ages 21 to 25.[8,9]

The ACA's Medicaid expansion to low-income adults also significantly reduced disruptions in insurance coverage over time ("churning"), which can lead to delayed care, less preventive care, and higher monthly health care costs due to pent-up demand for health care services.[10] Churning is especially common in Medicaid during the perinatal period (pregnancy and the first year postpartum), as the pregnancy-related eligibility pathway has a higher income threshold than other Medicaid eligibility pathways such as for parents or low-income adults. The ACA's Medicaid expansion was associated with decreased postpartum churn, including increased duration of postpartum enrollment and use of outpatient care in the 6 months postpartum, particularly among women who experience significant maternal morbidity at delivery.[11] Medicaid expansion has also been associated with increased use of health services and better self-reported health among women of reproductive age.[12] For example, research has found that Medicaid expansion led to increased rates of preconception health counseling, pre-pregnancy folic acid intake, and effective use of birth control after pregnancy among low-income women, compared to their counterparts in non-expansion states.[13] However, coverage disparities remain. Low-income women, women of color, and women who are non-citizens are at greater risk of being uninsured.[14]

Access to comprehensive and continuous health coverage for women, particularly those of reproductive age, is critical to improving maternal and infant health, which is a key priority of the Biden Administration.[15] This is especially important for Black and American Indian/Alaska Native women, who experience far worse maternal health outcomes.[16] This brief presents estimates over time and characteristics of uninsured women (including those of reproductive age), identifying those who are likely to be eligible for Medicaid coverage under the ACA or qualify for subsidized Marketplace coverage.

METHODS

We estimated the number of uninsured adult women (19-64) and women of reproductive age (15-44*) using the American Community Survey (ACS) Public Use Microdata Sample 1-Year Estimates from 2010 to 2019. We then calculated the number of uninsured women ages 15-44 with family incomes† that would likely qualify for Medicaid expansion coverage or subsidized Marketplace coverage in the 2019 ACS.[17] We did not use 2020 ACS data due to disruptions in data collection caused by the COVID-19 pandemic; as a result, the Census Bureau does not recommend comparing the 2020 ACS 1-year experimental estimates with previous ACS estimates. [18] Our analysis accounts for the American Rescue Plan's (ARP) premium tax credit (PTC) expansion, which temporarily increases the PTC amount for those who are eligible and extends eligibility to individuals with incomes above 400 percent of the federal poverty line (FPL) for the first time.[19]

We also provide estimates of the number of uninsured women in the 12 states‡ that have not adopted the Medicaid expansion, as of March 2022. These estimates are drawn from ASPE's Transfer Income Model version 3 (TRIM3), which simulates major government tax, benefit, and health insurance programs in the United States. TRIM3 estimates come from an analysis of the Census Bureau's Current Population Survey for calendar year 2018, using each state's rules for Medicaid eligibility as of 2021.[20]

In this report, we did not assess immigration status in the sample, which means our estimates of the uninsured include some women who are not legally present and would not be eligible for Medicaid or Marketplace subsidies.

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* While women aged 15-17 are minors, we define them as women because this is the standard language in demography about reproductive age.

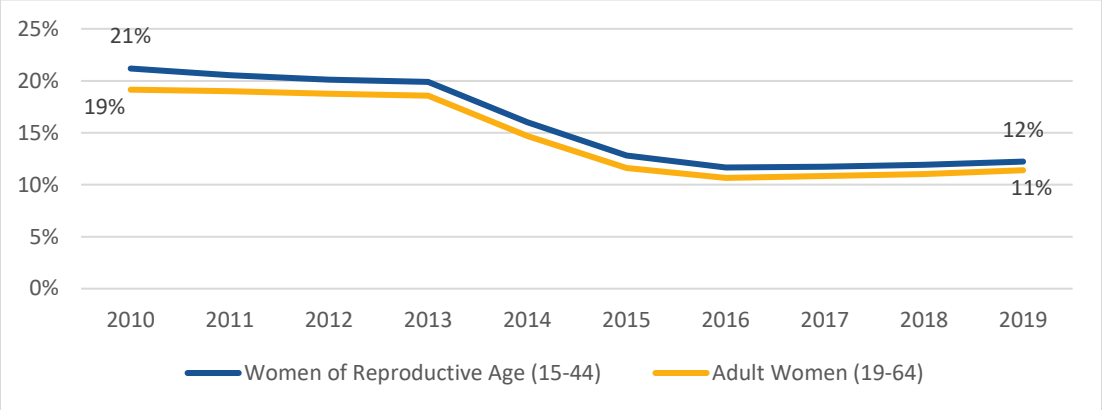
† Family income is defined based on the health insurance unit, which consist of an adult, their spouse, and any dependent children.

‡ The non-expansion states are Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.

RESULTS

Over 10 million adult women (ages 19-64) and over 7 million women of reproductive age (ages 15-44) gained health insurance coverage between 2010 and 2019. During this period, the percent of uninsured adult women decreased from 19 percent to 11 percent, and the percent of uninsured women of reproductive age decreased from 21 percent to 12 percent (Figure 1).

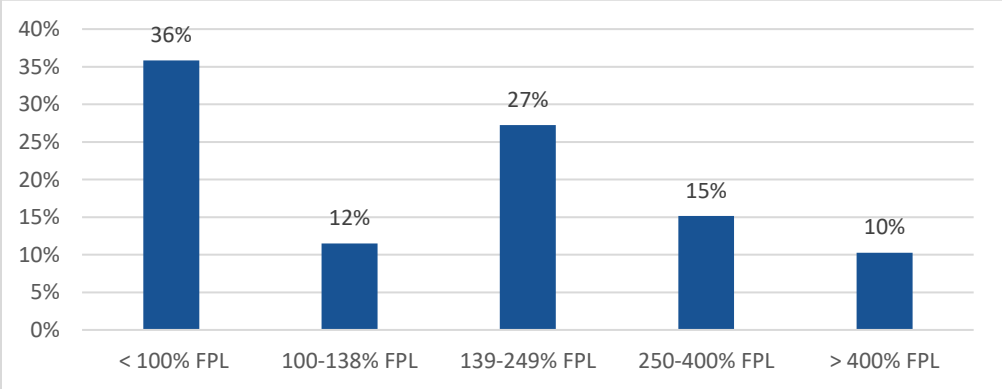
Figure 1. Uninsured Adult Women (Ages 19-64) and Women of Reproductive Age (Ages 15-44), 2010-2019



Source: ASPE analysis of 2019 ACS data

As of 2019, approximately 7.9 million women of reproductive age were uninsured. Of these women, 48 percent had incomes of 138% FPL or below, qualifying them for Medicaid in states that had expanded Medicaid[§], while 52 percent were likely eligible for PTCs for Marketplace coverage (Figure 2). In non-expansion states, only pregnant women (through 60 days postpartum), low-income parents, and adults with disabilities who have incomes below their states' income thresholds generally qualify for Medicaid. Overall, 36 percent of uninsured women of reproductive age had incomes below 100% FPL, meaning that if they lived in one of the 12 non-expansion states, they could fall into the coverage gap if they have income too high to qualify for Medicaid and too low to qualify for Marketplace subsidies. Most Marketplace subsidy-eligible uninsured women (42 percent) had incomes between 139%-400% FPL, which is within the ACA's income-based subsidy eligibility range of 100-400% FPL; an additional 10 percent (those with incomes above 400% FPL) may be newly eligible for subsidies due to the ARP's subsidy expansion.

Figure 2. Income Distribution Among Uninsured Women of Reproductive Age (15-44)



Source: ASPE analysis of 2019 ACS data

[§] A proportion of these women live in non-expansion states and may not be eligible for Medicaid.

A prior ASPE analysis estimated that 1.9 million low-income women in the remaining 12 non-expansion states would be newly eligible for Medicaid if the states extended coverage to adults with income up to 138% FPL.[21] Of these 1.9 million uninsured women, 47 percent are ages 19-34, most have incomes below the poverty level (59 percent), 41 percent are White, 25 percent are Black, and 30 percent are Latino.[**]

Table 1 shows the number of women in the 12 non-expansion states currently eligible for Medicaid, the number who would be eligible for Medicaid if all non-expansion states were to adopt the Medicaid expansion, and the number of women who would be newly eligible for Medicaid coverage after Medicaid expansion in non-expansion states (i.e., the difference between the first two groups).

Table 1. Demographic Characteristics of Uninsured Non-Elderly Women (Ages 19-64) Potentially Eligible for Medicaid if All 12 Non-Expansion States Adopted Medicaid Expansion

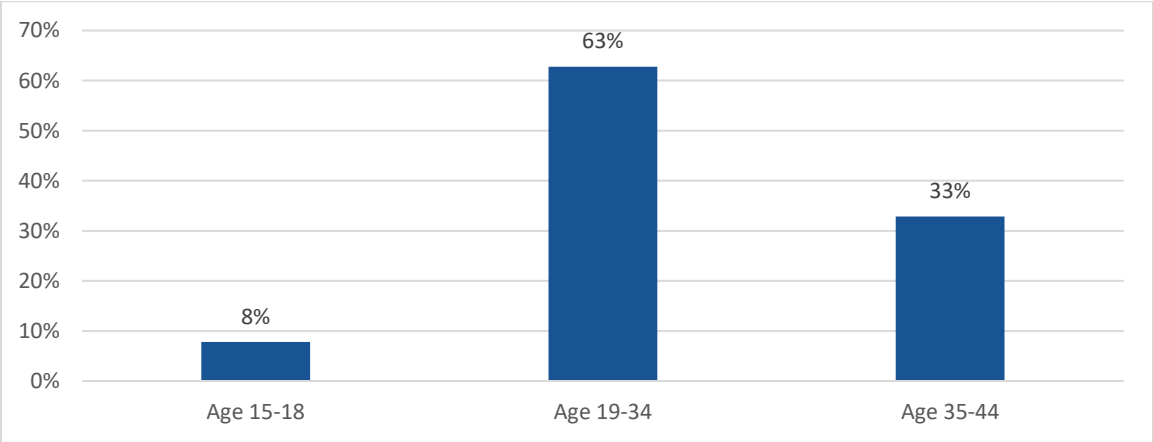
	Before Expansion		After Expansion		Newly Eligible After Expansion	
	#	%	#	%	#	%
Total Female Eligible	515,596	100.0	2,402,438	100.0	1,886,842	100.0
Age						
19-34	239,017	46.4	1,115,666	46.4	876,649	46.5
35-49	184,126	35.7	670,376	27.9	486,251	25.8
50-64	92,453	17.9	616,395	25.7	523,942	27.8
Annual Income (FPL)						
<100%	439,595	85.3	1,554,548	64.7	1,114,953	59.1
100%-138%	24,355	4.7	521,884	21.7	497,529	26.4
Above 138%*	51,645	10.0	326,005	13.6	274,360	14.5
Race/Ethnicity**						
White Non-Latino (NL)	215,230	41.7	989,198	41.2	773,968	41.0
Black NL	135,362	26.3	600,136	25.0	464,773	24.6
Asian American, Native Hawaiian, or Pacific Islander (NL)	7,247	1.4	37,912	1.6	30,665	1.6
American Indian/Alaska Natives	9,385	1.8	28,257	1.2	18,872	1.0
Other Races (NL)	9,081	1.8	41,143	1.7	32,062	1.7
Latino	139,291	27.0	705,792	29.4	566,501	30.0

Source: HHS/ASPE TRIM3 model applied to March 2019 / CY 2018 CPS data combined with TRIM3 imputations.
Notes: The estimates compare simulated eligibility data without and then with the Medicaid expansion.
* These persons have monthly MAGI below 138 in at least one month.
** "Latino" includes all people reporting Latino ethnicity, regardless of race(s). Non-Latino individuals were categorized as White, Black, or Asian American, Native Hawaiian, or Pacific Islander only if they reported a single race.

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

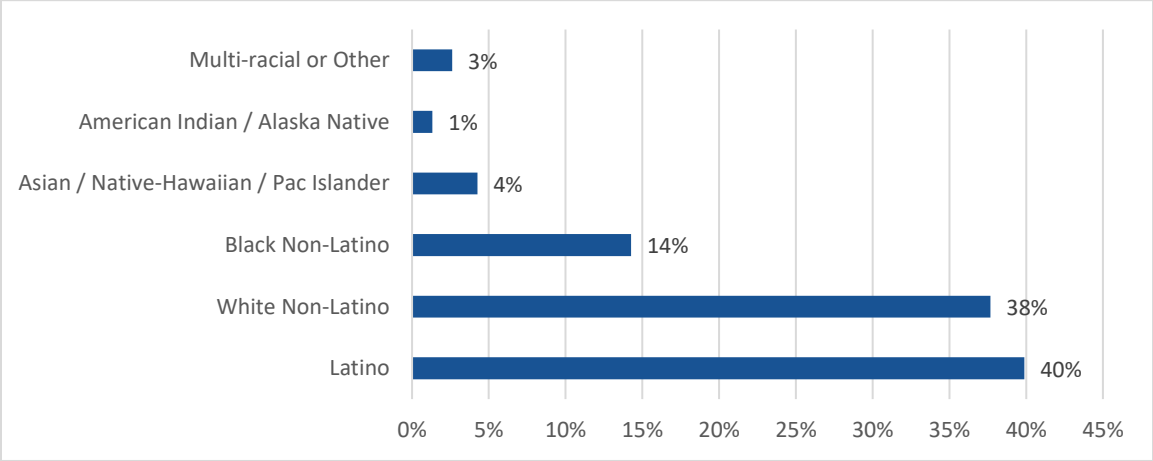
Figures 3 and 4 describe demographic factors among uninsured women of reproductive age, across all states. Most uninsured women of reproductive age are between the ages of 19-34 and are Latino (40 percent), White (38 percent), or Black (14 percent). Table 2 shows language spoken and education among the same population; 15 percent live in households with no English-speaking adults, and 20 percent have less than a high school education.

Figure 3. Age Distribution Among Uninsured Women of Reproductive Age (15-44)



Source: ASPE analysis of 2019 ACS data

Figure 4. Race and Ethnicity Among Uninsured Women of Reproductive Age (15-44)



Source: ASPE analysis of 2019 ACS data

Table 2. Language Spoken and Education Among Uninsured Women of Reproductive Age (15-44)

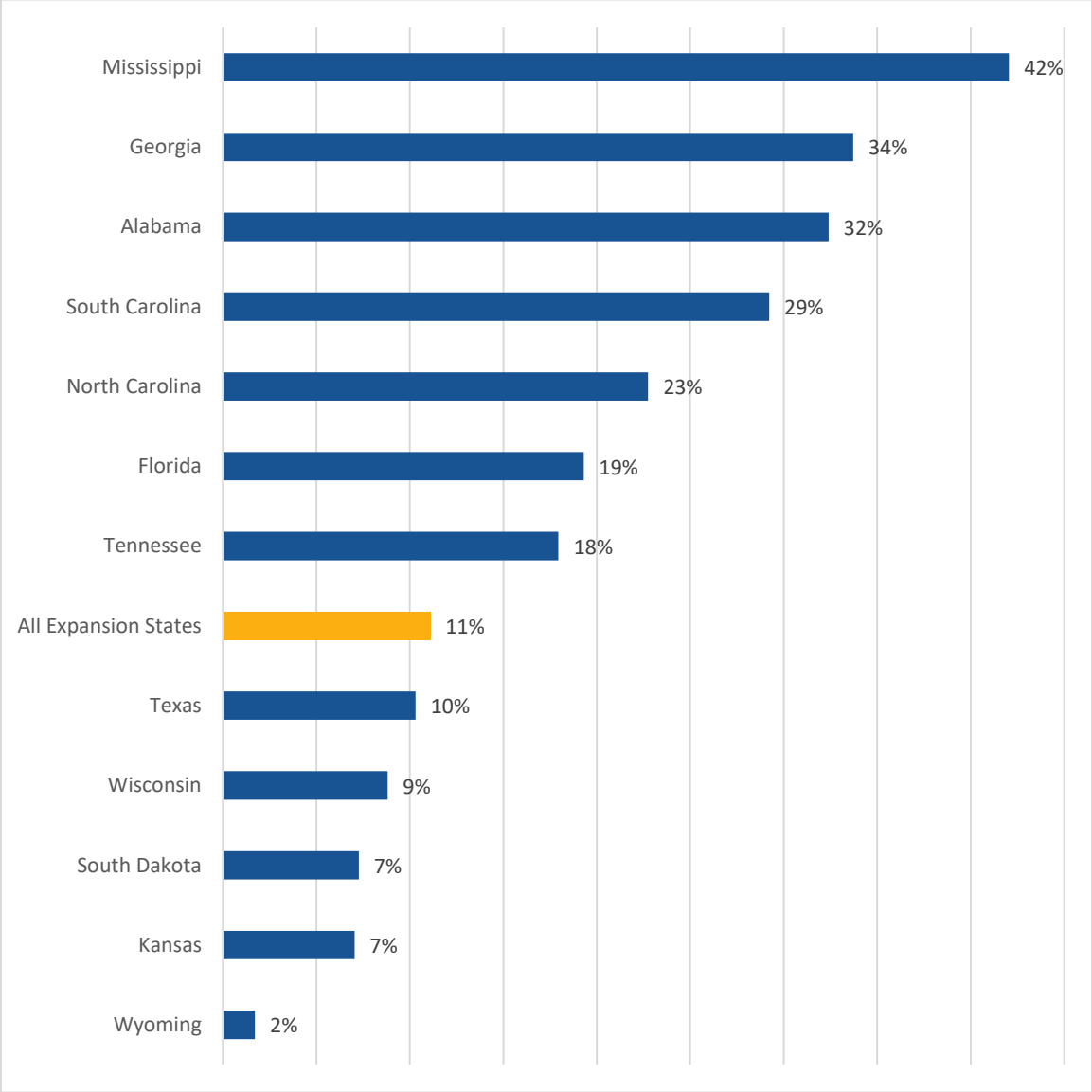
Demographic	
Language	
No English Speaking Adults in Household	15%
English Spoken in Household	78%
Spanish Spoken in Household	18%
Educational Attainment	
Less than High School	20%
High School Diploma	65%
College Grad	15%

Notes: ASPE analysis of 2019 ACS data. Language categories sum to more than 100 percent because they are not mutually exclusive.

There is significant variation in the number of uninsured women of reproductive age at the state level (Appendix Table A). Of the five states with the largest number of uninsured women of reproductive age, four are Medicaid non-expansion states (Texas, California, Florida, Georgia, and North Carolina). Forty-seven percent of all uninsured women of reproductive age reside in the 12 states that have not adopted the Medicaid expansion. Among women of reproductive age with incomes at or below 138% FPL, over 50 percent live in Medicaid non-expansion states and could fall in the coverage gap.

Given the large disparities in maternal health outcomes for Black women, we also assessed the share among uninsured women of reproductive age who are Black by state (Figure 5). On average, non-expansion states have a higher proportion of Black women among this population compared to states that have adopted the Medicaid expansion.

Figure 5. Share of Uninsured Women of Reproductive Age who are Black, in Medicaid Non-Expansion States vs. All Expansion States



Source: ASPE analysis of 2019 ACS data

DISCUSSION

Under the ACA, the U.S. has made significant strides in improving women's access to comprehensive health coverage. After implementation of ACA Medicaid and Marketplace coverage provisions, the proportion of women of reproductive age who were uninsured dropped from 21 percent in 2010 to 12 percent in 2017. This decline was pronounced in states that extended Medicaid to low-income adults with incomes up to 138 percent of the federal poverty level (FPL): ACA expansion states saw their uninsured rates drop by more than half among women of reproductive age (19-44), while non-ACA expansion states experienced only a 28 percent decrease. Further, most women can now obtain coverage that provides a wide range of recommended preventive services at no-cost and includes essential services such as maternity care and contraception.[22] The ARP's enhanced Marketplace subsidies and state option for extended postpartum coverage in Medicaid are critical tools in helping expand coverage in this population.

Despite these gains, approximately 11 million women under age 65 remained uninsured in 2019. Most of these women (approximately 7.9 million) are of reproductive age and are eligible for subsidized Marketplace coverage or would be eligible for Medicaid if all states adopted the Medicaid expansion. Health coverage for women of reproductive age is critical to improving maternal and infant health, especially for Black and American Indian/Alaska Native women, who experience far worse outcomes.[23] Closing the coverage gap in the 12 remaining non-expansion states would be an important step in improving access to coverage and continuity of coverage among women of reproductive age. Currently, nearly 1.5 million women of reproductive age in non-expansion states have incomes below 100% FPL and could fall in the coverage gap. Medicaid expansion would provide this population with a pathway to coverage and, for women who become pregnant, promote continuity of coverage prior to pregnancy, throughout pregnancy and postpartum, and beyond.

The ARP included a temporary state option to extend continuous Medicaid and Children's Health Insurance Program (CHIP) eligibility for pregnant individuals from 60 days up to 12 months postpartum. Previous ASPE research found that if all states extended pregnancy-related Medicaid eligibility to 12 months postpartum, approximately 720,000 women annually would be eligible for expanded postpartum coverage.[24]

Outreach and enrollment efforts could also help boost coverage rates among the remaining uninsured women of reproductive age. Research has found that many uninsured individuals are not aware of their coverage options and cite cost and difficulty with the enrollment process as barriers to enrolling in coverage. 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.[25] To support this effort, the Centers for Medicare and Medicaid Services (CMS) awarded $80 million in grant awards for the 2022 plan year and another almost $11.5 million in additional funding to support outreach and enrollment efforts.[26]

CONCLUSION

The ACA has produced major gains in coverage among women since 2010. Early evidence indicates that efforts to expand coverage by the Biden-Harris administration, including enhanced outreach efforts, the ARP's expanded Marketplace subsidies, and efforts to boost postpartum coverage in Medicaid, have produced further reductions in the uninsured rate in 2021.[27] Future efforts to build on these coverage gains can help improve health care access and health outcomes for women in the U.S.

APPENDIX

Table A. Number of Uninsured Women of Reproductive Age (15-44), by State

State	# of Uninsured Women (Ages 15-44)	State	# of Uninsured Women (Ages 15-44)
U.S. Total	**7,872,202**	Missouri	170,220
Alabama*	132,237	Montana	20,725
Alaska	19,295	Nebraska	39,660
Arizona	206,392	Nevada	90,075
Arkansas	74,239	New Hampshire	23,012
California	779,289	New Jersey	181,592
Colorado	122,108	New Mexico	48,477
Connecticut	46,536	New York	244,312
Delaware	15,283	North Carolina*	319,600
District of Columbia	4,517	North Dakota	14,187
Florida*	720,953	Ohio	186,954
Georgia*	398,480	Oklahoma	170,276
Hawaii	15,244	Oregon	71,358
Idaho	54,057	Pennsylvania	173,368
Illinois	231,470	Rhode Island	12,299
Indiana	150,645	South Carolina*	138,796
Iowa	30,019	South Dakota*	23,790
Kansas*	78,940	Tennessee*	173,124
Kentucky	70,625	Texas*	1,515,954
Louisiana	98,525	Utah	84,053
Maine	26,095	Vermont	5,721
Maryland	93,605	Virginia	172,626
Massachusetts	47,412	Washington	129,932
Michigan	135,773	West Virginia	24,788
Minnesota	67,078	Wisconsin*	80,913
Mississippi*	116,917	Wyoming*	20,656

Source: ASPE analysis of 2019 ACS data

* States that have not expanded Medicaid under the ACA, as of March 2022.

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ACA | AFFORDABLE CARE ACT

Celebrating 12 Years

THE STATE OF THE ACA REPORT

Affordable Care Act is at its Strongest on its 12th Anniversary:

President Biden will Cement Progress and Build on the Affordable Care Act

March 23, 2022

Today, the Affordable Care Act (ACA) is at the strongest point in its history, thanks to 12 years of diligent implementation efforts, defense alongside the passage, and implementation of the American Rescue Plan Act of 2021. As a result, health care costs are historically low. A record high of 14.5 million people signed up for coverage through the health insurance Marketplaces during the recent Open Enrollment Period (OEP), two new states have expanded Medicaid over the last year, and the health care system is providing access to better quality and more affordable health care to millions of Americans across this country.

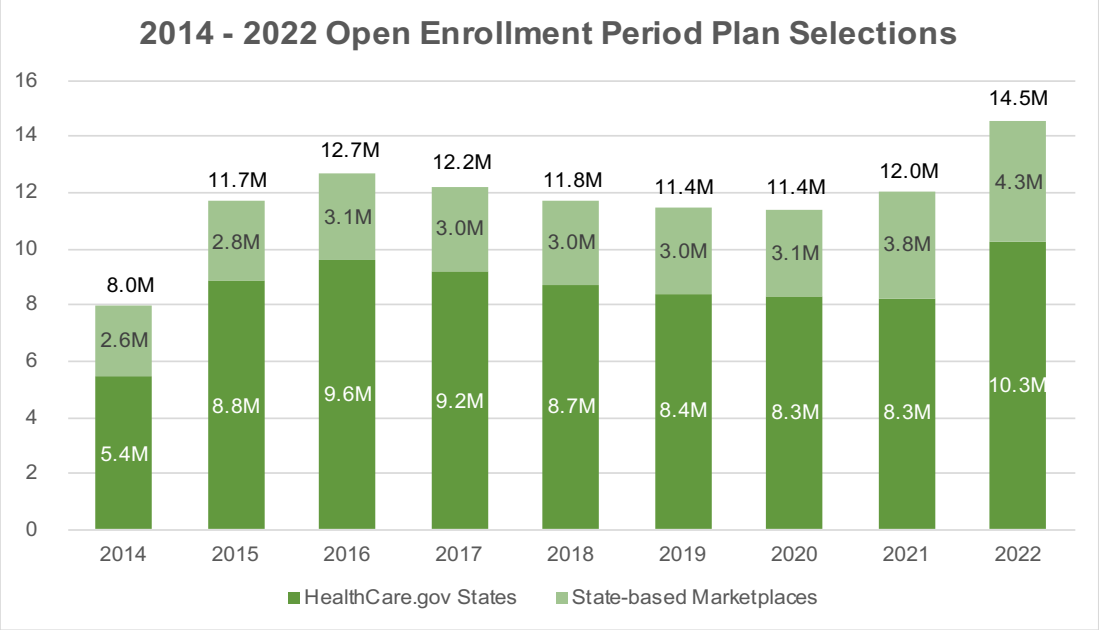
The ACA fundamentally changed the American health care system. It established the health care Marketplaces, allowing consumers without access to affordable, employer-sponsored insurance to access quality coverage. It created Medicaid expansion to help states make Medicaid accessible for people under 138% of the Federal Poverty Level (FPL). It instituted consumer protections that meant people with pre-existing conditions could not be denied health insurance. It reduced costs for seniors by changing cost-sharing in the Medicare program. It changed how we define value-based care and created the Center for Medicare & Medicaid Innovation Center (CMMI), allowing CMS to evaluate innovative approaches to care.

The Biden-Harris Administration has made it a priority to build on the success of the ACA by continuing to invest in and strengthen the law, most notably through the passage of the American Rescue Plan (ARP). The ARP's subsidies enabled record enrollment and eased financial burdens on Americans during the worst public health crisis in a generation. President Biden is committed to extending financial assistance that reduces health coverage premiums for millions of Americans who enroll in Marketplace coverage and closing the Medicaid coverage gap, which would lead 4 million uninsured people to gain coverage.

The report below highlights the historic gains of the ACA under the Biden-Harris Administration, as a result of the American Rescue Plan Act of 2021 and a strong commitment to enrollment outreach, showing the importance of investing in affordable and accessible health care. To view a comprehensive Briefing Book on the ACA, highlighting HHS reports from the past year, visit: https://aspe.hhs.gov/reports/aca-accomplishments

Nearly 6 million people newly signed up for Health Coverage on Health Insurance Marketplaces During First Year of Biden-Harris Administration

The 2022 OEP resulted in a record-breaking high of 14.5 million consumers signed up for ACA Marketplace coverage, representing a 2.5 million, or 21% increase, from the 2021 OEP. During the first full year of the Biden-Harris Administration, nearly 6 million new consumers signed up for coverage through the Health Insurance Marketplaces nationwide during the 2021 Special Enrollment Period (SEP) and the 2022 OEP. This includes 2.8 million people who newly enrolled during the SEP and more than 3 million who newly enrolled during the OEP. To view the 2022 Health Insurance Marketplaces Open Enrollment Report, visit: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources#Health_Insurance_Marketplaces

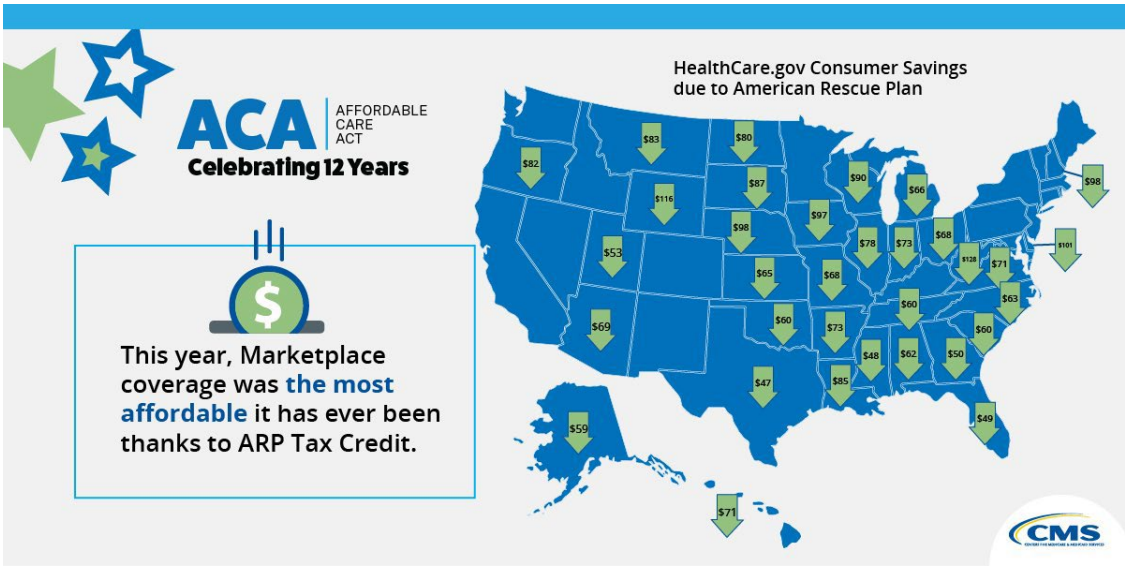


These gains add to the nearly 31 million Americans enrolled in Medicaid or Marketplace ACA-related coverage at the beginning of 2021. Thanks to the ACA, this is the highest number of covered individuals. As a result of the new insurance programs and patient protections offered under the ACA, millions of Americans who do not have health insurance can get it and get the care they need.

Health Care Costs Are Historically Low on the Health Care Marketplaces

In 2021, Biden-Harris Administration passed and implemented the ARP, including provisions which temporarily increased and expanded premium tax credits for consumers. As a result, Marketplace health insurance coverage is the most affordable it has ever been. The ARP lowered health care costs for most consumers. This meant that 4 in 5 consumers were able to find a plan for $10 or less per month, and 28% of all enrollees selected coverage for $10 or less after the ACA subsidies during the 2022 Open Enrollment Period.

Without the ARP, the average monthly premium after tax credits would have been $59 per month higher, or 53 %, had the ARP not been in effect. Nationwide, 2.8 million more consumers are receiving tax credits for 2022 compared to 2021, and 1.1 million consumers previously excluded from financial assistance are now eligible for savings thanks to the ARP.



Demand for Marketplace Coverage is High in States that Have Not Expanded Medicaid

Investing in outreach and engagement has taken HealthCare.gov enrollment to new heights. Under the Biden-Harris Administration, increased outreach in states that have not expanded Medicaid ensured more people in uninsured or underinsured communities understand and know about the high-quality health insurance available to them. As a result, during the 2022 Marketplace OEP, enrollment in states that have not expanded Medicaid increased by 32% compared to the 2021 OEP, while enrollment increased by 12% in states that have expanded Medicaid. Notably, Texas saw a year-over-year increase in plan selections of 42% during the 2022 OEP, and Georgia saw a year-over-year increase of 36% during the 2022 OEP. The table below includes Medicaid non-expansion states' enrollment increases during this year's Open Enrollment compared to last year's Open Enrollment.

State Name	Percentage Increase in Marketplace Enrollment in OEP 2022 Compared to OEP 2021
Alabama	30%
Florida	28%
Georgia	36%
Kansas	22%
Mississippi	29%
North Carolina	25%
South Carolina	31%
South Dakota	32%
Tennessee	29%
Texas	42%
Wisconsin	11%
Wyoming	30%

18.7 Million Adults Are Now Covered Across 39 States and the District of Columbia Due to Medicaid Expansion

In 2021, Oklahoma and Missouri became the two most recent states to expand Medicaid to low-income adults. Since expanding Medicaid on July 1, Oklahoma has enrolled over 260,000 individuals in the program. In October, Missouri kicked off its adult expansion efforts and estimates that an additional 275,000 people are eligible to enroll. Over 18.7 million adults are now covered across 39 states (including the District of Columbia) due to Medicaid expansion, though 12 states have not expanded. The ACA also streamlined the application and enrollment process, making coverage more accessible to eligible individuals. Medicaid is the largest payer for long-term services, supports behavioral health, and covers more than 40% of births in America.

Today, 12 states have not expanded Medicaid to adults under 138% of the FPL as made available under the ACA. The ARP incentivizes states to expand coverage through Medicaid by offering a five percentage point increase in their regular federal matching rate. This is in addition to the 90% federal matching funds currently available through the ACA for medical services for Medicaid expansion enrollees. The President is committed to delivering health care coverage to the 4 million people who remain in the coverage gap — those who are uninsured, but would be eligible for Medicaid if their states expanded — by allowing them access to Affordable Care Act premium tax credits for the first time

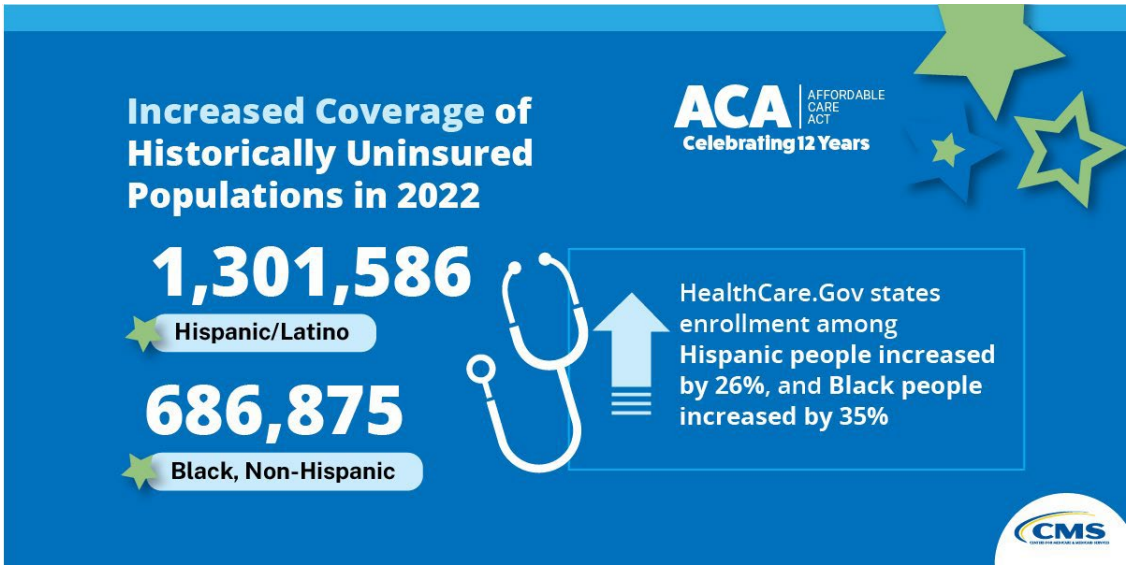
Connecting People to Health Coverage During the COVID-19 Public Health Emergency

Overall, after the passage of the ACA, the uninsured population has declined from roughly 50 million in 2009 to 29 million in the fall of 2021. The uninsured rate in 2021 fell after the Biden-Harris Administration enacted the ARP, opened a SEP, and expanded outreach efforts to historically uninsured communities. The uninsured rate for the U.S. population was 8.9% for the third quarter of 2021 (July - September 2021), down from 10.3% for the last quarter of 2020. Coverage gains occurred among children and working-age adults, with the most significant coverage gains for those with household incomes under 200% of the FPL (roughly $27,000 for a single adult or $56,000 for a family of four). Because of the ACA and COVID-19 relief efforts, these individuals and families were able to enroll in the ACA Marketplaces or join and remain in Medicaid in states where the program has expanded for adults under 138% of the FPL.

Building on this success and recognizing an ongoing need for modest-income individuals, the Biden-Harris Administration created a new monthly SEP for consumers with household incomes below 150% of the FPL (around $19,000 for an individual and $40,000 for a family of four). On HealthCare.gov, 45% of 2021 SEP enrollees were consumers with household incomes under 150% of the FPL. Most State-based Marketplaces have implemented or have plans to implement the same SEP. The new 150% SEP will make it easier for low-income people to enroll in ACA Marketplace coverage throughout the year and benefit from the ARP savings in 2022. Savings that would be made permanent in legislation President Biden has proposed.

Increased Coverage of Historically Uninsured Populations

The Biden-Harris Administration made a concerted effort to make affordable health care more accessible to historically uninsured and underinsured populations by conducting targeted outreach to historically underserved communities. This included advertising in Chinese (Mandarin and Cantonese), Korean, Vietnamese, Tagalog, and Hindi, and specific campaigns to the Black and Latino communities. As a result of this work, HealthCare.gov states enrollment among Hispanic people increased by 26% and Black people increased by 35%.



Overall, among consumers who attested to a race or ethnicity, 19% identified as Hispanic/Latino, compared to 18% in the 2021 OEP. The percentage of consumers who self-reported as Black, Non-Hispanic increased to 9% from 8% in 2021. Similarly, 20% of HealthCare.gov consumers attested to being Hispanic/Latino, an increase from 19% in 2021, and 11% of enrollees self-reported as Black compared to 9% in 2021. SBM consumers who identified as Hispanic/Latino and those who attested to being Black remained steady at 17% and 5%, respectively, for 2022 and 2021.

Biden-Harris Administration Increased Enrollment Help Available to Consumers

Expanded access to affordable coverage is critical to advancing health equity. Those who are uninsured or underinsured often face barriers to affordable, quality health coverage. This disparity was highlighted during the COVID-19 pandemic when communities of color were disproportionately affected.

The Biden-Harris Administration expanded the help available for consumers to navigate enrollment and coverage options. There were four times as many Navigators— more than 1,500— available to help consumers in nearly every HealthCare.gov state and county during the recent Open Enrollment Period, making health coverage more accessible to everyone. In addition, the Administration reinvested in the Champions for Coverage program, which doubled the number of organizations to more than 2,700 that volunteered to help consumers understand Marketplace coverage this year. The Biden-Harris Administration remains committed to building on the success of the ACA to ensure everyone who needs health care can access it.

The Affordable Care Act Advanced Quality and Accountability in Medicare

The ACA created the Center for Medicare & Medicaid Innovation Center (Innovation Center) to develop and test new health care payment and service delivery models. The Biden-Harris Administration is working through CMS to ensure all Medicare Fee for Service (FFS) beneficiaries and the vast majority of Medicaid beneficiaries beneficiaries will be in a care relationship with accountability for quality and total cost of care by 2030. The CMS Innovation Center has launched more than 50 new models and, from 2018 to 2020, impacted more than 28 million people with Medicare and Medicaid and 528,000 providers and provider groups. In addition, the Medicare Shared Savings Program—established by the Affordable Care Act—has generated consistent savings for Medicare, saving the Trust Fund approximately $6 billion over the past five years.

The Affordable Care Act closed the Part D prescription drug “donut hole” to make drugs more affordable for older adults. It also reformed payments in traditional Medicare through payment updates to hospitals, skilled nursing facilities, and certain other providers, partly to account for economy-wide productivity improvements and reduced excessive payments to home health agencies and inpatient rehabilitation facilities.

Enrollment in Medicaid and Children's Health Insurance Program (CHIP) is at a Record High

The ACA expanded access to Medicaid and Children's Health Insurance Program (CHIP) coverage, increased stability in children's health insurance coverage, and helped bring uninsured rates for children to record lows. A historic more than 84 million individuals enrolled in Medicaid and CHIP in the 50 states and the District of Columbia who reported enrollment data for September 2021, including more than 77 million individuals enrolled in Medicaid and 6 million individuals enrolled in CHIP. View the Final Medicaid/CHIP Enrollment Report here.

Enrollment for states that have implemented Basic Health Programs (BHP), which the ACA established, is also at a high. In New York and Minnesota, consumers with household incomes at or below 200 percent of the FPL, who are not eligible for Medicaid or the Children's Health Insurance Program (CHIP), who apply for coverage are enrolled in the applicable state Basic Health Program instead of a Qualified Health Plan (QHP). Year over year, total BHP enrollment increased 8 percent to approximately 1.1 million enrollees during the 2022 OEP. Minnesota's BHP enrollment increased by 7 percent and New York's increased by 8 percent from 2021 to 2022.

FOR IMMEDIATE RELEASE
March 18, 2022

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Fact Sheet: Celebrating the Affordable Care Act

12 Years of Advancing Health Equity for All Americans

Since its enactment on March 23, 2010, the Affordable Care Act has led to an historic advancement of health equity in the United States. This landmark law improved the health of all Americans, including women and families, kids, older adults, people with disabilities, LGBTQI+ and communities of color. Thanks to the ACA, millions more Americans have gained health coverage without limits, and protections are in place for people with preexisting conditions. People have access to essential health benefits, including preventive and rehabilitative care, prescription drugs, wellness visits and contraceptives, mental health and substance use treatment, among many others. The Biden-Harris Administration is committed to building on the success of the ACA and making health care a right for all Americans.

Below is the fact sheet highlighting some of the accomplishments of the ACA:

Health of Women and Families

- Required plans cover women's preventive health services, including birth control and counseling, well-woman visits, breast and cervical cancer screenings, prenatal care, interpersonal violence screening and counseling, and HIV screening and STI counseling, with no cost-sharing to the woman. [HRSA (https://www.hrsa.gov/womens-guidelines/index.html)] [CMS]

  - An estimated 58 million women with private insurance currently benefit from these preventive service provisions, in addition to 37 million children with access to free preventive care. [Assistant Secretary for Planning and Evaluation (https://aspe.hhs.gov/reports/aca-preventive-services-without-cost-sharing)]

- Allowed states to expand Medicaid eligibility up to 138% of the Federal Poverty Level ($17,774 for an individual; $36,570 for a family of four) and remove categorical requirements that previously prevented many low-income people from being able to enroll in the program. Medicaid expansion – adopted by 38 states and Washington DC, as of March 2022, has connected people to coverage and improved health outcomes for women of color and families. [CMS (https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/)]

- Created the Pregnancy Assistance Fund (PAF) to improve the health, educational, social, and economic outcomes of expectant and parenting teens, women, fathers, and their families. The PAF has provided funds to grantees in 32 states and seven tribal organizations, serving nearly 110,000 expectant and parenting young people. [OASH (https://opa.hhs.gov/grant-programs/pregnancy-assistance-fund-paf)]

- Created the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), which has appropriated over $4.7 billion in grants to states, territories and tribes to support home visiting services to pregnant people and parents with young children who live in communities that face greater risks and barriers to achieving positive maternal and child health outcomes. [HRSA (https://mchb.hrsa.gov/programs-impact/programs/home-visiting/maternal-infant-early-childhood-home-visiting-miechv-program) and ACF (https://www.acf.hhs.gov/ecd/tribal/tribal-home-visiting)]

  - MIECHV (HRSA) provided over 7.1 million home visits between 2012 and 2020, with over 925,000 home visits provided in fiscal year 2020 alone.

  - Since programs started implementing services, Tribal MIECHV (ACF) recipients have provided over 142,500 home visits, including virtual visits during the COVID-19 pandemic, and served over 3,500 caregivers and children during FY 2021.

- Provided $11 billion in funding to bolster and expand community health centers: Nearly 1,400 HRSA-funded health centers operate more than 14,000 service delivery sites that provide comprehensive and preventive health care to nearly 29 million people – 1 in 11 nationwide – in every U.S. state, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. [HRSA (https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html)]

Health of Older Adults and People with Disabilities

- Extended protection for Americans with disabilities from being discriminated against by health insurance plans on the basis of medical history or pre-existing conditions; and eliminated lifetime dollar caps on essential health benefits. As a result, many more people with disabilities are able to access quality health insurance that meets their needs, and they will no longer lose coverage based on their health status when they need it most. Lowered the share of adults with disabilities under age 65 who were uninsured for a full year by nearly half. [ASPE]

- Created the Center for Medicare & Medicaid Innovation (CMS Innovation Center) to develop and test new health care payment and service delivery models. This was intended to improve patient care, lower costs, and promote patient-centered practices in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). [CMS (https://innovation.cms.gov/)]

- Brought community living options to more people through Medicaid options such as Community First Choice, the Balancing Incentive Program and Money Follows the Person. [CMS (https://www.medicaid.gov/medicaid/home-community-based-services/index.html)]

- Provided $50 million to support further development of the Aging and Disability Resource Center (ADRC) Program, which works to assist individuals in critical pathways, defined as times or places where people make important decisions about long-term care. [ACL (https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Facl.gov%2Fprograms%2Fcare-transitions%2Fevidence-based-care-transitions-program&data=04%7C01%7CChristine.Phillips%40acl.hhs.gov%7Cf574b89fe97746dcfc1b08d9f87b4806%7Cd58addea50534a808499ba4d944910df%7C0%7C0%7C637814030632925439%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=9wUMDtVGditIbs431QT6mjmVS7fXTweltuari0OaJ%2Fo%3D&reserved=0)]

- Supported 33 states with grant funding to plan and implement a “No Wrong Door System,” a partnership between the ACL, the Centers for Medicare & Medicaid Services (CMS), and the Veterans Health Administration, to make it easier for consumers to learn about and access Long Term Supports and Services (LTSS). [ACL (https://nwd.acl.gov/)]

- Closed the Part D prescription drug “donut hole” to make drugs more affordable for older adults.

- Reformed payments in traditional Medicare through payment updates to hospitals, skilled nursing facilities, and certain other providers, partly to account for economy-wide productivity improvements and reduced excessive payments to home health agencies and inpatient rehabilitation facilities. [CMS]

- Created the largest value-based purchasing program in the country, the Medicare Shared Savings Program (SSP); there are now 483 SSP Accountable Care Organizations (groups of doctors, hospitals, and other health care providers) that serve over 11 million Medicare beneficiaries, with over 525,000 participating clinicians. [CMS]

Coverage Gains & Patient Protections

- Produced historic gains in health insurance, reducing the number of uninsured Americans by approximately 20 million - PDF (https://www.aspe.hhs.gov/sites/default/files/migrated_legacy_files/198861/trends-in-the-us-uninsured.pdf?_ga=2.133451849.639786395.1646968197-1682771927.1611176133) , and extending Marketplace insurance or Medicaid expansion coverage to more than 31 million people as of early 2021. [ASPE (https://aspe.hhs.gov/reports/health-coverage-under-affordable-care-act-enrollment-trends-state-estimates)]

  - This year, the Biden-Harris Administration announced a record-breaking 14.5 million people have signed up for 2022 health care coverage through the Marketplaces during the historic Marketplace Open Enrollment Period (OEP) from November 1, 2021 through January 15, 2022. [CMS (https://www.hhs.gov/about/news/2022/01/27/biden-harris-administration-announces-14-5-million-americans-signed-affordable-health-care-during-historic-open-enrollment-period.html)]

- Protected more than 133 million people with pre-existing conditions, like cancer, asthma or diabetes, pregnancy, from being denied coverage for their pre-existing condition.

- Mandated that most insurers cover 10 essential health benefits (https://www.healthcare.gov/coverage/what-marketplace-plans-cover/), including mental health and prescription drugs. It covered young people up to age 26 on their parent's health plans.

- Established vaccinations as a routine and expected part of the health care visit and required that people had a right to the full set of vaccinations recommended for them. For example, hepatitis A and hepatitis B vaccination covered without deductible or co-pay. [CMS, CDC]

- Established the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) which serves people who are dually enrolled in both Medicare and Medicaid, also known as dually eligible individuals or Medicare-Medicaid enrollees, to make sure dually eligible individuals have full access to seamless, high quality health care and to make the system as cost-effective as possible. [CMS (https://www.cms.gov/About-CMS/Agency-Information/CMSLeadership/Office_FCHCO)]

Mental Health and Substance Use Support

- Established the Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Behavioral Health Equity, which coordinates efforts to reduce disparities in mental and substance use disorders across populations. [SAMHSA (https://www.samhsa.gov/behavioral-health-equity)]

- Extended parity protections to individual health insurance, including qualified health plans offered through exchanges and required coverage of mental and substance use disorder treatment services as a category of Essential Health Benefits, guaranteeing coverage for consumers enrolled in individual and small group market plans. This impacted approximately 30.4 million enrollees in insurance plans and helped reduce stigma while supporting treatment for vulnerable populations. [CMS (https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet)]

- Created the Health Home State Plan Option to provide comprehensive care coordination for individuals with chronic conditions, including mental and substance use disorders. [CMS (https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/index.html)]

- Contributed millions of dollars to the Garrett Lee Smith State and Tribal Program, GLS Campus Suicide Prevention, and Primary Behavioral Health Care Integration grant programs. This successful program has trained more than 143,000 individuals who work in the mental health field or a related profession and more than 300,000 people in communities across the country on suicide prevention and mental health promotion. It has reached approximately 55 million people with mental health awareness messaging. [SAMHSA]

Health of LGBTQI+ and Communities of Color

- Established the Offices of Minority Health within six agencies at HHS: Agency for Healthcare Research and Quality (AHRQ); Centers for Disease Control and Prevention (CDC); Centers for Medicare & Medicaid Services (CMS); Food and Drug Administration (FDA); Health Resources and Services Administration (HRSA); and Substance Abuse and Mental Health Services Administration (SAMHSA). [HHS (https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=7)]

- Elevated the NIH National Institute on Minority Health and Health Disparities to lead and coordinate activities that improve the health of racial and ethnic minority populations and reduce health disparities. [NIH (https://www.nimhd.nih.gov/)]

- Prohibited discrimination on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), in covered health programs or activities, including health insurance. [OCR (https://www.hhs.gov/about/news/2021/11/18/hhs-takes-action-to-prevent-discrimination-and-strengthen-civil-rights.html)]

- Reduced the uninsured rate among LGBTI+ populations by nearly half since 2010. [ASPE (https://aspe.hhs.gov/reports/health-insurance-coverage-lgbtq)]

- Provided coverage to approximately 4 million Latinos and 3 million Black Americans since 2010 when the ACA was enacted. [ASPE - PDF (https://www.aspe.hhs.gov/sites/default/files/migrated_legacy_files/198861/trends-in-the-us-uninsured.pdf?_ga=2.133451849.639786395.1646968197-1682771927.1611176133)]

- Strengthened the safety net of HIV care and treatment services to people with HIV served by HRSA's Ryan White HIV/AIDS Program by helping cities, states, counties, and locally-based community organizations stretch their resources to build a comprehensive system of HIV care. [HRSA]

- Established the Health Profession Opportunity Grant, a unique training and employment program that enrolled low-income individuals from historically underserved and marginalized communities in high demand health care training programs, thus providing career pathways for low-income individuals to assist families in becoming self-sufficient. [ACF (https://www.acf.hhs.gov/ofa/programs/hpog)]

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ASPE
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

The Affordable Care Act and Its Accomplishments

BRIEFING BOOK

March 2022

aspe.hhs.gov

Office of the Assistant Secretary for Planning and Evaluation

The Assistant Secretary for Planning and Evaluation (ASPE) advises the Secretary of the U.S. Department of Health and Human Services (HHS) on policy development in health, disability, human services, data, and science; and provides advice and analysis on economic policy. ASPE leads special initiatives; coordinates the Department's evaluation, research, and demonstration activities; and manages cross-Department planning activities such as strategic planning, legislative planning, and review of regulations. Integral to this role, ASPE conducts research and evaluation studies; develops policy analyses; and estimates the cost and benefits of policy alternatives under consideration by the Department or Congress.

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This Briefing Book was designed by Rose Chu and Aldren Gonzales, ASPE Office of Health Policy.

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EXECUTIVE SUMMARY

The Affordable Care Act (ACA) was signed into law on March 23, 2010. Since then, the law has led to a historic expansion of health insurance coverage across all states and all demographic groups within the U.S. This Briefing Book features key findings from two dozen reports published by the Biden-Harris Administration in 2021-2022. Most of the reports were published by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in the Department of Health and Human Services (HHS), working in collaboration with the Centers for Medicare & Medicaid Services (CMS), which is primarily responsible for the implementation of many of the ACA's provisions and also releases regular Medicaid and Marketplace enrollment reports. The Briefing Book also includes a report by the White House Council of Economic Advisors.

The Briefing Book summarizes key findings in five areas:

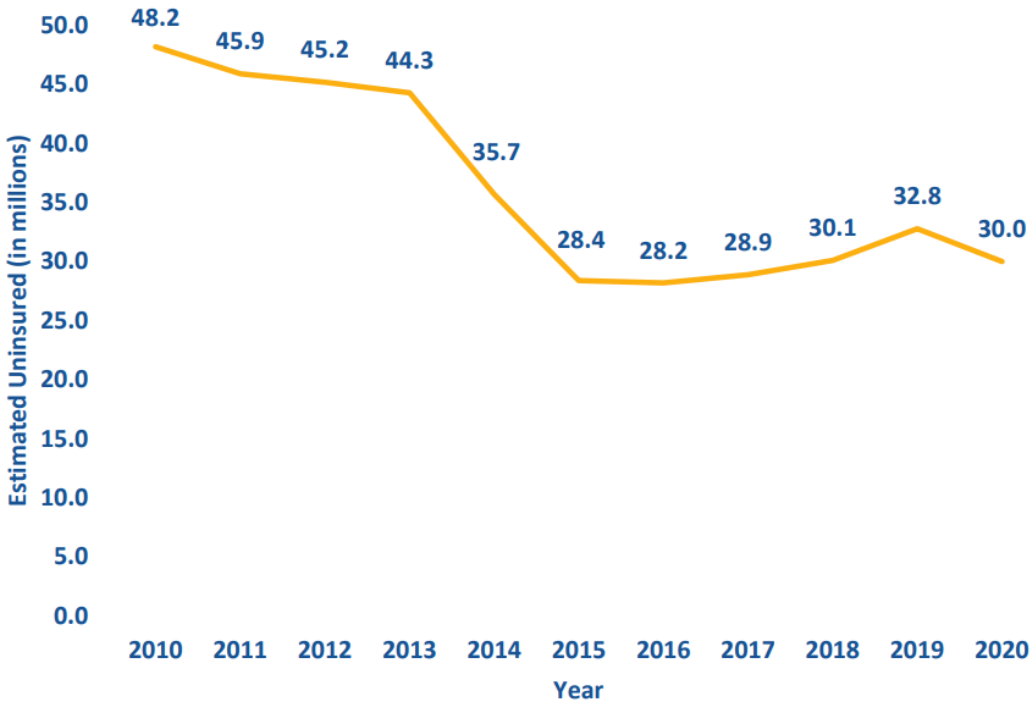
- **Health Coverage and Uninsured Rates:** The ACA reduced the size of the uninsured population by approximately 20 million people from 2010 to 2020, though some of this progress was reversed from 2017-2019. Early evidence indicates that the uninsured rate has begun to decline again in 2021, after actions taken by the Biden-Harris administration to strengthen the ACA, including passage of the American Rescue Plan (ARP) and robust enrollment outreach.
- **Marketplace Coverage:** Marketplace enrollment reached an all-time high of 14.5 million individuals in 2022, building on the success of the 2021 Special Enrollment Period and the enhanced Premium Tax Credits implemented by the American Rescue Plan, which made low-premium and zero-premium Marketplace plans available to millions of current enrollees and uninsured Americans.
- **Medicaid:** Medicaid expansion has been a key tool in expanding coverage to low-income adults, improving access to care, and improving health outcomes in the states that have chosen to do so. 12 states, however, have not yet expanded, leaving 3.8 million potential expansion-eligible adults uninsured in those states. The Biden-Harris Administration has also taken steps to improve continuity of coverage for those in Medicaid, particularly during the postpartum period.
- **Preventive Care:** The ACA requires coverage of recommended preventive services, including well-child visits, cancer screenings, immunizations, and contraception. This policy has produced increased rates of preventive care and provides free access to these services among more than 150 million Americans with private insurance.
- **Populations of Interest:** In a series of reports, HHS examined the large gains in coverage under the ACA that have occurred among all races and ethnic groups, people living in rural areas, LGBTQ+ individuals, people with disabilities, and immigrants, while noting the major disparities in coverage and access to care that remain in need of additional policy interventions to improve health equity.

This Briefing Book provides summaries of the reports in each of these areas, along with links to the full reports. It also highlights a select number of key figures from the reports included:

- Annual uninsured rates in the U.S. since 2010 (Figure 1),
- Changes in the uninsured rate by state between 2010 and 2019 (Figure 2),
- ACA-Related Enrollment 2014-2021 (Figure 3),
- The county-level pattern of urban and rural uninsured rates (Figure 4), and
- Trends over time in uninsured rates by race and ethnicity (Figure 5).

SELECT KEY FIGURES

Figure 1. U.S. Nonelderly Uninsured Population, 2010 – 2020 (in millions)



Source: Analysis of the National Health Interview Survey's Health Insurance Coverage Reports in https://aspe.hhs.gov/reports/trends-us-uninsured-population-2010-2020

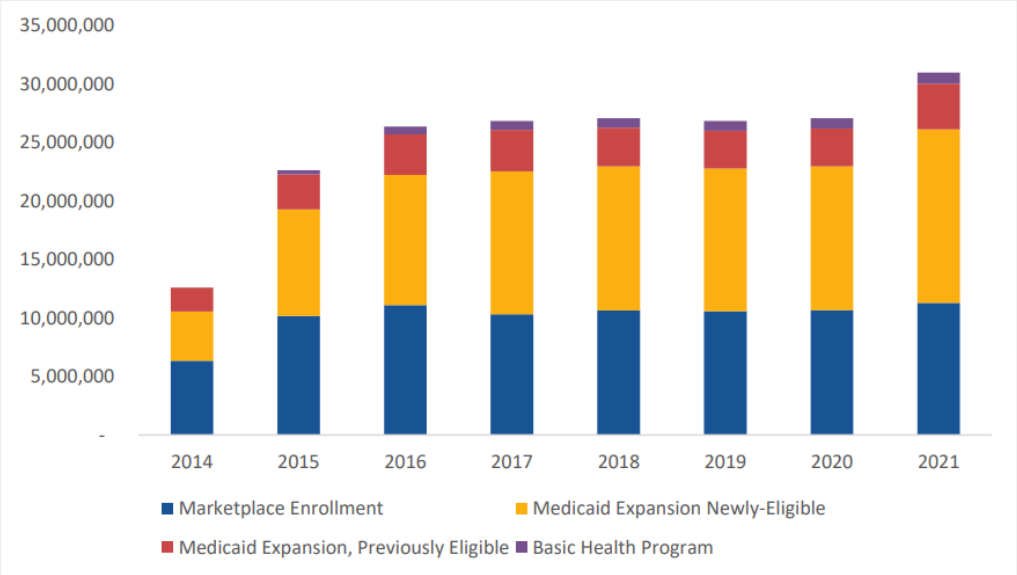
Figure 2. Uninsured Rates for Individuals Ages 0 to 64, by State, for 2010 and 2019

State	2010	2019	2010 to 2019 Change
United States	18.0%	11.1%	-6.9%
Alabama	17.4%	12.1%	-5.3%
Alaska	19.2%	12.9%	-6.2%
Arizona	20.2%	14.1%	-6.1%
Arkansas	20.8%	11.5%	-9.3%
California	20.9%	9.1%	-11.7%
Colorado	17.7%	9.4%	-8.3%
Connecticut	10.4%	7.0%	-3.4%
Delaware	12.1%	8.8%	-3.4%
District of Columbia	8.4%	4.0%	-4.4%
Florida	26.0%	16.8%	-9.2%
Georgia	22.6%	16.2%	-6.4%
Hawaii	8.6%	5.1%	-3.5%
Idaho	20.7%	12.4%	-8.3%
Illinois	16.0%	8.7%	-7.3%
Indiana	17.5%	10.6%	-6.9%
Iowa	11.1%	5.8%	-5.3%
Kansas	16.0%	11.2%	-4.9%
Kentucky	18.1%	8.0%	-10.0%
Louisiana	21.0%	11.2%	-9.8%
Maine	12.6%	10.2%	-2.4%
Maryland	13.0%	7.0%	-6.0%
Massachusetts	5.1%	3.6%	-1.4%
Michigan	14.6%	7.2%	-7.5%
Minnesota	10.3%	5.8%	-4.5%
Mississippi	21.4%	16.2%	-5.1%

State	2010	2019	2010 to 2019 Change
Missouri	15.7%	12.5%	-3.2%
Montana	19.8%	10.3%	-9.5%
Nebraska	13.5%	9.7%	-3.8%
Nevada	25.5%	13.9%	-11.7%
New Hampshire	12.9%	7.9%	-5.0%
New Jersey	15.2%	9.5%	-5.8%
New Mexico	23.1%	12.2%	-10.9%
New York	13.8%	6.3%	-7.5%
North Carolina	19.3%	13.6%	-5.7%
North Dakota	11.8%	8.5%	-3.2%
Ohio	14.4%	8.2%	-6.2%
Oklahoma	22.4%	18.0%	-4.4%
Oregon	20.0%	8.8%	-11.2%
Pennsylvania	12.4%	7.4%	-5.0%
Rhode Island	14.0%	5.0%	-9.0%
South Carolina	20.4%	13.3%	-7.0%
South Dakota	14.0%	11.7%	-2.3%
Tennessee	16.9%	12.6%	-4.3%
Texas	26.7%	21.4%	-5.3%
Utah	17.1%	11.0%	-6.2%
Vermont	9.2%	5.4%	-3.8%
Virginia	14.4%	9.5%	-4.8%
Washington	16.1%	7.7%	-8.4%
West Virginia	17.7%	8.8%	-8.9%
Wisconsin	11.4%	7.2%	-4.2%
Wyoming	16.5%	14.9%	-1.7%

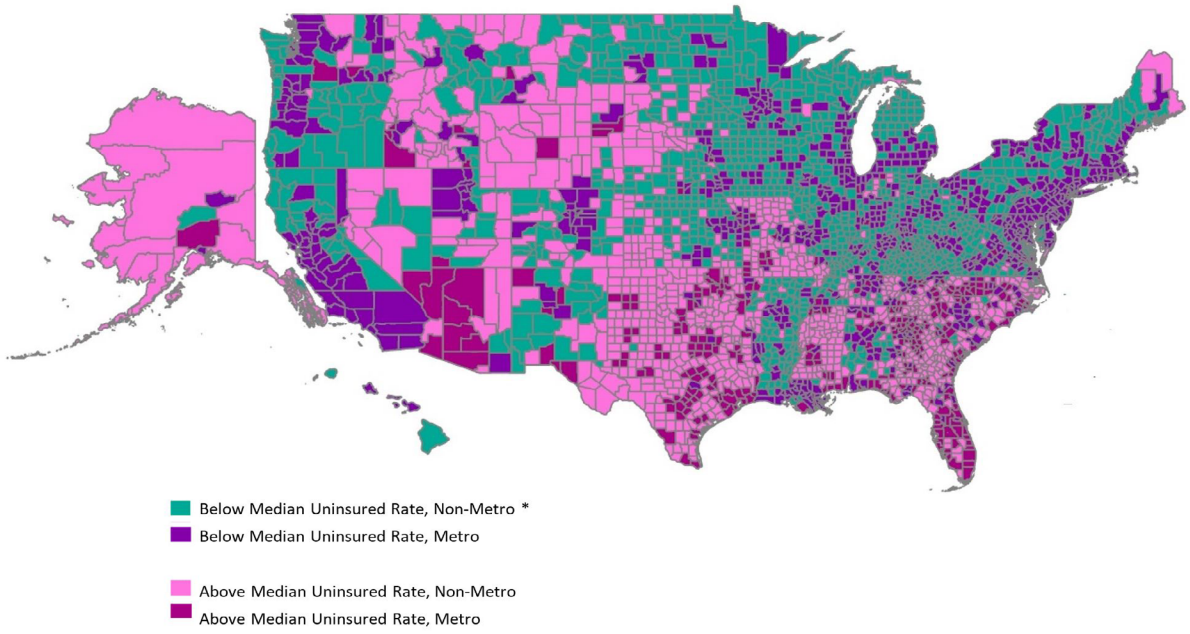
Source: ASPE analysis of 2010 and 2019 data from the American Community Survey. We use 2019 data for these estimates, since the Census Bureau reports that the COVID-19 pandemic affected data quality for 2020.

Figure 3. ACA-Related Enrollment: Marketplace, Medicaid Expansion and the Basic Health Program 2014-2021



Source: https://aspe.hhs.gov/reports/health-coverage-under-affordable-care-act-enrollment-trends-state-estimates

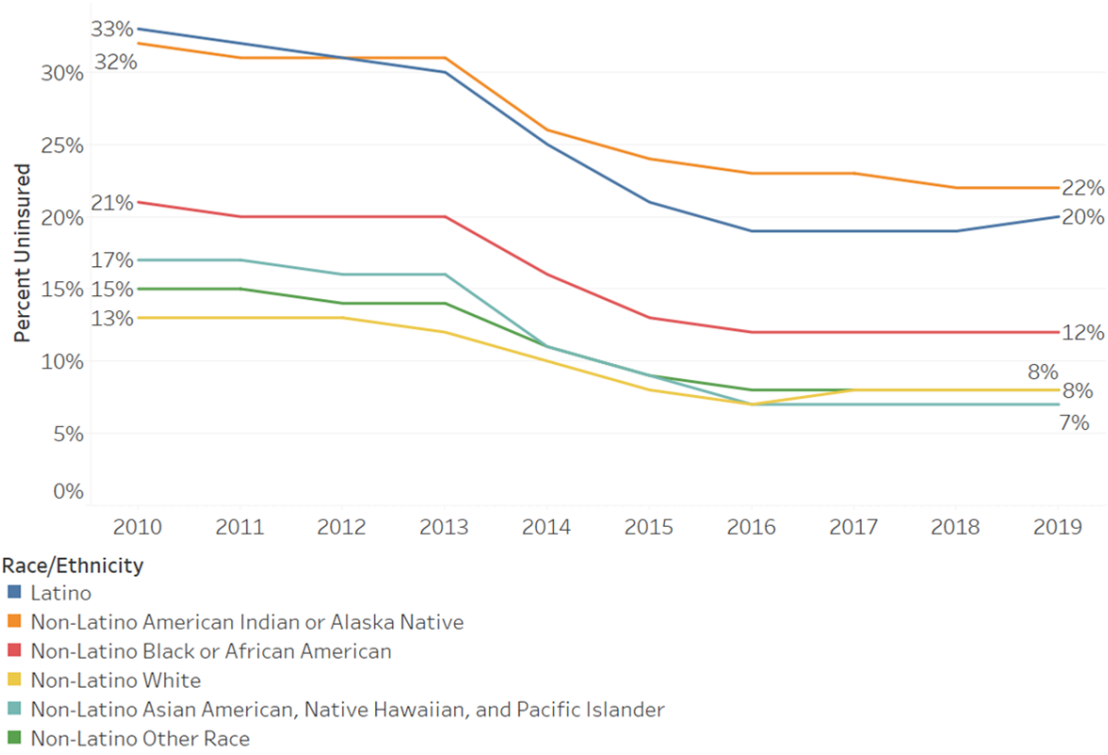
Figure 4. High and Low Uninsured Rates among the Non-Elderly Population by County Metropolitan Status, 2019



**The median uninsured rate is defined as the median uninsured rate across rural and urban counties.*

Source: Small Area Health Insurance Estimates from the U.S. Census Bureau, as shown in https://aspe.hhs.gov/reports/access-care-rural-america

Figure 5. Uninsured Rate for Nonelderly U.S. Population by Race and Ethnicity, 2010-2019



Source: Analysis of American Community Survey Public Use Microdata Sample, 2010-2019, in: https://aspe.hhs.gov/reports/health-insurance-coverage-access-care-among-latinos

HEALTH COVERAGE AND UNINSURED RATES

1

Trends in the U.S. Uninsured Population, 2010-2020

Publication Date: February 10, 2021

Newly released estimates from the National Health Interview Survey show that 11.1 percent of U.S. residents (or 30.0 million) under age 65 lacked health insurance as of January-June 2020. This number reflects a sharp decline in the number of uninsured Americans since 2010, before implementation of the Affordable Care Act's large coverage expansions. The implementation of the Affordable Care Act increased coverage especially for Blacks, Latinos, Asians, American Indians/Alaska Natives, families with lower incomes, and those living in states that expanded Medicaid. However, the uninsured rate rose between 2016-2019. The issue brief concludes with an overview of current efforts to expand health coverage.

KEY POINTS

- 30 million U.S. residents lacked health insurance in the first half of 2020, according to newly released estimates from the National Health Interview Survey (NHIS).
- This number reflects a sharp decline in the number of uninsured Americans since 2010, before implementation of the large coverage expansions under the Affordable Care Act (ACA). The ACA produced particularly large coverage gains for Blacks, Latinos, Asian Americans, and Native Americans, as well for lower-income families.
- However, the uninsured rate has increased since 2016, even prior to the COVID-19 pandemic. From 2017-2019, the uninsured rate rose by 1.7 percentage points, most likely due to new policy changes to coverage options available under the ACA and Medicaid.
- Estimates from the NHIS show no significant change in uninsured rates during the early months of the COVID-19 pandemic. However, the pandemic itself created challenges in conducting the survey that may affect estimates of the uninsured, due to reduced response rates and a temporary shift from an in-person survey to a telephone survey.
- Compared with other Americans, the uninsured are disproportionately likely to be Black or Latino; be young adults; have low incomes; or live in states that have not expanded Medicaid.

Read the publication

2
The Remaining Uninsured: Geographic and Demographic Variation

Publication Date: March 22, 2021

The Affordable Care Act (ACA), signed into law on March 23, 2010, extended health coverage to millions of Americans through Medicaid (in the states participating in Medicaid expansion) and subsidized Marketplace coverage. However, research prior to enactment of the American Rescue Plan suggests many remaining uninsured people are not aware of their coverage options. This Issue Brief illustrates the geographic and demographic variation in the uninsured population, including those eligible to enroll in health coverage through the Marketplace during the COVID-19 Special Enrollment Period. This Issue Brief is intended to support state and local outreach efforts to make uninsured individuals aware of their options for affordable coverage.

KEY POINTS

- Efforts to expand health insurance coverage are central to improving health equity and responding to the health and economic challenges of the COVID-19 pandemic. Millions of uninsured individuals are currently eligible for subsidized coverage under the Affordable Care Act (ACA), and this number is anticipated to grow with the provisions of the American Rescue Plan Act of 2021 (ARP).
- Though the national uninsured rate has decreased substantially since the implementation of the ACA, high uninsured rates persist in some states such as Texas and Florida.
- In some areas of the country, large portions of the uninsured population, up to 69 percent, reside in households in which the adults have limited English proficiency.
- Hispanic individuals represent 19 percent of the total U.S. population but account for 29 percent of the uninsured.
- Black individuals comprise approximately 13 percent of the U.S. population but 16 percent of the uninsured.
- Data on the uninsured population can assist with outreach efforts to inform eligible individuals about their health insurance coverage options.

Read the publication

3
Health Coverage Changes From 2020-2021

Publication Date: January 27, 2022

The National Health Interview Survey (NHIS) provides annual and quarterly data on health insurance coverage by insurance type, age, and income. This Data Point examines health coverage trends over time using recently-released NHIS data through September 2021 to assess coverage changes during the pandemic and how they compare to pre-pandemic years, both for the population as a whole, as well as by age and income.

KEY POINTS

- The most recent National Health Interview Survey shows that the uninsured rate for the U.S. population was 8.9 percent for Q3 2021 (July – September 2021), down from 10.3 percent for Q4 2020.
- Individuals with incomes below 200% of the federal poverty level experienced the largest decrease.
- The uninsured rate for children decreased by 2.2 percentage points and for working-age adults (18-64) decreased by 1.5 percentage points.
- Coverage gains were somewhat larger for private coverage than public coverage.
- These data suggest that policies including the American Rescue Plan, the 2021 Marketplace Special Enrollment Period, and state Medicaid expansions, in addition to the economic recovery, have helped Americans gain insurance coverage during the COVID-19 public health crisis.
- Additional analysis and data will be needed to explore changes in health coverage for specific populations and geographical regions, as well as assessing changes in different sources of coverage.

Read the publication

4

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

Publication Date: June 4, 2021

Based on enrollment data from late 2020 and early 2021, approximately 31 million people are currently enrolled in Marketplace or Medicaid expansion coverage related to provisions of the Affordable Care Act (ACA), the highest total on record. This Issue Brief presents current estimates of enrollment in health insurance coverage purchased through the ACA Marketplaces and the Medicaid expansion and the subsequent reductions in state-level uninsured rates since the ACA was implemented in 2014.

KEY POINTS

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

Read the publication

5

Access to Marketplace Plans with Low Premiums on the Federal Platform Part I: Availability Prior to the American Rescue Act

Publication Date: March 28, 2021

Many uninsured individuals can access zero-premium or low-premium health plans after application of premium tax credits under the Affordable Care Act. Among the 11 million uninsured non-elderly adults eligible for Marketplace plans in HealthCare.gov states, two in five (42 percent) could find a plan for $0 and more than half (57 percent) could find a plan for $50 or less per month, as of March 2021. Among the nearly eight million individuals currently enrolled in Marketplace plans through HealthCare.gov, 15 percent are enrolled in zero-premium plans and 43 percent are enrolled in low-premium plans. This Issue Brief is the first in a series that examines the availability of zero- and low-premium health plans in HealthCare.gov states. Follow-up analyses will examine the effect of the American Rescue Plan provisions for 2021 coverage through HealthCare.gov.

KEY POINTS

- Many uninsured and underinsured individuals can access plans with no premiums ("zero-premium plans") or premiums for $50 or less per month ("low-premium plans") after application of advance payments of premium tax credits (APTCs). These individuals may enroll in coverage under the Special Enrollment Period currently being made available on HealthCare.gov due to the COVID-19 pandemic.
- Among non-elderly uninsured adults potentially eligible for Marketplace plans in HealthCare.gov states, zero- and low-premium plans are most commonly available to lower-income individuals. For example, approximately 90 percent or more of eligible uninsured individuals with incomes between 100 and 150 percent of the federal poverty level (FPL) can currently find a plan for $0, and all such individuals may find a plan for $50 or less per month.
- By age group, more than half (52 percent) of eligible individuals ages 55-64 can find a zero-premium plan, and 62 percent could find a low-premium plan. Many eligible young uninsured adults (ages 18-24) can also find a zero-premium (44 percent) or low-premium (62 percent) plan.
- Half (50 percent) of eligible uninsured Hispanic / Latino adults can find a zero-premium plan and 64.5 percent can find a low-premium plan. Among eligible Black uninsured adults, 45 percent likely have available a zero-premium plan and 59 percent can find a low-premium plan.
- Among the nearly eight million individuals currently enrolled in plans on the federal Marketplace, 15 percent are enrolled in a zero-premium plan after application of APTC (66 percent have access to a zero-premium plan), and 43 percent are enrolled in a low-premium (78 percent have access to such plans).
- Access to zero-premium and low-premium plans will increase when the subsidies newly enacted in the American Rescue Plan become available on April 1. ASPE will be providing updated analyses in the future.

Read the publication

6

Access to Marketplace Plans with Low Premiums on the Federal Platform Part II: Availability Among Uninsured Non-Elderly Adults Under the American Rescue Plan

Publication Date: April 1, 2021

The American Rescue Plan (ARP) enhances and expands eligibility for premium tax credits under the Affordable Care Act. Under the ARP, we estimate that the availability of zero-premium plans has increased by 19 percentage points and low-premium plans by 16 percentage points, respectively, among uninsured non-elderly adults potentially eligible for Marketplace coverage in HealthCare.gov states. This Issue Brief is the second in a series that examines the availability of zero- and low-premium health plans in HealthCare.gov states.

KEY POINTS

- The American Rescue Plan (ARP) enhances and expands eligibility for advance payments of premium tax credits (APTCs) to purchase Marketplace insurance coverage under the Affordable Care Act (ACA). This Issue Brief estimates the changes in the availability of health plans with no premiums ("zero-premium plans") or premiums for $50 or less per month ("low-premium plans") after APTCs among uninsured non-elderly adults potentially eligible for Marketplace plans in HealthCare.gov states under the ARP.
- Under the ARP, we estimate that the availability of zero-premium plans has increased by 19 percentage points in this population, and low-premium plans by 16 percentage points.
- Whereas most low-premium plans before the ARP were in the bronze tier, the ARP has substantially increased the availability of low-premium silver and gold plans. Availability of silver tier plans for zero-premium has increased by 22 percentage points, with approximately a quarter (25 percent) of this population now able to access such a plan.
- Availability of low-premium plans for this population increased by 28 percentage points, with approximately half (50 percent) now potentially able to find a low-premium silver plan. Zero-premium gold plan availability also increased for this population substantially, from 3 to 11 percent, and for low-premium gold plan availability from 13 to 30 percent.
- The ARP reduced the expected individual contribution of household income toward benchmark plan premiums to zero percent for applicable taxpayers with income between 100 and 150 percent of the Federal Poverty Level (FPL). Combined with cost-sharing reductions, this means that nearly all eligible uninsured adults in this income range can find a zero-premium plan with an actuarial value (AV) of 94 percent.

Read the publication

7

Access to Marketplace Plans with Low Premiums on the Federal Platform Part III: Availability Among Current HealthCare.gov Enrollees Under the American Rescue Plan

Publication Date: April 13, 2021

The American Rescue Plan (ARP) enhances and expands Marketplace premium tax credits under the Affordable Care Act. Among the nearly 8 million current HealthCare.gov enrollees, we estimate 79 percent could find a zero premium health plan and 87 percent could find a low premium health plan under the ARP. We estimate availability of zero-premium and low-premium health plans in the silver metal tier among current HealthCare.gov enrollees increased 41 percentage points and 25 percentage points, respectively, under the ARP. This Issue Brief is the third in a series that examines the availability of zero- and low-premium health plans in HealthCare.gov states.

KEY POINTS

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

Read the publication

8

The American Rescue Plan and the Unemployed: Making Health Coverage More Affordable After Job Loss

Publication Date: July 1, 2021

The American Rescue Plan (ARP) offers enhanced health insurance premium tax credits and cost-sharing reductions for people receiving unemployment compensation (UC) benefits in 2021. The enhanced subsidies are accessible on HealthCare.gov as of July 1, 2021. This Issue Brief examines the UC premium tax credit and cost-sharing reduction provisions under the ARP, describes the populations likely to benefit from these new temporary provisions, and provides illustrative examples to highlight the possible household impacts of these provisions.

KEY POINTS

- Under the American Rescue Plan Act of 2021 (ARP), people who receive or were approved to receive unemployment compensation (UC) for any week beginning in 2021 are eligible for enhanced Marketplace subsidies to obtain health insurance and to pay for care. The enhanced subsidies are accessible on HealthCare.gov as of July 1, 2021.
- Marketplace advanced premium tax credits (APTCs) are newly available for taxpayers receiving UC with household income less than 100 percent of the Federal Poverty Level (FPL), while those with higher household incomes now generally qualify for zero-premium benchmarks plans, since the ARP treats taxpayers receiving UC benefits as if their household income was at least 100 percent and no more than 133 percent FPL.
- The Congressional Budget Office and the Joint Economic Committee estimated that 1.4 million people will benefit from these new provisions, including 500,000 new Marketplace enrollees saving on average more than $7,000 this year on health insurance. These ARP provisions will build on the record growth in health insurance coverage related to the Affordable Care Act.
- Those newly eligible for premium tax credit subsidies under the ARP (household income above 400% FPL) are likely to see some of the greatest decreases in post-APTC premiums if they received UC in 2021.
- This Issue Brief presents several case studies, showing premium savings as a result of the ARP, in some cases of more than $700 a month.

Read the publication

9

Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces

Publication Date: December 28, 2021

Standardized plans are a policy option that can simplify Marketplace consumer comparison shopping and bring more value to consumers by offering the same deductibles and cost-sharing across plans. This report provides an overview of the evidence to date on how standardized plans can potentially benefit consumers, improve health equity, and enhance plan competition. This brief also describes the current landscape of standardized plans in State-based Marketplaces and the current proposal to add standardized plans to HealthCare.gov for Plan Year 2023.

KEY POINTS

- Standardized plans are a tool that can help consumers make plan choices and can also improve plan competition. These plans standardize actuarial value, maximum out-of-pocket, deductibles, and cost-sharing for a given metal level of coverage.
- Almost three quarters of HealthCare.gov consumers (72.9 percent) have more than 60 plan options to choose from, and the average number of plans is over 100 – far higher than in previous years. Research suggests too many choices can lead to "choice overload," making it hard for consumers to find plans that best fit their needs.
- Research evidence indicates that standardized plans make it easier for consumers to choose plans based on provider network, premiums, and quality, instead of cost-sharing differences within a metal level.
- For Plan Year 2022, nine states require Marketplace issuers to offer plans with detailed standardized designs, and six of these states limit the number of non-standardized plans on their State-based Marketplaces. Two additional states require Marketplace issuers to offer plans with limits on deductibles.
- The introduction of standardized plans to HealthCare.gov starting in 2023, consistent with the President's 2021 Executive Order on competition, may help consumers navigate their options, improve transparency, and increase plan competition.

Read the publication

10
Health Insurance Deductibles Among HealthCare.gov Enrollees, 2017-2021

Publication Date: January 13, 2022

The Affordable Care Act provides premium subsidies for Marketplace eligible individuals to improve health insurance affordability, as well as cost-sharing reductions (CSRs) for many enrollees that limit out-of-pocket spending such as deductibles. This report examines deductible trends among HealthCare.gov enrollees, comparing them with deductible trends for individuals with employer coverage, and shows the substantial reduction in deductible costs due to CSRs among eligible enrollees.

KEY POINTS

- Cost-sharing reduction subsidies (CSRs) provide substantial financial protection to eligible Marketplace enrollees who enroll in silver metal tier plans, by lowering deductibles, copayments, coinsurance, and out-of-pocket maximums.
- Median and average deductibles, after CSRs, differ substantially among HealthCare.gov enrollees. The median deductible decreased from $1,000 to $750 between 2017 and 2021 (prior to implementation of the American Rescue Plan (ARP)), while the average deductible increased from $2,405 to $2,825.
- The difference between median and average deductibles is primarily driven by the fact that the majority of enrollees are eligible for and select CSR-silver plans; the average deductible is driven up by the smaller share of enrollees enrolled in plans without CSRs.
- Deductibles for consumers receiving CSRs and the overall median deductible on HealthCare.gov are generally lower than employer coverage deductibles, while the average deductible in bronze plans without CSRs is higher than the average employer coverage deductible.
- Slightly over half of HealthCare.gov enrollees – 51 percent in the 2021 open enrollment period and 58 percent of new plan selections during the 2021 Special Enrollment Period (from February to August) – receive CSRs, making a CSR plan the median HealthCare.gov offering. The average silver CSR deductible, after subsidy, has been well below $1,000 for the past 5 years, and is even lower for those with incomes below 200 percent of the Federal Poverty Level who qualify for more generous CSRs.
- Among those not receiving CSRs, the average HealthCare.gov bronze plan deductible generally remained steady between 2017 and 2021, with an average deductible of $6,094 in 2021. The average silver non-CSR deductible grew from $3,491 to $4,500 over the same time.
- The ARP contains provisions that reduce premiums for many Marketplace eligible individuals. Among new consumers enrolling during the 2021 HealthCare.gov Special Enrollment Period, median deductibles fell from $450 to $50 after the ARP premium provisions were implemented on April 1, 2021, indicating most new consumers are opting into CSR silver plans.

Read the publication

11
Medicaid Churning and Continuity of Care

Publication Date: April 11, 2021

Research shows that disruptions in Medicaid coverage are common and often lead to periods of uninsurance, delayed care, and less preventive care for beneficiaries. Studies suggest that beneficiaries moving in and out of Medicaid coverage (sometimes called "churning") results in higher administrative costs, less predictable state expenditures, and higher monthly health care costs due to pent-up demand for health care services. This Issue Brief reviews evidence on churning among the Medicaid population and different policy options for states and the federal government to reduce churning, including continuous eligibility, Medicaid expansion for adults, express lane eligibility, presumptive eligibility, multimarket plans, and limiting premiums and cost-sharing.

KEY POINTS

- Research shows that disruptions in Medicaid coverage are common and often lead to periods of uninsurance, delayed care, and less preventive care for beneficiaries.
- Studies indicate that beneficiaries moving in and out of Medicaid coverage (sometimes called "churning") results in higher administrative costs, less predictable state expenditures, and higher monthly health care costs due to pent-up demand for health care services.
- One study found adults with 12 full months of Medicaid coverage in 2012 had lower average costs ($371/month in 2021 after adjusting for inflation) than those with six months of coverage ($583/month) or only three months of coverage ($799/month).
- The postpartum period is a particularly high-risk time for churning as studies show that 55 percent of women with Medicaid coverage at delivery experience a coverage gap in the following six months compared to 35 percent of women with private insurance. This is of particular concern for pregnant women of color, who experience large disparities in maternal mortality before and after childbirth and account for a larger proportion of Medicaid beneficiaries compared to the overall U.S. population.
- The Families First Coronavirus Recovery Act has helped reduce Medicaid churning, temporarily, through its continuous enrollment requirements for enhanced funding for the duration of the COVID-19 Public Health Emergency.
- State decisions, such as adopting the Affordable Care Act's Medicaid expansion to adults and the extended continuous eligibility option for postpartum coverage starting in April 2022 under the American Rescue Plan, can play an important role in reducing rates of churning.

Read the publication

12

Medicaid After Pregnancy: State-Level Implications of Extending Postpartum Coverage

Publication Date: December 7, 2021

The postpartum period is increasingly recognized as a target for policy intervention to improve maternal health. The American Rescue Plan Act included an option for states to offer 12 months of postpartum Medicaid eligibility, a significant extension from the current requirement of 60 days. This brief provides an overview of the important role Medicaid plays in postpartum maternal health, reviews existing pregnancy-related Medicaid eligibility limits in state Medicaid programs, and assesses the projected eligibility impact if all states were to extend postpartum Medicaid eligibility to 12 months.

KEY POINTS

- One in three pregnancy-related deaths occur between one week and one year after childbirth. Disruptions in postpartum health coverage are common, particularly among those enrolled in Medicaid, as most states continue pregnancy-related Medicaid coverage for only 60 days after childbirth.
- The American Rescue Plan (ARP) included a temporary state option to extend continuous Medicaid and CHIP eligibility for pregnant individuals from 60 days up to 12 months postpartum. Seven states have approved or pending 1115 demonstrations to extend postpartum eligibility, and currently pending proposed legislation in Congress could extend 12 months of Medicaid postpartum eligibility nationwide.
- If all states extended pregnancy-related Medicaid eligibility to 12 months postpartum, the proportion of pregnant Medicaid beneficiaries who would remain eligible for the full postpartum year would increase from 52 percent to 100 percent, representing approximately 720,000 people annually with expanded coverage.
- Individuals in non-expansion states and states with more restrictive Medicaid parental income eligibility limits would benefit most from 12 months of postpartum Medicaid eligibility. Postpartum Medicaid eligibility would increase by 65 percentage points in non-expansion states (from 35 to 100 percent, roughly 350,000 people) and 38 percentage points in expansion states (from 62 to 100 percent, approximately 370,000 people).
- Gains in postpartum eligibility would be largest for individuals with incomes between 138-250 percent of the Federal Poverty Level, whose incomes are too high to qualify for Medicaid as parents in most states.

Read the publication

13

Updated Estimates of Uninsured Adults Newly Eligible for Medicaid If Remaining 12 Non-Expansion States Expand Medicaid

Publication Date: February 15, 2022

Approximately 3.8 million uninsured non-elderly adults would be newly eligible for Medicaid if the remaining 12 non-expansion states were to expand eligibility for adults with incomes up to 138% of the Federal Poverty Level (FPL).

KEY POINTS

- In the 12 states that have not expanded Medicaid, we estimate that 3.8 million uninsured non-elderly adults would be newly eligible for Medicaid if all the states were to expand eligibility for adults with incomes up to 138% FPL.
- In the 12 states that have not expanded Medicaid, approximately 2.2 million uninsured non-elderly adults with incomes below 100% FPL – who are in what is sometimes called the "coverage gap" – would become newly eligible for Medicaid if their states were to expand the program.
- Among uninsured Black adults in the 12 non-expansion states, expansion would increase the number who are eligible for Medicaid nearly fivefold, while the number of Medicaid-eligible individuals among uninsured Hispanic adults would increase approximately sixfold.

Read the publication

14
The Effects of Earlier Medicaid Expansions: A Literature Review (Council of Economic Advisors)

Publication Date: June 2021

A review of the literature focused on ACA Medicaid expansions shows that the ACA Medicaid expansions improved health through greater access to health care, and also appeared to promote health through raising incomes of low-income households (e.g., reduced hunger from less out-of-pocket health care costs) and information effects (e.g., reduced risky health behaviors from more exposure to doctors). They may also have beneficial non-health effects that operate through income effects, including greater financial security.

KEY POINTS

- The ACA's Medicaid expansion led to significant improvements in access to care, chronic disease management, and behavioral health care.
- In turn, this improved care has been linked to improved self-reported health and reduced mortality.
- Medicaid expansion has led to more continuous coverage. This decrease in coverage disruption has been even more pronounced among perinatal women.
- Expansions have also led to a narrowing of coverage disparities. The balance of evidence shows that ACA Medicaid expansions helped narrow racial disparities in health insurance coverage, especially for Black and Latino individuals.
- Beyond health care effects, Medicaid expansion also has been shown to reduce food and housing insecurity and improve household finances.
- The ACA Medicaid expansions did not lead to increased state spending on Medicaid and has not reduced state spending in other areas.

Read the publication

15

Access to Preventive Services without Cost-Sharing: Evidence from the Affordable Care Act

Publication Date: January 11, 2022

This Issue Brief summarizes the Affordable Care Act's preventive services provisions for private health coverage, Medicare, and Medicaid; provides updated estimates of the number of people benefiting from these provisions nationally; and examines evidence on trends in utilization of preventive services and outcomes since the ACA's preventive services coverage requirements went into effect.

KEY POINTS

- The ACA substantially increased access to care and coverage of preventive services without cost-sharing for millions of Americans.
- Many preventive services including vaccinations, well-child visits, screening for HIV and sexually transmitted infections, HIV pre-exposure prophylaxis, contraception, and cancer screening are required to be covered by most group and individual health plans and for many Medicaid beneficiaries without cost-sharing.
- Expanded access to recommended preventive services resulted from increases in the number of people covered through private health insurance and Medicaid expansion under the ACA.
- Analysis of recent data indicates that more than 150 million people with private insurance –including 58 million women and 37 million children – currently can receive preventive services without cost-sharing under the ACA, along with approximately 20 million Medicaid adult expansion enrollees and 61 million Medicare beneficiaries that can benefit from the ACA's preventive services provisions.
- Evidence from studies examining the impact of the ACA indicate increased colon cancer screening, vaccinations, use of contraception, and chronic disease screening.

Read the publication

16

Health Insurance Coverage Changes: Asian Americans and Pacific Islanders

Publication Date: May 23, 2021

This Issue Brief analyzes changes in coverage from 2013-2019 among Asian Americans and Pacific Islanders (AAPIs) and AAPI subgroups, using a combination of data from the American Community Survey (ACS) and Marketplace data, including estimated impacts of the 2021 American Rescue Plan. AAPIs experienced larger relative gains in health insurance coverage than any other racial group since the Affordable Care Act was fully implemented in 2014.

KEY POINTS

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

Read the publication

17

Health Insurance Coverage and Access to Care for LGBTQ+ Individuals: Recent Trends and Key Challenges

Publication Date: June 30, 2021

This Issue Brief analyzes national survey data to discuss demographic characteristics of the LGB+* community, recent trends in insurance coverage for this population, and various challenges and barriers to care faced by the broader LGBTQ+ community.

KEY POINTS

- Individuals in the LGBTQ+ community face unique challenges and barriers to care. Expanding access to health insurance coverage is one important tool in improving access to care in this population.
- Analyzing sexual orientation data from the National Health Interview Survey (NHIS), we find that uninsured rates in the LGB+ community have fallen substantially since the passage of the Affordable Care Act (ACA), from 17.4 percent in 2013 to a low of 8.3 percent in 2016. However, the uninsured rate increased after 2016.
- While the NHIS does not have information on gender identity, non-government data sources suggest similar benefits of the ACA on coverage rates among transgender individuals.
- Overall uninsured rates in 2019 were 12.7 percent for LGB+ individuals vs. 11.4 percent for non-LGB+ individuals, with higher rates of Medicaid coverage but similar Marketplace enrollment and lower Medicare enrollment.
- The American Rescue Plan (ARP) increased the generosity of premium subsidies available in the Marketplace. If the same share of LGB+ enrollees who have Marketplace coverage have a zero-premium option under the ARP as exists for all Marketplace enrollees, we estimate that roughly 210,000 LGB+ Marketplace enrollees now have access to a zero-premium plan.
- Barriers besides coverage also contribute to persistent disparities in access and health outcomes. In the NHIS, LGB+ individuals report being 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-LGB+ counterparts. Other contributing factors include a lack of healthcare professionals adequately trained in providing culturally competent care, as well as high cost-sharing and/or lack of coverage for certain services including hormone treatments and other gender-affirming care.

**We use terminology applicable to the original information sources we cite. When discussing findings based on analysis of the National Health Interview Survey (NHIS), which reports on individuals who self-identify as Gay/Lesbian, Bisexual, or "something else", we use the terminology "LGB+". Though NHIS does not include questions that allow for identification of transgender individuals, many individuals who identify as transgender are included in the LGB+ cohort. LGB+ does not include individuals who identify as "straight, that is, not gay" or those that responded, "I don't know." We use "LGB+" when referring to data from the NHIS, and the broader term "LGBTQ+" in all contexts other than that specific dataset.*

Read the publication

18

Access to Affordable Care in Rural America: Current Trends and Key Challenges

Publication Date: July 9, 2021

Medicaid and the Marketplace are important sources of affordable, comprehensive healthcare coverage for millions of Americans living in rural areas, and the American Rescue Plan (ARP) bolsters rural coverage options. But challenges in accessing care remain in many rural areas, including provider shortages, infrastructure limitations, and long distances to care. In this brief, we describe patterns in insurance coverage and uninsured rates in rural and urban areas; review non-financial challenges in accessing care for rural residents and disparities in health outcomes between rural and urban areas; and conclude by discussing policies, programs, and resources designed to address barriers to care in rural America.

KEY POINTS

- Many rural communities face challenges that contribute to persistent health disparities compared to urban areas.
- Uninsured rates among non-elderly adults in rural areas have fallen substantially since the passage of the Affordable Care Act (ACA), from 23.7 percent in 2010 to 16.0 percent in 2019.
- Despite this progress, uninsured rates in rural areas have been and continue to be about 2-3 percentage points higher than in urban areas over the 2010-2019 period.
- Medicaid expansion played a key role in expanding health insurance coverage; Medicaid coverage rates increased from 12.2 percent of the rural population in 2010 to 17.1 percent in 2019.
- Uninsured rates among rural residents are disproportionally higher in states that have not yet expanded Medicaid. The rural uninsured rate was nearly twice as high in non-expansion states as expansion states (21.5 vs. 11.8 percent) in 2019. More than 440,000 uninsured non-elderly adults in the 13 non-expansion states would gain eligibility for Medicaid if those states expanded.
- Approximately 15 percent of Marketplace enrollees in HealthCare.gov states live in rural areas.
- Under the ARP, 65 percent (1.3 million) of the 1.9 million rural uninsured individuals of HealthCare.gov states may be able to find a zero-premium plan on the platform.
- Although uninsured rates have fallen in rural areas, other barriers to care such as geographic distances, infrastructure limitations, and provider shortages contribute to rural health disparities.
- Programs and services such as telehealth, healthcare workforce programs, Community Health Centers, and Rural Health Clinics all help improve access to care in rural communities.

Read the publication

19

Health Insurance Coverage and Access to Care for American Indians and Alaska Natives: Current Trends and Key Challenges

Publication Date: July 21, 2021

The uninsured rate among American Indian and Alaska Native (AI/AN) working age adults decreased 16 percentage points since the passage of the Affordable Care Act (ACA), from 44 percent in 2010 to 28 percent in 2018. This Issue Brief describes changes in the uninsured rate, health coverage, and access to care for AI/ANs since 2013 and discusses key policies for this population, including how the American Rescue Plan Act of 2021 (ARP) builds on the Affordable Care Act (ACA) and invests additional resources in the Indian health care system.

KEY POINTS

- The uninsured rate among American Indians and Alaska Natives (AI/AN) under age 65 decreased 16 percentage points since the passage of the ACA, from 44 percent in 2010 to 28 percent in 2018.
- However, according to 2019 Census data, the AI/AN population continues to have the highest uninsured rate compared to other populations.
- The ARP offers expanded financial assistance for purchasing Marketplace health insurance, and the ARP has made zero-premium plans available to an estimated 26,000 additional uninsured AI/AN people.
- Oklahoma expanded Medicaid as of July 1, 2021; prior to expanding Medicaid, Oklahoma had the largest uninsured AI/AN population of any state - more than 79,000 people.
- If remaining non-expansion states were to adopt the ACA Medicaid expansion, approximately 55,000 more uninsured AI/AN non-elderly adults would be eligible for Medicaid coverage.
- Significant disparities remain, as AI/AN people are disproportionately affected by chronic conditions and die at higher rates than other Americans from chronic liver disease, diabetes, and chronic lower respiratory diseases, as well as non-chronic causes of death such as suicide and accidents.
- AI/ANs have experienced higher rates of COVID-19 infection, hospitalization, and death compared to White persons during the pandemic. However, after COVID-19 vaccines became available, AI/AN communities have achieved higher COVID-19 vaccination rates compared to other racial and ethnic groups.
- Strengthening the Indian health care system, together with broader efforts across the federal government and cross-sector partnerships, can promote health equity by addressing social determinants of health such as housing, education, and employment.

Read the publication

20
Health Insurance Coverage Among Working Age Adults with Disabilities

Publication Date: July 28, 2021

In this Brief, we show that adults with disabilities have experienced major gains in full-year coverage since 2010 but as of 2017-18 remained less likely to have health insurance than adults without disabilities. For this vulnerable population, consistent access to health insurance may be even more critical to continuity of care and improved health outcomes. While having health insurance coverage for part of the year is associated with better outcomes than being uninsured for an entire year, coverage interruptions may prevent timely access to needed health services, disrupt existing courses of treatment, and increase financial hardship for people with disabilities and their families. Little has been reported, however, about the extent to which working-age adults with disabilities continue to experience gaps in coverage post-Affordable Care Act (ACA).

KEY POINTS

- From 2010-11 to 2017-18, the proportion of working-age adults (i.e., age 18-64) with disabilities who had health insurance coverage for the whole year increased from about 71 percent to 81 percent. The proportion of adults with disabilities who were uninsured for the whole year was nearly halved, falling from about 17 percent to about 9 percent.
- Increases in Medicaid coverage gains were particularly large among adults with disabilities, coinciding with the ACA's Medicaid expansions that took effect in most states starting in 2014.
- These improvements were concentrated immediately after 2014, when the ACA's main insurance expansions took effect.
- Throughout the study period, however, adults with disabilities remained about 50 percent more likely than adults without disabilities to be insured for only part of the year.
- The American Rescue Plan Act of 2021 (ARP) expanded subsidies for Marketplace plans, which has the potential to increase coverage further for adults with disabilities.
- Under the ARP, an estimated 532,000 uninsured adults with disabilities (roughly 67 percent) have access to a zero-premium plan after premium tax credits on HealthCare.gov, an increase of 16.8 percentage points from pre-ARP estimates.

Read the publication

21

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

Publication Date: October 8, 2021

Health outcomes among Latinos* are affected by factors such as lack of health insurance, language and cultural barriers, and lack of access to care. This issue brief analyzes changes in health insurance coverage and examines disparities in access to care between Latinos and non-Latinos 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 Affordable Care Act (ACA) among select racial and ethnic populations.

KEY POINTS

- Uninsured rates in the Latino population have fallen since the passage of the 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.

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

Read the publication

22
Assessing Uninsured Rates in Early Care and Education Workers

Publication Date: November 19, 2021

This Data Point presents current estimates of uninsured rates among early care and education workers (ECE), which includes individuals employed by Head Start, childcare center providers, and preschools. These populations have lower incomes on average and often lack access to benefits, including health coverage, commonly received by teachers in the K-12 system and post-secondary schools.

KEY POINTS

- ECE workers have lower incomes on average and often lack access to benefits commonly received by teachers in the K-12 system and post-secondary schools.
- In 2019, 15.7 percent of workers in ECE centers were uninsured, while 8.1 and 16.5 percent of listed and unlisted paid home-based ECE providers, respectively, were uninsured.
- Preschool and kindergarten teachers have a higher uninsured rate – 9 percent – than teachers of older students. By comparison, 2.4 percent of secondary school teachers (high school teachers) and 3.0 percent of post-secondary school teachers (college instructors and professors) are uninsured. Teaching assistants also have a higher uninsured rate than other educators, at 7.3 percent.
- The American Rescue Plan (ARP) expanded and enhanced subsidies for purchasing Marketplace health insurance, including for the 2022 Open Enrollment Period, which can provide opportunities for increased coverage rates for ECE workers.

Read the publication

23
Health Insurance Coverage and Access to Care for Immigrants: Key Challenges and Policy Options

Publication Date: December 21, 2021

This report provides an overview of the characteristics of the immigrant population in the United States, their health status and barriers to care, recent trends in health insurance coverage, their access to Federal health programs, and how they have been affected by the COVID-19 pandemic. It also offers possible policy approaches to improve health care equity for this diverse population.

KEY POINTS

- The foreign-born population in the United States is large and diverse, and health outcomes vary widely across immigrant groups. However, barriers to health care and health insurance coverage are common due to the complex nature of the health care system, policy exclusions, cultural and linguistic barriers, discrimination, mistrust, and legal concerns.
- The Affordable Care Act (ACA) and more recently the American Rescue Plan (ARP) expanded health coverage eligibility and subsidies for certain immigrant populations including naturalized citizens and lawful permanent residents. After passage of the ACA, the uninsured rate fell substantially for both children and adults in immigrant communities, with the largest change occurring among adult non-citizens who immigrated to the United States within the last 5 years (48.1 percent in 2013 to 30.6 percent in 2019). However, gaps in coverage for immigrants persist, with uninsured rates still substantially higher than those among the U.S.-born population.
- Several studies suggest that concerns over actual and perceived adverse legal consequences tied to seeking public benefits have affected whether or not immigrants seek to enroll in public programs and can lead to barriers to needed care.
- Additional actions at the national and state levels, including targeted outreach efforts, can be taken to increase health insurance coverage among eligible immigrant populations and to address challenges related to social determinants of health in order to improve health equity.

Read the publication

24
Health Insurance Coverage and Access to Care Among Black Americans: Recent Trends and Key Challenges

Publication Date: February 22, 2022

This issue brief analyzes changes in health insurance coverage and examines trends in access to care among Black Americans using data from 2011-2020. This Issue Brief is part of a series of ASPE Issue Briefs examining the change in coverage rates and access to care after implementation of the Affordable Care Act (ACA) among different racial and ethnic populations.

KEY POINTS

- Since the implementation of the ACA's coverage provisions, the uninsured rate among Black Americans under age 65 decreased by 8 percentage points, from 20 percent in 2011 to 12 percent in 2019. The uninsured rate for Black Americans, however, is still higher than that for White Americans: 12 percent compared to 9 percent.
- The uninsured rate among Black Americans that report Latino ethnicity is similar to the uninsured rate among non-Latino Black Americans.
- Southern states that have not expanded Medicaid have some of the nation's highest uninsured rates for all population groups, as well as large Black populations.
- While access to care improved for Black Americans between 2011 and 2020, disparities in affordability of health care between Black and White Americans persist.
- Starting in 2021, the Biden-Harris Administration implemented legislative and administrative actions to expand affordable coverage options. Under the American Rescue Plan (ARP), which increased health insurance Marketplace subsidies, 76 percent of uninsured Black Americans could find a plan for less than $50 a month and 66 percent could find a plan for $0 a month in 2021.
- The Administration made a health insurance Marketplace Special Enrollment Period (SEP) available on Healthcare.gov in 2021 to offer uninsured individuals and current HealthCare.gov enrollees an opportunity to enroll in affordable coverage.
- To encourage enrollment during the SEP, the Administration increased funding and partnered with organizations to increase outreach to uninsured Black Americans, among other populations. Results show that among SEP enrollees reporting their race and ethnicity, the share of enrollees that were Black increased from 9 percent in 2019 to 15 percent in 2021.

Read the publication

PUBLICATION LIST AND WEB LINKS

HEALTH COVERAGE AND UNINSURED RATES

1. Trends in the U.S. Uninsured Population, 2010-2020
   - https://aspe.hhs.gov/reports/trends-us-uninsured-population-2010-2020
2. The Remaining Uninsured: Geographic and Demographic Variation
   - https://aspe.hhs.gov/reports/remaining-uninsured-geographic-demographic-variation
3. Health Coverage Changes From 2020-2021
   - https://aspe.hhs.gov/reports/health-coverage-changes-2020-2021
4. Health Coverage Under the Affordable Care Act: Enrollment Trends and State Estimates
   - https://aspe.hhs.gov/reports/health-coverage-under-affordable-care-act-enrollment-trends-state-estimates

MARKETPLACE COVERAGE (INCLUDING AMERICAN RESCUE PLAN)

5. Access to Marketplace Plans with Low Premiums on the Federal Platform Part I: Availability Prior to the American Rescue Act
   - https://aspe.hhs.gov/reports/access-marketplace-plans-low-premiums-federal-platform
6. Access to Marketplace Plans with Low Premiums on the Federal Platform Part II: Availability Among Uninsured Non-Elderly Adults Under the American Rescue Plan
   - https://aspe.hhs.gov/reports/access-marketplace-plans-low-premiums-uninsured-american-rescue-plan
7. Access to Marketplace Plans with Low Premiums on the Federal Platform Part III: Availability Among Current HealthCare.gov Enrollees Under the American Rescue Plan
   - https://aspe.hhs.gov/reports/access-marketplace-plans-low-premiums-current-enrollees-american-rescue-plan
8. The American Rescue Plan and the Unemployed: Making Health Coverage More Affordable After Job Loss
   - https://aspe.hhs.gov/reports/arp-unemployed-ib
9. Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces
   - https://aspe.hhs.gov/reports/standardized-plans-health-insurance-marketplaces
10. Health Insurance Deductibles Among HealthCare.gov Enrollees, 2017-2021
    - https://aspe.hhs.gov/reports/marketplace-deductibles-federal-platform-2017-2021

MEDICAID

11. Medicaid Churning and Continuity of Care
    - https://aspe.hhs.gov/reports/medicaid-churning-continuity-care
12. Medicaid After Pregnancy: State-Level Implications of Extending Postpartum Coverage
    - https://aspe.hhs.gov/reports/potential-state-level-effects-extending-postpartum-coverage

13. Updated Estimates of Uninsured Adults Newly Eligible for Medicaid If Remaining 12 Non-Expansion States Expand Medicaid
    - https://aspe.hhs.gov/reports/updated-estimates-medicaid-eligibility-non-expansion-states

14. The Effects of Earlier Medicaid Expansions: A Literature Review [Council of Economic Advisors]
    - https://www.whitehouse.gov/wp-content/uploads/2021/06/Medicaid-Expansions-Lit-Review-CEA-.pdf

PREVENTIVE CARE

15. Access to Preventive Services without Cost-Sharing: Evidence from the Affordable Care Act
    - https://aspe.hhs.gov/reports/aca-preventive-services-without-cost-sharing

POPULATIONS OF INTEREST

16. Health Insurance Coverage Changes: Asian Americans and Pacific Islanders
    - https://aspe.hhs.gov/reports/health-insurance-coverage-changes-asian-americans-pacific-islanders

17. Health Insurance Coverage and Access to Care for LGBTQ+ Individuals
    - https://aspe.hhs.gov/reports/health-insurance-coverage-lgbtq

18. Access to Affordable Care in Rural America
    - https://aspe.hhs.gov/reports/access-care-rural-america

19. Health Insurance Coverage and Access to Care for American Indians and Alaska Natives
    - https://aspe.hhs.gov/reports/health-insurance-coverage-changes-aian

20. Health Insurance Coverage Among Working Age Adults with Disabilities
    - https://aspe.hhs.gov/reports/health-insurance-coverage-among-working-age-adults-disabilities-2010-2018

21. Health Insurance Coverage and Access to Care Among Latinos
    - https://aspe.hhs.gov/reports/health-insurance-coverage-access-care-among-latinos

22. Assessing Uninsured Rates in Early Care and Education Workers
    - https://aspe.hhs.gov/reports/assessing-uninsured-rates-early-care-education-workers

23. Health Insurance Coverage and Access to Care for Immigrants: Key Challenges and Policy Options
    - https://aspe.hhs.gov/reports/insurance-coverage-access-care-immigrants

24. Health Insurance Coverage and Access to Care Among Black Americans: Recent Trends and Key Challenges
    - https://aspe.hhs.gov/reports/health-insurance-coverage-access-care-among-black-americans

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OFFICE OF HEALTH POLICY

ISSUE BRIEF
February 22, 2022

HP-2022-07

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

KEY POINTS

- Since the implementation of the Affordable Care Act (ACA)'s coverage provisions, the uninsured rate among Black Americans under age 65 decreased by 8 percentage points, from 20 percent in 2011 to 12 percent in 2019. The uninsured rate for Black Americans, however, is still higher than that for White Americans: 12 percent compared to 9 percent.
- The uninsured rate among Black Americans that report Latino ethnicity is similar to the uninsured rate among non-Latino Black Americans.
- Southern states that have not expanded Medicaid have some of the nation's highest uninsured rates for all population groups, as well as large Black populations.
- While access to care improved for Black Americans between 2011 and 2020, disparities in affordability of health care between Black and White Americans persist.
- Starting in 2021, the Biden-Harris Administration implemented legislative and administrative actions to expand affordable coverage options. Under the American Rescue Plan (ARP), which increased health insurance Marketplace subsidies, 76 percent of uninsured Black Americans could find a plan for less than $50 a month and 66 percent could find a plan for $0 a month in 2021.
- The Administration made a health insurance Marketplace Special Enrollment Period (SEP) available on Healthcare.gov in 2021 to offer uninsured individuals and current HealthCare.gov enrollees an opportunity to enroll in affordable coverage.
- To encourage enrollment during the SEP, the Administration increased funding and partnered with organizations to increase outreach to uninsured Black Americans, among other populations. Results show that among SEP enrollees reporting their race and ethnicity, the share of enrollees that were Black increased from 9 percent in 2019 to 15 percent in 2021.

BACKGROUND

In 2020, there were 41.1 million Black Americans who identified as one race and 46.9 million Black Americans who identified as Black or African American in combination with another race or ethnicity accounting for 12.4 percent and 14.2 percent of the total U.S. population, respectively.[1*] Since 2010, the number of

[*] We use the term "Black Americans" in this report to describe Black or African Americans, who are defined as anyone who identified as Black or African American alone or in combination with other races. In general, statistics for Black Americans in this report do not include people reporting Latino ethnicity, unless otherwise specified. For ASPE's report analyzing coverage and access for Latinos, please see: https://aspe.hhs.gov/reports/health-insurance-coverage-access-care-among-latinos

Black Americans in combination with at least one other race grew 88.7 percent, and the number of Black Americans who identify as one race increased 5.6 percent since 2010.[2]

Black Americans are diverse in their racial and ethnic identity and experiences. In 2019, more than half (58.7 percent) of Black Americans in the U.S. lived in the South.[3] The ten states with the largest Black population in 2019 were Texas, Georgia, Florida, New York, North Carolina, California, Maryland, Illinois, Virginia, and Louisiana.[4] Black Americans on average are younger than the U.S. population as a whole, with more than half (58 percent) being less than 40 years old.[5] The median age of Black Americans in 2019 was 35 years old, six years younger than the total U.S. population's median age.[6] The number of Black Americans in the U.S. is growing and is expected to increase 34 percent by 2045.[7]

There are large disparities in the health status and health outcomes for Black Americans compared to White Americans. Chronic disease burden, morbidity, and mortality are all significantly higher among young adult Black Americans than the U.S. population as a whole.[8,9] According to the U.S. Census Bureau, Black Americans' life expectancy in 2020 was 3.6 years shorter than non-Latino White Americans.[10] In 2020, the leading causes of death among Black Americans were heart disease, cancer, and COVID-19.[11] With respect to maternal and child health, while Medicaid expansion has in some cases slowed the increase in maternal mortality among Black mothers, maternal and infant mortality among Black mothers and babies remains significantly higher than non-Latino White Americans.[12] Black American infants have a death rate of 10.8 deaths per 1,000 live births - almost twice the national average (5.7 deaths per 1,000 live births).[13] Additionally, Black Americans are three times more likely to die from pregnancy-related causes than their White counterparts.[14] Experts have argued that these inequities are consequences of multiple socio-economic factors that are largely the result of structural racism.[15]

The Affordable Care Act (ACA) increased availability of affordable coverage options via Medicaid expansion in participating states and Marketplace coverage with premium subsidies. Studies show that the ACA's coverage expansions narrowed racial and ethnic health disparities in coverage and access to care.[16,17,18] Additional coverage expansion efforts implemented during 2021 including a Marketplace Special Enrollment Period and passage of the American Rescue Plan (ARP) may help reduce health care disparities further.

This issue brief analyzes changes in health insurance coverage and examines trends in access to care among Black Americans using data from 2011-2020.[†] This Issue Brief is part of a series of ASPE Issue Briefs examining the change in coverage rates and access to care after implementation of the Affordable Care Act (ACA) among different racial and ethnic populations.

DATA SOURCES AND METHODS

This issue brief relies on analysis of U.S. Census Bureau's American Community Survey (ACS) and the National Health Interview Survey (NHIS) data. The ACS is a national household survey conducted by the Census Bureau that collects demographic information, including race and ethnicity, and source of health insurance. This brief uses ACS data from 2010 through 2020 for annual estimates of individuals who are uninsured. Due to data collection limitations during the COVID-19 pandemic that resulted in significant nonresponse bias, the U.S. Census Bureau did not release its standard 2020 ACS data and instead developed an experimental dataset for 2020. The Census Bureau cautions comparing the 2020 experimental estimates with experimental weights against estimates from previous years.[19,20,21] Thus, while we included 2020 estimates in our long-term trends,

[†] Due to data collection limitations during the COVID-19 pandemic that resulted in significant nonresponse bias, the U.S. Census Bureau did not release standard 2020 American Community Survey (ACS) 1 year data, and instead developed experimental estimates. 2020 ACS experimental estimates should be interpreted with caution due to the impact the COVID-19 pandemic on data collection and overall data quality. Similarly, 2019 and 2020 National Health Interview Survey (NHIS) data should be interpreted with caution and not compared to previous years, due to survey redesign and the COVID-19 pandemic, respectively.

when analyzing more detailed data on current coverage patterns, we preferentially used 2019 rather than 2020 ACS data. To account for the intersectionality of Black Americans, some of whom also identify as Latino Americans, we developed different variables for race and ethnicity in this analysis, examining differences in coverage between non-Latino and Latino Black Americans.

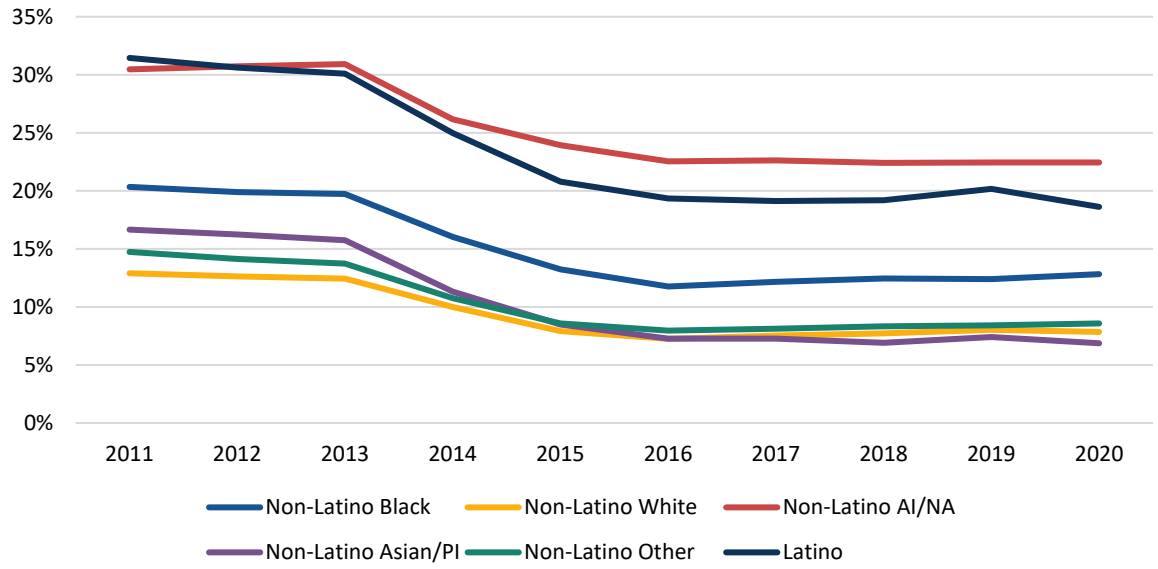
To analyze trends in access to health care for Black Americans and differences compared to White Americans, we used data from the National Health Interview Survey (NHIS) for the years 2011 to 2020.[‡] Administered by the National Center for Health Statistics (NCHS) housed within the Center for Disease Control and Prevention (CDC), the NHIS is the largest federal survey that collects health information on the U.S. population. Analyses are weighted to represent the noninstitutionalized population and to adjust for complex survey design. The 2020 NHIS was also impacted by the COVID-19 pandemic leading to challenges conducting in-person interviews, nonresponse bias, and lower response rates.[22] The health care access measures included in the analysis are as follows: lacking a usual source of care, having delayed care due to cost, worried about medical bills, delayed filling prescriptions medications to save money, and problems paying or unable to pay medical bills. We included additional measures from NHIS 2020 data related to the effects of the COVID-19 pandemic on Black Americans accessing health care including having delayed getting medical care because of the pandemic, not getting needed medical care other than for coronavirus because of the pandemic, and having had a virtual medical appointment for reasons related to the pandemic.

HEALTH INSURANCE COVERAGE

Since the implementation of the ACA's coverage provisions, the uninsured rate among nonelderly Black Americans decreased by 8 percentage points, from 20 percent in 2011 to 12 percent in 2019 (Figure 1). Essentially all of the decrease in the uninsured rate among Black Americans occurred between 2013 and 2016, after implementation of the Marketplace and Medicaid expansion coverage provisions in the ACA. Non-Latino American Indians and Alaska Natives had the highest uninsured rate in 2019 (22 percent), followed by Latinos of all races (20 percent). Asian American and Pacific Islanders and White Americans had uninsured rates in the 7 to 8 percent range in 2019. Figure 1 includes results of the experimental 2020 ACS estimate, which should be interpreted with caution; they show a very modest increase in the uninsured rate among Black Americans from 2019 to 2020 (12 percent to 13 percent) – but no major increase in the uninsured rate despite the pandemic and corresponding economic recession.[23]

[‡] Due to data collection limitations during the COVID-19 pandemic that resulted in significant nonresponse bias, the U.S. Census Bureau did not release standard 2020 American Community Survey (ACS)-1 year data and instead developed experimental estimates. 2020 ACS experimental estimates should be interpreted with caution due to the impact the COVID-19 pandemic had on data collection and overall data quality. Similarly, 2019 and 2020 National Health Interview Survey (NHIS) data should be interpreted with caution when comparing to previous years, due to survey redesign and the COVID-19 pandemic, respectively.

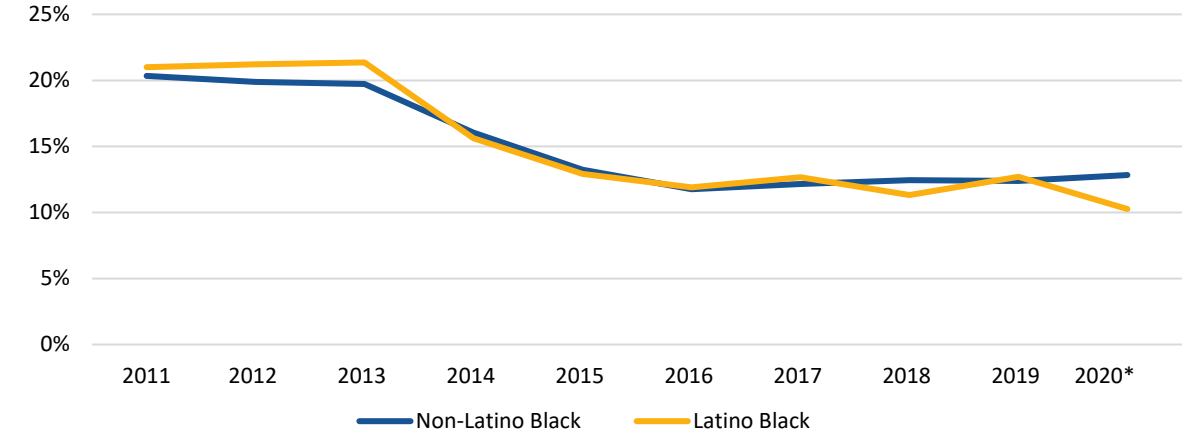
Figure 1. Uninsured Rate among Nonelderly U.S population (Ages 0-64) by Race and Ethnicity, 2011-2020*



Source: ASPE analysis of the ACS
Notes: Black Americans are defined as anyone who identified as Black or African American alone and in combination with other races. Non-Latino AI/NA are Non-Latino American Indians and Alaska Natives. Non-Latino Asian/PI are Non-Latino Asian Americans and Pacific Islanders. Non-Latino Other are individuals who responded "Other" race and multi-racial people, who answered more than two races.
* Due to pandemic-related survey collection concerns, the Census Bureau urges caution when comparing the experimental 2020 ACS dataset to previous years.

We also analyzed the uninsured rate among Black Americans who identify as Latino compared to Black Americans who do not identify as Latino (Figure 2). Overall, non-Latino Black Americans have a similar uninsured rate compared to Latino Black Americans. Latino Black Americans had a slightly higher uninsured rate than non-Latino Black Americans in 2013, prior to the implementation of the ACA's coverage provisions, but the two groups have had similar uninsured rates since 2014. These findings demonstrate that while there are many differences for Latino Black Americans in their experiences with accessing health insurance coverage options, especially for those who are not born in the U.S., they still have comparable uninsured rates as non-Latino Black Americans.[24]

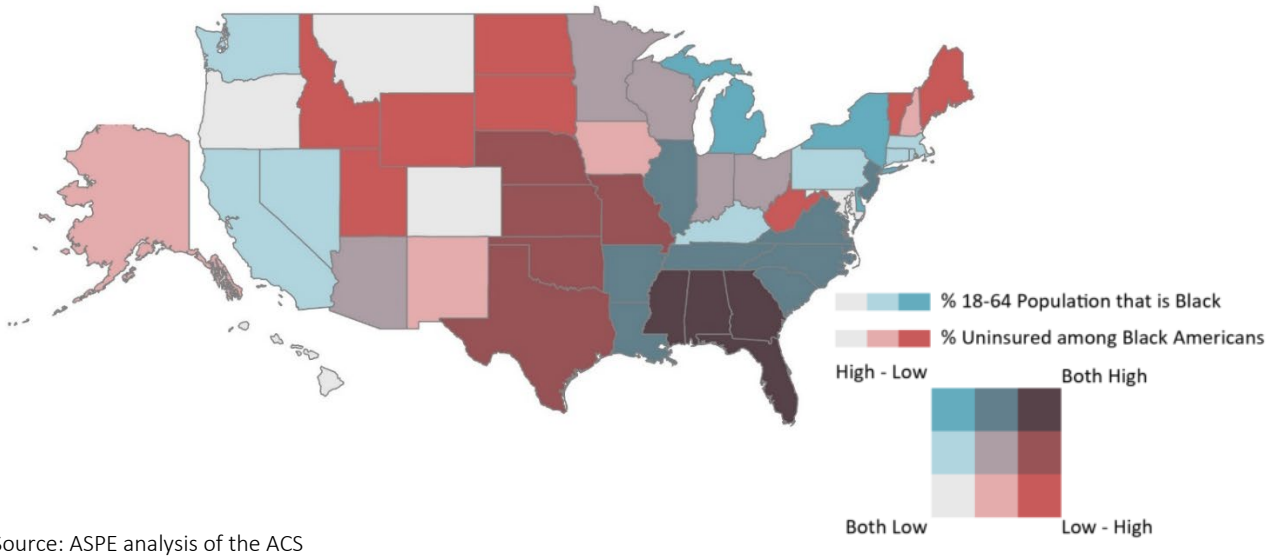
Figure 2. Uninsured Rate among Nonelderly Black Americans (Ages 0-64) by Latino Ethnicity, 2011-2020*



Source: ASPE analysis of the ACS
Notes: Latino Black Americans includes those who identify as Latino in combination with any race (e.g., multiracial).
* Due to pandemic-related survey collection concerns, the Census Bureau urges caution when comparing the experimental 2020 ACS dataset to previous years.

Figure 3 displays state level statistics for two measures: 1) the percentage of the 18-64 population who identify as Black Americans; and 2) the uninsured rate among Black Americans. Alabama, Florida, Georgia, and Mississippi are the states with both the highest percentage of Black Americans and the highest uninsured rates among Black adults in 2019. Notably, Alabama, Florida, Georgia, and Mississippi have not expanded Medicaid eligibility to low income adults with incomes up to 138 percent of the Federal Poverty Level (FPL), as of February 2022.[25] ASPE analysis estimates that approximately 957,000 non-Latino Black American adults would gain Medicaid eligibility if the remaining 12 states expanded Medicaid.[26] Among the remaining uninsured Black Americans, 37 percent live in three states that have not expanded Medicaid: Texas, Florida, and Georgia.[27] Uninsured Black Americans are more likely to reside in southern states that have not expanded Medicaid.[28] Michigan and New York, which have both expanded Medicaid, both have a low uninsured rate among Black Americans, and large Black American populations.

Figure 3. Uninsured Rate and Overall Population Share Among Black Americans (Ages 18-64) by State, 2019

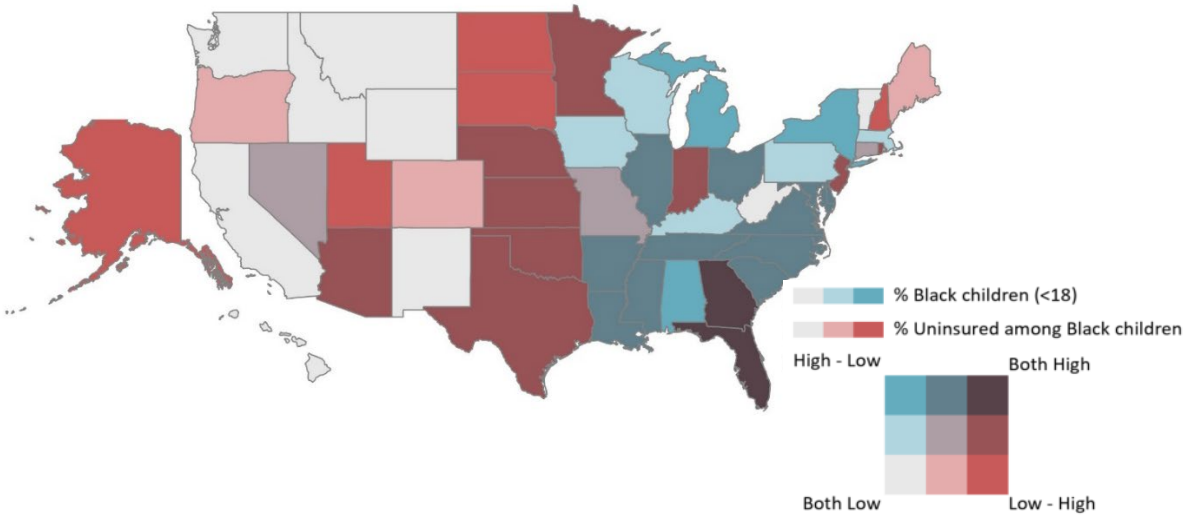


Source: ASPE analysis of the ACS

Note: This map uses quantile breaks to distribute data equally across intervals. Breaks are as follows: % of 18-64 adults: Low (0-4 percent), Medium (4-13 percent) High (13-41 percent). % of Uninsured who are Black: Low (0-13 percent), Medium (13-18 percent), High (18-33) percent.

Figure 4 displays state-level percentage of Black children under age 18 and the uninsured rate among Black children. Florida and Georgia, states that have not expanded Medicaid, both have high percentages of Black children and a high uninsured rate among Black children in 2019.

Figure 4. Uninsured Rate and Overall Population Share Among Black Children, By State (2019)



Source: ASPE Analysis of ACS
Notes: This map uses quantile breaks to distribute data equally across intervals. Breaks are as follows: % of Black children (blue): Low (0-5 percent), Medium (5-14 percent) High (14-55 percent). % of Uninsured children that are Black (red): Low (0-3 percent), Medium (3-5 percent), High (15-30 percent).

Table 1 shows the change in uninsured rate among Black Americans from 2011 to 2020 by income. All income groups experienced a reduction in the uninsured rate, likely due to coverage provisions in the ACA. Black Americans with incomes less than 100 percent FPL experienced the largest decrease in the uninsured rate from 2011 to 2019, by 9 percentage points. After 2016, uninsured rates in all income groups remained roughly stable.

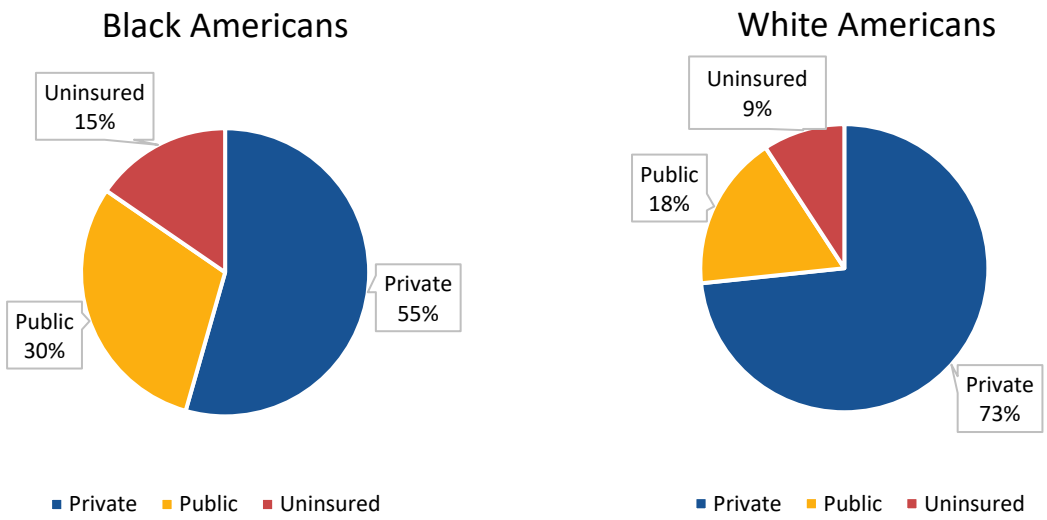
Table 1. Annual Uninsured Rate Among Nonelderly Black Americans (Ages 0-64) By Income, 2011-2020*

	Percent Uninsured									
Income as Percentage of Federal Poverty Level	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020*
<100%	26%	25%	25%	22%	19%	17%	17%	17%	17%	17%
100-138%	26%	24%	23%	18%	15%	13%	14%	14%	14%	14%
139-249%	21%	22%	22%	17%	13%	12%	13%	13%	13%	14%
250-400%	16%	15%	15%	12%	10%	9%	9%	10%	10%	11%
400%+	9%	8%	9%	7%	6%	5%	5%	6%	6%	6%

Source: ASPE analysis of the ACS
Note: Includes Latino Black Americans. * Due to pandemic-related survey collection concerns, the Census Bureau urges caution when comparing the experimental 2020 ACS dataset to previous years.

Figure 5 shows differences in insurance coverage type between Black Americans and White Americans in 2019. White Americans were more likely to have private insurance coverage (73 percent) compared to Black Americans (55 percent), while Black Americans were more likely to have public insurance coverage (30 vs. 18 percent) or be uninsured (15 vs. 9 percent).

Figure 5. Insurance Coverage Type among Black Americans compared to White Americans (Ages 18-64), 2019

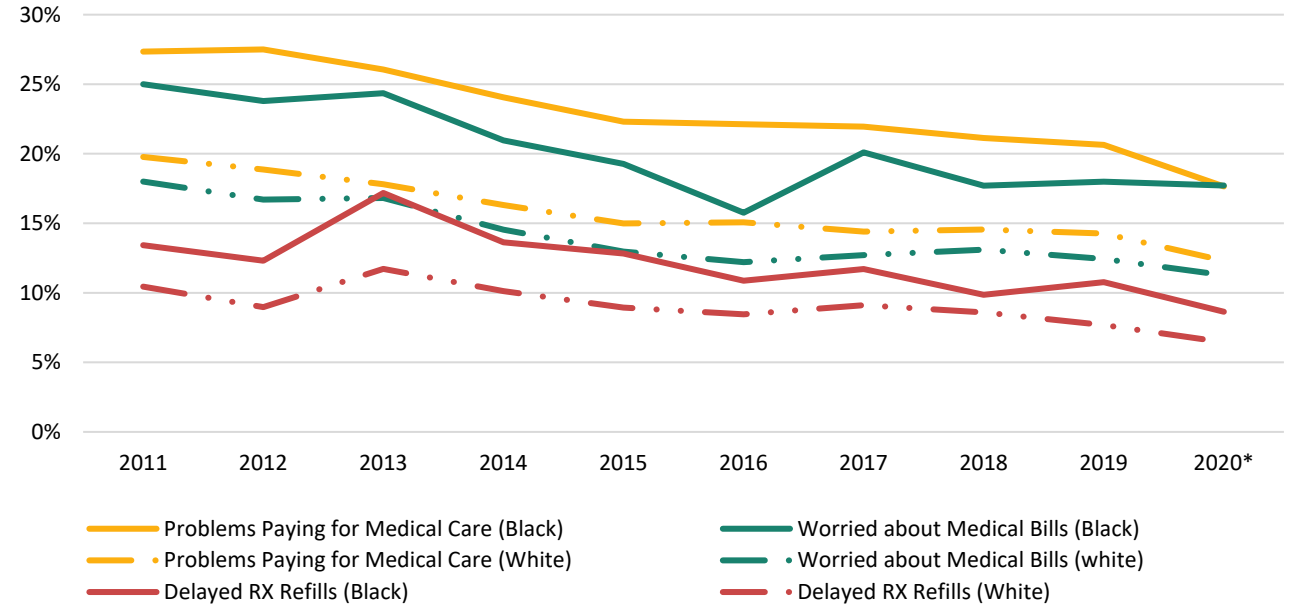


Source: ASPE Analysis of ACS
Notes: Private coverage includes employment-based, direct purchase and TRICARE. Public coverage includes Medicaid/CHIP, and VA coverage. Uninsured classified as a respondent not having any health insurance coverage at the time of interview. Estimates do not include Latino individuals.

ACCESS TO CARE

Implementation of the ACA's coverage provisions led to significant coverage gains among Black Americans. However, despite the decrease in uninsured rate, disparities in access to care persists for Black Americans. Figure 6 shows us that since implementation of the ACA, the proportion of Black Americans reporting problems paying for medical care has decreased from 27 percent in 2011 to 18 percent in 2020. Similar trends were observed in other access to health care measures, such as worries about medical bills (25 percent in 2011 to 18 percent in 2020) and delayed prescription refills to save money (13 percent in 2011 to 9 percent in 2020). The proportion of Black Americans reporting delaying refilling prescription medications to save money has decreased since 2013 and rates in these access to care barriers were higher among Black Americans compared to White Americans over time.

Figure 6. Trends in Access to Care for Black and White Adults (Ages 18-64), 2011-2020*



Source: ASPE Analysis of NHIS
Notes: Black = non-Latino Black or African American; White = non-Latino White. 2019 and 2020 National Health Interview Survey (NHIS) data should be interpreted with caution and not compared to previous years, due to survey redesign and the COVID-19 pandemic, respectively.

Table 2 demonstrates yearly trends in access to care for non-elderly Black Americans compared to their White American counterparts. Black Americans were more likely to report lacking a usual source of care in 2011, 2012, and 2018 compared to White Americans. Between 2011 and 2020, Black Americans were more likely to report being worried about medical bills, and problems paying or unable to pay medical bills, compared to White Americans. We observed similar findings for delayed refilling prescription medications to save money, except in 2017 and 2018, where there were no statistical differences.

Table 2. Access to Care Trends for Black and White American Adults (Ages 18-64), 2011-2020*

	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	
Year	Black	White	Black	White	Black	White	Black	White	Black	White
2011	13%**	11%	10%	10%	25%***	18%	13%***	10%	27%***	20%
2012	14%*	12%	9%	9%	24%***	17%	12%***	9%	28%***	19%
2013	13%	12%	9%	8%	24%***	17%	17%***	12%	26%***	18%
2014	12%	11%	8%	8%	21%***	15%	14%**	10%	24%***	16%
2015	12%	11%	7%	7%	19%***	13%	13%***	9%	22%***	15%
2016	11%	11%	7%	7%	16%***	12%	11%**	8%	22%***	15%
2017	10%	11%	7%	7%	20%***	13%	12%	9%	22%***	14%
2018	14%*	11%	8%	8%	18%***	13%	10%	9%	21%***	15%
2019	9%	9%	9%	8%	18%***	12%	11%**	8%	21%***	14%
2020	9%	8%	7%	6%	18%***	11%	9%**	6%	18%***	12%

Source: ASPE Analysis of NHIS
Notes: Black = non-Latino Black or African American; White = non-Latino White; * p < 0.05 ** p < 0.01 ***p<0.001.

Table 3. Access to Care Trends for Non-Latino Black and Latino Black American Adults (Ages 18-64), 2011-2020*

	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	
Year	NL Black	L Black	NL Black	L Black	NL Black	L Black	NL Black	L Black	NL Black	L Black
2011	13%*	20%	10%	11%	25%	30%	13%	10%	27%	28%
2012	14%	16%	9%	8%	24%	30%	12%**	5%	28%*	20%
2013	13%	14%	9%	11%	24%	33%	17%	17%	26%	30%
2014	12%	15%	8%	7%	21%**	33%	14%	10%	24%	23%
2015	12%	10%	7%	5%	19%	24%	13%	15%	22%	23%
2016	11%	13%	7%	5%	16%	18%	11%	11%	22%	21%
2017	10%	10%	7%	6%	20%	17%	12%	12%	22%	20%
2018	14%	17%	8%	9%	18%	25%	10%*	3%	21%	19%
2019	9%	8%	9%	11%	18%*	24%	11%	8%	21%	18%
2020	9%	11%	7%	8%	18%	30%	9%	7%	18%	25%

Source: ASPE Analysis of NHIS
Notes: NL Black, non-Latino Black or African American; L Black, Latino Black or African American; * p < 0.05 ** p < 0.01 ***p<0.001.

Table 3 examines differences in access for Black Americans, stratified by Latino ethnicity. We did not observe major differences between non-Latino and Latino Black Americans in access to care over time.

The 2020 NHIS collected information on how the COVID-19 pandemic impacted respondents. We observed that among nonelderly adults and youth, more White Americans reported having delayed care due to the COVID-19 pandemic (Table 4). This may be explained by White Americans are more likely to have coverage and regular sources of care and therefore would be more likely to experience delays in receiving care during the pandemic.

Table 4. Access to Care During the COVID-19 Pandemic (2020) for Black and White Americans, 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	Black	White	Black	White	Black	White
2020: Adults (Ages 18-64)	21%	25%***	16%	16%	88%	86%
2020: Children (Ages 0-17)	8%	15%*	5%	9%	74%	85%

Source: ASPE Analysis of NHIS.
Notes: Black = non-Latino Black or African American; White = non-Latino White; * p < 0.05 ** p < 0.01 *** p<0.001.

AMERICAN RESCUE PLAN AND 2021 POLICY CHANGES

Since taking office in January 2021, the Biden-Harris Administration has implemented legislative and administrative actions to increase availability and affordability of coverage.

The American Rescue Plan (ARP) of 2021 expanded eligibility for premium tax credits and increased subsidies for coverage on the federally-facilitated Marketplace, Healthcare.gov. Under the ARP, 76 percent of uninsured Black Americans can find a plan on Healthcare.gov for less than $50 a month and 66 percent can find a plan for $0 a month.[29]

The ARP also included a temporary state option to extend continuous Medicaid and CHIP eligibility for pregnant individuals from 60 days up to 12 months postpartum.[30] ASPE analysis estimates 133,000 Black Americans would gain coverage if all states participated.[31]

Finally, as of February 2022, 12 states have not yet adopted Medicaid expansion.[32] If the remaining non-expansion states were to expand Medicaid, an estimated 957,000 Black Americans without insurance coverage would become eligible for Medicaid coverage and increased access to affordable health care services. The ARP includes a provision offering non-expansion states a five-percentage point increase in their Federal Medical Assistance Percentage (FMAP) for eight quarters if they elect to expand Medicaid after March 11, 2021.[33]

The Biden-Harris Administration has also taken administrative action to help people to acquire and maintain affordable coverage. To help mitigate high unemployment and potential loss of health insurance coverage during the COVID-19 pandemic, the Administration opened a Special Enrollment Period (SEP) on Healthcare.gov. The SEP offered uninsured individuals and current HealthCare.gov enrollees an opportunity outside of the open enrollment period (OEP) to enroll in affordable coverage. To encourage enrollment and increase health insurance coverage uptake among uninsured Americans during the 2021 SEP, the Administration partnered with community partners including many Black organizations to conduct a campaign for outreach and increase media attention.[34,35] In total, 2.1 million individuals enrolled in new coverage on HealthCare.gov during the 2021 Marketplace SEP.[36] Among SEP enrollees reporting their race and ethnicity, the share of Black enrollees increased from 9 percent in 2019 to 15 percent in 2021. [37]

In advance of the 2022 Marketplace OEP, the Administration announced increased Navigator funding to the highest amount to date, $80 million, and extended the enrollment period by one month.[38] The 2022 Marketplace OEP reported record-breaking enrollment.[39] The Administration also proposed the HHS Notice of Benefit and Payment Parameters for 2023 Proposed Rule to further the goal of advancing health equity by addressing the health disparities that underlie our health system.[40] A recent ASPE report highlighted the latest federal survey data on the national uninsured rate, which showed that the uninsured rate decreased 1.5 percentage points from the end of 2020 to the fall of 2021.[41] While data on uninsured rates by race and ethnicity during 2021 are not yet available, these results suggest that the Administration's efforts to expand coverage are succeeding.

DISCUSSION

We report historic improvements in coverage among Black Americans since implementation of the ACA, with the percentage of Black Americans who were uninsured decreasing by 8 percentage points from 2011 to 2019. However, despite that progress in 2019, 12 percent of Black Americans were still uninsured, compared to 9 percent of White Americans, and disparities in health care access persist. A growing body of research shows that centuries of racism in the U.S. has had a profound and negative impact on communities of color, especially Black Americans. Black Americans have experienced many forms of oppression and explicit racism,

either structural or interpersonal, and studies show that this negatively affects the mental and physical health and economic well-being of millions of people.[42,43,44,45]

We report access to care improved for Black Americans between 2011 and 2020. However, disparities in the ability to afford health care between Black and White Americans have also persisted. Uninsured or underinsured Black Americans are more likely to forgo care, which impacts the already lower life expectancy observed in Black Americans compared to their White counterparts. [46,47] Further, differences in access to care for Black Americans are important to note given that Black Americans are more likely to live with or die prematurely from preventable health conditions and diseases compared to their White counterparts.[48,49] Some barriers to improved access to care among Black Americans are also rooted in systemic racism.[50] Both implicit and explicit bias among health care providers, inconvenient provider office hours, limited providers who see patients with public insurance due to lower reimbursement rates, and transportation barriers are also contributors to decreased access to care for Black Americans. [51,52,53,54,55,56]

Community health centers (CHC) are the nation's largest source of comprehensive primary care for both individuals with Medicaid coverage and those without coverage. Under the ACA, CHCs experienced increased patient revenues due to coverage expansions and substantially increased direct federal funding. These changes shifted CHC financial standing and led to increased number of health centers, along with improved capacity to provide services. CHCs are community-based and patient-directed organizations that deliver health care for some of the most underserved populations in the U.S., including Black Americans.[57] Health care delivered at these centers is also often culturally competent, comprehensive, and integrates different components of care.[58] In 2016, 23 percent of CHC patients were Black Americans and 62 percent of total CHC patients were people of color. Approximately 83 percent of patients that receive care at CHCs are uninsured or have public insurance coverage, with 92 percent being low-income.[59]

COVID-19 Pandemic Economic & Health Effects

The COVID-19 pandemic had disparate impacts on Black Americans.[60] The COVID-19 pandemic exposed and exacerbated longstanding economic and health inequities.[61,62] Black American women and Latino women experienced the largest decrease in employment during the COVID-19 pandemic and, despite economic recovery, continue to experience the lowest labor force participation, below pre-pandemic levels.[63] Many Black Americans lacked sufficient income and wealth to offset the economic crises such as job losses that arose from the COVID-19 pandemic.[64] Additionally, Black Americans are overrepresented in essential worker occupations and are more likely to hold labor and hourly wage jobs that cannot be performed from home. [65,66,67] In turn, Black Americans have been at an increased risk for contracting COVID-19, becoming hospitalized, and/or dying from COVID-19 compared to their White counterparts.[68] While telehealth has been an important source of care during the pandemic, recent research indicates that Black Americans are less likely to have video-enabled telehealth services, raising concerns about another potential dimension of care in need of attention to promote equitable care.[69] While the long history of mistreatment of Black Americans in the U.S. health care system has been linked to increased vaccine hesitancy, recent studies report COVID-19 vaccine hesitancy among Black Americans is improving and vaccination rates for Black Americans as of 2022 were similar to the general population. [70,71,72,73,74]

CONCLUSION

Insurance coverage increased substantially among Black Americans as a result of coverage expansions under the ACA. However, health insurance coverage disparities between Black and White Americans persist, and the COVID-19 pandemic has had disparate economic and health effects on Black Americans. The Biden Harris Administration has implemented legislative and administrative actions including the ARP, SEP in the HealthCare.gov, and robust outreach efforts aimed at expanding and maintaining coverage, including for underserved communities. Recent survey data indicates that the national uninsured rate decreased 1.5

percentage points from the end of 2020 to the fall of 2021, with results approaching an all-time low.[75] While data on the uninsured rate by race and ethnicity during 2021 are not yet available, these results suggest that the Administration's efforts to expand coverage are succeeding.

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Geographic Variation in Health Insurance Coverage: United States, 2020

by Emily P. Terlizzi, M.P.H., and Robin A. Cohen, Ph.D.

Abstract

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

Methods—Data from the 2020 National Health Interview Survey were used to estimate health insurance coverage. Estimates were categorized by age group, state Medicaid expansion status, urbanization level, expanded region, and state. Estimates by state Medicaid expansion status, urbanization level, and expanded region were based on data from all 50 states and the District of Columbia. State estimates are shown for 32 states and the District of Columbia for people under age 65 and adults aged 18–64, and 16 states for children.

Results—In 2020, among people under age 65, 11.5% were uninsured, 64.3% had private coverage, and 26.5% had public coverage at the time of the interview. Among adults aged 18–64, the percentage who were uninsured ranged from 11.8% for those living in large fringe (suburban) metropolitan counties to 17.9% for those living in nonmetropolitan counties. Adults aged 18–64 living in non-Medicaid expansion states (20.7%) were twice as likely to be uninsured compared with those living in Medicaid expansion states (10.3%). A similar pattern was observed among children aged 0–17 years. The percentage of adults aged 18–64 who were uninsured was significantly higher than the national average (13.9%) in Florida (19.5%), Georgia (25.4%), North Carolina (20.3%), and Texas (28.1%), and significantly lower than the national average in California (11.5%), Michigan (6.7%), New York (9.0%), and Pennsylvania (7.7%). The percentage of people under age 65 who were uninsured was lowest in the New England region (3.3%).

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

Introduction

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

This report is updated annually to provide the most current description of geographic variation in health insurance coverage in the United States (12). Estimates of the percentage of people who were uninsured, had private coverage, and had public coverage at the time of the interview are presented by urbanization level, state Medicaid expansion status, expanded region, and selected states. The primary focus of this report is on people under age 65 because nearly all people in the United States aged 65 and over are eligible for Medicare (13).

Methods

Data source

The estimates in this report are based on data from the Sample Adult and Sample Child modules of the 2020 National Health Interview Survey

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(NHIS), a nationally representative household survey of the U.S. civilian noninstitutionalized population. It is conducted continuously throughout the year by the National Center for Health Statistics (NCHS). In 2019, the NHIS questionnaire was redesigned to better meet the needs of data users. One sample adult from each household is randomly selected to answer detailed questions about their health. One sample child, if present, is also randomly selected from each household, and an adult knowledgeable about and responsible for the child's health answers questions on the child's behalf. Interviews are typically conducted in respondents' homes, but follow-ups to complete interviews may be conducted over the telephone when necessary. However, due to the COVID-19 pandemic, NHIS data collection switched the Sample Adult and Child interviews to a telephone-only mode beginning on March 19, 2020 (14). Personal visits to households resumed in selected areas in July 2020 and in all areas of the country in September 2020. However, cases were still attempted by telephone first, and a majority were completed by telephone.

Additionally, starting in August and continuing through the end of December, a subsample of adult respondents who completed NHIS in 2019 were recontacted by telephone and asked to participate again, completing the 2020 NHIS questionnaire. These reinterviewed participants are included as part of the regular Sample Adult file and estimates in this report are based on data from both reinterviewed participants and participants sampled only in the 2020 NHIS. The 2020 NHIS Sample Adult (excluding reinterviewed sample adults) and Sample Child response rates were 48.9% and 47.8%, respectively. A nonresponse bias assessment of the 2020 sample detected no biases for estimates of health insurance coverage (15). For more information about the impact of these changes on the 2020 data and general information about NHIS, visit https://www.cdc.gov/nchs/nhis/2020nhis.htm.

Both the Sample Adult and Sample Child modules include a full range of questions addressing health insurance such as coverage status, sources of coverage, characteristics of coverage, and reasons for no coverage. The sample adult and sample child receive similar sets of health insurance questions, so the Sample Adult and Sample Child files can be combined to create a file that contains people of all ages. Estimates are based on a combined file containing 37,358 people (5,790 sample children and 31,568 sample adults).

State identifiers were used to examine health insurance by state Medicaid expansion status, expanded region, and state. These identifiers are not available on the NHIS public-use data files but are available through the NCHS Research Data Center. For more information, see https://www.cdc.gov/rdc/index.htm.

Insurance coverage

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

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

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

Definition of geographic terms

State Medicaid expansion status—Under provisions of the Affordable Care Act (ACA), states have the option to expand Medicaid eligibility to cover adults who have family incomes up to and including 138% of the federal poverty level. There is no deadline for states to choose to implement the Medicaid expansion, and they may do so at any time. As of January 1, 2020, 35 states and the District of Columbia had expanded Medicaid. Medicaid expansion states include: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Washington, and West Virginia. The District of Columbia also has expanded Medicaid. States without expanded Medicaid include: Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.

Urbanization level—In this report, urbanization level is measured using a condensed categorization of the NCHS urban–rural scheme (16,17). The NCHS urban–rural classification is based on metropolitan statistical area (MSA) status defined by the Office of Management and Budget according to published standards that are applied to U.S. Census Bureau data.

This report condenses the NCHS urban–rural classification into four categories: large central metropolitan (similar to inner cities), large fringe metropolitan (similar to suburbs), medium and small metropolitan, and nonmetropolitan (17,18). Large metropolitan areas have populations of 1 million or more. Metropolitan areas with populations of less than 1 million were classified as medium (250,000–999,999 population) or small (less than 250,000 population) metropolitan areas (17).

The MSA classification scheme used in this report is consistent with other

NHIS reports and products (19,20). This classification is available on the public-use data files (21).

Expanded regions—Expanded region classifications are based on a subdivision of the four census regions (Northeast, Midwest, South, and West) into nine divisions. For this report, the nine census divisions were modified by moving Delaware, the District of Columbia, and Maryland into the Middle Atlantic division. This approach was used previously by Holahan et al. (22).

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

State-level estimates—For this report, direct state-level estimates are provided for 32 states and the District of Columbia. No state-specific estimates are presented for Alaska, Hawaii, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, South Dakota, Utah, Vermont, West Virginia, and Wyoming because they did not meet the criteria for inclusion, which were determined in a previous report (12). Note that for specific age groups and domains (uninsured, private, and public), fewer state-level estimates may be provided because estimates may not meet additional criteria for inclusion. For example, for the measure of uninsured children, state-level estimates are only provided for five states.

Statistical analysis

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

NCHS only publishes a direct state-level estimate if the estimate meets NCHS acceptance criteria for measures of estimate uncertainty (for example, standard errors, relative standard errors, and confidence interval [CI] width). Depending on the state sample size, the measure being studied, and possible subdomain of interest, a state may have many publishable estimates, few, or none. NHIS is designed for estimation at the national level, and available statistical software packages (SAS Survey Procedures [SAS, Cary, N.C.] or SUDAAN [RTI International, Research Triangle Park, N.C.]) can be used directly to obtain point estimates along with standard errors. These software packages account for the complex sampling design of NHIS. However, with direct state-level estimation, more attention must be given to the state sampling procedure that produces the data.

The NHIS state-level procedure developed to determine whether an estimate may be published was motivated by the "National Center for Health Statistics Data Presentation Standards for Proportions" (23) and by variations in state sampling design structures encountered, with the 50 states and the District of Columbia using the same methodology provided in more detail in a previous report (12).

For this report, direct state-level point estimates and their standard errors and Korn–Graubard CIs were calculated using SUDAAN software. The Taylor series linearization method was chosen for estimation of standard errors for the 12 states with the largest sample sizes. State-specific estimates are not presented for Alaska, Hawaii, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, South Dakota, Utah, Vermont, West Virginia, and Wyoming because they did not have at least eight degrees of freedom. For the remaining 20 states and the District of Columbia, an estimated design effect was used to calculate standard errors. Massachusetts was considered a special situation. This state had some small estimated proportions relative to the other states, which led to the state estimate not meeting the relative CI width criterion occasionally. However, because the sample sizes and degrees of freedom met the NCHS criteria for presentation of estimates, estimates for Massachusetts are presented. For a list of the average design effects used in the standard error calculations in this report, see Table I.

Percentages and 95% CIs are presented for prevalence estimates of health insurance coverage based on questions about coverage at the time of the NHIS Sample Adult and Sample Child interviews. The 95% CIs were generated using the Korn–Graubard method for complex surveys (24). Estimates were calculated using the NHIS survey weights and are representative of the U.S. civilian noninstitutionalized population. The weighting adjustment method incorporates robust multilevel models predictive of response propensity. Nonresponse-adjusted weights were further calibrated to U.S. Census Bureau population projections and American Community Survey 1-year estimates for age, sex, race and ethnicity, educational attainment, housing tenure, census division, and MSA status (14).

Point estimates and the corresponding variances were calculated using SUDAAN software version 11.0.0. All estimates in this report meet NCHS standards of reliability as specified in "National Center for Health Statistics Data Presentation Standards for Proportions" (23). Respondents with missing data or unknown information were generally excluded from the analysis unless specifically noted. For the types of health insurance coverage shown in this report (uninsured, private, and public), the item nonresponse rate was about 0.5%.

Differences in percentages by state Medicaid expansion status were evaluated using two-sided significance

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

Terms such as "higher than" and "lower than" indicate a statistically significant difference. Lack of comment regarding the difference between any two estimates does not necessarily mean that the difference was tested and found to be not significant. Furthermore, these tests did not take multiple comparisons into account.

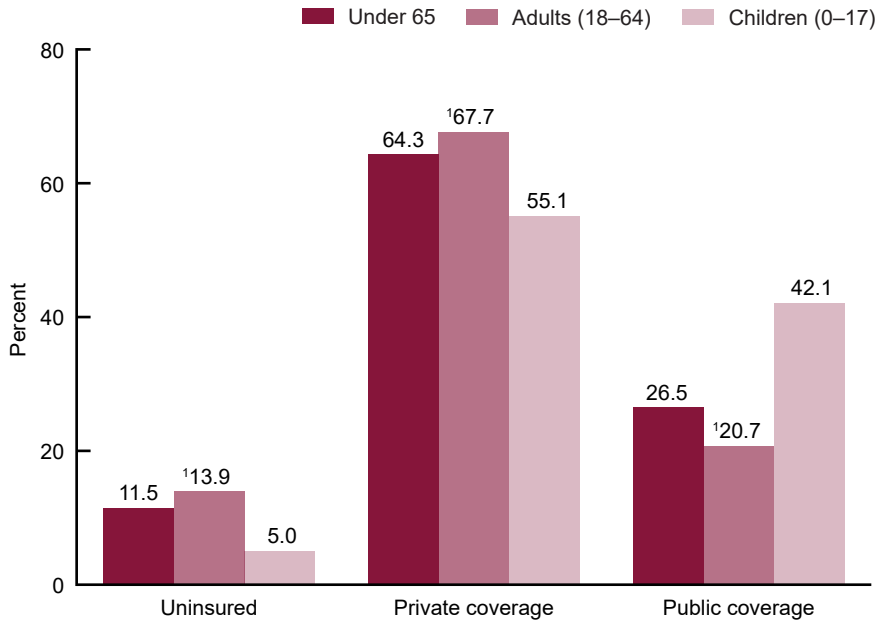
Tables 1–3 show national estimates (as well as those by state Medicaid expansion status, urbanization level, region, and state) of the percentages of people who were uninsured, had private coverage, and had public coverage in 2020. Additionally, these estimates are presented by geographic subdivisions and nationally for people of all ages who were uninsured, had private coverage, and had public coverage in Table II. In this report, tables are provided for reference and detailed results may not be discussed.

Results

National estimates of health insurance coverage

In 2020, among people under age 65, 11.5% were uninsured, 64.3% had private coverage, and 26.5% had public coverage at the time of the interview (Figure 1). Children aged 0–17 years were less likely than adults aged 18–64 to be uninsured (5.0% and 13.9%, respectively) and have private coverage (55.1% and 67.7%, respectively), but they were more likely to have public coverage (42.1% and 20.7%, respectively).

Figure 1. Percentage of people under age 65 who were uninsured, had private coverage, or had public coverage at the time of interview, by age group: United States, 2020



[1]Significantly different from children ($p < 0.05$).
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2020.

National estimates of health insurance coverage by urbanization level

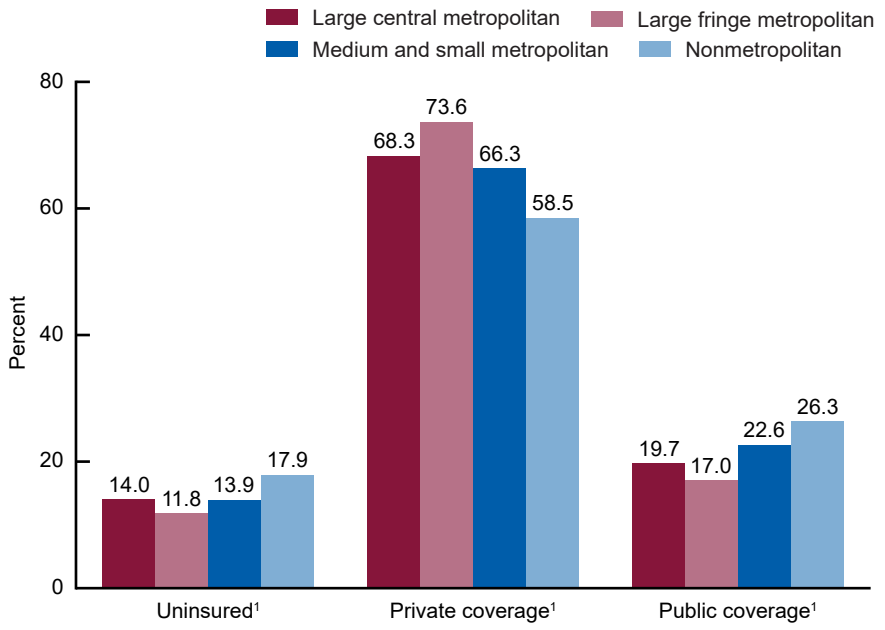
In 2020, among people under age 65, health insurance coverage varied by urbanization level. Among adults aged 18–64, the percentage who were uninsured was lower for those living in large fringe metropolitan counties (11.8%) compared with those living in large central metropolitan counties (14.0%), and then increased with decreasing levels of urbanization (Figure 2). Adults aged 18–64 living in large fringe metropolitan counties (73.6%) were more likely to have private coverage than those living in large central metropolitan (68.3%), medium and small metropolitan (66.3%), and nonmetropolitan (58.5%) counties. The percentage of adults aged 18–64 who had public coverage was lowest among those living in large fringe metropolitan counties (17.0%), followed by those living in large central metropolitan (19.7%), medium and small metropolitan (22.6%), and nonmetropolitan (26.3%) counties.

For children, the percentage who were uninsured among those living in medium and small metropolitan counties (3.3%) was lower than among those living in large central metropolitan (5.9%) and nonmetropolitan (7.7%) counties (Figure 3). Children living in large fringe metropolitan counties (63.9%) were more likely than those living in large central metropolitan (56.4%), medium and small metropolitan (51.8%), and nonmetropolitan (43.5%) counties to have private coverage. Children living in large fringe metropolitan counties (33.1%) were the least likely to have public coverage compared with those living in large central metropolitan (39.5%), medium and small metropolitan (47.6%), and nonmetropolitan (52.0%) counties.

Health insurance coverage by state Medicaid expansion status

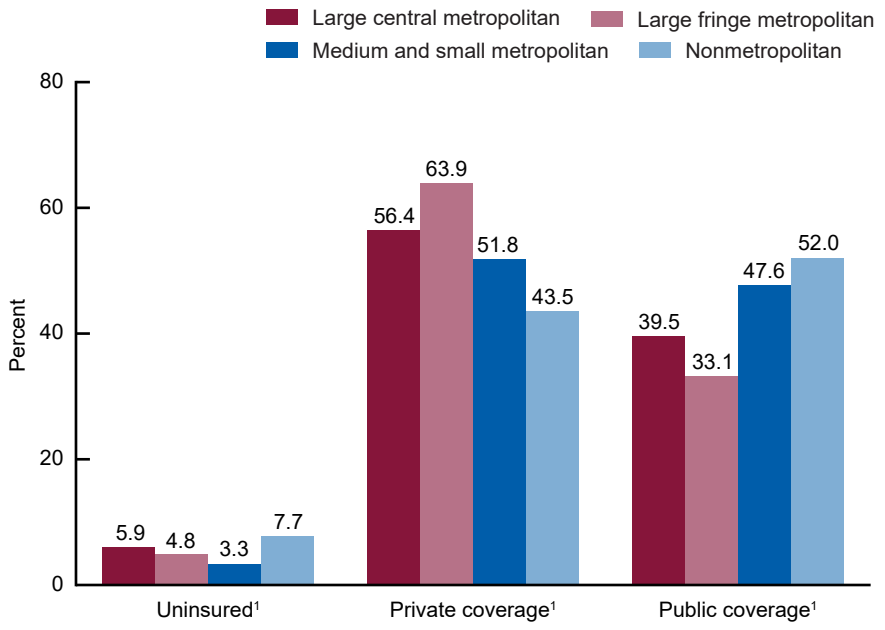
As of January 1, 2020, 35 states and the District of Columbia had expanded Medicaid. Among adults aged 18−64, those living in Medicaid expansion states were less likely to be uninsured (10.3%) and more likely to have private insurance (69.5%) and public coverage (22.7%) than those living in nonexpansion states (20.7%, 64.4%, and 17.2%, respectively) (Figure 4). Children living in Medicaid expansion states were less likely than those in nonexpansion states to be uninsured (3.6% compared with

Figure 2. Percentage of adults aged 18–64 who were uninsured, had private coverage, or had public coverage, by urbanization level: United States, 2020



1Significant quadratic trend with decreasing urbanization level ($p < 0.05$).
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2020.

Figure 3. Percentage of children aged 0–17 years who were uninsured, had private coverage, or had public coverage, by urbanization level: United States, 2020



1Significant quadratic trend with decreasing urbanization level ($p < 0.05$).
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2020.

7.7%) and more likely to have private insurance (57.6% compared with 50.8%) (Figure 5). The observed difference in public coverage for children between Medicaid expansion states (41.2%) and nonexpansion states (43.6%) was not significant.

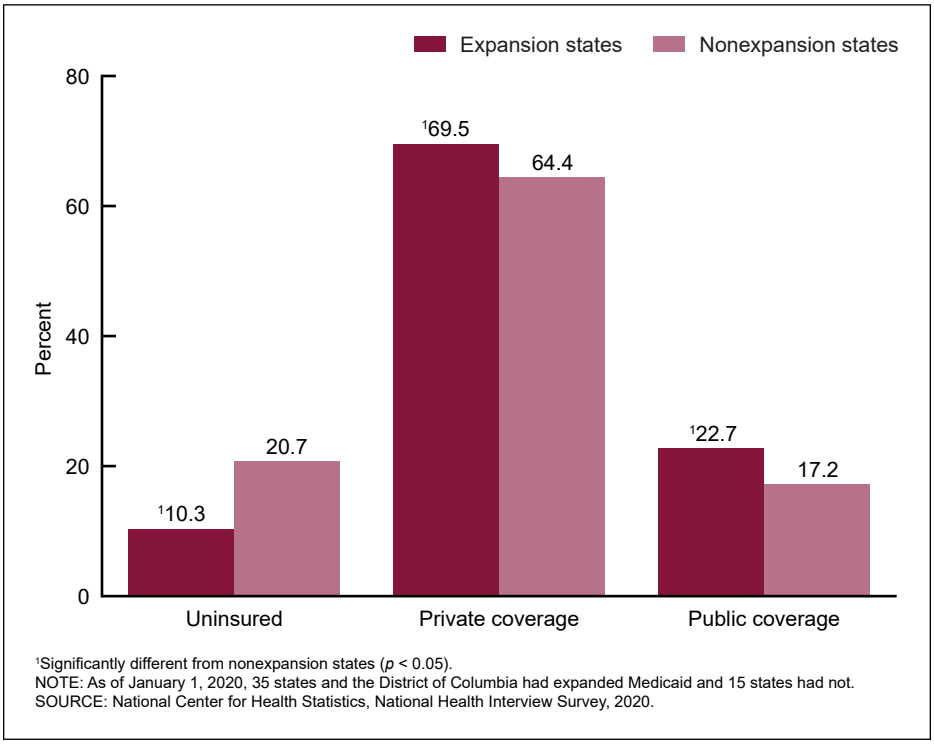
Regional estimates of health insurance coverage

In 2020, among people under age 65, percentages of uninsured people in the South Atlantic (15.6%) and West South Central (20.5%) regions were significantly higher than the national average (11.5%), and percentages in the New England (3.3%), Middle Atlantic (7.9%), East North Central (8.8%), West North Central (9.4%), and Pacific (8.9%) regions were significantly lower than the national average (Table 1). The percentage with public coverage was significantly higher in the East South Central region (32.4%) than the national average (26.5%), and the percentage in the West North Central region (19.6%) was significantly lower than the national average. Percentages of private coverage were significantly higher in the New England (74.3%), East North Central (68.7%), and West North Central (73.9%) regions than the national average (64.3%), and percentages were significantly lower than the national average in the South Atlantic (59.8%), East South Central (58.0%), and West South Central (55.6%) regions.

State estimates of health insurance coverage

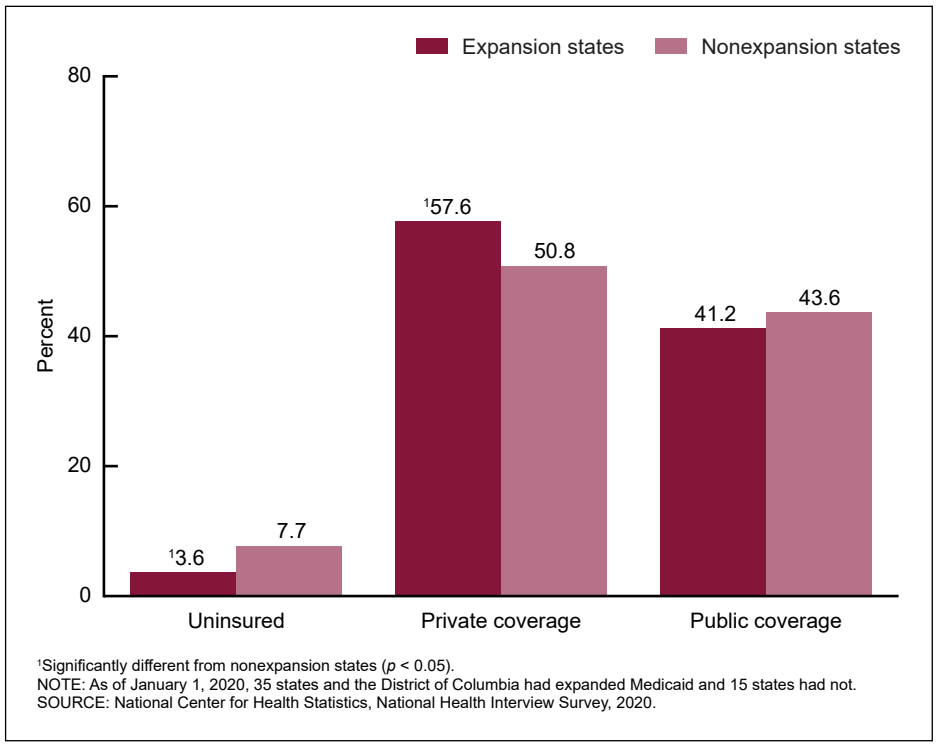
State-level estimates are shown for 32 states and the District of Columbia for people under age 65 and adults aged 18–64. Among adults aged 18−64, the percentage who were uninsured was significantly higher than the national average (13.9%) in Florida (19.5%), Georgia (25.4%), North Carolina (20.3%), and Texas (28.1%), and significantly lower than the national average in California (11.5%), Michigan (6.7%), New York (9.0%), and Pennsylvania (7.7%) (Figure 6, Table 2). Among adults aged 18–64, the percentage who had public coverage was significantly higher than the national average (20.7%) in Louisiana (41.2%), Michigan (27.4%), and New York (29.4%), and significantly lower than the national average in Georgia (16.3%), Illinois (15.3%), and Texas (13.1%) (Figure 7, Table 2). Among adults aged 18–64, the percentages with private insurance were significantly higher

Figure 4. Percentage of adults aged 18–64 who were uninsured, had private coverage, or had public coverage, by state Medicaid expansion status: United States, 2020



[1]Significantly different from nonexpansion states ($p < 0.05$).
NOTE: As of January 1, 2020, 35 states and the District of Columbia had expanded Medicaid and 15 states had not.
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2020.

Figure 5. Percentage of children aged 0–17 years who were uninsured, had private coverage, or had public coverage, by state Medicaid expansion status: United States, 2020



[1]Significantly different from nonexpansion states ($p < 0.05$).
NOTE: As of January 1, 2020, 35 states and the District of Columbia had expanded Medicaid and 15 states had not.
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2020.

than the national average (67.7%) in Illinois (76.2%), Massachusetts (77.4%), Minnesota (80.3%), and Pennsylvania (76.8%), and significantly lower than the national average in Georgia (59.5%), Louisiana (51.4%), and Texas (60.5%) (Figure 8, Table 2).

Among children aged 0–17 years, state-level estimates are shown for 16 states (Table 3). The percentage of children without health insurance coverage was significantly higher than the national average (5.0%) in Texas (11.7%), and significantly lower than the national average in California (2.0%) and Michigan (0.7%). State-level estimates for public coverage among children are shown for 12 states and for private coverage, 13 states. None of the presented state-level estimates of public coverage among children were significantly higher or lower than the national average (42.1%). The percentage of children with private coverage was significantly higher than the national average (55.1%) in Minnesota (83.3%) and Pennsylvania (68.1%), and significantly lower than the national average in Florida (43.4%).

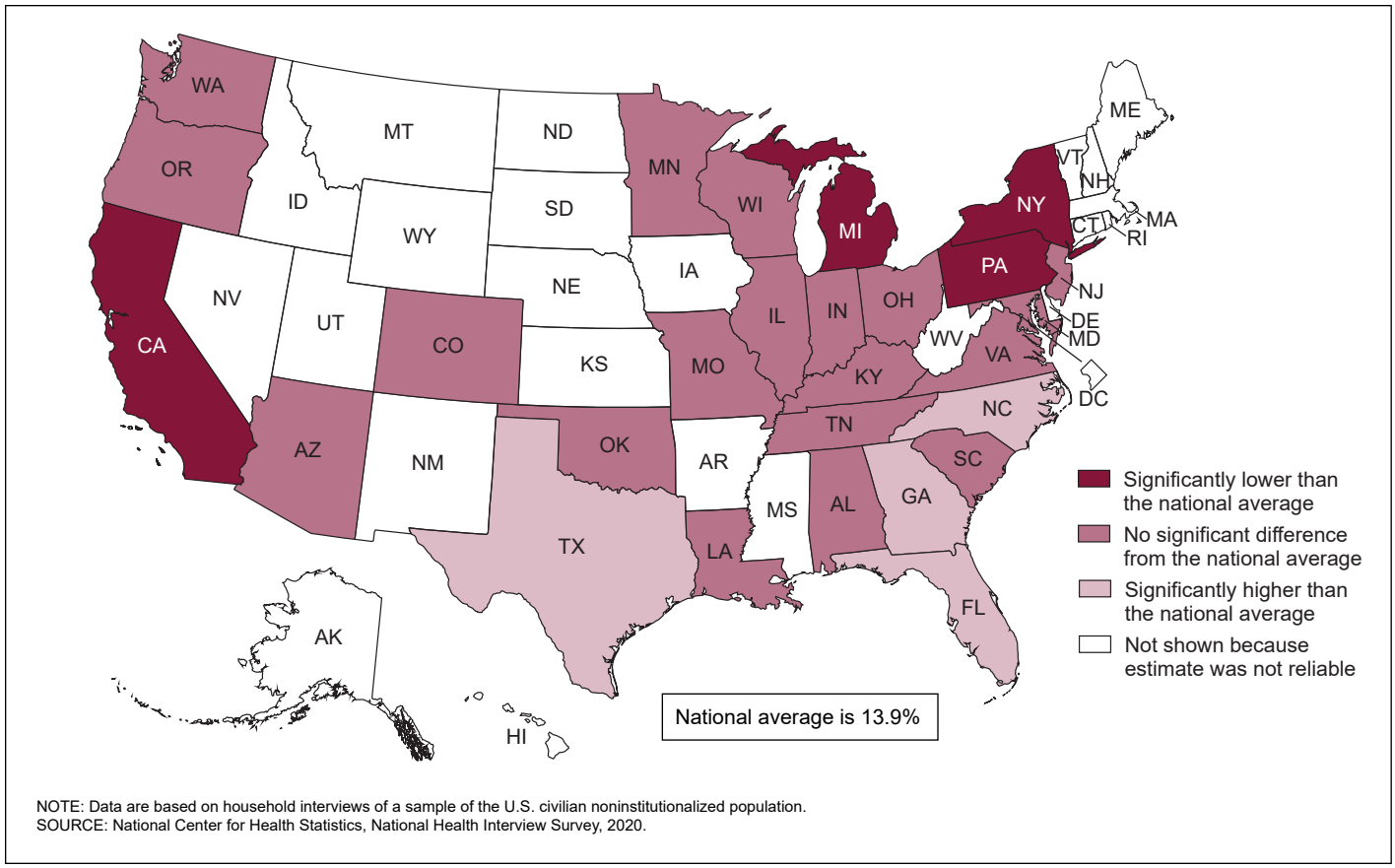
Summary

This report provides an overall picture of health insurance coverage in the United States by selected geographic subdivisions. In 2020, variation in health insurance coverage was found by urbanization level, state Medicaid expansion status, expanded region, and selected states and the District of Columbia. Generally, people living in Medicaid nonexpansion states, nonmetropolitan counties, and the West South Central region were the most likely to be uninsured. Variation in the percentage of uninsured people was also observed among the selected states shown in this report.

This report is not without limitations. NHIS responses are self-reported, so they may be subject to recall bias. Data collection procedures were modified due to the COVID-19 pandemic, leading to a smaller Sample Child file (14). Moreover, the 2020 NHIS data file retained some biases after weighting adjustments, notably an underrepresentation of adults living alone and those in the lowest income category, and an overrepresentation of adults living in households with both landline and cell telephones (15). However, no biases were detected for estimates of health insurance coverage based on the full sample (15).

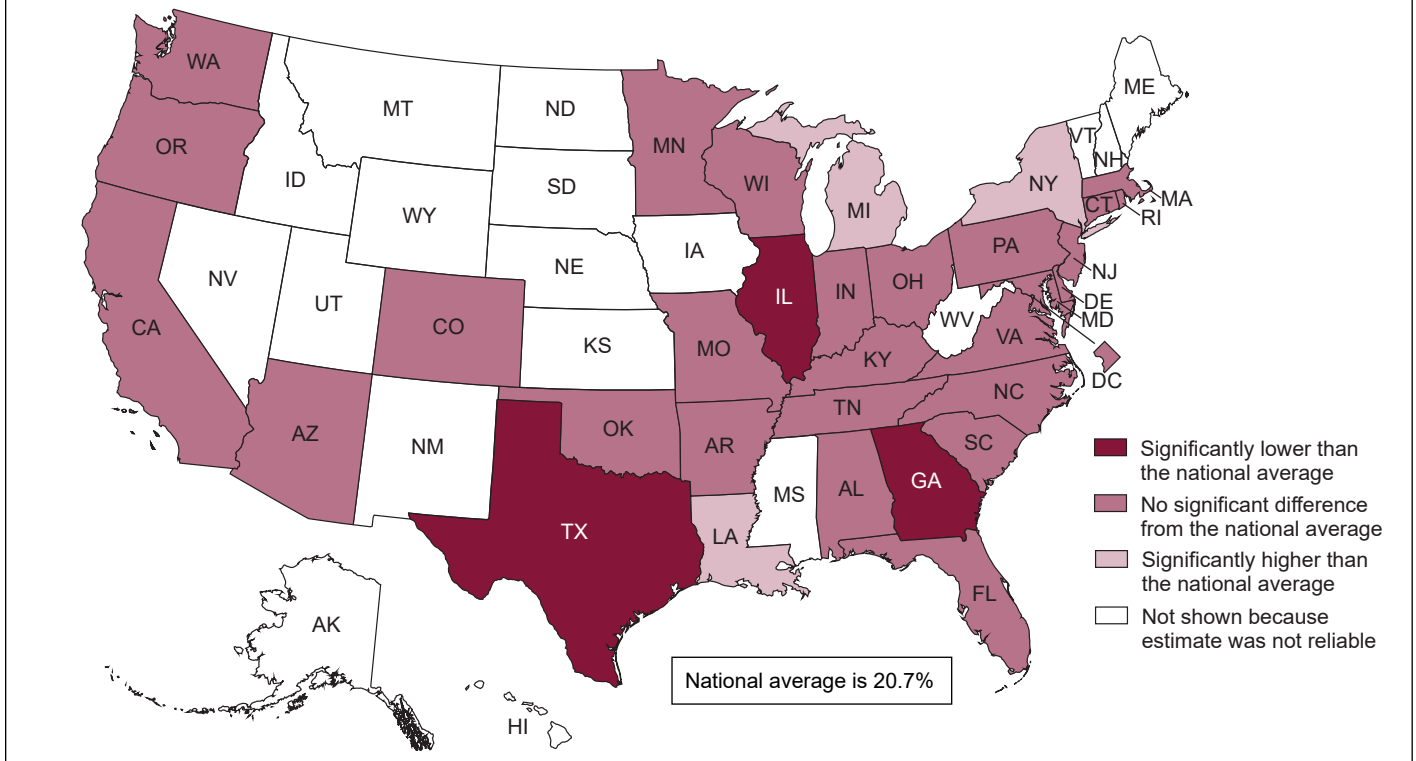
One strength of NHIS is that it has a very low nonresponse rate to questions about the type of health insurance coverage (about 0.5%). Additionally, a

Figure 6. Adults aged 18–64 who were uninsured at the time of interview: United States, 2020



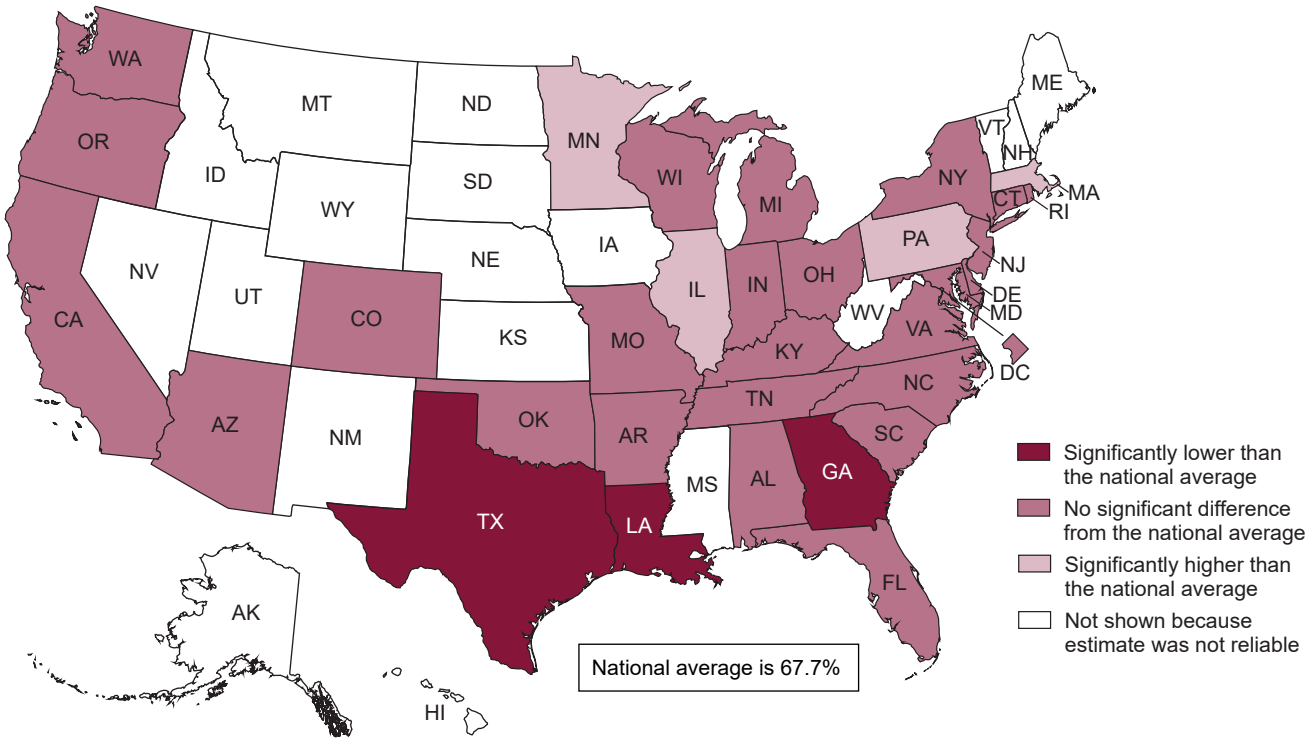
NOTE: Data are based on household interviews of a sample of the U.S. civilian noninstitutionalized population.
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2020.

Figure 7. Adults aged 18–64 who had public coverage at the time of interview: United States, 2020



NOTE: Data are based on household interviews of a sample of the U.S. civilian noninstitutionalized population.
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2020.

Figure 8. Adults aged 18–64 who had private coverage at the time of interview: United States, 2020



NOTE: Data are based on household interviews of a sample of the U.S. civilian noninstitutionalized population.
SOURCE: National Center for Health Statistics, National Health Interview Survey, 2020.

feature that distinguishes NHIS estimates of health insurance coverage from other survey-based estimates is the use of responses to follow-up questions to evaluate the reliability of the reported health insurance coverage and resolve conflicting information (see NHIS, Health Insurance Information: https://www.cdc.gov/nchs/nhis/insurance.htm).

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Table 1. Percentage of people under age 65 who had private health insurance coverage, public health coverage, or were uninsured at the time of the interview, by urbanization level, state Medicaid expansion status, expanded region, and selected states: United States, 2020

Selected geographic characteristic and Medicaid expansion status	Private[1]	Public[2]	Uninsured[3]
	Percent (95% confidence interval)		
Total[4]	64.3 (63.2–65.4)	26.5 (25.5–27.5)	11.5 (10.9–12.2)
Urbanization level[5]			
Large central metropolitan[6]	65.3 (63.6–67.1)	24.6 (23.1–26.1)	12.0 (11.0–13.1)
Large fringe metropolitan[7]	70.9 (68.9–72.9)	21.4 (19.7–23.3)	9.9 (8.7–11.1)
Medium and small metropolitan[8]	62.2 (60.1–64.2)	29.6 (27.6–31.7)	10.9 (9.9–12.0)
Nonmetropolitan[9]	54.3 (50.4–58.1)	33.5 (30.4–36.8)	15.0 (12.6–17.7)
State Medicaid expansion status[10]			
Medicaid expansion states[11]	66.3 (65.0–67.7)	27.6 (26.4–28.8)	8.5 (7.8–9.2)
Non-Medicaid expansion states[12]	60.7 (58.8–62.6)	24.4 (22.8–26.1)	17.1 (15.9–18.4)
Expanded region[13]			
New England	74.3 (70.1–78.3)	24.5 (21.2–28.0)	3.3 (2.3–4.7)
Middle Atlantic	66.6 (63.7–69.4)	27.9 (25.0–30.9)	7.9 (6.4–9.6)
East North Central	68.7 (66.0–71.3)	25.5 (23.0–28.2)	8.8 (7.4–10.4)
West North Central	73.9 (70.4–77.2)	19.6 (17.2–22.1)	9.4 (7.5–11.6)
South Atlantic	59.8 (57.1–62.5)	27.1 (24.7–29.6)	15.6 (13.8–17.4)
East South Central	58.0 (53.3–62.6)	32.4 (28.5–36.5)	12.3 (10.3–14.6)
West South Central	55.6 (52.0–59.2)	25.6 (22.4–29.0)	20.5 (18.1–23.0)
Mountain	64.9 (59.8–69.7)	25.6 (22.3–29.2)	11.8 (9.1–14.9)
Pacific	65.3 (62.9–67.6)	27.8 (25.7–29.9)	8.9 (7.7–10.2)
Selected states[14]			
Alabama	59.3 (48.9–69.2)	33.4 (23.8–44.1)	10.0 (5.4–16.5)
Arizona	58.1 (48.3–67.5)	31.6 (22.7–41.6)	12.7 (7.8–19.2)
Arkansas	61.4 (45.9–75.3)	28.9 (16.1–44.7)	*
California	64.4 (61.4–67.3)	28.4 (25.8–31.1)	8.9 (7.5–10.4)
Colorado	62.8 (54.5–70.7)	27.2 (20.0–35.5)	11.8 (7.7–17.2)
Connecticut	70.0 (59.2–79.4)	26.2 (17.0–37.3)	*
Delaware	*	*	*
District of Columbia	67.8 (53.1–80.4)	27.9 (15.7–43.0)	*
Florida	59.7 (55.5–63.8)	25.6 (21.6–29.8)	16.7 (13.6–20.2)
Georgia	56.3 (49.4–63.1)	24.6 (19.0–30.9)	20.3 (16.5–24.5)
Illinois	72.1 (67.5–76.3)	21.4 (17.3–26.0)	9.2 (6.6–12.3)
Indiana	64.8 (56.1–72.8)	27.1 (19.6–35.8)	10.5 (6.5–15.9)
Kentucky	52.9 (42.8–62.9)	42.4 (32.3–52.9)	7.9 (4.0–13.8)
Louisiana	46.2 (36.1–56.6)	46.9 (36.4–57.7)	*
Maryland	66.7 (56.3–76.1)	27.4 (18.4–37.9)	*
Massachusetts	76.2 (69.5–82.0)	22.0 (16.2–28.8)	2.6 (1.0–5.3)
Michigan	66.3 (58.5–73.5)	32.3 (25.8–39.3)	5.3 (3.2–8.2)
Minnesota	81.1 (73.6–87.2)	13.7 (8.3–20.9)	7.1 (3.8–11.8)
Missouri	73.9 (65.9–80.9)	17.8 (11.7–25.4)	10.4 (6.5–15.7)
New Jersey	66.7 (58.1–74.5)	24.1 (17.0–32.3)	11.2 (6.7–17.2)
New York	60.9 (56.4–65.2)	34.4 (30.2–38.7)	7.4 (5.0–10.3)
North Carolina	60.5 (52.9–67.8)	25.9 (19.6–33.1)	16.9 (12.8–21.7)
Ohio	68.5 (62.9–73.7)	24.2 (19.3–29.8)	10.5 (7.1–14.7)
Oklahoma	52.6 (40.0–65.0)	27.9 (17.3–40.8)	24.0 (15.6–34.3)
Oregon	62.4 (53.4–70.7)	29.8 (21.8–38.9)	11.4 (7.1–17.1)
Pennsylvania	74.7 (68.2–80.6)	20.9 (14.3–28.8)	6.9 (4.9–9.4)
Rhode Island	77.7 (62.9–88.6)	25.3 (13.2–41.0)	*
South Carolina	57.2 (46.8–67.2)	33.4 (23.8–44.1)	13.1 (7.8–20.1)
Tennessee	64.2 (55.8–72.0)	25.3 (18.2–33.4)	13.3 (8.9–18.9)
Texas	57.0 (52.7–61.2)	21.5 (18.2–25.0)	23.1 (20.1–26.3)
Virginia	60.9 (54.3–67.2)	31.9 (25.6–38.7)	10.2 (6.6–15.0)
Washington	72.8 (65.6–79.3)	22.2 (16.0–29.3)	7.4 (4.4–11.5)
Wisconsin	68.7 (61.9–75.0)	26.2 (20.1–33.0)	8.0 (5.1–11.8)

See footnotes at end of table.

Table 1. Percentage of people under age 65 who had private health insurance coverage, public health coverage, or were uninsured at the time of the interview, by urbanization level, state Medicaid expansion status, expanded region, and selected states: United States, 2020—Con.

* Estimate is not shown because it does not meet National Center for Health Statistics standards of reliability.
[1]Private health insurance coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as dental, vision, or prescription drugs. People with private coverage may also have public coverage.
[2]Public health plan coverage includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plans, Medicare, and military (TRICARE, Veterans Administration [VA], and CHAMP–VA) plans. People with public coverage may also have private coverage.
[3]People were considered uninsured if they did not have coverage through private health insurance, Medicare, Medicaid, CHIP, military (TRICARE, VA, and CHAMP–VA), other state-sponsored health plans, or other government programs. People also were defined as uninsured if they only had Indian Health Service coverage or only had a private plan that paid for one type of service such as dental, vision, or prescription drugs.
[4]Includes all 50 states and the District of Columbia.
[5]Urbanization level is measured using metropolitan statistical area (MSA) status. The Office of Management and Budget defines MSAs according to published standards that are applied to U.S. Census Bureau data. Generally, an MSA consists of a county or group of counties containing at least one urbanized area with a population of 50,000 or more (see reference 16 in this report). See Methods section in this report for more detail.
[6]Living within a large central MSA with a population of 1 million or more (similar to inner cities).
[7]Living within a large fringe MSA with a population of 1 million or more (similar to suburbs).
[8]Living within a medium or small MSA with a population of less than 1 million.
[9]Not living in an MSA.
[10]Under provisions of the Affordable Care Act of 2010 (Pub L No 111–148, Pub L No 111–152), states have the option to expand Medicaid eligibility to cover adults who have incomes up to and including 138% of the federal poverty level. There is no deadline for states to choose to implement the Medicaid expansion, and they may do so at any time. As of January 1, 2020, 35 states and the District of Columbia moved forward with Medicaid expansion.
[11]For 2020, states that had expanded Medicaid included: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Washington, and West Virginia. The District of Columbia also moved forward with Medicaid expansion.
[12]For 2020, states that had not expanded Medicaid included: Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.
[13]The New England region includes: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. The Middle Atlantic region includes: Delaware, District of Columbia, Maryland, New Jersey, New York, and Pennsylvania. The East North Central region includes: Illinois, Indiana, Michigan, Ohio, and Wisconsin. The West North Central region includes: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota. The South Atlantic region includes: Florida, Georgia, North Carolina, South Carolina, Virginia, and West Virginia. The East South Central region includes: Alabama, Kentucky, Mississippi, and Tennessee. The West South Central region includes: Arkansas, Louisiana, Oklahoma, and Texas. The Mountain region includes: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming. The Pacific region includes: Alaska, California, Hawaii, Oregon, and Washington.
[14]Estimates are not shown for Alaska, Hawaii, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, South Dakota, Utah, Vermont, West Virginia, and Wyoming.

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

SOURCE: National Center for Health Statistics, National Health Interview Survey, 2020.

Table 2. Percentage of adults aged 18–64 who had private health insurance coverage, public health coverage, or were uninsured at the time of the interview, by urbanization level, state Medicaid expansion status, expanded region, and selected states: United States, 2020

Selected geographic characteristic and Medicaid expansion status	Private[1]	Public[2]	Uninsured[3]
	Percent (95% confidence interval)		
Total[4]	67.7 (66.7–68.8)	20.7 (19.9–21.6)	13.9 (13.2–14.7)
Urbanization level[5]			
Large central metropolitan[6]	68.3 (66.6–69.9)	19.7 (18.3–21.1)	14.0 (12.8–15.4)
Large fringe metropolitan[7]	73.6 (71.8–75.3)	17.0 (15.5–18.5)	11.8 (10.5–13.2)
Medium and small metropolitan[8]	66.3 (64.2–68.2)	22.6 (20.9–24.4)	13.9 (12.6–15.3)
Nonmetropolitan[9]	58.5 (54.8–62.1)	26.3 (23.2–29.7)	17.9 (15.0–21.1)
State Medicaid expansion status[10]			
Medicaid expansion states[11]	69.5 (68.3–70.8)	22.7 (21.6–23.7)	10.3 (9.5–11.1)
Non-Medicaid expansion states[12]	64.4 (62.7–66.2)	17.2 (15.7–18.6)	20.7 (19.2–22.3)
Expanded region[13]			
New England	76.8 (72.3–80.9)	21.6 (18.0–25.4)	4.0 (2.7–5.6)
Middle Atlantic	70.5 (68.0–72.9)	22.8 (20.5–25.2)	9.4 (7.8–11.3)
East North Central	71.4 (69.0–73.7)	20.9 (18.8–23.0)	10.2 (8.8–11.8)
West North Central	75.0 (71.4–78.4)	16.1 (13.8–18.6)	11.6 (9.3–14.2)
South Atlantic	64.4 (61.8–66.8)	19.3 (17.3–21.5)	18.9 (16.8–21.1)
East South Central	63.6 (59.0–68.1)	23.9 (20.1–28.0)	15.6 (13.0–18.4)
West South Central	59.0 (55.7–62.1)	18.4 (15.7–21.5)	24.6 (21.5–27.8)
Mountain	67.6 (62.2–72.7)	20.5 (16.8–24.6)	14.1 (11.0–17.8)
Pacific	68.1 (65.8–70.3)	22.5 (20.8–24.3)	11.3 (9.7–13.0)
Selected states[14]			
Alabama	66.0 (56.9–74.4)	23.6 (16.1–32.5)	13.2 (7.6–20.8)
Arizona	60.8 (51.7–69.3)	25.0 (17.5–33.8)	15.6 (9.6–23.3)
Arkansas	59.1 (45.1–72.2)	28.6 (16.9–42.9)	*
California	67.5 (64.6–70.4)	22.5 (20.4–24.7)	11.5 (9.7–13.6)
Colorado	69.9 (62.5–76.6)	18.1 (12.5–24.9)	14.6 (9.6–20.9)
Connecticut	74.3 (65.1–82.2)	21.7 (14.2–30.9)	*
Delaware	71.7 (56.4–84.0)	22.5 (11.1–37.9)	*
District of Columbia	64.8 (52.4–75.9)	31.0 (20.1–43.8)	*
Florida	64.9 (60.7–68.9)	17.5 (14.0–21.5)	19.5 (15.9–23.4)
Georgia	59.5 (54.6–64.3)	16.3 (12.3–21.0)	25.4 (20.9–30.4)
Illinois	76.2 (72.0–80.0)	15.3 (11.6–19.6)	11.4 (8.4–15.1)
Indiana	68.5 (60.9–75.4)	21.7 (15.6–29.0)	11.6 (7.1–17.6)
Kentucky	60.3 (51.0–69.1)	32.8 (24.2–42.3)	10.2 (5.3–17.2)
Louisiana	51.4 (42.4–60.2)	41.2 (32.3–50.5)	8.2 (4.0–14.6)
Maryland	74.1 (64.9–82.0)	18.2 (11.2–27.1)	10.0 (5.0–17.5)
Massachusetts	77.4 (71.5–82.6)	20.3 (15.1–26.2)	*
Michigan	69.8 (62.8–76.1)	27.4 (22.0–33.2)	6.7 (4.0–10.3)
Minnesota	80.3 (73.6–85.9)	13.1 (8.3–19.3)	8.8 (5.0–14.2)
Missouri	74.9 (67.9–81.1)	15.9 (10.7–22.4)	11.9 (7.5–17.8)
New Jersey	73.0 (66.6–78.8)	16.3 (11.9–21.5)	13.6 (8.6–20.0)
New York	64.6 (60.2–68.8)	29.4 (25.6–33.3)	9.0 (6.4–12.2)
North Carolina	64.8 (57.7–71.5)	18.1 (13.4–23.7)	20.3 (15.7–25.5)
Ohio	69.3 (63.9–74.4)	21.4 (17.0–26.3)	11.2 (8.1–14.9)
Oklahoma	57.2 (46.0–68.0)	21.9 (13.4–32.7)	26.5 (17.2–37.5)
Oregon	62.7 (54.8–70.1)	27.6 (20.7–35.4)	13.7 (8.7–20.1)
Pennsylvania	76.8 (72.2–81.0)	18.0 (13.4–23.4)	7.7 (5.5–10.4)
Rhode Island	81.1 (68.7–90.2)	23.4 (13.0–37.0)	*
South Carolina	62.5 (53.3–71.1)	25.1 (17.4–34.1)	16.2 (10.1–24.2)
Tennessee	68.1 (60.8–74.9)	19.2 (13.6–26.0)	15.9 (10.8–22.3)
Texas	60.5 (56.9–64.0)	13.1 (10.3–16.5)	28.1 (24.2–32.3)
Virginia	65.1 (58.6–71.2)	25.5 (19.5–32.3)	13.1 (8.4–19.1)
Washington	75.1 (68.9–80.7)	18.4 (13.3–24.4)	8.7 (5.2–13.4)
Wisconsin	70.3 (64.4–75.8)	22.0 (17.0–27.8)	9.7 (6.3–14.1)

See footnotes at end of table.

Table 2. Percentage of adults aged 18–64 who had private health insurance coverage, public health coverage, or were uninsured at the time of the interview, by urbanization level, state Medicaid expansion status, expanded region, and selected states: United States, 2020—Con.

* Estimate is not shown because it does not meet National Center for Health Statistics standards of reliability.
[1]Private health insurance coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as dental, vision, or prescription drugs. People with private coverage may also have public coverage.
[2]Public health plan coverage includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plans, Medicare, and military (TRICARE, Veterans Administration [VA], and CHAMP–VA) plans. People with public coverage may also have private coverage.
[3]People were considered uninsured if they did not have coverage through private health insurance, Medicare, Medicaid, CHIP, military (TRICARE, VA, and CHAMP–VA), other state-sponsored health plans, or other government programs. People also were defined as uninsured if they only had Indian Health Service coverage or only had a private plan that paid for one type of service such as dental, vision, or prescription drugs.
[4]Includes all 50 states and the District of Columbia.
[5]Urbanization level is measured using metropolitan statistical area (MSA) status. The Office of Management and Budget defines MSAs according to published standards that are applied to U.S. Census Bureau data. Generally, an MSA consists of a county or group of counties containing at least one urbanized area with a population of 50,000 or more (see reference 16 in this report). See Methods section in this report for more detail.
[6]Living within a large central MSA with a population of 1 million or more (similar to inner cities).
[7]Living within a large fringe MSA with a population of 1 million or more (similar to suburbs).
[8]Living within a medium or small MSA with a population of less than 1 million.
[9]Not living in an MSA.
[10]Under provisions of the Affordable Care Act of 2010 (Pub L No 111–148, Pub L No 111–152), states have the option to expand Medicaid eligibility to cover adults who have incomes up to and including 138% of the federal poverty level. There is no deadline for states to choose to implement the Medicaid expansion, and they may do so at any time. As of January 1, 2020, 35 states and the District of Columbia moved forward with Medicaid expansion.
[11]For 2020, states that had expanded Medicaid included: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Washington, and West Virginia. The District of Columbia also moved forward with Medicaid expansion.
[12]For 2020, states that had not expanded Medicaid included: Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.
[13]The New England region includes: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. The Middle Atlantic region includes: Delaware, District of Columbia, Maryland, New Jersey, New York, and Pennsylvania. The East North Central region includes: Illinois, Indiana, Michigan, Ohio, and Wisconsin. The West North Central region includes: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota. The South Atlantic region includes: Florida, Georgia, North Carolina, South Carolina, Virginia, and West Virginia. The East South Central region includes: Alabama, Kentucky, Mississippi, and Tennessee. The West South Central region includes: Arkansas, Louisiana, Oklahoma, and Texas. The Mountain region includes: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming. The Pacific region includes: Alaska, California, Hawaii, Oregon, and Washington.
[14]Estimates are not shown for Alaska, Hawaii, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, South Dakota, Utah, Vermont, West Virginia, and Wyoming.

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

SOURCE: National Center for Health Statistics, National Health Interview Survey, 2020.

Table 3. Percentage of children aged 0–17 years who had private health insurance coverage, public health coverage, or were uninsured at the time of the interview, by urbanization level, state Medicaid expansion status, expanded region, and selected states: United States, 2020

Selected geographic characteristic and Medicaid expansion status	Private[1]	Public[2]	Uninsured[3]
	Percent (95% confidence interval)		
Total[4]	55.1 (53.0–57.2)	42.1 (40.0–44.2)	5.0 (4.2–6.0)
Urbanization level[5]			
Large central metropolitan[6]	56.4 (52.9–59.8)	39.5 (36.1–43.0)	5.9 (4.6–7.5)
Large fringe metropolitan[7]	63.9 (59.7–67.9)	33.1 (29.2–37.2)	4.8 (3.4–6.6)
Medium and small metropolitan[8]	51.8 (48.3–55.2)	47.6 (44.0–51.1)	3.3 (2.2–4.7)
Nonmetropolitan[9]	43.5 (36.5–50.6)	52.0 (45.1–59.0)	7.7 (4.5–12.0)
State Medicaid expansion status[10]			
Medicaid expansion states[11]	57.6 (55.0–60.0)	41.2 (38.8–43.7)	3.6 (2.6–4.7)
Non-Medicaid expansion states[12]	50.8 (47.0–54.5)	43.6 (39.9–47.4)	7.7 (6.2–9.4)
Expanded region[13]			
New England	66.6 (58.9–73.6)	33.6 (26.6–41.2)	1.4 (0.2–4.4)
Middle Atlantic	55.6 (49.6–61.5)	41.9 (36.0–48.0)	3.6 (1.7–6.6)
East North Central	61.3 (55.4–66.9)	38.3 (32.4–44.5)	*
West North Central	71.1 (62.5–78.6)	28.7 (21.9–36.4)	*
South Atlantic	46.7 (41.7–51.8)	49.3 (43.9–54.6)	6.1 (4.2–8.4)
East South Central	43.3 (37.1–49.7)	54.9 (49.3–60.5)	3.8 (2.0–6.4)
West South Central	47.7 (41.7–53.7)	42.6 (36.6–48.7)	10.7 (7.9–14.1)
Mountain	57.9 (49.7–65.9)	39.0 (33.0–45.2)	*
Pacific	57.5 (53.1–61.8)	42.4 (37.7–47.2)	2.3 (1.4–3.5)
Selected states[14]			
Alabama	*	*	*
Arizona	*	*	*
Arkansas	*	*	*
California	56.0 (50.7–61.3)	44.0 (38.2–49.9)	2.0 (1.0–3.6)
Colorado	*	*	*
Connecticut	*	*	*
Delaware	*	*	*
District of Columbia	*	*	*
Florida	43.4 (35.6–51.5)	50.7 (41.2–60.1)	8.1 (4.2–14.1)
Georgia	*	*	7.0 (3.6–12.1)
Illinois	60.6 (51.5–69.1)	38.6 (30.1–47.7)	*
Indiana	*	*	*
Kentucky	*	*	*
Louisiana	*	*	*
Maryland	*	*	*
Massachusetts	72.3 (59.1–83.2)	27.4 (16.3–41.0)	*
Michigan	*	*	0.7 (0.0–4.4)
Minnesota	83.3 (67.3–93.5)	*	*
Missouri	*	24.0 (11.3–41.3)	*
New Jersey	*	*	*
New York	49.7 (41.6–57.9)	49.2 (41.2–57.2)	*
North Carolina	47.4 (35.2–59.8)	49.7 (36.3–63.2)	*
Ohio	66.3 (53.0–78.0)	32.1 (21.3–44.5)	*
Oklahoma	*	*	*
Oregon	*	*	*
Pennsylvania	68.1 (53.2–80.8)	*	*
Rhode Island	*	*	*
South Carolina	*	*	*
Tennessee	*	*	*
Texas	49.1 (42.0–56.3)	40.3 (33.5–47.5)	11.7 (8.3–15.9)
Virginia	50.2 (41.1–59.3)	48.0 (38.1–57.9)	*
Washington	65.8 (50.6–79.1)	33.6 (20.2–49.3)	*
Wisconsin	64.7 (49.7–77.9)	36.7 (23.0–52.1)	*

See footnotes at end of table.

Table 3. Percentage of children aged 0–17 years who had private health insurance coverage, public health coverage, or were uninsured at the time of the interview, by urbanization level, state Medicaid expansion status, expanded region, and selected states: United States, 2020—Con.

* Estimate is not shown because it does not meet National Center for Health Statistics standards of reliability.
[1]Private health insurance coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as dental, vision, or prescription drugs. People with private coverage may also have public coverage.
[2]Public health plan coverage includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plans, Medicare, and military (TRICARE, Veterans Administration [VA], and CHAMP–VA) plans. People with public coverage may also have private coverage.
[3]People were considered uninsured if they did not have coverage through private health insurance, Medicare, Medicaid, CHIP, military (TRICARE, VA, and CHAMP–VA), other state-sponsored health plans, or other government programs. People also were defined as uninsured if they only had Indian Health Service coverage or only had a private plan that paid for one type of service such as dental, vision, or prescription drugs.
[4]Includes all 50 states and the District of Columbia.
[5]Urbanization level is measured using metropolitan statistical area (MSA) status. The Office of Management and Budget defines MSAs according to published standards that are applied to U.S. Census Bureau data. Generally, an MSA consists of a county or group of counties containing at least one urbanized area with a population of 50,000 or more (see reference 16 in this report). See Methods section in this report for more detail.
[6]Living within a large central MSA with a population of 1 million or more (similar to inner cities).
[7]Living within a large fringe MSA with a population of 1 million or more (similar to suburbs).
[8]Living within a medium or small MSA with a population of less than 1 million.
[9]Not living in an MSA.
[10]Under provisions of the Affordable Care Act of 2010 (Pub L No 111–148, Pub L No 111–152), states have the option to expand Medicaid eligibility to cover adults who have incomes up to and including 138% of the federal poverty level. There is no deadline for states to choose to implement the Medicaid expansion, and they may do so at any time. As of January 1, 2020, 35 states and the District of Columbia moved forward with Medicaid expansion.
[11]For 2020, states that had expanded Medicaid included: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Washington, and West Virginia. The District of Columbia also moved forward with Medicaid expansion.
[12]For 2020, states that had not expanded Medicaid included: Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.
[13]The New England region includes: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. The Middle Atlantic region includes: Delaware, District of Columbia, Maryland, New Jersey, New York, and Pennsylvania. The East North Central region includes: Illinois, Indiana, Michigan, Ohio, and Wisconsin. The West North Central region includes: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota. The South Atlantic region includes: Florida, Georgia, North Carolina, South Carolina, Virginia, and West Virginia. The East South Central region includes: Alabama, Kentucky, Mississippi, and Tennessee. The West South Central region includes: Arkansas, Louisiana, Oklahoma, and Texas. The Mountain region includes: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming. The Pacific region includes: Alaska, California, Hawaii, Oregon, and Washington.
[14]Estimates are not shown for Alaska, Hawaii, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, South Dakota, Utah, Vermont, West Virginia, and Wyoming.

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

SOURCE: National Center for Health Statistics, National Health Interview Survey, 2020.

Technical Notes Tables

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

Table	Type of health insurance coverage estimate by age group	Average design effect based on 12 states with the largest populations[1]
1	People under age 65 with private coverage	3.64
1	People under age 65 with public coverage	3.92
1	People under age 65 who are uninsured	2.72
2	Adults aged 18–64 with private coverage	2.33
2	Adults aged 18–64 with public coverage	2.50
2	Adults aged 18–64 who are uninsured	2.45
3	Children aged 0–17 years with private coverage	2.73
3	Children aged 0–17 years with public coverage	2.87
3	Children aged 0–17 years who are uninsured	2.09
II	People of all ages with private coverage	3.57
II	People of all ages with public coverage	3.06
II	People of all ages who are uninsured	3.01

[1]The 12 states with the largest populations are California, Florida, Georgia, Illinois, Michigan, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Texas, and Virginia. The design effect was defined as the ratio of the true standard error, accounting for the complex survey design, to the standard error for a simple random sample of the same size.

SOURCE: National Center for Health Statistics, National Health Interview Survey, 2020.

Table II. Percentage of people of all ages who had private health insurance coverage, public health coverage, or were uninsured at the time of the interview, by urbanization level, state Medicaid expansion status, expanded region, and selected states: United States, 2020

Selected geographic characteristic and Medicaid expansion status	Private[1]	Public[2]	Uninsured[3]
	Percent (95% confidence interval)		
Total[4]	62.0 (61.0–62.9)	38.2 (37.3–39.0)	9.7 (9.2–10.3)
Urbanization level[5]			
Large central metropolitan[6]	61.9 (60.4–63.5)	34.9 (33.5–36.3)	10.4 (9.5–11.4)
Large fringe metropolitan[7]	68.2 (66.5–69.9)	33.3 (31.8–34.9)	8.4 (7.4–9.4)
Medium and small metropolitan[8]	60.4 (58.6–62.2)	41.0 (39.3–42.6)	9.2 (8.3–10.1)
Nonmetropolitan[9]	54.3 (50.9–57.7)	47.8 (45.4–50.3)	11.8 (9.9–14.0)
State Medicaid expansion status[10]			
Medicaid expansion states[11]	64.0 (62.8–65.1)	38.9 (37.9–39.9)	7.2 (6.6–7.8)
Non-Medicaid expansion states[12]	58.3 (56.6–60.1)	36.8 (35.3–38.3)	14.4 (13.3–15.4)
Expanded region[13]			
New England	72.2 (68.7–75.5)	36.6 (33.6–39.7)	2.8 (2.0–3.9)
Middle Atlantic	64.4 (62.0–66.8)	40.2 (37.8–42.5)	6.5 (5.2–7.9)
East North Central	67.3 (65.0–69.6)	37.2 (35.0–39.4)	7.4 (6.2–8.7)
West North Central	72.1 (68.9–75.0)	31.5 (29.1–34.0)	8.2 (6.5–10.3)
South Atlantic	57.0 (54.6–59.3)	40.1 (37.8–42.3)	12.8 (11.4–14.3)
East South Central	56.5 (52.4–60.5)	44.0 (41.0–47.0)	10.2 (8.6–12.0)
West South Central	53.7 (50.4–56.9)	36.5 (33.7–39.4)	17.4 (15.5–19.6)
Mountain	61.4 (56.9–65.7)	36.6 (33.8–39.4)	10.1 (7.8–12.8)
Pacific	62.0 (59.9–64.1)	38.1 (36.3–40.0)	7.7 (6.6–8.8)
Selected states[14]			
Alabama	55.3 (46.7–63.8)	45.2 (37.4–53.2)	8.2 (4.5–13.5)
Arizona	54.4 (46.2–62.6)	42.2 (34.8–49.8)	10.7 (6.6–16.2)
Arkansas	58.5 (46.5–69.8)	42.7 (32.2–53.7)	*
California	61.1 (58.5–63.7)	37.9 (35.7–40.1)	7.8 (6.6–9.2)
Colorado	61.1 (53.9–68.0)	36.3 (30.1–42.9)	10.4 (6.8–15.1)
Connecticut	66.5 (57.2–75.0)	37.4 (29.3–46.1)	*
Delaware	68.0 (54.3–79.7)	40.4 (28.6–53.1)	*
District of Columbia	68.0 (55.3–79.0)	35.6 (25.0–47.5)	*
Florida	54.3 (50.8–57.8)	41.7 (38.2–45.2)	13.2 (10.8–15.9)
Georgia	55.3 (49.2–61.2)	35.0 (29.0–41.5)	17.3 (14.1–20.9)
Illinois	70.8 (66.6–74.7)	32.3 (28.7–36.0)	7.9 (5.8–10.5)
Indiana	65.0 (57.8–71.7)	38.9 (32.5–45.6)	8.7 (5.4–13.2)
Kentucky	51.5 (42.9–60.0)	51.7 (43.8–59.6)	6.9 (3.5–11.8)
Louisiana	44.9 (36.3–53.7)	53.3 (45.2–61.3)	6.5 (3.2–11.5)
Maryland	67.3 (58.4–75.4)	37.4 (29.5–45.7)	*
Massachusetts	75.6 (69.9–80.6)	33.4 (28.1–38.9)	2.2 (0.9–4.5)

See footnotes at end of table.

Table II. Percentage of people of all ages who had private health insurance coverage, public health coverage, or were uninsured at the time of the interview, by urbanization level, state Medicaid expansion status, expanded region, and selected states: United States, 2020—Con.

Selected geographic characteristic and Medicaid expansion status	Private[1]	Public[2]	Uninsured[3]
	Percent (95% confidence interval)		
Selected states[14]—Con.			
Michigan	63.3 (57.3–69.1)	46.6 (40.4–52.8)	4.2 (2.6–6.3)
Minnesota	80.2 (73.9–85.5)	28.2 (22.5–34.4)	5.9 (3.2–9.7)
Missouri	69.6 (62.6–76.1)	30.1 (24.2–36.6)	8.9 (5.5–13.4)
New Jersey	65.7 (58.6–72.3)	36.1 (30.6–41.9)	9.3 (5.6–14.4)
New York	59.0 (55.0–62.8)	45.4 (41.9–48.9)	6.1 (4.1–8.5)
North Carolina	59.1 (52.5–65.4)	37.9 (33.4–42.5)	14.0 (10.6–18.0)
Ohio	66.9 (62.1–71.5)	35.7 (31.6–40.1)	9.0 (6.1–12.6)
Oklahoma	50.8 (40.7–60.8)	43.6 (34.6–53.0)	18.4 (12.0–26.5)
Oregon	60.1 (52.5–67.4)	40.1 (33.3–47.1)	9.7 (6.0–14.5)
Pennsylvania	70.2 (65.9–74.3)	36.1 (31.4–41.1)	5.5 (3.9–7.6)
Rhode Island	72.0 (59.8–82.2)	39.5 (28.7–51.1)	*
South Carolina	55.5 (47.0–63.8)	47.1 (39.4–54.9)	10.7 (6.5–16.3)
Tennessee	63.6 (56.7–70.1)	38.5 (32.4–44.9)	10.9 (7.3–15.4)
Texas	55.1 (51.0–59.0)	32.2 (29.1–35.4)	20.0 (17.5–22.7)
Virginia	59.5 (53.3–65.5)	42.5 (36.2–48.9)	8.7 (5.7–12.6)
Washington	68.6 (62.5–74.3)	36.8 (31.2–42.6)	5.9 (3.5–9.3)
Wisconsin	68.2 (62.4–73.7)	36.2 (30.9–41.7)	6.9 (4.4–10.2)

* Estimate is not shown because it does not meet National Center for Health Statistics standards of reliability.
[1]Private health insurance coverage includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as dental, vision, or prescription drugs. People with private coverage may also have public coverage.
[2]Public health plan coverage includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plans, Medicare, and military (TRICARE, Veterans Administration [VA], and CHAMP–VA) plans. People with public coverage may also have private coverage.
[3]People were considered uninsured if they did not have coverage through private health insurance, Medicare, Medicaid, CHIP, military (TRICARE, VA, and CHAMP–VA), other state-sponsored health plans, or other government programs. People also were defined as uninsured if they only had Indian Health Service coverage or only had a private plan that paid for one type of service such as dental, vision, or prescription drugs.
[4]Includes all 50 states and the District of Columbia.
[5]Urbanization level is measured using metropolitan statistical area (MSA) status. The Office of Management and Budget defines MSAs according to published standards that are applied to U.S. Census Bureau data. Generally, an MSA consists of a county or group of counties containing at least one urbanized area with a population of 50,000 or more (see reference 16 in this report). See Methods section in this report for more detail.
[6]Living within a large central MSA with a population of 1 million or more (similar to inner cities).
[7]Living within a large fringe MSA with a population of 1 million or more (similar to suburbs).
[8]Living within a medium or small MSA with a population of less than 1 million.
[9]Not living in an MSA.
[10]Under provisions of the Affordable Care Act of 2010 (Pub L No 111–148, Pub L No 111–152), states have the option to expand Medicaid eligibility to cover adults who have incomes up to and including 138% of the federal poverty level. There is no deadline for states to choose to implement the Medicaid expansion, and they may do so at any time. As of January 1, 2020, 35 states and the District of Columbia moved forward with Medicaid expansion.
[11]For 2020, states that had expanded Medicaid included: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, Virginia, Washington, and West Virginia. The District of Columbia also moved forward with Medicaid expansion.
[12]For 2020, states that had not expanded Medicaid included: Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, Nebraska, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming.
[13]The New England region includes: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. The Middle Atlantic region includes: Delaware, District of Columbia, Maryland, New Jersey, New York, and Pennsylvania. The East North Central region includes: Illinois, Indiana, Michigan, Ohio, and Wisconsin. The West North Central region includes: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota. The South Atlantic region includes: Florida, Georgia, North Carolina, South Carolina, Virginia, and West Virginia. The East South Central region includes: Alabama, Kentucky, Mississippi, and Tennessee. The West South Central region includes: Arkansas, Louisiana, Oklahoma, and Texas. The Mountain region includes: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming. The Pacific region includes: Alaska, California, Hawaii, Oregon, and Washington.
[14]Estimates are not shown for Alaska, Hawaii, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, South Dakota, Utah, Vermont, West Virginia, and Wyoming.

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

SOURCE: National Center for Health Statistics, National Health Interview Survey, 2020.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

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NASHP

New State Data Show ARPA Increased Affordability and Access for Consumers in State-Based Health Insurance Marketplaces

March 22, 2022 / by NASHP Staff

SBMs anticipate thousands may disenroll from coverage if the enhanced subsidies expire

Washington DC—Key findings reported by the state-based marketplaces (SBMs) show that the American Rescue Plan Act (ARPA) lowered costs and expanded access to health insurance for over 4.2 million Americans. These data further show that expiration of ARPA provisions will lead to significant premium increases for the majority of consumers enrolled in coverage through the SBMs.

ARPA has had a significant impact on the health insurance marketplaces, both by enhancing the amount of tax credits available to marketplace consumers and extending eligibility for premium tax credits to more middle-income Americans. Currently, these provisions are set to expire on December 31, 2022.

“ARPA’s enhanced subsidies enable greater financial security and health protections for marketplace consumers,” said Hemi Tewarson, President and Executive Director, National Academy for State Health Policy (NASHP). “Expiration of the enhanced subsidies will lead to market disruptions and premium increases for millions of

consumers, resulting in an increase in the uninsured across the country."

NASHP operates the State Health Exchange Leadership Network, a consortium of the state leaders and staff operating the SBMs. To understand the impact of ARPA's tax credit enhancements and potential ramifications if those policy changes expire, NASHP engaged its SBM Network and gathered data that reflects the impact of ARPA.

Key findings reported by states include:

- **Historic enrollment growth** including record-high enrollment in California, Colorado, Connecticut, Maryland, Minnesota, New Jersey, Pennsylvania, and Washington. Over 600,000 individuals newly enrolled in SBM coverage in 2022.
- **Substantial affordability support**: ARPA's enhanced subsidies enabled average premium savings that ranged from 7–47 percent across the SBMs. In addition, at least 8 states report that 20% or more of their enrollees are paying less than $25 per month for coverage.

"The reality of even modest increases of premium subsidies on enrollees is notable because people can use the savings to make ends meet. ARPA's enhanced tax credits have a direct impact in helping individuals mitigate the effects of current inflation. Further, they have allowed the Massachusetts Health Connector to apply state funds otherwise needed for additional premium assistance toward reducing cost-sharing for critical services including primary care, mental health visits, and prescription drugs," said **Louis Gutierrez, Executive Director, Massachusetts Health Connector Authority.**

- **Significant increases in SBM enrollment of target populations including communities of color**: Several SBMs reported notable enrollment increases from key target populations including Black, Latino, and young and older adult populations.

"The American Rescue Plan opened the doors of health insurance to more people than ever before, literally changing millions of lives, by increasing affordability through enhanced and expanded subsidies. Overall, the majority of Covered California's record-high 1.8 million enrollees saw a 20 percent reduction in what they pay for their coverage, which directly translates into improvements in equity for California's diverse communities of color. Without the American Rescue Plan subsidies, the financial help for approximately 150,000 middle-income Californians will vanish, and one million Covered California lower-income enrollees with incomes at or below 250% of the federal poverty level will see their premiums double on average," said **Jessica Altman, Executive Director, Covered California**.

- **Increased purchasing power and financial security**: ARPA's premium savings enabled thousands of SBM customers to "purchase up" (e.g., from bronze plans to silver or gold), granting them more robust benefits and improved financial protection from high out-of-pocket spending on healthcare.

"Developing closer relationships with rural communities has helped to ensure residents in every corner of our state knew about the enhanced savings available. In fact, this Open Enrollment, some of the largest year-over-year increases in signups came from rural counties. From Moffat to Rio Blanco to Mesa County, Coloradans are seeing lower

average net premiums than they have in years. Not too long ago, residents in these same counties faced some of the highest premiums in the country and too many families were priced out of coverage. It is critical that we protect access and affordability for these families and for families across Colorado," said **Kevin N. Patterson, Chief Executive Officer, Connect for Health Colorado**.

- **The majority of SBM enrollees will lose financial support if the enhanced subsidies are not extended**. SBMs estimate that consumers' average spending on premiums may increase by 15-70 percent.
- **Thousands may disenroll from coverage if the enhanced subsidies expire, changing the dynamics of insurance markets resulting in premium increases**. In addition to dropping coverage, increased costs will drive many customers to "purchase down" eliminating increased financial security as well as improved access to health care services enabled by plans at higher metal tiers.

Timing is critical if Congress is to extend ARPA's subsidies. SBMs, state Departments of Insurance, and insurance carriers have already begun planning for the 2023 plan year, with SBMs beginning operation changes and modifications in June. In addition, most states' insurance rates will be finalized by July, with consumers alerted to changes in renewal notices issued as early as August.

Consumers are also facing the potential end of the federal public health emergency, after which millions are expected to move from Medicaid to the marketplaces. ARPA enhancements make it possible for low-income enrollees to transition into $0 coverage available through the marketplaces, limiting potential rate shock. However, if the

end of the public health emergency coincides with the end of APRA subsidies, millions of transitioning individuals will risk coverage losses. Without ARPA, consumers with incomes up to 150 percent FPL could be expected to pay up to $70 per month for a marketplace benchmark plan — unaffordable for most at this income level.

Except where otherwise noted, information for this analysis includes data collected from 17 SBM states: CA, CO, CT, DC, ID, ME, MD, MA, MN, NV, NJ, NY, OR, PA, RI, VT, and WA.

See more information from the SBMs on ARPA's impact [https://www.nashp.org/state-based-marketplaces-say-many-will-lose-coverage-if-premium-assistance-expires/] .

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Preparing for the Biggest Coverage Event since the Affordable Care Act

Perspectives from State Health Officials on the End of Medicaid's Continuous Coverage Requirement

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March 2022

Introduction

The United States government declared a public health emergency (PHE) on January 31, 2020, and has extended it eight times since then.[1] However, the government is expected to lift the PHE at some point in 2022. Allowing the PHE to expire represents more than the symbolic end of the pandemic; it will mean the termination of numerous federal policies that have had far-reaching effects across our health care system. One of those policies is the Medicaid continuous coverage requirement; it requires that state Medicaid agencies refrain from disenrolling people or tightening eligibility requirements during the PHE in exchange for enhanced federal Medicaid funding.[2] Once the PHE ends, the requirement will end and states will begin reassessing eligibility, resulting in a projected 13 to 16 million people being disenrolled from Medicaid (Buettgens and Green 2022). However, many of these people—an estimated one-third—could be eligible for a subsidized Marketplace health plan.

Helping several million people make the transition from Medicaid coverage to a Marketplace plan in 2022 will be an unprecedented challenge for state Medicaid and Marketplace officials. Many people have changed addresses since they first signed up for Medicaid, making it difficult for Medicaid agency staff to communicate with enrollees about eligibility redetermination. And some people will likely find applying for premium tax credits and selecting a Marketplace plan daunting. At the same time, many Medicaid agencies may face pressure to process eligibility determinations quickly to reduce states' fiscal obligations when the federal share of Medicaid costs returns to traditional levels. The uncertainty over when the federal government will end the PHE is also creating challenges for state officials trying to plan for the large number of redeterminations that will be needed.

If transitions from Medicaid to the Marketplace are not executed well, many of the millions of people eligible for subsidized Marketplace coverage could become uninsured. However, states that operate their own Marketplaces could be better positioned to help people successfully navigate this process, because they have significant autonomy and flexibility over their eligibility and enrollment systems, communications, and consumer assistance efforts. This brief examines preparations for the end of the PHE in 11 states with state-based Marketplaces (SBMs). We attempt to identify major challenges the state officials are facing and best practices for keeping people in coverage that could be adopted by the federally facilitated Marketplace and SBMs.

About US Health Reform—Monitoring and Impact

With support from the Robert Wood Johnson Foundation, the Urban Institute has undertaken US Health Reform—Monitoring and Impact, a comprehensive monitoring and tracking project examining the implementation and effects of health reforms. Since May 2011, Urban Institute researchers have documented changes to the implementation of national health reforms to help states, researchers, and policymakers learn from the process as it unfolds. The publications developed as part of this ongoing project can be found on both the Robert Wood Johnson Foundation's and Urban Institute Health Policy Center's websites.

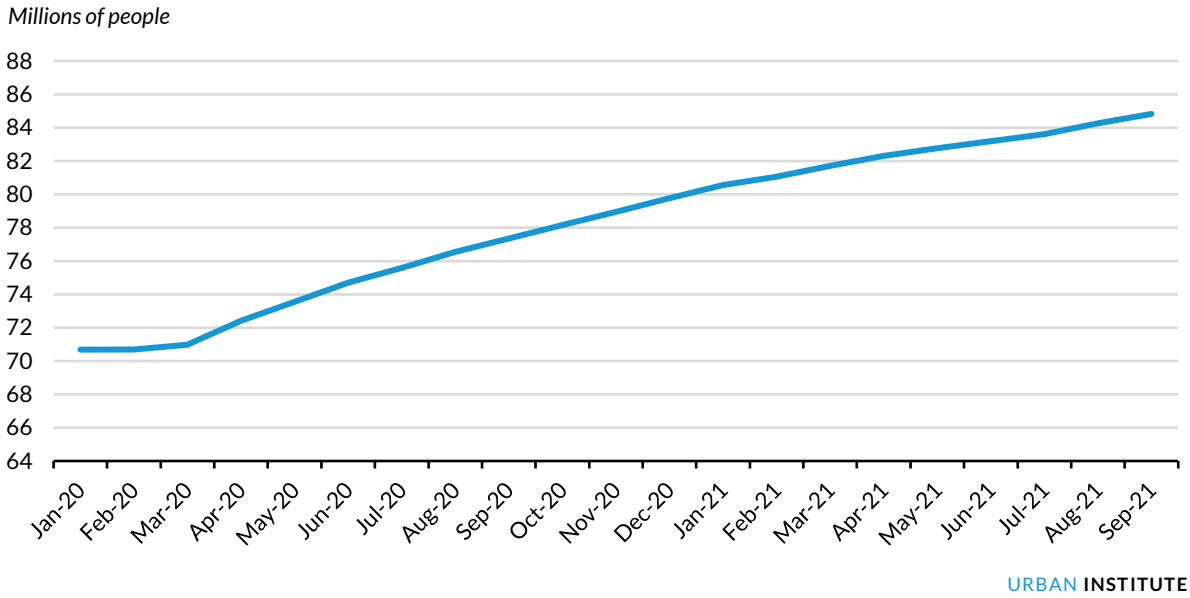
Background

The onset of the pandemic prompted Congress to enact several measures to combat the public health crisis and ameliorate the economic fallout, including the losses of employer-based health insurance resulting from an estimated 23 million people having been laid off or furloughed by April 2020.[3] The first of those measures, the Families First Coronavirus Response Act, enacted on March 18, 2020, increased federal funds flowing to states to support Medicaid. To receive the enhanced matching funds, states are prohibited from disenrolling anyone who enrolled in Medicaid on or after March 18, 2020, until the PHE ends.[4] Specifically, the Families First Coronavirus Response Act increased the federal medical assistance percentage for states (which traditionally ranges from 50 to almost 78 percent) by 6.2 percentage points in exchange for states meeting maintenance-of-effort requirements through the end of the month in which the PHE ends. In general, states may only disenroll people if they are no longer state residents or they voluntarily terminate their own Medicaid coverage.[5]

The Biden administration has extended the PHE to April 16, 2022, and could extend it again if other coronavirus variants arise.[6] As the PHE duration lengthens, state Medicaid enrollment continues to grow, as new enrollees significantly outnumber people leaving the program. Many people who lost their employer-based insurance at the start of the pandemic were able to enroll in Medicaid, and they have stayed with the program. As of September 2021 (the most recent estimate available), 84.8 million people were enrolled in Medicaid or the Children's Health Insurance Program (CHIP), an increase of more than 14.1 million since February 2020 (figure 1).[7]

FIGURE 1

Medicaid and Children's Health Insurance Program Enrollment, January 2020 to September 2021



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Source: Centers for Medicare & Medicaid Services, "August and September 2021 Medicaid and CHIP Enrollment Trends Snapshot," accessed March 14, 2022, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/august-september-2021-medicaid-chip-enrollment-trend-snapshot.pdf.

Acknowledging that processing eligibility redeterminations for this number of people is unprecedented, the Centers for Medicare & Medicaid Services issued guidance to state Medicaid agencies giving them up to 14 months after the PHE ends to complete eligibility verifications, terminations, or renewals.[8] However, states that use the full 14 months must do so without the enhanced federal match, presenting a fiscal challenge for many states. At the same time, to reduce the risk that people eligible for Medicaid are erroneously dropped from the program, the Centers for Medicare & Medicaid Services will require states to newly review eligibility on the basis of an enrollee's current circumstances before terminating Medicaid coverage.[9]

The House of Representatives has passed the Build Back Better Act, which includes provisions to (1) prescribe a timeline and process for states' Medicaid eligibility redeterminations and (2) extend expanded premium tax credits for Marketplace enrollees previously enacted under the American Rescue Plan Act.[10] Without congressional action that provides a clear financial and procedural off-ramp for the Medicaid continuous coverage requirement, states' decisions about whether to adhere to the Centers for Medicare & Medicaid Services' guidance is likely to vary considerably. Furthermore, if Congress does not extend the American Rescue Plan's enhanced premium tax credits, many fewer people losing Medicaid eligibility at the end of the PHE will have access to an affordable Marketplace plan, increasing the number of people likely to become uninsured.

Determining and Redetermining Medicaid Eligibility

The Affordable Care Act sought to provide a "no-wrong-door" coverage eligibility process for consumers. The law requires that states use a single streamlined application for determining eligibility for subsidized health insurance coverage through the Marketplaces, Medicaid, CHIP, and the Basic Health Program.[11] The federally facilitated Marketplace and all SBMs must assess a person's eligibility for Medicaid, and if a person is found to be eligible, their data must be transferred to the state Medicaid agency. In some states, the Marketplace is empowered to make the final determination of Medicaid eligibility. In other states, the Marketplace makes an initial assessment of eligibility and then refers a person to the relevant state agency, which makes the final determination (Rosenbaum et al. 2016).

When people initially apply for coverage through their state Medicaid agency or are enrolled in Medicaid and undergo an eligibility redetermination, federal law requires the state to assess their eligibility not only for Medicaid but for subsidized Marketplace insurance. If they are found ineligible for Medicaid but potentially eligible for Marketplace premium tax credits, the state must transfer the person's account to the Marketplace.[12]

Within this federal framework, state systems and processes for conducting eligibility redeterminations vary. Before the pandemic, most states generally checked an enrollee's Medicaid eligibility annually to process a renewal, although such checks can be conducted more frequently if data sources suggest an enrollee is no longer eligible or if an enrollee submits new information. Although states are required to try to verify eligibility for enrollees using their own data sources, Medicaid agency staff often must ask enrollees to submit information and documentation to prove they remain eligible for the program. Most states rely on mail for these communications, although most also have web-based accounts or permit enrollees to submit information through other electronic means (Serafi and Boozang 2021).

Many Medicaid enrollees with low incomes experience housing insecurity, and Black and Latino enrollees are disproportionately affected (Boozang and Striar 2021). This means enrollees' addresses or phone numbers may change, leaving the Medicaid agency with outdated contact information. When a person does not respond to a Medicaid agency's request for information necessary to conduct an eligibility redetermination, they can be terminated from the program, even if they remain eligible on the basis of their income. These are sometimes called "administrative" or "procedural" denials. Under the continuous coverage requirement during the PHE, many Medicaid enrollees may not have been in contact with a Medicaid agency since early 2020, increasing the likelihood that the agency lacks their current contact information.

No-Wrong-Door Approach Is More Aspirational Than Actual; Most States Lack Integrated Eligibility Systems

The 33 states that use the federal Marketplace platform HealthCare.gov and many SBMs do not have an integrated eligibility system that allows consumers to (1) receive a real-time determination of eligibility for either Medicaid coverage or Marketplace premium tax credits and (2) seamlessly enroll in

the appropriate program. Rather, these states rely on account transfer systems that require consumers to newly apply for coverage with a different agency.

Conversely, several SBMs have integrated their eligibility systems to create a more seamless experience for consumers and reduce the risk that people will become uninsured when their program eligibility shifts from Medicaid to Marketplace coverage or vice versa. The ways in which states have integrated their systems vary. New York runs a single, unified eligibility engine for its subsidized coverage programs (Medicaid, the Marketplace, CHIP, and the Basic Health Program). The state also houses Medicaid and its Marketplace in the same agency (SHADAC 2018). Idaho's SBM relies on its Medicaid agency to conduct eligibility determinations, but once a person is deemed eligible for premium tax credits, they must proactively enroll in a plan through the Marketplace. In Rhode Island, the Medicaid agency works with the Marketplace to provide close-to-real-time eligibility decisions, but people deemed ineligible for Medicaid must still be transferred to the Marketplace to select a plan (Ario and Zhan 2020).

Research Approach

To assess states' planning and preparedness for the end of the PHE and resumption of Medicaid eligibility redeterminations, we reviewed federal guidance and any relevant published state documents relating to the end of the PHE and interviewed Medicaid and SBM officials from 11 states: California, Colorado, Idaho, Kentucky, Massachusetts, Nevada, New Mexico, New York, Rhode Island, Virginia, and Washington. All but Virginia, which has an SBM that uses the federal HealthCare.gov platform, operate their own Marketplace eligibility and enrollment systems. Some of the states have highly integrated eligibility systems, whereas others' systems are more siloed. We selected these states to provide geographic diversity and to represent a range of approaches to system integration. We conducted interviews between October 7 and December 22, 2021.

Findings

State officials we spoke with identified several significant challenges associated with unwinding the PHE, which we describe below. Some officials have begun to plan or implement solutions designed to improve their systems, policies, and business processes to minimize coverage losses.

Challenge #1: Huge Caseloads and Limited Budgets and Time

Fifteen million or more current Medicaid enrollees will potentially be ineligible for Medicaid at the end of the PHE. Thus, states face a monumental task catching up on delayed renewals and redeterminations. Officials in most of our study states expected to take the full time period offered by the Centers for Medicare & Medicaid Services to complete the process. However, a few officials indicated they are facing budgetary pressure to complete redeterminations in less time because of the loss of enhanced

federal matching funds. "Not everyone is clear on whether 12 months is fiscally feasible," said one Medicaid official. "It's left uncertainty about whether…a shorter period will be in play."

Medicaid officials were concerned about having sufficient staff to support the redetermination process, given the unprecedented volume. Some noted they intend to hire additional staff but are struggling to determine when to begin, given uncertainty over when redeterminations will recommence. "We don't want a lot of people sitting around with nothing to do," said one official. Other Medicaid representatives said that though they expect to need more staff, they do not have the budget to hire new employees. Still others thought their current staffing levels will be able to handle the caseload. A few hoped to resolve some of the volume concerns by using internal or external data sources to determine eligibility for as many beneficiaries as possible, a process known as *ex parte* renewals. This can also help relieve the demands on enrollees to submit documentation proving their eligibility.

Having sufficient staff is only one challenge. Another is training. One Medicaid official noted that many of their eligibility caseworkers have never processed a redetermination or renewal because they were hired after March 2020; for staff with longer tenures, it will have been at least two years since they have processed a renewal. Medicaid agencies will need to provide these caseworkers with new training on the rules and processes for managing redeterminations, renewals, and terminations.

Medicaid officials also identified system and technology challenges associated with processing the anticipated volume of redeterminations. States that continued processing redeterminations throughout the PHE (but stopped terminations) will likely be better off than those that stopped conducting redeterminations altogether. As one official put it, "We didn't implement any system changes [to stop redeterminations], so everything is currently done manually every month.…Even though it's tedious...I think in the long run we're better off than other states, because they are having to make huge system changes to get back on track."

SEVERAL STATES WILL MINIMIZE ADVERSE EFFECTS BY TARGETING SUBGROUPS OF ENROLLEES FOR EARLIER OR LATER RENEWALS

Several state officials indicated they intend to manage post-PHE Medicaid eligibility redeterminations by triaging their populations. For example, one state will soon provide continuous 12-month enrollment for postpartum women enrolled in Medicaid. The Medicaid agency will therefore target these people for renewal at the time that continuous eligibility takes effect to avoid coverage losses among those eligible for a full year of coverage. "We don't want to terminate anyone that might be able to continue [with Medicaid]," the official said. Officials in the state were also considering conducting redeterminations first for enrollees for whom the state pays managed-care organizations' capitated rates but who do not use services. This would provide the state some fiscal relief while targeting for potential termination a group of people least likely to need medical services.

Challenge #2: Reducing the Number of People Who Fall through the Cracks

A second central challenge the end of the continuous coverage requirement poses is limiting the number of people who become uninsured after their Medicaid coverage is terminated. If Congress

extends the American Rescue Plan's enhancements to the Marketplace premium tax credits, a substantial share of this group will be eligible for Marketplace health plans with significant premium and cost-sharing subsidies (with many eligible for $0 premium plans, at least in 2022; Branham et al. 2021). However, completing the eligibility determination and selecting a plan in the Marketplace can be challenging. In addition, a large number of people will lose Medicaid coverage for administrative reasons though they will remain eligible for the program on the basis of their incomes. Many of these people could ultimately become uninsured if they apply for Marketplace subsidies only to be rejected because their incomes make them eligible for Medicaid. Additionally, many children disenrolled from Medicaid will be eligible for CHIP, whereas their parents may be eligible for a Marketplace plan. These families will likely need targeted messaging and assistance to help each family member enroll in the appropriate coverage option.

Interview respondents with state Medicaid agencies and SBMs reported that before the start of the PHE, transfers from Medicaid to subsidized Marketplace coverage were considerably less successful than transfers from a Marketplace plan to Medicaid. "If someone's income goes down…it works quite well," one SBM official said. "They are determined eligible for Medicaid…and they move over to the Medicaid program. But if it goes the other direction…in our experience, only a small percentage of people come in that direction; we generally don't get them." This could be because many people coming from Medicaid are unused to paying the premiums often required for Marketplace plans. It could also be that Marketplace consumers experience "choice overload" from the large volume of plans they must navigate and compare (compared with only one or two choices in Medicaid). When confronted with an overwhelming volume of complicated plan choices, many consumers make no decision at all (Taylor et al. 2016). In this particular circumstance, the consumer will likely become uninsured.

Although many SBM officials acknowledged that the end of the PHE presents an opportunity to increase the rate of people transitioning out of Medicaid coverage, they also frequently noted that they are not in control. "The Medicaid agencies have to make the first move," one SBM official said. Several expressed particular concerns about the inaccurate, inadequate data they have received from their state Medicaid agency's account transfers.

STATES WITH INTEGRATED ENROLLMENT SYSTEMS WILL LIKELY FARE BETTER

SBMs that have eligibility systems well integrated with the state's Medicaid system will likely better identify and transfer people from Medicaid into Marketplace plans than will states without integrated systems. California will roll out a new autoenrollment system for Marketplace coverage beginning in mid-2022. This new program was authorized in 2019, so it is only coincidentally likely to be operationalized just as the PHE ends. However, the program is ideally suited to help smooth the transition for people losing Medicaid when the continuous coverage mandate expires. California's novel approach will preliminarily enroll people losing Medicaid eligibility into the lowest-priced silver-level plan available to them, notify them of the enrollment, and then require enrollees to confirm or decline the autoenrollment. Those who take no action will not ultimately be enrolled. Such a program would not be feasible without the integrated eligibility system between Medi-Cal and Covered California.

Officials from other states with integrated systems were confident in their abilities to identify transferees and access the necessary data to connect them with the most appropriate coverage option. According to one official, "We don't have to 'talk to' another system, transfer a file, or worry about files being in two different [computer] languages. The [data] are all just right there." Another SBM official in a state with an integrated system observed that the ability to see why someone is disenrolled from Medicaid can better help SBM staff identify who would benefit from eligibility and enrollment assistance. For example, the SBM would not need to devote resources to someone terminated from Medicaid because they had gained eligibility for Medicare; it could instead use those resources to focus on people more likely to be eligible for Marketplace subsidies on the basis of their incomes. Having an integrated system also makes it easier for an SBM to prepopulate a prior Medicaid enrollee's Marketplace application, reducing the time and effort needed for the consumer to enroll.

States without integrated eligibility systems will face greater hurdles in maximizing insurance coverage as the PHE ends. For these SBMs, the only data staff can see about terminated Medicaid enrollees are from the files the Medicaid agency actively transfers to them. Officials in these states frequently reported that these files are often incomplete and slow to arrive and lack critical data, including the reason someone is disenrolled from the program. As one SBM director said, "We only receive account transfers for [people with] income changes....That is the only group of people I can do anything with...and probably only 1 out of every 30 [files] will have a phone number." Another Marketplace official reported that they have not received data on terminated enrollees in a way that is actionable or timely. They added, "I don't think we get a lot of detail. We don't get something saying, 'Here are the people you should reach out to because...they will benefit from [advanced premium tax credits] due to their income.' We don't know that."

These Marketplace officials also noted that they have no way to know who is being terminated from Medicaid for administrative reasons, such as failure to respond to a mailing. Consequently, the Marketplace has limited ability to initiate outreach or leverage its assister workforce to encourage these people to update their account information or reapply for Medicaid.

MOST SBM OFFICIALS IDENTIFY BARRIERS TO AUTOMATING ELIGIBILITY DETERMINATIONS AND MARKETPLACE ENROLLMENT

One way to increase the number of people who successfully transition from Medicaid to Marketplace coverage is to reduce the time and effort they must put into the process. However, among SBMs, California's appears to stand alone with its autoenrollment system described above. Most interview respondents flagged significant challenges in establishing automated programs in their states. For many, the costs and effort associated with the necessary system changes are too high; some pointed out that the PHE will likely end well before any such changes can be implemented. Others were uncomfortable with autoenrolling people into plans they had not actively shopped for and enrolled in (although California would require consumers to actively opt into the plan before effectuating enrollment). These officials felt greater discomfort over people receiving premium tax credits that they might have to return to the IRS during the annual reconciliation process if their projected income is miscalculated. As one SBM director put it, "There are things we could engineer in our system that would

make it easier for someone to check a box saying, 'If I'm coming out of Medicaid and qualify for a $0 premium [plan], put me in it.' The question is, can we do that from a legal perspective, and could we do that in our [IT] system?"

MOST STATE-BASED MARKETPLACES INTEND TO OFFER YEAR-ROUND ENROLLMENT TO PEOPLE WITH LOW INCOMES

Another strategy to help people remain insured after losing Medicaid eligibility is ensuring they have sufficient time to understand their options and take the necessary steps to enroll in other coverage. But until 2022, most people who lose access to Medicaid, employer-sponsored insurance, or other coverage were given only a two-month special enrollment period (SEP) to sign up for a Marketplace plan.

Beginning in January 2022, however, people enrolling in coverage via the federal Marketplace with incomes below 150 percent of the federal poverty level, or FPL, ($39,750 for a family of four) are eligible for an SEP each month of the year.[13] This year-round opportunity to enroll will apply for as long as the American Rescue Plan's enhanced subsidies that make people with low incomes eligible for $0 premium silver-level plans remain in place. In adopting the monthly SEP for people with low incomes, the Biden administration noted that the SEP would help ensure people who lose Medicaid after the PHE's continuous coverage mandate expires have sufficient time to shift to Marketplace coverage.[14]

The SBMs can, but are not required to, implement this new monthly SEP for people with low incomes. Most of our interview respondents intended to do so, but several indicated it is not high on their lists of priorities. Providing this SEP will require changes to state IT systems that will cost money and take time. Several officials further noted that the SEP would benefit a very small subset of potential enrollees (those with incomes between 138 and 150 percent of FPL who miss the standard 60-day SEP). Massachusetts, Minnesota, and New York already provide year-round enrollment for people with low incomes (under 200 percent of FPL in New York's and Minnesota' Basic Health Programs and under 300 percent of FPL in Massachusetts' ConnectorCare). Another SBM official reported they are advocating to expand the monthly SEP to people with incomes up to 200 percent of FPL. New Jersey has already done so.[15]

Challenge #3: Building Awareness and Assisting Consumers with Coverage Transitions

For consumers losing Medicaid to successfully transition to new coverage, they must be aware of the coverage options available to them. Such consumers can also benefit from assistance with enrolling in new coverage and, once enrolled, assistance with navigating the benefits and requirements of their new coverage, which will differ from those in Medicaid. Stakeholders highlighted several tactics for supporting consumers through coverage transitions.

THE NEED FOR MULTILAYERED, COORDINATED, AND TARGETED COMMUNICATIONS

State officials wishing to minimize coverage losses must communicate early and often with affected people. Current Medicaid enrollees need to know their eligibility will be reassessed and what to do to

ensure the Medicaid agency has accurate and up-to-date information about them. Inaccurate contact information is a huge problem; one Medicaid official reported that roughly half of the mailings they send to enrollees are returned because of incorrect addresses.

People who lose Medicaid coverage will need to know what their coverage options are. This will require a mix of direct-to-enrollee and broader community-level communications and, to the extent possible, coordination between Medicaid and SBMs to ensure consistent messaging and to reduce consumer confusion.

Given limited resources, SBM officials will need to target their community-level communications to the most affected areas and populations. A disproportionate share of people terminated from Medicaid for administrative reasons, such as failing to respond to a mailing, are people of color (Boozang and Striar 2021). States will need to identify the communities in which many nonrespondents live, tailor messaging strategies, and leverage trusted intermediaries to ensure their outreach has an impact.

Officials from two of our study SBMs indicated that they were not, at the time of the interviews, crafting a communications campaign specifically tied to the end of the PHE. "We're waiting for [the Medicaid agency] to let us know what their plans are," one official said. However, most of the state respondents recognized the magnitude of the effort needed and the importance of developing and refining their strategies as early as possible. In general, officials from both Medicaid agencies and SBMs told us SBMs are better staffed and resourced to conduct such proactive public outreach than Medicaid agencies are. "[The Medicaid agency] just doesn't have that same infrastructure and doesn't prioritize things like that," one official said. "The exchanges know that you have to advertise insurance." Many Medicaid agencies have no budget or ability to do any paid media.

Officials from several states reported that their SBMs are gearing up to develop and implement a multilayered communications campaign associated with the PHE's unwinding, and they are doing so in close coordination with the state Medicaid agency. This includes efforts to modernize the ways in which Medicaid agencies and SBMs communicate with enrollees. Whereas representatives of several Medicaid agencies reported that they primarily communicate via mailings, several others discussed coordinated efforts with their SBMs to use email, text messaging, and outbound phone calls to reach people. "We're trying to reach people in more ways they are receptive to," said one state official.

Several SBM officials agreed that it will be important to target their outreach to populations of color, and a few have identified strategies for doing so. One SBM official discussed their work to create "health equity zones," which are "community-based groups that work together and provide a web of agencies in particular neighborhoods." Another SBM official similarly reflected on the importance of having people embedded in targeted communities to conduct effective outreach. "Our best champions are people in the community," they said. "No one knows better what the community needs." Representatives of several of the study states reported that this community-level outreach workforce starts with their Navigator program grantees. However, although some state representatives indicated they would develop training materials and other resources for navigators and other assisters, few had

concrete plans to provide supplemental funding to support PHE-related work, nor did any report they would expand the number or types of organizations to whom they issue Navigator grants.

One state official observed that insurance brokers, not navigators, facilitate most of their Marketplace enrollment. However, many Marketplace plans pay brokers only a nominal commission, or in some cases no commission, for enrollments outside the annual enrollment period (typically November 1 through mid-January). This significantly limits brokers' financial incentives to help people transition from Medicaid to the Marketplace at the end of the PHE, which will likely occur outside open enrollment.

Similarly, few state officials reported concrete plans to increase call center staffing, although many believed they can quickly ramp up capacity if needed. Officials pointed to uncertainty over the timing of the end of the PHE and how quickly the Medicaid agency would be conducting eligibility redeterminations. No one wanted to pay for call center operators to sit idle. As one state representative put it, "It will be difficult for us to assess whether we need additional staffing until we have a better sense of how spread out people will be rolling off [of Medicaid]."

Some SBM and Medicaid agency officials also told us about their efforts to enlist outside organizations, such as managed-care organizations and Marketplace plans, consumer advocacy groups, and providers, to help spread messages about how to prevent Medicaid termination if a person remains eligible and what to do if one's coverage is terminated. However, others pointed to challenges engaging some of these stakeholders, particularly insurers that offer both Medicaid and Marketplace plans. These insurers are uniquely incentivized to ensure terminated Medicaid enrollees retain coverage, and states could provide them with data on recently terminated Medicaid enrollees and their eligibility for Marketplace coverage. These companies could then use their own workforces and customer support infrastructures to conduct outreach and encourage people to sign up for a Marketplace plan, relieving some of the strain on state resources. However, some state officials flagged potential legal and market-related risks associated with sharing enrollee data. SBM officials, in particular, expressed concerns about giving these insurers a competitive advantage over those that do not participate in Medicaid.

THE NEED FOR POSTTRANSITION CONSUMER ASSISTANCE WITH NAVIGATING COVERAGE CHANGES

Although most state officials focused on limiting the number of people who become uninsured after losing Medicaid coverage, officials in 2 of the 11 study states flagged another challenge: ensuring people who switch to a Marketplace plan can successfully navigate a different insurance product. Compared with Medicaid, Marketplace plans can have premiums, higher enrollee cost sharing, and different provider networks and benefits. As one official noted, "People have had free health care [in Medicaid] and see they have to pay something, even a small amount…That's not good." Rhode Island's governor has proposed automatically transitioning some residents who lose Medicaid into a Marketplace plan, with the state providing financial support to cover the first month's premium.[16] The higher cost sharing associated with Marketplace plans is also a concern. For people with low incomes, even a small deductible or low cost sharing can be a significant deterrent to obtaining needed care.

Additionally, the transition from Medicaid to Marketplace coverage may end long-standing patient-provider relationships. "We have seen a frightening narrowing of [provider] networks in [Marketplace plans] over the years," said one SBM official. "If you have 200,000 people coming out of Medicaid and they can't keep their providers…this is not acceptable." However, although they recognized this as a potential concern, most SBM officials had not yet considered policies or strategies to help consumers maintain access to providers, even consumers who may be in treatment when they lose eligibility for Medicaid. In early March 2022, Oregon's legislature passed a bill requiring a state task force to create a "bridge program" to "improve the continuity of coverage" for those terminated from Medicaid.[17]

Challenge #4: Expect the Unexpected

Repre[18]sentatives from all of our study states were attempting to prepare for the end of the PHE without knowing when that will be or when Medicaid will resume eligibility redeterminations. Uncertainty over federal requirements and standards for how eligibility redeterminations will be processed compounds uncertainty about timing. The Build Back Better Act would unlink the Families First Coronavirus Response Act's continuous coverage requirement from the PHE, but it would place new requirements on states if they wish to retain the enhanced federal matching rate as it phases down. The legislation would, for example, bar states from disenrolling anyone on the basis of returned mail until the state makes at least two attempts to contact the person through different modalities (e.g., mail and telephone). States would also have to provide at least a 30-day notice before terminating coverage (Park et al. 2021). Policymakers are still debating this legislation, meaning state officials must plan without knowing what may be required of them.

State legislatures could also inject themselves into the process. In most of our study states, legislators have taken little to no action related to the end of the PHE and the potential termination of Medicaid coverage for thousands (and in some cases millions) of their constituents. No Medicaid official reported any pressure from legislators to speed up redeterminations for fiscal reasons. A few state legislatures are considering providing additional funding to either Medicaid or the SBM to aid in outreach and enrollment assistance. With the 2022 legislative sessions underway, state agencies' planning and preparedness may start to receive more attention. Ohio's legislature has already required the state Medicaid agency to complete its redeterminations within 60 days of the PHE ending.

SBMs must also grapple with uncertainty over the market impact of the huge volume of people shifting from Medicaid coverage to commercial Marketplace plans, potentially in a short time frame. In addition to questions about the capacity of SBMs' infrastructure to support this inflow of enrollees, states must consider the capacity of participating Marketplace plans. These plans may need to increase their customer service staff to respond to consumers' questions, particularly from former Medicaid enrollees unused to commercial insurance. Insurers may also want to consider adjusting broker commissions so their broker workforce has sufficient financial incentives to assist transitioning consumers outside of the annual enrollment period.

Another concern is that Marketplace plans have narrow provider networks that may be inadequate to meet the needs of the large influx of new enrollees.[19] If a large share of people in a given service area

gravitate to just one or two narrow-network plans in a short period of time, they may face delays or difficulties accessing timely appointments for needed services.

Additionally, Marketplace insurers have already locked in their premium rates for 2022. If the nongroup insurance market receives unanticipated new enrollment that leads to higher-than-average medical claims, it could incur financial losses. Representatives of almost all of the SBMs in our study had yet to engage with their respective departments of insurance on these issues, but most were confident that their plans can absorb additional enrollment without any adverse effects.

Discussion

How well integrated Medicaid and Marketplace agencies are, how much planning is taking place, and how agencies coordinate data sharing and outreach strategies vary significantly across states. However, most of our state respondents recognized the significant concern that millions of current Medicaid enrollees could become uninsured at the end of the PHE. They also acknowledged that they are on the front lines of trying to ensure as many of these people as possible transition into appropriate new coverage. As the end of the PHE approaches, state officials identified several potential risks.

Lack of lead time. State officials were concerned that the federal government will not provide them with sufficient time and policy certainty to undertake the planning and IT system changes required to execute a smooth redetermination process and warm hand-offs to their SBMs. A few also noted concerns that their legislatures will require them to complete redeterminations in an unrealistically fast time frame because of fiscal pressures.

Workload and staffing challenges. State Medicaid agency staff are bracing for a significant increase in their workloads to process redeterminations, respond to consumer questions and complaints, and provide enrollment assistance. At the same time, all are facing the same labor shortages as private-sector employers, and few expected significant increases in funding from the state to support hiring additional staff or augmenting their Navigator grants.

Lack of data. State Medicaid officials expressed concerns about inaccurate and outdated contact information for current enrollees, and SBM officials worried that the account transfers they receive from Medicaid frequently lack the information needed to determine Marketplace and premium tax credit eligibility.

Technology glitches. Several Medicaid officials noted that turning their systems back on to process redeterminations is not easy. Doing so could result in technical glitches, such as enrollees being inundated with outdated messages or receiving inaccurate data. On the Marketplace side, most SBM officials expressed confidence in the capacities of their systems to absorb new applications and enroll a significant number of new consumers.

Market instability. A few SBM officials noted that a rapid influx of new enrollees, particularly if concentrated in one insurance plan, could result in challenges for plans and delays or difficulties for enrollees trying to access in-network services.

Strategies to Mitigate Risks Associated with the End of the PHE

Medicaid and Marketplace officials are attempting to mitigate these risks by conducting as much cross-agency planning as feasible; many state respondents reported weekly or even daily communications with their interagency counterparts. In several states, officials were also developing a coordinated communications campaign to ensure current and former Medicaid enrollees receive consistent and unified messages about what they need to do to retain coverage or transition to new coverage. Many also said they intend to leverage the infrastructure and workforce of external stakeholders, including Medicaid managed-care organizations, Marketplace plans, navigators and other assisters, and providers, to assist with consumer education and provide enrollment assistance.

One state, California, will be launching a new automatic enrollment program that should significantly reduce the time and effort transitioning consumers must undertake to maintain coverage. Although none of the state officials in our study were planning a similar program, the looming end of the PHE has prompted several to explore implementing more automation in their eligibility and enrollment processes, such as greater use of prepopulated applications.

Fewer people may become uninsured at the end of the PHE in states with their own Marketplaces than in states using the federally facilitated Marketplace. SBMs have greater abilities to closely coordinate with state Medicaid agencies and to be nimble in the face of unexpected policies or events. The SBMs with eligibility and enrollment systems fully integrated with Medicaid appear to be in the strongest position to successfully transition eligible people into subsidized Marketplace coverage.

That said, the end of the continuous coverage requirement for Medicaid will inevitably result in coverage losses in all states. The federal government can assist by ensuring state officials have clear and timely policy guidance, encouraging cross-agency collaboration, and providing real-time technical assistance both in preparation for and during the unwinding of the PHE.

The risk of coverage losses at the end of the PHE is considerable, but it may also offer a silver lining. A key goal of the Affordable Care Act was to ensure consumers would face no wrong door in their search for affordable insurance options. Eleven years later, that goal has not been fully realized in most states. However, many of the state officials we spoke with have begun to reprioritize the consumer experience in transfers from one coverage option to another and to invest in system changes and processes designed to make the transition as easy as possible. If the end of the PHE brings more states closer to that no-wrong-door goal, the long-term benefits will be considerable.

Notes

[1] "Public Health Emergency Declarations," US Department of Health and Human Services, last reviewed January 14, 2022, https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx.

[2] The Families First Coronavirus Response Act, Pub. L. No. 116-127 (2020).

[3] "Tracking COVID-19 Unemployment and Job Losses," Georgetown University Center on Education and the Workforce, accessed January 24, 2022, https://cew.georgetown.edu/cew-reports/jobtracker/.

[4] Pub. L. No. 116-127, 134 Stat. 178 (2020). The Families First Coronavirus Response Act's continuous coverage requirement does not extend to CHIP or the Basic Health Program.

[5] Tricia Brooks and Andy Schneider, "Families First Coronavirus Response Act Medicaid and CHIP Provisions Explained," *Say Ahhh!* (blog), Georgetown University Health Policy Institute, Center for Children and Families, March 22, 2020, https://ccf.georgetown.edu/2020/03/22/families-first-coronavirus-response-act-medicaid-and-chip-provisions-explained/.

[6] "Renewal of Determination That a Public Health Emergency Exists," US Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, January 14, 2022, https://aspr.hhs.gov/legal/PHE/Pages/COVID19-14Jan2022.aspx.

[7] Centers for Medicare & Medicaid Services, "August and September 2021 Medicaid and CHIP Enrollment Trends Snapshot," accessed March 14, 2022, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/august-september-2021-medicaid-chip-enrollment-trend-snapshot.pdf.

[8] Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, letter to state health officials, regarding "Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) upon Conclusion of the COVID-19 Public Health Emergency," March 3, 2022, https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

[9] Centers for Medicare & Medicaid Services, letter regarding "Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, CHIP, and BHP Operations."

[10] Build Back Better Act, H.R. 5376, 117th Cong. (2021).

[11] 45 C.F.R. § 155.40 and § 435.907.

[12] 42 C.F.R. § 435.1200(e).

[13] 45 C.F.R. § 155.420.

[14] 86 Fed. Reg. 35170 (Jul. 1, 2021).

[15] State of New Jersey Department of Banking and Insurance, "Governor Murphy and DOBI Commissioner Caride Announce Record Health Insurance Sign-Ups during Open Enrollment, Introduce Effort to Further Expand Health Care Access for NJ Residents," news release, February 23, 2022, https://www.state.nj.us/dobi/pressreleases/pr220223.html.

[16] Office of the Governor of Rhode Island, "Governor McKee Proposes Initiative to Help Keep Rhode Islanders Insured," news release, February 4, 2022, https://www.ri.gov/press/view/43002.

[17] H.B. 4035, 81st Gen. Assemb. (Or. 2022).

[18] Am. Sub. H.B. 110 § 5163.52, 134th Gen. Assemb. (Oh. 2021).

[19] See, for example, Dafny and colleagues (2017); McKinsey Center for US Health System Reform (2016); Polsky, Ciday, and Swanson (2016); and Caroline F. Pearson, Elizabeth Carpenter, and Chris Sloan, "Plans with More Restrictive Networks Comprise 73% of Exchange Market," news release, Avalere Health, November 30, 2017, https://avalere.com/press-releases/plans-with-more-restrictive-networks-comprise-73-of-exchange-market.

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Impact of Key Provisions of the American Rescue Plan Act of 2021 COVID-19 Relief on Marketplace Premiums

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DATA NOTE

The Affordable Care Act (ACA) made premium tax credits available to people purchasing health coverage on the Marketplaces, but generally only when their incomes fall between 100% and 400% of the federal poverty level. These subsidies work by capping what an enrollee must spend on a silver benchmark plan premium at no more than a certain percentage of the enrollee's household income. The premium tax credit amount equals the difference between the actual benchmark plan premium for that individual and the required contribution. The tax credit can be applied to any metal level plan.

However, a sharp cliff exists at 400% of the poverty level. Under the ACA before any legislative changes, a 60-year-old making $50,000 per year (392% of poverty) would pay no more than $410 per month for a benchmark silver plan (9.83% of her income, after receiving an average subsidy of $548 per month). However, if her income crossed above $51,040 per year (400% of poverty), health insurance would become much more expensive. For example, at an income of $52,000 per year (408% of poverty), a 60-year-old would pay the full-priced premium, which, for a benchmark silver plan, averages $957 per month nationwide (22% of her income). This doubling of the premium payment for people with incomes just over 400% of poverty has been called the "subsidy cliff," as shown in the blue line in Figure 1 below.

Additionally, there are millions of uninsured people who could be getting subsidized coverage on the ACA Marketplaces, but have not taken advantage of this financial help. In many cases, it may be that the financial help available to them is not sufficient to make the premium or the deductible affordable.

COVID-19 Relief Marketplace Subsidy Expansions

The American Rescue Plan Act of 2021 (COVID-19 relief) law passed in March 2021 expands Marketplace subsidies above 400% of poverty and also increases subsidies for those making between 100% and 400% of the poverty level, for two years (2021 and 2022), consistent with what President Biden proposed during his campaign.

These additional subsidies will yield substantially lower premium payments for the vast majority of the nearly 15 million uninsured (https://www.kff.org/private-insurance/issue-brief/marketplace-eligibility-among-the-uninsured-implications-for-a-broadened-enrollment-period-and-aca-outreach/) people who are eligible to buy on the Marketplace and the nearly 14 million people insured (https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/) on the individual market. With some exceptions (in the case of the highest income enrollees whose premiums may not be high enough to qualify for a subsidy), most of these 29 million people could see lower health insurance premiums as a result of these subsidies, and many could also afford lower deductible plans. However, it is far from certain how many people will take advantage of the new financial assistance.

Table 1 below compares the ACA and COVID-19 relief subsidy schedule, both of which are benchmarked to the premium of the second-lowest cost silver plan. The COVID-19 relief subsidy schedule increases subsidies across the board, notably extending them for the first time to people with incomes over 400% of the poverty level and guaranteeing access to a plan with a zero dollar premium payment for people with incomes between 100-150% of poverty. The COVID-19 relief law also expands Marketplace subsidies to people receiving unemployment insurance (UI), which we discuss more below.

Table 1: Percent of Income Paid for Marketplace Benchmark Silver Premium, by Income

Income (% of poverty)	**Affordable Care Act** (before legislative change)	**COVID-19 Relief (current law 2021-2022)**
Under 100%	Not eligible for subsidies*	Not eligible for subsidies**
100% – 138%	2.07%	0.0%
138% – 150%	3.10% – 4.14%	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%
Over 400%	Not eligible for subsidies	8.5%

NOTES: *Lawfully present immigrants whose household incomes are below 100% FPL and are not otherwise eligible for Medicaid are eligible for tax subsidies through the Marketplace if they meet all other eligibility requirements.
**In the COVID-19 relief law, lawfully present immigrants in states that have not expanded Medicaid would continue to be eligible for marketplace subsidies. In addition, people receiving Unemployment Insurance (UI) are treated as though their income is no more than 133% of poverty for the purposes of the premium tax credit. This could extend premium tax credits to some individuals with incomes below poverty.
SOURCE: KFF

Removing the Subsidy Cliff

We estimate that there are about 8 million people who either are buying unsubsidized plans or faced paying full-price for ACA coverage before the COVID-19 relief legislation went into effect. This included an estimated (https://www.kff.org/private-insurance/issue-brief/marketplace-eligibility-among-the-uninsured-implications-for-a-broadened-enrollment-period-and-aca-outreach/) 3.4 million uninsured people who fell into the subsidy cliff (i.e. had incomes too high to qualify them for subsidies under the ACA). Additionally, it included about 3.3 million people buying off-exchange (https://www.kff.org/private-insurance/issue-brief/data-note-changes-in-enrollment-in-the-individual-health-insurance-market-through-early-2019/) coverage and 1.4 million people buying unsubsidized on-exchange (https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Early-2020-2019-Effectuated-Enrollment-Report.pdf) plans, presumably because many were ineligible to buy subsidized coverage.

By extending eligibility for Marketplace subsidies above 400% of poverty, the COVID-19 relief law flattens out the ACA's subsidy cliff and lowers premiums for virtually everyone already eligible for Marketplace subsidies. As shown in Figure 1, older people with incomes just above 400% of poverty ($51,040 for a single individual) would receive substantial new subsidies. The benefit would gradually phase out at higher incomes, as benchmark silver premiums no longer cross the 8.5% of income threshold.

As noted above, older adults with incomes above 400% of poverty would generally see some of the most significant savings from the COVID-19 relief law. Uninsured people in the subsidy cliff tend to be older (https://www.kff.org/private-insurance/issue-brief/marketplace-eligibility-among-the-uninsured-implications-for-a-broadened-enrollment-period-and-aca-outreach/), on average, than those eligible for subsidies, because premiums were so high for this group under the ACA. Figure 2 below shows the amount of

savings available to older enrollees currently falling in the subsidy cliff. Compared to current premium payments, a 60-year-old with a $55,000 income would pay 77% less for a bronze plan ($146 vs. $634 per month), 56% less for a benchmark silver plan ($390 vs. $887 per month), and 52% less for a gold plan ($453 vs. $951 per month), on average, under the COVID-19 Relief law. Many young adults with incomes above 400% of poverty who are currently in the subsidy cliff would also see savings under the COVID-19 relief law, but those savings would be more modest (a 6-9% drop, depending on the metal level, for an average 27 year old).

Expanded Subsidies for Those Already Eligible

While removing the subsidy cliff would provide some of the largest drops in premium payments, the COVID-19 relief's additional subsidies to those already eligible are also substantial, particularly because they would guarantee zero-premium silver plans to millions of low-income enrollees. At least 3.4 million of the lowest income enrollees would see a 100% decrease in their premium contribution.

The COVID-19 relief sets benchmark silver premium contributions at $0 of income for all enrollees with incomes below 150% of poverty. These zero-premium silver plans would also come with cost-sharing reductions that lower deductibles substantially. Enrollees with incomes between 100-150% of poverty would become eligible for a zero-premium silver plan with an average deductible of $177.

Most of these enrollees would have already been eligible for a zero-premium bronze plan under the ACA, but bronze plans have a typical deductible of about $6,900. For the same $0 premium, the lowest-income Marketplace enrollees could have a deductible that is 97% lower under COVID-19 relief law.

People Receiving Unemployment Insurance

The COVID-19 relief law makes special considerations for people approved to receive or receiving unemployment compensation at any point in 2021. Under the COVID-19 relief law, if a person is receiving unemployment compensation and she qualifies to purchase insurance on the Marketplace, she and any eligible

dependents can get a silver plan with a $0 premium. That is because, under the proposal, any household income above 133% of poverty is not considered in the calculation of her premium tax credit if she receives unemployment insurance.

For people receiving unemployment compensation at any point in 2021, their income up to 133% of poverty is counted in determining eligibility for a cost-sharing reduction, which is only available to people with incomes between 100% and 250% of poverty. That is, a person with income, including unemployment compensation, of 260% of poverty would receive a premium and cost-sharing reduction subsidy as if her income is 133% of poverty. A person receiving unemployment income would still need to attest that they do not have an affordable offer of employer-sponsored insurance from their spouse or other family member. As the COVID-19 relief law does not change the so-call "family glitch" in the ACA, if an employer offer is deemed affordable (9.83% of household income for 2021 for self-only coverage), this may disqualify people receiving unemployment income from receiving ACA subsidies if they still have a working family member with an employer offer.

State-Level Differences

As is the case under the ACA, the amount of the subsidy in the COVID-19 relief law would vary by age, income, and geography. Tables in the Appendix (https://www.kff.org/report-section/impact-of-key-provisions-of-the-american-rescue-plan-act-of-2021-covid-19-relief-on-marketplace-premiums-appendix) show premium payment at the national level for various age and income scenarios, and at the state level for a 60-year-old currently in the ACA subsidy cliff. Note that all tables take into account additional state subsidies that are already provided in California and Vermont, so the typical savings would be even greater if those state were excluded.

Older adults in the ACA subsidy cliff who are living in states with high premiums would see the largest premium savings from the COVID-19 relief law. As shown in the map below, a 60-year-old making $55,000 per year living in Wyoming, West Virginia, South Dakota, Nebraska, Connecticut, or Alabama would save over 70% on the benchmark silver plan, on average. Older adults previously in the ACA subsidy-cliff in several states would even become eligible for free bronze plans, as shown in the state-level Appendix table.

Implications for Federal Government Costs and the Uninsured Rate

The Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) project that the enhanced premium tax credits in the original House COVID-19 relief proposal would increase federal deficits by $34.2 billion over ten years (including an increase in direct federal spending of $22.0 billion and a reduction in revenues of $12.2 billion). Additionally, CBO and JCT expect the enhanced subsidies

for people receiving unemployment insurance to add another $4.5 billion over the next ten years (including an increase in outlays of $2.4 billion and a decrease in revenues of $2.1 billion).

CBO projections are generally over a 10-year period. Because the enhanced subsidies only last two years, though, most of the costs would be concentrated in 2021 and 2022. However, CBO and JCT expect some new enrollees to continue purchasing subsidized Marketplace coverage for a few years, even if those enrollees are no longer receiving enhanced subsidies.

The CBO and JCT estimate that, in 2022, 1.7 million people would gain coverage through the Marketplace. They estimate that new enrollees will account for $13.0 billion in federal costs, with the remaining going to enhanced premium tax credits for existing enrollees.

Methods

We analyzed data from the 2021 Individual Market Medical files to determine premiums and the benchmark amounts to calculate premium tax credits for the scenarios presented. Premiums for state-based Marketplaces are from KFF analysis of data received from Massachusetts Health Connector, Covered CA, and KFF analysis of data published by HIX Compare from the Robert Wood Johnson Foundation. This analysis only includes on-exchange plans. The premium caps used to model premiums under the ACA and the COVID-19 relief law are shown in Table 1 above.

All averages are weighted by county-level 2020 plan selections. 2020 plan selections come from the 2020 Marketplace Open Enrollment Period County-Level Public Use file provided by CMS. In states running their own exchanges, we gathered county-level plan selection data where possible and otherwise estimated county plan selections based on the county population in the 2010 Census and total state plan selections in the 2020 OEP State-Level Public Use File provided by CMS.

PREMIUM INTERACTIVE (HTTPS://WWW.KFF.ORG/REPORT-SECTION/IMPACT-OF-KEY-PROVISIONS-OF-THE-AMERICAN-RESCUE-PLAN-ACT-OF-2021-COVID-19-RELIEF-ON-MARKETPLACE-PREMIUMS-PREMIUM-INTERACTIVE/) ›

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Bolstered by Recovery Legislation, the Health Insurance Safety Net Prevented a Rise in Uninsurance between 2019 and 2021

Stacey McMorrow, Michael Karpman, Andrew Green, and Jessica Banthin

March 2022

Key Findings

When the COVID-19 pandemic began, many people were concerned that millions of Americans would lose employer-sponsored health insurance coverage and become uninsured. The normal lag in official health insurance estimates from federal sources and data collection challenges brought on by the pandemic have made it challenging to clearly assess how insurance coverage has changed in recent years. In this study, we analyze data from the National Health Interview Survey (NHIS), the Current Population Survey (CPS), and the Health Reform Monitoring Survey (HRMS) to explore trends in coverage status and type between early 2019 and early 2021. We also incorporate administrative data on enrollment in Medicaid, the Marketplaces, and employer-sponsored insurance (ESI) to help reconcile the variation in estimates across surveys. We find the following:

- The uninsurance rate among nonelderly adults (ages 18 to 64) remained flat between early 2019 and early 2021, according to all three surveys.
- Gains in public coverage offset estimated private coverage losses on all three surveys, but the CPS showed much smaller public and private coverage changes than the HRMS and the NHIS.
- Administrative data on Medicaid and ESI enrollment show substantial changes consistent with the estimates reported on the NHIS and the HRMS.
- Medicaid enrollment data indicate that the Medicaid continuous coverage requirement, which has prohibited states from disenrolling Medicaid beneficiaries during the public health emergency, has been a key driver of enrollment trends. Marketplace enrollment trends also suggest the Marketplace has played a smaller but important role in preventing uninsurance during the pandemic.

As of early 2021, the health insurance safety net, enhanced by the Families First Coronavirus Response Act, had largely prevented the catastrophic coverage losses feared at the outset of the pandemic. Moreover, evidence suggests the enhanced Marketplace subsidies under the American Rescue Plan Act may have further reduced uninsurance since early 2021. But the continuous coverage requirement in Medicaid will expire when the public health emergency ends, and the enhanced Marketplace subsidies are set to expire at the end of 2022. The Build Back Better Act, passed by the House in November 2021, could strengthen the health insurance safety net by extending the enhanced Marketplace subsidies through 2025 and filling the Medicaid coverage gap, but the bill has stalled in the Senate and its future is uncertain. Thus, without additional action, uninsurance rates could begin to rise again in the coming years.

About US Health Reform—Monitoring and Impact

With support from the Robert Wood Johnson Foundation, the Urban Institute has undertaken US Health Reform—Monitoring and Impact, a comprehensive monitoring and tracking project examining the implementation and effects of health reforms. Since May 2011, Urban Institute researchers have documented changes to the implementation of national health reforms to help states, researchers, and policymakers learn from the process as it unfolds. The publications developed as part of this ongoing project can be found on both the Robert Wood Johnson Foundation's and Urban Institute Health Policy Center's websites.

Background

As the number of unemployed Americans surged early in the pandemic, concerns about dramatic losses of ESI coverage and increases in uninsurance also surfaced (Banthin and Holahan 2020). Early predictions varied widely, given the unprecedented nature of the crisis. Some estimated that more than 5 million workers and their dependents could become uninsured (Dorn 2020; Garrett and Gangopadhyaya 2020), whereas others predicted about 3 million nonelderly people could become uninsured (Banthin et al. 2020). Researchers and analysts generally agreed that the number of people losing ESI would be larger than the number becoming uninsured, assuming that many people losing job-based coverage would be able to obtain other coverage. Estimates of employer coverage losses ranged from about 10 million to 30 million workers and dependents (Banthin et al. 2020; Garfield et al. 2020; Garrett and Gangopadhyaya 2020).

Estimating the pandemic's coverage implications has been particularly challenging because the associated recession has differed from past recessions in at least four ways. First, the types of jobs lost because of the pandemic have differed from jobs lost in past recessions; workers in service industries and occupations requiring in-person contact with customers have been among the hardest hit (Dvorkin 2020).[1] These workers are less likely to have ESI than other workers, which has had implications for the health insurance effects of the recession (Blumberg et al. 2020). Second, many workers were furloughed

or laid off temporarily rather than permanently dismissed, which allowed them to keep their health insurance coverage.[2]

Third, the federal government initiated a rapid and robust policy response, providing direct financial assistance to households and businesses that may have helped people maintain coverage. The Coronavirus Aid, Relief, and Economic Security Act and the Families First Coronavirus Response Act, passed in March 2020, expanded unemployment insurance and required states to maintain Medicaid coverage for beneficiaries enrolled during the public health emergency in exchange for an increased federal matching percentage for Medicaid. Finally, the economic recovery started relatively quickly after the precipitous drop in employment in March and April 2020, so some coverage losses were concentrated in a short period. The normal lag in the availability of data from federal surveys that collect information on insurance coverage and new data collection complications associated with the pandemic exacerbated these measurement challenges (Stewart 2021).

Published estimates from the US Census Bureau's Household Pulse Survey,[3] developed to monitor the pandemic's effects, showed that the number of uninsured nonelderly adults was 2 million higher by July 2020 (Gangopadhyaya, Karpman, and Aarons 2020) and about 2.7 million higher by December 2020 than at the start of the pandemic (Bundorf, Gupta, and Kim 2021). These estimates are consistent with the more modest predictions at the outset of the pandemic. But, low response rates and other methodological concerns with the Pulse Survey require some caution in interpreting these estimates (Banthin 2021). Moreover, the Pulse Survey estimates suggest increases in uninsurance were concentrated in the spring and summer of 2020. With estimates of health insurance coverage for all of 2020 and early 2021 available from several other sources, however, we can now more comprehensively assess coverage trends during the pandemic.

In October 2021, the US Department of Health and Human Services summarized coverage estimates from several sources and reported a stable uninsurance rate in 2020 alongside declining employer coverage and rising Medicaid and Marketplace coverage (Ruhter et al. 2021). In this study, we provide additional analysis of coverage estimates from the NHIS, the CPS, and the HRMS to further explore trends in coverage status and type between early 2019 and early 2021. We also incorporate administrative data on enrollment in Medicaid, the Marketplaces, and employer coverage to help reconcile the variation in estimates across surveys. Finally, we discuss implications for coverage in 2022 and beyond as pandemic protections expire and policymakers consider additional recovery legislation.

Data and Methods

We rely on data from three nationally representative surveys for this analysis: the NHIS, the CPS, and the HRMS. We chose these surveys because they each provide point-in-time coverage estimates for early 2019 and early 2021. This allows us to explore comparable coverage trends without relying on 2020 survey estimates, which likely suffered the most significant data collection challenges and nonresponse bias related to the pandemic (Dahlhamer et al. 2021; Stewart 2021).

The NHIS is the principal source of information on the nation's health, providing nationally representative estimates for the noninstitutionalized civilian population. We use publicly reported estimates from the 2019 and 2021 NHIS Early Release Program, which produces nationally representative estimates for each calendar-year quarter (Cohen and Cha 2020, 2021). The reported estimates include the shares of nonelderly adults with public, private, and no health insurance coverage at the time of the survey. Public coverage includes Medicaid, the Children's Health Insurance Program (CHIP), Medicare, military health plans, and other government- or state-sponsored coverage. Private coverage includes ESI and insurance purchased directly, purchased through local or community programs, and purchased through the federal or state-based Marketplaces. People can report multiple coverage types, and those identified as uninsured report no comprehensive public or private coverage.[4] Following a redesign in 2019, the survey has approximately 8,000 responses each quarter for a randomly selected adult from each family surveyed.

The CPS is a nationally representative survey of the noninstitutionalized civilian population conducted by the Census Bureau and the Bureau of Labor Statistics that serves as the primary source of monthly US labor force statistics. In addition to the demographic and labor force data the survey collects monthly, the CPS Annual Social and Economic Supplement (ASEC), fielded between February and April, collects detailed data on health insurance coverage, income, work experience, noncash benefits, and migration. Most of the ASEC data are collected in March. The ASEC samples more than 90,000 households annually, providing information on about 107,000 nonelderly adults in 2019 and about 96,000 in 2021.

The ASEC, redesigned in 2014, asks about health insurance coverage at the time of the survey and during the prior calendar year. Though published Census Bureau reports emphasize estimates for the prior year, our analysis focuses on coverage at the time of the survey for consistency with the NHIS and the HRMS. ASEC respondents can report more than one coverage type for themselves and the other members of their households. In this brief, we focus on the shares of nonelderly adults reporting ESI (defined as employment-based coverage and excluding coverage through the military), public coverage (defined as Medicaid, CHIP, and other means-tested programs; Medicare; and CHAMPVA or Veterans Affairs health care), and no coverage at the time of the survey.

The Urban Institute's HRMS is a nationally representative, internet-based survey of adults ages 18 to 64 launched in 2013 to provide timely information on the Affordable Care Act before data from federal surveys are available. HRMS samples are drawn from Ipsos's KnowledgePanel, the nation's largest probability-based online research panel, which includes households with and without internet access. The HRMS is currently fielded annually in the spring, and this analysis draws on data from the March 2019 and April 2021 survey rounds. Approximately 9,500 adults participated in the survey in March 2019, and approximately 9,000 participated in April 2021. Though the cumulative response rate for the HRMS is much lower than the response rates for federal surveys such as the NHIS and the CPS, analyses have found that estimated coverage changes in the HRMS benchmark well against those from the NHIS and other surveys (Karpman and Long 2015).

The HRMS measures health insurance coverage on the basis of responses to a question adapted from the American Community Survey about current coverage at the time of the survey. Respondents can report more than one coverage type, and the survey asks respondents who do not report any coverage to verify that they do not have health insurance. The survey uses additional follow-up questions to develop a logical editing process for determining the most likely type of insurance among respondents reporting multiple coverage types; it applies the following hierarchy of responses so that coverage estimates sum to 100 percent: ESI, including coverage through a current or former employer or union and coverage through the military (e.g., TRICARE and Veterans Affairs health care); public coverage, including Medicare, Medicaid, CHIP, and other state- or government-sponsored plans for which eligibility is based on income or disability; private nongroup coverage purchased through or outside the Marketplaces; and other unspecified coverage. We use previously published HRMS estimates in this brief (Karpman and Zuckerman 2021).

We also rely on administrative estimates of Medicaid and Marketplace coverage to provide additional context for interpreting patterns in the population-based surveys. The Centers for Medicare & Medicaid Services provides monthly Medicaid enrollment counts for all 50 states and the District of Columbia, which are based on information submitted by each state's Medicaid agency. The monthly Medicaid enrollment estimates in this brief represent the total number of enrollees with comprehensive benefits as of the last day of each month.[5] These estimates exclude CHIP enrollees but include children with Medicaid. The Centers for Medicare & Medicaid Services also provides information on the number of people enrolled in Marketplace coverage each month. For the purposes of this brief, we focus on effectuated enrollment, which reflects the total number of people who have an active Marketplace policy and have paid any required premiums. Effectuated enrollment differs from plan selections in that some people who select a plan during the open enrollment period do not make their required premium payment, and their coverage does not become effective.

Limitations

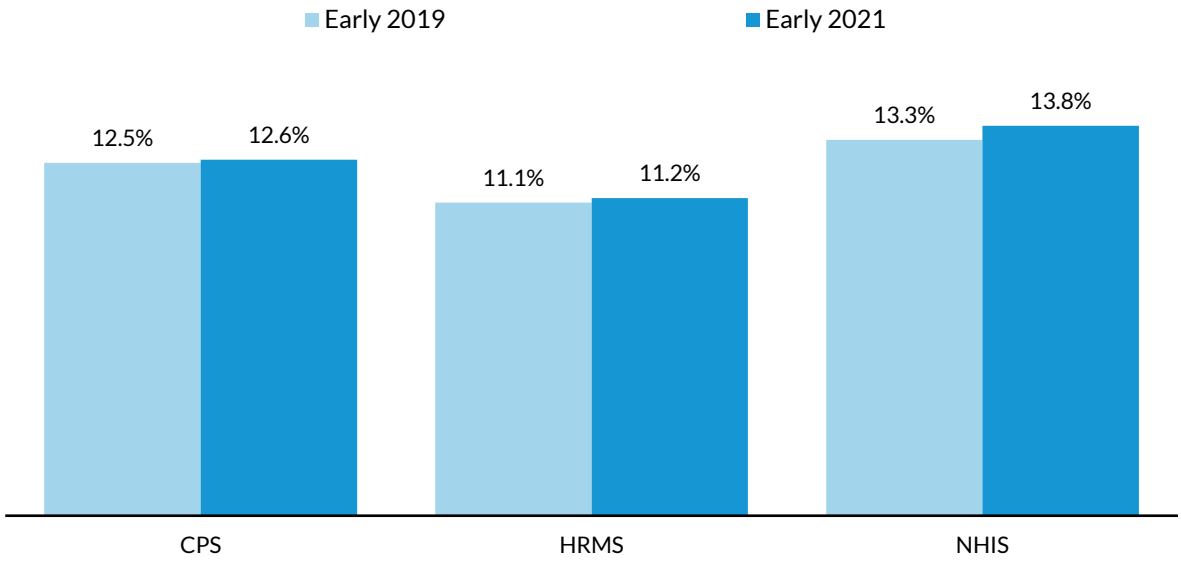
This analysis has several limitations; some predate the public health emergency and others were directly caused by it. First, comparing coverage estimates across surveys always presents challenges. The three surveys vary in the timing of their data collection; in their classification of specific coverage types into public and private categories; and in their designs, including question order and mode of data collection (SHADAC 2020). We do not report 2020 data to avoid the worst effects of the pandemic on data collection, but some nonresponse bias may linger into 2021 on all surveys. In addition, we can identify ESI separately from other private coverage in the HRMS and the CPS, but we cannot do so with the NHIS because of the data limitations of the Early Release reports. We therefore refer to "ESI/private insurance" when comparing private coverage in the NHIS with ESI coverage in the CPS and the HRMS. Further, despite our best efforts to produce comparable estimates, all coverage data are self-reported and subject to measurement error. Data from 2021 are not yet available from other major surveys of US health insurance coverage, including the American Community Survey, the Medical Expenditure Panel Survey, and the Behavioral Risk Factor Surveillance System.

Results

Across all three surveys, increases in uninsurance between early 2019 and early 2021 were small and statistically insignificant (figure 1). Uninsurance rates were relatively flat on both the CPS and the HRMS; they were 12.5 percent and 12.6 percent in March 2019 and March 2021 on the CPS and 11.1 percent and 11.2 percent in March 2019 and April 2021 on the HRMS. Both the uninsurance rates and the magnitude of the increases in such rates were somewhat larger on the NHIS; uninsurance grew from 13.3 to 13.8 percent from early 2019 to early 2021, but this increase was statistically insignificant.

FIGURE 1

Uninsured Share of Nonelderly Adults Ages 18 to 64, by Survey, Early 2019 and Early 2021



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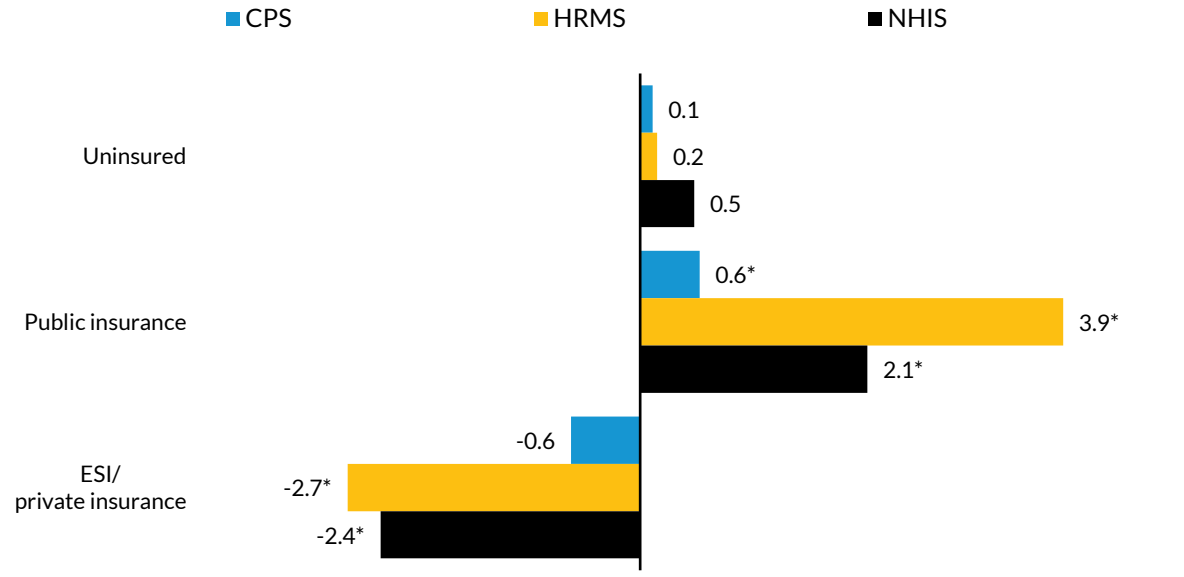
Sources: Current Population Survey (CPS) estimates are from authors' tabulations of public-use data. Health Reform Monitoring Survey (HRMS) estimates are from Michael Karpman and Stephen Zuckerman, "The Uninsurance Rate Held Steady during the Pandemic as Public Coverage Increased" (Washington, DC: Urban Institute, 2021). National Health Interview Survey (NHIS) estimates are from Robin A. Cohen and Amy E. Cha, "Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey, January–December 2019" (Hyattsville, MD: National Center for Health Statistics, 2020); and Robin A. Cohen and Amy E. Cha, "Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey, January 2020–March 2021" (Hyattsville, MD: National Center for Health Statistics, 2021).
Notes: All estimates are based on insurance status at the time of the interview. CPS estimates are from February to April of each year, and most interviews occurred in March. HRMS estimates are from March 2019 and April 2021. NHIS estimates are from the first quarter of each year (January through March). For all data sources, estimates for 2021 are not statistically different ($p > 0.05$) from those for 2019.

These small changes in uninsurance obscure some larger changes in underlying coverage sources (figure 2). Both the HRMS and the NHIS show meaningful declines in ESI/private insurance coverage from early 2019 to early 2021. The share of adults with ESI declined by 2.7 percentage points from March 2019 to April 2021 on the HRMS, whereas the rate of private coverage on the NHIS declined by 2.4 percentage points from the first quarter of 2019 to the first quarter of 2021. The CPS, however, showed a much smaller and statistically insignificant decline in ESI of 0.6 percentage points from March 2019 to March 2021. On all three surveys, increases in public insurance coverage largely offset declines in ESI/private coverage. The rate of public insurance coverage increased by 3.9 percentage points on the HRMS and by 2.1 percentage points on the NHIS,[6] but it increased by a much smaller amount, 0.6 percentage points, on the CPS.

FIGURE 2

Percentage-Point Change in Coverage Type among Nonelderly Adults Ages 18 to 64, by Survey, Early 2019 to Early 2021



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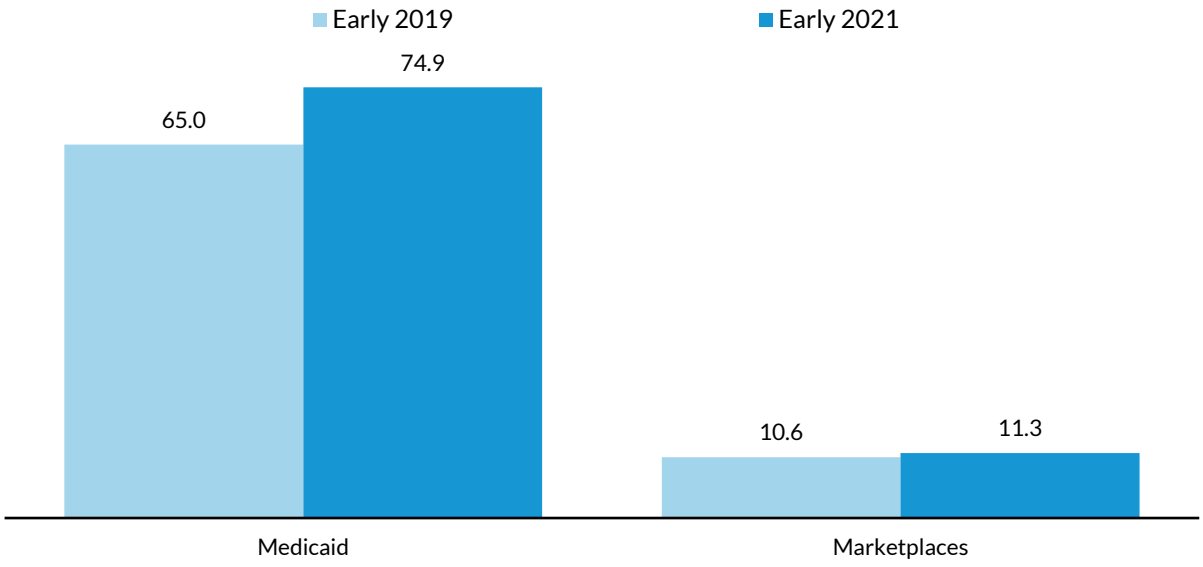
Sources: Current Population Survey (CPS) estimates are from authors' tabulations of public-use data. Health Reform Monitoring Survey (HRMS) estimates are from Michael Karpman and Stephen Zuckerman, "The Uninsurance Rate Held Steady during the Pandemic as Public Coverage Increased" (Washington, DC: Urban Institute, 2021). National Health Interview Survey (NHIS) estimates are from Robin A. Cohen and Amy E. Cha, "Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey, January–December 2019" (Hyattsville, MD: National Center for Health Statistics, 2020); and Robin A. Cohen and Amy E. Cha, "Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey, January 2020–March 2021" (Hyattsville, MD: National Center for Health Statistics, 2021).
Notes: ESI = employer-sponsored insurance. All estimates are based on insurance status at the time of the survey. CPS estimates are from February to April of each year, and most interviews occurred in March. HRMS estimates are from March 2019 and April 2021. NHIS estimates are from the first quarter of each year (January through March). The "ESI/private insurance" category reflects changes in ESI on the CPS and the HRMS, but it reflects changes in all private coverage on the NHIS. The CPS and the NHIS report some people with both public coverage and ESI or private coverage. The HRMS reports each person in a single coverage category.
* Estimate is statistically different from zero ($p < 0.05$).

When we examine administrative data on Medicaid and Marketplace enrollment from early 2019 to early 2021, the patterns align more closely with those observed on the HRMS and the NHIS than those on the CPS. Medicaid enrollment increased by more than 9.9 million people, or more than 15 percent, between March 2019 and March 2021, whereas enrollment in the Marketplaces increased by more than 700,000 people, or 6.7 percent, between February 2019 and February 2021 (figure 3).[7] The increase in Marketplace enrollment may contribute to the decline in private coverage observed on the NHIS being somewhat smaller than the decline in ESI only observed on the HRMS.

FIGURE 3

Medicaid and Marketplace Enrollment, Early 2019 and Early 2021

Millions of people



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Sources: Medicaid and Children's Health Insurance Program enrollment trend snapshots and Marketplace effectuated enrollment reports from the Centers for Medicare & Medicaid Services.
Notes: Medicaid enrollment estimates are for March of each year and include adults and children but exclude Children's Health Insurance Program enrollment. Marketplace estimates reflect total effectuated enrollment in both the state-based and federal Marketplaces for February of each year.

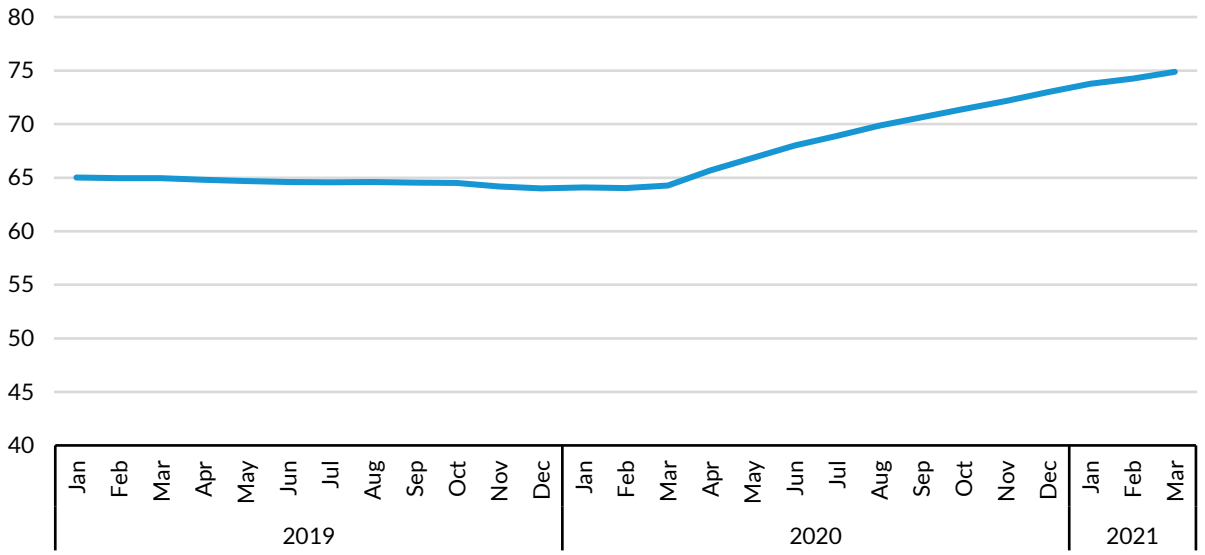
Medicaid enrollment increases coincided with the Families First Coronavirus Response Act's continuous coverage requirement. In exchange for an enhanced federal match, this requirement prevents states from disenrolling beneficiaries from Medicaid while the public health emergency is in place, and Medicaid enrollment has increased steadily since the law was passed in March 2020 (figure 4). Marketplace enrollment was also notably more stable in 2020 than in recent years prior; Marketplace enrollment declined beginning in about April of 2018 and 2019 but remained more stable throughout 2020 (figure 5). This likely reflects (1) less attrition among people who enroll during the annual open enrollment period and (2) more people signing up for Marketplace plans outside of that

window either because of new qualifying life events during the pandemic, like losing ESI, or because many state-based Marketplaces opened special enrollment periods in 2020.[8]

FIGURE 4

Monthly Medicaid Enrollment, January 2019 to March 2021

Millions of people



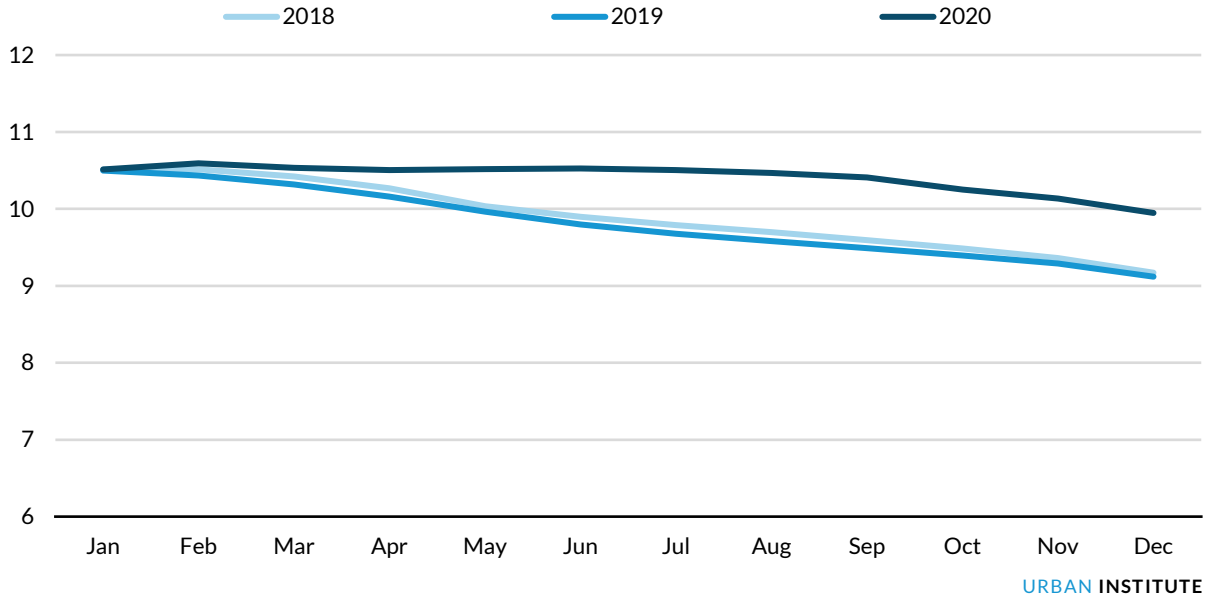
Source: Medicaid and Children's Health Insurance Program enrollment trend snapshots from the Centers for Medicare & Medicaid Services.

Note: Enrollment includes adults and children but excludes enrollment in the Children's Health Insurance Program.

FIGURE 5

Monthly Marketplace Enrollment, January 2018 to December 2020

Millions of people



Source: Effectuated enrollment reports from the Centers for Medicare & Medicaid Services.
Note: Marketplace estimates reflect total effectuated enrollment for both the state-based and federal Marketplaces.

Though no comprehensive administrative data source tracks ESI enrollment, several sources appear to confirm a significant decline in group health insurance enrollment between 2019 and 2021. Ruhter and colleagues (2021) reported a decline in group health insurance enrollment of about 2.3 million people between January 2019 and January 2021 based on Interstudy data. Estimates from Mark Farrah Associates indicate a decline in ESI enrollment of about 3.3 million people between December 2019 and December 2020 across both full-risk and administrative-services-only employer plans.[9] Using midyear estimates for June 2019 and June 2021,[10] a longer period that aligns better with our survey estimates, the estimated decline in ESI was about 4.6 million enrollees.[11] Assuming a denominator of about 201 million nonelderly adults,[12] implied estimates of 5.5 million nonelderly adults losing ESI from the HRMS and 4.8 million losing private coverage from the NHIS between early 2019 and early 2021 are relatively consistent with the highest estimate from these other data sources.

Discussion

Data from the NHIS, the CPS, and the HRMS show that the uninsurance rate remained relatively flat between early 2019 and early 2021, suggesting that the 2020 increase in uninsurance of about 2.7 million nonelderly adults found on the Household Pulse Survey was fleeting. Our analysis of the NHIS and the HRMS also finds substantial gains in public coverage that largely offset significant losses in ESI/private coverage between early 2019 and early 2021. Estimates from the CPS also suggest offsetting public coverage gains and ESI losses, but the magnitudes are less remarkable than those on

the other surveys. The estimated increase in public coverage on the CPS was only 0.6 percentage points, compared with 2.1 percentage points on the NHIS and 3.9 percentage points on the HRMS. Moreover, administrative data on Medicaid and ESI appear to support the larger changes indicated by the NHIS and the HRMS. Together, these findings suggest the health insurance safety net successfully prevented a lasting rise in uninsurance about a year after the pandemic began.

Our findings also underscore the importance of the various enhancements to the safety net instituted during the pandemic. In aggregate, gains in Medicaid coverage largely offset significant losses of employer coverage. However, these shifts in aggregate numbers do not mean the same people who lost ESI also gained Medicaid. Evidence suggests much of the increase in Medicaid enrollment during the pandemic was not from new enrollees but rather existing enrollees maintaining their coverage (Dague et al. 2022).[13] Moreover, estimates from the Commonwealth Fund suggest that among the 6 percent of adults who lost ESI since the start of the pandemic, one-third remained uninsured in mid-2021, whereas about half had regained ESI or other private coverage, and only about 16 percent had enrolled in Medicaid (Collins, Aboulafia, and Gunja 2021). Without the Families First Coronavirus Response Act protections that allowed Medicaid beneficiaries to stay enrolled in the program, the observed pattern among people losing ESI would almost certainly have resulted in a significant increase in uninsurance through early 2021.

The American Rescue Plan Act, passed in March 2021, has important implications for coverage patterns at the end of 2021 and in 2022. The law included several provisions aimed at making coverage more affordable, most notably the establishment of more generous federal subsidies for Marketplace coverage.[14] Administrative data suggest Marketplace enrollment has grown considerably since the law was enacted. During the February to August 2021 special enrollment period, during which the American Rescue Plan Act's enhanced subsidies were in place for the first time, more than 2.8 million Americans signed up for Marketplace coverage; this number is in addition to the number of people who had already signed up during the annual open enrollment period ending in December 2020.[15] By August 2021, effectuated Marketplace enrollment was about 12.2 million, an increase of more than 1.5 million relative to August 2020.[16] Based on evidence from the 2022 open enrollment period, during which 14.5 million plan selections were made between November 1, 2021, and January 15, 2022, Marketplace enrollment patterns in early 2022 appear similarly strong.[17]

Medicaid enrollment was also still growing in July 2021, the date of the most recent available estimates.[18] Together, administrative data on both Medicaid and Marketplace enrollment suggest uninsurance may have been lower at the end of 2021 than it was at the start. The most recent NHIS estimates suggest uninsurance among nonelderly adults declined from 13.8 percent in the first quarter of 2021 to 13.0 percent in the third quarter, but the decline does not appear to be statistically significant (Cohen and Cha 2022). Household Pulse Survey estimates also suggest a decline in uninsurance between April and October 2021 but no further declines through early 2022.[19]

Ultimately, the health insurance safety net, including Medicaid and subsidized Marketplace coverage enhanced by the Families First Coronavirus Response Act and the American Rescue Plan Act, has largely prevented the catastrophic coverage losses feared at the outset of the pandemic. It also may

have further reduced uninsurance from prepandemic levels. However, the approaching expiration of the continuous coverage requirement has considerable implications for Medicaid enrollees. Assuming the requirement would expire at the end of 2021 and that the enhanced federal matching rate would expire in March 2022, Buettgens and Green (2021) found that Medicaid enrollment could decline by as many as 15 million people in the year following the requirement's termination. However, the authors also found that almost two-thirds of children and roughly one-third of adults losing Medicaid coverage could qualify for CHIP or subsidized private health coverage in the Marketplaces. This implies that coordination between state Medicaid agencies and the Marketplaces will be critical to avoid large coverage losses (Corlette et al. 2022). State policymakers have also noted that setting a specific date for the expiration of the continuous coverage requirement, rather than relying on the uncertain end of the public health emergency, would help states plan for resuming their redetermination processes.[20] Experts also suggest that timely public reporting of call center statistics and disenrollments for procedural reasons will be essential to monitoring the requirement's rollback and will allow states to react quickly to avoid disenrolling people who remain eligible for Medicaid.[21]

In November 2021, the House passed the Build Back Better Act, which would extend the American Rescue Plan Act's enhanced Marketplace subsidies currently set to expire at the end of 2022 and would fill the Medicaid coverage gap by extending eligibility for Marketplace subsidies to people with incomes below the federal poverty level in the 12 states that have not yet expanded Medicaid.[22] Urban Institute research has documented these provisions' potential to reduce uninsurance: If both provisions were made permanent, as many as 7.0 million fewer people would be uninsured in 2022 than in the absence of the American Rescue Plan Act (Banthin, Simpson, and Green 2021). Even if only the subsidies were made permanent, as many as 4.2 million fewer people would be uninsured in 2022 (Banthin et al. 2021). Moreover, the bill would provide enhanced federal Medicaid funding for states that make "good faith efforts" to avoid disenrollments due to administrative burdens (Schpero and Ndumele 2022). However, as noted, the legislation has stalled in the Senate, and its future is uncertain. Consequently, some current Marketplace enrollees will lose their enhanced subsidies when they expire at the end of 2022, and adults with incomes below the federal poverty level in states that have not expanded Medicaid will continue to have few options for affordable coverage. Moreover, administrative hurdles to getting and staying enrolled and restrictions that exclude millions of immigrants from eligibility for any subsidized coverage will continue to present challenges to reaching universal coverage. The pandemic has demonstrated the importance of the health insurance safety net in the US, but addressing its remaining weaknesses will be critical for continuing to lower the uninsurance rate.

Notes

1 "Where Low-Income Jobs Are Being Lost to COVID-19," Urban Institute, last updated August 6, 2021, https://www.urban.org/features/where-low-income-jobs-are-being-lost-covid-19.

2 US Bureau of Labor Statistics, "The Employment Situation – June 2020," news release, July 2, 2020, https://www.bls.gov/news.release/archives/empsit_07022020.pdf.

[3] "Household Pulse Survey: Measuring Social and Economic Impacts during the Coronavirus Pandemic," US Census Bureau, last revised January 21, 2022, https://www.census.gov/householdpulse.

[4] We also consider people reporting only Indian Health Service coverage or a single-service insurance plan (e.g., dental, accidents) to be uninsured.

[5] See "Medicaid and CHIP Eligibility and Enrollment Performance Indicators: Data Dictionary," Centers for Medicare & Medicaid Services, May 20, 2014, https://www.medicaid.gov/medicaid/downloads/performance-indicators-datadictionary.pdf; and July 2021 data available from "Medicaid and CHIP Enrollment Trend Snapshot," Medicaid.gov, accessed February 7, 2022, https://www.medicaid.gov/medicaid/program-information/medicaid-chip-enrollment-data/medicaid-and-chip-enrollment-trend-snapshot/index.html.

[6] The estimated increase in public coverage on the HRMS might be inflated by an anomalous result for unspecified coverage in 2019. For details, see Karpman and Zuckerman (2021).

[7] These estimates include enrollment for adults and children, but where separate estimates are available for adults only, the patterns are similar. See "May 2021 Medicaid and CHIP Enrollment Trends Snapshot," Centers for Medicare & Medicaid Services, Center for Medicaid and CHIP Services, and Medicaid and CHIP Learning Collaboratives, accessed February 7, 2022, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/downloads/may-2021-medicaid-chip-enrollment-trend-snapshot.pdf; and "Marketplace Plan Selections by Age," Kaiser Family Foundation, accessed February 7, 2021, https://www.kff.org/health-reform/state-indicator/marketplace-plan-selection-by-age/.

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[12] The American Community Survey estimates the number of nonelderly adults ages 18 to 64 in 2019 was 201,197,710.

[13] Centers for Medicare & Medicaid Services, "CMS Releases August Medicaid and CHIP Enrollment Trends Snapshot Showing Continued Enrollment Growth," news release, December 21, 2020, https://www.cms.gov/newsroom/press-releases/cms-releases-august-medicaid-and-chip-enrollment-trends-snapshot-showing-continued-enrollment-growth; and Centers for Medicare & Medicaid Services, "New Medicaid and CHIP Enrollment Snapshot Shows Almost 10 Million Americans Enrolled in Coverage during the COVID-19 Public Health Emergency," news release, June 21, 2021, https://www.cms.gov/newsroom/press-releases/new-medicaid-and-chip-enrollment-snapshot-shows-almost-10-million-americans-enrolled-coverage-during.

[14] Premium contributions for a benchmark silver plan for people with incomes below 150 percent of the federal poverty level (FPL) were reduced to zero; required premium contributions were significantly reduced for people 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. The law also made people receiving unemployment compensation eligible for enhanced subsidies.

[15] The 2021 special enrollment period ran from February 15 to August 15, 2021, in the 36 states that use the HealthCare.gov platform. Special enrollment period dates varied for the 15 states that use state-based

Marketplaces. HealthCare.gov implemented the enhanced subsidies from the American Rescue Plan Act on April 1, 2021. See "2021 Final Marketplace Special Enrollment Period Report," Centers for Medicare & Medicaid Services, accessed February 7, 2022, https://www.hhs.gov/sites/default/files/2021-sep-final-enrollment-report.pdf.

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Research Letter | Health Policy

Changes in Coverage and Cost-Related Delays in Care for Latino Individuals After Elimination of the Affordable Care Act's Individual Mandate

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Introduction

The Patient Protection and Affordable Care Act (ACA) has been associated with improvements in health insurance coverage and access to care. However, inequities persist.[1] Studies show that while Latino individuals had significant gains in insurance coverage and access to care, they lag far behind non-Latino Black and White populations.[1-4] Since 2010, several changes have occurred in the ACA because of legislative, executive, and court actions. It is important to continue assessing its progress in improving insurance coverage for all US residents and to monitor health care inequities. We analyzed 2019 National Health Interview Survey (NHIS) data[5] and compared observations with prior periods to examine whether improvements in insurance coverage and access to care continued for Black, Latino, and White populations after the 2019 elimination of the individual mandate.

Methods

In this cross-sectional study, we grouped 2011-2019 NHIS data by the period before the national ACA implementation (2011-2013), the start of the ACA implementation (2014-2015), the implementation of the health insurance mandate (2016-2018), and the year the individual mandate was eliminated (2019). We limited the sample to participants aged 18 to 64 years. All results were nationally representative. Since NHIS is publicly available with deidentified observations, the Drexel University human research protection program deemed it exempt from institutional review board approval. This study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline for cross-sectional studies.

We estimated weighted predictive probabilities for the following 4 measures according to self-reported race and ethnicity during the 4 periods: (1) being currently uninsured, (2) having a usual source of care, (3) any emergency department (ED) visit in the past year, and (4) any delay of care due to cost in the past year. Usual source of care is a global measure that does not differentiate types of care. Confidence intervals were used to measure uncertainty. Data analyses were performed using Stata statistical software, version 16.0 (StataCorp LLC).

Results

Our final sample using NHIS 2011 to 2018 data included 318 056 adults (mean [SD] age, 41.5 [13.1] years). The unweighted sample consisted of 50 104 (15.8%) Black, 64 073 (20.2%) Latino, and 203 879 (64.1%) White individuals; 172 921 (54.4%) were females. Our final sample using NHIS 2019 data included 20 600 adults (mean [SD] age, 43.2 [13.2] years). The unweighted sample for 2019 consisted of 2664 (12.9%) Black, 3516 (17.1%) Latino, and 14 420 (70.0%) White individuals; 10 765 (52.3%) were females.

The percentage of uninsured individuals decreased from the period before the ACA was implemented (19.5% in 2011-2013) until the period when the individual insurance mandate was enforced (12.3% in 2016-2018). However, in 2019, the year the mandate was eliminated, there was a 3–percentage-point increase from the prior period in the probability of being uninsured for everyone

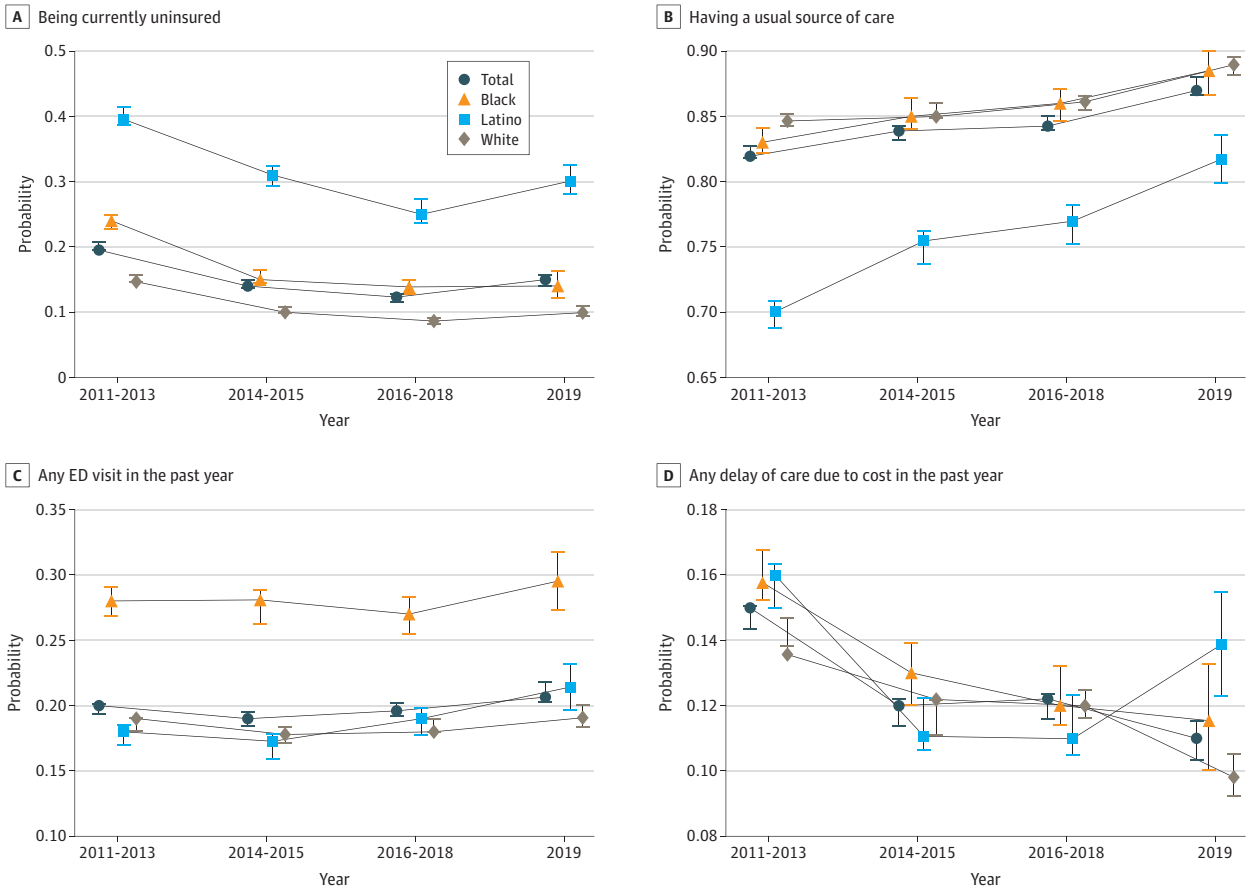
(from 12.3% to 15.0%) (**Figure**). Between the periods of 2016-2018 and 2019, Latino persons had a 5-percentage-point increase in the probability of being uninsured (from 25.0% to 30.1%), and that probability was more than double the probability for Black (14.0%) and White (9.9%) populations in 2019. For ED visits, Black and Latino populations experienced a 3-percentage point and 2-percentage point increase between 2016-2018 and 2019 (Black individuals, from 27.0% to 29.5%; Latino individuals, from 19.0% to 21.4%).

Latino populations had a 5-percentage-point increase in the probability of having a usual source of care between 2016-2018 and 2019 (from 77.0% to 81.7%). They also had an increase in the probability of any delay of care due to cost between these periods (from 11.0% to 13.9%); the probability of delay for Black and White populations decreased (Black individuals, from 12.0% to 11.5%; White individuals, from 12.0% to 9.8%).

Discussion

When we compared observations from the period when the health insurance mandate penalty was in full effect (2016-2018) and the year the mandate was eliminated (2019), we observed that the Latino population had an increase in the probabilities of being uninsured, having an ED visit, and delaying care due to cost, despite an increase in the probability of having a usual source of care.

Figure. Weighted Probabilities of Self-reported Health Care Access and Utilization by Race and Ethnicity Among Adults Aged 18 to 64 Years



Data are from the 2011-2019 National Health Interview Survey (NHIS). All analyses used weighted predictive probabilities. For each data point, 95% CIs are included to show the measure of uncertainty. Results are nationally representative. The Total category includes Black, Latino, and White population groups. The unweighted total number of respondents was 198 514, which consisted of 29 340 Black, 37 670 Latino, and 131 504 White individuals. The NHIS weighting process was updated in the 2019 questionnaire redesign; 2019 NHIS sampling weights were applied to the 2019 period in our analyses. Usual source of care is a global measure that does not differentiate types of care.

However, usual source of care did not differentiate by types of care. A reversal in these health care equity indicators for Latino populations is evident from these findings.

The elimination of the ACA health insurance mandate may partially explain the increase in the probability of being uninsured for everyone. For Latino populations, the chilling effects of the Trump administration's public charge regulations and other policies restricting public benefits for immigrants could have played important roles. Policies to reduce out-of-pocket costs, including the continued availability of cost-sharing reductions and enhanced premium tax credits from the 2021-2022 American Rescue Plan, should be continued to address delays in care due to costs.[6] A limitation of this study is that we did not look at state policy differences. Nevertheless, the findings of this cross-sectional study suggest that encouraging states to expand Medicaid and bolster the health care safety net to improve community-based services will also be beneficial in reversing health care inequities for Latino populations.

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RESEARCH ARTICLE | AFFORDABLE CARE ACT

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Marketplace Health Insurance Ratings: Most Potential Enrollees Have Access To Plans Of Medium Or High Quality

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Abstract

The Affordable Care Act (ACA) Marketplace plays a critical role in providing affordable health insurance for the nongroup market, yet the accessibility of plans from insurers

with high quality ratings has not been investigated. Our analysis of recently released insurer quality star ratings for plan year 2020 found substantial variation in access to high rated plans in the federally facilitated ACA Marketplace. In most participating counties (1,390 of 2,265, or 61.4 percent), the highest-rated ACA Marketplace insurer had a three-star rating. Fewer than one-third of counties (703, or 31.0 percent) had access to four- or five-star-rated insurers. Fewer than 10 percent (172, or 7.6 percent) had access to only one- or two-star-rated insurers. In plan-based analyses, each one-point increase in star rating was associated with a $28 increase in the average monthly plan premium. Counties with the highest proportion of residents obtaining individual coverage through the ACA Marketplace and counties with more insurers were the most likely to have access to plans from high-rated insurers. We found no systematic racial or ethnic disparities in access to plans from high-rated insurers. Policy makers should continue to monitor the quality of available health plans.

TOPICS

ACCESS TO CARE | RATING | QUALITY OF CARE | HEALTH INSURANCE EXCHANGES | AFFORDABLE CARE ACT | PREMIUMS | MARKETS

A key goal of the Affordable Care Act (ACA) is to improve access for all to health insurance coverage that is both affordable and of high quality. In 2020 more than eight million consumers in thirty-eight states obtained health coverage on the federally facilitated ACA Marketplace, and another three million obtained coverage on state-based Marketplaces.[1] Although health plan quality ratings were mandated in the ACA, delays in development prevented ratings covering a national set of health plans from being made publicly available until open enrollment began for the 2020 plan year.[2]

With the development of the ACA Marketplace Quality Rating System, quality ratings ranging from one to five stars now appear alongside listings of plans on HealthCare.gov, with the goal of empowering consumers to make better-informed health insurance decisions while also incentivizing improvement of health plan quality through public reporting. For the first time on the Marketplace, consumers have the opportunity to assess information on the cost and the quality of a plan to make informed enrollment decisions based on a plan's overall value. These data also allow consumers to assess trade-offs among the breadth of coverage, cost of premiums, and quality of Marketplace plans.

The ACA Marketplace Quality Rating System rates plans from one to five stars by creating a composite score across forty-one quality measures within three domains:

medical care, primarily measured by process measures; member experience, assessed by the Consumer Assessment of Healthcare Providers and Systems survey; and plan administration, judged on the basis of customer service, customers' access to information, and appropriateness of care use.[3,4]

With increasing enrollment in the Marketplace, it is unknown whether there is equitable access to plans from high-rated insurers.[5,6] If counties with a higher concentration of impoverished or racial and ethnic minority customers have access only to plans from lower-rated insurers, then underlying disparities in health care access could be exacerbated. Empirical data on whether disparities in access to high-quality insurers exist would be helpful for policy makers as they develop incentives and regulations to improve access to high-rated insurers.

In this study we used recently released ACA Marketplace Quality Rating System data to examine three main questions. First, what is the variation in quality star ratings across US counties, and, related, what are the characteristics of counties with access to plans from low-, medium-, and high-rated insurers? Second, is there a relationship between premiums and quality star ratings? Last, what factors are the predictors of county-level access to high-rated plans?

Study Data And Methods

Data

For plans offered on the federally facilitated ACA Marketplace, quality ratings from the plan year 2020 Nationwide Quality Rating System Public Use File (NatQRS-PUF) were merged with premium and actuarial value information from the plan year 2020 Qualified Health Plan Landscape Medical Individual Market File.[7] The NatQRS-PUF contained data on thirty-eight states, but we included thirty-five states in our analyses based on the availability of quality ratings and premium data from the Quality Rating System Landscape and Public Use File. State-based Marketplaces using state-based platforms are not included in the plan-level NatQRS-PUF and were excluded from this analysis. State-based Marketplaces using the federal platform were aggregated with states using the federally facilitated Marketplace; this group of states is referred to as the federally facilitated Marketplace for brevity. County-level demographic and market characteristics were obtained from the 2020 Area Health Resources File from the Health Resources and Services Administration.[8]

Quality ratings, first released at the beginning of plan year 2020 open enrollment, were assigned only to plans that had been available in the Marketplace for at least three years

and had at least 500 enrollees in the prior year. As we looked at the data, we found that 15,331 plans, or 28 percent of plans on the federally facilitated Marketplace, did not have available quality ratings in the plan year 2020 file. As a result of the COVID-19 pandemic, quality ratings were not released for plan year 2021 and were instead based on plan year 2020 ratings (performance data from 2019). Details of the measures included in the Quality Rating System are in online appendix exhibit 1.[9] Quality ratings are assigned at the insurer level such that all plan types (health maintenance organization [HMO], preferred provider organization [PPO], and so on) offered by the same insurer have the same rating. Accordingly, in our analyses, references to low-, medium-, or high-rated plans therefore apply to plans offered by low-, medium-, or high-rated insurers.

Variables

Our main dependent variable was the quality rating ("star rating") of the highest-rated insurer in each county on the federally facilitated ACA Marketplace. Within a rating area, insurers offer plans at the county level; therefore, we chose the county as the main unit of analysis. We chose the highest star rating in each county as our outcome as opposed to the average star rating, as we wanted to assess disparities in access to high-rated plans.

Our main predictors for the star rating of an insurer's plan were actuarial value and premiums. Insurers calculate premiums on the basis of age, tobacco use, family composition, and the residence of the individual, which are defined for a given geographic unit known as community rating areas. Given that premiums vary by age and health status within each plan, we defined the plan premium as the premium for a twenty-seven-year-old nonsmoker before Advance Premium Tax Credits, in line with prior studies of ACA Marketplace premiums.[10,11] When an insurer offered multiple plan types (HMO, PPO, and so on), these plan types were considered separately, as they could have different actuarial values (also called metal levels). Actuarial values reflect the proportion of covered medical costs paid by an insurer. Actuarial values for the metal levels are platinum (90 percent), gold (80 percent), silver (70 percent), and bronze (60 percent).

Market-level factors included the number of rated insurers in each county, the percentage of county residents who were uninsured, and the percentage of county residents who obtained coverage in the nongroup market through the ACA federally facilitated Marketplace (hereafter referred to as the percentage of Marketplace enrollees) in each county. Health care supply variables included the total number of physicians and of hospital beds per 10,000 residents in each county. Socioeconomic factors included deep poverty, which was defined as the percentage of county residents with income less than

half of the federal poverty threshold, and education, which was defined as the percentage of residents in the county with a college degree or higher. The racial composition variable was the percentage of Black residents in the county, and the ethnic composition variable was the percentage of Hispanic residents in the county. These variables were as defined in the Area Health Resources File and derived from census data; they were not altered for this analysis. We focused on Black and Hispanic residents based on sample size and on existing literature on disparities in insurance access for these populations.[12,13] The geographic variable was a dichotomous urban/rural county-level measure from the Medicare core-based statistical area definition.[14]

Analyses

We first aggregated plans by county and created a county-level map showing the variations of maximum star ratings across counties in the federally facilitated Marketplace. Then we looked at the characteristics of counties that had access to low-, medium-, and high-rated plans.

We next assessed the relationship between plan premiums and star ratings, using two plan-level linear regressions. In the first regression we assessed the change in premiu associated with each unit increase in star rating, with a model in which rating was tre as a continuous predictor, adjusting for actuarial value, plan type, and out-of-pocket maximum. One-star plans were excluded from this regression because these plans were all offered by the same insurer, which was located in West Virginia. In the second regression we treated star rating as a categorical predictor and estimated the average premium at each star rating, adjusted for actuarial value, plan type, and out-of-pocket maximum.

Next we assessed predictors of county-level access to plans from high-rated insurers. We divided counties into three groups: counties with access to only plans from low-rated (one to two stars), those with access to medium-rated (three stars), and those with access to high-rated (four to five stars) insurers. We then assessed the distribution of each explanatory variable across these categories by calculating the median and interquartile range of each variable, stratified by access to low-, medium-, and high-rated insurers. Five small counties without available demographic information were excluded.

We then created a multivariate ordinal logistic regression model to assess the independent relationship of market-level, health care supply, socioeconomic, racial and ethnic composition, and geographic factors with the probability of having access to plans from high-rated insurers. The predictor in this regression was the highest-rated insurer offering plans in the county. To capture potentially nonlinear relationships

between variables and star ratings, we categorized predictor variables as quartiles across all counties included in the analysis; the lowest quartile served as the reference group. The first, second, third, and fourth quartiles are referred to throughout as the lowest, low, high, and highest quartiles, respectively, for ease of presentation. The results are presented as adjusted odds ratios and 95% confidence intervals comparing each quartile with the reference group. On the basis of our ordinal logistic regression approach, the model estimates the adjusted odds ratio of access to a five-star plan compared with access to plans rated four stars or lower, or access to four- or five-star plans compared with access to plans rated three stars or lower, and so on for each unit increase of the relevant county-level market, health care supply, socioeconomic, and racial and ethnic composition factor. Our regression model was weighted by the county-level population. Because of concerns of multiple hypothesis testing with the variables in our multivariable model, we applied a Bonferroni correction, and a p value less than 0.0045 was considered significant. Details of the model outputs are in appendix exhibit 2.[9] All analyses were performed in R, version 3.6.2.

Sensitivity Analyses

We created additional county-level maps of insurer counts and plan premiums, using second-lowest silver premium in a county for a twenty-seven-year-old nonsmoker as t benchmark premium. We performed a sensitivity analysis of the relationship between plan ratings and premiums by constructing new regression models that adjusted not only for metal level, plan type, and out-of-pocket maximum but also for rating-area fixed and random effects to assess between- and within-rating-area variations. We also performed a sensitivity analysis in which the outcome was the star rating of the second-lowest-cost silver plan in the county to coincide with the benchmark premium plan. However, as every insurer offered a silver plan in each county and the star ratings for all plan types offered by a given insurer are the same across actuarial values, these results were the same as those of our main analyses. Results from this sensitivity analysis therefore are not shown. Given that one- and five-star plans were offered in only one state each during plan year 2019, we reran our multivariable logistic regression excluding all one- and five-star plans to test whether this small subset of plans was skewing results. We also performed a sensitivity analysis with an interaction term between proportion of Black residents and rurality to assess for the interaction of race with rurality on access to high-rated health plans. Finally, to assess for potential biases in the relationship between rurality and plan ratings, we performed a sensitivity analysis interacting the rurality of the county with the insurer count.

Limitations

This study had several limitations. First, the plan landscape and star ratings data sets included only plans in the thirty-eight states that use the federally facilitated ACA Marketplace. These results might not extend to the individual Marketplaces managed by other states. State-based Marketplaces were more likely to have access to five-star insurers and less likely to have only one insurer, but overall the distribution of plans and insurers in these states appears similar to that in states on the federally facilitated Marketplace (appendix exhibit 3).[9] Second, plans must be offered on the ACA Marketplace for at least three years before receiving a star rating. As such, newer plans are excluded from these analyses, and recent shifts in the characteristics of ACA Marketplace plans might not be captured. In addition, rural counties with few insurers may be disproportionately affected by missing quality ratings as a result of insurer exit and entry or not meeting enrollment thresholds for inclusion in the Quality Rating System.

Third, the Centers for Medicare and Medicaid Services (CMS) insurer file included a one-star insurer in New Mexico, but the plan landscape file did not include any plans from this insurer, and therefore it did not appear in our analyses. We are unaware of any other data discrepancies, but we were dependent on CMS for the completeness and validity of the data we analyzed. Fourth, actuarial values reflect a range of values within a given met level, but for ease of presentation, we categorized the actuarial value by the metal lev Fifth, we chose to display premiums before application of Advance Premium Tax Credits ("subsidies") to make our results more generalizable without assumptions of subsidy amounts. Therefore, the effect size of the relationship between plan rating and premium may be higher than that experienced by enrollees after subsidies are applied. Sixth, because individual-level data on plan selections are not publicly available, we could not assess the actual variation in plan enrollment by race or ethnicity. Last, our investigation of racial and ethnic disparities was limited to Hispanic and Black residents.

Study Results

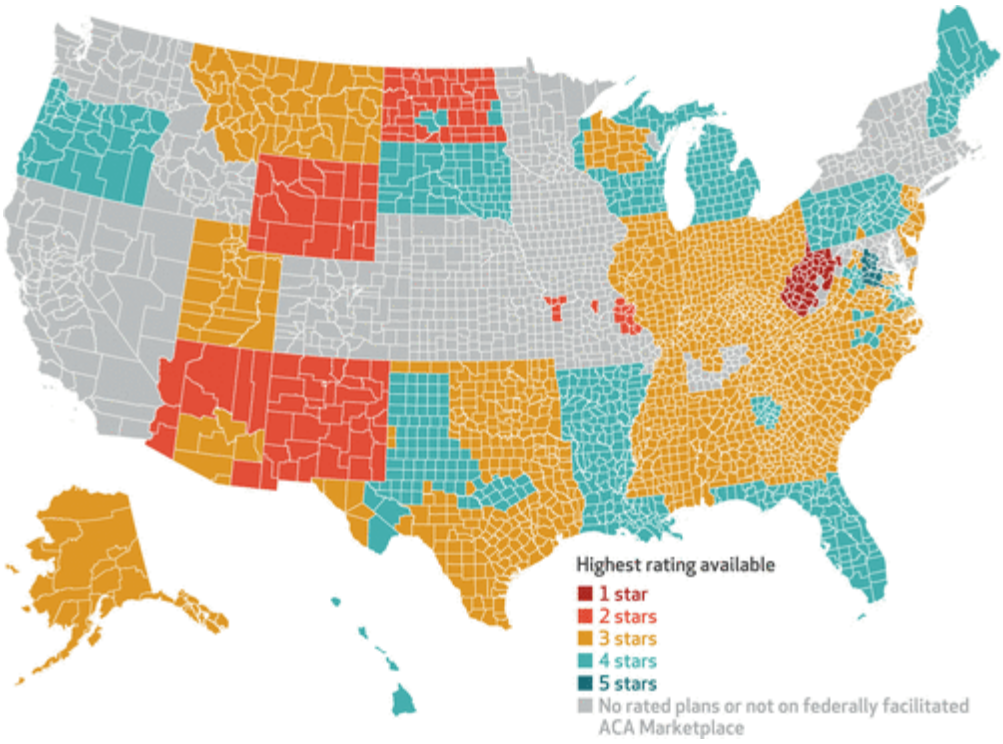
Geographic Variation In Star Ratings Across Counties

A total of 38,562 plans with ratings on the federally facilitated ACA Marketplace were offered in 2,265 counties in thirty-five states. In most counties (1,390, or 61.4 percent) the highest-rated plans were three-star plans. Fewer than one-third of counties (703, or 31.0 percent) had access to plans from insurers with four- or five-star ratings. Fewer than 10 percent (172, or 7.6 percent) had access to only one- or two-star-rated insurers. About half (50.5 percent) of Marketplace enrollees lived in counties where the highest-rated

insurer offering plans had a three-star rating, although 46.0 percent had access to at least one insurer offering four- or five-star-rated plans (data not shown).

Counties within a state or region tended to have access to plans from insurers of similar quality (exhibit 1). The only insurer in West Virginia had a one-star rating, and only Virginia had plans from a five-star insurer. The benchmark plan premiums and number of Marketplace insurers per county also varied predominantly across states rather than within states (appendix exhibit 4).[9]

Exhibit 1 Geographic variation in access to high-rated health plans on the federally facilitated Affordable Care Act (ACA) Marketplace, 2020



SOURCE Authors' analysis of data from the plan year 2020 Nationwide Quality Rating System Public Use File, Centers for Medicare and Medicaid Services. NOTE Data reflect states in the federally facilitated Marketplace as well as state-based Marketplaces using the federal platform in 2020.

Characteristics Of Counties By Access To Low-, Medium-, And High-Rated Plans

Plans from high-rated insurers tended to be in more populous counties than those from medium- and low-rated insurers; the median population of a county with access to high-rated plans was 32,500 residents compared with 28,200 and 18,100 residents for medium- and low-rated plans, respectively. The number of insurers offering plans in a

county was strongly associated with access to high-rated plans: 65.6 percent of counties with access to high-rated plans had three or more insurers, whereas just 6.6 percent of counties with access only to low-rated plans had three or more insurers. Counties with access to high-rated plans were associated with greater health care supply, with a median of twenty-five physicians per 10,000 residents and sixty-two hospital beds per 10,000 residents compared with a median of eleven physicians and forty-three hospital beds per 10,000 residents in counties with access only to low-rated plans. There did not appear to be a monotonic relationship between star ratings and the percentage of county residents in deep poverty or the percentage of residents with college degrees (exhibit 2).

Exhibit 2 Characteristics of counties by access to low-, medium-, and high-rated plans on the federally facilitated Affordable Care Act (ACA) Marketplace, 2020

	Highest star rating available in county		
	Low-rated (1–2 stars)	Medium-rated (3 stars)	High-rated (4–5 stars)
Median population (thousands of residents)	18.1	28.2	32.5
3 or more insurers offering plans (%)	6.6	31.2	65.6
Market factors			
Rated insurers, mean (no.)	1.4	1.6	2.7
Uninsured, median (%)	10.0	12.3	9.8
Marketplace enrollees, median (%)	3.5	3.7	4.0
Health care supply factors			
Total MDs per 10,000 residents, median (no.)	11	19	25
Hospital beds per 10,000 residents, median (no.)	43	47	62

	Highest star rating available in county		
	Low-rated (1–2 stars)	Medium-rated (3 stars)	High-rated (4–5 stars)
Socioeconomic factors			
Residents in deep poverty, median (%)	**6.5**	**7.0**	**6.3**
Residents with college degree, median (%)	**13.6**	**11.7**	**13.7**
Racial and ethnic composition			
Black residents, median (%)	**0.6**	**4.7**	**2.9**
Hispanic residents, median (%)	**2.00**	**3.1**	**3.6**
Geography			
Rural (%)	**73.3**	**61.7**	**56.9**

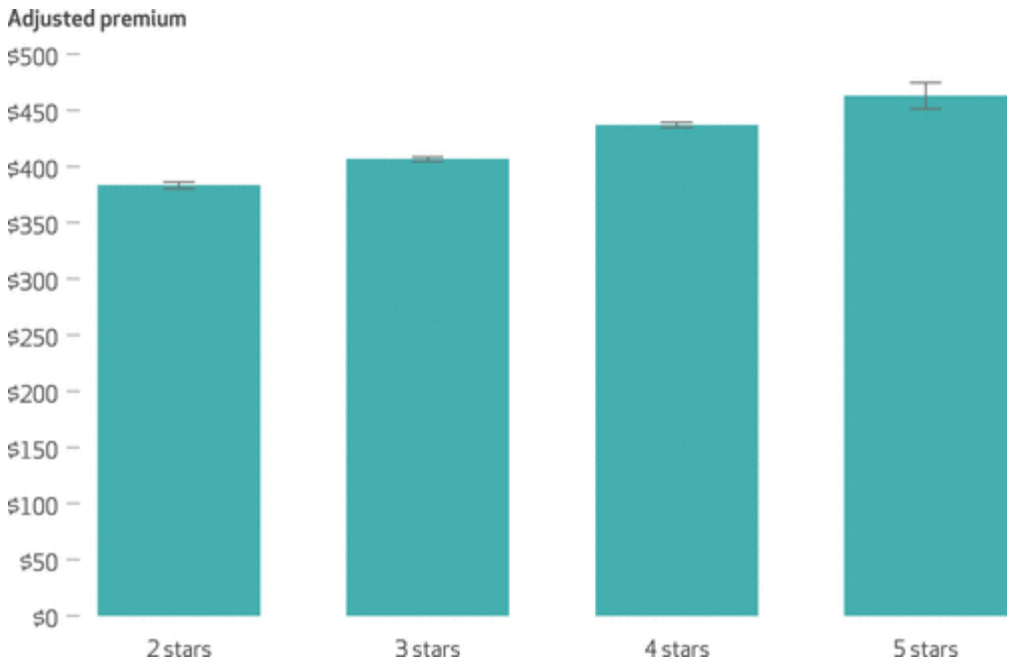
SOURCE Authors' analysis of data from the plan year 2020 Nationwide Quality Rating System Public Use File, Centers for Medicare and Medicaid Services, and from the Area Health Resources File, Health Resources and Services Administration, 2020. NOTES "Percent of Marketplace enrollees" refers to the percent of county residents who obtained coverage in the nongroup market through the federally facilitated ACA Marketplace. "Deep poverty" was defined as the proportion of county residents with income less than half of the federal poverty threshold. A county was defined as rural based on the Medicare core-based statistical area definition.

Counties with access only to low-rated plans had a lower median percentage of Black and Hispanic residents, but there was not a clear monotonic relationship across counties with access to low-, medium-, and high-rated plans. Counties with access to only to low-rated plans were predominantly rural: 73.3 percent of such counties were rural compared with 56.9 percent of counties with access to high-rated plans.

Association Of Star Ratings And Premiums

On average, high-rated plans tended to have higher monthly premiums (exhibit 3). Excluding plans in West Virginia, which had a single insurer with only one-star plans, each increase in plan quality star rating was associated with a $27.69 (95% CI: $26.28, $29.11, p<0.001) increase in average monthly premium (appendix exhibit 5).[9] This relationship was similar after we adjusted for rating-area fixed and random effects ($24.36 [p<0.001] and $24.50 [p<0.001], respectively) (appendix exhibit 5).[9] One-star plans, available exclusively in West Virginia, deviated from this trend with a high average monthly premium of $557 (data not shown).

Exhibit 3 Association between health plan star ratings and premiums on the federally facilitated Affordable Care Act (ACA) Marketplace, 2020



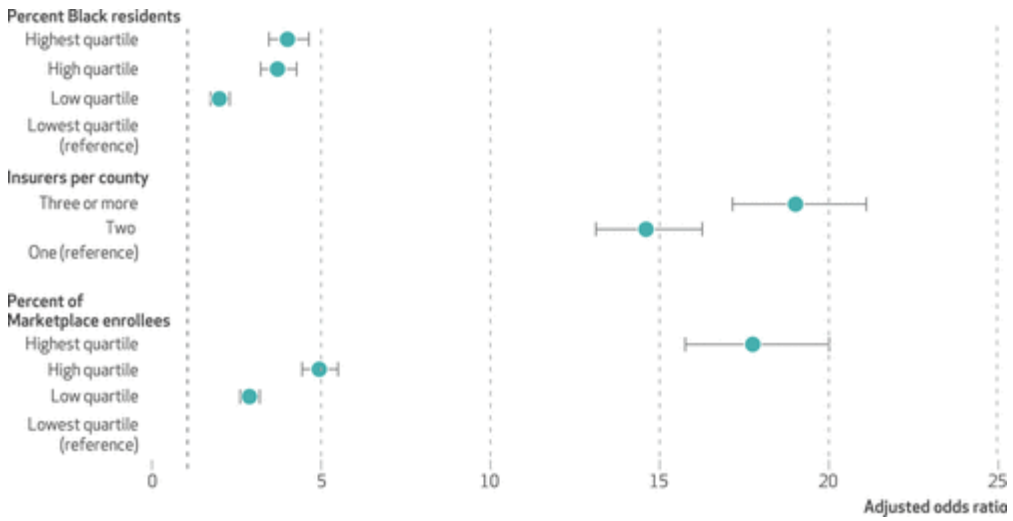
SOURCE Authors' analysis of data from the plan year 2020 Nationwide Quality Rating System Public Use File, Centers for Medicare and Medicaid Services. NOTES Adjusted premiums for each star-rating group are from a multivariable linear regression model with controls for actuarial value, plan type, and out-of-pocket maximum. Star rating refers to the plan's quality star ratings.

Independent Predictors Of Access To High-Rated Plans

Using a multivariable ordinal logistic regression, we assessed the probability of a county having access to plans from high-rated insurers. There were significant but not monotonic associations between access to high-rated plans and median hospital beds per 10,000 residents and between access to high-rated plans and median percentage of residents with a college degree. There were no significant and monotonic associations

between access to high-rated plans and other socioeconomic factors, other health care supply factors, or rurality. Among racial and ethnic composition variables, only the percentage of Black residents had a monotonic relationship with access to high-rated plans. Counties in the highest quartile with respect to the percentage of Black residents had four times higher odds of access to plans from high-rated insurers than those in the lowest quartile (adjusted odds ratio: 4.0; p<0.001). Among market factor variables, the percentage of Marketplace enrollees and the number of rated insurers in a county had a monotonic relationship with access to high-rated plans. Counties in the highest quartile with respect to the percentage of Marketplace enrollees had seventeen times higher odds of access to high-rated plans than those in the lowest quartile (AOR: 17.7; p<0.001). Counties with more insurers also had substantially higher odds of access to high-rated plans, with two-insurer counties having more than fourteen times higher odds as one-insurer counties and counties with three or more insurers having nineteen times higher odds (AORs: 14.6 and 19.0, respectively; p<0.001) (exhibit 4).

Exhibit 4 Predictors of county-level access to high-rated plans on the federally facilitated Affordable Care Act (ACA) Marketplace, 2020



SOURCE Authors' analysis of data from the plan year 2020 Nationwide Quality Rating System Public Use File, Centers for Medicare and Medicaid Services, and from the Area Health Resources File, Health Resources and Services Administration, 2020. NOTES Results are from a multivariable ordinal logistic regression model with additional controls for percent of county uninsured, supply of per capita physicians and hospital beds, percent of county that is Hispanic, percent of county in deep poverty, percent of county residents with college degrees, and rurality of county. Model results are weighted by the county population. "Percent of Marketplace enrollees" refers to the percent of county residents who obtained coverage in the nongroup market through the federally facilitated ACA Marketplace. Independent variables were categorized as quartiles across all counties included in the analysis, and the lowest quartile served as the reference group. Lowest, low, high, and highest quartiles refer to the first, second,

third, and fourth quartiles, respectively. Based on the ordinal logistic regression approach, the adjusted odds ratios reflect the odds of access to the highest-rated plan in a given county compared with the odds of access to lower-rated plans. For all reference values, the odds ratio is 1. The whiskers represent 95% confidence intervals. All results are statistically significant based on application of the Bonferroni correction ($p<0.0045$).

Sensitivity Analyses

The trend of higher premiums for high-rated plans remained largely intact when we stratified by actuarial values, although there was slight variation from the pattern for gold and platinum plans (appendix exhibit 6).[9] Results of ordinal logistic regression were unchanged when we excluded all one- and five-star plans and when we conducted analyses at the rating-area level (appendix exhibits 7 and 8).[9] Both urban and rural counties with a greater percentage of Black residents were associated with higher odds of access to high-rated plans (appendix exhibit 9).[9] Last, we found a significant association between rurality and the number of insurers where access to more insurers was associated with improved access to high-rated plans in rural areas more than in urban areas ($p<0.001$) (appendix exhibit 10).[9]

Discussion

In this analysis of recently released ACA Marketplace data, we found that residents in most counties had access to plans from medium- and high-rated insurers in plan year 2020. Counties that were more populous, had a greater number of insurers, and had a greater percentage of Marketplace enrollees were more likely to have access to plans from high-rated insurers. High-rated plans were associated with higher premiums. Overall, we found no disparities in access to high-rated plans in counties with a higher percentage of Black or Hispanic residents. Taken together, these results suggest that medium- and high-rated plans are widely available on the federally facilitated ACA Marketplace, but consumers will need to consider the potential trade-offs of quality versus premium cost.

Counties with multiple insurers had higher odds of access to high-rated plans, suggesting that increasing the number of insurer options available to consumers in the ACA Marketplace could play a valuable role in improving the quality of Marketplace plans. Given that in plan year 2021 an additional thirty insurers entered the ACA Marketplace and 1,207 counties (38 percent) gained one insurer, access to high-rated plans might increase.[15]

Our study suggests a few important implications for policy makers. First, the release of the quality star ratings provides an important opportunity to monitor the quality of plans offered on the ACA Marketplace. The current iteration of the ACA Marketplace Quality Rating System is primarily based on process measures of clinical quality, patient satisfaction, and administrative measures of efficiency. Given the predominance of three-star plans, more sensitive measures of quality may be needed if star ratings are to truly aid consumers in selecting plans of higher quality. Opportunities to incorporate metrics on clinical outcomes, access, and affordability from the consumer perspective in the Quality Rating System should therefore be considered. Potential affordability metrics may include rates of claims denials or financial toxicity to consumers in the form of catastrophic health expenditures and medical bankruptcy.

Second, there is a trade-off between plan affordability and quality. Research is needed on whether new consumers are more likely to select plans based on quality rating or premium cost and whether consumers switch plans during open enrollment based on quality rating or premium cost. To incentivize plan selection based on quality ratings, policy makers could employ choice architecture by displaying high-rated plans first on HealthCare.gov.

Third, efforts should be made by policy makers to ensure that consumers have acces an adequate supply of insurance offerings to be able to choose plans based on quality. This could be accomplished by offering financial incentives for insurers entering a new market or imposing penalties on insurers exiting a market. Last, given the predominance of high-rated insurance plans in more populous counties, policy makers should carefully monitor the quality of insurance offerings in less populous or rural counties.

Conclusion

In the first analysis of quality star ratings for plans on the federally facilitated ACA Marketplace, we found that most potential Marketplace enrollees had access to plans of medium or high quality in plan year 2020. However, there may be trade-offs between higher-rated plans and premium costs to Marketplace enrollees. Overall, counties with three or more insurers and those with the highest percentage of county residents obtaining individual coverage through the ACA Marketplace were most likely to have access to plans from high-rated insurers. Importantly, there does not appear to be any evidence of reduced access to high-rated plans among Black and Hispanic consumers. Policy makers should explore additional options to encourage insurers to enter the ACA Marketplace, which remains an important source of nongroup insurance coverage.

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9

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Original Investigation

Effectiveness of Behaviorally Informed Letters on Health Insurance Marketplace Enrollment
A Randomized Clinical Trial

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Abstract

IMPORTANCE Every year during the open enrollment period, hundreds of thousands of individuals across the Affordable Care Act marketplaces begin the enrollment process but fail to complete it, thereby resulting in coverage gaps or going uninsured.

OBJECTIVE To investigate if low-cost ($0.55 per person) letters can increase health insurance enrollment.

DESIGN, SETTING, AND PARTICIPANTS This intent-to-treat randomized clinical trial was conducted during the final 2 weeks of the 2015 open enrollment period among the 37 states on the HealthCare.gov platform. The trial targeted 744 510 individuals who started the enrollment process but had yet to complete it. Data were analyzed from January through August 2021.

INTERVENTIONS Study participants were randomized to either a no-letter control group or to 1 of 8 letter variants that drew on evidence from the behavioral sciences about what motivates individuals to take action.

MAIN OUTCOMES AND MEASURES The primary outcome was the health insurance enrollment rate at the end of the open enrollment period.

RESULTS Of the 744 510 individuals (mean [SD] age, 41.9 [19.6] years; 53.9% women), 136 122 (18.3%) were in the control group and 608 388 (81.7%) were in the treatment group. Most lived in Medicaid nonexpansion states (72.7%), and a plurality were between 30 and 50 years old (41.0%). For race and ethnicity, 3.0% self-identified as Asian, 14.0% as Black, 5.1% as Hispanic, 39.8% as non-Hispanic White, and 38.2% as other or unknown. By the end of the open enrollment period, 4.0% of the control group enrolled in health insurance coverage. Comparatively, the enrollment rate in the pooled treatment group was 4.3%, which demonstrated an increase of 0.3 percentage points (95% CI, 0.2-0.4 percentage points; $P<.001$), yielding 1753 marginal enrollments. Letters that used action language caused larger enrollment effects, particularly among Black individuals (increase of 1.6 percentage points; 95% CI, 0.6-2.7 percentage points; $P = .003$) and Hispanic individuals (increase of 1.5 percentage points; 95% CI, 0.0-3.0 percentage points; $P = .046$) in Medicaid expansion states.

CONCLUSIONS AND RELEVANCE This randomized clinical trial shows that letters designed with best practices from the behavioral sciences literature were a low-cost way to increase health insurance enrollment in the Affordable Care Act marketplaces. More research is needed to understand what messages are most effective amid the recently passed American Rescue Plan.

(continued)

Key Points

Question How much do behaviorally informed letters increase health insurance enrollment?

Findings In this randomized clinical trial that included 744 510 individuals on the HealthCare.gov platform during the final 2 weeks of the 2015 open enrollment period, use of a single behaviorally informed letter caused a statistically significant increase in health insurance enrollment. Letters that used action language caused larger effects, particularly among Black and Hispanic individuals in Medicaid expansion states.

Meaning Policy makers can use low-cost letter nudges to increase enrollment across Affordable Care Act marketplaces.

+ Supplemental content

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

Abstract (continued)

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Introduction

Through the expansion of Medicaid eligibility and the creation of health insurance marketplaces, the Affordable Care Act (ACA) has helped reduce the uninsured rate to record lows.[1] But every year during the open enrollment period, hundreds of thousands of individuals who initiate the enrollment process fail to complete it. Gaps in coverage or prolonged bouts of being uninsured cause disruptions in access to care and medication, increased financial strain, higher rates of medical debt, and lower levels of self-reported health.[2-4] Thus, identifying effective strategies to help individuals who have started the enrollment process obtain health insurance remains a priority for policy makers.[5]

Barriers to health insurance take-up are well documented and include cost, application complexity, procrastination, a lack of awareness about available options, choice overload, and inertia.[6-9] A growing body of research seeks to understand how different forms of outreach can overcome these barriers to increase enrollment. A recent set of nonexperimental studies, for example, found an association between the volume of health insurance TV advertisements and reductions in the uninsured rate, as well as in ACA marketplace enrollment.[10,11] And randomized clinical trials (RCTs) have found that nudges using emails, letters, and telephone outreach increased health insurance take-up.[12-14]

We build on this empirical evidence in 2 principal ways. First, in contrast with single-state RCTs, the present randomized intervention includes all 37 states that used the HealthCare.gov platform in 2015. The inclusion of multiple states is important within the context of the ACA, where states' policy decisions, such as Medicaid expansion, affect the cost of coverage and, in turn, whether individuals with low incomes can afford health insurance. Second, in lieu of nonexperimental studies that draw on self-reported survey data, we use administrative data paired with an RCT.

In the final weeks of the 2015 open enrollment period, we conducted an intent-to-treat RCT using behaviorally informed letters to increase health insurance enrollment among individuals who started the enrollment process but had yet to finish it. With 37 states and more than 744 500 individuals, this is, to our knowledge, one of the largest RCTs conducted on the ACA marketplaces to date, though there has been a larger RCT targeting tax filers who owed a positive penalty amount owing to the individual mandate.[14] Because letters are a low-cost option to reach a large number of uninsured individuals, they could represent a valuable tool for ACA marketplace administrators seeking to increase enrollment.

Methods

Study Design and Participants

This study used a parallel 9-arm design with 8 letter variants, each designed based on different insights from the behavioral science literature. The ninth arm was a hold-out control group that did not receive any letter, enabling us to measure the effect of receiving any letter as well as to tease apart the relative effect of the different behavioral features. The study followed the Consolidated Standards of Reporting Trials (CONSORT) reporting guidelines, its protocol was approved by the California Health and Human Services Agency's institutional review board (Supplement 1), and it was overseen by an interdisciplinary team at the Office of Evaluations Sciences in the US General Services Administration and the Centers for Medicare & Medicaid Services Office of Communications in the US Department of Health and Human Services (HHS).

Study participants were English-speaking individuals who, as of mid-January 2015, had visited HealthCare.gov and registered for a user account but not yet enrolled in an insurance plan. We chose mid-January as the cutoff to maximize the number of individuals eligible for the intervention while also leaving enough time to complete the requisite implementation steps so letters would arrive during the final 2 weeks of the open enrollment period.

Of the 811 795 individuals initially included, 18% were assigned to the no-letter control group, while the remaining 82% were assigned to 1 of 8 letter treatments (**Table 1**; see eAppendix in Supplement 2 for copies of each of the letters used). The sample size and randomization scheme were chosen because HHS wanted to treat as many consumers as possible before the open enrollment period ended, while also learning about the effects of letter outreach.

Intervention

Individuals in the treatment arms were assigned to receive letters at the beginning of February 2015, giving them approximately 2 weeks to complete their enrollment. The 8 letters varied behavioral dynamics, including action language, an implementation intention prompt, a picture of then–chief executive officer of the marketplace Kevin Counihan, social norm messaging, a pledge, and loss aversion. These messages drew on evidence from prior randomized interventions that suggested these appeals would induce individuals to take action.[15-17] All letters included the same core information about the benefits of enrolling, the February 15 sign-up deadline, the HealthCare.gov website, and the call center telephone number. The trial ended on February 15, 2015, because that marked the end of the open enrollment period, as well as the call-to-action date in the letters. Data were analyzed from January through August 2021.

Randomization

Randomization was conducted by the first study author (D.Y.) based on user identification numbers using the sample function and a fixed seed in R, version 3.0.2 (R Foundation). The list with assignments was given to a contractor who mailed the letters.

Data Sources and Primary Outcome

At the end of the open enrollment period, we obtained administrative enrollment data from HHS that identified the primary outcome: whether an individual enrolled in an ACA plan on or before the February 15 open enrollment deadline. The sample size for analysis included 744 510 individuals

Table 1. Characteristics of Study Participants at Baseline

Covariate	Treatment arm, %								
	Control (no letter)	Basic letter	Action letter	Action, implementation letter	Action, implementation, picture letter	Norm letter	Norm, pledge letter	Loss aversion letter	Kitchen sink (all features) letter
No.	136 122	75 828	75 993	75 990	76 039	76 164	76 125	76 086	76 163
Race and ethnicity									
Asian	3.0	3.0	2.9	2.9	2.9	2.9	3.0	3.1	2.9
Black	14.1	14.0	13.9	13.9	14.0	13.9	14.1	13.8	14.0
Hispanic	5.1	5.0	5.3	5.0	5.2	4.9	5.1	5.1	5.1
Non-Hispanic White	39.7	39.6	39.9	39.9	39.3	40.0	39.9	39.9	40.0
Other/unknown[a]	38.0	38.4	38.0	38.4	38.6	37.9	37.9	38.1	38.1
Medicaid status									
Expansion state	27.3	27.2	27.3	27.2	27.3	27.3	27.3	27.5	27.4
Nonexpansion state	72.7	72.8	72.7	72.8	72.7	72.7	72.7	72.5	72.6
Age, y									
<30	23.5	23.1	23.6	23.2	23.1	23.5	23.2	23.3	23.5
30-50	41.3	41.1	40.8	41.4	40.8	41.1	40.9	40.8	40.8
>50	35.3	35.8	35.6	35.4	36.1	35.4	35.9	36.0	35.7

[a] Other/unknown corresponds to individuals who opted not to provide a specific race or ethnicity when applying for health insurance.

because 67 285 individuals provided invalid mailing addresses, leaving them unable to receive letters or unable to enroll through the HealthCare.gov platform (**Figure 1**). In eTables 1 and 2 in Supplement 2, we show that the rate of invalid mailing addresses was approximately 8% across arms and was not correlated with treatment assignment. The administrative data also included pretreatment characteristics that we used to assess the validity of the random assignment and for stratification analyses, including self-reported race and ethnicity, state of residence, and age bracket.

Statistical Analysis

To estimate the effect of the letters overall and by subgroup, we used linear regression models with robust standard errors to account for heteroscedasticity. Data were analyzed using Stata, version 15 (StataCorp), and statistical significance was defined as a 2-sided $P < .05$.

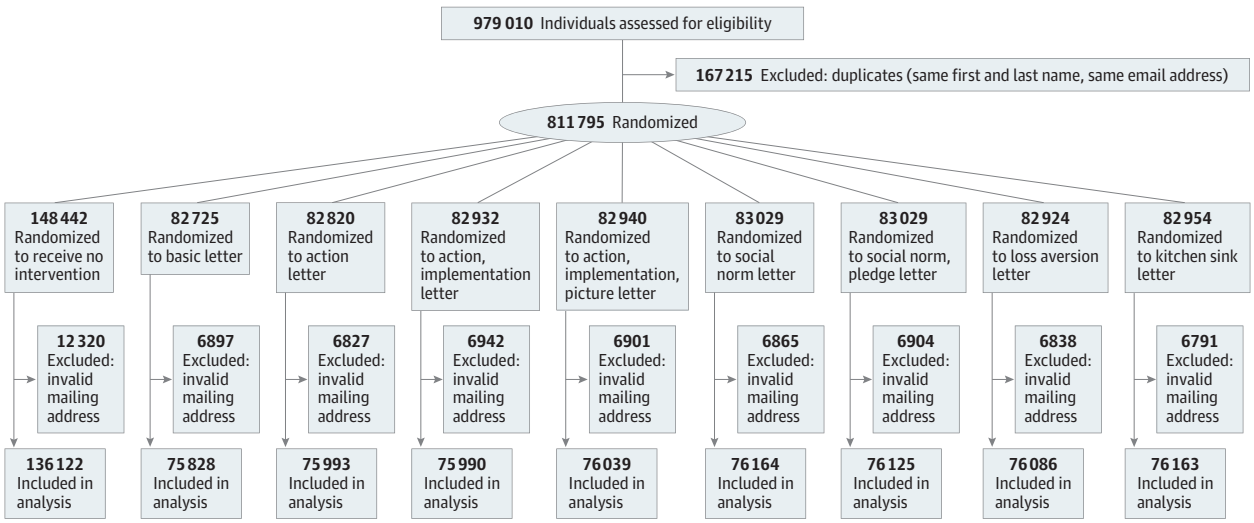
Results

Of the 744 510 individuals included in the analysis, the mean (SD) age was 41.9 (19.6) years, and 53.9% were women. By the end of the open enrollment period, 4.0% of the control group had enrolled in ACA health insurance. Relative to the control group, assignment to a letter increased enrollment by a statistically significant 0.3 percentage points (95% CI, 0.2-0.4 percentage points; $P<.001$), which represents a 7% increase above the control group mean and amounts to 1753 marginal enrollments (**Figure 2**). Each letter cost $0.55 per individual, yielding an overall cost per new enrollee of $191.

However, not all letters were equally effective; of the 8 letter variants, 2—the social norm with a pledge and the "kitchen sink" with all features—did not increase enrollment relative to the control group by a statistically significant amount. Letters that used action language (ie, treatment arms 2, 3, and 4) yielded the largest effects, increasing enrollment by 0.5 percentage points (95% CI, 0.3-0.6 percentage points; $P<.001$). If the best-performing letter—the variant that used action language, an implementation prompt, and a picture—was implemented at scale, this would have translated to 3228 marginal enrollees and a cost per new enrollee of $104.

In exploratory analyses, we detected statistically significant differences across most subgroups, except for individuals younger than 30 years and those who did not provide a race and/or ethnicity when applying. The point estimate for Asian adults is substantively large (0.6 percentage points) but imprecisely estimated owing to a relatively small sample size (**Table 2**). The largest enrollment

Figure 1. CONSORT Flow Diagram of Included Individuals

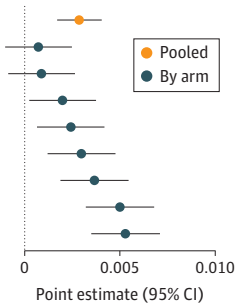


increase was among Hispanic adults, which was an increase of 0.7 percentage points (95% CI, 0.1-1.3 percentage points; *P* = .02), or 14%.

We additionally examined the effect of action letters by race and ethnicity and states' Medicaid expansion status (**Figure 3**). In expansion states, the effect of action letters was especially pronounced among racial and ethnic minorities, causing enrollment increases of 1.6 percentage points (95% CI, 0.6-2.7 percentage points; *P* = .003) among Black adults, 1.3 percentage points (95% CI, −0.3 to 2.8 percentage points; *P* = .11) among Asian adults, and 1.5 percentage points (95% CI, 0.0-3.0 percentage points; *P* = .046) among Hispanic adults, a pattern consistent with cost as an

Figure 2. Effect of Letter on Affordable Care Act Enrollment Rate Pooled, by Arm, and Cost per Enrollee

Cost per enrollee/treatment arm	Point estimate (95% CI)
$191/Any letter	0.3 (0.2 to 0.4)
$742/Kitchen sink letter	0.1 (−0.1 to 0.2)
$607/Social norm, pledge letter	0.1 (−0.1 to 0.3)
$277/Social norm letter	0.2 (0 to 0.4)
$225/Basic letter	0.2 (0.1 to 0.4)
$184/Loss aversion letter	0.3 (0.1 to 0.5)
$150/Action, implementation letter	0.4 (0.2 to 0.5)
$110/Action letter	0.5 (0.3 to 0.7)
$104/Action, implementation, picture letter	0.5 (0.3 to 0.7)



Each point represents the average effect in percentage points. Error bars denote 95% CIs.

Table 2. Absolute and Relative Changes in Health Insurance Enrollment by Consumer Characteristics

Subgroup	No.	Control group mean	Effect of any letter (SE)	Change, %
Total	744 510	0.04	0.003 (0.001)[a]	7.5
Medicaid expansion				
Yes	203 290	0.046	0.003 (0.001)[b]	6.7
No	541 220	0.038	0.003 (0.001)[a]	7.4
Characteristics of the head of household				
Race and ethnicity				
Asian	22 103	0.061	0.006 (0.004)	10.6
Black	104 047	0.044	0.004 (0.002)[a]	10.2
Hispanic	37 708	0.050	0.007 (0.003)[b]	14.2
Non-Hispanic White	296 418	0.051	0.003 (0.001)[a]	6.1
Other/unknown[c]	284 234	0.025	0.001 (0.001)	4.8
Age, y				
<30	173 729	0.047	0.002 (0.001)	3.6
30-50	305 401	0.045	0.003 (0.001)[a]	7.0
>50	265 380	0.030	0.004 (0.001)[a]	11.6

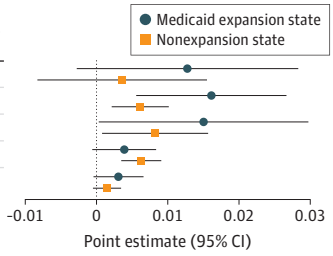
[a] *P* < .01.

[b] *P* < .05.

[c] Other/unknown corresponds to individuals who opted not to provide a specific race or ethnicity when applying for health insurance.

Figure 3. Effect of Action Letters on Affordable Care Act Enrollment Rate by Race and Ethnicity and States' Medicaid Expansion Status

Race and ethnicity	Medicaid expansion state point estimate (95% CI)	Nonexpansion state point estimate (95% CI)
Asian	1.3 (−0.3 to 2.8)	0.4 (−0.8 to 1.6)
Black	1.6 (0.6 to 2.7)	0.6 (0.2 to 1.0)
Hispanic	1.5 (0 to 3.0)	0.8 (0.1 to 1.6)
Non-Hispanic White	0.4 (−0.1 to 0.8)	0.6 (0.3 to 0.9)
Other/unknown	0.3 (0 to 0.7)	0.2 (−0.1 to 0.3)



Each row represents the average effect of a letter in percentage points. Error bars denote 95% CIs.

enrollment barrier for those living in nonexpansion states where premiums tend to be higher and subsidies are inaccessible to residents with the lowest income.[18]

Discussion

In this RCT, during the final weeks of the 2015 open enrollment period, we found that low-cost ($0.55 per person) behaviorally informed letters targeting individuals on the HealthCare.gov platform led to statistically significant increases in health insurance enrollment, yielding 1753 marginal enrollments. Letters that used action language, emphasizing that only minimal, marginal effort was required (ie, included the phrase "You're almost done"), were most effective. Subgroup analyses demonstrated that the largest enrollment increases occurred among Black and Hispanic adults in Medicaid expansion states. These results suggest that low-cost reminders could be a useful tool for ACA marketplace administrators seeking to help individuals obtain coverage prior to sign-up deadlines.

In terms of cost-effectiveness, this study's $191 cost per marginal enrollment compares favorably with other reported estimates, which range from less than $100 to as high as $1000.[19] The observed effect sizes are similar in relative terms to those found in the 2 prior studies[12,13] evaluating mailers to increase health insurance enrollment in single-state contexts. In California, letters sent to applicants of Covered California (that state's marketplace), who were determined eligible but had not yet selected a plan, led to a 1.3 percentage point (16%) increase over a base enrollment rate of 8.1%. In Oregon, a suite of outreach activities (mail, email, and telephone reminders) led to a 3.5 percentage point (10%) increase in Medicaid enrollment over a base rate of 38%. The absolute percentage point differences across these interventions could be owing to premium costs (or the absence thereof in the case of Medicaid enrollment), the amount of time individuals had to complete the call to action, differences in the duration over which outcomes are measured, or numerous other factors.

While the present randomized intervention was conducted in 2015, recent surveys of uninsured adults indicate that more than 50% still lack awareness of marketplaces and subsidies to make health insurance more affordable, pointing to the need for continued outreach.[20] With the March 2021 passage of the American Rescue Plan, which expands subsidies for people at every income level through 2022, it will be important for marketplaces to test a variety of different messages to identify what resonates with prospective enrollees and to avoid deploying ineffective outreach strategies.

Limitations

This research design is based on random assignment, which provides a strong basis for causal inference, but the study is not without limitations. First, owing to operational timelines, letters were only printed in English and sent to households with a written language preference of English; thus, we do not measure effects among harder-to-reach non-English–speaking households.[21] But because the intervention sought to address commonly cited barriers to enrollment, including procrastination and lack of awareness about the deadline or how to get help, we would expect the reminder letters to have comparable effects among Spanish-speaking individuals. Ultimately, though, this is an empirical question, and we encourage marketplace administrators to draw on promising experimental evidence—including in-language personalized telephone assistance, which has been found to considerably increase marketplace enrollment—during future open enrollment cycles.[22] Second, because race and ethnicity are optional questions on the ACA application, they are subject to missingness. In the present study, 62% of individuals answered these application questions. Third, letters were sent to individuals who took the initial steps of beginning the enrollment process. Outreach efforts to the uninsured who have not interacted with marketplaces could have different effects. Finally, the letters arrived during the last 2 weeks of the open enrollment period, and we received anecdotal reports of letters arriving in mailboxes after the February 15 deadline. Thus, the estimated treatment effect potentially represents an underestimate because late letters could not

have affected enrollment prior to the deadline, and it is possible that letters sent near the start of the open enrollment period could have had different effects.

Conclusions

In this RCT, we found that a low-cost letter, targeting individuals who took the first steps toward enrolling in ACA marketplace coverage but stopped short of selecting a plan, caused statistically significant and meaningful increases in ACA health insurance enrollment. From 2017 to 2020, enrollment in the ACA marketplaces declined from 12.2 million to 11.4 million in part because of a reduction in marketing and advertising. As the Biden administration seeks to expand coverage, particularly among racial and ethnic minorities hard hit by the COVID-19 pandemic, this study provides evidence that low-cost outreach—especially messages informed by the behavioral sciences—could help increase ACA marketplace enrollment.

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ARE STATE PUBLIC OPTION HEALTH PLANS WORTH IT?

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ABSTRACT

The COVID-19 pandemic exposed the weaknesses of the U.S. health care system's reliance on private, employer-based health insurance. The crisis in health care access and affordability has increased support for a public option—the choice to purchase a state-initiated health plan with publicly determined rates. Congressional gridlock, however, may dim the chances for a federal public option. States have stepped into the policy vacuum, proposing forty-nine bills to establish state public options since 2010, including three that became law. This article provides a comprehensive survey and taxonomy of state public option proposals from 2010–2021, identifying three main models: (1) Medicaid Buy-In Public Options; (2) Marketplace-Based Public Options; and (3) Comprehensive Public Options. Though each model serves different policy goals and varies in scope, the defining aim of all public option plans is to improve access to affordable health coverage by applying public payment rates to the private insurance market. We seek to answer whether state public option plans are legally viable and "worth it" for states to pursue. The answer is yes to both, but, surprisingly, the degree of legal difficulty is inversely related to the scope of the plan's reach—the broadest plans have fewer legal hurdles than narrower plans. Moreover, the policy effects increase with the scope of the plan and the robustness of the controls on provider payment rates. Public options with modest provider rate controls may have too little impact on affordability and costs, falling short of their defining goal of improving affordability. As a result, the legal and political difficulty of enacting such plans may not be worth it. State public option plans may be most effective when they cover a broad swath of the population and pursue robust provider rate controls. In short, for state public option plans to be worth it, bigger is better.

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INTRODUCTION

The COVID-19 pandemic laid bare the inadequacies of the U.S. healthcare system for the nation, and the world, to see. One of the most glaring deficiencies was the tether between employment and health insurance.[1] As more than five million Americans watched in disbelief as the pandemic took their jobs,[2] many of them had the dual realization that they also lost their employer-sponsored health insurance in the midst of the largest pandemic in over a century.[3] The need for comprehensive and affordable public health insurance options irrespective of employment has never been more apparent. Yet with the nation embroiled in the continued onslaught of COVID-19, comprehensive action at the federal level remains a distant possibility. Even with the election of Joe Biden, who favors a national public health insurance option,[4] Congress remains closely divided, so the path to sweeping federal health reform appears difficult. Back in 2010, when the Democrats controlled far more seats in Congress, insurance companies successfully lobbied to strip the public option from the Affordable Care Act ("ACA").[5] With a

[1] *See generally* Jaime S. King, *Covid-19 and the Need for Health Care Reform*, 382 N. ENG. J. MED. e104(1) (2020).

[2] *See* GENE FALK, PAUL D. ROMERO, ISAAC A. NICCHITTA & EMMA C. NYHOF, CONG. RSCH. SERV., R46554, UNEMPLOYMENT RATES DURING THE COVID-19 PANDEMIC: IN BRIEF 2 (2021).

[3] *See* Daniel McDermott, Cynthia Cox, Robin Rudowitz & Rachel Garfield, *How Has the Pandemic Affected Health Coverage in the U.S.?*, KAISER FAM. FOUND. (Dec. 9, 2020), https://www.kff.org/policy-watch/how-has-the-pandemic-affected-health-coverage-in-the-u-s/ [https://perma.cc/4B3W-RBRM].

[4] *See Health Care*, BIDEN HARRIS, https://joebiden.com/healthcare/ [https://perma.cc/SYC7-KJZH].

[5] *See* Jacob S. Hacker, *From the ACA to Medicare for All*, *in* THE TRILLION DOLLAR REVOLUTION 333, 336 (Ezekiel J. Emanuel & Abbe R. Gluck eds., 2020); Richard M. Scheffler & Taylor L. Wang, *The Public Option: From Hacker to Biden*, PETRIS CTR. (Sept. 22,

bare Senate majority in 2021, passing a federal public option will prove even more challenging, as such a broad reform would require sixty votes to overcome the Senate filibuster.[6] Due to federal gridlock, the most likely path to health reform in the near-term is through the states, which have been devising their own policies to provide increased access to affordable health care.

One mechanism for achieving health reform is through the creation of a state-based public health insurance plan or a "public option." A state public option is a state-initiated health insurance plan created by the state legislature that pays providers publicly determined rates and is offered to a significant share of the private health insurance market. Designed to place competitive pricing pressure on private plans, public options offer coverage to individuals who are privately insured or uninsured.[7]

The concept of a federal public option was launched into the national health policy debate by Barack Obama and health policy scholar Jacob Hacker, who argued for its inclusion in the ACA.[8] Hacker argued that public option plans could operate more efficiently than private plans by lowering administrative costs, eliminating corporate profits, negotiating and setting prices for health care services and prescription drugs, and providing a competitive benchmark to private plans.[9] In the political push to pass the ACA, however, the public option was dropped from the legislation, leaving the health insurance Marketplaces, websites where eligible individuals can purchase subsidized, comprehensive health plans that are barred from certain discriminatory practices, to offer only private health plans.[10] Absent competitive pressure from a public option, private plans both on and off the ACA Marketplaces have suffered from dwindling competition and have not substantially controlled costs.[11]

2020), https://petris.org/wp-content/uploads/2020/09/The-Public-Option-From-Hacker-to-Biden.pdf [https://perma.cc/AGX5-9VCG].

[6] *See* Sarah Kliff & Margot Sanger-Katz, *With New Majority, Here's What Democrats Can (and Can't) Do on Health Care*, N.Y. Times (Jan. 7, 2021), https://www.nytimes.com/2021/01/07/upshot/biden-democrats-heath-plans.html [https://perma.cc/RP4R-M2RC].

[7] *See* Hacker, *supra* note 5, at 336; Helen A. Halpin & Peter Harbage, *The Origins and Demise of the Public Option*, 29 Health Aff. 1117, 1117–18 (2010) ("The concept was to offer a publicly insured plan in direct competition with other options for private health insurance coverage, in the hope of driving down both premiums and underlying health care costs.").

[8] *See* Halpin & Harbage, *supra* note 7, at 1118–19; Jacob S. Hacker, Inst. for Am.'s Future & Univ. of Cal. Berkeley L., The Case for Public Plan Choice in National Health Reform: Key to Cost Control and Quality Coverage 1 (2008), https://www.law.berkeley.edu/files/Hacker_final_to_post.pdf [https://perma.cc/7N42-XQ8V].

[9] *See* Hacker, *supra* note 5, at 6.

[10] *See* Timothy Stoltzfus Jost & John E. McDonough, *The Path to the Affordable Care Act*, *in* The Trillion Dollar Revolution, *supra* note 5, at 35–36; Sheryl Gay Stolberg, *'Public Option' in Health Plan May Be Dropped*, N.Y. Times (Aug. 17, 2009), https://www.nytimes.com/2009/08/18/health/policy/18talkshows.html [https://perma.cc/XNL9-EF3J].

[11] *See, e.g.*, Josh Bivens, *The Unfinished Business of Health Reform*, Econ. Pol'y Inst. (Oct. 10, 2018), https://www.epi.org/publication/health-care-report/ [https://perma.cc/83ZL-F7HH]; Lemore Dafny, *Health Care Markets a Decade after the ACA, Bigger, but Probably Not Better*, *in* The Trillion Dollar Revolution, *supra* note 5, at 264, 264–66, 272–73;

States have tried to pick up where the ACA fell short by legislating state public option plans to solve their persistent health care coverage and cost problems. Yet state policymakers' hands are tied by federal law, which imposes a variety of requirements and restrictions on state public option proposals, depending on the type of plan. Some requirements ensure minimum levels of coverage and quality. For instance, if a state wants to offer a public option on the Marketplace, the plan must satisfy the ACA's requirements for qualified health plans ("QHPs") and include the essential health benefits ("EHBs") or receive a waiver from the Department of Health and Human Services ("HHS").[12] Other federal laws hinder the development and efficacy of state public option plans by limiting design options, target populations, and the scope of coverage. Federal Medicaid law significantly constrains Medicaid buy-in options by prohibiting states from using federal funds to expand Medicaid coverage beyond those statutorily eligible and from placing public option enrollees in the same risk pool as Medicaid enrollees.[13] The ACA prohibits undocumented individuals from enrolling in health insurance plans on the Marketplaces. It requires states to ignore one of the largest segments of the uninsured population or offer public option plans off the Marketplaces, diminishing their ability to build on Marketplace investments and potentially destabilizing the Marketplaces. The Employee Retirement and Income Security Act of 1974 ("ERISA"), whose broad preemption provision has long stymied state health regulation,[14] prohibits states from requiring self-insured employers to participate in public option plans, but allows states to nudge employers to adopt the plans.[15] States also have a comparative disadvantage in financing their public option plans, as they must balance their budgets and have limited ability to raise new taxes.[16] In sum, state public option plans have more legal and fiscal constraints than a federal version.

Despite these limitations, states have persisted in proposing public option plans. Yet we lack a comprehensive understanding of how states are designing their public option proposals. This article fills the gap. We define a state public option as a state-initiated health insurance plan that is offered to

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Ezekiel J. Emanuel & Amol S. Navathe, *Delivery-System Reforms: Evaluating the Effectiveness of the ACA's Delivery System Reforms at Slowing Cost Growth and Improving Quality and Patient Experience*, *in* THE TRILLION DOLLAR REVOLUTION, *supra* note 5, at 225, 228; Carrie H. Colla & Jonathan Skinner, *Has the ACA Made Health Care More Affordable?*, *in* THE TRILLION DOLLAR REVOLUTION, *supra* note 5, at 250, 251; Joseph R. Antos & James C. Capretta, *The ACA: Trillions? Yes. A Revolution? No.*, HEALTH AFFS. (Apr. 10, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200406.93812/full/ [https://perma.cc/GJ9S-KWNJ].

[12] *See* 42 U.S.C. §§ 18021, 18022, 18052.

[13] *See infra* Section I.B.

[14] *See, e.g.*, Erin C. Fuse Brown & Ameet Sarpatwari, *Removing ERISA's Impediment to State Health Reform*, 378 N. ENG. J. MED. 5 (2018).

[15] *See infra* Section III.C.1.

[16] *See* Lindsay F. Wiley, *Medicaid for All? State-Level Single-Payer Health Care*, 79 OHIO ST. L.J. 843, 875 (2018).

a significant share of the private health insurance market—the individual, small group, or large group market—and pays publicly determined rates. State public option plans are state-initiated if they enter the market as a result of a state legislative action and they pay publicly-determined rates by pegging payments to existing public program rates (e.g., Medicare or Medicaid rates) or through administrative rate-setting. Consistent with other health policy and economics experts' understanding of a public option, states need not administer or finance a plan for it to be "public."[17] Although some may contest whether a privately administered plan with publicly determined rates is sufficiently "public" to be called a public option, we adopted this broad definition to capture the range of states' attempts to create—in their words—a public option health plan as an alternative to private coverage.[18]

This article provides the first comprehensive analysis of state efforts to create public option plans and offers a roadmap of the legal issues and policy tradeoffs states must navigate to reform their health systems through a public option plan. As each state must analyze its own economic and political environment to determine the viability of a particular health reform, it is impossible to prescribe a single best public option for all states. Instead, the article seeks to answer whether a state public option is legally possible and, if so, when it is worth it.

To answer these questions, we analyzed all public option bills introduced in state legislatures from 2010–2021 and assessed the legal viability of each.[19] We limited our search to bills that could, if passed, implement a public option health plan. We excluded bills that need further legislative action to implement, including those that created a task force to examine the possibility of a public option. We counted a bill in each legislative session it was introduced but did not count a bill twice if it was introduced into both chambers during the same session. Applying this methodology, we identified forty-nine bills introduced by twenty-three states between 2010 and 2021 to create a public health insurance option as shown in the Appendix. To date, three states have enacted a public option: Washington's 2019 law began offering coverage on January 1, 2021;[20] Colorado's law passed in 2021, begin-

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[17] *See, e.g.*, Leemore Dafny, *Health Care Markets a Decade After the ACA*, *in* THE TRILLION DOLLAR REVOLUTION, *supra* note 5, at 273–74; Allison K. Hoffman, *The Irony of Health Care's Public Option*, *in* DEBATING THE PUBLIC OPTION (Anne Alstott & Ganesh Sitaraman eds., Cambridge University Press) (forthcoming) (manuscript at 1) (on file with authors); Lindsay F. Wiley, *Privatized Public Health Insurance and the Goals of Progressive Health Reform*, 54 U.C. DAVIS L. REV. (forthcoming 2021).

[18] This article attempts to categorize and analyze recent state attempts to create what they view as a public option plan, and sidesteps the debate of what should qualify as a "public" option, being held elsewhere in the literature. *See, e.g.*, Wiley, *supra* note 16, at 864–67.

[19] Our original survey focused on state public option bills introduced from 2010 to 2020. Due to the timing of this publication, we added bills that were introduced or passed in the 2021 legislative session as of June 30, 2021, when most, but not all state legislative sessions concluded. The 2021 bills are discussed in Part IV. *See infra* Part IV.

[20] WASH. REV. CODE §43.71.095 (2019); *see* Sara Hansard, *Public Option Experiment Hits Speed Bump as Premiums Don't Fall,* BLOOMBERG LAW (Aug. 10, 2020, 2:30 AM), https:/

ning coverage in 2023;[21] and Nevada enacted a public option in 2021 to go into effect in 2026.[22]

This article provides a taxonomy and detailed analysis of state public option bills to determine whether and how state policymakers can design bills to fit their policy goals. From our survey of state public option bills, we identify three main models for state public options: Medicaid Buy-In Public Options; Marketplace-Based Public Options; and Comprehensive Public Options.[23] Although most bills fall into only one model, a handful of bills straddle models. Five main policy goals motivate state public options: (1) controlling health insurance costs; (2) covering the uninsured; (3) reducing the effects of cycling on and off public coverage (i.e., churn); (4) improving competition; and (5) simplifying plan administration. Although these policy goals are not mutually exclusive, some may be contradictory.[24] As a result, state policy goals should drive the design of public option plans. The most important considerations include: (1) the target population; (2) plan administration; (3) plan financing and cost control; and (4) the impact on the private health insurance and provider markets.

We conclude that state public option plans are both legally possible and worth it, but, surprisingly, the legal viability and policy effects increase with the scope of the plan. In other words, with state public option plans, bigger is better. The degree of legal difficulty to establish a state public option plan is inversely related to the scope of the plan's reach—the broadest plans have surprisingly fewer legal hurdles than narrower plans, though broad plans may significantly disrupt the existing health care market, creating greater political opposition. A public option plan with modest provider rate controls may have too little impact on affordability and costs to make it worth the legal and political difficulties passing it would entail. This is especially true considering that this type of plan would fall short of its defining goal—improving affordability through the application of public payment rates to the private insurance market. Overall, state public option plans that cover a broader swath of the population and pursue robust provider rate controls are most likely to be effective.

This article proceeds in five parts. Parts I–III provide taxonomies and detailed analyses of the three state public option models. Each Part uses

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/news.bloomberglaw.com/health-law-and-business/public-option-experiment-hits-speed-bump-as-premiums-dont-fall [https://perma.cc/ULM6-KCK3].

[21] H.B. 21-1232, 73rd Gen. Assemb., 1st Reg. Sess. (Colo. 2021).

[22] S.B. 420, 2021 Leg., 81st Reg. Sess. (Nev. 2021). Though our survey only covered 2010–2020, we discuss the 2021 bills in Part IV. *See infra* Part IV.

[23] We also identified a couple of states that proposed a buy-in to their State Employee Health Benefit Plan (SEHBP) but dismissed it due to legal and practical constraints. States seeking to create a public option based on their SEHBP should offer a similar plan on the Marketplace. *See* H.P. 91, 129th Leg., 1st Reg. Sess. (Me. 2019); C.B. 134, Jan. 2019 Sess. § 7 (Conn. 2019); S.B. 1004, Jan. 2019 Sess. § 1(i) (Conn. 2019).

[24] For example, covering the remaining uninsured and reducing churn may be mutually compatible, but creating a public option to increase competition on the Marketplaces may work against the goals of administrative simplification. *See infra* Section I.

specific examples from state legislation to analyze each public option model based on its design features, policy goals, target population, administrative requirements, financing options, market impact, and potential legal and political challenges. Part IV provides an update of public option legislation in 2021, including the passage of marketplace-based public option plans in Nevada and Colorado. Though we do not prescribe what any state ought to do or how it should weigh the tradeoffs in the first four Parts, Part V then synthesizes and draws lessons from the last decade of state public option legislation and provides guidance and recommendations to states on the development of a public option plan based on their specific policy goals, resources, and political environment.

Overall, states should design their public option plan with a clear sense of their policy goals and tolerance for administrative burdens, financial risk, and political opposition. Only once they consider their options in light of these factors will they know if it is truly "worth it."

I. Medicaid Buy-In Public Options

Since the ACA's expansion of Medicaid, appreciation for the program has grown due to its comprehensive benefits, low costs, existing infrastructure, and access to federal matching funds, making it an especially attractive framework for states seeking to craft a public option.[25] Medicaid provides publicly funded coverage for people living in low-income households and is jointly financed and regulated by the state and federal governments.[26] The ACA allowed states to expand Medicaid coverage to include adults under age sixty-five with incomes at or below 138% of the federal poverty level ("FPL"), with the federal government providing ninety percent of the funding for the Medicaid expansion and states funding ten percent.[27] Medicaid offers comparatively comprehensive benefits at relatively low costs because of low provider reimbursement rates and administrative costs.[28] And, most

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[25] *See* Michael Ollove, *The Politics of Medicaid Expansion Have Changed*, Pew: Stateline (Nov. 13, 2019), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/11/13/the-politics-of-medicaid-expansion-have-changed [https://perma.cc/3T3Q-MD97].

[26] *See* Wiley, *supra* note 16, at 848 (citing Elicia J. Herz, Jean Hearne, Julie Stone-Axelrad, Karen Tritz, Evelyne Baumrucker, Christine Scott, Chris Peterson, Aoril Grady & Richard Rimkunas, Cong. Rsch. Serv., RL 32277, How Medicaid Works: Program Basics 1–2 (2006)); *Federal and State Share of Medicaid Spending,* Kaiser Fam. Found., https://www.kff.org/medicaid/state-indicator/federalstate -share-of-spending/ [https://perma.cc/Z22V-US4J].

[27] 42 U.S.C. § 1396a(k).

[28] *See* Teresa A. Coughlin, Sharon K. Long, Lisa Clemans-Cope & Dean Resnick, Kaiser Fam. Found., What Difference Does Medicaid Make? Assessing Cost Effectiveness, Access, and Financial Protection under Medicaid for Low-Income Adults 1, 7 (2013), https://www.kff.org/wp-content/uploads/2013/05/8440-what-difference-does-medicaid-make2.pdf [https://perma.cc/DWV7-YP24].

critically from the perspective of a state, at least half of the costs of Medicaid are funded by the federal medical assistance percentage ("FMAP").[29]

But, as we discuss below, the legal constraints of the federal Medicaid statute mean that a pure buy-in is impossible for states to effectuate, belying its intuitive simplicity. Instead, two types of Medicaid buy-ins emerged as viable options. First, states may require their contracted Medicaid managed care organizations to offer a similar plan—in terms of benefits, provider network, and rates—to individuals ineligible for Medicaid.[30] Second, states may create a public option, administered by the state Medicaid agency, that targets the uninsured who are ineligible for federal Marketplace subsidies or Medicaid.[31] To encompass both viable alternatives, our analysis includes any state proposal that builds upon or leverages the Medicaid program to cover residents that are otherwise ineligible for Medicaid.

In the past eleven years, sixteen states introduced twenty-two bills that met our criteria of a Medicaid buy-in.[32] The Medicaid buy-in bills typically direct the state agency overseeing the Medicaid program to establish a public option and apply for any necessary federal waivers, many without further detail.[33] These bills tend to be much less specific than the public option plans

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[29] *See* ALISON MITCHELL, CONG. RSCH. SERV., R43847, MEDICAID'S FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) 2 (2020).

[30] A few states already require contracted Medicaid managed care organizations to offer a plan on the exchange, but we do not consider those public options, as the state does not determine the specifics of these plans or provider rates, except that they must meet the requirements of the state exchange. *See* Louise Norris, *Nevada Health Insurance Marketplace: History and News of the State's Exchange*, HEALTHINSURANCE.ORG (Aug. 25, 2021), https://www.healthinsurance.org/nevada-state-health-insurance-exchange/#MCO [https://perma.cc/VP6E-Q9MA]; Kevin Lucia, Jack Hoadley, Sabrina Corlette, Dania Palanker & Olivia Hoppe, *Stepping into the Breach: How States and Insurers Worked Together to Prevent Bare Counties for 2018*, URB. INST. (Nov. 9, 2017), https://www.urban.org/research/publication/stepping-breach-how-states-and-insurers-worked-together-prevent-bare-counties-2018 [https://perma.cc/2RL3-CZQY]. For an example of a state requiring Medicaid managed care organizations to offer a public option, *see, e.g.*, S.B. 339, 2019 Leg., 155th Gen. Assem. (Ga. 2020) (stating "The department shall be authorized to. . . Make health care coverage available for purchase through the Georgia Reliable Insurance Network. . .Such network shall: (1) Include, at a minimum: (A) The same coverage provided to recipients of Medicaid. . .The department shall: (1) Administer the network through the managed care organizations under contract with the department to provide Medicaid services and benefits").

[31] *See, e.g.*, S.B. 405, 54th Leg., Reg. Sess. (N.M. 2019) (stating that "the department shall establish a medicaid buy-in plan and shall offer the buy-in plan for purchase by a resident: (1) who is ineligible for the following: (a) medicaid; (b) medicare; and (c) advance premium tax credits under the federal Patient Protection and Affordable Care Act; and (2) whose employer has not disenrolled or denied the resident enrollment in employer-sponsored health coverage on the basis that the resident would otherwise qualify for enrollment in medicaid buy-in coverage.").

[32] In addition to these bills, Minnesota legislators introduced five state proposals to build on the state's Basic Health Program (BHP). *See* S.F. 58, 2017 Leg., 90th Sess. (Minn. 2017); S.F. 684, 2019 Leg., 91st Sess. (Minn. 2019); S.F. 720, 2019 Leg., 91st Sess. (Minn. 2019); S.F. 1080, 2019 Leg., 91st Sess. (Minn. 2019); S.F. 2356, 2019 Leg., 91st Sess. (Minn. 2019). While conceptually similar to Medicaid buy-ins, BHP buy-ins face distinct legal hurdles and are not included here.

[33] *See, e.g.*, S.B. 444, 121st Gen. Assemb., 1st Reg. Sess. (Ind. 2019) (providing that "[t]o the extent allowed by federal law, the office shall establish the Indiana statewide health

discussed in the following sections. The brevity of these bills may reflect uncertainty about the legal constraints that determine the structure of a Medicaid buy-in plan, such as the need for or approval of federal waivers, or it may purposefully grant state Medicaid officials the flexibility to design the plan to fit the specific population and policy goals of the state and permit the legislature to avoid tackling more politically fraught decisions like provider reimbursement.

Of the Medicaid buy-in efforts, bills in Nevada (2017) and New Mexico (2019) advanced the furthest.[34] In Nevada, the governor vetoed the 2017 bill passed by the state legislature to offer a Medicaid-based plan on the state Marketplace.[35] The New Mexico state legislature passed a study bill in 2018[36] that examined four options for a public option based on the state Medicaid program, but bills introduced the following year to implement the recommendations of the study failed to pass.[37] To date, no Medicaid buy-in plans have been created, but at least six states have convened task forces to develop state-level Medicaid buy-in plans and assess their impact on state insurance markets.[38]

Notably, as policymakers grapple with the legal and practical difficulties of crafting Medicaid buy-ins, the policy goals and target populations have diminished, too. What started as a broad idea to provide a public option to anyone who wanted it and increase coverage options for all has become more focused on extending coverage to discrete and difficult-to-cover popu-

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plan within the Medicaid program and make coverage available for purchase through the plan to an individual who is not otherwise eligible for Medicaid" and further explaining that "[t]he office shall apply to the United States Department of Health and Human Services for any waiver required to implement or administer this chapter" without providing additional details about how to implement the public option).

[34] *See* Assemb. B. 374, 2017 Leg., 79th Sess. (Nev. 2017); S.B. 405, 54th Leg., Reg. Sess. (N.M. 2019).

[35] Letter from Brian Sandoval, Governor of Nev., to Hon. Barbara Cegavske, Secretary of State of Nev. (June 16, 2017) (on file with author) (vetoing Nevada Assembly Bill No. 374 and providing Governor Sandoval's reasoning vetoing the bill); *see also* Michelle Hackman, *Nevada's Governor Vetoes 'Medicaid for All' Insurance Plan*, WALL ST. J. (June 17, 2017), https://www.wsj.com/articles/nevadas-governor-vetoes-medicaid-for-all-insurance-plan-1497701687 [https://perma.cc/4R9X-GKLT].

[36] S. Memorial 3, 53rd Leg., 2nd Sess. (N.M. 2018); H. Memorial 9, 53rd Leg., 2nd Sess. (N.M. 2018); New Mex. House Meas. 9 (2020).

[37] *See* Michael S. Sparer, *Redefining the "Public Option": Lessons from Washington State and New Mexico*, MILBANK MEM'L FUND: MILBANK Q. (2020), https://www.milbank.org/quarterly/articles/redefining-the-public-option-lessons-from-washington-state-and-new-mexico/ [https://perma.cc/9FWC-UEMG].

[38] The six states are Colorado, Delaware, Massachusetts, Nevada, New Mexico, and Oregon. *See, e.g.*, PATRICIA BOOZANG, CHIQUITA BROOKS-LASURE & ASHLEY TRAUBE, MEDICAID BUY-IN: STATE OPTIONS, DESIGN CONSIDERATIONS AND SECTION 1332 WAIVER IMPLICATIONS (2018) https://www.shvs.org/wp-content/uploads/2018/05/Medicaid_Buyin_-FINAL.pdf [https://perma.cc/JFH2-DY3Y]; STATE OF DELAWARE SENATE CONCURRENT RESOLUTION 70 STUDY GROUP, FINAL REPORT (2019), https://news.choosehealthde.com/wp-content/uploads/2019/01/SCR-70-Medicaid-Buy-In-Study-Group-Final-Report-01.15.19.pdf [https://perma.cc/L4WB-54D5].

lations—undocumented immigrants and those who earn too much to qualify for Medicaid but still find Marketplace coverage unaffordable.

A. Policy Goals

The primary policy goals of Medicaid buy-in plans are: (1) cover the remaining uninsured; (2) reduce churn between Medicaid and other coverage; and (3) control costs so that residents have an affordable insurance option.[39] To cover the remaining uninsured, Medicaid buy-ins typically target residents with low incomes.[40] Fluctuations in household income may alter eligibility for Medicaid and federal Marketplace subsidies, disrupting the continuity of care.[41] Medicaid buy-ins reduce the destabilizing effects when enrollees cycle between private and public insurance by allowing individuals with low incomes to remain in similar plans whether on or off Medicaid.

In addition, Medicaid buy-ins seek to control costs by extending Medicaid's lower provider reimbursement rates and administrative costs to a broader patient population.[42] These cost-saving measures may make Medicaid buy-ins affordable coverage options for those who cannot currently afford coverage. Consequently, a Medicaid buy-in may be a reasonable choice for states trying to reach universal coverage by targeting affordable coverage and state resources to the remaining uninsured.

B. Legal Issues for Medicaid Buy-In

Conceptually, a Medicaid buy-in public option leverages the Medicaid program to extend coverage to those who are currently ineligible for Medicaid coverage, either by actually enrolling them in the program[43] or allowing purchase of a separate health plan modeled on Medicaid.[44] As we explain, however, statutory constraints make direct enrollment in Medicaid through a buy-in option by otherwise ineligible populations practically infeasible.

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[39] For example, Iowa's bill declares: "[i]t is the intent of the general assembly to establish a public health care coverage safety net by utilizing a Medicaid program buy-in option to counteract the effects of inadequate private competition and make affordable health care coverage accessible to those Iowans without individual health care coverage." H.F. 2002, 87th Gen. Assemb., Reg. Sess. (Iowa 2018).

[40] *See infra* Section I.C.

[41] In 2018, twenty-one percent of uninsured adults reported that they lost health coverage when a family member lost or changed jobs, and ten percent of uninsured adults reported they lost Medicaid coverage due to a status change, such as getting married, having a baby, or a wage increase that made them ineligible. *See* Jennifer Tolbert, Kendal Orgera & Anthony Damico, *Key Facts about the Uninsured Population*, KAISER FAM. FOUND. (Nov. 6, 2020), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/ [https://perma.cc/WGN7-U9EB].

[42] *See* BOOZANG ET AL., *supra* note 38, at 11; *infra* Section I.E.2.

[43] *See, e.g.*, Assemb. B. 374, 2017 Leg., 79th Sess. (Nev. 2017) (contemplating a new plan to be established "within Medicaid").

[44] *See, e.g.*, S.B. 405, 54th Leg., Reg. Sess. (N.M. 2019) (contemplating a buy-in plan that "leverages the medicaid coverage structure").

The Medicaid statute does not permit states to use federal matching funds to extend Medicaid eligibility to non-disabled adults or pregnant women with incomes above 138% of the federal poverty limit.[45] Section 1115 of the Medicaid statute[46] grants the HHS Secretary authority to waive certain statutory requirements, including group eligibility requirements, through a demonstration or pilot project.[47] In theory, a state might be able to obtain a Section 1115 waiver to allow non-eligible populations to buy into Medicaid.[48] However, for both statutory and practical reasons, states are unlikely to receive waivers permitting expansion of these programs that would enable them to draw down federal matching dollars for the buy-in population.

First, federal law bars the use of federal Medicaid funds to pay for non-Medicaid program costs. This prohibition includes using federal Medicaid dollars for administration or to pay providers for non-Medicaid enrollees.[49] As a result, a risk pool that includes both current Medicaid beneficiaries and those that purchase a Medicaid buy-in would require a Section 1115 waiver covering the entire state population or whomever the state deems eligible for the public option. Otherwise, risk pooling or joint oversight of the Medicaid and public option plans might result in prohibited cross-subsidization between the Medicaid program (and its federal funds) and services for the buy-in enrollees.[50]

Second, CMS policy requires Section 1115 waivers to be budget neutral, meaning federal spending under the waiver cannot exceed what it would have been in absence of the waiver.[51] If the state applies for a Section 1115 waiver to extend Medicaid coverage to a larger portion of state residents previously ineligible for Medicaid benefits, it would almost certainly increase federal spending even when including modest offsetting savings—such as a reduction in Marketplace premium tax credits for individuals that shift from an exchange plan to the Medicaid buy-in option—because the federal government carries an open-ended responsibility to finance program expenditures for each Medicaid-covered life.[52] Alternatively, a state may

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[45] *See* 42 U.S.C. §§ 1396a, 1396b(a)(7); 42 C.F.R. § 433.15(b) (2021); *see also Non-Disabled Adults*, MACPAC , https://www.macpac.gov/subtopic/nondisabled-adults/ [https://perma.cc/SHX4-B4EK] (last visited Oct. 20, 2021). While states may not expand Medicaid to non-disabled adults, states have an option to create a Medicaid buy-in program for persons with disabilities. *See* 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(XV), 1396o(g)(1)(A), (B).

[46] Social Security Act of 1935 § 1115, 42 U.S.C. § 1315.

[47] Eligibility requirements set forth at § 1902 of the Social Security Act may be waived under Section 1115. Social Security Act of 1935 § 1902, 42 U.S.C. § 1396a.

[48] *See* Wiley, *supra* note 16, at 867–68.

[49] *See* 42 U.S.C. §§ 1396a, 1396b(a)(7); 42 C.F.R. § 433.15(b) (2021).

[50] *See* Wiley, *supra* note 16, at 868.

[51] *See id.*; Letter from Timothy B. Hill, Acting Director of Ctrs. for Medicaid and CHIP Svcs. on Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects, to State Medicaid Directors (Aug. 22, 2018) (on file with author).

[52] *See* Sara Rosenbaum, *Racial and Ethnic Disparities in Healthcare: Issues in the Design, Structure, and Administration of Federal Healthcare Financing Programs Supported Through Direct Public Funding, in* INSTITUTE OF MEDICINE, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 664, 673 (Brian D. Smedley,

choose to create a public option plan that allows residents ineligible for Medicaid to purchase similar coverage using state funds or fully financed by premiums and cost-sharing without obtaining a Section 1115 waiver.

The third Section 1115 hurdle requires that the demonstration project promote the goals of the Medicaid program, which courts have interpreted as providing access to health coverage.[53] Presumably, a Medicaid buy-in would expand access to coverage, but a court could read the purpose more narrowly to promote coverage *for those who cannot afford it*, and determine that allowing higher-income populations to buy-in to Medicaid coverage would not promote Medicaid's narrower goals of providing medical coverage to low-income people.[54]

In sum, it is unlikely that any state could allow additional groups to buy into Medicaid coverage directly under current Medicaid requirements. Indeed, none of the Medicaid buy-in public option proposals we examined explicitly contemplates risk-sharing arrangements with the state's Medicaid program. Instead, states may offer a separate, Medicaid-like plan, offering similar benefits, provider networks, and administration for non-Medicaid eligible individuals to purchase on or off the Marketplace.[55] Offering a Medicaid-like plan that does not pool risk or share funding with the state's existing Medicaid program would not require a Section 1115 waiver.[56] Furthermore, by not seeking federal matching funds, the buy-in plan would not have to comply with all the requirements for Medicaid beneficiaries, such as strict limits on premiums and cost-sharing and benefits required in Medicaid (such as non-emergency transportation) that are not typically covered elsewhere.[57] Thus, throughout the remainder of this article, when we refer to a "Medicaid buy-in" plan, we are referring to state proposals that allow non-Medicaid eligible individuals to purchase a plan that is based upon the state's Medicaid benefit plan and overseen by the state's Medicaid agency, rather than to the direct purchase of Medicaid coverage by individuals ineligible for Medicaid.

Adrienne Y. Stith, & Alan R. Nelson eds., 2003) (describing the Medicaid program's structure and open-ended financing).

[53] *See, e.g.*, Gresham v. Azar, 950 F.3d 93, 99 (D.C. Cir. 2020) (affirming District Court's finding that "the principal objective of Medicaid is providing health care coverage").

[54] *See* Arkansas Dep't of Health & Human Servs. v. Ahlborn, 547 U.S. 268, 275 (2006) ("The Medicaid program . . . provides joint federal and state funding of medical care for individuals who cannot afford to pay their own medical costs.").

[55] *See, e.g.*, Nev. Assemb. B. 374, 79th Leg., Reg. Sess. § 3 (2017).

[56] *See* Wiley, *supra* note 16, at 869.

[57] *See* Jennifer Lav & Héctor Hernández-Delgado, *State Medicaid Buy-Ins: Implications for Low-Income Enrollees,* NAT'L HEALTH L. PROGRAM 4–5 (Feb. 14, 2018), https://healthlaw.org/wp-content/uploads/2018/02/MedicaidBuyIns-2.14.18.pdf [https://perma.cc/JK65-YC8Z].

C. Target Population

Medicaid buy-in plans typically target uninsured state residents who struggle to find affordable coverage on the Marketplaces and who are ineligible for Medicaid. In states that expanded Medicaid eligibility via the ACA, the remaining uninsured population includes individuals who earn too much to qualify for Medicaid, but for whom Marketplace coverage remains unaffordable due to the "family glitch" or the "subsidy cliff" and undocumented immigrants who are ineligible for coverage through either the Marketplaces or Medicaid.[58] The family glitch refers to the spouses and children of a covered employee who are ineligible for financial subsidies because the employee's self-only coverage qualifies as affordable. It affects an estimated six million people.[59] The subsidy cliff refers to the abrupt end to federal subsidies for purchasing Marketplace coverage for those who earn more than 400% of FPL.[60] To cover those subject to the family glitch or subsidy cliff, who find existing coverage options unaffordable, states likely need to use state funds and maximize access to federal funds.

The ACA provides two subsidies applicable to individual plans hosted on the state and federal Marketplaces—premium tax credits ("PTCs") and cost sharing reductions ("CSRs")—to reduce out-of-pocket health care spending for low to middle income Americans.[61] PTCs reduce premium costs for individuals with incomes between 100% and 400% of FPL, who lack access to public programs and affordable employer sponsored insurance.[62] In the 2021 American Rescue Plan, Congress increased the generosity of PTCs and expanded availability of PTCs to those earning more than 400% of FPL, limiting premiums to 8.5% of household income, temporarily eliminating the subsidy cliff.[63] Although set to expire at the end of the 2022 plan year, the increased PTC subsidies should increase the pot of money states may access through Section 1332 waivers.[64] CSRs reduce cost-shar-

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[58] More than sixteen percent of the uninsured population in 2019 were ineligible for Medicaid or federal subsidies to purchase coverage on the Marketplaces due to their immigration status. Tolbert et al., *supra* note 41.

[59] *See* 26 C.F.R. § 601.105 (2021) (setting affordability standards for coverage); *see also* Tricia Brooks, Health Affs., The Family Glitch (2014), https://www.healthaffairs.org/do/10.1377/hpb20141110.62257/full/healthpolicybrief_129.pdf [https://perma.cc/Z2XR-MWVA].

[60] *See* Jodi Liu & Christine Eibner, *Extending Marketplace Tax Credits Would Make Coverage More Affordable for Middle-Income Adults*, Commonwealth Fund (July 2017), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_jul_liu_extending_marketplace_tax_credits_ib.pdf [https://perma.cc/L7EA-449N].

[61] *See* 26 U.S.C. § 36B; 42 U.S.C. § 18071.

[62] *See* 26 U.S.C. § 36(b)(3)(A); 42 U.S.C. § 18081–18082.

[63] *See* American Rescue Plan Act of 2021, Pub. L. No. 117–2, § 9661.

[64] *See* Jason Levits & Daniel Meuse, *The American Rescue Plan's Premium Tax Credit Expansion—State Policy Considerations*, Brookings (Apr. 19, 2021), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/04/19/what-does-

ing—deductibles, copays, and coinsurance—for individuals with household incomes between 100% and 250% of FPL that purchase silver-tiered plans.[65]

Most Medicaid buy-in bills tailor the eligible population to avoid jeopardizing existing federal funds flowing into the state, and all attempt to maximize federal PTCs to state residents.[66] Most Medicaid buy-in bills would authorize state officials to apply for ACA Section 1332 waivers to allow residents to use Marketplace PTCs to purchase the state public option plan.[67] Some states proposed initially excluding any residents eligible for PTCs from the Medicaid buy-in plan, while contemplating using federal waivers to expand eligibility to these residents.[68]

To cover undocumented immigrants, some bills would specifically allow any resident to purchase the Medicaid buy-in plan and broadly defined "resident" to include undocumented immigrants.[69] However, the political opposition to the use of state money to subsidize insurance for the state's undocumented immigrants[70] may partly explain why these bills have not yet passed and why some state proposals took the opposite approach and specifically excluded undocumented immigrants from the Medicaid buy-in.

The Medicaid buy-in proposals further diverge on whether to permit those with private, employer-based insurance to enroll. To avoid crowding out employer sponsored coverage,[71] New Mexico and West Virginia would not allow residents to purchase the public option if they have been denied or disenrolled from employer-sponsored coverage on the basis that they would qualify for the public option.[72] Massachusetts, Texas, Wisconsin, and Wyoming take a different approach by allowing employers to purchase public option coverage on behalf of their employees.[73]

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the-american-rescue-plans-premium-tax-credit-expansion-and-the-uncertainty-around-it-mean-for-state-health-policy/ [https://perma.cc/RV6Z-VNBQ].

[65] *See* 42 U.S.C. § 18022(d); 42 U.S.C. § 18071(b)–(c).

[66] For example, Georgia's bill would have required the department to design the public option "in a manner that prioritizes affordability for enrollees and provides opportunities to maximize federal dollars." S.B. 339, 155th Gen. Assemb., Reg. Sess. (Ga. 2020).

[67] *See, e.g.*, H.B. 1132, 191st Gen. Ct., Reg. Sess. (Mass. 2019). For a discussion of the requirements for ACA Section 1332 waivers for plans on the Exchange, see *infra* Section II.B.2.

[68] *See* S.B. 405, 54th Leg., Reg. Sess. (N.M. 2019); H.B. 4789, 84th Leg., 2d. Reg. Sess. § 9-4F-2 (W. Va. 2020).

[69] *See, e.g.*, H.B. 4789, 84th Leg., 2d. Reg. Sess. § 9-4F-2 (W. Va. 2020); Ga. S.B. 339; H.B. 2009, 81st Leg. Assemb., Reg. Sess. (Or. 2019); *cf.* H.B. 5463, 2018 Gen. Assemb., Reg. Sess. (Conn. 2018).

[70] *See* Sparer, *supra* note 37, at 269; *see, e.g.*, Ass. Bill 449, 2017 Leg., Gen. Assemb., (Wis. 2017) (limiting enrollment to individuals with incomes above the maximum limit "who otherwise meet the eligibility requirements" of the Medicaid program).

[71] *See* Gestur Davidson, Lynn A. Blewett & Kathleen Thiede Call, *Public Program Crowd-Out of Private Coverage: What Are the Issues?*, ROBERT WOOD JOHNSON FOUND. (2004), https://www.rwjf.org/en/library/research/2004/06/public-program-crowd-out-of-private-coverage.html [https://perma.cc/5ASQ-5FZ8].

[72] *See* H.B. 416, 54th Leg., 1st Sess., (N.M. 2019); W. Va. H.B. 4789.

[73] *See, e.g.*, H.B. 1132, 191st Gen. Ct., Reg. Sess. (Mass. 2019) ("[A]ny optional expanded plan offered to an employer shall require the employer to pay not less than 50 per cent of the projected cost of coverage for participating employees.").

In short, the target populations of the Medicaid buy-in bills resemble a patchwork, driven by design considerations such as minimizing disruption to employer-based coverage or maximizing federal dollars flowing to state residents. Nonetheless, the common target population for all of these plans remains low-income residents who are ineligible for Medicaid and remain unable to find affordable coverage.

D. Administration of Medicaid Buy-In Plans

One of the most appealing features of Medicaid buy-in plans is that they allow states to build on the existing administrative framework of the state Medicaid program to offer comprehensive benefits at a relatively low cost and leverage the program's existing provider network and contractual arrangements. As such, all of the Medicaid buy-in bills task the state Medicaid agency with oversight of the public option. In most states, the Medicaid agency has experience contracting with managed care plans to administer benefits, which makes the Medicaid program an attractive choice for many states when trying to deliver a new state-based plan. Once a state has opted for a Medicaid buy-in, more decisions follow, such as whether to offer the plan on the Marketplace and administer it publicly or privately.

1. On or Off the Marketplace

The decision about whether to offer the plan on the Marketplace is driven by the policy goals and target population that the state seeks to cover with the Medicaid buy-in. All fourteen Medicaid buy-in bills we reviewed would *allow* the state official overseeing the plan to sell it on the Marketplace if all necessary federal waivers were granted.[74] Offering the Medicaid buy-in on the Marketplace is necessary if a state wants to capture federal Marketplace PTCs and increase options on the Marketplace. In addition, many states use the state-based Marketplace to determine eligibility for Medicaid coverage,[75] so offering the Medicaid buy-in plan on the Marketplace makes it easier for individuals to enroll in the appropriate plan and reduces the effects of churn.

If a state wants to use a Medicaid buy-in to cover undocumented immigrants, however, then the public option plan cannot be offered *solely* on the Marketplace.[76] Further, offering a Medicaid buy-in plan on the Marketplace limits design flexibility, as it must receive QHP certification.[77] Furthermore,

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[74] *See, e.g.*, H.F. 2002, 87th Gen. Assemb., Reg. Sess. 3 §§ 1(a), 2(2) (Iowa 2018).

[75] *See Medicaid and Health Insurance Marketplace Coordination*, KAISER FAM. FOUND., https://www.kff.org/health-reform/state-indicator/medicaid-and-health-insurance-marketplace-coordination/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/2AKQ-W8J4] (last updated Jan. 1, 2021).

[76] *See infra* Section II.B.

[77] *See* 42 U.S.C. § 18021 (codifying Section 1301 of the ACA, which sets forth requirements of a QHP); *infra* Section II.B.1.

the guaranteed issue requirements for Marketplace plans[78] would prevent a state from limiting eligibility for the public option to low-income residents, as contemplated by Oregon.[79]

With the legal and political uncertainties surrounding the choice to offer the Medicaid buy-in on the Marketplace, states may want to preserve flexibility by allowing the plan to be sold both on and off the Marketplace, but also be prepared to change course if unanticipated consequences, such as adverse selection, occur.[80]

2. Public or Private Administration

States can contract with private entities to administer Medicaid buy-in plans, or they can do so internally. States that deliver Medicaid benefits through private managed care plans can build on existing infrastructure and procurement processes to contract with Medicaid Managed Care Organizations ("MCOs") to offer similar plans to non-Medicaid enrollees. In the thirty-eight states that use MCOs to manage Medicaid benefits, the state typically pays a fixed amount per member, and the MCO assumes financial risk for providing health care services for the covered beneficiary.[81] If the MCO kept the Medicaid plans, risk pools, administration, and financing separate from the Medicaid buy-in plans, the state would not need a Section 1115 waiver.[82]

Conversely, if a state Medicaid agency directly administers the buy-in plan alongside Medicaid coverage, the state may be able to streamline administrative functions and generate cost-savings through economies of scale and bulk purchasing power. However, the Medicaid agency may not use federal Medicaid funds to administer the Medicaid buy-in plan (absent a Section 1115 waiver), rendering truly integrated administration difficult to attain.[83] The agency's ability to use joint purchasing arrangements for pharmaceuticals for the Medicaid buy-in plan by leveraging the combined

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[78] *See infra* Section II.B.1.

[79] *See* H.B. 2009, 80th Leg. Assemb., Reg. Sess. § 1(3) (Or. 2019).

[80] *See* H.B. 5463, 2018 Gen. Assemb., Reg. Sess. (Conn. 2018) (requiring the Commissioner of Social Services, the Office of Health Strategy, and the Health Care Cabinet to study whether the state should apply for waivers, charge copayments and deductibles, and sell the public option plan on the Marketplace as a QHP).

[81] *See* Isaac Buck, *Managing Medicaid*, 11 ST. LOUIS U.J. HEALTH L. & POL'Y 107, 110–11 (2017); Wiley, *supra* note 17, at 850; *Medicaid and Managed Care – Policy Brief*, KAISER FAM. FOUND. (May 30, 1995), https://www.kff.org/medicaid/issue-brief/medicaid-and-managed-care-policy-brief [https://perma.cc/FWH9-6X7M].

[82] *See* Wiley, *supra* note 16, at 869–70 ("In states that have largely privatized Medicaid, the most natural approach would be to develop a public option that relies on the state's infrastructure for Medicaid managed care contracts, but is otherwise separate from Medicaid. . . . [T]he impact on Medicaid could be negligible and a waiver may be unnecessary.").

[83] *See* U.S.C. §§ 1396a, 1396b(a)(7); 42 C.F.R. 433.15(b) (2021).

populations of the Medicaid buy-in plan and the Medicaid program, however, remains promising.[84]

Of the thirteen states that considered bills to create a Medicaid buy-in, eleven currently use MCOs to manage at least a portion of their Medicaid program.[85] Administration of a Medicaid buy-in through existing Medicaid MCOs was the predominant approach. Among these, bills in Georgia, Oregon, and Wisconsin would require MCOs to administer the public option in contract with the state Medicaid agency,[86] while bills in Massachusetts, Nevada, New Mexico, and West Virginia would allow the director to offer the program through MCOs.[87] However, Medicaid MCOs have mixed performance in cost savings,[88] which likely explains why Iowa proposed requiring its Medicaid agency to establish and administer the Medicaid buy-in plan in addition to terminating all of its existing MCO contracts.[89] To avoid violating federal funding restrictions, the Iowa bill would require the Iowa Medicaid agency to obtain any necessary Section 1115 waivers.[90] In sum, a state's prior experience with Medicaid MCOs will likely determine whether it chooses to administer a Medicaid buy-in internally or via private carriers.

E. Financial Considerations

1. Financing Sources

In addition to administration, policymakers must determine how to pay for Medicaid buy-in plans. Medicaid buy-in plans are primarily funded through enrollee premiums and cost-sharing.[91] For Medicaid buy-ins offered on the Marketplace, federal subsidies, such as PTC and CSR payments, can also help fund the plan.[92] Relying only on individual and federal funds makes the Medicaid buy-in plan more politically palatable and keeps the plan budget-neutral to the state, allowing it to comply with state balanced-

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[84] *See infra* text accompanying notes 91–92.

[85] Connecticut and Wyoming do not use Medicaid MCOs.

[86] *See* Ga. S.B. 339 (2020); Or. H.B. 2009 (2019); Assemb. B. 449, 2017–2018 Legis. (Wisc. 2017). Oregon uses coordinated care organizations to manage their Medicaid program.

[87] *See* Nev. Assemb. B. 374 (2017); N.M. H.B. 416 (2019); W. Va. H.B. 4789 (2020).

[88] *See* Michael S. Sparer, *Medicaid Managed Care*, Robert Wood Johnson Found. (Sept. 4, 2012), https://www.rwjf.org/en/library/research/2012/09/medicaid-managed-care.html [https://perma.cc/FCE4-M7E8]; *see also* Jeff C. Goldsmith, David Mosley & Anne Jacobs, *Medicaid Managed Care: Lots of Unanswered Questions (Part 2)*, Health Affs. (May 4, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180430.510086/full/ [https://perma.cc/D3C3-JKCH].

[89] *See* H.F. 2002, 87th Gen. Assemb., Reg. Sess. § 3 (Iowa 2018).

[90] *Id.* § 2-(2)(b).

[91] *See, e.g.*, N.M. S.B. 405 (2019) ("The department shall . . . set the total amount of premiums that should be assessed to [M]edicaid buy-in plan enrollees, after an actuarial analysis, to ensure maximum access to coverage. Premiums imposed may be set at a level sufficient to offset the costs of health benefits under the [M]edicaid buy-in plan and related administrative costs.").

[92] *See supra* text accompanying notes 54–56.

budget requirements.[93] However, the remaining uninsured population that many states seek to cover through a Medicaid buy-in are uninsured because they are ineligible for Medicaid coverage or sufficient PTCs to afford Marketplace coverage. So, the key financing challenge remains: how to reach low-income residents who aren't eligible for federal subsidies? In particular, states must decide whether to use state funds to subsidize costs for lower income residents.

Of the Medicaid buy-in plans, Connecticut, Massachusetts, Oregon, and Wyoming require the state to set premiums intended to cover the actuarial value of the health services provided,[94] while New Mexico and West Virginia require the public option to offer financial assistance through discounted premiums and reduced cost-sharing fees to residents with household incomes below 200% of FPL.[95] To offer this financial assistance, the bills from New Mexico and West Virginia establish non-reverting funds in the state treasury, but do not specify how the states will raise the necessary funds.[96] As states have few federal funding sources to help cover the remaining uninsured, tensions exist between state coverage goals and financial realities.

2. Cost Control

Expanding the availability of coverage to the uninsured makes cost containment a central concern of any public option plan. States have primarily sought to restrain provider payment rates to limit public option premiums. Medicaid buy-in plans would base provider rates on those paid by the Medicaid program.[97] Medicaid pays the lowest provider rates of all payers—less than Medicare and far below private insurance plans.[98] While the tradi-

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[93] *See* Nicholas Bagley, *Federalism and the End of Obamacare*, 127 YALE L.J.F. 1, 10 (2017) (noting that the states, unlike the federal government, cannot deficit-spend to cover health care costs in times of revenue contraction); Sparer, *supra* note 37, at 269.

[94] *See, e.g.*, H.B. 1132, 191st Gen. Ct., Reg. Sess. § 1(b) (Mass. 2019); S.F. 133, 2019 Leg., Reg. Sess. § 42-4-123(b) (Wyo. 2018).

[95] *See* H.B. 4789, 84th Leg., 2d. Reg. Sess. § 9-4F-4 (W. Va. 2020) (requiring the department administering the plan to "establish an affordability scale for premiums and other cost-sharing fees . . . based on household income. The department shall offer discounted premiums and cost-sharing fees . . . provided, that the financial assistance is, at a minimum, offered to residents with household incomes below 200% of the federal poverty level."); N.M. H.B. 416 (offering state-funded premium subsidies to residents earning at or below 200% of FPL).

[96] *See* N.M. S.B. 405 (2019) § 6(B); W.Va. H.B. 4789 (2020).

[97] *See* W. Va. H.B. 4789 § 9-4F-3(f); N.M. H.B. 416 § 4(F) ("Health care provider reimbursement rates shall be based on the Medicaid fee schedule[.]"); *see also* Michael Ollove, *Medicaid 'Buy-In' Could Be a New Health Care Option for the Uninsured*, PEW: STATELINE (Jan. 10, 2019), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/01/10/medicaid-buy-in-could-be-a-new-health-care-option-for-the-uninsured [https://perma.cc/GGN8-YSQ9].

[98] *See* Thomas M. Selden, Zeynal Karaca, Patricia Keenan, Chapin White & Richard Kronick, *The Growing Difference Between Public and Private Payment Rates for Inpatient Hospital Care*, 34 HEALTH AFFS. 2147, 2147 (2015). While Medicaid rates for specific services rendered overall are about fifty-five percent of Medicaid payments to hospitals, other

tional Medicaid fee schedule is administratively set by each state and not subject to negotiation by providers, Medicaid MCOs typically negotiate payment rates for providers that participate in their network within established state restrictions, including minimum payment rates for providers in some categories.[99] Most of the Medicaid buy-in bills do not specify reimbursement rates, and even when they reference Medicaid rates, the buy-in plan could conceivably pay a higher multiple of Medicaid rates, such as 150% of current rates. Most states contemplate higher reimbursement rates when possible, but offer few specifics in the bills about how to accomplish that goal.[100]

In addition to controlling costs through provider reimbursement rates, some states also consider mechanisms to control prescription drug costs. The New Mexico and West Virginia bills, for example, allow the health services department to contract with other entities or states to combine purchasing power and seek federal authority to create a wholesale drug importation program.[101] Georgia's bill requires the state Medicaid agency to "establish a method for procuring prescription drugs consistent with the manner utilized for Medicaid,"[102] but the bill does not specify whether that would include extending the Medicaid best price rule to the state public option.

Medicaid buy-in plans must walk a fine line with cost-control. On the one hand, extending Medicaid provider reimbursement rates to the buy-in population holds the greatest promise for making premiums more affordable. On the other hand, if states set provider reimbursement rates too low, providers may drop out of the public option or Medicaid programs, creating unintended effects on the private insurance market.

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supplemental payments, including disproportionate share hospital payment, upper payment limit, uncompensated care pool payments, and delivery system reform incentive payments, mean that Medicaid payments to hospitals on par with Medicare. *See* MEDICAID BASE AND SUPPLEMENTAL PAYMENTS TO HOSPITALS (2020), https://www.macpac.gov/wp-content/uploads/2020/03/Medicaid-Base-and-Supplemental-Payments-to-Hospitals.pdf [https://perma.cc/UYG8-SBFZ]; *Fact Sheet: Underpayment by Medicare and Medicaid*, AHA (Jan. 2021), https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid [https://perma.cc/R9VG-T86T]. The public option bills we studied are silent on whether Medicaid buy-in public option payments would be based on an aggregate Medicaid payment rate or on the fee for service schedule.

[99] *See* 42 U.S.C. 1396a(a)(13); KATHLEEN GIFFORD, EILEEN ELLIS, AIMEE LASHBROOK & MIKE NARDONE, KAISER FAM. FOUND., A VIEW FROM THE STATES: KEY MEDICAID POLICY CHANGES: RESULTS FROM A 50-STATE MEDICAID BUDGET SURVEY FOR STATE FISCAL YEARS 2019 AND 2020 70 (2019), http://files.kff.org/attachment/Report-A-View-from-the-States-Key-Medicaid-Policy-Changes [https://perma.cc/MC7E-CFXD] (noting that nearly half (nineteen) of MCO states reported mandating minimum provider reimbursement rates in their MCO contract).

[100] For instance, Connecticut requires and Massachusetts allows excess funds to be used to increase reimbursement rates for providers. *See* R.B. 5463, 2018 Gen. Assemb., Reg. Sess. §§ 3, 4 (Conn. 2018); H.B. 1132, 191st Gen. Ct., Reg. Sess. § 1(b) (Mass. 2019).

[101] *See* N.M. S.B. 405 § 5(C)(4) (2019); W. Va. H.B. 4789 (2020).

[102] *See* Ga. S.B. 339 (2020).

F. Market Effects

One of the most difficult design considerations for policy makers seeking to implement a Medicaid buy-in is identifying and minimizing adverse effects on existing markets. In particular, a public option with payments pegged to Medicaid rates has the potential to destabilize both provider and insurance markets and reduce access. Some federal public option proposals would require providers to accept the public option in order to participate in Medicare and Medicaid,[103] and a state could require any provider that accepts Medicaid patients or Marketplace plans to accept the public option plan.[104] In many markets, however, Medicaid MCOs already struggle to recruit sufficient providers,[105] and if large portions of state residents are covered by a plan that uses Medicaid rates, providers may leave the state. Not only would this harm enrollment in the Medicaid buy-in, but it could have deleterious effects on access to providers by actual Medicaid enrollees.

Disruptions to the insurance market are more ambiguous. A Medicaid buy-in plan that undercuts premiums for private plans on the Marketplace could slow premium growth—a good disruption—but it could also reduce consumers' choices if private insurance carriers and providers leave the market.[106] Nonetheless, private insurer exit may not be a problem so long as sufficient providers participate—in fact, this may be the goal of a public option.[107] A cheaper, comprehensive Medicaid buy-in could also cause adverse selection between Marketplace plans and the Medicaid buy-in if the public option disproportionately attracts individuals with high health care costs. In this case, the premiums calculated by the state will not be sufficient to cover expenditures. The ACA helps mitigate this risk by applying risk adjustment to Marketplace plans and by requiring insurers to place all indi-

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[103] *See* Tricia Neuman, Karen Pollitz, Jennifer Tolbert, Robin Rudowitz & Wyatt Koma, *10 Key Questions on Public Option Proposals*, KAISER FAM. FOUND. (Dec. 18, 2019), https://www.kff.org/health-reform/issue-brief/10-key-questions-on-public-option-proposals/ [https://perma.cc/ES3Y-2TNS].

[104] *See* MATTHEW FIEDLER, USC BROOKINGS-SCHAEFFER INITIATIVE FOR HEALTH POL'Y, CAPPING PRICES OR CREATING A PUBLIC OPTION: HOW WOULD THEY CHANGE WHAT WE PAY FOR HEALTH CARE 10 (2020).

[105] *See* RACHEL GARFIELD, ELIZABETH HINTON, ELIZABETH CORNACHIONE & CORNELIA HALL, KAISER FAM. FOUND., MEDICAID MANAGED CARE PLANS AND ACCESS TO CARE: RESULTS FROM THE KAISER FAMILY FOUNDATION 2017 SURVEY OF MEDICAID MANAGED CARE PLANS 7 (2018), http://files.kff.org/attachment/Report-Medicaid-Managed-Care-March-Plans-and-Access-to-Care [https://perma.cc/YSG6-BYJT] (finding eighty percent of Medicaid MCO plans report difficulty in finding adult or pediatric subspecialists and forty percent report difficulty in recruiting primary care physicians).

[106] *See* CHIQUITA BROOKS-LASURE, APRIL GRADY, ASHLY TRAUBE & PATRICIA BOOZANG, MANATT HEALTH, QUANTITATIVE EVALUATION OF A TARGETED MEDICAID BUY-IN FOR NEW MEXICO 16 (2019), https://www.manatt.com/Manatt/media/Documents/Articles/Final-New-Mexico-Buy-In-Phase-2-Paper-1-25.pdf [https://perma.cc/C6PT-HSS5] (arguing that offering a Medicaid-like QHP on the Marketplace could decrease competition if private insurers struggle to compete with lower-cost options and exit the market).

[107] *See* Hoffman, *supra* note 17, at 12.

vidual plan enrollees, both on and off the Marketplace, in one risk pool.[108] Therefore, Medicaid buy-in plans offered on and off the Marketplace would presumably participate in risk-adjustment.[109] A legislatively authorized study analyzing four options for a proposed Medicaid buy-in in New Mexico suggested that offering two plans—one a QHP on the Marketplace and one off the Marketplace targeting those impacted by the family glitch or immigration status—could minimize disruptions to the state Marketplace because they could be implemented in the same ACA risk pool.[110]

At first glance, Medicaid buy-in plans are an appealing vehicle for a public option because they build on existing infrastructure, offer comprehensive benefits, control costs by importing Medicaid's low provider rates and administrative costs, and come with significant federal funding. The reality, however, is much more constrained and complicated. To comply with the legal constraints of the Medicaid statute and the Affordable Care Act, a state must contort and narrow a Medicaid buy-in, significantly diminishing its resemblance to actual Medicaid. In implementing Medicaid buy-ins, states will likely require Medicaid-managed care plans to offer a separate but similar plan on and off the ACA Marketplaces to allow those eligible for PTCs to use them to purchase the plan, and those who are ineligible (like undocumented immigrants) to purchase a similar plan outside the Marketplace. For legal and practical reasons, the benefits, premiums, cost-sharing, provider reimbursement, and plan design would look more like a Marketplace plan than a Medicaid plan. Thus, the scale of innovation and the scope of increased coverage would probably be modest. Viable Medicaid buy-ins are small-bore public option plans. Perhaps this is why the first states to actually implement a public option follow the next model we review, the Marketplace-based public option plan.

II. Marketplace-Based Public Options

Marketplace-based public options ("MBPOs") offer states the opportunity to provide affordable, comprehensive coverage to large portions of the population, while generating competition on the ACA Marketplace and bringing federal funds into the state to support health care expenses. MBPOs are health insurance plans that satisfy ACA Marketplace specifications, including state QHP certification, and also conform to coverage, provider payment, and other specifications established by the state for the public option. We examined twenty-one MBPO bills across ten states introduced between

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[108] *See* 42 U.S.C. § 18032.

[109] *See* Cori E. Uccello, Am. Acad. of Actuaries, Expanding Access To Public Insurance Plans 9 (2019), https://www.actuary.org/sites/default/files/files/publications/PublicInsurancePlans.pdf [https://perma.cc/3P6V-F9GY].

[110] *See* Brooks-LaSure et al., *supra* note 107, at 14.

2010 and 2021, including three in Washington, Colorado, and Nevada that were signed into law.[111] MBPOs' largest advantage in comparison to other public option plans is the opportunity to capitalize on the federal subsidies, in the form of PTCs and CSRs. MBPO plans also face fewer legal constraints than Medicaid buy-ins.

A. Policy Goals

As the most flexible public option model, state MBPOs can take a variety of forms depending on the state's policy goals. States can design MBPOs to meet any of the policy goals of a public option, including increasing affordability, reducing churn, providing near-universal coverage untethered to employment (with notable exceptions), increasing competition and market function, and simplifying administration.

Nearly all states contemplating a public option hope to offer comprehensive and affordable coverage, while controlling or reducing health care spending.[112] The Colorado legislature stated that the purpose of the public option plan was to "increas[e] the availability of affordable health insurance statewide to any resident seeking coverage in the individual market[.]"[113] States hope MBPOs will control health spending by reducing provider payments to below commercial rates through price caps,[114] lowering administrative expenses,[115] and generating price competition within the Marketplace to drive down commercial plan rates.[116]

Beyond affordability, states have proposed MBPOs to achieve additional policy goals. For instance, Massachusetts and Illinois sought to achieve universal coverage and serve as a glide path to a public single payer by offering MBPO coverage to enrollees in the individual, small group, and large group markets.[117] As noted above, MBPOs can also reduce the harms of churning on and off Medicaid by ensuring that people can keep their doctors even if their plan technically changes.[118] Finally, states seeking to improve market function and enhance patient choice can create an MBPO to

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[111] *See* Appendix A. Washington enacted its public option in 2019, and Colorado and Nevada enacted theirs in 2021. *See* S.B. 5526, 66th Leg., 2019 Reg. Sess. (Wash. 2019); H.B. 21-1232, 73rd Gen. Assemb., 1st Reg. Sess. (Colo. 2021); S.B. 420, 2021 Leg., 81st Reg. Sess. (Nev. 2021).

[112] *See, e.g.*, Wash. S.B. 5526; Raised B. 346, 2020 Gen. Assemb., Feb. Sess. § 2(a) (Conn. 2020).

[113] Colo. H.B. 20-1349 § 10-16-1202(2)(a).

[114] *See, e.g.*, Wash. S.B. 5526 § 3(2)(g)(i) (limiting the total reimbursement amount for all covered benefits to 160% of Medicare reimbursement for the same or similar services in the statewide aggregate).

[115] *See, e.g.*, Conn. Raised B. 346 § 2(2) (establishing a medical loss ratio of ninety percent).

[116] *See, e.g.*, Colo. H.B. 20-1349 § 10-16-1205(2)(a)(II)(A).

[117] *See* S.B. 697, 191st Gen. Ct., 2019–2020 Sess. § 3 (Mass. 2019); H.B. 5733, 98th Gen. Assemb., Reg. Sess. § 20 (Ill. 2014).

[118] *See supra* Section I.A.

provide coverage in "bare counties" without any plan offerings, generate competition in areas with minimal existing offerings, and provide consumers and employers more affordable coverage options.[119] The structure of any state MBPO will depend on ACA requirements for all plans offered on the Marketplace as well as the particular needs and policy goals of the state.

B. Legal Issues for Marketplace-Based Public Option Plans

The ACA creates significant financial incentives for states to offer a public option on the Marketplace, but it also imposes requirements on those plans, some of which may be altered via a Section 1332 waiver from HHS.

1. ACA Marketplace Requirements

To access federal Marketplace subsidies, Marketplace-based plans must satisfy the requirements of the ACA. The Marketplaces offer competing health insurance plans with standardized minimum benefits and coverage levels to simplify and facilitate consumer plan selection. Any public option plan offered on the Marketplace must meet the ACA's guaranteed issue[120] and modified community rating provisions,[121] which require plans to accept all individuals and charge them the same premium as other similarly-situated individuals, regardless of health status.[122] Further, all plans offered on the Marketplace must be QHPs,[123] which means they must: (1) be offered by a health insurance issuer in the state that is licensed, in good standing, and has agreed to the requirements for offering a plan on the Marketplace; (2) cover all of the Essential Health Benefits ("EHBs"); and (3) be certified for sale on the Marketplace.[124] The ACA also mandates compliance with federal medical loss ratio ("MLR") limits, which require Marketplace plans to spend at least eighty percent of individual and small group premium revenue to provide health care to patients, or return the difference to enrollees.[125] Each of these requirements aims to ensure meaningful access to comprehensive and affordable health care coverage, therefore many of them, such as the EHBs and MLR, a state would likely include in the design of a public option plan even in the absence of the ACA requirements.

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[119] *See, e.g.*, Colo. H.B. 20-1349 § 10-16-1205(1)(a)–(b) (requiring commercial plans to offer the Colorado Option Plan in the individual market in each county where the carrier offers an individual plan and requiring the commissioner to ensure that there are at least two carriers that offer the Colorado option plan in each county in the state); *see also* S.B. 5526, 66th Leg., 2019 Reg. Sess. § 1(1)–(2)(a) (Wash. 2019); Mass. S.B. 697 § 3; Ill. H.B. 5733 § 20.

[120] *See* 42 U.S.C. § 300gg–1.

[121] *See id.* § 300gg.

[122] *See id.* The ACA's modified community rating provision allows health plans to vary premiums based on geographic area, age (up to 3x), and tobacco usage (up to 1.5x). *See id.*

[123] *See id.* § 18021; 45 C.F.R. § 155.1000 (2021).

[124] *See* 42 U.S.C. § 18021(a)(1).

[125] *See id.* § 300gg-18.

Yet, the specificity of some requirements can affect a state's design of its MBPO plan. For instance, most states do not have an existing state entity that qualifies as a licensed health insurance issuer. Federal regulations define a health insurance issuer as an "insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance . . . ."[126] Therefore, to offer a plan on the Marketplace, states will need to have existing commercial carriers offer the public option plans on the Marketplace,[127] modify the eligibility requirements for Marketplace certification,[128] or grant an existing state agency the authority to offer plans as QHPs on the Marketplace.[129] A state agency seeking the authority to issue QHPs must ensure that each QHP complies with federal and state benefit design standards, remain licensed and in good standing with the State, implement quality improvement strategies, and satisfy the necessary reporting requirements established by the ACA.[130]

Once a state has established a licensed health insurance issuer for the MBPO, the plan must be certified by the Marketplace as a QHP.[131] Many of the certification requirements involve benefit design, including covering the EHBs.[132]

Second, a QHP must also offer coverage of a specific actuarial value, which establishes the percentage of health care costs the plan will cover for a standard population. Plans offered on the Marketplace are divided into four metal tiers based on their actuarial value:[133] Bronze (60%); Silver (70%); Gold (80%); and Platinum (90%).[134] Issuers that offer plans on the Marketplace must offer at least one QHP at the silver level and one at the gold level in each service area in which it offers coverage on the Marketplace.[135] However, issuers do not have to offer plans in all counties in a state or at all four

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[126] 45 C.F.R. § 144.103 (2021).

[127] *See, e.g.*, S.B. 5526, 66th Leg., 2019 Reg. Sess. § 3 (Wash. 2019).

[128] *See* S.B. 697, 191st Gen. Ct., 2019–2020 Sess. § 4 (Mass. 2019) (modifying Chapter 176Q § 5(a) to read: "Only health insurance plans and stand-alone vision or stand-alone dental plans that have been approved by the commissioner and underwritten by a carrier, as well as the public health insurance option, may be offered through the connector.").

[129] *See* S.F. 2302, 91st Leg., 2019 Reg. Sess. § 14(1)(d) (Minn. 2019) (stating that the Dep't of Human Services is deemed to meet and receive certification and authority as a managed care organization).

[130] *See* 45 C.F.R. § 156.200(b) (2021).

[131] *Id.* § 156.200(a).

[132] *See* 42 U.S.C. § 18022. The ten categories of EHBs include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitation and habilitation services, laboratory services, preventive and wellness services, and pediatric services. *Id.*; 45 C.F.R. § 156.110(a) (2021).

[133] *See* 42 U.S.C. § 18022(d); *see also What the Actuarial Values in the Affordable Care Act Mean*, KAISER FAM. FOUND. (Apr. 1, 2011), https://www.kff.org/health-reform/issue-brief/what-the-actuarial-values-in-the-affordable/ [https://perma.cc/Q7US-6EV9].

[134] *See* 45 U.S.C. § 18022(d); 45 C.F.R. § 156.140 (2021).

[135] *See* 45 C.F.R. § 156.200(c) (2021).

levels of coverage, which can create significant geographic and financial gaps in coverage that states may want to address through the creation of MBPOs.

Finally, states can impose their own requirements on health plans offered on the Marketplace via state insurance laws and QHP certification requirements. All states have insurance laws that require plans offered in the state to meet criteria for licensure, including mandatory benefits and maintaining and reporting financial reserves. States operating their own Marketplaces can impose conditions on QHP certification, including requiring issuers selling plans on the Marketplace to offer the MBPO.[136] On the other hand, states with a federally-facilitated Marketplace have less flexibility to impose individual state conditions on issuers because the federal Marketplace has historically certified plans in a unified manner.[137]

Overall, states seeking to create an MBPO will need to design their public option plans to satisfy both federal ACA requirements and state insurance laws. Nevertheless, states may apply for a Section 1332 waiver from HHS to deviate from ACA requirements.

2. Deviations from ACA Requirements: Section 1332 Waivers

To offer an MBPO that deviates from ACA requirements, states can apply for a State Innovation Waiver under ACA Section 1332, which allows them to adapt plans offered on the Marketplace to address their specific needs and to try innovative strategies. Section 1332 permits states to waive or modify certain requirements for ACA Marketplace plans, including: the individual and employer mandates, EHB requirements, the definition of a QHP, limits on cost sharing for covered benefits, metal coverage tiers, health insurance Marketplace standards and requirements, PTCs, and CSRs.[138]

For example, the ACA's employer mandate requires large employers to offer "minimum essential coverage" to their employees or pay a penalty.[139] The penalty is triggered for every full-time employee that receives a PTC to purchase coverage on the Marketplace, instead of using employer coverage.[140] This provision may need to be waived if the MBPO were offered to large employers, to ensure the MBPO counts as minimum essential coverage

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[136] *See id.* § 156.200(d); *see, e.g.*, S.B. 5526, 66th Leg., 2019 Reg. Sess. § 1(2)(a) (Wash. 2019).

[137] *See* Waivers for State Innovation, 80 Fed. Reg. 78,131, 78,135 (Dec. 16, 2015) ("Until further guidance is issued, the Federal platform cannot accommodate different rules for different states."). CMS's 2018 guidance notes that technical enhancements may support some variation and flexibility for states using the federal Marketplace to try models through use of Section 1332 waivers. *See* State Relief and Empowerment Waivers, 83 Fed. Reg. 53,575, 53,581 (Oct. 24, 2018).

[138] *See* 42 U.S.C. § 18052(a)(1).

[139] *See* 26 U.S.C. § 4980H(a)–(c).

[140] *See id.*

and to prevent employers from being penalized if employees choose the MBPO.

The ACA, however, imposes significant requirements on states seeking a Section 1332 waiver: they must pass legislation permitting the state to seek such a waiver and comply with strict guardrails when proposing changes to ACA requirements.[141] For instance, the proposed plan must not reduce the comprehensiveness of benefits, increase cost sharing, or cover fewer residents than would be covered absent the waiver.[142] Furthermore, the proposal must not increase the federal deficit, which means that the projected federal spending with the waiver must be equal to or less than the projected spending without the waiver.[143] Numerous factors can affect the federal revenue and net federal spending, including changes to federal income, payroll or excise tax revenue, premium tax credits, small business credits, employer shared responsibility payments, Medicaid spending and other forms of federal assistance, and administrative costs.[144]

Needless to say, designing a plan modification that can meet these requirements, passing legislation, and submitting a Section 1332 waiver can be onerous for states, and HHS has considerable discretion to deny the waiver, even those that successfully meet these criteria.[145] Faced with these challenges and uncertainties, states wishing to deviate from the ACA requirements may consider offering their public option plan off the Marketplace to avoid the Section 1332 waiver process.

However, Congress created strong incentives for states to innovate within the ACA structure by offering federal pass-through funding to states that receive Section 1332 waivers.[146] If the state reduces the costs of Marketplace plans through Section 1332 innovation, the federal government will pass any savings it incurred from reductions in federal ACA assistance, including PTCs, CSRs, and small business credits, back to the state.[147] States can use the federal pass-through funding to help fund their new state plan. In particular, states may use pass-through funds to increase subsidies for individuals earning above 400% of FPL (the cutoff for federal ACA subsidies) and limit the percentage of income enrollees spend on health care.[148] How-

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[141] *See* 42 U.S.C. § 18052(b)(2).

[142] *See id.* § 18052(b)(1)(A)–(C).

[143] *See id.* § 18052(b)(1)(D) (stating that waivers cannot increase the deficit during the waiver term (up to 5 years) or in total over the ten-year budget plan); State Relief and Empowerment Waivers, 45 C.F.R. §§ 155.1300–155.1328 (2021).

[144] *See* Waivers for State Innovation, 80 Fed. Reg. 78,131, 78,133 (Dec. 16, 2015) (to be codified at 45 C.F.R § 155 (2021)); State Relief and Empowerment Waivers, 83 Fed. Reg. 53,575 (Oct. 24, 2018).

[145] *See* Waivers for State Innovation, 80 Fed. Reg. 78,131, 78,133 (Dec. 16, 2015).

[146] *See* 42 U.S.C. § 18052 (a)(3).

[147] *See id.* The pass-through savings does not include any savings other than the reductions in federal assistance provided by the ACA. *See* State Relief and Empowerment Waivers, 45 C.F.R. § 155 (2021).

[148] *See, e.g.*, Raised S.B. 346, 2020 Gen. Assemb., Feb. Sess. § 2(a)(4)(B) (Conn. 2020) (offering cost-sharing subsidies to public option plan enrollees who are ineligible to receive

ever, states must be mindful that the federal government will reduce pass-through savings by losses in federal revenue arising from the waiver to ensure deficit neutrality.[149] The promise of federal money to subsidize health reform may provide powerful motivation for states that must balance their budgets to obtain a Section 1332 waiver for their public option plans.

When designing MBPOs, states must scaffold around ACA requirements as they seek to fulfill their goals for target population, plan administration, financing, and market impact. State goals and priorities can affect the design, legal, and financial implications of offering various MBPO models on the Marketplaces.

C. Target Population

MBPOs primarily target populations that seek individual or small group coverage through the ACA Marketplace, although some MBPOs would also allow large groups to participate. Unlike Medicaid buy-in models, states have less ability to offer MBPO plans directly to a specific target population. Instead, at a minimum, MBPO plans must be offered to any eligible individual in a particular geographic area, which generally includes all lawfully present residents who are not incarcerated.[150] As a result, states cannot limit plan eligibility to individuals that make below certain income levels. They can, however, use financial incentives, such as enhanced subsidies, to encourage certain individuals to enroll in the public option.[151] For example, Washington, aiming to prevent individuals from spending more than ten percent of their income on individual coverage, would require state authorities to develop a plan to offer state-sponsored premium subsidies for individuals earning up to 500% of FPL who purchase individual coverage on the exchange.[152] States, in their capacity as employers, can also use automatic enrollment of public employees to expand the plan's risk pool and purchasing power.[153]

States can also target citizens of specific geographic areas by offering or requiring commercial insurers to offer MBPO plans in areas that currently lack coverage or have minimal coverage in the Marketplace. To address the fact that twenty-two counties had only one plan offered on the Marketplace,

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CSRs offered by the ACA); S.B. 5526, 66th Leg., 2019 Reg. Sess. § 6(1) (Wash. 2019) (increasing subsidies to those earning up to 500% of FPL and limiting individual premium spending to ten percent of adjusted gross income). Both Connecticut's and Washington's proposals would require Section 1332 waivers to use federal pass-through funds and vary the ACA rules in this way.

[149] For instance, if the Section 1332 waivers result in lower federal tax revenue or higher Medicaid enrollment, the amount of pass-through savings offered back to the state will be offset by those losses. State Relief and Empowerment Waivers, 45 C.F.R. § 155 (2021).

[150] *See* 42 U.S.C. § 300gg–1; *see, e.g.*, S. 109, Gen. Assemb., 2011–2012 Reg. Sess. §§ 4402, 4403(7) (Vt. 2011).

[151] *See, e.g.*, S.B. 5526, 66th Leg., 2019 Reg. Sess. § 6(1) (Wash. 2019).

[152] *See id.*

[153] *See* UCCELLO, *supra* note 109, at 13.

the Colorado legislature proposed that at least two carriers offer the Colorado Option Plan in the individual market in every county and granted the Insurance Commissioner the authority to require carriers to offer the Colorado Option Plan in specific counties to fulfill this mandate.[154] Geographic market requirements can help states ensure the availability of individual market coverage throughout the state.

Beyond the individual market, states can also offer MBPO plans to allow small and large employers to enroll their employees. Expanding MBPOs to small employers can ease premium volatility and provide a more affordable choice in this typically dysfunctional market.[155] Broadening MBPO enrollment to include large groups would significantly expand the risk pool and increase its purchasing power, while offering employers and employees an affordable coverage option that reduces administrative burden. As noted above, offering large group plans on the Marketplace may require the state to apply for a Section 1332 waiver of the ACA's employer mandate and other requirements.[156] Over the last decade, Massachusetts proposed a series of nearly identical bills that would offer a state public option in both small and large group markets.[157] Illinois followed suit in 2013 by offering HB 5733, which largely mirrored the Massachusetts bills.[158] These bills proposed allowing a wide array of associations and entities to offer their employees and members insurance through the MBPO.[159] Section 1332 waivers can enable states to cover a very broad target population through MBPOs and move toward removing the tether between employment and health insurance.

In the absence of a Section 1332 waiver, however, the ACA imposes eligibility restrictions that limit states' ability to reach some target populations. For instance, states cannot use MBPO plans to offer insurance options to undocumented immigrants or individuals who have access to employer-sponsored insurance that qualifies as affordable under the ACA without a Section 1332 waiver.[160] Given these limits and the political uncertainty of

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[154] *See* H.B. 20-1349, 72nd Gen. Assemb., 2d Reg. Sess. § 10-16-1205(1) (b) (Colo. 2020); *see also* S.F. 2302, 91st Leg., 2019 Reg. Sess. art. 9 § 15 subd. 1–2 (Minn. 2019).

[155] *See, e.g.*, COLO. DIV. OF INS. & DEP'T OF HEALTH CARE POL'Y & FIN., FINAL REPORT FOR COLORADO'S PUBLIC OPTION 21 (2019) [hereinafter COLORADO REPORT ON THE PUBLIC OPTION].

[156] *See supra* text accompanying notes 129–30.

[157] *See* H.B. 1228, 187th Gen. Ct., Reg. Sess. (Mass. 2011); S.B. 514, 188th Gen. Ct., Reg. Sess. (Mass. 2013); H.B. 1033, 189th Gen. Ct., Reg. Sess. (Mass. 2015); S.B. 638, 190th Gen. Ct., Reg. Sess. (Mass. 2017); S.B. 697, 191st Gen. Ct., Reg. Sess. § 3 (Mass. 2019).

[158] *See* H.B. 5733, 98th Gen. Assemb., Reg. Sess. § 20 (Ill. 2013).

[159] *See* Mass. S.B. 697 § 3 (including sole proprietors, labor unions, trade associations, and others).

[160] *See* 42 U.S.C. § 18081(a)(1). In 2016, California applied for a Section 1332 waiver to permit undocumented individuals to purchase plans on the state-based Marketplace, but withdrew the application when the Trump Administration took office. *See* Letter from Peter V. Lee, Exec. Dir., Covered Cal. Bd. of Dirs., to Sylvia Matthews Burwell, Sec. of Health & Hum. Servs., U.S. Dep't of Health & Hum. Servs. on Covered California 1332 State Innovation Waiver Application – Resubmission (Dec. 16, 2016) (on file with authors); *see also* Letter

obtaining a Section 1332 waiver, state legislatures aiming to cover currently ineligible populations can provide the implementing agency the flexibility to offer the public option plan on the Marketplace, off the Marketplace, or both.[161]

Defining the target population for an MBPO often determines the scope of the public option proposal. States should consider whether to specify the target population in implementing legislation or leave the ultimate decision up to the administrative agency implementing the MBPO. That decision will depend on how involved a state wants to be in administering the plan.

D. Administration

One of the most consequential decisions states must make in the development of an MBPO is how involved to be in plan administration. As with Medicaid buy-ins, the choice between a public-private partnership or a state-administered MBPO depends on the amount of control and authority the state wants over the MBPO and the state's willingness to invest time and resources to gain that control. The easiest and least resource-intensive path for states is to contract with commercial carriers to offer the MBPO on the Marketplace—the approach taken by Washington, Colorado, and Virginia.[162] As the least "public" of the models, this public-private model allows the state to specify certain terms of the MBPO, but places the majority of the administrative burden and financial risk on commercial carriers. The trade-off for minimal state burden or investment, however, is that the state cedes control and financial savings. A more traditionally public state-administered model, exemplified by Connecticut, Massachusetts, and Illinois, would give states control over finances and unify administration within one government-run entity. The downsides of the state-administered model include greater financial risk, administrative burden, and resource allocation constraints. As noted above, states with a state-based Marketplace will have more flexibility

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from Peter V. Lee, Exec. Dir., Covered Cal. Bd. of Dirs., to Kevin J. Counihan, Dir. & Marketplace Exec. Officer, U.S. Dep't of Health & Hum. Servs. on Covered California 1332 State Innovation Waiver Application Withdrawal Request (Jan. 18, 2017) (on file with authors).

[161] *Compare* S.B. 346, 2020 Gen. Assemb., Feb. Sess. § 2(a)(1), (3) (Conn. 2020) (leaving decisions of how to define enrollment eligibility and whether to offer the ConnectHealth plan, Connecticut's public option, on the Marketplace to the state Comptroller, the entity assigned to administer the plan), *with* H.B. 20-1349, 72nd Gen. Assemb., 2d Reg. Sess. § 10-16-1205(2)(a)(1) (Colo. 2020) (requiring the Insurance Commissioner to offer the public option plan to all individuals that purchase health insurance in the individual market in plans offered both on and off the Marketplace). *See also* H.B. 21-1232, 73rd Gen. Assemb., 1st Reg. Sess. § 10-16-1304(1) (Colo. 2021) (requiring the Commissioner to establish a standardized health benefit plan to be offered by carriers in the individual and small group markets both on and off the Marketplace).

[162] *See* S.B. 5526, 66th Leg., 2019 Reg. Sess. § 3(1)(c) (Wash. 2019); H.B. 20-1349, 72nd Gen. Assemb., 2d Reg. Sess. § 10-16-1205 (Colo. 2020); H.B. 530, 2020 Gen. Assemb., Reg. Sess. § 32.1-329.1(B) (Va. 2020).

to administer their own MBPO than states with federally-run Marketplaces, due to uniformity requirements on the federal Marketplace.[163]

1. Public-Private Partnership with Commercial Plans

The simplest way for states to create an MBPO is to contract with commercial insurance carriers to offer plans with state-specified criteria. These state-specified criteria can range from little more than the ACA requirements for QHPs and some provider reimbursement restrictions[164] to complex benefit design models and cost-saving mechanisms. Two of the three states that have gone farthest in implementing a public option, Washington and Colorado, took the latter approach, requiring commercial carriers to implement state-designed plans with a broad range of specifications.[165]

In 2019, Washington created the nation's first public health insurance option, known as CascadeCare.[166] Though not publicly administered, Washington called the plan a "public option" because the state imposed "public-sector reimbursement rates on a commercial insurance market."[167] According to Michael Sparer, Washington's "goal was to derive the benefits of a public option without the political, organizational, and economic tasks of creating a new, state-administered insurer."[168]

Washington created a public-private hybrid that required the Health Care Authority, in consultation with the Health Benefit Exchange, to contract with commercial carriers to offer the public option plan on the Marketplace.[169] Carriers, however, are not required to participate.[170] Instead, the Health Care Authority must contract with sufficient carriers to offer the public option in every county.[171]

Washington imposed several conditions on its public option plans.[172] Significantly, the law limits provider reimbursement in the aggregate to 160% of Medicare reimbursement rates for the same or similar services.[173] Other requirements include rate review and network adequacy, care coordination, value-based purchasing, and generic drug and utilization review re-

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[163] *See supra* discussion accompanying notes 126–27.

[164] *See, e.g.*, H.B. 530, Gen. Assemb., 2020 Reg. Sess. § 32.1-329.1(D) (Va. 2020).

[165] *See* Wash. S.B. 5526; Colo. H.B. 20-1349; Colo. H.B. 21-1232.

[166] *See* Billy Wynne, *Public Option 1.0: Washington State Takes an Important Step Forward*, HEALTH AFFS.: BLOG (May 1, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190430.353036/full/ [https://perma.cc/VWC8-T477]; *Cascade Care*, WASH. STATE HEALTH CARE AUTH., https://www.hca.wa.gov/about-hca/cascade-care [https://perma.cc/WYD5-FEVX].

[167] Sparer, *supra* note 38, at 263.

[168] *Id.*

[169] 2019 Wash. Sess. Laws, enacting Engrossed Substitute S.B. 5526, 66th Leg., 2019 Reg. Sess. § 3(1) (Wash. 2019).

[170] *See* Sparer, *supra* note 38, at 264.

[171] *See* S.B. 5526, 66th Leg., 2019 Reg. Sess. § 3(1) (Wash. 2019).

[172] *See id.* § 3(2).

[173] *See id.* § 3(2)(g)(i). For a discussion of Washington's provider rate limits, see *infra* Section II.E.2.

quirements.[174] The authority granted to Washington state agencies gives them significant control over the features and functions of the contracted CascadeCare plans.

Like Washington, Colorado pursued a public-private hybrid that requires commercial insurers to offer a state-regulated "Colorado Option Plan" on the Marketplace. In 2019, the Colorado legislature directed state health authorities to develop a proposal to create an "innovative state option for health insurance coverage."[175] A bill to implement the ensuing plan appeared poised to pass in 2020, but was tabled due to COVID-19.[176] The bill, H.B. 20-1349, would have required all carriers that offer a health plan in the individual market to also offer the Colorado Option Plan in the same county. Colorado's H.B. 20-1349 covered the EHBs; provided at least bronze and silver levels of coverage; and offered first-dollar, pre-deductible coverage for certain services, such as primary health care and behavioral health care.[177] Further, the bill granted the Insurance Commissioner the ability to require carriers to offer public option plans in specific counties.[178]

Colorado's 2020 bill was unique because it created a powerful, independent board to oversee public option development.[179] The Board would advise the Commissioner on all aspects of the development, implementation, and operation of the Colorado Option Plan,[180] and has the ability to override any decision made by the Commissioner concerning the Colorado Option Plan.[181] The combination of a state official with significant power over plan design, private entities to implement it, and an independent advisory and oversight body with override power would have allowed the state to tailor the public option plan to its specifications while avoiding many of the challenges of self-administering the plan and keeping the risk of agency capture in check.[182] With significant concessions to health care providers and private

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[174] *See* Wash. S.B. 5526 § 3.

[175] H.B. 19-1004, 72nd Gen. Assemb., 1st Reg. Sess. § 25.5-1-129 (1)(a)(VII)(b) (Colo. 2019).

[176] *See* Ryan Osborne, *Colorado Public Health Insurance Option Put on Hold Due to Covid-19*, DENV. CHANNEL (May 4, 2020), https://www.thedenverchannel.com/news/local-news/colorado-public-health-insurance-option-bill-put-on-hold-due-to-covid-19 [https://perma.cc/E2YA-Z7D4]. The state will likely reintroduce the bill in 2021.

[177] *See* H.B. 20-1349, 72nd Gen. Assemb., 2d Reg. Sess. § 10-16-1205 (2)(a) (Colo. 2020).

[178] *See id.* § 10-16-1205(1)(b).

[179] *See id*. New Jersey also proposed the creation of the New Jersey Public Option Health Care Board within the Department of Health, but it has less authority, as its power to establish and amend regulations are subject to approval by the Commissioner of Health. *See* S. 1947, 219th Leg., Reg. Sess. § 5.a. (N.J. 2020).

[180] This includes plan standardization, allocation of federal pass-through funds, the federal waiver application process, value-based payment models, the possibility of offering the Colorado Option Plan in the small group market, and ways to improve quality, access, and affordability of health care. *See* Colo. H.B. 20-1349 § 10-16-1204(5)(a)–(g).

[181] *See id.* § 10-16-1204(6) (allowing override by a vote of seven of nine Board members).

[182] For a detailed description of the membership requirements, appointment proceedings, and powers of the Colorado Option Advisory Board, *see id.* § 10-16-1204.

health carriers, the Colorado legislature passed a scaled-back version of its public option in 2021, described in Part IV below.

By partnering with private commercial carriers to administer and provide MBPO plans, states can dictate certain aspects of the public option, such as provider reimbursement caps and benefit design features, without taking administrative and financial responsibility for the plans themselves. However, this public-private model risks sacrificing much of the potential savings and premium reductions available through a more traditionally public MBPO model.

2. State-Administered MBPOs

Instead of partnering with commercial carriers, several states have proposed a state-administered MBPO.[183] State-administered MBPOs provide greater control over all aspects of the public option without the constraints of working with commercial carriers, their profit demands, or the concern that carriers may intentionally compromise the public option.

States may authorize the state official in charge of administering the MBPO to contract with third party administrators ("TPAs"), insurance companies that agree to handle only the administrative functions of a plan, to carry-out various tasks including receipt of individual premiums and PTCs.[184] The main difference between this and the hybrid approach taken in Washington is that the state retains the insurance risk, essentially operating like a self-funded plan sponsor with a commercial TPA to administer some portion or all of the plan.[185]

While state-administered MBPOs offer states greater autonomy and flexibility to design their public option plan, state administration also creates some challenges. One of the largest challenges is that the ACA requires a state-licensed issuer of insurance to offer QHPs,[186] and PTCs may only be paid to an issuer of a QHP.[187] Without state legislative action, state entities are not generally considered issuers of insurance. Furthermore, the ACA's risk adjustment program, which stabilizes the individual market by transferring funds from health insurance issuers with lower-risk enrollees to issuers with higher-risk enrollees, is only available to health insurance issuers, so

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[183] *See* H. 88, 2015 Gen. Assemb., Reg. Sess. (Vt. 2015); H.B. 5733, 98th Gen. Assemb., Reg. Sess. (Ill. 2013); S.B. 697, 191st Gen. Ct., Reg. Sess. (Mass. 2019); S.B. 346, 2020 Gen. Assemb., Feb. Sess. (Conn. 2020); S.F. 2302, 91st Leg., 2019 Reg. Sess. (Minn. 2019).

[184] *See, e.g.*, Conn. S.B. 346 § 2(a)(6); Mass. S.B. 697 § 1 (amending Chapter 176 by adding Chapter 176S which includes Sec. 4 discussing the use of TPAs).

[185] The decision of whether the state retains insurance risk is discussed *infra* Section II.E.1.

[186] *See* 42 U.S.C. § 18021(a)(1).

[187] *See id.* § 18082(c)(2)(A) ("The Secretary of the Treasury shall make the advance payment under this section of any premium tax credit allowed under section 36B of [the Internal Revenue Code of 1986] to the issuer of a qualified health plan on a monthly basis . . . ."); *see also* BOOZANG ET AL., *supra* note 38, at 4.

the state would need to qualify as an insurance issuer to participate.[188] The state could have more flexibility to extend risk adjustment to the state-offered MBPO if it runs its own risk adjustment program, but this large undertaking may require the state to operate its own Marketplace.[189]

States proposing to administer their MBPOs have tried several approaches. First, Connecticut authorized a state official to contract directly with a TPA to administer the MBPO and receive premiums and premium tax credits.[190] Second, Minnesota passed legislation designating a state entity as an issuer of insurance or a managed care organization capable of offering a QHP and receiving federal PTCs and pass-through funds.[191] Third, Massachusetts passed legislation allowing the MBPO to be offered on the Marketplace.[192] Finally, Illinois proposed creating a new state entity authorized by the legislature to stand in the shoes of a carrier for the purposes of administering and funding a QHP offered on the Marketplace.[193] Each of these options represents a state's attempt to satisfy the ACA's requirement that a QHP be offered by a state-licensed insurance issuer. While none have been implemented or tested, Minnesota's approach appears to the most robust in terms of satisfying the ACA requirements.

In sum, the choice about who administers the public option depends on state agency capacity and political will—the more a state has of both, the more likely it can shoulder MBPO administration. Options that designate a state entity to certify the MBPO for Marketplace eligibility or contract with a TPA to offer the plans on the Marketplace are unlikely to require a Section 1332 waiver because they do not interfere with any of the ACA's specific requirements. However, the creation of an entirely new state entity to design and manage an MBPO on the Marketplace may require a Section 1332 waiver because it would modify the requirements for QHP certification. Whether it does will also depend on the financing features of the new plan.

E. Financial Considerations

Financing for a public option can come from three sources: (1) premiums and cost-sharing; (2) federal funds; and (3) state tax revenues. A public

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[188] *See* 42 U.S.C. § 18063.

[189] *See* BOOZANG ET AL., *supra* note 38, at 5.

[190] *See* S.B. 346, 2020 Gen. Assemb., Feb. Sess. § 2(a)(6) (Conn. 2020).

[191] *See* S.F. 2302, 91st Leg., 2019 Reg. Sess. art. 9 § 14 subd. 1(d) (Minn. 2019) (stating that the Dep't of Human Services is deemed to meet and receive certification and authority under Section 62D.03).

[192] *See* S.B. 697, 191st Gen. Ct., Reg. Sess. § 4 (Mass. 2019) (modifying Chapter 176Q § 5(a) to read: "Only health insurance plans and stand-alone vision or stand-alone dental plans that have been approved by the commissioner and underwritten by a carrier, as well as the public health insurance option, may be offered through the connector.").

[193] *See* H.B. 5733, 98th Gen. Assemb., Reg. Sess. § 15 (Ill. 2013) (creating Health Insurance Connector Authority that would operate as independent public entity to develop and administer Illinois public option plan, which must be offered exclusively on Illinois's Marketplace and meet all Marketplace plan requirements).

option that relies only on funding from enrollees may not be affordable, particularly to the remaining uninsured population. Accordingly, many models seek federal funds to offer subsidies to low-income residents, and federal funds from ACA subsidies and pass-through funds for plans sold on the Marketplaces serve as a large well of funding.[194] The ACA provides strong financial incentives for states to offer their public option plans on the Marketplace.[195] At a baseline level, MBPO enrollees are eligible for the federally funded PTCs and CSRs offered through the ACA. Furthermore, if states can qualify for a Section 1332 waiver, the state can also receive pass-through savings from the federal government to help fund the plan.[196] These Marketplace-based financial supports can help bolster states' ability to offer public option plans and drive the decision to offer them on the Marketplace.

All state models we reviewed would finance MBPOs in large part through premiums paid by enrollees. Where states differ is whether the state or commercial carriers bear the financial risk of offering the MBPO plans. A second financial consideration is what cost control mechanisms to implement. There is a relationship between the two—the more financial risk and administrative burden a state can shoulder, the greater the potential savings it can generate.

1. Financial Risk-Bearing

As with administration, a state can shift financial risk and the attendant resources to manage the risk (such as maintaining adequate financial reserves) to commercial carriers offering MBPO plans. In this public-private model, commercial carriers bear the insurance risk in exchange for the ability to earn a profit from the public option. Colorado noted the value of this type of model in its Final Report, stating "[t]he public option will not put the State budget at risk. Insurance companies—not the State—will bear the risk for the payment of health claims, as they currently do in the Individual market."[197] Yet, the reduction in risk comes at the expense of working through profit-driven commercial insurers, which may compromise cost-savings overall.

States choosing the public-private model have taken varied roles in setting premiums to control costs. These models include: (1) allowing commercial carriers to set rates;[198] (2) requiring the insurance commissioner to

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[194] *See* 26 U.S.C. § 36B (providing PTCs on Marketplace); 42 U.S.C. § 18071 (providing CSRs); *see generally* Matthew B. Lawrence, *Fiscal Waivers and State "Innovation" in Health Care*, 62 WM. & MARY L. REV. 1477, 1487–92 (2021) (noting that these funds are "big money").

[195] *See supra* notes 61–65 and accompanying text.

[196] *See supra* notes 148–51 and accompanying text.

[197] COLO. REP. ON THE PUB. OPTION, *supra* note 155, at 17.

[198] For example, Virginia's H.B. 530 would require commercial carriers to design MBPO plans to limit increases in premium rates, while the state does not take an active role in setting

regulate how commercial carriers set premiums;[199] (3) requiring the insurance commissioner to review and approve proposed rates; and (4) designating a state agency to establish premiums for the MBPO. States may also combine approaches. Washington requires carriers offering the public option plan to have their rates reviewed and approved by the Insurance Commissioner.[200] Granting the Insurance Commissioner the authority to deny premium rates and even provider rate increases, as Rhode Island has done, can restrain premium growth and provide an additional lever to control provider reimbursement rates.[201] Public-private partnership models shift the state's financial risk to insurers, while allowing the state to retain some oversight over MBPO premiums, particularly if the state grants the Insurance Commissioner prior approval authority.

Other states would retain financial risk and administer the financial aspects of the MBPO, including setting premiums and cost sharing, to control costs.[202] By retaining financial risk, the state can keep the MBPO revenues rather than having them go to insurance carrier profits. States typically propose implementing this model by assigning financial responsibility to existing state agencies.[203] For instance, Minnesota's S.F. 2302 would make the Commissioner of Human Services responsible for ensuring the financial sustainability of the MBPO, establishing premiums and provider payment rates, accounting for administrative costs, and creating a reserve account within the state treasury to collect enrollee premiums and pay claims.[204] The Commissioner would be able to accept and expend all federal funds available to the state through the MBPO.[205] Similarly, Massachusetts' 2019 MBPO proposal would grant the Commonwealth Connector, the state Marketplace, the authority to set premiums for the public health insurance option and estab-

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or approving premium rates for the MBPO. *See* H.B. 530, 2020 Gen. Assemb., Reg. Sess. § 32.1-329.1(D) (Va. 2020).

[199] *See, e.g.*, H.B. 20-1349, 72d Gen. Assemb., 2d Reg. Sess. § 10-16-1205 (3)(b) (Colo. 2020) (allowing carriers to establish premium rates for the Colorado Option plan, but requiring the Insurance Commissioner to adopt rules "concerning the premium amounts for silver plans" based on their actuarial value).

[200] *See* S.B. 5526, 66th Leg., 2019 Reg. Sess. § 3(1) (Wash. 2019).

[201] Although none of the state MBPO proposals we reviewed included this authority, Rhode Island has given its Insurance Commissioner broad authority to disapprove of insurance premiums or contracts if they exceed caps on provider reimbursement increases. This authority could be added to premium oversight in an MBPO to enforce provider reimbursement limits in the MBPO plan. *See* Aaron Baum, Zirui Song, Bruce E. Landon, Russell S. Phillips, Asaf Bitton & Sanjay Basu, *Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers*, 38 HEALTH AFFS. 237, 242–43 (2019).

[202] *See* S.B. 346, 2020 Gen. Assemb., Feb. Sess. 2020 §§ 2, 4 (Conn. 2020); S.F. 2302, 91st Leg., 2019 Reg. Sess. art. 9 § 14 subd. 1 (Minn. 2019); S.B. 697, 191st Gen. Ct., Reg. Sess. § 6 (Mass. 2019); H.B. 5733, 98th Gen. Assemb., Reg. Sess. § 35 (Ill. 2013).

[203] *But see* Ill. H.B. 5733 § 35 (creating a new public entity, the Health Insurance Connector Authority, to administer the public health option).

[204] *See* Minn. S.F. 2302 art. 9 § 14 subdiv. 1(b), 1(e), 3–4.

[205] *See id.* art. 9 §§ 14 subdiv. 1(b)(2), 15 subdiv. 3 (specifically noting that the Department of Human Services is not an insurance company).

lish the Public Health Insurance Option Fund to hold funds designated for public option plans.[206]

In sum, states must determine how much to invest in MBPO plan financing based on their policy goals. Avoiding reliance on commercial carriers will improve affordability and expand coverage, but will also place the state at greater financial risk.

2. Cost Control

Regardless of a state's financing strategy, all states considering a public option plan seek to reduce the cost of health care. While MBPO plans employ a range of cost control mechanisms,[207] provider payment caps hold the most promise for reducing costs throughout the Marketplace.

Nearly all MBPO bills would limit provider payments to a percentage of Medicare rates or other established payment schedule.[208] Medicare-based caps on provider rates ranged from 100% of Medicare rates in Virginia to 160% of Medicare in Washington.[209] Establishing provider payment rates is often the most politically contentious aspect of an MBPO. As a result, some state legislatures proposed delegating decisions regarding provider payments and participation to the state agency leading implementation.[210]

In terms of controlling provider rates, the Colorado legislature went through several iterations. Initially, the legislature proposed setting the benchmark for provider payments between 175% and 225% of Medicare rates, but instead its 2020 bill charged the Commissioner of Insurance with establishing "a clear, public, and transparent formula, which may very well fall in that range, but importantly, will be applied on a hospital-by-hospital

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[206] *See* Mass. S.B. 697 §§ 1, 3.

[207] Aside from provider payment caps, states have increased medical loss ratios and implemented pharmaceutical cost controls. *See, e.g.*, H.B. 20-1349, 72nd Gen. Assemb., 2d Reg. Sess. § 10-16-1205(2)(a)(VI)–(VII) (Colo. 2020) (raising the medical loss ratio to eighty-five percent and requiring all carriers to pass-through pharmaceutical rebates); Conn. S.B. 346 § 2(a)(2)(F) (raising the medical loss ratio to ninety percent); S.B. 5526, 66th Leg., 2019 Reg. Sess. § 3(2)(j) (Wash. 2019) (promoting generic substitution and evidence-based formularies).

[208] *See* Minn. S.F. 2302 art. 9 § 14 subd. 3 (basing provider payments rates for the state's Basic Health Plan); Mass. S.B. 697 § 1 (basing payment rates on Medicare Parts A and B with adjustments); H.B. 5733, 98th Gen. Assemb., Reg. Sess., § 40 (Ill. 2013) (mirroring Massachusetts); Colo. H.B. 20-1349 § 10-16-1206(1)(c) (establishing a base rate of 155% of Medicare rates with adjustments); Wash. S.B. 5526 § 3(2)(g)(i) (stating that total qualified health plan reimbursement cannot exceed 160 % of Medicare rates); H.B. 530, 2020 Gen. Assemb., Reg. Sess. § 32.1-329.1(D) (Va. 2020) (stating rates shall not exceed Medicare rates).

[209] *See, e.g.*, Va. H.B. 530 § 32.1-329.1(D); Wash. S.B. 5526 § 3(2)(g)(i).

[210] *See, e.g.*, Conn. R.B. 346 § 2(c)(1)(B), (D) (Conn. 2020) (charging the Comptroller with developing both "strategies to ensure that health care providers and health care facilities in this state participate in the ConnectHealth Plan;" and "a proposed schedule of the initial payments and reimbursement rates for the ConnectHealth Plan."); Colo. H.B. 20-1349 § 10-16-1206(1)(a) (requiring the Commissioner to implement a formula that "sets reasonable carrier reimbursement rates" and helps "lower premiums and out-of-pocket costs for consumers and to increase access to health care in rural areas.").

basis to incentivize efficiency and results."[211] Colorado recognized not all hospitals were equally able to reduce rates without compromising patient care and access, particularly critical access hospitals and smaller, independent hospitals.[212] To address this variability, the 2020 bill proposed a reimbursement formula considering a range of factors, including: (1) a hospital's payer mix; (2) whether the hospital is critical access, rural, urban, independent, or part of a larger system; (3) patient margins, total margins, and accumulated earnings over time; and (4) administrative expenses compared to national norms.[213] Under this formula, the base hospital payment rate would be 155% of Medicare rates, with increases for specified providers.[214] Designed to rein in costs over time, the formula would have evolved in response to analysis of its impact on critical access, rural, and other vulnerable hospitals.[215] As Washington did initially but later repealed,[216] Colorado's 2020 bill would have granted the Commissioner the discretion to exempt hospitals that demonstrated that the prescribed reimbursement rate would have "a significant adverse effect on its financial sustainability."[217] Interestingly, Colorado's 2021 legislation shifted tactics away from provider rate controls to focus on achieving a fifteen percent premium reduction over three years.[218] The Commissioner can only set rates, for which the hospital base rate remains 155%, if the carriers cannot achieve the required premium reductions.[219] Furthermore, the Commissioner cannot set the final hospital reimbursement rate less than 165% of Medicare rates.[220]

Overall, regulating provider payment rates for MBPOs will be one of the most politically challenging and practically difficult implementation tasks, but it is also one of the most important for controlling costs.

F. Market Effects

In addition to controlling costs, states must account for the effect of MBPOs on Marketplace dynamics. Several state bills require those implementing an MBPO to submit reports to the legislature regarding the impact

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[211] *Id.* Colo. H.B. 20-1349 § 10-16-1206(1); COLO. REP. ON THE PUB. OPTION, *supra* note 156, at 13.

[212] *See* COLO. REP. ON THE PUB. OPTION, *supra* note 156, at 13.

[213] *Id.*

[214] *See* Colo. H.B. 20-1349 § 10-16-1206(1)(c) (adding twenty percentage points to rates for either critical access or independent hospitals among others).

[215] *See* COLO. REP. ON THE PUB. OPTION, *supra* note 156, at 13–14; Colo. H.B. 20-1349 § 10-16-1206(2) (requiring the Colorado Public Option Board to advise the Commissioner on modifications to the reimbursement formula and the percentage point adjustments after the first two years of the program).

[216] *See supra* Introduction.

[217] Colo. H.B. 20-1349 § 10-16-1206(2)(5)(a) (requiring the Commissioner to make this decision in consultation with the Department of Health Care Policy and Financing and the Board).

[218] *See* Colo. H.B. 21-1232 § 10-16-1304(1); *infra* Part IV.

[219] *See* Colo. H.B. 21-1232 § 10-16-1306(4)(a)(II).

[220] *See* Colo. H.B. 21-1232 § 10-16-1306(5)(a).

or potential impact of the MBPO on the health care market, including provider and plan participation, federal funding, cost-shifting, and risk adjustment.[221]

1. The Potential for the MBPO to Reduce Provider and Plan Participation

The introduction of an MBPO can disrupt both provider and plan participation in certain markets, especially if the provider rate or premium controls are significant. States designing MBPOs have implemented a range of provisions that either incentivize or require provider and plan participation.

The largest potential market effect from an MBPO is the reduction in provider participation resulting from price controls, which can, in turn, compromise plan participation. In setting provider payment rates, state policymakers must balance the desire for cost savings against the need to retain sufficient provider participation to satisfy network adequacy requirements.[222] If provider payment rates sink too low, providers will not participate in MBPO plans, threatening their viability. While states have exercised some leverage to require commercial carriers that offer plans on the Exchange to also offer MBPO plans, most MBPO bills do not require provider participation. Instead, to encourage provider participation, state MBPO proposals rely on: (1) commercial carriers;[223] (2) automatic enrollment of Medicare providers with an opt-out;[224] and (3) payment rates.[225]

Washington's experience highlights the difficult balancing act of setting provider rates and ensuring provider participation. State representative Eileen Cody, the architect of S.B. 5526, originally sought a reimbursement cap at 100% of Medicare rates, but the final legislation increased the rate cap to 160% of Medicare, calculated in aggregate. At this level, actuaries estimated that carriers could offer public option premiums five to ten percent cheaper than current Marketplace premiums without destabilizing the insurance markets and alienating providers.[226] However, the 160% of Medicare rate cap may have been too low to attract providers and too high to reduce premi-

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[221] *See* S.B. 5526, 66th Leg., 2019 Reg. Sess. § 5 (Wash. 2019); Colo. H.B. 20-1349 § 10-16-1207; R.B. 346, 2020 Gen. Assemb., Feb. Sess. § 2(a)(5)(Conn. 2020); S.F. 2302, 91st Leg., 2019 Reg. Sess. §§ 14 subd. 1(b)(2), 15 subd. 2 (Minn. 2019); S.B. 697, 191st Gen. Ct., 2019–2020 Sess. § 5 (Mass. 2019); H.B. 5733, 98th Gen. Assemb., Reg. Sess. § 30 (Ill. 2013).

[222] *See* Chapin White, Christine Eibner, Jodi L. Liu, Carter C. Price, Nora Leibowitz, Gretchen Morley, Jeanene Smith, Tina Edlund & Jack Meyer, *A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon,* RAND HEALTH Q., 2017, at 1, 4. Network adequacy laws require health plans to include sufficient numbers of providers within a certain geographic area in their networks to provide care to the patient population.

[223] *See* Va. H.B. 530 § 32.1-329.1(A).

[224] *See, e.g.*, Ill. H.B. 5733 § 45; Mass. S.B. 697 § 8.

[225] *See* Wash. S.B. 5526 § 2(g)–(i) (establishing a payment floor for primary care providers at 135%).

[226] Sparer, *supra* note 38, at 265 (noting that the aggregate cap allows plans to pay some providers more than 160% of Medicare and others less).

ums.[227] At least one carrier found providers, especially hospitals, reluctant to contract even at 160% of Medicare rates.[228] In its first year, 2021, insurers offered public option plans in only twenty of the state's thirty-nine counties.[229] Washington responded by passing S.B. 5377 in 2021, which provides that if a public option plan is not offered in every county, any hospital licensed in the state that provides services to enrollees in the public or school employee benefit programs or Medicaid must contract with at least one public option plan.[230] In addition, the average proposed 2021 premium for plans offered via the CascadeCare public exchange was five percent higher than the 2020 average Marketplace premium and varied among carriers and geographic areas.[231] These proposed CascadeCare premiums represent some carriers' first attempt to rate the Washington public option population, and they may stabilize with experience. If not, states may need to incorporate additional tools to improve MBPO affordability.

To address the hydraulic relationship of provider rates and network participation, MBPO legislation often includes exceptions to ensure sufficient provider participation. For instance, Washington's MBPO law initially allowed the Director of the Health Care Authority, in his or her sole discretion, to waive the provider payment cap of 160% of Medicare rates for any carrier that is "unable to form a provider network that meets the network access standards adopted by the insurance commissioner" but remains able "to achieve actuarially sound premiums that are ten percent lower than the previous plan year through other means."[232] In its effort to strengthen the public option in 2021, Washington eliminated this waiver authority with the passage of S.B. 5377, which also requires hospital participation if all counties were not covered by a public option plan by 2022.[233] To encourage participation, Washington also included a minimum payment threshold of 101% of Medicare rates for rural critical access hospitals and sole community hospitals, as well as 135% of Medicare rates for primary care providers.[234]

Policymakers designing Colorado's 2020 public option proposal also stressed the importance of ensuring provider participation for public option viability, noting that "if there are areas where networks are not adequate, the State could implement measures to ensure that health systems participate

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[227] *See* Hansard, *supra* note 20.

[228] *See id.*

[229] *See* Louise Norris, *Washington's Health Insurance Marketplace: History and News of the State's Exchange*, HEALTHINSURANCE.ORG (Sept. 1, 2021), https://www.healthinsurance.org/health-insurance-marketplaces/washington/ [https://perma.cc/YU4A-6J3M].

[230] *See* S. 5377, 67th Leg., Reg. Sess. (Wash. 2021).

[231] *See id.*; Norris, *supra* note 229. For instance, Community Health Network of Washington, a non-profit carrier that offers Medicaid managed care plans, proposed lower CascadeCare premiums than the benchmark silver plan in certain areas, while United Healthcare of Washington proposed monthly premiums for the CascadeCare plan for a forty-year-old non-smoker that were fifty dollars higher than premiums for a comparable silver tier non-standardized plan.

[232] *See* S. 5526, 66th Leg., Reg. Sess. (Wash. 2019).

[233] *See* Wash. S. 5377.

[234] *See id.*

and provide cost effective, quality care to covered individuals."[235] Colorado's 2020 bill took a stronger position than Washington did initially, requiring hospitals licensed by the Department of Health Care Policy and Financing, with some exceptions, to participate in the Colorado Option plan and accept its reimbursement rates.[236] The Department could fine hospitals that refuse to participate up to $10,000 for the first thirty days and up to $40,000 a day thereafter, and could suspend, revoke, or impose conditions on the hospital's license.[237] Yet, the two states ended up switching places—with Washington adding a requirement in 2021 for hospitals to participate in the public option and Colorado limiting its hospital participation and rate-setting requirements to instances where it is established in a series of hearings that a carrier is unable to meet the required premium reductions or network adequacy requirements due to hospital recalcitrance.[238]

Unlike Washington, Colorado has consistently required plan participation. The 2020 bill would have required all carriers that offer a health plan in the individual markets to also offer the Colorado Option Plan in the same county.[239] The 2021 legislation maintained this requirement for standardized plans in the individual and small group markets.[240] Furthermore, the Commissioner, subject to certain considerations, can compel a carrier to offer the standardized plan in specific counties where no carrier is offering the standardized plan.[241] By requiring plan participation and minimum premium reductions, the Colorado legislation bolsters insurance companies' abilities and incentives to wrest price reductions from providers.

Whether through mandated participation or participation requirements only if certain premium and coverage goals are not met, states implementing a public option need a mechanism to monitor and, if needed, require provider and plan participation in the public option.

2. The Impact of MBPO on Federal Funding

Introducing an MBPO plan into the Marketplace could also inadvertently increase consumers' premium costs for commercial Marketplace plans by reducing the amount of premium tax credits, which are calculated based on the second-cheapest silver plan on the Marketplace.[242] If the MBPO

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[235] COLORADO REPORT ON THE PUBLIC OPTION, *supra* note 155, at 20.

[236] *See* H.R. 20-1349, 72d Gen. Assemb., 2d Reg. Sess. (Colo. 2020).

[237] *See id.*

[238] *See* S. 5377, 67th Leg., Reg. Sess. (Wash. 2021); H.R. 21-1232, 73d Gen. Assemb., Reg. Sess. (Colo. 2021).

[239] *See* Colo. H.R. 20-1349 .

[240] *See* Colo. H.R. 21-1232.

[241] *See id.*

[242] *See Key Facts: Premium Tax Credit*, HEALTH REFORM: BEYOND THE BASICS, (Aug. 2020), https://www.healthreformbeyondthebasics.org/premium-tax-credits-answers-to-frequently-asked-questions/ [https://perma.cc/E6W3-7K4B] (explaining how the benchmark plan premium interacts with the premium tax credit and other plans on the market).

reduces premiums for the second-lowest silver plan, then, absent a Section 1332 waiver, all the premium tax credits would also decline.[243]

The Final Report for Colorado's Public Option recommends the state apply for a Section 1332 waiver to enable the state to "draw down federal savings that would otherwise be spent on tax credits for higher-premium QHPs absent the lower-cost public option."[244] The state could then use these pass-through funds to provide additional subsidies to improve affordability on the Marketplace, including extending CSRs to individuals earning up to 400% of FPL, funding additional high-value benefits, such as dental care, or increasing premium subsidies available to enrollees.[245] Without a Section 1332 waiver, the state would lose access to any federal savings that resulted from its public option plans, and effectively increase the unsubsidized premium costs of non-MBPO plans on the Marketplace.

3. Cost Shifting

All states seek to use the MBPO to control health care costs, both directly through caps on provider payments and indirectly through competition. Yet some fear that MBPOs' rate limits may cause providers and insurers to increase their rates and premiums, respectively, in other markets.[246] While the empirical literature casts doubt on the extent of cost shifting between public and private payers,[247] state public option proposals include mechanisms to monitor for this potential effect. As noted in the Final Report for Colorado's Public Option, "cost shifting only happens if we let it."[248] The Final Report also identified several policy tools to prevent the threat of cost shifting, including expanding the public option to the small group market, transitioning provider payment rates gradually, and publishing the public option rates for use in private payers' negotiations with providers.[249] Colorado authorized the Commissioner to monitor commercial health insurers for cost-shifting attempts and disapprove the requested rate increase if "the rate filing reflects a cost shift between the standardized plan . . . and the health

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[243] *See* UCCELLO, *supra* note 109, at 14.

[244] COLORADO REPORT ON THE PUBLIC OPTION, *supra* note 155, at 23–24 (estimating that Colorado would receive approximately $89 million per year in federal pass-through savings); *see also* Colo. H.B. 21-1232 § 10-16-1308(1) (granting the Commissioner the authority to apply for a Section 1332 waiver to capture all applicable savings to the federal government).

[245] *See* COLORADO REPORT ON THE PUBLIC OPTION, *supra* note 155, at 23.

[246] *See id.* at 16.

[247] *See, e.g.*, Austin B. Frakt, *How Much Do Hospitals Cost Shift? A Review of the Evidence*, 89 MILBANK Q. 90, 123 (2011); Chapin White, *Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates*, 32 HEALTH AFFS. 935, 941 (2013); David Dranove, Craig Garthwaite & Christopher Ody, *How Do Hospitals Respond to Negative Financial Shocks? The Impact of the 2008 Stock Market Crash* 29 (Nat'l Bureau of Econ. Rsch., Working Paper No. 18853, 2013); Chapin White & Tracy Yee, *When Medicare Cuts Hospital Prices, Seniors Use Less Inpatient Care*, 32 HEALTH AFFS. 1789, 1794 (2013).

[248] COLORADO REPORT ON THE PUBLIC OPTION, *supra* note 155, at 17.

[249] *See id.*

benefit plan" requesting the rate increase.[250] The combination of a transparent formula for calculating public option rates and an Insurance Commissioner with the power to review and approve both commercial carrier rates and the negotiated provider rates helps safeguard against any potential cost shifting.

4. Adverse Selection and Risk Adjustment

States might also be wary that the MBPO could attract higher-risk, unhealthier enrollees, which could drive up the cost of the MBPO and threaten its financial viability. States can implement safeguards to minimize these risks, such as risk adjustment or reinsurance, but they may need the additional regulatory flexibility that comes with a state-run Marketplace and a Section 1332 waiver to do so. Offering a public option plan both on and off the Exchange or altering the MBPO's benefit design or benefits can shift enrollment patterns in ways that affect premiums and challenge risk adjustment methods.[251] To address this risk, states introducing an MBPO into the individual and small group markets can alleviate fear that the public option plan will destabilize the market by including the MBPO in state risk adjustment programs.[252]

Of all MBPO bills, Colorado's 2020 bill proposed the most extensive market oversight framework. It would have required an annual evaluation and report to the legislature of the public option's effect on the individual market, cost shifting between markets, the premium tax credits and cost sharing reductions received by individuals, and the adequacy of provider networks.[253] In addition, the bill would require an evaluation of "the impact of the Colorado Option Plan on hospital sustainability, the health care workforce, and health care wages" be reported to the legislature.[254]

Regardless of policy goals, all states should monitor the MBPO's impact on the healthcare markets to ensure the plan is having the desired effect and not causing unintended harm. To do so, states need access to data that shows both price and utilization for both providers and insurers, whether from a state's all-payer claims database ("APCD") or direct reporting from the Marketplace.[255]

Overall, MBPOs offer states significant flexibility in achieving their policy goals, access to federal funding, and coverage untethered to employment. States can design MBPOs to accommodate various levels of adminis-

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[250] Colo. H.B. 21-1232 § 2 (amending Colo. Rev. Stat. § 10-16-107).

[251] *See* UCCELLO, *supra* note 109, at 14.

[252] *See, e.g.*, S.B. 697, 191st Gen. Ct., 2019–2020 Sess. §§ 2, 8K(a) (Mass. 2019); H.B. 5733, 98th Gen. Assemb., Reg. Sess. § 155.44 (Ill. 2013).

[253] *See* Colo. H.B. 20-1349 § 10-16-1207(1).

[254] *Id.* at § 10-16-1207(2).

[255] *See, e.g.*, Conn. R.B. 346 § 2(a)(5); Minn. S.F. 2302 § 15 subd. 2 (permitting the Commissioner to use APCD data to evaluate the impact of OneCare on the individual market, and to require submission of additional information to the state APCD).

trative burden and financial risk by allowing state entities to contract with commercial insurers or administer the MBPO itself. Yet, decisions regarding state administration and financing face tradeoffs between cost control and commitment of state resources. In addition, certain plan designs may require the additional burden of obtaining a Section 1332 waiver.

III. Comprehensive Public Options

Comprehensive public option plans are the broadest category of state-sponsored plans. They are "comprehensive" in terms of whom they target (e.g., any resident), their benefits and provider network, and their anticipated disruption in the health insurance market. The most ambitious Comprehensive public option plans are closest to state single-payer plans, despite their acknowledgement that a multi-payer system will persist. In Comprehensive public option plans, the state is assertively entering the market—either as an insurer itself or through broad regulation of a commercially administered plan—to offer a public source of coverage to all residents. We found fifteen bills proposing Comprehensive public option plans in five states: Massachuestts, Michigan, New Jersey, Vermont, and Washington.[256] Some of these models straddle both categories for Marketplace-based plans and Comprehensive plans.

A. Policy Goals

The policy goals of the Comprehensive public option include achieving universal coverage untethered from employment, applying the state's rate setting-authority to the commercial insurance market to control health care costs, simplifying administrative burdens, reducing fragmentation, and at its most ambitious, providing a glide-path to a state single-payer system.[257] These policy goals are more ambitious than those of the Medicaid buy-in or MBPO plans that target a narrower, dysfunctional segment of the individual market or cover the remaining uninsured. Comprehensive plans also try to reduce fragmentation to pursue administrative simplification and unify the risk pools of large, small, and individual markets into one state-sponsored plan.[258] The potential cost-savings for Comprehensive public option plans are greater than their narrower counterparts because the rate-controls and reduced administrative costs are implemented across a broader swath of the market, including the large-group market.[259]

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[256] *See* Appendix A.

[257] *See*, *e.g.*, H.B. 1104, 66th Leg., 2019 Reg. Sess. § 1 (Wash. 2019) (declaring the people's intentions in the preamble).

[258] *See, e.g.*, H. 28, Gen. Assemb., 2017–2018 Reg. Sess. § 1852(a)(4) (Vt. 2017) (providing that "[a]ll participants in the Vermont Public Option shall be maintained in a single risk pool").

[259] *See*, *e.g.*, Wash. H.B. 1104 § 1.

B. Target Population

Comprehensive public option plans are state-sponsored plans available to anyone in the state—a broad combination of different health insurance market segments, including large groups (both public and private employers), small groups, individuals, and possibly those with Medicaid coverage.

In some proposals, the Comprehensive public option plan would be available to any resident of the state.[260] For example, New Jersey's S. 1947 provides that "Every resident of the State shall be eligible and entitled to enroll as a member under the program."[261] Other Comprehensive plans have broad eligibility, but apply different rules or defaults to the different segments of the market. For example, a 2015 Vermont bill proposed a public option plan that would cover all public employees automatically and be offered to all other residents, except those eligible for Medicare or Medicaid.[262] Finally, Massachusetts proposed a public option plan that straddles the categories for Marketplace-based and Comprehensive plans. These plans would be offered exclusively on the Marketplace, which traditionally only serves the individual and small group markets, and would be available to large groups in the future.[263]

C. Legal Issues for Comprehensive Public Option Plans

The distinguishing feature of Comprehensive plans is that they explicitly include the large group markets—those with employer-based coverage. Reaching those with employer-based coverage means that, in addition to the legal requirements for Marketplace or Medicaid-based plans, Comprehensive plans also must contend with ERISA—the federal law that governs employer-based health benefits—and federal tax laws that subsidize employer spending on health benefits and limit the tax deductibility of state taxes, which may be needed to finance the plan. Because they would also target the individual market and Medicaid, the legal framework for Comprehensive public option plans rests upon the same legal requirements for Medicaid plans and Marketplace-based plans, described above.

Due to the resemblance between Comprehensive public option plans and state single-payer plans, the legal issues of public option plans are comparable to those of single-payer plans.

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[260] *See, e.g.*, H.B. 6285, 2018 Leg., Reg. Sess. § 202 (Mich. 2018); S.B. 5222, 66th Leg., 2019 Reg. Sess. § 101 (Wash. 2019); Wash. H.B. 1104.

[261] S. 1947, 219th Leg., Reg. Sess. § 6 (N.J. 2020).

[262] *See* H. 88, 2015 Leg., Reg. Sess. § 1853 (Vt. 2015).

[263] *See* S.B. 697, 191st Gen. Ct., 2019–2020 Sess. § 1 (Mass. 2019). Lawmakers in Massachusetts have introduced substantially similar public option bills in every legislative session in our search period. *See supra* note 147.

1. ERISA Preemption

One of the biggest legal hurdles states face in comprehensive health reform is ERISA, which generally hampers states' abilities to regulate employer-based health benefits and places self-funded employer plans beyond the reach of state laws. ERISA's preemption provision expressly preempts "any and all" state laws that "relate to" employee benefit plans.[264] As comprehensively described elsewhere in the literature on public benefits law, the scope of "relates to" is so indeterminate that it has spawned a convoluted and voluminous jurisprudence struggling to define the bounds of ERISA's sweeping preemption.[265]

The rule articulated by the courts is that a state law is preempted if it bears an "impermissible connection with" an ERISA plan.[266] This occurs when a state law requires sponsors "to structure their plans in particular ways, such as requiring payment of specific benefits," or if it directly or indirectly produces "acute . . . economic effects" which would "force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers."[267] In other words, state laws that mandate employers adopt, alter, or administer their employee benefit plans in compliance with state law are preempted because they bear an "impermissible connection with" and thus "relate to" an ERISA plan.[268] However, courts have recognized a limit on what it means to "relate to" an ERISA plan. To the extent that the presence of a public option may "merely increase costs or alter incentives for ERISA plans," state laws with such economic effects are not preempted by ERISA.[269]

The legal question is whether ERISA would preempt a Comprehensive state public option plan offered to employers. ERISA would preempt states from mandating that employers participate in the state plan,[270] but state public option proposals that merely nudge, rather than require, employer participation would find surer footing. The ERISA analysis turns on whether the plan's funding mechanisms, such as payroll taxes, cross the line into a "Hob-

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[264] 29 U.S.C. § 1144(a) (included as Section 514 in the ERISA).

[265] *See, e.g.*, Erin C. Fuse Brown & Elizabeth McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. PENN. L. REV. 389, 392–93 (2020); Peter D. Jacobson, *The Role of ERISA Preemption in Health Reform: Opportunities and Limits*, 37 J.L. MED. & ETHICS 88, 89–90 (2009).

[266] *See* Gobeille v. Liberty Mut. Ins. Co., 136 S. Ct. 936, 943 (2016). A state law may also be preempted if it makes "reference to" an ERISA plan, but that test is not applicable here. *See* Rutledge v. Pharm. Care Mgmt. Ass'n, 141 S. Ct. 474, 478 (2020).

[267] *Rutledge*, 141 S. Ct. at 480; *Gobeille*, 136 S. Ct. at 943; N.Y. State Conf. of B.C.B.S. Plans v. Travelers Ins. Co., 514 U.S. 645, 668 (1995); *see Gobeille*, 136 S. Ct. at 943 (collecting cases)*; see also* Egelhoff v. Egelhoff ex rel. Breiner, 532 U.S. 141, 146–47 (2001); Shaw v. Delta Air Lines, 463 U.S. 85, 97–100 (1983) (finding that laws effectively requiring employers to "pay employees specific benefits" are preempted).

[268] This includes data reporting requirements by self-funded employer plans. *See Gobeille*, 136 S. Ct. at 943.

[269] *Rutledge*, 141 S. Ct at 480; *see also Travelers*, 514 U.S. at 668.

[270] *See* Fuse Brown & McCuskey, *supra* note 265, at 393.

son's choice" for the employer, forcing the employer to change or drop its employee health plan in favor of the public option plan.[271] A state law that imposes such a forced choice on the employer would be preempted.

State public option plans avoid ERISA preemption because they simply offer the state plan as a voluntary option to employers. Compared to a single-payer plan, a public option more clearly and readily preserves for employers the choice of maintaining their employee benefit plans, which should place them on firmer ground under ERISA than single-payer plans. Unlike state single-payer plans, which nearly all rely on payroll taxes either alone or together with income taxes or other individual assessments,[272] the Comprehensive public option plans use a more diverse set of funding mechanisms and vary in their reliance on employers to collect, remit, and pay for their employees' enrollment in the state public option plan. After all, neither the employees nor the employers are required to participate in the state public option plan. Yet a more granular examination of the various funding mechanisms employed by particular public option proposals is necessary to determine whether they would avoid ERISA preemption.

For example, a Comprehensive public option like New Jersey's A.B. 1343 would rely on individual premiums.[273] A state-assessed individual premium would not implicate ERISA because it does not target employers, and, unless the employer is required to collect the premium from its employees, does not involve the employer at all.[274] The problem with a premium-only model is that the state might not capture all the current employer expenditure on health benefits. Currently, employers pay eighty-three percent of the premiums for individual coverage and seventy-three percent for family coverage.[275] Although the employer contribution comes out of the employee's wages, the premium that an employee experiences is only a small fraction of the total cost.[276]

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[271] *See id.* at 433.

[272] *See id.* at Table 2, 413 (finding that 45 of 66 state single-payer proposals contained a funding mechanism including payroll taxes).

[273] A.B. 1343, 218th Leg., 2018–2019 Reg. Sess. § 10.c. (N.J. 2018); *see also* H.146, 2011 Leg., Reg. Sess. § 1806 (3)(c) (Vt. 2011) (requiring employers to deduct premiums upon request, presumably of the employee).

[274] *See, e.g.*, Vt. H. 146 § 1806 (3)(c) (requiring employers to deduct premiums upon request, presumably of the employee).

[275] *See* GARY CLAXTON, MATTHEW RAE, GREGORY YOUNG & DANIEL MCDERMOTT, KAISER FAM. FOUND., 2020 EMPLOYER HEALTH BENEFITS SURVEY 81 (2020), http://files.kff.org/attachment/Report-Employer-Health-Benefits-2020-Annual-Survey.pdf [perma.cc/9K56-22B9].

[276] *See generally* Jonathan Gruber, *Health Insurance and the Labor Market* (Nat'l Bureau of Econ. Rsch., Working Paper No. 6762, 1998) (reviewing the empirical literature and finding "a fairly uniform result: the costs of health insurance are fully shifted to wages"); Matthew Rae, Rebecca Copeland & Cynthia Cox, *Tracking the Rise in Premium Contributions and Cost-Sharing for Families with Large Employer Coverage*, PETERSON-KFF HEALTH SYS. TRACKER (Aug. 14, 2019), https://www.healthsystemtracker.org/brief/tracking-the-rise-in-premium-contributions-and-cost-sharing-for-families-with-large-employer-coverage/ [https://perma.cc/S446-AUCG]; *Economic News Release: Table 3 Medical Plans: Share of Premiums Paid by Employer and Employee for Single Coverage*, U.S. BUREAU OF LAB. STAT., https://

If a state public option were to rely solely on individual premiums rather than payroll taxes, it would lack a mechanism to capture the employer's share of the cost of coverage. But requiring the employer to pay a percentage of the employee's public option premium or even collect and remit the employee's premium share could potentially amount to an impermissible employer mandate that would be preempted by ERISA.[277] Thus, the employer's contribution to or collection of premiums should be voluntary to avoid entanglement with ERISA.

Other Comprehensive public option plans would rely on payroll taxes to fund the public option and capture the employer health benefit expenditures, raising the question of whether these payroll taxes would be preempted by ERISA. Bills in Vermont and Washington[278] would rely on a combination of premiums and payroll taxes to fund their public option plans. Vermont would assess a payroll tax on the employer, calculated as a percentage of an employee's gross wages with no exemption for employers that offered employer-based coverage.[279] While Vermont's bills do not prohibit employers from offering employer-based coverage, they would not allow individuals to have plans with overlapping coverage, only supplemental.[280] The mandatory payroll taxes in Vermont's H.B. 146 and H.B. 88 are unlikely to implicate ERISA (as they do not regulate an ERISA plan),[281] and the public option plan would provide employers with a meaningful choice between maintaining their own plans or the state plan, thus avoiding a preempted forced choice.[282]

Washington's S.B. 5222 would impose a payroll tax of 10.5% of wages. But, the bill would exempt from the payroll tax those employers that maintained a benefit plan at least as comprehensive and affordable as the state plan.[283] ERISA might preempt a bald "maintenance of effort" requirement that imposes a state mandate on the employer's administration of its plan, but here instead the maintenance of effort provision appears as a condition of the

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www.bls.gov/news.release/ebs2.t03.htm [https://perma.cc/S6EX-D7HH] (last modified Sept. 20, 2019).

[277] *Compare* H. 88, 2015 Leg., Reg. Sess. § 2104 (Vt. 2015) (requiring employers to deduct employee premiums for the state public option plan or other health coverage as prescribed by the state) *with* S.B. 5222, 66th Leg., 2019 Reg. Sess. § 208 (Wash. 2019) (providing that employers *may* withhold and remit premiums for employees). *See* Mary Anne Bobinski, *Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured*, 24 U.C. DAVIS L. REV. 255, 292 (1990) (stating that "state level employer mandates" are preempted).

[278] Wash. S.B. 5222. Note, this is a different, more comprehensive bill than the public option that ultimately passed in 2019, Wash. S.B. 5526.

[279] H. 146 2011 Leg., Reg. Sess. (Vt. 2011) § 2103 (establishing a ten percent payroll tax); Vt. H. 88 § 2103 (establishing an eight percent payroll tax for employers and four percent for employees).

[280] Vt. H. 146 § 1808(f); Vt. H. 88, § 1856(f).

[281] Payroll taxes are calculated on the basis of wages, not on the value of health benefits.

[282] *See* N.Y. State Conf. of B.C.B.S. Plans v. Travelers Ins. Co., 514 U.S. 645, 664 (1995). Some uncertainty remains whether a ten percent payroll tax would be high enough to create a Hobson's choice and force employers to drop or alter their own employer-based plan. *Id.*

[283] Wash. S.B. 5222 § 126.

exemption from the state's payroll tax. Thus, employers have choices; they can: (1) pay the payroll tax and drop their plan; (2) offer a plan at least as generous and affordable as the state plan and qualify for an exemption from the payroll tax; or (3) offer a skimpier or more expensive plan and pay the payroll tax. Because it offers employers at least three viable options, the WA S.B. 5222 bill would likely survive an ERISA challenge.[284]

Finally, some Comprehensive public option plans do not rely on payroll or income taxes at all. This premium-only financing model is illustrated by Massachusetts' MBPO proposals, under which the state would offer a health plan on its Marketplace to individuals, small groups, and large employers with more than fifty employees.[285] An employer could offer employees coverage under the state plan the way it normally would purchase health insurance or it could offer employees a voucher to shop for coverage among the options on the Marketplace. Either way, the state does not dictate the employer's choice of plan or whether or how much of employees' premiums the employer will pay. Because it does not impinge on employers' health benefit choices, a purely premium-financed public option would not implicate ERISA at all. However, a public option financed entirely through premiums may not raise sufficient funds for the state to provide additional subsidies to those who find the plan unaffordable.

To the extent that all state public option plans are more "optional" for employers than a state single-payer plan, they would all be on surer footing under ERISA than their single-payer cousins. Some Comprehensive public option plans that we studied are closer to one end of the spectrum between a mandate and an option. The more a state makes its public option plan, including the financing mechanism, truly optional on the part of employers and preserves a system for the employer to continue to offer its own health plan, the lower the risk of ERISA preemption.

One tradeoff, though, is that improving a state public option plan's resistance to ERISA preemption reduces its momentum toward broad systemic change. Mandatory payroll taxes without exceptions accelerate the glidepath toward single-payer because employers and employees will have significant incentives not to double-pay for both employer- and state-based coverage, and may quickly stop offering and purchasing employer coverage if they are eligible to enroll in public coverage that is at least as comprehensive and affordable.[286] The more exceptions and optionality that a state public option presents to employers, the less of a threat ERISA preemption becomes. Yet maintaining options also increases the chance that the market will remain fragmented and stratified by income, wealth, health, employ-

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[284] *See* Golden Gate Rest. Ass'n v. City of San Francisco, 546 F.3d 639, 646–47 (9th Cir. 2008) (holding a municipal pay-or-play law was not preempted because, by offering a meaningful coverage alternative, it did not force the employers to adopt or change their health plans).

[285] H.B. 1228, 187th Gen. Ct., Reg. Sess. § 1 (Mass. 2011).

[286] *See* Fuse Brown & McCuskey, *supra* note 265, at 404.

ment status, race, or other socio-economic variables that undermine solidarity and risk spreading.[287] Another tradeoff in reducing the threat of ERISA preemption is that the state may fail to fully capture a large and deep source of health expenditures from employers. As a result, the state may lose some of its ability to raise revenues or pool risk in the volumes necessary to extend coverage to those parts of the market that are difficult to reach under current legal and political constraints—namely, undocumented immigrants who are ineligible for coverage on the Marketplace or under Medicaid.[288]

2. Federal Tax Law

The second legal issue Comprehensive public option plans confront are limitations in their financing mechanisms posed by federal tax law. As described above, to finance a Comprehensive public option plan, state bills propose varying combinations of payroll taxes, personal income taxes, and premium payments. Currently, employers can deduct their spending on employee health benefits as a business expense,[289] and health insurance benefits are likewise excluded from employees' taxable income and federal payroll taxes.[290] This foregone federal tax revenue is a form of federal spending, subsidizing the cost of employer-provided health coverage to the tune of $273 billion in 2019.[291]

There are two major tax-related challenges for Comprehensive public option plans. First, states may try to capture not only what employers spend on health benefits, but also the hefty federal tax subsidies for employer-sponsored health benefits. How can states preserve employers' existing tax advantage for health benefit spending under current federal law or draw upon even a fraction of the billions in federal tax expenditures? Second, to the extent that states levy additional individual taxes—such as an employee's share of payroll taxes—to pay for the public option plan, the new state taxes must contend with the cap on state and local tax deductions (SALT) under the 2017 Tax Cuts and Jobs Act. The answers depend on the type of financing mechanism used and who is paying for it: employer-paid payroll taxes; employee-paid payroll taxes; or employer or individual premiums.

State payroll taxes levied on employers to finance Comprehensive public option plans would largely preserve the existing tax benefits for employer-based health spending. The employer-portion of state payroll taxes used to finance a public option plan would be treated like federal payroll taxes or state unemployment taxes, so these employer-paid state payroll

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[287] *See* Erin Fuse Brown, Matthew Lawrence, Elizabeth McCuskey & Lindsay Wiley, *Social Solidarity in Health Care, American-Style*, 48 J.L. MED. ETHICS 411, 423 (2020).

[288] *See* Fuse Brown & McCuskey, *supra* note 265, at Section I.B.

[289] I.R.C. § 162(a)(1).

[290] *Id.* § 162(l)(1) (discussing deductions for self-employed individuals).

[291] *See* JOINT COMM. ON TAX'N, ESTIMATES OF FED. TAX EXPENDITURES FOR FISCAL YEARS 2019–2023 (2020), https://www.jct.gov/publications.html?func=startdown&id=5238 [https://perma.cc/7SHJ-G84G].

taxes would be excluded from employees' taxable income and deductible as business expenses to the employer.[292] To the extent the payroll taxes approximate the employer's spending on health benefits, the employer-paid state payroll taxes would roughly retain the existing federal tax advantage for employer health spending.[293]

However, if the state levies payroll taxes on employees or income taxes on individuals, the existing tax advantage for employees' health spending would be lost. Currently, employees' share of their health plan premiums are excluded from their taxable income and federal payroll taxes.[294] Some states' public option proposals would levy taxes on employees' wages to finance the public plan, perhaps to replicate the current split between employer- and employee-contributions to health insurance premiums.[295] Although an employee's share of state payroll taxes would be deductible to the employee, it would be subject to a $10,000 cap on SALT deductions.[296] The SALT cap effectively increases the tax liability for higher income earners in high income-tax states by limiting the amount of SALT deductions the individual may take.[297] The employee's portion of payroll taxes used to finance a public option plan would be added to other state and local taxes, such as income or property taxes, for purposes of the SALT cap, limiting the deductibility of these tax obligations for the employee.[298] For example, if a single individual paid $3,000 in local property taxes, $7,000 in state income taxes, and $6,000 for the public option plan, the SALT cap would limit the individual's deduction on state and local taxes to the $10,000 allowed maximum, despite the fact that the individual incurred $16,000 in state and local taxes (including the cost to the individual for the public option plan).

States also depend on premiums to finance their public option plans. The question is whether premium payments for the state plan would be subject to the SALT cap. In 2020, the average annual premium was $7,470 for

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[292] *See* I.R.C. § 162(a) (allowing employers to deduct payroll taxes as business expenses).

[293] *See* White et al., *supra* note 222, at xiv (assessing tax impact of a state payroll tax to finance a single-payer plan and noting, "Currently, employer spending on health benefits is excluded from taxable income for federal income and payroll taxes, creating an implicit subsidy for state residents with employer-sponsored coverage. Under the Single Payer option, employers would no longer make tax-advantaged premium payments and would instead pay the new state payroll tax. Those employer-paid payroll taxes would, like employer Federal Insurance Contributions Act (FICA) contributions, be excluded from employees' taxable income, which would roughly preserve the current tax advantage.").

[294] *See* I.R.C. §§ 106, 3121.

[295] *See, e.g.*, H. 88, 2015 Leg., Reg. Sess. (Vt. 2015) (assessing a four percent payroll tax on employees in addition to an eight percent payroll tax on employers); S.B. 5222, 66th Leg., 2019 Reg. Sess. § 203 (Wash. 2019) (assessing a two percent payroll tax on employees in addition to a 10.5% payroll tax on employers).

[296] *See* I.R.C. §§ 164(a)(1), (b)(2) (addressing the deductibility of state and local taxes); I.R.C. § 164(b)(6).

[297] *See* Wiley, *supra* note 16, at 884; *How Does the Deduction for State and Local Taxes Work?*, TAX POL'Y CTR. (May 2020), https://www.taxpolicycenter.org/briefing-book/how-does-deduction-state-and-local-taxes-work [http://perma.cc/SBD5-QZZA].

[298] *See* I.R.C. § 164(b)(6)(B) (aggregating all state and local taxes for purposes of applying the SALT cap).

individual coverage and $21,342 for family coverage.[299] For taxpayers with significant medical expenses, the tax-deductibility of the health insurance premiums has a significant impact on their finances and their coverage choices. Generally, individuals can deduct their health insurance premium costs if they itemize deductions and if their premium and out-of-pocket medical expenses exceed ten percent of their adjusted gross income in a given year.[300] Unlike income or payroll taxes, premium payments may not be considered state or local taxes subject to the SALT cap. Because the public option plan is, in fact, optional, only individuals who elect to enroll in the public plan must pay the premiums. In this way, the premiums are distinguishable from individual income or payroll taxes, which are universally assessed. By contrast, premiums are only remitted by those who are paying to obtain coverage under the public plan.

If employers pay their employees' premiums in order to enroll in the state public option plan, the premium payments would be deductible to the employer as a business expense, no different than premium payments for any insurance plan.[301]

Thus, a state public option financed primarily with an employer payroll tax preserves the tax advantage of the status quo, but raises greater ERISA questions, whereas shifting more of the financing to the individual taxes potentially raises the tax burden particularly for high- or even moderate-income earners. States looking to enact a robust, comprehensive public option that is adopted by private employers and employees and raises revenues for more generous premium subsidies should rely on a combination of employer payroll taxes and individual premiums (rather than individual income or payroll taxes) to finance the public option plan, navigate the maze of ERISA preemption, and preserve the current tax advantages for employer-based health benefits.

D. Administration

Comprehensive public option plans generally call for the creation of a new, publicly administered health plan. State administration is most common, but a state could allow the state agency to contract with a private health insurance company to administer the public option plan.[302] Comprehensive

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[299] Gary Claxton, Matthew Rae, Gregory Young, Daniel McDermott, Heidi Whitmore, Jason Kerns, Jackie Cifuentes, Anthony Damico & Larry Strange, *2020 Employer Health Benefits Survey*, KAISER FAM. FOUND. (Oct. 8, 2020), https://www.kff.org/report-section/ehbs-2020-section-1-cost-of-health-insurance/ [https://perma.cc/L3FL-JDCT].

[300] *See* I.R.C. § 213 (the threshold is 7.5% of adjusted gross income in 2019 and 2020 tax years and increases to ten percent in subsequent years).

[301] *See* I.R.C. § 162.

[302] *See* H. 88, 2015 Leg., Reg. Sess. § 1852(a) (Vt. 2015) ("The Agency of Human Services shall establish Vermont Care, a public health care coverage option for all Vermont residents . . . . The Agency may establish Vermont Care directly or through a contract with a health insurer to act as the third-party administrator.").

plans seek bolder disruption and social solidarity—not simply offering a fallback option if a resident becomes uninsured, but rather creating a single plan to cover an increasingly broad swath of the state's residents.[303] The state sees itself as creating and administering a new public program of health coverage rather than expanding existing programs to patch holes in dysfunctional market segments.

To access federal subsidies, Comprehensive plans would have to be offered on the Marketplace. The broadest versions of these plans conceived of the Marketplace being subsumed into the state plan via a Section 1332 waiver (allowing those eligible for Marketplace subsidies to use them to enroll in the public option plan) rather than attempting to offer the state plan as one of the options on the Marketplace.[304] While these broad proposals faced political hurdles under the Trump administration,[305] the Biden administration may be more welcoming of such a bold use of Section 1332 waivers.

A more modest variant of the Comprehensive public option plan could be sold on the Marketplaces as an MBPO offered to large group enrollees.[306] The state could create and administer a Comprehensive public option plan, essentially entering the market as a public insurer, and design the plan to be offered both on and off the Marketplace.[307] However, offering the plan on the Marketplace would inevitably fragment the market and risk pools, sacrificing the administrative simplification and cost savings achieved through a single risk pool and unified state public option plan.[308]

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[303] *See, e.g.*, A.B. 1343, 218th Leg., 2018–2019 Reg. Sess. § 2 (N.J. 2018) (declaring, "It is the intent of the Legislature to create the New Jersey Public Option Health Care Program to provide a universal health plan option available to every New Jerseyan.").

[304] *See, e.g.*, H.B. 6285, 2018 Leg., Reg. Sess. § 402 (Mich. 2018) ("As soon as allowed under federal law, the director shall seek a waiver to allow this state to suspend operation of the exchange and to enable this state to receive the appropriate federal fund contribution in lieu of the federal premium tax credits, cost-sharing subsidies, and small business tax credits provided in the federal act."); N.J. A.B. 1343 § 9.b.

[305] *See* State Relief and Empowerment Waivers, 83 Fed. Reg. 53,575 (Oct. 24, 2018); Jennifer Tolbert & Karen Pollitz, *New Rules for Section 1332 Waivers: Changes and Implications*, KAISER FAM. FOUND. (Dec. 10, 2018), https://www.kff.org/health-reform/issue-brief/new-rules-for-section-1332-waivers-changes-and-implications/ [https://perma.cc/Z7BM-SMGF] ("By prioritizing private coverage over public programs, the new guidance appears to make it more difficult for states to obtain waivers that would build on Medicaid, adopt a public plan option in the marketplace, or create a single payer plan.").

[306] *See, e.g.*, S.B. 697, 191st Gen. Ct., 2019–2020 Sess. § 2 (Mass. 2019).

[307] *See* S.B. 5222, 66th Leg., 2019 Reg. Sess. §§ 112(6), 115 (Wash. 2019). Washington's S.B. 5222 (2018) contemplates that the state public option plan could be offered on the Marketplace until a waiver is obtained and the entire Marketplace is folded into the state plan.

[308] Fragmentation would persist between separate risk pools for individuals that seek coverage on the Marketplace and those ineligible for Marketplace coverage, like those with employer-based coverage or government-sponsored coverage.

E. Financial Considerations

1. Financing Sources

As with all public option plans, there are three main sources of financing for Comprehensive public option plans: (1) premiums and cost-sharing; (2) federal funds, including Marketplace premium tax credits and Medicaid matching funds; and (3) state revenues from payroll and other taxes. The first two sources, premiums and premium tax credits, are the most common, but tax revenues may be necessary for the state to provide additional premium subsidies to individuals or populations who may be underserved by or ineligible for federal premium tax credits on the Marketplaces.

Many of the Comprehensive public option proposals would be financed by individual premiums and cost-sharing established by the administering agency or a contractor, though some populations may be exempt from these requirements.[309] Plans offered on the Marketplaces would have to follow the ACA's premium requirements, which include modified community rating.[310]

State bills to establish Comprehensive public option plans generally seek to draw down federal sources of funding and pool these with premiums and state tax revenues to finance the plan. They typically authorize state administrators to seek federal waivers as needed to collect ACA premium tax credits, federal pass-through funds from the Marketplaces, Medicaid matching funds, and other federal funds to enroll these populations in the state plan.[311] In reality, however, the Marketplace premium tax credits and pass-through funds are a more feasible source of federal funding than Medicaid matching funds, due to legal constraints described above.[312] Like MBPOs, a Comprehensive public option plan can be designed to tap into the extensive federal premium tax credits to finance the plan when offered on the Marketplace.[313]

Unlike MBPOs, Comprehensive plans can capture employers' and individuals' expenditures to finance large group coverage in the public option plan. To finance large groups' participation, Comprehensive plans (like their single-payer cousins) can draw upon a combination of payroll taxes on employers and premiums or income taxes for employees.[314] Payroll taxes create incentives for employers and employees to switch to the public option plan

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[309] *See, e.g.*, S.B. 5222, 66th Leg., 2019 Reg. Sess. §§ 111, 112 (Wash. 2019); S. 1947, 219th Leg., Reg. Sess. § 6.a (N.J. 2020).

[310] *See* discussion *supra* Section II.B.1.

[311] *See, e.g.*, A.B. 1343, 218th Leg., 2018–2019 Reg. Sess. § 9.b (N.J. 2018); H.B. 1104, 66th Leg., 2019 Reg. Sess. § 7 (Wash. 2019) ("The board shall . . . seek all necessary waivers so that current federal and state payments for health services to residents will be paid directly to the trust.").

[312] *See* discussion *supra* Section I.B.

[313] *See, e.g.*, S.B. 697, 191st Gen. Ct., 2019–2020 Sess. § 2 (Mass. 2019) (offering the public option exclusively on the state Marketplace).

[314] *See, e.g.*, H.B. 6285, 2018 Leg., Reg. Sess. § 402 (Mich. 2018).

(to avoid double-paying for coverage), but employers may hesitate to pay for employees to obtain public option coverage if they remain subject to the ACA's employer mandate penalties. Thus, if a state includes a payroll tax, obtaining a Section 1332 waiver of employer mandate penalties is advisable.[315] State tax revenues may also be necessary for the state to finance additional premium subsidies beyond those available on the Marketplaces or cover the remaining uninsured, particularly undocumented immigrants who are not eligible for Medicaid, Medicare, or Marketplace premium tax credits.

Washington and Vermont had bills that called for a combination of all three sources: (1) premiums; (2) federal premium tax credits for Marketplace plans; and (3) tax revenues. Washington's bills called for a funding plan that included a 10.5% payroll tax on employers (called a "health security assessment"), an 8.5% long-term capital gains tax, a 2% personal income tax (called a "personal health assessment"), premiums, cost-sharing, and federal health care funding.[316]

The evolution of Vermont's public option bills from 2011 to 2017 demonstrates the evolution in policymaker thinking on financing possibilities. In 2011, Vermont passed a single-payer plan and also proposed H. 146, a public option to be offered to all residents that combined the state's Medicaid, Marketplace, and large group market into a single public plan with a shared risk pool.[317] The bill relied on a complex financing formula including a ten percent payroll tax, individual and employer premiums, Medicaid funds (necessitating a Medicaid Section 1115 waiver), federal premium tax credits, an assortment of taxes on sugary foods and cigarettes, and penalties for noncompliance with the state's individual mandate.[318] Only Medicare beneficiaries were ineligible to participate in the state plan. After the state's single payer plan fell apart in 2014,[319] a similarly broad public option was re-introduced in 2015.[320] The 2015 bill (H.B. 88) was financed by a 12% payroll tax (8% on employers and 4% on employees), individual premiums, federal Medicaid funds and Marketplace premium tax credits, and penalties for noncompliance with the state's individual mandate.[321] By the 2017 legislative session, Vermont's public option bill had been scaled back significantly. It relied primarily on employer and individual premiums, federal premium tax

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[315] *See*, *e.g.*, H. 88, 2015 Leg., Reg. Sess. § 1811 (Vt. 2015) (requiring the state to apply for a waiver of the employer responsibility requirement of the ACA).

[316] S.B. 5222, 66th Leg., 2019 Reg. Sess. §§ 117, 202, 203 (Wash. 2019). Another public option bill in Washington in 2019 included a similar set of funding sources, except it did not include a long-term capital gains tax. *See* Wash. H.B. 1104 §§ 16, 18.

[317] *See* H. 146, 2011 Leg., Reg. Sess. (Vt. 2011).

[318] *Id.* § 1812 (drawing upon revenues from taxes on candy, sugary beverages, and cigarettes).

[319] *See* John E. McDonough, *The Demise of Vermont's Single-Payer Plan*, 372 NEW ENG. J. MED. 1584, 1584 (2015).

[320] *See* H. 88, 2015 Leg., Reg. Sess. § 1860 (Vt. 2015).

[321] *Id.* (setting forth financing sources for the Vermont Care Trust Fund); *id.* § 2 (discussing federal waivers under Sections 1115 and 1332); *id.* §§ 2103–04 (setting forth the employer and employee payroll taxes and premium payments).

credits, and, in lieu of an explicit payroll tax, a vague reference to other revenues "generated by a public funding mechanism" to be established by the legislature at a later date.[322] The 2017 bill eliminated the Medicaid population from public option eligibility and as a funding source. By narrowing its scope, the 2017 Vermont public option bill avoided the legal complexities of Medicaid waiver, the political difficulty of imposing new payroll taxes, and a new federal administration hostile to waiver applications to expand public coverage.

Michigan stands out as the only state in our dataset that relied entirely on taxes to finance its public option plan, prohibiting the use of premiums and cost-sharing.[323] In this regard, the Michigan public option financing most closely resembles state single-payer proposals, which more commonly rely on tax-financing and eschew cost-sharing and even premiums.[324]

2. Cost Control

As noted above, constraining payments to health care providers is the primary mechanism for public option plans to control costs. Lower costs for health care services translate to lower premiums and exert downward pressure on premiums in the health insurance market. Comprehensive public option plans generally use one of two approaches to control health care payment rates: administrative rate setting or centralized negotiations with providers.

Administrative rate setting typically pegs provider payments to a federal benchmark, such as Medicare rates. Michigan's H.B. 6285, for example, would set provider payment rates at 110% of Medicare and payment rates for drugs and devices at 100% of the rate paid by the Department of Veterans Affairs.[325] Similarly, Vermont's H. 88 would pay providers at 110% of Medicare rates.[326] In other instances, Comprehensive public option bills do not set rates or tie them to Medicare, but rather authorize state officials or the governing board to establish payment rates via negotiation with providers.[327] These negotiations potentially offer providers more ability to maintain higher payment rates, closer to private insurance rates, which typically pay providers about double what Medicare pays.[328]

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[322] H.B. 28, 2017 Leg., Reg. Sess. § 1855 (Vt. 2017).

[323] H.B. 6285, 2018 Leg., Reg. Sess. § 405(3) (Mich. 2018) ("MIcare must not include premiums or cost-sharing requirements."). H.B. 6285 was introduced and referred to the Committee on Health Policy in August 2018, but the bill never made it out of Committee. *Id.*

[324] *See* Fuse Brown & McCuskey, *supra* note 265, at 399 (describing how most state single-payer proposals feature low or no cost-sharing).

[325] Mich. H.B. 6285 § 306(5)–(6) (Mich. 2018).

[326] H. 88, 2015 Leg., Reg. Sess. § 1859(b) (Vt. 2015).

[327] *See, e.g.*, A.B. 1343, 218th Leg., 2018–2019 Reg. Sess. §§ 7.c–d (N.J. 2018); S.B. 5222, 66th Leg., 2019 Reg. Sess. §§ 09(2), 110(1) (Wash. 2019).

[328] *See* Eric Lopez, Tricia Neuman, Gretchen Jacobson & Larry Levitt, *How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature*, KAISER FAM. FOUND.

Provider rate controls are not the only ways public option plans save money. They also promise improvements in administrative efficiency. Comprehensive plans offer greater potential for administrative simplification than the narrower Marketplace-based plans or Buy-In models because Comprehensive plans further reduce fragmentation of the health insurance market and unify administration for many market segments into one body.

F. Market Effects

Comprehensive state public option plans are close cousins of state-based single-payer plans in terms of their aims, scope, and financing.[329] The main difference is that public option plans explicitly contemplate or anticipate that private employer-based coverage will continue to exist alongside the public option plan.[330] To the extent the plans reference employers at all, the state would offer private employers or employees an option to obtain coverage under the state public option plan either in lieu of or in addition to existing employer-based plans.[331] Nevertheless, the market for private coverage may be disrupted by the entrance of a public plan that will compete with private plans on the basis of comprehensiveness of benefits, cost, and provider network.[332] The extent of disruption to the private health insurance market depends on several factors, such as the breadth of the provider network, the strength of provider rate controls, ease of enrollment, whether employers or employees must contribute to financing the public plan if employers offer private coverage, and whether it would preserve the same tax advantage as current plans.[333]

(Apr. 15, 2020), https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/ [https://perma.cc/JKB9-S9VR].

[329] For example, Michigan's H.B. 6285 is a public option plan whose policy goals are nearly indistinguishable from a single-payer plan, providing that "all residents of this state are eligible for [the state plan] MIcare, a universal health care program that will provide health care coverage through a single payment system." H.B. 6285, 2018 Leg., Reg. Sess. § 202 (Mich. 2018); *see also* S.B. 5222, 66th Leg., 2019 Reg. Sess. § 101 (Wash. 2019) (providing that "[a]ll residents of the state of Washington are eligible for coverage through this chapter.").

[330] For example, the Michigan public option bill explicitly permits individuals to maintain alternate sources of coverage: "This chapter does not require an individual with health coverage other than MIcare to terminate that coverage." Mich. H.B. 6285 § 408.

[331] *See, e.g.*, *id.* § 202 ("MIcare includes health care coverage provided under Medicaid, under Medicare, under MIChild, *by employers that choose to participate*, and to state and local government employees including public school employees.") (emphasis added); Vt. H. 88 § 1853 ("An individual may enroll in Vermont Care regardless of whether the individual's employer offers health insurance for which the individual is eligible.").

[332] *See, e.g.*, Margot Sanger-Katz, *Why the Less Disruptive Health Care Option Could Be Plenty Disruptive*, N.Y. TIMES (Dec. 3, 2019), https://www.nytimes.com/2019/12/03/upshot/public-option-medicare-for-all.html [https://perma.cc/VTZ6-YT3L] (discussing the disruptive effect of a federal public option plan).

[333] *See* Fuse Brown et al., *supra* note 287, at 422; *see also* Sanger-Katz, *supra* note 332; Matthew Yglesias, *Joe Biden's Health Care Plan, Explained*, VOX (July 16, 2019), https://www.vox.com/2019/7/16/20694598/joe-biden-health-care-plan-public-option [https://perma.cc/BAC9-7DD8].

IV. Update for 2021 Legislative Session

While outside the scope of our original survey, 2021 was an active year for state public option plans. In the 2021 legislative session, twelve bills were introduced in eleven states to implement a public option health plan.[334] All of these bills fit into the taxonomy described in Parts I–III, with six states introducing Medicaid buy-ins,[335] five states introducing MBPOs,[336] and one state introducing a comprehensive public option plan.[337] Most states introducing bills had introduced similar public option bills in previous sessions, but three states—Oklahoma, South Carolina, and Tennessee—introduced public option bills for the first time in 2021, all of which were Medicaid buy-in plans.[338] As with prior years, most bills failed to pass or advance out of committee, but Nevada and Colorado enacted an MBPO in 2021.[339] In addition, the 2021 Washington legislature strengthened its public option plan by authorizing the Insurance Commissioner to require certain hospitals to contract with at least one public option plan[340] and eliminating the Commissioner's ability to waive the cap on provider rates at 160% of Medicare rates.[341] The successful 2021 bills in Nevada, Colorado, and Washington demonstrate the continuing traction of state public option legislation.

Nevada nearly implemented a Medicaid buy-in public option in 2017,[342] but the passage of an MBPO-type public option in 2021, S.B. 420, shows an

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[334] *See* H.B. 21-1232, 73d Gen. Assemb., 1st Reg. Sess. (Colo. 2021); S.B. 842, 2021 Gen. Assemb., Reg. Sess. (Conn. 2021); S.B. 83, 156th Gen. Assemb., Reg. Sess. (Ga. 2021); S.B. 787, 192d Gen. Ct., Reg. Sess. (Mass. 2021); S.B. 420, 2021 Leg., 81st Sess. (Nev. 2021); A.B. 5029, 219th Leg., Reg. Sess. (N.J. 2021); H.B. 1808, 58th Leg., 1st Sess. (Okla. 2021); H.B. 3573, 124th Gen. Assemb., Reg. Sess. (S.C. 2021); S.B. 418, 2021 Leg., 112th Sess. (Tenn. 2021); H.B. 602, 2021 Leg., 112th Sess. (Tenn. 2021); H.B. 4984, 2021 Leg., 87th Sess. (Tex. 2021); H.B. 512, 2021 Leg., 87th Sess. (Tex. 2021); H.B. 3001, 2021 Reg. Sess. (W.V. 2021). Note that West Virginia also introduced H.B. 2241, but because the bill is so similar to H.B. 3001, we count West Virginia as introducing one bill.

[335] S.B. 83, 156th Gen. Assemb., Reg. Sess. (Ga. 2021); H.B. 1808, 58th Leg., 1st Sess. (Okla. 2021); H.B. 3573, 124th Gen. Assemb., Reg. Sess. (S.C. 2021); S.B. 418, 2021 Leg., 112th Sess. (Tenn. 2021); H.B. 602, 2021 Leg., 112th Sess. (Tenn. 2021); H.B. 4984, 2021 Leg., 87th Sess. (Tex. 2021); H.B. 512, 2021 Leg., 87th Sess. (Tex. 2021); H.B. 3001, 2021 Reg. Sess. (W.V. 2021).

[336] H.B. 21-1232, 73d Gen. Assemb., 1st Reg. Sess. (Colo. 2021); S.B. 842, 2021 Gen. Assemb., Reg. Sess. (Conn. 2021); S.B. 787, 192d Gen. Ct., Reg. Sess. (Mass. 2021); S.B. 420, 2021 Leg., 81st Sess. (Nev. 2021).

[337] A.B. 5029, 219th Leg., Reg. Sess. (N.J. 2021).

[338] H.B. 1808, 58th Leg., 1st Sess. (Okla. 2021); H.B. 3573, 124th Gen. Assemb., Reg. Sess. (S.C. 2021); S.B. 418, 2021 Leg., 112th Sess. (Tenn. 2021); H.B. 602, 2021 Leg., 112th Sess. (Tenn. 2021).

[339] H.B. 21-1232, 73d Gen. Assemb., 1st Reg. Sess. (Colo. 2021); S.B. 420, 2021 Leg., 81st Sess. (Nev. 2021).

[340] *See* S.B. 5377, 67th Leg., Reg. Sess. § 5 (Wash. 2021). The requirement applies to hospitals that serve patients from the public employee or school employee benefit plans or Medicaid. This provision was designed to address the poor hospital participation in the public option, which led to only twenty of thirty-nine counties offering a public option plan. *See supra* text accompanying notes 218–19.

[341] S.B. 5377, 67th Leg., Reg. Sess. § 6(2)(g)(ii) (Wash. 2021).

[342] *See* discussion *supra* Part I.

evolution in public option design. Specifically, S.B. 420 requires the public option to be sold both on and off the marketplace and to be available to all state residents starting on January 1, 2026.[343] The law requires the state Director of Health and Human Services to apply for a waiver from HHS to obtain federal pass-through funds[344] and authorizes the Director to apply for a waiver to combine risk pools for the public option and Medicaid, if doing so would lower costs.[345] If Nevada is able to combine its Medicaid MCO and public option plans in this way, the public option would be a hybrid MBPO/Medicaid buy-in plan, perhaps reflecting its 2017 origins and aiming to reduce churn on and off Medicaid. S.B. 420 also grants the Director broad discretion about how to implement the public option, including whether to directly administer the plan or to contract with a health carrier to do so and whether to offer it to small employers or their employees.[346] Recognizing that there are tradeoffs between a public-private partnership and direct administration of the public option, the Nevada law requires all carriers offering a Medicaid-managed care plan to submit a "good faith proposal" for a public option plan, then allows the Director to choose one of those plans or to implement the public option directly.[347] Rather than impose provider rate caps on the public option, the Nevada law requires its premiums be at least five percent cheaper than a reference premium and limits future premium increases to the Medicare Economic Index.[348] This premium cap gives the public option plan broad flexibility in how to control costs, but the premium limits appear to end on January 1, 2030, potentially leaving Nevada without mandatory cost controls after 2030.[349] The Nevada public option also sets a payment floor commensurate with Medicare rates for most provider reimbursements.[350] Finally, to ensure adequate provider participation in the public option, Nevada's law requires all providers that participate in the Public Employees' Benefits Program to enroll in at least one public option plan and to accept public option patients equitably compared to other patients.[351]

The strengths of Nevada's public option legislation are the significant flexibility given to state agencies to design and implement the public option

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[343] S.B. 420, 2021 Leg., 81st Sess. § 41 (Nev. 2021).
[344] *Id.* § 11.
[345] *Id.* § 11(1)(b)(1).
[346] *See id.* § 10.
[347] *See id.* §§ 12(1), 12(2), 12(5).
[348] *Id.* §§ 10(4), 10(6)(d) (defining the "Reference premium" as "for any zip code, the lower of: (1) The premium for the second-lowest cost silver level plan available through the Exchange in the zip code during the 2024 plan year, adjusted by the percentage change in the Medicare Economic Index between January 1, 2024, and January 1 of the year to which a premium applies; or (2) The premium for the second-lowest cost silver level plan available through the Exchange in the zip code during the year immediately preceding the year to which a premium applies.").
[349] *See id.* §§ 38, 41 (removing the premium controls for the public option plan effective January 1, 2030).
[350] *See id.* § 14(2)–(5).
[351] *See id.* §§ 13, 21, 29.

plan, including the authority to administer the plan directly, and the provider participation requirements. This strength from flexibility may be undermined, however, by the lack of permanent statutory provider or premium rate controls necessary to achieve the public option's central aim of cost control. Additionally, the long five-year runway to implementation gives the state many opportunities to kill the public option in the face of unfavorable actuarial or budgetary analyses or overwhelming political opposition from industry.

In 2021, the Colorado legislature passed H.B. 21-1232,[352] a bill that reflects significant modifications from earlier years' models. The extent of concession and delegation to private insurers and providers begs the question of whether the law can fairly be called a "public option."[353] All mention of public option plans was eliminated from the law.[354] Instead, the legislation requires all carriers that offer a health plan in the individual and small-group market to also offer a standardized health benefit plan in the same county both on and off the Marketplace beginning in 2023.[355] Its benefit design is similar to earlier years' proposals for the Colorado Public Option Plan.[356] Furthermore, the standardized plans are entirely privately administered and lack the defining feature of publicly-determined provider rates except under limited circumstances.[357] Instead of imposing state-established provider rate caps, the 2021 bill relies upon premium constraints, leaving private carriers to negotiate health care reimbursement rates with health care providers to achieve the mandated premium savings.[358] Beginning in 2023, premiums for the standardized plans must decrease five percent per year compared with inflation-adjusted 2021 rates until they achieve a fifteen percent reduction overall in 2025.[359] As a fallback, the Commissioner may set provider reimbursement rates only for hospitals and health systems that prevent a carrier from meeting specified premium rate reductions or meeting network adequacy requirements (by refusing to negotiate their own rate reductions or participate), but state-imposed rates for hospital services cannot be lower than 165% of Medicare rates.[360] In addition, the 2021 law eliminated the

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[352] H.B. 21-1232, 73d Gen. Assemb., 1st Reg. Sess. (Colo. 2021).

[353] *See, e.g.*, Marianne Goodland, *Public Option Bill, Now Just a Health Care Plan with More Oversight, Approved by House Committee's Democrats*, COLO. POLS. (Apr. 27, 2021), https://www.coloradopolitics.com/legislature/public-option-bill-now-just-a-health-care-plan-with-more-oversightapprovedby-house/article_9ceefb20-a78c-11eb-b2d0-fb9e0559f168.html [https://perma.cc/5LAS-79SD].

[354] *See id.*

[355] H.B. 21-1232, 73d Gen. Assemb., 1st Reg. Sess. § 1(10-16-1304(1)(c)) (Colo. 2021).

[356] *See id.* §§ 1(10-16-1304–05) (requiring the Colorado Standardized Plans to cover pediatric care and other essential health benefits; offer bronze, silver, and gold levels of coverage; be designed to improve racial health equity; and offer first-dollar, pre-deductible coverage for certain services, such as primary health care and behavioral health care).

[357] *See id.* § 10-16-1304(1).

[358] *Id.* § 1(10-16-1305).

[359] *Id.* § 1(10-16-1305(2)).

[360] *Id.* § 1(10-16-1306(5)(a)). *But see id.* § 1(10-16-1306(4)(a)) (establishing a base rate of 155% Medicare rates and allowing add-ons for certain types of hospitals).

override power of the Advisory Board.[361] Overall, the 2021 version delegates significantly more responsibility to private industry, but if the industry does not achieve the legislature's goals, the state can impose fines,[362] reject premium requests,[363] restrict reimbursement rates,[364] and suspend the license of any hospital that does not accept the standardized plan.[365] Unlike Nevada's model, Colorado's does not authorize the state to administer the plan directly or combine risk pools with Medicaid, but rather imposes increasingly stringent requirements on private plans offered on and off the marketplace as well as mechanisms to compel provider participation. Colorado's new approach appears to more actively regulate insurance rates, akin to Rhode Island's hospital rate caps via insurance rate regulation,[366] coupled with standardized plan requirements. The provider rate controls are considerably more modest than even Washington's, setting a floor for hospitals of 165% of Medicare rates versus Washington's ceiling of 160%, and only as a fallback if private negotiations fail. But compared to Nevada's five-year period, implementation in Colorado is a relatively quick two-year time frame.

The 2021 legislative session demonstrated the growth and evolution of state public option bills. Perhaps learning from Washington's struggle with provider rate controls, the new state models lean on premium rate controls and leave the negotiations of how to achieve these premium cuts to the industry players themselves. However, the new models also absorbed Washington's lesson that providers must be made to participate in the public option—carrots will not work as well as sticks. And the biggest stick is the threat of greater state control over the public option plan and provider rates if the private industry players cannot achieve the goals of coverage and cost reduction on their own.

V. Are State Public Option Plans Worth It?

This project surveys and analyzes state legislative proposals since 2010 that aim to establish a public option plan as a health reform tool. Here is

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[361] *Compare id.* § 6 *with* H.B. 20-1349, 72d Gen. Assemb., 2d Reg. Sess. (10-16-1204 (6)) (Colo. 2020) (stating that "the Board may override a decision of the Commissioner concerning the development, implementation, and operation of the Colorado Option Plan by an affirmative vote of at least seven of the voting members of the board.").

[362] Colo. H.B. 21-1232 § 6.

[363] *Id.* § 2.

[364] *Id.* § 1(10-16-1306(4)(I)).

[365] *Id.* § 6.

[366] *See* Johanna Butler, *Insurance Rate Review as a Hospital Cost Containment Tool: Rhode Island's Experience*, Nat'l Acad. State Health Pol'y (Feb. 1, 2021), https://www.nashp.org/insurance-rate-review-as-a-hospital-cost-containment-tool-rhode-islands-experience/ [https://perma.cc/3L6Z-YYGB]; Robert Berenson, Jaime King, Katherine Gudiksen, Roslyn Murray & Adele Shartzer, Urb. Inst. & U.C. Hastings L., Addressing Health Care Market Consolidation and High Prices: The Role of the States 54–56 (2020), https://www.urban.org/sites/default/files/publication/101508/addressing_health_care_market_consolidation_and_high_prices_3.pdf [https://perma.cc/JLC7-DPMF].

what we have learned. First, "public option" means many different things to different people.[367] Notably, state public option plans differ from their federal counterparts in that they are not necessarily publicly financed; rather, what makes them "public" is that they are state-initiated and that they impose state-mandated provider rate caps, even if the plan is administered by a private contractor and financed from a variety of public and private sources. Second, there are three main types of state public option plans, listed from narrowest to broadest in scope: (1) Medicaid buy-in public option; (2) Marketplace-based public option; and (3) Comprehensive public option. The type of plan a state should pursue depends on the state's policy goals. Third, and somewhat ironically, the degree of legal difficulty in establishing a state public option plan is inversely related to the scope of the plan's reach—the broadest plans have surprisingly fewer legal hurdles than narrower plans, though the broad plans may be more disruptive and politically difficult. This Part assesses these tradeoffs and sets forth a menu of options for states to help answer whether pursuing a public option as a health reform is worth it, and, if so, which kind of public option to pursue.

A. A Public Option Road Map for States

1. Medicaid Buy-In Public Option

A Medicaid buy-in public option is best for states whose primary goal is to provide access to difficult-to-cover, lower-income populations. These groups include undocumented immigrants and those who earn too much for Medicaid but for whom Marketplace coverage is unaffordable due to the family glitch or the subsidy cliff.[368] Offering a plan based on a Medicaid-managed care plan would reduce coverage disruptions for those churning on and off Medicaid and keep premiums affordable by reimbursing providers at rates pegged to Medicaid. These populations may be well-served by a Medicaid-like plan because their health and social support needs may resemble those of Medicaid beneficiaries.

Several constraints limit the scope of Medicaid buy-in plans. First, the Medicaid statute does not permit non-eligible individuals to enroll directly in Medicaid, and federal Medicaid matching funds cannot be used to pay for or subsidize non-Medicaid enrollees. Medicaid buy-in thus typically means a state would require its Medicaid-managed care plans to offer parallel plans to the buy-in population, often on the Marketplace.[369]

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[367] We are not the first observers of state public option plans to note this. *See* Sparer, *supra* note 37, at 262.

[368] *See supra* Sections I.A, I.C.

[369] *See supra* Section I.B.

Second, if the state wants to cover undocumented immigrants, the Medicaid buy-in plan cannot be offered solely on the Marketplace.[370] This means that a single Medicaid buy-in plan could not simultaneously create cost competition on the Marketplace and cover undocumented immigrants. A state could offer off- and on-Marketplace versions of the plan, but this bifurcation would sacrifice the plan's administrative simplification.

Another tradeoff is that paying Medicaid rates, which is necessary to maintain the plan's affordability, could also threaten provider participation, limiting the scope of the Medicaid buy-in plan.[371] Such a plan could never be expanded to large groups, for example, without triggering widespread provider backlash and exit. Further, if offered on the Marketplace, the downward pressure in the market created by a Medicaid buy-in plan could drive down premiums so much as to reduce the available subsidies on the rest of the Marketplace, which would necessitate a Section 1332 waiver to capture federal pass-through funds of amounts saved in lower premium subsidies. Thus, for Medicaid buy-in plans, the state must face all the legal constraints of the Medicaid program and the Marketplaces and thread the needle with provider rates that are low enough to ensure affordability and high enough to maintain sufficient provider participation to serve a larger portion of state residents.

As a result, Medicaid buy-in proposals have not proliferated or progressed very far toward passage. New Mexico has arguably taken the proposal the furthest with its significant Medicaid population, program infrastructure, and a modest goal of expanding access for its remaining uninsured. Nevertheless, the political difficulty of funding coverage for its uninsured, particularly undocumented immigrants, stymied the plan's ultimate passage.[372] The legal and practical constraints of the Medicaid buy-in make it the narrowest type of public option; however, it is no less politically difficult than some of the broader types.

2. Marketplace-Based Public Option

MBPOs offer states the most flexibility to achieve their specific policy goals, yet states may have to choose between conflicting policy goals from the outset. Some decisions are simple. MBPOs are clearly best for states that aim to cover bare (or nearly bare) counties. For enrollees of individual and small group Marketplace plans, lack of competition in the Marketplace is significant: residents of over seventy percent of counties in the United States—nearly a third of all enrollees in the ACA Marketplaces—had a choice of only one or two insurers in 2021.[373] MBPOs would provide an

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[370] *See supra* Section I.D.1.

[371] *See supra* Sections I.E, I.F.

[372] *See* Sparer, *supra* note 37, at 269–70.

[373] *See* Daniel McDermott & Cynthia Cox, *Insurer Participation on ACA Marketplaces 2014-2020*, KAISER FAM. FOUND. (Nov. 23, 2020), https://www.kff.org/private-insurance/is-

additional option in these underserved areas, which may drive beneficial price competition.

Yet MBPOs face a surprising tradeoff between the goals of improving competition and reducing premiums. MBPOs' ability to improve affordability hinges on states' willingness to constrain provider payments through ambitious rate caps. States that set timid reimbursement limits may see few, if any, savings or improvements in affordability from the introduction of the MBPO.[374] Similarly, states that rely heavily on private insurers to administer and finance the MBPO may lose some of the MBPO's competitive effects or provoke lukewarm efforts by private insurers reluctant to offer MBPO plans that compete with their existing plans.[375] On the other hand, a state that administers its own plan, imposes stringent payment caps, retains financial risk and administrative control over the MBPO, and requires (or strongly nudges) provider participation could shift the market with a substantially cheaper more desirable plan option. The downside is that some insurers may exit rather than compete.[376] The sweet spot between driving cost savings and maintaining a competitive public-private Marketplace may be as difficult to find as the proverbial needle in the haystack. In sum, the state must decide how willing it is to disrupt the existing market in order to achieve its goals of increased access and affordability.

Despite this challenge, MBPOs remain the most viable form of state public option because they can mobilize federal dollars to achieve state health care coverage goals.[377] Most of the public option bills we reviewed, and the plans that have advanced the furthest—in Washington, Nevada, and Colorado—use the Marketplace to access federal financial subsidies.[378] States rely on Marketplace federal subsidies to fund their MBPOs in two ways. First, residents who purchase MBPO plans on the Marketplace can use premium tax credits towards purchasing the plan.[379] The MBPO directly receives these premium tax credits and, through a more circuitous path, the cost-sharing reduction payments for eligible residents. The federal funds not only offset the cost of the plan to the state, they help pay for the MBPO. Second, if the state obtains a Section 1332 waiver from the federal government, it can access federal pass-through funds of federal savings obtained from the MBPO's provider rate controls or other administrative savings.[380] Further, states can use Section 1332 to create shared savings programs, al-

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sue-brief/insurer-participation-on-aca-marketplaces-2014-2020/ [https://perma.cc/7WQ4-CLFG].

[374] *See supra* Section II.E.2.

[375] *See supra* Sections II.D, II.E.

[376] *See supra* Section II.F.

[377] *See supra* Sections II.B, II.E.

[378] *See* 2019 Wash. Sess. Laws, enacting Engrossed Substitute S.B. 5526, 66th Leg., 2019 Reg. Sess. § 3(1) (Wash. 2019); H.B. 20-1349, 72d Gen. Assemb., 2d Reg. Sess. § 1(10-16-107(3.7)(a)) (Colo. 2020).

[379] *See supra* Section II.B.1.

[380] *See supra* Section II.B.2.

lowing them to keep any federal savings they generate by the public option plan and potentially use those funds to subsidize additional coverage.

Though there are several ways a state could structure its MBPO, the big choices revolve around scale and disruption. States that are wary of market disruption could create a commercially-administered MBPO with modest provider payment caps, but the results, if any, may likewise be modest, such as creating an extra plan option here or there and slight downward pressure on commercial premiums over time.[381] Washington and Colorado's public options are examples of modest MBPOs. States that want bigger results must assume a greater role administering, financing, and controlling their MBPOs.[382] Nevada's model moves in this direction by authorizing the state to directly administer the public option or award a single contract to a private carrier, requiring providers to participate, and authorizing application for a Section 1332 ACA waiver to capture premium savings and a Section 1115 Medicaid waiver to combine risk pools with the Medicaid program. However, these bolder MBPOs must aggressively cap provider payments or premium rates and consider extending their MBPOs to the large group market to draw in additional covered lives and funds.[383] Like any innovation, Washington's modest first move may facilitate more robust internal iterations and inspire other states to take the reform further, building toward a more transformational vision for a state public option.

3. Comprehensive Public Option

A Comprehensive public option plan is best for states whose goals are to broadly expand access to all residents of the state, pursue administrative simplification through a unified public plan that covers previously segmented markets (individual, small, and large groups), improve affordability and control spending through broadly applicable provider rate caps, and provide a glide-path to single-payer health care.[384] Comprehensive plans are distinguishable from other types of state public option plans because they explicitly extend public coverage to the large group market of employer-based coverage.

Adding the large group target population increases the level of administrative and political difficulty to establish a Comprehensive public option compared with MBPOs. A state could develop a Comprehensive public option by offering a broad version of the MBPO and opening it up to large group enrollees, as proposed by Massachusetts, which would require a Section 1332 waiver of the employer mandate and application of federal pass-through funds to new, enlarged subsidies.[385] All the lessons for MBPOs

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[381] *See supra* Section II.E.2.
[382] *See* Hansard, *supra* note 20.
[383] *See supra* Section II.E.2.
[384] *See supra* Section III.A, III.B.
[385] *See* S.B. 697, 191st Gen. Ct., Reg. Sess. § 2 (Mass. 2019).

would apply, but the scope and stakes would be higher. The administration, risk pool, provider rate limits, benefits, and premium and cost-sharing rates would apply to the entirety of the private insurance market, heightening the tradeoffs between affordability and insurance market disruption. Yet, presumably, Comprehensive plans are designed to disrupt the market, so the tradeoff decision has already been made. In addition, Comprehensive plans offered solely on the Marketplace cannot reach undocumented immigrants, who cannot purchase coverage on the Marketplace.

The most ambitious Comprehensive public option plans would subsume the Marketplace into the new state health plan via an expansive Section 1332 waiver, allowing the state to receive all the federal Marketplace subsidies and pass-through savings and combine these funds and administration into a larger system that includes Marketplace enrollees and off-Marketplace populations, those ineligible for Marketplace coverage or subsidies, public employees, and even potentially Medicaid beneficiaries.[386] This ambitious version of the Comprehensive public option would entail creation of a new administrative agency to run the new state health program.

Financing Comprehensive public option plans is also more complex than financing MBPOs, particularly if the plan aims to capture employer health spending. To capture the employer share of health coverage, Comprehensive plans will require payroll taxes or mechanisms to collect an employer premium payment for employees who choose the public plan.[387] Although these mechanisms may simply replace existing health spending by large employers and employees, opponents may frame them as new tax increases. Some states, like Massachusetts, have proposed financing narrower Comprehensive plans through premiums and federal Marketplace subsidies, while others, like Vermont, also contemplate raising additional state revenue to provide subsidies to those ineligible for federal subsidies or to supplement federal subsidies where inadequate.[388] Ultimately, Comprehensive plans are limited to the same three sources of financing as all state-based public option plans: federal Marketplace subsidies, premiums, and state tax revenue. The broader the plan, the more sources are tapped.

Surprisingly, the level of legal difficulty for Comprehensive public option plans is not significantly higher than for MBPOs. This doesn't mean these plans are easy; a Comprehensive public option plan must still run the gauntlet to satisfy the ACA's requirements and obtain an extremely broad and, to date unheard of, Section 1332 waiver. However, if it can secure the waiver, then a state can structure its Comprehensive plan to avoid further entanglements with ERISA and federal tax law. To avoid ERISA preemption, Comprehensive plans should avoid requiring employers to take any specific action with their health plans, such as including mandating employ-

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[386] *See supra* Section III.D.
[387] *See supra* Section III.E.1.
[388] *See supra* Section III.E.1.

ers enroll their employees in public coverage or requiring premium contributions if the employee chooses to do so.[389] A payroll tax to encourage participation and capture employer health spending should not raise ERISA concerns, particularly if the payroll tax preserves employers' plan choices. A voluntary, premium-based Comprehensive plan like Massachusetts' proposal would avoid ERISA entirely, but it might also fail to capture employers' health spending. A state payroll tax on employers would roughly preserve employers' current tax advantage for offering employee coverage; structuring individual contributions as premiums rather than individual income or employee payroll taxes would likely avoid the $10,000 cap on state and local tax deductions.[390]

B. Universal Advice and Conclusions

To be sure, states have policy alternatives beyond this taxonomy of public option plans. For instance, states seeking to control costs could regulate provider rates across payers rather than establish a public option, which may be more economically efficient but may not create coverage options where they are lacking.[391] For administrative simplification, states could pursue a single-payer plan to displace the private insurance market more decisively than contemplated even by Comprehensive public options.[392] On the narrower end of the spectrum, states could pursue a Basic Health Plan or expand community health centers to provide coverage or services to difficult-to-reach populations.[393] We focused on state public option plans, not because they are the only or even the best health reform model, but rather because states have been actively pursuing them. These are the lessons we gleaned from states' laboratory of public option experimentation.

1. For State Public Option Plans, Bigger Is Better

Narrow plans that target limited slices of the population may not benefit enough people to gain political support or be worth the inevitable political battle. A major goal for many states contemplating public options is to reach populations, such as undocumented immigrants, that have traditionally not

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[389] *See supra* Section III.C.1.

[390] *See supra* Section III.C; Wiley, *supra* note 16, at 884–85.

[391] *See, e.g.*, MICHAEL E. CHERNEW, LEEMORE S. DAFNY & MAXIMILIAN J. PANY, THE HAMILTON PROJECT, A PROPOSAL TO CAP PROVIDER PRICES AND PRICE GROWTH IN THE COMMERCIAL HEALTH-CARE MARKET (2020), https://www.hamiltonproject.org/assets/files/CDP_PP_WEB_FINAL.pdf [https://perma.cc/TEZ9-AGQY]; Fiedler note 104.

[392] *See, e.g.*, Fuse Brown & McCuskey, *supra* note 265; Wiley, *supra* note 16.

[393] *See, e.g.*, Lynn A. Blewett & David Anderson, *Examining the New Basic Health Plan Financing Rule,* HEALTH AFFS.: BLOG (Oct. 3, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180927.980559/full [https://perma.cc/ULS3-Z5E5]; Samantha Artiga & Maria Diaz, *Health Coverage and Care of Undocumented Immigrants*, KAISER FAM. FOUND. (July 15, 2019), https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-and-care-of-undocumented-immigrants/ [https://perma.cc/59KT-XSE7].

been covered by existing public or private plans who will likely require additional state subsidies. This throws some cold water on Medicaid buy-in plans. Not only are they harder to navigate legally, but they do not benefit enough people to secure a broad coalition of defenders or create enough market pressure to meaningfully impact health care spending or private prices.[394] While there may be good reasons to try to cover difficult-to-reach populations through an incremental extension of Medicaid, the state should be clear that it is not pursuing systemic reform typically associated with a public option.

Similarly, Marketplace-based plans with a limited target population, minimal state involvement, and timid provider rate caps are less likely than more ambitious plans to achieve the goal of cost containment.[395] A weak public option may exert little competitive pressure on private health plans and do little to control costs or expand coverage. Moreover, a neutered public plan may strengthen the idea that the government cannot do better than private markets to provide affordable coverage to the population. Since a weak version of the public option requires nearly as much political capital as a bolder version, it may only be worth the fight to establish a weak public option if the state plans to increase cost control measures over time.[396]

2. *Affordability Hinges on Strong Provider Reimbursement Controls*

The most common goal of all public option proposals is to improve the affordability of health care coverage for individuals, employers, and the state.[397] And the most powerful tool to achieve that goal is a state-mandated cap on provider rates. In fact, a provider rate cap may be all that distinguishes a public option plan that is privately administered and financed from purely private plans.[398]

Without question, setting provider payment limits in a public option plan is politically contentious. Set the rate too low, and providers may not

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[394] For a discussion of the dangers of a narrow public option in the national context, see Hacker, *supra* note 5, at 343 ("Small scale is a policy liability, increasing the changes the plan would end up attracting enrollees with disproportionately high costs and decreasing its leverage over the system. It is also a political liability because . . . the lack of a strong constituency or serious stakeholder investment could quell opportunities for expanding the public plan . . . .").

[395] *See* Hoffman, *supra* note 17, at 12 (noting that adding a public option to regions with only one Marketplace plan could hold down premiums and that "[s]uch benefits are laudable, but far short of the transformative vision that the public option's architects had for it").

[396] *See id.* ("[T]he marginal gains from a competitive public option would have come at a cost. The public option would have further justified preserving the existing system and problems with it. Injecting this option into the existing ACA exchanges would perpetuate, and perhaps even validate, this structure that is causing fundamental problems of inequity and regulatory bloat in health care.").

[397] *See supra* Sections I.A, II.A, III.A.

[398] *See* Dafny, *supra* note 17.

participate or may leave altogether.[399] Set the rate too high, and the public option plan will not increase affordability or create competitive pressure for private plans to reduce their provider rates.[400]

To create savings, most public option plans benchmark provider payments to public program rates—either Medicare or Medicaid—which are set by the government and are typically significantly lower than private rates.[401] Because Medicaid rates are the lowest, Medicaid buy-in plans that peg provider payments to Medicaid may keep plans affordable, but risk limiting the plans' viability and reach due to low provider participation. Marketplace-based or Comprehensive plans typically use Medicare rates as the benchmark, but selecting the Medicare multiple (101%, 125%, 160%) is politically fraught and also risks entrenching fee-for-service payment, cost-shifting, and incentives for providers to make up in volume what they lose in price.

Owing to the political challenges of imposing stringent provider rate caps, states are now shifting their cost control efforts to mandated premium cuts for the public option plan paired with stronger provider participation requirements.[402] It remains to be seen whether this strategy of forcing private payers and providers to the table to negotiate their own cuts will prove effective at controlling costs and fairly distribute payment cuts across providers and services.

3. Not "Buying In"

Due to legal constraints, allowing anyone to simply "buy in" to existing public coverage, such as Medicaid, is not viable.[403] Instead, states interested in a buy-in typically lean on their private contractors, such as Medicaid-managed care plans, to create a parallel plan that uses similar provider networks, reimbursement rates, benefit design, and administration. This parallel public plan can then be offered to non-eligible groups and individuals on and off the Marketplace. But these mock "buy ins" do not allow states to capture the efficiencies of a direct buy-in: risk pooling, administrative and communication efficiencies, access to federal funds, and legal pro-

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[399] *See* Fiedler, *supra* note 104, at 7–9 (concluding that a public option that pays lower rates than private rates would reduce premiums in the market, but noting that provider exit and negotiating rather than setting prices would diminish impact).

[400] *See* ROBERT BERENSON, JOHN HOLAHAN & STEPHEN ZUCKERMAN, URB. INST., GETTING TO A PUBLIC OPTION THAT CONTAINS COSTS: NEGOTIATIONS, OPT-OUTS AND TRIGGERS 2 (2009), https://www.urban.org/sites/default/files/publication/30756/411984-Getting-to-a-Public-Option-that-Contains-Costs-Negotiations-Opt-Outs-and-Triggers.PDF [https://perma.cc/38VX-ERWZ] ("A strong public option can contribute significantly to reducing subsidy costs and to system wide cost containment. A weak public option would likely not serve that role. A public option that begins with a small market share and would be required to negotiate prices with providers, often from a position of weakness, would do little to contain health care costs.").

[401] *See supra* Sections I.E.2, II.E.2, III.E.2.

[402] *See supra* Part IV (discussing 2021 bills).

[403] *See supra* Section I.B.

tections that come with participation in actual Medicaid or state employee health plans. Thus, despite its intuitive appeal, a direct buy-in to public coverage is a nonstarter for states.

4. Finance Through the Marketplaces

As noted above, a deep well of federal funds runs through the Marketplaces.[404] Congress deepened the well with a two-year enhancement of Marketplace subsidies in the pandemic response package, the American Rescue Plan.[405] This makes Marketplace-based public option plans both the most enticing and financially viable option for states. However, for a state to capture the maximum amount of savings possible by adding a public option to the Marketplace, it needs to run its own state-based Marketplace and secure a Section 1332 waiver from the federal government. The wellspring of federal funds flowing through the Marketplace means that in addition to MBPOs, states contemplating Medicaid buy-in plans and Comprehensive plans should consider a version of the plan that could be sold on the Marketplace. So central are the Marketplaces to state public option plans that, if the ACA were to be struck down by the Supreme Court, the entire structure for modern state public options would need reimagining.[406]

Other than federal subsidies available via the Marketplaces, few other sources of federal funding exist to support a state public option. The simplest funding source, both legally and politically, is premiums. States could offer Marketplace plans to large employers to slow the growth of commercial premiums and expand the public option's reach, buying power, and risk pool, but this strategy would require a Section 1332 waiver.[407] Relying solely on premiums, however, may make the public option plan unaffordable to many (including undocumented immigrants and those affected by the family glitch or subsidy cliff) and may fail to fully capture employers' coverage contributions. The broadest versions of the public option draw on all three available funding sources, including pass-through federal Marketplace funds via a Section 1332 waiver, individual premiums, and new state revenues from payroll taxes to capture the employer contributions.

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[404] *See supra* Sections II.B.2, II.E.

[405] American Rescue Plan Act of 2021, H.R. 1319, 117th Cong. § 9661 (2021). The Act increased existing premium tax credits for those earning between 100% and 400% of the FPL and extended premium tax credits to those earning more than 400% of the FPL, eliminating the subsidy cliff through the end of plan year 2022.

[406] The Supreme Court denied the most recent constitutional challenge to the ACA on the grounds that the plaintiffs lacked standing. *See* California v. Texas, 141 S. Ct. 2104, 2120 (2021).

[407] States seeking a Section 1332 waiver for sweeping changes should also be aware of the deficit neutrality requirement that would reduce pass-through savings by any reduction in federal revenue caused by the plan, including increases in Medicaid enrollment or decreases in federal tax revenue. *See supra* note 139 and accompanying text.

5. Competition and Disruption

All public option plans seek to inject competition into the private health insurance market by adding a public plan that can exert downward pressure on prices and provide additional choices to consumers. Indeed, all the plans we reviewed would initially increase competition. Yet the proposals and their endgames diverge from there. States must decide how much they want the public option to disrupt the private health insurance market. Answers can range from "not at all" (just seeking to cover remaining uninsured) to "maximally" (seeking a glide path to single-payer). A state's answer to this question will drive the design of its public option.

States that use the full arsenal of regulatory authority to control prices by imposing stringent, market-wide rate caps will achieve the greatest potential cost savings and radically displace the incumbent private health insurance system by outcompeting on price.[408] To states favoring this approach, the private insurance market has failed to deliver universal coverage or control costs. In this maximalist view, the public plan would eventually cover most state residents—including those with employer-based coverage—harnessing economies of scale from administrative savings, a massive and stable risk pool, and formidable purchasing power. Providers would have no choice but to participate in a public plan this large. This comprehensive version of the public option promises significant market disruption, especially for commercial insurers, but also the greatest potential savings and scope.

Other states may be wary or politically incapable of enacting a public option plan that disrupts providers and drives commercial insurers out of the market. These states can instead preserve a multi-payer system and increase choice and affordability for consumers, particularly in the individual and small group markets. These models embrace a managed competition approach, and if private insurers can compete efficiently within the state's price constraints, the public option has done its job.[409] These middle-path states, like Washington, may enlist private insurers to administer and potentially profit from the public option plan and set generous provider rate caps to mollify and encourage their participation, but the plans' effects on costs, choice, access, and coverage may be accordingly modest.[410]

Taken together, the range of state public option plans reveal a fundamental tension between competition and cost control. The more ambitious the provider rate controls, the more likely the public plan will constrain health care prices and premiums, but also the more likely it will disrupt the extant market, perhaps even displacing private insurance options and ulti-

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[408] *See* Brian J. Miller & Robert E. Moffit, *Choice, Competition, and Flexibility, Part I: Post-ACA Consumer Challenges*, HEALTH AFFS.: BLOG (Aug. 19, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200813.191190/full/ [https://perma.cc/9WW5-B9LB]; *see also* UCCELLO, *supra* note 109, at 12–13.

[409] *See* Wiley, *supra* note 16, at 2191.

[410] *See supra* Section I.E.2.

mately reducing choices. On the other hand, a strong commitment to preserving choices and competition among private health plans will require more modest public plan provider rate caps, sacrificing the public option's downward pressure on costs. This paradox means that a public option cannot simultaneously increase choice among competitors and significantly reduce costs. As Allison Hoffman has argued, the paradox results from a misplaced commitment to choice among multiple health plans.[411] In health insurance, choice is less important and less valuable than cost-control, and were a state to choose between a public option that increases choices and one that reduces costs for consumers, it should choose the latter.

In the end, the state must identify its goal and its role in the reform effort, and that will answer how much disruption it will tolerate. To take an analogy from education, is the state trying to establish an affordable flagship public university system that will serve as a market leader and benchmark for private competitors, or is the state trying to establish a charter school system to inject a few additional choices that are publicly funded but privately run? The former is more disruptive, more expensive, and more transformative. The latter is much more modest and may hardly be called systemic reform.

C. Federalism Implications

Our comprehensive review of state public option proposals also reveals some lessons for federalism in health reforms. Although this article does not set out to answer whether any state should pursue a public option or whether the federal government is better suited to such reforms, it does show that states have a considerably more difficult path to public option health reform than the federal government. States are faced with legal constraints from federal statutes (e.g., Medicaid, ACA, ERISA, and federal tax law), many of which are intended to protect beneficiaries and the federal budget, which means that states cannot simply extend existing public programs to new populations.[412] To give states a path through the labyrinthine legal requirements to systemic reforms, progressive members of Congress have proposed federal legislation that would modify these statutory constraints to give states greater flexibility to pursue state-level public options or other universal health reforms.[413] Even if federal reform is on the table, it would be worth enacting these federal pathways to state-based reform so we can learn from the laboratory of the states. However, broad federal waivers and additional state flexibility risk being weaponized to scale back coverage and protec-

[411] *See* Hoffman, *supra* note 17, at 2.
[412] *See supra* Sections I.B, II.B, III.C.
[413] *See* State-Based Universal Health Care Act of 2018, H.R. 6097, 115th Cong. (2018); State Public Option Act, H.R. 1277, 116th Cong. (2019).

tions.[414] Thus, any additional state flexibility legislation must contain sufficient guardrails to serve as a one-way ratchet—allowing state experimentation that enhances coverage, access, equity, and consumer protections over federal baselines, while prohibiting state policies that would undermine existing federal coverage.[415] This is no small feat. The guardrails in Section 1115 of Medicaid and Section 1332 of the ACA have been systematically assaulted but have largely held fast. Attempts to promote greater state flexibility must preserve these protective bulwarks.

Given his support for a federal public option while a candidate, President Biden could take concrete steps to advance state public option reforms. In particular, the Biden Administration could enact regulations designed to assist states in obtaining Section 1332 waivers, Section 1115 waivers, or an unprecedented super-waiver combining both, to promote a state public option as a vehicle for systemic reforms.[416] These regulations could streamline access to federal pass-through funds and provide guidance on expanding eligible populations, the limitations on use of federal funds, establishing a state-agency as a QHP, and receiving premiums and premium tax credits.

Equally as important as federal legal constraints are fiscal constraints. States cannot deficit-spend, and most are constitutionally required to balance their budgets every year.[417] Thus, states are inherently more limited in their ability to generate new funding streams to pay for or subsidize coverage for difficult-to-reach populations. States must therefore rely on federal funding and private spending to finance the bulk of their public option proposals. This reliance on federal financing imposes a significant structural limit on state universal health reform.

Although federal reform may be the ultimate answer, states have an essential role to play. They are the engines of federalist innovation. Salutary and failed state experiments provide essential policy design lessons. Even with all their limitations, successful state public option plans will inform and enhance federal health reform. Thus, we all benefit from clearing existing

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[414] *See* Nicole Huberfeld, Sidney Watson & Alison Barkoff, *Struggle for the Soul of Medicaid*, 48 J. L. MED. ETHICS 429, 430–31 (2020); *see also* Matthew B. Lawrence, *Fiscal Waivers and State "Innovation" in Health Care*, 62 WM. & MARY L. REV. 1477, 1506 (2021); Sara Rosenbaum, *Weakening Medicaid from Within*, AMERICAN PROSPECT (Oct. 19, 2017), https://prospect.org/power/weakening-medicaid-within/ [https://perma.cc/A2LK-C93F].

[415] *See* Elizabeth Y. McCuskey, *Agency Imprimatur and Health Reform Preemption*, 78 OHIO ST. L. J. 1099, 1146, 1164 (2017) (describing the importance of standards in Section 1332 waivers); *see also* William W. Buzbee, *Asymmetrical Regulation: Risk, Preemption, and the Floor/Ceiling Distinction*, 82 N.Y.U. L. REV. 1547, 1566 (2007) (describing how federal floor preemption can function as a one-way ratchet, allowing state laws more protective than federal baselines).

[416] *See* Dylan Scott, *What Biden Could Do to Expand Health Coverage—Without Congress*, VOX (Nov. 17, 2020, 10:30 AM), https://www.vox.com/policy-and-politics/21562986/president-joe-biden-health-care-plan-obamacare-medicaid [https://perma.cc/ZK3M-52WZ]; *see also* Lawrence, *supra* note 194.

[417] *See* Bagley, *supra* note 93, at 10.

legal and fiscal hurdles to state health reforms that move toward universal coverage and effective cost control.

Conclusion

Are public option plans worth it? Yes, if the state goes big. The ACA advanced the U.S. health system toward the perennial goals of universal access to affordable, comprehensive coverage. Nevertheless, political and legal setbacks have stymied the full realization of these goals. The next big thing in health reform appears to be a public option, and the states have been actively developing a variety of state-level public option proposals. Three main models of a state public option have emerged that vary in scope and ambition. Though all three models are viable, the degree of legal difficulty is not much greater for the broadest plans than the narrowest ones, while effectiveness increases with the plan's scope. Thus, for state public option plans, bigger is better. Though states have a path forward, they remain constrained by current fiscal and legal federalism. When states can't test models of health reform, we all lose. Thus, for states to function as true laboratories of health reform, they need greater flexibility from Congress and the administration in the forms of broad statutory waivers and new legal pathways to prove whether a public option is indeed worth it.

* * *

APPENDIX: TABLE OF STATE PUBLIC OPTION BILLS 2010-2021

	State	Year	Bill Number
Medicaid Buy-ins			
1	Connecticut	2018	H.B. 5463
2	Georgia	2020	S.B. 339
3	Georgia	2021	S.B. 83
4	Indiana	2019	S.B. 444
5	Iowa	2018	H.F. 2002
6	Massachusetts	2017	S.B. 2211
7	Massachusetts	2019	H.B. 1132
8	Minnesota	2015	H.F. 2749 / S.F. 2356
9	Nevada	2017	A.B. 374
10	Nevada	2021	S.B. 420*,**
11	New Mexico	2019	H.B. 416 / S.B. 405
12	Oklahoma	2021	H.B. 1808
13	Oregon	2019	H.B. 2009
14	South Carolina	2021	H.B. 3573
15	Tennessee	2021	S.B. 418 / H.B. 602
16	Texas	2019	H.B. 2313
17	Texas	2021	H.B. 512
18	Texas	2021	H.B. 4084
19	Wisconsin	2017	A.B. 449 / S.B. 363
20	West Virginia	2020	H.B. 4789
21	West Virginia	2021	H.B. 3001
22	Wyoming	2018	S.B. 88
Total	**16 states**		**22 bills**

Marketplace-based Public Options			
1	Colorado	2020	H.B. 1349
2	Colorado	2021	H.B. 1232**
3	Connecticut	2019	H.B. 7267 LCO 9710
4	Connecticut	2020	S.B. 346
5	Connecticut	2021	S.B. 842
6	Illinois	2014	H.B. 5733
7	Massachusetts	2011	H.B. 1228*
8	Massachusetts	2013	S.B. 514*
9	Massachusetts	2015	H.B. 1033*
10	Massachusetts	2017	S.B. 618*

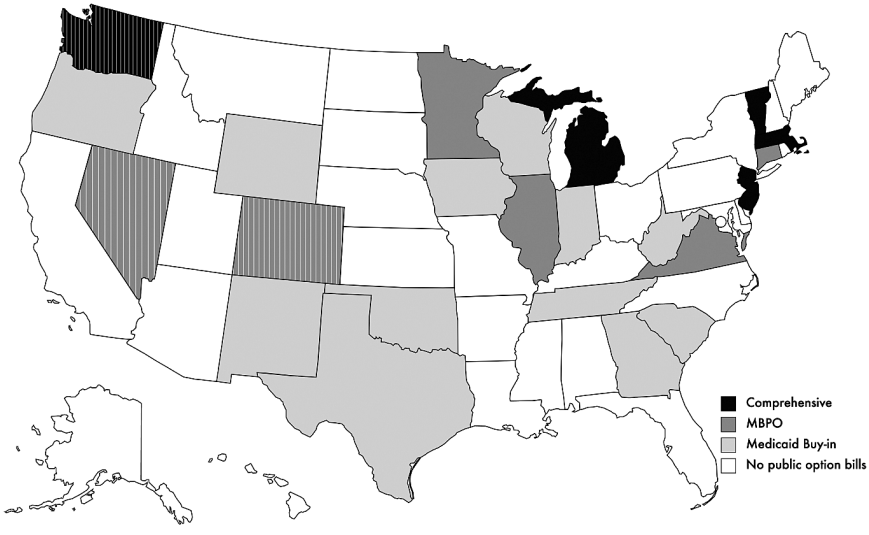
	State	Year	Bill Number
11	Massachusetts	2017	S.B. 638*
12	Massachusetts	2019	S.B. 697*
13	Massachuestts	2021	S.B. 787
14	Minnesota	2019	H.F. 2184 / S.F. 2302
15	Nevada	2021	S.B. 420*,**
16	New Jersey	2020	S.B. 1947*
17	Vermont	2011	S.B. 109
18	Vermont	2015	H.B. 88*
18	Vermont	2017	H.B. 28*
19	Virginia	2020	H.B. 530
20	Washington	2019	S.B. 5526**
21	Washington	2017	S.F. 5984
Total	**10 states**		**21 bills**

Comprehensive Public Options			
1	Massachusetts	2011	H.B. 1228*
2	Massachusetts	2013	S.B. 514*
3	Massachusetts	2015	H.B. 1033*
4	Massachusetts	2017	S.B. 638*
5	Massachusetts	2019	S.B. 697*
6	Michigan	2018	H.B. 6285
7	New Jersey	2016	A.B. 4211 / S.B. 3138
8	New Jersey	2018	A.B. 1343
9	New Jersey	2020	S.B. 1947*
10	New Jersey	2021	A.B. 5029
11	Vermont	2011	H.B. 146
12	Vermont	2015	H.B. 88*
13	Vermont	2017	H.B. 28*
14	Washington	2019	H.B. 1104
15	Washington	2019	S.B. 5222
Total	**5 states**		**15 bills**

Overall Totals	**23 states**	**49 bills**

* Bills counted in more than one category
** Bills signed into law

FIGURE: STATES THAT INTRODUCED PUBLIC OPTION BILLS 2010-2021**



**States are shaded based on the most comprehensive public option introduced. For example, Massachusetts considered all three types of public option plans and is therefore shown in the darkest color.

Vertical lines denote a state that signed a public option bill into law. Note that Washington passed an MBPO but is shown in black because it also considered a comprehensive public option bill in 2019.

Reshaping the Narrative on Public Charge to Reach Immigrant Populations that Need Affordable Health Insurance

Prepared by GMMB and Manatt Health

STATE Health & Value STRATEGIES | *Driving Innovation Across States*

A grantee of the Robert Wood Johnson Foundation

March 2022

Introduction

Over the last year, the Biden Administration has made improving access to coverage and care a core policy priority across all of the healthcare programs it administers [Medicaid/the Children's Health Insurance Program (CHIP), Medicare, and Marketplace], with a particular focus on low-income populations. Despite the administration's proactive steps to fund outreach, promote affordable health coverage, and simplify enrollment processes for federally funded health coverage, a key barrier remains: many immigrants and their families are concerned that enrolling in Medicaid/CHIP, Marketplace, and other public health insurance programs will run afoul of public charge rules and jeopardize their immigration status.

These fears remain despite the fact that the administration has reinstated longstanding public charge guidance that does not consider the use of Medicaid/CHIP benefits (other than government-funded institutionalization for long-term care) or Marketplace coverage in a public charge determination. On February 18, 2022 the Department of Homeland Security (DHS) released a new proposed rule to codify this approach in regulations.

State Medicaid/CHIP agencies, Marketplaces, and community-based organizations (CBOs) working to help enroll individuals in health insurance have important roles in helping immigrants access coverage for which they are eligible, including by informing them that enrolling in health coverage will not hurt their chances of obtaining a green card or becoming a citizen.

This issue brief, the third in a series, *Supporting Health Equity and Affordable Health Coverage for Immigrant Populations*, provides an overview of the status of the public charge rule and presents strategies to help connect eligible individuals to affordable coverage.

What is a Public Charge?

Public charge is a longstanding concept in immigration law that refers to individuals who are likely to be dependent on the government for support. Under the Immigration and Nationality Act, the DHS Citizenship and Immigration Services (USCIS) may deny an immigrant admission to the country or a green card if the agency determines that the individual is, or is likely to become, a public charge. (Public charge determinations do not apply to green card holders seeking to renew a green card or to become a U.S. citizen.)

Between 1999 and 2019, federal guidance defined "public charge" as someone who is likely to be "primarily dependent" on two sets of public benefits: cash assistance for income maintenance or long-term institutionalization at government expense.[i] On August 14, 2019, DHS published a final rule that made significant changes to the standards for determining whether an immigrant is likely to become a "public charge," including by expanding the scope of benefits included in a public charge determination to encompass Medicaid as well as other benefits like the Supplemental Nutrition Assistance Program (SNAP) and various housing benefits.[ii] Because of the breadth of the 2019 rule, *which is no longer in effect*, many immigrant families chose not to use an array of public benefits, even in cases where the benefits or the families themselves were not directly implicated by the rules. This reaction is known as the "chilling effect." In an effort to reduce the chilling effect, the Biden administration recently proposed new public charge rules to restore the longstanding interpretation of public charge.

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[i] Field Guidance on Deportability and Inadmissibility on Public Charge Grounds, 64 Federal Register 101 (26 May 1999), pp. 28689-28693. Available at: https://www.govinfo.gov/content/pkg/FR-1999-05-26/pdf/99-13202.pdf ("Field Guidance").

[ii] Inadmissibility on Public Charge Grounds, 84 Federal Register 157 (14 August 2019), pp. 41292-41508. Available at: https://www.govinfo.gov/content/pkg/FR-2019-08-14/pdf/2019-17142.pdf; "Inadmissibility on Public Charge Grounds; Correction," 84 Federal Register 191 (2 October 2019), pp. 52357-52363. Available at: https://www.govinfo.gov/content/pkg/FR-2019-10-02/pdf/2019-21561.pdf. For more information about the 2019 public charge rule, see Public Charge Final Rule: Frequently Asked Questions, State Health & Values Strategies, February 26, 2020. Available at: https://www.shvs.org/wp-content/uploads/2020/02/SHVS_Public-Charge-FAQ_Updated-02.26.2020.pdf

How Can State Medicaid/CHIP Agencies, Marketplaces, and Others Help With Outreach to Immigrants About Their Public Charge Concerns?

Since taking office, the Biden Administration has sought to clearly communicate with states, stakeholders, and people that enrolling in healthcare coverage is safe. State Medicaid/CHIP agencies, Marketplaces, and community groups working to help facilitate enrollment can amplify federal messaging and develop strategies to help address immigrants' concerns about using coverage and connect immigrants to coverage they are eligible to receive. As a starting point, state agencies, Marketplaces, and other outreach, education, and enrollment facilitator organizations can create and deploy plans to reach eligible immigrant communities about the change in public charge, with the key message that enrollment in Medicaid/CHIP and Marketplace coverage is not implicated in public charge determinations.

Suggested strategies include:

- Developing health coverage application materials in multiple languages that clearly indicate that Medicaid/CHIP and Marketplace coverage is not implicated in public charge determinations.
- Creating informational flyers in multiple languages, which can be distributed at locations frequented by immigrants, such as community centers, churches, and/or health centers.
- Posting social media updates that contain some of the messages below and that direct individuals to state helplines and/or counselors that can help them enroll.
- Leveraging established campaigns (e.g., open enrollment initiatives) to amplify education about changes in public charge rules.
- Providing training for outreach coordinators on public charge and helping them incorporate public charge messaging into their interactions with enrollees.
- Engaging CBOs and other trusted messengers to assist with education and outreach.

The following checklist can help states and their outreach partners ensure that these strategies will be as impactful as possible:

- ✓ Is the information presented in simple and straightforward language?
- ✓ Are materials and messages available in multiple languages?
- ✓ Is information consistent and shared across multiple state agencies?
- ✓ Is "public charge" defined clearly and accurately?
- ✓ Do materials and messages link back to federal resources (e.g., USCIS)?
- ✓ Is the content regularly updated to reflect ongoing developments and new resources?

What are Some Key Messages That States and Their Partners Can Use in These Materials?

There are some key messages that will be important for states and their outreach partners to disseminate through these strategies:

- Everyone who is eligible should have the ability to access healthcare, and the best way to do this is to enroll and obtain health insurance for you and your family.
- The 2019 public charge rules are no longer in effect. The federal government ended that policy. Contrary to what you might have heard or read, many immigrants qualify for financial help to purchase a private plan through the [YOUR STATE MARKETPLACE NAME] or free or low-cost coverage through Medicaid and/or CHIP.
- You don't have to be a U.S. citizen to qualify for health insurance. Those in your family, including yourself, who are in the United States legally, and are also residents of [YOUR STATE NAME] might be eligible.
- All information you provide during your application is kept confidential and not shared with other government agencies.

How Did the Public Charge "Chilling Effect" Impact Coverage?

Various researchers have studied the "chilling effect" that the 2019 public charge rule had on the use of public benefits by immigrants. According to the Urban Institute, in 2020, almost one in seven adults in immigrant families (13.6%) reported that they or a family member avoided a noncash government benefit program, such as Medicaid, CHIP, SNAP, or housing assistance because of concerns about future green card applications. Researchers noted that this "chilling effect" was most significant in families more likely to be directly affected by the rule: those in which one or more members do not have a green card (27.7%).[1] In a survey of CBOs that serve immigrant populations, an overwhelming number of respondents reported that public charge, as well as other anti-immigrant policies, deterred immigrants from seeking Medicaid and other programs that were included in the 2019 rule. The survey also showed that these policies deterred immigrants from seeking COVID-19 testing and treatment, and emergency Medicaid services, which would not have counted under the public charge rule.[2]

What Is the Status of the Public Charge Rule Today?

The 2019 public charge rule was invalidated by courts last year and then fully rescinded by DHS. DHS subsequently reinstated longstanding guidance that was first issued in 1999 and that sets out a clear expectation that only a very narrow set of benefits (cash assistance and long-term care) will be weighed in a public charge determination. Medicaid benefits (other than institutionalization for long-term care at government expense[3]), CHIP, and Marketplace subsidies are not considered in public charge determinations. Using public assistance for immunization or testing for COVID-19, emergency services, or other state-funded health coverage programs also is not considered. In a new proposed rule released in February 2022, DHS proposes to codify these standards in regulations, with some additional clarifications aimed at reassuring immigrants that applying for benefits on behalf of family members will not be counted against the individual applying. The proposed rule also seeks to improve transparency by requiring denial determinations to be supported in writing.

What Federal Resources Explain the Current Public Charge Policy?

To amplify the policy reversal on public charge and to explain the health coverage implications, the Centers for Medicare & Medicaid Services (CMS) issued an informational bulletin to remind state Medicaid/CHIP agencies about the current policy. In recognition of the ongoing fear and confusion about the status of public charge, in November 2021, the USCIS at DHS also issued a letter to interagency partners reiterating the agency's current approach to public charge (including restating the benefits that are not considered in public charge determinations). DHS has a resource page with frequently asked questions (FAQs) about the policy and is developing promotional activities, including a social media campaign and local community engagements, to address the confusion and fear among immigrants that remain regarding public charge.

What Barriers to Health Coverage Still Remain?

Focus group research funded by the Robert Wood Johnson Foundation establishes that almost all immigrants surveyed want health insurance, and coverage is perceived positively, saying that health insurance would offer them peace of mind and is another way to provide for their families.[4] However, despite this overwhelming desire and need, many immigrants still believe the public charge rules are in effect and that using benefits could negatively impact their immigration status. Some immigrant families continue to avoid public benefits out of concern that the rules could change again or hinder them from getting a green card or citizenship.

In addition, immigrants who have never had health insurance find it difficult to enroll, potentially because of language barriers, inexperience with enrolling, or long, complex applications. One source of complexity and confusion may be application questions that ask about family members in the household, which can raise concerns for those family members who are not eligible for benefits.

Are There Examples of States Doing Outreach and Education About Public Charge Changes?

States across the country have taken initial steps to help update consumers about public charge changes. States including Colorado, Kentucky, and Washington proactively disseminated clear information on their websites or through social media channels to alert consumers about the change in federal public charge policies and reassure them that public benefits are safe. Oregon and the District of Columbia both include straightforward public charge FAQs in multiple languages on their websites. California also collaborated with immigrant-serving organizations to develop and post an updated "public charge guide," which reassures applicants that using most benefits and services will not harm their immigration status. An Illinois website focused on coverage for immigrant seniors includes a link directing consumers who have questions about how using benefits could impact their immigration status to nonprofit organizations that can help, a strategy that may help connect consumers with trusted sources to reiterate the state's messaging.

In New Mexico, BeWellnm, the state's official health insurance marketplace, hosts in-person events throughout the year with its partners, such as a local chamber of commerce, consulates, and community organizations that serve immigrant communities. The idea behind such events is to partner with a trusted advisor so that BeWellnm can correct any misinformation about public charge and also use the opportunity to enroll more individuals in health insurance.

Sharing resources like these on easy-to-find webpages and regularly reiterating messaging through social media can help get–and keep–the word out that using Medicaid, CHIP, and Marketplace benefits is safe.[5]

Are There Other Strategies That State Medicaid/CHIP Agencies Can Pursue to Mitigate the "Chilling Effect"?

Because mixed-status families (families that include both citizen and non-citizen household members) may have particularly acute fears about signing up for benefits, states can also take steps to design non-applicant options such as allowing an applicant, such as a parent, to apply on behalf of a citizen dependent. Refraining from asking non-applicants to disclose their immigration status or to provide their Social Security number as part of an application is another way to allay concerns about accessing benefits.

What's the Bottom Line?

The Biden administration's reorientation on public charge policy is an opportunity to enroll more individuals and provide much-needed health insurance to eligible immigrants. Especially given that Medicaid and CHIP enrollment happens year-round, states can take steps now to encourage eligible immigrants to enroll in Medicaid and CHIP.

ENDNOTES

1. Hamutal Bernstein, Michael Karpman, Dulce Gonzale, and Stephen Zuckerman, Urban Institute, "Immigrant Families Continued Avoiding the Safety Net during the COVID-19 Crisis" February 2021. Available at: https://www.urban.org/sites/default/files/publication/103565/immigrant-families-continued-avoiding-the-safety-net-during-the-covid-19-crisis.pdf.
2. Hamutal Bernstein, Jorge Gonzale, Dulce Gonazalez, Jahnavi Jagannath, Urban Institute, "Immigrant-Serving Organizations' Perspectives on the COVID-19 Crisis" August 2020. Available at: https://www.urban.org/research/publication/immigrant-serving-organizations-perspectives-covid-19-crisis.
3. Under the 1999 Field Guidance, only Medicaid benefits for individuals who are institutionalized for long-term care (such as nursing facility residents or residents of mental health institutions) are considered in a public charge determination; institutionalization for short periods of rehabilitation are not considered in public charge determinations.
4. Communicating about the Public Charge Rule Change, PerryUndem and Betty&Smith, July 2021
5. For other strategies that states, localities, and service providers can undertake to support immigrant access to benefits, see the Protecting Immigrant Families Toolkit for State and Local Government Officials, September 2021. Available at: https://protectingimmigrantfamilies.org/wp-content/uploads/2021/10/Public-Officials-Toolkit-1.pdf.

Support for this issue brief was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

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The 2022-23 Budget:

Health Care Access and Affordability

Summary

This brief focuses on access to health insurance coverage and the affordability of health care costs. We assess various Governor's proposals intended to improve health care access and/or affordability, discuss options to improve affordability of health plans purchased through Covered California, and highlight some key access and affordability challenges that remain to address.

Expand Full-Scope Medi-Cal Coverage to All Remaining Income-Eligible Undocumented Populations. Building on previously approved expansions, the Governor proposes to expand full-scope Medi-Cal coverage to income-eligible, undocumented residents aged 26 through 49 beginning no sooner than January 1, 2024. We discuss options to provide coverage earlier and ensure certain young adults do not lose coverage prior to January 1, 2024.

Reduce Medi-Cal Premiums to Zero Cost. Certain individuals who are otherwise not income-eligible for Medi-Cal can enroll if they pay premiums. The Governor proposes reducing these premiums to zero. While we agree with the policy basis for this proposal, additional information is needed to determine if it should be approved as is or with modifications.

Establish Office of Health Care Affordability. The Governor re-proposes to create the Office of Health Care Affordability—intended to control rising overall health care costs. We find that, in concept, the proposal to create this new office is reasonable, but ambitious. Continued monitoring would be necessary to ensure the office achieves its goals. As such, we recommend the Legislature consider (1) whether any adjustments are needed to the proposed trailer bill language creating the office and (2) establishing a process for legislative oversight.

Reduce the Cost of Insulin Through State Partnership. Chapter 207 of 2020 (SB 852, Pan) directed the state to enter into partnerships to produce and distribute generic prescription drugs to improve affordability. The Governor announced a future proposal to manufacture insulin. We recommend withholding approval until more information is provided to ensure the proposal meets SB 852's criteria for viability and other factors.

Options to Improve Covered California Affordability. At the direction of the Legislature, Covered California developed options for cost-sharing reductions to improve the affordability of plans offered on its exchange. We discuss various issues for the Legislature to consider when deciding on any actions related to these options.

Various Access and Affordability Issues Remain. In the final section, we discuss various access and affordability issues that will remain even if the Legislature approves the Governor's proposals and addresses affordability of Covered California health plans.

LAO

GABRIEL PETEK | LEGISLATIVE ANALYST

FEBRUARY 2022

INTRODUCTION

Health Care Access and Affordability. Health care access and affordability are a challenge for many Californians. Notably, roughly 3.2 million Californians lack access to comprehensive health insurance. Even those who do have health insurance can struggle with health care costs that can consume a large portion of their annual income. These challenges have prompted recent actions by the Legislature and a number of additional proposals in the Governor's budget as well as other issues for the Legislature to consider during the current budget cycle.

Report Focuses on Issues Related to Health Insurance Coverage and Health Care Costs. While there are a broad range of issues impacting both the affordability and access to quality health care services, this report focuses on access to health insurance coverage and the affordability of health care costs Californians face. In this context, we first provide an assessment of various Governor's budget proposals intended to improve health care access and/or affordability. (We provide an assessment of proposals potentially affecting access through other means, such as by increasing Medi-Cal provider payment levels, in other budget publications.) We then discuss issues for the Legislature to consider as it evaluates options to improve the affordability of health insurance coverage offered on the state's health benefit exchange—Covered California. Finally, we conclude with a brief discussion of some key access and affordability challenges that likely would remain even if the Legislature approves the Governor's proposals and takes action to improve affordability within Covered California.

BACKGROUND

Most Californians Have Health Insurance... As shown in **Figure 1**, we estimate that most Californians—92 percent—have health insurance coverage. (Compared with other states, California's rate of insurance is roughly in the middle—some states have higher rates of insurance, while others have lower rates of insurance.) Employer-sponsored insurance is the most common source of coverage. Major public health insurance programs, including Medi-Cal, the state's Medicaid program which covers low-income people, and Medicare, the federal program that primarily provides health coverage to the elderly, also cover large portions of the state's residents.

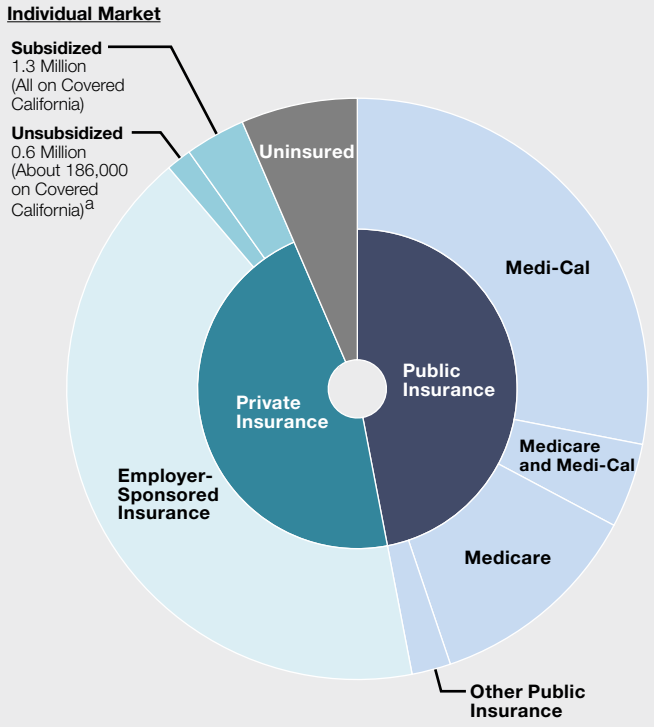
...But an Estimated 3.2 Million Californians Lack Comprehensive Insurance. While most Californians have comprehensive health insurance, an estimated roughly 3.2 million people (about 8 percent) in the state lack such coverage in 2022—including people who are uninsured or have "restricted-scope" Medi-Cal that only covers emergency- and pregnancy-related health services. However, these figures do not reflect a previously approved expansion of comprehensive Medi-Cal coverage to undocumented residents who are 50 or older which will go into effect in May 2022. In addition, the estimate does not reflect impacts of a federal policy change regarding Medi-Cal enrollment during the COVID-19 national public health emergency (which likely increased insurance coverage). As shown in **Figure 2**, the majority of uninsured Californians are undocumented residents, followed by individuals who are eligible for but not enrolled in insurance from a variety of sources.

Affordability of Health Care Remains a Challenge. Over the last several decades, health care costs have grown significantly. To a significant degree, this cost growth has been driven by growth in health care prices. As **Figure 3** shows, medical inflation in major California metro areas has far outpaced inflation for other goods and services in recent decades, reducing what Californians can afford to spend on these other goods and services. While other expenditures such as housing have a greater impact on California's cost of living, Californians need to balance health care costs with these other expenditures.

Figure 1

Most Californians Have Health Insurance, Obtained From a Variety of Sources

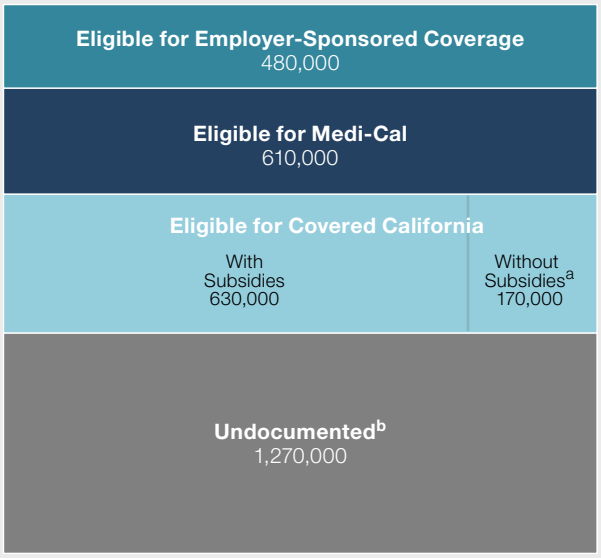
2020 Estimated



a Remaining roughly 400,000 purchased coverage "off exchange."
Note: Estimates reflect LAO adjustments to California Health Interview Survey 2020 data.

Figure 2

Roughly 3.2 Million Californians Lack Health Insurance in 2022



a Documented residents who can purchase plans through Covered California but do not meet certain federal requirements to qualify for federal subsidies.

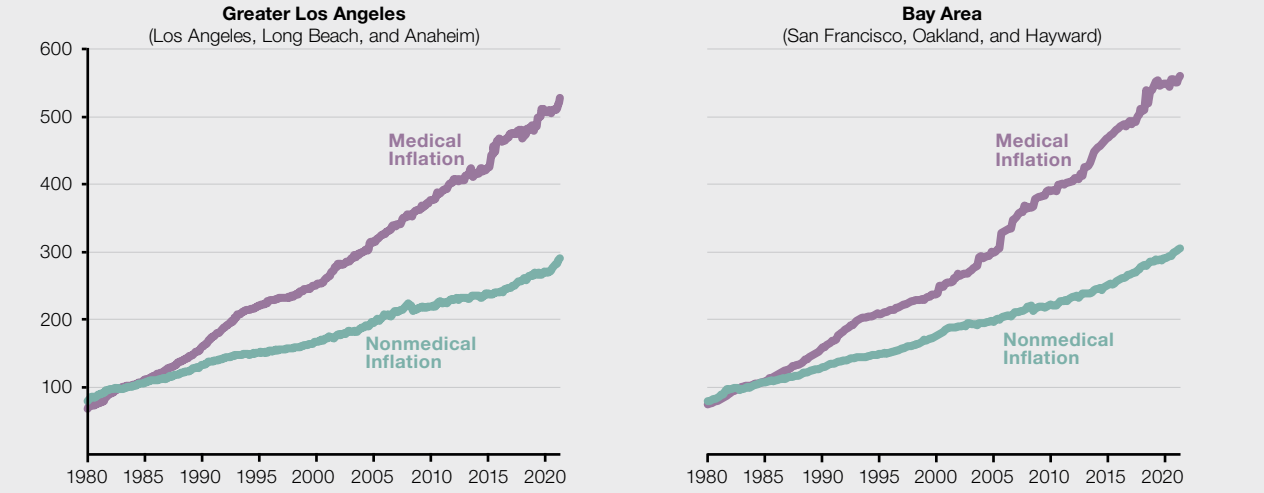
b This number does not reflect a previously-authorized expansion of full-scope Medi-Cal benefits to undocumented residents who are 50 or older, which will be implemented in May 2022.

Source: UC Berkeley, UC Los Angeles; California Simulation of Insurance Markets, Version 3.0.

Figure 3

Medical Prices Have Grown Significantly Faster Than Nonmedical Prices in Major California Metro Areas

Consumer Price Index



Source: LAO estimate based on Bureau of Labor Statistics Consumer Price Index for all urban consumers.

According to a survey conducted between November 2020 and January 2021, roughly 82 percent of Californians stated that it was either very or extremely important for the Legislature and Governor to make health care more affordable. In the same survey, roughly half of Californians decided to delay, skip, or reduce their utilization of health care in the prior 12 months due to costs. Of those who made such decisions, 41 percent stated that the steps they took to reduce costs had a negative impact on their health.

GOVERNOR'S PROPOSALS TO IMPROVE HEALTH CARE ACCESS AND AFFORDABILITY

EXPAND FULL-SCOPE MEDI-CAL COVERAGE TO REMAINING UNDOCUMENTED POPULATIONS

Background

Historically, Undocumented Residents Were Eligible Only for Restricted-Scope Medi-Cal Coverage. Medi-Cal eligibility depends on a number of individual and household characteristics, including, for example, income, age, and immigration status. Historically, income-eligible citizens and immigrants with documented status generally have qualified for comprehensive, or full-scope, Medi-Cal coverage, while otherwise income-eligible undocumented immigrants have not qualified for full-scope Medi-Cal coverage. Up until recently, all undocumented residents who met the income criteria for Medi-Cal have been eligible only for restricted-scope Medi-Cal coverage, which only covers emergency- and pregnancy-related health care services. The federal government pays for a portion of undocumented immigrants' restricted-scope Medi-Cal services according to standard federal-state cost-sharing rules.

State Has Expanded Full-Scope Medi-Cal Coverage to Many, but Not All, Otherwise Income-Eligible Undocumented Residents. The state has taken steps to expand eligibility for full-scope Medi-Cal coverage to otherwise eligible undocumented residents in various age groups. First, in 2016, the state expanded full-scope Medi-Cal coverage to otherwise eligible undocumented children from birth through age 18. Then, in 2020, the state expanded full-scope Medi-Cal coverage to otherwise eligible undocumented young adults ages 19 through 25. Most recently, as part of the 2021-22 budget package, the state passed legislation to expand eligibility to undocumented residents who are 50 or older beginning May 1, 2022. The costs of these expansions are paid almost entirely by the state because the federal government only shares in the cost of restricted-scope services. Accounting for these recently enacted expansions, undocumented adults who are between the ages of 26 and 49, inclusive, are the remaining undocumented population eligible for only restricted-scope Medi-Cal. Once the 50-and-older expansion is fully implemented, we estimate that a little over 1 million undocumented immigrants will have full-scope Medi-Cal coverage.

Proposal

The Governor proposes to expand full-scope Medi-Cal coverage to income-eligible undocumented residents aged 26 through 49 beginning no sooner than January 1, 2024. Due to past expansions, this proposal would effectively provide universal access to Medi-Cal regardless of immigration status. The administration estimates that in 2023-24, the first year of the expansion, 714,000 undocumented residents between the ages of 26 through 49 would enroll in Medi-Cal and that this would increase to 764,000 residents at full implementation. Due to the proposed implementation date, there is no budgetary impact in 2022-23. The administration estimates that the expansion would result in costs of $613.5 million General Fund ($819.3 million total funds) in 2023-24 and $2.2 billion General Fund ($2.7 billion total

funds) annually at full implementation. The growth in projected spending primarily is due to annualizing half-year costs in 2023-24 and projected gradual increases in the uptake of In-Home Supportive Services among beneficiaries, along with gradual increases in caseload.

Assessment

Proposal Consistent With Statutory Goals and Recent Legislation. The Governor's proposal is consistent with past legislative efforts to expand Medi-Cal coverage to younger and older undocumented residents. It also further the goals established in Chapter 34 of 2018 (AB 1810, Committee on Budget) which, among other goals, declared an intent that all Californians (1) receive high-quality health care regardless of various factors including age and immigration status and (2) have access to affordable health coverage.

Proposal Would Significantly Reduce Number of Californians Who Lack Comprehensive Insurance. If the administration's caseload assumptions are correct, this proposal would substantially reduce the number of Californian's who do not have access to comprehensive health insurance. Using the administration's assumptions for this proposal, and assuming that 235,000 undocumented residents who are 50 or older will enroll in Medi-Cal once they are eligible this May under previously enacted legislation, we estimate that the number of Californians who lack comprehensive health insurance would go down to about 2.2 million people following the proposal's full implementation, which is roughly 1 million lower than the current level of about 3.2 million people.

Continuing to Evaluate Administration's Caseload and Cost Estimates. Due to the availability of data at the time of this analysis, we have not yet evaluated the reasonableness of the administration's estimates of the caseload and cost impacts of this proposal. Any estimate of expansion cost and caseload, however, is subject to considerable uncertainty. For example, while restricted-scope enrollees generally automatically would shift over to full-scope coverage once eligible, how many of the individuals who are not currently enrolled in restricted-scope coverage would choose to enroll in full-scope coverage once eligible is unclear. In addition, average costs for this caseload could be significantly different than the average costs for current full-scope enrollees due to differences in their health needs. For example, research on the health of the U.S. and California populations shows that immigrants, including undocumented immigrants, have lower disability rates than other residents. To the extent this is true for the proposed expansion population, their average per-enrollee costs could be significantly lower than existing full-scope enrollees. This is because Medi-Cal enrollees with disabilities tend to have health care costs that are two to ten times higher on a per-enrollee basis than other enrollees.

Extended Time Frame Relative to Past Expansions Impacts Access to Coverage. As currently structured, this expansion would occur no sooner than a year and a half following its approval (provided it is approved). In comparison, past expansions were implemented within a year of being approved. Adopting a similar implementation time frame as past expansions for all or part of this remaining age group would accelerate implementation and could improve access to health care sooner. Moreover, the extended implementation time frame could result in some young adults losing coverage while waiting for the proposal to be implemented. Currently, the potential number of young adults who could lose full-scope coverage prior to January 1, 2024 is particularly large because many young adults who otherwise would have aged out of full-scope Medi-Cal (upon turning 26 years of age) have been able to keep their benefits as a result of a federal policy that effectively prevented eligibility terminations except in limited circumstances during the COVID-19 national public health emergency. (For more information on this federal policy and its impacts on the Medi-Cal caseload, please see our recent publication, *The 2022-23 Budget: Analysis of the Medi-Cal Budget*.) While there is some uncertainty regarding the number of young adults who would lose full-scope coverage once the public health emergency ends, we estimate that upwards of 40,000 undocumented young adults could lose full-scope coverage between the end of the public health emergency until they would regain eligibility after January 1, 2024. These lapses

could have a negative impact on health outcomes for the affected population and also would create additional administrative workload—first to convert them to restricted-scope coverage when they lose eligibility upon aging out and then to re-enroll them in full-scope coverage once the expansion is implemented.

Administration States That Earlier Implementation Could Create Workload Challenges. The administration has stated that, due to competing workload, implementing the proposed expansion any sooner than January 1, 2024 would be difficult. The competing workload largely is attributed to the following:

- ***Conversion to the California Statewide Automated Welfare System (CalSAWS)***. Eighteen counties plan to convert to CalSAWS (a statewide system to manage eligibility and enrollment data across various public benefit programs) between October 2022 and October 2023. In addition to this process increasing administrative workload temporarily, updating CalSAWS to reflect changes in Medi-Cal eligibility policies is challenging, such that carrying out eligibility policy changes while the information technology systems changes are taking place could result in information being inaccurate in one or both systems due to a need to rely on manual processes.
- ***Resumption of Eligibility Redeterminations.*** In addition, during the national COVID-19 public health emergency, the federal government effectively prohibits terminating Medi-Cal coverage for existing beneficiaries except in limited circumstances. After the public health emergency ends, counties will need to complete eligibility redeterminations for the entire Medi-Cal caseload (which we estimate could be at about 14.9 million enrollees depending on the end date of the public health emergency) and end coverage for any enrollees who are no longer eligible for Medi-Cal.
- ***Implementation of Full-Scope Medical Expansion to Undocumented Residents Aged 50 or Older***. As was noted previously, undocumented residents who are aged 50 or older will become eligible for full-scope Medi-Cal beginning May 1, 2022. Doing an additional expansion within a short time frame potentially could complicate work associated with the 50-and-older expansion, as it affects the training of eligibility workers and outreach provided to potential beneficiaries.

We acknowledge that similar to past expansions, implementing this proposal likely would result in a temporary increase in administrative workload, largely for counties due to their key role in Medi-Cal eligibility administration. While counties would be facing additional workload demands simultaneously, we suggest the Legislature consider alternative strategies for implementation.

Incremental Approach Could Expand Coverage Faster and Partially Reduce Workload Impacts. While we recognize that the workload challenges of an earlier expansion than that proposed by the administration could be impactful, they are not necessarily insurmountable. Notably, the Legislature could take a more incremental approach to the expansion that could reduce, although not fully eliminate, some of the workload challenges noted previously. For example, the Legislature could take steps to prevent lapses in full-scope coverage for young adults who would age out of coverage prior to January 1, 2024. Two potential approaches would include (1) directing counties to maintain full-scope coverage for enrollees who would otherwise be moved to restricted-scope coverage due to their age or (2) expanding coverage to people up to age 30 ahead of the broader January 1, 2024 expansion date. (The latter option would extend eligibility to people who would otherwise lose eligibility due to turning 26 after the start of the national COVID-19 public health emergency in 2020, when eligibility terminations were suspended and prior to January 1, 2024, when the proposed expansion would be implemented.)

Recommendation

To the extent the Legislature is interested in adopting an accelerated time line for all or part of the population impacted by this proposal, we recommend that the Legislature request that the administration provide information about

the feasibility, administrative cost, and caseload impact of adopting an alternative approach to implementation. (The Legislature also might seek similar input from counties due to their key role in Medi-Cal eligibility administration.) Potential alternatives could, but do not necessarily need to, include the options raised above to prevent coverage lapses for undocumented residents who are currently enrolled in full-scope Medi-Cal but, due to their age, would lose their coverage while waiting for the proposal to be implemented.

REDUCE MEDI-CAL PREMIUMS TO ZERO COST

Background

Certain Medi-Cal Enrollees Must Pay Premiums to Be Enrolled in Medi-Cal. The vast majority of California's Medi-Cal enrollees do not pay premiums. However, state residents with certain characteristics and who have incomes above standard Medicaid thresholds may enroll in Medi-Cal provided they pay premiums. Figure 4 provides more details on the specific groups of state residents who may enroll in Medi-Cal with premiums, as well as the amount of premiums they pay. Populations that potentially can enroll in Medi-Cal with premiums despite otherwise not being income-eligible include children, pregnant women, and persons with disabilities who are employed.

Reduce All Medi-Cal Premiums to $0. The Governor proposes to reduce all Medi-Cal premiums to $0 beginning July 2022. The administration estimates that this would cost $18.9 million General Fund ($53.2 million total funds) in 2022-23, increasing to $31 million General Fund ($89 million total funds) ongoing.

Assessment

Proposal Would Help Improve Affordability and Access. Reducing premiums to zero would help reduce health care costs for the impacted populations who are relatively low income. It also could help to improve coverage among people who are otherwise qualified for these programs but are not enrolled. First, research shows that premium costs deter enrollment—including in similar programs. As such, reducing premiums to $0 should remove any deterrent effect of the current premiums. Second, because failure to pay premiums can result in people being disenrolled from Medi-Cal, this proposal likely would result in fewer people losing Medi-Cal coverage.

Fiscal Impact of Potential Increase in Caseload Is Lacking in Administration's Cost Estimate. The administration has stated that it expects any caseload impacts of the premium reductions would be minor and difficult to predict. As such, they do not estimate a caseload impact from the proposed policy change, nor any associated costs. However, because the proposal would remove the deterrent effect of premiums and reduce the number of people who are disenrolled from Medi-Cal for not paying premiums, we think that there is a high likelihood there would be at least some impact on caseload. While there is considerable uncertainty about the caseload impact and corresponding costs, we think these costs could be in the tens of millions of dollars General Fund.

Figure 4

Medi-Cal Populations Currently Required to Pay Premiums

Demographic Group	FPL Income Range[a]	Estimated Caseload	Monthly Premium
Children ages 1 through 18	161% - 266%	504,000	$13 per child, $39 family max
Children ages 0 through 1	267 - 322	2,000	$13 per child, $39 family max
Children 0 through 18 in select counties[b]	267 - 322	9,000	$21 per child, $63 family max
Pregnant or postpartum persons	214 - 322	6,000	1.5 percent of income
Working persons with disabilities	139 - 250	15,000	From $20 to $250 per person[c]

[a] Generally counted as household income.
[b] Counties include San Francisco, San Mateo, and Santa Clara.
[c] Amounts reflect premiums for an individual rather than for a couple and vary based on income.

FPL = federal poverty level.

Unclear How Policy Would Impact Potential Enrollees Who Owe Backpay. At the time of this analysis, how the proposal would impact potential enrollees who owe past-due premiums is unclear. If left unaddressed, these enrollees would still need to pay the past-due premiums before they can re-enroll in Medi-Cal, even after premiums have been eliminated.

Recommendation

Request Additional Information Before Approving. Due to the potential impact this could have on improving access and affordability for low-income Californians, we agree with the policy basis for the proposal. However, before approval, we recommend that the Legislature ask the administration why their assumption of no caseload impact is reasonable and how past-due premiums would be handled. This information will be key to fully understanding both the budget and policy implications of the proposal—and to determining whether the proposal should be approved as is or with modifications to the cost estimates and/or trailer bill language.

ESTABLISH OFFICE OF HEALTH CARE AFFORDABILITY

In this section, we (1) provide additional background on how overall health care costs have grown in California over time, (2) give context to efforts in recent years to establish the state Office of Health Care Affordability to control rising overall health care costs, (3) describe the Governor's proposal to establish—through budget-related legislation and an associated re-appropriation of funds—an Office of Health Care Affordability housed within the Department of Health Care Access and Information (HCAI) to control health care cost growth, and (4) provide issues for legislative consideration regarding this proposal.

Background

Health Care Costs in California Generally Have Grown Significantly Over Time. Increases in both health care prices and utilization of health care services generally have led to higher health care costs over time. (For example, there was substantial growth in health insurance premiums for employer-sponsored health plans of nearly 80 percent—or roughly 4.7 percent per year—between 2000 and 2017.) For comparison, inflation in the price of nonmedical services grew by roughly 4 percent per year in both Greater Los Angeles and the Bay Area over the same time period.

To some extent, health care—like other parts of the service sector—is structurally predisposed to greater growth in costs. (For example, the inflation in nonmedical service sectors discussed above is still higher than overall inflation over the same time period.) Nevertheless, growth in health care costs is attributed at least in part to distinctive market conditions that particularly impact health care prices such as reduced competition among health care payers and providers due to mergers and acquisitions in the health care sector. As discussed earlier, these increased health care costs have led to Californians foregoing or deferring needed medical care.

Some States Have Created Entities to Control Health Care Costs. One approach to controlling health care cost growth is to establish a regulatory body or independent entity tasked with implementing a strategy for doing so. To achieve the goal of controlling health care cost growth, these regulatory bodies or independent entities could perform several functions, such as (1) collecting detailed financial information from a comprehensive set of health care payers and providers, (2) providing incentives to encourage health care payment models based on the quality of care provided rather than strictly costs, (3) setting targets for health care cost growth, and (4) levying penalties on health care entities that do not meet health care cost growth targets. Some states—including Massachusetts, Maryland, Rhode Island, and Oregon—have created entities that perform some or all of the cost control functions described above. The efforts implemented in Maryland, Rhode Island, and Oregon are relatively new. Accordingly, a comprehensive picture of how effective they have been at controlling health care costs in these states is not available. However, the independent entity in Massachusetts has been in place since 2012. In the decade since, Massachusetts stayed within its state health care cost growth targets for the first several years of implementation. However, it has exceeded its growth targets in two consecutive years since then.

Prior Efforts to Create Office of Health Care Affordability Were Either Delayed or Stalled. The Governor first proposed the establishment of an Office of Health Care Affordability—to be housed in the California Health and Human Services Agency (CalHHS)—in the January 2020 budget. This proposal subsequently was withdrawn after the onset of the COVID-19 pandemic. However, the 2020-21 budget package included budget-related legislation authorizing the establishment of the Health Care Data Payments Program (HPD). The HPD—currently housed within HCAI—is intended to function as a large research database derived from individual health care payment transactions. When it comes online in 2023, the database will be used to analyze total health care expenditures statewide to identify key cost drivers and inform recommendations on how to mitigate rising costs. The HPD is envisioned as a key component of the Office of Health Care Affordability. The Governor's January 2021 budget re-proposed the establishment of the Office of Health Care Affordability, to be housed instead within the Office of Statewide Health Planning and Development (later reorganized and reconstituted into HCAI). In addition to the Governor's January 2021 proposal, there was (and remains) a legislative proposal to establish this office being considered in the policy process. While no budget-related or policy legislation has been enacted to establish the office, the 2021-22 budget did include an appropriation of $30 million one-time General Fund to establish the office.

Proposal

Establish Office of Health Care Affordability Through Budget-Related Legislation. The Governor re-proposes establishing the Office of Health Care Affordability within HCAI (through the enactment of budget trailer bill legislation). To fulfill its goal of controlling statewide health care costs, the office broadly is intended to increase health care price and quality transparency, develop specific strategies and cost targets for different health care sectors, and impose financial consequences on health care entities that fail to meet these targets. The office would rely heavily on data collected by the HPD to analyze key trends in health care costs to identify underlying causes for health care cost growth (including by reviewing mergers and acquisitions in the health care sector). It also would publicly report total health care spending and factors contributing to health care cost growth, and publish an annual report and conduct public hearings about its findings. In addition, the office broadly would encourage the adoption of health care payment models based on the quality of care provided, as well as monitor the effects of health care cost targets on the health care workforce.

Within the office, the Governor also proposes to establish a Health Care Affordability Board composed of eight members, as follows:

- Four members appointed by the Governor and confirmed by the Senate.
- One member appointed by the Senate Committee on Rules.
- One member appointed by the Speaker of the Assembly.
- The CalHHS Secretary or their designee.
- The Chief Health Director (or their deputy) of the California Public Employees' Retirement System (as a nonvoting member).

The proposed board would be charged with key implementation decisions for the office. For example, it would be tasked with approval of the office's health care cost targets.

Proposed Statutory Language Includes Several Revisions to Prior-Year Proposal. The Governor's proposed statutory language to implement the Office of Health Care Affordability includes several revisions compared to the administration's proposal last year. These revisions include, for example, (1) changes to the size of the internal board (from 11 members in last year's proposal to 8 members in the current proposal), (2) the addition of authority for the affordability board—rather than the HCAI director—to approve health care cost targets, (3) the addition of certain conditions under which cost targets could be adjusted for health care entities that demonstrate substantial growth in labor costs, (4) updates to financial information required to be collected (to include nonclaims based payments), (5) additions of exemptions for provider groups of

certain sizes from the office's requirements, and (6) modifications to the type of financial statements that would be accepted by the office (to include unaudited statements).

Re-Appropriate $30 Million General Fund One Time for Establishment of Office. The Governor proposes to re-appropriate the $30 million General Fund one time to establish the Office of Health Care Affordability provided in the 2021-22 budget. This amount is intended to fund the first two years of implementation of the office. The 2021-22 budget assumed that the General Fund eventually would be reimbursed for this cost by the California Health Data and Planning Fund, which is supported by fee revenues collected from health care facilities. This special fund is intended to support the ongoing costs of the office.

Legislative Proposal to Establish Office Will Be Revised to Mirror Governor's Proposal. As discussed earlier, there also is a legislative proposal to establish an Office of Health Care Affordability currently being considered in tandem with the Governor's proposal. We understand that it is the author's intent is to modify this proposal to mirror the Governor's proposal, so this will be the single proposal for legislative consideration.

Assessment

In Concept, Creating the Proposed Office a Reasonable Yet Ambitious Step Toward Controlling Health Care Cost Growth Statewide... Establishing an Office of Health Care Affordability—tasked with collecting comprehensive financial information from across the health care sector, resourced with the internal expertise necessary to analyze the data it collects, and empowered to enforce targets for health care cost growth—would be a reasonable step for the state to take in an effort to control health care costs. However, this proposal also is quite ambitious. Due to its geographic size, population, and regional diversity, California's health care system—and its total health care spending—is much larger and more complex than those of the other states that have attempted to establish independent entities or regulatory bodies to control health care costs. Accordingly, carrying out the office's core functions may be more challenging than it has been in other states. In addition, although other states—in particular Massachusetts—have established similar models to control health care costs, these efforts generally do not have a clear and consistent track record of success. To some extent, this proposed office will need to develop its own best practices to ensure that health care cost growth remains within the specified targets.

...But Continued Monitoring of Implementation Necessary to Ensure Office Achieves Goals. In light of the considerations we raise above, continued monitoring of the implementation of the Office of Health Care Affordability would be necessary to ensure it is successful at controlling health care costs statewide. This would allow the state to identify areas where adjustments to the office—such as in its staffing levels and regulatory authority—would increase the likelihood that it would achieve its intended goals.

Issues for Legislative Consideration

Consider Where Further Adjustments to Proposal Are Needed to Address Legislative Priorities. As discussed earlier, the Governor's proposal includes a number of changes relative to last year's proposal. The Legislature may wish to ask the administration to explain the rationale for these changes and then consider the extent to which it agrees with the changes to the proposed office. If it does not agree with all or some of the revisions relative to last year's proposal, the Legislature may wish to make its own adjustments to the proposed statutory language to establish the office.

Consider Putting a Regular Process in Place to Ensure Legislative Oversight of Implementation Given continued monitoring of implementation for this office is warranted (if enacted), the Legislature may wish to consider putting a process in place to ensure legislative oversight of its implementation and ongoing efforts. The proposed statutory language to establish the office broadly requires that the Office of Health Care Affordability be responsive to legislative requests for information and testimony. Given the ambitious nature of this proposal, the Legislature may wish to consider creating a more defined process to

carry out its oversight functions. This could include requiring regular check-ins, such as on a biannual basis, with the administration to gain information on how implementation is going.

REDUCE THE COST OF INSULIN THROUGH STATE PARTNERSHIP

Background

Addressing High Pharmaceutical Costs Has Been a Key Priority of the Governor and Legislature. High pharmaceutical costs have been identified as a concern of both the Legislature and Governor. These costs have been attributed to a variety of factors, including a lack of competition within the pharmaceutical industry. The state has taken a number of efforts to address prescription drug costs. For example, the Governor signed executive orders in 2019 directing various actions to address high pharmaceutical costs. These orders included directing the state to (1) expand a statewide bulk purchasing program to include nonstate entities such as local governments and (2) transition the Medi-Cal pharmacy services benefit from managed care to fee for service (a change now known as "Medi-Cal Rx") in order to achieve state savings and standardize the Medi-Cal pharmacy services benefit. In 2020, the Legislature passed Chapter 207 of 2020 (SB 852, Pan) which authorized efforts to expand the state's role in securing lower cost drugs for Californians. Specifically, SB 852 directed CalHHS to enter into partnerships resulting in the production or distribution of generic prescription drugs with the intent of making these drugs widely available to the public and private purchasers.

SB 852 Includes Criteria to Ensure Partnerships Are Viable and Able to Achieve Established Goals. Senate Bill 852 requires that before a partnership is entered into, CalHHS must (1) only enter into a partnership to produce a generic prescription drug at a price that results in savings, targets failures in the market for generic drugs, and improves patient access to affordable medications, and (2) examine the extent to which legal, market, policy, and regulatory factors could impact the viability of the proposed partnership.

In addition, SB 852 requires reporting by the administration regarding the potential impacts and feasibility of a partnership. First, by July 1, 2022, SB 852 requires the administration to report on its findings related to the status of drugs being targeted and how state efforts could impact competition, access to drugs, and their costs. Second, by July 1, 2023, SB 852 requires the administration to produce a report on the feasibility of directly manufacturing and selling generic drugs.

Governor's Forthcoming Proposal

The Governor has announced a forthcoming proposal for a potential partnership to manufacture insulin. The stated intent is to increase the availability of insulin that is priced at a fraction of current market prices. According to the administration, more detail on this proposal will be released in the spring.

Assessment

Insulin Could Be an Appropriate Focus for a Partnership... Insulin costs have increased substantially over the last two decades. Currently, even with insurance, patients can end up paying thousands of dollars in annual out-of-pocket costs for insulin. In addition, the production of insulin is heavily dominated by a handful of companies. Due to the high prices and market consolidation, a state partnership to produce and distribute generic insulin has the potential to be an appropriate focus under SB 852. Moreover, SB 852 explicitly requires that at least one partnership the state enters into shall be for the production of insulin, provided that there is a viable pathway to manufacturing a more affordable form of insulin and that the partnership meets the SB 852 criteria previously discussed.

... But Uncertainty Remains Regarding Whether Proposal Would Meet SB 852 Criteria for Viability and Other Factors. While the proposed partnership has the potential to be an appropriate focus, whether the partnership would meet the criteria under SB 852 is unclear. As noted earlier, SB 852 requires the administration to examine legal, market, policy, and regulatory factors that could impact the viability of the proposed partnership. While the administration

notes that these efforts are underway, they have not yet been completed. In addition, if the state ultimately would be able to produce generic insulin at a price that results in savings and improves patient access to affordable medication as required by SB 852 remains unclear.

Reporting Required by SB 852 Likely Critical to Assessing Feasibility of the Proposal. As noted earlier, SB 852 requires the administration to report on both (1) its findings related to the status of drugs being targeted and how state efforts could impact competition, access to drugs, and their costs, and (2) the feasibility of directly manufacturing and selling generic drugs. This reporting (which is due later in 2022 and 2023) likely would be critical to assessing the feasibility of the proposal. As such, why the administration appears to be moving forward with this proposal ahead of this reporting is unclear.

Recommendation

Withhold Any Necessary Approvals Until Additional Information Provided. While we acknowledge that a partnership to produce and distribute insulin has the potential to be an appropriate partnership under SB 852, we recommend that the Legislature hold off on approving the proposal until information is provided to ensure that the proposed partnership meets the criteria included in the legislation. This information should include (1) an evaluation of legal, market, policy, and regulatory factors that could impact the viability of the partnership, and (2) whether the state would be able to produce generic insulin at a price that results in savings and improves patient access to affordable medication. The Legislature also might want to consider awaiting the legislative evaluation of the reporting required by SB 852 before providing the authority to the administration to enter into any partnerships.

OPTIONS TO IMPROVE COVERED CALIFORNIA AFFORDABILITY

During last year's budget process, the Legislature directed Covered California to develop options, for consideration during the 2022-23 budget process, to improve affordability for Californians who have purchased health insurance through Covered California and make up to 400 percent of the federal poverty level (FPL). On January 10, 2022, Covered California released a report with affordability options for consideration by the administration and Legislature. At this time, there are no budget proposals before the Legislature regarding these options. The administration has stated that it is still reviewing the options. As such, if the administration decides to propose affordability options for Covered California, the proposal would be later in the budget cycle. Regardless of whether the administration ultimately comes forward with a proposal, the Legislature could consider the options in the Covered California report and decide whether to take action regarding the affordability of plans offered through Covered California.

Background

Federal Patient Protection and Affordable Care Act (ACA) Substantially Changed Individual Health Insurance Market Landscape. The ACA—most of the provisions of which became effective in 2014—brought about significant changes to the way that health insurance coverage is provided in California. This included significant changes within the individual health insurance market. Notably, the ACA provided for the establishment of state health benefit exchanges, such as Covered California. Consumers who shop for coverage on Covered California can choose among health insurance plans organized into standardized metal tiers, including bronze, silver, gold, and platinum. These tiers vary in the amount of monthly premiums they charge and out-of-pocket costs they require households to pay, such as annual deductibles and co-pays for medical visits. Bronze plans have the lowest premiums but have the highest out-of-pocket costs. For example, bronze plans feature a large deductible that

must be met before many medical services are covered. Silver, gold, and platinum plans require progressively lower out-of-pocket costs, but also come with higher premiums.

To improve affordability, the ACA created two types of subsidies that work together to reduce the cost of health insurance for households who purchase coverage through Covered California if they meet certain income-eligibility criteria and do not otherwise have access to affordable coverage—such as through an employer, Medi-Cal, Medicare, or another qualifying program. (The federal government currently considers coverage to be affordable if self-only premium costs [that is, excluding other family members] are no higher than 9.6 percent of household income.)

- ***Advance Premium Tax Credit (APTC).*** The APTC—as structured under the ACA—offsets the cost of health insurance premiums for households with incomes between 100 percent and 400 percent of the FPL. This tax credit effectively limits a household's net premium for a silver plan (after accounting for the tax credit) to between 2 percent and 10 percent of annual income. (This percentage increases as income increases.)
- ***Cost-Sharing Reductions.*** While the APTC offsets premium costs, cost-sharing reductions are subsidies that reduce households' out-of-pocket costs such as co-pays, deductibles, and annual out-of-pocket maximums. Under the initial years of the ACA, the federal government provided funding for cost sharing reductions for insurers in Covered California to offer various "enhanced" silver plan options to households with incomes between 100 percent and 250 percent of the FPL. These plans are often referred to by the average percent of a member's health care costs that the plan pays. For example, on average, a Silver 94 plan pays 94 percent of member health care costs. Plans with higher numbers—which have a lower income threshold for enrollment—are considered more generous because the consumer pays lower out-of-pocket costs. In 2017, the federal government stopped providing funding for cost-sharing reductions but did not remove the requirement for insurers to offer enhanced silver plans that included cost-sharing reductions. In order to accommodate the increased cost of silver plans, insurers raised premiums for silver plans. (We note that due to the APTC, the federal government ultimately paid for the increased premium costs for consumers making less than 400 percent of the FPL.)

ACA Created Individual Mandate That Was Subsequently Set to Zero. As originally enacted, the ACA imposed a requirement, referred to as the individual mandate, that most individuals obtain specified minimum health insurance coverage or pay a penalty. The individual mandate was intended to discourage people from going without health insurance coverage, particularly younger and healthier individuals who have lower risk of incurring health care costs and who otherwise would be less likely to enroll in coverage. Increased coverage of younger, healthier populations leads to a more balanced insurance risk pool and allows the costs of covering higher-risk populations to be spread more broadly. This, in turn, reduces the average cost of coverage and helps to offset the increased cost of making individual market coverage more comprehensive under the ACA. However, due to subsequent federal legislation, the penalty for violating the individual mandate has been reduced to zero, effectively eliminating the requirement.

State Introduced Individual Mandate Penalty and Established Three-Year Premium Subsidy Program. In 2019-20, the Legislature enacted a state individual mandate penalty as well as a three-year state premium subsidy program intended to supplement federal subsidies through Covered California. The state's individual mandate penalty, which was modeled on the federal individual mandate penalty, went into effect in 2020 and is ongoing. The subsidy program was designed as a three-year program from 2020 through 2022 that would reduce premium costs for most Covered California enrollees—including those making between 400 percent and 600 percent of the FPL who were not eligible for the federal premium subsidies. The state subsidies were structured to limit premium costs to a percentage of income (with the percentage increasing with income) for households making up to 600 percent of the FPL.

Enhanced Federal Premium Subsidies in Effect Supplanted State Subsidies in 2021 and 2022. The American Rescue Plan (ARP) Act was passed by Congress in 2021 in response to COVID-19. As part of this act, the level of federal support for premium subsidies for coverage purchased on health benefit exchanges have been temporarily increased for the 2021 and 2022 plan enrollment years. As seen in **Figure 5**, the increased federal premium subsidies substantially lower the cost of premiums Californians need to pay for plans purchased through Covered California—including for households whose incomes made them ineligible for the preexisting premium subsidies under the ACA. In total, the increased federal support has resulted in about $1.6 billion in reduced premium costs for Californians annually in each of 2021 and 2022.

State Set Aside Funding for Future Affordability Program and Required Report on Affordability Options. The increased federal support effectively supplanted the state premium subsidies because it reduced premium costs as a percent of income below the thresholds established in the state program. This freed up General Fund that otherwise would have gone toward the state premium program. As part of the 2021-2 budget package, Chapter 143 of 2021 (AB 133, Committee on Budget) set aside $333.4 million of this freed-up General Fund to support future affordability efforts. Assembly Bill 133 also required Covered California to develop options for reducing out-of-pocket costs for enrollees making up to 400 percent of the FPL and to provide these options to the Legislature and Governor for consideration in the 2022-23 budget process.

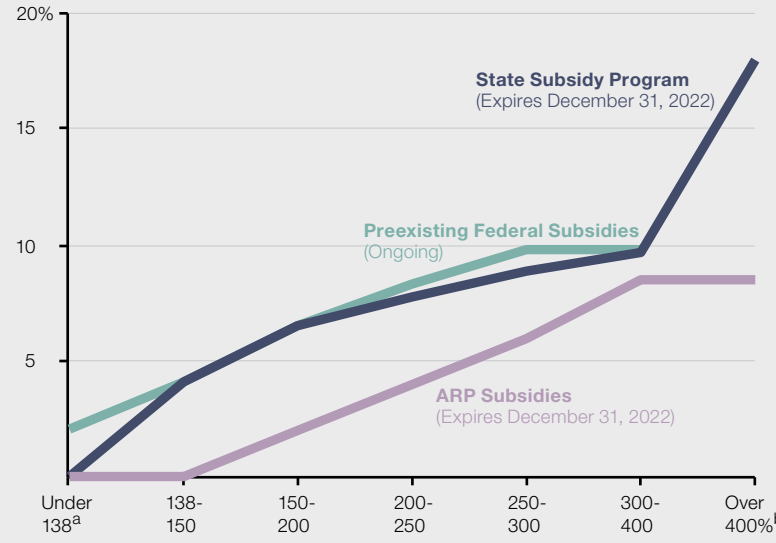
Pending Federal Legislation Could Extend ARP Act Premium Subsidies and Provide Additional Cost-Sharing Reductions. As noted above, the increased federal support through the ARP Act only extends through 2022. However, pending federal legislation (referred to as the Build Back Better Act) would extend the increased federal support through 2025. The legislation also would provide a total of $10 billion nationwide annually between 2023 and 2025 to support new cost-sharing reductions. (The likelihood of the pending federal legislation—or legislation with similar provisions—ultimately being approved by Congress is highly uncertain at this time.)

Affordability Remains an Issue for Households With High Out-of-Pocket Costs. Even with the federal premium subsidies and the cost-sharing reductions established through the ACA, affordability remains an issue for both low-income consumers who are eligible for plans

Figure 5

ARP Reduced Premium Costs in Covered California, Supplanting State Premium Subsidies

Maximum Required Contribution Toward Silver Plan Premiums as a Share of Income by FPL Group



[a] Because individuals with incomes below 138 percent of the FPL generally are eligible for Medi-Cal, Californians below this income level rarely, but sometimes, receive subsidized coverage through Covered California.

[b] Federal subsidies were not previously available for individuals with incomes over 400 percent of the FPL. Eligibility for the California state subsidy program ends at 600 percent of the FPL, while the ARP has no such income limit for eligibility.

ARP = American Rescue Plan and FPL = federal poverty level.

that include the ACA cost-sharing reductions as well as higher-income households. As shown in Figure 6, households at various income levels who are enrolled in silver plans potentially can end up paying a high percent of their annual income on health expenditures. For example, a family of four making about $40,000 per year and enrolled in an enhanced Silver 87 plan (with cost-sharing reductions) could end up paying $5,700 out of pocket (over 14 percent of their income) over the course of a year and potentially within a much shorter period of time. A four-person household, making roughly $67,000 per year and enrolled in a standard Silver 70 plan (with no cost-sharing reductions) could end up paying $16,400 (almost 24 percent of their income) in out-of-pocket costs over the course of a year.

Recent Report Provides Various Options to Improve Affordability

Report Highlights Various Options to Improve Affordability. On January 10, 2022, Covered California released a report with various options for cost-sharing reductions to improve affordability for silver plans purchased through Covered California in response to AB 133's reporting requirement. These options are laid out in more detail in Figure 7 on the next page, but generally involve eliminating deductibles (which are primarily assessed for inpatient services) and providing at least some portion of enrollees with more "generous" plans than they would otherwise qualify for—which would reduce out-of-pocket costs. (The generosity of a plan refers to the percentage of a member's health care costs that it is assumed to cover.) At this time, the administration has not put forward a proposal regarding these options.

Funding Issues Affecting Affordability Options

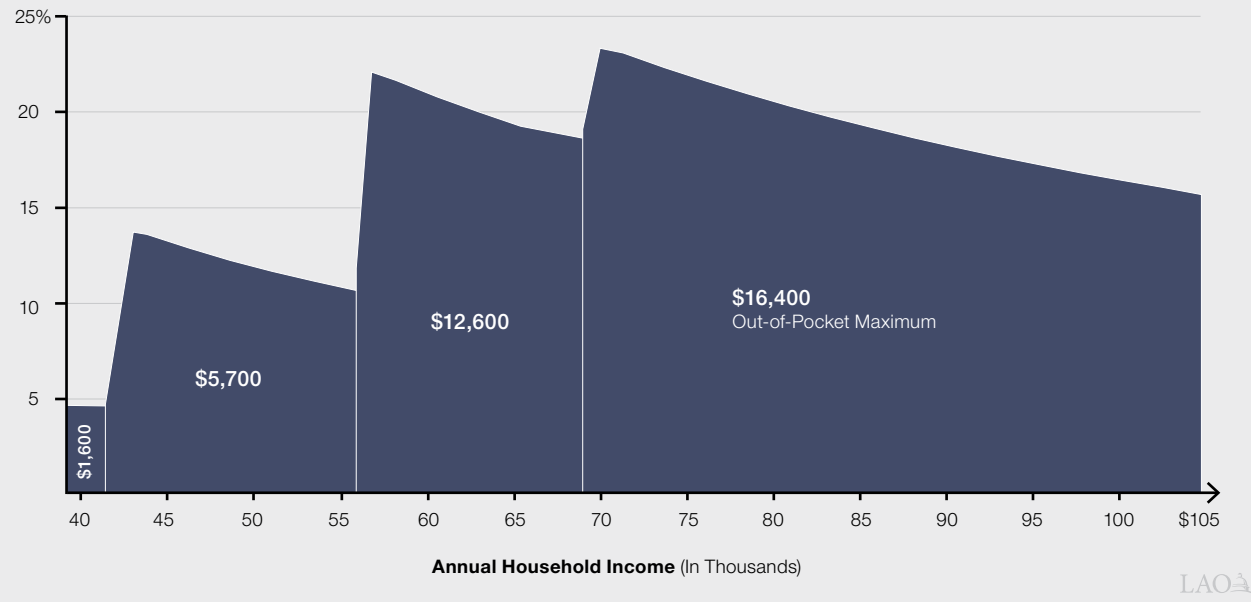
The section below discusses some issues for legislative consideration regarding potential changes in the amount of federal funding available to improve affordability in Covered California and other potential sources of funding.

Will Federal Support for Premium Subsidies in ARP Act Be Extended? As noted earlier, pending federal legislation potentially would extend the federal support for enhanced premium subsidies provided through the ARP Act through 2025. However, if the enhanced premium subsidies are not extended and the state took no action in response, this would result

Figure 6

Silver Plan Out-of-Pocket Maximums as a Percent of Annual Household Income

Family of Four, 2022



in a substantial increase in premium costs for households enrolled in Covered California. Covered California noted in its report that if faced with increased premiums, thousands of existing enrollees might choose to drop coverage. In the event the federal premium subsidies under ARP are not extended, the Legislature may wish to consider reestablishing a state premium subsidy program before considering adopting state-funded cost-sharing reductions (such as the options provided in the Covered California report) due to the potential adverse impact increased premium costs could have on affordability and thus access to coverage.

Will the Federal Government Provide Funding for Cost-Sharing Reductions? The pending federal legislation would provide $10 billion in federal funding for additional cost-sharing reductions. California's share could potentially exceed $1 billion, although the amount of funding and level of discretion provided to the state remains uncertain. In the event this funding is approved, the state would have considerably more resources to address affordability of plans provided through Covered California. However, the Legislature would need to take into consideration potential federal requirements on how this funding is utilized. In addition, the Legislature will want to take into consideration that even if the pending federal legislation is approved, the federal funding for cost-sharing reductions would only be provided through 2025.

Beyond Federal Funding, What Other Funding Could Be Used? Aside from the potential for enhanced federal funding, the Legislature could choose to authorize General Fund for the purpose of implementing affordability options in Covered California. For example, the Legislature may wish to spend an amount similar to the estimated revenues from the state's individual mandate penalty for a state subsidy program. Revenues from the penalty for the 2020 tax year were about $400 million.

Figure 7

Summary of Options Presented in Covered California Report

Options	Estimated State Fiscal Impact[a,b]
Option 1	
Households with incomes above 150 percent up to 600 percent of the FPL would be upgraded to more generous plans. All deductibles would be eliminated.	$475 million to $626 million
Option 2	
Households with incomes above 150 percent up to 400 percent of the FPL would be upgraded to more generous plans. All deductibles would be eliminated.	$463 million to $604 million
Option 3	
Households with incomes above 150 percent up to 400 percent of the FPL would be upgraded from existing plans to plans somewhat less generous than in Option 2. All deductibles would be eliminated.	$386 million to $489 million
Option 4	
Similar to Option 3 but with less generous upgrades for households with incomes above 250 percent up to 300 percent of the FPL. All deductibles would be eliminated.	$362 million to $452 million
Option 5	
Households with incomes above 150 percent up to 250 percent of the FPL would be upgrade to more generous plans. All deductibles would be eliminated.	$278 million to $322 million
Option 6	
No change for households at or below 200 percent of the FPL. Households above 200 percent and up to 400 percent of the FPL would be upgraded to a more generous plan. All deductibles would be eliminated.	$128 million to $189 million
Option 7	
No change for households up to 250 percent of the FPL. Relative to Option 6, somewhat less generous upgrades for households above 250 percent up to 400 percent of the FPL. Deductibles would not be eliminated.	$37 million to $55 million

[a] Estimates provided by Covered California with low to high estimates varying by the extent to which existing enrollees shift to more generous plans as a result of the option.

[b] Estimated costs do not assume any new enrollment resulting from the plans. To the extent options encourage new enrollment into Covered California, state costs could be higher than listed in the table.

FPL = federal poverty level.

Other Issues for Legislative Consideration

Regardless of what sources of funding are used, we suggest the Legislature consider various other issues if it chooses to establish a state cost-sharing reduction program (such as one of the options provided in the Covered California report). A few issues for consideration are discussed below.

What Specific Affordability Goals Should Be Pursued? If the Legislature decides to establish a cost-sharing reduction program, determining what specific affordability goals should be pursued will be important. For example, the Legislature could focus on improving affordability for lower-income households who, despite being eligible for federal cost-sharing reductions, can still pay a significant portion of their income on health care due to deductibles and out-of-pocket maximums. Alternatively, the Legislature could focus on expanding cost-sharing reductions to households with incomes above 250 percent of the FPL who do not currently qualify for federal cost-sharing reductions and, as a result, potentially could end paying an even higher percent of their income on health care.

While Covered California's report is heavily focused on affordability for existing enrollees, in 2023, about 700,000 Californians are projected to be uninsured but eligible for subsidized Covered California plans while an additional 200,000 uninsured Californians would be eligible for unsubsidized Covered California plans. Encouraging these Californians to enroll in Covered California could significantly reduce the number of uninsured Californians. Accordingly, the Legislature might want to focus on affordability options that promote further take-up of insurance coverage. While Covered California provides detailed information about the impacts of its options on affordability for different income groups, however, the report does not consider potential impacts the options would have on enrollment.

What Out-of-Pocket Costs Should a State Cost-Sharing Reduction Program Address? The Legislature also may wish to consider what type of out-of-pocket costs should be focused on by such a cost-sharing reduction program. The majority of the options put forward by Covered California include eliminating deductibles and providing consumers with more generous plans that reduce various out-of-pocket costs. Only one option would provide more generous plans but would not eliminate deductibles. The options that eliminate deductibles are considerably more expensive. However, the Legislature might want to consider these options for two reasons. First, inpatient deductibles are substantially higher than other forms of out-of-pocket costs. While many consumers do not utilize these services, those who do are much more likely to reach their out-of-pocket maximums. Second, deductibles can have a deterrent effect on consumers. Notably, if consumers are confused about when such deductibles apply, they may avoid enrolling in plans or receiving health care, including services that are not subject to inpatient deductibles.

Would the Cost-Sharing Reduction Program Be Limited Term or Ongoing? The Legislature also may want to consider what duration a state-funded cost-sharing reduction program should be. A one-year or limited-term program would reduce the state's fiscal exposure and potentially avoid exceeding the $333.4 million that was set aside in 2021-22. In addition, if the pending federal legislation to provide funding for cost sharing is approved, the associated federal funding would expire in 2025. As such, a limited-term state program could be better aligned with that funding source and later restructured or eliminated when the federal funding goes away. However, there are trade-offs of a limited-term program. For example, consumers may be less willing or able to make any necessary changes to their health plans in order to benefit from a program that has a short duration.

Legislative Next Steps

While no specific proposal has been put forward by the administration, action would need to be taken within the 2022-23 budget process in order to take effect in Covered California's 2023 plan year. We recommend that the Legislature take into consideration the issues raised above when considering what actions to take—either in reviewing any potential proposal from the administration that might be released at May Revision or in developing direction to the administration on what options to implement.

VARIOUS ACCESS AND AFFORDABILITY ISSUES REMAIN

The Governor's proposals—if approved by the Legislature—would improve significantly access to comprehensive health coverage and to some extent improve affordability. In addition, potential actions taken to improve affordability in Covered California would reduce health costs for impacted households. However, various issues regarding access to comprehensive health coverage and affordability of health care would remain even if the above actions were all taken. We provide a few notable examples of these issues below.

Examples of Issues Impacting Access to Comprehensive Coverage. These access issues include:

- ***Access to Covered California for Undocumented Residents.*** While the Governor's proposal would expand Medi-Cal coverage to all income-eligible undocumented residents, access to coverage would remain an issue for undocumented residents who are not income-eligible for Medi-Cal. While there is considerable uncertainty about the size of this population, we estimate there likely are 300,000 people affected. Due to federal requirements, such individuals are excluded from purchasing coverage through Covered California. However, the state potentially could seek a federal waiver to allow such individuals to purchase coverage. Even with a waiver, however, costs of plans purchased likely would either need to be unsubsidized or the state would need to pay for any subsidies that would otherwise be funded by the federal government.
- ***Reducing Number of People Eligible for but Not Enrolled in Medi-Cal.*** Roughly 500,000 people are eligible for but not enrolled in Medi-Cal, although it is not necessarily the same 500,000 people at a given time due to an issue known as "churning." Churning refers to when individuals lose eligibility for Medi-Cal on a temporary basis before resuming coverage, often within a year. The lapses in coverage due to churning can result in issues with continuity of care. Reasons for churning can be due to short-term changes in circumstances such as temporary increases in income, but it also can be due to administrative issues such as failure to respond to Medi-Cal eligibility redetermination notices within a given amount of time. The Legislature could consider asking the Department of Health Care Services for other options to streamline the eligibility redetermination process from a beneficiary perspective for the purpose of reducing churn. Alternatively, the Legislature could consider adopting a continuous coverage policy to allow enrollees to remain on Medi-Cal for a period of time, such as a year, without being subject to an eligibility redetermination (this would require a federal waiver).

Examples of Issues Impacting Affordability. These affordability issues include:

- ***Addressing Share of Costs in Medi-Cal.*** Certain individuals who would otherwise not be eligible for Medi-Cal due to their income are allowed to enroll in the program but must pay a share of cost before enrolling in Medi-Cal. Most share-of-cost Medi-Cal recipients are enrolled in the medically needy program which is largely comprised of persons with disabilities as well as people who are aged or blind. In contrast to the payment of premiums, individuals who pay a share of cost must meet a monthly deductible before Medi-Cal begins to pay for health care. The amount of deductible that must be paid each month is calculated as the enrollee's net nonexempt income minus a basic amount determined to be necessary for cost of living, known as the "maintenance need level." California has not applied cost-of-living adjustments to the calculation of the maintenance need level since 1989, even though federal law allows for such adjustments, resulting in a current maintenance need level of only $600. Introducing inflation adjustments into the program could help mitigate increasing affordability challenges for its enrollees.

- ***Fixing the "Family Glitch."*** Under the ACA, households that have access to affordable health insurance through other sources such as an employer are ineligible for federally subsidized health plans through exchanges such as Covered California. Under the ACA, households are considered to have access to affordable insurance if at least one member of the household has access to health insurance in which the cost of self-only coverage is less than a certain percent of household income (currently 9.66 percent). The definition does not consider the cost of coverage for other household members and accordingly has become known as the family glitch because of its potentially adverse impact on families being able to access affordable coverage through the health benefit exchanges. In some circumstances, such as if an employer contributes little to nothing for the coverage of spouses and dependents, households may find it cost-prohibitive to either add other family members to an employer-sponsored plan or purchase nonsubsidized coverage through Covered California. While this issue could be addressed through a change in federal legislation, Minnesota recently passed legislation to address the family glitch at the state level. (However, we note that Minnesota's equivalent to Covered California is structured very differently—and as such, attempting to fix the family glitch in California could require a different approach and be more complicated.)

- ***Reducing Pharmaceutical Costs.*** This publication discusses the Governor's proposal to address high insulin costs. Even if that proposal is approved and implemented successfully, high pharmaceutical costs likely will remain a challenge—even after considering he state's other efforts to reduce such costs. Attempting to address this issue could require additional market interventions—such as attempting to increase competition, consolidating the purchase of pharmaceuticals to a greater extent than today to increase bargaining power, or passing legislation to regulate costs. However, the feasibility of any such intervention is uncertain and could lead to unintended consequences, such as reduced availability if manufacturers choose to reduce the availability of their drugs to Californians due these state interventions.

To the extent the Legislature would like to further the goals of improving access and affordability, it could consider looking into ways to address the issues identified above. This could include asking the administration during budget deliberations about its plans, if any, to address the issues identified, as well as about the feasibility of options to address them. We recognize that options to address some of these remaining access and affordability issues may be costly and complicated and come with significant trade-offs that warrant serious consideration before proceeding.

LAO PUBLICATIONS

This report was prepared by Luke Koushmaro, Ben Johnson, and Corey Hashida, and reviewed by Mark C. Newton and Carolyn Chu. The Legislative Analyst's Office (LAO) is a nonpartisan office that provides fiscal and policy information and advice to the Legislature.

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Gaps in Health Care Access and Health Insurance Among LGBT Populations in California

Susan H. Babey, Joelle Wolstein, Jody L. Herman, and Bianca D.M. Wilson

"LGBT adults are more likely to experience delays in getting needed health care."

SUMMARY: This study examined differences in health insurance coverage and health care access by sexual orientation and gender identity among California adults. Based on data from the California Health Interview Survey, the results show that although lesbian, gay, and bisexual women and men had similar or better rates of insurance coverage compared to straight women and men, they were more likely to experience barriers in accessing health care, particularly delays in getting needed health care. In addition, gay men, lesbian women, and bisexual women were more likely than straight men and women to report experiencing unfair treatment when getting medical care. Transgender adults had higher rates of public insurance coverage than cisgender adults but were not more likely to lack health insurance. However, transgender adults were more likely to experience a number of barriers to care, including being less likely to have preventive care visits, more likely to have difficulty finding primary or specialty care providers, and more likely to experience delays in getting needed health care. These findings highlight the need to identify health care and structural interventions that will improve access to care for sexual and gender minorities.

Lesbian, gay, bisexual, and transgender (LGBT) adults in the United States experience many of the same challenges and barriers to accessing health care as straight and cisgender adults, including lack of insurance and poverty. However, research shows that LGBT populations are more likely to be uninsured, to be living in poverty, and to have disabilities that may impact access to health care.[1] Furthermore, sexual and gender minorities have unique barriers to health care that include experiences of discrimination, lack of competent providers, and barriers to gender-affirming health care.[2]

Nationally, research suggests several differences in health care access by sexual orientation.[3] For example, lesbian women and bisexual men and women are more likely than straight women and men to have unmet medical needs due to cost in the past year. Other research indicates that transgender adults are more likely than cisgender adults to be uninsured and to experience cost-related barriers to health care.[4] Our previous research in California suggested that lesbian, gay, and bisexual women and men have similar or better rates of insurance coverage compared to straight women and men.[5] Despite this, LGB women and men are more likely to experience delays in getting needed health care. Transgender adults are more likely to experience delays in getting medicine that a doctor has prescribed for them.[6]

This report uses data from the California Health Interview Survey (CHIS) to examine differences in health insurance coverage and health care access by sexual orientation and gender identity. The analyses of sexual

The California Endowment

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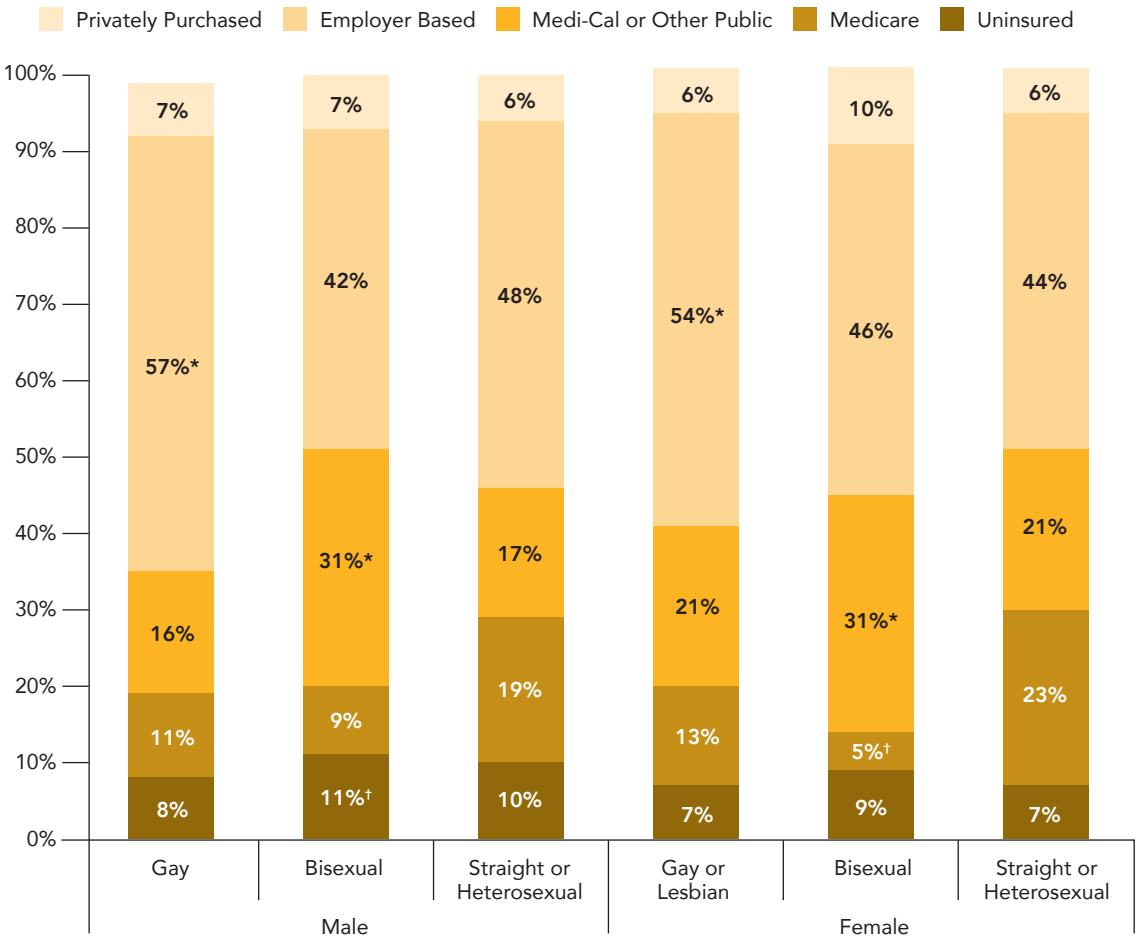
Exhibit 1

Current Health Insurance Coverage by Sexual Orientation and Gender, Adults Ages 18 and Older, California, 2017–2020



Source: Combined 2017–2020 California Health Interview Surveys

Note: Analysis does not include adults who did not report male or female as their current gender.

* Significantly different from "Straight or Heterosexual," with $p < 0.05$.

† Estimate is not statistically reliable.

"Gay men and lesbian women had higher rates of employer-based coverage than straight men or women."

orientation differences include all gender identities (i.e., both transgender and cisgender adults), and the analyses of gender identity differences include people of all sexual orientations. Findings by sexual orientation combine data from 2017 to 2020. Combining data from these recent years allows for the presentation of findings stratified by gender, which is important because disparities vary across lesbian, gay, and bisexual people who identify as either female or male.[7] Findings by gender identity use data from 2015 to 2020. Combining all the years of available data provides for more reliable estimates for this population. Measures are described in more detail under "Data Source and Methods" at the end of this report.

Gay Men and Lesbian Women More Likely To Have Employer-Based Coverage; Bisexual Men and Women More Likely To Be Insured With Medi-Cal

In 2019–2020, 3.3% (95% CI=3.1–3.6) of California adults described their sexual orientation as lesbian, gay, or homosexual, and an additional 3.6% (95% CI=3.3–3.9) described themselves as bisexual.

The percentage of adults with no health insurance did not vary significantly by sexual orientation (Exhibit 1). However, having employer-sponsored insurance (ESI) or Medi-Cal did. Gay men (57%) and lesbian women (54%) were more likely to have ESI than heterosexual men (48%) or women (44%).

Indicators of Access to Health Care by Sexual Orientation and Gender, Adults Ages 18 and Older, California, 2017–2020 **Exhibit 2**

	Male			Female		
Access Indicator	**Gay**	**Bisexual**	**Straight or Heterosexual**	**Gay or Lesbian**	**Bisexual**	**Straight or Heterosexual**
No Usual Source of Care	13%*	27%*	18%	18%	24%*	12%
No Doctor Visit in Past Year	13%*	25%	22%	12%†	18%*	14%
No Preventive Care Visit in Past Year	25%*	40%	32%	30%	34%*	23%
Trouble Finding Primary Care Doctor	4%	5%†	4%	5%	9%*	5%
Trouble Finding Specialist	13%	18%†	10%	13%	20%*	11%
Delayed or Did Not Get Needed Health Care	18%*	22%*	12%	23%*	33%*	16%
Delayed or Did Not Get Prescribed Medication	12%*	16%*	8%	14%	21%*	11%

Source: Combined 2017–2020 California Health Interview Surveys

Note: Analysis does not include adults who did not report male or female as their current gender.

* Significantly different from "Straight or Heterosexual," with $p < 0.05$.

† Estimate is not statistically reliable.

Bisexual men and women (31%) were more likely to have Medi-Cal coverage than other groups. The higher rates of public health insurance coverage among bisexual adults compared to monosexual adults (i.e., heterosexual, gay, or lesbian) likely reflects differences in economic stability between these subgroups. Bisexual adults in the U.S., particularly women, have among the highest rates of poverty.[1,3]

Sexual Minorities, Especially Bisexual Women, Experience Barriers in Access to Health Care

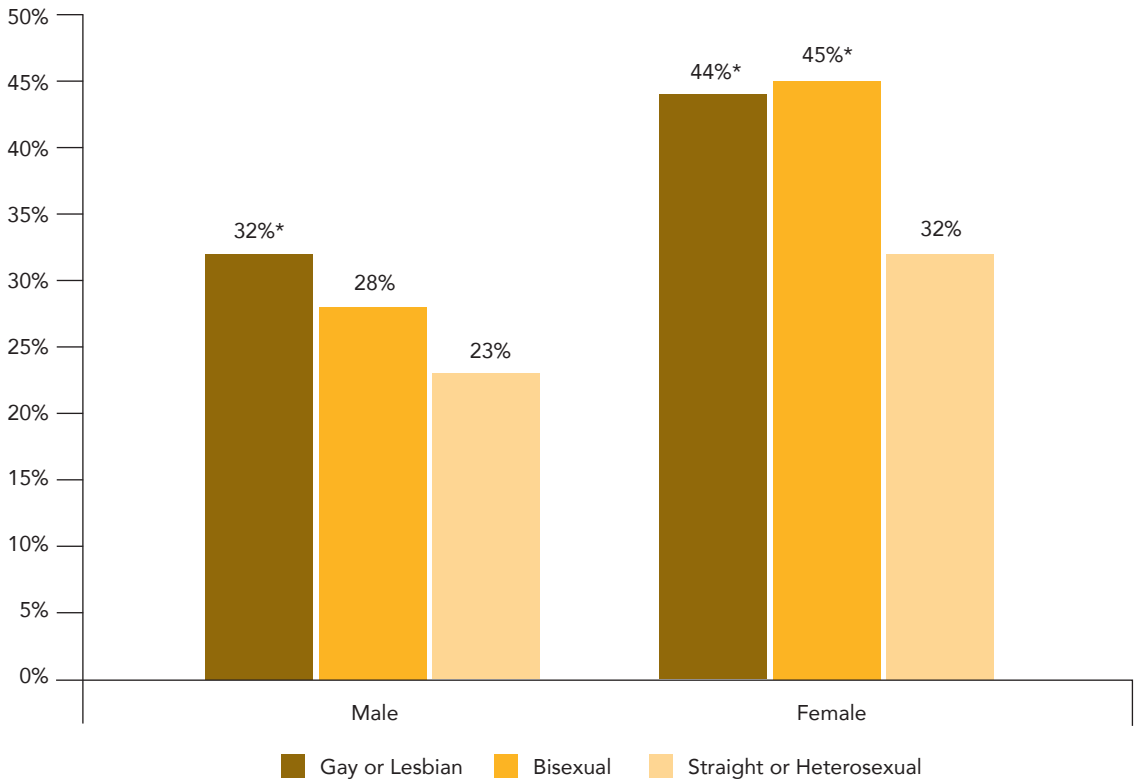
Several indicators of access to care varied by sexual orientation and gender (Exhibit 2). Having a usual source of health care is important for receiving appropriate and timely care. Among women, the proportion with no usual source of care was twice as high for bisexual adults as for heterosexual adults (24% vs. 12%). Bisexual women were also more likely than heterosexual women to have had no doctor visit (18% vs. 14%) and no preventive care visit in the past year (34% vs. 23%). Differences between lesbian and straight women were not statistically significant.

Among men, gay men had the lowest proportion with no usual source of care (13%), significantly lower than the proportions among straight men (18%) or bisexual men (27%). The same pattern is seen for having a doctor visit or a preventive care visit in the past year: Gay men were less likely to have had no doctor visit (13%) and no preventive care visit (25%) in the past year than straight men (22% and 32%, respectively) or bisexual men (25% and 40%, respectively). Differences between straight men and bisexual men were not statistically significant with regard to doctor visits or preventive care visits. Previous research in California indicated that, among men, there were no differences in having a usual source of health care across sexual orientations.[8] However, unlike this current study, the earlier work did not look at differences between gay and bisexual men. This highlights the need to explore within LGB differences when studying sexual minority disparities in health care access.

"Among women, the proportion with no usual source of care was twice as high for bisexual adults as for heterosexual adults."

Exhibit 3

Ever Experienced Unfair Treatment When Getting Medical Care by Sexual Orientation and Gender, Adults Ages 18 and Older, California, 2015–2017



Source: Combined 2015–2017 California Health Interview Surveys

Note: Analysis does not include adults who did not report male or female as their current gender. The question about unfair treatment in medical care was included in CHIS 2015–2017 only.

* Significantly different from "Straight or Heterosexual," with $p < 0.05$.

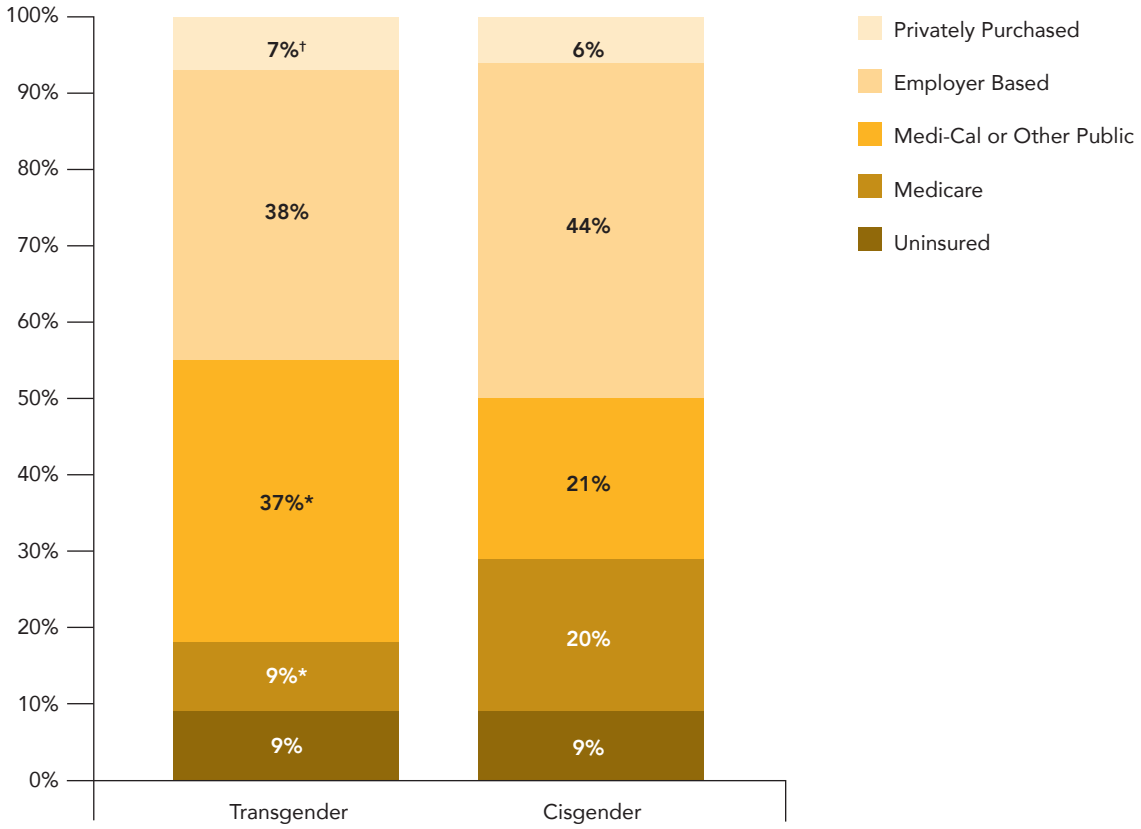
"Gay men, lesbian women, and bisexual women were more likely than straight men and women to report experiencing unfair treatment when getting medical care."

Bisexual women were more likely than straight women to experience difficulty finding a primary care provider (9% vs. 5%) and finding a specialist (20% vs. 11%). Among men, there were no statistically significant differences by sexual orientation in those who experienced difficulty finding a primary care provider or finding a specialist.

Sexual minorities were more likely to experience delays in receiving needed medical care or getting prescription medications (Exhibit 2). Among women, the proportion who experienced delays in needed medical care was higher among lesbians (23%) and bisexuals (33%) than among straight women (16%). Bisexual women (21%) were more likely than lesbians (14%) or straight women (11%) to delay getting a prescription medication. Among men, the proportions who experienced delays in getting needed medical care were higher among gay men (18%) and bisexuals (22%) than among straight men (12%). Bisexual men (16%) and gay men (12%) were more likely than straight men (8%) to delay getting a prescription medication.

There were no statistically significant differences by sexual orientation in the percentage of people who cited the reasons for delaying care provided by the survey. However, in response to a question about whether they had been "treated unfairly" when getting medical care, sexual minorities were more likely to say that they had been (Exhibit 3). More than 40% of lesbian (44%) and bisexual (45%) women reported being treated unfairly, compared to 32% of straight women. Nearly one-third of gay men (32%) reported being treated unfairly, compared to less than one-quarter (23%) of straight men.

Current Health Insurance Coverage by Gender Identity, Adults Ages 18 and Older, California, 2015–2020 **Exhibit 4**



Source: Combined 2015–2020 California Health Interview Surveys

* Significantly different from "Cisgender," with $p < 0.05$.
† Estimate is not statistically reliable.

Transgender Adults More Likely To Have Medi-Cal Coverage, Less Likely To Have Medicare

In 2019–2020, approximately 0.8% (95% CI=0.6–1.0) of California adults were transgender. The percentages of transgender and cisgender adults with no health insurance did not differ (Exhibit 4). Transgender and cisgender adults had similar rates of insurance coverage through privately purchased plans and employer-based plans. However, transgender adults were significantly more likely than cisgender adults to be covered by Medi-Cal or other public health insurance (37% vs. 21%). Similar to bisexual adults, transgender people have higher rates of poverty.[1,3] This difference in economic stability between cisgender and transgender people likely contributes to differences in rates of coverage by public health insurance. Transgender adults were also less likely to be covered by Medicare (9% vs. 20%). The difference in Medicare coverage could be explained, at least in part, by differences in age between transgender and cisgender adults, because California adults identifying as transgender tend to be younger.[9]

"Transgender adults were significantly more likely than cisgender adults to be covered by Medi-Cal."

Transgender Adults Experience Several Barriers in Access to Health Care

Transgender and cisgender adults were similar in regard to having a usual source of health

Exhibit 5

Indicators of Access to Health Care by Gender Identity, Adults Ages 18 and Older, California, 2015–2020

Access Indicator	Transgender	Cisgender
No Usual Source of Care	20%	16%
No Doctor Visit Past Year	19%	18%
No Preventive Care Visit Past Year	39%	28%*
Trouble Finding Primary Care Doctor	8%	4%*
Trouble Finding Specialist	29%	11%*
Delayed or Did Not Get Needed Health Care	33%	14%*
Delayed or Did Not Get Prescribed Medication	23%	10%*
Main Reason for Delaying or Not Getting Needed Health Care		
Cost or Lack of Insurance	36%	42%
Insurance Not Accepted or Did Not Cover the Care	9%	3%*
Transportation Problems	17%	2%*
Could Not Get Appointment	4%†	11%*
Did Not Have Time	10%	19%*
Forgot or Procrastinated	5%†	4%
Anxiety, Fear, Avoid Medical Care	3%†	4%
Other	15%	15%

Source: Combined 2015–2020 California Health Interview Surveys

Note: The "Other" category includes a number of different reasons that were provided by smaller proportions of respondents. The most common "other" responses provided were "did not think serious enough" and "not satisfied with care received."

* Statistically significant difference between transgender and cisgender, with $p < 0.05$.

† Estimate is not statistically reliable.

"Transgender adults were more likely to experience delays in care."

care and having no doctor visits in the past year (Exhibit 5). However, transgender adults were significantly more likely to have had no preventive care visit in the past year (39% vs. 28%). Transgender adults were also more likely to report having trouble finding a primary care doctor (8% vs. 4%) and finding a health care specialist (29% vs. 11%). It is possible that the much higher rate of having trouble finding health care specialists could be due, at least in part, to difficulty finding providers offering gender-affirming medical care.[10]

Gender minorities were more likely to experience delays in care (Exhibit 5). Transgender adults were significantly more likely than cisgender adults to delay or not get needed health care (33% vs. 14%) and to delay or not get prescribed medications (23% vs. 10%). When asked about the main reason they had delayed or gone without needed health care, cisgender adults were more likely to report that they did not have enough time or could not get an appointment. Transgender adults were more likely than cisgender adults to report transportation problems as their main reason for delaying or going without needed care (17% vs. 2%), and they were also more likely to report that their insurance was not accepted or did not cover the care (9% vs. 3%).

When asked if they had ever been treated unfairly when getting medical care, a greater percentage of transgender respondents reported experiencing unfair treatment compared to cisgender respondents (42% vs. 28%). Although this difference is large, it was not a statistically significant difference, possibly due in part to the smaller sample size of transgender adults available in the three cycles of data collection that included this question.

Conclusions

Sexual and gender minorities in California experience a number of barriers in access to health care, despite having similar or better rates of insurance coverage. Gay men were more likely than straight men to have experienced delays in getting needed health care and prescribed medication, even though they were less likely than straight men to have no usual source of care and to have had no preventive care visit in the past year. Bisexual men were more likely than straight men to have no usual source of care and to have experienced delays in getting needed health care and prescribed medication. Bisexual women, in particular, experienced significant barriers to accessing care relative to straight women, including being more likely to have no usual source of care, to have had no doctor visit or preventive care visit in the past year, to have had trouble finding primary care and specialty care providers, and to have delayed or not received needed health care or prescribed medication.

Transgender adults had higher rates of Medi-Cal coverage than cisgender adults, but they were not more likely to be uninsured. Despite this, transgender adults were more likely to have experienced a number of barriers to care, including being less likely to have had preventive care visits, more likely to have had difficulty finding primary or specialty care providers, and more likely to have experienced delays in getting needed health care.

Gay men, lesbian women, and bisexual women were more likely than straight men and women to report experiencing unfair treatment when getting medical care. A higher percentage of transgender adults than cisgender adults also reported experiencing unfair treatment when getting medical care, although this difference was not statistically significant. Other research suggests that sexual and gender minorities experience unique barriers to accessing health care. These include concerns about discrimination and negative experiences with providers, such as not being believed, being blamed for a health problem, or having their concerns dismissed.[11] Taken together, these findings suggest that previous negative experiences or discrimination could contribute to some of the barriers experienced by sexual and gender minorities, including the higher rates of delayed care.

In our previous examination of differences in access to care by sexual orientation using CHIS data from 2011 to 2014, we found that gay men were less likely than straight men to have no insurance, whereas there was no difference by sexual orientation among women.[5] In addition, employer-based coverage did not vary by sexual orientation, but bisexual men and women were more likely to be covered by Medi-Cal. In contrast to the previous study, the current study found no differences in the percentages of adults without health insurance by sexual orientation among either men or women. This is likely due in part to declines in uninsured rates across all demographic groups following implementation of the Affordable Care Act (ACA) in 2013. In addition, in the current study, gay men and lesbian women were more likely than straight men and women to have ESI. This could be due in part to increases in the proportions of lesbian and gay adults who are married.[12] Similar to the previous study, the current study found that bisexual men and women have higher rates of Medi-Cal coverage than straight and gay or lesbian men and women. These higher rates of Medi-Cal coverage may reflect differences in income and disability rates.[13] Bisexual men and women have higher rates of poverty and disability than straight men and women.

These findings highlight the need for clinical and structural interventions to improve health care access for sexual and gender minorities. The findings reinforce the importance of examining within LGB differences in health care access when studying sexual minority disparities, but they

"These findings suggest that previous negative experiences or discrimination could contribute to some of the barriers experienced by sexual and gender minorities, including the higher rates of delayed care."

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.***

also suggest the need for additional research to explain existing disparities as well as similarities in access to health care. Future research should also consider within-group differences for transgender men, transgender women, and nonbinary transgender people.

Data Source and Methods

The findings in this study are based on data from the California Health Interview Survey (CHIS). All analyses presented in this policy brief incorporate survey weights to account for the complex survey design.

Analyses of sexual orientation differences include all gender identities (i.e., they include both transgender and cisgender adults), and the analyses of gender identity differences include people of all sexual orientations. For analyses by sexual orientation, we combined data from 2017 to 2020 to obtain stable estimates and allow for analyses to be stratified by gender (comparing females and males). Adults ages 18 and older were asked to identify their sexual orientation, using the following question: "Do you think of yourself as straight or heterosexual; as gay, lesbian, or homosexual; or as bisexual?" (N=79,965 straight or heterosexual; 2,477 lesbian, gay, or homosexual; and 2,377 bisexual). Responses to this question were used to examine health and access to care by sexual orientation. Analyses stratified by gender are based on self-reported current gender and exclude adults who did not report female or male as their current gender. To examine differences between transgender and cisgender adults, we combined data from all years in which this information was available, 2015 to 2020. To determine whether respondents were transgender or cisgender, adults were asked two questions: "On your original birth certificate, was your sex assigned as male or female?" and "Do you currently describe yourself as male, female, or transgender?" Adults whose assigned sex at birth differs from their current gender identity or who self-report being transgender are transgender (N=451), and those whose sex assigned at birth is the same as their current gender identity are cisgender (N=127,773).

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Endnotes

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JAMA Network Open

Original Investigation | Health Policy

Trends in Disenrollment and Reenrollment Within US Commercial Health Insurance Plans, 2006-2018

Hanming Fang, PhD; Molly Frean, PhD; Gosia Sylwestrzak, MA; Benjamin Ukert, PhD

Abstract

IMPORTANCE The commercial health insurance market is characterized by consistently high enrollee turnover. Turnover can disrupt care continuity for patients and create challenges for insurers in managing the health of their enrollee populations. Yet the extent to which enrollees reenroll is not widely known.

OBJECTIVE To characterize rates of disenrollment (hereafter, *external turnover*) and reenrollment in commercial health plans.

DESIGN, SETTING, AND PARTICIPANTS In this retrospective longitudinal cohort study, trends in turnover and reenrollment in commercial health plans between January 1, 2006, and August 31, 2018, were analyzed. Data analysis was conducted from January 21, 2020, through December 23, 2021. Participants included 3 018 633 primary members and their dependents with employer-sponsored coverage.

MAIN OUTCOMES AND MEASURES Primary outcomes included external turnover from commercial coverage and subsequent reenrollment into any line of business with the insurer (commercial, Medicaid Managed Care, and Medicare Advantage). Within commercial coverage, external turnover was analyzed separately for group (ie, employer-sponsored) and individual markets.

RESULTS In the sample of 3 018 633 members, 50.2% were men; mean (SD) age, including dependents, was 30.68 (19.05) years. A total of 2.2% of members experienced external turnover each month and 21.5% experienced external turnover each year. The individual market had the highest average monthly turnover rate of 3.4% compared with 2.1% in the group market. December had the highest rate of external turnover, with 13.8% experiencing external turnover in the individual market and 6.9% of members experiencing external turnover in the group market. Fourteen percent of the members who left the insurer from an individual plan reenrolled with the insurer after 1 year, and 34% had reenrolled after 5 years. Among members who left the insurer from a group plan, 12% reenrolled after 1 year and 32% reenrolled after 5 years. After 10 years, reenrollment reached 47% in the 2 markets. More than 80% of enrollees returned to the same line of business and within the same state, suggesting findings may generalize to smaller insurers.

CONCLUSIONS AND RELEVANCE The findings of this cohort study suggest that insurers may benefit from investing in members' long-term health outcomes despite substantial short-term turnover rates.

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Key Points

Question What is the level of disenrollment and reenrollment within commercial health plans?

Findings In this longitudinal cohort study of 3 018 633 individuals, approximately 1 in 5 members disenrolled from a commercial insurer each year; however, among departing enrollees, approximately 1 in 3 returned to the insurer within 5 years.

Meaning The findings of this study suggest that insurers can benefit from investing in members' long-term health outcomes despite substantial short-term turnover rates.

+ Supplemental content

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

Introduction

Unlike other countries with national health systems, the organization of the US health insurance industry creates numerous opportunities for enrollee turnover. In the commercial market (also referred to as the private market), multiple insurers compete for employment-based insurance contracts and individual enrollees. As a result, commercial insurers' enrollee turnover reflects not only member choices to switch insurers but also member choices to switch employers and employer choices to switch insurers. Medicare and Medicaid are also subject to turnover (churn), with beneficiaries often choosing among privatized plans, and Medicaid enrollees face the added risk of losing eligibility owing to income fluctuations.

Between 15% and 20% of both privately and publicly insured individuals experience coverage disruptions or change plans each year.[1-7] Research on health insurance plan choice has identified factors that explain turnover in both contexts, including individual characteristics and behavioral factors, such as inertia or inattention.[8-13] A complementary set of studies has evaluated the direct and relatively short-term consequences of turnover, including how associated disruptions in insurance coverage can lead to disruptions in health care use.[14-16]

Turnover, especially within commercial insurance, has implications for the long-term health of insured populations in the US. From a single insurer's perspective, turnover may occur internally across their menu of plan offerings—often without any gaps in coverage—or externally when a member leaves the insurer entirely. External turnover can be negatively associated with the affordability of insurance when insurers must continuously use resources to attract and enroll new members. In addition, a lack of historical health information on a member at the start of their tenure with an insurer may limit the insurer's ability to improve health outcomes through tailored care management programs and personalized outreach. Another implication of external turnover, which we highlight in this study, was raised by prior research[17-19]: external turnover reduces insurer incentives to invest in preventive care for which benefits accrue over longer time horizons; as such, benefits may not necessarily accrue to the same insurer making the investment. Fang and Gavazza[17] reported that labor market turnover causes employers to underinvest in their employees' health during working years, leading to higher health care expenditures during retirement. These authors also noted that specific benefits vary according to industry turnover rates, providing evidence that firms recognize and respond to these dynamic incentives.[18] Such results explain the findings of Herring,[19] who documented a negative outcome associated with turnover and actual use of preventive care services. Cebul et al[2] reported that search frictions in the market for group-based insurance lead to additional turnover beyond that attributable to labor market turnover, further reducing investment incentives.

The objectives of this study were 2-fold. First, we sought to document the extent of external turnover from commercial group and individual plans at one of the country's largest commercial insurers. Second, we explored the extent to which former enrollees return to the insurer at a later date, including returns to all lines of business (commercial, Medicare Advantage, and Medicaid Managed Care). To our knowledge, no study has explored this possibility empirically.

Methods

Data Source

In this cohort study, we used administrative data from Anthem, one of the largest national insurers in the US, from January 1, 2006, through August 31, 2018 (hereafter, *study period*). Data include fully adjudicated medical and pharmacy claims and enrollment data with plan characteristics, such as the line of business and plan type. Anthem operates commercial plans in 14 states, including both employer-sponsored group coverage (fully insured and self-insured) and individual plans (either on or off the Affordable Care Act's insurance exchanges). In some states, Anthem additionally administers plans through 2 other lines of business: Medicare Advantage and Medicaid Managed

Care. The insurer's predominant plan types in the commercial line of business are preferred provider organizations, health maintenance organizations, and consumer-directed health plans. We used data from a 5% random sample of members enrolled in a commercial plan with the insurer during the study period. For each member, we observed their first segment of commercial coverage during the study period as well as any subsequent enrollment segments in the same or other lines of business. More details on enrollment and sample construction can be found in the eMethods in the Supplement.

This project was determined not to be human participant research by the Texas A&M University Institutional Review Board. This study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline for cohort studies.

Outcomes

The primary outcomes we studied were external turnover from commercial coverage and subsequent reenrollment into any line of business with the insurer. We analyzed both outcomes separately for the group and individual markets. We defined external turnover as occurring in a given calendar month if the member was enrolled with the insurer for the full month but no longer enrolled at the start of the following month. External turnover therefore marks the end of a unique segment of continuous enrollment with the insurer. We allowed for small gaps up to 2 days in coverage when defining periods of continuous enrollment. We also calculated an annual rate of external turnover, defined as the share of members experiencing external turnover at least once in the calendar year. We refer to instances of external turnover as external turnover episodes, as a given member may experience external turnover multiple times if they have multiple periods of continuous enrollment with the insurer. A member observed for only 1 segment of continuous enrollment that spans the end of the study period would have no external turnover episodes. For external turnovers from group plans, we additionally separated whether the turnover was the member's choice or the employer's choice. We used information on the employer associated with the health plan to evaluate whether the member turnover was due to the employer discontinuing its contract with Anthem (employer choice) or whether the member disenrolled despite the employer's contract remaining in place (member choice). In the individual market, turnover may be the member's choice or a reflection of Anthem's exit from select state marketplaces beginning in 2017.[20]

We defined reenrollment following each external turnover episode based on whether a subsequent enrollment segment was observed for the member after any amount of time has passed. We included returns to both commercial and noncommercial (ie, Medicare Advantage and Medicaid Managed Care, which are combined into other) lines of business. We also describe trends in reenrollment across years after the initial turnover.

Statistical Analysis

Data analysis was conducted from January 21, 2020, through December 23, 2021. We constructed an analytic data set at the member-month level and used descriptive methods to quantify the extent of external turnover and reenrollment. We used Kaplan-Meier curves to characterize the variation in time to reenrollment following external turnover. We also identified members who experienced multiple instances of external turnover. In some analyses, we accounted for potential censoring owing to the end of the study period by limiting the sample to those whom we were able to observe for 3 years after external turnover. Because the sample of members includes both primary policyholders and dependents (eg, spouses, children) and because insurance coverage decisions may not be independent within a household, we conducted sensitivity analyses in which we separately analyzed both types of members. We also completed subgroup analyses by age (25, ≥26, 64, and ≥65 years), by health (0 vs ≥1 comorbidity), and for 4 large states where Anthem has varying market shares.

All statistical analyses were performed using Stata, version 15.0 (StataCorp LLC). Flowcharts were created using R Studio, version 4.0.2 (R Foundation for Statistical Computing).

Results

Sample

Our sample consisted of 3 018 633 unique members. Men (50.2%) and women (49.8%) were equally represented in the sample, and the mean (SD) age of all enrollees, including dependents, was 30.68 (19.05) years. Primary policyholders (mean [SD], 50% [0.50]) and dependents were common plan holders (eTable in the Supplement). The share of members residing in the Northeast was 18%; South, 32%; West, 23%; and Midwest, 28%, which is broadly consistent with Anthem's presence across the US. At their first observed enrollment segment, 92% of the selected members were enrolled in the insurer's commercial group plans and 8% were enrolled in individual plans. Most members were enrolled in preferred provider organizations (76%), with smaller shares enrolled in health maintenance organizations (14%) and consumer-directed health plans (10%).

External Turnover

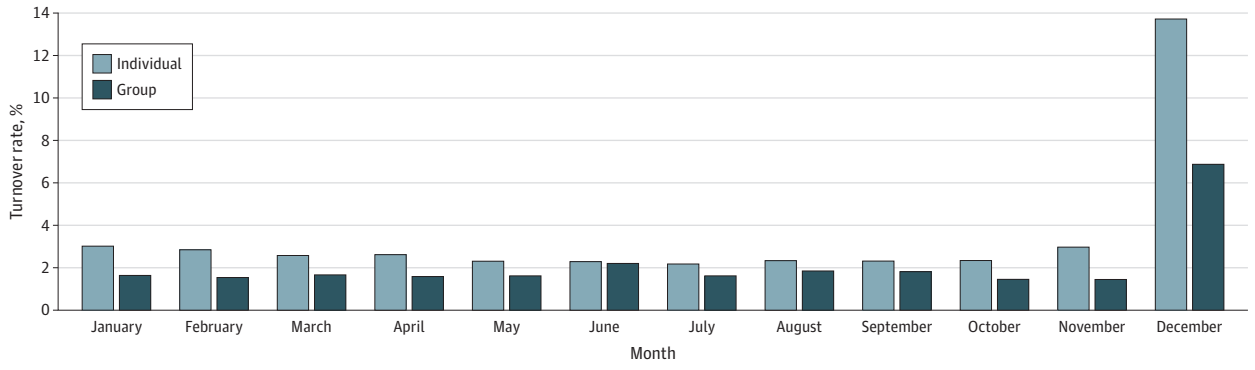
We found that 80% of Anthem members experienced external turnover during the study period. On average, each member was enrolled with the insurer for 48 months during the study period and not necessarily continuously. However, there was substantial variation in the total length of enrollment, with some members enrolled for only 1 month and others for more than 12 years (the full study period). eFigure 1 in the Supplement further characterizes the distribution of enrollment duration. About 28% of members had more than 1 enrollment segment in the study period (eTable in the Supplement).

A total of 2.2% of the members experienced external turnover each month and 21.5% experienced external turnover each year. Few members experienced external turnover multiple times within a given year. **Figure 1** includes the rates of external turnover by calendar month and commercial line of business (group or individual). The individual market had higher average monthly turnover (3.4%) compared with the group market (2.1%). Compared with other calendar months, December had the highest rate of external turnover: 13.8% for the individual market and 6.9% for the group market. External group turnover did not vary substantially in the state-by-state analysis for group coverage but was substantially higher in the individual market in all states (eFigure 2 in the Supplement). Among external turnovers from group plans, 25% was the result of employer choices to leave the insurer and 75% was associated with member choices to leave the insurer and/or their employer.

Reenrollment

We next analyzed the probability of reenrollment with the insurer following external turnover. **Figure 2** displays Kaplan-Meier curves of time to first return, stratified by individual and group line of

Figure 1. External Turnover Rates by Line of Business



Monthly turnover rates by line of business across all years.

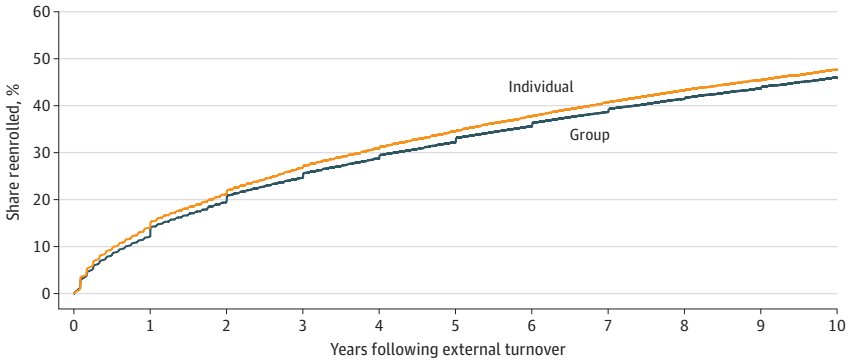
business at departure (ie, at external turnover). We found little variation in the reenrollment rates by the line of business. Specifically, 14% of the members who left the insurer from an individual plan reenrolled with the insurer after 1 year, and 34% had reenrolled after 5 years. For members who left the insurer from a group plan, 12% reenrolled after 1 year and 32% reenrolled after 5 years. After 10 years, reenrollment was 47% for both individual and group members. The eTable in the Supplement displays the socioeconomic characteristics of members who reenrolled: compared with the full sample, reenrollees were younger (mean [SD] age, 28.2 [17.2] years) and healthier (mean [SD], 0.36 [0.93] comorbidities). In addition, 22% of the members returned via the same employer.

In state-specific analyses, we observed lower reenrollment in low market-power states (28%-33%) and higher reenrollment in high market-power states (34%-43%). After 10 years, reenrollment remained higher in high market-power states (eFigure 3 in the Supplement). We also found that a substantial share of reenrollment occurred within the same state and/or line of business (>80%).

Figure 3 depicts the flows of members in the 3 years following an external turnover among members with their first external turnover 3 or more years before the end of the study period (n = 1 887 837). eFigure 4 in the Supplement shows an analogous figure in which the sample is not restricted and censoring is an outcome (n = 2 423 297). The line of business composition of the initial external turnover episodes was 93% for group members and 7% for individual members. After 1 year, 10% of departing enrollees had returned in some capacity: 8% to the group line of business and the remainder split between individual and other. After 3 years, 15% had returned to the insurer, with most reenrolled in a group plan (86%). Although most reenrollees returned to the same line of business (81%), we also observed that 19% returned to another line of business. Figure 3 captures the subsequent episodes of external turnover following the first external turnover. This phenomenon is represented by flows from the different lines of business after 1 year to the no return outcome. Among members included in the Figure, 0.7% (n = 12 557) had more than 1 external turnover episode within the 3 years, meaning they left the insurer once, returned, and then left again.

The member retention rate is a common business metric used by insurers when calculating the return on investment of certain health investments they could incorporate into their benefit design. In **Figure 4**, we show the share of members who were enrolled with the insurer at 1, 2, 3, 4, and 5 years following their first observed enrollment period. Allowing for coverage gaps raised retention rates at each year, creating a gap that widened over time. After 5 years, only 25% of the members remained continuously enrolled without any gaps; however, this share increased to 35% after accounting for members who disenrolled and subsequently reenrolled. Allowing for censoring provided similar results (eFigure 5 in the Supplement). State-specific results in eFigure 6 in the Supplement display similar continuously enrolled retention rates in the 2 low and 1 high market-power states.

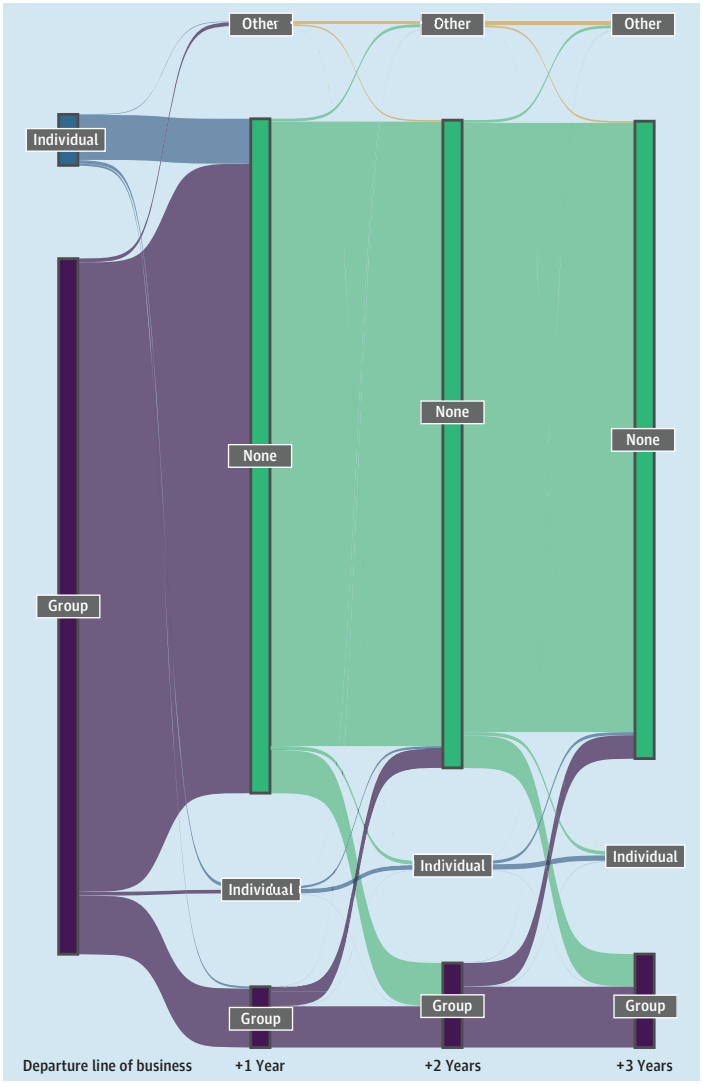
Figure 2. Reenrollment Following External Turnover by Line of Business at Departure



Potential reenrollment										
Group	1 816 307	1 530 612	1 314 914	1 128 860	960 878	792 472	620 379	477 789	336 312	194 576
Individual	146 889	115 908	92 514	70 574	52 425	44 069	37 172	29 227	21 318	12 591

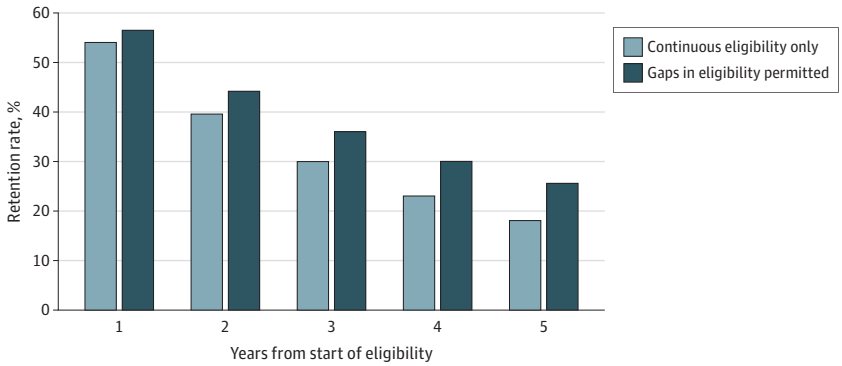
Data on each member from their first episode of external turnover until reenrollment in any line of business or the end of the study period, whichever came first. By limiting the data to the first episode, the assumption that the data are independent allows the assumption that the data are independently and identically distributed across external turnover episodes, thus avoiding the possibility of serially correlated unobservable characteristics. Mortality once a member left the insurer was not documented; thus, we could not distinguish whether a former member did not reenroll due to death or choice. With this inability to account for mortality-related censoring, a lower bound on reenrollment as a share of potential returning enrollees was estimated.

Figure 3. Transitions Following External Turnover (No Censoring)



Members with external turnover (n = 1 887 837) that occurred 3 years before the end of the study period to avoid censoring. Each column displays the coverage type in years 1, 2, and 3 after the initial external turnover of the member.

Figure 4. Member Retention Over Time (No Censoring)



Retention rates for members in subsequent years with and without continuous eligibility from their first eligibility year-month. This share varied according to whether the member was continuously enrolled with the insurer the entire time or whether there were gaps in eligibility (ie, the possibility of return).

Trends Over Time in External Turnover and Reenrollment

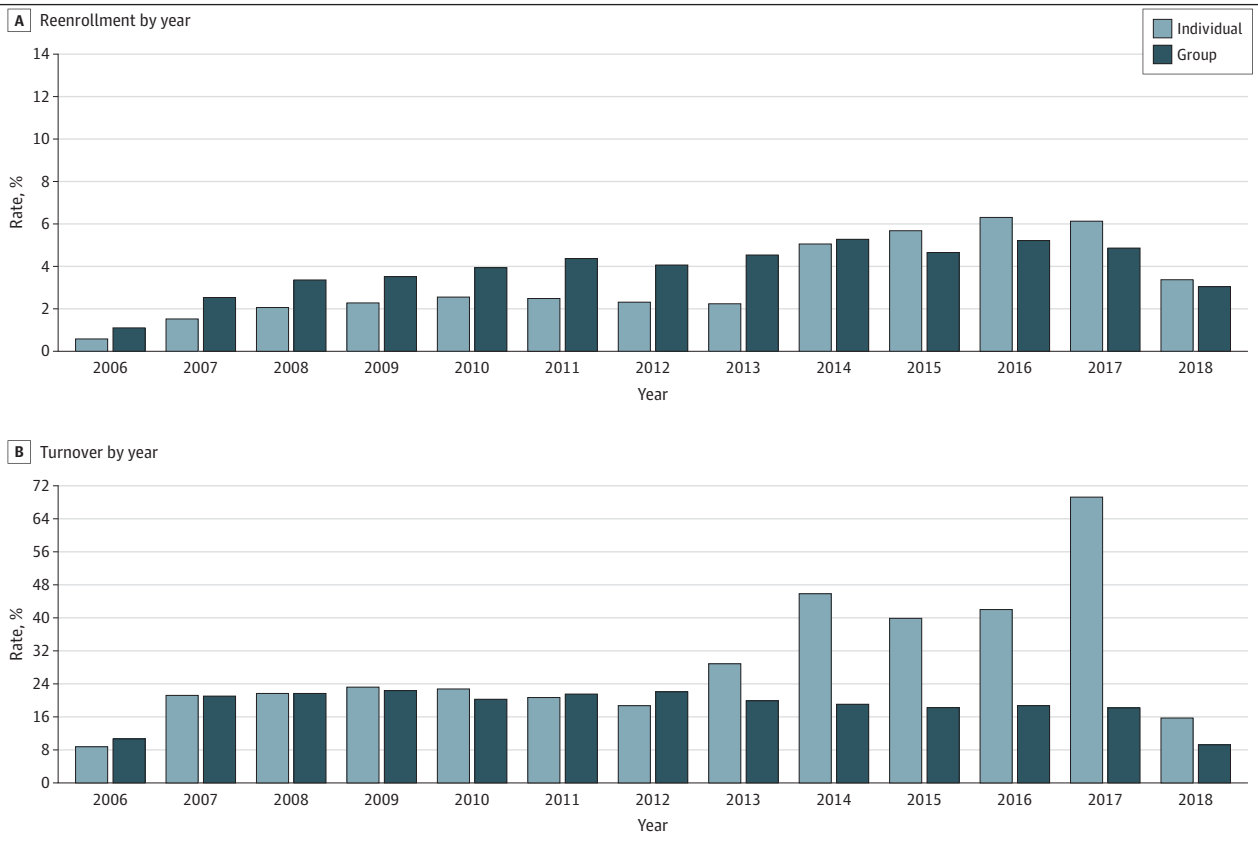
Figure 5 displays annual trends in external turnover and reenrollment by line of business. The turnover rate decreased slightly from 21% in 2007 to 18% in 2017. External turnover in the individual group market accelerated beginning in 2013 and peaked in 2017, after which Anthem stopped participating in many individual marketplaces. Reenrollment rates in the group market increased from 2007 (2.5%) to 2017 (4.5%); reenrollment rates also increased in the individual market from 1.8% in 2007 to 6% in 2017.

Subgroup Analyses

Turnover trends did not differ from Figure 1 by primary coverage or dependent status (eFigure 7 in the Supplement). Substantially different individual turnover rates emerged by age group; adults aged 25 years had generally higher turnover in any given month (4%) and experienced higher group turnover in December (11%). Those aged 64 years experienced substantially higher turnover in the individual market with monthly rates ranging around 6% between January and November and 23% in December. Similarly high rates of individual turnover were observed for those aged 65 years or older. Turnover for healthy individuals was generally higher by approximately 1% across the individual and group markets relative to the unhealthy members.

Reenrollment rates for primary policyholders, dependents, individuals aged 25 years, those aged 26 years and older, more healthy individuals, and less healthy individuals did not vary much compared with the full sample results (eFigure 8 in the Supplement). Generally, reenrollment rates were slightly higher for the individual market than the group market and were 33% after 5 years and between 45% and 50% after 10 years. Reenrollment rates were lower for those aged 64 years and older (15% after 5 years in the individual market and 11% in the group market). After 10 years, the

Figure 5. Trends in Turnover and Reenrollment Over Time



Annual turnover rates and reenrollment rates by line of business across all years.

reenrollment rate in the group market did not surpass 20% but increased to 30% in the individual market.

Discussion

In this study, we noted high rates of external turnover at a large national insurer. Disenrollment was common between 2006 and 2018; however, 25% of the members remained with the insurer for 5 years before disenrolling and 34% returned within 5 years after disenrolling. Accounting for such high reenrollment leads to greater retention rates, which are relevant to health investment decisions. Failure to account for reenrollment can substantially underestimate the share of members expected to be covered at a future time when health investment returns accrue.

Our finding of relatively high reenrollment likely reflects a combination of factors. The insurer's multiple lines of business and its often large market share within these states serve to increase the probability that a given member reenrolls. However, these characteristics are not unique to Anthem. According to the Kaiser Family Foundation, the average market share for the largest insurer in each of the 50 states is above 60%.[21] Thus, one can expect to find similar trends in reenrollment in other non-Anthem states where another insurer has the dominant market share. Our findings may also be relevant to smaller insurers that operate in more narrowly defined markets (eg, within a single region and/or line of business) but with considerable market share. Because we observed that most people in this study reenrolled in the same state and line of business, our results are unlikely to be associated with enrollees leaving the insurer because they move to another state or market.

We noted similar rates of external turnover in most months and reenrollment in Anthem's group and individual businesses. In the commercial markets, annual open enrollment periods prevail, outside of which individuals may change their coverage only when they experience certain qualifying events, such as birth of a child or marriage. However, subgroup analyses showed higher turnover for younger individuals in the group market as well as older individuals in the individual market. Turnover differed across states, especially in the individual market, where we observed lower turnover in states where Anthem has higher market power in the individual market. Our finding that reenrollment rates were substantially higher in high market-power states suggests that market shares are important for both turnover and reenrollment.

Our findings have possible implications for current and future health policy. First, in most states, 90% of the commercial market is captured by 3 insurers or fewer.[21] Given this level of consolidation and the increasing enrollment in Medicaid Managed Care and Medicare Advantage, concerns have been raised about insurer consolidation leading to increased market power and higher health insurance premiums.[22] However, consolidation across and within different lines may also lead to greater continuity in insurance coverage over a person's lifetime. Second, the shifts toward greater privatization of publicly funded insurance benefits, such as Medicaid and Medicare, will likely continue, which will further increase reenrollment rates among commercial insurers. To date, 40 states have Medicaid Managed Care contracts; enrollment grew by 20% from 2020 to 2021, and Medicare Advantage enrollment has been increasing by about 8% per year since 2010.[23] Federal policy discussions, such as Medicare-for-All, which may entail expansions through Medicare Advantage plans, would lead to additional growth in publicly funded insurance benefits administered through commercial insurance companies. Overall, the current health insurance policy sentiment favors growing enrollment and reenrollment among commercial insurance companies across all lines of business.

In addition, our findings carry implications for insurance benefit design, particularly in regard to the extent of mandated care benefits. Certain benefits, such as a policy of no cost-sharing for diabetes care, may be more or less important to mandate depending on how much reenrollment might mitigate underinvestment in these benefits. An insurer must weigh upfront costs of preventive care, screenings, and treatments against the likelihood that any future cost-savings will be realized while the member is still enrolled. High turnover and greater time between the investment and its

future payoff will discourage the coverage of a given service. However, our findings suggest that the probability of reenrollment should also be factored into this decision. When upfront investment costs are low relative to eventual cost-savings, an insurer may find it in their best interest to cover a service at an earlier time so long as a sufficiently large share of members are expected to be covered at the time when savings will be realized. A higher rate of reenrollment upon disenrollment may reduce the leakage of the cost-saving benefits of preventive care investments by the insurer, thus better incentivizing the insurer to offer such benefits.

Limitations

This study has limitations. First, our analysis was limited to one insurer that operates plans across the country. Although our findings may be generalized to other for-profit and nonprofit insurers, they may not generalize to smaller insurers with operations limited to a single line of business. However, even regional insurers often command a large market share in their respective areas.[21] Second, our data are subject to censoring. We did not observe the duration of tenure with the insurer for members enrolled in the first month of the study period. Similarly, right-censoring limited our ability to observe reenrollment that occurred beyond the end of the data window. Third, we may have underestimated the rates of reenrollment among living persons, particularly older members in our sample because we did not have mortality data.

Conclusions

In this study, we observed that the commercial health insurance market displays a substantial level of external turnover. However, many individuals also reenrolled with the same insurer within 5 years. The findings imply that it may be useful for insurers to focus on the long-term health of individuals because many members will return to the same insurer within a relatively short period.

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SUPPLEMENT.

JAMA Health Forum™

Research Letter

Affordability and Access Challenges Among US Subscribers to Nongroup Insurance Plans

Alison A. Galbraith, MD, MPH; Joachim O. Hero, PhD; Alon Peltz, MD, MBA, MHS; Jon Kingsdale, PhD; Rachel S. Gruver, MPH; Anna D. Sinaiko, PhD

Introduction

The Affordable Care Act (ACA) expanded access to nongroup health insurance through insurance Marketplaces with subsidies and decision support. Health care affordability and accessibility in nongroup plans have improved, but challenges remain.[1-5] This cohort study assessed cost-related experiences in nongroup plans purchased on or off the ACA Marketplace and variation by Marketplace enrollment, decision support use, and other characteristics.

Methods

We conducted a panel survey linked to enrollment and claims data from a single insurer in Massachusetts, Maine, and New Hampshire. We surveyed a stratified random sample of subscribers aged 18 to 63 years in 2017 nongroup plans purchased on or off the ACA Marketplaces after open enrollment and again 1 year later. Predictors were enrollment on vs off Marketplace; household income; chronic conditions among family members sharing a plan; health insurance literacy; and use of brokers or navigators, cost estimators, or *provider finders* (tools used to search for in-network physicians, other health care professionals, and hospitals and other health care facilities) at enrollment. Outcomes included self-reported delayed or forgone care due to cost and financial burden, and high out-of-pocket health care costs (>10% of income) and high total spending (net premiums plus out-of-pocket costs >19.5% of income) from claims for all family members in the plan. Analyses excluded subscribers with 6 or fewer months of enrollment and were weighted for sampling design and subscriber nonresponse. We assessed the association between predictors and outcomes using multivariable logistic and linear regression models controlling for subscriber and family characteristics and including an interaction between Marketplace and income group and between Marketplace and family chronic conditions. We estimated the same models adding use of a broker or navigator, cost estimator, and provider finder tool as predictors. Analyses were conducted using Stata, version 14.2 (StataCorp LLC).

This study followed the American Association for Public Opinion Research (AAPOR) and Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guidelines. The Harvard Pilgrim Institutional Review Board approved the study and waived the requirement for written informed consent. See eMethods in the Supplement for details.

Results

Both surveys were completed by 1223 subscribers (response rate of 18%). Of the weighted sample of 1068 subscribers with more than 6 months of enrollment, 25% were aged 35 years or younger, 38% were aged 36 to 55 years, and 37% were aged 56 to 63 years; 47% were male. Of 1068 subscribers with more than 6 months of enrollment, 40.3% had delayed or forgone care due to cost, 41.1% had financial burden, 9.1% had high out-of-pocket costs, and 23.6% had high total spending. In off-Marketplace plans compared with in-Marketplace plans, those with incomes 250% or less of the

+ Supplemental content

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

federal poverty level (FPL) and 250% to 400% FPL had greater probability of high out-of-pocket costs and of high total spending; those with incomes 250% or less FPL also had higher mean total spending and greater probability of high total spending in off-Marketplace plans (**Table 1**). Families with chronic conditions had higher out-of-pocket spending than those without, but for families both with and without chronic conditions, mean total spending and probability of high total spending were greater in off-Marketplace than in-Marketplace plans. There were no differences in delayed/forgone care due to cost or financial burden based on Marketplace enrollment and few differences in outcomes by health insurance literacy or use of decision support (**Table 2**).

Discussion

Affordability challenges were common among nongroup enrollees. For low-income, subsidy-eligible families, enrollment in Marketplace plans was associated with lower risk of high out-of-pocket and high total spending compared with enrollment off-Marketplace, although delayed/forgone care due to cost and financial burden did not differ. Use of brokers or navigators was associated with lower probability of high out-of-pocket costs, but otherwise experiences were no better with decision support. These results suggest that downstream cost-related experiences are less influenced by Marketplace shopping tools. Limitations of this study include low response rate, selection effects, a single regional carrier, a Massachusetts sample that did not include subsidy data or enrollees with incomes less than 300% FPL in a separate Marketplace program, and lack of Marketplace eligibility

Table 1. Adjusted Estimates of Experiences for Enrollees in Nongroup Plans[a]

	Delayed/forgone care (n = 841)[b]		Financial burden (n = 890)		High OOP costs (n = 595)[c]		High total spending (n = 595)[d]		Total spending (n = 595)	
Characteristic	Predicted probability, %	*P* value	Predicted probability, %	*P* value	Predicted probability, %	*P* value	Predicted probability, %	*P* value	Predicted mean, $	*P* value
Income										
<250% FPL										
Marketplace	40.4	.45	43.9	.14	14.0	.002[e]	36.1	<.001[e]	6415	<.001[e]
Off Marketplace	34.2		56.6		43.9		72.3		11 036	
250%-400% FPL										
Marketplace	44.9	.46	45.9	.33	8.7	.92	15.6	<.001[e]	7576	<.001[e]
Off Marketplace	50.9		53.8		8.2		48.1		11 328	
>400% FPL										
Marketplace	40.9	.22	32.6	.46	1.4	.31	11.5	.33	11 158	.91
Off Marketplace	34.1		28.6		0.3		8.2		11 222	
Family with chronic condition										
Marketplace	41.7	.98	49.0	.92	11.8	.001[e]	27.6	<.001[e]	9386	<.001[e]
Off Marketplace	41.8		49.7		32.1		50.1		13 218	
Family without chronic condition										
Marketplace	41.5	.27	35.9	.11	5.0	.21	17.0	.001[e]	8072	<.001[e]
Off Marketplace	35.8		44.1		11.3		35.4		10 072	
Health insurance literacy tertile										
Lowest	45.4	.02	46.7	.02	7.8	.98	22.3	.95	8607	.20
Middle	40.5	.16	37.6	.70	9.6	.60	23.4	.86	8915	.52
Highest	34.0	NA	35.8	NA	7.9	NA	22.6	NA	9243	NA

Abbreviations: FPL, federal poverty level; NA, not applicable; OOP, out-of-pocket.

[a] Results are predicted outcomes from logistic and linear models that were weighted using inverse probability weights to account for sampling and survey nonresponse and controlled for listed variables plus state, age, sex, race and ethnicity, education, employment, family size, having a child in the family, and interaction between Marketplace and income and between Marketplace and chronic condition.

[b] Delayed/forgone care due to cost was measured only among enrollees who reported that they or a family member needed health care during 2017.

[c] High OOP costs = OOP costs for health care services greater than 10% of income.

[d] High total spending = OOP costs for health care services for all family members plus family premium (net of Advanced Premium Tax Credit) greater than 19.5% of family income.

[e] Statistically significant based on Holm-Bonferroni correction.

Table 2. Adjusted Estimates of Experiences in Nongroup Plans Based on Use of Decision Support Tools and Resources During Plan Selection[a]

	Delayed/forgone care (n = 830)[b]		Financial burden (n = 879)		High OOP costs (n = 588)[c]		High total spending (n = 588)[d]		Total spending (n = 595)	
Decision support tool/ resource use	Predicted probability, %	*P* value	Predicted probability, %	*P* value	Predicted probability, %	*P* value	Predicted probability, %	*P* value	Predicted mean, $	*P* value
Used broker or navigator										
Yes	37.5	.45	40.0	.82	3.6	.006[e]	24.0	.76	9060	.83
No, neither	41.3		41.1		9.1		22.6		8943	
Used cost estimator										
Yes	44.5	.08	44.2	.12	7.2	.44	21.5	.49	9067	.62
No	37.4		38.2		9.1		24.0		8880	
Used provider finder										
Yes	39.0	.48	41.8	.69	6.7	.22	24.8	.27	8967	.99
No	41.9		40.2		9.4		21.1		8962	

Abbreviation: OOP, out-of-pocket.

[a] Adjusted results are from models that include all of the listed variables and Marketplace, income, chronic condition in family, health insurance literacy, state, age, sex, race and ethnicity, education, employment, family size, having a child in the family, and interaction between Marketplace and income and between Marketplace and chronic condition.

[b] Delayed/forgone care due to cost was measured only among enrollees who reported that they or a family member needed health care during 2017.

[c] High OOP costs = OOP costs for health care services greater than 10% of income.

[d] High total spending = OOP costs for health care services for all family members plus family premium (net of Advanced Premium Tax Credit) greater than 19.5% of family income.

[e] Statistically significant based on Holm-Bonferroni correction.

data. Despite lower out-of-pocket spending among subsidy-eligible Marketplace enrollees, negative cost-related experiences persist. Our findings suggest that building on ACA coverage gains by expanding eligibility and the amount of subsidies[6] could address the remaining affordability challenges facing nongroup enrollees.

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SUPPLEMENT.

eMethods.

How Has Access to Care for Medi-Cal Enrollees Fared Relative to Employer-Sponsored Insurance 4 Years After the Affordable Care Act Expansion?

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BACKGROUND: The number of Californians covered by Medi-Cal increased more than 50% between 2013 and 2018, largely due to expansion under the Affordable Care Act (ACA). This rapid expansion of Medicaid rolls prompted concerns that Medi-Cal enrollees would face greater difficulty accessing health care.

OBJECTIVE: Examine whether gaps in access to care between Medi-Cal and employer-sponsored insurance (ESI) present in 2013 (prior to ACA implementation) had changed by 2018 (several years post implementation).

DESIGN: Secondary analysis of data from the 2013 and 2018 California Health Interview Survey. The sample included adults of ages 18–64 insured all year and covered by ESI or Medi-Cal at time of interview. Logistic regressions were used to examine variation across years in the association between access to care and insurance type.

MAIN MEASURES: Five access to care outcomes were assessed: no usual source of care, not accepted as new patient in past year, insurance not accepted in past year, delayed medical care in past year, and difficulty getting timely appointment. The main predictors of interest were type of insurance (Medi-Cal or ESI) and survey year (2013 or 2018).

KEY RESULTS: The association between insurance type and access to care changed significantly over time for three outcomes: not accepted as new patient in past year (OR = 0.55, 95% CI = 0.32–0.97), delayed medical care in past year (OR = 1.55, 95% CI = 1.06–2.25), and difficulty getting timely appointment (OR = 0.41, 95% CI = 0.23–0.74). Predicted probabilities indicate gaps between Medi-Cal and ESI narrowed for not accepted as new patient in past year and difficulty getting timely appointment, but widened for delayed medical care.

CONCLUSIONS: Despite the rapid expansion in the number of Californians covered by Medi-Cal, most gaps in access to care between Medi-Cal and ESI enrollees improved or did not significantly change between 2013 and 2018.

KEY WORDS: Medi-Cal; Medicaid; Employer-sponsored insurance; Access to care.

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INTRODUCTION

Medi-Cal, California's Medicaid program, serves as a critical component of the state's health care safety net by providing health insurance coverage for Californians with low incomes. The number of Californians covered by Medi-Cal increased more than 50% from 8 million in 2013 to over 13 million in 2018, largely due to the program's expansion under the Affordable Care Act (ACA).[1] Nationally, total enrollment in Medicaid also increased significantly over this time period.[2] In California, although enrollment in Medi-Cal increased sharply between 2013 and 2015, between 2016 and 2018, enrollment leveled off.[1,3,4]

The sharp increases between 2013 and 2015 in the number of people enrolled in Medi-Cal prompted concerns about the program's ability to meet the health care needs of so many new enrollees. Access to care for Medicaid enrollees is better than that for the uninsured and improved for those who were uninsured and gained Medicaid coverage through ACA expansion.[5,6] However, Medicaid enrollees have consistently reported lower access to care than those enrolled in employer-sponsored insurance (ESI).[7]

This study assesses changes over time in the quality of Medi-Cal participants' access to health care by comparing access to care for Medi-Cal to ESI and determining whether the association between insurance type and access to care changed between 2013 (prior to implementation of the ACA) and 2018. The rapid expansion in Medi-Cal enrollment between 2013 and 2016 and subsequent stability in enrollment through 2018 make this time period particularly interesting to examine changes in any gaps in access to care between Medi-Cal and ESI.

METHODS

Data Source and Population

Data were from the adult sample of the California Health Interview Survey (CHIS) public use files from 2013 and 2017–2018. CHIS is a survey of households drawn from every county in California and is designed to be representative of California's non-institutionalized population. A 2-stage, geographically stratified design with random-digit dialing of landlines and cell phones was used. One randomly selected adult (aged 18 or older) was interviewed in each household. Interviews were conducted in English, Spanish, Chinese, Vietnamese, Korean, and Tagalog (in 2017–2018). The adult response rate after the screening interview (in which survey is introduced and respondents are randomly selected) was 51.5% in 2013 and 42.3% in 2017–2018.[8,9] Detailed descriptions of CHIS methodology are available elsewhere.[10,11]

A total of 20,724 adults completed the survey in 2013 and 42,330 in 2017–2018. To compare access to care for adults with Medi-Cal to those with ESI, our analytic sample was limited to adults of ages 18–64 who were insured for the entire year prior to being interviewed and who had Medi-Cal or ESI coverage at the time of interview. We excluded 23,946 adults of age 65+, 9377 with insurance other than ESI/Medi-Cal, and 1270 not continuously insured. This resulted in an analytic sample of 28,461.

Measures

The primary predictors of interest were type of insurance at time of interview (Medi-Cal or ESI) and survey year (2013 or 2018). Five indicators of access to care were examined as outcomes: (1) no usual source of care other than emergency room, (2) not accepted as new patient by a doctor in past year, (3) insurance not accepted by doctor in past year, (4) delaying or foregoing needed medical care in past year, and (5) not able to get a timely appointment in past year. The last indicator was limited to 9419 adults who reported trying to get an appointment within the next 2 days due to sickness or injury. These respondents were asked about scheduling the appointment. We selected these measures to inform health care system enabling opportunities for the Medi-Cal program to improve access for beneficiaries. The first three measures capture difficulties in making connections to health care systems. The last two measures demonstrate gaps in receiving needed health care.

Our analytic approach follows Long et al.'s use of the Andersen Behavioral Model by augmenting population adjustments based on an individual's health care need, which is conditioned by age, gender, health status, and disability status, with social risk factors that shape access to health care: race/ethnicity, education, English proficiency, income, and rural/urban status.[6,12] Adjustments for these factors increase the comparability of individuals enrolled in Medi-Cal with those in ESI in empirical models.

The following characteristics were included as covariates: age (continuous), gender, race/ethnicity (Latino, non-Latino White, non-Latino Asian, non-Latino Black or African-American, non-Latino American Indian, and a combined category of non-Latino Native Hawaiian/Pacific Islander, non-Latino other race and non-Latino two or more races), income, education level (less than high school, high school graduate, college graduate or higher), English proficiency (limited English proficiency, speaks English well, or speaks English very well combined with speaks only English), and living in an urban or rural area. Household income was examined as percent of the federal poverty level (below 100%, 100–199%, 200–299%, 300% and above). This variable is a ratio of household income to federal poverty threshold (which varies by household size) and is constructed based on household size, household income, and U.S. Census Bureau poverty thresholds. Two health indicators were included: self-reported health status was categorized into excellent/very good, good, and fair/-poor, and self-reported receipt of social security disability income (yes or no) was included as a proxy for long-term disability.

Analyses

Logistic regression analyses were used to examine the association of insurance type with access to care adjusting for the covariates discussed above. Models included year-by-insurance type interactions to test for variations over time in the association between insurance type and access indicators. Post-estimation predicted probabilities were estimated to determine the magnitude of the changes. A difference-in-differences(DID) estimate measuring the net percentage point change between Medi-Cal and ESI over time was estimated, and we applied the delta method to test the significance of the DID estimate. A significant positive DID indicates widening gaps in access over time, whereas a significant negative DID indicates narrowing gaps. CHIS data from 2017 and 2018 were pooled, and weights representing the 2018 California population were applied. Thus, we refer to this year as 2018 throughout the paper. Survey weights are applied to adjust for non-response and survey design effects and to ensure weighted estimates are representative. Several dimensions are used in survey weight development: demographics (age, sex, race, and ethnicity), geographic variables (county), household composition (presence of children in the household), and socioeconomic variables (home ownership and education). The weighted sample was shown to be representative of California's population not living in correctional or congregate housing facilities.[13] Analyses were conducted using SAS 9.4 and Stata 16.0.

RESULTS

Table 1 displays characteristics of the study population and outcome measures stratified by year and insurance type.

Table 1 Population Characteristics of California Adults, Ages 18–64, Insured All Year and Insured by Medi-Cal or ESI at Time of Interview

	2013				2018			
	(*N* = 8776)				(*N* = 19,685)			
	Medi-Cal		ESI		Medi-Cal		ESI	
	%	SE	%	SE	%	SE	%	SE
Age								
18–34	40.23	2.01	32.1	0.78	45.13	1.72	31.61	0.68
35–49	32.35	2.2	35.02	0.79	29.3	0.94	34.84	0.94
50–64	27.42	1.59	32.88	0.62	25.56	1.37	33.55	0.58
Gender								
Male	43.97	2.27	48.96	0.77	43.82	1.29	50.6	0.67
Female	56.03	2.27	51.04	0.77	56.18	1.29	49.4	0.67
Race/ethnicity								
Latino	55.58	2.25	28.32	0.77	57.96	2.52	29.18	1.37
Black or African-American	10.7	1.45	4.93	0.33	6.75	0.59	5.08	0.99
American Indian or Alaska Native	0.76	0.25	0.45	0.09	0.64	0.16	0.25	0.07
Asian	6.39	1.23	17.86	0.71	10.82	2.57	17.46	2.61
Other	2.75	0.67	2.35	0.2	2.69	0.64	2.8	0.42
White	23.82	1.84	46.09	0.84	21.13	1.18	45.22	1.03
Income (as percent of federal poverty level)								
0–99% FPL	53.96	2.3	3.5	0.45	39.92	2.25	4.22	0.83
100–199% FPL	29.57	2.16	11.9	0.86	33.43	1.49	8.07	0.49
200–299% FPL	9.41	1.26	12.7	0.57	13.48	0.97	11.61	1.6
300% FPL and above	7.06	1.15	71.9	0.82	13.18	1.64	76.1	1.13
Educational attainment								
Less than high school	33.67	1.8	7.27	0.49	30.9	1.06	6.32	0.85
High school graduate	58.44	1.98	44.71	1.07	53.57	3.37	38.63	1.44
College graduate or higher	7.89	1.22	48.02	1.07	15.53	2.73	55.05	0.93
English proficiency								
English only/very well	56.2	2.55	82.46	0.78	61.69	2.88	85.68	0.66
Well	16.5	1.93	10.38	0.68	12.94	0.82	8.47	0.69
Limited English proficiency	27.3	2.05	7.16	0.64	25.36	3.15	5.85	0.81
Lives in urban or rural area								
Urban	88.82	1.11	91.53	0.52	88.46	2.16	91.4	0.38
Rural	11.18	1.11	8.47	0.52	11.54	2.16	8.6	0.38
Health status								
Excellent or very good	28.41	2.15	61.39	1.02	31.41	2.17	58.69	1.38
Good	34.64	2.25	27.84	0.97	35.07	2.91	29.97	1.26
Fair or poor	36.95	2.07	10.77	0.74	33.52	1.48	11.35	0.55
Receiving SSDI								
Yes	20.84	1.57	1.21	0.21	11.42	0.87	0.84	0.14
No	79.16	1.57	98.79	0.21	88.58	0.87	99.16	0.14
Has usual source of care								
Yes	82.48	2.03	92.16	0.7	79.05	1.49	91.77	0.65
No	17.52	2.03	7.84	0.7	20.95	1.49	8.23	0.65
Not accepted as new patient by doctor, past year								
Yes	6.41	1.28	2.17	0.21	5.11	0.58	3.3	0.34
No	93.59	1.28	97.83	0.21	94.89	0.58	96.7	0.34
Insurance not accepted by doctor, past year								
Yes	8.41	1.38	2.36	0.29	8.64	0.61	3.4	0.92
No	91.59	1.38	97.64	0.29	91.36	0.61	96.6	0.92
Delayed medical care, past year								
Yes	14.98	1.9	14.44	0.72	16.44	1.17	11.95	0.47
No	85.02	1.9	85.56	0.72	83.56	1.17	88.05	0.47
Able to get timely appointment, past year (among those who sought)								
Yes	82.81	2.93	94.49	0.78	82.61	1.9	86.65	1.65
No	17.19	2.93	5.51	0.78	17.39	1.9	13.35	1.65

Source: 2013 and 2017–2018 pooled California Health Interview Survey. CHIS data from 2017 and 2018 were pooled, and weights representing the California population in 2018 were applied. Thus, we refer to this year as 2018 throughout the paper

Changes in the study population composition were the result of both demographic shifts in California and changes in the populations enrolled in Medi-Cal and ESI. The proportion Latino increased between 2013 and 2018, with a corresponding decrease in the proportion non-Latino White among both Medi-Cal and ESI enrollees. Due to Medi-Cal expansion to all low-income adults (excluding those who are undocumented), Medi-Cal enrollees comprised a larger proportion of the sample in 2018 than in 2013 (32.7% vs 18.2%). A smaller proportion of Medi-Cal enrollees had incomes below 100% federal poverty level (FPL) in 2018 than in 2013, whereas this proportion was slightly larger in 2018 among ESI enrollees. The proportion in fair or poor health decreased among Medi-Cal enrollees but increased among ESI enrollees.

Table 2 and Figure 1 show predicted probabilities for each access indicator as a function of insurance type and year adjusting for sociodemographic and health covariates.

Table 2 Adjusted Probability for Each Access Indicator as a Function of Year and Insurance Type, California Adults Ages 18–64, Insured All Year and Insured by Medi-Cal or ESI at Time of Interview

	2013		2018		2018–2013
	%	95% CI	%	95% CI	
No usual source of care					
Medi-Cal	12.46	8.93–16.00	15.63	11.38–19.89	3.17
ESI	9.01	7.37–10.65	9.66	8.28–11.03	0.65
Medi-Cal-ESI	3.45		5.97		**2.52**
Not accepted as new patient by doctor, past year					
Medi-Cal	5.55	2.71–8.39	4.85	3.45–6.25	− 0.70
ESI	2.23	1.78–2.68	3.43	2.54–4.32	1.20
Medi-Cal-ESI	3.32		1.42		**− 1.90***
Insurance not accepted by doctor, past year					
Medi-Cal	8.06	4.62–11.51	8.54	6.15–10.94	0.48
ESI	2.40	1.81–2.98	3.46	1.35–5.56	1.06
Medi-Cal-ESI	5.66		5.98		**− 0.58**
Delayed medical care, past year					
Medi-Cal	11.94	8.62–15.27	14.00	12.06–15.95	2.06
ESI	15.63	14.07–17.2	12.73	11.66–13.80	− 2.9
Medi-Cal-ESI	− 3.69		1.27		**4.96***
Not able to get timely appointment, past year					
Medi-Cal	14.11	8.25–19.97	15.00	10.11–19.89	0.89
ESI	5.92	4.17–7.67	14.06	9.98–18.14	8.14
Medi-Cal-ESI	8.19		0.94		**− 7.25***

Source: 2013 and 2017–2018 pooled California Health Interview Survey. CHIS data from 2017 and 2018 were pooled, and weights representing the California population in 2018 were applied. Thus, we refer to this year as 2018 throughout the paper. Bolded estimates are difference in differences ESIemployer-sponsored insurance
**Significant at $p < .05$*

Between 2013 and 2018, the percent with no usual source of care increased from 12.5 to 15.6% for Medi-Cal and from 9.0 to 9.7% for ESI (aOR: 1.23, 95% CI: 0.77–1.94). The percent not accepted as new patient decreased from 5.6 to 4.9% for Medi-Cal and increased from 2.2 to 3.4% for ESI (aOR: 0.55, 95% CI: 0.32–0.97). The percent whose insurance was not accepted increased from 8.1 to 8.5% for Medi-Cal and increased from 2.4 to 3.5% for ESI (aOR: 0.73, 95% CI: 0.34–1.56). The percent who reported delaying medical care increased from 11.9 to 14.0% for Medi-Cal and decreased from 15.6 to 12.7% for ESI (aOR: 1.55, 95% CI: 1.06–2.25). The percent not able to get a timely appointment went from 14.1 to 15.0% for Medi-Cal and increased from 5.9 to 14.1% for ESI (aOR: 0.41, 95% CI: 0.23–0.74).

Table 3 displays the logistic regression results adjusted for covariates shown. Year-by-insurance type interactions were significant for three access indicators suggesting gaps in access to care between Medi-Cal and ESI changed between 2013 and 2018 for the following indicators: not accepted as new patient in past year, unable to get timely appointment in the past year, and delayed or did not get needed medical care in past year. Additionally, women were more likely to not be accepted as a new patient or to delay care and those with fair or poor health status were more likely to delay care and to have difficulty getting a timely appointment.

On most measures, Medi-Cal enrollees reported lower access to care than ESI enrollees in 2013. In 2013, Medi-Cal enrollees were significantly more likely than those with ESI to have no usual source of care other than the emergency room, to not be accepted as a new patient, and to not have their insurance accepted. In addition, Medi-Cal enrollees were twice as likely to have had difficulty getting a timely appointment in the past year. Despite these gaps in access, Medi-Cal enrollees were less likely to have delayed receiving needed medical care than those with ESI.

In 2018, Medi-Cal enrollees remained significantly more likely than ESI enrollees to have no usual source of care and to not have their insurance accepted. However, there was no longer a statistically significant difference between Medi-Cal and ESI in the percent not accepted as new patients or that had difficulty getting a timely appointment. Though Medi-Cal enrollees were less likely than ESI enrollees to have delayed care in the past year in 2013, by 2018, they were more likely than those with ESI to do so.

The final column in Table 3 presents the difference-in-differences estimates showing the changes over time in gaps in access between Medi-Cal and ESI with positive values indicating widening gaps between Medi-Cal and ESI. Gaps in access between Medi-Cal and ESI changed for three of five outcomes in this study. Medi-Cal significantly improved relative to ESI on two measures—not accepted as new patient (− 1.90 percentage points) and not being able to get a timely appointment (− 7.25 percentage points)—but experienced a growing gap on delaying needed medical care (4.96 percentage points).

DISCUSSION

Medi-Cal serves as a critical health safety net for more than 13 million Californians. Although research suggests access to care for those with Medi-Cal is better than for the uninsured,

Figure 1 Adjusted predicted probabilities for each access indicator, California adults of ages 18–64, insured all year and insured by Medi-Cal or ESI at time of interview. Blue line, Medi-Cal; orange line, ESI; asterisk, significantly different from 2013; caret, significantly different from ESI. ESI = employer-sponsored insurance. CHIS data from 2017 and 2018 were pooled, and weights representing the California population in 2018 were applied. Thus, we refer to this year as 2018 throughout the paper. Source: 2013 and 2017–2018 pooled California Health Interview Survey

gaps exist between those with Medi-Cal and those with private insurance, particularly ESI.[6] We examined whether these gaps in access to care changed between 2013, prior to implementation of the ACA, and 2018, several years after implementation.

Our findings suggest that access to care within Medi-Cal improved relative to ESI between 2013 and 2018 on some access indicators but not others. When this occurred, it was due less to improvements over time in access to Medi-Cal than to declining access to care among those with ESI. Notably, the narrowed gap between Medi-Cal and ESI on difficulty getting a timely appointment is due almost entirely to an increase among ESI enrollees (from 6 to 14%). More research is needed to understand this increase for ESI as there was little change for Medi-Cal enrollees. Despite the large increase in Medi-Cal enrollment after the ACA's coverage expansion, the proportion of Medi-Cal enrollees that were told a doctor was

Table 3 Logistic Regressions Testing Year-by-Insurance Type Interaction in Models of Access to Care Indicators, California Adults Ages 18–64, Insured All Year and Insured by Medi-Cal or ESI at Time of Interview

	No usual source of care		Not accepted as new patient by doctor, past year		Insurance not accepted by doctor, past year		Delayed medical care, past year		Not able to get timely appointment, past year*	
	AOR	95% CI	AOR	95% CI	AOR	95% CI	AOR	95% CI	AOR	95% CI
Year-by-insurance type interaction	1.23	(0.77–1.94)	**0.55**	**(0.32–0.97)**	0.73	(0.34–1.56)	**1.55**	**(1.06–2.25)**	**0.41**	**(0.23–0.74)**
Year (ref = 2018)										
2013	0.75	(0.52–1.10)	1.15	(0.71–1.88)	0.94	(0.62–1.42)	0.83	(0.58–1.17)	0.93	(0.58–1.49)
Insurance type (ref = Medicaid)										
ESI	**0.55**	**(0.39–0.78)**	0.69	(0.43–1.13)	**0.38**	**(0.16–0.93)**	0.89	(0.72–1.1)	0.93	(0.47–1.81)
Covariates										
Age (continuous)	**0.96**	**(0.95–0.97)**	1.00	(0.99–1.01)	1.00	(0.99–1.01)	1.00	(0.99–1.01)	0.99	(0.98–1.00)
Gender (ref = male)										
Female	**0.47**	**(0.38–0.57)**	**1.49**	**(1.15–1.93)**	1.25	(0.94–1.66)	**1.49**	**(1.18–1.89)**	1.13	(0.66–1.93)
Race/ethnicity (ref = white)										
Latino	1.05	(0.85–1.28)	0.62	(0.36–1.08)	0.73	(0.36–1.48)	**0.79**	**(0.67–0.94)**	1.12	(0.67–1.84)
Black	1.17	(0.49–2.78)	0.76	(0.34–1.72)	0.75	(0.42–1.34)	**0.72**	**(0.52–0.99)**	1.12	(0.57–2.18)
AIAN	0.82	(0.25–2.71)	0.42	(0.09–1.99)	0.90	(0.19–4.32)	1.46	(0.59–3.62)	1.59	(0.12–21.09)
Asian	1.05	(0.78–1.41)	1	(0.63–1.59)	0.85	(0.51–1.41)	**0.67**	**(0.51–0.89)**	0.81	(0.49–1.34)
Other	1.1	(0.41–2.93)	1.53	(0.83–2.85)	1.44	(0.83–2.49)	0.99	(0.59–1.68)	1.49	(0.67–3.34)
Income (ref = 300% FPL and above)										
0–99% FPL	1.38	(0.81–2.34)	1.14	(0.77—1.71)	1.30	(0.86–1.96)	**1.60**	**(1.23–2.07)**	1.28	(0.52–3.16)
100–199% FPL	1.35	(0.95–1.92)	1.06	(0.67–1.67)	1.13	(0.54–2.36)	1.07	(0.78–1.46)	1.10	(0.76–1.58)
200–299% FPL	1.18	(0.71–1.97)	0.94	(0.51–1.71)	1.55	(1.00–2.42)	1.09	(0.83–1.45)	1.36	(0.89–2.08)
Educational attainment (ref = college graduate or higher)										
Less than high school	**1.8**	**(1.32–2.44)**	0.88	(0.46–1.69)	0.86	(0.41–1.80)	1.09	(0.69–1.71)	1.06	(0.60–1.90)
High school graduate	0.99	(0.66–1.47)	1.49	(0.76–2.90)	1.18	(0.75–1.85)	1.02	(0.71–1.46)	1.01	(0.61–1.67)
English proficiency (ref = English only/very well)										
Limited English proficiency	**1.94**	**(1.06–3.55)**	0.87	(0.13–5.68)	0.71	(0.08–6.66)	**0.38**	**(0.24–0.61)**	0.47	(0.17–1.31)
Speaks English well	0.99	(0.66–1.49)	1.14	(0.70–1.86)	0.81	(0.49–1.35)	**0.60**	**(0.45–0.81)**	0.79	(0.36–1.71)
Lives in urban or rural area (ref = urban)										
Rural	1.03	(0.67–1.59)	1.41	(0.62–3.23)	1.09	(0.77–1.54)	0.98	(0.71–1.36)	1.06	(0.75–1.52)
Health status (ref = excellent/very good)										
Fair or poor	0.98	(0.75–1.27)	1.28	(0.83–1.97)	1.46	(0.90–2.37)	**2.44**	**(1.98–3.01)**	**1.77**	**(1.18–2.66)**
Good	0.98	(0.82–1.18)	0.99	(0.66–1.50)	1.07	(0.82–1.40)	**1.59**	**(1.32–1.92)**	**1.44**	**(1.03–2.02)**
Receiving SSDI (ref = no)										
Yes	0.83	(0.55–1.26)	**1.99**	**(1.13–3.52)**	1.04	(0.60–1.78)	1.05	(0.76–1.45)	0.93	(0.51–1.72)

Source: 2013 and 2017–2018 pooled California Health Interview Survey. CHIS data from 2017 and 2018 were pooled, and weights representing the California population in 2018 were applied. Thus, we refer to this year as 2018 throughout the paper. Bold type indicates significant association, $p < 0.05$

AIAN American Indian or Alaska Native

**Limited to adults who sought an appointment within 2 days*

not accepting new patients or who were not able to get a timely appointment did not change significantly after adjusting for changes in the Medi-Cal population. Instead, declines in access among ESI enrollees played a larger role in declining gaps between Medi-Cal and ESI. This suggests that changes in access to care are not specific to Medi-Cal but associated with a broader shift in accessibility of health care within California. However, the fact that Medi-Cal coverage expanded so dramatically within a short time period without leading to a corresponding erosion in access to care should not be ignored.

One exception occurred among the percentage who delayed needed medical care in the past year. The percentage who delayed care among Medi-Cal enrollees increased slightly, while decreasing among those with ESI, leading to a significant increase in the gap between Medi-Cal and ESI. It is notable that this occurred despite the lack of change in Medi-Cal enrollees' ability to find a doctor that accepts new patients and/or accepts their health insurance and to make an appointment with their doctor in a timely manner. This suggests that these delays in care derive from a source other than the failure of connections with the health care system. It is possible that the expansion of Medi-Cal to the long-term uninsured might have led to different health care use patterns that may dissipate over time as these populations learn to navigate the health care system.

Though the change was not significant, the results also show an increase in the proportion of Medi-Cal enrollees who report having no usual source of care. This could be due to new enrollment of the previously long-term uninsured population and might indicate difficulties these populations face in creating connections to the health care system.[14,15] Other research suggests that the newly insured experience

barriers to care including problems navigating the health system, not knowing how to use coverage, cost concerns, or difficulty finding a provider.[15,16] Enabling connections to the health care system is important for long-term health outcomes of these populations. Those with a usual source of care are more likely to seek preventive treatment, which can lead to fewer hospitalizations and medical costs in the future.[17]

In most cases, improved access for Medi-Cal enrollees relative to ESI was driven by declines in access among ESI enrollees. While enrollment in Medi-Cal was considerably higher in 2018 than 2013, the proportion with ESI did not differ between 2013 and 2018.[18] It is unlikely that worse access among ESI enrollees was due to decreases in the proportion with employer coverage. Rather, other factors likely influenced health care access within California. For example, health literacy has been associated with delaying health care and difficulty finding a provider, and adults with public insurance, like Medi-Cal, are more likely to have lower health literacy.[19,20] It is also possible that new Medi-Cal enrollees delay care due to cost concerns because they may not realize there are no copays, deductibles, or out-of-pocket payments.

It is worth noting that after 2018, enrollment in Medi-Cal began declining but then increased again in 2020–2021, likely due to economic impacts of the pandemic and rules preventing eligibility redeterminations.[4,21] Although the present study used data collected prior to the Covid-19 pandemic, the overall finding that sharp increases in Medi-Cal enrollment were not associated with worse access to care for Medi-Cal enrollees suggests that Medi-Cal is an asset that may have helped mitigate some of the economic impacts of the pandemic in California.

This study has some limitations. First, while individuals had to be insured continuously for the past year to be included, they did not have to be insured with the same coverage type. This means that individuals could have been enrolled in a different source of coverage at the time of any gaps that they reported. However, restricting the sample to respondents with continuous health insurance coverage reduces the likelihood of churn in this sample. Medi-Cal coverage is renewed annually, although renewal is automatic for most. Second, our analysis was based on data from a single state and the findings may not extend to the experience of enrollees in other states. Third, the outcomes we examined rely on self-report and may be subject to recall bias or error. Finally, California prepared for the implementation of the ACA's Medicaid expansion, through its Low Income Health Program (LIHP). Starting in 2010, LIHP allowed counties to expand coverage to adults with incomes below 138% FPL before the federal Medicaid expansion went into effect. Nearly 500,000 Californians participated in LIHP. This early expansion of Medi-Cal helped boost enrollment in Medicaid and prepare Californians for coverage protections offered by the ACA.[22] As a result, a comparison between 2013 and 2018 may not fully capture pre- and post-expansion. However, there was still a 50% increase in Medi-Cal enrollment between 2013 and 2018 (5 million more enrollees), so the current analysis still provides a useful assessment of how gaps in access to care may have changed following a large influx of enrollees.

Despite the rapid expansion in the number of Californians covered by Medi-Cal, most gaps in access to care between Medi-Cal and ESI enrollees improved or did not significantly change between 2013 and 2018. However, when gaps between Medi-Cal and ESI improved, this tended to occur because of declines in access to care among those with ESI, and gaps on delays in care widened. Thus, our findings broadly suggest that there is room for improving connections to the health system—ensuring a usual source of care, increasing the supply of providers that will take Medi-Cal patients, and incentivizing providers to see Medi-Cal patients. Some of these connections to the health care system were more favorable for Medi-Cal enrollees in 2018 than they were in 2013. Strengthening health care system connections could reverse the troubling trend of widening disparities between Medi-Cal and ESI in delays or foregone needed medical care. Policy improvements in these access-to-care areas are critical for timely and appropriate care, and would improve the health and well-being of the 13 million Californians covered by Medi-Cal. Nevertheless, the fact that Medi-Cal coverage expanded so dramatically within a short time period without leading to a corresponding erosion in access to care suggests that access to care for Medi-Cal enrollees was not significantly negatively impacted by the sharp increase in enrollment.

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Declarations:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

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Resource

Estimates of Sources of Health Insurance in California for 2023

February 11, 2022

Prepared by
California Health Benefits Review Program

www.chbrp.org

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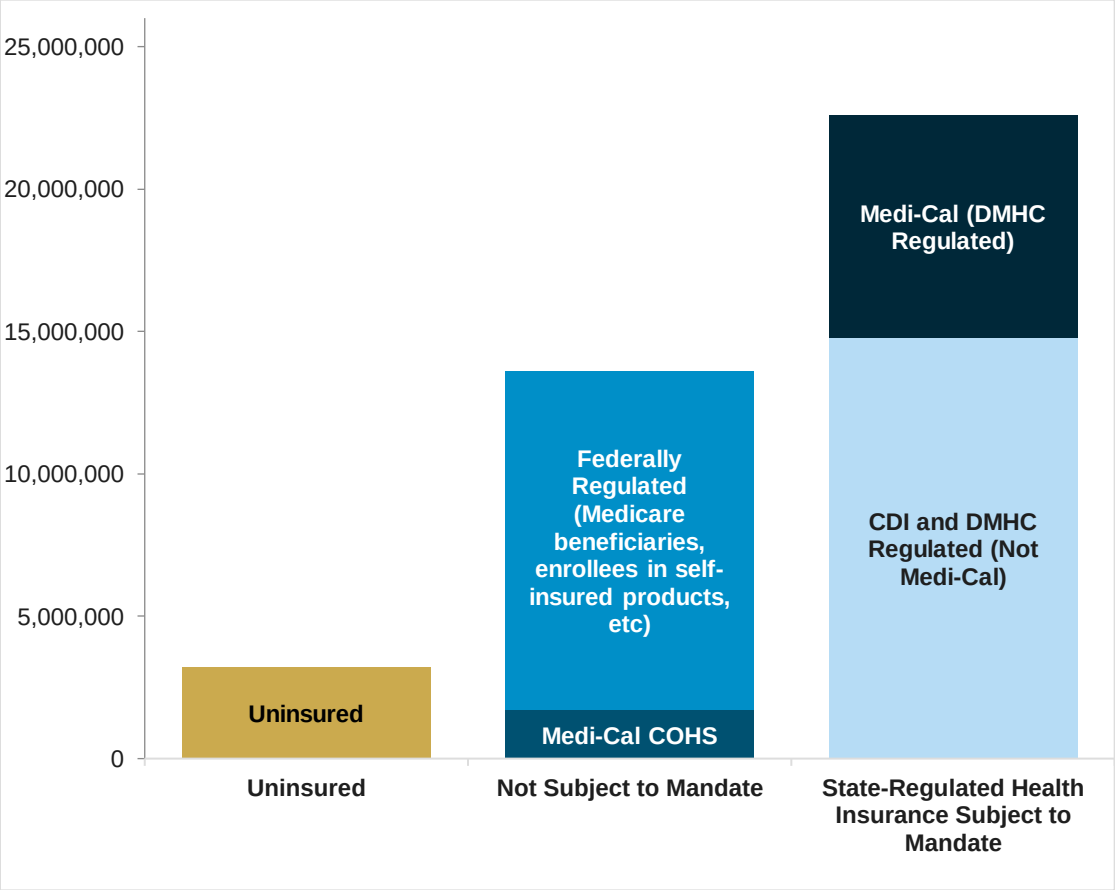
OVERVIEW

At the request of the California State Legislature, the California Health Benefits Review Program (CHBRP) provides prompt, independent, and rigorous evidence-based analyses of proposed health insurance benefit[1] laws that would impact Californians enrolled in health plans regulated by the California Department of Managed Care (DMHC) and health policies regulated by the California Department of Insurance (CDI). These are enrollees whose benefits are subject to state regulation and can be influenced by the proposed state-level legislation.

As shown in Figure 1, most Californians will be enrolled in health insurance regulated by either the California Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI). Other Californians will have other types of health insurance or will remain uninsured.

Figure 1. Health Insurance by Regulator in California, 2023



Source: California Health Benefits Review Program, 2022.
Key: COHS = County-Organized Health System; CDI = California Department of Insurance; DMHC = California Department of Managed Health Care

In 2023, CHBRP estimates that California's population will be 39.4 million. Figure 1 presents several key elements regarding the sources of health insurance in California:

- 57.9% will be enrolled in DMHC-regulated health care service plans or CDI-regulated health insurance policies. This figure includes beneficiaries of Medi-Cal (California's Medicaid program) who are enrolled in DMHC-regulated plans (about 82.4% of all Medi-Cal beneficiaries).

[1] Established in 2002, CHBRP's authorizing statute is available at: http://www.chbrp.org/faqs.php.

- 34% will have health insurance associated with some other regulator. These are primarily Californians who are Medicare beneficiaries or who are enrolled in self-insured products. This figure also includes Medi-Cal beneficiaries enrolled in County-Organized Health System (COHS) managed care plans. These Californians will have health insurance that is not subject to state-level health insurance laws.
- Approximately 8.1% of Californians will be uninsured in 2023.

CHBRP most frequently analyzes state-level health insurance laws to which only DMHC-regulated plans or CDI-regulated policies may be subject.

ESTIMATES OF SOURCES

Annually, CHBRP updates its Cost and Coverage Model to estimate baseline health insurance enrollment and to project marginal, incremental impacts on benefit coverage, utilization, and cost of proposed health insurance benefit legislation.[2] The California Legislature generally proposes laws that would take effect in the following calendar year or later (if enacted, bills proposed in 2022 would generally take effect in 2023). For this reason, CHBRP annually projects the state's future distribution of health insurance by market segment for the calendar in which analyzed legislation would go into effect (following January).

As noted, health insurance available through DMHC-regulated plans and CDI-regulated policies may be subject to state-level benefit-related legislation written into one or two sets of laws: the Health and Safety Code (enforced by DMHC) and/or the Insurance Code (enforced by CDI). However, such legislation may be written to exempt some health insurance market segments or to exempt health insurance associated with certain purchasers. To correctly determine the impact of proposed legislation, CHBRP determines estimates of Californians' sources of health insurance, as displayed in Table 1 (Appendix A).[3]

Although some Californians have more than one type of health insurance either at the same time or throughout the year, for analytic purposes, CHBRP identifies (excepting those dually eligible for Medi-Cal and Medicare) enrollment in the person's primary form of health insurance and presents a snapshot in time. For this reason, some estimates of sources of insurance may be different than the numbers CHBRP estimates. Medi-Cal, for example, reported annual enrollment of almost 14 million beneficiaries in 2021.[4] The Department of Health Care Services (DHCS) reports every individual receiving benefits through Medi-Cal at any point during the year, which is a different type of estimate than that presented by CHBRP.

Enrollment by Regulator

Among Californians with health insurance coverage:

- 13.9 million Californians will be enrolled in non-CalPERS commercial DMHC-regulated plans or CDI-regulated policies.
- 9.75 million Californians will be Medi-Cal beneficiaries, the majority of whom are enrolled in DMHC-regulated plans.

[2] Information on the Cost and Coverage Model is available at: http://www.chbrp.org/analysis_methodology/cost_impact_analysis.php.
[3] Technically, some sources of what are commonly referred to as "health insurance," such as Medicare, are actually "entitlements." For ease of communication CHBRP has grouped all sources together.
[4] Medi-Cal enrollment figures are available at: https://www.dhcs.ca.gov/dataandstats/Pages/Medi-Cal-Eligibility-Statistics.aspx.

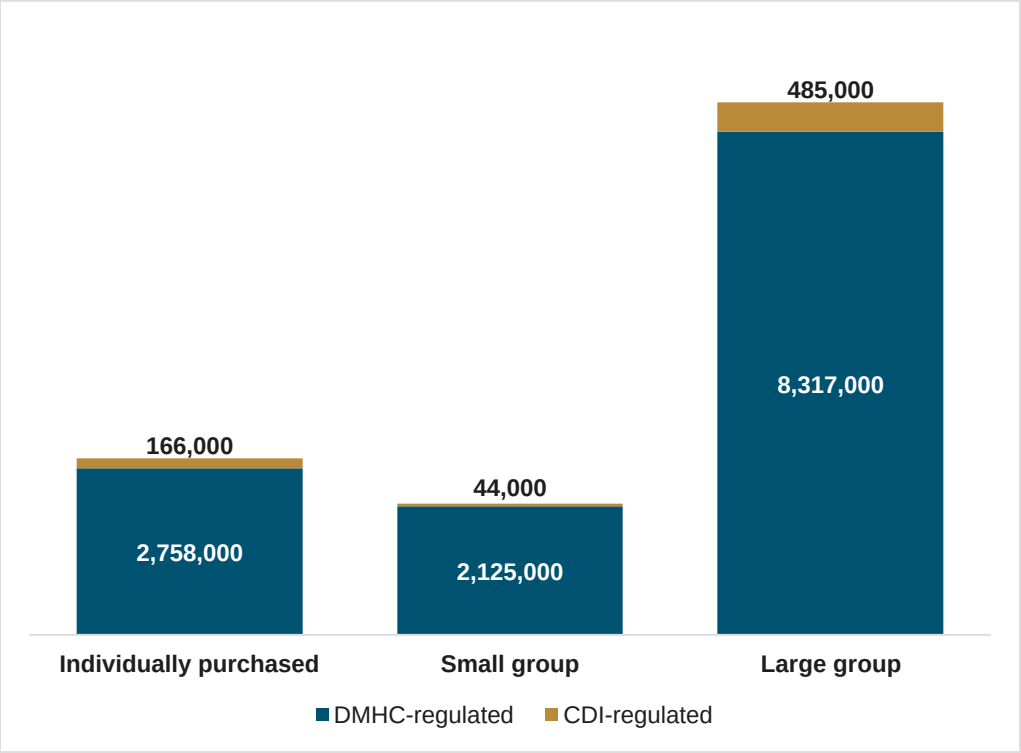
- 1.2 million Californians will have health insurance associated with CalPERS, the majority of whom are enrolled in DMHC-regulated plans.

- As will 325,000 enrollees associated with CalPERS, 5.4 million more Californians will be enrolled in self-insured products, which are not subject to state-level health insurance legislation. Almost 6 million Californians will be enrolled in Medicare (non-Duals) or other public coverage such as TRICARE or Veterans Affairs health care.

Enrollment by State-Regulated Market Segment

As shown in Figure 2, 63.3% of enrollees in privately funded commercial DMHC-regulated plans or CDI-regulated policies will be associated with the large group market (101+ enrollees). A majority of these enrollees will be in DMHC-regulated plans.

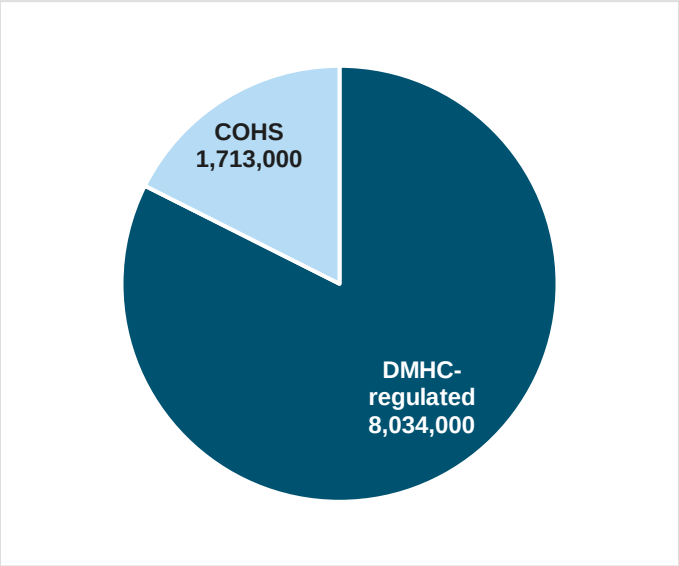
Figure 2. Enrollment in Privately Funded Commercial DMHC-Regulated Plans or CDI-Regulated Policies, 2023



Source: California Health Benefits Review Program, 2022.

Key: DMHC = California Department of Managed Health Care; CDI = California Department of Insurance

Figure 3. Enrollment in Medi-Cal, 2023

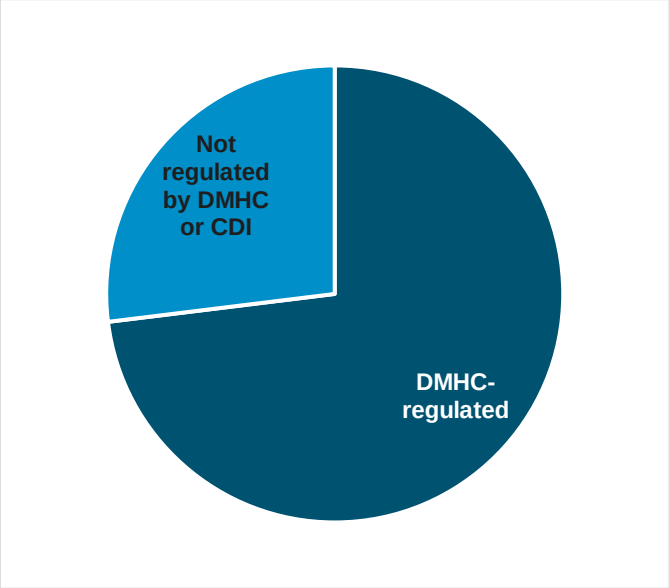


More than three-quarters (82.4%) of Medi-Cal beneficiaries will be enrolled in DMHC-regulated plans. The rest will be enrolled in County-Organized Health System (COHS) managed care.[5]

Source: California Health Benefits Review Program, 2022.

Key: DMHC = California Department of Managed Health Care; COHS = County-Organized Health System

Figure 4. Enrollment in CalPERS, 2023



Approximately 73.1% of CalPERS enrollees will be enrolled in DMHC-regulated plans. The remaining CalPERS enrollees are associated with CalPERS' self-insured health insurance products, which are not subject to state-level health insurance legislation.

Source: California Health Benefits Review Program, 2022.

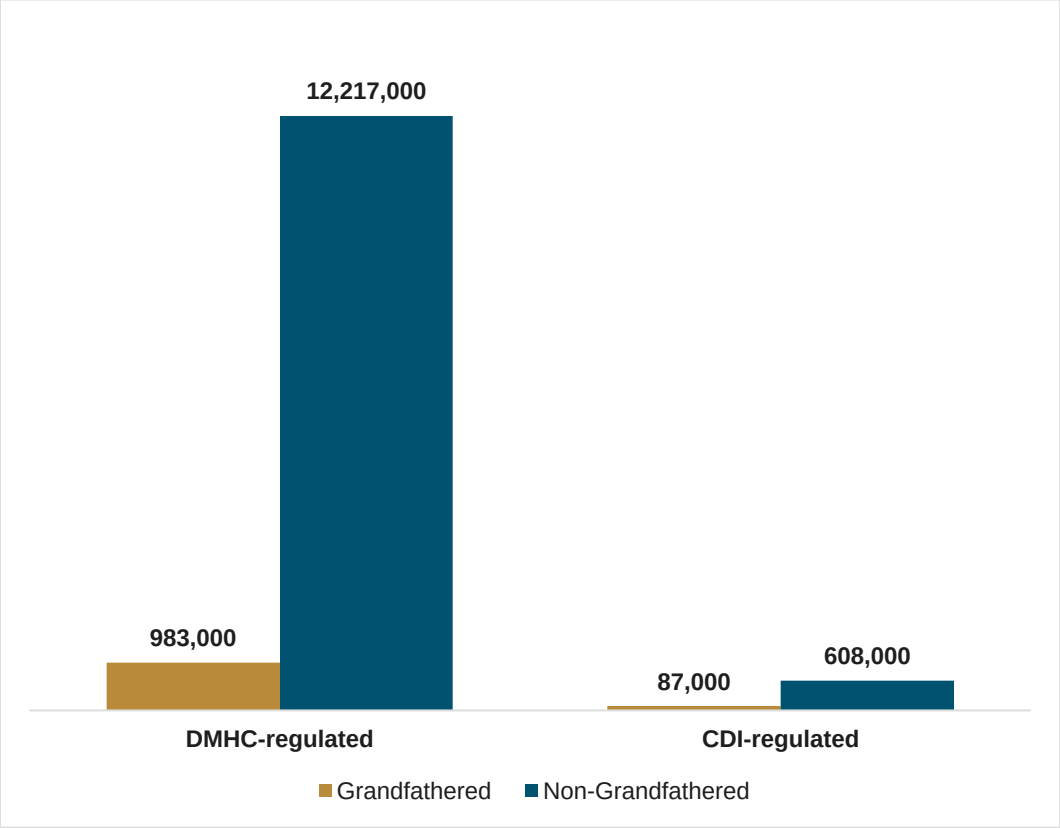
Key: DMHC = California Department of Managed Health Care; CDI = California Department of Insurance

[5] Beginning in 2022, the Department of Health Care Services (DHCS) began implementing the California Advancing and Innovating Medi-Cal (CalAIM) initiative. Major changes include a shift of most beneficiaries from fee-for-service to DMHC-regulated Medi-Cal managed care plans. Of those who remain in fee-for-service, the benefits are not equivalent to full-scope Medi-Cal and, for CHBRP's purposes, beneficiaries are therefore classified as uninsured or with other insurance sources, if present. More information about CHBRP's approach is included in the *2022 Cost Impact Analyses: Data Sources, Caveats, and Assumptions* document, available at: https://www.chbrp.org/analysis_methodology/cost_impact_analysis.php.

Grandfathered Plans and Policies

The continued, although diminishing, presence of grandfathered plans and policies [privately funded plans and policies in existence before the Affordable Care Act (ACA) was signed] is relevant to CHBRP's analyses of health insurance bills because these plans and policies are not subject to the same requirements as are others (and so could be differently affected by a new health insurance law).[6] For example, grandfathered plans and policies are not required by the ACA to: (1) cover specific preventive services without cost sharing; (2) restrict cost sharing for emergency services; or (3) cover essential health benefits (EHBs).[7,8] As shown in Figure 5, 7.45% of DMHC-regulated plans are grandfathered and 12.52% of CDI-regulated policies are grandfathered.

Figure 5. Grandfathered vs. Non-Grandfathered DMHC-Regulated Plans and CDI-Regulated Policies



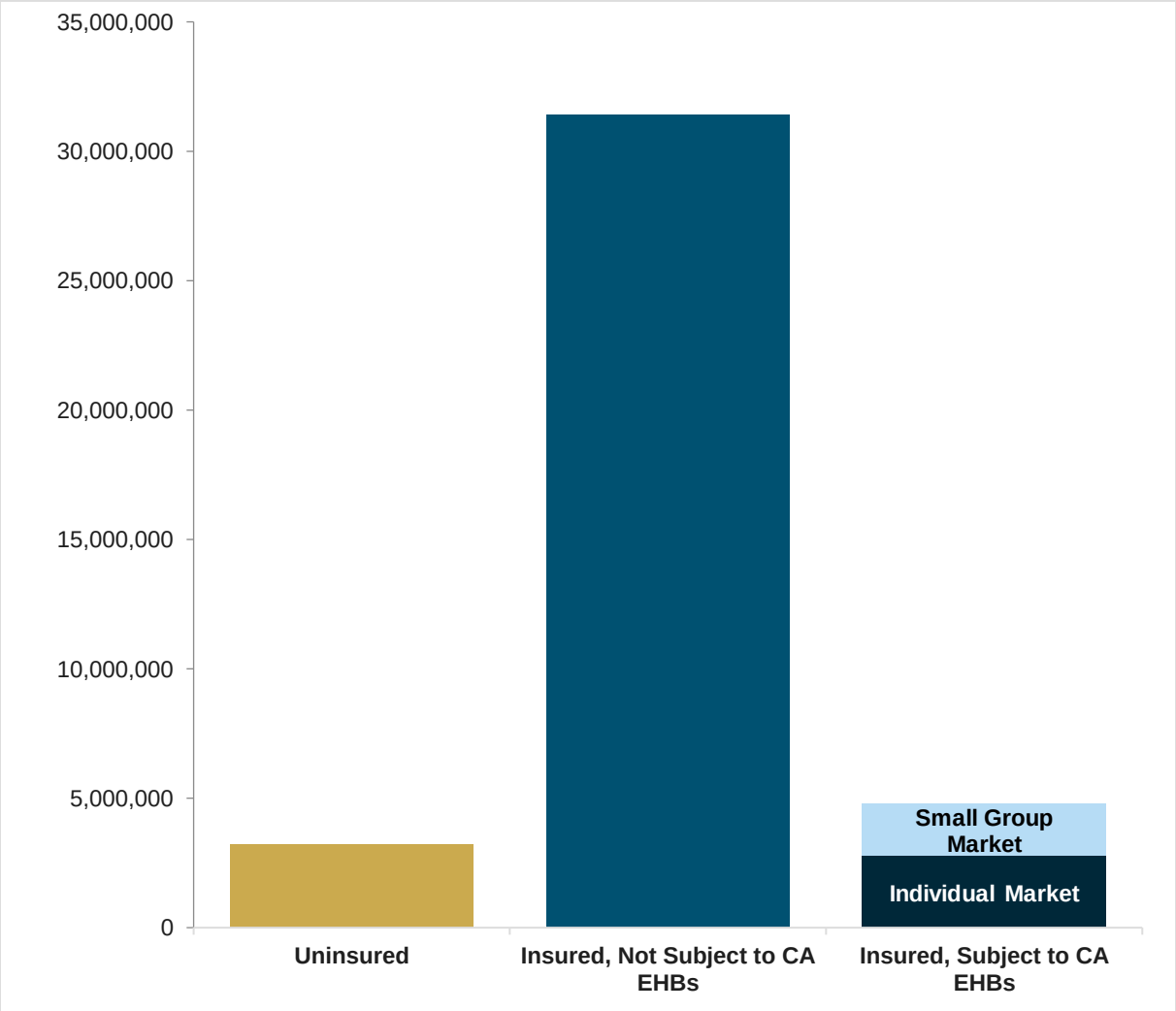
Source: California Health Benefits Review Program, 2022.
Key: DMHC = California Department of Managed Health Care; CDI = California Department of Insurance

[6] A grandfathered health plan is "a group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Plans or policies may lose their 'grandfathered' status if they make certain significant changes that reduce benefits or increase costs to consumers." See http://www.healthcare.gov/glossary/grandfathered-health-plan, accessed on December 7, 2021.
[7] As indicated in federal and California state law, non-grandfathered group and individual health insurance plans and policies must cover certain preventive services. See CHBRP's resource, *Federal Preventive Services Mandate and California Benefit Mandates*, available at: http://chbrp.org/other_publications/index.php.
[8] The essential health benefits categories are: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, including behavioral health treatment, prescription drugs, rehabilitation and habilitation services and devices, laboratory services, preventive and wellness services and chronic disease management, pediatric services, including oral and vision care. See CHBRP's brief, *California's State Benefit Mandates and the Affordable Care Act's "Essential Health Benefits*," available at: http://chbrp.org/other_publications/index.php.

Essential Health Benefits

The Affordable Care Act requires each state to create a set of essential health benefits (EHBs) that some state-regulated health insurance must cover.[9] In California, individual and small-group health insurance regulated by DMHC or CDI is generally required to cover EHBs. As noted in Figure 6 below, approximately 12.1% of California's population (4.77 million enrollees) has health insurance required to cover EHBs. Approximately 2.1 million enrollees purchase individual or small group coverage directly through Covered California and 916,000 enrollees purchase off-exchange mirror plans. The remaining 1.75 million enrollees purchase other off-exchange non-grandfathered individual and small group coverage.

Figure 6. Enrollees in California Health Insurance Subject to Essential Health Benefits, 2023



Source: California Health Benefit Review Program, 2022.
Notes: *"Insured, Not Subject to CA EHBs" includes Medicare beneficiaries, enrollees in self-insured or large group plans/policies, and enrollees in grandfathered individual and small group plans/policies
Key: CA = California; EHBs = Essential Health Benefits

[9] Essential Health Benefits requirements and parameters are discussed in Section 1302 of the Affordable Care Act. More information is available online at https://www.healthcare.gov/glossary/essential-health-benefits/.

CONCLUSION

To estimate potential impacts of health insurance benefits legislation, CHBRP develops forward-looking estimates of health insurance enrollment in California. Annual updates to CHBRP's Cost and Coverage Model are necessary to project insurance enrollments by market segment and associated with certain purchasers.

The resulting projections of sources of health insurance in California are key to CHBRP's analytic work, and may be of use to the Legislature and to others interested in California health policy.

APPENDIX A

Table 1. Sources of Health Insurance in California, 2023

Publicly Funded Health Insurance				
	Age	**DMHC-regulated**	**Not regulated by DMHC or CDI**	**Total**
Medi-Cal	0-17	3,349,000	**	3,349,000
	18-64	3,271,000	**	3,271,000
	65+	56,000	**	56,000
Medi-Cal COHS	All	-	1,713,000	1,713,000
Other Public	All	-	-	544,000
Dually eligible Medicare & Medi-Cal	All	1,358,000	0	1,358,000
Medicare (non Medi-Cal)	All	-	-	5,388,000
CalPERS	All	881,000	325,000	1,206,000

Privately Funded Health Insurance						
		DMHC-regulated		**CDI-regulated**		
	Age	*Grand-fathered*	*Non-Grand-fathered*	*Grand-fathered*	*Non-Grand-fathered*	**Total**
Self-insured	All	-	-	-	-	5,404,000
Individually purchased, Subsidized CovCa	0-17	-	66,000	-	2,000	68,000
	18-64	-	1,719,000	-	53,000	1,772,000
	65+	-	-	-	-	-
Individually purchased, Non-Subsidized CovCA and outside CovCA	0-17	15,000	174,000	16,000	6,000	211,000
	18-64	61,000	708,000	64,000	24,000	857,000
	65+	1,000	14,000	1,000	*	16,000
Small group	0-17	38,000	450,000	*	10,000	498,000
	18-64	124,000	1,476,000	*	33,000	1,633,000
	65+	3,000	34,000	*	1,000	38,000
Large group	0-17	203,000	2,080,000	2,000	132,000	2,417,000
	18-64	525,000	5,363,000	4,000	339,000	6,231,000
	65+	13,000	133,000	*	8,000	154,000

Uninsured	
Age	**Total**
0-17	323,000
18-64	2,839,000
65+	36,000
California's Total Population	**39,382,000**

Source: California Health Benefits Review Program, 2022.
Notes: *Less than 500 enrollees.

**The implementation of CalAIM will result in most fee-for-service Medi-Cal beneficiaries migrating to managed care. Of those who remain in fee-for-service, the benefits are not equivalent to full-scope Medi-Cal and, for CHBRP's purposes, beneficiaries are therefore classified as uninsured or with other insurance sources, if present.
Key: CDI = California Department of Insurance; CalPERS = California Public Employees' Retirement System; COHS = County-Organized Health System; CovCA = Covered California (the state's health insurance marketplace); DMHC = California Department of Managed Health Care

Table 1 includes CHBRP's estimates of Californians' sources of health insurance. Table 1 is organized by column (regulation) and row (market segment) and divided in two (publicly and privately funded health insurance).

This table indicates: (1) the number of Californians enrolled in health insurance market segments and (2) the number of Californians associated with a purchaser that might be of interest to the California Legislature - including enrollees associated with Medi-Cal, California Public Employees' Retirement System (CalPERS), and Covered California.

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.

Detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP analyses and other publications are available at http://www.chbrp.org/.

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